Subject:	Integrated Performance Report
Supporting Directors:	Victoria Leckie, Interim Chief Operating Officer; Neil Priestley, Chief Financial Officer; Chris Morley, Chief Nurse; Mark Gwilliam, Director of Human Resources and Staff Development; David Black, Medical Director (Development); Jennifer Hill, Medical Director (Operations); Mark Tuckett, Director of Strategy & Planning.
Author(s):	Performance and Information Team
Status (see footnote):	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:

a) Receive the Integrated Performance Report for April 2022 and May 2022.

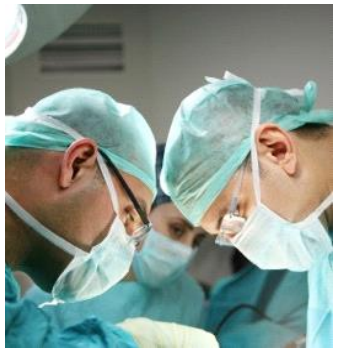
b) Note the performance standards that are being achieved.

c) 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		
STH Strategic Aims		Tick as appropriate
1	Deliver the best clinical outcomes	☑
2	Provide patient centred services	☑
3	Employ caring and cared for staff	☑
4	Spend public money wisely	☑
5	Deliver excellent research, education and innovation	☑
6	Create a Sustainable Organisation	☑

APPROVAL PROCESS		
Meeting:	Trust Executive Group	Board of Directors
Approved Y/N:		
Date:	13 July 2022	26 July 2022
A = Approval; A* = Approval and Requiring Board Approval; D = Debate; N = Note		

Sheffield Teaching Hospitals NHS
NHS Foundation Trust





INTEGRATED **PERFORMANCE** REPORT


BOARD OF DIRECTORS
26 July 2022

EXECUTIVE SUMMARY

DELIVER THE BEST CLINICAL OUTCOMES

- The number of cases of Trust attributable pressure ulcers for the month of April 2022 was 111, 28 above the Trust threshold of 83, the total for May 2022 was 82, 1 below the threshold at 83 cases. The weekly Pressure Ulcer Review meetings have identified 0 category 4 pressure ulcers.
- The Trust has had 0 cases of Trust Attributable MRSA bacteraemia in 2021/22 and therefore met the external threshold of 0.
- 5 new never events were reported in May 2022.
- 81.17% of incidents were approved within 35 days, which is below the internal target of 95%.
- Average Length of Stay for elective and non-elective patient spells was above the benchmark.
- The birth rate below 27 and 37 weeks as a proportion of all registerable births is above the expected level, which is related to STH's status as a specialist maternity centre. The birth rate between 24 and 27 weeks is at the expected level.
- The massive obstetric haemorrhage rate is above the expected range at 3.8%. Actions to reduce the rate of massive obstetric haemorrhage continue to be progressed by Maternity services.
- There were 368 patient falls reported in May 2022 and 385 reported in April 2022.

PROVIDING PATIENT CENTRED SERVICES

- Complaints – the Trust threshold for the rate of complaints responded to within the agreed timescale was met in April 2022 and May 2022.
- FFT score Inpatient – the scores for April 2022 and May 2022 were 90% & 92% respectively.
- FFT score A&E – the scores for April 2022 and May 2022 were 77% and 78% respectively against the internal threshold of 86%.
- FFT score Maternity – the scores for April 2022 and May 2022 were 69% & 86% respectively against the internal threshold of 95%.
- FFT score Community – the scores for April 2022 and May 2022 were 86% and 93% respectively against the internal threshold of 90%. As this is an improving position, an exception report will not be included.
- Patient Activity during May 2022 was higher than April 2022.
- The number of operations cancelled on the day for non-clinical reasons was 79 in May 2022, compared to 77 in April 2022.
- 13 patients had their operation cancelled on the day of admission for non-clinical reasons and were not re-admitted within 28 days during May 2022, compared to 29 patients in April 2022. 34 of these patients have now received their treatment.
- A&E 4-hour performance was 74.46% in May 2022 and 74.82% in April 2022. The local target is 90% and the national target is 95%. The national performance in May 2022 was 73%. STH is ranked second highest in A&E 4-hour performance when benchmarking against Large Northern Acute Trusts.
- In May 2022, 37.15% of ambulance handovers occurred within 15 minutes, compared to 36.93% in April 2022.
- 15.07% of ambulance handovers took more than 30 minutes in May, compared to 17.16% in April.
- 15.32% of handovers took longer than 60 minutes in May, compared with 10.80% in April.
- The percentage of patients who had been waiting less than 18 weeks for their treatment at the end of the month was 72.35% for May 2022. The national target is 92%. The national performance for April 2022 was 61.7%. STH is ranked the highest in RTT 18-week performance when benchmarking against Large Northern Acute Trusts.
- There were 2,122, 52-week breaches in May 2022. This was an increase of 287 on the April 2022 position.
- The percentage of patients waiting 6 weeks or less for their diagnostic test was 72.19% at the end of May 2022. The national target is 99%. The national performance for April 2022 was 71.6%.
- The percentage of outpatient appointments cancelled by the hospital remains higher than the national benchmark.
- The percentage of outpatient appointments cancelled by the patient remains 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.

- Two Week Wait performance was non-compliant at 87.0% for April and non-compliant at 82.0% for May (threshold 93%)
- Breast Symptomatic performance was non-compliant at 0.0% for April and non-compliant at 3.6% for May (threshold 93%)
- 28 Day Faster Diagnosis performance was 64.7% for April and 63.4% for May (threshold 75%)
- 62 Day referral to treatment (GP Referral) performance for April was non-compliant at 59.8% whilst STH only performance for non-shared pathways was 47.2%. May performance was non-compliant at 56.6% whilst STH only performance for non-shared pathways was 65.7% (threshold 85%)
- 31 Day First Treatment performance was non-compliant at 88.3% for April and non-compliant at 85.4% for May (threshold 96%)
- 31 Day Subsequent radiotherapy performance was non-compliant at 90.7% for April and non-compliant at 93.3% for May (threshold 94%)
- Subsequent Surgery performance was non-compliant at 66.4% for April and non-compliant at 68.0% for May (threshold 94%)
- Subsequent Drug performance was non-compliant at 93.7% for April and non-compliant at 95.7% for May (threshold 98%)
- Screening performance was non-compliant at 61.5% for April and non-compliant at 54.5% for May (threshold 90%)

EMPLOYING CARING AND CARED FOR STAFF

- Safer staffing – overall, the percentage of care hours per patient day (CHPPD) for registered nurses was 88.55% (April 2022) and 92.55% (May 2022) and for all care staff was 91.26% (April 2022) and 93.79% (May 2022). 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, People Strategy plans, Workforce matters, and Agency control continue to be prioritised.
- The sickness absence rate for May 2022 was 5.48%, which is above the Trust target of 4%. Of this 1.05% relates to COVID absence and 4.43% is due to non-COVID reasons. Short term absence for May is 2.34%. Long term absence for May is 3.14%. The year-to-date position is 5.77%
- The Trust appraisal rate was 85% in May, which is below the Trust Target of 90%.
- Compliance levels for mandatory training are at 92%, which is above the Trust Target of 90%.
- The Trust Annual Turnover Rate for May was 9.81%. Lowest turnover rates for May were 6.9% for Add Prof Scientific and Technic staff and the highest leaver rates were 12.4% for Administrative and Clerical roles.
- Retention figures for the Trust are at 89% which has been consistently above the target of 85% for over 12 months now and we are proud to be one of the best Trusts for retention.
- We continue to develop and promote the Trust Health and Wellbeing offer as well as the resources available nationally. Colleagues have ongoing access to our 24/7 telephone Employee Assistance Programme through Vivup we have launched a summer of menopause support and are promoting the resources we have available on financial well-being.

SPEND PUBLIC MONEY WISELY

- The position at Month 2 is £664k (0.3%) adverse against plan.
- Month 2 reports against the revised breakeven Financial Plan as approved by Finance and Performance Committee in June following delegated authority to do so by the Board.
- The £664k YTD overspend to date shows a continuation of the Month 1 overspend position and is largely driven by lower than required P&E delivery and overspends in Medical and Dental spend which have been partially offset by vacancies and under delivery of activity in comparison to 2019/20 levels.
- Within the position, the assessed non-pay savings to month 2 from activity being below the funded (2019/20) level is £0.8m (£0.2m in month).
- Year-to-date efficiency savings (P&E) amount to £2.0m compared to the £2.8m (1%) target.
- Overall Pay is £0.5m (0.4%) under spent with Medical & Dental overspend of £1.2m and Nurses and Midwives underspend of £1.0m. The underspend across other remaining staff groups to date totals £0.7m.
- Specific Directorate Covid costs/income losses continue to be funded from the Trust's Covid allocation.
- At Month 2 12/37 Directorates are in a balanced position with 12 having deficits in excess of 3% of year-to-date budgets. The overall position across Directorates deteriorated in May to a deficit of £3.2m.
- Elective Recovery targets, and therefore retention of ERF, requires delivery of 104% of the 2019/20 elective activity (Elective plus Outpatients). This has not been delivered in month or cumulatively. In May, the Trust has delivered 98.1% of the value of activity delivered in M2 of 2019/20. Full receipt of ERF has however been recognised in the

position, on the basis that it is hoped the scheme will be suspended for Q1 due to levels of COVID being much higher than anticipated in the Planning Guidance. If this is not to be the case, then the financial position of the Trust would be significantly worse.

- The key risks for 2022/23 are the delivery of the required level of efficiency savings, any unanticipated inflation/other cost pressures, and non-delivery of the Elective Recovery Targets which would require repayment of Elective Recovery Funding.

DELIVER EXCELLENT RESEARCH, EDUCATION & INNOVATION

- The National Institute of Health Research (NIHR) metrics reporting has now re-commenced and reported for Q3 FY21-22:
  - Performance in Initiating: Date Site Selected to First Patient Recruited – STH Median 50 days (National Median 71 days)
- 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 13 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 international vaccine roll out programme and 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 April 2022 and May 2022 below. An exception report is provided for any indicator receiving a red rating in either month and has been benchmarked against an appropriate peer group and identified as an outlier. The Executive Lead has confirmed if the report is required. This is identified down the lefthand side of the table on the following page as follows:

Exception Report Included in IPR | Metric not achieved target, but no exception report included | Achieved Target

Data quality markers for each indicator are in development and will be available in the next report.

TRUST PERFORMANCE OVERVIEW - MAY 2022

Indicator	Measure	Standard	Target Type	Current Reporting Period Data Range	*R	*V	*A	Previous Reporting Period Data Range	*R	*V	*A
CQC Compliance	Outcome of CQC inspection	Good in all five domains	SOF	May-22				Apr-22			
Deliver The Best Clinical Outcomes											
Hospital Mortality	Hospital Standardised Mortality Ratio	As expected or lower	SOF	Feb-2021 to Jan-2022				Jan-2021 to Dec-2021			
	Summary Hospital-level Mortality Indicator	As expected or lower	SOF	Dec-20 to Nov-21				Nov-20 to Oct-21			
MRSA bacteraemia	Hospital onset	Zero cases	SOF	May-22				Apr-22			
MSSA bacteraemia	Hospital onset	63 per year	SOF	Q1 22/23				Q4 21/22			
C.diff	Hospital onset	100 per year (25 per quarter)	SOF	Q1 22/23				Q4 21/22			
	Community onset/ healthcare associated	36 per year (9 per quarter)	SOF	Q1 22/23				Q4 21/22			
Serious Incidents	Number of serious incidents (SI)	Number	Local	May-22	17			Apr-22	13		
	Approved SI Report submitted within timescales	No overdue reports	Local	May-22				Apr-22			
Incidents	Percentage of incidents approved within 35 days based on approval date	95% within 35 days	Local	May-22				Apr-22			
	Number of finally approved incidents based on incident date	Number of incidents	Local	May-22	2,457			Apr-22	2,617		
Average Length of Stay (by discharges)	Average Length of Stay Elective	4.27 days (Dr Foster)	Local	Feb-21 to Jan-22				Jan-21 to Dec-21			
	Average Length of Stay Non Elective	4.45 days (Dr Foster)	Local	Feb-21 to Jan-22				Jan-21 to Dec-21			
Birth rate 24-37 weeks	Birth rate between 24 and 37 weeks as proportion of all births >24 weeks, rolling 12 months	6%	Local	May-22				Apr-22			
Birth rate 24-27 weeks	Birth rate between 24 and 27 weeks as proportion of all births >24 weeks, rolling 12 months	1%	Local	May-22				Apr-22			
Obstetric haemorrhage	Massive obstetric haemorrhage >=1500ml as proportion of deliveries (singleton cephalic births 37-42	2.9%	Local	May-22				Apr-22			
Patient Falls	Number of patient falls	< 3526 per year / 294 per month (19-20 total)	Local	May-22				Apr-22			
Pressure Ulcers	Number of pressure ulcers acquired within STH	Max 83 per month (996 per year)	Local	May-22				Apr-22			
	Category 4 pressure ulcers	Zero	Local	May-22				Apr-22			
Never Events	Number of never events	Zero	SOF	May-22				Apr-22			
VTE	VTE Risk Assessment completed as proportion of all inpatient	95%	SOF	Q1 21/22							
Dementia	Dementia Assessment as a proportion of all inpatient non-elective admissions	90%	SOF	Q1 21/22							
Provide Patient Centred Services											
A&E 4-hour wait	Patients seen within 4 hours	95%	SOF	May-22				Apr-22			
>12 hr Trolley waits in A&E	No. of patients waiting > 12 hours	Zero	National	May-22				Apr-22			
Ambulance turnaround	Time taken for ambulance handover of patient	100% within 15 minutes	National	May-22				Apr-22			
	Time taken for ambulance handover of patient	0% in excess of 30 minutes	National	May-22				Apr-22			
	Time taken for ambulance handover of patient	0% in excess of 60 minutes	Local	May-22				Apr-22			

Indicator	Measure	Standard	Target Type	Current Reporting Period Data Range	*R	*V	*A	Previous Reporting Period Data Range	*R	*V	*A
18 weeks RTT	Percentage of patients on incomplete pathways waiting less than 18 weeks	92%	SOF	May-22				Apr-22			
52 week waits	Actual numbers	Zero	National	May-22				Apr-22			
Size of PTL	Total size of Patient Treatment List	<= Sep-21 (61,416)	Local	May-22				Apr-22			
6 week diagnostic waiting	Percentage of patients seen within 6 weeks	99%	SOF	May-22				Apr-22			
Cancelled Operations	Number of operations cancelled on the day for non clinical reasons	75 per month	Local	May-22				Apr-22			
	Number of patients cancelled on the day and not readmitted within 28 days	Zero	National	May-22				Apr-22			
Cancelled Outpatient appointments	Percentage of out-patient appointments cancelled by hospital	8.71% (National figure 2019/20)	Local	May-22				Apr-22			
	Percentage of out-patient appointments cancelled by patient	7.51% (National figure 2019/20)	Local	May-22				Apr-22			
DNA rate	Percentage of new out-patient appointments where patients DNA	7.27% (National figure 2019/20)	Local	May-22				Apr-22			
	Percentage of follow-up out-patient appointments where patients DNA	7.36% (National figure 2019/20)	Local	May-22				Apr-22			
Cancer Waits	Patient seen within 2 weeks of urgent referral	93%	National	Q1 22/23				Q4 21/22			
	Breast symptomatic seen within 2 weeks	93%	National	Q1 22/23				Q4 21/22			
	62 days from referral to treatment (GP referral)	85%	SOF	Q1 22/23				Q4 21/22			
	62 days from referral to treatment (Cancer Screening Service)	90%	SOF	Q1 22/23				Q4 21/22			
	31 day first treatment from referral	96%	National	Q1 22/23				Q4 21/22			
	31 day subsequent treatment (Surgery)	94%	National	Q1 22/23				Q4 21/22			
	31 day subsequent treatment (Radiotherapy)	94%	National	Q1 22/23				Q4 21/22			
	31 day subsequent treatment (Drugs)	98%	National	Q1 22/23				Q4 21/22			
e-Referral Service	Percentage of eligible GP referrals received through Electronic Referral Service	90%	Local	May-22				Apr-22			
Ethnic group data collection	Percentage of inpatient admissions with a valid ethnic group code	85%	National	May-22				Apr-22			
Elective Inpatient activity	Variance from contract schedules	On plan	Local	May-22				Apr-22			
Non elective inpatient activity	Variance from contract schedules	On plan	Local	May-22				Apr-22			
New outpatient attendances	Variance from contract schedules	On plan	Local	May-22				Apr-22			
Follow up op attendances	Variance from contract schedules	On plan	Local	May-22				Apr-22			
A&E attendances	Variance from contract schedules	On plan	Local	May-22				Apr-22			
Complaints	Percentage of complaints closed within agreed timescales	90% within agreed timescale	Local	May-22				Apr-22			
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	May-22				Apr-22			
	Intermediate Care at home Community Intermediate Care response time	98% within 1 day	Local	May-22				Apr-22			
	Intermediate Care Beds Occupancy	88%	Local	May-22				Apr-22			
	Intermediate Care Beds Length of Stay	<35 days	Local	May-22				Apr-22			

Indicator	Measure	Standard	Target Type	Current Reporting Period Data Range	*R	*V	*A	Previous Reporting Period Data Range	*R	*V	*A
Out of Hours GPC	% Seen Within 4 hours	95%	Local	May-22				Apr-22			
FFT Recommended	Patients recommending STH for Inpatient treatment	95%	SOF	May-22				Apr-22			
	Patients recommending STH for A&E treatment	86%	SOF	May-22				Apr-22			
	Patients recommending STH for Maternity treatment	95%	SOF	May-22				Apr-22			
	Patients recommending STH for Community treatment	90%	SOF	May-22				Apr-22			
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	May-22				Apr-22			
Mixed Sex Accommodation	Number of breaches of Mixed Sex Accomodation standard	Zero	SOF	Mar-22				Apr-22			
Employ Caring & Cared for Staff											
Sickness Absence	All days lost as a percentage of those available	4%	SOF	May-22				Apr-22			
Appraisals	Completed appraisals in last year	90%	Local	May-22				Apr-22			
Mandatory Training	Overall percentage of completed mandatory training	90%	Local	May-22				Apr-22			
Safer Staffing	Care Hours per patient day (Registered Nurses)	85% of planned hours or greater	Local	May-22				Apr-22			
	Care Hours per patient day (Total)	85% of planned hours or greater	Local	May-22				Apr-22			
Staff Turnover	Executive Team turnover (number of leavers as a percentage of total executive head count - rolling 1	0%	SOF	May-22				Apr-22			
	Number of leavers as a percentage of total head count (rolling 12 months)	to be determined	SOF	May-22	9.8%			Apr-22	9.8%		
	Retention Rate	85%	SOF	May-22				Apr-22			
Recruitment	Request to fill to unconditional final offer	Average <= 8 weeks	Local	May-22				Apr-22			
Spend Public Money Wisely											
I & E	YTD actual I & E surplus/deficit in comparison to YTD plan I & E surplus/deficit	>=0	SOF	May-22				Apr-22			
I & E Margin	I & E surplus/deficit as a percentage of total revenue	>=0	SOF	May-22				Apr-22			
Efficiency	Variance from plan	On plan	Local	May-22				Apr-22			
Cash	Actual	Above profile	Local	May-22				Apr-22			
Liquidity	Days of operating costs held in cash or cash equivalents	>0	SOF	May-22				Apr-22			
Capitol	Expenditure - variance from plan	On plan	Local	May-22				Apr-22			
Deliver Excellent Research, Education & Innovation											
Recruitment to trials	Total number of patient accruals to portfolio studies	0	Regional - Y&H	Q4 21/22							
Annually Reported Indicators											
Staff Survey	National average or better in all 9 domains	0 domains below national average	Local	2021				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

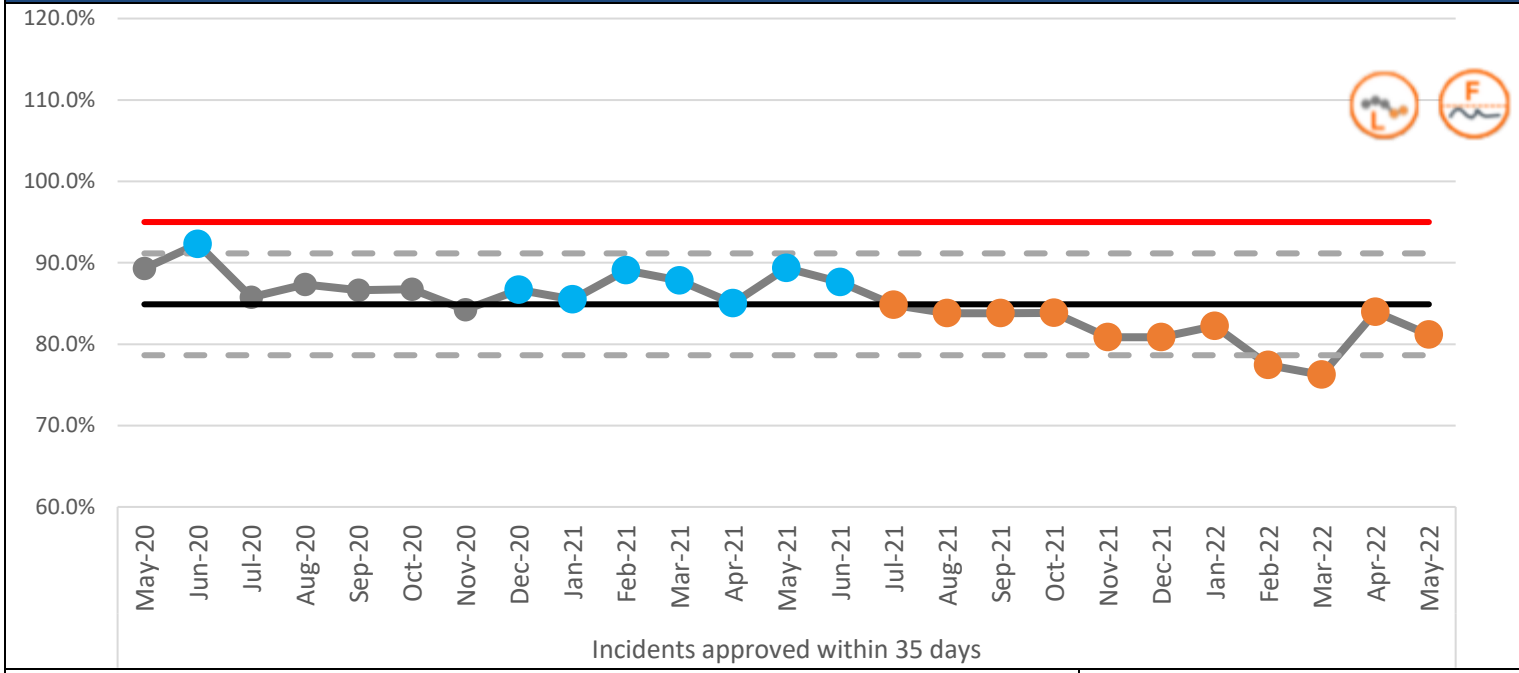
These icons are used to indicate if a target is likely to be achieved next month, has the potential to be achieved or is expected to fail.

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

CQC COMPLIANCE			Target	Good in all 5 Domains
CQC Inspection Report Ratings, published 5 April 2022 (LINK) Safe — Inadequate ● Effective — Requires Improvement ● Caring — Requires Improvement ● Responsive — Requires Improvement ● Well-led — Requires Improvement ● Overall rating — Requires Improvement ●			Apr-22	Requires Improvement in 4 domains Inadequate in 1 domain
			Variance Type	Not applicable
			Assurance Type	Not applicable
Lead: Jennifer Hill, Medical Director (Operations)		**Action Plan Timescales:** July 2022	What the chart is telling us	Not applicable
Board Committee Providing Oversight: Quality Committee				

Summary of current issues	Actions to recover performance
Following an unannounced CQC inspection on 5, 6 and 7 October and a CQC Well-Led review on 9, 10 and 11 November, the Trust received an overall rating of 'Requires Improvement' and a Section 29a Warning Notice outlining areas for improvement by 17 July 2022.	The Trust CQC Action Plan was approved by the Trust Executive Group on 4 May 2022 and submitted to CQC on 5 May 2022. A report providing an overview of progress against each outcome is presented to the to the Trust Executive Group, Quality Committee and Board of Directors each month. The CQC Compliance Oversight Group is chaired by the Medical Director (Operations). A programme of 'quality support' ward visits commenced on 17 May. The level of assurance against each outcome for the wards assessed is RAG rated and identifies which areas and outcomes require additional support to ensure that improvements have been made and are embedded in practice. A weekly meeting shares the themes and actions arising from the Ward Quality Support Visits with Sisters, Matron, Deputy Nurse Directors and Nurse Directors.

INCIDENTS
(Percentage of incidents approved within 35 days based on approval date)



Target	95%	
May-22	81.17%	
Variance Type		Metric is experiencing special cause for concern because of low values
Assurance Type		Metric is consistently falling short of the target
What the chart is telling us	The target is not being met consistently.	

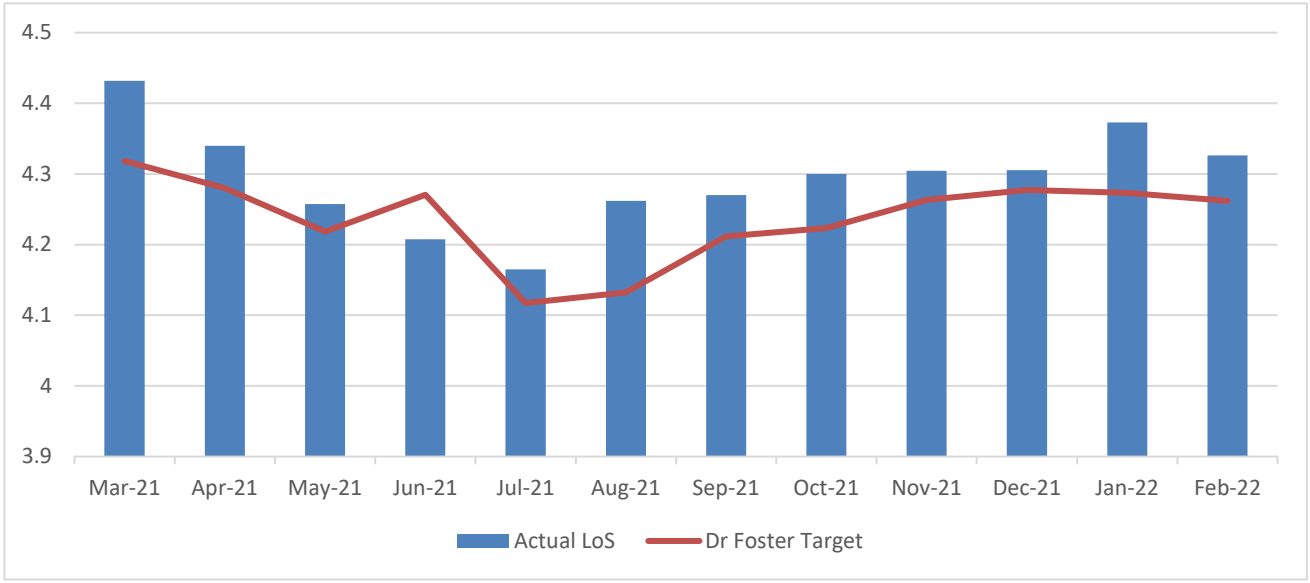
Lead: Jennifer Hill, Medical Director (Operations)

Action Plan Timescales: June 2022

Board Committee Providing Oversight: Quality Committee

Summary of current issues	Actions to recover performance
Performance in April and May remains below target.	• From June 2022, performance data by directorate will be shared at the Safety and Risk Committee monthly. • Changes to the incident management process, timing of uploading incidents to NRLS, and severity grading by the incident reporter were introduced on 1 June 2022. This is likely to reduce the time taken to approve incidents.

AVERAGE LENGTH OF STAY (Elective)



Target	4.26
Feb-22	4.33
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 elective episodes is increasing and is above the national benchmark.

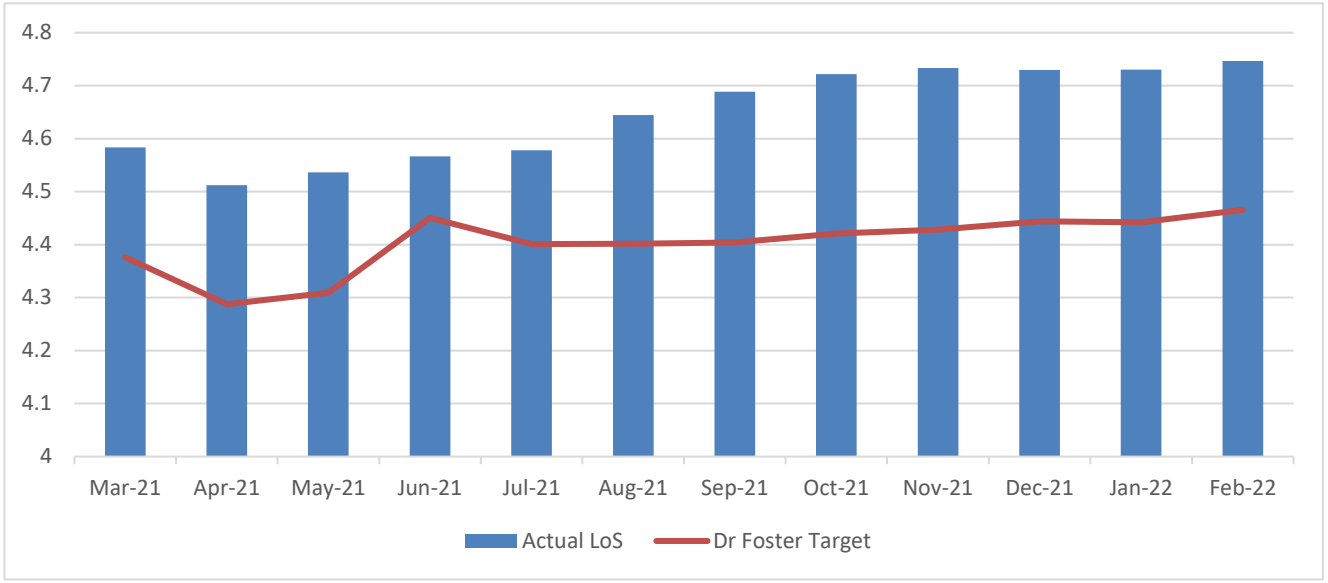
Lead: Jennifer Hill, Medical Director (Operations)

Action Plan Timescales: June 2022

Board Committee Providing Oversight: Quality Committee

Summary of current issues	Actions to recover performance
Access to adequate number of theatre lists Access to area to admit and discharge patients for day case surgery at NGH Elective inpatient bed capacity	Focus to maximise day case activity for admitting specialities aligning this with recommendations from GIRFT (getting it right first time) data. Maximise high volume low complexity (HVLC) cases to increase throughout (as per national guidance) Test use of theatre admission lounge (TAL) for admission and discharge of day case surgery patients at NGH to design future space requirements.

AVERAGE LENGTH OF STAY (Non-Elective)



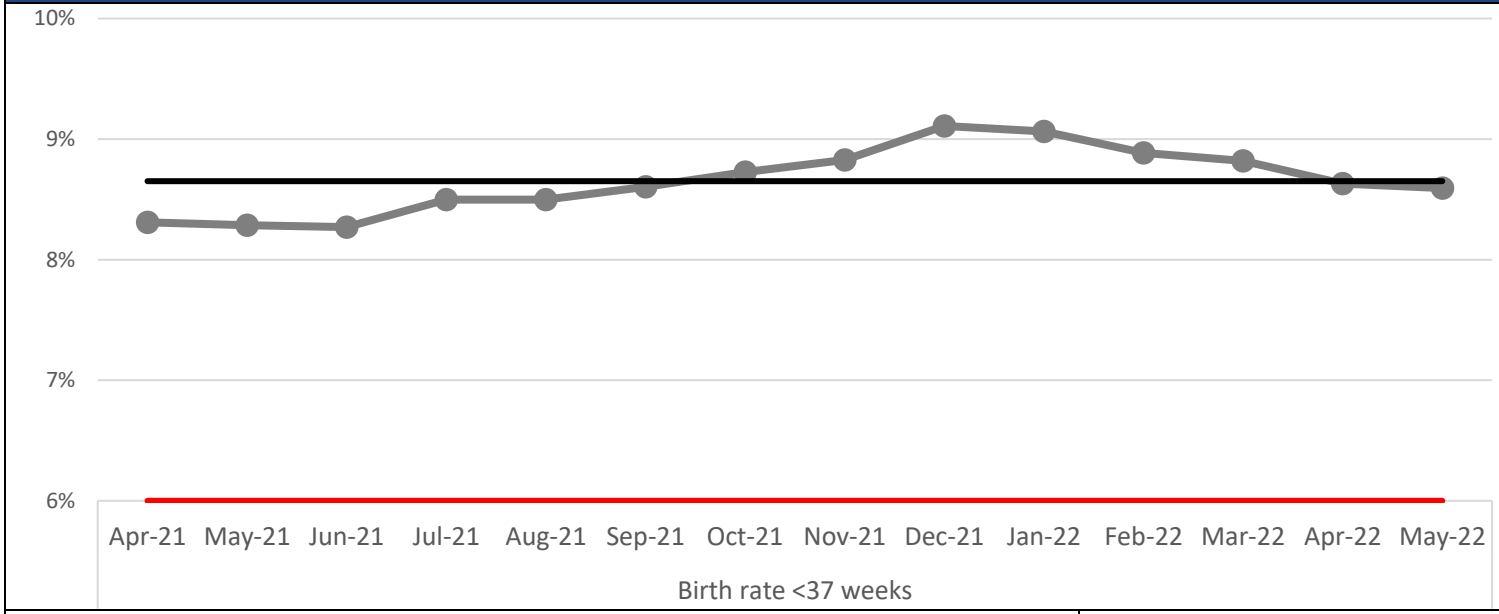
Target	4.47
Feb-22	4.75
Variance Type	Data is provided on a rolling 12-month basis, so not suitable for SPC analysis
Assurance Type	Data is provided on a rolling 12-month basis, so not suitable for SPC analysis
What the chart is telling us	Average LOS for non-elective episodes has been increasing steadily since April-21 and consistently above the national benchmark.

Lead: Jennifer Hill, Medical Director (Operations)

Action Plan Timescales: June 2022

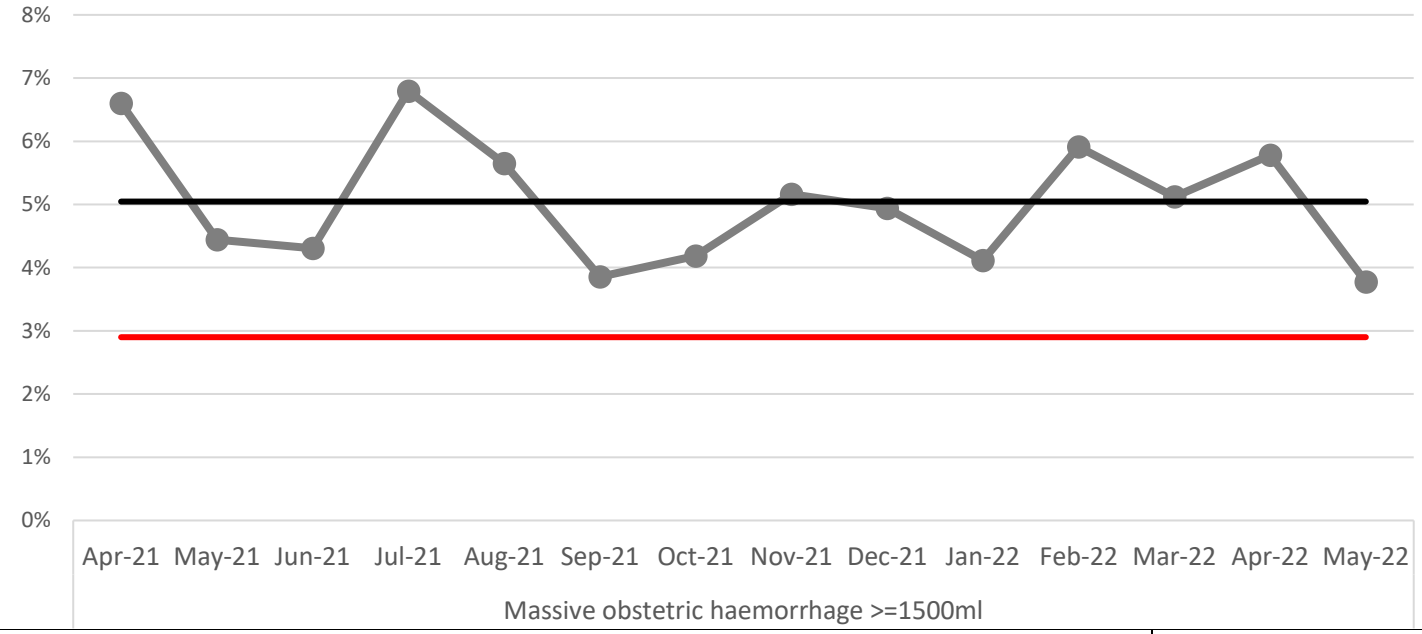
Board Committee Providing Oversight: Quality Committee

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. There has been an increase in numbers of patients with length of stay over 14 days	Excellent Emergency Care (EEC) agenda continues to focus on five key areas of work: • Develop Same Day Emergency Care Strategy (SDEC) to achieve maximum benefits of offering SDEC on admission and to support timely discharge. • Work with clinical teams to strengthen ward processes to support daily review of every patient, embedding criteria to reside and supporting clinical staff to review risk thresholds. • Focussed work with MAPS on long length of stay (LLoS) as a pilot area to shape a future approach to support teams to reduce LLoS • Improve processes for the assessment and transition of care for patients needing care/support following an acute admission. • Increase the number of patients discharged before 5pm.

PRETERM BIRTH RATE (Birth rate between 24 and 37 weeks as proportion of all births >24 weeks, rolling 12 months)		
	Target	6%
	May-22	9%
	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	**Action Plan Timescales**: Ongoing	
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 the Trust metrics will be considered to ensure that reporting is aligned

MASSIVE OBSTETRIC HAEMORRHAGE (MOH)
(MOH >=1500ml as proportion of deliveries (singleton cephalic births 37-42 weeks gestation only))



Target	2.9%
May-22	3.8%
Variance Type	Not applicable. Insufficient number of data points for SPC
Assurance Type	Not applicable. Insufficient number of data points for SPC
What the chart is telling us	The percentage of patients having massive obstetric haemorrhage has been consistently above the target.

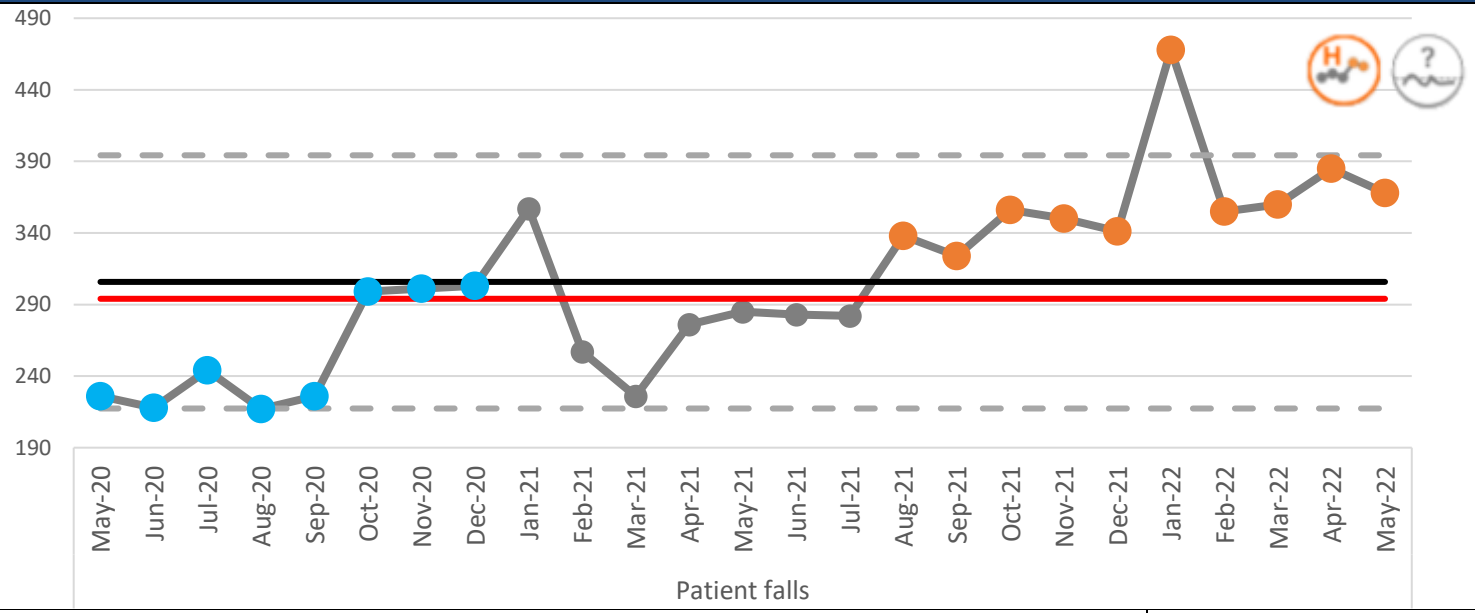
Lead: Chris Morley, Chief Nurse

Action Plan Timescales: Ongoing

Board Committee Providing Oversight: Quality Committee

Summary of current issues	Actions to recover performance
The postpartum Haemorrhage (PPH) % remains higher than the <2.9% target set using National Maternity and Perinatal Audit (NMPA) data from 2017.	The massive obstetric haemorrhage rate fluctuates at around 5% (defined as blood loss greater than 1500mls peripartum) for all deliveries. The national target is 2.9% (based on 2017 data). A recent audit has informed the quality of the PPH prevention and active management reviews. PPH continues to be a quality and safety service improvement workstream as part of the Maternity Improvement Programme. Developments include a recently implemented risk assessment tool, and an updated guideline. Management of PPH and Massive Obstetric Haemorrhage (MOH) which are covered in the PROMPT skills and drills mandatory training. All cases are subject to 72 hour incident review and investigation to improve learning. Other changes include: - The DEALLT PPH pneumonic – to inform 1500mls – encouraging earlier action and escalation - Embedding risk assessment for PPH on arrival for intrapartum care – these are being seen in the notes during the PPH reviews - Easier access to Tranexamic acid to be used within all specific PPH cases – monitoring reflects this practice is becoming embedded in practice. - Feedback to staff members involved both positive actions and any areas of the care delivered where improvements are required - Standardisation of escalation for assistance at 30mins when placentas have not been delivered

PATIENT FALLS
(Number of patient falls)



Target	< 3526 per year / 294 per month (19-20 total)	
May-22	368	
Variance Type		Metric is experiencing special cause for concern because of high values
Assurance Type		Indicator is showing random variation
What the chart is telling us	Consistently high values above the target	

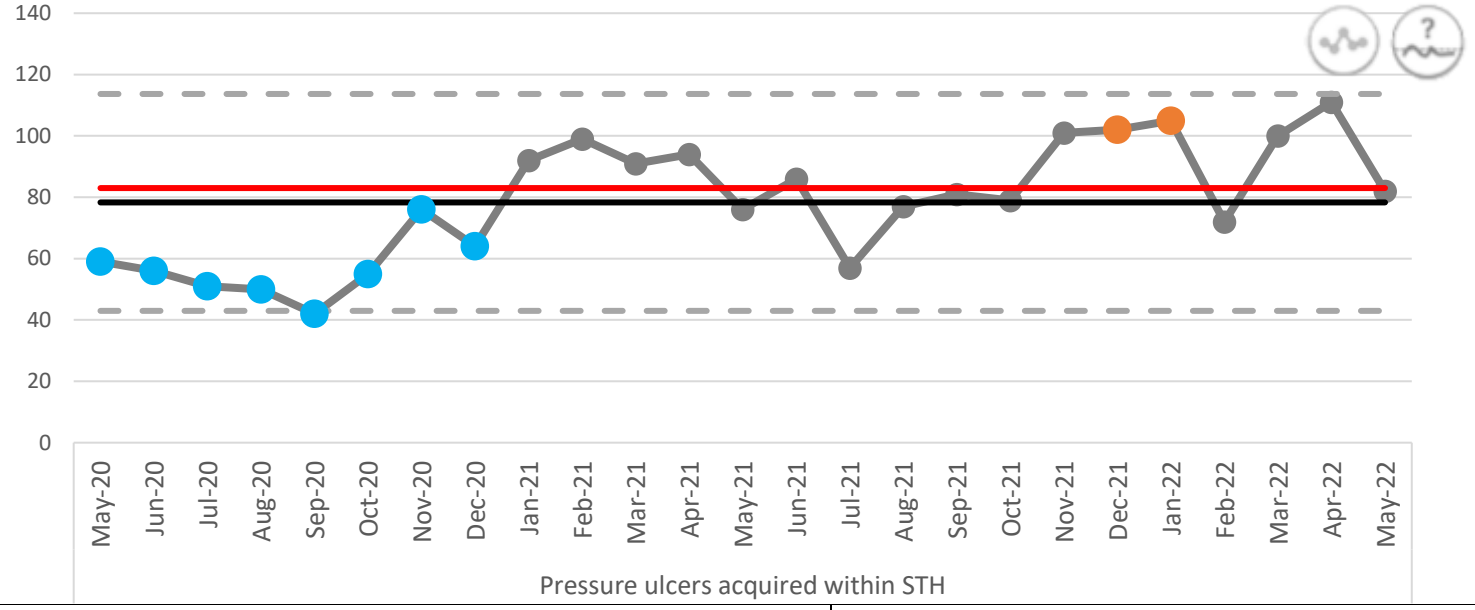
Lead: Jennifer Hill, Medical Director (Operations)

Action Plan Timescales: July 2022

Board Committee Providing Oversight: Quality Committee

Summary of current issues	Actions to recover performance
The trust continues to have high bed occupancy with winter surge capacity remaining open but seeing a slow fall in falls per 1000 bed nights from 7.7 in February and March to 7.2 and 7.0 in April and May, respectively. Rates per 1000 bed night reflects the position more accurately, taking into account the number of patients in the Trust and adjusts for longer and shorter months.	Focused falls improvement work continues to improve awareness of the multifactorial actions needed to reduce falls: lying and standing blood pressure, patients having items in reach, safety huddles and appropriate risk assessments.

PRESSURE ULCERS
(Number of pressure ulcers acquired within STH)



Target	83
Apr-22	113
Variance Type	Metric is experiencing common cause variation
Assurance Type	Indicator is showing random variation
What the chart is telling us	There has been an increase in the number of pressure ulcers acquired within STH since July 2021.

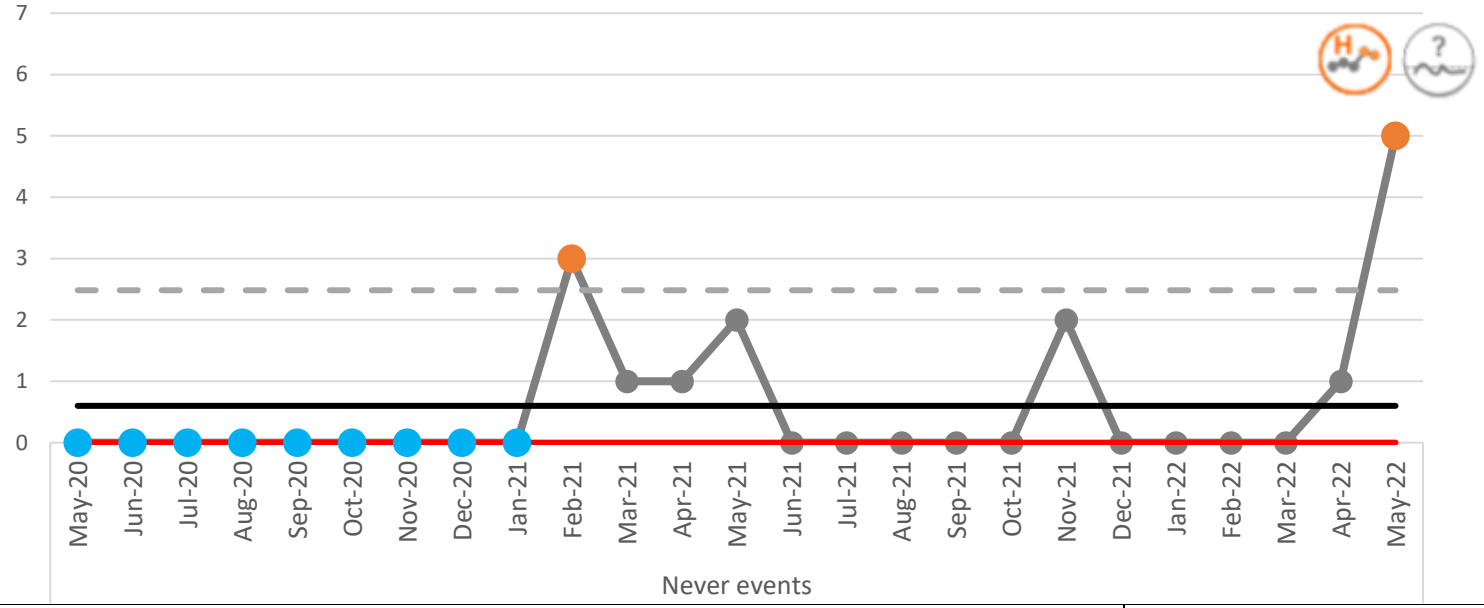
Lead: Chris Morley, Chief Nurse

Action Plan Timescales:
Purpose T pilot to be completed by 1st December 2022

Board Committee Providing Oversight: Quality Committee

Summary of current issues	Actions to recover performance
During April the threshold for the number of inpatient pressure ulcers has been breached.	The number of Trust attributable PU's is above the monthly agreed threshold for April. This is reflective of the same period in 2020/21 and is within normal variation and is reflected nationally. Central Nursing are currently reviewing the IPR metric to ensure it reflects this variation. Central Nursing has overseen a weekly assurance review by the Matrons of pressure ulcer prevention and management in all in patient areas. This ten-week review has provided key indicators for targeted improvement work. This targeted work will include the Tissue Viability Lead Nurse managing a pilot project across ten wards assessing the potential benefits of Purpose T, an evidence based more comprehensive alternative skin risk assessment to the Waterlow assessment tool currently utilised across the Trust. The Tissue Viability team have continued to provide dedicated support and education to wards, including ED and AMU, in response to learning identified through the weekly Pressure Ulcer Review meeting process. There have been 0 cases of Category 4 pressure ulcers.

NEVER EVENTS
(Number of never events)



Target	0	
May-22	5	
Variance Type		Metric is experiencing special cause for concern because of high values
Assurance Type		Indicator is showing random variation
What the chart is telling us	Low usual values mean any variation from zero will flag and generate an exception report.	

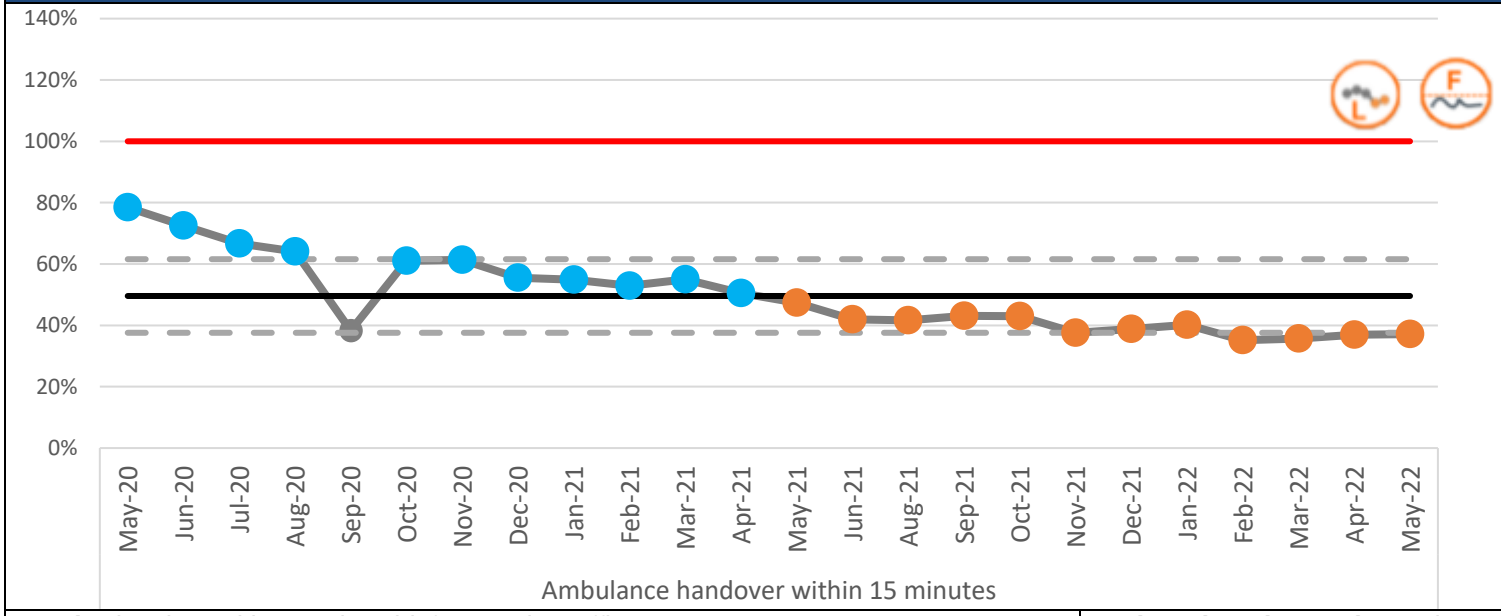
Lead: Jennifer Hill, Medical Director (Operations)

Action Plan Timescales: Closed

Board Committee Providing Oversight: Healthcare Governance Committee

Summary of current issues	Actions to recover performance
5 never events were reported in May 2022. The patients and families have been fully informed and full investigations have commenced.	Immediate actions and sharing of learning were taken at the time to reduce the risk of recurrence. A Programme of work on human factors is being progressed.

AMBULANCE TURNAROUND
(Time taken for ambulance handover of patient within 15 minutes)



Target	15 mins 100%
May-22	15 mins 37.15%
Variance Type	Metric is showing special cause of concerning nature due to underperformance
Assurance Type	Metric is consistently falling short of the target.
What the chart is telling us	The national standards have not been consistently met

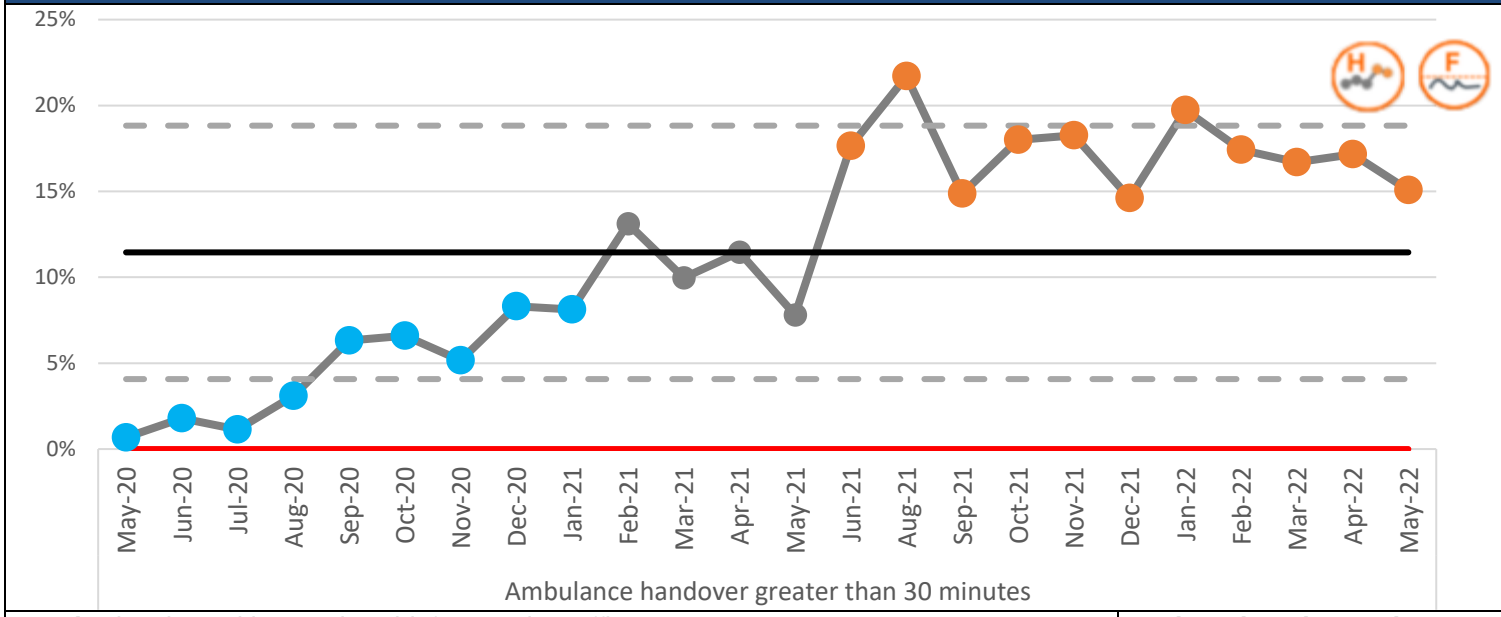
Lead: Victoria Leckie, Interim Chief Operating Officer

Action Plan Timescales: July 2022

Board Committee Providing Oversight: Finance and Performance Committee

Summary of current issues	Actions to recover performance
The May performance remains indicative of the challenges being faced nationally in managing the increase in patients needing emergency and acute care. The number of Ambulances handed over within 15 minutes is 37.15% which is steady compared to April's handover performance of 36.93%.	Close working with the Yorkshire Ambulance Service (YAS) means that urgent/ deteriorating patients are escalated appropriately in the event of any handover delay. Moreover, demand peaks are predicted using YAS data in order to inform the need for patient flow out of A&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 which ensures patients reach the best place to receive their care sooner.

AMBULANCE TURNAROUND
(Proportion of patients handed over in more than 30 minutes)



Target	30 mins 0%	
May-22	30 mins 15.07%	
Variance Type	H	Metric is experiencing special cause for concern because of high values
Assurance Type	F	Metric is consistently falling short of the target.
What the chart is telling us	The national standards have not been consistently met	

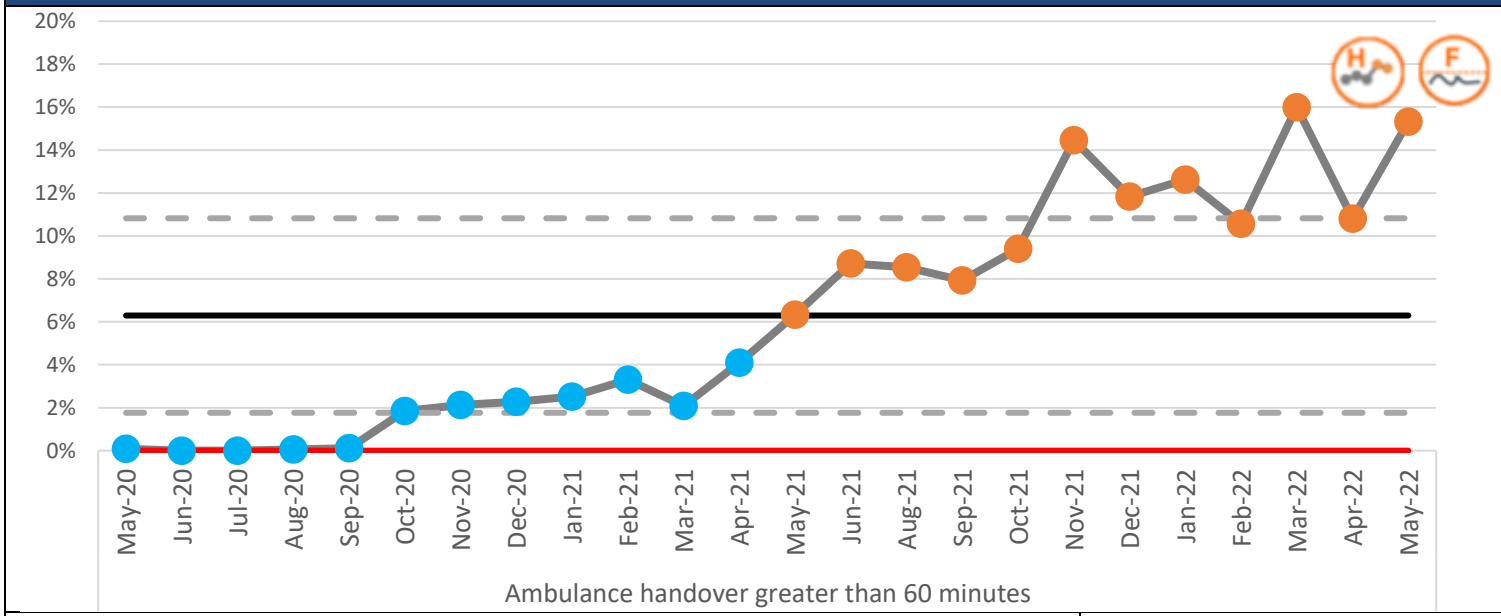
Lead: Victoria Leckie, Interim Chief Operating Officer

Action Plan Timescales: June 2022

Board Committee Providing Oversight: Finance and Performance Committee

Summary of current issues	Actions to recover performance
15.07% of the total number of handovers in May 2022 experienced a delay of 30-60 minutes. This is compared to April's performance of 17.16%.	To mitigate the risk of delayed handovers the Nurse in Charge (NIC) continuously monitors: • The number of inbound ambulances on the Yorkshire Ambulance Service (YAS) C3 screen • The number of ambulances waiting to handover • Current patients in the department and internal flows – i.e., the stage of assessment/transfer/plan • Flow out of A&E to assessment areas The A&E Escalation process has been refreshed with the aim to ensuring system wide actions are taken to improve performance.

AMBULANCE TURNAROUND
(Time taken for ambulance handover of patient over 60 minutes)



Target	60 mins 0%	
May-22	60 mins 15.32%	
Variance Type	H	Metric is experiencing special cause for concern because of high values
Assurance Type	F	Metric is consistently falling short of the target.
What the chart is telling us	The national standards have not been met	

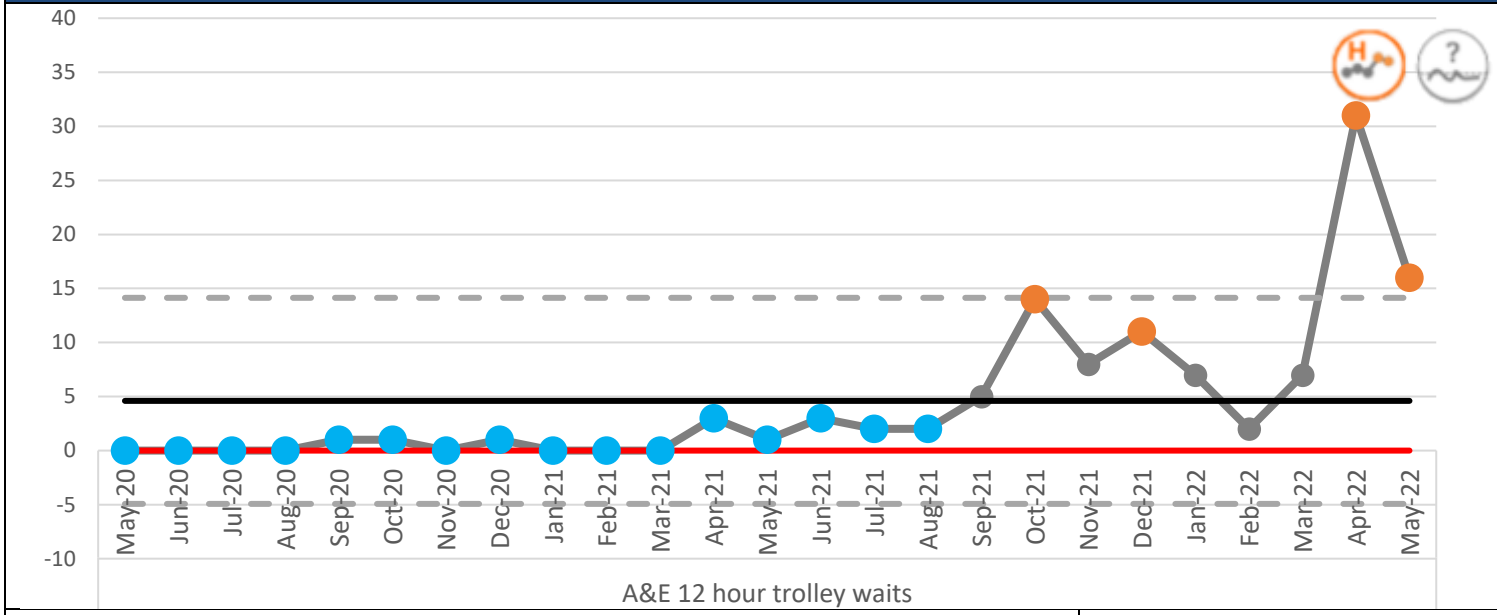
Lead: Victoria Leckie, Interim Chief Operating Officer

Action Plan Timescales: August 2022

Board Committee Providing Oversight: Finance and Performance Committee

Summary of current issues	Actions to recover performance
In May 15.32% of the total conveyances were over 1 hour. This is indicative of the challenges currently facing the department and wider organisation in managing the patient volumes attending Accident and Emergency and consequently requiring admission to inpatient beds.	Discussions are taking place with the Council to develop plans for reducing medically fit for discharge patients over the summer. Work continues with Yorkshire Ambulance Service to implement an Action Plan to reduce ambulance handover delays including cohorting ambulance patients safely adjacent to the A&E dept to release crews.

12 HOUR TROLLEY WAITS IN A&E
(No. of patients waiting > 12 hours)



Target	0
May-22	16
Variance Type	Metric is experiencing special cause for concern because of high values
Assurance Type	Indicator is showing random variation
What the chart is telling us	Since March 2021, we have seen an increased number of 12-hour trolley waits

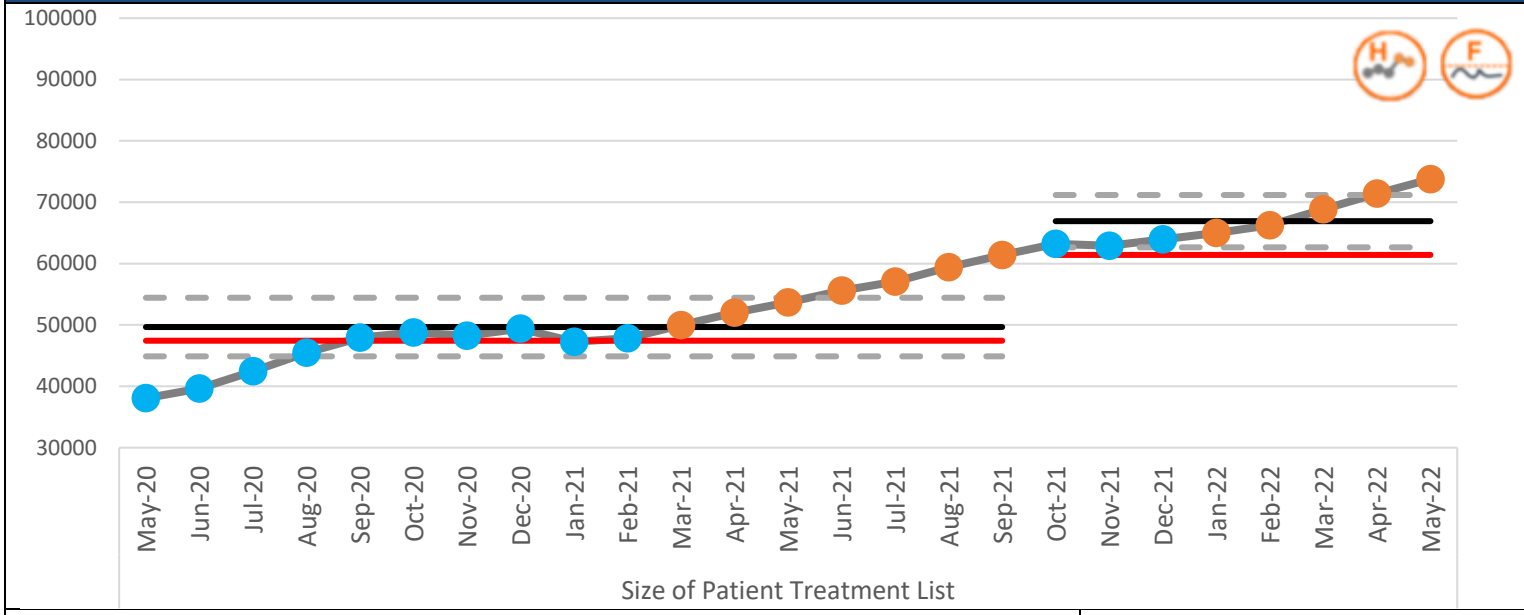
Lead: Victoria Leckie, Interim Chief Operating Officer

Action Plan Timescales: Ongoing

Board Committee Providing Oversight: Finance and Performance Committee

Summary of current issues	Actions to recover performance
There were sixteen 12 hour trolley breaches during May 2022, Eleven of these patients required admission to a specialist mental health bed in another orgniasation and the delay was related to this.	There has been a collaborative review of the circumstances that led to the 12 hour trolley breaches. We continue to work closely with Mental Health colleagues from the Sheffield Childrens' Hospital and Sheffield Health and Social Care Trust to improve the timeliness of care (including the availability of inpatient mental health facilities).

PATIENT TREATMENT LIST
(Total Numbers)



Target	61,416
May-22	73,773
Variance Type	Metric is experiencing special cause for concern because of high values
Assurance Type	Metric is consistently falling short of the target
What the chart is telling us	The total number of patients awaiting treatment has increased month on month since January 2021

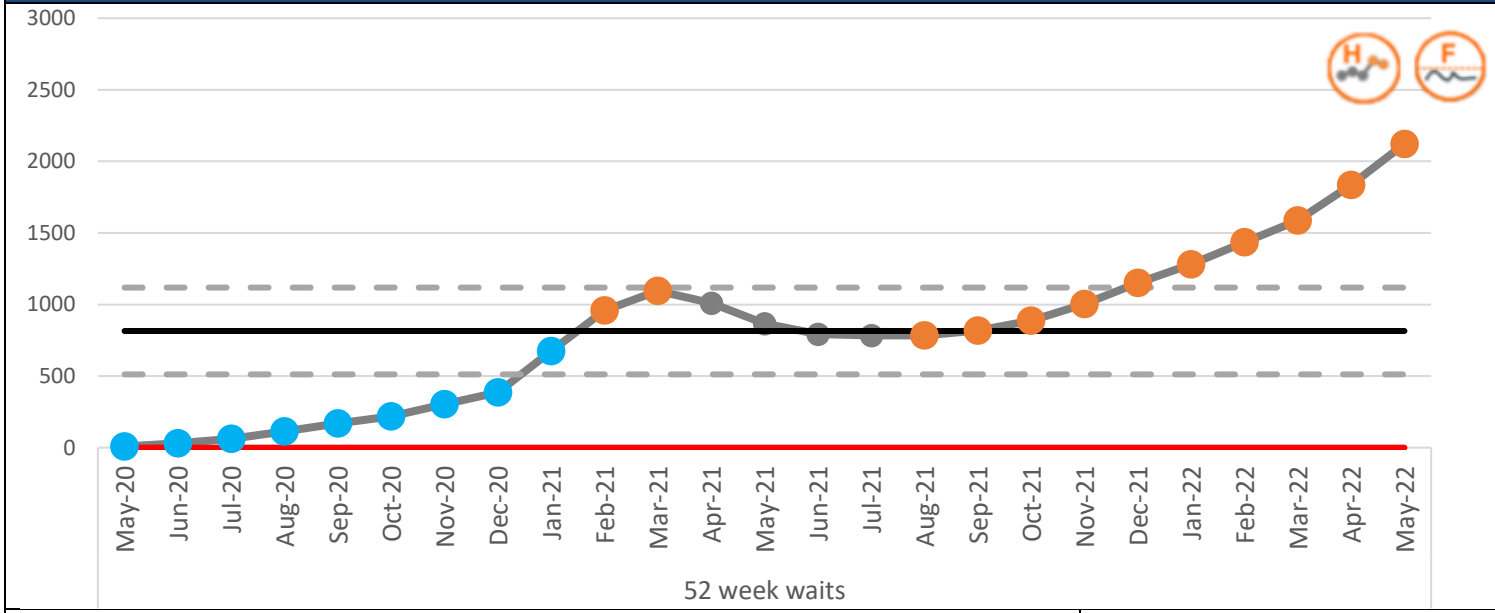
Lead: Victoria Leckie, Interim Chief Operating Officer

Action Plan Timescales: March 2023

Board Committee Providing Oversight: Finance and Performance Committee

Summary of current issues	Actions to recover performance
The total number of patients on the patient treatment list (PTL) or incomplete care pathway increased by 2,383 in May 2022 to 73,773. This is above the September 2021 target of 61,416.	The size of the PTL has been discussed at the Performance and Caseload Overview Group. 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.

52 WEEK WAITS
(Patients Waiting over 52 Weeks on an Incomplete Pathway)



Target	0
May-22	2,122
Variance Type	Metric is experiencing special cause for concern because of high values
Assurance Type	Metric is consistently falling short of target
What the chart is telling us	Following four months of reduction the number has risen once again.

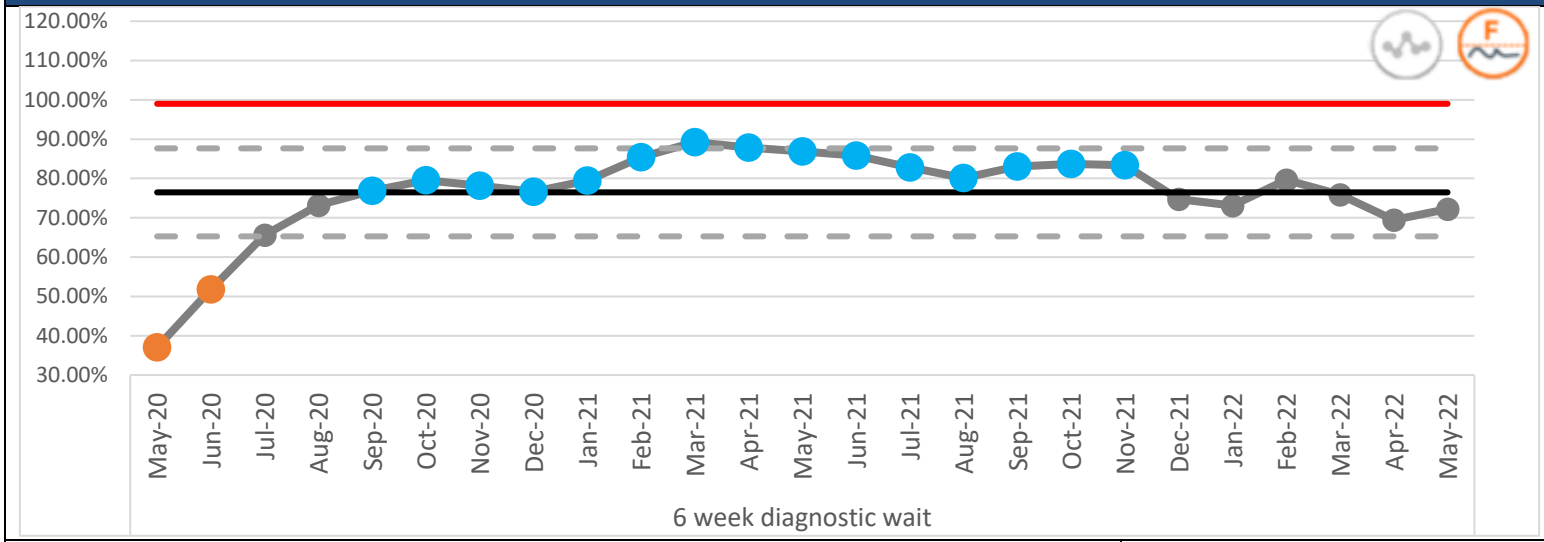
Lead: Victoria Leckie, Interim Chief Operating Officer

Action Plan Timescales: March 2023

Board Committee Providing Oversight: Finance and Performance Committee

Summary of current issues	Actions to recover performance
There were 2,122 patients waiting over 52 weeks on an incomplete pathway during May 2022, an increase of 287 on the April 2022 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. Focus remains on reducing the longest waits.

DIAGNOSTIC WAITING TIMES
(Percentage of patients waiting less than 6 weeks for a diagnostic test)



Target	99%	
May-22	72.19%	
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 decline in performance, but it is now stable.	

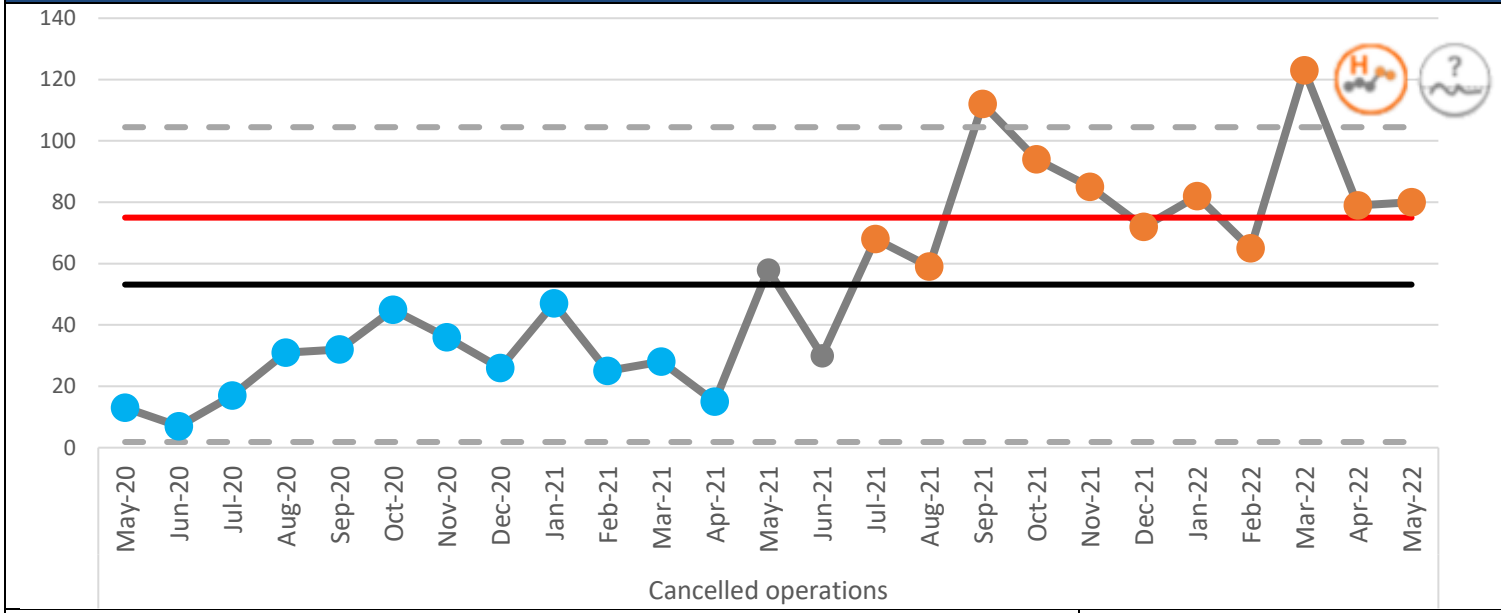
Lead: Victoria Leckie, Interim Chief Operating Officer

Action Plan Timescales: March 2023

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 May 2022 was 72.19%.	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 in place.

CANCELLED OPERATIONS
(Number of operations cancelled on the day for non-clinical reasons)



Target	75	
May-22	79	
Variance Type		Metric is experiencing special cause for concern because of high values
Assurance Type		Indicator is showing random variation
What the chart is telling us	The number of on-day elective cancellations for non- clinical reasons was below target for May 2022 and April 2022	

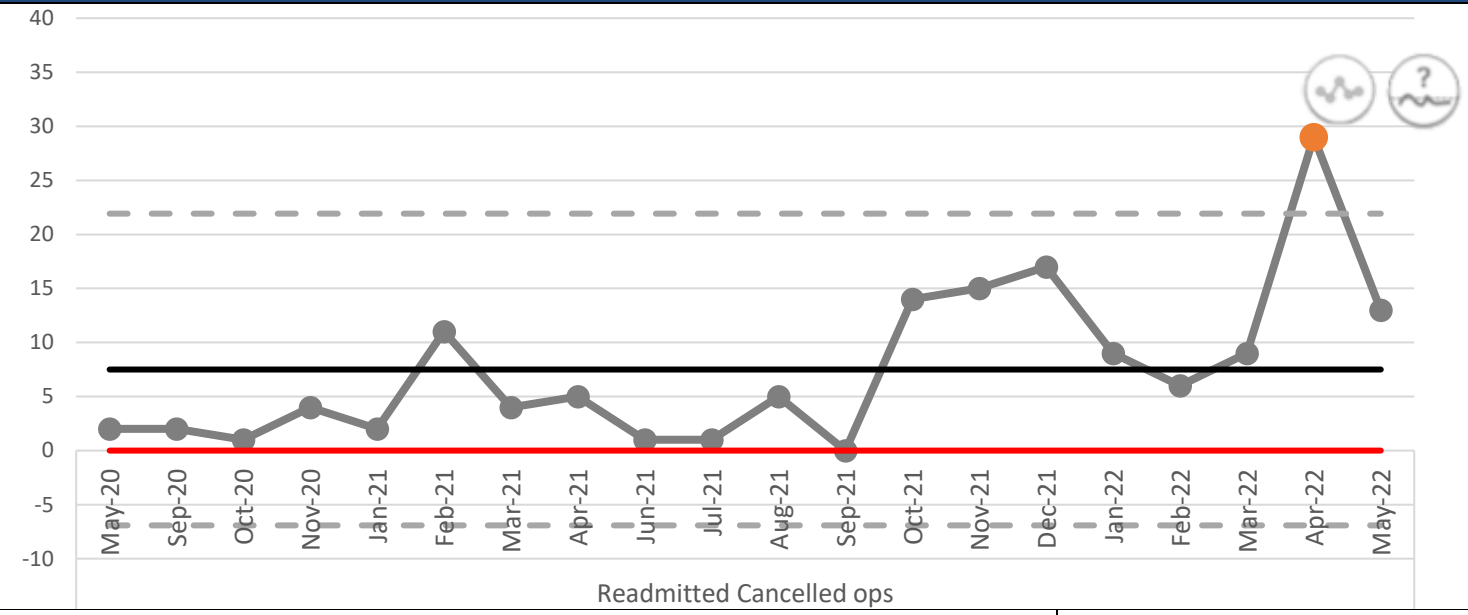
Lead: Victoria Leckie, Interim Chief Operating Officer

Action Plan Timescales: March 2023

Board Committee Providing Oversight: Finance and Performance Committee

Summary of current issues	Actions to recover performance
There were 79 on-day elective cancellations during May 2022.	Performance is reviewed on a regular basis by the Performance and Caseload Overview Group, supported by Seamless Surgery. The Trust is undertaking an exercise to model the number of elective beds required to support the Patient Care Recovery plan and developing a proposal to create a dedicated Theatre Admission Lounge at NGH to support the delivery of additional day case activity.

CANCELLED OPERATIONS
(Number of patients cancelled on the day and not readmitted within 28 days)



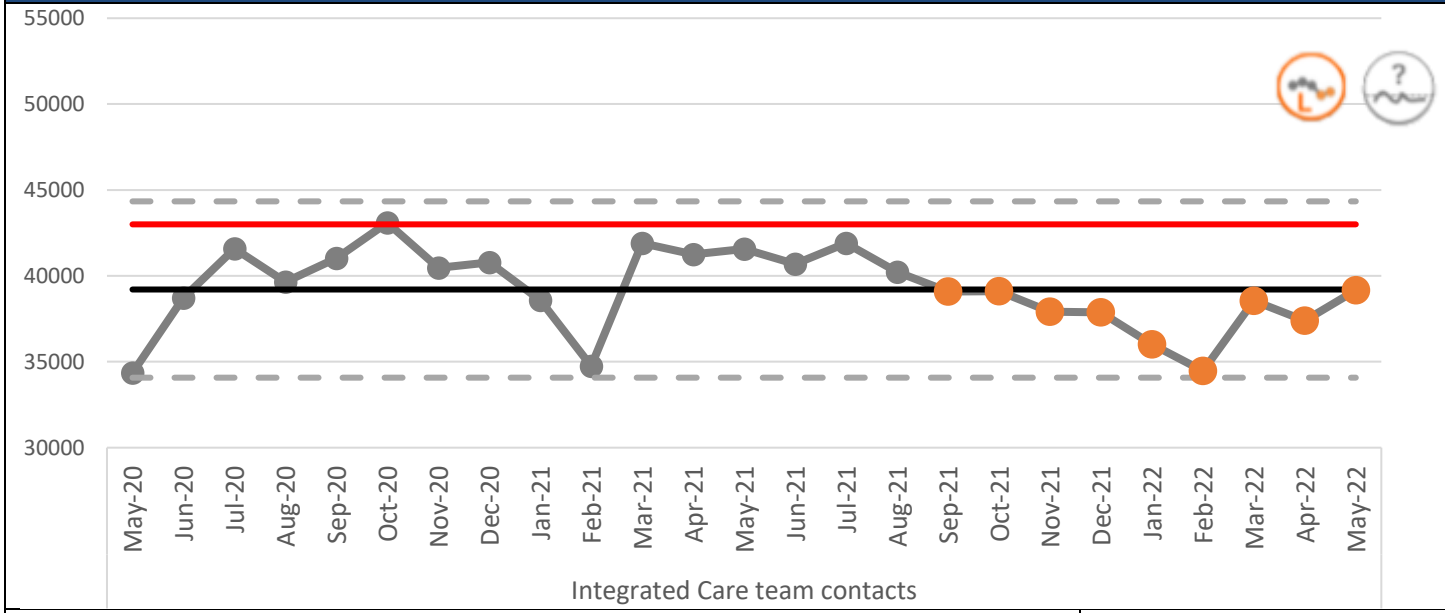
Target	0	
May-22	13	
Variance Type		Metric is experiencing common cause variation
Assurance Type		Indicator is showing random variation
What the chart is telling us	The number of on-day elective cancellations for non- clinical reasons was above target for May 2022	

Lead: Victoria Leckie, Interim Chief Operating Officer

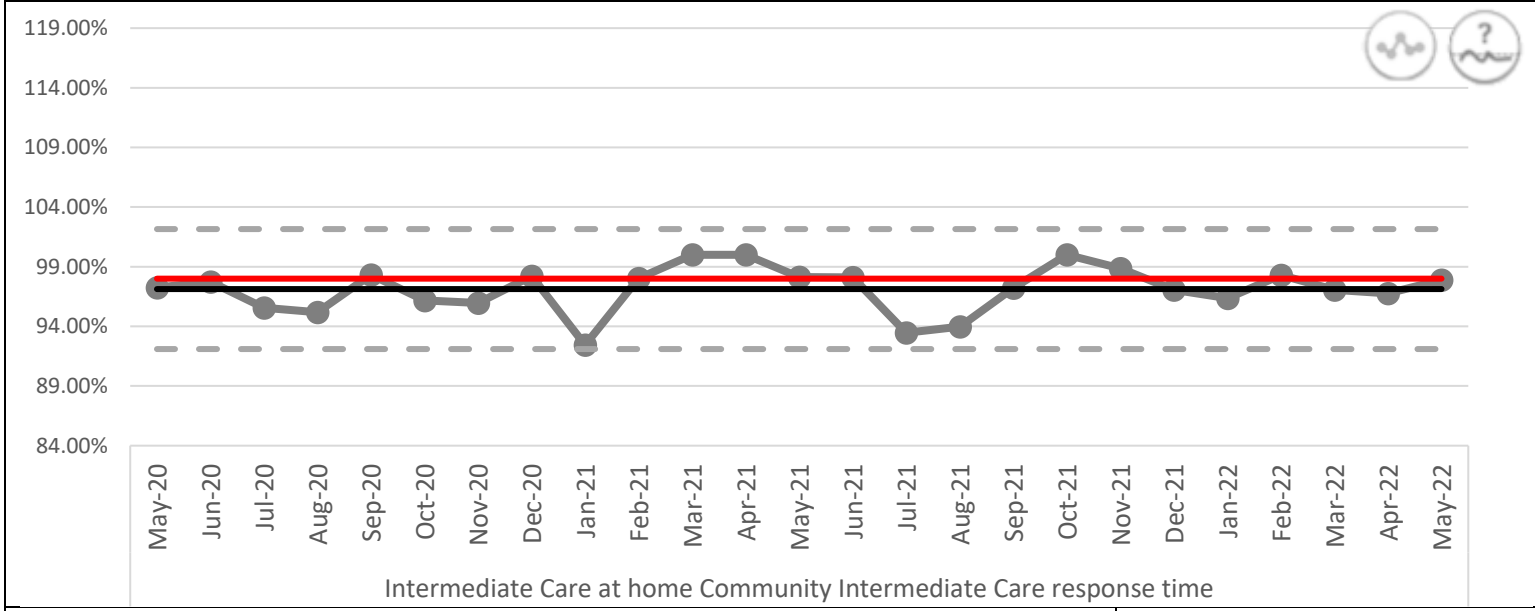
Action Plan Timescales: March 2023

Board Committee Providing Oversight: Finance and Performance Committee

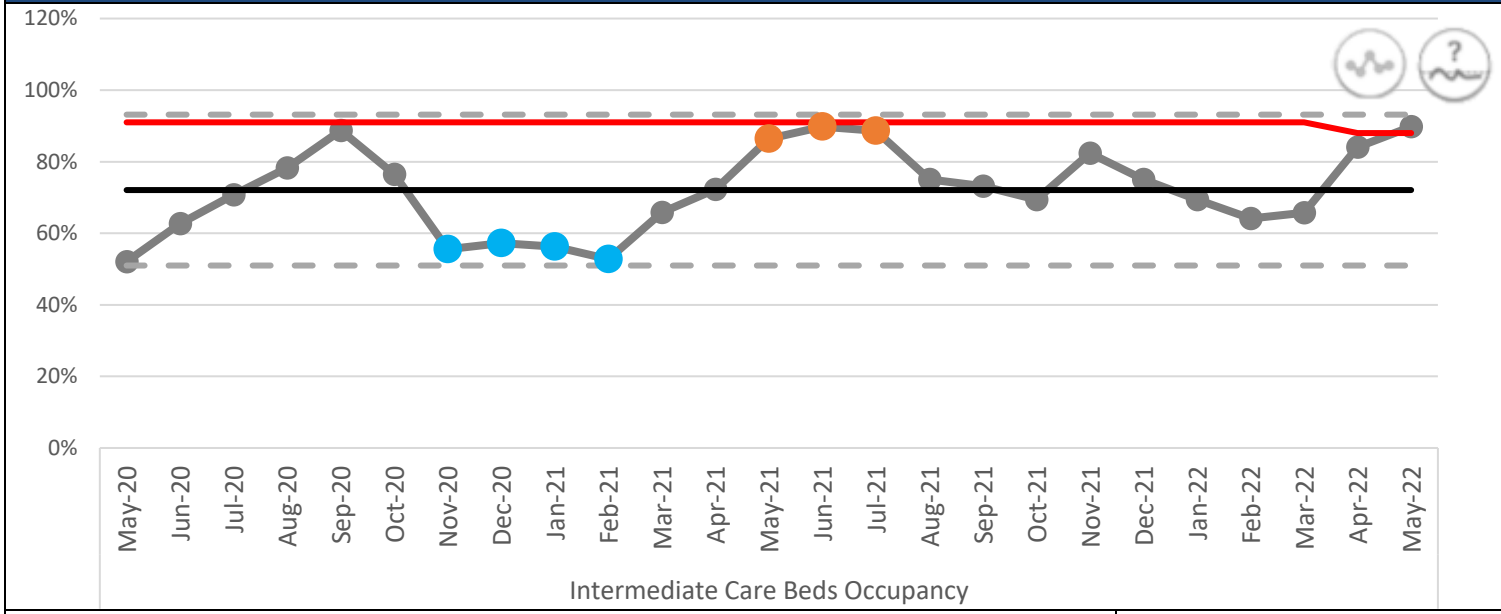
Summary of current issues	Actions to recover performance
There were 13 on-day elective cancellations during May 2022 which were not readmitted within 28 days. Nine patients have since been admitted and had their procedure.	Performance is reviewed on a regular basis by the Performance and Caseload Overview group.

COMMUNITY CARE (Integrated Care Team (ICT) contacts)			
		Target	43,000
		May-22	39,157
		Variance Type	Metric is showing special cause of concerning nature due to underperformance
		Assurance Type	Indicator is showing random variation
Lead: Victoria Leckie, Interim Chief Operating Officer	**Action Plan Timescales**: October 2022	What the chart is telling us	The number of ICT contacts dipped below target in April 2020 and has remained below target for all months other than Oct 2020.
Board Committee Providing Oversight: Finance and Performance Committee			

Summary of current issues	Actions to recover performance
Target now updated to show amalgamation of the agreed 2022/23 activity plans for Therapy, Community Nursing Day Teams and the Evening and Night Service.	• Additional investment agreed for Therapy and recruitment underway to enable increased activity. • Community nursing data quality project in place – improvement expected by the end of Q2.

COMMUNITY CARE (Response Time)		
	Target	98%
	May-22	97.9%
	Variance Type	Metric is experiencing common cause variation
	Assurance Type	Indicator is showing random variation
	What the chart is telling us	Performance is just falling short of the target
Lead: Victoria Leckie, Interim Chief Operating Officer	**Action Plan Timescales**: June 2022	
Board Committee Providing Oversight: Finance and Performance Committee		

Summary of current issues	Actions to recover performance
Ability to discharge patients to social care provided/commissioned services compromised in line with acute services resulting in patients being 'held' within Active Recovery Health until they can receive the service they are waiting for. The consequence is loss of assessment capacity resulting in waits for assessment.	• Sheffield City Council have articulated a recovery plan and are working in partnership across the city, including a new model of homecare in Sheffield from April 23. • In the interim, bids have been made for national support and for national funding on behalf of the city to increase capacity and a response is awaited. • System partners are working together to address the challenges in the home care provision sector • Active Recovery Health continues to measure and proactively escalate patients they are unable to move to the relevant provider. • Mechanisms are in place to maximise the hours available and maintain safety of the caseload.

COMMUNITY CARE (Intermediate Care Bed Occupancy)		
	Target	88%
	May-22	90%
	Variance Type	Metric is experiencing common cause variation
	Assurance Type	Indicator is showing random variation
	What the chart is telling us	Occupancy has been increasing since March 2022

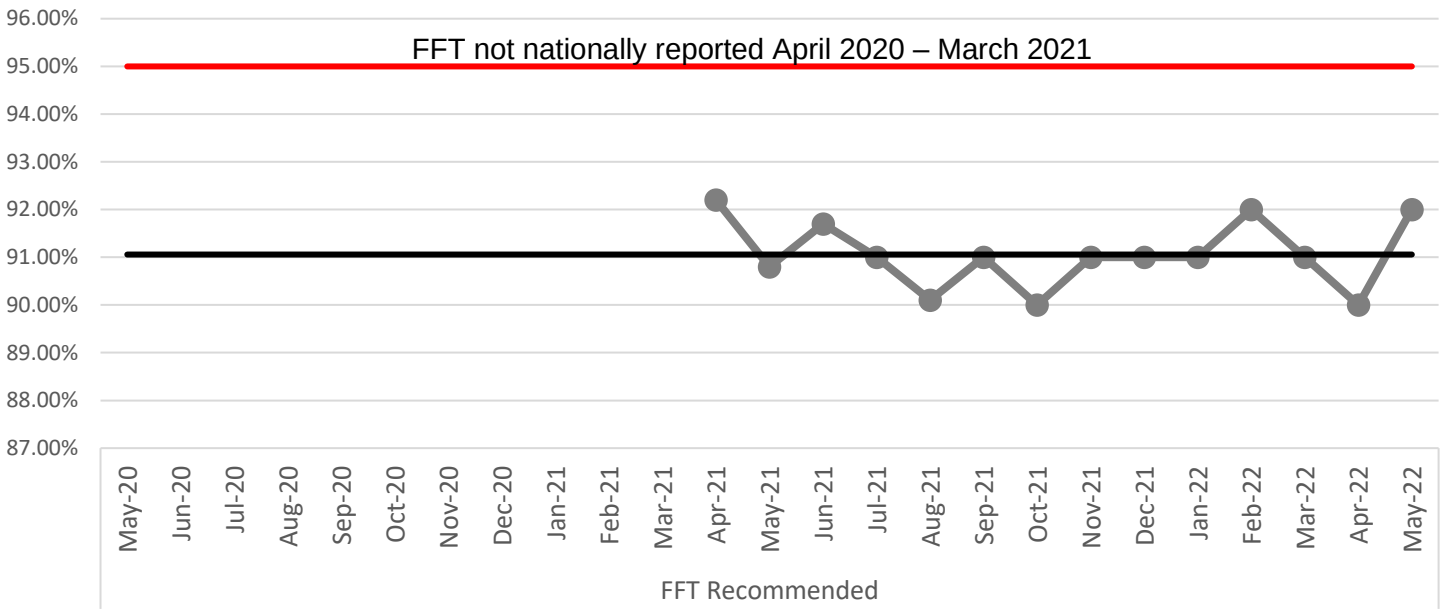
Lead: Victoria Leckie, Interim Chief Operating Officer

Action Plan Timescales: June 2022

Board Committee Providing Oversight: Finance and Performance Committee

Summary of current issues	Actions to recover performance
The target changed from 90% to 88% in April 2022. The target has not been met for a number of months due to Infection Control issues (outbreaks) in care homes which have affected the amount of capacity available to discharge patients to.	More beds have been temporarily commissioned in response to the increased occupancy numbers/

FRIENDS & FAMILY TEST (Inpatients)



Target	95%
May-22	92%
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 Inpatient services has not been consistently met

Lead: Chris Morley, Chief Nurse

Action Plan Timescales: Feedback Cards Fully reintroduced by June 2022.

Board Committee Providing Oversight: Quality Committee

Summary of current issues

The Inpatient positive score for May 2022 is 92%. This is a 2% increase from April and is the highest score achieved since April 2021 but remains 3% below the target.

A deep dive undertaken in April 2021 highlighted a number of factors which could be contributing to the fall in scores these are:

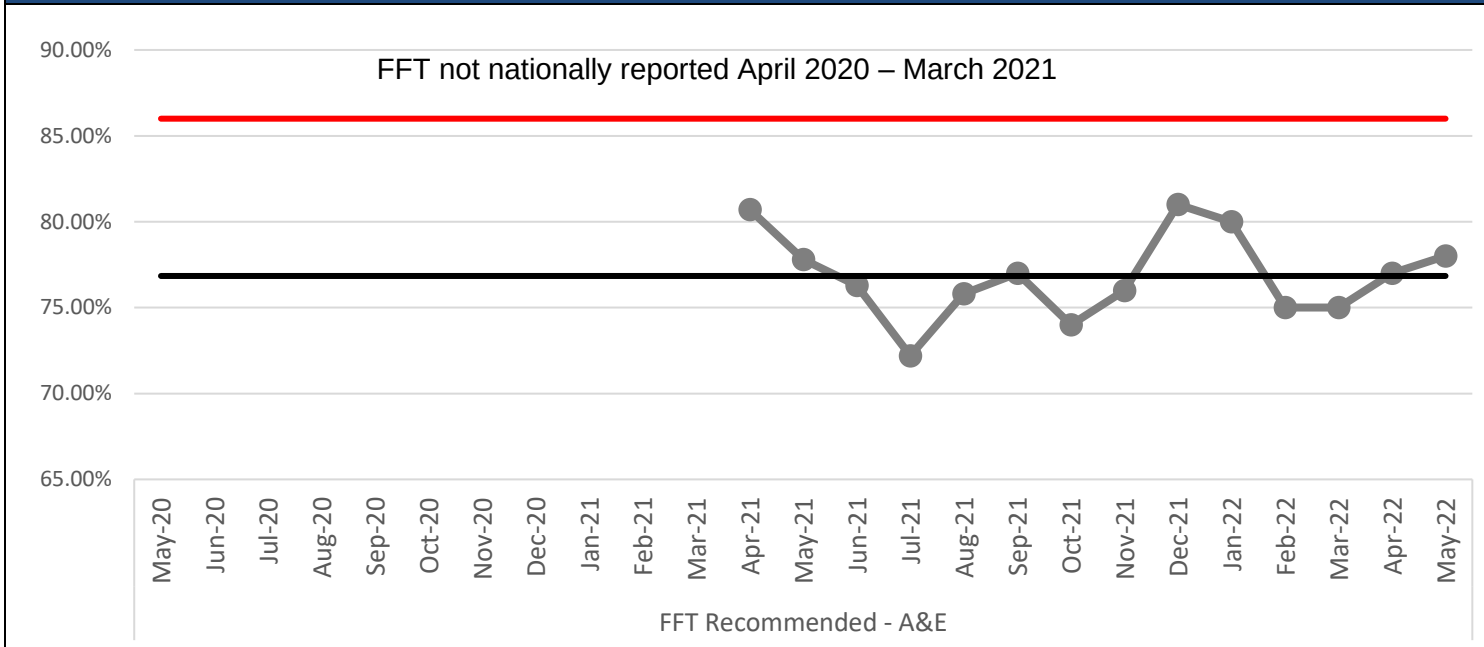
- Move to electronic methods
- Change in demographics of patients providing feedback
- Change in question
- Reduction in planned/elective pathways
- Change to the timing of the question meaning experience of discharge now included.

Actions to recover performance

Feedback cards have been made available to all inpatient areas as a supplement to electronic methods. The cards can also be used for patients to provide feedback at any point in their care, not just at discharge, and for carers and relatives to provide feedback. During May we have seen a significant increase in the number of responses received via this route with 1,210 feedback cards returned in May 2022 compared with 229 in April 2022.

The Patient Experience Team are currently reviewing which wards have returned the most cards and what impact, if any, this has had on individual scores and response rates.

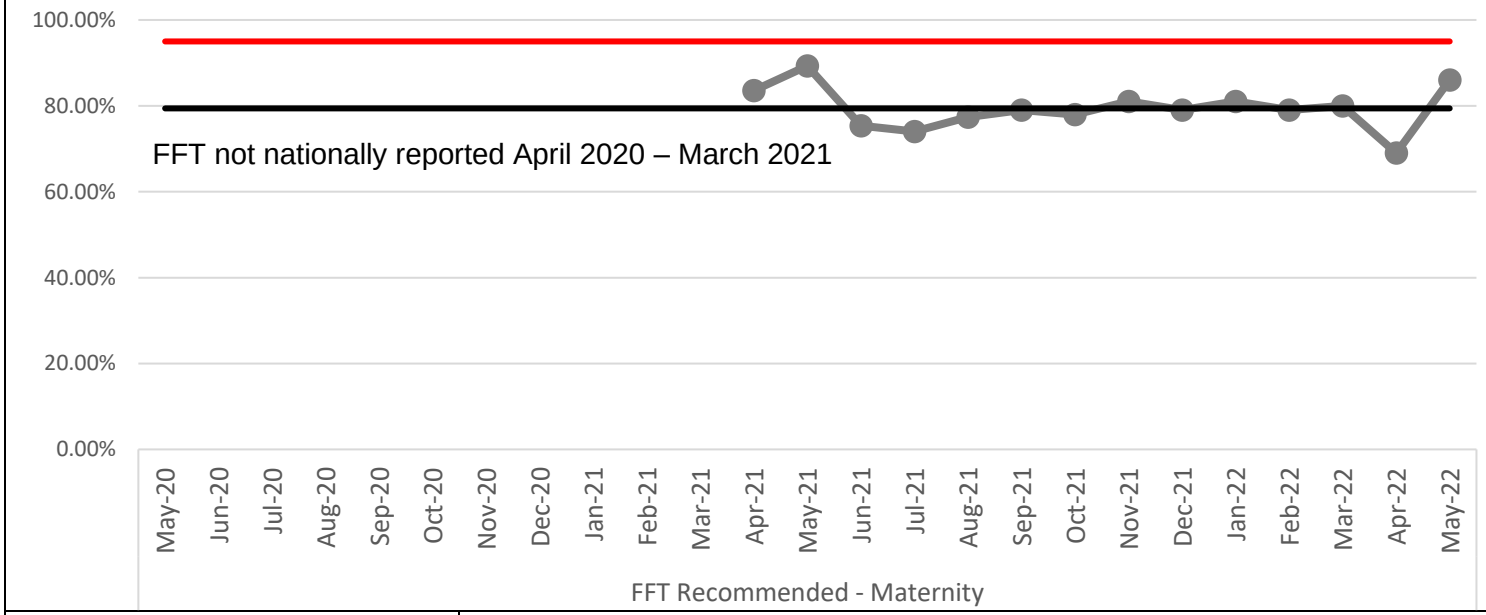
A benchmarking report using 2021/22 FFT data has been completed to review FFT scores against the national average score and Trusts in the Shelford group. This report shows that STH were the lowest scoring trust in the Shelford Group for Inpatients. The Patient Experience Team will review this data and compare methods and response rates to support understanding of the comparative data.

FRIENDS & FAMILY TEST (A&E)		
	**Target**	86%
	May-22	78%
	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 A&E has not been consistently met

Lead: Chris Morley, Chief Nurse	**Action Plan Timescales**: A&E Action Plan to be reviewed by directorate in June 2022.
Board Committee Providing Oversight: Quality Committee	

Summary of current issues	Actions to recover performance
The target of an 86% positive score has not been achieved since January 2021. A&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%.	The 2021/22 FFT benchmarking report, shows that the A&E average score for 2021/22 (77%) was only 1% behind the national average (78%) and 2% behind the Shelford average (79%). March 2022 data on 'Public View' shows that when compared to other acute and combined trusts, STH was in the median to upper quartile, and ranked 56th out of 118 (1st being the best). The upper quartile score was 81%, 5% below the Trust's target of 86%. 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. A review of waiting time performance and FFT positive score across all Shelford Trust show that there is a close correlation and therefore actions relating to patient flow will have a positive effect on FFT scores. The A&E team are currently working with the FFT Coordinator to increase staff awareness to increase response rates. This includes: - Business cards with the online survey and QR code to hand out to patients - Feedback cards - Staff recognition when they have been mentioned positively - FFT champions - Improved monthly comments analysis - Working with other hospitals to understand their FFT methods.

FRIENDS & FAMILY TEST (Maternity)



Target	95%
May-22	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 been consistently met

Lead: Chris Morley, Chief Nurse

Action Plan Timescales: Engagement Project in Maternity Services to start in June and run for 6 months.
Maternity Services Action Plan dates range from December 2021 to January 2023, these actions are monitored through OGN Governance.

Board Committee Providing Oversight: Quality Committee

Summary of current issues

Since restarting FFT in November 2020, the target of a 95% positive score has not been achieved.

The Maternity score for May is 86%, this is a 17% increase from April but remains 9% below the 95% target.

The overall score for maternity data is made up of scores relating to 4 phases of care (antenatal, labour, postnatal ward and postnatal community).

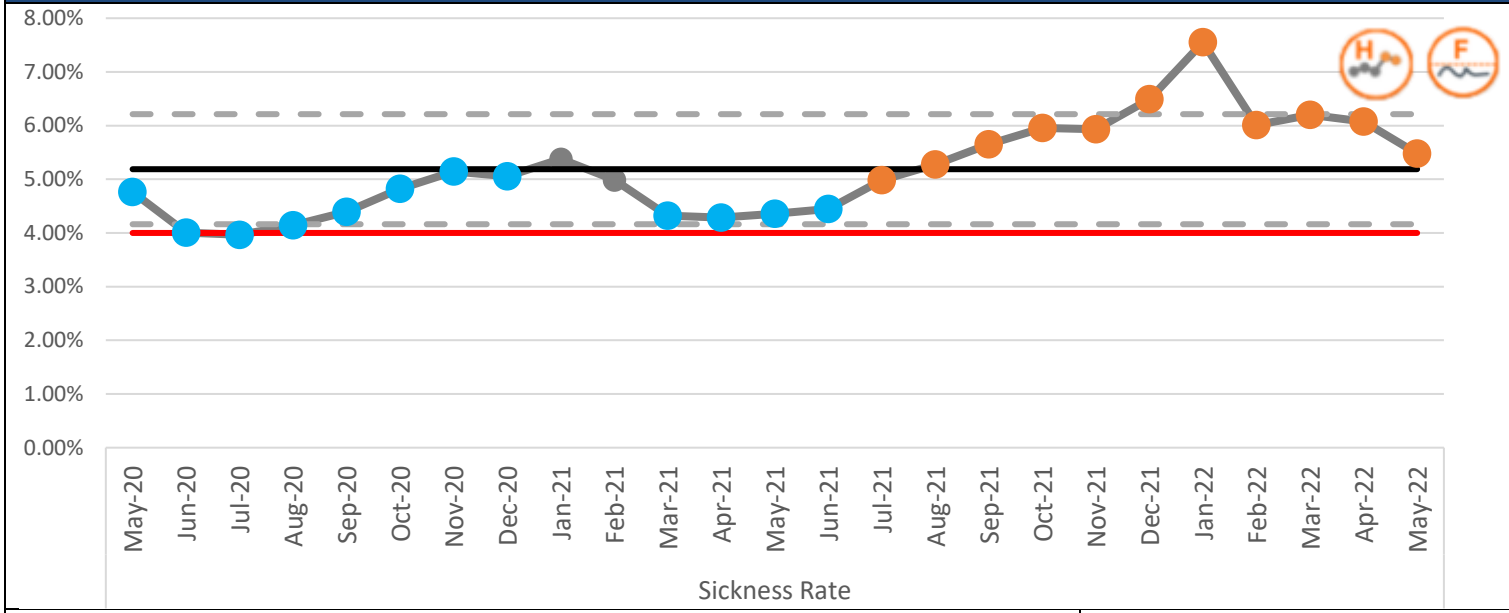
Actions to recover performance

The Maternity Service continues to deliver their improvement programme and maternity scores saw a significant increase in May, these are outlined below with the number of responses in brackets.

To increase the number of responses received, feedback cards will also be re-introduced in Maternity services. The Patient Experience Team have provided Maternity Services with the information they need to restart collection and will work with them to get the cards reintroduced.

Phase	April	May
Antenatal	63% (19)	82% (17)
Labour	70% (64)	92% (88)
Postnatal ward	70% (46)	81% (36)
Postnatal community	71% (28)	82% (50)

SICKNESS ABSENCE
(All days lost as a percentage of those available)



Target	4.0%
May-22	5.5%
Variance Type	Metric is indicating a special cause of concern due to its high values
Assurance Type	Metric is consistently falling short of the target
What the chart is telling us	From August-2020 sickness absence has not met the target.

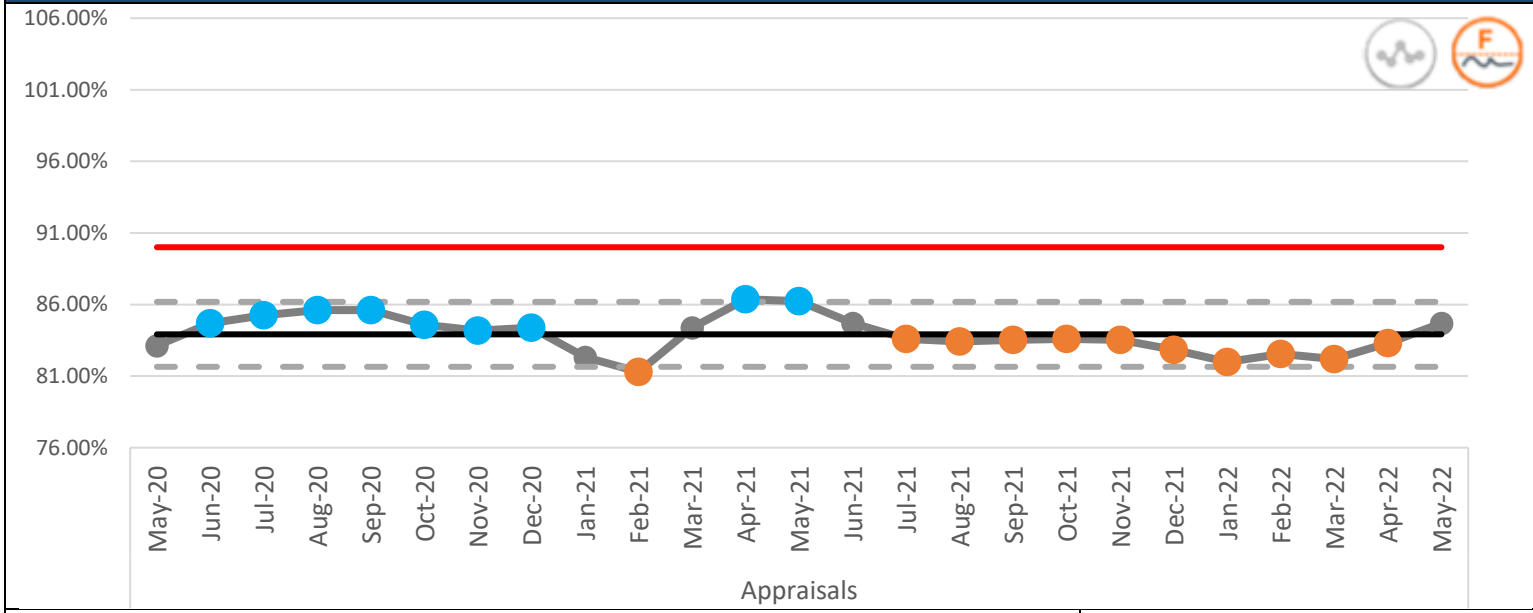
Lead: Mark Gwilliam, Director of Human Resources

Action Plan Timescales: H&WB offer in place for June 2022

Board Committee Providing Oversight: HR and OD Committee

Summary of current issues	Actions to recover performance
The monthly sickness absence figure is 5.48%.	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 also 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. We continue to develop and promote the Trust Health and Wellbeing offer as well as the resources available nationally. Colleagues have ongoing access to our 24/ telephone Employee Assistance Programme through Vivup we have launched a summer of menopause support and are promoting the resources we have available on financial well-being.

APPRAISALS
(Completed appraisals in last year)



Target	90%
May-22	85%
Variance Type	Metric is experiencing common cause variation
Assurance Type	Metric is consistently falling short of the target
What the chart is telling us	Appraisal rates have been consistently below target

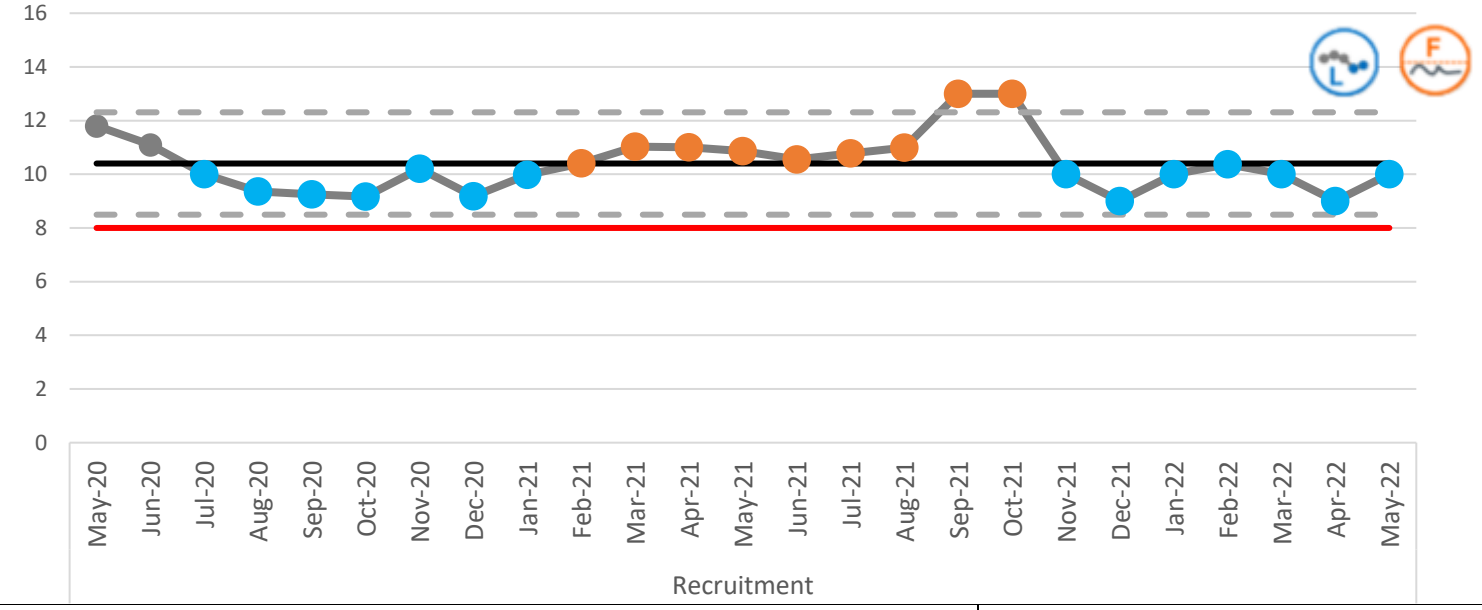
Lead: Mark Gwilliam, Director of Human Resources

Action Plan Timescales: Monitored Monthly against Directorate Plans

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 May 2022 is 85% linked to staff availability.	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.

RECRUITMENT
(Request to fill to unconditional offer)



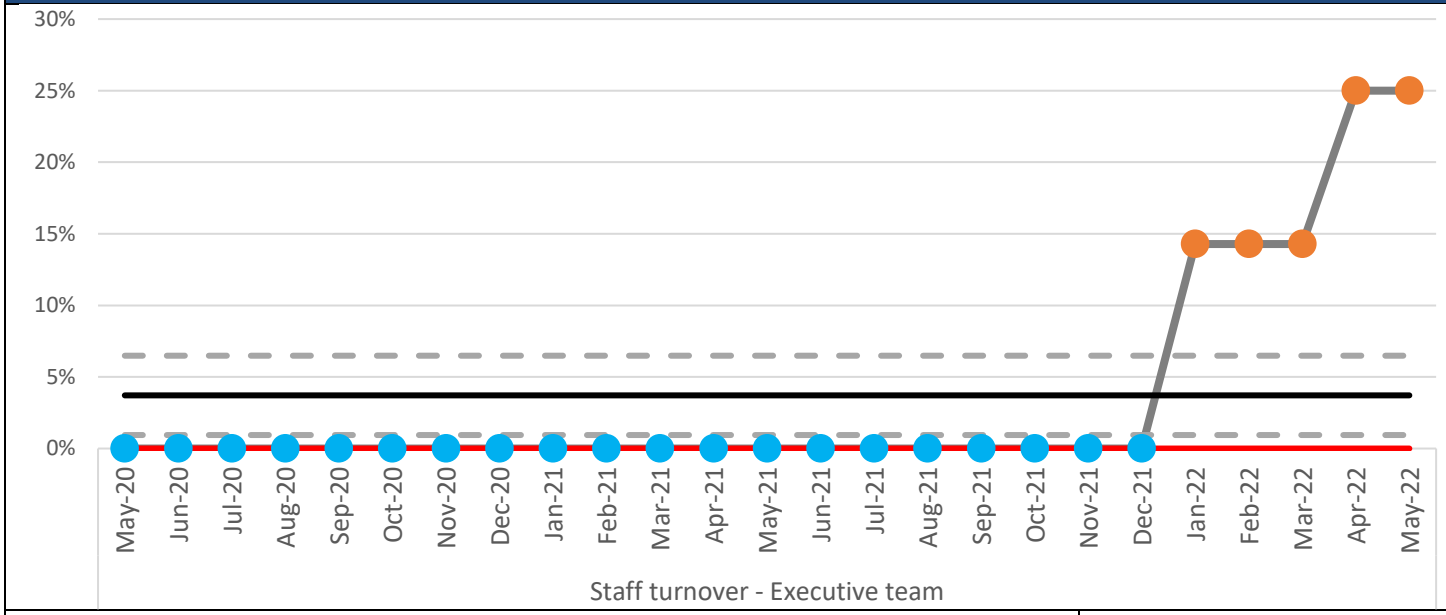
Target		8
May-22		10
Variance Type	L	Improvement in performance is not being achieved
Assurance Type	F	Metric is consistently falling short of the target
What the chart is telling us		Recruitment has been consistently above target

Lead: Mark Gwilliam, Director of Human Resources

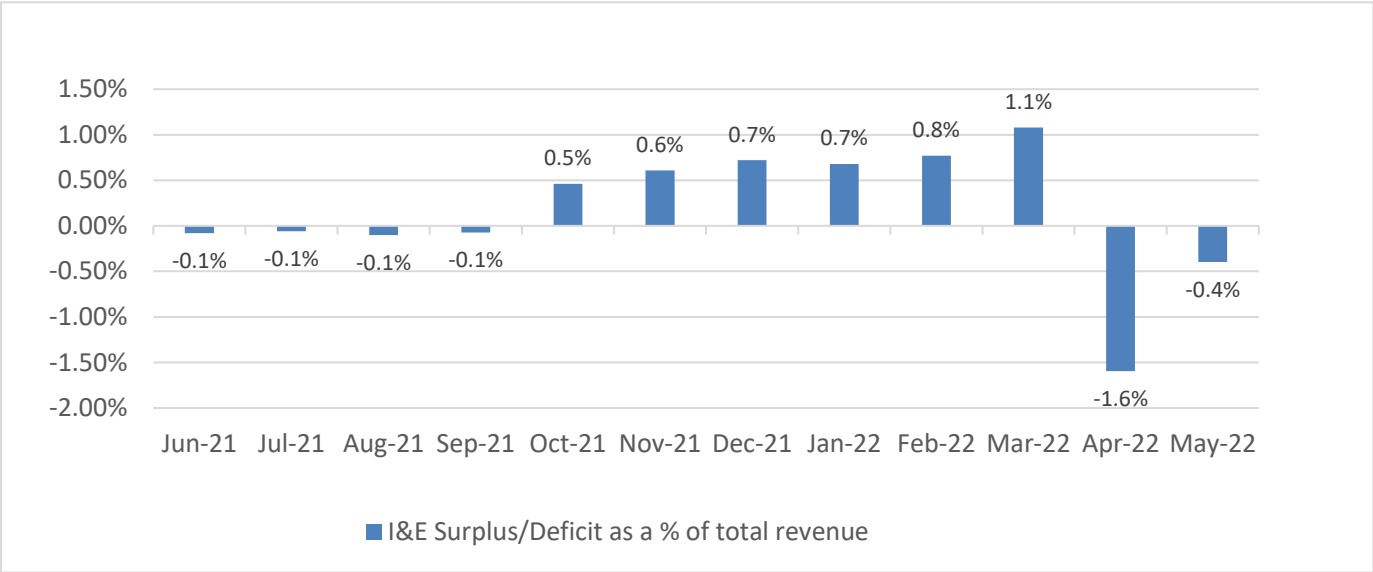
Action Plan Timescales: Achievement of target KPI 3 to 6 months from having a fully established team in place

Board Committee Providing Oversight: HR and OD Committee

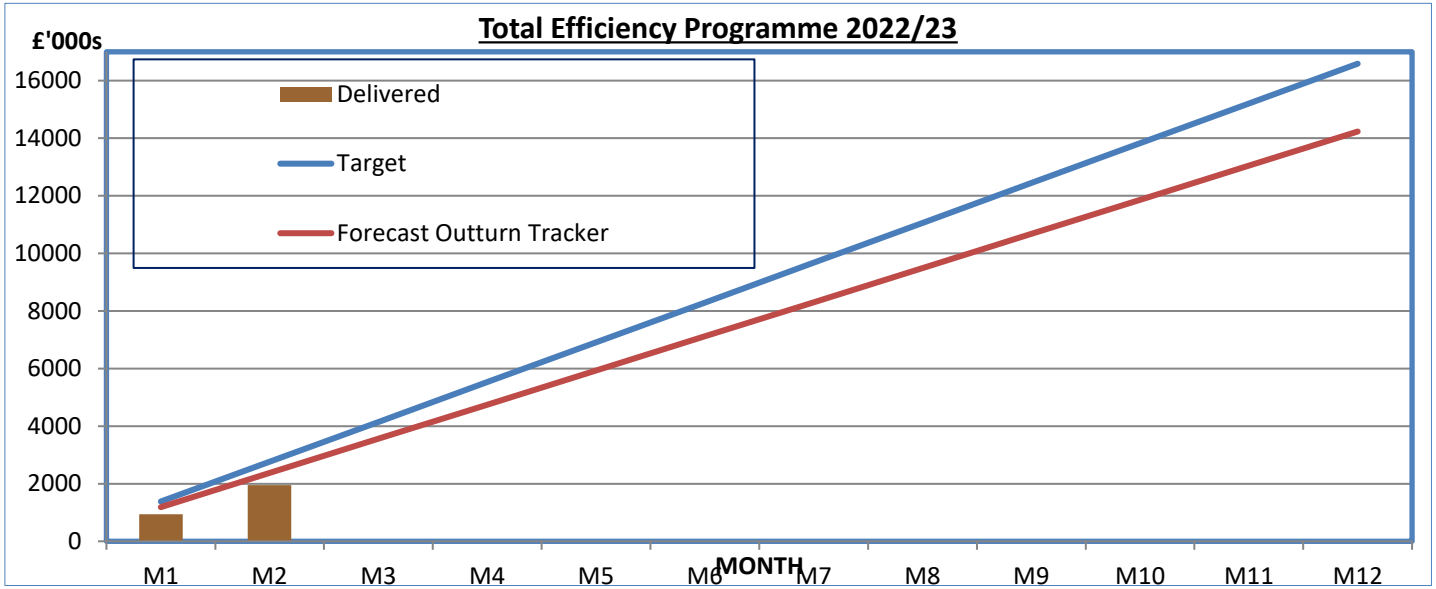
Summary of current issues	Actions to recover performance
• There is an overall increase in activity for both adverts and volume of appointed candidates • The recruitment team have been affected by increased absence levels and higher than normal turnover rates. • The effect of the pandemic has required ongoing work to reset and review processes. A significant process impact on timescales stems from challenges with accessing clearance documents from candidates which has been made more difficult during the course of the pandemic. This is being addressed through a revised candidate onboarding programme.	Process improvement programme in place with oversight from the Director of HR and Staff Development. Additional recruitment resource approved by TEG in response to increasing activity. Planning underway to expand service improvement work to include Trust managers once additional resource is in place.

STAFF TURNOVER (Number of leavers as a proportion of TEG members)		Target	0%
		Rolling 12 months to May-22	25%
		Variance Type	Rolling 12 months not suitable for SPC
		Assurance Type	Rolling 12 months not suitable for SPC
Lead: Mark Gwilliam, Director of Human Resources	**Action Plan Timescales**: Closed (Posts have been recruited)	What the chart is telling us	
Board Committee Providing Oversight: HR and OD Committee			

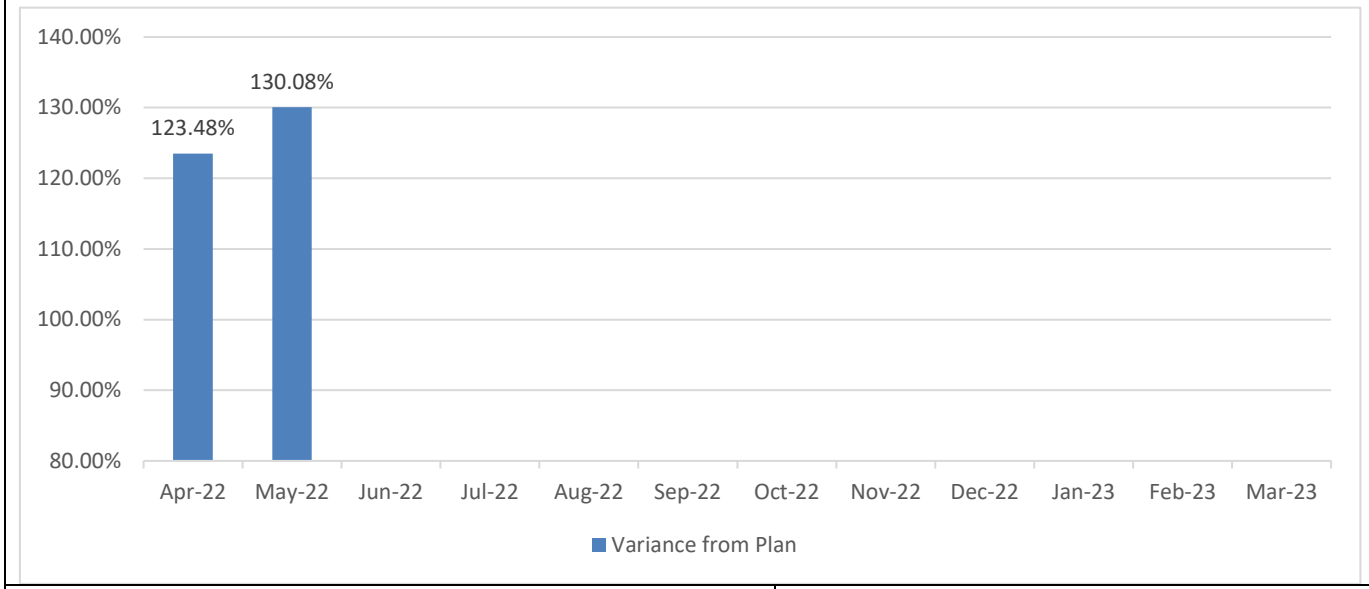
Summary of current issues	Actions to recover performance
The target of 0% turnover for the Executive team has not been met as a result of one colleague who left the Trust in December. Another colleague retired in February. The number of TEG colleagues increased from 7 to 8 in April.	No action required.

I & E MARGIN (I & E surplus/deficit as a percentage of total revenue)		
	**Target**	>= 0
	May-22	-0.4%
	Variance Type	Not applicable
	Assurance Type	Not applicable
	What the chart is telling us	The target for 22/23 is not being met.
Lead: Neil Priestley, Chief Financial Officer	**Action Plan Timescales**: Ongoing	
Board Committee Providing Oversight: Finance & Performance Committee		

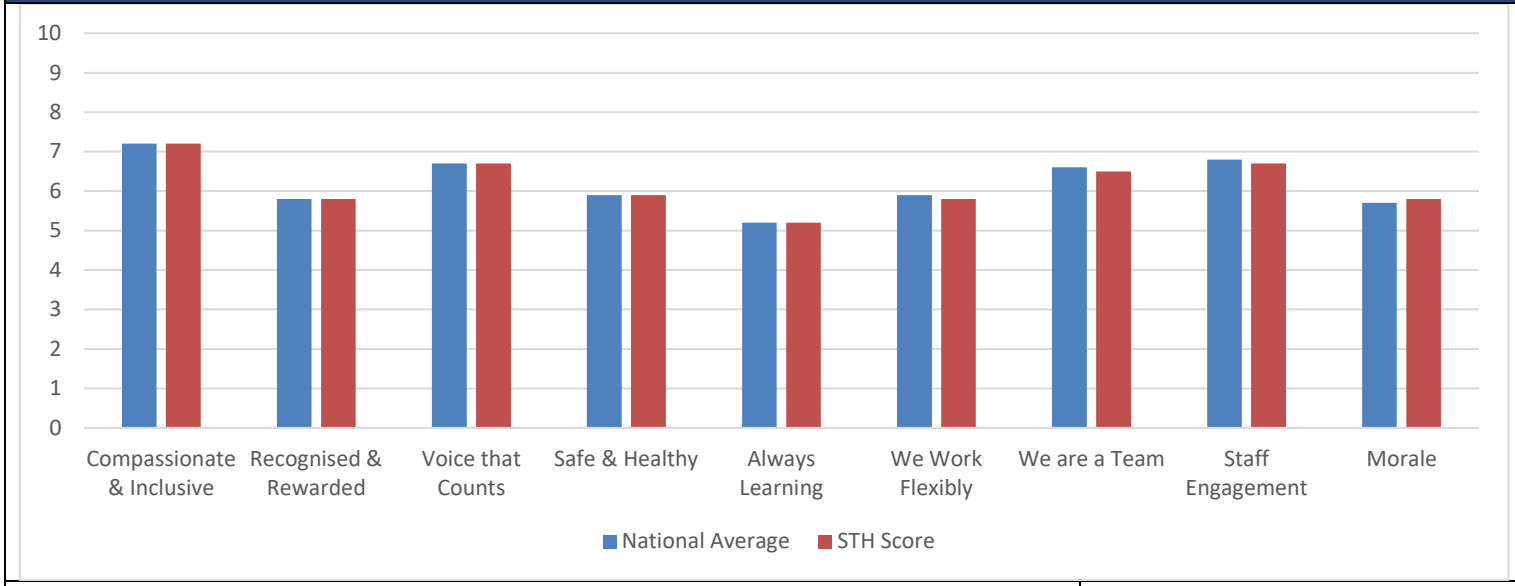
Summary of current issues	Actions to recover performance
The financial position at the end of May 2022 is a deficit of £847k and therefore the finance indicator which compares actual income with actual expenditure is rated Amber.	It should be noted that the Trust had a planned deficit position of £183k for M2 YTD, and therefore the more concerning element is that we are £664k behind plan. There is a deficit phasing to the plan early in the year to acknowledge the phasing of P&E planned delivery towards the later part of the year. The behind plan position is driven by under-delivery of P&E and other cost pressures driven by increased non elective activity at the Trust. A number of key actions are underway. • Directorates have been asked to ensure they have developed plans to deliver their full 1% P&E target for 2022/23 and tackle their bought forward under delivered balances. As the majority of the overspend sits in the directorate position, on the receipt of Month 3 information when we start to have more of a trend position, deep dives will be carried out in those directorates with the most financially challenged position.

EFFICIENCY Variance from Plan		
	**Target**	£2,765K
	Year to Mar	£1,956K
	Variance Type	Indicator monitored on an annual basis so SPC not appropriate.
	Assurance Type	Indicator monitored on an annual basis so SPC not appropriate.
	What the chart is telling us	The target for 22/23 is not being met.
Lead: Neil Priestley, Chief Financial Officer	**Action Plan Timescales**: May 2022	
Board Committee Providing Oversight: Finance & Performance Committee		

Summary of current issues	Actions to recover performance
For 2022/23 the trust has an efficiency target of 2% (£16,587k). The Directorates have been set a 1% target for the year, with the other 1% being delivered through Central schemes. Delivery year to date is £1,956k against a target of £2,765k (£809k and therefore 29% behind target). This shortfall is due to both insufficient P&E schemes being identified in the 22/23 Directorate plans, and an under-delivery year to date against the schemes identified.	Directorates have been formally set a 1% efficiency target for 22/23 – this has been reduced from a 2% target which was previously assumed, with the other 1% being picked up through central schemes. Cut 3 22/23 Efficiency Plans for Directorates identified £6.4m of schemes against a 1% target of £8.2m – representing a shortfall of £1.8m. CEO PMO meetings are in the process of being revamped for 22/23 – The focus has been on the drivers behind the shortfall against the 1% target and discussions on how 'nil value' and 'high risk' schemes identified can be worked up throughout the year to ensure further efficiency is delivered. Directorates have been asked to note the shortfall against P&E (where relevant) in their 22/23 Financial Plan with the expectation that the 1% target is fully delivered against.

CAPITAL EXPENDITURE (Variance from Plan)		
	**Target**	90-110% of plan
	May-22	130.08%
	Variance Type	Not applicable
	Assurance Type	Not applicable
	What the chart is telling us	The target for 22/23 is not being met.
Lead: Neil Priestley, Chief Financial Officer	**Action Plan Timescales**: July 2022	
Board Committee Providing Oversight: Finance & Performance Committee		

Summary of current issues	Actions to recover performance
Planned spend cumulatively was £3,098k. Actual cumulative spend to M2 was £4,013k. Slippage into 22/23 from schemes planned in 21/22 have resulted in earlier than planned spending in the current year (largely attributable to RHH B Road Resurfacing and Refurbishment of Wards H1 and H2 at RHH.)	Planned Q1 update in the next week which will enable an internal re-profiling of the capital spend plan.

STAFF SURVEY (National average or better in all 9 domains)		Target	0 domains below national average
		May-22	3
		Variance Type	Not Applicable. Insufficient data points for SPC
		Assurance Type	Not Applicable. Insufficient data points for SPC
Lead: Mark Gwilliam, Director of Human Resources	**Action Plan Timescales**: March 2023	What the chart is telling us	The Trust score is at the national average for 5 out of 9 domains. STH is higher than the National average in Morale.
Board Committee Providing Oversight: HR and OD Committee			

Summary of current issues	Actions to recover performance
The Trust score is at the national average for 5 out of 9 domains. STH is higher than the National average in Morale. The trust scored below average for three themes.	A comprehensive Trust level Staff Survey Action Plan has been drafted to address the outputs of the survey.

DEEP DIVE: CANCER WAITING TIMES

Over the years the Trust has had a relatively good performance record for several of the national cancer waiting time targets. However, like other NHS providers, performance has been adversely affected by the restrictions placed on activity due to COVID-19 and now the significant increase in demand for cancer care on top of recovering the paused care from the past two years. The impact on waiting times for patients is the key driver to make improvements as quickly as possible although the scale and complexity of the challenge cannot be underestimated.

National shortages in staffing across a number of professions which support the cancer pathways is one of major issues we are facing in terms of our ability to recover performance nationally and at our Trust.

In addition, as a tertiary centre for oncology care we are responsible for delivering care and many specialist services to a wider catchment than just Sheffield and so are impacted by the performance and timeliness of referrals from our partner referring hospitals. This means that a system wide response to reducing waiting times will be necessary and discussions are underway.

Delivering improvements in cancer waiting times presents a significant and growing challenge but it is one which is identified as a key priority and actions are underway and being overseen by the Trust Executive Group. A number of issues associated with cancer have already been discussed in detail by the Trust Executive in recent months, most notably the significant and complex issues impacting non-surgical oncology delivery within Weston Park Hospital and the wider network delivery of non-surgical oncology outpatients and chemotherapy (SACT) delivery.

Day-to-day oversight of Cancer services continues to be provided through the Cancer Triumvirate (Associate Medical Director – Cancer, Lead Cancer Nurse, Cancer Manager), Corporate Cancer Services and Trust's SRO for Cancer (Director of Strategy and Planning) as well as via existing corporate reporting arrangements to the Trust board. We maintain a strong operational relationship with the Integrated Care Board's Sheffield team, including their Clinical Director - Elective Care and Cancer, Clinical Director – Children, Young People and Maternity as well as Senior Cancer Commissioning Manager and Head of Commissioning – Elective Care

Response to the challenges to improve performance on waiting times

A review has been concluded to provide a clear picture of the current challenge for cancer delivery at directorate, tumour site pathway specific, and cross-cutting trust levels and this has been shared with trust operational and clinical leaders.

The areas of greatest challenge in terms of highest volume and biggest impact are:

- Breast Pathway (including Breast Symptomatic)
- GI Pathways (majority Lower GI)
- Urology Pathway
- Non-surgical oncology (Weston Park Hospital chemotherapy and radiotherapy)
- Diagnostics (radiology and histopathology)

Drivers for under-performance include, but are not limited to:

- Significant workforce gaps in key pathways in qualified (clinical/technical) and non-qualified (A&C) roles with challenges related to hard to recruit professions
- Significant workforce gaps in key support services (diagnostics, theatres etc).
- Higher than anticipated demand (sustained 2WW demand approximately double the expected year on year increase).

- Ongoing impact on elective pathways following (multiple) COVID waves and associated infection prevention control (IPC) changes/capacity restrictions, which, although largely now lifted, have a residual impact.
- Inability to deliver current best practice timed pathways in key high-volume pathways.

A number of priority workstreams have been identified to take forward solutions which will support the recovery of waiting times:

- Workforce planning: work to fill gaps in key areas; and consideration of different and new roles
- Demand and capacity (determining whether existing resource is being utilised effectively)
- Recruitment and retention
- Skill mix review
    - Targeted non-surgical oncology recovery and improvement work, including future recruitment of an Improvement Director and associated support
- Data quality/administrative support
- Radiology and histopathology turnaround times/review and development of associated operational processes to support identification and escalation of patients on/at risk of a prolonged pathway.
- Development of a wider Trust cancer culture and education program.
- Review of the corporate model supporting cancer delivery at STH
    - Governance structures and accountability
    - Links/accountability for MDT/cancer site leads
    - STH Cancer Executive membership and function
    - Corporate cancer services support

Additionally, we are receiving support from the NHSE regional team as part of the Tier 2 national Elective Recovery plan process. This particularly focusses on delivering against the national targets of reducing the cancer 62 day backlog back to pre-pandemic levels by March 2023 and reducing the number of 78 week elective long waiters to zero by April 2023.

Cancer recovery actions are also now aligned with the work of the newly established Patient Care Recovery Plan workstream, led by the Operations Improvement Director. The planned trajectory is to have no more than 180 2WW >62 days pathways by March 2023 and expect to deliver the contracted position of a return to our February 2020 baseline of no more than 223 2WW pathways > 62 days, the agreed STH contribution to the South Yorkshire and Bassetlaw system baseline of 349 2WW pathways, by March 2023. Our aim is to have no patients waiting more than 104 days from referral to first definitive treatment for cancer.
It is expected the waiting time performances will begin to improve from Autumn 2022.

Current performance

Table 1: Cancer waiting times performance (M2/Q1 provisional)

Standard	Compliance threshold	Month 10 January 2022	Month 11 February 2022	Month 12 March 2022	Q4 2021/22	Month 1 April 2022	Month 2* May 2022	Q1* 2021/22
28 day Faster Diagnosis	75%	61.8%	73.5%	66.4%	67.2%	64.7%	63.3%	64.0%
Two Week Wait	93%	82.8%	93.0%	91.5%	89.4%	87.0%	81.8%	83.2%
Breast Symptomatic (Two Week Wait)	93%	6.7%	6.8%	1.5%	5.0%	0.0%	4.1%	2.7%
31 Day First Definitive Treatment	96%	87.6%	93.4%	91.1%	90.7%	88.3%	85.9%	86.3%
31 Day Subsequent Treatment Radiotherapy	94%	97.3%	96.0%	95.1%	96.1%	90.7%	93.3%	91.5%
31 Day Subsequent Treatment Anti-Cancer Drug	98%	95.9%	98.4%	97.1%	97.1%	93.7%	96.5%	94.4%
31 Day Subsequent Treatment Surgery	94%	68.5%	64.9%	64.9%	66.1%	66.4%	66.7%	65.1%
62 Day Standard	85%	51.2%	56.6%	61.0%	57.6%	59.8%	45.4%	47.5%
62 Day Standard (STH only pathways)		54.7%	65.7%	67.1%	62.8%	66.4%	50.7%	52.3%
62 Day Screening	90%	35.9%	71.0%	65.4%	57.5%	61.5%	54.5%	50.0%
62 Day Consultant Upgrade Standard	*No Operational Standard*	76.1%	67.5%	62.9%	69.9%	55.4%	47.0%	49.4%

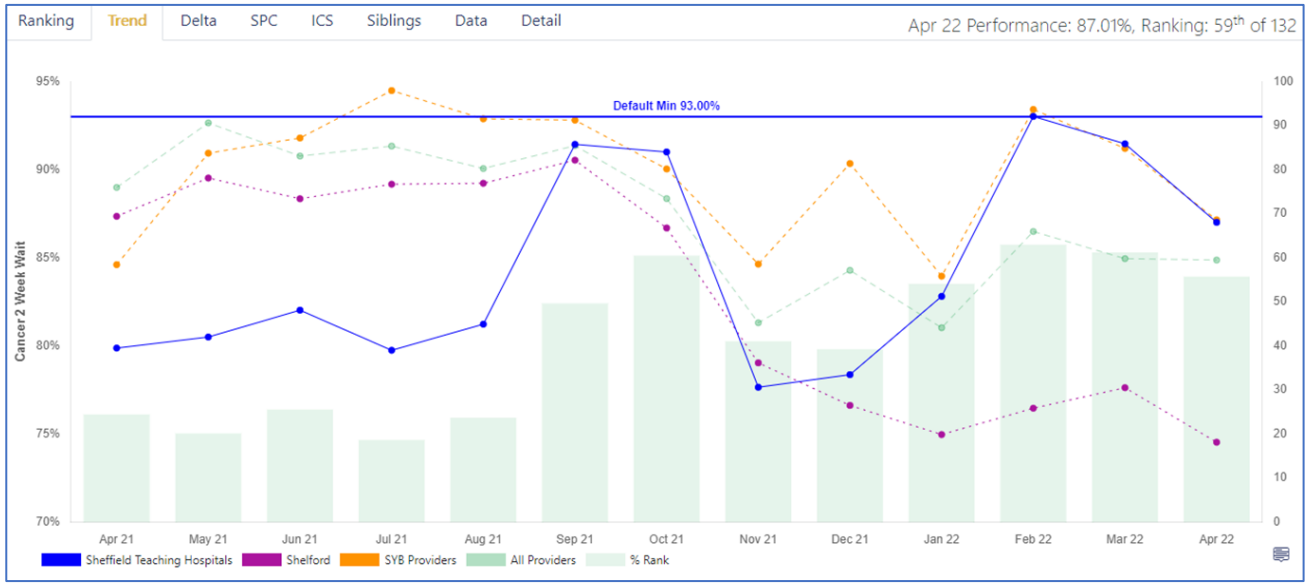
The total number of patients on the cancer patient treatment list (PTL) remains high and is approximately double pre-pandemic volumes. National guidance on a sustainable position is for a 62 day PTL to be in the region of three times weekly two week wait (2WW) demand but the current figures put this closer to six times weekly 2WW demand. A key driver of this position is a significant increase in 2WW demand seen since January 2022 (Table two).

Table 2: 2 Week Wait demand

	2019	2020			2021					2022						
	ERS Requests	ERS Requests	Change to previous year		ERS Requests	Change to previous year		Change to 2019		ERS Requests	Change to previous year		Change to 2019		Change to 2020	
2WW Brain	24	17	-7	-29.17%	31	14	82.35%	7	29.17%	16	-15	-48.39%	-8	-33.33%	-1	-5.88%
2WW Breast	2679	2111	-568	-21.20%	2807	696	32.97%	128	4.78%	2818	11	0.39%	139	5.19%	707	33.49%
2WW Gynaecology	826	684	-142	-17.19%	898	214	31.29%	72	8.72%	1122	224	24.94%	296	35.84%	438	64.04%
2WW Haematology	86	82	-4	-4.65%	113	31	37.80%	27	31.40%	109	-4	-3.54%	23	26.74%	27	32.93%
2WW Head and Neck	660	551	-109	-16.52%	606	55	9.98%	-54	-8.18%	662	56	9.24%	2	0.30%	111	20.15%
2WW Lower GI	2095	1835	-260	-12.41%	2180	345	18.80%	85	4.06%	2660	480	22.02%	565	26.97%	825	44.96%
2WW Lung	270	173	-97	-35.93%	221	48	27.75%	-49	-18.15%	277	56	25.34%	7	2.59%	104	60.12%
2WW Sarcoma	55	37	-18	-32.73%	56	19	51.35%	1	1.82%	39	-17	-30.36%	-16	-29.09%	2	5.41%
2WW Skin	2461	1816	-645	-26.21%	2588	772	42.51%	127	5.16%	2899	311	12.02%	438	17.80%	1083	59.64%
2WW Upper GI	911	767	-144	-15.81%	984	217	28.29%	73	8.01%	1072	88	8.94%	161	17.67%	305	39.77%
2WW Urology	1144	1016	-128	-11.19%	1155	139	13.68%	11	0.96%	1395	240	20.78%	251	21.94%	379	37.30%
Totals	**11211**	**9089**	**-2122**	**-18.93%**	**11639**	**2550**	**28.06%**	**428**	**3.82%**	**13069**	**1430**	**12.29%**	**1858**	**16.57%**	**3980**	**43.79%**

In summary the 2WW demand has been significantly higher in 2022 compared to 2021 (year on year increases usually average 3-4%), with far higher than expected volumes in gynaecology, haematology, lower GI and urology.

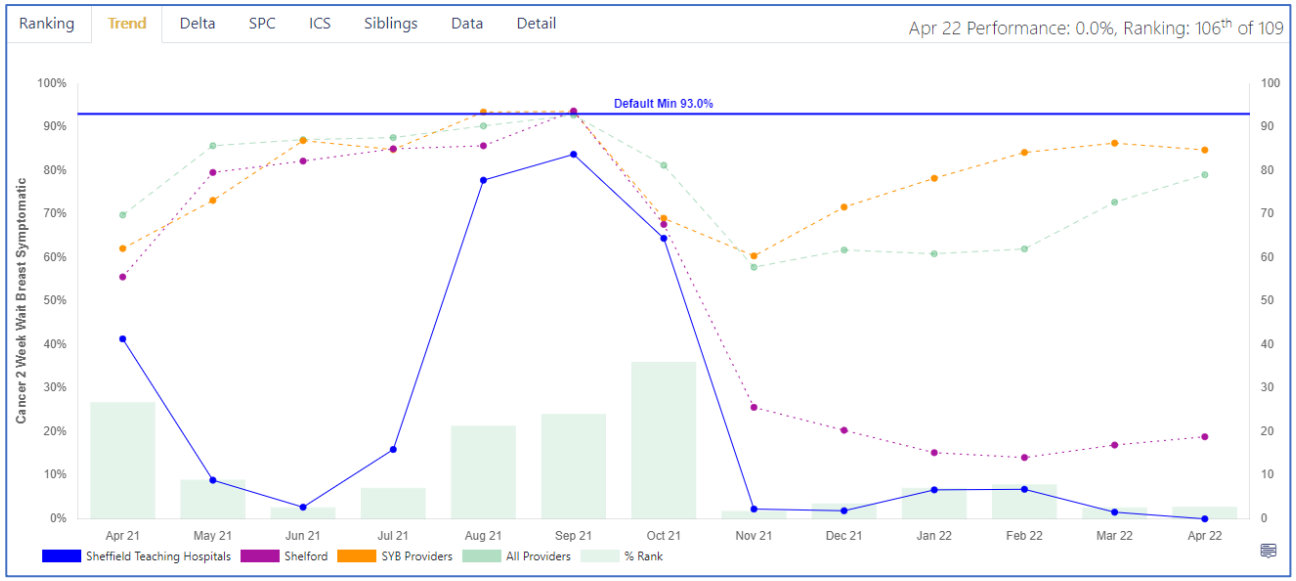
Chart 3: Two Week Wait performance



This high demand coupled with the ongoing limitations in capacity, due to COVID infection control measures has resulted in a significant reduction in overall 2WW performance.

However, STH performance is in-line with other Cancer Alliance providers, and we are performing favourably compared with Shelford peers and the national position as shown on the chart opposite.

Chart 4: Breast symptomatic performance

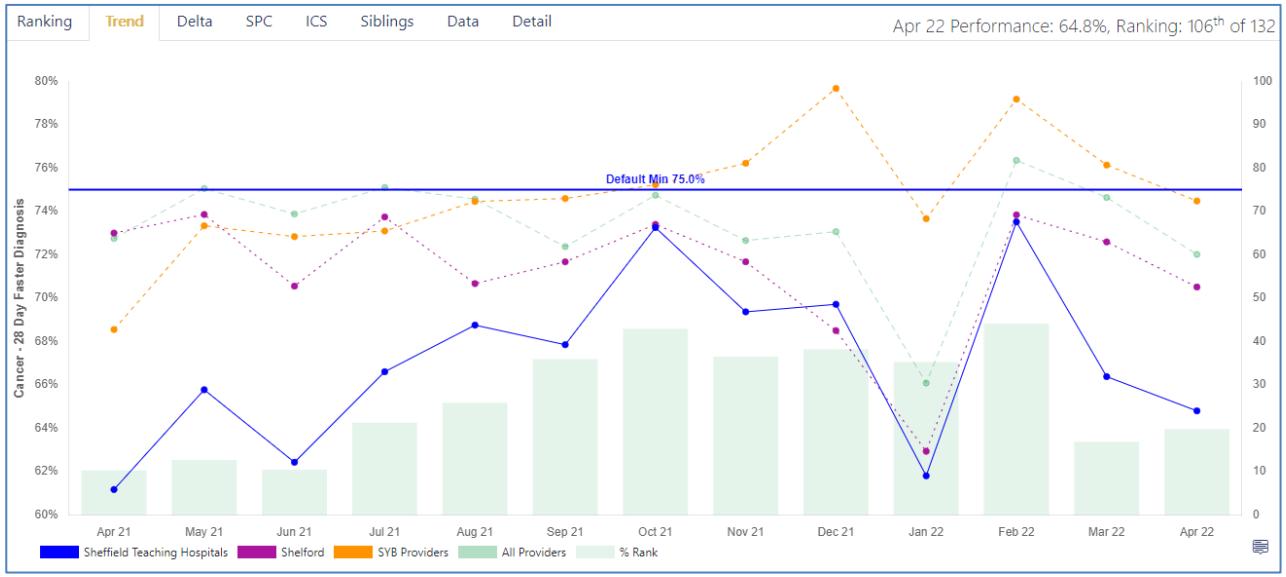


Significant capacity challenges in the breast service, predominantly due to radiology capacity, has resulted in a clinical prioritisation of the breast 2WW pathway resulting in a marked deterioration in performance on the symptomatic pathway. Work continues to recruit, though this is a nationally hard to recruit profession and work to provide capacity and support from across the ICS.

Triage and risk stratification in this cohort of patients (cancer not suspected) is in place and effectively mitigating clinical risk due to longer than expected waits.

Note: The Breast Symptomatic pathway is where ***cancer is not suspected***, but who also follow a 2ww target for referral.

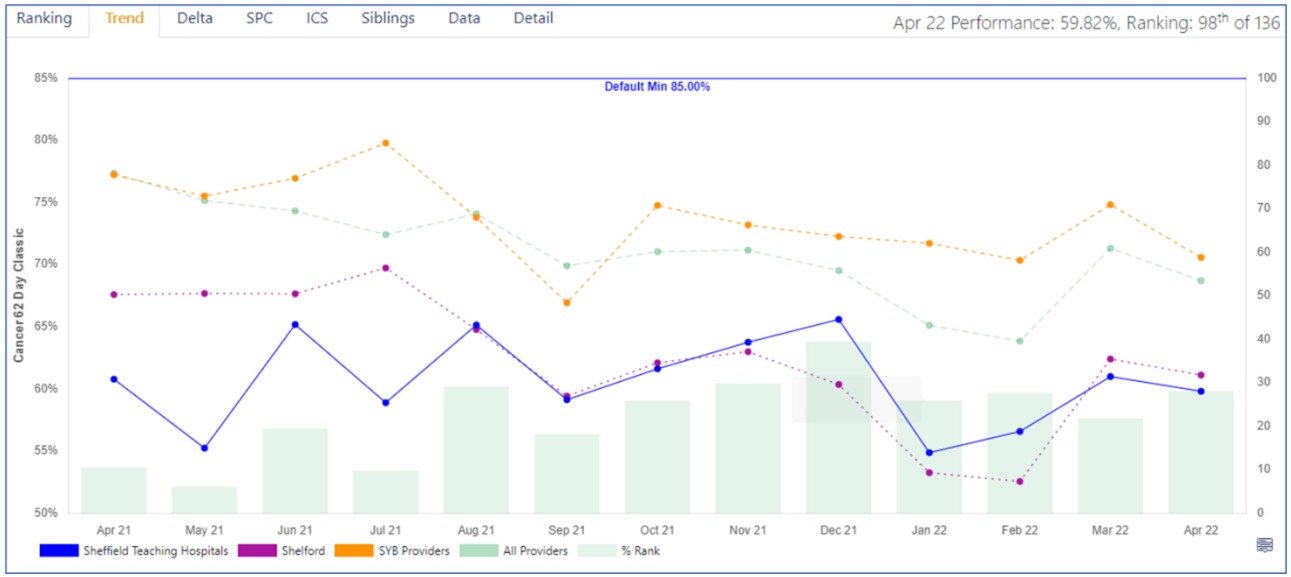
Chart 5: Faster diagnosis standard



Recovery actions to address the current long-waits position have already led to improvements with STH tracking in-line with national trends. However, performance in lower GI and urology, as well as breast symptomatic, need to improve further to meet the threshold.

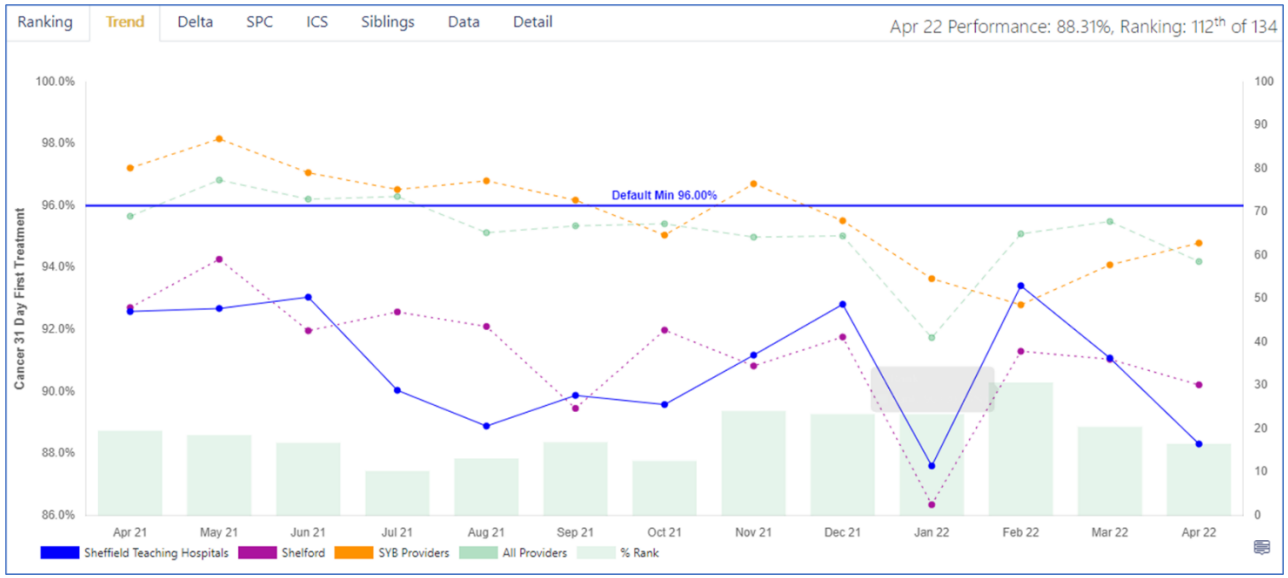
Recovery actions include specific breast, GI and urology pathway workstreams with a focus on rapid diagnostics and faster diagnosis performance.

Chart 6: GP 62 Day standard



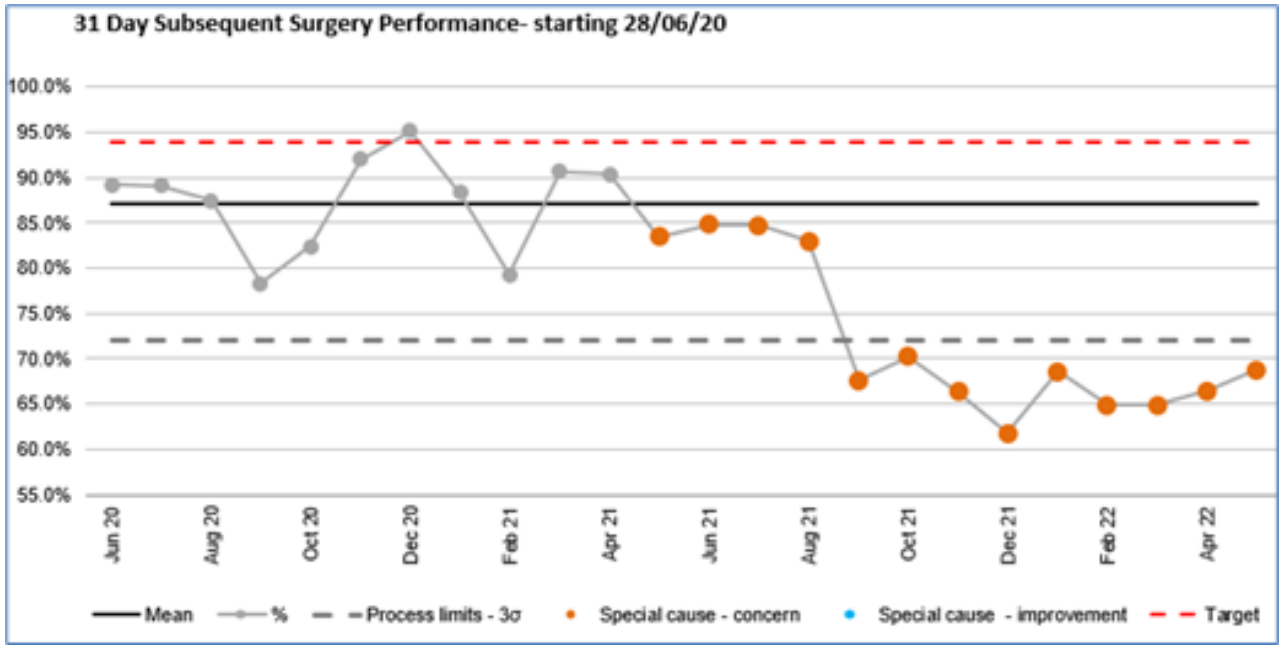
62 day performance continues to fluctuate in-line with national trends. Sustained recovery will not be seen until our long-waits position has also reduced further.

Chart 7: 31 Day First Definitive Treatment



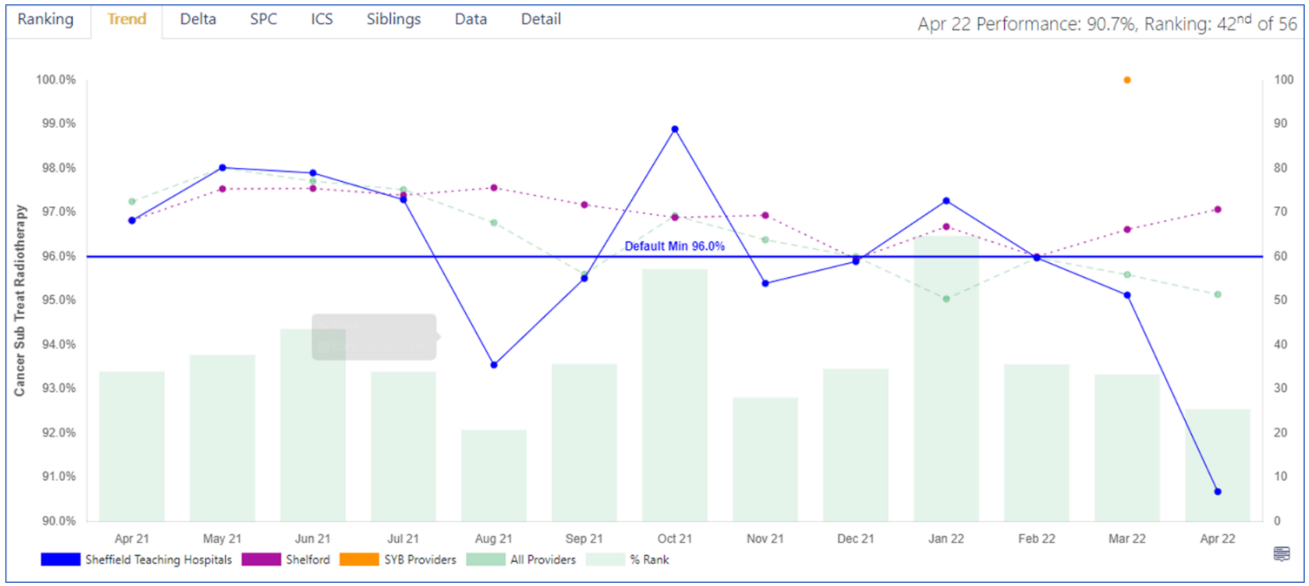
31 day performance continues to fluctuate in-line with national trends. There are particular challenges in non-surgical oncology pathways as well as gynae surgical pathway and theatres provision due to staff vacancies in hard to recruit professions.

Chart 8: 31 Day Subsequent Treatment Surgery



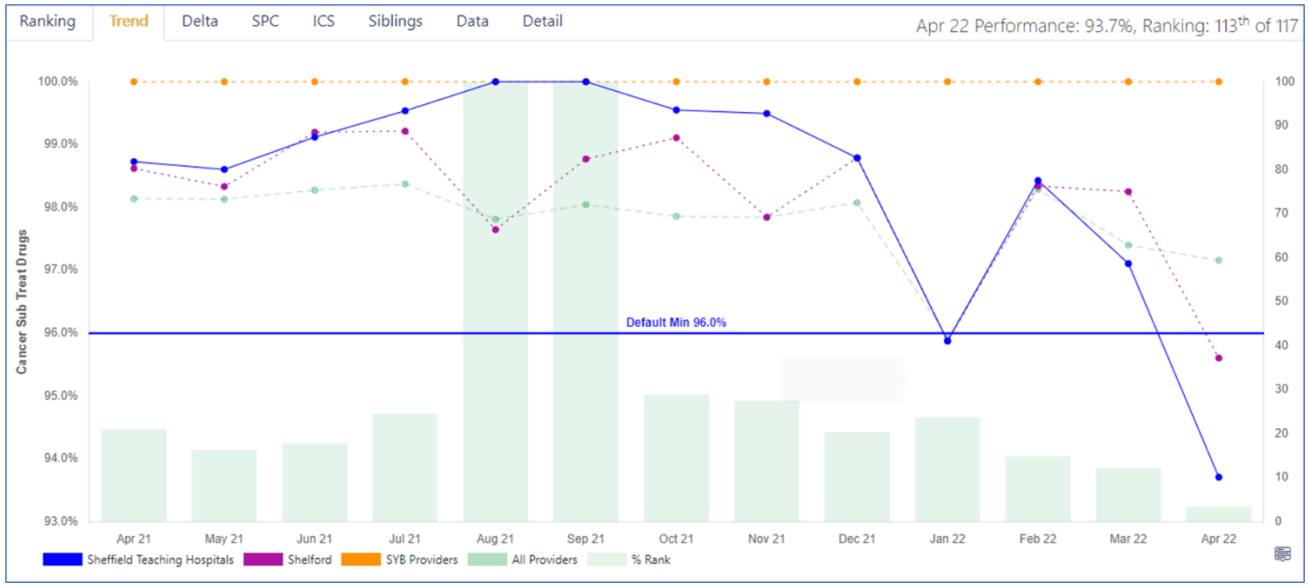
As described above there has been a significant impact on surgical capacity as a result of the pandemic and this has resulted in a similar deterioration against the subsequent surgical standard as that seen in surgical first treatment pathway.

Chart 9: 31 Day Subsequent Treatment Radiotherapy



Reduced capacity as a result of clinical and technical staff vacancies has adversely impacted performance and actions are identified to address the position.

Chart 10: 31 Day Subsequent Treatment Anti-Cancer Drug



High demand coupled with the challenges within non-surgical oncology pathways have seen a deterioration in performance, although this remains broadly in-line with Shelford Group peers.

62 Day Screening (Position = Stable) **62 Day Consultant Upgrade (Position = Stable)**	Screening and Consultant Upgrade performance remains volatile owing to a low denominator.
Day 38 Inter-provider Transfer (IPT) (Position = Stable)	Although not a reported cancer waiting time metric, IPT after day 38 has an adverse impact on the achievement of the 62 day targets and adversely impacts on the long-wait position. Roughly 50% of all IPTs from Cancer Alliance trusts occur beyond day 38. Actions for improving diagnostic flow and early transfer to STH are regularly discussed through Integrated Care Board forums including oversight at South Yorkshire Cancer Alliance Board.

Conclusion

Delivering improvements in cancer waiting times presents a significant and growing challenge but it is one which is identified as a key priority and recovery actions are underway and being overseen by the Trust Executive Group. Some improvements have been made. The impact on waiting times for patients is the key driver to make further improvements as quickly as possible although the scale and complexity of the challenge cannot be underestimated as outlined above.

We continue to seek the support and work collaboratively with place, system, and regional partners to address areas which are impacted by their individual or collective performance.

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)

DI&EN	Diabetes & Endocrinology	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.
PHAR	Pharmacy	
ICC	Integrated Community Care	
TH&P	Therapeutics and Palliative Care	
NEUR	Neurosciences	
OPHT	Ophthalmology	
LABM	Laboratory Medicine	
M&MP	MIMP	
GSUR	General Surgery	
PLAS	Plastic Surgery	
UROL	Urology	
GAST	Gastro and Hepatology *	
IG&SM	Geriatric and Stroke Medicine	
ENT	ENT	

PMF Level 2 Directorates (Watching Brief)

RESP	Respiratory Medicine	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
OR&DE	Oral & Dental Services	
MSK	MSK	
CARD	Cardiac Services	
RENA	Renal Services	
CD&S	Communicable Diseases and Specialised Medicine	
SCS	Specialised Cancer Services	
CRCA	Critical Care *	
SP&R	Specialised Rehabilitation	

PMF Level 3 Directorates (Highest Priority)

EmCr	Emergency Medicine	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.
OGN	Obstetrics, Gynaecology & Neonatology	
OPA	Operating Services & Anaesthetics	
VASC	Vascular Services	

Indicator	Metric	DI&E *R	EmCr *R	GAST *R	PHA *R	RESP *R	ICC *R	IG&S *R	TH& *R	OR& *R	ENT *R	NEU *R	OPHT *R
MRSA bacteraemia	Hospital onset												
MSSA bacteraemia	Hospital onset												
C.diff	Hospital onset												
Serious Incidents	Approved SI Report submitted within timescales												
	Number of serious incidents (SI)	1						1		2			3
Incidents*	Number of finally approved incidents based on incident date	88		46	21	81	125	280	46	50	18	74	11
	Percentage of incidents approved within 35 days based on approval date												
Average Length of Stay (by discharges)**	Average Length of Stay Elective												
	Average Length of Stay Non Elective												
Never Events	Number of never events												
18 weeks RTT*	Percentage of admitted patients treated within 18 weeks (90%)												
	Percentage of non-admitted patients treated within 18 weeks (90%)												
	Percentage of patients on incomplete pathways waiting less than 18 weeks												
52 week waits	Actual numbers												
6 week diagnostic waiting*	Percentage of patients seen within 6 weeks												
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												
	Breast symptomatic seen within 2 weeks												
	62 days from referral to treatment (GP referral)												
	31 day first treatment from referral												
e-Referral Service	Percentage of eligible GP referrals received through Electronic Referral Service												
Ethnic group data collection	Percentage of inpatient admissions 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 closed within agreed timescales												
FFT Recommended	Patients recommending STH for Inpatient treatment												
Day surgery rates	Aggregate percentage of all BADS procedures recommended to be treated as day case or												
Mixed Sex Accommodation	Number of breaches of Mixed Sex Accommodation standard												
Sickness Absence	All days lost as a percentage of those available												
Appraisals**	Completed appraisals in last year												
Mandatory Training**	Overall percentage of completed mandatory training												
I & E	YTD actual I & E surplus/deficit in comparison to YTD plan I & E surplus/deficit												
Contract Performance	Variance from plan												
Efficiency	Variance from plan												

Indicator	Metric	LABM *R	MI&M *R	OGN *R	Msk *R	OPA *R	CRCA *R	CRCA V	CARD *R	RENA *R	VAS *R	CD&S *R	SP&R *R	SCS *R	GSUR *R	PLAS *R	UROL *R
MRSA bacteraemia	Hospital onset							0									
MSSA bacteraemia	Hospital onset							0									
C.diff	Hospital onset							0									
Serious Incidents	Approved SI Report submitted within timescales																
	Number of serious incidents (SI)			9	3	2		0		1	3	1				1	
Incidents*	Number of finally approved incidents based on incident date	67	49	176	141	61	34	#	81	70	24	89	30	93	125	19	40
	Percentage of incidents approved within 35 days based on approval date																
Average Length of Stay (by discharges)**	Average Length of Stay Elective																
	Average Length of Stay Non Elective																
Never Events	Number of never events							0									
18 weeks RTT*	Percentage of admitted patients treated within 18 weeks (90%)																
	Percentage of non-admitted patients treated within 18 weeks (90%)																
	Percentage of patients on incomplete pathways waiting less than 18 weeks																
52 week waits	Actual numbers							0									
6 week diagnostic	Percentage of patients seen within 6 weeks																
Cancelled Operations	Number of operations cancelled on the day for non clinical reasons							0									
	Number of patients cancelled on the day and not readmitted within 28 days							0									
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Appraisals**	Completed appraisals in last year							1									
Mandatory Training**	Overall percentage of completed mandatory training							1									
I & E	YTD actual I & E surplus/deficit in comparison to YTD plan I & E surplus/deficit							0									
Contract Performance	Variance from plan																
Efficiency	Variance from plan																

Performance is YTD unless specified:

* Last complete month

** Rolling 12 months

*** Last complete quarter

R – Reliability
V – Validity
A - Accuracy