

<b>Subject:</b>	Integrated Performance Report
<b>Supporting Directors:</b>	Michael Harper, Chief Operating Officer; Neil Priestley, Chief Financial Officer; Chris Morley, Chief Nurse; Mark Gwilliam, Director of Human Resources and Staff Development; David Hughes, Medical Director (Development); Jennifer Hill, Medical Director (Operations); Paul Buckley, Interim Director of Strategy & Planning.
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<b>Status (see footnote):</b>	A

**PURPOSE OF THE REPORT:** To provide the Board with a detailed assessment of performance against the agreed indicators and measures. The report describes the specific actions that are under way to deliver the required standards. This report will also be used to track the impact of the ongoing COVID-19 pandemic.

## RECOMMENDATIONS

The Board is asked to:

- Receive the Integrated Performance Report for November 2021.
- Note the performance standards that are being achieved.
- Be assured that where performance standards are not currently met, a detailed analysis has been undertaken and actions are in place to ensure an improvement is made.

IMPLICATIONS			APPROVAL PROCESS		
STH Strategic Aims		Tick as appropriate	<b>Meeting:</b>	Trust Executive Group	Board of Directors
1	Deliver the best clinical outcomes	<input checked="" type="checkbox"/>	<b>Approved Y/N:</b>		
2	Provide patient centred services	<input checked="" type="checkbox"/>	<b>Date:</b>	19 January 2022	25 January 2022
3	Employ caring and cared for staff	<input checked="" type="checkbox"/>	A = Approval; A* = Approval and Requiring Board Approval; D = Debate; N = Note		
4	Spend public money wisely	<input checked="" type="checkbox"/>			
5	Deliver excellent research, education and innovation	<input checked="" type="checkbox"/>			
6	Create a Sustainable Organisation	<input checked="" type="checkbox"/>			



## INTEGRATED PERFORMANCE REPORT



**BOARD OF DIRECTORS**  
**25 January 2022**



Section	Page
<b>Executive Summary</b>	4
<b>Trust Performance Overview: November 2021</b>	7
<b>Trust Performance Report by Exception</b>	10
Incidents – Percentage of incidents approved within 35 days based on approval date	10
Non-Elective Average Length of Stay (LOS)	11
Caesarean section rates	12
Birth Rate between 24 and 37 weeks	13
Obstetric haemorrhage	14
Patient Falls	15
Pressure Ulcers – Number of pressure ulcers acquired within STH	16
Never Events	17
A&E 4-hour wait – Patients seen within 4 hours	18
Ambulance Turnaround times	19
12 Hour trolley waits in A&E	20
18 week Referral to Treatment Waiting Times (RTT) – Percentage of patients on incomplete pathways waiting less than 18 weeks	21
52 week waits - Actual numbers	22
Patient treatment list – total numbers	23
6 week diagnostic waiting: - Percentage of patients waiting 6 weeks or longer for a diagnostic test	24
On-day elective cancellations for non-clinical reasons	25
Number of patients cancelled on the day and not readmitted within 28 days	26
Cancelled Outpatient appointments - Percentage of out-patient appointments cancelled by hospital	27
Cancelled Outpatient appointments - Percentage of out-patient appointments cancelled by patient	28
Cancer Waits - Patient seen within 2 weeks of urgent referral	29
Cancer Waits - Breast symptomatic seen within 2 weeks	30
Cancer Waits - 62 days from referral to treatment (GP referral)	31
Cancer Waits - 62 days from referral to treatment (Cancer Screening Service)	32
Cancer Waits - 31 day first treatment from referral	33
Cancer Waits - 31 day subsequent treatment (Surgery)	34
Percentage of complaints closed within agreed timescales	35
Community Care – Integrated Care Team contacts	36
Community Care – Intermediate care beds average length of stay	37
GP Co-Operative – Patients seen within 4 hours	38
FFT Recommended – Inpatients	39
FFT Recommended – AE	40
FFT Recommended - Maternity	41
Sickness Absence - All days lost as a percentage of those available	42
Appraisals - Completed appraisals in last year	43
Efficiency	44
<b>Deep Dive : Infection Prevention &amp; Control</b>	45
<b>Directorate Dashboards</b>	54
<b>Trust Performance Overview: October 2021</b>	57

## EXECUTIVE SUMMARY

### DELIVER THE BEST CLINICAL OUTCOMES

- Trust attributable pressure ulcers: 69 cases reported for the month of October, 14 below the Trust threshold of 83. 95 cases reported for the month of November, 12 above the Trust threshold of 83.
- Category 4 pressure ulcers: the weekly Pressure Ulcer Review meetings have identified 0 category 4 pressure ulcers associated with a lapse in care in either October or November.
- Hospital standardised mortality data is 'within the expected range'.
- Never Events: 0 new never events were reported in October. There were 2 new never events reported in November.
- 80.75% of incidents were approved within 35 days, which is below the internal target of 95%.
- All serious incidents were approved within timescales.
- Average Length of Stay for non-elective patient spells was above the benchmark.
- Rates of Caesarean section are higher than the national expected range. The rates continue to be monitored and relate to complexity of the case mix and women's choice.
- The birth rate between 27 and 37 weeks as a proportion of all registerable births is higher than the expected level. The birth rate between 24 and 27 weeks is at the expected level.
- The STH massive obstetric haemorrhage rate is above the expected range at 5.16%. Work to understand and improve the rate is ongoing.

### PROVIDING PATIENT CENTRED SERVICES

- Complaints – 91% of complaints were responded to within the agreed timescale in October and 85% of complaints were responded to within the agreed timescale in November.
- FFT (The NHS Friends and Family Test) provides patients the ability to give quick and anonymous feedback after receiving NHS care or treatment; the metric indicates the proportion of respondents who would rate the service for treatment as good or very good. The inpatient score for was 90% and 91% for October and November respectively.
- FFT score A&E – the score for October 2021 was 74%. The score for November 2021 was 76%.
- FFT score Maternity – the score for October 2021 was 78%. The score for November 2021 was 81%.
- FFT score Community - the score for October 2021 was 88%. The score for November 2021 was 90%.
- Mixed sex accommodation – there were no breaches reported in November. The national standard is 0.
- Patient Activity during November 2021 was higher than October 2021, but lower than the same month in 2019.
- The number of operations cancelled on the day for non-clinical reasons was 85 in November, compared to 94 in October.
- Fifteen patients had their operation cancelled on the day of admission for non-clinical reasons and were not re-admitted within 28 days.
- The percentage of patients attending A&E within 4 hours was 73.03% in November. The local target is 90% and the national target is 95%. The National performance in November was 74%.
- In November, 37.61% of ambulance handovers occurred within 15 minutes, compared to 43% in October. 18.27% of ambulance handovers took more than 30 minutes, compared to 18.01% in October.
- The percentage of patients who had been waiting less than 18 weeks for their treatment at the end of the month was 76.68% for November. The national target is 92%. The national performance for November was 65.5%.
- There were 1,004 52 week breaches in November. This was an increase of 117 on the October position.
- The percentage of patients waiting 6 weeks or less for their diagnostic test was 83.36% at the end of November. The national target is 99%. The national performance for October was 75.02%.
- The percentage of outpatient appointments cancelled by the hospital remains higher than the national benchmark.

- The percentage of outpatient appointments cancelled by the patient was higher than the national benchmark.
- The percentage of patients that did not attend for their outpatient appointment was better than the national benchmark.
- Cancer Waiting Times performance remains variable across the targets and the impact of COVID-19 continues to present significant challenges. Urgent and obligatory care remain a priority. For September unpublished cancer waiting times performance, STH are currently compliant for Subsequent Radiotherapy and Subsequent Anti Cancer Drug treatments.
- Two Week Wait for October (as at 05/01/2022) is currently 91.0% and for Breast Symptomatic Two Week Wait referrals is 64.4%.
- 62 day referral to treatment (GP Referral), October STH performance for non-shared pathways is currently 61.6%.
- For pathways relating to 31 day first treatments, October performance is currently 89.6% (threshold 96%).
- October performance is below threshold for Subsequent Surgery at 66.3% (94% threshold).
- October performance for 62 day screening pathways is currently below threshold at 68.9% (90% threshold)

## EMPLOYING CARING AND CARED FOR STAFF

- Safer staffing – overall, the percentage of care hours per patient day (CHPPD) for registered nurses was 88.84% (October) and 89.91% (November) and for all care staff was 93.29% (October) and 94.03% (November). Any areas where the registered nurse CHPPD was below 85% will be highlighted in a report to the Human Resources & Organisational Development Committee.
- HR metrics, Engagement activity, and People Strategy plans continue to be prioritised, along with Workforce matters and Agency control.
- The non-COVID sickness absence rate for November was 5.9%, which is above the Trust target of 4%. The year to date non-COVID sickness absence rate was 5%.
- Short term absence for September was 2.45%. Long term absence for September was 3.48%.
- The Trust appraisal rate was 84% in November which is below the Trust Target of 90%.
- Compliance levels for mandatory training are at 91% against the Trust Target of 90%.
- The Trust Annual Turnover Rate for Nov was 8.70%. Lowest turnover rates for Nov were 6.3% for Medical and Dental staff and the highest leaver rates were 10.2% for Administrative and Clerical roles.
- Retention figures for the Trust are at 90.75% which has been consistently above the target of 85% for over 12 months now.
- We have specific COVID 19 related support for all staff and are promoting the national Health and Wellbeing offer in addition to support provided by the Trust. Vivup are fully supporting staff and are managing an increased call volume without delays in service provision.

## SPEND PUBLIC MONEY WISELY

- The position at Month 8 is a £2,418.5k (0.3%) surplus against plan. This is virtually the same as the Month 7 position and incorporates the planned over-commitment of reserves created by investing reported underspends via the Trust's Non-Recurrent Programme.
- Within this position, the assessed non-pay savings to month 8 from activity being below the funded (2019/20) level were £7.3m (£0.5m in month). The on-going impact of Covid means that such savings appear likely to continue for the rest of the financial year, albeit there is still considerable pressure to find ways to increase elective activity.
- There are further gains from lower PDC Dividend costs and released provisions.
- Specific Directorate Covid costs/income losses continue to be funded from the Trust's Covid allocation. The Omicron variant impact has added a degree of uncertainty to projections of spend but it is still likely that the available funding will be adequate.
- At Month 8 19/37 Directorates are in a balanced position (an improvement of 1) with 3 having deficits in excess of 3% of year-to-date budgets (an increase of 1). The overall position across Directorates deteriorated in November to a deficit of £1.6m.
- Pay is £3.4m (0.7%) under spent with the Medical & Dental overspend at £5.9m and the Nurses and Midwives underspend at £5.9m.
- Year-to-date efficiency savings amount to £2.8m compared to the £5.3m (1%) target.
- As expected. No Elective Recovery Fund (ERF) income has been earned since Quarter 1, although the value of that has increased to £12.5m. Additional ERF funding may be available in the remainder of the year to fund potential plans to further increase elective activity.
- The key risks for 2021/22 are the delivery of the required level of efficiency savings and any unanticipated inflation/other cost pressures.
- Work is progressing on Business/Financial Planning for 2022/23 and will be progressed as the National Planning Guidance, allocations, Financial Planning Guidance, etc. are

issued in the coming weeks

## DELIVER EXCELLENT RESEARCH, EDUCATION & INNOVATION

- As a result of COVID-19, the National Institute of Health Research (NIHR) metrics that we report were suspended. Reporting has now commenced and will be available in the next quarter.
- STH performance for COVID-19 Studies has been as follows:
- The set up of COVID studies has been significantly faster than the 40 day existing national benchmark; STH median time was 12 days
- Recruitment of First Patients First Visit into the COVID studies, has also in the majority of cases been within the 30 day existing national benchmark; STH median time was 15 days
- Recruitment to COVID trials has been above target, as demonstrated by the number of participants recruited to the studies.
- This work has contributed to the development of licenced vaccines now given as part of the vaccine roll out programme and also the development of new treatments for COVID-19 (e.g. Dexamethazone, Remdesivir) which improve the outcomes for patients with COVID-19.

**The Trust Performance overview is provided for the months of October and November 2021 below. An exception report is provided for any indicator receiving a red rating in either month (this includes indicators that received a red rating in October 2021, and a green rating in November 2021).**

# TRUST PERFORMANCE OVERVIEW - NOVEMBER 2021

Indicator	Measure	Standard	Target Type	Current Data Range	Current Rating	YTD	Trend	Data Quality A,V,R&C,T,R,C&C
CQC Compliance	Outcome of CQC inspection	Good in all five domains	SOF	November				■ ■ ■ ■ ■ ■ ■ ■
<b>Deliver The Best Clinical Outcomes</b>								
Hospital Mortality	Hospital Standardised Mortality Ratio	As expected or lower	SOF	Jul-20 to Jun-21				■ ■ ■ ■ ■ ■ ■ ■
Hospital Mortality	Summary Hospital-level Mortality Indicator	As expected or lower	SOF	Dec19 to Nov20				■ ■ ■ ■ ■ ■ ■ ■
MRSA bacteraemia	Hospital onset	Zero cases	SOF	November			▲ ▲	■ ■ ■ ■ ■ ■ ■ ■
MSSA bacteraemia	Hospital onset	63 per year	SOF	Q3 21/22			▲ ▲ ▲ ▲	■ ■ ■ ■ ■ ■ ■ ■
C.diff	Hospital onset	100 per year (25 per quarter)	SOF	Q3 21/22			▲ ▲ ▲ ▲	■ ■ ■ ■ ■ ■ ■ ■
C.diff	Community onset/ healthcare associated	36 per year (9 per quarter)	SOF	Q3 21/22				■ ■ ■ ■ ■ ■ ■ ■
E.coli	Hospital onset	172 per year (43 per quarter)	SOF	Q3 21/22			▲ ▲ ▲ ▲	■ ■ ■ ■ ■ ■ ■ ■
E.coli	Community onset/ healthcare associated	132 per year (33 per quarter)		Q3 21/22			▲ ▲ ▲ ▲	■ ■ ■ ■ ■ ■ ■ ■
Serious Incidents	Number of serious incidents (SI)	Number	Local	November	8	60	▲ ▲ ▲ ▲	■ ■ ■ ■ ■ ■ ■ ■
Serious Incidents	Approved SI Report submitted within timescales	No overdue reports	Local	November			▲ ▲ ▲ ▲	■ ■ ■ ■ ■ ■ ■ ■
Incidents	Number of finally approved incidents based on incident date	Number of incidents	Local	November	2050	19374	▲ ▲ ▲ ▲	■ ■ ■ ■ ■ ■ ■ ■
Incidents	Percentage of incidents approved within 35 days based on approval date	95% within 35 days	Local	November			▲ ▲ ▲ ▲	■ ■ ■ ■ ■ ■ ■ ■
Average Length of Stay (by discharges)	Average Length of Stay Elective	4.27 days (Dr Foster)	Local	Jul-20 to Jun-21			▲ ▲ ▲ ▲	■ ■ ■ ■ ■ ■ ■ ■
	Average Length of Stay Non Elective	4.45 days (Dr Foster)	Local	Jul-20 to Jun-21			▲ ▲ ▲ ▲	■ ■ ■ ■ ■ ■ ■ ■
Caesarean section rate	Elective Caesarean section rate as proportion of all deliveries	13%	Local	November				■ ■ ■ ■ ■ ■ ■ ■
	Emergency Caesarean section rate as proportion of all deliveries	17%	Local	November			▲ ▲ ▲ ▲	■ ■ ■ ■ ■ ■ ■ ■
Birth rate 24-37 weeks	Birth rate between 24 and 37 weeks as proportion of all births >24 weeks, rolling 12 months	6%	Local	November				■ ■ ■ ■ ■ ■ ■ ■
Birth rate 24-27 weeks	Birth rate between 24 and 27 weeks as proportion of all births >24 weeks, rolling 12 months	1%	Local	November				■ ■ ■ ■ ■ ■ ■ ■
Obstetric haemorrhage	Massive obstetric haemorrhage >=1500ml as proportion of deliveries (singleton cephalic births 37-42 weeks gestation only)	2.9%	Local	November				■ ■ ■ ■ ■ ■ ■ ■
Patient Falls	Number of patient falls	< 3526 per year / 294 per month (19-20 total)	Local	November			▲ ▲ ▲ ▲	■ ■ ■ ■ ■ ■ ■ ■
Pressure Ulcers	Number of pressure ulcers acquired within STH	Max 83 per month (996 per year)	Local	November				■ ■ ■ ■ ■ ■ ■ ■
Pressure Ulcers	Category 4 pressure ulcers	Zero	Local	November				■ ■ ■ ■ ■ ■ ■ ■
Never Events	Number of never events	Zero	SOF	November			▲ ▲ ▲ ▲	■ ■ ■ ■ ■ ■ ■ ■
VTE	VTE Risk Assessment completed as proportion of all inpatient admissions	95%	SOF	Q1 21/22			▲ ▲ ▲ ▲	■ ■ ■ ■ ■ ■ ■ ■
Dementia	Dementia Assessment as a proportion of all inpatient non-elective admissions	90%	SOF	Q1 21/22				■ ■ ■ ■ ■ ■ ■ ■
<b>Provide Patient Centred Services</b>								
A&E 4-hour wait	Patients seen within 4 hours	95%	SOF	November			▲ ▲ ▲ ▲	■ ■ ■ ■ ■ ■ ■ ■
>12 hr Trolley waits in A&E	No. of patients waiting > 12 hours	Zero	National	November				■ ■ ■ ■ ■ ■ ■ ■
Ambulance turnaround	Time taken for ambulance handover of patient	100% within 15 minutes	National	November			▲ ▲ ▲ ▲	■ ■ ■ ■ ■ ■ ■ ■
Ambulance turnaround	Time taken for ambulance handover of patient	0% in excess of 30 minutes	National	November			▲ ▲ ▲ ▲	■ ■ ■ ■ ■ ■ ■ ■
Ambulance turnaround	Time taken for ambulance handover of patient	0% in excess of 60 minutes	Local	November			▲ ▲ ▲ ▲	■ ■ ■ ■ ■ ■ ■ ■
18 weeks RTT	Percentage of patients on incomplete pathways waiting less than 18 weeks	92%	SOF	November				■ ■ ■ ■ ■ ■ ■ ■
52 week waits	Actual numbers	Zero	National	November				■ ■ ■ ■ ■ ■ ■ ■
Size of PTL	Total size of Patient Treatment List	<= Sep-21 (61,416)	Local	November				■ ■ ■ ■ ■ ■ ■ ■
6 week diagnostic waiting	Percentage of patients seen within 6 weeks	99%	SOF	November			▲ ▲ ▲ ▲	■ ■ ■ ■ ■ ■ ■ ■
Cancelled Operations	Number of operations cancelled on the day for non clinical reasons	75 per month	Local	November			▲ ▲ ▲ ▲	■ ■ ■ ■ ■ ■ ■ ■
	Number of patients cancelled on the day and not readmitted within 28 days	Zero	National	November			▲ ▲ ▲ ▲	■ ■ ■ ■ ■ ■ ■ ■
Cancelled Outpatient appointments	Percentage of out-patient appointments cancelled by hospital	8.71% (National figure 2019/20)	Local	November			▲ ▲ ▲ ▲	■ ■ ■ ■ ■ ■ ■ ■
	Percentage of out-patient appointments cancelled by patient	7.51% (National figure 2019/20)	Local	November			▲ ▲ ▲ ▲	■ ■ ■ ■ ■ ■ ■ ■
DNA rate	Percentage of new out-patient appointments where patients DNA	7.27% (National figure 2019/20)	Local	November			▲ ▲ ▲ ▲	■ ■ ■ ■ ■ ■ ■ ■
	Percentage of follow-up out-patient appointments where patients DNA	7.36% (National figure 2019/20)	Local	November			▲ ▲ ▲ ▲	■ ■ ■ ■ ■ ■ ■ ■
Cancer Waits	Patient seen within 2 weeks of urgent referral	93%	National	Q2 20/21			▲ ▲ ▲ ▲	■ ■ ■ ■ ■ ■ ■ ■
	Breast symptomatic seen within 2 weeks	93%	National	Q2 20/21			▲ ▲ ▲ ▲	■ ■ ■ ■ ■ ■ ■ ■
	62 days from referral to treatment (GP referral)	85%	SOF	Q2 20/21			▲ ▲ ▲ ▲	■ ■ ■ ■ ■ ■ ■ ■
	62 days from referral to treatment (Cancer Screening Service)	90%	SOF	Q2 20/21			▲ ▲ ▲ ▲	■ ■ ■ ■ ■ ■ ■ ■
	31 day first treatment from referral	96%	National	Q2 20/21			▲ ▲ ▲ ▲	■ ■ ■ ■ ■ ■ ■ ■
	31 day subsequent treatment (Surgery)	94%	National	Q2 20/21			▲ ▲ ▲ ▲	■ ■ ■ ■ ■ ■ ■ ■
	31 day subsequent treatment (Radiotherapy)	94%	National	Q2 20/21			▲ ▲ ▲ ▲	■ ■ ■ ■ ■ ■ ■ ■
	31 day subsequent treatment (Drugs)	98%	National	Q2 20/21			▲ ▲ ▲ ▲	■ ■ ■ ■ ■ ■ ■ ■






A = Accuracy, V = Validity, R&C = Reliability & Consistency, T = Timeliness, R = Relevance, C&C = Completeness & Coverage

Indicator	Measure	Standard	Target Type	Current Data Range	Current Rating	YTD	Trend	Data Quality A,V,R&C,T,R,C&C
<b>Provide Patient Centred Services</b>								
e-Referral Service	Percentage of eligible GP referrals received through Electronic Referral Service	90%	Local	November				
Ethnic group data collection	Percentage of inpatient admissions with a valid ethnic group code	85%	National	November				
Elective Inpatient activity	Variance from contract schedules	On plan	Local	November				
Non elective inpatient activity	Variance from contract schedules	On plan	Local	November				
New outpatient attendances	Variance from contract schedules	On plan	Local	November				
Follow up op attendances	Variance from contract schedules	On plan	Local	November				
A&E attendances	Variance from contract schedules	On plan	Local	November				
Complaints	Percentage of complaints closed within agreed timescales	90% within agreed timescale	Local	November				
Written Complaints Rate	Written complaints rate per 10,000 finished consultant episode	<19/20 rate ()	SOF	Q3 2019/20	39.3			
Community Care	Integrated Care team contacts	43,000 per month	Local	November				
	Intermediate Care at home Community Intermediate Care response time	98% within 1 day	Local	November				
	Intermediate Care Beds Occupancy	91%	Local	November				
	Intermediate Care Beds Length of Stay	<35 days	Local	November				
Out of Hours GPC	% Seen Within 4 hours	95%	Local	November				
FFT Recommended	Patients recommending STH for Inpatient treatment	95%	SOF	November				
FFT Recommended	Patients recommending STH for A&E treatment	86%	SOF	November				
FFT Recommended	Patients recommending STH for Maternity treatment	95%	SOF	November				
FFT Recommended	Patients recommending STH for Community treatment	90%	SOF	November				
Community care –information completeness	RTT information completeness	48.7%	National	2020/21 Q1				
	Referral information completeness	50%	National	2020/21 Q1				
	Activity information completeness	50%	National	2020/21 Q1				
Day surgery rates	Aggregate percentage of all BADS procedures recommended to be treated as day case or outpatient	88%	Local	November				
Mixed Sex Accommodation	Number of breaches of Mixed Sex Accommodation standard	Zero	SOF	November				
<b>Employ Caring &amp; Cared for Staff</b>								
Sickness Absence	All days lost as a percentage of those available	4.00%	SOF	November				
Appraisals	Completed appraisals in last year	90%	Local	November				
Mandatory Training	Overall percentage of completed mandatory training	90%	Local	November				
Safer Staffing	Care Hours per patient day (Registered Nurses)	85% of planned hours or greater	Local	November				
	Care Hours per patient day (Total)	85% of planned hours or greater	Local	November				
Staff Turnover	Executive Team turnover (number of leavers as a percentage of total executive head count - rolling 12 months)	0%	SOF	November				
	Number of leavers as a percentage of total head count (rolling 12 months)	to be determined	SOF	November	8.7%			
	Retention Rate	85%	SOF	November				
Recruitment	Request to fill to unconditional final offer	Average <= 8 weeks	Local	November	10			
<b>Spend Public Money Wisely</b>								
I & E	YTD actual I & E surplus/deficit in comparison to YTD plan I & E surplus/deficit	>=0	SOF	November				
I & E Margin	I & E surplus/deficit as a percentage of total revenue	>=0	SOF	November				
Efficiency	Variance from plan	On plan	Local	November				
Cash	Actual	Above profile	Local	November				
Liquidity	Days of operating costs held in cash or cash equivalents	>0	SOF	November				
Capital	Expenditure - variance from plan	On plan	Local	November				
<b>Deliver Excellent Research, Education &amp; Innovation</b>								
Recruitment to trials	Total number of patient accruals to portfolio studies	0	Regional -Y&H	Q3 19/20				
<b>Annually Reported Indicators</b>								
Staff Survey	National average or better in all 10 domains	0 domains below national average	Local	2020				

## Key to Variation and Assurance Icons

The IPR continues to be developed and to use SPC charts where possible for exception reports. Given the current operational pressures it was agreed by Gold Command that data would be provided for each exception report but acknowledged that some teams may have been redirected to the COVID response and unable to complete the narrative this month. SPC charts use icons to indicate if a process is showing special cause or common cause variation. They also indicate whether the process is able to meet any stated target. Here is the key to the icons:




### Variation

Icon	Description
	Special cause variation - cause for concern (indicator where high is a concern)
	Special cause variation - cause for concern (indicator where low is a concern)
	Common cause variation
	Special cause variation - improvement (indicator where high is good)
	Special cause variation - improvement (indicator where low is good)

These icons are used to indicate statistical variation. We have identified special cause variation based on three rules which are shown below. If none of these rules are present then the metric is showing common cause variation.

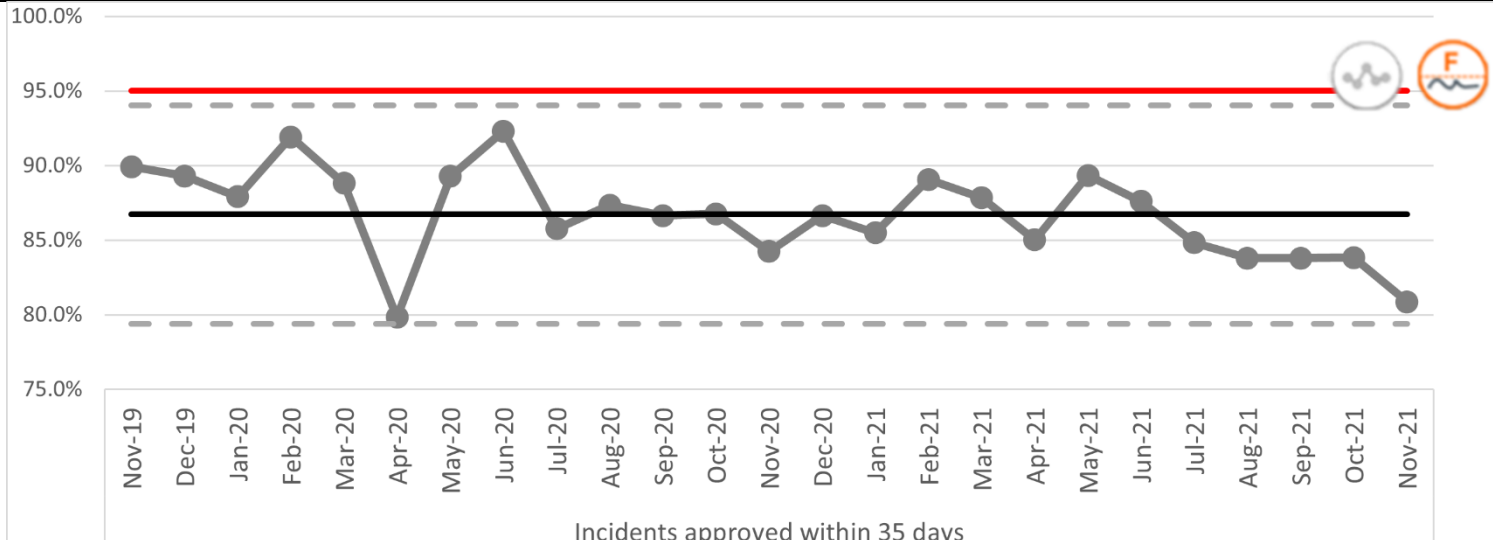
- An upward or downwards trend in performance for seven or more consecutive months.
- Seven or more months above or below the average.
- One month or more outside the control limits

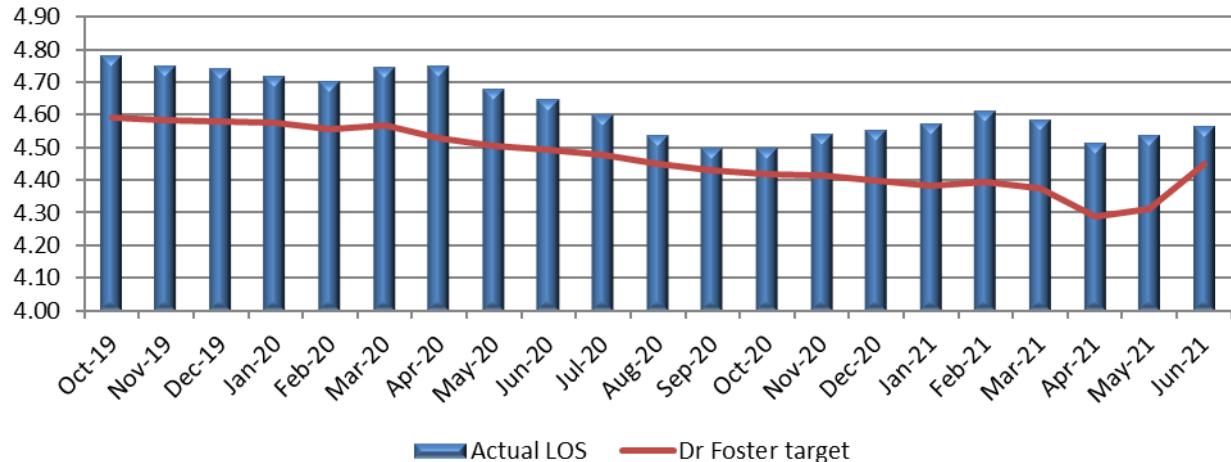
### Assurance

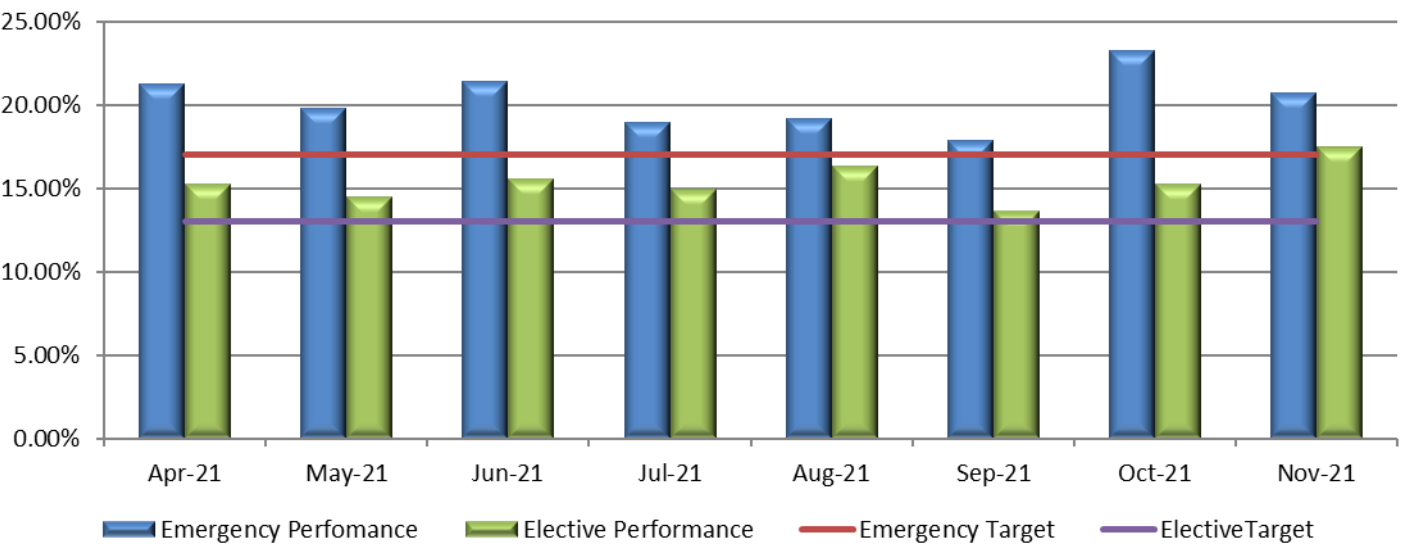
Icon	Description
	The system is expected to consistently fail the target
	The system is expected to consistently pass the target
	The system may achieve or fail the target subject to random variation

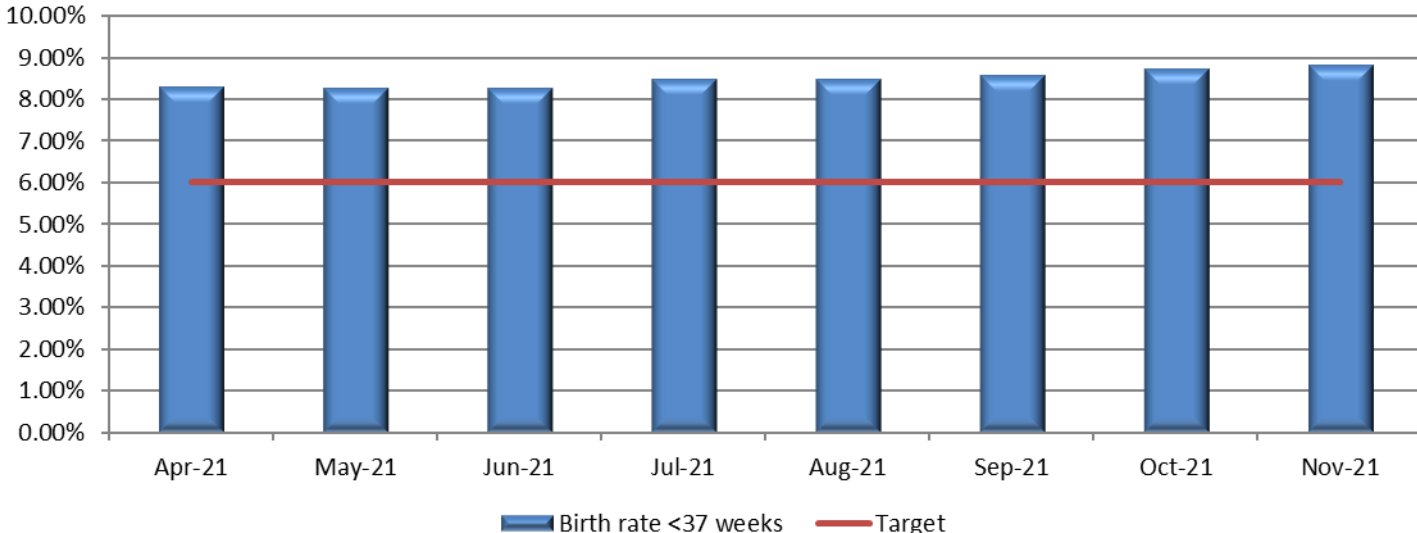
These icons are used to indicate if a target is likely to be achieved next month, has the potential to be achieved or is expected to fail.

**Please Note: On the SPC charts a red line is used to denote the target and a black line indicates the mean value for the indicator**

INCIDENTS (Percentage of incidents approved within 35 days based on approval date)		Target	95%
 <p>Incidents approved within 35 days</p>		Nov-21	80.75%
		Variance Type	Indicator is showing no significant change (common cause variation)
		Assurance Type	Metric is consistently falling short of the target.
		What the chart is telling us	The target has not been met in any month within the last two years.
Lead: Jennifer Hill, Medical Director (Operations)			
Board Committee Providing Oversight: Healthcare Governance Committee			
Summary of current issues		Actions to recover performance	
Performance in October and November shows no significant change and continues to be below target.		The Safety, Risk and Quality dashboard launched in September 2021 provides directorates with live data to monitor their performance against this target. A short training screencast on the use of the Safety, Risk and Quality dashboard which provides directorates with live data to monitor their performance against this target, was published and cascaded in early December. Ongoing COVID pressures and staff absence are posing a challenge to the process.	

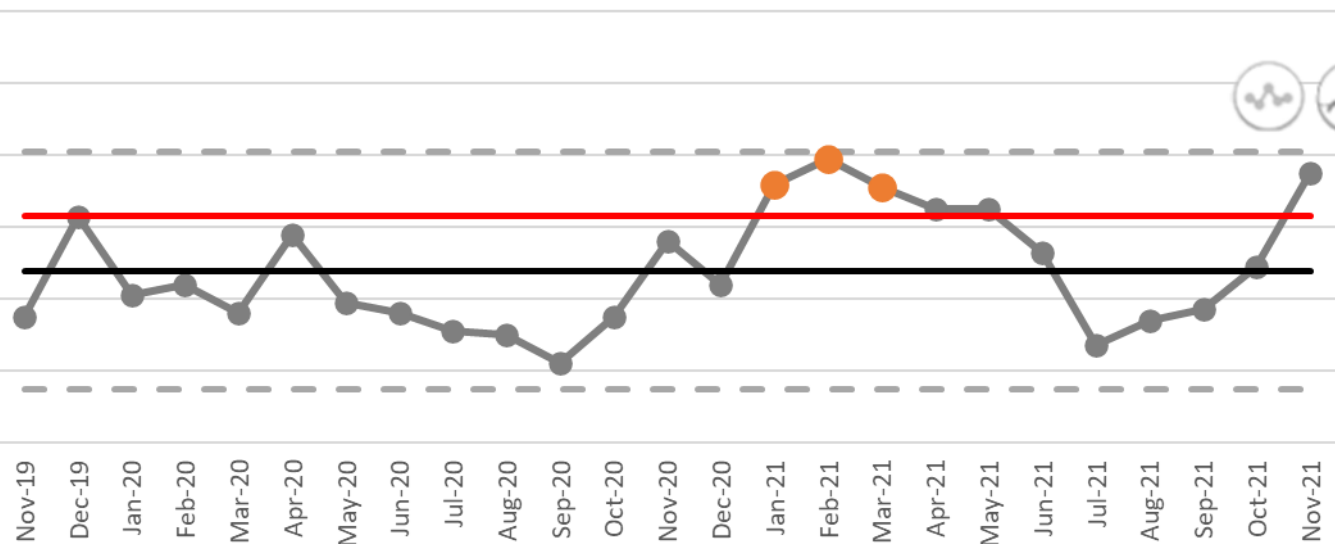
AVERAGE LENGTH OF STAY (Non Elective)		Target	4.45
 <p>Actual LOS      Dr Foster target</p>		Nov-21	4.57
		Variance Type	Data is provided on a rolling 12 month basis, so not suitable for SPC analysis
		Assurance Type	Data is provided on a rolling 12 month basis, so not suitable for SPC analysis
		What the chart is telling us	Average LOS for Non-elective episodes has reduced over time but remains above the national benchmark.
<b>Lead:</b> Jennifer Hill, Medical Director (Operations)		<b>Timescale:</b> Ongoing	
<b>Board Committee Providing Oversight:</b> Healthcare Governance Committee			
Summary of current issues		Actions to recover performance	
Approximately 20% of current STH inpatients have care needs that could be met outside of an acute inpatient setting. Data indicates that not only has the number of patients waiting for discharge increased but patients are also waiting longer to be discharged with a particularly significant increase in the number of patients waiting for discharge via the Discharge to Assess pathway. In addition, there has been an increase in numbers of patients with lengths of stay over 14 days, however the majority of these need acute care and are patients in tertiary services.		<p>The Excellent Emergency Care (EEC) programme is continuing to support a revised programme of work focussed on maintaining the flow of emergency care patients throughout the Trust and on improving discharge processes to both enhance the experience for our patients and to increase organisational flow.</p> <p>Acute Take redesign work continues with aims including reduction in time to senior review and reduced length of stay. Multiple elements of a potential new Acute Take model have been developed and tested to date, several of which were combined in a two week test in November 2021. Data from the trial has been reviewed and next steps are being considered.</p> <p>The Frailty Big Room has continued working on testing and developing the Frailty SDEC model which ultimately aims to reduce time in ED and increase the proportion of patients with a 0-1 day length of stay.</p> <p>The Trust-wide initiative around implementation of board rounds is continuing = A diagnostic has been undertaken to assess frequency and quality of board rounds.</p> <p>Partnership working across the system is focussed on increasing capacity for patients awaiting discharge, with 100 interim beds also provided as an alternative for patients waiting over winter.</p>	

CAESAREAN SECTION RATE (Elective and Emergency Caesarean section rate as proportion of all deliveries)								Target	Elective 13% Emergency 17%
 <p>25.00% 20.00% 15.00% 10.00% 5.00% 0.00%</p> <p>Apr-21 May-21 Jun-21 Jul-21 Aug-21 Sep-21 Oct-21 Nov-21</p> <p>Emergency Performance Elective Performance Emergency Target Elective Target</p>								Nov-21	Elective 17.49% Emergency 20.78%
								Variance Type	Not applicable. Insufficient number of data points for SPC
								Assurance Type	Not applicable. Insufficient number of data points for SPC
<b>Lead:</b> Chris Morley, Chief Nurse  <b>Board Committee Providing Oversight:</b> Healthcare Governance Committee								What the chart is telling us	The target for caesarean sections has not been met consistently.
<b>Timescale:</b> Closed – to be replaced, see actions below									
Summary of current issues								Actions to recover performance	
C section rates for Elective and Emergency are outside of the targets set using HES data 2019/20.								Comparative data taken from all maternity units in the Yorkshire and Humber region from quarter 1 2021/22 records a range of 0.0% - 36.7% with an interquartile range of 28.5% - 33.9%. 31.77%, (September's figures) are within these parameters therefore STH Jessop Wing are not outlying in comparison to other services.	
Caesarean section rate (Caesarean section targets are based on England HES for 2019/20)	% Caesarean sections: elective & emergency	29%	EL 13% EM17%	<30% <17%	<13% <17%	N/A	>33% >19%	>15% >19%	Trust/MSDSv2
								The crude Caesarean section indicator is being replaced with the Robson score indicators to provide a more intelligent measure. The Robson classification is recognised as a global standard for assessing, monitoring and comparing Caesarean section rates. Benchmarking using the Robson score is currently being undertaken across the Shelford Group and once complete will be used to reflect on any anomalies with other trusts.	

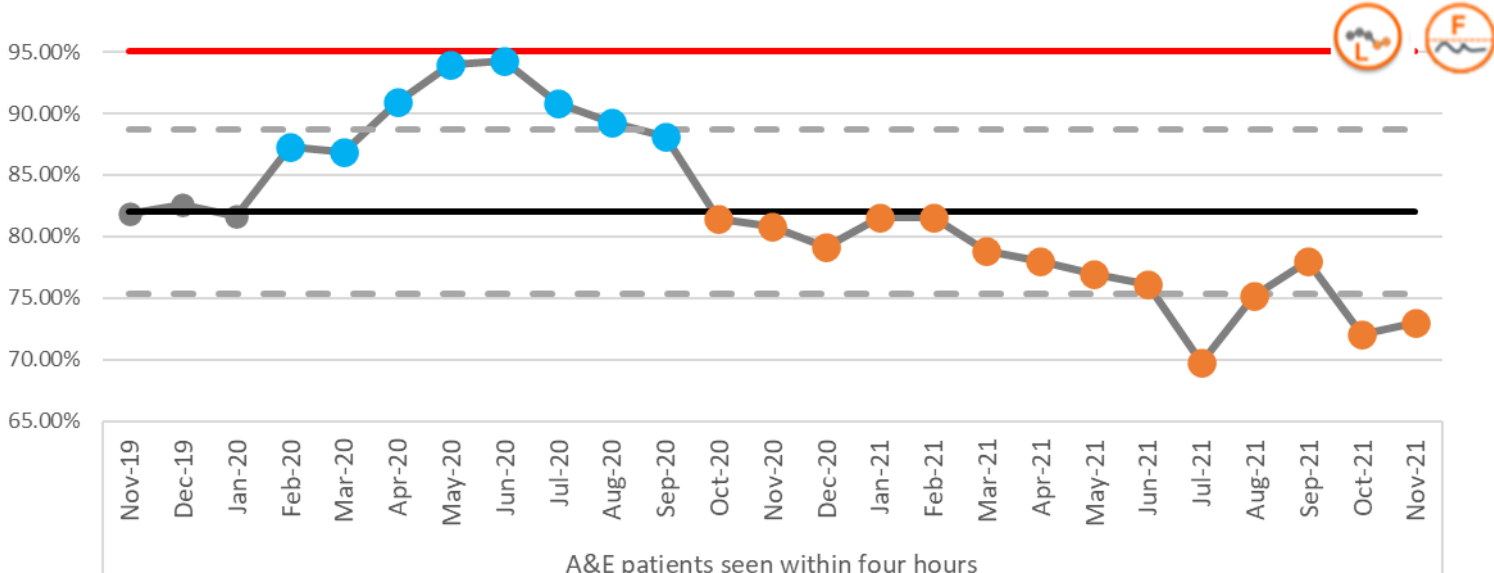
PRETERM BIRTH RATE (Birth rate between 24 and 37 weeks as proportion of all births >24 weeks, rolling 12 months)		Target	6%
 <p>Birth rate &lt;37 weeks    Target</p>		Nov-21	8.83%
		Variance Type	Data is provided on a rolling 12 month basis, so not suitable for SPC analysis
		Assurance Type	Data is provided on a rolling 12 month basis, so not suitable for SPC analysis
		What the chart is telling us	The birth rate between 24 & 37 weeks as a proportion of all births over 24 weeks continues to be higher than target,
Lead: Chris Morley, Chief Nurse		Timescale: Under review by the regional team	
Board Committee Providing Oversight: Healthcare Governance Committee			
Summary of current issues		Actions to recover performance	
The birth rate between 24 and 37 weeks as proportion of all births over 24 weeks is over the threshold originally set in the regional maternity dashboard.		The birth rate below both 37 weeks and 27 weeks will fluctuate and is believed to be affected by the Jessop Wing status as a Tertiary referral unit with a Level 3 Neonatal Unit. All babies born under 27 weeks should be born in a unit with Level 3 neonatal care and babies less than 32 weeks should be born in unit with a level 2 or 3 neonatal care.  The regional maternity dashboard has been refreshed and in the latest iteration thresholds have been removed and the information is for noting as it is agreed that this isn't a metric for maternity quality.	

MASSIVE OBSTETRIC HAEMORRHAGE (Massive obstetric haemorrhage >=1500ml as proportion of deliveries (singleton cephalic births 37-42 weeks gestation only))							Target	2.9%																		
<table><caption>Massive obstetric haemorrhage &gt;=1500ml (Estimated Data)</caption><thead><tr><th>Month</th><th>Percentage</th></tr></thead><tbody><tr><td>Apr-21</td><td>6.6%</td></tr><tr><td>May-21</td><td>4.4%</td></tr><tr><td>Jun-21</td><td>4.3%</td></tr><tr><td>Jul-21</td><td>6.8%</td></tr><tr><td>Aug-21</td><td>5.6%</td></tr><tr><td>Sep-21</td><td>3.8%</td></tr><tr><td>Oct-21</td><td>4.2%</td></tr><tr><td>Nov-21</td><td>5.2%</td></tr></tbody></table>							Month	Percentage	Apr-21	6.6%	May-21	4.4%	Jun-21	4.3%	Jul-21	6.8%	Aug-21	5.6%	Sep-21	3.8%	Oct-21	4.2%	Nov-21	5.2%	Nov-21	5.16%
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Variance Type	Not applicable. Insufficient number of data points for SPC																									
Assurance Type	Not applicable. Insufficient number of data points for SPC																									
<b>Lead:</b> Chris Morley, Chief Nurse							What the chart is telling us	The percentage of patients having massive obstetric haemorrhage has been consistently above the target.																		
<b>Board Committee Providing Oversight:</b> Healthcare Governance Committee																										
Summary of current issues							Actions to recover performance																			
The post-partum haemorrhage (PPH) % remains higher than the <1.5 l - <2.9% target set using NMPA data from 2017.							There are different ways of calculating massive obstetric haemorrhage rates. Using the National Maternity and Perinatal Audit definition, the rate is calculated from the population of women who gave birth vaginally to a singleton baby in the cephalic position between 37+0 and 42+6 weeks and have a post-partum haemorrhage (PPH) of greater than 1500mls. The STH massive obstetric haemorrhage rate using this criterium remains above the target taken from the 2017 audit of 2.9% or less, at 5.2%.																			
Massive obstetric haemorrhage (Based on NMPA data for 2017/17 for women who gave birth vaginally to a singleton baby in the cephalic position between 37+0 and 42+6 weeks)		Massive obstetric Haemorrhage >1500mls (denominator = total singleton cephalic births)	<2.9%	<2.9%	N/A	>2.9%	Trust/MSDSv2	A series of interventions have been put in place to improve the accuracy of the measurement of blood loss, such as using drapes that include a measuring pouch. These interventions are intended to enable more contemporaneous measurement of PPH, which is important in facilitating effective intervention when excessive blood loss is first recognised. Further audit work and improvements are planned over coming months.																		

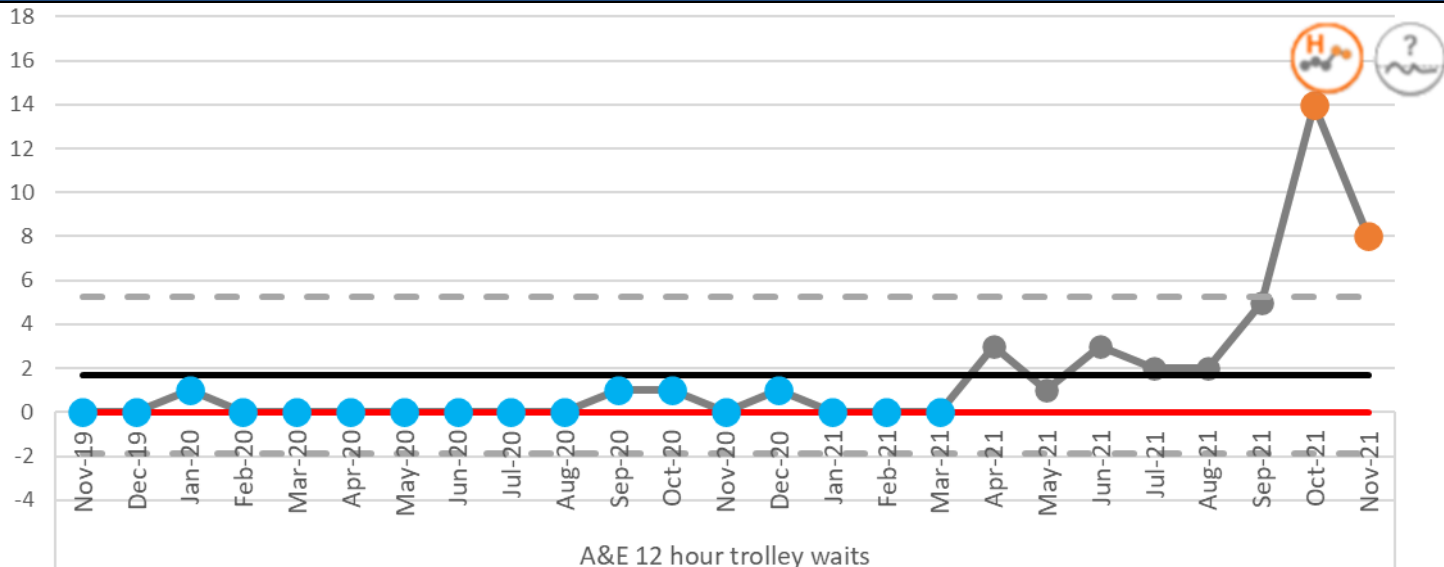
PATIENT FALLS (Number of patient falls)		Target	< 3526 per year / 294 per month (19-20 total)
<p>Nov-19 Dec-19 Jan-20 Feb-20 Mar-20 Apr-20 May-20 Jun-20 Jul-20 Aug-20 Sep-20 Oct-20 Nov-20 Dec-20 Jan-21 Feb-21 Mar-21 Apr-21 May-21 Jun-21 Jul-21 Aug-21 Sep-21 Oct-21 Nov-21</p> <p>Patient falls</p>		Nov-21	319
		Variance Type	Metric is experiencing special cause for concern because of high values
		Assurance Type	Variation indicates inconsistently passing the target
		What the chart is telling us	Consistently high values above the target
		Lead: Jennifer Hill, Medical Director (Operations)	
Board Committee Providing Oversight: Healthcare Governance Committee			
Summary of current issues		Actions to recover performance	
Due to the current operational pressures no formal exception report provided but work is underway to review the data and to provide assurance on current issues and performance.			

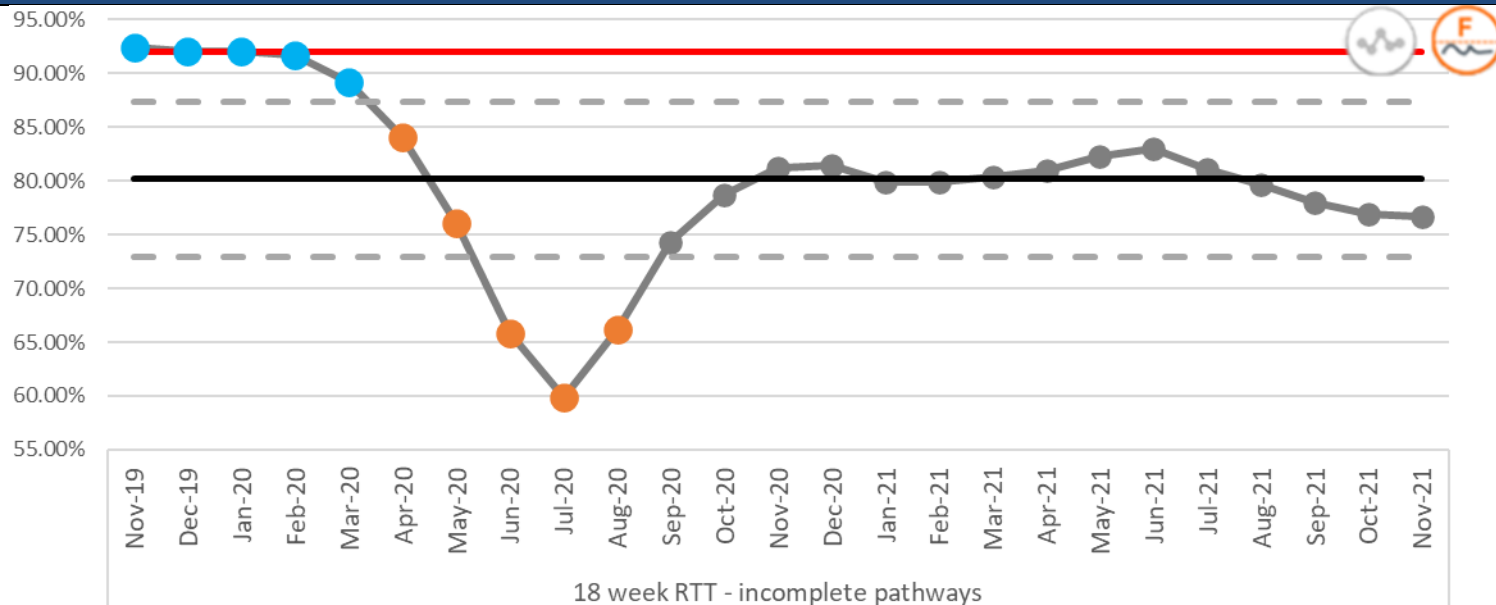
Pressure Ulcers (Number of pressure ulcers acquire within STH)		Target	83
 <p>Pressure ulcers acquired within STH</p>		Nov-21	95
		Variance Type	Indicator is showing no significant change (common cause variation)
		Assurance Type	Variation indicates inconsistency against the target
		What the chart is telling us	There has been an increase in the number of pressure ulcers acquired within STH since July 2021.
Lead: Chris Morley, Chief Nurse		Timescale: Ongoing	
Board Committee Providing Oversight: Healthcare Governance Committee			
Summary of current issues	Actions to recover performance		
During November the threshold for the number of inpatient pressure ulcers (PU) has been breached.	The number of Trust attributable PU's is above the monthly agreed threshold. The increase in recorded pressure ulcers is in the number of category 2 pressure ulcers recorded with the number of category 3, 4 and deep tissue injuries remaining static. The Tissue Viability team continue to monitor numbers and have implemented enhanced care planning tools including both a pressure ulcer prevention and wound assessment care plan to support inpatient areas to assess and prevent tissue damage. The inpatient and community Tissue Viability Teams have now been brought together to provide one integrated Tissue Viability Team thus providing greater resilience and targeted support and education in areas where there is a reported higher incidence of Trust attributable pressure ulcers. Pressure ulcer prevention and reduction continues to be an agreed nursing quality metric.		

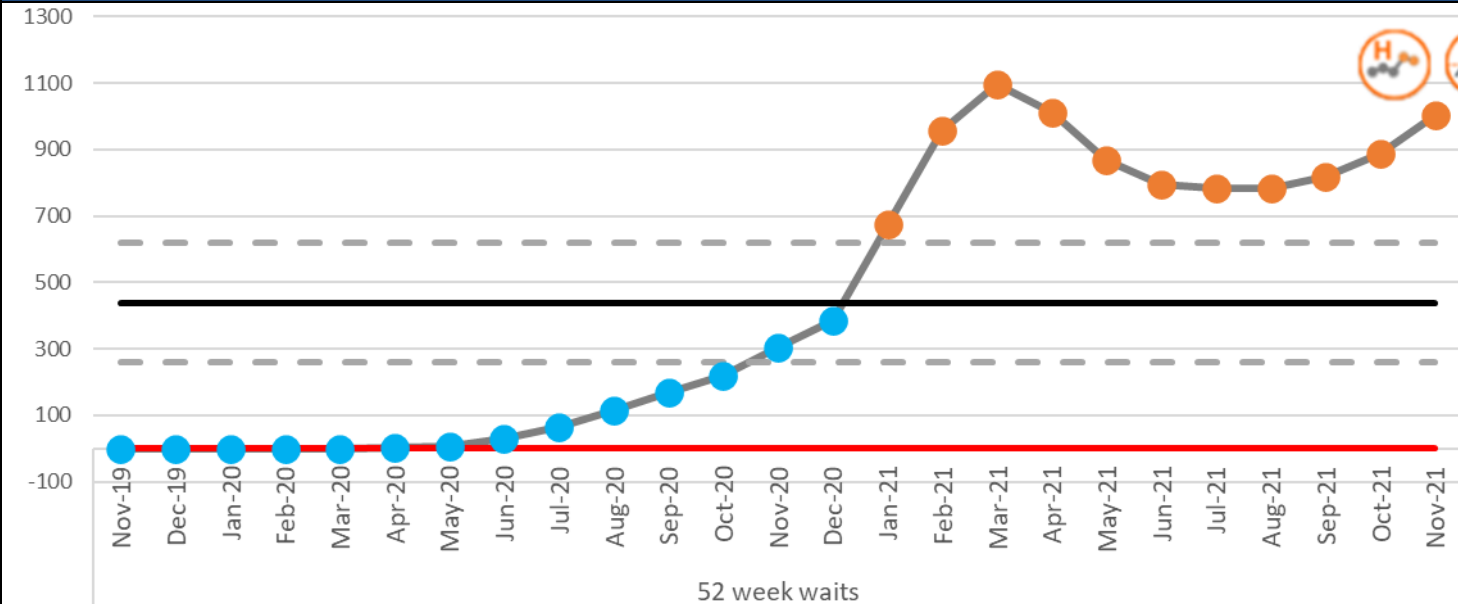
NEVER EVENTS (Number of never events)		Target	0
		Nov-21	2
		Variance Type	Indicator is showing no significant change (common cause variation)
		Assurance Type	Variation indicates inconsistency against the target
<p><b>Lead:</b> Jennifer Hill, Medical Director (Operations)</p> <p><b>Board Committee Providing Oversight:</b> Healthcare Governance Committee</p>		What the chart is telling us	Low usual values mean any variation from zero will flag and generate an exception report.
<p><b>Timescale:</b> Closed</p>		Summary of current issues	
<p>Two surgical never events have been reported in November 2021.</p>		Actions to recover performance	
		<p>The patients and families involved have been fully informed and full investigations have commenced.</p> <p>Immediate actions were taken at the time to reduce the risk of recurrence.</p>	

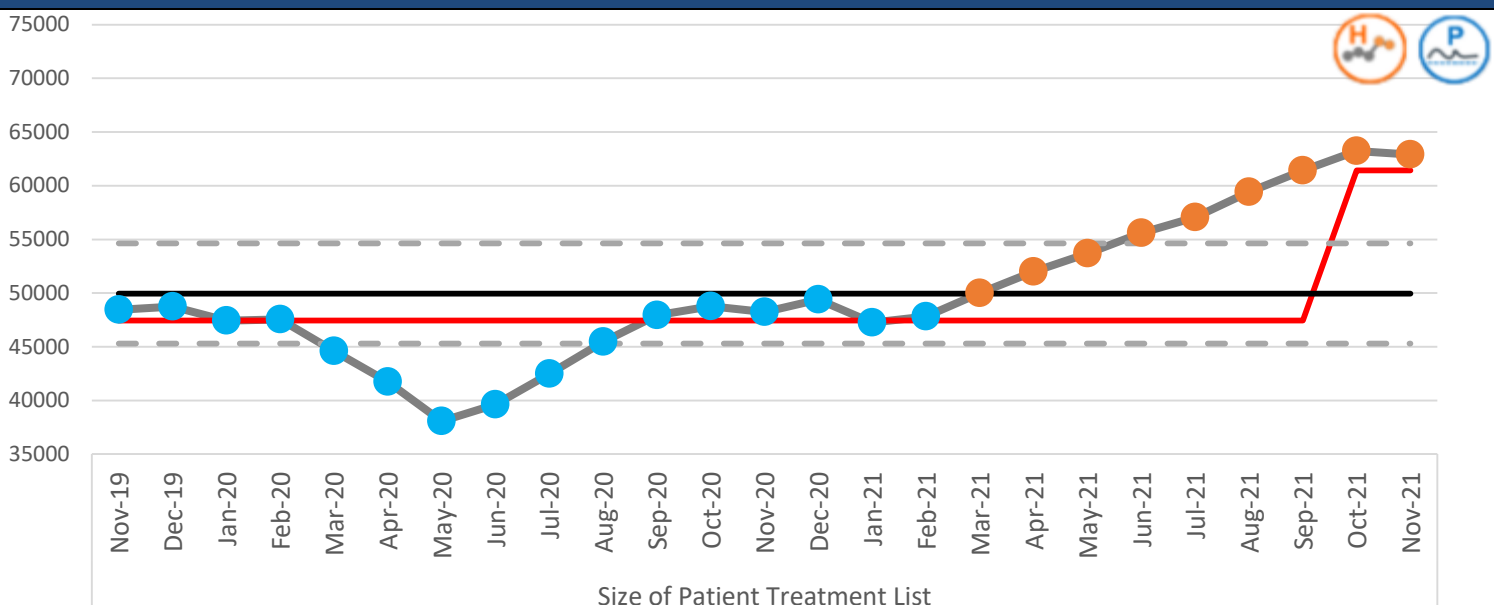
A&E 4 HOUR WAIT (Patients Seen Within 4 Hours)		Target	95%
 <p>A&amp;E patients seen within four hours</p>		Nov-21	73.03%
		Variance Type	Metric is showing special cause of concerning nature due to underperformance
		Assurance Type	Metric is consistently falling short of the target.
<b>Lead:</b> Michael Harper, Chief Operating Officer  <b>Board Committee Providing Oversight:</b> Finance and Performance Committee		What the chart is telling us	Performance dipped below the mean in October 2020, and has remained below the average performance since.
Summary of current issues		Actions to recover performance	
<p>The percentage of A&amp;E attendances who were discharged or admitted within 4 hours in November was 73.03% and in October 72.08%, indicative of the challenges facing the department, noting the impact of Covid upon patient pathways. There were 9,823 type 1 attendances in November, a increase from the 9,623 type 1 attendances in October.</p>		<p>Performance is managed daily through the Morning Operational Group/Bronze Command Meeting. There was a departmental focus on reduction of non-admitted breaches and maximising utilisation of SDEC (Same Day Emergency Care) which increased its operational hours to midnight. However SDEC has not been available to open on a daily basis given that it has been required as additional inpatient surge capacity. Actions to reconfigure the Accident and Emergency footprint are underway and expected to be completed by March 2022. These aim to improve the flow of patients through the department.</p> <p>Silver Command continues to work to oversee the improvement of flow and co-ordination of Covid and non-Covid inpatient pressures.</p>	

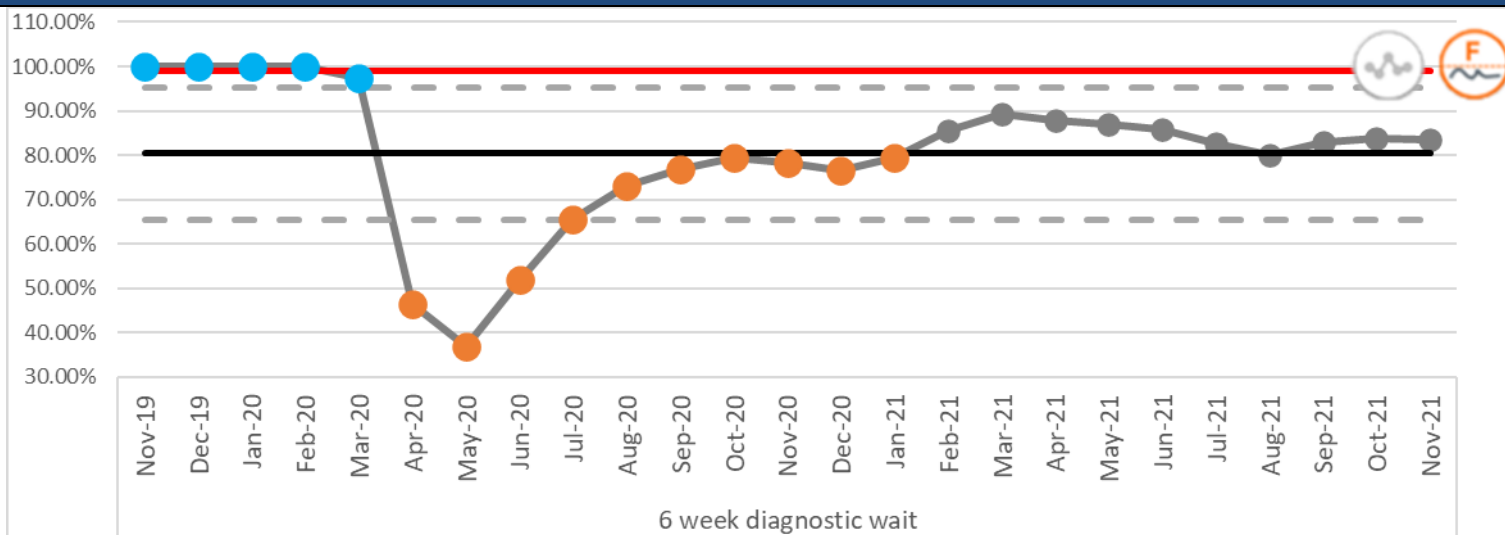
<b>&gt;AMBULANCE TURNAROUND</b> (Time taken for ambulance handover of patient within 15 and 30 minutes)		Target	15 mins 100% 30 mins 0%
<p>Handover ≤ 15 Min    Handover &gt; 30 Min</p>		Nov-21	15 mins 37.61% 30 mins 18.27%
		Variance Type	Not Applicable
		Assurance Type	Not Applicable
<b>Lead:</b> Michael Harper, Chief Operating Officer  <b>Board Committee Providing Oversight:</b> Finance and Performance Committee		What the chart is telling us	The national standards have not been met.
<b>Summary of current issues</b>		<b>Actions to recover performance</b>	
<p>The percentage of ambulance handovers completed within 15 minutes in November was 37.61%, a decrease from October's handover performance of 43%.</p> <p>This is indicative of the challenges currently facing the department and wider organisation in managing the increase in patients attending Accident and Emergency and consequently requiring admission to inpatient beds</p>		<p>Close working on-site within the A&amp;E Department with the Yorkshire Ambulance Service (YAS) means that patients are well cared for in the event of a handover delay. Moreover, demand peaks are predicted using YAS data in order to inform the need for patient flow out of A&amp;E, thereby making space for the ambulance patients on route. YAS are actively encouraging self-handover where appropriate and direct conveyance of appropriate patients to SDEC and to the Infectious diseases pathway at the Royal Hallamshire Hospital which reduces demand pressures upon the NGH A&amp;E Department and ensures patients reach the best place to receive their care sooner.</p> <p>The AEM Care Group has collaborated with the Clinical Operations Office and Yorkshire Ambulance Service to develop an Action Plan for the reduction of ambulance handover delays including cohorting ambulance patients safely adjacent to the A&amp;E dept to release crews.</p>	

>12 HOUR TROLLEY WAITS IN A&E (No. of patients waiting > 12 hours)		Target	0																																																				
 <p>A&amp;E 12 hour trolley waits</p> <table><thead><tr><th>Month</th><th>Number of patients waiting &gt; 12 hours</th></tr></thead><tbody><tr><td>Nov-19</td><td>0</td></tr><tr><td>Dec-19</td><td>0</td></tr><tr><td>Jan-20</td><td>1</td></tr><tr><td>Feb-20</td><td>0</td></tr><tr><td>Mar-20</td><td>0</td></tr><tr><td>Apr-20</td><td>0</td></tr><tr><td>May-20</td><td>0</td></tr><tr><td>Jun-20</td><td>0</td></tr><tr><td>Jul-20</td><td>0</td></tr><tr><td>Aug-20</td><td>0</td></tr><tr><td>Sep-20</td><td>1</td></tr><tr><td>Oct-20</td><td>1</td></tr><tr><td>Nov-20</td><td>0</td></tr><tr><td>Dec-20</td><td>1</td></tr><tr><td>Jan-21</td><td>0</td></tr><tr><td>Feb-21</td><td>0</td></tr><tr><td>Mar-21</td><td>0</td></tr><tr><td>Apr-21</td><td>3</td></tr><tr><td>May-21</td><td>1</td></tr><tr><td>Jun-21</td><td>3</td></tr><tr><td>Jul-21</td><td>2</td></tr><tr><td>Aug-21</td><td>2</td></tr><tr><td>Sep-21</td><td>5</td></tr><tr><td>Oct-21</td><td>14</td></tr><tr><td>Nov-21</td><td>8</td></tr></tbody></table>		Month	Number of patients waiting > 12 hours	Nov-19	0	Dec-19	0	Jan-20	1	Feb-20	0	Mar-20	0	Apr-20	0	May-20	0	Jun-20	0	Jul-20	0	Aug-20	0	Sep-20	1	Oct-20	1	Nov-20	0	Dec-20	1	Jan-21	0	Feb-21	0	Mar-21	0	Apr-21	3	May-21	1	Jun-21	3	Jul-21	2	Aug-21	2	Sep-21	5	Oct-21	14	Nov-21	8	Nov-21	8
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Variance Type	Metric is experiencing special cause for concern because of high values																																																						
Assurance Type	Variation indicates inconsistently passing and the target																																																						
What the chart is telling us	Since March 2021, we have seen an increased number of 12 hour trolley waits																																																						
Lead: Michael Harper, Chief Operating Officer		Timescale: Ongoing																																																					
Board Committee Providing Oversight: Finance and Performance Committee																																																							
Summary of current issues		Actions to recover performance																																																					
There were eight 12 hour trolley waits in November. Of these, 3 patients required admission to a specialist mental health bed in another organisation and the delay was related to this. 3 patients were awaiting beds, one of which was at another Trust. The remaining 2 patients were awaiting transfer to wards at the Royal Hallamshire Hospital.		There has been a full investigation in to the circumstances which led to the 12 hour trolley waits. Improved escalation processes and clarified pathways are now in place across partners including mental health providers and commissioners																																																					

18 WEEKS RTT (Percentage of patients on incomplete pathways waiting less than 18 weeks)		Target	92%
 <p>18 week RTT - incomplete pathways</p>		Nov-21	76.68%
		Variance Type	Metric is experiencing common cause variation
		Assurance Type	Metric is consistently falling short of the target.
		What the chart is telling us	Performance fell below standard in March 2020, and has not hit the target since. The pandemic has had a significant adverse impact on this performance standard.
Lead: Michael Harper, Chief Operating Officer		Timescale: Ongoing	
Board Committee Providing Oversight: Finance and Performance Committee			
Summary of current issues		Actions to recover performance	
Whilst the Trust continues to perform well compared to its peers, the percentage of patients on an incomplete pathway waiting less than 18 weeks declined again in November to 76.68%. This is below the national target of 92%. This is multifactorial in relation to the COVID situation.		Plans remain in place to recover non-COVID planned activity in order to recover performance. Processes have been established in each Care Group to ensure that patients within our caseload are regularly reviewed administratively by clinical staff and their care is prioritised appropriately.  The Trust has a focused validation exercise ongoing to give quality assurance to the reported position.	

52 WEEK WAITS (Patients Waiting over 52 Weeks on an Incomplete Pathway)		Target	0
		Nov-21	1,004
		Variance Type	Metric is showing special cause of concerning nature due to its high values.
		Assurance Type	Metric is now consistently falling short of target
		What the chart is telling us	From April 20 the number of long waiting patients grew peaking in March 2021. Following four months of reduction the number has risen once again.
Lead: Michael Harper, Chief Operating Officer		Timescale: Ongoing	
Board Committee Providing Oversight: Finance and Performance Committee			
Summary of current issues		Actions to recover performance	
There were 1,004 patients waiting over 52 weeks on an incomplete pathway during November, an increase of 117 on the October position. COVID impact continues to affect this position		Activity plans remain in place where possible to ensure continued delivery of treatment plans. Patients who continue to wait are being reviewed on a regular basis by the clinical teams as part of the Trust's caseload management approach, and treatment plans are being developed.  Focus is now on 104 week as part of the planning guidance with the requirement that the 52 week position does not deteriorate any further.	

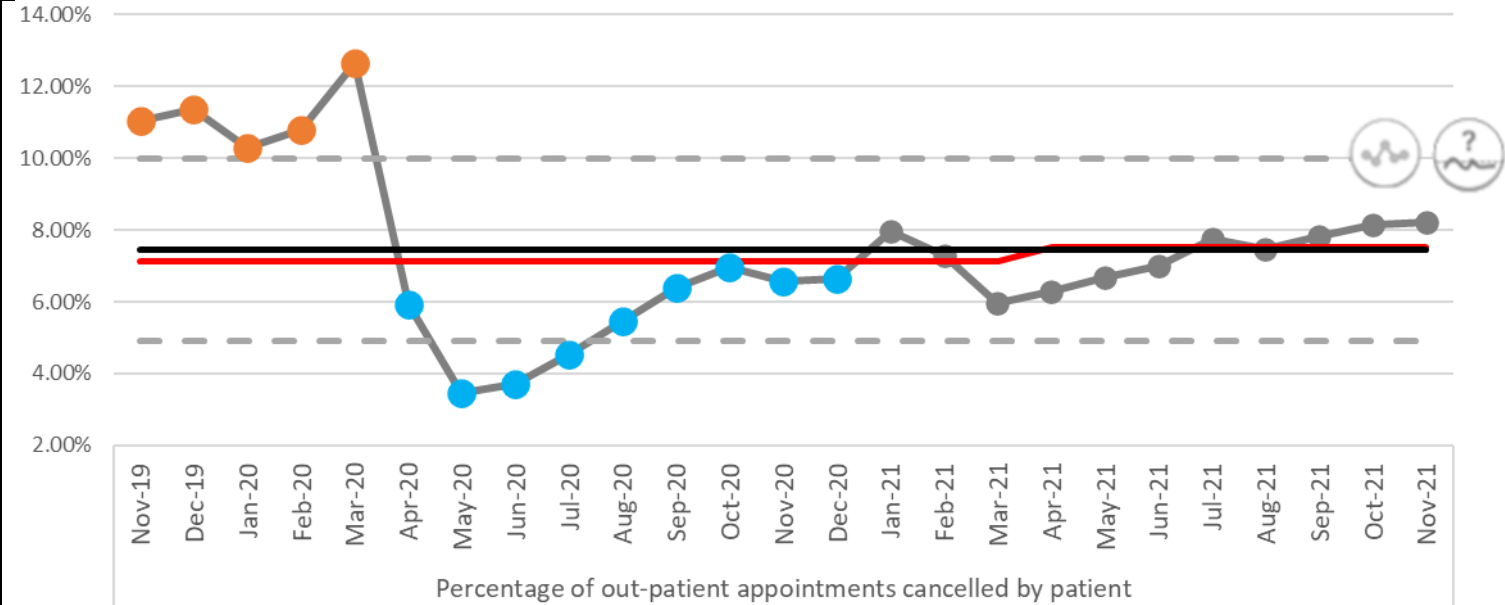
PATIENT TREATMENT LIST (Total Numbers)		Target	61,416
 <p>Size of Patient Treatment List</p>		Nov-21	62,891
		Variance Type	Special cause of concerning nature or higher pressure due to higher values
		Assurance Type	Variation indicates that the system is expected to consistently pass the target
<b>Lead:</b> Michael Harper, Chief Operating Officer  <b>Board Committee Providing Oversight:</b> Finance and Performance Committee		What the chart is telling us	The total number of patients awaiting treatment has increased month on month since January 2021
Summary of current issues		Actions to recover performance	
<p>The total number of patients on the patient treatment list (PTL) or incomplete care pathway decreased slightly by 330 in November to 62,891. This is above the September 2021 target of 61,416.</p> <p>There has been a growth in the volume of referrals with the rates in some areas increasing back to pre-covid levels. This in conjunction with capacity constraints is impacting on the maintenance and reduction in levels of patients waiting for treatment.</p>		<p>The size of the PTL has been discussed at the Performance and Caseload Overview Group. Validation continues and the PTL has been reviewed externally.</p> <p>The work involved to treat the number of patients waiting is significant and will take time to complete. Detailed work is underway to identify specific areas of growth and target actions to support reduction.</p>	

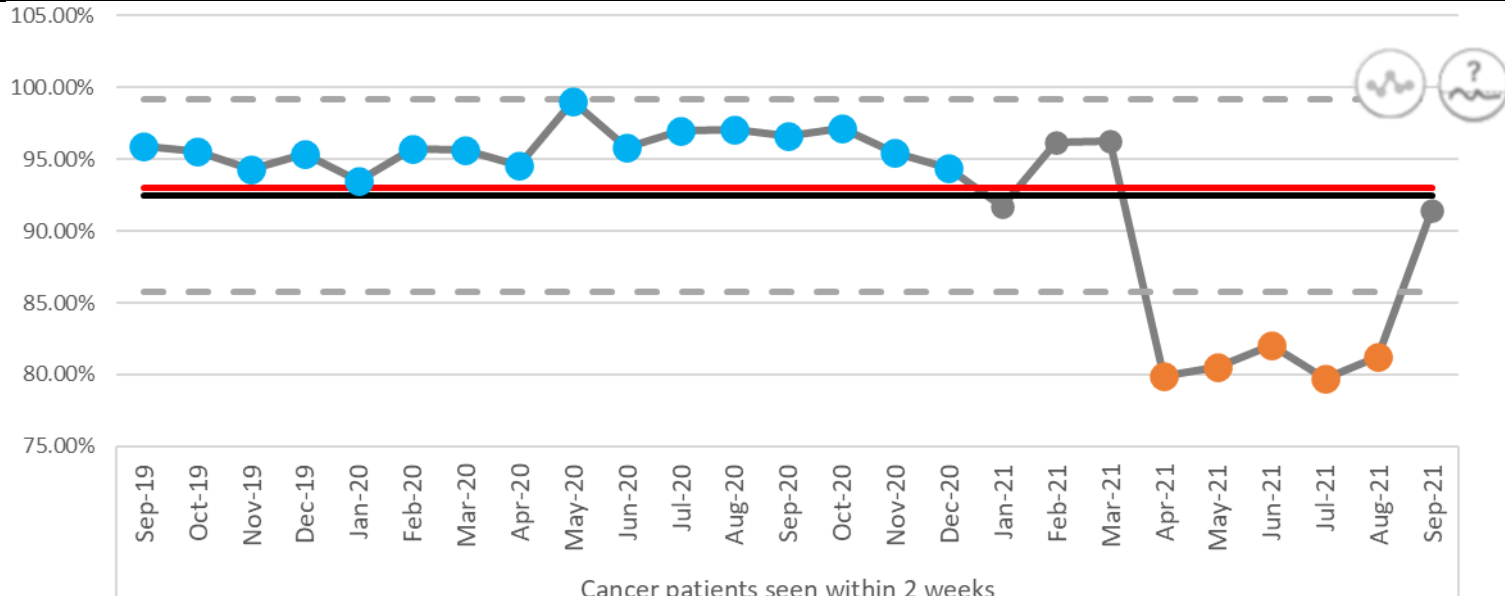
DIAGNOSTIC WAITING TIMES (Percentage of patients waiting less than 6 weeks for a diagnostic test)		Target	99%
<div><p>6 week diagnostic wait</p></div>		Nov-21	83.36%
		Variance Type	Metric is experiencing common cause variation
		Assurance Type	Metric is consistently falling short of the target.
		What the chart is telling us	There has been a slow recovery in performance.
Lead: Michael Harper, Chief Operating Officer		Timescale: Ongoing	
Board Committee Providing Oversight: Finance and Performance Committee			
Summary of current issues		Actions to recover performance	
The percentage of patients receiving diagnostic tests within 6 weeks in November was 83.36%.		Processes have been established to ensure that the details of patients on the diagnostic waiting list are regularly reviewed by clinical staff and their care is prioritised where required and in line with the currently national diagnostic validation prioritisation process. Recovery plans are being developed for Dexa scans, Echocardiography, urodynamics and flexible sigmoidoscopies.	

CANCELLED OPERATIONS (Number of operations cancelled on the day for non clinical reasons)		Target	75																																																				
<table><thead><tr><th>Month</th><th>Cancelled Operations</th></tr></thead><tbody><tr><td>Nov-19</td><td>90</td></tr><tr><td>Dec-19</td><td>110</td></tr><tr><td>Jan-20</td><td>105</td></tr><tr><td>Feb-20</td><td>65</td></tr><tr><td>Mar-20</td><td>75</td></tr><tr><td>Apr-20</td><td>15</td></tr><tr><td>May-20</td><td>10</td></tr><tr><td>Jun-20</td><td>5</td></tr><tr><td>Jul-20</td><td>15</td></tr><tr><td>Aug-20</td><td>30</td></tr><tr><td>Sep-20</td><td>30</td></tr><tr><td>Oct-20</td><td>45</td></tr><tr><td>Nov-20</td><td>35</td></tr><tr><td>Dec-20</td><td>25</td></tr><tr><td>Jan-21</td><td>45</td></tr><tr><td>Feb-21</td><td>25</td></tr><tr><td>Mar-21</td><td>25</td></tr><tr><td>Apr-21</td><td>15</td></tr><tr><td>May-21</td><td>60</td></tr><tr><td>Jun-21</td><td>30</td></tr><tr><td>Jul-21</td><td>65</td></tr><tr><td>Aug-21</td><td>60</td></tr><tr><td>Sep-21</td><td>200</td></tr><tr><td>Oct-21</td><td>90</td></tr><tr><td>Nov-21</td><td>85</td></tr></tbody></table> <p>Cancelled operations</p>		Month	Cancelled Operations	Nov-19	90	Dec-19	110	Jan-20	105	Feb-20	65	Mar-20	75	Apr-20	15	May-20	10	Jun-20	5	Jul-20	15	Aug-20	30	Sep-20	30	Oct-20	45	Nov-20	35	Dec-20	25	Jan-21	45	Feb-21	25	Mar-21	25	Apr-21	15	May-21	60	Jun-21	30	Jul-21	65	Aug-21	60	Sep-21	200	Oct-21	90	Nov-21	85	Nov-21	85
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Variance Type	Metric is experiencing common cause variation																																																						
Assurance Type	Variation indicates inconsistently passing and falling short of the target																																																						
What the chart is telling us		The number of on-day elective cancellations for non- clinical reasons remains above target.																																																					
Lead: Michael Harper, Chief Operating Officer		Timescale: Ongoing																																																					
Board Committee Providing Oversight: Finance and Performance Committee																																																							
Summary of current issues		Actions to recover performance																																																					
There were 85 on-day elective cancellations during November 2021, due to challenges with bed and theatre capacity as a result of the pandemic		Performance is reviewed on a regular basis by the Performance and Caseload Overview Group, supported by Seamless Surgery.																																																					

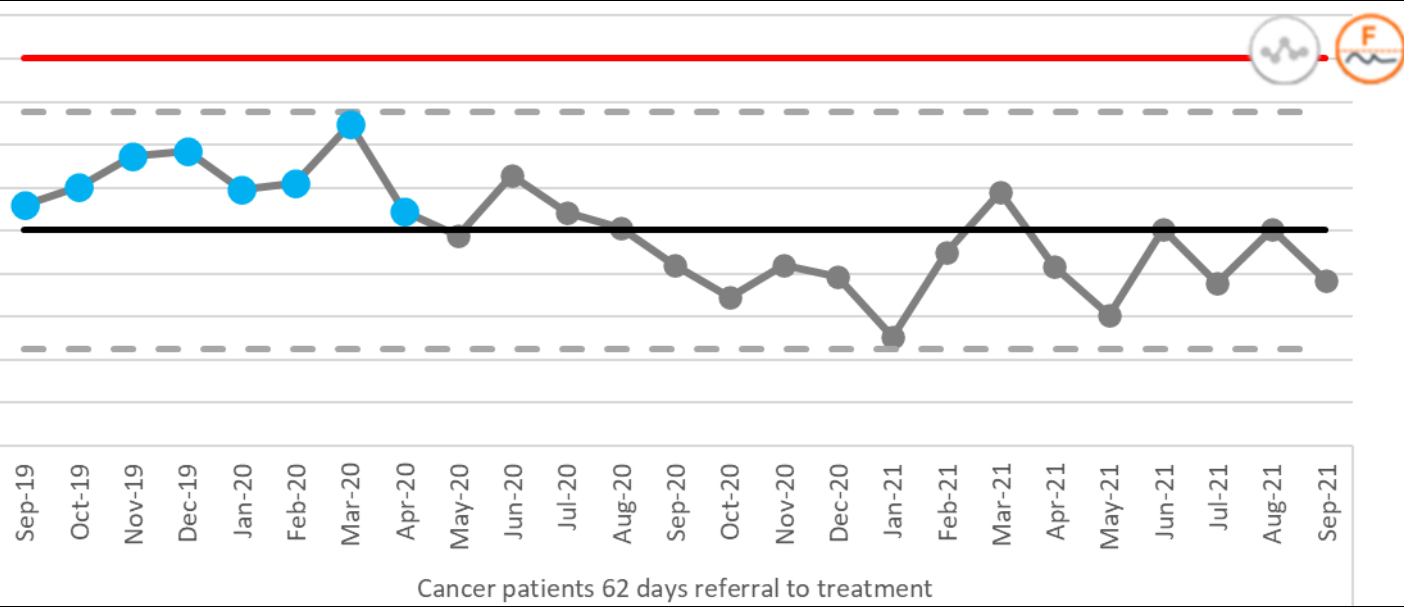
<b>CANCELLED OPERATIONS</b> (Number of patients cancelled on the day and not readmitted within 28 days)		Target	0
<p>Readmitted Cancelled ops</p>		Nov-21	15
		Variance Type	Metric is experiencing common cause variation
		Assurance Type	Variation indicates inconsistently passing the target
<b>Lead:</b> Michael Harper, Chief Operating Officer  <b>Board Committee Providing Oversight:</b> Finance and Performance Committee		What the chart is telling us	The number of on-day elective cancellations for non-clinical reasons was above target for November 2021
<b>Timescale:</b> Ongoing		<b>Summary of current issues</b>	
There were 15 on-day elective cancellations during November 2021 which were not readmitted within 28 days, due to challenges with bed and theatre capacity.		<b>Actions to recover performance</b>	
		Performance is reviewed on a regular basis by the Performance and Caseload Overview group.	

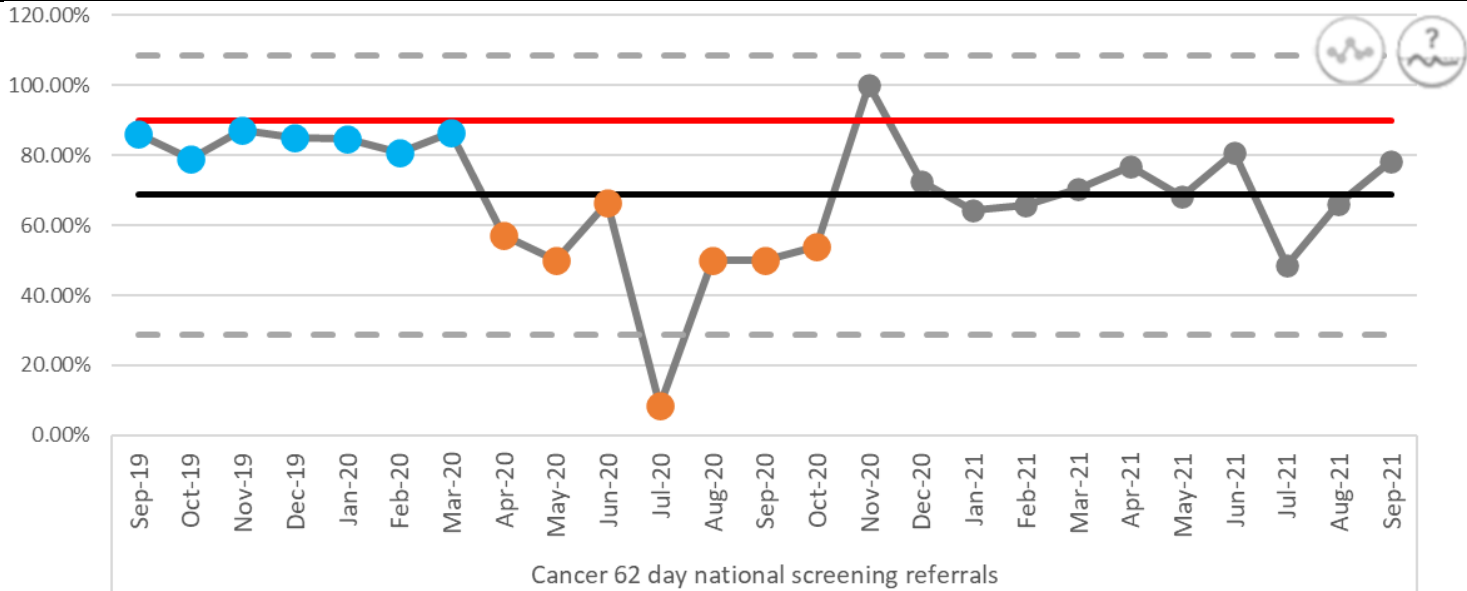
CANCELLED OUTPATIENT APPOINTMENTS (Percentage of out-patient appointments cancelled by hospital)		Target	8.71%																																																				
<table><caption>Percentage of out-patient appointments cancelled by hospital</caption><tr><th>Month</th><th>Percentage</th></tr><tr><td>Nov-19</td><td>10.00%</td></tr><tr><td>Dec-19</td><td>10.50%</td></tr><tr><td>Jan-20</td><td>10.20%</td></tr><tr><td>Feb-20</td><td>10.80%</td></tr><tr><td>Mar-20</td><td>17.00%</td></tr><tr><td>Apr-20</td><td>29.50%</td></tr><tr><td>May-20</td><td>16.50%</td></tr><tr><td>Jun-20</td><td>13.50%</td></tr><tr><td>Jul-20</td><td>13.20%</td></tr><tr><td>Aug-20</td><td>12.80%</td></tr><tr><td>Sep-20</td><td>12.50%</td></tr><tr><td>Oct-20</td><td>11.80%</td></tr><tr><td>Nov-20</td><td>11.50%</td></tr><tr><td>Dec-20</td><td>11.00%</td></tr><tr><td>Jan-21</td><td>13.50%</td></tr><tr><td>Feb-21</td><td>11.00%</td></tr><tr><td>Mar-21</td><td>10.20%</td></tr><tr><td>Apr-21</td><td>9.80%</td></tr><tr><td>May-21</td><td>9.80%</td></tr><tr><td>Jun-21</td><td>10.00%</td></tr><tr><td>Jul-21</td><td>10.50%</td></tr><tr><td>Aug-21</td><td>11.50%</td></tr><tr><td>Sep-21</td><td>11.20%</td></tr><tr><td>Oct-21</td><td>11.46%</td></tr><tr><td>Nov-21</td><td>10.24%</td></tr></table>		Month	Percentage	Nov-19	10.00%	Dec-19	10.50%	Jan-20	10.20%	Feb-20	10.80%	Mar-20	17.00%	Apr-20	29.50%	May-20	16.50%	Jun-20	13.50%	Jul-20	13.20%	Aug-20	12.80%	Sep-20	12.50%	Oct-20	11.80%	Nov-20	11.50%	Dec-20	11.00%	Jan-21	13.50%	Feb-21	11.00%	Mar-21	10.20%	Apr-21	9.80%	May-21	9.80%	Jun-21	10.00%	Jul-21	10.50%	Aug-21	11.50%	Sep-21	11.20%	Oct-21	11.46%	Nov-21	10.24%	Nov-21	10.24%
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Variance Type		Improvement in performance is being achieved.																																																					
Assurance Type		Metric indicates likely consistent performance below the target expected																																																					
What the chart is telling us		Although above target, performance has been below the mean for the last 10 months.																																																					
Lead: Michael Harper, Chief Operating Officer		Timescale: Ongoing																																																					
Board Committee Providing Oversight: Finance and Performance Committee																																																							
Summary of current issues		Actions to recover performance																																																					
The percentage of outpatient appointments cancelled by the hospital in November was 10.24% compared to 11.46% in October.		Appointments that are cancelled by the hospital are clinically reviewed to ensure that it remains safe for patients to wait. This is linked to the Trust's caseload management approach. Work is ongoing with services to mitigate these cancellations and understand issues and blockages causing them.																																																					

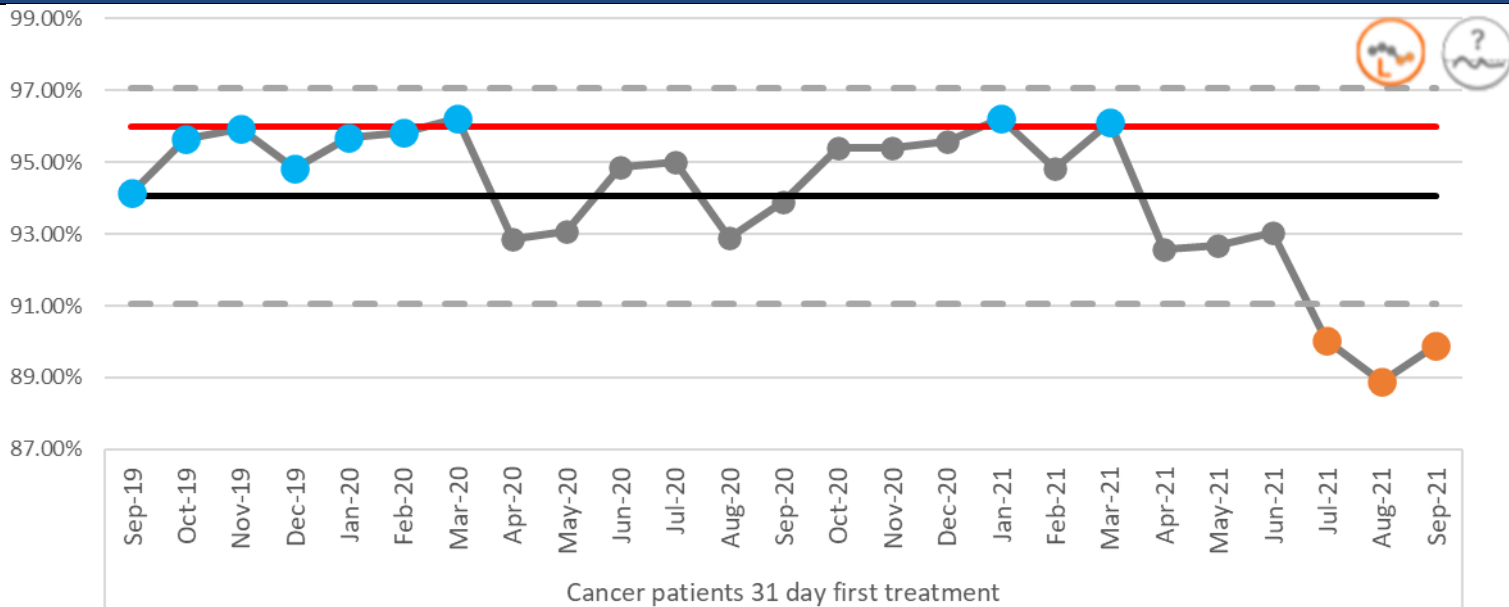
CANCELLED OUTPATIENT APPOINTMENTS (Percentage of out-patient appointments cancelled by patient)		Target	7.51%
 <p>Percentage of out-patient appointments cancelled by patient</p>		Nov-21	8.21%
		Variance Type	Indicator is showing no significant change (common cause variation)
		Assurance Type	Variation indicates inconsistently passing the target
<b>Lead:</b> Michael Harper, Chief Operating Officer  <b>Board Committee Providing Oversight:</b> Finance and Performance Committee		What the chart is telling us	The number of appointments cancelled by patients have been increasing steadily since March 2021 with a slight improvement in Aug 2021 only
<b>Timescale:</b> Ongoing			
<b>Summary of current issues</b>		<b>Actions to recover performance</b>	
<p>The percentage of outpatient appointments cancelled by the patient in November was 8.21% compared to the benchmark target of 7.51%.</p> <p>Issues remain in relation to the impact of the pandemic on patients and as such this is impacting on their ability to attend appointments.</p>		<p>Work is ongoing to understand this and address this increase. Discussion are ongoing in relation to processes to ensure we are doing all we can to support patients being able to attend.</p>	

CANCER WAITS Patient seen within 2 weeks of urgent referral		Target	93%
 <p>Cancer patients seen within 2 weeks</p>		Q2 21/22	84.3%
		Variance Type	Indicator is showing no significant change (common cause variation)
		Assurance Type	Indicator is showing random variation
		What the chart is telling us	Performance fell in April-21 however performance improved significantly in September 2021
Lead: Michael Harper, Chief Operating Officer		Timescale: Ongoing	
Board Committee Providing Oversight: Finance & Performance Committee			
Summary of current issues		Actions to recover performance	
The Trust performance for Q2 2021/22 was 84.3% (threshold 93%).		Due to the current operational pressures a detailed exception report is not provided but work is underway to review the data and to provide assurance on current issues and performance. A recovery plan has been developed with individual cancer sites to deliver additional capacity to recover performance. Being progressed for additional capacity.	

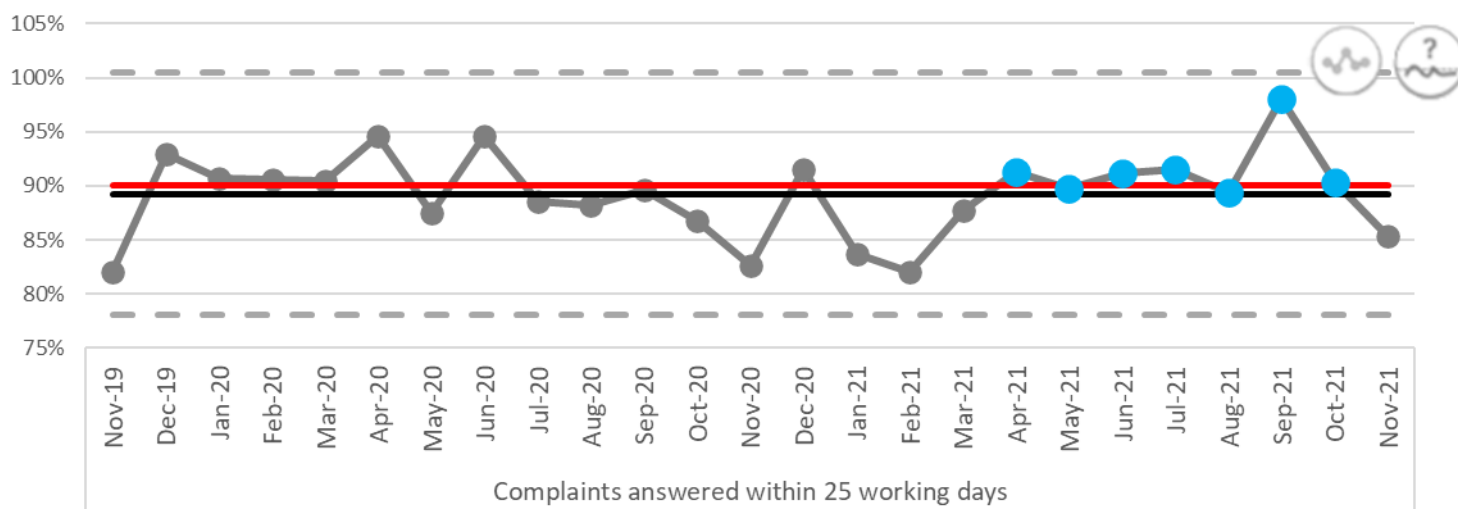
<div> <div>CANCER WAITS</div> <div>Breast symptomatic seen within 2 weeks</div> </div>		Target	93%
<div> <p>Cancer patients breast 2 week wait</p> </div>		Q2 21/22	50.7%
		Variance Type	Indicator is showing no significant change (common cause variation)
		Assurance Type	Indicator is showing random variation
<div> <div>Lead: Michael Harper, Chief Operating Officer</div> <div>Board Committee Providing Oversight: Finance &amp; Performance Committee</div> </div>		What the chart is telling us	<div> <div>Timescale: Ongoing</div> <div>Performance fell in April-21 and target has not been met since, but has returned to the mean value for the indicator.</div> </div>
Summary of current issues		Actions to recover performance	
The Trust performance for Q2 2021/22 is 50.7% (threshold 93%).		<div>Due to the current operational pressures a detailed exception report is not provided but work is underway to review the data and to provide assurance on current issues and performance. A recovery plan has been developed.</div>	

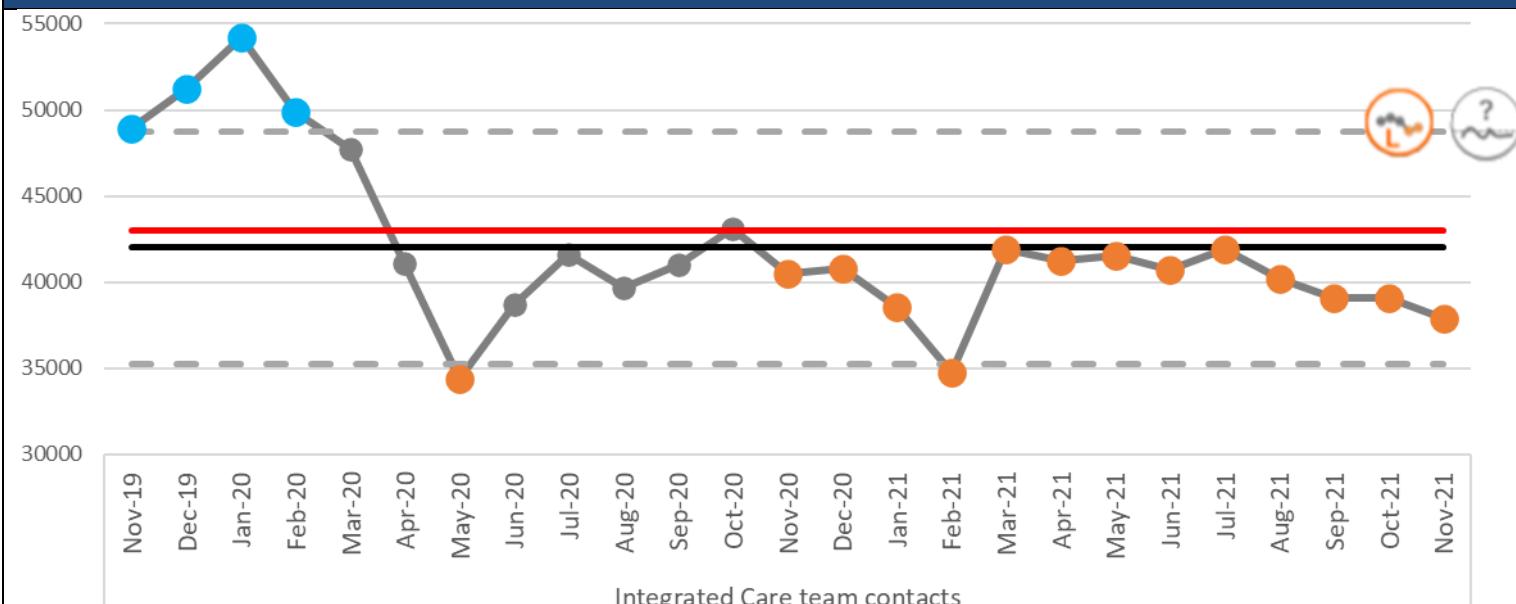
CANCER WAITS 62 days from referral to treatment (GP referral)		Target	85%
 <p>Cancer patients 62 days referral to treatment</p>		Q2 21/22	61.1%
		Variance Type	Indicator is showing no significant change (common cause variation)
		Assurance Type	Indicator is expected to consistently fail the target.
		What the chart is telling us	Performance remains consistently below target.
Lead: Michael Harper, Chief Operating Officer		Timescale: Ongoing	
Board Committee Providing Oversight: Finance & Performance Committee			
Summary of current issues		Actions to recover performance	
<p>The overall Trust performance for Q2 2021/22 is 61.1% (threshold 85%). STH performance for non-shared pathways in Q2 is 65.8%.</p> <p>The majority of breaches are attributed to delays resulting from the impact of COVID-19. Late inter-provider transfer continue to adversely impact performance (in Q2 STH received 140 district general hospital (DGH) referrals after day 38 of the pathway start date [56% of DGH referrals]).</p>		<p>Site specific plans are in place to ensure that risks are mitigated/minimised and that patients continue to receive clinically appropriate care. Cancer recovery action plans are in place supported by wider trust cancer recovery actions including workstreams overseen by a new Cancer Improvement Board.</p>	

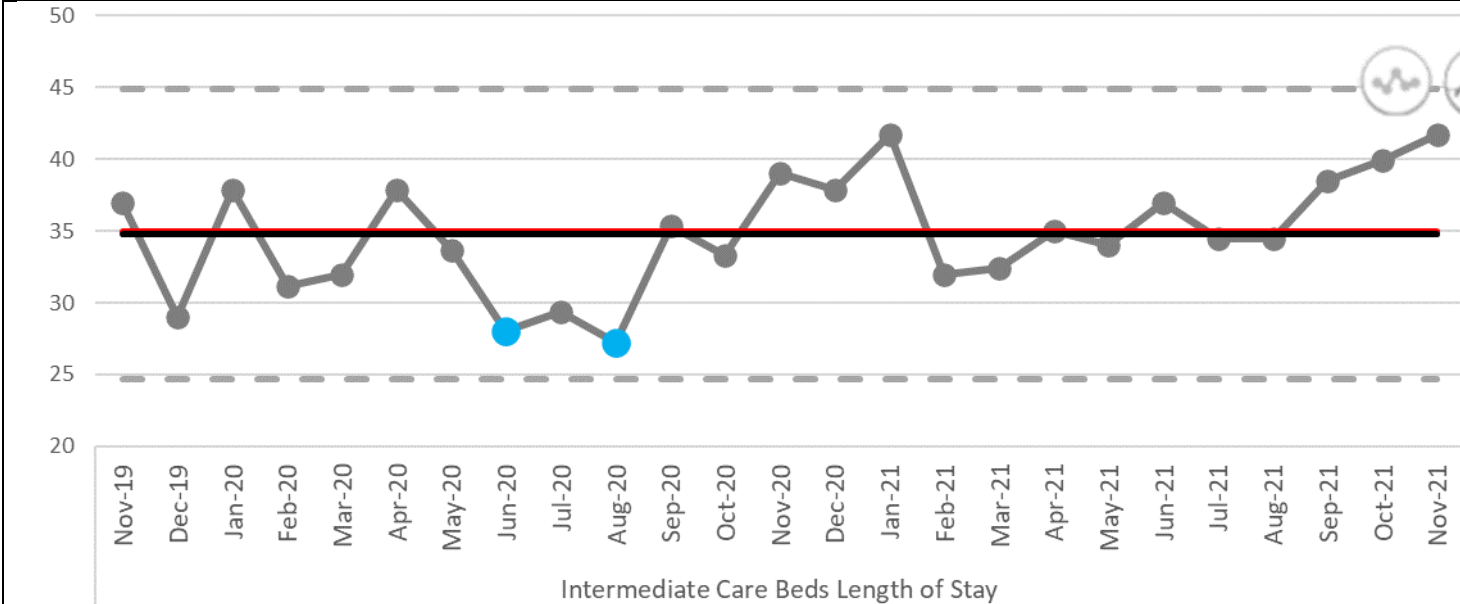
<b>CANCER WAITS</b> 62 days from referral to treatment (Cancer Screening Service)		Target	90%
 <p>Cancer 62 day national screening referrals</p>		Q2 21/22	65.2%
		Variance Type	Indicator is showing no significant change (common cause variation)
		Assurance Type	Indicator is showing random variation
<b>Lead:</b> Michael Harper, Chief Operating Officer  <b>Board Committee Providing Oversight:</b> Finance & Performance Committee		What the chart is telling us	Performance is below target.
<b>Timescale:</b> Ongoing			
<b>Summary of current issues</b>  The Trust performance for Q2 2021/22 is 65.2% (threshold 90%). Performance is highly volatile due to a low denominator.  Majority of breaches are attributed to delays resulting from the impact of COVID-19.		<b>Actions to recover performance</b>  Site specific plans are in place to ensure that risks are mitigated/minimised and that patients continue to receive clinically appropriate care. Cancer recovery action plans are in place supported by wider trust cancer recovery actions including workstreams overseen by a new Cancer Improvement Board.	

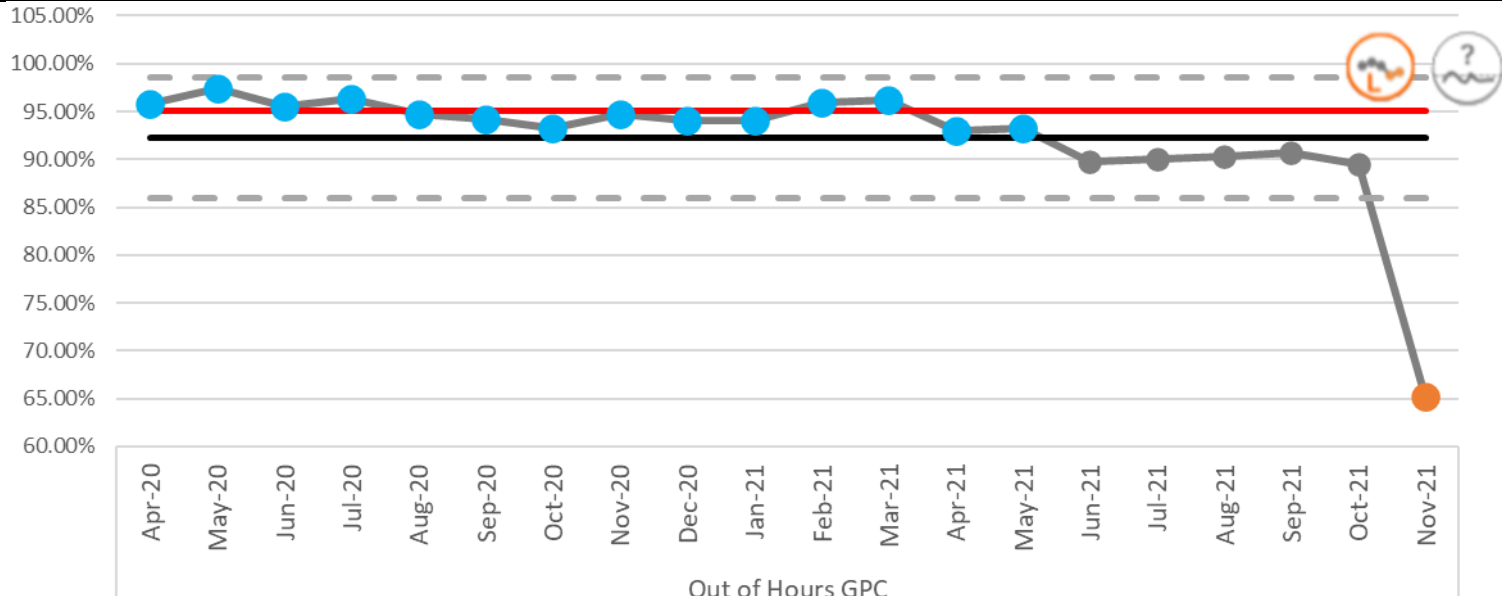
CANCER WAITS 31 day first treatment from referral		Target	96%
 <p>Cancer patients 31 day first treatment</p>		Q2 21/22	89.6%
		Variance Type	Metric is showing special cause of concerning nature due to its low values.
		Assurance Type	Indicator is showing random variation
		What the chart is telling us	Performance remains below target
Lead: Michael Harper, Chief Operating Officer		Timescale: Ongoing	
Board Committee Providing Oversight: Finance & Performance Committee			
Summary of current issues		Actions to recover performance	
The Trust performance for Q2 2020/21 is 89.6% (threshold 96%). The majority of breaches are attributed to delays resulting from the impact of COVID-19.		Site specific plans are in place to ensure that risks are mitigated/minimised and that patients continue to receive clinically appropriate care. Cancer recovery action plans are in place supported by wider trust cancer recovery actions including workstreams overseen by a new Cancer Improvement Board.	

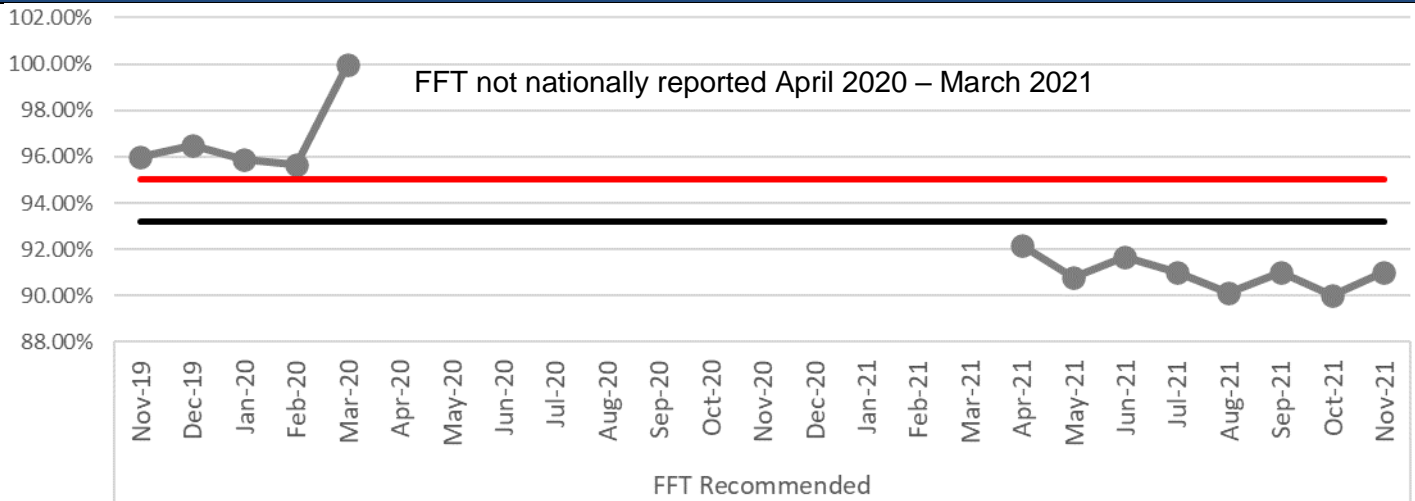
CANCER WAITS 31 day subsequent treatment (Surgery)		Target	94%																																																				
<table><caption>31 day subsequent treatment (Surgery)</caption><thead><tr><th>Month</th><th>Performance (%)</th></tr></thead><tbody><tr><td>Sep-19</td><td>92.0</td></tr><tr><td>Oct-19</td><td>94.0</td></tr><tr><td>Nov-19</td><td>97.0</td></tr><tr><td>Dec-19</td><td>99.0</td></tr><tr><td>Jan-20</td><td>86.0</td></tr><tr><td>Feb-20</td><td>96.0</td></tr><tr><td>Mar-20</td><td>92.0</td></tr><tr><td>Apr-20</td><td>89.0</td></tr><tr><td>May-20</td><td>89.0</td></tr><tr><td>Jun-20</td><td>89.0</td></tr><tr><td>Jul-20</td><td>87.0</td></tr><tr><td>Aug-20</td><td>78.0</td></tr><tr><td>Sep-20</td><td>82.0</td></tr><tr><td>Oct-20</td><td>92.0</td></tr><tr><td>Nov-20</td><td>95.0</td></tr><tr><td>Dec-20</td><td>88.0</td></tr><tr><td>Jan-21</td><td>80.0</td></tr><tr><td>Feb-21</td><td>91.0</td></tr><tr><td>Mar-21</td><td>90.0</td></tr><tr><td>Apr-21</td><td>83.0</td></tr><tr><td>May-21</td><td>85.0</td></tr><tr><td>Jun-21</td><td>84.0</td></tr><tr><td>Jul-21</td><td>83.0</td></tr><tr><td>Aug-21</td><td>67.0</td></tr><tr><td>Sep-21</td><td>70.0</td></tr></tbody></table>		Month	Performance (%)	Sep-19	92.0	Oct-19	94.0	Nov-19	97.0	Dec-19	99.0	Jan-20	86.0	Feb-20	96.0	Mar-20	92.0	Apr-20	89.0	May-20	89.0	Jun-20	89.0	Jul-20	87.0	Aug-20	78.0	Sep-20	82.0	Oct-20	92.0	Nov-20	95.0	Dec-20	88.0	Jan-21	80.0	Feb-21	91.0	Mar-21	90.0	Apr-21	83.0	May-21	85.0	Jun-21	84.0	Jul-21	83.0	Aug-21	67.0	Sep-21	70.0	Q2 21/22	73.5%
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<b>Lead:</b> Michael Harper, Chief Operating Officer		What the chart is telling us	Performance remains below target																																																				
<b>Board Committee Providing Oversight:</b> Finance & Performance Committee																																																							
Summary of current issues		Actions to recover performance																																																					
The Trust performance for Q2 2021/22 is 73.5% (threshold 94%).		Site specific plans are in place to ensure that risks are mitigated/minimised and that patients continue to receive clinically appropriate care. Cancer recovery action plans are in place supported by wider trust cancer recovery actions including workstreams overseen by a new Cancer Improvement Board.																																																					

COMPLAINTS (Percentage of complaints closed within agreed timescales)		Target	90% within agreed timescale
 <p>Complaints answered within 25 working days</p>		Nov-21	85.40%
		Variance Type	Indicator is showing no significant change (common cause variation)
		Assurance Type	Indicator is showing random variation
		What the chart is telling us	Performance has dipped in November falling below target for the first time since September 2021
Lead: Chris Morley, Chief Nurse		Timescale: Ongoing	
Board Committee Providing Oversight: Healthcare Governance Committee			
Summary of current issues		Actions to recover performance	
The 90% response time target has not been achieved.  A high number of complaints were closed in November, adversely impacting performance. The majority of complaints that are overdue are by a small timescale.		Weekly meetings held with Patient experience Managers to review any cases that are overdue or approaching timescale to ensure concerns are escalated.  Complainants are being updated and the reasons for delays explained to them.	

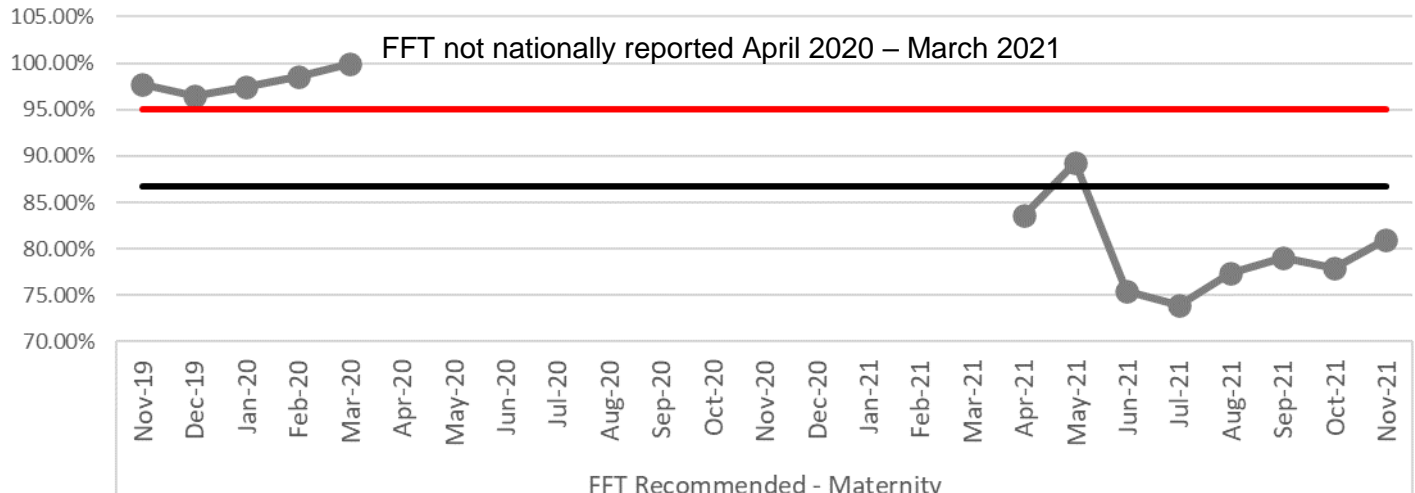
COMMUNITY CARE (Integrated Care Team (ICT) contacts)		Target	43,000
 <p>Integrated Care team contacts</p>		Nov-21	37,910
		Variance Type	Metric is indicating a special cause of concern due to its low values.
		Assurance Type	Indicator is showing random variation
		What the chart is telling us	The number of ICT contacts dipped below target in April-20, and has remained below target for all months other than Oct 2020.
Lead: Michael Harper, Chief Operating Officer		Timescale: Ongoing	
Board Committee Providing Oversight: Finance and Performance Committee			
Summary of current issues		Actions to recover performance	
To note is the significant increased demand on the ICT Nursing service for end of life care - the average number of deaths in the community per month is over 100% higher than 2019/20 baseline. This is impacting the day teams but significantly impacting the Evenings and Nights Service (ENS) due to an increasingly complex caseload. ICT therapy are also experiencing increased demand due to the number of hospital discharges and increasing acuity, resulting in a backlog risk. The service is also struggling to recruit to vacancies. Community Nursing levels have also been struck with high staff sickness levels and Covid isolation levels.		Integrated care team, end of life care and evening and night services demand have a covid bid for additional funding for the ENS service. ICT Therapy: obtained non-recurrent funding to recruit more rotational therapists in November 2021.	

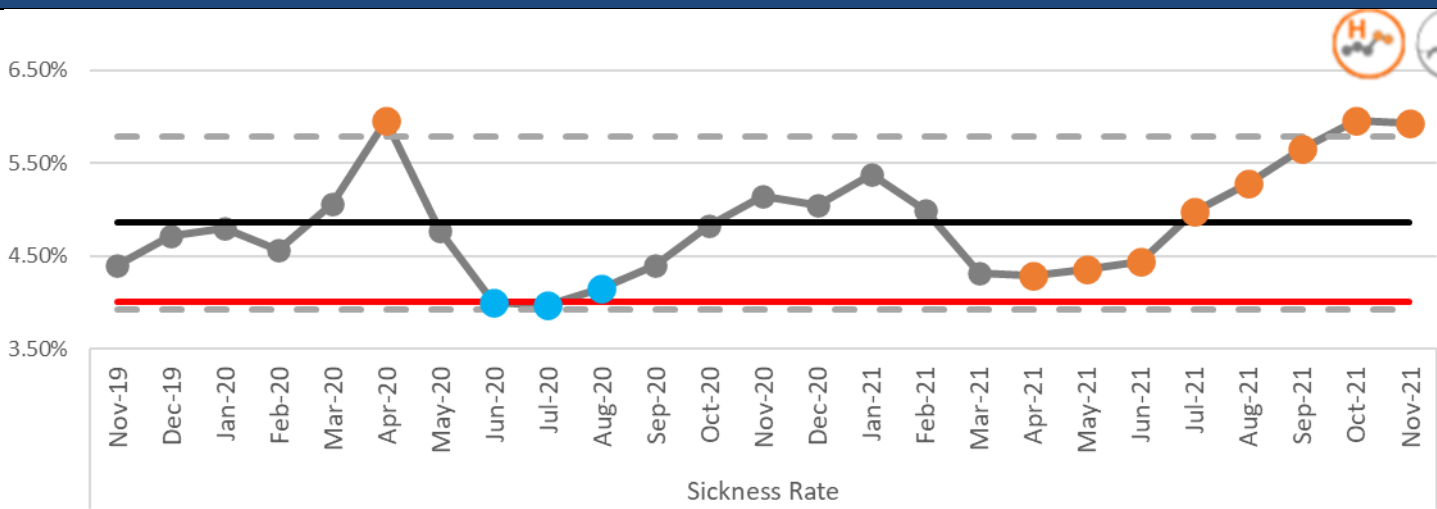
COMMUNITY CARE (Intermediate Care Bed Average Length of Stay)		Target	35 days
 <p>Intermediate Care Beds Length of Stay</p>		Nov-21	41.7 days
		Variance Type	Indicator is showing no significant change (common cause variation)
		Assurance Type	Indicator is showing random variation
		What the chart is telling us	Average LOS for Intermediate beds has increased since September 2021
Lead: Michael Harper, Chief Operating Officer		Timescale: Ongoing	
Board Committee Providing Oversight: Finance and Performance Committee			
Summary of current issues		Actions to recover performance	
Waits for Independent Sector care packages are continuing to cause delays. Delays also noted for S2A placements and housing, and acuity of patients also increased. Waits for Independent Sector care packages increased across all discharge points.		Continue to escalate named patient delays to the Discharge Hub and via Escalation meetings.	

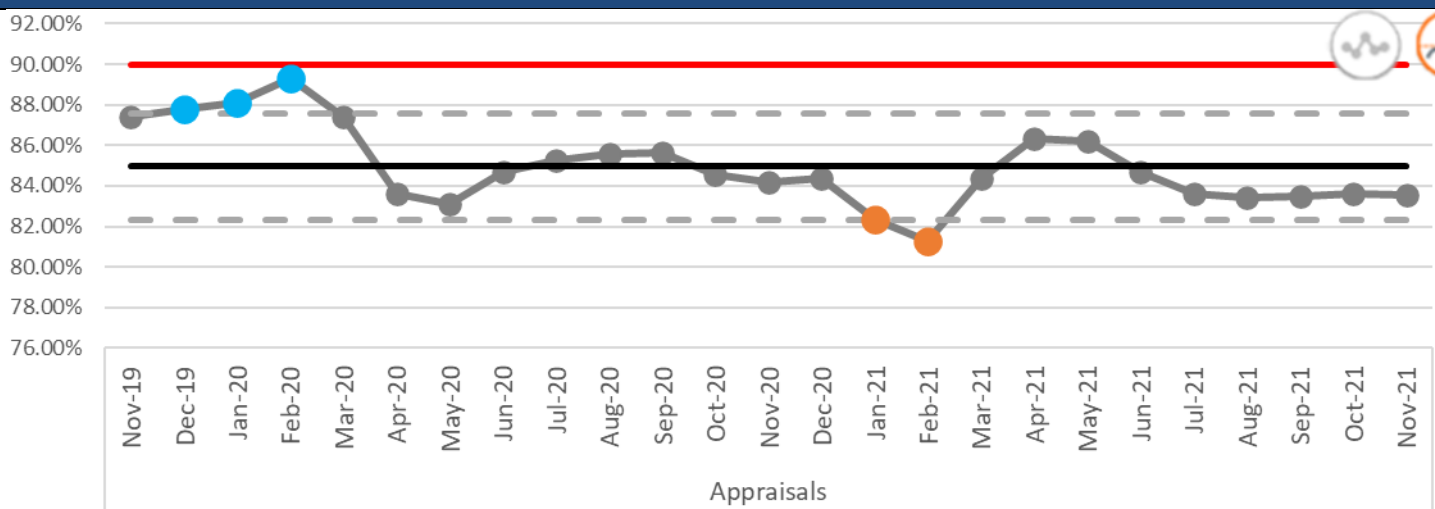
GP CO-OPERATIVE (GPC) (Patients seen within 4 hours)		Target	95%
 <p>Out of Hours GPC</p>		Nov-21	65.25%
		Variance Type	Metric is indicating a special cause of concern due to its low values.
		Assurance Type	Indicator is showing random variation
		What the chart is telling us	The percentage of patient seen within 4 hours dipped below target in April 2021 and has remained below target.
Lead: Michael Harper, Chief Operating Officer		Timescale: Ongoing	
Board Committee Providing Oversight: Finance and Performance Committee			
Summary of current issues		Actions to recover performance	
<p><b>The Adastra system was updated in November and the data quality has been impacted by this.</b></p> <p>Actual performance anticipated to be in line with last few months once issue rectified (approx. 90%). November demand levels remained high and continues to exceed both 2021/22 Plan and 2019/20 baseline by approximately 15%. This pressure is exacerbated further by the significant over-delivery of face to face activity driven by an increase in patients streamed from A&amp;E. An increase in advice calls and the proportion of urgent advice calls observed throughout 20/21 (approx. 13-14% higher than baseline) has remained consistent and created additional. Vacant shifts are exacerbating pressures.</p>		<p>1) Continued monitoring of rota fill rate. Survey circulated to GP workforce to understand drivers for lower fill rate. Session held with GPs to discuss and obtain engagement with rota planning.</p> <p>2) Escalation matrix developed with A&amp;E to enable collaborative management of patient flow between GPC and A&amp;E.</p> <p>3) Covid bid submitted and approved for additional hours until end of March 2022</p> <p>4) Annual pay review underway - assessing viability of parity with other GP pay rates.</p> <p>6) Submitted proposal for extension of Capacity Co-ordinator Pilot - now approved</p>	

FRIENDS & FAMILY TEST (Inpatients)		Target	95%
 <p>FFT not nationally reported April 2020 – March 2021</p> <p>FFT Recommended</p>		Nov-21	91%
		Variance Type	Not Applicable. Insufficient data points for SPC
		Assurance Type	Not Applicable. Insufficient data points for SPC
<b>Lead:</b> Chris Morley, Chief Nurse <b>Timescale:</b> Ongoing <b>Board Committee Providing Oversight:</b> Healthcare Governance Committee		What the chart is telling us	The FTT Target for Inpatient services has not been met since reporting re-commenced in April 2021
Summary of current issues	Actions to recover performance		
<p>The Inpatient score for October was 90% and increased to 91% in November.</p> <p>Positive scores have remained below target (95%) since FFT was restarted internally in October 2020.</p> <p>A deep dive undertaken in April 2021 highlighted a number of factors which could be contributing to the fall in scores these are:</p> <ul style="list-style-type: none"> <li>- Move to electronic methods</li> <li>- Change in demographics of patients providing feedback</li> <li>- Change in question</li> <li>- Change to the timing of the question meaning experience of discharge now included</li> </ul>	<p>Feedback cards have been reintroduced on 7 wards. The new methods will take time to fully embed but data from November shows that for the wards submitting feedback cards, the positive score increased and is above the target for 4 of the wards. 2 wards did not receive any responses and 1 ward increased the score from 79% to 88%. Using feedback cards increased the response rate on all of the wards. The impact of re-introducing cards will be reviewed after a further 2 months which will be presented to PEC for discussion.</p> <p>A local survey was sent to patients in September 2021. The wards selected for the survey were those with a good response rate (above 20%), and a low positive score (below 90%). Analysis of the patient comments suggests that the majority of patients received high quality care and had a positive experience, with positive comments frequently mentioning the caring attitude of staff, how hard the ward teams work and the efficiency of the service. The results were discussed at PEC in December 2021. It was agreed that wards areas would review their individual results and develop an action plan to make improvements based on the feedback.</p>		

FRIENDS & FAMILY TEST (A&E)		Target	86%																
<div><div>90.00% 88.00% 86.00% 84.00% 82.00% 80.00% 78.00% 76.00% 74.00% 72.00% 70.00%</div><div>FFT not nationally reported April 2020 – March 2021</div><div><div>Nov-19 Dec-19 Jan-20 Feb-20 Mar-20 Apr-20 May-20 Jun-20 Jul-20 Aug-20 Sep-20 Oct-20 Nov-20 Dec-20 Jan-21 Feb-21 Mar-21 Apr-21 May-21 Jun-21 Jul-21 Aug-21 Sep-21 Oct-21 Nov-21</div><div>FFT Recommended - A&amp;E</div></div></div> <tr><th>Nov-21</th><td>77%</td></tr> <tr><th>Variance Type</th><td>Not Applicable. Insufficient data points for SPC</td></tr> <tr><th>Assurance Type</th><td>Not Applicable. Insufficient data points for SPC</td></tr> <tr><td colspan="2"><div><div>Lead: Chris Morley, Chief Nurse</div><div>Timescale: Ongoing</div></div><div>Board Committee Providing Oversight: Healthcare Governance Committee</div></td><th>What the chart is telling us</th><td>The FTT Target for A&amp;E has not been met since reporting re-commenced in April 2021</td></tr> <tr><th colspan="2">Summary of current issues</th><th colspan="2">Actions to recover performance</th></tr> <tr><td colspan="2"><p>The target of an 86% positive score has not been achieved since January 2021.</p><p>A&amp;E at NGH continues to be the area which has the biggest impact on the lower positive score. Eye Casualty and Minor Injuries consistently score above the Trust target of 90%. Analysis of comments shows that the highest number of negative comments relate to waiting time, which reflects the significant pressures the department has been experiencing.</p></td><td colspan="2"><p>Following the 2020 national urgent and emergency care survey results, an action plan was created to make improvements to the patient experience. It is expected that, as these actions are implemented, they will have an impact on the patient experience.</p><p>A recent review of Shelford Trusts showed that STH's response rate of 22% is above the national response rate of 20%. STH have the third lowest positive score when compared with Shelford but are in line with the national average (79%). Nationally there has been a downward trend both in FFT score and waiting time performance since April 2021. The waiting time performance and FFT positive score appear to be closely related at all Shelford Trusts, which is reflected in patient comments which shows waiting time to be the top negative theme.</p></td></tr>		Nov-21	77%	Variance Type	Not Applicable. Insufficient data points for SPC	Assurance Type	Not Applicable. Insufficient data points for SPC	<div><div>Lead: Chris Morley, Chief Nurse</div><div>Timescale: Ongoing</div></div> <div>Board Committee Providing Oversight: Healthcare Governance Committee</div>		What the chart is telling us	The FTT Target for A&E has not been met since reporting re-commenced in April 2021	Summary of current issues		Actions to recover performance		<p>The target of an 86% positive score has not been achieved since January 2021.</p> <p>A&amp;E at NGH continues to be the area which has the biggest impact on the lower positive score. Eye Casualty and Minor Injuries consistently score above the Trust target of 90%. Analysis of comments shows that the highest number of negative comments relate to waiting time, which reflects the significant pressures the department has been experiencing.</p>		<p>Following the 2020 national urgent and emergency care survey results, an action plan was created to make improvements to the patient experience. It is expected that, as these actions are implemented, they will have an impact on the patient experience.</p> <p>A recent review of Shelford Trusts showed that STH's response rate of 22% is above the national response rate of 20%. STH have the third lowest positive score when compared with Shelford but are in line with the national average (79%). Nationally there has been a downward trend both in FFT score and waiting time performance since April 2021. The waiting time performance and FFT positive score appear to be closely related at all Shelford Trusts, which is reflected in patient comments which shows waiting time to be the top negative theme.</p>	
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FRIENDS & FAMILY TEST (Maternity)		Target	95%
 <p>FFT not nationally reported April 2020 – March 2021</p> <p>FFT Recommended - Maternity</p>		Nov-21	86%
		Variance Type	Not Applicable. Insufficient data points for SPC
		Assurance Type	Not Applicable. Insufficient data points for SPC
		What the chart is telling us	The FTT Target for Maternity services has not consistently been met
Lead: Chris Morley, Chief Nurse		Timescale: Ongoing	
Board Committee Providing Oversight: Healthcare Governance Committee			
Summary of current issues		Actions to recover performance	
Since restarting internal collection of FFT in November 2020, the target of a 95% positive score has not been achieved.		Once feedback cards have been established in Inpatient areas and the impact has been reviewed, PEC will discuss whether to extend the use of feedback cards to Maternity Services.	
A deep dive undertaken in April 2021 highlighted a number of factors which could be contributing to the fall in scores these are: <ul style="list-style-type: none"><li>- Move to electronic methods</li><li>- Change in question</li><li>- Change to the timing of the question meaning experience of discharge now included</li></ul>		The maternity team are in the process of reviewing the Trust's 2021 national maternity survey results and an action plan is currently being developed. This will be presented at PEC in January 2022, to coincide with publication of the national results. Themes in the action plan include Information, Patient Centred Care and Mental Health Support.	
		During a recent review of Shelford group Maternity scores it was found that response numbers are low for maternity services across Shelford and data is not available for all Trusts. For antenatal, none of the trusts scored the STH target of 95%.	

SICKNESS ABSENCE (All days lost as a percentage of those available)		Target	4.0%
 <p>Sickness Rate</p>		Nov-21	5.9%
		Variance Type	Metric is indicating a special cause of concern due to its high values.
		Assurance Type	Indicator is showing random variation
		What the chart is telling us	From August-20 sickness absence has not met the target.
Lead: Mark Gwilliam, Director of Human Resources		Timescale: Ongoing	
Board Committee Providing Oversight: HR and OD Committee			
Summary of current issues		Actions to recover performance	
<p>The monthly non-COVID sickness absence figure is 5.9%.</p> <p>Sickness figures over the Christmas and New Year holiday period increased significantly due to Omicron but appeared to be higher than expected because it was not being reflected in the operational position of the Trust. Work has been undertaken to verify the figures and it is clear that there were errors in the data caused by absence records that had not been closed after isolation periods had ended, or confirmation of a negative test result. There were also inaccuracies where the working from home status had not been captured. Work is underway to review the data quality, simplify systems being used and correct records. The current data is now reflecting a more accurate picture of staff absence, correlates with the operational position and the Trust has returned to providing data to the national collection system for COVID absence.</p>		<p>All directorates have developed their own action plans which are continuously reviewed; HR Business Partners continue to work with directorates to develop individual action plans for staff that have been off on long term sick. Cases that were paused due to COVID have re-started. We are focusing support to those areas with higher levels of non-COVID related absence. The Trust has a process to monitor self-isolations and support a swift return to work when staff either receive a negative test result or the isolation period comes to an end. Based on previous years we can see that sickness absence levels are higher than is usual for the time of year and recognise that is likely linked to the impact of the COVID pandemic. Additional support has been built into our Health and Wellbeing plan over the last 18 months and we continue to work on building this offer to support our colleagues to maintain their well-being. We are monitoring sickness absence levels closely on a weekly basis.</p>	

APPRAISALS (Completed appraisals in last year)		Target	90%																																																				
 <table><tr><th>Month</th><th>Appraisal Rate (%)</th></tr><tr><td>Nov-19</td><td>87.5</td></tr><tr><td>Dec-19</td><td>88.0</td></tr><tr><td>Jan-20</td><td>88.5</td></tr><tr><td>Feb-20</td><td>89.5</td></tr><tr><td>Mar-20</td><td>87.5</td></tr><tr><td>Apr-20</td><td>83.5</td></tr><tr><td>May-20</td><td>83.0</td></tr><tr><td>Jun-20</td><td>84.5</td></tr><tr><td>Jul-20</td><td>85.5</td></tr><tr><td>Aug-20</td><td>85.5</td></tr><tr><td>Sep-20</td><td>85.5</td></tr><tr><td>Oct-20</td><td>84.5</td></tr><tr><td>Nov-20</td><td>84.0</td></tr><tr><td>Dec-20</td><td>84.5</td></tr><tr><td>Jan-21</td><td>82.5</td></tr><tr><td>Feb-21</td><td>81.5</td></tr><tr><td>Mar-21</td><td>84.5</td></tr><tr><td>Apr-21</td><td>86.5</td></tr><tr><td>May-21</td><td>86.5</td></tr><tr><td>Jun-21</td><td>84.5</td></tr><tr><td>Jul-21</td><td>83.5</td></tr><tr><td>Aug-21</td><td>83.5</td></tr><tr><td>Sep-21</td><td>83.5</td></tr><tr><td>Oct-21</td><td>83.5</td></tr><tr><td>Nov-21</td><td>83.5</td></tr></table>		Month	Appraisal Rate (%)	Nov-19	87.5	Dec-19	88.0	Jan-20	88.5	Feb-20	89.5	Mar-20	87.5	Apr-20	83.5	May-20	83.0	Jun-20	84.5	Jul-20	85.5	Aug-20	85.5	Sep-20	85.5	Oct-20	84.5	Nov-20	84.0	Dec-20	84.5	Jan-21	82.5	Feb-21	81.5	Mar-21	84.5	Apr-21	86.5	May-21	86.5	Jun-21	84.5	Jul-21	83.5	Aug-21	83.5	Sep-21	83.5	Oct-21	83.5	Nov-21	83.5	Nov-21	84%
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Variance Type	Indicator is showing no significant change (common cause variation)																																																						
Assurance Type	Metric is consistently falling short of the target.																																																						
Lead: Mark Gwilliam, Director of Human Resources		What the chart is telling us	Appraisal rates have been consistently below target																																																				
Board Committee Providing Oversight: HR and OD Committee																																																							
Summary of current issues		Actions to recover performance																																																					
The cumulative position for completed appraisals during the past twelve months at the end of November 2021 is 84%.		All Directorates have developed action plans in conjunction with their HR Business Partners in order that they can achieve compliance with the target and are identifying contingencies in the context of both pandemic and winter pressures to ensure that staff continue to receive the support that appraisals provide.																																																					

Efficiency		Target	£5,257K
<p>£000's</p> <p>Legend: Delivered (Blue bars), Target (Red line), Forecast Outturn Tracker (Black line)</p>		Year to Nov	£2,821K
		Variance Type	Indicator monitored on an annual basis so SPC not appropriate.
		Assurance Type	Indicator monitored on an annual basis so SPC not appropriate.
<p><b>Lead:</b> Neil Priestley, Chief Financial Officer</p> <p><b>Timescale:</b> March 2022</p> <p><b>Board Committee Providing Oversight:</b> Finance &amp; Performance Committee</p>		What the chart is telling us	The target for 2021/22 is unlikely to be met.
Summary of current issues		Actions to recover performance	
<p>For 2021/22 an efficiency target of 1% (£7,886k) has been set for Directorates. Total delivery in M1-8 is £2,821k against a target of £5,257k (£2,436k and therefore 46% behind target). Most of this shortfall is due to insufficient P&amp;E being identified in Cut 3 plans – Cut 3 plans are £2,310k lower than the 1% target at the end of Month 8.</p> <p>Directorates are also being monitored against a 1.5% target across 20/21 (0.5%) and 21/22 (1%). Total delivery to date is £7,045k against a target of £9,200k (£1,388k and therefore 23% behind target).</p>		<p>CEO PMO meetings have been restarted from October to improve oversight and delivery of P&amp;E. These sessions so far have focussed on the 'Making it Better' programmes discussing both potential opportunities for P&amp;E in 22/23 and the impact workstreams have had on efficiency delivery in the current year.</p> <p>Cut 2 22/23 Efficiency plans for Directorates are due at the end of January 2022 – Confirm &amp; Challenge sessions are set to be held with relevant Care Groups throughout February 2022. Focussed support has been offered to assist Directorates with identifying potential P&amp;E schemes for 22/23 where requested through the Business Planning Reviews.</p>	

## 1 INTRODUCTION

This deep dive into the mandatory surveillance of infection prevention and control seeks to provide further detail and information to assist the Trust Board of Directors in understanding more about the historical and current performance on the organisms subject to mandatory surveillance. It also outlines the key programmes of work being pursued by the Infection Prevention and Control Team in relation to these organisms. To address the above objectives, this report has been organised as follows:

- Outline of the national targets
- Performance over time
- Comparison between Sheffield Teaching Hospitals NHS Foundation Trust (STH) and other trusts of a similar size and complexity
- Outline of the work programme being pursued by the Infection Prevention and Control Team

## 2 OUTLINE OF THE NATIONAL TARGETS

The Trust is required to submit data as part of the mandatory surveillance scheme for:

### 2.1 Methicillin resistant *Staphylococcus aureus* (MRSA) Bacteraemia

Since 2001 it has been mandatory for trusts to report MRSA bacteraemia figures to the Department of Health (DH). The results are published and the MRSA bacteraemia rate per 100,000 occupied beds is used as a performance indicator. Whilst over time the specific definition and methodology for allocating cases to the Trust has changed, for the purpose of this report we are just reporting those cases that at the time were allocated to the Trust.

### 2.2 Methicillin sensitive *Staphylococcus aureus* (MSSA) Bacteraemia

Since January 2011, it has been mandatory to report MSSA bacteraemia to the DH. The results are published including the MSSA bacteraemia rate per 100,000 occupied beds, the rates of MSSA bacteraemia are monitored via the Single Oversight Framework by NHS Improvement. Similar to MRSA bacteraemia despite changes over time to definitions we are reporting cases allocated to the Trust at the time.

### 2.3 *Clostridioides difficile* toxin associated diarrhoea (CDD)

Since 2004 it has been mandatory for trusts to report CDD figures to the DH. The results are published and the CDD rate per 100,000 occupied bed days is used as a performance indicator. From 2008/9 to 2017/18 CDD episodes were designated as either 'Trust attributable' or 'non-Trust attributable' depending on when the sample was taken in relation to admission and the 2018/19 figures have been modelled in a similar way. For 2019/20 onwards, the definitions used for Hospital Onset episodes changed to include more episodes than in previous years. This largely explains the increase in Hospital Onset cases noted from 2019/20 onwards compared to previous years.

### 2.4 Gram negative bacteraemia (*Escherichia coli* (*E.coli*), *Klebsiella species* and *Pseudomonas aeruginosa*)

Surveillance of *E.coli* bacteraemia became part of the DH national mandatory surveillance scheme from June 2011 onwards. As from 2017/18, the *E.coli* bacteraemia data has been published nationally detailing both the overall rates and rates for those episodes considered to be 'Hospital-onset'. The term Trust Attributable equates to Hospital Onset' in this report. *E. coli* rates are also monitored by NHS Improvement via the Single Oversight Framework. Surveillance of *Klebsiella species*

bacteraemia became part of the DH national mandatory surveillance scheme from April 2017 onwards. Surveillance of *Pseudomonas aeruginosa* bacteraemia became part of the DH national mandatory surveillance scheme from April 2017 onwards.

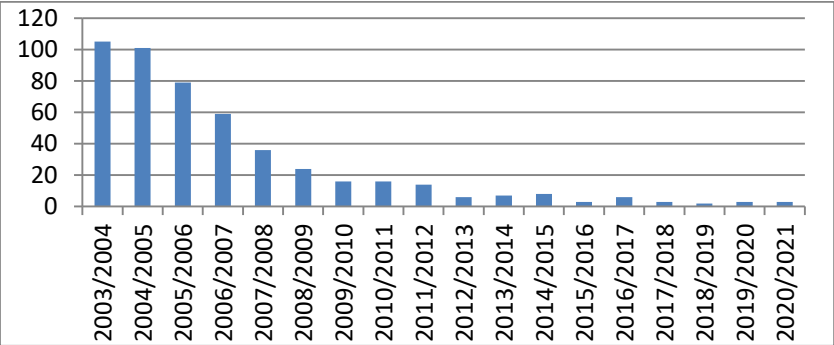
### 3 PERFORMANCE OVER TIME

#### 3.1 MRSA Bacteraemia

Chart 1 demonstrates the fall in the incidence of MRSA bacteraemia since 2003. The chart shows all cases detected by the Trust laboratories to allow a direct comparison of performance. Whilst the Trust was seeing over 100 cases per year of MRSA bacteraemia in 2003 this has been below 10 per year since 2012.

Table 1 shows the number of cases allocated to the Trust since 2008. It is extremely pleasing to note that the number of episodes allocated to the Trust has remained low since 2011.

Chart 1/Table 1: Total number of cases and rate per 100,000 bed days of MRSA Bacteraemia detected by the Trust Laboratories 2003-2021



Year	Rate (Number )
2008/09	2.1 (14)
2009/10	1.4 (9)
2010/11	1.4 (9)
2011/12	0.3 (2)
2012/13	0.5 (3)
2013/14	0.7 (4)
2014/15	0.7 (4)
2015/16	0.0 (0)
2016/17	0.4 (2)
2017/18	0.6 (3)
2018/19	0.4 (2)
2019/20	0.6 (3)
2020/21	0.6 (3)

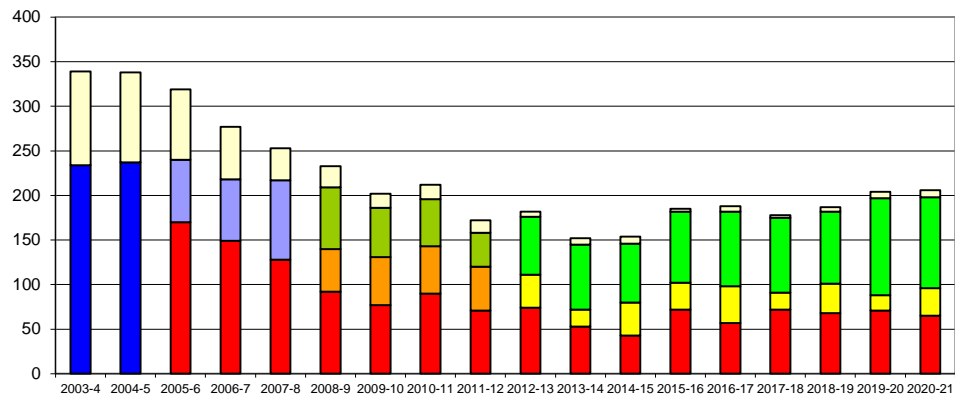
#### 3.2 MSSA Bacteraemia

Chart 2 shows data for all *S. aureus* bacteraemia episodes (MSSA and MRSA) detected within the Trust laboratories over the past few years. Much attention is given to MRSA but, as Chart 2 illustrates, MSSA is a far more common pathogen, both in the community and within hospitals. This is not surprising as MSSA naturally colonises approximately one third of the population at any one time. When people get an infection with this organism it is often caused by the organism they are already carrying but cross infection may also be a cause. It is generally not possible to ascertain where patients actually acquire the organism causing their infection, but infections can be reduced by optimal infection prevention and control practice.

The data published by the DHSC have revealed that the number of cases of MSSA bacteraemia detected by individual trusts can vary considerably from year to year.

Overall, between 2003/04 and 2018/19 the number of MSSA episodes within STH has decreased by 25%. However, the numbers detected over the past few years have stabilised, and further reductions have not been consistently attained. Table 2 shows the number of episodes of Trust Attributable/Hospital Onset MSSA bacteraemia detected since 2008/9. The overall trend is now stable with performance at similar levels over the last 10 years.

Chart 2/Table 2: Details of S aureus bacteraemia episodes detected by the Trust laboratories 2003-2021 & Episodes of Trust Attributable/Hospital Onset MSSA Bacteraemia 2008/09 – 2020/21



Time period	Trust attributable episodes
2008/09	92
2009/10	77
2010/11	90
2011/12	71
2012/13	74
2013/14	53
2014/15	43
2015/16	72
2016/17	57
2017/18	72
2018/19	68
2019/20	71
2020/21	65

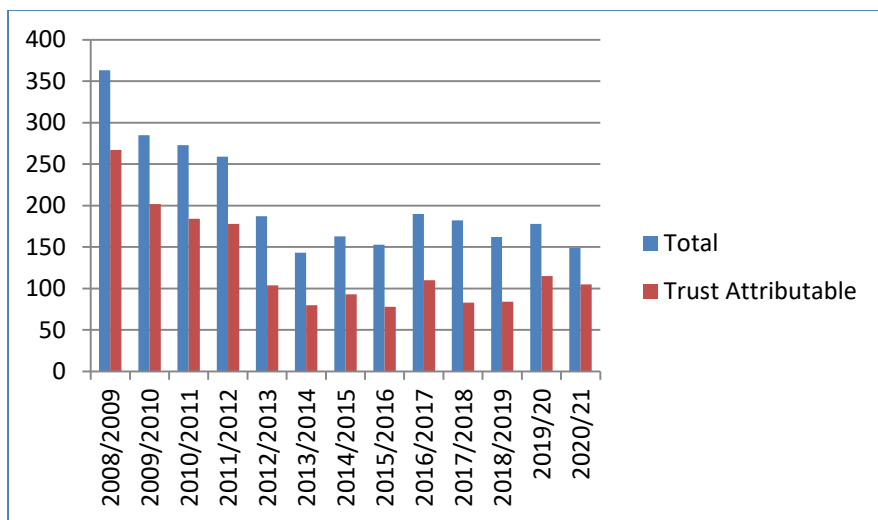
~ Community Acquired = cases detected in blood cultures taken on Day 0 or Day 1, where the day of admission is Day 0, and the patient has not been an STH in-patient within the past 28 days  
# Healthcare Associated = cases detected in blood cultures taken on Day 0 or Day 1, where day of admission is Day 0, but the patient had been an STH inpatient within the past 28 days  
\* Trust Attributable /Hospital Onset = episodes detected in blood cultures taken on Day 2 onwards after admission, where day of admission is Day 0  
MRSA = Methicillin resistant Staphylococcus aureus  
MSSA = Methicillin sensitive Staphylococcus aureus

MRSA: all cases	
MSSA: all cases (applies to 2003-5)	
MSSA: Community Acquired & Healthcare Associated cases (applies to 2005-8)	
MSSA: Trust Attributable/Hospital Onset cases (applies to 2005 onwards)	
MSSA: Community Acquired cases (applies to 2008-12)	
MSSA: Healthcare Associated cases (applies to 2008-12)	
MSSA: Likely Healthcare Associated cases (applies to 2012-onwards)	
MSSA: Community cases & Healthcare associated cases where review has determined that recent contact with the Trust was coincidental (applies to 2012-onwards)	

### 3.3 Clostridioides difficile toxin associated diarrhoea

Chart 3 highlights the significant reduction in the number of ‘Trust attributable’ CDD episodes detected over the period since 2008, with the Trust having less than 100 Trust attributable cases each year since 2013/14 apart from 2016/17. Overall, comparing 2019/20 with 2018/19 there was a 19% increase in the number of CDD episodes detected in patients within the Trust, whilst noting again that definitions used for Hospital Onset episodes changed to include more episodes than in previous years. 2020/21 shows a decrease compared with 2019/20 in the number of CDD episodes detected in patients within the Trust. The numbers do fluctuate from year to year and current levels are similar to those seen over the preceding years - see Table 3.

Chart 3/Table 3: Total number of CDD cases of Trust Attributable/Hospital Onset cases of CDD 2008/9 - 2020/21



Year	Rate (Number)
2008/09	267
2009/10	202
2010/11	184
2011/12	178
2012/13	104
2013/14	80
2014/15	93
2015/16	78
2016/17	110
2017/18	83
2018/19	84
2019/20	115
2020/21	105

### 3.4 *E.coli* Bacteraemia

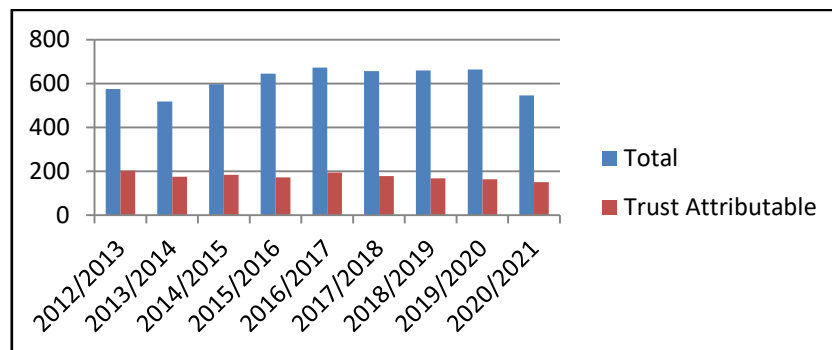
*E.coli* causes a range of infections in hospital, outpatient and community settings. The normal reservoir for this organism is the human gut and almost all people will carry the organism throughout their life. Infections occur when the organism enters other body cavities e.g. urinary tract infections, peritonitis and blood stream infections.

Chart 4 shows data for all *E.coli* bacteraemia episodes detected within the Trust laboratories over recent years, alongside those which are labelled as Trust attributable (*E.coli* bacteraemia detected 48 hours after hospital admission). Overall the number of episodes detected by the STH laboratories in 2020/21 reduced by 16% compared to the last few years, which is pleasing. However, whether this is a long term change or is in some way due to the impact of the Covid-19 pandemic remains to be seen. The numbers of Hospital Onset\* and Healthcare Associated# cases have continued to fall;

- Hospital Onset cases - 8.6% fall this year, following 2.4%, 6.2% and 7.8% year on year reductions over the previous 3 years
- Healthcare Associated cases - 21.6% this year, following 6.7%, 26.5% and 8.2% year on year reductions over the previous 3 years

For the first time in several years, Community Onset cases also fell showing a 20.5% reduction compared to 2019/20. This contrasts with a 4.6%, 18% and 4.3% increase in the year on year number of Community associated cases over the preceding three years.

Chart 4: Total number and Trust Attributable Onset cases of *E.coli* Bacteraemia 2012/13 -2020/21



### 3.5 *Klebsiella species* bacteraemia

Surveillance of *Klebsiella species* bacteraemia became part of the DH national mandatory surveillance scheme from April 2017 onwards. Overall the number of episodes detected by the STH laboratories in 2020/21 (187) rose compared to last year (174) but was in the range seen in previous years (195, 177). The number of Hospital Onset\* and Healthcare Associated# cases both reduced, whereas there was little change in Community Acquired cases. This follows an upward trend over the past few years.

### 3.6 *Pseudomonas aeruginosa* bacteraemia

Surveillance of *Pseudomonas aeruginosa* bacteraemia became part of the DH national mandatory surveillance scheme from April 2017 onwards. Overall, the number of episodes detected by the STH laboratories in 2020/21 (49) fell compared to last year (56) but was in the range seen in previous years (69, 60). The number of Hospital Onset\*, Healthcare Associated# and Community cases all reduced to a greater or lesser extent.

## 4 COMPARISON BETWEEN SHEFFIELD TEACHING HOSPITALS NHS FOUNDATION TRUST (STH) AND OTHER PROVIDERS

Data, submitted as part of the mandatory DHSC Healthcare Associated Infection (HCAI) scheme, can be used to provide an overall picture of the Trust's performance in relation to other similar organisations. As from 2017-18, the trusts chosen for comparison comprise the Shelford Group of trusts plus six other large regional acute teaching hospital organisations. In 2019/20 the Trust performance in relation to other organisations remained similar or compared less well. One reason for this may be that a number of the organisations have expanded by merging with local smaller and less complex hospital trusts. Such mergers tend to expand the denominator without necessarily expanding the number of cases of infection which tend to be higher in establishments with a more complex patient case mix. Another factor may have been the loss of overall single room capacity necessitated by the works required in the Hadfield Wing.

It is pleasing to note for 2020/21 as shown in table 4 below, that the Trust once again has a low MRSA bacteraemia rate compared to other similar trusts. The MSSA bacteraemia position remained similar to previous years in 2019/20 and improved in 2020/21. Performance in 2020/21 in respect of *E.coli* and *Klebsiella* bacteraemia improved compared to 2018/19. The Trust performance in 2020/21 in respect of *Pseudomonas* bacteraemia compared well with other organisations though a little less well than in 2019/20. In relation to *CDD* diarrhoea the Trust performance in 2019/20 was 14<sup>th</sup> out of 16 similar trusts and improved slightly in 2020/21. When all six modules were taken into account, the Trust improved its position coming 4<sup>th</sup> out of the 16 comparable organisations.

Addressing *CDD* diarrhoea, MSSA and *E.coli* bacteraemia will continue to be a key part of the 2021/22 IPC Programme and onwards.

Table 4: STH performance in relation to the sixteen other large acute teaching hospital trusts

Module	Position (1 <sup>st</sup> has lowest rate)			
	2017/18	2018/19	2019/20	2020/21
<i>CDD</i>	6 <sup>th</sup>	9 <sup>th</sup>	14 <sup>th</sup>	12 <sup>th</sup>
MSSA	12 <sup>th</sup>	12 <sup>th</sup>	13 <sup>th</sup>	8 <sup>th</sup>
MRSA	7 <sup>th</sup>	2 <sup>nd</sup>	7 <sup>th</sup>	6 <sup>th</sup>
<i>E.coli</i>	13 <sup>th</sup>	9 <sup>th</sup>	10 <sup>th</sup>	8 <sup>th</sup>
<i>Klebsiella</i>	7 <sup>th</sup>	5 <sup>th</sup>	7 <sup>th</sup>	2 <sup>nd</sup>
<i>Pseudomonas</i>	1 <sup>st</sup>	6 <sup>th</sup>	2 <sup>nd</sup>	4 <sup>th</sup>
All six modules combined	7 <sup>th</sup>	5 <sup>th</sup>	9 <sup>th</sup>	4 <sup>th</sup>

## 5 OUTLINE OF THE WORK PROGRAMME BEING PURSUED BY THE INFECTION PREVENTION AND CONTROL (IPC) TEAM

### 5.1 MRSA Bacteraemia

A great deal of work has taken place over the past few years designed to reduce the likelihood of patients experiencing MRSA generally and bacteraemia in particular. This includes:

- MRSA screening and follow up of positive cases for decolonisation.
- Antimicrobial prescribing; rolling review of antimicrobial prescribing policies and restriction of certain antimicrobials, as the restriction of some antimicrobials e.g. quinolones is associated with better control of MRSA.
- Insertion and on-going management of peripheral intravenous cannulae; range of initiatives to improve documentation and on-going management of these devices including switching to a chlorhexidine based skin wipe for skin preparation prior to insertion of the device and audit of the use of cannula charts. An electronic cannula chart has been developed to support staff in achieving the required standards of cannula management – this will be trialled shortly in Diabetes and Endocrinology and made available via the e-whiteboard in the Trust's electronic patient records.
- Liaison with primary care colleagues; patients deemed to be at higher than average risk of developing MRSA bacteraemia in the community are referred to community colleagues and protocols for treatment agreed.

### 5.2 MSSA Bacteraemia

MSSA is carried by approximately 30% of the population and most infections are due to organisms already carried by the patient, although cross infection from other patients and staff can also occur. Preventing infection with MSSA therefore requires a variety of interventions.

A clinical review is undertaken of all inpatients with MSSA bacteraemia. The review of the 2019/20 and 2020/21 cases has determined that the numbers for each ward and Directorate are small and can vary year on year. There are no clinical areas that stand-out as being 'outliers' with a rising trend over the years. Root-cause analysis of cases has not shown areas of consistently poor practice.

One issue where intervention may be beneficial is in the insertion, ongoing management and documentation of intravenous access devices (IVADs), including peripheral, central, arterial and peripherally inserted central catheter (PICC) devices. As with MRSA bacteraemia the IPC Team has worked with the Trust Informatics and Digital Services Teams to develop an electronic cannula chart to support staff in achieving the required standards of cannula management – this will be made available via the e-whiteboard in the Trust's electronic patient records following a pilot trial

Decolonisation around the time of central line insertion for Haematology patients is now embedded practice.

The areas where most cases of MSSA bacteraemia are detected appear to be the medical wards. A pilot study in 2018, investigating the pros and cons of introducing 'universal *Staphylococcus aureus* decolonisation/suppression' treatment for patients during their stay in hospital showed that this approach was acceptable to patients and staff and so this initiative has now been rolled out for dependant patients on the Trust medical wards in 2019/20. A similar approach has been introduced within the Musculoskeletal Directorate for patients having elective surgery and is now well established. Review of both these initiatives was postponed due to Covid-19 but forms part of the 2021/22 IC Programme.

### **5.3 *Clostridioides difficile* toxin associated diarrhoea**

The official name for *Clostridium difficile* changed during 2019 from '*Clostridium*' to '*Clostridioides*'. Clinically and infection prevention and control wise this change is irrelevant and the terms are interchangeable.

The on-going challenge faced by the Trust is to maintain optimal infection prevention and control practice, cleanliness standards and antimicrobial prescribing, despite caring for an increasingly elderly and frail population. The actions required to continue to maintain and improve on the reduction in cases of CDD are contained within the Infection Prevention and Control Programmes and can be summarised under the following headings:

- Reducing environmental contamination of wards/departments
- Optimising infection prevention and control practice
- Optimising antibiotic prescribing
- CDD case follow up and action
- Raising the profile of infection prevention and control
- Ongoing real time monitoring on cases

Every effort has been made to continue the rolling deep clean of wards and departments in 2019/20 and 2020/21, with good progress made, particularly at Central Campus. Operational issues have impacted on this programme, at the Northern campus due to the unavailability of the Hadfield Wing up to the summer of 2021. The disruption to Trust services necessitated by the Covid-19 pandemic, resulted in some planned deep cleans being postponed. However, deep cleans were undertaken as clinically required and opportunities taken to clean areas as service reconfiguration took place or areas became vacant when elective services ceased.

A review of the products available for the decontamination of the environment took place in 2017/18 and a disinfectant with enhanced activity against CDD identified and then rolled out across the Trust during 2018/19. Auditing of its use continues.

During 2018/19, the Trust enhanced CDD therapy unit on RH5 was disbanded as part of the temporary closure of the Hadfield wing for refurbishment. The patients who would have been cared for on this ward have subsequently been cared for on their base wards. The IPC Team and Medical Microbiologists have undertaken a weekly review of all these patients.

A project aimed at streamlining the process for undertaking RCAs for Hospital Onset cases of CDD was piloted in 2020. This was suspended due to the pandemic but restarted in 2020/21 and is now well established, with the majority of cases judged unavoidable following a thorough RCA.

Additional actions described in earlier reports also remain important to prevention and control of CDD and are:

- Antibiotics stewardship – review of antibiotic prescriptions regularly by experienced medical staff.
- Optimise commode and toilet cleaning – both the effectiveness and timeliness.

- Optimal practice in the Acute Medical Unit and other assessment units as they transfer patients throughout the Northern Campus.
- Standard infection prevention and control practice – optimal hand hygiene and use of Personal Protective Equipment (PPE).
- Improve the management of patients with diarrhoea whatever the cause, including early isolation of the patient in a single room.
- Reduce delayed sampling on admission. Delayed samples mean optimal management of the patient is delayed and community cases are assigned to the Trust.

#### **5.4 *E.coli* bacteraemia/ *Klebsiella* species bacteraemia/ *Pseudomonas aeruginosa* bacteraemia**

These infections are considered together as the bacteria, their pathogenesis and therefore potential solutions are similar. The discussion predominantly relates to *E.coli* as the most common of these infections and the area where most work has been done to date. At the present time, there is little information as to whether there are any interventions that will consistently reduce the number of these bacteraemia that occur.

Nationally, and locally, the majority of episodes of *E.coli* bacteraemia are detected on admission to hospital and therefore, this issue requires a whole healthcare community approach rather than just concentrating on the care provided by acute trusts. Reducing *E.coli* bacteraemia is complex and requires collaboration from multiple parties over the long-term and appropriate resourcing. This has been recognised nationally and, from 2019/20, the Integrated Care Systems (ICS) have been tasked with overseeing this issue.

The Trust and Sheffield CCG participated, in 2018, in an NHSI sponsored Urinary Tract Infection (UTI) Collaborative aimed at helping trusts/CCGs identify small changes in practice that might help reduce UTIs and undertake projects to implement and review such ideas. A Sheffield *E.coli* Action Group was convened, comprising STH and CCG colleagues, to begin gathering information on each episode with the aim of identifying trends, risk factors etc. that can then inform a healthcare community action plan.

A range of Trust and primary care based activities resulted from this project including:

- Exploring how General Practitioners triage patients who phone in with symptoms suggestive of UTI to determine if this process can be optimised
- Optimising signposting within the Sheffield primary care formulary for UTI antimicrobial prescribing.
- Investigating options for educating the public on how to reduce the likelihood of developing a UTI
- Reviewing urinary catheter management undertaken within community nursing
- Monitoring prescriptions for UTIs within Geriatric & Stoke Medicine wards.

The regional ICS convened two meetings during 2019/20 to discuss this issue and to start developing an action plan. Infection prevention and control, pharmacy and microbiology staff from STH attended these meetings and provided data of the STH experience to aid the discussion. Progress in developing and implementing an action plan was hindered by the Covid-19 pandemic. Members of the Sheffield *E.coli* Steering Group have continued to liaise with the ICS in 2020/21 and into 2021/22, as appropriate, and meetings have recently resumed to determine the focus of the Group's action plans for the coming years; this will apply to both Trust and primary care based actions.

The source of the bacteraemia i.e. the part of the body from which the organism probably entered the blood stream, is a key issue, as knowledge of this can help guide possible preventative actions. In this regard, analysis of the 2017/18 STH data showed a similar picture to that seen nationally as shown in table 5.

Given that the urinary tract is the most common source for *E.coli*, the action Group has concentrated on investigating possible effective interventions in regard to the urinary tract, current work includes improving communication with patients as to the reason they have a urinary catheter in situ, catheter management for patients, and empowering staff to remove urinary catheters when these were no longer required.

**Table 5 – Source of bacteraemia**

Source	<i>E.coli</i>	<i>Klebsiella</i>	<i>Pseudomonas</i>
Urinary source – no catheter <i>insitu</i>	31.4%	14.7%	11.7%
Urinary source – catheter <i>insitu</i>	13.3%	13.6%	10.0%
Hepatobiliary or Abdominal source	25.3%	28.8%	11.7%
Unclear source	20.3%	20.3%	26.7%
Other	9.7%	16.4%	40.0%
	No significant change in this distribution between 2017/18, 2018/19 and 2019/20		Some variation in percentage of each type of source for Hospital Onset, Healthcare Associated and Community Acquired cases – due to the small numbers, determining clear patterns of change for any of the categories between 2017/18, 2018/19 and 2019/20 is problematic

However, the majority of urinary source episodes are not related to catheters, possibly indicating that the presence or absence of devices is not the key issue. It has been identified that dehydration, constipation, mobility and ability to undertake optimal personal hygiene are key issues and work is underway to consider how to address this across the city.

For infections caused by *Klebsiella species*, many of the ‘unclear’ associated cases occur in Haematology patients and work is ongoing to investigate whether there are any interventions or changes in practice that might reduce these numbers.

Small numbers of cases of *Pseudomonas aeruginosa* bacteraemia occur within many Directorates although cases associated with the Haematology pathway are more common. A further complicating factor is that, in many cases, the cause is unclear particularly in Haematology patients who have multiple co-existing risk factors. However, there appears to be a rise in urinary catheter associated cases for Community Acquired cases and from patients within ITU settings. The *E.coli* Steering Group will consider this when determining possible actions for 2021/22.

## **6 CONCLUSION**

To conclude, it is pleasing to note for 2020/21 that the Trust once again has a low MRSA bacteraemia rate compared to other similar trusts. The year-end position for Trust-attributable episodes of CDD was similar to those seen over the preceding years. The overall trend for MSSA bacteraemia is stable but this does fluctuate from year to year, with the position in 2019/20 similar to previous years and improved in 2020/21.

It is very positive that the Trust performance in 2020/21 improved in relation to other similar organisations in respect of MRSA, MSSA, *C. difficile*, *E.coli* and *Klebsiella* bacteraemia. When all six modules of the mandatory surveillance scheme were taken into account, the Trust improved its position coming 4<sup>th</sup> out of the 16 comparable organisations. Addressing CDD diarrhoea, MSSA and Gram negative bacteraemia will continue to be a key part of the 2021/22 IPC Programme and beyond and this will be a further opportunity to consider the overall approach to Infection Prevention and Control at the Trust.

## PERFORMANCE MANAGEMENT FRAMEWORK & DIRECTORATE DASHBOARDS

The Performance Management Framework (PMF) provides a mechanism to review how safe, effective and efficient patient care is delivered within each directorate. This performance is measured against a set of agreed targets.

During a yearly review each directorate is assessed against a set of performance criteria and then a hierarchical level is allocated. There are three levels, 1, 2 and 3; level 3 identifies the most pressurised areas and the Trust Executive Group (TEG) is involved in the support of these Directorates.

### PMF Level 1 Directorates (Standard)

Diabetes & Endocrinology Pharmacy Integrated Community Care Therapeutics and Palliative Care Neurosciences Ophthalmology Laboratory Medicine MIMP General Surgery Plastic Surgery Urology Gastro and Hepatology * Geriatric and Stroke Medicine ENT	Level 1 reviews take place on a bi-monthly basis. The Performance and Information Director attends the review with members of the directorate as appropriate.
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### PMF Level 2 Directorates (Watching Brief)

Respiratory Medicine Oral & Dental Services MSK Cardiac Services Renal Services Communicable Diseases and Specialised Medicine Specialised Cancer Services Critical Care * Specialised Rehabilitation	Level 2 reviews take place on a monthly basis. These reviews are attended by members of the directorate as decided by the Operational Director along with the Performance and Information Director
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### PMF Level 3 Directorates (Highest Priority)

Emergency Medicine Obstetrics, Gynaecology & Neonatology Operating Services & Anaesthetics Vascular Services	Level 3 reviews take place on a monthly basis. The reviews are attended by both directorate and TEG members along with the Performance and Information Director.
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# DIRECTORATE DASHBOARDS

Indicator	Measure	Diab & Endo	Emerg Med	Gastro	Pharm	Resp Med	Integ Comm Care	GSM	Therap & Pall Care	CCDS	ENT	Neuro	Ophthal
MRSA bacteraemia	Trust Attributable / Assigned cases only												
MSSA bacteraemia	Trust Attributable cases only												
C Diff	Actual numbers												
Serious Incidents	Approved SI Report submitted within timescales												
Serious Incidents	Number of serious incidents (SI)		5	2			1	1		2		3	2
Incidents ●	Number of finally approved incidents based on incident date	21	349	47	28	72	91	228	42	42	11	72	15
Incidents ●	Percentage of incidents approved within 35 days based on approval date												
Average Length of Stay (by discharges) ⚡	Average Length of Stay Elective in days against Dr Foster expected												
	Average Length of Stay Non Elective in days against Dr Foster expected												
Never Events	Number of never events												
18 week waits referral to treatment time ●	Percentage of admitted patients treated within 18 weeks (90%)												
	Percentage of non-admitted patients treated within 18 weeks (95%)												
	Percentage of patients on incomplete pathways waiting less than 18 weeks (92%)												
52 week waits	Actual numbers												
6 week diagnostic waiting ●	Percentage of patients waiting 6 weeks or longer for a diagnostic test (1%)												
Cancelled Operations	Number of operations cancelled on the day for non clinical reasons												
	Number of patients cancelled on the day and not readmitted within 28 days												
Cancelled Outpatient appointments	Percentage of out-patient appointments cancelled by hospital												
	Percentage of out-patient appointments cancelled by patient												
DNA rate	Percentage of new out-patient appointments where patients DNA												
	Percentage of follow-up out-patient appointments where patients DNA												
Cancer Waits ⚡	Patient seen within 2 weeks of urgent referral (93% compliance)												
	Breast symptomatic seen within 2 weeks (93% compliance)												
	62 days from GP referral to treatment (85% compliance)												
	31 day first treatment from referral (96% compliance)												
e-Referral Service	Percentage of appointments booked through Electronic Referral Service												
Ethnic group data collection	Percentage of inpatient admission with a valid ethnic group code												
Elective Inpatient activity	Variance from contract schedules												
Non elective inpatient activity	Variance from contract schedules												
New outpatient attendances	Variance from contract schedules												
Follow up op attendances	Variance from contract schedules												
Complaints	Percentage of complaints answered within 25 working days												
FFT Recommended ●	Patients recommending STH for treatment												
Day surgery rates	BADS - day surgery rates												
Mixed Sex Accommodation	Number of breaches of Mixed Sex Accommodation standard												
Sickness Absence	All days lost as a percentage of those available												
Appraisals ⚡	Completed appraisal in last year												
Mandatory Training ⚡	Overall percentage of completed mandatory training												
Agency spend	Agency and bank spend as a percentage of total pay budget												
I & E	Variance from plan												
Contract performance	Variance from plan												
Productivity & Efficiency	Variance from plan												

Indicator	Measure	Lab Med	MIMP	OGN	MSK	OpServ Anaes	Critical Care	Cardiac	Renal	Vasc	Comm Dis & Spec Med	Spec Rehab	Spec Cancer	Gen Surg	Plastic Surg	Urology
MRSA bacteraemia	Trust Attributable / Assigned cases only															
MSSA bacteraemia	Trust Attributable cases only															
C Diff	Actual numbers															
Serious Incidents	Approved SI Report submitted within timescales															
Serious Incidents	Number of serious incidents (SI)			23	2	3		2	1	1	5			3	2	1
Incidents ●	Number of finally approved incidents based on incident date	68	55	74	95	58	34	107	73	37	83	28	99	103	16	25
Incidents ●	Percentage of incidents approved within 35 days based on approval date															
Average Length of Stay (by discharges) ⚡	Average Length of Stay Elective in days against Dr Foster expected															
	Average Length of Stay Non Elective in days against Dr Foster expected															
Never Events	Number of never events															
18 week waits referral to treatment time ●	Percentage of admitted patients treated within 18 weeks (90%)															
	Percentage of non-admitted patients treated within 18 weeks (95%)															
	Percentage of patients on incomplete pathways waiting less than 18 weeks (92%)															
52 week waits	Actual numbers															
6 week diagnostic waiting ●	Percentage of patients waiting 6 weeks or longer for a diagnostic test (1%)															
Cancelled Operations	Number of operations cancelled on the day for non clinical reasons															
	Number of patients cancelled on the day and not readmitted within 28 days															
Cancelled Outpatient appointments	Percentage of out-patient appointments cancelled by hospital															
	Percentage of out-patient appointments cancelled by patient															
DNA rate	Percentage of new out-patient appointments where patients DNA															
	Percentage of follow-up out-patient appointments where patients DNA															
Cancer Waits ⚡	Patient seen within 2 weeks of urgent referral (93% compliance)															
	Breast symptomatic seen within 2 weeks (93% compliance)															
	62 days from GP referral to treatment (85% compliance)															
	31 day first treatment from referral (96% compliance)															
e-Referral Service	Percentage of appointments booked through Electronic Referral Service															
Ethnic group data collection	Percentage of inpatient admission with a valid ethnic group code															
Elective Inpatient activity	Variance from contract schedules															
Non elective inpatient activity	Variance from contract schedules															
New outpatient attendances	Variance from contract schedules															
Follow up op attendances	Variance from contract schedules															
Complaints	Percentage of complaints answered within 25 working days															
FFT Recommended ●	Patients recommending STH for treatment															
Day surgery rates	BADS - day surgery rates															
Mixed Sex Accommodation	Number of breaches of Mixed Sex Accommodation standard															
Sickness Absence	All days lost as a percentage of those available															
Appraisals ⚡	Completed appraisal in last year															
Mandatory Training ⚡	Overall percentage of completed mandatory training															
Agency spend	Agency and bank spend as a percentage of total pay budget															
I & E	Variance from plan															
Contract performance	Variance from plan															
Productivity & Efficiency	Variance from plan															

# TRUST PERFORMANCE OVERVIEW - October 2021

Indicator	Measure	Standard	Target Type	Current Data Range	Current Rating	YTD	Trend	Data Quality A,V,R&C,T,R,C&C
CQC Compliance	Outcome of CQC inspection	Good in all five domains	SOF	October				■ ■ ■ ■ ■ ■ ■ ■
<b>Deliver The Best Clinical Outcomes</b>								
Hospital Mortality	Hospital Standardised Mortality Ratio	As expected or lower	SOF	Jul-20 to Jun-21				■ ■ ■ ■ ■ ■ ■ ■
Hospital Mortality	Summary Hospital-level Mortality Indicator	As expected or lower	SOF	Dec19 to Nov20				■ ■ ■ ■ ■ ■ ■ ■
MRSA bacteraemia	Hospital onset	Zero cases	SOF	October				■ ■ ■ ■ ■ ■ ■ ■
MSSA bacteraemia	Hospital onset	63 per year	SOF	Q3 21/22				■ ■ ■ ■ ■ ■ ■ ■
C.diff	Hospital onset	100 per year (25 per quarter)	SOF	Q3 21/22				■ ■ ■ ■ ■ ■ ■ ■
C.diff	Community onset/ healthcare associated	36 per year (9 per quarter)	SOF	Q3 21/22				■ ■ ■ ■ ■ ■ ■ ■
E.coli	Hospital onset	172 per year (43 per quarter)	SOF	Q3 21/22				■ ■ ■ ■ ■ ■ ■ ■
E.coli	Community onset/ healthcare associated	132 per year (33 per quarter)	SOF	Q3 21/22				■ ■ ■ ■ ■ ■ ■ ■
Serious Incidents	Number of serious incidents (SI)	Number	Local	October	3	60		■ ■ ■ ■ ■ ■ ■ ■
Serious Incidents	Approved SI Report submitted within timescales	No overdue reports	Local	October				■ ■ ■ ■ ■ ■ ■ ■
Incidents	Number of finally approved incidents based on incident date	Number of incidents	Local	October	2466	19374		■ ■ ■ ■ ■ ■ ■ ■
Incidents	Percentage of incidents approved within 35 days based on approval date	95% within 35 days	Local	October				■ ■ ■ ■ ■ ■ ■ ■
Average Length of Stay (by discharges)	Average Length of Stay Elective	4.27 days (Dr Foster)	Local	Jul-20 to Jun-21				■ ■ ■ ■ ■ ■ ■ ■
	Average Length of Stay Non Elective	4.45 days (Dr Foster)	Local	Jul-20 to Jun-21				■ ■ ■ ■ ■ ■ ■ ■
Caesarean section rate	Elective Caesarean section rate as proportion of all deliveries	13%	Local	October				■ ■ ■ ■ ■ ■ ■ ■
	Emergency Caesarean section rate as proportion of all deliveries	17%	Local	October				■ ■ ■ ■ ■ ■ ■ ■
Birth rate 24-37 weeks	Birth rate between 24 and 37 weeks as proportion of all births >24 weeks, rolling 12 months	6%	Local	October				■ ■ ■ ■ ■ ■ ■ ■
Birth rate 24-27 weeks	Birth rate between 24 and 27 weeks as proportion of all births >24 weeks, rolling 12 months	1%	Local	October				■ ■ ■ ■ ■ ■ ■ ■
Obstetric haemorrhage	Massive obstetric haemorrhage >=1500ml as proportion of deliveries (singleton cephalic births 37-42 weeks gestation only)	2.9%	Local	October				■ ■ ■ ■ ■ ■ ■ ■
Patient Falls	Number of patient falls	< 3526 per year / 294 per month (19-20 total)	Local	October				■ ■ ■ ■ ■ ■ ■ ■
Pressure Ulcers	Number of pressure ulcers acquired within STH	Max 83 per month (996 per year)	Local	October				■ ■ ■ ■ ■ ■ ■ ■
Pressure Ulcers	Category 4 pressure ulcers	Zero	Local	October				■ ■ ■ ■ ■ ■ ■ ■
Never Events	Number of never events	Zero	SOF	October				■ ■ ■ ■ ■ ■ ■ ■
VTE	VTE Risk Assessment completed as proportion of all inpatient admissions	95%	SOF	Q1 21/22				■ ■ ■ ■ ■ ■ ■ ■
Dementia	Dementia Assessment as a proportion of all inpatient non-elective admissions	90%	SOF	Q1 21/22				■ ■ ■ ■ ■ ■ ■ ■
<b>Provide Patient Centred Services</b>								
A&E 4-hour wait	Patients seen within 4 hours	95%	SOF	October				■ ■ ■ ■ ■ ■ ■ ■
>12 hr Trolley waits in A&E	No. of patients waiting > 12 hours	Zero	National	October				■ ■ ■ ■ ■ ■ ■ ■
Ambulance turnaround	Time taken for ambulance handover of patient	100% within 15 minutes	National	October				■ ■ ■ ■ ■ ■ ■ ■
Ambulance turnaround	Time taken for ambulance handover of patient	0% in excess of 30 minutes	National	October				■ ■ ■ ■ ■ ■ ■ ■
Ambulance turnaround	Time taken for ambulance handover of patient	0% in excess of 60 minutes	Local	October				■ ■ ■ ■ ■ ■ ■ ■
18 weeks RTT	Percentage of patients on incomplete pathways waiting less than 18 weeks	92%	SOF	October				■ ■ ■ ■ ■ ■ ■ ■
52 week waits	Actual numbers	Zero	National	October				■ ■ ■ ■ ■ ■ ■ ■
Size of PTL	Total size of Patient Treatment List	<= Sep-21 (61,416)	Local	October				■ ■ ■ ■ ■ ■ ■ ■
6 week diagnostic waiting	Percentage of patients seen within 6 weeks	99%	SOF	October				■ ■ ■ ■ ■ ■ ■ ■
Cancelled Operations	Number of operations cancelled on the day for non clinical reasons	75 per month	Local	October				■ ■ ■ ■ ■ ■ ■ ■
	Number of patients cancelled on the day and not readmitted within 28 days	Zero	National	October				■ ■ ■ ■ ■ ■ ■ ■
Cancelled Outpatient appointments	Percentage of out-patient appointments cancelled by hospital	8.71% (National figure 2019/20)	Local	October				■ ■ ■ ■ ■ ■ ■ ■
	Percentage of out-patient appointments cancelled by patient	7.51% (National figure 2019/20)	Local	October				■ ■ ■ ■ ■ ■ ■ ■
DNA rate	Percentage of new out-patient appointments where patients DNA	7.27% (National figure 2019/20)	Local	October				■ ■ ■ ■ ■ ■ ■ ■
	Percentage of follow-up out-patient appointments where patients DNA	7.36% (National figure 2019/20)	Local	October				■ ■ ■ ■ ■ ■ ■ ■
Cancer Waits	Patient seen within 2 weeks of urgent referral	93%	National	Q2 20/21				■ ■ ■ ■ ■ ■ ■ ■
	Breast symptomatic seen within 2 weeks	93%	National	Q2 20/21				■ ■ ■ ■ ■ ■ ■ ■
	62 days from referral to treatment (GP referral)	85%	SOF	Q2 20/21				■ ■ ■ ■ ■ ■ ■ ■
	62 days from referral to treatment (Cancer Screening Service)	90%	SOF	Q2 20/21				■ ■ ■ ■ ■ ■ ■ ■
	31 day first treatment from referral	96%	National	Q2 20/21				■ ■ ■ ■ ■ ■ ■ ■
	31 day subsequent treatment (Surgery)	94%	National	Q2 20/21				■ ■ ■ ■ ■ ■ ■ ■
	31 day subsequent treatment (Radiotherapy)	94%	National	Q2 20/21				■ ■ ■ ■ ■ ■ ■ ■
	31 day subsequent treatment (Drugs)	98%	National	Q2 20/21				■ ■ ■ ■ ■ ■ ■ ■

A = Accuracy, V = Validity, R&C = Reliability & Consistency, T = Timeliness, R = Relevance, C&C = Completeness & Coverage

Indicator	Measure	Standard	Target Type	Current Data Range	Current Rating	YTD	Trend	Data Quality A,V,R&C,T,R,C&C
<b>Provide Patient Centred Services</b>								
e-Referral Service	Percentage of eligible GP referrals received through Electronic Referral Service	90%	Local	October				■ ■ ■ ■ ■ ■ ■ ■
Ethnic group data collection	Percentage of inpatient admissions with a valid ethnic group code	85%	National	October				■ ■ ■ ■ ■ ■ ■ ■
Elective Inpatient activity	Variance from contract schedules	On plan	Local	October				■ ■ ■ ■ ■ ■ ■ ■
Non elective inpatient activity	Variance from contract schedules	On plan	Local	October				■ ■ ■ ■ ■ ■ ■ ■
New outpatient attendances	Variance from contract schedules	On plan	Local	October				■ ■ ■ ■ ■ ■ ■ ■
Follow up op attendances	Variance from contract schedules	On plan	Local	October				■ ■ ■ ■ ■ ■ ■ ■
A&E attendances	Variance from contract schedules	On plan	Local	October				■ ■ ■ ■ ■ ■ ■ ■
Complaints	Percentage of complaints closed within agreed timescales	90% within agreed timescale	Local	October				■ ■ ■ ■ ■ ■ ■ ■
Written Complaints Rate	Written complaints rate per 10,000 finished consultant episode	<19/20 rate ()	SOF	Q3 2019/20	39.3			■ ■ ■ ■ ■ ■ ■ ■
Community Care	Integrated Care team contacts	43,000 per month	Local	October				
	Intermediate Care at home Community Intermediate Care response time	98% within 1 day	Local	October				
	Intermediate Care Beds Occupancy	91%	Local	October				
	Intermediate Care Beds Length of Stay	<35 days	Local	October				
Out of Hours GPC	% Seen Within 4 hours	95%	Local	October				
FFT Recommended	Patients recommending STH for Inpatient treatment	95%	SOF	October				■ ■ ■ ■ ■ ■ ■ ■
FFT Recommended	Patients recommending STH for A&E treatment	86%	SOF	October				■ ■ ■ ■ ■ ■ ■ ■
FFT Recommended	Patients recommending STH for Maternity treatment	95%	SOF	October				■ ■ ■ ■ ■ ■ ■ ■
FFT Recommended	Patients recommending STH for Community treatment	90%	SOF	October				■ ■ ■ ■ ■ ■ ■ ■
Community care –information completeness	RTT information completeness	48.7%	National	2020/21 Q1				■ ■ ■ ■ ■ ■ ■ ■
	Referral information completeness	50%	National	2020/21 Q1				■ ■ ■ ■ ■ ■ ■ ■
	Activity information completeness	50%	National	2020/21 Q1				■ ■ ■ ■ ■ ■ ■ ■
Day surgery rates	Aggregate percentage of all BADS procedures recommended to be treated as day case or outpatient	88%	Local	October				■ ■ ■ ■ ■ ■ ■ ■
Mixed Sex Accommodation	Number of breaches of Mixed Sex Accommodation standard	Zero	SOF	October				■ ■ ■ ■ ■ ■ ■ ■
<b>Employ Caring &amp; Cared for Staff</b>								
Sickness Absence	All days lost as a percentage of those available	4.00%	SOF	October				■ ■ ■ ■ ■ ■ ■ ■
Appraisals	Completed appraisals in last year	90%	Local	October				■ ■ ■ ■ ■ ■ ■ ■
Mandatory Training	Overall percentage of completed mandatory training	90%	Local	October				■ ■ ■ ■ ■ ■ ■ ■
Safer Staffing	Care Hours per patient day (Registered Nurses)	85% of planned hours or greater	Local	October				■ ■ ■ ■ ■ ■ ■ ■
	Care Hours per patient day (Total)	85% of planned hours or greater	Local	October				■ ■ ■ ■ ■ ■ ■ ■
Staff Turnover	Executive Team turnover (number of leavers as a percentage of total executive head count - rolling 12 months)	0%	SOF	October				■ ■ ■ ■ ■ ■ ■ ■
	Number of leavers as a percentage of total head count (rolling 12 months)	to be determined	SOF	October	8.8%			■ ■ ■ ■ ■ ■ ■ ■
	Retention Rate	85%	SOF	October				■ ■ ■ ■ ■ ■ ■ ■
Recruitment	Request to fill to unconditional final offer	Average <= 8 weeks	Local	October	13			
<b>Spend Public Money Wisely</b>								
I & E	YTD actual I & E surplus/deficit in comparison to YTD plan I & E surplus/deficit	>=0	SOF	October				■ ■ ■ ■ ■ ■ ■ ■
I & E Margin	I & E surplus/deficit as a percentage of total revenue	>=0	SOF	October				■ ■ ■ ■ ■ ■ ■ ■
Efficiency	Variance from plan	On plan	Local	October				■ ■ ■ ■ ■ ■ ■ ■
Cash	Actual	Above profile	Local	October				■ ■ ■ ■ ■ ■ ■ ■
Liquidity	Days of operating costs held in cash or cash equivalents	>0	SOF	October				■ ■ ■ ■ ■ ■ ■ ■
Capital	Expenditure - variance from plan	On plan	Local	October				■ ■ ■ ■ ■ ■ ■ ■
<b>Deliver Excellent Research, Education &amp; Innovation</b>								
Recruitment to trials	Total number of patient accruals to portfolio studies	0	Regional -Y&H	Q3 19/20				■ ■ ■ ■ ■ ■ ■ ■
<b>Annually Reported Indicators</b>								
Staff Survey	National average or better in all 10 domains	0 domains below national average	Local	2020				