Board of Directors' Meeting
10 February 2022

Agenda item	011/22			
Report	Integrated Performance Report			
Executive Lead	**Louise Barnett, Chief Executive Officer**			
	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:	QSAC and FPAC during January 2022.			
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 December 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. Where performance is below expected levels an exception report has been included that describes the key issues, actions and mitigations being taken to improve the performance. Planned year-end positions have been included in the overall dashboard and planned monthly performance trajectories have been included on a number of the SPC charts. The executive summary is included at the front of the report and metrics reported under functional headings for quality and Safety: Patient Harm, Patient Experience, and Maternity Services. Indicators performing in accordance with plan are included in Appendix 1 for completeness. The overarching dashboard indicates the Committee of the Board that has responsibility for scrutinising the performance of the particular indicator. The Committee is requested to **Discuss** the content of this report.			
Appendices	1.Indicators performing in accordance with expected standards 2.Understanding SPC charts 3. Glossary of terms			

Integrated Performance Report

Purpose

This report provides the Board with an overview of the performance of the Trust. It reports the key performance measures determined by the board using analysis over time to demonstrate the type of variation taking place and the level of assurance that can be taken in relation to the delivery of performance targets. Narrative reports to explain the position, actions being taken and mitigations in place are provided for each measure. Following scrutiny by the appropriate Committees of the Board where performance is below expected levels the narrative provides an exception report for the Board of Directors.

The Board of Directors integrated performance report is aligned to the Trust's functional domains and includes an overarching executive summary.

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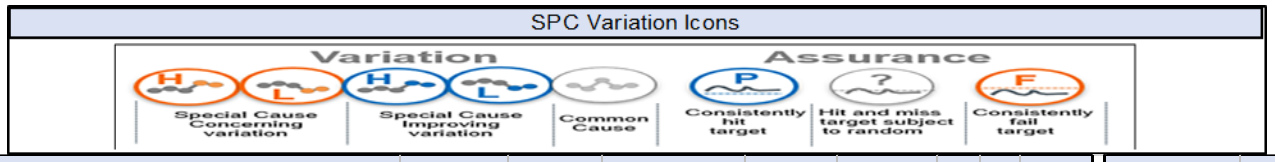
1. Executive Summary
Louise Barnett, Chief Executive

- During December a level 4 national incident was declared. The trust responded well in mobilising its control centre, stepping down non-essential activities and focussing on meeting the challenges created by the Omicron wave of the COVID-19 pandemic. Our staff have continued to work tirelessly to meet the additional challenges.
- December has seen a continuation in the prevalence of COVID-19 in the community and the number of patients admitted with COVID-19.This has had significant impact on our staff availability and that of partner organisations resulting in us experiencing difficulty in discharging patients in a timely fashion to create the necessary capacity for newly admitted patients. The flow out of the hospital to safely discharge our patients has been constrained, necessitating us instigating our surge plans during the latter part of the month. Unfortunately this has resulted in loss of some of our elective activity, which we are working to recover both internally and with independent sector partners during January.
- Our staffing vacancies have been compounded by staff absences due to COVID-19 and other illness in December. We actively are supporting staff to improve their health and well-being as well as promoting the vaccination programmes for both COVID-19 and influenza vaccines to staff. Our recruitment of overseas staff has continued with our first overseas radiographers coming into post during December and further increases in our overseas nursing.
- We continue to work to deliver our plans for elective and non-elective activity. We have had good patient take-up of opportunities to have treatment in the independent sector, continue to make use of the Vanguard, new eye suite facilities and the additional mobile CT scanner. We have seen an increase in demand for cancer services and are clinically prioritising these patients.
- Our work on unscheduled care is striving to improve flow at our front door by reducing the time from being medically fit for discharge to being discharged. We are working closely with local authority and community partners to focus on discharge ready patients on pathways 1, 2 and 3 and to bring earlier in the day the time of discharge to release beds to our emergency department admissions and enable ambulance handover to improve. We have run several multi-agency discharge events during the first half of January to further support this. We are also working with partners on the winter admission avoidance schemes and set up a virtual ward to enable patients to be managed with clinical supervision in their own homes.
- Our Getting to Good CQC action plan has been developed and submitted in response to the recent inspection report.
- We remain focussed on delivering the actions outlined in the first Ockenden report and are continuing to make positive progress with 75% of action complete.
- The financial position, while showing an improved cashflow, is one of an adverse deficit position due to the impact of expenditure on elective recovery and operational and workforce pressures. The capital programme has increased in value and is currently underspent.

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 2021-2022 Plan
Mortality										
HSMR	QSAC	Oct 21	104.1	100	100			Yes		100
RAMI	QSAC	Oct 21	98.8	100	100			No		100
Infection										
HCAI - MSSA	QSAC	Dec 21	3	0	<2.3			Yes	21	28
HCAI - MRSA	QSAC	Dec 21	0	0	0			No	1	0
HCAI - C.Difficile	QSAC	Dec 21	2	<4.08	<2.5			No	24	30
HCAI - E-coli	QSAC	Dec 21	5	<10.17	<3.16			Yes	38	38
HCAI - Klebsiella	QSAC	Dec 21	1	2	<1			No	10	13
HCAI - Pseudomonas Aeruginosa	QSAC	Dec 21	3	<0.83	0			Yes	6	3
Patient harm										
Pressure Ulcers - Category 2 and above	QSAC	Dec 21	14		<13			Yes	119	152
Pressure Ulcers - Category 2 Per 1000 Bed Days	QSAC	Dec 21	0.63							tbc
VTE	QSAC	Dec 21	93.7%	95%	95%			Yes		95%
Falls - total	QSAC	Dec 21	114		<89			Yes	1002	1074
Falls - per 1000 Bed Days	QSAC	Dec 21	5.16	6.60	<4.5			Yes	4.66	4.50
Falls - with Harm per 1000 Bed Days	QSAC	Dec 21	0.05	0.19	<0.17			No	0.10	0.17
Never Events	QSAC	Dec 21	0	0	0			No	1	0
Coroners Regulation 28s	QSAC	Dec 21	0		0			No	1	0
Serious Incidents	QSAC	Dec 21	4		N/A				73	57
Mixed Sex Breaches	QSAC	Dec 21	45	0	0			Yes	323	tbc
Patient Experience										
Complaints	QSAC	Dec 21	50		<56			No	520	672
Complaints Responded within agreed time	QSAC	Oct 21	67%	85%	85%			Yes		85%
Complaints Acknowldeged within agreed time	QSAC	Dec 21	94%		100%			Yes		100%
Compliments	QSAC	Dec 21	39 letters of thank you received.						372	tbc
Friends and Family Test	QSAC	Dec 21	98.5%	80%	80%			No	94.6%	80.00%
Maternity										
Smoking rate at Delivery	QSAC	Dec 21	11.9%	6%	6.0%			Yes	12.2%	6.0%
One to One Care In Labour	QSAC	Dec 21	98.4%	100%	100.0%			Yes	99.0%	100.0%
Delivery Suite Acuity	QSAC	Dec 21	65%	85%	85.0%			Yes		85.0%
Caesarean Sections rate of Robson Group 1 Delive	QSAC	Dec 21	13.7%						15.5%	
Caesarean Sections rate of Robson Group 2 Delive	QSAC	Dec 21	28.8%						41.2%	
Caesarean Sections rate of Robson Group 5 Delive	QSAC	Dec 21	80.0%						76.7%	

Workforce - KPI		Latest month	Actual Month Performance	National Standard for month	SaTH trajectory for month	Perfomance	Assurance	Exception	Year to Date	SaTH 2021-2022 Plan
Activity										
WTE Employed**Contracted	FPAC	Dec 21	5955		6732			Yes		6732
Total temporary staff -FTE	FPAC	Dec 21	658					Yes		tbc
Staff turnover rate (excludes junior doctors)	FPAC	Dec 21	1.4%	0.8%	0.75%			Yes	1.2%	0.8%
Sickness absence rate Excluding Covid Related	FPAC	Dec 21	5.6%		4%			Yes	5.0%	4%
Covid Related absence rate	FPAC	Dec 21	2.9%					Yes		
Agency Expenditure	FPAC	Dec 21	£2.893m		£2.860m			Yes	£23.965m	
Appraisal Rate	FPAC	Dec 21	82%	90%	90%			Yes		90%
Appraisal Rate (Medical Staff)	FPAC	Dec 21	88%	90%	90%			Yes		90%
Vacancies	FPAC	Dec 21	647 (10.9%)	<10%	<10%			Yes		<10%
Statutory and Mandatory Training	FPAC	Dec 21	83%	90%	90%			Yes		90%
Trust MCA – DOLS & MHA	FPAC	Dec 21	77%	90%	90%			Yes		90%
Safeguarding Adults - level 2	FPAC	Dec 21	81%	90%	90%			Yes		90%
Safeguarding Children – level 2	FPAC	Dec 21	83%	90%	90%			Yes		90%

Operational - KPI		Latest month	Actual Month Performance	National Standard for month	SaTH trajectory for month	Perfomance	Assurance	Exception	Year to Date	SaTH 2021-2022 Plan
Elective Care										
RTT Waiting list -Total size	FPAC	Dec 21	35008					Yes		34443
RTT Waiting list -English	FPAC	Dec 21	31226		29614			Yes		30779
RTT Waiting list -Welsh	FPAC	Dec 21	3782					Yes		3503
18 Week RTT % compliance -incomplete pathways	FPAC	Dec 21	56.9%	92%				Yes		
26 Week RTT % compliance -incomplete pathways	FPAC	Dec 21	68.0%	92%				Yes		
52+ Week breaches - Total	FPAC	Dec 21	2480	0				Yes		2755
52+ Week breaches - English	FPAC	Dec 21	2201	0	2451			No		2485
52+Week breaches - Welsh	FPAC	Dec 21	279	0				Yes		272
78+ Week breaches - Total	FPAC	Dec 21	438	0				Yes		
78+ Week breaches - English	FPAC	Dec 21	400	0				Yes		
78+ Week breaches - Welsh	FPAC	Dec 21	38	0				Yes		
104+ Week breaches - Total	FPAC	Dec 21	55	0	44			Yes		74
104+ Week breaches - English	FPAC	Dec 21	50	0	40			Yes		71
104+ Week breaches - Welsh	FPAC	Dec 21	5	0	4			Yes		3
Cancer										
Cancer 2 week wait	FPAC	Nov-21	73.6%	93%	83%			Yes	81.6%	93%
Cancer 62 day compliance	FPAC	Nov-21	62.5%	85%	62%			Yes	66.1%	85%
Diagnostics										
Diagnostic % compliance 6 week waits	FPAC	Dec 21	58.7%	99%				Yes		tbc
DM01 Patients who have breached the standard	FPAC	Dec 21	5158	0	1254			Yes		tbc
Emergency Department										
ED - 4 Hour performance	FPAC	Dec 21	58.2%	95.0%	64%			Yes	63.7%	78%
ED - Ambulance handover > 60mins	FPAC	Dec 21	803 (25.8%)	0				Yes	6447	tbc
ED 4 Hour Performance - Minors	FPAC	Dec 21	90.4%	95%	95%			Yes	91.6%	95%
ED 4 Hour Performance - Majors	FPAC	Dec 21	32.6%	95%				Yes	38.3%	tbc
ED time to initial assessment (mins)	FPAC	Dec 21	29	15	15			Yes		15mins
12 hour ED trolley waits	FPAC	Dec 21	322	0	0			Yes	1119	tbc
Total Emergency Admissions from A&E	FPAC	Dec 21	2785					Yes	25964	29744
% Patients seen within 15 minutes for initial assessr	FPAC	Dec 21	46.86%					Yes	45.0%	
Mean Time in ED Non Admitted (mins)	FPAC	Dec 21	228					Yes	211	
Mean Time in ED admitted (mins)	FPAC	Dec 21	583					Yes	468	
No. Of Patients who spend more than 12 Hours in E	FPAC	Dec 21	1127					Yes	6479	
12 Hours in ED Performance %	FPAC	Dec 21	10.1%					Yes	6%	
Hospital Occupancy and activity										
Bed Occupancy -G&A	FPAC	Dec 21	86.8%	92%	91%			Yes		92%
ED activity (total excluding planned returns)	FPAC	Dec 21	11183		12231			No	113687	148493
ED activity (type 1&2)	FPAC	Dec 21	9383		9970			No	95934	123702
Total Non Elective Activity	FPAC	Dec 21	4836		5697			Yes	45296	65129
Outpatients Elective Total activity	FPAC	Dec 21	46472		39355			No	479514	565514
Total Elective IPDC activity	FPAC	Dec 21	4908		5098			Yes	47608	65183
Diagnostic Activity Total	FPAC	Dec 21	17209		19240			Yes		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	Dec 21	15.320		1.700			Yes		3.963
Efficiency	FPAC	Dec 21	0.681		7.550			Yes	4.567	7.594
Income and Expenditure	FPAC	Dec 21	1.889		(7.043)			Yes	(7.929)	(10.989)
Cumulative Capital Expenditure	FPAC	Dec 21	4.687		48.961			Yes	14.774	44.618

3. Quality Executive Summary

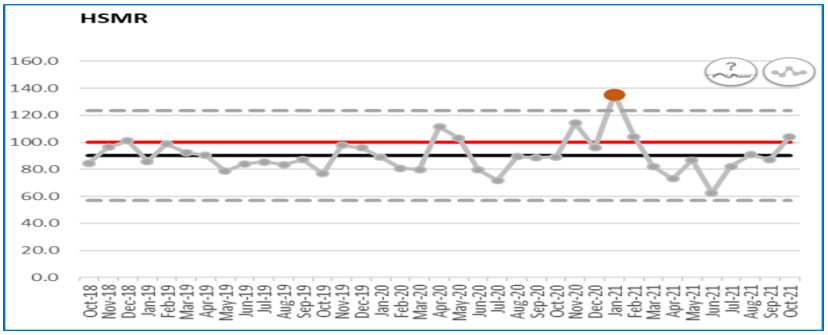
Hayley Flavell, DoN, Richard Steyn and John Jones Acting Medical Directors

- HSMR has been rebased and this month is showing as slightly above the reference level. We are expecting a further re-basing within CHKS to be applied before the end of January which is likely to raise all Trusts' baseline by approximately 10. This is to reflect that the national average of HSMR has improved to around 90 and so rebasing will set the national average back to the 100 level. The conditions with the highest number of excess deaths are pneumonia, UTI and acute and unspecified renal failure (based on primary diagnosis code only). Septicaemia has been added to these conditions and is the second highest number of excess deaths. Audits in relation to these areas are presented to the learning from deaths group.
- Following the work undertaken to ensure patients are not admitted to wards without a VTE assessment completed the delivery has deteriorated slightly and clinical staff have been reminded of the importance of completing this assessment prior to the patient being admitted to wards.
- Our performance on all the HCAIs remains better than the national standard set. There have been no further cases of MRSA this month. MSSA, c.Difficile and Klebsiella infection rate for the year to date are broadly in line with delivery of the local improvement trajectory set. Pseudomonas aeruginosa infections have now exceeded the local improvement trajectory and E.coli is currently at the level set locally for the year and so is likely to exceed the local stretch improvement target.
- There were 14 pressure ulcers (0.63 per 1000 beddays) last month. The Trust is on broadly course to deliver the year end improvement trajectory with year to date performance being 119 (78% of the local stretch improvement target).
- The number of falls continues to remain an area of concern, with 114 reported this month. The number of falls is consistently higher than the improvement target, with 1,002 falls having occurred in the year to date (93% of the improvement target for the full year).The falls per 1000 bed days remains above the local stretch target for improvement, however the falls with harm per 1,000 bed days has improved this month, although two were reported as serious incidents resulting in fracture neck of femur.
- There were four serious incidents this month.Two related to falls with harm, one grade 3 pressure ulcer and one maternity serious incident.
- There was a slight improvement in mixed sex breaches this month with 45 reported. All breaches related to transfers from critical care or COVID-19 designated wards.
- The response time for concerns remains unsatisfactory at 67% for October. 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.
- Recruitment in midwifery is improving and is having a positive impact on the delivery suite acuity level reported which improved to 65% this month. However COVID-19 short term absences and the level of maternity leave amongst the staff have necessitated the temporary intermittent closures of the Wrekin Unit to support the staff staffing levels and ensure 1-2-1 care in labour has continued with over 98.4% being achieved.
- There are no coroner section 28s or never events to report this month.
- Cleanliness and food satisfaction scores remain above the locally set targets.

3.1. Quality Exception Reports – Harm

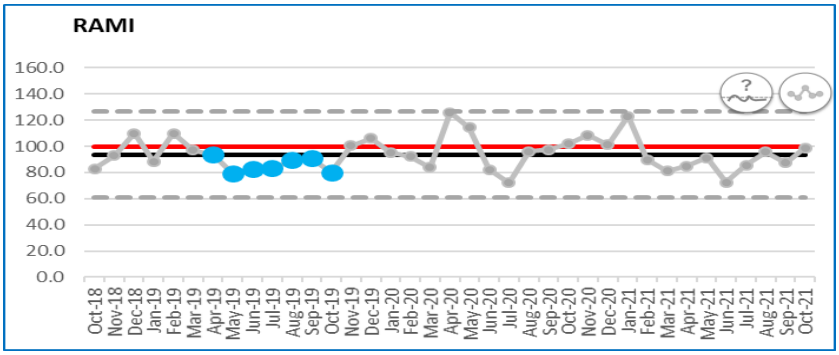
Mortality

HSMR



October 2021 actual performance
104.14
Variance Type
Common Cause
National Target
100
Target / Plan Achievement
Slightly higher than national reference level

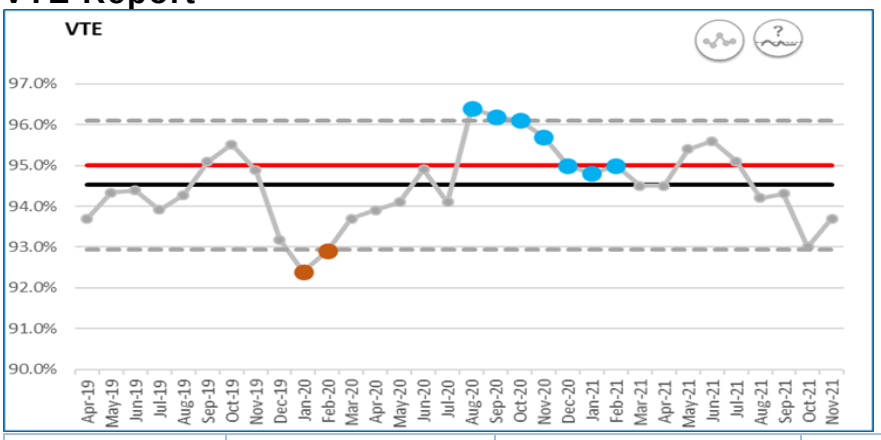
RAMI



October 2021 actual performance
98.84
Variance Type
Common Cause
National Target
100
Target / Plan Achievement
Monthly variation means that the 100 reference level may not be delivered month on month

Background	What the Chart tells us:	Issues	Actions	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 Risk Adjusted Mortality Index is a quality measure used to predict death within the organisation.	Both HSMR and RAMI performance for October 2021 demonstrate common cause variation. Patients coded with a primary diagnosis of COVID-19 are excluded from the HSMR however if COVID-19 appears elsewhere in the spell or in subsidiary diagnoses, the patient may then be included in HSMR. The RAMI indicator excludes COVID-19 patients.	No Dr Foster Imperial alerts have been received this month. The HSMR and RAMI models both continue to show the conditions with the highest number of excess deaths as pneumonia, UTI and acute and unspecified renal failure (based on primary diagnosis code only). In the latest available CHKS data for the 12-month period to September 2021 and within the RAMI model only, septicaemia has been added to these conditions and is now the condition with the second highest number of excess deaths within this model. CHKS will be rebasing HMSR nationally at the end of January 2022 as the national mean performance is currently around 90 and so approximately 10 will be added to bring the mean back to 100 nationally.	Two further reviews following an audit undertaken for patients who have died where urinary tract infection was the primary diagnosis code, are in progress. A similar audit has now been completed for patients who have died where acute and unspecified renal failure was the primary diagnosis code. This was presented at the January 2022 learning from deaths group. Further work is being discussed with senior medical staff from the renal team. The audit of care provided to patients who have died where pneumonia was the primary diagnosis code is underway. The recognition and escalation of sepsis and the deteriorating patient are incorporated within the Getting to Good action plans and quality standards.	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. Additional monthly CHKS updates have been introduced to the learning from deaths group specifically to monitor mortality performance relating to urinary tract infections, septicaemia, pneumonia and acute renal failure.

VTE Report



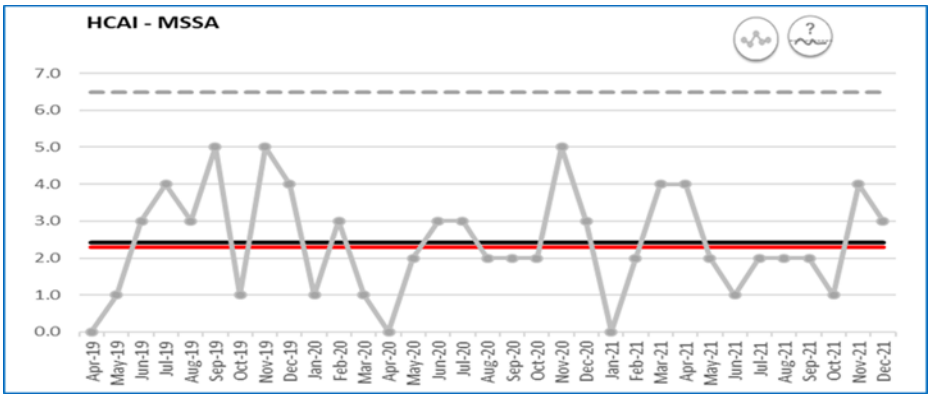
November 2021 actual performance
93.7%
Variance Type
Common Cause
National Target
95%
Target / Plan Achievement
Delivery continues to be close to target

Background	What the Chart tells us	Issues	Actions	Mitigations
This is clinically important in order to protect inpatients from harm.	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	24	32
E. coli	122	38	38	51
Pseudomonas aeruginosa	10	3	6	8
Klebsiella spp.	24	13	10	13

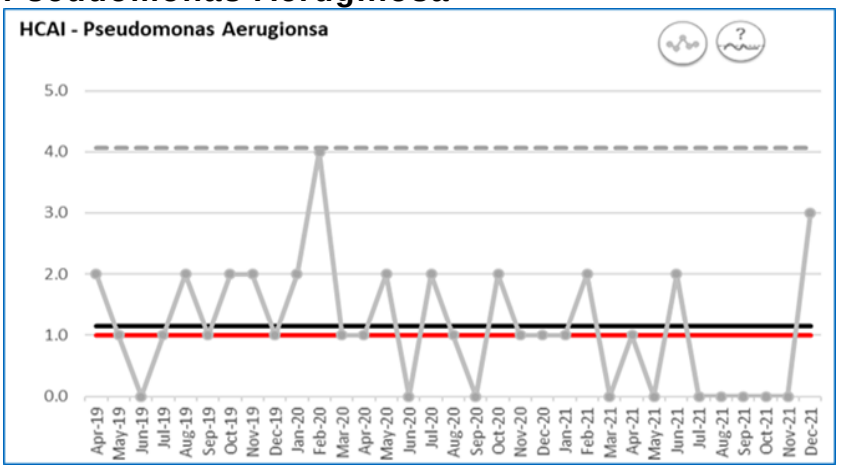
MSSA



December 2021 actual performance
3
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 three cases of MSSA bacteraemia in December 2021. The Trust remains below both its local and nationally agreed target for 2021/22.	RCAs are being undertaken in cases where the source is considered to be device or intervention related to establish any learning points. One of the three cases was considered to be service/intervention related.	Aseptic non-touch technique training for staff. Recording of VIP scores. Use of catheter insertion document and care plans.	Monitored via Divisional Reporting to IPCOG.

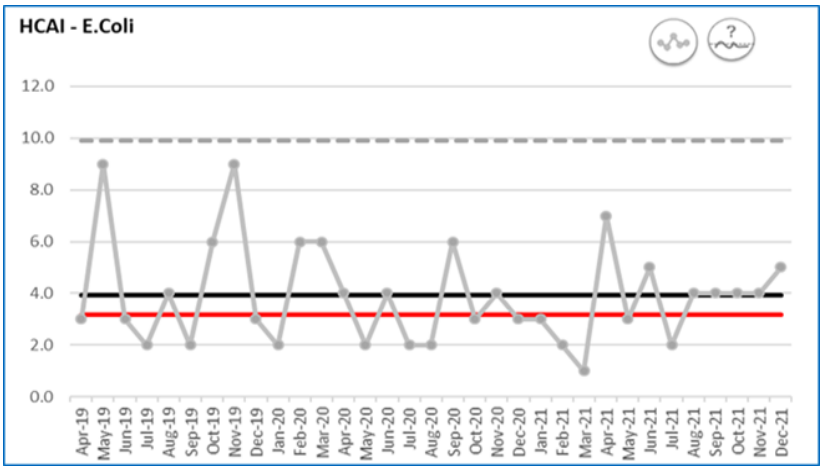
Pseudomonas Aeruginosa



December 2021 actual performance	
3	
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 6 infections have occurred	

Background	What the Chart tells us	Issues	Actions	Mitigations
Reporting of Pseudomonas is a mandatory requirement.	There were three cases of Pseudomonas bacteraemia in December 2021 after five months of no cases being reported. The Trust remains within the national target set for 2021/22.	Two of the three cases were considered to be device related and the sources were dialysis line infection, and a line infection. RCAs will be completed on these cases	VIP scores monitored daily to ensure these are being completed. Ensure staff have completed ANTT training. Matrons' monthly assurance audits include IPC and care of cannula, clinical areas who have compliance issues to be supported by the Quality Matron.	Matrons' monthly assurance audits. Monthly Nursing Assurance meetings. Divisional Reporting to IPCOG.

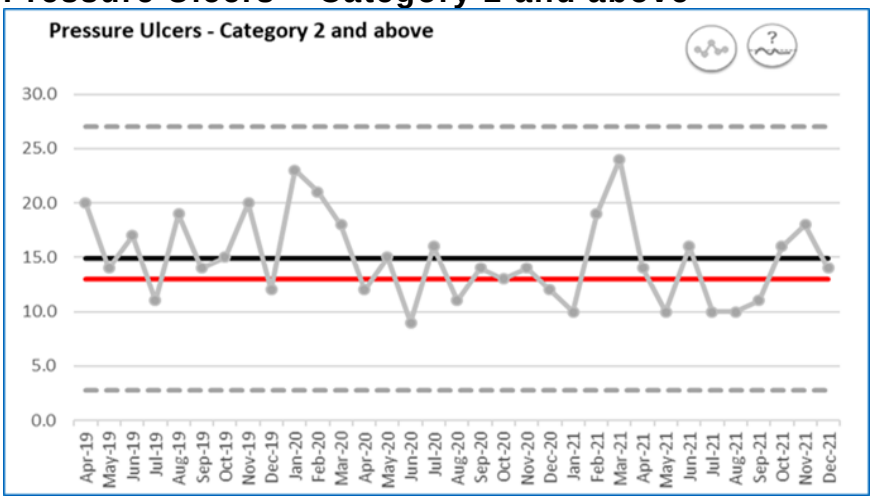
E-Coli



December 2021 actual performance
5
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.

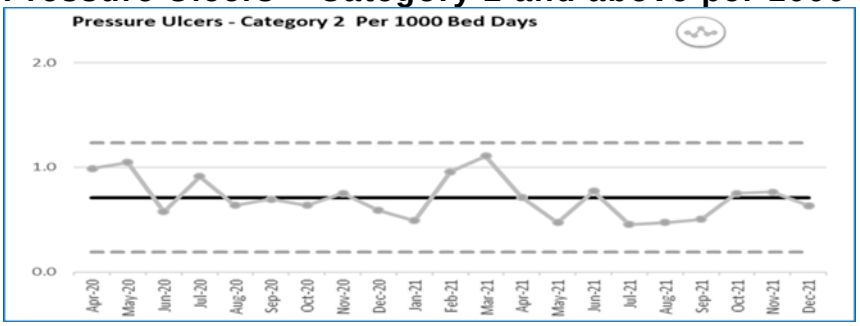
Background	What the Chart tells us	Issues	Actions	Mitigations
Reporting E. coli bacteraemia has been a mandatory requirement since 2011.	There were five cases of E.coli bacteraemia in December 2021 that were taken post 48 hours of admission. Although we will not achieve our local improvement target, we are well within the nationally set target for 2021/22.	RCAs are being undertaken in cases where the source is considered to be device or intervention related to establish any learning points. Three of the five cases were considered to be device or intervention related and the sources were 2 x Catheter associated UTIs and a fracture of prosthetic hip.	Ongoing work continues around improvements in catheter care and catheter care planning.	Catheter care is monitored via the monthly matron's quality assurance metrics.

Pressure Ulcers – Category 2 and above



December 2021 actual performance
14
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



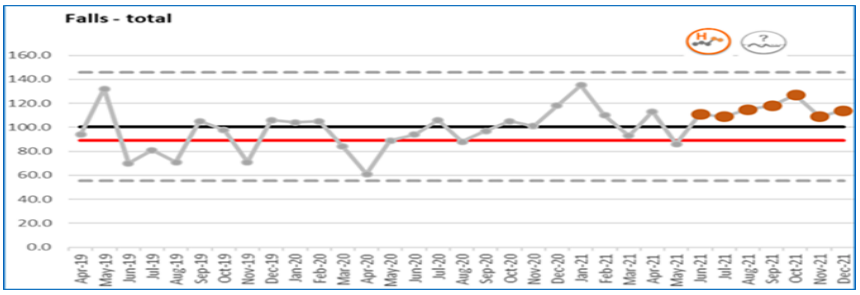
December 2021 actual performance
0.63
Variance Type
Common Cause
Local Standard
tbc

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

Background	What the Chart tells us	Issues	Actions	Mitigations
The Trust aims to reduce the number of hospital acquired pressure ulcers.	The overall number of pressure ulcers and pressure ulcers per 1000 bed days reduced in December 2021.	The highest number of pressure ulcers reported are on the Medical Wards. There continue to be Category 3 PU	Focused support from TVN and Quality Team for wards with PU continues with; Tuesday Talks with Tissue Viability Team have been set up weekly. These sessions are for any staff to attend. Thematic review of all PU investigations is being carried out and overarching improvement plan developed for	All category 2 or above pressure ulcers have an investigation completed and presented at the Pressure Ulcer Panel. Those, which meet the

		reported which patients have developed in our care, there were three in December on ward 25, 6 and 22 T&O.	reporting to QOC in Feb 2022. Spot checks of documentation by ward managers/matrons to ensure assessments and care plans in place. Work to improve ward safety huddles to ensure includes all patients at risk of PU.	threshold for an SI, are investigated and presented at NIQAM and a summary reported through to RALIG.

Falls

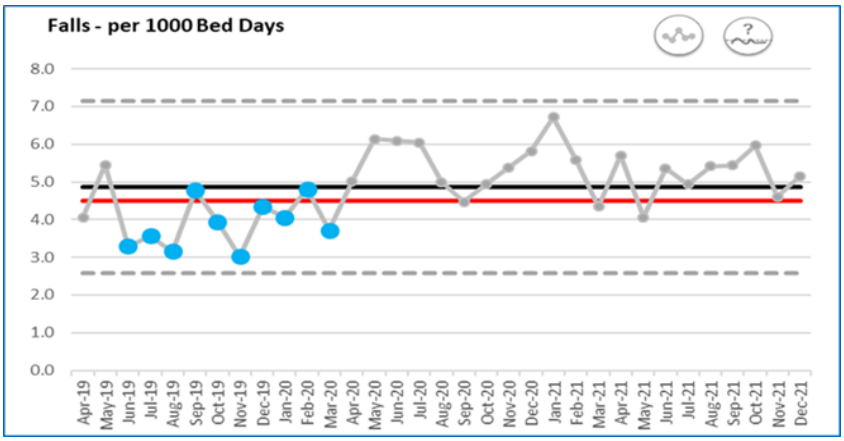


December 2021 actual performance
114
Variance Type
Common Cause
Local Target
<89
Target / Plan Achievement
10% reduction on 20/21

Falls – Total per Division	Number Reported
Medicine and Emergency Care	78
Surgery, Anaesthetics and Cancer	34
Women and Children	1
Other	1

Background	What the Chart tells us	Issues	Actions	Mitigations
Falls amongst inpatients are the most frequently reported patient safety incident in the Trust. Reducing the number of patients who fall in our care is a key quality and safety priority.	There were 114 falls in December 2021.	The number of falls across the Trust remains higher than our local target.	Ongoing falls improvement work includes: Falls practitioner is undertaking refresher training for cohorting and bay tagging with wards. Trial of falls alarms continues on nominated wards. Falls Prevention Plan updated to include all new improvement actions. Ongoing monthly review of falls risk assessment and care plans. Revised nursing documentation booklet including revised falls paperwork, quality matrons supporting staff in clinical areas when rolled out.	Weekly falls review meetings. All falls in last 24 hours reviewed daily. Monitoring via monthly nursing metrics audits meetings with DON. - baseline exemplar peer reviews. All SI investigations reviewed at NIQAM and summary report of cases will now go to RALIG.

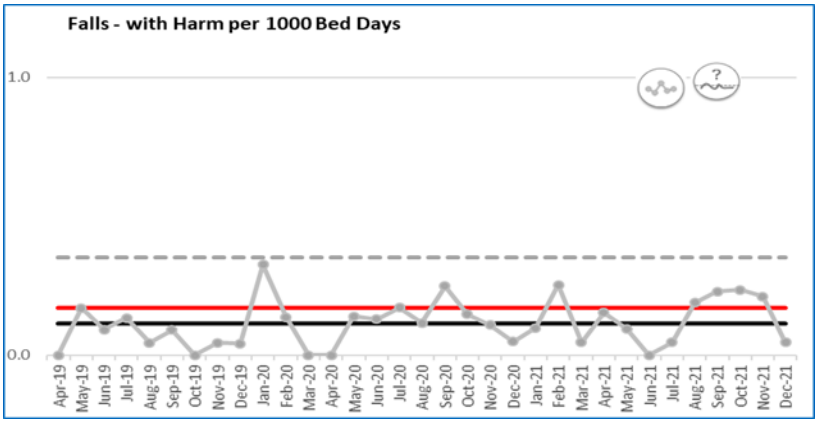
Falls – per 1000 Bed Days



December 2021 actual performance
5.16
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 1,000 bed days in December was above our local improvement target but below national ratio per 1,000 bed days.	As per falls slide	As per falls slide	As per falls slide

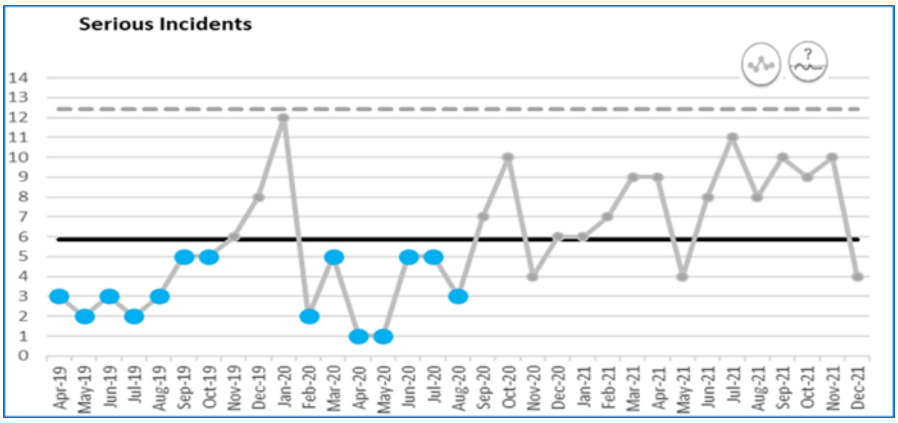
Falls – with Harm per 1000 Bed days



December 2021 actual performance
0.05
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.	The falls with harm per 1000 bed days had increased since September 2021, however performance this month has improved.	There were 2 falls with harm reported as SIs in December compared to 5 in November. A patient on Ward 9 and a patient on ward 28 both had a fall resulting in a fractured neck of femur.	As per Falls per 1000 bed days slide.	As per Falls per 1000 bed days slide.

Serious Incidents

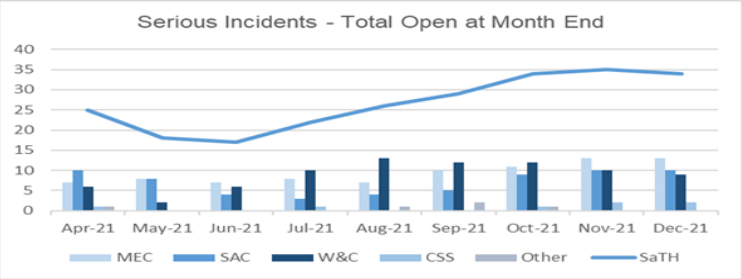


December 2021 actual performance
4
Variance Type
Common Cause
Local Standard
n/a
Target/ Plan achievement
n/a –seeking to encourage reporting of incidents

SI theme –	Number Reported
Fall resulting in fractured NOF (Ward 26)	1
Fall resulting in fractured NOF (Ward 6)	1
Category 3 Pressure Ulcer (Ward 22TO)	1
Maternity affecting baby (baby went for cooling – HSIB investigation)	1
Total	**4**

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.	There have been minor fluctuations in the number of SIs reported month by month since August 2021, but a decrease since reporting the period the previous year, where there were six SIs reported. Monitoring of variation is in place.	Monitoring is in place and thematic reviews for common concerns is in place and a working group established to monitor high risk incidents.	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.

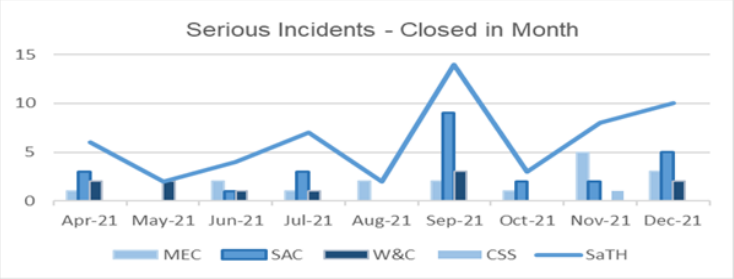
Serious Incidents – Total Open at Month End



SI – Total Open at Month End per Division	Number Reported
Medicine & Emergency Care	13
Surgery, Anaesthetics and Cancer	10
Women and Children's	9
Clinical Support Services	2
Other	2
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, four of which are being investigated by HSIB externally to the organisation. The number of open SIs is stabilising.	Monitoring of progress of investigation.	Weekly review of mitigations.

Serious Incidents – Closed in Month

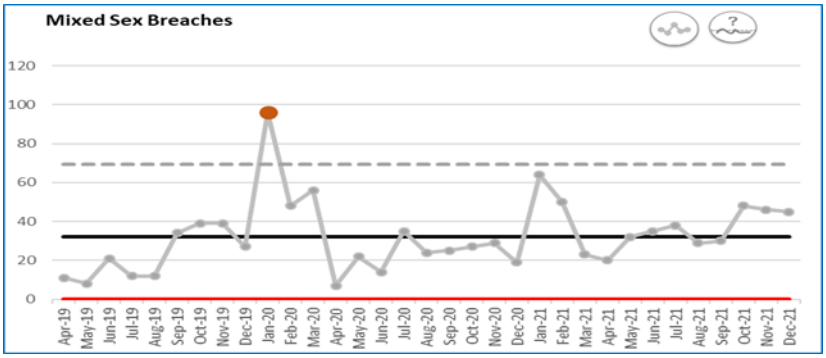


SI – Closed in Month per Division	Number Reported
Medicine & Emergency Care	3
Surgery, Anaesthetics and Cancer	5
Women and Children's	2
Clinical Support Services	0
Total	**10**

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 ten SIs closed in month with a 100% completion within the 60 day target.	SIs to be completed in a timely manner.	Monitor reviews and feedback. Maintain investigation within national framework deadlines for timely learning. Attain sustainable learning from incidents.	Weekly review of progress of investigations.

3.2 Quality Exception Reports – Patient Experience

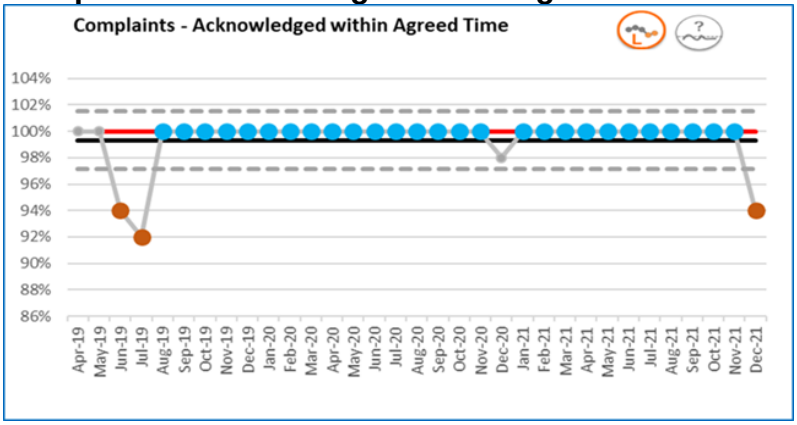
Mixed Sex Breaches Exception Report



December 2021 actual performance
45
Variance Type
Common Cause
National Target
0
Target/ Plan achievement
Continuing to breach this target.

Location	Number of breaches	Additional Information
ITU / HDU (PRH)	14 Primary breaches	
ITU / HDU (RSH)	24 Primary breaches	
Ward 32R	4 Primary breaches	COVID-19 related ward
Ward 17 – Respiratory (PRH)	3 Primary Breaches	COVID-19 related ward

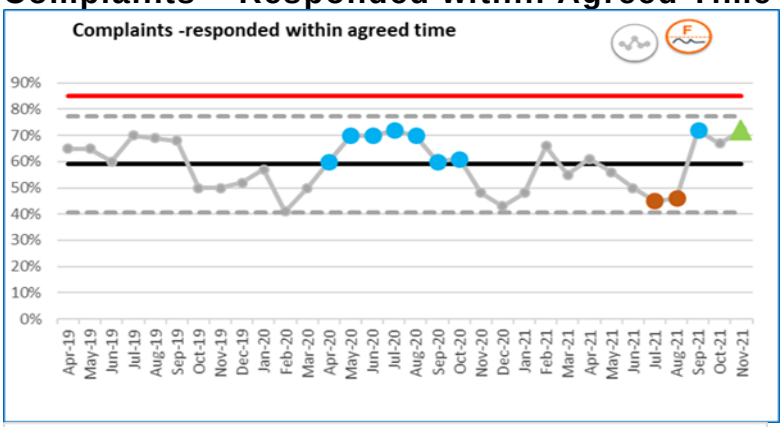
Complaints acknowledged within agreed time

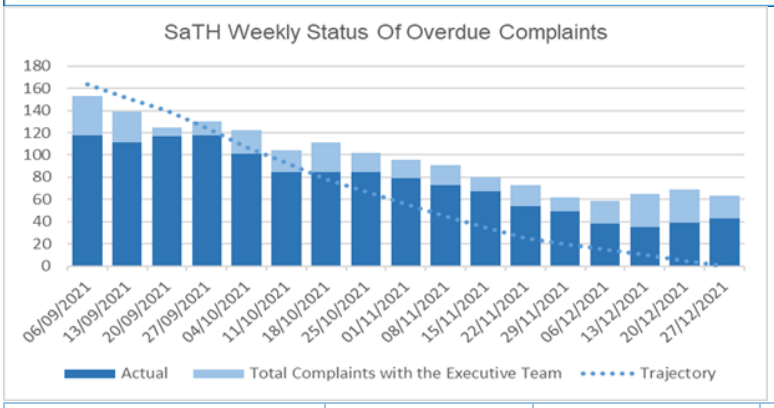


December 2021 actual performance
94% (82% within two days)
Variance Type
Special Cause Improvement
National Target
100%
Target/ Plan achievement
Target achieved consistently

Background	What the Chart tells us	Issues	Actions	Mitigations
Acknowledging a complaint on receipt is important for patients raising concerns to both ensure that the patient knows we have received the complaint and are addressing it.	Two complaints did not receive a written acknowledgement within three working days, however in both cases, the complainant received a verbal acknowledgement within two working days.	No issues.	Additional check has been put in place in Complaints Team.	Verbal acknowledgements in place.

Complaints – Responded within Agreed Time



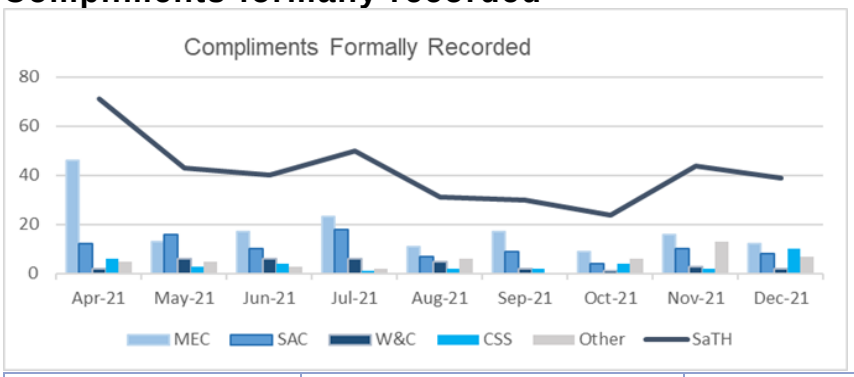


October 2021 actual performance	
67% (November Forecast 72%)	
Variance Type	
Common Cause	
National benchmark	**SaTH internal target**
85% compliant with time agreed with complainer	85% responded to within 60 days of receipt
Target/ Plan achievement	
Target is unlikely to be achieved within current processes.	

Overdue Complaints per Division	Number Reported
Medicine and Emergency Care	41
Surgical, Anaesthetics and Cancer	5
Women and Children's	7
Clinical Support Services	2
Total	**59**

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.	Improvements are being maintained but are still not at the expected levels.	Clinical pressures continue to impact on timeliness of responses to complaints, and approval of draft responses.	Regular meetings with divisions to review open complaints. Transforming care support M&E division in piloting new processes, although clinical pressures have delayed progress.	Complainants are kept updated regularly.

Compliments formally recorded

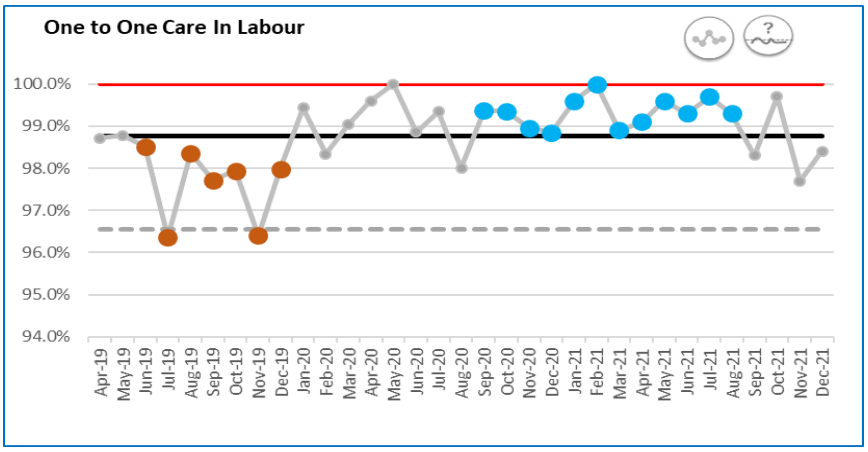


December 2021 actual performance
SATH
39
Divisions
MEC – 12
SAC - 8
W&C - 2
CSS – 10
Other - 7

Background	What the Chart tells us:	Issues	Actions	Mitigations
By collecting data on positive feedback, the Trust will be able to identify well performing areas, and seek to spread good practice.	The number of compliments recorded has dropped, although it remains within common cause variation; it is thought that this is due to low 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.

4. Maternity Indicators

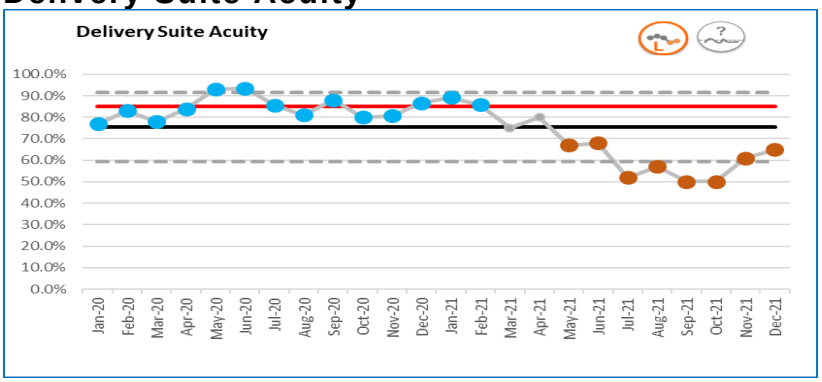
One to One Care in Labour



December 2021 actual performance
98.4%
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 two 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.	The provision of 1:1 care in labour is a priority for the service and the result is reassuring that the actions and mitigations in place are effective.	Staffing often below template on delivery suite, despite ongoing successful recruitment, due to short-term COVID-19 absence and high unavailability rates due to maternity leaves.	Intermittent closure of the Wrekin birthing unit to support safe staffing levels on delivery suite. A review of all cases where the dashboard indicates that 1:1 care does not look like it has been achieved is ongoing with the findings available shortly.	Excellent compliance with the use of the Birth Rate + tool to measure acuity and use of the escalation policy to prioritise 1:1 care in labour.

Delivery Suite Acuity



December 2021 actual performance
65%
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	Acuity has improved in the last 2 months but remains below the national standard.	Staffing levels variable due to high levels of maternity leave and both short term COVID-19 related absence and long term sickness rates.	Intermittent closure of the Wrekin birthing unit to support safe staffing levels on delivery suite. Vacancies identified and being monitored	Acuity tool consistently being completed – reassurance of data quality. Twice daily SMT huddles to monitor and

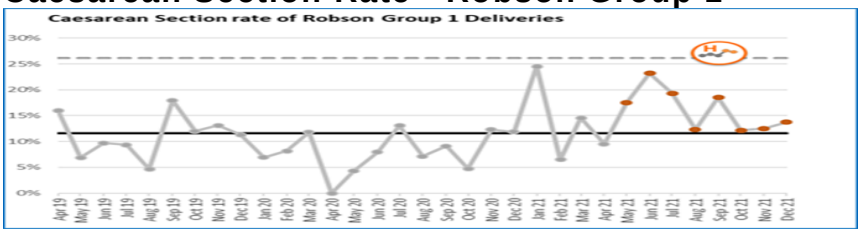
monthly in line with the CNST standard safety action number 5.		Reassured by other indicators, such as 1-2-1 care in labour, PPH rates, 3rd and 4th degree tears below expected rates, Term admissions to NNU below national rates.	monthly to ensure staffing position understood. Recruitment ongoing including planning for next cohort of band 5 preceptee midwives. Use of temporary staffing to ensure staffed to template where possible.	manage acuity and instigate escalation policy when required. Incentivised bank shifts in place for CU 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 September 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.

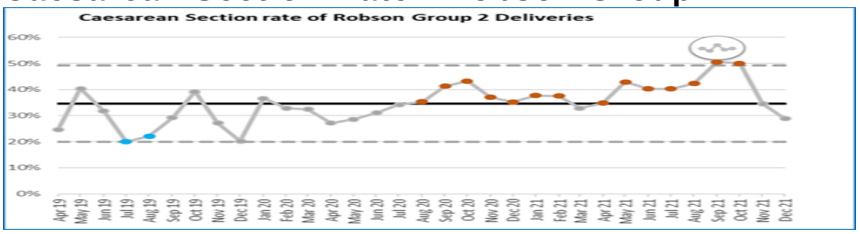
Key Performance Indicator		SPC	Last 12 Months	Centile
Robson group 1 c-section with no previous births	8.3%			14
Robson group 2 c-section with no previous births	46.7%			28
Robson group 5 c-section with 1+ previous births	79.2%			49

Caesarean Section Rate - Robson Group 1



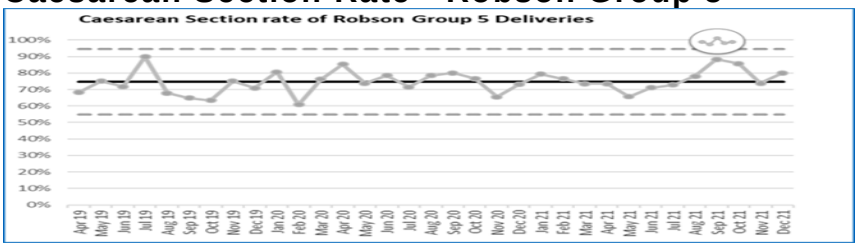
December 2021 actual performance
13.7%
Variance Type
Special Cause Concern

Caesarean Section Rate - Robson Group 2



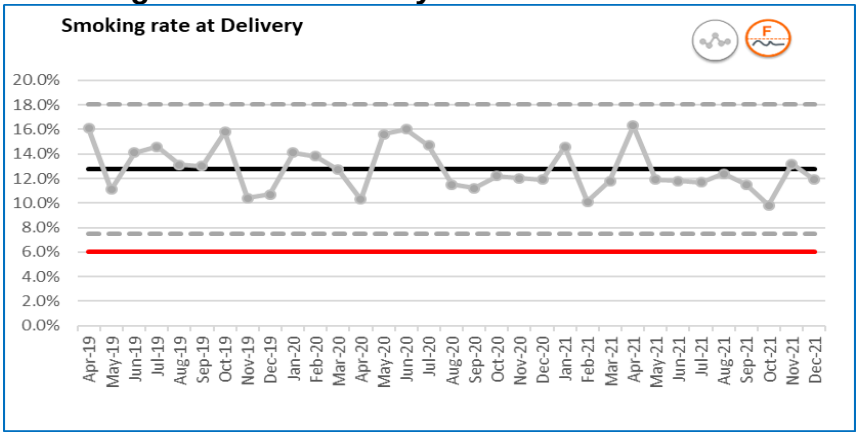
December 2021 actual performance
28.8%
Variance Type
Common Cause

Caesarean Section Rate - Robson Group 5



December 2021 actual performance
80%
Variance Type
Common Cause

Smoking Rate at Delivery



December 2021 actual performance
11.9%
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.	Average rates for this year maintained (approx.. 12%). No anomalous data for local population.	National target won't be reached by March 2022 as per Government target.	Launch HPSS (Healthy Pregnancy Support Service) in Q4 21/22 to provide family support and target areas of deprivation with trajectory for improvement to be developed and implemented. Provide face to face home visits in combination with Nicotine Replacement Therapy.	Currently there are two different smoking cessation referral pathways and services in place that patients are signposted to.

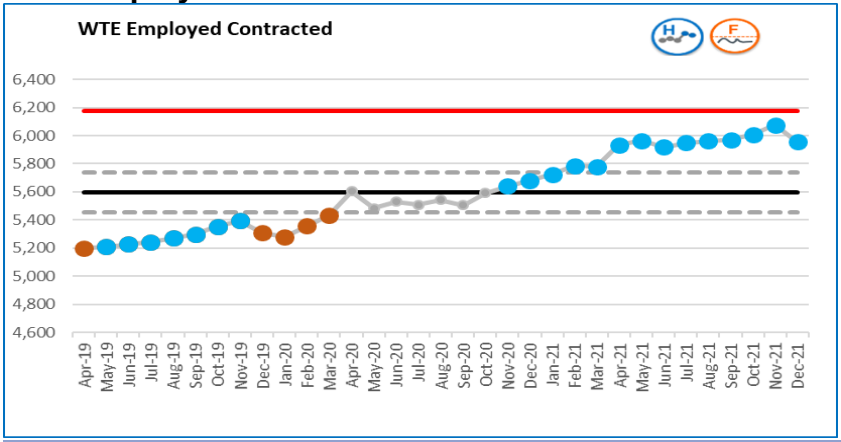
5. Workforce Summary
Rhia Boyode, Director of People and Organisational Development

- Higher absence levels than normally expected for this time of year. Absence rate of 5.6% equating to 338WTE. Absence attributed to mental health continues to be high with 195 episodes equating to 98WTE in December. Increasing levels of COVID-19 related absence continues to add to staffing pressures. We have experienced high levels of staff testing positive with COVID-19.On average 11 staff were testing positive per day through December, with marked increase in cases at the end of the month.
- In order to provide additional support we have established a 'listening ear' service where our peer to peer listeners and coaches provide listening support. A counselling service is provided and we have mental health first aiders and have over 25 trained Trauma and Resilience Management (TRiM) Practitioners to support our staff who have experienced a traumatic incident.
- We have implemented health and wellbeing packs and contact cards have been distributed across sites and we continue to work with Shropshire Mental Health Services, the ICS TRiM Hub and the STW Staff Psychological Wellbeing Hub to provide additional psychological support for our people.
- Statutory training compliance rate has been at 85% for the past few months but has now reduced to 83% however we have seen increases in safeguarding training. The corporate education team are supporting ward/departmental managers with 1:1 advisor support to prioritise and schedule training completion and validate data within training reports. All of our core leadership development programmes from aspiring leaders,

supervisors, first-line, band 7 nursing, middle and senior managers have launched. Our new improvement development programme will be launched later in 2022.

- The launch of the Learning Management System within maternity took place on 15 November 2021. The full roll out to the Trust is currently on track for the end of March 2022. This system will give visibility of staff competencies at individual level.
- Staff leavers in December (78WTE) is above the average number of leavers per month of 65 WTE over the last 12 months. Top three reasons for leaving in December were: relocation (16WTE); work life balance (14WTE); other/not known (11WTE).
- In January 2022, the Trust launched an academy to train health care support workers, alongside partner organisations within the county's health and care system and Telford College. We continue to deliver internal recruitment events, including an open day for theatres which attracted applications from 23 nursing associates and registered nurses, and a therapies one stop shop recruitment event.
- From Sept 2019 to February 2022, the Trust recruited 290 international nurses, who are now working in SaTH as registered nurses. Additionally, we have recruited a further 197 who are in the process of arriving or going through OCSE training and, from May 2022, we will start a new recruitment drive to bring another 100 international nurses in over the coming year.

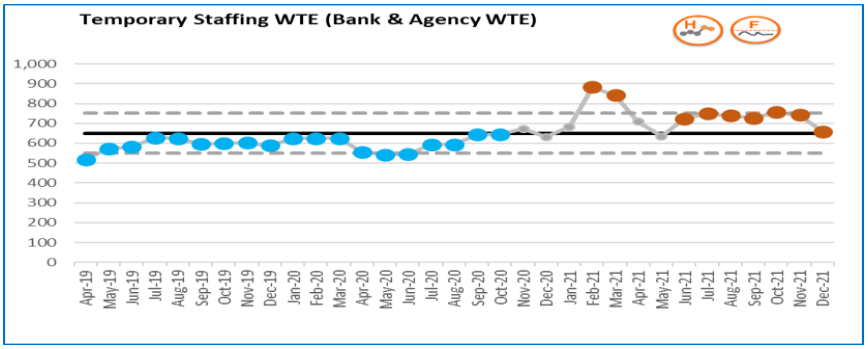
WTE employed



November 2021 actual performance
5955
Variance Type
Special Cause Improvement
Local Target
6732
Target / Plan Achievement
Seeking 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 with a slight dip in December. 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. Increased levels of staff leavers also present issues.	Recruitment activity continues to increase staffing levels. Promote timely roster approvals to maximise opportunities for bank utilisation. Continue to monitor leavers and support with early intervention.	Utilisation of bank and agency staff to support workforce gaps.

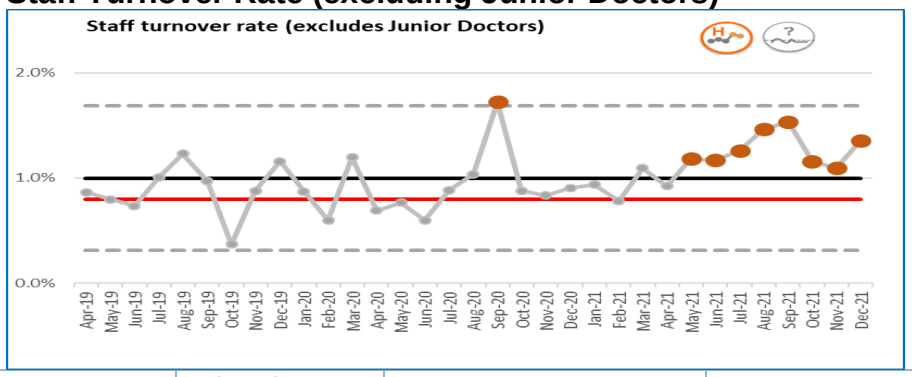
Temporary/ Agency Staffing



December 2021 actual performance
658
Variance Type
Special Cause Concern
National Target
N/A
Target / Plan Achievement
TBC

Background	What the Chart tells us	Issues	Actions	Mitigations
The measure is an indicator of agency and bank usage expressed as WTE.	Special cause concern between June 21 and Dec 21.	Staff absences attributed to both sickness (non-COVID-19) and COVID-19 related absence due to requirements to isolate continue to present staffing challenges along with high patient acuity levels and escalation.	Continue to monitor staff absence levels. Monitor roster approvals to help ensure unfilled duties are sent to temporary staffing in timely manner. Ongoing work with system to support agency utilisation cost improvement programme; increase in bank workers over the last 12 month.	Escalated bank rates in at risk areas. Progress with recruitment activities to increase substantive workforce including international nurse recruitment.

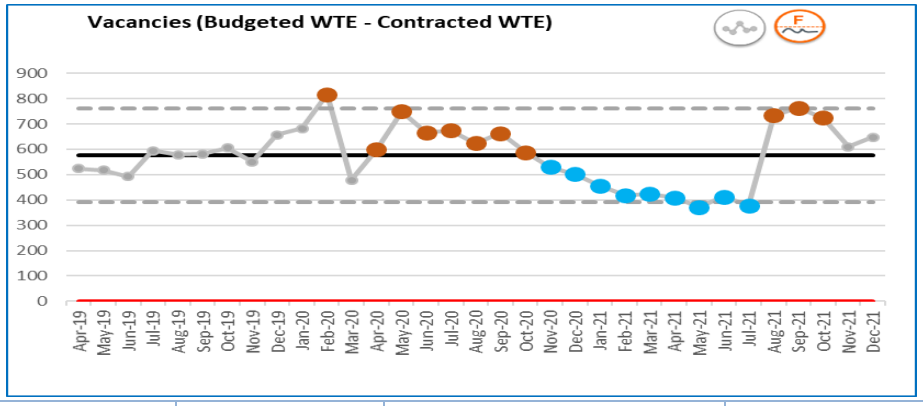
Staff Turnover Rate (excluding Junior Doctors)



December 2021 actual performance
1.4%
Variance Type
Special Cause Concern
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.	Special cause concern between May 21 and Dec 21.	Staff leavers in December (78WTE) is above the average number of leavers per month of 65 WTE over the last 12 months. Top 3 reasons for leaving in December were: relocation (16WTE); work life balance (14WTE); other/not known (11WTE). 25% (21WTE) of leavers in December had less than one year's service.	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.

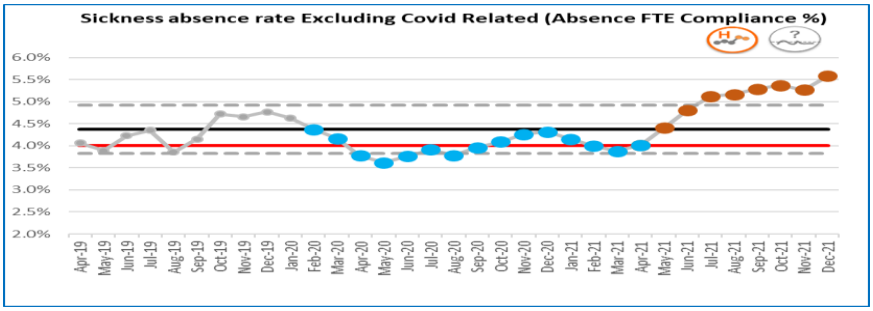
Vacancies



December 2021 actual performance
647 = 10.9%
Variance Type
Common Cause
National Target
<10%
Target / Plan Achievement
Note change post reconciliation work

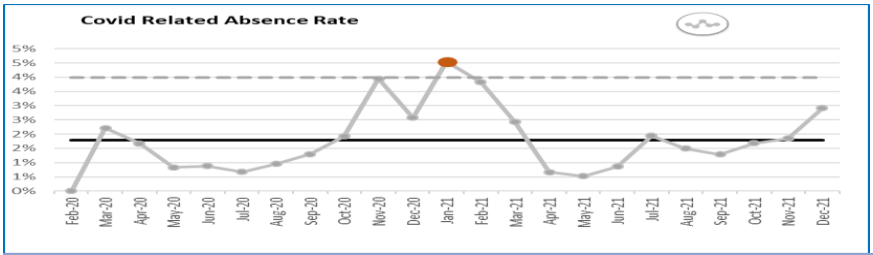
Background	What the Chart tells us	Issues	Actions	Mitigations
This is a measure of the gap between budgeted WTE and contracted WTE.	Common cause in Nov21 and Dec 21.	Revised budget position from Aug21. Review of vacancy reporting continues to ensure alignment and consistency in reporting. Shortfall in gap between contracted WTE and budgeted WTE continues to put pressure on bank and agency usage.	Continue recruitment activities to increase contracted WTE staffing levels and reduce vacancy gap. Initiatives to help retain existing staff. Ongoing work to review vacancy gaps against temporary staffing usage to better understand workforce utilisation. Review of fixed term working arrangements to support retention of staff and engage new recruits.	Recruitment activity continues to reduce workforce gaps. Use of temporary staff to cover vacant posts.

Sickness Absence



December 2021 actual performance
5.6%
Variance Type
Special Cause Concern
National Target
4%
Target / Plan Achievement
4%

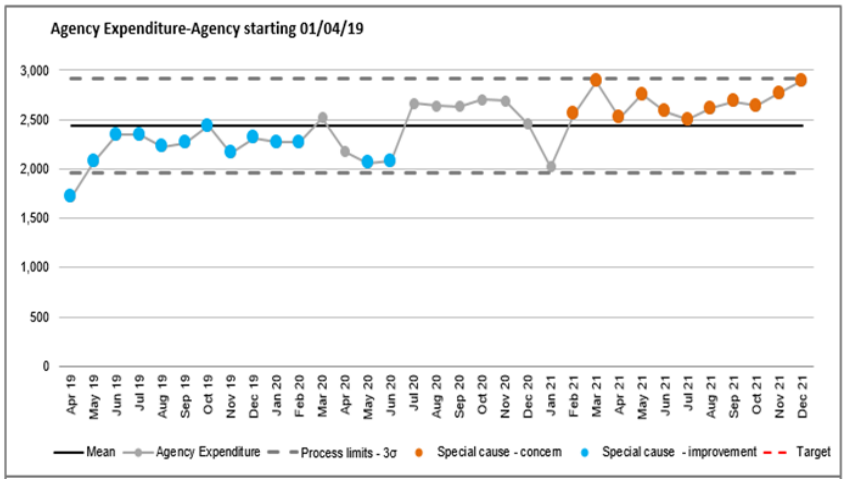
Background	What the Chart tells us	Issues	Actions	Mitigations
The measure is an indicator of staff sickness absence and is a % of WTE calendar days absent. COVID-19 related sickness and absence is not included.	Special cause concern from Apr21 – Dec21.	Higher absence levels than normally expected for this time of year. Absence rate of 5.6% equating to 338WTE. Absence attributed to mental health continues to be high with 195 episodes equating to 98WTE in December. 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% (40WTE) with additional clinical services at 7.0% (83WTE) and nursing and midwifery at 6.0% (107WTE).	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.



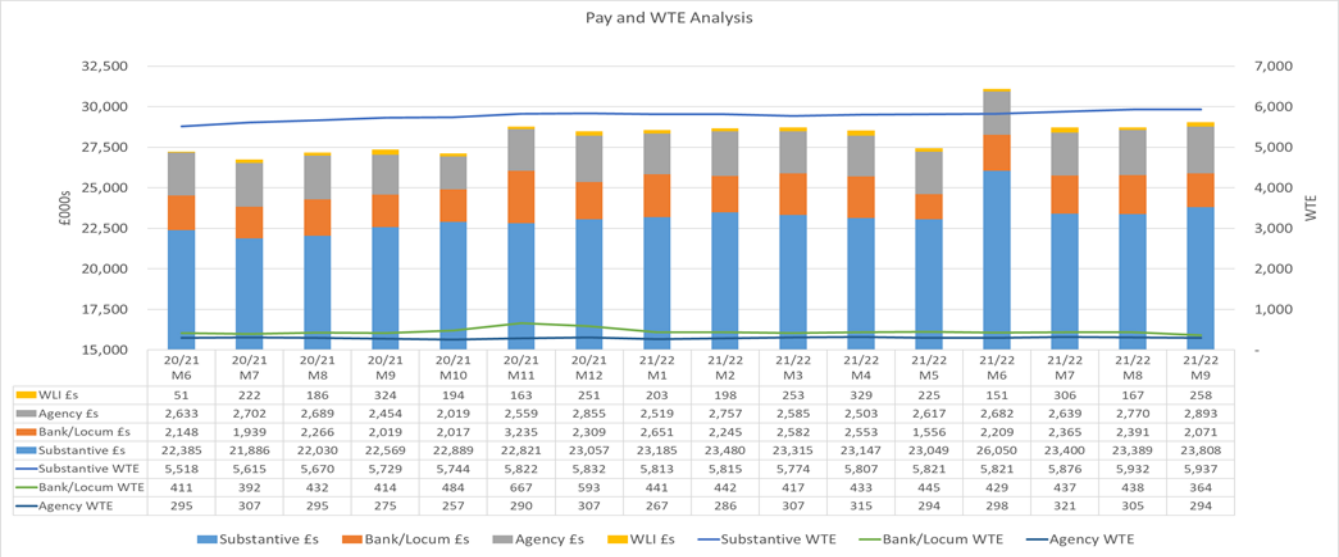
December 2021 actual performance
2.9%
Variance Type
Common Cause
National Target
N/A

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 Dec 21.	Increasing levels of COVID-19 related absence continues to add to staffing pressures. High levels of staff testing positive with COVID-19. Average of 11 staff testing positive per day through December with marked increase in cases at the end of the month.	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 promoting of booster jab and flu vaccine.	Maintain social distancing; regular and timely staff testing; identification of positive cases and effective contact tracing. Continue risk assessments for staff identified as contacts.

Agency Expenditure



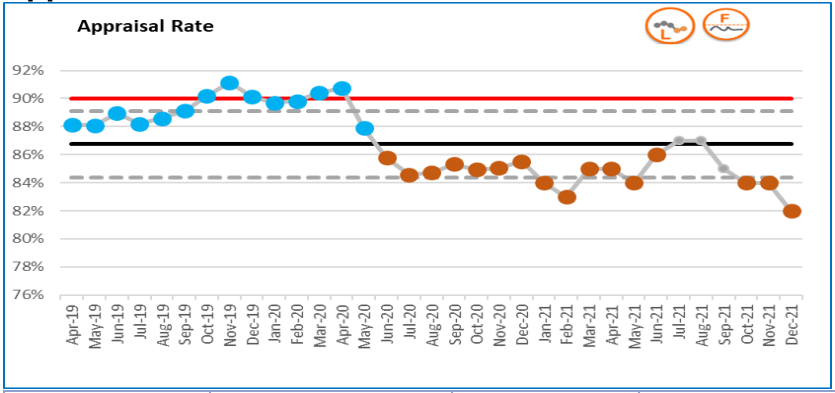
December 2021 actual performance
£2.893m
Variance Type
Special cause
SaTH Plan
£2.860m
Target/ Plan achievement
Deterioration this month. Remaining within annual plan overall.



	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	21/22 M8	21/22 M9
WLI £s	51	222	186	324	194	163	251	203	198	253	329	225	151	306	167	258
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	2,770	2,893
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	2,391	2,071
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	23,389	23,808
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	5,932	5,937
Bank/Locum WTE	411	392	432	414	484	667	593	441	442	417	433	445	429	437	438	364
Agency WTE	295	307	295	275	257	290	307	267	286	307	315	294	298	321	305	294

Background	What the Chart tells us:	Issues	Actions	Mitigations
The Trust's agency costs have increased over the past two years due mainly to the COVID-19 pandemic and additional quality service investment requirements. There is a strong focus on reducing agency spend across the Trust which is integral to the Trust efficiency programme.	Agency costs were £2.893m in the month, the highest recorded in over two years. This is primarily due to a level of substantive and bank fill which is both a consequence of COVID-19 sickness/isolation and the festival holidays.	Due to workforce fragility the Trust is consistently reliant upon agency premium resource. 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.

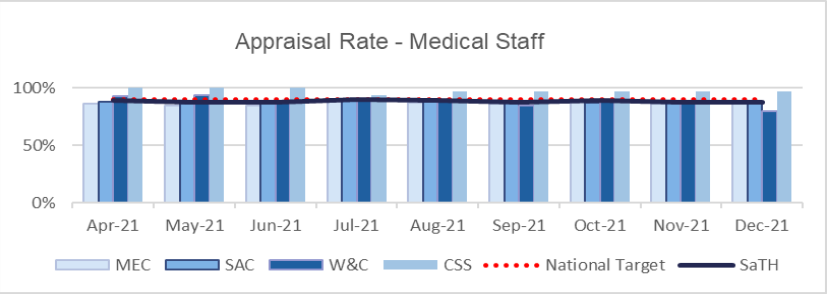
Appraisals



December 2021 actual performance
82%
Variance Type
Special Cause Concern
National Target
90%
Target / Plan Achievement
Below target level of performance

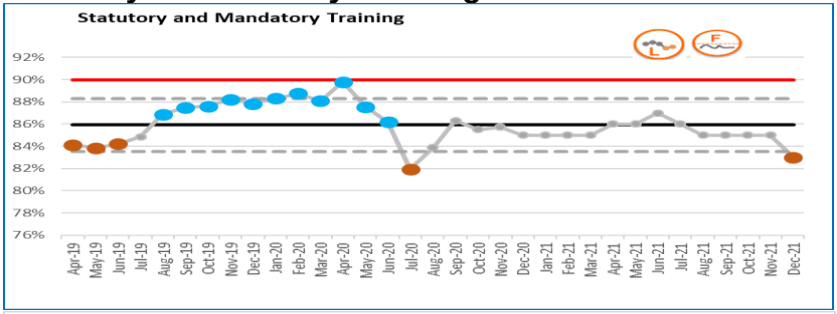
Background	What the Chart tells us:	Issues	Actions	Mitigations
The measure is a key indicator for patient safety in ensuring staff are compliant in having completed their annual appraisal.	The 90% target was achieved January to April 2020 then started to drop. In August 2021, we achieved 87% but this has dropped to 84% in November and dropped this month to 82%.	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 72 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

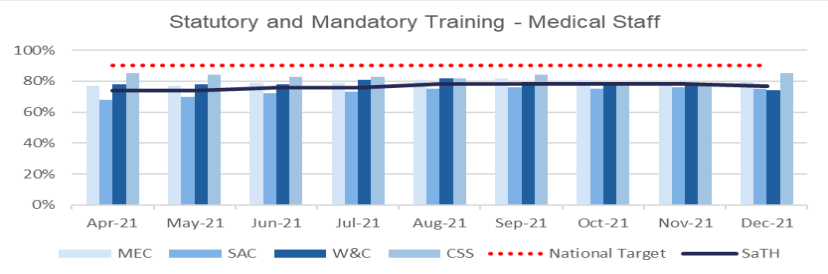


December 2021 actual performance
88%
Variance Type
Common Cause
National Target
90%
Target / Plan Achievement
90%

Statutory & Mandatory Training



December 2021 actual performance
83%
Variance Type
Special Cause Concern
National Target
90%
Target / Plan Achievement
The target is above the upper

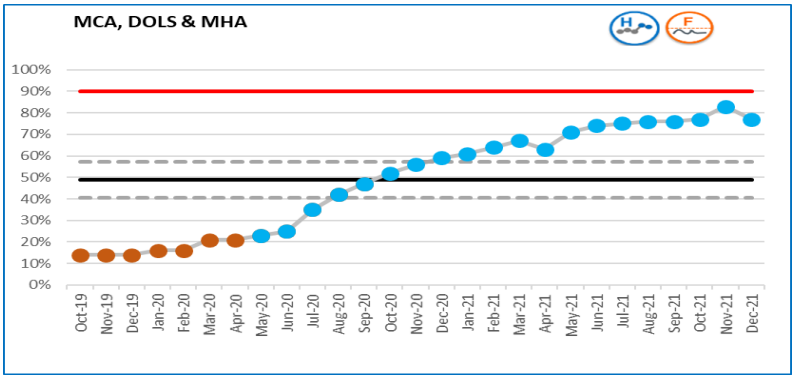


December 2021 actual performance
77%
Variance Type
Common Cause
National Target
90%
Target / Plan Achievement
90%

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
78%	90%	77%	95%	91%	72%	68%	89%	80%	88%

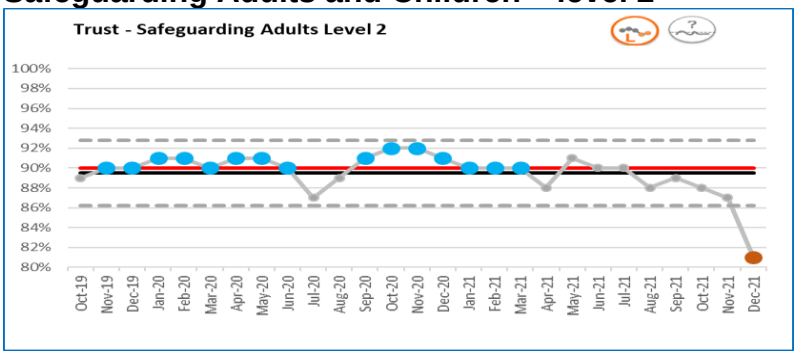
Background	What the Chart tells us:	Issues	Actions	Mitigations
The measure is a key indicator for patient safety in ensuring staff are compliant in having completed their training needs.	Compliance rate has been at 85% for the past few months but has now dropped to 83%. DNA % has dropped from 28% to 26%. 6% increase in adult Safeguarding level 2. 3% increase in adult safeguarding level 3. 2 % increase in children's safeguarding level 3.	COVID-19 and, staffing constraints and service improvement have reduced ability of wards to release staff for training. Poor IT literacy impacting on e-learning completion. Some data validation issues.	Corporate Education is working with Care Groups to identify and reduce data conflicts. Corporate Education is supporting additional ward/dept. 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 2021 with full role out across the Trust in April. 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.	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. New e-Learning packages being released for SGAL3 & Sepsis for Non-registered and Registered staff.

Trust MCA – DOLS & MHA



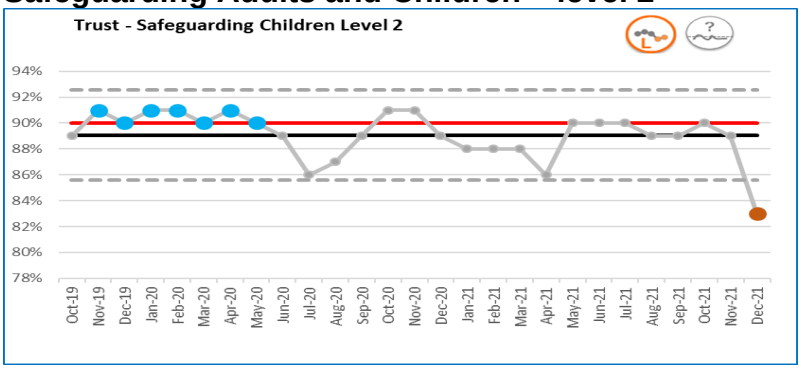
December 2021 actual performance
77%
Variance Type
Special Cause Improvement
National Target
90%
Target / Plan Achievement
Improvement trajectory in place

Safeguarding Adults and Children – level 2



December 2021 actual performance
81%
Variance Type
Special Cause Concern
National Target
90%
Target Achievement
90%

Safeguarding Adults and Children – level 2



December 2021 actual performance
83%
Variance Type
Special Cause Concern
National Target
90%
Target Achievement
90%

6. Operational Summary
Nigel Lee, Chief Operating Officer

December 2021 saw a continuation of the combination of pressures seen in November, with Urgent & Emergency Care (UEC) demand remaining significant and acuity of patients high, but with an increasing COVID-19 impact on both patient admissions as well as on staff absence. This in turn has affected elective capacity and activity. COVID-19 inpatient numbers varied across December, gradually declining in the month, although rising once again after Christmas; community COVID-19 incidence remained high in both the Shropshire and Telford & Wrekin areas. The local and national forecast is for a rise in COVID-19 admission in early January 2022. COVID-19 admissions to critical care remain low.

UEC flow through the two sites has been impacted by a number of issues, especially workforce and flow, but the Trust is very aware of the clinical pressures in both the Emergency Departments (EDs) and in the community caused by crowding in the EDs and ambulance handover delays. This continues to be the highest clinical priority for all senior

leaders. There continues to be excellent joint working between the site teams (and EDs in particular) with the ambulance services (West Midlands Ambulance Service and Welsh Ambulance Service), with on-site solutions including cohorting of patients with an ambulance crew to release other crews to community calls, and the use where possible of alternatives to hospital conveyance. All possible capacity in the two acute sites has been used, although this does limit elective capacity. Internally, use of pathways to minimise overnight admission have been used (such as Same Day Emergency Care units for surgery at RSH and for medicine at both sites) and options to increase direct access pathways are being developed where capacity allows. In addition, the programme of improvement for ward flow continues, and regular 'Multi-Agency Discharge Events' (MADEs) have been used in December to add additional staff to support wards, with expertise from community and local authority staff adding to the process. The SATH Improvement team provides additional expert support to this programme. However, the level and length of ambulance handover delays are high, and there is very close monitoring of the patients and pressures at all levels in the Trust. The number of 12-hour breaches also reflects these pressures.

The wider system has also seen significant demand and workforce pressures with constraints on capacity, which in turn reduced discharge to home-based care and community, care or residential home settings. As with many other systems, the numbers of patients medically fit for discharge but delayed in acute wards has risen significantly as has the length of stay of these patients once medically fit. The Trust is working very closely with Shropshire Community Trust, Powys Health Board and Local Authorities to maximise the capacity available; in parallel, system partners are seeking additional capacity (albeit some is further afield) as well as working with local providers on COVID-19 outbreaks and staffing challenges. However, both internally in SATH as well as across the system, outbreaks and staffing absence are likely to remain as key factors affecting capacity and flow well into January 2022.

Within the elective programme, cancer pathways are the Trust's priority alongside the most urgent surgery (Emergency/ very urgent Priority 1 and Priority 2). Cancer demand remains high, and activity for outpatients under the 2-week wait pathway is also high; in a number of areas, a combination of demand and workforce challenges mean that waiting times are longer than 2 weeks. Where workforce vacancies are a factor, the divisions are actively recruiting as well as looking at agency and locum options. However, services such as oncology are a pressured specialty across England. Emergency and cancer demand for imaging, both MRI and CT also remains very high, and despite the additional mobile capacity in place for both, radiology is also seeing waiting times higher than planned. In parallel, the combination of workforce issues and theatre capacity has meant that the number of cancer patients over 62 days has risen. With the support of NHSI and the CCG, options to increase the use of independent sector capacity is being investigated to support activity in Q4. However, whilst cancer and P1/ P2 patients are prioritised, the reduction in beds and day surgery unit capacity for elective activity is leading to some cancellations of long waiting elective patients (categorised as Priority 3 or 4), and there is risk to the planned trajectory of patients waiting over 104 weeks at the end of March 2022. All possible options continue to be explored.

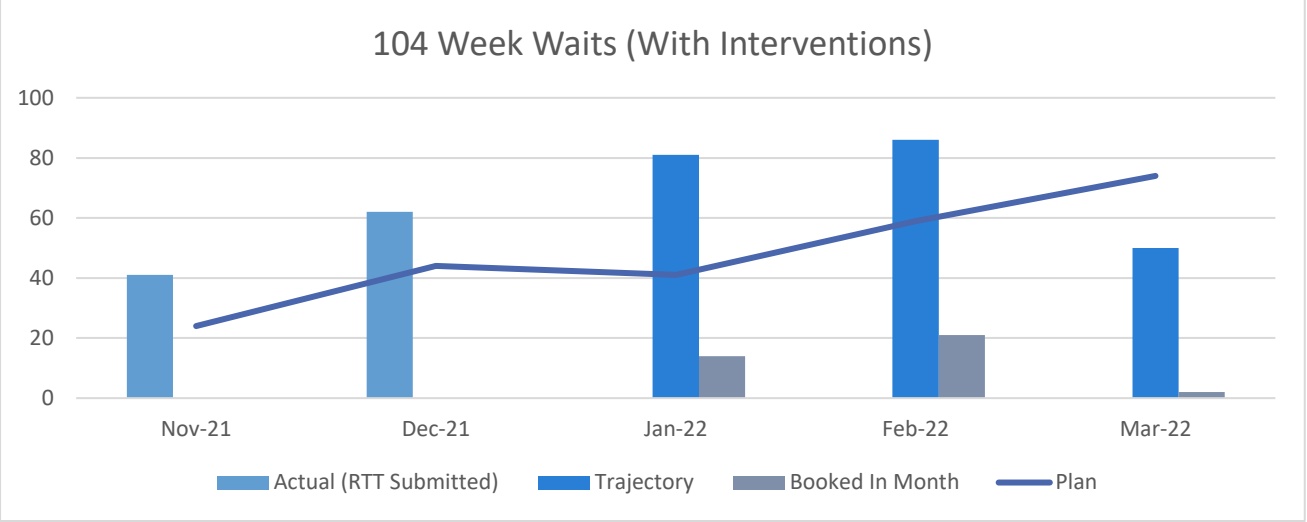
Elective Care

The H2 plan agreed for elective activity from October 2021-March 2022 is under pressure due to the reduction in elective beds. The additional interventions are being supported and aim to deliver a positive impact on the volume of patients waiting for treatment, although not

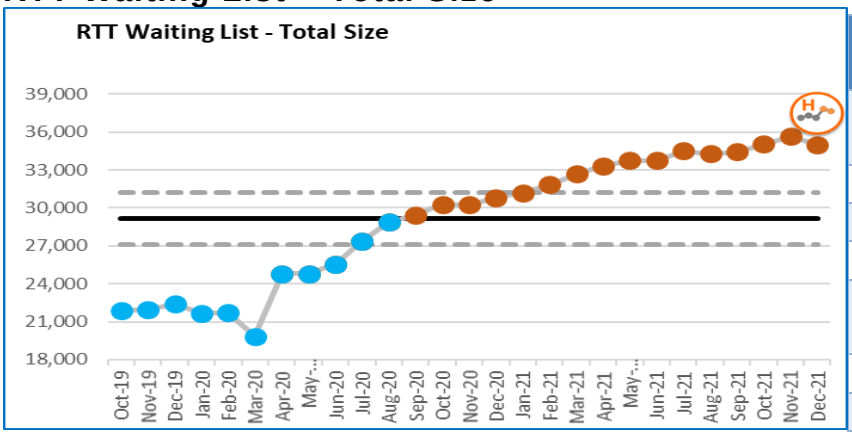
being sufficient to remove the backlog developed in a single year. The plan is being closely monitored both for activity delivered, aligned to each intervention and its impact on waiting times and waiting lists in line with the profile agreed to year end:

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

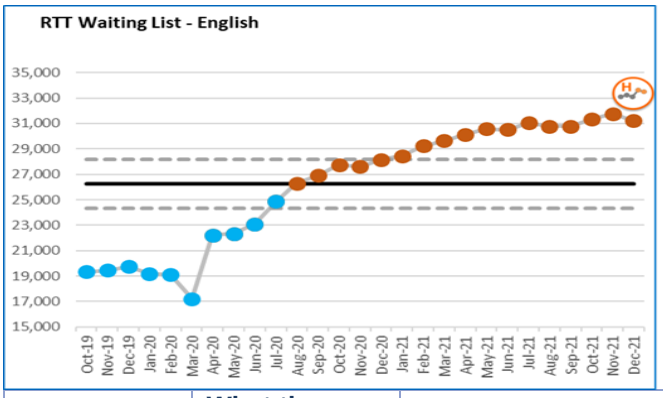
The cohort of patients who potentially could be waiting over 104 weeks from referral to treatment is continuing to reduce each week, although the rate of reduction reduced during December, in part due to lost bed capacity, the staffing challenges and the bank holiday period. Performance in December was therefore worse than the plan for actual 104 weeks wait, however the cohort of patients needing to be treated to avoid 104 week waits at 31st March 2022. had reduced. The position as at 16th January 2022 shows 240 patients remain within the cohort. The latest trajectory show the risk to delivery of the year-end target primarily being in the surgical specialties due to the loss of elective capacity.

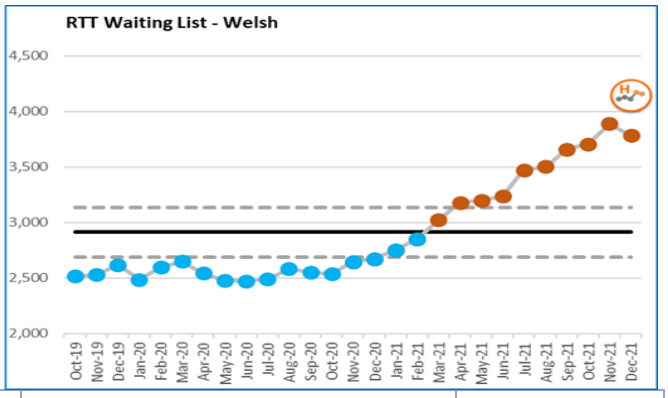


RTT Waiting List – Total Size



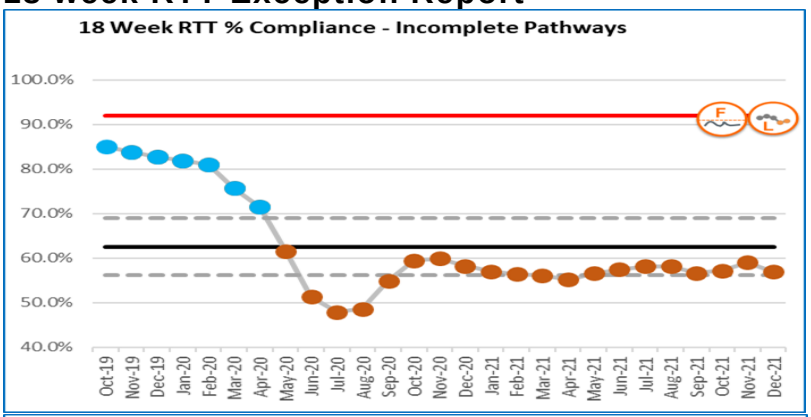
December2021 actual performance
35008 (English 31226, Welsh 3782)
Variance Type
Special Cause Concern
Local Plan
34,443 total, 30779 (English) by Mar 2022
Target / Plan Achievement
H2 to hold Sept.2021 position



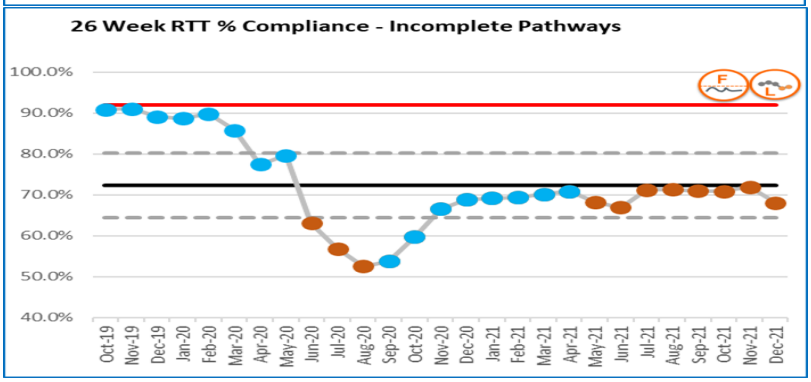


Background	What the Chart tells us	Issues	Actions	Mitigations
Total list size continues to increase because of the inability to treat clinically routine patients and close RTT pathways.	Continuation of the increase in the total waiting list size. With the interventions agreed in H2 it is expected that the waiting list size will start to reduce but remain at a higher level than pre-COVID-19 by March 2022.	Reduced capacity to see and treat patients due to clinic space restrictions, bed capacity due to emergency pressures and staff absences/theatre vacancies. Increase in cancer referrals particularly in colorectal. Conversion rate as more patients are seen in outpatients and placed on a waiting list. Increased routine diagnostic waiting times emergency demands.	Centre PTL pod meeting Weekly RTT Restore and Recovery. Exploring increased use of the independent sector for insourcing work at weekends as no capacity at SaTH due to increased emergency admissions. Training staff for surgical transfer to Vanguard. Optimising utilisation of eye unit and vanguard. Outsourcing of pain interventions, some urological procedures, some ophthalmology and some general surgery to IS providers. Continuing used of virtual clinics where appropriate. Adoption of patient initiated follow up as clinically appropriate.	As actions Additional 32-bedded unit from April will hopefully mitigate some bed pressures. Theatre staff recruitment and supernumerary to substantive trajectory.

18 week RTT Exception Report



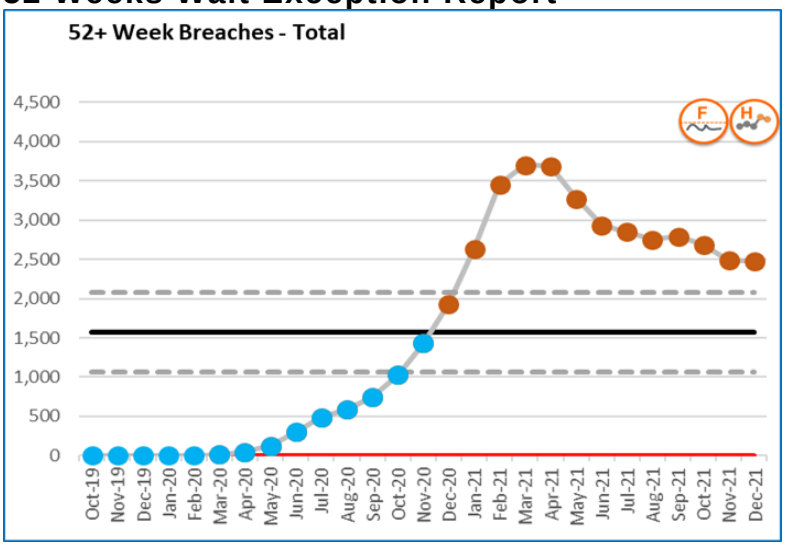
December2021 actual performance
56.9%
Variance Type
Special Cause Concern
National Target
92%
Target / Plan Achievement
Clinical prioritisation and the backlog developed mean target will not be achieved.



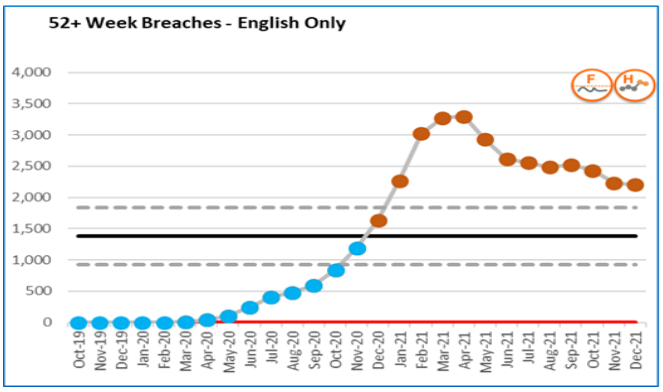
December2021 actual performance
68%
Variance Type
Special Cause Concern
National Target
92%

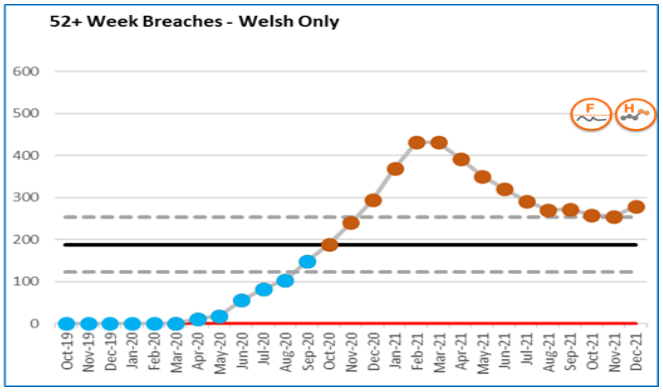
Background	What the Chart tells us	Issues	Actions	Mitigation
This is the National standard for patients referred for elective care. Headline performance against this measure has now stabilised but is well below the pre-pandemic performance.	Incomplete pathway appear to have stabilised at a level significantly below the national target. Total waiting list is forecast to reduce as the most urgent patients are treated. This means that the 18-week/26-week performance will continue to decline, as urgent patients tend to wait in shorter time bands.	Limited resources, outpatients with social distancing, theatre capacity due to theatre nursing teams and theatres prioritised to clinical urgent patients Staff related absences due to COVID-19. Increase in 2ww and urgent demand across a number of specialties.	Monitoring of referral demand and capacity Weekly centre PTL meetings Insourcing and outsourcing options.	Established system meeting to monitor elective and cancer.

52 Weeks Wait Exception Report



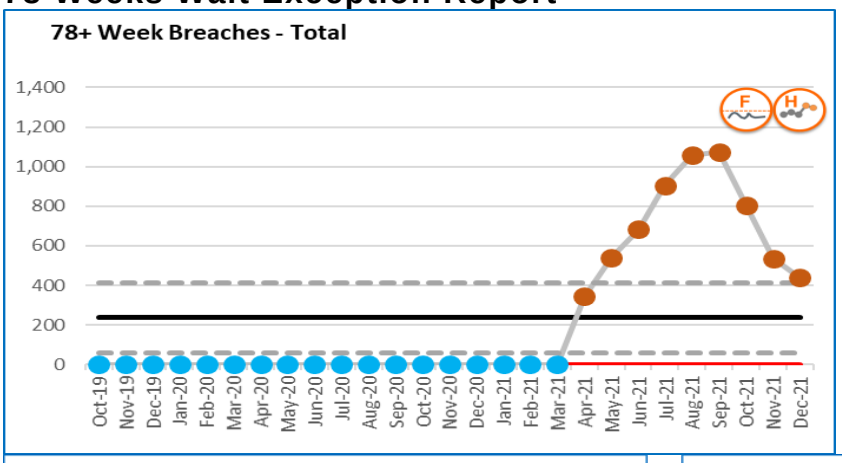
December 2021 actual performance	
2480 (English 2201, Welsh 279)	
Variance Type	
Special Cause Concern	
National H2 Target	**Local Forecast**
2755 (2485 English)	2108 (English)
Target / Plan Achievement	
Local forecast developed aligned to the H2 plan post interventions applied.	



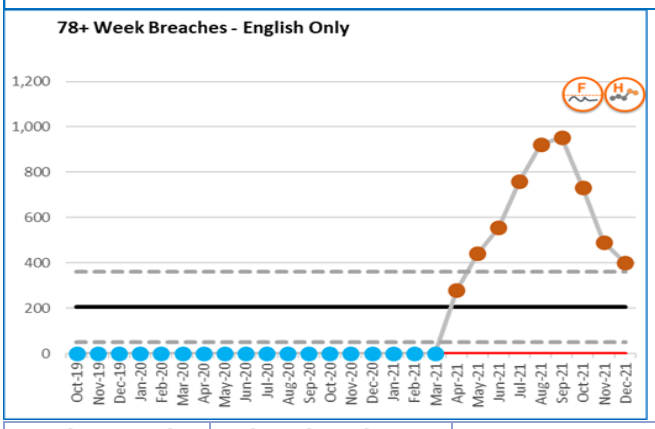


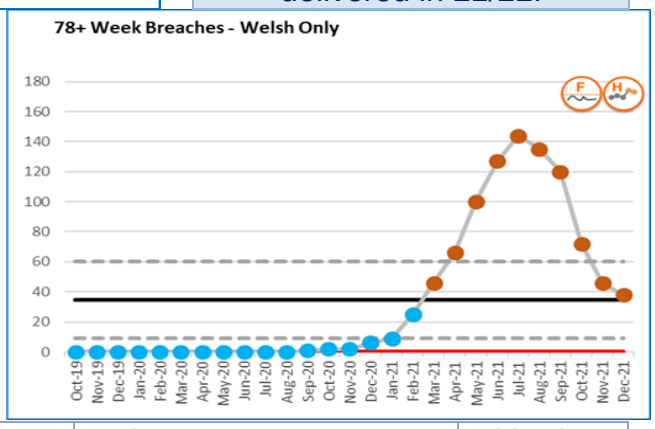
Background	What the Chart tells us	Issues	Actions	Mitigations
From a baseline position of zero pre-pandemic, the volume of patients waiting in excess of 52 weeks on an open RTT pathway has increased significantly. It reflects routine patients are not currently being able to be prioritised for treatment.	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 English patients forecast to be waiting over 52 weeks at year-end. This will be increased by c10% to allow for non-English patients waiting.	Theatre staffing Reduced elective capacity Urgent care pressures resulting in the loss of elective 'green' capacity.	Clinical prioritisation patients. Use of outsourcing including: Rowley Hall, Nuffield, vanguard and insourcing capacity via 18 weeks. Continue to booking in line with clinical priority and longest wait.	Monitored by weekly RTT meeting & cancer performance meeting.

78 Weeks Wait Exception Report



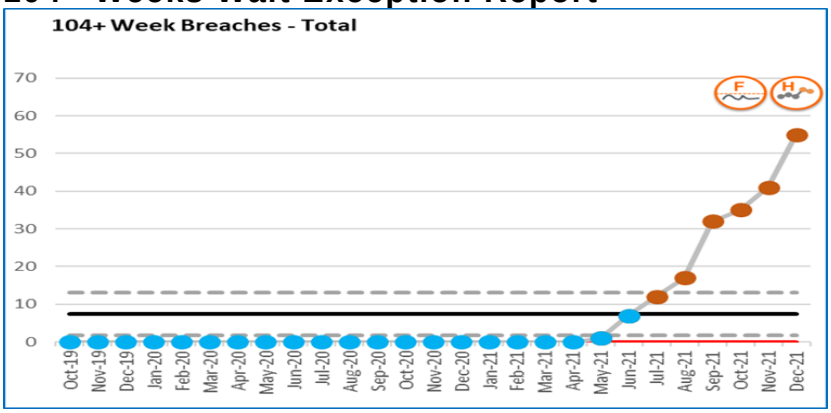
December 2021 actual performance	
438 (English 400, Welsh 38)	
Variance Type	
Special Cause Concern	
National Target	**Local Forecast**
0	tbc
Target / Plan Achievement	
The target will not be delivered in 21/22.	





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

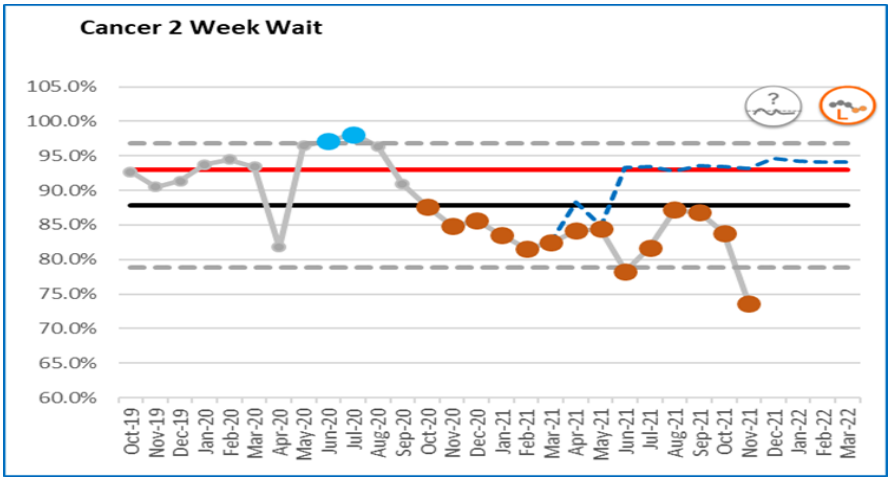


December 2021 actual performance	
55 (English 50, Welsh 5)	
Variance Type	
Special Cause Concern	
National Target	**Local Forecast**
0	74
Target / Plan Achievement	
H2 monthly trajectory	

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. The H2 target is to reduce to zero by 31.3.22. The SaTH H2 plan including interventions has 74 patients remaining over 104+weeks at 31.3.22.	Number of 104+ week waiters is increasing. The end of Dec.21. position is 11 patients worse than the H2 planned trajectory.	Loss of the surgical beds to support unscheduled care pressures during December has further reduced capacity, resulting in some patient cancellations. Lack of capacity in outpatients, Daycase and inpatients linked to outpatient space restrictions, lack of elective capacity due to unscheduled escalation into elective bed space on both sites	Clinical prioritisation of patients within limited available capacity Scoping options to use Nuffield for cancers and insourcing activity at weekends. Optimising vanguard and training staff to undertake laparoscopic activity previously not done in vanguard. Seeking resolution to radiology support for treatment of the patients awaiting Pain and Urology interventional procedures. Improving discharge of pathway 1-3 patients so as to restore elective capacity.	Monitored via weekly RTT meeting. Trajectory for 104 weeks monitored by region fortnightly and reported weekly.

Cancer

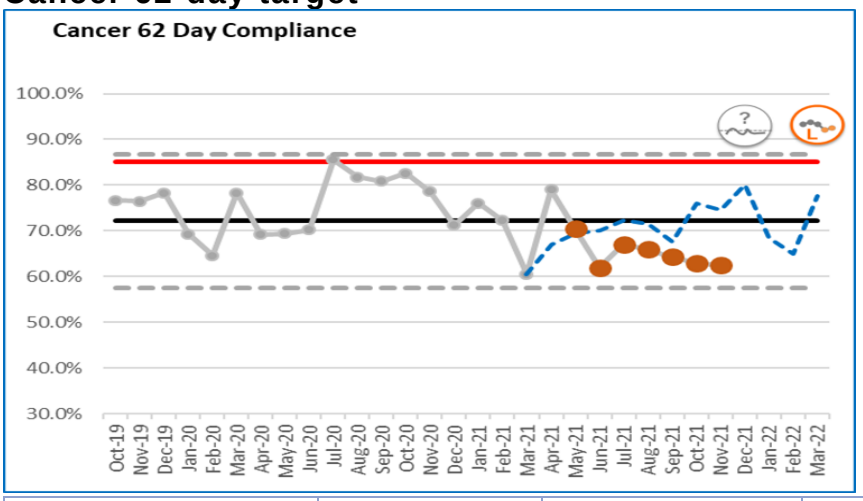
Cancer 2 week waits



November 2021 actual performance
73.6% (December Forecast 74.4%)
Variance Type
Special Cause Concern
National Target
93%
Target / Plan Achievement
Improvement trajectory not being achieved

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 time's 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/ and Lung services.	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. Increased referrals for 2ww.	Breast Pain only clinics to start in November, which will reduce the amount of 2WW, Breast referrals. Gynaecology working on extra capacity and alternatives to one stop.	Implementation of revised 2WW Breast Referral Proforma. Implementation of revised 2WW Gynaecology Proforma.

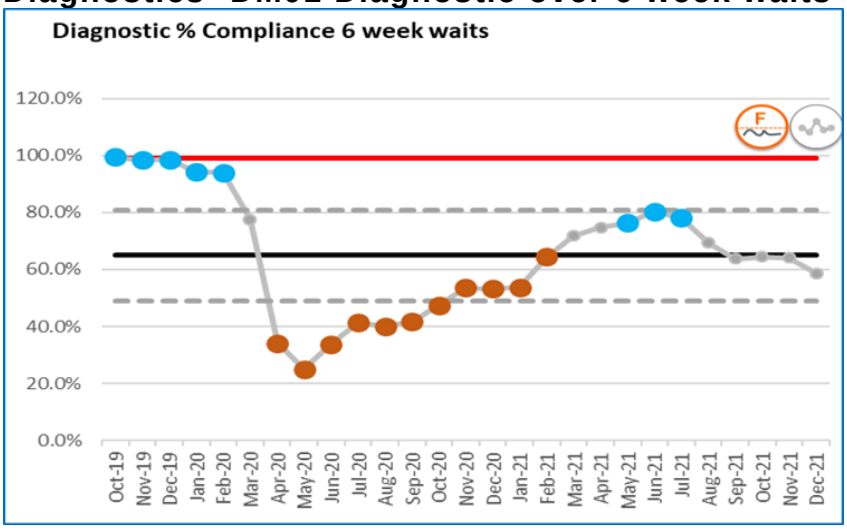
Cancer 62-day target



November 2021 actual performance
63.2% (December forecast 66.1%)
Variance Type
Special Cause Concern
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 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. Loss of surgical capacity during Dec.21 and into Jan. 22.	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 Early 2022. This is staff dependant. Transfer of suitable patients to the Nuffield from January 2022.	Cancer Performance and Assurance Meetings on going chaired by Deputy COO.

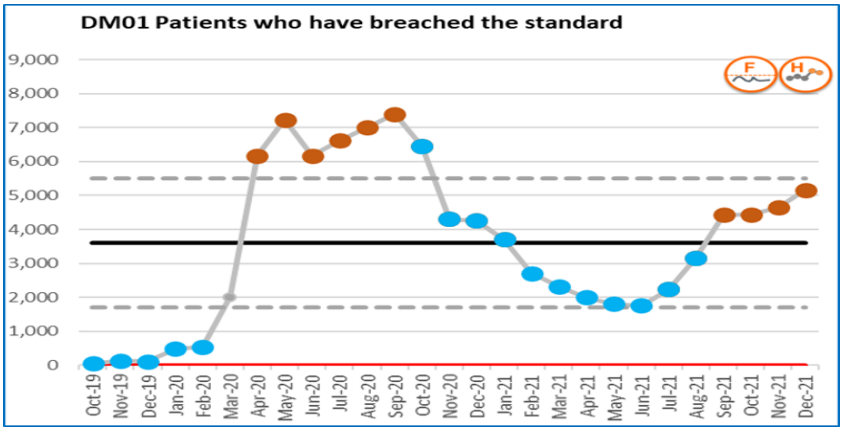
Diagnostics -DM01 Diagnostic over 6 week waits



December 2021 actual performance
58.7%
Variance Type
Common Cause
National Target
99%
Target / Plan Achievement
Recovery is no longer expected to be achieved by March 2022. Plan for further additional capacity being developed for 2022-23.

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, despite good levels of activity being delivered in radiological modalities. Demand is outstripping the capacity available.	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. Recruited staff are gradually taking up post and being inducted but have not yet been sufficient to staff the new imaging POD. Cessation of mutual aid for imaging from end of November at RJAH in line with agreed plan, has reduced available capacity.	Return of mobile CT from 11th October to increase staffed capacity. 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. Mutual aid from Nuffield continuing at low level but has ceased from RJAH and being re-requested in January. Case for extension and further mobile scanners to be completed Jan. 2022.	Clinical prioritisation of appointments. Utilisation of all available mutual aid from RJAH and Nuffield.

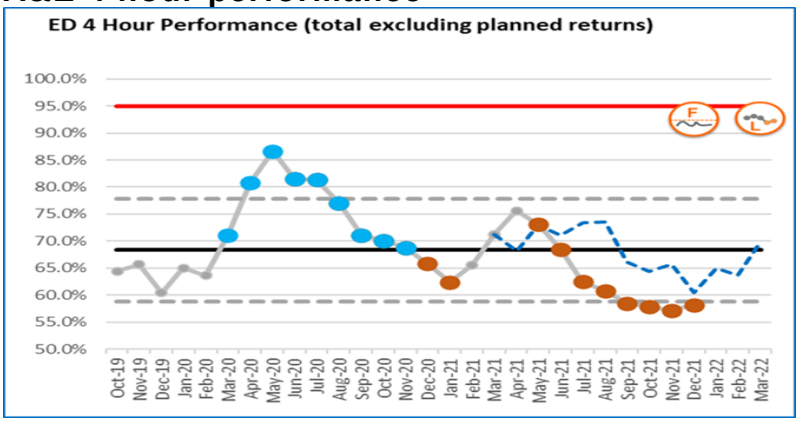
DM01 Patients who have breached the Standard



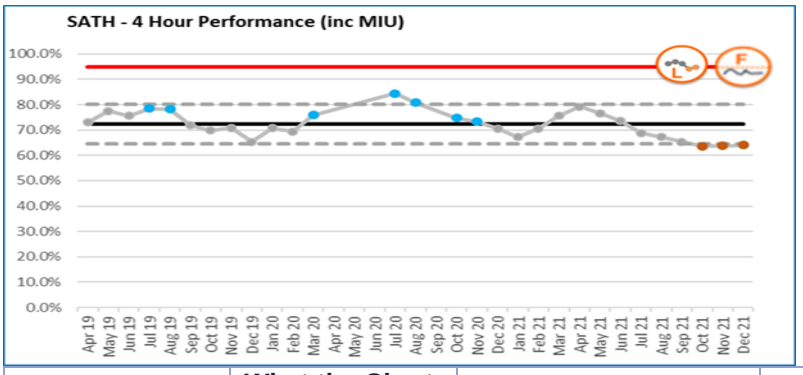
December 2021 actual performance
5158
Variance Type
Special Cause Concern
National Target
0 - < 6weeks
Target / Plan Achievement
Clinical prioritisation and then addressing longest waits.

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. Loss of mutual aid capacity in Dec.21.	Ongoing recruitment into cross sectional team. Approval of mobile CT business case saw the mobile return to site and commence scanning on 11th October. Business case to extend use of mobile scanners. Request for re-commencement of mutual aid from RJAH.	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



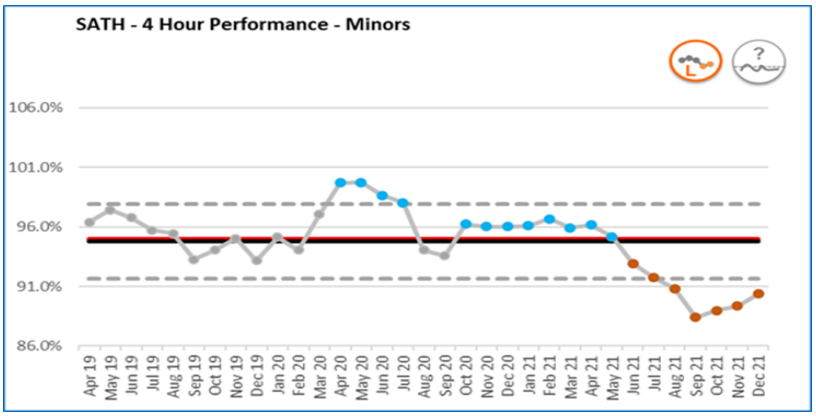
December performance
58.2%
Variance Type
Special Cause Concern
National Target
95%
SaTH Local Plan
60.4%
Target / Plan Achievement
Performance is worse than the improvement trajectory.



December 21 performance
65.3%
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, working with system partners. Working with WMAS on conveyance improvements. MADE events taking place with system partners. Reconfiguration of wards on RSH to create an acute medical floor for 2022-23.	System UEC action plan. Support from NHSEI MFFD and criteria to reside.

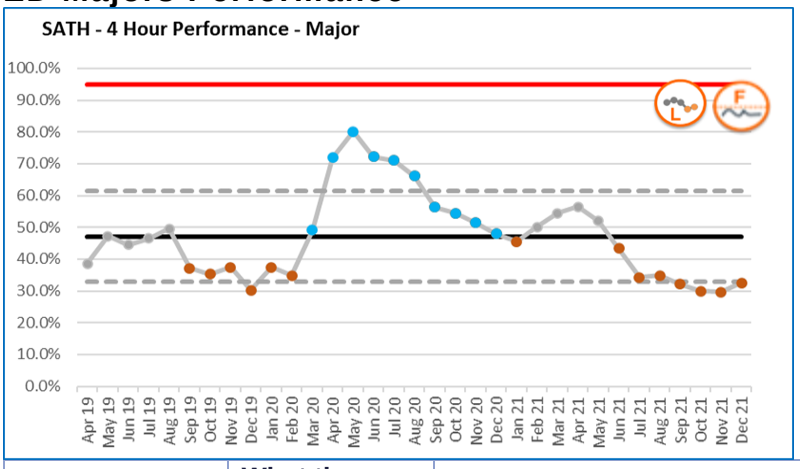
ED Minors Performance



December 2021 actual performance
90.4%
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.	Improvement in performance since September 21. but still below the expected standard and with special cause variation demonstrating change from previous achievement of this target.	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. Single point of Access for referrals in place. Implementation of ED re-direction programme with NHSEI expected in Q4.	Patients assessed on clinical priority need.

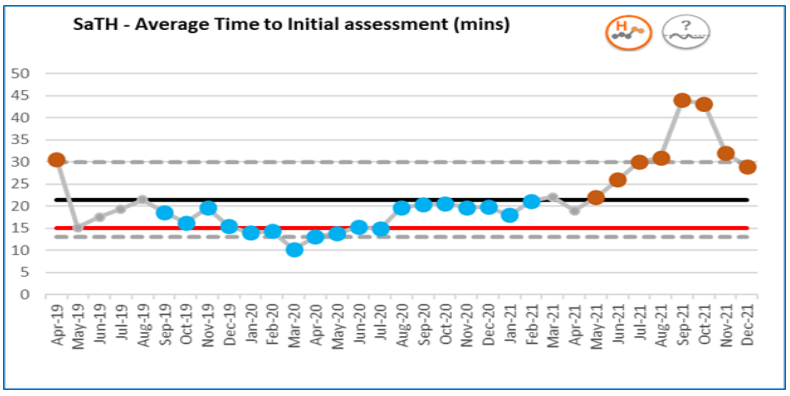
ED Majors Performance



December 2021 actual performance
32.6%
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.

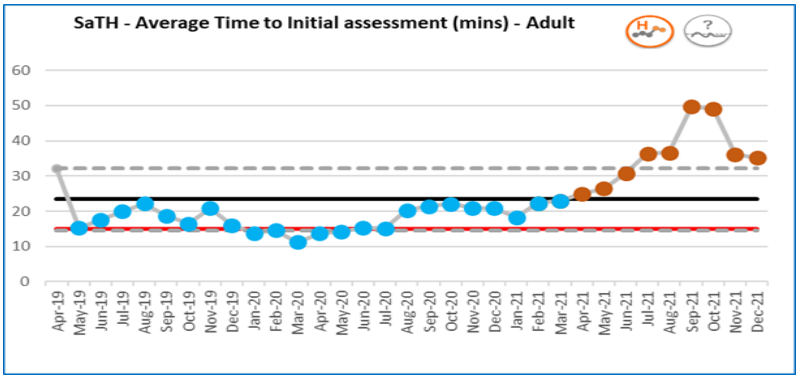
Background	What the Chart tells us	Issues	Actions	Mitigations
The national target is for all patients to be seen treated, admitted, transferred or discharged within 4 hours of arrival at the emergency department.	Deterioration in performance in Quarter 3. Marginal improvement in December 21.	Physical 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. Increasing MFFD list which is resulting in an increase in length of stay.	Reconfiguration of wards and increase in acute medical capacity. Direct access plans in place to reduce footfall in ED. Improvement plan roll out for flow improvements in ED and wards.	Patients assessed on clinical priority need.

ED –Time of Initial assessment (mins)



December 2021 actual performance
29 Minutes
Variance Type
Special Cause Concern
National Target
15 Minutes
Target / Plan Achievement
Aim to recover to national target.

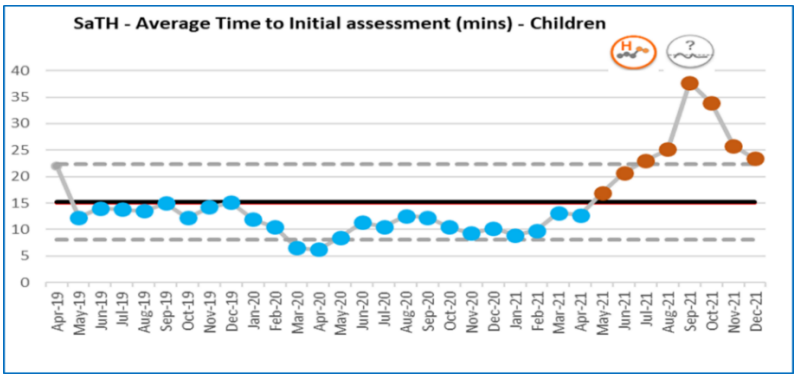
ED Time to Initial Assessment - Adult



December 2021 actual performance
35 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.	Oversight by Divisional Director and COO.

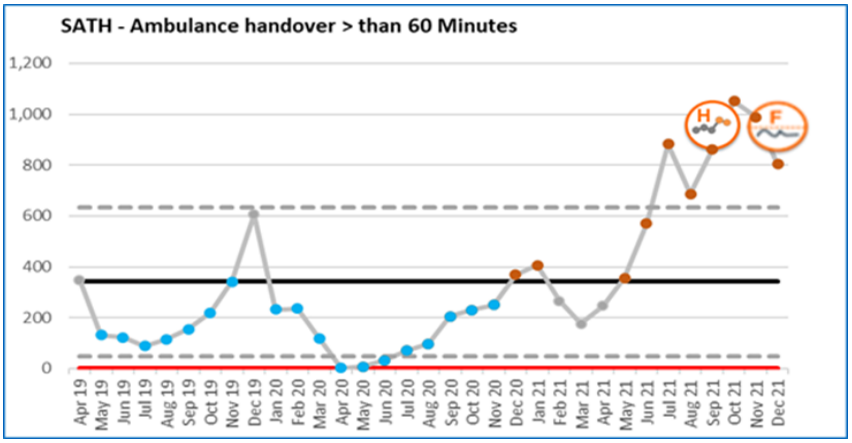
ED Time to Initial Assessment - Children



December 2021 actual performance
23 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.	Space within both departments to assess patients within 15 minutes. Increase in paediatric activity.	Matrons focussing on restoration of initial assessment times, improvement plan developed, in the process of implementation. Paediatric support to ED at high escalation levels. Access to paediatric ward and PAU to avoid ED overcrowding.	Oversight by DD and COO. .

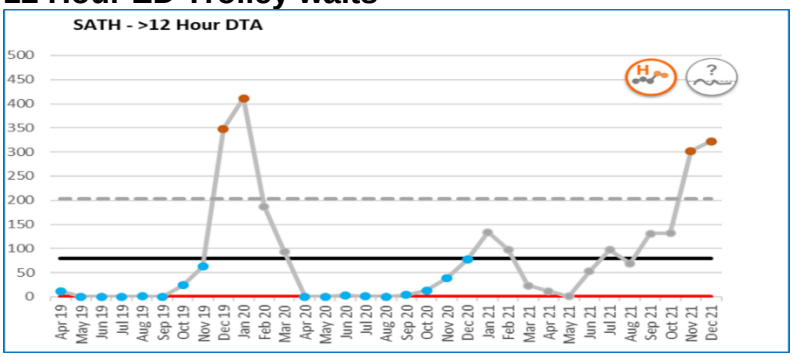
Ambulance handover> 60 Mins



December 2021 actual performance
803 (25.8%)
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.	Direct Access to both SDECS by WMAS. Single point of access for redirection in the system. Bed reconfiguration plans. Validation of category 3& 4 patient by WMAS to avoid conveyance. Virtual ward for respiratory and frailty to increase discharges.	System UEC action plan. System transformation group. Focussed system IDT. .

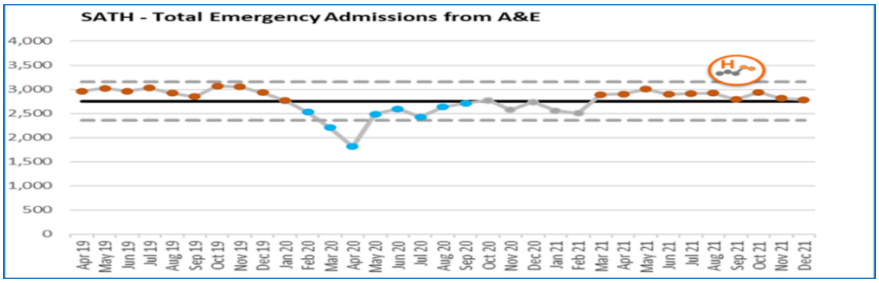
12 Hour ED Trolley waits



December 2021 actual performance
322
Variance Type
Special Cause Concern
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.	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.	Reconfiguration of wards and increase in acute medical capacity. Direct access plans in place to reduce footfall in ED. Improvement plan roll out for flow improvements in ED and wards.	ED Safe Today processes in place to mitigate risk where possible within the department.

Total Emergency Admissions from A&E



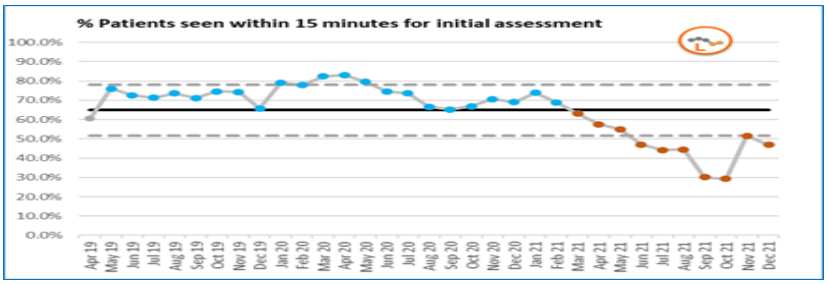
December 2021 actual performance
2785
Variance Type
Special Cause Concern
National Target
N/A

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.	Segmentation of patients continues to be necessary to ensure good IPC is maintained. Beds are required across elective and emergency care. Impact of admission avoidance schemes not fully realised in Dec.21.	Bed capacity is flexed to meet the demand of COVID-19 and non COVID-19 admissions. Criteria to admit programme being led by Medical Director. Monitoring through system of winter admission avoidance schemes. Working with partners to support schemes.	System wide plans to avoid admission and use of virtual ward and other pathways.

UEC metrics – shadow reporting.

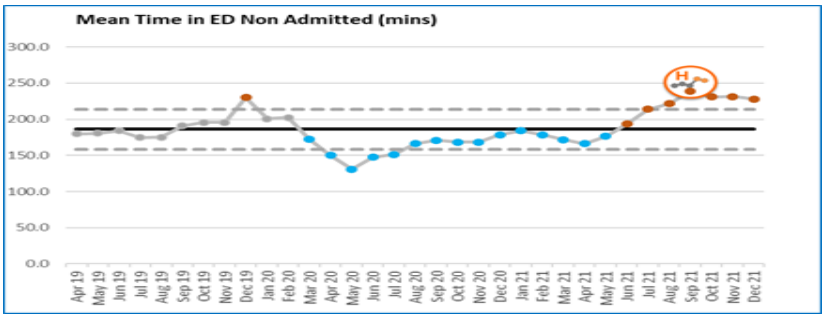
The measures below are reported in shadow form ahead of adoption expected nationally for 2022-23. The Operating Planning guidance for 2022-23 was received during the Christmas period and will be reviewed to establish which of the indicators have been adopted and the standards expected...

% Patients seen within 15 minutes for Initial Assessment



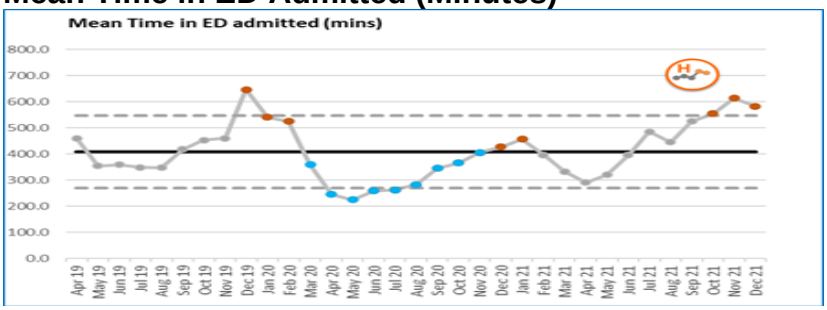
December 2021 actual performance
46.9%
Variance Type
Special Cause Concern
National Target
n/a

Mean Time in ED Non-Admitted (Minutes)



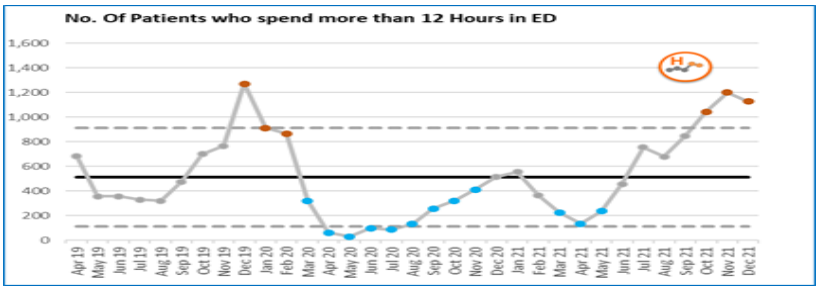
December 2021 actual performance
228
Variance Type
Special Cause Concern
National Target
n/a

Mean Time in ED Admitted (Minutes)



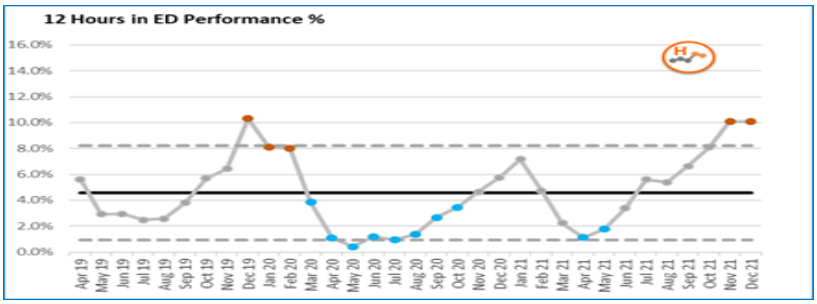
December 2021 actual performance
582
Variance Type
Special Cause Concern
National Target
n/a

Number of Patients who spend more than 12 hours in ED



December 2021 actual performance
1127
Variance Type
Special Cause Concern
National Target
N/A

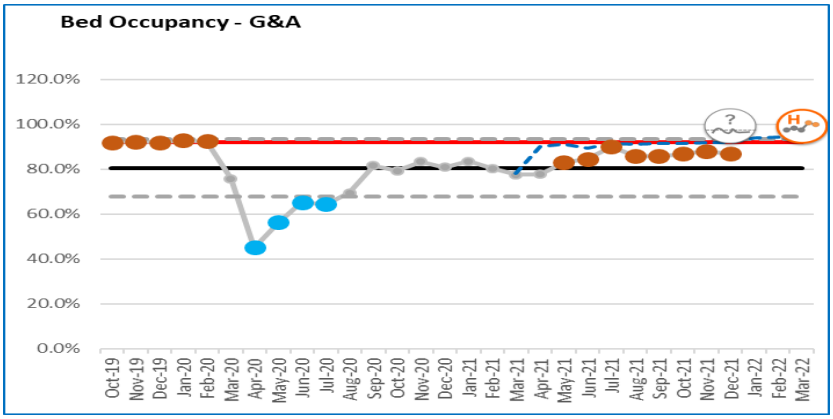
12 Hours in ED Performance %



December 2021 actual performance
10.1%
Variance Type
Special Cause Concern
National Target
N/A

Hospital Occupancy and Activity

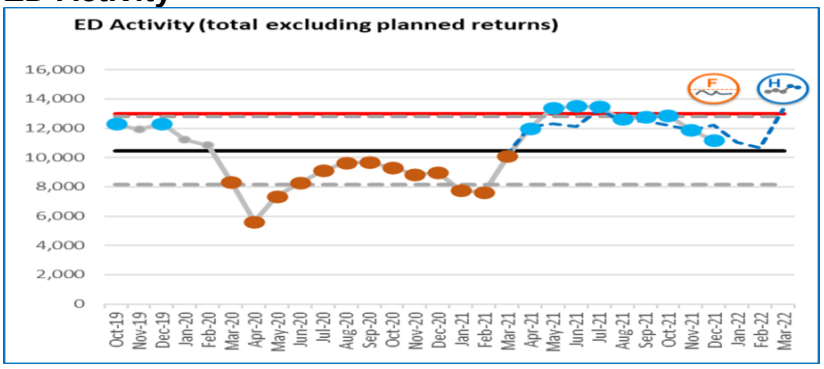
Bed Occupancy



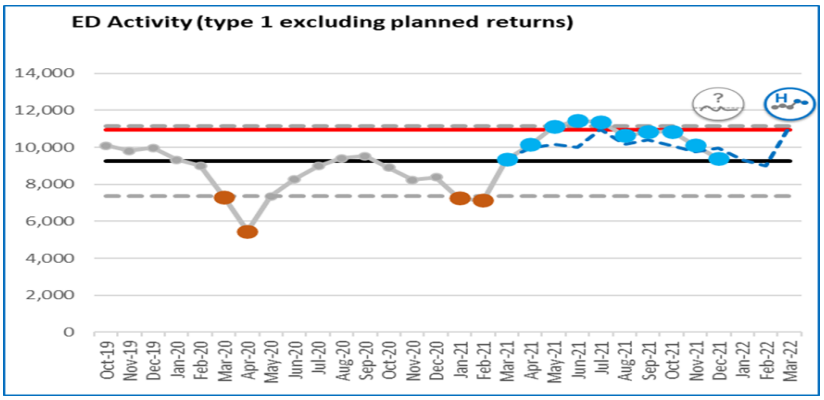
December 2021 actual performance
86.8%
Variance Type
Common Cause
Local Target
92%
Target / Plan Achievement
Occupancy slightly lower than pre-COVID-19

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. The % occupancy is a national measure against G&A beds at midnight – due to the specialty specific nature of some beds they are not all suitable for all patients. Occupancy on wards admitting emergency patients is much higher than the mean and occupancy at midday is higher than at midnight. Morning discharges remain low in number contributing to the flow issues in being able to admit patients from ED.	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. Cross Divisional ward reconfiguration group established chaired by MEC Divisional manager to re-configure ward allocation and align more closely to specialty requirements for 2022-23.

ED Activity



December 2021 actual performance
11183
Variance Type
Special Cause Improvement
Local Target
12231
Target/ Plan achievement
Trajectory Based on H2 plan



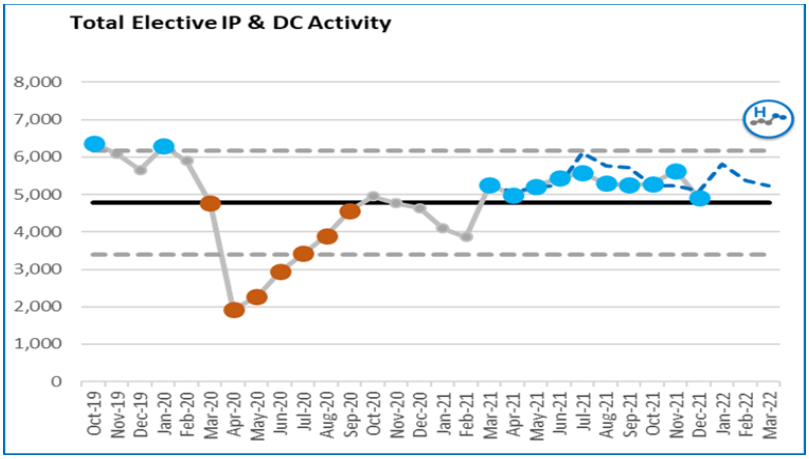
December 2021 actual performance
9383
Variance Type
Special Cause Improvement
Local Target
9970
Target/ Plan achievement
Trajectory Based on H2 plan

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 is reducing through both ED departments following the work that has commenced with our system partners and WMAS to reduce conveyance to each site and the Single point of access redirecting a cohort of patients to other pathways. Activity is performing in line with the H1 and H2 activity plans.	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. MADE events taking place with system partners. Reconfiguration of wards on RSH to create an acute medical floor.	Support from NHSEI MFFD and criteria to reside.

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

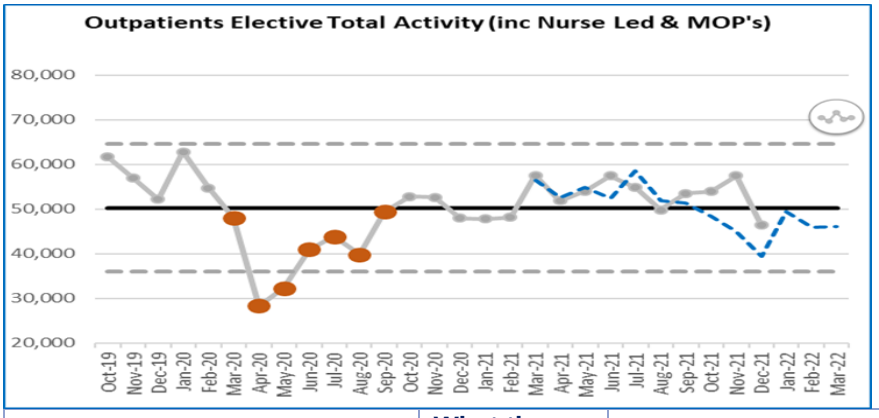


December 2021 actual performance	
4908 (Recovery 89.7%) (IP 279 , DC 4629)	
Variance Type	
Special Cause Improvement	
National Target	**Local Target**
95%	5098
Target/ Plan achievement	
Trajectory Based on H2 plan above	

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 below plan due to the reduced bed base	Reduced elective bed base due to emergency pressures increased use of day surgery beds to support emergency admissions. Theatre staffing issues.	Patient treated based on clinical priority i.e. cancer and urgency cases. Additional sessions planned at Nuffield January 2022 and further sessions sought. Recovery of day surgery unit beds RSH during Jan.2022.	As Actions

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

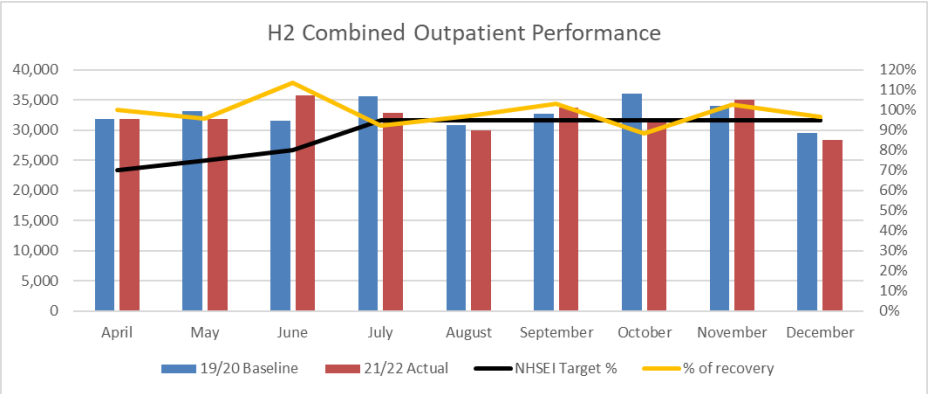


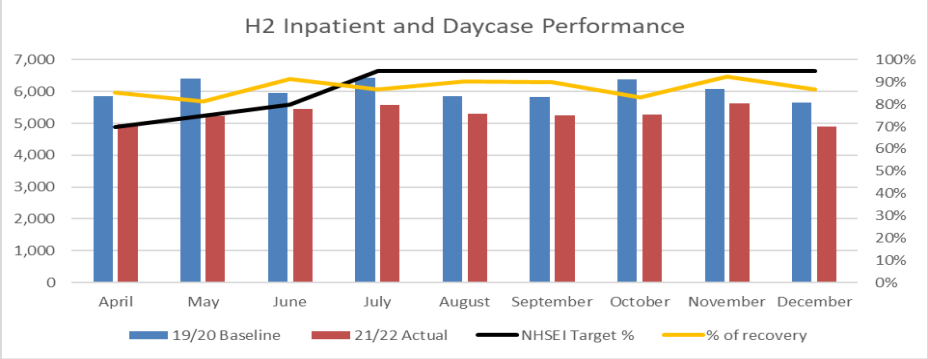
December 2021 actual performance
46472
Variance Type
Common Cause
Local Target
39355
Target/ Plan achievement
Delivery of H2 plan

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.	Plan -v- actual activity. Delivery of H2 plan.	Outpatient capacity remains a constraint due to staff / family related absence/ isolation/ COVID-19 is having some an impact on running clinic. Delivery of the plan itself does not eliminate the backlog of waits created during the pandemic.	Waiting list initiative. Options for agency staff in challenged specialties. Bank staff support.	Clinical prioritisation of patients.

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 – December 21. The diagnostic recovery plan is shown in the next section of the report.
The activity from October 2021 is part of the H2 plan and is in shown in relation to the 2019-20 baseline activity. Performance for December 2021 was below the baseline in Dec.2019.





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

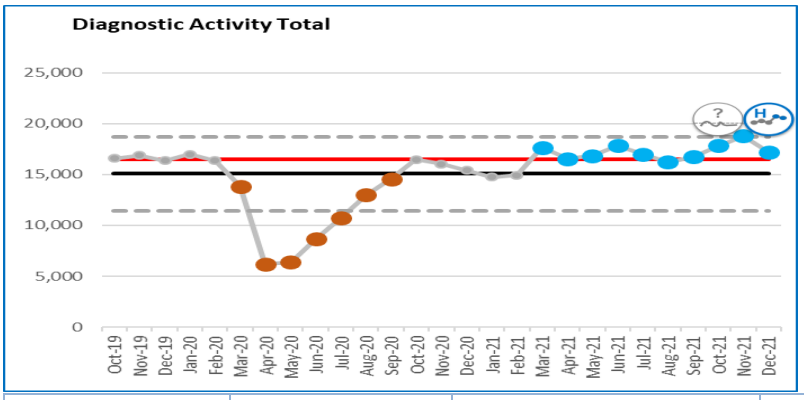
Matchfield	19/20 Baseline - Working Day Adjusted	21/22 H2 Pla	21/22 Actual	21/22 Actual % of 19/20 Working Day	21/22 Actual % of 21/22 H1 Pla
44531Diagnostic Tests - Magnetic Resonance Imaging	2458	2984	2183	89%	73%
44531Diagnostic Tests - Computed Tomography	6235	8228	6943	111%	84%
44531Diagnostic Tests - Non-Obstetric Ultrasound	5298	5257	4779	90%	91%
44531Diagnostic Tests - Colonoscopy	531	634	500	94%	79%
44531Diagnostic Tests - Flexi Sigmoidoscopy	418	219	161	39%	74%
44531Diagnostic Tests - Gastroscopy	701	751	405	58%	54%
44531Diagnostic Tests - Cardiology - Echocardiography	1090	1167	1074	99%	92%

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



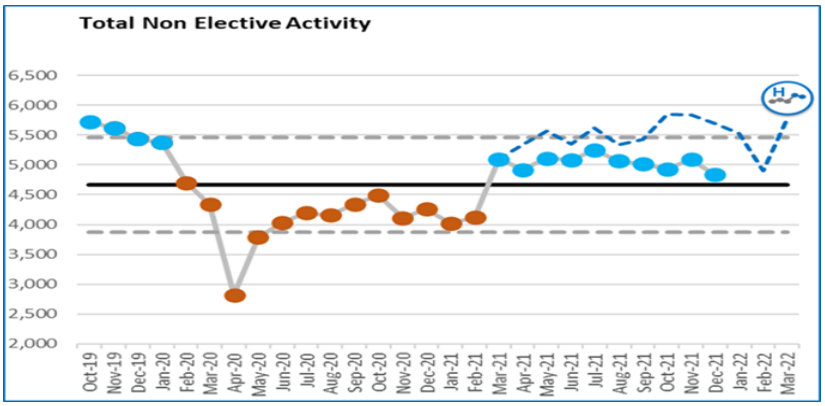
December 2021 actual performance
17,209
Variance Type
Special Cause Improvement
Local Target
197,619 for year 19,240 Dec.2021.
Target/ Plan achievement
Worse than H2 plan in Dec.

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 relatively 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. International radiographers commenced in December with further recruitment expected in Q4. Requesting re-instatement of mutual aid and business case of extension of staffed mobile capacity.	Ongoing recruitment. International Radiographers with more expected to join 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



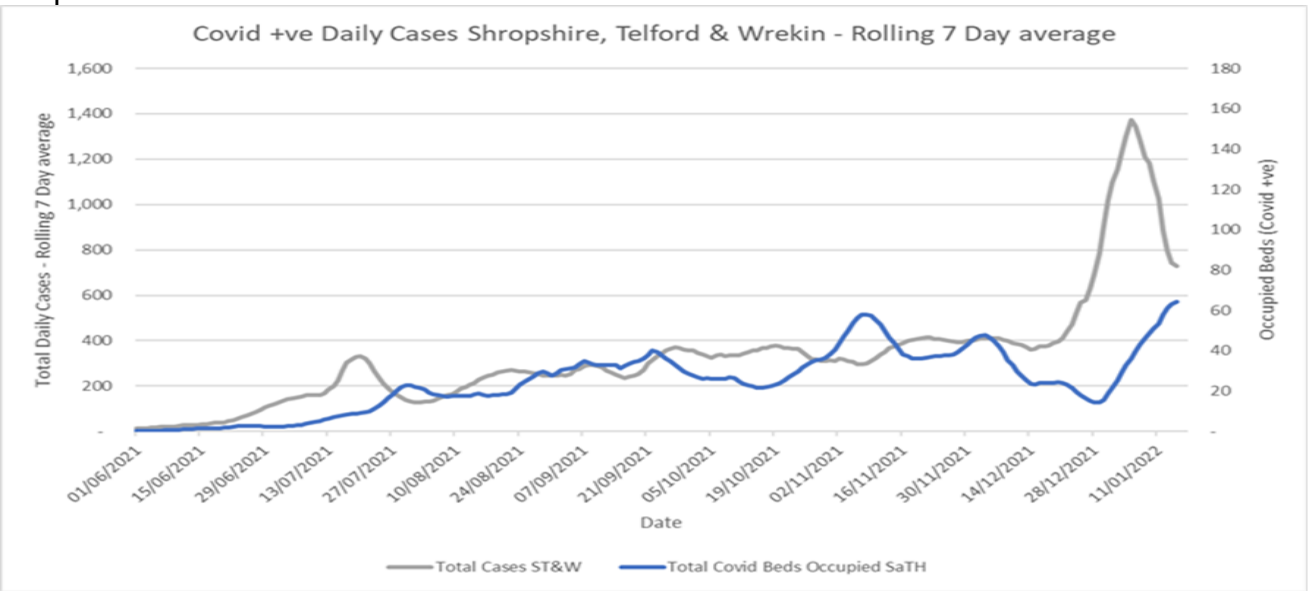
December 2021 actual performance
4836
Variance Type
Special Cause Improvement
Local Target
5697 (H2 plan)
Target/ Plan achievement
Demand is forecast to return to 19/20 baseline

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 lower than the 2019-20 baseline and the level expected in the H2 plan.	Increase in non-elective activity via ED. Increase in time from MFFD to discharge. Increase in length of stay. Flow issues across the site. COVID-19 admission increase resulting in segmentation of patients. Possible increase in surgical emergency admissions.	Dedicated CEPOD surgeon Clinical prioritisation Reduced elective 'green' capacity to increase emergency beds in both day surgery units.	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 quarter 3 and is leading to increases in hospitalisations, albeit at a lower level than in the previous wave.

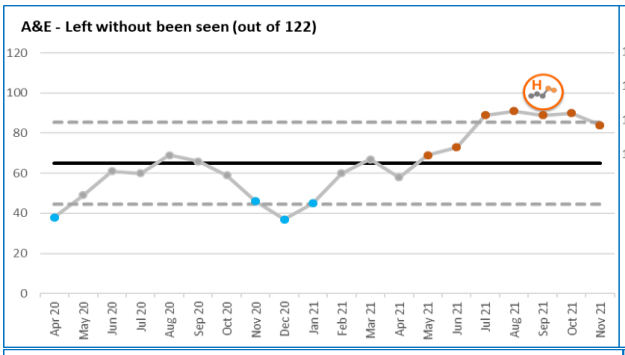


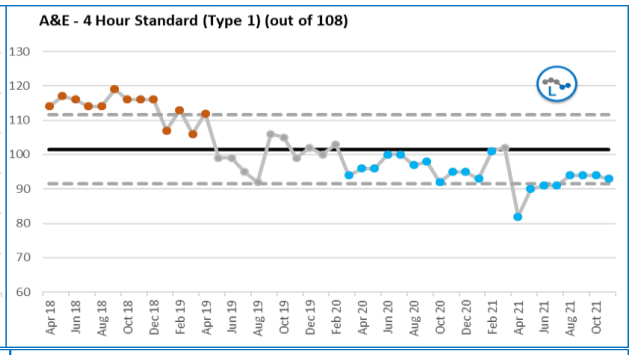
Operational Performance Benchmarking

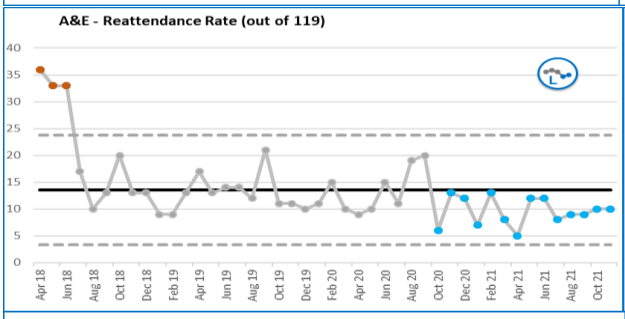
This table demonstrates the benchmarked position of the trust at a point in time compared to other English trusts reporting the same indicator. The icon shows the trend of ranking over time of the trust in relation to other trusts.

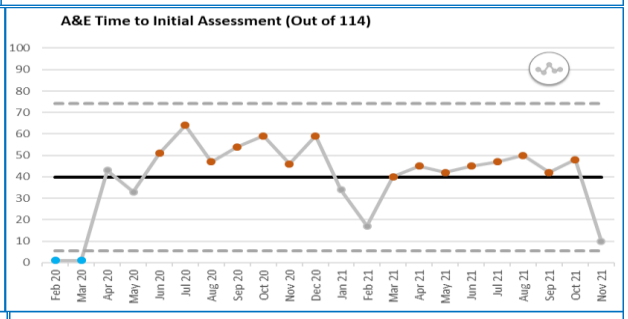
KPI	Latest month	Actual Performance Ranking	Performance	Lower process limit	Upper process limit
A&E - Left without been seen (out of 122)	Nov 21	84	H	45	85
A&E - 4 Hour Standard (Type 1) (out of 108)	Nov 21	93	L	91	112
A&E - Reattendance Rate (out of 119)	Nov 21	10	L	3	24
A&E Time to Initial Assessment (Out of 114)	Nov 21	10		6	74
Cancer 2 Week (out of 122)	Nov 21	83		50	121
Cancer 2 Week Breast Symptomatic (out of 112)	Nov 21	86		36	128
Cancer 62 Day Classic Metric (out of 122)	Nov 21	89	H	20	131
Cancer 62 Day Breast Cancer (out of 119)	Nov 21	49		16	143
Cancer 62 Day Lower Gastrointestinal Cancer (out of 122)	Nov 21	112		0	122
Cancer 62 Day Lung Cancer (out of 116)	Nov 21	72		10	140
Cancer 62 Day Other Cancer (out 123)	Nov 21	109		-23	139
Cancer 62 Day Skin Cancer (out 115)	Nov 21	51		-23	136
Cancer 62 Day Urological Cancer (out of 120)	Nov 21	63		15	135
Diagnostic 6 Week Standard (out of 122)	Nov 21	100	H	37	97
Diagnostic 6 Week Standard - Cardiology : echocardiography (out of 120)	Nov 21	12	L	-5	40
Diagnostic 6 Week Standard - Audiology Assessments (out of 108)	Nov 21	75	H	13	99
Diagnostic 6 Week Standard - Urodynamics: pressures & flows (out of 104)	Nov 21	103	H	10	103
Diagnostic 6 Week Standard - Respiratory physiology : sleep studies (out of 93)	Nov 21	3		-27	96
Diagnostic 6 Week Standard - Magnetic Resonance Imaging (out of 122)	Nov 21	104	H	47	107
Diagnostic 6 Week Standard - Computed Tomography (out of 122)	Nov 21	114	H	30	118
Diagnostic 6 Week Standard - Non-obstetric ultrasound (out of 122)	Nov 21	89		83	118
Diagnostic 6 Week Standard - Colonoscopy (out of 121)	Nov 21	114	H	2	87
Diagnostic 6 Week Standard - Flexi sigmoidoscopy (out of 121)	Nov 21	65	H	-4	90
Diagnostic 6 Week Standard - Cystoscopy (out of 117)	Nov 21	81		14	107
Diagnostic 6 Week Standard - Gastroscopy (out of 121)	Nov 21	83	H	7	79
RTT 52 Week Breach (out of 122)	Nov 21	87	H	67	86
RTT Incomplete 18 Week Standard – (out of 122)	Nov 21	97	H	49	85
RTT Incomplete 18 Week Standard Metric - Gynaecology (out of 120)	Sep 21	77		44	86
Robson Group 1 - C-section with no previous births (out of 78)	Sep 21	67	H	15	63
Robson Group 2 - C-section with no previous births (out of 78)	Sep 21	57	H	3	26
Robson Group 5 - C-section with 1+ births (out of 78)	Sep 21	40		-10	42
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	L	32	75

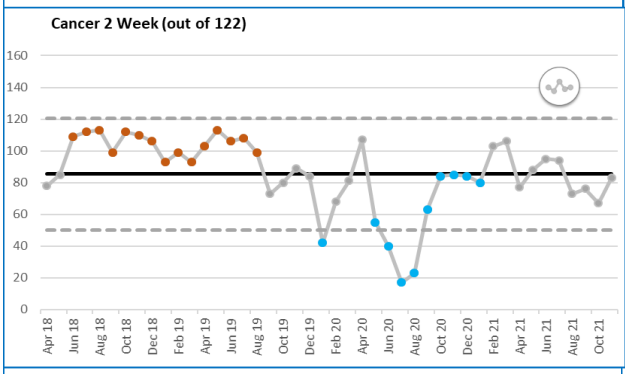
The SPC charts overleaf show the relative ranking of the Trust compared to other English trusts over time and so demonstrates the change in relative position compared to previous periods and the variation in the Trust ranking. The lower the ranking the better the relative position of the Trust is compared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

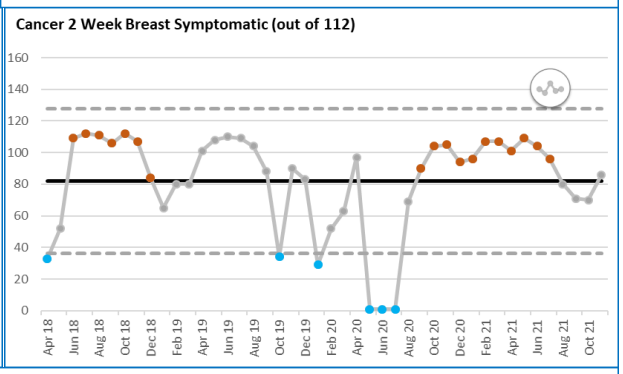

A&E - Left without been seen (out of 122)

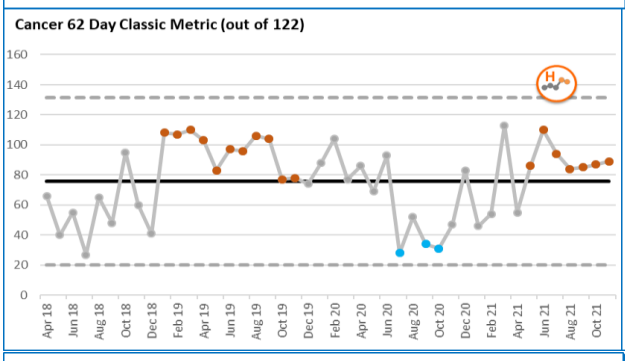

A&E - 4 Hour Standard (Type 1) (out of 108)

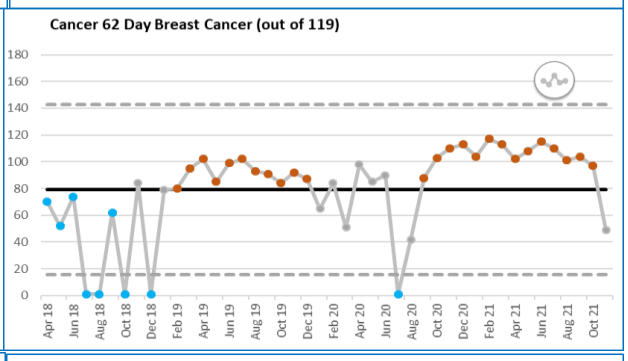

A&E - Reattendance Rate (out of 119)

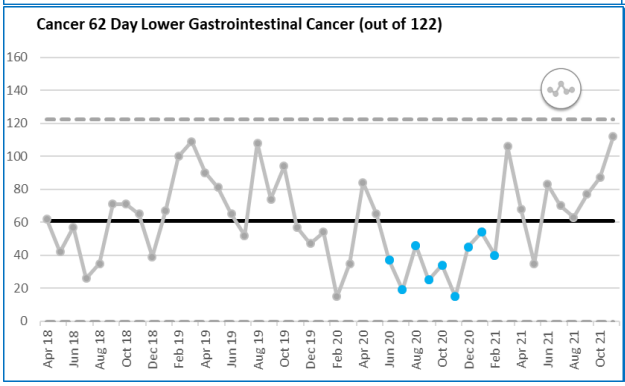

A&E Time to Initial Assessment (Out of 114)

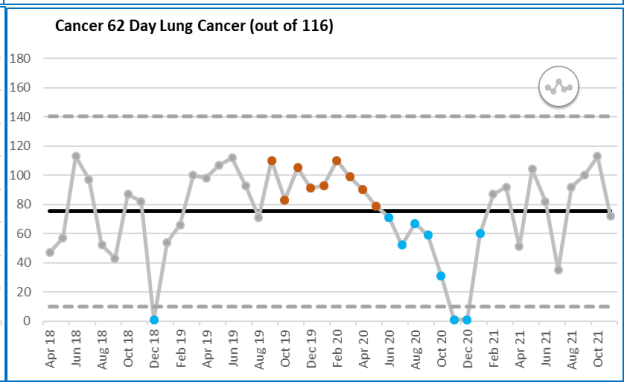

Cancer 2 Week (out of 122)

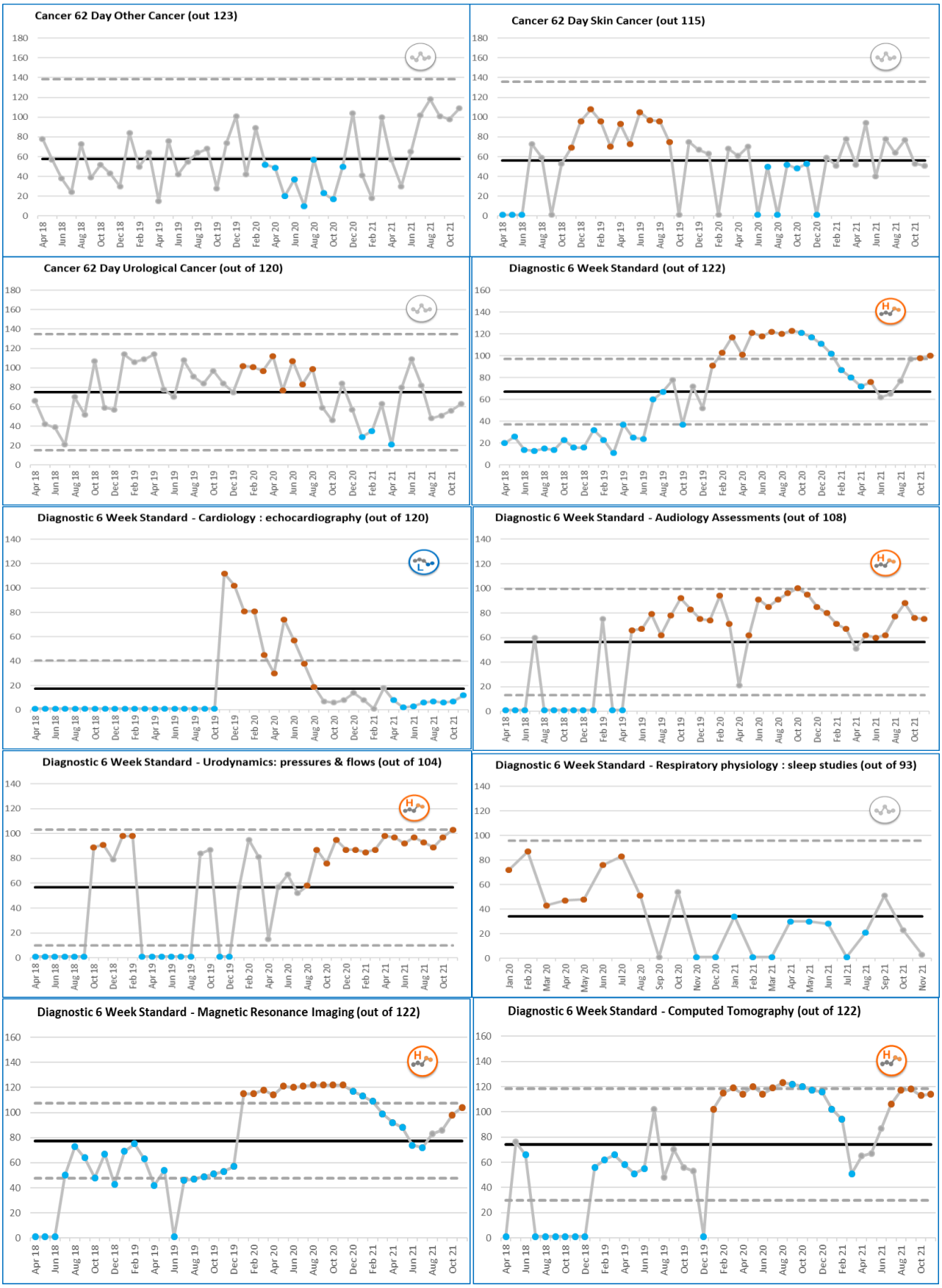

Cancer 2 Week Breast Symptomatic (out of 112)

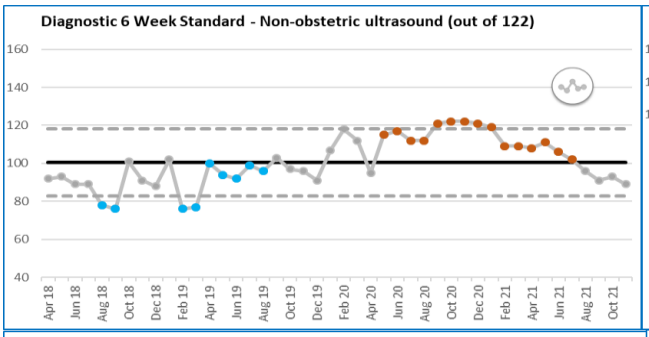

Cancer 62 Day Classic Metric (out of 122)

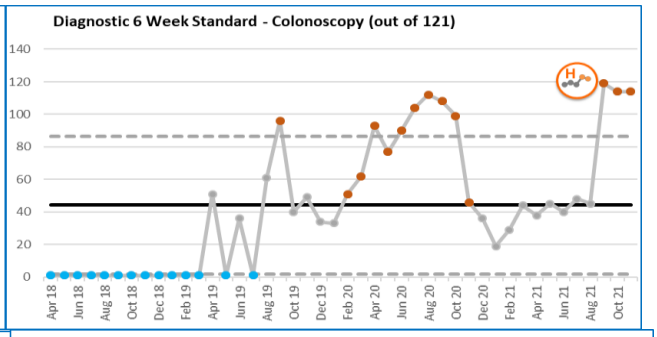

Cancer 62 Day Breast Cancer (out of 119)

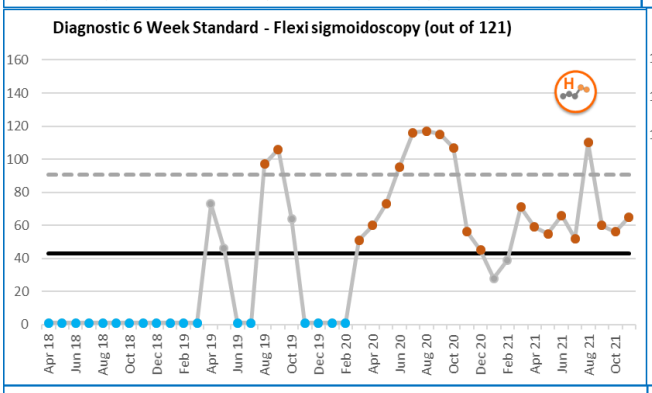

Cancer 62 Day Lower Gastrointestinal Cancer (out of 122)

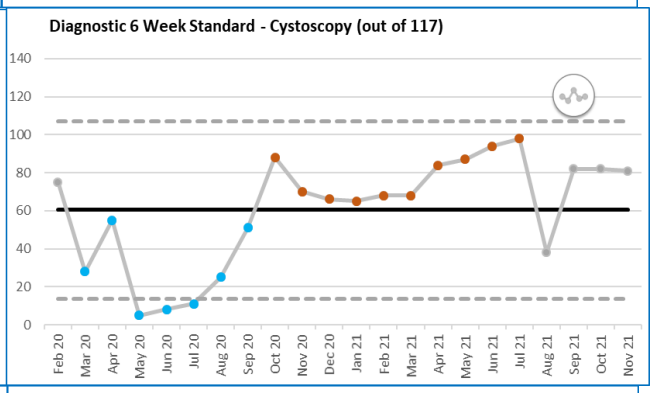

Cancer 62 Day Lung Cancer (out of 116)

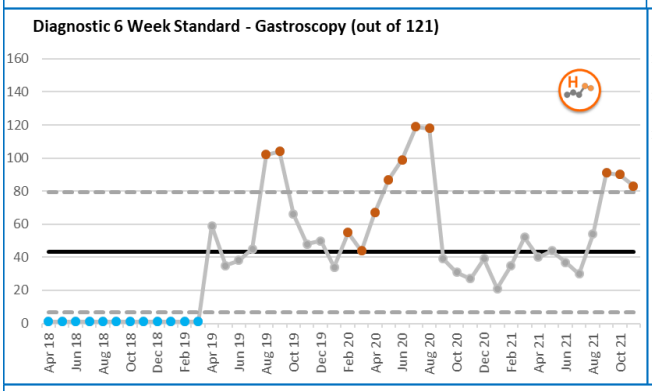

Cancer 62 Day Other Cancer (out 123)
Cancer 62 Day Skin Cancer (out 115)
Cancer 62 Day Urological Cancer (out of 120)
Diagnostic 6 Week Standard (out of 122)
Diagnostic 6 Week Standard - Cardiology : echocardiography (out of 120)
Diagnostic 6 Week Standard - Audiology Assessments (out of 108)
Diagnostic 6 Week Standard - Urodynamics: pressures & flows (out of 104)
Diagnostic 6 Week Standard - Respiratory physiology : sleep studies (out of 93)
Diagnostic 6 Week Standard - Magnetic Resonance Imaging (out of 122)
Diagnostic 6 Week Standard - Computed Tomography (out of 122)

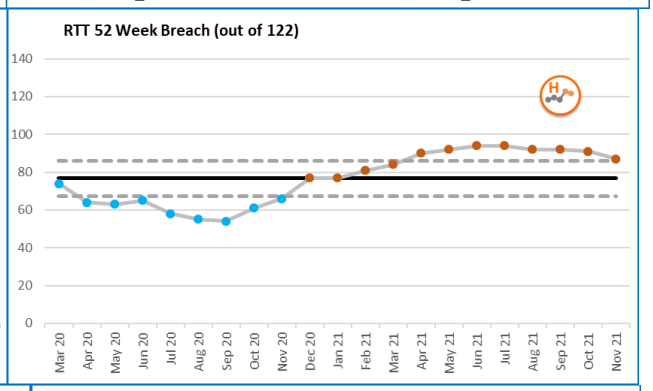

Diagnostic 6 Week Standard - Non-obstetric ultrasound (out of 122)

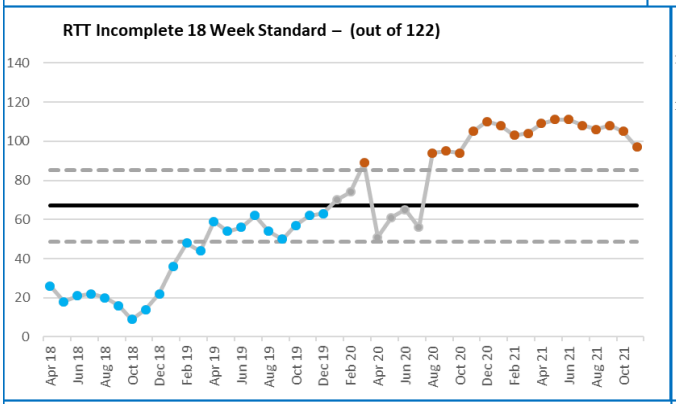

Diagnostic 6 Week Standard - Colonoscopy (out of 121)

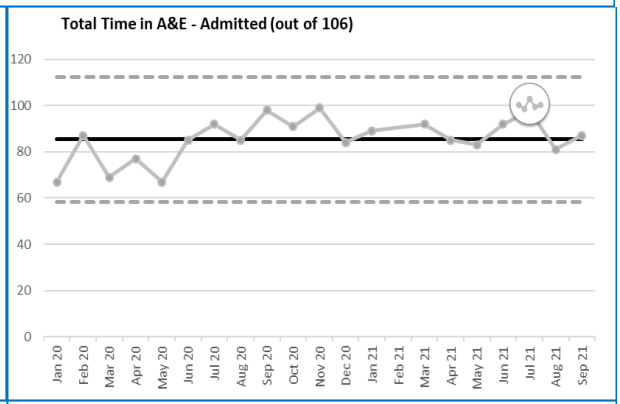

Diagnostic 6 Week Standard - Flexi sigmoidoscopy (out of 121)

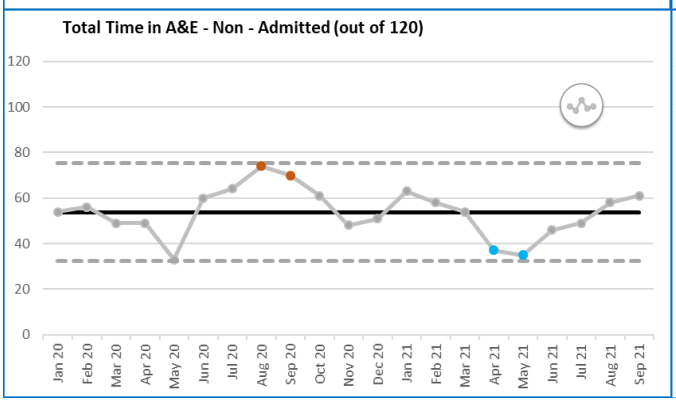

Diagnostic 6 Week Standard - Cystoscopy (out of 117)

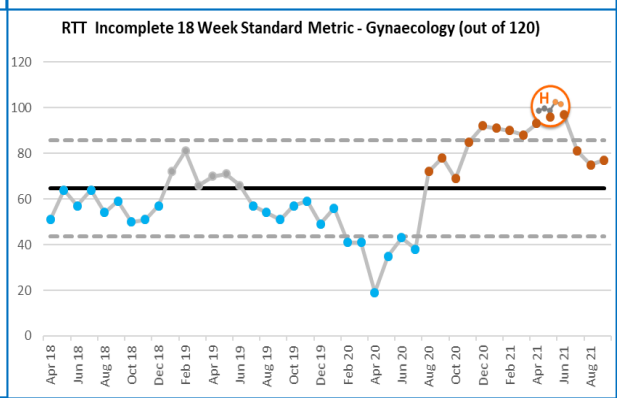

Diagnostic 6 Week Standard - Gastroscopy (out of 121)


RTT 52 Week Breach (out of 122)


RTT Incomplete 18 Week Standard – (out of 122)


Total Time in A&E - Admitted (out of 106)


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


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

7. Finance Summary
Helen Troalen, Director of Finance

- The Trusts reported position after month nine of the 2021/22 financial period is a deficit of £7.929m, £3.055m adverse to plan. This adverse position is a result of two key issues:

    1. £2.566m overspend on the elective recovery programme during the first six months of the financial year (H1), and;
    2. £0.588m adverse position linked mainly to additional costs associated with the operational and workforce pressures experienced during Q3.

- A surplus of £1.889m was recorded during December which is driven by the timing of the elective recovery funding (ERF) for Q3, recorded for the full Q3 period during month nine. The year-to-date position for ERF is a deficit of £1.167m, £2.467m adverse to plan. This adverse position is primarily due to H1 ERF expenditure being above income.

- Operational pressures during December have limited recovery of the elective and cancer waiting lists but work continues to optimise the independent sector capacity funded through ERF over the H2 period. The Trust spent £1.043m on this capacity during December.

- Income overall is £7.495m higher than expected year-to-date. This is due to additional unplanned income received mid-year to fund the pay award, additional high-cost drugs, maternity transformation, screening income and income associated with the Trust's hosting of the ICS finances, all of these income streams are offset in full by additional expenditure.

- The Trust has spent £9.879m year-to-date on expenditure directly associated with the COVID-19 response (£0.893m in the month). It is important to note however, that there continue to be additional incremental COVID-19 associated costs, which continue to be charged to core budgets, mainly pay, linked to the urgent need to flex resource to support surge capacity. £12.526m of funding has been received to date to support these costs.

- The Trust has an agreed plan to deliver a deficit of £9.590m at the end of the 2021/22 financial period. However, given the on-going costs associated with the operational and workforce pressures, it is likely that costs will increase and negatively impact the forecast outturn. The forecast is a deficit of £10.9m which is £1.5m adverse to the plan. This has been discussed with the ICS and it is likely that the system as a whole will still deliver the overall financial plan.

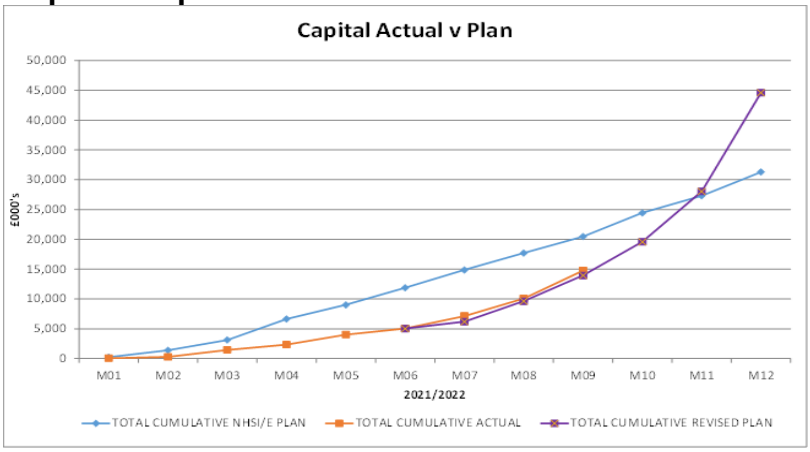
- £4.567m of efficiency savings have been delivered YTD slightly behind plan with 41% delivered non-recurrently. The overall recurrent annual efficiency requirement is for £7.550m (1.6%) which the Trust is forecasting to deliver in full.

- The Trust's total capital allocation for 2021/22 as at month nine has been increased to £48.961m, following inclusion of IT- Cyber Security £0.250m and adjustment for HTP planning work.

Total capital spend YTD is £14.774m against a revised planned spend of £13.964m. The Trust is currently forecasting capital expenditure of only £44.6m, an underspend of £4.354m against allocation. This is due to a projected underspend of £2.900m relating to the recently transferred Community Diagnostic Centre Scheme and £1.454m underspend against an additional capital allocation made at the beginning of the financial year.

- The Trust held a cash bank balance at the end of December of £15.320m.

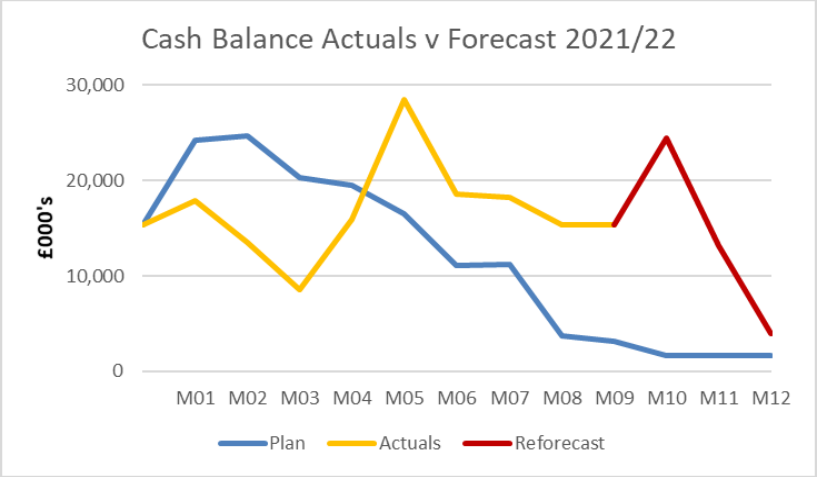
Capital Expenditure



December 2021 actual performance
Spend year to date is £14.774m
Variance Type
Underspend (against original NHSEI Plan) £5.703m
SaTH Plan 2021/22
£44.618m
Target/ Plan achievement
To meet the Trust's capital resource limit (CRL).

Background	What the Chart tells us	Issues	Actions	Mitigations
The Trust's total capital allocation for 2021/22 as at month 09 has been increased to £48.961m, following inclusion of IT- Cyber Security £0.250m and adjustment for HTP planning work.	Within the original capital plan submitted to NHSEI, the Trust forecast spend at month 09 of £20.477m, £14.774m has been expended giving an underspend of £5.703m to plan.	Capital expenditure to date is lower than projected in original plan. The Trust is currently forecasting capital expenditure of only £44.618m, an underspend of £4.343m against allocation. This is due to a projected underspend of £2.900m relating to the recently transferred Community Diagnostic Centre Scheme and £1.454m underspend against an additional capital allocation. A revised capital plan was agreed at October's capital planning group (CPG). Against this plan of £13.964m at month nine, the actual spend is £0.810m more than this.	Capital Planning Group have agreed schemes which can be brought forward from next financial year to cover the projected slippage in the 2021/22 Capital Programme.	No mitigations required.

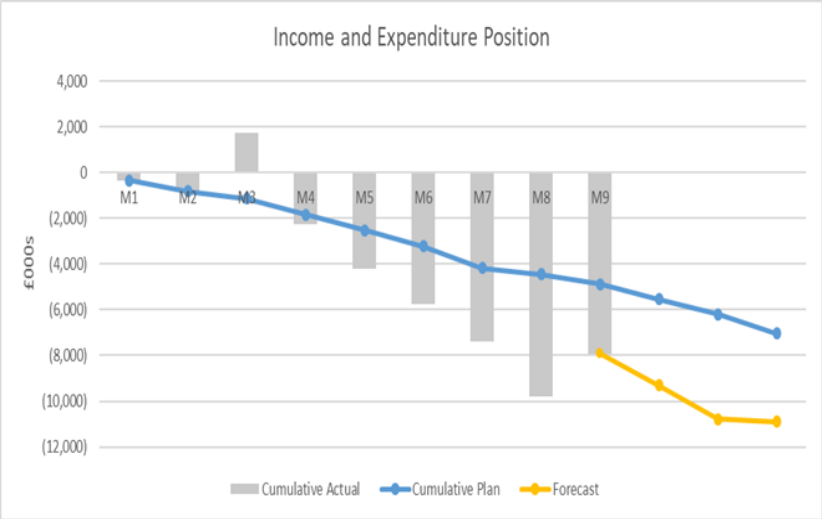
Cash



December 2021 actual performance	
£15.320m	
Variance Type	
Higher Cash Balance	
SaTH Original Forecast	**SaTH Rolling Forecast**
£3.179m	£11.959m
Target/ Plan achievement	
£3.361m higher cash balance than rolling forecast.	

Background	What the Chart tells us	Issues	Actions	Mitigations
The Trust has revised the cashflow forecasting and is now based on average spend to date for the year, taking account of known variations and changes in working capital balances. The cashflow has been revised based on H2 Plan. The Trust reforecasts on a monthly basis.	The cash balance at the end of December was £15.320m (ledger balance of £15.352m due to reconciling items).	The Trust is not forecasting a requirement for cash support. The revised forecast currently projects a year-end cash balance of £3.963m against a required minimum cash balance of £1.700m.	The Trust to continue to review the assumptions within the cashflow. Rolling monthly forecasting to continue. .	No mitigations required.

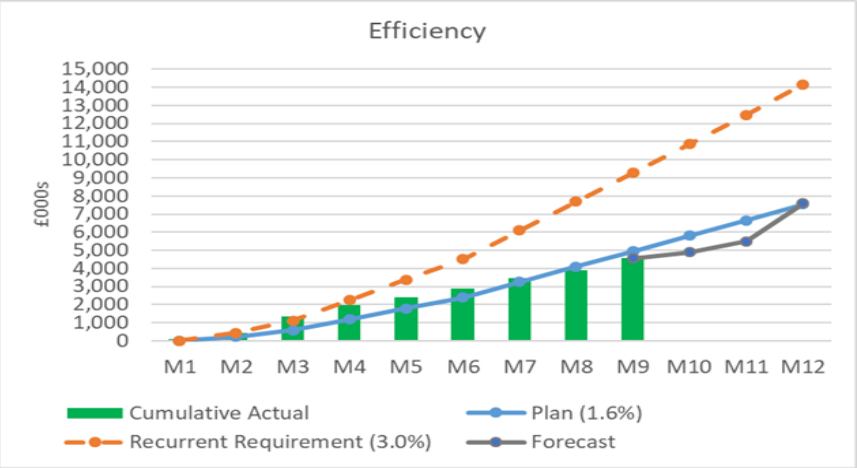
Income and Expenditure Position



December 2021 actual performance	
Income & Expenditure Position year to date (£7.929m)	
Variance Type	
Adverse Overspend to date (£3.055m)	
National Target	**SaTH Plan 2021/22**
b/even	(£7.043m)
Target/ Plan achievement	
(£3.854m) Adverse full year	

Background	What the Chart tells us	Issues	Actions	Mitigations
The NHS continues to operate within a temporary finance regime for 2021/22 due to the COVID-19 pandemic. This regime, akin to the previous financial year, has been managed over two six month periods (H1 and H2) due to the timing of the funding.	The Trust recorded a £7.929m cumulative deficit after nine months, £3.055m adverse to plan. £2.467m of this overspend is driven by an acceptable overspend linked to the elective recovery programme. Excluding the impact of the elective recovery programme the financial position would be £0.588m adverse to plan YTD which is driven by increased operational and workforce pressures. An improved in-month position was recorded, £1.889m surplus. This is purely a result of the timing of ERF recorded for the full Q3 period in December. The Trust is now forecasting a deficit of £10.898m, £1.470m adverse to plan (excluding the impact of ERF).	Operational pressures continue to increase cost and further limit the Trusts ability to recover elective activity. Recurrent efficiency savings are also compromised.	Mitigation plans discussed with STW partners to offset the increased costs in the Trust.	Additional system savings/underspends Slippage against investments

Efficiency



December 2021 actual performance	
Efficiency year to date is £4.567m	
Variance Type	
Under performance to date £0.143m	
National Target	**SaTH Plan 2021/22**
£0.000m	£7,550m
Target/ Plan achievement	
£0.094m favourable variance FOT	

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 £4.567 of efficiency savings after 9 months, £0.143m behind plan. The challenge is that 59% 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 £7.594m.	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. Focus on efficiency has been stood down due to operational pressures, therefore little progress has been made to address this issue.	Increased programme focus in H2 to progress the material efficiency schemes. Focus on developing recurrent pipeline for 2022/23 to address the gap from 2021/22.	Non-recurrent opportunities

8. Transformation
Helen Troalen Director of Finance

Executive Summary

Four of the nine programmes are progressing well with the following programmes reporting all of their projects as being on track this period:

- Culture
- Leadership
- Maternity
- Workforce

Two programmes continue to report all projects with a status of reasonable:

- Digital transformation
- Operational effectiveness

There has been a decline this month within the following three programmes:

- Finance and Resources
- Quality and Safety
- Corporate Governance

The finance and resources programme shows a decline this month having previously reported all of its projects as on track. Two of its projects are now reporting as reasonable. This is due to operational pressures resulting in a number of key approval committees being stood down, causing a delay to the Trust wide launch of the key objectives and a pause in the reporting and planning project to allow for the year end accounts to be produced in the current version of Oracle.

A status of off track is being reported against the performance and business intelligence project as additional metrics are required from the eight areas of the quality strategy to provide a more comprehensive dashboard. A workshop is planned to identify and develop further metrics with key leads.

The quality and safety programme also shows a slight decline due to the levelling-up clinical standards project now reporting a status of reasonable due to a request to extend the date for specialty standards to be completed to allow the specialties time to define their requirements. The remaining five projects within this programme have remained on track.

The corporate governance programme continues to show progression with three of the five projects reporting as on track; a declining status of reasonable is reported against the anti-fraud, bribery and corruption project, this reflects a request to change delivery dates from December 2021 to February 2022.

The communication and engagement project is reporting an improved status of reasonable. The three remaining projects in this programme continue to report as on track**.**

Exceptions and Mitigations

There is one project out of 26 currently reporting as off track (Performance & BI) and 10 projects currently reporting as reasonable. The remaining 15 projects are on track. An explanation for these statuses is provided for each project below:

Performance & BI: Prior month milestones for the Performance & BI project have now been delivered. However as at the end of December, 17 metrics were available and presented within the Quality & Safety Dashboard, which can be viewed following successful completion of training. Further metrics are required from the eight areas of the Quality Improvement Strategy to provide a more comprehensive dashboard, a workshop is planned to identify and develop these.

Levelling-up Clinical Standards: The SRO has attended the specialty governance meeting for both ENT and orthopaedics during December 2021, with meetings scheduled in January 2022 for the remaining five specialties. An initial set of clinical standards will be finalised in January 2022, working with the performance team to include these in the quality dashboard. A request to extend the date for specialty standards to be completed by March 2022 has been made, to allow the specialties time to define their requirements.

Digital Transformation Programme, comprising of two projects:

Applied Digital Healthcare: Scoping work continues to identify opportunities for changing clinical delivery models to make use of applied digital healthcare and improve patient pathways. It was agreed at the December Getting to Good Committee on the 17th December to transfer Executive Director ownership to the Medical Director. The Medical Director will work with clinical teams to identify opportunities and scope the projects. Once scoped, a new Senior Responsible Officer will be identified, and projects will be aligned to the Digital Roadmap.

Digital Infrastructure: A Digital Workshop was held on the 16th December to agree a revised delivery plan of the Digital Programme. Sequencing of a revised roadmap has been agreed. Three options were proposed and agreement was made to proceed with option three, the benefits of option three are:

- Earliest implementation date for the theatre system
- Reduces the number of simultaneous system go lives
- Allows replacement of SemaHelix within current contract.

The revised programme is due to start in January 2022, however the digital team have been asked to prioritise support to the COVID-19 Vaccination Programme. This will draw on the resource of the digital team, and could impact on the delivery of the revised roadmap.

Operational Effectiveness Programme, comprising of three projects:

Restoration and Recovery: As part of the RTT restore and recovery weekly meeting both outpatient improvements (remote appointments, PIFU and advice and guidance) and all elements of H2 intervention activity plus the 104 week trajectory at specialty level is reported and monitored. Collaboration is ongoing with number of IS providers both insourcing and outsourcing across the region in the following specialties – gynaecology, urology, general surgery, orthopaedics, ophthalmology, pain management and vascular to support the H2 plan and 104 trajectory. This also includes working with RJAH and Nuffield in terms of orthopaedics due to the lack of an elective bed base. A number of key risks and issues are affecting the ability to meet the elective recovery targets including bed availability and ward capacity, theatre staffing shortages, radiography capacity and COVID-19 related sickness.

Theatre Productivity: A total of 70% theatre utilisation was realised for the month of December 2021 despite the ongoing challenges of IPC, bed capacity (loss of bays A and B in Day Ward at PRH and a limited bed base at RSH i.e. DSU). In addition to this within month there has been a further increase in theatre staffing shortages, consultant sickness and emergency demand leading to cancellation of elective patients. Theatre sessions continue to be allocated according to waiting list priority and theatre lists are planned to between 85% and 100% through weekly 6-4-2 and list planning meetings and backfill short notice patient cancellations. With the current escalation level at both sites it is unlikely that 75% theatre utilisation will be achieved in January 2022 but performance will continue to be monitored and cancellations reported.

Urgent and Emergency Care (UEC): Implementation of Vitals 4.2 was successfully completed 1st December 2021. Implementation of the ED Careflow system has been delayed. At the digital workshop held on the 16th December 2021 the executive team agreed a revised delivery plan for the digital programme. ED Careflow will now commence roll out in July 2022 and complete in March 2023. The delivery date for milestone 'Engagement with CQC to lift remaining Section 31 notices' has been revised to March 2023 in line with the revised quality and regulatory plan.

Recognising that further work still needs to be progressed on flow and site management, a revised delivery date of March 2022 has been instigated to enable defined delivery criteria to be established and implemented.

Many improvements have been made through Phase 1 and Phase 2 of the Getting to Good Programme in urgent and emergency care. A revised programme of work is currently being scoped in light of the missed opportunities audit. This programme will encompass more than the original urgent and emergency care programme to incorporate UEC and other

directorates to maximise the opportunity for the right patient to see the right clinician, right place, first time, every time. The programme will include direct access pathways, bed reconfiguration as well as other programmes that are currently being scoped. A more detailed programme structure will be available in January 2022.

Corporate Governance Programme, comprising of two projects:

Anti-Fraud, Bribery and Corruption: Progress is being made with an updated Trust-wide policy having been signed off by Audit and Risk Assurance Committee (ARAC) in December, which will go to the next Board meeting, in February, for approval. This will be following board training provided by our counter fraud team in January 2022 at which our new counter fraud statement for the Trust website, will be agreed. The project status reflects the need to change December 2021 delivery dates to enable the above to occur by February 2022.

Communications & Engagement: Team recruitment has now been completed, aside from Head of Communications. Media and communications training for relevant senior leaders has been scheduled for later in February 2022 and project timelines updated to reflect this.

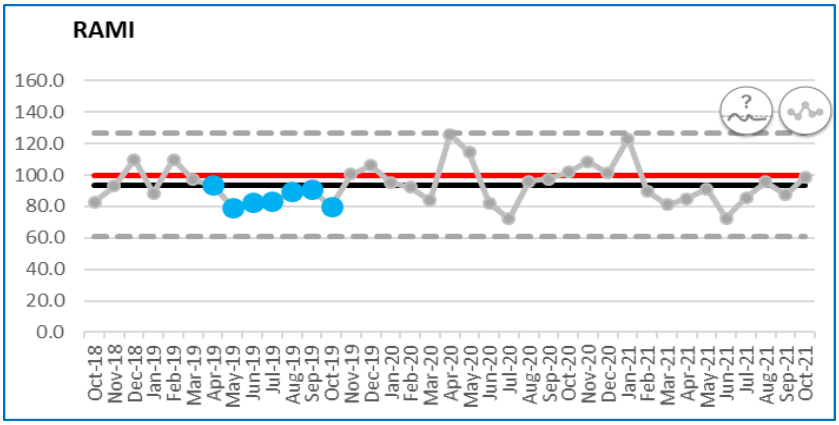
Finance and Resources Programme, comprising of two projects:

Financial Literacy: The priorities to date have been completed in line with the original plan, however, operational pressures during Q3 have resulted in a number of key approval committees being stood down, slightly delaying the Trust wide launch of the key objectives i.e. new business case governance process. In light of the corporate support to the operational areas and the difficulties with wider operational and clinical engagement, the objectives for the remainder of the year will be prioritised through the Finance Project Steering Group early in Q4, resources allocated accordingly, and an update provided during January around any potential delays.

Financial Reporting and Planning: The Oracle upgrade programme was paused in November 21 to address governance issues surrounding the sharing of data between sites and parties. This issue has now been resolved and steps have been taken to mitigate future similar delays. As a result, the go live date for the implementation of the Oracle upgrade is now July 2022. This includes a pause in the project to allow for the year end accounts to be produced in the current version of Oracle. Mitigations are being worked through regarding the impact of the delay. The questions are being finalised for the Financial Effectiveness Survey before being signed off by HR and is on track to be sent out to budget holders in January 22.

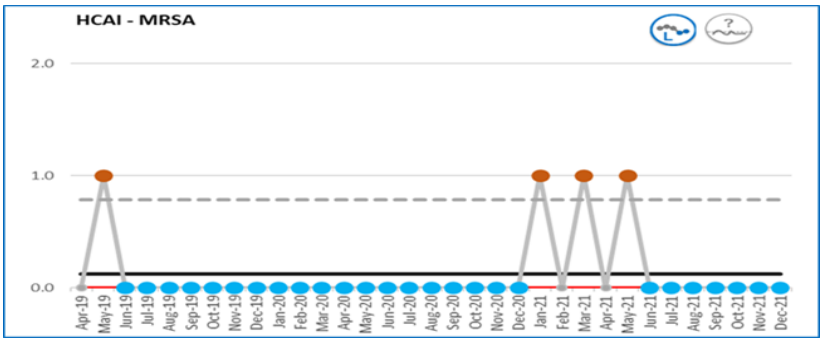
Appendix 1: Indicators performing in accordance with expected standards

RAMI



October 2021 actual performance
98.84
Variance Type
Common Cause
National Target
100
Target / Plan Achievement
Monthly variation means that the 100 reference level may not be delivered month on month

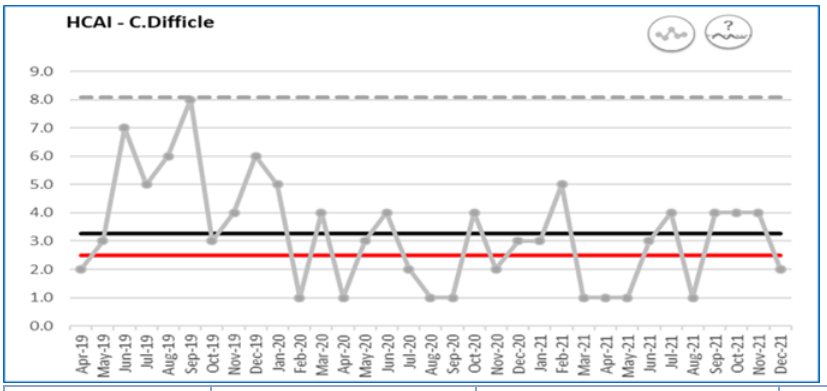
MRSA



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

Background	What the Chart tells us:	Issues	Actions	Mitigations
The Target for all Acute Trusts is Zero cases of MRSA bacteraemia.	There have been no MRSA Bacteraemia since May 2021.	No new issues identified.	As per the HCAIs in relation to cannula care, ANTT, and Catheter, care improvement work.	Reported and monitored monthly through IPC Operational Group.

C-Difficile

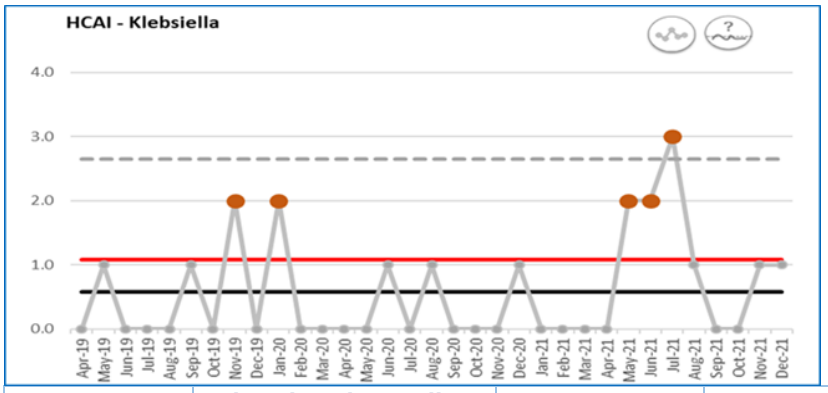


December 2021 actual performance
2
Variance Type
Common Cause
Local Standard
<ave.2.5pm
Target / Plan Achievement
Sustain or improve on 2020/21.

Background	What the Chart tells us:	Issues	Actions	Mitigations
Locally agreed continuous improvement target is set at 30, compared to the target of	There were 2 cases of C.Diff in December 2021 which is a reduction in the 4 cases per	All cases have an RCA completed by the clinical teams responsible for their care. Issues identified	Divisional Teams have reminded staff of the importance of timely taking of stool samples and prompt isolation and escalation when patients	Actions are reported via Divisional IPC reports and monitored via

43 agreed with the CCG for 2019/20. The National target has been set at 49.	month reported in the last 3 months The Trust remains below both its local and nationally agreed targets for 2021/22.	from previous RCAs include: Timeliness of obtaining stool sample. Timeliness of isolating patients. Use of stool charts.	cannot be isolated in a timely manner due to lack of isolation facilities Use of Redi-rooms to isolate patients when side rooms unavailable.	the IPC Operational Groups as part of their monthly reporting.

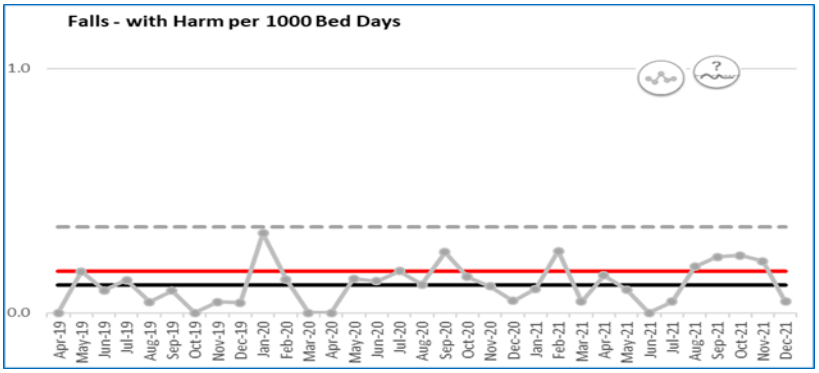
Klebsiella



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

Background	What the Chart tells us	Issues	Actions	Mitigations
Reporting of Klebsiella is a mandatory requirement.	There was 1 case of Klebsiella in December 2021. There were low numbers of cases in 2020/21. The Trust is close to achieving its local target. There have been low numbers of cases in Q2 and the Trust will achieve its national target for 2021/22.	No new issues identified. The December case is currently being reviewed and if device related a RCA investigation will be completed to ensure actions and learning.	There is ongoing improvement work to embed the use of catheter care plans across the Trust. Revised Nursing Assessment and Care Plan documentation and care plan booklet being rolled out at end of January, there will be a program of support, and education to support clinical staff with this from Quality Team so will enable a further focus on the catheter documentation already in place across the Trust.	Monitored at IPCOG and Monthly Metrics meetings.

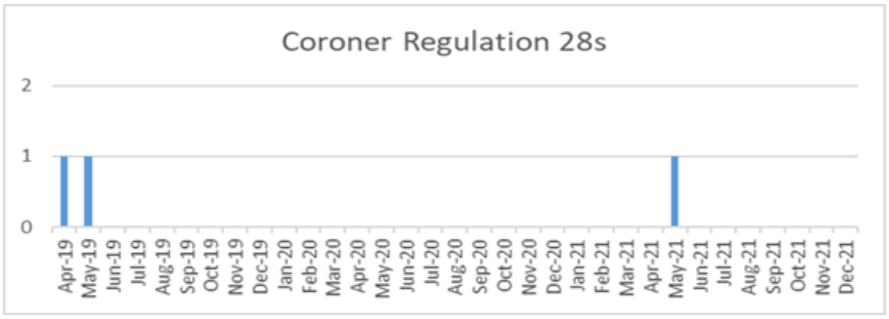
Falls – with Harm per 1000 Bed days



December 2021 actual performance
0.05
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.	The falls with harm per 1000 bed days had increased since September 2021, however performance this month has improved.	There were 2 falls with harm reported as SIs in December compared to 5 in November. A patient on Ward 9 and a patient on ward 28 both had a fall resulting in a fractured neck of femur.	As per Falls per 1000 bed days slide.	As per Falls per 1000 bed days slide.

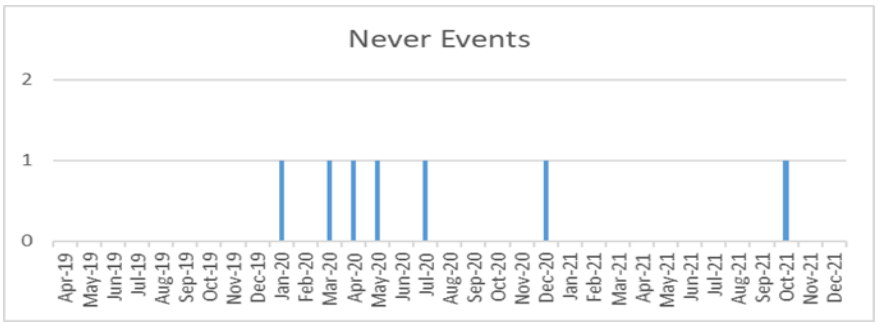
Coroner Regulation 28s



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

Background	What the Chart tells us	Issues	Actions	Mitigations
Key patient safety measure.	No Regulation 28s have been submitted to the organisation since May 2021.	No issues.	No Actions	No Mitigations.

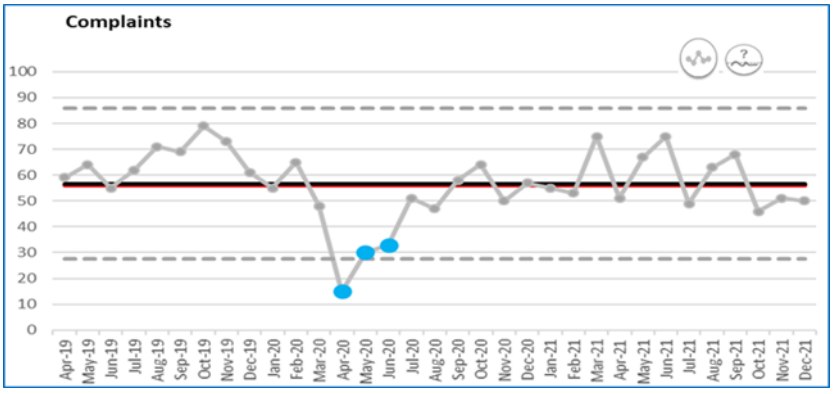
Never Events



December 2021 actual performance
0
Variance Type
Common Cause
Local Standard
0
Target/ Plan achievement
1 never event ytd.

Background	What the Chart tells us	Issues	Actions	Mitigations
Key patient safety measure.	The last Never Event was reported in October 2021.	Never Events pose a risk for the organisational reputation as well as potential harm to patients.	The investigation into the Never Event in nearing completion in preparation for presentation at RALIG.	Initial risk reduction measures were identified and action instigated to address the system issue. Further risk reduction measures will be identified as part of the investigation process.

Complaints

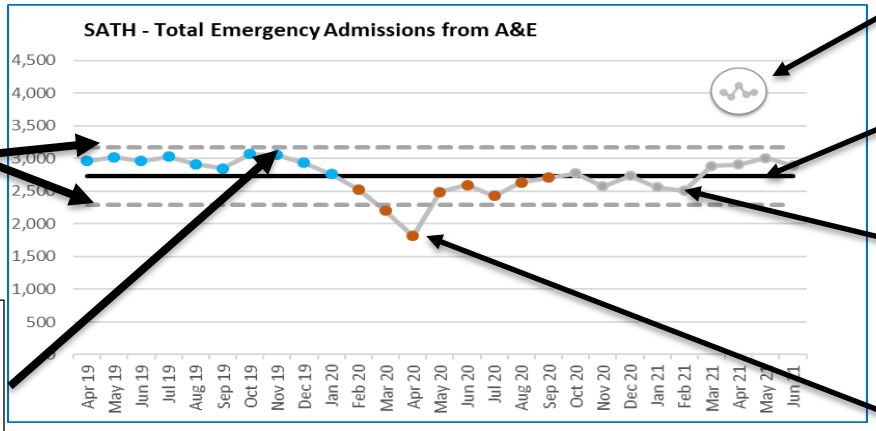


December 2021 actual performance
50
Variance Type
Common Cause
SATH internal target
<56
Target/ Plan achievement
>10% reduction on 19/20 total complaints

Background	What the Chart tells us	Issues	Actions	Mitigations
Complaints provide a valuable source of learning to the organisation.	Numbers remain within the expected range.	The main theme of complaints continues to be problems with communication.	Ongoing work to improve communication with Transforming Care Team working with pilot wards.	No Mitigations.

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

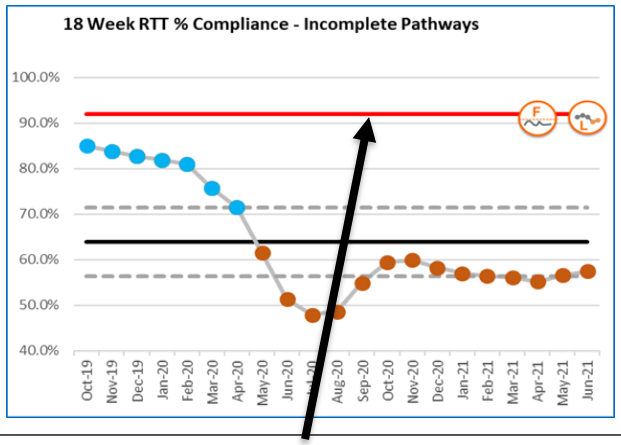
Mean or median line

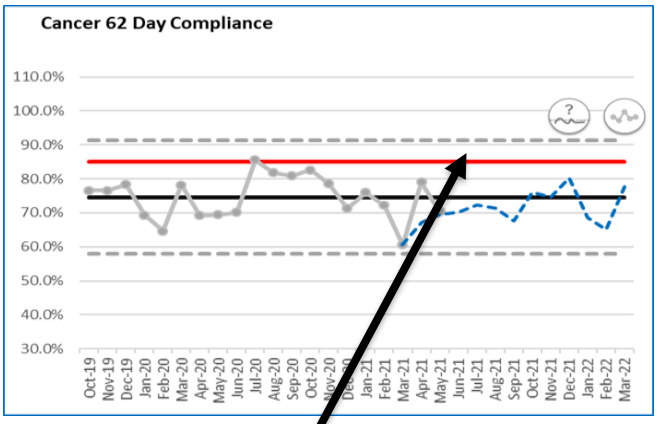
Common cause variation

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 this report

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-sections	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 2021-September 2021 inclusive
H2	October 2021-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
MD	Medical Director

Term	**Definition**
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
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