Bundle Escalation Reports - Web Site 4 August 2022

1 Audit Committee
- 1 Escalation report from Committee to Board - Audit Committee 21 July 2022.docx

2 Finance and Performance Committee
- 2 Finance and Performance Committee escalation paper 26th July 2022.docx

3 Trust Management Committee
- 3 TMC Escalation Report for Board.docx

4 Clinical Governance Committee
- 4 Escalation report - from July 2022 CGC to Aug Board 2022.docx

5 People and Culture Committee
- 5 PC Committee 28 July 22 v2.docx

6 Integrated Performance Report
- 6a IPR Trust Board cover 040822.docx
- 6b IPR August 2022 DRAFT TB.pdf

Salisbury NHS Foundation Trust

Report to:	Trust Board (Public)	**Agenda item:**	2.1
Date of Meeting:	4th August 2022		

Report from: (Committee Name)	Audit Committee		**Committee Meeting Date:**	21st July 2022
Status:	**Information**	**Discussion**	**Assurance**	**Approval**
	X		X	
Prepared by:	Paul Kemp (Audit Committee Chair)			
Board Sponsor (presenting):	Paul Kemp			

Recommendation
The Trust Board is asked to note the matters below.

Key Items for Escalation

Internal Audit Report Follow Up – Five Steps to Safer Surgery

In December 2021, the Committee received an internal audit report regarding the Trust's adoption of the World Health Organisation Five Steps to Safer Surgery. Although the report was rated as medium risk overall, there was concern at the Committee, subsequently echoed at Board, that this was an important topic and resolution of the risks identified should be prioritised. Jenifer Evans, supported by Duncan Murray, made a presentation to the committee as to progress on the actions identified. It was clear that a lot of work had been undertaken to ensure that the necessary education and training has now been embedded in the relevant teams and these actions were robust. However, as the presentation made clear, whilst this has cleared the action points on the internal audit report (confirmed by PWC lead), they did not in themselves give assurance on compliance with the requirements of the process. The team have identified a series of internal monitoring/auditing by appropriate directorate management, the results of which will be escalated through the normal process. The Committee were happy with this approach and made two recommendations,

1. The Clinical Governance Committee should fold this into their standard periodic compliance monitoring processes (subsequently confirmed as in hand by Chair of CGC)
2. A further deep dive type of report should be undertaken in approximately one year's time to extract learning points from the process. The Committee felt that this also fitted more closely into the CGC remit, rather than Audit Committee

The Committee recognised the significant progress made in this area and asked Jenifer to pass on our compliments to the team.

Deep Dive – Counter Fraud Risks and Mitigating Controls

The Committee received a short presentation from Lisa Thomas and there was a general discussion on fraud risks in the hospital, particularly in the current economic environment, and what measures were in place to mitigate these risks. The Local Counter Fraud Officer (Tony Hall from TIAA) was asked to comment and stated that the areas reviewed and the controls in place were well matched to the risks he would have highlighted.

CLASSIFICATION:

Salisbury NHS Foundation Trust

Report to:	Trust Board	**Agenda item:**	2.2
Date of Meeting:	4th August 2022		

Committee Name:	Finance and Performance		**Committee Meeting Date:**	26th July 2022
Status:	**Information**	**Discussion**	**Assurance**	**Approval**
			X	
Prepared by:	Eiri Jones, Non-Executive Director			
Board Sponsor (presenting):	Eiri Jones, Non-Executive Director			

Recommendation
To note and discuss key aspects of the Finance and Performance (F&P) Committee meeting held on the 26th July 2022

Items for Escalation to Board
(1) IT managed business case The business case was discussed in detail. It outlined that whilst the ideal was to move to a full cloud solution (the long term, strategic solution) this was high risk due to the current infrastructure. It was noted that some newer systems are already cloud based and where possible, any future systems will be cloud based. The business case was also reviewed in terms of alignment with the system and it was confirmed that the system are assessing how to achieve a cloud based solution across BSW. The next step for the Trust is to move to a hybrid model. It was agreed that a legacy programme needs to be put in place. The committee supported the business case coming to the Board, whilst noting the financial risk.

(2) New ward business case

This business case is part of the TIF national work stream. The committee again discussed this in detail, confirming that this ward (24 beds) would support the 3 further theatres needed to meet the elective care recovery. Whilst the timescale for delivery is challenging, the committee supported the submission of the business case to the next stage of the process. This decision was delegated to Finance and Performance committee by the Board at its last meeting due to the deadline requirements for submission.

(3) Integrated Performance Report (finance and performance)

High attendance numbers and Covid, with the resultant staff sickness, continue to be key issues for the Trust alongside the high numbers of no criteria to reside patients (NCTR) making for high occupancy numbers. Discussion at the committee included the mitigations being taken to maintain the Trust's commitment to safety. Positively, the Trust has delivered the requirements for the 104 week waits by the target date. Cancer and stroke performance continue to be challenging. The diagnostic challenges were discussed in detail, with the committee asking for further assurance at individual service level.

(4) Spinal services

The committee was appraised of the current challenge in the spinal unit due to staffing and outlying medical patients. The CFO has written to specialist commissioning outlining the plan to temporarily reduce the number of beds from 39 to 31. This will be considered further at the next meeting and it was also discussed at the Clinical Governance committee (see separate upward report).

(5) Finance report

The financial position was presented, noting that the break even currently being achieved was mainly due to unfilled vacancies. A key issue to report to the Board is the staffing challenges in coding which has resulted in a large amount of uncoded activity for which there is no quick solution. This is on the risk register. The CFO also presented the new financial system reports which the Trust will receive monthly.

(6) Board Assurance Framework and Corporate Risk Register (F&P)

The newly refreshed BAF was presented. This has been revised to reflect the Board discussion on risk appetite.

(7) Supply Chain concerns

The committee was appraised of potential risks and issues in terms of supplies. This is being monitored proactively by the team. The committee felt it was appropriate to report to the Board.

The Board is asked to note and, where relevant, discuss the content of this upward report.

NHS Salisbury NHS Foundation Trust

Report to:	Trust Board (Public)	**Agenda item:**	2.3
Date of Meeting:	04 August 2022		

Report Title:	Trust Management Committee Escalation Report			
Status:	**Information**	**Discussion**	**Assurance**	**Approval**
	X		X	
Approval Process (where has this paper been reviewed and approved)	Reviewed and signed off by Stacey Hunter Chief Executive Officer.			
Prepared by:	Gavin Thomas, Executive Services Manager			
Executive Sponsor (presenting):	Stacey Hunter Chief Executive Officer			
Appendices (list if applicable):				

Recommendation:
The Board is asked to note the report from the Trust Management Committee.

Escalation Summary:
The Trust Management Committee was scheduled for 27th July and took place in the Boardroom now that restrictions continue to be eased. This month saw the first of our new format of the committee with the first session of our Leadership Forum taking place. The idea behind this new approach is to have greater dialogue between the Senior Leadership Team and the Executive. The first session was led by the Child Support and Family Services (CSFS) Division and Jo Baden fuller, Clinical Director. CSFS brought a discussion around Mental Health Provision for both paediatrics and adults in SFT and broadly at BSW level. Jo talked candidly about the challenges we are facing in SFT with the ever-increasing need of patients with Mental Health problems, the challenges of caring for the cohort of patients in an acute setting and also the challenges of the environment, as well as the need for greater interaction between us and Mental Health Care Providers such as AWP. The committee had an interactive discussion about the need to review the model of care in respect of Mental Health patients, but also the need for a clear revision of a mental health strategy, both of which are things which CSFS have in train. The committee also heard from the Chief People Officer about steps the Trust is looking at taking in respect of helping staff members who maybe experiencing financial hardship owing

to the cost-of-living increases, such as rise in fuel and energy and also increased commuting costs.

The committee discussed a range of ideas ranging from allowing fruit and veg stall holders onto site and instead of charging them rental space, a discount is given to staff with an NHS badge. Furthermore, ideas such as selling hot food at cost price, the opening of an internal staff food bank, and the provision of children's lunchboxes for staff to take home were all looked at.

The session was lively and energised with everyone seemingly recognising the need for the Trust to do something to help its staff, whilst also recognising that the subject may well be a difficult subject for many to talk about.

In respect of the normal business of TMC, the committee still received all of the escalation reports from the Sub committees of TMC, all of which were noted by the committee. The committee heard that in respect of the Operational Management Board (OMB) there were a number of internal operational policies which still require some work in order to get them into a standard where they can be ratified and approved, and a discussion was had around how we could utilise TMC to help those discussions and make progress on the outstanding policies.

In respect of Business cases, as this month's TMC was a leadership forum session, Business cases will come to next month's TMC with the return of the formal committee.

Board Assurance Framework – Strategic Priorities	Select as applicable
Population: Improving the health and well-being of the population we serve	☒
Partnerships: Working through partnerships to transform and integrate our services	☒
People: Supporting our People to make Salisbury NHS Foundation Trust the Best Place to work	☒
Other (please describe) -	☐

NHS Salisbury NHS Foundation Trust

Report to:	Trust Board (Public)	**Agenda item:**	2.4
Date of Meeting:	4th August 2022		

Report from: (Committee Name)	Clinical Governance Committee		**Committee Meeting Date:**	26th July 2022
Status:	**Information**	**Discussion**	**Assurance**	**Approval**
	X	X	X	
Prepared by:	Miss Eiri Jones, Chair CGC			
Board Sponsor (presenting):	Miss Eiri Jones, Chair CGC			

Recommendation

Trust Board members are asked to note and where relevant, discuss the items escalated from the Clinical Governance Committee (CGC) meeting held on the 26th July 2022. The report both provides assurance and identifies areas where further assurance has been sought and is required.

Key Items for Escalation

- Key information / issues / risks / positive care to escalate to the Board are as follows:
  - The committee were appraised of the spinal services challenges (discussed earlier at F&P) whereby the number of beds had been reduced temporarily. This was felt to be the appropriate action based on feedback from both patients and staff. Other changes were being implemented to ensure a continued focus on safety with the service receiving additional support from the Executive team. A new matron has been appointed and a new consultant is coming to join the team from Stoke Mandeville.
  - The supply chain concerns were discussed, focussing on any potential quality impacts. It was noted that the supplies team are keeping a strong handle on this and a clinical nurse is supporting the team for a 6 month period.
  - An update was presented in relation to the Mental Health Liaison Committee work. It was noted that has been impacted on by the Covid challenges and therefore the Deputy CMO has taken the opportunity to review and reset the Trust approach with its partners. The key question explored was whether the Trust was doing all it could and should. An update will come to the committee in the next planned report.
  - The IPR was presented in detail and whilst the stroke challenge was acknowledged, it was good to note that some 'green shoots' were present with improving performance in some of the SNAPP requirements. 'Green shoots' also seemed to be emerging in relation to the breakthrough objective for falls with an overall reduction in falls with harms over time. The SHMI was

discussed with the CMO confirming that he had discussed our data in relation to the hospice with the Dr Foster team.

- The newly refreshed BAF was presented and discussed. The Committee reviewed it from a quality perspective, supporting the refreshed presentation and noting it would be discussed further at Board.
- The Cancer Annual Report was presented and received. Whilst noting the current performance challenges there were many positives to note. A new lead nurse has been appointed and attended the meeting alongside the Trust cancer lead. The team are networking with the other acute alliance partners and with the system at large to share best practice and learning. The clinical lead confirmed that resources were being directed to where it was most needed in terms of performance with a focus on the shift to the new 28 day standard. Whilst the Trust did well in the national patient survey (mostly within expected range or above, with only one below average metric) some variation was noted for those patients not based on the cancer ward and this would be one of the focuses for the new lead nurse. Cancer navigators were proving to be positive and successful and there was consideration of an information hub to be established at the front of the hospital.
- The clinical effectiveness section covered the annual clinical audit plan report, the national clinical audit biannual report, the annual NICE report and the New Health Technologies annual report. Whilst the committee received assurance that the relevant audits were being completed, there was further work to do to ensure learning is embedded and improvements made where required. The Divisions were being supported to lead on this work.
- The complaints survey results were presented to the Committee. This is the Trust survey where complainants are asked about their satisfaction with how their complaint has been handled. The new patient experience lead outlined a plan to refresh the way this is done so that a better response rate (currently 15%) and wider engagement is achieved. The plan includes increasing accessibility, aligning with the new Ombudsman framework for complaints and co-production with Healthwatch Wiltshire.
- The upward report from the CMB outlined that there is a focus on the governance around consent, the paediatric early warning system and the emerging effectiveness of the new sub groups for safety, effectiveness and experience.

The Board is asked to note and discuss the content of this report.

NHS Salisbury NHS Foundation Trust

Report to:	Trust Board (Public)	**Agenda item:**	2.5
Date of Meeting:	4 August 2022		

Report from: (Committee Name)	People & Culture Committee		**Committee Meeting Date:**	28th July 2022
Status:	**Information**	**Discussion**	**Assurance**	**Approval**
			X	
Prepared by:	Michael von Bertele; Non-Executive Director			
Board Sponsor (presenting):	Michael von Bertele; Non-Executive Director			

Recommendation
Trust Management Committee are asked to note the items escalated from the People and Culture Committee meeting held on 28th July 2022, and items for assurance.

Items for Escalation
For Escalation: 1. The committee received draft reports on the Gender Pay Gap and the Workforce Race Equality and Workforce Disability schemes. Since we are mandated to report these to NHS(E) and they contain a lot of data it was suggested additional analysis and further contextual explanation would be helpful, it was also felt that the Trust Board would benefit from a longer session exploring what lies behind the data and what might be done to improve our understanding of diversity within the Trust. 2. The annual report from the Guardian of Safe Working was presented and showed that although we are allocated trainees to almost fill the number of posts we need, the allocation does not take account of trainees who work part time or are unable to work nightshifts. As a result we must backfill up to 20% of posts with locally employed doctors who are not on recognised training schemes. Since these doctors make up an important and often more stable element of our workforce we must ensure that we match their working conditions to those of doctors in formal training schemes, as far as is possible. An uplift in medical staffing this year at Foundation level means that our previously non-compliant rotas in emergency medicine and the hospice will be compliant from August 2022. For Assurance: 3. It was noted that although there are ongoing vacancies within the OD&P directorate, a number of critical posts will be filled in the next few months.

Recruiting across the Trust remains a challenge in light of a very competitive external jobs market.

4. The Chief People Officer is confident that she will have finalised a comprehensive people plan by the Autumn. This is a considerable undertaking that will bring together the very many diverse strands of work necessary to ensure that we have the right people to deliver our objectives.

5. Salisbury stepped into the lead on the implementation of the NHS Reservists initiative, recognising the criticality of the request, in support of BSW, although we do not feel ideally placed or resourced to do this work. The Team have shown considerable resilience and modelled good system working

6. Completion and recording of Staff appraisals continue to be a problem and the directorate is exploring ways to make the process more user-friendly.

7. The committee reviewed the BAF in its new guise and noted how clearly the risks and mitigation are now displayed. No new risks were identified.

Salisbury NHS Foundation Trust

Report to:	Trust Board (Public)	**Agenda item:**	2.6
Date of Meeting:	04 August 2022		

Report Title:	Integrated Performance Report			
Status:	**Information**	**Discussion**	**Assurance**	**Approval**
			x	
Approval Process (where has this paper been reviewed and approved)	Sections approved by responsible committee: Operational Performance & Resources – Finance & Performance Committee Quality and Care – Clinical Governance Committee Workforce – People and Culture Committee			
Prepared by:	Louise Drayton, Performance & Capacity Manager			
Executive Sponsor (presenting):	Andy Hyett, Chief Operating Officer			
Appendices (list if applicable):				

Recommendation:
The Trust Management Committee are asked to note the Trust's performance for Month 3 (June 2022).

Executive Summary:
The trust continued to operate under significant operational pressure with average bed occupancy at 97% for M3. Attendance levels to the emergency department remained fairly static, performance against the 4-hour standard reduced from 75.3% in M2, to 72.8% in M3. The number of patients that waited over 12 hours from decision to admit in the emergency department reduced from 7 in M2 to 2 in M3. The number of handover delays from the ambulance service increased, with a big rise in the number delayed by more than an hour (166 in M3 compared to 91 in M2). The levels of patients in the hospital not meeting the criteria to reside remains high at an average of 120, although there is marginal improvement from M2. Increasing covid related admissions exacerbated the complexity of this further. There was also an increase in covid related admissions as community prevalence increased once again. Alongside this sickness absence peaked at 5.11% with 'infectious diseases' being the top cause of sickness. The high occupancy levels and non elective pressure puts the elective pathway at risk, with escalation into the Day surgery unit throughout the month, and some cancellations of surgery due to this. The number of patients waiting over 52 weeks for surgery reduced by 25 to a total of 526. There were no patients waiting longer that 104 weeks, with the longest waiter at 99

weeks. Despite the challenge's elective activity was only 5 cases short of the plan, and 107 cases higher than the same month last year.

There were two falls with moderate harm reported in June, however significant progress has been made with reducing hospital falls. The number of falls per 1,000 bed days has reduced from 9.96 in April to 6.97 in June. There were no category 3 or 4 pressure ulcers in June. Concerningly, the number of category 2 pressure ulcers has further increased to 36, and further work to reduce this is planned.

Performance against the cancer standards deteriorated further with only 2 out of the 8 standards (31 Day drug and 31 Day surgery) being achieved. Performance against the Two Week Wait standard at 75% with clinic and endoscopy capacity being the biggest contributor to breach reasons. Performance against the 62 Day referral to treatment standard fell to the lowest position since pre covid at 62%. Patient choice continues to factor in the breach reasons, but also capacity and complex pathways.

There was some improvement in the Stroke standards, 31% of patients arrived on the stroke unit within 4 hours, 100% of patients received a CT scan within 12 hours, and nearly 80% of patients spent at least 90% of their stay in a designated stroke unit.

Despite early recovery of the 6-week diagnostic standard continuing achievement of it remains vulnerable. Workforce challenges in small teams, particularly affecting MRI, Cardiac Echo and Ultrasound, and increased referrals for cardiac echo further compound capacity issues.

During the week of the 13th June the MLE system used for mandatory training, amongst other things was retired as Kallidus migrated us across to the new and improved LEARN platform. Overall, Trust compliance is now 92.27%, this improvement reflects the benefit of work that has gone in within the system to rebuild the training matrix, ensuring accuracy in reporting of different levels of training. In addition, as more staff have accessed the system to see the new platform, any outstanding training is more obvious, which appears to be prompting people to complete at that time

The 2022/23 financial arrangements are transitional following the Covid block payments of the last two years and are designed to promote additional elective activity to address the Covid backlog. Although the majority of the Trusts NHS contractual income base is fixed, the guidance allows for additional income to be earned through the Elective Services Recovery Fund (ESRF), this is earned at a BSW system level. Although £28m is available to BSW as a whole, SFT has only assumed £1.4m in the 2022/23 plan, as this is agreed as a minimum 25% 'floor' payment.

22-23 has also seen the return of an efficiency requirement and recurrent savings targets totalling £6.6m have been allocated to corporate and clinical divisions. While £6.6m has been identified, this is inclusive of an assessment of non-recurrent vacancies. At present the recurrent efficiencies identified are £2.6m. In month 3 the Trust recorded a small control total surplus of £0.012m against a target of £0.13m - a favourable variance of £0.14m.

Board Assurance Framework – Strategic Priorities	**Select as applicable**
Population: Improving the health and well-being of the population we serve	☒
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Other (please describe) -	☐

NHS
Salisbury
NHS Foundation Trust

Integrated Performance Report

August 2022

(data for June 2022)

An outstanding experience for every patient

Summary

Salisbury NHS Foundation Trust

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The high occupancy levels and non elective pressure puts the elective pathway at risk, with escalation into the Day surgery unit throughout the month, and some cancellations of surgery due to this. The number of patients waiting over 52 weeks for surgery reduced by 25 to a total of 526. There were no patients waiting longer that 104 weeks, with the longest waiter at 99 weeks. Despite the challenge's elective activity was only 5 cases short of the plan, and 107 cases higher than the same month last year.

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Summary Performance June 2022

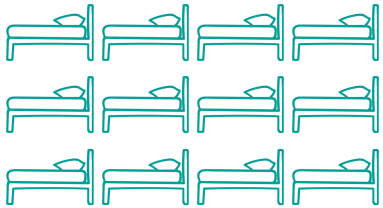
Salisbury NHS Foundation Trust

There were **2,702** Non-Elective Admissions to the Trust

We delivered **33,242** outpatient attendances, **17.5%** through video or telephone appointments

We met **2 out of 8** Cancer treatment standards

We carried out **319** elective procedures & **2,006** day cases



We provided care for a population of approximately **270,000**

RTT 18 Week Performance: **65.94%** ↑

Total Waiting List: **21,660** ↑

76.5% ↑ of patients received a diagnostic test within **6 weeks**

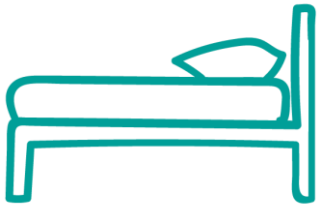
Our income was **£26,307k** (£291k above plan)

18.5% ↓ of discharges were completed before 12:00

Emergency (4hr) Performance **72.8%** ↓

(Target trajectory: 95%)

100 patients stayed in hospital for longer than 21 days



Our overall vacancy rate was **12.9%** ↓

Reading a Statistical Process Control (SPC) Chart

The two dotted grey lines represent the boundaries of "normal"

There should always be a minimum of 24 months worth of data

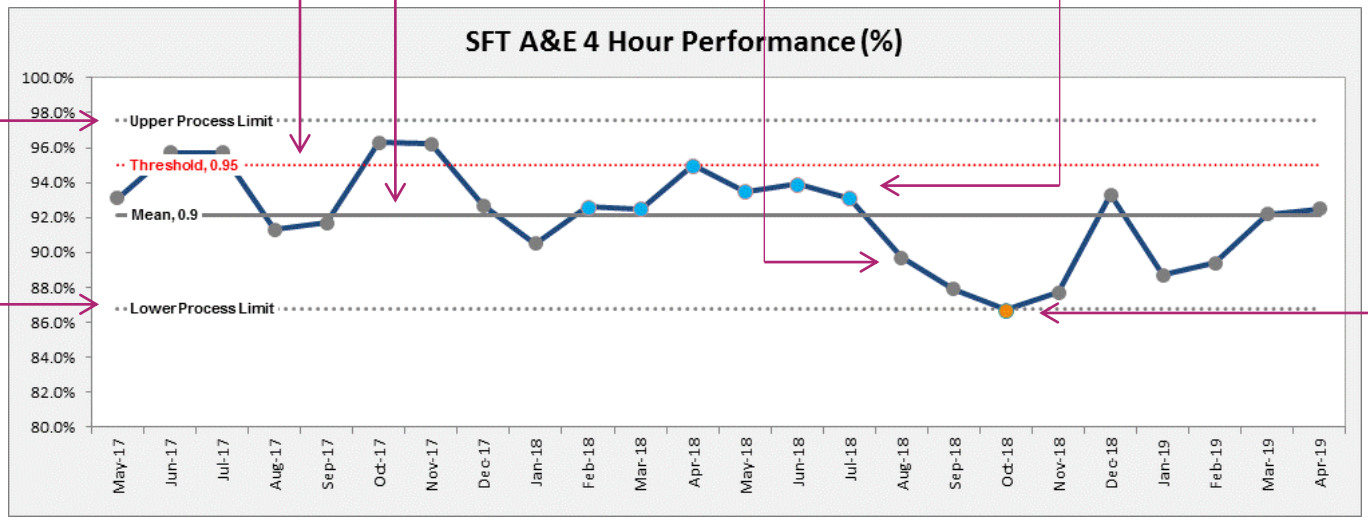
The red line shows the target for the KPI, if there is one

The solid grey line shows the mean value for the dataset

Grey markers show normal behaviour with no significant cause for variation

Blue markers indicate that there has been a marked improvement in performance, showing 6 or more points continuously improving or any point above the upper limit

Orange markers indicate that there has been a marked decline in performance, showing 6 or more points continuously deteriorating or any point below the lower limit



Statistical Process Control Chart Key:

- Target
- Mean
- Upper / Lower Process Control Limits (UPL/LPL)
- Special Cause Variation Improvement (6 or more points with continuous improving performance, or a single point outside the control limit)
- Special Cause Variation Concern (6 or more points with continuous deteriorating performance, or a single point outside the control limit)
- Common Cause Variation

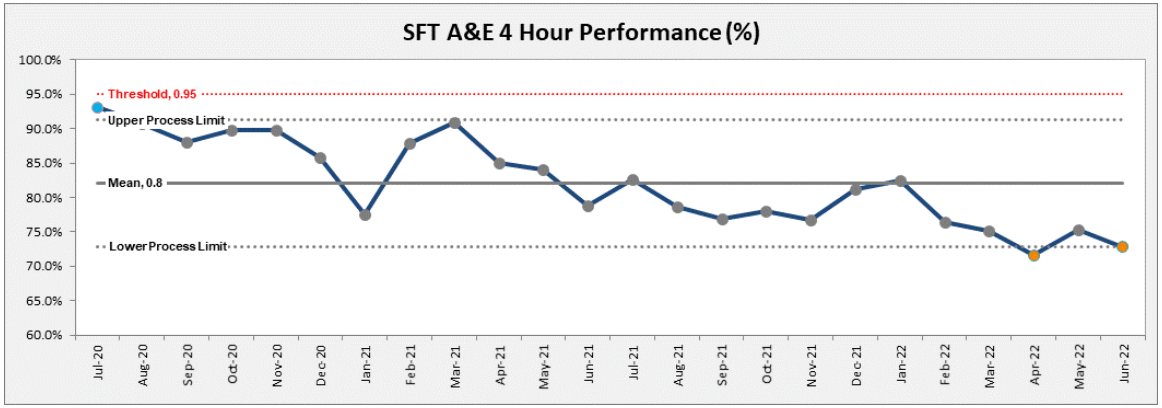
Part 1: Operational Performance

Performance against our Strategic Priorities and Key Lines of Enquiry

Our Priorities	How We Measure	
People	Are We Effective?	Are We Responsive?
Population	Are We Safe?	Are We Caring?
Partnerships	Are We Well Led?	Use of Resources

Emergency Access (4hr) Standard Target 95% / Trajectory 95%

National Key Performance Indicators



Data Quality Rating:	
Performance Latest Month:	72.8%
Attendances:	6611
12 Hour Breaches:	2
ED Conversion Rate:	29.0%

Background, what the data is telling us, and underlying issues

Total attendances were high in M3 at 6611, the highest monthly number to date. The largest increase was in Type 3 activity at the Walk in Centre (2005 attendances compared to 1624 in M2).

Performance against the 4-hour standard decreased to 72.77% (75.3% in M2). There were two twelve-hour breaches from decision to admit to leaving the department.

Flow out of the department is the biggest challenge, with average time in the department in M3 for admitted patients at 7 hours and 56 minutes, and the average time in department for non admitted patients at 4 hours and 2 minutes.

Staffing gaps across all staff groups due primarily to Covid, impacting on existing staff has contributed to the drop in the 4-hour performance standard.

Improvement actions planned, timescales, and when improvements will be seen

Phase 2 of the minors rebuild was completed and officially opened at the end of M3. The new minors build incorporates separate waiting areas for adult and paediatric patients ensuring compliance with CGC regulations.

A HALO is used by agreement with SWAST at times of pressure to assist with identification of deteriorating patients being held in ambulances. Three HALO' have been appointed to be based at SFT and once in place SFT will have a full HALO service.

We have seen a reduction of the WHC frailty rapid response pilot, which has been successful and the DDM is looking into how we can continue with this role in the future.

Recruitment into vacant nursing, medical and administration posts are ongoing, all Band 5 vacancies have been recruited to and are in the process of agreeing start dates. The Matron for ED and AMU commenced in post in M3.

Risks to delivery and mitigations

Flow out of the department and capacity across the Trust continues to the biggest challenge for the 4-hour performance standard. Most of the flow out of the department continues to be in the late evening, adding extra pressures on staffing resources across the Trust.

AMU SDEC (Same Day Emergency Care) has remained escalated into overnight, resulting in poor flow out of the Department. This then impacts poor flow out of ED with the medical take diverted to ED and AMU's capacity to deliver SDEC. This remains a major contributory factor to capacity concerns within ED and the ability to off load ambulances in a timely manner.

Staffing Gaps continue to impact on existing staff and the department. Banding of reception posts is likely to be a contributor, and the department is progressing a review of job descriptions which are awaiting banding.

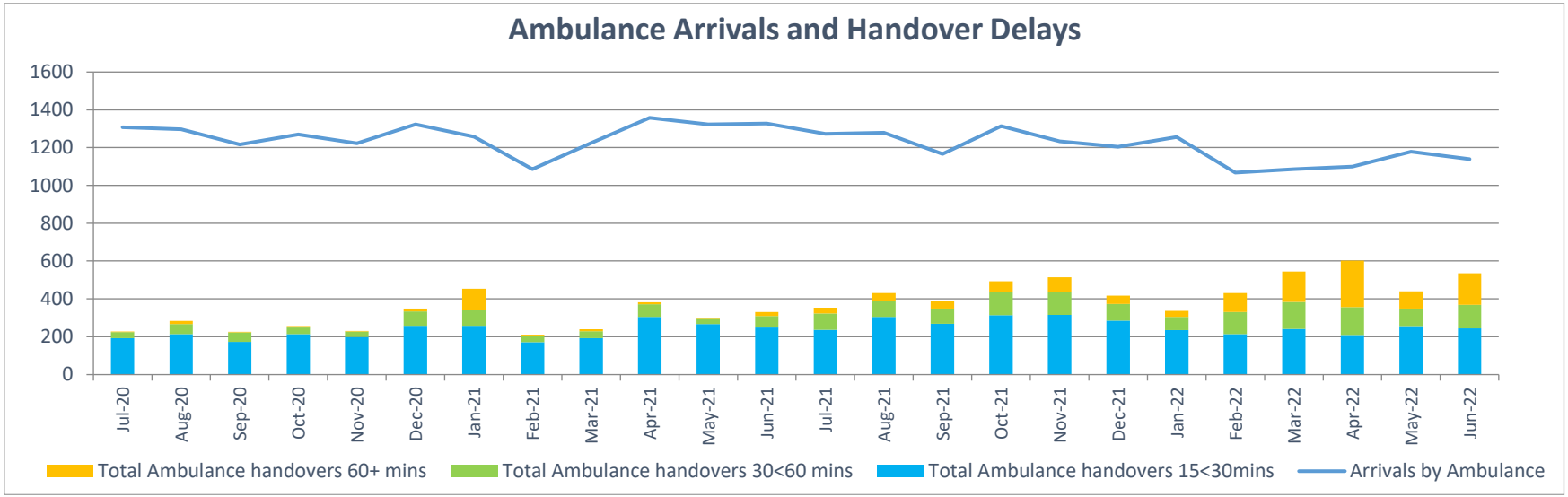
Nursing training affected by staffing levels and operational pressures.

Statistical Process Control Chart Key:

- Target
- Mean
- Upper / Lower Process Control Limits (UPL/LPL)
- Special Cause Variation Improvement (6 or more points with continuous improving performance, or a single point outside the control limit)
- Special Cause Variation Concern (6 or more points with continuous deteriorating performance, or a single point outside the control limit)
- Common Cause Variation

Ambulance Handover Delays

National Key Performance Indicators



Background, what the data is telling us, and underlying issues

M3 saw a small decrease in the number of ambulances presenting to SFT of 1139 compared to M2 of 1178. There was a significant decrease in performance from 84.38% in M2 to 76.73% in M3. These figures are unvalidated and will be validated with SWAST partners.

Breaches over 60 minutes saw a significant increase in M3 of 166 compared to 91 in M2. Breaches between 30 and 60 minutes increased from 93 in M2 to 125 in M3.

SWAST reset day in M3 saw a large number of ambulances conveyed to SFT which put pressure on the department and wider trust. A hospital ambulance liaison officer (HALO) from SWAST was present throughout the day assisting with queuing ambulances

Improvement actions planned, timescales, and when improvements will be seen

Recruitment has nearly been finalised for permanent HALO at SFT, the Halo continues to be present in times of escalation which is conducive to collaborative working with SWAST and ensuring the identification of any deteriorating patients held in ambulances waiting to off load.

SFT continue working collaboratively with SWAST and BSW partners in order to provide good quality of care for our patients.

Bedside handover agreement for transfers out of the department which will reduce lost time trying to contact wards and allow transfers out of the department to be actioned more quickly when beds become available.

Professional standards framework to be agreed with specific response times.

Time from decision to admit to transfer out of the department is a driver metric for the division and a plan for improvement is expected to be completed in M5.

Risks to delivery and mitigations

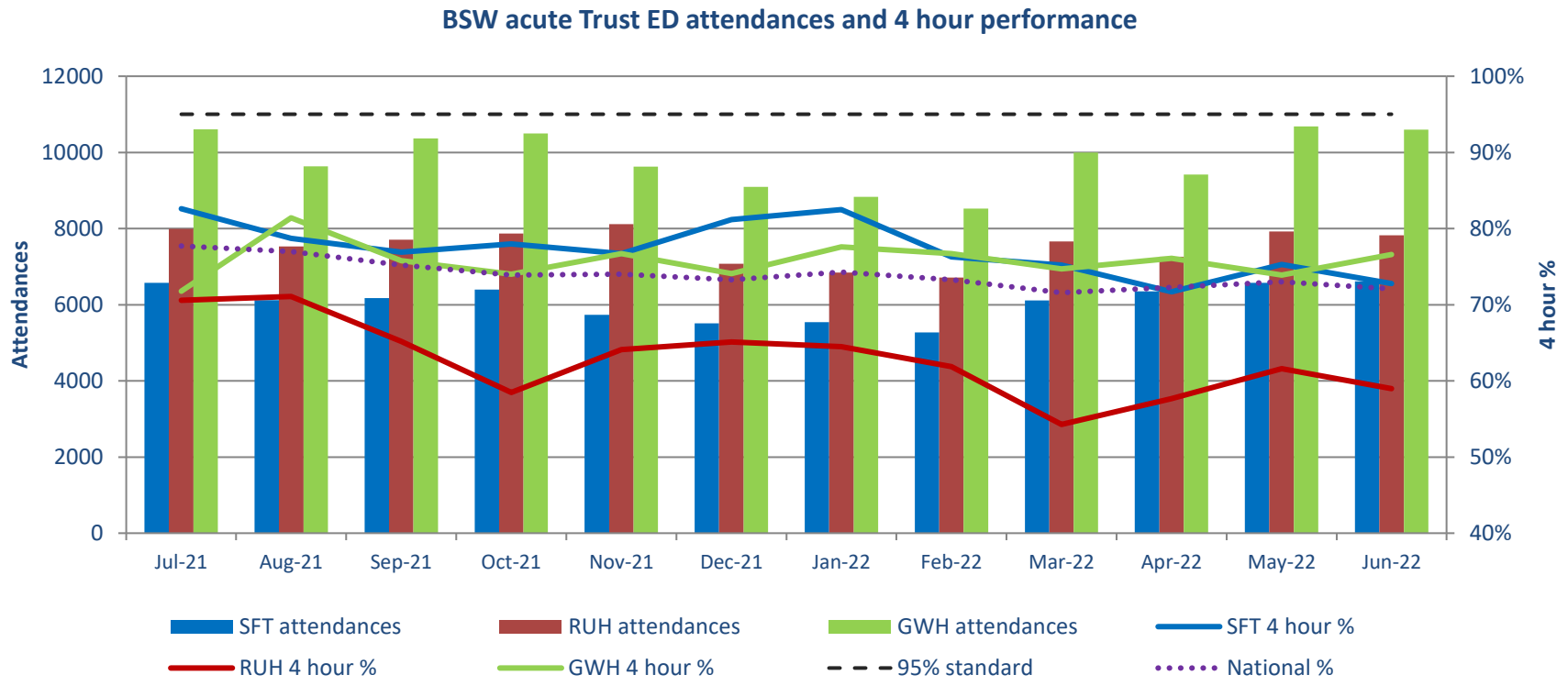
Flow into the hospital is a significant challenge when assessment areas are escalated into. This results in long waits for beds which blocks space in the emergency department to be able to offload ambulances quickly when they arrive. Bedside handover and professional standards agreement are being finalised.

Staffing levels and skill mix – poor staffing and/or skill mix can contribute to it taking longer to process patients, resulting in a high workload which is challenging to effectively manage and ensure flow in and out remains timely. All band 5 vacancies have been recruited to and are in the pre-employment process. Medical staffing gaps remain challenging to fill.

Awaiting feedback regarding pilot for WHC frailty response at the Front Door.

BSW Context – Emergency Access (4hr) standard

Are We Effective?

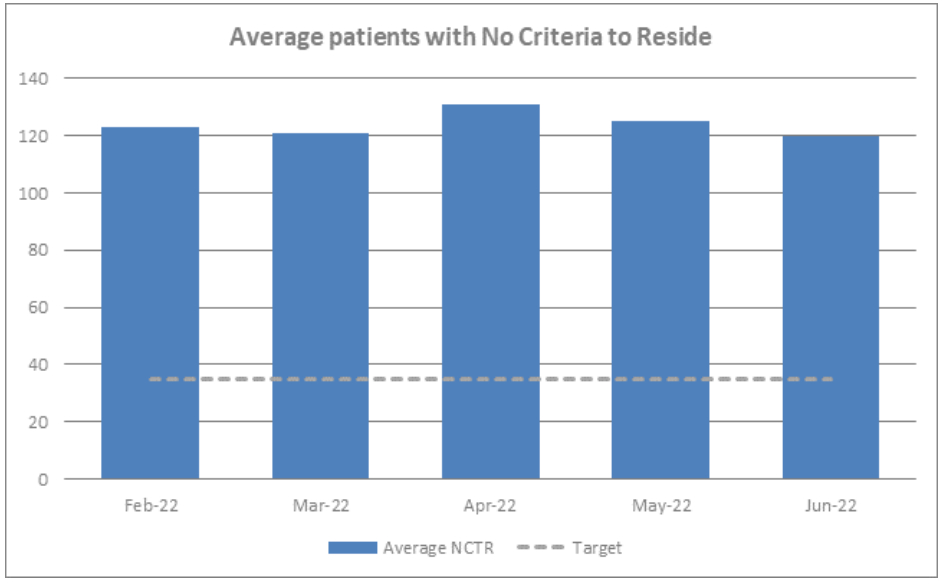


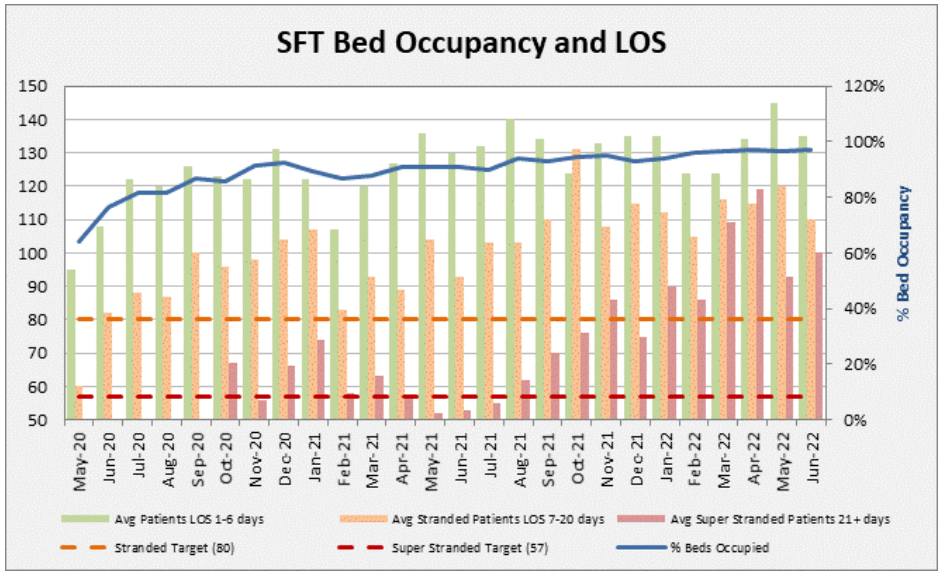
ED attendances and performance against the 4 hour standard were broadly in line with previous months. There continues to be a small number of 12 hour breaches (2 at SFT, 11 at RUH and 67 at GWH).

When considering Type 1 activity (main hospital Emergency Department) alone performance at the three Trusts is very similar – 58.5% at SFT, 59% at RUH and 58.7% at GWH. This is also reflected nationally with the percentage of type 1 attendances in England seen and treated or discharged within 4 hours at 58.8%.

Patient Flow and Discharge

Are We Effective?





Background, what the data is telling us, and underlying issues

June continued to see a high level of patients in the Trust with no criteria to reside. Additionally, with bed occupancy at a sustained high level the group of patients staying 21 days + has continued to increase in June.

June saw a steady increase in the pressures around managing COVID and combined with the new testing regime meant that the Trust began to see discharges halted on day of discharge to care home, as results came back positive, requiring the patient to be isolated. Care homes and other 24 care settings have been seen to close, reducing the flexibility to support acute services with additional capacity

Staffing has been a significant issue in June, contributing to the slower patient journeys seen in this data

Improvement actions planned, timescales, and when improvements will be seen

Breamore has been commenced for use as a ward area specifically accommodating patients with NC2R, supporting placement of patients with specialty needs elsewhere as required. This will not support a reduction in NC2R nor LOS however.

The results of SAFER at the end of May are being collated with the purpose of identifying actions that are sustainable within the Trust and with partners to improve both the numbers and LOS of patients with NC2R.

Risks to delivery and mitigations

Staffing across acute and community health and social care services will be critical to contributing to a reduction in extended length of stay and numbers of patients with no criteria to reside. All efforts both within the acute setting and across community services to maximize meaningful staffing levels will be required.

The current experience of managing covid implies July will be difficult if the trend continues- and will negatively impact flow and patient journeys.

Resources in community services further impacted by covid and infection control restrictions will also impact the potential for patients in the acute setting being able to access services they require on discharge.

Theatre Performance

Theatre KPI's

	Apr	May	Jun	Jul	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar
19/20	497	532	501	531	453	522	524	555	476	548	481	364
20/21	239	294	327	317	346	362	379	401	328	248	263	383
21/22	301	378	379	442	455	473	507	520	465	469	472	419
22/23 Actual	301	510	486									
22/23 Plan	477	501	491	TBC	TBC	TBC	TBC	TBC	TBC	TBC	TBC	TBC

Measure - Theatre Performance & Efficiency	Area	Target	June 22
% Utilisation	Day Surgery Theatres	90%	71.46%
	Main Theatres	85%	83.71%
Turnaround	Day Surgery Theatres	8 mins	21 mins
	Main Theatres	12 mins	29 mins
% short notice Hospital Cancellations (0-3 days)	Total	2%	2.09%
% Short notice Patient Cancellations (0-3 days)	Total	2%	7.84%

Background, what the data is telling us, and underlying issues

An average of 116 theatre sessions a week were run in M3. This is slightly below the 22/23 plan of 491 lists. List utilisation in both DSU and Main Theatre declined in month driven by the impact of escalation in DSU and increasing hospital-led cancellations due to high levels of COVID related absence. 13th in week theatre open but continuing high staff sickness and elective cancellations meant that this increase was not fully realised. Some lists at lower list numbers due to bed pressures and a continuing high levels of patient cancellations although these have reduced when compared to M2

Elective activity in M3 was significantly ahead of plan at 124% of 22/23 plan, a surplus of 62 cases, although remains short of pre-Covid levels, at 75%. Urology and Plastic Surgery were the specialties driving this

Daycase activity was also ahead of plan, at 103%, and remained ahead of pre-COVID levels, at 106%. This demonstrates the continuing focus to protect activity whenever possible by utilising the main theatre footprint to accommodate lists that would otherwise have been impacted by the escalation in DSU. Colorectal Surgery, Ophthalmology and Plastic Surgery daycase levels were particularly affected by challenges in the clinical workforce

Improvement actions planned, timescales, and when improvements will be seen

Theatre Staff Incentive Payment Scheme uptake increased to £11,930 in M3. This is higher than the previous 3 months

Theatre Education continues with increased numbers of Scrub Nurses, ODP's and SFA's in full time training

SFT IPC guidelines continue to reflect most national processes for low risk pathways, improving the ability to book patients into cancelled slots with less notice required, in turn improving utilisation. Move to remove pre-surgery LFT testing requirement for all vaccinated, daycase patients planned for M5. This will further improve booking efficiency and flexibility

Continuation of High Volume Low Complexity (HVLC) lists running both in week and at weekends for several specialties as targeted Waiting List Initiatives focusing on Plastic Surgery and Urology as the specialties with the highest volume of elective surgery backlog and high levels of 52w+ wait times

Productivity and efficiency work continues focussing on the Day Surgery Unit. This continues to be supported by the weekly specialty Scheduling Meetings bringing together representation from multidisciplinary teams, including the theatre lead for the specialty, supported by the theatre management team and the booking teams

Risks to delivery and mitigations

Theatre workforce for local lists continues to be a risk despite slow improvement. The resilience of the local workforce is a particular focus as transition from reliance on TXM (insourced staff) to a more stable substantive workforce

High levels of trauma, in both Plastic Surgery and T&O, and other non-elective emergency demand which continue to be higher than pre-COVID levels at 102%. This is being mitigated by daily reviews by the Specialty, Theatre and DMT to ensure patients are clinically prioritised appropriately.

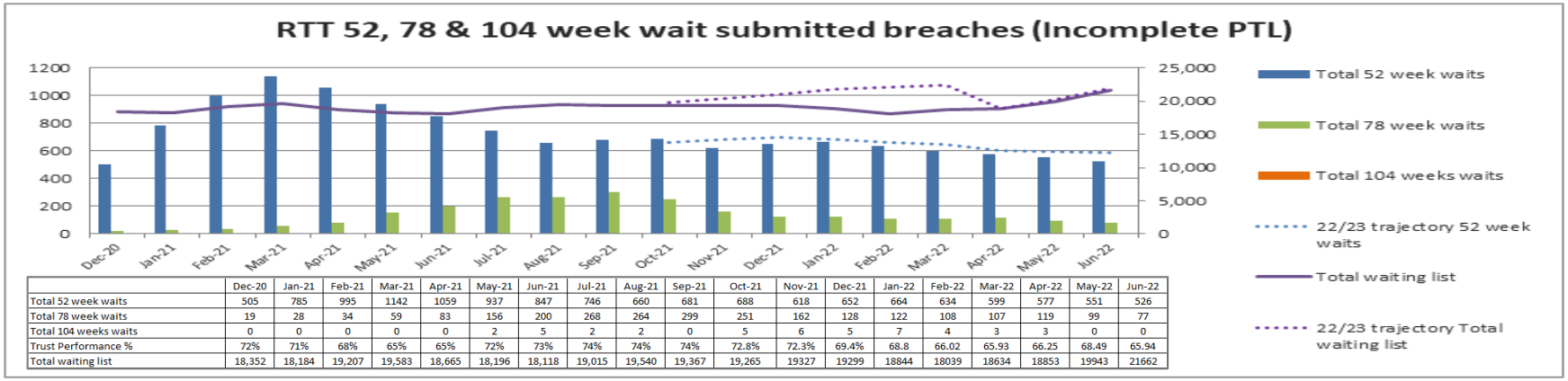
Bed pressures continue to impact the elective programme and have led to cancellations throughout M3 of elective cases and the use of DSU for inpatients has also impacted performance. Daily review by the Matrons and DMT undertaken as required, avoiding cancellations whenever practical. The work undertaken throughout the month by DMT's and matrons, utilising the approach of the SAFER events, has supported this focusing on increasing discharges creating capacity to both improve patient flow and support the activity of the elective programme.

Ongoing risk due to high levels of patient cancellations which in M2 remain at 7.8%.

Theatre access is now being allocated in order to give the best opportunity to achieve planned activity. This plan has incorporated the need for trauma/cancer etc. balanced with clinical priority and performance targets. Work to relaunch the theatre timetable looks to support this and stabilise access to theatre across the specialties

Referral To Treatment (RTT) (Incomplete Pathways) Target 92%

National Key Performance Indicators



	Dec-20	Jan-21	Feb-21	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22
Total 52 week waits	505	785	995	1142	1059	937	847	746	660	681	688	618	652	664	634	599	577	551	526
Total 78 week waits	19	28	34	59	83	156	200	268	264	299	251	162	128	122	108	107	119	99	77
Total 104 weeks waits	0	0	0	0	0	2	5	2	2	0	5	6	5	7	4	3	3	0	0
Trust Performance %	72%	71%	68%	65%	65%	72%	73%	74%	74%	74%	72.8%	72.3%	69.4%	68.8	66.02	65.93	66.25	68.49	65.94
Total waiting list	18,352	18,184	19,207	19,583	18,665	18,196	18,118	19,015	19,540	19,367	19,265	19327	19299	18844	18039	18634	18853	19943	21662

Longest Waiting patient (Weeks)	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22
	112	103	106	110	110	107	111	116	120	99	99

Top 5 specialties with highest number of 52 week wait submitted breaches (Incomplete PTL)

Treatment function	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22	% change from previous month
Plastic Surgery	129	111	121	132	130	130	117	124	130	5%
Urology	59	60	63	57	60	59	80	75	64	-15%
Oral Surgery	44	38	38	38	37	34	34	32	43	34%
Trauma and Orthopaedic	56	48	39	45	41	26	28	25	22	-12%
Ophthalmology	71	55	44	25	24	24	21	11	8	-27%

Background, what the data is telling us, and underlying issues

The number of patients waiting longer than 52 weeks decreased by 25 to a total of 526 in M3. The number of patients waiting longer than 78 weeks also continues to decrease to 77. This is ahead of the month end target for June of 80. This position has recovered from being 19 behind trajectory at the end of April

There were no reportable patients waiting 104 weeks at the end of M3 and the Trust achieved the target to eliminate these by the end of June 22

The most challenged specialties at >78weeks are Plastic Surgery and Gynaecology, and at >52weeks Plastic Surgery, Gynaecology, Urology, Respiratory and Oral Surgery. Oral Surgery has been impacted by the recent high levels of list cancellations due to the escalation in DSU

Overall PTL size in M3, 21,662 which is over the current target of 21,917. A revised submission to NHSE was made in M3 which the table above reflects.

Improvement actions planned, timescales, and when improvements will be seen

HVLC lists for Plastics LA procedures have continued to run throughout June for this long waiting cohort although this was reduced due to challenges with consultant cover. Capacity was picked up by Urology another of the most challenged specialties

SFT was ahead with achievement of the national target to eliminate 104-week breaches (unless P6 patient choice to wait) by the end of June 22, achieving this in May 22, and work is ongoing to deliver the activity required to support the achievement of the national target to eliminate 78 week waits by the end of March 23

Ongoing use of IS with the transfer of clinically appropriate Orthopaedic patients to Newhall continuing

Risks to delivery and mitigations

As with theatre activity continued risks remain in relation to theatre workforce for local lists including the risk of high levels of sickness. The mitigation for this issue is linked to the Theatre Workforce Business Case which has been approved

Risks associated with staffing levels as a direct result of COVID-19 increased again in the second half of M3 alongside continuing high levels of non-COVID absence in clinical teams. This has especially impacted the GI Unit and Plastic Surgery clinical teams

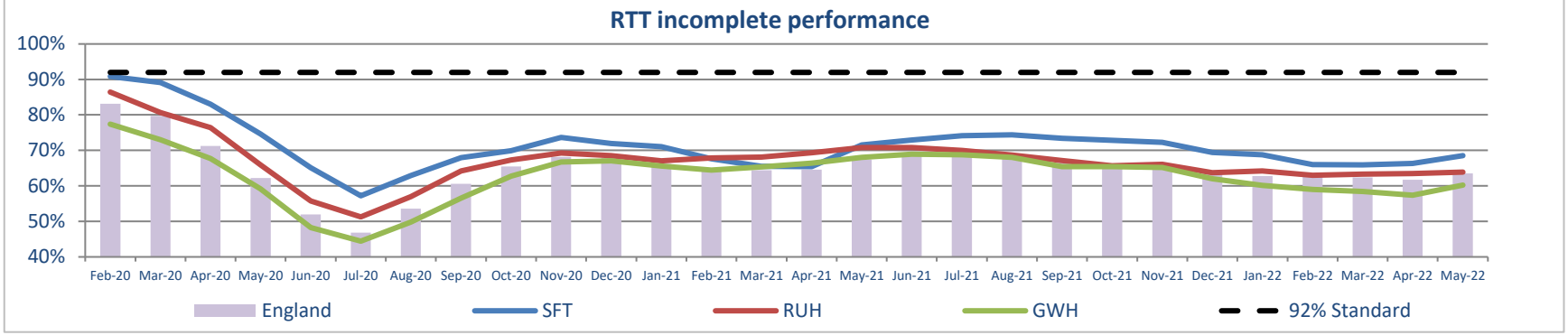
Capacity pressures continue to impact the elective programme and have led to elective cancellations in M3 exacerbated by use of DSU as an escalation area. Daily review by the Matrons and DMT undertaken as required avoiding cancellations whenever practical. Daily elective planning meeting set up chaired by Surgery Silver and attended by lead for theatres and lead for Chilmark elective to ensure the most efficient use of capacity to minimalise cancellations

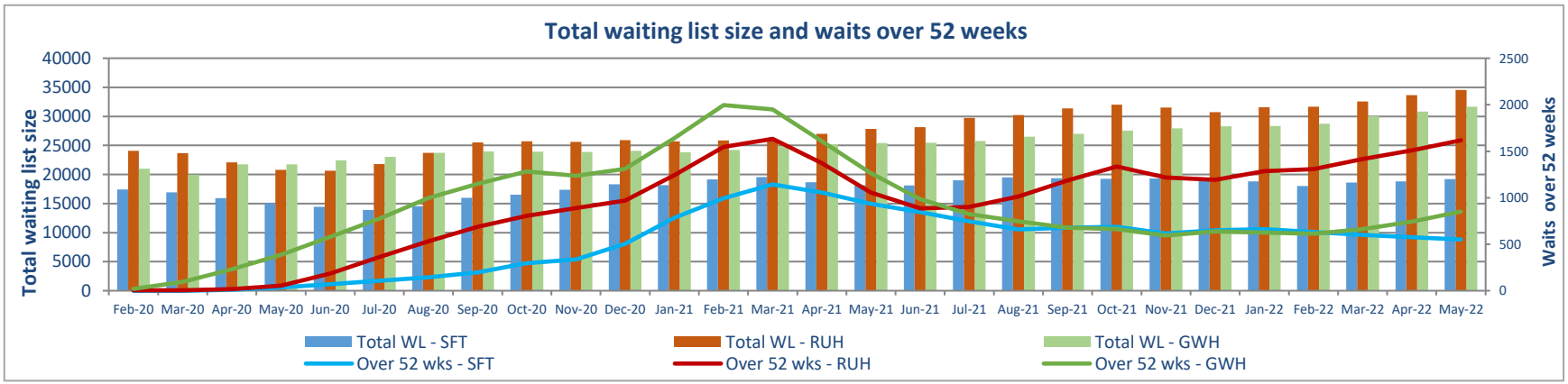
Continued high levels of patient led cancellations are also a risk to delivery

Space constraints across outpatient departments continue to be a risk as some services challenged to deliver activity levels that exceed pre-COVID levels in their footprint. Creep in some specialties back to onsite preferences. Focussed work is being undertaken with DMT's, Clinical Leads and Transformation team to continue to increase this in line with national targets and to improve medium-long virtual models in line with national and ICS targets and priority

BSW Context – Referral To Treatment (RTT)

Are We Effective?





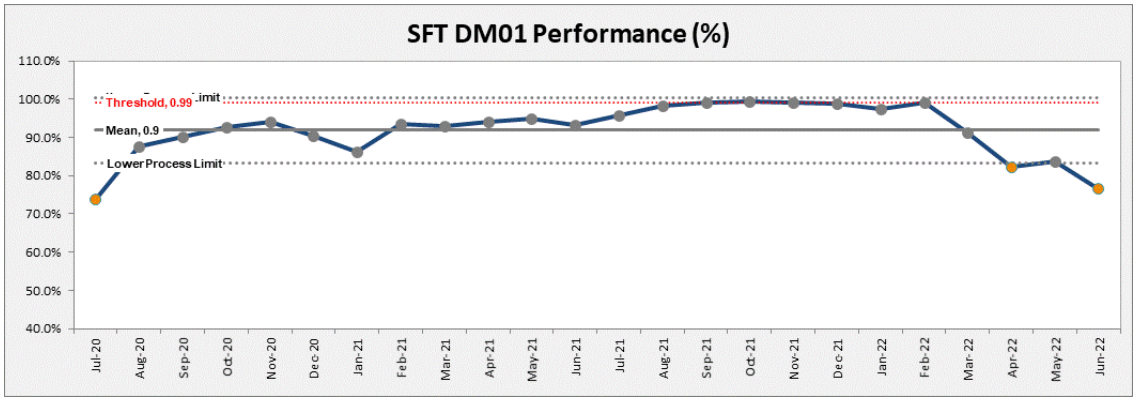
*Due to the time it takes to for NHSE to publish the data, RTT benchmark data on this slide is a month behind the reporting month.

Total waiting list size continues to increase marginally each month, with around 2% growth seen in M2 at all three acute Trusts. This growth in waiting list is mirrored nationally with 2.6% growth on total England waiting lists, and a total of 6.61m (4.42m Jan 20) patients waiting for elective treatment.

The focus continues on reducing the longest waiting patients – there were zero patients waiting longer than 104 weeks in M2 at SFT and GWH, and 3 at RUH, down from a collective 6 in M1. The number of patients waiting over 78 weeks collectively reduced from 286 in M1 to 264 in M2.

Diagnostic Wait Times (DM01) Target 99%

National Key Performance Indicators



Data Quality Rating:

Performance Latest Month: 76.56%

Waiting List Volume: 5729

6 Week Breaches: 1343

Diagnostics Performed: 6841

Modality performance

MRI	55.2%	US	84.9%	Audio	47.3%	Neuro	100.0%	Flexi sig	93.2%
CT	100.0%	DEXA	100.0%	Cardio	49.0%	Colon	95.4%	Gastro	96.6%

Background, what the data is telling us, and underlying issues

M3 resulted in further deterioration of the DM01 performance with and end of month position of 76.56% vs. M2 performance of 83.55%. This represents a total of 1343 patients breaching the 6 week wait standard in M3 as compared to 870 in M2.

The key modalities failing to meet the DM01 standard are MRI (551 breaches), USS (324 breaches) and Cardiology Echo (370 breaches). Audiology and Endoscopy also reported breaches – 77 and 21 respectively.

There were no breaches reported in CT, DEXA and Neurophysiology.

Activity reduced in M3 compared to M2, from 7396 tests completed to 6841. this will likely increase by +150 once endoscopy activity is coded.

Key contributing factor for the volume of breaches and reduction in activity are workforce availability (across all areas) and also a slightly reduced working day month due to double bank holiday. WTE vacancies exist in MRI (-4.5WTE in CT/MRI, -2.6WTE in USS, -2.84WTE in Echo)

Improvement actions planned, timescales, and when improvements will be seen

The three ongoing areas of concern for DM01 are MRI, USS and Echo:

MRI recovery options paper in discussion between Radiology & CSFS DMC. Restoration of MRI DM01 position circa six months to improve (MRI1 replacement project and reporting capacity issues constrain the options for a quicker solution).

USS seeking additional agency Sonographer resource as there are further leavers in the team M2-M5.

Echo continue to seek agency and outsourcing support although options are limited. Improved position on M1 due to team picking up additional capacity where possible. Looking to system partners (e.g., community heart services) for support.

Risks to delivery and mitigations

MRI scans take up to 1 hour per scan – backlog will require a high volume of lists to clear and require medium/long term 'fix'. Could consider insourcing from private provider for 'quicker fix' but financial impact will be high.

MRI1 replacement project from late M4 resulting in one less scanner in operation for 4 months. Mobile van scanner has recently been replaced; service will plan to utilize 10-14 session per week.

USS substantive workforce – reducing numbers, hard to recruit to posts. Rolling advert and agency staff to mitigate. Long term have trainees in team.

Echo – sustainability risk of overtime within small team. Mitigate with agency but very limited options of candidates.

Statistical Process Control Chart Key:

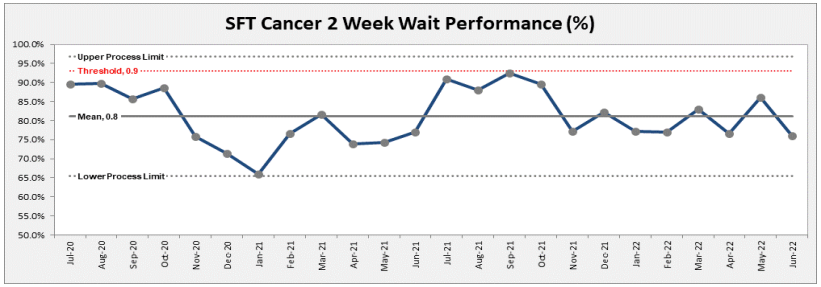
- Target
- Mean
- Upper / Lower Process Control Limits (UPL/LPL)
- Special Cause Variation Improvement (6 or more points better than the mean, or a single point outside the control limit)
- Special Cause Variation Concern (6 or more points worse than the mean, or a single point outside the control limit)
- Common Cause Variation

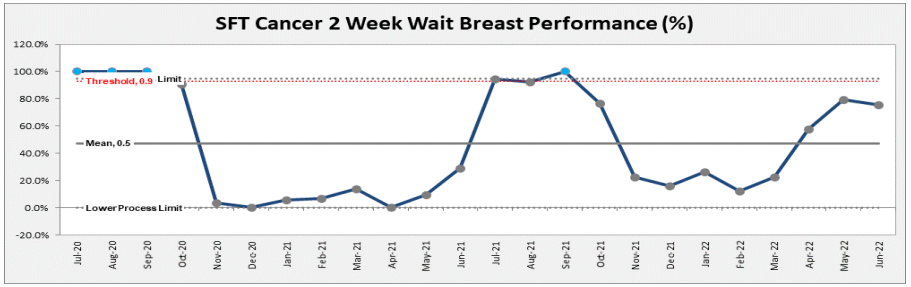
Cancer 2 Week Wait Performance Target 93%

National Key Performance Indicators

Performance Latest Month	Performance	Num/Den	Breaches
Two Week Wait Standard:	75.91%	772/1017	245 (77 patient choice)
Two Week Wait Breast Symptomatic Standard:	75.68%	28/37	9 (1 patient choice)

Data Quality Rating:





Background, what the data is telling us, and underlying issues

Two week wait standard not achieved for Month 3, with validated month end performance of 75.91% (1017 patients seen; 772 in target; 245 breaches). Breach reasons associated with:

- Clinic capacity: 78 breaches (across all services)
- Patient choice: 77 breaches
- Delayed vetting of requests: 6 breaches
- Endoscopy capacity: 68 breaches
- COVID-19 delay: 1 breach
- Incomplete GP referrals: 2 breaches
- Clinical delay: 4 breaches
- Administrative delay: 7 breaches
- Care home/prison delay: 2 breaches

Breast symptomatic two week wait standard not achieved for Month 3 (37 patients seen; 28 in target; 9 breaches). Breach associated with clinic capacity.

28-day Faster Diagnosis Standard not achieved for Month 3, with month end performance of 72.73% (1012 patients diagnosed; 736 in target; 276 breaches).

Improvement actions planned, timescales, and when improvements will be seen

Cancer Waiting Times Guidance Consultation: Consultation on revised national standards has now concluded. The proposal includes the phase out of the two week wait standard, to be replaced by the 28-day Faster Diagnosis standard. National team have suggested that revised guidance is due to be published from July 2022, with changes enforced from October 2022 onwards.

CQUIN 2022/23 re compliance with timed diagnostic pathways for Cancer Services: Expectation that 65% of prostate, colorectal, lung and OG cancers meet the pathway milestones outlined within the national optimum timed diagnostic pathways. Services have already completed a plan on a page to facilitate delivery, and retrospective data collection is underway.

Colorectal Consultant Capacity: GI Unit have recruited a locum Colorectal Consultant from ID Medical to alleviate 2WW OPA capacity pressures, and to assist with Endoscopy lists for GI.

Risks to delivery and mitigations

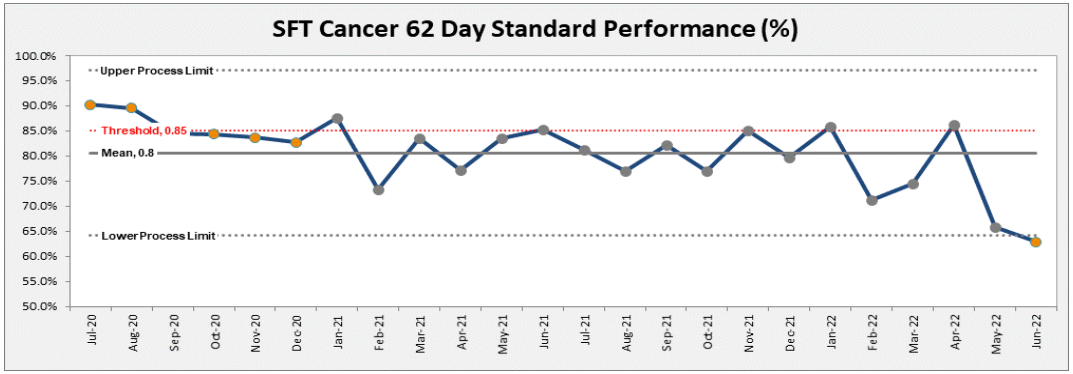
Patient choice: Ongoing challenges with patient choice delays and cancellations. There are however limited opportunities to offer a second appointment within the two-week timeframe due to capacity constraints.

Colorectal Consultant Capacity: Challenges associated with workforce pressures and high volumes of two week wait referrals.

Statistical Process Control Chart Key:
- Target
- Mean
- Upper / Lower Process Control Limits (UPL/LPL)
- Special Cause Variation Improvement (6 or more points better than the mean, or a single point outside the control limit)
- Special Cause Variation Concern (6 or more points worse than the mean, or a single point outside the control limit)
- Common Cause Variation

Cancer 62 Day Standards Performance Target 85%

National Key Performance Indicators



Data Quality Rating:

June 22	Performance	Num/Den
62 Day Standard:	62.88%*	41.5/66
62 Day Screening:	28.57%	1/3.5

*62 day performance is subject to change prior to final submission

Background, what the data is telling us, and underlying issues

Month 3 62-day performance standard not achieved, with a validated month end performance of 62.88% (66 patients treated; 41.5 in target; 24.5 breaches).

- **Colorectal:** 5 breaches (complex pathways, patient choice, Oncology capacity)
- **Gynae:** 1 breach (complex pathway)
- **Haematology:** 1 breach (COVID-19 delay)
- **Lung**: 1.5 breaches (patient choice, COVID-19 delay, complex pathway)
- **Skin:** 2 breaches (patient choice)
- **Upper GI:** 4 breaches (complex pathways, patient choice)
- **Urology:** 10 breaches (insufficient prostate cancer diagnostic capacity, incomplete diagnostic resections, complex pathways).

62 day screening standard not achieved for Month 3, with validated month end performance of 28.57% (3.5 patients treated, 1 in target, 2.5 breaches). Breaches associated with insufficient bowel cancer screening diagnostic capacity.

31 day performance standard not achieved for Month 3, with validated month end performance of 93.75% (96 patients treated; 90 in target; 6 breaches).

Improvement actions planned, timescales, and when improvements will be seen

Impact of pharmacy capacity on delivery of chemotherapy: Business case within pharmacy to increase staffing capacity and provide resilience has been approved.

Establishment of non-specific symptom pathway: Pathway currently being scoped with BSW ICB to support patients with "vague symptoms" who may otherwise undergo lengthy diagnostic pathways. Pathway Navigator due to commence in post in August 2022, and recruitment of GP Lead role currently underway.

Prostate pathway improvement: Surgery DMT working alongside Urology Services to develop an improvement plan to reduce the length of cancer diagnostic and treatment pathways for prostate patients.

Access to PET-CT: Capacity constraints raised within Alliance Medical, as well as through SWAG/Wessex cancer alliances and BSW ICB. Working group established with regards to mobile PET-CT scanner for Salisbury patients. Timescales yet to be confirmed.

Cancer waiting times guidance consultation: Consultation has now concluded. Proposal includes amalgamation of all 31-day standards (including subsequent treatments) and all 62-day standards (including upgraded and screening). National team have suggested that revised guidance is due to be published from July 2022, with changes to be enforced from October 2022 onwards.

Histopathology reporting: A Consultant Histopathologist will be starting in August 2022 to report GI cases, which will allow existing Consultants to report other cancer cases.

Risks to delivery and mitigations

Patient fitness: Increase in number of 62-day breaches associated with patient fitness and comorbidities.

Access to PET-CT: Service provided by Alliance Medical. Capacity has the potential to adversely affect pathways across all tumour sites and could affect delivery of the 62-day standard.

Histopathology reporting turnaround times: Ongoing challenges associated with Consultant Histopathologist capacity, which often results in cancer histology being outsourced. This in turn increases the timeframes for reporting and can delay diagnosis and treatment.

Diagnostic capacity within the prostate cancer pathway: Challenges associated with diagnostic pathway for prostate patients, in part due to historical pathway processes but also insufficient template biopsy capacity and accessibility to equipment. This is impacting 28- and 62-day performance.

Oncology capacity: Issues in aseptic and staff workforce have had a knock-on effect to waiting times for chemotherapy.

Capacity at tertiary centre: capacity issues around radiotherapy at tertiary centres, because of an increase in demand, has resulted in longer waits.

Statistical Process Control Chart Key:
- Target
- Mean
- Upper / Lower Process Control Limits (UPL/LPL)
- Special Cause Variation Improvement (6 or more points better than the mean, or a single point outside the control limit)
- Special Cause Variation Concern (6 or more points worse than the mean, or a single point outside the control limit)
- Common Cause Variation

Stroke & TIA Pathways

Are We Effective?

SSNAP Case Ascertainment Audit

Highest level = Grade A

Lowest level = Grade E

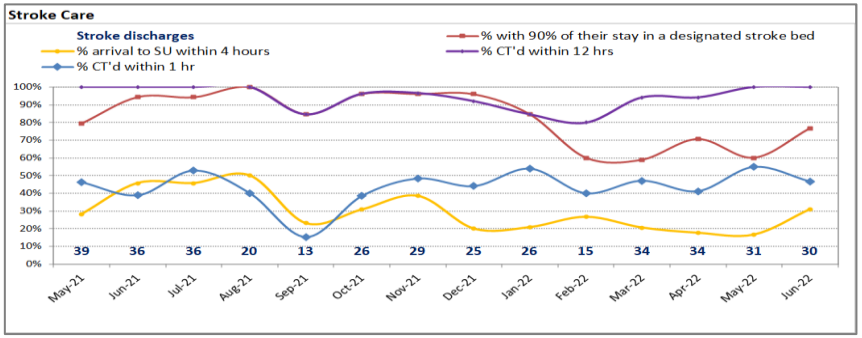
Quarterly	Q1	Q2	Q3	Q4
2020-21	Not Reported	Not Reported	Not Reported	Not Reported
2021-22	C	C	C	D
2022-23				

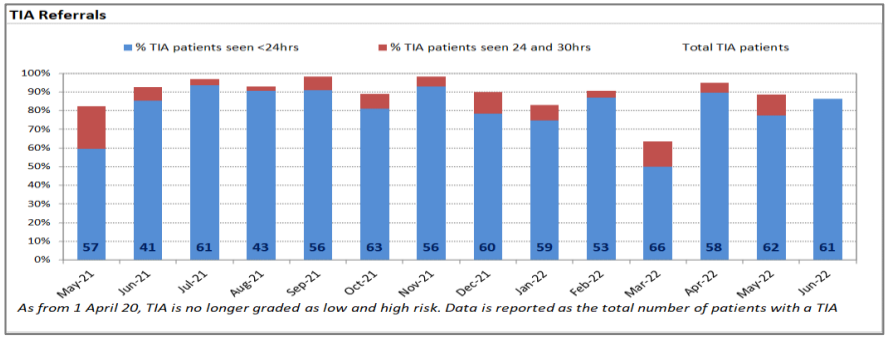
Data Quality Rating:

% Arrival on SU <4 hours: 31.0%

% CT'd < 12 hours: 100%

% TIA Seen < 24 hours: 86.2%





Background, what the data is telling us, and underlying Issue*[Please note: Data is often only partially validated with informatics at the time of publishing. Coding can sometimes result in minor adjustments to the data at a later date].*

- There were 30 stroke discharges this month.
- There was 1 stroke death within 7 days and 2 deaths within a 30-day period in June.
- 90% stay in the stroke unit was 77% this month which is an increase from last month: 1 to AMU first, 6 SLOS.
- The number of patients reaching the stroke unit within 4 hours is 31%
- Average stroke unit length of stay was 10 days and average total length was 10 days.
- 47% of patients had a CT within an hour which is a slight decrease from the last month. CT within 12 hours was 100%
- 3 patients were thrombolysed with an average door to needle time of 75 minutes.
- 13 of the eligible 27 patients were referred to ESD in June.
- 86% of the 65 TIA's had treatment completed within 24hrs; with 1 full clinic, 1 MRI next day, 5 delayed referrals

**We received a SSNAP Level of D with a score of 54.2 for the period Jan-Mar 2022 **

Improvement actions planned, timescales, and when improvements will be seen

As of the 6th of May, Farley has returned as a fully operational Stroke unit and patients are no longer required to go to Breamore ward for rehab.

There are ongoing plans in place for collaborative efforts with the team leaders, emergency department, Radiology and Site matrons to discuss multiple factors impacting on targets, and how to improve future targets.

- There will be simulation training to the emergency department to improve recognition of a stroke and hyperacute care and the importance of timely transfers to the stroke unit. Date TBC.
- Training has been started to all new staff members on the ward which focuses on the stroke targets to give more of an understanding of the importance of these and how to achieve them more effectively. This is ongoing.

The Emergency Department has still been experiencing an increased workload as well as operational pressures and staff shortages due to another wave of COVID-19. This is likely to impact on targets.

Part 2: Our Care

Performance against our Strategic Priorities and Key Lines of Enquiry

Our Priorities	How We Measure	
People	Are We Effective?	Are We Responsive?
Population	Are We Safe?	Are We Caring?
Partnerships	Are We Well Led?	Use of Resources

Maternity

Are We Safe?

01/06/2022 <- Reporting Month (Input the first of the REPORTING month)

	SFT Assurance Dashboard	Guidance	Standard	Improvement Directio	Rolling 6 months Jan-22	Feb-22	Mar-22	Apr-22	######	Jun-22	Rolling 6m averag
Perinatal Morbidity and Mortality (M&M)	Number of late fetal losses (22+0 to 23+6 weeks excl TOP)			Down	0	0	0	0	0	0	0
	Number of stillbirths (> + 24 weeks excl TOP)	ONS	3.8 per 1000 live births	Down	0	0	2	0	0	0	0
	Number of neonatal deaths : 0-28 days	ONS	2.7 per 1000 live births	Down	0	0	0	0	1	0	0
	Medical termination over 24 +0 registered			Down	1	0	0	0	0	1	0
Maternal M&M	Number of Maternal Deaths	ONS	9.1 per 100,000 women who delivered	Down	0	0	0	0	0	0	0
	Number of women requiring admission to ITU	6 month SFT rolling		Down	0	0	0	0	0	2	0
Insight	Number or datix incidents - moderate or above	6 month SFT rolling		Down	0	2	1	1	2	3	2
	Datix incidents moderate harm (not SII)	6 month SFT rolling		Down	0	2	1	0	1	3	1
	Datix incidence SII	6 month SFT rolling		Down	0	0	1	0	1	0	0
	HSIB referrals	6 month SFT rolling		Down	0	0	0	0	0	0	0
	HSIB/NHSR/CQC or other organisation with a concern or request	6 month SFT rolling		Down	0	0	0	0	0	0	0
	Coroner Reg 28 made directly to trust	6 month SFT rolling		Down	0	0	0	0	0	0	0
Workforce	Minimum safe staffing in maternity services : Obstetric cover	RCOG guidence		NA	40	40	40	40	40	40	40
	Midwife to Birth ratio	RCM;NHSR;BR+	1.28	NA	1.26	1.31	1.28	1.31	1.32	1.32	NA
	Midwifery vacancy rate (black= over establishment; red =under			up	10 WTE	14.65	14.65	17.2	17.4	17.4	NA
	Provision of 1 to 1 care in established labour (%)	NICE, RCM, MIS	100%	Up	100	NA	NA	100	100	100	NA
	Datix relating to workforce	6 month SFT rolling		Down	1	0	2	3	1	0	1
	Compliance with supernumery status of the LW coordinator - %	NICE;RCM;NHSR	100% rostered	Up	100	NA	NA	100	100	100	NA
	Numbers of times maternity unit on divert	6 month SFT rolling		Down	0	0	0	0	0	0	0
Involvement	Service user feedback : Number of Compliments	6 month SFT rolling		Up	19	31	32	27	27	31	28
	Service user feedback : Number of Complaints	6 month SFT rolling		Down	2	4	2	2	0	1	2
	Number of SOX	6 month SFT rolling		Up	5	11	7	8	7	6	7
Assurance	Progress in achievement of 10 safety actions(CNST)	NHSR	10	Up	4	4	4	5	5	7	5
	Training compliance - MDT PROMPT %	NHSR	90%	Up	74	74.2	75.2	72.3	83.63	86.5	NA

Perinatal Quality Surveillance Tool

The information provided represents the recommendation from the Ockenden report. SFT is further developing this dataset to ensure the Board is informed of safety metrics and indicators.

What does the data tell us ?

- The midwife vacancy rate is stable but remains challenging.
- There have been delays with international recruitment (due to delays with the agency and collaboration).
- Agency midwives have been block-booked to help fill vacancies over the summer.

What actions are being taken to improve?

Recruitment is ongoing. There has been targeted support from the recruitment team around making the process as seamless as possible in order to assist new starters into the workplace. The communications team are also providing support for a media campaign.

Incidents

2 ITU admissions, following a massive obstetric haemorrhage (MOH), were appropriately reported as moderate on Datix. 72-hour reviews did not identify any care omissions and concluded that the ITU admissions were appropriate.

An insight visit from the local maternity and neonatal system (LMNS) and local commissioners occurred in early June. There was some extremely positive feedback around the team and service, particularly noting the improvements made in the last 12 months.

Maternity Clinical Dashboard

Data Quality Rating:

Are We Safe?

	South West Region						National			
Measure	**Min**	**Median**	**Max**	**Improve direction**	**Green**	**Red**	**Mar-21**	**Apr-22**	**May-22**	**Jun-22**
Babies (incl Non Reg)	179	180	190					180	179	190
Women Delivered	175	176	188					175	176	188
Homebirth rate	3.3%	3.4%	4.8%					3.3%	3.4%	4.8%
Inductions %	36.4%	43.1%	43.4%					43.4%	36.4%	43.1%
Apgar less than 6 @ 5 min %				Down	1.2%	3.5%	Green <1.2%, red >3.5% NMPA	0.6%	0.6%	0.5%
Shoulder dystocia (severe & moderate)	1.7%	2.1%	4.5%	Down				0.0%	0.0%	0.0%
PPH >= 1, 500 %	0.0%	0.0%	0.0%	Down	2.7%	5.6%	Green <2.7%, red >5.6% NMPA	4.0%	4.5%	2.7%
Third & Fourth degree tears SVD	0.0%	0.0%	0.0%	Down				2.7%	0.9%	2.7%
Third & Fourth degree tears assisted	0.0%	0.0%	0.0%	Down				0.0%	13.3%	7.7%
Total 3 + 4 degree tears	0.0%	0.0%	0.0%	Down	3.5%	6.5%	green <3.5%, red >6.5% NMPA	2.3%	2.4%	3.6%
Term babies admitted to NNU unexpectedly %	0.0%	0.0%	0.0%	Down	5.5%	5.8%	<5.8% NMPA	1.7%	4.5%	2.1%

Clinical outcomes within expected ranges.

Maternity Incentive Scheme (CNST) year four

All available data has been submitted to auditors who will be producing a report shortly.

Current risks for MIS are:

- **Safety action 2** – As we do not have the 'continuity of carer' model running at present this will affect compliance, however, Ockenden has recommended not putting 'continuity of carer' into place unless the building-blocks are embedded firstly (one of which is staffing), and our staffing currently does not allow us to proceed with this model of care. We have worked with *Euroking* (digital programme) to increase our compliance from 7/11 to 9/11 MSDS CQIMS.

- **Safety action 6-** Uterine artery Dopplers have not yet been introduced at SFT, although relevant staff have received training. Carbon monoxide monitoring also remains a risk, but work has been done to increase reporting and data for this, and the data collection required for this safety action.

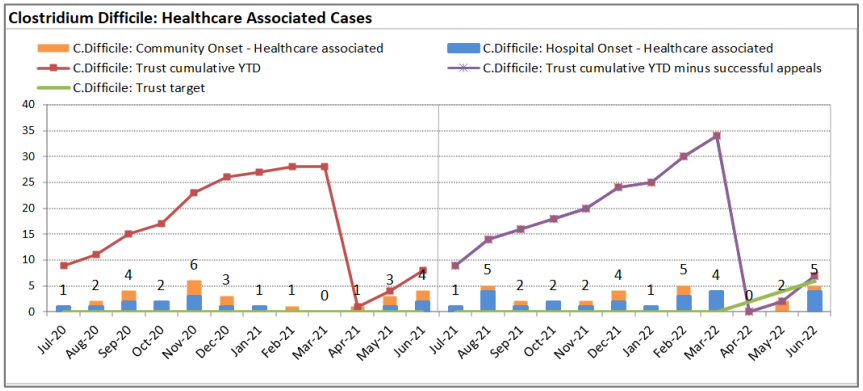
Infection Control

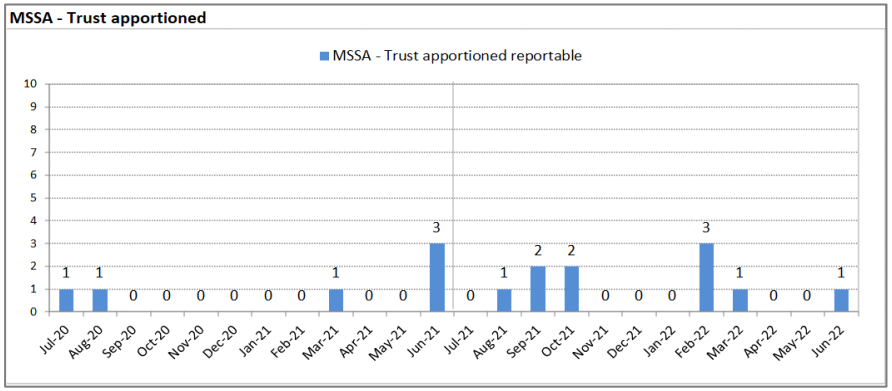
Data Quality Rating:

Are We Safe?

Clostridium Difficile	Sep 21	Oct 21	Nov 21	Dec 21	Jan 22	Feb 22	Mar 22	Apr 22	May 22	Jun 22
Cases Appealed	0	0	0	0	0	0	0	0	0	0
Successful Appeals	0	0	0	0	0	0	0	0	0	0

MRSA	2021-22	2022-23
Trust Apportioned	3	0





Summary including learning outcomes and actions – June 2022

- **No MRSA bacteraemia** cases were identified.
- **No hospital onset *E.coli* bacteraemia cases** were identified.
- **One hospital onset healthcare associated MSSA bacteraemia case** was identified. [Source of bloodstream infection unknown with associated clinical infection identified as lower respiratory tract infection - awaiting outcome of investigation by the division].
- **Four hospital onset healthcare associated reportable *C.difficile* cases** were identified within the Medicine and Women & Newborn divisions. [Awaiting outcomes of investigations – A period of increased incidence (PII) of *C.difficile was* identified for Farley Ward following the identification of 3 cases linked to the ward template occurring within a defined timeframe].
- **One community onset healthcare associated reportable *C.difficile* case** was identified. [The patient had been recently discharged from an inpatient area - additional investigation is ongoing for this case].

(Of note: there are outstanding investigations for some of these cases and therefore the learning or themes have not yet been identified. These hospital onset cases are scheduled for discussion at the next 'Share & Learn' meeting which will take place in July).

Pressure Ulcers

Are We Safe?

Per 1000 Bed Days	2021-22 Q1	2021-22 Q2	2021-22 Q3	2021-22 Q4	2022-23 Q1
Pressure Ulcers	1.47	1.30	1.84	1.88	2.11

Data Quality Rating:

Summary and Action

There were 36 Category 2 PU's in June, small increase from 33 in May. Medicine contributed 19 to this number, with one ward having seen a significant number. The Tissue Viability team have discussed actions with this ward, have identified learning opportunities, and will provide bitesize teaching sessions as well as working with the ward leads to further improve knowledge and understanding. There were 13 Category 2 PU's within Surgery and 4 within CSFS. Cat 2 PU's continue to be most found on sacrum/buttocks and heels. As in previous months, we have found that most of the patients with hospital acquired PU's are being nursed on pressure relieving mattresses.

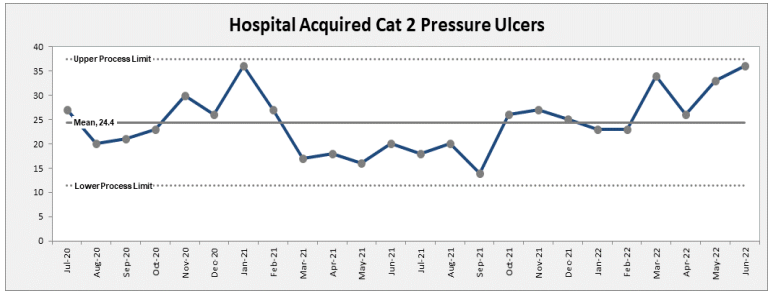
No Category 3 or 4 PU's were identified in June.

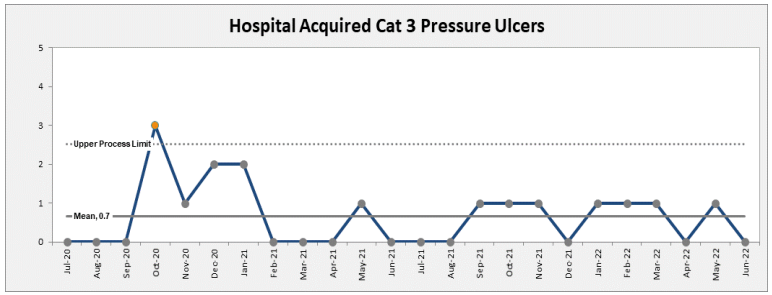
18 Deep Tissue Injuries in June, a significant increase from 7 in May. 16 of these were acquired within the medical division and most commonly on patient heels. One patient was found to have multiple Deep Tissue Injuries on their feet. This patient was wearing Orthotic pressure relieving boots and it is thought that the boots may be the cause of these multiple DTI's in conjunction with extremely frail and fragile skin. This patient was acutely unwell and has unfortunately passed away. No fault was found with the orthotic pressure relieving boots. As in previous months, it is likely that there were missed opportunities for early identification of vulnerable areas due to operational pressures and missed education opportunities leading to DTI's.

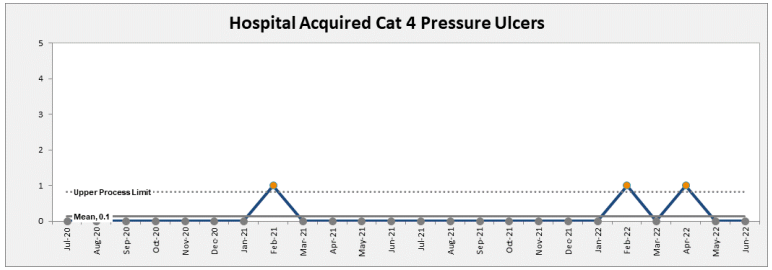
There have been significant operational pressures and acute staff shortage in all divisions, reflected within Safecare data, which may have contributed to the increased number of PU's.

Weekly Matron Huddle meeting time changed to aid attendance. Pressure Ulcer Prevention education available twice a month and can be booked via Learn. Tissue Viability also undertake education and training with wards informally, where possible, providing bitesize education on skin checks and pressure ulcer prevention methods during ward visits and attending ward arranged training days to deliver education in areas that have had significant PU numbers or hospital acquired cat 3/4 PUs.

The monthly Share and Learn meeting took place in June, time used as a forum for all ward leads to review and discuss what they would like from the Share and Learn meetings and how it could be utilised more effectively for better learning and development. Attendance was mandatory for all ward leads; however, several people did not attend. It was decided that incidents would be reviewed by focusing primarily on the themes identified from wards who have had multiple PUs and the actions each ward have or are taking to prevent this from happening in the future. Wards to be tasked with an action to complete and feedback on in the next meeting to encourage improved involvement and ensure the group remain effective and proactive. We have devised a new agenda and Terms of Reference, and this will be utilised for the first time in July's Share and Learn meeting. The Tissue Viability team are looking into improving the way PU's are investigated and fed back to the wider MDT.







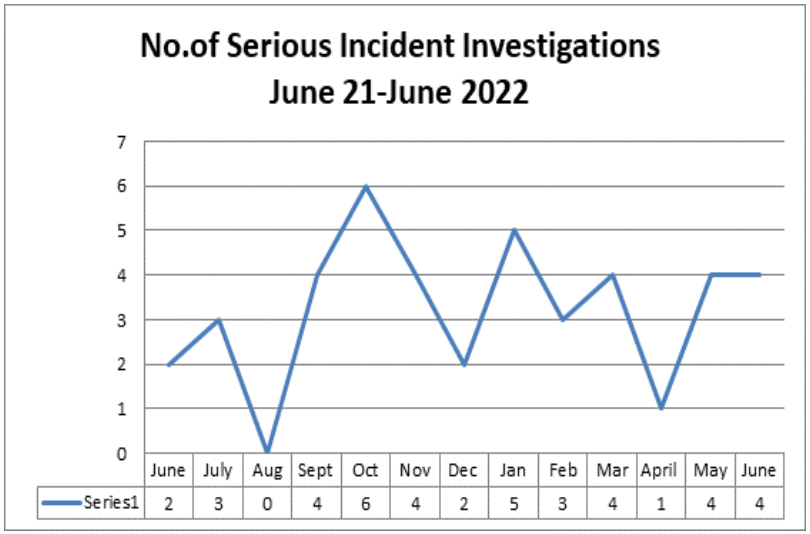
Statistical Process Control Chart Key:
- Target
- Mean
- Upper / Lower Process Control Limits (UPL/LPL)
- Special Cause Variation Improvement (6 or more points better than the mean, or a single point outside the control limit)
- Special Cause Variation Concern (6 or more points worse than the mean, or a single point outside the control limit)
- Common Cause Variation

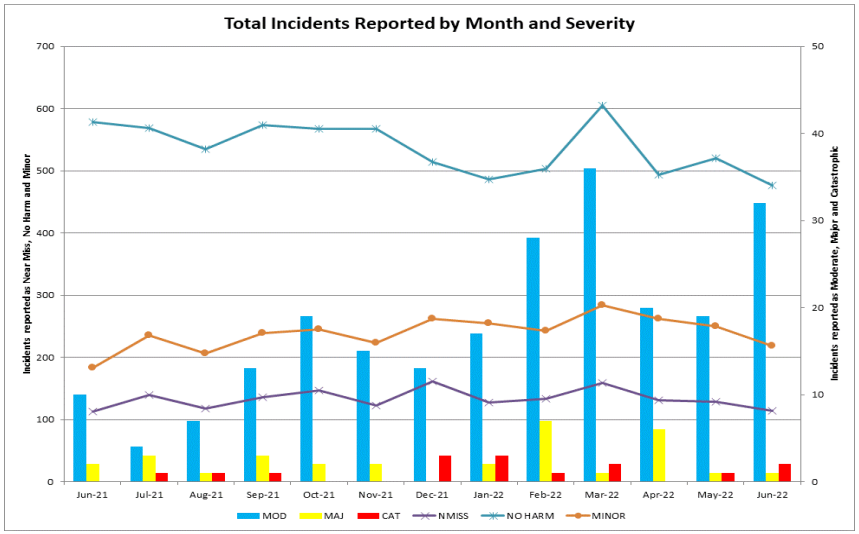
Incidents

Are We Safe?

Year	2021-22	2022-23
Never Events	3	0

Data Quality Rating:





Summary:

SII 487 – A grade 3 pressure ulcer in a patient with a learning disability (incident occurred in May)

SII 488 – A lack of mortuary freezer space.

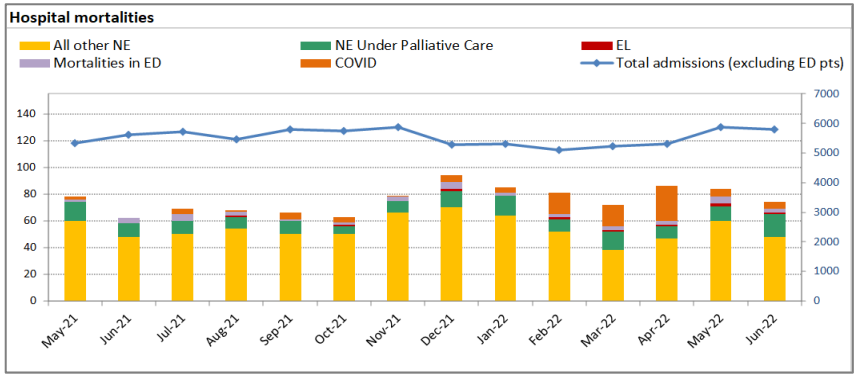
SII 489 - A 23-week neonatal death (maternity)

SII 490 - A major haemorrhage occurring post-biopsy

Mortality Indicators

Data Quality Rating:

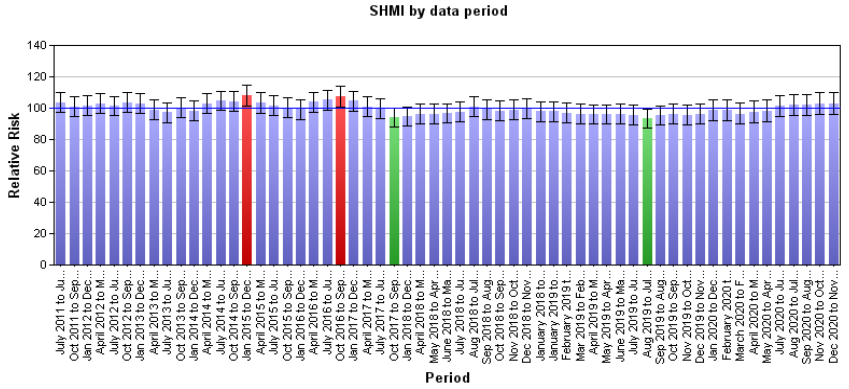
Are We Safe?

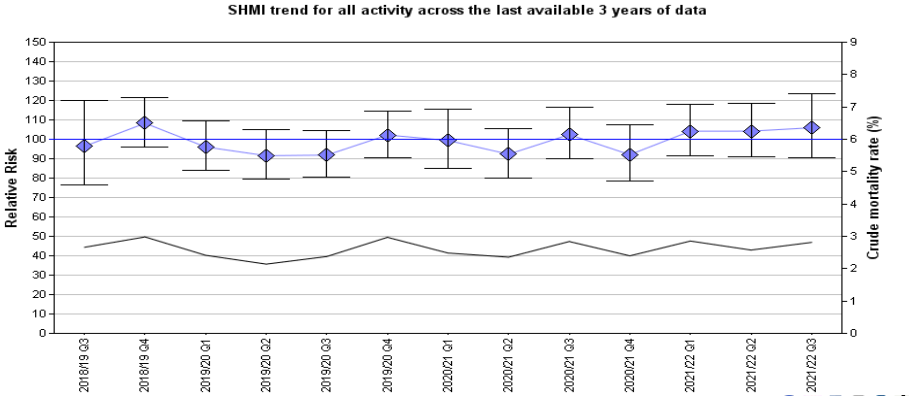


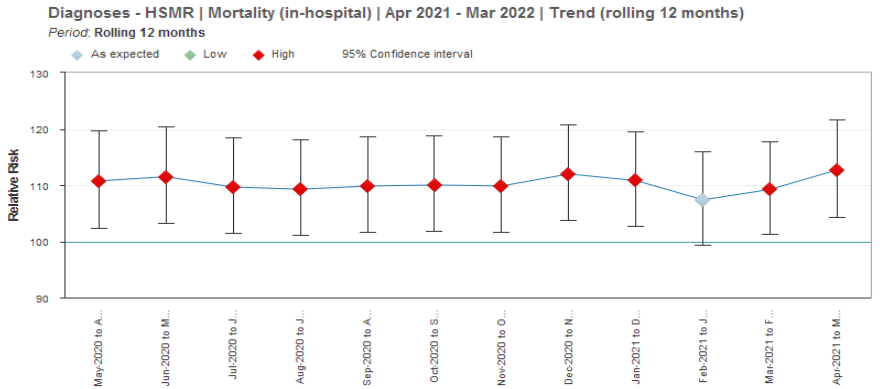
Summary and Action

- **The latest SHMI** for Salisbury District Hospital represents the 12-month period of March 2021 – February 2022 and is 1.0548. This is within the expected range.
- **The latest HSMR** represents the 12-month rolling period of April 2021 – March 2022. The relative risk is 112.7 and this is statistically higher than expected.
- There were 5 reported COVID deaths in June (deaths within 28 days of a positive PCR test and/or COVID on death certificate).

Site code	Site name	Provider spells	Observed deaths	Expected deaths	SHMI value
RNZ02	Salisbury District Hospital	34,280	990	940	1.0548
RNZ78	Salisbury Hospice	100	65	30	2.3086

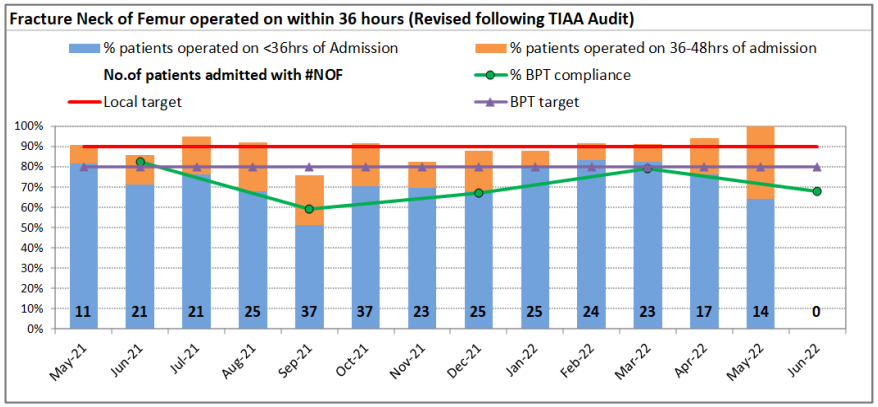






Fracture Neck of Femur & VTE Risk Assessment/Prophylaxis

Are We Safe?



(Please note: due to the time it takes to complete clinical coding, the fracture neck of femur data for the current month may not be displayed on the graph above)

BPT%: June 2022

- Total patients discharged: 28
- Not applicable for BPT: 4 (2 PP# & 2 no operation)
- Number of patients who failed to meet BPT: 8

Reason for failure:

- Awaiting Theatre Space: 4 patients
- Other (Awaiting hip surgeon & Transfer from Poole): 2 patients
- Awaiting medical review/investigation or stabilisation: 1 patient
- Awaiting orthopaedic diagnosis/investigation: 1 patient

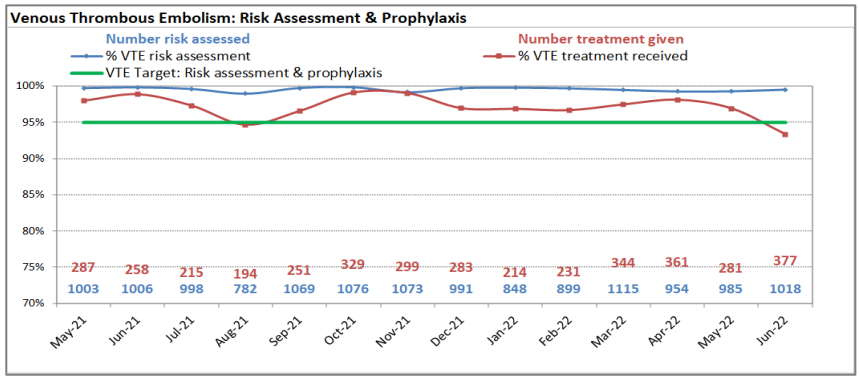
- **BPT %: 66.7%**
- **Average LOS** = 24.93 days
- **Median LOS** = 13 days

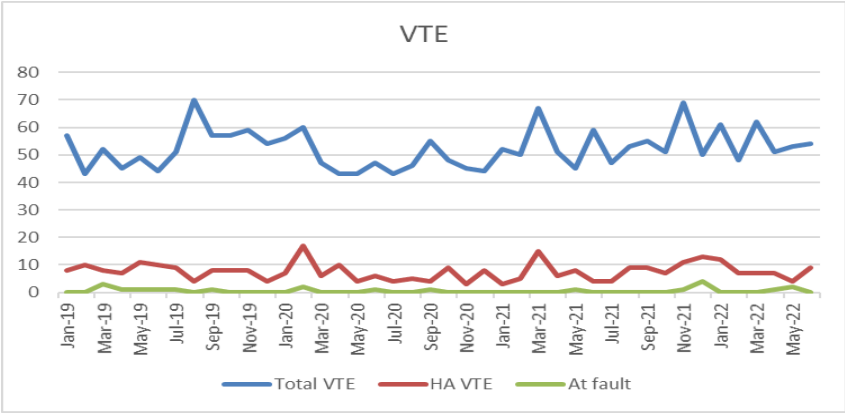
BPT% Q1 Figures 22/23

- Total patients discharged: 87
- Not applicable for BPT: 12 (7 PP# & 5 no operation)
- Number of patients who failed to meet BPT: 24

- **BPT %: 68%**
- **Average LOS:** 24.8 Days
- **Median LOS:** 18 Days

Data Quality Rating:





Hospital Associated VTE

Total number of VTE in June 2022: 54

Hospital Acquired (HA) VTE: 9 – 16.6% of total VTE, National average 25%

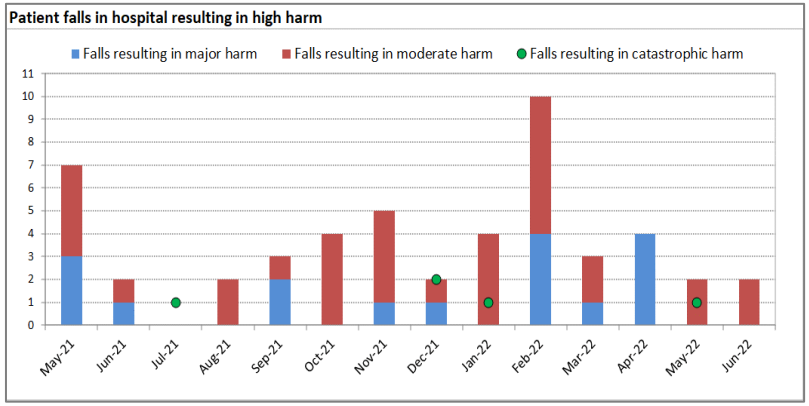
0.18% of total admission. National average 0.5 – 1.6%

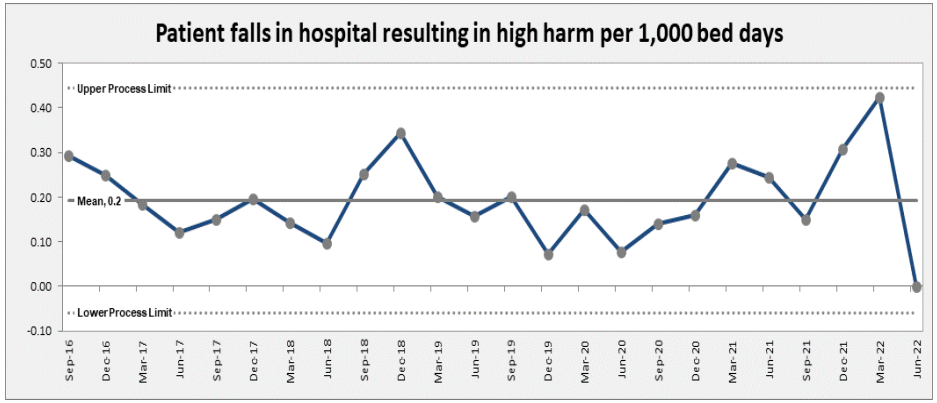
All patients diagnosed with a VTE are assessed and flagged as HA if associated with a hospital admission / surgery within 90 days of their diagnosis and a root cause analysis is completed. No obvious concerns were noted, and all patients has received appropriate thromboprophylaxis.

Patient Falls

Are We Safe?

Data Quality Rating:





Summary and Action

In June there were **2 falls with moderate harm** reported:

- 1 extension of a subdural hematoma and 1 subarachnoid hemorrhage. Both patients were referred to the neurologist specialists and were treated conservatively.

At the end of quarter 4, **the falls rate per 1000 bed days has consistently dropped:**

- April 9.96
- May 7.86
- June 6.97 [as has fractures per 1000 bed days which was 0.00 for June].

Training continues at ward level with 127 members of staff attending falls reduction training by the end of June. Improving Together work will regenerate in July, although Pitton Ward continue to trial 3 initiatives to reduce the Ward's fall rate.

Lack of lying and standing BP monitoring continues to be a theme, as does accurate and timely risk assessments. Ward staffing levels has also had an impact with data being retrieved from mid-July onwards.

All wards have been reminded to complete their falls monthly audit which has been inconsistent and will be a focus for the summer months.

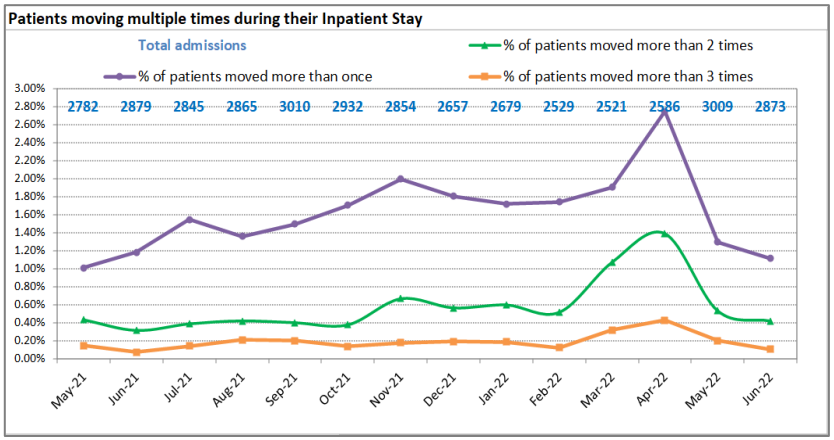
Statistical Process Control Chart Key:
- Target
- Mean
- Upper / Lower Process Control Limits (UPL/LPL)
- Special Cause Variation Improvement (6 or more points better than the mean, or a single point outside the control limit)
- Special Cause Variation Concern (6 or more points worse than the mean, or a single point outside the control limit)
- Common Cause Variation

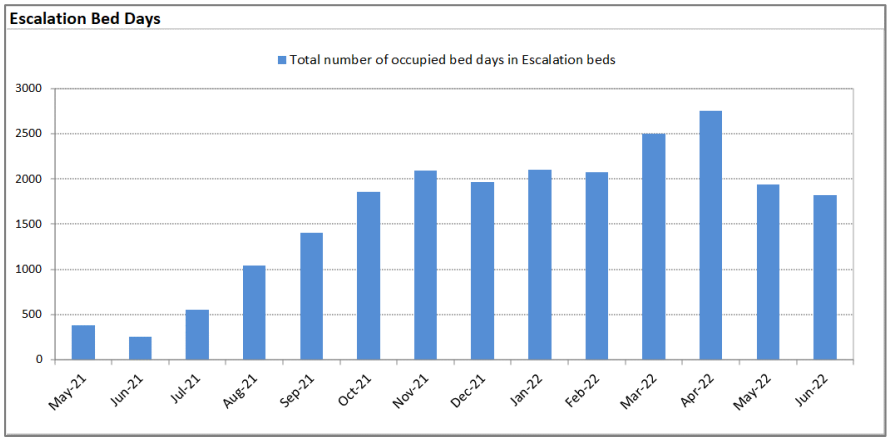
Patient Experience

Are We Safe?

Last 12 months	Jul 21	Aug 21	Sep 21	Oct 21	Nov 21	Dec 21	Jan 22	Feb 22	Mar 22	Apr 22	May 22	Jun 22
Bed Occupancy %	90.0	93.9	93.0	94.6	95.0	93.2	93.8	96.3	96.7	97.2	96.6	97.0

Data Quality Rating:





Summary and Action

Bed occupancy remained high at 97% in June however the trend post spike in April, shows moves at a similar level to June last year. However, the number of occupied bed days in escalation beds is approximately 4 times the number it was in June 21 and indicates a static group of patients after the reduction seen in May with SAFER.

The focus remains for all clinical and divisional teams to be able to provide the care needed by the right teams in the most appropriate space. Breamore has been used as a ward for patients no longer meeting criteria to reside but requiring services from health and social care on discharge which it is hoped has facilitated greater access to specialty beds for those who require them.

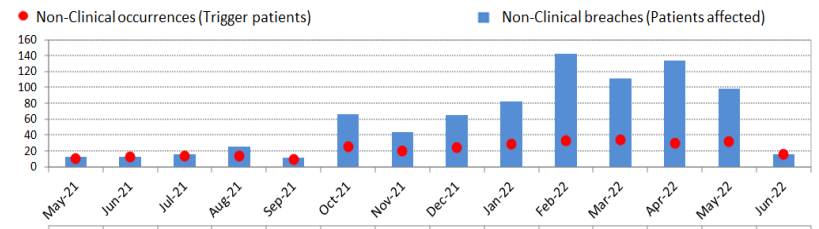
DSU on both floors has provided inpatient services in escalation and the patients in all escalation areas are reviewed by senior nursing representatives to gain assurance that safety and quality of service delivery and experience remain at the forefront of the team's agenda.

Patient Experience

Are We Safe?

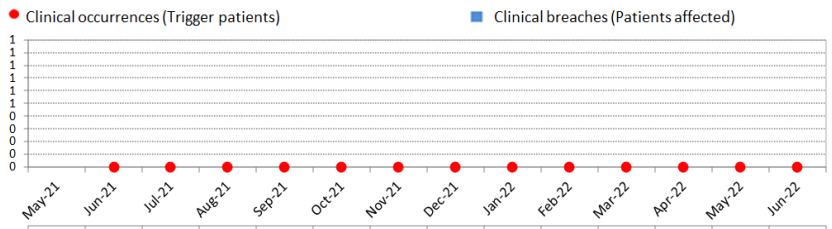
Data Quality Rating:

Delivering Same Sex Accommodation - Non-clinical



	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22
■	13	13	16	26	12	66	44	65	82	142	111	134	98	16
●	10	13	14	14	9	25	20	24	29	33	34	30	32	16

Delivering Same Sex Accommodation - Clinical



	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22
■		0	0	0	0	0	0	0	0	0	0	0	0	0
●		0	0	0	0	0	0	0	0	0	0	0	0	0

Summary and Action

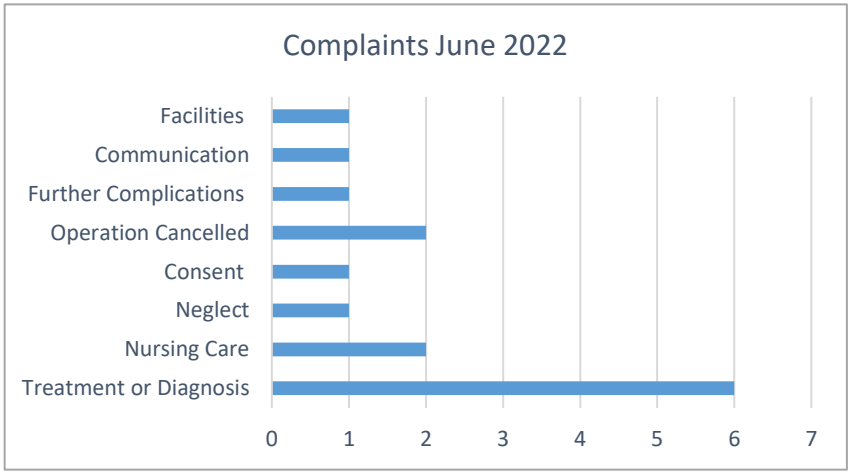
Delivering same sex accommodation for month of June has remaining a challenge for the organisation. Whilst no non-clinical breeches have been reported concerns exist as to the availability of accurate information due to a gap in personnel for what is predominantly a manual process. The reported 16 trigger patients represent patients classified as wardable from Radnor (ITU) and are reported with a level of certainty and confidence.

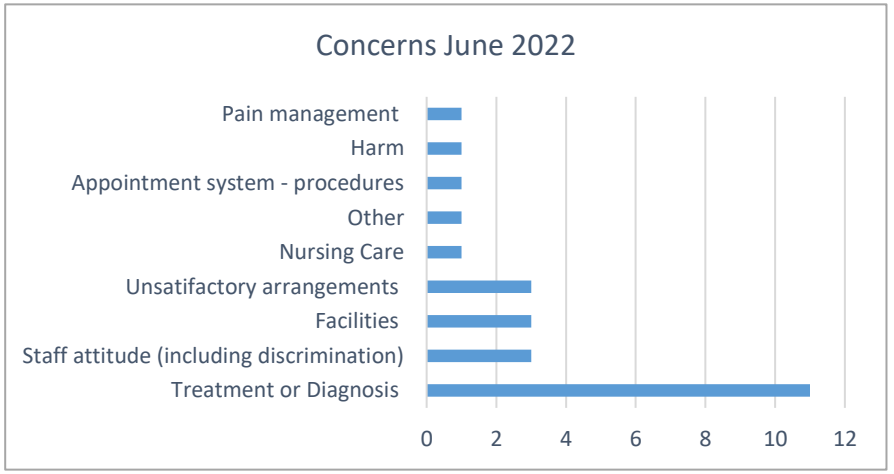
For all other patients who would breach single sex accommodation guidance, the wards are required to submit relevant paperwork capturing the incident, patients affected, timings, and cause. As part of a safety net to capture the required information a manual process and trawl through Lorenzo is undertaken. Due to concurrent challenges, staff shortages and prioritisation of direct clinical care, ward reporting of mixed sex breeches did not occur in the month of June, which also coincided with the departure of the key individual tasked with completing the manual Lorenzo process. Recruitment processes are already underway with replacement due to start August 2022, along with ongoing conversations and developments with IT partners to develop an automated process.

Patient & Visitor Feedback: Complaints, Concerns & Compliments

Are We Responsive?

Data Quality Rating:





Summary and Action

Complaints: Total of 15 complaints - this is a consistent number with those received in April and May.

Concerns: Total of 25 concerns - a small increase on May and April, but a considerable increase on March (+13).

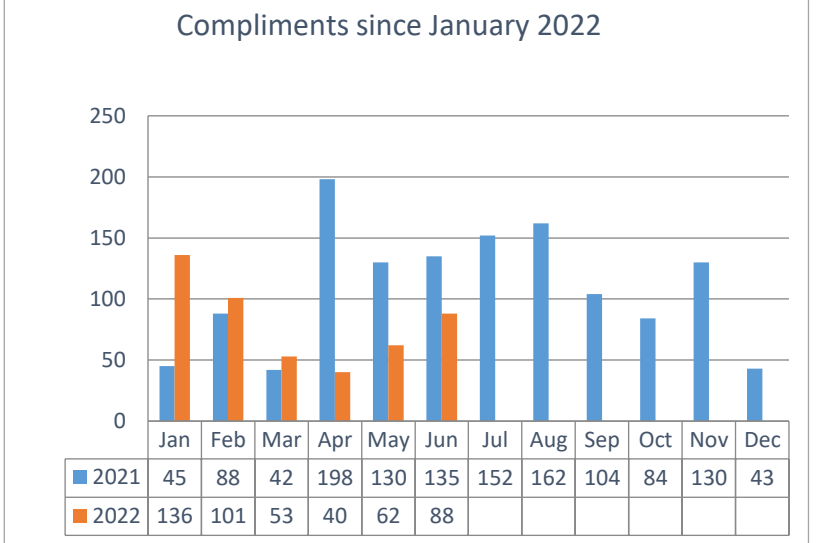
The main theme this month across both complaints and concerns is in relation to diagnosis or treatment* (**this includes Datix coding under inappropriate, dissatisfied, delayed or incorrect)*

The majority of concerns came from ED, accounting for 28% of the total concerns (n~7).

The majority of complaints came from Longford Ward, accounting for 13% of total complaints (n~2)

Compliments:

Number of compliments have doubled from April and FFT continues to show high levels of satisfaction from services users surveyed.



	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
2021	45	88	42	198	130	135	152	162	104	84	130	43
2022	136	101	53	40	62	88						

Part 3: Our People

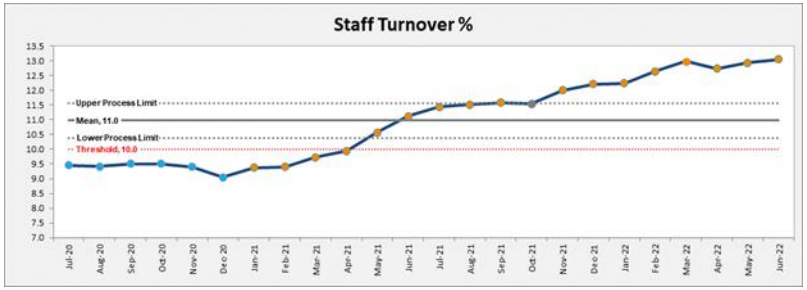
Performance against our Strategic Priorities and Key Lines of Enquiry

Our Priorities	How We Measure	
People	Are We Effective?	Are We Responsive?
Population	Are We Safe?	Are We Caring?
Partnerships	Are We Well Led?	Use of Resources

Workforce – Turnover

Use of Resources

Total Workforce vs Budgeted Plan - WTEs



Background – What is the data telling us, and underlying issues.

12 month turnover for month 3 (June) is 13.05%. This is a slight increase from last month's position of 12.93%.

In the month there were 39 leavers and 31 starters by headcount

Where recorded, principal reasons for leaving were "Retirement/Age" and "Relocation", which combined formed a third of all reasons for leaving.

Highest turnover by division was Women and Newborn (17.38%). Best performance was in Surgery (11.55%).

Highest churn was among Administrative and Clerical (16.96%) and Additional Clinical Services staff (16.39%).

BSW Benchmarking March 2022 - RUH Bath : 10.80%, GWH Swindon 15.26%.

2022/23 Q1			
	April	**May**	**June**
Leavers	40	39	39
Exit Q's	10	5	10
%	25%	13%	26%

Improvement actions planned, timescales and when improvements will be seen.

1. Career conversations:

BPs have been identifying staff in the three critical groups (under 30s, 45-year-olds and over and international nurses) and selecting priority teams for phase 1 based on high turnover and importance for 2022/23 operational plans. BPs have sourced supporting documents from the national NHS People Promise materials to assist managers.

In CSFS conversations have started with staff from Speech & Language and Medical Devices. Sexual Health team will be next in August. In Surgery priority teams have been identified (Secretariat, Central Booking, Theatres/DSU and Burns Unit, Downton and Amesbury wards). Medicine and Women & Newborn have identified Healthcare Support Workers as a priority staff group to have conversations in July/August. Both divisions will share the materials with relevant line managers.

2. Wellbeing conversations

After a successful pilot on Transformation & Informatics and Amesbury, Education are now launching the next phase of the programme to introduce wellbeing conversations. Agreed with BPs to demo the materials and process to DMTs, then to proceed with training further trainers to support the current training group and later wellbeing champions. Plan is for voluntary conversations in hard pressed clinical areas and wider roll out in non-clinical departments.

Risks to delivery and mitigation

Risk - defaulting on career conversation as per 22/23 planning guidance

Mitigation: Re-organising & targeting monthly completion as above

Risk: Line Managers not insisting staff complete exit interviews, in spite of regular communications designed to ensure that staff are aware of the opportunity and benefits.

Mitigation TBC

Workforce – Vacancies

Use of Resources

Total Workforce vs Budgeted Plan - WTEs

Jun-22	Plan WTEs	Actual WTEs	Variance WTEs
Medical Staff	490.6	449.9	40.8
Nursing	1103.6	1001.1	102.4
HCAs	516.3	498.1	18.2
Other Clinical Staff	717.4	694.2	23.3
Infrastructure staff	1432.2	1373.8	58.4
TOTAL	**4260.1**	**4017.1**	**243.0**

Background – What is the data telling us, and underlying issues.

Vacancy rate in month 3 (June) has seen an increase to 12.82%, compared to 12.00% in May. Vacancy rate in April saw a step change increase to 12.20%, compared to 3.88% in March.

Taking the additional establishment out, the vacancy rate would be 5.23% which would be above target (amber).

The Division with the highest vacancy rate was Women and Newborn at 17.05%. The Corporate area with the highest number of Vacancies was Procurement (15.91 FTE), followed by Informatics (13.29 FTE).

BSW benchmarking March 2022 – RUH Bath : 3.21%, GWH Swindon 6.33%.

Improvement actions planned, timescales and when improvements will be seen.

International RN recruitment – 30 offers of employment have been made to international nurses against an initial target of 40. First cohort of 9 international nurses due to arrive at the Trust on 11.08. An NHSEI bid was submitted on 08.07 for funding to recruit an additional 40 international nurses by 31.12. 10 of these would be for Theatres. No date has been confirmed for the Trust to receive the outcome from this bid.

International midwives – The Band 7 Practice Educator commenced on 01.07.2022. First international midwife arrivals expected to arrive in August. Interviews continue through the collaborative to recruit to 5 midwives for the Trust.

HCA's – 91.73 wte vacancies. It has been identified that vacancy numbers for HCA's has been incorrectly reported on since month 1. Work is currently ongoing to rectify the reporting as well as checking with Divisions that the vacancy numbers are accurate. A recruitment event is being held on 16.07. Recruitment campaign being devised to run from August through to October with a view to continually recruit HCA's to reduce the vacancy gap by end of 31.10.2022. A working group has been set up to review the current HCA training and induction programme with changes to the way induction training is currently delivered being implemented from 16 July 2022. Further work is ongoing to review the end to end onboarding process for HCA's to ensure that they are receiving the best welcome into the Trust from the point of offer through to being deployed on the wards.

Recruitment Team – recruiting to 7 vacancies which consists of four band 3 recruitment administrators (general x 2, theatres and international recruitment), one band 4 International Recruitment Co-ordinator, one band 5 Resourcing Specialist for Theatres and one band 7 Resourcing Manager. Appointments have already been made to two band 5 Resourcing Specialists, who will support Divisions with recruitment campaigns, improving candidate experience. Interviews for the band 7 are being held on 20.07. Appointments have also been made to three of the band 3's all due to commence during July. These appointments will strengthen the team's ability to attract, recruit and provide the best onboarding experience for candidates looking to join the Trust. Support is being provided to the Head of Resourcing by a People Business Partner over the next 6 – 8 weeks.

Hard to recruit – an offer of employment has been made to an international doctor to join the Gastroenterology Team. This candidate will be supported through the CESR route to enable them to obtain Consultant status within the UK. Three offers made to Consultant Radiographers. 1 Consultant Radiographer commenced in June. The two remaining candidates are expected to commence October.

Theatre Recruitment Campaign – work is underway to finalise the recruitment campaign to support the recruitment of Theatre Practitioners. It is expected that the main campaign will commence in September. The target is to recruit 30 by 31.03.2023.

Risks to delivery and mitigation.

Step change in no of resources requiring recruitment support- Mitigation: review and support resourcing plan by Division

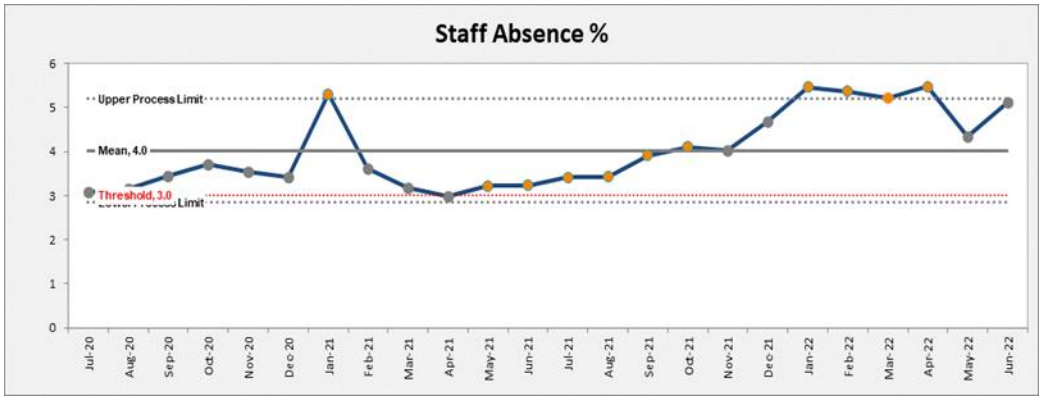
No of LM trained as recruiters and available to lead the process – Mitigation: hosting LM training

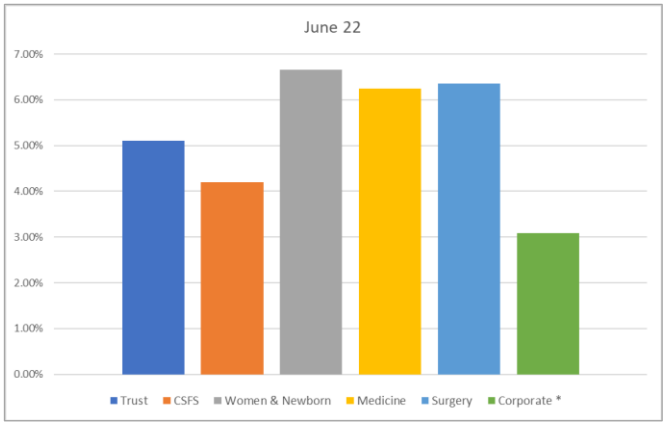
Resources in recruitment team due to recent resignation -

Mitigation: to secure rapid, specialist help to resource the recruitment team

Workforce - Sickness

Use of Resources





Background – What is the data telling us, and underlying issues.

Sickness in month 3 saw an increase to 5.11%, sickness for the rolling year was at 4.72%. All Divisions are above the Trust target of 3%. For the month of June, "Infectious Diseases" (Coronavirus) continued to be the top cause of sickness across all Divisions, just ahead of Anxiety/Stress/Depression/Other Psychiatric Illnesses.

BSW Benchmarking data for February 2022: RUH Bath 5.50%, GWH Swindon : 6.11%.

Improvement actions planned, timescales and when improvements will be seen.

75 long-term sickness absence cases to be reviewed with OH in July to review risks and where possible take actions to return staff to work or otherwise close these cases.

Work has begun on transitional arrangements from Covid-19 terms and conditions which have been withdrawn nationally. Long Covid staff to be contacted one to one by 3 August and new arrangement to begin 1 September.

Short Term sickness absence management underway to risk assess all cases and identify management actions

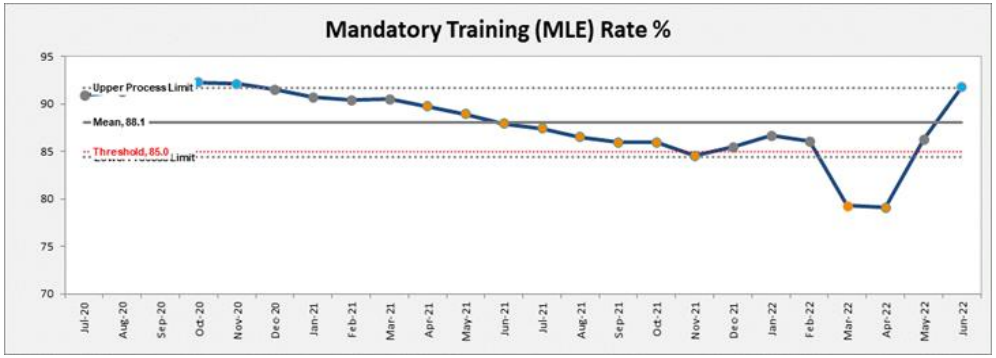
New attendance management policy in consultation process and final version reviewed by OMB in June. Further information required to establish position on COVID and national pay guidance and pay protection for staff redeployed due to Disability before final Approval.

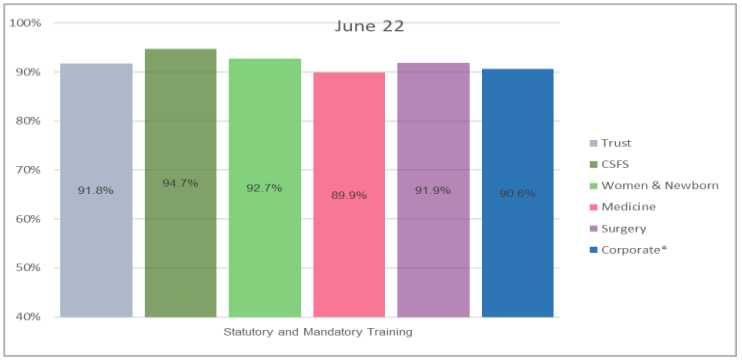
Risks to delivery and mitigation.

Operational pressures reducing managers time to undertake return to work interviews.

Workforce – Staff Training

Use of Resources





Background – what is the data telling us, and underlying issues.

During the week of the 13th June the MLE Classic system was decommissioned as Kallidus migrated us across to the new and improved LEARN platform. Supported by teams across the divisions testing took place to ensure that the system worked how we intended it to and to correct any issues that arose. A number of minor issues have been identified and corrected but we are confident that degrees of error in the data have been minimised as much as possible until the areas regarding the starters and leavers processes have been rectified within ESR.

Feedback from the organisation gathered through walk arounds and from communications to Education have predominantly been positive and compliance has improved this month which we believe to be due to the improved usability of the interface for all including managers. Further improvements have been made since the launch on 20th June to improve visibility of staff records for line managers. All reports have been rebuilt and scheduled and Quick Guides have been created to address common problems.

Compliance Data

Overall Trust compliance is now 92.27%, this improvement reflect the benefit of work that has gone in within the system to rebuild the training matrix, ensuring accuracy in reporting of different levels of training. In addition as more staff have accessed the system to see the new platform, any outstanding training is more obvious, which appears to be prompting people to complete at that time.

Improvement actions planned, timescales and when improvements will be seen

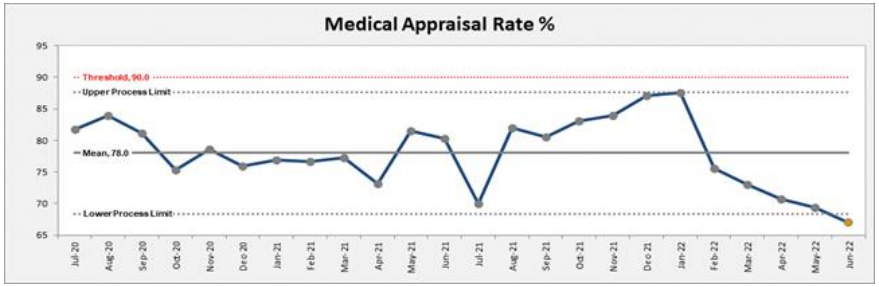
All divisions have seen an increase in compliance. This reflects work done within divisions to improve individual compliance and this work will be ongoing to address specific topics such as Advanced Adult and Basic Life Support and Hand Hygiene which remains below target in several divisions.

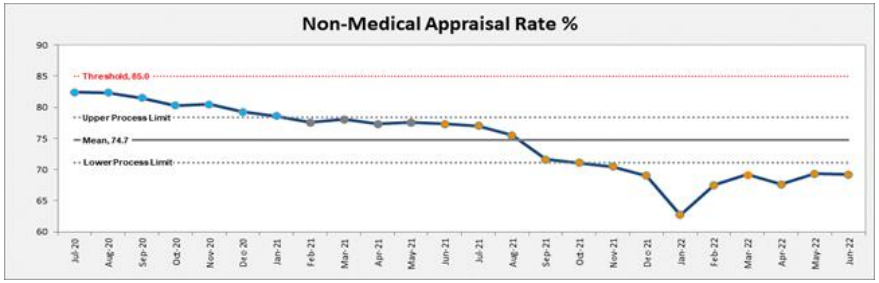
Risks to delivery and mitigation.

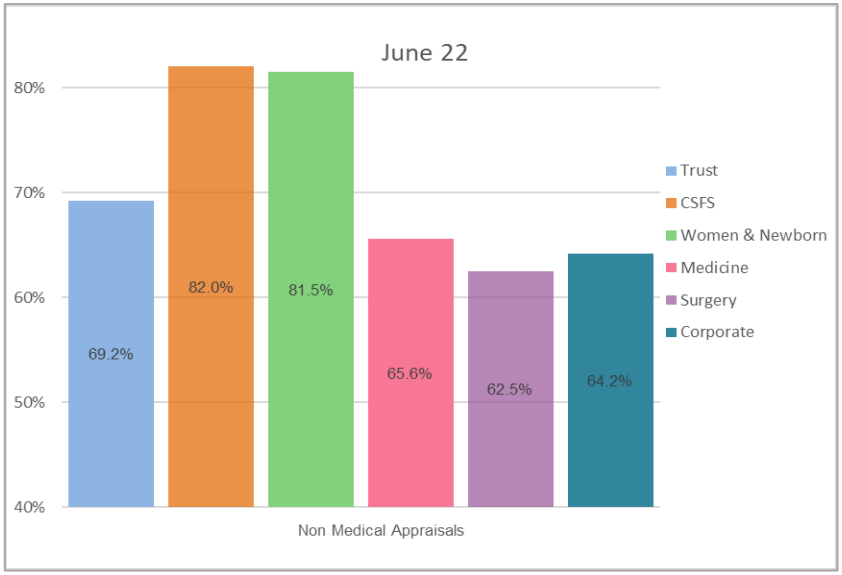
Accuracy of data requires line managers/supervisors to identifying any outstanding errors- this process will commence after the launch and will require formal response.

Workforce – Appraisals

Use of Resources







Background – What is the data telling us, and underlying issues.

Non-Medical Appraisals for month 3 (June) remain under target at 69.2%, this is a slight deterioration on the previous month's position (69.3%).

Hotspot areas are Corporate (64.2%) and Surgery (62.5%)

BSW Benchmarking -

RUH Bath: 61.1% (March 2022), GWH Swindon 68.85% (March 2022)

Improvement actions planned, timescales and when improvements will be seen.

Work continues to produce divisional lists of managers with significant numbers of appraisals outstanding requiring assistance, and trajectories for improvement.

Progress has been made with Procurement who have improved from 24% in January to 100% in June.

Medical BP is meeting with CDs and discussing actions to address declining medical appraisal compliance rate.

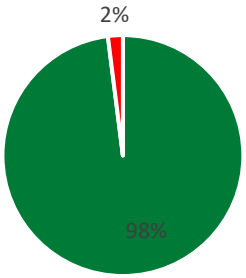
Risks to delivery and mitigation.

Risk – Lack of management time from operational pressures to undertake the appraisals. Mitigation To be revised after deep dive. It is likely that we will need to resume focus from informatics team or OD&P admin, to add weight to increase compliance. One key threat to our organisation is if / when NHSE reinstates the completion of objectives and training as a hurdle to pay increases.

Feedback from Friends and Family test – June 2022

Are We Responsive?

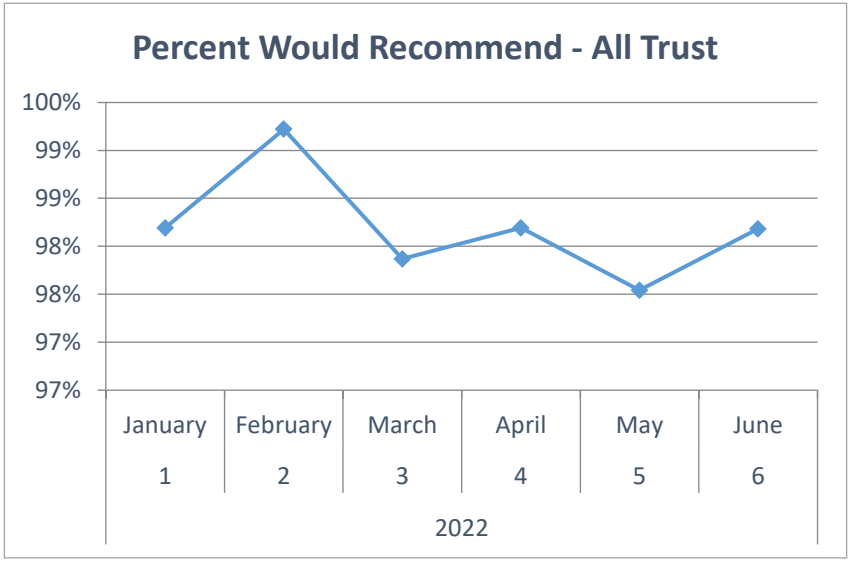
Percentage who reported a positive/negative experience of our service



"From the very first meet with Dr Tan (amazing man) I have been cared for, listened to, heard, helped, even felt loved. I have prior to this ward, had very poor negative experience yet Tisbury are remarkable. Everyone from doctors, nurses, students to cleaners and volunteers. I am very grateful to everyone plus the surgical team. Thank you isn't enough. Special thanks to Peter, Neethu, Liezl. Dr Tan, Renjuh" Tisbury ward

"GP referred my mother, but no bed available so sent home. Told to return the next day by 8am. We live an hour away. Waited all day, no drain done. Mum had no drink all day from the night before as we waited for drain"

"Professional way the hospital goes about diagnosis and how the departments are able to liaise. Staff are really kind and efficient" Pitton ward



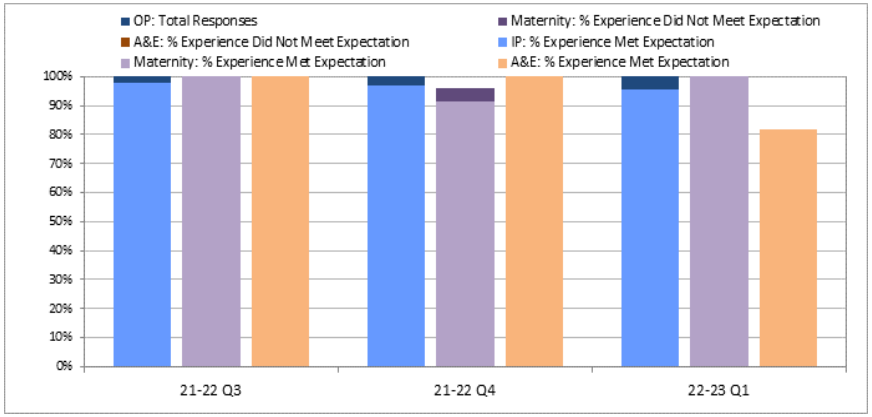
"Genuine care from each of the therapists. Highly professional and systematic sessions. Noticeable progress throughout. First class therapy team" Plastic surgery therapy – upper limb

"All of the staff have been extremely supportive. Fiona has worked with me on a 1 to 1 approach that has helped me to recover mentally, physically and holistically with a positive outlook. I am very grateful for all efforts on my behalf" Wessex rehab

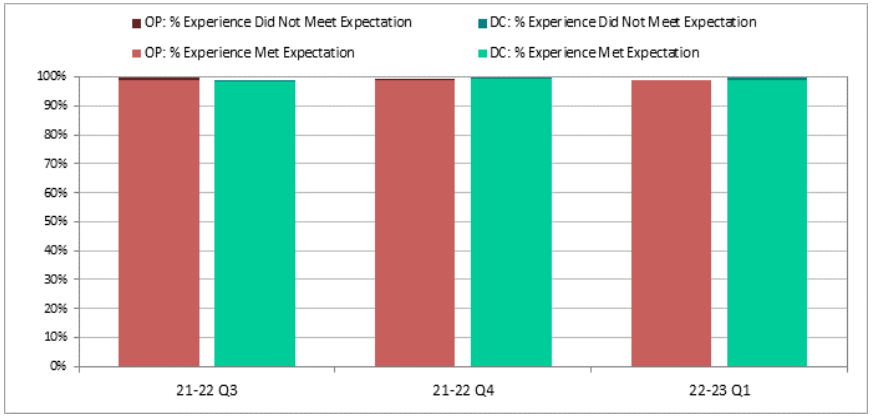
Friends and Family Test – Patients and Staff

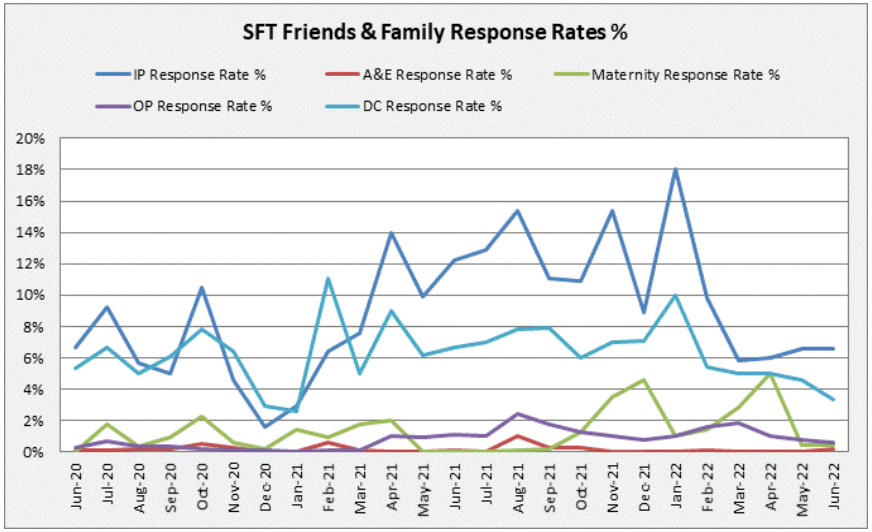
Use of Resources

Patient Responses: Inpatient, Maternity and A&E



Patient Responses: Outpatient and Daycase





Summary:

- Almost 20% of Odstock ward patients gave feedback in June
- Almost 35% of burns unit outpatients gave feedback
- Over 20% of patients from the cardiac suite left feedback

Part 4: Use of Resources

Performance against our Strategic Priorities and Key Lines of Enquiry

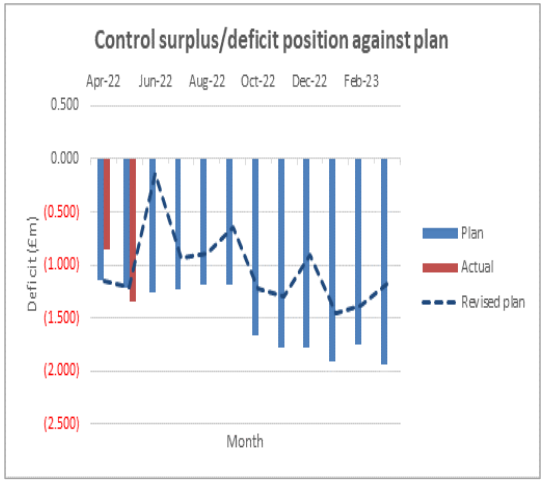
Our Priorities	How We Measure	
People	Are We Effective?	Are We Responsive?
Population	Are We Safe?	Are We Caring?
Partnerships	Are We Well Led?	Use of Resources

Income and Expenditure

Income & Expenditure:

Use of Resources

	June '22 In Mth			June '22 YTD			22-23 Plan
	Plan £000s	Actual £000s	Variance £000s	Plan £000s	Actual £000s	Variance £000s	Plan £000s
Operating Income							
NHS Clinical income	22,234	22,289	55	65,194	65,493	299	257,761
Other Clinical Income	791	994	203	2,143	2,509	365	11,587
Other Income (excl Donations)	2,991	3,024	33	8,785	9,598	813	34,540
Total income	**26,016**	**26,307**	**291**	**76,122**	**77,600**	**1,478**	**303,888**
Operating Expenditure							
Pay	(16,577)	(16,277)	300	(49,597)	(49,536)	61	(199,429)
Non Pay	(7,912)	(8,310)	(398)	(24,040)	(25,109)	(1,069)	(96,646)
Total Expenditure	**(24,489)**	**(24,587)**	**(98)**	**(73,637)**	**(74,645)**	**(1,008)**	**(296,075)**
EBITDA	**1,527**	**1,720**	**193**	**2,485**	**2,955**	**470**	**7,813**
Financing Costs (incl Depreciation)	(1,659)	(1,708)	(49)	(4,979)	(5,139)	(160)	(20,213)
Share of Gains on Joint Ventures	**(132)**	**12**	**144**	**(2,494)**	**(2,184)**	**310**	**(12,400)**
NHSI Control Total	*(68)*	*(60)*	*8*	*(204)*	*(179)*	*25*	*(816)*
Add: impact of donated assets	22,234	22,289	55	65,194	65,493	299	257,761
Surplus/(Deficit)	***(200)***	***(48)***	***152***	***(2,698)***	***(2,363)***	***335***	**(13,216)**



Variation and Action

A revised plan was submitted to NHSE on 20th June showing a revised control total deficit of £12.4m, including an additional £2.5m of contract income from BSW that has 3/12ths phased into June 2022 and 1/12th per month thereafter. It should be noted that planned deficits in BSW providers are offset by a planned surplus in the ICB. Discussions on a methodology for the distribution of these funds are underway.

The 2022/23 financial arrangements are transitional following the Covid block payments of the last two years and are designed to promote additional elective activity to address the Covid backlog. Although the majority of the Trusts NHS contractual income base is fixed, the guidance allows for additional income to be earned through the Elective Services Recovery Fund (ESRF), this is earned at a BSW system level. Although £28m is available to BSW as a whole, SFT has only assumed £1.4m in the 2022/23 plan, as this is agreed as a minimum 25% 'floor' payment.

22-23 has also seen the return of an efficiency requirement and recurrent savings targets totalling £6.6m have been allocated to corporate and clinical divisions. While £6.6m has been identified, this is inclusive of an assessment of non-recurrent vacancies. At present the recurrent efficiencies identified are £2.6m.

In month 3 the Trust recorded a small control total surplus of £0.012m against a target of £0.13m - a favourable variance of £0.14m.

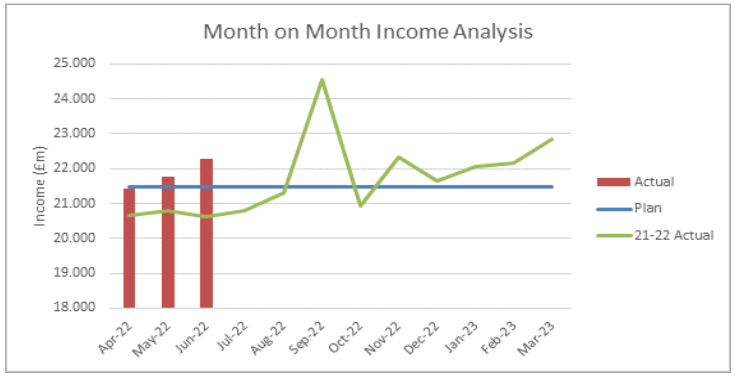
Income & Activity Delivered by Point of Delivery

Clinical Income:

Use of Resources

Income by Point of Delivery (PoD) for all commissioners	June'22 YTD		
	Plan (YTD) £000s	Actual (YTD) £000s	Variance (YTD) £000s
A&E	2,651	2,555	(96)
Day Case	4,963	4,590	(373)
Elective inpatients	3,016	3,362	346
Excluded Drugs & Devices (inc Lucentis)	5,503	5,903	400
Non Elective inpatients	17,263	17,937	674
Other	22,801	22,719	(82)
Outpatients	8,997	8,427	(570)
TOTAL	**65,194**	**65,493**	**299**

SLA Income Performance of Trusts main NHS commissioners	Contract Plan (YTD) £000s	Actual (YTD) £000s	Variance (YTD) £000s
BSW CCG	38,594	38,594	0
Dorset CCG	6,466	6,466	0
Hampshire, Southampton & IOW CCG	5,273	5,273	0
Specialist Services	10,076	10,390	314
Other	4,785	4,770	(15)
TOTAL	**65,194**	**65,493**	**299**



Activity levels by Point of Delivery (POD)	YTD Plan	YTD Actuals	YTD Variance	Last Year Actuals	Variance against last year
A&E	17,593	18,703	1,110	16,936	1,767
Day case	5,753	5,501	(252)	4,932	569
Elective	754	862	108	622	240
Non Elective	7,190	6,688	(502)	7,245	(557)
Outpatients	63,179	61,143	(2,036)	66,634	(5,491)

Variation and Action

The Trust is now ahead of plan which is predominantly due to more income being receivable from NHS E in respect of cost and volume activity - devices. The level of uncoded day cases and inpatient spells is 91% of activity uncoded in June and 25% in May at the time the activity was taken for reporting purposes. A&E activity has been higher in June than May due to higher activity at the Walk-In-Centre whilst ED activity levels this month were lower than in May. Day case activity in June was 94 more cases than in May and exceeded the in-month plan by 61 cases although behind plan year to date. Increased activity was seen in Urology (123 cases) and Gastroenterology (66 cases). Activity in elective inpatients continued was to above plan in month by 62 cases although activity was slightly lower than the levels seen in May. Outpatient activity reported this month was also lower than planned levels and Non elective activity was marginally lower than plan with additional activity within Obstetrics.

The Trust is not expected to achieve ESRF funding above the 25% rate as the expected activity increase on 2019/20 out-turn is not expected to reach the 104%. The current forecast is 90%.

Contracts with commissioners are in the main block agreements although there remains some cost and volume elements related to drugs and devices for NHSE Specialised services.

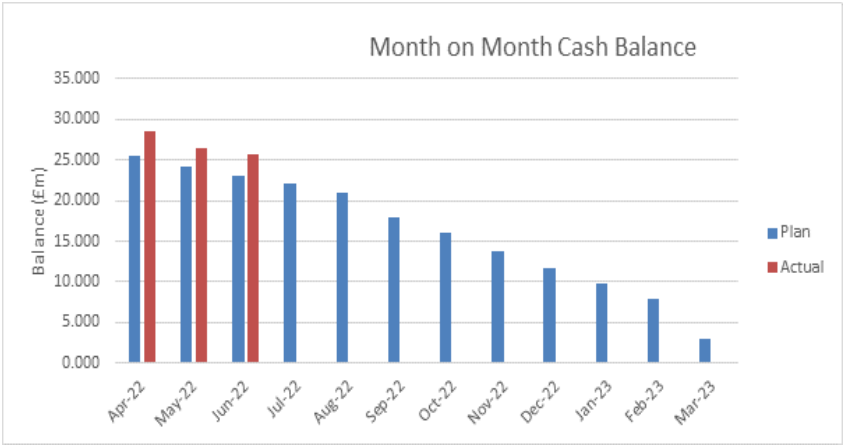
Significant progress is being made with the signing of the contract with BSW ICB and it is expected to be signed by 31st July. Draft contract documentation and schedules are yet to be received from NHS England for the main and HIV contracts.

Cash Position & Capital Programme

Capital Spend: 

Cash & Working: 

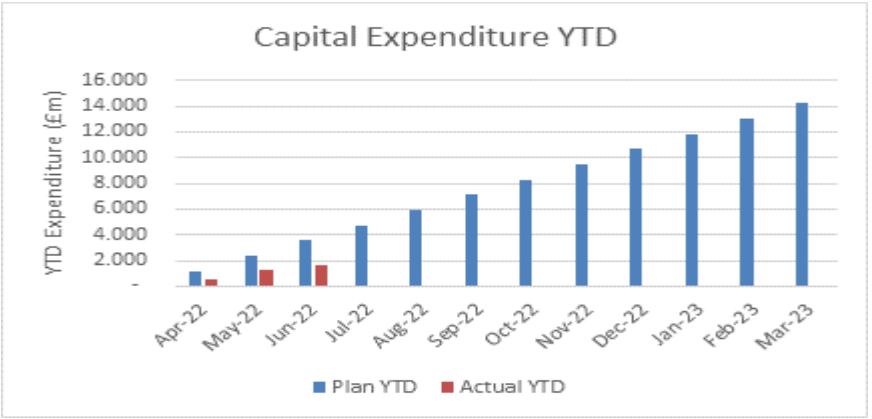
Use of Resources



Variation & Action

Creditors have decreased significantly since the year end, and this is primarily due to the payment of large 21-22 invoices relating to capital.

Capital Expenditure Position				
		June'22 YTD		
Schemes	Annual Plan £000s	Plan £000s	Actual £000s	Variance £000s
Building schemes	3,758	921	314	607
Building projects	2,740	762	232	530
IM&T	4,106	957	733	224
Medical Equipment	2,207	813	246	567
Other	1,414	106	106	(0)
Additional Funds approved in year	**14,225**	**3,559**	**1,631**	**1,928**
TOTAL	3,758	921	314	607



Summary and Action

22-23 capital allocations have again been made at a system level and the Trust remains capital constrained, particularly in the Estates area: confirmed by the findings of a six-facet survey.

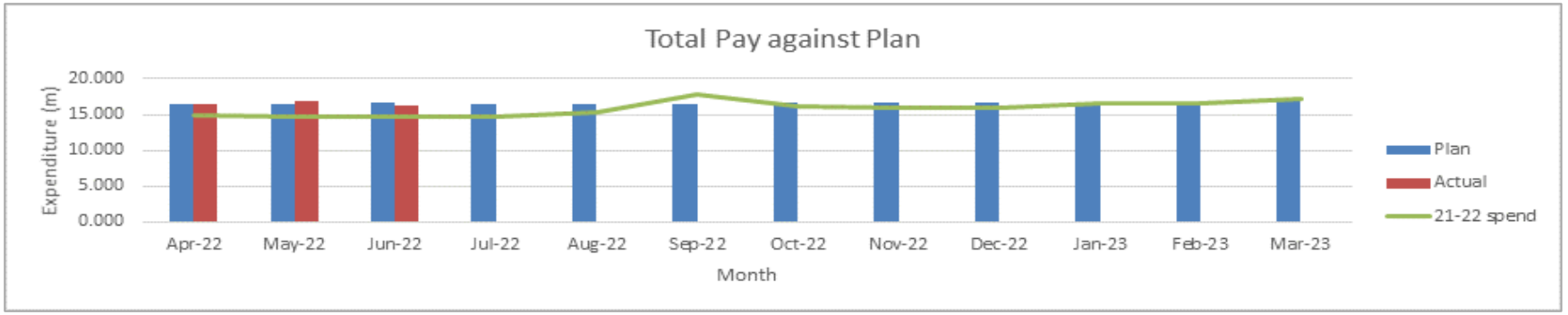
The 22-23 Capital Plan was approved by the Board in April 22 and included an amount of £989k set aside for further prioritisation at the time of approval, however £740k will be required for the BSW shared EPR should the business case be approved. The remainder is badged as contingency against which capital priorities for each of the groups will be allocated by the end of Q1 (this contingency is included in the Other category). Forecast underspends on certain projects will provide further slippage to play into the remaining contingency to be allocated.

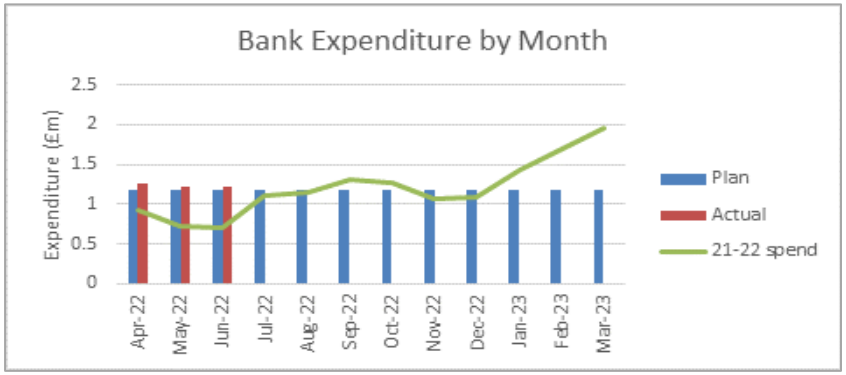
Additional national funding has now been confirmed in the IM&T workstream in Digital Pathology for three years totalling £3.13m. Planning for deployment is already underway given procurement and implementation lead times.

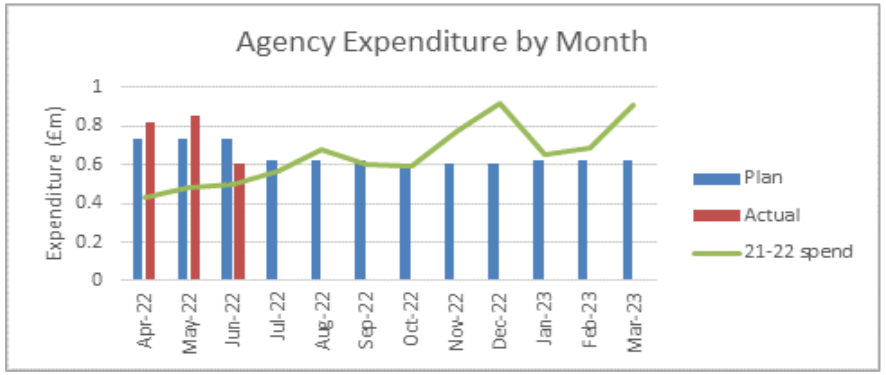
Workforce and Agency Spend

Pay:

Use of Resources







Summary and Action

Pay expenditure fell by £540k (3.3%) in month 3, bringing the year-to-date position to a favourable variance of £12k. This position includes pay savings targets of £1.6m YTD, which is being met non recurrently due to vacancies not being backfilled. Pay costs fell across all clinical divisions, and across all contract types, mainly due to the non-availability of staff. Similarly, pay costs fell across all staff groups with the exception of "Other Clinical Staff" and this exception was driven by increases in Radiology and Pathology. Falls in nursing expenditure was the most dramatic with a reduction in total expenditure by £365k: this was all accounted for by a reduction in agency use.

Agency costs overall have reduced by £240k,reflectd in the 5% month on month reduction in Nursing and HCA WTE.

The drivers of NHS Infrastructure WTE variances are vacancies within the BSW procurement team (although this has been offset by a loss of income in M3), the transformation team, and slippage in pipeline business case assumptions. An opportunity of £0.8m has been identified against non recurrent vacancies in H1.

A 2% pay award has been provided for within the reported figures, with an expectation that if this figure is exceeded then further funding will be made available to NHS providers to offset the financial pressure.