Subject:	Integrated Performance Report
Supporting Directors:	Michael Harper, 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); Paul Buckley, Interim Director of Strategy & Planning.
Author(s):	Balbir Bhogal, Performance and Information Director; James Redfern, Information and Contract Support Manager; Ella Patrickson, Acting Operational Manager
Status (see footnote):	A

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

RECOMMENDATIONS

The Board is asked to:

a) Receive the Integrated Performance Report for December 2021 and January 2022.

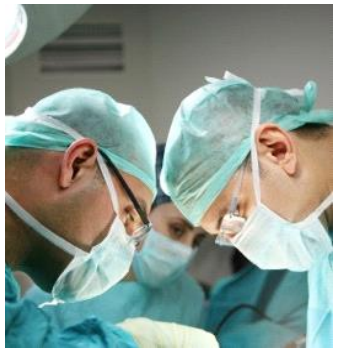
b) Note the performance standards that are being achieved.

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

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

APPROVAL PROCESS		
Meeting:	Trust Executive Group	Board of Directors
Approved Y/N:		
Date:	9 March 2022	29 March 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
29 March 2022

EXECUTIVE SUMMARY

DELIVER THE BEST CLINICAL OUTCOMES

- Trust attributable pressure ulcers: 102 cases reported for the month of December 2021, 19 above the Trust threshold of 83. 105 cases reported for the month of January 2022, 11 above the Trust threshold of 94.
- Category 4 pressure ulcers: the weekly pressure ulcer review meetings have identified 0 category 4 pressure ulcers associated with a lapse in care in either December 2021 or January 2022.
- Hospital standardised mortality data is 'higher than expected'.
- 0 new never events were reported in December 2021 or January 2022.
- 82.24% of incidents were approved within 35 days, which is below the internal target of 95%.
- All serious incidents were approved within timescales.
- Average Length of Stay for non-elective patient spells was above the benchmark.
- On 15th February 2022, NHS England and NHS Improvement asked all maternity services to stop using total caesarean section rates as a means of performance management. Therefore, the data will no longer be provided on the report.
- The birth rate between 27 and 37 weeks as a proportion of all registerable births is higher than the expected level. The birth rate between 24 and 27 weeks is at the expected level.
- The STH massive obstetric haemorrhage rate is above the expected range at 5.2%. The actions to reduce the rate of massive obstetric haemorrhage were discussed at the Healthcare Governance Committee in December 2021.
- Patient falls: 403 patient falls reported in January 2022.

PROVIDING PATIENT CENTRED SERVICES

- Complaints – 89.7% of complaints were responded to within the agreed timescale in December 2021 and 97% of complaints were responded to within the agreed timescale in January 2022.
- FFT (The NHS Friends and Family Test) provides patients the ability to give quick and anonymous feedback after receiving NHS care or treatment; the metric indicates the proportion of respondents who would rate the service for treatment as good or very good. The inpatient score was 91% for both December 2021 and January 2022.
- FFT score A&E – the score for December 2021 was 81%. The score for January 2022 was 80%.
- FFT score Maternity – the score for December 2021 was 79%. The score for January 2022 was 81%.
- FFT score Community - the score for December 2021 was 87%. The score for January 2022 was 89%.
- Mixed sex accommodation – there were 3 breaches reported in January 2022. The national standard is 0.
- Patient Activity during January 2022 was higher than December 2021, but lower than the same month in 2020.
- The number of operations cancelled on the day for non-clinical reasons was 79 in January 2022, compared to 71 in December 2021.
- Nine patients had their operation cancelled on the day of admission for non-clinical reasons and were not re-admitted within 28 days. Eight patients have now received their treatment and the ninth is unfit for surgery.
- A&E 4 hour performance was 70.72% in January 2022. The local target is 90% and the national target is 95%. The National performance in January was 74.3%.
- In January 2022, 40.20% of ambulance handovers occurred within 15 minutes, compared to 38.81% in December 2021. 19.73% of ambulance handovers took more than 30 minutes, compared to 14.61% in December 2021.
- The percentage of patients who had been waiting less than 18 weeks for their treatment at the end of the month was 74.13% for January 2022. The national target is 92%. The national performance for January 2022 was 62.8%.
- There were 1,276 52 week breaches in January 2022. This was an increase of 272 on the December 2021 position.

- The percentage of patients waiting 6 weeks or less for their diagnostic test was 73.10% at the end of January 2022. The national target is 99%. The national performance for January 2022 was 70.0%.
- The percentage of outpatient appointments cancelled by the hospital remains higher than the national benchmark.
- The percentage of outpatient appointments cancelled by the patient was higher than the national benchmark.
- The percentage of patients that did not attend for their outpatient appointment was better than the national benchmark.
- Cancer Waiting Times performance remains variable across the targets and the impact of COVID-19 continues to present significant challenges. Urgent and obligatory care remain a priority. For January unpublished cancer waiting times performance, STH are currently compliant for Subsequent Radiotherapy treatments.
- Two Week Wait for January is currently 82.7% and Breast Symptomatic Two Week Wait referrals is 6.7%.
- 62 day referral to treatment (GP Referral), January STH performance for non-shared pathways is currently 54.7%, and shared performance is 55.1% (threshold 85%).
- For pathways relating to 31 day first treatments, January performance is currently 87.6% (threshold 96%).
- January performance is below threshold for Subsequent Surgery at 66.7% (94% threshold) and Subsequent Anti Cancer Drug treatments is 94.8% (98% threshold)
- January performance for 62 day screening pathways is currently below threshold at 37.8% (90% threshold).

EMPLOYING CARING AND CARED FOR STAFF

- Safer staffing – overall, the percentage of care hours per patient day (CHPPD) for registered nurses was 88.26% (December 2021) and 84.65% (January 2022) and for all care staff was 90.38% (December 2021) and 86.89% (January 2022). Any areas where the registered nurse CHPPD was below 85% will be highlighted in a report to the Human Resources & Organisational Development Committee.
- HR metrics, Engagement activity, People Strategy plans, Workforce matters, and Agency control continue to be prioritised.
- The sickness absence rate for January 2022 was 7.6%, which is above the Trust target of 4%. This includes COVID related sickness absence broken down as 2.79% COVID sickness absence and 4.76% non-COVID absence.
- Short term absence for January 2022 is 3.94%. Long term absence for January 2022 was 3.61%. The year-to-date position is 5.51%
- The Trust appraisal rate was 82% in January 2022 which is below the Trust Target of 90%.
- Compliance levels for mandatory training are at 91%, which is above the Trust Target of 90%.
- The Trust Annual Turnover Rate for Jan was 9.02%. Lowest turnover rates for Jan were 6.8% for Medical and Dental staff and the highest leaver rates were 10.8% for Administrative and Clerical roles.
- Retention figures for the Trust are at 90% which has been consistently above the target of 85% for over 12 months now and we are proud to be one of the best Trusts for retention.
- We have specific COVID 19 related support for all staff and are promoting the national Health and Wellbeing offer in addition to support provided by the Trust. Vivup are fully supporting staff and are managing an increased call volume without delays in service provision.

SPEND PUBLIC MONEY WISELY

- The position at Month 10 is a £2,501.4k (0.2%) surplus against plan. The position has remained stable in recent months and incorporates the planned over-commitment of reserves created by investing reported underspends via the Trust's Non-Recurrent Programme.
- Within this position, the assessed non-pay savings to month 10 from activity being below the funded (2019/20) level were £8.8m (£0.9m in month). The on-going impact of Covid means that such savings appear likely to continue for the rest of the financial year, albeit there is still considerable pressure to find ways to increase elective activity.
- There are further gains from lower PDC Dividend costs and released provisions.
- Specific Directorate Covid costs/income losses continue to be funded from the Trust's Covid allocation. It is likely that the available funding will be adequate.
- At Month 10 20/37 Directorates are in a balanced position (an improvement of 1) with just 2 having deficits in excess of 3% of year-to-date budgets. The overall position across Directorates deteriorated in January to a deficit of £1.7m.
- Year-to-date efficiency savings amount to £3.6m compared to the £6.6m (1%) target.
- As expected, no Elective Recovery Fund (ERF) income has been earned since Quarter 1, although the value of that has increased to £12.5m.

- Whilst the key risks for 2021/22 remain the delivery of the required level of efficiency savings and any unanticipated cost pressures, a satisfactory year-end position is anticipated.

- Work is progressing on Business/Financial Planning for 2022/23 but there remain many operational and financial issues to resolve and on-gong uncertainty about the level and impact of Covid.

DELIVER EXCELLENT RESEARCH, EDUCATION & INNOVATION

- The National Institute of Health Research (NIHR) metrics reporting has now re-commenced and reported for Q2 FY21-22:
    - Performance in Initiating: Date Site Selected to First Patient Recruited – STH Median 40.5 days (National Median 67 days)
- STH performance for COVID-19 Studies has been as follows:
    - The setup of COVID studies has been significantly faster than the 40 day existing national benchmark; STH median time was 12 days
    - Recruitment of First Patients First Visit into the COVID studies, has also in the majority of cases been within the 30 day existing national benchmark; STH median time was 15 days
    - Recruitment to COVID trials has been above target, as demonstrated by the number of participants recruited to the studies.
    - This work has contributed to the development of licenced vaccines now given as part of the vaccine roll out programme and also the development of new treatments for COVID-19 (e.g. Dexamethazone, Remdesivir) which improve the outcomes for patients with COVID-19.

The Trust Performance overview is provided for the months of December 2021 and January 2022 below. An exception report is provided for any indicator receiving a red rating in either month (this includes indicators that received a red rating in December 2021, and a green rating in January 2022).

TRUST PERFORMANCE OVERVIEW - JANUARY 2022

Indicator	Measure	Standard	Target Type	Current Reporting Period Data Range	*R	*V	*A	Previous Reporting Period Data Range	*R	*V	*A
CQC Compliance	Outcome of CQC inspection	Good in all five domains	SOF	Jan-22				Dec-21			
Deliver The Best Clinical Outcomes											
Hospital Mortality	Hospital Standardised Mortality Ratio	As expected or lower	SOF	Nov-20 to Oct-21				Oct-20 to Sep-21			
	Summary Hospital-level Mortality Indicator	As expected or lower	SOF	Dec-19 to Nov-20							
MRSA bacteraemia	Hospital onset	Zero cases	SOF	Jan-22				Dec-21			
MSSA bacteraemia	Hospital onset	63 per year	SOF	Q3 21/22							
C.diff	Hospital onset	100 per year (25 per quarter)	SOF	Q3 21/22							
	Community onset/ healthcare associated	36 per year (9 per quarter)	SOF	Q3 21/22							
E.coli	Hospital onset	172 per year (43 per quarter)	SOF	Q3 21/22							
	Community onset/ healthcare associated	132 per year (33 per quarter)		Q3 21/22							
Serious Incidents	Number of serious incidents (SI)	Number	Local	Jan-22	7			Dec-21	9		
	Approved SI Report submitted within timescales	No overdue reports	Local	Jan-22				Dec-21			
Incidents	Number of finally approved incidents based on incident date	Number of incidents	Local	Jan-22	2,025			Dec-21	2,259		
	Percentage of incidents approved within 35 days based on approval date	95% within 35 days	Local	Jan-22				Dec-21			
Average Length of Stay (by discharges)	Average Length of Stay Elective	4.27 days (Dr Foster)	Local	Jul-20 to Jun-21				Jun-20 to May-21			
	Average Length of Stay Non Elective	4.45 days (Dr Foster)	Local	Jul-20 to Jun-21				Jun-20 to May-21			
Birth rate 24-37 weeks	Birth rate between 24 and 37 weeks as proportion of all births >24 weeks, rolling 12 months	6%	Local	Jan-22				Dec-21			
Birth rate 24-27 weeks	Birth rate between 24 and 27 weeks as proportion of all births >24 weeks, rolling 12 months	1%	Local	Jan-22				Dec-21			
Obstetric haemorrhage	Massive obstetric haemorrhage >=1500ml as proportion of deliveries (singleton cephalic births 37-42	2.9%	Local	Jan-22				Dec-21			
Patient Falls	Number of patient falls	< 3526 per year / 294 per month (19-20 total)	Local	Jan-22				Dec-21			
Pressure Ulcers	Number of pressure ulcers acquired within STH	Max 83 per month (996 per year)	Local	Jan-22				Dec-21			
	Category 4 pressure ulcers	Zero	Local	Jan-22				Dec-21			
Never Events	Number of never events	Zero	SOF	Jan-22				Dec-21			
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	Jan-22				Dec-21			
>12 hr Trolley waits in A&E	No. of patients waiting > 12 hours	Zero	National	Jan-22				Dec-21			
Ambulance turnaround	Time taken for ambulance handover of patient	100% within 15 minutes	National	Jan-22				Dec-21			
	Time taken for ambulance handover of patient	0% in excess of 30 minutes	National	Jan-22				Dec-21			
	Time taken for ambulance handover of patient	0% in excess of 60 minutes	Local	Jan-22				Dec-21			

*R = RAG rating, *V = Variation, *A = Assurance. Definitions of Variation and Assurance icons provided at end of dashboard.

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	Jan-22				Dec-21			
52 week waits	Actual numbers	Zero	National	Jan-22				Dec-21			
Size of PTL	Total size of Patient Treatment List	<= Sep-21 (61,416)	Local	Jan-22				Dec-21			
6 week diagnostic waiting	Percentage of patients seen within 6 weeks	99%	SOF	Jan-22				Dec-21			
Cancelled Operations	Number of operations cancelled on the day for non clinical reasons	75 per month	Local	Jan-22				Dec-21			
	Number of patients cancelled on the day and not readmitted within 28 days	Zero	National	Jan-22				Dec-21			
Cancelled Outpatient appointments	Percentage of out-patient appointments cancelled by hospital	8.71% (National figure 2019/20)	Local	Jan-22				Dec-21			
	Percentage of out-patient appointments cancelled by patient	7.51% (National figure 2019/20)	Local	Jan-22				Dec-21			
DNA rate	Percentage of new out-patient appointments where patients DNA	7.27% (National figure 2019/20)	Local	Jan-22				Dec-21			
	Percentage of follow-up out-patient appointments where patients DNA	7.36% (National figure 2019/20)	Local	Jan-22				Dec-21			
Cancer Waits	Patient seen within 2 weeks of urgent referral	93%	National	Q3 21/22							
	Breast symptomatic seen within 2 weeks	93%	National	Q3 21/22							
	62 days from referral to treatment (GP referral)	85%	SOF	Q3 21/22							
	62 days from referral to treatment (Cancer Screening Service)	90%	SOF	Q3 21/22							
	31 day first treatment from referral	96%	National	Q3 21/22							
	31 day subsequent treatment (Surgery)	94%	National	Q3 21/22							
	31 day subsequent treatment (Radiotherapy)	94%	National	Q3 21/22							
	31 day subsequent treatment (Drugs)	98%	National	Q3 21/22							
e-Referral Service	Percentage of eligible GP referrals received through Electronic Referral Service	90%	Local	Jan-22				Dec-21			
Ethnic group data collection	Percentage of inpatient admissions with a valid ethnic group code	85%	National	Jan-22				Dec-21			
Elective Inpatient activity	Variance from contract schedules	On plan	Local	Jan-22	No contract in 2021/22						
Non elective inpatient activity	Variance from contract schedules	On plan	Local	Jan-22							
New outpatient attendances	Variance from contract schedules	On plan	Local	Jan-22							
Follow up op attendances	Variance from contract schedules	On plan	Local	Jan-22							
A&E attendances	Variance from contract schedules	On plan	Local	Jan-22							
Complaints	Percentage of complaints closed within agreed timescales	90% within agreed timescale	Local	Jan-22				Dec-21			
Written Complaints Rate	Written complaints rate per 10,000 finished consultant episode	<19/20 rate ()	SOF	Q3 2019/20	39.3						
Community Care	Integrated Care team contacts	43,000 per month	Local	Jan-22				Dec-21			
	Intermediate Care at home Community Intermediate Care response time	98% within 1 day	Local	Jan-22				Dec-21			
	Intermediate Care Beds Occupancy	91%	Local	Jan-22				Dec-21			
	Intermediate Care Beds Length of Stay	<35 days	Local	Jan-22				Dec-21			

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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	Jan-22				Dec-21			
FFT Recommended	Patients recommending STH for Inpatient treatment	95%	SOF	Jan-22				Dec-21			
	Patients recommending STH for A&E treatment	86%	SOF	Jan-22				Dec-21			
	Patients recommending STH for Maternity treatment	95%	SOF	Jan-22				Dec-21			
	Patients recommending STH for Community treatment	90%	SOF	Jan-22				Dec-21			
Community care – information completeness	RTT information completeness	48.7%	National	Q1 20/21							
	Referral information completeness	50%	National	Q1 20/21							
	Activity information completeness	50%	National	Q1 20/21							
Day surgery rates	Aggregate percentage of all BADS procedures recommended to be treated as day case or outpatient	88%	Local	Jan-22				Dec-21			
Mixed Sex Accommodation	Number of breaches of Mixed Sex Accommodation standard	Zero	SOF	Jan-22				Dec-21			
Employ Caring & Cared for Staff											
Sickness Absence	All days lost as a percentage of those available	4%	SOF	Jan-22				Dec-21			
Appraisals	Completed appraisals in last year	90%	Local	Jan-22				Dec-21			
Mandatory Training	Overall percentage of completed mandatory training	90%	Local	Jan-22				Dec-21			
Safer Staffing	Care Hours per patient day (Registered Nurses)	85% of planned hours or greater	Local	Jan-22				Dec-21			
	Care Hours per patient day (Total)	85% of planned hours or greater	Local	Jan-22				Dec-21			
Staff Turnover	Executive Team turnover (number of leavers as a percentage of total executive head count - rolling 12 months	0%	SOF	Jan-22				Dec-21			
	Number of leavers as a percentage of total head count (rolling 12 months)	to be determined	SOF	Jan-22	9.0%			Dec-21	8.9%		
	Retention Rate	85%	SOF	Jan-22				Dec-21			
Recruitment	Request to fill to unconditional final offer	Average <= 8 weeks	Local	Jan-22	10			Dec-21	9		
Spend Public Money Wisely											
I & E	YTD actual I & E surplus/deficit in comparison to YTD plan I & E surplus/deficit	>=0	SOF	Jan-22				Dec-21			
I & E Margin	I & E surplus/deficit as a percentage of total revenue	>=0	SOF	Jan-22				Dec-21			
Efficiency	Variance from plan	On plan	Local	Jan-22				Dec-21			
Cash	Actual	Above profile	Local	Jan-22				Dec-21			
Liquidity	Days of operating costs held in cash or cash equivalents	>0	SOF	Jan-22				Dec-21			
Capitol	Expenditure - variance from plan	On plan	Local	Jan-22				Dec-21			
Deliver Excellent Research, Education & Innovation											
Recruitment to trials	Total number of patient accruals to portfolio studies	0	Regional - Y&H	Q3 19/20							
Annually Reported Indicators											
Staff Survey	National average or better in all 10 domains	0 domains below national average	Local	2020							

*R = RAG rating, *V = Variation, *A = Assurance. Definitions of Variation and Assurance icons provided at end of dashboard.

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)

Assurance

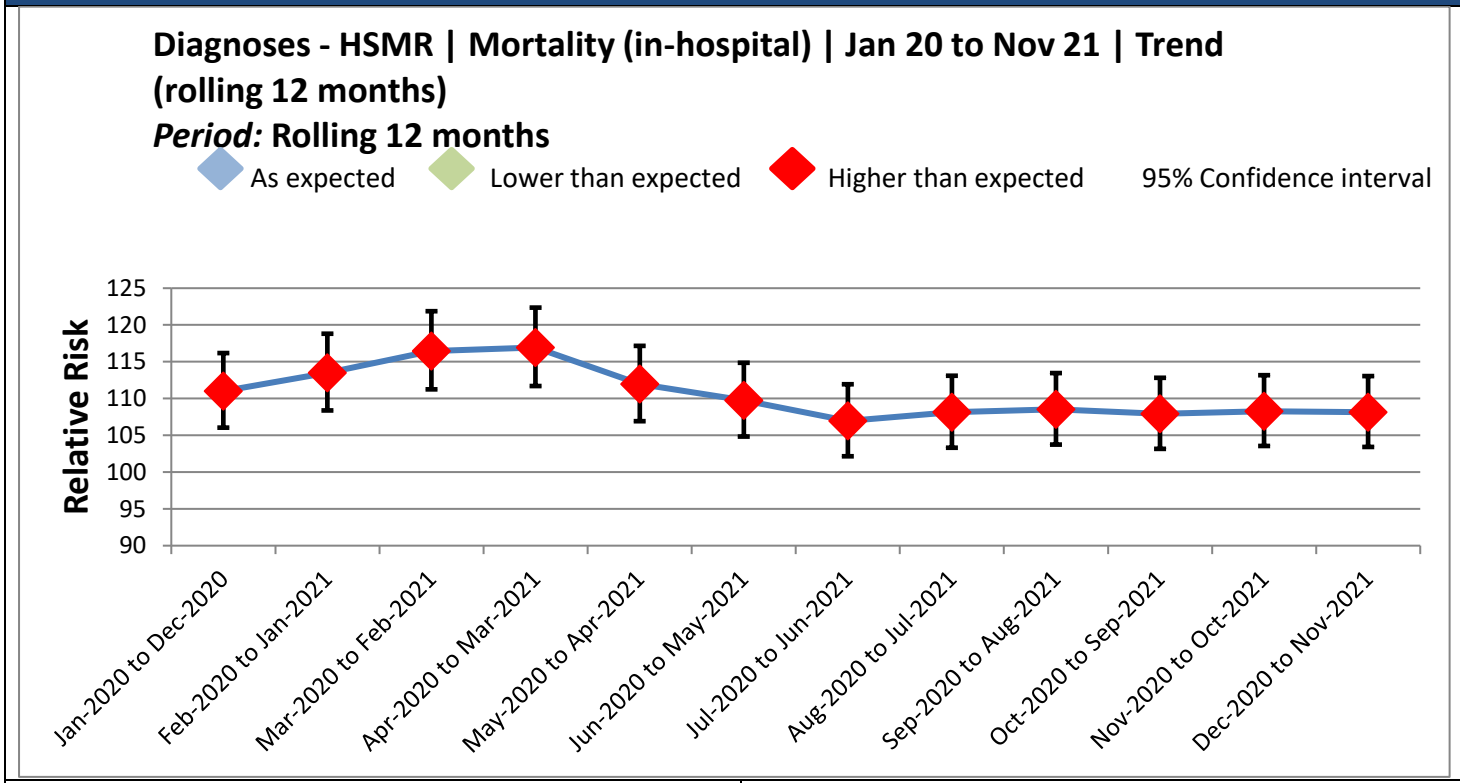
Icon	Description
	The system is expected to consistently fail the target
	The system is expected to consistently pass the target
	The system may achieve or fail the target subject to random variation

These icons are used to indicate 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

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.

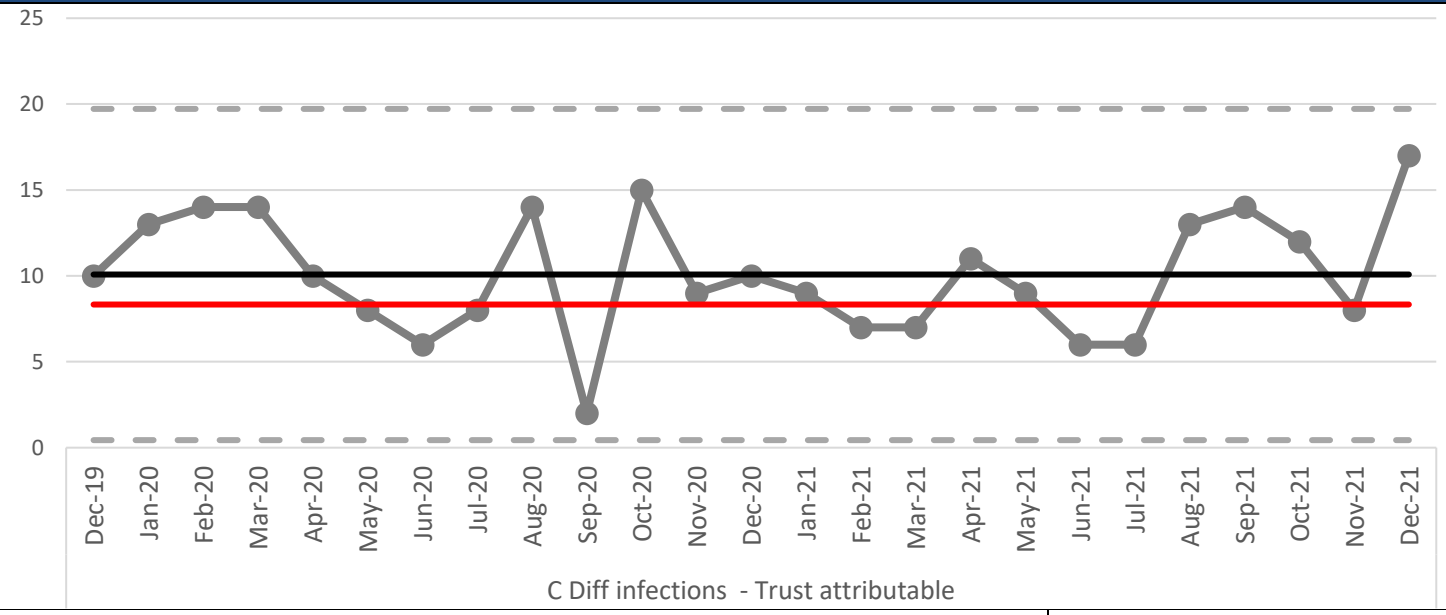
Please Note: On the SPC charts a red line is used to denote the target and a black line indicates the mean value for the indicator

Hospital Standardised Mortality Ratio (HSMR)		
		
Lead: Jennifer Hill (Medical Director, Operations)	**Timescale**: March 2022	
Board Committee Providing Oversight:		

Target	100
Sept-21	108.2
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 108.2.

Summary of current issues	Actions to recover performance
Resetting of the National Benchmark has resulted in our HSMR moving into the higher than expected range.	To improve the quality of data inputted to the model, the Task and Finish has resumed weekly meetings. This reduced expected deaths and our HSMR last year and should do so again.

Clostridioides Difficile (CDD) (Hospital onset)



Target		25
Q3 21/22		37
Variance Type		Indicator is showing no significant change (common cause variation)
Assurance Type		Indicator is showing random variation
What the chart is telling us		

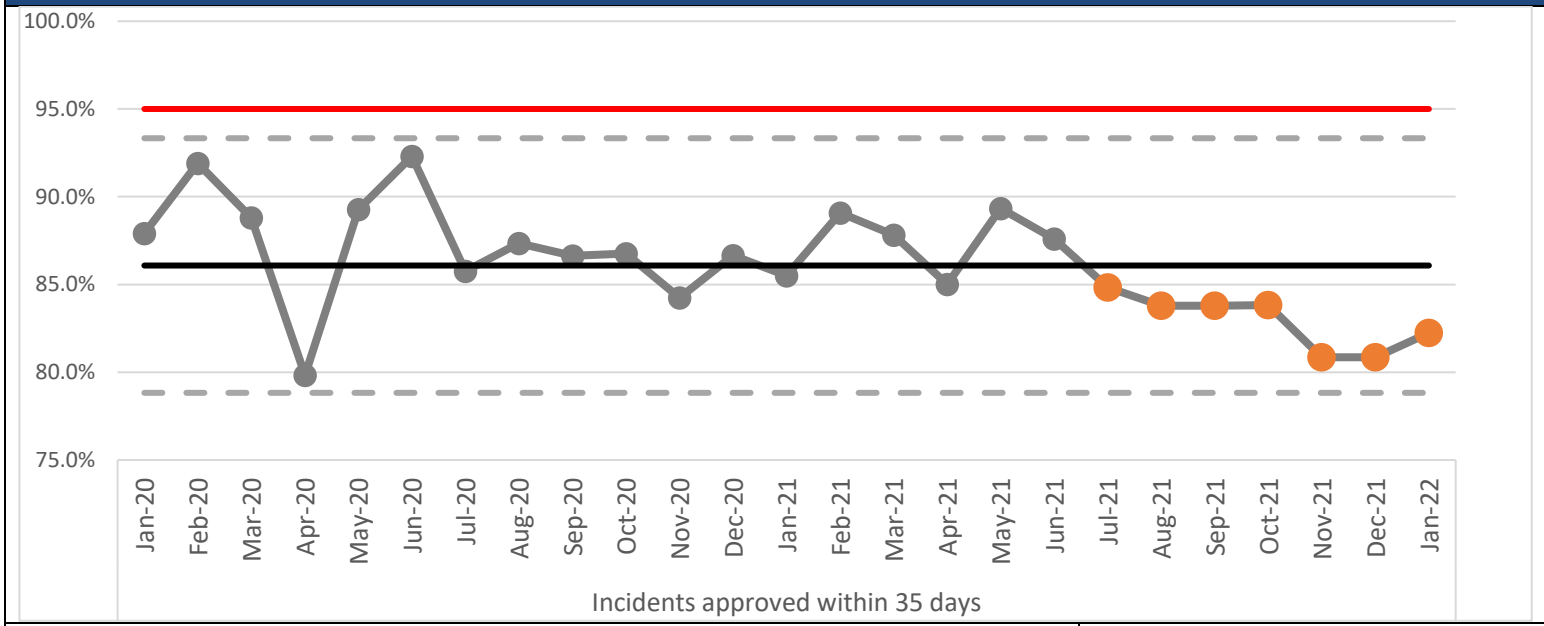
Lead: Chris Morley, Chief Nurse

Timescale: Ongoing

Board Committee Providing Oversight: Healthcare Governance Committee

Summary of current issues	Actions to recover performance
The number of cases of C.Diff Hospital onset are above threshold for the quarter.	The actions to prevent and reduce C.diff are contained within the Infection, Prevention and Control Programme. The Infection Control Operational Group have discussed the rise in cases of C.diff identified by the Trust and have considered the findings and agreed actions from the root cause analyses undertaken including greater scrutiny of antibiotic use within this identified cohort of patients. There is nothing to indicate that this is an outbreak situation.

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

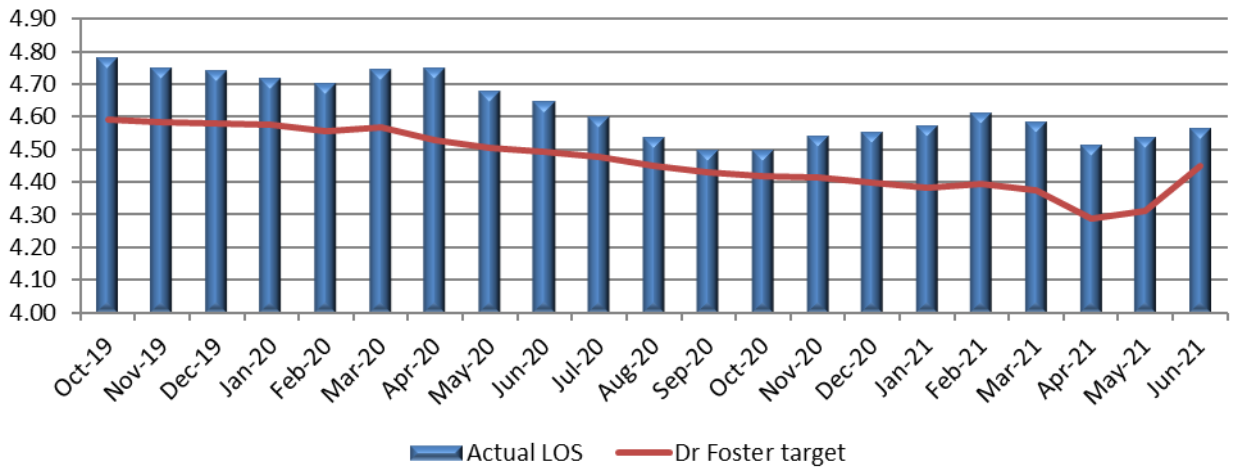


Target	95%
Jan-22	82.24%
Variance Type	Metric is experiencing special cause for concern because of low values
Assurance Type	Metric is consistently falling short of the target
What the chart is telling us	The target has not been met in any month within the last two years.

Lead: Jennifer Hill, Medical Director (Operations)

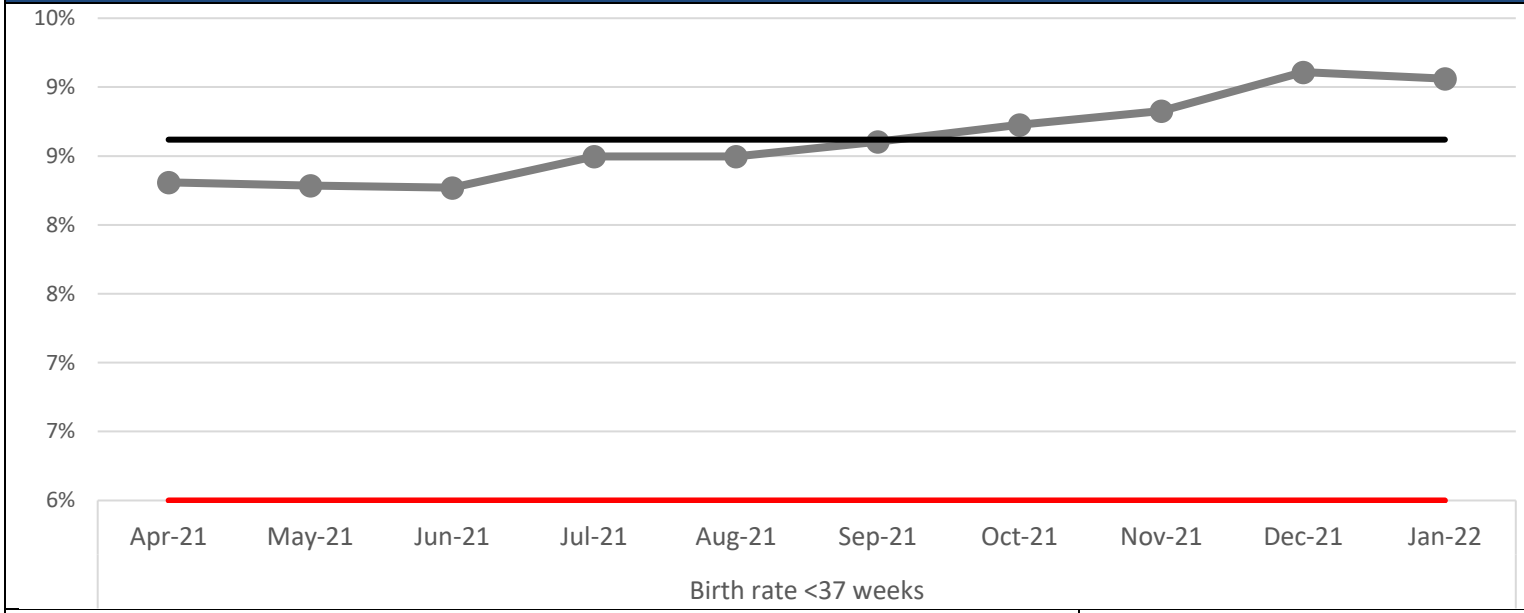
Board Committee Providing Oversight: Healthcare Governance Committee

Summary of current issues	Actions to recover performance
Performance in January continues to be below target, although shows a slight improvement on the previous two months since launch of the Safety, Risk and Quality Dashboard.	Patient and Healthcare Governance continue to provide weekly reports to directorate indicating the numbers of overdue incidents. This is in addition to the availability of live data on the Safety, Risk and Quality Dashboard and discussions at the safety and Risk Forum which has been held monthly since December 2021. On-going operational pressures make this target challenging to meet but Directorates continue to implement actions to ensure that where possible available staff resource supports the timely review of incidents.

AVERAGE LENGTH OF STAY (Non Elective)		
	Target	4.45
	Jun-21	4.57
	Variance Type	Data is provided on a rolling 12 month basis, so not suitable for SPC analysis
	Assurance Type	Data is provided on a rolling 12 month basis, so not suitable for SPC analysis
	What the chart is telling us	Average LOS for Non-elective episodes has reduced over time but remains above the national benchmark.
Lead: Jennifer Hill, Medical Director (Operations)	**Timescale**: Ongoing	
Board Committee Providing Oversight: Healthcare Governance Committee		

Summary of current issues	Actions to recover performance
Approximately 20% of current STH inpatients have care needs that could be met outside of an acute inpatient setting. Data indicates that not only has the number of patients waiting for discharge increased but patients are also waiting longer to be discharged with a particularly significant increase in the number of patients waiting for discharge via the Discharge to Assess pathway. In addition, there has been an increase in numbers of patients with lengths of stay over 14 days, however the majority of these need acute care and are patients in tertiary services.	The Excellent Emergency Care (EEC) programme is continuing to support a revised programme of work focussed on maintaining the flow of emergency care patients throughout the Trust and on improving discharge processes to both enhance the experience for our patients and to increase organisational flow. A recent visit by the ECIST has provided a report, recommendations and offer of support to improve ward and discharge processes.

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



Target	6%
Jan-22	9%
Variance Type	Data is provided on a rolling 12 month basis, so not suitable for SPC analysis
Assurance Type	Data is provided on a rolling 12 month basis, so not suitable for SPC analysis
What the chart is telling us	The birth rate between 24 & 37 weeks as a proportion of all births over 24 weeks continues to be higher than target,

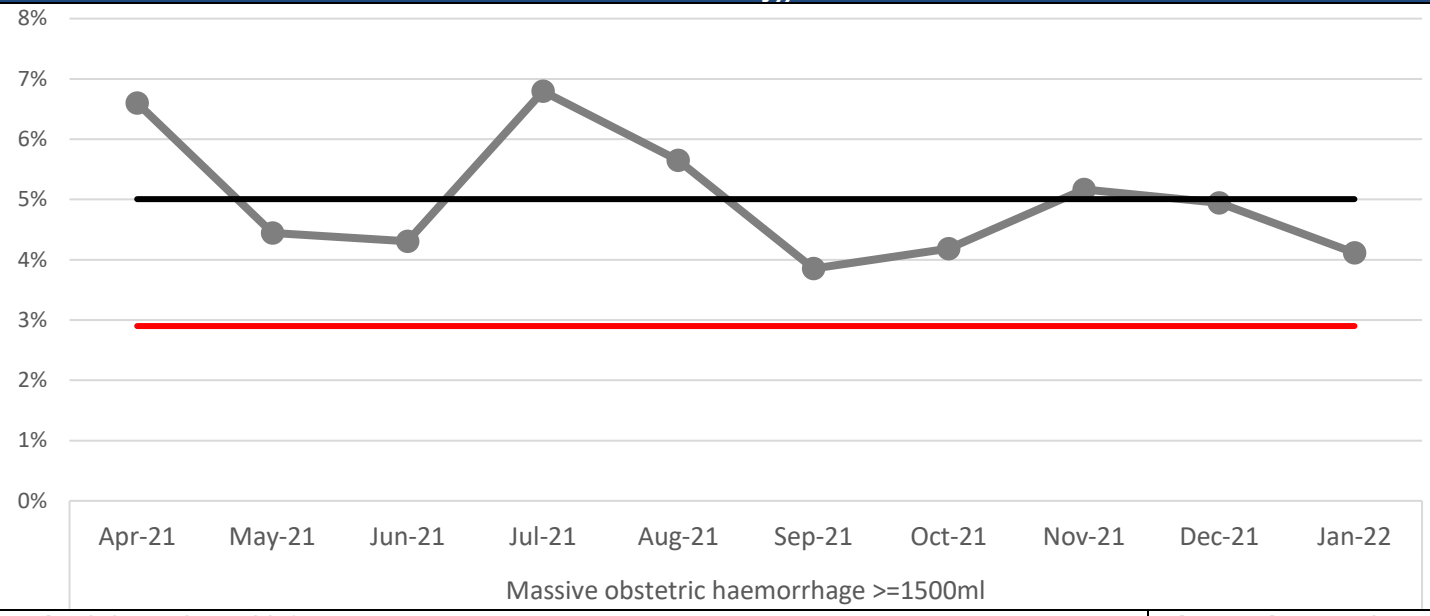
Lead: Chris Morley, Chief Nurse

Timescale: Under review by the regional team

Board Committee Providing Oversight: Healthcare Governance Committee

Summary of current issues	Actions to recover performance
The birth rate between 24 and 37 weeks as proportion of all births over 24 weeks is over the threshold originally set in the regional maternity dashboard.	The birth rate below both 37 weeks and 27 weeks will fluctuate and is believed to be affected by the Jessop Wing status as a Tertiary referral unit with a Level 3 Neonatal Unit. All babies born under 27 weeks should be born in a unit with Level 3 neonatal care and babies less than 32 weeks should be born in unit with a level 2 or 3 neonatal care. The regional maternity dashboard has been refreshed and the STH metrics will be considered to ensure that reporting is aligned

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



Target	2.9%
Jan-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 has been consistently above the target.

Lead: Chris Morley, Chief Nurse

Timescale: Ongoing

Board Committee Providing Oversight: Healthcare Governance Committee

Summary of current issues

The post-partum haemorrhage (PPH) % remains higher than the <1.5 l - <2.9% target set using NMPA data from 2017.

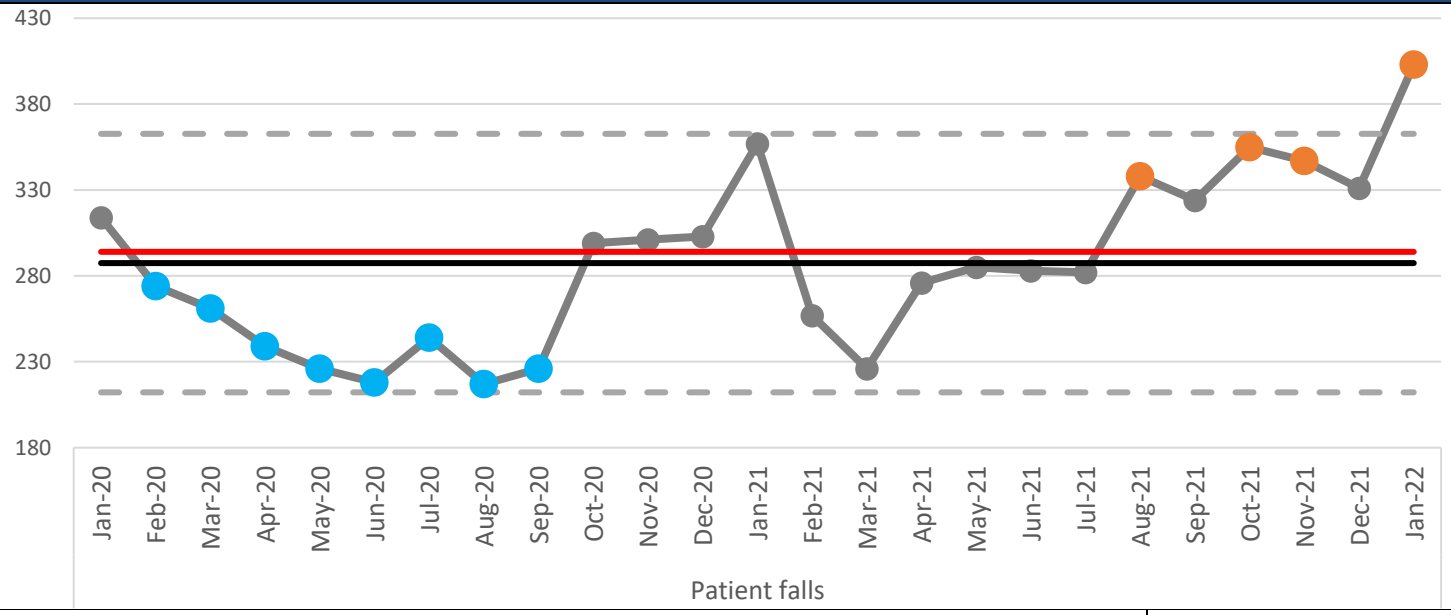
Massive obstetric haemorrhage (Based on NMPA data for 2017/17 for women who gave birth vaginally to a singleton baby in the cephalic position between 37+0 and 42+6 weeks)	Massive obstetric Haemorrhage >1500mls (denominator = total singleton cephalic births)	<2.9%	<2.9%	N/A	>2.9%	Trust/MSDSv2

Actions to recover performance

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). The Maternity Safety Learning Network has commenced work on standardisation of measurement across the LMNS, to improve the accuracy of comparative data.

An audit of the use of oxytocics, (medication used in the management of the third stage of labour to deliver the placenta after the baby is born), is currently underway. The report for this has been delayed due to data collection issues. Data collection for a full re-audit of all Major Obstetric Haemorrhage (MOH) is nearing completion. This will further inform our prevention and active management of haemorrhage.

PATIENT FALLS
(Number of patient falls)



Target	< 3526 per year / 294 per month (19-20 total)	
Jan-22	403	
Variance Type		Metric is experiencing special cause for concern because of high values
Assurance Type		Indicator is showing random variation
What the chart is telling us	Consistently high values above the target	

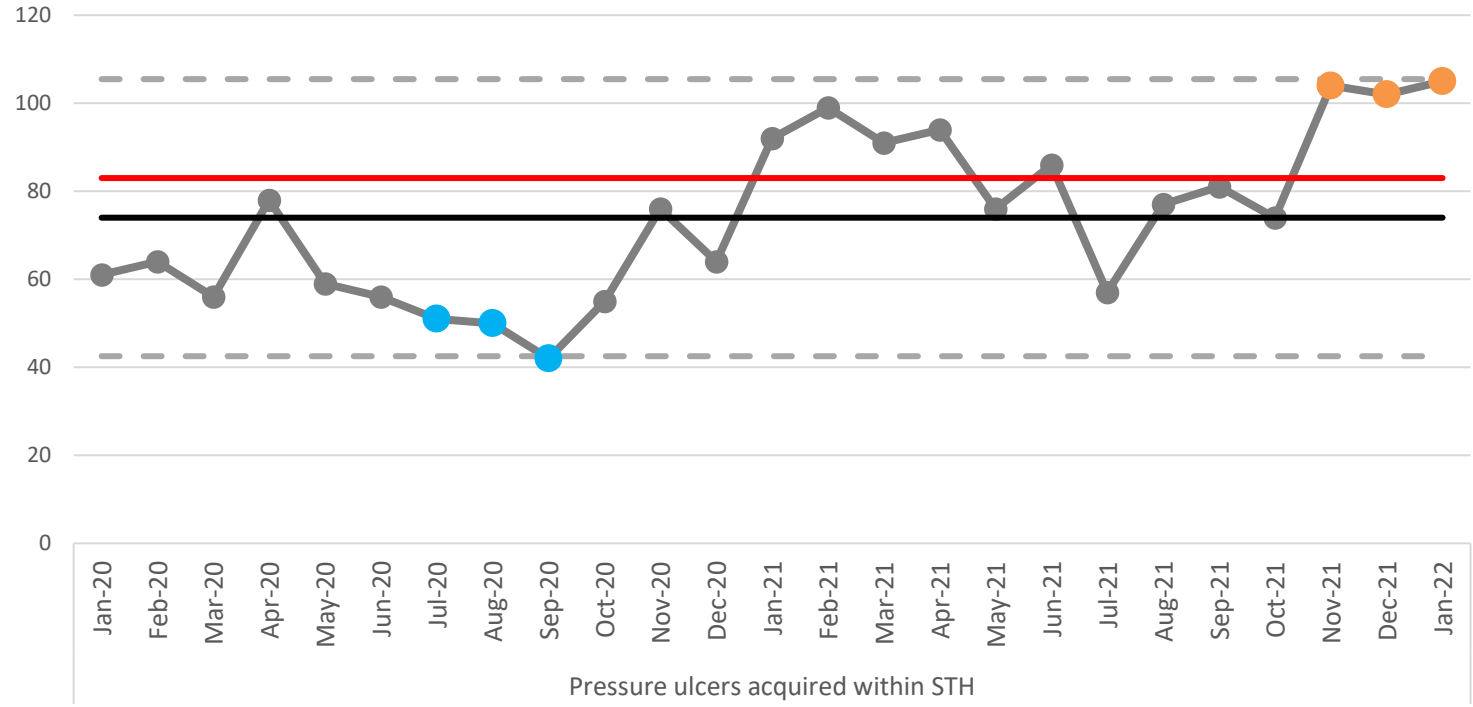
Lead: Jennifer Hill, Medical Director (Operations)

Timescale: Ongoing

Board Committee Providing Oversight: Healthcare Governance Committee

Summary of current issues	Actions to recover performance
The most significant rise was in the insignificant category (308), followed by minor(91) and moderate harm (4), in line with the average for the last 12 months, which was 3.3 falls with moderate harm. The biggest rises seen within the medical specialties and MSK. This is likely to be due to a combination of factors including reduced visiting and deconditioning of patients due to the pandemic, and delayed discharges due to lack of social care provision.	All falls improvement work continues including the Quality Objective, Huddles, in patient falls review meetings and falls packs.

Pressure Ulcers
(Number of pressure ulcers acquire within STH)



Target	83
Jan-22	105
Variance Type	Metric is experiencing special cause for concern because of high values
Assurance Type	Indicator is showing random variation
What the chart is telling us	There has been an increase in the number of pressure ulcers acquired within STH since July 2021.

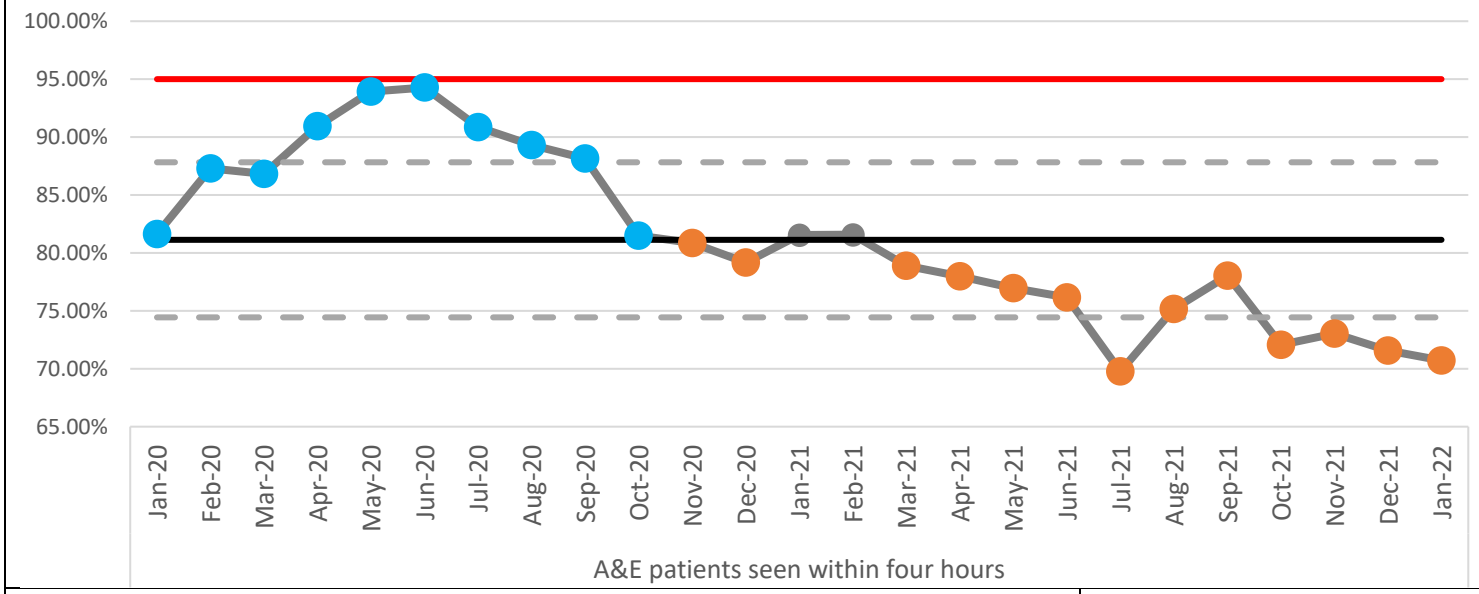
Lead: Chris Morley, Chief Nurse

Timescale: Ongoing

Board Committee Providing Oversight: Healthcare Governance Committee

Summary of current issues	Actions to recover performance
During December 2021 and January 2022, the threshold for the number of inpatient pressure ulcers has been breached.	The number of Trust attributable PU's is above the monthly agreed threshold for both reported months. The increase in recorded pressure ulcers is in the number of category 2 pressure ulcers recorded with the number of category 3, 4 and deep tissue injuries remaining static. The Integrated Tissue Viability team were again deployed to support operational pressures during December and January and returned in early February to continue the provision of clinical expertise, support and education in areas where there is a reported higher than expected incidence of Trust attributable pressure ulcers. The increase in hospital attributable pressure ulcers has been identified nationally and is also reflective of the increase seen in the same months of 2020/21 suggesting that the high occupancy and acuity of patients may be a factor. The Lead Tissue Viability Nurse is working in collaboration with her colleagues from the Shelford Tissue Viability Group to identify trends and support tools. Pressure ulcer prevention and reduction continues to be an agreed nursing quality metric.

A&E 4 HOUR WAIT
(Patients Seen Within 4 Hours)



Target	95%
Jan-22	70.72%
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 dipped below the mean in October 2020, and has remained below the average performance since.

Lead: Michael Harper, Chief Operating Officer

Timescale: March 2022

Board Committee Providing Oversight: Finance and Performance Committee

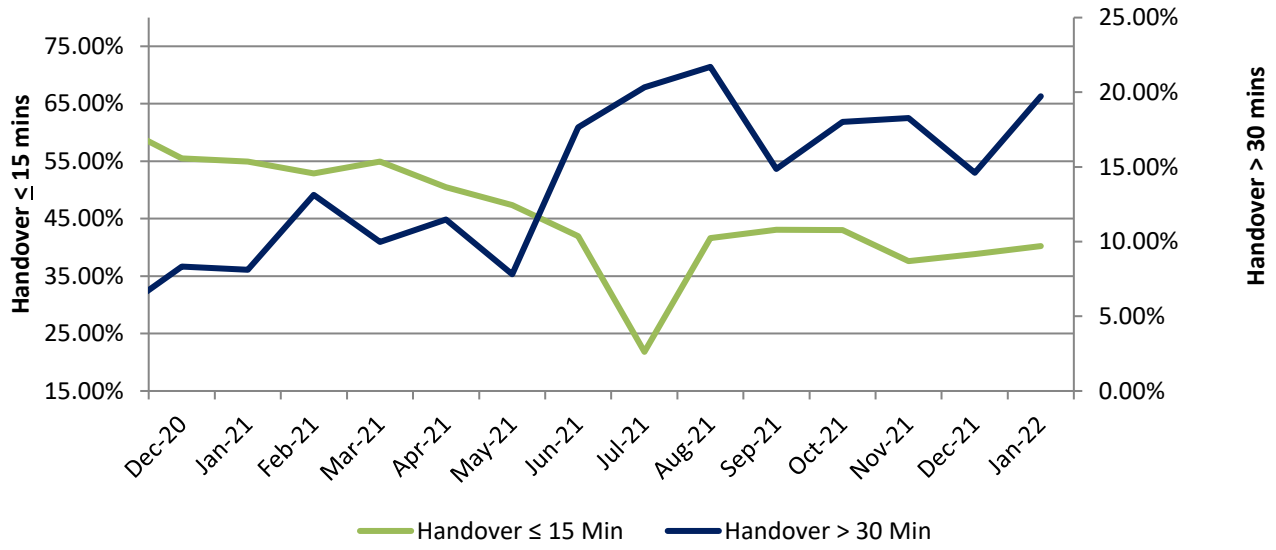
Summary of current issues

The percentage of A&E attendances who were discharged or admitted within 4 hours in January 2022 was 70.72% and in December 2021 71.58%, indicative of the challenges facing the department, noting the impact of Covid upon patient pathways. There were 9,061 type 1 attendances in January 2022, a slight increase from the 9,002 type 1 attendances in December 2021.

Actions to recover performance

Performance is managed daily through the Morning Operational Group/Bronze Command Meeting. There was a departmental focus on reduction of non-admitted breaches and maximising utilisation of SDEC (Same Day Emergency Care) which increased its operational hours to midnight. However SDEC has not been available to open on a daily basis given that it has been required as additional inpatient surge capacity. Actions to reconfigure the Accident and Emergency footprint are underway and expected to be completed by March 2022. These aim to improve the flow of patients through the department.
Silver Command continues to work to oversee the improvement of flow and co-ordination of Covid and non-Covid inpatient pressures.

>AMBULANCE TURNAROUND
(Time taken for ambulance handover of patient within 15 and 30 minutes)



Target	15 mins 100% 30 mins 0%
Jan-22	15 mins 40.20% 30 mins 19.73%
Variance Type	Not Applicable
Assurance Type	Not Applicable
What the chart is telling us	The national standards have not been met.

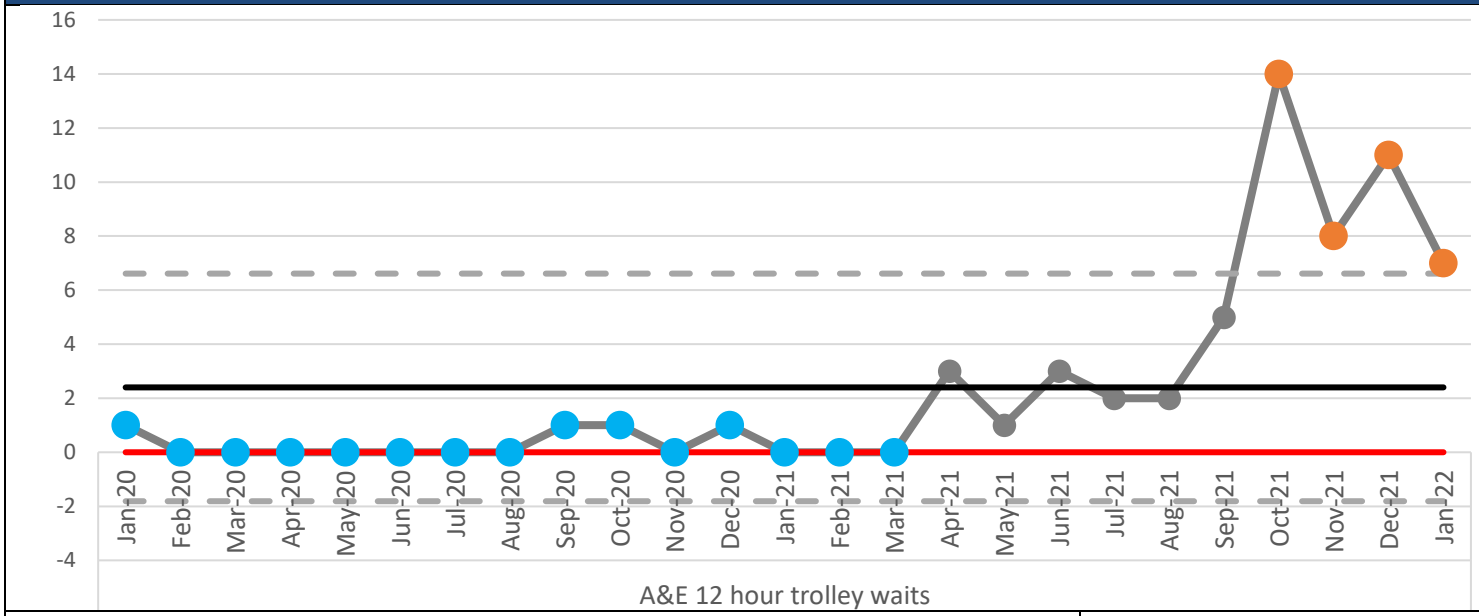
Lead: Michael Harper, Chief Operating Officer

Timescale: Ongoing

Board Committee Providing Oversight: Finance and Performance Committee

Summary of current issues	Actions to recover performance
The percentage of ambulance handovers completed within 15 minutes in January was 40.2% which is stable based on December's performance of 38.8% of handovers within 15 minutes. This is indicative of the challenges currently facing the department and wider organisation in managing the increase in patients attending Accident and Emergency and consequently requiring admission to inpatient beds.	Close working on-site within the 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. 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. The AEM Care Group has collaborated with the Clinical Operations Office and Yorkshire Ambulance Service to develop an Action Plan for the reduction of ambulance handover delays including cohorting ambulance patients safely adjacent to the A&E dept to release crews.

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



Target	0
Jan-22	7
Variance Type	Metric is experiencing special cause for concern because of high values
Assurance Type	Indicator is showing random variation
What the chart is telling us	Since March 2021, we have seen an increased number of 12 hour trolley waits

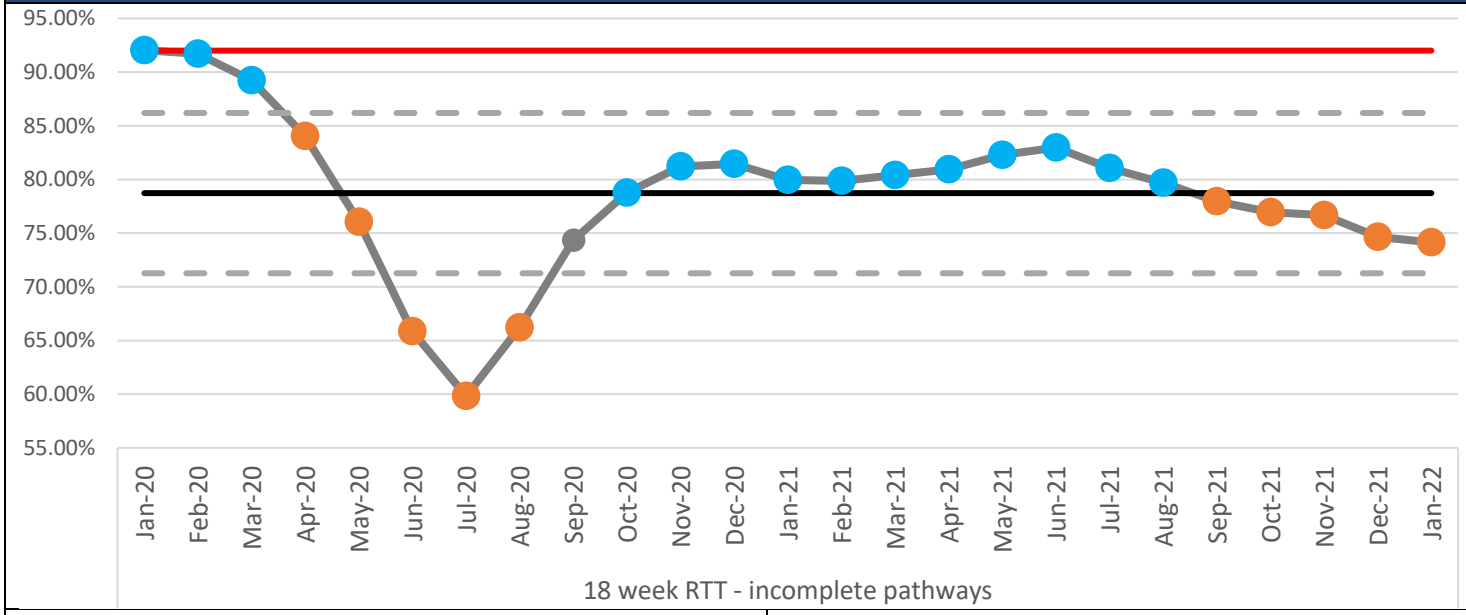
Lead: Michael Harper, Chief Operating Officer

Timescale: Ongoing

Board Committee Providing Oversight: Finance and Performance Committee

Summary of current issues	Actions to recover performance
There were seven 12 hour trolley waits in January 2022. Six of these patients required admission to a specialist mental health bed in another organisation and the delay was related to this. One patient was delayed due to waiting for ambulance to a ward at the Royal Hallamshire Hospital.	There has been a full review of the circumstances which led to the 12 hour trolley waits. Improved escalation processes and clarified pathways are now in place across partners including mental health providers and commissioners. The Care Group work closely with the Yorkshire Ambulance Service including as part of the daily Morning Operational Group meetings to escalate concerns about patients waiting for transport.

18 WEEKS RTT
(Percentage of patients on incomplete pathways waiting less than 18 weeks)



Target	92%
Jan-22	74.13%
Variance Type	Metric is showing special cause of concerning nature due to its low values.
Assurance Type	Metric is consistently falling short of the target.
What the chart is telling us	Performance fell below standard in March 2020, and has not hit the target since. The pandemic has had a significant adverse impact on this performance standard.

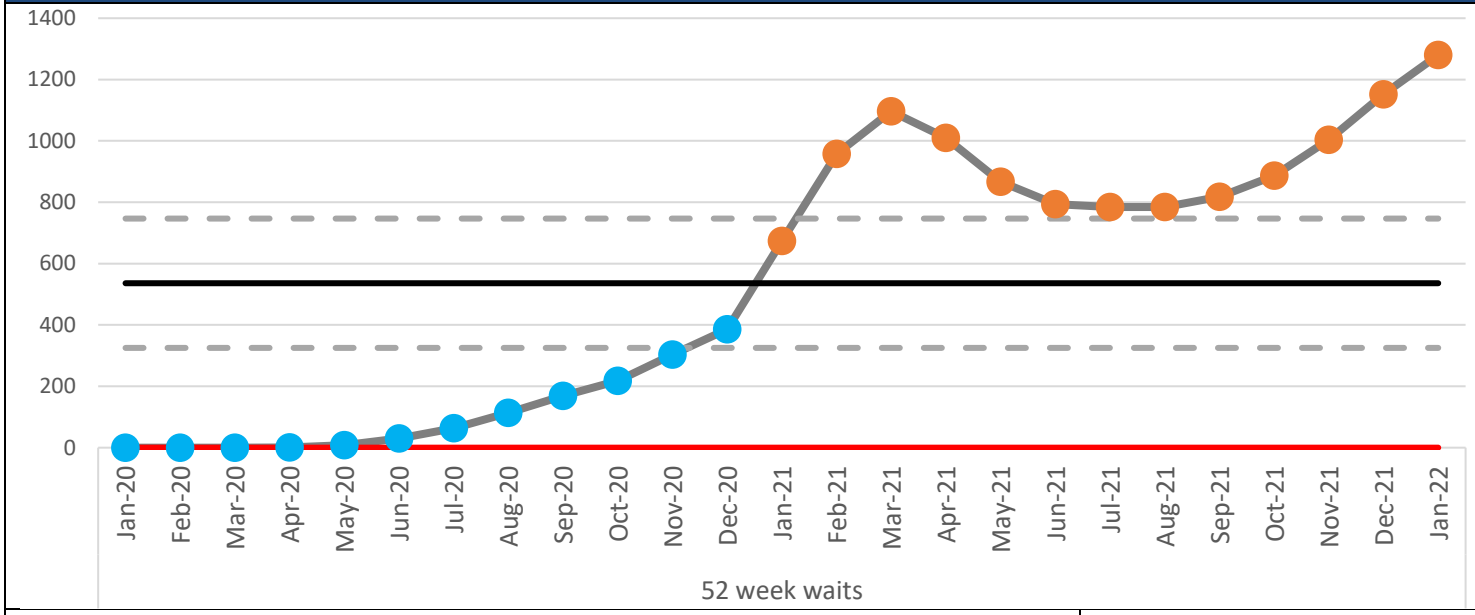
Lead: Michael Harper, Chief Operating Officer

Timescale: Ongoing

Board Committee Providing Oversight: Finance and Performance Committee

Summary of current issues	Actions to recover performance
Whilst the Trust continues to perform well compared to it's peers, the percentage of patients on an incomplete pathway waiting less than 18 weeks declined again in January 2022 to 74.13%. This is below the national target of 92%. This is multifactorial in relation to the COVID situation.	Plans remain in place to recover non-COVID planned activity. Processes have been established in each Care Group to ensure that patients within our caseload are regularly reviewed administratively by clinical staff and their care is prioritised appropriately. The Trust has a focused validation exercise ongoing to give quality assurance to the reported position.

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



Target	0
Jan-22	1,280
Variance Type	Metric is showing special cause of concerning nature due to its high values.
Assurance Type	Metric is now consistently falling short of target
What the chart is telling us	From April 20 the number of long waiting patients grew peaking in March 2021. Following four months of reduction the number has risen once again.

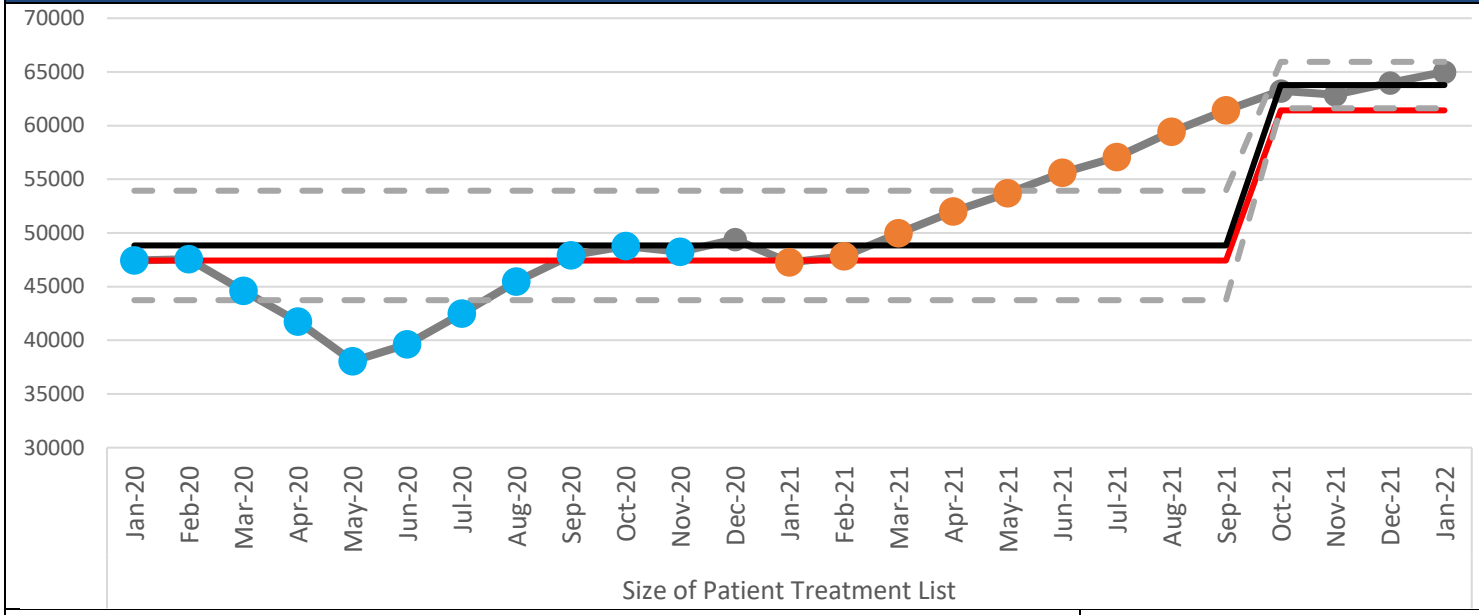
Lead: Michael Harper, Chief Operating Officer

Timescale: Ongoing

Board Committee Providing Oversight: Finance and Performance Committee

Summary of current issues	Actions to recover performance
There were 1,280 patients waiting over 52 weeks on an incomplete pathway during January 2022, an increase of 128 on the December 2021 position. COVID impact continues to affect this position	Activity plans remain in place where possible to ensure continued delivery of treatment plans. Patients who continue to wait are being reviewed on a regular basis by the clinical teams as part of the Trust's caseload management approach, and treatment plans are being developed. Focus is now on 104 week as part of the planning guidance with the requirement that the 52 week position does not deteriorate any further.

PATIENT TREATMENT LIST
(Total Numbers)



Target	61,416
Jan-22	64,999
Variance Type	Metric is experiencing common cause variation
Assurance Type	Variation indicates that the system is expected to consistently fail the target
What the chart is telling us	The total number of patients awaiting treatment has increased month on month since January 2021

Lead: Michael Harper, Chief Operating Officer

Timescale: Ongoing

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 1,021 in January 2022 to 62,891. This is above the September 2021 target of 61,416.

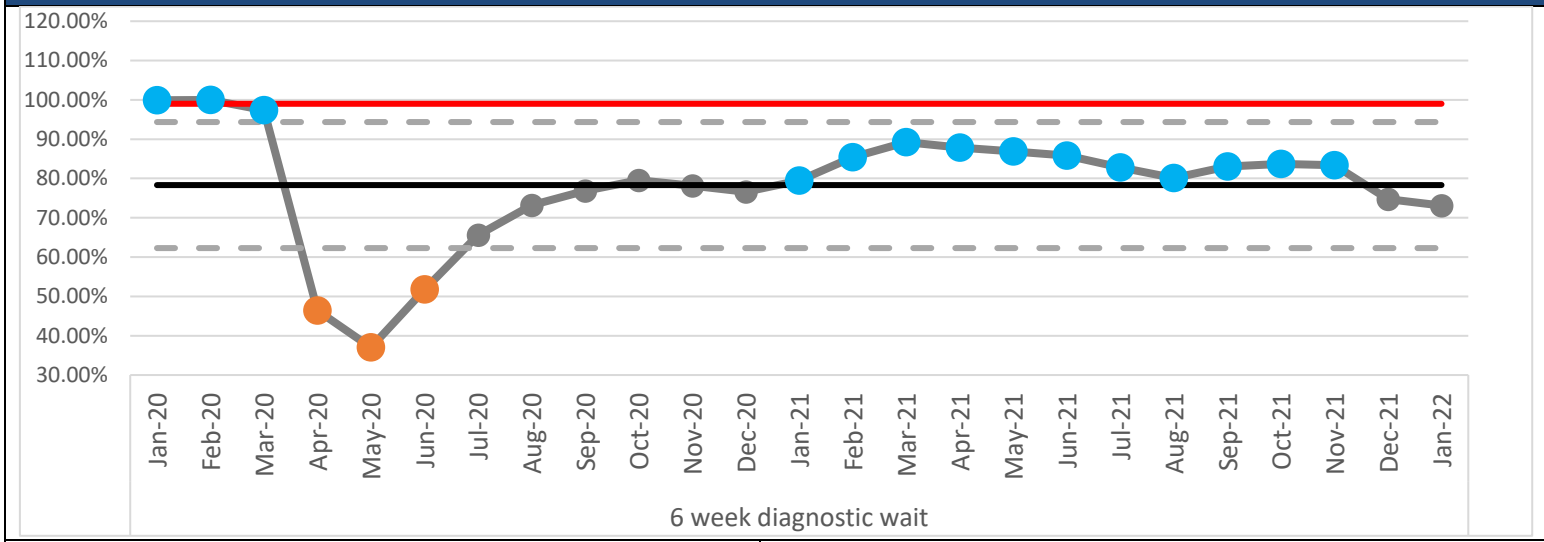
There has been a growth in the volume of referrals with the rates in some areas increasing back to pre-covid levels. This in conjunction with capacity constraints is impacting on the maintenance and reduction in levels of patients waiting for treatment.

Actions to recover performance

The size of the PTL has been discussed at the Performance and Caseload Overview Group. Validation continues and the PTL has been reviewed externally.

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.

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



Target	99%
Jan-22	73.10%
Variance Type	Metric is experiencing common cause variation
Assurance Type	Metric is consistently falling short of the target.
What the chart is telling us	There has been a slow recovery in performance.

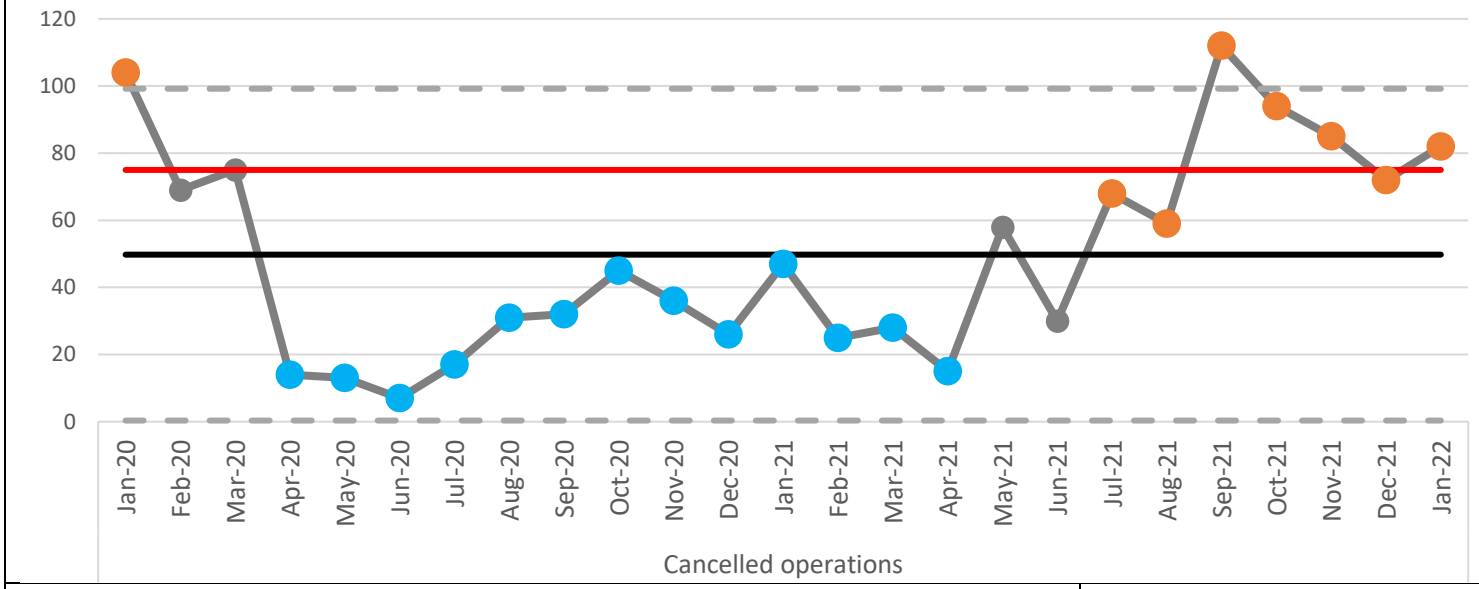
Lead: Michael Harper, Chief Operating Officer

Timescale: Ongoing

Board Committee Providing Oversight: Finance and Performance Committee

Summary of current issues	Actions to recover performance
The percentage of patients receiving diagnostic tests within 6 weeks in January 2022 was 73.10%.	Processes have been established to ensure that the details of patients on the diagnostic waiting list are regularly reviewed by clinical staff and their care is prioritised where required and in line with the currently national diagnostic validation prioritisation process. Recovery plans are being developed for Dexa scans, Echocardiography, urodynamics and flexible sigmoidoscopies.

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



Target	75
Jan-22	82
Variance Type	Metric is experiencing special cause for concern because of high values
Assurance Type	Indicator is showing random variation
What the chart is telling us	The number of on-day elective cancellations for non- clinical reasons was on target for December 2021 but was not achieved in January 2022

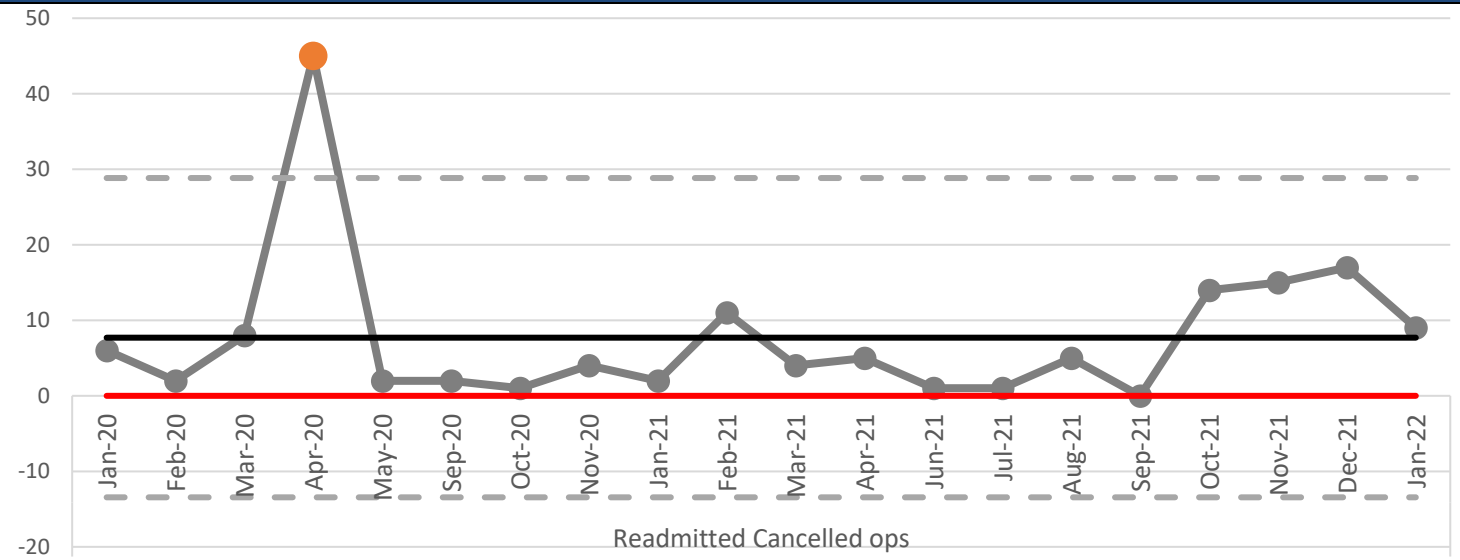
Lead: Michael Harper, Chief Operating Officer

Timescale: Ongoing

Board Committee Providing Oversight: Finance and Performance Committee

Summary of current issues	Actions to recover performance
There were 82 on-day elective cancellations during January 2022, due to challenges with bed and theatre capacity as a result of the pandemic	Performance is reviewed on a regular basis by the Performance and Caseload Overview Group, supported by Seamless Surgery.

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



Target	0
Jan-22	9
Variance Type	Metric is experiencing common cause variation
Assurance Type	Indicator is showing random variation
What the chart is telling us	The number of on-day elective cancellations for non- clinical reasons was above target for January 2022

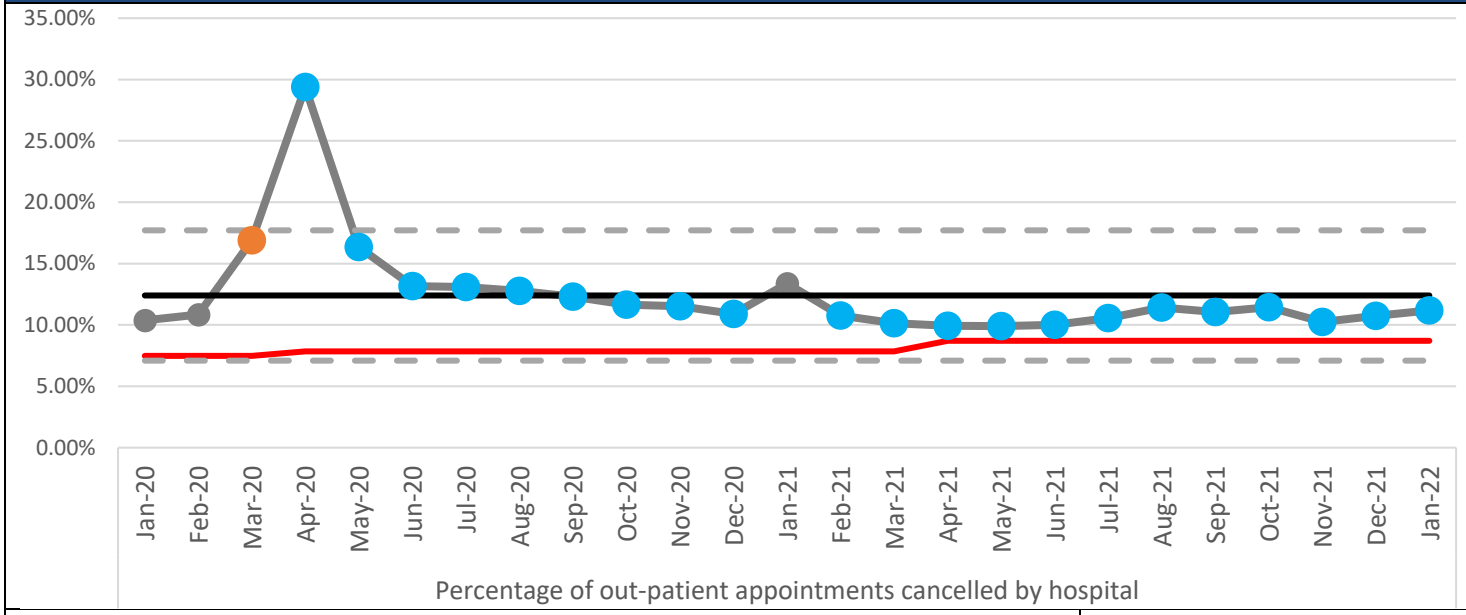
Lead: Michael Harper, Chief Operating Officer

Timescale: Ongoing

Board Committee Providing Oversight: Finance and Performance Committee

Summary of current issues	Actions to recover performance
There were 9 on-day elective cancellations during January 2022 which were not readmitted within 28 days, due to challenges with bed and theatre capacity. All patients have since been admitted and had their procedure.	Performance is reviewed on a regular basis by the Performance and Caseload Overview group.

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



Target	8.71%
Jan-22	11.20%
Variance Type	Improvement in performance is not being achieved
Assurance Type	Indicator is showing random variation
What the chart is telling us	Although above target, performance has been below the mean for the last 10 months.

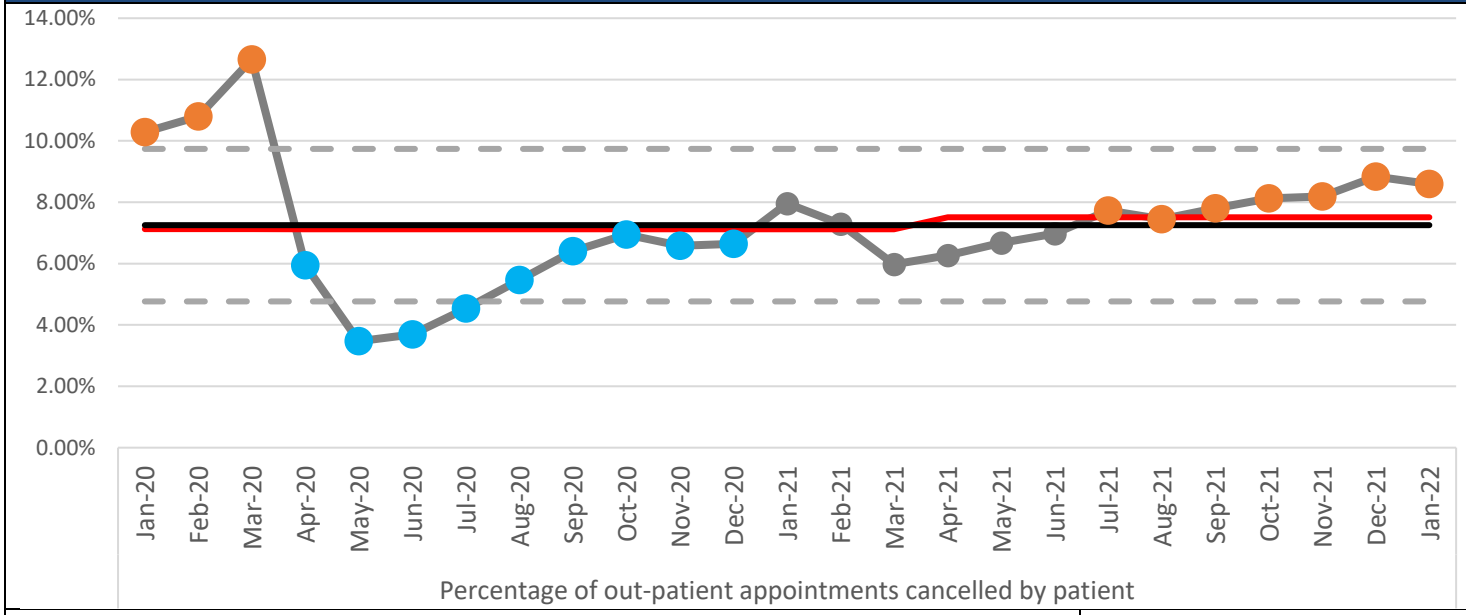
Lead: Michael Harper, Chief Operating Officer

Timescale: Ongoing

Board Committee Providing Oversight: Finance and Performance Committee

Summary of current issues	Actions to recover performance
The percentage of outpatient appointments cancelled by the hospital in January 2022 was 11.20% compared to 10.74% in December 2021.	Appointments that are cancelled by the hospital are clinically reviewed to ensure that it remains safe for patients to wait. This is linked to the Trust's caseload management approach. Work is ongoing with services to mitigate these cancellations and understand issues and blockages causing them.

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



Target	7.51%
Jan-22	8.59%
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 a slight improvement in Aug 2021 only

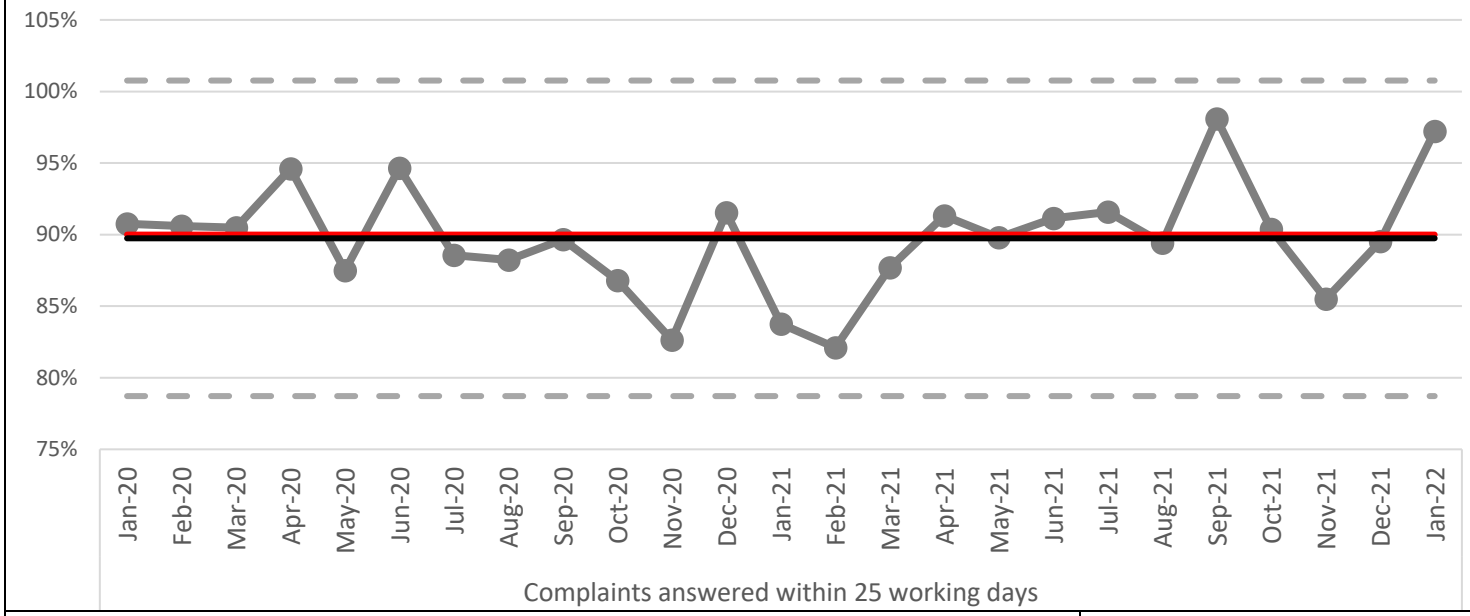
Lead: Michael Harper, Chief Operating Officer

Timescale: Ongoing

Board Committee Providing Oversight: Finance and Performance Committee

Summary of current issues	Actions to recover performance
The percentage of outpatient appointments cancelled by the patient in January 2022 was 8.59% compared to the benchmark target of 7.51%. Issues remain in relation to the impact of the pandemic on patients and as such this is impacting on their ability to attend appointments.	Work is ongoing to understand this and address this increase. Discussion are ongoing in relation to processes to ensure we are doing all we can to support patients being able to attend.

COMPLAINTS
(Percentage of complaints closed within agreed timescales)



Target	90% within agreed timescale
Jan-22	97%
Variance Type	Indicator is showing no significant change (common cause variation)
Assurance Type	Indicator is showing random variation
What the chart is telling us	Performance has increased in January 2022 and is above target

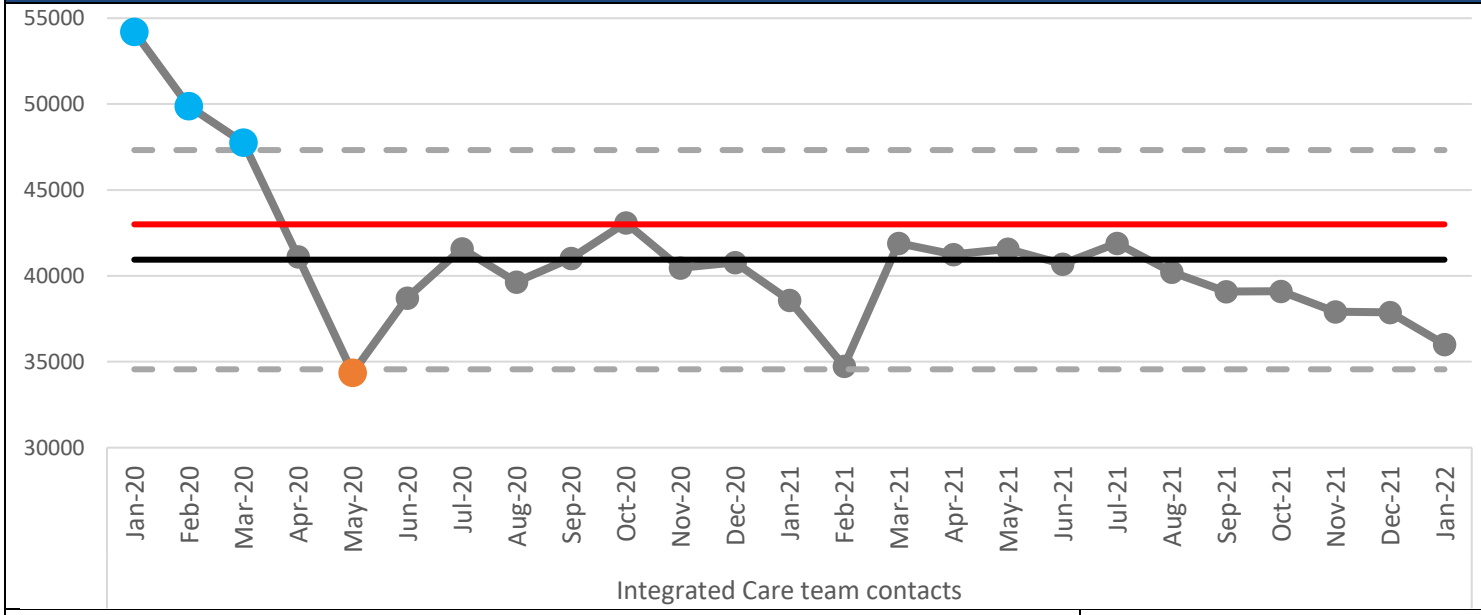
Lead: Chris Morley, Chief Nurse

Timescale: Ongoing

Board Committee Providing Oversight: Healthcare Governance Committee

Summary of current issues	Actions to recover performance
The complaints target was narrowly missed in December (89.7%). This was in part due to high number of cases that had been received in previous months. There were 13 complaints open and overdue at the end of October and 9 at the end of November, which when closed had an impact on the response time.	The trust achieved a response time of 97% in January 2022 and had only four open and overdue complaints at the end of January 2022, the lowest since March 2020. Weekly meetings remain in place with Patient Experience Managers to review any cases that are overdue or approaching timescale to ensure concerns are escalated.

COMMUNITY CARE
(Integrated Care Team (ICT) contacts)



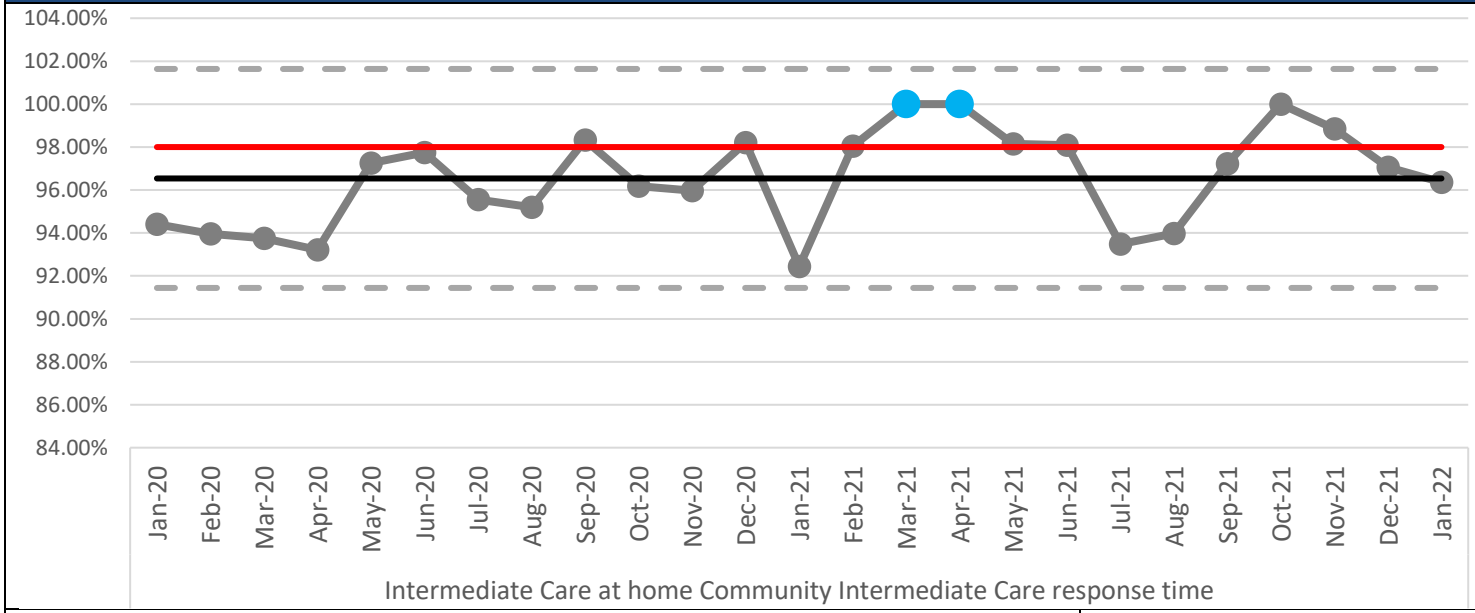
Target	43,000
Jan-22	36,014
Variance Type	Indicator is showing no significant change (common cause variation)
Assurance Type	Indicator is showing random variation
What the chart is telling us	The number of ICT contacts dipped below target in April-20, and has remained below target for all months other than Oct 2020.

Lead: Michael Harper, Chief Operating Officer

Timescale: Ongoing

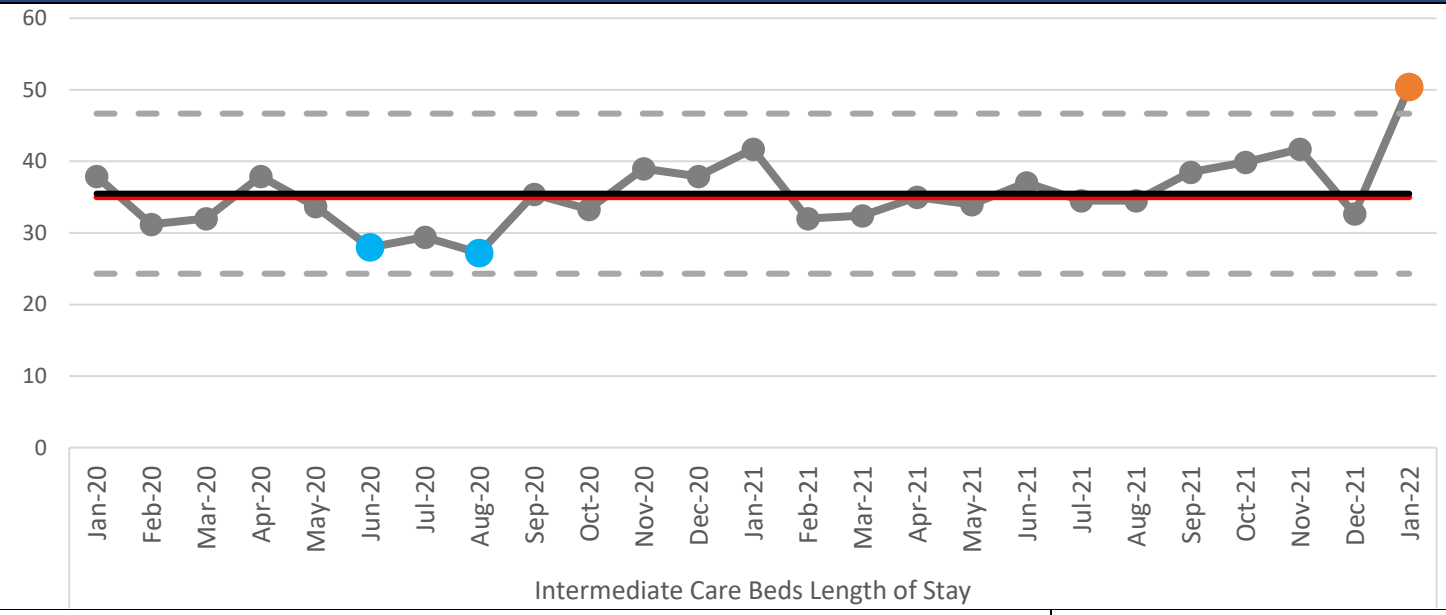
Board Committee Providing Oversight: Finance and Performance Committee

Summary of current issues	Actions to recover performance
Through deep dive work as part of planning for 22/23, it has become apparent that the target set was based on unreliable data and there are data quality issues around activity reporting in ICT Nursing. Activity in January was slightly lower than YTD average in all 3 services (Community Nursing, ENS and ICTT) as a result of Covid-related absence.	Work ongoing to rectify data quality reporting issue in ICT Nursing and additional resources being considered where funding available.

COMMUNITY CARE (Response times)		
	Target	98%
	Jan-22	97%
	Variance Type	Indicator is showing no significant change (common cause variation)
	Assurance Type	Indicator is showing random variation
	What the chart is telling us	Performance has been falling since October 2021
Lead: Michael Harper, Chief Operating Officer	**Timescale**: Ongoing	
Board Committee Providing Oversight: Finance and Performance Committee		

Summary of current issues	Actions to recover performance
Target not met in January. LoS averaging 13 days currently (vs expected 5-7 days)	1) Additional funding secured through Ageing Well for UCR admissions avoidance pathway for 22/23. Commissioner case prepared relating to discharge capacity requirements

COMMUNITY CARE
(Intermediate Care Bed Average Length of Stay)



Target	35 days
Jan-22	50.0 days
Variance Type	Metric is indicating a special cause of concern due to its high values
Assurance Type	Indicator is showing random variation
What the chart is telling us	Average LOS for Intermediate beds has increased since September 2021. It was on target for December 2021 but target was not achieved in January 2022

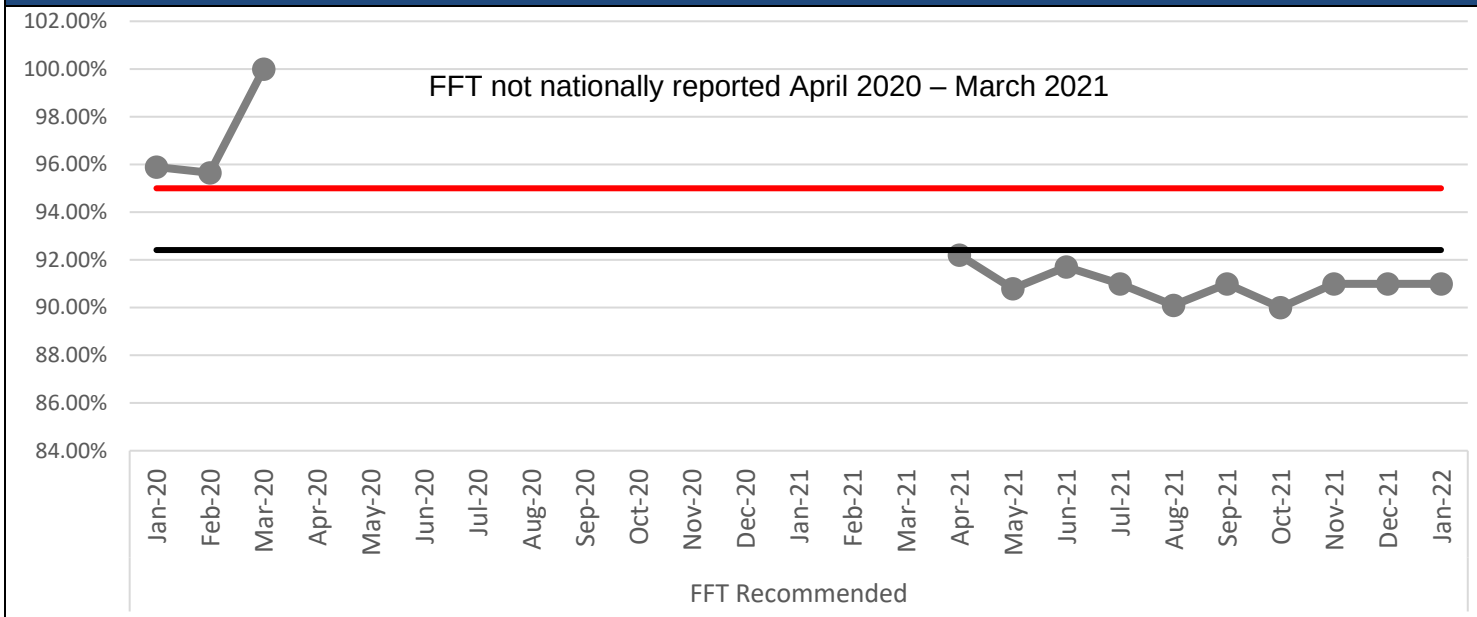
Lead: Michael Harper, Chief Operating Officer

Timescale: Ongoing

Board Committee Providing Oversight: Finance and Performance Committee

Summary of current issues	Actions to recover performance
Waits for Independent Sector care packages are causing delays. Escalated to Discharge Hub. Delays also noted for S2A placements and housing, and acuity of patients also increased. Review of delays via Discharge Hub huddle daily. Waits for Independent Sector care packages increased across all discharge points.	1. Continue to escalate named patient delays to discharge hub and via Escalation meetings 2. Ensure impact of delays is included in citywide discharge plan seeking to increase capacity within independent sector

FRIENDS & FAMILY TEST (Inpatients)



Target	95%
Jan-22	91%
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 met since reporting re-commenced in April 2021

Lead: Chris Morley, Chief Nurse

Timescale: Ongoing

Board Committee Providing Oversight: Healthcare Governance Committee

Summary of current issues

The Inpatient score for December and January was 91%, 4% below the Trust target.

Positive scores have remained below target since FFT was restarted 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
- Change to the timing of the question meaning experience of discharge now included

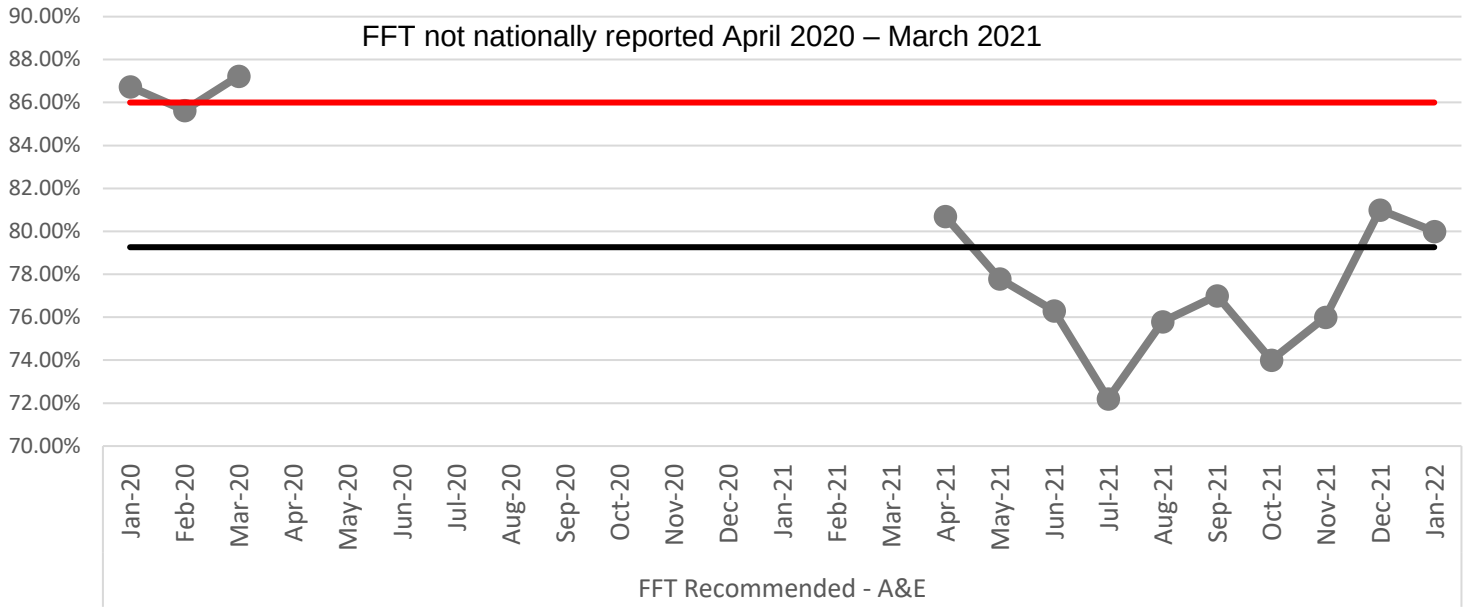
Actions to recover performance

Feedback cards have been reintroduced on 7 wards where a response rate using electronic methods was low. Using cards has increased the positive score for these areas however there is variation in the number of responses received. The Patient Experience Team are working with these areas to support them to increase the response rate achieved by using feedback cards. The Trust wide reintroduction of feedback cards as an option alongside electronic feedback cards will commence in March.

In order to identify opportunities for improvement a local survey was sent to patients in September. The wards selected for the survey were those with a good response rate (above 20%), and a low positive score (below 90%). Analysis of the patient comments suggests that the majority of patients received high quality care and had a positive experience, with comments frequently mentioning the caring attitude of staff, how hard the ward teams work and the efficiency of the service.

The results were discussed at PEC in December 2021. It was agreed that wards areas would review their individual results and develop an action plan to make improvements based on the feedback.

FRIENDS & FAMILY TEST (A&E)



Target	86%
Jan-22	80%
Variance Type	Not Applicable. Insufficient data points for SPC
Assurance Type	Not Applicable. Insufficient data points for SPC
What the chart is telling us	The FTT Target for A&E has not been met since reporting re-commenced in April 2021

Lead: Chris Morley, Chief Nurse

Timescale: Ongoing

Board Committee Providing Oversight: Healthcare Governance Committee

Summary of current issues

The target of an 86% positive score has not been achieved since January 2021.

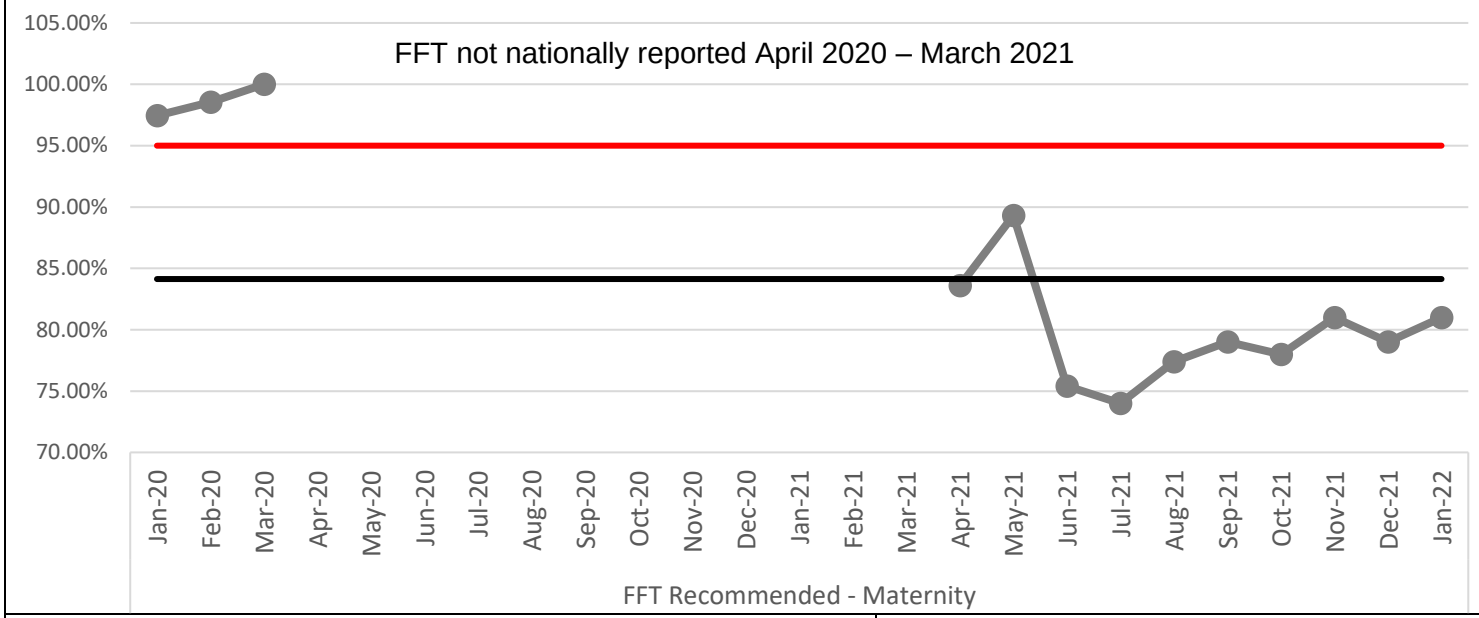
A&E at NGH continues to be the area which has the biggest impact on the lower positive score. Eye Casualty and Minor Injuries consistently score above the Trust target of 90%.

Actions to recover performance

The average score over 6 months for STH is 76%. A recent review of national FFT scores showed the 6 month average is 77%, 1% above STH average and 9% below the Trusts target, suggesting that performance at STH is in line with other organisations.

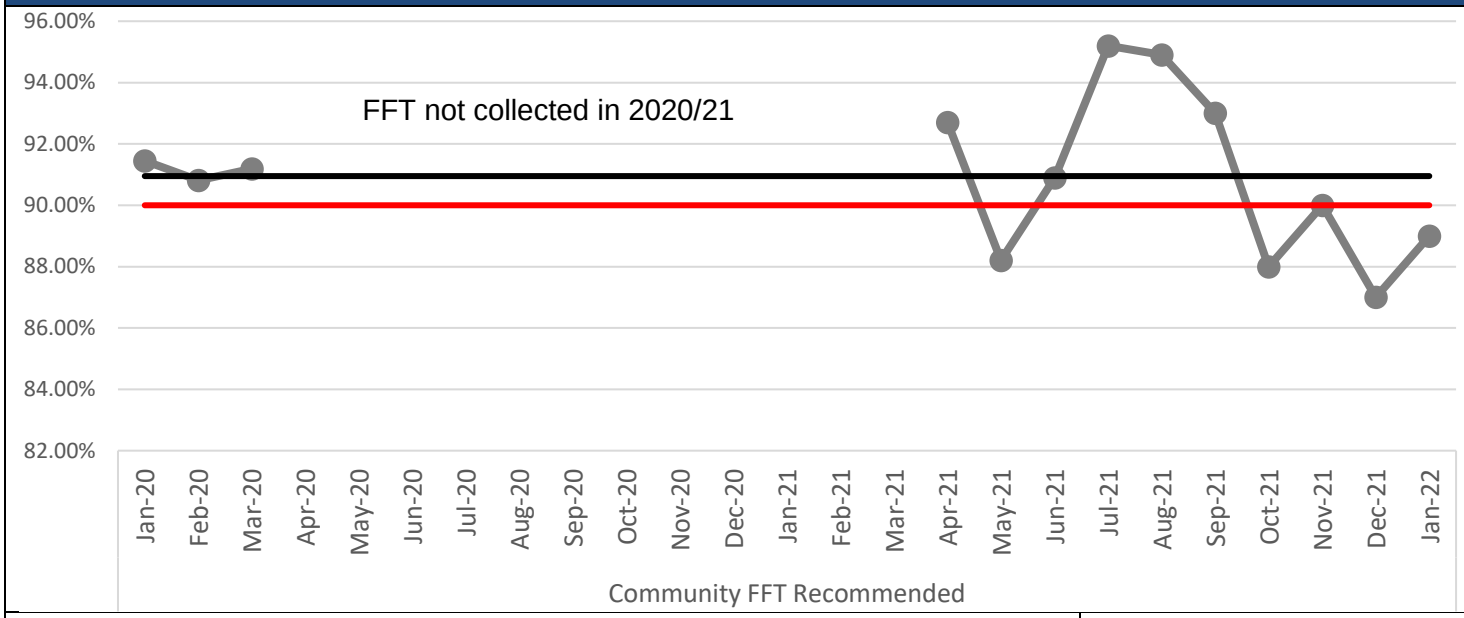
Analysis of comments shows that the highest number of negative comments relate to waiting time, which reflects the significant pressures the department has been experiencing. A review of waiting time performance and FFT positive score across all Shelford Trust show that there is a close correlation and therefore actions relating to patient flow will have a positive effect of FFT scores.

In addition, it is expected that as the actions are implemented in response to the 2020 national urgent and emergency care survey results, these will have an impact on the patient experience.

FRIENDS & FAMILY TEST (Maternity)		
	**Target**	95%
	Jan-22	81%
	Variance Type	Not Applicable. Insufficient data points for SPC
	Assurance Type	Not Applicable. Insufficient data points for SPC
	What the chart is telling us	The FTT Target for Maternity services has not consistently been met
Lead: Chris Morley, Chief Nurse	**Timescale**: Ongoing	
Board Committee Providing Oversight: Healthcare Governance Committee		

Summary of current issues	Actions to recover performance
Since restarting FFT in November 2020, the target of a 95% positive score has not been achieved. 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 question • Change to the timing of the question meaning experience of discharge now included	The maternity team are in the process of reviewing the Trust's 2021 national maternity survey results and an action plan is currently being developed. This will be presented at PEC in March 2022. Themes in the action plan include Information, Patient Centred Care and Mental Health Support. The Patient Experience Team has conducted a deep dive into FFT scores and comments which will be shared at PEC and with the Maternity Team. Additionally, the next project to run through the STH Engagement Network will be Maternity Services. This will aim to provide a more thorough insight into the patient experience and identify opportunities for improvement. During a recent review of Shelford group Maternity scores, it was found that response numbers are low for maternity services across Shelford and data is not available for all Trusts. For antenatal, none of the trusts scored the STH target of 95%. In terms of national data, the 6 month national average is 92%, 3% below the Trust's target.

FRIENDS AND FAMILY TEST (Community)



Target	90%
Jan-22	89%
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 Community target was not met in December 2021 and January 2022.

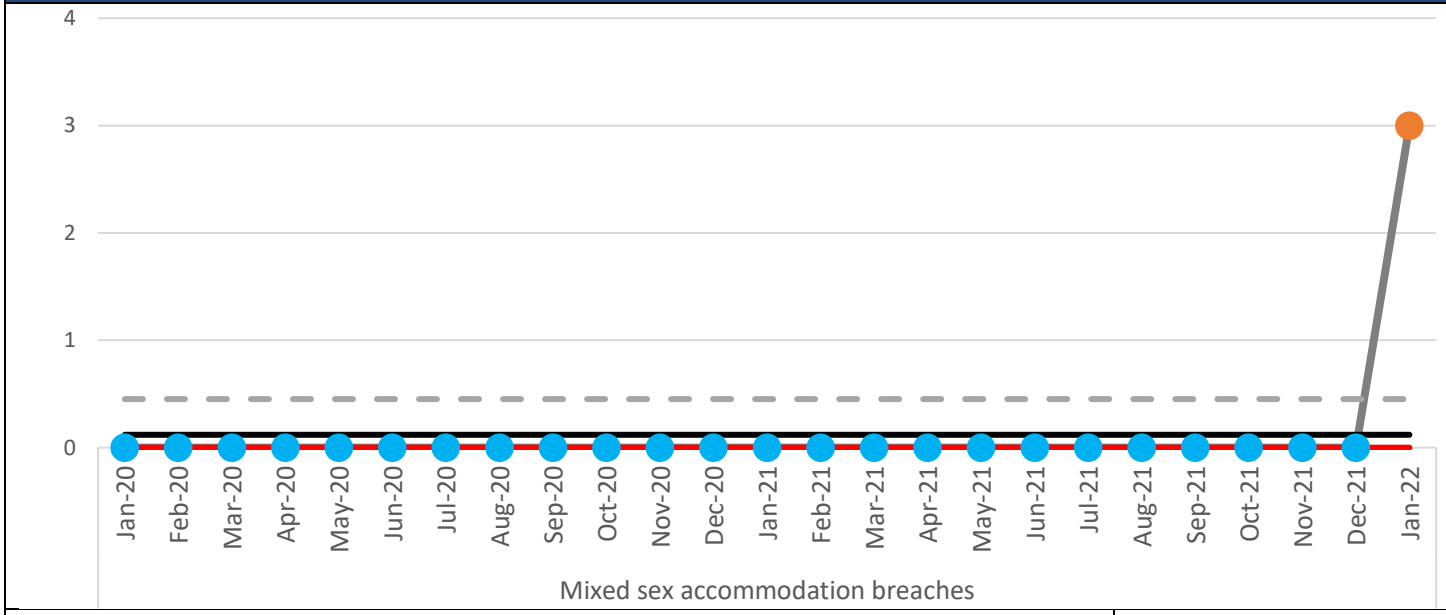
Lead: Chris Morley, Chief Nurse

Timescale: Ongoing

Board Committee Providing Oversight: Healthcare Governance Committee

Summary of current issues	Actions to recover performance
Community Services did not achieve the 90% positive score target in December or January. The score was 87% in December, increasing to 89% in January; however, this remains 1% below the target.	The score has been adversely impacted by the result for the GP collaborative which was 71% for December and 78% for January. If GP Collaborative was removed from Community, the overall Community Score would have been 92% for both December and January, 2% above the target. A review of the free-text comments for GP Collaborative showed that the vast majority of negative comments mentioned the waiting times.

MIXED SEX ACCOMODATION
(Number of breaches of Mixed Sex Accommodation standard)



Target	0
Jan-22	3
Variance Type	Metric is indicating a special cause of concern due to its high values
Assurance Type	Indicator is showing random variation
What the chart is telling us	There were 3 MSA breaches in January 2022

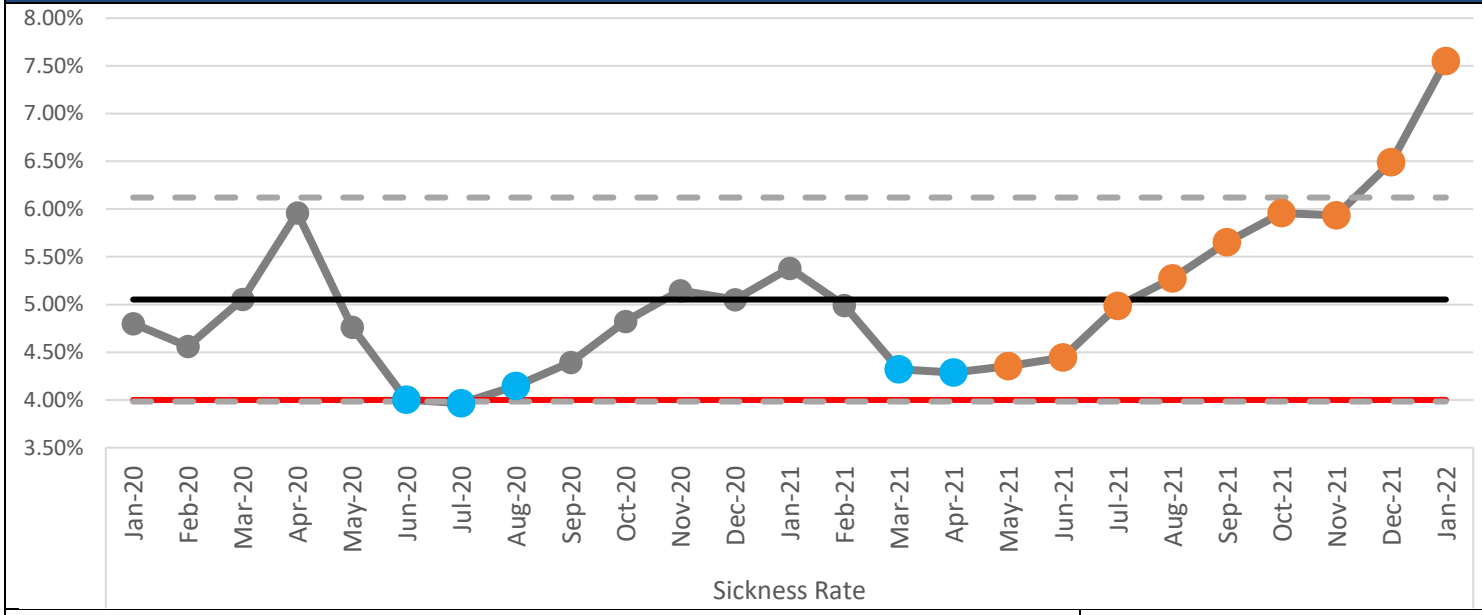
Lead: Chris Morley, Chief Nurse

Timescale: Ongoing

Board Committee Providing Oversight: Healthcare Governance Committee

Summary of current issues	Actions to recover performance
During January 2022, extreme operational pressures in relation to the Omicron Covid19 variant, resulted in closed capacity and reduction in patient flow	Due to a period of exceptional operational demand combined with beds requiring closure due to COVID19 a decision was made after careful clinical consideration to place 3 surgical patients in the NGH Post Anaesthetic Care Unit (PACU) overnight. Due to further clinical implications changes were made to the patients identified for transfer, resulting in 2 women and 1 man being placed in PACU overnight. There were no other surgical patients being nursed in PACU at the time and the PACU staff kept curtains around the patients at all times. Following a review by the Deputy Chief Operating Officer with the Clinical Operations team involved at the time, the operational pressures were such that unfortunately on this occasion the inability to provide same sex accommodation was not a consideration and therefore the usual process of escalation and resolution was not followed. The following morning the 3 patients were able to be moved to suitable accommodation or discharged home. This is the first time a breach of same sex accommodation has occurred since January 2019.

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



Target	4.0%	
Jan-22	7.6%	
Variance Type	H	Metric is indicating a special cause of concern due to its high values
Assurance Type	?	Indicator is showing random variation
What the chart is telling us	From August-20 sickness absence has not met the target.	

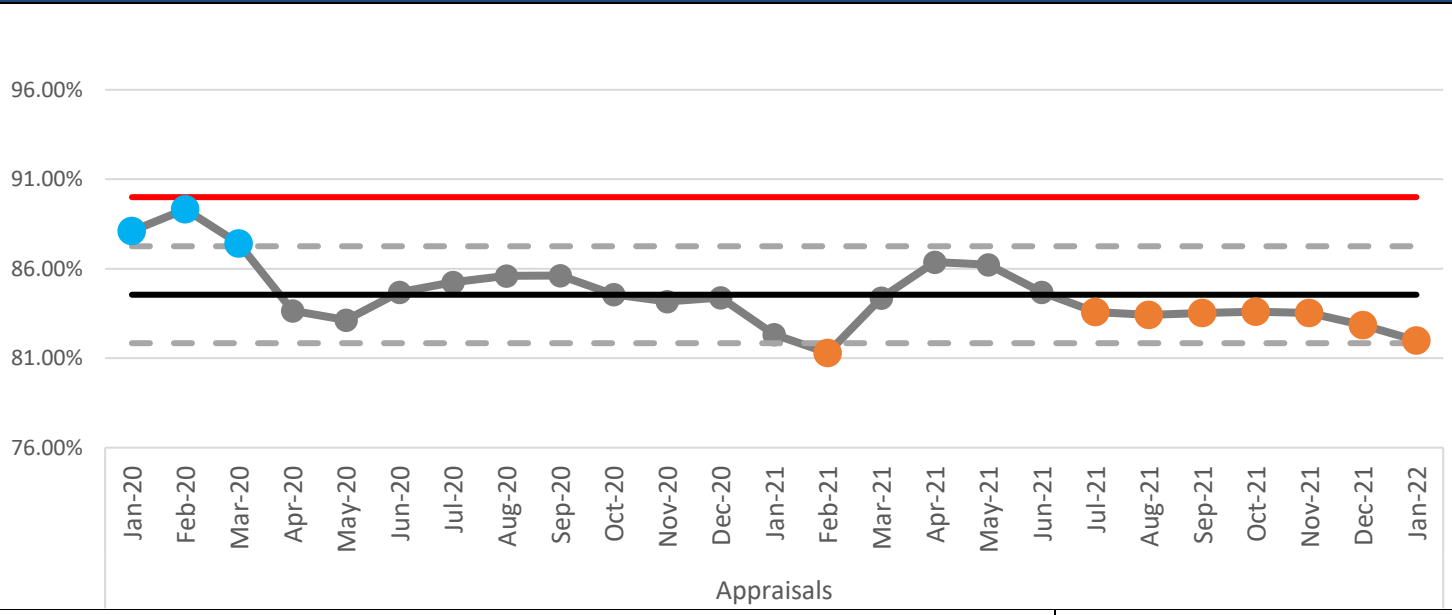
Lead: Mark Gwilliam, Director of Human Resources

Timescale: Ongoing

Board Committee Providing Oversight: HR and OD Committee

Summary of current issues	Actions to recover performance
The monthly non-COVID sickness absence figure is 7.6%.	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. We are also focusing support to those areas with higher levels of non-COVID related absence. The Trust has a process to monitor self-isolations and support a swift return to work when staff either receive a negative test result or the isolation period comes to an end. Based on previous years we can see that sickness absence levels are higher than is usual for the time of year and recognise that is likely linked to the impact of the COVID pandemic. Additional support has been built into our Health and Wellbeing plan over the last 18 months and we continue to work on building this offer to support our colleagues to maintain their well-being. We are monitoring sickness absence levels closely on a weekly basis.

APPRAISALS
(Completed appraisals in last year)



Target	90%
Jan-22	82%
Variance Type	Metric is indicating a special cause of concern due to its low values
Assurance Type	Metric is consistently falling short of the target
What the chart is telling us	Appraisal rates have been consistently below target

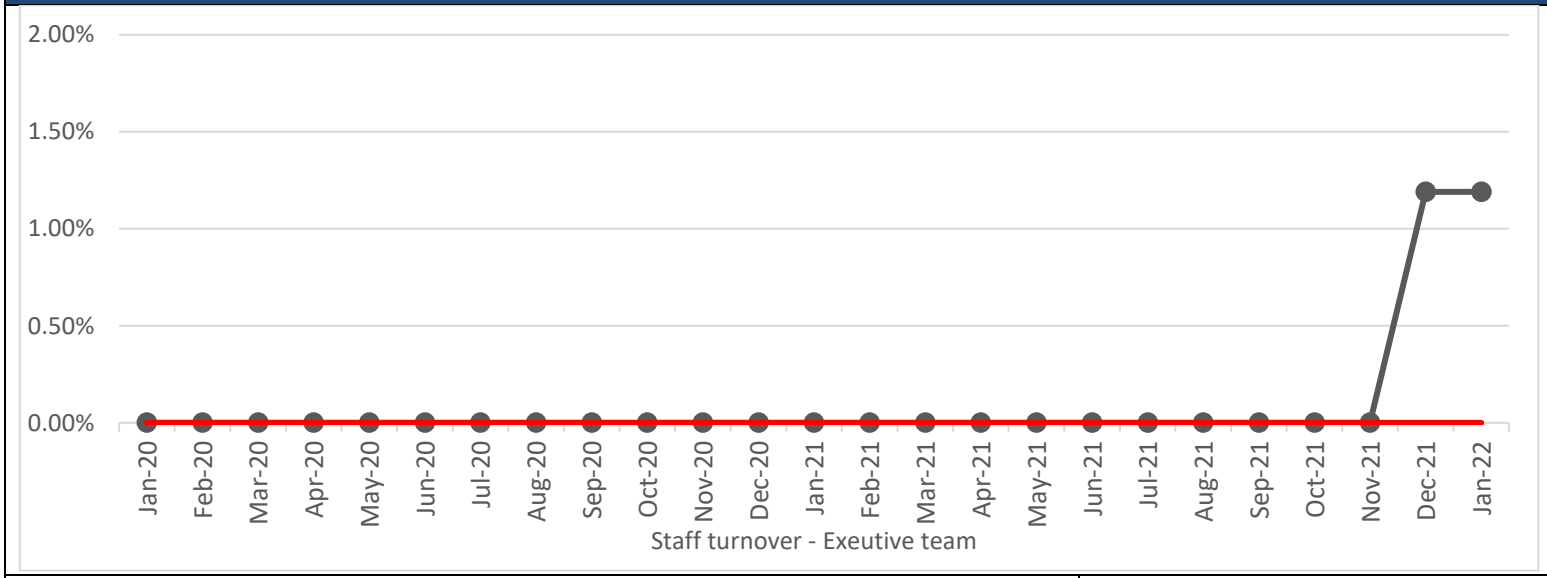
Lead: Mark Gwilliam, Director of Human Resources

Timescale: Ongoing

Board Committee Providing Oversight: HR and OD Committee

Summary of current issues	Actions to recover performance
The cumulative position for completed appraisals during the past twelve months at the end of January 2022 is 82%.	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.

STAFF TURNOVER
(Number of leavers as a proportion of TEG members)



Target	0%
Rolling 12 months to Jan-22	1.2%
Variance Type	Rolling 12 months not suitable for SPC
Assurance Type	Rolling 12 months not suitable for SPC
What the chart is telling us	One of the seven members of TEG retired in January 2022. This is the first leaver in over 2 years.

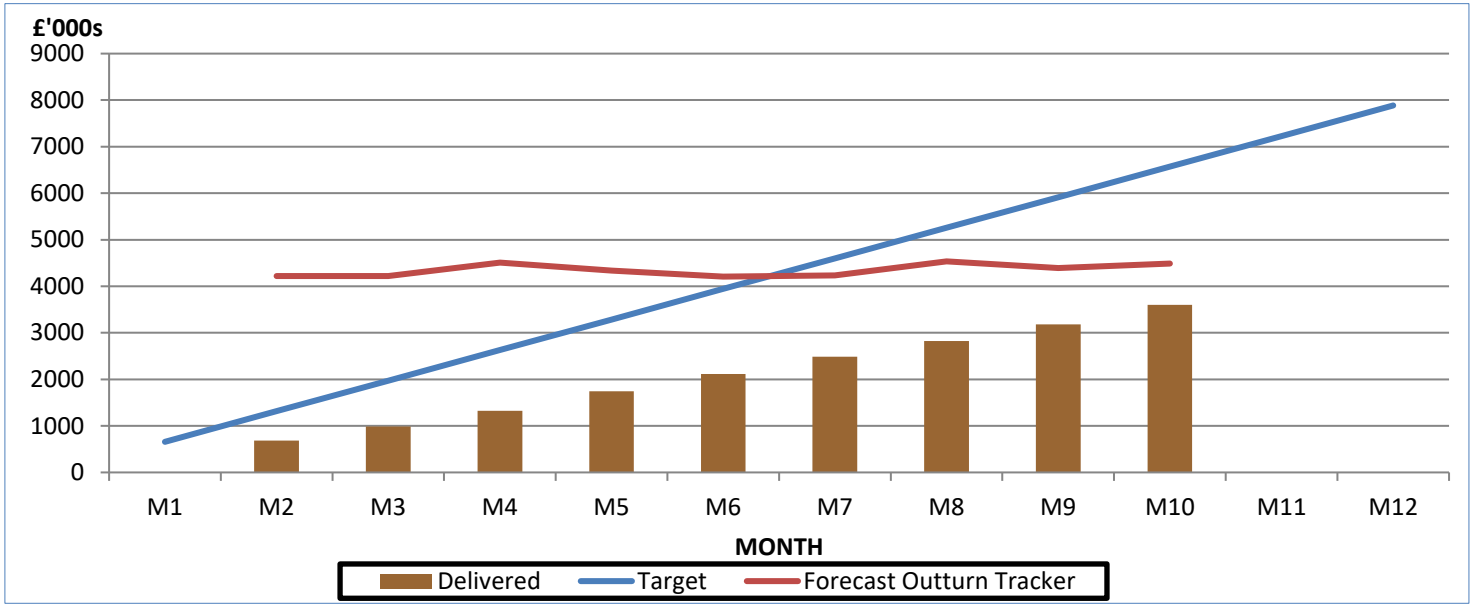
Lead: Mark Gwilliam, Director of Human Resources

Timescale: January 2022

Board Committee Providing Oversight: HR and OD Committee

Summary of current issues	Actions to recover performance
The target of 0% turnover for the Executive team has not been met as a result of one colleague who left the Trust in December. The turnover rate will increase again in February following a retirement from the team.	No action required.

Efficiency



Target	£6,572K
Year to Jan	£3,600K
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 2021/22 is unlikely to be met.

Lead: Neil Priestley, Chief Financial Officer

Timescale: January 2022

Board Committee Providing Oversight: Finance & Performance Committee

Summary of current issues

For 2021/22 an efficiency target of 1% (£7,886k) has been set for Directorates. Total delivery in M1-10 is £3,600k against a target of £6,572k (£2,971k and therefore 45% behind target). Most of this shortfall is due to insufficient P&E being identified in Cut 3 plans – Cut 3 plans are £2,786k lower than the 1% target at the end of Month 10.

Directorates are also being monitored against a 1.5% target across 20/21 (0.5%) and 21/22 (1%). Total delivery to date is £7,825k against a target of £10,515k (£2,689k and therefore 26% behind target).

Actions to recover performance

CEO PMO meetings have been restarted from October to improve oversight and delivery of P&E. These sessions so far have focussed on the 'Making it Better' programmes discussing both potential opportunities for P&E in 22/23 and the impact workstreams have had on efficiency delivery in the current year.

Cut 2 22/23 Efficiency plans for Directorates have been submitted at the end of January in addition to opportunities identified by the Making It Better Workstreams. Confirm & Challenge sessions are being held with Care Groups throughout February 2022 with the focus on ensuring plans are deliverable and robust in time for Cut 3 submission in March 2022. Focussed support has been offered to assist Directorates with identifying potential P&E schemes for 22/23 where requested through the Business Planning Reviews.

DEEP DIVE: A&E

This deep dive describes the impact of COVID-19 on A&E performance.

Tuesday 22nd February 2022 marked the two-year anniversary of Sheffield's first Covid-19 hospital admission. STH's Accident and Emergency (A&E) Department has been at the forefront of the organisation's pandemic response. This Deep Dive will explore the impact of the pandemic upon A&E and detail how the A&E Department has responded to maximise the provision of safe, high quality and timely patient care.

The measures required to manage the pandemic, along with increased demand and other factors have regrettably had an inevitable impact on performance in a number of areas for both the A&E department and partners such as the Ambulance Service.

<u>During the pandemic</u>

To mitigate the risks of COVID-19 and manage increased demand, the following actions were taken to help support social distancing and to enable cohorting as well as changing patient pathways as the pandemic entered different waves:

- Expansion into the adjacent Fracture Clinic, shared with the Musculoskeletal Care Group to create additional space.
- Location of the A&E Covid-19 patient pathway within the Inpatient Ultrasound unit which was vacated by the Radiology Department.
- Ongoing comprehensive internal flow reconfigurations in the A&E department to respond to changing patient demand.

In addition to the physical space expansion and reconfiguration a number of innovative practices were introduced:

- Implementation of Single Assessment for all admitted medical patients, reducing the time to patient review by a senior clinician.
- Transfer to a full Electronic Patient Record (EPR), virtually removing the use of paper in A&E.
- Virtual teaching for all clinicians was maintained and enhanced. 100% of all junior doctors who rotated through the A&E recommended the placement.
- Point of Care Testing ('POCT') to determine Coivd-19 status for all patients in A&E and AMU awaiting admission to ensure appropriate patient placement and reduced likelihood of infection transfer between patients.
- Development of a consultant-led A&E SharePoint resource for all local guidelines, standard operating procedures, and escalation protocols to be easily accessed quickly.
- Medical and Advanced Practitioner self-rostering and annualised hours now provides a profiled workforce response to periods of high patient demand while supporting a work/life balance.
- Joint development and introduction with the Musculoskeletal Care Group of a virtual Fracture Clinic.
- Collaborative work with several groups representing Sheffield's ethnic minority populations to ensure patient needs were met. This work will be built on further post pandemic.
- Significant focus upon staff wellbeing with the introduction of a Nursing Hub, easy access to psychological support and the creation of a Wellbeing Room.

<u>Further actions being undertaken to continue to improve performance</u>

As the 4th Covid-19 wave wanes, the A&E Department continues to look to improve the timeliness of patient care. In the short term, priority actions include:

- The A&E Department forms part of the larger Acute and Emergency Medicine Care Group (AEM). This is enabling a programme of work focussed on both system and process optimisation to improve patient flow and waiting times. The work is supported by fortnightly delivery meetings with the Trust's Medical Director (Operations), Deputy Chief Nurse, Deputy Chief Operating Officer and Performance and Information Director.

- Working with the Clinical Operations Team to deliver more timely flow for admitted patients out of A&E into an Inpatient Assessment Area. This work is complex because it continues to be impacted by reduced capacity associated with more complex pathways for admitted patients and increased delayed transfers of care.

- The re-location of the Same Day Emergency Care Unit (SDEC) to the Fracture Clinic estate adjacent to A&E in late January 2022 provides some increased capacity and easier access for ambulance crews to transport patients to an alternative location other than A&E. Moreover, SDEC reduces the demand upon Inpatient Assessment Area beds and therefore improves out-flow from A&E, creating space for more timely ambulance handover. Further estates expansion and extended opening hours are planned.

- Delivery of an Ambulance Handover Improvement plan which includes:

    - An embedded mew escalation process
    - a focus on system and organisational flow to deliver improved out-flow from A&E into wards or assessment units.
    - the re-location of SDEC.
    - the introduction of ambulance cohorting in space adjacent to A&E (which allows the earlier release of ambulance crews to provide more-timely 999 responses).
    - increased opportunity for ambulance crews to transport patients directly to inpatient specialties located at the RHH without accessing A&E.

- Through the Excellent Emergency Care programme, implementation of the Ward Collaborative programme to ensure ward processes are focussed on Why Not Home, Why Not Today to increase the proportion of patient discharges from wards before 5pm each day.

- Maximising potential benefits from the '111 First', '111 Booking' and 'Streaming and Redirection' initiatives with a view to reducing attendances at A&E and redirecting patients to the most appropriate provider of urgent care across Sheffield.

- Collaboration with commissioners and providers of mental health services space to deliver a reduction in the volume and intensity of mental health presentations to A&E.
- Work with Community partners to un-block inpatient discharge delays.

In the medium term, the focus is upon:

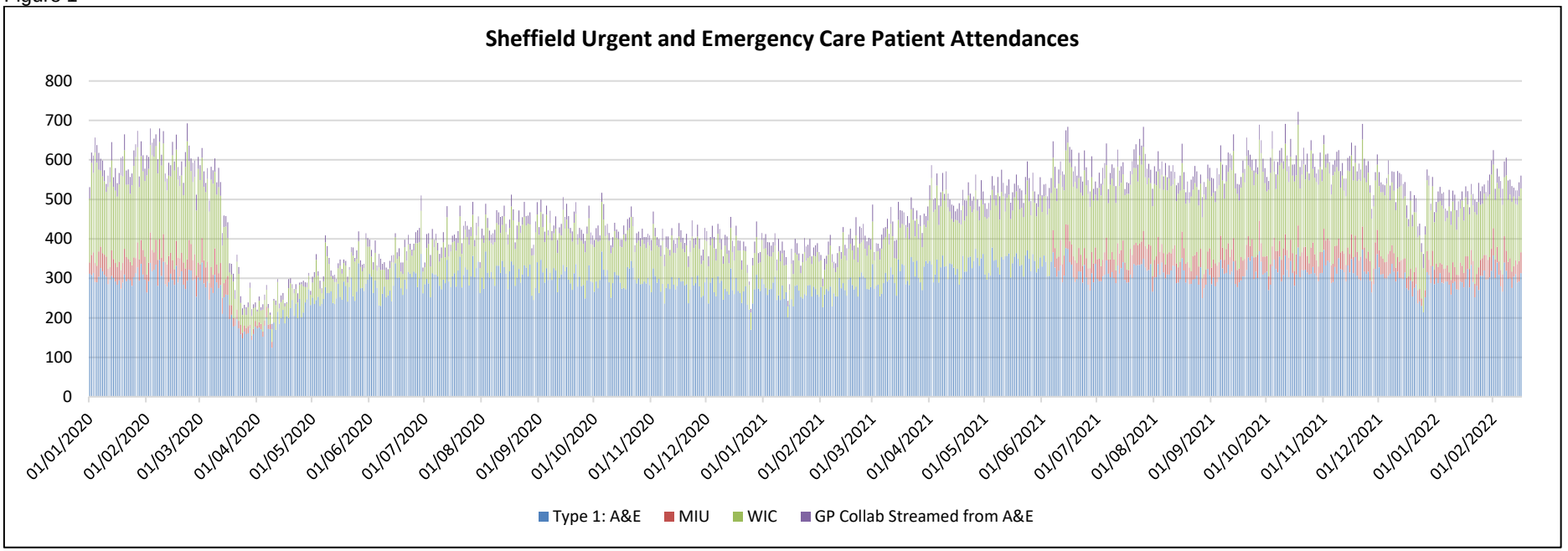
- The appointment of additional Consultants from August 2022 to work in A&E to provide additional weekday and weekend capacity building on the additional investment made in Junior doctors in August 2021.
- An improved 'Acute Take Model' to get maximum benefit from the implementation of Single Assessment in A&E which will deliver earlier Senior Review of all admitted medical patients and improved clinical outcomes plus reduced lengths of stay.
- Expansion of the A&E footprint to meet increasing patient volume and continued zero tolerance of corridor care.

The data below demonstrates the impact of the pandemic, challenges affecting performance and opportunities for improvement.

<u>Patient Attendances</u>

The impact of the pandemic in late March 2020 can be clearly seen in Figure 1, with less urgent attendances across all Sheffield's urgent and emergency care providers. As a result, the RHH Minor Injuries Unit was closed until June 2021 in order that the clinical staff could support the NGH A&E. The end of Sheffield's 3rd pandemic wave in April 2021 saw total attendances begin to grow, initially surpassing previous levels before stabilising just below pre-pandemic levels. NGH A&E volumes are now back to the levels seen before March 2020.

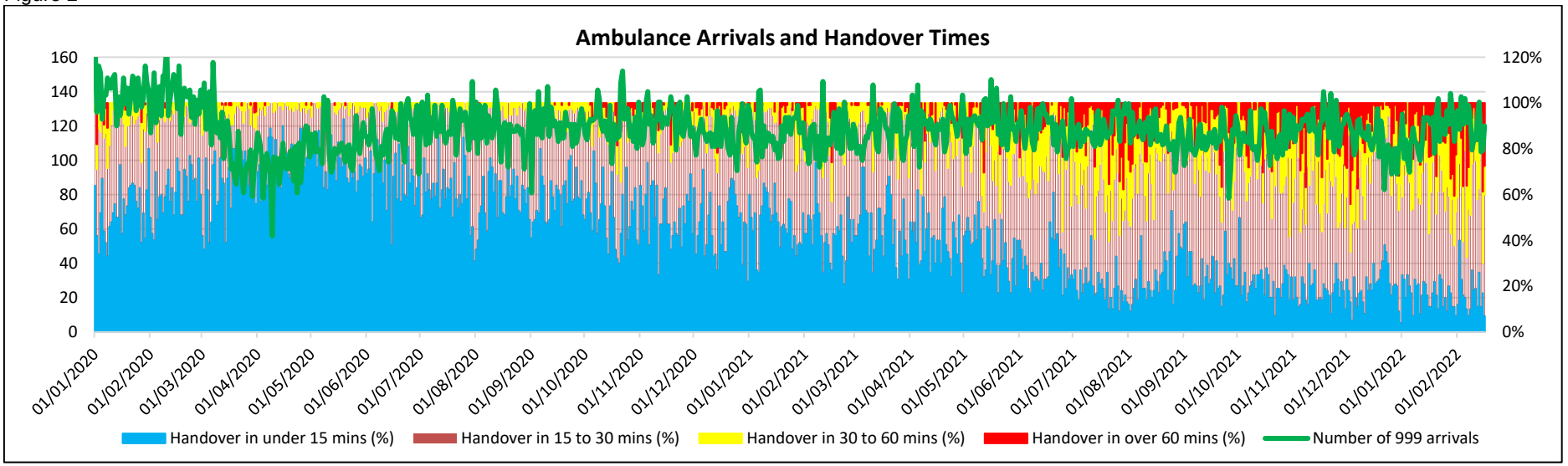
Figure 1



Ambulance Arrivals and Handover Performance

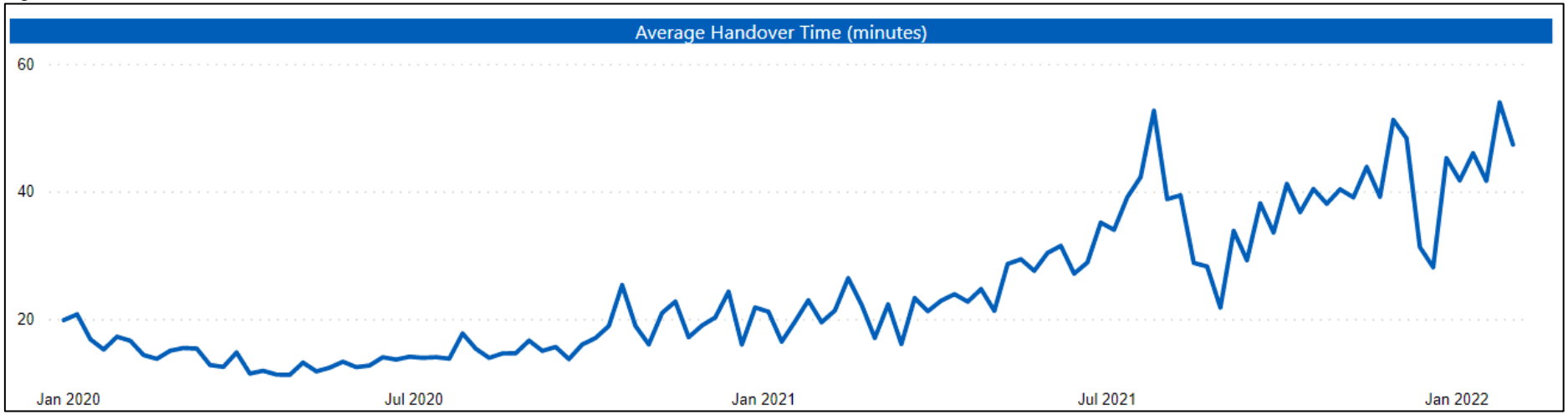
The changing number of ambulance arrivals (Figure 2 – green line) follows a similar pattern to that seen in Figure 1, with numbers initially reducing in March 2020 from a nationally benchmarked high-volume position prior to a steady increase as the first pandemic wave came to an end. Ambulance volumes however are still yet to return to pre-pandemic levels, but the impact on handover delays can be seen in the background data

Figure 2



The national standard for ambulance handover of patients is within 15 minutes of an ambulance arriving. Figures 2 (above) and 3 (below) show handover timeliness has deteriorated.

Figure 3

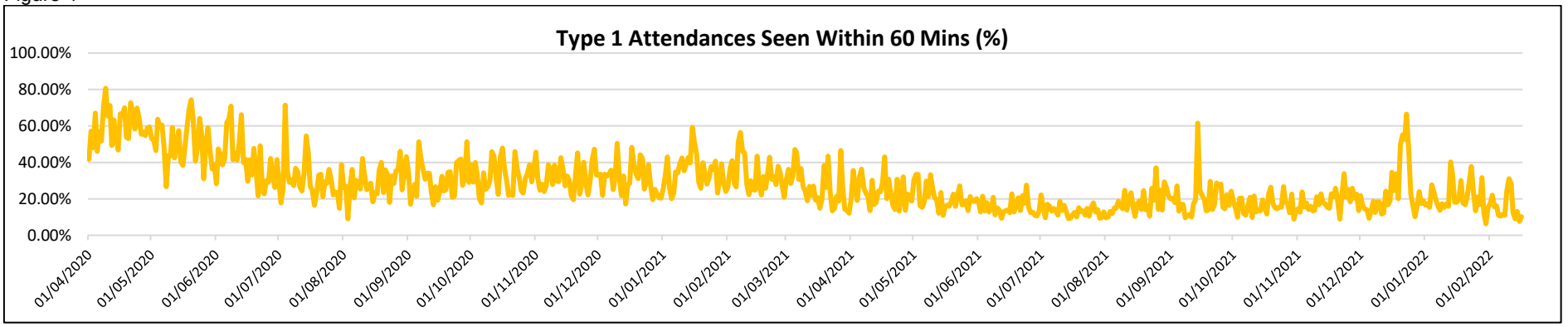


Reduced timeliness of Ambulance handovers have been predominantly associated with a lack of cubicle capacity within the A&E linked to extended stays in the department for patients requiring admission to an inpatient Assessment Area.

Time to See a Doctor

Once in A&E, patients are assessed either during ambulance handover (above) or via a nurse triage process. Patients then wait to see an A&E Doctor, ideally within 60 minutes of arriving. Performance has deteriorated through the pandemic but investment in additional Junior Doctors in August 2021 has meant a stabilisation in performance and some recent improvement. (figure 4)

Figure 4



Patient Admissions from A&E

The number of patients who attend A&E and are subsequently admitted to an inpatient bed has remained consistent during the last 2 years. However, a number of factors have resulted in a deterioration in the timeliness of bed availability and an increase in patients waiting over 4 hours to be admitted to an inpatient bed. (figure 5) These factors include:

- More complex patient pathways necessary for the separation of patients with and without covid-19 within and beyond A&E
- A significant increase in the number on inpatients who cannot be discharged due to lack of capacity or staffing in social and community-based care (figure 6)
- The ongoing infection issues (predominantly Covid) results in temporary closed beds.
- Rising mental health presentations where patients need transfer to or care in a specialist facility.

The work detailed in the introduction to this report is attempting to address all of these factors.

Figure 5

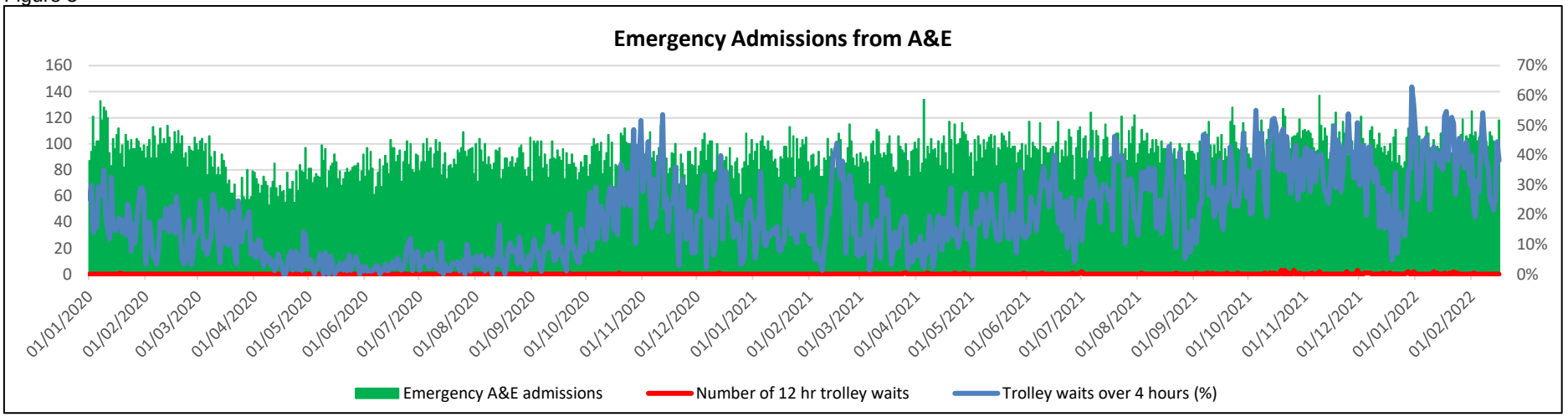
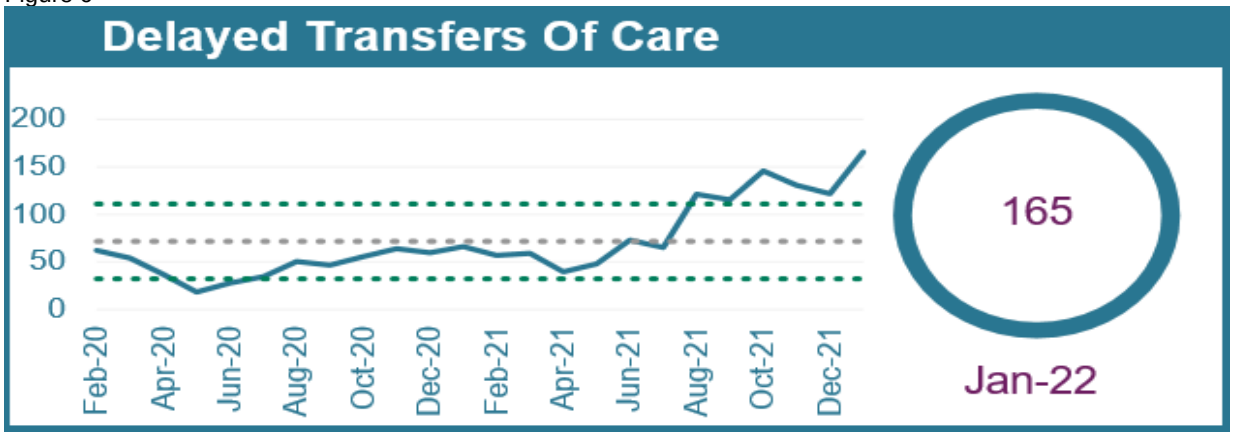


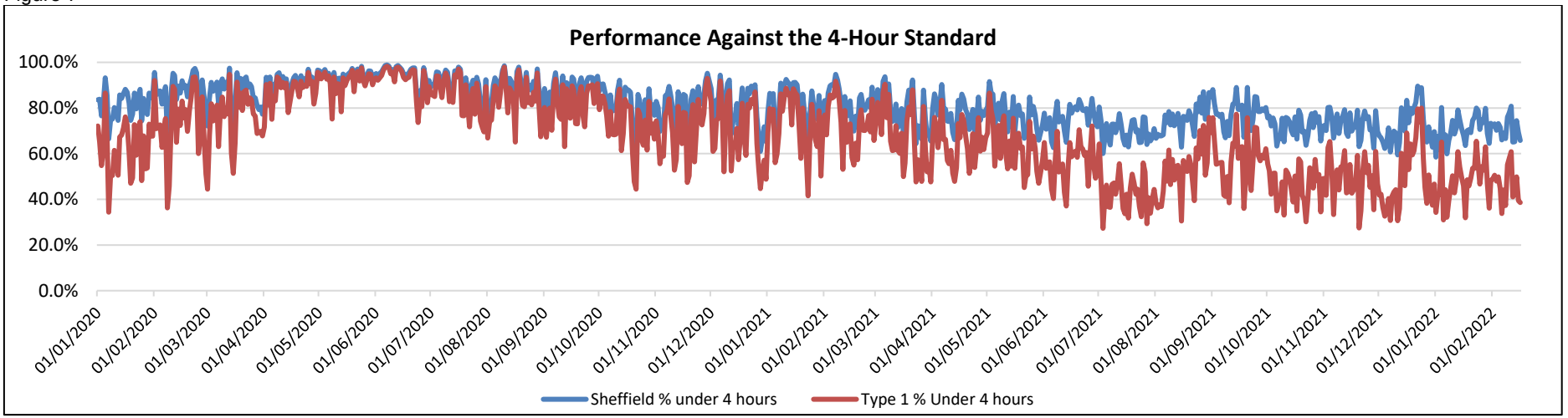
Figure 6



Performance Against the 4-Hour Standard

As a result, increasing attendances in tandem with the impact of extended ambulance handover delays, the wait to see a Doctor, time for an inpatient bed to become available and significant staff sickness due to COVID has impacted upon achieving the 4 hour standard and longer waits for some patients. (figure 7)

Figure 7



Conclusion

The A & E department has been a key service in supporting the response to Covid over the last two years. Significant service, pathway and estate change was done at pace, to respond to the demands. Patient activity levels fluctuated but have returned to pre-covid levels. However, issues with ongoing pathway complexity, staff absence and delayed discharges continues to impact on four hour and ambulance handover performance. Organisation-wide, and city wide, programmes of work are underway to recover performance, and improve patient experience.

PERFORMANCE MANAGEMENT FRAMEWORK & DIRECTORATE DASHBOARDS

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

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

PMF Level 1 Directorates (Standard)

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

PMF Level 2 Directorates (Watching Brief)

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

PMF Level 3 Directorates (Highest Priority)

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

Indicator	Metric	DI & EN	EmCr	GAST	PHAR	RESP	ICC	IG & SM	TH & PC	OR & DE	ENT	NEUR	OPHT
MRSA bacteraemia	Hospital onset												
MSSA bacteraemia	Hospital onset												
C.diff	Hospital onset												
Serious Incidents	Approved SI Report submitted within timescales												
	Number of serious incidents (SI)	2	5	2		1	1	1		2		3	3
Incidents ⊙	Number of finally approved incidents based on incident date	57	362	52	32	82	97	258	38	35	12	65	14
	Percentage of incidents approved within 35 days based on approval date												
Average Length of Stay (by discharges) ⌖	Average Length of Stay Elective												
	Average Length of Stay Non Elective												
Never Events	Number of never events												
18 weeks RTT ⊙	Percentage of admitted patients treated within 18 weeks (90%)												
	Percentage of non-admitted patients treated within 18 weeks (95%)												
	Percentage of patients on incomplete pathways waiting less than 18 weeks (92%)												
52 week waits	Actual numbers												
6 week diagnostic waiting ⊙	Percentage of patients seen within 6 weeks												
Cancelled Operations	Number of operations cancelled on the day for non clinical reasons												
	Number of patients cancelled on the day and not readmitted within 28 days												
Cancelled Outpatient appointments	Percentage of out-patient appointments cancelled by hospital												
	Percentage of out-patient appointments cancelled by patient												
DNA rate	Percentage of new out-patient appointments where patients DNA												
	Percentage of follow-up out-patient appointments where patients DNA												
Cancer Waits ⌖	Patient seen within 2 weeks of urgent referral												
	Breast symptomatic seen within 2 weeks												
	62 days from referral to treatment (GP referral)												
	31 day first treatment from referral												
e-Referral Service	Percentage of eligible GP referrals received through Electronic Referral Service												
Ethnic group data collection	Percentage of inpatient admissions with a valid ethnic group code												
Elective Inpatient activity	Variance from contract schedules												
Non elective inpatient activity	Variance from contract schedules												
New outpatient attendances	Variance from contract schedules												
Follow up op attendances	Variance from contract schedules												
Complaints	Percentage of complaints answered within 25 working days												
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 outpatient												
Mixed Sex Accommodation	Number of breaches of Mixed Sex Accommodation standard												
Sickness Absence	All days lost as a percentage of those available												
Appraisals ⌖	Completed appraisals in last year												
Mandatory Training ⌖	Overall percentage of completed mandatory training												
Agency Spend	Agency and bank spend as a percentage of total pay budget												
I & E	YTD actual I & E surplus/deficit in comparison to YTD plan I & E surplus/deficit												
Contract Performance	Variance from plan												
Efficiency	Variance from plan												

Performance is YTD unless specified:

⊙ Last complete month
⌖ Rolling 12 months
⌖ Last complete quarter

Indicator	Metric	LABM	MI & MP	OGN	Msk	OPA	CRCA	CARD	RENAL	VASC	CD & SM	SP & RH	SCS	GSUR	PLAS	UROL
MRSA bacteraemia	Hospital onset															
MSSA bacteraemia	Hospital onset															
C.diff	Hospital onset															
Serious Incidents	Approved SI Report submitted within timescales															
	Number of serious incidents (SI)			28	3	4		3	1	1	6			4	2	3
Incidents ⊙	Number of finally approved incidents based on incident date	27	48	91	107	39	40	88	75	30	82	24	72	100	29	21
	Percentage of incidents approved within 35 days based on approval date															
Average Length of Stay (by discharges) ⌖	Average Length of Stay Elective															
	Average Length of Stay Non Elective															
Never Events	Number of never events															
18 weeks RTT ⊙	Percentage of admitted patients treated within 18 weeks (90%)															
	Percentage of non-admitted patients treated within 18 weeks (95%)															
	Percentage of patients on incomplete pathways waiting less than 18 weeks (92%)															
52 week waits	Actual numbers															
6 week diagnostic waiting ⊙	Percentage of patients seen within 6 weeks															
Cancelled Operations	Number of operations cancelled on the day for non clinical reasons															
	Number of patients cancelled on the day and not readmitted within 28 days															
Cancelled Outpatient appointments	Percentage of out-patient appointments cancelled by hospital															
	Percentage of out-patient appointments cancelled by patient															
DNA rate	Percentage of new out-patient appointments where patients DNA															
	Percentage of follow-up out-patient appointments where patients DNA															
Cancer Waits ⌖	Patient seen within 2 weeks of urgent referral															
	Breast symptomatic seen within 2 weeks															
	62 days from referral to treatment (GP referral)															
	31 day first treatment from referral															
e-Referral Service	Percentage of eligible GP referrals received through Electronic Referral Service															
Ethnic group data collection	Percentage of inpatient admissions with a valid ethnic group code															
Elective Inpatient activity	Variance from contract schedules															
Non elective inpatient activity	Variance from contract schedules															
New outpatient attendances	Variance from contract schedules															
Follow up op attendances	Variance from contract schedules															
Complaints	Percentage of complaints answered within 25 working days															
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 outpatient															
Mixed Sex Accommodation	Number of breaches of Mixed Sex Accommodation standard															
Sickness Absence	All days lost as a percentage of those available															
Appraisals ⌖	Completed appraisals in last year															
Mandatory Training ⌖	Overall percentage of completed mandatory training															
Agency Spend	Agency and bank spend as a percentage of total pay budget															
I & E	YTD actual I & E surplus/deficit in comparison to YTD plan I & E surplus/deficit															
Contract Performance	Variance from plan															
Efficiency	Variance from plan															

Performance is YTD unless specified:

⊙ Last complete month
⌖ Rolling 12 months
⌖ Last complete quarter