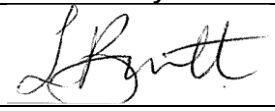
Board of Directors' Meeting
14 July 2022

Agenda item	124/22			
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 June 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 May 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.

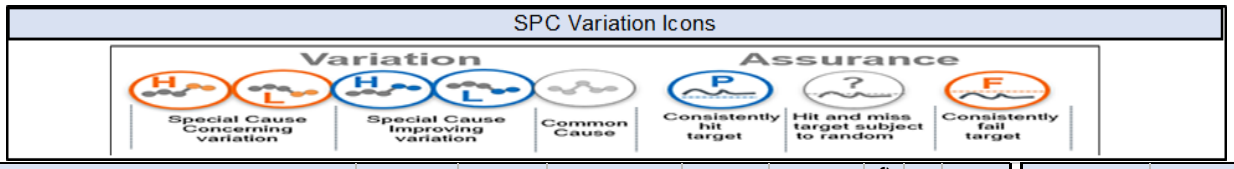
The Board of Directors integrated performance report is aligned to the Trust's functional domains and includes an overarching executive summary.

Table of Contents

1. Executive Summary
Louise Barnett, Chief Executive

- May has been another very busy month at SaTH. There have been some very positive things happening including our preparations for the Jubilee celebrations which took us into June. The celebrations were part of our determination to celebrate events throughout the year such as special occasion and key cultural and religious occasions.
- We also saw a marked decrease in the number of patients who were diagnosed with Covid-19. However, we remain cautious as the numbers have steadily started to increase in June.
- We are reviewing all of our IPC policies in relation to Covid-19 and are looking to implement national guidance as quickly and safely as we can because we know this will help with being able to increase the capacity we have to see and treat patients.
- With the easing of some of our operational pressures we have been able to focus more on education and training and we have launched several staff training initiatives. We know that our staff really value training, and we want to support them to continue in their journey of lifelong learning. We hope to be able to deliver more training in person over the coming months as well as further embrace opportunities for flexible working.
- We have now also received further analysis on the staff survey results. The reports that we get at departmental level are crucial for us to be able to respond in a much more targeted away about our staff concerns and our teams will be taking this forward over the coming months.
- We have also begun to put in place a more robust and systematic approach to performance management across the Trust which again reflects the expectations of the us now that we are in a new phase of the pandemic. We have reinstated some internal performance management processes and we will in the coming month enhance our getting to good programme to ensure our key programme are managed using a standard methodology.
- Operational performance remains challenged across the board. However, we have several plans in place to improve performance over the coming months and prepare for winter which is anticipated to be challenging again.

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	Mar 22	81.7	100	100			No		100
RAMI	QSAC	Mar 22	78.2	100	100			No		100
Infection										
HCAI - MSSA	QSAC	May 22	4	0	<2			Yes	9	28
HCAI - MRSA	QSAC	May 22	0	0	0			No	0	0
HCAI - C.Difficile	QSAC	May 22	5	<4	<3			Yes	10	33
HCAI - E-Coli	QSAC	May 22	1	<8	<4			No	3	49
HCAI - Klebsiella	QSAC	May 22	3	<2	<1			Yes	4	12
HCAI - Pseudomonas Aeruginosa	QSAC	May 22	2	<2	<1			Yes	4	6
Patient harm										
Pressure Ulcers - Category 2 and above	QSAC	May 22	16		<11			Yes	32	134
Pressure Ulcers - Category 2 Per 1000 Bed Days	QSAC	May 22	0.7							
VTE	QSAC	Apr 22	91.5%	95%	95%			Yes		95%
Falls - total	QSAC	May 22	135		<70			Yes	255	835
Falls - per 1000 Bed Days	QSAC	May 22	5.6	6.6	<4.5			Yes	5.4	4.5
Falls - with Harm per 1000 Bed Days	QSAC	May 22	0.17	0.19	<0.17			Yes	0.10	0.17
Never Events	QSAC	May 22	0	0	0			No	0	0
Coroners Regulation 28s	QSAC	May 22	0		0			No	0	0
Serious Incidents	QSAC	May 22	3						11	
Mixed Sex Breaches	QSAC	May 22	47	0	0			Yes	77	
Patient Experience										
Complaints	QSAC	May 22	64					Yes	122	
Complaints Responded within agreed time	QSAC	May 22	65%	85%	85%			Yes		85%
Complaints Acknowldeged within agreed time	QSAC	May 22	100%		100%			No		100%
Compliments	QSAC	May 22	49	Letters of thank you received.					68	
Friends and Family Test	QSAC	May 22	98.8%	80%	80%			No		80.00%
Maternity										
Smoking rate at Delivery	QSAC	May 22	10.6%	5%	5%			Yes	14.0%	5%
One to One Care In Labour	QSAC	May 22	99.7%	100%	100%			Yes		100%
Delivery Suite Acuity	QSAC	May 22	68%	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	May 22	6158					No		6732
Total temporary staff -FTE	FPAC	May 22	836					Yes		
Staff turnover rate (excludes junior doctors)	FPAC	May 22	0.71%	0.8%	0.75%			No	0.95%	0.8%
Sickness absence rate Excluding Covid Related	FPAC	May 22	4.9%		4%			Yes	5.0%	4%
Covid Related absence rate	FPAC	May 22	0.5%					No		
Agency Expenditure	FPAC	May 22	£6.295m					Yes		
Appraisal Rate	FPAC	May 22	81%	90%	90%			Yes		90%
Appraisal Rate (Medical Staff)	FPAC	May 22	93%	90%	90%			No		90%
Vacancies	FPAC	May 22	574 (9.3%)	<10%	<10%			No		<10%
Statutory and Mandatory Training	FPAC	May 22	80%	90%	90%			Yes		90%
Trust MCA – DOLS & MHA	FPAC	May 22	73%	90%	90%			Yes		90%
Safeguarding Adults - level 2	FPAC	May 22	84%	90%	90%			Yes		90%
Safeguarding Children – level 2	FPAC	May 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	May 22	38810					Yes		
RTT Waiting list -English	FPAC	May 22	34655		33205			Yes		32944
RTT Waiting list -Welsh	FPAC	May 22	4155					Yes		
18 Week RTT % compliance -incomplete pathways	FPAC	May 22	58.7%	92%				Yes		
26 Week RTT % compliance -incomplete pathways	FPAC	May 22	65.1%	92%				Yes		
52+ Week breaches - Total	FPAC	May 22	2910	0				Yes		
52+ Week breaches - English	FPAC	May 22	2564	0	2333			Yes		2112
52+Week breaches - Welsh	FPAC	May 22	346	0				Yes		
78+ Week breaches - Total	FPAC	May 22	393	0				Yes		
78+ Week breaches - English	FPAC	May 22	354	0	207			Yes		211
78+ Week breaches - Welsh	FPAC	May 22	39	0				Yes		
104+ Week breaches - Total	FPAC	May 22	41	0				Yes		
104+ Week breaches - English	FPAC	May 22	40	0	55			Yes		0
104+ Week breaches - Welsh	FPAC	May 22	1	0	0			Yes		
Cancer										
Cancer 2 week wait	FPAC	Apr 22	71%	93%	83%			Yes	71%	93%
Cancer 62 day compliance	FPAC	Apr 22	52.6%	85%	62%			Yes	52.6%	85%
Diagnostics										
Diagnostic % compliance 6 week waits	FPAC	May 22	63%	99%				Yes		
DM01 Patients who have breached the standard	FPAC	May 22	5513	0	1254			Yes		
Emergency Department										
ED - 4 Hour performance	FPAC	May 22	58.5%	95.0%	64%			Yes	58%	
ED - Ambulance handover > 60mins	FPAC	May 22	958	0				Yes	2020	tbc
ED 4 Hour Performance - Minors	FPAC	May 22	89.1%	95%	95%			Yes	90%	95%
ED 4 Hour Performance - Majors	FPAC	May 22	29.8%	95%				Yes	29%	
ED time to initial assessment (mins)	FPAC	May 22	35	15	15			Yes		15mins
12 hour ED trolley waits	FPAC	May 22	176	0	0			Yes	714	
Total Emergency Admissions from A&E	FPAC	May 22	3065					Yes	5928	71136
% Patients seen within 15 minutes for initial assessr	FPAC	May 22	25%					Yes	28.9%	
Mean Time in ED Non Admitted (mins)	FPAC	May 22	300					Yes	330	
Mean Time in ED admitted (mins)	FPAC	May 22	618					Yes	664	
No. Of Patients who spend more than 12 Hours in El	FPAC	May 22	1181					Yes	1460	
12 Hours in ED Performance %	FPAC	May 22	8.7%					Yes	10.3%	
Hospital Occupancy and activity										
Bed Occupancy -G&A	FPAC	May 22	89%	92%	91%			Yes		92%
ED activity (total excluding planned returns)	FPAC	May 22	13604		13604			No	25944	149762
ED activity (type 1&2)	FPAC	May 22	11386		11386			No	21637	123572
Total Non Elective Activity	FPAC	May 22	5186		5537			Yes	10059	TBC
Outpatients Elective Total activity	FPAC	May 22	46193		46193			Yes	84831	TBC
Total Elective IPDC activity	FPAC	May 22	5521		5521			No	10147	TBC
Diagnostic Activity Total	FPAC	May 22	19003					Yes		TBC
Finance - KPI		Latest month	Latest Value (£m)	National Standard for month	Plan for year (£m)	Perfomance	Assurance	Exception	Year to Date(£m)	Year End Planned Trajectory (£m)
Cash	FPAC	May 22	14.145		1.700			No	14.145	1.700
Efficiency	FPAC	May 22	0.379		7.660			No	0.379	7.660
Income and Expenditure	FPAC	May 22	(5.453)		(22.330)			No	(5.453)	(22.330)
Cumulative Capital Expenditure	FPAC	May 22	0.315		19.822			No	0.315	19.822

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

MSSA bacteraemia and Clostridium Difficile remains over target in month and a root cause analysis (RCA) process has been reviewed and strengthened which ensures all Clostridium Difficile cases and device related hospital acquired bacteraemia (DRHAB) are completed within 20 working days. The outcomes from these RCAs are discussed and shared via the IPC operational group and monitoring will take place via the IPC assurance committee chaired by the Director of Infection Prevention ControI (DIPC). In addition, performance data is triangulated via the monthly metric audits with a particular focus on cannula and catheter care.

Pressure ulcers remain slightly over the monthly target and the four cases of category 3 pressure ulcers are under investigation and improvement work continues.

Falls prevention remains a priority within the Trust and there is an ongoing improvement plan as part of our Quality Strategy. Training continues, along with embedding processes within operational practice i.e., bay tagging. There is a focus regarding neurology observations post fall and the recruitment of the enhanced supervision lead nurse and team has commenced.

VTE screening performance remains below target. An improvement project has commenced and is working on improving this.

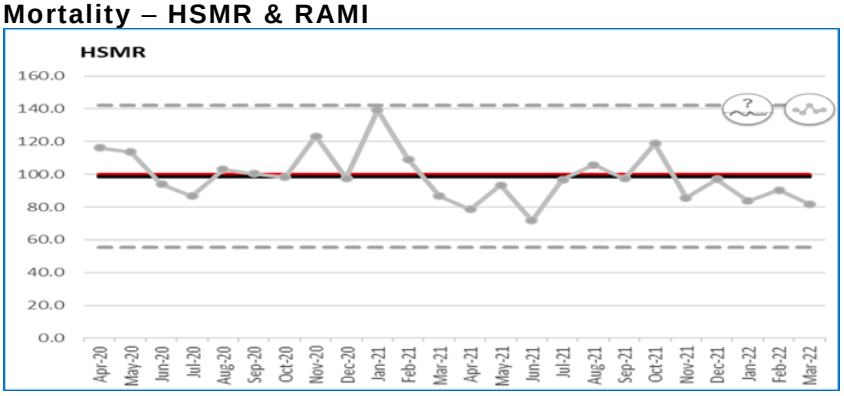
There has been a reduction in same sex accommodation breaches in month, this may be attributed to no longer cohorting “Covid contact” patients, which is in line with national guidance. This process is currently being reviewed as the Covid-19 numbers are increasing in June, in line with national trends.

Complaints remains a challenge and we have increased the resources within the team, which should hopefully see an improvement over the coming months. Progress in this area will be monitored via the monthly divisional performance meetings.

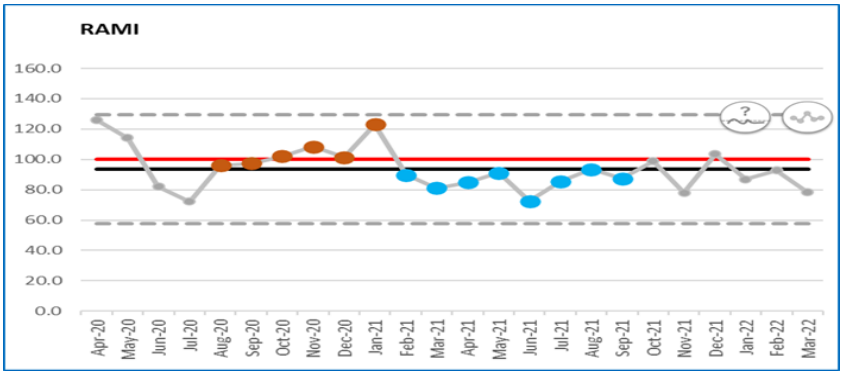
Delivery suite acuity continues to improve for the 3rd consecutive month, demonstrating the escalation policy and mitigations are appropriate.

Quality exception reports – Harm

Mortality – HSMR & RAMI



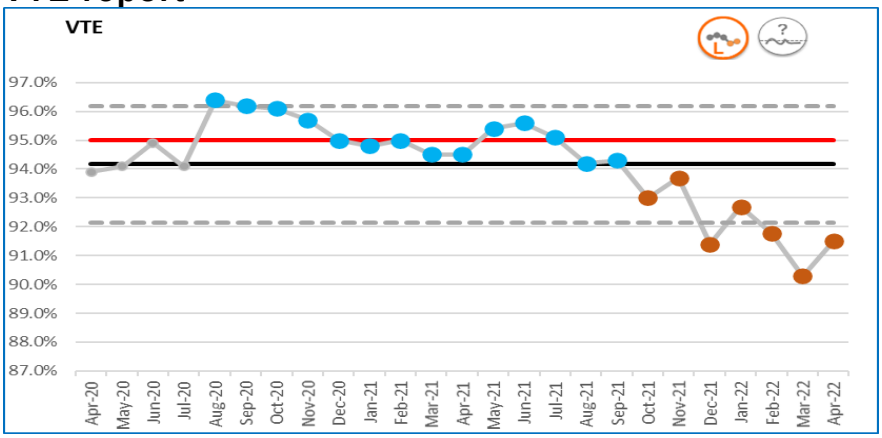
March 2022 actual performance
81.7
Variance Type
Common Cause
National Target
100
Target / Plan Achievement
Note rebasing of national reference level has taken place from this month's data



March 2022 actual performance
78.2
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.	Both HSMR and RAMI indicators continue 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. The RAMI indicator excludes COVID-19 patients.	No Dr Foster Imperial alerts have been received this month.	A learning from deaths dashboard developed by NHSE/I is in development with a planned release date of July 2022. Once this dashboard is 'live' it 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 the 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. 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 that are above the expected range are discussed and appropriate action agreed. Additional monthly CHKS updates have been introduced to the Learning from Deaths Group specifically to monitor mortality performance relating to urinary tract infections, septicaemia, pneumonia, and acute and unspecified renal failure.

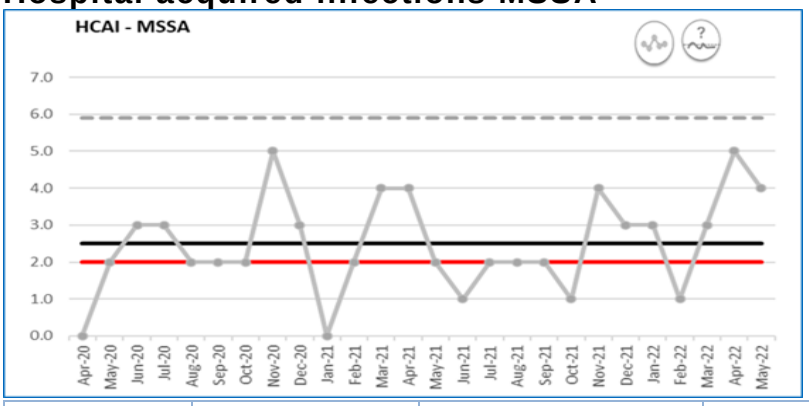
VTE report



April 2022 actual performance
91.5%
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 April 2022 as there has been a significant decline in this measure recently.	Performance improved following intervention in May/June 2021 but has varied around the target since this intervention however 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.

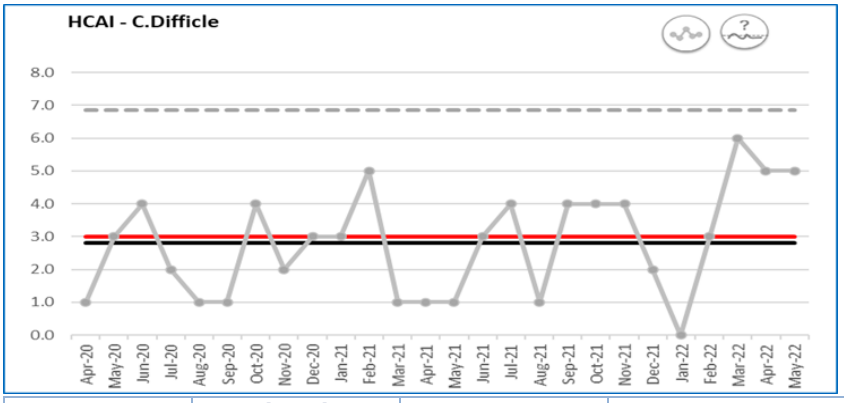
Hospital acquired infections MSSA



May 2022 actual performance
4
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 4 cases of MSSA bacteraemia in May 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. One of the cases was considered to be device / intervention related with the source of 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.

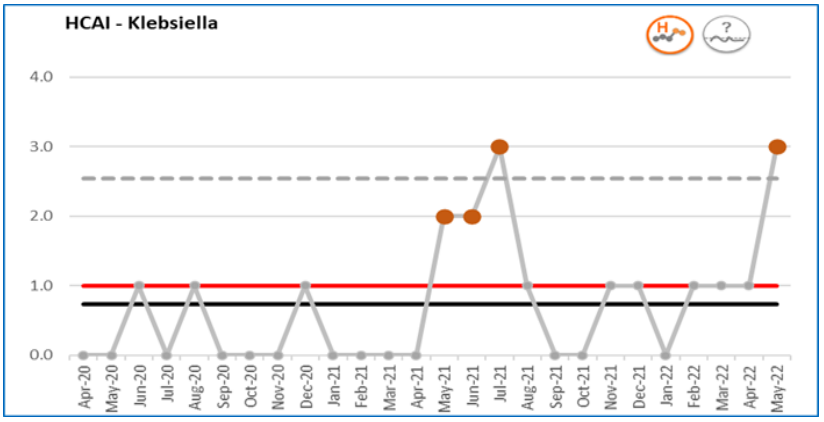
C. Difficile



May 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 May 2022, which is over our Trust monthly target of no more than 3 cases.	4 cases were taken post 48 hours of admission and 1 was taken on readmission following a recent discharge from the Trust.	All C. Diff cases have an RCA completed and actions include a reminder to staff of the importance of obtaining timely stool sample and prompt isolation of patients with diarrhoea. Use of redi-rooms to isolate patients when side rooms are unavailable. Ensure appropriate anti-microbials and 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.

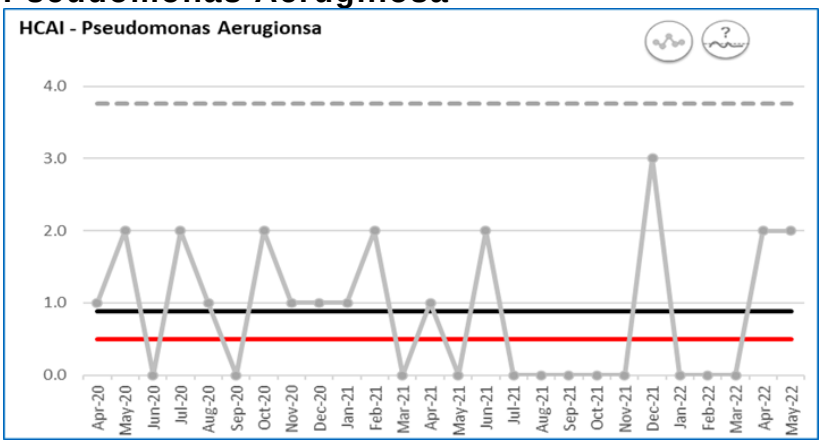
Klebsiella



May 2022 actual performance
3
Variance Type
Special Cause Concern
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 3 cases of post 48-hour Klebsiella in May 2022. This is above the new monthly target for 2022/23 which has been set at no more than 2 cases a month. However, we are on trajectory to have no more than 23 cases in the financial year.	One of these cases was considered to be device related and the source was a CAUTI. The sources in the remaining two cases were considered to be: SSI (post-surgery at another Trust); and biliary sepsis.	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 metric meetings.

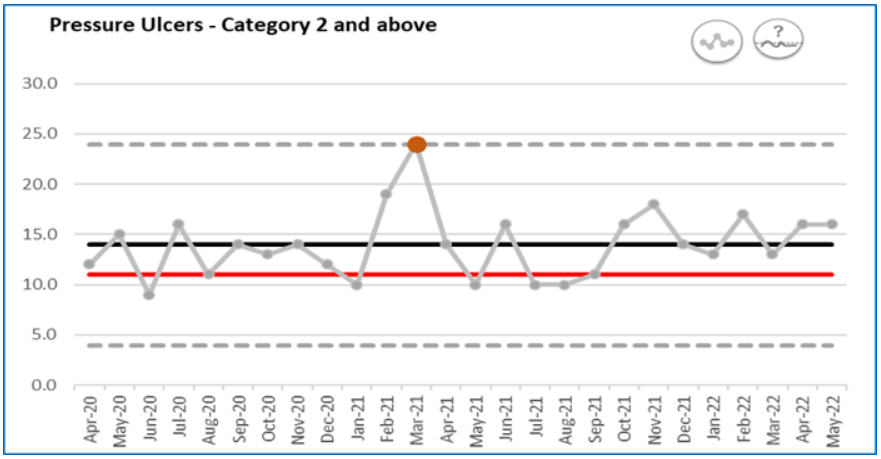
Pseudomonas Aeruginosa



May 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.

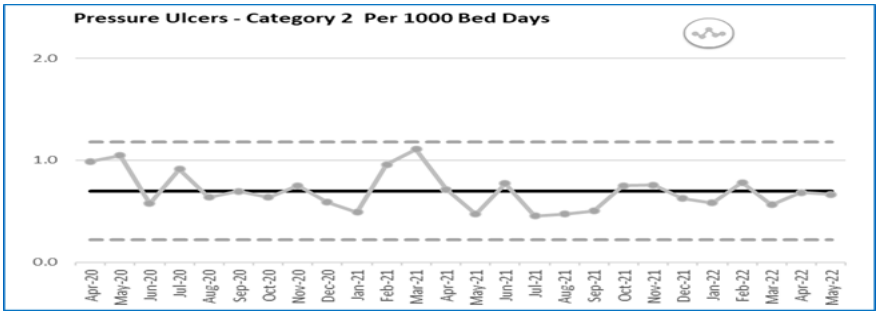
Background	What the Chart tells us	Issues	Actions	Mitigations
Reporting of Pseudomonas is a mandatory requirement.	There have been 2 cases of pseudomonas aeruginosa bacteraemia in May 2022,	One of the cases was not considered to be device /intervention related with the source being neutropenic sepsis. The other case is under review to determine the source.	As per other HCAIs, consistent use of catheter documentation and care plans. ANTT training. 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



May 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

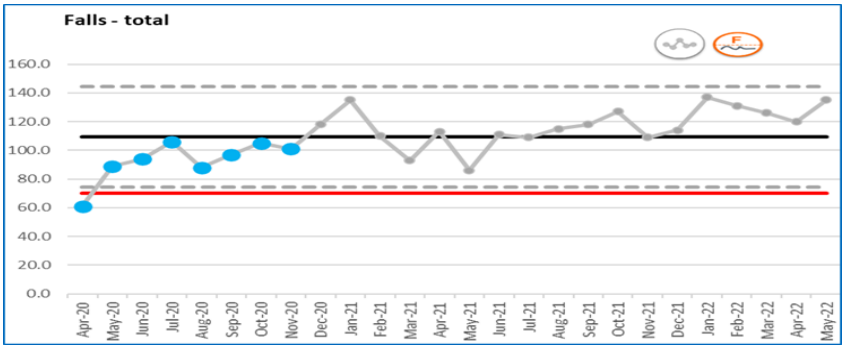


May 2022 actual performance
0.66
Variance Type
Common Cause
Local Standard
tbc

Pressure Ulcers – Total per Division	Number Reported
Medicine and Emergency Care	10
Surgery, Anaesthetics and Cancer	6

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 May 2022.	There were 12 category 2 pressure ulcers and 4 category 3 pressure ulcers 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 are 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 the management of skin integrity.

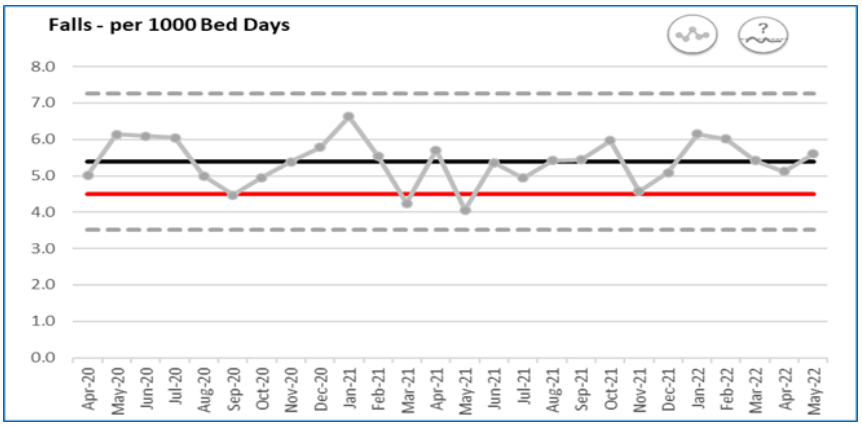
Falls



May 2022 actual performance
135
Variance Type
Common Cause
Local Target
<70
Target / Plan Achievement
10% reduction on 21/22

Falls – Total per Division	Number Reported
Medicine and Emergency Care	97
Surgery, Anaesthetics and Cancer	37
Clinical Support Services	1

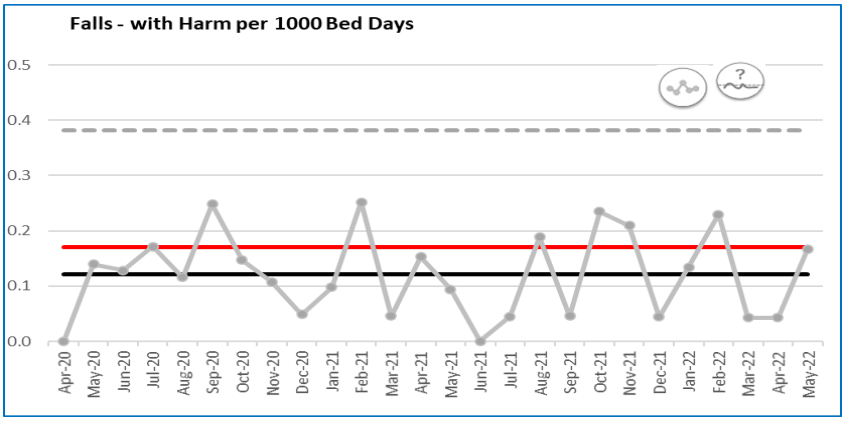
Falls – per 1000 bed days



May 2022 actual performance
5.6
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 May have increased following 3 consecutive months of improvement.	Falls remain above the Trust target. Falls per 1000 bed days remains higher than the 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 are completed in line with post falls protocol and 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 the last 24 hours reviewed daily. Monitoring via monthly nursing metric audit meetings with DON. Baseline exemplar peer reviews. All SI investigations are reviewed at NIQAM, and a summary report of cases will now go to RALIG.

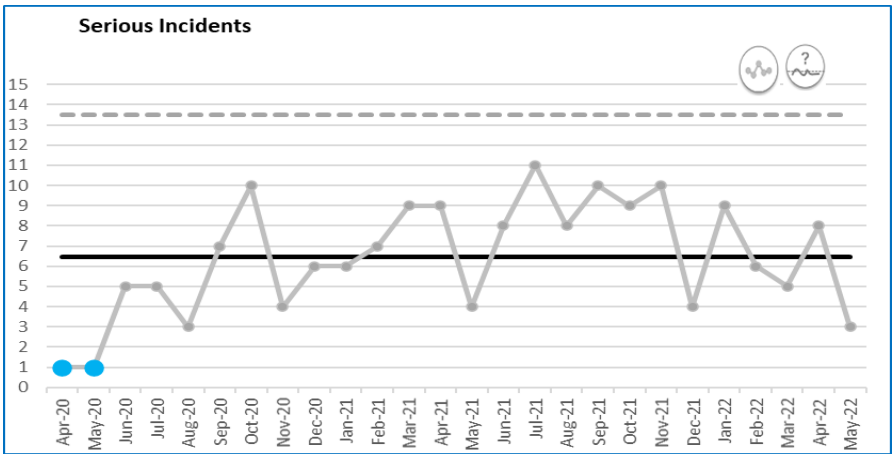
Falls – with harm per 1000 bed days



May 2022 actual performance
0.17
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 May 2022, but the Trust continues to see falls that result in moderate harm or above for patients.	There were four falls with harm reported in May 2022	As per falls slide.	As per falls slide.

Serious incidents

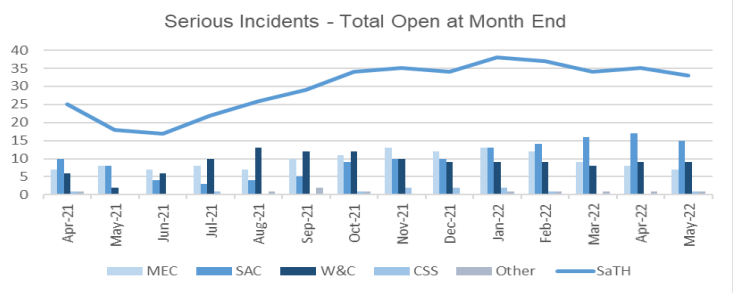


May 2022 actual performance
3
Variance Type
Common Cause
Local Standard
N/A
Target/ Plan achievement
N/A –seeking to encourage reporting of incidents

SUI theme	Number Reported
Unexpected Paediatric Death (CDOP notification)	1
Fall - Head injury and subsequent death	1
Diagnostic Incident - results not acted upon	1
Total	3

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, although the number did fall in May. .	No issues identified.	Monitor review and maintain investigation reporting within national framework deadlines for timely learning. Embed learning from incidents.	Weekly rapid review of incidents with early identification of themes. Standardised investigation processes and early implementation of actions.

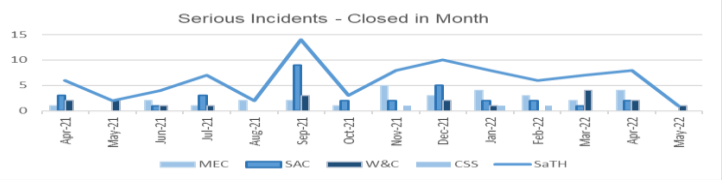
Serious incidents – total open at month end



SI – Total Open at Month End per Division	Number Reported
Medicine & Emergency Care	7
Surgery, Anaesthetics and Cancer	15
Women and Children's	9
Clinical Support Services	1
Other	1
Total	**33**

Background	What the Chart tells us	Issues	Actions	Mitigations
Current number of open serious incidents.	Number of open SIs.	There are currently 33 open SIs.	Monitoring progress of investigation.	Weekly review of mitigations.

Serious incidents – closed in month

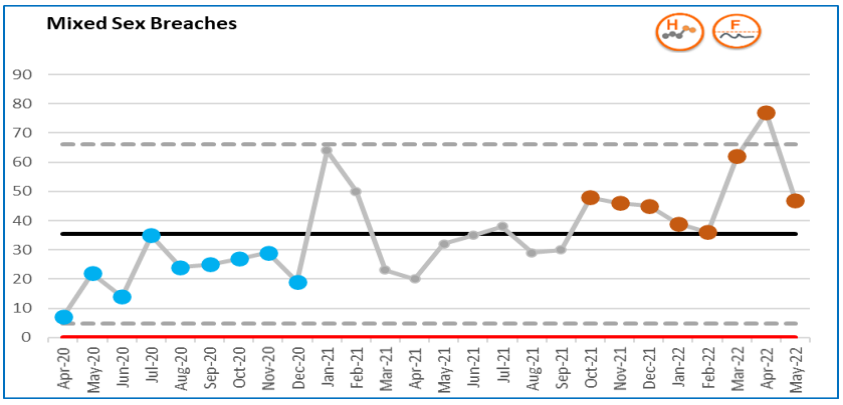


SI – Closed in Month per Division	Number Reported
Women and Children's	1
Total	**1**

Background	What the Chart tells us	Issues	Actions	Mitigations
The number of SIs closed in month will vary dependent on the number reported.	One SI was closed in month for May which is unusually low. This will be monitored for trends.	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

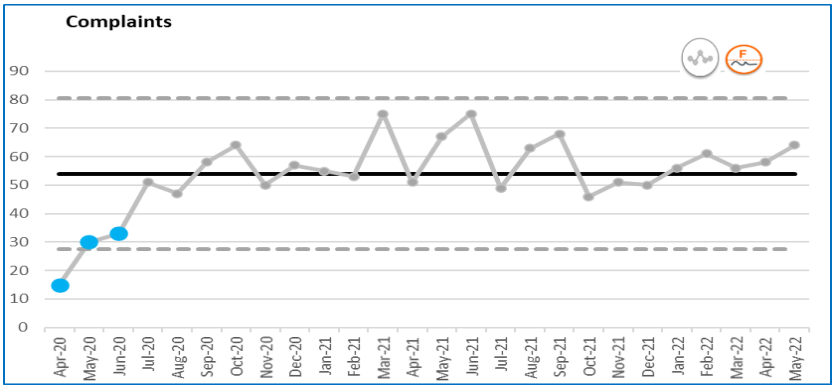
Mixed sex breaches exception report



May 2022 actual performance
47
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 breaches	
DSU (PRH)	1 Local breach	due to access of washroom and toilet facilities (not national)
ITU / HDU (PRH)	4 Primary breaches	3 Medical, 1 Surgical
ITU / HDU (RSH)	20 Primary breaches	11 Medical, 9 Surgical
Ward 32 (RSH)	2 Occasions resulting 8 breaches	

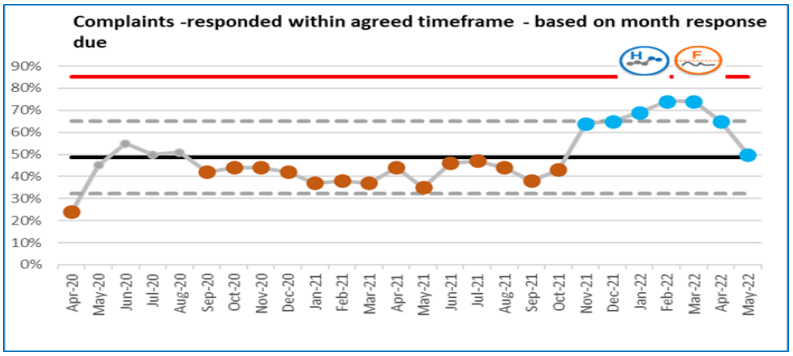
Complaints



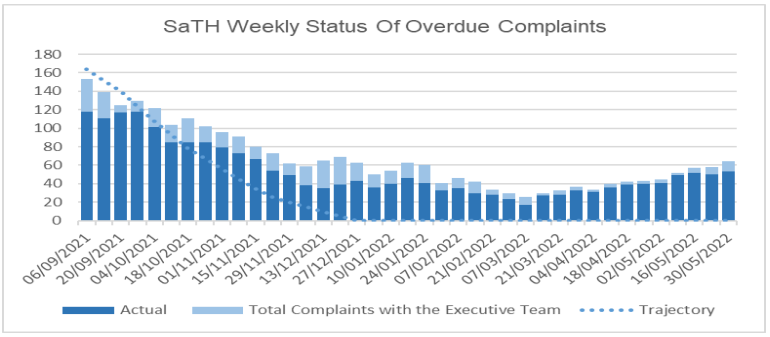
May 2022 actual performance
64
Variance Type
Common Cause
Local Standard
N/A
Target/ Plan achievement
Seeking to encourage reporting of Complaints.

Background	What the Chart tells us	Issues	Actions	Mitigations
Complaints provide a valuable source of learning to the organisation.	Numbers remain within the expected range with a slight uptake in recent months.	There have been no trends or concerns identified this month.	No actions.	No mitigations.

Complaints – Responded within agreed timeframe



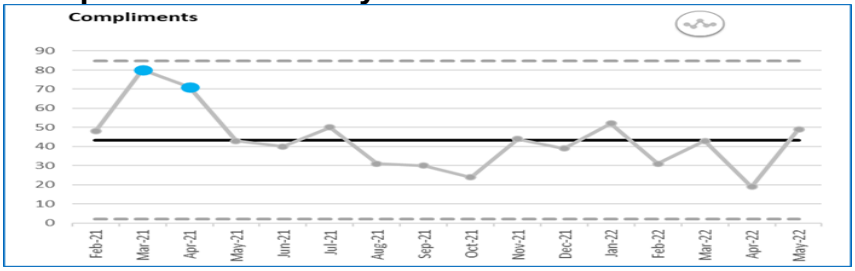
May 2022 performance
50%
Variance Type
Special Cause Improvement
SaTH internal target
85% responded to with the time agreed with the complainant.
Target/ Plan achievement
Target is unlikely to be achieved



Overdue Complaints per Division	Number Reported
Medicine and Emergency Care	46
Surgical, Anaesthetics and Cancer	6
Other	1
Total	**53**

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.	Performance has decreased slightly in recent months after a number of months near the target response rate.	This drop in performance is mainly as a result of recent site pressures and the impact of this on staff ability to respond.	Increased staffing in complaints team to provide greater support to divisions, with increased ability to offer training in responding to complaints. Ongoing work with divisions to support more timely responses; recent improvements have been noted particularly in paediatrics where all complaints have now been investigated by clinical staff.	Regular contact with complainants when cases go overdue to keep them updated

Compliments formally recorded

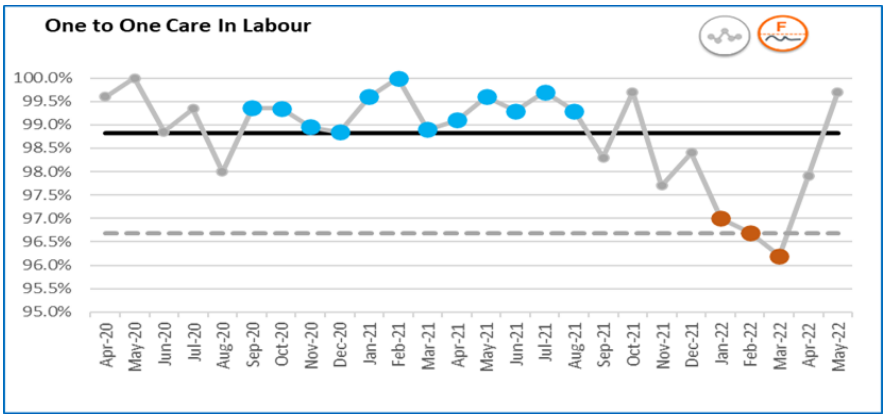


May 2022 actual performance
SATH
49
Divisions
MEC – 29
SAC – 9
CSS – 10
Other - 1

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 and is thought to be due to the 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.	No mitigations.

Quality Exception Reports – Maternity services

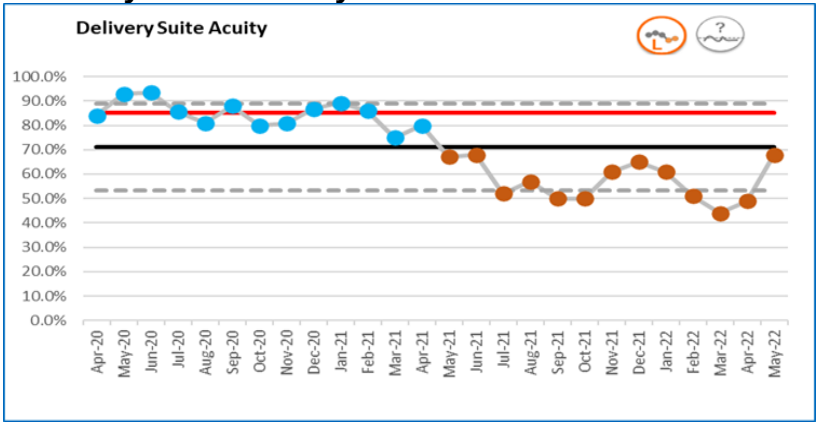
Maternity - One to One care in labour



May 2022 actual performance
99.7%
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 the delivery suite, despite ongoing successful recruitment. This is due to high unavailability rates because of maternity leave and 9 substantive vacancies in the midwifery workforce.	A weekly review of any cases where 1:1 care is recorded as not provided is now undertaken by the matron for the delivery suite. Intermittent closure of the Wrekin birthing unit to support safe staffing levels on delivery suite. Incentivised bank rate in place for all areas of the service. Revised draft escalation policy currently being circulated for comments and feedback. 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. A 7-day manager rota has now commenced to ensure oversight and action at weekends.

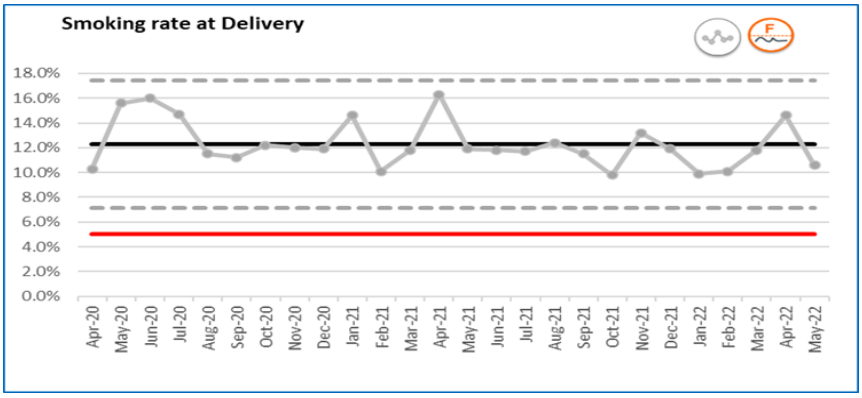
Delivery suite acuity



May 2022 actual performance
68%
Variance Type
Special Cause Concern
National Standard
85% (Birth Rate Plus)
Target / Plan Achievement
Part of overall maternity care dashboard and benchmarking

Background	What the Chart tells us	Issues	Actions	Mitigations
In 2015, NICE set out guidance for safe midwifery staffing which included the use of a tool endorsed by NICE to measure and monitor acuity. This has been in place at SaTH since 2018 and is reported monthly in line with the CNST standard safety action number 5.	There was a significant improvement in acuity recording this month, although this remains just below the mean.	Staffing levels often below template because of high unavailability rates due to maternity leave and vacancies in the midwifery workforce.	Intermittent closure of the Wrekin birthing unit to support safe staffing levels on delivery suite. 3 nurses have commenced the shortened midwifery course and a further 3 will start in September. Specialist midwives and managers undertaking rostered shifts. A 7-day manager rota has commenced to ensure support and action at weekends. Band 6 midwifery posts currently being shortlisted. Incentivised bank shifts in place for all areas. Revised draft escalation policy currently being circulated for comments and feedback.	Acuity tool consistently being completed, which is a reassurance of data quality. Twice daily SMT huddles embedded, including at weekends, to monitor and manage acuity and instigate the escalation policy when required. Assured by other indicators, such as provision of one-to-one care in labour, below expected rates of 3rd and 4th degree tears and term admissions to NNU below national rates.

Smoking rate at delivery



May 2022 actual performance
10.6%
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.	Decrease in SATOD rates since April 2022. Usual fluctuation in rates, although year on year reduction for June since 2020.	Target for March 2022 has not been met by the Trust despite drastically reducing rates in maternity. Only 14 out of 106 submitting CCGs achieved the 6% target and the Trust will now work towards the new target of 5%. There continues to be inaccuracies with reporting to the monthly dashboard SATOD rates due to issues with Badgernet data quality. Data input at time of delivery has improved immensely (smoking status). Continued issues with correct CO monitoring rates at booking	2 WTE band 5 nurses appointed to HPSS currently going through recruitment checks. Discussions are taking place with Performance colleagues re. accuracy of dashboard data and management are aware. HPSS going through data manually each month to check accuracy and ensure correct data is published.	There have been barriers to launching HPSS due to recruitment issues, however these are now resolved. Will continue to monitor data quality now Badgernet is the only data system being used by maternity. Continue to communicate the need for routine CO monitoring and accurate reporting on Badgernet.

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

Divisional recruitment plans have been developed this month which allows us to track vacancies and recruitment activity. These plans will be used to monitor progress against our operational plan and to highlight areas of risk in delivery.

Progress has been made on the recruitment of 100 additional international nurses and 31 offers have been made this month. We are also taking the action to survey all our current international recruits to establish their plans and aspirations after they reach three years of service which will aid our planning for future cohorts.

This month we have made 141 job offers, including doctors in training and 6 locum Consultant Anaesthetists via a head-hunting agency. Preparations continue for the August junior doctor change over with 105 conditional offer letters sent to incoming trainees. As part of our medical improvement plan all rosters are being reviewed (23 rota templates completed so far). The rosters are amended and aligned to service delivery models, terms, and conditions of service and best practice rostering principles.

The National staff survey divisional breakdowns have now been received and we continue to support our divisions to inform their priority actions. A key area of concern is around civility, respect, and inclusion and we are working with our leaders to ensure we all take accountability and ownership supported with four key building blocks to improve working life at SaTH.

Another key area is flexible working and we have already held an online conversation via making a difference together, where 1135 people engaged in this which is the highest to date. We are now aiming to share the feedback with our leaders and people to support and develop a change in mindset when it comes to flexible working.

We are embarking on a new leadership development and coaching programme for up to 30 delegates over 2 cohorts. The aim is to commence from September 2022, and this will be a 10-month modular in person programme to develop current senior leaders and rising stars. Our four leadership programmes (1 - supervisors and team leaders, 2- first line managers, 3- middle managers, 4 – senior managers) continue with improved attendance and our leadership masterclasses are planned throughout the year. In addition, we are developing a BAME mentorship programme to commence in September 2022 to increase opportunities and BAME representation in leadership positions.

We are also working with the ICS on the high potential scheme, a uniquely tailored two-year career development opportunity aimed at bands 8a-8d to help ‘accelerate your progress’ and several roadshows are taking place during June. In partnership with colleagues across the Trust we are also set to launch in the next quarter our management technical competency programme to ensure a consistent standard across our leaders and improved staff experience and patient care.

The people experience team have supported our Jubilee celebrations and are busy planning the NHS birthday on 5 July 2022 when the NHS will mark 74 years of service. This milestone will present us with opportunities to showcase how the NHS has innovated and adapted to meet the changing needs of each successive generation. We will continue to

recognise key dates including celebratory days and special occasions including key cultural and religious events throughout the year.

We continue to build our health and wellbeing offer, to our people and across the ICS which is set to expand further with the launch of our psychology hub later in 2022 and sleep school programme which commenced in June. One of the key priorities is to support many of our people that are feeling the impact of the cost-of-living increases and our hardship group have launched a support booklet and work is under way on the living wage.

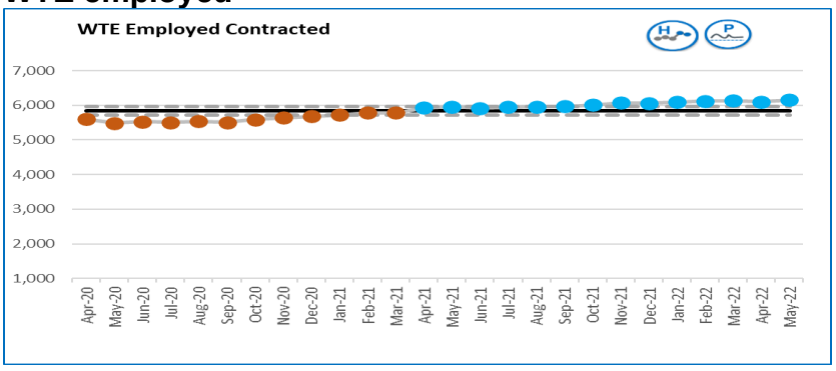
Wellbeing week is 27th June, and wellbeing walks will take place every day with our EDI, FTSU and staff experience colleagues where healthy snacks and fruit will be available, and Menopause/HWB/ EDI stand in the restaurants during the week.

Our first Schwartz round was held on 14th June where 25 people attended SECC, RSH, where a panel of speakers presented personal stories, inspiring and engaging the audience in conversation. Our next Schwartz round is on 6th July 2.00-3.30pm in the Lecture Theatre at PRH.

We have formally been recognised as an 'Employer with heart' by the premature baby charity The Smallest Things. This is in recognition of our work to support staff whose babies are born prematurely.

The people advisory team have scheduled 3 training sessions for resolving bullying and harassment in June, all of which are fully booked. More sessions are being delivered over the coming months and since October 2021 we have delivered training to 351 managers covering the following modules: Managing employee health and wellbeing, Managers HR fundamentals, managing behaviours and performance and Managing change.

WTE employed

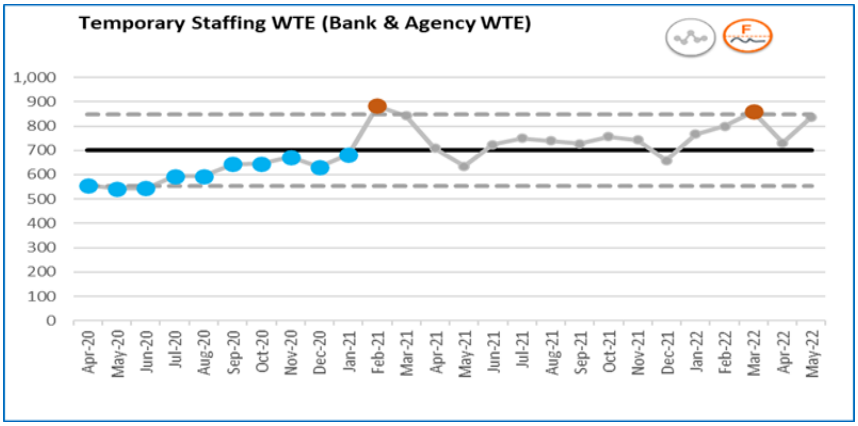


May 2022 actual performance
6158
Variance Type
Special Cause Improvement
Local Target
TBC
Target / Plan Achievement
Seeking month on month improvement

Background	What the Chart tells us	Issues	Actions	Mitigations
This is a measure of the WTE contracted staff in post.	WTE numbers remain consistent and have shown special cause improvement since Apr	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	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	Utilisation of bank and agency staff to support workforce gaps. Promote timely roster

	2021.	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 fully implemented in ward rosters.	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.	approvals to maximise opportunities for bank utilisation. Continue to monitor leavers and support with early intervention.

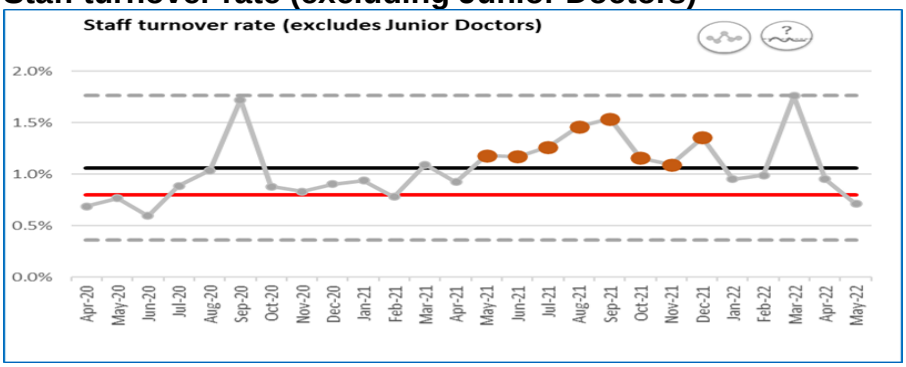
Temporary/agency staffing



May 2022 actual performance
836
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 variation between April and May 2022.	Staff absences attributed to sickness continue to present staffing challenges. High patient acuity levels, patient flow 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 the framework agency by December 2022. Recruitment programmes are in place including international recruitment and apprenticeship programme e.g., nursing associates and ODP's. Continue to monitor roster approvals and unavailability to support better utilisation of the temporary workforce.	Escalated bank rates in at risk areas. Progress with recruitment activities to increase substantive workforce including international nurse recruitment.

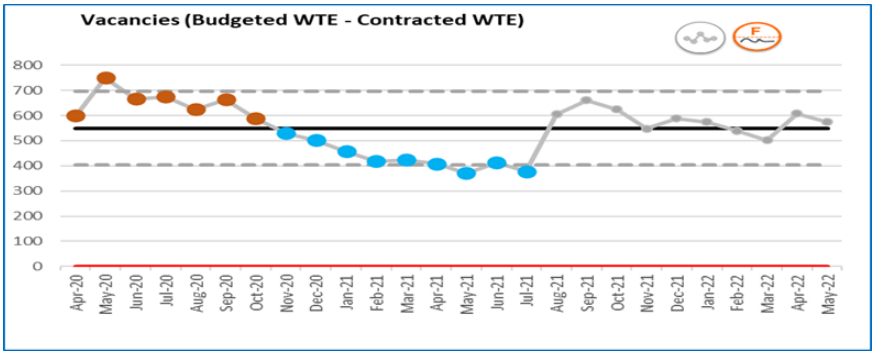
Staff turnover rate (excluding Junior Doctors)



May 2022 actual performance
0.71%
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.	Staff Turnover rate has decreased from a high in March 2022 and was slightly below the target level for May.	Turnover rate continues to be higher than in previous years with a 15% turnover rate for the last 12 months. There have been 200 WTE more leavers in the last 12 months compared to the previous 12 months.	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. Continued 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.

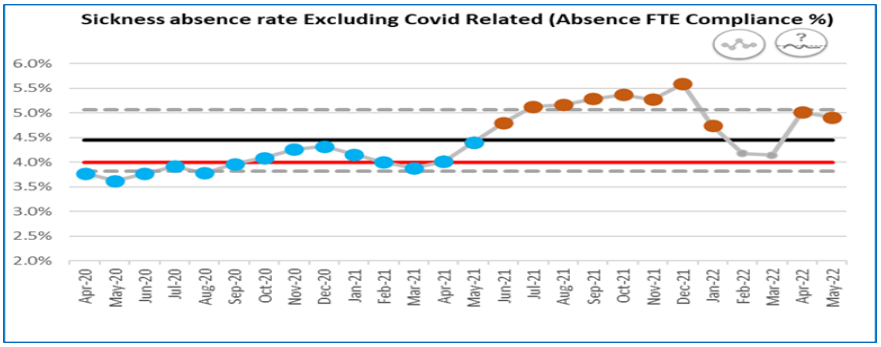
Vacancies



May 2022 actual performance
574 (9.3%)
Variance Type
Common Cause
National Target
<10%
Target / Plan Achievement
Note change post reconciliation work

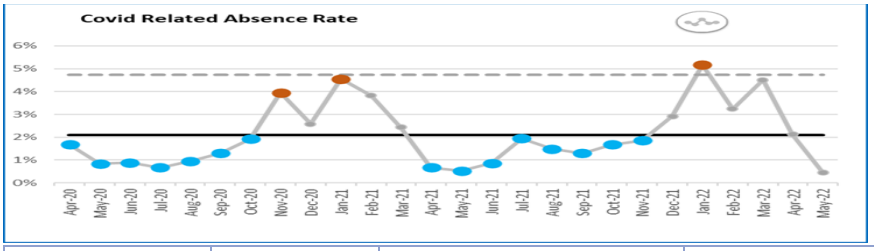
Background	What the Chart tells us	Issues	Actions	Mitigations
This is a measure of the gap between budgeted WTE and contracted WTE. Further review of establishments will continue as part of operational planning this year.	Improving vacancy position following revised budget position in August 21. Common cause variation has been seen since August 2021.	A competitive marketplace presents challenges in attracting candidates. Vacancy gaps continue to put pressure on bank and agency usage. Sickness absence creates an 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. Retention programmes to encourage people to stay.	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



May 2022 actual performance
4.9%
Variance Type
Common Cause
National Target
4%
Target / Plan Achievement
The target is unlikely to be delivered month on month

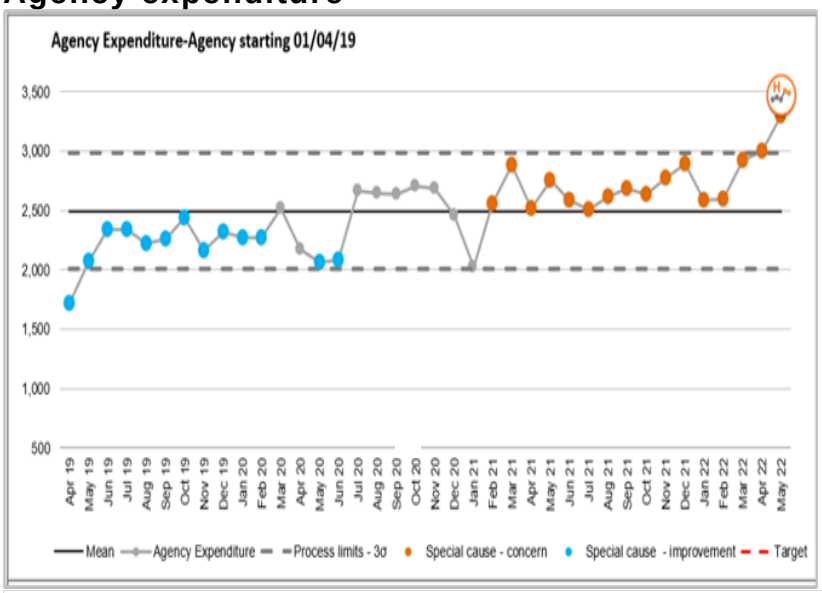
Background	What the Chart tells us	Issues	Actions	Mitigations
The measure is an indicator of staff sickness absence and is a % of WTE calendar days absent. COVID-19 related sickness and absence is not included.	Sickness absence rates increased in April and May, although this is partially due to the new inclusion of COVID-19 related absence.	From April-22, the sickness absence rate includes employee sickness attributed to COVID-19. Absence rate of 4.9% equating to 301 WTE. Absence attributed to mental health continues to be high at 26% of the calendar days lost equating to 80 WTE with musculoskeletal sickness (which excludes back problems and injuries) attributing to 12% of calendar days lost equating to 37 WTE.	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 a range of health and wellbeing initiatives and programmes. Continue to support appropriate PPE adherence and vaccination uptake. Promote initiatives such as well-being weeks.	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.



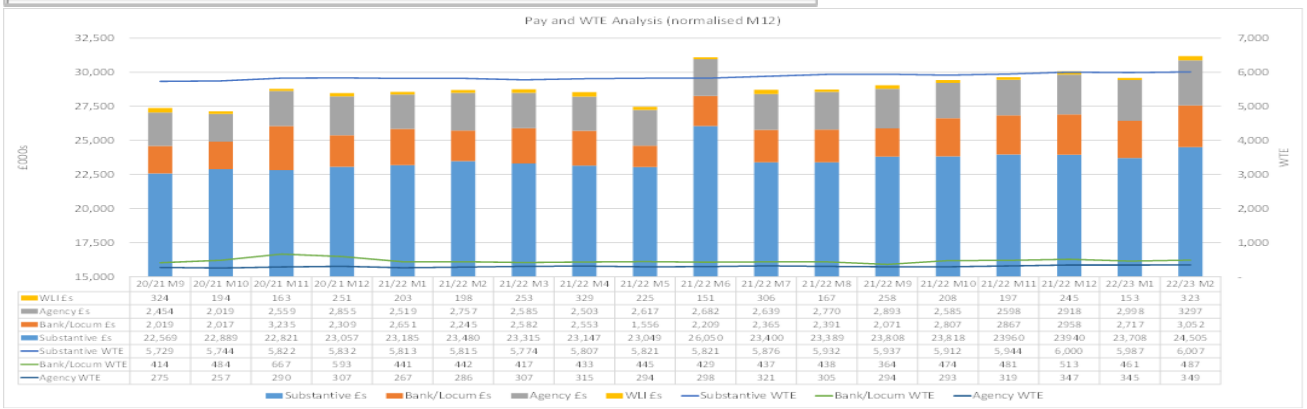
May 2022 actual performance
0.5%
Variance Type
Common Cause
National Target
N/A

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 fell in May, returning to levels seen last summer.	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 continue to monitor absence levels and help ensure staff can safely return to work following risk assessments. Communication to staff 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

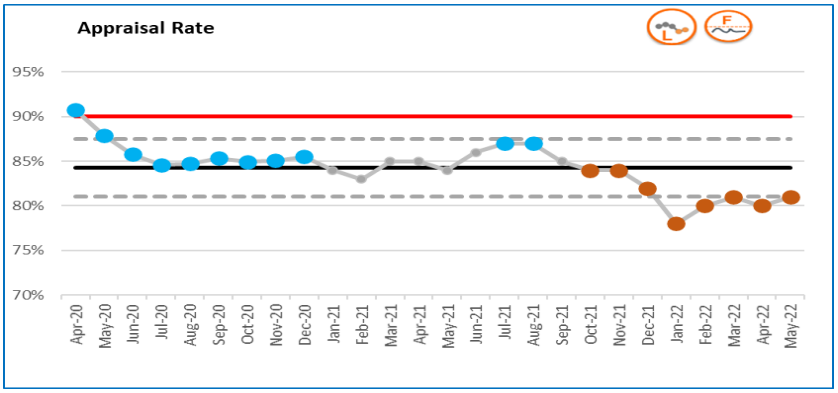


May 2022 actual performance
£6.295m spend year to date. Overspend to plan by £1.617m
Variance Type
Special cause Concern overspend
SaTH Plan
£2.324m
Target/ Plan achievement
Remaining within annual plan overall and NHSEI agency cap.



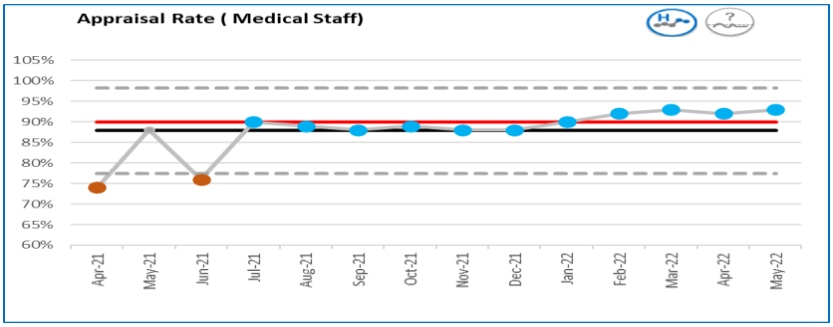
Background	What the Chart tells us:	Issues	Actions	Mitigations
The Trust agency costs have increased over the past 2 years due mainly to the COVID-19 pandemic and additional quality service investment requirements. There is a strong focus on reducing agency spend across the Trust which is integral to the Trust efficiency programme.	Agency costs are £6.295m year to date. In month costs are £0.299m higher than month one. The increase is mainly due to further increases in off-framework agency within nursing and an increase in medical agency across both Medicine and Surgery divisions.	Due to workforce fragility the Trust is consistently reliant upon agency premium resource. There has been a significant increase in the use of off-framework agencies in recent months within the medicine division. Operational and workforce pressures continue to force an increase in agency expenditure.	Direct engagement groups now set up to focus on agency spend and approval hierarchy, including a monthly dashboard review across key nursing metrics. Overseas registered nursing recruitment continues and is expected to reduce the reliance on agency nurses once the supernumerary period is complete. Recruitment and retention strategy approved with a key focus on brand and reputation, retention of staff and targeted recruitment campaigns for hard to fill roles. Review of agency procurement strategy with National Procurement team (HTE).	Develop measurable metrics and action plans to understand where we can control agency expenditure. Increased focus on junior doctor rotas and recruitment to ensure effective use of medical locums. Delivery of Recruitment and Retention strategy to increase substantive workforce and improve retention levels.

Appraisals



May 2022 actual performance
81%
Variance Type
Special Cause Concern
National Target
90%
Target / Plan Achievement
Below target level of performance

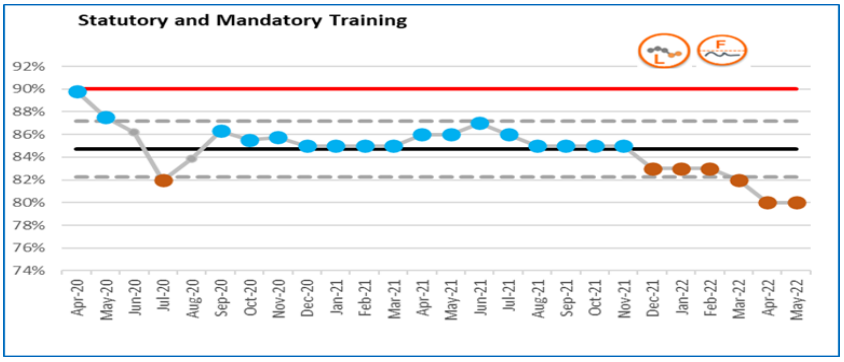
Appraisal – medical staff



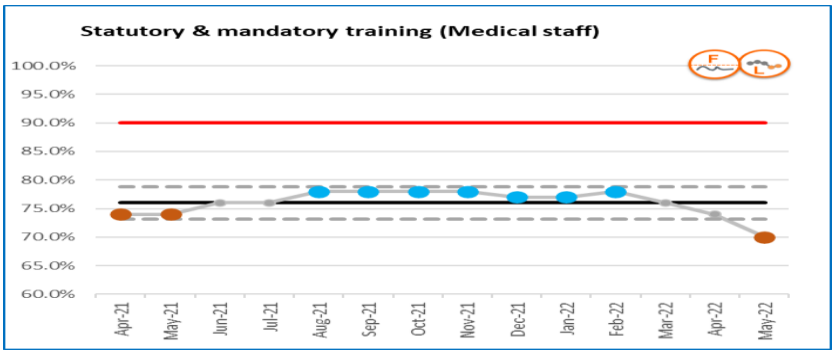
May 2022 actual performance
93%
Variance Type
Special Cause Improving
National Target
90%
Target / Plan Achievement
90%

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.	This month we have seen a 1% increase in appraisal compliance, although this remains much lower than average.	The system is currently in a critical incident with staff sickness running at high levels. COVID-19, staffing constraints, escalation levels and service improvement has reduced the 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 HRBPs with regards to any areas of concern.	Ensure the health and wellbeing offer is advertised widely throughout the Trust. Internal audit of appraisal record accuracy.

Statutory & mandatory training



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

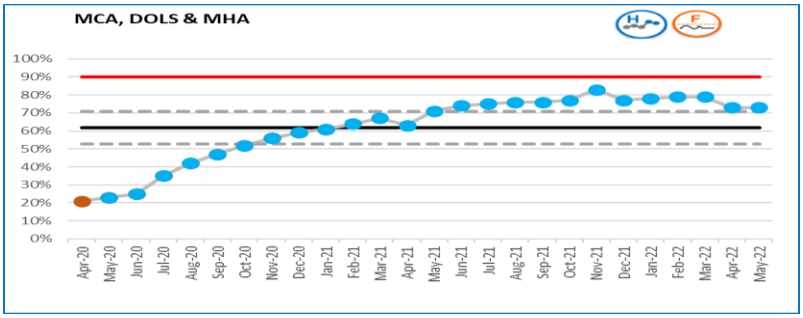


May 2022 actual performance
70%
Variance Type
Special Cause Concern
National Target
90%
Target / Plan Achievement
90%

Fire Safety Awareness	Moving and Handling - Level 1 (Load Handling)	Moving and Handling - Level 2 (Patient Handling)	Infection Prevention and Control - Level 1	Adult Basic Life Support (Classroom)	Paediatric Basic Life Support	Conflict Resolution	Equality, Diversity and Human Rights	Information Governance and Data Security Awareness	Health, Safety and Welfare
82%	84%	69%	69%	67%	44%	80%	84%	74%	85%

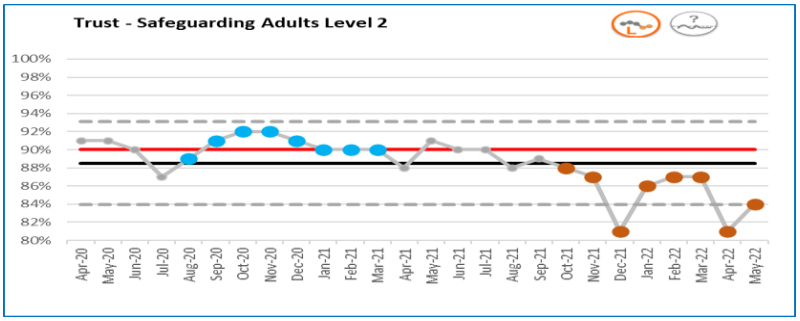
Background	What the Chart tells us:	Issues	Actions	Mitigations
The measure is a key indicator for patient safety in ensuring staff are compliant in having completed their annual appraisal.	Compliance remains at 80%. Medical staff compliance with mandatory training is lower than the overall staff compliance.	The system has been in a critical incident and staff sickness running at high levels which will have contributed to the decrease in training %. L2 Moving and Handling refresher rate reduced from 3 years to 2 years as per health & safety committee action, resulting in 1% decrease to overall compliance.	Full roll out of the new Learning Made Simple (LMS) training platform has now been implemented across the Trust. This system gives visibility of staff competencies at an individual level and makes 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. To date we have had 60% of staff registering on the system within three weeks of the launch and 10,000 eLearning modules accessed. Mandatory training reminder notifications to be turned on in June.	Requirements made more transparent to staff via Learning Made Simple platform. Libraries supporting learners to access e-learning. Phone support for e-learning.

Trust MCA – DOLS & MHA



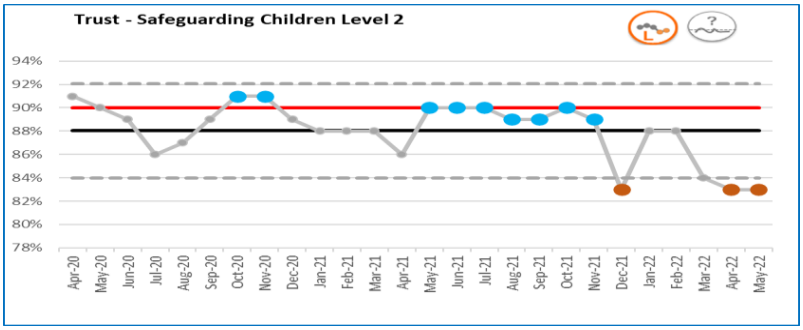
May 2022 actual performance
73%
Variance Type
Special Cause Improvement
National Target
90%
Target / Plan Achievement
Improvement trajectory in place

Safeguarding adults – level 2



May 2022 actual performance
84%
Variance Type
Special Cause Concern
National Target
90%
Target Achievement
90%

Safeguarding children – level 2



May 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 RTT elective waiting lists have increased in May 2022, due to a reduced bed base at both sites because of urgent care pressures. Additional insourcing activity is in place at weekends to treat our patients who have been waiting more than 78 and 104 weeks. Our Trust is on trajectory to deliver our target for 104 weeks at the end of June and to achieve the zero target by end of July 2022. Weekly meetings are established to monitor performance against our trajectories and take corrective action, as necessary. A theatre productivity programme has been established to ensure all available theatre lists are fully utilised in conjunction with planning our bed availability, together with looking at alternative workforce roles with other providers.

Cancer two week wait performance is below the national standard, however due to the workforce and capacity constraints in radiology, achieving the standard is challenged. Insourcing of ultrasound capacity is now in place to assist with capacity and potentially release capacity to be redirected to 'one stop' pathways. Internal improvement meetings are established, and weekly system assurance meetings have been established to monitor performance against the standard and to seek mutual aid.

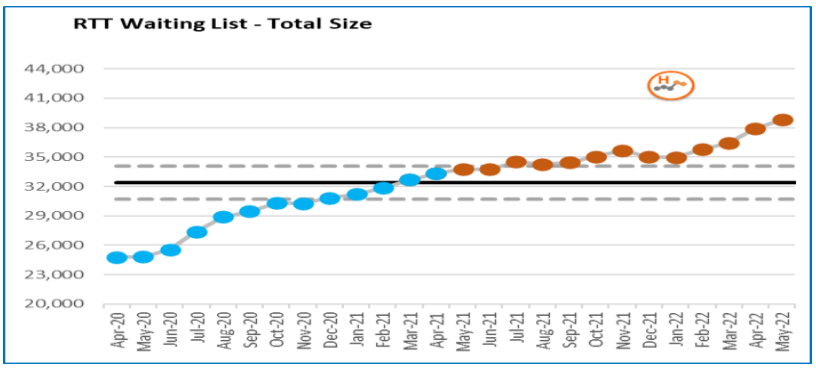
The number of patients waiting over 62 days for cancer diagnosis and treatment has significantly increased since February 2022. This is due to a reduction in access to diagnostics (CT, MR ultrasound, endoscopy), although prioritisation is given to cancer pathways and urgent care, this is not enough to keep up with the increasing demand for cancer referrals. Work is established with our neighbouring trusts for mutual aid support, to improve our diagnostic capacity. A recovery trajectory has been established and will be monitored weekly at hospital and system level.

Diagnostic performance has marginally improved in May 2022 but is still below the national standard. The improvement plan is dependent on successful recruitment campaigns which are in progress and the development of apprentice grades in radiology. The workforce plan is about attracting and developing local talent. The additional endoscopy rooms are nearing completion and the outcome of the NHSE capital bid for equipment is awaited, which will give the physical resources to improve capacity.

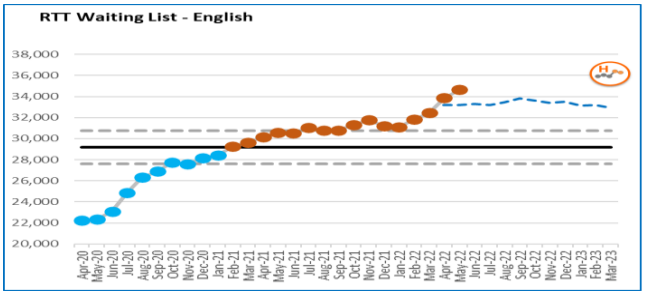
Overall, the emergency pathway continues to be under pressure, with an increase in ED attendances in May 2022. The number of COVID-19 cases within the hospitals fell in May, but we are now seeing an increase in presentations through our admission areas. There is still a need to segregate pathways to maintain IPC compliance, which slows down the management of patients through the hospital.

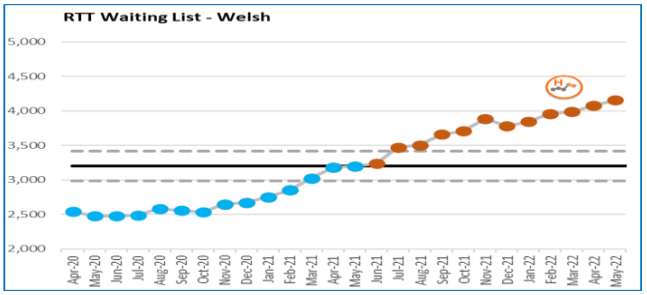
Elective Care

RTT Waiting list – total size



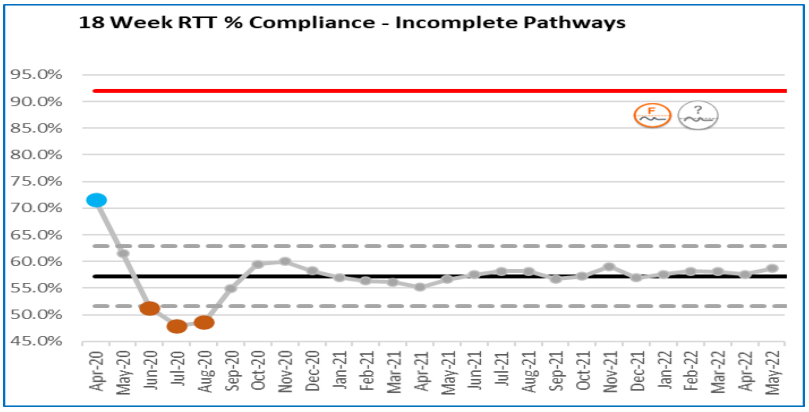
May 2022 actual performance
38810 (English 34655, Welsh 4155)
Variance Type
Special Cause Concern
Local Plan
33205 (English 22-23 Plan)
Target / Plan Achievement
(22-23 plan)



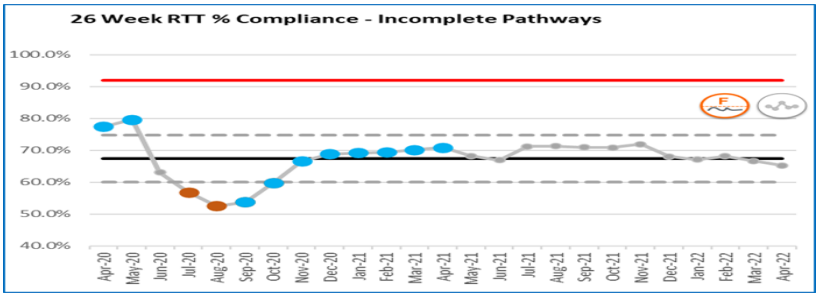


Background	What the Chart tells us	Issues	Actions	Mitigations
The total number of patients waiting for treatment.	The total waiting list size remains at a higher level than planned. The list has increased at a faster rate since January 2022 than in previous months.	Reduced capacity to see and treat patients due to clinic space restrictions, bed capacity due to emergency pressures and full escalation of DSU at PRH. 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. ITU air conditioner work has been extended due to delay with parts to August 2022.	Weekly restore and recovery meetings in place. Further development of PIFU and virtual plans by specialty and clinical engagement. 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. Theatre trajectories for staffing elective activity at weekends via 18 weeks on both sites.	As actions, additional 32 bedded unit and 16 additional elective beds from August 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



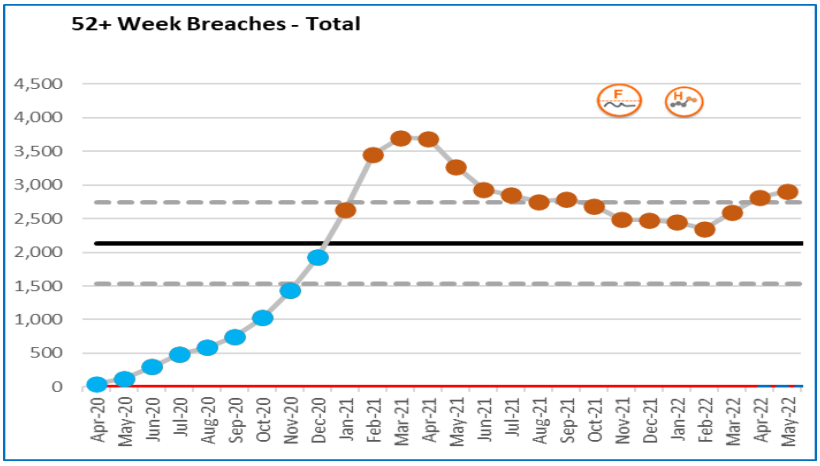
May 2022 actual performance
58.7%
Variance Type
Common Cause
National Target
92%
Target / Plan Achievement
Clinical prioritisation and the backlog developed mean target will not be achieved.



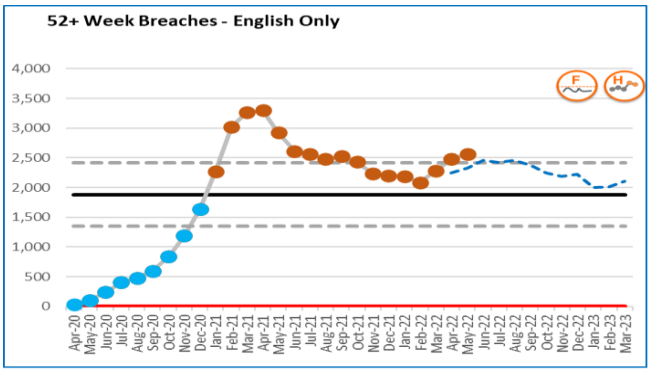
May 2022 actual performance
65.1%
Variance Type
Common Cause
National Target
92%

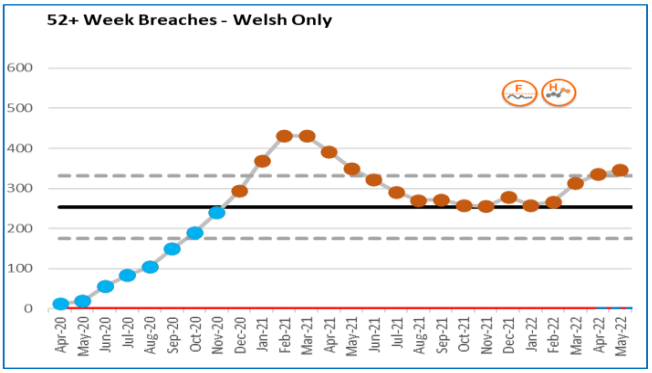
Background	What the Chart tells us	Issues	Actions	Mitigations
This is the national standard for patients referred for elective care. Headline performance against this measure has now stabilised but is well below the pre-pandemic performance.	Incomplete pathways appear to have stabilised at a level significantly below the national target.	Limited resources. Outpatients taking place with social distancing. Theatre capacity issues due to theatre nursing teams and theatres prioritised to clinically urgent patients. Staff absences. Inability to open up additional theatre lists to due to theatre staffing. 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.	Established system meeting to monitor elective recovery and cancer.

52 Weeks wait exception report



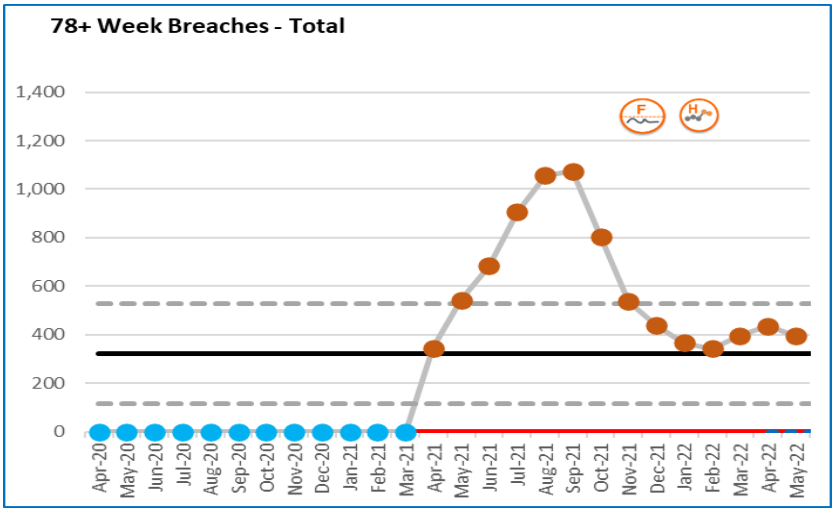
May 2022 actual performance
2910 (English 2564, Welsh 346)
Variance Type
Special Cause Concern
Local Forecast
2333 May (English 22-23 plan)
Target / Plan Achievement
NHSEI target reduction on 52+ breaches



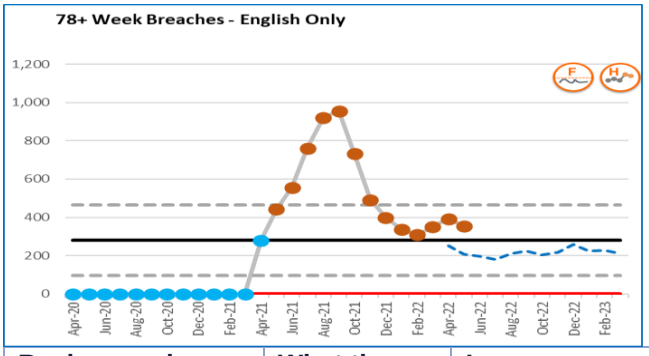


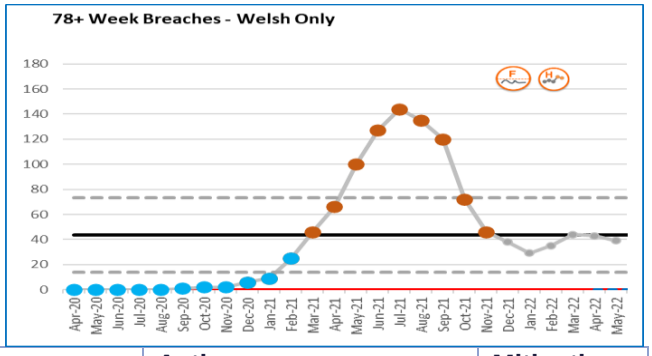
Background	What the Chart tells us	Issues	Actions	Mitigations
From a baseline position of zero pre-pandemic, the volume of patients waiting in excess of 52 weeks on an open RTT pathway has increased significantly. It reflects routine patients not currently being able to be prioritised for treatment.	The number of patients waiting over 52 weeks is increasing. Although this number of patients is slightly higher than planned, an increase in this month was expected before the planned number begins to fall in September 2022. The difference to plan is slightly lower than it was in April.	Theatre Staffing. Reduced elective capacity. Urgent care pressures resulting in the loss of elective 'green' capacity due to increased escalation into DSUs.	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



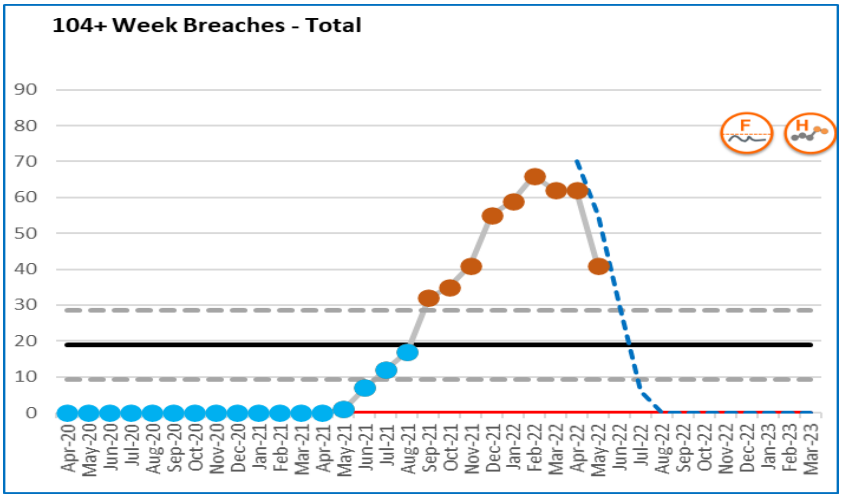
May 2022 actual performance	
393 (English 354, Welsh 39)	
Variance Type	
Special Cause Concern	
National Target	**Local Forecast**
0	207 May (English 22-23 plan)
Target / Plan Achievement	
NHSE national target 0 by 31st March 23	





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 fallen slightly from April but remains above the planned level.	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. Current operational plan indicates we will potentially have 211 patients waiting over 78 weeks as at 31.3.23.	Theatre vacancies being addressed through recruitment and overseas nursing and trajectory in place which is being monitored and escalation process in place. COVID-19 and non-COVID-19 related absences are being closely monitored. Additional 8 ring fenced DSU beds on ward 36 from 20.6.2022. Recovery plans developed as part of the 2022-23 integrated operational planning cycle are being monitored /reviewed.	Monitored via weekly RTT meeting. Operational plan monitored through system and weekly divisional meetings.

104+ Weeks wait exception report

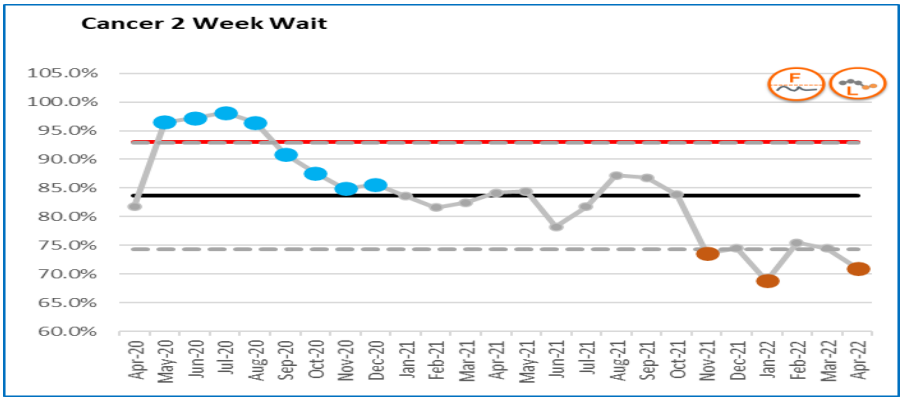


May 2022 actual performance	
41 (English 40, Welsh 1)	
Variance Type	
Special Cause Concern	
National Target	**Local Forecast**
0	55 May (English 22-23 plan)
Target / Plan Achievement	
NHSE 0 by 30th June 22	

Background	What the Chart tells us:	Issues	Actions	Mitigations
From a baseline position of zero pre-April 2021, 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 July 2022. The trust target was 30 but has reduced to 6.	Number of patients waiting 104+ weeks has fallen sharply this month in line with the Trust's plan.	Significant progress made and teams fully engaged but there is a residual risk of 9 at the end of July 2022 – 5 orthopaedic, 3 gynae and 1 colorectal.	Clinical priority of cases continues, and lists are allocated on clinical need. Optimising vanguard mutual aid with joint working on elective orthopaedic cases with RJAH. ERF plan to continue to utilise insourcing 18 weeks. Weekly monitoring of 104s via RTT.	6-4-2 theatre meeting list planning. Weekly restore and recovery meeting. RTT weekly meeting.

Cancer

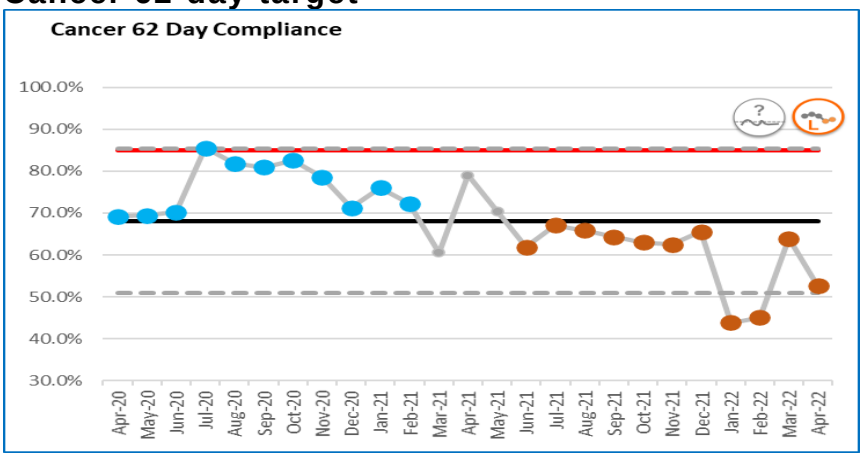
Cancer 2 week waits



April 2022 actual performance
71% (May 2022 Revised forecast 77.2%)
Variance Type
Special Cause Concern
National Target
93%
Target / Plan Achievement

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 fallen in recent months with April's position the second lowest since 2020.This is attributed to capacity within the 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 have commenced which will reduce the amount of 2WW breast referrals. Gynaecology is working on extra capacity and alternatives to one stop. Lung trying to recruit and also provide some WLI clinics.	Implementation of revised 2WW breast and gynaecology referral proformas.

Cancer 62-day target

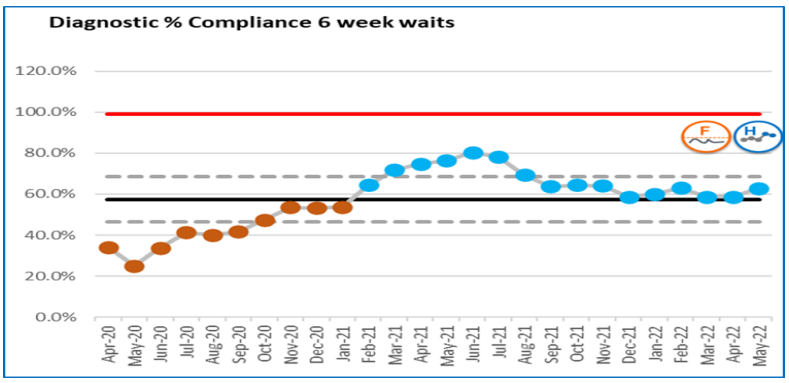


April 2022 actual performance
52.6% (May revised forecast 44.3%)
Variance Type
Special Cause Concern
National Target
85%
Target / Plan Achievement
Performance

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 and 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

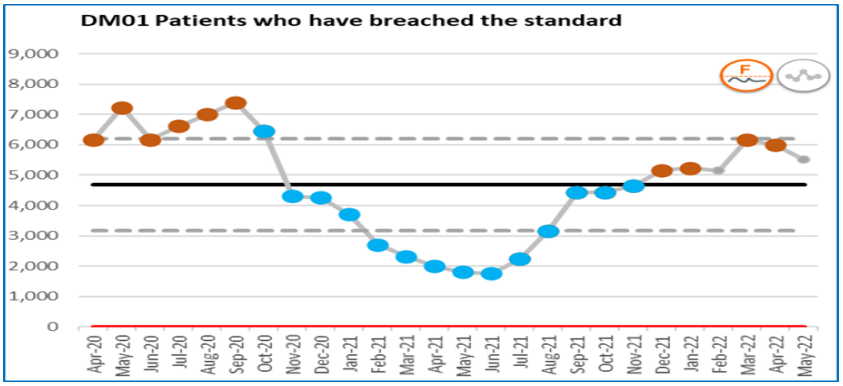
Diagnostics - DM01 diagnostics over 6 week waits



May 2022 actual performance
63%
Variance Type
Special Cause Improvement
National Target
99%
Target / Plan Achievement
Operational 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.	Performance has stabilised around 60-65% for 2022, well below the national target.	Staff availability continues to affect capacity and workforce resilience. Increased inpatient demand affecting outpatient availability, particularly in MRI. Fragility of staff continues, particularly for MRI. Short notice absence leading to cancellation of lists in line with business continuity plans.	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 increasing available capacity. Use of insourcing in US and breast. Use of agency where available, however availability and quality are a concern.

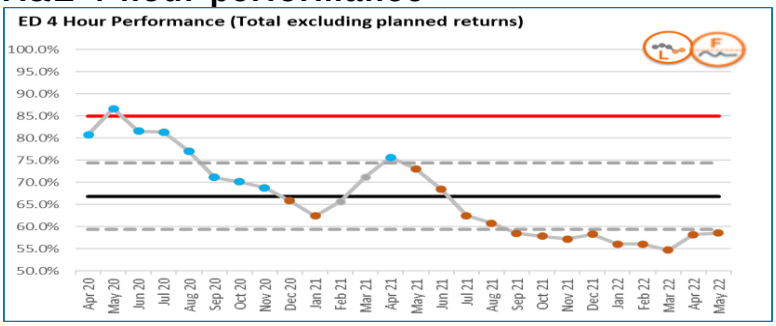
DM01 Patients who have breached the standard



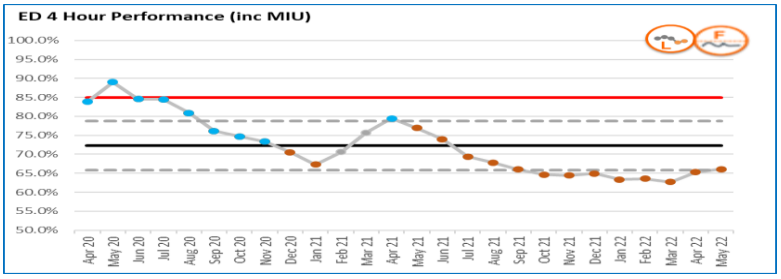
May 2022 actual performance
5513
Variance Type
Common Cause
National Target
0 - < 6weeks
Target / Plan Achievement
Clinical prioritisation and then addressing longest waits.

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. There was a reduction of 480 patients breaching the standard this month.	Staff availability/ absence affects imaging capacity and requires short-notice cancellation of lists. Reduced capacity due to ongoing Covid measures. While activity has increased in May, DM01 is being affected by the number of long-waiters on our lists. Increasing acute demand affecting outpatient capacity.	Ongoing recruitment across all areas, including year 1 of workforce plan. 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. Awaiting outcome of potential changes to Covid IPC measures to review appointment templates.	Use of agency/bank as available. Mobile scanners on site. Insourcing for US and breast.

Emergency Care
A&E 4-hour performance



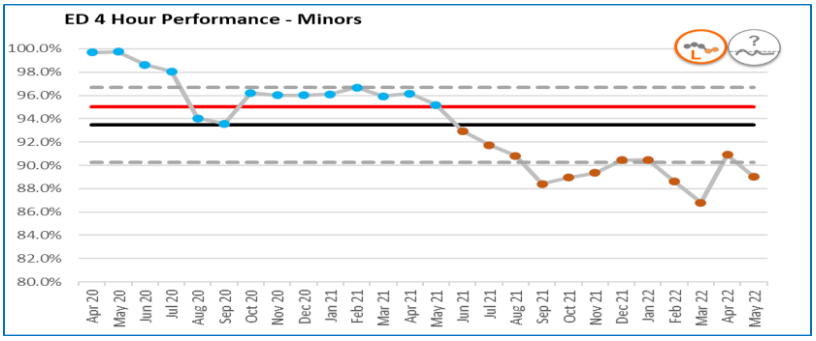
May 2022 performance
58.5%
Variance Type
Special Cause Concern
National Target
95%
Target / Plan Achievement
Performance is below national target.



May 2022 performance
66.1%
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, although has stabilised around 65%.	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.	Reconfiguration of wards on RSH to create an acute medical floor. Business case is currently going through Trust and then system sign off. Reconfiguration of RSH ED to enhance patient experience and access to most appropriate area in ED. Final stage of works commencing week of the 20th June. Expected completion date end of July. Primary care streaming trial took place in May. Initial feedback and summary data presented with plan to review next steps in June. Extension of PRH SDEC – agreed design may have to be altered due to space required for new elective hub. Finalisation of designs for elective hub required before project can progress. Improved use of SDEC including direct access from WMAS & WAS in place. 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. Dedicated Programme Manager and workstream structure in place. System UEC improvement programme finalised. Local UEC improvement programme under development.	System UEC action plan. Support from NHSEI MFFD and criteria to reside.

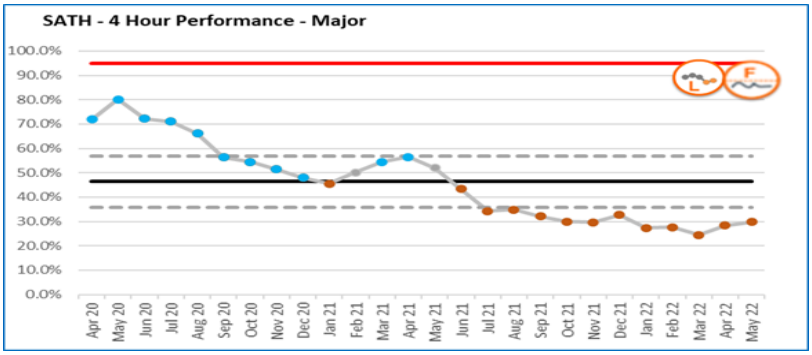
ED Minors performance



May 2022 actual performance
89.1%
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.	Performance has fluctuated in recent months, with a fall in May outside the process control limit.	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.

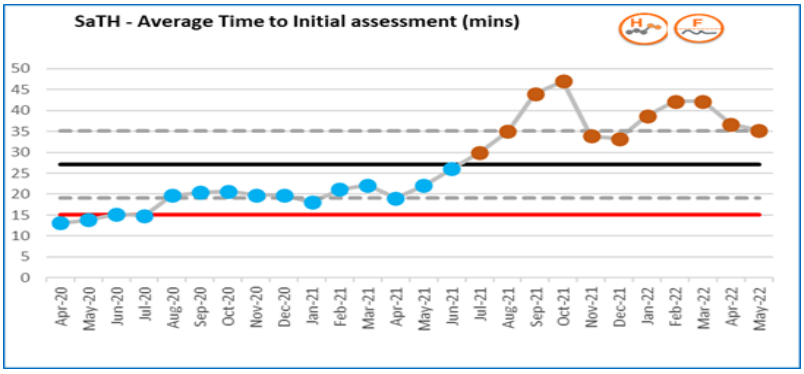
ED Majors performance



May 2022 actual performance
29.8%
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.

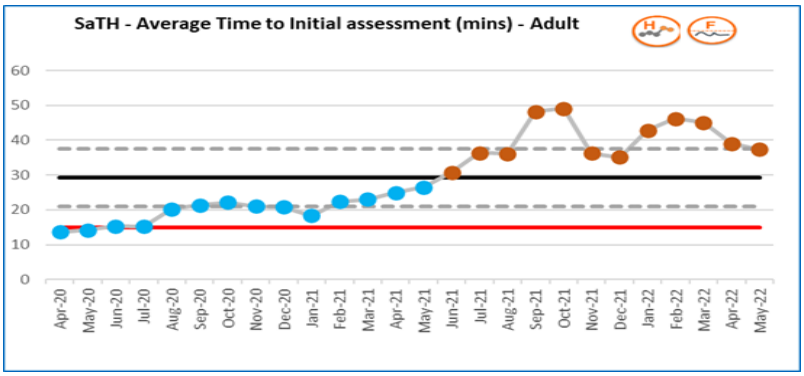
Background	What the Chart tells us	Issues	Actions	Mitigations
The national target is for all patients to be seen treated, admitted, transferred, or discharged within 4 hours of arrival at the emergency department.	Performance has stabilised slightly since the start of this financial year, although remains historically low.	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.	Reconfiguration of wards on RSH to create an acute medical floor. Business case is currently going through Trust and then system sign off. Reconfiguration of RSH ED to enhance patient experience and access to most appropriate area in ED. Extension of PRH SDEC. Finalisation of designs for elective hub required before project can progress. 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. Dedicated Programme Manager and workstream structure in place. System UEC improvement programme finalised. 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)



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

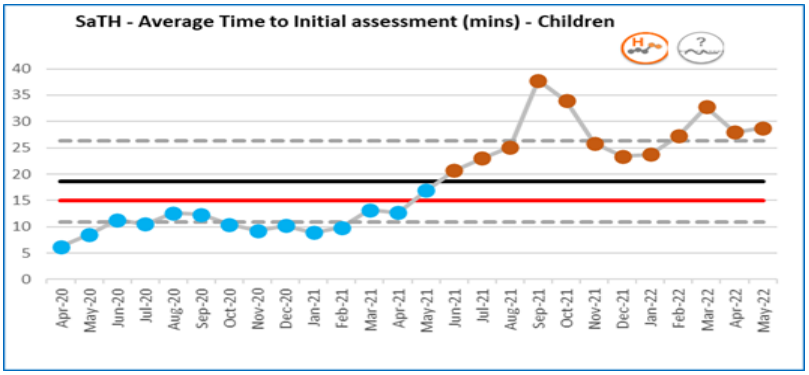
ED Time to initial assessment - adult



May 2022 actual performance
37 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 although it has improved slightly in the last few months. 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 leading task and finish groups focusing on initial assessment times and patients who leave without treatment. Process mapping completed with transformation team support and working groups being established. Recruited 7 WTE band 6 paramedics who will support with initial assessment and due to commence post late June/early July. Work to increase SDEC throughput and 'pull model' continues and band 7 lead nurse recruited to help standardise and provide consistency across site.	Oversight by divisional director, divisional director of nursing and COO.

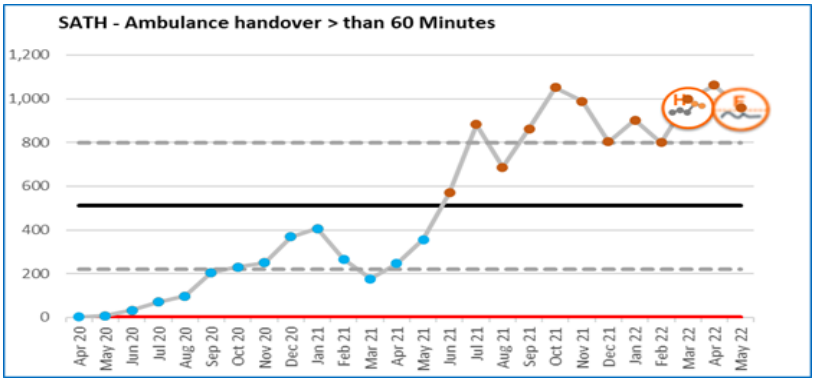
ED time to initial assessment - children



May 2022 actual performance
29 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.	Band 7 paediatric lead (Senior Sister) planning initial assessment trail for paeds in early July supported by transformation team. Paediatric support to ED remains inconsistent due to staffing issues and capacity in PAU. Children and young person assessment area opened at RSH and reviewing PRH estate to identify opportunities to expand assessment capacity. Play therapists now fully recruited and in post, cross site and patient feedback has been extremely positive. Matrons leading task and finish groups focusing on initial assessment times and patients who leave without treatment. Process mapping completed with transformation team support and working groups being established	Oversight by divisional director, divisional director of nursing and COO. .

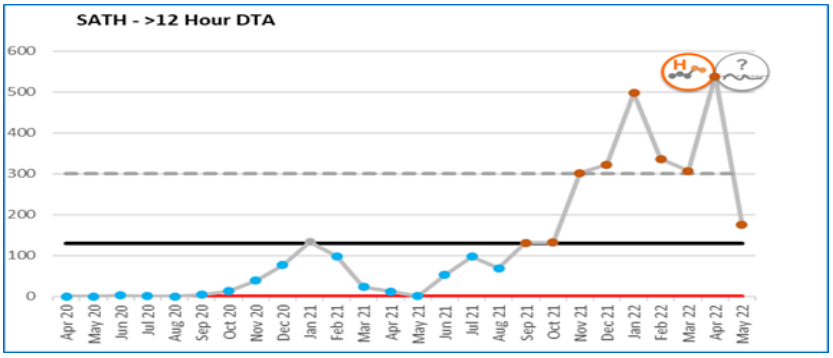
Ambulance handover> 60 Mins



May 2022 actual performance
958
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 & WAS. Single point of access for redirection in the system. Reconfiguration of wards on RSH to create an acute medical floor and direct admission pathways within T&O and oncology. Business case is currently going through the Trust and then system sign off. Validation of category 3&4 patients by WMAS to avoid conveyance. Virtual ward for respiratory and frailty to increase discharges. System UEC improvement programme finalised. Local UEC improvement programme under development.	System UEC action plan. System transformation group. Focussed system IDT. .

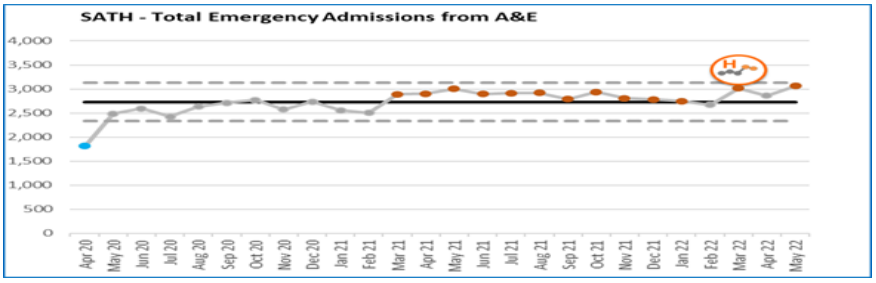
12 Hour ED trolley waits



May 2022 actual performance
176
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.	Performance has improved considerably this month, with less than half the number of 12 hour waits than in April. However, this remains well above the target and the level seen last year.	There has been a significant increase in both the number and length of stay for MFFD patients, which has impacted on flow from the departments. There is a known shortfall in medical bed capacity to meet demand. Increase in COVID -19 presentations has impacted on flow due to the necessity to segregate patients.	Reconfiguration of wards on RSH to create an acute medical floor. Business case is currently going through Trust and then system sign off. Reconfiguration of RSH ED to enhance patient experience and access to most appropriate area in ED. Final stage of works commencing week of the 20th of June. Expected completion date end of July. Extension of PRH SDEC – agreed design may have to be altered due to space required for new elective hub. Finalisation of designs for elective hub required before project can progress. Improved use of SDEC including direct access from WMAS & WAS in place. 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. Dedicated programme manager and workstream structure in place. System UEC improvement programme finalised. Local UEC improvement programme under development. Direct access plans in place as part of acute floor reconfiguration to reduce footfall in ED. Embed ownership of Internal Professional Standards (IPS).	ED Safe Today processes in place to mitigate risk where possible within the department.

Total emergency admissions from A&E



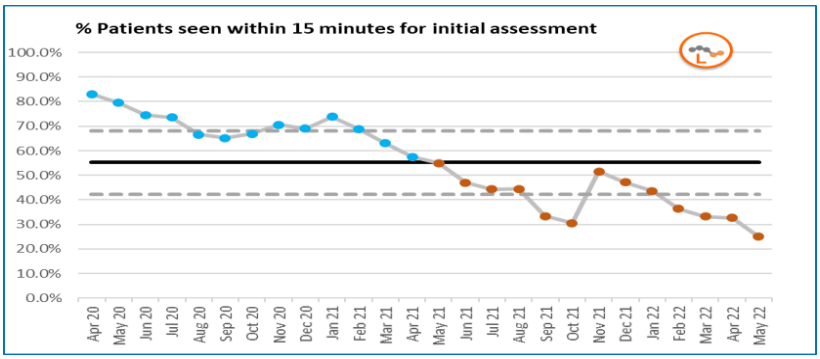
May 2022 actual performance
3065
Variance Type
Special Cause Concern
National Target
N/A

Background	What the Chart tells us	Issues	Actions	Mitigations
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 were particularly high in May, breaching 3,000 for the month.	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 finalised.	System wide plans to avoid admission and use of virtual ward and other pathways.

UEC metrics – shadow reporting.

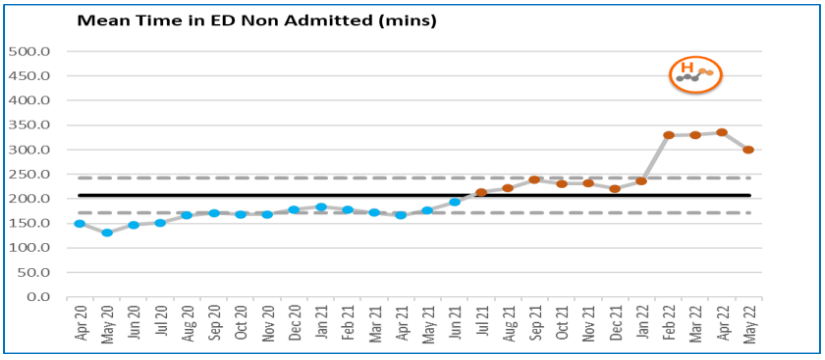
The measures below are reported in shadow form ahead of adoption expected nationally for 2022-23.

% Patients seen within 15 minutes for initial assessment



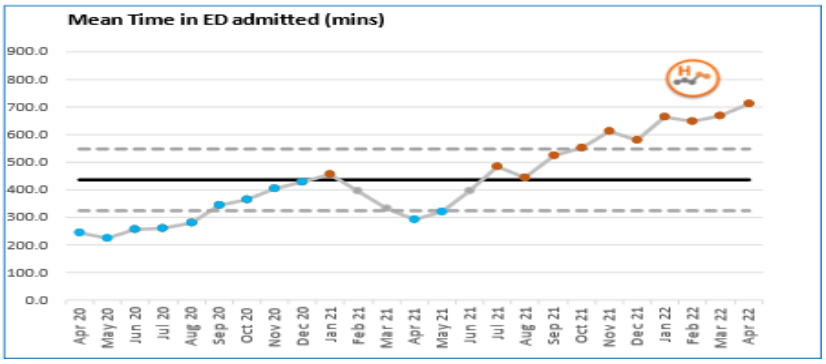
May 2022 actual performance
25%
Variance Type
Special Cause Concern
National Target
n/a

Mean time in ED non-admitted (minutes)



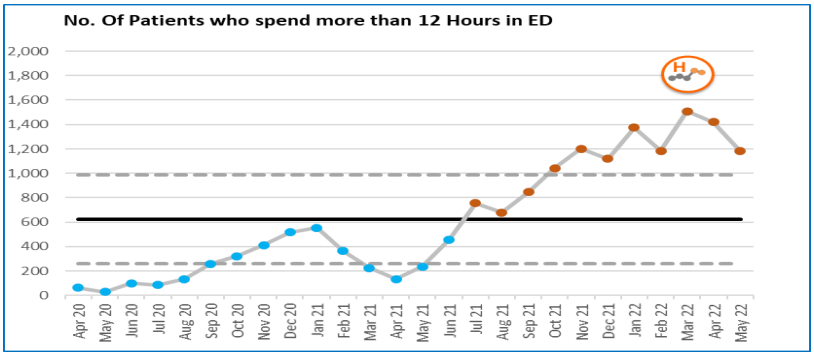
May 2022 actual performance
300
Variance Type
Special Cause Concern
National Target
n/a

Mean time in ED admitted (minutes)



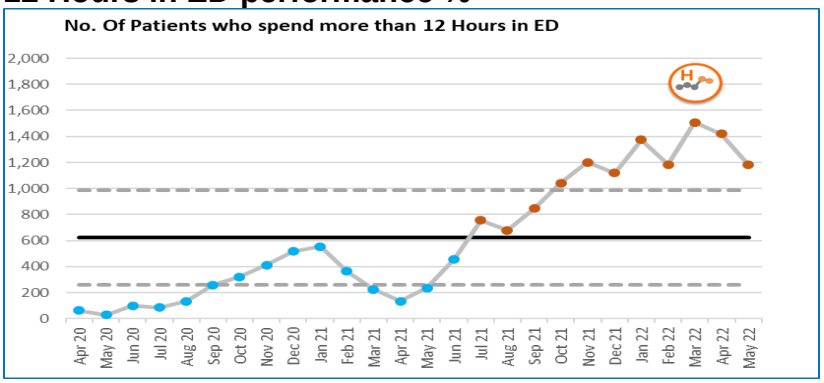
May 2022 actual performance
617.7
Variance Type
Special Cause Concern
National Target
n/a

Number of patients who spend more than 12 hours in ED



May 2022 actual performance
1181
Variance Type
Special Cause Concern
National Target
n/a

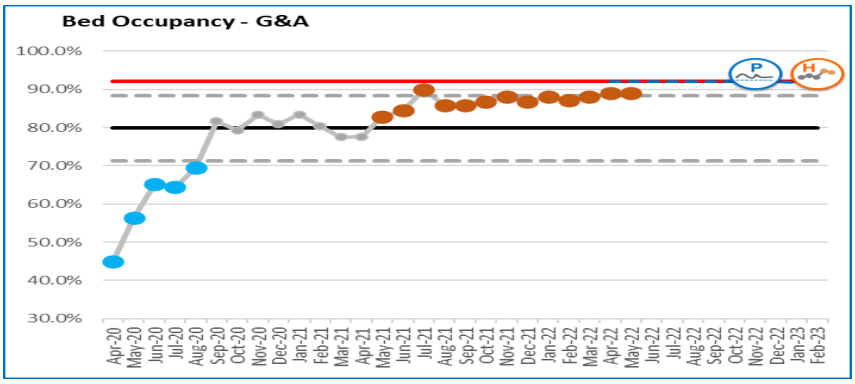
12 Hours in ED performance %



May 2022 actual performance
8.7%
Variance Type
Special Cause Concern
National Target
N/A

Hospital occupancy and activity

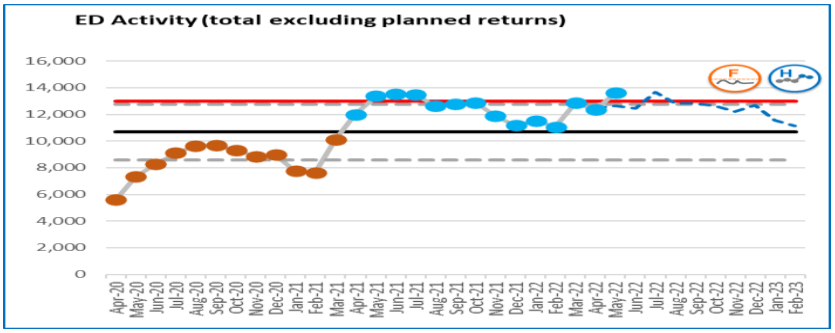
Bed occupancy



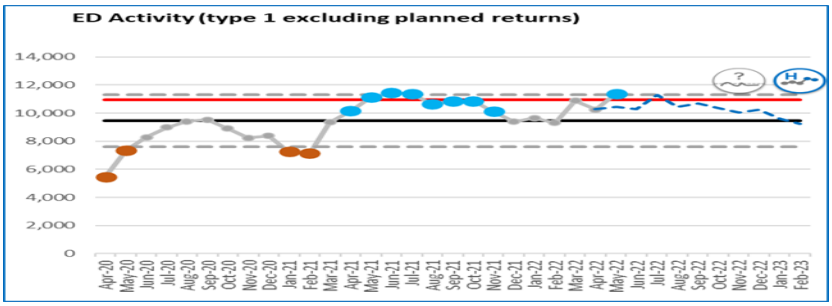
May 2022 actual performance
89%
Variance Type
Special Cause Concern
Local Target
92%
Target / Plan Achievement
Operational plan (22-23)

Background	What the Chart tells us	Issues	Actions	Mitigations
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 and chaired by MEC divisional manager to re-configure ward allocation and align more closely to specialty requirements for 2022-23.

ED Activity



May 2022 actual performance
13604
Variance Type
Special Cause Improvement
Local Target
13604 (Monthly Average)
Target/ Plan achievement
22-23 Operational plan



May 2022 actual performance
11386
Variance Type
Special Cause Improvement
Local Target
11386 (Monthly Average)
Target/ Plan achievement
22-23 Operational plan

Background	What the Chart tells us	Issues	Actions	Mitigations
The ED activity levels reflect the demand for unscheduled care presenting at the A&E departments. Type 1 activity is the major A&E activity and excludes minor injury unit and urgent care centre activity.	Activity for May was higher than average and exceeded the planned value for the month.	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.	Reconfiguration of wards on RSH to create an acute medical floor. Business case is currently going through Trust and then system sign off. Reconfiguration of RSH ED to enhance patient experience and access to most appropriate area in ED. Final stage of works commencing week of the 20th of June. Expected completion date end of July. Primary care streaming trial took place in May. Initial feedback and summary data presented with plan to review next steps in June. Extension of PRH SDEC – agreed design may have to be altered due to space required for new elective hub. Finalisation of designs for elective hub required before project can progress. Improved use of SDEC including direct access from WMAS & WAS in place. 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. Dedicated Programme Manager and workstream structure in place. System UEC improvement programme finalised. Local UEC improvement programme under development. Re-direction programme of improvement to commence on the PRH site before the end of 2022-23.	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. The formal tracking process for monitoring performance against the plan in 2022-23 has been agreed and the year-to-date performance can be seen in the table below:

Total first outpatient attendances	April	May	YTD
19/20 Baseline	14,420	15,850	30,270
22/23 Actual	14,487	17,146	31,633
22/23 Forecast	16,116	17,120	33,236
Actual/Forecast % vs Baseline	100.5%	108.2%	104.5%
vs plan	-11%	0%	-5%
Actual vs plan	89.9%	100.2%	95.2%

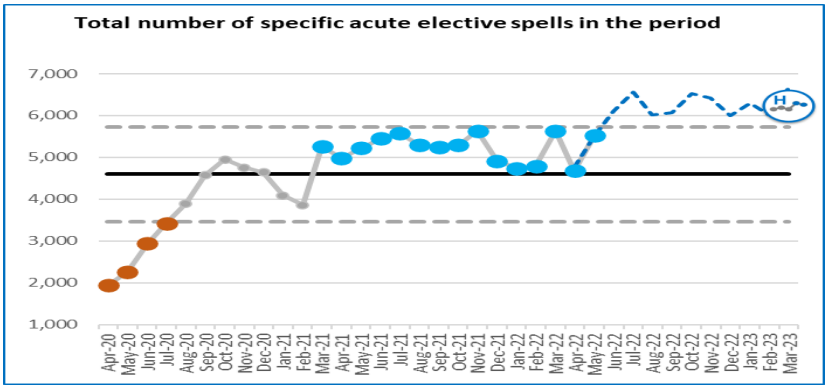
Total follow up outpatient attendances	April	May	YTD
19/20 Baseline	29,958	30,804	60,762
22/23 Actual	27,113	29,047	56,160
22/23 Forecast	29,229	29,093	58,322
Actual/Forecast % vs Baseline	90.5%	94.3%	92.4%
vs plan	-7%	0%	-4%
Actual vs plan	92.8%	99.8%	96.3%

Total number of specific acute elective spells in the period	April	May	YTD
19/20 Baseline	329	385	714
22/23 Actual	193	296	489
22/23 Forecast	163	279	442
Actual/Forecast % vs Baseline	58.7%	76.9%	68.5%
vs plan	9%	4%	7%
Actual vs plan	118.4%	106.0%	110.5%

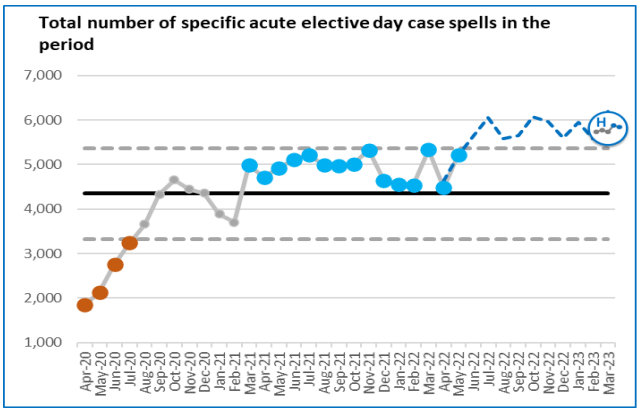
Total number of specific acute elective day case spells in the period	April	May	YTD
19/20 Baseline	4,997	5,434	10,431
22/23 Actual	4,477	5,225	9,702
22/23 Forecast	4,560	5,123	9,684
Actual/Forecast % vs Baseline	89.6%	96.2%	93.0%
vs plan	-2%	2%	0%
Actual vs plan	98.2%	102.0%	100.2%

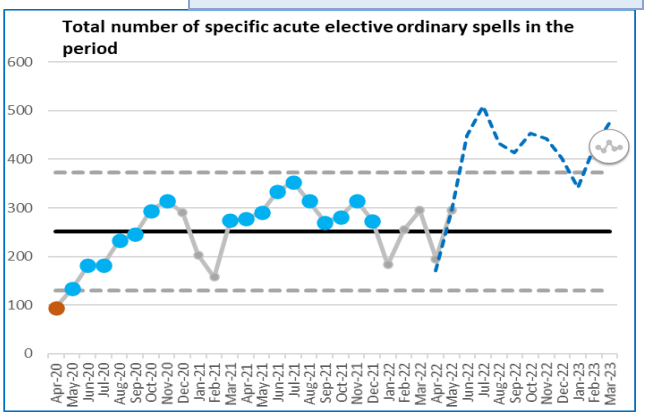
Number of specific acute non-elective spells in the period	April	May	YTD
19/20 Baseline	4,809	5,120	9,929
22/23 Actual	4,511	4,809	9,320
22/23 Forecast	5,659	5,612	11,271
Actual/Forecast % vs Baseline	93.8%	93.9%	93.9%
vs plan	-24%	-16%	-20%
Actual vs plan	79.7%	85.7%	82.7%

Total elective inpatient and day case activity



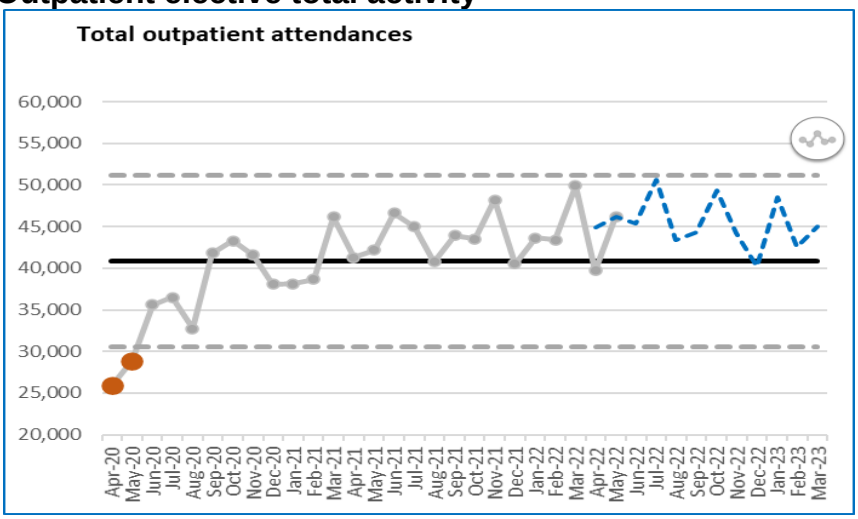
May 2022 actual performance
5521 (DC 5225, IP 296)
Variance Type
Special Cause Improvement
Local Target
5827 (5225 English 22-23 plan + 602 Welsh actual)
Target/ Plan achievement
(22-23 operational plan)



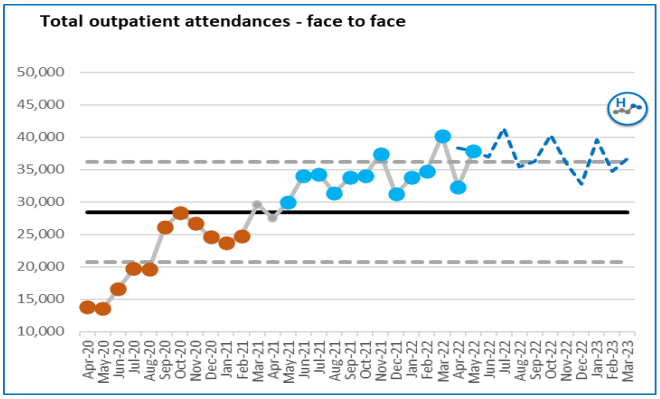


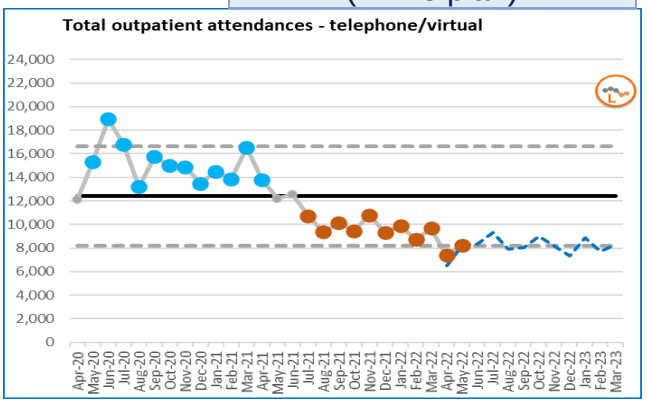
Background	What the Chart tells us	Issues	Actions	Mitigations
The Trust is working to recover services in line with the level of activity delivered in 2019-20, which is being used as a baseline. The Trust has developed an activity plan for 2022-23. This aims to optimise the internally available capacity to address urgent elective cases, to increase capacity and reduce the longest waits for routine surgery.	Overall activity remains low. The planned figure for May was submitted as the actual completed. There is a significant increase in the plan for June that may be a challenge to achieve.	Reduced theatre capacity and theatre staffing constraints. Emergency pressures impacting on elective bed base.	Clinical prioritisation of patients in terms of PL2 and PL2Cs and patients waiting a long period of time. 642 processes for theatre allocation. Weekly restore and recovery meeting with specialties. Restoration of elective orthopaedics from 20.6.2022 will support elective orthopaedics and give 8 ring fenced day-case beds while DSU PRH remains escalated.	As actions.

Outpatient elective total activity

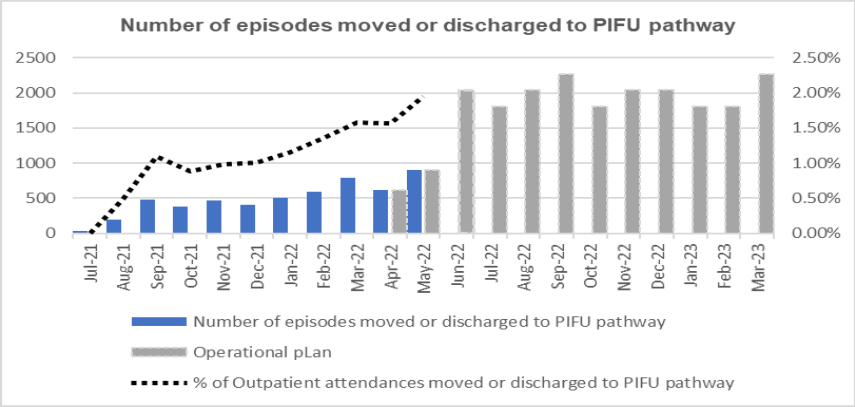


May 2022 actual performance
46193 (excl. TFC 812) Face to face – 37933 Telephone/Virtual - 8260
Variance Type
Common Cause
Local Target
46193 (42054 English 22-23 plan + 4139 Welsh actual)
Target/ Plan achievement
(22-23 plan)





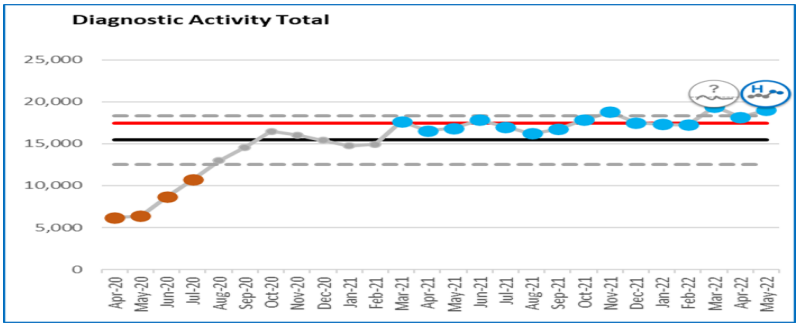
Background	What the Chart tells us	Issues	Actions	Mitigations
The operational activity plan aims to recover activity for 2022-23. In addition, transformation is expected to support new ways of working such as virtual activity, patient initiated follow up (PIFU) and increased use of advice and guidance. Large proportion of outpatient activity has returned to face to face, but we are working with teams on outpatient transformation in terms of PIFU, virtual and A&G in line with the 22/23 targets.	Increase in activity. Our compliance against PIFU is improving. Proportion of face-to-face activity has increased.	Some outpatient capacity constraints remain, and this is having an impact on running clinics. Delivery of the plan itself does not eliminate the backlog of waits created during the pandemic. PIFU and the volume of virtual consultations has declined, as some patients do need to be seen and examined.	CD for outpatient transformation is working with the clinical teams and operational teams to further develop trajectories around PIFU and virtual. Options to increase capacity being explored and different ways of working. Clinical priority of patients. Activity monitored via RTT and outpatient transformation groups.	Clinical prioritisation of patients.



May 2022 actual performance
902 (2%)
Variance Type
Common Cause
Local Target
902 (22-23 plan)
Target/ Plan achievement
NHSEI target 5% of total OP attendances

Background	What the Chart tells us	Issues	Actions	Mitigations
The PIFU target by March 2023 is 5%	Our compliance against PIFU is improving although remains below the 5%.	PIFU and the volume of virtual consultations has declined, as some patients do need to be seen and examined.	Working with the specialties to further develop clinical lead specialty specific trajectories as per of the outpatient transformation work which will be monitored weekly via RTT and monthly at the internal and external outpatient transformation meetings and escalated as needed.	As actions.

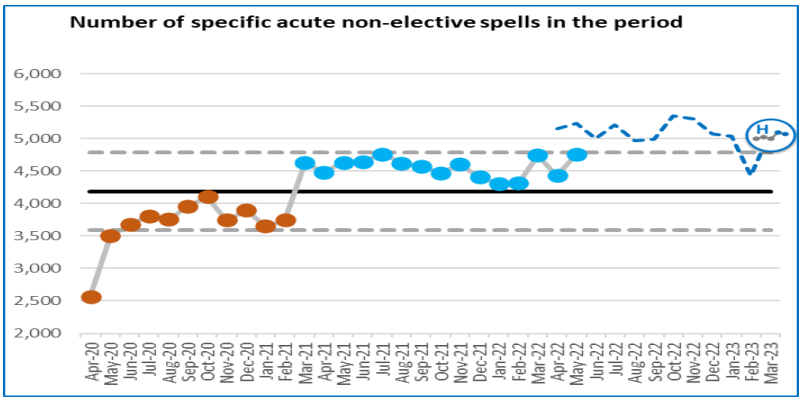
Diagnostics recovery



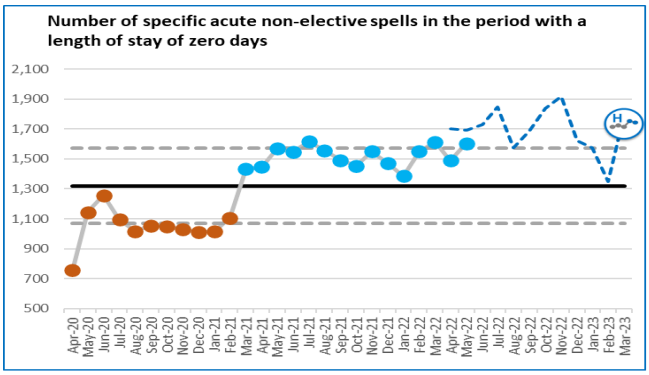
May 2022 actual performance
19003
Variance Type
Special Cause Improvement
Local Target
TBC
Target/ Plan achievement
(22-23 plan)

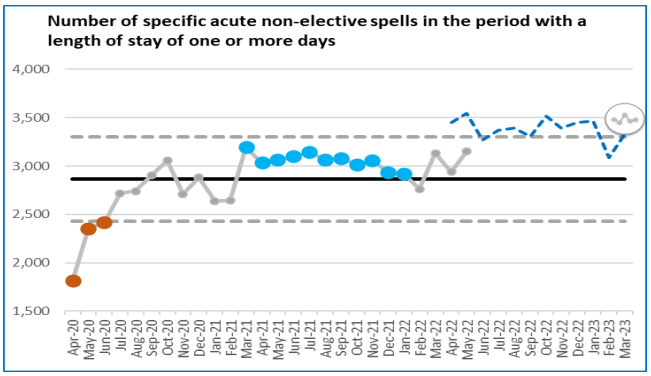
Background	What the Chart tells us	Issues	Actions	Mitigations
Diagnostic activity is made up of the number of tests/procedures carried out during the month; it contains imaging, physiological measurement, and endoscopy tests.	Actual performance in May has exceeded the local target. Activity increased >2,000 compared to April.	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. Review of appointment templates to take place in light of an expected change IPC guidance. This may increase available capacity.	Use of bank and agency when available. Mobile scanners on site. Insourcing US and breast. Use of voluntary overtime.

Non-elective activity



May 2022 actual performance
5186
Variance Type
Special Cause Improvement
Local Target
5537 (5107 English 22-23 plan + 430 Welsh actual)
Target/ Plan achievement
(22-23 plan)

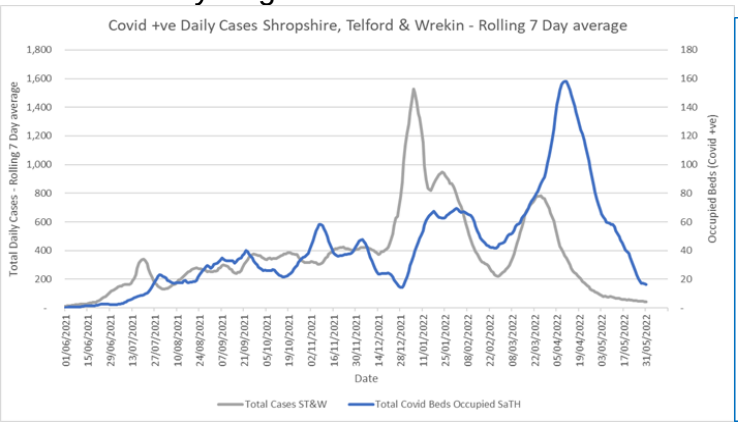


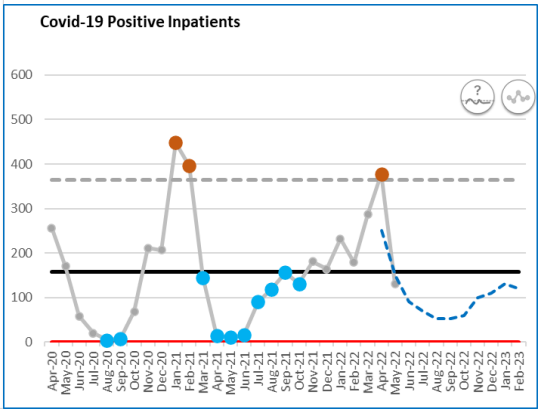


Background	What the Chart tells us	Issues	Actions	Mitigations
Non-elective activity reflects the demand from unscheduled care for admissions to hospital. It represents the greatest demand on beds and increases can result in constraints on elective activity, while reductions impact negatively on contract income.	Non elective activity has increased.	Increase in non-elective activity. Flow issues across both sites.	Dedicated CEPOD surgeon to support surgical emergency demands.	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 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, especially in light of the new variant modelled to impact the Trust in July/August.





Operational performance benchmarking

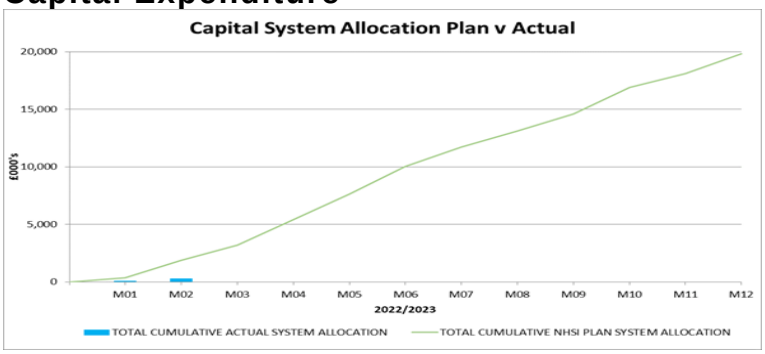
This table demonstrates the benchmarked position of the trust at a point in time compared to other English trusts reporting the same indicator. The icon shows the trend of ranking over time of the trust in relation to other trusts.

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.
- At the end of month two, the Trust has recorded a year-to-date deficit of £5.453m against a draft planned deficit of £3.656m, an adverse variance to plan of £1.797m.
- The year-to-date deficit is driven by:
    - Pay costs, excluding covid and ERF are £3.57m adverse to plan. This is driven by an increase in agency expenditure, especially off-framework bookings in both April and May for nursing, opening of unfunded escalation areas and increases in substantive staffing with no corresponding decrease in temporary expenditure due to supernumerary periods.
    - Covid costs (in envelope) are £2.23m which is £1.017m adverse to the draft plan. There is an expectation that Covid costs will begin to reduce over Q1 as Covid prevalence drops within the community, however escalation areas remain open.
    - Elective recovery costs are £1.57m which is £0.13m overspent against plan which is driven by increased activity levels compared to plan.
    - However, elective activity as a whole remains below plan resulting in a non-pay underspend of £2.1m which has mitigated the above adverse variances to a degree.
- As a result of the year-to-date variance the executive team have set up a weekly group to ensure there is oversight of the strengthening of financial governance measures.
- £0.38m of efficiency savings has been delivered year-to-date against an evenly phased plan of £1.28m. The efficiency programme has been formally launched during quarter one with a combination of Trust wide and local divisional schemes and as such delivery is expected to be low during the quarter. Of the target of £7.66m for 2022/23, £2m of these are to be identified at a divisional level.
- For 2022/23 the Trust's system allocation for capital is £19.822m. Planned expenditure at Month two was £1.876m, of which £0.315m has been incurred. The capital plan will be rephased in the final operating plan submission.
- The Trust held a cash bank balance at the end of May 2022 of £14.145m.

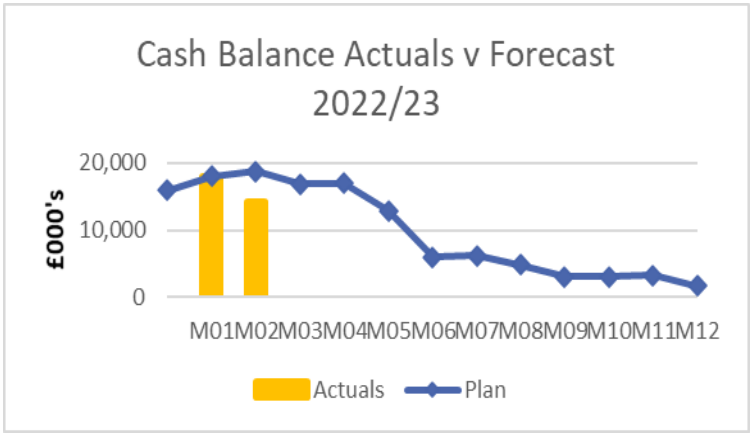
Capital Expenditure



May 2022 actual performance	
Spend year to date is £0.315m	
Variance Type	
Underspend of £1.561m	
National Target	**Forecast**
£19.822m	£19.822m
Target/ Plan achievement	
To meet he Trust's capital resource limit (CRL)at year-end.	

Background	What the Chart tells us	Issues	Actions	Mitigations
For 2022/23 the Trust's system allocation is £19.822m. Included within this is the continuation of the endoscopy reconfiguration of £0.925m, with sales proceeds to match this expenditure.	Within the submitted plan it was projected that expenditure of £1.876m would be incurred in May 2022, the actual expenditure as at M2 was £0.315m. The main drivers for the under delivery in M2 are the continued delay in planned delivery of the endoscopy reconfiguration (£0.363m); delay in offsite renal scheme (£0.485m) and estates backlog schemes (£0.332m).	No issues of concern.	The Trust is submitting a revised plan in June, in which the capital programme has been reprofiled based on project managers revised expenditure profiles and it is against this plan, that the Trust will report in future months.	No mitigations required.

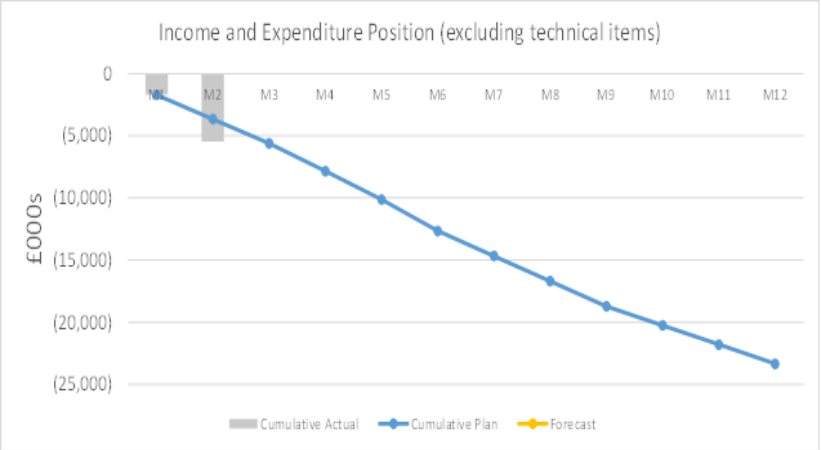
Cash



May 2022 actual performance
£14.145m 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 plan submission of I&E deficit of £23.330m and projected changes in working capital balances.	The cash balance brought forward in 2022/23 was £15.918m with a cash balance of £14.145m held at end of May 2022 (ledger balance of £14.054m due to reconciling items).	No issues of concern currently.	Following plan resubmission in June, the cashflow will be reforecast and a review of the assumptions within the cashflow will be undertaken.	No mitigations required.

Income and Expenditure Position

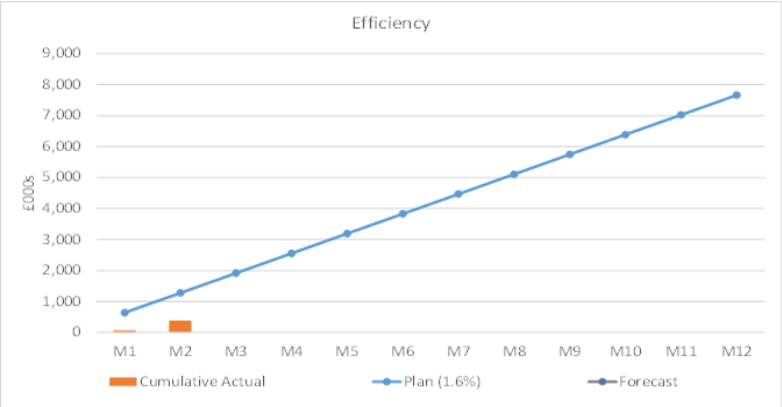


May 2022 actual performance	
(£5.453m) Deficit at month two.	
Variance Type	
Deficit variance of (£1.797m)	
National Target	**SaTH Plan 2021/22**
Breakeven	(£22.330m) *
Target/ Plan achievement	
(£22.330m) Deficit full year*	

*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 year-to-date deficit of £5.453m at month two which is £1.797m adverse to the plan submitted to NHSEI in April. The year-to-date deficit is predominantly related to pay expenditure which is driven by premium cost staffing amongst both medical staffing and nursing.	High usage of off-framework agency nursing in both April and May. Continued use of unfunded escalation areas. Increase in substantive staffing yet to result in reductions in temporary staffing expenditure. Continued escalated bank rates across numerous areas within the Trust.	Monitoring of agency nurse booking reasons and deep dives into high usage areas. Job planning for consultants and sign off of junior doctor rotas. Review of escalation areas with a view to close where appropriate. Review of all enhanced bank payments to ensure exit plans are in place.	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

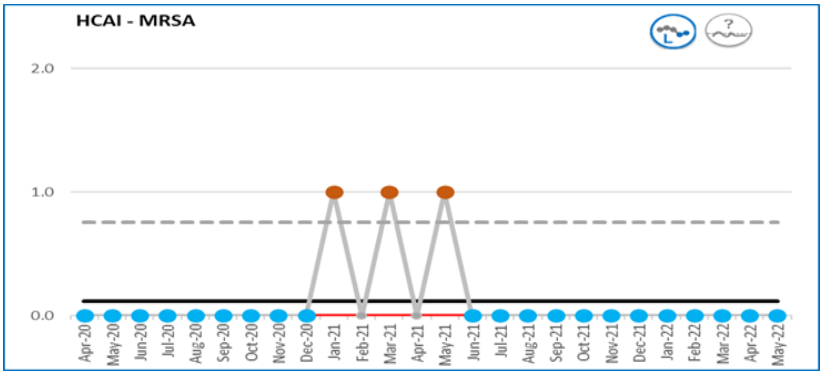


May 2022 actual performance
Year to Date Delivery of £0.379m
Variance Type
Adverse to plan (£0.898m)
SaTH Plan 2022/23
£7.660m
Target/ Plan achievement
Full achievement by year end

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 and MSK big ticket items **(**BTI's) are also required in 2022/23 of which the Trust has a share totalling £3.0m for workforce and £0.1m for MSK.	The Trust delivered £0.379m of efficiency savings year to date at the end of month two which is £0.898m 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

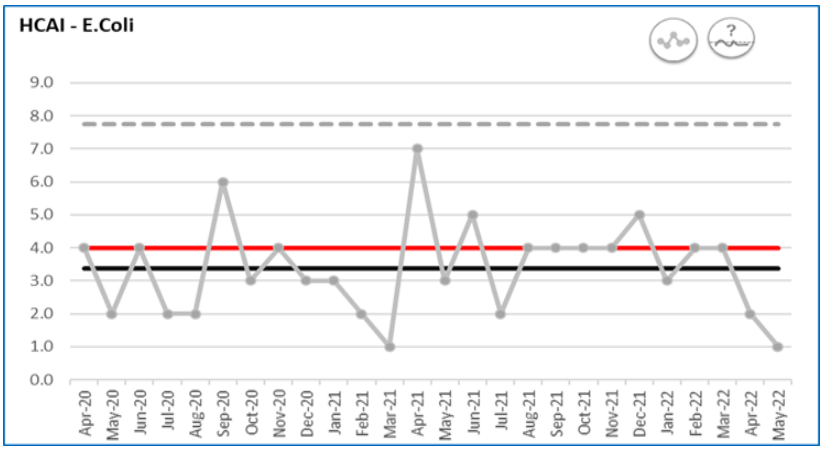
MRSA



May 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 has 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.

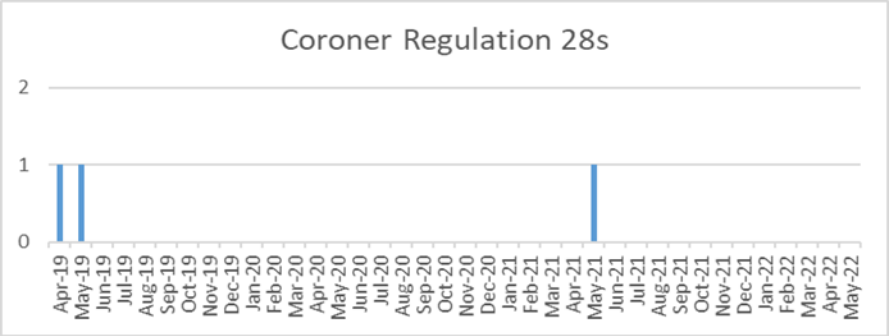
E-Coli



May 2022 actual performance
1
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 was1 case of E. Coli bacteraemia in May 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.	There was 1 case of E. Coli bacteraemia in May 2022 that was taken post 48 hours of admission.	HCAI actions, and actions from previous RCAs which include consistent use of catheter insertion documentation. Catheter care plan and 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.

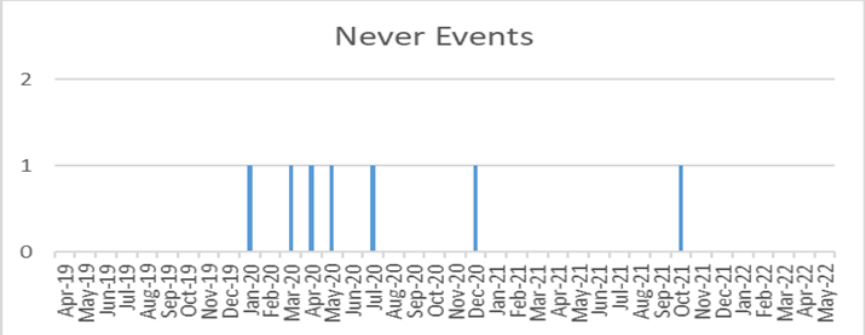
Coroner Regulation 28s



May 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.

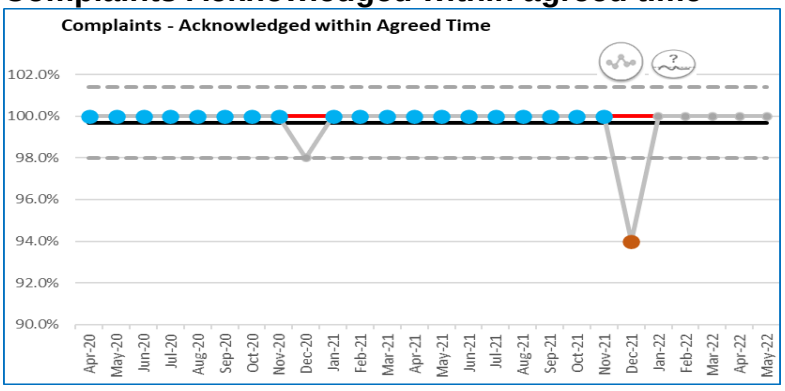
Never Events



May 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.

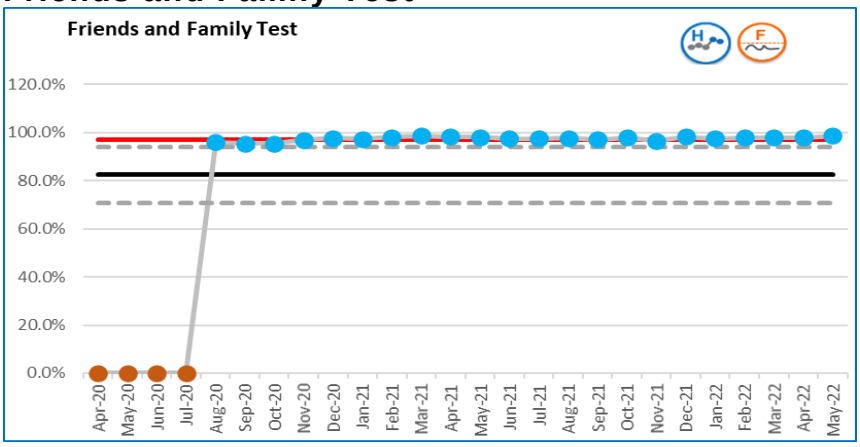
Complaints Acknowledged within agreed time



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

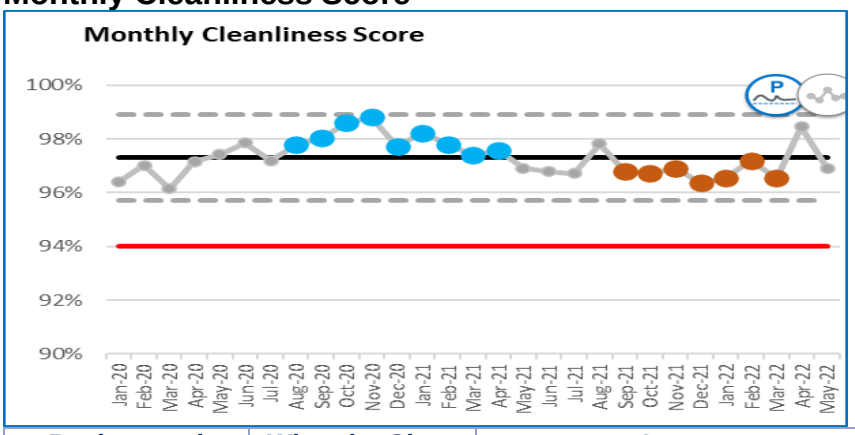
Background	What the Chart tells us	Issues	Actions	Mitigations
Acknowledging a complaint on receipt is important for patients raising concerns to both ensure that the patient knows we have received the complaint and that we are addressing it.	The target of three working days continues to be met, with 97% of complaints acknowledged within one working day.	No issues	No actions.	No mitigations.

Friends and Family Test



May 2022 actual performance
98.8%
Variance Type
Special Cause Improvement
National Standard
85%
Target/ Plan achievement
Target achieved consistently

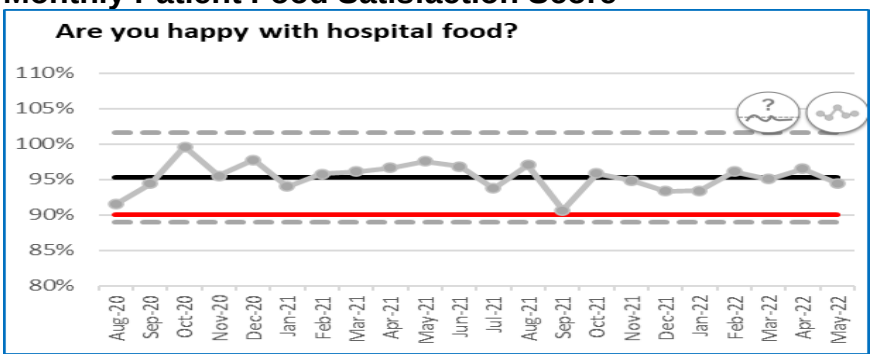
Monthly Cleanliness Score

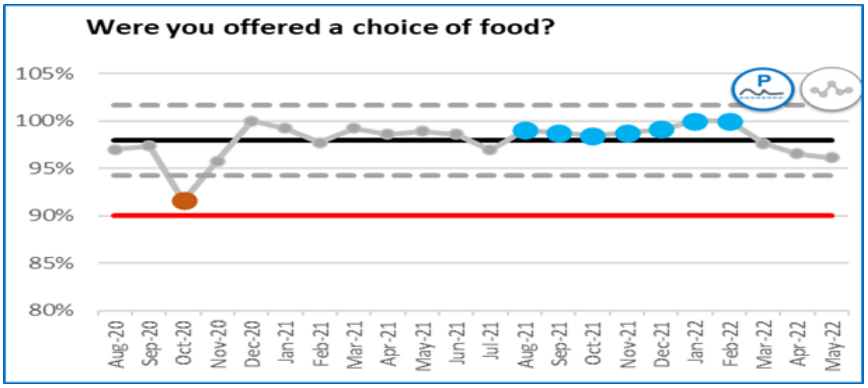


May 2022 actual performance
96.9%
Variance Type
Common Cause
Local SaTH standard
94%
Target/ Plan achievement
On target to achieve above local standard

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.	There was a slight decrease. This month as the score fell to just below the mean.	There are high levels of sickness at PRH which combined with some vacancies have resulted in staff from non-clinical areas being used to cover clinical areas – this has resulted in slightly lower scores in circulation spaces.	We continue to use agency and contract staff to cover as many gaps as possible and recruitment is on-going.	No Mitigations.

Monthly Patient Food Satisfaction Score



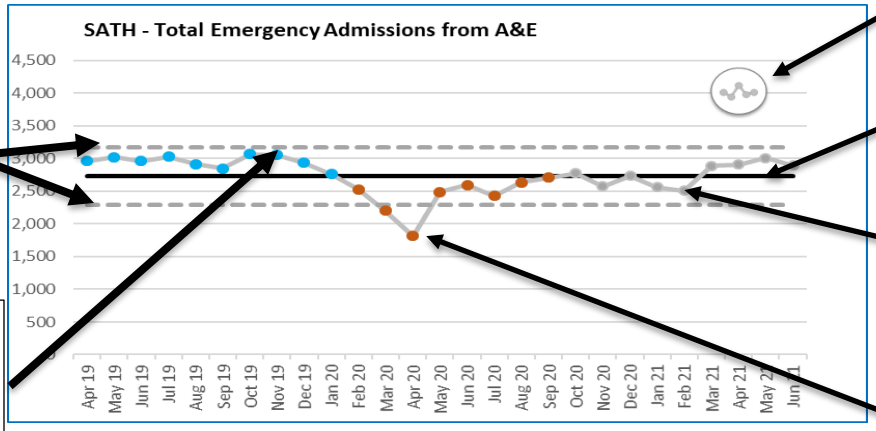


May 2022 actual performance
94.5% for satisfaction with food. 96.2% for satisfaction with choice.
Variance Type
Common Cause
Local SaTH standard
90%
Target/ Plan achievement
On target to achieve local standard

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

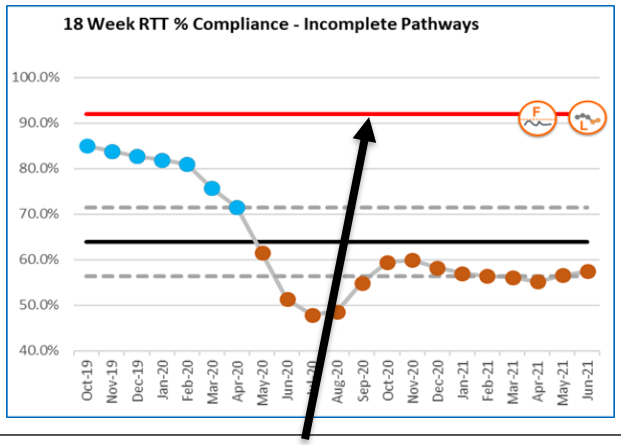
Mean or median line

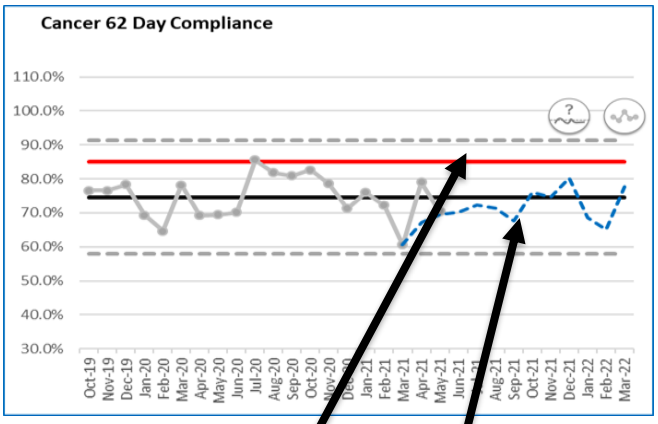
Common cause variation

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