Board of Directors' Meeting
11 August 2022

Agenda item	151/22			
Report Title	Integrated Performance Report			
Executive Lead	Louise Barnett, Chief Executive Officer			
Report Author	Helen Troalen, Director of Finance			
	Link to strategic goal:		**Link to CQC domain:**	
	Our patients and community	√	Safe	√
	Our people	√	Effective	√
	Our service delivery	√	Caring	√
	Our governance	√	Responsive	√
	Our partners	√	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:	2022.07.19: Quality Operational Committee 2022.07.26: Finance and Performance Assurance Committee 2022.07.27 Quality and Safety Assurance Committee 2022.07.28 Senior Leadership Committee – Operational			
Executive summary:	This report provides an overview of the performance indicators of the Trust to the end of June 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.			
Appendices	Appendix 1: Indicators performing in accordance with expected standards. Appendix 2: Understanding SPC charts. Appendix 3: Glossary of terms			
Executive Lead				

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.

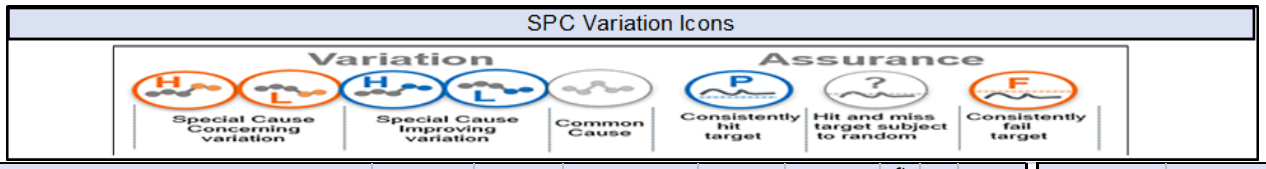
The Board of Directors integrated performance report is aligned to the Trust's functional domains and includes an overarching executive summary.

Table of Contents

1. Executive Summary
Louise Barnett, Chief Executive

- We had seen 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 our Infection Prevention & Control policies in relation to COVID-19, and looking to implement fresh 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 aspects 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 colleagues 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 receive at departmental level are crucial for us to be able to respond in a much more targeted way to our colleagues' concerns, and our leadership 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 us now that we are in a new phase of the pandemic. We have reinstated more of our internal performance management processes, and we will, in the coming months, enhance our Getting to Good programme to ensure our key projects 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 extremely challenging again.
- Despite a rise in COVID-19 inpatient case numbers, a range of celebrations took place across the Trust in June to mark the Queen's Platinum Jubilee. It was heartening to see so many of our colleagues joining in with these activities. The celebrations were part of our determination to celebrate events, such as national recognition days and key cultural and religious occasions.

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	0.66							
VTE	QSAC	Apr 22	92%	95%	95%			Yes		95%
Falls - total	QSAC	May 22	6		<70			Yes	255	835
Falls - per 1000 Bed Days	QSAC	May 22	135	6.6	<4.5			Yes	0.0	4.5
Falls - with Harm per 1000 Bed Days	QSAC	May 22	0	0.19	<0.17			Yes	0.00	0.17
Never Events	QSAC	May 22	4	0	0			No	0	0
Coroners Regulation 28s	QSAC	May 22	0		0			No	0	0
Serious Incidents	QSAC	May 22	0						11	
Mixed Sex Breaches	QSAC	May 22	3	0	0			Yes	124	
Patient Experience										
Complaints	QSAC	May 22	64					Yes	122	
Complaints Responded within agreed time	QSAC	May 22	50%	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	Jun 22	6166		6720			No		
Total temporary staff -FTE	FPAC	Jun 22	839					Yes		
Staff turnover rate (excludes junior doctors)	FPAC	Jun 22	1.08%	0.8%	0.75%			Yes	0.96%	0.8%
Sickness absence rate	FPAC	Jun 22	5.7%		4%			Yes	5.1%	4%
Agency Expenditure	FPAC	Jun 22	9.708					Yes	9.708	6.988
Appraisal Rate	FPAC	Jun 22	81%	90%	90%			Yes		90%
Appraisal Rate (Medical Staff)	FPAC	Jun 22	94%	90%	90%			No		90%
Vacancies	FPAC	Jun 22	554 (9.3%)	<10%	<10%			No		<10%
Statutory and Mandatory Training	FPAC	Jun 22	81%	90%	90%			Yes		90%
Trust MCA – DOLS & MHA	FPAC	Jun 22	77%	90%	90%			Yes		90%
Safeguarding Adults - level 2	FPAC	Jun 22	83%	90%	90%			Yes		90%
Safeguarding Children – level 2	FPAC	Jun 22	85%	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	Jun 22	39545					Yes		
RTT Waiting list -English	FPAC	Jun 22	35250		33205			Yes		32944
RTT Waiting list -Welsh	FPAC	Jun 22	4295					Yes		
18 Week RTT % compliance -incomplete pathways	FPAC	Jun 22	57.4%	92%				Yes		
26 Week RTT % compliance -incomplete pathways	FPAC	Jun 22	66.9%	92%				Yes		
52+ Week breaches - Total	FPAC	Jun 22	3049	0				Yes		
52+ Week breaches - English	FPAC	Jun 22	2673	0	2333			Yes		2112
52+Week breaches - Welsh	FPAC	Jun 22	376	0				Yes		
78+ Week breaches - Total	FPAC	Jun 22	315	0				Yes		
78+ Week breaches - English	FPAC	Jun 22	271	0	207			Yes		211
78+ Week breaches - Welsh	FPAC	Jun 22	44	0				Yes		
104+ Week breaches - Total	FPAC	Jun 22	18	0				Yes		
104+ Week breaches - English	FPAC	Jun 22	17	0	55			Yes		0
104+ Week breaches - Welsh	FPAC	Jun 22	1	0	0			Yes		
Cancer										
Cancer 2 week wait	FPAC	May 22	76.6%	93%				Yes	74%	93%
Cancer 62 day compliance	FPAC	May 22	50%	85%				Yes	51%	85%
Cancer 31 Day Compliance	FPAC	May 22	90%	96%				Yes	91%	96%
Cancer 28 Day Faster Diagnosis	FPAC	May 22	64%	75%				Yes	62%	75%
Diagnostics										
Diagnostic % compliance 6 week waits	FPAC	Jun 22	61%	99%				Yes		
DM01 Patients who have breached the standard	FPAC	Jun 22	5920	0	1254			Yes		
Emergency Department										
ED - 4 Hour performance	FPAC	Jun 22	54.4%	95.0%	64%			Yes	57%	
ED - Ambulance handover > 60mins	FPAC	Jun 22	1142	0				Yes	3162	tbc
ED 4 Hour Performance - Minors	FPAC	Jun 22	81.7%	95%	95%			Yes	90%	95%
ED 4 Hour Performance - Majors	FPAC	Jun 22	25.1%	95%				Yes	29%	
ED time to initial assessment (mins)	FPAC	Jun 22	42	15	15			Yes		15mins
12 hour ED trolley waits	FPAC	Jun 22	392	0	0			Yes	1111	
Total Emergency Admissions from A&E	FPAC	Jun 22	2959					Yes	8884	35536
% Patients seen within 15 minutes for initial assessr	FPAC	Jun 22	24%					Yes	27.1%	
Mean Time in ED Non Admitted (mins)	FPAC	Jun 22	318					Yes	285	
Mean Time in ED admitted (mins)	FPAC	Jun 22	697					Yes	658	
No. Of Patients who spend more than 12 Hours in E	FPAC	Jun 22	1563					Yes	4126	
12 Hours in ED Performance %	FPAC	Jun 22	11.8%					Yes	10.5%	
Hospital Occupancy and activity										
Bed Occupancy -G&A	FPAC	Jun 22	90%	92%	91%			Yes		92%
ED activity (total excluding planned returns)	FPAC	Jun 22	13280		12362			No	39223	149762
ED activity (type 1&2)	FPAC	Jun 22	11115		10173			No	32751	123572
Total Non Elective Activity	FPAC	Jun 22	5035		5465			Yes	15082	TBC
Outpatients Elective Total activity	FPAC	Jun 22	44427		49209			Yes	133079	TBC
Total Elective IPDC activity	FPAC	Jun 22	5277		6658			No	15487	TBC
Diagnostic Activity Total	FPAC	Jun 22	18587					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	Jun 22	5.412		1.700			No	5.412	1.700
Efficiency	FPAC	Jun 22	0.839		7.660			No	0.839	7.660
Income and Expenditure	FPAC	Jun 22	(8.353)		(19.135)			No	(8.353)	(19.135)
Cumulative Capital Expenditure	FPAC	Jun 22	0.936		19.822			No	0.936	19.822

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

Note: the quality and safety data is reported a month in arrears to allow for the data to have been scrutinised at the relevant quality governance meetings prior to Board.

MSSA bacteraemia and clostridium difficile remain over target in month and the 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 infection prevention and control operational group (IPCOG) and monitoring will take place via the infection prevention and control assurance committee (IPCAC), chaired by the Director of Infection Prevention and Control (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 important measure.

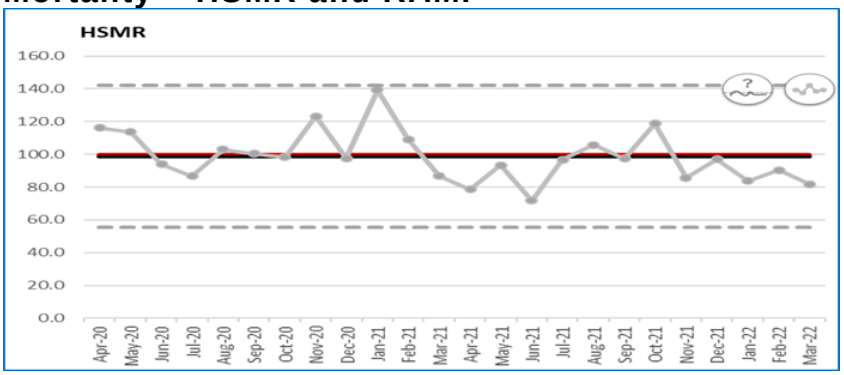
There has been a reduction in same sex accommodation breaches in month. This is attributed to no longer cohorting “COVID-19 contact” patients, which is in line with national guidance. This process is currently being reviewed as the COVID-19 numbers are increasing in June, in line with national trends.

The timeliness of complaint responses 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.

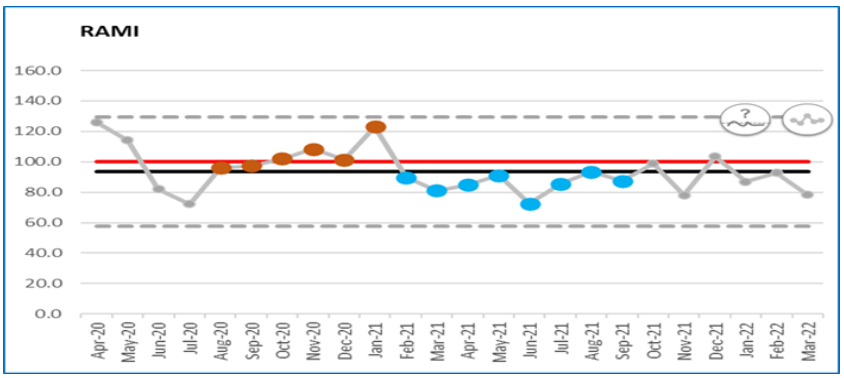
Delivery Suite acuity continues to improve for the third consecutive month, demonstrating that the escalation policy and mitigations are appropriate.

Quality exception reports – Harm

Mortality – HSMR and RAMI



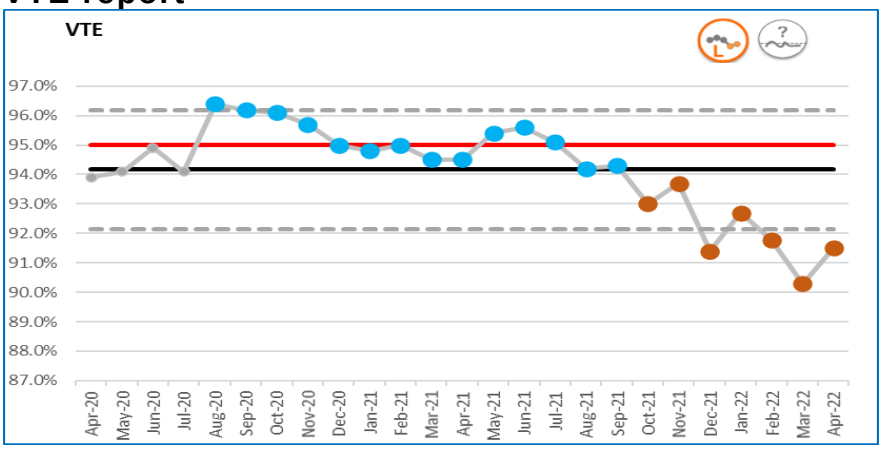
March 2022 actual performance
81.7
Variance Type
Common Cause
National Target
100
Target / Plan Achievement
Note rebasing of national reference level has taken place from this month's data



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 is nearing completion 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.

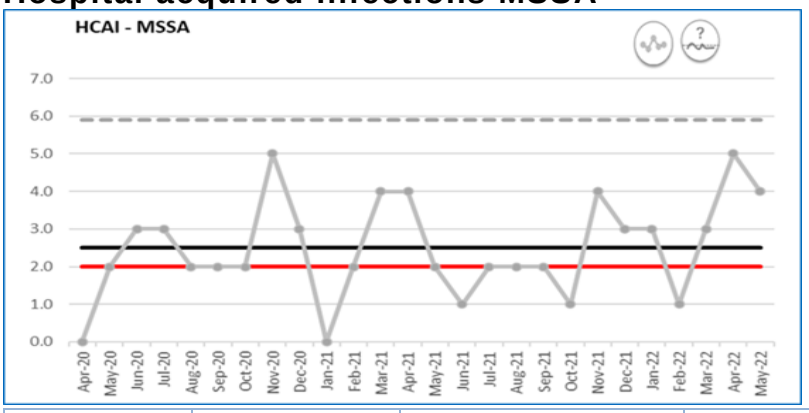
VTE report



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.	VTE assessment continues to be below target	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. Work continues on accurate consultant allocation to support performance management. Project leadership capacity being reviewed, with plan for a new role to be advertised. 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.

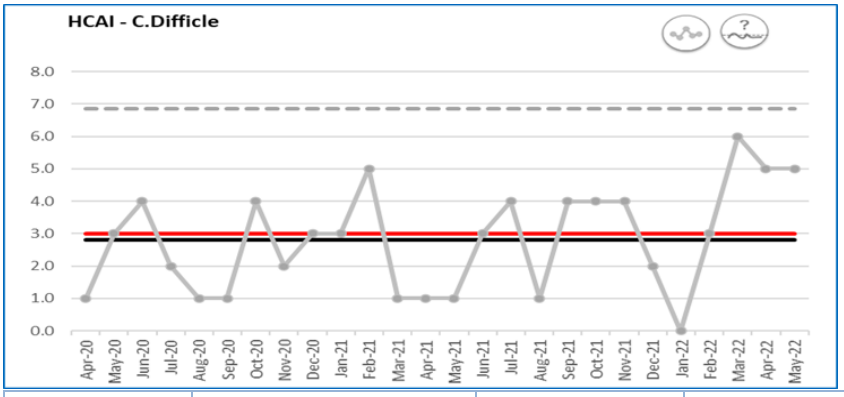
Hospital acquired infections MSSA



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 an infected IV cannula.	Ongoing actions from previous RCAs include ensuring use of catheter care plan and catheter insertion documentation. Staff reminded about correct labelling of blood cultures. ANTT training to be delivered by CPE team. Cannula care/VIPs.	RCA summary and actions from RCAs presented as part of divisional updates monthly at IPCOG. Catheter documentation and cannula care is audited through the monthly matrons' quality audits.

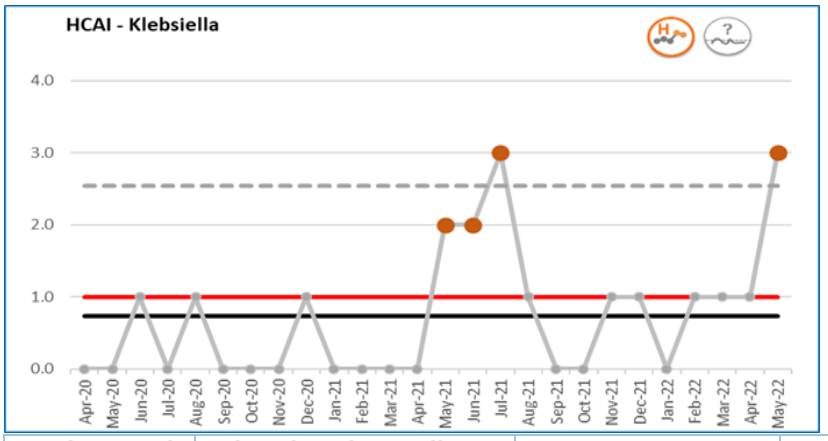
C. Difficile



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. Cases of these have been higher than target for the last three months.	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 samples 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 meetings.	Actions are reported via divisional IPC reports and monitored via the IPCOG as part of their monthly reporting.

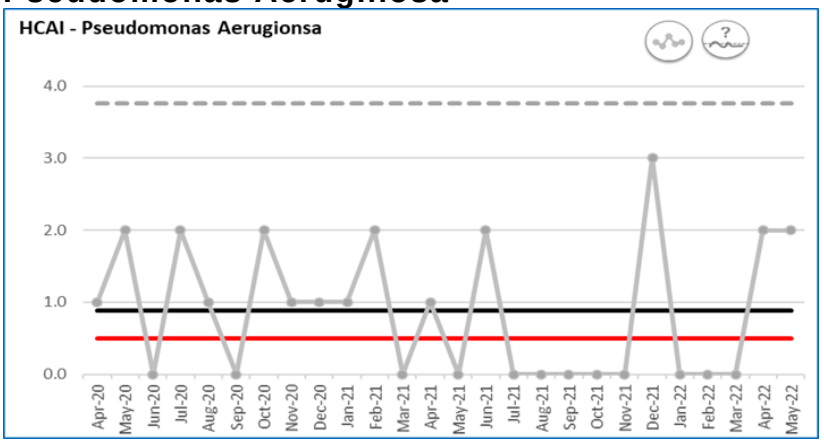
Klebsiella



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 and has triggered a special cause concern. 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 is undertaken, as well as 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.

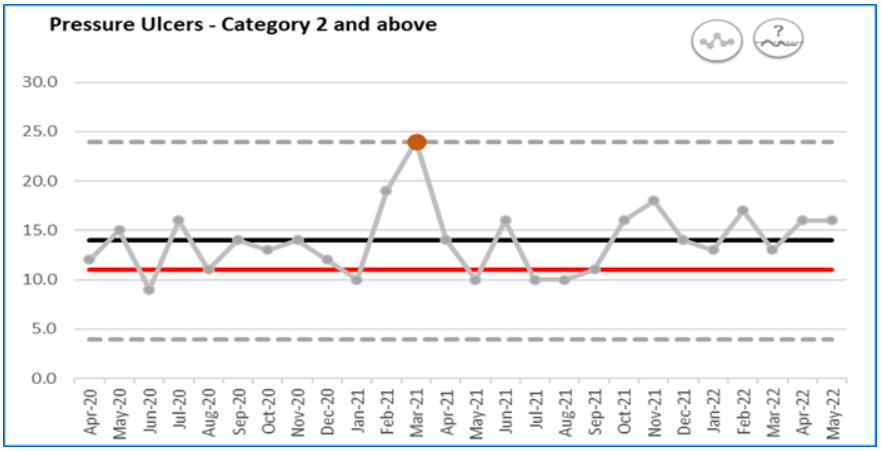
Pseudomonas Aeruginosa



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.

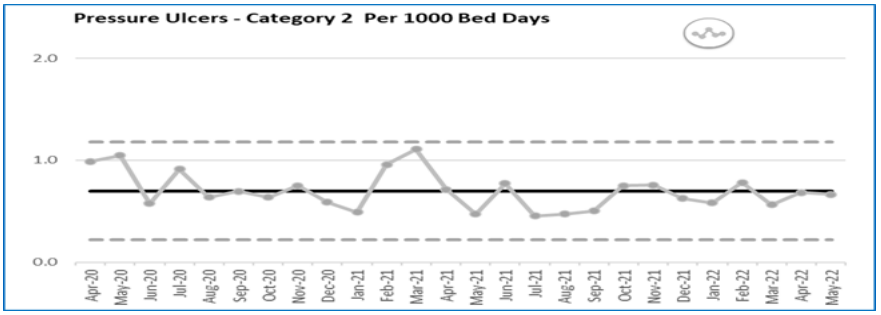
Background	What the Chart tells us	Issues	Actions	Mitigations
Reporting of Pseudomonas is a mandatory requirement.	There have been 2 cases of pseudomonas aeruginosa bacteraemia in May 2022. There have been 4 cases in the first two months of the year, indicating the target of 6 is likely to be exceeded in the next 10 months	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

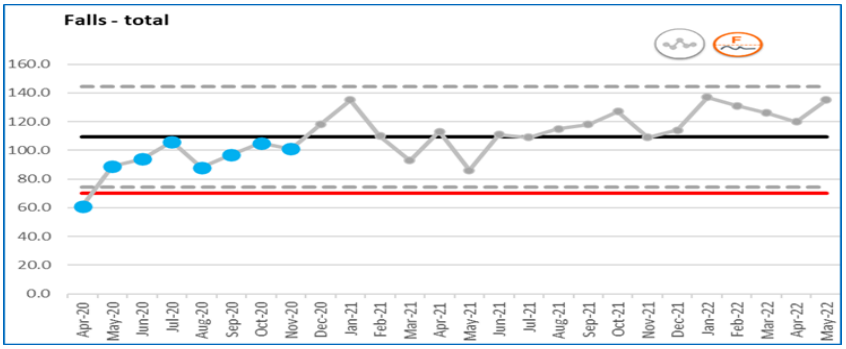


May 2022 actual performance
0.66
Variance Type
Common Cause
Local Standard
tbc

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. This measure remains consistently above the target of 11 cases per month	There were 12 category 2 pressure ulcers and 4 category 3 pressure ulcers which are currently being investigated.	Ongoing actions include tissue viability nurse (TVN) and quality team support for wards with pressure ulcers continues. Tuesday talks with tissue viability team continue. Thematic review of all pressure ulcers 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.

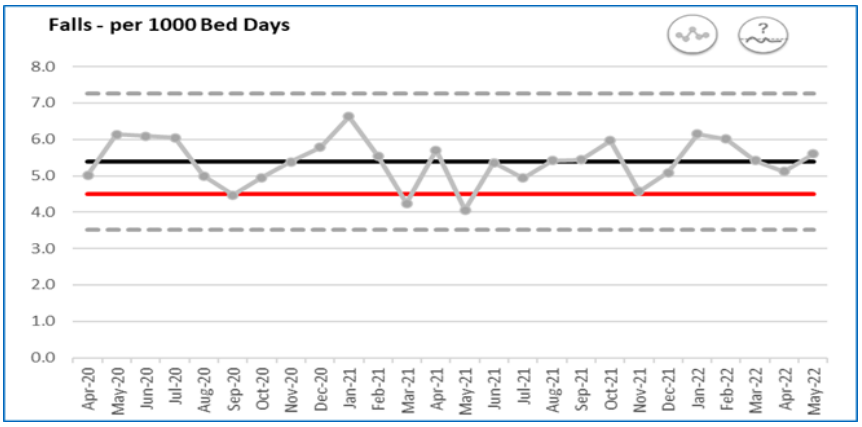
Falls



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

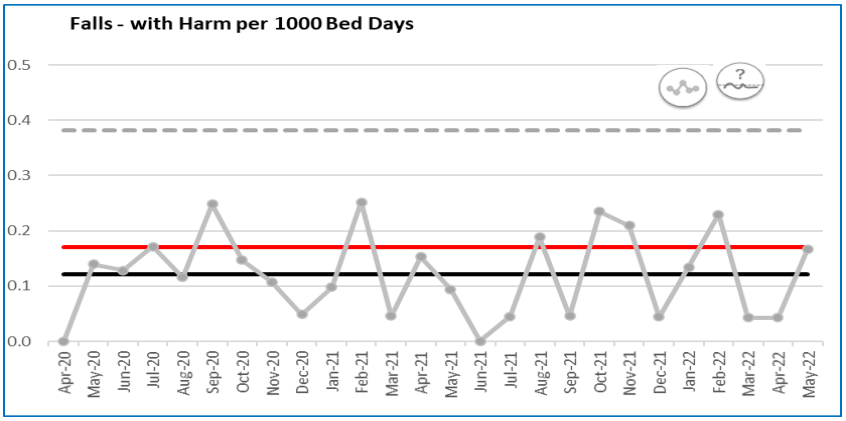
Falls – per 1000 bed days



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 and remain well above target	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 rates. Ongoing monthly review of falls risk assessments 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.

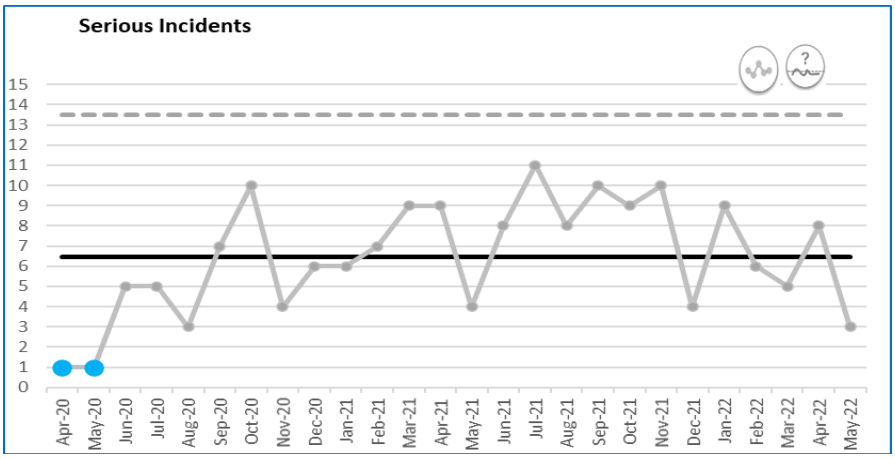
Falls – with harm per 1000 bed days



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

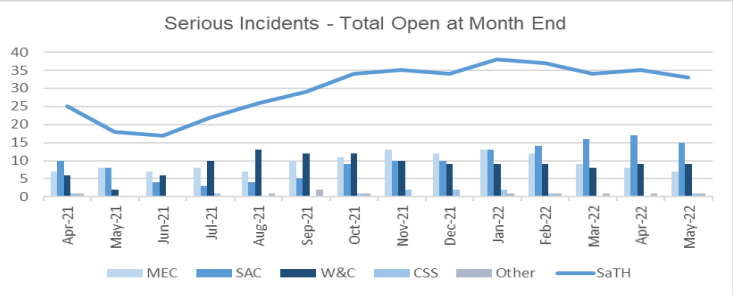


May 2022 actual performance
3
Variance Type
Common Cause
Local Standard
N/A
Target/ Plan achievement
N/A –seeking to encourage reporting of incidents

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.

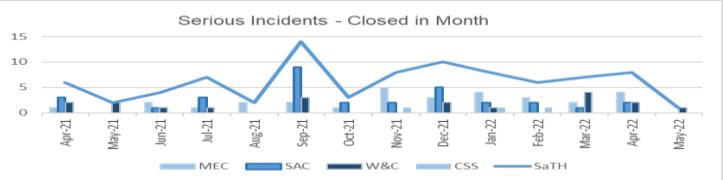
Serious incidents – total open at month end



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

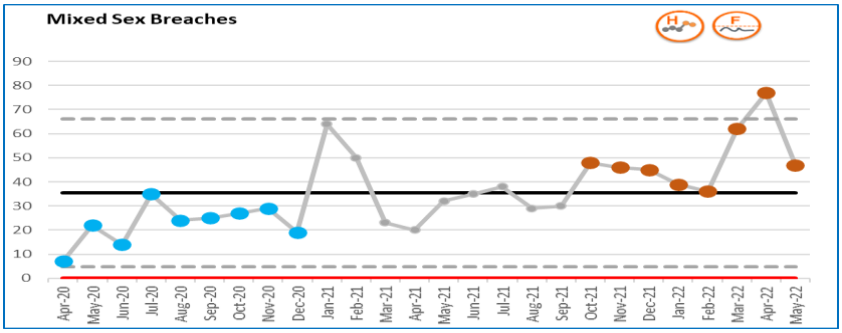


SI – Closed in Month per Division	Number Reported
Women and Children's	1
Total	**1**

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.

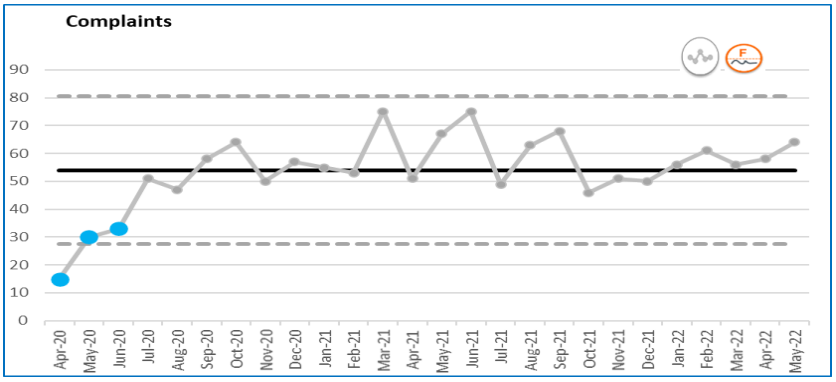
Quality Exception Reports – Patient Experience

Mixed sex breaches exception report



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	

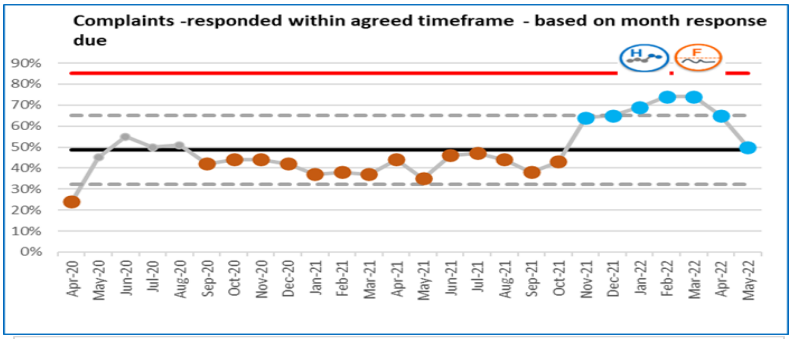
Complaints

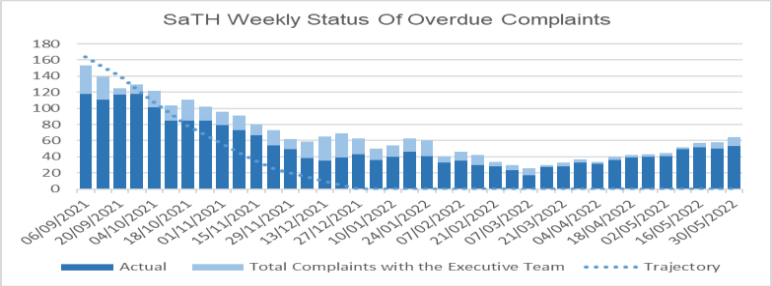


May 2022 actual performance
64
Variance Type
Common Cause
Local Standard
N/A
Target/ Plan achievement
Seeking to encourage reporting of Complaints.

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 uptick in recent months.	There have been no trends or concerns identified this month.	No actions.	No mitigations.

Complaints – Responded within agreed timeframe



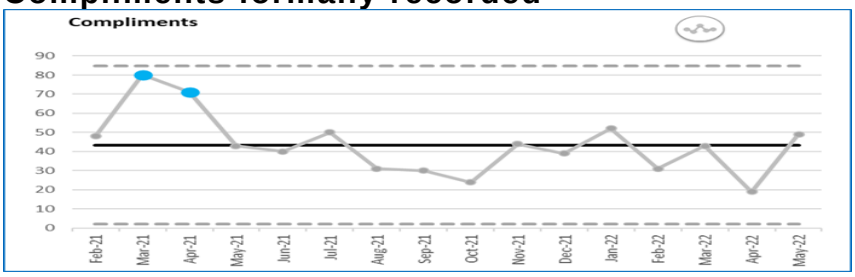


May 2022 performance
50%
Variance Type
Special Cause Improvement
SaTH internal target
85% responded to with the time agreed with the complainant.
Target/ Plan achievement
Target is unlikely to be achieved

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

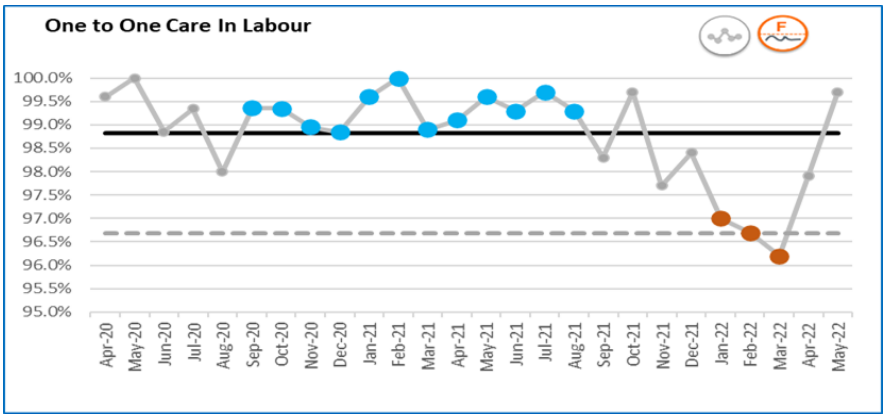


May 2022 actual performance
SATH
49
Divisions
MEC – 29
SAC – 9
CSS – 10
Other - 1

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

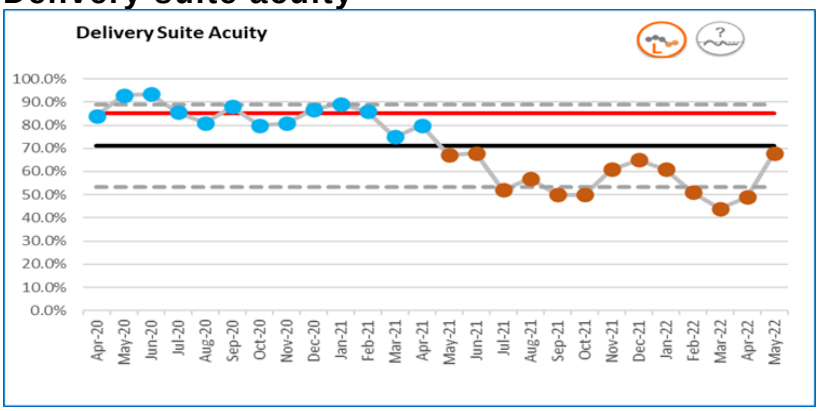
Maternity - One to One care in labour



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. This has increased substantially this month and is above the target for the first time since October 2021	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.

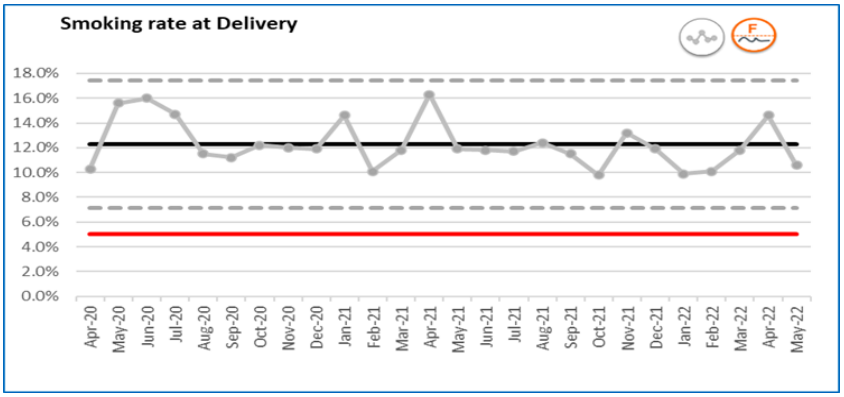
Delivery suite acuity



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 from 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

Our recruitment activity in month has continued to grow our substantive workforce (6166 WTE) which is helping to reduce our overall vacancy position. Despite the substantive growth, our agency usage has increased. This has been driven by the need for additional workforce to support escalation activity (in areas such as ward 31 and DSU at PRH), and to cover staff absence. Several workstreams have been set up to tackle the growing agency usage including review of roster management including education programme for roster managers, actions to implement national agency controls and support for managers to improve budgetary control. This will be monitored over the coming month to track progress and ensure it is making a difference to agency spend.

Our statutory and mandatory training compliance has increased to 81%. Compliance rates have been particularly challenging due to high levels of sickness and significant pressures across our sites. The learning made simple (LMS) platform is now used more widely with 66% staff registered on the system and over 10,000 eLearning completions administered through the system. This month we have designed a logo & QR code to make it easier for staff to access the system. This is supporting compliance and providing staff improved access to training.

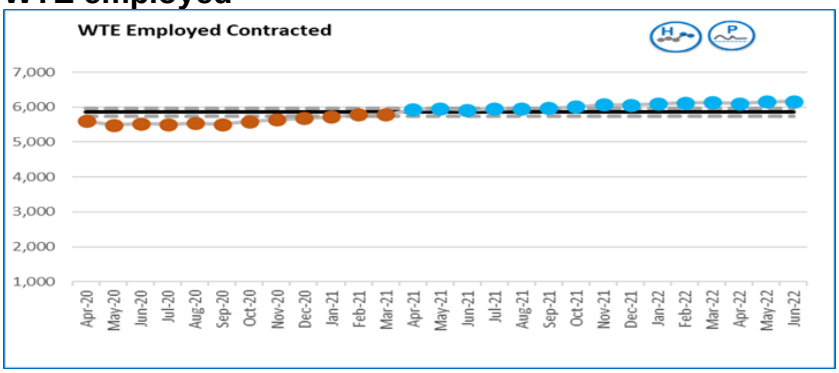
Our medical improvement programme has continued to progress and in the last month we received 464 applications from doctors, 15 interview panels were attended, 23 adverts and 35 offers were made, and 9 doctors commenced in post. Our international nurse programme has recruited 51 of the 100 overseas recruits and we expect all 100 places to be filled by December. This is helping grow our workforce to meet the increasing demand on our services.

Our turnover rate this month has increased, and our overall rate is higher than in previous years with a 15% turnover rate for the last 12 months. We continue to support our divisional teams with their action plans in response to the national staff survey findings. This will take time to embed before we see change however plans are in place to increase retention levels and tackle concerns around civility, respect, and inclusion, which will be driven through our flagship programme.

Total absence has increased by 0.8 % this month. The main reason for absence is due to mental health and Covid-19. To support the health of our people we continue to build on and offer an excellent health and well-being offer to our people and across the integrated care system (ICS). Our psychology hub is set to launch later in 2022, our sleep programme is underway, and we are providing support for colleagues experiencing hardship. Regular menopause stands are taking place across the hospitals to promote menopause support to our staff and educate on the signs, symptoms and help available. These initiatives are supporting our staff particularly with the psychological support that is in place. We have seen a reduction in the proportion of calendar days lost due to mental health this month which we will closely monitor over coming months.

This month we have delivered five manager training sessions on topics including wellbeing & attendance, behaviours & performance, and bullying & harassment. This is helping our managers to develop skills in how to support staff in returning to work and to put in in place practices to address bullying and harassment in the workplace. This training is contributing to reducing long term absence and we have seen a reduction in long-term sickness this month to 2.7% and is the lowest it has been in the previous 12 months.

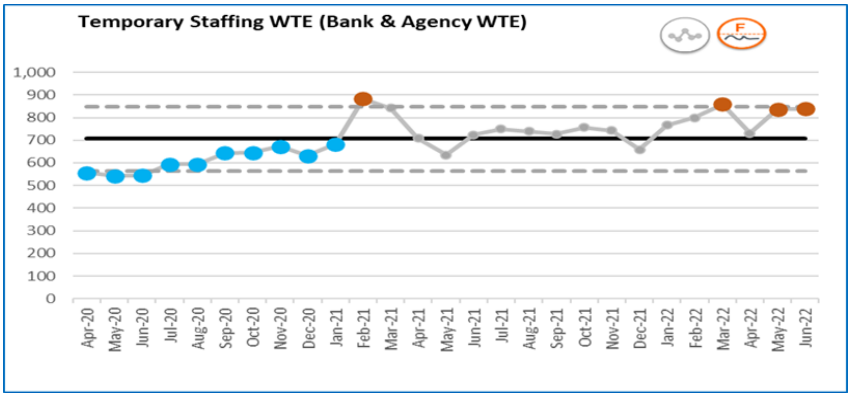
WTE employed



June 2022 actual performance
6166
Variance Type
Special Cause Improvement
Local Target
6720
Target / Plan Achievement
Seeking month on month improvement

Background	What the Chart tells us	Issues	Actions	Mitigations
This is a measure of the WTE contracted staff in post.	WTE numbers show special cause improvement since Apr 2021.	There has been good recruitment activity helping to continue the growth in the workforce. However, the number of staff leaving the Trust is a challenge and makes meeting demand more difficult. In the previous 12 months we have lost 859 WTE staff and recruited 951 WTE.	Continued recruitment campaigns including international recruitment programme (delivery of 100 additional nurses by December 2022). Focus on retention plans including leadership development and support for our mangers (rollout of management skills framework), flexibility for our staff and initiatives agreed following feedback from Making a difference discussions. Support for early careers is also in place and improved onboarding of new staff, along with the review of cases for legacy mentors (experienced staff able to support new recruits).	Utilisation of bank and agency staff to support workforce gaps. Promote timely roster approvals to maximise opportunities for bank utilisation. Continue to monitor leavers and support with early intervention

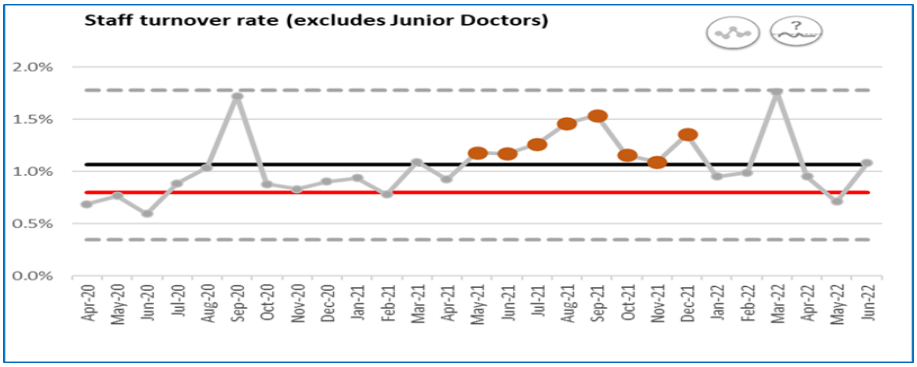
Temporary/agency staffing



June 2022 actual performance
839
Variance Type
Special Cause Concern
National Target
N/A
Target / Plan Achievement
TBC

Background	What the Chart tells us	Issues	Actions	Mitigations
The measure is an indicator of agency and bank usage expressed as WTE.	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. Due to demand and staffing gaps higher costs agency outside of our framework are being used more commonly which is an area to be addressed.	Review of incentives for bank shifts and promotion of bank. Plans to remove off framework agency by December 2022. Continue to monitor roster approvals and unavailability to support better utilisation of temporary workforce.	Escalated bank rates in at risk areas. Progress with recruitment activities to increase substantive workforce including international nurse recruitment.

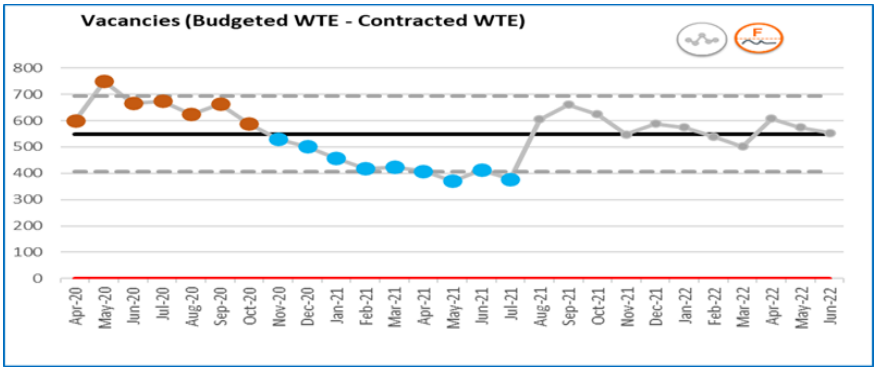
Staff turnover rate (excluding Junior Doctors)



June 2022 actual performance
1.08%
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 percentage of staff who have left the organisation.	Common cause variation in January 2022 to June 2022.	Turnover rate continues to be higher than in previous years with a 15% turnover rate for the last 12 months. There have been 200WTE more leavers in the last 12 months compared to the previous 12 months. Staff leaving from the estates and ancillary (1.6%) staff group and admin and clerical (1.3%) have the highest turnover rate in June.	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. Review of utilisation of exit questionnaires to gain further intelligence around leaving reasons.	Recruitment activity to help ensure minimal workforce gaps. Utilisation of temporary workforce to maintain suitable staffing levels. Escalated bank rates in challenged areas.

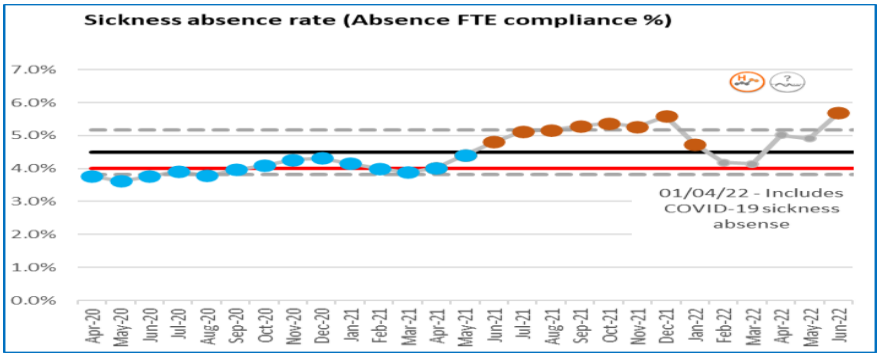
Vacancies



June 2022 actual performance
554 (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 2021. Common cause variation taking place between August 2021 and June 2022.	A competitive marketplace presents challenges in attracting candidates. Vacancy gaps continue to put pressure on bank and agency usage. Sickness absence creates additional workforce unavailability challenge. High attrition levels result in vacancies occurring at a higher-than-expected rate.	Review broader international recruitment practices including AHP's and Medical roles. Further development of development programmes, apprentices, and new roles. Focus on retention of staff via supporting early career support and staff at the end of their careers. Better utilisation of existing workforce through improved roster management via education programme	Recruitment activity continues to reduce workforce gaps. Use of temporary staff to cover vacant posts.

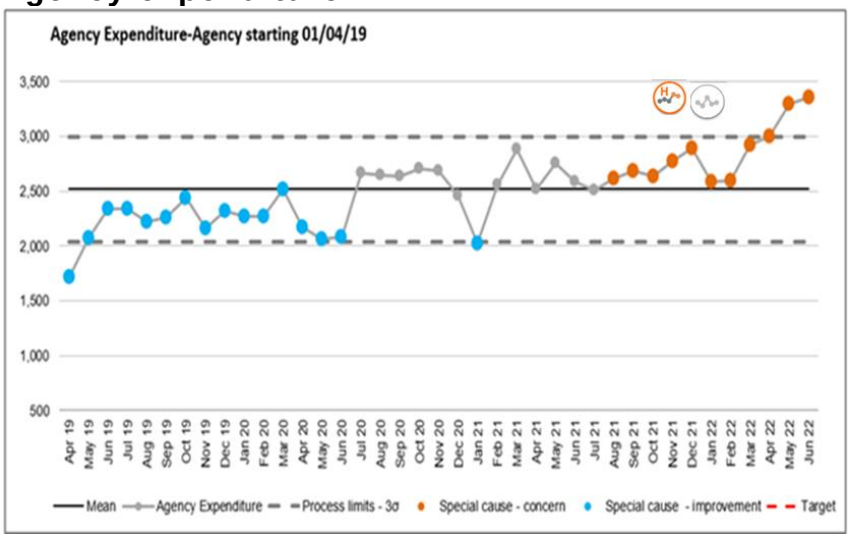
Sickness absence



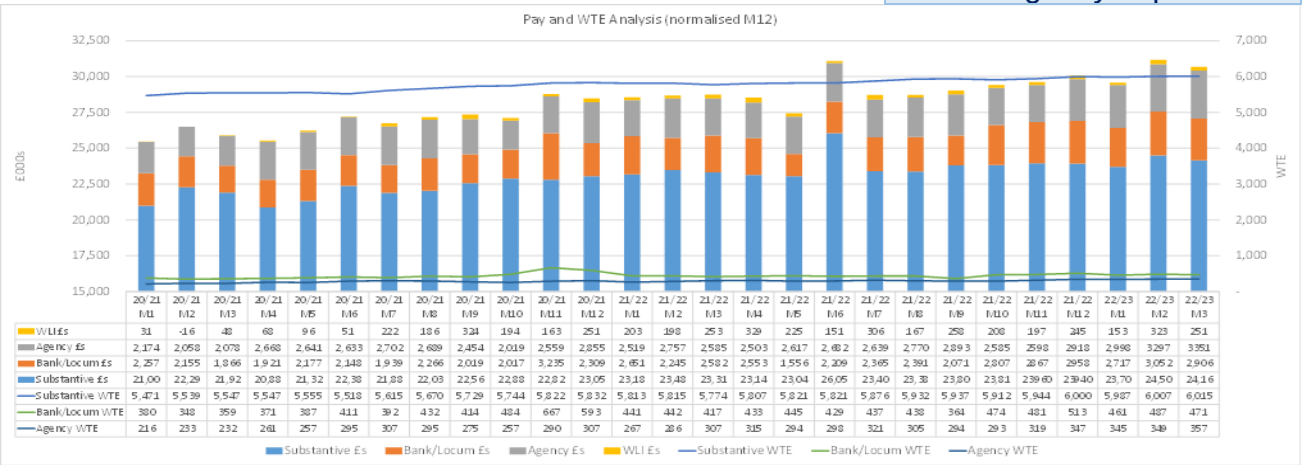
June 2022 actual performance
5.7%
Variance Type
Special Cause Concern
National Target
4%
Target / Plan Achievement
The target is unlikely to be delivered month on month

Background	What the Chart tells us	Issues	Actions	Mitigations
The measure is an indicator of staff sickness absence and is a percentage of WTE calendar days absent.	Special cause concern in June 2022 with common cause in February 2022 to May 2022	From April 2022 sickness absence rate includes employee sickness attributed to COVID-19. Sickness rate of 5.7% equating to 351WTE. Sickness absence attributed to COVID-19 contributes to a high sickness rate in June accounting for 21% of calendar days lost, which equates to 75 WTE. Mental health also continues to be high at 22% of the calendar days lost equating to 75WTE. Musculoskeletal sickness (which excludes back problems and injuries) attributes to 11% of calendar days lost equating to 38WTE.	Occupational health support to help fast track staff returning 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.

Agency expenditure

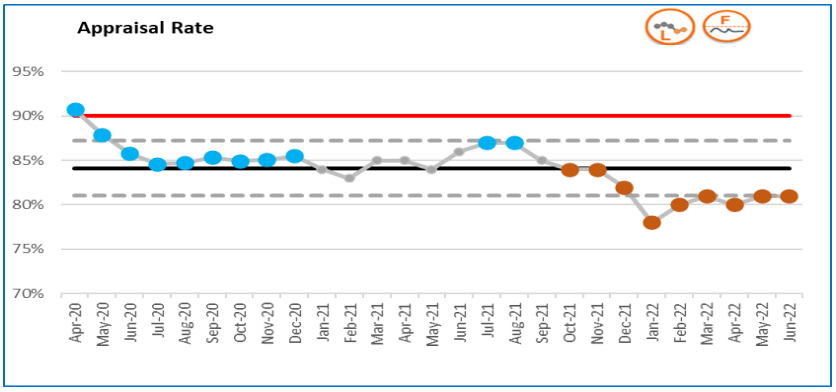


June 2022 actual performance
£9.708m spend year to date. Overspend to plan by £2.720m
Variance Type
Special Cause Concern
SaTH Plan
£6.988m
Target/ Plan achievement
Remaining within annual plan overall and NHSE agency cap.



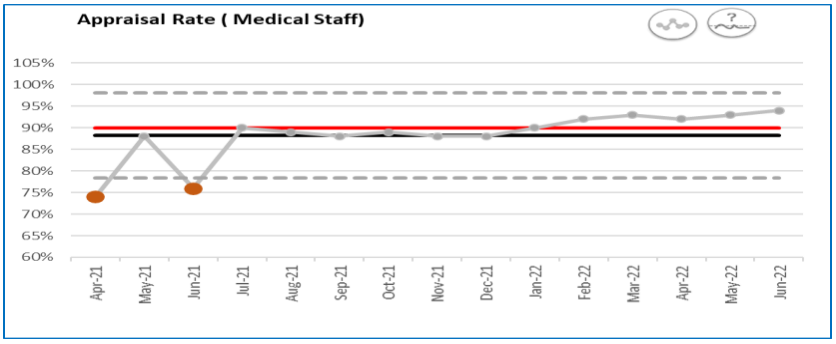
Background	What the Chart tells us:	Issues	Actions	Mitigations
The Trust agency costs have increased over the past 2 years due mainly to the COVID-19 pandemic and additional quality service investment requirements. There is a strong focus on reducing agency spend across the Trust which is integral to the Trust efficiency programme.	Agency costs are £9.708m year to date. In month costs are £0.353m higher than April and £0.054m higher than May. This 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 agency 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 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 has been 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



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

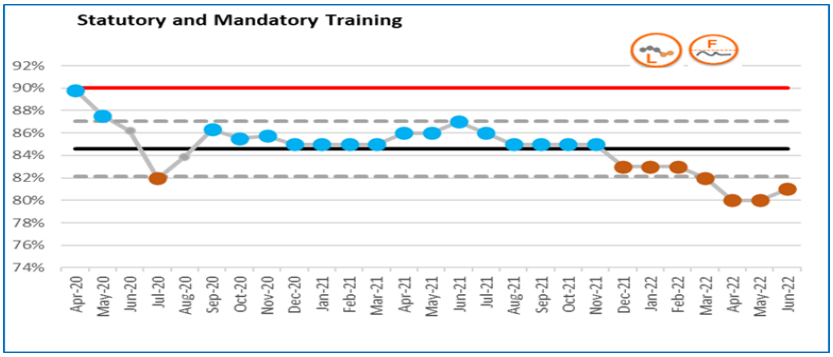
Appraisal – medical staff



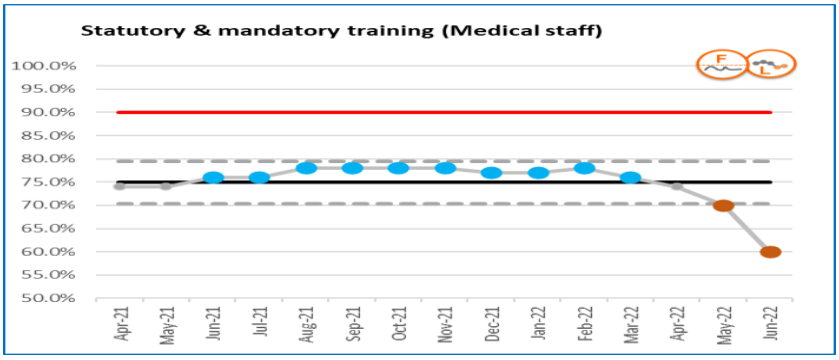
June 2022 actual performance
94%
Variance Type
Common Cause
National Target
90%
Target / Plan Achievement
90%

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.	We have remained at 81% following on from a 1% increase in May 2022.	The system is currently in a critical incident and staff sickness is running at high levels. COVID-19, staffing constraints, escalation levels and service improvement has reduced ability of ward staff to have time to complete appraisals	Appraisals being linked to pay progression. Focused support is being provided to the managers of any ward that is below target. Linking in with HRBPs with regards to any areas of concern.	Ensure Health and Wellbeing offer is advertised widely throughout the Trust. Internal audit of appraisal record accuracy.

Statutory and mandatory training



June 2022 actual performance
81%
Variance Type
Special Cause Concern
National Target
90%
Target / Plan Achievement
90%

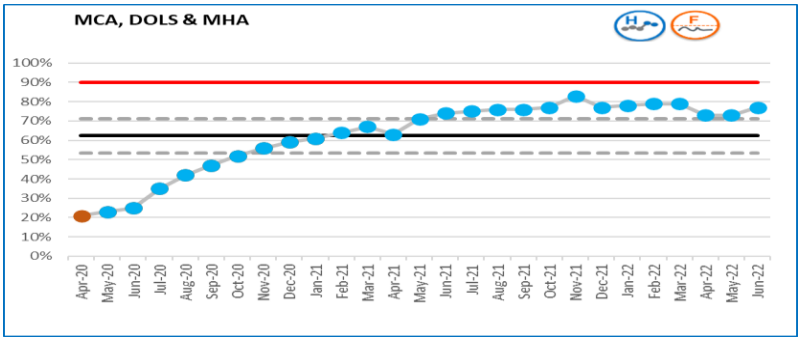


June 2022 actual performance
60%
Variance Type
Special Cause Concern
National Target
90%
Target / Plan Achievement
90%

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
80%	80%	69%	71%	63%	33%	79%	82%	71%	83%

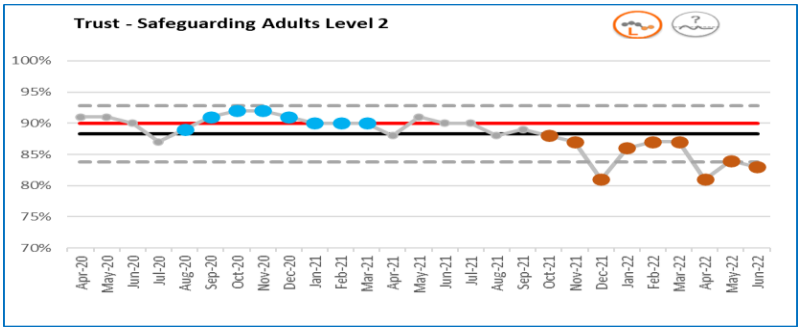
Background	What the Chart tells us:	Issues	Actions	Mitigations
The measure is a key indicator for patient safety in ensuring staff are compliant in having completed their statutory and mandatory training.	Compliance has increased to 81%. The first increase since June 2021. Medical staff compliance with mandatory training is lower than the overall staff compliance and has fallen by 10% in May 2022.	The system has been in a critical incident level and staff sickness is running at high levels.	Learning Made Simple Training (LMS) platform has now been implemented across the trust with 67% of staff registered. QR code linking to learning made simple designed. ESR to LMS data reconciliation work completed. Mandatory training reminder notifications phased in. The 5 departments with lowest compliance being provided with targeted support. Medical performance team proactively booking medical staff on to mandatory training update, prioritising least compliant first. This has been received well. Mandatory training non-compliance escalation process drafted.	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 and MHA



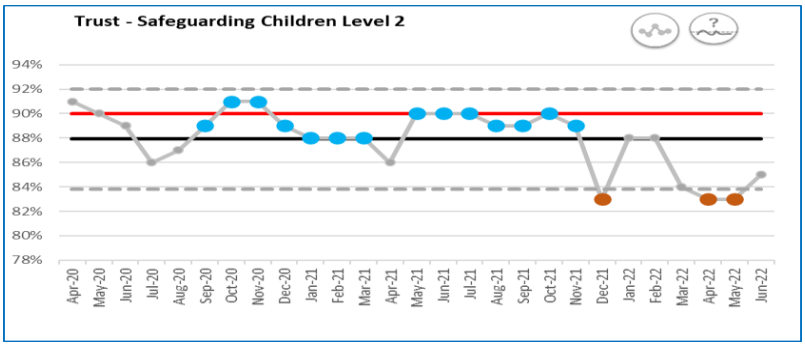
June 2022 actual performance
77%
Variance Type
Special Cause Improvement
National Target
90%
Target / Plan Achievement
Improvement trajectory in place

Safeguarding adults – level 2



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

Safeguarding children – level 2



June 2022 actual performance
85%
Variance Type
Common Cause
National Target
90%
Target 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 statutory and mandatory training.	Performance dropped with the inclusion of the medical staffing groups being added into the training cohort figures in March 2022. For safeguarding children, the performance declined due to including designated adult wards who are now caring for 16/17 year olds.	All are now improving following the adjustment for the medical staff being added into the cohorts.	All courses have training dates through to end Q4 available. In addition, the medical staffing is being booked onto the Level 3 training which includes MCA & DoLS training, via the medical directorate with notable improvements in booking figures from August 2022.	No mitigations

5. Operational Summary
Sara Biffen, Acting Chief Operating Officer

Overall, the emergency pathway continues to be under pressure, with a continued high level of demand, although slightly lower than May 2022. The A&E 4-hour performance was lower than May, this was because of worsening performance within minor injuries and minor illness pathway. This was due to overcrowding in both Emergency Departments (ED) and increased staff absence due to covid related sickness.

Work is progressing on the building works in ED at RSH which are planned to be completed at the end of August and currently awaiting confirmation to proceed with an extension to PRH SDEC. A business case to support the reconfiguration of the acute floor at RSH is also due to be submitted to support additional assessment space for acute medicine and also support direct admission pathways for orthopaedic trauma and oncology patients.

Whilst some COVID-19 restrictions eased, with the removal of masks in non-clinical areas and the removal of plastic curtains, the number of COVID-19 cases within the hospitals began to rise at the end of June. There is still a need to segregate pathways to maintain IPC compliance, which slows down the management of patients through the hospital.

The number of patients that are medically fit for discharge continue to be a challenge and we are working with system partners to develop an urgent and emergency care improvement programme, which will incorporate pre-hospital, in hospital and discharge elements. In addition, a SaTH flow improvement group has been established to support and monitor internal improvement actions in relation to hospital admissions, hospital flow and discharge.

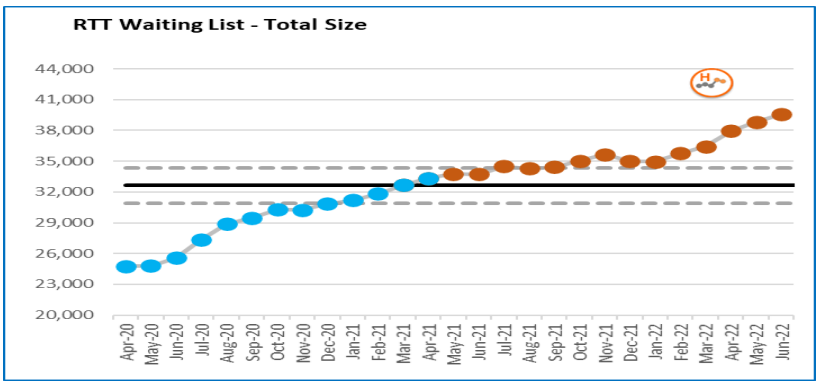
Overall RTT elective waiting lists have increased in June 2022, due to persistent urgent care pressures and resultant reduced bed base at both sites. Additional insourcing activity remains in place at weekends. Our Trust is on trajectory to deliver our target for 104 weeks at the end of July and to achieve the zero target by the end of July 2022. Although the loss of ward 36 for planned orthopaedic surgery means that achievement of this target is now at risk, we are exploring any mutual aid opportunities possible to avoid breaches. Weekly meetings are established to monitor performance against our trajectories and take corrective action.

Cancer two week wait performance remains below the national standard, with radiology workforce being a significant constraint in delivering more rapid improvement. The number of patients waiting over 62 days for cancer diagnosis and treatment rose only slightly in June, with radiology being a major factor. Prioritisation is given to cancer pathways and urgent care, but we are seeing increasing demand in cancer referrals. A recovery trajectory has been established and is monitored weekly at hospital and system level. Internal improvement meetings are established, and weekly system and national assurance meetings have been established to monitor performance against the standard and to seek mutual aid.

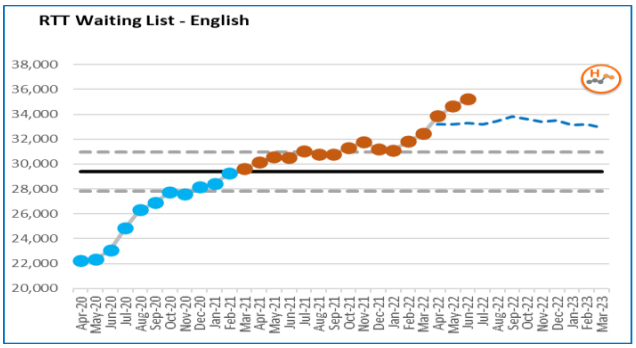
Diagnostic performance deteriorated slightly in June, due to increased absence due to COVID-19, and remains below the national standard. The improvement plan is dependent on a successful international radiographer recruitment campaign which is at the shortlisting stage and, longer term, the development of apprentice grades in radiology. The additional endoscopy rooms on both sites are nearing completion, and the capital bid for equipment has progressed to the next stage.

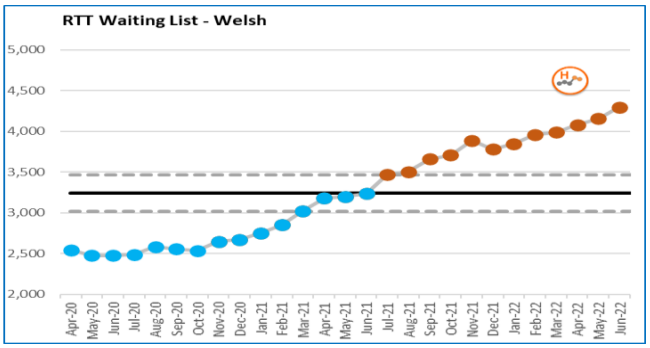
Elective Care

RTT Waiting list – total size



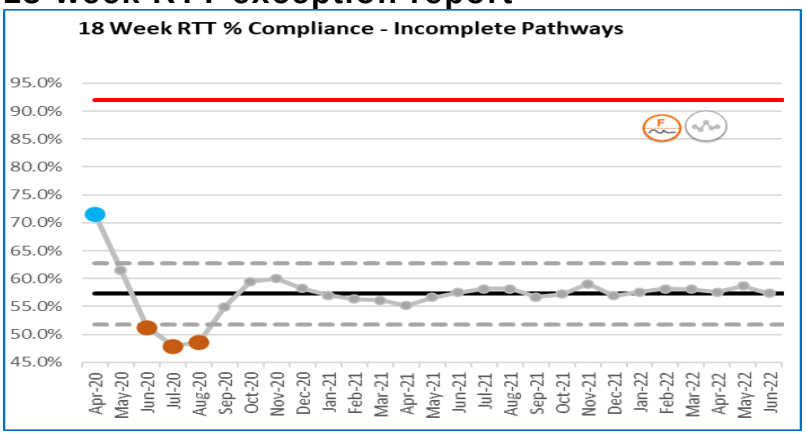
June 2022 actual performance
39545 (35250 English, 4295 Welsh)
Variance Type
Special Cause Concern
Local Plan
33278 (English 22-23 Plan)
Target / Plan Achievement
(22-23 plan)



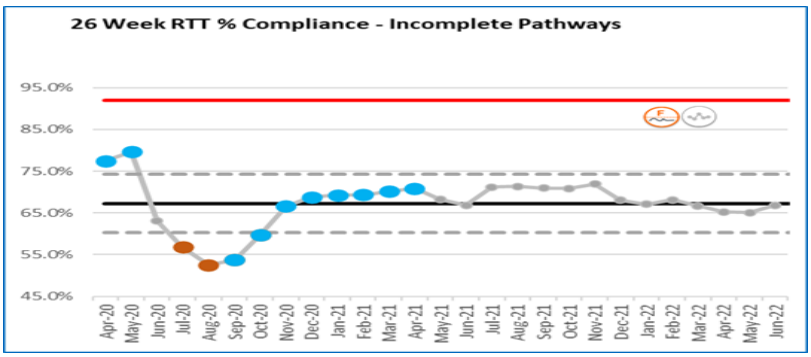


Background	What the Chart tells us	Issues	Actions	Mitigations
The total number of patients waiting for treatment.	The total waiting list size remains at a higher level and continues to increase. The list continues to be larger than the planned level	Bed capacity due to emergency pressures and full escalation of DSU at PRH. Staff absences and theatre vacancies. Increase in cancer referrals. Conversion rate as more patients are seen in outpatients and placed on a waiting list. Increased routine diagnostic waiting times.	Weekly restore and recovery meetings in place. Established weekly outpatient transformation meeting with centre to further develop and monitor the PIFU and virtual plans by specialty and with clinical engagement. Insourcing at weekends but internal staffing remains challenging. Theatre trajectories for staffing.	Theatre staff recruitment is challenged and looking at all options. Awaiting outcome of the elective hub bid for PRH site for additional day case capacity from NHSE.

18-week RTT exception report



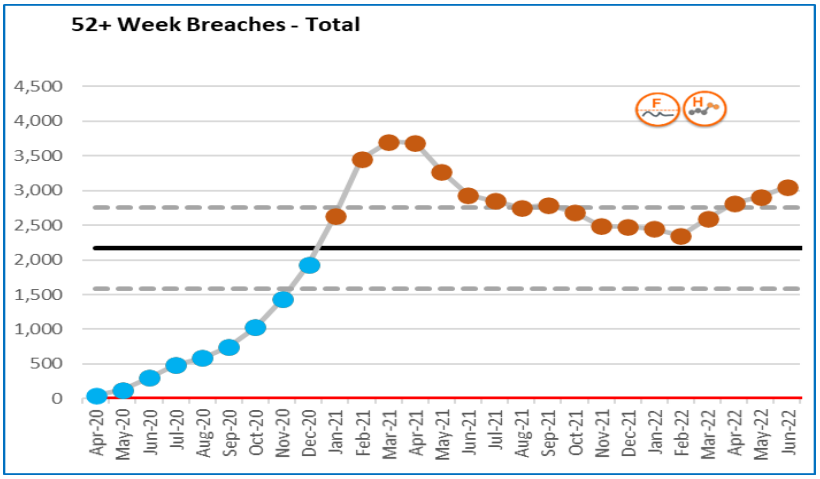
June 2022 actual performance
57.4%
Variance Type
Common Cause
National Target
92%
Target / Plan Achievement
Clinical prioritisation and the backlog developed mean target will not be achieved.



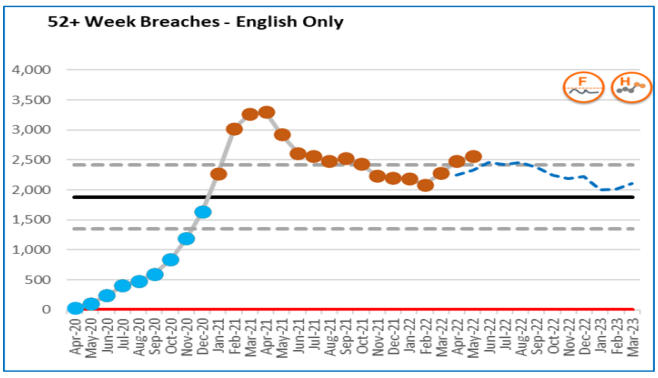
June 2022 actual performance
66.9%
Variance Type
Common Cause
National Target
92%

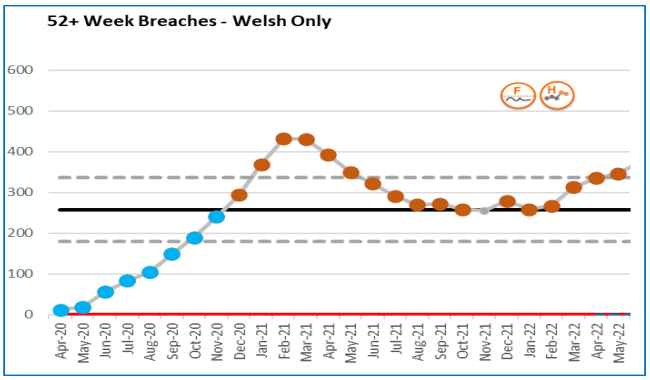
Background	What the Chart tells us	Issues	Actions	Mitigations
This is the national standard for patients referred for elective care. Headline performance against this measure has now stabilised but is well below the pre-pandemic performance.	Incomplete pathways appear to have stabilised at a level significantly below the national target. The 18-week and the 26-week performance will continue to decline, as urgent patients tend to wait in shorter time bands.	Limited resources. 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 capacity on both sites.	Monitoring of referral demand and capacity. Weekly centre PTL meetings.	Established system meeting to monitor elective recovery and cancer.

52 Weeks wait exception report



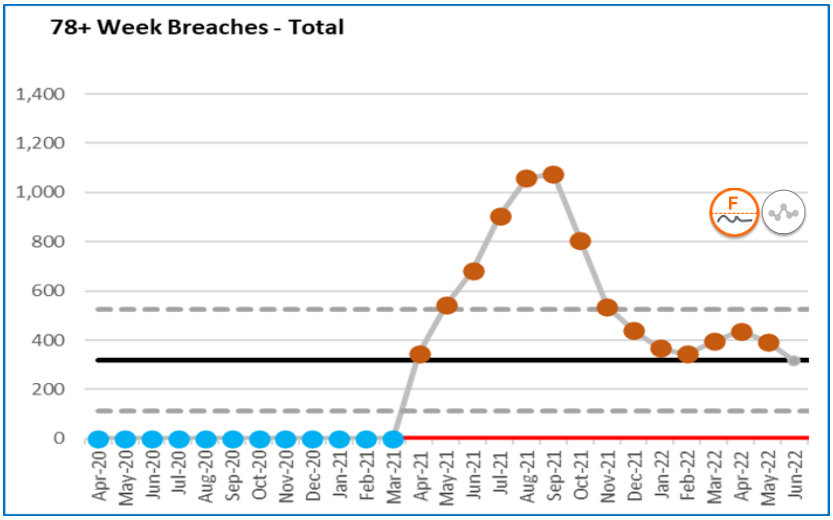
June 2022 actual performance
3049 (2673 English, 376 Welsh)
Variance Type
Special Cause Concern
Local Forecast
2462 June (English 22-23 plan)
Target / Plan Achievement
NHSE target reduction on 52+ breaches



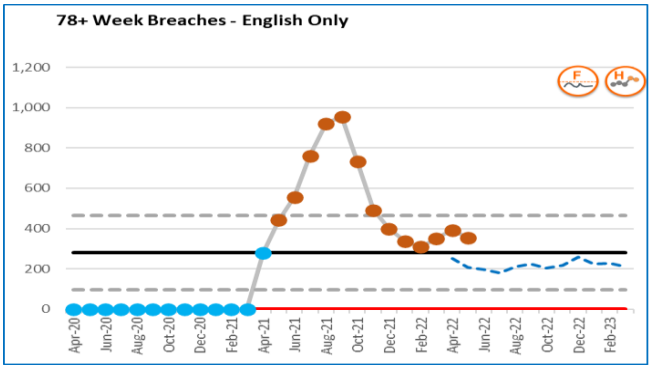


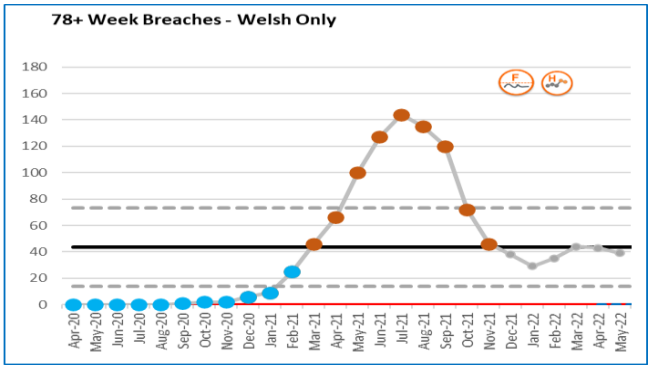
Background	What the Chart tells us	Issues	Actions	Mitigations
From a baseline position of zero pre-pandemic, the volume of patients waiting in excess of 52 weeks on an open RTT pathway has increased significantly. It reflects routine patients not currently being able to be prioritised for treatment.	The number of patients waiting over 52 weeks is increasing. The increase in English 52+ week patients waiting has increased less than previously and is just higher than the planned value.	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



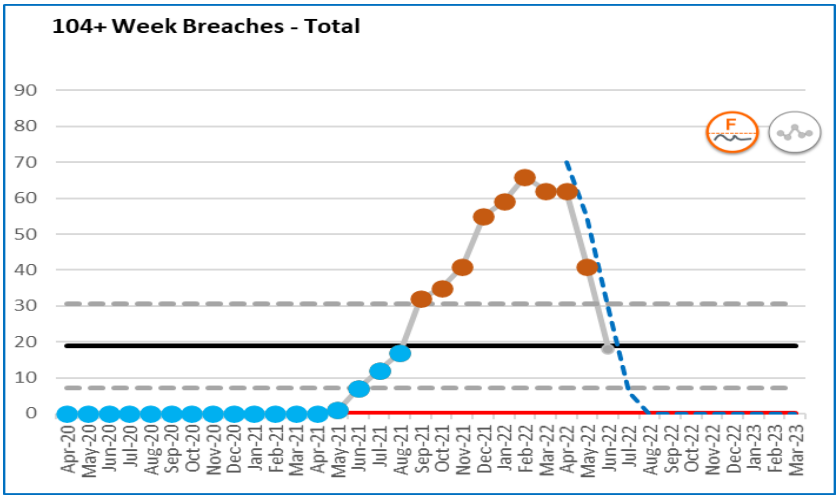
June 2022 actual performance	
315 (271 English, 44 Welsh)	
Variance Type	
Common Cause	
National Target	**Local Forecast**
0	196 June (English 22-23 plan)
Target / Plan Achievement	
NHSE national target 0 by 31st March 23	





Background	What the Chart tells us:	Issues	Actions	Mitigations
From a baseline position of zero pre-April 2021, 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 patients who are waiting over 78 weeks is reducing, although not at a level planned for at this point in the year.	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. Limited theatre capacity unable to open up additional lists and limited elective bed and DSU capacity on both sites.	Theatre vacancies being addressed through recruitment and overseas nursing and trajectory in place, which is being monitored, with an escalation process in place. COVID-19 and non-COVID-19 related absences are being closely monitored. Recovery plans developed as part of the 2022-23 integrated operational planning cycle are being monitored and reviewed.	Monitored via weekly RTT meeting.

104+ Weeks wait exception report

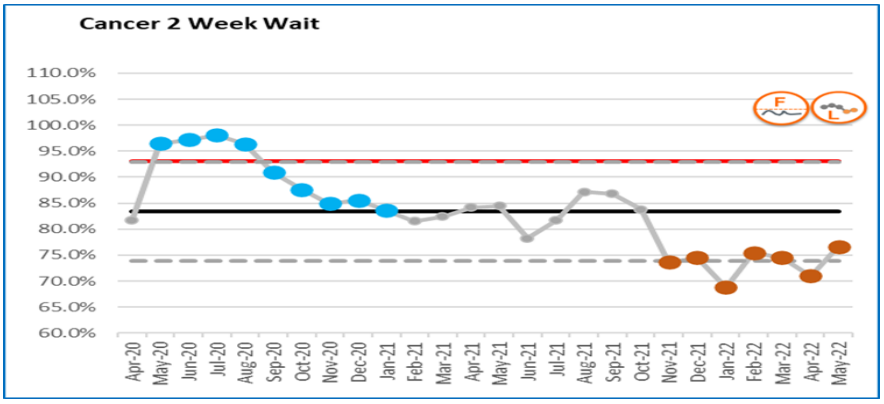


June 2022 actual performance	
18 (17 English, 1 Welsh)	
Variance Type	
Common Cause	
National Target	**Local Forecast**
0	30 June (English 22-23 plan)
Target / Plan Achievement	
NHSE 0 by end of July 22	

Background	What the Chart tells us:	Issues	Actions	Mitigations
NHSE target for 104s is 0 by end of July 22. Achieved 18 as at the end of June 2022.	The number of 104+ week patients waiting is decreasing in line with the trust's plan.	Significant progress made and teams fully engaged. No elective orthopaedic capacity. Limited DSU beds. Theatre staffing sickness, COVID-19 related and vacancies.	Clinical priority of cases continues, and lists are allocated on clinical need. Optimising vanguard. ERF plan to continue to utilise insourcing 18 weeks. Daily meeting and weekly monitoring of 104s via RTT.	6-4-2 theatre meeting list planning. Weekly restore and recovery meeting. RTT weekly meeting.

Cancer

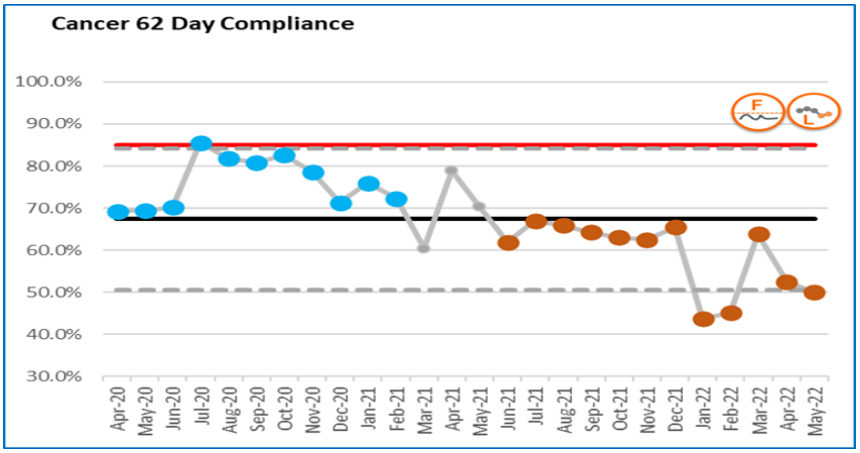
Cancer 2 week waits



May 2022 actual performance
76.6% (June 2022 Revised forecast 75.9%)
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 fluctuated since April 2019 and is attributed to poor performance (capacity) within the breast, gynaecology, and lung services. Current OPA waiting times: Breast - Day 15 Lung - Day 26 Gynaecology - 22	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.	Additional ultrasound capacity to be to support gynaecology clinics. Additional clinics to be scoped to improve lung capacity.	Implementation of revised 2WW breast referral and gynaecology proforma.

Cancer 62-day target

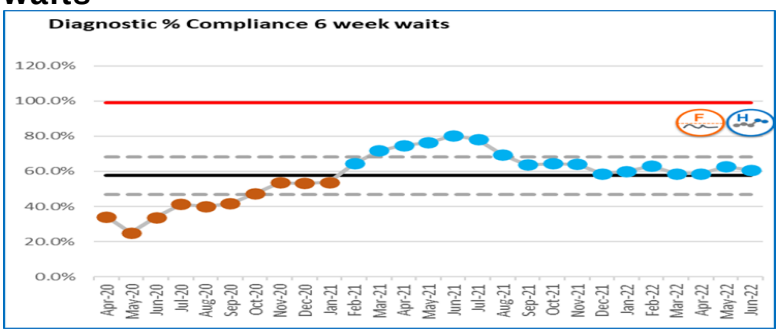


May 2022 actual performance
50% (June revised forecast 56.4%)
Variance Type
Special Cause Concern
National Target
85%
Target / Plan Achievement
Performance

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 only been achieved once since April 2019.	Capacity does not meet demand (diagnostics a significant issue even prior to COVID-19). Surgical capacity not back to pre-COVID-19 levels. Rise in 2WW referrals. Staffing levels in oncology.	Weekly review of PTL lists using somerset cancer register – escalations made as per cancer escalation procedure. Best practice pathways being reviewed, and improvement plans and trajectory for each tumour site to be in place by end of August.	Cancer performance and assurance meetings in place.

Diagnostics

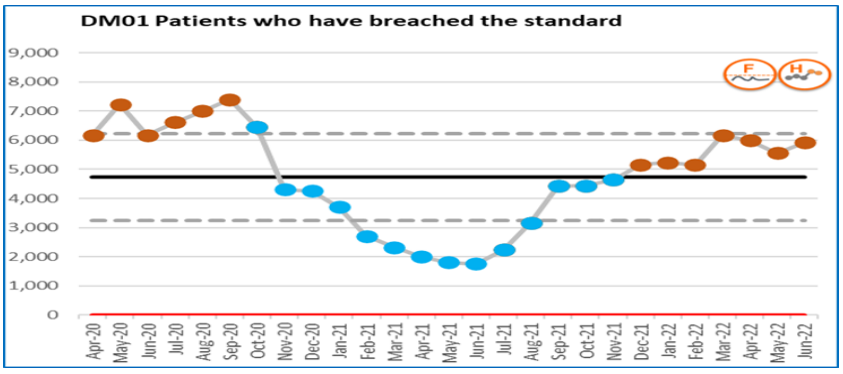
Diagnostics - DM01 diagnostics over 6 week waits



June 2022 actual performance
60.8%
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.	Special cause improvement maintained. Slight reduction (2.2%) in DM01 performance since May. 99% target is not being met.	Staff availability due to rising COVID-19 incidence. Increased inpatient demand affecting outpatient capacity. Fragility of staff and ongoing long-term absence in some modalities.	Regular review of appointment templates. Redeployment of available staff to maintain acute services across all areas.	Clinical prioritisation of all radiology bookings. On site mobile CT/MRI scanners and Ultrasound insourcing to increase capacity. Agency radiographers used when available.

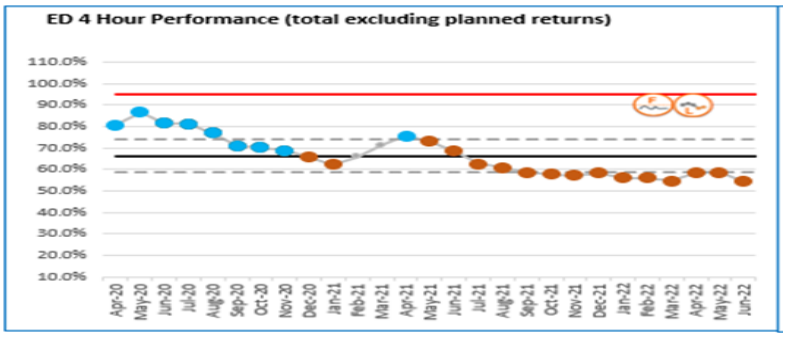
DM01 Patients who have breached the standard



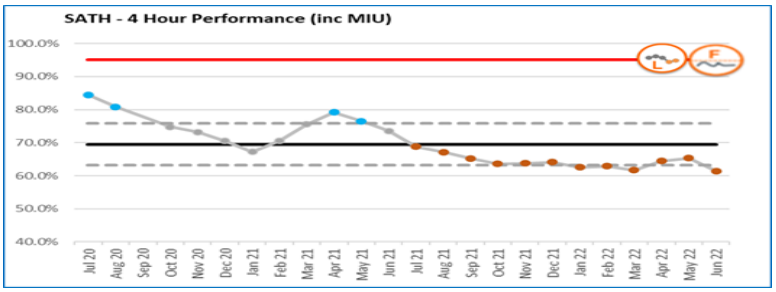
June 2022 actual performance
5920
Variance Type
Special Cause Concern
National Target
0 - < 6weeks
Target / Plan Achievement
Clinical prioritisation and then addressing longest waits.

Background	What the Chart tells us	Issues	Actions	Mitigations
DM01 is the national standard for non-urgent diagnostics completed within 6 weeks of the referral. There must be no more than 1% of patients waiting longer than 6 weeks.	Increase in the number of breaches in June. Increase by 407 compared to May 2022.	Impact of increasing COVID-19 and other sickness on capacity. Requirement to cancel some lists at short notice in response to staff availability.	Regular review of templates to maximise appointment availability. Year 1 of workforce plan progressing, to support staff to improve current capacity efficiency. Request for enhanced bank rates to incentivise staff to work additional duties. Telephoning patients in areas of high DNAs to reallocate unwanted appointments.	Repeated/ongoing recruitment. Clinical prioritisation of all bookings. Staffed mobile CT/MRI scanners and US insourcing are increasing capacity. Use of agency radiographers.

Emergency Care
A&E 4-hour performance



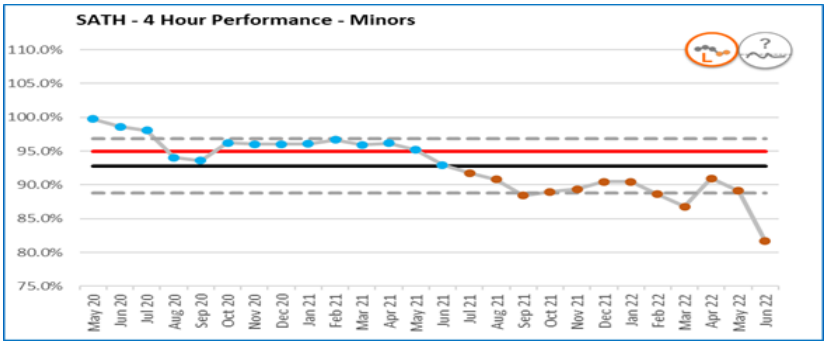
June 2022 performance
54.4%
Variance Type
Special Cause Concern
National Target
95%
Target / Plan Achievement
Performance is below national target.



June 2022 performance
61.5%
Variance Type
Special Cause Concern
National Target
95%

Background	What the Chart tells us	Issues	Actions	Mitigations
The total number of patients waiting for treatment.	ED performance is forecast to continue to be below national target and although it had stabilised around 65% it has fallen further in June	Flow out of ED continues to be a significant issue. Increase in MFFD patients and reduction in number of complex discharges. Direct referrals referred to ED. Environmental challenges due to ongoing building work within RSH ED and continued requirement for Respiratory isolation unit (RIU) at PRH. Staffing pressures due to insufficient templates and recruitment challenges.	RSH ward reconfiguration to create acute medical floor. Business case to be presented to the system on 22/07/22. RSH ED reconfiguration in final stage due for completion by end of August. Extension of PRH SDEC – awaiting confirmation to proceed. Direct access for WAS and WMAS patients to SDEC, coloured phones to be introduced to support process. ED transformation programme to be launched September 2022 – business case being presented to business case review group and I&IC in July for funding approval. Embed ownership of internal professional standards (IPS). UEC Improvement action plan – internal and system wide in place covering pre-hospital, in hospital and post discharge workstreams. Staffing template reviews completed and will be operationalised by September. Recruitment event planned for August 2022.	System UEC action plan.

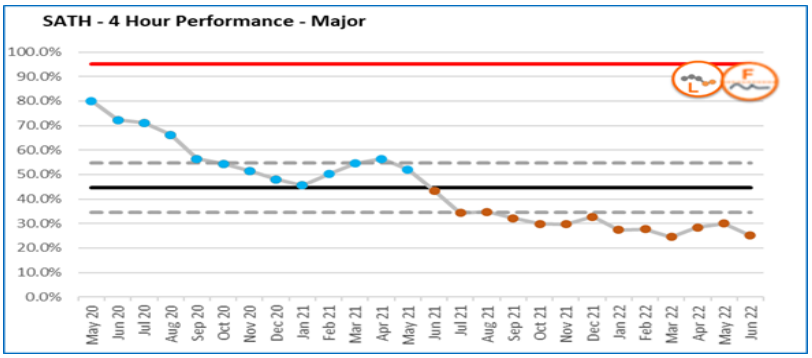
ED Minors performance



June 2022 actual performance
81.7%
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 taken a significant dip in June compared to previous months, contributing to the overall decline in performance	Workforce constraints including within minor injury and illness. Physical space to assess patients within department. Data quality issues.	Reviewing potential to rotate workforce between sites. Dedicated consultant lead for minors. Single point of access in place. Improved communications around MIU capacity. Review of potential developments with UTC provider. Introduction of ED redirection tool pilot.	Patients assessed on clinical priority need.

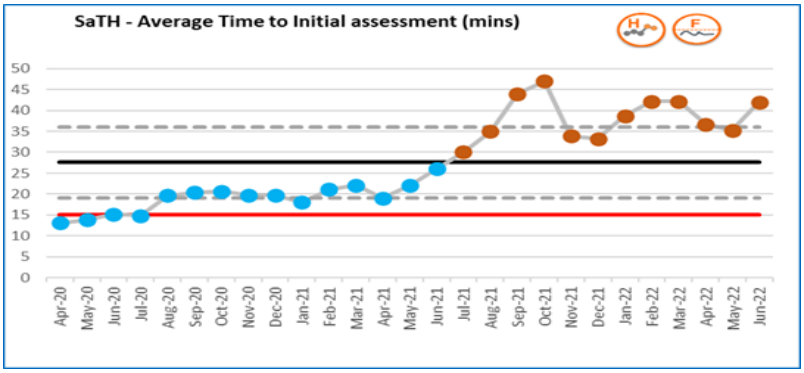
ED Majors performance



June 2022 actual performance
26%
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.

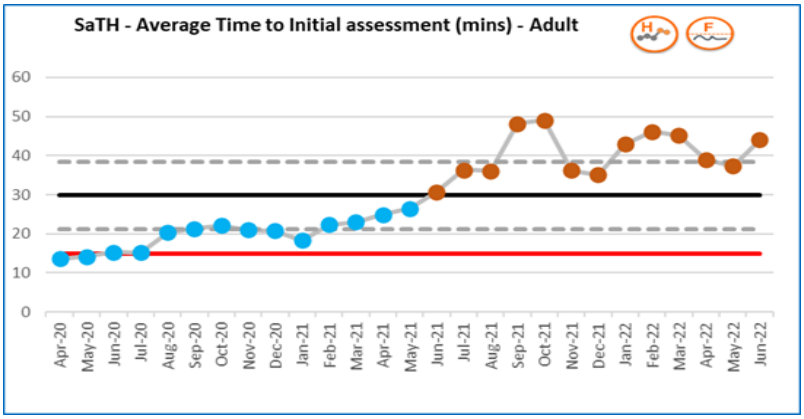
Background	What the Chart tells us	Issues	Actions	Mitigations
The national target is for all patients to be seen treated, admitted, transferred, or discharged within 4 hours of arrival at the emergency department**.**	Performance continues to decline and remains below the national target.	Flow out of ED continues to be a significant issue. Increase in MFFD patients and reduction in number of complex discharges. Direct referrals referred to ED.	Included in the A&E 4-hour performance section.	Patients assessed on clinical priority need.

ED –Time of initial assessment (mins)



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

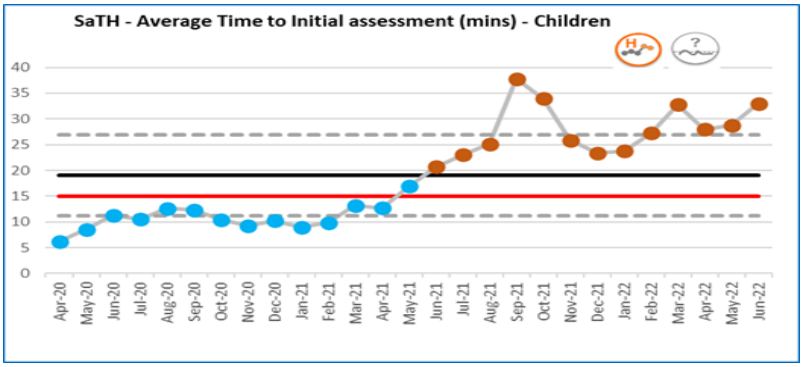
ED Time to initial assessment - adult



June 2022 actual performance
44 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.	There has been deterioration in this metric seen in June.	Workforce and physical capacity constraints to meet the demand for both walk in and ambulance arrivals leads to bottlenecks in the department. The volume of nursing documentation required per patient for assurance purposes.	Senior ED Matron recruited and will lead task and finish groups to improve and standardise performance across both sites. Process mapping completed in partnership with transformation team. Work will feed into wider ED transformation project. Recruitment of 7wte band 6 paramedics into the ED – rolling start dates over the coming months. Recruitment of band 7 lead nurse for SDEC. Pathway developments to increase pull from ED to SDEC.	Oversight by divisional director, divisional director of nursing and COO.

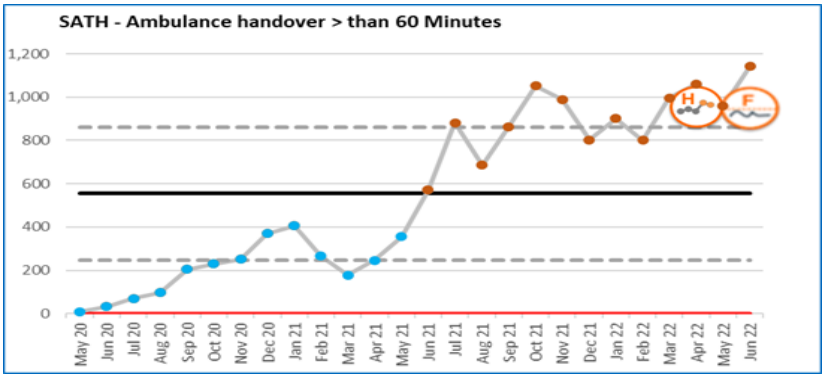
ED time to initial assessment - children



June 2022 actual performance
33 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.	There has been a deterioration in this metric seen in June	Workforce and physical capacity constraints to meet the demand for both walk in and ambulance arrivals leads to bottlenecks in the department. The volume of nursing documentation required per patient for assurance purposes. Paediatric support to ED remains inconsistent due to staffing issues and capacity in PAU.	Matron led task and finish groups. Working groups being established following process mapping exercise. Recruitment of 7wte band 6 paramedics into the ED – rolling start dates over the coming months. Recruitment of band 7 lead nurse for SDEC. Pathway developments to increase pull from ED to SDEC. Band 7 paediatric Lead supporting with initial assessment trial for paediatrics. Introduction of CYP assessment area has opened at RSH. Scoping exercise to look at estate's developments at PRH to introduce a CYP area in line with RSH. Reinstatement of paediatric stakeholder group to encourage collaborative working with W&C divisional team.	Oversight by divisional director, divisional director of nursing and COO.

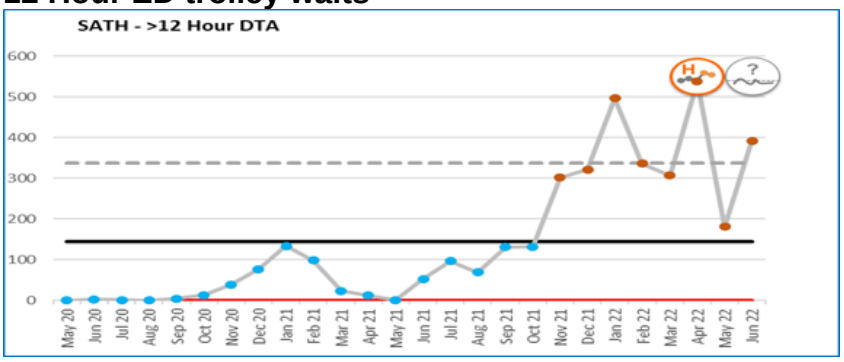
Ambulance handover> 60 Mins



June 2022 actual performance
1142
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 continue to increase in volume and performance is showing special cause for concern. The number in June was almost twice as high as at the same point in 2021	High volume of ambulance presentations with a large number presenting in batches. Continued implications due to COVID-19. Inability to safely staff all areas impacting on the pull from ambulances. Flow out of ED continues to be a significant issue. Increase in MFFD patients and reduction in number of complex discharges. Direct referrals referred to ED.	RSH ward reconfiguration to create acute medical floor. Business case to be presented to the system on 22/07/22. RSH ED reconfiguration in final stage due for completion by end of August. Extension of PRH SDEC – awaiting confirmation to proceed. Direct access for WAS and WMAS patients to SDEC – coloured phones to be introduced to support process. ED transformation programme to be launched September 2022 – business case being presented to Business Case Review Group and I&IC in July for funding approval. Embed ownership of internal professional standards (IPS). UEC Improvement Action plan – internal and system wide in place covering pre-hospital, in hospital and post discharge workstreams. WMAS asked to participate in joint approach to 4 hours off load harm proforma's.	System UEC action plan.

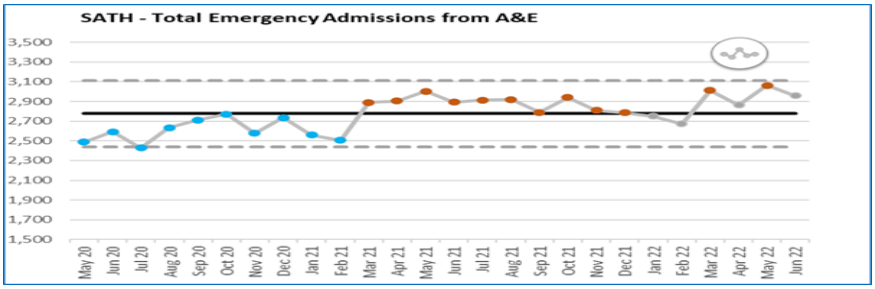
12 Hour ED trolley waits



June 2022 actual performance
392
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.	12-hour ED trolley waits have increased this month following a reduction in May	Flow out of ED continues to be a significant issue. Increase in MFFD patients and reduction in number of complex discharges. Direct referrals referred to ED.	RSH ward reconfiguration to create acute medical floor. Business case to be presented to the system on 22/07/22. RSH ED reconfiguration in final stage due for completion by end of August. Extension of PRH SDEC – awaiting confirmation to proceed. Direct access for WAS and WMAS patients to SDEC – coloured phones to be introduced to support process. ED transformation programme to be launched September 2022 – awaiting funding of business case. Embed ownership of internal professional standards (IPS). UEC Improvement Action plan – internal and system wide in place covering pre-hospital, in hospital and post discharge workstreams. Surge staffing shifts requested to ensure basic care needs are met for patients with prolonged ED stays.	ED Safe today processes in place to mitigate risk where possible within the department .

Total emergency admissions from A&E



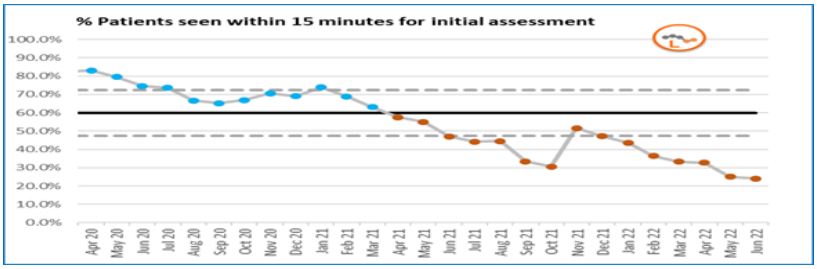
June 2022 actual performance
2959
Variance Type
Common Cause
National Target
N/A

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.	ED Safe today processes in place to mitigate risk where possible within the department.	Segmentation of patients continues to be necessary to ensure good IPS is maintained.	Bed capacity is flexed to meet the demand of COVID-19 and non-COVID-19 admissions.	System wide plans to avoid admission and use of alternative pathways.

UEC metrics – shadow reporting.

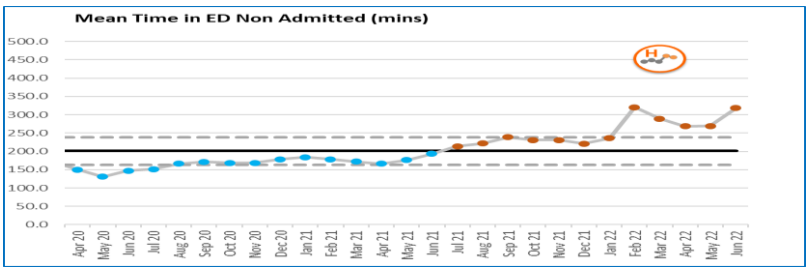
The measures below are reported in shadow form ahead of adoption expected nationally for 2022-23.

% Patients seen within 15 minutes for initial assessment



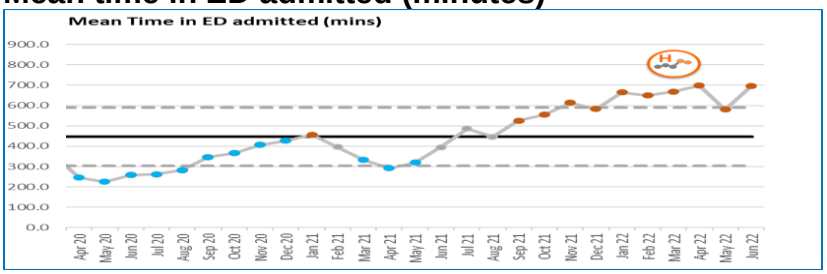
June 2022 actual performance
24%
Variance Type
Special Cause Concern
National Target
n/a

Mean time in ED non-admitted (minutes)



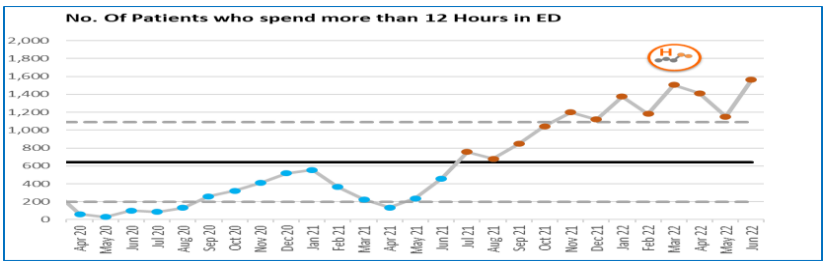
June 2022 actual performance
318
Variance Type
Special Cause Concern
National Target
n/a

Mean time in ED admitted (minutes)



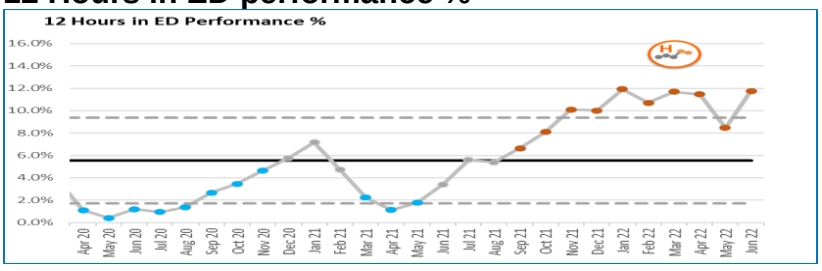
June 2022 actual performance
697
Variance Type
Special Cause Concern
National Target
n/a

Number of patients who spend more than 12 hours in ED



June 2022 actual performance
1563
Variance Type
Special Cause Concern
National Target
n/a

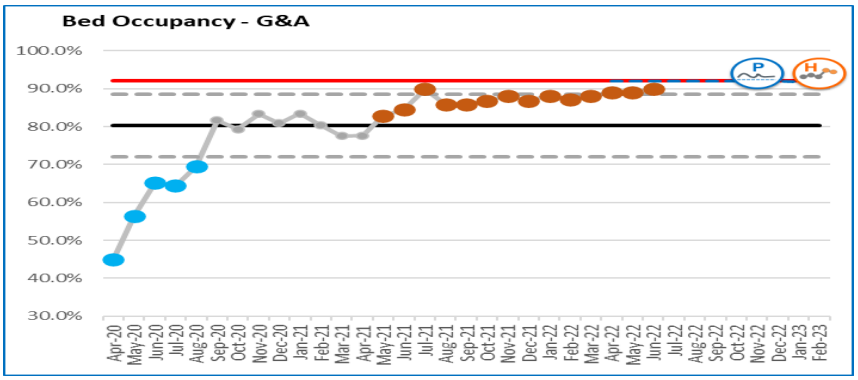
12 Hours in ED performance %



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

Hospital occupancy and activity

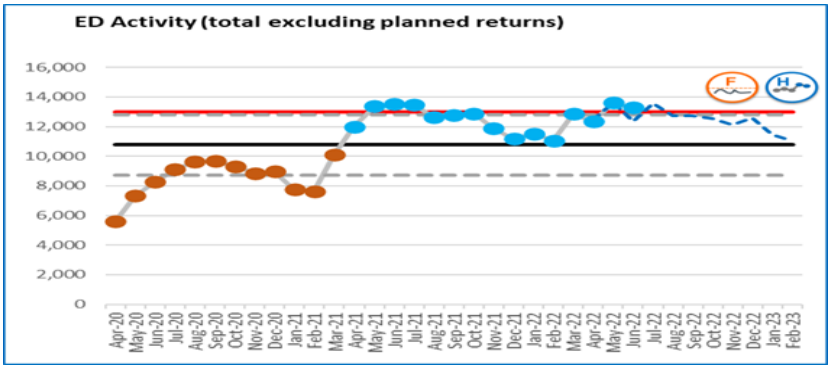
Bed occupancy



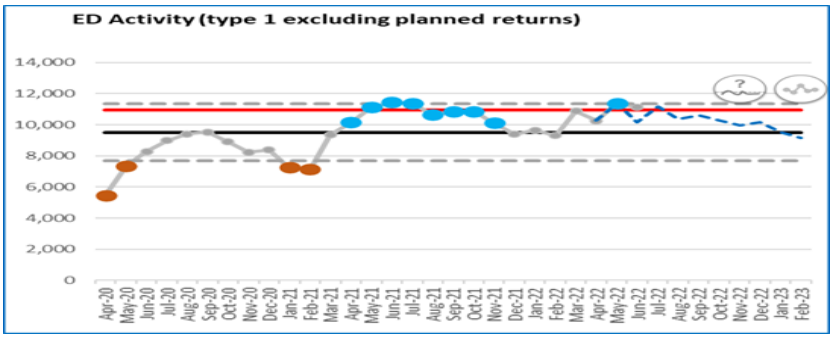
June 2022 actual performance
90%
Variance Type
Special Cause Concern
Local Target
92%
Target / Plan Achievement
Operational plan (22-23)

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, with most of the increase representing 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.	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



June 2022 actual performance
13280
Variance Type
Special Cause Improvement
Local Target
12362 (Monthly Average)
Target/ Plan achievement
22-23 Operational plan



June 2022 actual performance
11115
Variance Type
Special Cause Improvement
Local Target
10173 (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.	ED activity was lower than the previous month but remains high	Flow out of ED continues to be a significant issue. Increase in MFFD patients and reduction in number of complex discharges. Direct referrals referred to ED. Lack of usage of alternative pathways.	RSH ward reconfiguration to create acute medical floor. Business case to be presented to the system on 22/07/22. RSH ED reconfiguration in final stage due for completion by end of August. Extension of PRH SDEC – awaiting confirmation to proceed. Direct access for WAS and WMAS patients to SDEC, coloured phones to be introduced to support process. ED transformation programme to be launched September 2022 – business case being presented to Business Case Review Group and I&IC in July for funding approval. Embed ownership of internal professional standards (IPS). Pathway developments to increase pull from ED to SDEC. Introduction of ED redirection tool. UEC Improvement Action plan – internal and system wide in place covering pre-hospital, in hospital and post discharge workstreams.	Support from NHSE 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 ICS 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:

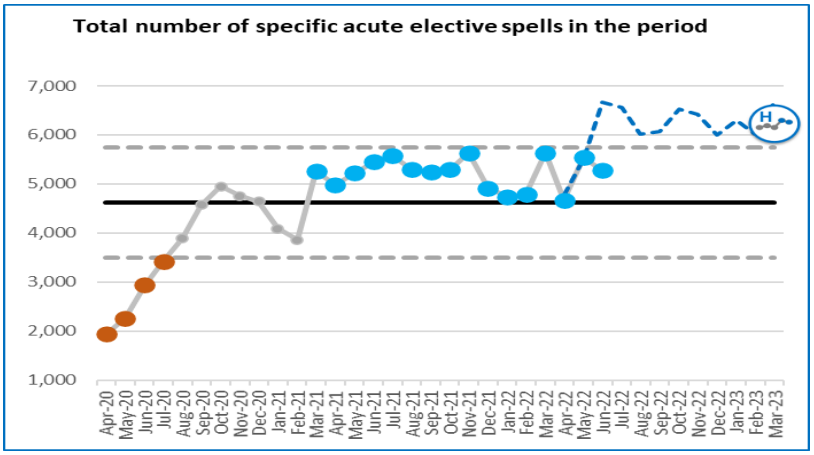
Total first outpatient attendances	April	May	June	YTD
19/20 Baseline	14,420	15,850	14,859	45,129
22/23 Actual	14,487	18,102	16,278	48,867
22/23 Plan	16,116	17,120	18,056	51,292
22/23 vs Baseline	100.5%	114.2%	109.5%	108.3%
vs plan	-11%	6%	-12%	-5%
Actual vs plan	89.9%	105.7%	90.2%	95.3%

Total follow up outpatient attendances	April	May	June	YTD
19/20 Baseline	29,958	30,804	28,545	89,307
22/23 Actual	27,113	30,874	28,537	86,524
22/23 Plan	29,229	29,093	31,749	90,071
22/23 vs Baseline	90.5%	100.2%	100.0%	96.9%
vs plan	-7%	6%	-11%	-4%
Actual vs plan	92.8%	106.1%	89.9%	96.1%

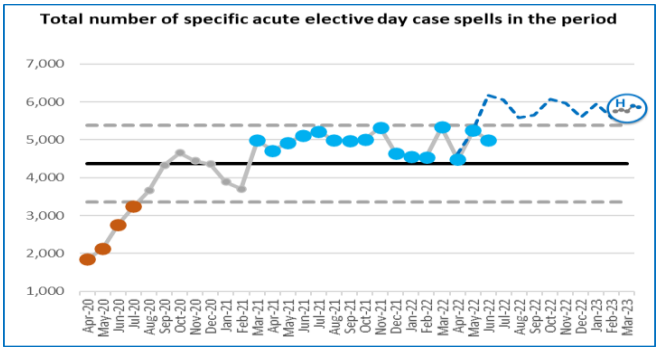
Total number of specific acute elective spells in the period	April	May	June	YTD
19/20 Baseline	329	385	426	1,140
22/23 Actual	193	296	280	769
22/23 Plan	163	279	487	929
22/23 vs Baseline	58.7%	76.9%	65.7%	67.5%
vs plan	9%	4%	-49%	-14%
Actual vs plan	118.4%	106.0%	57.5%	82.7%

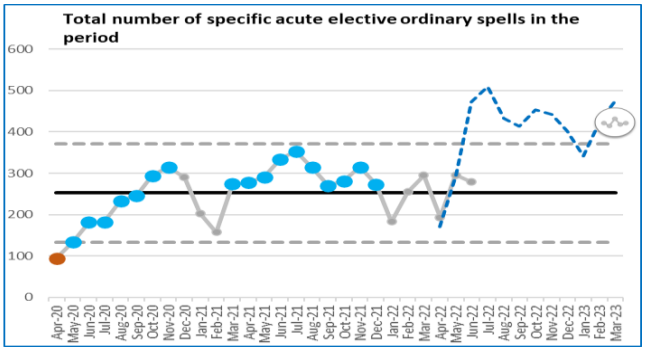
Total number of specific acute elective day case spells in the period	April	May	June	YTD
19/20 Baseline	4,997	5,434	5,015	15,446
22/23 Actual	4,477	5,240	5,019	14,736
22/23 Plan	4,560	5,123	6,214	15,898
22/23 vs Baseline	89.6%	96.4%	100.1%	95.4%
vs plan	-2%	2%	-24%	-8%
Actual vs plan	98.2%	102.3%	80.8%	92.7%

Total elective inpatient and day case activity



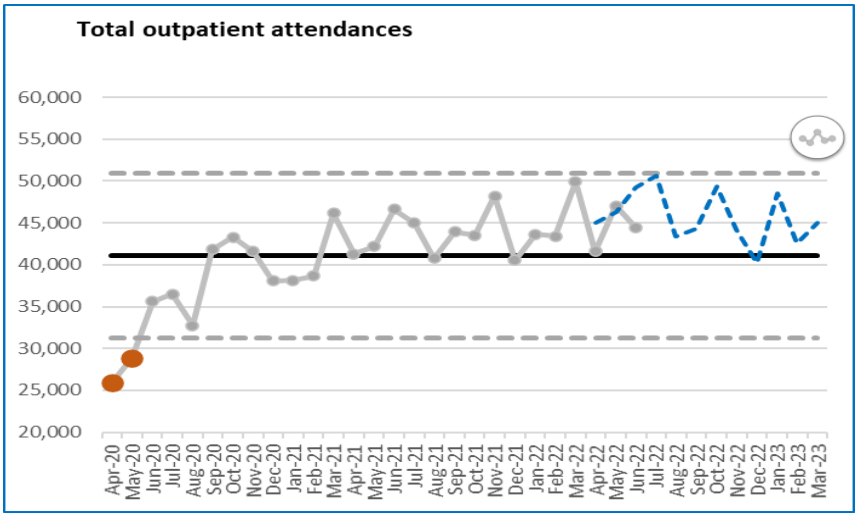
June 2022 actual performance
5227 (5019 DC, 280 IP)
Variance Type
Special Cause Improvement
Local Target
6658 (6103English 22-23 plan + 555 Welsh actual)
Target/ Plan achievement
(22-23 operational plan)



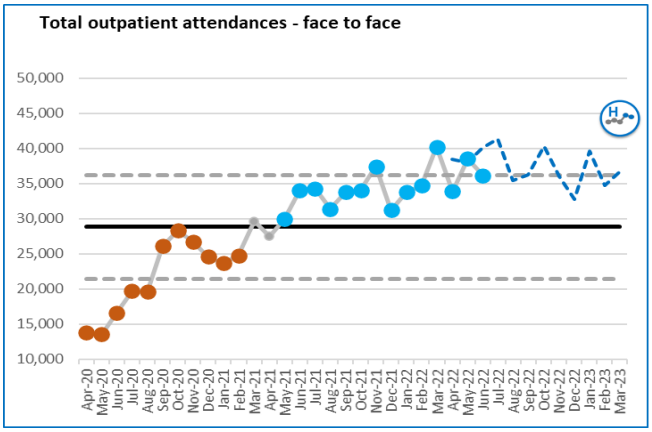


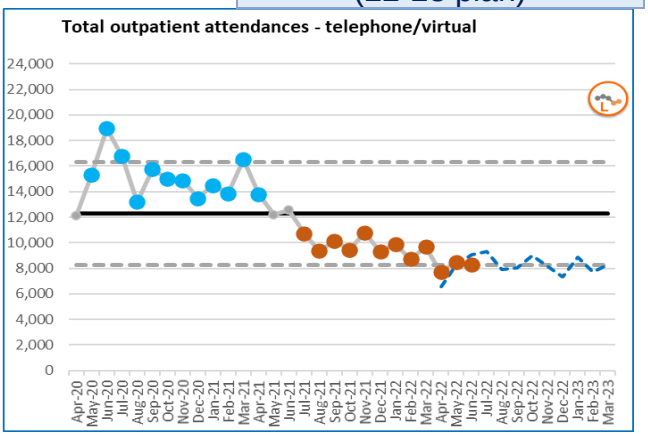
Background	What the Chart tells us	Issues	Actions	Mitigations
The Trust is working to recover services in line with the level of activity delivered in 2019-20, which is being used as a baseline. The Trust has developed an activity plan for 2022-23. This aims to optimise the internally available capacity to address urgent elective cases, to increase capacity and reduce the longest waits for routine surgery.	Activity remains below historic levels and below expectation with regard to “restoration & recovery.”	Reduced theatre capacity, theatre-staffing constraints linked to vacancies and sickness. Emergency pressures impacting on the elective bed base. Lack of orthopaedic bed base, inpatient and DSU capacity.	Clinical prioritisation of patients in terms of PL2 and PL2Cs and long patients waiting 6-4-2 processes for theatre allocation. Weekly restore and recovery meeting with specialties.	As actions.

Outpatient elective total activity

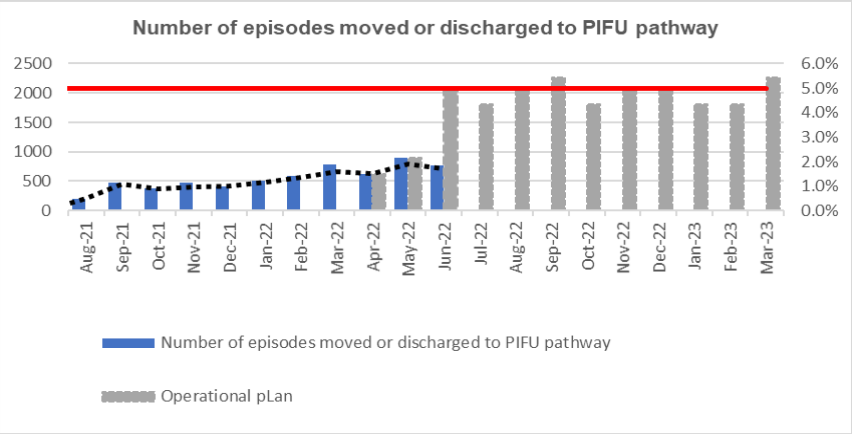


June 2022 actual performance
44815 (excl. TFC 812) Face to face – 36314 Telephone/Virtual – 8501
Variance Type
Common Cause
Local Target
49209 (45323 English 22-23 plan + 3886 Welsh actual)
Target/ Plan achievement
(22-23 plan)





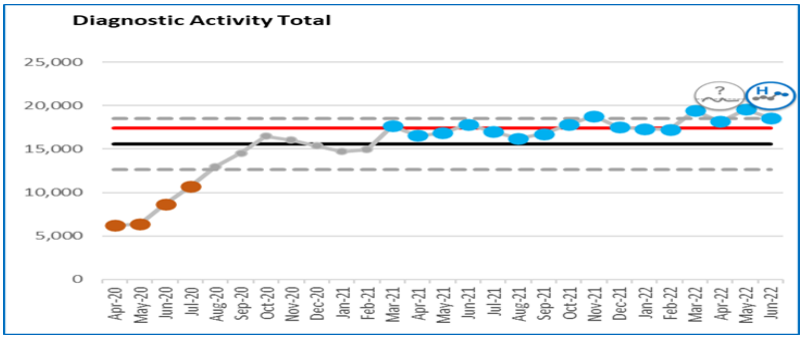
Background	What the Chart tells us	Issues	Actions	Mitigations
The operational activity plan aims to recover activity for 2022-23. In addition, transformation is expected to support new ways of working such as virtual activity, patient initiated follow up (PIFU) and increased use of advice and guidance. 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 face-to-face activity and decrease in telephone and virtual. The overall number of appointments has fallen this month and is below the plan.	Delivery of the plan itself does not eliminate the backlog of waits created during the pandemic. Ongoing work with the centre teams around PIFU, stratified follow up and virtual to improve engagement.	Waiting list initiative. Options for agency staff in challenged specialties. Bank staff support. CD for outpatient transformation is working with the clinical teams to around clinical engagement.	Clinical prioritisation of patients.



June 2022 actual performance
764 (1.7%)
Variance Type
Common Cause
Local Target
2040 (22-23 plan)
Target/ Plan achievement
NHSE target 5% of total OP attendances

Background	What the Chart tells us	Issues	Actions	Mitigations
The PIFU target by March 2023 is 5%	PIFU numbers are below the operational plan, with a decrease in initiations in June. The total started this month was around a third of the planned value	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. Weekly meeting established with centres to monitor and support progress which feeds into the monthly steering group.	As actions.

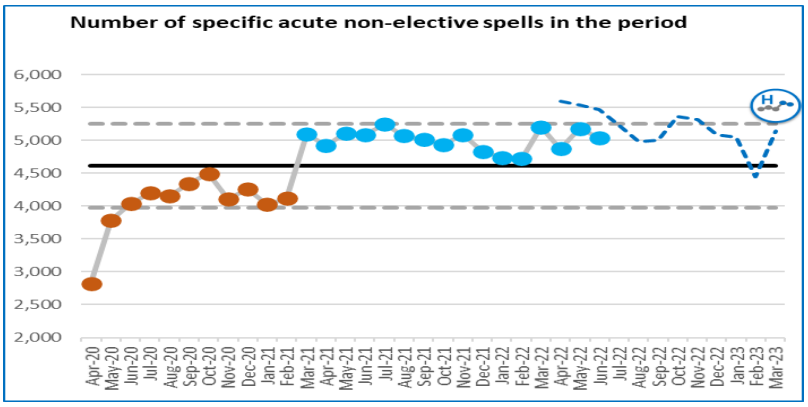
Diagnostics recovery



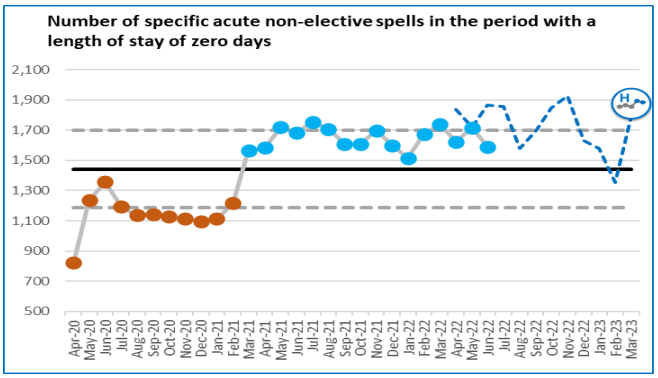
June 2022 actual performance
18587
Variance Type
Special Cause Improvement
Local Target
TBC
Target/ Plan achievement
(22-23 plan)

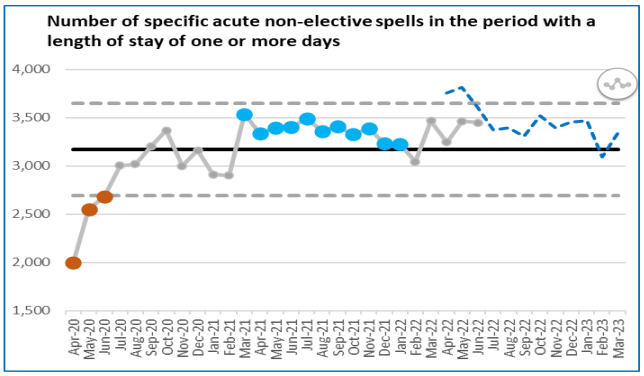
Background	What the Chart tells us	Issues	Actions	Mitigations
Diagnostic activity is made up of the number of tests/procedures carried out during the month; it contains imaging, physiological measurement, and endoscopy tests.	Special cause improvement has been maintained. Activity has reduced in comparison to May, although local target has been met.	Staff availability is affecting capacity. Impact of increasing incidence of COVID-19. There are difficulties in recruiting to lower band Radiographer posts.	Ongoing and repeated recruitment, including international routes. Review of training capacity to safely increased number of apprentices and undergraduates within our departments. Regular review of the appointment templates. Request for enhanced payments for the substantive staff to encourage overtime in all areas.	Bank/agency usage where available. Mobile CT/MRI scanners and US insourcing to increase the capacity.

Non-elective activity



June 2022 actual performance
5035
Variance Type
Special Cause Improvement
Local Target
5465 (5009 English 22-23 plan + 456 Welsh actual)
Target/ Plan achievement
(22-23 plan)

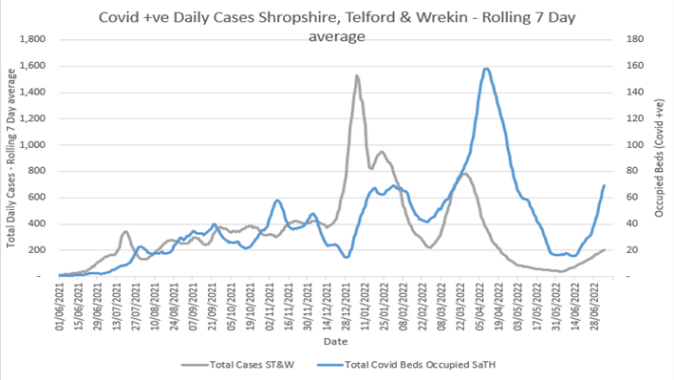


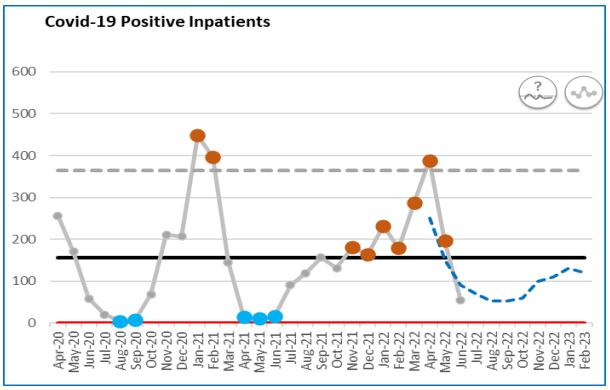


Background	What the Chart tells us	Issues	Actions	Mitigations
Non-elective activity reflects the demand from unscheduled care for admissions to hospital. It represents the greatest demand on beds and increases can result in constraints on elective activity, while reductions impact negatively on contract income.	Non elective activity has decreased this month and is below the planned value.	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

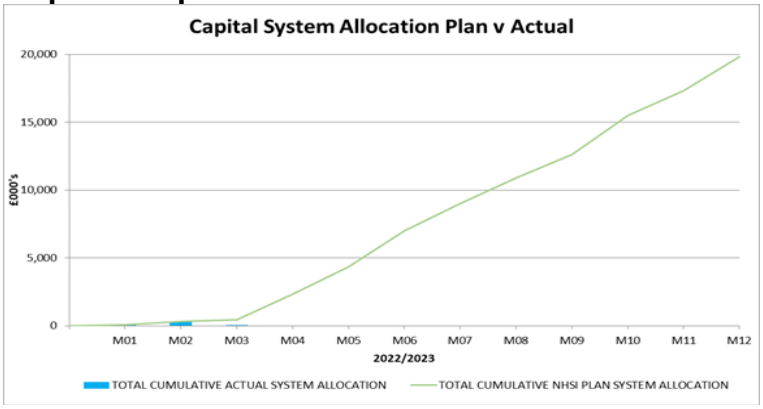
This table demonstrates the benchmarked position of the trust at a point in time compared to other English trusts reporting the same indicator. The icon shows the trend of ranking over time of the trust in relation to other trusts.

KPI	Latest month	Actual Performance Ranking	Performance
A&E - Left without been seen (out of 122)	May 22	74	
A&E - 4 Hour Standard (Type 1) (out of 106)	Jun 22	93	
A&E - Reattendance Rate (out of 118)	May 22	5	
A&E Time to Initial Assessment (Out of 113)	May 22	62	
Cancer 2 Week (out of 118)	Apr 22	97	
Cancer 2 Week Breast Symptomatic (out of 108)	Apr 22	88	
Cancer 62 Day Classic Metric (out of 121)	Apr 22	101	
Cancer 62 Day Breast Cancer (out of 113)	Apr 22	110	
Cancer 62 Day Lower Gastrointestinal Cancer (out of 119)	Apr 22	64	
Cancer 62 Day Lung Cancer (out of 114)	Apr 22	83	
Cancer 62 Day Other Cancer (out 120)	Apr 22	107	
Cancer 62 Day Skin Cancer (out 109)	Apr 22	90	
Cancer 62 Day Urological Cancer (out of 117)	Apr 22	88	
Diagnostic 6 Week Standard (out of 120)	May 22	96	
Diagnostic 6 Week Standard - Cardiology : echocardiography (out of 120)	May 22	8	
Diagnostic 6 Week Standard - Audiology Assessments (out of 108)	May 22	63	
Diagnostic 6 Week Standard - Urodynamics: pressures & flows (out of 101)	May 22	96	
Diagnostic 6 Week Standard - Respiratory physiology : sleep studies (out of 93)	May 22	42	
Diagnostic 6 Week Standard - Magnetic Resonance Imaging (out of 120)	May 22	110	
Diagnostic 6 Week Standard - Computed Tomography (out of 120)	May 22	78	
Diagnostic 6 Week Standard - Non-obstetric ultrasound (out of 122)	May 22	106	
Diagnostic 6 Week Standard - Colonoscopy (out of 120)	May 22	110	
Diagnostic 6 Week Standard - Flexi sigmoidoscopy (out of 120)	May 22	93	
Diagnostic 6 Week Standard - Cystoscopy (out of 117)	May 22	91	
Diagnostic 6 Week Standard - Gastroscopy (out of 120)	May 22	100	
RTT 52 Week Breach (out of 119)	May 22	85	
RTT Incomplete 18 Week Standard – (out of 119)	May 22	94	
RTT Incomplete 18 Week Standard Metric - Gynaecology (out of 118)	May 22	69	
Total Time in A&E - Admitted (out of 103)	May 22	89	
Total Time in A&E - Non - Admitted (out of 117)	May 22	46	
RTT Total Incompletes (out of 122)	May 22	48	
RTT 78 Week Breach (out of 119)	May 22	81	
RTT 104 Week Breach (out of 119)	May 22	86	

6. Finance Summary
Helen Troalen, Director of Finance

- The Trust has submitted a revised plan for a deficit of £19.135m for 2022/23 on the 20th June. 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 June, the Trust has recorded a year-to-date deficit of £8.353m against a draft planned deficit of £5.222m, an adverse variance to plan of £3.131m.
- The year-to-date deficit is driven by:
    - Pay costs, excluding covid and ERF are £5.33m adverse to plan. This is driven by an increase in agency expenditure, especially off-framework bookings since April 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 £2.92m which is £1.11m adverse to the draft plan. There was an expectation that Covid costs will begin to reduce over Q1 as Covid prevalence drops within the community, however given the current increase in prevalence escalation areas remain open.
    - Elective recovery costs are £2.65m which is £0.07m underspent against plan which is driven by decreased activity levels compared to plan.
    - Elective activity as a whole remains below plan resulting in a non-pay underspend of £2.65m 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.
- £0.84m of efficiency savings have been delivered year-to-date. 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 this is due to be identified at a divisional level.
- For 2022/23 the Trust's system allocation for capital is £19.822m. Following June's plan resubmission, expenditure at month 03 was forecast at £0.443m (including sale proceeds), £0.936m was incurred, with sale proceeds of £0.925m being received, resulting in net expenditure of £0.011m.
- The Trust held a cash bank balance at the end of June 2022 of £5.412m.

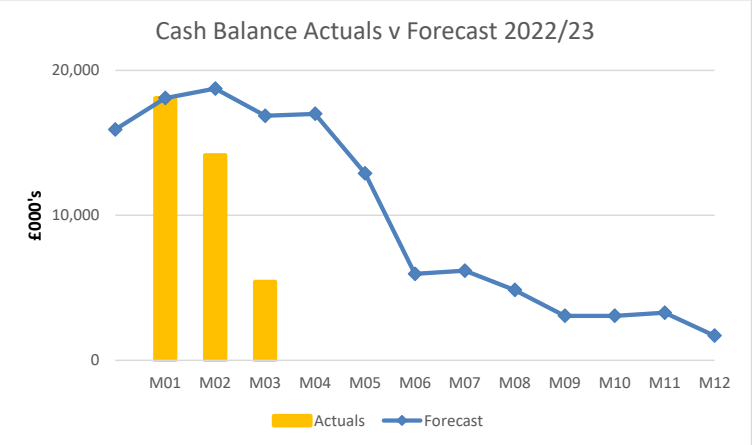
Capital Expenditure



June 2022 actual performance	
Spend year to date is £0.936m, offset by sale proceeds resulting in a net spend of £0.011m	
Variance Type	
Underspend of £0.432m	
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. The capital programme was reforecast in the June's plan resubmission	Within the submitted plan it was projected that expenditure of £0.443m would be incurred in June 2022 (including sale proceeds).The actual expenditure as at month 3 was £0.936m gross, after sale proceeds of £0.925m, this gives net expenditure of £0.011m. The main drivers for the under delivery at month 3 are renal offsite (£0.250m) and estates backlog (£0.133m).	The Trust is awaiting confirmation of national PDC funded schemes (CDC and elective hub).	No actions required.	No mitigations required.

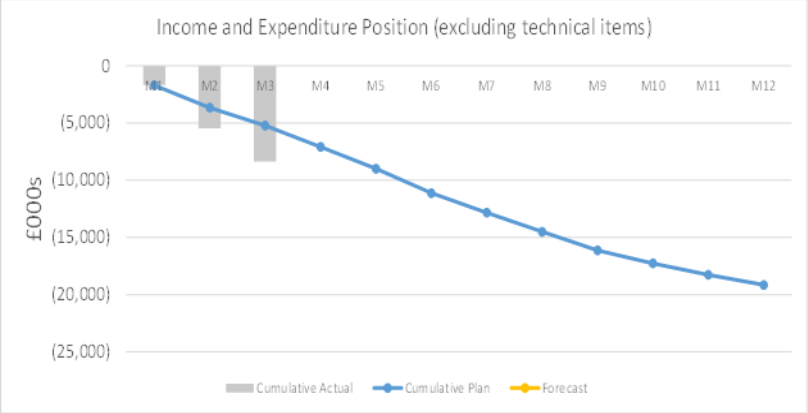
Cash



June 2022 actual performance
£5.412m cash in the bank
Variance Type against year-end forecast cash balance
£1.700m
SaTH Year End Cash Balance
Required £1.700m
Target/ Plan achievement
Balanced position.

Background	What the Chart tells us	Issues	Actions	Mitigations
The Trust undertakes monthly cashflow forecasting. A review of the cashflow assumptions is currently underway following June's plan resubmission.	The cash balance brought forward in 2022/23 was £15.918m with a cash balance of £5.412m held at end of June 2022 (ledger balance of £5.329m due to reconciling items). The chart demonstrates that our cash position is much lower than forecast in June.	The cash balance held at the end of June was lower than previous forecast. This is due to less income being received due to year-to-date adjustments with healthcare contracts and pay costs continuing at a higher level than plan due to continuing covid costs, escalation areas being open and off framework agency spend.	The cash position is concerning, and we are currently undertaking an in-depth review to inform our next steps.	Review of all assumptions to be carried out and discussions with key stakeholders to take place.

Income and Expenditure Position

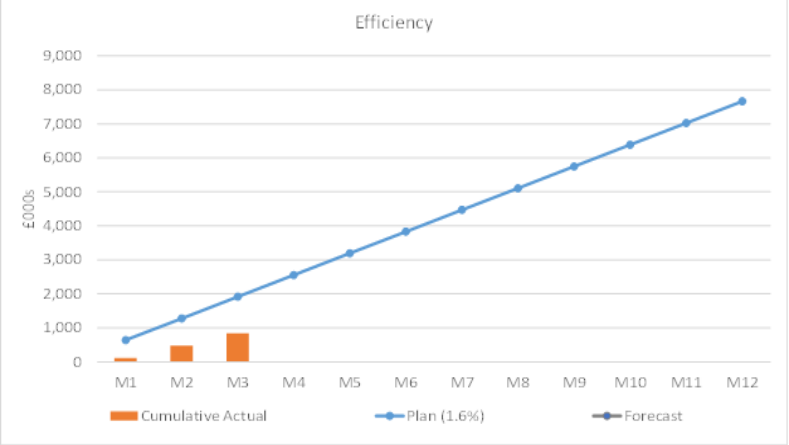


June 2022 actual performance	
(8.353m) Deficit at month three	
Variance Type	
Deficit variance of (£3.131m)	
National Target	**SaTH Plan 2022/23**
Breakeven	(£19.135m)*
Target/ Plan achievement	
(£19.135m) deficit full year*	

*Plan is currently draft

Background	What the Chart tells us	Issues	Actions	Mitigations
The Trust has submitted a revised financial plan for a deficit of £19.135m 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 £8.353m at month three which is £3.131m adverse to the plan submitted to NHSE in June. 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 since April. 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

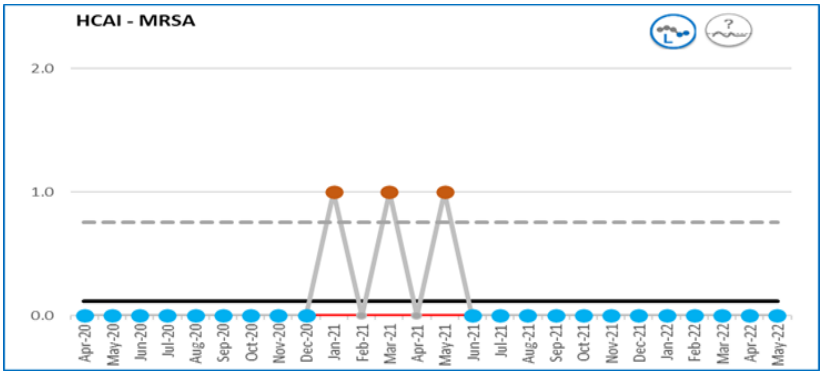


June 2022 actual performance
Year to Date Delivery of £0.839m
Variance Type
Adverse to straight line plan (£1.076m)
SaTH Plan 2022/23
£7.660m
Target/ Plan achievement
Full achievement by year end

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 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 £0.839m of efficiency savings year to date at the end of month two which is £1.076m adverse to the straight-line 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

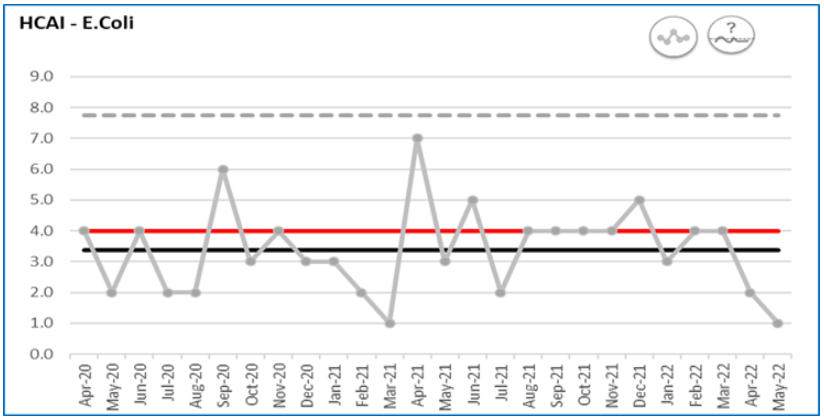
MRSA



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 IPCAC.

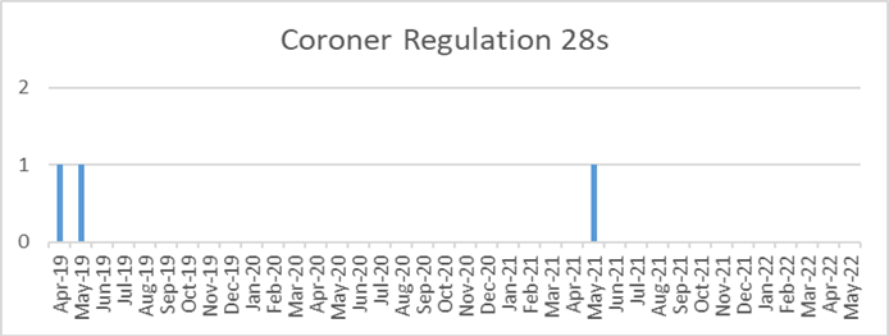
E-Coli



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.

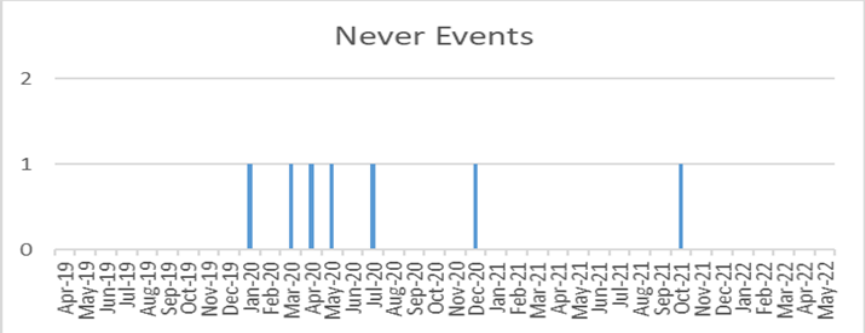
Coroner Regulation 28s



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.

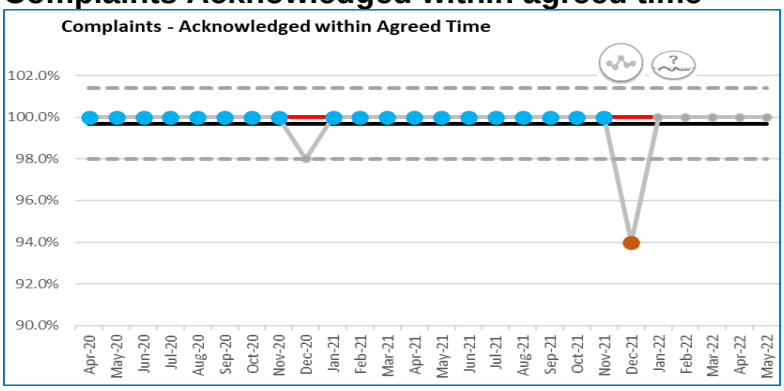
Never Events



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.

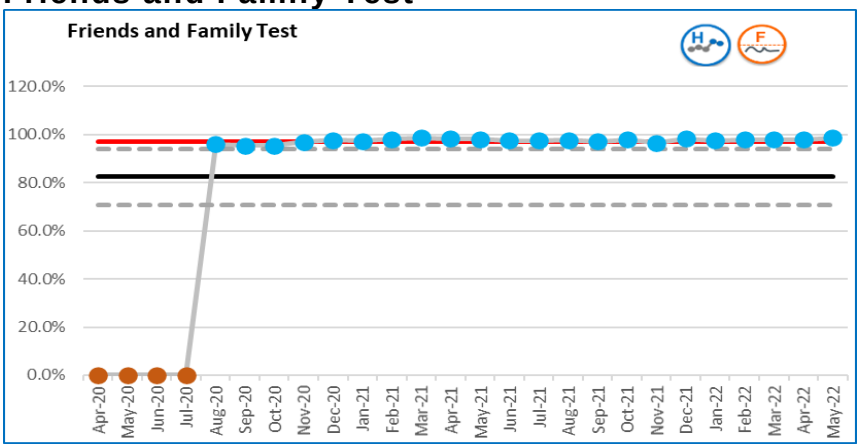
Complaints Acknowledged within agreed time



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

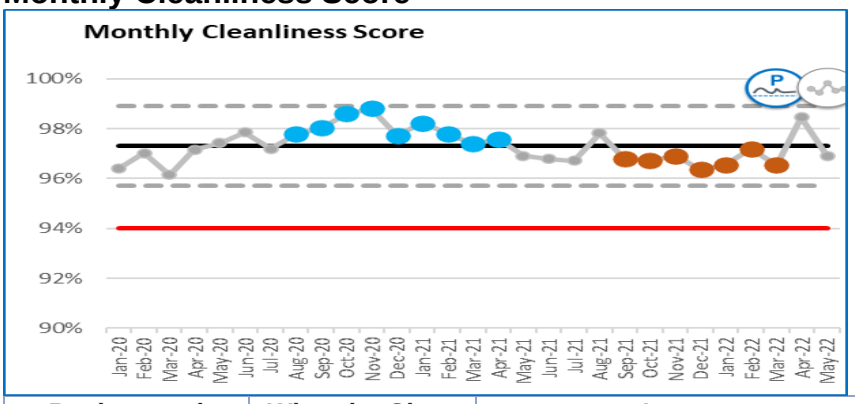
Background	What the Chart tells us	Issues	Actions	Mitigations
Acknowledging a complaint on receipt is important for patients raising concerns to both ensure that the patient knows we have received the complaint and that we are addressing it.	The target of three working days continues to be met, with 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

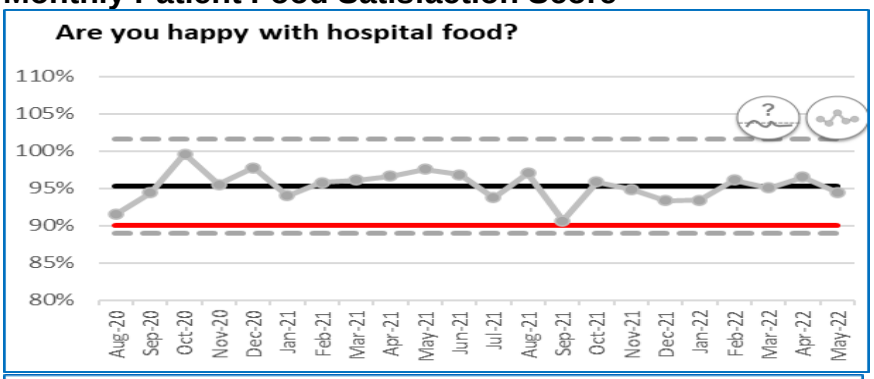
Monthly Cleanliness Score

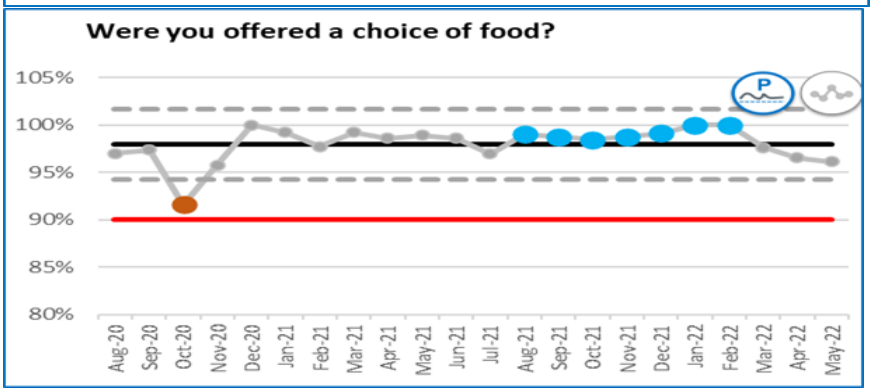


May 2022 actual performance
96.9%
Variance Type
Common Cause
Local SaTH standard
94%
Target/ Plan achievement
On target to achieve above local standard

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



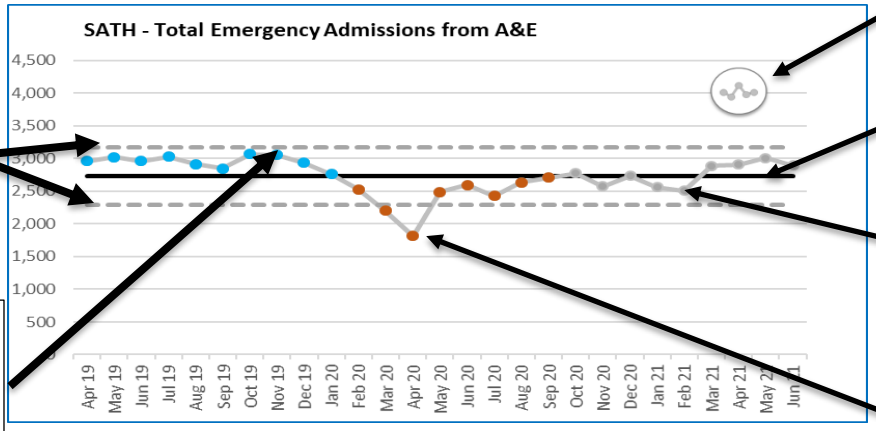


May 2022 actual performance
94.5% for satisfaction with food. 96.2% for satisfaction with choice.
Variance Type
Common Cause
Local SaTH standard
90%
Target/ Plan achievement
On target to achieve local standard

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

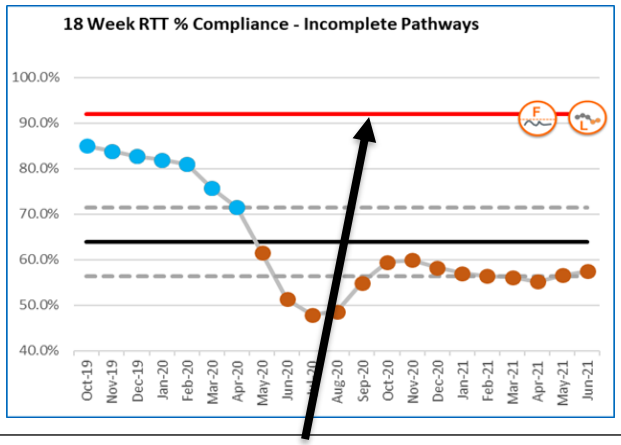
Mean or median line

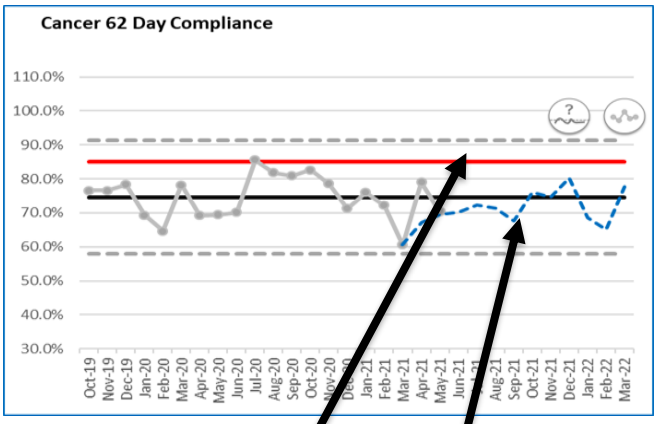
Common cause variation

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
A&G	Advice and Guidance
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
IPCOG	Infection Prevention Control Operational Group
IPAC	Infection Prevention Control Assurance Committee
IPDC	Inpatients 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
MEC	Medicine and Emergency Care
	Medically fit for discharge
MFFD	

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
MUST	Malnutrition Universal Screening Tool
NEL	Non-Elective
NHSE	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
PU	Pressure Ulcer
RALIG	Review Actions and Learning from Incidents Group
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
RIU	Respiratory Isolation Unit
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
TVN	Tissue Viability Nurse
UEC	Urgent and Emergency Care service
US	Ultrasound
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