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.

RECOMMENDATIONS

The Board is asked to:

a) Receive the Integrated Performance Report for June 2022 and July 2022.

b) Note the performance standards that are being achieved.

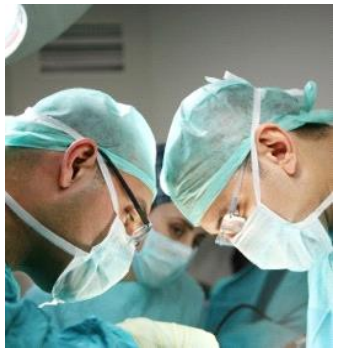
c) Be assured that where performance standards are not currently met, a detailed analysis has been undertaken and actions are in place to ensure an improvement is made.

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

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	Create a Sustainable Organisation	☑
6	Deliver excellent research, education and innovation	☑

APPROVAL PROCESS		
Meeting:	Trust Executive Group	Board of Directors
Approved Y/N:		
Date:	14 September 2022	27 September 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
27 September 2022

Section	Page
Executive Summary	5
Trust Performance Overview: July 2022	7
Trust Performance Report by Exception	10
Ambulance Turnaround within 15 mins	11
Ambulance Turnaround more than 30 mins	12
Ambulance Turnaround over 60 mins	13
52 Week Waits	14
Cancer Waits - 62 days from referral to treatment (GP referral)	15
Sickness Absence	16
Hospital Standardised Mortality Ratio	17
Clostridioides Difficile (CDD) – Community Onset / Healthcare Associated	18
E.Coli – Hospital Onset	19
E.Coli – Community Onset / Healthcare Associated	20
Incidents – Percentage of incidents approved within 35 days based on approval date	21
Non-Elective Average Length of Stay (LOS)	22
Birth Rate between 24 and 37 weeks	23
Obstetric haemorrhage	24
Patient Falls	25
Pressure Ulcers - Number of pressure ulcers acquired within STH	26
12 Hour Trolley Waits in A&E	27
Patient Treatment List	28
Diagnostic Waiting Times	29
On-day elective cancellations for non-clinical reasons	30
Number of patients cancelled on the day and not readmitted within 28 days	31
Cancelled Outpatient appointments - Percentage of out-patient appointments cancelled by hospital	32
Cancelled Outpatient appointments - Percentage of out-patient appointments cancelled by patient	33
Cancer Waits - Patient seen within 2 weeks of urgent referral	34
Cancer Waits - Breast symptomatic seen within 2 weeks	35
Cancer Waits - 62 days from referral to treatment (Cancer Screening Service)	36
Cancer Waits – 31 day first treatment from referral	37
Cancer Waits - 31 day subsequent treatment (Surgery)	38
Cancer Waits - 31 day subsequent treatment (Radiotherapy)	39
Cancer Waits - 31 day subsequent treatment (Drugs)	40
Community Care – Integrated Care Team Contacts	41
Community Care – Intermediate Care at Home Community Intermediate Care Response Time	42
Community Care - Intermediate Care Beds Length of Stay	43
FFT Recommended – Inpatients	44
FFT Recommended – AE	45
FFT Recommended – Maternity	46
Appraisals - Completed appraisals in last year	47
Recruitment – Request to fill to unconditional final offer	48

Efficiency – Variance from Plan	49
Deep Dive: Clostridioides Difficile	50
Directorate Dashboards	58

EXECUTIVE SUMMARY

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 – 83.54% of ambulance handovers were completed within 30 minutes in July 2022, compared to 79.86% in June 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 – 11.94% of handovers took longer than 60 minutes in July 2022, compared with 16.45% in June 2022

Activity recovery

New Attendances - There were 27,055 new outpatient attendances in July 2022, which was 79.21% of the activity delivered in July 2019. Year to date for 2022/23 there have been 108,470 new outpatient attendances, which is 84.79% of the YTD activity for 2019/20

Follow up Attendances - There were 60,236 follow up outpatient attendances in July 2022, which was 83.58% of the activity delivered in July 2019. Year to date for 2022/23 there have been 248,271 follow up outpatient attendances, which is 93.48% of the YTD activity for 2019/20

Elective inpatients - There were 1,642 elective inpatient spells in July 2022, which was 82.10% of the activity delivered in July 2019. Year to date for 2022/23 there have been 6,332 elective inpatient spells, which is 83.66% of the YTD activity for 2019/20

Day cases - There were 10,587 day cases in July 2022, which was 89.08% of the activity delivered in July 2019. Year to date for 2022/23 there have been 42,135 day cases completed, which is 94.79% of the YTD activity for 2019/20

Non-elective inpatients - There were 5,264 non elective spells in July 2022 which was 95.67% of the activity delivered in July 2019. Year to date there have been 21,173 inpatient non elective spells, which is 98.05% of the YTD activity for 2019/20

Bed nights – There were 43,384 bed nights for elective and non-elective patients in July 2022, this compares to 40,912 bed nights in July 2019 or 106%.

Cancer care – 49% of cancer patients were seen for their first definitive treatment within 62 days of a GP referral in July 2022. This is consistent with performance of 48.5% in Quarter 1 2022/23; but performance for the same metric in Q4 2021/22 was 57.6%

Long waiting patients

52 week breaches - There were 2,864 52-week (incomplete RTT pathway) breaches in July, compared to 2,479 in June. These patients are being prioritised for scheduling as quickly as possible.

78 week breaches – There were 462 78-week breaches in July compared to 439 in June. These patients are being prioritised for scheduling as quickly as possible.

104 week breaches - There were 25 patients waiting more than 104 weeks in July 2022, compared to 24 in June 2022 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 6.53% in July, compared to 5.64% in June against the target of 4%. Of the total absence COVID absence represented 1.93% compared to 1.23% in June.

Delivery against financial plan
The position for July is a £94k (0.0%) adverse against plan. The overspend is an improvement in the position from month 3. 10/37 Directorates are on or ahead of plan and 10 have deficits in excess of 3% of year-to-date budgets There is an underperformance against the efficiency target. The July delivery is £4.3m against the £5.5m target, a shortfall of £1.2m (22.6%).

Overall Pay is £2.7m (1.0%) under spent with a Medical & Dental overspend of £0.9m and Nurses and Midwives underspend of £2.3m. The underspend across other remaining staff groups to date totals £1.3m.

There is an overspend on Non-Pay of £3.3m (2.0%). £2.6m of this relates to High Cost Drugs, for which we are re-imbursed for within income, and £0.4m is an overspend on offsite activity expenditure as part of activity recovery.

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.

The Trust Performance overview is provided for the months of June 2022 and July 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 at the end of Q3.

TRUST PERFORMANCE OVERVIEW

Indicator	Measure	Standard	Target Type	Current Reporting Period Data Range	*R	*V	*A	Previous Reporting Period 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			

Indicator	Measure	Standard	Target Type	Current Reporting Period Data Range	*R	*V	*A	Previous Reporting Period Data Range	*R	*V	*A
Deliver The Best Clinical Outcomes											
Hospital Mortality	Hospital Standardised Mortality Ratio	As expected or lower	SOF	Jun-2021 to May-2022				Feb-2021 to Jan-2022			
	Summary Hospital-level Mortality Indicator	As expected or lower	SOF	Apr-21 to Mar-22				Dec-20 to Nov-21			
MRSA bacteraemia	Hospital onset	Zero cases	SOF	Jul-22				Jun-22			
MSSA bacteraemia	Hospital onset	63 per year	SOF	Q2 22/23				Q1 22/23			
C.diff	Hospital onset	112 per year (28 per quarter)	SOF	Q2 22/23				Q1 22/23			
	Community onset/ healthcare associated	36 per year (9 per quarter)	SOF	Q2 22/23				Q1 22/23			
E.coli	Hospital onset	136 per year (34 per quarter)	SOF	Q1 22/23				Q4 21/22			
	Community onset/ healthcare associated	84 per year (21 per quarter)		Q1 22/23				Q4 21/22			
Serious Incidents	Number of serious incidents (SI)	Number	Local	Jul-22	9			Jun-22	10		
	Approved SI Report submitted within timescales	No overdue reports	Local	Jul-22				Jun-22			
Incidents	Number of finally approved incidents based on incident date	Number of incidents	Local	Jul-22	2,383			Jun-22	2,685		
	Percentage of incidents approved within 35 days based on approval date	95% within 35 days	Local	Jul-22				Jun-22			
Average Length of Stay (by discharges)	Average Length of Stay Elective	4.27 days (Dr Foster)	Local	May-21 to Apr-22				Apr-21 to Mar-22			
	Average Length of Stay Non Elective	4.45 days (Dr Foster)	Local	May-21 to Apr-22				Apr-21 to Mar-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	Jul-22				Jun-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	Jul-22				Jun-22			
Obstetric haemorrhage	Massive obstetric haemorrhage >=1500ml as proportion of deliveries (singleton cephalic births 37-42	2.9%	Local	Jul-22				Jun-22			
Patient Falls	Number of patient falls	< 3526 per year / 294 per month (19-20 total)	Local	Jul-22				Jun-22			
Pressure Ulcers	Number of pressure ulcers acquired within STH	Max 83 per month (996 per year)	Local	Jul-22				Jun-22			
	Category 4 pressure ulcers	Zero	Local	Jul-22				Jun-22			
Never Events	Number of never events	Zero	SOF	Jul-22				Jun-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	Jul-22				Jun-22			
>12 hr Trolley waits in A&E	No. of patients waiting > 12 hours	Zero	National	Jul-22				Jun-22			
Ambulance turnaround	Time taken for ambulance handover of patient	65% within 15 minutes	National	Jul-22				Jun-22			
	Time taken for ambulance handover of patient	95% within 30 minutes	National	Jul-22				Jun-22			
	Time taken for ambulance handover of patient	0% in excess of 60 minutes	Local	Jul-22				Jun-22			

Indicator	Measure	Standard	Target Type	Current Reporting Period Data Range	*R	*V	*A	Previous Reporting Period 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	Jul-22				Jun-22			
52 week waits	Actual numbers	Zero	National	Jul-22				Jun-22			
Size of PTL	Total size of Patient Treatment List	<= Sep-21 (61,416)	Local	Jul-22				Jun-22			
6 week diagnostic waiting	Percentage of patients seen within 6 weeks	99%	SOF	Jul-22				Jun-22			
Cancelled Operations	Number of operations cancelled on the day for non clinical reasons	75 per month	Local	Jul-22				Jun-22			
	Number of patients cancelled on the day and not readmitted within 28 days	Zero	National	Jul-22				Jun-22			
Cancelled Outpatient appointments	Percentage of out-patient appointments cancelled by hospital	8.71% (National figure 2019/20)	Local	Jul-22				Jun-22			
	Percentage of out-patient appointments cancelled by patient	7.51% (National figure 2019/20)	Local	Jul-22				Jun-22			
DNA rate	Percentage of new out-patient appointments where patients DNA	7.27% (National figure 2019/20)	Local	Jul-22				Jun-22			
	Percentage of follow-up out-patient appointments where patients DNA	7.36% (National figure 2019/20)	Local	Jul-22				Jun-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	Jul-22				Jun-22			
Ethnic group data collection	Percentage of inpatient admissions with a valid ethnic group code	85%	National	Jul-22				Jun-22			
Elective Inpatient activity	Variance from contract schedules	On plan	Local	Jul-22				Jun-22			
Non elective inpatient activity	Variance from contract schedules	On plan	Local	Jul-22				Jun-22			
New outpatient attendances	Variance from contract schedules	On plan	Local	Jul-22				Jun-22			
Follow up op attendances	Variance from contract schedules	On plan	Local	Jul-22				Jun-22			
A&E attendances	Variance from contract schedules	On plan	Local	Jul-22				Jun-22			
Complaints	Percentage of complaints closed within agreed timescales	90% within agreed timescale	Local	Jul-22				Jun-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	Jul-22				Jun-22			
	Intermediate Care at home Community Intermediate Care response time	98% within 1 day	Local	Jul-22				Jun-22			
	Intermediate Care Beds Occupancy	88%	Local	Jul-22				Jun-22			
	Intermediate Care Beds Length of Stay	<35 days	Local	Jul-22				Jun-22			

Indicator	Measure	Standard	Target Type	Current Reporting Period Data Range	*R	*V	*A	Previous Reporting Period Data Range	*R	*V	*A
Provide Patient Centred Services											
Out of Hours GPC	% Seen Within 4 hours	95%	Local	Jul-22				Jun-22			
FFT Recommended	Patients recommending STH for Inpatient treatment	95%	SOF	Jul-22				Jun-22			
	Patients recommending STH for A&E treatment	86%	SOF	Jul-22				Jun-22			
	Patients recommending STH for Maternity treatment	95%	SOF	Jul-22				Jun-22			
	Patients recommending STH for Community treatment	90%	SOF	Jul-22				Jun-22			
Community care – information completeness	RTT information completeness	50%	National	2022/23 Q1				2021/22 Q4			
	Referral information completeness	50%	National	2022/23 Q1				2021/22 Q4			
	Activity information completeness	50%	National	2022/23 Q1				2021/22 Q4			
Day surgery rates	Aggregate percentage of all BADS procedures recommended to be treated as day case or outpatient	88%	Local	Jul-22				Jun-22			
Mixed Sex Accommodation	Number of breaches of Mixed Sex Accommodation standard	Zero	SOF	Jul-22				Jun-22			
Employ Caring & Cared for Staff											
Sickness Absence	All days lost as a percentage of those available	4%	SOF	Jul-22				Jun-22			
Appraisals	Completed appraisals in last year	90%	Local	Jul-22				Jun-22			
Mandatory Training	Overall percentage of completed mandatory training	90%	Local	Jul-22				Jun-22			
Safer Staffing	Care Hours per patient day (Registered Nurses)	85% of planned hours or greater	Local	Jul-22				Jun-22			
	Care Hours per patient day (Total)	85% of planned hours or greater	Local	Jul-22				Jun-22			
Staff Turnover	Executive Team turnover (number of leavers as a percentage of total executive head count - rolling 1	0%	SOF	Jul-22				Jun-22			
	Number of leavers as a percentage of total head count (rolling 12 months)	to be determined	SOF	Jul-22	9.8%			Jun-22	9.8%		
	Retention Rate	85%	SOF	Jul-22				Jun-22			
Recruitment	Request to fill to unconditional final offer	Average <= 8 weeks	Local	Jul-22				Jun-22			
Spend Public Money Wisely											
I & E	YTD actual I & E surplus/deficit in comparison to YTD plan I & E surplus/deficit	>=0	SOF	Jul-22				Jun-22			
I & E Margin	I & E surplus/deficit as a percentage of total revenue	>=0	SOF	Jul-22				Jun-22			
Efficiency	Variance from plan	On plan	Local	Jul-22				Jun-22			
Cash	Actual	Above profile	Local	Jul-22				Jun-22			
Liquidity	Days of operating costs held in cash or cash equivalents	>0	SOF	Jul-22				Jun-22			
Capitol	Expenditure - variance from plan	On plan	Local	Jul-22				Jun-22			
Deliver Excellent Research, Education & Innovation											
Recruitment to trials	Total number of patient accruals to portfolio studies	0	Regional - Y&H	Q1 22/23				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

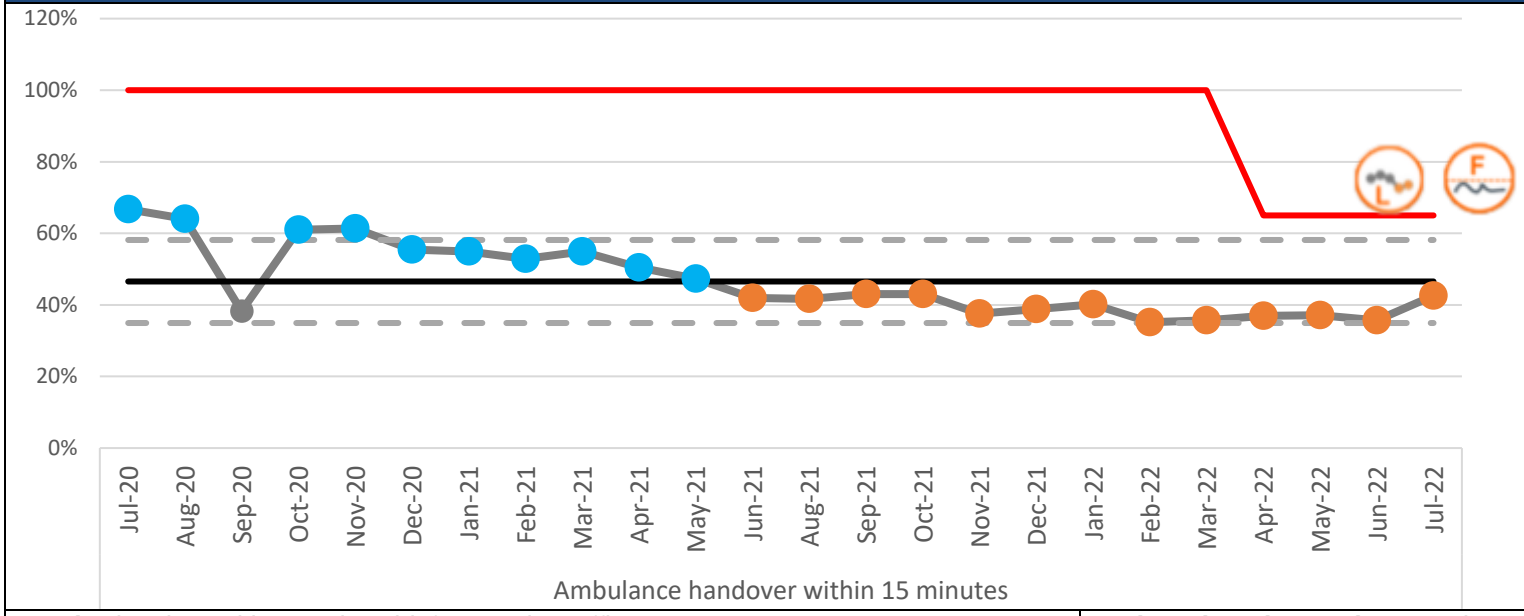
Assurance

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

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



Target	65% within 15 minutes
Jul-22	42.61% within 15 minutes
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: October 2022

Board Committee Providing Oversight: Finance and Performance Committee

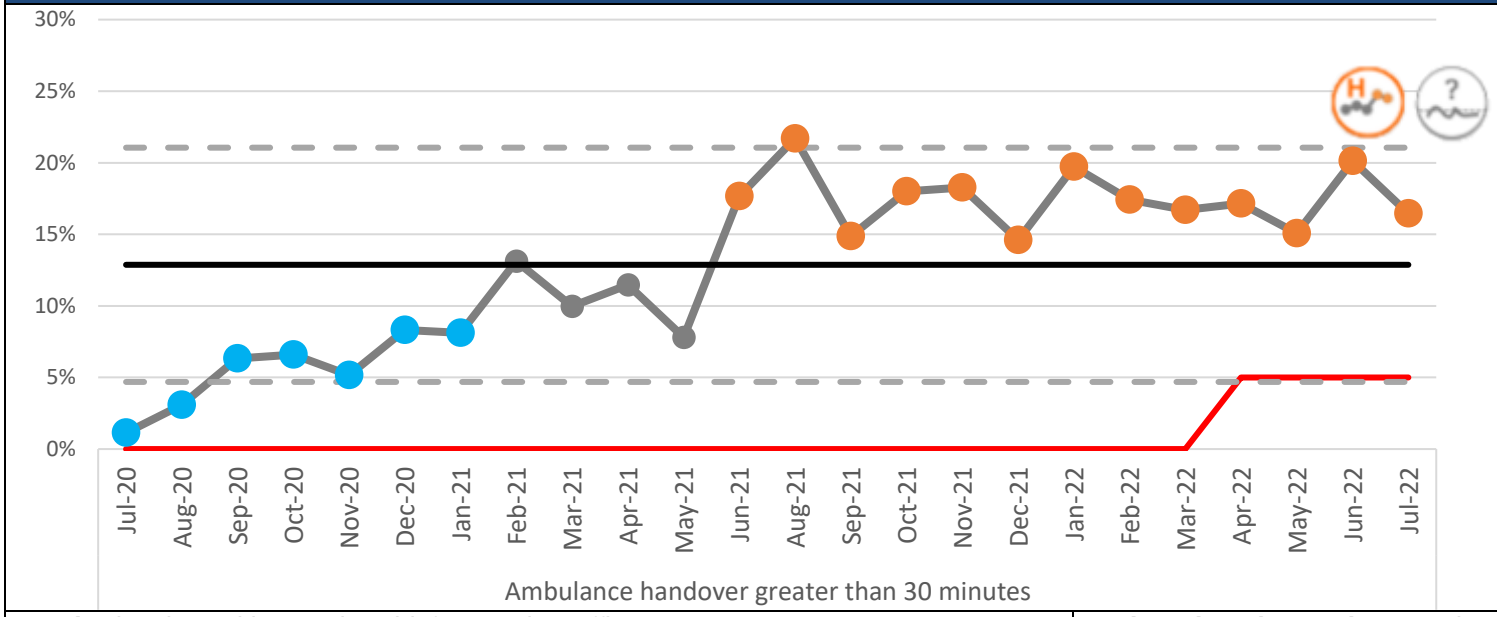
Summary of current issues

- As of April 2022, the national standard for handovers within 15 minutes changed to 65% or more. The previous target was 100%.
- 42.61% of the overall number of Ambulance Conveyances to A&E were within 15 minutes. This is an increase against June's performance of 35.71%, demonstrative of the collaborative work AEM are undertaking with YAS to identify patients who are suitable to self-handover in the A&E department, which will form part of the Rapid Process Improvement work (RPIW) the two trusts are planning in October.

Actions to recover performance

- 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.
- 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.

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



Target	<5% over 30 mins	
Jul-22	16.46% over 30 minutes	
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 national standards have not been consistently met	

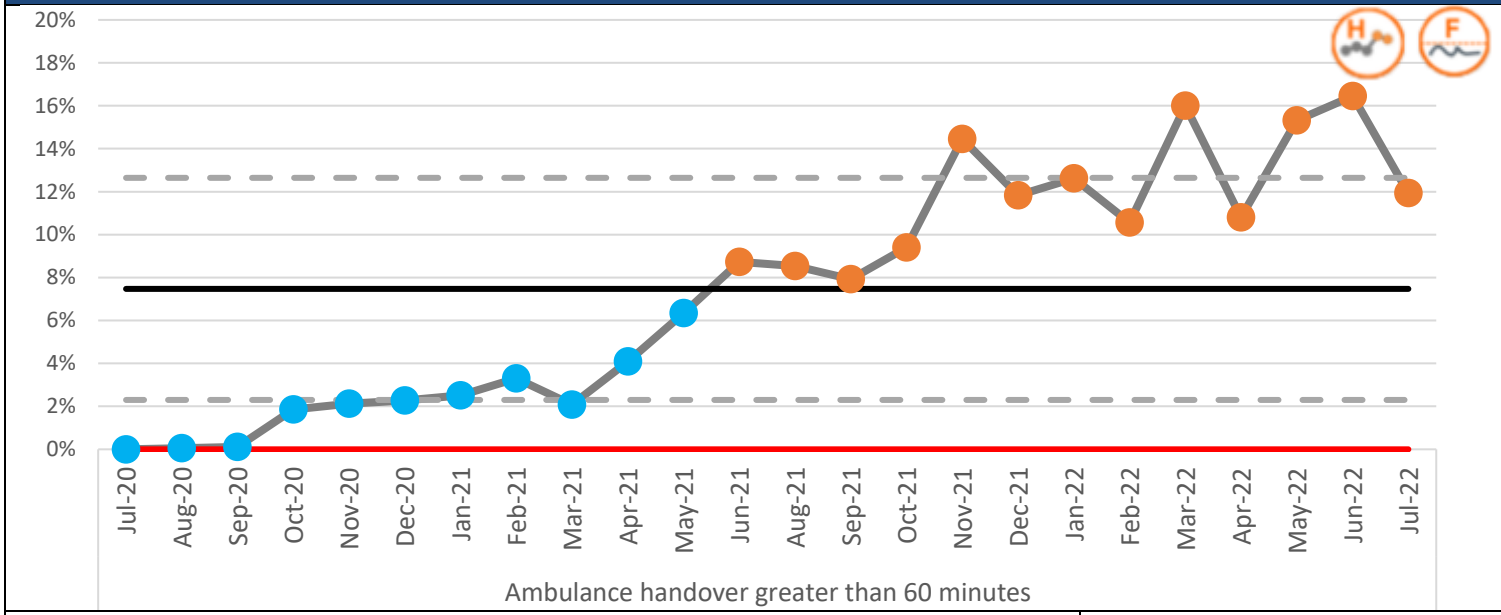
Lead: Victoria Leckie, Interim Chief Operating Officer

Action Plan Timescales: October 2022

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 more than 30 minutes changed to less than 5%. The previous target was 0%. • 16.46% of ambulance handovers were over 15 minutes in July and 20.14% in June.	• 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.

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



Target	0% over 60 minutes
Jul-22	11.94% over 60 minutes
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 national standards have not been met

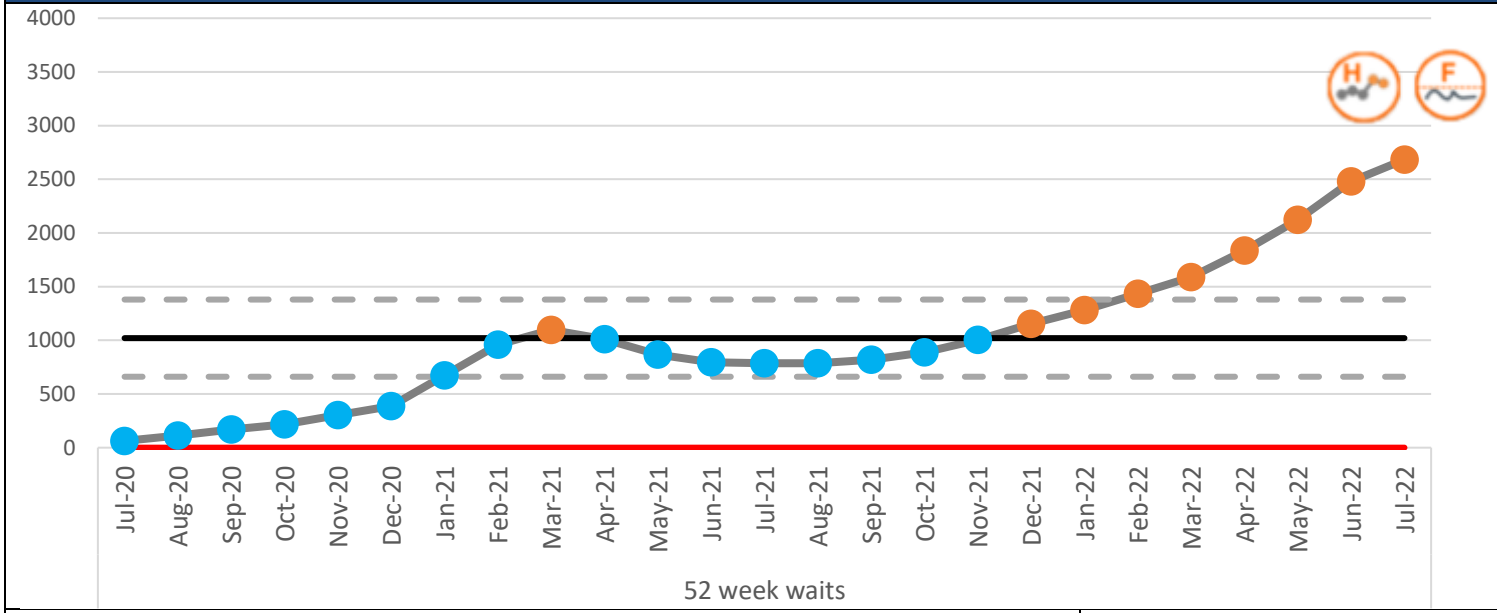
Lead: Victoria Leckie, Interim Chief Operating Officer

Action Plan Timescales: October 2022

Board Committee Providing Oversight: Finance and Performance Committee

Summary of current issues	Actions to recover performance
• In July 16.69% of ambulances handover was over 60 mins. This is stable against the June's performance of 22.11%.	• 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 crowding and ambulance handover delays including cohorting ambulance patients safely adjacent to the A&E dept to release crews. • 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
Jul-22	2,683
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 continued to rise.

Lead: Victoria Leckie, Interim Chief Operating Officer

Action Plan Timescales: March 2023

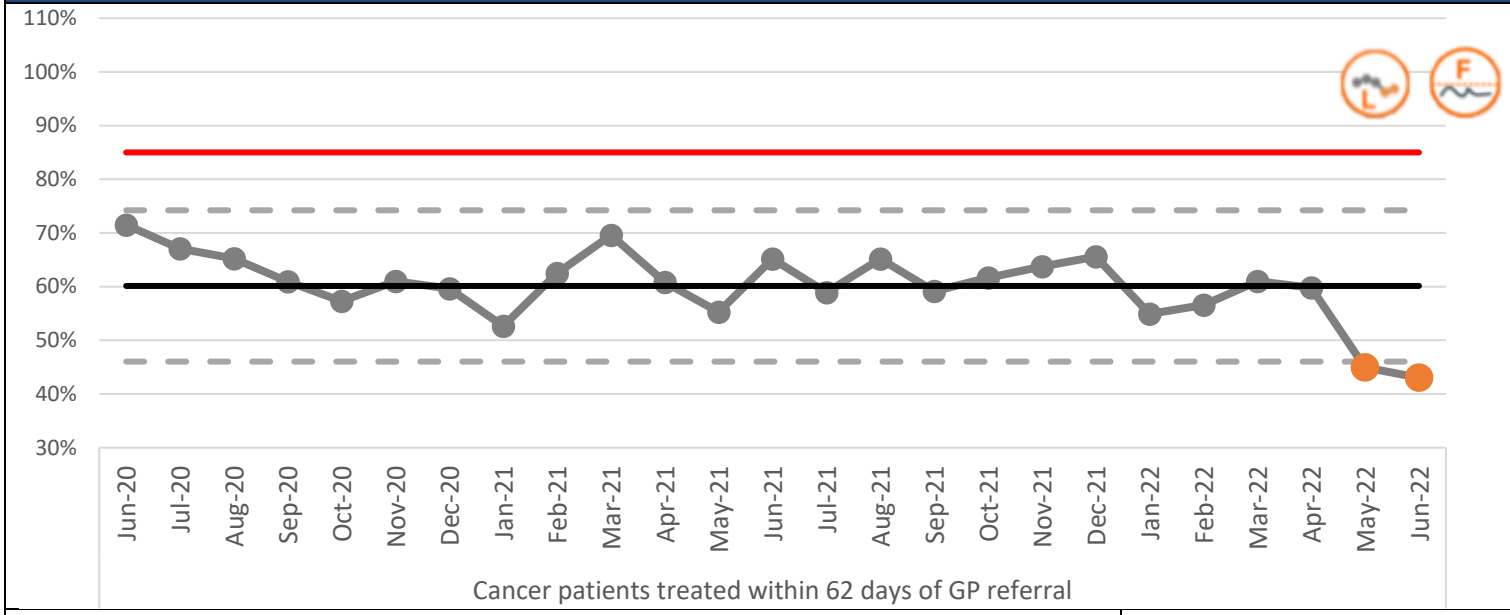
Board Committee Providing Oversight: Finance and Performance Committee

Summary of current issues

- There were 2,683 patients waiting over 52 weeks on an incomplete pathway during July 2022, an increase of 205 on the June 2022 position.

Actions to recover performance

- 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.

CANCER WAIT (Cancer patients treated within 62 days of GP referral)		
	Target	85.00%
	Q1 2022/23	48.49%
	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	Performance is consistently falling short of the target.

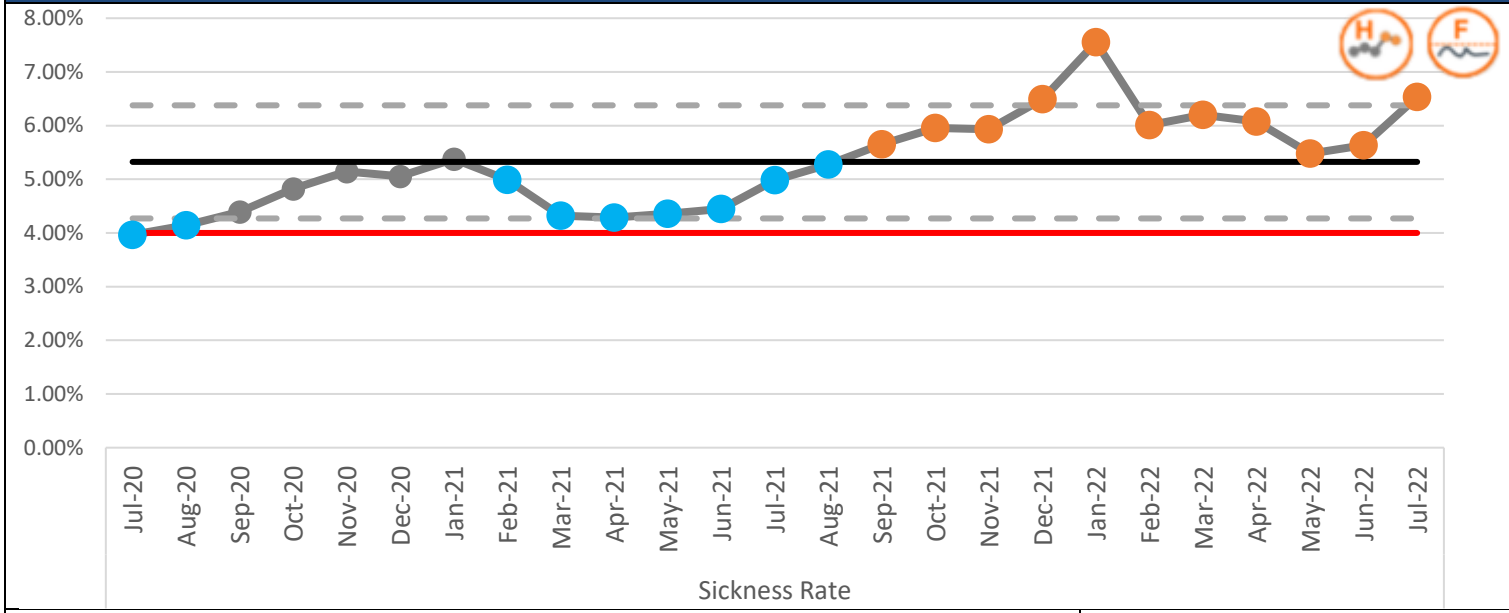
Lead: Mark Tuckett, Director of Strategy and Planning

Action Plan Timescale: Ongoing

Board Committee Providing Oversight: Finance & Performance Committee

Summary of current issues	Actions to recover performance
• The overall Trust performance for Q4 2021/22 was 57.6% (threshold 85%). STHFT performance for non-shared pathways in Q4 was 62.8%. • Majority of breaches attributed to delays resulting from the impact of COVID-19 and late inter-provider transfer continue to adversely impact performance. • The position for Q1 2022/23 is 48.5% for shared pathways and 53.1% for non-shared pathways.	• Recovery plans being progressed in-line with Patient Care Recovery Plan. • Individual Cancer sites are describing their recovery plans and identifying specific areas of support around capacity and tracking.

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



Target	4.0%	
Jul-22	6.5%	
Variance Type	H	Metric is indicating a special cause of concern due to its high values
Assurance Type	F	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: Monitored on a weekly basis

Board Committee Providing Oversight: HR and OD Committee

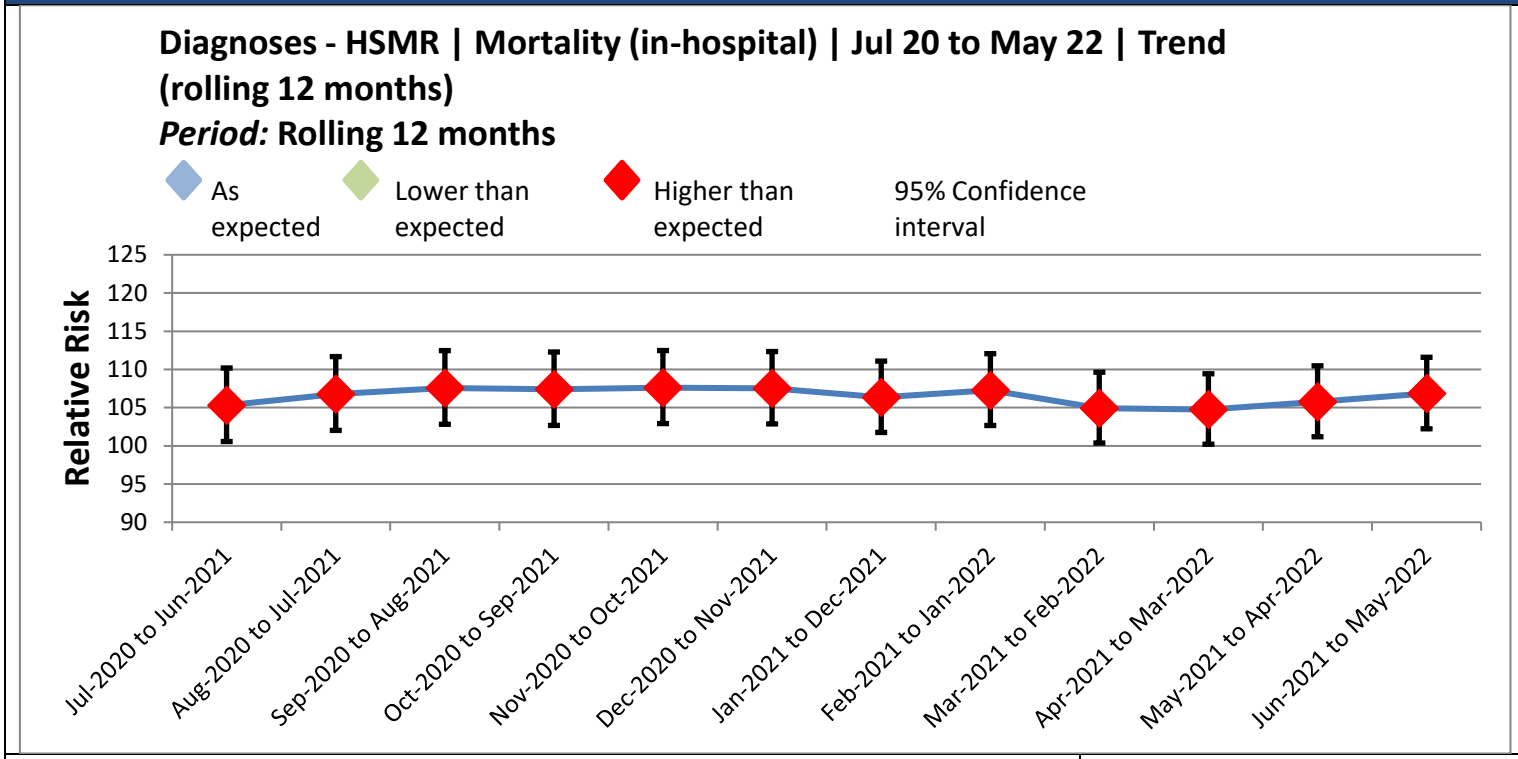
Summary of current issues

- The monthly sickness absence figure is 6.53%.
- Sickness absence has increased as COVID prevalence in the community increased.

Actions to recover performance

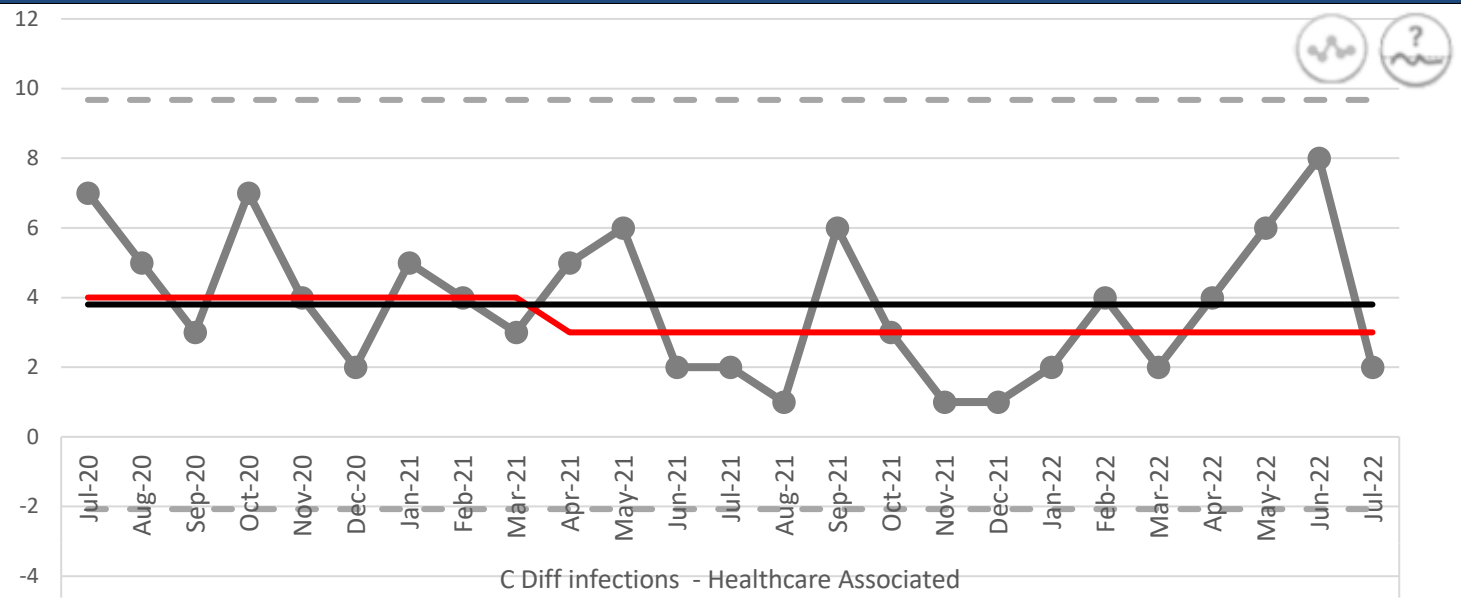
- All directorates have developed their own action plans which are continuously reviewed; HR Business Partners continue to work with directorates to develop individual action plans for staff that have been off on long term sick. Cases that were paused due to COVID have re-started.

- Support is being focussed on 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.

HOSPITAL STANDARDISED MORTALITY RATIO (HSMR)		
	Target	As expected or lower
	Jun21 – May22	106.8
	Variance Type	Not Applicable
	Assurance Type	Not Applicable
	What the chart is telling us	All values are 'higher than expected', with the latest HSMR at 106.8
Lead: Chris Morley, Chief Nurse	**Action Plan Timescale**: October 2022	
Board Committee Providing Oversight: Quality Committee		

Summary of current issues	Actions to recover performance
• The Dr Foster model has been rebased and as a result the HSMR position is now 'higher than expected. January 2022 is the month that is causing the alert.	• Deep dive underway into January 2022 with support from the Dr Foster team.

CLOSTRIDIOIDES DIFFICILE (CDD) (Healthcare Associated)



Target	9
Q1 22/23	18
Variance Type	Indicator is showing no significant change (common cause variation)
Assurance Type	Indicator is showing random variation
What the chart is telling us	The target was not achieved in Q1 22/33

Lead: Chris Morley, Chief Nurse

Timescale: Ongoing, linked to national work, and reflects a new way of working

Board Committee Providing Oversight: Quality Committee

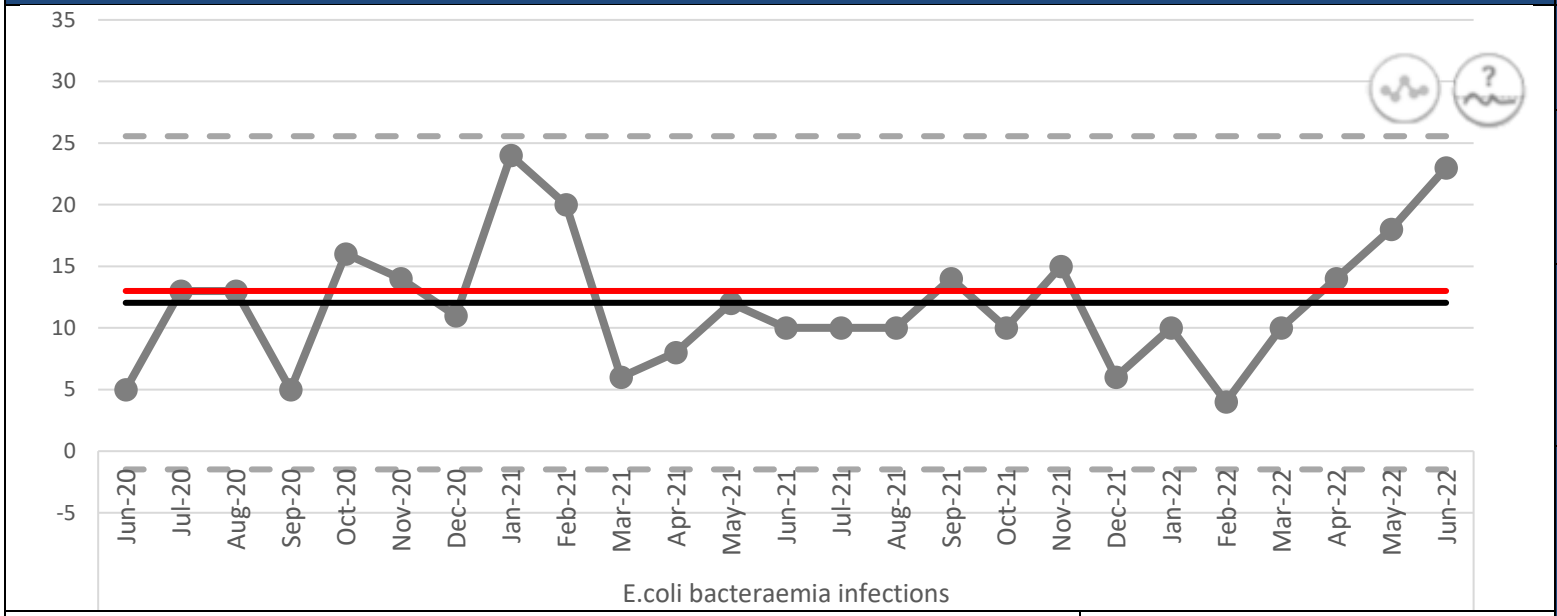
Summary of current issues

- In total (including hospital onset and community / healthcare associated), there were 2 more C.Diff cases in the quarter than the Q1 target.
- In Q1, community/healthcare associated cases were 9 above the target
- Overall, there has been an increase in C.diff cases both locally and nationally. The United Kingdom Health Security Agency (UKSHA) noted a 25.5% increase in the count of cases when comparing Q4, in 2019 and 2022; at STH this was 17.4%. The reason for this is currently unclear.

Actions to recover performance

- The Trust was represented at a local meeting arranged to explore the increase and identify any common themes that can be identified with the rise in case numbers.
- As a direct result of this meeting, collaborative working in respect of root cause analysis has commenced between the acute setting and community, with the aim to identify themes within the cases of Community Onset/Healthcare Associated infection.

E. COLI (Hospital onset)



Target		34
Q1 22/23		55
Variance Type		Indicator is showing no significant change (common cause variation)
Assurance Type		Indicator is showing random variation
What the chart is telling us		The target was not achieved in Q1 22/33

Lead: Chris Morley, Chief Nurse

Timescale: Launch of hydration pilot across all primary and secondary care settings planned for November 2022.

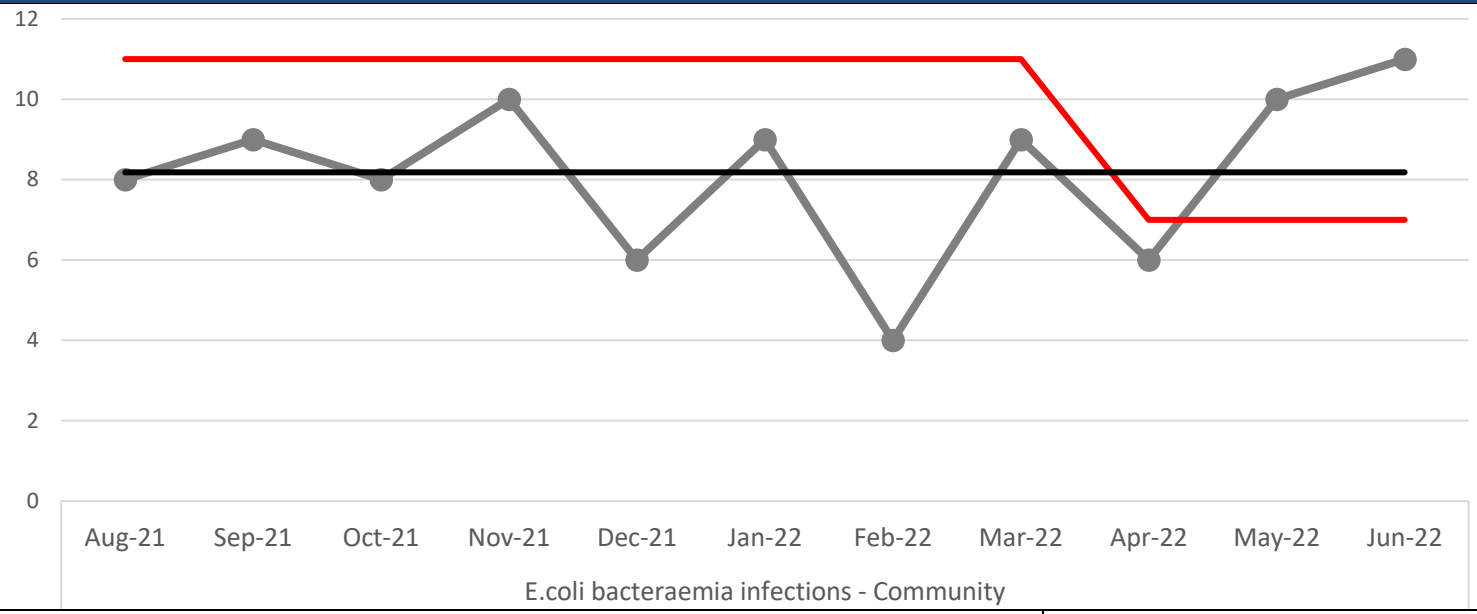
Board Committee Providing Oversight: Quality Committee

Summary of current issues

- There has been a higher number of E.Coli cases in Q1 than the Trust Target.
- Through Covid there was a significant fall in Gram negative bacteraemia numbers and the rise in cases in Q1 may reflect a return to pre pandemic case rates.
- The United Kingdom Health Security Agency (UKSHA) note that there appears to be a seasonality to the incidence of all reported E. coli bacteraemia cases, with the highest rates observed between July to September of each year.
- A recently launched Trust wide project to optimise blood cultures to increase the number of correctly taken and transported blood cultures may be leading to higher diagnosis rates.

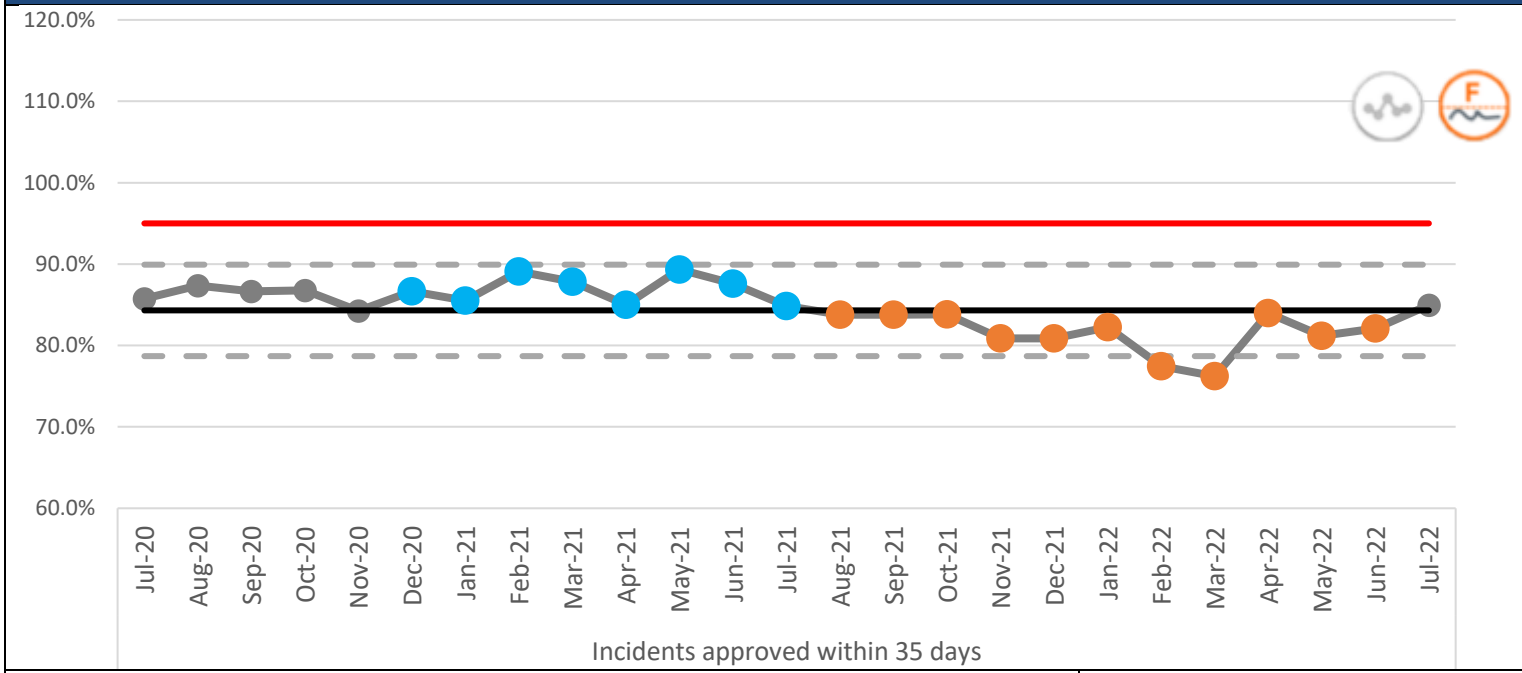
Actions to recover performance

- The data indicates that the three main infection sources are urinary tract infections, hepatobiliary infection and gastrointestinal infections. A recent project undertaken within the Trust found no themes of causation for the hepatobiliary and gastrointestinal infections.
- Therefore, continued collaboration with the South Yorkshire and Bassetlaw Integrated Care System (SYB ICS) and NHS Sheffield CCG ICS has focussed on work to reduce rates of E.Coli bacteraemia related to urinary tract infections with a proposal to launch a hydration pilot across all primary and secondary care settings.

E. COLI (Community Onset / Healthcare Associated)			
		Target	21
		Q1 22/23	26
		Variance Type	Not applicable. Insufficient number of data points for SPC
		Assurance Type	Not applicable. Insufficient number of data points for SPC
Lead: Chris Morley, Chief Nurse	**Timescale**: Launch of hydration pilot across all primary and secondary care settings planned for November 2022.	What the chart is telling us	The target was not achieved in Q1 22/33
Board Committee Providing Oversight: Quality Committee			

Summary of current issues	Actions to recover performance
• There has been a higher number of E.Coli cases in Q1 than the Trust Target. • Through Covid there was a significant fall in Gram negative bacteraemia numbers and the rise in cases in Q1 may reflect a return to pre pandemic case rates. • The United Kingdom Health Security Agency (UKSHA) note that there appears to be a seasonality to the incidence of all reported E. coli bacteraemia cases, with the highest rates observed between July to September of each year. • A recently launched Trust wide project to optimise blood cultures to increase the number of correctly taken and transported blood cultures may be leading to higher diagnosis rates.	• The data indicates that the three main infection sources are urinary tract infections, hepatobiliary infection and gastrointestinal infections. A recent project undertaken within the Trust found no themes of causation for the hepatobiliary and gastrointestinal infections. • Therefore, continued collaboration with the South Yorkshire and Bassetlaw Integrated Care System (SYB ICS) and NHS Sheffield CCG ICS has focussed on work to reduce rates of E.Coli bacteraemia related to urinary tract infections with a proposal to launch a hydration pilot across all primary and secondary care settings.

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



Target	95%
Jul-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	The target is not being met consistently.

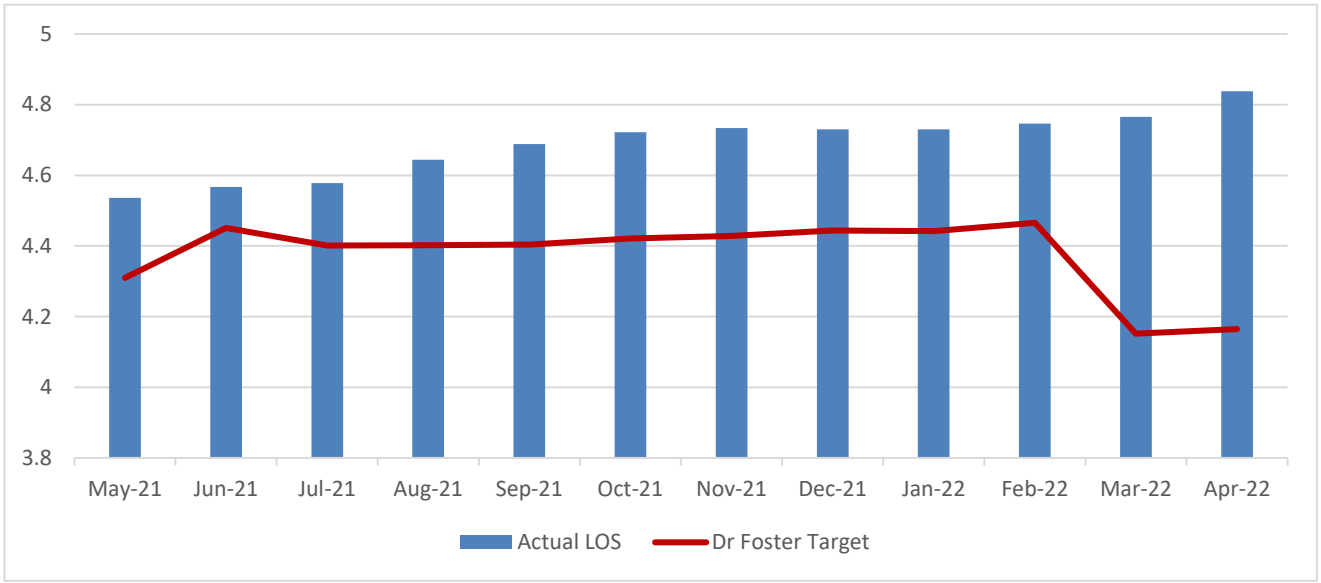
Lead: Jennifer Hill, Medical Director (Operations)

Action Plan Timescales: October 2022

Board Committee Providing Oversight: Quality Committee

Summary of current issues	Actions to recover performance
• Performance in July represents the best position in twelve months but remains below target.	• From June 2022 performance by directorate has been shared monthly at the Safety and Risk Committee. • Impact of the changes made to the incident management process in June will be reviewed to identify potential for further improvement in time to final approval of incidents.

AVERAGE LENGTH OF STAY (Non-Elective)



Target	4.17
Apr-22	4.84
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 May-21 and consistently above the national benchmark.

Lead: Jennifer Hill, Medical Director (Operations)

Action Plan Timescales: October 2022

Board Committee Providing Oversight: Quality Committee

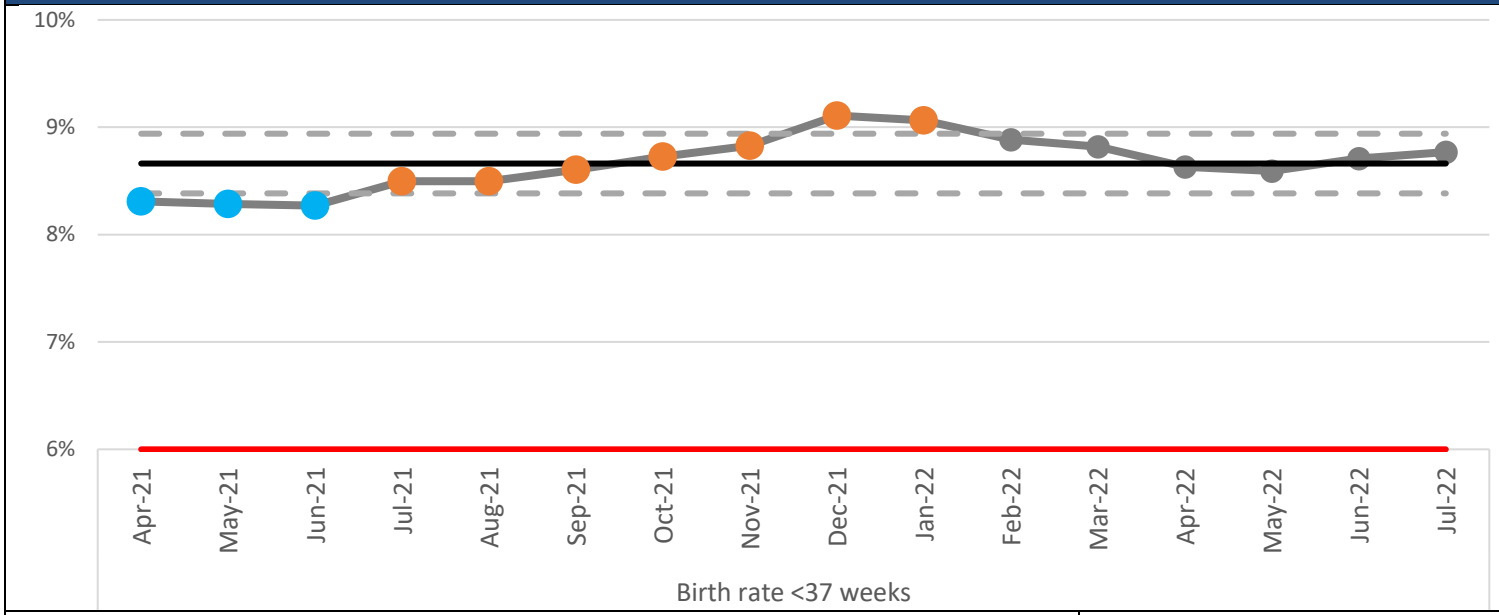
Summary of current issues

- 20% of current STH inpatients have care needs that could be met outside of an acute inpatient setting.
- An increase in numbers of patients with length of stay over 14 days

Actions to recover performance

- Increase Same Day Emergency Care Strategy (SDEC) to support timely discharge.
- 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) to shape future approach to reduce LLoS
- Improve processes for assessment and transition of care for patients needing care/support following an acute admission.
- Embed planning for discharge from the point of admission
- Newly refreshed Patient Care Recovery Plan Emergency strand to be established and active from October.

PRETERM BIRTH RATE
(Birth rate between 24 and 37 weeks as proportion of all births >24 weeks, rolling 12 months)



Target	6%
Jul-22	8.66%
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 but is believed to be affected by being a Tertiary referral unit with a Level 3 Neonatal Unit.

Lead: Chris Morley, Chief Nurse

Action Plan Timescales: Ongoing

Board Committee Providing Oversight: Quality Committee

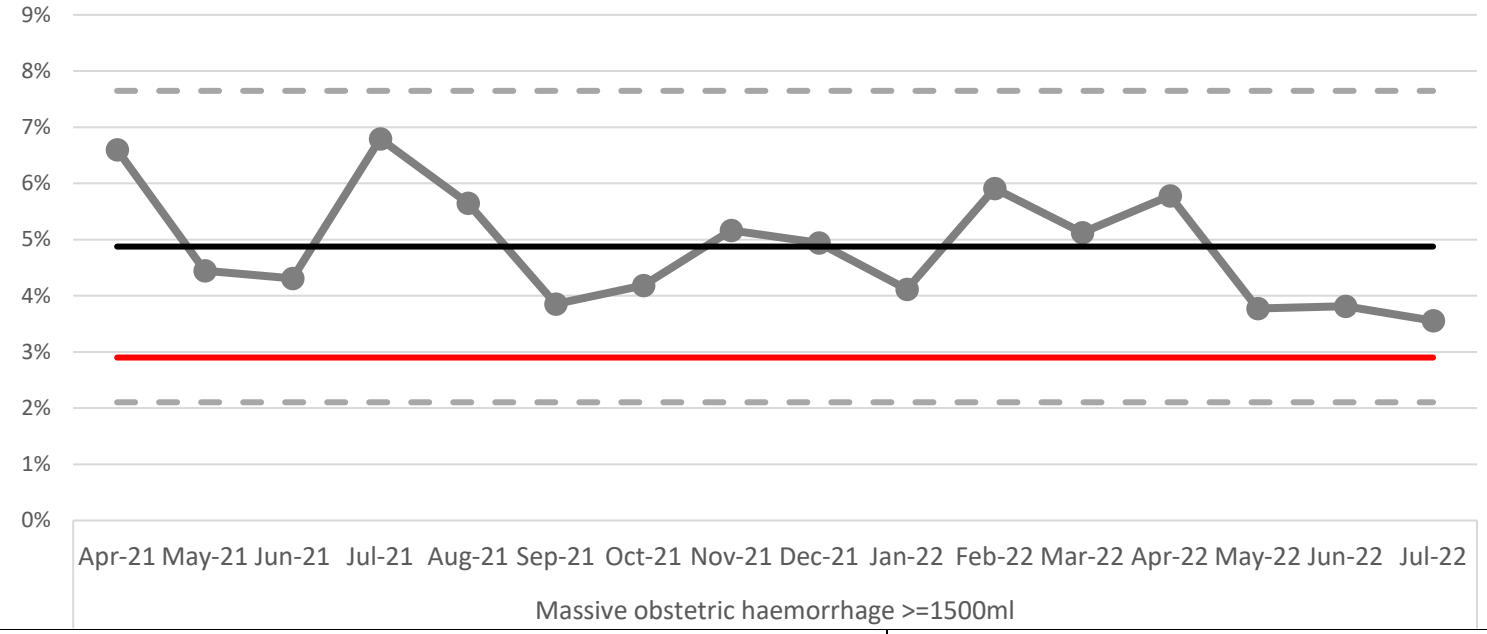
Summary of current issues

- 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.

Actions to recover performance

- The birth rate below both 37 weeks and 27 weeks will fluctuate and is 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.
- In addition, uncomplicated monochorionic birth of twins is planned to birth at 36 weeks.
- Preterm Risk assessment is completed at time of booking.
- Preterm birth clinic for women at risk.
- Use of Tommy's app to identify the risk of preterm birth.
- The regional maternity dashboard has been refreshed and the STH 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%
Jul-22	4%
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 is above the target.

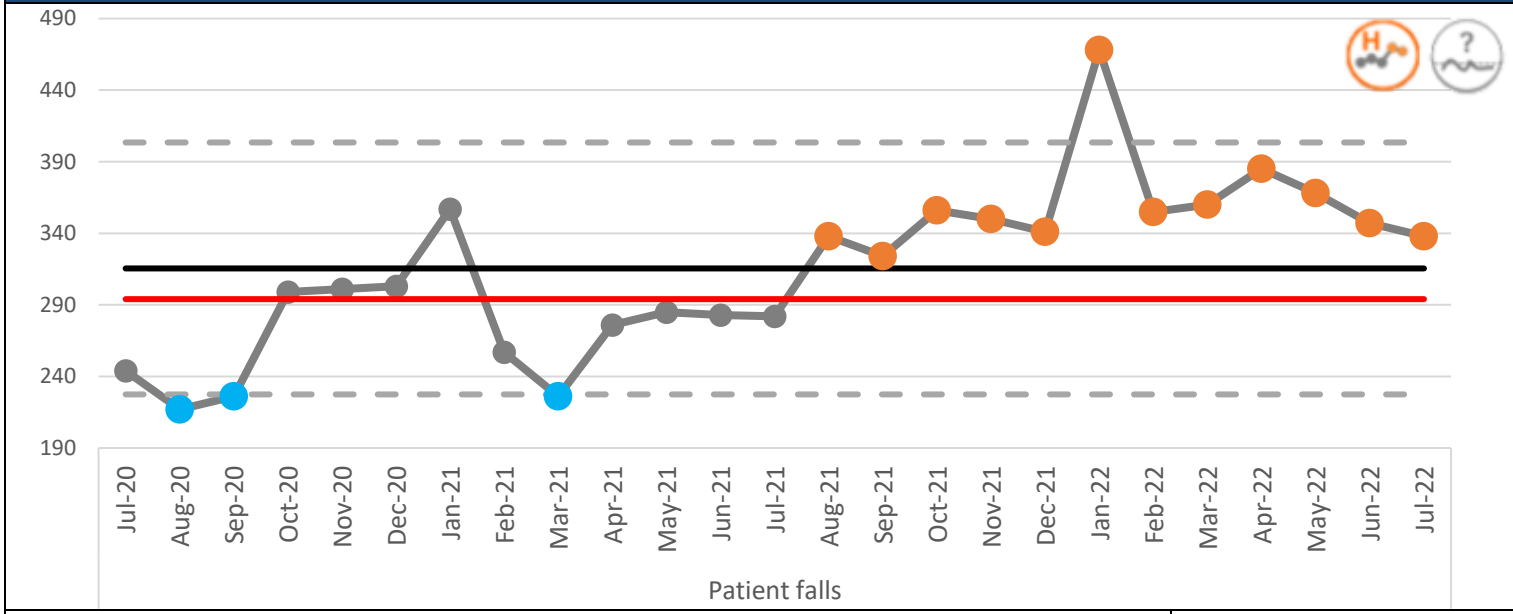
Lead: Chris Morley, Chief Nurse

Action Plan Timescales: Observing month on month to review if actions have been effective.

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 of PPH are reviewed during the weekly review meeting led by Consultant Obstetrician to identify immediate risks and learning. • All cases of PPH who are subsequently transferred to critical care are reviewed within 72 hours in the Patient Safety review meeting to identify immediate risks and learning. • Other innovations 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 notes during 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)
Jul-22	338
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 above the target

Lead: Jennifer Hill, Medical Director (Operations)

Action Plan Timescales: Ongoing

Board Committee Providing Oversight: Quality Committee

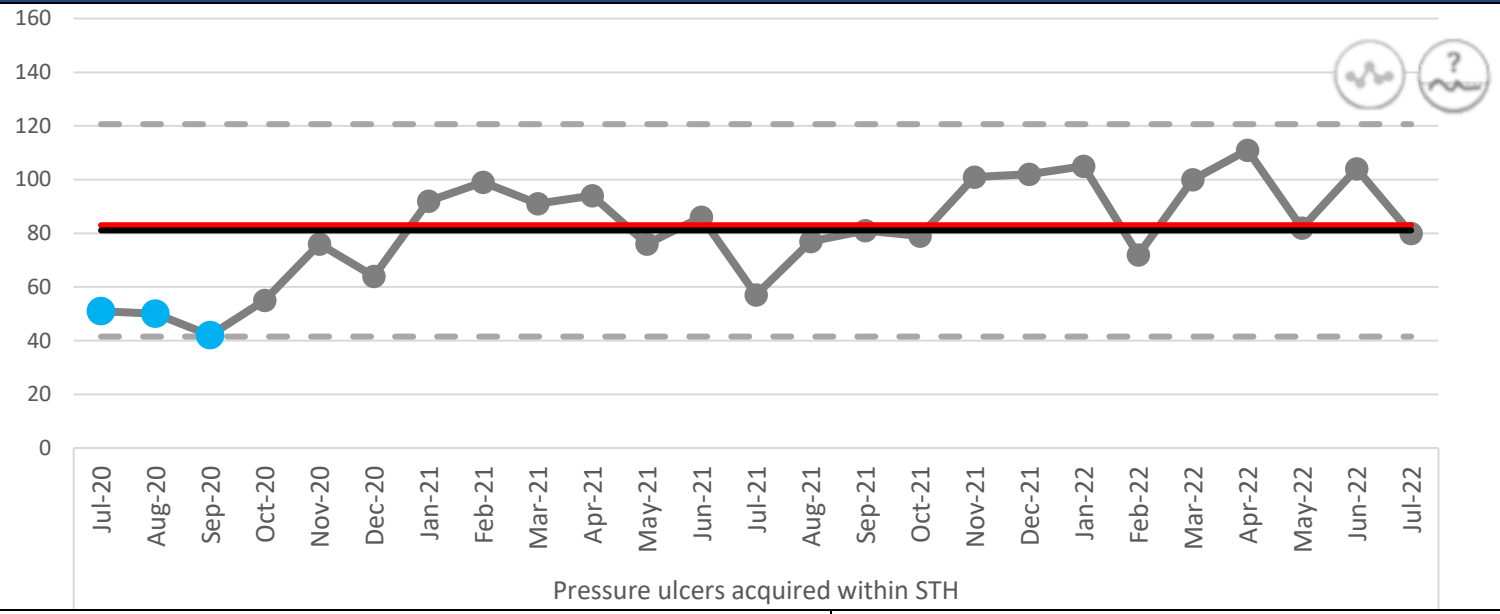
Summary of current issues

- The Trust continues to see an improvement in the falls per 1000 bed nights which takes into account the number of patients in the Trust and adjusts for longer and shorter months.
  - May – 7.2
  - June – 6.4
  - July – 6.4

Actions to recover performance

- Continued focused falls improvement work to improve awareness of actions needed to reduce falls: safety huddles, risk assessments, lying and standing blood pressure, and patients having items in reach.
- Investment through the Inpatient Recovery Plan will provide additional clinical staff to support the continued high bed occupancy through the summer.

PRESSURE ULCERS
(Number of pressure ulcers acquired within STH)



Target	83	
Jul-22	80	
Variance Type		Metric is experiencing common cause variation
Assurance Type		Indicator is showing random variation
What the chart is telling us	There has been reduction in pressure ulcers acquired within STH in July 2022.	

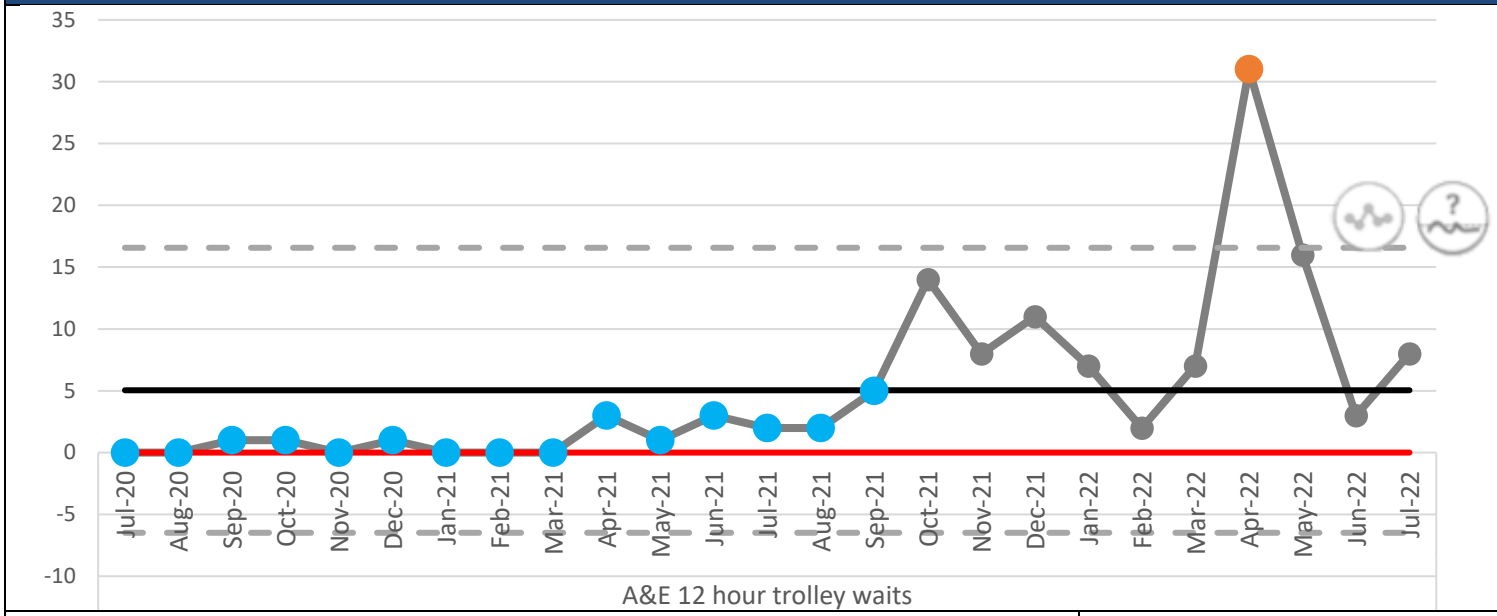
Lead: Chris Morley, Chief Nurse

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
• The number of pressure ulcers in June was 104 which is 21 above the target of 83. • In July, the number of pressure ulcers was below target at 80.	• Category 2 pressure ulcers continue to constitute the greatest proportion of reported pressure damage. • The Tissue Viability team have commenced a retrospective review of the reported category 2 pressure ulcers to identify themes of causation and prevention. Initial findings have identified that there has been both a higher incidence of moisture damage, possibly associated with the extended hot weather, which in turn has been inaccurately categorised as category 2 pressure damage. The Tissue Viability team have integrated these findings into the link worker training days that recommenced in August. • The Purpose T pilot commences in September 2022 and in addition to the identified ten pilot inpatient wards has been expanded to include Accident and Emergency and Maternity Services. There have been 0 cases of Category 4 pressure ulcers.

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



Target	0
Jul-22	8
Variance Type	Metric is experiencing common cause variation
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

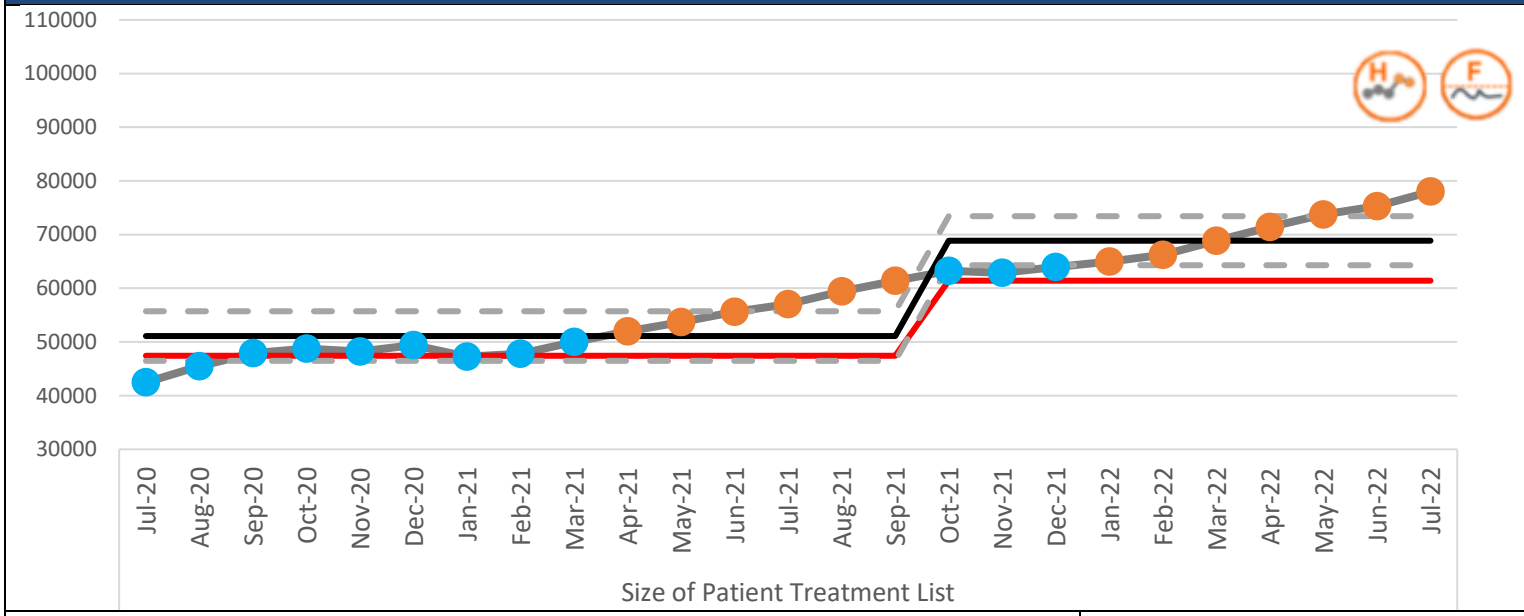
Lead: Victoria Leckie, Interim Chief Operating Officer

Action Plan Timescales: Ongoing

Board Committee Providing Oversight: Finance and Performance Committee

Summary of current issues	Actions to recover performance
• There were 8, 12 hour trolley breaches during July 2022, 5 of these patients required admission to a specialist mental health bed in another orgniasation.	• 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
Jul-22	78,009
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

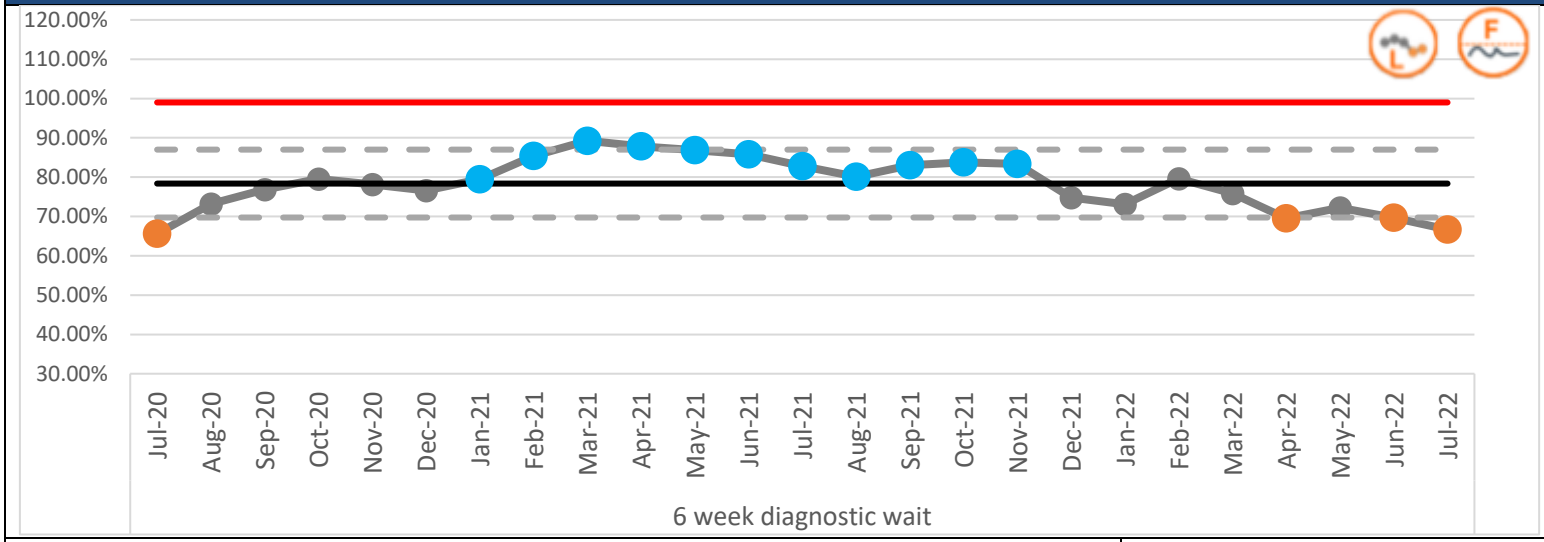
Summary of current issues

- The total number of patients on the patient treatment list (PTL) or incomplete care pathway increased by 2,699 in July 2022 to 78,009. This is above the September 2021 target of 61,416.

Actions to recover performance

- 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.
- Supporting directorates to identify vaidation resources.

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



Target	99%
Jul-22	66.70%
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 decreased since November 2021 with small improvements

Lead: Victoria Leckie, Interim Chief Operating Officer

Action Plan Timescales: March 2023

Board Committee Providing Oversight: Finance and Performance Committee

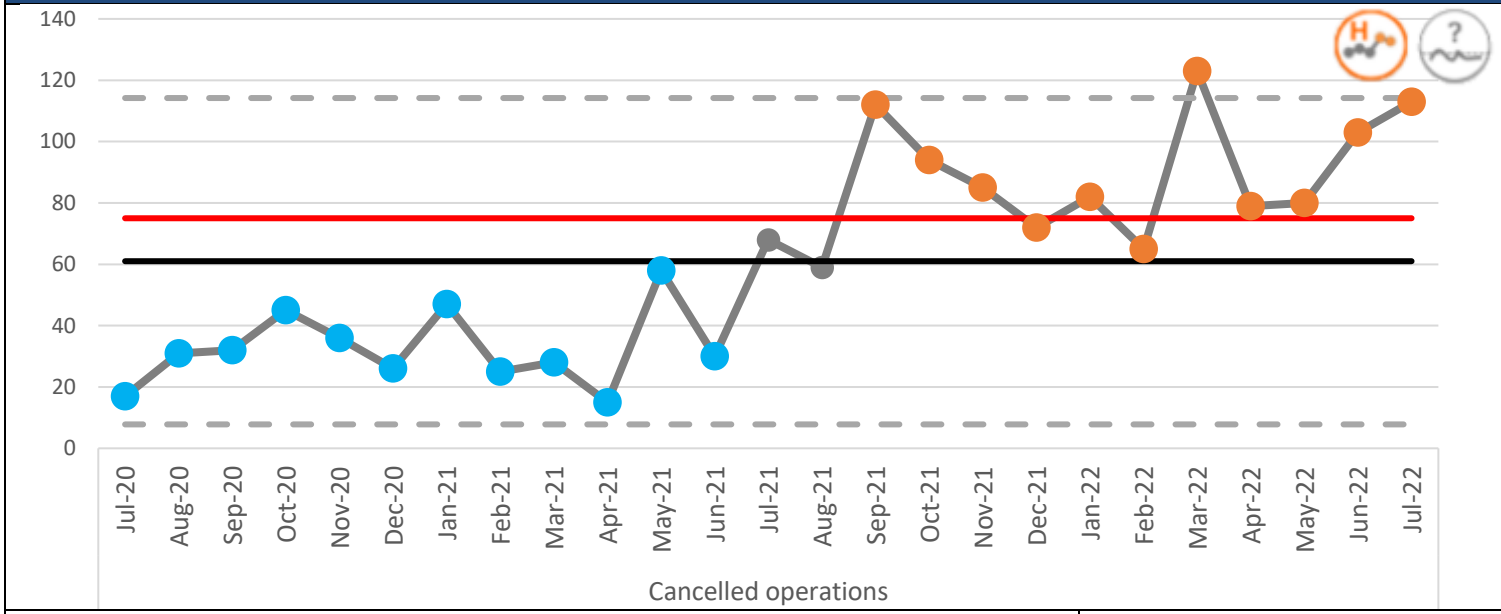
Summary of current issues

- The percentage of patients receiving diagnostic tests within 6 weeks in July 2022 was 66.70%.
- Modalities experiencing performance issues in July:
  - Neurophysiology
  - Non-obstetric ultrasound
  - Urodynamics
  - Flexi sigmoidoscopy

Actions to recover performance

- 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	
Jul-22	113	
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 below target since March 2022.	

Lead: Victoria Leckie, Interim Chief Operating Officer

Action Plan Timescales: March 2023

Board Committee Providing Oversight: Finance and Performance Committee

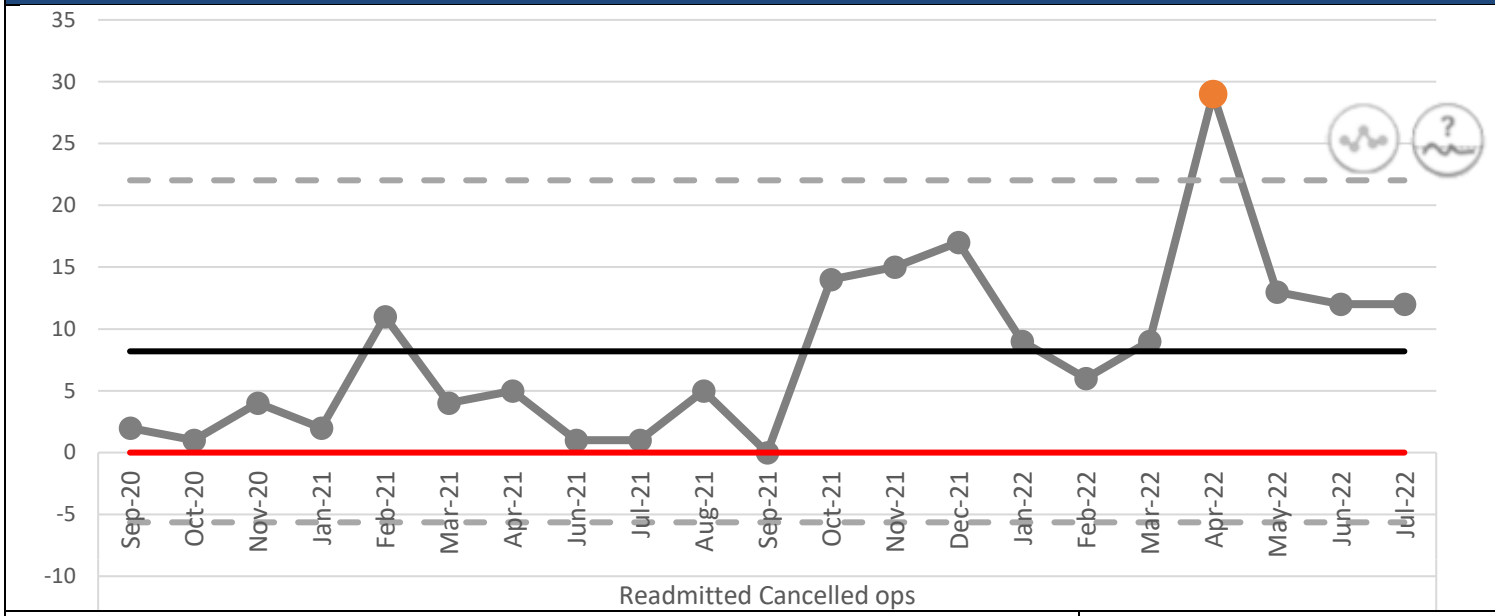
Summary of current issues

- There were 113 on-day elective cancellations during July 2022.

Actions to recover performance

- 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 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
Jul-22	12
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 and not readmitted within 28 days was below target for July 2022

Lead: Victoria Leckie, Interim Chief Operating Officer

Action Plan Timescales: March 2023

Board Committee Providing Oversight: Finance and Performance Committee

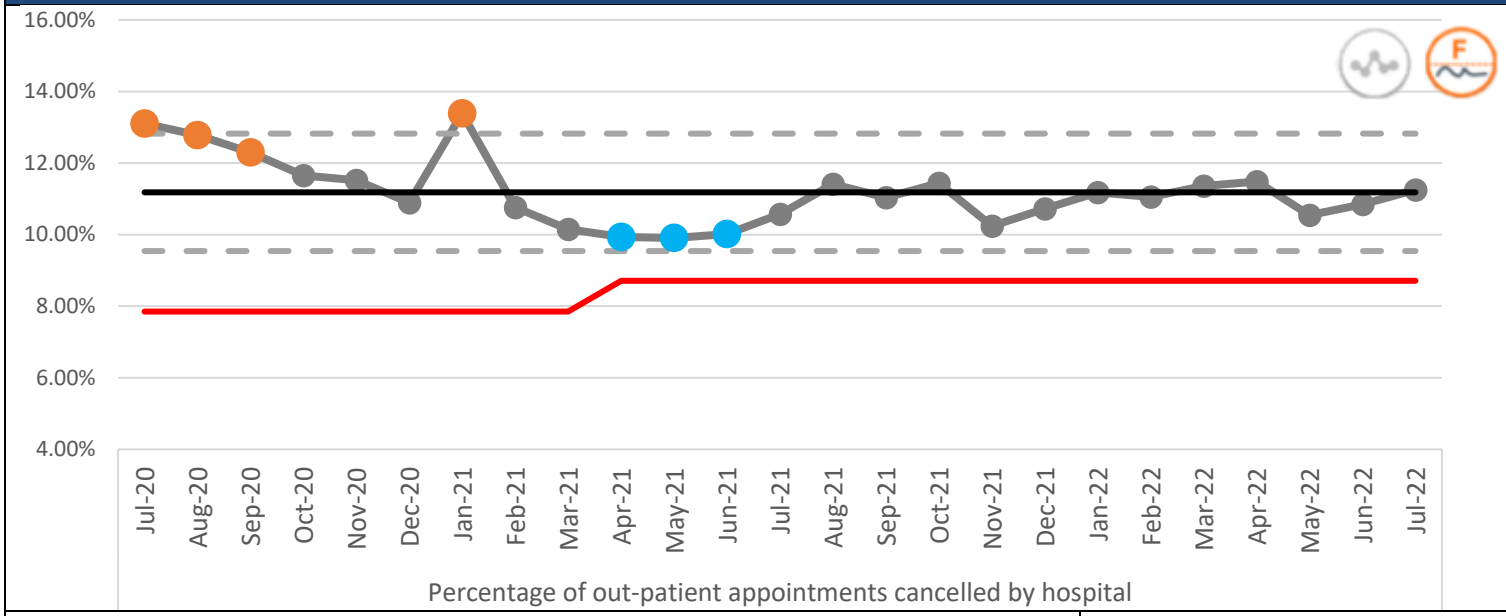
Summary of current issues

- There were 12 on-day elective cancellations during July 2022 which were not readmitted within 28 days.
- 8 patients have since been admitted and had their procedure.

Actions to recover performance

- Performance is reviewed on a regular basis by the Performance and Caseload Overview group.

CANCELLED OUTPATIENT APPOINTMENTS
(Percentage of out-patient appointments cancelled by hospital)



Target	8.71%
Jul-22	11.25%
Variance Type	Metric is experiencing common cause variation
Assurance Type	Metric is consistently falling short of the target.
What the chart is telling us	Performance is consistently falling short of the target.

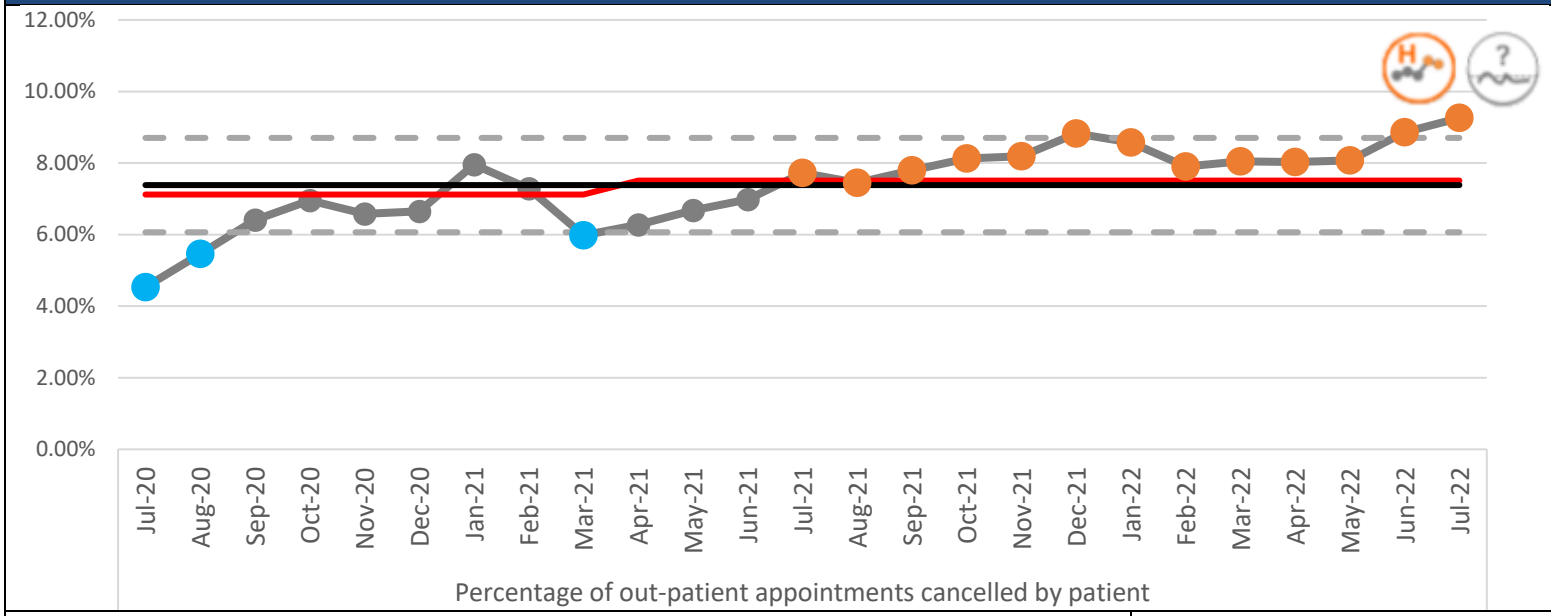
Lead: Victoria Leckie, Interim Chief Operating Officer

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 July 2022 was 11.25% compared to 10.84% in June 2022.	• Appointments that are cancelled by the hospital are clinically reviewed to ensure that it remains safe for patients to wait. This is linked to the Trust's caseload management approach. Work is ongoing with services to mitigate these cancellations and understand issues and blockages causing them.

CANCELLED OUTPATIENT APPOINTMENTS
(Percentage of out-patient appointments cancelled by the patient)



Target	7.51%
Jul-22	9.26%
Variance Type	Metric is showing special cause of concerning nature due to its high values
Assurance Type	Indicator is showing random variation
What the chart is telling us	The number of appointments cancelled by patients have been increasing steadily since March 2021 with slight improvements in Aug 21, Jan 22, and Feb 22

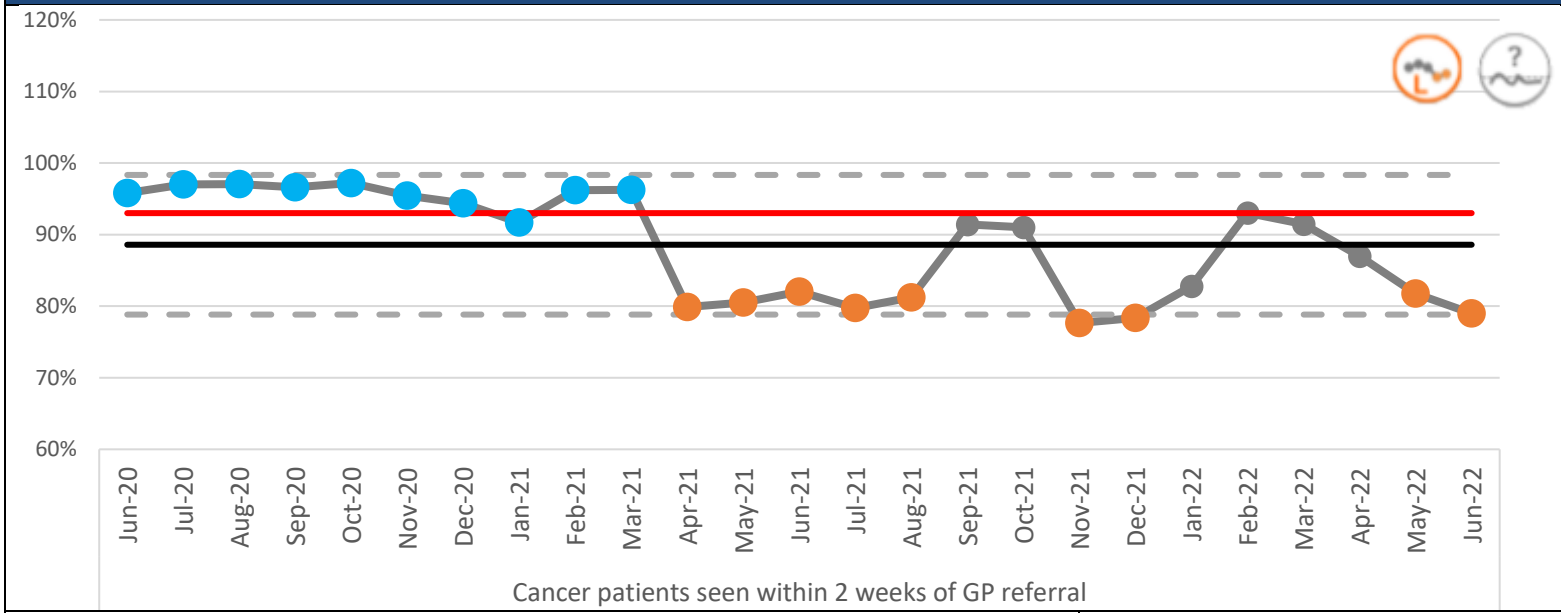
Lead: Victoria Leckie, Interim Chief Operating Officer

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 patient in July 2022 was 9.26% compared to the benchmark target of 7.51%.	• Work is ongoing to understand this and address the increase. Discussions are ongoing in relation to processes to ensure we are doing all we can to support patients being able to attend.

CANCER WAIT
(Cancer patients seen within 2 weeks of urgent referral)



Target	93.00%
Q1 2022/23	82.41%
Variance Type	Metric is showing special cause of concerning nature due to underperformance
Assurance Type	Indicator is showing random variation
What the chart is telling us	Performance has declined since February 2022.

Lead: Mark Tuckett, Director of Strategy and Planning

Action Plan Timescale: Ongoing

Board Committee Providing Oversight: Finance & Performance Committee

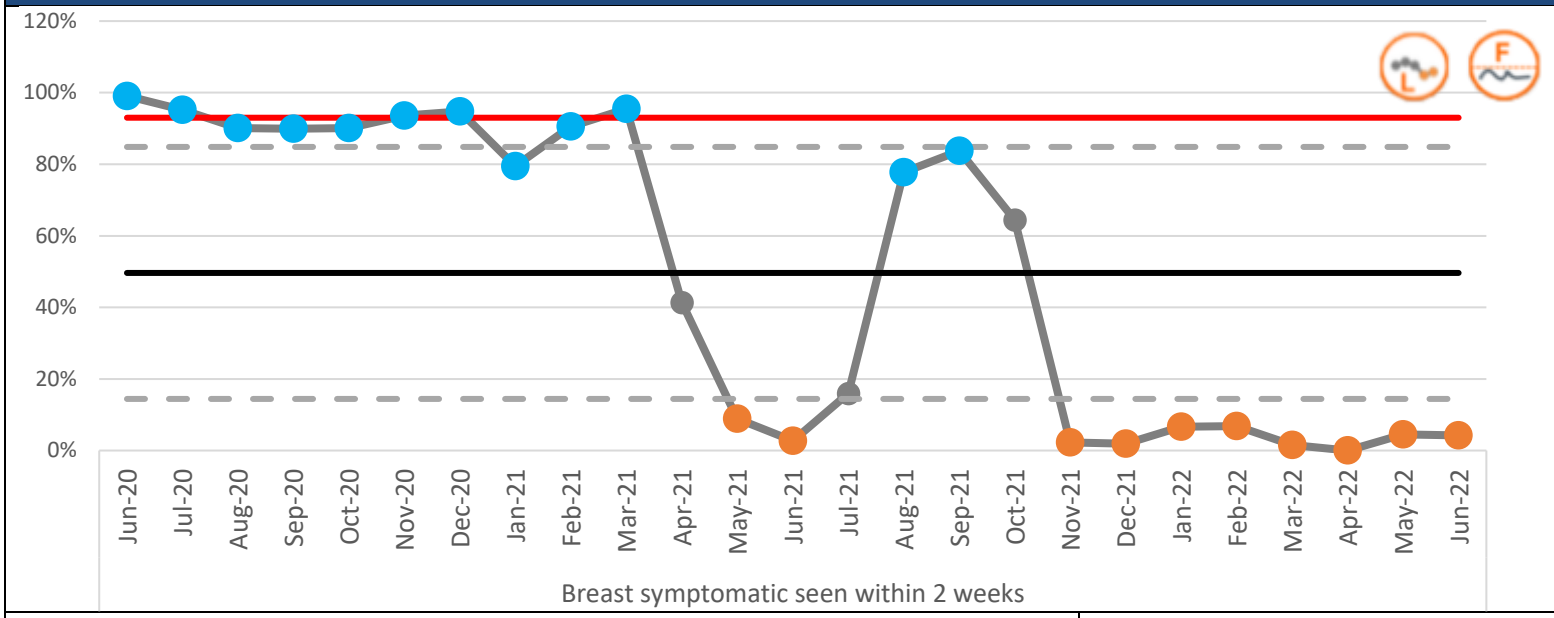
Summary of current issues

- The Trust performance for Q4 2021/22 was 89.4% (threshold 93%). Performance remains variable. Performance for Q1 2022/23 is 82.4%.
- Challenges in breast pathway capacity remain.

Actions to recover performance

- Recovery plans are being progressed in-line with the Patient Care Recovery Plan.

CANCER WAIT
(Breast symptomatic seen within 2 weeks)



Target	93.00%
Q1 2022/23	3.36%
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	Performance has consistently fallen short of the target since April 2021.

Lead: Mark Tuckett, Director of Strategy and Planning

Action Plan Timescale: Ongoing

Board Committee Providing Oversight: Finance & Performance Committee

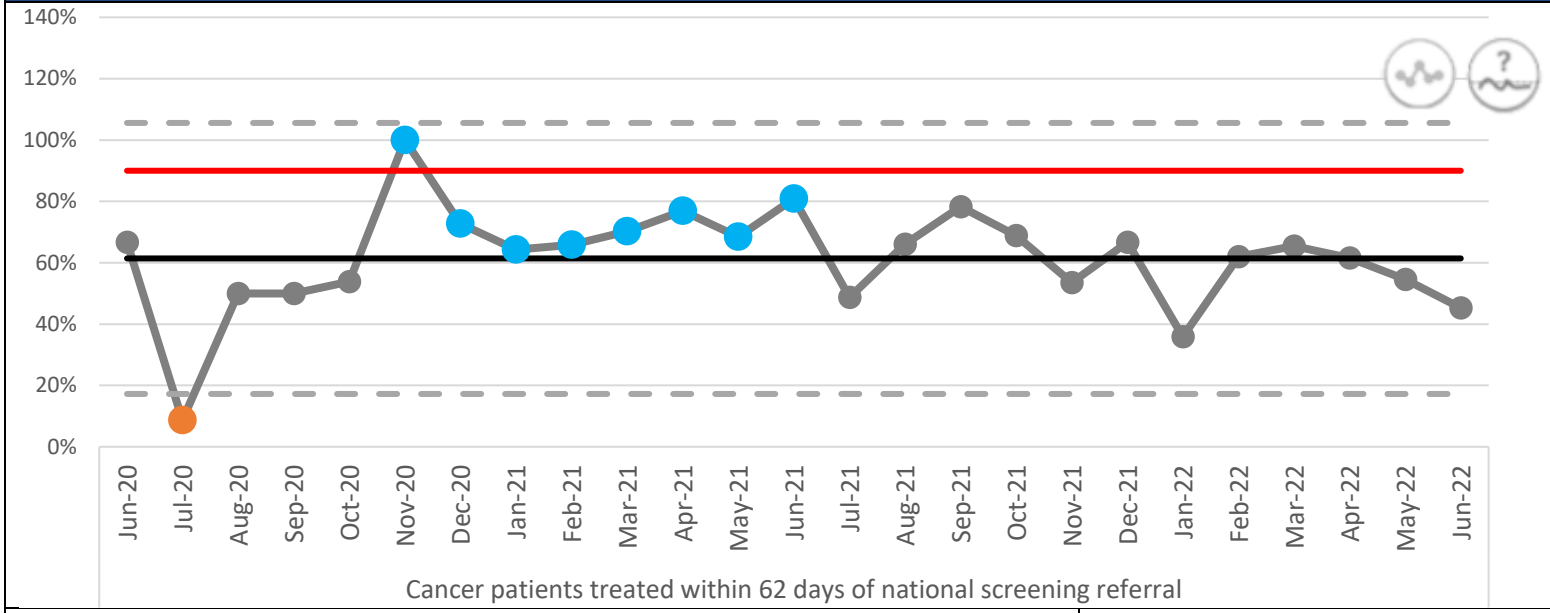
Summary of current issues

- The Trust performance for Q4 2021/22 was 5.0% (threshold 93%). Performance remains significantly below threshold Q1 2022/23 at 3.4%.
- Challenges in breast pathway capacity remain.

Actions to recover performance

- Work is ongoing to identify additional radiology capacity to support the pathway. In the meantime, capacity is being clinically prioritised to support the Two Week Wait pathway.
- Recovery plans being progressed in-line with Patient Care Recovery Plan.

CANCER WAIT
(Cancer patients treated within 62 days of national screening referral)



Target	90.00%
Q1 2022/23	53.6%
Variance Type	Indicator is showing no significant change (common cause variation)
Assurance Type	Indicator is showing random variation
What the chart is telling us	Performance is consistently falling short of the target.

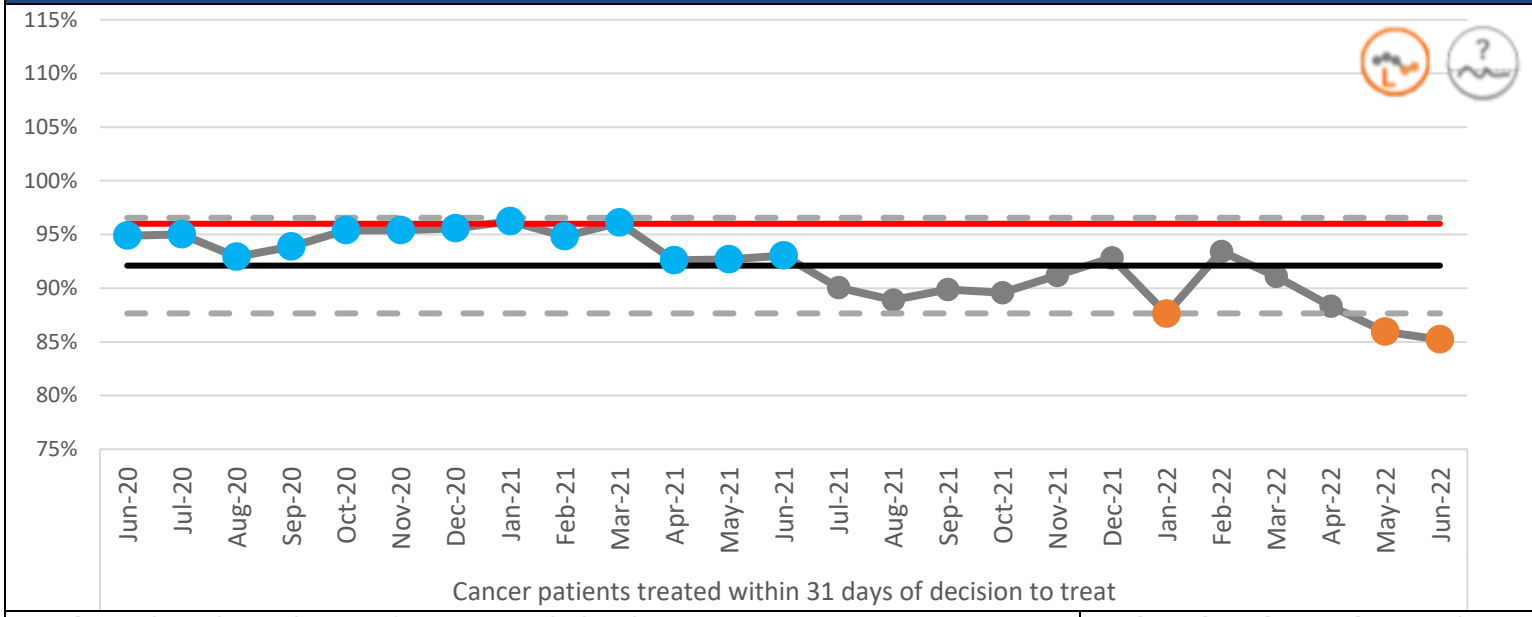
Lead: Mark Tuckett, Director of Strategy and Planning

Action Plan Timescale: Ongoing

Board Committee Providing Oversight: Finance & Performance Committee

Summary of current issues	Actions to recover performance
• The Trust performance for Q4 2021/22 was 57.5% (threshold 90%). Performance is highly variable due to a low denominator. • Majority of breaches attributed to delays resulting from the impact of COVID-19. The current position for Q1 2022/23 is 53.6%.	• Recovery plans being progressed in-line with Patient Care Recovery Plan.

CANCER WAIT
(Cancer patients treated within 31 days of decision to treat)



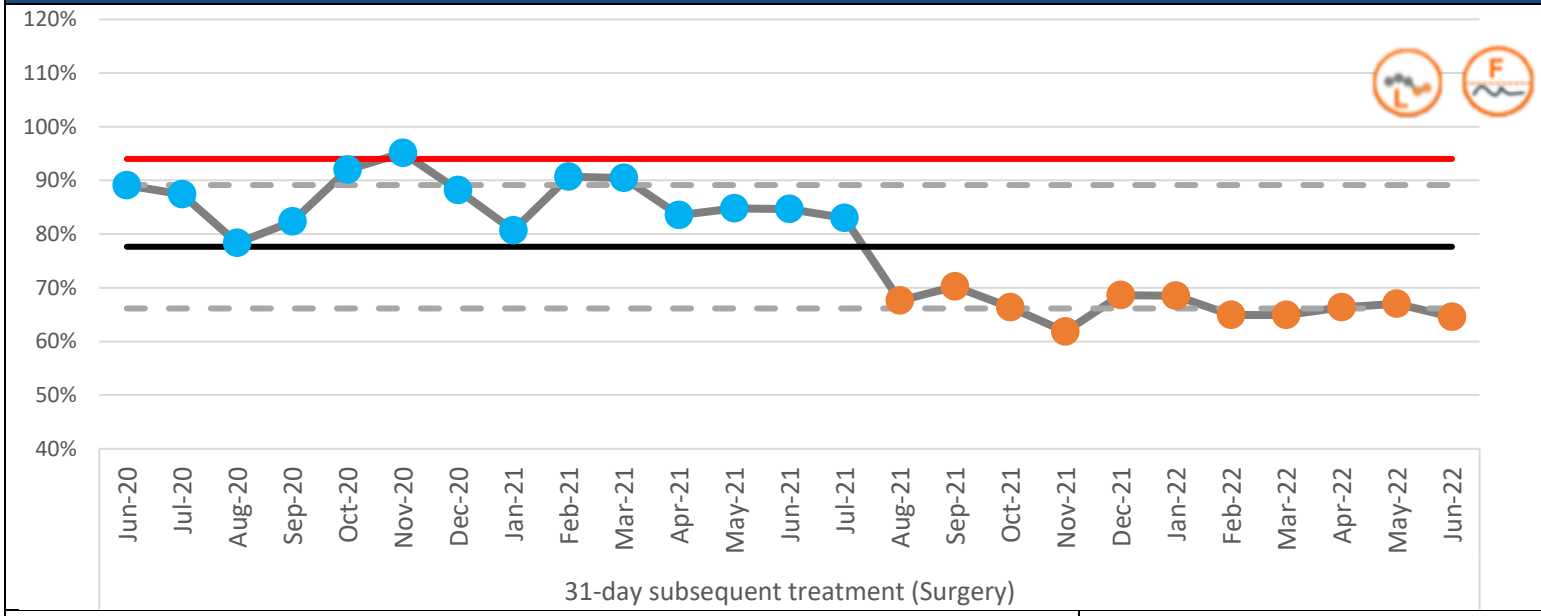
Target	96.00%
Q1 2022/23	86.39%
Variance Type	Metric is experiencing special cause for concern because of low values
Assurance Type	Indicator is showing random variation
What the chart is telling us	Performance has consistently fallen short of the target since April 2021.

Lead: Mark Tuckett, Director of Strategy and Planning

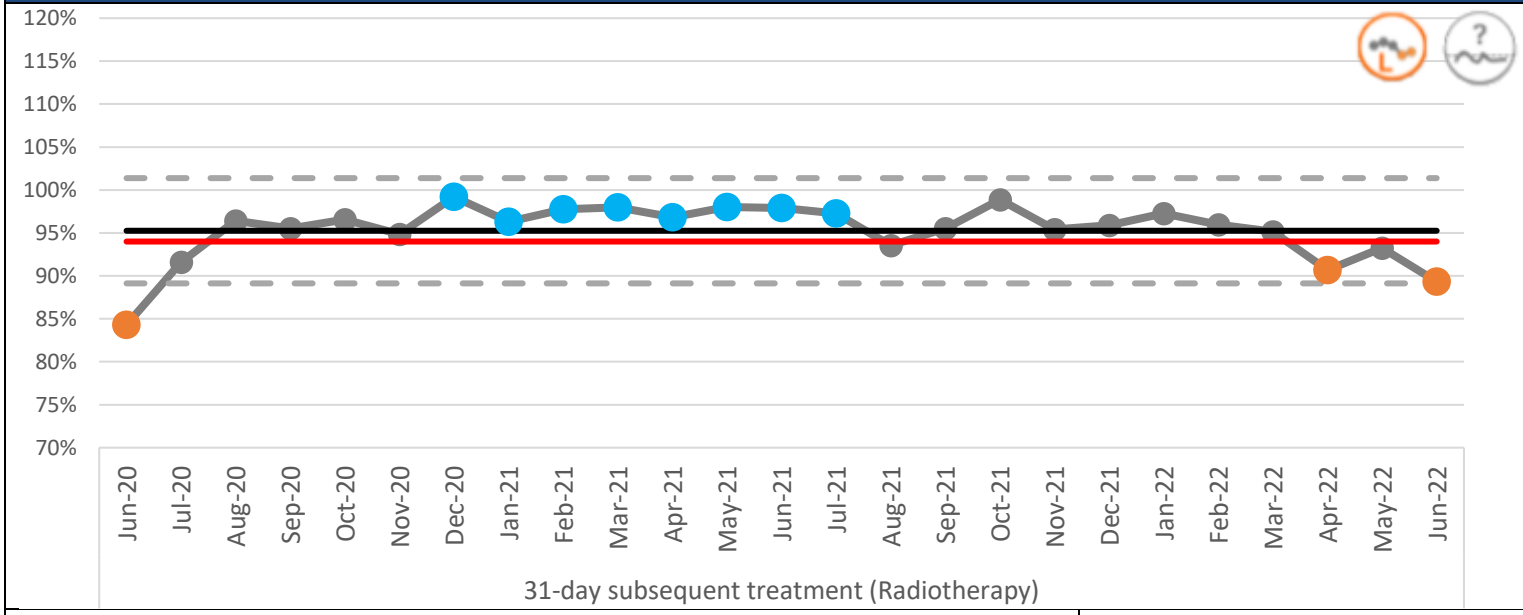
Action Plan Timescale: Ongoing

Board Committee Providing Oversight: Finance & Performance Committee

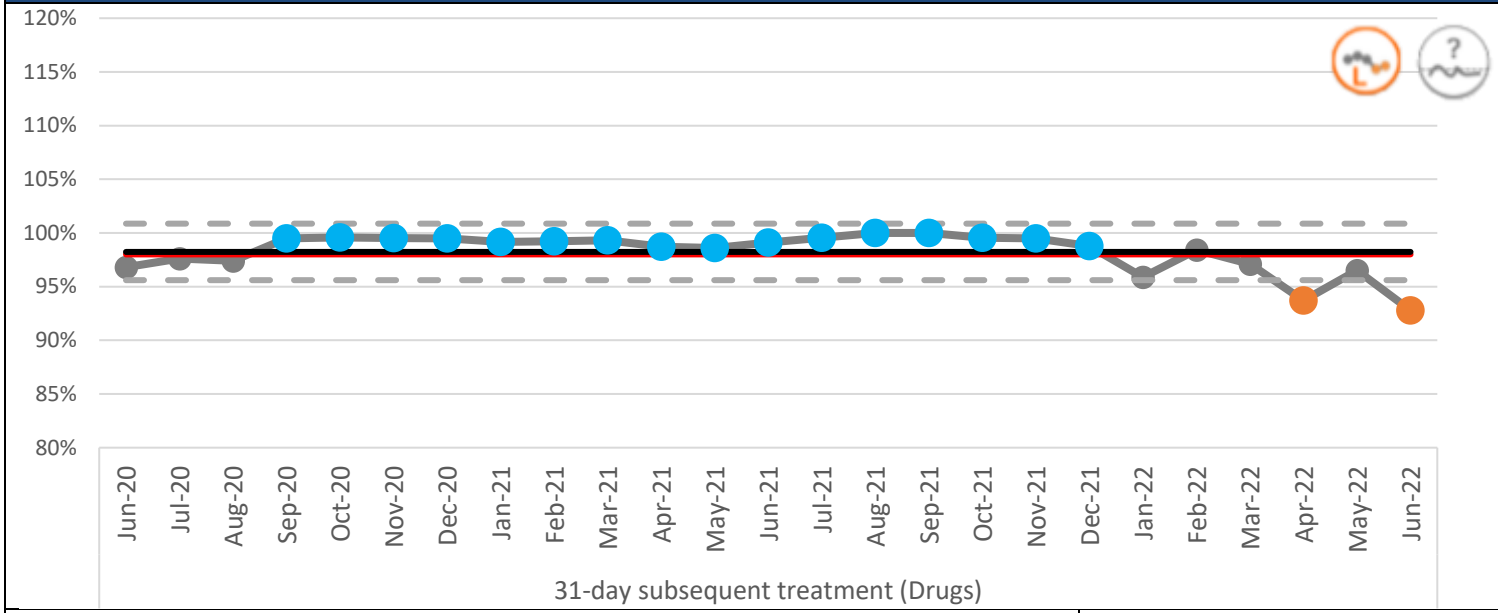
Summary of current issues	Actions to recover performance
• The Trust performance for Q4 2021/22 was 90.7% (threshold 96%). • Majority of breaches attributed to delays resulting from the impact of COVID-19. The current position for Q1 2022/23 is 86.4%.	• Recovery plans being progressed in-line with Patient Care Recovery Plan.

CANCER WAIT (31 day subsequent treatment (Surgery)		
	Target	94.00%
	Q1 2022/23	65.94%
	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	Performance is consistently falling short of the target.
Lead: Mark Tuckett, Director of Strategy and Planning	**Action Plan Timescale**: Ongoing	
Board Committee Providing Oversight: Finance & Performance Committee		

Summary of current issues	Actions to recover performance
• The Trust performance for Q4 2021/22 was 66.1% (threshold 94%). • Performance remains volatile. Q1 2022/23 performance is at 65.9%.	• Recovery plans being progressed in-line with Patient Care Recovery Plan • Work continues to model the theatre timetable to prioritise capacity for clinical priority and cancer patients.

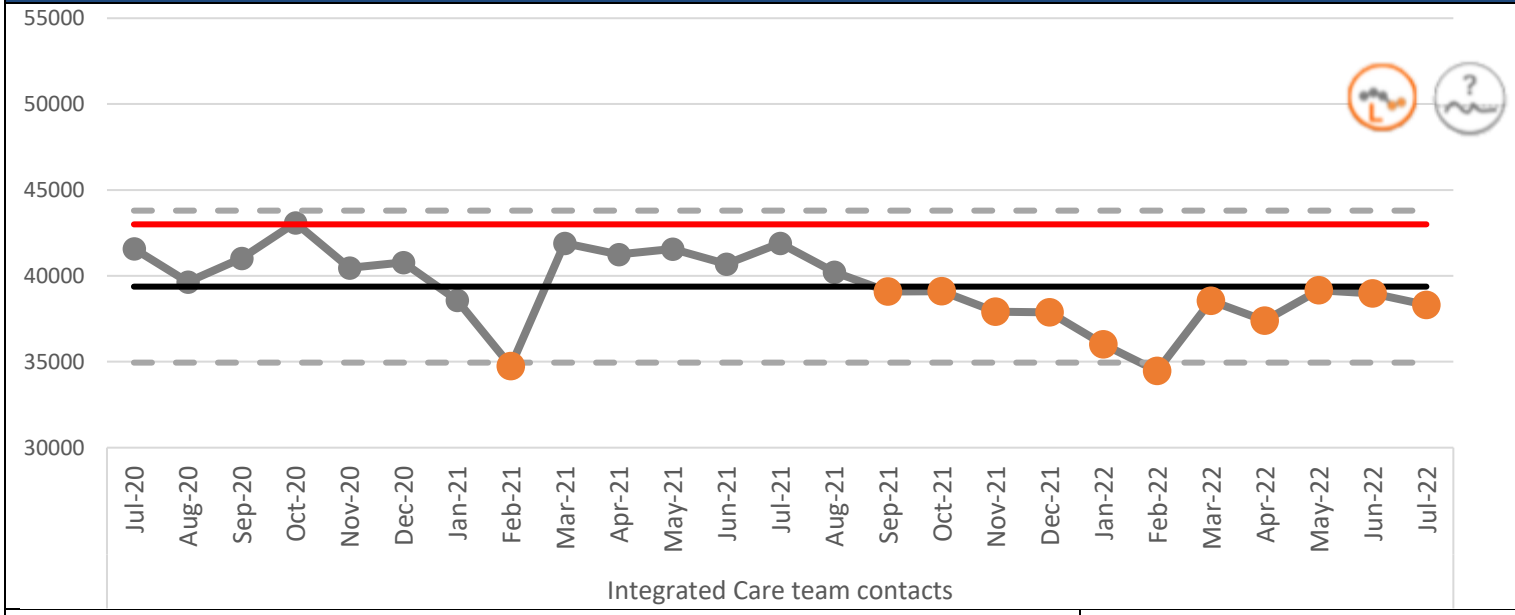
CANCER WAIT (31 day subsequent treatment (Radiotherapy)			
		Target	94.00%
		Q1 2022/23	90.98%
		Variance Type	Metric is experiencing special cause for concern because of low values
		Assurance Type	Indicator is showing random variation
		What the chart is telling us	The target for Q1 22/23 has not been met.
Lead: Mark Tuckett, Director of Strategy and Planning	**Action Plan Timescale**: Ongoing		
Board Committee Providing Oversight: Finance & Performance Committee			

Summary of current issues	Actions to recover performance
• The Trust performance for Q4 2021/22 was 96.1% (threshold 94%). • Adverse performance attributed to delays resulting from the impact of COVID-19. The current performance for Q1 2022/23 is 91.0%.	• Recovery plans being progressed in-line with Patient Care Recovery Plan.

CANCER WAIT (31 day subsequent treatment (Drugs)			
		Target	98.00%
		Q1 2022/23	94.47%
		Variance Type	Metric is experiencing special cause for concern because of low values
		Assurance Type	Indicator is showing random variation
		What the chart is telling us	The target for Q1 22/23 has not been met.
Lead: Mark Tuckett, Director of Strategy and Planning	**Action Plan Timescale**: Ongoing		
Board Committee Providing Oversight: Finance & Performance Committee			

Summary of current issues	Actions to recover performance
• The Trust performance for Q4 2021/22 was 97.1% (threshold 98%). • Adverse performance attributed to delays resulting from the impact of COVID-19. The current performance for Q1 2022/23 is 94.5%.	• Recovery plans being progressed in-line with Patient Care Recovery Plan.

COMMUNITY CARE
(Integrated Care Team (ICT) contacts)



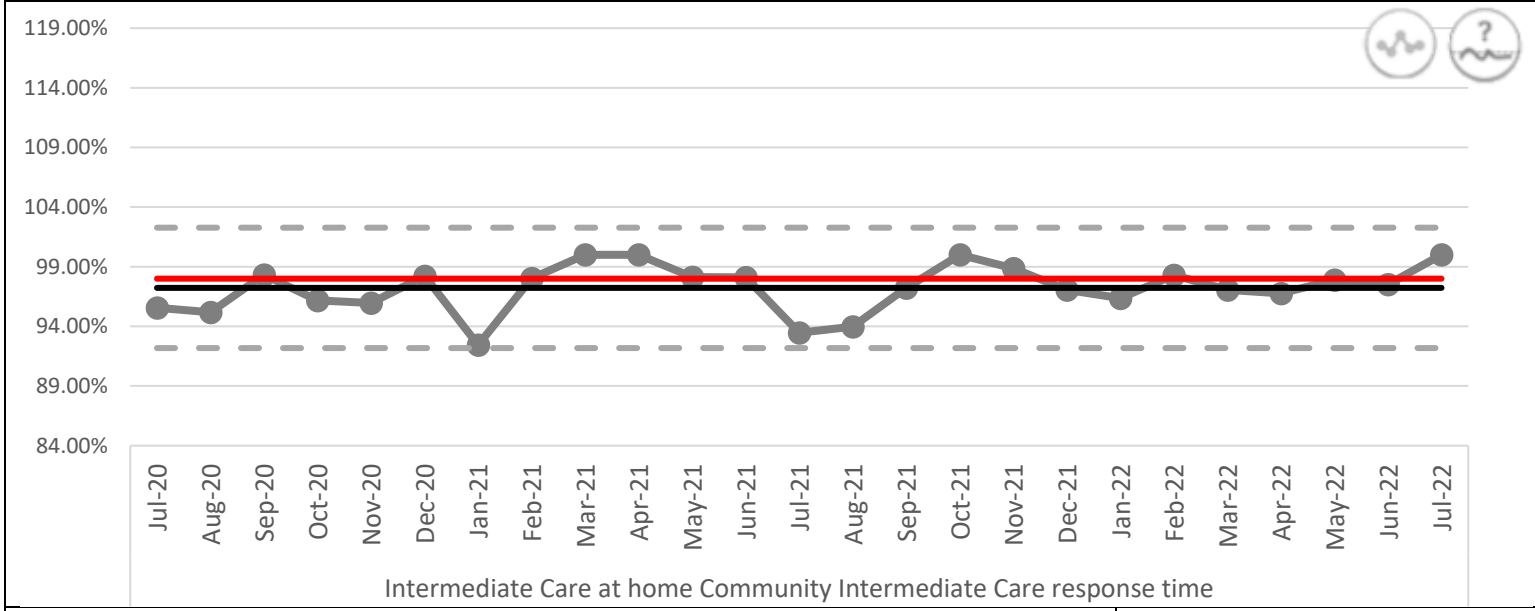
Target	43,000	
Jul-22	38,301	
Variance Type		Metric is showing special cause of concerning nature due to underperformance
Assurance Type		Indicator is showing random variation
What the chart is telling us	The number of ICT contacts dipped below target in April 2020 and has remained below target for all months other than Oct 2020.	

Lead: Victoria Leckie, Interim Chief Operating Officer

Action Plan Timescales: October 2022

Board Committee Providing Oversight: Finance and Performance Committee

Summary of current issues	Actions to recover performance
• The number of ICT contacts is below target due to a number of issues and data quality issues in ICT Nursing that impacts on the number of visits which are reportable.	• Work has progressed to identify two causes of the data quality reporting issue - work has been undertaken to rectify one of them, which can be backdated to April and shown from Q3. Ongoing work is taking place on the second cause, we are yet to identify if this can be backdated. • Working Group established for recovery plan for ICT Therapy Activity

COMMUNITY CARE (Response Time)			
		Target	98%
		Jul-22	100%
		Variance Type	Metric is experiencing common cause variation
		Assurance Type	Indicator is showing random variation
		What the chart is telling us	Performance was above target in July 2022.

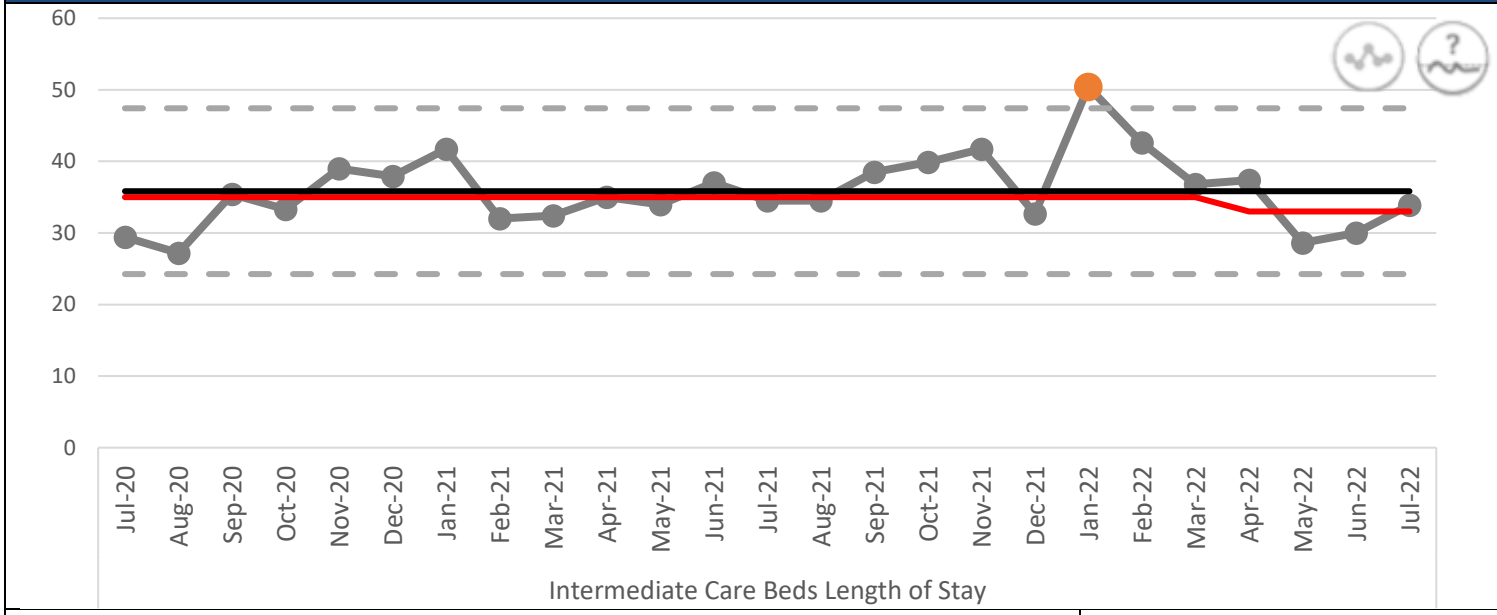
Lead: Victoria Leckie, Interim Chief Operating Officer

Action Plan Timescales: September 2022

Board Committee Providing Oversight: Finance and Performance Committee

Summary of current issues	Actions to recover performance
• Flow has been reduced due to teams being unable to handover to the Short-Term Intervention Team (STIT) or Independent Sector who do not currently have the capacity in the Independent Sector for patients to transfer to.	• Changes to the delivery model in active recovery (AR) to improve performance and achieve target. • Active recovery continue to measure and proactively escalate patients they are unable to move to the relevant next provider of care. • Council are reprocuring homecare in Sheffield to empower local providers of homecare and improve pick up from next year; in the interim bids have been made for national support and for national funding on behalf of the city to increase capacity.

COMMUNITY CARE
(Intermediate Care Bed Average Length of Stay)



Target	33 days
Jul-22	35.8 days
Variance Type	Metric is experiencing common cause variation
Assurance Type	Indicator is showing random variation
What the chart is telling us	Average LOS for Intermediate beds has decreased since January 2022. It was on target for June 2022, but target was not achieved in July 2022

Lead: Victoria Leckie, Interim Chief Operating Officer

Action Plan Timescales: August 2022

Board Committee Providing Oversight: Finance and Performance Committee

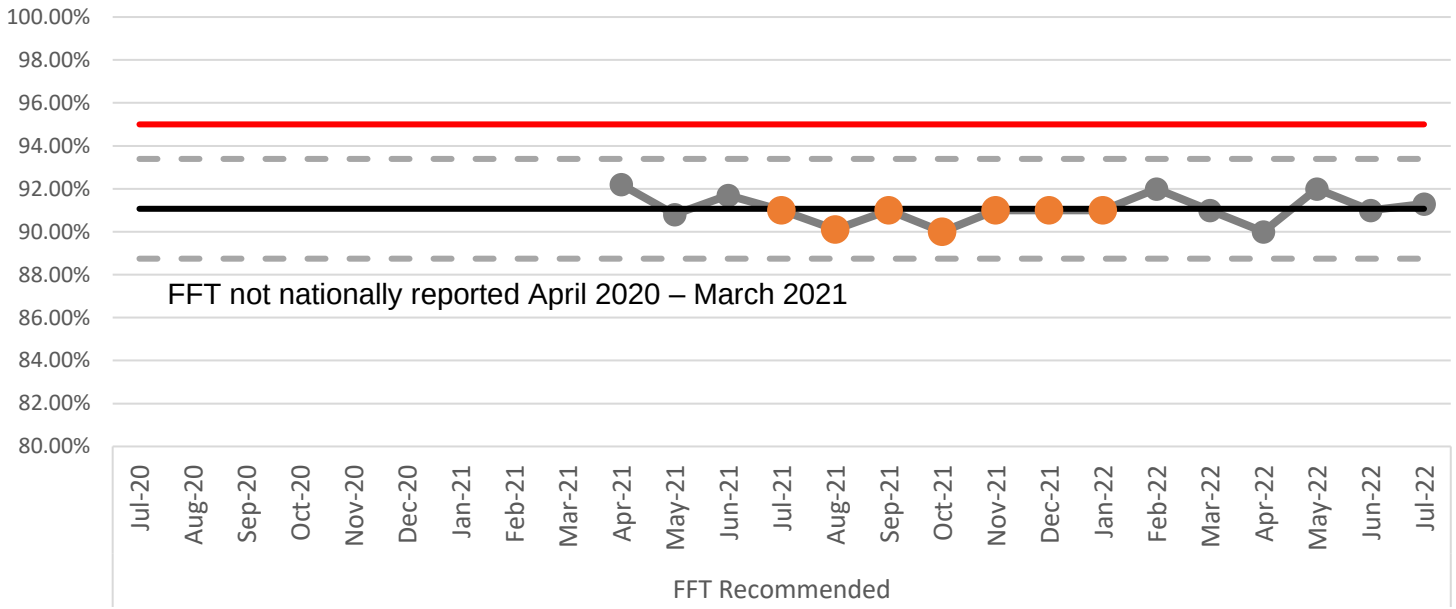
Summary of current issues

- There are delays for discharge of patients to S2A (Somewhere else for Assessment) placements, Enhanced EMI (Elderly Mentally Infirm) bed, and home care packages.

Actions to recover performance

- Individual patient delays are escalated to the Discharge Hub and via Escalation meetings.
- Ensure impact of delays is included in citywide discharge plan seeking to increase capacity within independent sector.
- Council are reprocuring homecare in Sheffield. Interim bids have been made for national support and for national funding on behalf of the city to increase capacity.
- Sheffield ICB (Integrated Care Board) and Council are reprocuring S2A beds to support improved allocation.

FRIENDS & FAMILY TEST (Inpatients)



Target	95%
Jul-22	91.3%
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: October 2022

Board Committee Providing Oversight: Quality Committee

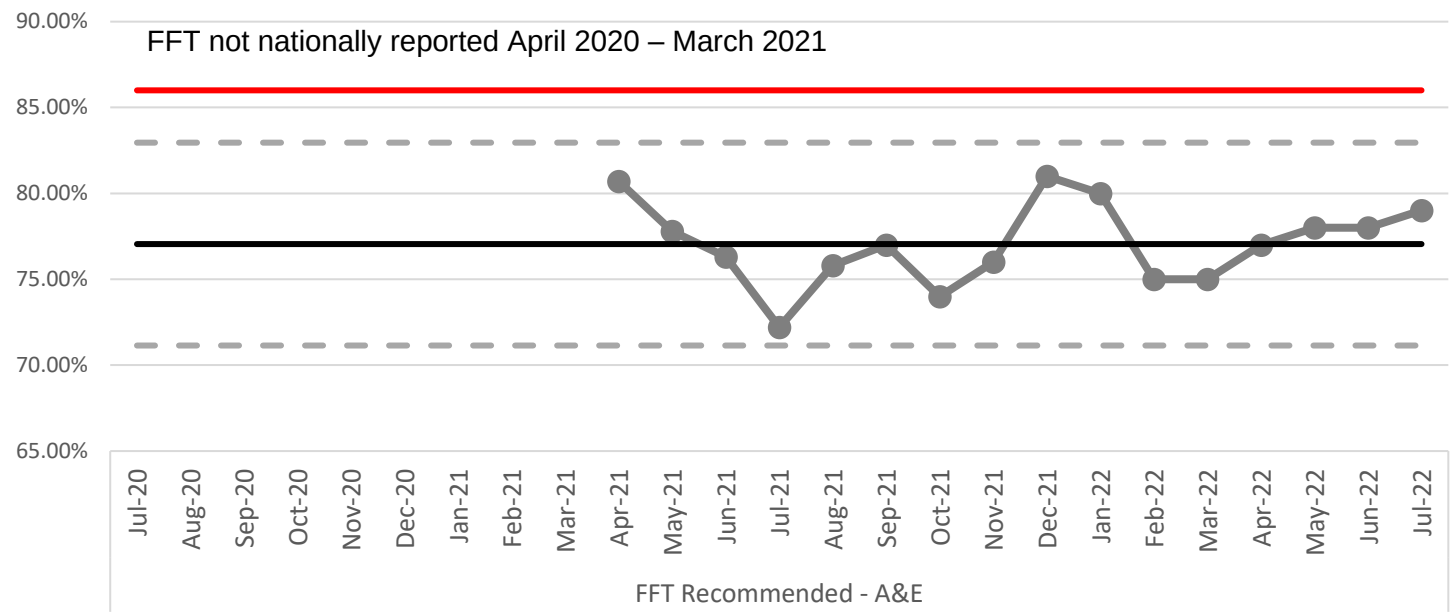
Summary of current issues

- The Inpatient positive score for June is 91.0% and 91.3% in July. This remains 4% below the target but within the expected range seen since restarting in October 2020.
- 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 there was a significant increase in the number of responses received via this route which correlated with an increased positive score of 92%. The number of cards received reduced in June and then increased in July. This fluctuation is expected whilst wards establish a consistent system for the cards. 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. 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%
Jul-22	79%
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 FFT Target for A&E has not been consistently met

Lead: Chris Morley, Chief Nurse

Action Plan Timescales: September 2022

Board Committee Providing Oversight: Quality Committee

Summary of current issues

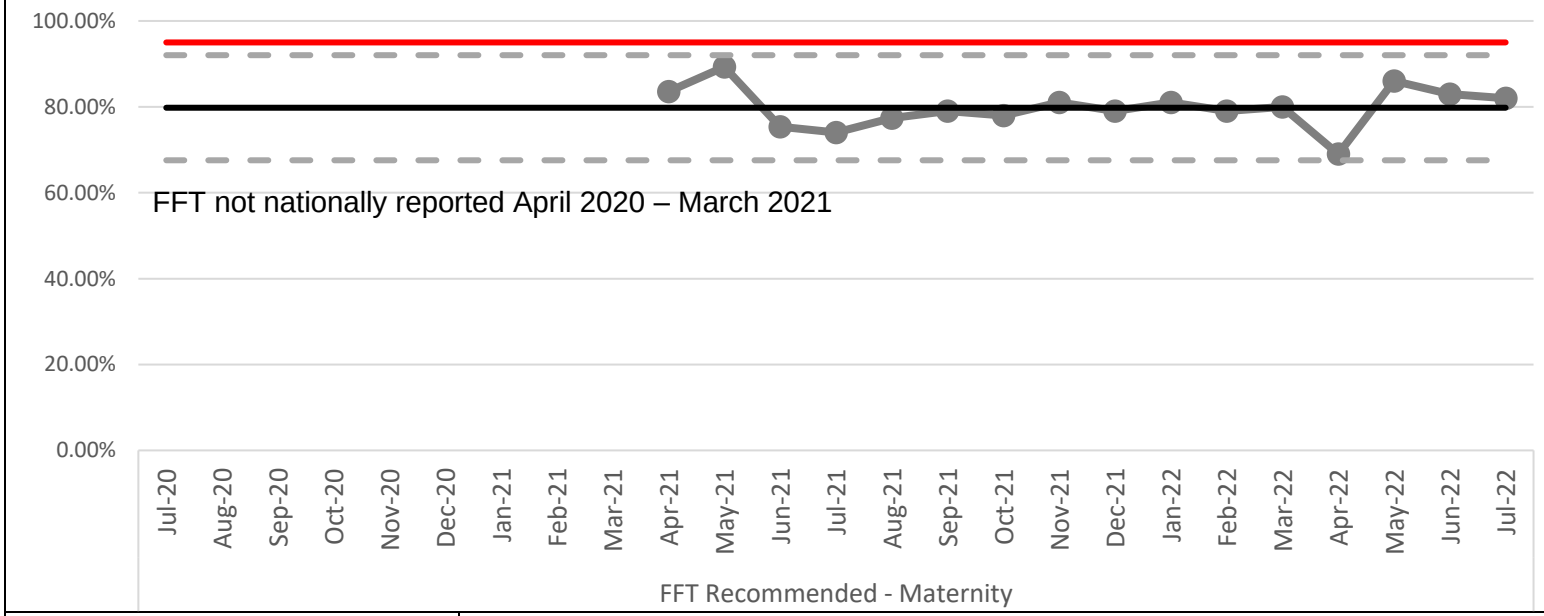
- The target of an 86% positive score has not been achieved since January 2021.
- A&E at NGH continues to be the area which has the biggest influence on the lower positive score. Eye Casualty and Minor Injuries consistently score above the Trust target of 90%.

	June	July
A&E	68.2%	70.9%
MIU	88.5%	86.1%
Eye Casualty	94.9%	96.6%
Total	**77.6%**	**79.2%**

Actions to recover performance

- The 2021/22 FFT benchmarking report, shows that the STH A&E average score for 2021/22 (77%) was only 1% behind the national average (78%) and for the 12 months to July A&E is 3% above the national average. Consideration is now being given to mirroring the national average as the IPR benchmark.
- 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

FRIENDS & FAMILY TEST (Maternity)



Target	95%
Jul-22	82%
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 FFT 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 score for June is 83.4%, and for July is 81.6%
- The overall score for maternity data is made up of scores relating to 4 phases of care (antenatal, labour, postnatal ward and postnatal community). The areas that score most positively are Labour and Postnatal wards.

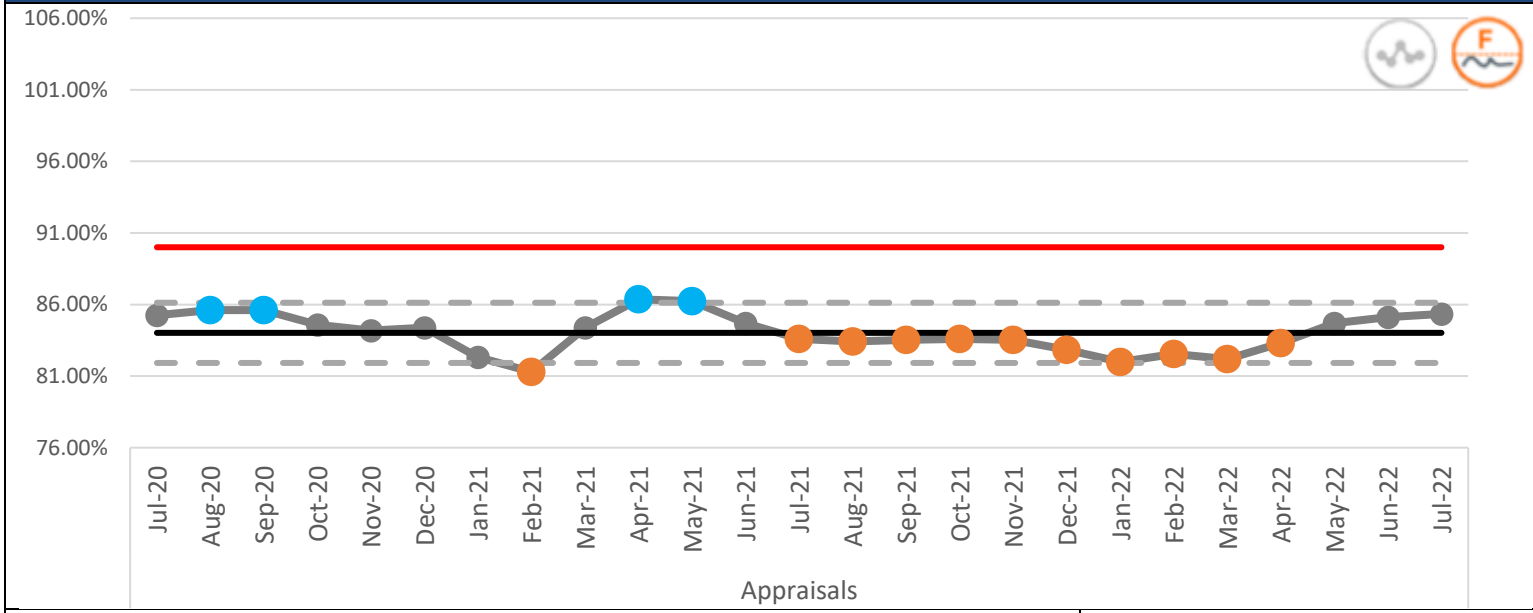
Actions to recover performance

- The Maternity Service continues to deliver their improvement programme and scores vary significantly across the four phases, as outlined below with the number of responses in brackets.

Phase	June	July
Antenatal	70.6% (17)	70.4% (27)
Labour	85.9% (78)	88.2% (85)
Postnatal wards	85.4% (48)	85.7% (49)
Postnatal community	82% (50)	71.1% (45)

- To increase the number of responses received, feedback cards have re-started in maternity services. An increased response rate will provide more information on the issues impacting on patient's experiences.

APPRAISALS
(Completed appraisals in last year)



Target	90%
Jul-22	86%
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

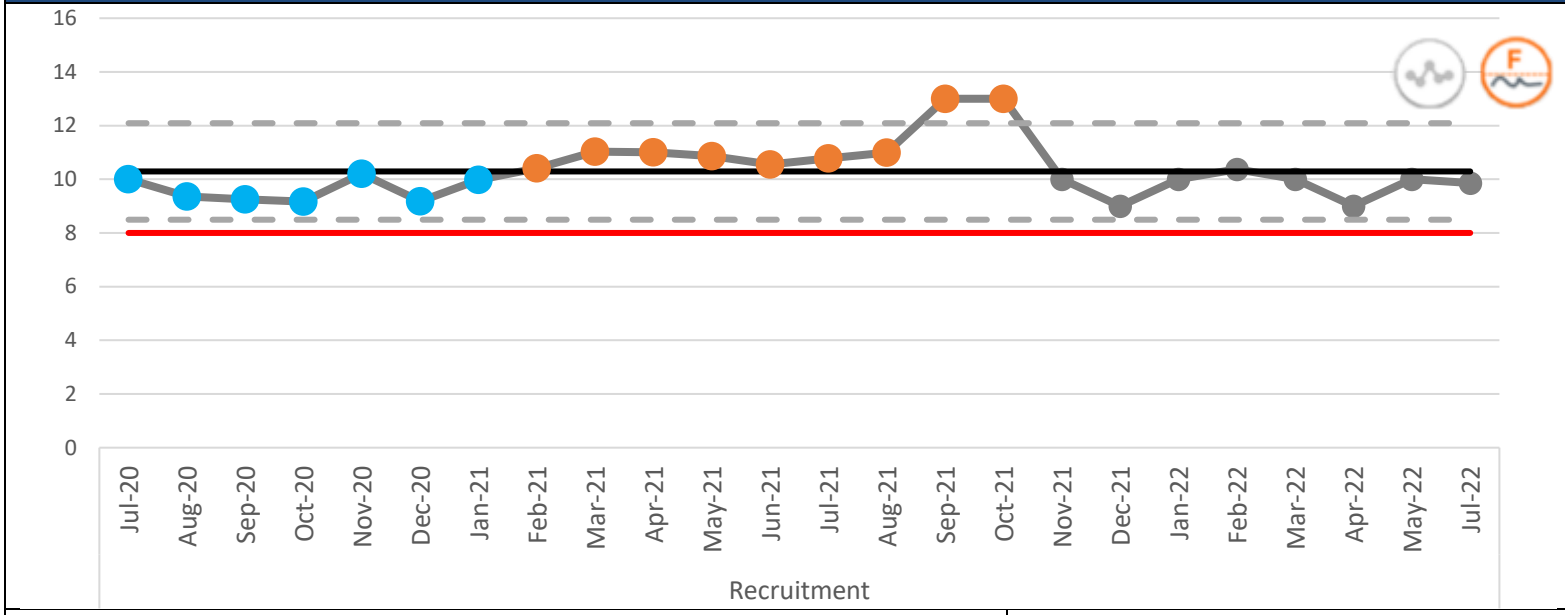
Summary of current issues

- The cumulative position for completed appraisals during the past twelve months at the end of July 2022 is 86%.

Actions to recover performance

- 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
(Weeks taken from request to fill to unconditional offer)



Target	8
Jul-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

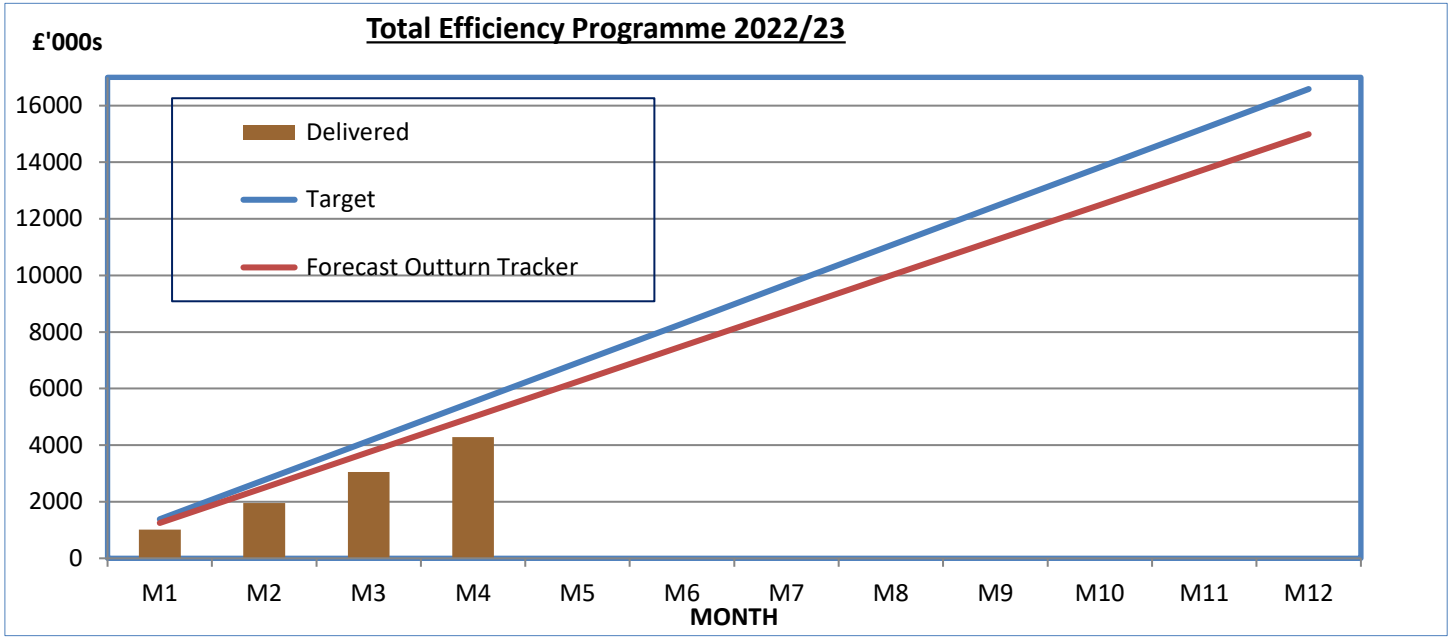
Board Committee Providing Oversight: HR and OD Committee

Summary of current issues

- 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.
- Additional recruitment is required in accordance with the EPR programme and the additional ward activity

Actions to recover performance

- 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. This is in hand. Further interviews have been established
- Candidate progress is monitored daily and workload for the team is managed accordingly.
- Planning underway to expand service improvement work to include Trust managers once additional resource is in place.

EFFICIENCY Variance from Plan		
	**Target**	£5,529K
	Year to Mar	£4,281K
	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 achieved.
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
• 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 £4,281k against a target of £5,529k (£1,248k and therefore 23% behind target). This shortfall is due to both insufficient P&E (performance and evaluation) 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 (Project Management Office) 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.

DEEP DIVE: CLOSTRIDIOIDES DIFFICILE

1. Introduction

Clostridioides difficile (C.diff) is a bacteria that naturally occurs in the environment and is also carried, usually harmlessly, along with many other types of bacteria in the human gastrointestinal system. The UK Health Security Agency estimate that 3% of adults and 66% of babies within the UK population have C.diff asymptomatically.

C.diff causes disease when the normal bacteria in the gut are disadvantaged which allows C. diff to grow to unusually high levels. It also allows the toxin that some strains of C. diff produce to reach levels where it attacks the intestines and causes mild to severe diarrhoea.

2. Risk Factors

As indicated, carriage is common in very young children as their immature gastrointestinal tracts do not react to the toxin in the same way as adults, so disease is far less common. After early childhood, carriage increases with age and exposure to healthcare or care home facilities. The following factors increase the risk of the organism producing toxin and therefore the development of disease.

- Over 65 years of age.
- Taking agents that alter the balance of the normal gut flora - the most common reason being antibiotics, but chemotherapy, surgery can be a causation.
- A weakened immune system from an existing long-term condition such as diabetes or kidney failure. Chemotherapy and other aggressive drug therapies can also weaken the immune system.
- Taking proton pump inhibitors (PPI), such as omeprazole, or other medicines that reduce stomach acid.
- Previous C. diff infection.

3. Reducing transmission

C.diff is transmitted via contact (both direct with those persons carrying it and indirect through contaminated environments) and in addition via the faecal-oral route. The organism can contaminate the environment at any time but is more likely if a person has diarrhoea or is incontinent. C.diff flora can survive in the environment for many months, meaning that people can acquire the organism from a setting many months after the patient from whom it originally came has left.

A range of infection prevention and control measures are essential to limiting the spread of C.diff in the healthcare setting.

- Meticulous hand washing with liquid soap and water is recommended for all staff after contact with body substances (including faeces), or following any other potential contamination of hands, e.g., contact with the environment in which a C.diff infected (CDI) patient is being nursed, when caring for known CDI patients.
- Barrier precautions for any patient with loose stools (for whatever reason) reduces the extent of environmental contamination.
- Early testing and diagnosis are essential in prevention and controlling disease spread.
- Surveillance is a tool that is key to monitoring, preventing, and controlling C.diff. National reporting supports the long-term planning and implementation of interventions and monitors their impact. Local surveillance is intended to monitor the specific number of cases by ward, unit or facility, and disease severity in real-time (i.e., daily or weekly at least) to prompt immediate action when an increased number of cases or increased disease severity has been observed.
- Regular environmental disinfection, with a chlorine-based solution, including high touch surfaces helps reduce the risk from known/unknown environmental contamination from patients with and without diarrhoea.
- Meticulous cleaning of toilets and commodes and items which are more likely to be contaminated.

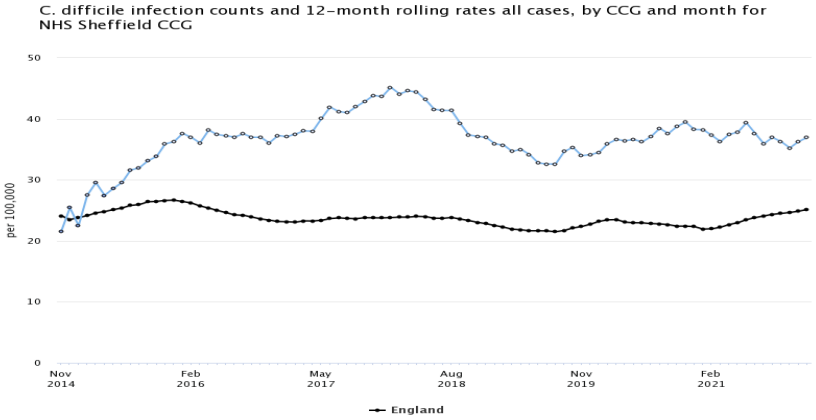
- Additional decontamination using hydrogen peroxide vapour (HPV) following thorough manual cleaning.
- Good antimicrobial stewardship should always be promoted as standard in combination with other infection prevention and control measures. Good antimicrobial stewardship minimises the antimicrobial exposure of patients in healthcare settings (and elsewhere) and thereby reduces the number of patients predisposed to CDI, even if C.diff transmission occurs.

4. Sheffield and Sheffield Teaching Hospitals Foundation Trust

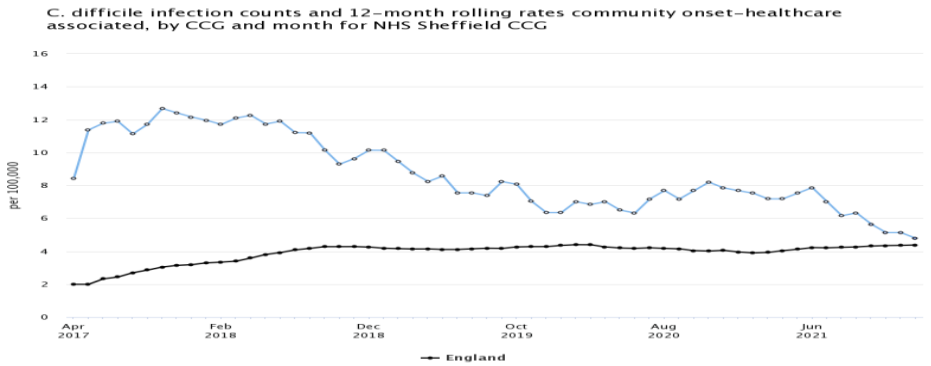
Since 2004 it has been mandatory for trusts and other healthcare providers to report C.diff figures to the Department of Health. Positive detected cases are classified as follows:

- Hospital onset healthcare associated (HOHA): cases that are detected in the hospital two or more days after admission.
- Community onset healthcare associated: cases that occur in the community (or within one day of admission) when the patient has been an inpatient in the trust reporting the case in the previous four weeks
- Community onset indeterminate association: cases that occur in the community (or within one day of admission) when the patient has been an inpatient in the trust reporting the case in the previous 12 weeks but not the most recent four weeks
- Community onset community associated: cases that occur in the community (or within one day of admission) when the patient has not been an inpatient in the trust reporting the case in the previous 12 weeks.

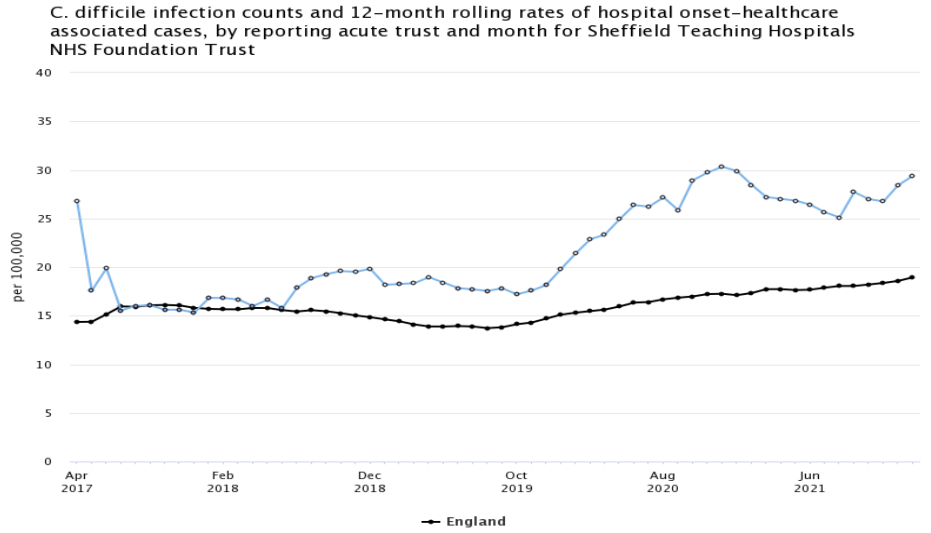
The graph below depicts the C.diff counts and 12 month rolling rates for all cases, by CCGs in England and for NHS Sheffield CCG. It depicts a higher case rate for Sheffield CCG than that of England. The denominator for Sheffield CCG cases is all cases from a Sheffield resident, wherever C.diff is detected.



Sheffield CCG has had a continual downward trajectory for community onset healthcare associated cases since 2017.



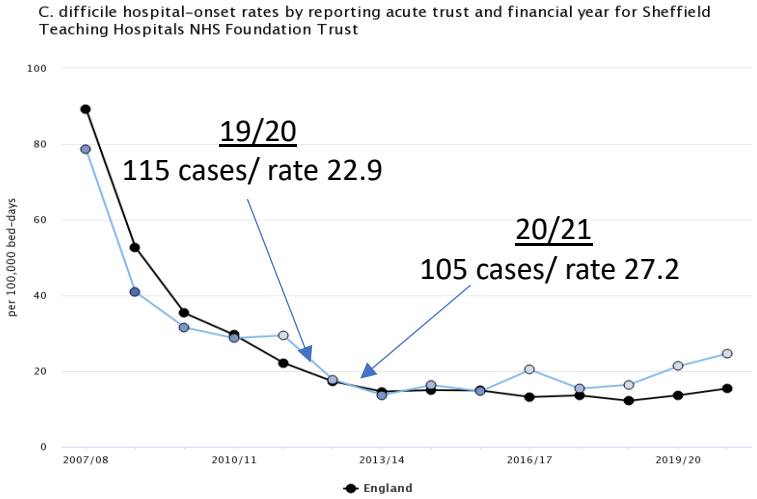
In comparison the hospital onset healthcare associated rolling rates for Sheffield Teaching Hospitals NHS Foundation Trust (STHFT) have risen since 2019.



Factors affecting the reported rise in hospital onset healthcare associated rates.

I. *Denominator*.

In financial year 2019/20 the Trust recorded 501606 occupied hospital beds; this number dropped in the first year of the pandemic, 2020/21, to 385976. Occupied beds increased in 2021/22 to 443969, although this was still 11.5% lower than before the pandemic. This change in the denominator will make the rate higher even if the actual number of C.diff cases is lower, as demonstrated below.



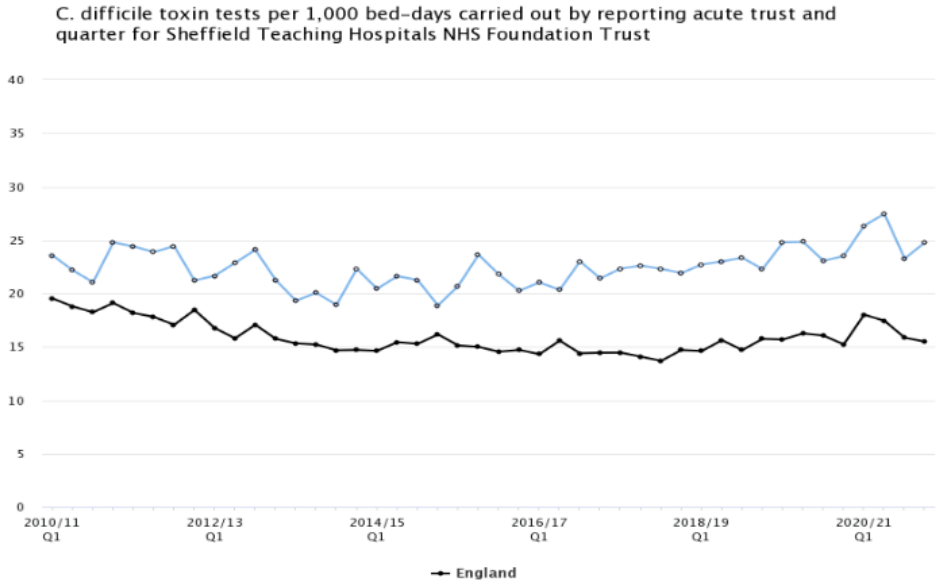
II. Casemix

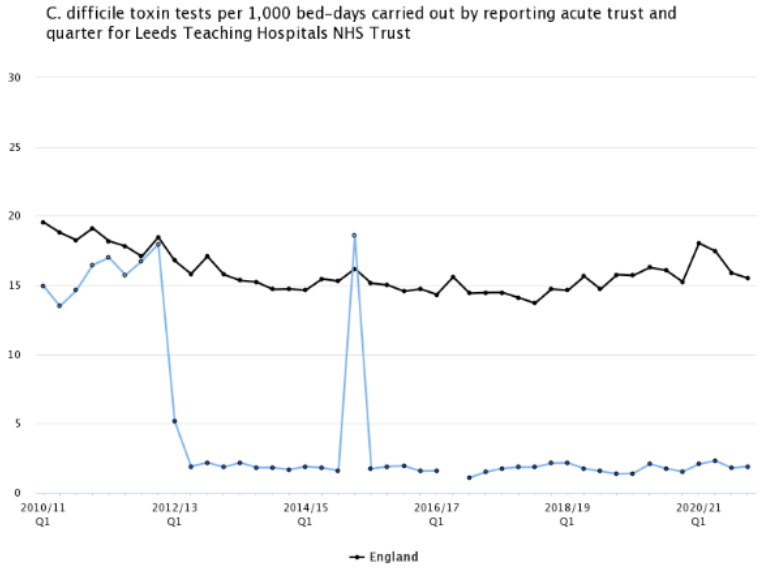
C.diff is more common in older people or patients with comorbidities therefore the more patients from these categories that have an inpatient stay the higher the likelihood of cases of C.diff. In both 2020/21 and 2021/22 the proportion of patients at greater risk of C.diff increased as a result of increased emergency medical admissions and associated length of stay and a corresponding decrease in inpatient elective activity.

III. Testing for C.diff

STHFT has historically performed more diagnostic testing for C.diff in comparison to other comparable Trusts (see below graphs, as an example). This may be a reflection of staff obtaining samples at the first sign of loose stools, staff awareness of predisposing risk factors and higher prevalence of diarrhoea caused by effects of chemotherapy, newer immunotherapeutic modalities, and transplant-related gastrointestinal complications.

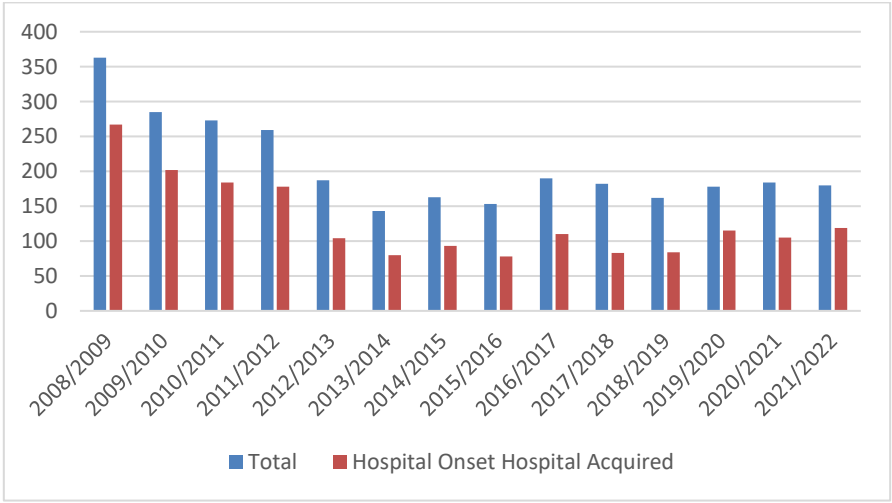
C.diff can be carried in the gut and its presence in a stool sample does not necessarily mean it is the cause of a patient's diarrhoea. The national rules are that the laboratory has to test all inpatient samples of diarrhoea for C.diff, once they are received in the laboratory, regardless of any symptoms, risk factors etc. By being assiduous at sending samples to try and determine/rule out an infective cause for a person diarrhoea, C.diff may be detected and need to be logged as an episode, even if clinically the cause of a patient's diarrhoea is thought to be an alternative cause e.g. norovirus, chemotherapy etc.





The graph below highlights the significant reduction in the number of Hospital Onset Healthcare Associated C.diff episodes detected over the period since 2008.

The number of cases have however been fairly static from 2013/14 onwards although a step rise has been seen from 2019/20 onwards. It should be noted that the definitions of which epsiodes should be considered 'HOHA' changed in 2019/20 to included more episodes than in previous years. Based on historical data this change in definition would be expected to result in a 10-15% rise in 'HOHA' cases. 2020/21 shows a decrease, compared with 2019/20, in the number of C.diff episodes detected in patients within the Trust, perhaps associated with the lower number of inpatients during the initial phases of the pandemic, as this trend reversed in 2021/22.



5. Trust reduction strategies

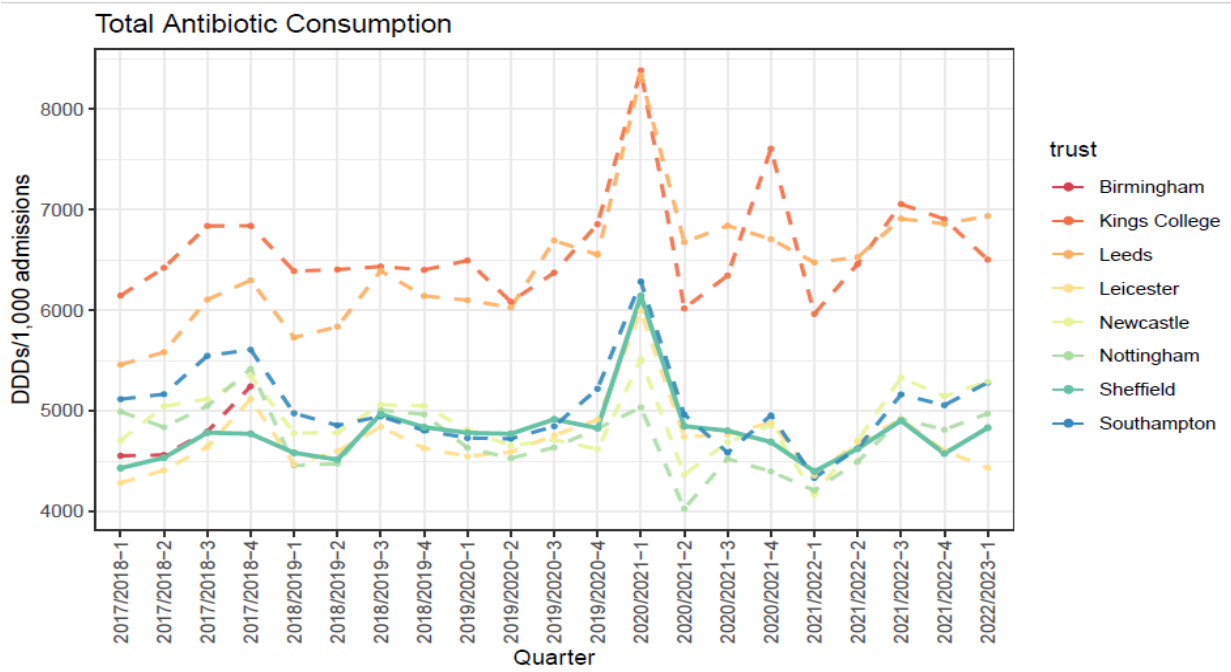
The Trust's aim is to further reduce C.diff by ensuring optimal infection prevention and control practices, cleanliness standards and antimicrobial prescribing against a background of caring for an increasingly elderly and frail population. The Trust actions required to continue to maintain and improve on the reduction in cases of C.diff are contained within the Infection Prevention and Control Programme and can be summarised under the following headings:

- Reducing environmental contamination of wards/departments. Regular cleaning and HPV of all wards, not only in response to cluster or outbreak situations, but on a regular rolling programme is a recognised risk reduction measure. Deep cleaning has been targeted to very high-risk wards and to cleaning vacated rooms or bays on a bay-by-bay basis. Vacated wards have also been fully deep cleaned prior to reoccupation. Ensuring that all equipment is deep cleaned, as well as the ward environment, is important but this has also become increasingly challenging in recent months due to the erratic availability of sufficient beds, ward furniture etc. There is a deep cleaning programme for all wards across the Trust which is monitored by the Infection Prevention and Control Nursing team and the Infection Prevention and Control Committee.
  The Trust has benchmarked against the National Standards of Healthcare Cleanliness (2021) and have exceeded the required standards. The standards are incorporated into cleanliness audits that are submitted monthly as part of the IPC Accreditation programme.

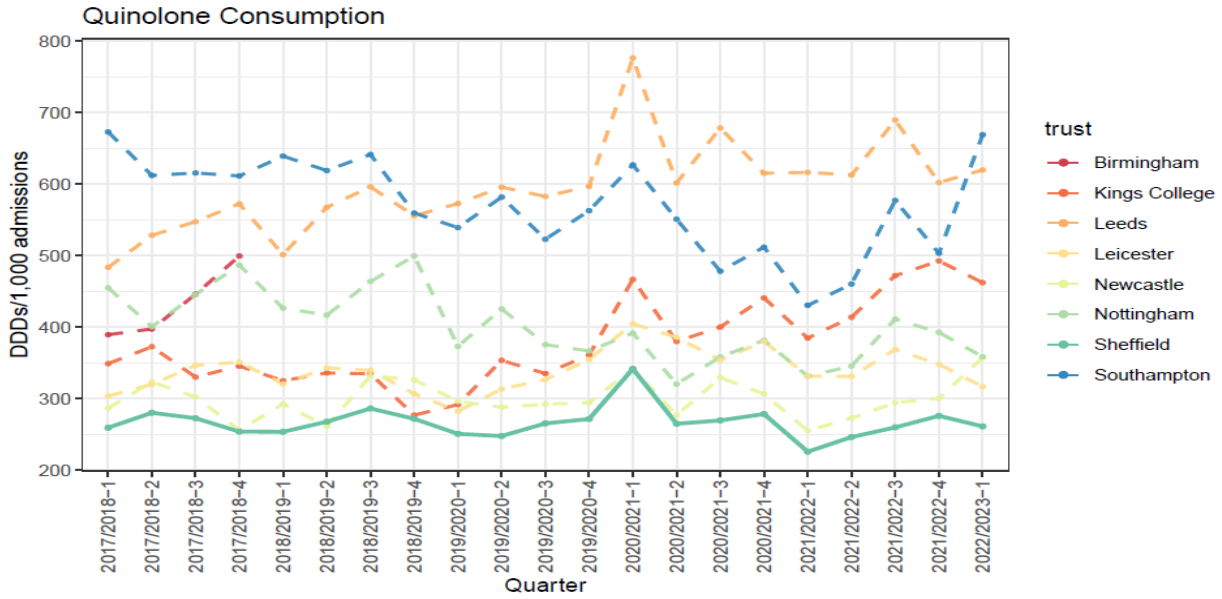
- Optimising infection prevention and control practice. The Trust has an annual IPC Programme that describes and records progress against the infection prevention and control activities that the Trust is focused on a yearly basis. The Infection Prevention and Control Accreditation Programme continues to be the main means by which infection prevention and control practice is optimised and assessed throughout the Trust on an ongoing basis.

  Audits undertaken as part of the Accreditation Programme, and in response to possible clusters of infection, on occasion identify less than 100% compliance in relation to key measures designed to reduce C.diff transmission e.g., hand hygiene, commode cleaning, environmental cleanliness and equipment decontamination. When this is the case, the Infection Prevention and Control Teamwork with the area concerned to rectify the situation. Busy wards/departments and high occupancy increase the likelihood of this occurring.

- Antimicrobial stewardship. Overall total antibiotic usage across the Trust compares favourably when measured against organisations of a similar size. To further improve this position a key focus of the annual IPC programme is antimicrobial stewardship.



The use of C.diff inducing quinolones, a family of broad spectrum antibiotics, is far less at STHFT than the same group of comparable trusts as the graph below indicates.



- Surveillance.
  The results of mandatorily submitted positive C.diff cases are published as rates per 100,000 occupied bed days and are used as a performance indicator. Internally the data is scrutinised by the Director of Infection Prevention and Control and monitored by the Infection Prevention and Control Committee with a quarterly IPC report to TEG.
  Each sample of C.diff identified undergoes ribotyping; a molecular technique for bacterial identification and characterization that uses information from rRNA-based phylogenetic analyses. Such analysis allows scrutiny of case linkage and whether there has been cross infection. The Infection Prevention and Control Team undertake reviews and audits of all areas where possible clustering of cases is detected. This is enhanced where ribotyping shows possible case linkage.

  All cases of HOHA C.diff infection undergo a review utilising a root cause analysis (RCA) to determine if practices need improving. A preliminary review of each episode is undertaken by an Infection Prevention and Control Doctor. If learning is identified at this stage a joint more in-depth review is undertaken in conjunction with the responsible clinical team. This process was reviewed and improved following external audit in 2020 which has resulted in improved engagement and collaborative working. Over the last twelve months there has been no common themes identified from RCA's, with the majority of cases judged unavoidable.

In addition to internal risk reduction strategies there are wider health strategies that the Trust is engaged with both at a city wide and Integrated Care Board level that support C.diff reduction in the population as a whole which in turn reduces the risk of HOHA cases;

- Reducing comorbidity and frailty needs
- Reducing the need for antibiotics within the community
- Strategies to keep older people out of hospital

6. Conclusion

- C.diff carriage is common, and the Trust is caring for an increasingly high risk population in terms of both carriage and active disease.
- The number of HOHA cases has been fairly static since 2013/14, particularly when changes to episode definitions are taken into account.
- The rate of HOHA cases has risen over the past two years; this is difficult to interpret given the change in declared local occupied bed-day data.
- It is difficult to provide a meaningful comparison with other Trusts due to a number of factors e.g., differences in patient case mix, sampling practices, changes in organisational structure and declared occupied bed-days, trust amalgamations.
- The deep clean programme has been more challenging in light of the impact of the pandemic.
- The Trust already performs well in relation to antimicrobial stewardship.
- Day to day infection prevention and control practice is not always optimal and the risk of this occurring is increased in times of high activity and occupancy.

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	LABM *R	MI&MP *R	OGN *R	Msk *R	OPA *R	CRCA *R	CARD *R	RENAL *R	VASC *R	CD&SM *R	SP&RH *R	SCS *R	GSUR *R	PLAS *R	UROL *R
18 weeks RTT	Percentage of non-admitted patients treated within 18 weeks (90%)															
	Percentage of 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	Breast symptomatic seen within 2 weeks															
	31 day first treatment from referral															
	Patient seen within 2 weeks of urgent referral															
	62 days from referral to treatment (GP 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 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&E *R	EmCr *R	GAST *R	PHA *R	RES *R	ICC *R	IG&S *R	TH&P *R	OR&D *R	ENT *R	NEU *R	OPHT *R
18 weeks RTT	Percentage of non-admitted patients treated within 18 weeks (90%)												
	Percentage of 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	Breast symptomatic seen within 2 weeks												
	31 day first treatment from referral												
	Patient seen within 2 weeks of urgent referral												
	62 days from referral to treatment (GP 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 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												

R – Reliability V – Validity A - Accuracy