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|-------------------------|----------------------|---------------------|-----|
| Report to: | Trust Board (Public) | Agenda item: | 2.2 |
| Date of Meeting: | 06 August 2020 | | |

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|---|--|-------------------|------------------|-----------------|
| Report Title: | Integrated Performance Report | | | |
| Status: | Information | Discussion | Assurance | Approval |
| | ✓ | | ✓ | |
| Prepared by: | Louise Drayton, Performance and Capacity Manager | | | |
| Executive Sponsor (presenting): | Lynn Lane, Executive Director for OD and People | | | |
| Appendices (list if applicable): | | | | |

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| Recommendation: |
| The Board is requested to note the report and highlight any areas of performance where further information or assurance is required. |

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| Executive Summary: |
| During June the impact of Covid-19 upon the Trust remained significant, though the numbers of patients testing positive in the hospital had fallen to 4, with no Covid-19 positive patients requiring ITU care throughout the month. The demand for unplanned care continues to increase with non-elective admissions at 90% for June. Sickness levels across the Trust have seen improvement as the number of Covid-19 cases have decreased, with sickness levels falling to under 3% (2.95% total – 2.53% non Covid-19 and 0.42% Covid-19 related) for the first time this year. |
| Emergency Department performance remained good, with 95.7% of patients being admitted or discharged within 4 hours. Notably, the quarter 1 position was 95.1%, the highest quarterly position for a number of years. Attendances have been steadily rising, with levels Friday – Monday now at usual levels. Stroke performance continues to be excellent with levels of Stroke and TIA patients returning to near pre Covid-19 levels. The Stroke unit will relocate back to Farley ward in Q3 which will support therapy rehab provision. |
| Elective care continues to be significantly affected, with the return of elective services heavily affected by the requirements of social distancing and isolation, and the reduced capacity in services in order to maintain this. As a result of this patients are waiting longer for routine access to services, with urgent and cancer services being prioritized. The RTT performance dropped further to 65.12% (74.6% in May). The total waiting list size fell to 14,443 in June, with the fall being attributed to referral levels not yet reaching pre Covid-19 levels. |

The reduction in activity has allowed improvement in Statutory and Mandatory training (90.5%), and non-medical appraisals (82.93%). Medical appraisals were suspended during the initial pandemic response, and therefore compliance is low at 83.15%. Divisions are now working on recovery of this.

Improvement has been made in the Diagnostics standard, with performance at 66.9% (47.2% in May). Patients choosing to wait for appointments and procedures continues to be a theme, and referral levels remain a concern. Cancer performance was improved with achievement of the 2 Week Wait and the 62 Day standard, helped by the restarting of elective services boosting treatment numbers.

Category 2 pressure ulcers were up slightly at 19 (16 in May), and although are trending down over the last 5 months, they remain at a higher level than they were for most of 2019. Focused work continues with baseline education around prevention of pressure damage being identified as requiring improvement.

The block contracts and 'top-up' payment received as part of the Covid-19 response were not quite enough to cover the baseline costs of the Trust, with a claim for a £0.15m retrospective top up lodged by the Trust (YTD figure including £0.1m claim in Month 2). This is inclusive of the recognised £0.3m per month 'shortfall' in the top up methodology caused by the instruction from NHSE&I not to invoice for provider-to-provider genetics tests.

As part of reviewing the functionality of the integrated performance report, the SPC graphs have been updated. The graphs will no longer highlight when performance is above or below the mean for six consecutive data points or more. Instead it will just show a) when performance has continually improved or deteriorated for 6 or more consecutive data points or when a data point is outside of a control limit.

| Board Assurance Framework – Strategic Priorities | Select as applicable |
|--|-------------------------------------|
| Local Services - We will meet the needs of the local population by developing new ways of working which always put patients at the centre of all that we do | <input checked="" type="checkbox"/> |
| Specialist Services - We will provide innovative, high quality specialist care delivering outstanding outcomes for a wider population | <input checked="" type="checkbox"/> |
| Innovation - We will promote new and better ways of working, always looking to achieve excellence and sustainability in how our services are delivered | <input checked="" type="checkbox"/> |
| Care - We will treat our patients, and their families, with care, kindness and compassion and keep them safe from avoidable harm | <input checked="" type="checkbox"/> |
| People - We will make SFT a place to work where staff feel valued and are able to develop as individuals and as teams | <input checked="" type="checkbox"/> |
| Resources - We will make best use of our resources to achieve a financially sustainable future, securing the best outcomes within the available resources | <input checked="" type="checkbox"/> |

Integrated Performance Report

August 2020
(data for June 2020)

An outstanding experience for every patient

Summary

As part of reviewing the functionality of the integrated performance report, the SPC charts have been updated. The charts will no longer highlight when performance is above or below the mean for six consecutive data points or more. Instead it will just show a) when performance has continually improved or deteriorated for 6 or more consecutive data points or (b) when a data point is outside of a control limit.

During June the impact of Covid-19 upon the Trust remained significant, though the numbers of patients testing positive in the hospital had fallen to 4, with no Covid-19 positive patients requiring ITU care throughout the month. The demand for unplanned care continues to increase with non-elective admissions at 90% for June. Sickness levels across the Trust have seen improvement as the number of Covid-19 cases have decreased, with sickness levels falling to under 3% (2.95% total – 2.53% non Covid-19 and 0.42% Covid-19 related) for the first time this year.

Emergency Department performance remained good, with 95.7% of patients being admitted or discharged within 4 hours. Notably, the quarter 1 position was 95.1%, the highest quarterly position for a number of years. Attendances have been steadily rising, with levels Friday – Monday now at usual levels. Stroke performance continues to be excellent with levels of Stroke and TIA patients returning to near pre Covid-19 levels. The Stroke unit will relocate back to Farley ward in Q3 which will support therapy rehab provision.

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Structure of Report

Performance against our Strategic and Enabling Objectives



Our Priorities

Local Services

Specialist Services

Innovation

Care

People

Resources

How We Measure

Are We Effective?

Are We Responsive?

Are We Safe?

Are We Caring?

Are We Well Led?

Use of Resources

Summary Performance

June 2020

There were **2,508** Non-Elective Admissions to the Trust



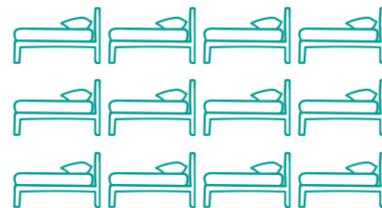
We delivered **14,850** outpatient attendances cases (-8,195 vs plan)



We met **6 out of 7** Cancer treatment standards



We carried out **108** elective procedures & **1,113** day cases



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



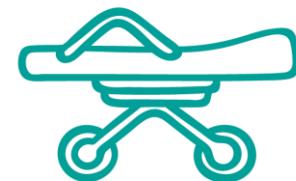
66.9% ↑ of patients received a diagnostic test within **6 weeks**



Our income was **£21,896k** (£527k over plan)



Emergency (4hr) Performance
95.7% ↑
(Target trajectory: 95%)



1,116 patients arrived by Ambulance



RTT 18 Week Performance:
65.12% ↓
Total Waiting List: **14,443 ↓**



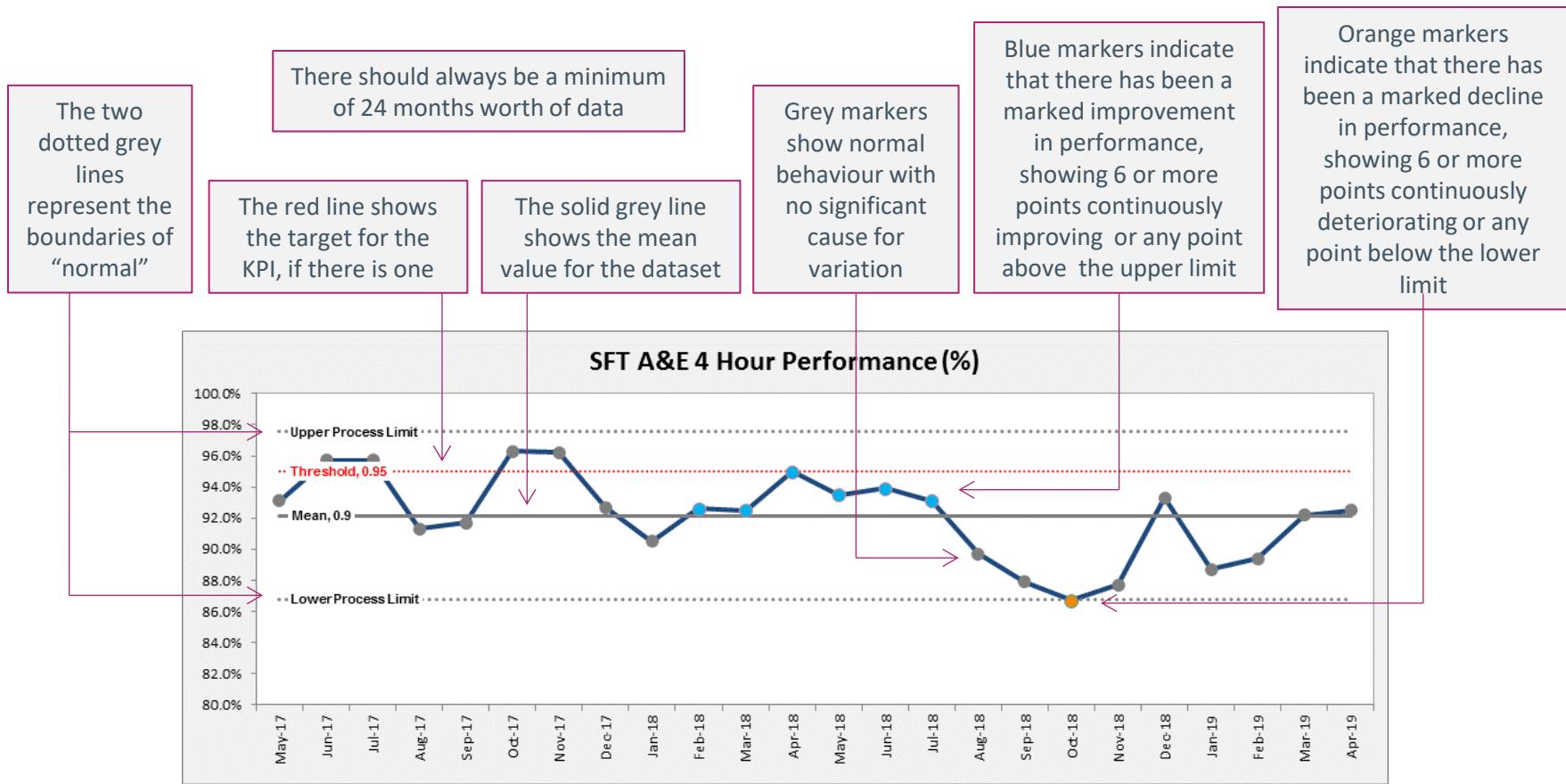
19.8% ↓ of discharges were completed before 12:00



Our overall vacancy rate was **1.55% ↓**



Reading a Statistical Process Control (SPC) Chart



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



Our Priorities

Local Services

Specialist Services

Innovation

Care

People

Resources

How We Measure

Are We Effective?

Are We Responsive?

Are We Safe?

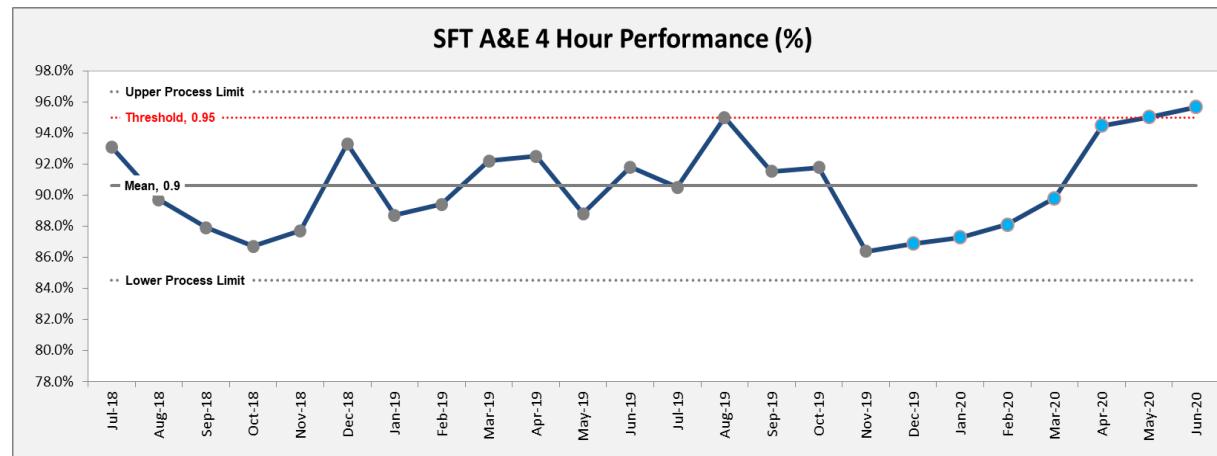
Are We Caring?

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:

95.7%

Attendances:

4605

12 Hour Breaches:

0

ED Conversion Rate:

31.9%

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

M3 saw the gap in pre and post Covid-19 ED activity close with only a 16% difference to M3 activity in 2019. RAZ activity reducing slowly over M3 but Majors and Minors activity rising to normal levels Friday – Monday each week. Minors is now open daily until 10pm

Paediatric activity remains with the Sarum team however adolescents returned to ED care towards the end of June (majority of paediatric activity routed through ED to paediatrics therefore activity figures fairly accurate)

Flow into hospital good therefore ED flow and performance held steady in M3 – fluctuations on Friday / Saturday propped up by excellent performance Tuesday – Thursday when attendances are lower.

Current performance supported by experienced junior doctors and flow

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

Work to increase number of side rooms needs to be completed to allow decommissioning of RAZ and improve flow of staffing around ED – anticipated end of August if agreement for increased costs can be agreed.

ED to review plans for taking paediatrics back into ED end of July – awaiting strategic decision on space allocation for ED Minors to inform choices relating to Paediatrics. If RAZ decommissioned Paediatric area could potentially re-open for paediatric patients.

Risks to delivery and mitigations

Staffing – Gaps in Registrar rota from September – offering development posts to internal trainee and CESR trainee moving to the area. Still unable to cover all night gaps.

New Junior doctors in August – losing skilled ED staff – induction and training program in place but risk unavoidable.

Space and social distancing in ED waiting room for majors and minors is a daily struggle – await decisions from space allocation and recovery group around potential solutions.

Locum consultant has handed in notice – applying for substantive – interview on 29th -if unsuccessful this leaves 1.8wte consultant gaps in ED. Previous advertisements have not been fruitful. Workforce business case in production looking at alternative options.

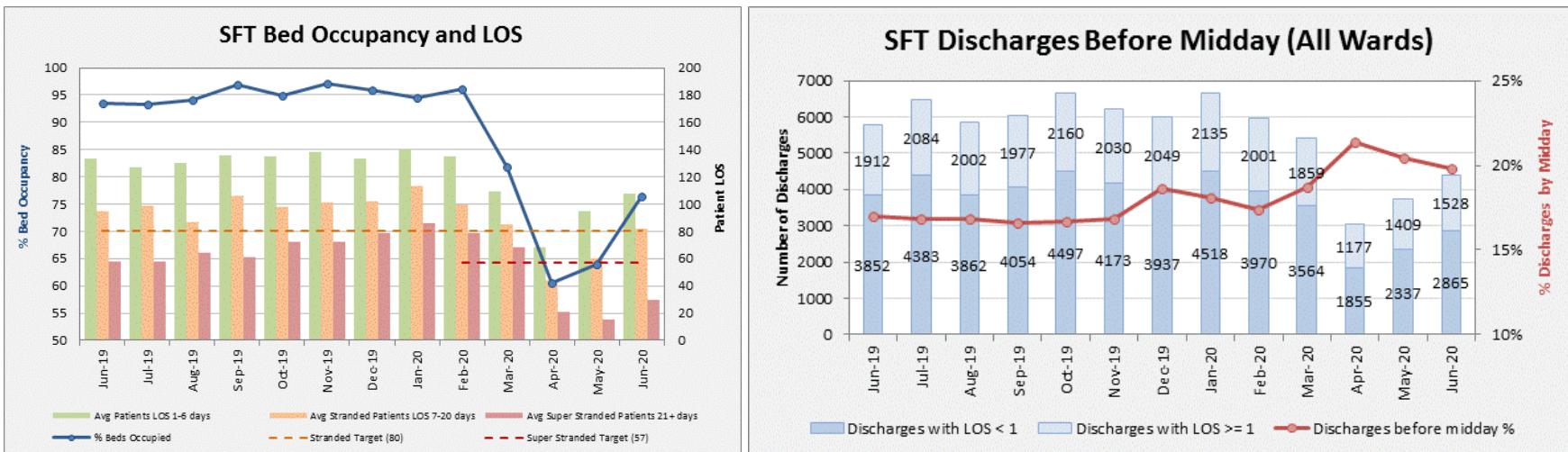
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Patient Flow and Discharge

Are We Effective?



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

Occupancy levels continue to rise, reflecting the increase in patients coming to hospital, although still not at pre Covid-19 levels. Anticipate non-elective demand in medicine is likely to match previous levels by M5.

The requirements to segregate patients in relation to Covid-19 swab and isolation status has reduced the flexibility in how bed capacity is managed.

Escalation ward (Laverstock) remains open to house Stroke Unit whilst RCU is needed (escalation area for Covid-19 response).

Super-stranded patients have increased, although still below target levels.

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

RCU is now only working out of the Farley template. Spire is continuing to be used for cohorting purposes. Ward reconfiguration planned for week of 31st August to relocate Stroke back to Farley and adapt the requirements for Covid-19 response.

The Acute Medical Unit continue to increase the percentage of patients that are discharged within 24, 48 and 72 hours – 37%, 43% and 45% respectively.

A focus on super-stranded patients is required and is identified as a strategic priority, improvement options are currently being scoped.

Risks to delivery and mitigations

Uncertainty re future Covid-19 demand - RCU will remain on level 2 for the foreseeable future, although condensed to the Spire ward footprint. Stroke will return to Farley template week of 31st August but would relocate if Covid-19 demand increased.

Estate footprint of ED due to Covid-19 response is constraining space within the Department – minors is relocated and waiting room space is challenging. Risk of queuing patients and increased waiting times. Some estates work to commence late August to increase cubicle space. Long term minors footprint needs confirmation.

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

National Key Performance Indicators

SFT RTT PTL Volume by CCG:

| Total WL | Jul-18 | Aug-18 | Sep-18 | Oct-18 | Nov-18 | Dec-18 | Jan-19 | Feb-19 | Apr-20 | May-20 | Jun-20 |
|--------------------------|---------------|---------------|---------------|---------------|---------------|---------------|---------------|---------------|---------------|---------------|---------------|
| Dorset CCG (11U) | 2,480 | 2,460 | 2,424 | 2,459 | 2,537 | 2,588 | 2,650 | 2,762 | 2,268 | 2,128 | 2,048 |
| West Hampshire CCG (11A) | 1,583 | 1,574 | 1,565 | 1,620 | 1,639 | 1,666 | 1,628 | 1,696 | 1,424 | 1,333 | 1,279 |
| BSW (92G) | 10,481 | 10,616 | 10,335 | 10,343 | 10,441 | 10,192 | 10,384 | 10,500 | 9,672 | 9,095 | 8,715 |
| Other CCGs | 3,135 | 3,016 | 2,989 | 2,834 | 2,526 | 2,411 | 2,180 | 2,105 | 2,594 | 2,499 | 2,401 |
| Trust Total | 17,679 | 17,666 | 17,313 | 17,256 | 17,143 | 16,857 | 16,842 | 17,063 | 15,958 | 15,055 | 14,443 |

Data Quality Rating:



Performance Latest Month:

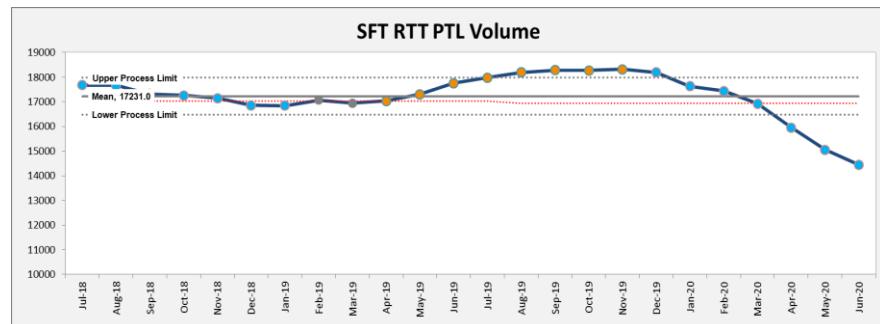
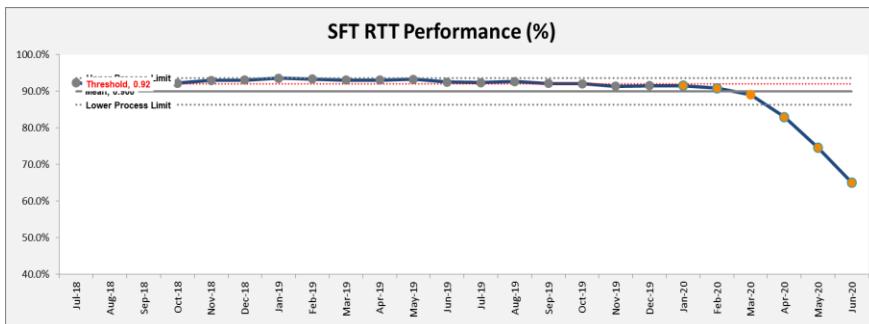
65.12%

PTL Volume:

14,443

52 Week Breaches:

70



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

Overall RTT performance fell further in June due to the continued impact of elective cancellations and restrictions during the height of Covid-19 and the limitations on recovery including social distancing, isolation requirements, impact of measures to ensure staff safety and reduced theatre list capacity. Poorest performance can be seen in those specialties that had significant capacity pressures prior to Covid-19 and also in those most impacted by the above limitations and restraints.

This has been further impacted by the slow increase of routine referral numbers which continue to be below those in the pre Covid-19 period. If we now see referrals start to increase more rapidly there will be a slight improvement on RTT performance although the effects of this will be limited by capacity constraints in theatres and outpatients and also influenced by how quickly referral rates move towards those previously seen.

The total PTL size continues to be below the target of 16,924 and was at the end of June -2481 under target at 14,443.

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

Capacity in outpatient areas is being mapped in detail to ensure the ability to increase face-to-face activity as much as required for all specialties. Activity mapping is also being undertaken to identify those specialties not yet back to pre- Covid-19 levels so that the limiting factors for this can be identified and work undertaken to resolve these.

All new outpatient demand currently held by each specialty is being regularly monitored and these overviews are being used to ensure that backlogs are reducing and that improvements in wait times start to be seen during this recovery phase.

Urgent and cancer surgical activity continues to be undertaken and elective recovery theatre lists are now running for most specialties in all theatres in the day surgery unit . Cases also continue to be transferred to Newhall, if clinically suitable to be undertaken there. Work is currently being undertaken to increase the usage of this capacity for T&O and cataract surgery. Activity mapping is also being undertaken for all surgery lists to ensure maximum efficiency of the lists bearing in mind the limitations on capacity due to turnaround and PPE.

Risks to delivery and mitigations

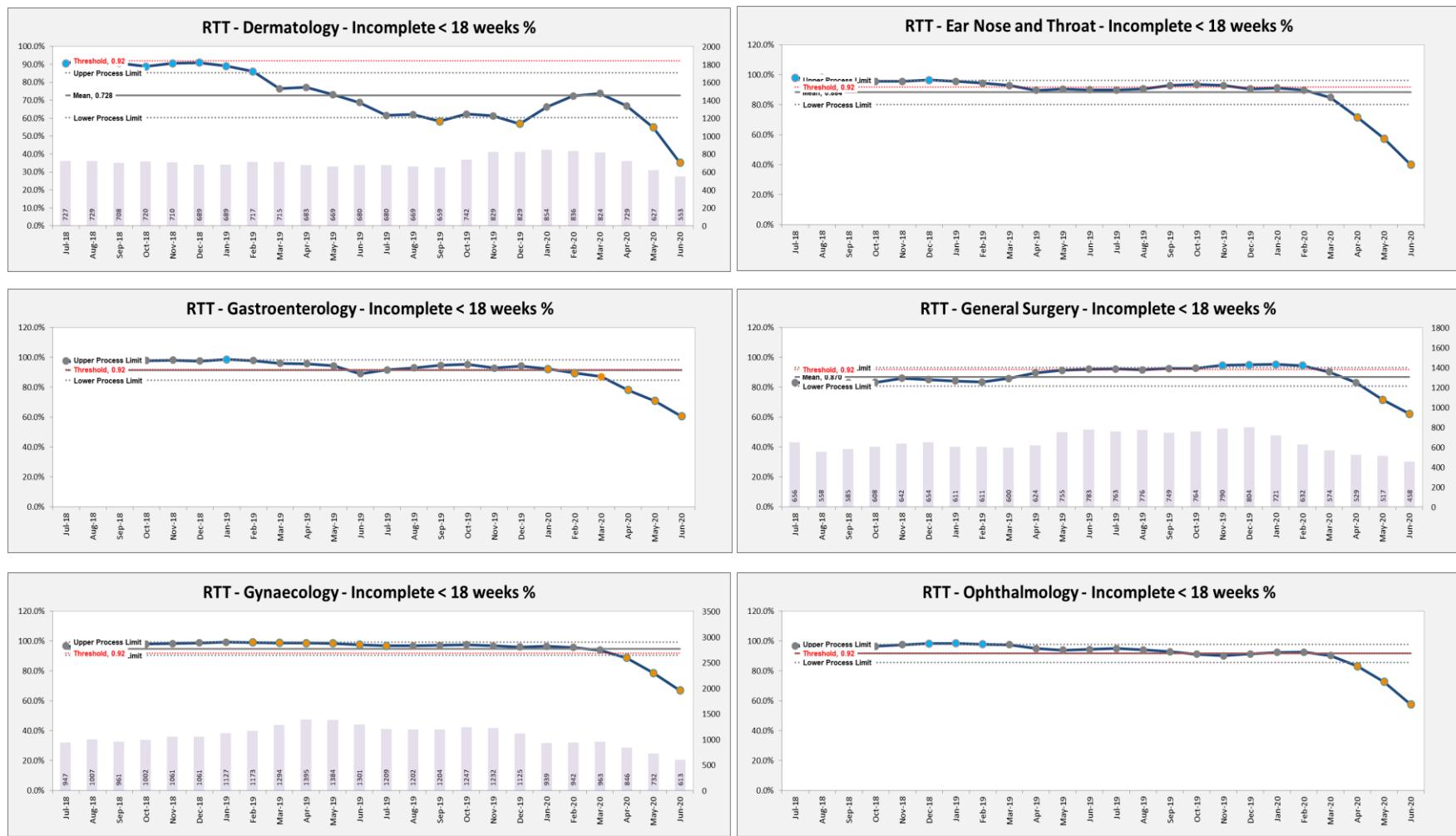
Continued risk of not achieving the performance standard in coming months due to the continued impact of the pandemic which has exacerbated the impact of previous capacity pressures.

Validation of the outpatient PTL, follow up waiting lists and surgery PTL have all been undertaken during the pandemic period to both confirm accuracy and also to ensure recovery plans are based on the clinical priority of patients.

We are also seeing an impact of patient choice on the recovery progress as high volumes of patients are choosing to delay attendances and procedures at this time due to an inability to be able to isolate for 14 days prior to surgery, as per the national requirements, and also due to concerns about coming to the hospital at this time work is now being undertaken to produce videos and leaflets to reassure patients of the safety measures put in place to try and increase numbers accepting bookings.

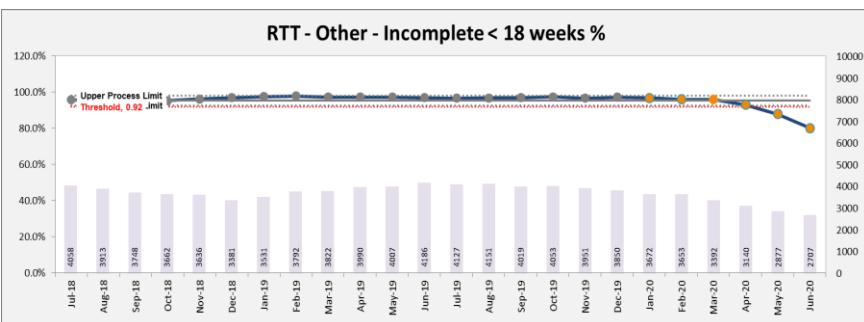
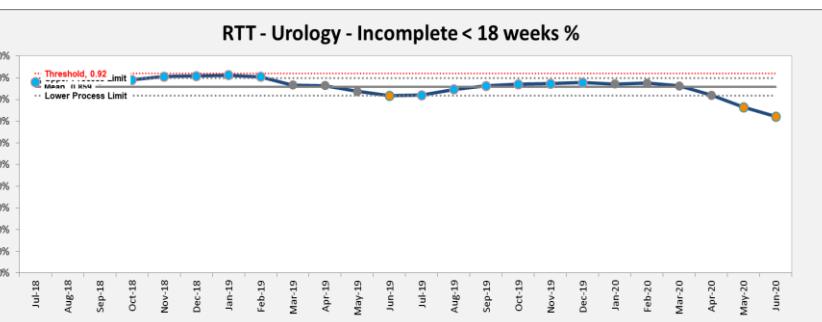
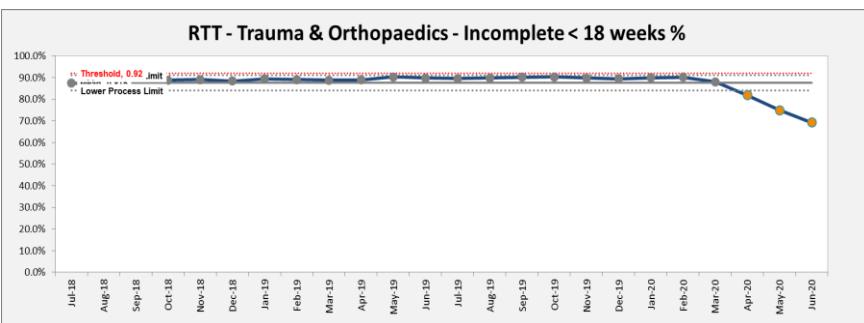
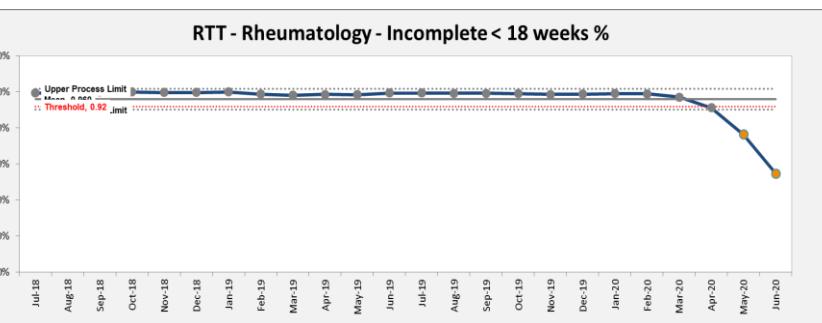
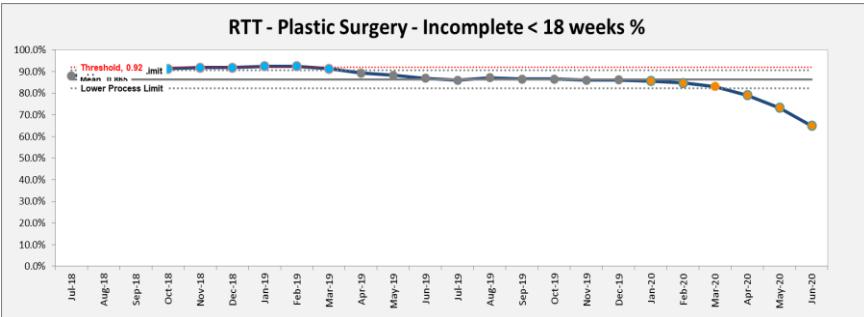
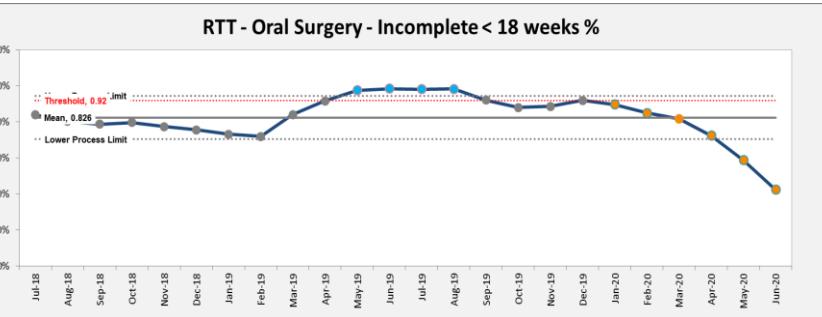
Referral To Treatment (RTT) (Incomplete Pathways) Target 92%

National Key Performance Indicators



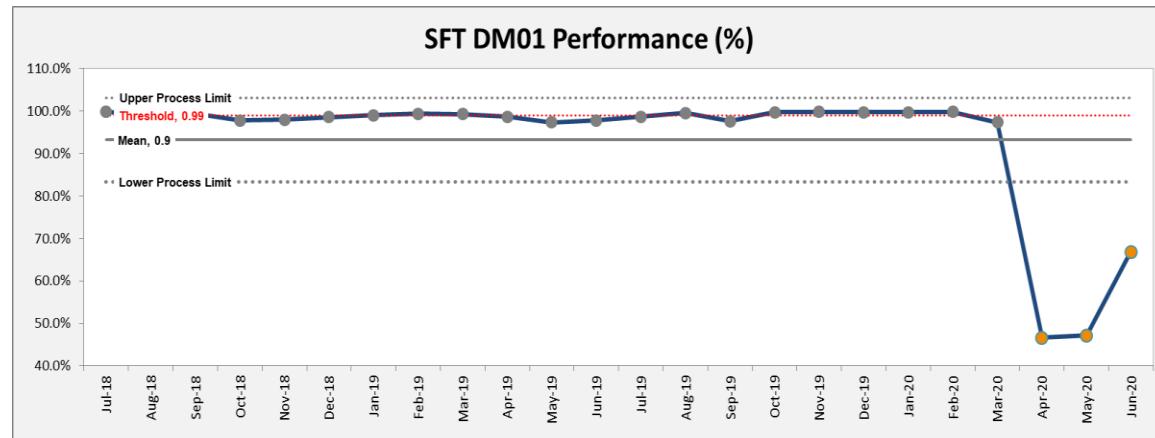
Referral To Treatment (RTT) (Incomplete Pathways) Target 92%

National Key Performance Indicators



Diagnostic Wait Times (DM01) Target 99%

National Key Performance Indicators



Data Quality Rating:



Performance Latest Month: 66.9%

Waiting List Volume: 3,237

6 Week Breaches: 1,072

Diagnostics Performed: 5,179

Background, actions being taken and risks and mitigations

Performance standard in month has not been achieved as a direct impact of Covid-19. July projections confirm that the target is not achievable for M4, however there has been an improvement in performance in M3 following the re-start of capacity constrained routine activity across multiple specialties and modalities. Specialties continue to feedback that some patients do not want to attend for their diagnostic test, until 'after Covid-19'. This is further impacting on the ability to improve performance against the Diagnostic standard as the majority of these patients have already breached 6weeks.

Endoscopy

27 confirmed in month breaches, all attributable to Covid-19

Radiology (Inc. DEXA)

559 confirmed in month breaches, all attributable to Covid-19

Radiology Reporting

Go live of the second provider for outsourcing remains on hold. IT remain in dialogue with the provider to resolved, but timescales for completion remain unknown. Reduced activity has positively impacted on the number of outstanding scans for reporting so the risk of this service not being available at this time is mitigated against.

Audiology

0 confirmed in month breaches

Cardiology

291 confirmed in month breaches, all attributable to Covid-19

Neurophysiology

195 in month breaches, all attributable to Covid-19

Cancer 2 Week Wait Performance Target 93%

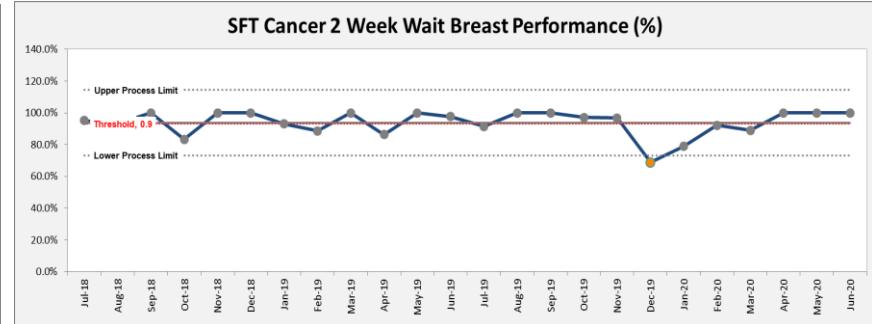
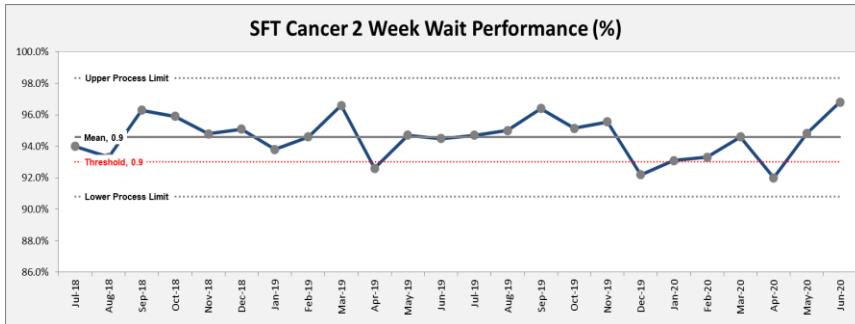
National Key Performance Indicators

Performance Latest Month:

Two Week Wait Standard: 96.9%

Two Week Wait Breast Standard: 100%

Data Quality Rating:



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

M3 Two Week Wait and breast symptomatic performance achieved in light of reduced referral numbers and revised Cancer Waiting Times (CWT) guidance around triage and telephone appointments during Covid-19.

There has been deterioration in referral figures since March 2020, though increase noted during June.

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

Weekly cancer ops meetings re-instated to focus on 2ww appointments and clinic capacity.

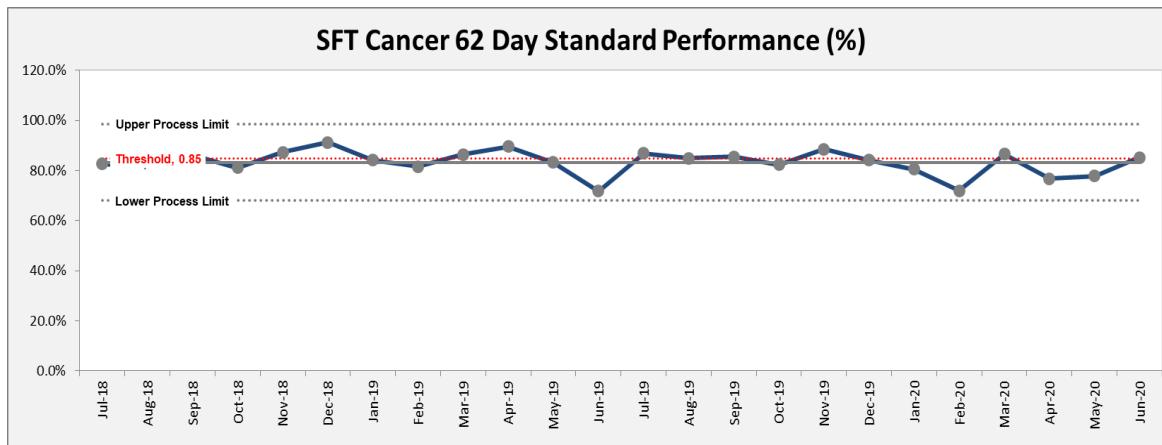
Risks to delivery and mitigations

Diagnostic backlog is likely to significantly effect our ability to achieve the 2ww standard going forward once CWT revise the protocol implemented during Covid-19. This will be of particular concern in light of face to face restrictions within the medical & surgical outpatient department.

Booking teams continue to prioritise cancer patients, though ongoing concerns related to patient choice and fear in attending hospital remain; this is likely to impact on service delivery for a significant period of time.

Cancer 62 Day Standards Performance Target 85%

National Key Performance Indicators



Data Quality Rating:



Performance Latest Month:

62 Day Standard: 85.1%

62 Day Screening: 0 patients

Risks to delivery and mitigations

M3 validated 62 day performance of 85.07%, with a total of 10 breaches. Increase in treatments during June in light of restarting diagnostic services.

Future performance remains fragile; services continue to focus on long waiters and overall PTL backlog, though it remains evident that patient choice is impacting service delivery significantly. Performance likely to be compromised whilst backlog is worked through based on clinical prioritisation.

Screening services postponed during Covid-19, therefore standard not currently applicable.

Statistical Process
Control Chart Key:

— Target

— Mean

..... Upper / Lower Process Control Limits (UPL/LPL)

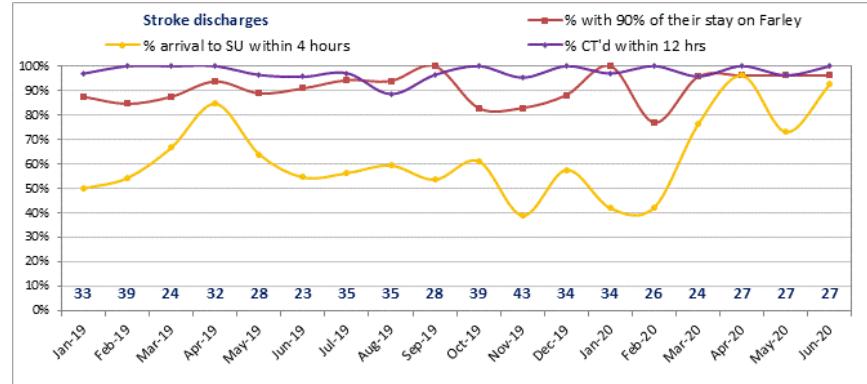
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- Common Cause Variation

Stroke & TIA Pathways

Are We Effective?

SFT SSNAP Case Ascertainment Audit Score:

| Year | Q1 | Q2 | Q3 | Q4 |
|---------|--------------|----|----|--------------|
| 2019-20 | B | B | B | Not Reported |
| 2020-21 | Not Reported | | | |



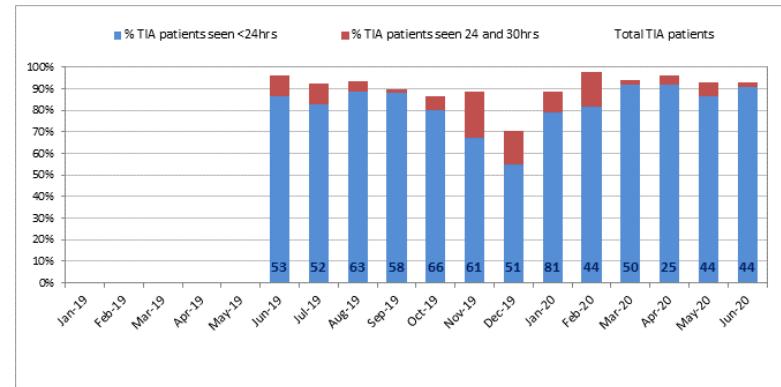
Data Quality Rating:



% Arrival on SU <4 hours: 92.6%

% CT'd < 12 hours: 100%

% TIA Seen < 24 hours: 90.9%



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

The stroke unit remains relocated on Laverstock ward due to the Covid-19 emergency but plans are now underway for it to return to its original location on level 2. 70% of stroke patients had a CT within 1 hour (target 50%) and door to needle time for patients suitable for thrombolysis was 74 minutes. Excellent performance (92%) of patients reaching the stroke unit in 4 hours - 2 patients were affected by a delay in ED - 1 waiting for treatment. The other patient was a late referral. There were 3 (11%) stroke deaths in June – lower than expected (17%). 96% of patients spent 90% of their time on the stroke unit exceeding the national target (80%).

SSNAP have confirmed that Q4 19/20 and Q1 20/21 will not be published as many hospitals have not submitted data during the Covid-19 emergency. SFT continued to submit data throughout this period.

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

As part of the Covid-19 arrangements, the stroke unit has acted as a hyper-acute unit with patients who require rehabilitation discharged to community hospitals or 'discharge to assess' at home with therapy provision in the community. This model has replaced the early supported discharge (ESD) stroke team during the Covid-19 emergency and is working well.

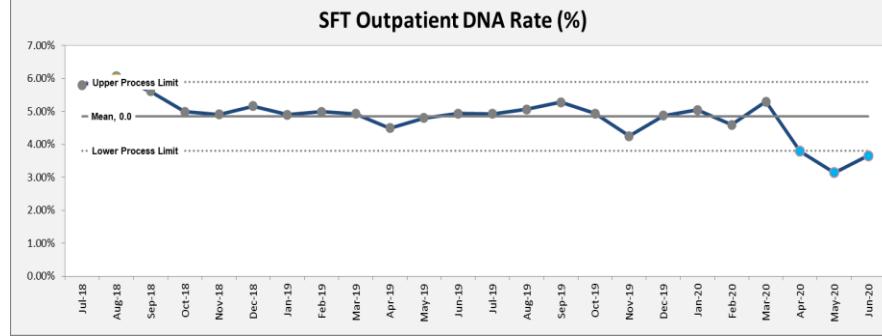
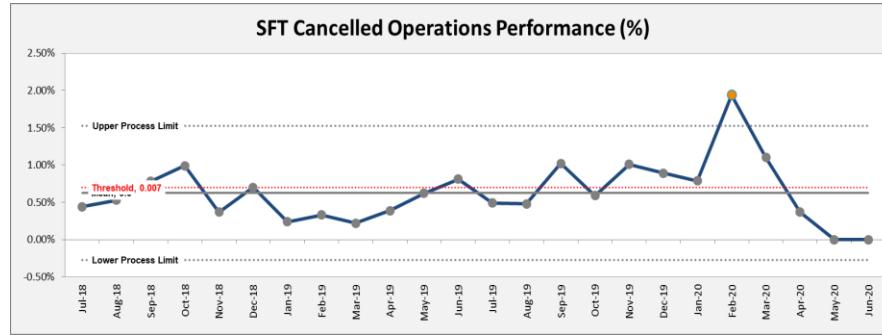
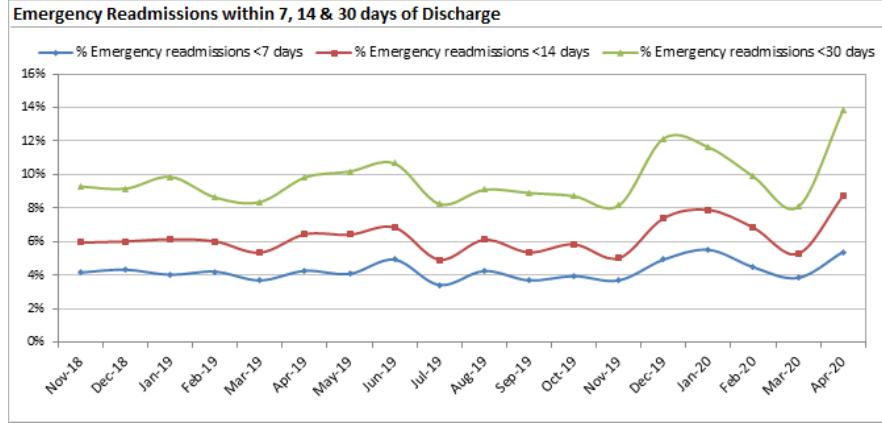
East Dorset community team has restarted the ESD stroke service and Wiltshire is in the planning stage. SFT's stroke service is compliant with NHSE Covid-19 response stroke specialty guidance.

Risks to delivery and mitigations

The average number of stroke admissions has increased over the last 3 months and has returned to normal levels (3 month rolling average - 19.7 admissions in April, 21.7 in May and 28 in June). The increase in the number of TIA patients attending clinic within 24 hours has also continued to near normal levels – 44 in May and June compared to 25 in April.

Are We Effective?

Other Measures



To note, the outpatient DNA rate measurement was changed by the PMO OP Transformation Board in April 2020 to remove a filter that excluded a set of OP clinics. By removing the filter the number of attendances has gone up, and therefore the DNA rate has dropped.

Part 2: Our Care



Our Priorities

Local Services

Specialist Services

Innovation

Care

People

Resources

How We Measure

Are We Effective?

Are We Responsive?

Are We Safe?

Are We Caring?

Are We Well Led?

Use of Resources

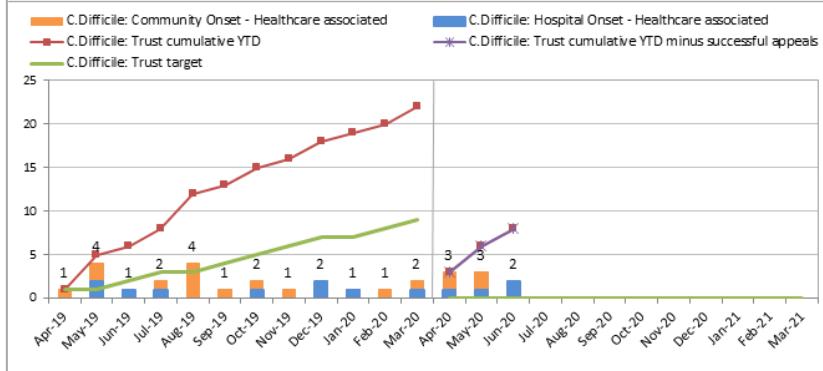
Infection Control

Data Quality Rating:



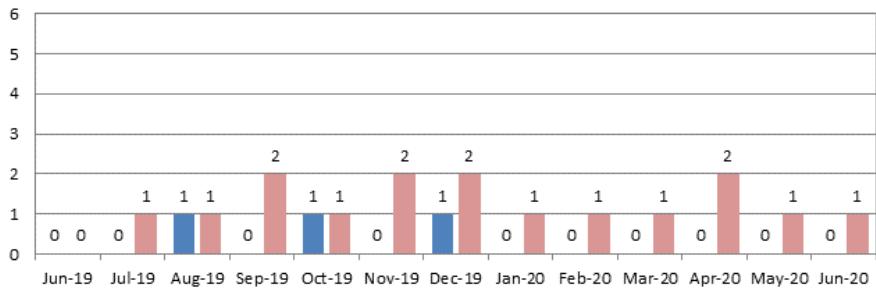
| Clostridium Difficile | Sep 19 | Oct 19 | Nov 19 | Dec 19 | Jan 20 | Feb 20 | Mar 20 | Apr 20 | May 20 | Jun 20 | MRSA | 2019-20 | 2020-21 |
|-----------------------|--------|--------|--------|--------|--------|--------|--------|--------|--------|--------|-------------------|---------|---------|
| CasesAppealed | 7 | 0 | 0 | 0 | 1 | 0 | 0 | 0 | 0 | 0 | Trust Apportioned | 0 | 1 |
| Successful Appeals | 5 | 0 | 0 | 0 | 1 | 2 | 0 | 0 | 0 | 0 | | | |

Clostridium Difficile: Healthcare Associated Cases



E Coli and MSSA

MSSA Trust Apportioned E Coli Trust Apportioned



Are We Safe?

Summary and Action

PHE have not yet set a C.Difficile upper limit for hospital onset healthcare associated and community onset healthcare associated cases.

In June, two hospital onset healthcare associated cases of C.Difficile occurred on the oncology unit. Both cases are currently under investigation and samples were sent to the external reference laboratory for ribotyping. The two hospital onset healthcare associated cases of C.difficile from April and May remain under investigation.

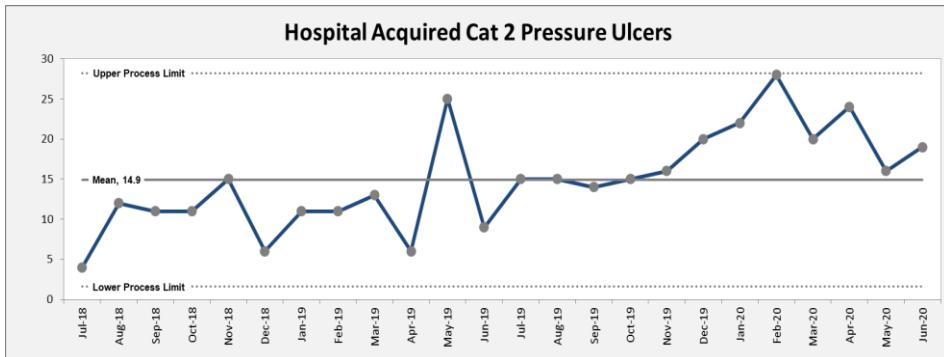
One hospital onset E. Coli bacteraemia - the source of infection is likely lower urinary tract. The patient was admitted to a surgical ward with urosepsis on a background of bladder cancer. The case is currently under investigation.

In respect of the Covid-19 emergency, the number of positive cases has significantly reduced over the last month. No new positive cases have been reported since 2 July. Regular meetings continue to take place to ensure national guidance is implemented. A Covid-19 clinical reference group meets twice a week to consider the clinical response to the pandemic, restarting non-Covid services and associated risks and makes recommendations to the recovery cell. In June, all staff in the hospital were required to wear face masks in public areas reduce the risk of transmission of Covid-19 and a staff antibody testing programme started.

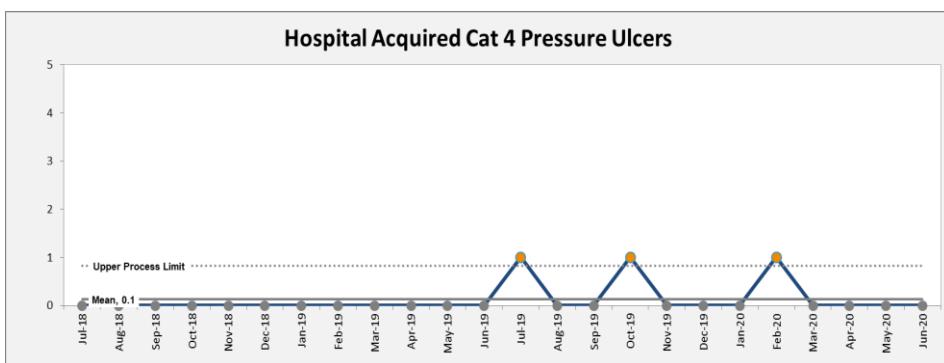
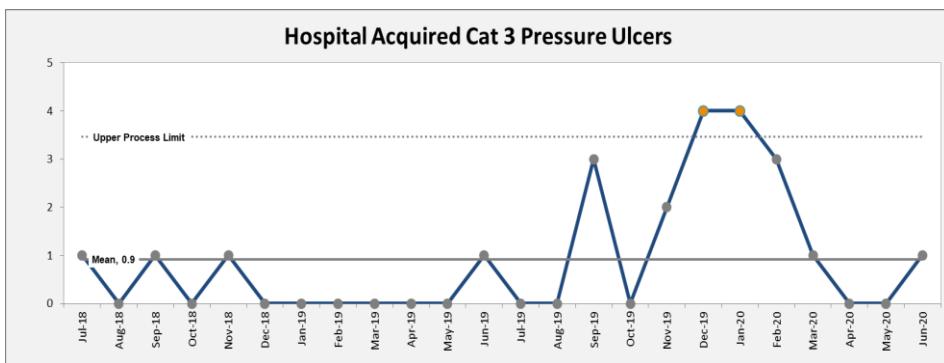
Pressure Ulcers

Are We Safe?

Data Quality Rating:



| Per 1000 Bed Days | 2019-20 Q1 | 2019-20 Q2 | 2019-20 Q3 | 2019-20 Q4 | 2020-21 Q1 |
|-------------------|------------|------------|------------|------------|------------|
| Pressure Ulcers | 1.05 | 1.10 | 1.22 | 1.73 | 2.27 |



Summary and Action

One category 3 pressure ulcer in June in a spinal patient where there were missed opportunities for mental health assessments that may have impacted on the patient's care. This case is subject to a serious incident inquiry.

An increase in the number of category 2 pressure ulcers from 16 in May to 19 in June with hotspots in 3 wards. A theme in June, was patients who developed pressure ulcers from skin shearing caused by inappropriate use of sliding sheets when transferring a patient from trolley to bed. Education sessions were adapted to train staff in transfer and the use of sliding sheets. Nutritional guidelines for patients at risk of, and those with pressure damage, have been rolled out in June. In total, 140 – 150 staff received education in the recognition, assessment and care planning of pressure ulcers over the last 3 months. The quality improvement project to reduce pressure ulcers is focused on AMU where observational studies have been undertaken to identify missed opportunities for skin inspection and subsequent care planning.

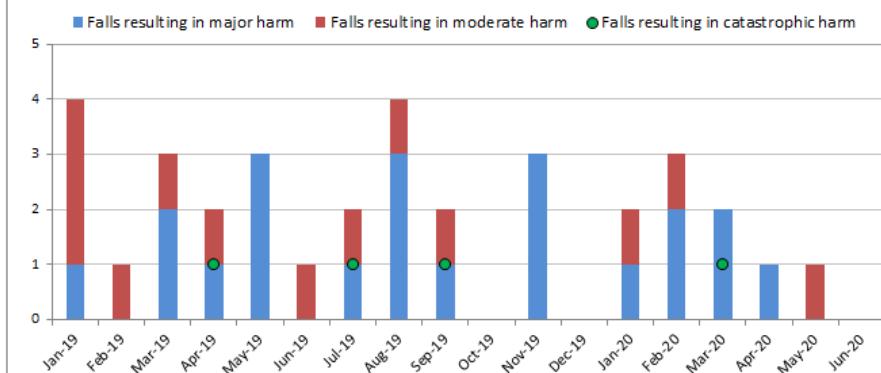
The cluster review and improvement plan was reported to the Clinical Governance Committee in June by the Heads of Nursing. The review highlighted a concern regarding baseline knowledge and education in our nursing staff on prevention of pressure damage.

It is too early to conclude any impact.

Patient Falls

Are We Safe?

Patient falls in hospital resulting in high harm



Definition of a high harm fall: A fall resulting in moderate, major or catastrophic harm

Data Quality Rating:



| Per 1000 Bed Days | 2019-20 Q1 | 2019-20 Q2 | 2019-20 Q3 | 2019-20 Q4 | 2020-21 Q1 |
|-------------------|------------|------------|------------|------------|------------|
| Patient Falls | 0.16 | 0.20 | 0.07 | 0.17 | 0.08 |

Summary and Action

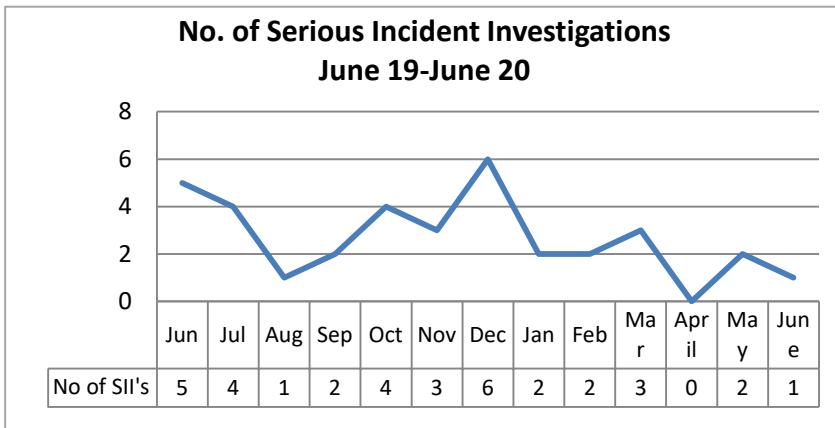
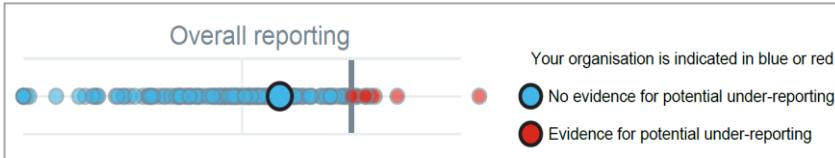
In June there were no high harm falls.

In June, the national inpatient falls audit 2020 (data 2019) was reported to the Clinical Management Board. This showed that 3 of the 4 key quality metrics were better than the national average. Our inpatient high harm falls data shows a decrease over the last 5 years.

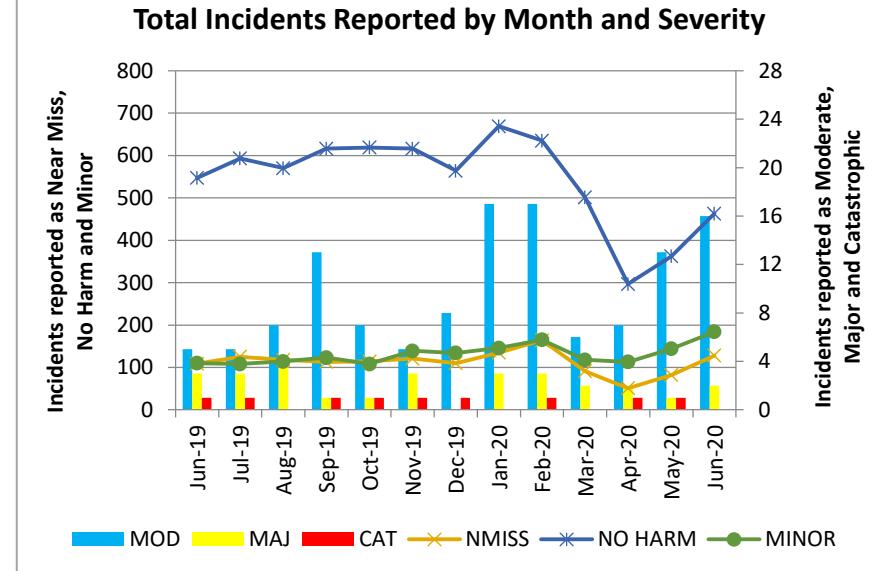
Incidents

Are We Safe?

| Year | 2019-20 | 2020-21 |
|--------------|---------|---------|
| Never Events | 2 | 0 |



Information from NRLS benchmarks SFT in regard to reporting of incidents and reflects a positive reporting culture.



Summary and Action

The number of incidents reported decreased during the peak of the Covid-19 emergency but have now increased again, probably related to increased activity.

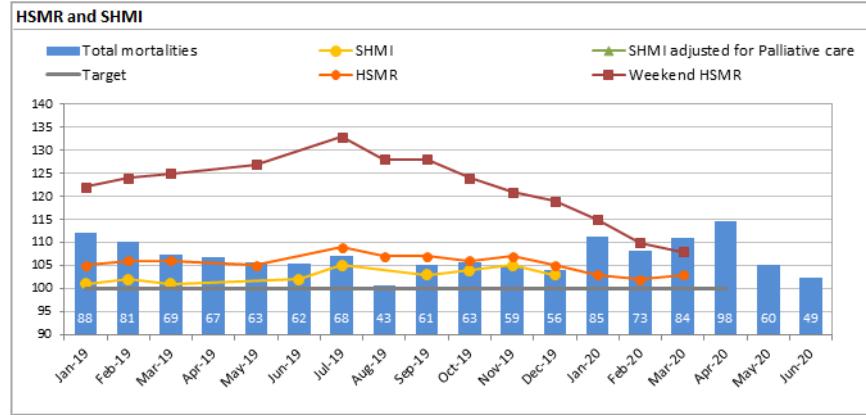
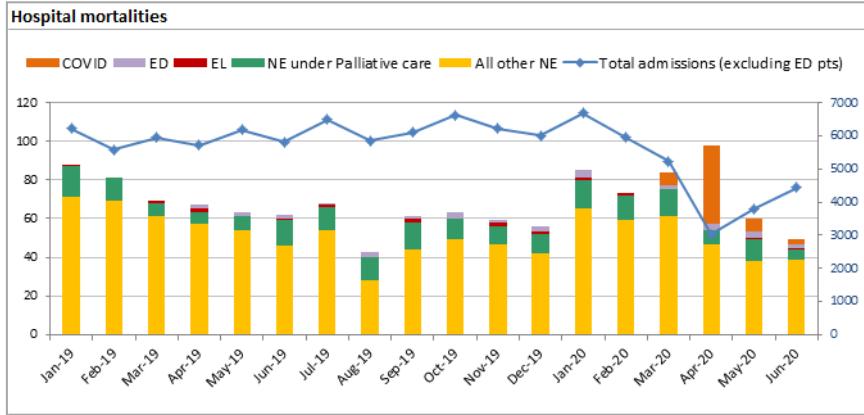
There was one newly commissioned serious incident inquiry in June. A spinal patient who sustained a category 3 pressure ulcer where there were missed opportunities for mental health and capacity assessments that may have impacted on the patient's care.

The pressure ulcer review and improvement plan was approved at the Clinical Risk Group and was presented to Clinical Governance Committee in June. A quality improvement project is underway to support the ongoing work with the improvement plan. The commissioners have been appraised of the review and the actions being taken to improve.

Mortality Indicators

Are We Safe?

Data Quality Rating:



Summary and Action

HSMR is as expected. The weekend HSMR has decreased again and is within the expected range.

Covid-19 associated mortality is now included in the report. Total deaths associated with Covid-19 are 57 (16 July) patients with a positive swab. The last death was reported on 13 June. 72% were men, the majority over 80 with underlying health conditions and the cause of death recorded as Covid-19 pneumonia. A total of 8 (16 July) patients had a negative swab but Covid-19 was recorded on their medical certificate of cause of death.

The Mortality Surveillance Group has partially completed a review of the deaths from Covid-19 to ascertain whether patients were involved in decisions about their care, escalation was appropriate, and if patients required ventilation, received it. This review will be reported to the Mortality Surveillance Group in September 2020.

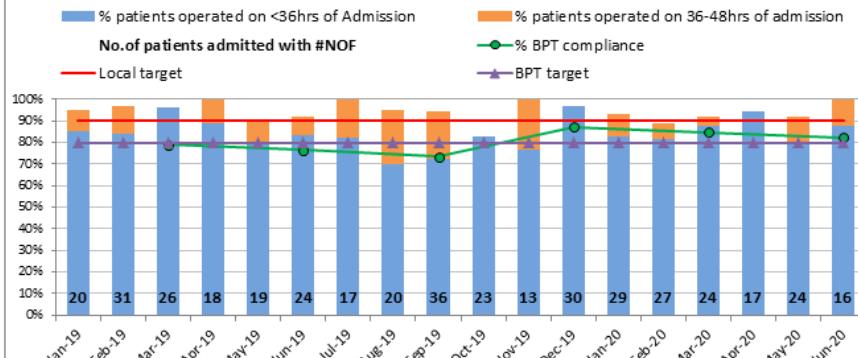
The Specialist Palliative Care Team and bereavement service have been contacting all relatives whose loved ones died during the Covid-19 emergency to ascertain their wellbeing, listen to and respond to concerns, offer support and signpost to other organisations.

Fracture Neck of Femur & VTE Risk Assessment/Prophylaxis

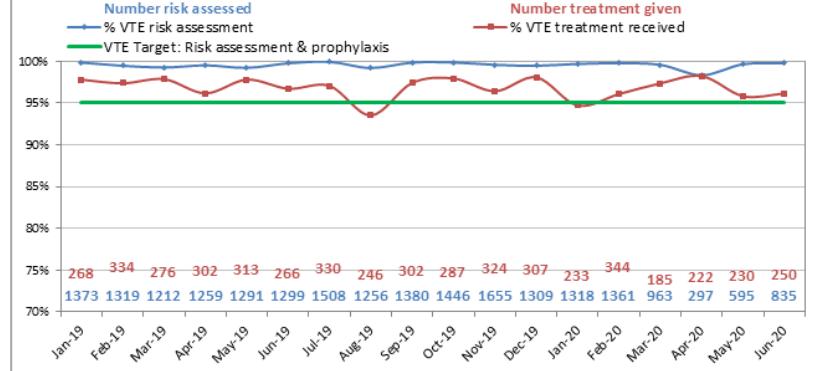
Data Quality Rating:



Fracture Neck of Femur operated on within 36 hours (Revised following TIAA Audit)



Venous Thrombus Embolism: Risk Assessment & Prophylaxis



Are We Safe?

Summary and Action

In June, three patients did not receive hip surgery for a fractured neck of femur within 36 hours. Two patients waited for theatre space, of whom one had surgery at 36.5 hours and the other at 44 hours. One patient had a missed fracture in ED and was recalled and had surgery the day after re-admission at 99 hours. Best practice tariff compliance in Q1 20/21 was 82.3%

NHSE and NHSI suspended reporting of VTE assessment and prophylaxis in Q1 20/21 but the Trust continued to report a high level of performance to provide assurance on the quality of care.

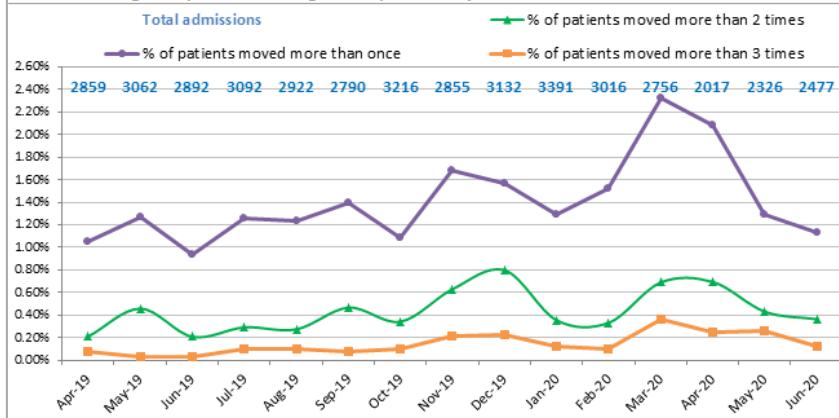
Patient Experience

| Last 12 months | Jul 19 | Aug 19 | Sep 19 | Oct 19 | Nov 19 | Dec 19 | Jan 20 | Feb 20 | Mar 20 | Apr 20 | May 20 | Jun 20 |
|-----------------|--------|--------|--------|--------|--------|--------|--------|--------|--------|--------|--------|--------|
| Bed Occupancy % | 93.3 | 94.1 | 96.9 | 94.9 | 97.1 | 95.9 | 94.4 | 96.1 | 81.8 | 60.5 | 64.0 | 76.4 |

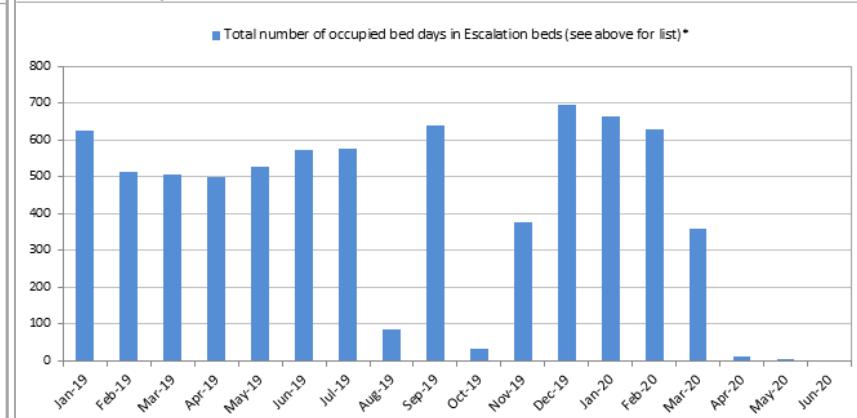
Data Quality Rating:



Patients moving multiple times during their Inpatient Stay



Escalation Bed Days



Are We Safe?

Summary and Action

No escalation bed capacity was opened in June as bed occupancy was low at 76.4%. Laverstock ward is currently included in our baseline bed capacity. The percentage of multiple ward moves decreased again as co-horting for suspected and confirmed Covid-19 patients was established and fewer patients with suspected Covid-19 were admitted. Since 2nd July no new Covid-19 cases have occurred.

At the end of June, as the national lockdown started to be lifted, all staff in hospitals were required to wear facemasks in corridors and public areas to stop the transmission of Covid-19. This is an additional layer of protection to social distancing and hand hygiene. A staff antibody testing programme was also started. The number of Covid-19 positive patients in hospital in the South West is now very low (36 of which 2 are in critical care on 8 July).

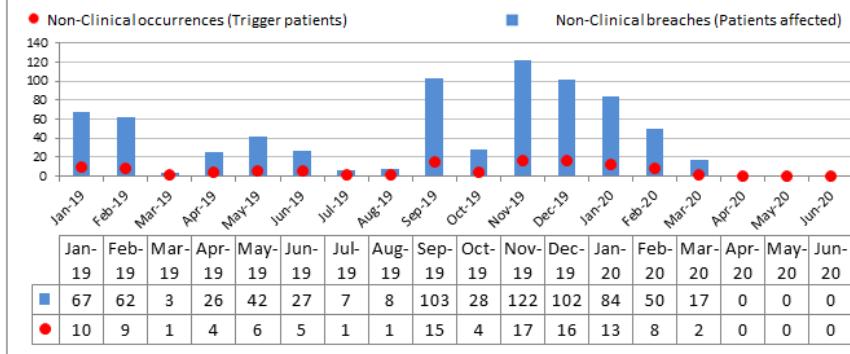
Patient Experience

Are We Safe?

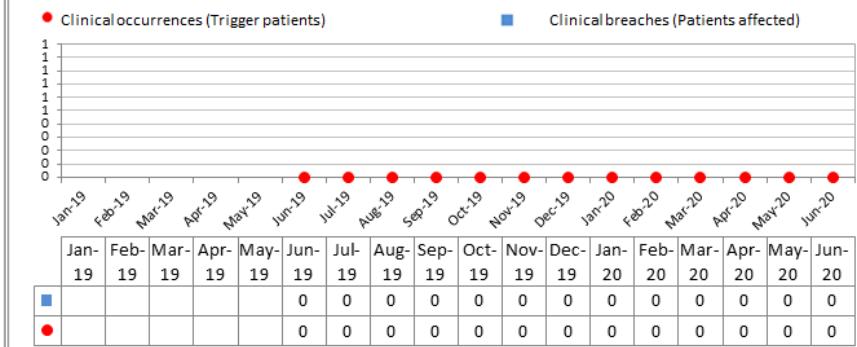
Data Quality Rating:



Delivering Same Sex Accommodation - Non-clinical



Delivering Same Sex Accommodation - Clinical



Summary and Action

No reported mixed sex accommodation breaches in June. The impact of managing the Covid-19 emergency has seen a reduction in the number of trolleys in AMU from 10 to 6 so that social distancing is maintained, along with the Trust wide reduced bed occupancy rate which has enabled patients to be moved quickly to downstream wards thereby avoiding any breaches. Whilst patient flow remains good we anticipate there will be very few, if any, mixed sex accommodation breaches.

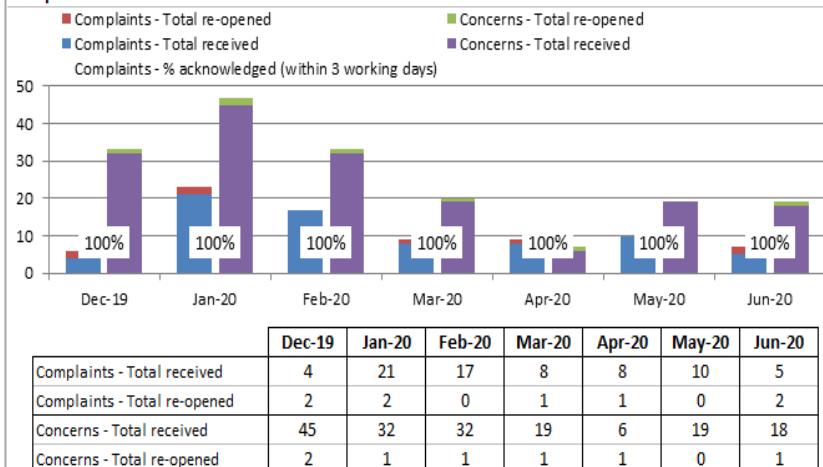
Patient & Visitor Feedback: Complaints and Concerns

Are We Responsive?

Data Quality Rating:



Complaints and Concerns

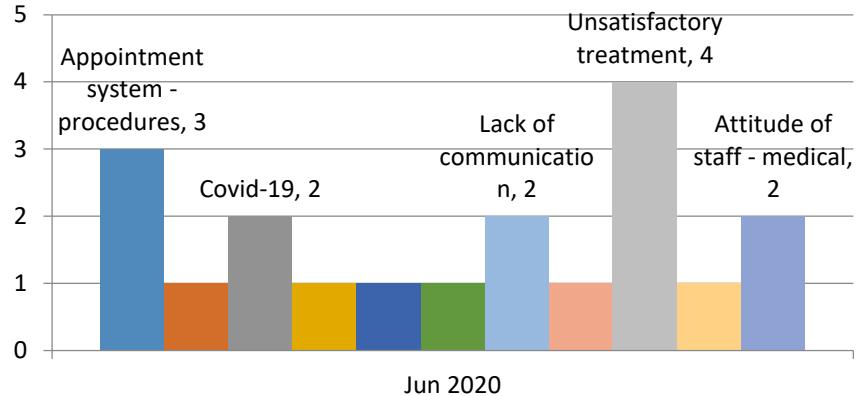


Summary and Actions:

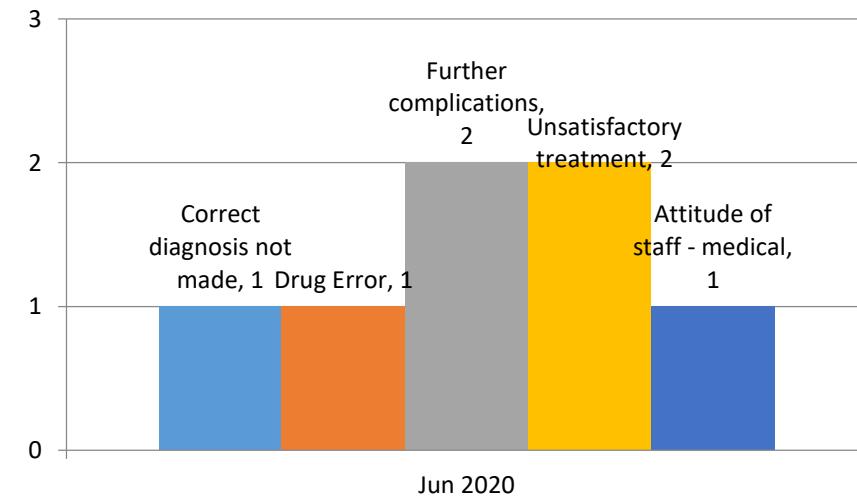
The top 2 themes of complaints are 'further complications' and 'unsatisfactory treatment'. Unsatisfactory treatment remains a theme for concerns in June, together with 'Appointments systems and Procedures'.

Actions from closed complaints in June include: Feedback to the relevant clinical team, for learning and reflection.

Themes From Concerns - June 2020



Themes From Complaints - June 2020



Part 3: Our People



Our Priorities

Local Services

Specialist Services

Innovation

Care

People

Resources

How We Measure

Are We Effective?

Are We Responsive?

Are We Safe?

Are We Caring?

Are We Well Led?

Use of Resources

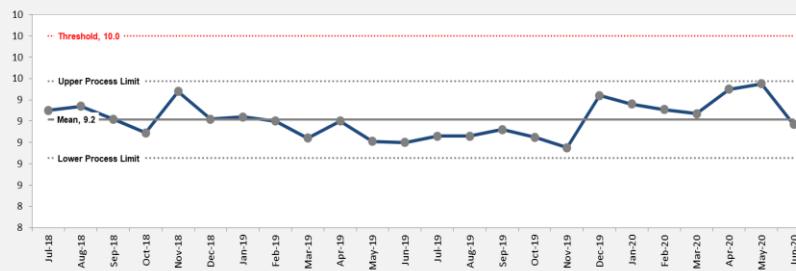
Workforce - Total

Use of Resources

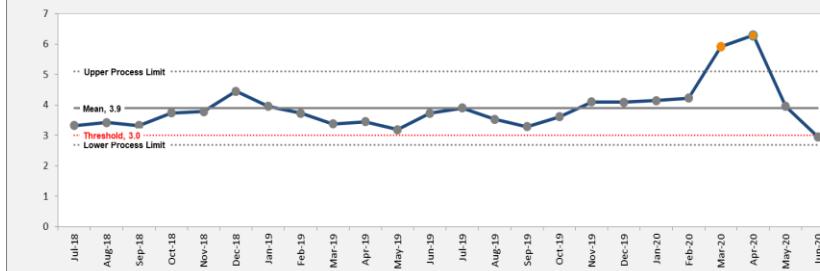
Total Workforce vs Budgeted Plan - WTEs

| | Jun '20 | | |
|----------------------|----------------|----------------|---------------|
| | Plan WTEs | Actual WTEs | Variance WTEs |
| Medical Staff | 425.1 | 508.6 | (83.4) |
| Nursing | 950.5 | 1002.2 | (51.8) |
| HCAs | 412.1 | 497.4 | (85.3) |
| Other Clinical Staff | 619.3 | 611.5 | 7.9 |
| Infrastructure Staff | 1,227.9 | 1,011.6 | 216.3 |
| TOTAL | 3,634.8 | 3,631.2 | 3.6 |

Staff Turnover %



Staff Absence %



Summary and Action

Turnover has taken a slight dip in month 3 as there were the lowest number of leavers in June, at 13, for the year so far. This was coupled with a marginal increase in number of starters (37) over last month although still not reaching pre Covid-19 levels in the 50s and 60s. It is anticipated that the numbers will steadily increase in the next few months until we return to these levels. Recruitment activity has increased over the last few weeks and will continue to do so as things return to a degree of normality.

Sickness in June reduced again to 2.95% (from 3.95% last month) with a 50/50 split between long and short terms absences. Of this total, 2.53% was non Covid-19 related and 0.42% Covid-19 related absence. This is the first month in 2020 that the Trust has been below the 3% target overall for sickness.

Currently there are a total of 86 staff in Stages 2-4 of the Attendance Management Policy for short term sickness absence, 2 long term sickness absence retiring or resigning and 13 others in other stages of process. Overall, managers, People Business Partners and Advisors are working together with Occupational Health colleagues to support staff to return to work (or prevent individuals from being absent).

During the last few months, there has been an increasing emphasis on staff wellbeing and the ability to link with the national helpline has been a real benefit. Over the next month or so, we will be developing the tender for our own Employee Assistance Programme so that we have continued local access to such arrangements if/when the national support comes to an end.

We are also refreshing our Health and Wellbeing Strategy and seeking ways of improving our wellbeing offer in the wake of the COVID pandemic. This is intended to include monthly calendar events around both physical and mental health and reflecting national days. We are working closely with Communications to develop this as an easily accessible resource for all staff.

Workforce – Nursing and Care

% Fill of Registered Nurse/HealthCare Assistant Shifts

Table 1 – June Data

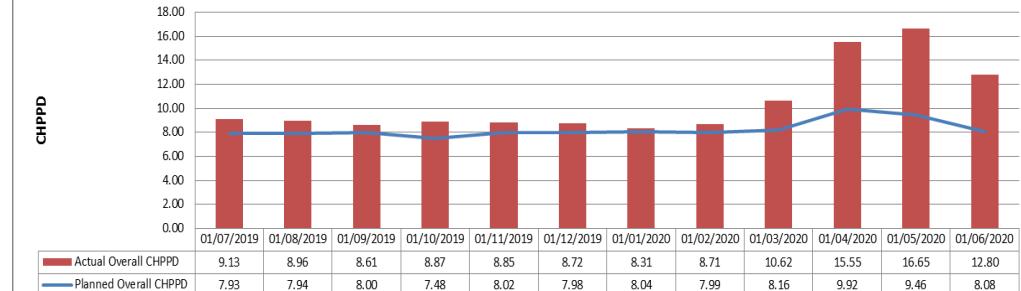
| Day | RN | HCA |
|---------------------|-------|-------|
| Total Planned Hours | 36264 | 19111 |
| Total Actual Hours | 38159 | 17823 |
| Fill Rate (%) | 105% | 93% |

| Night | RN | HCA |
|---------------------|-------|-------|
| Total Planned Hours | 26662 | 11448 |
| Total Actual Hours | 27661 | 11281 |
| Fill Rate (%) | 103% | 98.5% |

Care Hours Per Patient Day (CHPPD) - Monthly, 12 Month Trend

Table 2

Average Planned vs Average Actual Overall CHPPD



Summary and Action

Table 1 shows planned vs actual hours for RNs and HCAs across the wards for June. The graph on the right shows planned vs actual Care Hours per Patient Day at Trust level. (CHPPD is a simple calculation dividing the number of actual nursing/midwifery (both registered and unregistered) hours available on a ward per 24-hour period by the number of patients on the ward that day. It therefore nominally represents the average number of nursing hours that are available to each patient on that ward.) Of note this month we have re-calculated the planned CHPPD by dividing the number of staff planned for a roster by the total number of beds - this shows the expected impact of Covid-19 when wards were closed and/or had high numbers of empty beds through an increase in actual CHPPD. Prior to Covid-19 wards planned and actual establishment were very closely aligned.

Table 1 shows the overall planned vs actual fill rate for June. The RN rate has shown an increase to 105% and the HCAs a drop to 95% - due to both significant reduction in RN vacancy levels, several wards remaining closed with staff redeployed and reduction in demand for enhanced care requiring additional staff. The continued focus on reducing bank and agency also accounts for some of the reduction in HCA fill. All wards had sufficient staff for the numbers of patients admitted, with staffing templates remain set for normal bed occupancy and a slow return to normal bed occupancy is starting to be seen.

The skill mix of RN:HCA has remained consistent with last month with RN 69% /HCA 31%. The broad recommendation is 65%:35%.

2019/20 saw an overall nursing underspend which by end of M3 is now a £500k overspend, at the time of completing this report a deep dive is being undertaken into nursing expenditure. Factors being explored include 65 students in paid placement where budget has been received centrally but not offset, number of staff shielding/pregnant and not working clinically requiring backfill, increased establishments for RCU/ICU alongside log established gap in headroom. Compared to M1 there has been 50% reduction in spend on bank and agency from nearly £600k to £300k.

With regards to Nurse Sensitive Indicators the concern continues in the number of pressure ulcers. Trust wide review of practice and recovery programme underway and has been presented to Clinical Governance Committee. Increases in NSI's can be associated with suboptimal staffing levels, this is the only indicator currently flagging for us, and requires further investigation into underlying causes before a link can be made.

Workforce – Staff Training and Appraisals

Use of Resources

Summary and Action

Medical Appraisals

Although those due between March and September have been cancelled and the deferred appraisals counted as green, overall compliance is below 90% target at 83.15%, with the lowest compliance in Medicine at 75%. BPs are working with managers to target those who are awaiting appraisals as we start moving back towards business as usual.

Non Medical Appraisals

The compliance rate for non-medical appraisals is just below the 85% target at almost 83% with all Divisions focussed on improving this to reach target. It has been challenging to sign these off in recent months although this should now start to improve.

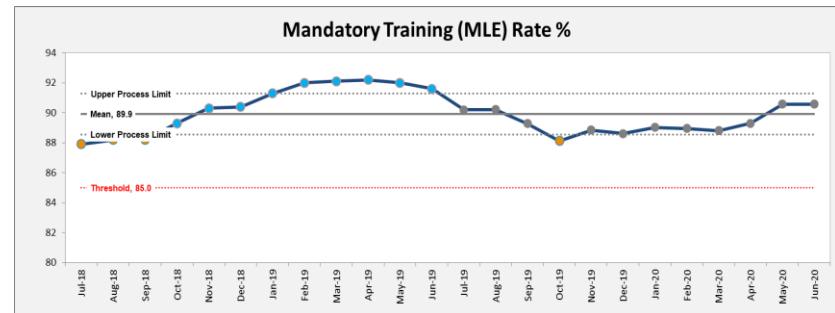
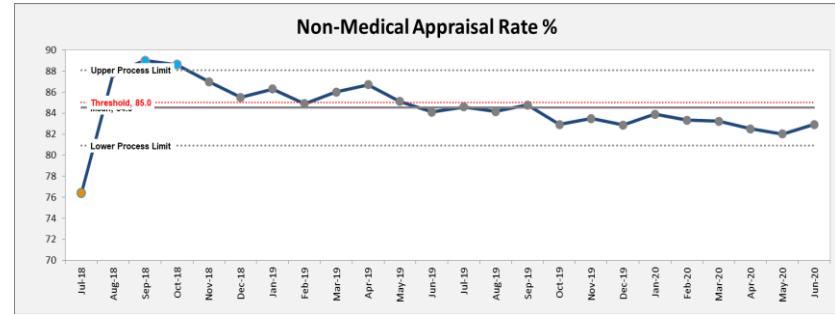
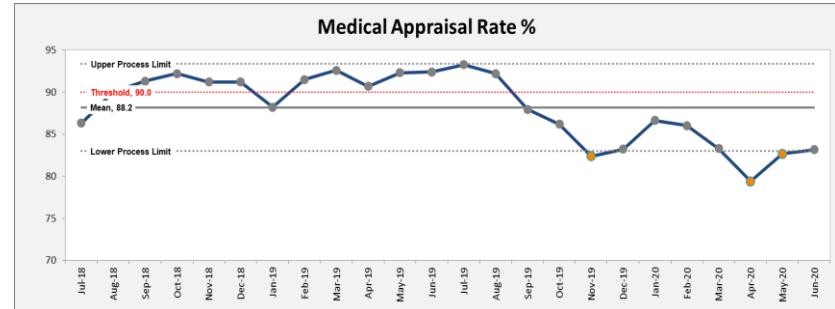
The movement of appraisal recording/administration from SPIDA to ESR will take place through the ESR Project from the Autumn onwards, so there is likely to be a dip on compliance at that time whilst individuals and managers adjust to a new system.

Training

The Mandatory and Statutory Training compliance rate has been somewhat static at just over 90.5% for the past two months. Divisions are still reporting that individuals have been able to complete MLE either due to working from home or being able to access a computer during quieter periods whilst we have been in the Covid-19 incident.

The decision has been taken to increase the target for MaST to 90% from the beginning of Quarter 2 – 1st July – which will be reflected in next month's report.

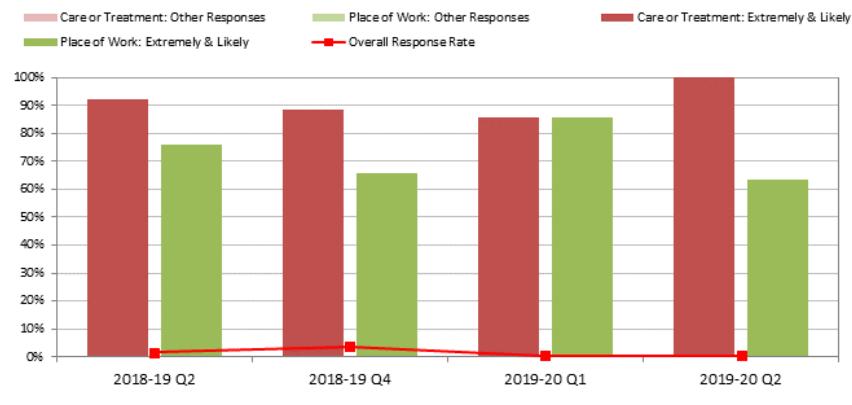
At least one Division is reporting compliance issues with GDPR and Hand Hygiene both of which appear to be a common thread. We know that GDPR is a particular issue because of the requirement to reach 95% compliance to satisfy the DSPT and we are considering whether a specific campaign for these two topics would be a way of improving both specific and overall compliance.



Friends and Family Test – Patients and Staff

Use of Resources

Staff Responses: Place of Work and Place of Care



In April, NHSE advised Trusts to cease collecting paper based Friends and Family Test cards due to health and safety concerns. The new Friends and Family Test question will go live in September 2020 and be reported from October. However in June, 173 responses were received as some wards and departments continued to ask patients for their feedback.

Since April, all patients attending a virtual appointment were invited to give their feedback. Over 400 patients responded and the feedback was overwhelmingly positive. This will be reported in the Patient Experience report.

Part 4: Use of Resources



Our Priorities

Local Services

Specialist Services

Innovation

Care

People

Resources

How We Measure

Are We Effective?

Are We Responsive?

Are We Safe?

Are We Caring?

Are We Well Led?

Use of Resources

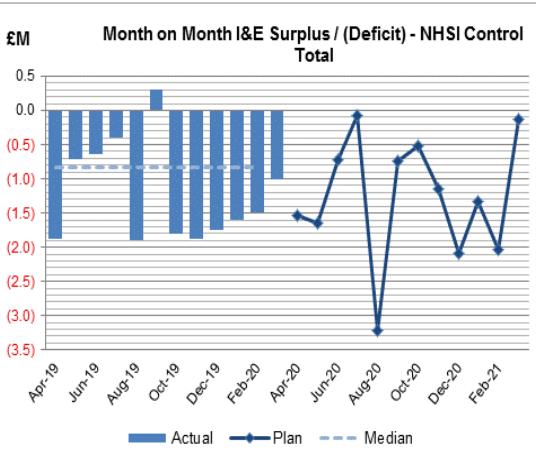
Income and Expenditure

Income & Expenditure:



Use of Resources

| | Position | | | 2019/20 Plan £000s | |
|--|-----------------|-----------------|-------------------|--------------------------|--|
| | Jun '20 In Mth | | | | |
| | Plan £000s | Actual £000s | Variance £000s | | |
| Operating Income | | | | | |
| NHS Clinical Income | 18,076 | 17,330 | (746) | 208,163 | |
| Other Clinical Income | 877 | 2,259 | 1,382 | 12,789 | |
| Other Income (excl Donations) | 2,416 | 2,307 | (109) | 28,992 | |
| Total income | 21,369 | 21,896 | 527 | 249,944 | |
| Operating Expenditure | | | | | |
| Pay | (13,637) | (14,061) | (424) | (163,634) | |
| Non Pay | (7,011) | (6,391) | 620 | (84,050) | |
| Total Expenditure | (20,648) | (20,451) | 197 | (247,684) | |
| EBITDA | 721 | 1,444 | 723 | 2,260 | |
| Financing Costs (incl Depreciation) | (1,449) | (1,444) | 5 | (17,474) | |
| NHSI Control Total | (728) | 0 | 728 | (15,214) | |
| Add: impact of donated assets | 52 | (66) | (118) | 1,626 | |
| Add: Impairments | 0 | 0 | 0 | 0 | |
| Add: Central MRET | 0 | 0 | 0 | 0 | |
| Add: FRF | 0 | 0 | 0 | 0 | |
| Surplus/(Deficit) | (676) | (66) | 610 | (13,588) | |



Variation and Action

For the purposes of financial reporting during the Phase 1 Covid-19 response the Trust is using the original 2020/21 plan as a baseline. This had assumed a deficit of £0.7m for the month, and a £15.2m deficit for the year, no central MRET or FRF was therefore assumed.

The block contracts and 'top-up' payment received as part of the Covid-19 response were not quite enough to cover the baseline costs of the Trust, with a claim for a £0.15m retrospective top up lodged by the Trust (YTD figure including £0.1m claim in Month 2). This is inclusive of the recognised £0.3m per month 'shortfall' in the top up methodology caused by the instruction from NHSE&I not to invoice for provider-to-provider genetics tests.

Pay showed a modest increase in the period, and non-pay increased by 10% as some limited activity returned, particularly around day cases (up 72% in month). This increase is forecast to continue as SOPs for routine activity are approved, although it should be noted that social distancing and deep clean arrangements mean that previous levels of productivity will not be reached. Discussions on how to reflect this in system contractual arrangements are on going at a national and regional level.

Income & Activity Delivered by Point of Delivery

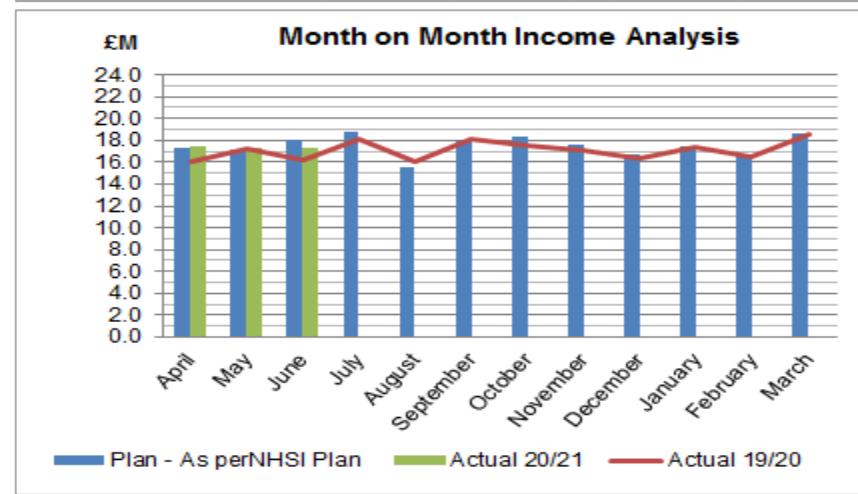
Clinical Income:



Use of Resources

| Income by Point of Delivery (PoD) for all commissioners | Jun '20 YTD | | |
|---|---------------|---------------|----------------|
| | Plan (YTD) | Actual (YTD) | Variance (YTD) |
| | £000s | £000s | £000s |
| A&E | 2,353 | 1,763 | (590) |
| Day Case | 4,320 | 1,510 | (2,810) |
| Elective inpatients | 4,575 | 855 | (3,720) |
| Excluded Drugs & Devices (inc Lucentis) | 4,812 | 3,879 | (933) |
| Non Elective inpatients | 15,571 | 11,630 | (3,941) |
| Other | 12,681 | 28,276 | 15,595 |
| Outpatients | 8,222 | 4,115 | (4,107) |
| TOTAL | 52,534 | 52,028 | (506) |

| Activity levels by Point of Delivery (POD) | YTD | | YTD | | YTD | | Last Year | Variance against |
|--|--------|---------|----------|---------|---------|-----------|-----------|------------------|
| | Plan | Actuals | Variance | Actuals | Actuals | last year | | |
| A&E | 18,328 | 11,625 | (6,703) | | | | 17,373 | (5,748) |
| Day case | 5,714 | 2,145 | (3,569) | | | | 5,361 | (3,216) |
| Elective | 1,212 | 328 | (884) | | | | 1,228 | (900) |
| Non Elective | 7,945 | 5,731 | (2,214) | | | | 6,633 | (902) |
| Outpatients | 63,894 | 37,119 | (26,775) | | | | 62,534 | (25,415) |



Variation and Action

Activity in June has increased above May levels across all of the main points of delivery. The most significant increases by specialty are General Surgery, Plastic Surgery and Cardiology Day cases, General Medicine and Urology within Non Elective and Plastic Surgery, Ophthalmology and Paediatrics within Outpatients.

Contracts with main payment values with main commissioners have been based on Month 9 agreement of Balances (from a provider perspective), adjusted by 2.803% for inflationary pressures. Over the first quarter of the year underlying activity has been valued at less than the agreed block by £18,258k (35%), owing to the temporary cessation of non-urgent planned work. The June adjustment has reduced by £1,237k as activity levels begin to reduce.

Cash Position & Capital Programme

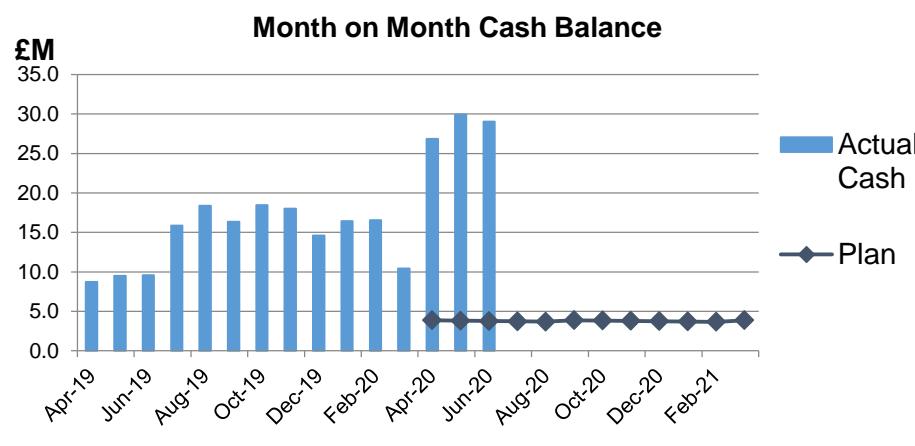
Capital Spend:



Cash & Working:



Use of Resources



Covid-19 response contractual arrangements are designed to ensure that there is sufficient cash in NHS providers to respond appropriately to clinical and operational challenges.

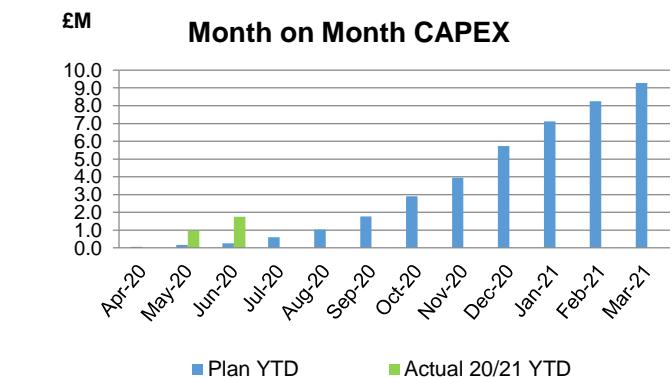
Payments on account in advance up until 31st July 2020 have been agreed and received. Plans for the next phase have yet to be communicated - this brings with it risk as at present there is no certainty around any payment in August, although balances are currently sufficient to return to a payment in arrears arrangement.

As an interim arrangement the NHSE&I SW regional team agreed commissioner payments on account would be made in July, effectively continuing the payments in advance.

Borrowings had included £23m of working capital loans due for repayment by 31 March 2021. The Trust has now received confirmation that these have been converted to PDC on 1 April 2020.

Capital Expenditure Position

| Schemes | Annual | | Jun '20 YTD | |
|-------------------|---------------|------------|--------------|----------------|
| | Plan | Plan | Actual | Variance |
| | £000s | £000s | £000s | £000s |
| Building schemes | 850 | 0 | 9 | (9) |
| Building projects | 2,600 | 50 | 91 | (41) |
| IM&T | 2,600 | 50 | 1,047 | (997) |
| Medical Equipment | 2,778 | 50 | 117 | (67) |
| Other | 449 | 112 | 112 | 0 |
| Covid 19 | 778 | 369 | 369 | 0 |
| TOTAL | 10,055 | 631 | 1,745 | (1,114) |



Summary and Action

Delays in capital works at the end of 2019/20, including those due to the Covid-19 response, has meant slippage into 2020/21. While agreed items were brought forward to offset a proportion of this slippage, the final 2019/20 outturn was c£900k short of that initially planned for. This has inevitably affected the phasing of the plan as the delays to committed spend has mostly been incurred in the first three months of 2020-21. The most material element falls in IT, where the Microsoft environment replacement project phases out Windows 7.

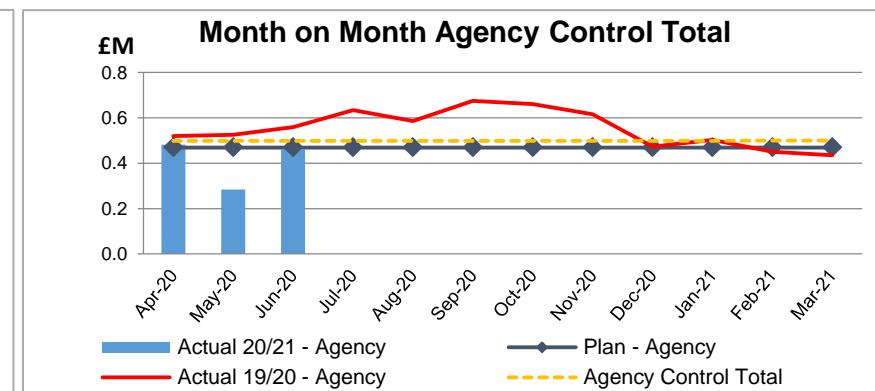
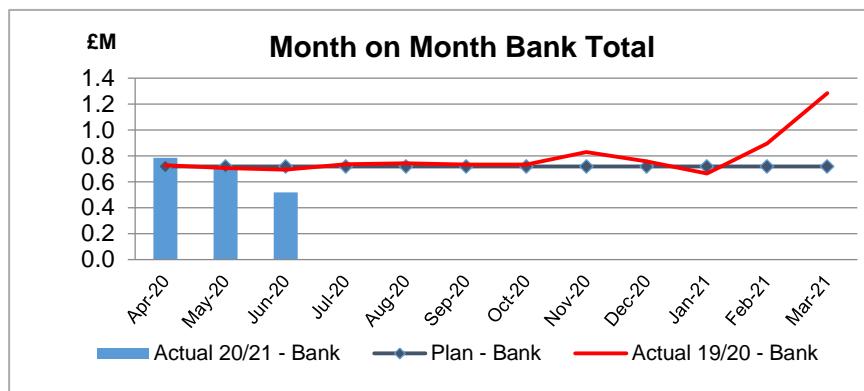
The Trust had £778k of funding for medical and IT equipment in 2020-21 as part of the Covid-19 response approved by the NHSE&I regional team and passed to the national team for final decision.

Workforce and Agency Spend

Pay:



Use of Resources



Summary and Action

Overall pay expenditure has remained broadly at the same level as May, representing a £424k overspend versus plan for the period. Additional costs continue to be incurred in relation to Covid with £1.5m of additional staffing costs incurred year to date, 80% of which relates to shifts by the incumbent workforce who would have been deployed elsewhere under normal circumstances. The rate at which this spend is being incurred has reduced drastically, although costs will not return to the same baseline due to the incremental costs of streaming patients on admission based on symptoms at presentation.

Sickness and self isolation due to Covid-19 continues to fall. Overall sickness absence rate in June was 2.95%, down from 3.95% in May and 6.29% in April.

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|-------------------------|-----------------------------|---------------------|-----|
| Report to: | Trust Board (Public) | Agenda item: | 2.3 |
| Date of Meeting: | 6 th August 2020 | | |

| | | | | |
|--|-----------------------------------|-------------------|--------------------------------|----------------------------|
| Report from: (Committee Name) | Audit Committee | | Committee Meeting Date: | 16 th July 2020 |
| 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.

The Board is recommended to accept the proposal by the Executive to reverse the adjustments made to the Standing Financial Instructions in response to the recent peak of the Covid 19 pandemic.

Key Items for Escalation

Capital Planning Deep Dive

The committee received a presentation regarding the capital planning process. The Committee were assured that the process was sufficiently robust to meet the Trust's basic needs, but there was a substantial discussion as to proposals for potential improvements. The Executive agreed to review these and bring back any revised process at some future date.

Annual Review of Committee Effectiveness

The Committee undertook its annual review of its effectiveness. There was a brief discussion, including inputs from stakeholders present at the meeting. The Committee concluded that its operation was sufficiently effective.

Proposal to Change Standing Financial Instructions (SFI)

In April there was Board approval to some temporary adjustments to the Trust's SFI in order to ensure that there was sufficient Executive cover for urgent spending approvals.

The Executive presented a short paper laying out why these adjustments were no longer required, now that the new mode of operation within the Trust has become regularised, and recommending that these adjustments are removed, reverting the

Trust's SFI's to those approved by the Board in December 2019.

There was a brief discussion by the Committee, who agreed that this change was now appropriate and agreeing to recommend this to the Board.

Review of Charitable Giving

Given the increase in charitable giving during the height of the recent Covid 19 pandemic and the risk that this might have created opportunities for bad actors to perpetrate fraud, the Local Counter Fraud Officer was asked to undertake a review of processes and recent transactions.

The review gave positive results, with investigations both into the effectiveness of internal control processes and scanning of internet giving processes failing to identify any substantive issues.

Other Matters

The Committee also received reports on planning for the Task and Finish Group, progress on outstanding overdue Internal Audit action points, planning and responses to external audit management points and the process for reporting reference costs. All of these reports were discussed and accepted.

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| Report to: | Trust Board (Public) | Agenda item: | 2.4 |
| Date of Meeting: | 6 August 2020 | | |

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|--|---|-------------------|------------------------------------|----------------------------|
| Report from: (Committee Name) | People and Culture Committee | | Committee Meeting Date: | 23 rd July 2020 |
| Status: | Information | Discussion | Assurance | Approval |
| | | | X | |
| Prepared by: | Michael von Bertele; Non-Executive Director | | | |
| Board Sponsor (presenting): | Michael von Bertele; Non-Executive Director | | | |

| Recommendation |
|--|
| The Trust Board are asked to note the items escalated from the People and Culture Committee meeting held on Thursday 23rd July 2020. |

| Key Items for Escalation |
|---|
| <p>1. The Committee noted good progress on the Best Place to Work (BPTW) programme and the importance of collecting feedback from staff noting all sources of intelligence, good and bad. It is important to demonstrate that all feedback is noted and that action is seen to be taken. This work will be presented at main Board in September as an update on progress.</p> <p>2. The committee noted progress in formalising the consultant job planning process and recognised that the link to productivity will only be achieved if consultants accept the importance of this, and if the clinical directors of each directorate are able to oversee adherence to agreed plans. It was agreed that challenging targets should be set for the signing of job plans with 50% being complete by end of October, 100% by end of January.</p> <p>3. The Medical Director and Guardian of Safe Working provided excellent updates on out of hours working and the concerns of junior doctors and trainees which provided reassurance that we have a much better understanding of the issues that contribute to overall safety. It was however noted that the extraordinary circumstances of the past 5 months were unusual, but we are in a better place from which to monitor issues such as 7 day and weekend working and the Hospital at Night, in the future.</p> <p>4. An update on retention, in particular of nursing staff was very encouraging. There is however still an absence of data from exit interviews which we hope to restart.</p> <p>5. The outcome of a deep dive was presented that provided a useful reminder of how apparently intractable risks should be managed. Risk 5972, "the Risk that improvement and transformation is not delivered in a timely manner" had an overall score of 16 for over 6 months. This provided a trigger to focus attention on the control measures, and actions that need to be taken. As a result there is greater focus on the programme, the risk description was revised and the risk score has been reduced.</p> |

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| Report to: | Trust Board | Agenda item: | 2.5 |
| Date of Meeting: | 6 August 2020 | | |

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|------------------------------------|-------------------------------------|-------------------|--------------------------------|----------------------------|
| Committee Name: | Finance and Performance | | Committee Meeting Date: | 28 th July 2020 |
| Status: | Information | Discussion | Assurance | Approval |
| | | | X | |
| Prepared by: | Paul Miller, Non Executive Director | | | |
| Board Sponsor (presenting): | Paul Miller, Non Executive Director | | | |

| Recommendation |
|---|
| To note key aspects of the Finance and Performance Committee meeting of the 28 th July 2020. |

| Items for Escalation to Board |
|---|
| e-PMA Business Case – The Committee received this business case for a new electronic prescribing system, the costs are approximately £2.2m over 5 years, with hopefully about £1.7m coming from a national IT funding bid to be submitted in mid-September 2020, with planned implementation early in 2021. The committee agreed the following (a) it was a high Trust priority to implement an electronic prescribing (e-PMA) system (b) the business case was agreed in principle, however (c) key aspects of the business case did not fully record or detail; why the recommended choice of supplier, how the implementation would be project managed, clinical ownership going forward and wider risk management. It was agreed that an updated business case would come back to the committee at its next meeting on the 25 th August 2020, with these issues addressed, before a formal recommendation would be made to the Trust Board on the 3 rd September 2020. |
| Commercial retail development, front hospital entrance – the Board have previously agreed a preferred bidder to enter into a commercial partnership with for the front hospital entrance. This paper updated the committee on recent developments in the detailed commercial contract negotiations. The key issue being COVID-19 has resulted in a downward projection of customer “footfall” with a consequential adverse impact on future income. The preferred bidder has submitted a revised financial forecast and income shares. The committee reviewed this (and other options) and decided to recommend acceptance of the revised reduced proposals as the best of the currently available options. |
| Salisbury Trading Limited (STL) loan – As part of the response to COVID-19, STL (a wholly owned subsidiary company of the Trust) made an additional purchase of £500k of additional linen. The committee received a recommendation to finance this purchase via a £500k loan from the Trust, repayable over 5 years at an interest rate of 3.5%, finally it was |

agreed to recommend deferral of the first repayment for 12 months after receipt of the loan.

COVID-19 – Recovery Planning Update – The paper updated the committee on progress as at the end of June 2020 and covered patient demand, trust capacity and the ongoing management of constraints. The paper highlighted four key challenges;

- (1) Infection, prevention and control measures impacting on beds and theatres
- (2) Flexible staffing rotas to support escalation but also de-escalation
- (3) Estates infrastructure both physical space and safe ventilation space
- (4) Patient choice

The paper also looked ahead to start planning the winter of 2020/21 and highlighted the importance of effective system working to ensure the hospital can safely provide services, at a time when covid-19 will still likely be present in the population. Finally the paper identified a series of next steps within an action plan, with named executive directors having lead responsibility and the committee would receive monthly progress reports against these actions until further notice.

Integrated performance and finance reports as at 30th June 2020 – both reports were received and noted the key issues were (a) elective activity and diagnostic performance were concerns, however actions are in hand to improve performance and address operational constraints and (b) the Trust continues to financially break even, as at month three, as a consequence of the current interim NHS finance regime, which provides a nationally agreed financial “top up” to cover covid-19 excess costs and a locally agreed “true up” to bring the trust back to exact break-even.

Estates Critical Infrastructure Report – The Board were briefed on key estates risks at its meeting in December 2019 and informed that a detailed technical survey of estates infrastructure had been commissioned. This report was presented to the committee and a wide range of high risk issues were identified. The committee agreed that the risk register should be revised to recognise the significant risks we face and that a wide range of very urgent actions were required to minimise and mitigate these risks. As for the root cause of these problems, it was reported that it was a combination of historically low investment, gaps in technical estates competence and a culture of historically not proactively raising concerns.

Going forward there is a new local estates leadership team in place, meetings have been held with partner trusts in our STP to provide interim estates advice and support and the Trust has benefited from a recent £3m plus increase in capital funding to address estates backlog maintenance concerns. Finally, these issues will be discussed further at the next Trust Board on the 6th August 2020 and the Board can then decide whether follow up progress on agreed actions will be directly overseen by the Board or delegated to the F&P committee.

STP drivers of the deficit report – This detailed STP report as received by the committee and it was noted that the STP as a whole had a reported recurring deficit of £70m and Salisbury NHS FT's share of that was £17.1m. The report was a diagnostic piece of work that analysed this Salisbury £17.1m deficit by;

- (a) Structural, outside the Trusts control (£2.7m)
- (b) Strategic, within the Trusts control (£3.8m)
- (c) Operational, within the Trusts control (£2.8m)
- (d) Cost shift, outside the Trusts control (£7.8m)

Finally the committee thanked Lisa Thomas for personally leading this STP wide piece of work.

Board Assurance Framework and Corporate Risk Register – The committee reviewed these documents and amendments will be made to them in light of the discussions at this committee, in particular the increased risk on estates.