Salisbury NHS Foundation Trust

Report to:	Trust Board (Public)	**Agenda item:**	2.1
Date of Meeting:	3rd December 2020		

Report from: (Committee Name)	Clinical Governance Committee		**Committee Meeting Date:**	24th November 2020
Status:	**Information**	**Discussion**	**Assurance**	**Approval**
	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 the items escalated from the Clinical Governance Committee (CGC) meeting held on the 24th November 2020. The report both provides assurance and identifies areas where further assurance was sought and is required.

Key Items for Escalation

- Key information / issues / risks / positive care to escalate to the Board are as follows:
  - A Covid-19 update was provided this month by the Medical Director. It was noted that numbers are rising in the Trust noting the possibility that the peak of wave 2 has not yet been reached. However, it was positive to note that the system is coping with the current impact. It was also noted that an outbreak had been declared in one area of the hospital. Assurance was provided that the necessary actions have been taken in relation to the outbreak in order to contain it and that the relevant reporting has taken place. Communication with the individuals affected by this has been led by the Executives and relevant clinical leads.
  - A presentation in relation to care for people with Learning Disability was provided. This outlined national drivers and how the Trust is responding. It was clear that there is good practice in the organisation and that the Trust is supporting the work regionally in addition to working with the charitable sector, namely MENCAP. Assurance was also provided in relation to ambitions for improvement, particularly in use of the flagging system and improving transitional care. An update will be provided to CGC in due course.
  - An assurance update in relation to maternity services was provided, firstly in a verbal update about the external quality review. The report had been received and was being analysed. It was positive to note that there were no major concerns. Two areas to address were identified as the senior structure in the department (it is currently very flat) and training. Then the service senior team presented their update on the improvement plan already in place. A detailed discussion outlined where further assurance is required and this along with the quality and culture reviews will come back to CGC in early 2021.
  - No new issues or risks were flagged in the IPR. Areas of concern continue to be

access to stroke unit (noting lower than expected mortality) and pressure ulcers. On positive notes, firstly, in relation to service delivery, the criteria led discharge plan commences this month. Secondly, in relation to patient experience, a new initiative linking feedback to medical appraisal is commencing. This relates to the themes of relating to communication and attitude. The process used will be assisted reflection and will focus on learning.

- A detailed discussion was undertaken in relation to the BAF and corporate risk register's care and innovation section. Areas for further discussion and consideration included recognition of the enormity of the current health agenda and the resource required to manage this. In addition, there was a discussion about the forthcoming vaccination requirements in addition to the business as usual work. It was agreed that this would be flagged to the Finance and Performance committee and at Board for further consideration.
- The update in relation to serious incidents provided further assurance that progress is being made in closing actions and that there is a shift from process to learning. This will continue to receive focus at CGC.
- From a transformation perspective, one area to flag relates to the e-outcomes plan. On the current trajectory this would take 2 years to implement in all services. This is now being reviewed to increase the pace of embedding.
- A detailed presentation and discussion on learning from deaths was provided. Good assurance was provided that the process is now well established in the Trust and the focus is now on embedding learning. Examples were provided of how this is starting to work at Trust, Department and individual practitioner levels. Areas for further consideration include sepsis and oxygen prescribing with good practice identified in end of life care.
- A separate review of deaths during the initial wave of COVID-19 was presented. The data identified that some deaths were possibly, probably or definitely acquired in hospital (according to standard Public Health England definitions). The review has not found any lapses of care or failure to follow national guidance published at the time. The Trust has made changes to its environment and care pathways to reduce the current risk of hospital acquired COVID-19 infection in line with national requirements and recommendations. Where it has not already occurred, it was agreed that Duty of Candour will be applied in relation to these findings and families will be informed of the findings of the review and the steps the Trust has taken to reduce risk.
- A timely presentation on End of Life care in the Trust was presented by the palliative care lead and lead nurse. This outlined how support had been provided in a 7 day service for bereaved families during the past months. Discussing the recent NACEL report, assurance was provided that the service recognises areas they wish to improve in addition to celebrating the good practice. A further focus is required in relation to end of life education and proactively the team is looking to work across the BSW system.
- Due to time pressures the report on 7 day working was deferred to a future meeting.
- A report on medicines management was presented and the new medicines safety officer was introduced to the committee. It was positive to note that the Trust has received funding from NHSE/I to support the e-prescribing programme. This is expected to have a positive impact on safety, as will the plan to increase pharmacy services to a 7 day service.
- Regular reports from research, safeguarding, freedom to speak up (FTSU) and CMB were received and noted.

Salisbury NHS Foundation Trust

Report to:	Public Trust Board	**Agenda item:**	2.2
Date of Meeting:	3rd December 2020		

Committee Name:	Finance and Performance		**Committee Meeting Date:**	24th November 2020
Status:	**Information**	**Discussion**	**Assurance**	**Approval**
			X	
Prepared by:	Paul Miller, Non-Executive Director			
Board Sponsor (presenting):	Paul Miller, Non-Executive Director			

Recommendation
To note key aspects of the Finance and Performance (F&P) Committee meeting of the 24th November 2020

Items for Escalation to Board
Integrated performance report as at 31st October 2020 – In absolute terms performance across a range of indicators is below the expected national targets, but in relative terms, when compared against other organisations who are also dealing with the second wave of Covid, the Trust is fairing better than most. That said performance on (a) stroke, 33.3% of patients achieving the 4 hour target for admission into our stroke unit (b) main theatre cases and (c) inpatient discharges before midday were are all areas singled out for discussion in the November 2020 meeting. However perhaps the most significant performance concern was not around 2020/2, but around 2021/22. As the short term focus of the Trust will be to deal with the current Covid second wave and associated issues, which may leave a challenging legacy of untreated patients to catch up on next year. **Workforce deep dive, pay analysis** – The Trust is currently £3.8m overspent on pay and 191 WTE above budgeted establishments. This paper provided a historic analysis of the reasons behind this performance, which in the main appears to be driven by our Covid response affecting the 2020/21 transformation programme (130 WTE adverse impact) and additional Covid related increases in clinical and non-clinical staffing. The Committee was assured about the "*past*" but the recognised significant work was required going forward into the "f*uture*" i.e. 2021/22, to agree future staffing levels, that reflected agreed clinical models and safer staffing requirements. **Update on the 2020/21 Capital Plan** – The Committee received a set of comprehensive

papers that gave the background to £3.3m of forecast capital slippage in 2020/21 (out of a total programme of £17.9m). £1.5m of this slippage has already been managed in-year and the Committee agreed a set of recommendations to manage the balance. Key to these new schemes totaling £1.8m was bringing forward a planned replacement cardiac catheter room from 2021/22 into 2020/21 and a wide range of smaller building and works schemes and medical devices (totaling £950,000).

Operational Planning 2021/22 – The Committee received a paper and presentation that highlighted the complexity and uncertainty surrounding next years planning round. It also received a high level timetable, which targeted approving the final 2021/22 operational plan at the March 2021 Trust Board (most probably the 8th April 2021 meeting). Finally given this level of complexity and uncertainty the Committee offered the executive any assistance (and time) it wished to discuss any key strategic assumptions and risks in the future monthly F&P committee meetings between now and the 8th April 2021 Trust Board meeting.

Transformation and Quality Improvement (QI) programme update – the Committee received a comprehensive verbal update on a wide range of planned and ongoing transformational changes. A few issues that came of this presentation and discussion were (a) future transformational change should focus on clinical changes, that engage clinicians, rather than simply saving money (b) a future discussion was likely around the Trusts future appetite to invest in future transformation and QI support i.e. how far and fast we go, may depend on how much support we invest in and (c) our future transformation programme will be significantly driven by our future clinical strategy, which we are currently revisiting.

Maternity tender evaluation – The Committee received a procurement recommendation report and accepted the recommended way forward. Details will go to the Private Board meeting on the 3rd December 2020.

Board Assurance Framework (BAF) and Corporate Risk Register – Finally the Committee reviewed the BAF and Corporate Risk Register and had a wide-ranging conversation about the wider impact of Covid going forward i.e. the pressures on staff and generally the high levels of uncertainty that currently exists in the NHS, the wider system and the hospital itself.

Salisbury NHS Foundation Trust

Report to:	Trust Board (Public)	**Agenda item:**	2.4
Date of Meeting:	03 December 2020		

Report Title:	Integrated Performance Report			
Status:	**Information**	**Discussion**	**Assurance**	**Approval**
	✓		✓	
Prepared by:	Louise Drayton, Performance and Capacity Manager			
Executive Sponsor (presenting):	Lynn Lane, Director of OD & People			
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:
Focus on increasing elective activity levels as part of the Phase 3 NHS response to Covid-19 continued throughout October, and as a result of this areas of improvement were seen against some statutory standards. Phase 3 plan activity levels improved, with elective levels meeting plan, outpatients exceeding, and daycases being within 1% of trajectory. Although activity levels were on trajectory the plan does not meet the elective incentive scheme required levels and would amount to penalty of £301k, however NHSE/I have instructed the Trust to only inform Trust Boards of this value at this point, but not include it within our financial position RTT performance improved to 69.9% (67.61% in M6), but as expected the number of patients waiting over 52 weeks has increased to 295. This is above the trajectory position of 196 for M7 that was submitted as part of the Phase 3 plan. Challenges remain around increasing theatre capacity further with theatres closed due to need to provide Covid-19 critical care, and staffing challenges. Recovery of the diagnostic standard continues with performance rising further to 92.7% (90% in M6). The number of 6 week breaches has fallen to 252 from 347 in M6. Cancer Two week wait performance improved to 88.72% (85.47% in M6), however the 62 day performance reduced slightly to 82.58%. Increased monitoring of long waiting cancer patients is in place. ED performance increased in M7 (89.8% versus 88% in M6). Attendance spikes during the

evening are causing pressure on the department. Flow out of ED remains a challenge with the number of Stroke patients reaching the Stroke Unit within 4 hours falling to 33.3%. The Stroke Unit bed capacity has increased back to 30 beds with a split across Laverstock and Breamore wards, and a dedicated assessment room.

Challenges in flow were also seen with 11 occurrences of non-clinical mixed sex accommodation breaches, affecting 33 patients. This was reduced from M6 (20 occurrences affecting 59 patients).

The number of category 2 pressure ulcers remained higher than expected with hotspots in 2 wards, observational visits have been carried out and improvements identified. A cluster of category 3 pressure ulcers of patients in 3 different wards is subject to a serious incident inquiry led by the Medicine Division. Progress of the cluster review improvement plan was reported to the Clinical Governance Committee in October.

Reassuringly, all wards had sufficient staff for the numbers of the patients admitted, although the overspend on nursing increased in month by £100k ytd. Whilst some high risk / shielding staff have returned to their clinical departments, some remain in non-clinical or extended leave ahead of maternity roles impacting on spend. In addition there is still additional pressure from areas requiring additional staffing due to Covid-19 in areas such as ED RAZ and the Respiratory Care Unit (RCU). The number of Covid-19 hospital admissions is increasing so this pressure is not expected to reduce.

Financial arrangements mean the Trust is now able to report a surplus or deficit, following the removal of the retrospective top up payment. In October the Trust has reported a modest deficit of £0.2m, however this represents an improvement on both the original M07 plan and the Phase 3 forecast.

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

Integrated Performance Report

December 2020

(data for October 2020)

An outstanding experience for every patient

Summary

Salisbury NHS Foundation Trust

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RTT performance improved to 69.9% (67.61% in M6), but as expected the number of patients waiting over 52 weeks has increased to 295. This is above the trajectory position of 196 for M7 that was submitted as part of the Phase 3 plan. Challenges remain around increasing theatre capacity further with theatres closed due to need to provide Covid-19 critical care, and staffing challenges.

Recovery of the diagnostic standard continues with performance rising further to 92.7% (90% in M6). The number of 6 week breaches has fallen to 252 from 347 in M6.

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ED performance increased in M7 (89.8% versus 88% in M6). Attendance spikes during the evening are causing pressure on the department. Flow out of ED remains a challenge with the number of Stroke patients reaching the Stroke Unit within 4 hours falling to 33.3%. The Stroke Unit bed capacity has increased back to 30 beds with a split across Laverstock and Breamore wards, and a dedicated assessment room.

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Structure of Report

Performance against our Strategic and Enabling Objectives

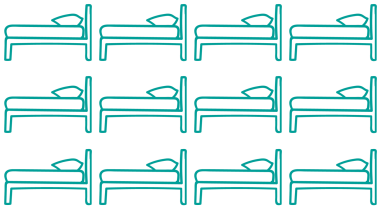
Our Priorities	How We Measure	
Local Services	Are We Effective?	Are We Responsive?
Specialist Services		
Innovation		
Care	Are We Safe?	Are We Caring?
People	Are We Well Led?	Use of Resources
Resources		

Summary Performance
October 2020

NHS Salisbury NHS Foundation Trust

There were **2,649** Non-Elective Admissions to the Trust

We carried out **249** elective procedures & **1,681** day cases



92.7% ↑ of patients received a diagnostic test within **6 weeks**

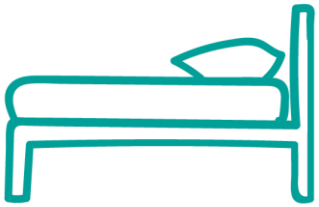
Emergency (4hr) Performance **89.8%** ↓
(Target trajectory: 95%)

We delivered **19,478** outpatient attendances, **32%** through video or telephone appointments

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

Our income was **£22,975k** (£1,401k over plan)

68 patients stayed in hospital for longer than 21 days



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

RTT 18 Week Performance:
69.9%% ↑
Total Waiting List: **16,574** ↑

18.3% ↑ of discharges were completed before 12:00

Our overall vacancy rate was **1.06%** ↓

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

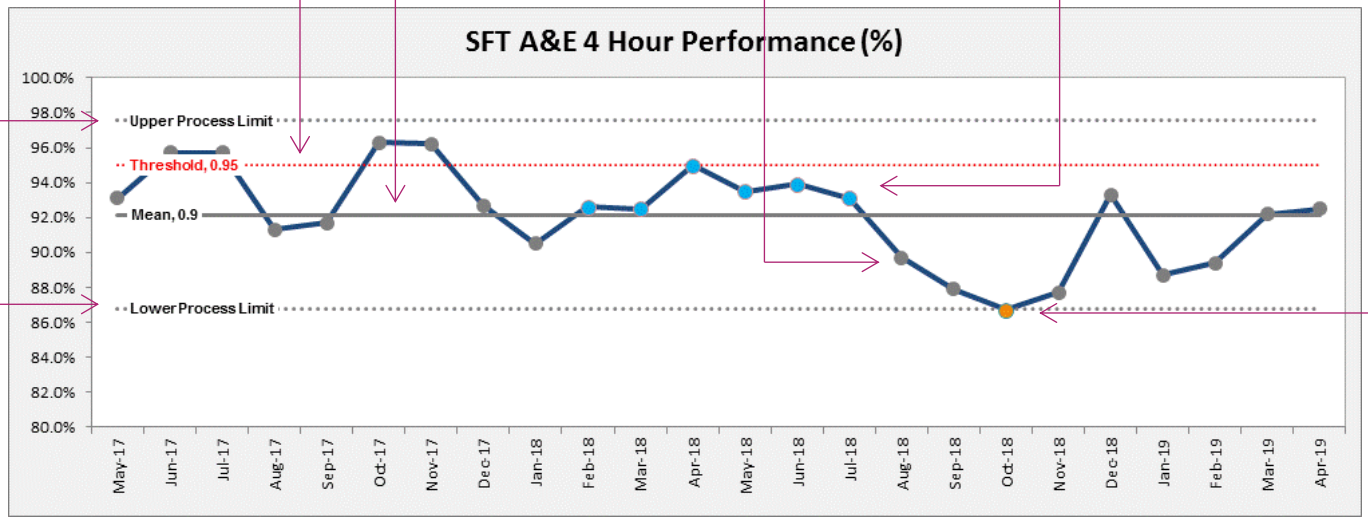
The red line shows the target for the KPI, if there is one

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

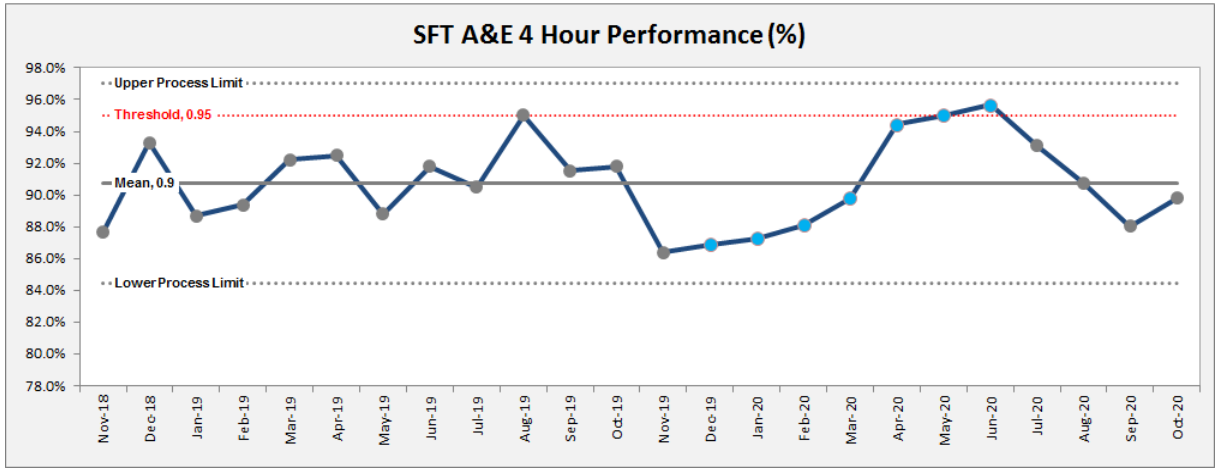
Salisbury NHS Foundation Trust

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:	89.8%
Attendances:	4818
12 Hour Breaches:	0
ED Conversion Rate:	30.3%

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

M7 saw an increase in ED attendances by 558 on M7 last year. However, there is a decrease in attendances as compared to M6 20/21.

There is an associated decrease in performance from 91.78% in M7 19/20 to 89.8% in M7 20/21. An improvement in performance compared to M6 20/21 is noted.

Sharp spikes in attendances post 6pm for majors patients continuing to put pressure on later half of the day.

Pressure on the twilight/evening part of the day has caused some increases in time to assessment and time to treatment, although time to assessment and treatment for the most unwell (resus) patients remains within the targeted range.

Workforce gaps in junior, middle and Consultant tiers continue, mitigated by Locum cover where possible.

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

Temporary cubicle solutions are in place in majors – permanent arrangement is due for installation by end of Q3 – this will serve to increase flexibility for managing infection control issues.

Substantive Consultant appointment achieved in month, likely start date of early 2021.

Returning Consultant from employment break expected M10.

Increase in Registrar level cover expected M11.

Bolstering of junior and middle grade rotas with appropriate rota cover continues as BAU.

Think 111 EDDI successfully launched.

Risks to delivery and mitigations

Increasing numbers of Covid-19 positive patients needing hospital admission will put increased pressure on RCU capacity and flow from ED. Division have escalation plan in place and actions agreed to initiate increased capacity when required.

Turnaround time for swabbing to cover critical staffing gaps – this has been escalated but currently no capacity for rapid swabbing staff regardless of critical nature of staffing gap.

Gaps in consultant workforce – Workforce plan underway but some posts will remain locum reliant until Q4.

Nursing gaps on the rota and reduced nursing skill mix continues to create risk. Reliant on staff support from other areas and some bank shift uptake but since return to school this has been variable.

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)
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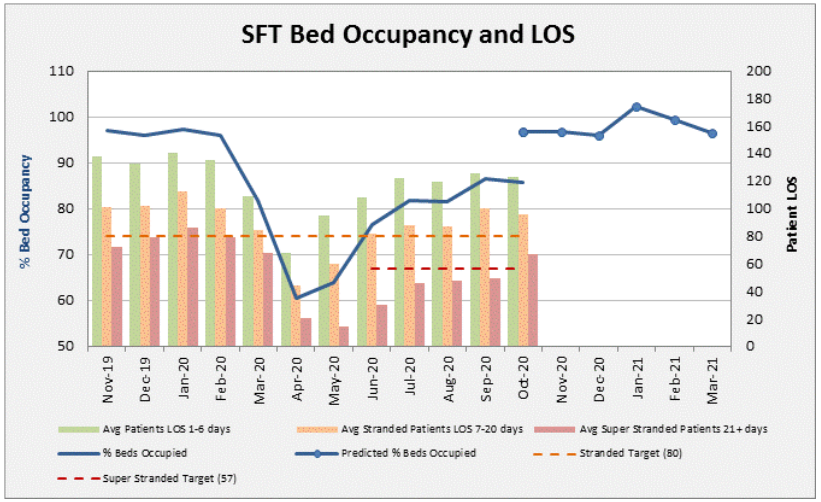
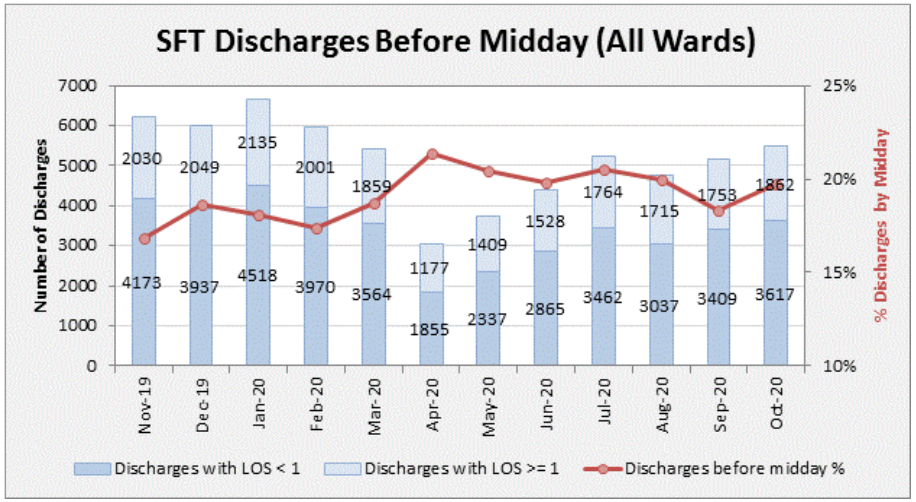
Patient Flow and Discharge

Are We Effective?





As expected, the number of 21 day + LOS has increased to above the target set by NHSE/I pre Covid-19. The group is a combination of people who do and don't meet the criteria to reside.

Occupancy is predicted to remain steady but high in the next 2 months, which also prompts additional consideration of impacts of internal and external actions relating to flow and escalation capacity. A reduction in lost bed days to patients not meeting the criteria to reside in all LOS groups will offer a greater capacity to meet increased demand and reduce pressure on escalated capacity.

Discharges pre noon have seen a steady increase in the last 3 months, reflecting the focus and attention to this area of flow in the Trust. Although the number is not at last year's level, the proportion of pre noon discharges has increased and is significantly improved to this time last year (Nov)

Concentrated time is spent at the expert panel to talk through next steps for patients on journeys at SFT, supporting teams to ensure internal and external processes are expedited appropriately

Wiltshire has reviewed the bed base for discharges from hospital and new rehabilitation resources in care homes are anticipated to come on line in November.

SFT working together with Wiltshire Health and Care to support discharges home from hospital, combing skill and reviewing process to expedite discharges. This is anticipated for December.

Criteria Led Discharge (CLD) is planned for implementation in November in trial areas which will lead to anticipated increases in morning and weekend flow.

An audit is planned for November to examine the issues relating to medication prescription, process and provision affecting discharge and will inform next steps in this area as part of the pre noon discharge project.

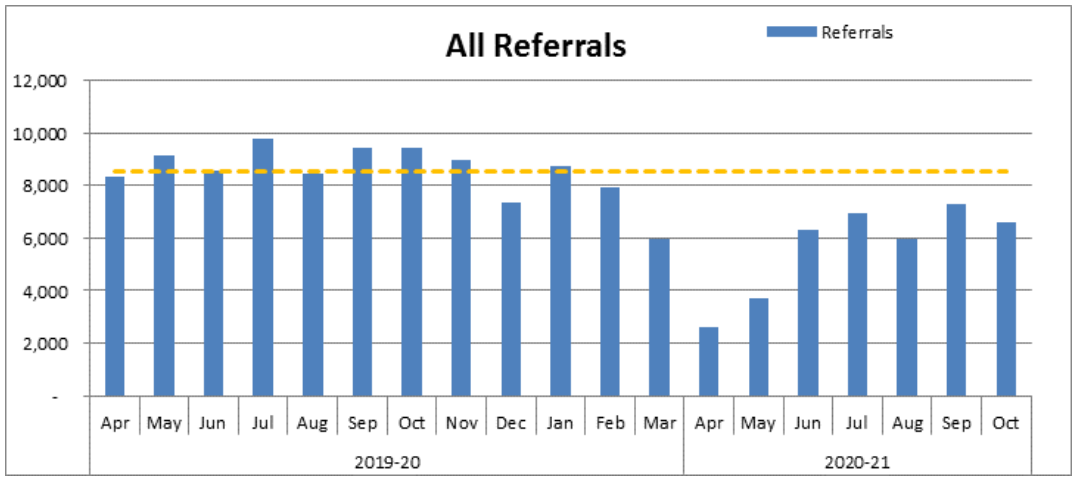
Covid-19 may affect admission to independent providers either care agencies, community services or care homes and affecting staff in SFT reducing the ability to promote flow

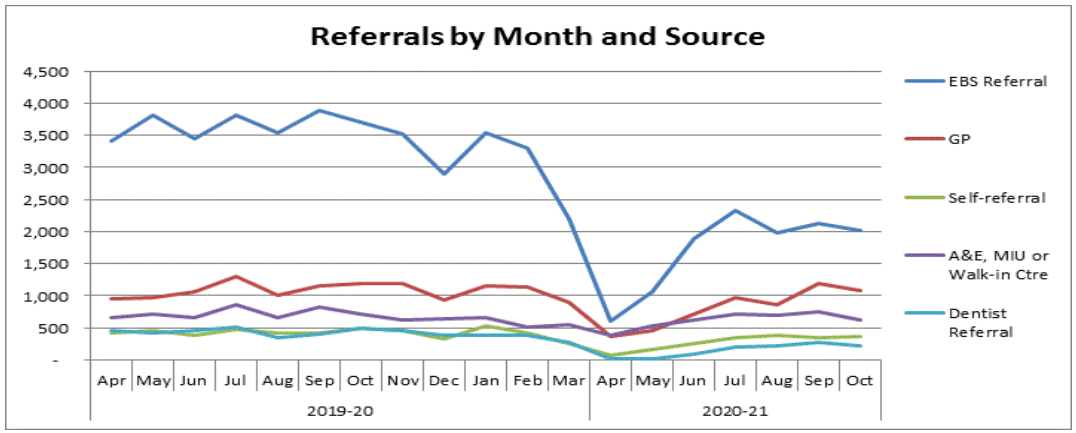
Governance arrangements for CLD not being in place in time for November launch due to more immediate operational pressures.

A surge in occupancy is predicted for January but if it comes before in exceptional circumstances, it may affect Trust ability to promote timely journeys particularly when combined with the risks above.

Referrals

Additional Supporting Information





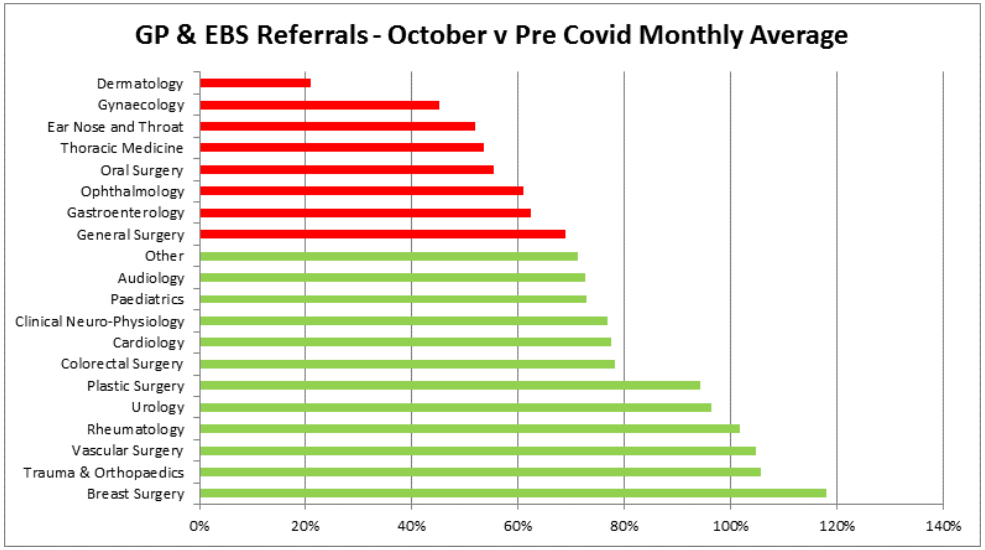
Comments

Referral levels remain under 2019-20 levels and have been at a fairly consistent level since June. Dental referral remain affected by low levels of activity in dental practices.

Referrals

Additional Supporting Information

Specialty	October	Pre Covid Monthly Average	% of Pre Covid Monthly Average
Breast Surgery	265	225	118%
Trauma & Orthopaedics	192	182	106%
Vascular Surgery	60	57	105%
Rheumatology	172	169	102%
Urology	232	241	96%
Plastic Surgery	277	294	94%
Colorectal Surgery	224	287	78%
Cardiology	196	253	78%
Clinical Neuro-Physiology	100	130	77%
Paediatrics	124	170	73%
Audiology	224	309	73%
Other	421	591	71%
General Surgery	59	86	69%
Gastroenterology	102	164	62%
Ophthalmology	251	412	61%
Oral Surgery	29	52	55%
Thoracic Medicine	55	103	53%
Ear Nose and Throat	157	303	52%
Gynaecology	137	304	45%
Dermatology	39	186	21%

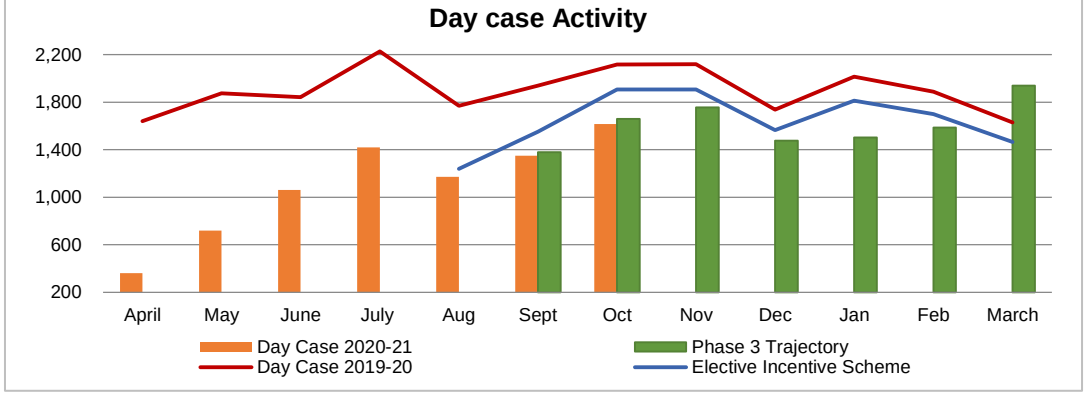


Comments

Specialties affected more disproportionally by aerosol generating procedures remain also appear to be more affected by slow return to normal referral levels – such as ENT, Ophthalmology, Thoracic Medicine and Dermatology.

Activity recovery – Day case (target 80%)

Are We Effective?



Specialty	October 20 activity	Phase 3 Plan - Oct 20	Variance	% of October 2019
Urology	106	136	-30	83%
Cardiology	85	105	-20	71%
Ophthalmology	90	106	-16	57%
General Medicine	65	81	-16	88%
Dermatology	5	15	-10	167%
Gynaecology	26	35	-9	39%
ENT	28	34	-6	56%
Interventional Radiology	4	10	-6	24%
Rheumatology	79	85	-6	68%
Breast Surgery	9	13	-4	64%
Geriatric Medicine	2	6	-4	50%
Upper Gastrointestinal Surgery		2	-2	0%
Paediatrics	3	5	-2	300%
Respiratory Medicine	14	15	-1	67%
Colorectal Surgery	96	97	-1	77%
Obstetrics	4	5	-1	0%
Neurology	17	16	1	71%
Plastic Surgery	259	253	6	92%
Gastroenterology	356	347	9	75%
General Surgery	258	245	13	106%
Spinal Surgery	13	0	13	72%
Trauma & Orthopaedics	16	2	14	26%
Oral Surgery	76	46	30	83%
Total	**1616**	**1660**	**-49**	**77%**

Daycase activity for October was almost in line with the Phase 3 trajectory that was submitted to NHSE/I in August. 1616 daycases were carried out against a trajectory of 1660, with a shortfall of just 49 (less than 1% variance).

Activity in M7 increased compared to M6 (1616 versus 1380 in M6).

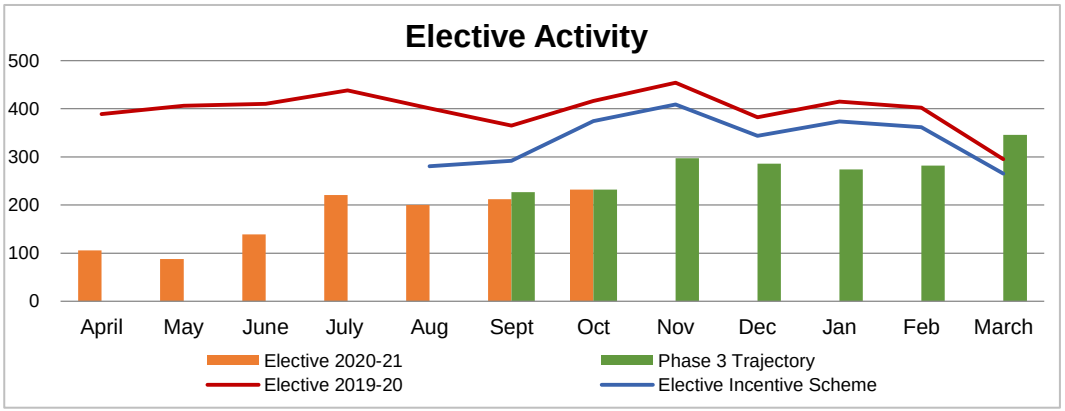
Theatre space continues to be allocated by clinical priority and need resulting in theatre access varying by specialty month to month.

Outsourcing to New Hall continues in Trauma & Orthopaedics, Plastics, Spinal and Ophthalmology. New Hall activity is not included within SFT numbers.

ENT and Oral Surgery remain challenging to increase with proportionally higher numbers of aerosol generating procedures.

Activity recovery – Electives (target 80%)

Are We Effective?



Specialty	October 20 activity	Phase 3 Plan - Oct 20	Variance	% of October 2019
Trauma & Orthopaedics	14	36	-22	15%
Plastic Surgery	36	46	-10	40%
Gynaecology	8	17	-9	32%
Colorectal Surgery	24	26	-2	133%
Oral Surgery	3	5	-2	50%
Breast Surgery	10	10	0	53%
General Surgery	22	21	1	92%
Spinal Surgery	2	1	1	11%
Clinical Haematology	7	5	2	117%
Paediatrics	3	1	2	300%
General Medicine	6	4	2	150%
Gastroenterology	4	1	3	133%
Ophthalmology	3		3	300%
Cardiology	10	6	5	91%
Urology	49	44	5	86%
ENT	16	4	12	62%
Total	**232**	**232**	**0**	**57%**

Elective activity levels met the Phase 3 trajectory submitted by the Trust to NHSE/I in August. Elective activity remains significantly lower than 2019-20 levels, but in line with our trajectory.

As activity levels are below our 2019-20 levels the Trust did not reach the levels required for the Elective Incentive Scheme (EIS). The trajectory submitted by the Trust forecast that the elective activity would not reach the EIS levels until March 2022.

Outsourcing to New Hall continues in Trauma & Orthopaedics, Plastics and Spinal. New Hall activity is not included within SFT numbers.

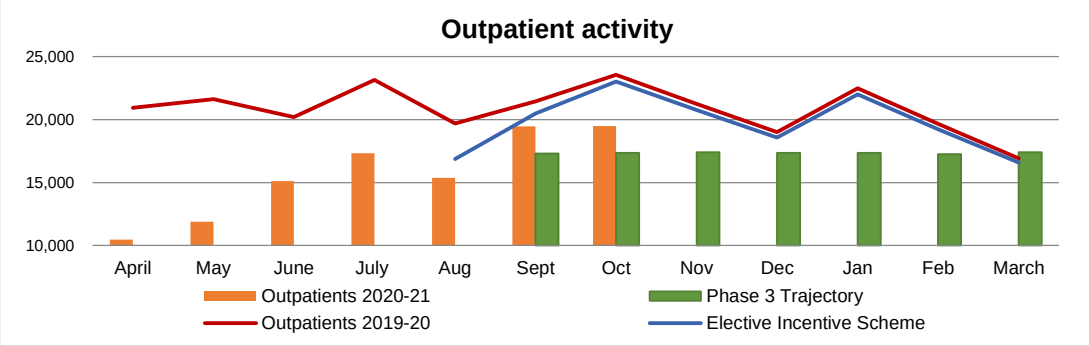
Activity is planned to rise in November with theatres 7 and 10 due to open.

Theatre lists continue to be allocated on clinical prioritisation, specialities with lower levels of urgent patients will recover activity levels more slowly – Gynaecology and Urology were affected by this in October.

ENT were slow to get off ground due to the safeguards needed to be put in place around aerosol generating procedures, but have now begun to exceed plan.

Activity recovery – Outpatients (target 100%)

Are We Effective?



Specialty	October 20 activity	Phase 3 Plan - Oct 20	Variance	% of October 2019
Trauma & Orthopaedics	1302	1694	-392	62%
Respiratory Medicine	695	1009	-314	105%
Endocrinology	449	692	-243	153%
Paediatrics	728	945	-217	75%
Cardiology	662	757	-95	102%
Orthodontics	218	299	-81	58%
General Surgery	179	252	-73	53%
Vascular Surgery	145	198	-53	57%
General Medicine	44	90	-46	33%
ENT	687	723	-36	76%
Ophthalmology	2129	2163	-34	78%
Breast Surgery	407	430	-23	89%
Anticoagulant Service	72	90	-18	74%
Interventional Radiology	50	63	-13	42%
Clinical Oncology	68	74	-6	155%
Oral Surgery	510	514	-4	66%
Clinical Psychology	109	108	1	77%
Gastroenterology	342	340	2	105%
Rheumatology	908	900	8	97%
Transient Ischaemic Attack	55	41	15	83%
Neurophysiology	135	108	27	87%
Geriatric Medicine	174	140	35	83%
Clinical Haematology	461	409	52	109%
Gynaecological Oncology	53		53	69%
Medical Oncology	433	376	57	105%
Paediatric Ear Nose And Throat	57		57	61%
Dermatology	555	492	63	73%
Hepatology	65		65	46%
Paediatric Trauma And Orthopaedics	75		75	341%
Gynaecology	712	622	90	98%
Clinical Cardiac Physiology	295	180	115	230%
Colorectal Surgery	590	473	117	91%
Burns Care	133		133	166%
Orthotics	588	450	138	93%
GUM	595	450	145	107%
Orthoptics	158		158	81%
Spinal Surgery	161	0	161	60%
Spinal Injuries	168		168	80%
Urology	817	638	179	85%
Diabetic Medicine	205		205	64%
Plastic Surgery	2165	1445	720	93%
Audiology	763		763	77%
Total	**19487**	**17354**	**2133**	**83%**

Outpatient activity levels for M7 exceeded the forecast Phase 3 trajectory submitted to NHSE/I. Although the plan was met, outpatient activity remains lower than pre Covid-19 levels. With increased numbers of appointments being undertaken virtually, the level of outpatient procedures has reduced.

An air change solution for ENT & oral surgery outpatient department has been identified, and is expected to be in place during Q4, with activity expected to rise following this.

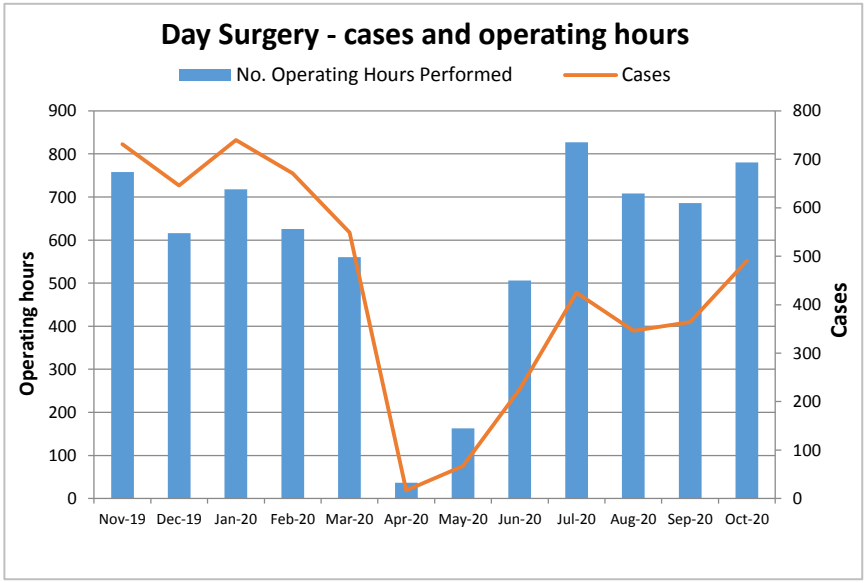
Space constraints across outpatient department continue to be a challenge, particularly in specialties with low levels of patients suitable for virtual appointments such as Trauma & Orthopaedics. The modular build expected in mid-Q4 will increase the number of patients that can be safely seen.

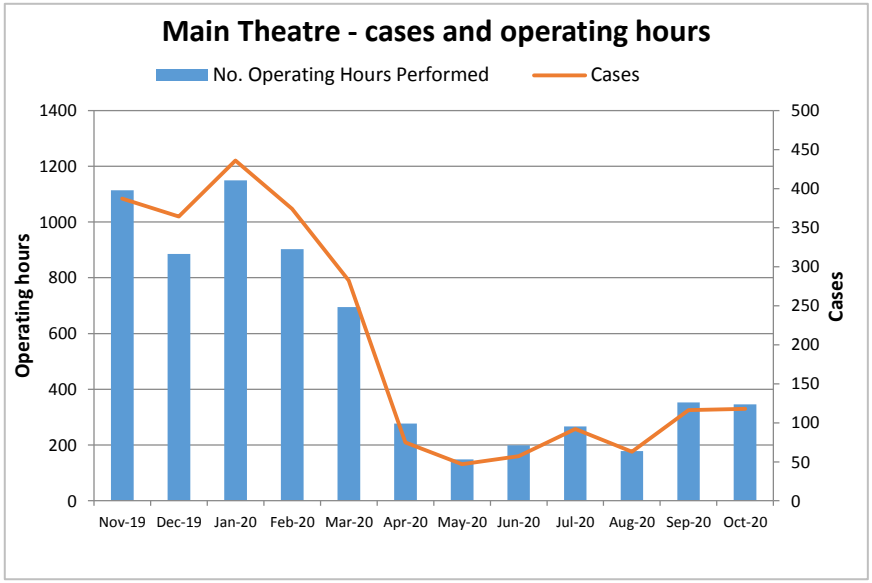
Virtual appointments are working well in some specialties with Gastroenterology seeing 99% of their outpatients virtually, Urology and Colorectal surgery are also seeing good use of virtual appointments.

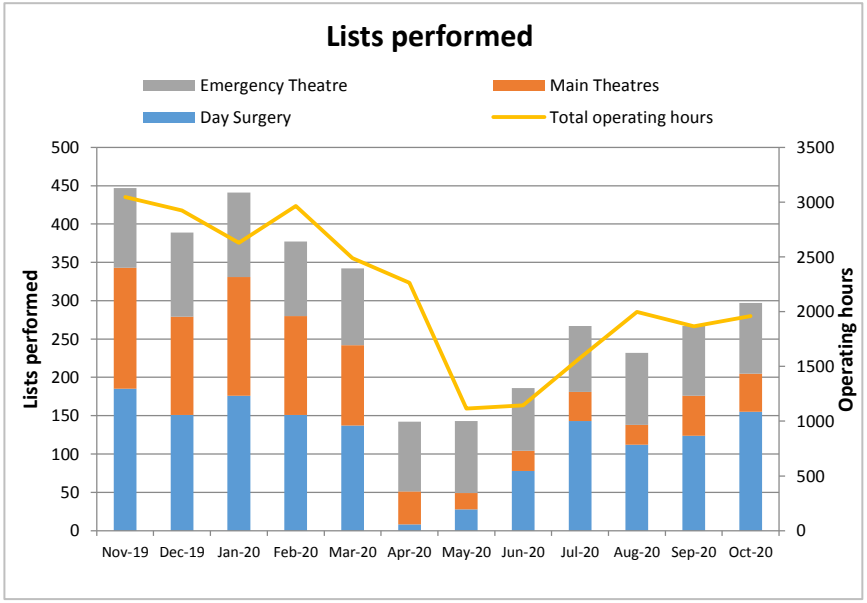
Specialties with activity or plan below 50 in month are excluded from the specialty breakdown chart.

Activity recovery - Theatres

Additional Supporting Information







The overall number of theatre lists undertaken in Month 7 increased from M6.

The number of lists undertaken in October was slightly reduced due to half term at the end of the month. Additional staffing challenges were generated due to an unknown Covid-19 positive patient being treated in theatres, this resulted in 10 staff needing to isolate for 14 days.

An expected increase in Covid-19 activity increases the risk of the need to use theatre space to create a Covid-19 critical care. An increase in the phase 3 recovery plan is planned to begin in November.

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

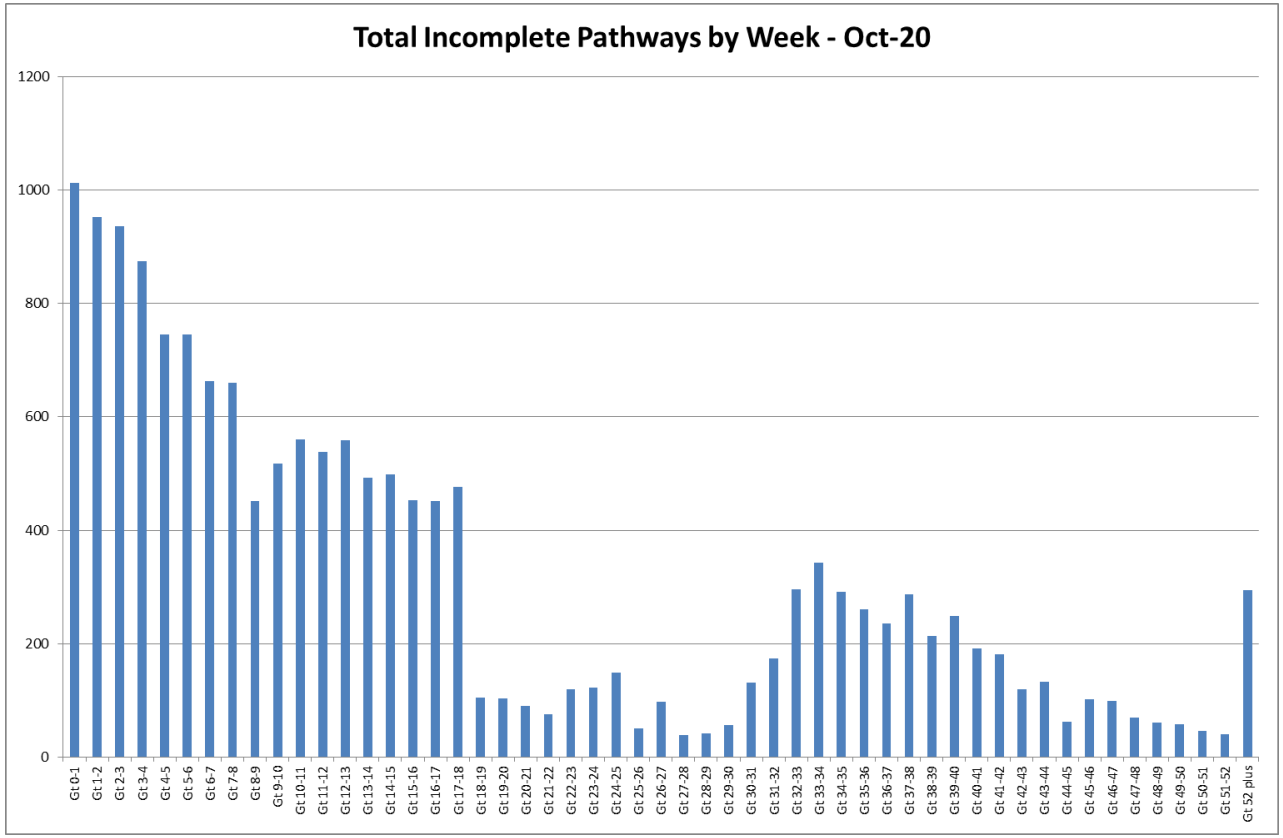
National Key Performance Indicators

Top 5 lowest 18 week performance

Specialty	WL Total	Total <18 weeks	% <18 weeks
Dermatology	307	107	34.9%
Ear, Nose & Throat (ENT)	1122	450	40.1%
Ophthalmology	1763	846	48.0%
Oral Surgery	1441	788	54.7%
Plastic Surgery	1334	808	60.6%

Top 5 largest 18 week breach backlog

Specialty	WL Total	Total 18 wk breaches	% <18 weeks
Ophthalmology	1763	917	48.0%
Ear, Nose & Throat (ENT)	1122	672	40.1%
Oral Surgery	1441	653	54.7%
Other	3055	553	81.9%
Plastic Surgery	1334	526	60.6%

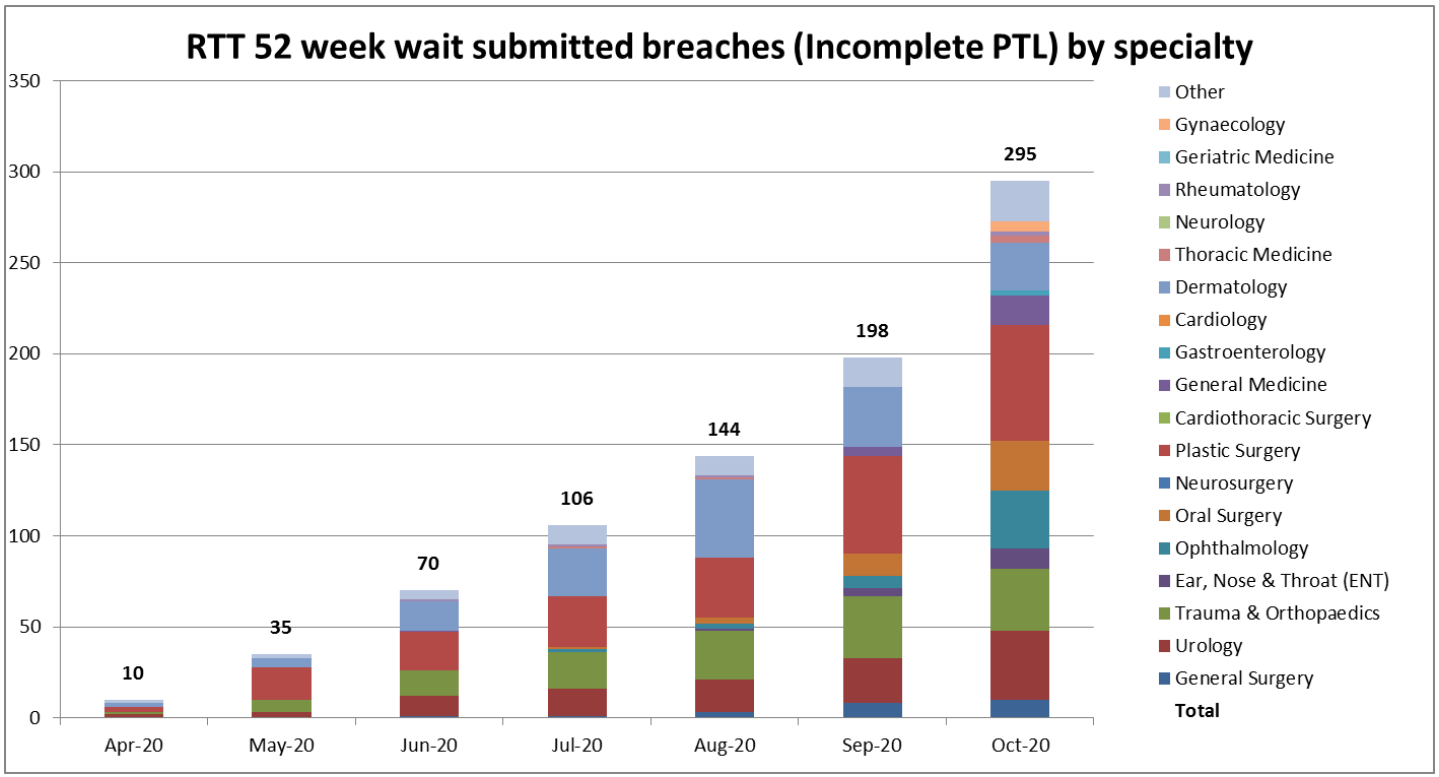


RTT performance continued to improve slightly in October at 69.9% (67.61% in M6). This is due to increased activity especially in outpatients and day cases.

As part of the support work for areas with the poorest compliance, and largest volumes, the Surgical DMT are focussing on Ophthalmology - conducting a deep dive into outpatient capacity options, and have outsourced some patients to Newhall as part of this. Additionally air change solutions for ENT have now been identified and will be installed during Q4 but improvement will be limited until these are in place. Work on Dermatology productivity continues and additional minor operation capacity has been set up for November and December including Saturday outpatient and surgical lists.

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

National Key Performance Indicators



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

Treatment function	Apr-20	May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	% change from previous month
Plastic Surgery	3	18	21	28	33	54	64	19%
Urology	2	3	11	15	18	25	38	52%
Trauma & Orthopaedics	1	7	14	20	27	34	34	0%
Dermatology	2	5	16	26	43	33	26	-21%
Other	2	2	5	11	11	16	22	38%

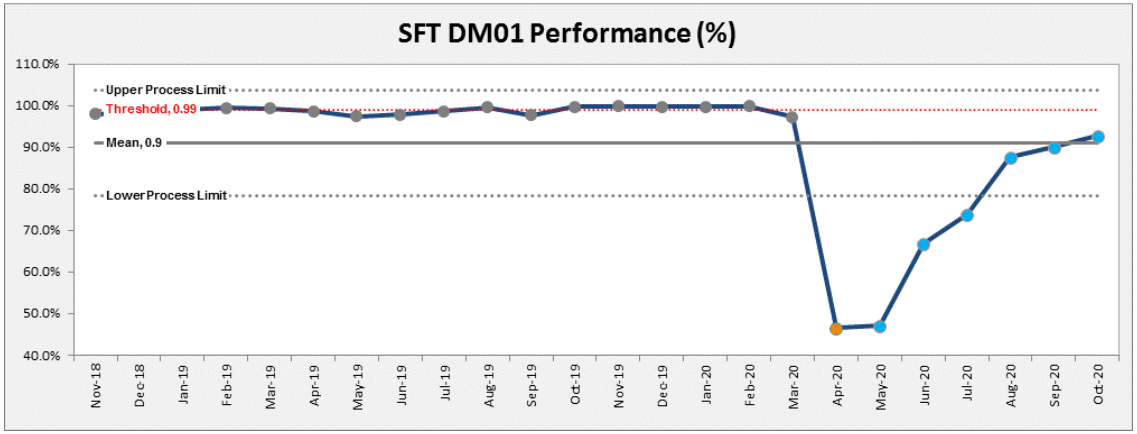
The number of patients waiting longer than 52 weeks has grown by 97 patients to a total of 295. Of these though 21 are patients who have requested to pause their pathway due to Covid-19 concerns.

As part of the phase 3 activity assumptions the Trust forecast that the number of over 52 week patients would grow every month until the end of 2020-21.

The forecast position for M7 was 196 patients over 52 weeks. Theatre capacity continues to be allocated on the basis of clinical priority and then longest waiters.

Diagnostic Wait Times (DM01) Target 99%

National Key Performance Indicators



Data Quality Rating:	
Performance Latest Month:	92.7%
Waiting List Volume:	3464
6 Week Breaches:	252
Diagnostics Performed:	6928

Background, actions being taken and risks and mitigations
Performance standard in month has not been achieved as a direct impact of Covid-19. November projections confirm that the target is not achievable for M8, however further progress against waits in all areas are contributing to an improved position. Recovery plans for both Audiology and Cardiology are in place, with reductions in M7 breaches as a direct comparison to M6. Concerns relating to CT breaches remain, ongoing discussions taking place with New Hall Hospital in relation to increased capacity. Improvements continue to be noted in relation to the number of patients who are deferring tests owing to Covid-19, this continues to be monitored on a weekly basis.

Endoscopy
13 confirmed in month breaches, all attributable to Covid-19.

Radiology (Inc. DEXA)
36 confirmed in month breaches, all attributable to Covid-19.

Radiology Reporting
Go live of the second provider on hold. Go/No go decision deferred to 18th November 2020. Reduced activity has positively impacted on the number of outstanding reports to the risk to the service is being mitigated against. Interventional Radiology remain the exception, and this is owing to reduced functionality in the work station located at the Royal Bournemouth and Christchurch Hospital (RBCH) SFT IT are supporting to resolve.

Audiology
98 confirmed in month breaches, all attributable to Covid-19.

Cardiology
98 confirmed in month breaches all attributable to Covid-19.

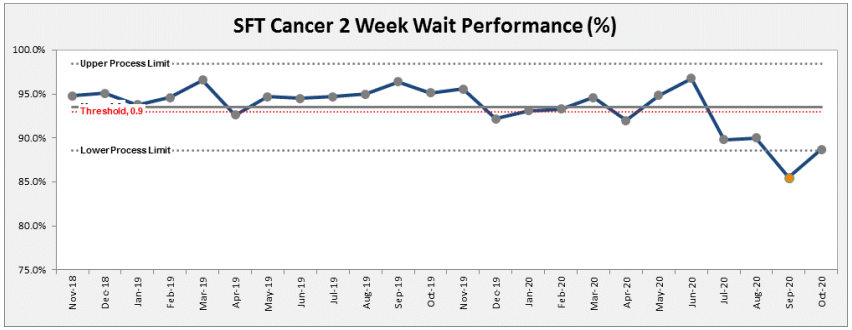
Neurophysiology
7 confirmed in month breaches all attributable to Covid-19.

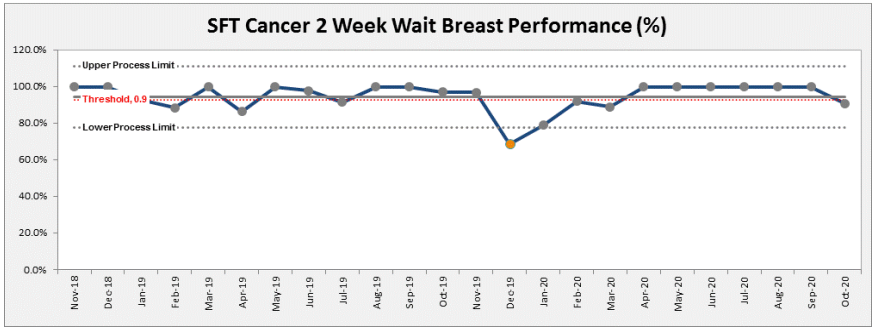
Cancer 2 Week Wait Performance Target 93%

National Key Performance Indicators

Performance Latest Month	Performance	Num/Den	Breaches
Two Week Wait Standard:	88.72%	834/940	106 (38 patient choice)
Two Week Wait Breast Symptomatic Standard:	90.91%	10/11	1

Data Quality Rating:





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

Two week wait standard not achieved for M7 (940 patients seen in total; 834 seen within target; 106 breaches). This is due to a variety of reasons including:

- Patient choice (38 breaches);
- GP delays (i.e. incomplete referrals/lack of completed qFIT); 36 breaches)
- Endoscopy capacity (14 breaches);
- Radiology capacity (4 breaches);
- Clinical delays (3 breaches);
- Administrative delays (5 breaches)
- OPA capacity (3 breaches);
- Prison delays (2 breaches)

Breast symptomatic two week wait performance standard not achieved for M7 (11 patients seen in total; 1 breach)

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

Booking teams continue to prioritise cancer pathways, though ongoing concerns related to patient choice remain; this is likely to impact on service delivery for a significant period of time. Patients are increasingly wanting to be seen face to face as opposed to telephone appointments; this is then exacerbated by social distancing restrictions within medical & surgical outpatients.

Weekly PTL meetings in place, which look to mitigate against any upcoming breaches. This then enables cancer services to work with the relevant team to expedite where possible. Use of cancer escalation process reinvigorated to reduce unnecessary delays.

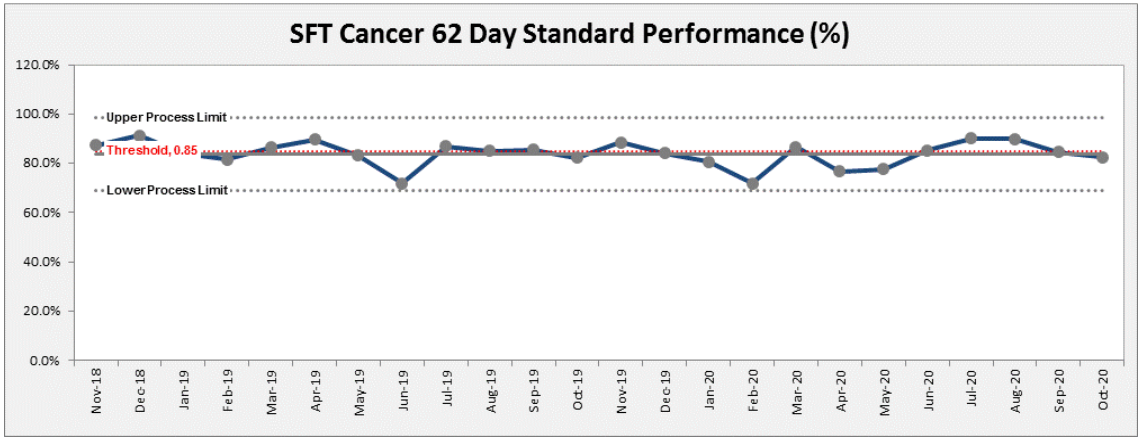
Risks to delivery and mitigations

Diagnostic capacity is likely to significantly affect our ability to achieve the 2ww standard going forward, particularly with services with well established straight to test pathways.

The SWAG cancer alliance has proposed that secondary care will be unable to book or perform diagnostic tests without the completion of a qFIT; this should be completed within primary care though there is a risk that as this is not mandated, that patient's pathways will be significantly delayed.

Cancer 62 Day Standards Performance Target 85%

National Key Performance Indicators



Data Quality Rating:

Performance Latest Month	Performance	Num/Den
62 Day Standard:	82.58%	54.5/66
62 Day Screening:	50%	0.5/1

Risks to delivery and mitigations

Month 7 62 day performance of 82.58% (66 patients treated in total; 54.5 within target; 11.5 breaches). Breach reasons predominantly as a result of complex diagnostic pathways, patient choice and clinical delays.

Two 104 day breaches reported in October following treatment:

- 1 x colorectal; delay associated with endoscopy capacity/national restrictions and further diagnostics required due to ?lymphoma;
- 1 x head & neck; complex diagnostic pathway and delays at tertiary centre to commence treatment

Future performance continues to remain fragile in light of the number of long waiters. Cancer services and DMT continue to focus on such long waiters and the overall PTL backlog (patients waiting over 62 days); this focus is showing an improvement.

Month 7 62 day screening performance standard not achieved (2 patients treated in total; 0.5 breaches). Breach as a result of diagnostics delays as multiple biopsies taken prior to diagnosis.

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

Stroke & TIA Pathways

Are We Effective?

SFT SSNAP Case Ascertainment Audit Score:

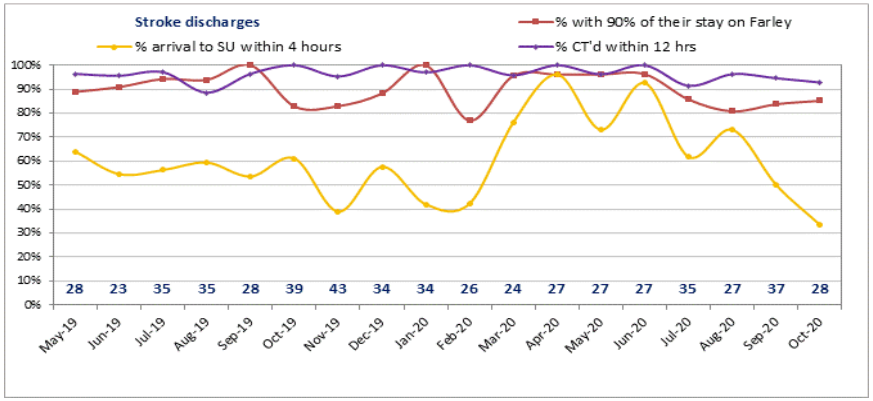
Year	Q1	Q2	Q3	Q4
2019-20	B	B	B	Not Reported
2020-21	Not Reported	Not Reported		

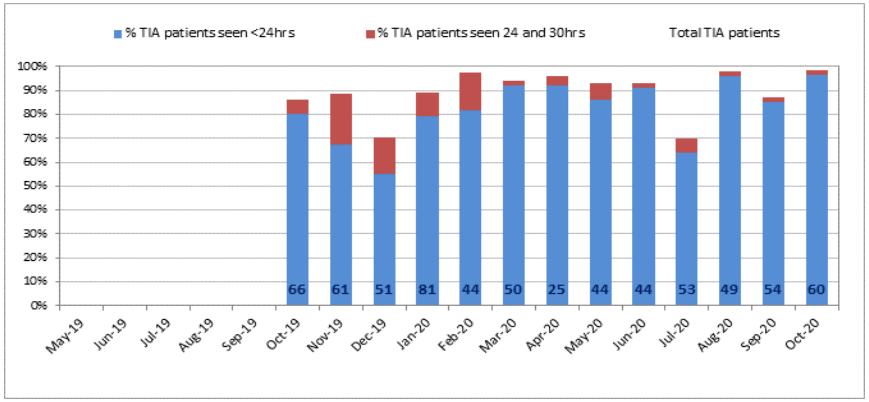
Data Quality Rating:

% Arrival on SU <4 hours: 33.3%

% CT'd < 12 hours: 92.9%

% TIA Seen < 24 hours: 96.7%





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

36% of stroke patients had a CT within 1 hour (target 50%) reflecting the number of patients arriving out of hours and increased pressure on ED. A reduction of patients reaching the stroke unit within 4 hours affected 18 patients. Delays were due to waiting for a bed (9), waiting for first doctor/speciality doctor (6), admitted to AMU (2) and ED workload (1). 3 (10.7%) stroke deaths in October – lower than expected (17%). 85% of patients spent 90% of their time on the stroke unit exceeding the national target (80%).

TIA performance improved to 97% – 1 patient was not seen within 24 hours due to a late referral from ED. 1 patient required an MRI scan which occurred the following day.

SSNAP confirmed that Q2 20/21 scores will not be published as many hospitals did not submit data during the Covid-19 emergency. SFT continued to submit data throughout the entire Covid-19 period. As yet there is no indication when SSNAP plan to start publishing Trust scores.

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

Early Supported Discharge (ESD) services returned to normal levels and 58% of eligible patients achieved ESD exceeding the 40% national target.

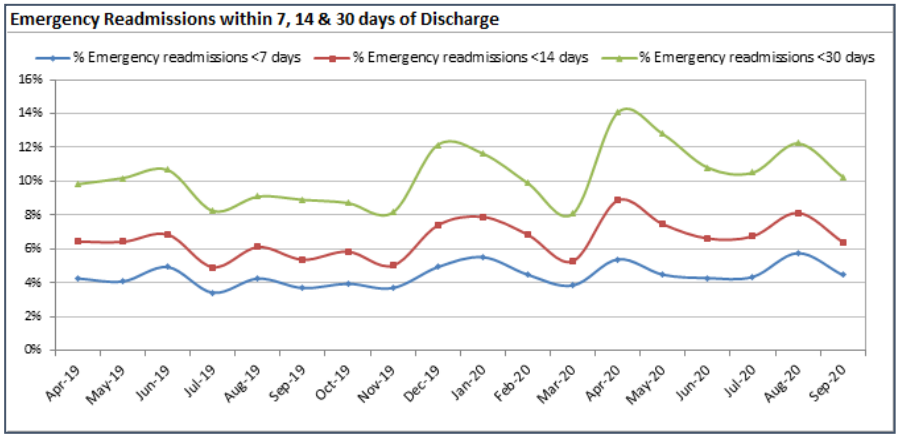
Risks to delivery and mitigations

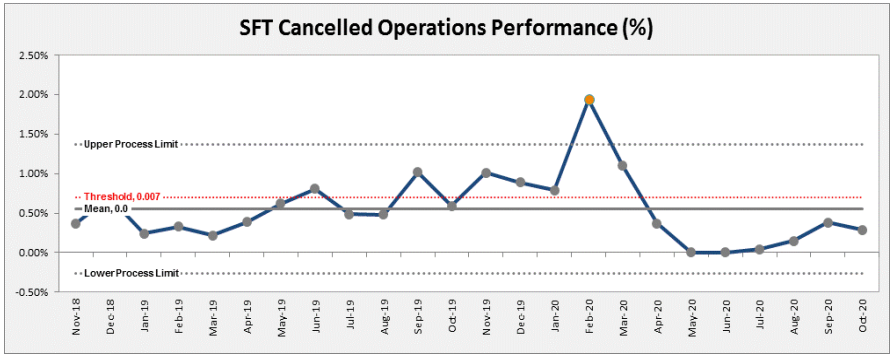
Laverstock ward has reduced in size to 17 beds due to a planned expansion of ITU. Inpatient stroke services are now running across 2 wards. Laverstock ward will continue as the hyper-acute/acute unit. Stroke Rehabilitation will be provided on Breamore Ward. Both wards will operate under the leadership of the Stroke Unit, Senior Sister and be managed by the Stroke Team.

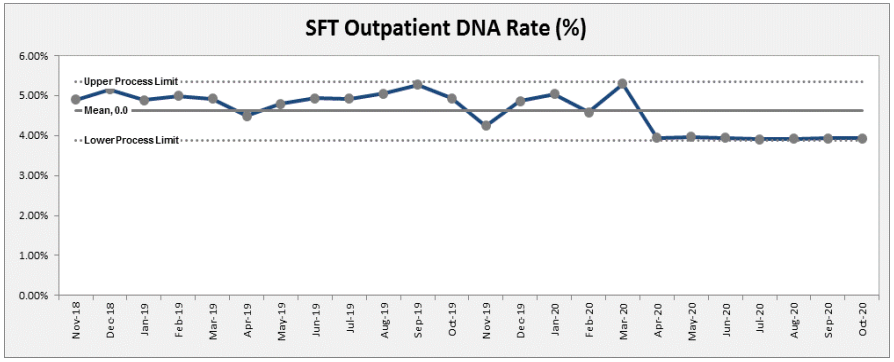
The Stroke Unit now has 30 beds available for stroke patients again . The assessment bed has been re-instated enabling GP direct admissions again and is anticipated to improve the time to the stroke unit within 4 hours of arrival in ED.

Other Measures

Are We Effective?







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

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		

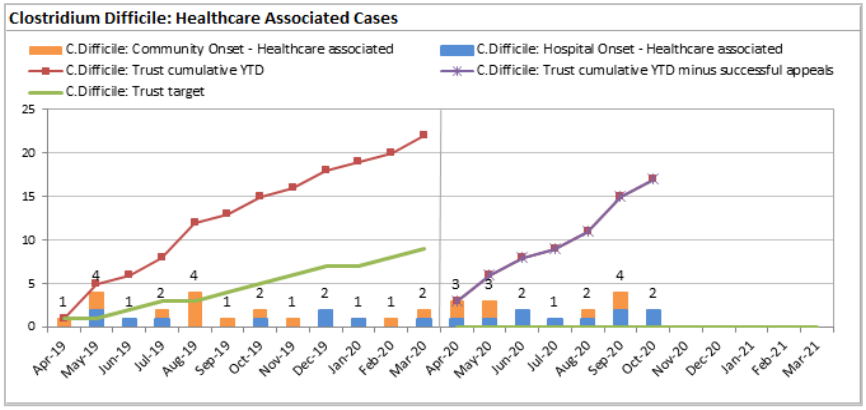
Infection Control

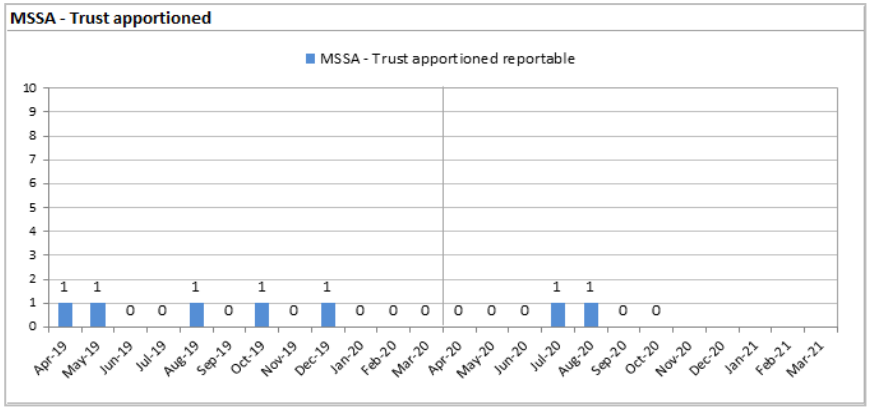
Data Quality Rating:

Are We Safe?

Clostridium Difficile	Jan 20	Feb 20	Mar 20	Apr 20	May 20	Jun 20	Jul 20	Aug 20	Sep 20	Oct 20
Cases Appealed	1	0	0	0	0	0	0	0	0	0
Successful Appeals	1	2	0	0	0	0	0	0	0	0

MRSA	2019-20	2020-21
Trust Apportioned	0	1





Summary and Action

PHE has not set a C.Difficile upper limit for hospital onset healthcare associated and community onset healthcare associated cases. The Trust has not submitted any cases for appeal to the CCG for no lapses in care.

2 hospital onset healthcare associated C.difficile cases in October:

- A patient who was being isolated on Pitton Ward admitted to Redlynch Ward for alcohol detoxification and electrolyte replacement who had a history of chronic diarrhoea. Initially, symptoms were assessed to be secondary to his underlying condition, but a sample was requested when symptoms persisted and the patient transferred to Pitton ward.
- A patient on Downton Ward with a complex history, and was admitted generally unwell with urinary retention, infection and haematuria having recently been discharged from New Hall Hospital. A CT scan undertaken showed thickening of the sigmoid colon, which could have been related to colitis, a lesion or may have been caused by C.difficile.

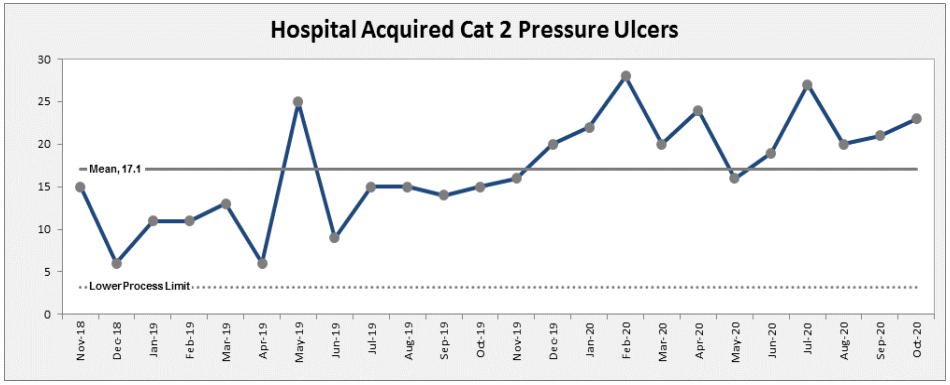
Outcome of investigations/learning from hospital onset healthcare associated cases not previously reported:

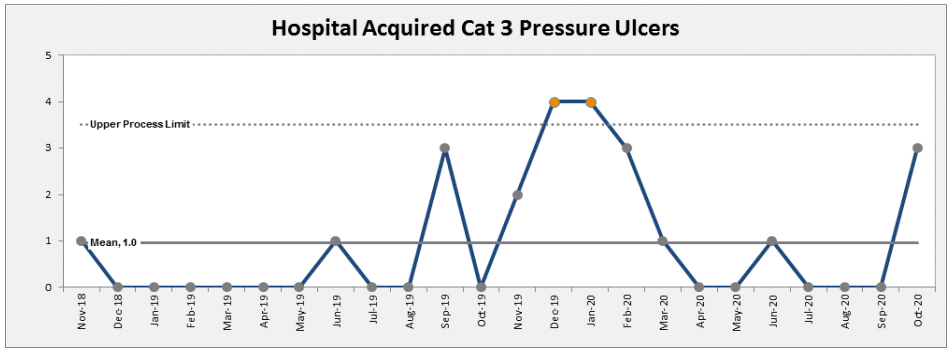
- In September - a patient on Pembroke Ward with a complex history and had previously tested C.difficile detected in June. Learning showed the pathway for re-sampling was not followed whereby a discussion with a Microbiologist should have occurred prior to the decision to sample.

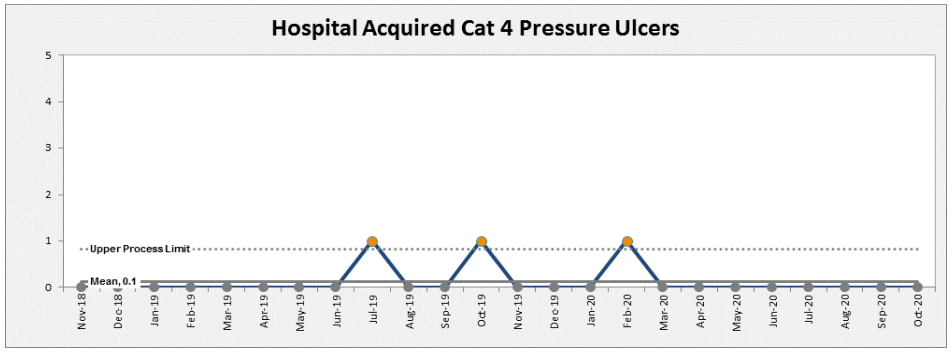
Pressure Ulcers

Are We Safe?

Data Quality Rating:







Per 1000 Bed Days	2019-20 Q2	2019-20 Q3	2019-20 Q4	2020-21 Q1	2020-21 Q2
Pressure Ulcers	1.10	1.22	1.73	2.27	1.92

Summary and Action

The number of category 2 pressure ulcers remained higher than expected with hotspots in 2 wards. The Tissue Viability Team undertook an observational visit on Pitton ward and identified that information about wound care was not being discussed at handover. The Senior Nurse is reviewing the handover process to ensure wound care is highlighted within the safety brief. The AMU pressure ulcer quality improvement project planned 'Plan Do See Act' cycle is still planned and has been taken on by the interim Senior Nurse.

A cluster of three category 3 pressure ulcers of patients in 3 different wards is subject to a serious incident inquiry led by the Medicine Division. One of these category 3 ulcers progressed from previously unstageable in September to a category 3 pressure ulcer in October.

Progress of the cluster review improvement plan was reported to the Clinical Governance Committee in October by the Divisional Heads of Nursing.

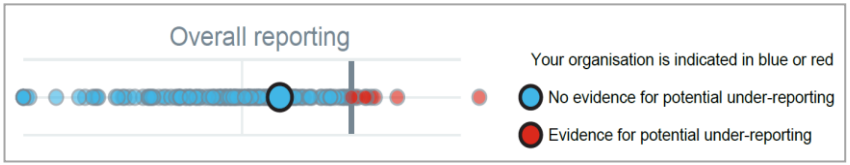
Preparation is underway for the global 'Stop the pressure' campaign on 19 November. The focus will be on education and an e-learning package will be available on the prevention and management of pressure ulcers.

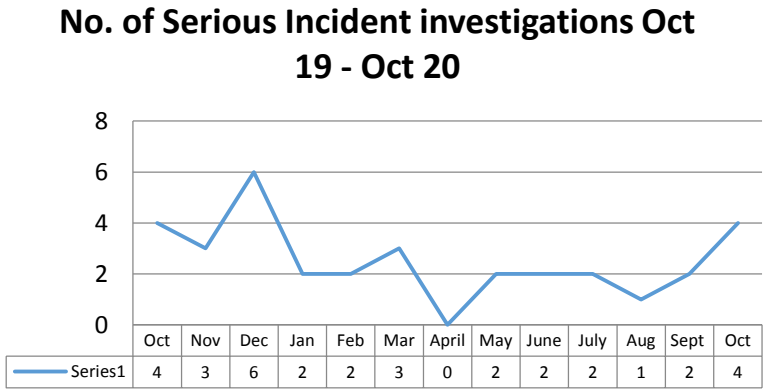
Incidents

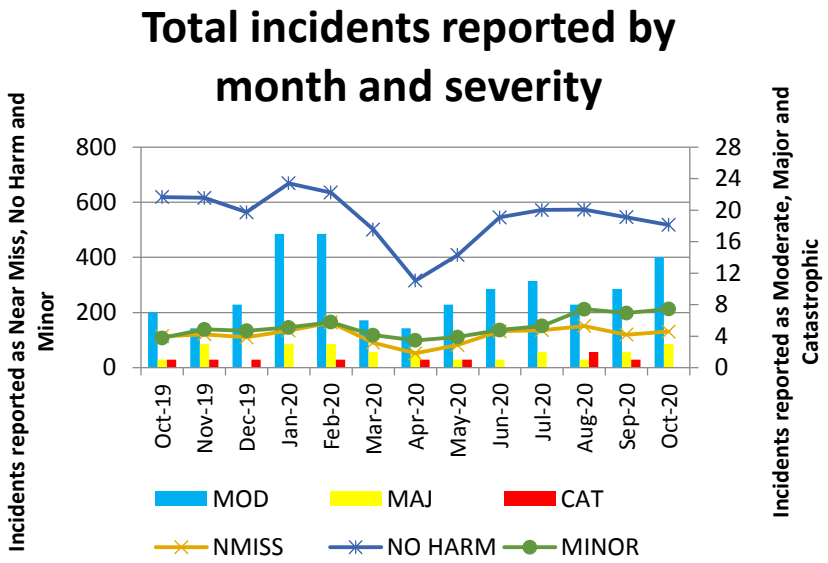
Are We Safe?

Year	2019-20	2020-21
Never Events	2	0

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







Summary and Action

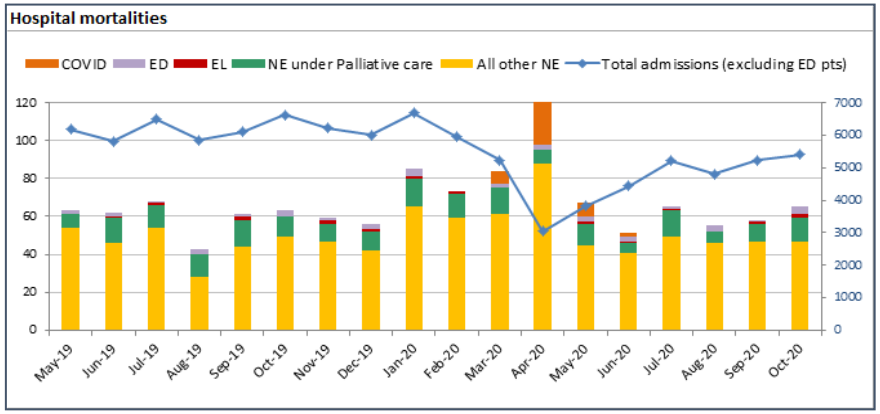
4 serious Incident investigations commissioned in October:

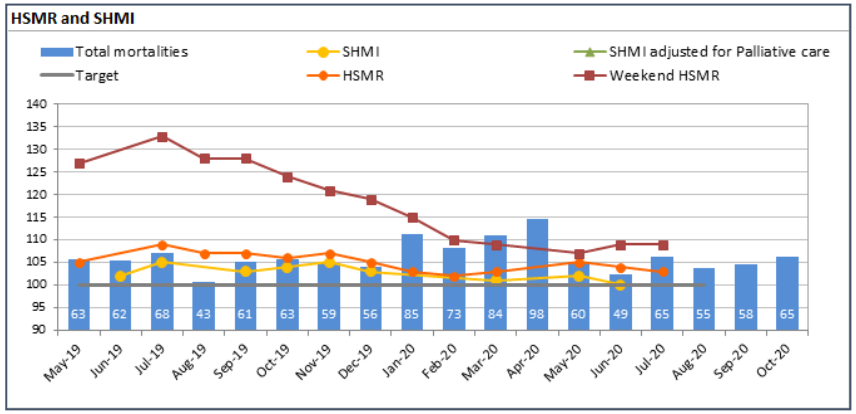
- A bladder Injury (maternity) - the woman remains self-catheterising 6 times a day and is awaiting video urodynamics.
- A Covid-19 positive patient underwent an aerosol generating procedure in Day Surgery - it was not highlighted in advance that the patient had a positive test result. Theatre staff were exposed to a Covid-19 positive patient from a procedure that took over 20 minutes, were not able to socially distance and were not wearing level 3 PPE. The staff were required to self-isolate for 14 days.
- Fall resulting in a catastrophic subdural haemorrhage (fall reported in September) – a decision was made for palliative care and the patient sadly died a week later.
- Pressure ulcer cluster review - 3 cases of category 3 hospital acquired pressures ulcers across the Medicine Division.

Mortality Indicators

Are We Safe?

Data Quality Rating:





Summary and Action

HSMR is as expected to July 20. The weekend HSMR has increased and remains within the expected range.

3 deaths in October associated with Covid-19. All the cases were community onset.

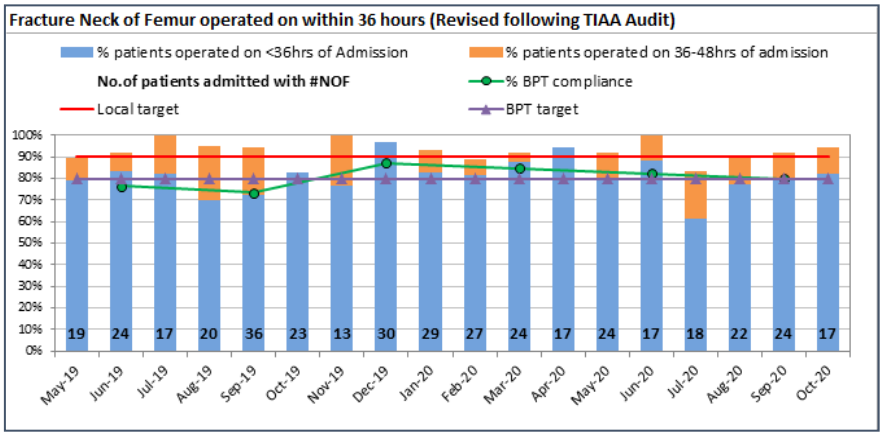
The Mortality Surveillance Group has completed a review of deaths from Covid-19 and will report the findings to the Clinical Governance Committee in November 20. Risks associated with nosocomial transmission have been reduced with measures already put in place. Evaluation of the effectiveness of these measures will be assessed in the 2nd wave.

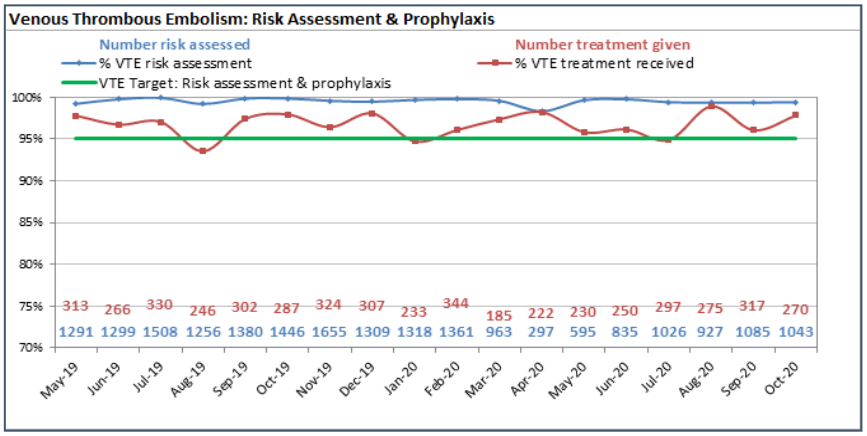
The Q2 Learning from Deaths report sets out the learning and outcomes this year and will be reported to the Clinical Governance Committee in November 20.

Fracture Neck of Femur & VTE Risk Assessment/Prophylaxis

Are We Safe?

Data Quality Rating:





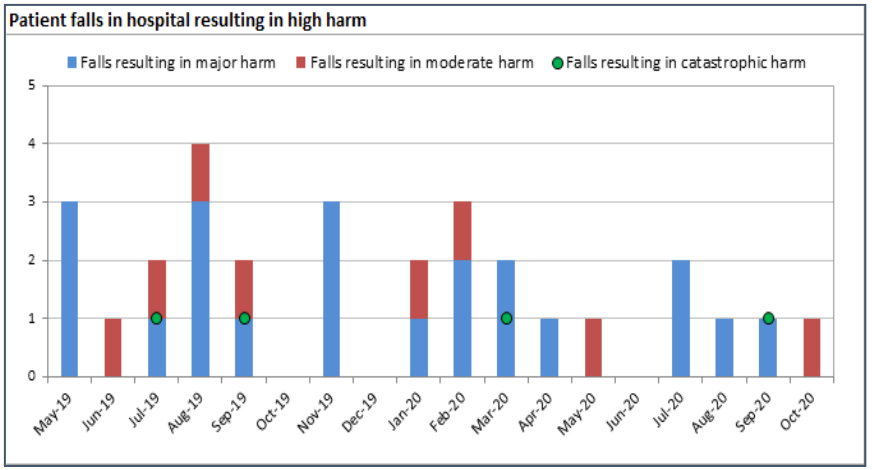
Summary and Action

In October, 4 patients did not receive hip surgery for a fractured neck of femur within 36 hours. 2 patients waited for theatre space - 1 patient had surgery at 39 hours and 1 patient had surgery at 69 hours. Root cause analysis showed that the patient who had surgery at 69 hours developed a post-operative lower respiratory tract infection successfully treated with antibiotics and a pulmonary embolism treated with an anti-coagulant. He was discharged on day 13 fully able to mobilise.

The Trust continued to report good performance in VTE risk assessment and prophylaxis. NHSE&I notified the Trust on 29 September that due to the continued impact of Covid-19 and the ongoing need to release capacity across the NHS to support the response, a pause on VTE data collection and publication will continue until March 2021.

Patient Falls

Are We Safe?



Data Quality Rating:

Per 1000 Bed Days	2019-20 Q2	2019-20 Q3	2019-20 Q4	2020-21 Q1	2020-21 Q2
Patient Falls	0.20	0.07	0.17	0.08	0.11

Summary and Action

In October, 1 moderate harm fall.

- The patient fell and suffered a fractured wrist treated with a splint. As a result, the patient was unable to use his Zimmer frame and instead needed a Gutter frame which was too big to get in his house and led to a delay in discharge. Learning related to the timeliness of assessment and use of intentional rounding.

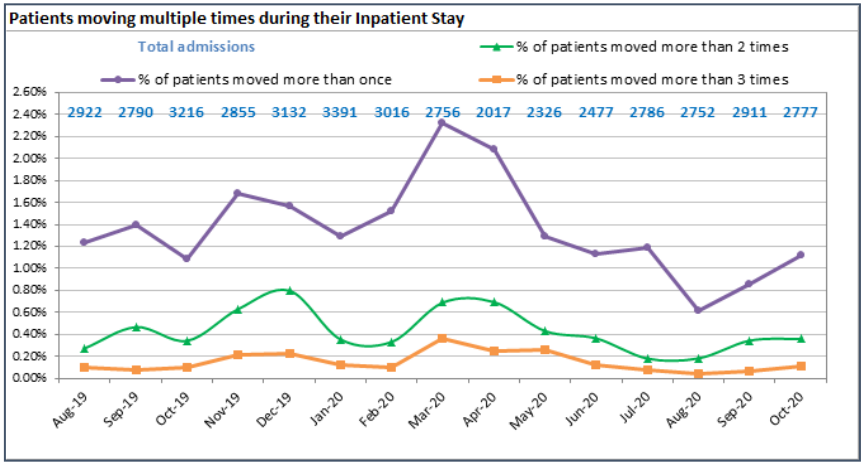
A Trust wide falls improvement plan with aggregated learning from SWARMs and serious incident inquiries is in place. The number of high harm falls has reduced over the last 5 years.

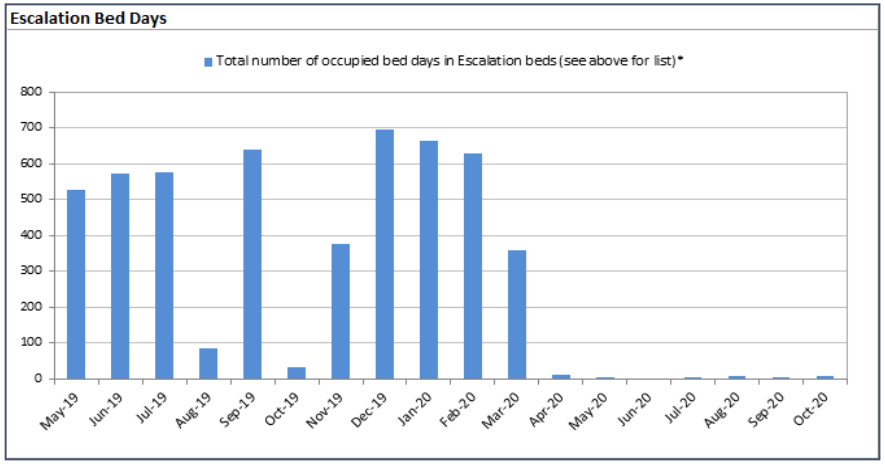
Patient Experience

Are We Safe?

Last 12 months	Nov 19	Dec 19	Jan 20	Feb 20	Mar 20	Apr 20	May 20	Jun 20	Jul 20	Aug 20	Sep 20	Oct 20
Bed Occupancy %	97.1	95.9	94.4	96.1	81.8	60.5	64.0	76.4	81.7	81.5	86.6	85.7

Data Quality Rating:





Summary and Action

Minimal escalation bed capacity was opened in October as bed occupancy remained at 86%. The percentage of multiple ward moves started to increase in preparation for the 2nd wave of Covid-19.

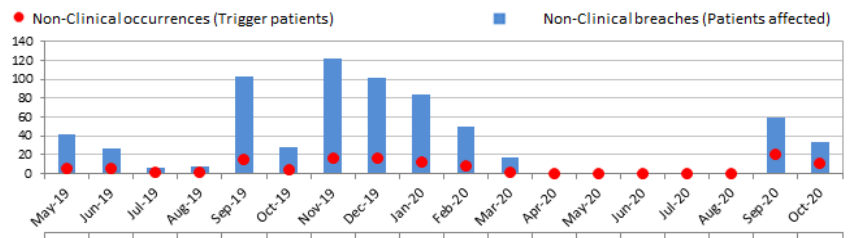
The Medicine Division supported by the PMO are leading a piece of work to increase the percentage of patients discharged by midday to meet the 33% standard and implement criteria led discharge.

Patient Experience

Are We Safe?

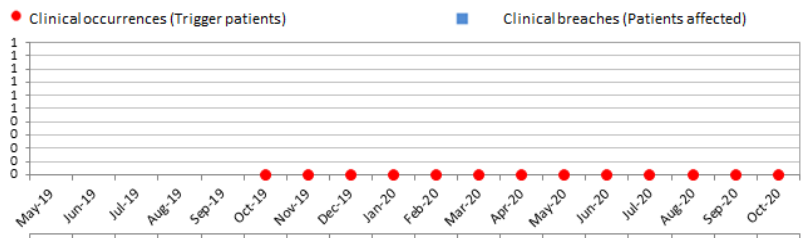
Data Quality Rating:

Delivering Same Sex Accommodation - Non-clinical



	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20	Apr-20	May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20
■	42	27	7	8	103	28	122	102	84	50	17	0	0	0	0	0	59	33
●	6	5	1	1	15	4	17	16	13	8	2	0	0	0	0	0	20	11

Delivering Same Sex Accommodation - Clinical



	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20	Apr-20	May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20
■						0	0	0	0	0	0	0	0	0	0	0	0	0
●						0	0	0	0	0	0	0	0	0	0	0	0	0

Summary and Action

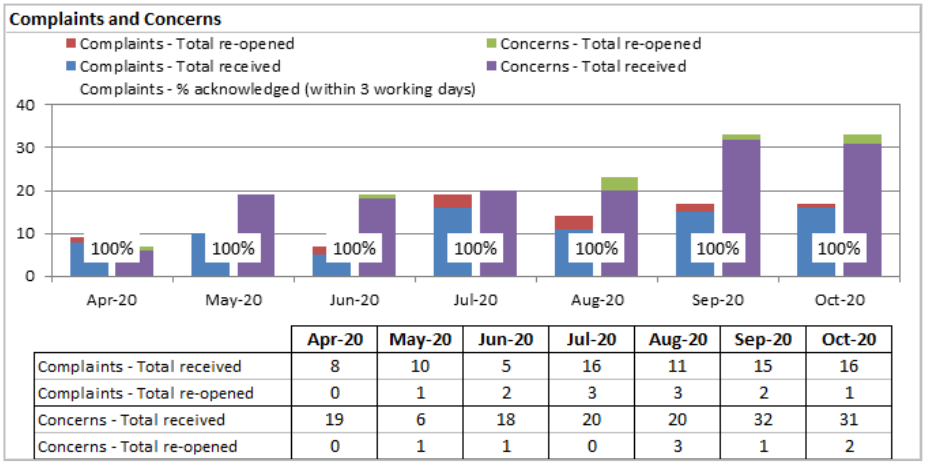
11 occurrences of non-clinical mixed sex accommodation breaches in October affecting 33 patients. 4 occurrences affected 26 patients in AMU and all were resolved within 24 hours. Privacy and dignity was maintained during these times with the use of quick screens and identification of separation bathroom facilities. There were no breaches on any of the general wards.

7 occurrences affected 7 patients were in Radnor ward (Critical Care) and all resolved within 24 hours. Privacy and dignity was maintained in the individual bed space. These were patients who were not able to be transferred out to a general ward within 4 hours of the decision that the patient was fit to be moved. Potential discharges from Radnor ward are raised at the twice daily bed meeting.

NHSE&I notified the Trust on 29 September that due to the continued impact of Covid-19 and the ongoing need to release capacity across the NHS to support the response, a pause on mixed sex accommodation data collection and publication will continue until March 2021.

Patient & Visitor Feedback: Complaints and Concerns

Are We Responsive?



	Apr-20	May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20
Complaints - Total received	8	10	5	16	11	15	16
Complaints - Total re-opened	0	1	2	3	3	2	1
Concerns - Total received	19	6	18	20	20	32	31
Concerns - Total re-opened	0	1	1	0	3	1	2

Summary and Actions:

The main theme from complaints and concerns is attitude of medical staff.

It is acknowledged that this is an emerging theme from Q2 and in October's figures.

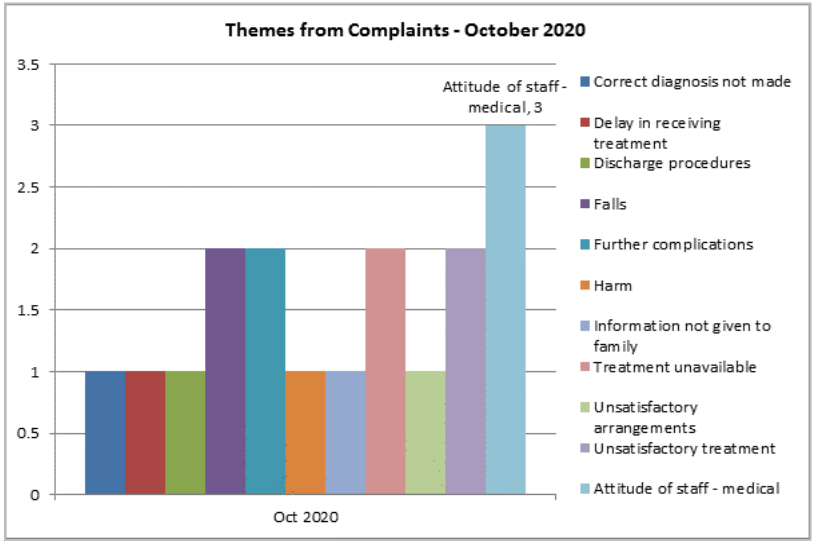
All Q2's cases will be reviewed by the Clinical Directors and those involved asked to write a personal reflection and include it within their appraisal. Themes will be presented at the Patient Experience and Patient Safety Steering Group.

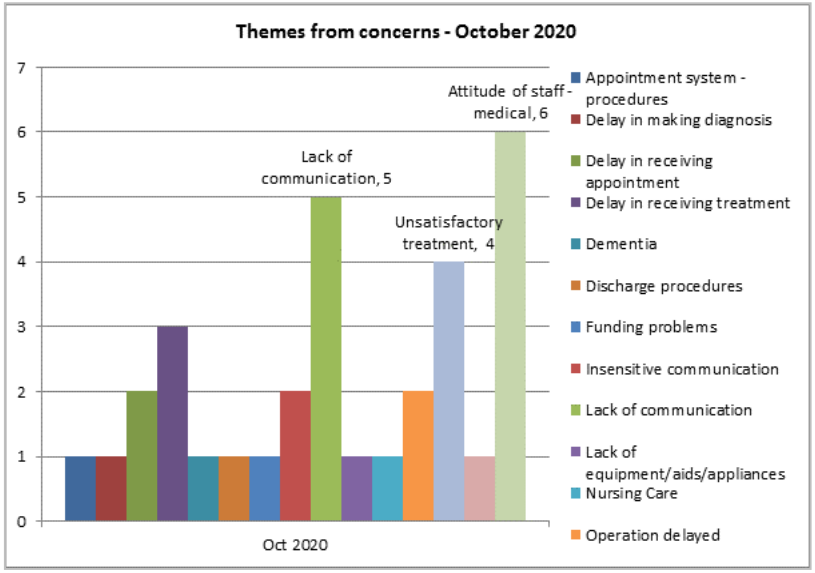
There were 11 complaints closed in October, of those, 5 were upheld or partially upheld.

Example of actions from closed complaints in October:

- A multiagency care plan has been developed for a patient with complex care needs who frequently presents at various emergency departments within the region.
- Patient's feedback surrounding the discharge process has been shared with the Discharge Team.
- A Serious incident investigation was commissioned to investigate an incident raised through the complaint procedures.
- The medical staff cited in the complaint is employed by another service provider. They will summarise the experience on a learning log to aid reflection; and monitor complaints and feedback for this clinician over the next 3 months.

Data Quality Rating:





Friends and Family Test – Patients and Staff

Use of Resources

In April, NHSE advised Trusts to cease collecting paper-based Friends and Family Test cards due to health and safety concerns. Updated guidance was released in June and following approval of a local standard operating procedure the Trust recommenced the use of paper-based Friends and Family Test cards with the new questions. The Trust will restart reporting in December 2020.

The staff Friends and Family test was also suspended this year due to Covid-19.

In September, the Best Place to Work discovery phase report was published which describes the experience of our workforce. The aim was to understand the culture and the 'way we do things around here' as these shape the behaviour of everyone in the organisation and directly affects the quality of care they provide.

The discovery work acknowledged the Trust as a caring, friendly organisation with professional staff who strive to provide the best possible care for patients. Staff are proud of the hospital and proud of the care and treatment we give to our local community. The Board discussed the recommendations at its meeting in October 2020. It was agreed a further seminar session should be held to review and prioritise the 20 recommendations. This is scheduled to take place at the beginning of December. The Board also agreed a co-creation approach whereby sessions with staff are scheduled to obtain their views on the areas that should be prioritised from the 20 recommendations.

Part 3: Our People

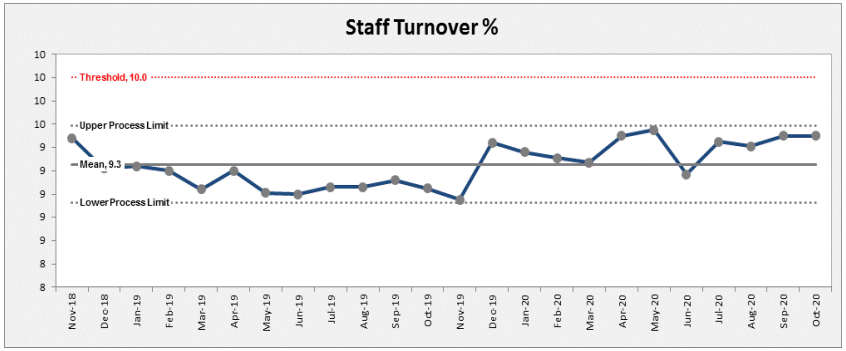
Our Priorities	How We Measure	
Local Services	Are We Effective?	Are We Responsive?
Specialist Services		
Innovation		
Care	Are We Safe?	Are We Caring?
People	Are We Well Led?	Use of Resources
Resources		

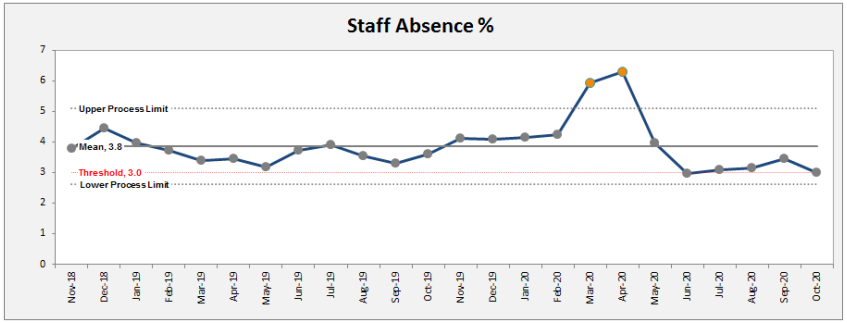
Workforce - Total

Use of Resources

Total Workforce vs Budgeted Plan - WTEs

	Oct '20		
	Plan WTEs	Actual WTEs	Variance WTEs
Medical Staff	425.1	428.4	(3.3)
Nursing	950.5	1,039.1	(88.6)
HCAs	412.1	463.8	(51.8)
Other Clinical Staff	619.3	643.0	(23.7)
Infrastructure Staff	1,227.9	1,251.4	(23.6)
TOTAL	**3,634.8**	**3,825.8**	**(191.0)**





Summary and Action

During October, there were 42 starters and 28 leavers, with turnover holding below the 10% target. Surgery showed a decrease in leavers and Housekeeping had 3 leavers, the Business Partner is following up to try to determine whether there is any underlying cause.

As part of the ESR Optimisation Project, we are mapping a revised Exit Questionnaire/Interview process which currently provides insufficient feedback to be useful. The intention is for all staff leaving to have either an interview or complete a questionnaire prior to leaving, which provides meaningful feedback for targeting any areas of concern identified. The new process is planned for commencement in January 2021.

Sickness has again risen this month to 3.72%; 0.27% of which is Covid-19 related, with 3.45% non Covid-19 related. The top reason for absence is anxiety, stress & depression followed by musculoskeletal. Both of these are being addressed in our relaunched Health and Wellbeing Strategy.

There are a total of 53 cases (decreased from 50 in September) in short term sickness absence processes at Stages 2-4 and managers are supported by the People Advisors. A total of 23 long term sickness cases (increased from 20 in September) are also being managed, 4 of whom are in planned return arrangements and two have made applications for Ill Health Retirement.

Medical sickness absences are being more actively managed through the Clinical Directors.

A decision has been made to hold off on volunteers returning to site for the time being, except in well defined patient & ward support roles.

Workforce – Nursing and Care

Use of Resources

% Fill of Registered Nurse/HealthCare Assistant Shifts

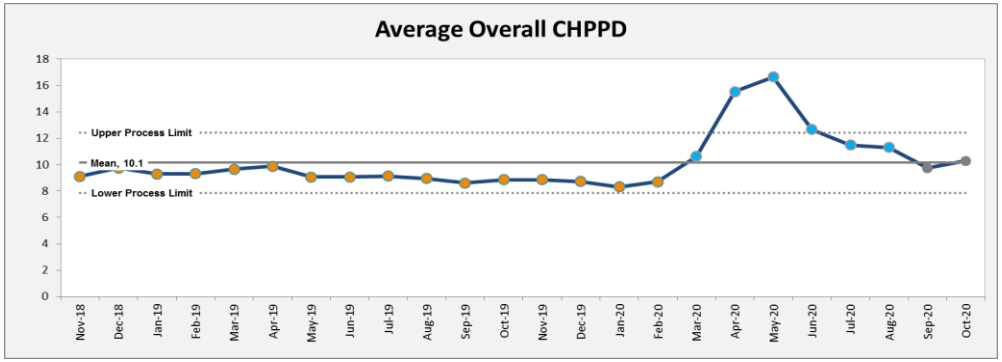
Table 1 – October Data

Day	RN	HCA
Total Planned Hours	36873	20368
Total Actual Hours	39808	17782
Fill Rate (%)	108%	87%

Night	RN	HCA
Total Planned Hours	25279	12905
Total Actual Hours	27579	12487
Fill Rate (%)	109%	96%

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

Table 2



Summary and Action

Table 1 shows planned vs actual hours for RNs and HCAs across the wards for October. The graph on the right shows planned vs actual Care Hours per Patient Day at Trust level. (CHPPD is a simple calculation dividing the number of actual nursing/midwifery (both registered an unregistered) hours available on a ward per 24-hour period by the number of patients on the ward that day. It therefore nominally represents the average number of nursing hours that are available to each patient on that ward.) The graph on the right shows the average overall CHPPD across all wards and the impact of bed closures for Covid-19 can be clearly seen from April – as services start to realign to 'normal' then CHPPD can be seen to have returned to previous levels and plateaued.

Table 1 shows the overall planned vs actual fill rate for October. Overall the RN rate is slightly up on last month and the HCA has remained static at around 87% on days- the fill rate on days has decreased as demand increases are starting to be seen in the requirements for additional staff for enhanced care, and pockets of HCA vacancies (national requirement to be at zero HCA vacancies post Covid-19). All wards had sufficient staff for the numbers of patients admitted, with staffing templates remain set for normal bed occupancy and a slow return to normal bed occupancy is starting to be seen. Twice daily staffing meetings continue to provide review of actual staffing requirements and ensuring staff are redeployed before temporary staffing use approved. There are virtually zero RN vacancies at RN level across the wards. The skill mix of RN:HCA has remained fairly consistent with last month with RN 69% /HCA 31%. The broad recommendation is 65%:35%.

2019/20 saw an overall nursing underspend. At the end of M7 (2020/21) there is a £840k overspend, which is a £100k deterioration on last month, although the previous month had seen a significant improvement. Students on paid placement have broadly completed their placements at the end of September and have converted to RN posts or left the Trust. Agency spend has increased to £15k which is mainly attributable to theatres. Whilst some high risk / shielding staff have returned to their clinical departments, some remain in non-clinical or extended leave ahead of maternity roles impacting on spend. In addition there is still additional pressure from areas requiring additional staffing due to Covid-19 e.g. ED RAZ, RCU. Deep dives into nursing workforce spend been held with surgery and medicine and a paper being developed for F&P.

Nurse Sensitive Indicators no specific concerns at present, increases in NSI's can be associated with suboptimal staffing. Trust wide programme for pressure ulcers improvement as previously reported continues.

Workforce – Staff Training and Appraisals

Use of Resources

Summary and Action

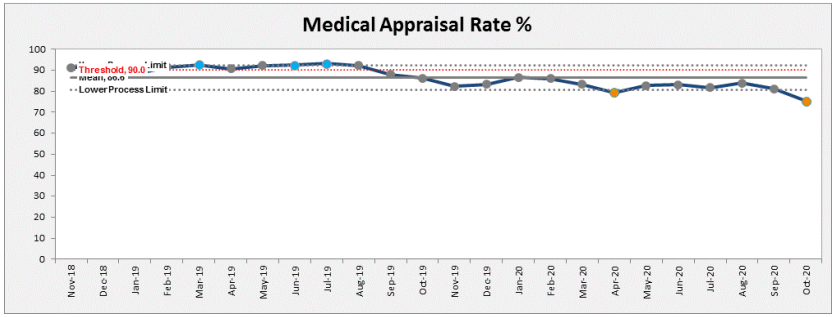
Medical appraisals have seen a significant drop in this month, from over 80% in September to 75.37% . This can be partly attributable to the earlier suspension of appraisals for medical staff. A plan is being developed in conjunction with the Medical Director for improvement, ensuring all staff are able to benefit from an appraisal.

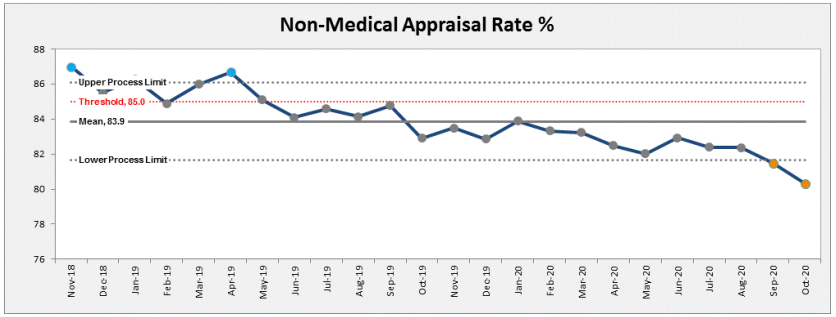
Non-Medical appraisals are seeing a gradual decline at 80.32% this month, with challenges still apparent as a result of absences and individuals being relocated from their normal place of work, due to Covid-19. There are significant numbers delayed which are being followed up with managers by the Business Partners.

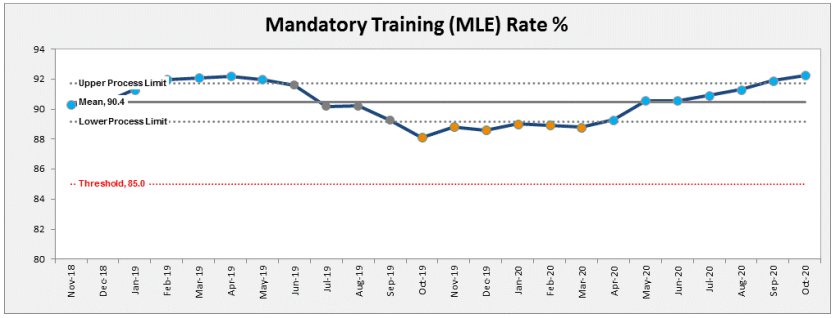
The Staff Survey results last year indicated a concern around the quality of appraisals and Education have been running training to address this matter. Positive feedback has been received from managers on this training.

Mandatory & Statutory training is remaining above the 90% target at 92.25%. Lists of individuals who are non-compliant are shared with managers on a regular basis.

Hand Hygiene is a common area of non-compliance in CSFS, Medicine and Estates, with Safeguarding also an issue in CSFS. No other areas have been identified.







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Part 4: Use of Resources

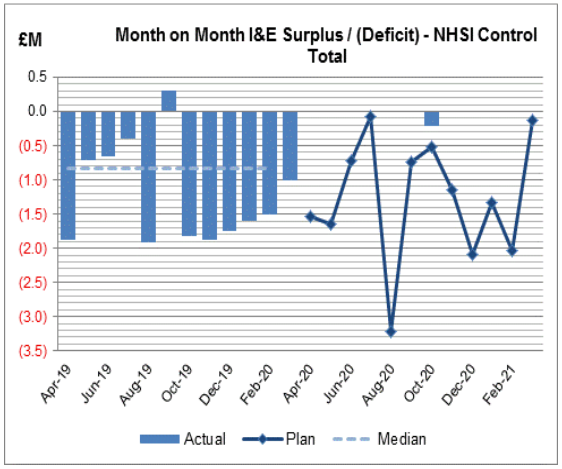
Our Priorities	How We Measure	
Local Services	Are We Effective?	Are We Responsive?
Specialist Services		
Innovation		
Care	Are We Safe?	Are We Caring?
People		
Resources	Are We Well Led?	Use of Resources

Income and Expenditure

Income & Expenditure:

Use of Resources

Position	Oct '20 In Mth			Oct '20 YTD			2020/21
	Plan	Actual	Variance	Plan	Actual	Variance	Plan
	£000s	£000s	£000s	£000s	£000s	£000s	£000s
Operating Income							
NHS Clinical Income	18,278	20,119	1,841	123,234	124,437	1,203	220,952
Other Clinical Income	880	662	(218)	6,071	16,131	10,060	0
Other Income (excl Donations)	2,416	2,193	(223)	16,912	14,854	(2,058)	28,992
Total income	**21,574**	**22,975**	**1,401**	**146,217**	**155,422**	**9,205**	**249,944**
Operating Expenditure							
Pay	(13,637)	(14,324)	(687)	(95,454)	(99,217)	(3,763)	(163,634)
Non Pay	(7,001)	(7,494)	(493)	(49,068)	(46,756)	2,312	(84,050)
Total Expenditure	**(20,638)**	**(21,817)**	**(1,179)**	**(144,522)**	**(145,973)**	**(1,451)**	**(247,684)**
EBITDA	**936**	**1,157**	**221**	**1,695**	**9,448**	**7,753**	**2,260**
Financing Costs (incl Depreciation)	(1,462)	(1,368)	94	(10,165)	(9,660)	505	(17,474)
NHSI Control Total	**(526)**	**(210)**	**315**	**(8,470)**	**(211)**	**8,258**	**(15,214)**
Add: impact of donated assets	*(48)*	*(66)*	*(18)*	*(44)*	*(419)*	*(375)*	*1,626*
Add: Impairments	*0*	*0*	*0*	*0*	*0*	*0*	*0*
Add: Central MRET	*0*	*0*	*0*	*0*	*0*	*0*	*0*
Add: FRF	*0*	*0*	*0*	*0*	*0*	*0*	*0*
Surplus/(Deficit)	***(574)***	***(277)***	***297***	***(8,514)***	***(631)***	***7,883***	***(13,588)***



Variation and Action

For the purposes of financial reporting during the Phase 3 Covid-19 response the Trust continues to use the original 2020/21 plan as a baseline, performance against the Phase 3 forecast is shown on p.7). This plan had assumed a deficit of £0.5m for the month, and a £15.2m deficit for the year, no central MRET or FRF was therefore assumed. Performance against the original plan is summarised in the table above.

Performance management arrangements by NHSEI have changed in month 7. The Trust is now being performance managed to a revised forecast submitted in October 20. This outlined a control total deficit of £0.65m in month 7, and a year end deficit of £3.2m. This is after total Covid-19 top up funding of £27.8m.

Pay showed an decrease of £0.1m (1%) in the period and non-pay increased by £0.2m (3%) . The latter is explained by the continuing increase in activity across most points of delivery.

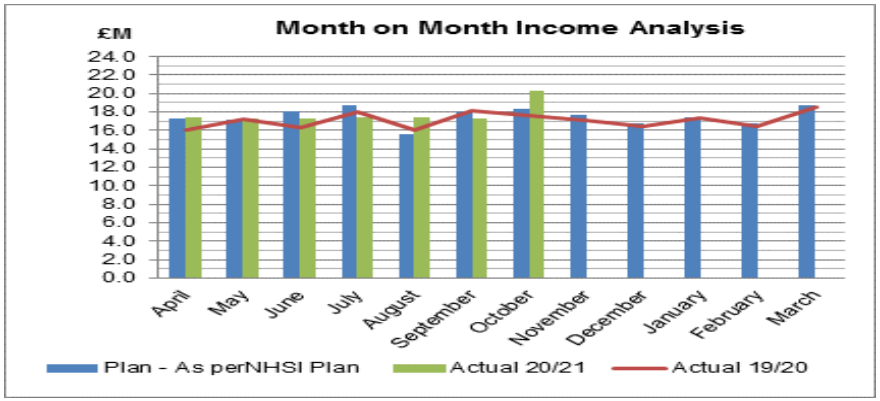
The Elective Incentive Scheme income reduction has been assessed at £301k but not included within the position per instruction from NHSEI.

Income & Activity Delivered by Point of Delivery

Clinical Income:

Use of Resources

Income by Point of Delivery (PoD) for all commissioners	Oct '20 YTD		
	Plan (YTD) £000s	Actual (YTD) £000s	Variance (YTD) £000s
A&E	5,533	4,707	-826
Day Case	10,126	5,702	-4,424
Elective inpatients	10,725	3,340	-7,385
Excluded Drugs & Devices (Inc. Lucentis)	11,241	9,784	-1,457
Non Elective inpatients	36,629	31,388	-5,241
Other	29,706	57,648	27,942
Outpatients	19,274	11,868	-7,406
TOTAL	**123,234**	**124,437**	**1,203**



SLA Income Performance of Trusts main NHS commissioners	Contract Plan (YTD) £000s	Actual (YTD) £000s	Variance (YTD) £000s	Phase 3 Forecast (YTD) £000s	Phase 3 FC Var (YTD) £000s
BSW CCG	68,614	70,720	2,106	70,721	(1)
Dorset CCG	14,018	14,492	474	14,492	(0)
West Hampshire CCG	10,076	10,048	(28)	10,048	(0)
Specialist Services	19,133	18,795	(338)	18,919	(124)
Other	11,393	10,382	(1,011)	10,174	208
TOTAL	**123,234**	**124,437**	**1,203**	**124,354**	**83**

Activity levels by Point of Delivery (POD)	YTD Plan	YTD Actuals	YTD Variance	Last Year Actuals	Variance against last year
A&E	43,033	31,705	(11,328)	41,183	(9,478)
Day case	13,394	7,694	(5,700)	13,407	(5,713)
Elective	2,841	1,198	(1,643)	2,845	(1,647)
Non Elective	18,678	14,937	(3,741)	15,601	(664)
Outpatients	149,785	109,133	(40,652)	150,552	(41,419)

Variation and Action

Activity in October has increased above September across all of the main points of delivery with the exception of A&E. The most significant increases by specialty are Gastroenterology, Ophthalmology and Oral Surgery Day cases, Urology and Cardiology Elective, Ophthalmology, Orthotics and Audiology Outpatients.

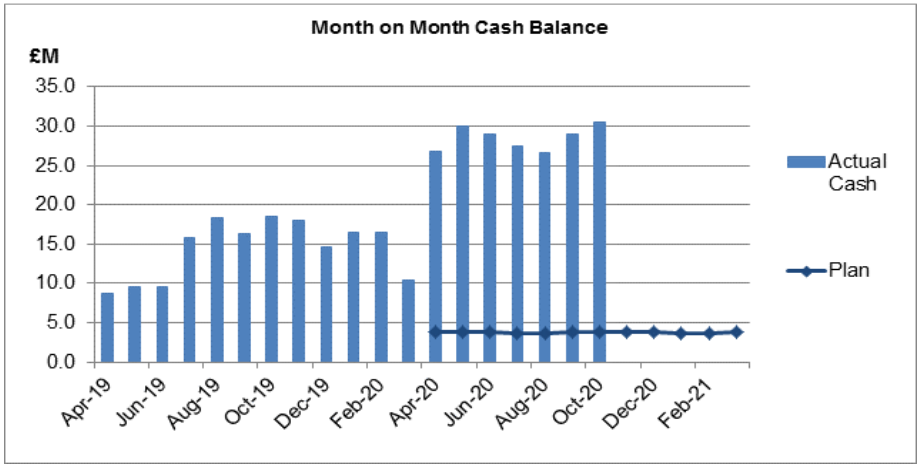
Covid-19 response contractual payment values with main commissioners were based on Month 9 agreement of Balances (from a provider perspective), adjusted by 2.8% for inflationary pressures. From October onwards, Top up and Covid-19 funding will now be received from BSW CCG c£2.5m per month. Over the first seven months of the year underlying activity has been valued at less than the agreed block by £32,542k (26%), owing to the temporary cessation of non-urgent planned work and phased recovery response. The October adjustment has increased by £2,624k mainly due to the additional Top up and Covid-19 funding (this funding stream now flows via BSW, rather than directly from NHSEI as was the case during phase 1). The October Elective Incentive scheme has been assessed at a reduction of c£301k but not included within the position per instruction from NHSEI.

The variance to the Phase 3 forecast is due to adjustments for high cost drugs that sit outside of the block arrangement, predominantly Spec Comm and cancer drugs fund.

Cash Position & Capital Programme

Capital Spend:  **Cash & Working:** 

Use of Resources



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

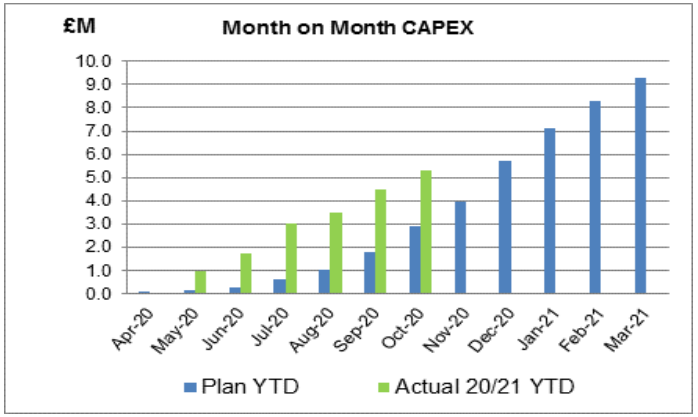
Payments on account in advance up until 30th November 2020 have been received. New guidance has indicated these payments will continue for the remainder of the financial year, with the clawback potentially due to take place in March 2020. Core block payments for months 7-12 will be at a lower level than for the first 6 months due to the Phase 3 contracting guidance but these will be supplemented by further funding from within the STP system. The cash flow position will continue to be closely monitored to ensure any potential shortfalls are identified.

The Trust received £2,164k of its additional capital fund allocations in the month, with the majority of the outstanding balance due to be received in November.

Borrowings have previously included £21m of working capital loans. These were repaid In September and funding was returned to the Trust simultaneously as Public Dividend Capital.

Capital Expenditure Position

	Annual	Oct '20 YTD		
	Plan	Plan	Actual	Variance
Schemes	**£000s**	**£000s**	**£000s**	£000s
Building schemes	850	400	47	353
Building projects	2,600	750	462	288
IM&T	2,600	750	2,022	(1,272)
Medical Equipment	2,778	950	789	161
Other	449	261	261	0
Addition: Critical Infrastructure Fund	3,455	433	223	210
Addition: Covid 19	4,711	778	1,482	(704)
TOTAL	**17,443**	**4,322**	**5,286**	**(470)**



Summary and Action

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

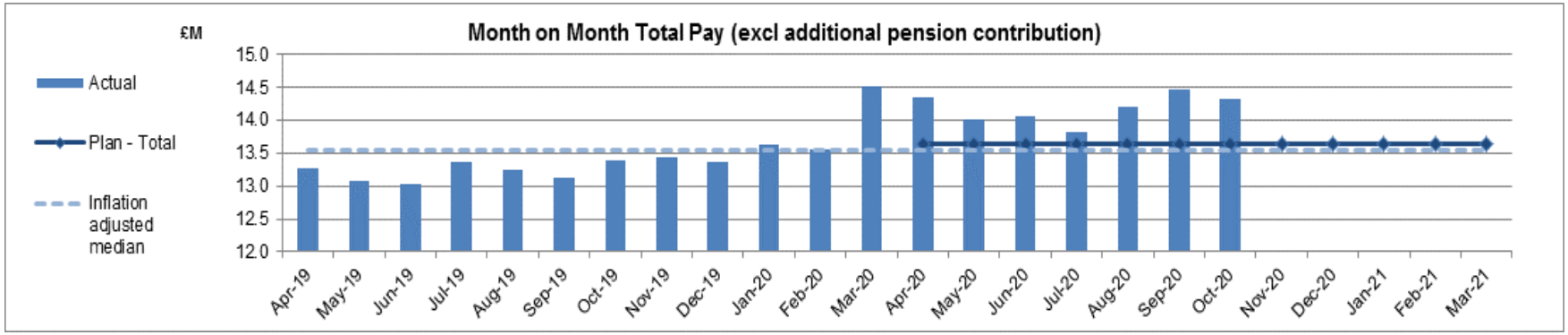
The Trust has received a number of capital allocations so far this year. These include £2,000k Emergency Department Configuration, £421k of funding for medical and IT equipment, £700k Ventilation and Endoscopy, and £1,233k Regional ICU Plan (including release of theatres as escalation space), all of which are included under the Additional Covid-19 heading above. This is additional to the £3,455k Critical Infrastructure Fund. Plans are underway to ensure schemes are fully developed, with the necessary resources in place, to complete these projects in 2020-21. All schemes will be funded through additional Public Dividend Capital.

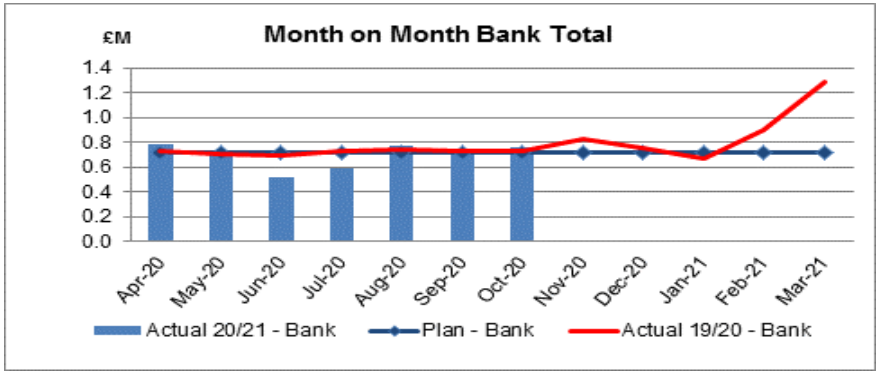
As a result of the considerable additional funding allocated to the Trust in the year, substantial funds still remain to be spent in order to achieve a balanced capital position for 2020-21. Although it is considered the majority of these funds can be spent, potential slippage of circa £3m has been identified. A draft capital programme for 2020-21 has been compiled and schemes highlighted within this which could be brought forward into the current year to cover the slippage. A paper is being presented to the November meeting of the Finance and Performance Committee in order to obtain approval to bring forward these schemes.

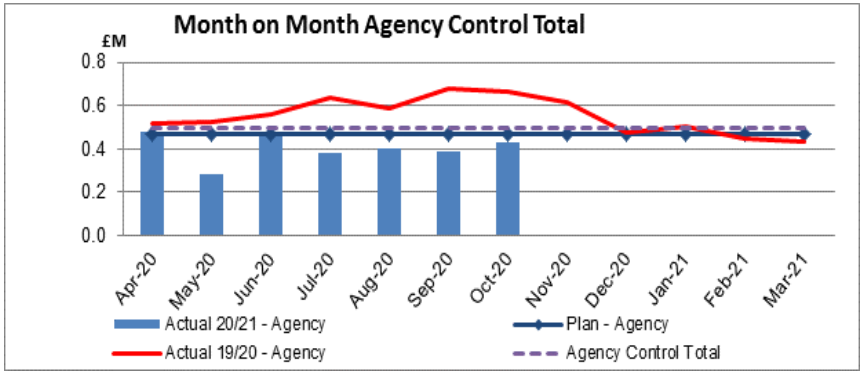
Workforce and Agency Spend

Pay:

Use of Resources







Summary and Action

Pay expenditure decreased by £0.1m, or 0.9% month on month, following the spike in pay in month 6 due to the backdated medic pay rises rather than a reduction in the underlying cost of the workforce. The underlying Pay position has actually increased, driven in particular by increases in activity in both Theatres (+5% sessions run vs September) and the GI unit, both key to the Trust's Elective recovery plans.

The costs directly driven by the Covid-19 response have now reached £3.63m, 70% of which relates to additional hours worked by the Trust's existing workforce. Covid-19 response costs continue to reduce as redeployed clinical staff return to their normal areas of work, however the residual cost of streamed patient pathways and protected capacity remain, this leads to a requirement to maintain (and staff) an increased bed footprint to achieve the same level of patient flow.

In addition to these directly reported costs, analysis has been undertaken on the reduced availability of rostered staff (caused by a variety of reasons including sickness, self-isolation, shielding etc.), this now stands at c30%, Trust 2020/21 budgeted assumptions had been 19%. The Trust's strong recruitment position means that despite this reduction in availability, there have been sufficient temporary staffing availability to ensure this has not translated to an increase in unfiled shifts (this does however lead to increased costs).

As set out above, bank costs have increased by £58k (8%), due to increased bank nursing costs. Agency costs have increased by £43k (11%), driven by usage in Salisbury Trading.