

Executive Summary

Report to the Board of Directors

Being Held on 31 January 2023

Subject	Integrated Performance Report
Supporting TEG Member	Michael Harper, Chief Operating Officer
Author	Performance and Information Team
Status¹	D&N

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.

KEY POINTS

- This report assesses key performance indicators against their targets for November 2022 and October 2022.
- An exception report will be provided for indicators not meeting their target, unless stated otherwise in the executive summary.
- The deep dive in this report will be covering mandatory and job specific essential training.

IMPLICATIONS²

Aim of the STHFT Corporate Strategy		✓ 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	Create a Sustainable Organisation	✓
6	Deliver Excellent Research, Education and Innovation	✓

RECOMMENDATIONS

The Board is asked to:

- Receive the Integrated Performance Report for October 2022 and November 2022.
- Note the performance standards that are being achieved.
- Be assured that where performance standards are not currently met, a detailed analysis has been undertaken and actions are in place to ensure an improvement is made.

Comment on the revised approach to ensure easier reference to those metrics where pandemic recovery actions are being focussed.

APPROVAL PROCESS

Meeting	Date	Approved Y/N
Trust Executive Group	18 January 2023	
Board of Directors	31 January 2023	

¹ Status: A = Approval
A* = Approval & Requiring Board Approval
D = Debate
N = Note

² Against the six aims of the STHFT Corporate Strategy 'Making a Difference – The next Chapter 2022-27'



INTEGRATED PERFORMANCE REPORT



BOARD OF DIRECTORS
31 January 2023



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The full performance report against all of the tracked metrics is provided here as standard practice. Since the start of the pandemic, in line with the whole NHS, performance against national targets has proved extremely challenging. We have previously discussed and agreed at Board of Directors that continued reporting and remedial actions should continue. However, in line with clearly stated national priorities, this Executive Summary will now provide a synopsis relating to a number of key metrics that have been prioritised for recovery and our own internal Getting Back on Track programme of work. The exception reports have also been reordered to provide these metrics first.

Ambulance waits

Percentage of ambulance handovers in excess of 30 minutes – 83.83% of ambulance handovers were completed within 30 minutes in November 2022, compared to 81.73% in October 2022. The national standard changed in April 2022 from 100% within 30 minutes to 95% within 30 minutes.

Percentage of ambulance handovers in excess of 60 minutes – 11.73% of handovers took longer than 60 minutes in November 2022, compared with 14.03% in October 2022.

Activity recovery

New Attendances - There were 31,490 new outpatient attendances in November 2022, which was 97.1% of the activity delivered in November 2019. Year to date for 2022/23 there have been 225,091 new outpatient attendances, which is 88.0% of the YTD activity for 2019/20.

Follow up Attendances - There were 72,299 follow up outpatient attendances in November 2022, which was 106.3% of the activity delivered in November 2019. Year to date for 2022/23 there have been 518,620 follow up outpatient attendances, which is 97.4% of the YTD activity for 2019/20.

Elective inpatients - There were 1,801 elective inpatient spells in November 2022, which was 90.6% of the activity delivered in November 2019. Year to date for 2022/23 there have been 12,890 elective inpatient spells, which is 83.8% of the YTD activity for 2019/20.

Daycases - There were 11,512 daycases in November 2022, which was 102.6% of the activity delivered in November 2019. Year to date for 2022/23 there have been 86,110 daycases completed, which is 98.1% of the YTD activity for 2019/20. Daycase activity in November accounted for 86.5% of total Elective work, against a target of 85%.

Theatre Efficiency – November 2022 had Theatre Utilisation of 88.3% against an 85% target.

Non-elective inpatients - There were 5,590 non elective spells in November 2022 which was 103.8% of the activity delivered in November 2019. Year to date there have been 42,411 inpatient non elective spells, which is 98.7% of the YTD activity for 2019/20.

Bed nights – There were 39,343 bed nights for elective and non-elective patients in November 2022, this compares to 40,120 bed nights in November 2019. Work is underway to improve the quality of data on bed occupancy.

Cancer care – 43.3% of cancer patients were seen for their first definitive treatment within 62 days of a GP referral in November 2022 compared to 46.0% in October 2022. Performance for the same metric in Q2 2022/23 was 48.9%.

52-week breaches – There were 3,391 52-week (incomplete RTT pathway) breaches in November 2022, compared to 3,363 in October 2022. These patients are being prioritised for scheduling as quickly as possible. The national deadline for elimination of 52-week breaches is March 2025.

78-week breaches – There were 610 78-week breaches in November 2022 compared to 573 in October 2022. These patients are being prioritised for scheduling as quickly as possible. The national deadline for elimination of 78-week breaches is March 2023.

104-week breaches - There were 43 patients waiting more than 104 weeks in November 2022, compared to 31 in October 2022. This is against a target of zero. These patients have either elected not to go elsewhere to receive earlier care or they are extremely complex pathways.

Sickness absence

Total absence was at 5.61% in November 2022, compared to 5.76% in October 2022 against the target of 4%. Of the total absence, COVID absence represented 0.63% in November 2022.

Delivery against financial plan

The position at Month 8 is £908k (0.1%) adverse against plan. The £908k YTD overspend shows a deterioration from the month 7 position of £564k, which is a bigger deterioration than in previous months. This includes some one-off items, but also an overall deterioration within directorate positions.

There is an underperformance against the efficiency target. The month 8 delivery is £9.1m against the £11.1m target, a shortfall of £1.9m (17.5%), along with under delivery of prior year targets.

Overall Pay is £4.4m (0.8%) under spent with a Medical & Dental overspend of £2.4m and Nurses and Midwives underspend of £4.4m. The underspend across other remaining staff groups to date totals £2.4m.




There is an overspend on Non-Pay at Month 8 of £7.5m (2.2%). £3.4m of this relates to High-Cost Drugs, for which we are re-imbursed for within income and therefore is not a concern, and £1.4m is an overspend on offsite activity expenditure as part of Trust recovery.

At Month 8 27 out of 37 Directorates are behind plan, and of these 10 have deficits more than 3% of year-to-date budgets. The overall position across Directorates further declined in November to a deficit of £10.8m.

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 November, the Trust has delivered 96% of the value of activity delivered in M8 of 2019/20. An assumed clawback of ERF has not been included in the position for Month 8 and it has been confirmed that there will be no clawback for H1. Whilst not confirmed, any H2 clawback is unlikely due to levels of COVID being much higher than anticipated in the Planning Guidance (which was written on the assumption of low levels of COVID prevalence).

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 may require repayment of Elective Recovery Funding.

The Trust Performance overview is provided for the months of October 2022 and November 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

				Current Reporting Period				Previous Reporting Period			
Indicator	Measure	Standard	Target Type	Data Range	*R	*V	*A	Data Range	*R	*V	*A
Deliver The Best Clinical Outcomes											
CQC Compliance	Outcome of CQC inspection	Good in all five domains	SOF	Jul-22				Jun-22			
				Current Reporting Period				Previous Reporting Period			
Indicator	Measure	Standard	Target Type	Data Range	*R	*V	*A	Data Range	*R	*V	*A
Deliver The Best Clinical Outcomes											
Hospital Mortality	Hospital Standardised Mortality Ratio	As expected or lower	SOF	Sep-2021 to Aug-2022				Aug-2021 to Jul-2022			
	Summary Hospital-level Mortality Indicator	As expected or lower	SOF	Aug-21 to Jul-22				Jul-21 to Jun-22			
MRSA bacteraemia	Hospital onset	Zero cases	SOF	Nov-22				Oct-22			
MSSA bacteraemia	Hospital onset	63 per year	SOF	Q3 22/23				Q2 22/23			
C.diff	Hospital onset	112 per year (28 per quarter)	SOF	Q3 22/23				Q2 22/23			
	Community onset/ healthcare associated	36 per year (9 per quarter)	SOF	Q3 22/23				Q2 22/23			
E.coli	Community onset/ healthcare associated	84 per year (21 per quarter)		Q3 22/23				Q2 22/23			
	Hospital onset	136 per year (34 per quarter)	SOF	Q3 22/23				Q2 22/23			
Serious Incidents	Number of serious incidents (SI)	Number	Local	Nov-22				Oct-22			
	Approved SI Report submitted within timescales	No overdue reports	Local	Nov-22				Oct-22			
Incidents	Number of finally approved incidents based on incident date	Number of incidents	Local	Nov-22				Oct-22			
	Percentage of incidents approved within 35 days based on approval date	95% within 35 days	Local	Nov-22				Oct-22			
Average Length of Stay (by discharges)	Average Length of Stay Elective	4.27 days (Dr Foster)	Local	Aug-21 to Jul-22				Jul-21 to Jun-22			
	Average Length of Stay Non Elective	4.45 days (Dr Foster)	Local	Aug-21 to Jul-22				Jul-21 to Jun-22			
Birth rate 24-37 weeks	Birth rate between 24 and 37 weeks as proportion of all births >24 weeks, rolling 12 months	6%	Local	Nov-22				Oct-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	Nov-22				Oct-22			
Obstetric haemorrhage	Massive obstetric haemorrhage >=1500ml as proportion of deliveries (singleton cephalic births 37-42)	2.9%	Local	Nov-22				Oct-22			
Patient Falls	Number of patient falls	< 3526 per year / 294 per month (19-20 total)	Local	Nov-22				Oct-22			
Pressure Ulcers	Number of pressure ulcers acquired within STH	Max 83 per month (996 per year)	Local	Nov-22				Oct-22			
	Category 4 pressure ulcers	Zero	Local	Nov-22				Oct-22			
Never Events	Number of never events	Zero	SOF	Nov-22				Oct-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	Nov-22				Oct-22			
>12 hr Trolley waits in A&E	No. of patients waiting > 12 hours	Zero	National	Nov-22				Oct-22			
Ambulance turnaround	Time taken for ambulance handover of patient	65% within 15 minutes	National	Nov-22				Oct-22			
	Time taken for ambulance handover of patient	95% within 30 minutes	National	Nov-22				Oct-22			
	Time taken for ambulance handover of patient	0% in excess of 60 minutes	Local	Nov-22				Oct-22			

Indicator	Measure	Standard	Target Type	Current Reporting Period				Previous Reporting Period			
				Data Range	*R	*V	*A	Data Range	*R	*V	*A
Provide Patient Centred Services											
18 weeks RTT	Percentage of patients on incomplete pathways waiting less than 18 weeks	92%	SOF	Nov-22				Oct-22			
52 week waits	Actual numbers	Zero	National	Nov-22				Oct-22			
Size of PTL	Total size of Patient Treatment List	<= Sep-21 (61,416)	Local	Nov-22				Oct-22			
6 week diagnostic waiting	Percentage of patients seen within 6 weeks	99%	SOF	Nov-22				Oct-22			
Cancelled Operations	Number of operations cancelled on the day for non clinical reasons	75 per month	Local	Nov-22				Oct-22			
	Number of patients cancelled on the day and not readmitted within 28 days	Zero	National	Nov-22				Oct-22			
Cancelled Outpatient appointments	Percentage of out-patient appointments cancelled by hospital	8.71% (National figure 2019/20)	Local	Nov-22				Oct-22			
	Percentage of out-patient appointments cancelled by patient	7.51% (National figure 2019/20)	Local	Nov-22				Oct-22			
DNA rate	Percentage of new out-patient appointments where patients DNA	7.27% (National figure 2019/20)	Local	Nov-22				Oct-22			
	Percentage of follow-up out-patient appointments where patients DNA	7.36% (National figure 2019/20)	Local	Nov-22				Oct-22			
Cancer Waits	Patient seen within 2 weeks of urgent referral	93%	National	Q3 22/23				Q2 22/23			
	Breast symptomatic seen within 2 weeks	93%	National	Q3 22/23				Q2 22/23			
	62 days from referral to treatment (GP referral)	85%	SOF	Q3 22/23				Q2 22/23			
	62 days from referral to treatment (Cancer Screening Service)	90%	SOF	Q3 22/23				Q2 22/23			
	31 day first treatment from referral	96%	National	Q3 22/23				Q2 22/23			
	31 day subsequent treatment (Surgery)	94%	National	Q3 22/23				Q2 22/23			
	31 day subsequent treatment (Radiotherapy)	94%	National	Q3 22/23				Q2 22/23			
	31 day subsequent treatment (Drugs)	98%	National	Q3 22/23				Q2 22/23			
e-Referral Service	Percentage of eligible GP referrals received through Electronic Referral Service	90%	Local	Nov-22				Oct-22			
Ethnic group data collection	Percentage of inpatient admissions with a valid ethnic group code	85%	National	Nov-22				Oct-22			
Elective Inpatient activity	Variance from contract schedules	On plan	Local	Nov-22				Oct-22			
Non elective inpatient activity	Variance from contract schedules	On plan	Local	Nov-22				Oct-22			
New outpatient attendances	Variance from contract schedules	On plan	Local	Nov-22				Oct-22			
Follow up op attendances	Variance from contract schedules	On plan	Local	Nov-22				Oct-22			
A&E attendances	Variance from contract schedules	On plan	Local	Nov-22				Oct-22			
Complaints	Percentage of complaints closed within agreed timescales	90% within agreed timescale	Local	Nov-22				Oct-22			
Written Complaints Rate	Written complaints rate per 10,000 finished consultant episode	<19/20 rate ()	SOF	Q3 2019/20							
Community Care	Integrated Care team contacts	43,000 per month	Local	Nov-22				Oct-22			
	Intermediate Care at home Community Intermediate Care response time	98% within 1 day	Local	Nov-22				Oct-22			
	Intermediate Care Beds Occupancy	88%	Local	Nov-22				Oct-22			
	Intermediate Care Beds Length of Stay	<35 days	Local	Nov-22				Oct-22			






Indicator	Measure	Standard	Target Type	Current Reporting Period				Previous Reporting Period			
				Data Range	*R	*V	*A	Data Range	*R	*V	*A
Provide Patient Centred Services											
Out of Hours GPC	% Seen Within 4 hours	95%	Local	Nov-22	<div></div>	<div></div>	<div></div>	Oct-22	<div></div>	<div></div>	<div></div>
FFT Recommended	Patients recommending STH for Inpatient treatment	95%	SOF	Nov-22	<div></div>	<div></div>	<div></div>	Oct-22	<div></div>	<div></div>	<div></div>
	Patients recommending STH for A&E treatment	86%	SOF	Nov-22	<div></div>	<div></div>	<div></div>	Oct-22	<div></div>	<div></div>	<div></div>
	Patients recommending STH for Maternity treatment	95%	SOF	Nov-22	<div></div>	<div></div>	<div></div>	Oct-22	<div></div>	<div></div>	<div></div>
	Patients recommending STH for Community treatment	90%	SOF	Nov-22	<div></div>	<div></div>	<div></div>	Oct-22	<div></div>	<div></div>	<div></div>
Community care – information completeness	RTT information completeness	50%	National	2022/23 Q2	<div></div>	<div></div>	<div></div>	2022/23 Q1	<div></div>	<div></div>	<div></div>
	Referral information completeness	50%	National	2022/23 Q2	<div></div>	<div></div>	<div></div>	2022/23 Q1	<div></div>	<div></div>	<div></div>
	Activity information completeness	50%	National	2022/23 Q2	<div></div>	<div></div>	<div></div>	2022/23 Q1	<div></div>	<div></div>	<div></div>
Day surgery rates	Aggregate percentage of all BADS procedures recommended to be treated as day case or outpatient	88%	Local	Nov-22	<div></div>	<div></div>	<div></div>	Oct-22	<div></div>	<div></div>	<div></div>
Mixed Sex Accommodation	Number of breaches of Mixed Sex Accommodation standard	Zero	SOF	Nov-22	<div></div>	<div></div>	<div></div>	Oct-22	<div></div>	<div></div>	<div></div>
Employ Caring & Cared for Staff											
Sickness Absence	All days lost as a percentage of those available	4%	SOF	Nov-22	<div></div>	<div></div>	<div></div>	Oct-22	<div></div>	<div></div>	<div></div>
Appraisals	Completed appraisals in last year	90%	Local	Nov-22	<div></div>	<div></div>	<div></div>	Oct-22	<div></div>	<div></div>	<div></div>
Mandatory Training	Overall percentage of completed mandatory training	90%	Local	Nov-22	<div></div>	<div></div>	<div></div>	Oct-22	<div></div>	<div></div>	<div></div>
Safer Staffing	Care Hours per patient day (Registered Nurses)	85% of planned hours or greater	Local	Nov-22	<div></div>	<div></div>	<div></div>	Oct-22	<div></div>	<div></div>	<div></div>
	Care Hours per patient day (Total)	85% of planned hours or greater	Local	Nov-22	<div></div>	<div></div>	<div></div>	Oct-22	<div></div>	<div></div>	<div></div>
Staff Turnover	Executive Team turnover (number of leavers as a percentage of total executive head count - rolling 1	0%	SOF	Nov-22	<div></div>	<div></div>	<div></div>	Oct-22	<div></div>	<div></div>	<div></div>
	Number of leavers as a percentage of total head count (rolling 12 months)	to be determined	SOF	Nov-22		<div></div>	<div></div>	Oct-22		<div></div>	<div></div>
	Retention Rate	85%	SOF	Nov-22	<div></div>	<div></div>	<div></div>	Oct-22	<div></div>	<div></div>	<div></div>
Recruitment	Request to fill to unconditional final offer	Average <= 8 weeks	Local	Nov-22	<div></div>	<div></div>	<div></div>	Oct-22	<div></div>	<div></div>	<div></div>
Spend Public Money Wisely											
I & E	YTD actual I & E surplus/deficit in comparison to YTD plan I & E surplus/deficit	>=0	SOF	Nov-22	<div></div>	<div></div>	<div></div>	Oct-22	<div></div>	<div></div>	<div></div>
I & E Margin	I & E surplus/deficit as a percentage of total revenue	>=0	SOF	Nov-22	<div></div>	<div></div>	<div></div>	Oct-22	<div></div>	<div></div>	<div></div>
Efficiency	Variance from plan	On plan	Local	Nov-22	<div></div>	<div></div>	<div></div>	Oct-22	<div></div>	<div></div>	<div></div>
Cash	Actual	Above profile	Local	Nov-22	<div></div>	<div></div>	<div></div>	Oct-22	<div></div>	<div></div>	<div></div>
Liquidity	Days of operating costs held in cash or cash equivalents	>0	SOF	Nov-22	<div></div>	<div></div>	<div></div>	Oct-22	<div></div>	<div></div>	<div></div>
Capitol	Expenditure - variance from plan	On plan	Local	Nov-22	<div></div>	<div></div>	<div></div>	Oct-22	<div></div>	<div></div>	<div></div>
Create a Sustainable Organisation											
Emissions	Annual gas carbon dioxide emissions (tCO2)	<19/20 rate (15,291 (tCO2))	Local	Apr-21	<div></div>	<div></div>	<div></div>				
	Annual electricity carbon dioxide emissions (tCO2)	<19/20 rate (12,592 (tCO2))	Local	Apr-21	<div></div>	<div></div>	<div></div>				
	Desflurane as a % of volatile anaesthetic gases to be less than 10%	<10%	National	Nov-22	<div></div>	<div></div>	<div></div>	Oct-22	<div></div>	<div></div>	<div></div>
	Total domestic waste carbon emissions (kgC02e) to reduce by 10%	reduce by 10% on 20/21 (590.23K)	Local	Apr-21	<div></div>	<div></div>	<div></div>				
	Total clinical waste carbon emissions (kgC02e) by 5%	reduce by 10% on 20/21 (509.48K)	Local	Apr-21	<div></div>	<div></div>	<div></div>				
Deliver Excellent Research, Education & Innovation											
Recruitment to trials	Total number of patient accruals to portfolio studies	0	Regional - Y&H	Q2 22/23	<div></div>	<div></div>	<div></div>	Q1 22/23	<div></div>	<div></div>	<div></div>
Annually Reported Indicators											
Staff Survey	National average or better in all 9 domains	0 domains below national average	Local	2021	<div></div>	<div></div>	<div></div>	2020	<div></div>	<div></div>	<div></div>

TRUST PERFORMANCE REPORT BY EXCEPTION

Key to Variation and Assurance Icons

The IPR continues to be developed and to use SPC charts where possible for exception reports. 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 (indicated by a red line). 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)

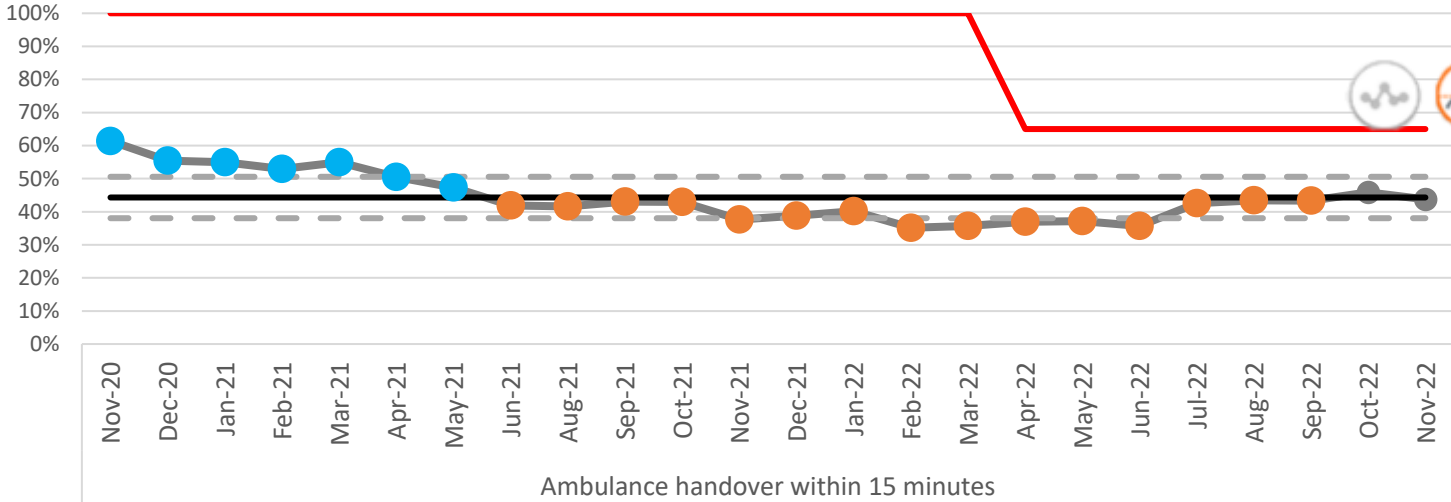


These icons are used to indicate statistical variation. We have identified special cause variation based on three rules which are shown below. If none of these rules are present, then the metric is showing common cause variation.

- 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

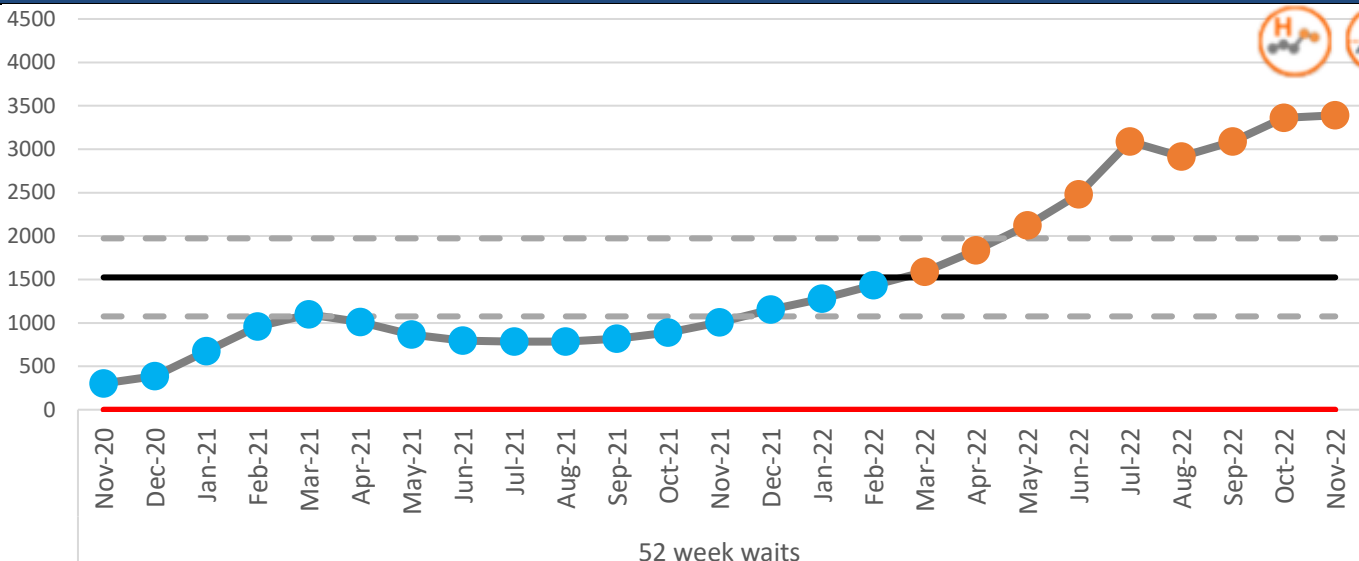


Icon	Description
	The system is expected to consistently fail the target
	The system is expected to consistently pass the target
	The system may achieve or fail the target subject to random variation

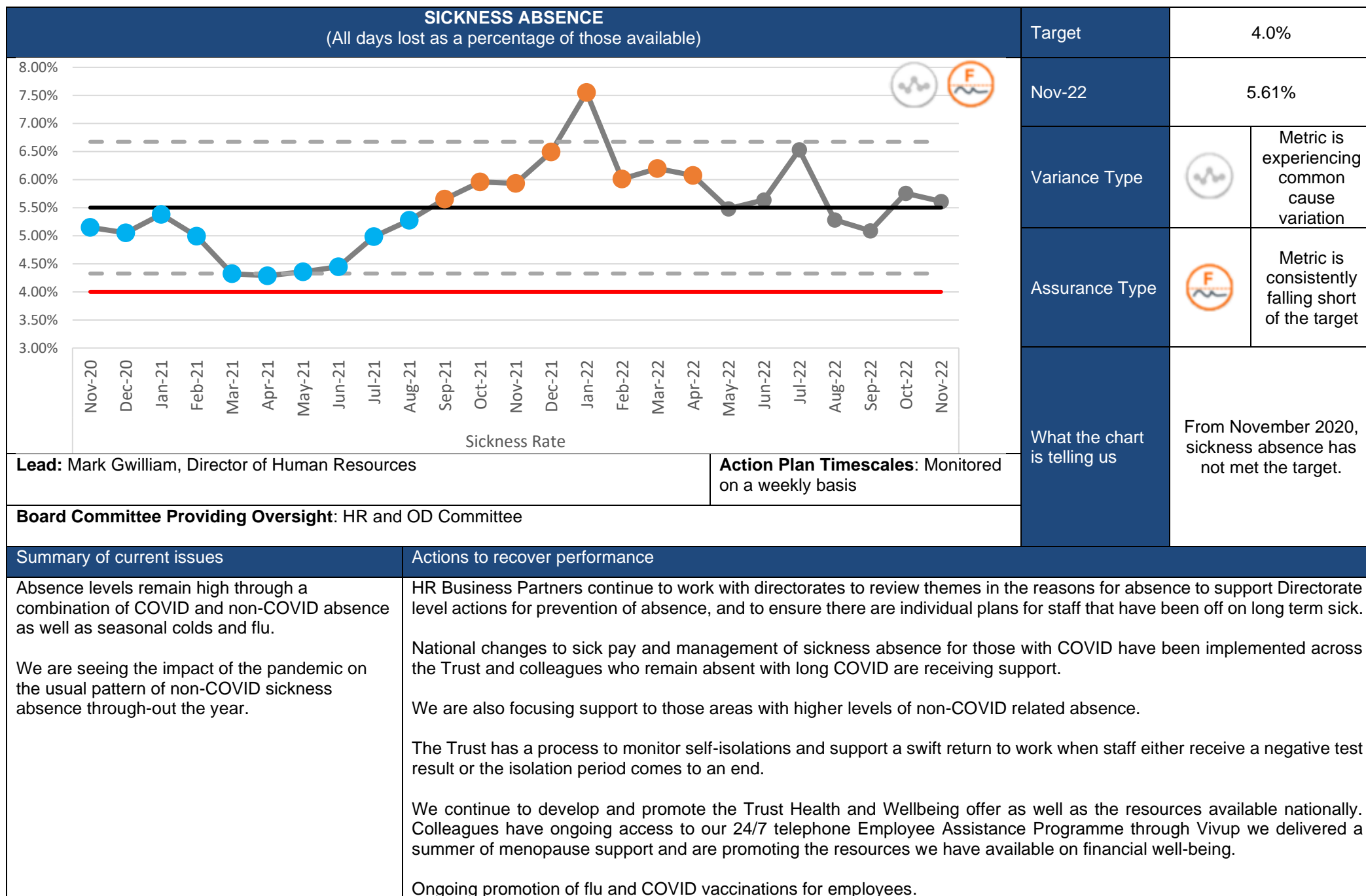
These icons are used to indicate if a target is likely to be achieved next month, has the potential to be achieved or is expected to fail.

AMBULANCE TURNAROUND (Time taken for ambulance handover of patient within 15 minutes)		Target	65% within 15 minutes		
 <p>Ambulance handover within 15 minutes</p>		Nov-22	43.76% within 15 minutes		
		Variance Type		Metric is experiencing common cause variation	
		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: Michael Harper, 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 1,410 ambulances in November with a handover within 15 minutes totalling 43.76% of the overall number of Ambulance Conveyances to A&E. This is consistent against October's performance of 45.86% and again demonstrative of the collaborative work AEM are undertaking with YAS to identify patients who are suitable to self-handover to A&E, along with the additional provision of STH staff at the front door during periods of predicted high intensity.		Close working on-site within the NGH A&E Department with the Yorkshire Ambulance Service (YAS) means that patients are well cared for in the event of a handover delay. Demand peaks are predicted using YAS data to inform the need for patient flow out of A&E, thereby making space for the ambulance patients on route. Work at Sheffield Place is focussing on discharges and bed occupancy to improve A&E flow.			

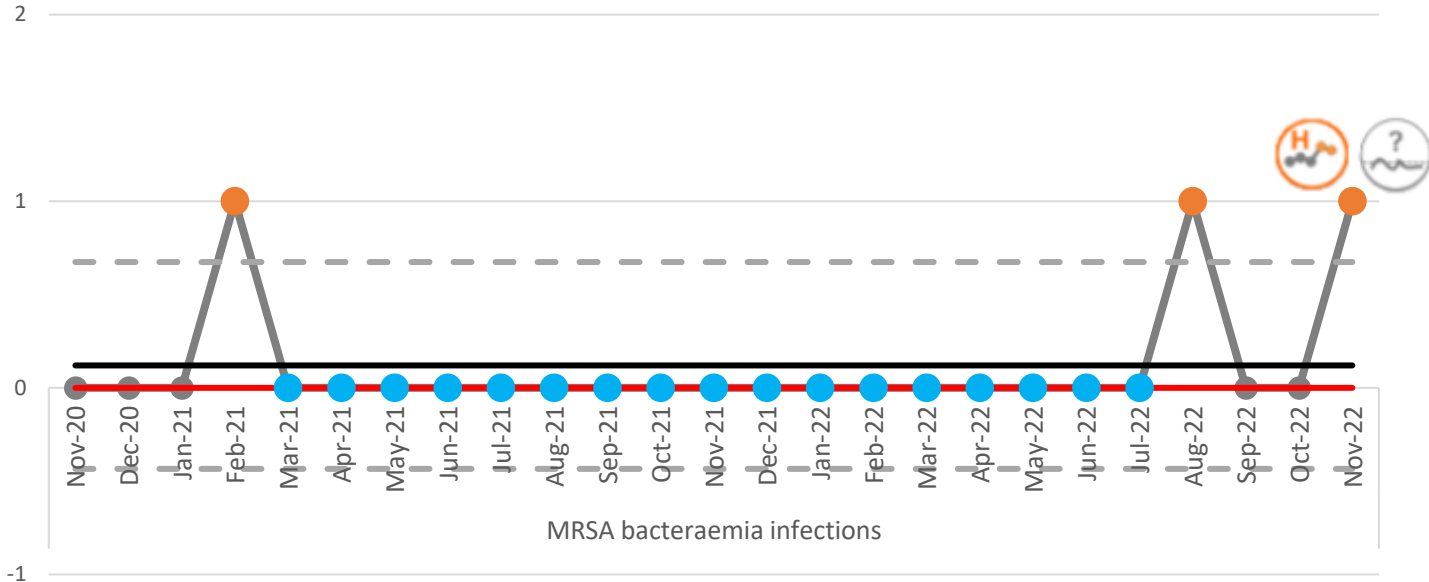


AMBULANCE TURNAROUND (Proportion of patients handed over in more than 30 minutes)		Target	<5% over 30 mins																																																			
<p>Ambulance handover greater than 30 minutes</p> <table border="1"><caption>Approximate data from the chart</caption><thead><tr><th>Month</th><th>Proportion of patients handed over in more than 30 minutes</th></tr></thead><tbody><tr><td>Nov-20</td><td>5%</td></tr><tr><td>Dec-20</td><td>8%</td></tr><tr><td>Jan-21</td><td>8%</td></tr><tr><td>Feb-21</td><td>13%</td></tr><tr><td>Mar-21</td><td>10%</td></tr><tr><td>Apr-21</td><td>11%</td></tr><tr><td>May-21</td><td>8%</td></tr><tr><td>Jun-21</td><td>18%</td></tr><tr><td>Aug-21</td><td>22%</td></tr><tr><td>Sep-21</td><td>15%</td></tr><tr><td>Oct-21</td><td>18%</td></tr><tr><td>Nov-21</td><td>18%</td></tr><tr><td>Dec-21</td><td>15%</td></tr><tr><td>Jan-22</td><td>20%</td></tr><tr><td>Feb-22</td><td>18%</td></tr><tr><td>Mar-22</td><td>17%</td></tr><tr><td>Apr-22</td><td>17%</td></tr><tr><td>May-22</td><td>15%</td></tr><tr><td>Jun-22</td><td>20%</td></tr><tr><td>Jul-22</td><td>17%</td></tr><tr><td>Aug-22</td><td>33%</td></tr><tr><td>Sep-22</td><td>32%</td></tr><tr><td>Oct-22</td><td>18%</td></tr><tr><td>Nov-22</td><td>16.17%</td></tr></tbody></table>		Month	Proportion of patients handed over in more than 30 minutes	Nov-20	5%	Dec-20	8%	Jan-21	8%	Feb-21	13%	Mar-21	10%	Apr-21	11%	May-21	8%	Jun-21	18%	Aug-21	22%	Sep-21	15%	Oct-21	18%	Nov-21	18%	Dec-21	15%	Jan-22	20%	Feb-22	18%	Mar-22	17%	Apr-22	17%	May-22	15%	Jun-22	20%	Jul-22	17%	Aug-22	33%	Sep-22	32%	Oct-22	18%	Nov-22	16.17%	Nov-22	16.17% over 30 minutes	
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What the chart is telling us		After a significant deterioration in performance in late summer, performance is back to more expected levels																																																				
Lead: Michael Harper, Chief Operating Officer		Action Plan Timescales: Ongoing																																																				
Board Committee Providing Oversight: Finance and Performance Committee																																																						
Summary of current issues		Actions to recover performance																																																				
As of April 2022, the national standard for handovers of more than 30 minutes changed to less than 5%. The previous target was 0%.		YAS are actively encouraging self-handover where appropriate and direct conveyance of appropriate patients to SDEC and to the Infectious Diseases pathway at the Royal Hallamshire Hospital which reduces demand pressures upon the NGH A&E Department and ensures patients reach the best place to receive their care sooner. A cohorting policy is in place with YAS to allow the release of Ambulance crews back into operation.																																																				
16.17% of ambulance handovers were over 30 minutes in November and 18.27% in October.		Work at Sheffield Place is focussing on discharges and bed occupancy to improve A&E flow.																																																				

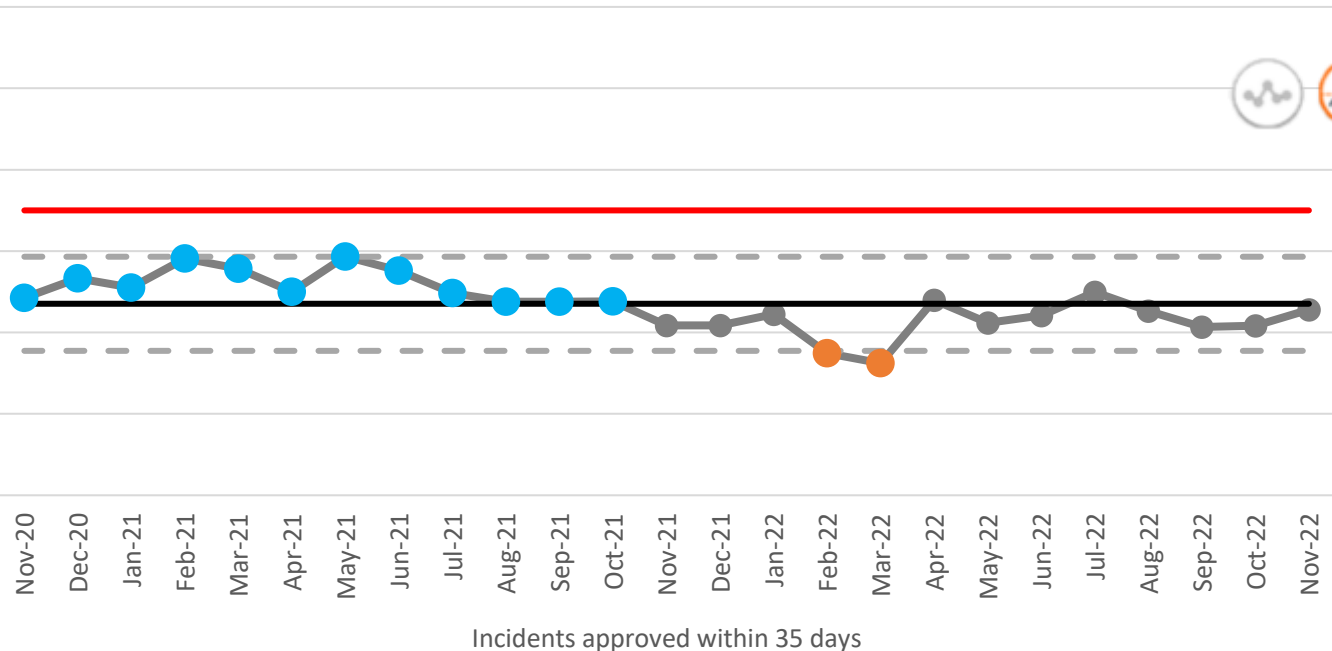


AMBULANCE TURNAROUND (Time taken for ambulance handover of patient over 60 minutes)		Target	0% over 60 minutes																																																			
<p>Ambulance handover greater than 60 minutes</p> <table><thead><tr><th>Month</th><th>Percentage</th></tr></thead><tbody><tr><td>Nov-20</td><td>2.0%</td></tr><tr><td>Dec-20</td><td>2.2%</td></tr><tr><td>Jan-21</td><td>2.5%</td></tr><tr><td>Feb-21</td><td>3.2%</td></tr><tr><td>Mar-21</td><td>2.0%</td></tr><tr><td>Apr-21</td><td>4.0%</td></tr><tr><td>May-21</td><td>6.5%</td></tr><tr><td>Jun-21</td><td>8.8%</td></tr><tr><td>Aug-21</td><td>8.5%</td></tr><tr><td>Sep-21</td><td>8.0%</td></tr><tr><td>Oct-21</td><td>9.5%</td></tr><tr><td>Nov-21</td><td>14.5%</td></tr><tr><td>Dec-21</td><td>12.0%</td></tr><tr><td>Jan-22</td><td>12.5%</td></tr><tr><td>Feb-22</td><td>10.5%</td></tr><tr><td>Mar-22</td><td>16.0%</td></tr><tr><td>Apr-22</td><td>10.8%</td></tr><tr><td>May-22</td><td>15.5%</td></tr><tr><td>Jun-22</td><td>16.5%</td></tr><tr><td>Jul-22</td><td>12.0%</td></tr><tr><td>Aug-22</td><td>15.5%</td></tr><tr><td>Sep-22</td><td>15.0%</td></tr><tr><td>Oct-22</td><td>14.0%</td></tr><tr><td>Nov-22</td><td>11.73%</td></tr></tbody></table>		Month	Percentage	Nov-20	2.0%	Dec-20	2.2%	Jan-21	2.5%	Feb-21	3.2%	Mar-21	2.0%	Apr-21	4.0%	May-21	6.5%	Jun-21	8.8%	Aug-21	8.5%	Sep-21	8.0%	Oct-21	9.5%	Nov-21	14.5%	Dec-21	12.0%	Jan-22	12.5%	Feb-22	10.5%	Mar-22	16.0%	Apr-22	10.8%	May-22	15.5%	Jun-22	16.5%	Jul-22	12.0%	Aug-22	15.5%	Sep-22	15.0%	Oct-22	14.0%	Nov-22	11.73%	Nov-22	11.73% over 60 minutes	
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What the chart is telling us		The national standards have not been met																																																				
Lead: Michael Harper, Chief Operating Officer Action Plan Timescales: Ongoing Board Committee Providing Oversight: Finance and Performance Committee																																																						
Summary of current issues		Actions to recover performance																																																				
In November, 11.73% of ambulances handover were over 60 minutes. This is lower than October's performance of 14.03%. The position is indicative of the challenges currently facing the department and the wider organisation in managing patient volumes attending Accident and Emergency and consequently requiring admission to inpatient beds.		The AEM Care Group is currently collaborating with the Clinical Operations Office and Yorkshire Ambulance Service to implement an Action Plan for the reduction of ambulance handover delays. Work continues across the broader health and care system to improve discharges, reduce bed occupancy, and improve flow out of A&E in order to create capacity for ambulance patients.																																																				

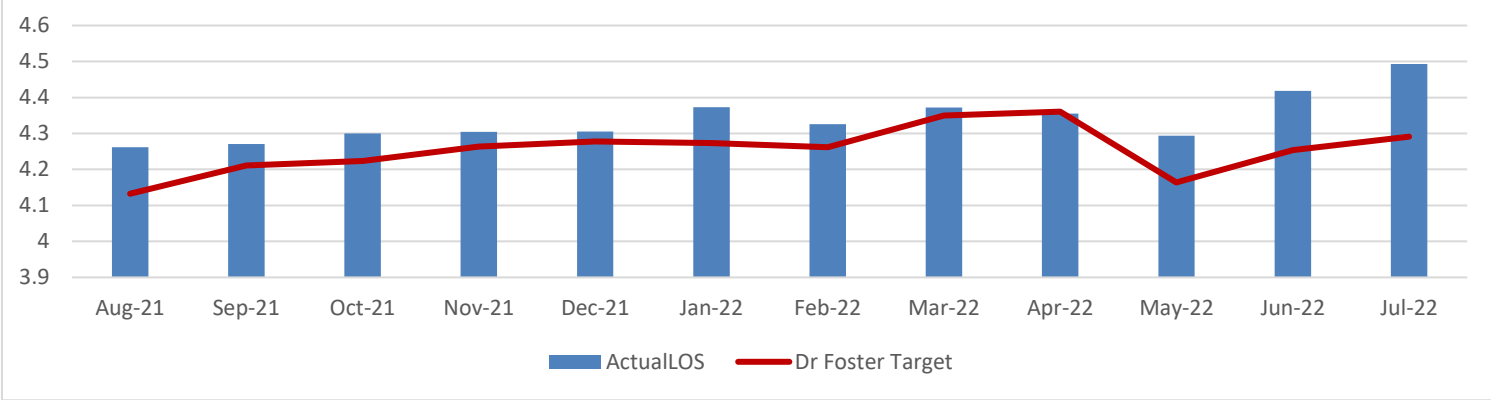
52 WEEK WAITS (Patients Waiting over 52 Weeks on an Incomplete Pathway)		Target	0 104-week waits & 0 78 week waits by end of March 2023	
 <p>52 week waits</p>		Nov-22	3,391	
		Variance Type		Metric is experiencing special cause for concern because of high values
		Assurance Type		Metric is consistently falling short of target
Lead: Michael Harper, Chief Operating Officer		What the chart is telling us	Despite a small drop in August 2022, the number has continued to rise.	
Action Plan Timescales: March 2023				
Board Committee Providing Oversight: Finance and Performance Committee				
Summary of current issues		Actions to recover performance		
There were 3,391 patients waiting over 52 weeks on an incomplete pathway during November 2022, an increase from 3,363 on the October 2022 position.		Activity plans remain in place 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 with the Patient Care Recovery Plan established to increase activity volumes.		

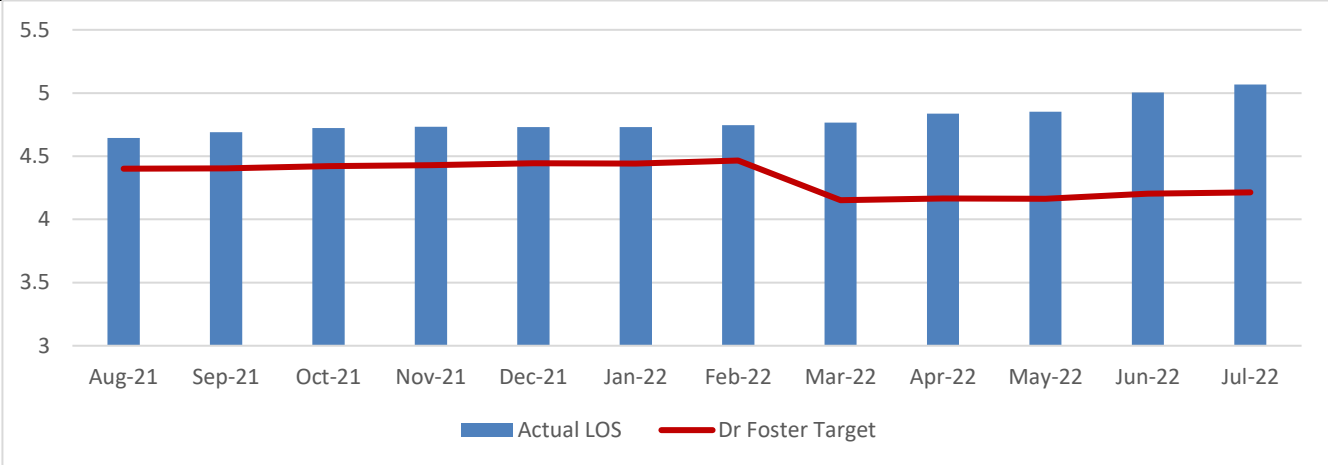


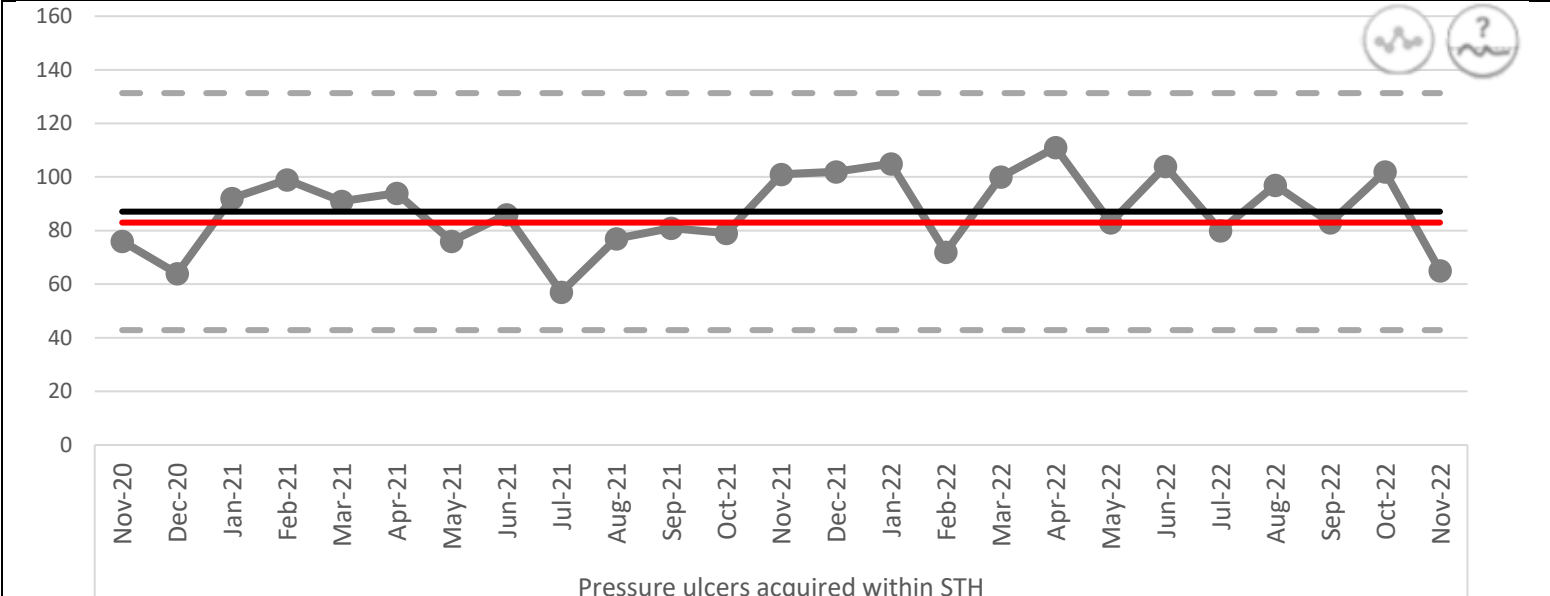


HOSPITAL STANDARDISED MORTALITY RATIO (HSMR)		Target	As expected or lower																									
<div>Diagnoses - HSMR Mortality (in-hospital) Oct 20 to Aug 22 Trend (rolling 12 months)</div> <div>Period: Rolling 12 months</div> <div><div><div>As expected</div><div>Below Expected</div><div>Above expected</div><div>95% Confidence interval</div></div><table><caption>HSMR Data Points (Estimated from Chart)</caption><thead><tr><th>Period</th><th>Relative Risk (HSMR)</th></tr></thead><tbody><tr><td>Oct-2020 to Sep-2021</td><td>108.0</td></tr><tr><td>Nov-2020 to Oct-2021</td><td>107.5</td></tr><tr><td>Dec-2020 to Nov-2021</td><td>107.0</td></tr><tr><td>Jan-2021 to Dec-2021</td><td>105.5</td></tr><tr><td>Feb-2021 to Jan-2022</td><td>106.0</td></tr><tr><td>Mar-2021 to Feb-2022</td><td>103.5</td></tr><tr><td>Apr-2021 to Mar-2022</td><td>103.5</td></tr><tr><td>May-2021 to Apr-2022</td><td>104.0</td></tr><tr><td>Jun-2021 to May-2022</td><td>105.0</td></tr><tr><td>Jul-2021 to Jun-2022</td><td>107.0</td></tr><tr><td>Aug-2021 to Jul-2022</td><td>111.0</td></tr><tr><td>Sep-2021 to Aug-2022</td><td>113.01</td></tr></tbody></table></div> <div>Jul21 – Jun22</div> <div>113.01 (108.3-117.87)</div> <div>Variance Type</div> <div>Not Applicable</div> <div>Assurance Type</div> <div>Not Applicable</div> <div>What the chart is telling us</div> <div>The latest HSMR is higher than expected at 113.01</div>		Period	Relative Risk (HSMR)	Oct-2020 to Sep-2021	108.0	Nov-2020 to Oct-2021	107.5	Dec-2020 to Nov-2021	107.0	Jan-2021 to Dec-2021	105.5	Feb-2021 to Jan-2022	106.0	Mar-2021 to Feb-2022	103.5	Apr-2021 to Mar-2022	103.5	May-2021 to Apr-2022	104.0	Jun-2021 to May-2022	105.0	Jul-2021 to Jun-2022	107.0	Aug-2021 to Jul-2022	111.0	Sep-2021 to Aug-2022	113.01	<div>Lead: Jennifer Hill, Medical Director (Operations)</div> <div>Action Plan Timescale: January 2023</div>
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Board Committee Providing Oversight: Quality Committee																												
Summary of current issues		Actions to recover performance																										
The HSMR remains in the 'higher than expected range'. The crude mortality and SHMI remain low and in the expected rate.		Detailed review is underway with the Dr Foster team to review the particular clinical pathways and ensure data is being captured correctly. An external coding review of fractured neck of femur pathway is underway and will be concluded at the end of January. Dr Foster is providing analysis to drive the key lines of enquiry for the forthcoming month.																										

MRSA Bacteraemia (Hospital onset)		Target	0		
<div><p>MRSA bacteraemia infections</p></div>		Nov-22	1		
		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	There have been two cases of MRSA bacteraemia since April 2021.		
		Lead: Chris Morley, Chief Nurse		Action Plan Timescales: Ongoing and reflects a new way of working	
Board Committee Providing Oversight: Quality Committee					
Summary of current issues		Actions to recover performance			
There has been one case of MRSA bacteraemia.		<p>A case of MRSA bacteraemia was identified in November 2022. A post infection review (PIR) is underway.</p> <p>The patient was admitted from a neighbouring NHS Trust for urgent vascular surgery. Pre-operative swabs and subsequent tissue sample obtained intra operatively were both reported as positive for MRSA. Blood cultures were taken at 48hrs post admission which identified the MRSA bacteraemia. A pre-transfer blood culture was not undertaken by the neighbouring Trust.</p> <p>The initial findings prior to conclusion of the PIR are that the patient was both colonised and infected with MRSA prior to transfer however as Sheffield undertook the blood culture after 48hrs the MRSA is classed as Trust attributable to STH.</p>			

INCIDENTS (Percentage of incidents approved within 35 days based on approval date)		Target		95%	
 <p>Incidents approved within 35 days</p>		Nov-22		82.8%	
		Variance Type			Metric is experiencing common cause variation
		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: January 2023			
Board Committee Providing Oversight: Quality Committee					
Summary of current issues			Actions to recover performance		
Performance in October and November remains below target.			The guidance document being developed to provide directorates with clear direction on the use of each review and approval stage within Datix will be taken to the Safety and Risk Committee for approval in January.		

AVERAGE LENGTH OF STAY (Elective)		Target	4.29																																							
 <table><thead><tr><th>Month</th><th>ActualLOS</th><th>Dr Foster Target</th></tr></thead><tbody><tr><td>Aug-21</td><td>4.25</td><td>4.15</td></tr><tr><td>Sep-21</td><td>4.25</td><td>4.20</td></tr><tr><td>Oct-21</td><td>4.30</td><td>4.22</td></tr><tr><td>Nov-21</td><td>4.30</td><td>4.25</td></tr><tr><td>Dec-21</td><td>4.30</td><td>4.28</td></tr><tr><td>Jan-22</td><td>4.35</td><td>4.28</td></tr><tr><td>Feb-22</td><td>4.30</td><td>4.25</td></tr><tr><td>Mar-22</td><td>4.35</td><td>4.35</td></tr><tr><td>Apr-22</td><td>4.35</td><td>4.35</td></tr><tr><td>May-22</td><td>4.30</td><td>4.15</td></tr><tr><td>Jun-22</td><td>4.40</td><td>4.25</td></tr><tr><td>Jul-22</td><td>4.50</td><td>4.30</td></tr></tbody></table>		Month	ActualLOS	Dr Foster Target	Aug-21	4.25	4.15	Sep-21	4.25	4.20	Oct-21	4.30	4.22	Nov-21	4.30	4.25	Dec-21	4.30	4.28	Jan-22	4.35	4.28	Feb-22	4.30	4.25	Mar-22	4.35	4.35	Apr-22	4.35	4.35	May-22	4.30	4.15	Jun-22	4.40	4.25	Jul-22	4.50	4.30	Jul-22	4.49
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		What the chart is telling us	Average LOS for elective episodes has seen some variation but has been consistently above the national benchmark.																																							
Lead: Jennifer Hill, Medical Director (Operations)		Action Plan Timescales: March 2023																																								
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Summary of current issues		Actions to recover performance																																								
<p>Length of Stay continues to increase due to the complexity of patients being admitted and current operational pressures.</p> <p>Clinical teams have identified an increase in post operative length of stay due to the work required to prepare some complex patients after longer waits for surgery.</p>		<p>Directorates continue to review further opportunities to maximise day case activity and High Volume Low complexity lists to maximise theatre capacity and minimise post operative recovery whilst minimising length of stay.</p> <p>The Theatre Admission Lounge (TAL), for elective admission and discharge, is being re-established at NGH as bed occupancy decreases and wards become available.</p> <p>Patient Care Recovery Plan Elective Strand projects include:</p> <ul style="list-style-type: none">End to End pathway review and improvement work to reduce LOS in Gynaecology and OrthopaedicsWork in Bev Stokes to improve day case utilisation, capacity and LOSTheatre Admissions Lounge to include Cardiology patients																																								

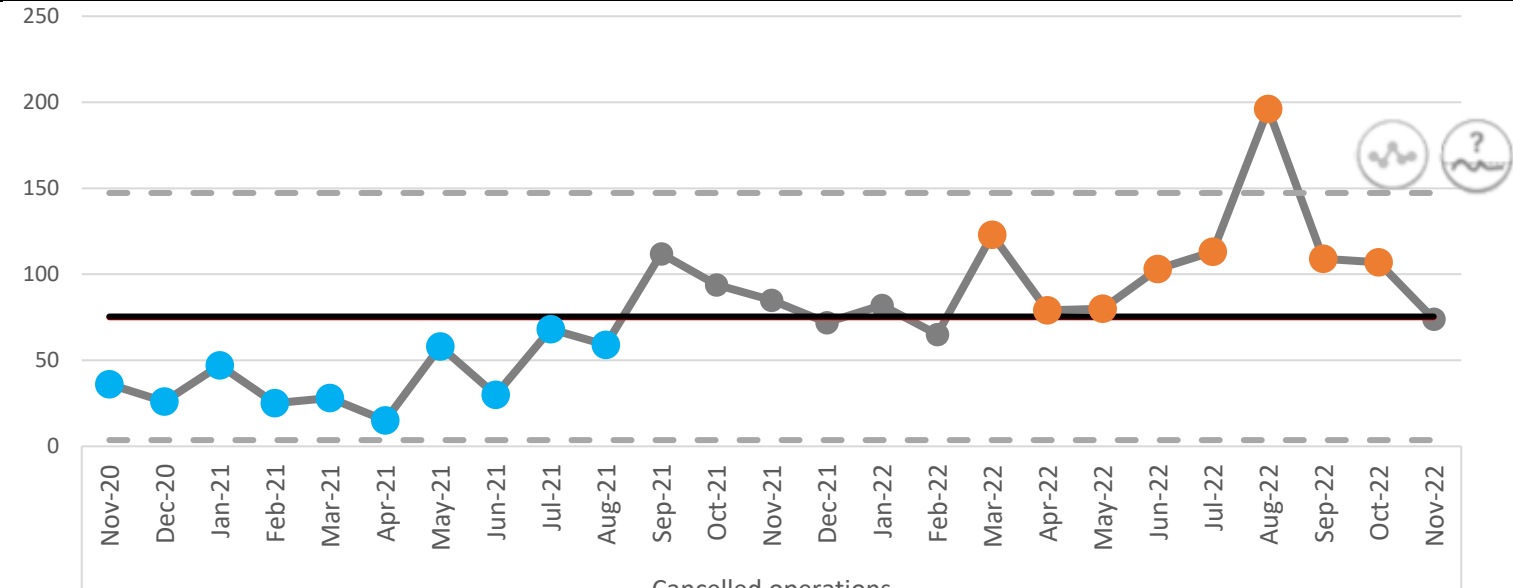


AVERAGE LENGTH OF STAY (Non-Elective)		Target	4.21																																							
 <table><caption>Actual LOS Data (Estimated from Chart)</caption><thead><tr><th>Month</th><th>Actual LOS</th><th>Dr Foster Target</th></tr></thead><tbody><tr><td>Aug-21</td><td>4.65</td><td>4.40</td></tr><tr><td>Sep-21</td><td>4.70</td><td>4.42</td></tr><tr><td>Oct-21</td><td>4.75</td><td>4.44</td></tr><tr><td>Nov-21</td><td>4.75</td><td>4.45</td></tr><tr><td>Dec-21</td><td>4.75</td><td>4.46</td></tr><tr><td>Jan-22</td><td>4.75</td><td>4.47</td></tr><tr><td>Feb-22</td><td>4.75</td><td>4.48</td></tr><tr><td>Mar-22</td><td>4.80</td><td>4.15</td></tr><tr><td>Apr-22</td><td>4.85</td><td>4.18</td></tr><tr><td>May-22</td><td>4.85</td><td>4.20</td></tr><tr><td>Jun-22</td><td>5.00</td><td>4.25</td></tr><tr><td>Jul-22</td><td>5.05</td><td>4.25</td></tr></tbody></table>		Month	Actual LOS	Dr Foster Target	Aug-21	4.65	4.40	Sep-21	4.70	4.42	Oct-21	4.75	4.44	Nov-21	4.75	4.45	Dec-21	4.75	4.46	Jan-22	4.75	4.47	Feb-22	4.75	4.48	Mar-22	4.80	4.15	Apr-22	4.85	4.18	May-22	4.85	4.20	Jun-22	5.00	4.25	Jul-22	5.05	4.25	Jul-22	5.07
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Lead: Jennifer Hill, Medical Director (Operations)		What the chart is telling us	Average LOS for non-elective episodes has been increasing steadily since Aug-21 and consistently above the national benchmark.																																							
Board Committee Providing Oversight: Quality Committee																																										
Summary of current issues		Actions to recover performance																																								
20% of current STH inpatients have care needs that could be met outside of an acute inpatient setting.		Continued development of Same Day Emergency Care Strategy (SDEC).																																								
Increase in numbers of patients with length of stay over 14 days.		Rapid improvement work ('focus on flow') commenced Dec 2022. Key areas of focus: 1. increasing and earlier use of the discharge lounge. 2. supporting ward teams with turnaround teams. 3. modelling data in emergency pathways for anticipatory flow. Continued focus on Why Not Home, Why Not Today? Work at Place to reduce waits for patients with no criteria to reside																																								

PRESSURE ULCERS (Number of pressure ulcers acquired within STH)		Target	Max 83 per month (996 per year)	
 <p>Pressure ulcers acquired within STH</p>		Nov-22	83	
		Variance Type		Indicator is showing no significant change (common cause variation)
		Assurance Type		Indicator is showing random variation
		What the chart is telling us	Consistently above the target but the target was met in November 2022.	
Lead: Chris Morley, Chief Nurse		Action Plan Timescales: Closed		
Board Committee Providing Oversight: Quality Committee				
Summary of current issues		Actions to recover performance		
During October the threshold for the number of inpatient pressure ulcers (PUs) has been breached but then met in November.		The number of Trust attributable PU's is above the monthly agreed threshold for October. Category 2 pressure ulcers constitute the greatest proportion of reported pressure damage with a continued reduction in Category 3 and above. In response to an identified increased trend associated with plaster casts, the Tissue Viability Team have commenced work with both the nursing and medical teams within the Spinal Injuries Unit to support both pressure ulcer prevention and management. The Purpose T pilot in December 2022, across ten inpatient wards and in the Emergency Department. There have been 0 cases of Category 4 pressure ulcers. The target was met in November.		

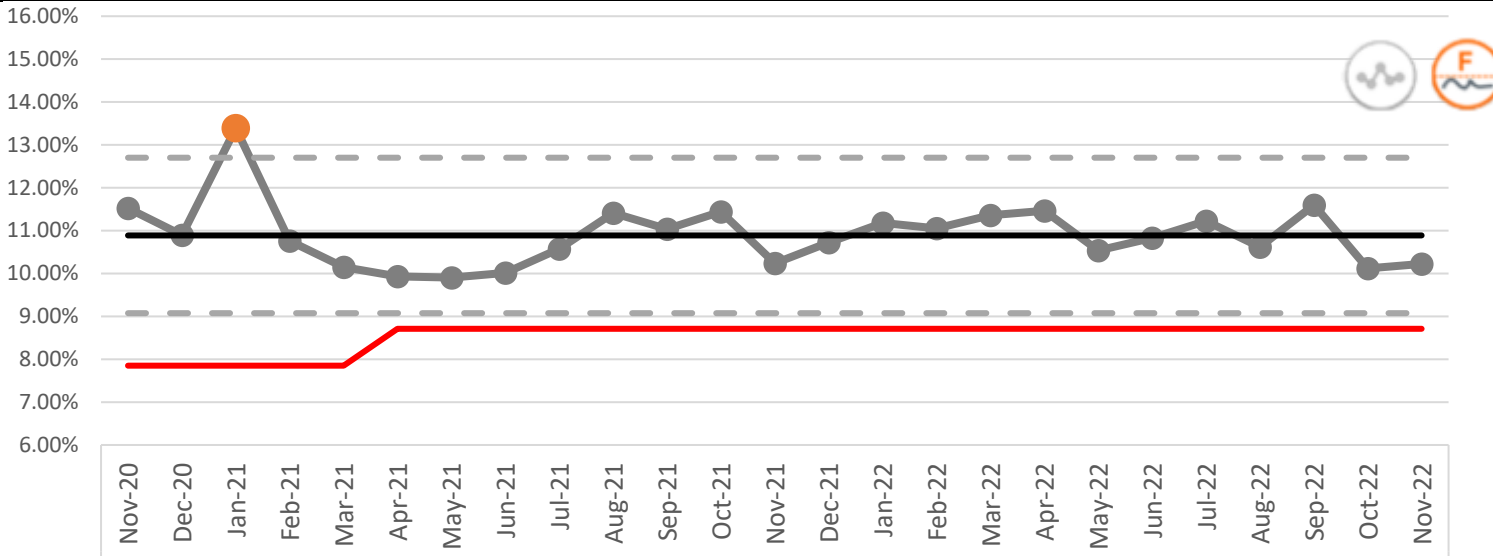


12 HOUR TROLLEY WAITS IN A&E (No. of patients waiting > 12 hours)		Target		0																																																					
<p>A&E 12 hour trolley waits</p> <table><caption>Approximate data from the chart</caption><thead><tr><th>Month</th><th>Number of patients waiting > 12 hours</th></tr></thead><tbody><tr><td>Nov-20</td><td>0</td></tr><tr><td>Dec-20</td><td>1</td></tr><tr><td>Jan-21</td><td>0</td></tr><tr><td>Feb-21</td><td>0</td></tr><tr><td>Mar-21</td><td>0</td></tr><tr><td>Apr-21</td><td>3</td></tr><tr><td>May-21</td><td>1</td></tr><tr><td>Jun-21</td><td>3</td></tr><tr><td>Jul-21</td><td>2</td></tr><tr><td>Aug-21</td><td>2</td></tr><tr><td>Sep-21</td><td>5</td></tr><tr><td>Oct-21</td><td>14</td></tr><tr><td>Nov-21</td><td>8</td></tr><tr><td>Dec-21</td><td>11</td></tr><tr><td>Jan-22</td><td>7</td></tr><tr><td>Feb-22</td><td>2</td></tr><tr><td>Mar-22</td><td>7</td></tr><tr><td>Apr-22</td><td>31</td></tr><tr><td>May-22</td><td>16</td></tr><tr><td>Jun-22</td><td>3</td></tr><tr><td>Jul-22</td><td>8</td></tr><tr><td>Aug-22</td><td>42</td></tr><tr><td>Sep-22</td><td>3</td></tr><tr><td>Oct-22</td><td>30</td></tr><tr><td>Nov-22</td><td>7</td></tr></tbody></table>		Month	Number of patients waiting > 12 hours	Nov-20	0	Dec-20	1	Jan-21	0	Feb-21	0	Mar-21	0	Apr-21	3	May-21	1	Jun-21	3	Jul-21	2	Aug-21	2	Sep-21	5	Oct-21	14	Nov-21	8	Dec-21	11	Jan-22	7	Feb-22	2	Mar-22	7	Apr-22	31	May-22	16	Jun-22	3	Jul-22	8	Aug-22	42	Sep-22	3	Oct-22	30	Nov-22	7	Nov-22		7	
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Variance Type			Metric is experiencing common cause variation																																																						
Assurance Type			Indicator is showing random variation																																																						
What the chart is telling us		Since March 2022, we have seen a variable and increased number of 12-hour trolley waits																																																							
Lead: Michael Harper, 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 7, 12 hour trolley breaches during November 2022. The majority of these patients required admission to a specialist mental health bed in another organisation.		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 Sheffield Childrens' and Sheffield Health and Social Care to improve the timeliness of care (including the availability of inpatient mental health facilities).																																																							

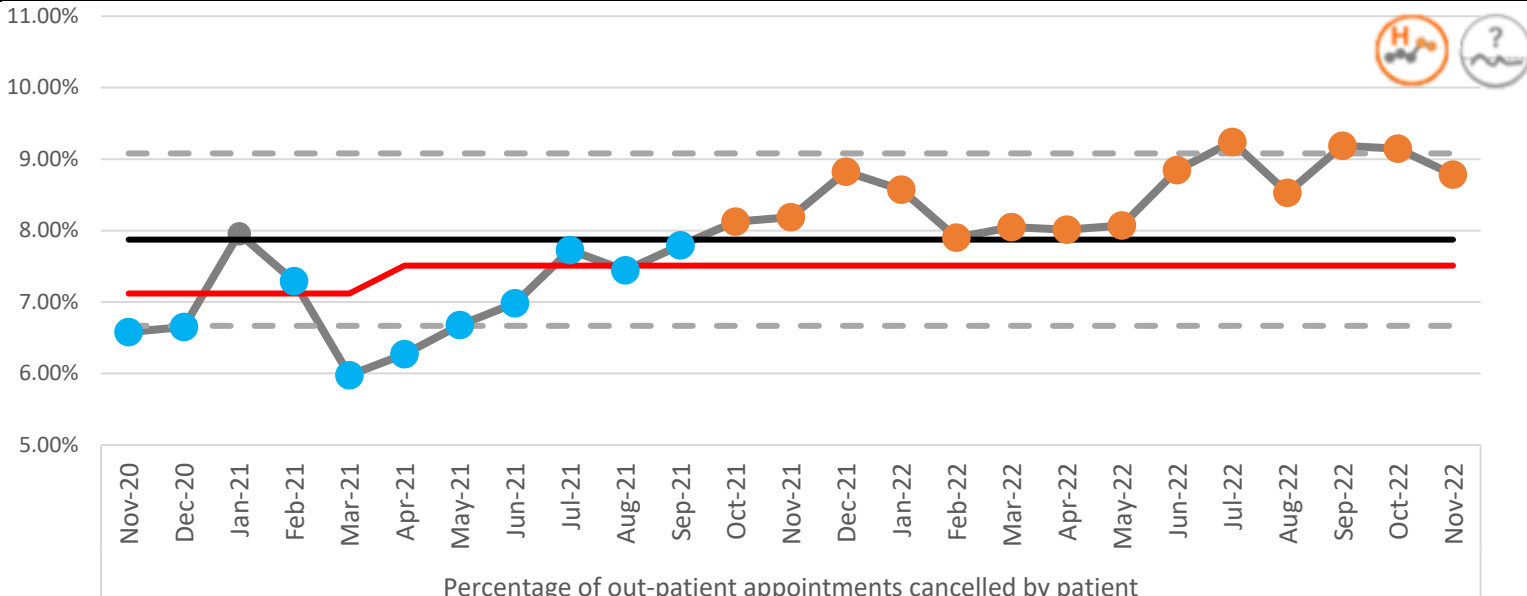


PATIENT TREATMENT LIST (Total Numbers)		Target	61,416
<p>Size of Patient Treatment List</p>		Nov-22	80,210
		Variance Type	<p>Metric is experiencing special cause for concern because of high values</p>
		Assurance Type	<p>Metric is consistently falling short of the target</p>
Lead: Michael Harper, Chief Operating Officer Board Committee Providing Oversight: Finance and Performance Committee		What the chart is telling us	<p>The total number of patients awaiting treatment has increased month on month since January 2021 but has levelled off over the last four months</p>
Action Plan Timescales: March 2023			
Summary of current issues		Actions to recover performance	
<p>The total number of patients on the patient treatment list (PTL) or incomplete care pathway decreased by 493 in November 2022 to 80,210. This is above the September 2021 target of 61,416.</p>		<p>The size of the PTL has been discussed at the Performance and Caseload Overview Group.</p> <p>The work involved to treat the number of patients waiting is significant and will take time to complete. Targeted validation is well established and underway to support our elective recovery plan and improve our position.</p> <p>Work continues at the ICB level to identify options for patient choice.</p>	

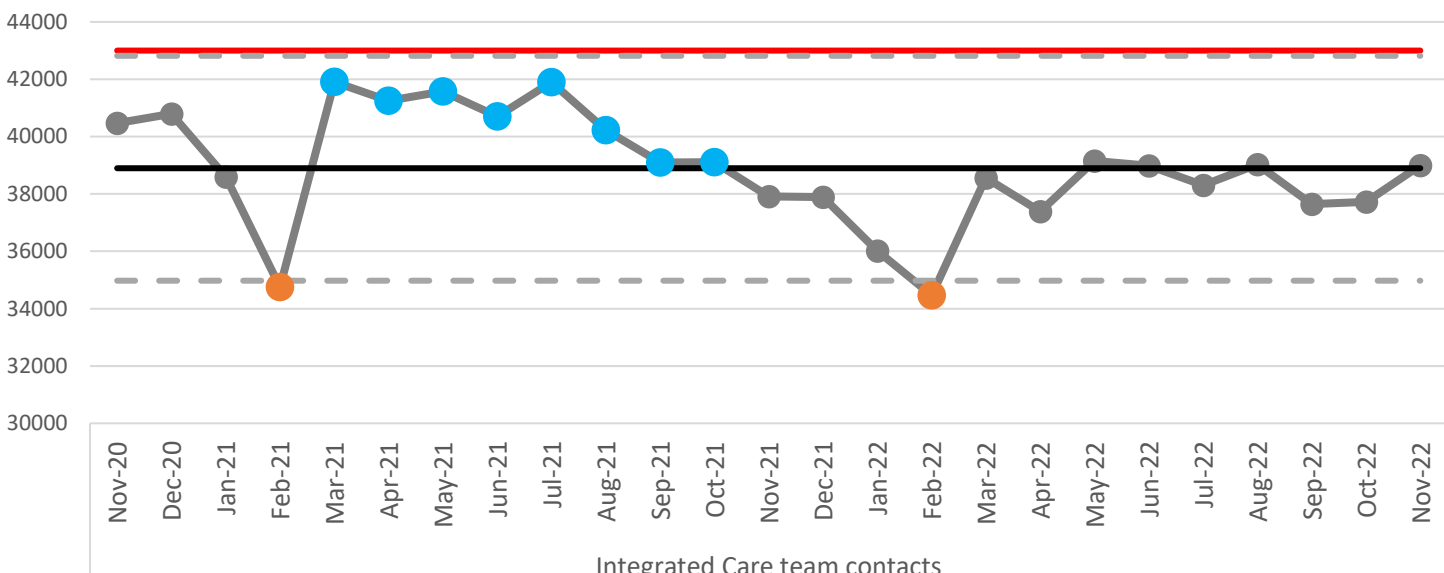


DIAGNOSTIC WAITING TIMES (Percentage of patients waiting less than 6 weeks for a diagnostic test)		Target		99%	
<div><p>6 week diagnostic wait</p></div>		Nov-22		73.94%	
		Variance Type			Metric is showing special cause of concerning nature due to underperformance
		Assurance Type			Metric is consistently falling short of the target.
		What the chart is telling us		Performance has gradually increased since August 2022	
Lead: Michael Harper, 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 November 2022 was 73.94%.			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 across all specialties.		

CANCELLED OPERATIONS (Number of operations cancelled on the day for non-clinical reasons)		Target	75		
 <p>Cancelled operations</p>		Nov-22	74		
		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 has remained above target since March 2022.		
Lead: Michael Harper, 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 74 on-day elective cancellations during November 2022. The majority of these were due to theatre issues.		Performance is reviewed on a regular basis by the Performance and Caseload Overview Group. The Trust is undertaking an exercise to model the number of elective beds required to support the Patient Care Recovery plan and the Theatre Admission Lounge at NGH will support the delivery of additional day case activity.			

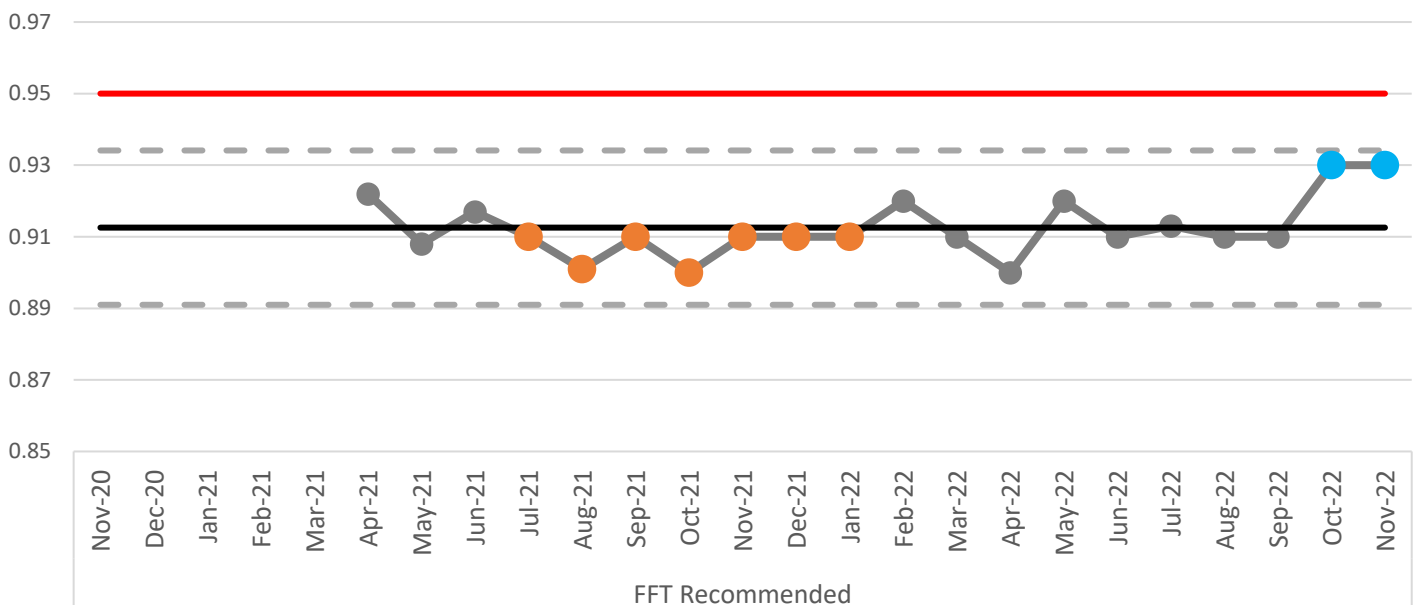


CANCELLED OPERATIONS (Number of patients cancelled on the day and not readmitted within 28 days)		Target	0
<p>Readmitted Cancelled ops</p>		Nov-22	1
		Variance Type	Metric is experiencing common cause variation
		Assurance Type	Indicator is showing random variation
Lead: Michael Harper, Chief Operating Officer Board Committee Providing Oversight: Finance and Performance Committee		What the chart is telling us	The number of on-day elective cancellations for non-clinical reasons and not readmitted within 28 days has consistently been above the zero target
Action Plan Timescales: March 2023			
Summary of current issues		Actions to recover performance	
There was 1 on-day elective cancellation during November 2022 which was not readmitted within 28 days. The patient has since been admitted and had their procedure.		Performance is reviewed on a regular basis by the Performance and Caseload Overview group.	

CANCELLED OUTPATIENT APPOINTMENTS (Percentage of out-patient appointments cancelled by the hospital)		Target		8.71%	
 <p>Percentage of out-patient appointments cancelled by hospital</p>		Nov-22		10.22%	
		Variance Type			Metric is experiencing common cause variation
		Assurance Type			Metric is consistently falling short of the target.
		What the chart is telling us		The number of appointments cancelled by the hospital has remained relatively consistent since August 2021	
Lead: Michael Harper, Chief Operating Officer			Timescale: Ongoing		
Board Committee Providing Oversight: Finance and Performance Committee					
Summary of current issues			Actions to recover performance		
The percentage of outpatient appointments cancelled by the hospital in November 2022 was 10.22% compared to the benchmark target of 8.71%.			Appointments that are cancelled by the hospital are clinically reviewed to ensure that it remains safe for patients to wait. This is linked to the Trust's caseload management approach.		
Operational pressures have resulted in some outpatient clinics being cancelled to allow clinical teams to support the inpatient caseload.					

CANCELLED OUTPATIENT APPOINTMENTS (Percentage of out-patient appointments cancelled by patient)		Target		7.51%	
<div><p>Percentage of out-patient appointments cancelled by patient</p></div>		Nov-22		8.78%	
		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		Performance is consistently falling short of the target and decreasing.	
Lead: Michael Harper, Chief Operating Officer			Timescale: Ongoing		
Board Committee Providing Oversight: Finance and Performance Committee					
Summary of current issues			Actions to recover performance		
The percentage of outpatient appointments cancelled by patients in November 2022 was 8.78% compared to 9.15% in October 2022.			Discussions are ongoing in relation to processes to ensure we are doing all we can to support patients being able to attend.		

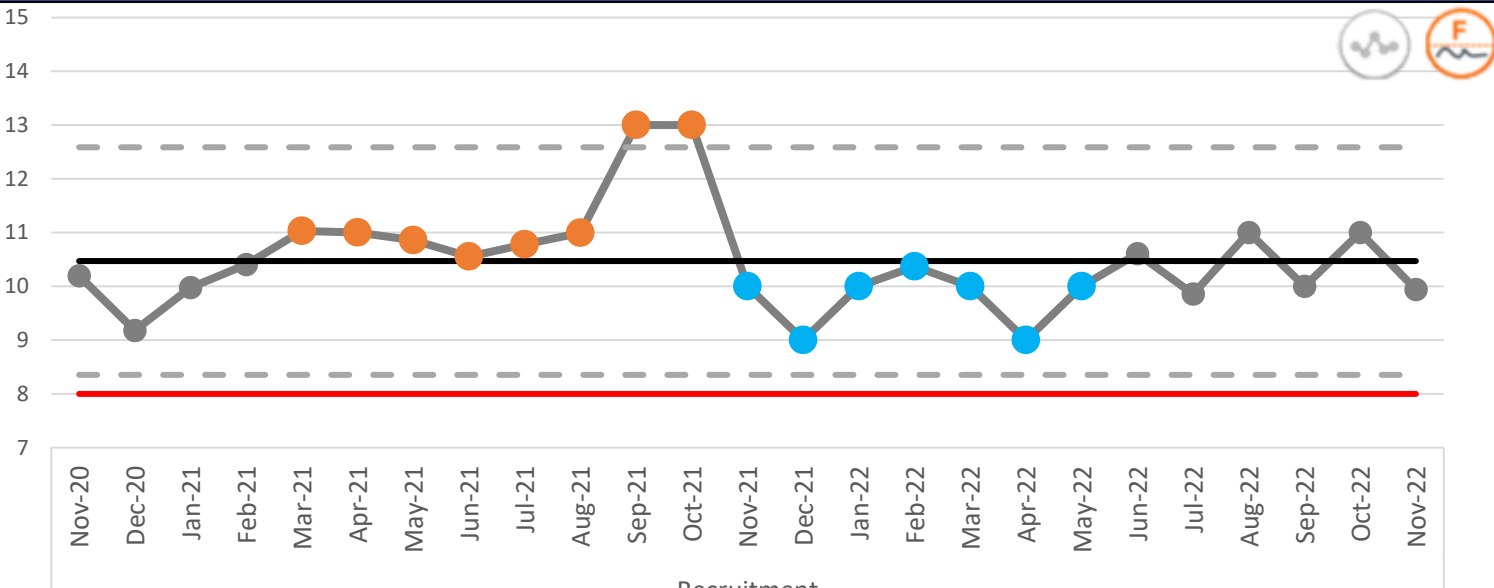


COMMUNITY CARE (Integrated Care Team (ICT) contacts)		Target		41,717	
<div><p>Integrated Care team contacts</p></div>		Nov-22		38,993	
		Variance Type			Metric is experiencing common cause variation
		Assurance Type			Metric is consistently falling short of the target
		What the chart is telling us		The target for ICT contacts is consistently not being met.	
Lead: Michael Harper, Chief Operating Officer		Action Plan Timescales: April 2023			
Board Committee Providing Oversight: Finance and Performance Committee					
Summary of current issues			Actions to recover performance		
Under-performance recorded of approx. 3000 visits. This is due to under-performance in ICT Therapy (vacancies, sickness) and data quality issues in ICT Nursing that impacts number of visits reportable.			Work has progressed to identify the two causes of the data quality reporting issue - work has been undertaken to rectify one of them, which has been backdated to April and shown from Q3 reporting onwards. Ongoing work is taking place on the second cause, we are yet to identify if this can be backdated however it is now being reported from November 2022 onwards. Working Group established for recovery plan for ICT Therapy Activity - Completed in October 2022 - working group has now concluded and made recommendations for recovery plan which have been accepted by ICC Exec and is being implemented during Q3 and Q4 of 22/23 with monthly progress reports reportable to ICC executive. Weekly dashboard has now been put in place from early Oct 2022 to track this in detail and to inform recovery plans and trajectory and updates to exec- ongoing.		

COMMUNITY CARE (Intermediate Care Bed Occupancy)		Target		88%																																																				
<div><table><thead><tr><th>Month</th><th>Occupancy (%)</th></tr></thead><tbody><tr><td>Nov-20</td><td>55</td></tr><tr><td>Dec-20</td><td>57</td></tr><tr><td>Jan-21</td><td>56</td></tr><tr><td>Feb-21</td><td>53</td></tr><tr><td>Mar-21</td><td>66</td></tr><tr><td>Apr-21</td><td>72</td></tr><tr><td>May-21</td><td>86</td></tr><tr><td>Jun-21</td><td>90</td></tr><tr><td>Jul-21</td><td>89</td></tr><tr><td>Aug-21</td><td>75</td></tr><tr><td>Sep-21</td><td>73</td></tr><tr><td>Oct-21</td><td>69</td></tr><tr><td>Nov-21</td><td>82</td></tr><tr><td>Dec-21</td><td>75</td></tr><tr><td>Jan-22</td><td>69</td></tr><tr><td>Feb-22</td><td>64</td></tr><tr><td>Mar-22</td><td>66</td></tr><tr><td>Apr-22</td><td>84</td></tr><tr><td>May-22</td><td>90</td></tr><tr><td>Jun-22</td><td>92</td></tr><tr><td>Jul-22</td><td>78</td></tr><tr><td>Aug-22</td><td>87</td></tr><tr><td>Sep-22</td><td>84</td></tr><tr><td>Oct-22</td><td>74</td></tr><tr><td>Nov-22</td><td>89</td></tr></tbody></table></div> <p>Intermediate Care Beds Occupancy</p>		Month	Occupancy (%)	Nov-20	55	Dec-20	57	Jan-21	56	Feb-21	53	Mar-21	66	Apr-21	72	May-21	86	Jun-21	90	Jul-21	89	Aug-21	75	Sep-21	73	Oct-21	69	Nov-21	82	Dec-21	75	Jan-22	69	Feb-22	64	Mar-22	66	Apr-22	84	May-22	90	Jun-22	92	Jul-22	78	Aug-22	87	Sep-22	84	Oct-22	74	Nov-22	89	Nov-22	89%	
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What the chart is telling us		The target has not been consistently met but was met in November.																																																						
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																																																						
Patients continue to have high needs on discharge from hospital. Specific delays for discharge to Somewhere else to assess (S2A) placements, Enhanced EMI bed, and home care packages.		Continue to escalate named patient delays to discharge hub and via Escalation meetings Completion Date: Ongoing process Council are reprocurring homecare in Sheffield to empower local providers of homecare and improve pick up from next year; national monies have been received and are being provided to the council on behalf of the city to increase home care capacity over winter period LOS has improved compared to last month, with a number of individuals with long LOS being discharged. We still have a number of patients waiting for ongoing care at home which has lead to an increase in LOS overall.																																																						


FRIENDS & FAMILY TEST (Inpatients)		Target	95%		
<div></div> <p>FFT Recommended</p>		Nov-22	92.7%		
		Variance Type		Metric is indicating a special cause of concern but showing improvement	
		Assurance Type		Metric is consistently falling short of the target	
		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: January 2023			
Board Committee Providing Oversight: Quality Committee					
Summary of current issues		Actions to recover performance			
The Inpatient positive score is 92.7% for October and November. This is a 1.7% improvement from August and September but is 2.3% below the target.		At September's Patient Experience and Engagement Group (PEEG), it was agreed that each care group would select one low scoring ward to undertake focused improvement work to drive up the FFT positive score. This will include reviewing the use of postcards, undertaking a review of all negative comments, gathering further patient feedback to understand the issues driving scores, and implementing an action plan. Care Groups will report an update on this work to PEEG in January 2023. Care Groups are also working towards actions set out in the action plan from the Inpatient National Survey 2021 to improve experiences on inpatient wards.			

FRIENDS & FAMILY TEST (Maternity)			Target	95%
<div><div>1</div><div>FFT not nationally reported April 2020 – March 2021</div><div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><d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APPRAISALS (Completed appraisals in last year)		Target		90%	
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RECRUITMENT (Weeks taken from request to fill to unconditional offer)		Target		8	
 <p>Recruitment</p>		Nov-22	10		
		Variance Type		Metric is experiencing common cause variation	
		Assurance Type		Metric is consistently falling short of the target	
		What the chart is telling us	Recruitment process times 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		
<p>There is an ongoing increase in activity for both adverts and volume of appointed candidates.</p> <p>The recruitment team have been affected by increased absence levels and higher than normal turnover rates.</p> <p>The pandemic has required ongoing work to reset and review processes.</p> <p>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.</p>			<p>Internal process improvement group in place with oversight from the Director of HR and Staff Development. This includes implementation of a Welcome team to support on-boarding and focused work to improve candidate employment clearance timescales</p> <p>Additional recruitment resource approved by TEG in response to increasing activity has been in place since the end of October and is being used to clear backlogs due to the high volumes of recruitment. Training of these team members is continuing.</p> <p>Attraction and Recruitment Strategic and Operational meetings are being establish as a part of the Trusts Getting Back on Track Programme, with positive results from joint work between the Recruitment and Communications teams to improve attraction for Admin posts.</p>		

EFFICIENCY Variance from Plan		Target to November	£11,058k
<div><p>£'000s</p><p>Total Efficiency Programme 2022/23</p><p>Legend: Delivered/Forecast (Green bars), Target (Blue line), Plan (Cut 3) (Red line)</p></div>		Actuals to November	£9,120k
		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	Forecast outturn is below target. Forecast performance included for remaining months of the year.
Lead: Neil Priestley, Chief Financial Officer		Action Plan Timescales: November 2022	
Board Committee Providing Oversight: Finance & Performance Committee			
Summary of current issues		Actions to recover performance	
<p>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.</p> <p>Delivery year to date is £9,120k against a target of £11,058k (£1,938k/17.5% behind target). This shortfall is due to both insufficient P&E schemes being identified in the 22/23 Directorate plans (£1,443k), and an under-delivery year to date against the schemes identified (£495k) all of which sits within the Directorates 1%.</p> <p>Forecast outturn delivery against the 2% target of £16,587k is £13,999k. This represents a 15.6% shortfall of £2,589k.</p>		<p>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.</p> <p>The new Use of Resource approach to P&E has been launched in October, replacing CEO PMO meetings to support the identification of the largest areas of opportunity at the Trust. The first couple of these meetings have been productive in understanding where opportunities are and now action is required in respect of translating these into actual savings.</p> <p>The focus with directorates 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.</p> <p>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, to ensure they remain focused on identifying outstanding balances throughout the year.</p>	

CAPITAL EXPENDITURE Expenditure - variance from plan		Target to November	£29,406k				
<div><p>CAPITAL EXPENDITURE (CUMULATIVE VARIANCE FROM PLAN)</p><table border="1"><caption>Capital Expenditure Data</caption><thead><tr><th>Month</th><th>Expenditure (%)</th></tr></thead><tbody><tr><td>Nov-22</td><td>~55%</td></tr></tbody></table></div>		Month	Expenditure (%)	Nov-22	~55%	Actuals to November	£16,164k
		Month	Expenditure (%)				
		Nov-22	~55%				
		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							
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					
Cumulative capital expenditure to the end of November was £16,164k against a plan of £29,406k, which equates to an under-spend of £13,242k. This is primarily due to re-phasing of major medical equipment delivery into the 3rd quarter of the year and higher than anticipated VAT recovery against capital schemes.		To ensure timely equipment delivery whilst continuing to review the overall capital programme. Programme review will enable Identification of any risks and opportunities for mitigation, and ensure focus is maintained on driving larger schemes to completion in order to achieve target spend for the year.					

1. Introduction

The following report provides an in-depth analysis of the Trusts Mandatory and Job Specific Essential Training (JSET) performance. Mandatory and JSET is essential for the safe and effective delivery of services, reducing organisational risks and complying with local and national policies and government guidelines. There are no nationally agreed subjects for JSET; the locally adopted definition at STH included in the Induction Mandatory and Job Specific Essential Training policy (2021) is as follows:

Job Specific Essential Training will apply to training for certain staff groups that enables an individual to practice safely and effectively, ensuring they have the skills and knowledge required to be 'fit for purpose' in that job. This training relates to identified risks associated with the nature and purpose of that particular Group, Directorate and/or job. This may include elements of statutory training for some staff. All Mandatory and JSET subjects are accessed and recorded within the Personal Achievement Learning Management System (PALMS) and the system for reporting and monitoring is embedded across the organisation with reports on mandatory training fed through to the Board in the Integrated Performance Report. Nominated committees receive a training compliance report for the mandatory and JSET they are responsible for overseeing.

2. Developments in 2022

The Induction, Mandatory and Job Specific Training Policy has been reviewed and refreshed in 2022. The Trust's mandatory training provision aligns with the Core Skills Training Framework (CSTF) which sets out ten statutory and mandatory training topics for staff working in health and social care settings and includes nationally agreed learning outcomes and training delivery standards. By adopting this framework, STH can facilitate the smooth transfer of staff between NHS organisations. Work continues to maintain the performance for the current twelve JSET subjects and a Mandatory and JSET panel has been established to ratify existing subjects and approve existing and new Mandatory and JSET requirements. The panel meets regularly to:

- I. Confirm that the subject meets the criteria to be categorised as JSET.
- II. Agree and validate the audience (those staff who need the training).
- III. Implement roll-out of a training package and make available via PALMs.
- IV. Agree trajectory with timescales to achieve 90% compliance.

3. Mandatory Training – Target 90% - overall position

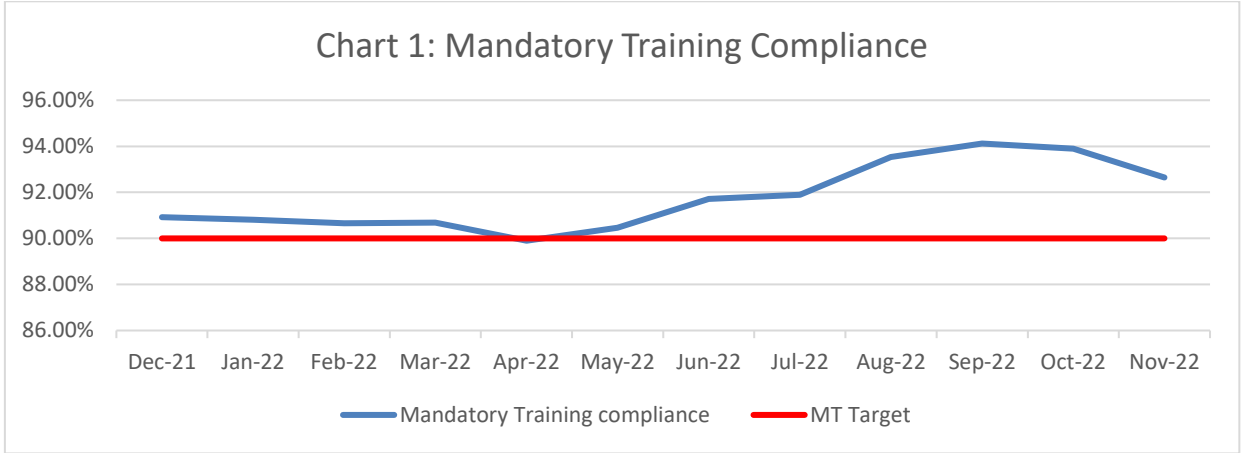


Chart 1 shows that performance for mandatory training has consistently achieved the 90% target. Resuming face to face training, engaging with subject leads, professional leads and key stakeholders in each of the directorates has contributed to this achievement alongside the commitment from managers and staff to maintain and enhance their knowledge and skills. Given the operational pressures facing our services, maintaining this level of performance is a success story demonstrating the commitment and expertise from our educators, managers and operational teams. Learning Education and Development have led on much of this work implementing effective systems for providing accurate and timely training data and supporting managers, teams and training leads.

3.1 Mandatory Training – by staff group

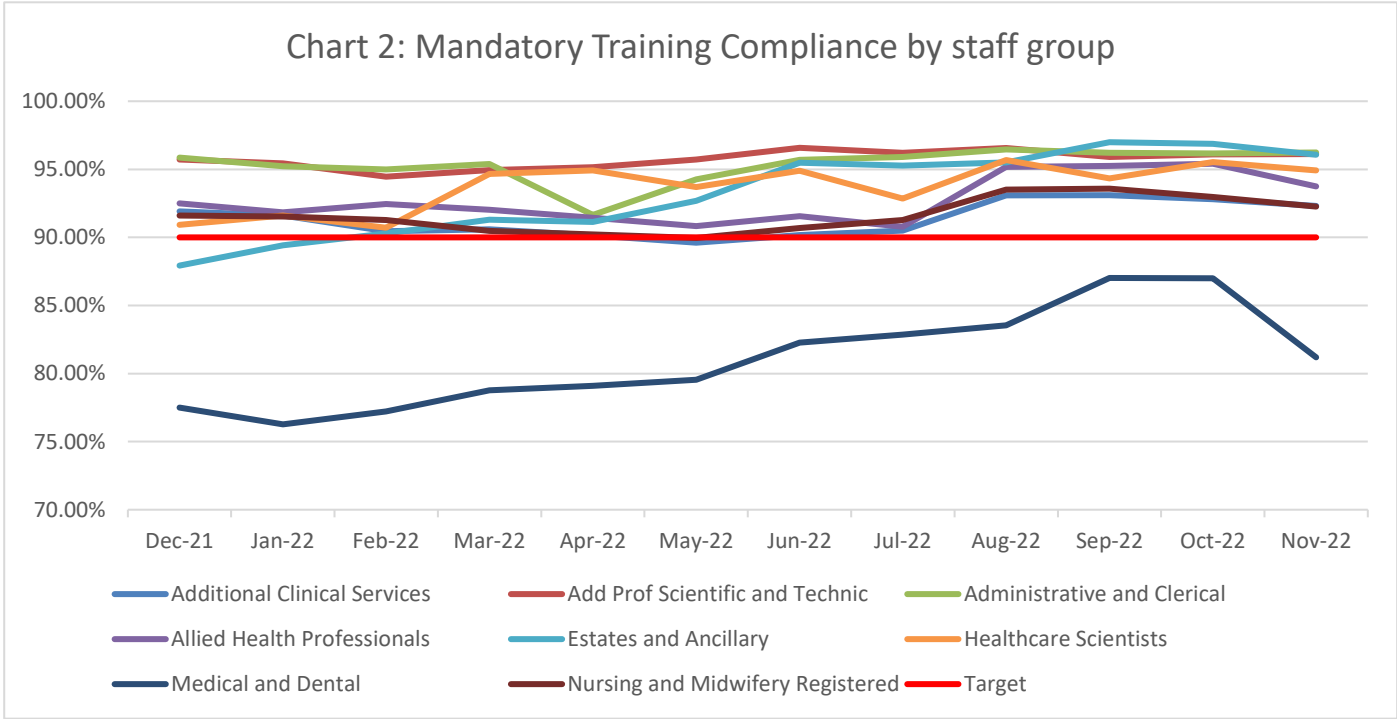


Chart 2 shows that performance for mandatory training has consistently achieved the 90% target for all staff groups with the exception of medical and dental staff. The Trust’s Learning Management System (PALMS) is integrated with ESR which means that mandatory training records are transferred for new starters when they are coming from an NHS Trust which is also signed up to the mandatory training passport scheme. This process is being reviewed for doctors on rotation to ensure training that is currently in date is not being requested unnecessarily. Learning, Education and Development are working with the Medical Directors office to provide regular reports with more details in respect of performance by speciality, grade and directorate to agree actions and support to achieve the required level of performance.

3.2 Mandatory Training by subject

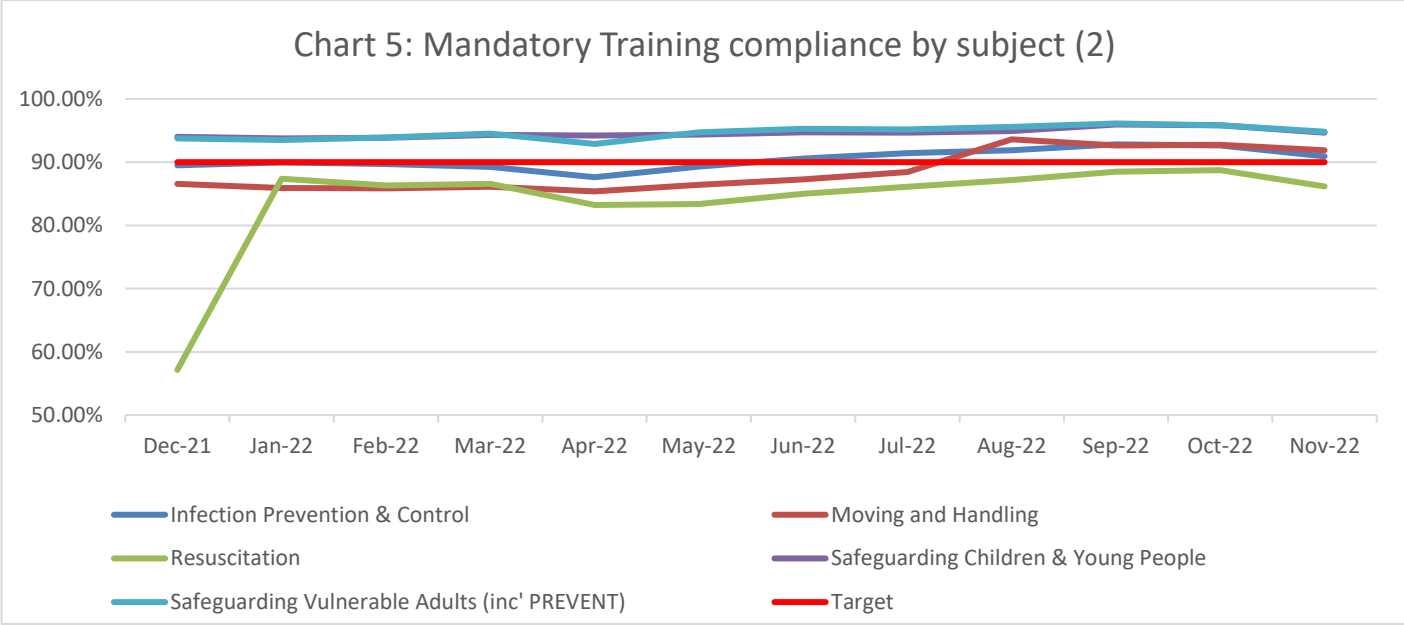
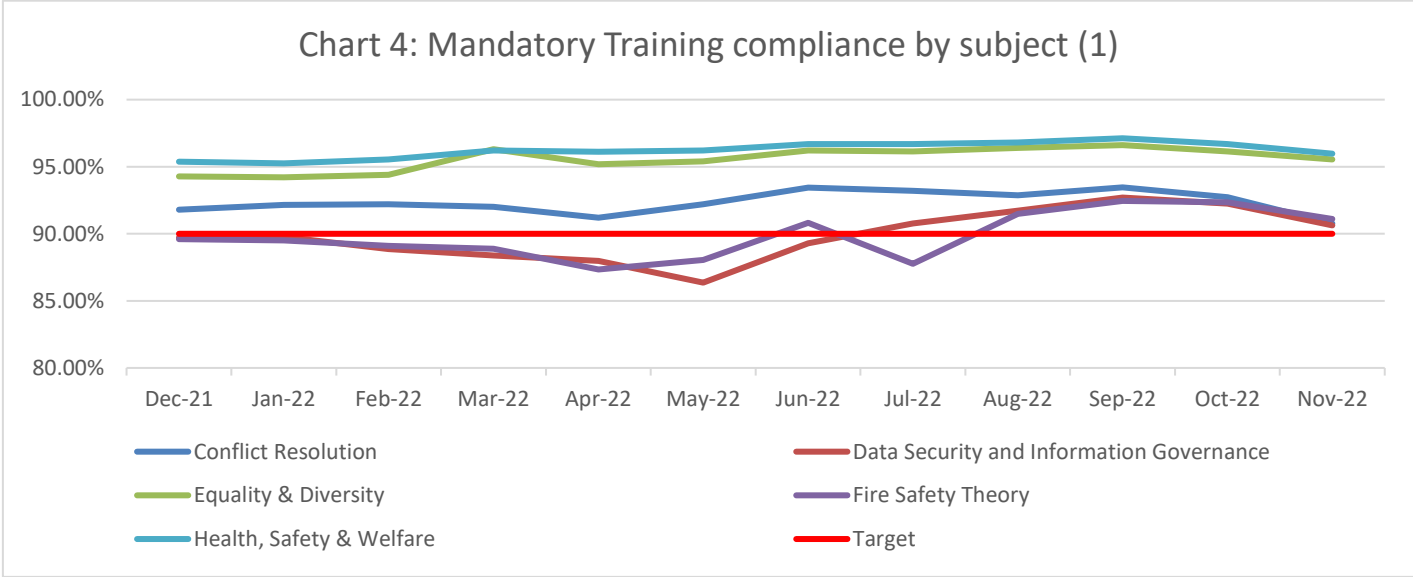


Chart 4 & 5 shows that with the exception of Resuscitation training all mandatory subjects are performing at 90% or above. The Resuscitation training team are focussing on targeting the right people for training, i.e., only delivering to staff where the training is a requirement for their role. Moving and Handling and Resuscitation training rely on face-to-face delivery and performance has been adversely affected when Covid restrictions have impacted on the ability to deliver classroom-based

training. Directorate managers are sent reports monthly showing staff with outstanding mandatory training. Subject leads are aware of the need to make reasonable adjustments when requested so that our training is accessible to all. These adjustments can include enabling accessible formats for individuals that require them.

4. JSET Training – Target 90% - overall position

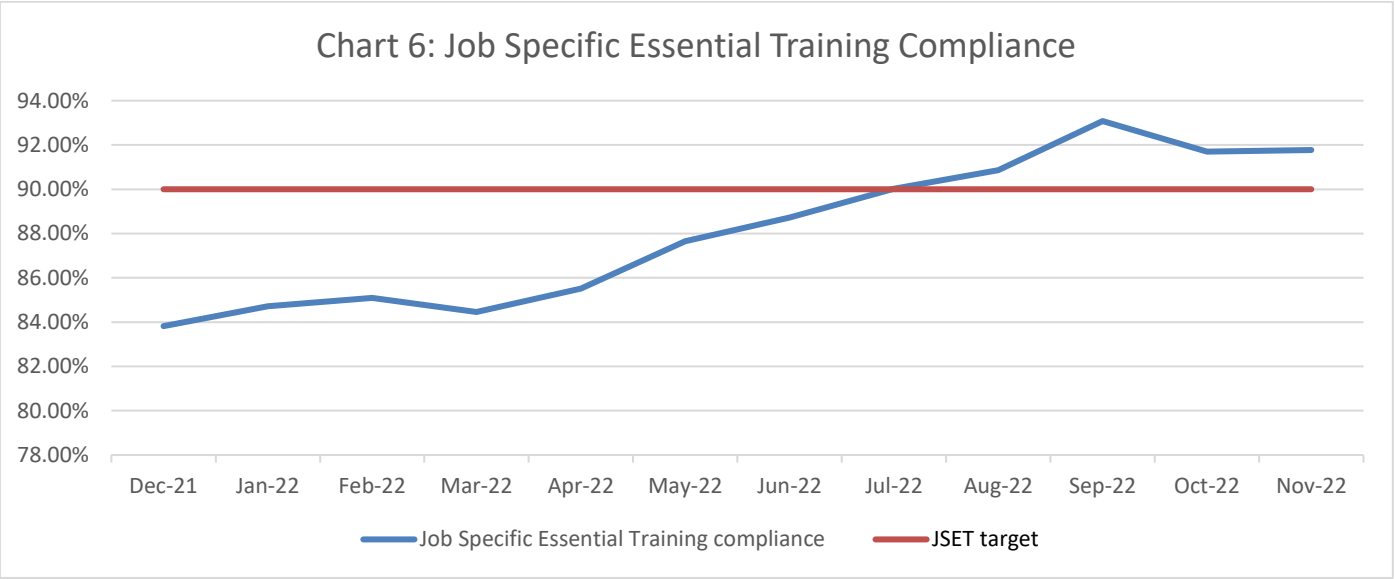


Chart 6 shows performance for the current 12 JSET subjects has achieved the 90% target. This represents a “good news story” for STH with the 90% target consistently achieved since June 2022. The performance achieved is a direct result of the collaborative, purposeful and patient first focus from our educators, managers and operational teams. Learning Education and Development have led on much of this work implementing effective systems for agreeing, delivering, recording and reporting training taking into account the needs of individuals and operational teams.

4.1 JSET by staff group

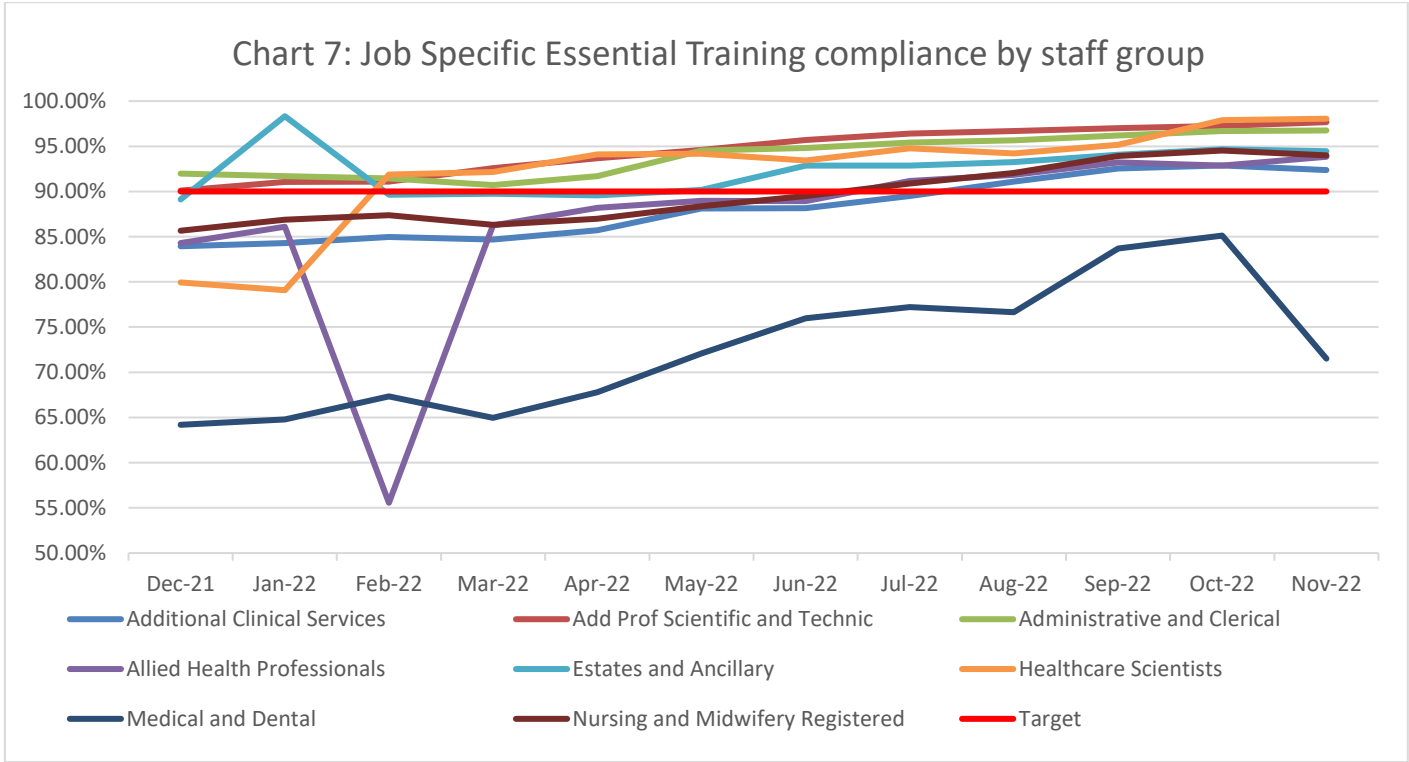


Chart 7 shows that performance for JSET has consistently achieved the 90% target for all staff groups with the exception of medical and dental staff. The JSET panel have ratified all twelve JSET subjects to validate the training content, delivery method and target audience with a goal of ensuring that the training is evidence based, accessible and being delivered only to the staff that need it. Learning, Education and Development are working with the Medical Directors office to provide regular reports with more details in respect of performance by speciality, grade and directorate to agree actions and support to achieve the required level of performance.

4.3 JSET by subject

Chart 9: Job Specific Essential training compliance by subject (1)

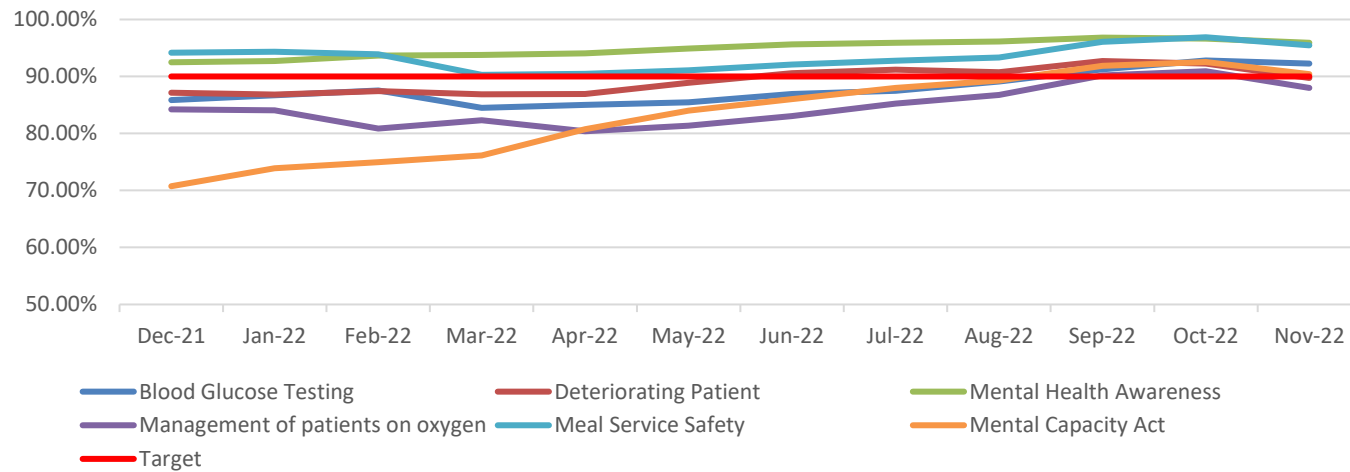


Chart 10: Job Specific Essential Training compliance by subject (2)

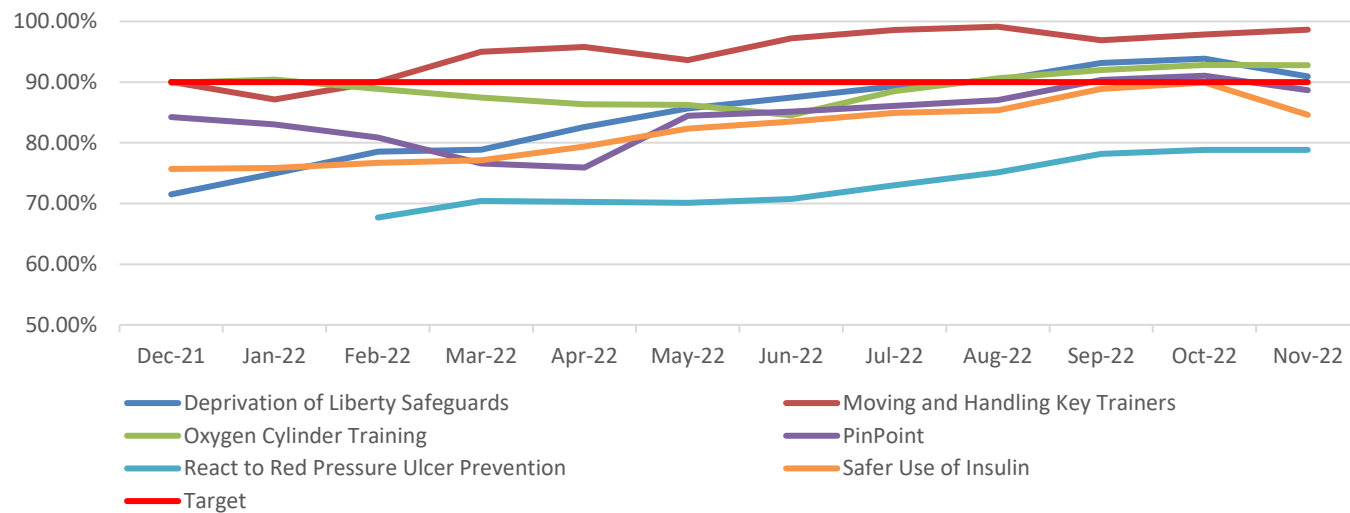


Chart 9 & 10 shows the improvement in JSET performance for the current twelve subjects. The JSET panel has carefully considered all requests for new subjects to be categorised as JSET applying a consistent set of criteria and assessing associated risks.

5. Future Work Programme

The Learning, Education and Development team oversee a programme of work to ensure that all staff complete the mandatory and JSET required for their role. Work continues to agree local JSET requirements at a directorate level with a dashboard reporting system set up in PALMS ready to go live when audiences have been ratified.

Key activity for the next twelve months includes:

- Continue to send reports showing non-compliance for named individuals to Clinical, Nursing and Operations Directors as well as corporate leads monthly to facilitate timely action so that all of our staff complete the mandatory training and JSET assigned to their role.
- Continue to support JSET performance through the Performance Framework Management structure.
- Continue to provide Mandatory and JSET reporting to MBB and the People Committee.
- Incorporating JSET into the Integrated Performance Report.
- Ensure that new subjects are introduced in a planned and timely way.
- Support directorates to identify and maintain local JSET requirements.
- Support subject leads to develop workable training capacity plans, keep their training materials up-to-date, accessible and fit for purpose.
- Provide the identified lead group or committee for all mandatory and JSET with regular performance reports working collaboratively to develop action plans where there are gaps in compliance.
- Feeding learning from incidents into training curricula.
- Evaluating staff feedback on the mandatory and JSET provision.

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 ICC TH&P NEUR OPHT LABM PLAS IG&SM ENT RESP CRCA	Diabetes & Endocrinology Integrated Community Care Therapeutics and Palliative Care Neurosciences Ophthalmology Laboratory Medicine Plastic Surgery Geriatric and Stroke Medicine ENT Respiratory Medicine Critical Care	Level 1 reviews take place on a bi-monthly basis. The Performance and Information Director attends the review with members of the directorate as appropriate.
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PMF Level 2 Directorates (Watching Brief)

OR&DE MSK CARD RENA CD&S SP&R UROL GSUR PHAR GAST	Oral & Dental Services MSK Cardiac Services Renal Services Communicable Diseases and Specialised Medicine Specialised Rehabilitation Urology General Surgery Pharmacy Gastro and Hepatology	Level 2 reviews take place on a monthly basis. These reviews are attended by members of the directorate as decided by the Operational Director along with the Performance and Information Director
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PMF Level 3 Directorates (Highest Priority)

EmCr OGN OPA VASC SCS M&MP	Acute and Emergency Medicine Obstetrics, Gynaecology & Neonatology Operating Services & Anaesthetics Vascular Services Specialised Cancer Services MIMP	Level 3 reviews take place on a monthly basis. The reviews are attended by both directorate and TEG members along with the Performance and Information Director.
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Indicator	Metric	LAB	MI&MP	OGN	Msk	OPA	CR	CARD	RENA	VASC	CD&	SP&	SCS	GSU	PLA	URO
		*R	*R	*R	*R	*R	*R	*R	*R	*R	*R	*R	*R	*R	*R	*R
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															
MRSA bacteraemia	Hospital onset															
MSSA bacteraemia	Hospital onset															
C.diff	Hospital onset															
Serious Incidents	Number of serious incidents (SI)															
	Approved SI Report submitted within timescales															
Incidents	Number of finally approved incidents based on incident date															
	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															
52 week waits	Actual numbers															
6 week diagnostic	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	62 days from referral to treatment (GP referral)															
	Patient seen within 2 weeks of urgent referral															
	31 day first treatment from referral															
	Breast symptomatic seen within 2 weeks															
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 Accommodatio	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															
Efficiency	Variance from plan															

Indicator	Metric	DI&EN	EmCr	GAST	PHAR	RESP	ICC	IG&SM	TH&PC	OR&D	ENT	NEUR	OPHT
		*R	*R	*R	*R	*R	*R	*R	*R	*R	*R	*R	*R
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	●	●	●	●	●	●	●	●	●	●	●	●
MRSA bacteraemia	Hospital onset	●	●	●	●	●	●	●	●	●	●	●	●
MSSA bacteraemia	Hospital onset	●	●	●	●	●	●	●	●	●	●	●	●
C.diff	Hospital onset	●	●	●	●	●	●	●	●	●	●	●	●
Serious Incidents	Number of serious incidents (SI)	●	●	●	●	●	●	●	●	●	●	●	●
	Approved SI Report submitted within timescales	●	●	●	●	●	●	●	●	●	●	●	●
Incidents	Number of finally approved incidents based on incident date	●	●	●	●	●	●	●	●	●	●	●	●
	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	●	●	●	●	●	●	●	●	●	●	●	●
52 week waits	Actual numbers	●	●	●	●	●	●	●	●	●	●	●	●
6 week diagnostic	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	62 days from referral to treatment (GP referral)	●	●	●	●	●	●	●	●	●	●	●	●
	Patient seen within 2 weeks of urgent referral	●	●	●	●	●	●	●	●	●	●	●	●
	31 day first treatment from referral	●	●	●	●	●	●	●	●	●	●	●	●
	Breast symptomatic seen within 2 weeks	●	●	●	●	●	●	●	●	●	●	●	●
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	●	●	●	●	●	●	●	●	●	●	●	●
Efficiency	Variance from plan	●	●	●	●	●	●	●	●	●	●	●	●

R – Reliability

V – Validity

A - Accuracy