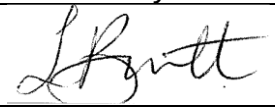
Board of Directors' Meeting
9 June 2022

Agenda item	103/22			
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 May 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 April 2022. 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 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 performance of indicators. The Board of Directors is requested to **note** the content of this report.			
Appendices	1. Indicators performing in accordance with expected standards. 2. Understanding SPC charts. 3. Glossary of terms			
Lead Executive				

Integrated Performance Report

Purpose

This report provides the Board with an overview on 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

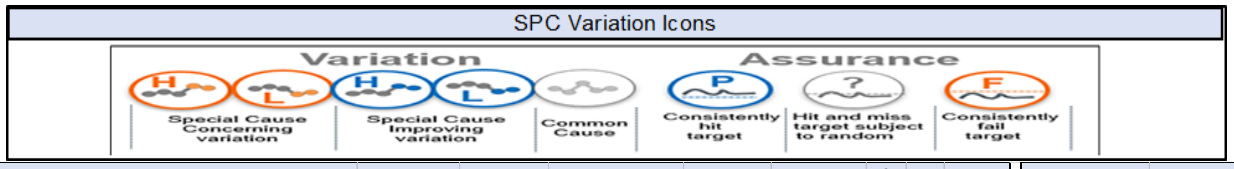
- April has seen another challenging month for the Trust. The Trust was under significant pressure with Covid-19 during April with the current wave peaking at 169 patients with Covid-19 in hospital. This is the highest number of inpatients recorded during the pandemic and has now reduced significantly to less than 20 inpatients. The STW system declared a critical incident from 14-25 April due to the significant urgent and emergency care pressures being experience, with higher than average sickness within the workforce exacerbated by Covid-19.

- The number of permanently employed staff continues to increase, with actions to ensure that retention is improved, particularly supporting staff who have been with the Trust for less than a year. Further work is being done to support leaders across the organisation from bands 3 to senior leaders in line with our People Strategy.

- In April there has been continuing efforts to tackle and improve ambulance handover times, which remain at unacceptable levels. Progress was made with regards to primary care streaming and SDEC in-reach to ED to support this improvement, alongside refinement of plans to implement the acute floor which is aimed at improving flow and patient experience. The ICS is also leading work with partners to support improvement.

- Finally, the Trust draft operating plan has been drawn up in conjunction with the STW system which sets out the activity, workforce, and financial plans for the Trust with a requirement to comply with nationally set planning requirements for the year. NHS England have reviewed all the plans across the country and have asked systems and providers to continue to revise and refine their plans. There has been increased divisional engagement in the plan, with further work in train to ensure effective oversight of delivery and associated risks and to communicate progress.

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 2022-2023 Plan
Mortality										
HSMR	QSAC	Feb 22	95.8	100	100			No		100
Infection										
HCAI - MSSA	QSAC	Apr 22	5	0	<2			Yes	5	28
HCAI - MRSA	QSAC	Apr 22	0	0	0			No	0	0
HCAI - C.Difficile	QSAC	Apr 22	5	<4	<3			Yes	5	33
HCAI - E-Coli	QSAC	Apr 22	2	<8	<4			No	2	49
HCAI - Klebsiella	QSAC	Apr 22	1	<2	<1			No	1	12
HCAI - Pseudomonas Aeruginosa	QSAC	Apr 22	2	<2	<1			Yes	2	6
Patient harm										
Pressure Ulcers - Category 2 and above	QSAC	Apr 22	16		<11			Yes	16	134
Pressure Ulcers - Category 2 Per 1000 Bed Days	QSAC	Apr 22	0.7							
VTE	QSAC	Mar 22	90%	95%	95%			Yes		95%
Falls - total	QSAC	Apr 22	120		<70			Yes	120	835
Falls - per 1000 Bed Days	QSAC	Apr 22	5.2	6.6	<4.5			Yes	5.2	4.5
Falls - with Harm per 1000 Bed Days	QSAC	Apr 22	0.04	0.19	<0.17			Yes	0.04	0.17
Never Events	QSAC	Apr 22	0	0	0			No	0	0
Coroners Regulation 28s	QSAC	Apr 22	0		0			No	0	0
Serious Incidents	QSAC	Apr 22	8						8	
Mixed Sex Breaches	QSAC	Apr 22	77	0	0			Yes	77	
Patient Experience										
Complaints	QSAC	Apr 22	58.0		<56			Yes	58	672
Complaints Responded within agreed time	QSAC	Apr 22	65%	85%	85%			Yes		85%
Complaints Acknowldeged within agreed time	QSAC	Apr 22	100%		100%			No		100%
Compliments	QSAC	Apr 22	19	Letters of thank you received.					19	
Friends and Family Test	QSAC	Apr 22	98.0%	80%	80%			No		80.00%
Maternity										
Smoking rate at Delivery	QSAC	Apr 22	14.6%	5%	5%			Yes	14.6%	5%
One to One Care In Labour	QSAC	Apr 22	97.9%	100%	100%			Yes		100%
Delivery Suite Acuity	QSAC	Apr 22	49%	85%	85%			Yes		85%
Workforce - KPI		Latest month	Actual Month Performance	National Standard for month	SaTH trajectory for month	Perfomance	Assurance	Exception	Year to Date	SaTH 2022-2023 Plan
Activity										
WTE Employed**Contracted	FPAC	Apr 22	6104		6173			Yes		6732
Total temporary staff -FTE	FPAC	Apr 22	731					Yes		
Staff turnover rate (excludes junior doctors)	FPAC	Apr 22	0.95%	0.8%	0.75%			Yes	0.95%	0.8%
Sickness absence rate Excluding Covid Related	FPAC	Apr 22	5.0%		4%			Yes	5.0%	4%
Covid Related absence rate	FPAC	Apr 22	2.1%					No		
Agency Expenditure	FPAC	Apr 22	£2.998m					Yes		
Appraisal Rate	FPAC	Apr 22	80%	90%	90%			Yes		90%
Appraisal Rate (Medical Staff)	FPAC	Apr 22	92%	90%	90%			No		90%
Vacancies	FPAC	Apr 22	608 (10%)	<10%	<10%			Yes		<10%
Statutory and Mandatory Training	FPAC	Apr 22	80%	90%	90%			Yes		90%
Trust MCA – DOLS & MHA	FPAC	Apr 22	73%	90%	90%			Yes		90%
Safeguarding Adults - level 2	FPAC	Apr 22	81%	90%	90%			Yes		90%
Safeguarding Children – level 2	FPAC	Apr 22	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 2022-2023 Plan
Elective Care										
RTT Waiting list -Total size	FPAC	Apr 22	37936					Yes		
RTT Waiting list -English	FPAC	Apr 22	33855		33650			Yes		35275
RTT Waiting list -Welsh	FPAC	Apr 22	4081					Yes		
18 Week RTT % compliance -incomplete pathways	FPAC	Apr 22	57.6%	92%				Yes		
26 Week RTT % compliance -incomplete pathways	FPAC	Apr 22	65.3%	92%				Yes		
52+ Week breaches - Total	FPAC	Apr 22	2815	0				Yes		
52+ Week breaches - English	FPAC	Apr 22	2480	0	2295			Yes		2561
52+Week breaches - Welsh	FPAC	Apr 22	335	0				Yes		
78+ Week breaches - Total	FPAC	Apr 22	436	0				Yes		
78+ Week breaches - English	FPAC	Apr 22	393	0	271			Yes		261
78+ Week breaches - Welsh	FPAC	Apr 22	43	0				Yes		
104+ Week breaches - Total	FPAC	Apr 22	62	0				Yes		
104+ Week breaches - English	FPAC	Apr 22	60	0	70			Yes		30
104+ Week breaches - Welsh	FPAC	Apr 22	2	0	0			Yes		
Cancer										
Cancer 2 week wait	FPAC	Mar-22	74.5%	93%	83%			Yes	79.4%	93%
Cancer 62 day compliance	FPAC	Mar-22	63.9%	85%	62%			Yes	62.5%	85%
Diagnostics										
Diagnostic % compliance 6 week waits	FPAC	Apr 22	58.7%	99%				Yes		
DM01 Patients who have breached the standard	FPAC	Apr 22	5994	0	1254			Yes		
Emergency Department										
ED - 4 Hour performance	FPAC	Apr 22	58%	95.0%	64%			Yes	58%	78%
ED - Ambulance handover > 60mins	FPAC	Apr 22	1062	0				Yes	1062	tbc
ED 4 Hour Performance - Minors	FPAC	Apr 22	90.8%	95%	95%			Yes	90.8%	95%
ED 4 Hour Performance - Majors	FPAC	Apr 22	28.1%	95%				Yes	28.1%	
ED time to initial assessment (mins)	FPAC	Apr 22	37	15	15			Yes		15mins
12 hour ED trolley waits	FPAC	Apr 22	538	0	0			Yes	538	
Total Emergency Admissions from A&E	FPAC	Apr 22	2863					Yes	2863	34356
% Patients seen within 15 minutes for initial assessr	FPAC	Apr 22	32.7%					Yes	32.7%	
Mean Time in ED Non Admitted (mins)	FPAC	Apr 22	330					Yes	330	
Mean Time in ED admitted (mins)	FPAC	Apr 22	711					Yes	711	
No. Of Patients who spend more than 12 Hours in E	FPAC	Apr 22	1460					Yes	1460	
12 Hours in ED Performance %	FPAC	Apr 22	11.8%					Yes	11.8%	
Hospital Occupancy and activity										
Bed Occupancy -G&A	FPAC	Apr 22	89%	92%	91%			Yes		92%
ED activity (total excluding planned returns)	FPAC	Apr 22	12340		12500			No	12340	149762
ED activity (type 1&2)	FPAC	Apr 22	10251		10300			No	10251	123572
Total Non Elective Activity	FPAC	Apr 22	4873		5614			Yes	4873	66353
Outpatients Elective Total activity	FPAC	Apr 22	38638		44978			Yes	38638	585121
Total Elective IPDC activity	FPAC	Apr 22	4626		4687			Yes	4626	78446
Diagnostic Activity Total	FPAC	Apr 22	16899		16096			Yes		208989
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	Apr 22	18.083		1.700			No	18.083	1.700
Efficiency	FPAC	Apr 22	0.069		7.660			No	0.069	7.660
Income and Expenditure	FPAC	Apr 22	(1.686)		(23.330)			No	(1.686)	(23.330)
Cumulative Capital Expenditure	FPAC	Apr 22	0.134		40.012			No	0.134	40.012

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

National targets are now agreed for hospital acquired infections. MSSA and C. difficle are over trajectory in month root cause analysis has been undertaken and work is ongoing with regards to anti-microbial stewardship. To ensure increased scrutiny in relation to urine catheter care, catheter care is now incorporated into the matrons' monthly audits.

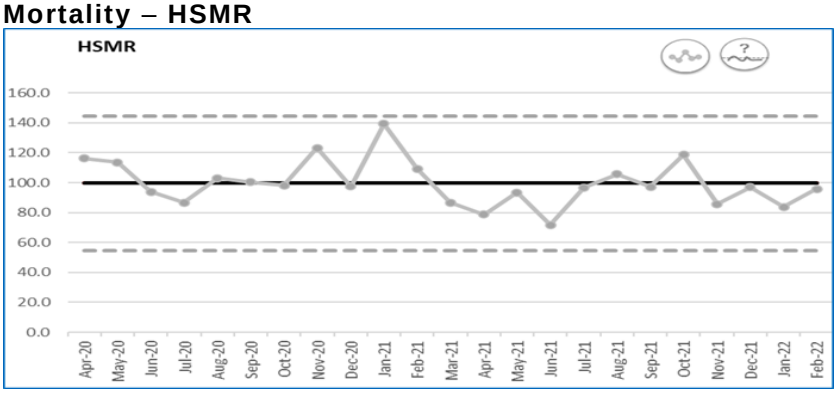
Falls remains a priority, however, we have seen an improved position in numbers of falls in month and falls per 1000 bed day for three consecutive months. Daily falls reviews continue with immediate and real time feedback to the clinical teams. Cohorting and bay tagging continues, and the Trust has commenced recruitment of an enhanced patient safety team for our most vulnerable patients at high risk.

Due to a combination of midwifery vacancies, increased sickness and unavailability, delivery suite acuity level remains a challenge at 49% in month. Mitigation is in place to reallocate staff to support the delivery suite and there is successful recruitment on going. The seven day a week manager oversees appropriate escalation and triangulation with any adverse incidents. One-to-one in labour is an improved position of 97.9%.

The indicator on smoking at time of delivery continues to be poorly preforming. System wide work has been undertaken and will be fed back into the Maternity Transformation Assurance Committee (MTAC).

Quality Exception Reports – Harm

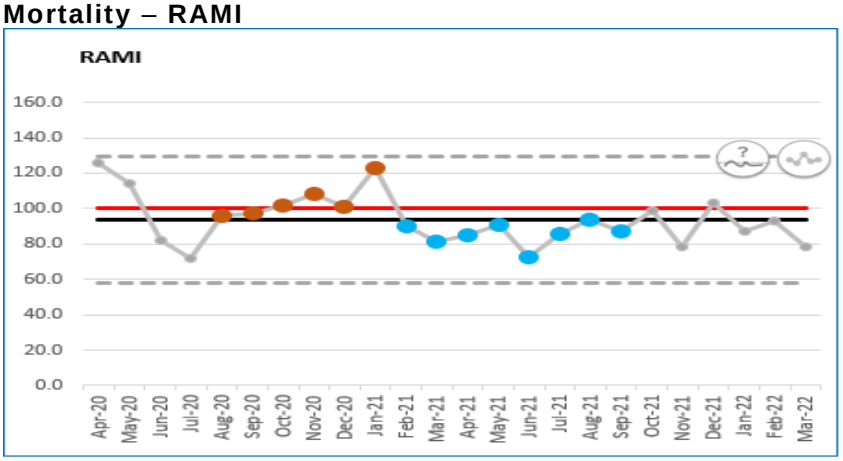
Mortality – HSMR



February 2022 actual performance
95.8
Variance Type
Common Cause
National Target
100
Target / Plan Achievement
Note rebasing of national reference level has taken place from this month's data

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 (RAMI) is a quality measure used to predict deaths within the organisation.	HSMR continues to 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.	No Dr Foster Imperial alerts have been received this month.	A Learning from Deaths dashboard being produced by NHSE/I is in development and when 'live' will be available for potential integration into performance reporting and monitoring. The indicators used will provide transparency and context around the Learning from Deaths agenda including number of deaths, Summary Hospital Mortality Indicator (SHMI) data, hospital occupancy, length of stay, safe staffing, number of mortality reviews, Medical Examiner scrutiny, coding, and a summary of learning identified through completed online mortality reviews. The available resource to support and sustain the coordination of the dashboard requires further review. Audit work continues to review mortality outliers as identified within the CHKS quarterly reports.	Mortality performance indicators are a standing agenda item at the monthly Learning from Deaths Group where all indicators 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 and unspecified renal failure.

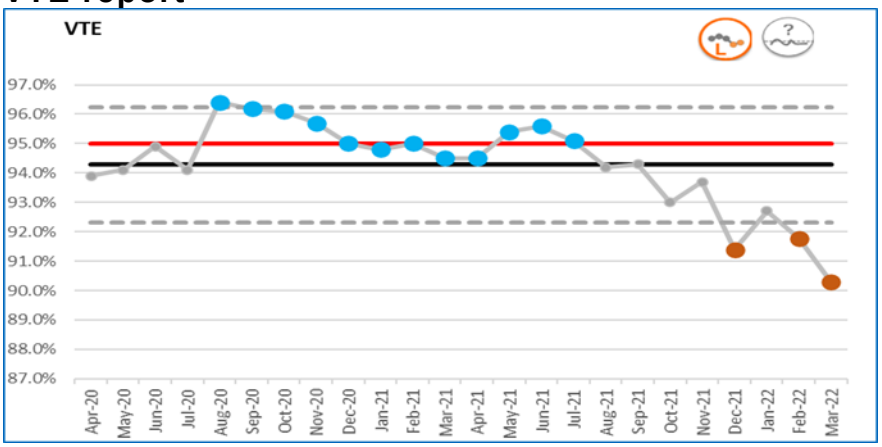
Mortality – RAMI



March 2022 actual performance
78.26
Variance Type
Common Cause
National Target
100

Data was incorrectly reported in the Integrated Performance Report for April and showed significantly higher rates of RAMI than was accurate. This has been updated and the data going forward will only be reported based on the final published position within CHKS. Discussions are being held with CHKS to ensure we report on the most accurate data position going forward and that any refreshes of their data are clearly highlighted within future IPR reporting.

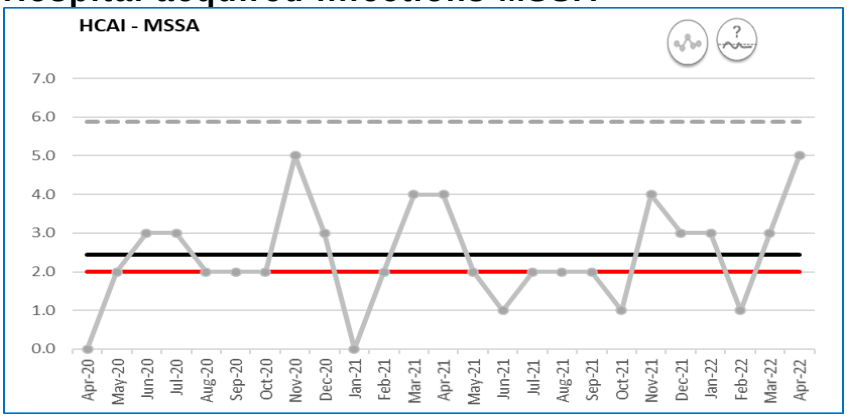
VTE report



March 2022 actual performance
90.3 %
Variance Type
Special Cause Concern
National Target
95%
Target / Plan Achievement
Performance has deteriorated and needs intervention to recover.

Background	What the Chart tells us	Issues	Actions	Mitigations
The number and proportion of patients admitted to hospital (aged 16 and over at the time of admission) that had a risk assessment for venous thromboembolism (dangerous blood clots). This is clinically important in order to protect inpatients from harm.	The graph is showing special cause concern for March 2022.	Performance improved following intervention in May/June 2021 but has varied around the target since this intervention and the performance is now declining. Special cause concern requires further investigation and remedial action to be taken.	An action plan has been put in place to address the issues. Communication with divisional MDs, CDs, consultants, matrons, and ward managers to identify an outstanding VTE assessment and ensure completion in a timely manner. Monitoring will continue to ensure the change in practice is embedded.	Divisional PRMs review performance by division. Regular escalation of outlier wards and consultants will be undertaken.

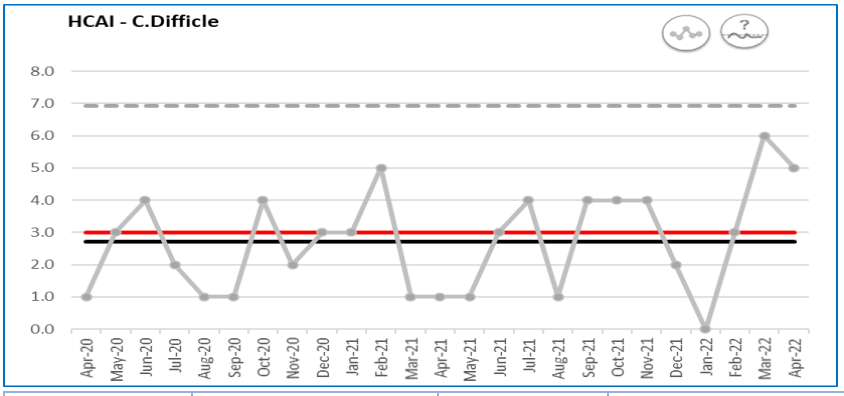
Hospital acquired infections MSSA



April 2022 actual performance
5
Variance Type
Common Cause
Local Standard
<ave.2 per month
Target / Plan Achievement
Local target is no more than 28 cases in 2022/23 There is no national target set

Background	What the Chart tells us:	Issues	Actions	Mitigations
Reporting of MSSA bacteraemia is a mandatory requirement.	There were 5 cases of MSSA bacteraemia in April 2022. This is above our local target of no more than 2 cases a month.	RCAs undertaken on all cases deemed to be device related or where source is unknown. Two of the cases were considered to be device/intervention related and the sources were: deep surgical site infection and the other an Infected IV cannula.	Ongoing actions from previous RCAs include ensuring use of catheter care plan and catheter insertion documentation. Staff reminded about correct labelling of blood cultures. ANTT training to be delivered by CPE team. Cannula care/VIPs.	RCA summary and actions from RCAs presented as part of divisional updates monthly at IPC Ops Group. Catheter documentation and cannula care is audited through the monthly matron's quality audits.

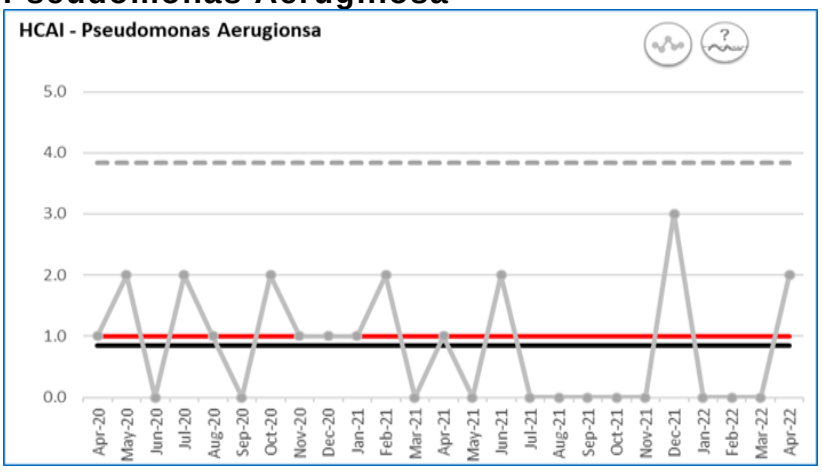
C. Difficile



April 2022 actual performance
5
Variance Type
Common Cause
Local Standard
<avg. 3 per month
Target / Plan Achievement
No more than 33 cases in 2022/23

Background	What the Chart tells us:	Issues	Actions	Mitigations
National target for 2022/23 is no more than 33 cases.	There were 5 cases of C. difficile attributed to the Trust in April 2022. This is over our Trust monthly target of no more than 3 cases.	All 5 cases were taken post 48 hours of admission.	All C. diff cases have an RCA completed. Actions include reminder to staff of importance of obtaining timely stool sample and prompt isolation of patients with diarrhoea. Use of Redi-rooms to isolate patients when side rooms unavailable. Ensure appropriate anti-microbials, antimicrobial pharmacist to ensure antimicrobial stewardship report is provided to all divisions for discussion at divisional governance.	Actions are reported via divisional IPC reports and monitored via the IPC operational groups as part of their monthly reporting.

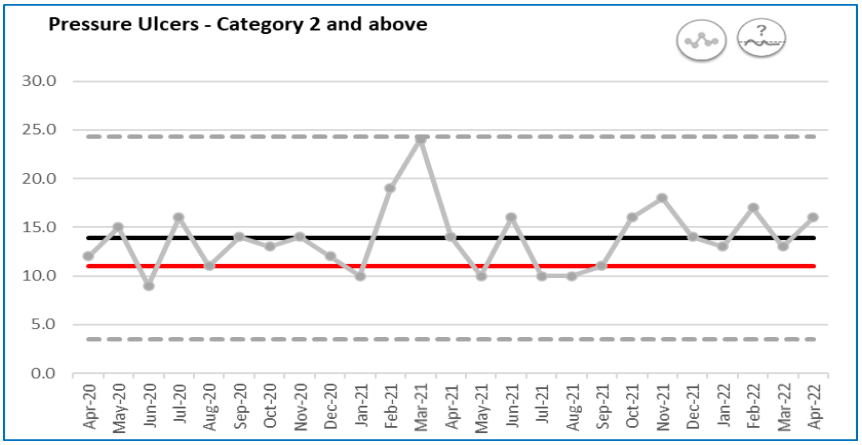
Pseudomonas Aeruginosa



April 2022 actual performance
2
Variance Type
Common Cause
Local Standard
No more than 6 per annum
Target / Plan Achievement
Local Target no more than 6 cases in 2022/23. National target of no more than 19 cases.

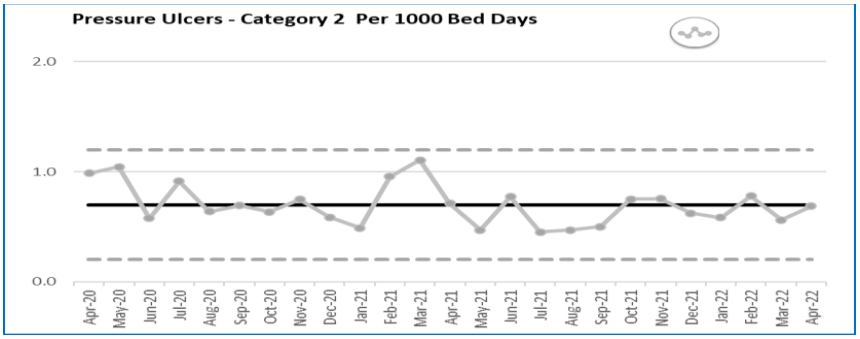
Background	What the Chart tells us	Issues	Actions	Mitigations
Reporting of Pseudomonas is a mandatory requirement.	There have been 2 cases of pseudomonas aeruginosa bacteraemia in April 2022. The Trust was above its local target in April 2022 but below national target.	Both cases are currently being reviewed to determine the sources.	As per other HCAIs, consistent use of catheter documentation and care plans. ANTT. cannula care and 12 hourly checks. IPC training. Compliance with IPC procedures and practices.	Ongoing monitoring of care through matron's audits discussed at monthly quality review meetings and divisional reports to IPCOG.

Pressure Ulcers – category 2 and above



April 2022 actual performance
16
Variance Type
Common Cause
Local Standard
11
Target/ Plan achievement
10% Improvement for 22/23 Pro rata =<11.16pm (No more than 134 cases)

Pressure ulcers – category 2 and above per 1000 bed days

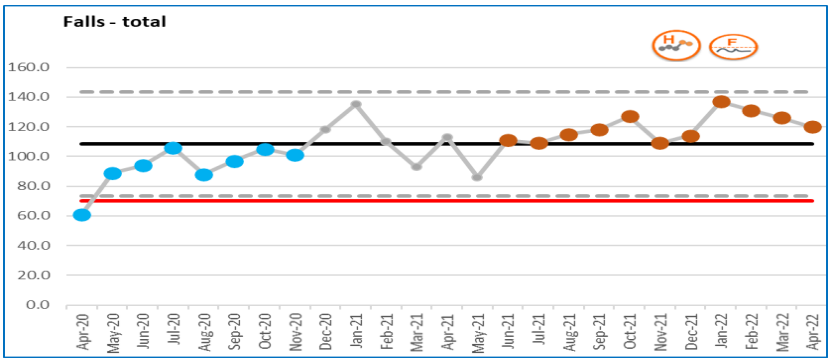


April 2022 actual performance
0.7
Variance Type
Common Cause
Local Standard
tbc

Pressure Ulcers – Total per Division	Number Reported
Medicine and Emergency Care	12
Surgery, Anaesthetics and Cancer	4

Background	What the Chart tells us	Issues	Actions	Mitigations
The Trust aims to reduce the number of hospital acquired pressure ulcers.	There were 16 acquired pressure ulcers in April 2022.	There were 14 category 2 pressure ulcers and 2 category 3 pressure ulcers reported on Ward 24 and Ward 4 which are currently being investigated.	Ongoing Actions include: TVN and quality team support for wards with PU continues. Tuesday talks with tissue viability team continue. Thematic review of all PU investigations is being carried out and overarching improvement plans developed. Spot checks of documentation by ward managers/matrons to ensure assessments and care plans in place. Ongoing Work to improve ward safety huddles.	All category 2 or above pressure ulcers have an investigation completed and presented at the pressure ulcer panel. Those which meet the threshold for an SI are investigated and presented at NIQAM and a summary reported through to RALIG. Exemplar audits also review management of skin integrity.

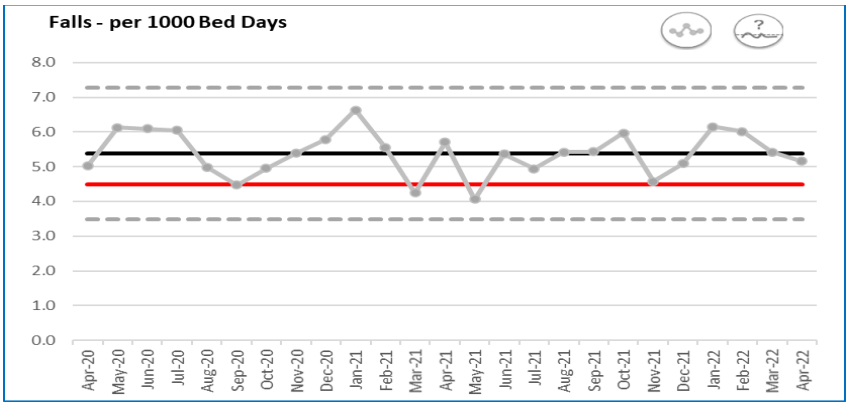
Falls



April 2022 actual performance
120
Variance Type
Special Cause Concern
Local Target
<70
Target / Plan Achievement
10% reduction on 21/22

Falls – Total per Division	Number Reported
Medicine and Emergency Care	88
Surgery, Anaesthetics and Cancer	30
Women and Children's	2

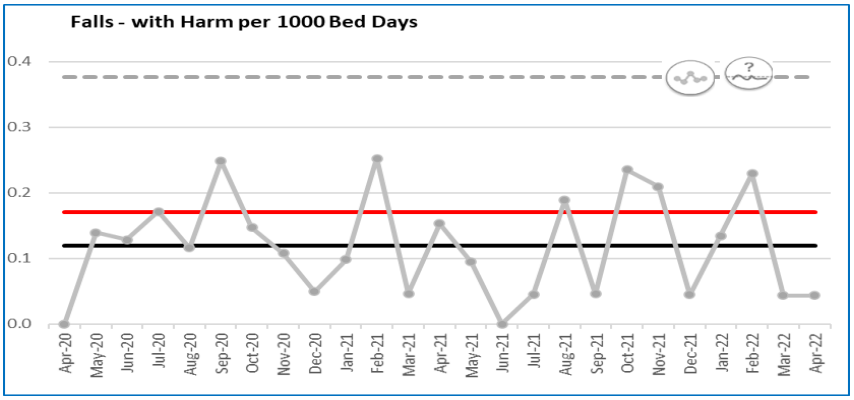
Falls – per 1000 bed days



April 2022 actual performance
5.2
Variance Type
Common Cause
Local Plan
4.5
National Standard
6.6
Target/ Plan achievement
Local Target set for 22/23

Background	What the Chart tells us	Issues	Actions	Mitigations
Falls amongst inpatients are the most frequently reported patient safety incident in the Trust. Reducing the number of patients who fall in our care is a key quality and safety priority.	The number of falls in April reduced for the 3rd consecutive month.	Although falls have started to reduce slightly, they remain above the Trust target. Falls per 1000 bed days remains higher than Trust target of 4.5 but below the national standard of 6.6.	Ongoing falls improvement work includes focused additional falls training on wards with high incidence. Ongoing monthly review of falls risk assessment and care plans. Ongoing work to ensure lying and standing BP completed as part of falls risk assessment. Ensuring neuro observations post fall completed in line with post falls protocol, some improvements have been seen in relation to compliance with this. Embed cohorting and bay tagging for care of patients at high risk of falls. Recruitment has commenced for an enhanced supervision team for our most vulnerable patients at high risk of falls.	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.

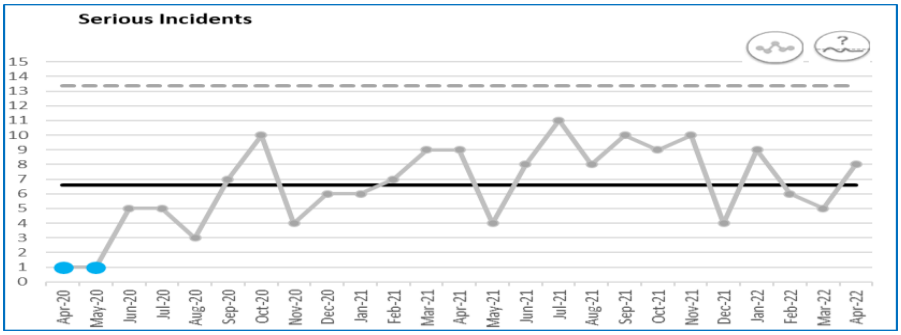
Falls – with harm per 1000 bed days



April 2022 actual performance
0.04
Variance Type
Common Cause
Local Target
0.17
National Standard
0.19
Target/ Plan achievement
10% reduction on 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, remained low in April 2022, but the Trust continues to see falls that result in moderate harm or above for patients.	There was one fall with harm reported in April 2022, due to a patient falling on Ward 24 and sustaining a head injury.	As per falls slide.	As per falls slide.

Serious incidents

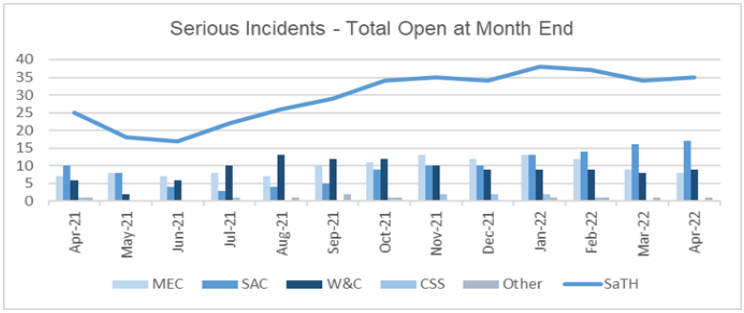


April 2022 actual performance
8
Variance Type
Common Cause
Local Standard
N/A
Target/ Plan achievement
N/A –seeking to encourage reporting of incidents

SUI theme	Number Reported
Death following airway issues	1
Sub-optimal care of the deteriorating patient meeting SI criteria	1
Suboptimal care	1
Delay in treatment leading to death	1
Inappropriate discharge	1
Delayed Diagnosis	1
Fall Head injury	1
Term Intrauterine death	1
Total	**8**

Background	What the Chart tells us:	Issues	Actions	Mitigations
Serious Incidents are adverse events with likely harm to patients that require investigation to support learning and avoid recurrence. These are reportable in line with the national framework.	The number of SIs reported continues to show common cause variation.	No issues identified	Monitor review, 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.

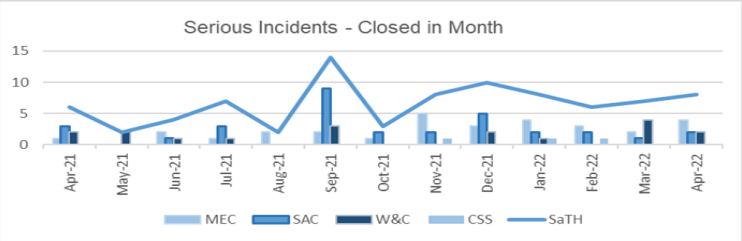
Serious incidents – total open at month end



SI – Total Open at Month End per Division	Number Reported
Medicine & Emergency Care	8
Surgery, Anaesthetics and Cancer	17
Women and Children's	9
Clinical Support Services	0
Other	1
Total	**35**

Background	What the Chart tells us	Issues	Actions	Mitigations
Current number of open serious incidents.	Number of open SIs.	There are currently 35 open SIs.	Monitoring of progress of investigation.	Weekly review of mitigations.

Serious incidents – closed in month

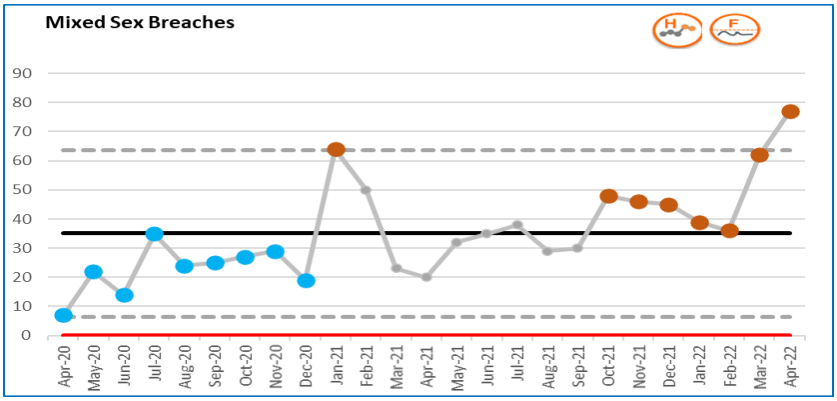


SI – Closed in Month per Division	Number Reported
Medicine & Emergency Care	4
Surgery, Anaesthetics and Cancer	2
Women and Children's	2
Total	**8**

Background	What the Chart tells us	Issues	Actions	Mitigations
The number of SIs closed in month will vary dependent on the number reported.	There were 8 SIs closed in month demonstrating consistency in completion rates.	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.

Quality Exception Reports – Patient Experience

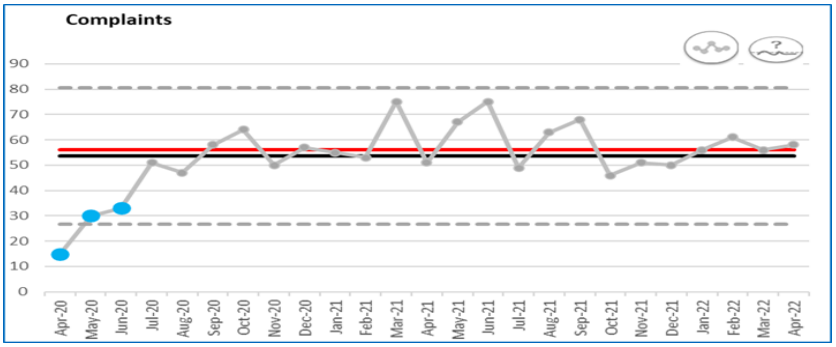
Mixed sex breaches exception report



April 2022 actual performance
77
Variance Type
Special Cause Concern
National Target
0
Target/ Plan achievement
Continuing to breach this target.

Location	Number of breaches	Additional Information
AMU (PRH)	15 primaries in SDEC	
DSU (PRH)	8 breaches	One occasion resulting in the 8 breaches
ITU / HDU (PRH)	12 primary (8 medical, 4 surgical)	
Ward 16 (PRH)	12 breaches	Two occasions resulting in 8 breaches
Ward 17 (PRH)	3 breaches	One occasion resulting in the 3 breaches
Ward 36	4 breaches	One occasion resulting in the 4 breaches
ITU / HDU (RSH)	23 breaches (11 Medical, 12 Surgical)	

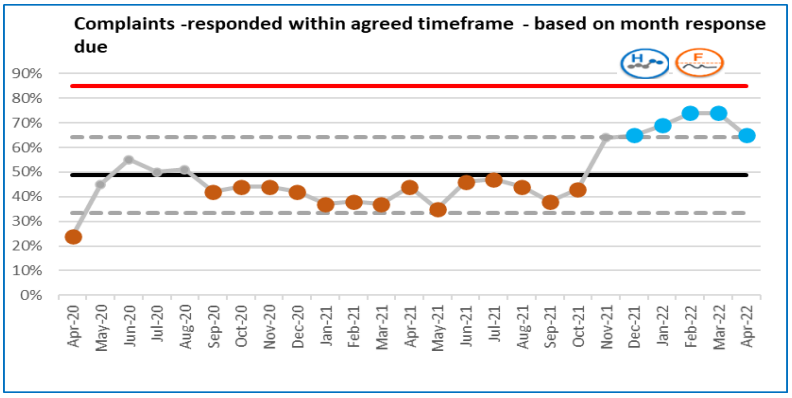
Complaints



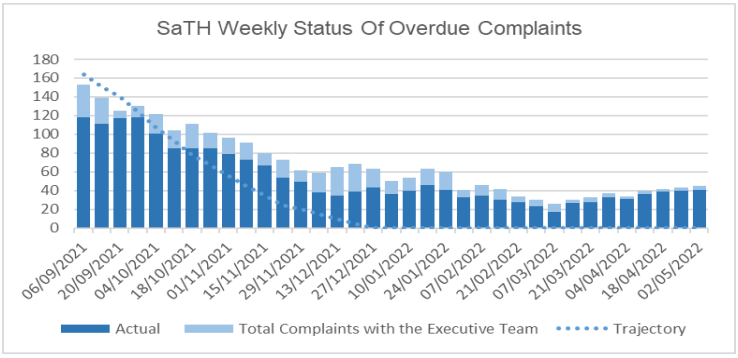
April 2022 actual performance
58
Variance Type
Common Cause
SATH internal target
<56
Target/ Plan achievement
>10% reduction on 19/20

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.	There have been no trends or concerns identified this month.	No actions.	No mitigations.

Complaints – Responded within agreed time



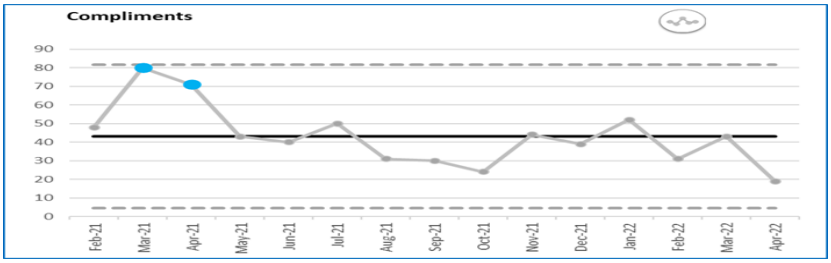
April 2022 performance	
65%	
Variance Type	
Special Cause Improvement	
National benchmark	**SaTH internal target**
85% compliant with time agreed with complainer	85% responded to within 30 days of receipt
Target/ Plan achievement	
Target is unlikely to be achieved	



Overdue Complaints per Division	Number Reported
Medicine and Emergency Care	26
Surgical, Anaesthetics and Cancer	7
Women and Children's	12
Total	**45**

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.	There has been a slight decrease in performance.	Ongoing clinical pressures and staff absences have had an impact in time that investigations are taking.	Ongoing work, with new processes implemented in the emergency centre to assist in providing more timely responses. New member of staff appointed to focus on the backlog of overdue cases, and free up the complaints team to focus on new cases.	Regular updates to complainants

Compliments formally recorded

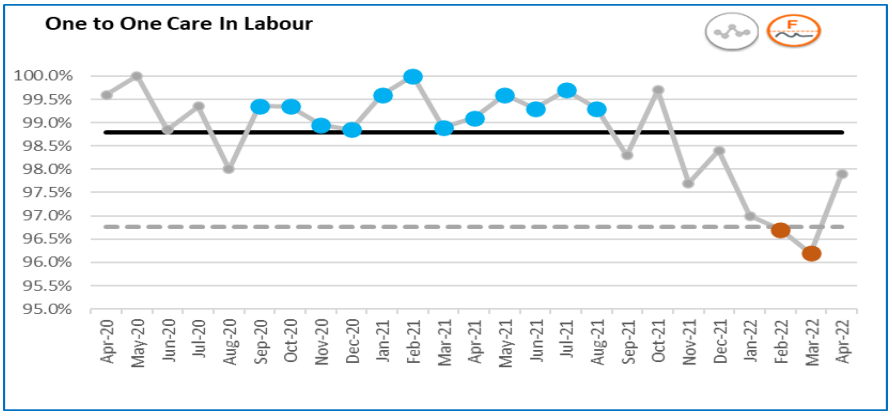


April 2022 actual performance
SATH
19
Divisions
MEC – 3
SAC – 10
CSS – 3
Other - 3

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 remains low; 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 compliments.	Remind staff to use the Datix system to record positive feedback.	None.

Quality Exception Reports – Maternity services

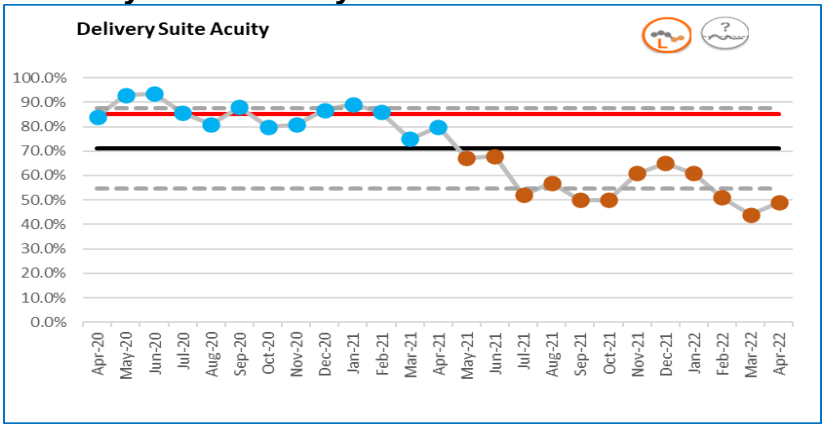
Maternity - One to One care in labour



April 2022 actual performance
97.9%
Variance Type
Common Cause
National Standard
100% (Better Births)
Target / Plan Achievement
Part of overall maternity care dashboard

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 CNST standard safety action number 5 that 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 continues to often be below template on delivery suite, despite ongoing successful recruitment. This is due to recent retirements, short term COVID-19 absence and high unavailability rates due to maternity leave.	Intermittent closure of the Wrekin birthing unit to support safe staffing levels on delivery suite. Incentivised bank rate in place. Ongoing recruitment for band 6 midwives. 26 band 5 midwives recruited to commence in the autumn. All births are now recorded on Badgernet which enables immediate matron oversight of all cases where 1:1 care is recorded as not provided. Introduction of 7-day manager cover to assist with appropriate escalation and movement of staff as required.	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.

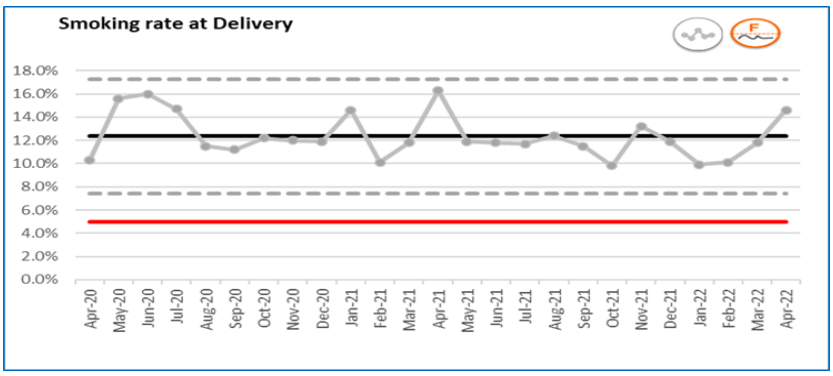
Delivery suite acuity



April 2022 actual performance
49%
Variance Type
Special Cause Concern
National Standard
85% (Birth Rate Plus)
Target / Plan Achievement
Part of overall maternity care dashboard and benchmarking

Background	What the Chart tells us	Issues	Actions	Mitigations
In 2015, NICE set out guidance for safe midwifery staffing which included the use of a tool endorsed by NICE to measure and monitor acuity. This has been in place at SaTH since 2018 and is reported monthly in line with the CNST standard safety action number 5.	There was an improvement in acuity this month.	Staffing levels often below template due to vacancies, high levels of maternity leave and sickness rates. Assured by other indicators, such as one to one care in labour, 3rd and 4th degree tears below expected rates, term admissions to NNU below national rates.	Intermittent closure of the Wrekin birthing unit to support safe staffing levels on delivery suite. Specialist midwives job plans reviewed creating additional 4.6 WTE clinical midwifery capacity. Senior midwifery leadership team now rostered for a clinical shift per week to support safe staffing levels. Vacancies identified and being monitored monthly to ensure staffing position understood. Recruitment ongoing with successful appointments to band 6 posts (both substantive and bank) and 26 band 5 preceptee midwives appointed to commence in the autumn. A 7-day manager rota due to commence to ensure support and action at weekends. Use of temporary staff to ensure staffed to template where possible. A review of the escalation policy to provide further detail and actions in times of high acuity.	Acuity tool consistently being completed – reassurance of data quality. Twice daily SMT huddles to monitor and manage acuity and instigate escalation policy when required. Incentivised bank shifts in place for all areas.

Smoking rate at delivery



April 2022 actual performance
14.6%
Variance Type
Common Cause
National Target
5% by 2025
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 5% by March 2025. All pregnant smokers in Shropshire and Telford and Wrekin are referred to and supported by the Healthy Pregnancy Support Service (HPSS) based at PRH.	Increase in SATOD this month. Lower than average number of births in April, therefore percentage increases. All Trust births at 14.6% SATOD, but all local population (women living in Shropshire Telford & Wrekin, who can access support directly from HPSS) return 13.2% this month.	Target for March 2022 not met by Trust despite drastically reducing rates in maternity. Only 14 out of 106 submitting CCGs achieved 6% target. The Trust will now work towards new target of 5%. There continues to be inaccuracies with reporting monthly dashboard SATOD rates, due to issues with Badgernet data quality (lack of data input at time of delivery).	2 WTE band 5 nurses appointed to HPSS, currently going through recruitment checks. Discussion with Performance team re. accuracy of dashboard data. HPSS going through data manually each month to check accuracy and ensure correct data is published. Meeting with digital midwife lead to look at improving data collection from midwives.	There have been barriers to launching HPSS due to recruitment issues, however these are now resolved. To continue to monitor data quality now Badgernet is the only data system being used by maternity.

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

Retaining our workforce is pivotal. A broader approach to improving SaTH's culture and leadership includes ensuring we are an inclusive employer, investing in continuous professional development, effective roster management and supporting our people through our health and wellbeing interventions. Also, during April over 1,000 staff have taken part in the 'making a difference together' conversation about flexible working, the conversation closed on 16th May 2022. An update will be provided in July.

During the month we have been successful in recruiting at several recent events, which have included: pharmacists and pharmacy technicians, theatres – staff nurses/theatres practitioners and physiotherapists. We have also seen an improvement in interest from candidates with nearly 400 medical applications in April.

The transformation workforce group is now focusing on new roles and apprentices in how they support longer term workforce gaps by growing our own workforce. We currently have nine nursing associates being supported on an 18 month programme to become qualified registered nurses who we expect to qualify in 2023. A further 10 will be commencing this programme this year and will qualify in 2024.

We recognise from feedback from the staff survey and engagement that bullying, and harassment continues to be a key area of concern. This is a key part of our culture work and development centres around leadership accountability and ownership, civility and respect, being open and transparent and creating a safe and inclusive environment. We will share updates with the Board of Directors in August as part of our staff survey progress update.

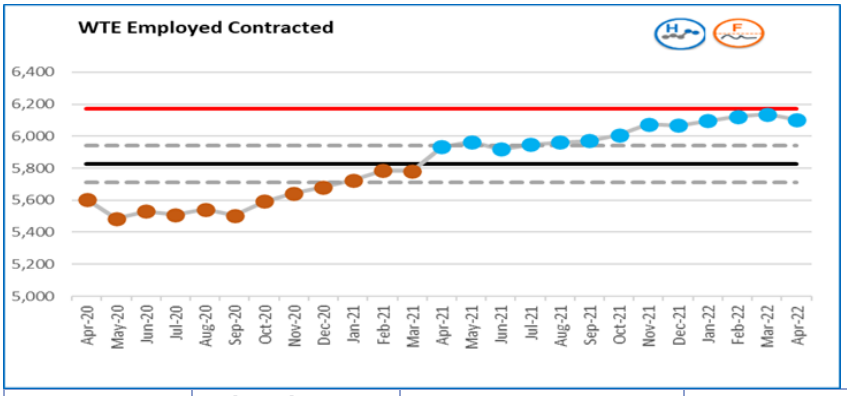
Our leadership programmes and masterclasses have re-commenced with 100 staff attending the most recent sessions on courageous conversations, unconscious bias, high performing teams; compassionate, inclusive and effective leadership masterclasses are on offer during May to develop more effective team working to ensure we have a positive impact on patient experience, quality of care.

Our Jubilee celebrations are coming up next, as well a planning for the Trust Awards later this year. We are also planning a celebratory afternoon tea for all colleagues who have received their long service award milestones. We have a recognition plan and calendar of events for throughout the year where we will be recognising key dates including celebratory days and special occasions. We will also be celebrating and acknowledging key cultural and religious events throughout the year.

Health and well-being of our people remains a key priority and we know many of our people are feeling the impact of the cost-of-living rises. We are seeking to become a living wage partner and in the meantime are implementing flexible ways for colleagues to access pay in different ways.

Statutory training compliance has continued to reduce this month to 80%, the focus is now to ensure we protect planned education and learning.

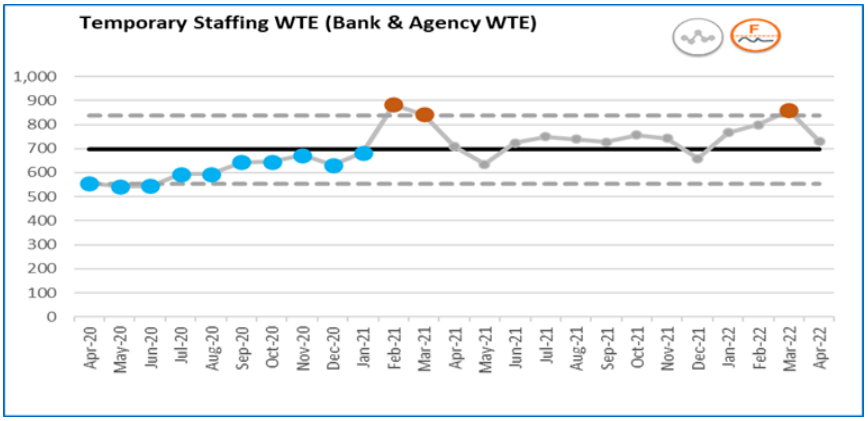
WTE employed



April 2022 actual performance
6104
Variance Type
Special Cause Improvement
Local Target
6173
Target / Plan Achievement
Seeking month on month improvement

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.	Overall WTE numbers have increased over the last 12 months despite a high turnover rate of 15%. 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. Review of templates has taken place however has not yet been implemented in ward rosters.	The number of staff recruited to the organisation continues to ensure overall growth with 950 WTE new starters over the last 12 months. The workforce will continue to grow throughout 22/23 as we invest in services to keep pace with demand. A newly established workforce programme focusing on delivery of initiatives to address demand will support the supply of workforce in the short and long term. This will include a number of groups implementing international recruitment, developing strategies to manage our temporary workforce new roles and apprentices and retention. Programme to update templates in ward areas is in progress.	Utilisation of bank and agency staff to support workforce gaps. Promote timely roster approvals to maximise opportunities for bank utilisation. Continue to monitor leavers and support with early intervention.

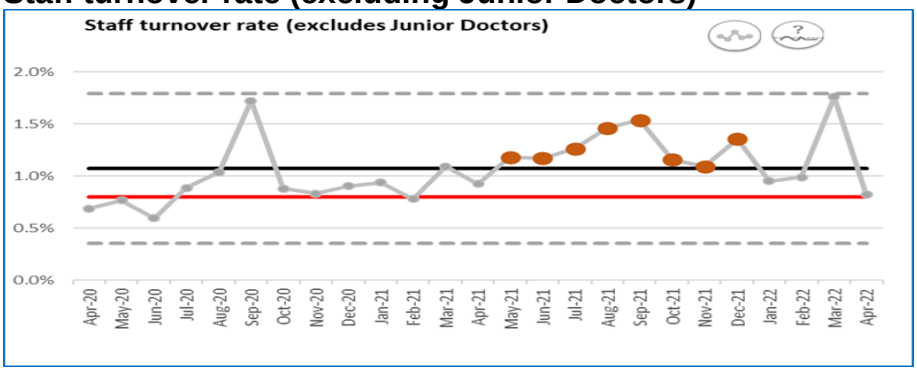
Temporary/agency staffing



April 2022 actual performance
731
Variance Type
Common Cause
National Target
N/A
Target / Plan Achievement
TBC

Background	What the Chart tells us	Issues	Actions	Mitigations
The measure is an indicator of agency and bank usage expressed as WTE.	Common cause between April 2021 and April 2022.	High levels of staff absences attributed to sickness continue to present staffing challenges. High patient acuity levels and escalation also continue to present further challenges to staffing levels.	Review of incentives for bank shifts and promotion of bank. Plans to remove off framework agency by December 2022. Recruitment programmes in place including international recruitment and apprenticeship programme e.g. nursing associates and ODPs. Continue to monitor roster approvals and unavailability to support better utilisation of temporary workforce.	Escalated bank rates in at risk areas. Progress with recruitment activities to increase substantive workforce including international nurse recruitment.

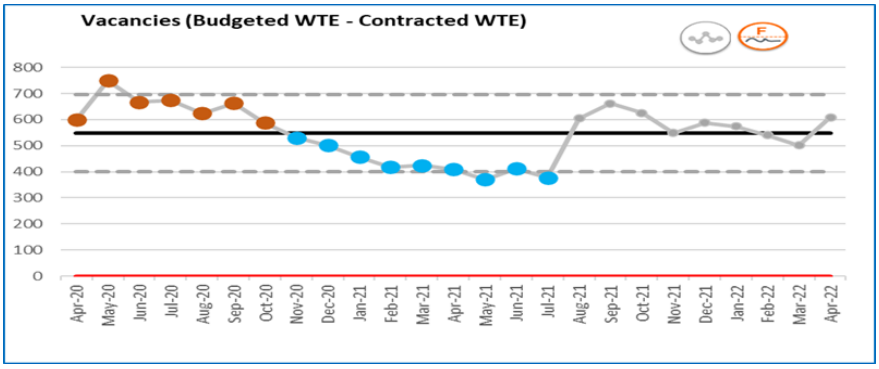
Staff turnover rate (excluding Junior Doctors)



April 2022 actual performance
0.95%
Variance Type
Common Cause
National Target
0.8%
Target / Plan Achievement
Target not achieved

Background	What the Chart tells us	Issues	Actions	Mitigations
The measure is an indicator of the % of staff who have left the organisation.	Common cause variation in January 22 – April 22.	Overall turnover rate continues to be high with a 15% turnover rate for the last 12 months. In April there were 57 WTE leavers with leaving reasons of other/not known and work life balance attributing to 35% (20WTE) of leavers for the month.	A focus on retention and flexible working with a range of practices to support our workforce including team-based rostering. Senior leader targets which will be included in the objectives of all our leaders from band 3 to Board for the next 12 months. This is seen as a positive move to ensure ownership and accountability at all levels across the Trust to demonstrate our individual and collective responsibilities in improving our working lives and culture. Continue focus on equality, diversity and inclusion and delivering interventions to support our cultural development. Response to staff survey and interventions to increase levels of employee engagement.	Recruitment activity to help ensure minimal workforce gaps. Utilisation of temporary workforce to maintain suitable staffing levels. Escalated bank rates in challenged areas.

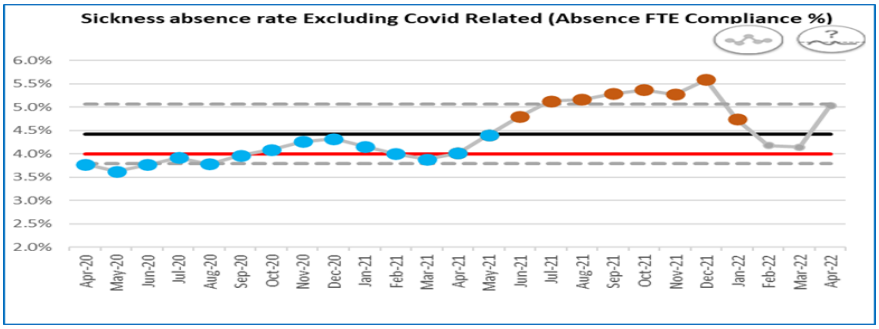
Vacancies



April 2022 actual performance
10% (608)
Variance Type
Common Cause
National Target
<10%
Target / Plan Achievement
Note change post reconciliation work

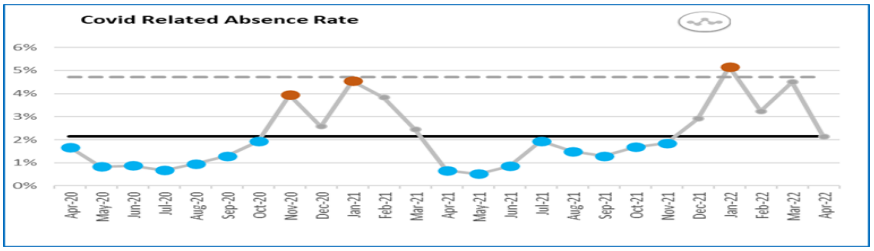
Background	What the Chart tells us	Issues	Actions	Mitigations
This is a measure of the gap between budgeted WTE and contracted WTE. Further review of establishments will continue as part of operational planning this year.	Improving vacancy position following revised budget position in August 21. Common cause variation August 2021 to April 2022	A competitive marketplace presents challenges in attracting candidates. Vacancy gaps continue to put pressure on bank and agency usage. Sickness absence creates additional workforce unavailability challenge. High attrition levels result in vacancies occurring at a higher-than-expected rate.	Range of recruitment events for specific roles. Partnership working with ICS recruitment events e.g., Telford College Academy. International recruitment programme. New roles and apprenticeships. Work with business partners to understand hotspot areas of focus and undertake targeted recruitment campaigns. Review attraction offerings including revising and refreshing of job descriptions for challenged posts; implementation of hardship to assist staff with budgeting and facilitate faster and responsible access to earlier payment.	Recruitment activity continues to reduce workforce gaps. Use of temporary staff to cover vacant posts. System Mutual Aid to support critical staff shortages.

Sickness absence



April 2022 actual performance
5.03%
Variance Type
Common Cause
National Target
4%
Target / Plan Achievement

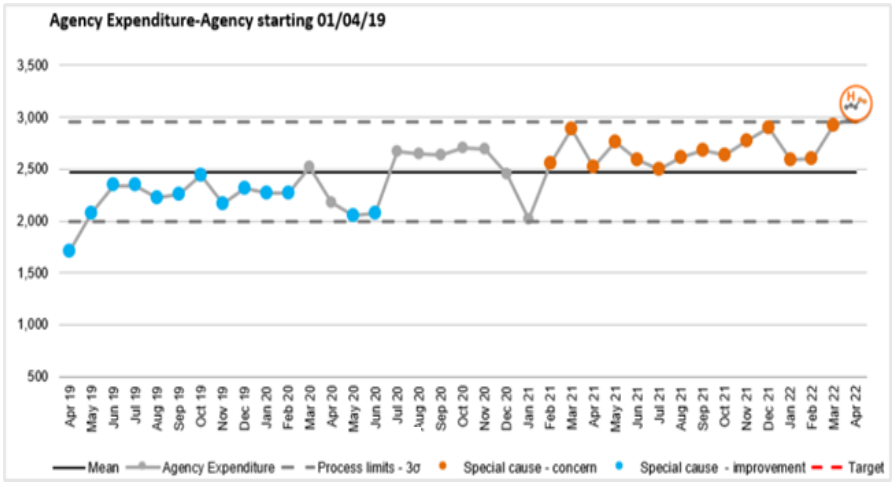
Background	What the Chart tells us	Issues	Actions	Mitigations
The measure is an indicator of staff sickness absence and is a % of WTE calendar days absent. COVID-19 related sickness and absence is not included.	Special cause concern from April 21 – January 22 with common cause in February 22 - April 22.	From April 22 sickness absence rate includes employee sickness attributed to COVID-19. Absence rate of 5.03% equating to 307WTE. Absence attributed to mental health continues to be high at 23% of the calendar days lost equating to 69WTE with COVID-19 sickness attributing to 20% of calendar days lost equating to 60WTE.	Occupational health support to help fast track staff return to work. Continue to embed new employee wellbeing and attendance management policy. Ensure all staff have access to range of health and wellbeing initiatives and programmes. Continue to support appropriate PPE adherence and vaccination uptake.	Continue to work with temporary staffing departments to ensure gaps can be filled with temporary workforce where necessary. Encourage bank uptake with escalated rates in challenged areas. Review unavailability rates with Divisions to support targeted interventions.



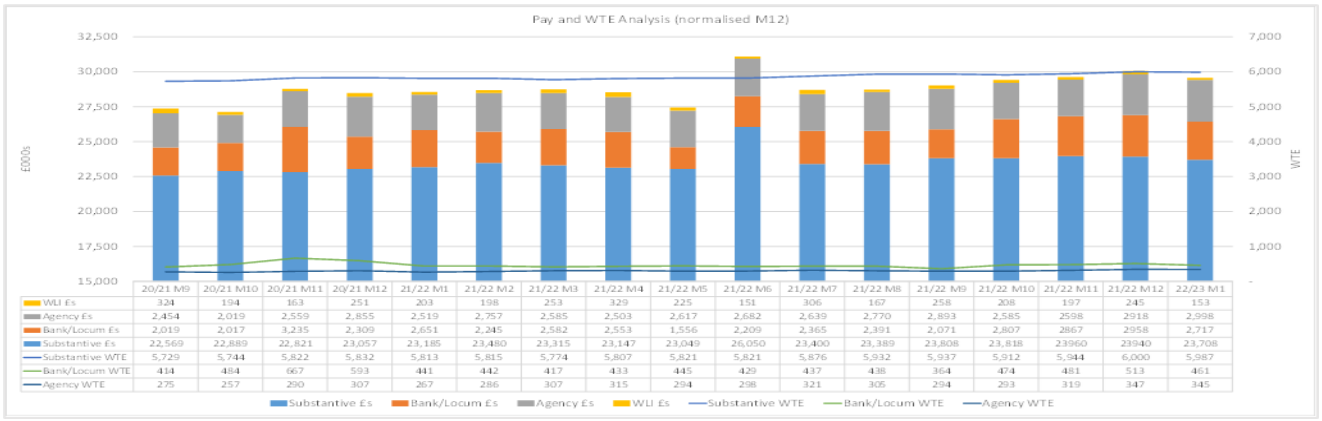
April 2022 actual performance
2.12%
Variance Type
Common Cause
National Target
N/A

Background	What the Chart tells us	Issues	Actions	Mitigations
The measure is an indicator of staff COVID-19 sickness absence. It reports the average number of staff absent due to COVID-19 related sickness.	COVID-19 related absence Common cause variation between February 22 and April 22.	COVID-19 absence now only includes those required to isolate. Staff with a sickness episode attributed to COVID-19 are now included as part of the normal sickness rate. COVID-19 absence not relating to sickness continues to add additional unavailability pressures.	Staff absence reporting line to continues to monitor absence levels and help ensure staff can safely return to work following risk assessments. Communication to staff of following 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 vaccine.	Regular and timely staff testing. Identification of positive cases and effective contact tracing. Continue risk assessments for staff identified as contacts.

Agency expenditure

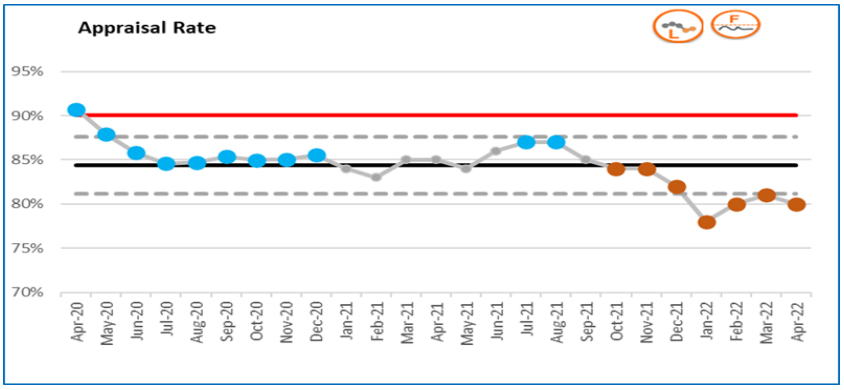


April 2022 actual performance
£2.998m Overspend to date £0.674m
Variance Type
Special cause Concern overspend
SaTH Plan
£2.324m
Target/ Plan achievement
Remaining within annual plan overall.



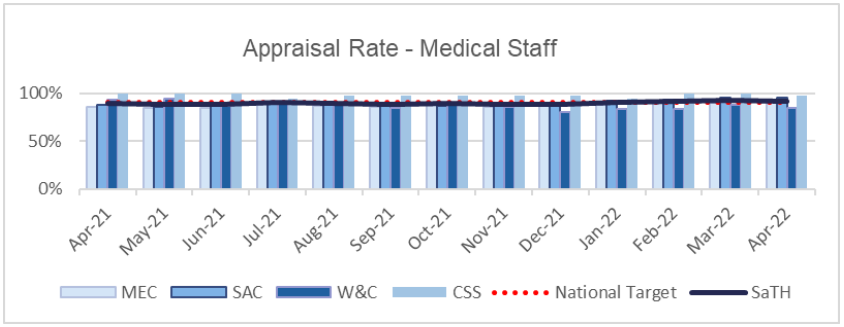
Background	What the Chart tells us:	Issues	Actions	Mitigations
The Trusts agency costs have increased over the past 2 years due mainly to the COVID-19 pandemic and additional quality service investment requirements. There is a strong focus on reducing agency spend across the Trust which is integral to the Trust efficiency programme.	Agency costs were £2.998m in the month, £0.080m higher than previous month. The increase is mainly due to the use of off-framework agency to support operational pressures.	Due to workforce fragility the Trust is consistently reliant upon agency premium resource. There has been a significant increase in the use of agency healthcare support workers linked to an increase in acuity and 1:1 care. Operational and workforce pressures force an increase in agency spend.	Direct engagement groups now set up to focus on agency spend and approval hierarchy, including monthly dashboard review across key nursing metrics. Overseas registered N nursing recruitment in 19/20, 20/21 and 21/22 has supported the vacancy position. 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



April 2022 actual performance
80%
Variance Type
Special Cause Concern
National Target
90%
Target / Plan Achievement
Below target level of performance

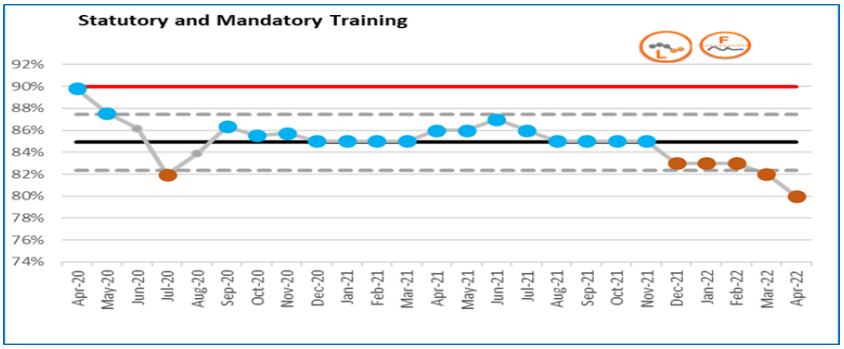
Appraisal – medical staff



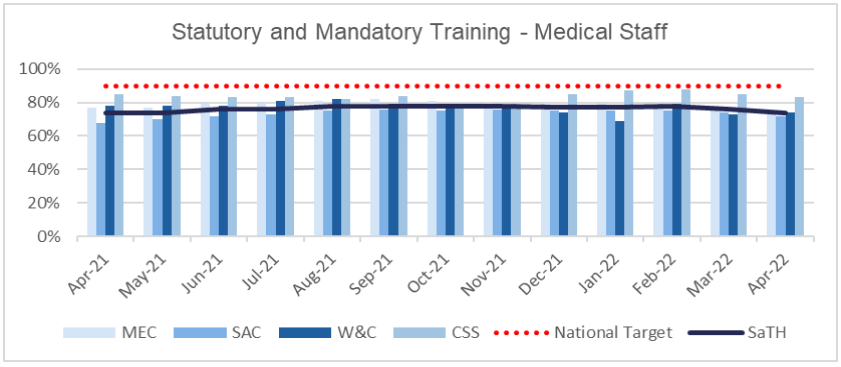
April 2022 actual performance
92%
Variance Type
N/A
National Target
90%
Target / Plan Achievement
90%

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.	In August 2021, we achieved 87% but this has progressively dropped, winter pressures, escalation levels and staff sickness would have contributed to the % decrease.	The system has periodically been in a critical incident and staff sickness running at high levels. COVID-19, staffing constraints, escalation levels and service improvement has reduced ability of ward staff to have time to complete appraisals.	Appraisals being linked to pay progression. Focused support is being provided to the managers of any ward that is below target. Linking in with HPBPs with regards to any areas of concern. This support has been extended to 1:1 advisor support for 72 wards/departments. Appraisal training sessions are available on the training diary as part of a new line manager induction. An eLearning package is also being developed.	Ensure health and wellbeing offer is advertised widely throughout the Trust. Internal audit of appraisal record accuracy.

Statutory & mandatory training



April 2022 actual performance
80%
Variance Type
Special Cause Concern
National Target
90%
Target / Plan Achievement
90%

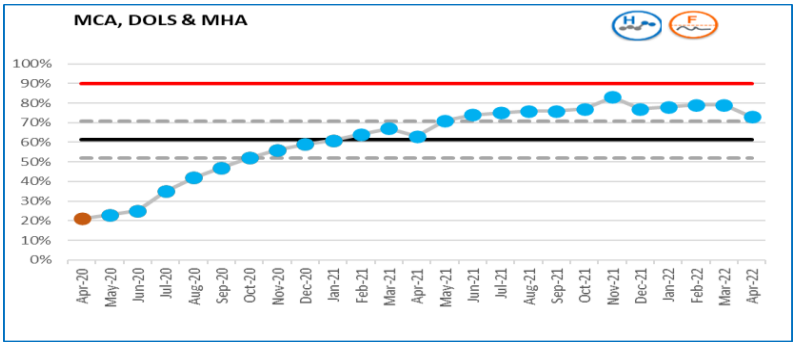


April 2022 actual performance
74%
Variance Type
N/A
National Target
90%
Target / Plan Achievement
90%

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%	**87%**	**72%**	**93%**	**89%**	**68%**	**57%**	**85%**	**74%**	**87%**

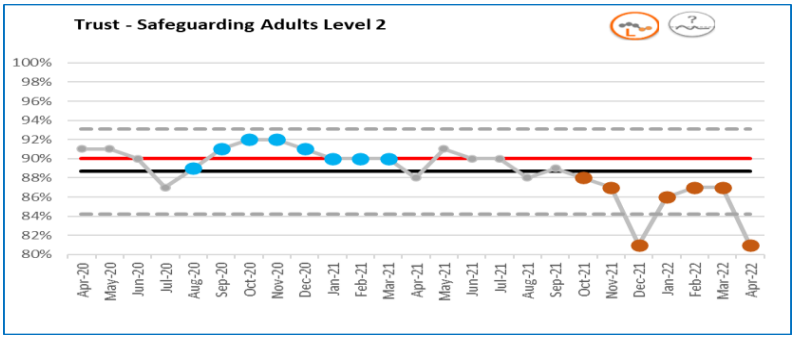
Background	What the Chart tells us:	Issues	Actions	Mitigations
The measure is a key indicator for patient safety in ensuring staff are compliant in having completed their annual appraisal.	Compliance rate has been at 82% for the past few months but has now dropped to 80%. Medical staff compliance with mandatory training is lower than the overall staff compliance. Medical staff now included on the report for Safeguarding Children & Adults L3.	The system has been in a critical incident and staff sickness running at high levels which will have contributed to the decrease in training %. Some data validation issues.	Full roll out of the new Learning Made Simple (LMS) training platform has now been implemented across the Trust from the 20th of April 2022. This system gives visibility of staff competencies at an individual level and make the process for undertaking and monitoring training far easier for our staff. This will help improve compliance rates and reduce risk across the Trust. Phase 3 of the LMS project to link unavailability due to training to health roster.	E-learning and workbooks offered as alternatives to face-to-face training, which has been well received with. Although utilised by individuals there are three departments that use this method instead of completing via eLearning. Requirements made more transparent to divisional teams and staff. Libraries supporting. learners to access e-learning. Phone support for e-learning.

Trust MCA – DOLS & MHA



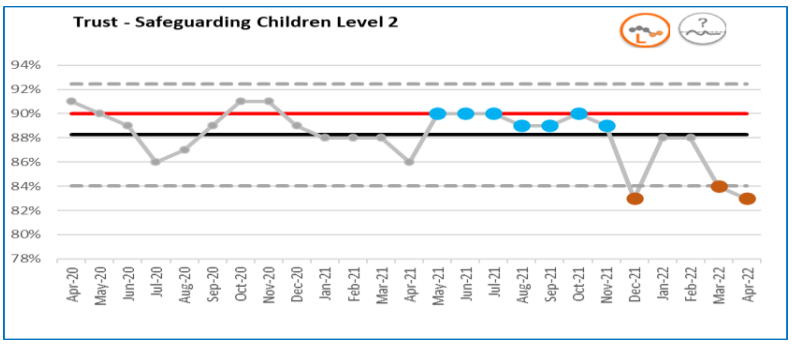
April 2022 actual performance
73%
Variance Type
Special Cause Improvement
National Target
90%
Target / Plan Achievement
Improvement trajectory in place

Safeguarding adults – level 2



April 2022 actual performance
81%
Variance Type
Special Cause Concern
National Target
90%
Target Achievement
90%

Safeguarding children – level 2



April 2022 actual performance
83%
Variance Type
Special Cause Concern
National Target
90%
Target Achievement
90%

5. Operational Summary
Sara Biffen, Acting Chief Operating Officer

- Overall, April 2022 has seen a reduction in urgent and emergency activity from the previous month (March 22), although the Princess Royal Hospital site has remained under pressure. The number of COVID-19 cases within the hospitals has fallen in April, in line with the community COVID-19 incidence rates, however the need to segregate emergency pathways is still necessary and therefore impacts on patient flow through the emergency portals.

- Time to initial assessment for both adults and children is below the expected standard, but marginally improved in April 2022. Plans for sustainable improvement are in progress on both sites.

- There has been a reduction in COVID-19 related staff absence, and a marginal improvement in the 4-hour performance target and a reduction in ambulance offload delays. As in previous months, close working with WMAS has been vital to ensure clinical prioritisation of ambulance handover, and joint support and care for patients waiting in ambulances and the Emergency Departments (EDs); cohorting of patients (allowing more ambulance vehicles to be released) has been used regularly to help balance risk as much as possible.

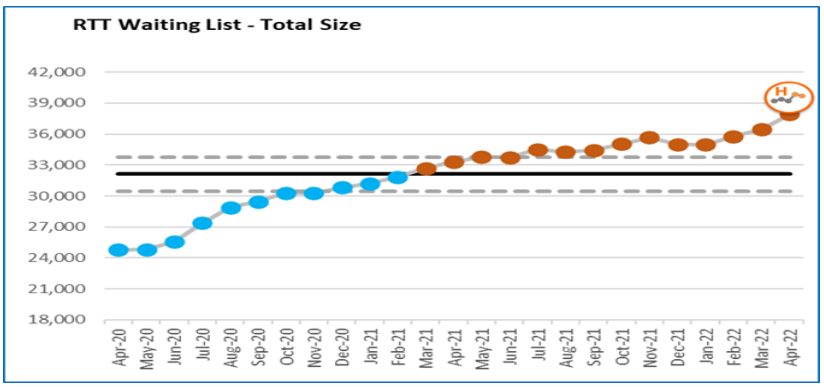
- Work is progressing to improve capacity within the urgent and emergency care pathways, improving discharge times and creating capacity for GP direct access.

- Elective recovery continues to be challenged, performance is significantly below the national standard, a range of plans are in place to increase activity for 2022/23. The divisional teams continue to work to reduce the number of 104 week waits at the end of June 2022.

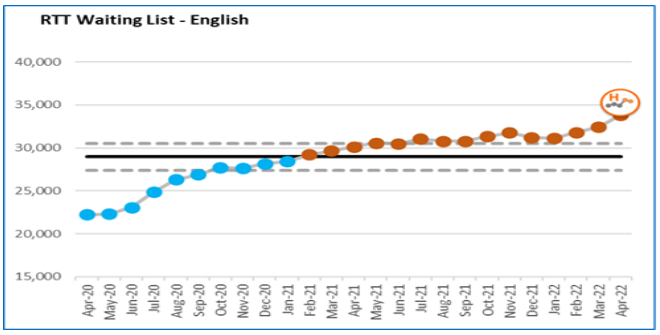
- Diagnostics high demand continues, as cancer referrals and routine referrals are back to pre-COVID-19 levels. Imaging and endoscopy activity are the main areas of activity, with both sets of services relying on additional capacity in the short term, with plans to expand the workforce and facilities in place during 22/23.

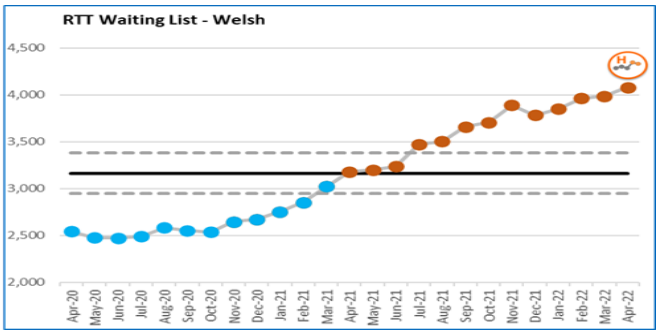
Elective Care

RTT Waiting list – total size



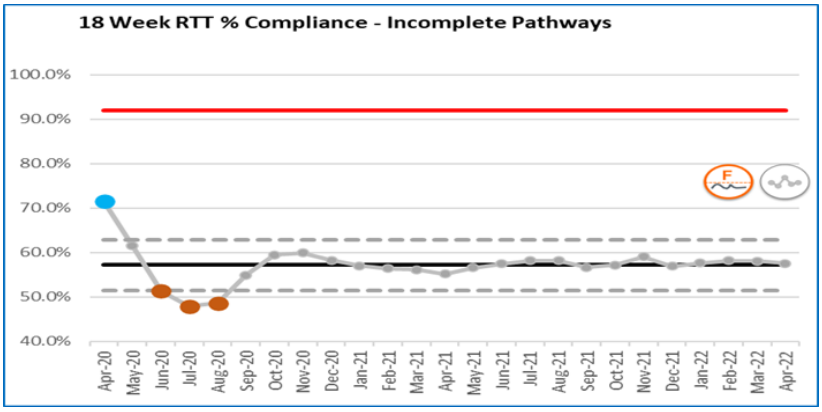
April 2022 actual performance
37936 (English 33855, Welsh 4081)
Variance Type
Special Cause Concern
Local Plan
TBC
Target / Plan Achievement
(22-23 plan)



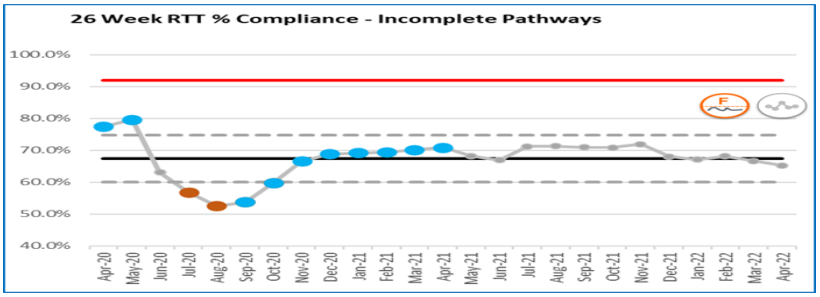


Background	What the Chart tells us	Issues	Actions	Mitigations
The total number of patients waiting for treatment.	The total waiting list size remains at a higher level and continues to increase.	Reduced capacity to see and treat patients due to clinic space restrictions, bed capacity due to emergency 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.	Weekly restore and recovery meetings in place. Training staff for surgical transfer to vanguard. Optimising utilisation of eye unit and vanguard. Adoption of patient initiated follow up as clinically appropriate. Phased recovery of elective inpatient capacity within day surgery units. We have restored some insourcing elective activity at weekends via 18 weeks on both sites.	As actions, additional 32- bedded unit and 16 additional elective beds from July 2022 subject to ITU air conditioning works going to plan. Theatre staff recruitment is challenged and looking at all options. Revised theatre structure, along with alternative roles, joint roles with RJAH and supernumerary training. Awaiting outcome of the elective hub bid for PRH site for day case capacity being split to give capacity before April 2023.

18-week RTT exception report



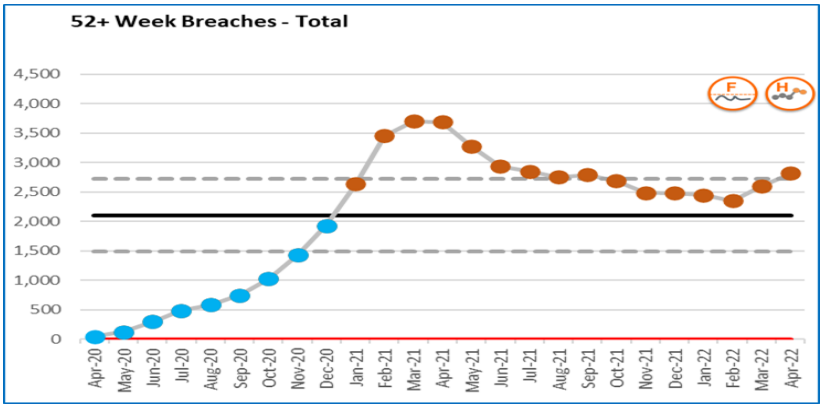
April 2022 actual performance
57.6%
Variance Type
Common Cause
National Target
92%
Target / Plan Achievement
Clinical prioritisation and the backlog developed mean target will not be achieved.



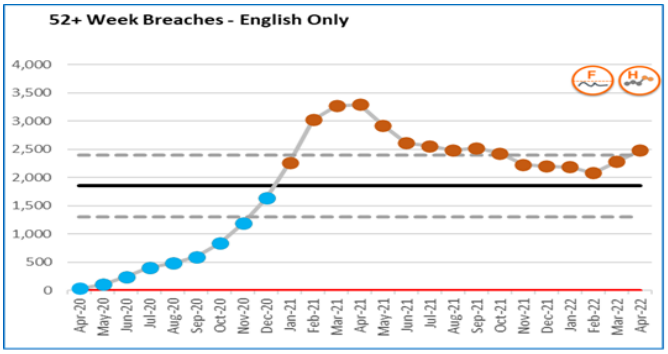
April 2022 actual performance
65.3%
Variance Type
Common Cause
National Target
92%

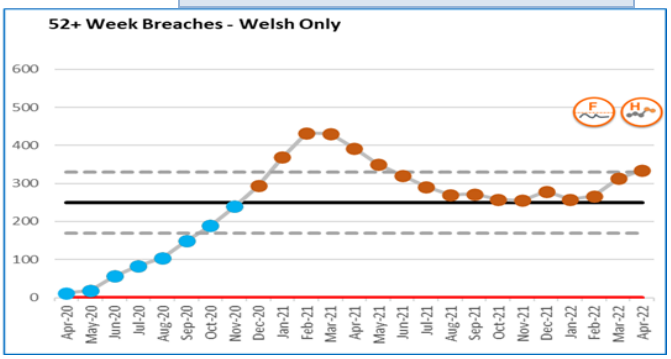
Background	What the Chart tells us	Issues	Actions	Mitigation
This is the national standard for patients referred for elective care. Headline performance against this measure has now stabilised but is well below the pre-pandemic performance.	Incomplete pathways appear to have stabilised at a level significantly 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 taking place with social distancing. Theatre capacity issues due to theatre nursing teams and theatres prioritised to clinically urgent patients. Staff related absences due to COVID-19. Increase in 2ww and urgent demand across a number of specialties. Loss of elective IP capacity through day surgery units.	Monitoring of referral demand and capacity. Weekly centre PTL meetings. Insourcing and outsourcing options.	Established system meeting to monitor elective recovery and cancer.

52 Weeks wait exception report



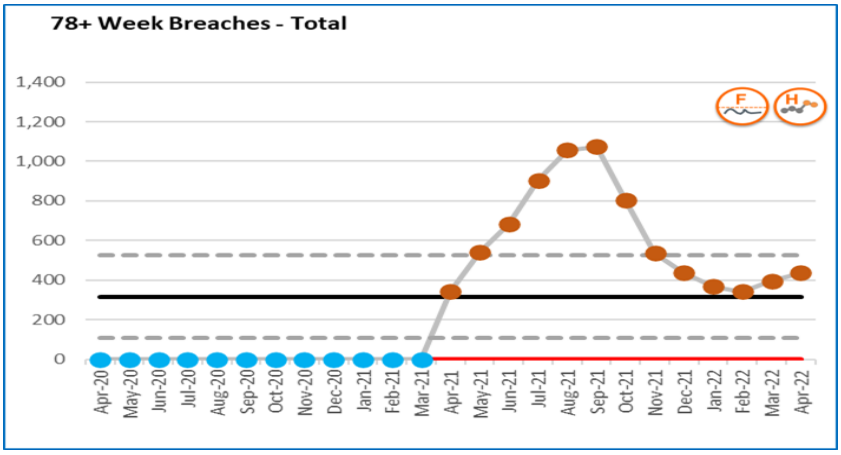
April 2022 actual performance
2815 (English 2480, Welsh 335)
Variance Type
Special Cause Concern
Local Forecast
2295 (English)
Target / Plan Achievement
Reduction on 52+ breaches



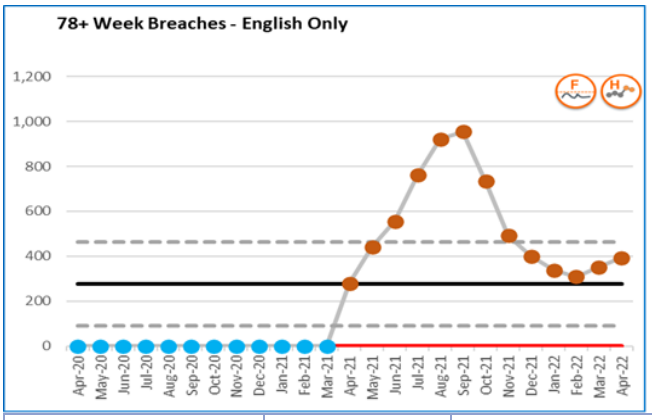


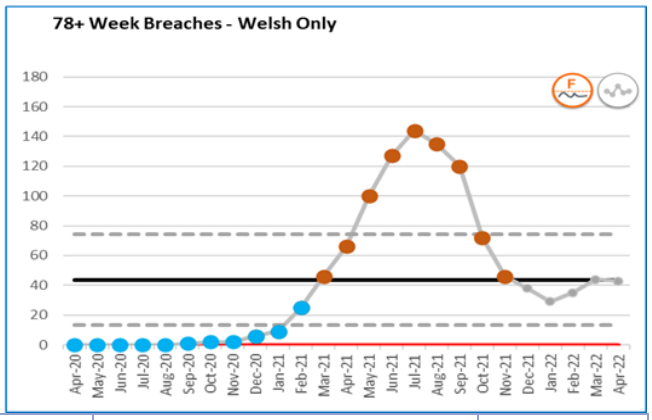
Background	What the Chart tells us	Issues	Actions	Mitigations
From a baseline position of zero pre-pandemic, the volume of patients waiting in excess of 52 weeks on an open RTT pathway has increased significantly. It reflects routine patients not currently being able to be prioritised for treatment.	The number of patients waiting over 52 weeks is increasing.	Theatre Staffing. Reduced elective capacity. Urgent care pressures resulting in the loss of elective 'green' capacity due to increased escalation into DSUs. Outsourced patients returning to SaTH untreated.	Clinical prioritisation of patients. Optimising vanguard and insourcing capacity via 18 weeks. Continue to book in line with clinical priority and longest waits.	Monitored by weekly RTT meeting and the cancer performance meeting.

78 Weeks wait exception report



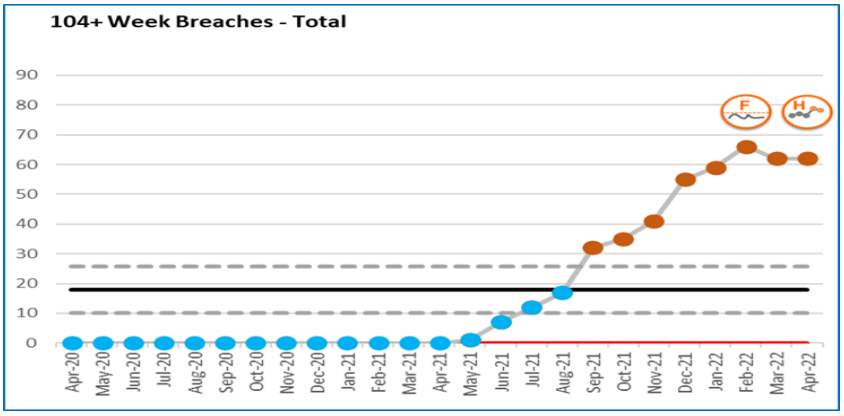
April 2022 actual performance	
436 (English 393, Welsh 43)	
Variance Type	
Special Cause Concern	
National Target	**Local Forecast**
0	271 (April)
Target / Plan Achievement	
NHSE National Target 0 by 31st March 23	





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 national target for 22/23 expects recovery to 0 patients waiting over 78 weeks by 31st March 2023.	The proportion of these long waiting patients who are over 78 weeks has started to increase.	The volume of patients over 78 weeks is related to the proportion of clinically urgent patients waiting and the unscheduled care demands reducing capacity for routine long waiting patients. The forecast for 2022-23 shows that additional interventions will continue to be required in order to reduce this back to zero by 31.3.2023.	Vacancies being addressed through recruitment and overseas nursing. COVID-19 and non-COVID-19 related absences are being closely monitored. Ring-fenced elective capacity retained in eye suite and vanguard unit plus green pathways and additional IS capacity secured. Developing recovery plans as part of the 2022-23 integrated operational planning cycle.	Monitored via weekly RTT meeting. Operational plan monitored through system and weekly divisional meetings.

104+ Weeks wait exception report

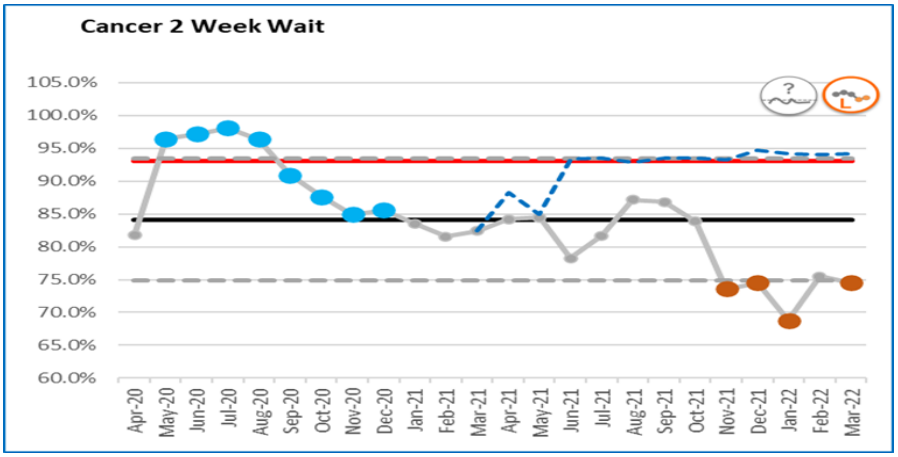


April 2022 actual performance	
62 (English 60, Welsh 2)	
Variance Type	
Special Cause Concern	
National Target	**Local Forecast**
0	70 (April)
Target / Plan Achievement	
NHSE 0 by 30th June 22	

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 104+ weeks on an open RTT pathway has increased. The operational plan 22/23 target is to reduce to zero by 31.3.22. The SaTH operational plan including interventions has 74 patients remaining over 104+weeks at 31.3.22 as a trust we achieved 60.	Number of 104+ week waiters is decreasing in line with the trusts plan to be at 30 by 30.6.22.	Limited routine elective capacity due to medical escalation. Only limited PL2 and PL2Cs patients and some long waiters.	Clinical priority of cases continues, and lists are allocated on clinical need. Optimising vanguard and training staff to undertake laparoscopic activity previously not done in vanguard. Mutual aid with joint working on elective orthopaedic cases with RJAH. ERF plan to continue to utilise insourcing 18 weeks.	6-4-2 theatre meeting list planning. Weekly restore and recovery meeting.

Cancer

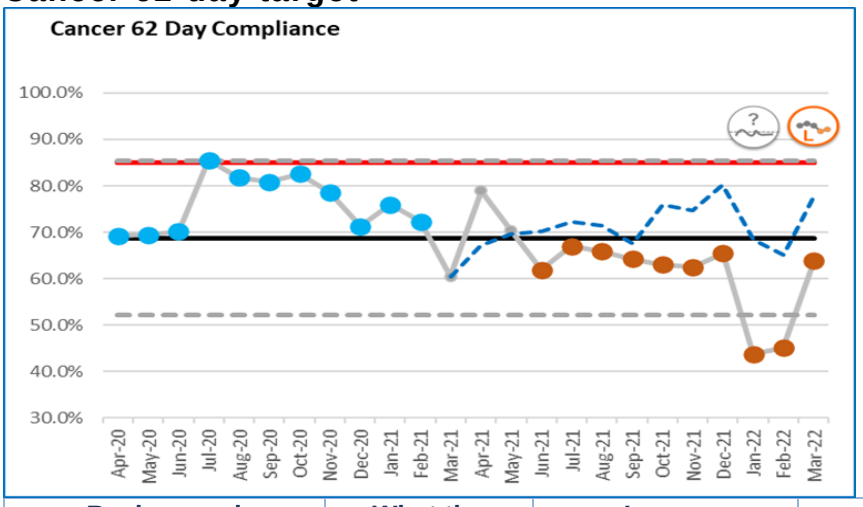
Cancer 2 week waits



March 2022 actual performance
74.5% (April 2022 Revised forecast 72.4%)
Variance Type
Special Cause Concern
National Target
93%
Target / Plan Achievement
Improvement trajectory not being achieved

Background	What the Chart tells us:	Issues	Actions	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 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 breast/ gynaecology/lung services.	No capacity to be seen within 2WW in breast, gynaecology, haematology, and Lung. This is due to radiology capacity for the one stop clinics in breast and gynaecology and consultant capacity in lung and haematology.	Breast pain only clinics haver commence which will reduce the amount of 2WW breast referrals. Gynaecology working on extra capacity and alternatives to one stop. Lung recruiting additional consultants and provide some WLI clinics.	Implementation of revised 2WW breast and gynaecology referral proformas.

Cancer 62-day target

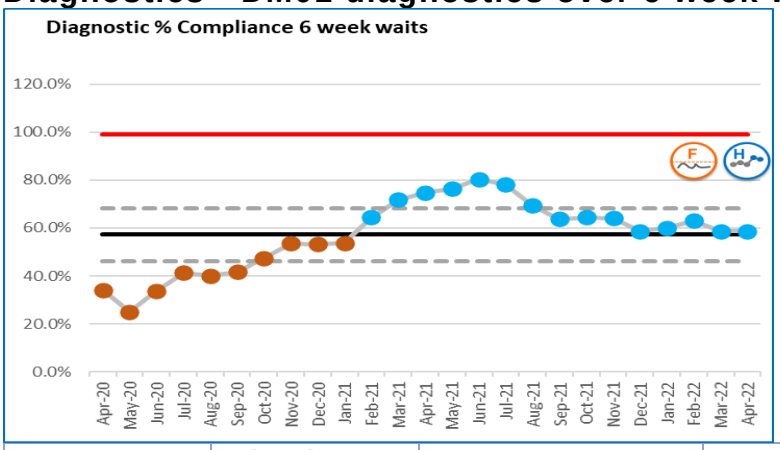


March 2022 actual performance
63.9% (April revised forecast 50.8%)
Variance Type
Special Cause Concern
National Target
85%
Target / Plan Achievement
Performance worse than improvement plan

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 not been achieved since April 2019.	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. Staffing levels in oncology.	Weekly review of PTL lists using somerset cancer register – escalations made as per cancer escalation procedure. Best practice pathways being reviewed, and improvement plans from divisions are being made.	Cancer performance and assurance meetings on-going chaired by deputy COO. Improvement plans being written by divisions.

Diagnostics

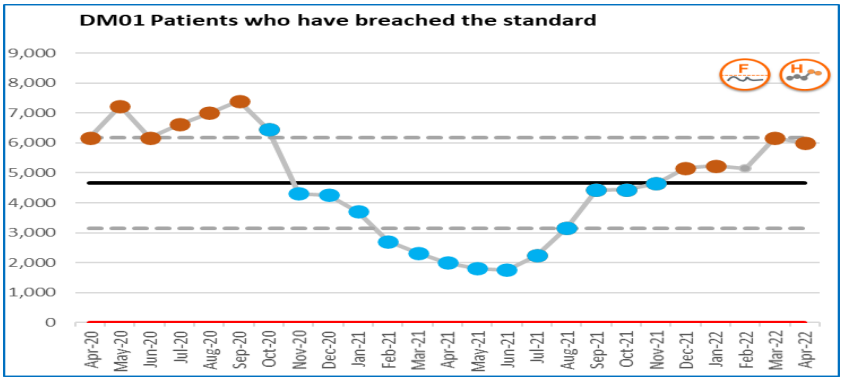
Diagnostics - DM01 diagnostics over 6 week waits



April 2022 actual performance
58.7%
Variance Type
Special Cause Improvement
National Target
99%
Target / Plan Achievement
Recovery not achieved in 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.	Special cause improvement compared to concern in March.	Staff availability continues to affect capacity and workforce. Short notice absence leading to cancellation of lists in line with business continuity plans. DM01 performance of MRI and US.	Ongoing recruitment. Progression of internal staff using apprenticeships. Redeployment of radiology staff to cover areas of clinical prioritisation. DM01 performance is improving for CT and MRI, static for US.	Clinical prioritisation of all radiology bookings. On site mobile scanners to increase available capacity. Use of insourcing in US and breast. Use of agency, however availability and quality are a concern.

DM01 Patients who have breached the standard

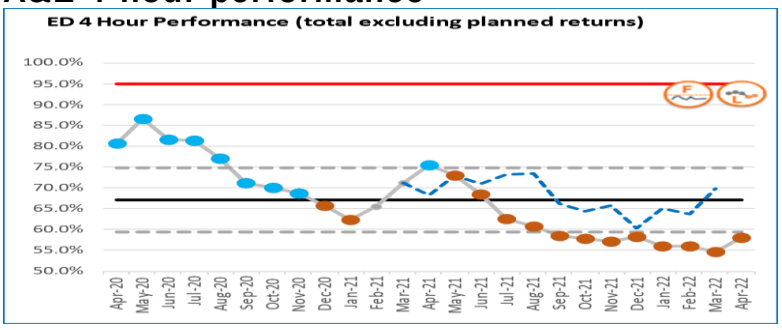


April 2022 actual performance
5994
Variance Type
Special Cause Concern
National Target
0 - < 6weeks
Target / Plan Achievement
Clinical prioritisation and then addressing longest waits.

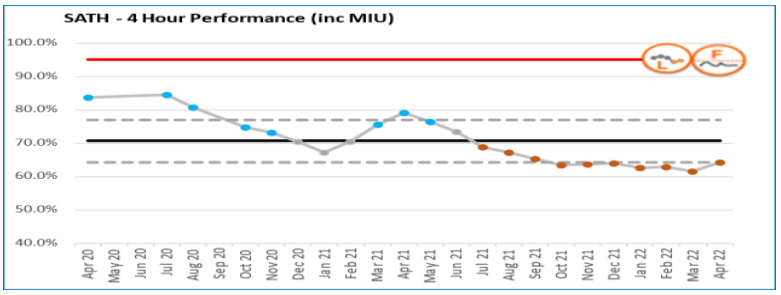
Background	What the Chart tells us	Issues	Actions	Mitigations
DM01 is the national standard for non-urgent diagnostics completed within 6 weeks of the referral. There must be no more than 1% of patients waiting longer than 6w.	Failure to reach the national target. Slight improvement in number of patients waiting longer than 6 weeks for diagnostic imaging.	Staff availability / absence affects imaging capacity and requires short-notice cancellation of lists. Reduced capacity due ongoing COVID-19 measures.	Ongoing recruitment across all areas. Implementation of year 1 of the workforce business case to improve capacity/efficiency. Recruitment of additional apprentices to increase substantive workforce. Training will take 18 months to 2 years. Telephoning patients in areas of high DNAs to reallocate unwanted appointments.	Use of agency/bank as available. Mobile scanners on site. Insourcing for US and breast.

Emergency Care

A&E 4-hour performance



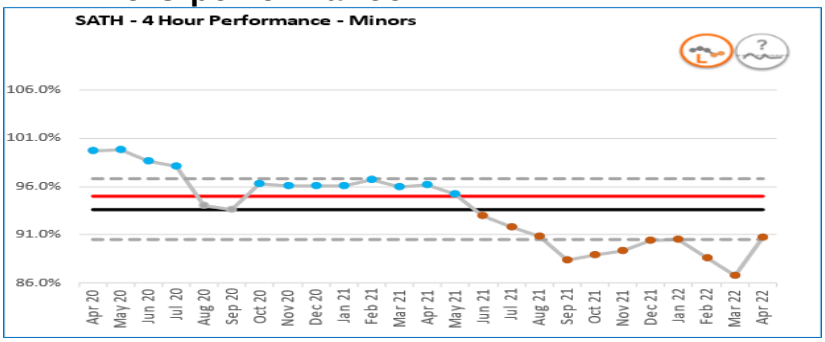
April 2022 performance
58%
Variance Type
Special Cause Concern
National Target
95%
Target / Plan Achievement
Performance is worse than the improvement trajectory.



April 2022 performance
64.3%
Variance Type
Special Cause Concern
National Target
95%

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 an overall lack of capacity as demonstrated within the Trust bed model, an increase in the number of MFFD patients and a reduction in the number of complex discharges. Direct medical patients are being referred to ED due to a lack of AMA capacity as a result of having to maintain COVID-19 segregated pathways and overall lack of capacity. Increased impact following Cardiology move to single site and issues with Stroke discharge capacity in the community.	A potential plan for reconfiguration of wards on RSH to create an acute medical floor is currently being discussed internally and across the system. Reconfiguration of RSH ED to enhance patient experience and access to most appropriate area in ED. Primary care streaming trial has taken place – impact review to take place w/c 16/05/22. Extension of PRH SDEC. Improved use of SDEC including direct access from WMAS & WAS. Focus on the reduction in MFFD patients occupying beds with system partners. Admission avoidance and Single Point of Access (SPA) in place to reduce footfall to ED. Working with NHS 111 to improve utilisation of booked appointment slots. Flow improvement work to be rolled out to all medical wards. System UEC improvement programme under development Local UEC improvement programme under development	System UEC action plan. Support from NHSEI MFFD and criteria to reside.

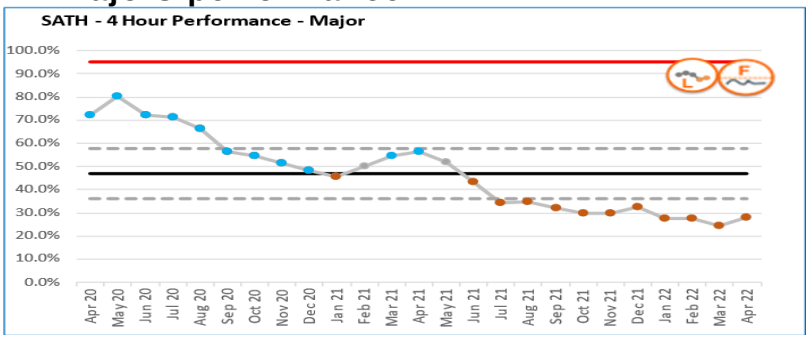
ED Minors performance



April 2022 actual performance
90.8%
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 and rotation between sites. Dedicated Consultant Lead. WMAS working with Community Trust to use MIU capacity. Single point of Access for referrals in place.	Patients assessed on clinical priority need.

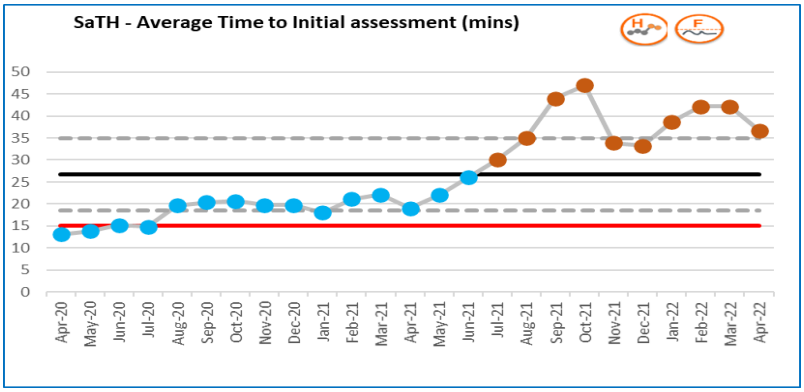
ED Majors performance



April 2022 actual performance
28.1%
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.

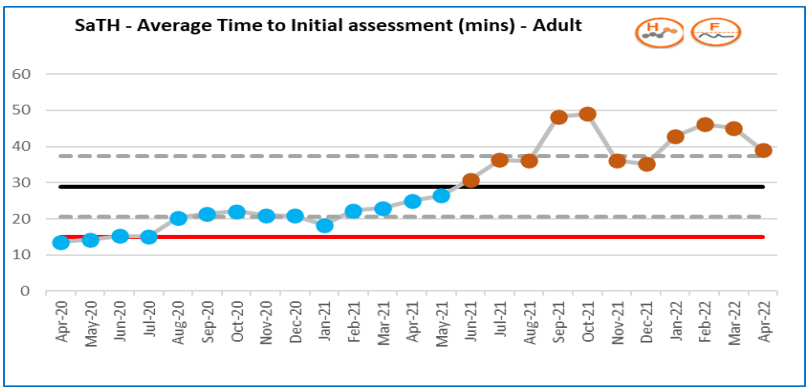
Background	What the Chart tells us	Issues	Actions	Mitigations
The national target is for all patients to be seen treated, admitted, transferred, or discharged within 4 hours of arrival at the emergency department.	Deterioration in performance in quarter 3 continued until the year end.	Flow out of ED restricted due to an overall lack of capacity as demonstrated within the Trust bed model, an increase in the number of MFFD patients, and a reduction in the number of complex discharges. Direct medical patients are being referred to ED due to a lack of AMA capacity as a result of having to maintain COVID-19 segregated pathways and overall lack of capacity. Due to lack of capacity, physical space in the department is an issue which results in medics having nowhere to see patients. Ambulance offload delays and significant waiting room delays continue to be a risk. Increased impact following Cardiology move to single site and issues with Stroke discharge capacity in the community.	Focus on the reduction in MFFD patients occupying beds with system partners. Admission avoidance and Single Point of Access (SPA) in place to reduce footfall to ED. Flow improvement work to be rolled out to all medical wards. System UEC improvement programme under development. Local UEC improvement programme under development. Working with NHS 111 to improve utilisation of booked appointment slots.	Patients assessed on clinical priority need.

ED –Time of initial assessment (mins)



April 2022 actual performance
37 Minutes
Variance Type
Special Cause Concern
National Target
15 Minutes
Target / Plan Achievement
Aim to recover to national target.

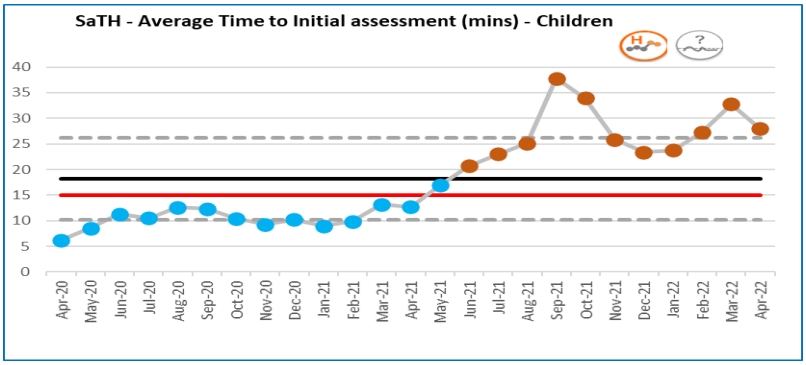
ED Time to initial assessment - adult



April 2022 actual performance
39 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 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. Recruiting 7WTE band 6 paramedics who will support with initial assessment. Primary care streaming trial has taken place – impact review to take place w/c 16/05/22. In reach from SDEC and UTC to support with completing initial assessment in conjunction with the 'pull' model.	Oversight by divisional director, divisional director of nursing and COO.

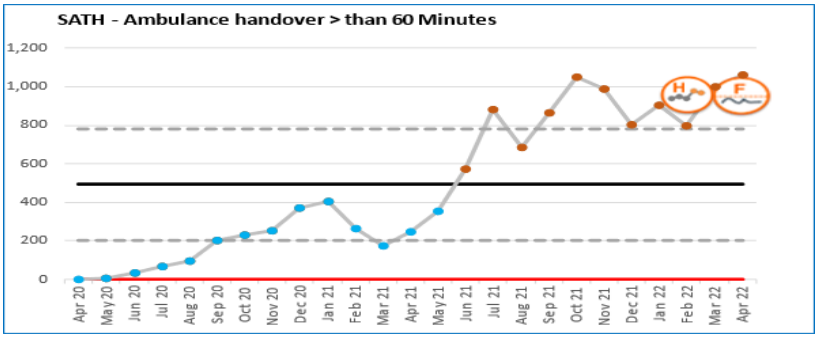
ED time to initial assessment - children



April 2022 actual performance
28 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 including direct access. Access to paediatric ward and PAU to avoid ED overcrowding. Children and Young Person assessment area opened at RSH. Reviewing PRH estate to identify opportunities to expand assessment capacity. Primary care streaming trial has taken place twice – impact review to take place w/c 16/05/22. In reach from SDEC and UTC to support with completing initial assessment in conjunction with the 'pull' model.	Oversight by divisional director, divisional director of nursing and COO. .

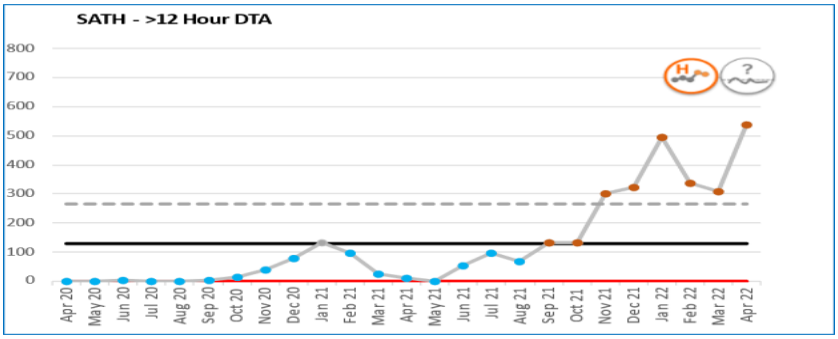
Ambulance handover> 60 Mins



April 2022 actual performance
1062
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 improvement programme under development. Local UEC improvement programme under development.	System UEC action plan. System transformation group. Focussed system IDT.

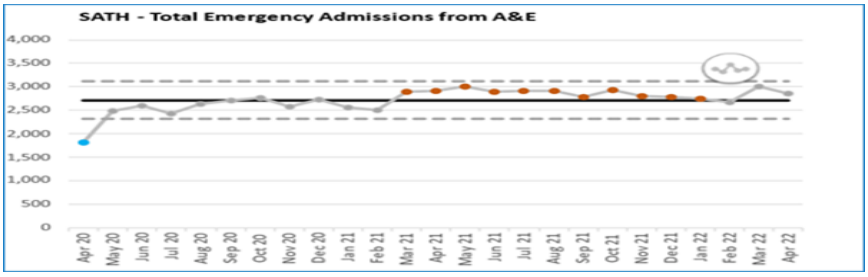
12 Hour ED trolley waits



April 2022 actual performance
538
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.	A potential plan for reconfiguration of wards on RSH to create an acute medical floor is currently being discussed internally and across the system. Reconfiguration of RSH ED to enhance patient experience and access to most appropriate area in ED. Primary care streaming trial has taken place – impact review to take place w/c 16/05/22. Extension of PRH SDEC. Improved use of SDEC including direct access from WMAS & WAS. Focus on the reduction in MFFD patients occupying beds with system partners. Admission avoidance and Single Point of Access (SPA) in place to reduce footfall to ED. Flow improvement work to be rolled out to all medical wards. System UEC improvement programme under development. Local UEC improvement programme under development. Direct access plans in place as part of acute floor reconfiguration to reduce footfall in ED. Improvement plan roll out for flow improvements in ED and wards. Embed ownership of IPS.	ED Safe Today processes in place to mitigate risk where possible within the department.

Total emergency admissions from A&E



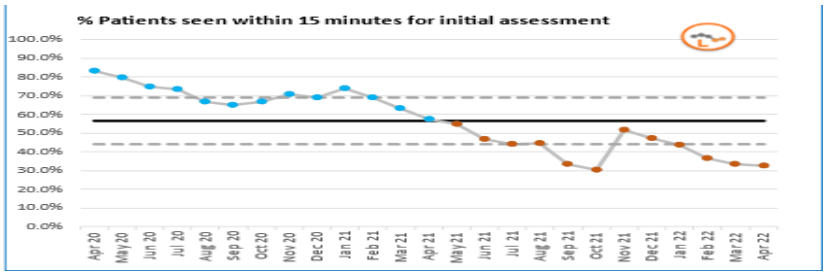
April 2022 actual performance
2863
Variance Type
Common Cause
National Target
N/A

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.	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. System UEC improvement programme under development director.	System wide plans to avoid admission and use of virtual ward and other pathways.

UEC metrics – shadow reporting.

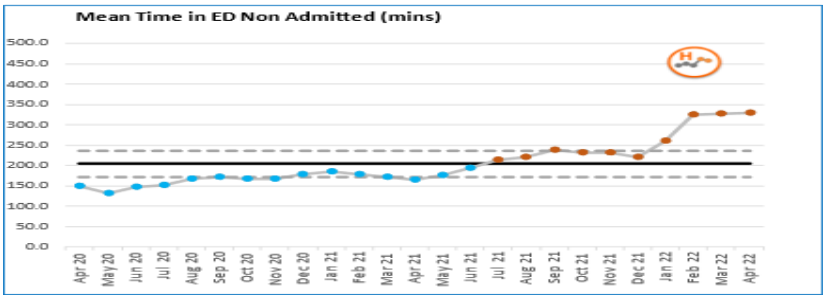
The measures below are reported in shadow form ahead of adoption expected nationally for 2022-23. Deterioration is reported against all these measures.

% patients seen within 15 minutes for initial assessment



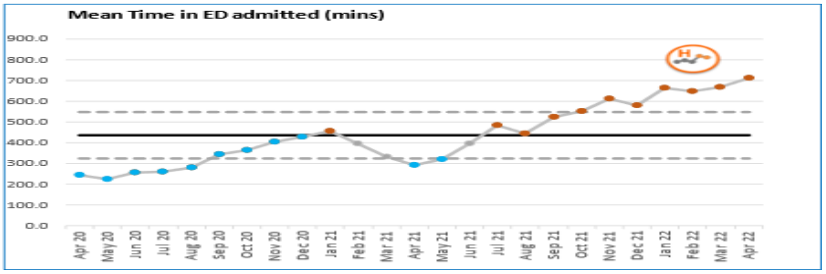
April 2022 actual performance
32.7%
Variance Type
Special Cause Concern
National Target
n/a

Mean time in ED non-admitted (minutes)



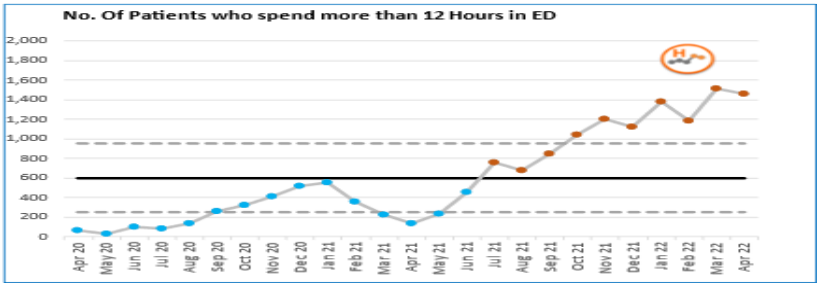
April 2022 actual performance
330
Variance Type
Special Cause Concern
National Target
n/a

Mean time in ED admitted (minutes)



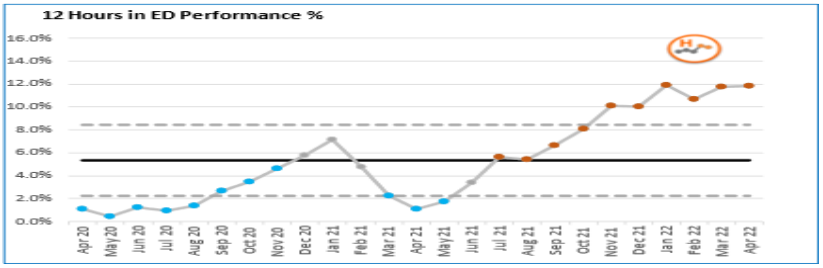
April 2022 actual performance
710.5
Variance Type
Special Cause Concern
National Target
n/a

Number of patients who spend more than 12 hours in ED



April 2022 actual performance
1460
Variance Type
Special Cause Concern
National Target
N/A

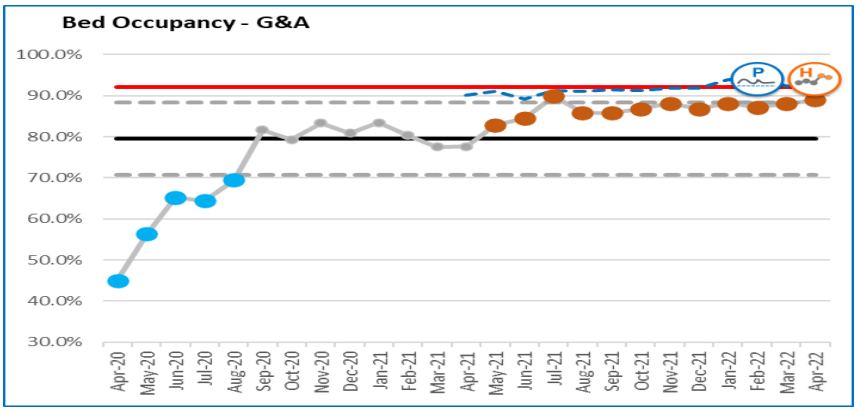
12 Hours in ED performance %



April 2022 actual performance
11.8%
Variance Type
Special Cause Concern
National Target
N/A

Hospital occupancy and activity

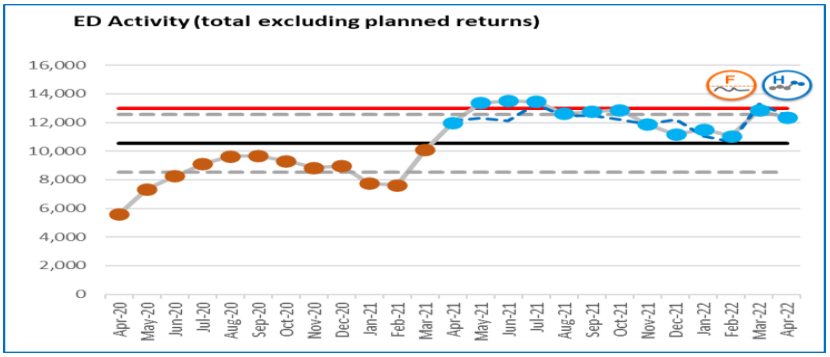
Bed occupancy



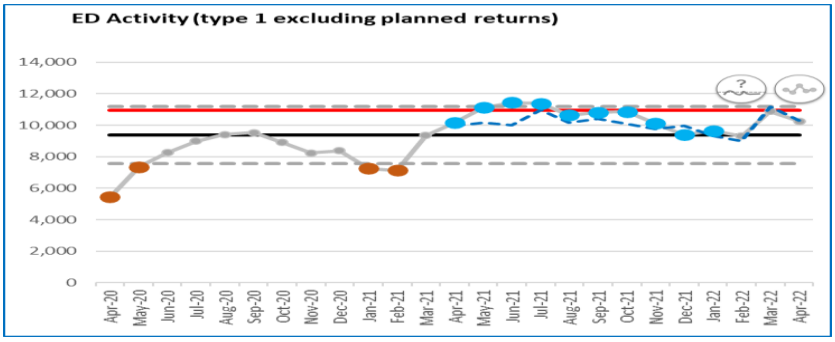
April 2022 actual performance
89%
Variance Type
Special Cause Concern
Local Target
92%
Target / Plan Achievement
Occupancy slightly lower than pre-COVID-19

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 most 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 into 2022-23 and will continue to be monitored.	Additional 32 beds planned from May 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



April 2022 actual performance
12340
Variance Type
Special Cause Improvement
Local Target
12500
Target/ Plan achievement
22-23 Operational plan



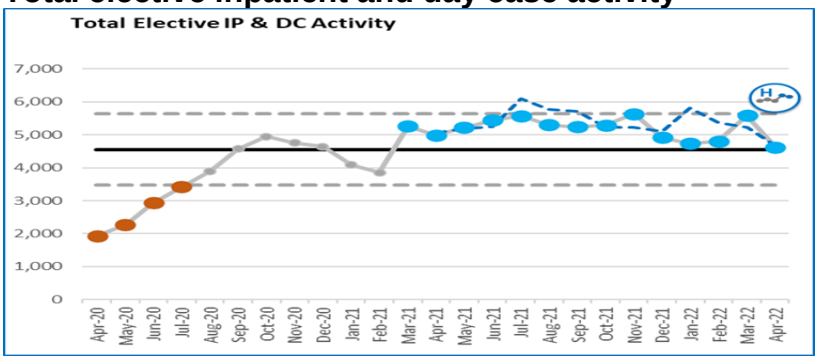
April 2022 actual performance
10251
Variance Type
Common Cause
Local Target
10300
Target/ Plan achievement
22-23 Operational plan

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.	ED activity has returned to pre-COVID-19 levels.	GP referrals are being managed through the ED due to the need for segregation of pathways. Flow out of ED is not sufficient to ensure timely management of patients now presenting to ED. Not all patients attending ED need the services of the ED.	A potential plan for reconfiguration of wards on RSH to create an acute medical floor is currently being discussed internally and across the system. Reconfiguration of RSH ED to enhance patient experience and access to most appropriate area in ED. Primary care streaming trial has taken place – impact review to take place w/c 16/05/22. Extension of PRH SDEC. Improved use of SDEC including direct access from WMAS & WAS. Focus on the reduction in MFFD patients occupying beds with system partners. Admission avoidance and Single Point of Access (SPA) in place to reduce footfall to ED. Flow improvement work to be rolled out to all medical wards. System UEC improvement programme under development. Local UEC improvement programme under development. Re-direction programme of improvement to commence on the PRH site before the end of 2021-22.	Support from NHSEI MFFD and criteria to reside.

Activity Levels

The operational activity plan has been submitted to the STW system and includes activity provided by our core services, our additional internal interventions and use of the Nuffield Hospital. In addition to this plan, the independent sector has been commissioned by the CCG to provide additional eye care, urology, and general surgery cases. Discussions are underway to agree the process for formal tracking of performance against the plan in 2022-23.

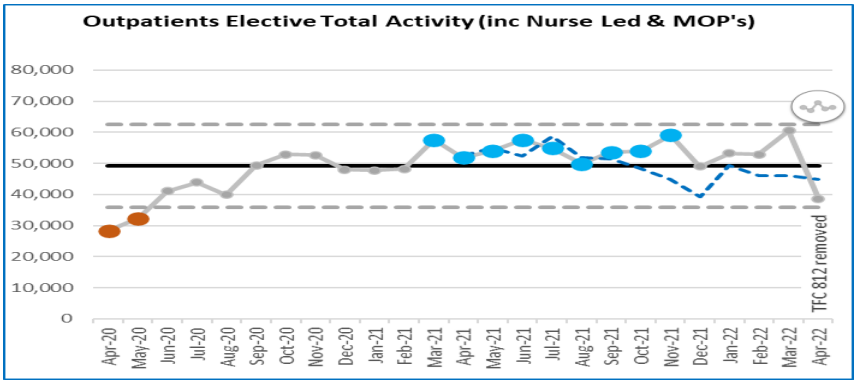
Total elective inpatient and day case activity



April 2022 actual performance
4626 (IP 193, DC 4433)
Variance Type
Common Cause
Local Target
4687
Target/ Plan achievement
(22-23 operational plan)

Background	What the Chart tells us	Issues	Actions	Mitigation
The Trust is working to recover services in line with the level of activity delivered in 2019-20, which is being used as a baseline. The Trust has developed an activity plan for 22-23. This aims to optimise the internally available capacity to address urgent elective cases and to increase capacity and to reduce the longest waits for routine surgery.	Activity remains below historic levels and below expectation regarding "Restoration & Recovery."	Reduced theatre capacity, theatre-staffing constraints.	Clinical prioritisation of patients in terms of PL2 and PL2Cs and long waiters 6-4-2 processes for theatre allocation. Weekly restore and recovery meeting with specialties.	As actions.

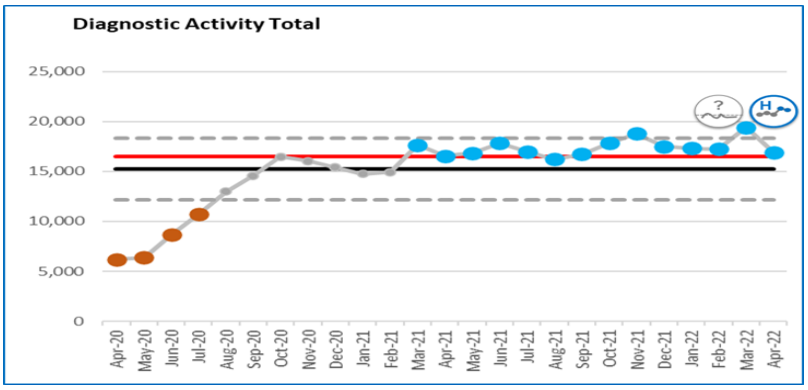
Outpatient elective total activity



April 2022 actual performance
38638 (excl. TFC 812)
Variance Type
Common Cause
Local Target
44978
Target/ Plan achievement
(22-23 plan)

Background	What the Chart tells us	Issues	Actions	Mitigation
The operational activity plan aims to recover activity for 22-23. 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.	Reduction in activity.	Outpatient capacity remains a constraint due to staff / family related absence/ isolation and COVID-19 is having some an impact on running clinics. Delivery of the plan itself does not eliminate the backlog of waits created during the pandemic. PIFU uptake remains low and the volume of virtual consultations is declining as some patient groups are not appropriate and require examination.	Waiting list initiative. CD for outpatient transformation is working with the clinical teams around clinical engagement for PIFU (patient-initiated follow ups), virtual consultations and stratified follow up.	Clinical prioritisation of patients.

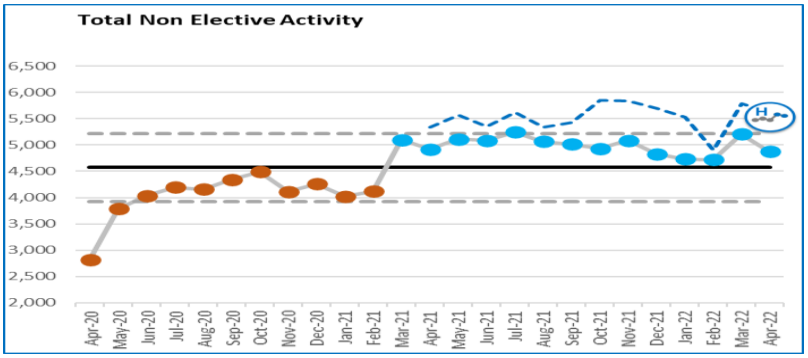
Diagnostics recovery



April 2022 actual performance
16899
Variance Type
Special Cause Improvement
Local Target
208989 for year 22/23
Target/ Plan achievement
(22-23 plan)

Background	What the Chart tells us	Issues	Actions	Mitigations
Diagnostic activity is made up of the number of tests/procedures carried out during the month; it contains Imaging, Physiological Measurement and Endoscopy Tests.	Performance has not achieved the target for April 22.	Performance is affected by staff availability and imaging capacity. Staff vacancies continue to affect resilience causing variability in performance.	Continued recruitment across all areas. “growing our own” through apprentice training and progression of support staff, but this takes time.	Use of bank and agency when available. Mobile scanners on site. Insourcing US and breast.

Non-elective activity

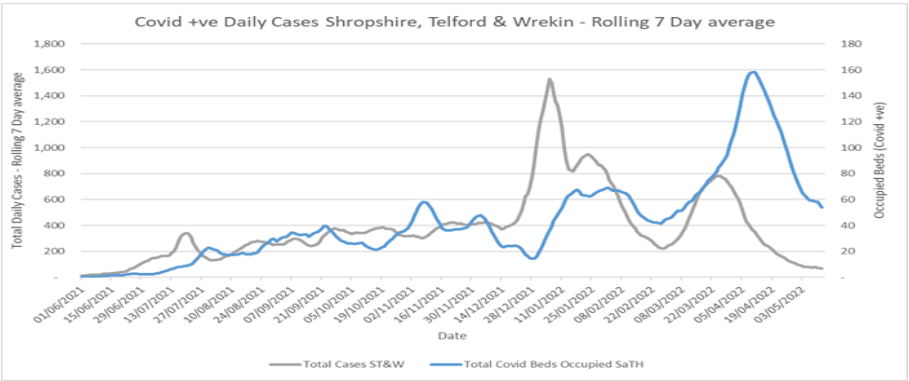


April 2022 actual performance
4873
Variance Type
Special Cause Improvement
Local Target
5614
Target/ Plan achievement
(22-23 plan)

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 impact negatively on contract income.	Activity remains lower than the 2019-20 baseline and the level expected in the operational 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 4 leading to a significant level of hospitalisations in April 2022. The number of COVID-19 inpatients peaked to 169 including those cared for in ITU, which is the highest number reported since COVID-19 reporting commenced. The national short term forecast along within the community prevalence data suggests a downward trend.



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
A&E - Left without been seen (out of 122)	Apr 22	97	
A&E - 4 Hour Standard (Type 1) (out of 107)	Apr 22	96	
A&E - Reattendance Rate (out of 120)	Mar 22	8	
A&E Time to Initial Assessment (Out of 111)	Mar 22	40	
Cancer 2 Week (out of 122)	Feb 22	86	
Cancer 2 Week Breast Symptomatic (out of 114)	Feb 22	99	
Cancer 62 Day Classic Metric (out of 122)	Mar 22	85	
Cancer 62 Day Breast Cancer (out of 119)	Mar 22	102	
Cancer 62 Day Lower Gastrointestinal Cancer (out of 122)	Mar 22	34	
Cancer 62 Day Lung Cancer (out of 120)	Mar 22	84	
Cancer 62 Day Other Cancer (out 122)	Mar 22	98	
Cancer 62 Day Skin Cancer (out 116)	Mar 22	71	
Cancer 62 Day Urological Cancer (out of 121)	Mar 22	95	
Diagnostic 6 Week Standard (out of 122)	Mar 22	110	
Diagnostic 6 Week Standard - Cardiology : echocardiography (out of 122)	Mar 22	11	
Diagnostic 6 Week Standard - Audiology Assessments (out of 110)	Mar 22	73	
Diagnostic 6 Week Standard - Urodynamics: pressures & flows (out of 102)	Mar 22	99	
Diagnostic 6 Week Standard - Respiratory physiology : sleep studies (out o	Mar 22	50	
Diagnostic 6 Week Standard - Magnetic Resonance Imaging (out of 122)	Mar 22	117	
Diagnostic 6 Week Standard - Computed Tomography (out of 122)	Mar 22	99	
Diagnostic 6 Week Standard - Non-obstetric ultrasound (out of 122)	Mar 22	109	
Diagnostic 6 Week Standard - Colonoscopy (out of 122)	Mar 22	119	
Diagnostic 6 Week Standard - Flexi sigmoidoscopy (out of 122)	Mar 22	87	
Diagnostic 6 Week Standard - Cystoscopy (out of 119)	Mar 22	100	
Diagnostic 6 Week Standard - Gastroscopy (out of 122)	Mar 22	107	
RTT 52 Week Breach (out of 122)	Mar 22	87	
RTT Incomplete 18 Week Standard – (out of 122)	Mar 22	96	
RTT Incomplete 18 Week Standard Metric - Gynaecology (out of 121)	Mar 22	67	
Total Time in A&E - Admitted (out of 114)	Feb 22	95	
Total Time in A&E - Non - Admitted (out of 117)	Feb 22	50	
RTT Total Incompletes (out of 122)	Mar 22	45	

6. Finance Summary
Helen Troalen, Director of Finance

- The Trust has submitted a plan for a deficit of £23.330m for 2022/23. This plan is yet to be approved at a national level and accordingly should be treated as draft. Once finalised, budgets will be updated to reflect the Trust's final plan for 2022/23.

- The Trust recorded a deficit of £1.686m in Month 1 against a draft planned deficit of £1.692m.

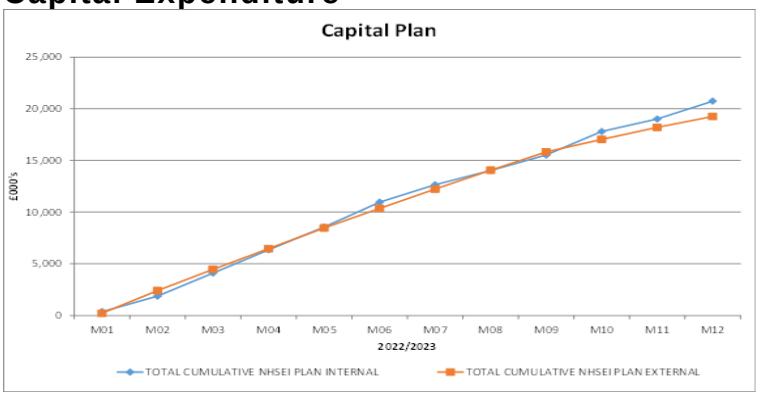
- The in-month deficit position is driven by:
    1) Pay costs, excluding COVID-19 and ERF were £1.23m adverse to plan. This is driven by an increase in agency expenditure, especially off-framework bookings, following the critical incident declared during April.
    2) COVID-19 costs (in envelope) were £1.033m which is £0.27m adverse to the draft plan. There is an expectation that COVID-19 costs will begin to reduce over Q1 as COVID-19 prevalence drops within the community
    3) Elective recovery costs were £0.539m which is £0.11m overspent against plan. This was driven by an increase activity level compared to plan.

- £0.07m of efficiency savings has been delivered in month against an evenly phased plan of £0.64m. The efficiency programme is to be formally launched during Q1 with a combination of Trust wide and local Divisional schemes. Of the target of £7.66m for 2022/23 £2m of these are to be identified at a Divisional level.

- The Trust's agreed capital plan for 2022/23 totals £40.01m (excluding donations). Expenditure against this plan at Month 1 is £0.13m.

- The Trust held a cash bank balance at the end of April 2022 of £18.08m.

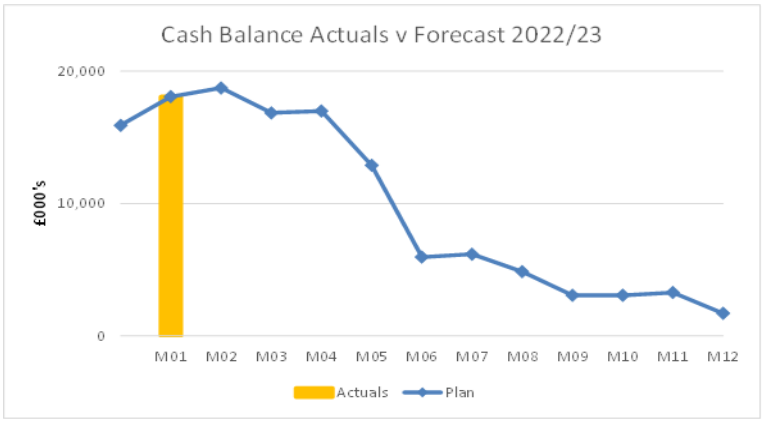
Capital Expenditure



April 2022 actual performance	
£0.134m Spend year to date	
Variance Type	
Underspend of £0.454m	
National Target	**Forecast**
£40.012m	£40.062m
Target/ Plan achievement	
To meet he Trust's capital resource limit (CRL)at year-end.	

Background	What the Chart tells us	Issues	Actions	Mitigations
The Trust's capital plan submission for 2022/23 totals £40.012m (excluding donations) based on the agreed outline capital programme.	Within the submitted plan it was projected that expenditure of £0.588m would be incurred in April 2022 (M1) although the actual expenditure at M1 was £0.134m. The plan and delivery are split between the internal capital plan and the externally funded capital plan. The main driver for the under delivery in month one is the delay in approval of PRH Elective Hub (£0.210m) and a delay in planned delivery of the endoscopy reconfiguration (£0.185m) which is expected to be completed by the end of August.	No issues of concern.	In March the outline capital programme was agreed at FPAC and the Trust Board, it was agreed that detailed plans would be considered by capital planning group (CPG) at May meeting for onward approval by FPAC.	No mitigations.

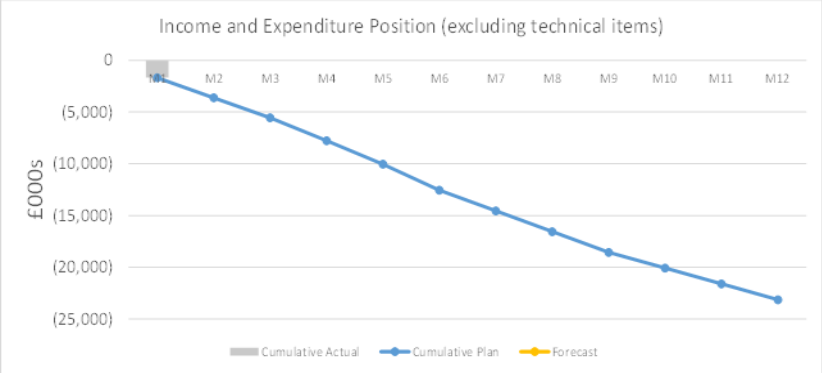
Cash



April 2022 actual performance
£18.083m cash in the bank
Variance Type
In line with plan
SaTH Year End Cash Balance Forecast
£1.700m
Target/ Plan achievement
Balanced position.

Background	What the Chart tells us	Issues	Actions	Mitigations
The Trust undertakes monthly cashflow forecasting. The above is based on draft plan submission of an income and expenditure deficit of £23.330m and projected changes in working capital balances.	The cash balance held at end of April 2022 was £18.083m (ledger balance of £18.122m due to reconciling items). A balanced position is currently being forecast, showing the required minimum cash balance of £1.7m at the end of the financial year.	No issues of concern currently.	The Trust to carry out a review of the assumptions within the cashflow for month two.	No mitigations required.

Income and Expenditure Position

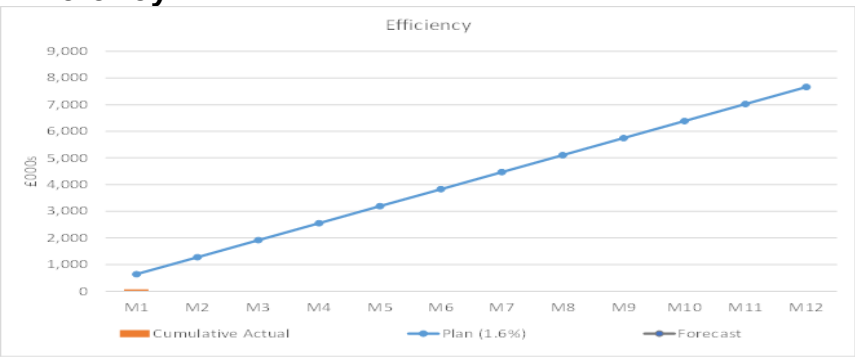


April 2022 actual performance	
(£1.686m) Deficit at month one.	
Variance Type	
Positive variance of £0.006m	
National Target	**SaTH Plan 2021/22**
Breakeven	(£22.330m) *
Target/ Plan achievement	
(£22.330m) Deficit full year*	

*Plan is currently draft

Background	What the Chart tells us	Issues	Actions	Mitigations
The Trust has submitted a financial plan for a deficit of £23.330m for 2022/23. This plan is yet to receive formal approval and as such should be treated as draft.	The Trust recorded a deficit of £1.686m in month one which is in-line with the plan submitted to NHSEI. The in-month deficit is predominantly related to pay expenditure which is driven by premium cost staffing amongst both medical staffing and nursing. Costs of off-framework nursing increased in month due to the critical incident.	High usage of off-framework agency nursing in April.	Monitoring of agency nurse booking reasons and deep dives into high usage areas. Job planning for consultants and sign off of junior doctor rotas.	Rollout of the revised nursing templates will support greater control and transparency across the nursing position. On-going international recruitment will continue to reduce vacancies and the need for high-cost agency nurses. Within medical staffing a review of rotas and job planning of consultants is underway.

Efficiency

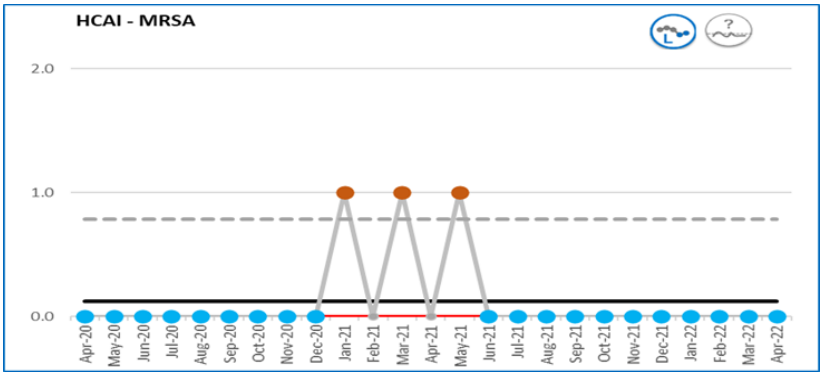


April 2022 actual performance
Year to Date Delivery of £0.0694m
Variance Type
Adverse to plan (£0.569m)
SaTH Plan 2022/23
£7.660m
Target/ Plan achievement
Full achievement by year end

Background	What the Chart tells us	Issues	Actions	Mitigations
A minimum of 1.6% in year recurrent savings are required in 2022/23 which is in line with the agreed efficiency required to deliver the STW financial sustainability plan. Further efficiencies as part of workforce are also required in 2022/23 of which the Trust has a share totalling £3.0m.	The Trust delivered £0.069m of efficiency savings in month one which is, £0.569m adverse to plan.	Efficiency plans are to be worked up during quarter one. Of the £7.660m target for 2022/23 there will be a combination of Trust wide and Divisional schemes. The Divisional schemes will account for £2.0m of the overall target.	A minimum of 1.6% in year recurrent savings are required to maintain financial stability across the STW system in addition to the system wide schemes known as big ticket items (BTIs). However, potentially further savings are required to fund additional priority investments.	Plans expected to be in place by the end of quarter one for the Trust to deliver the 1.6% in full by year end.

Appendix 1: Indicators performing in accordance with expected standards

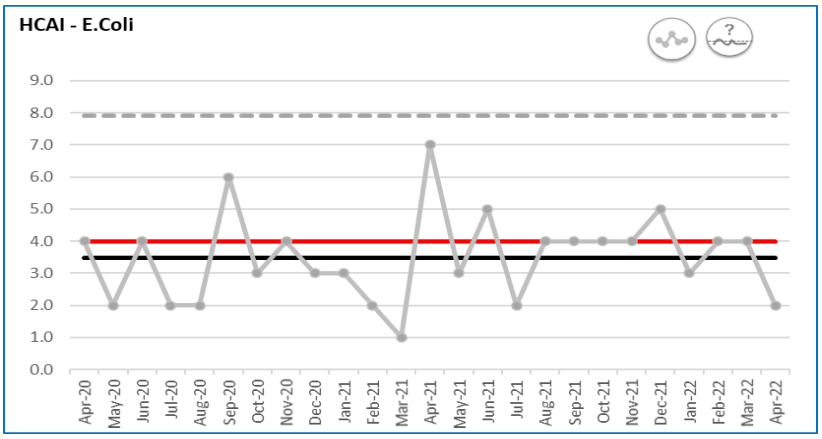
MRSA



April 2022 actual performance
0
Variance Type
Common Cause
Local Standard
0
Target / Plan Achievement
National target of 0 cases in 2022/2023.

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.	As per HCAI improvement actions.	Monitored at Divisional level and Trust level at IPCOG and IPC Assurance Committee.

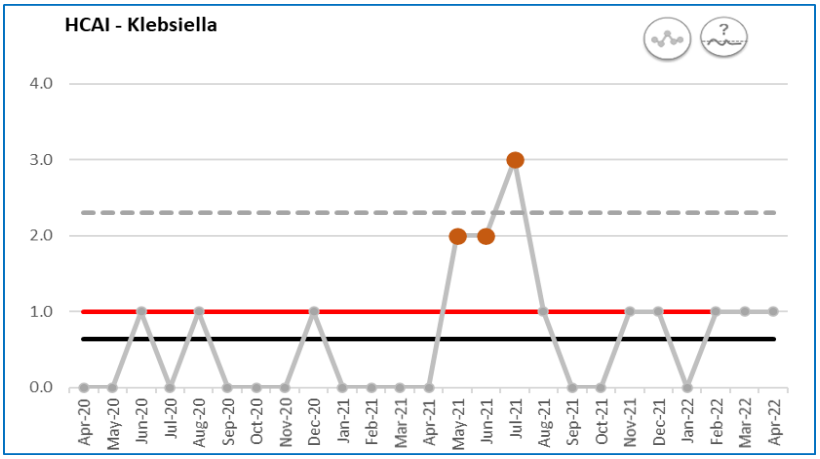
E-Coli



April 2022 actual performance
2
Variance Type
Common Cause
Local Standard
<ave.4per month National Target 8 per month
Target / Plan Achievement
Local Target for 2022/23 is no more than 49. National Target no more than 96

Background	What the Chart tells us:	Issues	Actions	Mitigations
Reporting E. Coli bacteraemia has been a mandatory requirement since 2011.	There were 2 cases of E. Coli bacteraemia in April 2022. This is below the new monthly target for 2022/23 which has been set at no more than 8 cases a month, and no more than 96 cases in the financial year.	All cases are reviewed by microbiology and those deemed to be device related or where the source is unknown have an RCA completed Neither of these cases were considered to be device or intervention related, with the sources being: cholecystitis; and source unknown (but not considered to be device or intervention related).	HCAI actions, and actions from previous RCAs which include consistent use of catheter insertion documentation. Catheter care plan. ANTT training. Divisions to ensure timely completion of RCAs to ensure prompt action taken and learning embedded. Compliance with IPC policies and procedures. Ensure all staff completed IPC mandatory training.	Catheter care is monitored via the monthly matron's quality assurance metrics audits, and high impact interventions audits. Actions from RCAs are reported at IPCOG

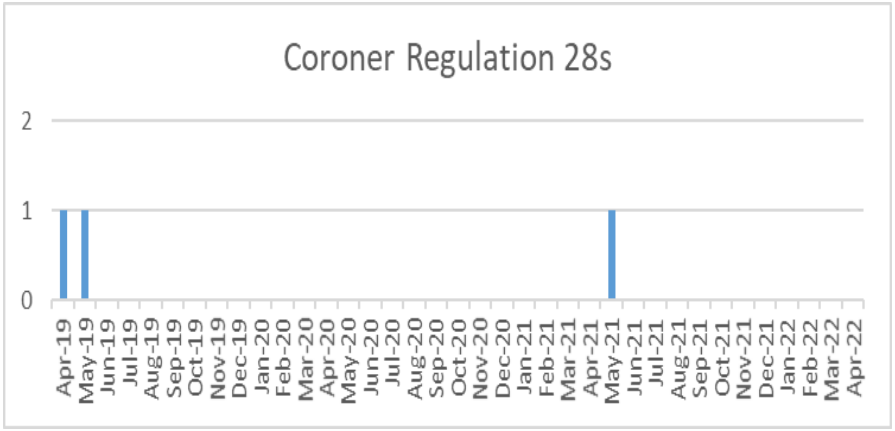
Klebsiella



April 2022 actual performance
1
Variance Type
Common Cause
Local Standard
<ave.1 pm
Target/ Plan achievement
Local Target no more than 12 cases in 2022/23. National Target no more than 23 cases.

Background	What the Chart tells us	Issues	Actions	Mitigations
Reporting of Klebsiella is a mandatory requirement.	There were 1 case of Klebsiella in April 2022. The number of cases in April is within our local improvement target and national target.	No new issues identified, ongoing actions in relation to HCAIs in place.	There is ongoing improvement work in relation to HCAIs which includes: embedding the use of catheter care plans across the Trust. ANTT training. Ensuring all staff have undertaken their IPC training. Ensuring cleanliness audits are undertaken jointly by Facilities and Nursing staff.	Monitored at IPCOG and monthly metrics meetings.

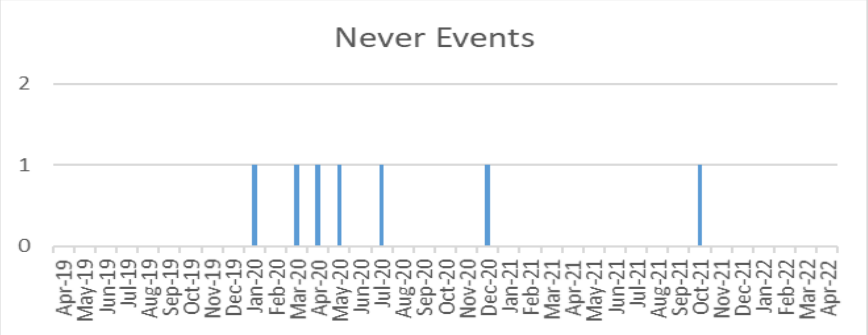
Coroner Regulation 28s



April 2022 actual
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.

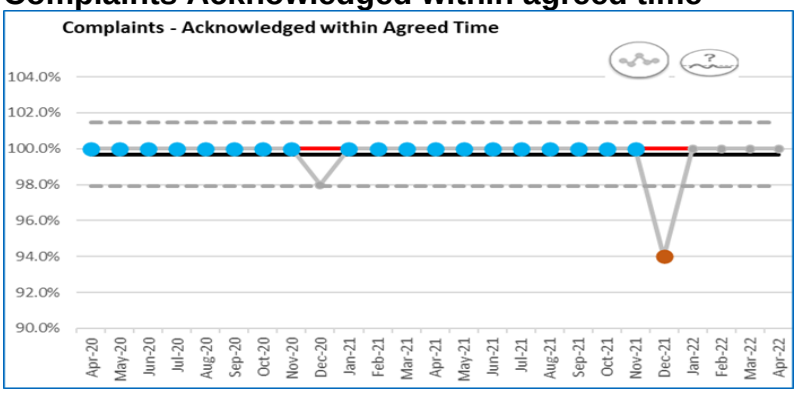
Never Events



April 2022 actual
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.	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.	No actions.	No mitigations.

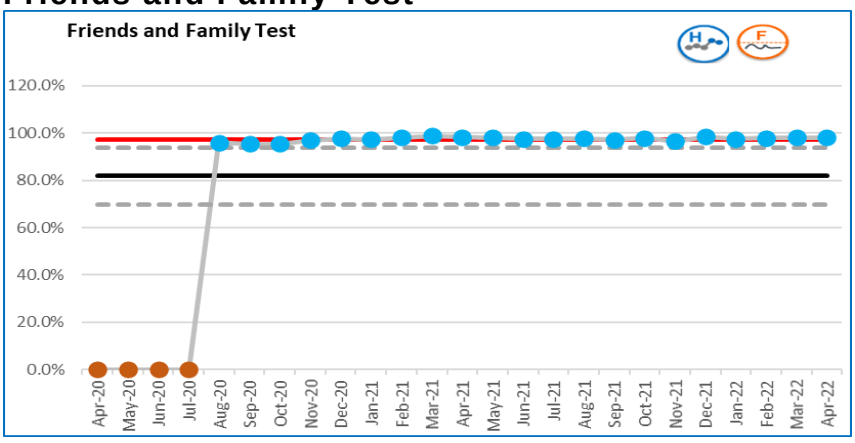
Complaints Acknowledged within agreed time



April 2022 actual performance
100% (100% within two days)
Variance Type
Common Cause
National Target
100%
Target/ Plan achievement
Target achieved consistently

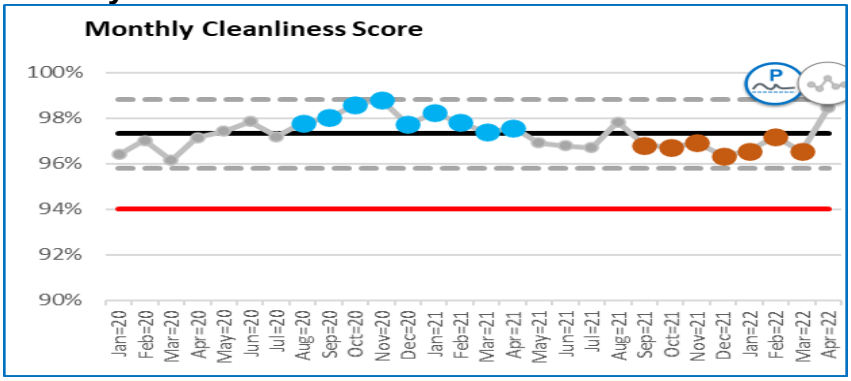
Background	What the Chart tells us	Issues	Actions	Mitigations
Acknowledging a complaint on receipt is important for patients raising concerns to both ensure that the patient knows we have received the complaint and are addressing it.	The target of three working days continues to be met, with 100% of complaints acknowledged within one working day.	No issues	No actions.	No mitigations.

Friends and Family Test



April 2022 actual performance
98%
Variance Type
Special Cause Improvement
National Standard
85%
Target/ Plan achievement
Target achieved consistently

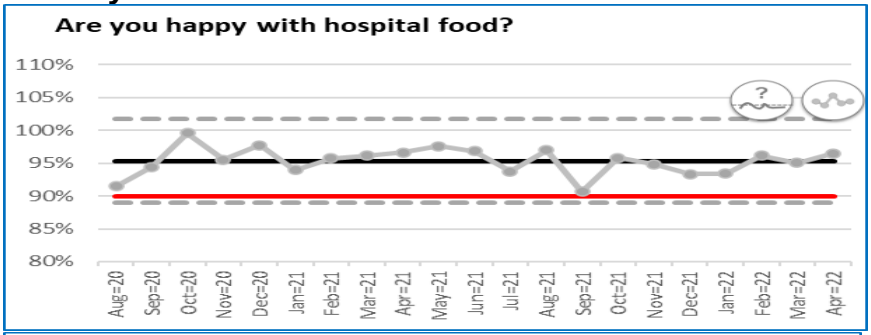
Monthly Cleanliness Score

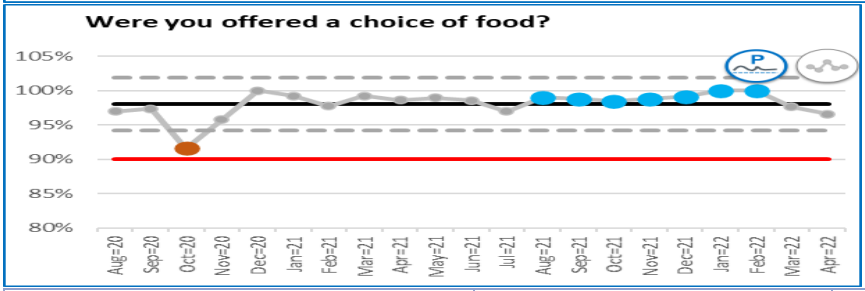


April 2022 actual performance
98.5%
Variance Type
Common Cause
Local SaTH standard
94%
Target/ Plan achievement
On target to achieve above local standard

Background	What the Chart tells us:	Issues	Actions	Mitigations
This is an independent monthly audit, which gives assurance of the standard of cleanliness undertaken by the cleanliness team.	Performance moved up to the upper control limit in April.	The cleanliness team has continued to suffer from high vacancy rates over the last month – particularly at RSH. Vacant posts are currently out to advert. Sickness levels have improved in April which might account for the improvement in scores.	We continue to use agency and contract staff to cover as many gaps as possible. There is also another recruitment day being held on 16 May 2022 which is led by the Recruitment Team alongside a heavy social media campaign to try and fill posts at RSH.	No Mitigations.

Monthly Patient Food Satisfaction Score



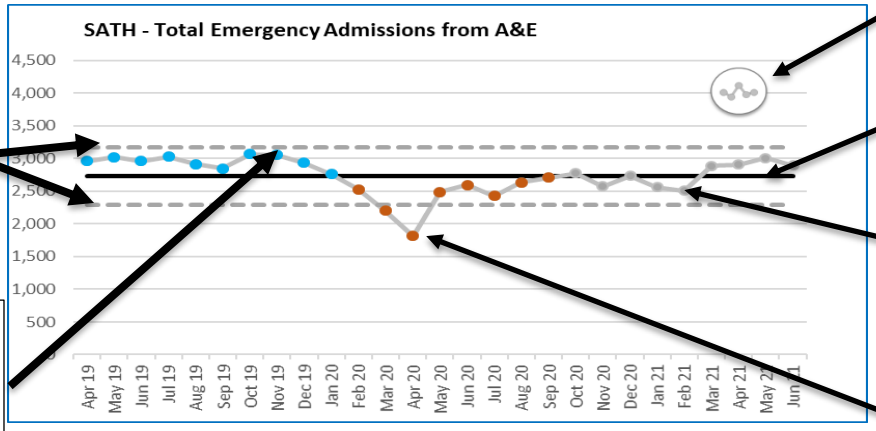


April 2022 actual performance
95.6% for satisfaction with food. 96.6% for satisfaction with choice.
Variance Type
Common Cause
Local SaTH standard
90%
Target/ Plan achievement
On target to achieve local standard

Background	What the Chart tells us:	Issues	Actions	Mitigations
This data is taken from the monthly Matron's Audit where 10 patients per month per ward are asked whether they are happy with the hospital food and the choice, they were given.	There is common cause variation with both measures for hospital food and they are both at and just below the mean this month.	No issues.	No actions.	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

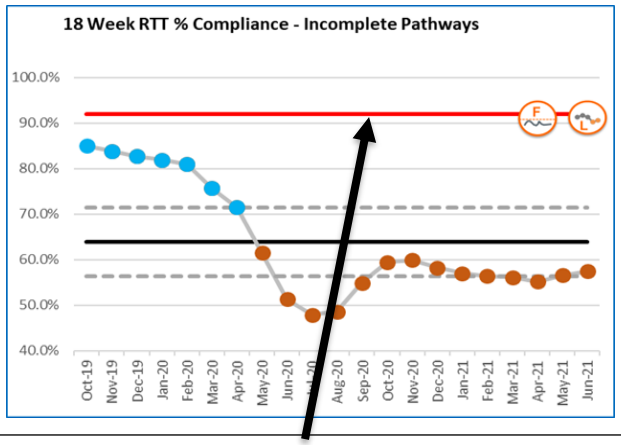
Mean or median line

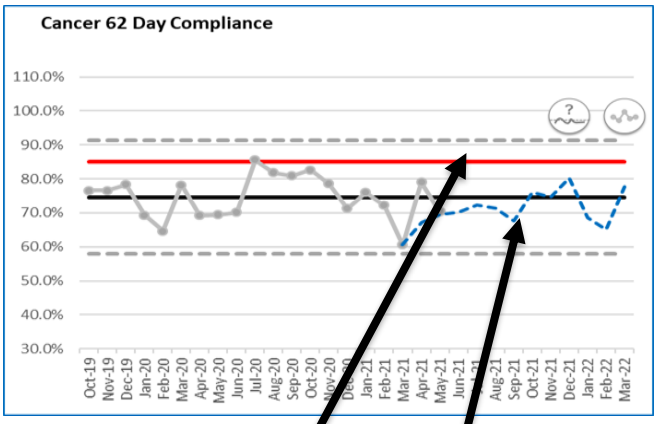
Common cause variation

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

Plan – this is the Operational Plan trajectory submitted for the current year.

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 too 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	Outpatient 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