Salisbury NHS Foundation Trust

Report to:	Trust Board	**Agenda item:**	3.5
Date of Meeting:	2nd February 2023		

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 & care: Clinical Governance Committee • Workforce: People & Culture Committee			
Prepared by:	Louise Drayton, Performance and Capacity Lead Emilia Scutt, Head of Performance			
Executive Sponsor (presenting):	Melanie Whitfield, Chief People Officer			
Appendices (list if applicable):	Not applicable			

Recommendation:
The Trust Board are asked to note the Trust's performance for Month 9 (December 2022)

Executive Summary:
The average wait to first appointment increased further in Month 9, with an average wait time of 125 days. This is not entirely unexpected given the Christmas and New Year period which sees a reduction in new referrals, alongside a reduced number of appointments offered, resulting in longer average waits for that period. Over 52 week waits saw a sharp increase in December, predominantly driven by Dermatology and Oral Surgery and to a lesser extent Cardiology and ENT but remained slightly ahead of trajectory. Work to reduce the number of patient falls continues as a key focus of the "Improving Together" programme, with a Month 9 position of 7.9 falls per 1000 bed days against a target of 7, which was a deteriorating position in comparison to 7.48 in Month 8. Work continues in relation to the roll out of "Bay watch", though further focus is required in terms of staff availability to attend formal training. Performance against the 4 hour standard remained static in Month 9 at 73.3% compared to 73.4% in Month 8. The total A&E attendances were high in M9 at 6839, which is the highest monthly number to date. Increased activity at the walk in centre (type 3 activity) is driving this, with attendances in M9 50% higher than in M8. Attendances in the main A&E department (type 1) and Eye Unit (Type 2) remain within normal limits. Pressure on flow into

the hospital remains a key factor in the ability to assess and admit or discharge patients in the Emergency Department in a timely manner.

An increasing number of patients required admission due to Winter respiratory viruses which culminated in around 100 beds occupied by patients with either Covid-19, Influenza or Respiratory Syncytial Virus (RSV). The impact of this was apparent in the occupancy levels in the hospital, the high number of escalation beds in use. Additionally, staff sickness absence spiked at 5.3% as a consequence of higher community prevalence of respiratory viruses. The impact of decreased flow was evident in the number of patients spending longer than 12 hours from arrival to discharge or admission in the Emergency Department which affected 201 patients (78 in M8).

Month 9 saw a significant increase in the number of ambulances attendances of 1403. 19% of patients waited >60 minutes to be handed over, with 7% waiting < 60 minutes and 74% of patients meeting target of <15 minutes. The department has mitigated ambulance handover delays with patients receiving initial assessment and diagnostic tests whilst waiting to off load into the department.

The total Referral to treatment (RTT) waiting list size position at the end of December stood at 24,904, 1,348 behind plan (an improvement of 65 in month).

Overall DM01 performance declined in Month 9 compared to Month 8 (from 62.22% to 55.61%), representing an increase in breaches (332 patients). There has also been an overall decline in total waiting list size of 617. The increasing number of breaches vs. a smaller waiting list exacerbates the overall decline in performance. Areas that continue to report high numbers of breaches are MRI, USS, Audiology and Endoscopy. Cardiology Echo has significantly improved and reduced breaches to 10 patients which is a significant achievement when reviewing historical performance. The largest constraint impacting DM01 performance remains as workforce capacity.

The proportion of patients referred on a suspected cancer pathway that were seen within 14 days decreased to 79.4% in comparison with Month 8 (89%), with ongoing capacity constraints most evident with skin due to staffing and recruitment challenges impacting outpatient capacity, as well as Lower GI due to endoscopy staffing issues and incomplete straight to test GP referrals. The 28 day faster diagnosis standard was achieved, with challenges associated with diagnostic capacity and administrative delays in informing patients of their no cancer diagnosis by letter. Opportunities for further improvement are monitored via Cancer Improvement Group. Improvement seen in relation to delivery against the 62 day standard, though standard continues not to be achieved with Month 9 performance of 78.6% (73.7% in Month 8). Breaches associated with patient choice, diagnostic capacity and reporting turnaround times as well as insufficient capacity throughout pathways.

There has been a growth in the number patients moved more than once in Month 9 (1.91%), compared to the previous month (1.65%), which is as a result of the increased number of escalation beds (inclusive of the Discharge Lounge due to operational pressures) as well as an increase in the incidence of respiratory illnesses, resulting in the moving and cohorting of patients in line with Infection Control processes.

The Trust reported a decrease in reported category 2 pressure ulcers per 1000 bed days in Month 9 (1.99) alongside a reduction if FFT responses in month (2.03% overall response rate). Three serious incident investigations were reported. It is important to note that the volume of reported pressure ulcers and incidents may be detrimentally affected by operational pressure and staff ability to report. This remains under close monitoring to identify trends.

Positively, there has been an improvement for the second month in fill rate on night health care assistant (HCA) shifts, attributed to the Allocation on Arrival shifts. 100% fill rate was achieved which is a considerable improvement on fill rate over the last 12 months.

There has been minimal change to fill rate of day HCA or day and night registered nurse shifts, and the care hours per patient day remains at 7.4 for December with an improving trend from 6.3 in M6.

In Month 9 the Trust recorded an in month control total deficit of £2.752m against an original target of £0.907m - an adverse variance of £1.845m. The year to date control total deficit is £12.660m compared to the original plan of £8.381m. Pay costs decreased slightly in month by £0.2m driven by a reduction in agency shifts with an increased level of unfilled shifts. Non pay costs increased markedly due to recharges for the Vaccination centre, which were backed by income, Computer software and STL related costs. 'Pass through' non pay costs continue to run in excess of those planned for and now account for 60% of costs above plan.

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) -	☐

Integrated Performance Report

NHS
Salisbury
NHS Foundation Trust

December 2022

Summary

December 2022

The average wait to first appointment increased further in Month 9, with an average wait time of 125 days. This is not entirely unexpected given the Christmas and New Year period which sees a reduction in new referrals, alongside a reduced number of appointments offered, resulting in longer average waits for that period. Over 52 week waits saw a sharp increase in December, predominantly driven by Dermatology and Oral Surgery and to a lesser extent Cardiology and ENT but remained slightly ahead of trajectory.

Work to reduce the number of patient falls continues as a key focus of the "Improving Together" programme, with a Month 9 position of 7.9 falls per 1000 bed days against a target of 7, which was a deteriorating position in comparison to 7.48 in Month 8. Work continues in relation to the roll out of "Bay watch", though further focus is required in terms of staff availability to attend formal training.

Performance against the 4 hour standard remained static in Month 9 at 73.3% compared to 73.4% in Month 8. The total A&E attendances were high in M9 at 6839, which is the highest monthly number to date. Increased activity at the walk in centre (type 3 activity) is driving this, with attendances in M9 50% higher than in M8. Attendances in the main A&E department (type 1) and Eye Unit (Type 2) remain within normal limits. Pressure on flow into the hospital remains a key factor in the ability to assess and admit or discharge patients in the Emergency Department in a timely manner.

An increasing number of patients required admission due to Winter respiratory viruses which culminated in around 100 beds occupied by patients with either Covid-19, Influenza or Respiratory Syncytial Virus (RSV). The impact of this was apparent in the occupancy levels in the hospital, the high number of escalation beds in use. Additionally, staff sickness absence spiked at 5.3% as a consequence of higher community prevalence of respiratory viruses. The impact of decreased flow was evident in the number of patients spending longer than 12 hours from arrival to discharge or admission in the Emergency Department which affected 201 patients (78 in M8).

Month 9 saw a significant increase in the number of ambulances attendances of 1403. 19% of patients waited >60 minutes to be handed over, with 7% waiting < 60 minutes and 74% of patients meeting target of <15 minutes. The department has mitigated ambulance handover delays with patients receiving initial assessment and diagnostic tests whilst waiting to off load into the department.

The total Referral to treatment (RTT) waiting list size position at the end of December stood at 24,904, 1,348 behind plan (an improvement of 65 in month).

Overall DM01 performance declined in Month 9 compared to Month 8 (from 62.22% to 55.61%), representing an increase in breaches (332 patients). There has also been an overall decline in total waiting list size of 617. The increasing number of breaches vs. a smaller waiting list exacerbates the overall decline in performance. Areas that continue to report high numbers of breaches are MRI, USS, Audiology and Endoscopy. Cardiology Echo has significantly improved and reduced breaches to 10 patients which is a significant achievement when reviewing historical performance. The largest constraint impacting DM01 performance remains as workforce capacity.

The proportion of patients referred on a suspected cancer pathway that were seen within 14 days decreased to 79.4% in comparison with Month 8 (89%), with ongoing capacity constraints most evident with skin due to staffing and recruitment challenges impacting outpatient capacity, as well as Lower GI due to endoscopy staffing issues and incomplete straight to test GP referrals. The 28 day faster diagnosis standard was achieved, with challenges associated with diagnostic capacity and administrative delays in informing patients of their no cancer diagnosis by letter. Opportunities for further improvement are monitored via Cancer Improvement Group. Improvement seen in relation to delivery against the 62 day standard, though standard continues not to be achieved with Month 9 performance of 78.6% (73.7% in Month 8). Breaches associated with patient choice, diagnostic capacity and reporting turnaround times as well as insufficient capacity throughout pathways.

There has been a growth in the number patients moved more than once in Month 9 (1.91%), compared to the previous month (1.65%), which is as a result of the increased number of escalation beds (inclusive of the Discharge Lounge due to operational pressures) as well as an increase in the incidence of respiratory illnesses, resulting in the moving and cohorting of patients in line with Infection Control processes.

The Trust reported a decrease in reported category 2 pressure ulcers per 1000 bed days in Month 9 (1.99) alongside a reduction if FFT responses in month (2.03% overall response rate). Three serious incident investigations were reported. It is important to note that the volume of reported pressure ulcers and incidents may be detrimentally affected by operational pressure and staff ability to report. This remains under close monitoring to identify trends.

Positively, there has been an improvement for the second month in fill rate on night health care assistant (HCA) shifts, attributed to the Allocation on Arrival shifts. 100% fill rate was achieved which is a considerable improvement on fill rate over the last 12 months. There has been minimal change to fill rate of day HCA or day and night registered nurse shifts, and the care hours per patient day remains at 7.4 for December with an improving trend from 6.3 in M6.

In Month 9 the Trust recorded an in month control total deficit of £2.752m against an original target of £0.907m - an adverse variance of £1.845m. The year to date control total deficit is £12.660m compared to the original plan of £8.381m. Pay costs decreased slightly in month by £0.2m driven by a reduction in agency shifts with an increased level of unfilled shifts. Non pay costs increased markedly due to recharges for the Vaccination centre, which were backed by income, Computer software and STL related costs. 'Pass through' non pay costs continue to run in excess of those planned for and now account for 60% of costs above plan.

What we are measuring – our Strategic Priorities

Improving the health and well being of the Population we serve

Working through Partnerships to transform and integrate our services

Supporting our People to make Salisbury NHS Foundation Trust the Best Place to Work

Our focus – Breakthrough Objectives and Strategic Initiatives

Strategic Initiatives	Breakthrough Objectives
Delivering the NHS People Promise	Reducing Falls in hospital
Improving Together	Reducing the number of patients in hospital with no criteria to reside
Improving health and reducing health inequalities	Reducing time to first outpatient appointment
Digital Care	Elective Recovery Programme

What is an Integrated Performance Report (IPR)?

NHS Salisbury NHS Foundation Trust

Our IPR is a summary view of how our Trust is performing against various strategic and operational objectives that are set as part of the recently updated strategy. It is divided into three sections (Quality of care, access and outcomes, People and Finance and Use of Resources) which contain the following within them:

Key Term	Definition
Breakthrough Objective	Area of focus for the whole organisation for the next 12-18 months. We are striving for an improvement of 30%+ in these metrics over this period.
Key Performance Indicator	Key metric that is monitored as part of NHS National Operating Framework for 2022/23 and heavily relates to improving patient care and increasing positive outcomes.
Alerting Watch Metric	A metric that has triggered one or more business rules and should be monitored more closely to analyse worsening performance, or achievement celebrated if performing is improving.
Non-alerting Watch Metric	A metric that we are monitoring but is not a current cause for concern as it is within expected range.

Business Rules - Driver Metrics

Rule No	Rule	What It means	Suggested Action for Metric Owner	Rationale
1	Driver does not meet target for a single month	Performance outside of expected range for a single month	Give Structured Verbal Update	Understanding required as to whether adverse performance will be due to a consistent issue or a one off event
2	Driver does not meet target for 2 or more months in a row	Performance outside of expected for multiple months in a row	Prepare Countermeasure Summary	Showing signs of continued difficulty meeting the target and need understanding of root cause.
3	Driver meets or exceeds target for a single month	Performance outside of expected range for a single month	Share top contributing reason	Showing early signs of improvement but not yet sustained
4	Driver meets or exceeds target for 2 or more months in a row	Performing above target for multiple months in a row	Share success and move on	Showing signs of continued improvement but not yet assured that the target will always be met
5	Driver meets or exceeds target for 4 or more months in a row	Performing above target for a sustained length of time	Consider swapping out for a Concerning Watch metric/increase target of Driver	Assess Watch metrics and consider switching out this high performing Driver metric for an underperforming Watch metric, or increasing target of Driver metric
6	Driver is orange	Performance outside of expected range in a negative/deteriorating direction	Refer to rules 1-4 above and act accordingly	Driver metrics are being deliberately targeted and therefore SPC rules are not strict enough for monthly performance assurance purposes
7	Driver is grey	Performance is in line with expectations (no special cause)	Refer to rules 1-4 above and act accordingly	Driver metrics are being deliberately targeted and therefore SPC rules are not strict enough for monthly performance assurance purposes
8	Driver is blue	Performance outside of expected range in a positive /improving direction	Refer to rules 1-4 above and act accordingly	Driver metrics are being deliberately targeted and therefore SPC rules are not strict enough for monthly performance assurance purposes

Business Rules - Watch Metrics

Rule No	Rule	What It means	Suggested Action	Rationale
9	Watch has one point out of control limits – orange	Concerning performance	Share top contributors and move on	**SPC logic** – Orange means special cause variation causing adverse performance. Understanding required as to whether adverse performance will be due to a consistent issue or a one off event
10	Watch has 2 out of 3 points low – orange	Worsening performance	Give Structured Verbal Update (includes top contributors)	**SPC logic** – Orange means special cause variation causing adverse performance. Understanding required as to whether adverse performance will be due to a consistent issue or a one off event
11	Watch has 4 points below mean or 4 points deteriorating - orange	Worsening performance	Consider: - Upgrading to a Driver and which driver to downgrade to a watch (include on Slide 4)	**SPC logic** – Row of orange dots means special cause variation causing adverse performance. Discussion required around whether this requires promotion to driver and replace current focus.
12	Watch has one point out of control limits - blue	Improving performance, not yet sustained	Do not discuss	**SPC logic** – achieving our stretch target. Sustained improvement, not natural variation. Blue dots = showing sustained improvement
13	Watch has 2 out of 3 points high - blue	Improving performance	Do not discuss	**SPC logic** – achieving our stretch target. Sustained improvement, not natural variation. Blue dots = showing sustained improvement
14	Watch has 6 points above mean or 6 points increasing - blue	Improving performance	Do not discuss	**SPC logic** – achieving our stretch target. Sustained improvement, not natural variation. Blue dots = showing sustained improvement
15	Watch is grey (no special cause)	Performance is as expected	Do not discuss	**SPC logic** – nothing special is going on, performance is within normal variation

Business Rules - Statutory/Mandatory Metrics

These are additional rules only applied to certain metrics that are statutory or mandatory to be monitored at Trust level.

Whether or not a metric has met its target each month will be indicated by a tick or cross icon in the "Target Met This Month?" column. The number to the right of that indicates how many months in a row the metric has **NOT** met its target for. Any metric that has met the target in the current reporting month will therefore show a 0 in this column. Different actions are suggested depending on how many months the target has not been met for.
These metrics are assessed against their improvement target, or their national target where no improvement target exists.

Rule No	Rule	What It means	Suggested Action for Metric Owner	Rationale
16	Mandatory does not meet target for a single month	Performance outside of expected range for a single month	Note performance Give structured verbal update by exception	Understanding required as to whether adverse performance will be due to a consistent issue or a one off event
17	Mandatory does not meet target for 2 or more months in a row	Performance outside of expected for multiple months in a row	Give structured verbal update, agree if counter measure summary required	Showing signs of continued difficulty meeting the target and need understanding of root cause.
18	Mandatory does not meet target for 4 or more months in a row	Performing below improvement target for a sustained length of time	Consider applying improvement target	Showing signs of continued difficulty meeting the target despite understanding of root cause. Current performance known and acknowledged.
19	Mandatory with improvement target meets or exceeds target for 4 or more months in a row	Performing above improvement target for a sustained length of time	Consider increase target of Mandatory	Assess Mandatory metrics and ensure performance culture is maintained.
20	Mandatory is orange	Performance outside of expected range in a negative/deteriorating direction	Refer to rules 16-17 above and act accordingly	Mandatory metrics are being deliberately monitored and therefore SPC rules are not strict enough for monthly performance assurance purposes

NHS
Salisbury
NHS Foundation Trust

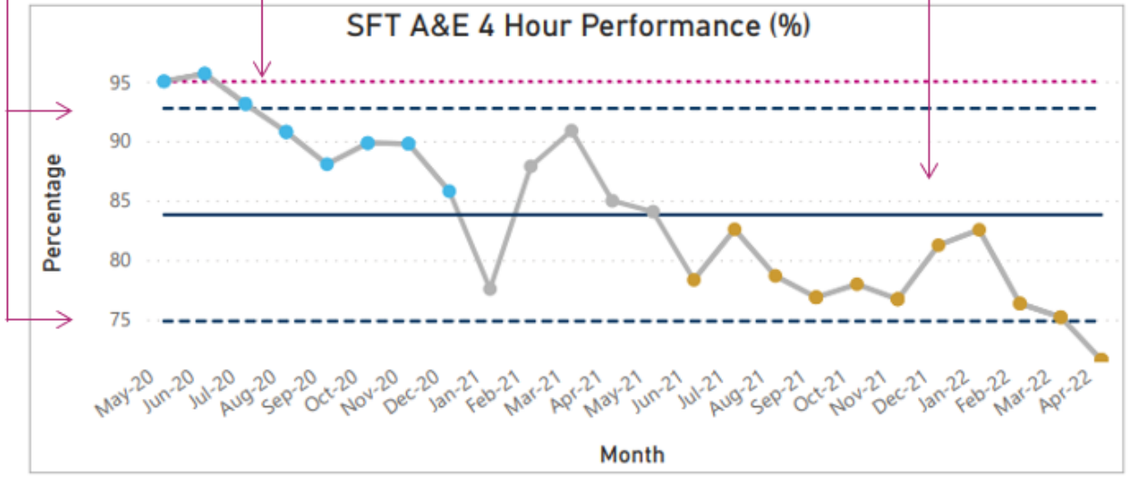
Reading a Statistical Process Control (SPC) Chart

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

There should always be a minimum of 15 months worth of data

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

The solid grey line shows the mean value for the dataset



Blue markers indicate that there has been a marked improvement in performance, meeting Business Rules 1-3

Orange markers indicate that there has been a marked decline in performance, meeting Business Rules 4-6

Grey markers show normal behaviour with no significant cause for variation

Part 1: Quality of Care, Access and Outcomes

Performance against our Strategic Priorities and Key Lines of Enquiry

Salisbury NHS Foundation Trust

Our Priorities

Population

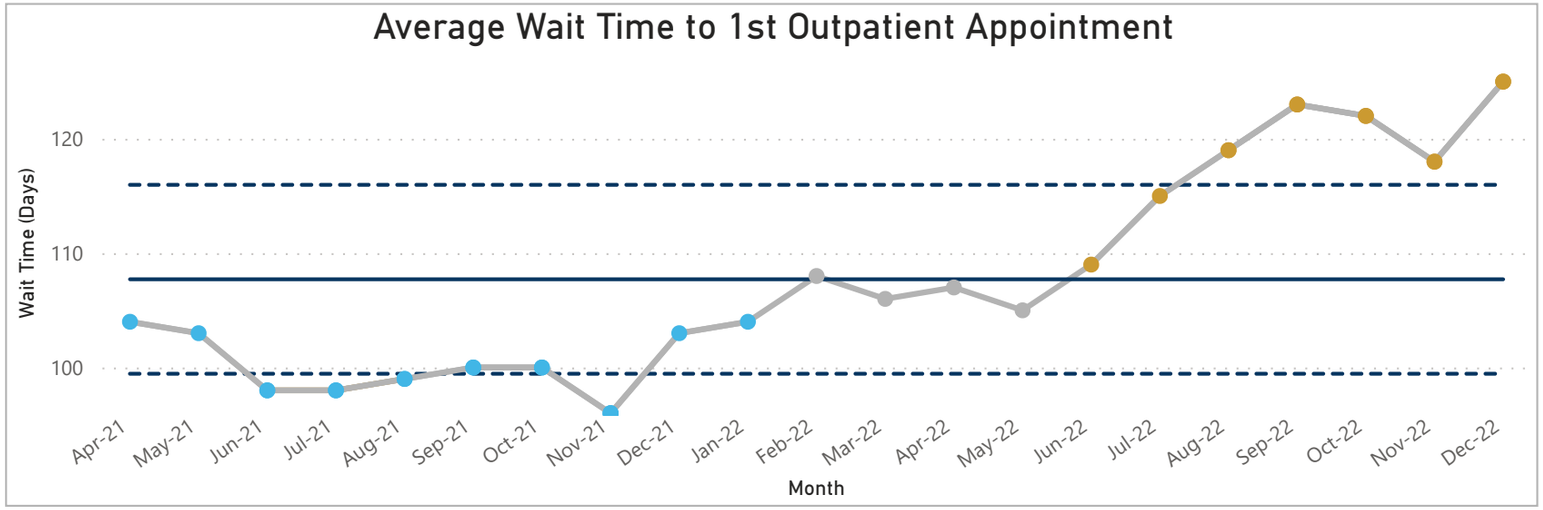
Partnerships

People

Reducing Patient Waiting Times

Target 87 days

Breakthrough Objective



We are driving this measure because…

SFT has a growing waiting list with increased numbers of patients waiting longer for their care and has not met the 92% RTT 18wk elective treatment target since October 21.

A small cohort of specialties account for the majority of the Trust's backlog of patients awaiting a 1st Outpatient appointment. An extended wait for a 1st Appointment places achievement of the 18 week RTT target at risk.
It is a poor patient experience to wait longer than necessary for treatment and failure against these key performance standards is a clinical, reputational, financial and regulatory risk for the Trust.

Understanding the performance:

- The average wait to first appointment increased further in Month 9, with an average wait time of 125 days. Position driven due to Christmas and New Year period and associated reduction in referrals, reduced number of offered appointments and therefore longer average waits for that period. Position exacerbated by a number of specialties facing operational and staffing pressures, resulting in steady increases in the number of longer waits and therefore the overall average waiting time.
- The Trust continues to focus on seeing patients in line with clinical need, referral type, e.g. Cancer 2week wait and Urgent referrals, and by longest wait, in line with NHS England requirements.
- SFT continues to have success in ensuring there are no >104week waits. The last 'at risk' patient was treated in December, and, as such, SFT has now ensured this target has been maintained for year end. Progress continues with reducing the number of at risk >78week waits and SFT remains on target to achieve the national expectation of zero at year end.
- Increase in over 52 week waits in December, predominantly driven by Dermatology and Oral Surgery and to a lesser extent Cardiology and ENT but remained slightly ahead of trajectory.

Actions (SMART):

- Trust progress against long waiting patients including those awaiting first Appointment to continue to be monitored weekly and to be reported to the CEO and COO via weekly summary updates.

- Patients to continue to be booked in line with NHSE recommendations, with weekly validation of long waiting patients.

- Support given to Divisions to better understand and map demand and capacity in preparation for 2023/24 planning round.

- Draft options plan for Dermatology currently being scoped for the end of January '23

Risks and mitigations:

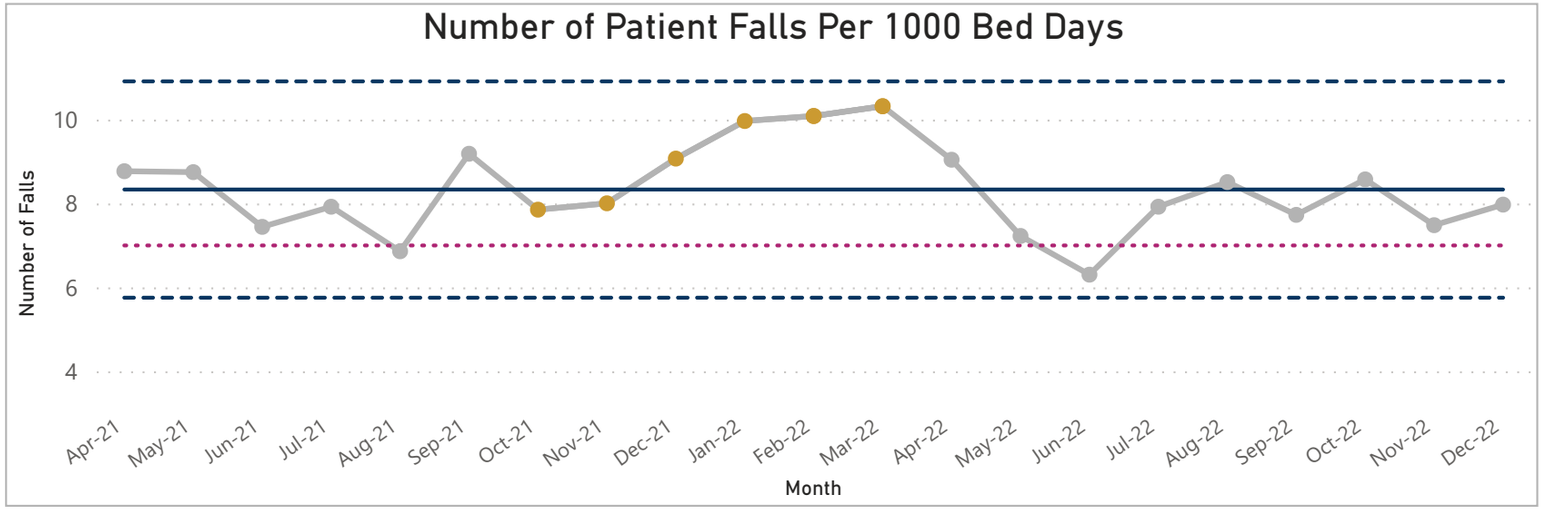
- Limitations continue in relation to the Trust's ability to comprehensively map demand and capacity at a subspeciality/pathway level, however support is planned and capacity in place, with the commencement in post for the new Head of Performance, to assist in improved modelling to better understand this in readiness for the 2023/24 planning round. Resource limitations at both DMT and Speciality level have been raised and a paper proposing enhanced Divisional structures has been drafted.

- Staffing pressures exist across a number of specialities not least Dermatology which present a potential individual speciality pressure into next financial year. The Division of surgery is drafting a set of possible proposals for consideration by the Executive Team.

Reducing Patient Harm

Target 7

Breakthrough Objective



We are driving this measure because...

Falls are the most frequent adverse event reported in hospital. The Trust continues to report a high level of falls per 1000 bed days with a significant spike over the last 12 months to 10.2 falls per 1000 bed days during the COVID-19 pandemic. The average nationwide falls data shows a rate of 6.7 falls per 1000 bed days and so this spike in combination with the increasing trend of all falls within SFT, is a concern which requires concentrated effort to address and improve.

Understanding the performance:

Overall falls for December '22 noted as 7.9 per 1000 bed days against the local target of 7 (20% reduction from Strategy 2021/22). Performance has remained variable over the last 6 months in particular.

2 reported falls with major harm in December '22. Both incidents resulted in a fractured neck of femur and have been presented to the Trust's PSS.

Lying and Standing BP compliance 52% in December '22; this is comparative to 6% in February '22 when data started to be collected.

400 members of staff have received training thus far; the strategy suggests that 95% of ward staff should receive formal training.

Actions (SMART):

- Research suggests that introducing Bay Watch and falls huddles post patient falls could reduce falls by 50%. Roll out will continue with a target of all wards having the knowledge and skills by August 2023. Farley ward have seen a reduction in falls by 33% in Q3 2022/23 compared with Q2.
- Post falls huddles were introduced to Pitton and Farley wards at the end of December as part of the Improving Together programme.
- Lying and standing BP compliance has steadily improved with ward audits once a month. Training has changed to indicate why it is important and what to do when a patient has a positive result.
- Implementation of study day for ward staff currently being scoped, with the intention for this to be made available by Q2 2023/24
- A flow diagram of "What to do if postural hypotension is recognised" has been developed by the falls group and will be presented to PSSG in January '23.

Risks and mitigations:

- The Trust has had both high staff vacancy rates and capacity issues along with high rates of Infection Control issues that may have had an impact on patients ability to be cared for in the right place by the correct staff.

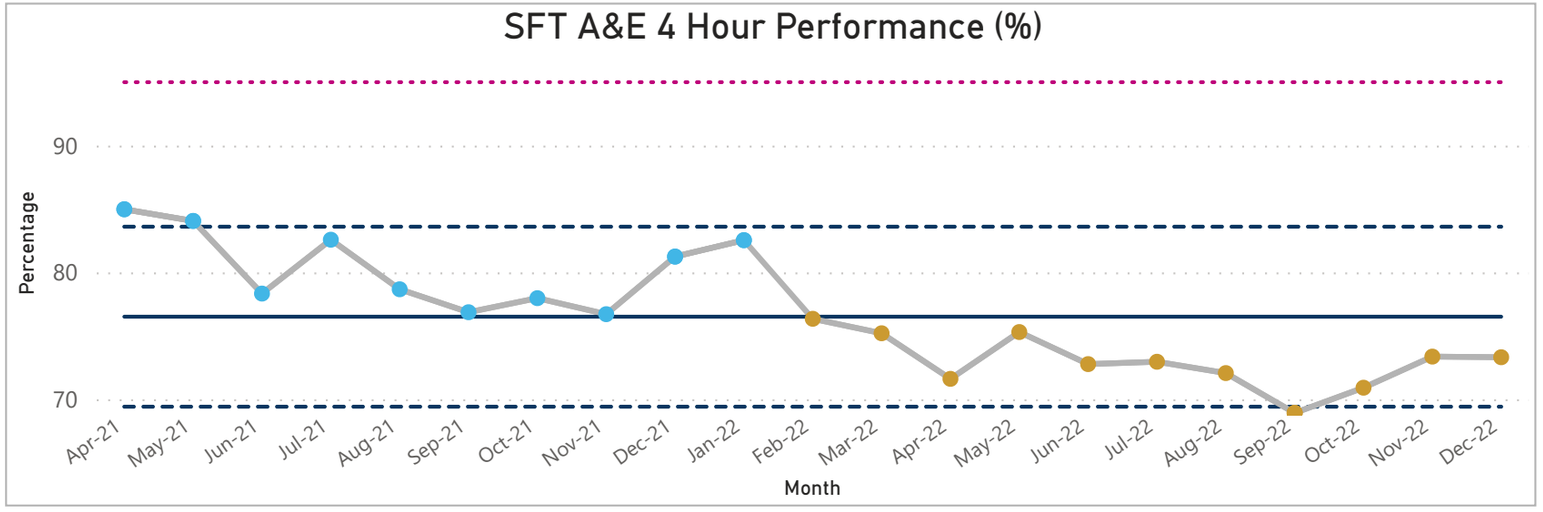
- Wards must have full bay watch training prior to roll out. Difficulty with full buy-in from all members of the MDT. However, roll out will continue with a target of all wards having the knowledge and skills by August 2023.

- Taking of lying and standing BP is lengthy and sometimes difficult though should be part of the admission process. Dedicated training to be provided to AMU staff over January '23 (95% target).

Emergency Access (4hr) Standard

Target 95%

National Key Performance Indicators



Performance Latest Month:	73.3%
Attendances:	6839
>12 hrs in ED Breaches:	201

Understanding the performance:

• The 4-hour standard performance remained static in Month 9 at 73.3% compared to 73.4% in Month 8. There has been an overall increase in attendances in Month 9 of 6839 compared to 6131 in Month 8, but this is mostly contributed by Type 3 attendances. There has been a steady increase in monthly emergency admissions during Q3, with 1745 in Month 7 compared to 1832 in Month 9.

• Increase in the number of patients waiting >12 hours in the Emergency department, from 72 in Month 8 to 201 . Flow out of the department has remained challenged with 25.7% occupancy of patients with no criteria to reside (NCTR) in Month 9. 30.3% of patients within Medicine received Same Day Emergency Care (SDEC). Month 9 saw an increase in the number of ambulances attendances to 1403. 19% of patients waited >60 minutes to be handed over, with 7% waiting < 60 minutes and 74% of patients meeting target of <15 minutes = 1161.4 hours lost in ambulance delays in Month 9.

• 49.51% of patients with a Decision to Admit (DTA) remaining in the Emergency Department >4 hours awaiting admission, equating to a total of 7.6 spaces lost daily. Average time to initial assessment of 53.89 minutes, with average time to treatment 113.06 minutes.

Actions (SMART):

• A week-long paediatric trial in the Emergency Department in Month 8 showed a reduced time to initial assessment from 63 minutes to 27 minutes. Further paediatric trial planned in Month 10, with findings to be presented to Medicine DMT in Month 11.

• The ED tracker role has now been confirmed to start in Month 11. This is a new role and will be vital in keeping accurate records of patients journeys and assisting the medical teams, in tracking outstanding investigations and bed allocations to increase 4 hour performance and coding.

• New staff induction created and Professional Nurse Advocate (PNA) role introduced to support the development and wellbeing of nursing staff as well as roll out of streaming training from Q4. Streaming will contribute to a reduction in the time to initial assessment and forms part of the divisional driver metrics through "Improving Together".

• Project Management Board for Same Day Emergency Care (SDEC) established from January '23, with separate working groups agreed. Current workstreams include space requirements, workforce and pathways. A planned visit to look at SDEC "village" model at the John Radcliffe Hospital to take place in Month 10.

Risks and mitigations:

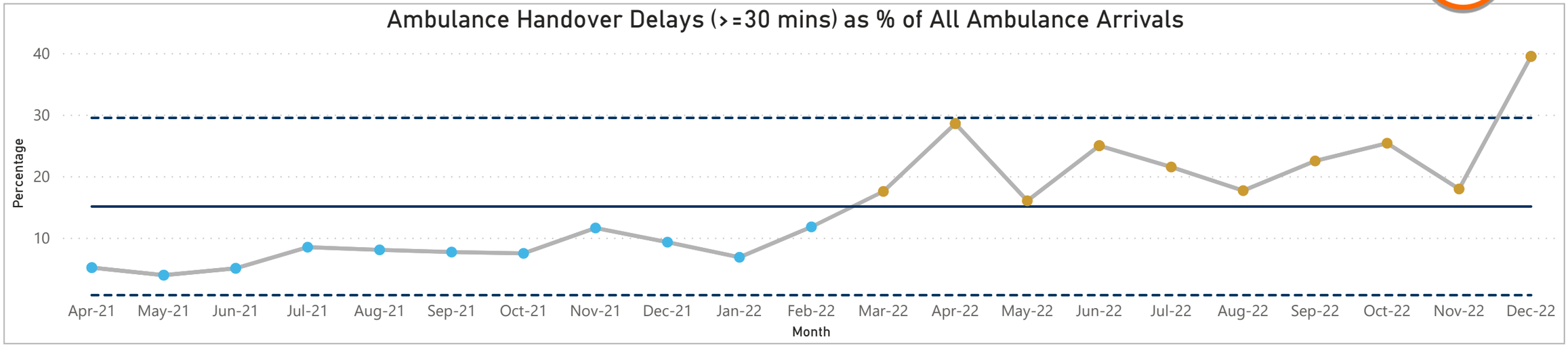
• Nursing staffing vacancies remain a high at B5 7.06 whole time equivalent (WTE), with a further 5.74WTE (12.8 WTE within the Emergency Department), with 4.0 WTE (40%) gaps in the Middle Grade rotas. This alongside resignations are detrimentally impacting on overall staffing within the department. A rolling advert is out to recruit, with an ED recruitment day planned for Month 12. Some of existing overseas junior doctor recruitment placements have commenced, with shadow shifts over Months 9 and 10, filling the middle grade gaps to support increased senior decision making in the department.

• Flow out of the Emergency Department continues to impact 4 and 12-hour performance targets, with high bed occupancy levels continue across the Trust resulting in limited capacity to see and treat patients. Escalation areas such as Interventional Radiology are used as required, dependent on staffing.

• The Emergency Department has additional staffing for both Nursing and Medical Staff on planned Industrial Action Strike days to mitigate risk at the Front Door.

Ambulance Handover Delays

National Key Performance Indicators



Understanding the performance:

December '22 saw a significant increase in the number of ambulances attendances of 1403. 19% of patients waited >60 minutes to be handed over, with 7% waiting < 60 minutes and 74% of patients meeting target of <15 minutes.
Month 9 saw the first day of Industrial Action by the ambulance service, with more strike dates planned in Month 10.
The department has mitigated ambulance handover delays with patients receiving initial assessment and diagnostic tests whilst waiting to off load into the department.
Collaborative working continues with between SWAST (South West Ambulance Service) partners and the SFT Hospital Ambulance Liaison Officer (HALO) to mitigate risk by cohorting of patients waiting to off-load in order to release crews. The department continues to provide a Category One space for queuing ambulance to be able to off load immediately to respond to a Category One call in the community.

Actions (SMART):

• Acute Medical Unit (AMU) Ambulatory area continues to be escalated into overnight due to high occupancy levels across the Trust, resulting in being unable to protect 4 Ambulatory Trolley spaces, with only 2 Trolley spaces being protected. This is impacting the delivery of Same Day Emergency Care (SDEC), along with the medical take often being diverted to the Emergency Department due to capacity issues, increasing delays in patients being off loaded in a timely manner.
• The development of Same Day Emergency Care (SDEC) is ongoing with both Project Board and working groups defined. This development will work towards improving flow out of the Emergency Department, facilitating patients being directed to specialities, rather than coming directly to the Emergency Department. This will support patients getting the right treatment, in the right place at the right time. Outcome of joint national bid to assist with the delivery of this project remains outstanding; timescales to be confirmed.
• The department will continue to mitigate delays in offloading ambulances, escalating into other areas when staffing levels allow.

Risks and mitigations:

• Further Industrial Action dates for both Ambulance Service and Nursing Staff will undoubtedly impact on performance in Month 10; mitigating actions s to minimise risk remain ongoing.

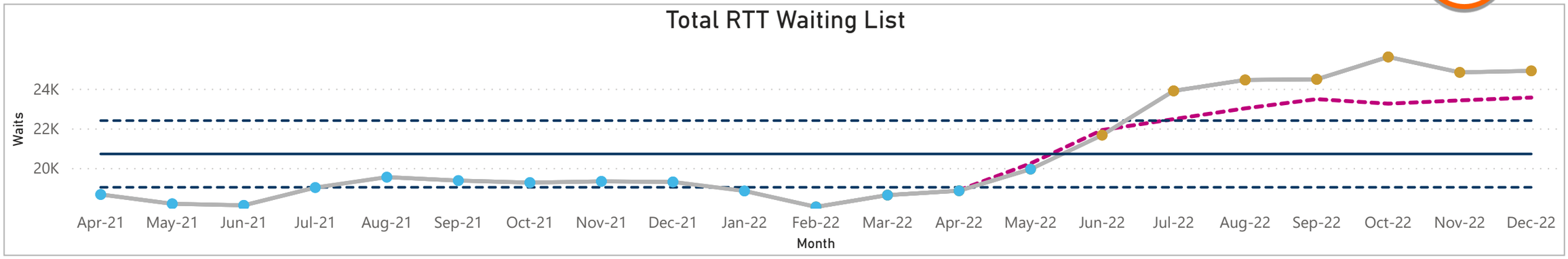
• High Bed Occupancy resulting in poor flow out of the department continues to impact capacity at the Front Door and remains the biggest challenge to our ambulance handover delays.

• Respiratory illnesses will continue to contribute to handover delays, this is to ensure the correct isolation processes are followed with the limited number of appropriate doored cubicles in the department.

• Staffing gaps, both nursing and medical staffing at the Front Door will also remain a contributory factor to ambulance hand over delays.

Total Elective Waiting List (Referral to Treatment)

National Key Performance Indicators



Month	Jan-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22
Longest Waiting Patient (Weeks)	111	116	116	120	99	99	95	98	94	95	87	83

Understanding the performance:

The total Referral to treatment (RTT) Waiting list size position at the end of December stood at 24904, 1348 behind plan (an improvement of 65 in month), a second month of reducing the gap between actual and plan. The number of non-admitted clock stops in month was as forecast lower than in November owing to the Christmas and New Year period, but was some way below the 2021 total by circa 250. However, admitted clock stops whilst reduced from November were 90 (14%) higher than December 2021, despite a very challenged month in terms of non-elective demand. New clock starts were significantly higher however, at 4770, 14% higher than that for the same period in 2021. As such, clock stops only accounted for 88% of the total number of clock starts.
A plan submitted by the Division of Surgery to mitigate the effects of likely high levels of escalation into the Day Surgery Unit (DSU) in at the end of December and into January, whilst ensuring patients safety, was approved and implemented and played a part in the reduced number of clock stops for that period whist DSU supported non elective demand and flow.

Actions (SMART):

SFT remains behind plan and it is clear that the post covid assumptions made in the original annual planning have not been reflected by both the activity delivered and against the number of referrals received.

The largest proportion of the waiting lists sits within the non-admitted pathways. There remains a number of specialities that have remained below their current year to date average, including a number of specialities with considerable operational and staffing pressures, however given the Christmas period it was unlikely that total monthly stops would increase in month. As such, the comparison with 2021 is the most appropriate measure. Capacity vs demand is forming the basis of analysis of activity vs plans by specialty to understand and support the planning round for 2023/24 to support achievement of national requirements, and ensure specialities are best placed to meet the referral demand being experienced.

Risks and mitigations:

Non-elective flow continues to place significant pressure on the elective programme. The use of upstairs in DSU throughout Nov continued into and through December, with the ongoing risk remaining with regard to increase demand from non-elective pathways and admissions. The impact upon the elective care programme and staffing morale should not be underestimated.

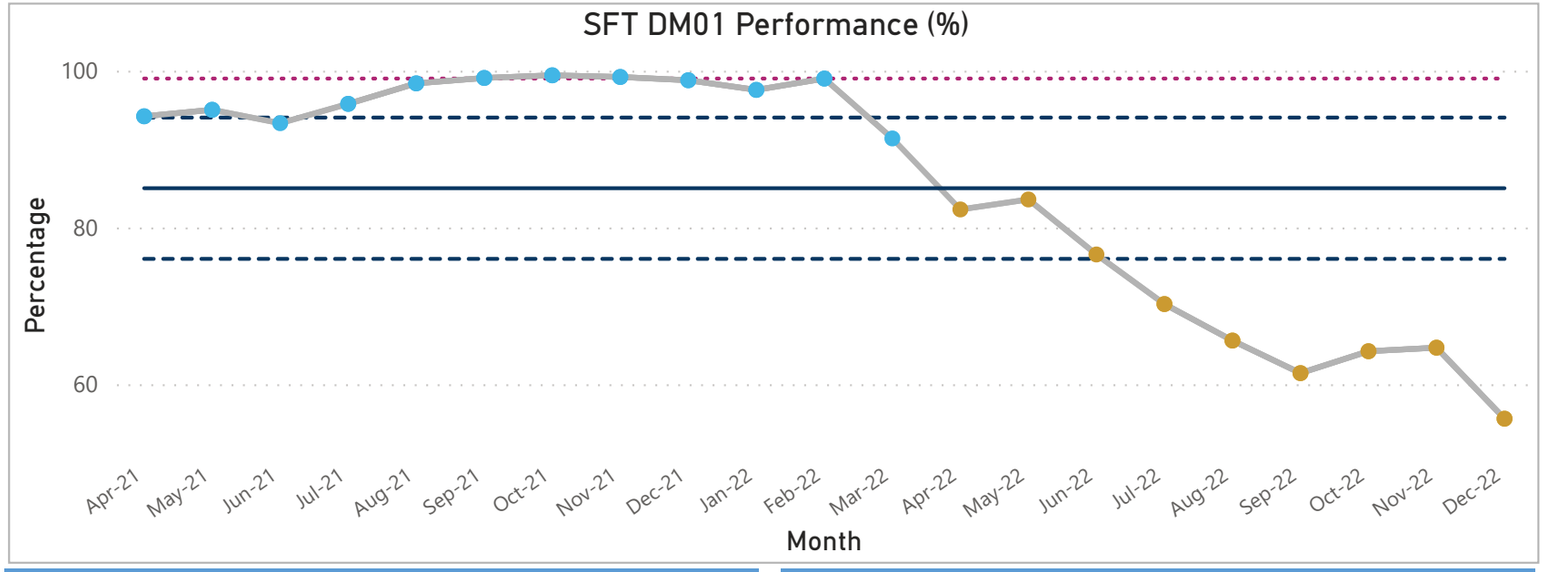
The Divisions of Surgery and Women and New Born both have specialities in the top three in terms of pressures for the March 2023 78week wait target. Clearly there remains on ongoing elevated risk as we progress further into winter with bed modelling suggesting a non-elective demand on beds peaking throughout January.

New ways of working across the two theatre footprints have been developed and signed off to maximise outputs through different ways of utilising the estate, not lest to help mitigate the impact upon DSU, with new Standard Operating Procedures (SOPs) providing a greater forward view and transparency in planning and delivering lists during ongoing periods of escalation.

Diagnostic Wait Times Performance (DM01)

Target 99%

National Key Performance Indicators



Performance Latest Month: 55.6%

Waiting List Volume: 6071

MRI	49.9%	CT	99.8%
US	43.1%	DEXA	100.0%
Audio	65.5%	Cardio	95.7%
Neuro	96.3%	Colon	64.0%
Flexi Sig	44.7%	Gastro	82.6%

Understanding the performance:

Overall DM01 performance has declined in Month 9 compared to Month 8 (from 62.22% to 55.61%). This represents an increase in breaches (332 patients). There has also been an overall decline in total waiting list size of 617 (waiting list size also declined in the previous month by 721 patients). The increasing number of breaches vs. a smaller waiting list exacerbates the overall decline in performance. Areas that continue to report high numbers of breaches are MRI (573 increase to 616), USS (1615 increase to 1795), Audiology (55 increase to 81) and Endoscopy (104 increase to 185), all reporting declining performance in month. Cardiology Echo has significantly improved and reduced breaches to 10 patients which is a significant achievement when reviewing historical performance. The largest constraint impacting DM01 performance remains as workforce capacity alongside equipment issues.

Actions (SMART):

- MRI capacity at New Hall to increase by an additional half session per month from Month 11
- Delay with USS insource arrangement (scanning capacity in January unlikely but will increase from Month 11)
- Increase overbooking to USS list to mitigate some of 4% DNA rate
- Continue with agency backfill and incentivised overtime rates in Radiology to increase weekend scanning provision
- Discussion with Endoscopy re capacity trajectories for Months 10-12 to understand performance trajectory at specialty level

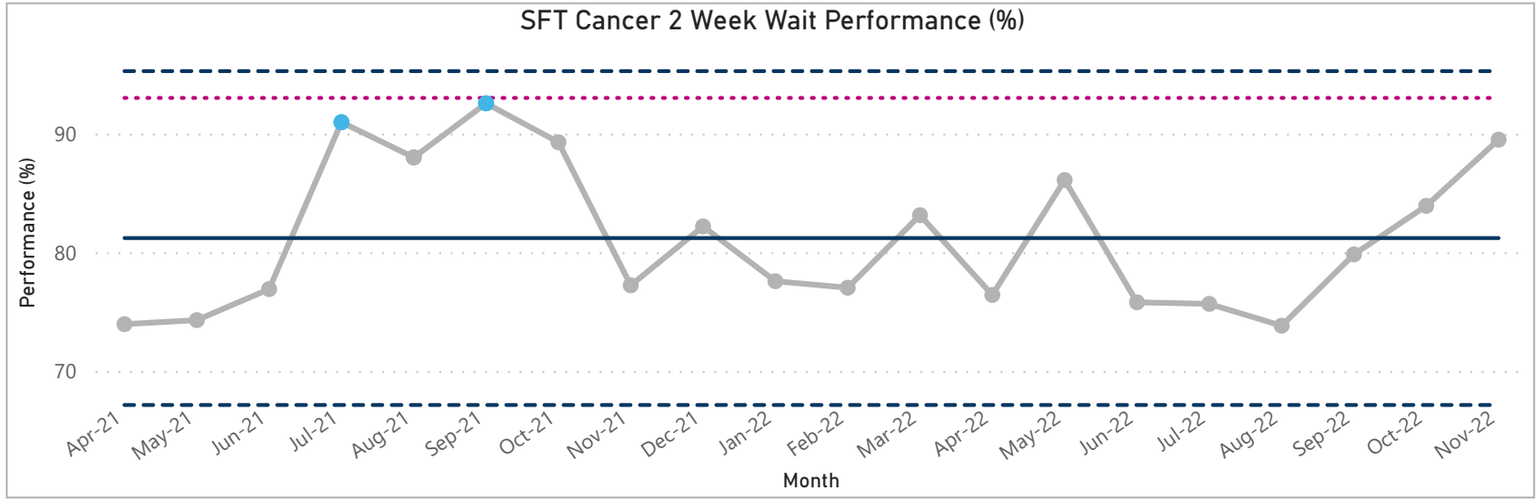
Risks and mitigations:

- MRI1 scanner downtime (quench fault) early Month 9 has reduced capacity at a time when it was planned to staff three scanners to clear proportion of backlog and long waiters. Scanner operational again at time of report but cold weather will cause risk to scanner running. Working with Siemens and Estates to mitigate risk. Further downtime reported in Month 10.
- RCN strikes Month 10 will impact endoscopy capacity
- Echocardiography, Radiography and Sonography remain dependent on high volume of agency/locum/overtime staffing to maintain capacity. Recruitment ongoing.
- Mobile MRI scanner removed from site 31/12/22 due to inability to adequately staff. Whilst unable to staff, if staffing capacity were to change, it will remove the option to enable three scanners of capacity. Division reviewing opportunities to staff fixed assets 7 days per week in place of scanner capacity.
- Nurse Endoscopist workforce has constrained capacity and impacted breaches; expected return date of staff from New Year.
- Admin resource within Radiology and Endoscopy depleted, ultimately impacting on booking and efficiency (further constrained by postal strikes etc. Recruitment plans in place.

Cancer 2 Week Wait Performance

Target 93%

National Key Performance Indicators



	Performance	Num	Den	Breaches
Two Week Wait Standard:	89.5%	970	1084	114
Two Week Wait Breast Symptomatic Standard:	96.1%	49	51	2

Understanding the performance:

December 2ww reported month end performance of 79.4%; deterioration in comparison with November (89%) with a total of 155 breaches reported. Capacity constraints most evident within Skin and Lower GI pathways as a result of increase in referrals, insufficient outpatient capacity, staffing and associated recruitment challenges.

Lower GI: 65 breaches with an average wait to first appointment of 12.7 days. 30 patients delayed as a result of incomplete GP referrals, predominantly due to lack of qFIT and up to date bloods to facilitate safe triage to straight to test pathway

Skin: 90 breaches with an average wait to first appointment of 14.1 days. 77 patients were delayed due to outpatient capacity due to insufficient staffing levels.

Actions (SMART):

Two week wait demand and capacity modelling: Demand and capacity planning to be completed by the end of January 2023, with support from the performance team, in conjunction with tumour-site level trajectories and referral predictions.

Skin pathway: System-wide review underway of community dermatology capacity and demand. Broader long term review of strategic direction of service planned, timescales to be confirmed.

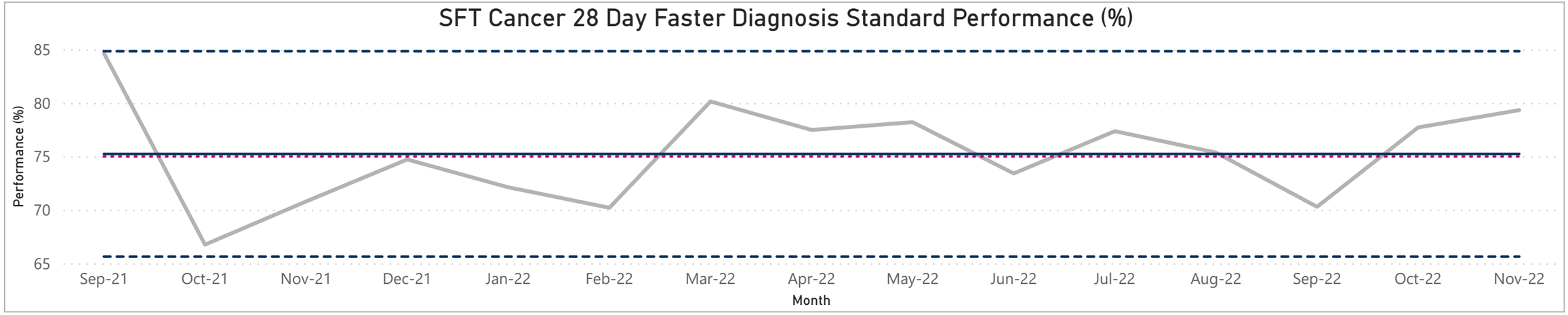
Lower GI pathway: Endoscopy capacity recovery anticipated from February '23 following period of staffing absence. RCN strikes likely to have impact on ability to deliver endoscopy, though impact remains under review. Further communication with GP practices and revisions to existing 2WW referral form re importance of completed referrals due for completion by the end of January '23 alongside with support from Macmillan GP and ICB Cancer GP Lead.

Risks and mitigations:

Pathway Improvement: Weekly Cancer Improvement Group (CIG) established to enable oversight of potential risks/challenges within services, as well as engagement from DMT. Work streams feeding in from Cancer PTL Meeting and onto Cancer Board. Delivery against optimum timed best practice pathway milestones monitored against CQUIN achievement data to measure the success of the current pathways.

Cancer 28 Day Faster Diagnosis Standard Performance — Target 75%

National Key Performance Indicators



* This measure is not currently suitable for SPC as it has less than 15 monthly data points.

Understanding the performance:

28 day Faster Diagnosis performance standard achieved for December '22, with month end performance of 80.9%., with high compliance noted within skin, breast and colorectal pathways. The average wait for patients to be informed of their diagnosis (whether cancer or benign) is 20.3 days from referral across all tumour sites.

Main constraints within Urology and Gynaecology pathways, predominantly due to administrative delays in informing patients of their no cancer diagnosis via letter. The average wait for patients to be informed of their diagnosis (whether cancer or benign) within Urology currently sits at 35.9 days and for Gynaecology, this is an average of 25.2 days as of December.

Actions (SMART):

Urology Pathway:

- Revised triage system implemented November '22; positive impact noted, with reduction in average waiting time to first appointment from ~11 to 4.9 days.
- Demand and capacity modelling in relation to mpMRI and template biopsies due for completion by the end of January '23.
- Close working between cancer services and radiology to align local KPIs to best practice timed pathway milestones. Next steps to be identified and agreed via follow up meeting in January '23
- Surgery DMT to support implementation of 'no cancer' template letter to facilitate timely discharge of patients

Gynaecology Pathway:

- Additional CNS in post from 09/01 to support implementation of straight to test pathway
- Template letter agreed within service alongside revised process between secretarial staff and cancer services to reduce timeframes of patient discharge for those with a no cancer diagnosis from January '23

Risks and mitigations:

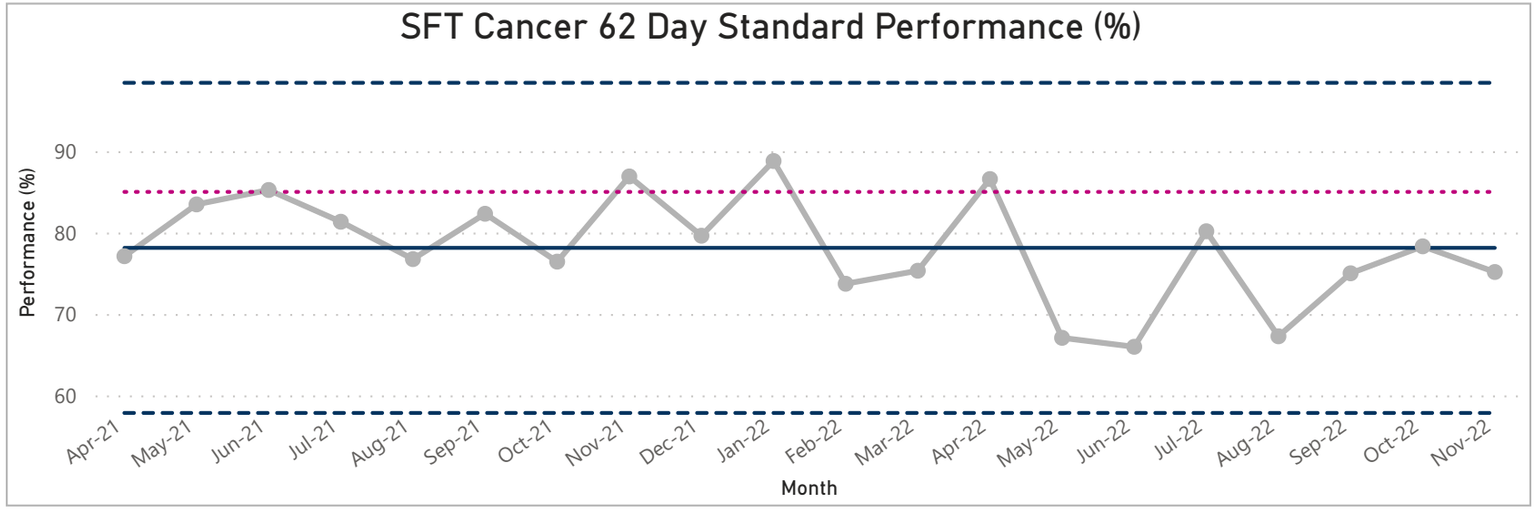
Histopathology reporting capacity: Histopathology reporting timeframes stretched as a result of consultant capacity. Cancer cases already outsourced to support capacity, though there have been restraints nationally. Cancer Services are currently undertaking a GAP analysis of the KPI's against the BPTP / CQUIN pathway milestones.

Pathway Improvement: Weekly Cancer Improvement Group established to enable oversight of potential risks/challenges within services. Delivery against optimum timed best practice pathway milestones monitored against CQUIN achievement data to measure the success of the current pathways in conjunction with Divisional Management. Work streams feeding in from Cancer PTL Meeting and onto Cancer Board.

Cancer 62 Day Standard Performance

Target 85%

National Key Performance Indicators



	Performance	Num	Den
62 Day Standard:	75.2%	59	79
62 Day Screening:	85.7%	6	7

Understanding the performance:

62 day performance standard not achieved in December '22, with month end performance of 78.6% (improvement in comparison with Month 8, 73.7%). Breakdown of breaches includes: Urology (7), Colorectal (2.5), Lung (2), Breast (1) and Haematology (1)

Breach reasons predominantly associated with complex and many diagnostic tests needed to obtain diagnosis (over and beyond normal expectations), capacity issues with diagnostic or treatment planning and patient initiated delays.

Actions (SMART):

Oncology capacity:

• Ongoing staffing capacity constraints within Pharmacy/Aseptics. Accountable Pharmacist due to commence in post from January '23, though vacancies within wider team remain; posts out to advert with the aim of recruiting in Q4 2022/23. Outsourcing of chemotherapy remains ongoing.

• Nursing staff constraints over January resulting in reduction in capacity on the Pembroke suite. Four additional chemotherapy trained nurses anticipated from February '23 with the aim of increasing capacity. Longer term actions planned with Pharmacy around implementing reduced waiting times between decision to treat and chemotherapy start date; timeframes to be confirmed.

Risks and mitigations:

Trajectory against performance standards and backlog reduction: As part of the CIG each speciality has been asked to complete a trajectory against CWT standards and backlog reduction, with the support of the performance team. This is on track for completion by the end of January 2023.

Day Surgery Unit (DSU) Closure:

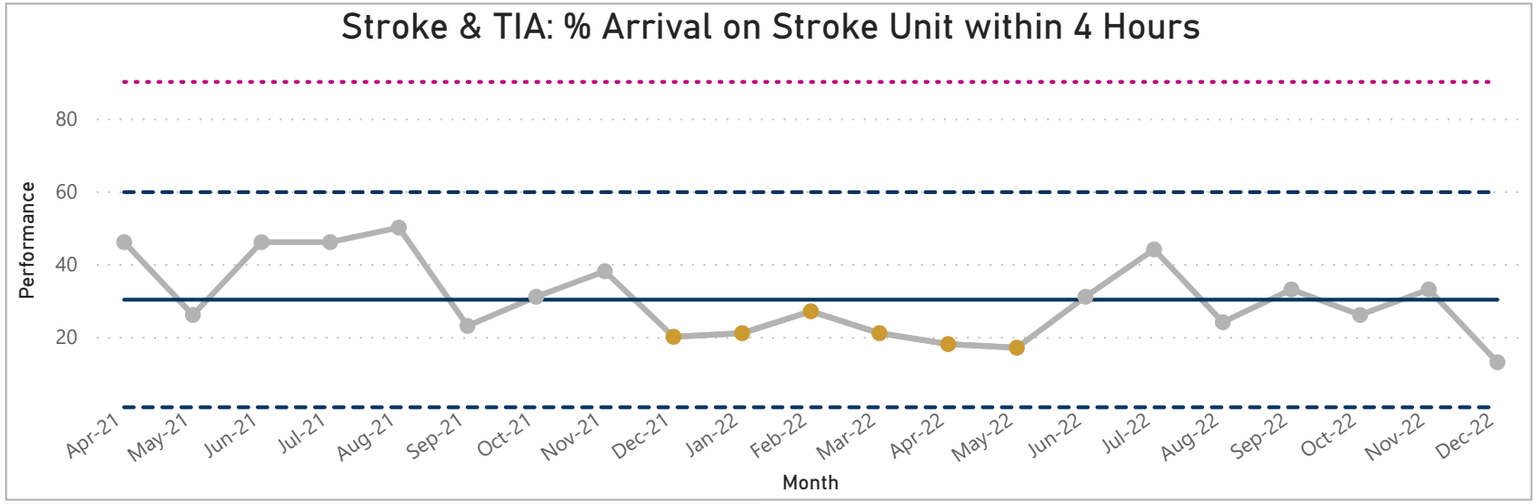
Anticipated detrimental impact of DSU closure during January '23 on diagnostic capacity. Inability to perform EBUS/bronchoscopy flagged by respiratory service; mutual aid in place with UHS, though Surgery DMT continue to review opportunities. Cancer surgery remains prioritised.

Nursing strikes:

Anticipated disruption in January '23 due to the RCN Strikes within the organisation. Assurance provided by Surgical teams in relation to minimising disruption to diagnostics and surgery during this time. No anticipated impact on chemotherapy delivery.

Stroke Care

National Key Performance Indicators



SSNAP Case Ascertainment Grade

Highest Level = Grade A
Lowest Level = Grade E

Fyear	Q1	Q2	Q3	Q4
2019-2020	B	B	B	Not Reported
2020-2021	Not Reported	Not Reported	Not Reported	Not Reported
2021-2022	C	C	C	C
2022-2023	D	C		

Understanding the performance:

• The national target for arrival on stroke unit within 4 hours is 90%; December '22 month end performance of 13% (deterioration in comparison with November '22, 33%). Although the length of stay for patients on the stroke unit have not increased by much since November, with November having an average length of stay (LOS) of 15 and December LOS at 17, the impact of high bed occupancy Trust wide has had an impact on timely availability of beds on the Stroke unit.
• Organisational bed pressures had led to more general medicine patients being out lied to stroke beds limiting the beds available to Stroke patients.
• Staffing vacancies for Farley remain high (Dec 9.37 WTE vacancy). Throughout December there were several occasions where staff were moved to support other ward due to increased sickness rates across the Division. This, along with additional escalation beds open, reduced the skill mix and number of staff trained to manage Stroke patients and able to be released to see patients in the Emergency Department. This ward has also been supporting escalation areas such as South Newton and Breamore Ward.
Spire ward also had several occasions where they boarded patients due to pressures in the Emergency Department.

Actions (SMART):

1. Simulation training to be implemented to increase staff understanding and ability to recognise stroke symptoms. This in turn will ensure timely transfer of priority patients from ED staff; date to be confirmed.
2. Prioritisation of bed moves out of Farley to facilitate stroke patients transferring is ongoing. This action includes identification of patients which are suitable to move off the ward daily, such as medical non stroke patients or patients that no longer need therapy input. This will feed into improving together daily huddle and to discuss issues with delayed transfers and how this can be improved. The use of the GP assessment room is also discussed daily to see if patients are appropriate to be seen there rather waiting in ED.
3. Meeting with ED Matron to be scheduled for Q4 2022/23 to facilitate development of a working group including Doctors, Site team, Matrons and Senior Sister to discuss actions to improve patient transfers within 4 hours from the decision to admit to admission to the stroke unit monthly.

Risks and mitigations:

• Hyperacute stroke patients at risk of worsening outcomes without access to specialist case within appropriate timeframes, in turn increasing LOS. Ongoing meetings with Medicine Matrons and bed managers to highlight importance of prioritisation of stroke patients and staffing issues.
• Weekly updates with site team to discuss arising issues of admitting and transferring patients from the wards; this has enabled prompt facilitation of bed moves when a potential stroke patient is identified in ED when capacity allows.
• Risk of staffing shortages during periods of operational pressure when stroke nurses are moved to support other clinical areas; direct impact on service's ability to receive patients from the Emergency Department (ED), especially those who are thrombolysed and require 1:1 input.
• Significant risk associated with bed allocation; service looking to ensure adequate allocation of stroke beds to improve transfer times from ED and ensure stroke patients are prioritised going forward, though this isn't achievable at present.

Maternity

Are We Safe?

SFT Assurance Dashboard

	Metrics	Target for RAG	Which Direction is Good	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22
Perinatal Morbidity and Mortality (M&M)	Number of late fetal losses (22+0 to 23+6 weeks excl TOP)	1	Down	0	0	0	0	0	0	0	0	0
	Number of stillbirths (>+ 24 weeks excl TOP)	1	Down	0	0	0	1	0	0	0	0	0
	Number of neonatal deaths : 0-28 days	1	Down	0	1	0	0	0	0	0	0	0
	Medical termination over 24 +0 registered	NA	Down	0	0	1	0	0	0	0	0	0
Maternal M&M	Number of Maternal Deaths	9.1	Down	0	0	0	0	0	0	0	0	0
	Number of women requiring admission to ITU	0	Down	0	0	2	0	0	0	0	0	0
Insight	Number or Datix incidents - moderate or above	1	Down	1	2	3	1	4	2	1	1	1
	Datix incidents moderate harm (not SII)	2	Down	0	1	3	3	4	1	1	1	1
	Datix incidence SII	0	Down	0	1	0	3	0	0	0	0	0
	HSIB referrals	NA	Down	0	0	0	0	0	1	0	0	1
	HSIB/NHSR/CQC or other organisation with a concern or request	0	Down	0	0	0	0	0	0	0	0	0
	Coroner Reg 28 made directly to trust	0	Down	0	0	0	0	0	0	0	0	0
Workforce	Minimum safe staffing in maternity services :Obstetric cover - hours	40	NA	40	40	40	40	40	40	40	40	40
	Midwife to Birth ratio	1.28	NA	1.31	1.32	1.32	1.32	1.33	1.35	1.33	1.29	1.31
	Midwifery vacancy rate (black= over establishment; red =under establishment)	0 WTE	Down	17.2	17.4	18.8	20	19.64	19.65	18.84	18.84	19
	Provision of 1 to 1 care in established labour (%)	100%	Up	100	100	100	100	100	100	100	100	100
	Datix relating to workforce	0	Down	3	1	0	2	1	1	1	0	1
	Compliance with supernumery status of the LW coordinator - %	100%	Up	100	100	100	100	100	100	100	100	100
	Numbers of times maternity unit on divert	0	Down	0	0	0	0	0	0	0	0	0
Involvement	Service user feedback : Number of Compliments	NA	Up	27	27	31	31	21	31	10	26	19
	Service user feedback : Number of Complaints	1	Down	2	0	1	1	4	2	1	2	2
	Number of SOX	NA	Up	8	7	6	5	2	7	4	7	3
Assurance	Progress in achievement of 10 safety actions(CNST)	10	Up	5	5	5	5	5	5	6	7	5
	Training compliance - MDT PROMPT %	0.9	Up	72.3	83.6	86.5	86.2	77.0	77.0	82.1	93.0	90.9
	Term babies admitted to NNU unexpectedly %	<5.8%	Down	1.8%	4.7%	2.3%	4.6%	6.1%	5.8%	4.7%	2.9%	
	Term babies admitted to NNU unexpectedly	-	Down	3	8	4	8	10	11	8	5	

Understanding the performance:

No available data for December relating to term admission to NICU at time of report.
Midwifery vacancies remain high impacting midwife to birth ratio. We are using bank to cover shortfall alongside use of nurses and over recruitment of support workers.
HSIB cases – one case of a full term baby transferred to a specialist unit for cooling of their brain – to reduce risk of brain damage. tertiary unit for cooling ; ongoing
Prompt training compliance over 90 % however when subdivided into professional categories it reduces compliance for some groups (88%) leading to overall non compliance with this safety action in accordance with Maternity Incentive Scheme (year 4).
Following oversight from NHSE Maternity Improvement Advisors SFT will be declaring compliance with 5 of the safety actions.

Actions (SMART):

Midwifery staffing vacancies remains a Driver for Improving Together (IT) which ensures action and oversight.

Continue to monitor midwifery staffing vacancy as an IT driver and for the Director of midwifery and deputy to continue to attend regional and system meetings to be involved in new ways of supporting midwifery numbers such as the return to practice and courses to enable nurses to convert to midwifery.

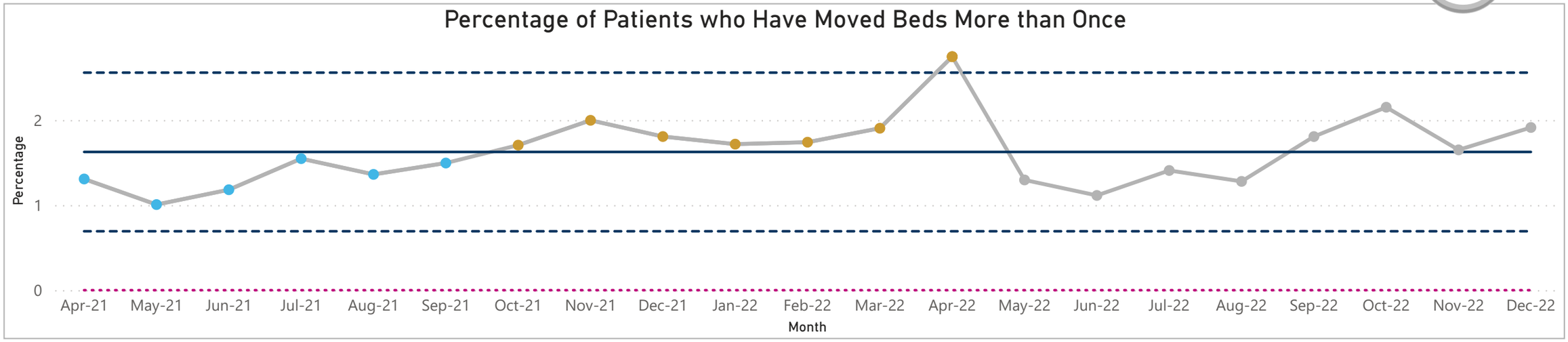
To drive with training session on fetal heart monitoring and Prompt (obstetric emergencies) to maintain/achieve compliance with safety action.

Risks and Mitigations:

Staffing – recruited more RGN into workforce, overrecruited support workers and now have 4 international midwives being supported in practice to achieve OSCE and entry onto NMC register filling a midwifery vacancy. Supporting a return to practice (RtP) midwife .

Patients Who Have Moved Beds More Than Once

Are We Safe?



Understanding the performance:

There has been a growth in the number patients moved more than once in December 2022 (1.91%), compared to the previous month (1.65%), which is the result of several factors. The Trust has been using an increased number of escalation beds, inclusive of the Discharge Lounge due to operational pressures.
The Trust has also seen an increase in the incidence of respiratory illnesses, resulting in the moving and cohorting of patients in line with Infection Control processes.

Actions (SMART):

• It continues to be a priority for all divisions to ensure that the patients receive their treatment in the appropriate speciality area. There has been continued support and effective communication with speciality teams despite the ongoing challenges with staffing across the Trust. The focus continues to be getting patients to the correct speciality ward.

• There is ongoing work with Farley Stroke unit to try to improve the SSNAP 4-hour targets. This includes monthly discussion and education between the Farley and Site teams.

• The work with the E-whiteboards to identify the patients already moved is ongoing and will aim to minimise moves per patient and allow of an opportunity to improve the patient experience. Progress reviewed on a monthly basis.

Risks and mitigations:

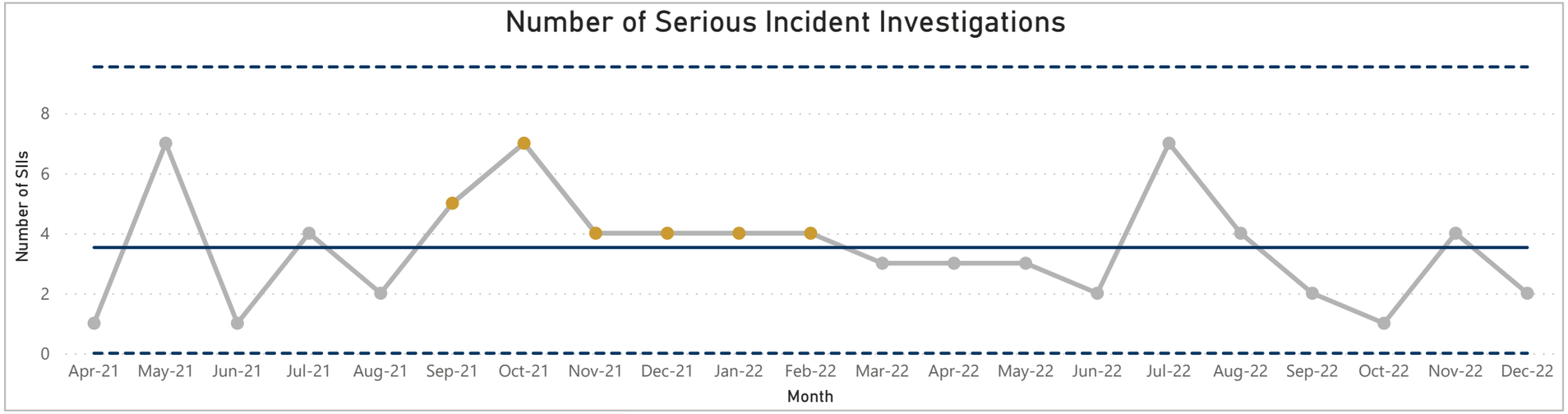
• A steady rise in the numbers of Infection Control issues within the Trust throughout this period made it challenging to achieve the right place and right time of patient allocation.

• There has been a sustained demand and capacity pressures, with many escalation beds being used across the organisation.

• Staffing across all MDTs, site, and administration has affected the patient journey, including the availability of the Discharge Lounge.

Incidents

Are We Safe?



Year	2021-2022	2022-2023
Never Events	3	0

Understanding the performance:

There were 3 Serious Incident Investigations (SSIs) commissioned in December- 1 was related to an incident in November and 2 in December.

- SII 537- Term admission to NICU- baby cooled- HSIB case
- SII 538- Failure to escalate the deteriorating patient
- SII 539- delay to treatment

The chart above shows the number of SII occurrences by month hence why the number of SII occurrences, and those commissioned
for review does not always align.

Actions (SMART):

- Following the commissioning of an SII the incident will be investigated as per Trust protocol.

- The current time frame set for the completion of these reports is 60 working days.

Risks and mitigations:

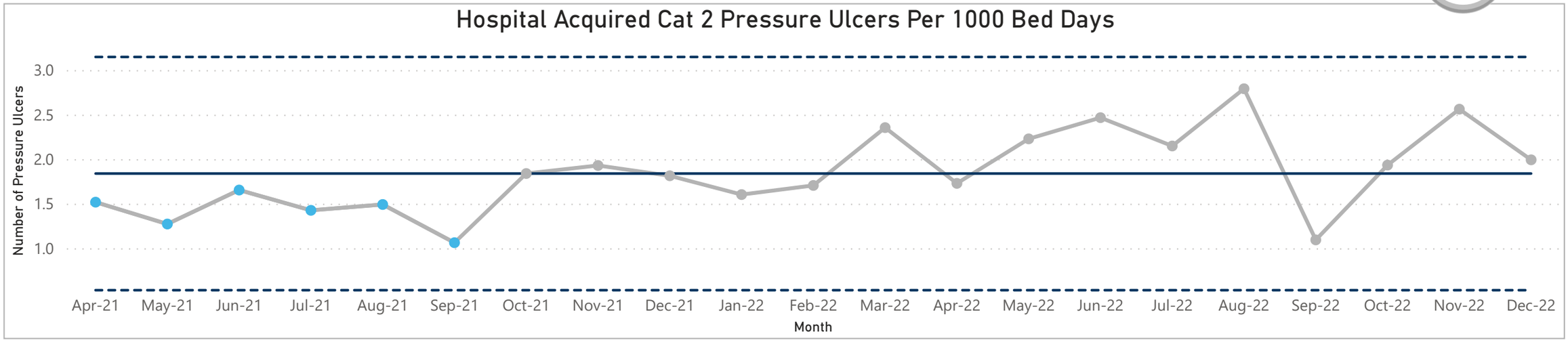
- Once an incident has been identified and a 72 hour report completed, it will be established as to whether there are immediate safety actions that need to be implemented or escalated immediately.

- On completion of the report, learning will be cascaded through the Intranet, Clinical Governance sessions, patient safety steering group and dissemination to staff via area leads.

- Recommendations and action plans will be completed as per set target dates.

Pressure Ulcers

Are We Safe?



Understanding the performance:

• A reduction in Hospital acquired pressure damage from 42 in November to 35 in December has been noted

• 0 device related pressure injuries were reported, also a reduction from November

• 3 hospital acquired DTI's and one unstageable PU were confirmed and SWARM's completed with any relevant actions to be carried forward by the ward lead

• No hospital acquired PU 3 or 4s have been reported
• 41 pressure ulcers were noted on admission

Actions (SMART):

• New Hospital acquired PU investigation process being implemented; there has been good engagement from ward leads with the SWARM investigations and actions. Learning has been identified and actions undertaken for teaching on wards with areas of concern.

• Electronic datix validation on Lorenzo has completed testing and is now live. All validation for patients in December will be completed in duplicate on Lorenzo and on excel spreadsheet to ensure the data collected for monthly PU figures is accurate.

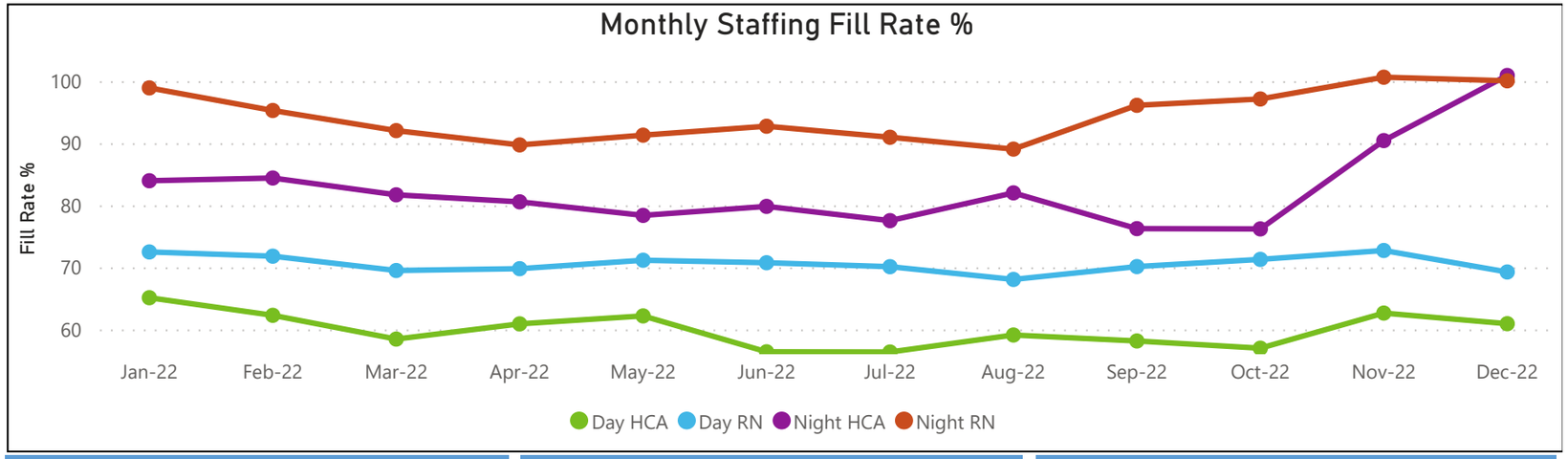
Risks and mitigations:

• Duplicate input of validation data on Lorenzo and excel spreadsheet will increase the workload during a period of increased operational pressure for the Tissue Viability (TV) team but must be completed to ensure data accuracy.

• TV team have appointed new staff into outstanding vacancies. Two CNS' to commence in post from January; this will reduce the output/speed of patient reviews whilst training is undertaken

Nurse Staff Fill Rate

Are We Safe?



Ward	Day RN	Night RN	Day HCA	Night HCA
Amesbury	95%	96%	63%	120%
Britford	86%	95%	83%	97%
Chilmark	85%	92%	69%	84%
Downton	120%	152%	76%	144%
Farley	75%	90%	59%	101%
Hospice	86%	102%	79%	113%
Longford	81%	117%	80%	103%
Maternity	82%	91%		
NICU	103%	98%	80%	
Odstock	99%	91%	83%	102%
Pembroke	85%	95%	86%	94%
Pitton	71%	98%	84%	140%
Radnor	87%	95%	50%	82%
Sarum	97%	118%	61%	
Spire	82%	120%	81%	116%
Tisbury	74%	91%	66%	139%
Whiteparish	127%	140%	84%	151%

Understanding the performance:

• Healthcare Assistant (HCA) night shift continues to see a significant increase in fill rate – achieving 100% - this is in part driven by the Allocation on Arrival shifts which show good uptake at night by HCAs.

• The other 3 markers have broadly plateaued or slightly decreased in month.

• Night shift remains the highest shift fill both for Registered Nurses (RNs) and HCAs, due to the unsocial hours rate and popular amongst temporary staff and often fits around childcare requirements.

• Daytime HCA and RN remain at below 70%; impact on winter incentive to be understood further over time and remains under review.

• CHPDD remains at 7.4 for December.

Actions (SMART):

• Increase hourly rate of pay for Band 2 staff to top of scale from December '22

• Review of all Band 2/Band 3 job descriptions with view of regarding Band 2 to Band 3 with effect from New Year; ongoing work prior to approval

• Review of all current vacancies by Division underway, due for completion by the end of February '23

• Development of non clinical support role underway, timescales to be confirmed (plan to appoint x18 full-time Band 2 posts)

•Winter bank incentive scheme in place – super-enhanced reviewed and being extended to avoid TNS fill and approval will be driven by red staffing levels Understand impact of agency usage from requirements for RMNs

• All actions being monitored as part of executive-led weekly winter planning meets.

Risks and mitigations:

Risks to this work include:

• Ongoing high turnover rate for RN and HCAs (risk)

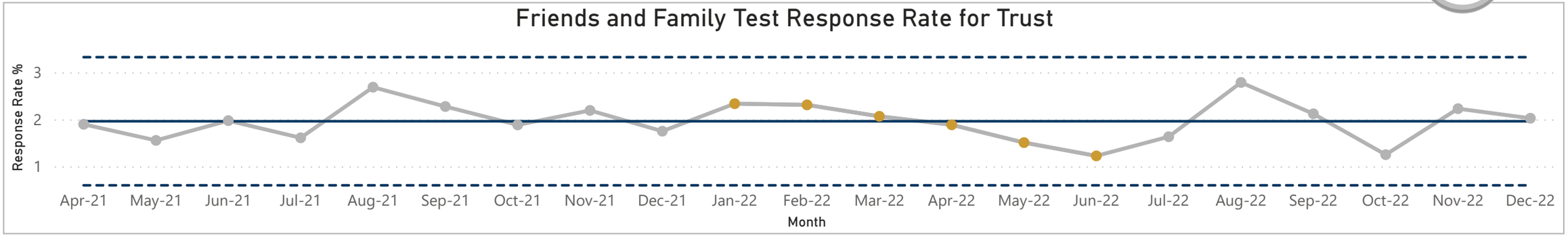
• National and international recruitments (mitigation)

• Twice monthly HCA inductions (mitigation)

• Ongoing support and intervention of NHS England re HCA gap (mitigation)

Friends and Family Test Response Rate

Our Care



Response Rate by Area	Jan-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22
FFT Response Rate - A&E	0.1%	0.1%	0.0%	0.2%	0.0%	0.2%	0.1%	0.3%	0.4%	0.3%	1.1%	0.3%
FFT Response Rate - Day Case	10.1%	5.3%	5.0%	4.8%	4.6%	3.3%	4.6%	8.9%	6.8%	3.1%	2.5%	1.4%
FFT Response Rate - Inpatient	13.4%	9.5%	7.1%	5.7%	7.1%	6.8%	7.5%	10.9%	11.5%	5.2%	10.5%	5.7%
FFT Response Rate - Maternity	0.9%	2.5%	5.9%	11.5%	0.9%	0.4%	1.6%	7.8%	1.1%	1.2%	0.0%	2.6%
FFT Response Rate - Outpatient	0.9%	1.6%	1.6%	1.3%	0.8%	0.6%	0.9%	1.5%	0.9%	0.9%	1.6%	2.0%

Understanding the performance:

FFT responses fell slightly again this month (2.03% overall response rate). Staff are still being encouraged and reminded to offer FFT through the PALS outreach services although we appreciate that this sole method of obtaining response will inevitably mean fluctuations in activity consequent to pressures.

It is noted that in the last few months the average responses of patients who are satisfied with the service they received, have dropped from 99% to 96% but this has improved again this month

Actions (SMART):

Long-term action: Securing a provider to gather patient feedback vis SMS will be key to moving towards achievement of our objectives under the Improving Together Programme over the next 6-12months:

Aims:

- Increase overall response rates to FFT
- Diverse methods for completion (including, online, SMS, over the phone)
- Increased accessibility and options for inclusivity (sight impairments, languages and additional demographic options)
- Robust analysis of data for insight and meaningful comparison/benchmarking via a real-time dashboard
- Opportunity to align our processes in FFT across the ICS

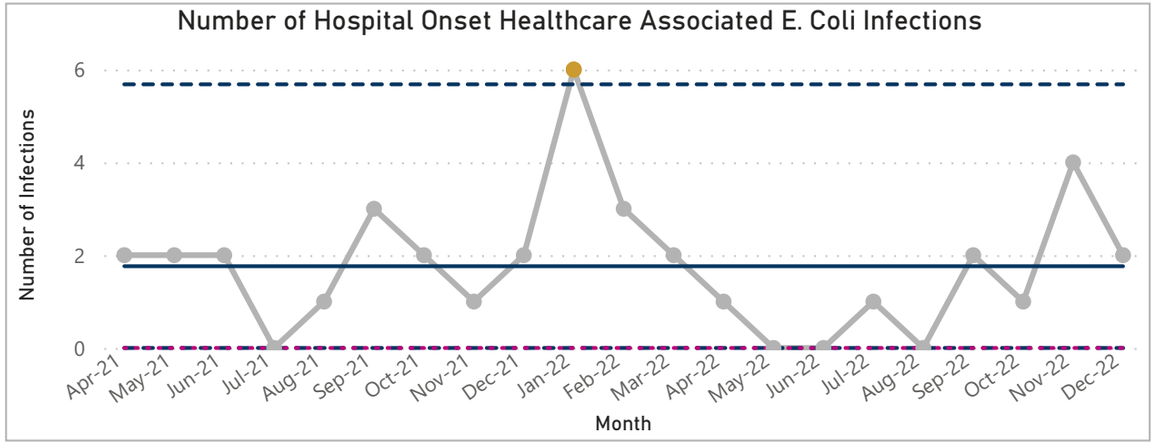
Risks and mitigations:

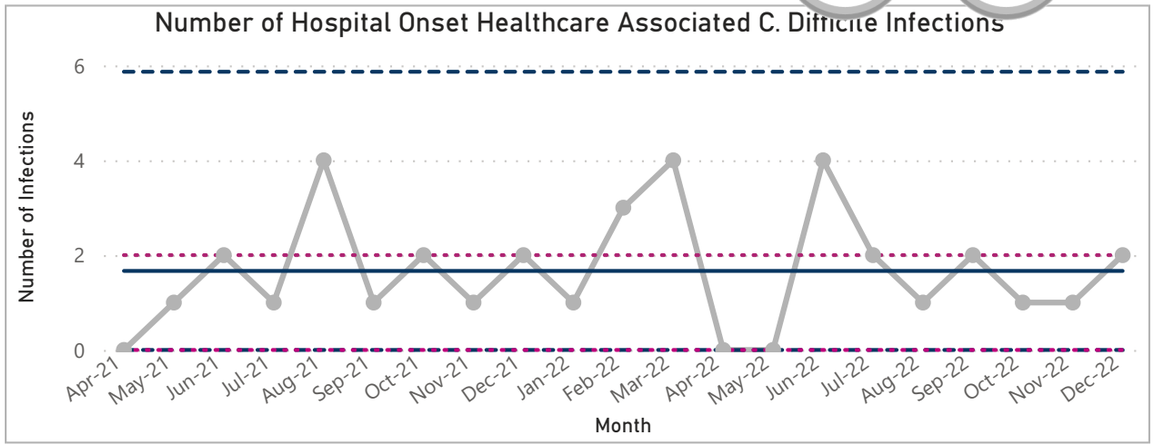
Continued low response rate, due to limited methods for accessibility and reliance on staff to promote completion of a physical card. This is directly impacted when there are staff shortages and operational pressures. The current method requires manual input and theming, which there is limited resource to undertake. Theming on a large scale is near impossible without the usual of manual approaches; this makes presenting accurate data for the Trust difficult to assure.

Implementation of the new IT solution to increase response rates and improve analysis is delayed from Autumn 2022 to early in the New Year of 2023. A revised implementation timescale is currently being worked through with CPPG and the related Work Package Groups.

Infection Control

Are We Safe?





Understanding the performance:

• There have been two hospital onset healthcare associated reportable E.coli bacteraemia infections and two hospital onset healthcare associated reportable C.difficile cases this month. Unfortunately, set trajectories for reportable healthcare associated C.difficile cases for 2022/23 have been exceeded.

• The Infection Control Nurses (ICNs) have undertaken targeted ward visits and utilise educational opportunities with different staff groups.

• Small practice improvements with infection prevention and control compliance noted from individual staff interactions undertaken, with the aim of sharing information with their colleagues.

Year	2021-2022	2022-2023
MSSA Bacteraemia Infections: Hospital Onset	12	6
MRSA Bacteraemia Infections: Hospital Onset	0	0

Actions (SMART):

• Alternative approach for staff in ward areas to complete hand hygiene education and assessments; roll out to be extended across divisions during quarter 4 2022/23.
• Ongoing action associated with the completion of required case investigations by clinical areas to identify good practice and learning. The Infection Prevention & Control (IPC) team facilitate this process so that areas can take ownership and progress any actions or identified learning.
• Ongoing feedback required from clinical areas at monthly 'Share & Learn' meeting to identify actions moving forward from any themes/trends arising from all cases (ICNs in attendance). December '22 meeting cancelled by the Chair due to operational pressures.
• Involvement with BSW IPC and Gram-Negative Bloodstream Infections (GNBSIs) collaborative workstreams. Feedback from sessions is shared routinely via the SFT IPC Working Group

Risks and mitigations:

• Exceptional workload for IPC nursing team including managing new COVID-19 outbreaks and an increase of respiratory illnesses (e.g. influenza and RSV cases) within the hospital, impacting on ability to focus on other HCAI prevention work.
• Ongoing nursing vacancy within the IPC team and unexpected sickness absence of existing team member has greatly reduced the ability of the service to complete any additional educational activities and policy practice reviews. Secondment plan for position was due to commence in January 2023 but has been delayed; timeframes to be confirmed.
• An underlying risk continues to be a potential increase in incidence of reportable healthcare associated infections with poor patient outcomes and Trust exceeding all agreed trajectories.
• Variable staffing levels continually reported by clinical areas affecting ability to facilitate learning in ward environment.
• Poor return rate (less than 50%) of completed case investigation documentation by relevant clinical areas, therefore unable to identify evidence of learning.
• Limited evidence of IPC practice assurance provided by the clinical divisions due to ongoing operational challenges and workload pressures for teams.

Mortality

Are We Safe?

Metric Name	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	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22
Crude Mortality	63	76	62	68	69	65	64	79	94	86	84	84	88	84	77	88	82	73	75	77
HSMR District Hospital (excludes deaths recorded by Salisbury Hospice)	100	102	100	101	102	102	103	106	105	101	104	107	109	109	111	112				
HSMR Trust	111	108	109	108	108	109	110	110	113	113	109	111	116	115	117	118				
SHMI District Hospital (excludes deaths recorded by Salisbury Hospice)	98	100	101	101	101	102	102	102	102	104	105	107	106	106	106	106				
SHMI Trust	103	105	106	106	106	107	107	107	107	108	109	111	110	110	110	111				

Please note: The data has been supplied by Telstra Health UK (Dr Foster) and a 2-month lag has been applied to the HSMR figures to allow for coding. It should be noted that 'expected' ranges are based on the 95% confidence intervals applied by Dr Foster, however the published SHMI figures from NHS Digital are based on 98% confidence intervals. This intended to be a more sensitive indicator in order to provide the trust with an early warning for potential areas to review.

***Key:** Red = Statistically higher than expected*

Understanding the performance:

Mortality statistical models compare across all acute hospital Trusts (the majority of which will not contain hospice services), therefore the number of expected deaths at Salisbury NHS Foundation Trust is likely to sit above expected levels.

The SHMI for the 12-month rolling period of August 2021 to July 2022 for Salisbury District Hospital is 106.90.

The HSMR for the 12-month rolling period of August 2021 to July 2022 for Salisbury District Hospital is 112.7

Actions (SMART):

N/A

Risks and mitigations:

The Trust's Mortality Surveillance Group (MSG) meet every two months, and our mortality data is reviewed at this meeting.

A representative from our Partner organisation, Telstra Health UK (Dr Foster), is invited to attend in order to help us to interpret and analyse our mortality data and identify variations in specific disease groups. Where alerts are generated, these are discussed and a further review of the patient's records may be undertaken.

Watch Metrics: Alerting

Quality of Care, Access and Outcomes

Metric	Two Months Ago	Last Month	This Month	Improvement Target	National Target	Variation	Variation Detail	Target Met This Month?	Consecutive Months Target Failed
Total Number of Compliments Received	26	47	12				Special Cause Concerning - Run Below Mean		
% of Total Incidents Resulting in High Harm (Mod/Maj/Cat)	26.0%	30.0%	22.0%				Special Cause Concerning - Run Above Mean		
Ambulance Handovers 30-<60 mins	180	164	148				Special Cause Concerning - Run Above Mean		
Trust Performance RTT %	63.7%	65.2%	61.8%		92%		Special Cause Concerning - Below Lower Control Limit	X	21
Ambulance Handovers 60+ mins	258	131	281		0		Special Cause Concerning - Above Upper Control Limit	X	21
Average hours lost to Ambulance Handover delays per day	22	14	34		0		Special Cause Concerning - Above Upper Control Limit	X	21
Average Patients with No Criteria to Reside	140	146	171	35			Special Cause Concerning - Above Upper Control Limit	X	21
DM01 Waiting List Volume	6975	6688	6071				Special Cause Concerning - Above Upper Control Limit		
ED 12 Hour Breaches (Arrival to Departure)	163	72	201		0		Special Cause Concerning - Above Upper Control Limit	X	21
Proportion of patients spending more than 12 hours in an emergency department	3.8%	1.7%	4.8%				Special Cause Concerning - Above Upper Control Limit		
% of Inpatients Undergoing VTE Risk Assessment	98.4%	98.7%	%		95%		Common Cause Variation	X	1
Cancer 31 Day Performance Overall	98.4%	98.6%	91.9%		96%		Common Cause Variation	X	1
Cancer 62 Day Screening Performance	80.0%	84.6%	85.7%		90%		Common Cause Variation	X	3
Mixed Sex Accommodation Breaches	26	14	22	0	0		Common Cause Variation	X	4
Total (Excess) Bed Days from NC2R to Discharge - Internal Reasons only	627	459	335	150	0		Common Cause Variation	X	21
Total Number of Complaints Received	27	19	11		0		Common Cause Variation	X	7

Watch Metrics: Alerting Narrative

Quality of Care, Access and Outcomes

Understanding the performance:

• Ongoing challenges highlighted within alerting quality watch metrics predominantly associated with urgent and emergency pathways across the Trust. Average adult bed occupancy remains at 97% which has resulted in minimal flow to wards. Further detail outlined within the Emergency Access (4hr) Standard slide.

• Operational pressures impacted by the number of patients in the hospital that do not meet the criteria to reside (NCTR), with a M9 average of 171 patients compared to the improvement target of 35 (146 in M8). This represents approximately 35% of the Trust's overall bed base, significantly reducing the number of available beds for admissions for both the elective (and thereby reducing elective waiting list lengths) and the non-elective pathway.

• Improving position in relation to the total (excess) bed days from no criteria to reside to discharge (internal reasons only), though total remains significantly above improvement target of 150. Challenging staffing levels contribute to delays in managing inpatient work, and progressing discharge planning for patients.

• Although common cause variation, deterioration in cancer 31 and 62 day screening performance noted. Deterioration predominantly associated with spike in referrals of confirmed cancer cases via national screening vans, resulting in insufficient capacity to facilitate surgery within expected timeframes. Additional capacity implemented and more robust communication established between the Trust and screening services to understand anticipated demand going forward. Ongoing engagement between cancer services and screening centres in relation to referral completeness and ensuring the patients are worked up for treatment locally.

Actions (SMART):

• The Winter Plan is focussed around three areas: protecting assessment capacity, discharge and recruitment of staff. There are specific actions associated with the development of a Same Day Emergency Care (SDEC) area with protected capacity, with the aim of seeing urgent and emergency patients quickly and facilitating treatment for patients as ambulatory and therefore not requiring admission. The Project Management Board for SDEC has been established from January '23, with separate working groups established. Outcome of joint national bid to assist with the delivery of the project remains outstanding; timescales to be confirmed.

• Actions in relation to Referral to Treatment and diagnostic backlog are detailed on the relevant earlier page within the pack.

Risks and Mitigations:

• Staffing risks remain high in terms of availability and vacancy, high turnover rates and high levels of short term absence. Significant work is being undertaken to recruit and retain staff with the aim of improving the number of care hours per patient per day, including the roll out of Leadership training courses from January '23.

• The ability to reduce the number of patients not meeting the criteria to reside is a significant risk. Work continues in partnership with the system with the intention to open additional bed capacity in South Wiltshire that all three acute Trusts can access. There are currently delays to this project as the system works with the Care Quality Commission (CQC) to progress.

Watch Metrics: Non-Alerting

Quality of Care, Access and Outcomes

Metric	Two Months Ago	Last Month	This Month	Improvement Target	National Target	Variation	Variation Detail	Target Met This Month?	Consecutive Months Target Failed
Ambulance Arrivals	1187	1144	1049			L	Special Cause Improving - Run Below Mean		
Ambulance Handovers 15-<30 mins	259	328	225				Common Cause Variation		
Cancer 2 Week Wait Breast Performance	96.0%	96.7%	96.1%		90%	H	Special Cause Improving - Two Out of Three High	✓	0
ED Attendances	6336	6131	6839				Common Cause Variation		
Neonatal Deaths Per 1000 Live Births	0	0	0		0	L	Special Cause Improving - Run Below Mean	✓	0
Number of High Harm Falls in Hospital	0	0	0	0	0	L	Special Cause Improving - Run Below Mean	✓	0
Pressure Ulcers Hospital Acquired Cat 2	30	38	31				Common Cause Variation		
Pressure Ulcers Hospital Acquired Cat 3	0	0	0			L	Special Cause Improving - Run Below Mean		
Pressure Ulcers Hospital Acquired Cat 4	0	0	0			L	Special Cause Improving - Run Below Mean		
RTT Incomplete Pathways: Total 104 week waits	0	0	0	0	0	L	Special Cause Improving - Run Below Mean	✓	0
RTT Incomplete Pathways: Total 52 week waits	485	448	549	560	0	L	Special Cause Improving - Run Below Mean	✓	0
RTT Incomplete Pathways: Total 78 week waits	28	6	8	15	0	L	Special Cause Improving - Below Lower Control Limit	✓	0
Serious Incident Investigations	1	4	2				Common Cause Variation		
Stillbirths Per 1000 Total Births	0	0	0				Common Cause Variation		
Stroke & TIA: % CT'd within 1 hour	42.0%	50.0%	50.0%		50%		Common Cause Variation	✓	0
Total Incidents (All Grading) per 1000 Bed Days	52	59	54				Common Cause Variation		

Part 2: People

Performance against our Strategic Priorities and Key Lines of Enquiry

Salisbury NHS Foundation Trust

Our Priorities

Population

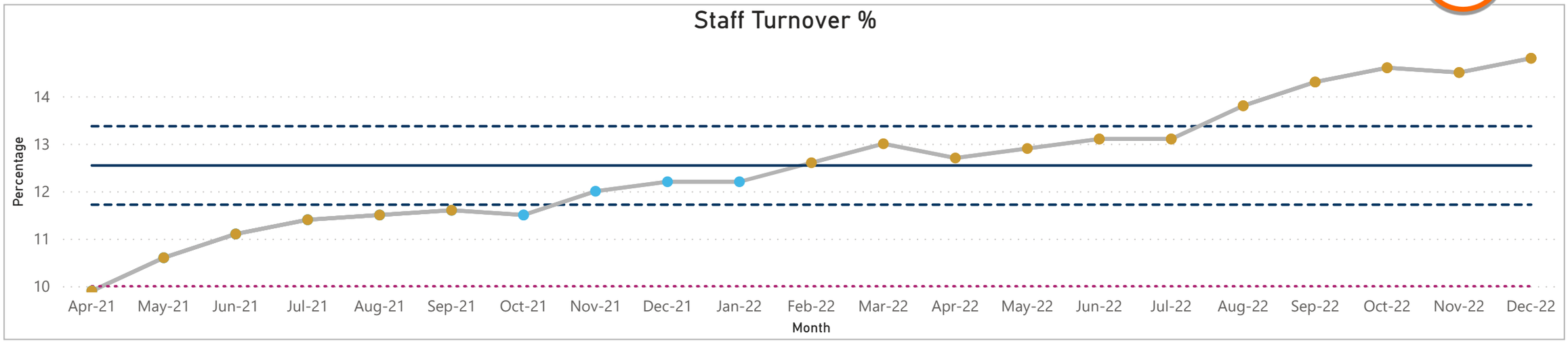
Partnerships

People

Workforce - Turnover

Target 10%

People



Understanding the performance:

In December '22, 35.37 Full Time Equivalent (FTE) staff started with the Trust compared with 49.95 FTE leavers, which has driven the 12 month rolling turnover data up to 14.80% this month. December is a challenging month as existing staff often target the end of the year as a natural point to leave, and fewer staff choose to start a new role before Christmas holidays have ended.

All Divisions remain red against the Trust 10% target.

Exit data remains incomplete with only 20% of staff completing a full exit survey, consequently understanding where the 75% of staff who did not declare their destination or why the 40% of leavers who left did so with less than 2 years service is challenging.

Of those who gave a reason for leaving 50% are within the categories of relocation, retirement and work-life balance.

Actions (SMART):

Initial Staff Survey results have been received, which indicate that the Trust has performed slightly worse than last year against key metrics relating to retention, albeit above the average for Acute Trusts. OD&P are analysing the data carefully to prepare interventions by Mar '23 as part of People Plan 23/24.

Work on the 'Movers and Leavers' project is ongoing with the project on track to confirm actions by end Jan 23 to improve the re-deployment and exit processes within the Trust. Project benefits will also include improved uptake and data definition from Exit interviews, which will support improved retention initiatives.

HR Business Partners (HRBPs) will continue to support Divisional Line managers deliver appraisals and career conversations. All those RN in the 45-55 age group will have had a career conversation before 31 Mar '23.

Risks and mitigations:

Corporate Risk – Sustainable Workforce. Action plans include: Agreement to include Staff Availability as a Trust Breakthrough Objective.

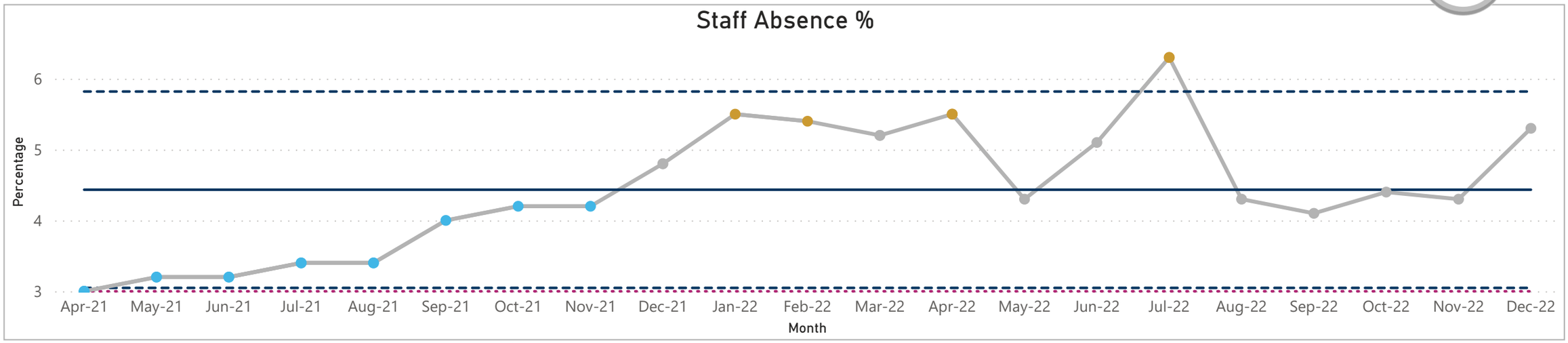
Improved toolkits to support Line Managers to deliver appraisals and other conversations. The new appraisals template is expected to be delivered by end Jan '23.

Training interventions to improve leadership and management skills will begin roll out in Feb '23, with 120 places available in the first year for leadership and a suite of management modules available to improve line management skillsets.

Workforce - Sickness

Target 3%

People



Understanding the performance:

• Sickness absence has risen to 5.3% in December '22 driven by a sharp increase in Cold, Cough, Flu and other infectious disease absence. The most affected areas have been the Women and New Born and Medicine Divisions, both sitting at 6.55%.
Only corporate services is below a 4% threshold and is graded 'amber' against the target of 3%.

• Mental Health illness remains the highest contributor to short term frequent absences after infectious diseases, with Musculo skeletal/back problems following.

• In the 2022 calendar year, 1454 staff hit the Trust's short term absence trigger 1 (3 occurrences) and 1263 hit Trigger 2 (1 episode of 14 days or greater).

• In total absence amounted to 49,791 Full Time Equivalent (FTE) days lost to sickness.

Actions (SMART):

• Recruitment has commenced against the business case agreed to recruit a member of staff to conduct a pilot to support Divisional and Line Managers with Absence Management and wellbeing conversations. The intent is to prove the concept of direct support to management to improve visibility and action on long term absence cases and, in conjunction with the 26 well being ambassadors, deliver well-being conversations to all staff by 31 Mar '23.
• The increased Occupational Health capacity has resulted in increased capacity for management referrals and pre-employment checks, with Key Performance Indicators (KPIs) met for this month and some spare capacity.
• The new permanent Head of Occupational Health commenced in post from 3 Jan '23, and will be tasked to look at maintaining the current service delivery against the KPIs, and expanding the service by Aug '23 to include a Health Intelligence capacity, in conjunction with the Health and Safety manager to target proactive interventions to reduce MSK incidences by 25%.

Risks and mitigations:

Corporate Risk – Delivery of OH service
OH staffing has improved, but a service lead (Band 7) and increased counselling hours remain vacant and are the barrier to delivering health intelligence and providing increased support to staff requiring counselling interventions.

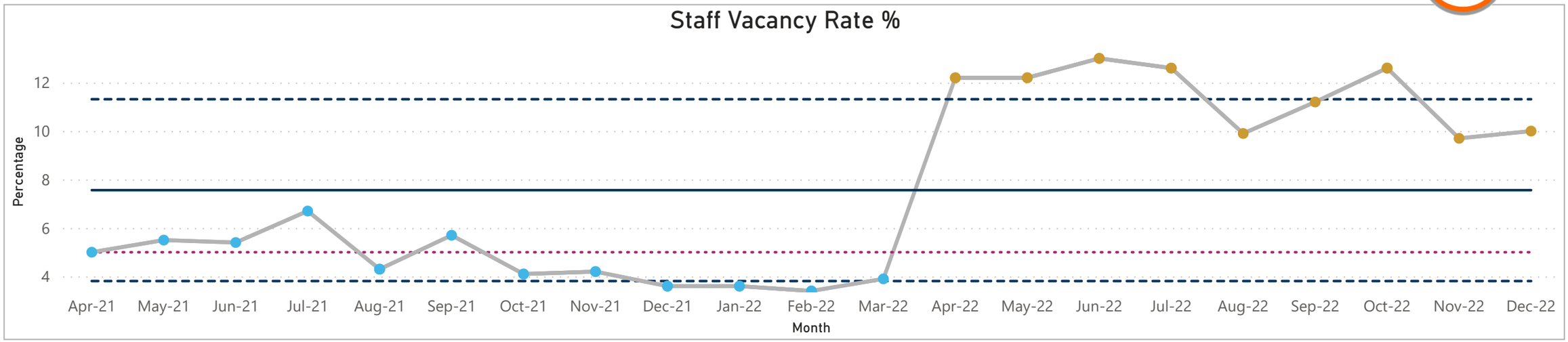
Corporate Risk – Sustainable Workforce
Absence management actions are not effective. AD HR Ops is now producing a targeted plan to reduce absence case work numbers.

OD&P delivered a number of direct support interventions with Head of Theatres and four line managers on absence management processes and assisted with casework, resulting in 13 staff members returning to work from absence this month.

Workforce - Vacancies

Target 5%

People



Understanding the performance:

The vacancy rate for December '22 sits at 9.98%, a minor rise from last month, exacerbated by an increased turnover number for December. Thirty nine staff (35.37 Full Time Equivalent, FTE) started with the Trust this month.

The effect of the concerted recruitment programme reported over the last 3 months has started to reduce vacancies as notice periods have elapsed and staff started work.

Actions (SMART):

Resourcing are hosting a general open day for Healthcare Assistants (HCAs) on 4 Feb '23, advertised throughout December '22 and January '23.

The theatres campaign has offered 21 nurse and 13 HCA positions, with a further HCA event on 14 Jan '23.

Therapy services will set up a recruitment campaign, with an Open Day in Mid-January '23, seeking to reduce to zero vacancy numbers.

The 'starters' project, highlighted by a PwC audit has begun. This seeks to improve onboarding processes, with delivery against medium term project plan benefits complete by Jun '23.

Throughout December, an assessment of social media platform presence has been conducted, changes identified in that analysis will be put into place in Jan '23, with results assessed in Mar '23.

Risks and mitigations:

Corporate Risk – Sustainable Workforce
Resourcing Plans delivered
Implementation of PWC 'overhauling recruitment' recommendations to generate more efficient processes.
Recruitment campaigns are being refreshed.
Communication of single version of recruiting picture across the Trust.
Creation of career pathways and improved career structures to better advertise roles and opportunities.

Since July '22, time from authorisation of a vacancy to employment checks completed has reduced from 58 to 49 days.

Watch Metrics: Alerting

People

Metric	Two Months Ago	Last Month	This Month	Improvement Target	National Target	Variation	Variation Detail	Target Met This Month?	Consecutive Months Target Failed
Medical Appraisal Rate %	85.8%	86.6%	86.9%	90.0%			Special Cause Improving - Run Above Mean	X	21
Non-Medical Appraisal Rate %	64.7%	65.5%	63.8%	86.0%			Special Cause Concerning - Below Lower Control Limit	X	21

Watch Metrics: Alerting Narrative

People

Understanding the performance:

Ineffective management of appraisals remains an area of concern in Staff Survey and Pulse survey data, leading to low morale amongst staff. The December completion figure of 63.8% maintains the average of c64% completion rate over the last year.
Surgery and Medicine division remain the worst performers at 55.7 and 57.4 % respectively, with Finance and Redlynch lowest performing departments, both under 20% completion rates.

Actions (SMART):

A simplified process for appraisals has been agreed and once rolled out in January, will be measured over a four month period to assess the impact on completion rates.

Delivery of SFT leadership programmes:
Aspiring leaders (Bands 4-6) programme starts with the first cohort of 20 managers in Feb 23.
Transformational Leadership Programme (Bands 7-8+) first cohort of 20 from Mar 23.
Management workshops incl managing appraisals and time management modules are being increased for 2023
Line Managers breakfast sessions have been re-instigated to support those line mangers who need help and guidance on delivery of appraisals to staff, pointing out training courses where required

Risks and Mitigations:

Corporate Risk - Sustainable Workforce.

Retention Mitigations – Appraisal Project, Development and Delivery of Leadership Training Modules for line managers

Watch Metrics: Non-Alerting

People

Metric	Two Months Ago	Last Month	This Month	Improvement Target	National Target	Variation	Variation Detail	Target Met This Month?	Consecutive Months Target Failed
Mandatory Training Rate %	91.0%	90.8%	90.6%	90.0%	85%	H	Special Cause Improving - Two Out of Three High	✓	0

Part 3: Finance and Use of Resources

Performance against our Strategic Priorities and Key Lines of Enquiry

Salisbury NHS Foundation Trust

Our Priorities

Population

Partnerships

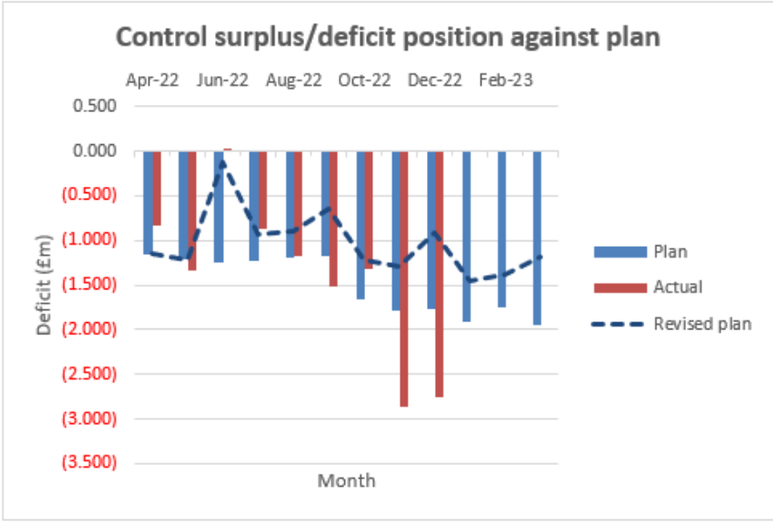
People

Income and Expenditure

Income & Expenditure:

Finance and Use of Resources

	Dec '22 In Month			Dec '22 YTD			22-23 Plan
	Plan £000s	Actual £000s	Variance £000s	Plan £000s	Actual £000s	Variance £000s	Plan £000s
Operating Income							
NHS Clinical income	21,946	22,159	213	198,169	200,217	2,048	260,775
Other Clinical Income	714	912	198	6,429	8,067	1,638	8,573
Other Income (excl Donations)	2,891	4,094	1,203	26,055	30,822	4,767	34,540
Total income	**25,551**	**27,165**	**1,614**	**230,653**	**239,105**	**8,452**	**303,888**
Operating Expenditure							
Pay	(16,899)	(17,826)	(927)	(151,757)	(156,675)	(4,918)	(199,429)
Non Pay	(7,874)	(10,438)	(2,564)	(72,232)	(80,273)	(8,041)	(96,646)
Total Expenditure	**(24,773)**	**(28,264)**	**(3,491)**	**(223,989)**	**(236,948)**	**(12,959)**	**(296,075)**
EBITDA	**778**	**(1,098)**	**(1,876)**	**6,664**	**2,157**	**(4,507)**	**7,813**
Financing Costs (incl Depreciation)	(1,685)	(1,654)	31	(15,045)	(14,818)	227	(20,213)
NHSI Control Total	**(907)**	**(2,752)**	**(1,845)**	**(8,381)**	**(12,660)**	**(4,279)**	**(12,400)**
Add: impact of donated assets	(68)	(61)	*7*	(612)	(297)	*315*	(816)
Surplus/(Deficit)	***(975)***	***(2,814)***	***(1,839)***	***(8,993)***	***(12,957)***	***(3,964)***	***(13,216)***
NHSI Control Total including BSW ICB support	**126**	**(1,719)**	**(1,845)**	**919**	**(3,360)**	**(4,279)**	**0**



Understanding the performance:

In month 9 the Trust recorded an in month control total deficit of £2.752m against an original target of £0.907m - an adverse variance of £1.845m. The year to date (YTD) control total deficit is £12.660m compared to the original plan of £8.381m. When the full year £12.400m ICB funding is taken into account (£9.3m at month 9) the deficit is adjusted to £3.360m against a surplus of £0.919m. A revised forecast of £6.4m deficit was approved by the Trust Board in early January.

Pay costs decreased slightly in month by £0.2m driven by a reduction in agency shifts with an increased level of unfilled shifts. Non pay costs increased markedly due to recharges for the Vaccination centre, which were backed by income, Computer software and STL related costs. 'Pass through' non pay costs continue to run in excess of those planned for and now account for 60% of costs above plan.

Actions (SMART):

Agreement was reached on the distribution of the Bath, Swindon & Wiltshire (BSW) Integrated Care Board (ICB) planned surplus and £12.4m was paid to SFT in October.

People workstreams are focusing on retention of staff, with the uplift of all Band 2s to the top of scale with effect from 1 December. A review of the Healthcare Assistant (HCA) roles that have fulfilled clinical competencies and can be regraded to Band 3 is under way with the expectation that this is effective from January 2023.

The BSW-wide procurement 2022/23 workplan levers the Integrated Care System (ICS) spending power to mitigate the impact of inflation.

Risks and mitigations:

Pressure on emergency care pathways which results in increased costs associated with the Trust's bed base, reductions of elective inpatient care and premium costs of bank and agency to cover vacancies and unavailability.

The requirement for the provision of additional beds at South Newton would represent a financial risk to the Trust if unfunded.

The Trust has a forecast delivery of £9.7m efficiency savings split 50:50 between recurrent and non-recurrent schemes. This signals a significant risk if further recurrent efficiencies are not identified.

Income & Activity Delivered by Point of Delivery

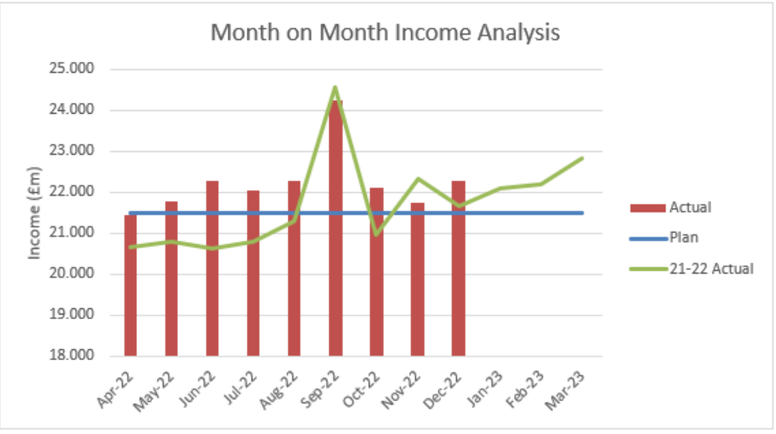
Clinical Income:

Finance and Use of Resources

Income by Point of Delivery (PoD) for all commissioners	December '22 YTD Plan (YTD) £000s	Actual (YTD) £000s	Variance (YTD) £000s
A&E	8,092	7,736	(356)
Day Case	15,055	14,684	(371)
Elective inpatients	10,057	10,445	388
Excluded Drugs & Devices (inc Lucentis)	16,628	18,221	1,593
Non Elective inpatients	52,754	54,005	1,251
Other	68,328	68,843	515
Outpatients	27,255	26,283	(972)
TOTAL	198,169	200,217	2,048

	Activity YTD Plan	Activity YTD Actuals	Activity YTD Variance	Activity Last Year Actuals	Variance last year
A&E	53,166	55,481	2,315	51,836	3,645
Day case	17,260	16,783	(477)	15,506	1,277
Elective	2,508	2,519	11	2,080	439
Non Elective	21,727	19,942	(1,785)	21,316	(1,374)
Outpatients	189,538	188,582	(956)	202,659	(14,077)

SLA Income Performance of Trusts main NHS commissioners	Contract Plan (YTD) £000s	Actual (YTD) £000s	Variance (YTD) £000s
BSW ICB	117,411	118,894	1,483
Dorset ICB	19,700	19,557	(143)
Hampshire, Southampton & IOW ICB inc Portsmouth	16,063	16,063	-
Specialist Services	29,238	30,764	1,526
Other	15,757	14,939	(818)
TOTAL	198,169	200,217	2,048



Understanding the performance:

The Trust is ahead of the Clinical income plan year to date due to BSW ICB Elective Recovery Fund (ERF), pay award and South Newton additional beds funding and overperformance on Channel Islands spinal patients and additional Cystic Fibrosis patients and drugs. NHS England Specialised services continues to overperform on cost and volume high cost drugs and devices which is being offset by the transfer of the Genetics service with an income reduction of £0.6m per month. Dorset ICB income has been adjusted for the agreement on the Sleep service. A&E activity higher in December than in November with less attendances at the A&E department but circa 840 attendances more at the Walk in centre in month. Day case activity in December was 353 less cases than in November with less activity undertaken in General Surgery (111) and Plastic Surgery (90) but exceeded the plan by 81 cases. Activity in Elective inpatients was above plan in month by 54 cases mainly within Trauma and Orthopaedics and Plastic Surgery. Non Elective activity was higher than in November by 32 cases and above plan mainly within medical specialties. Outpatient activity was understandably lower than in November but above planned levels.

Actions (SMART):

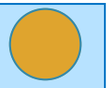
The BSW ICB contract has been signed by both parties.
The NHS England contracts require updating for the inclusion of agreed quality schedules, final agreement on the finance and information schedules and the removal of public health aspects within the HIV contract which were not part of the contract tender.

Risks and mitigations:

The BSW ERF funding has now been confirmed at £2,150k and is higher than originally planned.
£900k funding has been agreed for 14 South Newton beds and discussions are ongoing on the additional funding for a further 10 beds.

Cash Position & Capital Programme

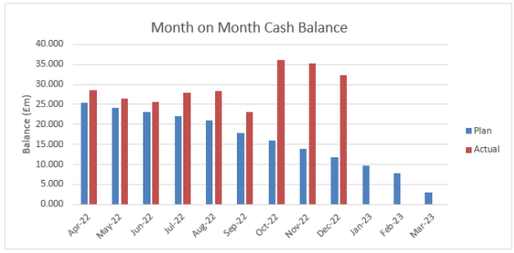
Capital Spend: 

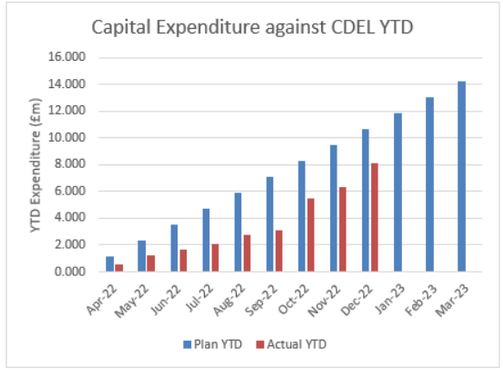
Cash & Working: 

Finance and Use of Resources

	Closing Balance March 2022 £000s	Current Month Balance £000s	Actual In Year Movement £000s	
Inventories (Stock)	7,939	8,793	854	
Debtors	14,296	19,200	4,904	
Cash	33,447	32,261	(1,186)	
TOTAL CURRENT ASSETS	**55,682**	**60,254**	**4,572**	
Creditors	(46,637)	(53,061)	(6,424)	
Borrowings	(1,102)	(1,263)	(161)	
Provisions	(1,235)	(972)	263	
TOTAL CURRENT LIABILITIES	**(48,974)**	**(55,296)**	**(6,322)**	
TOTAL WORKING CAPITAL	**6,708**	**4,958**	**(1,750)**	

Payables age profile	Total Payables £'000	0-30 days £'000	31-60 days £'000	61-90 days £'000	90+ days £'000
Dec-22	**8,474**	6,286	425	439	1,324
Nov-22	**7,152**	4,929	781	291	1,151
Oct-22	**6,373**	4,638	365	47	1,323
Movement vs prev mth	***1,322***	***1,357***	***(356)***	***148***	***173***





Schemes	Annual Plan £000s	December '22 YTD Plan £000s	Actual £000s	Variance £000s
CDEL Schemes				
Building schemes CIR	3,758	2,763	1,088	1,675
Building projects	3,154	2,286	2,577	(291)
IM&T	4,166	2,871	2,284	587
Medical Equipment	2,528	2,439	938	1,501
Other	1,414	318	394	(76)
Total CDEL schemes	**15,020**	**10,677**	**7,281**	**3,396**
National Funding				
TIF - New ward	*2,048*	*399*	*399*	0
Pathology LIMS	*712*	*86*	*86*	0
MRI Acceleration Upgrades	*178*	*31*	*31*	
Total National Funding	**2,938**	**516**	**516**	0
GRAND TOTAL	**17,958**	**11,193**	**7,797**	**3,396**

Understanding the performance:

Capital expenditure is significantly behind plan, -c32% year to date, particularly within Medical Equipment and Building schemes. Forecast expenditure by capital sub group is reviewed each month at the Trust Capital Control Group to ensure full allocations will be spent by the year end. The forecast includes the refurbishment of the Douglas Arter Centre as part of the decant for the additional ward scheme together with further agreed investment in medical equipment and building schemes. Targeted Investment funding (TIF) for the new ward (£14m) has now been formally agreed with £2.048m in 22/23. A further £1.909m of additional national funding is anticipated for nationally fund capital schemes.

The improvement in the cash position, following the receipt of the BSW ICB funding, mitigates any risk to the cash balance for the remainder of the financial year. It is anticipated that the cash balance will reduce markedly by year end due to capital expenditure over the last 3 months of the year.

Actions (SMART):

The capital plan has been reviewed in the context of known supply chain restraints. Alternative projects initially planned for 2023/24 which can be brought forward to 2022/23 have been identified to mitigate the risk of further slippage.

A further £300k BSW capital allocation has been confirmed and this is expected to be required for Digital schemes.

Risks and mitigations:

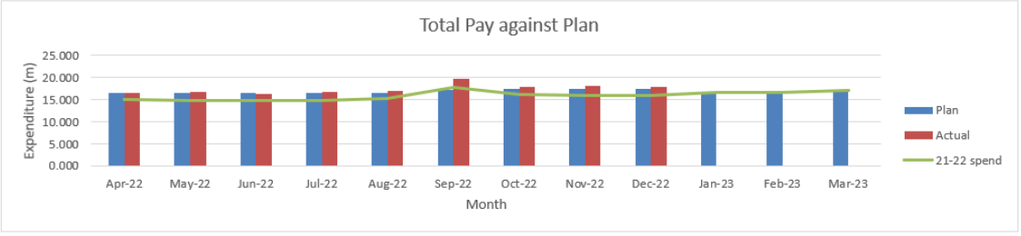
Supply chain disruption and inflationary pressures remain a significant draw of time on the procurement team. This gives rise to a risk in both lead times and overall procurement capacity.

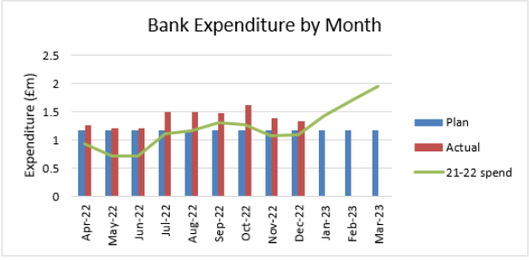
The constraint of both available cash and system capital expenditure limits gives rise to both a mid and long term risk to the Trust. The context of digital modernisation programmes, along with an aging estate and medical equipment means the Trust's five year capital requirement is well in excess of available resources. The Trust seeks to in part mitigate this risk through the proactive bidding for national funds where available. Bids for Digital diagnostics and to support Elective care have recently been submitted against available national funding in 2022/23.

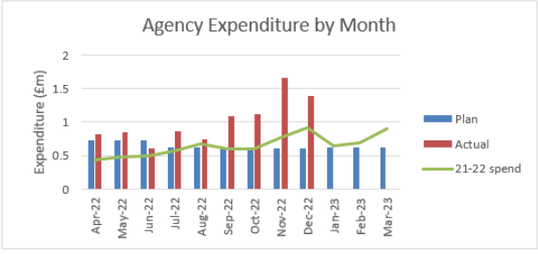
Workforce and Agency Spend

Pay:

Finance and Use of Resources







	December '22 YTD		
	Plan £000s	Actual £000s	Variance £000s
Pay - In Post	134,263	134,459	(196)
Pay - Bank	10,720	12,472	(1,752)
Pay - Agency	5,883	9,160	(3,277)
Other (eg. Apprenticeship Levy)	891	584	307
TOTAL	**151,757**	**156,675**	**(4,918)**
Medical Staff	40,035	40,769	(734)
Nursing	36,020	40,532	(4,512)
Support to Nursing	10,972	12,448	(1,475)
Other Clinical Staff	24,835	22,895	1,940
Infrastructure staff	39,004	39,448	(444)
Other (eg. Apprenticeship Levy)	891	584	307
TOTAL	**151,757**	**156,675**	**(4,918)**

	December '22		
	Plan WTEs	Actual WTEs	Variance WTEs
Medical Staff	490.6	477.9	12.7
Nursing	1,103.6	1,084.2	19.4
Support to Nursing	515.1	544.5	(29.4)
Other Clinical Staff	689.8	601.7	88.1
Infrastructure staff	1,461.1	1,394.1	67.0
TOTAL	**4,260.2**	**4,102.3**	**157.9**

Understanding the performance:

Pay expenditure reduced by £241k in month 9, although this was still £630k above the average run rate for the year (adjusted for Genetics). YTD adverse variance against plan of £4.9m. Expenditure on bank and agency fell by £53k and £265k respectively, while substantive staff costs rose by £77k. The number of staff employed fell by 97 WTEs across all contract types, but particularly agency by 65 WTE relating to NHS infrastructure staff, with the majority of the reduction in agency WTEs accounted for in Salisbury Trading Ltd (42 WTE).

The increase in substantive staff costs was due to backdated Clinical Excellence Awards (CEA) to Consultants offset by reductions in Trainee and Career/Staff doctors, Health care scientists and NHS Infrastructure support. Substantive vacancies has remained at 11% in month.

Nursing Agency costs have reduced in month by £150k due to an increase in unfilled shifts. Monthly costs were the second highest level seen in year, driven by the escalated bed base, higher patient acuity within ITU, continued ventilated patient care within the Spinal unit, accompanied by higher levels of sickness cover.

Actions (SMART):

Detailed actions on the response to the Trust's workforce challenges are set out in the People section of the IPR. These focus on recruitment, retention, and a focused review of short term sick leave.

Risks and mitigations:

Retention initiatives over and above those assumed as part of the winter forecast are in train to mitigate workforce gaps. Although in the longer term these would offset the need for high cost agency, in the short term it is likely that the Trust will require both.

Industrial action has now taken place with disruption to patient pathways and additional costs to mitigate.

Data Sources: Narrative and Breakthrough Objectives

Understand the Data

Metric Type	Metric Name	Data Source	Executive Lead	Data Quality Rating
Breakthrough Objective	% Beds Occupied	Site Team	Lisa Thomas	Medium
Breakthrough Objective	Staffing Availability	Health Roster/ESR	Melanie Whitfield	Medium
Breakthrough Objective	Total Patient Falls per 1000 Bed Days	DATIX Team	Judy Dyos	Medium
Breakthrough Objective	Wait time to first OPA (non-admitted)	Lorenzo via Trust Data Warehouse	Lisa Thomas	High
Narrative	% of patients moved more than once	Trust Data Warehouse	Judy Dyos	High
Narrative	C Difficile Hospital onset Healthcare associated	Infection Control Team	Judy Dyos	High
Narrative	Cancer 2 Week Wait Performance	Cancer Services	Lisa Thomas	High
Narrative	Cancer 28 Day Faster Diagnosis Standard	Cancer Services	Lisa Thomas	High
Narrative	Cancer 62 Day Standard Performance	Cancer Services	Lisa Thomas	High
Narrative	Cat 2 Pressure Ulcers per 1000 Bed Days	DATIX Team	Judy Dyos	High
Narrative	DM01 Performance	Trust Data Warehouse	Lisa Thomas	High
Narrative	E Coli Hospital onset Healthcare associated	Infection Control Team	Judy Dyos	High
Narrative	ED 4 Hour Performance	Lorenzo via Trust Data Warehouse	Lisa Thomas	High
Narrative	Friends and Family Test Response Rate - All Trust	Trust Data Warehouse	Judy Dyos	High
Narrative	Staff Sickness Absence %	Health Roster	Melanie Whitfield	High
Narrative	Staff Turnover	ESR	Melanie Whitfield	High
Narrative	Stroke & TIA: % Arrival on Stroke Unit within 4 hours	Trust Data Warehouse	Peter Collins	High
Narrative	Total Ambulance Handover Delays	Lorenzo via Trust Data Warehouse	Lisa Thomas	High
Narrative	Total Waiting List	Lorenzo via Trust Data Warehouse	Lisa Thomas	High
Narrative	Vacancies	ESR	Melanie Whitfield	High

Data Sources: Watch Metrics (1)

Understand the Data

Metric Type	Metric Name	Data Source	Executive Lead	Data Quality Rating
Watch	Ambulance Arrivals	Lorenzo via Trust Data Warehouse	Lisa Thomas	High
Watch	Ambulance Handovers 15-<30 mins	SWAST AR119 report	Lisa Thomas	High
Watch	Ambulance Handovers 30-<60 mins	SWAST AR119 report	Lisa Thomas	High
Watch	Ambulance Handovers 60+ mins	SWAST AR119 report	Lisa Thomas	High
Watch	Average hours lost to Ambulance Handover delays per day	Lorenzo via Trust Data Warehouse	Lisa Thomas	High
Watch	Average Patients with No Criteria to Reside	e-whiteboards via Trust Data Warehouse	Lisa Thomas	Medium
Watch	Cancer 2 Week Wait Breast Breaches	Cancer Services	Lisa Thomas	High
Watch	Cancer 2 Week Wait Breast Den	Cancer Services	Lisa Thomas	High
Watch	Cancer 2 Week Wait Breast Num	Cancer Services	Lisa Thomas	High
Watch	Cancer 2 Week Wait Breast Performance	Cancer Services	Lisa Thomas	High
Watch	Cancer 62 Day Screening Den	Cancer Services	Lisa Thomas	High
Watch	Cancer 62 Day Screening Num	Cancer Services	Lisa Thomas	High
Watch	Cancer 62 Day Screening Performance	Cancer Services	Lisa Thomas	High
Watch	Cancer 62 Days Standard Den	Cancer Services	Lisa Thomas	High
Watch	Cancer 62 Days Standard Num	Cancer Services	Lisa Thomas	High
Watch	DM01 Waiting List Volume	Trust Data Warehouse	Lisa Thomas	High
Watch	ED 12 Hour Breaches (Arrival to Departure)	Lorenzo via Trust Data Warehouse	Lisa Thomas	Medium
Watch	ED Attendances	Lorenzo via Trust Data Warehouse	Lisa Thomas	High
Watch	MSSA Bacteraemia Infections: Hospital Onset	Infection Control Team	Judy Dyos	High
Watch	RTT Incomplete Pathways: Total 104 week waits	Lorenzo via Trust Data Warehouse	Lisa Thomas	High
Watch	RTT Incomplete Pathways: Total 52 week waits	Lorenzo via Trust Data Warehouse	Lisa Thomas	High
Watch	RTT Incomplete Pathways: Total 78 week waits	Lorenzo via Trust Data Warehouse	Lisa Thomas	High
Watch	Stroke & TIA: % Bedside Swallow Assessment within 4 hours	Trust Data Warehouse	Peter Collins	High
Watch	Stroke & TIA: % CT'd within 1 hour	Trust Data Warehouse	Peter Collins	High

Data Sources: Watch Metrics (2)

Understand the Data

Metric Type	Metric Name	Data Source	Executive Lead	Data Quality Rating
Watch	% of Inpatients Undergoing VTE Risk Assessment	Quality Team	Peter Collins	High
Watch	% of Total Incidents Resulting in High Harm (Mod/Maj/Cat)	DATIX Team	Judy Dyos	Medium
Watch	Cancer 31 Day Performance Overall	Cancer Services	Lisa Thomas	High
Watch	Mandatory Training Rate %	MLE	Melanie Whitfield	High
Watch	Medical Appraisal Rate %	ESR	Melanie Whitfield	High
Watch	Mixed Sex Accommodation Breaches	Site Team	Judy Dyos	Low
Watch	Neonatal Deaths Per 1000 Live Births	E3 Maternity System	Peter Collins	High
Watch	Non-Medical Appraisal Rate %	ESR	Melanie Whitfield	High
Watch	Number of High Harm Falls in Hospital	DATIX Team	Judy Dyos	Medium
Watch	Pressure Ulcers Hospital Acquired Cat 2	DATIX Team	Judy Dyos	High
Watch	Pressure Ulcers Hospital Acquired Cat 3	DATIX Team	Judy Dyos	High
Watch	Pressure Ulcers Hospital Acquired Cat 4	DATIX Team	Judy Dyos	High
Watch	Proportion of patients spending more than 12 hours in an emergency department	Lorenzo via Trust Data Warehouse	Lisa Thomas	High
Watch	Serious Incident Investigations	DATIX Team	Judy Dyos	Medium
Watch	Stillbirths Per 1000 Total Births	E3 Maternity System	Peter Collins	High
Watch	Total (Excess) Bed Days from NC2R to Discharge - Internal Reasons only	e-whiteboards	Lisa Thomas	Medium
Watch	Total Incidents (All Grading) per 1000 Bed Days	DATIX Team	Judy Dyos	High
Watch	Total Number of Complaints Received	PALS Team	Judy Dyos	High
Watch	Total Number of Compliments Received	PALS Team	Judy Dyos	High
Watch	Trust Performance RTT %	Lorenzo via Trust Data Warehouse	Lisa Thomas	High

Data Sources: Other Metrics (1)

Understand the Data

Metric Type	Metric Name	Data Source	Executive Lead	Data Quality Rating
Other	Cancer 2 Week Wait Breaches	Cancer Services	Lisa Thomas	High
Other	Cancer 2 Week Wait Den	Cancer Services	Lisa Thomas	High
Other	Cancer 2 Week Wait Num	Cancer Services	Lisa Thomas	High
Other	DM01 Performance: Audio	Trust Data Warehouse	Lisa Thomas	High
Other	DM01 Performance: Cardio	Trust Data Warehouse	Lisa Thomas	High
Other	DM01 Performance: Colon	Trust Data Warehouse	Lisa Thomas	High
Other	DM01 Performance: CT	Trust Data Warehouse	Lisa Thomas	High
Other	DM01 Performance: DEXA	Trust Data Warehouse	Lisa Thomas	High
Other	DM01 Performance: Flexi Sig	Trust Data Warehouse	Lisa Thomas	High
Other	DM01 Performance: Gastro	Trust Data Warehouse	Lisa Thomas	High
Other	DM01 Performance: MRI	Trust Data Warehouse	Lisa Thomas	High
Other	DM01 Performance: Neuro	Trust Data Warehouse	Lisa Thomas	High
Other	DM01 Performance: US	Trust Data Warehouse	Lisa Thomas	High
Other	Longest Waiting Patient (Weeks)	Lorenzo via Trust Data Warehouse	Lisa Thomas	High
Other	Day HCA	Health Roster	Melanie Whitfield	High
Other	Day RN	Health Roster	Melanie Whitfield	High
Other	Night HCA	Health Roster	Melanie Whitfield	High
Other	Night RN	Health Roster	Melanie Whitfield	High

Data Sources: Other Metrics (2)

Understand the Data

Metric Type	Metric Name	Data Source	Executive Lead	Data Quality Rating
Other	Maternity: Compliance with supernumery status of the LW coordinator %	Maternity Dept	Judy Dyos	Medium
Other	Maternity: Coroner Red 28 made directly to trust	Maternity Dept	Judy Dyos	Medium
Other	Maternity: DATIX incidents moderate harm (not SII)	Maternity Dept	Judy Dyos	Medium
Other	Maternity: DATIX incidents SII	Maternity Dept	Judy Dyos	Medium
Other	Maternity: DATIX relating to workforce	Maternity Dept	Judy Dyos	Medium
Other	Maternity: HSIB referrals	Maternity Dept	Judy Dyos	Medium
Other	Maternity: HSIB/NHSR/CQC or other organisation with a concern or request	Maternity Dept	Judy Dyos	Medium
Other	Maternity: Midwifery vacancy rate	Maternity Dept	Judy Dyos	Medium
Other	Maternity: Minimum safe staffing in maternity services; Obstetric cover	Maternity Dept	Judy Dyos	Medium
Other	Maternity: Minimum to birth ratio	Maternity Dept	Judy Dyos	Medium
Other	Maternity: Number of DATIX incidents - moderate or above	Maternity Dept	Judy Dyos	Medium
Other	Maternity: Number of SOX	Maternity Dept	Judy Dyos	Medium
Other	Maternity: Number of times maternity unit on divert	Maternity Dept	Judy Dyos	Medium
Other	Maternity: Number of women requiring admission to ITU	Maternity Dept	Judy Dyos	Medium
Other	Maternity: Progress in achievement of 10 safety actions (CNST)	Maternity Dept	Judy Dyos	Medium
Other	Maternity: Provision of 1 to 1 care in established labour (%)	Maternity Dept	Judy Dyos	Medium
Other	Maternity: Service user feedback: number of complaints	Maternity Dept	Judy Dyos	Medium
Other	Maternity: Service user feedback: number of compliments	Maternity Dept	Judy Dyos	Medium
Other	Maternity: Training compliance - MDT Prompt %	Maternity Dept	Judy Dyos	Medium
Other	Maternity: Medical termination over 24+0 registered	E3 via Trust Data Warehouse	Peter Collins	Medium
Other	Maternity: Number of late fetal losses (22+0 to 23+6 weeks excl TOP)	E3 via Trust Data Warehouse	Peter Collins	Medium
Other	Maternity: Number of Maternal Deaths	E3 via Trust Data Warehouse	Peter Collins	Medium
Other	Maternity: Number of neonatal deaths (0-28 days)	E3 via Trust Data Warehouse	Peter Collins	Medium
Other	Maternity: Number of stillbirths (>+24 weeks excl TOP)	E3 via Trust Data Warehouse	Peter Collins	Medium
Other	SSNAP Case Ascertainment Audit	Stroke Team	Peter Collins	High

Data Sources: Other Metrics (3)

Understand the Data

Metric Type	Metric Name	Data Source	Executive Lead	Data Quality Rating
Other	Crude Mortality	Medical Examiners	Peter Collins	High
Other	FFT Response Rate - A&E	Trust Data Warehouse	Judy Dyos	High
Other	FFT Response Rate - Day Case	Trust Data Warehouse	Judy Dyos	High
Other	FFT Response Rate - Inpatient	Trust Data Warehouse	Judy Dyos	High
Other	FFT Response Rate - Maternity	Trust Data Warehouse	Judy Dyos	High
Other	FFT Response Rate - Outpatient	Trust Data Warehouse	Judy Dyos	High
Other	HSMR Trust	Telstra Health	Peter Collins	High
Other	MRSA Bacteraemia Infections: Hospital Onset	Infection Control Team	Judy Dyos	High
Other	Never Events	DATIX Team	Judy Dyos	Medium
Other	SHMI Trust	Telstra Health	Peter Collins	High

Data Sources: Other Metrics (4)

Understand the Data

Metric Type	Metric Name	Data Source	Executive Lead	Data Quality Rating
Other	Add: impact of donated assets	Finance Division	Mark Ellis	High
Other	Financing Costs	Finance Division	Mark Ellis	High
Other	Income by PoD: A&E Actual	Finance Division	Mark Ellis	High
Other	Income by PoD: A&E Plan	Finance Division	Mark Ellis	High
Other	Income by PoD: Daycase Actual	Finance Division	Mark Ellis	High
Other	Income by PoD: Daycase Plan	Finance Division	Mark Ellis	High
Other	Income by PoD: Elective IP Actual	Finance Division	Mark Ellis	High
Other	Income by PoD: Elective IP Plan	Finance Division	Mark Ellis	High
Other	Income by PoD: Excluded Drugs & Devices Actual	Finance Division	Mark Ellis	High
Other	Income by PoD: Excluded Drugs & Devices IP Plan	Finance Division	Mark Ellis	High
Other	Income by PoD: Non Elective IP Actual	Finance Division	Mark Ellis	High
Other	Income by PoD: Non Elective IP Plan	Finance Division	Mark Ellis	High
Other	Month on month I&E Surplus/(Deficit) Actual	Finance Division	Mark Ellis	High
Other	Month on month I&E Surplus/(Deficit) Plan	Finance Division	Mark Ellis	High
Other	NHS Clinical income	Finance Division	Mark Ellis	High
Other	NHS Clinical income Plan	Finance Division	Mark Ellis	High
Other	Non Pay	Finance Division	Mark Ellis	High
Other	Other Clinical income	Finance Division	Mark Ellis	High
Other	Other Clinical income Plan	Finance Division	Mark Ellis	High
Other	Other income (excl donations)	Finance Division	Mark Ellis	High
Other	Other income (excl donations) Plan	Finance Division	Mark Ellis	High
Other	Pay	Finance Division	Mark Ellis	High
Other	Share of Gains on Joint Ventures	Finance Division	Mark Ellis	High
Other	Surplus/(Deficit)	Finance Division	Mark Ellis	High

Data Sources: Other Metrics (5)

Understand the Data

Metric Type	Metric Name	Data Source	Executive Lead	Data Quality Rating
Other	Activity by PoD: A&E	Finance Division	Mark Ellis	High
Other	Activity by PoD: Day case	Finance Division	Mark Ellis	High
Other	Activity by PoD: Elective	Finance Division	Mark Ellis	High
Other	Activity by PoD: Non Elective	Finance Division	Mark Ellis	High
Other	Activity by PoD: Outpatients	Finance Division	Mark Ellis	High
Other	Capital Expenditure: Building Projects Actual	Finance Division	Mark Ellis	High
Other	Capital Expenditure: Building Projects Plan	Finance Division	Mark Ellis	High
Other	Capital Expenditure: Building Schemes Actual	Finance Division	Mark Ellis	High
Other	Capital Expenditure: Building Schemes Plan	Finance Division	Mark Ellis	High
Other	Capital Expenditure: IM&T Actual	Finance Division	Mark Ellis	High
Other	Capital Expenditure: IM&T Plan	Finance Division	Mark Ellis	High
Other	Capital Expenditure: Medical Equipment Plan	Finance Division	Mark Ellis	High
Other	Income by PoD: Other Actual	Finance Division	Mark Ellis	High
Other	Income by PoD: Other Plan	Finance Division	Mark Ellis	High
Other	Income by PoD: Outpatients Actual	Finance Division	Mark Ellis	High
Other	Income by PoD: Outpatients Plan	Finance Division	Mark Ellis	High
Other	Month on month cash balance	Finance Division	Mark Ellis	High
Other	Month on month Income Analysis Actual	Finance Division	Mark Ellis	High
Other	Month on month Income Analysis Plan	Finance Division	Mark Ellis	High
Other	SLA Income: BSW CCG	Finance Division	Mark Ellis	High
Other	SLA Income: Dorset CCG	Finance Division	Mark Ellis	High
Other	SLA Income: Hampshire, Southampton and IoW CCG	Finance Division	Mark Ellis	High
Other	SLA Income: Other	Finance Division	Mark Ellis	High
Other	SLA Income: Specialist Services	Finance Division	Mark Ellis	High

Data Sources: Other Metrics (6)

Understand the Data

Metric Type	Metric Name	Data Source	Executive Lead	Data Quality Rating
Other	Agency total Actual	Finance Division	Mark Ellis	High
Other	Agency Total Plan	Finance Division	Mark Ellis	High
Other	Bank total Actual	Finance Division	Mark Ellis	High
Other	Bank total Plan	Finance Division	Mark Ellis	High
Other	Capital Expenditure: Additional funds approved in year Actual	Finance Division	Mark Ellis	High
Other	Capital Expenditure: Additional funds approved in year Plan	Finance Division	Mark Ellis	High
Other	Capital Expenditure: Medical Equipment Actual	Finance Division	Mark Ellis	High
Other	Capital Expenditure: Other Actual	Finance Division	Mark Ellis	High
Other	Capital Expenditure: Other Plan	Finance Division	Mark Ellis	High
Other	Month on Month CAPEX Actual	Finance Division	Mark Ellis	High
Other	Month on Month CAPEX Plan	Finance Division	Mark Ellis	High
Other	Month on Month total pay Actual	Finance Division	Mark Ellis	High
Other	Month on Month total pay Plan	Finance Division	Mark Ellis	High