Bundle Escalation Reports - Web Site 7 October 2021

Agenda attachments

2.1 TMC Escalation report Oct.docx

2.2 Escalation report - from September CGC to October Board 2021.docx

2.3 Board - Finance and Performance Committee escalation paper 28th September 2021.docx

2.4 Escalation report from Committee to Board - Audit Committee 23rd September 2021.docx

2.6a 071021 Trust Board cover sheet.docx

2.6b IPR October 2021 DRAFT TB.pdf

NHS
Salisbury
NHS Foundation Trust

Report to:	Trust Board (Private)	**Agenda item:**	2.1
Date of Meeting:	07 October 2021		

Report Title:	Trust Management Committee Escalation Report			
Status:	**Information**	**Discussion**	**Assurance**	**Approval**
	x	x		
Prepared by:	Stacey Hunter, Chief Executive			
Executive Sponsor (presenting):	Stacey Hunter, Chief Executive			
Appendices (list if applicable):	N/A			

Recommendation:

The Board is asked to note the report outlining items raised at the Trust Management Committee meeting held on the 29th September 2021.

Executive Summary:

This month's Trust Management Committee Meeting had a full agenda which centred on updates against our actions for performance challenges, elective recovery, policy and strategy updates and business cases from the Clinical Divisions.

The Chief Nurse detailed the current status of the CQC action plan for Maternity services to be able to respond the Must Do recommendations. The deadline for further information from the service requested recently by the CQC is the 30th Sep 2021. The Chief Nurse and Medical Director have been asked to bring an update to Executive Directors on the 4th Oct 2021 summarising progress against the specific warning notice compliance gaps. Further to this I have asked them to bring a paper through TMC prior to the end of this calendar year which provides an update on readiness for potential CQC inspections for all of our services. This will need to reflect the changes the CQC have been consulting on with regard to how they intend to discharge inspection functions going forward.

The committee noted the escalation reports from the Executive Performance Reviews, Integrated Performance Report, Clinical Management Board and Operational Management Board. All of these have been discussed at the relevant board sub-committees this week and as such the Board will receive the escalations where needed via the Board sub-committee reports.
The consistent theme across all reports was the prolonged continuation of challenges in the availability of staff (sickness, absence, isolation and maternity leave) is causing significant constraints in how we are able to operate on a day to day basis. This is inevitably having an impact on the frequency we are working with minimum numbers of

staff (red staffing levels) and the workload pressure for the teams. The Chief Nurse and Chief Operating Officer reported that this is consistent with all acute providers across the ICS and South West and that teams are using the relevant escalation frameworks on a day to day basis to mitigate the risks.

The teams have made good progress recovering diagnostic waiting times for patients and TMC noted that we are holding steady progress on the overall waiting list size and reduction of people who have waited in excess of 52 weeks.
Overall we are not achieving the aggregate standard of elective recovery as set out in the elective recovery fund (ERF) which is having a negative impact on the financial position.
The Elective Recovery Group continues to explore ways to increase activity via additional sessions but also focusing on optimising activity via the current sessions. The verbal update to TMC is that September has been a more productive month for theatres which we will need to validate once the data is available.
The detail of how the ERF will work in H2 isn't yet confirmed albeit it is reasonable to assume it will continue to focus on an overall activity threshold and reduction in those people with the longest waiting times.
TMC had a discussion about the expected opportunity to bid against some additional capital and revenue monies that will be released for those who are able to identify schemes that can deliver an accelerated elective recovery plan during H2. This will be co-ordinated for SFT via the elective recovery group and will need to be agreed by the Executive Team with a further requirement for all bids to go via the ICS (BSW Elective Board) for prioritisation within the BSW ICS.
Colleagues were reminded that there needed to be robust plans that gave assurance t of delivery within H2 otherwise they wouldn't be supported.

TMC discussed the month 5 finance report and shared concern re the continued escalation in staff pay costs. This is something that needs to be addressed in the short, medium and long term to ensure the sustainability of services for our local population. In the short term the Chief People Officer is in the process of reviewing the workforce control measures and will make recommendations to Executive Colleagues on any short term improvements. This will need to link to the Division's and corporate teams annual and 3-5 year plans for transformation in service models, ways of working, workforce modernisation plans and clarity of areas for dis- investment over the coming months. It was acknowledged that further priority and attention needs to be given to recovering productivity which has been impacted by some of the measures in place to respond to COVID.

The committee received four business cases for consideration. The Trust Investment Group (TIG) had required some additional information for all of these cases which was highlighted to the Divisions as part of the usual process. After lengthy discussion it was agreed that 2 of the 4 business cases were not yet fit for purpose as they hadn't addressed all of the questions and requests for further information from TIG. It was noted that this is a common theme which is causing frustrations for all involved and a request for senior leaders who are accountable for the business cases to provide the support and advice needed to colleagues in their teams to ensure that the business cases were able to be progressed in a timely way. It is acknowledged that there may be a need to support colleagues with some further training and development in writing good business cases which can be provided where requested.

TMC considered and approved 2 business cases which are highlighted below.

1) Business Case for a Cardiology MDT Co-ordinator . This business case has arisen as a result of a combination of responding to national guidance from the British Cardiology Interventional Society and a local serious incident S11 406 which made a

recommendation that the Cardiology MDT needed support from this role to minimise the risks of losing patients to follow up – i.e. having insufficient clinical administration processes to co-ordinate ongoing care and treatment for patients. The business case identified benefits across quality, safety and experience of service for the people who use it and optimising the use of clinical colleagues' time in respect of freeing them up from clinical administration processes and work.

2) The second business case was from Pathology and was to support the ongoing investment in Microbiology to deliver a 7 day service. This has had to be put in place as a response to COVID over the last 18 months but is currently being secured via non substantive colleagues and temporary arrangements.

The case centred around making the budget recurrent as working with temporary staff and colleagues who are willingly to volunteer to do weekends and evenings isn't sustainable. TMC agreed the case but noted that in doing so this increased the substantive staffing costs in Microbiology significantly. The expectation is that the requirements to continue to provide additional testing for COVID 19 or similar viruses will continue in the mid to long term (i.e. the next 2-3 years). If /when this changes TMC were clear that the expectation would be a further discussion with the Pathology leadership re removing this additional budget. The turnover in Pathology staffing is such that this could be realistically achieved within 12- 18 months if required.

End of Report

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

NHS Salisbury NHS Foundation Trust

Report to:	Trust Board (Private)	**Agenda item:**	2.2
Date of Meeting:	7th October 2021		

Report from: (Committee Name)	Clinical Governance Committee		**Committee Meeting Date:**	28th September 2021
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 28th September 2021. 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:
  - A quarterly maternity report was presented which updated the committee on both the position in relation to current and the past CNST. Meeting the new CNST requirements remain a challenge for the service. The report also provided some assurance in relation to progress against both the Ockenden plan and the improvements required in response to the CQC notice. It was positive to note that several senior appointments had been made, however, noting that there would be lead in time for all the people appointed to start in post and therefore, implement and sustain some of the changes required. The leadership team were thanked for their ongoing work noting the positive impact of being their own Division.
  - The interim Director of Transformation provided his final report to the committee. This was a verbal report and covered the themes relating to quality of care. It was noted that the team are supporting the clinical services in key areas such as the Advice and Guidance developments to support outpatients and also the work on flow (urgent care, theatres, discharge and integration with community teams). Assurance was also provided that the e-outcomes programme would be completed in October. The impact of this will be considered in a future committee once the e-outcomes process is fully embedded. The new work focussing on population health management pilot was also presented. The interim Director of Transformation was thanked for his helpful contribution during his time with the Trust.
  - A detailed discussion was held on clinical risk and serious incidents. The committee was appraised about 2 Never Events. It was also noted that assaults against staff had increased. This will be reviewed at the People and Culture

committee. An example of learning from when things go wrong was shared with the relaunch of PEWS after a paediatric incident last year. An ongoing challenge is the closing of actions overdue. The clinical Executives review and discuss these at the regular patient safety summits. Oversight on repeated harms when actions remain open was requested.

- Quarterly reports were received in relation to Learning from Deaths (LFD), Patient Experience and Safeguarding. Key points included:
  - LFD – an increase in death from acute heart failure (not statistically significant) was noted and this is currently being reviewed. Overall, the Trust is not seen to be an outlier in mortality. Oversight of Covid mortality is continuing.
  - Patient Experience – Despite the current challenges, patient feedback shows that the Trust is valued by the people we care for. Notwithstanding the positives, learning from complaints continues to be an important focus. Attitude remains a theme though benchmarking with our AHA partners, this is in lower numbers than in other ICS hospitals. Despite small numbers, the Chief Medical Officer (CMO) confirmed that this is taken seriously and is addressed with individuals.
  - Safeguarding (CYP) – the biggest challenge currently remains around the number of children and young people presenting with mental health issues and requiring hospitalisation. This will be the hot topic in the October committee. It is also noted on the risk register and is a national issue currently. There is partnership working underway with our mental health provider, especially around meeting the needs of the patients and also supporting our staff. Positively, the Trust is doing well in terms of safeguarding supervision in the emergency department.
  - Safeguarding (Adults) – there has been a reduction in numbers of referrals and also a reduction in uptake of training. Audits continue to be undertaken. The committee was informed that a new senior safeguarding practitioner has been recruited who will work across adults and cyp safeguarding. Funding has also been provided for adult safeguarding supervision. Of the 3 domestic homicide reviews underway, 2 have been completed and whilst there are no specific actions for the Trust there is learning in the reports that will be shared across the organisation in training.
- The new format upward report from the CMB was noted with thanks to the new Associate MD for the work on this.
- The Board is asked to note and discuss the content of this report.

CLASSIFICATION:

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Report to:	Trust Board	**Agenda item:**	2.3
Date of Meeting:	7th October 2021		

Committee Name:	Finance and Performance Committee		**Committee Meeting Date:**	28th September 2021
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 28th September 2021. *Please note this escalation report is written based on the performance of Salisbury NHS FT and not the wider performance of the Bath, Wiltshire and Salisbury (BSW) Integrated Care System (ICS), unless otherwise indicated.*

Items for Escalation to Board

(1) **Informatics Internal Improvement Plan** – in December 2019, following a range of concerns, the Trust Board approved an internal improvement plan for the Informatics function. At the Committee a paper was received (supported by the Executive Team) to request a closure of these special arrangements and that Informatics revert back to "business as usual" management and governance arrangements. The Committee supported this recommendation and noted the corresponding reduction in the associated Informatic risks on the Trusts risk register.

(2) **Risk of a cyber or ransomware attack** – the Committee received a risk deep dive into this issue and whilst the Trusts risk score remained at 10 (2 likelihood x 5 consequence) the Committee requested further assurance that 3rd party suppliers were also effectively managing these risks. It was also noted that our Integrated Care System (ICS) and/or the wider NHS were also using the same 3rd party suppliers, therefore these 3rd party assurances could be obtained at a system or national level.

(3) **NHS Planning Guidance for 1st October 2021 to 31st March 2022 (known as H2)** – The Trust has been operating for the first six months of 2021/22 under a short term set of NHS planning guidance (known as H1) that ends on the 30th September

2021 and we are still awaiting the final guidance for the second half of the year (known as H2). That said the following high level issues are highlighted to the Board;

(a) **The first six months (H1)** – despite significant pressures the Trust is expected to have "held its own" on both operational and financial performance in H1. Operationally we are under pressure on Emergency Department (ED) and elective inpatients (main theatres) performance, but in relative terms our performance is comparable with our regional peers. While on finance, despite staffing pressures and productivity challenges, we are expected to achieve (or be near to) our first half year targets.

(b) **The second six months (H2)** – there are many unknown variables that will impact on both operational and finance performance up to the 31st March 2022. Firstly the size of our financial allocation and conditions attached to the Trusts H2 settlement, secondly the severity of the winter pressures (including covid), thirdly the ability of our partners to cope with the above e.g. primary care, social services and Wiltshire Health and Care and finally any wider economic, workforce or society challenges that may unexpectantly occur over the next six months e.g. workforce shortages, inflation, weather, industrial disputes or supply chain problems etc.

Therefore the Trust Board are asked to note the "relatively" good comparative performance in the first half of the year (though we have some hot spots), but be aware that (a) the Trusts H2 submission is likely to have to be returned within a short time period i.e. before the next F&P meeting on the 26th October 2021 and (b) there are many significant unknown local, regional and national variables to manage over the next 6 months.

(4) Estates Status update report – the Board has been aware of significant risks relating to the Trust Estates function and actions to mitigate these risks. The committee received a further update on progress and whilst good work is taking place and a robust plan agreed, the pace of improvement is still being held back by the inability to recruit into key permanent roles. The committee noted the report and the verbal assurance of how risks are currently being managed on a day-to-day basis. Finally the Committee requested that two actions need to be resolved between know and Christmas 2021 (a) our prioritised action plan to reduce the risks to our estates i.e. what to do and in what order and (b) given the above actions, how best to organise our Trust estates function i.e. how to deliver the plan?

NHS Salisbury NHS Foundation Trust

Report to:	Trust Board (Private)	**Agenda item:**	2.4
Date of Meeting:	7th October 2021		

Report from: (Committee Name)	Audit Committee		**Committee Meeting Date:**	23rd July 2021
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.

It has been agreed that the matter of the Internal Audit report on Equality Diversity and Inclusion report will be discussed in more depth as a separate agenda item at the Board.

Key Items for Escalation

Internal Audit Report – Equality, Diversity and Inclusion (EDI)

A report was received from PWC on their review of EDI control processes and practices in the Trust. The report was rated overall as "High Risk" and contained 6 specific findings all individually rated as medium risk. It was also notable that of the 13 categories of process control characteristics examined, 12 were assessed to either have some deficiencies in design or to be not designed well. The comprehensive nature of this negative assessment is unusual. Given that this report will be discussed in detail at the Board, this report will not go into depth on the issues raised.

The Executive accepted the report and pointed out that the concerns relating to this area had been recently exposed at Board meetings. The Executive were fully committed to addressing the issues raised and indicated that a six month period was likely to be necessary in order to properly assess and re-design the control processes and to begin to embed a new set operating practices and processes. At this point, a full reassessment from PWC will be considered.

It was noted that the management actions listed in the report, whilst necessary initial steps in the recovery process, would not completely resolve the issues raised and a more developed action plan will be required. This has begun to be pulled together and progress will be reported at the Board as appropriate.

Deep Dive – DM01 Waiting List Management

The committee received a presentation from Lisa Clarke focussing on the administration of waiting lists within diagnostics. The presentation was very

informative, helping the committee to better understand the processes and challenges around waiting list management in this area. There was a good discussion on the points raised and the Committee thanked Lisa for an excellent presentation

Register of Losses and Compensation

The Committee noted as part of its regular review of this report that there was a write off of £68k over the last six months for obsolete inventory, primarily out of date cardiac and orthopaedic implants. There were a number of factors driving this higher than normal outcome, including earlier bulk buying and lower surgical activity due to the coronavirus pandemic. Management agreed that future management would put stronger emphasis on the use of consignment inventory to help mitigate this exposure.

CLASSIFICATION: please select

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Report to:	Trust Board (Private)	**Agenda item:**	2.6
Date of Meeting:	07 October 2021		

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

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

Executive Summary:

The high level of Emergency Attendances seen from M2 to M4 continued in M5 (6233 in M4, 6119 in M5). Staffing challenges in the Emergency Department, and high hospital alert status made for a challenging month, with performance against the 4 hour standard falling to 78.7%, just above the National performance of 77%. Ambulance handover delays also increased marginally to 1279 (1272 in M4).

Flow into the hospital was challenging, with a high level of escalation bed usage – over 1000 occupied bed days in escalation beds compared to fewer than 600 in M4. Bed occupancy averaged at just under 94% for the month, the highest this has been since February 20. There was also an increased number of non-clinical mixed sex breaches as a result of limited flow. All of the breaches occurred in ITU or assessment areas.

The level of pressure on the organization was also felt by staff, with sickness levels increasing to 3.43% and Stress/Anxiety being the top cause of sickness. Compliance with non-medical appraisals and mandatory training reduced, with clinical pressures in departments being cited as a reason for the reduction. Spend on pay increased in month, with the main reasons being an increase in agency costs due to vacancies and sickness.

Encouragingly recovery of the 6 week diagnostic standard continued to improve, with 98.39% of patients receiving their diagnostic within 6 weeks (standard 99%). Further improvement is expected in M6, and focus now is on identifying any referral increases to ensure maintenance of

the improved position.

For patients referred with suspected cancer 88% were seen within 2 weeks of referral, a reduction from 90.96% in M4. Patient choice remains a challenge, with 63 of the 120 patients not seen within 2 weeks due to patients choosing to wait longer.

Similarly, the number of patients receiving treatment for cancer within 62 days of referral reduced slightly to 79.49% (not yet fully validated) from 80.88% (standard is 85%) in M4. Reasons for delays were predominantly complex diagnostic pathways, further underlining the importance of maintaining the diagnostic standard.

The threshold to meet the Elective Recovery Fund was not met, with activity under the threshold in Electives, Daycases and Outpatient Procedures. Although outpatient procedures did not meet the ERF threshold level, they did exceed the Trust plan. Outpatient Attendances remained above plan and ERF threshold. Elective activity had the most impact on overall ERF achievement, with 67% of 19/20 baseline and under plan with 256 electives delivered against a plan of 286 in M5. Theatre constraints continue to be predominantly the main factor, further impacted by high sickness rates and low uptake of the theatre incentive payment.

Despite the challenges in increasing elective activity the Trust did further reduce the number of patients waiting over 52 weeks for elective treatment from 746 in July to 660 in August, ahead of the trajectory plan to reach 660 by the end of September.

Performance against the Stroke standards improved slightly, with 50% of patients arriving on the Stroke Unit within 4 hours (47.1% in M4) and 100% of patients spending at least 90% of their stay in the Stroke Unit.

Board Assurance Framework – Strategic Priorities	Select as applicable
Local Services - We will meet the needs of the local population by developing new ways of working which always put patients at the centre of all that we do	☒
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Innovation - We will promote new and better ways of working, always looking to achieve excellence and sustainability in how our services are delivered	☒
Care - We will treat our patients, and their families, with care, kindness and compassion and keep them safe from avoidable harm	☒
People - We will make SFT a place to work where staff feel valued and are able to develop as individuals and as teams	☒
Resources - We will make best use of our resources to achieve a financially sustainable future, securing the best outcomes within the available resources	☒
Other (please describe) -	☐

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Integrated Performance Report

October 2021

(data for August 2021)

An outstanding experience for every patient

Summary

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The high level of Emergency Attendances seen from M2 to M4 continued in M5 (6233 in M4, 6119 in M5). Staffing challenges in the Emergency Department, and high hospital alert status made for a challenging month, with performance against the 4 hour standard falling to 78.7%, just above the National performance of 77%. Ambulance handover delays also increased marginally to 1279 (1272 in M4).

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The level of pressure on the organization was also felt by staff, with sickness levels increasing to 3.43% and Stress/Anxiety being the top cause of sickness. Compliance with non medical appraisals and mandatory training reduced, with clinical pressures in departments being cited as a reason for the reduction. Spend on pay increased in month, with the main reasons being an increase in agency costs due to vacancies and sickness.

Encouragingly recovery of the 6 week diagnostic standard continued to improve, with 98.39% of patients receiving their diagnostic within 6 weeks (standard 99%). Further improvement is expected in M6, and focus now is on identifying any referral increases to ensure maintenance of the improved position.

For patients referred with suspected cancer 88% were seen within 2 weeks of referral, a reduction from 90.96% in M4. Patient choice remains a challenge, with 63 of the 120 patients not seen within 2 weeks due to patients choosing to wait longer.

Similarly, the number of patients receiving treatment for cancer within 62 days of referral reduced slightly to 79.49% (not yet fully validated) from 80.88% (standard is 85%) in M4. Reasons for delays were predominantly complex diagnostic pathways, further underlining the importance of maintaining the diagnostic standard.

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Performance against the Stroke standards improved slightly, with 50% of patients arriving on the Stroke Unit within 4 hours (47.1% in M4) and 100% of patients spending at least 90% of their stay in the Stroke Unit.

Structure of Report

Performance against our Strategic and Enabling Objectives

Our Priorities	How We Measure	
Local Services	Are We Effective?	Are We Responsive?
Specialist Services		
Innovation		
Care	Are We Safe?	Are We Caring?
People	Are We Well Led?	Use of Resources
Resources		

Summary Performance
August 2021

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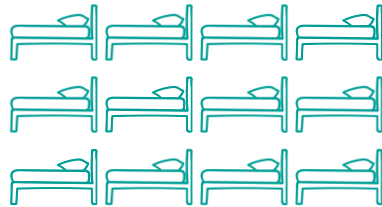
There were **2,745** Non-Elective Admissions to the Trust

We delivered **33,494** outpatient attendances, **24.4%** through video or telephone appointments

We met **2 out of 7** Cancer treatment standards

We carried out **259** elective procedures & **1,742** day cases



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

RTT 18 Week Performance:
74.4% ↑
Total Waiting List: **19,540** ↑

98.3% ↑ of patients received a diagnostic test within **6 weeks**

Our income was
£24,666k (£527k above plan)

18.3% ↓ of discharges were completed before 12:00

Emergency (4hr) Performance
78.7% ↓
(Target trajectory: 95%)

62 patients stayed in hospital for longer than 21 days

Our overall vacancy rate was
3.50% ↑

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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

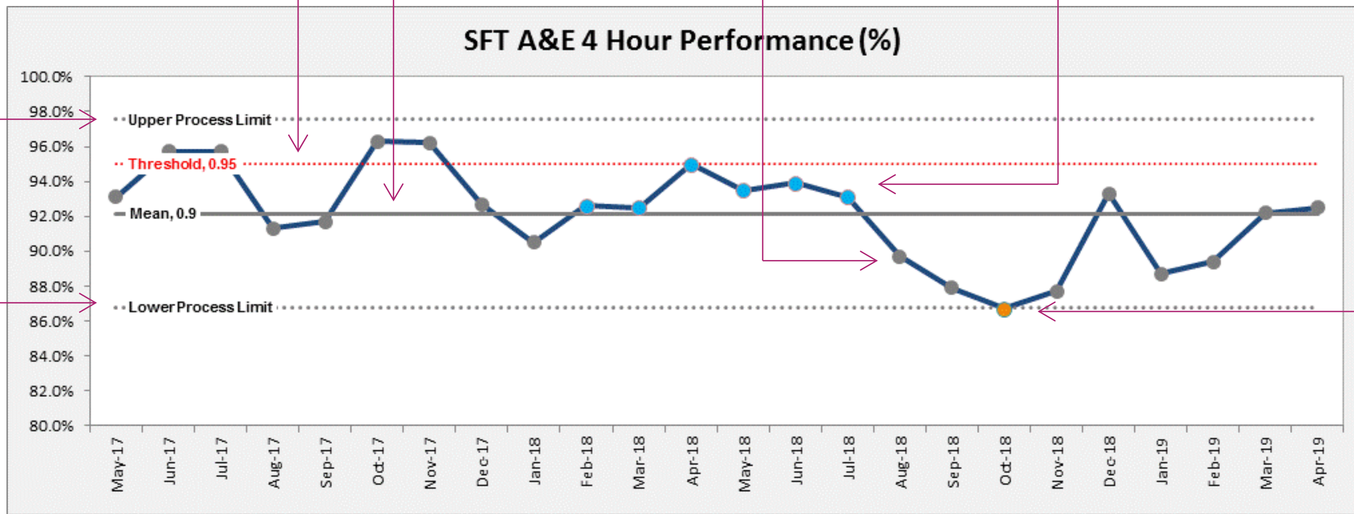
The red line shows the target for the KPI, if there is one

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

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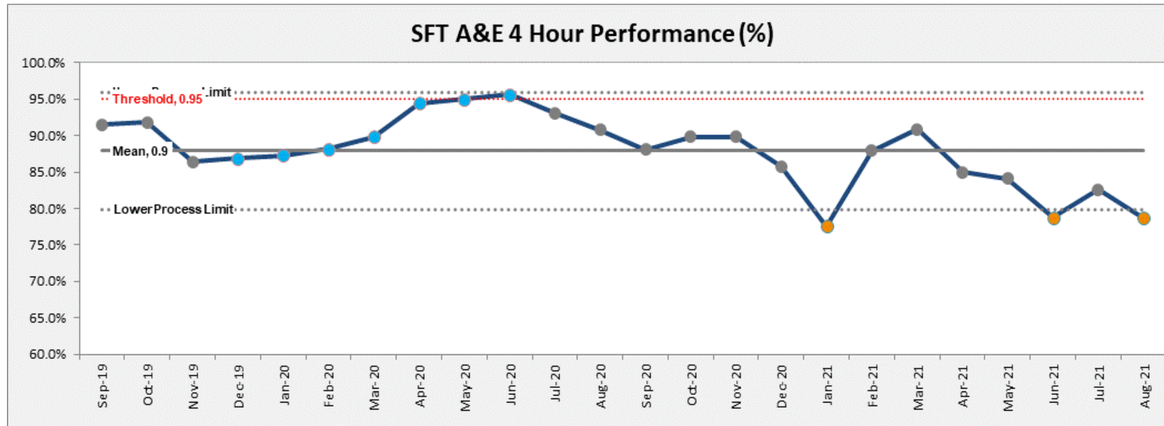
Part 1: Operational Performance

Our Priorities	How We Measure	
Local Services	Are We Effective?	Are We Responsive?
Specialist Services		
Innovation		
Care	Are We Safe?	Are We Caring?
People	Are We Well Led?	Use of Resources
Resources		

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

National Key Performance Indicators



Data Quality Rating:	
Performance Latest Month:	78.7%
Attendances:	6119
12 Hour Breaches:	0
ED Conversion Rate:	26.7%

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

Month 5 saw a decrease in performance for the 4 hour standard as compared to M4. There has been an decrease in numbers from 6573 in M4 compared to M5.

Staffing was particularly challenging in M5 especially within the nursing workforce. Nearly every shift had significant nursing gaps which were unfilled both within ED and across the Trust. We also still have significant middle grade gaps and M5 also saw annual change over of junior Doctors. All of these issues contributed to impact on the 4 hour performance .

Anecdotally access to primary care continues to impact on number of attendances into ED, with emphasis on our minors department. Adverts continue through locums nest for a GP to support our minors service, particularly in twilight hours where a significant number of attendances present, but there has still been no fill for this so far.

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

ED continue to add directly onto the AMU take to assist with flow out of the department, this will continue to be monitored through AMU SLT meetings by the UEC manager to address any issues. This has been challenging in M5 as AMU have had high acuity and the take has reverted back to ED in times of surges.

Ongoing meetings continue with the Think 111 First programme attended by UEC manager and ED Consultant.

SDEC and ED improvements continue with ED consultant exploring managing patients by utilising pathways that can avoid admission. Microguide has been explored and initial contacts made with specialties to implement SDEC.

We have successfully recruited X2 B6 posts internally for 12 month secondment.

Orthopedics fracture clinic due to move out of adjoining minors area in M6 which will then require some minor building works to increase the footprint of the minors department, which should be implemented by M7 when the department will regain use of the space.

Risks to delivery and mitigations

Significant middle grade gaps within the department and this will continue to impact on performance.

AMU have x2 Consultant gaps in M6 which may impact on flow out of the department. Flow out of the department has been challenging through M5 with the Trust in Opel 4 for long periods.

Nursing staffing remains a significant challenge. There is a reduction in B6's due to maternity leave and covering triage and shift coordinator roles will continue to be challenging in M6 along with B5 vacancies.

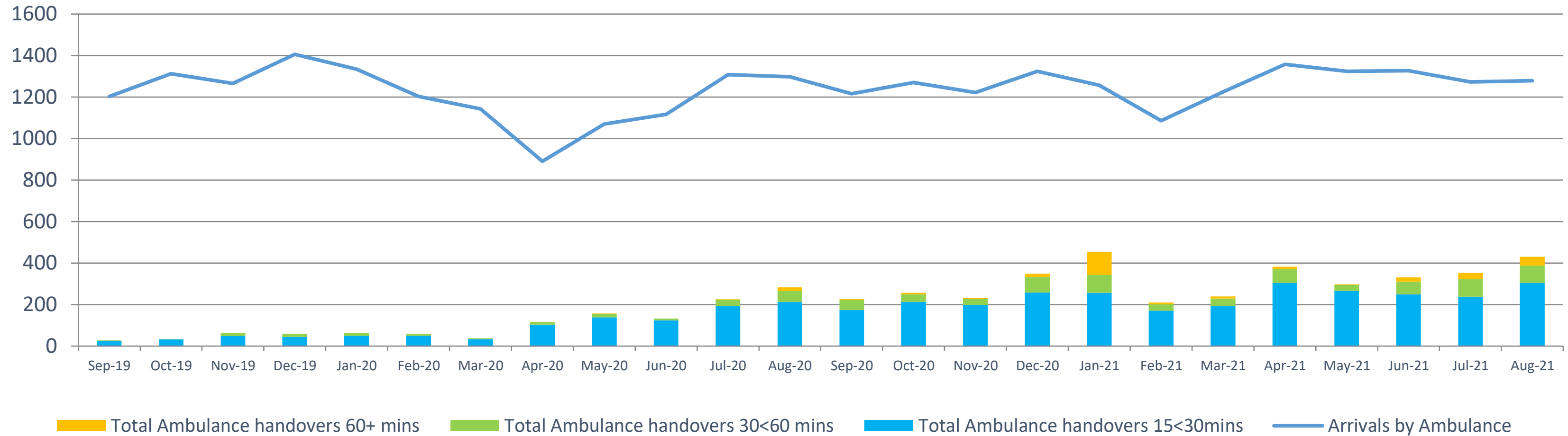
Anecdotally access to primary care continues to impact on attendances into department, in particular the minors service. Agreement has been made that ED1 consultant will address waiting room to keep patients informed of delays and options given to access WIC or MIU if appropriate.

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

There has been a small increase in number of ambulances in M5 of 1279 compared to M4 of 1272 with number of ambulances presenting remaining high.

SWAST have been in internal critical incident due to staffing and acuity throughout most of M5 and have seen significant delays in handovers within the region, although SFT have remained the highest performing Trust with the least lost hours in handing over.

Despite this a further increase in ambulance handover delays was seen within the department. Notably, there was an increase in delays of over 1 hour from 13 in M4 to 43 in M5. There was an increase in 30-60 minute breaches from 237 in M4, to 305 in M5.

Staffing shortages in both medical and nursing workforce alongside increase in demand has been contributory to the increase in delays.

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

SOP has been created and implemented in M5 to convert our paediatric area within the department into an ambulance off load/Nursed out area. This was the only space identified that could be converted. This provides space for X2 trollies and X1 chair space in order to minimise handover delays in times of spikes in attendances. Additional nursing support required in this area is difficult to identify at times due to nursing shortages across the Trust. Verbal agreement with Bronze commander at SWAST that if SFT are unable to identify staff to cohort these patients safely they may be able to support dependent on their staffing.

The inability to avoid ambulance delays remains high within the department and Trust when the department is full and flow out of the department is limited due to bed availability.

Bi-monthly meetings continue between SWAST and clinical leads to address concerns and contribute to collaborative working.

SDEC pathways and ED improvements groups are underway in order to provide capacity within the department to assist in avoiding ambulance delays.

The trial of new standards for ambulances to offload directly into AMU will start in M6. All staff are aware of focus in off loading ambulances and performance will continue to be monitored by UEC Manager

Risks to delivery and mitigations

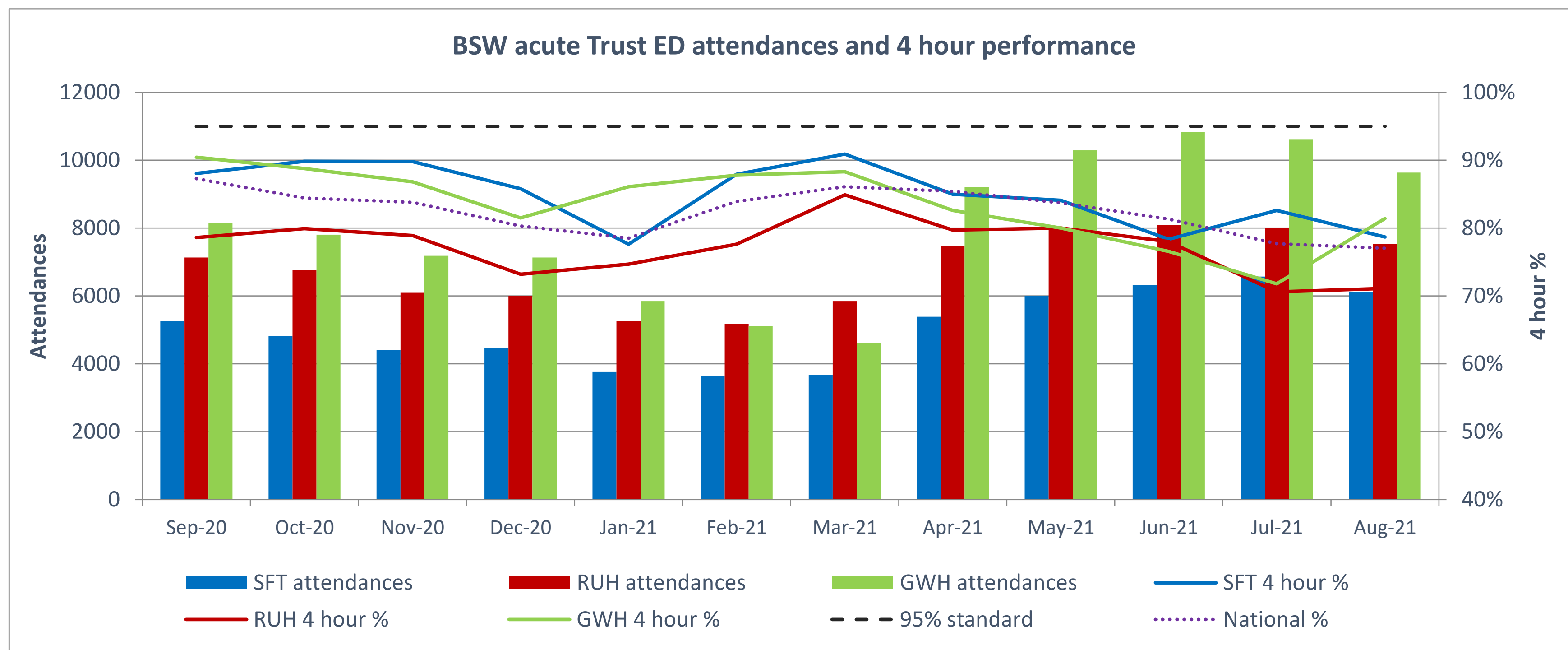
Capacity within the department continues to remain challenging especially with high volume of attendances presenting within similar timeframes (high number of presentations within one hour will continue to impact on the ability to avoid ambulance delays)

Medical workforce gaps both in ED and AMU, alongside high number of nursing gaps in ED will continue to remain a contributing factor in being able to accept handovers within 15 minutes.

Verbal agreement with SWAST if we have capacity to off load but do not have adequate staffing to receive patients safely, they will cohort patients so that other crews can leave to attend to other calls.

BSW Context – Emergency Access (4hr) standard

Are We Effective?

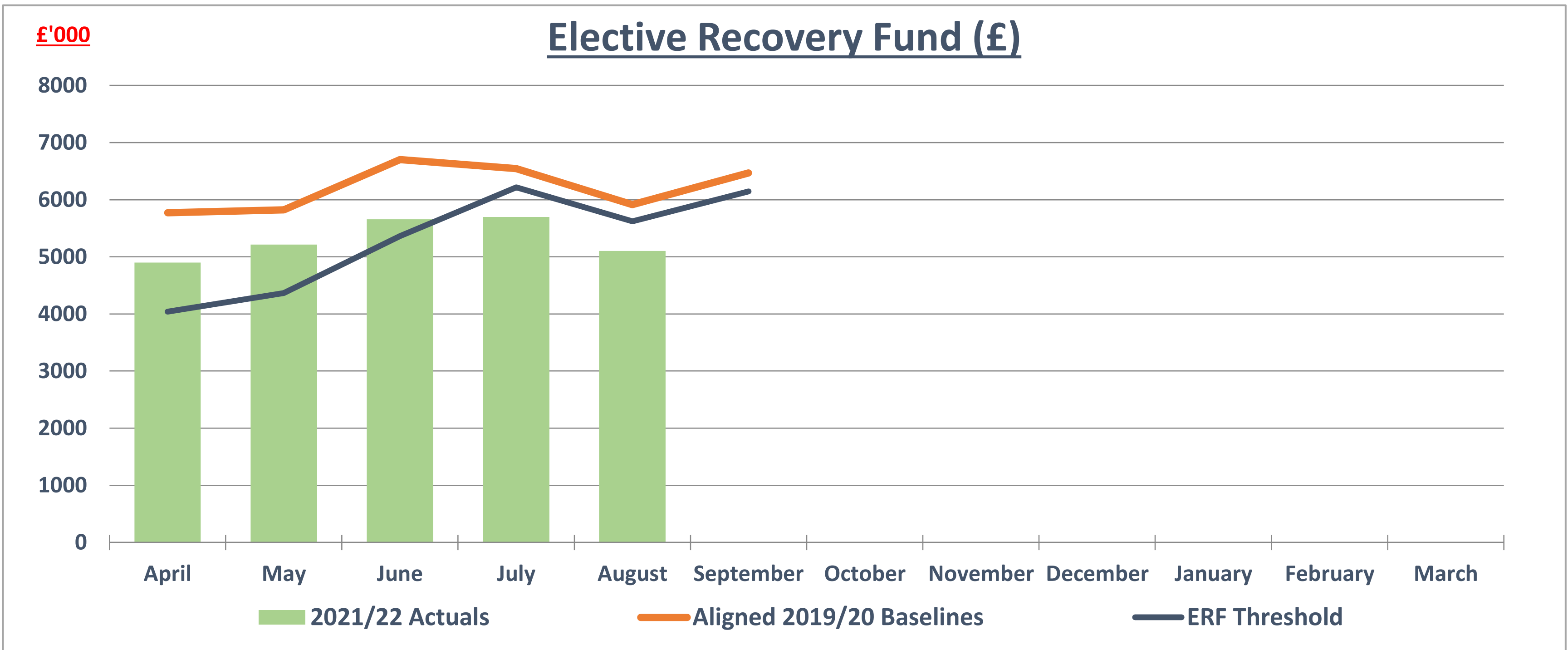


ED attendances reduced slightly in M5 at all three BSW acute Trusts. Attendances levels at RUH and SFT remain broadly in line with 2019/20 levels (6119 versus 6233 in M5 2019/20 at SFT and 7530 versus 7422 in M5 2019/20 at RUH). Attendance levels at GWH were below 2019/20 levels – 9638 in M5 compared to 11897 in M5 2019/20.

ED performance was above the M5 national average of 77% at SFT (78.7%) and GWH (81.4%).

Activity recovery – Elective Recovery Fund

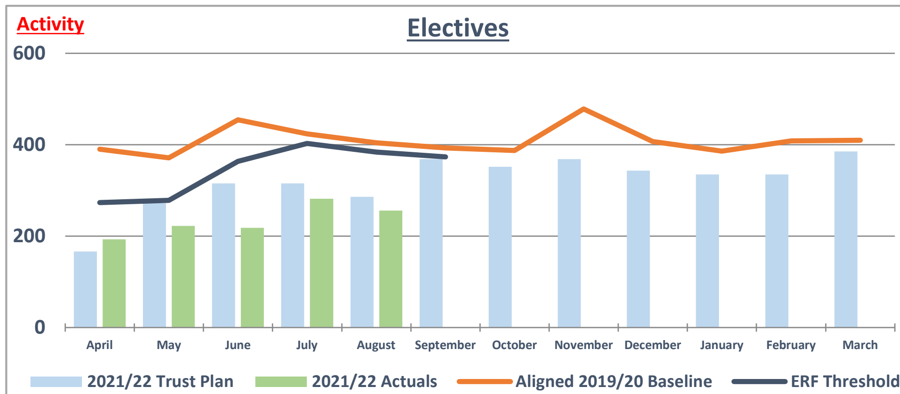
Are We Effective?



The delivery of day cases, electives, outpatient procedures and outpatients was at 86% against the revised threshold of 95% for August. The target is for individual months, therefore whilst no additional funding would be applicable in August, additional funding of circa £2.0m year to date has been achieved under the Elective Recovery mechanism. Income of £623k has been included in the financial position for ERF which matches the costs reported.

Activity recovery – Electives (target 95%)

Are We Effective?



Specialty	2019-20	2021-22	Delivery
Clinical Haematology	2	10	500%
Respiratory Medicine	2	4	200%
Colorectal Surgery	14	24	171%
General Medicine	8	8	100%
Maxillo-Facial Surgery	1	1	100%
Paediatrics	1	1	100%
Oral Surgery	15	13	87%
General Surgery	18	15	83%
Urology	57	38	67%
Trauma & Orthopaedics	77	49	64%
Gastroenterology	7	4	57%
Spinal Surgery Service	16	9	56%
Plastic Surgery	81	45	56%
Ophthalmology	2	1	50%
Gynaecology	22	10	45%
Spinal Injuries	9	4	44%
ENT	29	10	34%
Interventional Radiology	3	1	33%
Paediatric Ear Nose And Throat	4	1	25%
Breast Surgery	17	4	24%
Cardiology	12	0	0%

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

The target levels for Elective activity to meet the Elective Recovery Fund (ERF) threshold in month 5 was 95%. The Trust achieved performance of 67% therefore falling short of the ERF threshold, this was also a slightly lower level of electives than expected in the plan as 256 electives were performed against a plan of 286 resulting in a shortfall of 30 against plan. This was a slight decline from M4 though where the Trust performance was 48%.

Areas of underperformance continue to be Trauma & Orthopaedics, Spinal Surgery and ENT due to high proportions of clinically routine, low priority patients impacting their access to theatre capacity as specialties with higher volumes of clinically urgent patients are being prioritised however the running of a second daily T&O elective list in the week commenced in M3 has significantly improved this with Orthopaedics now achieving 64% and Spinal Surgery 56%. There was also a reduction in performance for both Urology and Plastic Surgery due to their access to theatres continuing to be slightly reduced compared to previous months in order to allow other more complex, routine services to restart and increase their capacity. Due to the complex nature of these services this means that the volume of patients on a list is lower than some of the other specialties due to case mix. High levels of trauma and emergency patients requiring main theatre capacity also impacted elective capacity throughout M5.

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

The Four Eyes productivity and efficiency work focusing on list utilisation and theatre efficiency. Commencement of Operational Theatre Group on 15th September which will focus on maximising efficiency of theatre usage.

Procurement of insourcing model to increase capacity continues however the majority of the capacity this has provided is for daycases.

Risks to delivery and mitigations

Theatre workforce for local lists. High levels of sickness impacted lists in M5 leading to the cancellation of planned elective work. Mitigation is work being undertaken by OD&P and the Division on recruitment and retention although this has been delayed until the end of M6.

Workforce fill and skill mix to allow running of all planned insourcing activity. Work ongoing with Procurement and the Division to ensure this is robust.

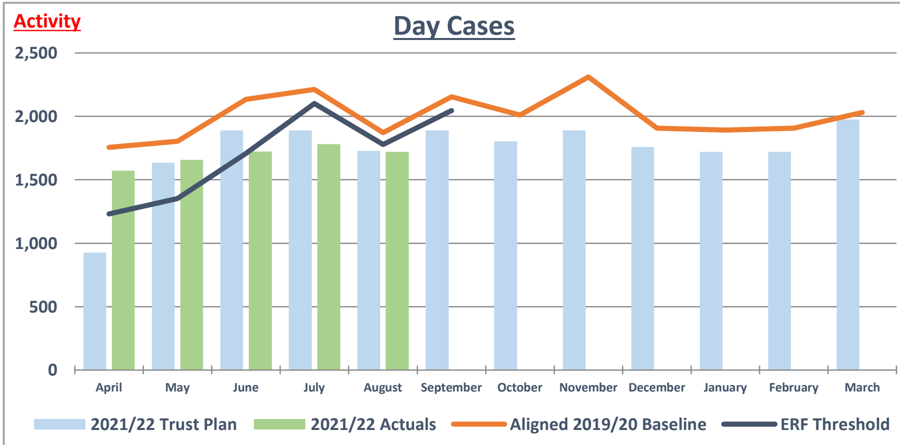
Risk that high levels of emergency and trauma will impact on elective lists.

Continued issues with late starts and slow turnarounds.

Theatre access continues to be allocated by clinical priority, and volumes of patients waiting over 52 week for surgery, resulting in theatre access varying by specialty month to month and the impact of this can be especially seen on specialities with a high proportion of clinically routine, low priority patients.

Activity recovery – Day case (target 95%)

Are We Effective?



Specialty	2019-20	2021-22	Delivery
Paediatrics	1	11	1100%
Spinal Surgery Service	5	15	300%
Urology	94	203	216%
Ophthalmology	107	127	119%
Respiratory Medicine	16	18	113%
Gynaecology	35	39	111%
Gastroenterology	398	415	104%
Plastic Surgery	227	232	102%
Cardiology	81	81	100%
Neurology	15	15	100%
Breast Surgery	16	15	94%
General Surgery	260	225	87%
Oral Surgery	74	53	72%
Trauma & Orthopaedics	51	36	71%
Rheumatology	117	80	68%
Interventional Radiology	22	14	64%
General Medicine	69	33	48%
ENT	44	17	39%
Colorectal Surgery	215	83	39%
Geriatric Medicine	11	3	27%
Dermatology	4	1	25%

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

The target levels for daycase activity to meet the Elective Recovery Fund (ERF) threshold in month 5 was 95%. The Trust achieved performance of 92% but this did not exceed the ERF threshold. This level of daycases is in line with the 21/22 plan though with 1720 performed against a plan of 1729. This was also a significant improvement from M4 where the Trust performance was 81%.

This lower level of activity than plan was impacted by lower levels of weekend high throughput WLI lists being able to be run due to challenges with theatre staffing. Workforce challenges also impacted weekday activity as the plan was for 540 sessions to run in August but due to high staff sickness only 455 ran. Theatre Staff Incentive Payment Scheme uptake very low in August, anecdotally pre-Elective Recovery burnout may be contributing.

Main areas of underperformance were Trauma & Orthopaedics, due to the transfer of their daycase activity to Newhall and ENT and Colorectal Surgery, who have both been impacted by the allocation of theatres based on clinical priority.

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

SFT IPC guidelines have now been updated to fall in line with the process recommended nationally for low risk pathways. This will enable improved utilisation of lists due to the ability to now utilise capacity that comes available due to cancellations within 14 days. However increased cancellations due to COVID and self-isolation made this challenging throughout M5.

The Four Eyes productivity and efficiency work focusing on list utilisation. Commencement of Operational Theatre Group on 15th September which will focus on maximising efficiency of theatre usage. This will be especially beneficial for daycases as these are the lists where the most opportunity for utilisation improvement can be seen.

Procurement of insourcing model to significantly increase capacity continues providing additional capacity focussed on Plastic Surgery, General Surgery and Urology.

Risks to delivery and mitigations

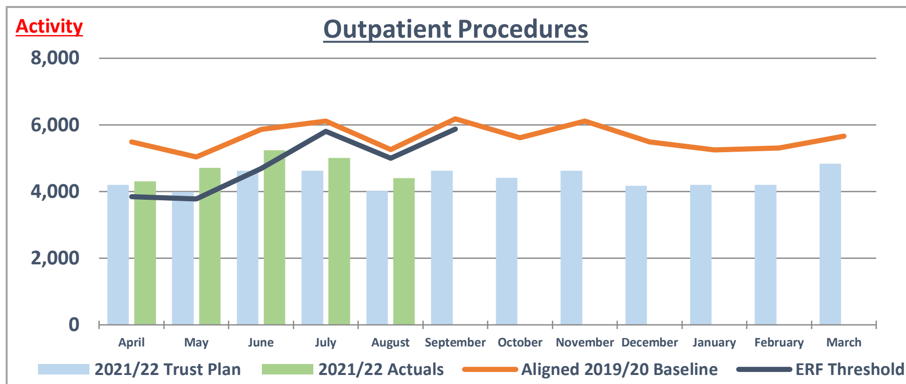
Theatre workforce for local lists. Mitigation is work being undertaken by ODP and the Division on recruitment and retention although this has been delayed until September. Workforce fill and skill mix to allow running of all planned insourcing activity. Work ongoing with Procurement and the Division to ensure this is robust.

Continued issues with late starts and slow turnarounds.

Theatre access continues to be allocated by clinical priority, and volumes of patients waiting over 52 week for surgery, resulting in theatre access varying by specialty month to month and the impact of this can be especially seen on specialities with a high proportion of clinically routine, low priority patients.

Activity recovery – Outpatient Procedures (target 95%)

Are We Effective?



Specialty	2019-20	2021-22	Delivery
Gynaecology	263	695	264%
Clinical Cardiac Physiology	118	229	194%
Gynaecological Oncology	23	40	174%
Breast Surgery	66	86	130%
Oral Surgery	151	184	122%
Respiratory Physiology	60	72	120%
Orthodontics	223	199	89%
Clinical Neurophysiology	197	170	86%
Paediatrics	17	14	82%
Audiology	566	434	77%
Rheumatology	25	19	76%
ENT	340	245	72%
Vascular Surgery	31	22	71%
Plastic Surgery	780	552	71%
Ophthalmology	1,279	884	69%
Urology	228	157	69%
Maxillo-Facial Surgery	12	7	58%
Dermatology	346	170	49%
Colorectal Surgery	19	9	47%
Trauma & Orthopaedics	68	28	41%
Respiratory Medicine	316	122	39%
Optometry	21	5	24%
Paediatric Ear Nose And Throat	31	1	3%
Neonatal care	30	0	0%

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

The target levels for Outpatient Procedure activity to meet the Elective Recovery Fund (ERF) threshold in month 5 was 95% but the Trust fell short of this achieving 84%. However performance was higher than plan with 4402 procedures undertaken against a plan of 4018. This was also a slight improvement when compared to M4 where the Trust performance was 82%.

This lower than pre-COVID activity number has been impacted by the increased numbers of appointments being undertaken virtually, and the space constraints in many outpatient areas, which is why the level of outpatient procedures has reduced compared to 19/20 baseline but exceeding the 20/21 Trust Plan.

Specialties with fewer Covid-19 related and physical space constraints can be seen to have fully recovered more effectively with activity for some being well over 100%.

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

The installation of the air change solution for both the ENT & Oral Surgery outpatient departments has meant that outpatient procedure activity for these specialties, both with high levels of aerosol generating procedures (AGP), is now significantly recovered with ENT now achieving 72% and Oral Surgery 122%.

New peripheral site identified to provide additional capacity for Ophthalmology outpatient procedure clinics. These are due to commence in M6.

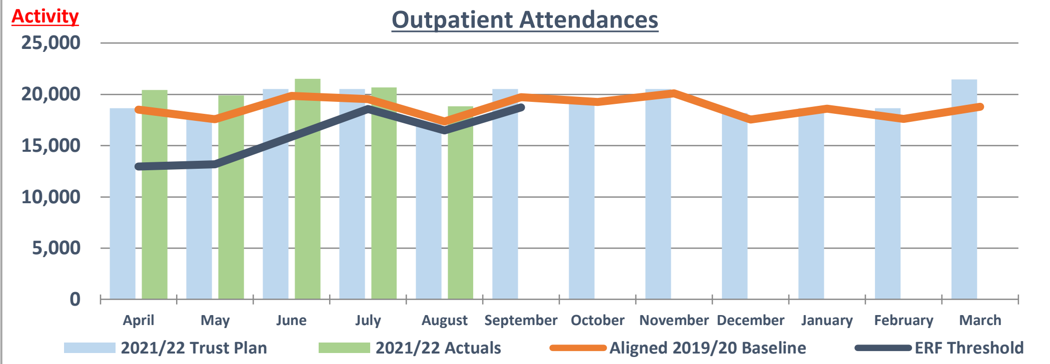
Audiology also experienced significant capacity pressures in M5 due to workforce which have been mitigated and the expectation is recovery in M6.

Risks to delivery and mitigations

Space constraints across outpatient departments continue to be a significant challenge, particularly in specialties. This is particularly impacting Ophthalmology and Respiratory Medicine. Insourcing solution for weekend capacity commenced for Respiratory Medicine who are significantly underperforming due to the impact of AGP procedures and limited space for these.

Activity recovery – Outpatient Attendances (target 95%)

Are We Effective?



Specialty	2019-20	2021-22	Delivery
Respiratory Medicine	344	2,032	591%
Clinical Cardiac Physiology	522	1,154	221%
Clinical Oncology	74	123	166%
Burns Care	113	179	158%
ENT	313	486	155%
Spinal Injuries	108	167	155%
Geriatric Medicine	124	183	148%
Endocrinology	260	349	134%
Dermatology	280	366	131%
Clinical Haematology	391	493	126%
Speech And Language Therapy	311	373	120%
Ophthalmology	1,131	1,343	119%
Anticoagulant Service	135	153	113%
Medical Oncology	432	486	113%
Orthoptics	157	173	110%
Rehabilitation	403	437	108%
Breast Surgery	396	428	108%
Gastroenterology	318	343	108%
Urology	518	533	103%
Colorectal Surgery	526	511	97%
Trauma & Orthopaedics	1,442	1,377	95%
Plastic Surgery	1,465	1,394	95%
General Surgery	334	297	89%
Oral Surgery	474	408	86%
Clinical Physiology	370	316	85%
Rheumatology	849	707	83%
Physiotherapy	304	251	83%
Orthotics	715	582	81%
Gynaecology	376	300	80%
Audiology	537	399	74%
General Medicine	120	88	73%
Cardiology	580	422	73%
Clinical Psychology	127	88	69%
Paediatrics	751	501	67%
Diabetic Medicine	275	165	60%
Vascular Surgery	232	136	59%
Cardiac Rehabilitation	367	214	58%
Spinal Surgery Service	272	106	39%
Hepatology	117	44	38%

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

The target levels for Outpatient activity to meet the Elective Recovery Fund (ERF) threshold in month 5 was 95%. The Trust achieved performance of 108% well exceeding the ERF threshold. This performance was significantly higher than plan with 18,828 attendances against a plan of 17, 237. This was also a slight improvement when compared to M4 where the Trust performance was 106%.

Specialties with fewer Covid-19 related constraints can be seen to have fully recovered with activity for some being well over 100%.

The impact of the increased capacity for Oral Surgery and ENT following the completion of the air handling solution and the opening of the modular build can be seen as there has been an improvement in their performance with Oral Surgery now at 86% and ENT at 155%.

Virtual appointments are working well in a number of specialties with Gastroenterology and Cardiology seeing high numbers of their outpatients virtually.

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

Increased capacity for T&O when the move into their new footprint completed. This move was successfully completed on the 31st August and the impact of this should be seen in M6.

New peripheral site identified to provide additional capacity for Ophthalmology outpatient procedure clinics. These are due to commence in M5.

Insourcing solution for weekend capacity commenced in M5 for Respiratory Medicine.

Risks to delivery and mitigations

Space constraints across outpatient departments continue to be a significant challenge, particularly in specialties with low levels of patients suitable for virtual appointments such as Trauma & Orthopaedics and Spinal Surgery with recovery for these specialties being limited by a lack of access to face-to-face clinical space exacerbated by limited suitability for virtual solutions.

Creep in some specialties back to onsite preferences. Focussed work is being undertaken to improve medium-long virtual models.

Theatre Performance

Theatre KPI's

	Apr 21	May 21	Jun 21	Jul 21	Aug 21	Sept 21	Oct 21	Nov 21	Dec 21	Jan 21	Feb 21	Mar 21
19/20	497	532	501	531	453	522	524	555	476	548	481	364
20/21	239	294	327	317	346	362	379	401	328	248	263	383
21/22 Actual	301	378	379	442	455							
21/22 Plan	252	411	452	456	441	463	451	463	451	435	423	482
21/22 Plan+	252	411	551	560	540	563	554	568	547	541	517	588

Measure - Theatre Performance & Efficiency	Area	Target	Aug 21
% Utilisation	Day Surgery Theatres	90%	79%
	Main Theatres	85%	88%
Turnaround	Day Surgery Theatres	8 mins	16
	Main Theatres	12 mins	27
% short notice Hospital Cancellations (0-3 days)	Total	2%	2.4%
% Short notice Patient Cancellations (0-3 days)	Total	2%	6%

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

Underperformance of elective activity accounts for the theatre activity being lower than plan in M5. This was mainly due to workforce issues in theatres which did not allow the running of as many theatres as anticipated in the plan.

This has been further exacerbated by issues around late starts and high levels of cancellations and high levels of emergency and trauma.

Theatre Staff Incentive Payment Scheme uptake continued to be low in M5, anecdotally pre-Elective Recovery burnout may be contributing.

Increased cancellations due to COVID and self-isolation were also seen throughout M5 which is reflected in the high percentage of patient cancellations.

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

Theatres Recruitment and Retention plan delayed to late September.

SFT IPC guidelines have now been updated to fall in line with the process recommended nationally for low risk pathways. This will enable improved utilisation of lists due to the ability to now backfill capacity that comes available due to cancellations within 14 days.

Procurement of insourcing model to significantly increase capacity continues. This focusses on Plastic Surgery, General Surgery and Urology and will provide opportunity to date increased numbers of long waiting, clinically routine, patients on additional day surgery unit lists and will also allow local teams to be utilised in main theatres to increase the number we are able to run therefore increasing elective capacity as well.

Plans to continue to run high volume, low complexity lists both in the week for a number of specialties and as WLI weekend lists for Plastic Surgery although workforce challenges are impacting the ability to do this currently.

The Four Eyes productivity and efficiency work focusing on list utilisation will drive forward the realisation of opportunity on lists especially in the Day Surgery Unit.

Commencement of Operational Theatre Group in M6 which will focus on utilisations, late starts, improved turnaround time and other operational issues that impact the optimisation of theatre usage with specialty level dashboards.

Education in Theatres going well, 5 WTE scrubs now training full time – 3 as ODPs and 2 as SFAs (medium term plan for Theatres).

Risks to delivery and mitigations

Theatre workforce for local lists. Mitigation work being undertaken by ODP and the Division on recruitment and retention.

Workforce fill and skill mix to allow running of all planned insourcing activity. Work ongoing with Procurement and the Division to ensure this is robust.

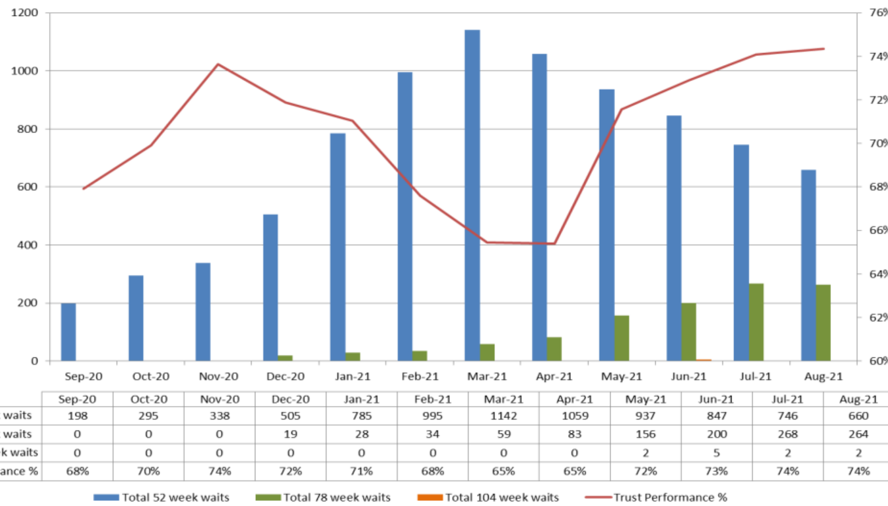
Risk that high levels of emergency and trauma will put elective lists at risk.

Continued issues with late starts and slow turnarounds. Commencement of Operational Theatre Group on 15th September which will focus on maximising efficiency of theatre usage.

Theatre access continues to be allocated by clinical priority and need resulting in theatre access varying by specialty month to month and the impact of this can be especially seen on specialities with a high proportion of clinically routine, low priority patients.

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

National Key Performance Indicators



	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21
Total 52 week waits	198	295	338	505	785	995	1142	1059	937	847	746	660
Total 78 week waits	0	0	0	19	28	34	59	83	156	200	268	264
Total 104 week waits	0	0	0	0	0	0	0	0	2	5	2	2
Trust Performance %	68%	70%	74%	72%	71%	68%	65%	65%	72%	73%	74%	74%

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

Treatment function	Dec-20	Jan-21	Feb-21	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21	% change from
Plastic Surgery	74	107	132	148	139	145	140	133	130	-2%
Ophthalmology	115	202	238	253	203	158	120	92	92	0%
Trauma and Orthopaedic	44	71	104	134	130	114	99	85	74	-13%
Oral Surgery	61	97	117	135	146	102	87	76	63	-17%
Urology	49	65	84	96	89	94	88	78	52	-33%

Longest Waiting patient (Weeks)	Apr-21	May-21	Jun-21	Jul-21	Aug-21
	101	106	110	108	112

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

The number of patients waiting longer than 52 weeks has decreased by 86 patients to a total of 660, exceeding the trajectory position of 740. The trajectory for reducing over 52 week patients is a reduction of 80 patients per month to a total of 660 in September 2021.

Approximately 10% are patients who have requested to pause their pathway, although this increases to 17% when looking at the cohort of patients whose wait time has exceeded 78 weeks. Approximately 20% of patients waiting longer than 52 weeks are waiting at the non-admitted stage of their pathway and 80% are waiting on an admitted pathway.

Of the patients waiting on an outpatient pathway, most are in Ophthalmology. Of the patients waiting on an admitted pathway the specialty split is more broad with the highest being in Plastic Surgery, followed by Urology, Orthopaedics and Oral Surgery with these specialties making up over 60% of those waiting over 52 weeks on an admitted pathway.

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

Transfer of Plastic Surgery patients waiting for hand surgery to Sulis Bath to commence in M5 and the extension of this to further specialties is planned.

Additional Saturday high volume lists at SFT for Plastic Surgery continue to run to further address this cohort. Further BSW WLI weekend lists planned for M6 has been delayed until M7 but will provide additional capacity for paediatric ENT and Oral Surgery.

Continued transfer of Orthopaedic patients to Newhall and continued outsourcing of cataract patients for surgery and outpatient appointments to two additional providers will work to reduce these further.

Additionally the insourcing theatre model will continue to provide increases in capacity to tackle this cohort of long waiting patients as will the increase of routine elective orthopaedic lists at SFT from M4 that this facilitates.

New peripheral site identified to provide additional capacity for Ophthalmology outpatient procedure clinics. These are now due to commence in M6.

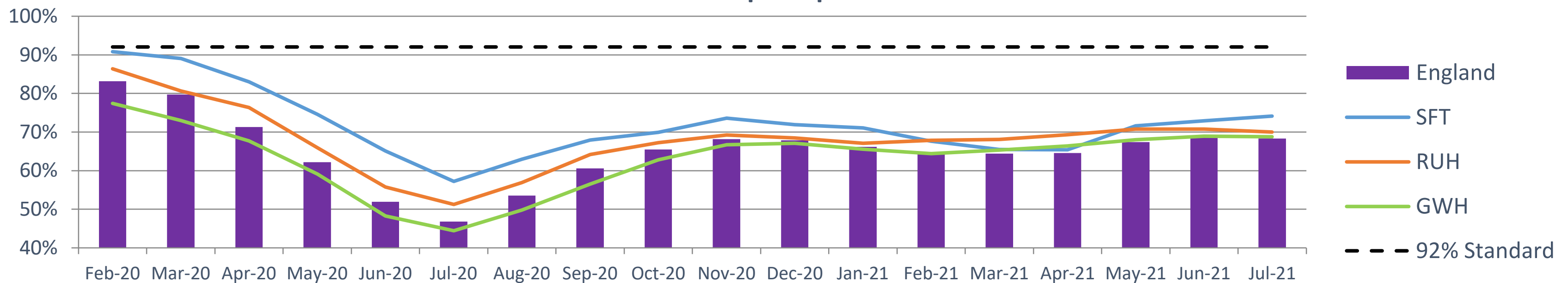
Risks to delivery and mitigations

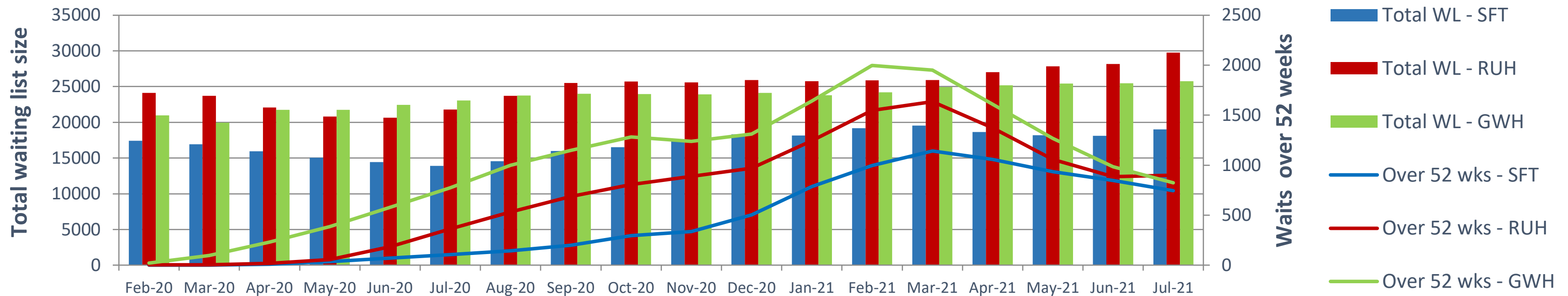
Impact of risks affecting delivery of electives, daycases and outpatient attendances and procedures especially space constraints across outpatient departments which continue to be a significant challenge. There have been specific challenges to increasing activity in Ophthalmology in relation to the ability to socially distance, outpatient capacity and the proportion of vulnerable patients in this group.

Theatre workforce challenges impacting capacity on local and insource lists are also a significant risk.

BSW Context – Referral To Treatment (RTT)

Are We Effective?





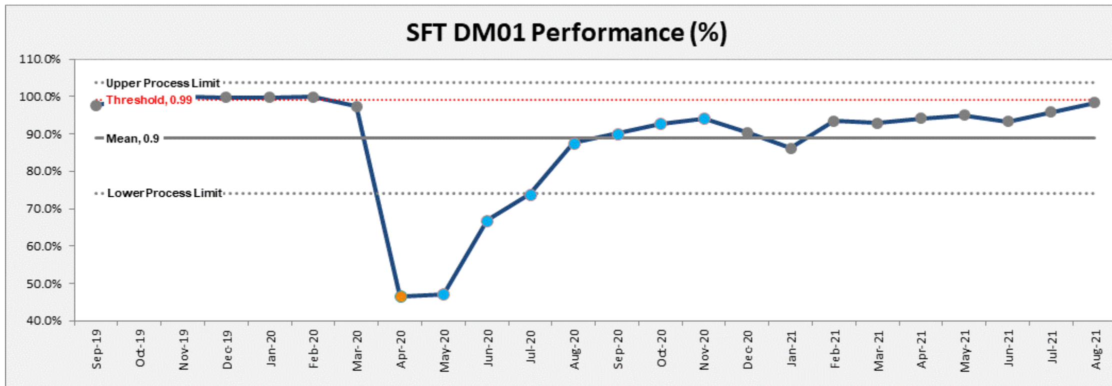
Total waiting list size increased for the sixth consecutive month at RUH and GWH, and for the first month increased at SFT (18102 in M3 to 19000 in M4) at SFT. Nationally the total waiting list size increased from 5.45 million to 5.61 million, with 5.2% of patients on the waiting list waiting over 52 weeks.

The number of patients waiting over 52 weeks reduced at SFT from 846 in M3 to 745 in M4, and at GWH from 984 in M3 to 823 in M4. At RUH the number of patients waiting over 52 weeks increased slightly from 885 in M3 to 901 in M4.

Performance against the RTT standard remained broadly static at RUH and GWH, but increased slightly from 72.9% to 74.1%. All three Trusts remained slightly ahead of the national position of 68.3%.

Diagnostic Wait Times (DM01) Target 99%

National Key Performance Indicators



Data Quality Rating:

Performance Latest Month: 98.39%

Waiting List Volume: 3283

6 Week Breaches: 53

Diagnostics Performed: 7208

Modality performance

MRI	99.4%	US	99.8%	Audio	81.9%	Neuro	100.0%	Flexi sig	100.0%
CT	100.0%	DEXA	100.0%	Cardio	95.8%	Colon	100.0%	Gastro	100.0%

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

DM01 performance continued to improved in M5 increasing from 95.77% in M4 to 98.39% in M5. The performance standard has not been fully achieved primarily due to a remaining issue in Audiology capacity (although Audiology performance has improved from 79.6% in the previous month).

Previous issues in Cardiology (Echo) and USS have been resolved with reduction in breaches from 57 to 13 and 49 to 2 respectively.

There were a small number of breaches in MRI affecting 3 patients in total and this was due to the sub specialty nature of the test required. There were no breaches within Endoscopy.

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

For USS and Echo to sustain performance, overtime will continue throughout M6 to ensure sufficient capacity. Both are expected to achieve 99% in M6.

Audiology: Capacity and overall performance against the 99% standard should continue to increase in M6 with improvements in utilisation within the rota of clinics being made.

Endoscopy: It is possible that breaches could occur in month due to the nature of demand on GA lists but it is not anticipated to be a significant issue.

Risks to delivery and mitigations

Increase in referral rate could result in capacity deficits in USS and/or MRI. This would be managed with in house over time in the first instance.

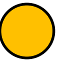
Increasing demand in some of the 2WW pathways (particularly GI) may cause for these referrals to be prioritised over routine referrals (preserving the 2WW standard but impacting the DM01). This is closely monitored through weekly activity meeting.

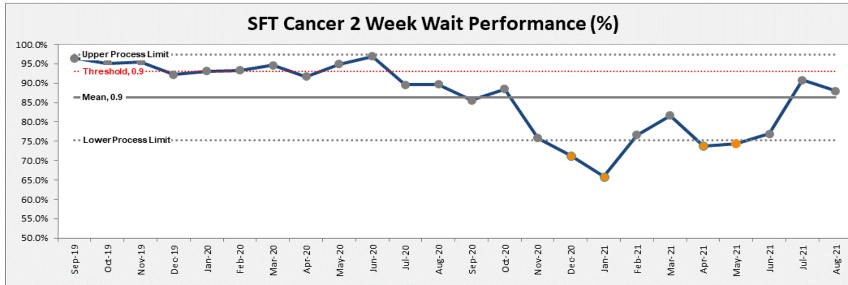
Statistical Process Control Chart Key:
- Target (red dashed line)
- Mean (solid line)
- Upper / Lower Process Control Limits (UPL/LPL) (dotted line)
- Special Cause Variation Improvement (6 or more points better than the mean, or a single point outside the control limit)
- Special Cause Variation Concern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

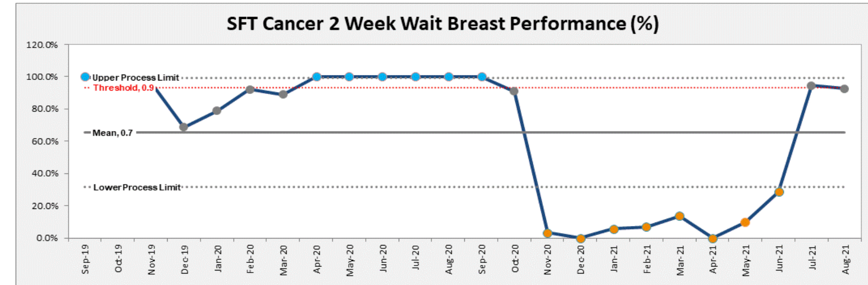
Cancer 2 Week Wait Performance Target 93%

National Key Performance Indicators

Performance Latest Month	Performance	Num/Den	Breaches
Two Week Wait Standard:	88%	880/1000	120 (63 patient choice)
Two Week Wait Breast Symptomatic Standard:	88.89%	24/27	3 (2 patient choice)

Data Quality Rating: 





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

Two week wait standard not achieved for Month 5, with month end validated performance of 88% (1000 patients seen; 880 in target; 120 breaches. Breach reasons associated with:

- Patient choice: 63 breaches
- Endoscopy capacity: 24 breaches
- Incomplete GP referrals: 13 breaches
- Administrative delays: 1 1 breaches
- OPA capacity: 4 breaches
- Clinical delays: 3 breaches
- Radiology capacity: 2 breaches

Breast symptomatic two week wait standard not achieved in Month 5 (27 patients seen; 24 in target; 3 breaches), with validated month end performance of 88.89%. Two breaches were as a result of patient choice and the other associated with a booking delay.

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

Breast one stop clinic capacity: Breach reasons predominantly associated with patient choice as opposed to capacity. Capacity to remain under review in light of recent celebrity death and upcoming breast cancer awareness month.

Patient choice delays: Incremental increase in patient choice 2ww breaches on a monthly basis. Revised comms has been shared with primary care to ensure patients are willing and able to attend hospital at the point of referral. Issue raised with BSW CCG to look at potential opportunities and solutions.

Endoscopy capacity: Reduction in capacity from July associated with staff sickness, annual leave and a spike in self-isolation which affected the service's ability to provide nursing cover for lists. Additional GA endoscopy lists in place from August onwards to help work through backlog. GI unit continues to push for an additional endoscopy room as per the national adapt and adopt priorities.

Risks to delivery and mitigations

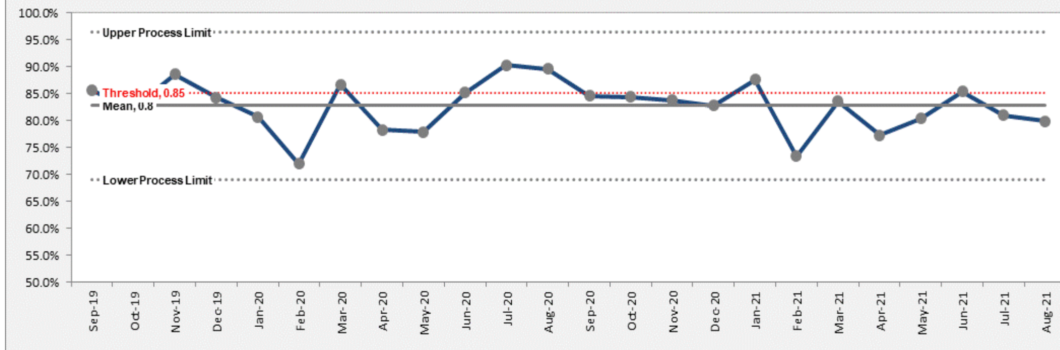
Impact of COVID-19: Risk associated with potential increase in referrals as a result of the 'COVID-19 backlog' (patients who chose not to present to their GP during the pandemic, who may present at a later date). Referral rates have remained consistently high across all tumour sites since March 2021 and are comparatively higher when compared with our BSW counterparts.

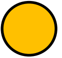
Patient choice: Incremental increase in patient choice 2ww breaches on a monthly basis. Delays associated with a variety of reasons including holidays, child care issues and self-isolation.

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

Cancer 62 Day Standards Performance Target 85%

National Key Performance Indicators



Data Quality Rating: 

March 21	Performance	Num/Den
62 Day Standard:	79.49%*	46.5/58.5
62 Day Screening:	62.50%	2.5/4

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

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

Month 5 62 day performance standard not achieved, with validated month end performance of 79.49% (58.5 patients treated in total; 46.5 within target; 12 breaches). Breach reasons summarised below:

- Breast: 1 breach (combination of patient choice delays and complex diagnostic pathway)
- Colorectal: 2 breaches (complex diagnostic pathways and lack of theatre capacity)
- Gynaecology: 1 breach (complex diagnostic pathway)
- Haematology: 2 breaches (both as a result of delayed transfers from other tumour sites, as well as outsourced histology reporting turnaround times and access to interventional radiology)
- Skin: 3 breaches (combination of patient choice delays as delayed reporting of outsourced histology reporting post incisional biopsy)
- Urology: 2 breaches (complex diagnostic pathways and delays in diagnostic reporting, both outsourced histology reporting and radiology reporting)

62 day screening standard not achieved for Month 5, with validated month end performance of 62.50% (4 patients treated in total; 2.5 within target; 1.5 breaches). Breaches associated with BCSP capacity, patient choice delays and complex diagnostic pathways.

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

Patient choice: Services continue to see patient choice delays throughout pathways, both at the point of diagnostics or treatment. Individualised input to each patient to help establish and address any concerns. Patient focus group established to receive feedback from service users to identify good practice and learning; first meeting held in July 2021 and will be rolled out across the year. Tumour site feedback mechanism is currently being piloted within skin cancer services in the hope that this can be replicated across all tumour sites.

Urology cancer pathways: Cancer Pathway Navigator in post from September 2021; this post will predominantly provide additional support to bladder and haematuria patients and hep to shorten diagnostic and treatment waiting times.

Access to PET CT: Service is provided by Alliance Medical. Capacity issues raised via Clinical Lead directly to provider, as well as through the SWAG cancer alliance and BSW ICS for resolution. Capacity has the potential to adversely affect pathways across all tumour sites and will hinder SFT's ability to deliver the nationally recommended optimum timed diagnostic pathways.

Outsourced histology reporting: Increased waiting times for histology reporting when outsourced; this is particularly affecting the prostate cancer pathway and skin services. Raised with CSFS via Cancer Action Group and weekly list of outstanding cases raised with division directly.

Risks to delivery and mitigations

Impact of COVID-19 and patient complexity: Risk associated with delayed presentation as a result of the COVID-19 pandemic. This may result in some patients being diagnosed with more advanced stages of cancer and multiple co-morbidities. Ongoing focus from BSW ICS and national campaigns to encourage patients to present to their GP with any concerns.

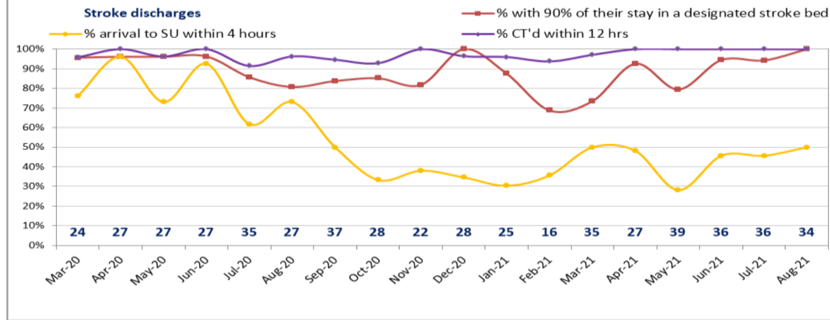
Patient choice: Services continue to see patient choice delays throughout pathways both at the point of diagnostics or treatment. Individualised input to each patient to help establish and address any concerns.

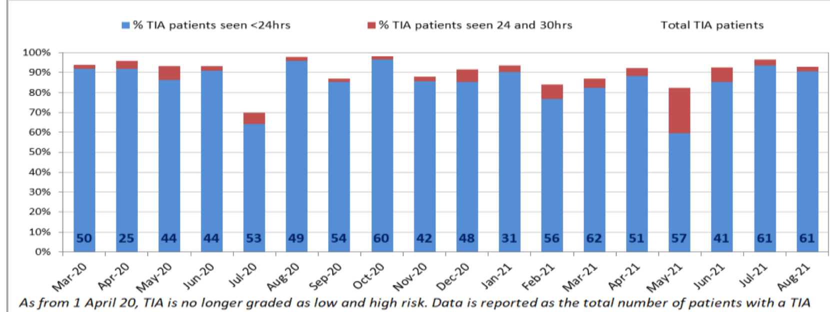
Accessibility to diagnostics and theatres as a result of routine backlog: Cancer patients have continued to be prioritised during the COVID-19 pandemic. There is a risk however that access to treatment is affected due to reduced capacity as the routine backlog is managed. Any delays are escalated promptly as per the cancer escalation policy.

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

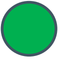
Stroke & TIA Pathways

Are We Effective?





As from 1 April 20, TIA is no longer graded as low and high risk. Data is reported as the total number of patients with a TIA

Data Quality Rating: 

% Arrival on SU <4 hours: 50.0%

% CT'd < 12 hours: 100%

% TIA Seen < 24 hours: 90.7%

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

- The number of patients reaching the stroke unit within 4 hours improved slightly to 50% with 4 waiting bed, 2 waiting 1st Doc, 1 waiting specialist Doc, 1 waiting senior review, 1 late referral to specialty, 1 workload/capacity.
- 30% of patients had a CT within an hour which was below the national target of 50%
- 90% of stay in the stroke unit was 100% in August
- There were 20 stroke discharges this month.
- There were 2 stroke deaths in August– with 7 and 30 day mortality below the national targets.
- The average stroke Unit length of stay was 8.6 and Average Total length was 8.8.
- A single patient discharged this month had been thrombolysed with a door to needle time of 57 minutes.
- 8 of the eligible 16 patients were referred to ESD in August.
- TIA's performance was 90.7% with 2 patients affected by a weekend system error and 2 nonstandard referrals.

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

A decline in stroke data and TIA performance has been seen during the global pandemic and has been under ongoing review at departmental and divisional level. The stroke service was moved from its base during this period, with the loss of direct admission to the unit and an emphasis on discharge over rehabilitation once deemed medically fit. The stroke service has now returned to the Farley ward base with Farley 'right' still utilised for respiratory care unit.

As part of the Trusts efforts to improve patient flow from the emergency department in September, a ring fenced direct admission bed has been identified on the stroke unit that should see improvements in the % patients admitted to the unit within four hours.

The business case for the stroke ANP role is currently being finalised and is due to be submitted to the TIG (October 2021). A band 7 senior sister has been appointed who will be helping to progress this further. This is in addition to the appointment of a locum consultant who started in July.

Risks to delivery and mitigations

To mitigate the loss of the assessment room and trolley on the right side of Farley, an assessment room and trolley has been made available on the left side of Farley (acute side). This should facilitate an improvement with direct admission to the stroke unit.

Stroke nursing remains stretched over three clinical areas; Farley left (acute stroke unit), Breamore ward (Rehabilitation stroke unit) and Farley right (Respiratory care unit). Each shift a senior stroke nurse on the stroke unit is designated the role of stroke liaison for rapid assessment of patients identified in ED for transfer to stroke. This role ensures front door stroke standards are maintained and ensures timely transfer to the stroke unit. With COVID pressures and being stretched over three clinical areas, this nurse rarely is able to function in this role as the numbers remaining on the ward would be too few. The newly appointed senior sister will therefore be looking at this factor.

There is still an unfilled vacancy for the third consultant stroke physician, currently advertised nationally. There have been long periods without a locum consultant which has impacted service delivery when one of the two stroke consultant is away. This has been partially mitigated by reducing daily TIA clinic to one session rather than two, although it is felt that the number of consultants required will still need to be expanded in order to sustain a seven-day service.

NHS
Salisbury
NHS Foundation Trust

Part 2: Our Care

Our Priorities	How We Measure	
Local Services	Are We Effective?	Are We Responsive?
Specialist Services		
Innovation		
Care	**Are We Safe?**	**Are We Caring?**
People	Are We Well Led?	Use of Resources
Resources		

Maternity Dashboard

Data Quality Rating:

Are We Safe?

		Aug 20	Sep 20	Oct 20	Nov 20	Dec 20	Jan 21	Feb 21	Mar21	Apr21	May21	Jun 21	Jul 21	Aug 21
Denominator	Number of live births	167	184	207	192	182	168	159	165	186	158	182	191	220
Still Birth	Number	0	1	0	0	4	0	0	0	1	0	1	0	0
Babies requiring cooling	Number	0	1	0	1	0	0	0	0	1	0	0	0	0
Maternal Mortality	Number	0	0	0	0	0	0	0	0	0	0	0	0	0
Neonatal deaths within 28 days Born at Trust	Number	0	0	0	1	0	0	0	2	0	0	1	0	0
Pre Term Birth Rates (24+0 – 27+0)	Number	0	0	0	0	2	0	0	0	0	2	0	0	1
Continuity of Carer	Number of women	28	16	24	19	21	19	17	34	5	11	7	6	9
	% of women with continuity	16.9%	8.7%	11.5%	9.7%	11.7%	11.1%	10.8%	19.3%	2.7%	7.0%	3.7%	3.%	4%

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

- In August there were no stillbirth's, maternal deaths or neonatal deaths within 28 days of birth
- 0 term babies required transfer for cooling in August
- 1 baby born at 26+4 weeks presented in labour, mother septic, unable to transfer as clinically unstable. Transferred ex-utero
- 9 women were booked on a continuity of carer pathway. (Continuity % is against all births not just live births)

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

- Continuity of carer action plan – also CQC Should do action – for completion by 30/11/21. Unable to complete at present due to high clinical pressures and acuity
- External review of all cases that meet the PMRT criteria underway – Bereavement lead in post

Risks to delivery and mitigations:

- Twice weekly case review meetings for all cases where harm has been caused or that trigger a review using agreed trigger list within the service
- If SII commissioned external reviewer present on every panel (100% of cases)
- Continue to monitor and track progress through our dashboard at Maternity Risk monthly
- Risk of not achieving 35% continuity of carer within service - action plan to be written

Saving Babies' Lives Care Bundle v2

Are We Safe?

Data Quality Rating:

Saving Babies Lives Care Bundle v2			
Last regional survey: April 21	Have any responses changed since last survey?	Are you meeting all requirements of the bundle	Are you carrying out any improvement activity?
Element 1: Reducing smoking in pregnancy	Yes	Yes	Yes
Element 2: Identification and surveillance of pregnancies with fetal growth restriction	Yes	No	Yes
Element 3: Reduced fetal movement (RFM)	Yes	Yes	No
Element 4: Effective fetal monitoring during labour	Yes	Yes	No
Element 5: Reducing preterm births	Yes	No	Yes

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

- SBLCBv.2 is a care bundle that brings together 5 elements of care to reduce perinatal mortality. Completion of quarterly surveys detailing compliance and change in practice at trust level (last completed April 2021). Within each element above there is criteria that determines compliance. Compliance of SVBLCBv.2 reported through NHSR Maternity Incentive Scheme annually

Element 1- Fully compliant

Element 2- Non compliant with 1 requirements

Element 3- Fully Compliant

Element 4- Fully Compliant

Element 5- Non compliant with 2 requirements

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

- Element 2 Uterine Artery Doppler scans for High risk women by 24 weeks. Additional Sonography hours approved with business case. Antenatal transformation work ongoing to support development of pathway – includes changes to Antenatal clinic set-up's, offering more flexibility across the week for high risk women
- Element 5 – Preterm birth guideline to be approved and Non compliant with recording of antenatal corticosteroids on Maternity Information system – Digital Lead (when appointed/seconded) to action by Q4 21/22. Preterm Birth guideline to be ratified at maternity governance in October 2021

Risks to delivery and mitigations:

- Non compliance to all elements of care bundle therefore unable to demonstrate full compliance with Safety Action 6 for CNST maternity incentive scheme at present
- Element 2 mitigation in place compliant with trust guidance, review of all cases of FGR by Fetal surveillance Lead Midwife and Lead Obstetrician reviews all unexpected FGR cases and babies born less than 3rd centile
- Element 5 Unable to recruit Digital Midwife, DMT to appoint an Associate CNIO role to support maternity for 2 years, this will enable progression of digital work supporting SVBLv.2

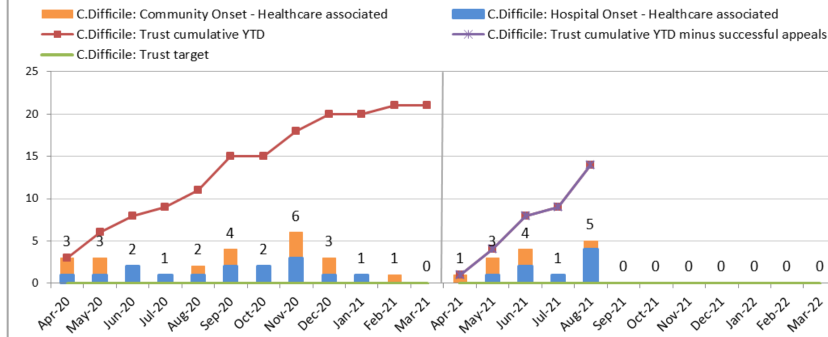
Infection Control

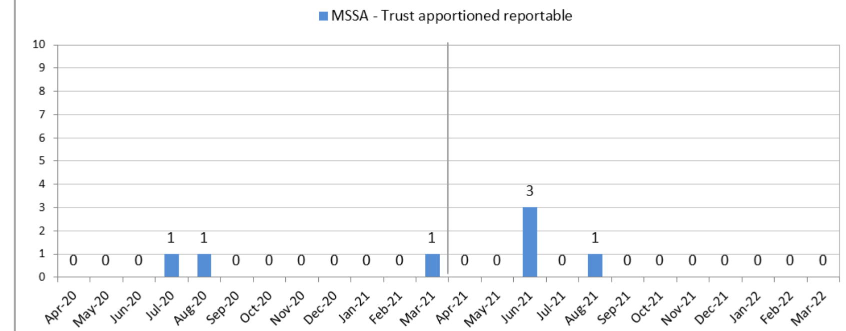
Data Quality Rating:

Are We Safe?

Clostridium Difficile	Nov 20	Dec 20	Jan 21	Feb 21	Mar 21	Apr 21	May 21	Jun 21	Jul 21	Aug 21
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



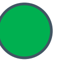


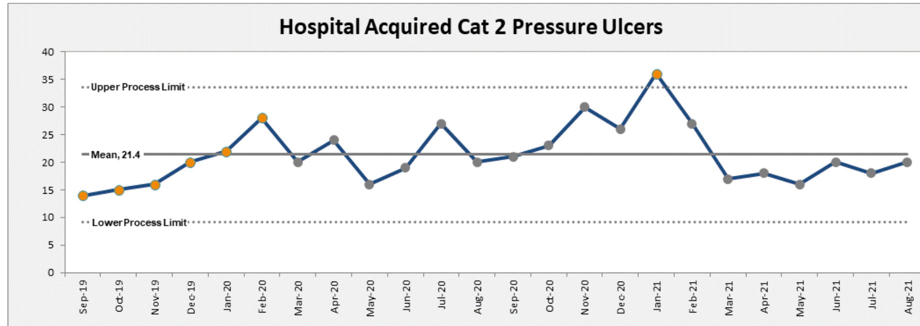
Summary and Action

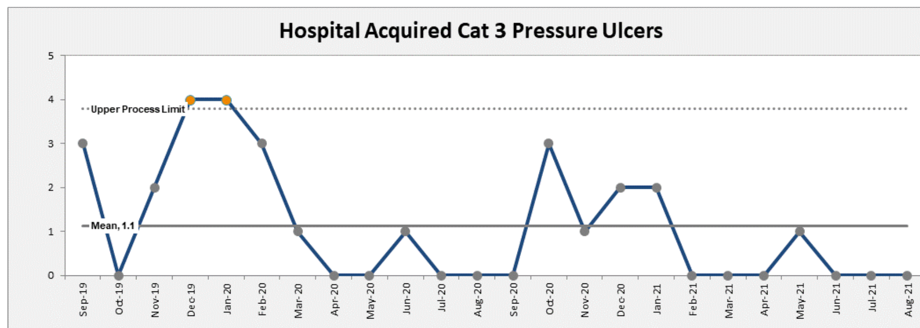
- **C. difficile –** 4 hospital onset healthcare associated case reportable to PHE. All unrelated cases:
  - Longford Ward – Lapses in care identified, non-compliance with established Trust policies, in relation to the assessment and management of the symptomatic patient and identified contacts. A review meeting with the ICNs is planned to agree actions from identified learning
  - Farley Ward – Lapse in care identified, with a delay in medical review of patient and request for stool sample. This has been escalated and identified as an action for the speciality team by the Senior Ward Sister
  - Radnor Ward – Awaiting the final outcomes of the review for this case from the division. The patient had been nursed on several wards in the surgical division, and the Interim Head of Nursing is coordinating the required investigation
  - Spire Ward – Lapse in care identified, with several missed opportunities to collect a stool sample after the medical review requested a stool sample was sent (the patient was already being isolation nursed in a sideroom facility as known to have another alert organism). This has been identified as an action for the ward team by the Senior Ward Sister
  - No C.difficile cases have been identified for appeal
  - In relation to a trajectory figure being set for C.difficile, the NHS Standard Contract 2021/22 document from July 2021 is going to the Infection Prevention & Control Working Group for discussion next week
- **MRSA bacteraemia –** no hospital onset cases have been recorded (also no community onset cases)
- **MSSA bacteraemia –** 1 hospital onset case for an inpatient on Tisbury CCU with source determined as endocarditis
- **E.coli bacteraemia –** 1 hospital onset case for an inpatient on Radnor Ward with source determined as unknown

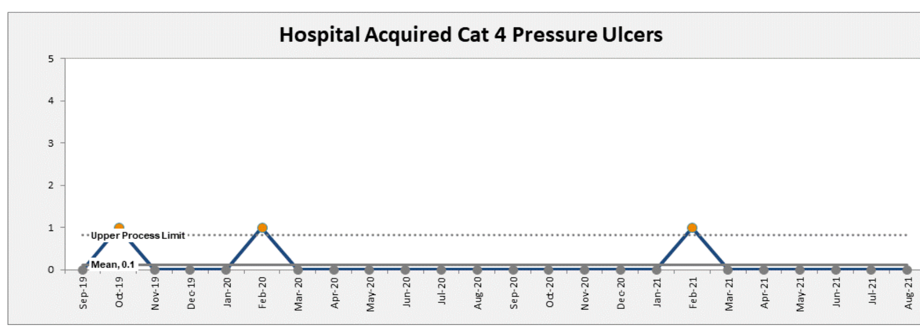
Pressure Ulcers

Are We Safe?

Data Quality Rating: 







Per 1000 Bed Days	2020-21 Q2	2020-21 Q3	2020-21 Q4	2021-22 Q1	2021-22 Q2
Pressure Ulcers	1.92	2.10	2.21	1.47	1.48

Summary and Action

Category 2 pressure ulcers increased to 20 in August from 19 in July. This is a small increase but there is an overall decrease of 10.3% compared to the figures from August 2020. There is no clear theme to identify causes.

No hospital acquired category 3 or 4 pressure ulcers have been identified for August.

Deep Tissue Injury and Unstageable pressure ulcers have decreased in August (4 DTIs in August compared with 7 in July and 2 unstageable in August compared with 3 in July). These were attributed across both divisions. The DTI's were on heels (2 patients) and buttock (2 patients). Advice given regarding heel pressure relief when elevating feet. Both buttock DTI patients were acutely unwell and discussions were had regarding these patients and balancing regular PAC with comfort based care within the End of Life Care pathway.

Actions

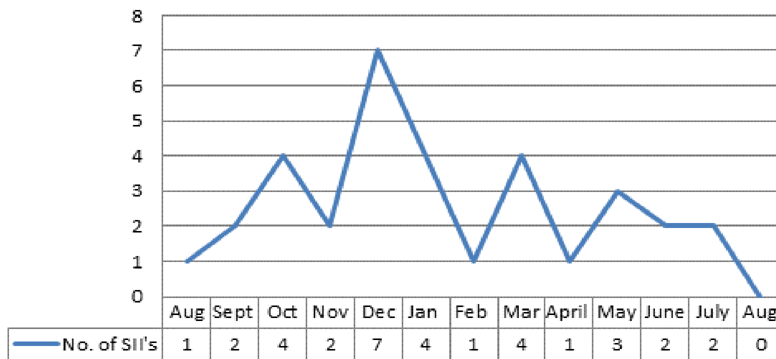
Exploring the option of tissue viability education becoming mandatory for all staff.

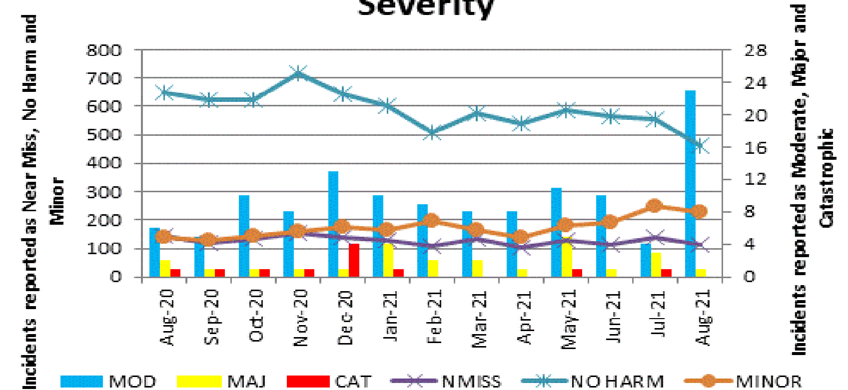
Statistical Process Control Chart Key:
- Target
- Mean
- Upper / Lower Process Control Limits (UPL/LPL)
- Special Cause Variation Improvement (6 or more points better than the mean, or a single point outside the control limit)
- Special Cause Variation Concern (6 or more points worse than the mean, or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

Incidents

Are We Safe?

Year	2020-21	2021-22
Never Events	0	0



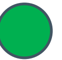


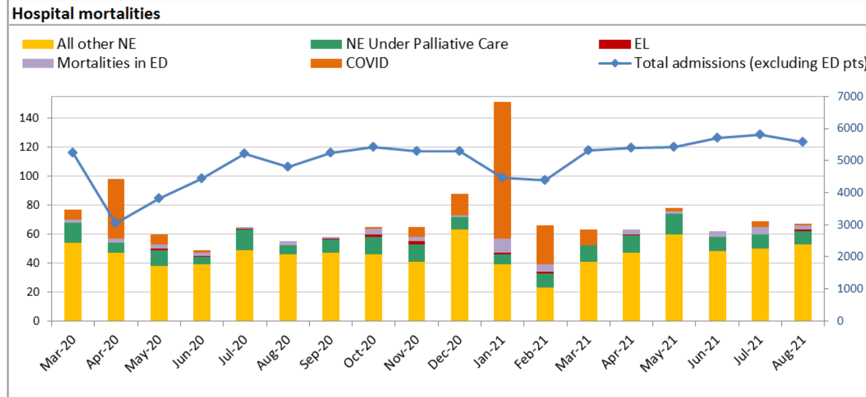
Summary and Action

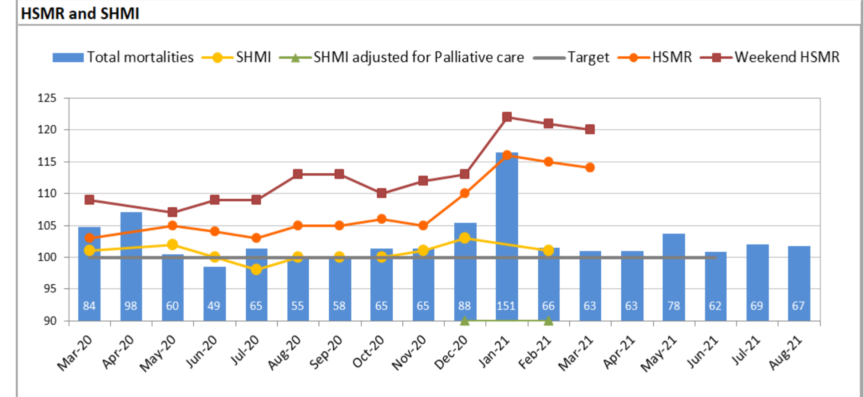
- There were no Serious Incident Investigations commissioned in August
- There was a significant increase in moderate incidents in August. Of the 23 reported as moderate harm, 4 were commissioned as Clinical Reviews which follow the same investigation process as Serious Incidents, but are not reported externally to the CCG

Mortality Indicators

Are We Safe?

Data Quality Rating: 





Summary and Action

1 death was reported in August due to Covid-19.

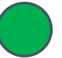
HSMR for March reduced as expected, due to the reduction in the crude mortality rate. The mortality rate appears to be returning to baseline following the COVID second wave.

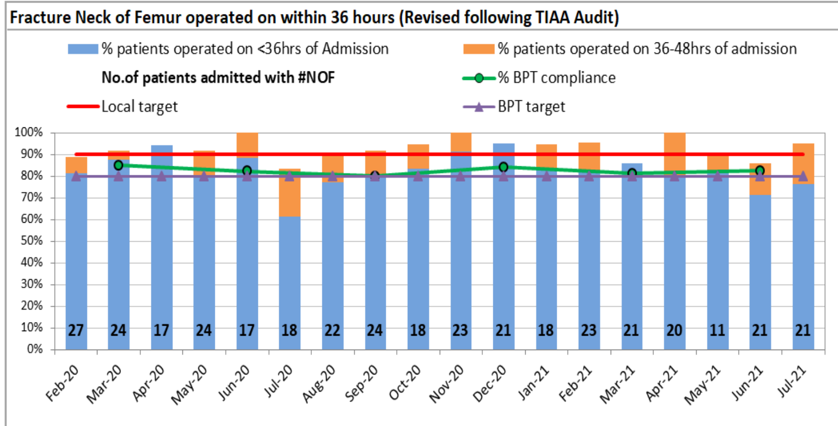
Reporting of mortality indices (SHMI HMSR) through our external partner (Telstra health UK) has been delayed due to data migration issues at Telstra Health. The Chief Medical Officer and the mortality surveillance group have received assurances that the issue will be resolved as quickly as possible and that there is no indication that the trust is an outlier for mortality compared to national or peer data. Separately reported data from NHS digital shows SHMI for the latest period (April 2020 to March 2021) is 1.03 for the Salisbury site and 0.98 (excluding hospice admissions).

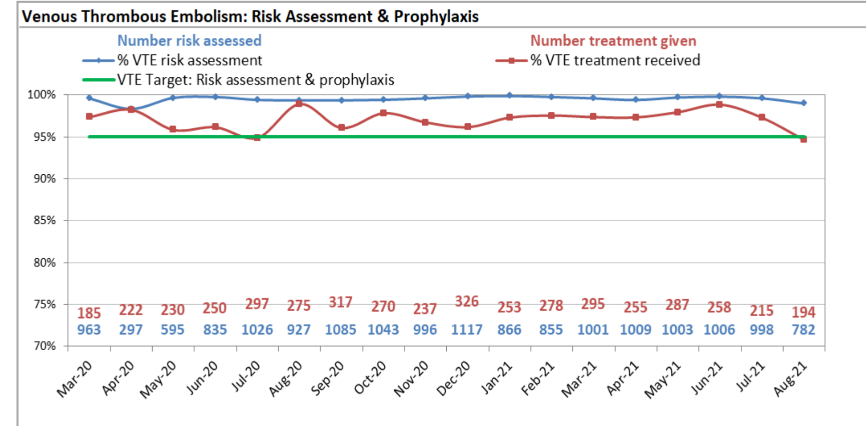
Fracture Neck of Femur & VTE Risk Assessment/Prophylaxis

Are We Safe?

Data Quality Rating:







(Please note: due to the time it takes to complete clinical coding, the fracture neck of femur data for August is not shown on the graph above).

Summary and Action

- 27 patients received their operation within 36 hours of admission in August
- 9 failed to meet Best Practice Tariff (BPT) - Total Aug 2021 BPT: 66.67%

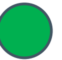
Of the 9 who did not meet BPT:

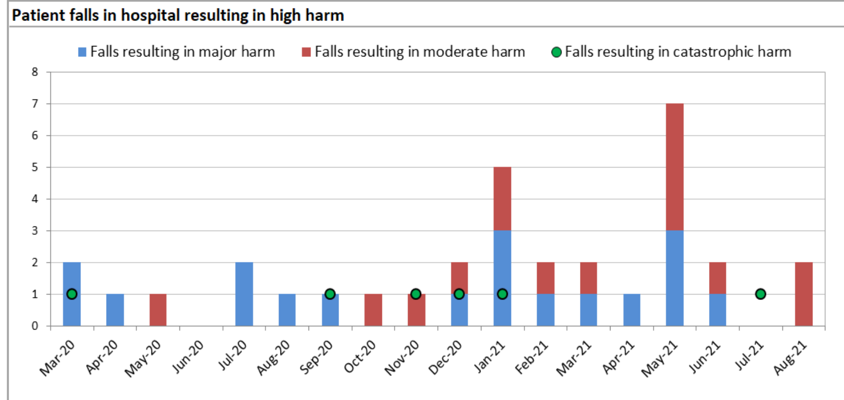
- 7 were awaiting a slot on the theatre list
- 1 patient was medically unfit, requiring treatment for Heart failure
- 1 was awaiting an investigation – CT needed to confirm fracture

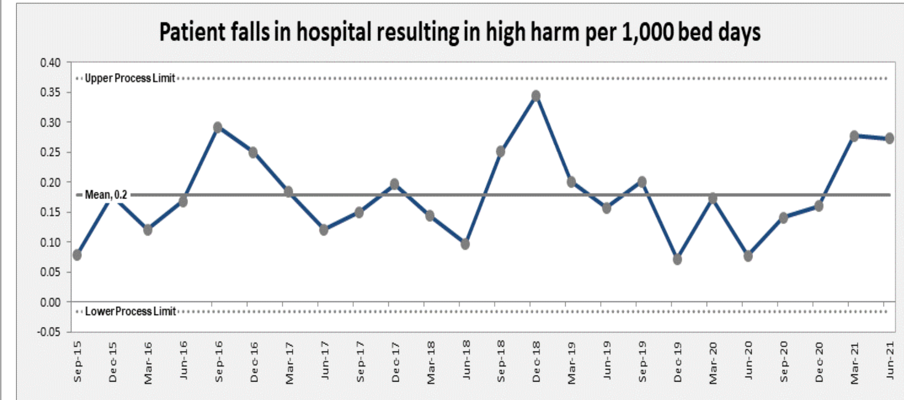
VTE – There has been a decrease in the 'treatment given' figures. The impact of non-recording of contra-indications to thromboprophylaxis on medication charts is potentially affecting compliance figures. There has been no harm to patients as a result of this. Clinical staff will be reminded of the need to record contraindications.

Patient Falls

Are We Safe?

Data Quality Rating: 





Summary and Action

- There were 2 high harm falls in August. Both were graded moderate and are being investigated through the SWARM CCG agreement:
  - Whiteparish – a patient suffered a small subdural bleed
  - Spire – a patient suffered a fractured ulna
- A new falls lead is due to commence in post on 4 October 2021.
- Both medicine and surgery are actively auditing documentation weekly to ensure falls risks are completed regularly
- Matrons are actively engaged with the ward managers in ensuring patients are risk assessed and that 'falls risks' are cascaded to the wider nursing teams, so they are all aware

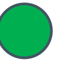
Statistical Process Control Chart Key:
- Target
- Mean
- Upper / Lower Process Control Limits (UPL/LPL)
- Special Cause Variation Improvement (6 or more points better than the mean, or a single point outside the control limit)
- Special Cause Variation Concern (6 or more points worse than the mean, or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

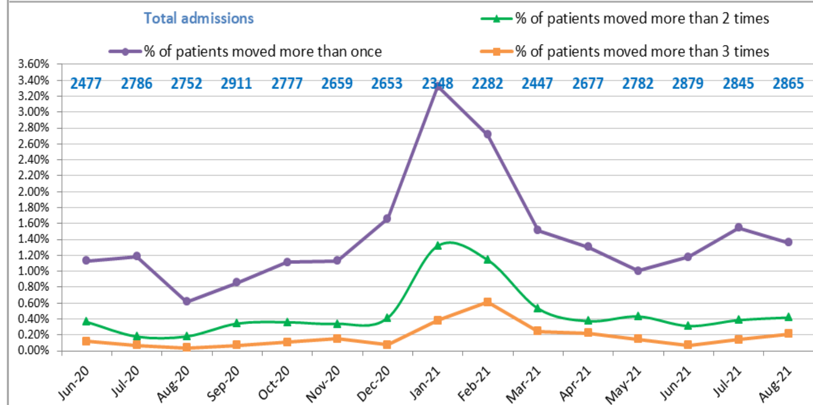
Patient Experience

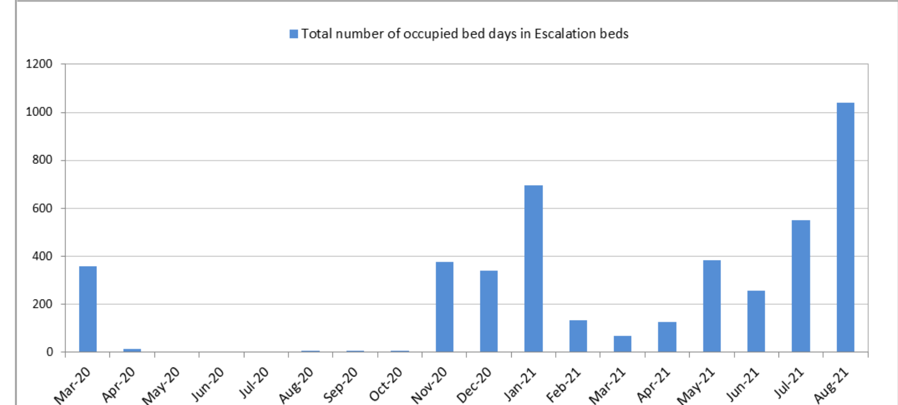
Are We Safe?

Last 12 months	Sep 20	Oct 20	Nov 20	Dec 20	Jan 21	Feb 21	Mar 21	Apr 21	May 21	Jun 21	Jul 21	Aug 21
Bed Occupancy %	86.6	85.8	91.6	92.4	89.4	86.8	87.6	90.8	91.2	90.8	90.0	93.9

Data Quality Rating:







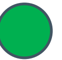
The number of moves patients have experienced during August have remained relatively static with patients moving more than once still at an escalated proportion.

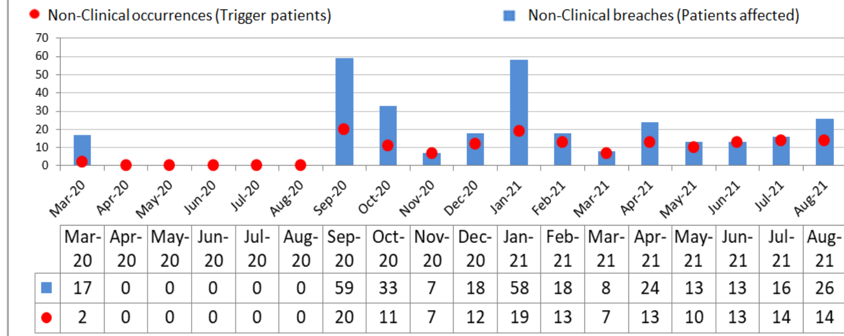
Operational pressures, indicated by the much increased use of escalation beds, have limited the ability of the Trust to place patients in the most appropriate bed first time, for the whole of their stay. In addition the accommodation of infection control safety measures also contribute to the movement of patients within the Trust. Risk based clinical decisions are made in escalated conditions that impose additional requirements for patient moves in a dynamic and ever changing picture.

Every effort is made across Divisions and Corporate Services regarding flow and capacity to ensure as far as possible, safe and appropriate capacity is utilised. Supporting this ambition is work in the newly formed urgent care and flow group set up to examine ways to expedite flow, create capacity and ensure appropriate length of stay and use of resources.

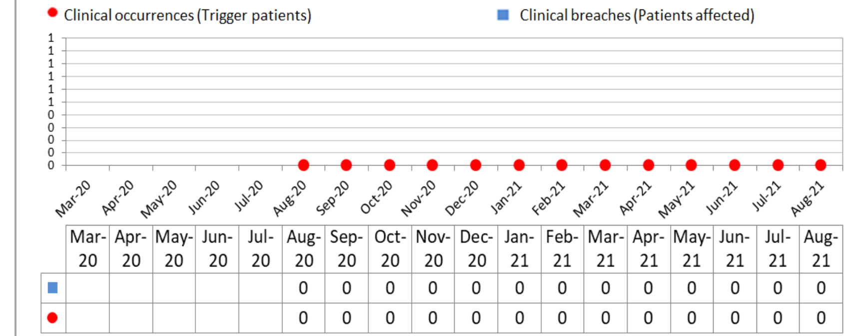
Patient Experience

Are We Safe?

Data Quality Rating: 



	Mar-20	Apr-20	May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21
Non-Clinical breaches (Patients affected)	17	0	0	0	0	0	59	33	7	18	58	18	8	24	13	13	16	26
Non-Clinical occurrences (Trigger patients)	2	0	0	0	0	0	20	11	7	12	19	13	7	13	10	13	14	14



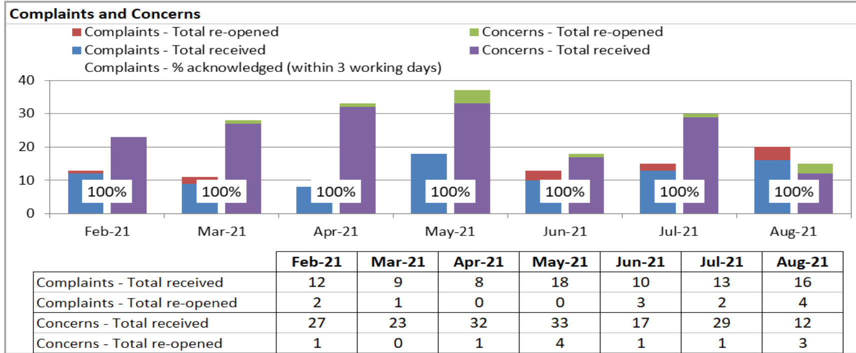
	Mar-20	Apr-20	May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21
Clinical breaches (Patients affected)						0	0	0	0	0	0	0	0	0	0	0	0	0
Clinical occurrences (Trigger patients)						0	0	0	0	0	0	0	0	0	0	0	0	0

Summary and Action

- 10 non-clinical breaches affecting 10 patients which occurred on Radnor. They were all pts who were unable to be moved off the unit within 4 hours of being declared fit to move. The majority were resolved within 48 hours. There was 1 patient who had a breach time of 3 days awaiting a speciality bed. Privacy and dignity was maintained at all times within the patients bed space
- 3 non-clinical breaches affecting 14 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. All breaches were resolved within 24 hours
- 1 non-clinical breach affecting 2 patients on SAU. All patients had access to single sex bathrooms within the ward and screens were used to maintain privacy and dignity. The breach was resolved with 24 hours

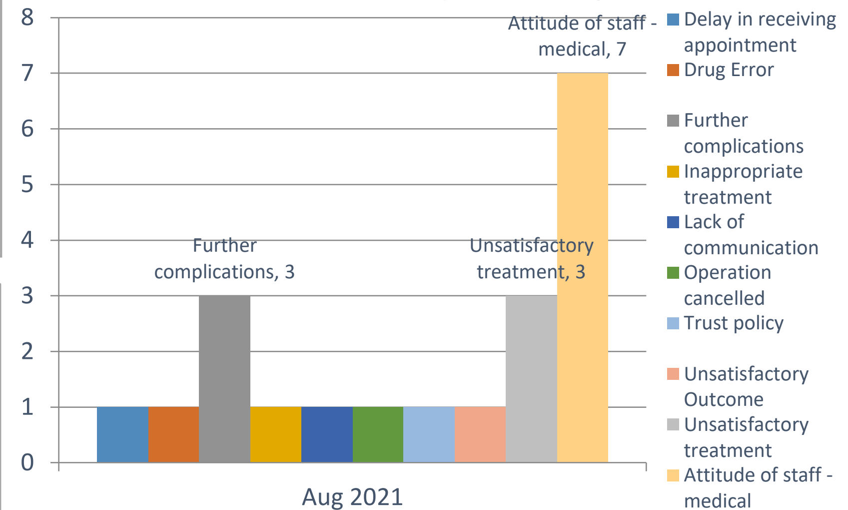
Patient & Visitor Feedback: Complaints and Concerns

Are We Responsive?



	Feb-21	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21
Complaints - Total received	12	9	8	18	10	13	16
Complaints - Total re-opened	2	1	0	0	3	2	4
Concerns - Total received	27	23	32	33	17	29	12
Concerns - Total re-opened	1	0	1	4	1	1	3

Data Quality Rating:



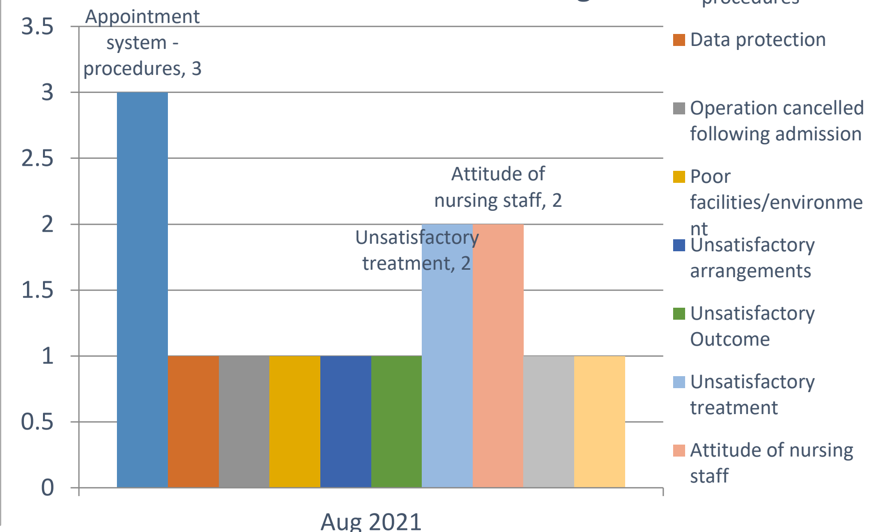
Summary and Actions:

Themes from complaints:
Attitude of medical staff
Unsatisfactory treatment
Further complications

Themes from concerns:
Appointment systems and procedures
Attitudes of nursing staff
Unsatisfactory treatment

Examples of actions from closed complaints in August 21:

- Gynaecology – apologies offered and a summary of the patient's ongoing clinical management plan discussed
- Urology – patients are now advised to use the toilet facilities prior to leaving the department
- Laverstock – to ensure all team members are aware of patient discharge dates in advance to facilitate a seamless 'short notice' discharge process



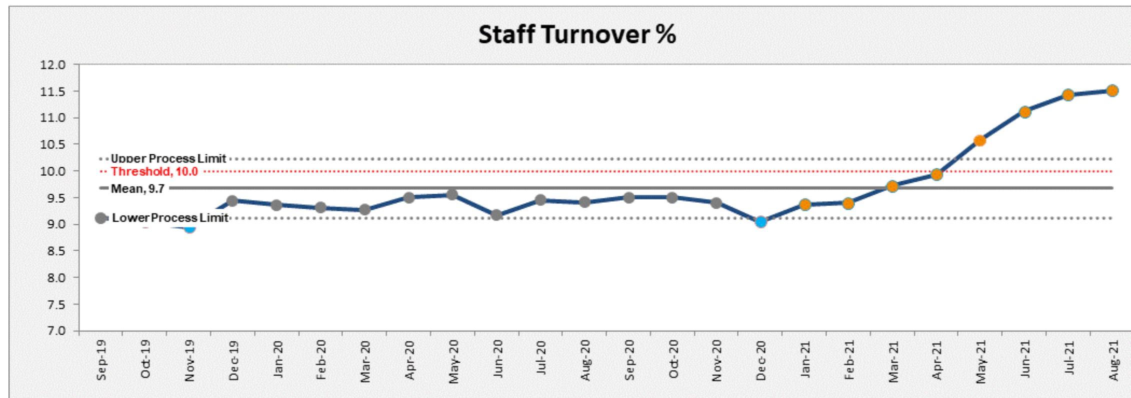
NHS
Salisbury
NHS Foundation Trust

Part 3: Our People

Our Priorities	How We Measure	
Local Services	Are We Effective?	Are We Responsive?
Specialist Services		
Innovation		
Care	Are We Safe?	Are We Caring?
People	Are We Well Led?	Use of Resources
Resources		

Workforce – Turnover

Use of Resources



Summary and Action

Turnover for month 5 has continued to be above the Trust target (11.47%). There were 33 leavers and 35 starters by headcount. Clinical Support and Family Services had the highest turnover of the Clinical Divisions (12.41%). Of the known reasons for voluntary turnover in the last three months, the most commonly selected were Voluntary Resignation – Relocation" and "Retirement – Age" Together these formed 48% of all voluntary reasons for leaving, where a reason was given.

CSFS have been offering exit interviews to all staff and these have been taking place. Feedback is that many staff are leaving due to a change in lifestyle/work life balance post COVID. For example Pathology have seen an increase in staff leaving who wish to move closer to their family as a direct result of COVID. Those staff who are leaving, are not reporting any concerns with their departments/line management. We are working closely with Line Managers to try and ensure that advertising of roles happens as early as possible to ensure service cover.

Medicine turnover this month was low with 3 starters and 6 leavers in the month of August. Exit interviews being offered to all leavers. These are being carried out my the managers unless the staff member request the People Team to meet with them.

Although Surgery's monthly turnover rate has continued to climb, the division is successfully recruiting to its vacancies (having recruited 127 FTE in the past 12 months against 100 FTE worth of leavers). Month 5 exit interviews have shown a range of reasons such as leaving for a job with no shifts and closer to childcare, returning overseas to be with family, going to university for nurse training, leaving their profession for better pay and prospects in another sector, leaving to do a job more relevant to their original degree and retiring fully. Surgery hotspots this month are Urology, Ophthalmology, GI Unit and Theatres. In part this reflects medical and dental rotational turnover in August.

- Hard to recruit positions in these services, e.g. Clinical Endoscopists, have received additional support from OD&P in the form of help with advertisement wording and campaign design and getting authorisation for assistance with relocation.
- Surgery is planning a review of Theatres to address long-standing cultural issues that influence turnover. FTSUG data on bullying, favouritism, lack of training, poor leadership/communications and harassment is being used to develop TORs for this. This is running alongside a major recruitment campaign for elective recovery which OD&P is heavily supporting through the BP, Recruitment and project management to develop a long-term workforce plan.
- Surgery DMT is expecting a revised flexible working policy reflecting new contractual flexible working provisions to help us support more flexibility and fuller consideration of staff requests and service options.

Statistical Process Control Chart Key:
- Target (dashed red line)
- Mean (solid line)
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- Special Cause Variation Improvement (6 or more points better than the mean, or a single point outside the control limit)
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- Common Cause Variation

Workforce – Vacancies

Use of Resources

Total Workforce vs Budgeted Plan - WTEs

	Aug '21		
	Plan WTEs	Actual WTEs	Variance WTEs
Medical Staff	444.71	526.33	(81.6)
Nursing	1,017.47	1,031.12	(13.6)
HCAs	472.74	561.96	(89.2)
Other Clinical Staff	662.21	628.85	33.4
Infrastructure staff	1,290.31	1,275.95	14.4
TOTAL	**3,887.44**	**4,024.21**	**(136.8)**

Summary and Action

Vacancy rate in month was 3.50%, compared to 6.69% in July. The Division with the highest vacancy rate was Corporate at 6.40%. The staff group with the highest number of vacancies Trust wide was Registered Nurses at 96.5 FTE (9.5%).

In month 5 93 vacancies (89 WTE) were advertised and a total of 77 offers were made. This compared to 91 vacancies and 84 offers made in month 4.

The are currently 3 vacancies which are rolling advertisements, 2 in Medical at Consultant level (Gastro, Respiratory), and registered nurses for ED. There are currently 67 active vacancies covering both medical and general.

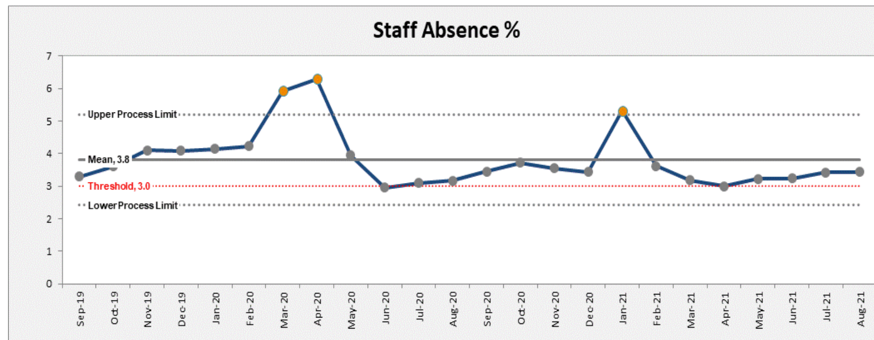
Recruit to hire time (authorisation to checks ok) for month 5 is 36 days against a target of 35.

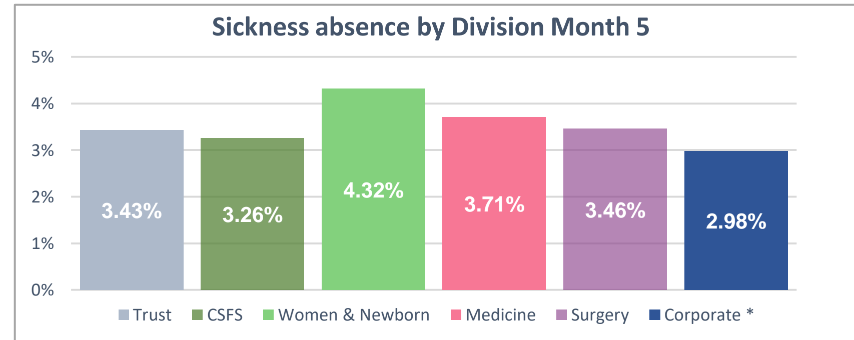
There were 39 offers of employment made to international nurses during month 5.

A significant recruitment campaign covering all disciplines of staff in Theatres (HCA, Scrub, Recovery and Anaesthetics) commenced in month 4 to support the Trust in meeting its elective recovery and longer term Theatre capacity goals. 17 offers have been made so far to date, with 34 more applications being reviewed. Additional administrator support has been put in place from month 5 for three months to support faster end-to-end recruitment of Theatre new starters.

Workforce - Sickness

Use of Resources





Summary and Action

Sickness for the month saw a slight increase to 3.43%, sickness for the rolling year was at 3.58%. Medicine, Surgery and Women and New-born and CSFS are the Divisions with sickness higher than the Trust target. In terms of the number of staff in sickness process, there are 170 in short term processes and 28 in long term sickness processes.

Anxiety, stress and depression remains the top cause of sickness across all Divisions. Through the staff survey action plans the People BPs are working with DMTs to put strategies in place to support staff's wellbeing. Support from the Mental Health First Aiders (MHFA) is being encouraged, along with the mental health support options in the Health and Wellbeing staff booklet. People Advisors supporting anxiety/stress hotspots and are in contact with Clinical Psychology to link up with post-Covid-19 recovery project activities that would help. A mandatory training module for line managers on Staff Psychological Wellbeing is being developed by OD&P and will be launched shortly.

Women and Newborn had seen an increase in sickness in month, all cases are being managed in conjunction with the People Advisor, with Stress/Anxiety remaining the highest reason for absence in the Division. Hotspot areas are Community Midwives and Maternity non clinical. A specific health and wellbeing strategy for staff in Maternity is being developed and expected to be completed by the end of October.

Within CSFS, an increase in Short Term sickness that has caused the division to be above target for the first time since March 2021. Stress/anxiety remains the highest reason for sickness within the Division. HR surgeries have also taken place within the Division with the People Advisor, where advice on managing sickness has been discussed. Divisional hotspots are Management Child Health, Genetics and Dietetics. There has been some success in staff returning to work from long term sick leave so this is expected to improve the overall sickness rate in the coming months. Sarum ward are reporting an increase in stress from staff, additional weekly support is being provided from the MHFA with weekly visits to the ward to speak with staff.

In Medicine, short term absence has decreased, but long term absence has increased. In month 4 Redlynch was a hotspot, however with some focused support there has been a decrease in M5. Tisbury and Pitton wards will be the next focus areas. The highest reason of absence is Anxiety, stress and Depression at 32% , which is a concern. it is thought this is linked to high workload demands and vacancies. In October there are 15 international nurse expected to arrive.

Surgery sickness fell by nearly 1% in month 5 with improvements in Rheumatology, Radnor, Main Outpatients, surgical inpatient wards and admin and clerical areas but the division still had 21 of 83 teams currently over the sickness target. Hotspots were Theatres/DSU, inpatient orthopaedics wards, Main Outpatients, Ophthalmology, Urology, ICU, Central Booking and Rheumatology. Primary reasons for short-term absence in these hotspots were GI disorders, MSK injuries, headache/migraine and pregnancy related sickness. Anxiety/stress is the main long-term cause. Theatres is a priority focus of the People Advisors, principally on Theatres ODP and Recovery absence, and additional People Advisor resource has been agreed for 6 months to support this work. Surgery has 24 staff in short-term absence management processes and 9 in long-term, though 3 long-term returned to work in August. OD&P is supporting staff back to work with reasonable adjustments. Manual handling support is being reviewed with the Manual Handling Advisor (extra training, new equipment and revised processes) to identify any improvements.

In Corporate areas the People Advisor has monthly meetings with the department management teams and has set up drop in clinics for both staff and managers for any queries. This has increased the number of Occupational Health referrals and stress forms being completed. Long term absence has stayed the same as last month 1.7% and short term absence has decreased to 0.94%

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)
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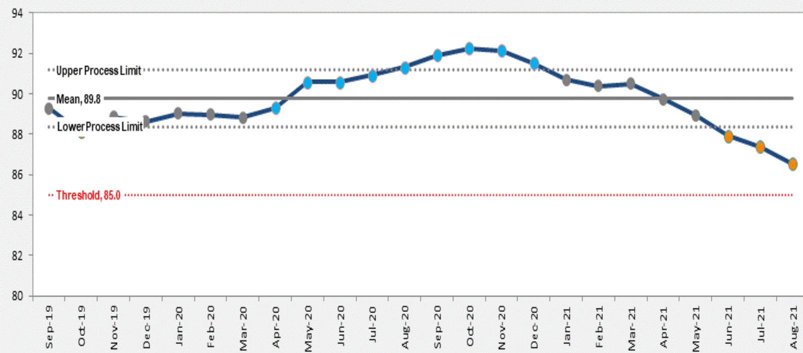
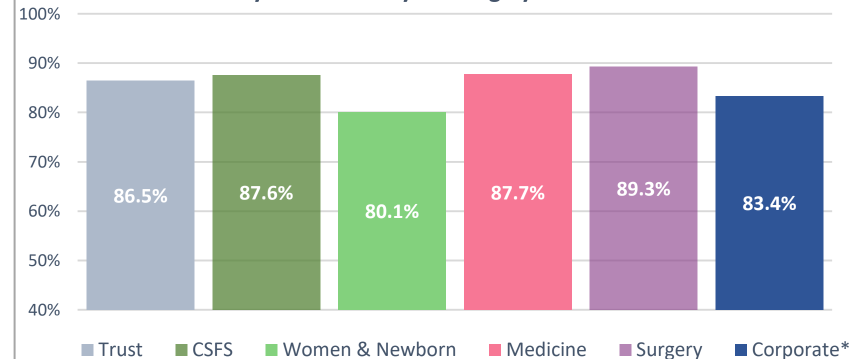
Workforce – Staff Training

Use of Resources





Summary and Action

Mandatory training was at 86.5% for month 5. This is slightly below the previous month and the same time last year. All 5 Divisions are below target – Corporate (83.4%), CSFS (87.6%), Medicine (80.1%), Surgery (89.3%) and Women & Newborn (80.1%).

Medicine have increased communications across the division to improve compliance, this is an ongoing effort, however due to shortages and sickness of staff it has been more difficult this month. The management team are focused on the Hand Hygiene (75%) this month as one of the hotspots. Also, staff are going to be ask complete their GDPR, which is at 83% in month.

Medical Staff in Women and Newborn has now been split from other staff to allow more of a focus. All medical staff out of date have now been contacted individually to detail where they need to complete to be compliant. The staff who are out of date with PREVENT have also been contacted directly asking them to complete this with a deadline for completion. Due to clinical pressures in the department however this is being reported as a block to getting this completed – and this was discussed at EPR last week so that the Exec team are aware.

In CSFS, staff continue to be contacted where they are out of date. Work continues with Education around the advanced and basic life support training – to ensure staff are in the correct level of training, if required, and we believe there has been some movement on this in M5. We are also working with Education around the levels of safeguarding for adults and children as different roles have different requirements and this is affecting compliance in both CSFS and Women and Newborn. We are also working with Education to ensure that staff who are currently exempt (e.g. due to maternity) are removed as we have had several appear as out of date when they should be exempt.

Estates (Maintenance & Improvements 63.5% and ETS Support staff 70.%). Although a training action plan and timetable has been put in place it has been difficult to implement due to staffing challenges to release staff from their operational duties to complete their training, also arranging extra computers to enable training to take place.

The hot spots in Corporate services are Finance 69% and Procurement 73%. Finance are devising a 3 month plan and timetable for compliance. Procurement have put a revised compliance plan in place, the plan is for a 4 month period to reflect the final TUPE transfer is in October and the focus being the new integrated service.

Out of 60 departments in Surgery, 26 are below the 90% compliance target overall (an improvement of 3). 15 are below 85% (red). Bowel Screening, Medical Staff in 5 different services, Theatres and POAU are hotspots. Staff are being contacted with details of their non-compliance. Local issues/pressures are being addressed e.g. staff in Bowel Screening are working at other sites and are being required to do multiple sets of mandatory training. Passporting is being agreed whereby as the lead employer staff will do our MaST plus local manual handling and ALS.

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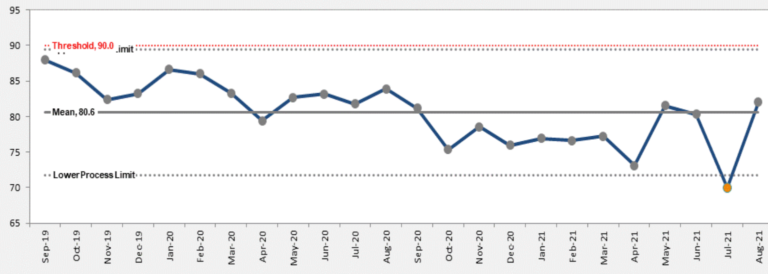
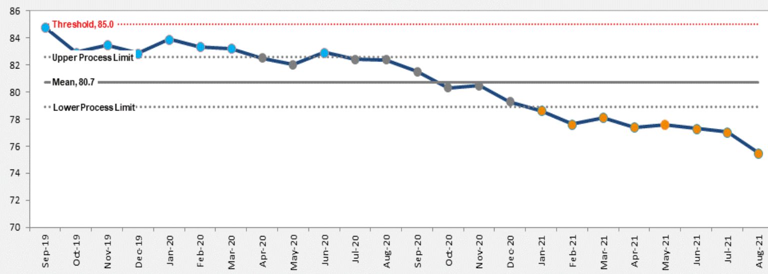
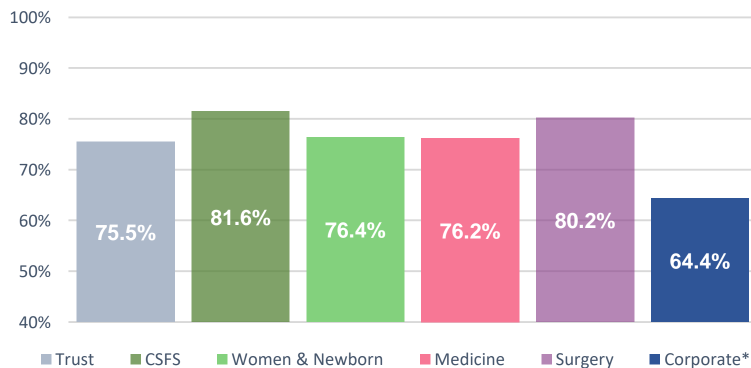
Workforce – Appraisals

Use of Resources







Summary and Action

Appraisals remain under target at 75.5%, this is a decrease on the previous month position (77.0%). Hotspot areas are Corporate (64.4%), Medicine (76.2%) and Women and Newborn (76.4). Within Corporate, those areas under target are : Estates 29%, Finance and Procurement 24%, OD & People 39%, Transformation & Informatics 73% and Quality 70%.

Medicine have 538 members of staff outstanding their appraisal. Managers are reporting more have been done but not reported as they are on windows 10 and cant report onto Spida. Managers have been asked once ESR is live for reporting to focus on reporting appraisals already completed, and to continue to book in people who are outstanding.

In Women and Newborn all staff have been contacted individually who are showing as overdue their appraisal and asked to get these completed and booked in, with action plans being completed to identify when each member of staff will receive their appraisal. Clinical pressures in the department and annual leave are very much halting these taking place with admin time being lost due to an increase in admissions/births (an additional 49 births took place in August than were predicted).

The hot spots in Corporate services continue to be Estates and until a management structure is in place it will be difficult to complete the appraisals for the team. Key roles are in the process of recruiting are the Head of Estates and Operations Manager. It is noted that they manage over 75% of the team. Within Procurement the TUPE staff records do not appear to transfer affecting the percentage rate, this is being investigated. Finance is also a Corporate hot spot, individual compliance reports are being shared with the managers to devise a plan and timetable to be compliant.

17 Surgery departments are currently below target, of which 13 are below 80%. Hotspot areas are DSU, ICU, Theatres, Endoscopy and Britford. From a medical point of view Anesthetics, Orthopedics and Plastic Surgery are hotspots. However compliance has rebounded well from a month 4 drop. Compliance data routinely used in HR 1:1s with line managers by People Advisor and by BP with clinical leads. Realistic timescales set for services under the most severe operational pressures (Theatres/DSU, ICU and Rheumatology). These services have agreed to be back to green by end of December. All others are expected to be green by end of October. OD&P are supplying clinicians with advanced notice each month that their medical appraisals are falling due.

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- Common Cause Variation

Feedback from Friends and Family test

"Interacting with whole dept. Everyone has been brilliant. Different exercises which I have now kept in my routine. Being asked to be the first person to go on the climbing wall! Thank you all for your support. "
Wessex rehab

"Everyone was extremely kind, knowledgeable and expert at treating and helping me to heal. I could not fault my treatment"
Plastic surgery therapy – upper limb

"Staff very nice, put up with me not wanting meds. Overall very nice, like a hotel and would stay again. Free food was the best" Sarum

"Excellent! Absolutely wonderful care. So blessed to be in this area, I shall write a letter when I get home" Whiteparish

What was good about your experience?

August 2021

"Excellent! Kind, knowledgeable and genuinely interested dietician. Dietician was up to date with my father's situation and sensitive to it. She grasped our knowledge of nutrition and gaps quickly and was helpful in her recommendations"
Macmillan Dieticians

"Not enough room to say how committed the staff are, working in such hard times, very kind, caring, professional and supportive. Nothing is too much bother. Made me feel really cared for, safe and secure. I will miss the smiles There is nothing that could have been done better. Circumstances within NHS as so much pressure being short staffed but they all work so hard to not show this. Well done" Odstock

"The care I received from everybody at the hospital has been incredible. I've felt like I was important and that I was treated like family" Amesbury

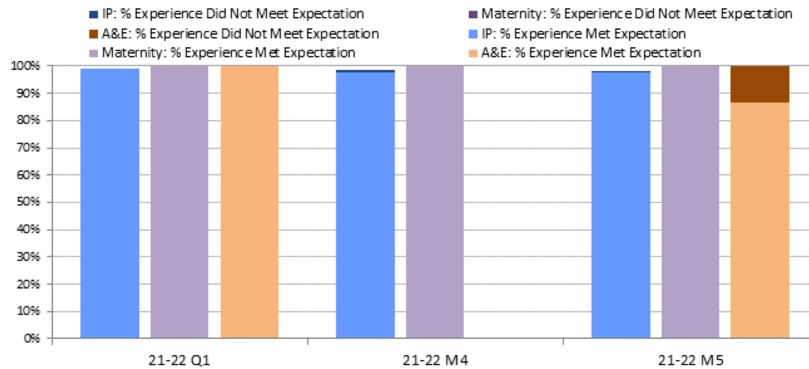
"The staff are fabulous from surgeons to cleaners. Very proud of the NHS. "
Amesbury

"To be cared for by people who care about you. The staff are brilliant. I now also have a better understanding of my condition which will help me to deal with it better in the future" Laverstock

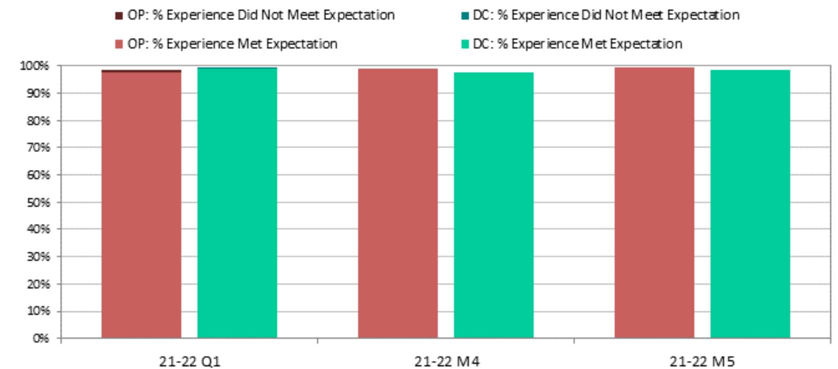
Friends and Family Test – Patients and Staff

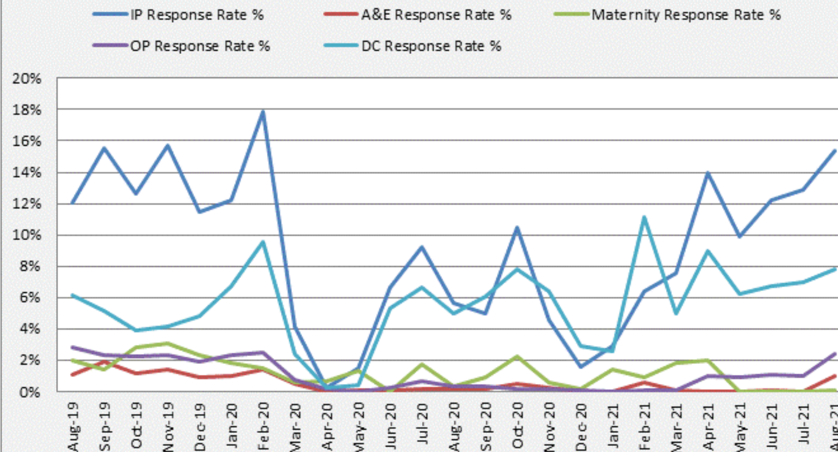
Use of Resources

Patient Responses: Inpatient, Maternity and A&E



Patient Responses: Outpatient and Daycase





More areas are now re-instating their processes for giving patients the FFT cards. All areas have a target of 30%. High achievers in August were:

- Chilmark Ward – 42.9%
- Britford Ward – 35.1%
- Pembroke Ward – 34.6%

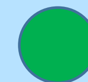
Most outpatient areas still have a response rate of 0% with only 8 out of 18 areas receiving responses this month. Pre-op assessment received feedback from 70% of patients which is great.

Matrons have been contacted to highlight low response rates and to ensure departments/wards are giving out cards.

Part 4: Use of Resources

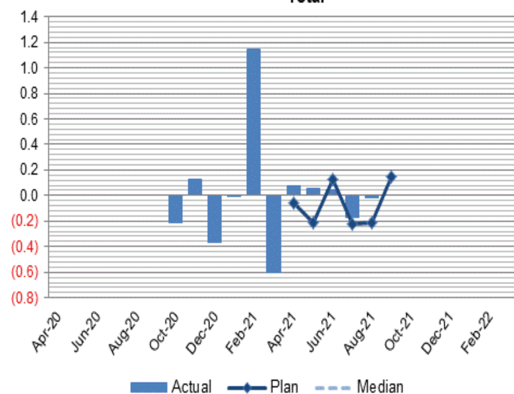
Our Priorities	How We Measure	
Local Services	Are We Effective?	Are We Responsive?
Specialist Services		
Innovation		
Care	Are We Safe?	Are We Caring?
People		
Resources	Are We Well Led?	Use of Resources

Income and Expenditure

Income & Expenditure: 

Use of Resources

	Aug '21 In Mth			Aug'21 YTD			2020/21
	Plan £000s	Actual £000s	Variance £000s	Plan £000s	Actual £000s	Variance £000s	Plan £000s
Operating Income							
NHS Clinical Income	20,691	21,294	603	103,453	104,174	721	124,144
Other Clinical Income	961	(85)	(1,046)	4,045	3,125	(920)	5,006
Other Income (excl Donations)	2,507	3,477	970	12,685	13,192	507	15,342
Total income	**24,159**	**24,686**	**527**	**120,183**	**120,491**	**308**	**144,492**
Operating Expenditure							
Pay	(14,758)	(15,324)	(566)	(74,017)	(74,422)	(405)	(88,775)
Non Pay	(7,996)	(7,821)	175	(38,661)	(38,398)	263	(46,453)
Total Expenditure	**(22,754)**	**(23,145)**	**(391)**	**(112,678)**	**(112,820)**	**(142)**	**(135,228)**
EBITDA	**1,405**	**1,541**	**136**	**7,505**	**7,671**	**166**	**9,264**
Financing Costs (incl Depreciation)	(1,544)	(1,553)	(9)	(7,720)	(7,668)	52	(9,264)
NHSI Control Total	**(139)**	**(13)**	**126**	**(215)**	**3**	**218**	**0**
Add: impact of donated assets	*(62)*	*7*	*69*	*(308)*	*(208)*	*100*	*(368)*
Surplus/(Deficit)	***(201)***	***(6)***	***195***	***(523)***	***(205)***	***318***	**(368)**



Variation and Action

The Trust continues to operate within its allocated H1 2021/22 contractual envelopes up to the end of August 2021, with a YTD reported surplus of £3k (excluding the impact of donated assets). Expenditure envelopes are derived from the system's winter 2019/20 run rate, meaning expenditure growth beyond baseline inflationary (excluding that specifically funded for Covid measures) will drive a cost pressure for the Trust that needs to be mitigated.

Pay spend, particularly in relation to medical costs, have increased in month. This includes additional agency spend. On going pressures around Medical specialties are driving the position.

Elective activity leves are at 86% of 2019/20 baseline activity year to date and in August. This is based on eligable activity under the Elective Recovery Fund calculation. The threshold is now 95% to receive Elective Recovery Funds.

As part of Month 5 reporting there has been a review of code mapping to ensure a greater consistency in categorisation of costs with those used in Salisbury prior to the implementation of SBS Oracle Version 12. This has particularly affected staffing costs and so some movement of categories between Month 4 and 5 can be seen.

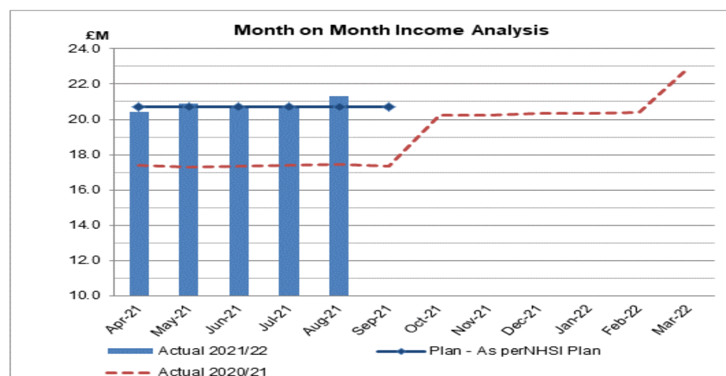
Income & Activity Delivered by Point of Delivery

Clinical Income:

Use of Resources

Income by Point of Delivery (PoD) for all commissioners	Aug '21 YTD		
	Plan (YTD) £000s	Actual (YTD) £000s	Variance (YTD) £000s
A&E	3,831	4,117	286
Day Case	5,903	6,452	549
Elective inpatients	4,730	3,834	(896)
Excluded Drugs & Devices (inc Lucentis)	8,659	8,085	(574)
Non Elective inpatients	26,347	26,908	561
Other	43,556	42,505	(1,051)
Outpatients	10,427	12,273	1,846
TOTAL	**103,453**	**104,174**	**721**

SLA Income Performance of Trusts main NHS commissioners	Contract Plan (YTD) £000s	Actual (YTD) £000s	Variance (YTD) £000s
BSW CCG	63,447	64,070	623
Dorset CCG	10,403	10,403	-
Hampshire,Southampton & IOW CCG	7,829	7,829	-
Specialist Services	14,160	14,084	(76)
Other	7,614	7,788	174
TOTAL	**103,453**	**104,174**	**721**



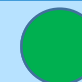
Activity levels by Point of Delivery (POD)	YTD Plan	YTD Actuals	YTD Variance	Last Year Actuals	Variance against last year
A&E	29,070	29,044	(26)	22,182	6,862
Day case	7,758	8,345	587	4,731	3,614
Elective	1,321	1,139	(182)	755	384
Non Elective	11,767	11,897	130	10,330	1,567
Outpatients	95,527	110,018	14,491	69,805	40,213

Variation and Action

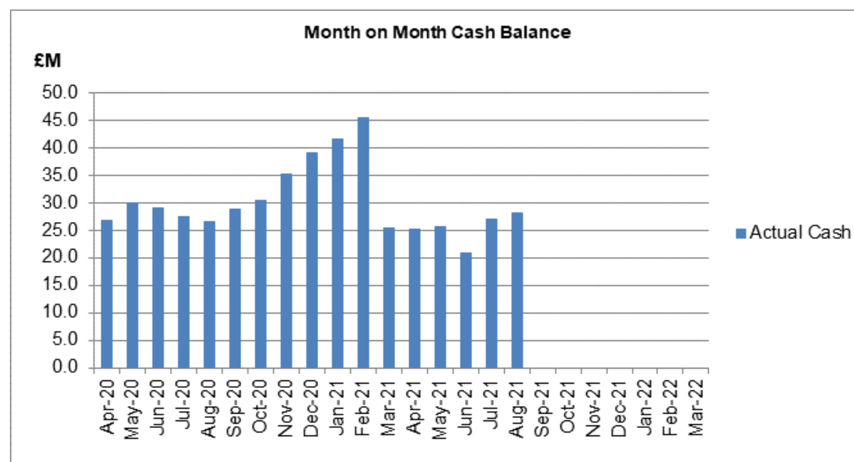
Activity in August in day cases recorded 36 spells less than in July, but still exceeded the plan for the month. Day case activity has improved against plan in the specialties of Urology and Gastroenterology, but activity levels have dipped this month in Plastic Surgery although activity is still above planned levels. Activity in elective inpatients was 23 spells lower than in July however T&O continued to achieve the planned level for the month. Non-Elective spells were higher than in July and remain above plan year to date. Less activity was seen this month in Urology, Medicine and Paediatrics but activity was higher in Gastroenterology, and Gynaecology. Outpatient performance is lower than last month with less activity this month in Paediatrics, Urology, GU Medicine, T&O and Plastic Surgery.

For the first six months of 2021/22 the Trust will continue to receive fixed payments from the main commissioners which have been based on Phase 3 payments (October 2020 to March 2021) uplifted by 0.5%. There is additional funding for growth and Covid. Some high cost drugs and devices are paid on a cost and volume basis by NHS E. An Elective Recovery Fund payment will be applicable in the first six months of 2021/22 to systems who achieve delivery above the set thresholds. The delivery of day cases, electives, outpatient procedures and outpatients was at 86% against the revised threshold of 95% for August. The target is for individual months, therefore whilst no additional funding would be applicable in August, additional funding of circa £2.0m year to date has been achieved under the Elective Recovery mechanism. Income of £623k has been included in the financial position for ERF which matches the costs reported. Therefore, the August position is concerning and significantly more work is required to trigger additional funding in quarter 2.

Cash Position & Capital Programme

Capital Spend: Cash & Working: 

Use of Resources



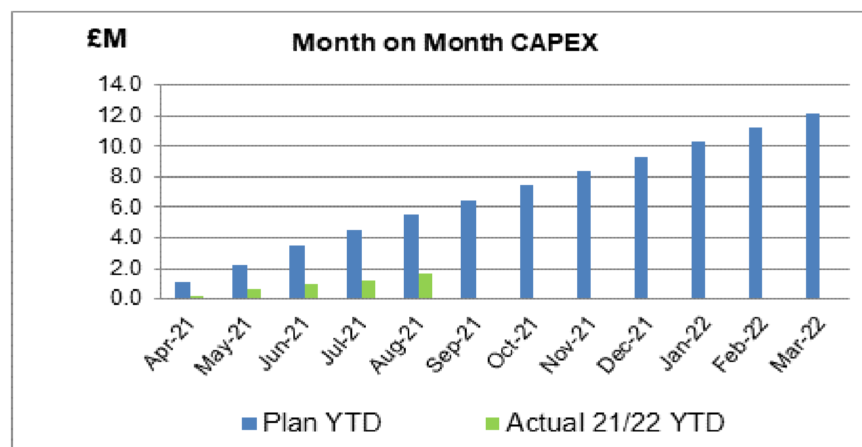
The Trust has now returned to the pre-Covid mid-month contractual payment arrangements. Block contracts and a balanced revenue plan have been agreed up to 30 September 2021, with guidance is awaiting for the second half of the year.

The base assumption from a cash forecasting perspective is that the Trust will continue to report a balanced revenue position throughout 2021/22.

The cash position increased in August 2021 primarily due to Health Education England paying their September contract value a month in advance. Although supplier payments for revenue expenditure were more in line with the normal monthly amounts, the capital programme remains behind plan and this is resulting in higher levels of cash than expected.

Capital Expenditure Position

Schemes	Annual Plan £000s	Aug '21 YTD		
		Plan £000s	Actual £000s	Variance £000s
Building schemes	900	790	195	595
Building projects	5,254	2,075	225	1,850
IM&T	3,872	1,615	691	924
Medical Equipment	1,728	836	366	470
Other	450	184	147	37
TOTAL	**12,204**	**5,500**	**1,624**	**3,876**



Summary and Action

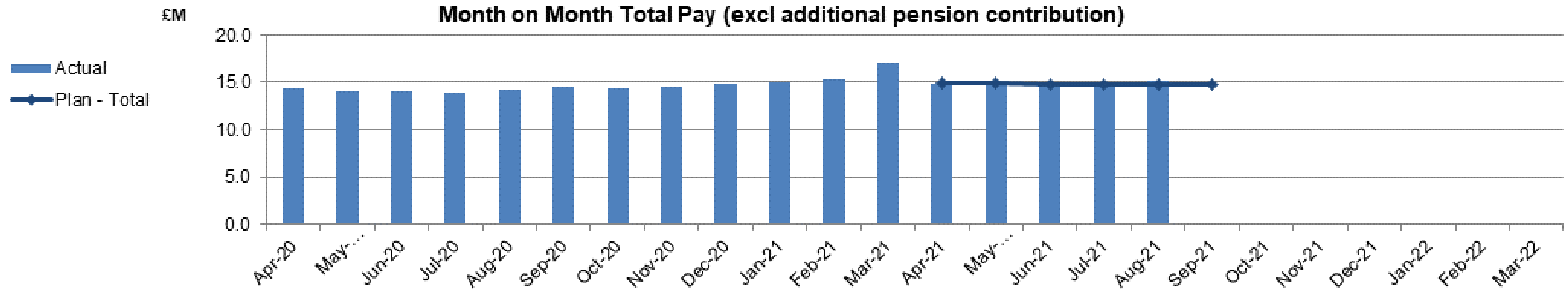
2021/22 capital allocations have been made at a system level, and although the Trust's baseline allocation of £12.2m exceeds the initial 2019/20 allocation by c£3m, the Trust remains capital constrained based on an initial assessment of over £20m. The internal funding of a £12.2m capital plan is contingent on the Trust delivering a balanced revenue position in 2021/22, and a further £0.5m from the opening cash balance.

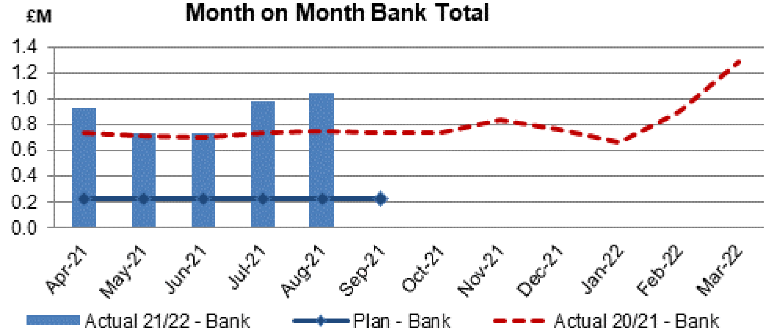
The original capital plan was based on a fairly even distribution of spend throughout the year. However, some building schemes have either been delayed or have been revised. A revised detailed profile plan of how all elements of the programme will be achieved by the end of the year has been developed. This will be challenging to achieve and further work is underway to identify the risks and issues associated with delivering this revised plan. Schemes will be reviewed in detail to identify what should be delivered on a monthly basis and how this compares with the actual position in order to provide assurance the programme remains on target.

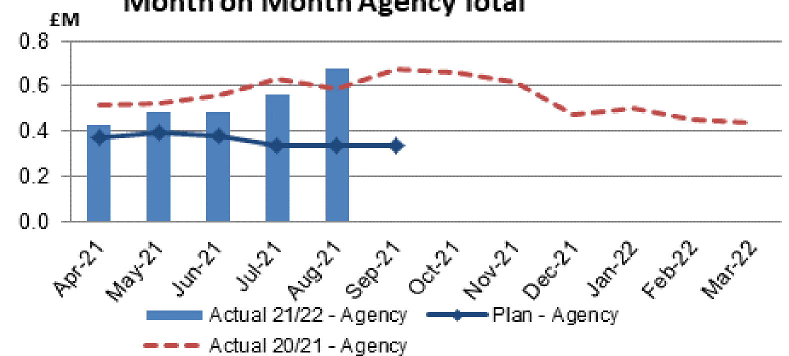
Workforce and Agency Spend

Pay:

Use of Resources







Summary and Action

The Trust's pay costs have increased in August and the Trust is now showing a pay overspend of £405k. The main increase has been seen in medical staff (increase of £380k and 90 WTE). The increase in WTEs is largely due to technical reasons around the rotation of junior doctors, but there has been an increase in junior slots filled by the deanery which has led to some increase in costs (£60k). The main increase in costs, however, is on consultants. There has been a £160k increase in agency consultant costs in Medicine in Spinal and stroke due to vacancies and sickness, some of which is backdated.

On going review of the classification of account codes following the SBS implementation is being undertaken to ensure consistency in reporting for the Trust. There has been reduction of substantive staff by 2.0 wtes in month, but an increase in 12 bank wtes.

Infrastructure staff costs rose by £80k from month 4, £73k of which was in Corporate areas. The Trust has reported 10 WTE infrastructure support staff (cost £36k) over planned levels which relates to the vaccination centre at Salisbury City Hall, where the plan is for staffing to be provided by RUH, but any staffing provided by SFT is considered 'out of envelope' and directly reimbursed through NHSEI.