Salisbury NHS Foundation Trust

Report to:	Trust Board	**Agenda item:**	2.1
Date of Meeting:	9 June 2022		

Committee Name:	Finance and Performance		**Committee Meeting Date:**	24th May 2022
Status:	**Information**	**Discussion**	**Assurance**	**Approval**
			X	
Prepared by:	Paul Miller, Non-Executive Director			
Board Sponsor (presenting):	Paul Miller, Non-Executive Director			

Recommendation
To note key aspects of the Finance and Performance (F&P) Committee meeting held on the 24th May 2022

Items for Escalation to Board

(1) F&P Annual Review of Committee Effectiveness – This paper was approved

(2) Theatre Business Case – The Trust Board has already approved the staffing required to open 13 operating theatres as part of the 2022/23 Operational Plan, as part of the elective recovery plan. This business case provided additional details of this £2.8m investment (an increase of £1.4m over the 2021/22 outturn spend). The Committee noted the efficiency improvements identified in a separate paper to the same meeting and after significant discussion noted this business case.

(3) Integrated Performance report (IPR) as at 30th April 2022 – The first month of the new year has been particularly challenging, with continued high levels of No Criteria to Reside (NC2R) patients (almost 100) and significant ambulance handover delays, as well as long waiting times in the Emergency Department. The Trust Board are aware of these issues and the consequential impact of these pressures on the majority of the Trusts

services. The key risk is failure to address these issues, will materially impact on the Trusts ability to achieve a significant number of key 2022/23 operational targets.

(4) Financial Report as at 30th April 2022 – The Trust has currently set deficit financial plan for 2022/23 of £18m overspend. As at the end of the first month the Trust was £0.8m overspent, which is £0.3m better than the planned deficit of £1.1m. The difference being due to receipt of non-recurrent income.

(5) Financial Sustainability (and 2022/23 Operational Plan) – As mentioned above the Trust Board has currently approved a £18m deficit plan for 2022/23. However this is being challenged by NHS England, as is the wider Bath and North East Somerset, Swindon and Wiltshire (BSW) Integrated Care System (ICS) plan (£55m deficit). Additional central funding will be made available in 2022/23 for excess inflation and ongoing Covid-19 costs, plus further Regional funding, but that will still leave a system financial gap of circa £10m. The Trust and system partners have until the 20th June 2022 to resubmit a balanced financial plan and failure to do so runs the risk of escalated regulatory interventions and further restrictions of financial freedoms.

(6) Capital Planning Process – Further details of the 2022/23 Trust capital programme were received alongside details of the associated procedures to ensure projects are well managed and spend achieved. The Committee noted these papers and thanked colleagues for their good work.

Salisbury NHS Foundation Trust

Report to:	Trust Board	**Agenda item:**	2.3
Date of Meeting:	9th June 2022		

Report from: (Committee Name)	Clinical Governance Committee		**Committee Meeting Date:**	24th May 2022
Status:	**Information**	**Discussion**	**Assurance**	**Approval**
	X	X	X	
Prepared by:	Miss Eiri Jones, Chair CGC			
Board Sponsor (presenting):	Miss Eiri Jones, Chair CGC			

Recommendation
Trust Board members are asked to note and where relevant, discuss the items escalated from the Clinical Governance Committee (CGC) meeting held on the 24th May 2022. The report both provides assurance and identifies areas where further assurance has been sought and is required.

Key Items for Escalation
• Key information / issues / risks / positive care to escalate to the Board are as follows: o The new Chief Pharmacist presented the medicines safety annual report to the committee. Information was provided in relation to current workstreams, noting that whilst medicines reconciliation is in place, further work is needed to ensure it is optimised. Examples were provided of how pharmacy staff, working with other clinical staff had prevented incidents relating to medicines management. A dashboard is currently under development and it was agreed that in future 6 monthly assurance reports will be provided to the committee. o Following a request at a previous committee meeting, the COO presented a deep dive review of the front door challenges and outlined the mitigations in place to minimise the risks to patients. The Trust had seen its first ever 12 hour trolley wait a month ago which outlines the level of pressure the department has experienced. In reviewing any harms from ambulance waits, it was noted that 1 Serious Incident review had been commissioned. o The Quality Account was presented in its latest draft. A lot of good work had gone into the report and the lead coordinator was thanked for his contribution. All committee members had the opportunity to read and comment and it was noted that the Governors had also had sight of this draft. It was noted that this will go to June Board for final sign off and publishing. o An update was provided on the GIRFT programme. Recent reports outlined good practice in the Trust though areas for improvement were also flagged. The AMD for Quality outlined the future approach to gaining ongoing

assurance that the Trust is reducing unwarranted variation and delivering effective care.

- The IPR sections on the quality of care outlined that the Trust had experienced ongoing pressures over the last month. Despite this, there were areas of good practice such as being the 4th best Trust in the region for the Best Practice tariff and reducing falls this month. A focus on areas for improvement such as stroke recovery and reducing the number of patient moves was also discussed.
- The quarterly research report demonstrated the Trust's continued good practice in this area as a small Trust.
- Quarterly reports on patient experience were received and noted.
- The quarter 4 maternity and newborn report was received and discussed in detail. Areas of improvement were clearly identified. For noting, the service plan to review their governance arrangements in the coming quarter. The Ockenden NHSE/I visit is taking place early June.
- A presentation was provided by the Trust Vaccination Director. The excellent results achieved were noted. Plans for the coming winter are now being developed. The committee thanked the Director and the team involved.

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

Salisbury NHS Foundation Trust

Report to:	Trust Board	**Agenda item:**	2.4
Date of Meeting:	9th June 2022		

Report from: (Committee Name)	Audit Committee		**Committee Meeting Date:**	26th May 2022
Status:	**Information**	**Discussion**	**Assurance**	**Approval**
	X		X	
Prepared by:	Paul Kemp (Audit Committee Chair)			
Board Sponsor (presenting):	Paul Kemp			

Recommendation
The Trust Board is asked to note the matters below, including the Committee's Annual Activity Summary for 2021/22

Key Items for Escalation
This was a short meeting held to deal with outstanding ordinary matters ahead of the review of the annual accounts in June. **Annual Activity Report** The annual activity report was reviewed and accepted as a true summary of the Committee's outputs and activity for the year. It was agreed that this would be sent to the Board for noting and is appended to this document. **Internal Audit Report – Workforce Strategy** At the last meeting, the Executive was asked to review the previously submitted action plan in order to better separate and deal with shorter term priorities identified. The revised plan was discussed and it was agreed that the revised plan more effectively dealt with the risks identified in the report. It was noted that several of these actions were necessary first steps, but would not in themselves address the risks identified in the report and the Committee asked for an update to come back to the December meeting, which was agreed.

Audit Committee Annual Activity Report

1 Purpose

1.1 The purpose of this report is to summarise the activity of the Committee over the 2021/22 financial year in order to provide the Board with assurance. Further details of any of the items raised in this report are available in the papers and minutes stored in the iBabs system.

2 Background

2.1 The Audit Committee has been put in place to provide the Governors, the Board and the Chief Executive with a point of focus to review and assure the effectiveness of non-clinical processes in the Trust and compliance of the Trust's personnel with those processes. In doing this the Committee will provide assurance to the Board, Governors and other key stakeholders.

3 Key Activity During 2021/22

3.1 Impact of Management of Covid Pandemic within the Hospital

Although the peak of the direct impact of the pandemic on patient numbers occurred during 2020/21, the delta variant in the early part of the current year and the subsequent omicron variant were significant factors in the management of the hospital. Although public restrictions were reduced in the latter part of the year, many of the hospital virus control measures were maintained. There was also a significant, if indirect, impact on the ability to be able to release otherwise fit patients, with the numbers tagged as having No Criteria to Reside rising significantly and disrupting patient flows throughout. This latter problem has not yet been resolved and continues to disrupt patient flow. These phenomena are prevalent across the whole of the NHS and are not particularly focused in Salisbury.

3.2 Review of 2020/21 Annual Report

As is required, the committee reviewed the draft financial statements and governance statements for the 2020/21 annual report and recommended their adoption to the Board. As in the previous year, there were some disruptions to the process and the final signing off of the accounts was slightly delayed. However, these issues related to delays in the audit process, rather than issues with the accounts and did not impact the final outcome. The Audit Committee signed off the Annual Accounts on the 18th June 2021, acting on the delegated authority of the Board.

3.3 Internal Audit Reviews

Overall, the Head of Internal Audit Opinion remained the same as for the last two years. That is to say that the formal opinion was that the control environment within the Trust was independently judged to be "***Generally satisfactory with some improvements required***. *Governance, risk management and control in relation to Trust critical areas is generally satisfactory. However, there are some areas of weakness and non-compliance in the framework of governance, risk management and control which potentially put the achievement of objectives at risk. Some improvements are required in those areas to enhance the adequacy and effectiveness of the framework of governance, risk management and control.*"

Over the financial year 2021/22, PWC carried out reviews in eight areas, agreeing a total of 39 actions with management. Three of the eight reports were rated as "High Risk" overall. Table 1 below summarises the number of findings by risk intensity for each of the reports.

On a positive note, the auditors were complimentary about the attention that was being given by management to the closure of agreed actions. Unlike previous years, there were only three actions still open relating to reviews from previous periods, and these were long term actions that were not yet due for completion.

Table 1

Results of individual assignments

Review	Report classification	Number of findings			
		Critical	High	Medium	Low
SSL Review	Medium risk	-	-	5	-
Human Resources – EDI	High risk	-	-	6	-
Safeguarding	Medium risk	-	-	3	1
Capacity Management and Discharge	Medium risk	-	1	-	1
Key Financial Systems – Accounts Payable	Medium risk	-	1	-	2
Key Financial Systems – Fixed Assets	Low risk	-	-	-	5
IT Disaster Recovery	High risk	-	1	2	-
Workforce planning	High risk	-	1	4	1
Five steps to safer surgery	Medium risk	-	-	4	1
	Total	-	4	24	11

However, there was some concern expressed that the trend of number of findings reported has grown over the last three years, particularly in the area of medium risk findings. The analysis of this trend is shown in Table 2.

Table 2

Direction of control travel

Finding rating	Trend between current and prior year	Number of findings		
		2021/22	2020/21	2019/20
Critical	⟷	0	0	0
High	↑	4	3	0
Medium	↑	24	13	12
Low	↑	11	7	6
Total	↑	**39**	**23**	**18**

3.4 Counter Fraud Activities

During the year the Local Counter Fraud Officer (LCFO) continued to work with management on both proactive and reactive work packages, linking in with guidance from the NHS Counter Fraud Authority. Local proactive work during the year included reviews of potential for staff working elsewhere whilst reporting as sick to the Trust. There was also a review of the process around managing declarations of interests.

There were no incidents reported in the year that required an investigation by the LCFO. Items from previous years were closed out, awaiting final disposal through referrals to either the GMC or NMC.

Good progress was achieved through the year on the actions required to improve the Trust's rating in the NHS Counter Fraud Functional Standard Return, with the two outstanding red rated items improved to green. The exercise on the Declaration of Interest process completed in the year has significantly improved the response rate from staff, but remains rated as amber. The Executive regard this as an appropriate level of response, which the members of the committee agreed with.

3.5 Pro-active Process Reviews

During the year, the committee continued its practice of inviting management teams to give a detailed presentation on a specific management process or area of concern.

Through the year, the Committee received presentations on the implementation of the new financial ledger system, programme management processes, diagnoistic wait time management and improvements in medicine controls in the pharmacy. All of the presentations were of a good standard and led to a good discussion in the committee on the issues raised.

3.6 Other Activities

Other regularly scheduled matters dealt with during the year included,

- Two reviews of the processes used by the Trust to manage risk and the Business assurance Framework,
- A discussion on the effectiveness of the committee and a review of its terms of reference,
- Review and discussion of the internal audit and counter fraud plans for 2022/23
- Review of the effectiveness of the Standing Financial Instructions and management proposals for changes

4 Summary

Given the externally driven constraints and environment encountered by the Trust during the 2021/22 financial year, it is pleasing to see that the control environment remained effective and that the level of management control was generally maintained. There has also been evidence that management's understanding of internal control matters and use of the internal audit services available to it has become more effective, although there will always be room for improvement.

5 Recommendations

The Board is recommended to note this report.

Paul Kemp
Audit Committee Chairman

NHS Salisbury NHS Foundation Trust

Report to:	Trust Board (Public)	**Agenda item:**	2.5
Date of Meeting:	09 June 2022		

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

Recommendation:
The Trust Management Committee are asked to note the Trust's performance for Month 1 (April 2022).

Executive Summary:
The continuing operational pressures escalated further in month resulting in the Trust declaring an internal critical incident on 27th April. The incident was declared in response to increasing numbers of ambulance handover delays, patients waiting in excess of 12 hours to be admitted into the hospital from the Emergency Department, and the number of inpatients not meeting the criteria to reside. The incident was de-escalated on 29th April following a tremendous amount of work to increase safe discharges, reduce ambulance handover delays and regain admitting capacity across the Trust. With the exception of the critical incident the Trust declared OPEL status 4 for the whole of the month. Ambulance handover delays of over 1 hour increased from 161 in M12 to 196 in M1, and, notably, there were 25 patients that waited over 12 hours for admission from the Emergency Department. The trust has only had one patient previously (in Sept 20) wait longer than 12 hours since the introduction of the 4-hour standard. A serious incident investigation (SII) was commissioned after the death of a patient following a delay in being able to accept handover of the patient after arrival at hospital by ambulance. The operational pressures continue to be driven by a high number of patients not meeting the criteria to reside (almost 100), and bed occupancy of 97.2% which limits effective flow around the organization. As a result, a high number of escalation beds were open including both Day

Surgery areas, and the Clarendon gym at times. The pressure of managing the workload is indicated in workforce measures – turnover remains high at 12.74%, absence increased to 5.48% the highest this has been since April 20. Mandatory training and appraisal rates both reduced compared to M12, which is expected when staff are pulled to work clinically.

Elective activity was constrained as a result of escalation into Day Surgery, with utilization in day surgery theatres affected at only 68%. Despite this 489 theatre cases were performed against a plan of 459. The total waiting list size increased marginally, but the number of patients waiting longer than 52 weeks for treatment reduced from 599 in M12 to 577.

The effect of operational pressures remains in the performance against the Stroke standards with only 18% of patients reaching the Stroke Unit within 4 hours, 41% of patients had a CT within one hour, and 71% of patients spent more than 90% of their stay in the Stroke Unit. Nevertheless, there was still evidence of progress in general care the number of pressure ulcers reported was improved at 26 (34 in M12). Falls per 1000 bed days have reduced from 10.178 in 2020-21 to 9.69 in 2021-22.

Performance against the 6-week diagnostic standard reduced to 82.3% (above England average of 75.2%) with expected challenges in Cardiology Echo, MRI and Ultrasound. Recovery trajectories are being prepared, however there are some vulnerabilities in small teams with difficulties recruiting so recovery is not expected to be Q1.

Delivery of the cancer standards was variable – 76.5% of patients referred from their GP with suspected cancer were seen within 2 weeks. Improvement continues within breast suspected cancer referrals, however across all specialties there were 106 breaches due to capacity and 58 breaches due to patient choice. Despite challenges meeting the Two Week Wait standard the 28-day faster diagnosis, 31-day referral to diagnosis and 62-day referral to treatment standards for cancer patients were all achieved.

Based on the planned level of activity, the Trust is planning for a control total deficit of £18.0m in 22-23; inflation, bed base pressures, increased costs in the Elective pathway, and investment in 24/7 services during the pandemic are driving this financial pressure. 22-23 also sees the return of an efficiency requirement and recurrent savings targets totalling £6.6m have been allocated to corporate and clinical divisions, £2.4m has been formally identified, with the balance currently offsetting non-recurrent vacancies. In month 1 the Trust recorded a control total deficit of £0.85m against a target of £1.15m - a favourable variance of £0.3m owing to a one-off income receipt. The underlying position was in line with that planned, albeit with vacancies offsetting the premium costs of agency on wards and in theatres.

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

NHS
Salisbury
NHS Foundation Trust

Integrated Performance Report

June 2022

(data for April 2022)

An outstanding experience for every patient

Summary

Salisbury NHS Foundation Trust

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The operational pressures continue to be driven by a high number of patients not meeting the criteria to reside (almost 100), and bed occupancy of 97.2% which limits effective flow around the organization. As a result, a high number of escalation beds were open including both Day Surgery areas, and the Clarendon gym at times. The pressure of managing the workload is indicated in workforce measures – turnover remains high at 12.74%, absence increased to 5.48% - the highest this has been since April 20. Mandatory training and appraisal rates both reduced compared to M12, which is expected when staff are pulled to work clinically.

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Summary Performance April 2022

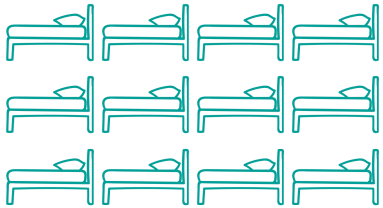
Salisbury NHS Foundation Trust

There were **2,828** Non-Elective Admissions to the Trust

We delivered **30,823** outpatient attendances, **16.8%** through video or telephone appointments

We met **3 out of 8** Cancer treatment standards

We carried out **266** elective procedures & **1,733** day cases



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

RTT 18 Week Performance: **66.3%** ↑

Total Waiting List: **18,853** ↓

82.3% ↓ of patients received a diagnostic test within **6 weeks**

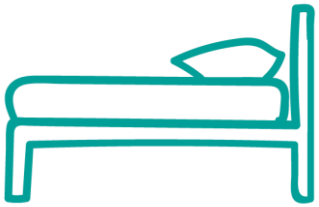
Our income was **£25,490k** (£437k above plan)

16.9% ↓ of discharges were completed before 12:00

Emergency (4hr) Performance **71.6%** ↓

(Target trajectory: 95%)

119 patients stayed in hospital for longer than 21 days



Our overall vacancy rate was **12.2%** ↑

Reading a Statistical Process Control (SPC) Chart

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

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

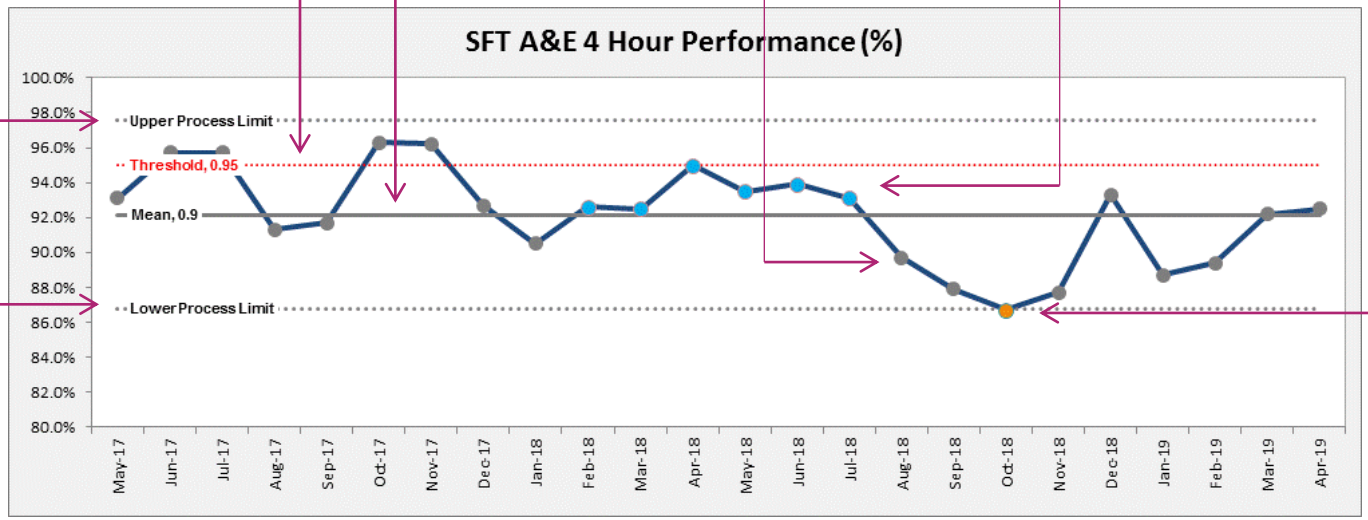
The red line shows the target for the KPI, if there is one

The solid grey line shows the mean value for the dataset

Grey markers show normal behaviour with no significant cause for variation

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

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



Statistical Process Control Chart Key:

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

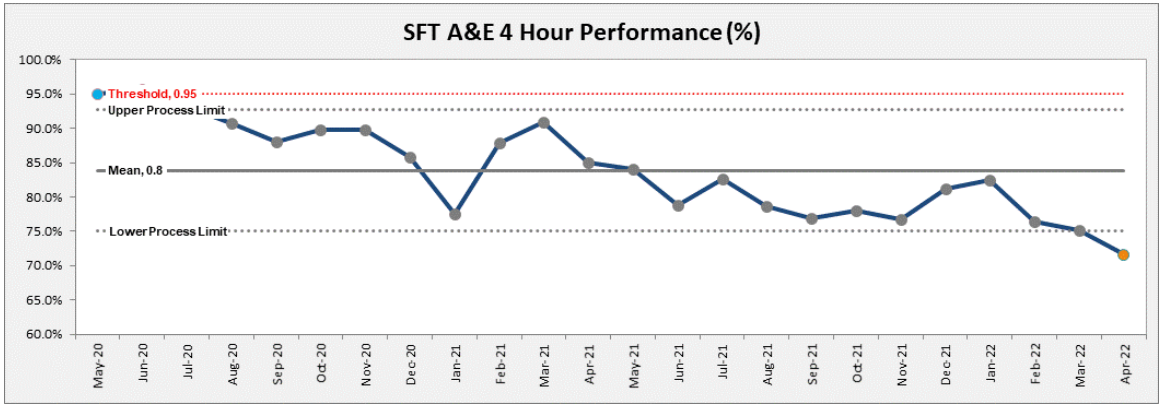
Part 1: Operational Performance

Performance against our Strategic Priorities and Key Lines of Enquiry

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

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

National Key Performance Indicators



Data Quality Rating:	
Performance Latest Month:	71.6%
Attendances:	6351
12 Hour Breaches:	25
ED Conversion Rate:	28.2%

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

M1 has seen another significant increase in attendances presenting to 6351 when compared to M12 of 6114. The 4-hour performance standard has unfortunately seen a further decline to 71.6% compared to M12 of 75.2%, which is a reflective of the continued growth of attendances presenting to ED.

Despite the increase in attendances the ED conversion rate has remained similar to that of M12 of 27.8%, compared to M1 of 28.2%. This again is reflective of the ongoing commitment to reduce admissions at the Front Door to support ongoing flow/capacity issues.

Capacity across the Trust and flow out of ED continues to be of the biggest contributory factors to the failing of the 4-hour performance target. M1 particularly challenging due to capacity issues within the Trust

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

Phase 2 of the minor's build is due for completion at the end of M2. Global communications will be sent with regards to the official opening of the new department.

The HALO trial in M1 went well and successful in identifying deteriorating patients being held in ambulances. Ongoing working partnership with SWAST continues.

The WHC frailty rapid response team pilot continues to work well in ED to treat appropriate patients and prevent admissions. They are adaptable between both the Front and Back door.

Minors have developed to incorporate trainee ENP role and have successfully recruited internally into this post. Application has been made to the CPD allocation fund in order to provide x2 trainee ENP roles in order to address aging workforce concerns in existing ENP staff.

Recruitment into nursing gaps is ongoing and working well, Successful recruitment into B2 and B5 roles and recruitment into B6 role providing promotional opportunities within the department.

ED are now looking at recovery of department living with Covid and continue to work with Estates regarding the layout and best utilization of space and how best to future proof, complying with CQC recommendations.

We are hopeful that the new Urgent & Emergency Care Matron is due to start in M4.

Risks to delivery and mitigations

Flow out of the department and capacity across the Trust continues to remain one of the biggest challenges for ED. With majority of flow out of the department not taking place until the evening.

AMU SDEC (Same Day Emergency Care) continues to be escalated into overnight, resulting in poor flow out of the ED department the following day and limiting AMU 's capacity to deliver SDEC the following day. This is a major contributory factor to capacity concerns within ED.

Staffing Gaps continue to impact on existing staff and the department as a whole and we are working hard as a department to address this.

We continue to monitor delays from specialty teams coming to review referred/expected patients according to internal Performance Standards and the consequent capacity concerns this raises within the department.

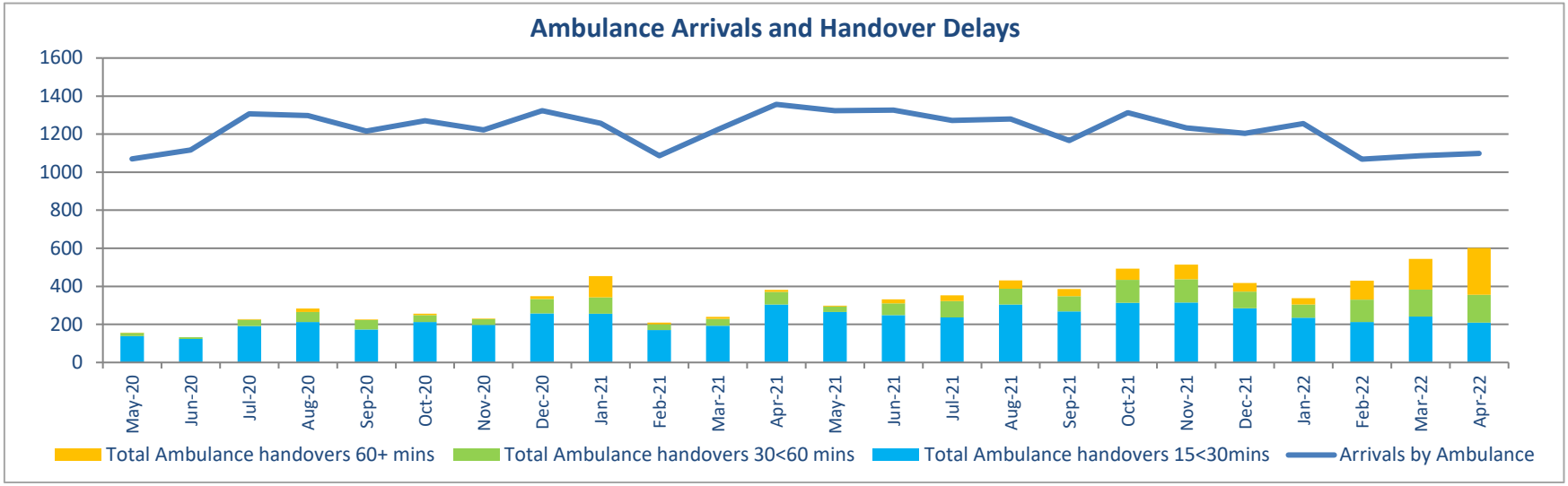
The reporting and investigation of 4-hour performance targets and ambulance breaches continue to have a significant impact on administration team within the department and the UEC Service Manager is currently looking at this.

Statistical Process Control Chart Key:

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

Ambulance Handover Delays

National Key Performance Indicators



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

Ambulance arrivals were broadly in line with numbers seen in M11 and M12.

Breaches >60 minutes saw a significant increase in M1 to 196 compared to M12 of 161. Breaches > 30 minutes saw a decrease to 113 compared to M12 of 142. There is also a significant decrease for breaches >15 minutes of 195 in M1 compared to 241 in M12.

M1 saw a significant number of breaches incurred at SFT for ambulance handover and this is a symptom of the pressures seen with regards to capacity and flow and SFT declaring Internal incident within M1.

With AMU ambulatory area continuing to be escalated into overnight regularly, this continues to add pressures in off loading ambulances as the medical take is often diverted to ED.

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

The Pilot with an ACP from Wiltshire Health & Care being at the front door to provide Rapid Frailty Response started in M1 and is ongoing. The Pilot will have ACP and HCA along with a Car in the aim to provide admission avoidance where possible, and also support discharge where appropriate.

ED continue to work looking into pathways for streaming of ambulances into dedicated specialty areas. SAU and Urology with associated DMT contacted to develop surgical access for SWAST

SFT continue to work collaboratively with SWAST and BSW partners in accepting peripheral diverts when required in order to provide the best quality of care to our patients.

Patient parking has been suspended from the entrance to ED, with drop off only, in order to ensure there is adequate space for ambulances to park safely when there are multiple ambulances.

Risks to delivery and mitigations

Hospital flow constraints and the resulting impact of the department reaching capacity, continues to remain the biggest challenge in being able to off load ambulances in a timely manner.

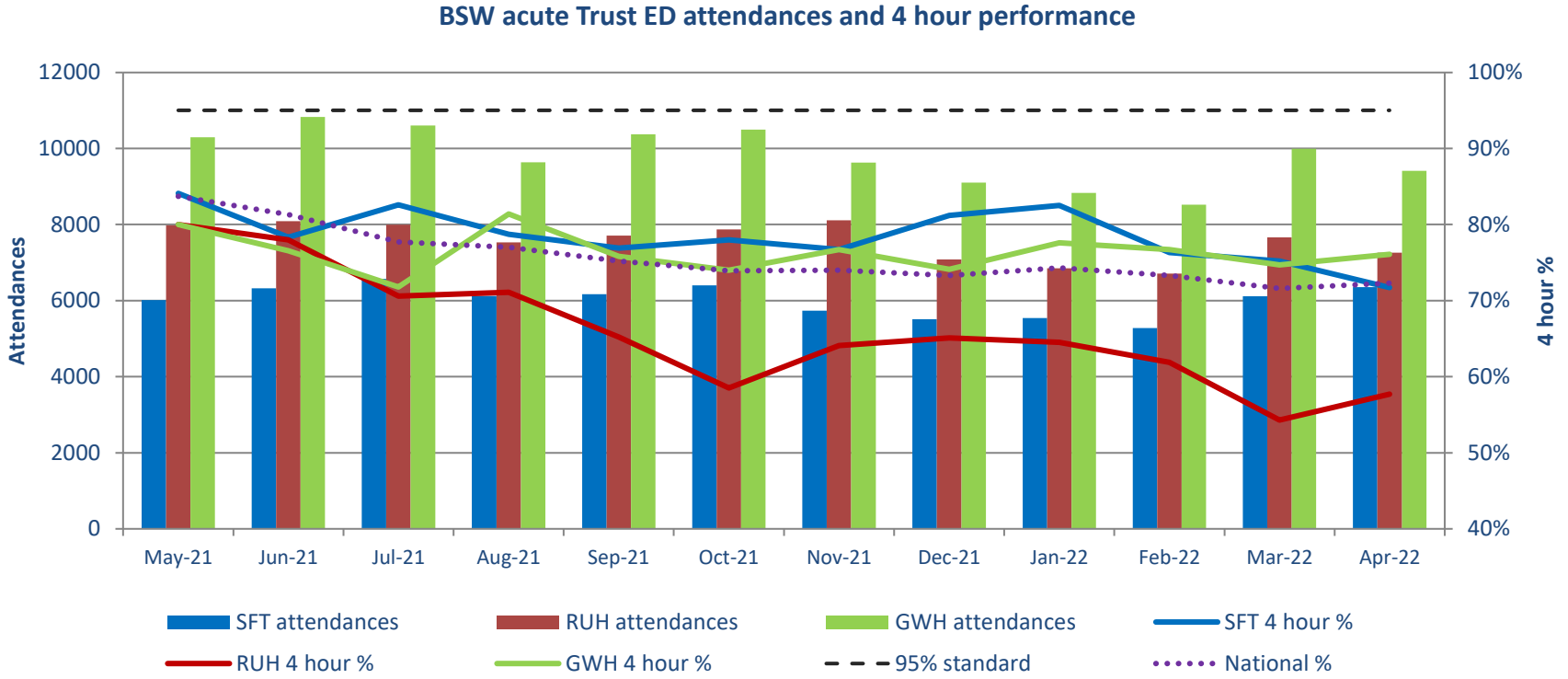
Staffing gaps, especially nursing, have a large impact on ambulance handover times within the department, gaps in workforce continue to remain a challenge at times and the department is working hard to address this.

AMU diverting the medical take will continue to impact on number of ambulances presenting to ED and our ability to take handover promptly.

The use of Paediatric space in ED as extra adult capacity when the department is full impacts on statutory requirements in the management of this group of patients.

BSW Context – Emergency Access (4hr) standard

Are We Effective?

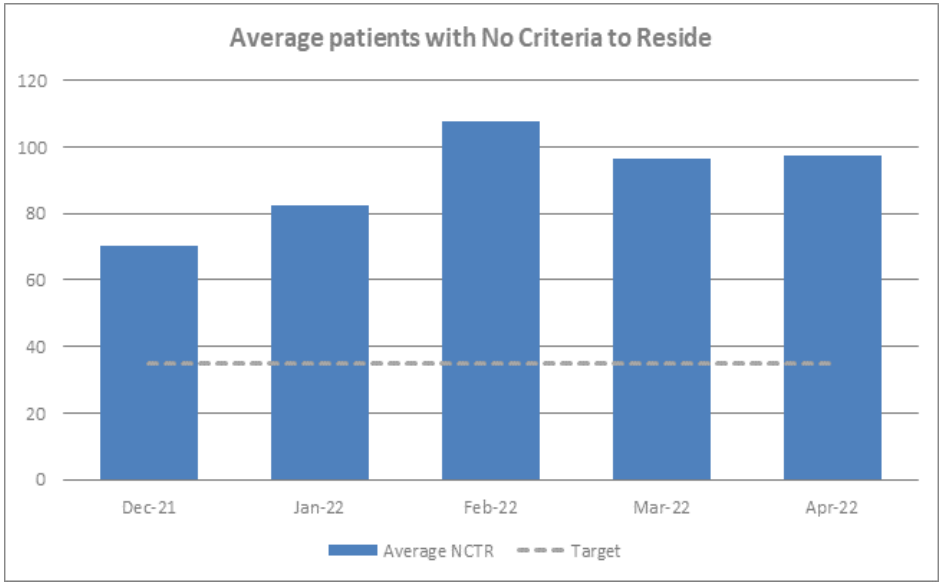


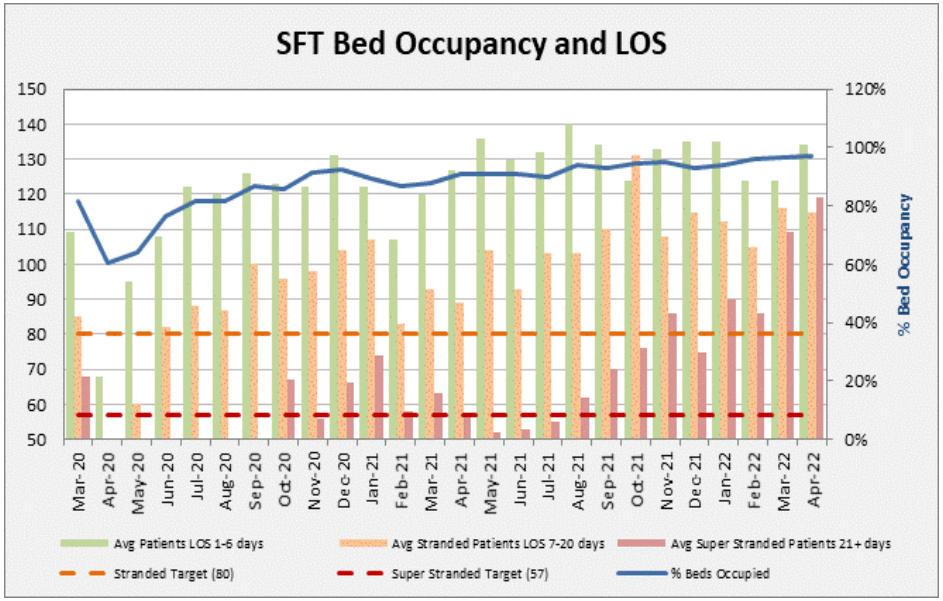
Delivery of the four-hour standard remains extremely challenging at all three acute Trusts. The proportion of patients discharged or admitted within 4 hours was 71.7% at SFT, 57.7% at RUH and 76.1% at GWH for all activity. At type 1 level (main hospital Emergency Department) performance at all three hospital departments is similar with SFT at 57.1%, RUH at 57.7% (RUH only report Type 1 activity), and GWH at 56.8%.

The number of patients waiting longer than 12 hours from decision to admit to admission increased with 25 at SFT (0 in M12), 7 at RUH (39 in M12) and 126 at GWH (93 in M12).

Patient Flow and Discharge

Are We Effective?





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

April saw a slight increase in the average number of patients with no criteria to reside. Contributing to this has been a lack of services in the community able to provide onward care and support – again often as a result of staffing and infection control challenges the acute setting is also contending with. The use of escalation beds has also contributed to slow flow, given the additional capacity is staffed by Doctors, AHPs and Nursing staff that are already stretched across existing core capacity. The number of patients in the 21 day+ LOS group are the highest in the last 12 months and is also an indicator of the challenges described.

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

The whole system in Wiltshire acknowledges the challenges all services have faced and are planning a BSWCCG wide super MADE/SAFER event that is focused on reducing the use of escalation beds, returning patients to the optimum setting for their care and treatment that can be delivered in an appropriate timescale by staff who are consolidated into core capacity.

This event is planned to feed longer term work that will have a sustained positive impact on patient journeys and experience and there is system collaboration planned to achieve the agreed aim.

Risks to delivery and mitigations

Risks to this planned programme include further challenges to staffing across the local health and social care system, continued challenges in infection control particularly COVID in care homes, community and acute settings.

Engagement in a significant working population across multiple organisations is required for a successful outcome and leadership for a sustained intensive effort will be required

Theatre Performance

Theatre KPI's

	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
19/20	497	532	501	531	453	522	524	555	476	548	481	364	19/20	497
20/21	239	294	327	317	346	362	379	401	328	248	263	383	20/21	239
21/22 Actual	301	378	379	442	455	473	507	520	465	469	472		21/22	301
21/22 Plan	252	411	452	456	441	463	451	463	451	435	423	482	22/23 Plan	459
21/22 Plan+	252	411	551	560	540	563	554	568	547	541	517	588	22/23 Actual	489

Measure - Theatre Performance & Efficiency	Area	Target	Apr-22
% Utilisation	Day Surgery Theatres	90%	68.85%
	Main Theatres	85%	86.73%
Turnaround	Day Surgery Theatres	8 mins	14 minutes
	Main Theatres	12 mins	28 minutes
% short notice Hospital Cancellations (0-3 days)	Total	2%	
% Short notice Patient Cancellations (0-3 days)	Total	2%	

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

Theatre sessions were up against plan; however, case numbers were down against plan – 255 actual versus 160 planned for electives and 1905 versus 1727 achieved for day case.

We achieved 98% of planned activity in main theatres and would have hit planned activity but for cancellations made due to a lack of bed availability. This performance is shown in the month's utilization within main theatres.

Day case utilization; 69% and activity against plan; 91% remained below target due to the ongoing impact of being escalated within the DSU footprint.

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

To date we remain escalated within the day surgery footprint, this makes recovery timescales hard to predict. However, a recovery of day case numbers is more achievable than electives as there is no reliance on empty beds within the Trust, and for M1 we achieved 91% of our day case planned activity despite only having between 40% and 60% of the day surgery bed footprint available.

Going forward weekend lists are being covered by SFT staff rather than agency staffing, as we move towards reducing our reliance on agency staffing.

Continuation of High-Volume Low Complexity (HVLC) lists running both in week and at weekends for a number of specialties as targeted Waiting List Initiatives focusing on Plastic Surgery as the specialty with the highest volume of elective surgery backlog

Productivity and efficiency work continues focused on the Day Surgery Unit. This is being supported by the relaunch of the weekly specialty Scheduling Meetings, returning to a F2F medium, with representation from multidisciplinary teams, including the theatre lead for the specialty, supported by the theatre management team

Risks to delivery and mitigations

Theatre workforce for local lists continues to be a risk despite slow improvement.

An ongoing risk to elective activity remains high levels of trauma, in both Plastic Surgery and T&O, and other non-elective emergency demand. This is being mitigated by daily reviews by the Specialty, Theatre and DMT to ensure patients are clinically prioritised appropriately

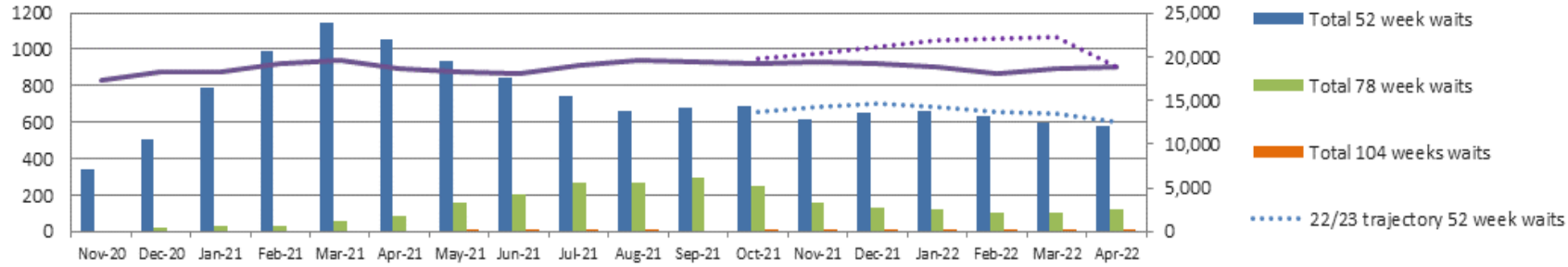
Bed pressures continue to impact the elective programme and have led to cancellations throughout M1 of elective cases and the simultaneous use of both upstairs and downstairs of DSU for inpatients has also impacted day case performance. Daily review by the Matrons and DMT undertaken as required, avoiding cancellations whenever practical. Daily elective planning meeting set up chaired by Surgery Silver and attended by lead for theatres and lead for Chilmark elective to ensure the most efficient use of capacity to minimise cancellations

Although M1 was still impacted we are seeing a reducing risk of activity being impacted by cancellations due to COVID

Theatre access is now being allocated in order to give us the best opportunity to achieve planned activity. This plan has incorporated the need for trauma/cancer etc.

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

National Key Performance Indicators



	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22
Total 52 week waits	338	505	785	995	1142	1059	937	847	746	660	681	688	618	652	664	634	599	577
Total 78 week waits	0	19	28	34	59	83	156	200	268	264	299	251	162	128	122	108	107	119
Total 104 weeks waits	0	0	0	0	0	0	2	5	2	2	0	5	6	5	7	4	3	3
Trust Performance %	74%	72%	71%	68%	65%	65%	72%	73%	74%	74%	74%	72.8%	72.3%	69.4%	68.8	66.02	65.93	66.25
Total waiting list	17,392	18,352	18,184	19,207	19,583	18,665	18,196	18,118	19,015	19,540	19,367	19,265	19327	19299	18844	18039	18634	18853

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

The number of patients waiting longer than 52 weeks decreased by 22 to a total of 577 in M1. The number of patients waiting longer than 78 weeks rose for the first time since July 2021, going from 107 to 119.

The number of patients waiting 104 weeks in M1 remained at 3, with the longest waiting patient waiting 120 weeks. These patients all had surgery and their clocks stopped in M2.

Of the patients waiting on non-admitted pathways the highest volumes are within Respiratory, Plastic Surgery and ENT. Of the patients on admitted pathways awaiting surgery Plastic Surgery, Gynaecology and Urology are the most challenged specialties. Overall, the most challenged areas remain Plastics, Gynaecology and Urology at both the 78 week and 52-week interfaces

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

HVLC lists for Plastics LA lists have continued to run throughout the month although this was reduced due to consultant cover reducing TXM lists

Weekend outpatient clinics planned in Ophthalmology for patients that are not clinically appropriate for transfer to the IS. These have been delayed to M2 due to significant sickness levels in the clinical team

H2 trajectories were set to reflect the national guidance to eliminate 104-week breaches by 31st March 22 (unless P6 patient choice to wait), hold or reduce the number of patients waiting longer than 52 weeks, and hold total waiting list size around September 21 levels however the national target for 104-week elimination has now been revised to the end of July 22. SFT achieved two of these targets by the end of M12 but ended the year with 3 patients waiting longer than 104 weeks however these have now been seen and we remain under our targeted PTL size.

Ongoing use of IS with the transfer of clinically appropriate Orthopaedic patients to Newhall and Ophthalmic Cataract patients to New Hall continuing although transfers to IHG are on hold awaiting an updated from them on capacity

Risks to delivery and mitigations

Theatre workforce for local lists including the risk of high levels of sickness. Theatre Workforce paper led by OD&P with support from the Theatre Service Manager, Theatre Clinical Lead and DMT has gone to the exec for approval

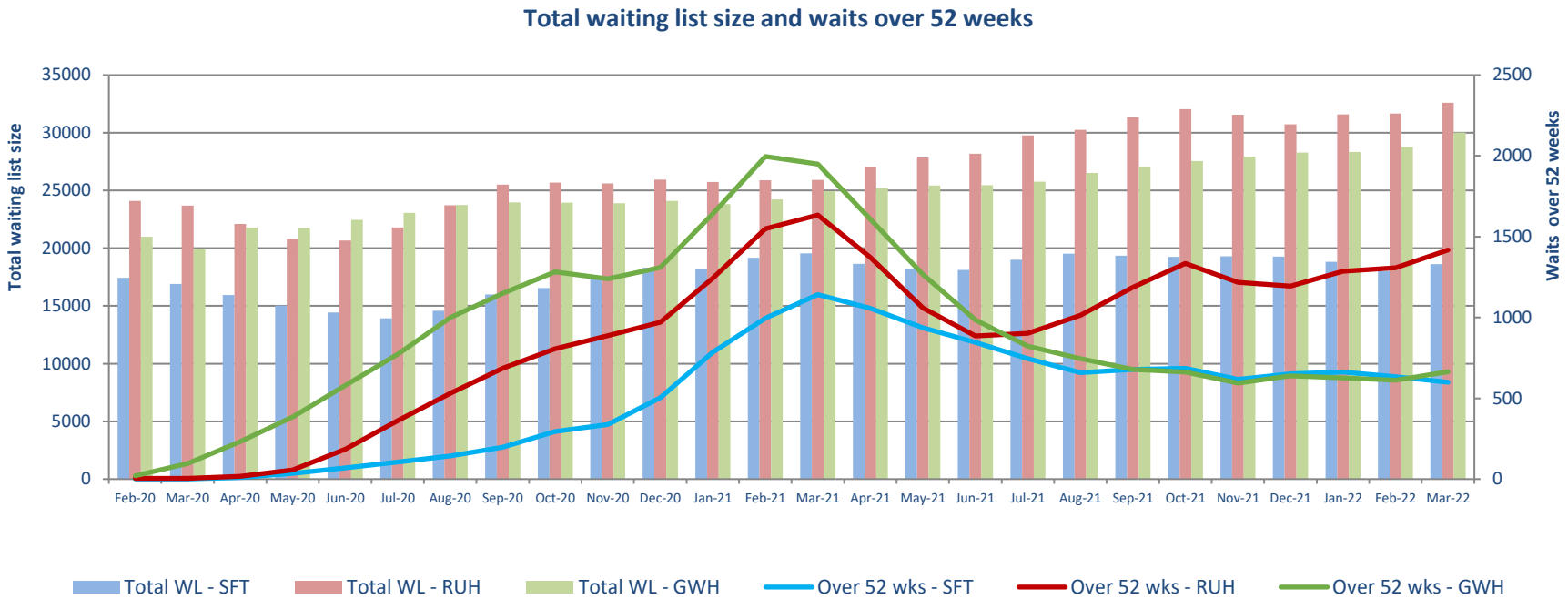
Risks associated with staffing levels as a direct result of COVID-19 with the risk of both theatre and outpatient activity being lost due sickness and isolation still exist but are reducing.

Risk of high levels of trauma, in Plastic Surgery and T&O, and other non-elective emergency demand as this may continue to result in cancellations of long waiting, clinically routine patients. Daily reviews in place to ensure patients are clinically prioritised appropriately minimising elective cancellations wherever possible

Capacity pressures continue to impact the elective programme and led to elective cancellations in M1. Daily elective planning meeting set up chaired by Surgery Silver and attended by lead for theatres and lead for Chilmark elective to ensure the most efficient use of capacity to minimalize cancellations. A further Trust wide SAFER week planned for M1 to support timely discharges.

BSW Context – Referral To Treatment (RTT)

Are We Effective?



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

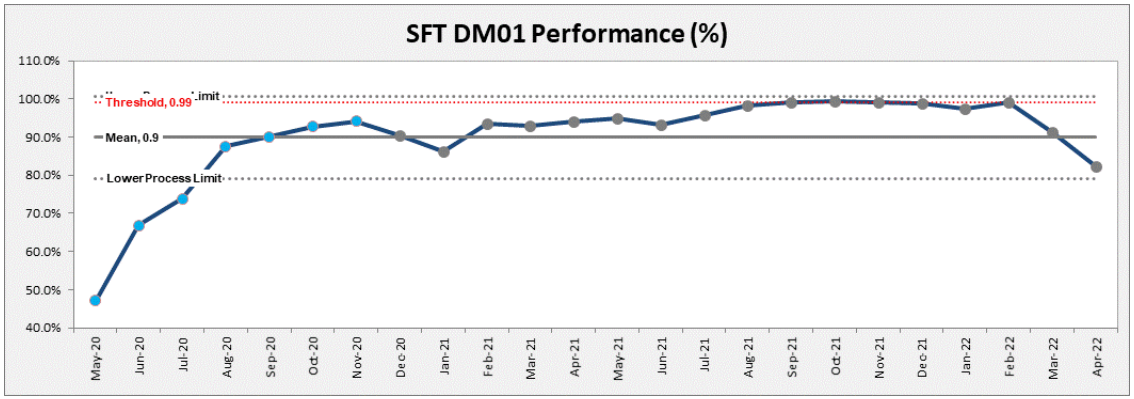
The total waiting list size grew marginally in M11 at all three acute Trusts. The biggest growth was seen at GWH with a 4% increase in total waiting list (30,028 in M11 compared to 28,764 in M11). There were increases in the number of patients waiting over 52 weeks at GWH (664 compared to 621 in M11) and more notably at RUH (1417 compared to 1307) in M11. SFT delivered a small reduction (599 compared to 633 in M11). The proportion of patients waiting over 52 weeks represents 3.2% of the total waiting list at SFT, 4.3% at RUH and 2.2% at GWH. All three Trusts are below the England acute trusts average of 4.8%.

There continues to be a small number of patients waiting over 104 weeks at SFT (3) and RUH (7). Collectively across the three Trusts the number of patients over 78 weeks reduced from 254 in M11 to 246 in M12).

Across Q4 there were 167 last minute elective operations cancelled for nonclinical reasons (61 at SFT, 48 at RUH and 67 at GWH.

Diagnostic Wait Times (DM01) Target 99%

National Key Performance Indicators



Data Quality Rating:	
Performance Latest Month:	82.3%
Waiting List Volume:	4735
6 Week Breaches:	838
Diagnostics Performed:	6423

Modality performance

MRI	66.0%	US	90.9%	Audio	68.9%	Neuro	94.3%	Flexi sig	84.9%
CT	100.0%	DEXA	100.0%	Cardio	60.0%	Colon	95.3%	Gastro	98.1%

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

M1 saw a decline in compliance against the DM01 standards with a reported position of 82.3% vs. 91.36% in M12 of 21/22. Performance represents a total of 838 breaches in M1 vs. 381 in M12.

Key contributing areas of non-compliance are within MRI (353 breaches), USS (150 breaches), Audiology (51 breaches) and Cardiology Echo (251 breaches). All represent increases in breaches compared to M12. Remaining modalities remained relatively stable.

Total activity was reduced in M1 compared to M12 with workforce availability being the key contributing factor for non-compliance. Vacancies, compounded by covid related sickness absence made it challenging to increase activity to recover the waiting list backlog that was created for similar reasons in M12..

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

MRI – improvement action plan is being led by CSFS DDO in conjunction with Radiology Senior Team. This is compounded by a high reporting backlog which constrains the ability to 'scan more'. Options to improve both reporting and scanning backlogs are being scoped (including increasing reporting outsourcing, consideration of additional locums and improvements in booking and utilisation efficiencies in general).

USS – locum support sourced. Utilisation efficiencies to be made. Lead Sonographer flexing admin/SPA time to increase list availability.

Echo – significant workforce concerns remain, with an increased referral rate. Continued deterioration of position is likely unless vacancies can be resolved.

Risks to delivery and mitigations

MRI – for M2 anticipated performance to reduce on M1 (circa 500 breaches compared to 353). Continued issues with reporting capacity constrain options for recovery. High number of lists required to recover (MRIs take up to 1hr so fewer can be completed per session). MRI1 replacement to commence from M4 which will further constrain capacity.

USS – likely to stabilise in M2. Risk to continued improvement due primarily to workforce and future retirements in team and inability to recruit.

Echo – likely to continue to deteriorate further until clear workforce plan in place and vacancies mitigated.

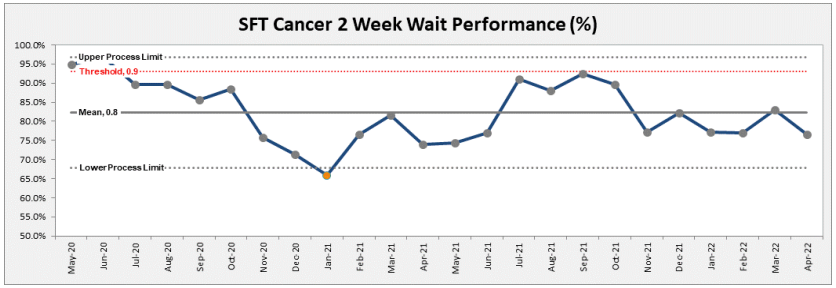
Statistical Process Control Chart Key:
- Target
- Mean
- Upper / Lower Process Control Limits (UPL/LPL)
- Special Cause Variation Improvement (6 or more points better than the mean, or a single point outside the control limit)
- Special Cause Variation Concern (6 or more points worse than the mean, or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

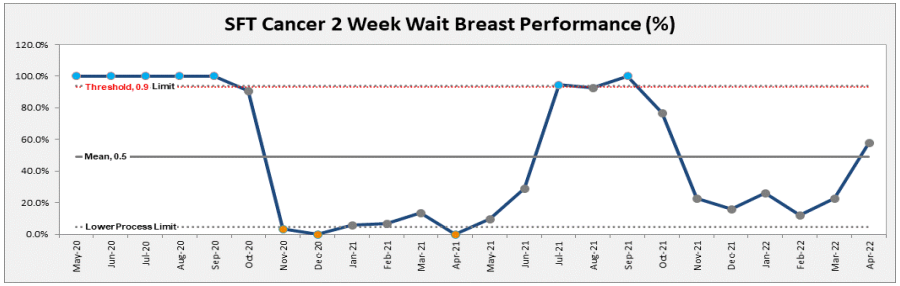
Cancer 2 Week Wait Performance Target 93%

National Key Performance Indicators

Performance Latest Month	Performance	Num/Den	Breaches
Two Week Wait Standard:	76.5%	677/885	208 (58 patient choice)
Two Week Wait Breast Symptomatic Standard:	57.78%	26/45	19 (7 patient choice)

Data Quality Rating:





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

Two week wait standard not achieved for Month 1, with validated month end performance of 76.5% (885 patients seen; 677 in target; 208 breaches). Breach reasons associated with:

- Clinic capacity: 106 breaches (across all services)
- Patient choice: 58 breaches
- Delayed triage: 22 breaches
- Endoscopy capacity: 10 breaches
- COVID-19 delay: 9 breaches
- Incomplete GP referrals: 4 breaches
- Clinical delay: 3 breaches
- Administrative delay: 3 breaches
- Prison delay: 1 breach
- Radiology capacity: 1 breach

Breast symptomatic two week wait standard not achieved for Mont 1 (45 patients seen; 26 in target; 19 breaches). Significant improvement in performance for both breast 2ww and breast symptomatic 2ww performance. Breaches associated with patient choice and one stop capacity. Average waiting time for first appointment for those breaching remains consistently at 17 days.

28-day Faster Diagnosis Standard achieved not for Month 1, with month end performance of 74.1% (870 patients diagnosed; 639 in target; 231 breaches).

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

Breast two week wait performance: Radiology and breast service have agreed to establish ad hoc monthly clinics as required. Significant improvement in performance noted.

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

CQUIN 2022/23 re compliance with timed diagnostic pathways for cancer services: Expectation that 65% of prostate, colorectal, lung and OG cancers meet the pathway milestones outlined within the national optimum timed diagnostic pathways. Services have already completed a plan on a page to facilitate delivery, though further consideration required in terms of data collection.

Timeliness of Head and Neck triage: Surgery DMT working closely with Head and Neck services to implement more robust triage process in line with national best practice recommendations.

Risks to delivery and mitigations

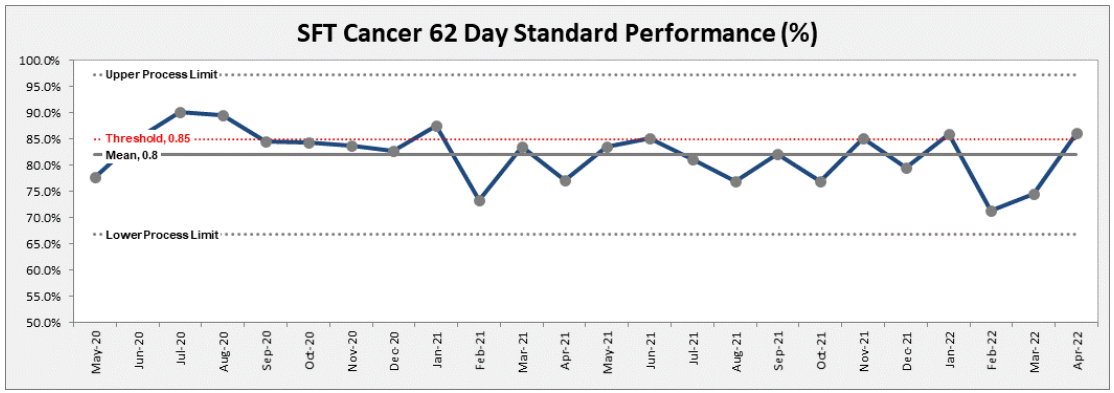
Patient choice: Ongoing challenges associated with patient choice delays and cancellations. There are however limited opportunities to offer a second appointment within the two-week timeframe due to capacity constraints across services.

Timeliness of consultant triage within head & neck: Robust process not currently in place to facilitate daily triage. Surgery DMT currently working alongside MDT lead to resolve

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

Cancer 62 Day Standards Performance Target 85%

National Key Performance Indicators



Data Quality Rating:

April 2022	Performance	Num/Den
62 Day Standard:	86.15%*	56/65
62 Day Screening:	33.33%	1/3

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

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

Month 1 62-day performance standard achieved, with validated month end performance of 86.15% (65 patients treated; 56 in target; 9 breaches).

- Colorectal: 3 breaches (complex diagnostic pathways)
- Haematology: 1 breach (complex pathway, delayed transfer from another tumour site)
- Skin: 1 breach (inconclusive diagnostic)
- Upper GI: 1 breach (delayed transfer from another tumour site; oncology capacity delays)
- Urology: 3 breaches (insufficient prostate cancer diagnostic capacity, delayed transfer from another tumour site)

62-day screening standard not achieved for Month 1, with validated month end performance of 33.33% (3 patients treated; 1 in target; 2 breaches). Breaches associated with insufficient bowel cancer screening diagnostic capacity.

31-day performance standard achieved, with validated month end performance of 97.32% (112 patients treated; 109 in target; 3 breaches).

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

Impact of pharmacy capacity on delivery of chemotherapy: Business case within pharmacy to increase staffing capacity and provide resilience due for presentation at Trust Management Committee in May 2022.

Establishment of vague symptoms /non-specific symptom pathway: Pathway currently being scope with BSW ICS to support patients with 'vague symptoms' who may otherwise undergo lengthy diagnostic pathways. Pathway Navigator due to commence in post from August 2022, though unsuccessful recruitment of GP lead. Alternative pathway models currently being considered to ensure there is equity in access across BSW.

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

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

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

Risks to delivery and mitigations

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

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

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

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

Fragility of existing workforce: Ongoing pressure on services has resulted in an increase in reported stress, staff burnout and need for annual leave. This has mean that several services have had insufficient consultant, nursing and administrative staff available to reduce waiting times.

Statistical Process Control Chart Key:
- Target
- Mean
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- Special Cause Variation Concern (6 or more points worse than the mean, or a single point outside the control limit)
- Common Cause Variation

Stroke & TIA Pathways

Are We Effective?

SSNAP Case Ascertainment Audit

Highest level = Grade A

Lowest level = Grade E

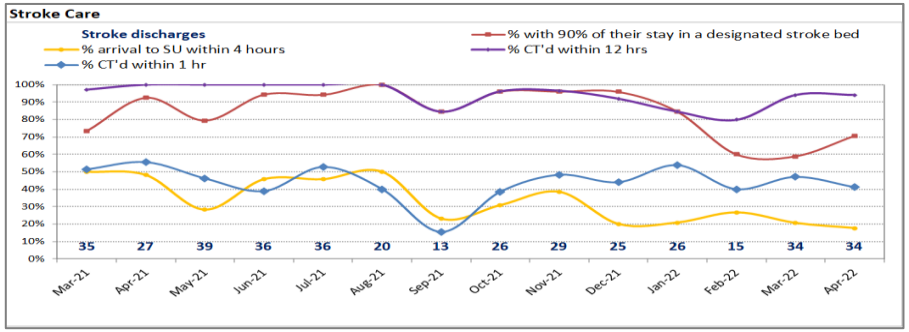
Quarterly	Q1	Q2	Q3	Q4
2019-20	B	B	B	Not Reported
2020-21	Not Reported	Not Reported	Not Reported	Not Reported
2021-22	C	C		

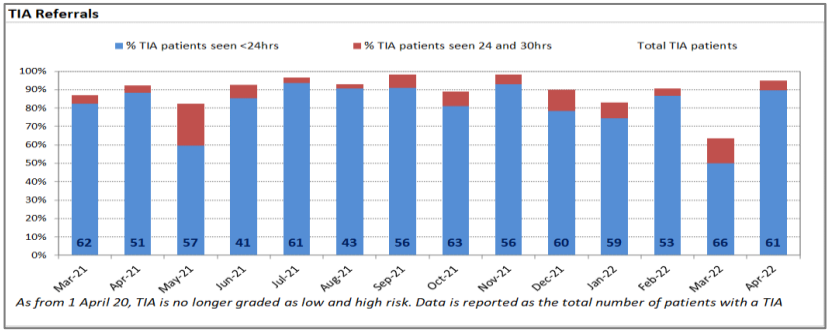
Data Quality Rating:

% Arrival on SU <4 hours: 17.6%

% CT'd < 12 hours: 94.1%

% TIA Seen < 24 hours: 89.7%





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

[Please note: Data is often only partially validated with informatics at the time of publishing. Coding can sometimes result in minor adjustments to the data at a later date]

- There were 34 stroke discharges this month.
- There were 0 stroke deaths within the 7-day period in April.
- 90% stay in the stroke unit was 71% this month which is an increase from last month; 1 to AMU first, 1 W/Parish ward first, 5 SLOS, 3 moved off ward due to covid.
- The number of patient reaching the stroke unit within 4 hours is 18%.
- The average Stroke unit length of stay was 18 days and an average total length of 20 days.
- 41% of patients had a CT within an hour which is a decrease from the last month. CT within 12 hours was at 94% which remains the same as last month.
- 1 patient was thrombolysed with an average door to needle time of 48 minutes.
- 28 of the eligible 30 patients were referred to ESD in April.
- 90% of the 58 TIA's had treatment complete within 24hrs; with 1 affected by a full clinic, 1 declined earlier appointment, 2 late ref., 1 declined service provider (Poole), 1 MRI next day.

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

- Covid operational pressures and staff shortages continue to impact the stroke targets. There are plans in place for collaborative efforts with the emergency department, radiology and bed managers to improve these targets, and to increase the number of patients reaching the stroke unit within 4 hours. The radiology department are due to undertake an audit of their scan times as part of this process. This work remains ongoing.
- The impact of COVID is still having an impact on the 90% stay on the stroke unit target, although some improvements were seen in April.

Part 2: Our Care

Performance against our Strategic Priorities and Key Lines of Enquiry

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

Maternity

Are We Safe?

	SFT Assurance Dashboard	Guidance	Standard	Improvement Direction	Rolling 6 months Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	Rolling 6m average
Perinatal Morbidity and Mortality (M&M)	Number of late fetal losses (22+0 to 23+6 weeks excl TOP)			Down	0	2	0	0	0	0	0
	Number of stillbirths (>+ 24 weeks excl TOP)	ONS	3.8 per 1000 live births	Down	0	2	0	0	2	0	1
	Number of neonatal deaths : 0-28 days	ONS	2.7 per 1000 live births	Down	0	2	0	0	0	0	0
	Medical termination over 24 +0 registered			Down	NA	NA	1	0	0	0	0
Maternal M&M	Number of Maternal Deaths	ONS	9.1 per 100,000 women who delivered	Down	0	0	0	0	0	0	0
	Number of women requiring admission to ITU	6 month SFT rolling		Down	1	0	0	0	0	1	0
Insight	Number or daytix incidents - moderate or above	6 month SFT rolling		Down	0	1	0	2	1	1	1
	Datix incidents moderate harm (not SII)	6 month SFT rolling		Down	5	1	0	2	1	0	2
	Datix incidence SII	6 month SFT rolling		Down	0	0	0	0	1	0	0
	HSIB referrals	6 month SFT rolling		Down	0	0	0	0	0	0	0
	HSIB/NHSR/CQC or other organisation with a concern or request	6 month SFT rolling		Down	0	0	0	0	0	0	0
	Coroner Reg 28 made directly to trust	6 month SFT rolling		Down	0	0	0	0	0	0	0
Workforce	Minimum safe staffing in maternity services :Obstetric cover	RCOG guidence		NA	40	40	40	40	40	40	40
	Midwife to Birth ratio	RCM;NHSR;BR +	1.28	NA	1.25	1.25	1.26	1.21	1.28	1.2	NA
	Midwifery vacancy rate (black= over establishment; red =under establishment)			Down	NA	NA	10 WTE	14.65	14.65	17	NA
	Provision of 1 to 1 care in established labour (%)	NICE, RCM, MIS	100%	Up	100	100	100	NA	NA	100	NA
	Datix relating to workforce	6 month SFT rolling		Down	1	0	1	0	2	3	1
	Compliance with supernumery status of the LW coordinator - %	NICE;RCM;NHSR	100% rostered	Up	NA	NA	100	NA	NA	100	NA
	Numbers of times maternity unit on divert	6 month SFT rolling		Down	0	0	0	0	0	0	0
Involvement	Service user feedback : Number of Compliments	6 month SFT rolling		Up	9	2	19	31	32	31	21
	Service user feedback : Number of Complaints	6 month SFT rolling		Down	1	1	2	4	2	2	2
	Number of SOX	6 month SFT rolling		Up	2	5	5	11	7	8	6
Assurance	Progress in achievement of 10 safety actions(CNST)	NHSR	10	Up	4	4	4	4	4	5	4
	Training compliance - MDT PROMPT %	NHSR	90%	Up	56.2	NA	74	74.2	75.2	72.3	NA

Perinatal Quality Surveillance Tool

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

What does the data tell us ?

- Our midwifery vacancy rate is increasing
- Progress on Maternity Incentive Scheme (MIS) – compliance expected to be 8/10 by submission date.

What actions are being taken to improve?

- There are ongoing recruitment plans to: increase support workers and upskill staff, to have nurses in postnatal areas (recruiting), and to collaborate with Gloucester and GWH around international recruitment to recruit 5 midwives from overseas.

- We are exploring the return to practice course.

- A new role of retention midwife has been filled, working with practice development team to support newly qualified midwives.

- A new role of international retention midwife is out to advert.

- We have registered on the workforce support programme with NHSE/I.

Ockenden Final Report – March 2022

Independent Review into Shrewsbury and Telford NHS Trust

There were 15 essential and immediate actions from this review.

As a result, there has been a gap analysis by the women and newborn division which was completed on 19th April. The findings of this report have been disseminated to all staff within the division, and we are engaged with the national and regional networks to deliver on the key safety actions.

Maternity Clinical Dashboard

Data Quality Rating:

Are We Safe?

Maternity Clinical Dashboard

Measure	Min	Median	Max	Improve direction	Green	Red	Mar-21	Apr-22
Babies (incl Non Reg)	180	180	180					180
Women Delivered	175	175	175					175
Homebirth rate	3.3%	3.3%	3.3%					3.3%
Inductions %	43.4%	43.4%	43.4%					43.4%
Total CS rate (planned & unscheduled)	25.1%	25.1%	25.1%	Down		32.0%	32% National Dash Mar21	25.1%
Elective caesarean sections %	12.0%	12.0%	12.0%	Down		15.0%	15% National Dash Mar 21	12.0%
Emergency caesarean sections %	13.1%	13.1%	13.1%	Down	17.0%	20.0%	17% National Dash Mar 21	13.1%
Instrumental deliveries %	11.7%	11.7%	11.7%	Down	12.0%	12.5%	12.5% NMPA	11.7%
Apgar less than 6 @ 5 min %				Down	1.2%	3.5%	Green <1.2%, red >3.5% NMPA	0.6%
PPH >= 1, 500 %	4.0%	4.0%	4.0%	Down	2.7%	5.6%	Green <2.7%, red >5.6% NMPA	4.0%
Term babies admitted to NNU unexpectedly %	1.7%	1.7%	1.7%	Down	5.5%	5.8%	<5.8% NMPA	1.7%

Clinical outcomes are within expected ranges.

Maternity Incentive scheme – year 4

- The June submission date had been delayed due to the pandemic, a year 4 updated MIS has been published with adjustments to the 10 safety actions. The new submission date is **Jan 2023.**
- A working party continues to collate evidence against the 10 safety actions, a gap analysis will be produced to understand any recent changes in safety actions and evidence needed.
- An update report was recently presented to clinical governance committee in April 22 – concerns around compliance with PROMPT training (although trajectory demonstrates compliance with safety action will be achieved in June 2020), anticipated non- compliance with data entry to the Maternity Services Data Set (MSDS) due to lack of digital maturity.

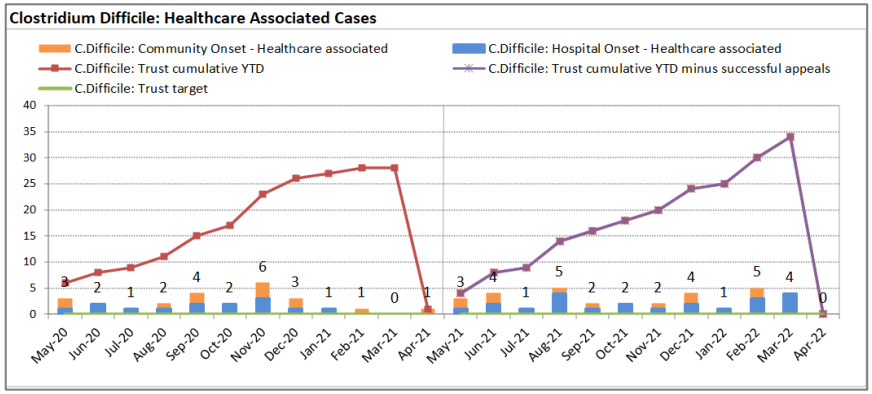
Infection Control

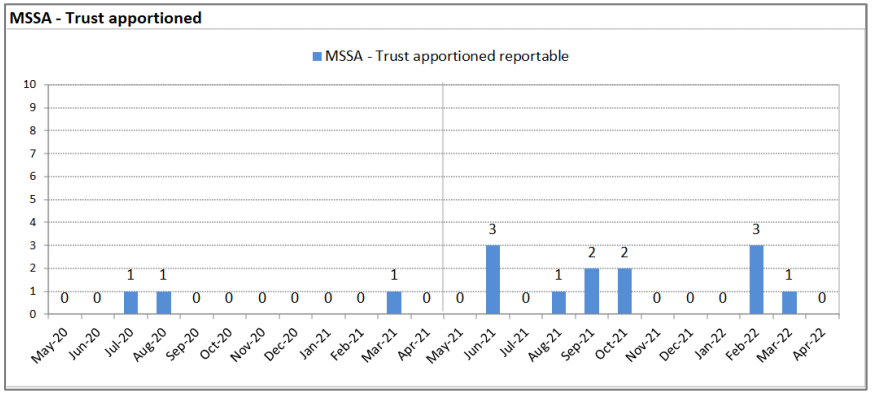
Data Quality Rating:

Are We Safe?

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

MRSA	2020-21	2021-22
Trust Apportioned	3	0





Summary including learning outcomes and actions – April 2022

- There were no MRSA bacteraemia cases identified.
- There were no MSSA bacteraemia cases identified.
- There were no hospital onset healthcare associated reportable *C.difficile* cases.
- There were no community onset healthcare associated reportable *C.difficile* cases.
- There has been one hospital onset *E.coli* bacteraemia case identified for an inpatient on Radnor Ward (upper urinary tract source).
- *Update from March 2022: There were no specific actions from the completed investigation for the MSSA bacteraemia case identified for an inpatient on Pembroke Ward (unknown source). However, the ward team have taken the opportunity to feedback the case at the ward team meeting and remind staff of the established cannula insertion and ongoing care policies.*

Pressure Ulcers

Are We Safe?

Per 1000 Bed Days	2020-21 Q4	2021-22 Q1	2021-22 Q2	2021-22 Q3	2021-22 Q4
Pressure Ulcers	2.21	1.47	1.30	1.84	1.88

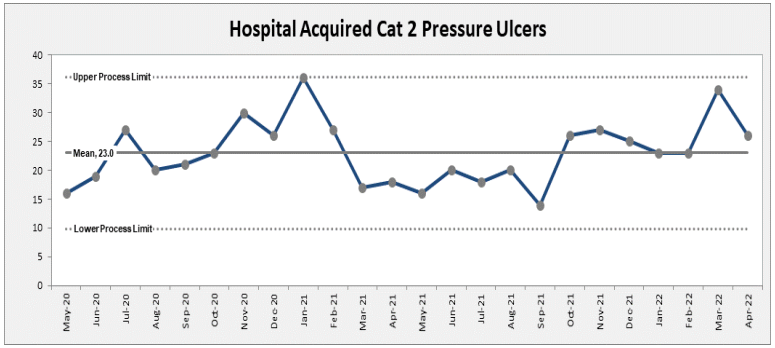
Data Quality Rating:

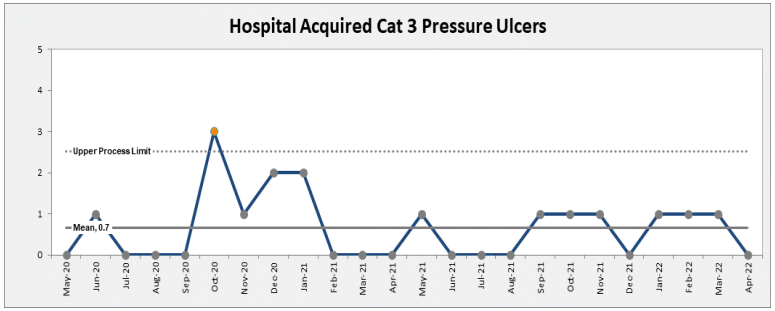
Summary and Action

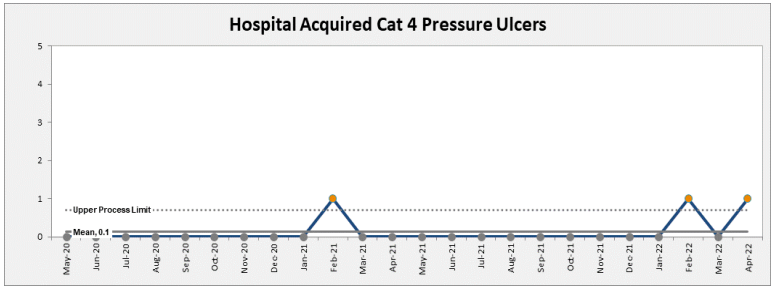
- **There are have been 26 Category 2 PU's in April**, this is a slight decrease from 34 in March. Medicine contributed to 15 of these PU's and there were 11 cat 2 PU's within Surgery. Cat. 2 PU's continue to be found mostly on sacrum/buttocks and heels. The majority of these PU's were found on patients who were already on pressure relieving devices such as air mattresses and/or orthotic boots. Pressure relieving devices are, for the most part, being utilised as patients are risk assessed and found to be high risk of developing new pressure damage but delays in pressure area care due to staffing shortages and operational pressures could contribute to this number. All ward areas with multiple hospital acquired PUs will present their learning at Share and Learn, where specific themes and actions for each ward area will be identified. The Tissue Viability team are working on a document to be circulated to the wards identifying clear and appropriate actions to be taken after Braden risk assessment completion.
- **One Category 4 PU was identified in April** within the medical division. This patient has a severe bunion to their left foot, which caused a PU to a second toe caused by constant pressure of the big toe from the altered anatomy of the foot. A 72-hour report has been completed and this case was discussed at the weekly patient safety summit where it was decided that this would be for local review. Unfortunately, due to ward staffing issues and operational pressures the SWARM has not yet been completed but a meeting will be arranged with ward leads at the earliest opportunity. No significant lapses in care were identified from the 72-hour report.
- **10 Deep Tissue Injuries were identified in April**; this is the same as March's figure. No significant themes or correlation have been identified for this number. As in previous months, it is likely that there were missed opportunities for early identification of vulnerable areas due to staff shortages and missed education opportunities leading to DTI's.
- **1 unstageable PU was identified in April**. This wound has been identified as a likely category 3 once clean, and a 72-hour report and SWARM has been completed for this patient, with minimal lapses in care identified. This patient is regularly non-compliant with aspects of care and has been assessed as having capacity for decision making.

Further plans/actions:

- Pressure Ulcer Prevention education continues to be available twice a month and can be booked via MLE. Tissue Viability also undertake education and training with wards informally, providing bitesize education on skin checks and pressure ulcer prevention methods during ward visits and attending ward arranged training days to deliver education in areas that have had significant PU numbers or hospital acquired cat 3/4 PUs.
- The monthly Share and Learn meeting took place in April but there was poor attendance from wards. The lack of ownership around completion of mini-RCA's and presentation was therefore discussed at the Share and Learn meeting, where it was agreed that effective learning and appropriate actions/themes will only be identified if wards are more engaged. Share and Learn Chairs will discuss non- attendance with relevant parties and the Tissue Viability team will monitor the completion of Mini-RCA's. The May Share and Learn meeting (to discuss April PU figures) will take place on 17th May.







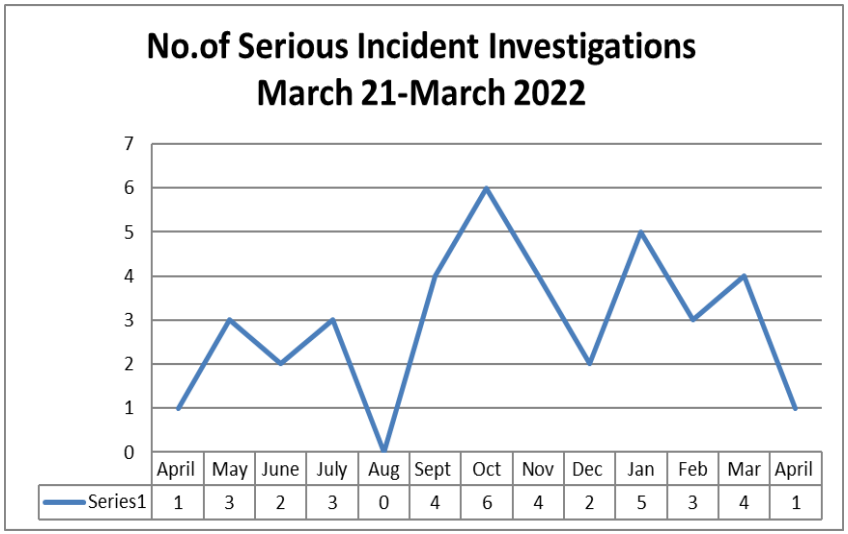
Statistical Process Control Chart Key:
- Target
- Mean
- Upper / Lower Process Control Limits (UPL/LPL)
- Special Cause Variation Improvement (6 or more points better than the mean, or a single point outside the control limit)
- Special Cause Variation Concern (6 or more points worse than the mean, or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

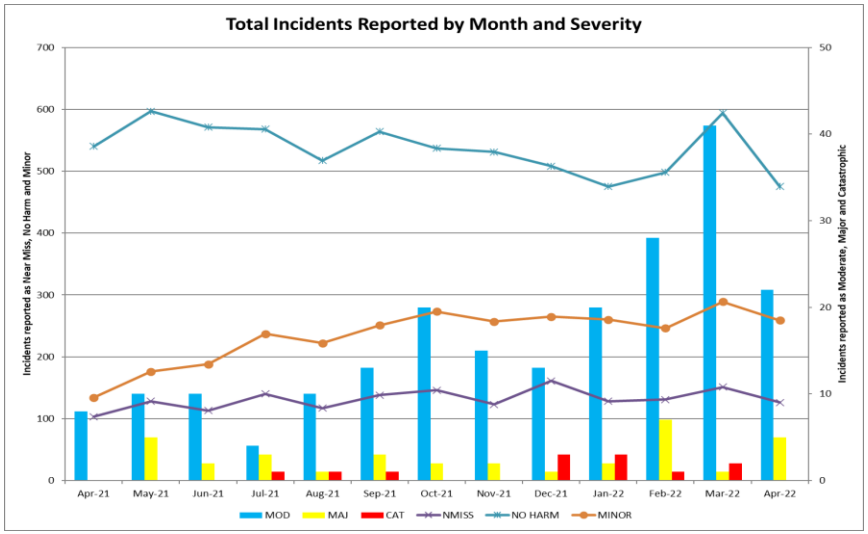
Incidents

Are We Safe?

Year	2020-21	2021-22
Never Events	0	3

Data Quality Rating:





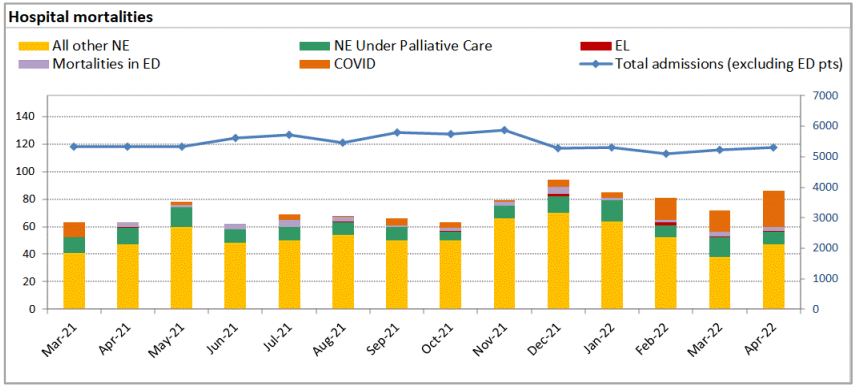
Summary:

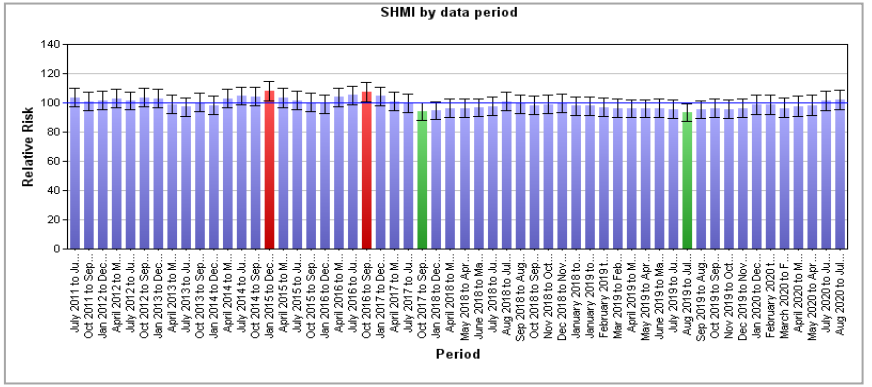
- **There was 1 SII commissioned in April-** A delay in waiting time for an ambulance at the emergency department. The patient died shortly after admission.

Mortality Indicators

Data Quality Rating:

Are We Safe?

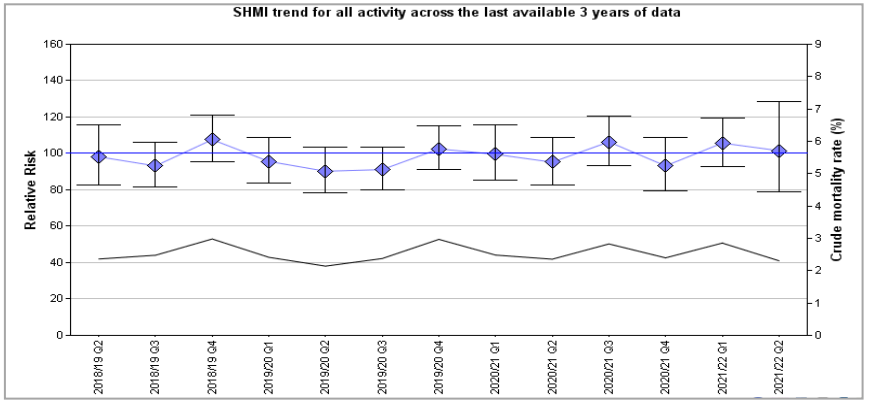


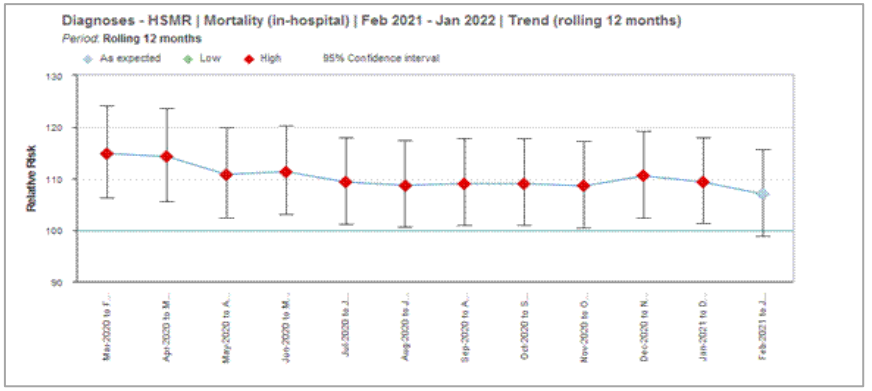


Summary and Action

- **The latest SHMI** for Salisbury District Hospital represents the 12-month period of January 2021 – December 2021 and is 1.0270. This is within the expected range.
- **The latest HSMR** represents the 12-month rolling period of February 2021 – January 2022. The relative risk is 106.9 and this is also within the expected range.
- There were 25 reported COVID deaths in April (deaths within 28 days of a positive PCR test and/or COVID on death certificate).

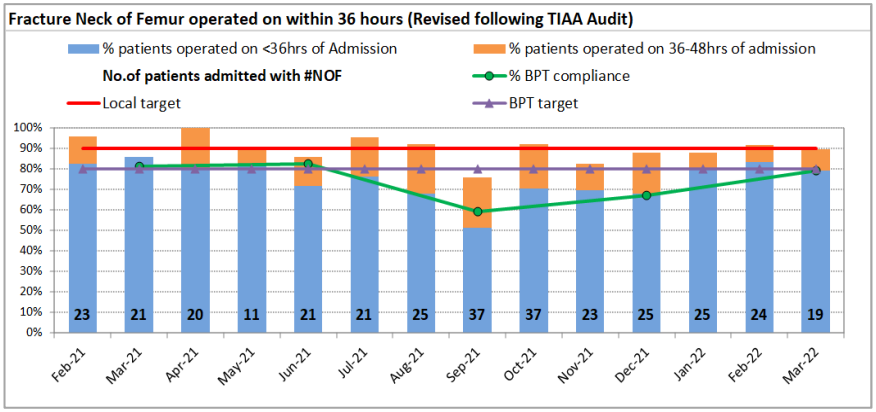
Site code	Site name	Provider spells	Observed deaths	Expected deaths	SHMI value	Banding description
RNZ02	Salisbury District Hospital	33,305	920	895	1.0270	As expected SHMI
RNZ78	Salisbury Hospice	100	65	25	2.4331	Higher than expected SHMI





Fracture Neck of Femur & VTE Risk Assessment/Prophylaxis

Are We Safe?



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

BPT%: April 2022

- Total patients discharged: 23
- Not applicable for BPT: 3 (2 PP# & 1 no operation)
- Number of patients who failed to meet BPT: 9

Reason for BPT failure:

- Awaiting Theatre Space: 3 patients
- Time to Geriatrician over 72 hours: 1 patient
- Awaiting space & time to Geriatrician over 72 hours: 1 patient
- No AMTS & Physio assessment: 1 patient
- Other (Awaiting Surgeon): 1 patient
- Other (Patient refused surgery at first): 1 patient
- No post op bone plan/delirium assessment: 1 patient

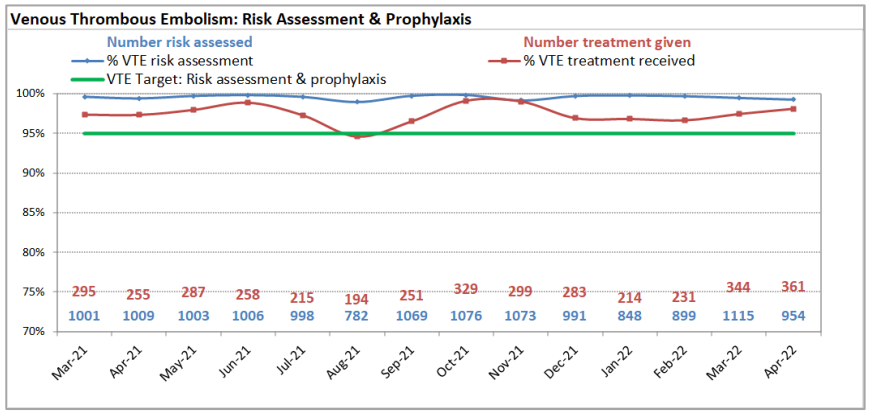
BPT %: 55% Average LOS: 28.04 days

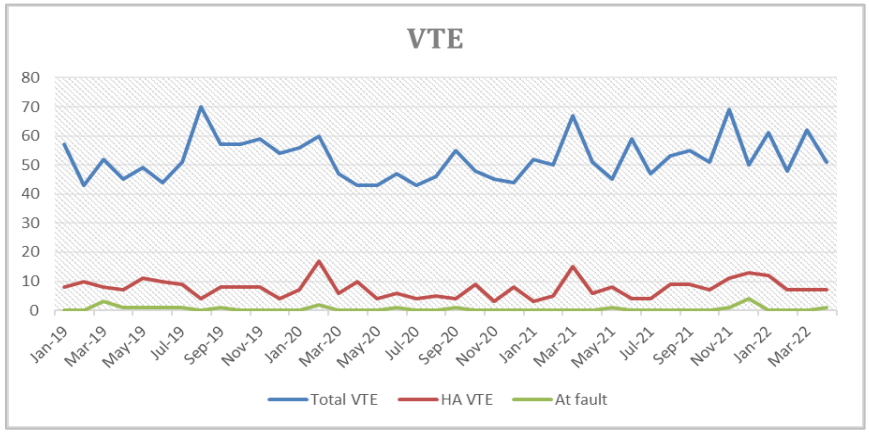
Assessment Benchmark Summary 2021 – South West

This is a summary of every hospitals' performance in the three main areas of assessment, surgery, and outcomes. Regarding how quickly a patient is assessed, Salisbury is ranked in the Top 4 best performing hospitals for BPT% for hip fractures:

- Musgrove Park: 75%
- Weston General: 73.6%
- Torbay: 73.1%
- **Salisbury District: 71.5%**

Data Quality Rating:





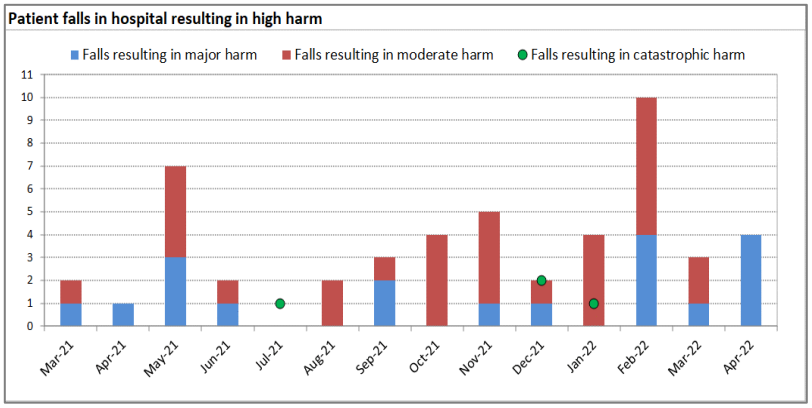
Hospital Associated VTE

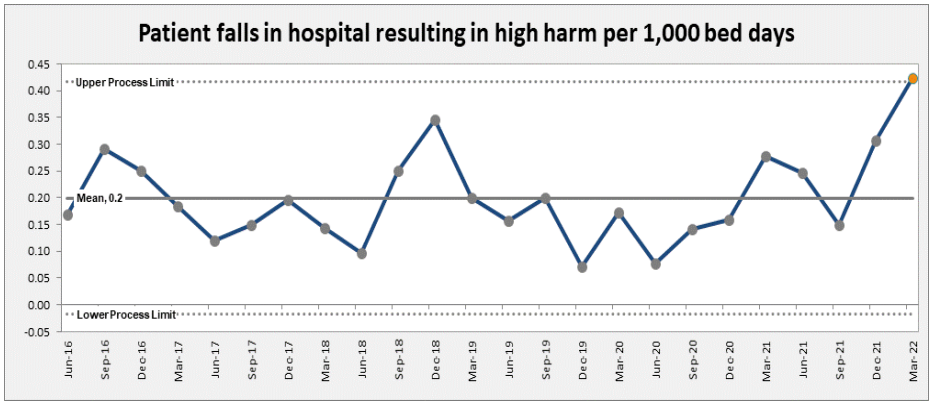
- Total number of VTE in April 2022 : 51
- Hospital Acquired (HA) VTE: 7 – 13.7% of total VTE, National average 25%
- 0.15% of total admissions. National average: 0.5 – 1.6%
- All patients diagnosed with a VTE are assessed and flagged as HA if associated with a hospital admission / surgery within 90 days of their diagnosis and a root cause analysis is completed.
- 1 case appears to have been preventable, but we are awaiting on feedback from clinical team. All other VTE events in April developed a VTE despite being provided with appropriate VTE prophylaxis.

Patient Falls

Are We Safe?

Data Quality Rating:





Summary and Action

There were 4 falls with Major harm reported in April - 3 fractured neck of femurs and 1 comminuted fractured Tibia. All have been investigated and have been presented at the patient safety summit group. None were commissioned for further investigation. Themes continue to be:

- Lack of timely and accurate risk assessments, lack of lye and standing BP monitoring, enhanced care availability.
- Falls per 1000 bed days have dropped for the year 21-22 from 10.178 in 20-21 to 9.69 in 21-22. This is despite the challenges of staffing levels across all professions and increased capacity within the Trust.
- 74 members of nursing staff have received falls reduction training to date. Junior Doctors will receive training from June 22. The training continues to be delivered at ward level rather than in the education center.
- Monthly data for falls sustained and audit data is being shared with ward leaders, matrons and heads of nursing to disseminate to their teams.

Other Improvement Work:

Improving Together has been postponed for a month although work continues with Pitton Ward to produce strategies to reduce the falls rate, and these will be piloted in June.

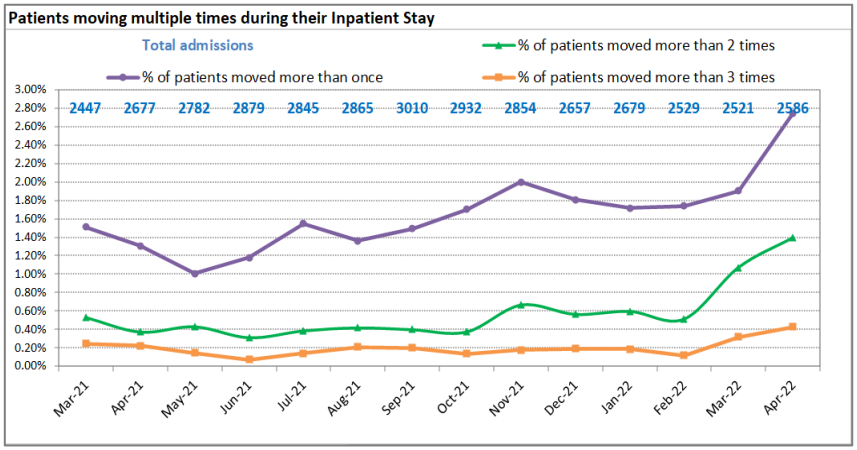
Statistical Process Control Chart Key:
- Target
- Mean
- Upper / Lower Process Control Limits (UPL/LPL)
- Special Cause Variation Improvement (6 or more points better than the mean, or a single point outside the control limit)
- Special Cause Variation Concern (6 or more points worse than the mean, or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

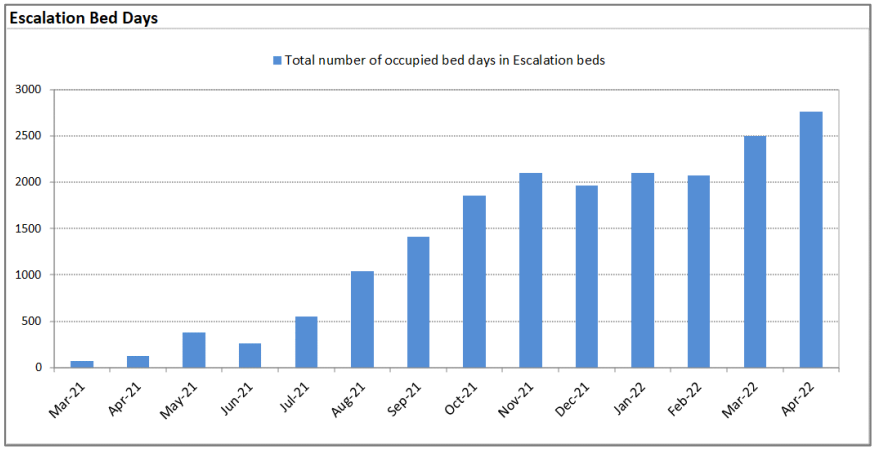
Patient Experience

Are We Safe?

Last 12 months	May 21	Jun 21	Jul 21	Aug 21	Sep 21	Oct 21	Nov 21	Dec 21	Jan 22	Feb 22	Mar 22	Apr 22
Bed Occupancy %	91.2	90.8	90.0	93.9	93.0	94.6	95.0	93.2	93.8	96.3	96.7	97.2

Data Quality Rating:





Summary and Action

April saw bed moves increase across all three measures. Capacity was at the highest for the year, indicating significant issues accommodating all safety and care requirements of patients. Infection control issues were also experienced which contributed to the increase in bed moves. Use of escalation beds were at a peak, including use of both upstairs and downstairs DSU and the spinal gym (also called Clarendon) which was converted at pace to accommodate inpatients. The aim of all clinical and management teams remains achieving the safest and most appropriate care and treatment delivery for all patients and ever-changing needs will contribute to patient moves.

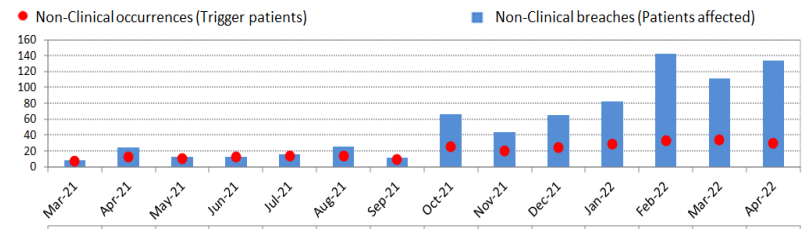
The SAFER/MADE event planned for May has an outcome focus to reduce the use of escalation beds, return patients to the most appropriate setting for their care and treatment requirements and so consolidate staffing back into core areas.

Patient Experience

Are We Safe?

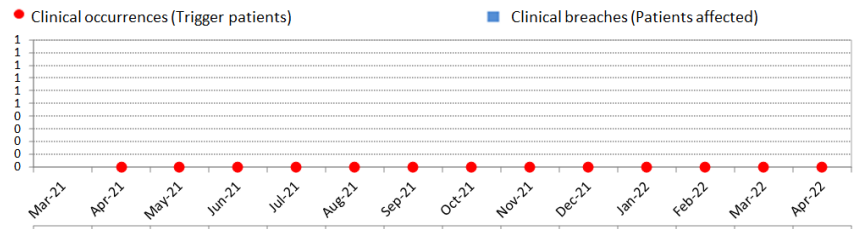
Data Quality Rating:

Delivering Same Sex Accommodation - Non-clinical



	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22
■	8	24	13	13	16	26	12	66	44	65	82	142	111	134
●	7	13	10	13	14	14	9	25	20	24	29	33	34	30

Delivering Same Sex Accommodation - Clinical



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

Summary and Action

- **There were 11 breaches affecting 11 patients which occurred on Radnor**. All were patients who were unable to be moved off the department within 4 hours of being declared fit to move. 7 breaches were resolved within 24 hrs. There were 4 patients who had a breach time of over 1 day while awaiting a speciality bed. Privacy and dignity was maintained at all times within the patients' bed space

- **There were13 breaches affecting 88 patients on AMU assessment bay**. All patients had access to single sex bathrooms within the ward and screens were used to maintain privacy and dignity. 4 of the breaches were resolved within 24 hours, 6 resolved within 48 hours, 3 which were resolved within 72 hours.

- **There was 1 breach on RCU affecting 5 patients.** Privacy and dignity was maintained at all times within the patients' bed space. The breach continued for 4 days due to covid isolation policy.

- **There were 2 breaches on Downton ward affecting 15 patients.** Privacy and dignity was maintained at all times within the patients' bed space. One breach was resolved within 72 hours, the other continued for 4 days due to Covid isolation policy.

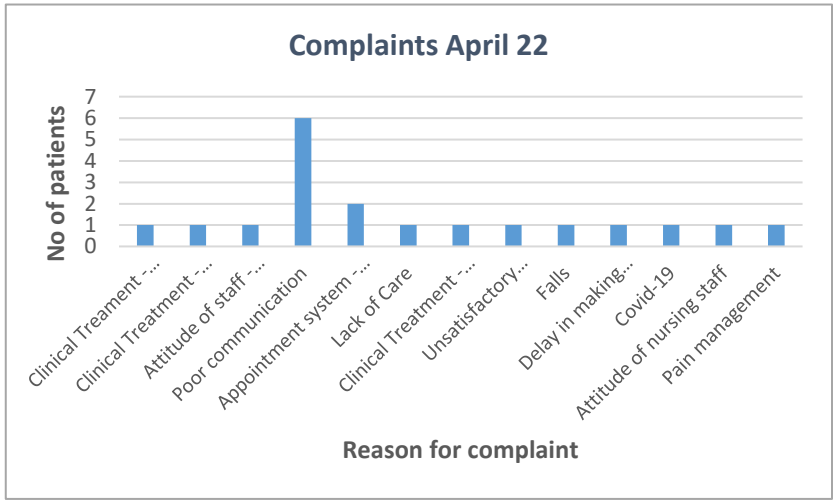
- **There were 2 breaches on Laverstock ward affecting 7 patients.** Privacy and dignity was maintained at all times within the patients' bed space. One breach was resolved within 72 hours , the other continued for 4 days due to Covid isolation policy.

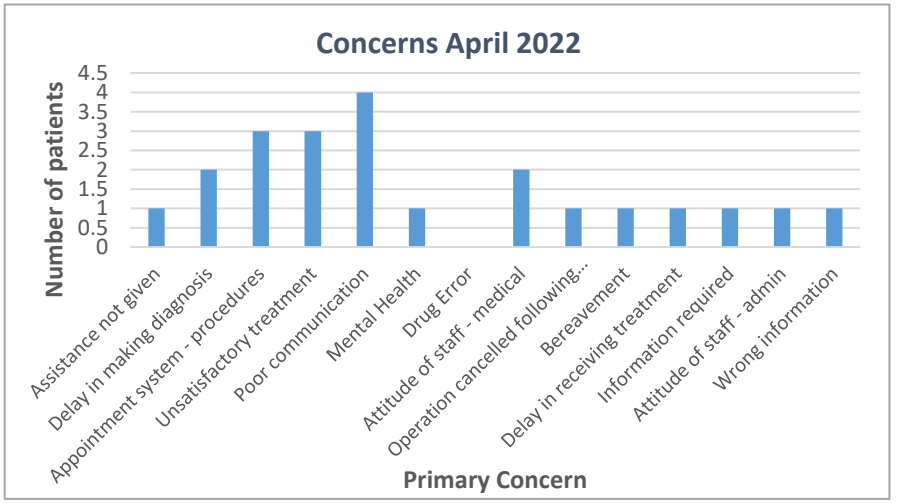
- **There was 1 breach on Tisbury ward affecting 8 patients.** Privacy and dignity was maintained at all times within the patients' bed space. The breach continued for 5 days due to Covid isolation policy.

Patient & Visitor Feedback: Complaints, Concerns & Compliments

Are We Responsive?

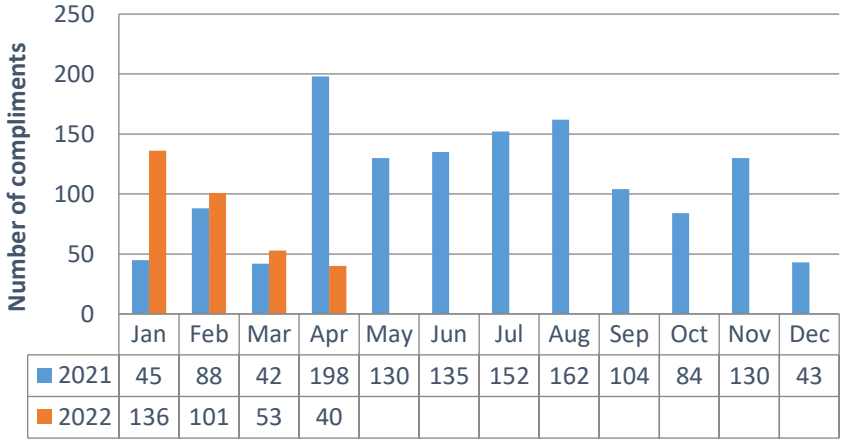
Data Quality Rating:





Summary and Action

- Poor communication is the biggest cause of complaint and concern during April 2022, although numbers do remain very low.
- Complaints and concerns about appointments are on the rise but still low in absolute numbers
- Compliments over time are lower than this time last year but do not include compliments from friends and family which are detailed on a separate slide.



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

Part 3: Our People

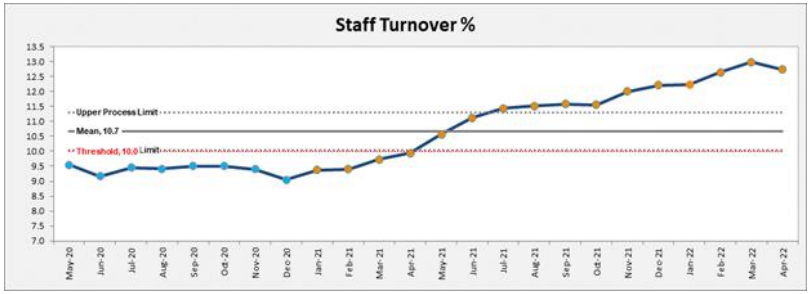
Performance against our Strategic Priorities and Key Lines of Enquiry

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

Workforce – Turnover

Use of Resources

Total Workforce vs Budgeted Plan - WTEs



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

12-month turnover for month 1 is 12.74%. This was a slight decrease from last month's position which was 12.98%. There were 35 leavers and 45 starters by headcount in month. The most common reason, where recorded, for leaving was "Retirement Age" 23% of all reasons for leaving. All retirements were anticipated, they were from posts within CSFS, Women & Newborn and Corporate. There were 7 retirements in month and 1 retire and return.

The Division with the highest turnover rate was Corporate (14.52%), the Divisions whose turnover was under 12% were Medicine (11.62%) and Surgery (11.53%). The staff groups with the highest turnover were clinical support staff and health care assistants (17.57%), and Administrative and Clerical (16.29%).

BSW Benchmarking Nov 2021 - RUH Bath : 9.61%, GWH 14.32% Corporate had the highest turnover (14.52%).

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

In the last month 26% of staff leaving (9 people) completed the exit questionnaire they received from ESR. The analysis from this showed a variety of reasons for leaving, such as childcare, career progression and the feeling isolation in the role over COVID. 3 exit interviews took place in month, the team are reminding line managers to ensure these are carried out. There were no concerns raised in these, reasons for leaving were change of role and personal reasons.

Since March the analysis carried on exit questionnaires showed that only 6% of those completing the questionnaire reported they looked forward to coming to work, 53% said enthusiastic about their job, whilst 60% said they were able to show initiative at wok. The team are aware of the Divisions these staff worked and have followed up.

From a Divisional perspective turnover is one of Surgery's driver metrics and an A3 is awaiting Executive sign off as part of the coach house process.

Work is ongoing in hot spot areas such as Theatres to gain greater soft intelligence to inform commissioning of OD interventions to help with cultural drivers of turnover.

Risks to delivery and mitigation

Early/mid/late career conversations were impacted by the 'critical incident' and staffing levels. Planning work on how best to achieve these conversations is underway.

Line Managers not offering staff exit interviews, this is being overcome by regular communications to ensure that staff are aware of the opportunity to have an exit interview.

Workforce – Vacancies

Use of Resources

Total Workforce vs Budgeted Plan - WTEs

Apr 22	Plan WTEs	Actual WTEs	Variance WTEs
Medical Staff	490.6	451.52	39.1
Nursing	1,104.6	1086.66	17.9
HCAs	516.3	519.61	-3.3
Other Clinical Staff	715.6	670.36	45.3
Infrastructure staff	1,436.0	1324.73	111.3
TOTAL	**4,263.1**	**4,052.9**	**210.3**

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

Vacancy rate in month 1 (April) has seen a step change increase to 12.20%, compared to 3.88% in March.

Taking the additional establishment out, the vacancy rate would be 4.48% which would be below (better than) target (green).

The increase in vacancy level is due to a 341.5 WTE increase in workforce establishments to meet elective recovery targets and funded service developments. The Division with the highest vacancy rate was Corporate at 16.67%. The Corporate area with the highest vacancy rate was Operations (20.56 FTE).

BSW benchmarking Nov 2021 – RUH Bath : 4.75%, GWH Swindon 6.55% (Dec 21)

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

International recruitment – 1st direct hire interviews to be held 18, 19, 26 and 27 May. Collaborative interviews to commence on 18.05.

International midwives – additional agencies are currently being sought to bolster pipeline due to challenges in recruiting international candidates that have passed their English language requirement.

HCA – large scale recruitment event being held on 21.05. Event promoted through local radio, paid Facebook campaign, social media platforms. Booking to attend in advance is required through Eventbrite. Current wte vacancy gap for HCA's is approximately 62.63. Task and finish group set up to review training and department induction for HCA's. Recruitment and Retention Facilitator appointed, commencement date 23.05.

Recruitment and Selection Workshops launched in month 1. Workshops have been designed to provide recruiting managers with practical skills on how to attract and select, subjects covered are job descriptions, advert writing, shortlisting and interviewing. As part of a license to recruit, recruiting managers will also need to attend the Trust's Equality, Diversity and Inclusion training. Recruiting managers will be issued with a certificate once the training has been completed.

Work with PWC to overhaul recruitment practices continues, positive involvement from all key stakeholders - project due to complete 13.06.

Reservist programme – discussions ongoing to set up a BSW Bureau, potentially hosted by SFT, to have reservists ready to be deployed across the system by September 2022. Target is to recruit 350 reservists – those working in the BSW vaccination centers would also join and so further discussion with RUH to retain the lead role are ongoing.

Risks to delivery and mitigation.

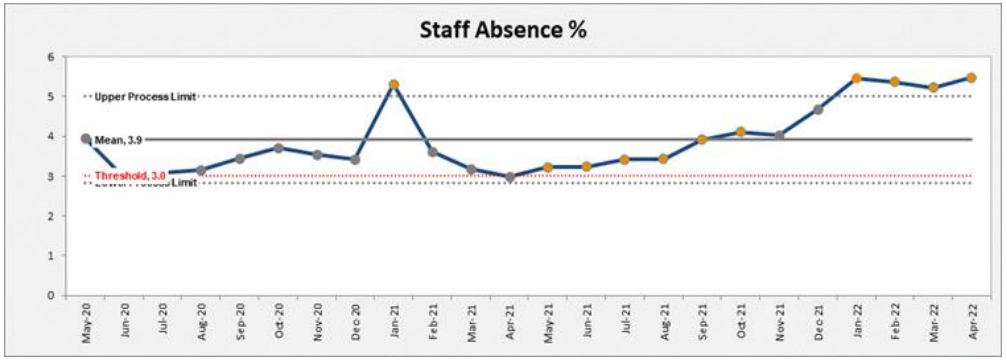
A step change in no of resources requiring recruitment support- Mitigation: review and support resourcing plan by Division

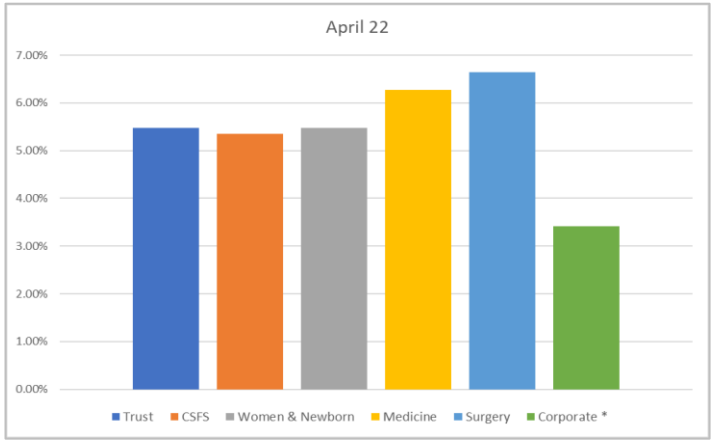
Number of LM trained as recruiters and available to lead the process – mitigation: hosting LM training

Resources in recruitment team due to recent resignation – mitigation: to secure rapid, specialist help to resource the recruitment team

Workforce - Sickness

Use of Resources





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

Sickness in month 1 saw an increase to 5.48%, sickness for the rolling year was at 4.43%. All Divisions are above the Trust target of 3%. For the month of April, "Infectious Diseases" (Coronavirus) was the top cause of sickness across all Divisions.

BSW Benchmarking data for Nov 2021: RUH Bath 5.63%, GWH Swindon : 5.29%

HWB conversation pilot has provided valuable feedback and will be extended to Spinal unit for a final validation with clinical services before a Trust wide launch

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

In month 1 (April) People Advisors contacted staff with COVID on day 5 of their sickness to ensure that lateral flow tests were being undertaken. 27 staff were contacted and although well received staff were still testing positive so there was no impact on early return

As COVID measures across the Trust continue to be reviewed, the COVID risk assessment form has been revised and trialed in Theatres.

Contact has also been made with all managers of staff previously in risk category C & D to establish if they have returned to their substantive posts. 107 staff have returned to their substantive post during the past weeks/ months

New attendance management policy in consultation process and final version to be completed for OMB approval in June.

Sickness absence will be relaunched in June to roll over the next 3 months as a result of the data intelligence from the Advisor team.

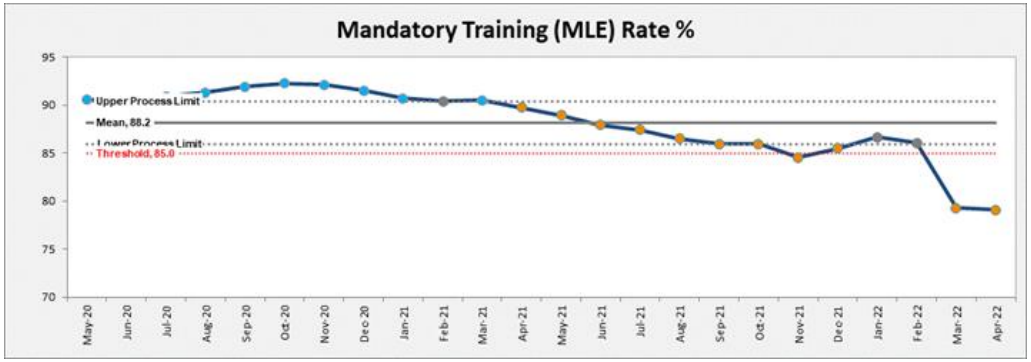
Risks to delivery and mitigation.

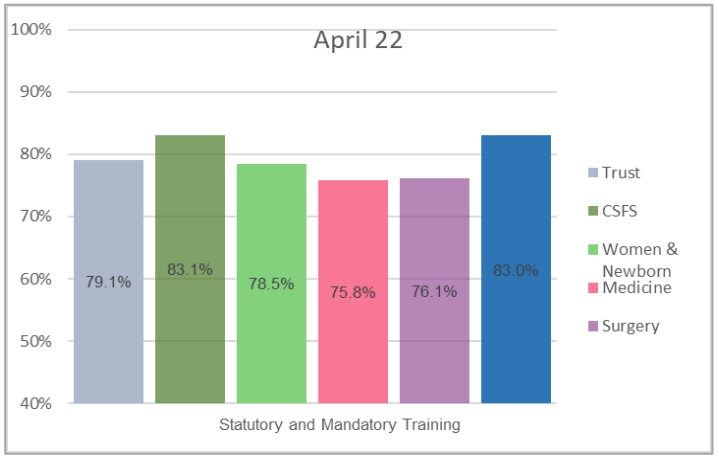
Operational pressures reducing managers time to undertake return to work interviews.

Critical incident pushed back training re-launch.

Workforce – Staff Training

Use of Resources





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

Trust compliance has dropped further from 79.34% in March to 79.11% at the end of April. It has been identified by Kallidus (Managed Learning Environment (MLE) provider) that code errors have contribution to this worsening picture due to changes made to the cost centres within ESR - linked to training groups on MLE. We are working closely with pay role and Kallidus to resolve this issue.

Consequently, Board are asked to note there is less assurance in the accuracy of figures this month.

IG focus for month – Procurement 95%, CSFS 94%. Surgery 81%, Facilities 88%, Transformation & Informatics 98%. Total Trust compliance is currently 87.3% (as of 17/05/2020) 7.7% below target. With actions identified below and continued communications regarding this it is possible for the target to be met, recognising however that this is dependent on individuals.

Surgery DMT agreed with Theatres management to release staff to do IG module using 7 new iPads they have bought in 'iPad breaks'. Also, BP is contacting IG about possibility of running F2F training in a clinical governance session for other critical areas e.g., Orthopaedics and medical staffing teams.

Facilities are offering paid time for bank staff to do their outstanding MLE modules since 40% of all their incomplete stat/man training models are owned by bank staff who are included in their data unlike clinical divisions. IG non-compliance data has been shared and targeting 95% by M3.

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

Recognising Compliance reporting is compromised we have suspended reports and rebuilding training needs analysis by job role. The new Kallidus system ready to go but important to get data right before launching and important to get new policy in place for clarity of responsibilities Deadline is end of May 2022, prior to the migration to the new platform.

Risks to delivery and mitigation.

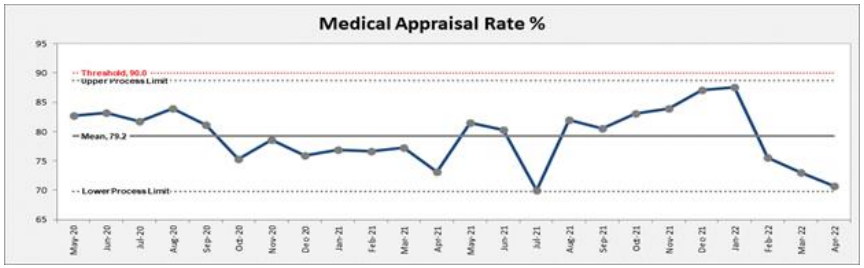
Lack of resource to carry out recovery work, unable to establish this until review has completed.

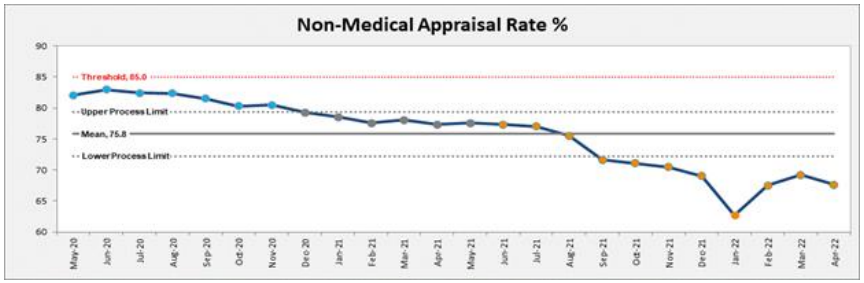
Current staff will prioritise this work, which will impact admin support available in other areas.

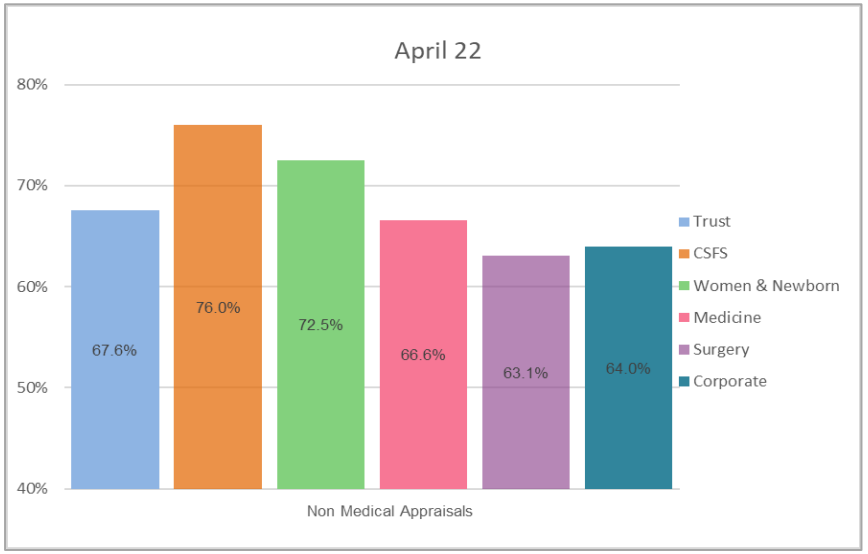
Risk to Trust as we are not able to accurately report compliance with training. Education will work with IG to ensure we are able to provide accurate data for that subject, but this may need to be managed manually on this occasion.

Workforce – Appraisals

Use of Resources







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

Non Medical Appraisals for month 1 remain under target at 67.6%, this is a decrease on the previous month position (69.2%). Hotspot areas are Corporate (64.0%) and Surgery (63.1%)

BSW Benchmarking - RUH Bath : 61.9% (Nov 21), GWH Swindon 74.17% (Dec 21).

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

BPs reviewing all outstanding appraisals, contacting line managers asking them to schedule the month and tracking. Hot spots being reviewed and targeted.

Corporate hot spots – Facilities (71%) department managers are planning in overdue appraisals to achieve compliance. This will involve supporting staff for whom English is not their first language.

Medicine – managers undertaking appraisal training with Education team in June over 4 dates and ensuring correct system access

Surgery – BP reviewing gaps of knowledge within more junior levels of management and putting action plan in place

Procurement are at 94%, Informatics 86% OD & P 53%.

Hot spots - Payroll, Estates, IT Operations, challenges of system use are being overcome by looking at alternative ways of uploading as a solution.

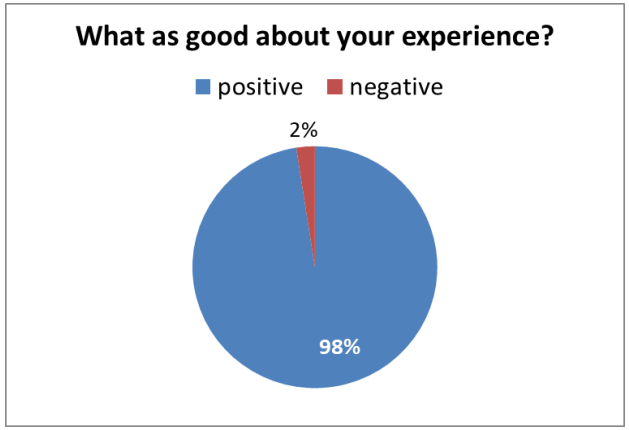
Risks to delivery and mitigation.

Management time from operational pressures to undertake the appraisals. Due to the critical incident the Divisions are still struggling wit capacity issues.

Exec colleagues to be advised on list of LM with outstanding appraisals and check of no of Heads of responsibility.

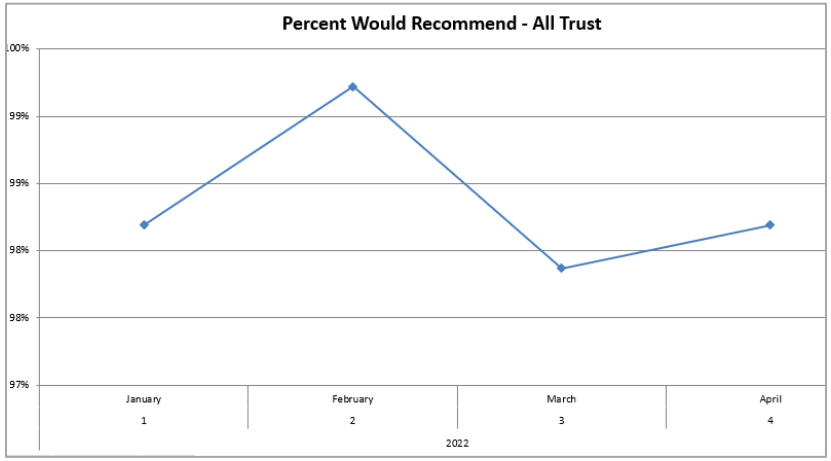
Feedback from Friends and Family test – April 2022

Are We Responsive?



All the doctors and nurses helped my daughter with empathy when it seemed no other dept would. They helped her feel safe and cared for and were also great me, the mum. Sarum

Team so friendly, professional, informative and felt safe in their hands. I had no pain during surgery. Whole process was efficient, from booking in to surgery finishing - Plastic Surgery - Theatres



There was a known delay of 40mins. It would have helped if that had been communicated. I could have walked around to ease the pain.

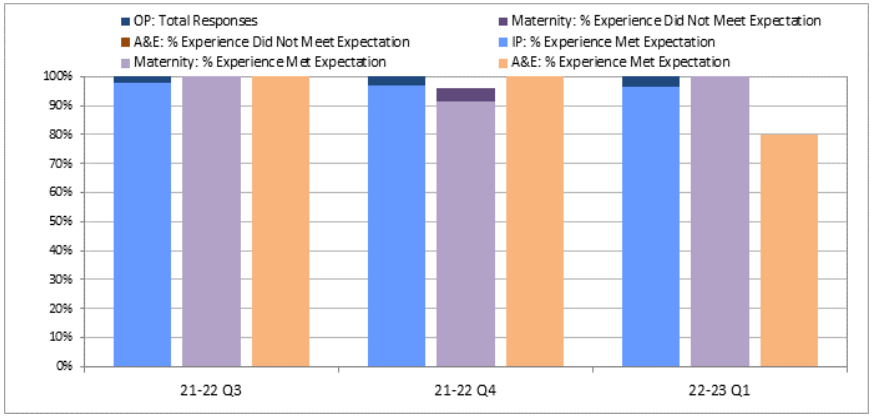
The staff were great and nothing was too much trouble for them. Such a lovely friendly place to be. Whiteparish ward

Signage from car park 15 not present. Walked around for 15mins to find building and late for appt.

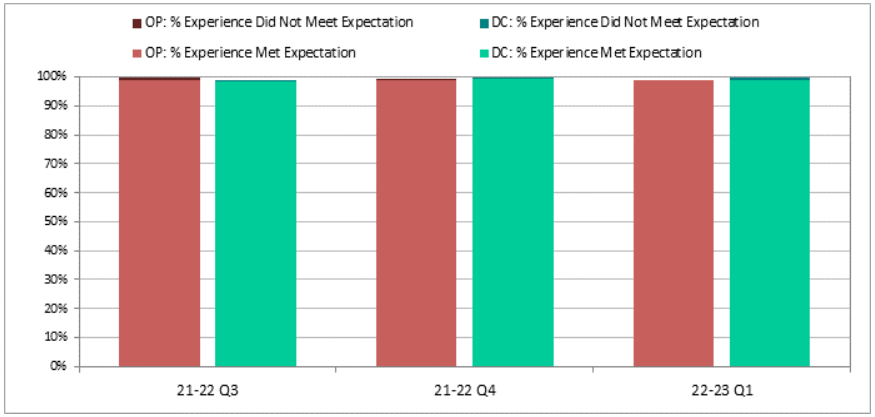
Friends and Family Test – Patients and Staff

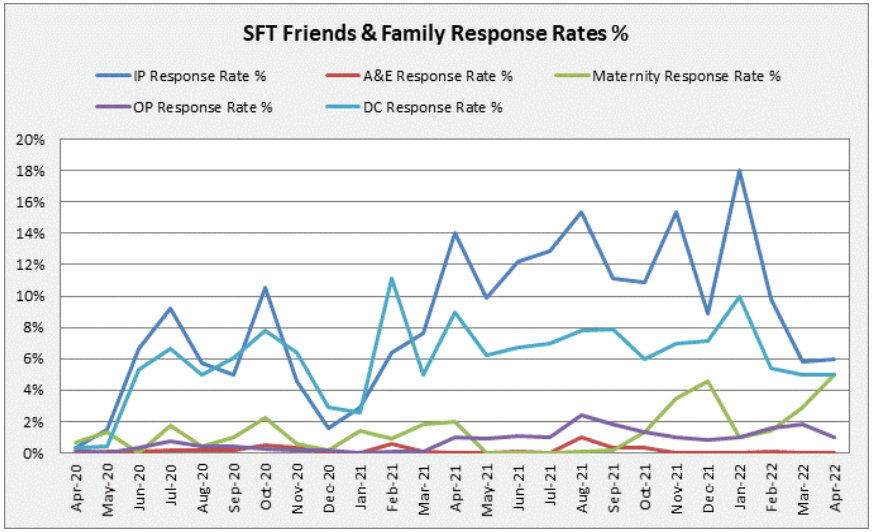
Use of Resources

Patient Responses: Inpatient, Maternity and A&E



Patient Responses: Outpatient and Daycase





Summary:

The returns for FFT data this month remained low in all areas except Postnatal who reported a return of feedback from over 40% of patients in April.

The following wards all received 100% positive feedback:

- Britford
- Downton
- Odstock
- Pembroke
- Pitton
- Sarum
- Tisbury

Part 4: Use of Resources

Performance against our Strategic Priorities and Key Lines of Enquiry

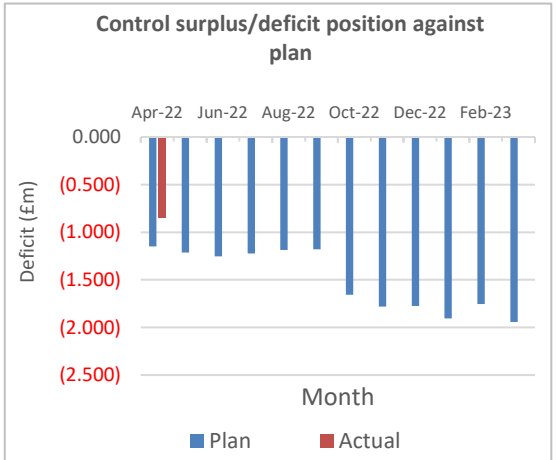
Our Priorities	How We Measure	
People	Are We Effective?	Are We Responsive?
Population	Are We Safe?	Are We Caring?
Partnerships	Are We Well Led?	Use of Resources

Income and Expenditure

Income & Expenditure:

Use of Resources

	April '22 In Month			April '22 YTD			21-22 Plan
	Plan £000s	Actual £000s	Variance £000s	Plan £000s	Actual £000s	Variance £000s	Plan £000s
Operating Income							
NHS Clinical income	21,480	21,433	(47)	21,480	21,433	(47)	257,761
Other Clinical Income	676	690	14	676	690	14	8,111
Other Income (excl Donations)	2,897	3,368	471	2,897	3,368	471	34,164
Total income	**25,053**	**25,490**	**437**	**25,053**	**25,490**	**437**	**300,036**
Operating Expenditure							
Pay	(16,472)	(16,441)	31	(16,472)	(16,441)	31	(199,429)
Non Pay	(8,070)	(8,237)	(167)	(8,070)	(8,237)	(167)	(98,413)
Total Expenditure	**(24,542)**	**(24,678)**	**(136)**	**(24,542)**	**(24,678)**	**(136)**	**(297,842)**
EBITDA	**511**	**812**	**301**	**511**	**812**	**301**	**2,194**
Financing Costs (incl Depreciation)	(1,660)	(1,661)	(1)	(1,660)	(1,661)	(1)	(20,213)
NHSI Control Total	**(1,149)**	**(849)**	**300**	**(1,149)**	**(849)**	**300**	**(18,019)**
Add: impact of donated assets	0	(60)	(60)	0	(60)	(60)	0
Surplus/(Deficit)	(1,149)	(909)	240	(1,149)	(909)	240	(18,019)



Variation and Action

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

Based on the planned level of activity, the Trust is planning for a control total deficit of £18.0m in 22-23; inflation, bed base pressures, increased costs in the Elective pathway, and investment in 24/7 services during the pandemic are driving this financial pressure.

22-23 also sees the return of an efficiency requirement and recurrent savings targets totalling £6.6m have been allocated to corporate and clinical divisions, £2.4m has been formally identified, with the balance currently offsetting non-recurrent vacancies.

In month 1 the Trust recorded a control total deficit of £0.85m against a target of £1.15m - a favourable variance of £0.3m owing to a one-off income receipt. The underlying position was in line with that planned, albeit with vacancies offsetting the premium costs of agency on wards and in theatres.

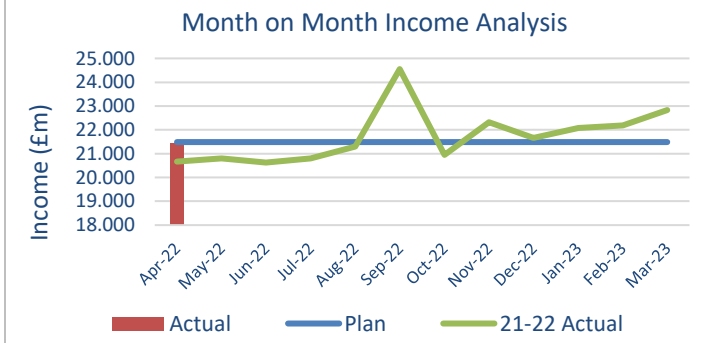
Income & Activity Delivered by Point of Delivery

Clinical Income:

Use of Resources

Income by Point of Delivery (PoD) for all commissioners	Apr '22 YTD		
	Plan (YTD) £000s	Actual (YTD) £000s	Variance (YTD) £000s
A&E	868	816	(52)
Day Case	1,561	1,399	(162)
Elective inpatients	948	878	(70)
Excluded Drugs & Devices (inc Lucentis)	1,814	1,738	(76)
Non Elective inpatients	5,653	5,969	316
Other	7,803	8,084	281
Outpatients	2,833	2,549	(284)
TOTAL	**21,480**	**21,433**	**(47)**

SLA Income Performance of Trusts main NHS commissioners	Contract		
	Plan (YTD) £000s	Actual (YTD) £000s	Variance (YTD) £000s
BSW CCG	12,703	12,703	-
Dorset CCG	2,141	2,141	-
Hampshire, Southampton & IOW CCG inc Portsmouth	1,715	1,715	-
Specialist Services	3,336	3,333	(3)
Other	1,585	1,541	(44)
TOTAL	**21,480**	**21,433**	**(47)**



Activity levels by Point of Delivery (POD)	Activity YTD Plan	Activity YTD Actuals	Activity YTD Variance	Activity Last Year Actuals	Activity Variance against last year
A&E	5,800	6,072	272	5,141	931
Day case	1,822	1,700	(122)	1,592	108
Elective	239	247	8	189	58
Non Elective	2,370	2,191	(179)	2,363	(172)
Outpatients	20,007	18,813	(1,194)	21,341	(2,528)

Variation and Action

The Trust is marginally behind plan which is predominantly due to less income being receivable from provider-to-provider agreements. A&E activity has been relatively high in April with significant increases noted in the Walk-In-Centre activity levels this month. Activity in April in Day cases recorded 689 spells fewer than in March and fell short of the plan for the month by 122 cases mainly in Ophthalmology (56 cases), Colorectal Surgery (50 cases), Urology (44 cases) and Cardiology (28 cases). Activity in elective inpatients is marginally above plan and actual activity in April but was lower than in March.

Outpatient activity reported this month was also lower than planned levels, although there may be a timing issue with some attendances not being fully reported in the data. Non elective activity also fell short of the plan with less activity than expected in Accident & Emergency ((86 spells), T&O (30 cases) and General Medicine/Elderly (60 cases). Both non elective activity and outpatient levels in April were lower than the levels seen in April 2021. The level of uncoded inpatient spells is 96% of planned activity uncoded and 83% of non elective activity uncoded at the time the activity was taken for reporting purposes. The focus had been on clearing the March coding backlog for the annual HES submission which has been achieved.

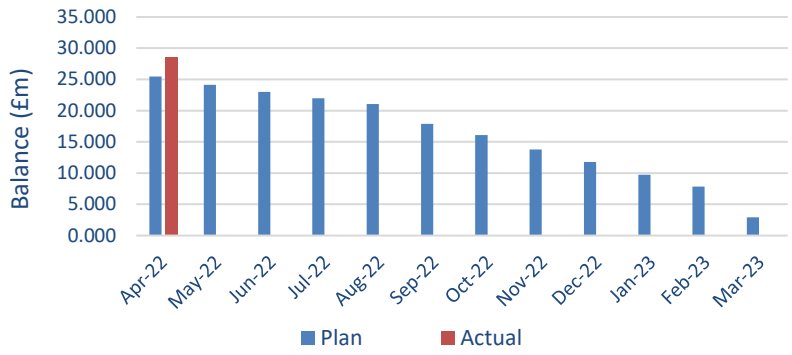
The Trust is unlikely to achieve ESRF funding this year above the base 25% rate as the expected activity increase on 2019/20 out-turn is not considered to be deliverable.

Contracts with commissioners are in the main block agreements although there remains some cost and volume elements related to drugs and devices for NHSE Specialised services. The BSW system is required to have a breakeven financial plan before contracts can be signed in line with national planning guidance.

Cash Position & Capital Programme

Capital Spend:  **Cash & Working:** 

Use of Resources



Summary and Action

The Trust cash balance is currently healthy, partly due to the level of significant capital creditors remaining on the balance sheet relating to 21-22.

Due to the size of the deficit planned for 22-23 the cash balance is forecast to reduce significantly over the year, and cash levels will need to be monitored closely to ensure early warning of any requirement for external support.

Capital Expenditure Position

Schemes	Annual Plan £000s	Apr '22 YTD		
		Plan £000s	Actual £000s	Variance £000s
Building schemes CIR	3,758	313	24	289
Building projects	2,740	228	233	(5)
IM&T	4,106	342	129	213
Medical Equipment	2,207	184	154	30
Other	1,414	118	35	83
TOTAL	**14,225**	**1,185**	**575**	**610**

Summary and Action

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

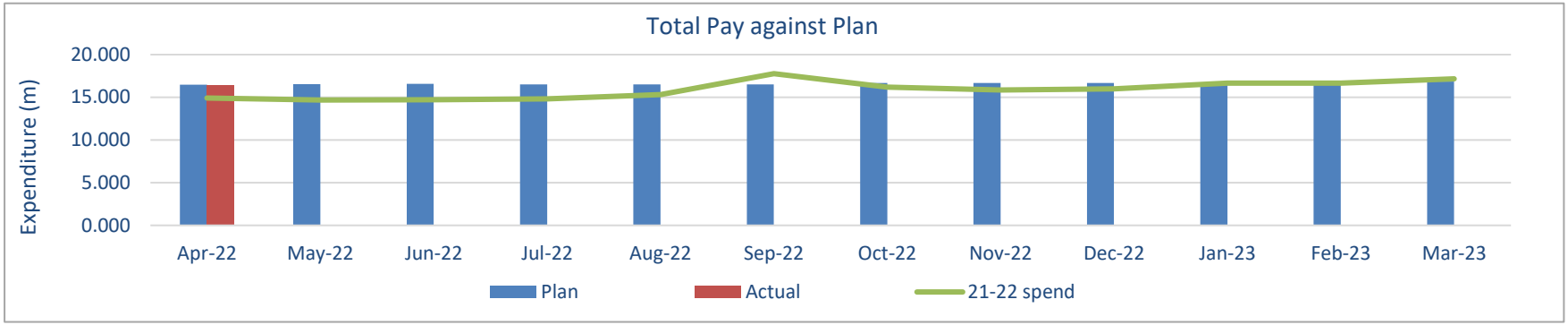
The 22-23 Capital Plan was approved by the Board in April 22 and included an unallocated £989k at the time of approval, however £740k will be required for the BSW shared EPR should the business case be approved. The remainder badged as contingency against which capital priorities for each of the groups will be allocated by the end of Q1. This contingency is included in the Other category.

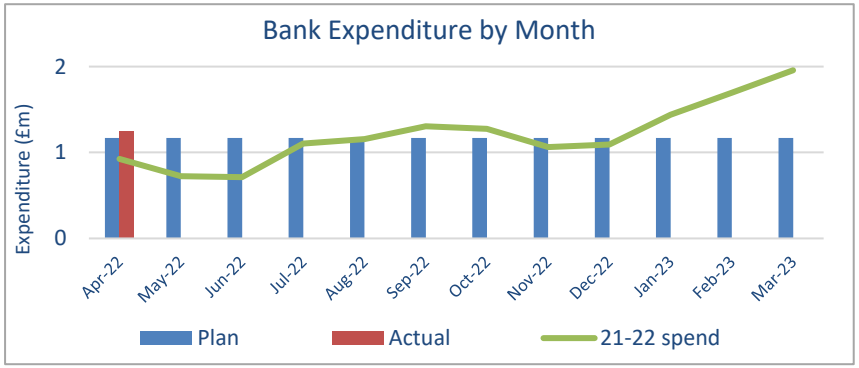
There remains the likelihood that further national funding will be available in the IM&T workstream, although allocations are not expected to be confirmed until the summer.

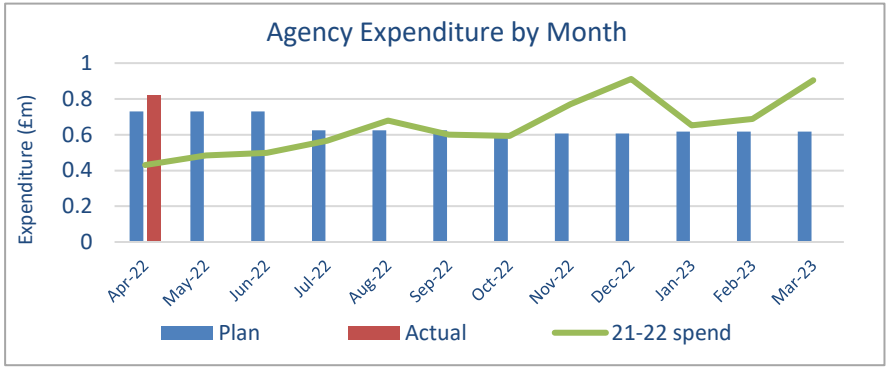
Workforce and Agency Spend

Pay:

Use of Resources







Summary and Action

Pay expenditure had a small favourable variance to plan of £31k, despite a Trust wide pay savings target of £461k in month 1. Most divisions under-spent against plan and CIP efficiencies were achieved due to non-recurring vacancies. The exception was Surgery division where there was a £202k pay overspend, caused by £204k expenditure on agency - this decision was made in order to staff 13 theatres prior to the recruitment of substantive staffing.

M01 shows a benefit from long standing vacancies that is being offset by premium costs of agency staffing (up to £400k), the requirement for which is being driven by bed pressures and the staffing of 13 theatres. Key drivers of WTE variances are: vacancies within the BSW procurement team, the transformation team, and slippage in pipeline business case assumptions, at present these are offsetting both the agency premium, and the Trust's efficiency target, but neither are sustainable in the longer term.