NHS
Wiltshire
Clinical Commissioning Group

# Integrated Performance Report

# June 2018

**Integrated Performance Report**
**Contents**

# Wiltshire CCG Quality Report

## June 2018

## CCG Level Indicators

### Quality Dashboard; CCG level indicators

NHS Wiltshire Clinical Commissioning Group

| Outcomes Framework Domain (1) | Indicator | Indicator Yellow Indicates IAF / Constitutional Target | Measure | Data Frequency (1) | Target / Threshold | Benchmark National / Regional (2) | 2017/18 TOTAL / AVERAGE (3) | 2017/18 Sparkline | May-17 | Jun-17 | Jul-17 | Aug-17 | Sep-17 | Oct-17 | Nov-17 | Dec-17 | Jan-18 | Feb-18 | Mar-18 | 2018/19 TOTAL / AVERAGE (3) | Apr-18 | Exception Identified? (4) |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Safety | S1 | Healthcare acquired infection (HCAI) measure - MRSA | Number of infections = 0 | M | 0 | n/a | 4 | | 0 | 1 | 1 | 0 | 0 | 0 | 1 | 0 | 0 | 0 | 0 | 0 | 0 | |
| Safety | S2 | Healthcare acquired infection (HCAI) measure - *C.difficile* (Post 72 hours) | Number of infections (see threshold for Provider) | M | Individual Provider Targets | n/a | 98 | | 9 | 8 | 4 | 12 | 9 | 13 | 4 | 7 | 8 | 10 | 8 | 6 | 6 | |
| Safety | S3 | Healthcare acquired infection (HCAI) measure - *E. coli* | Number of infections (see threshold for Provider) | M | Individual Provider Targets | n/a | 287 | | 23 | 26 | 23 | 36 | 26 | 25 | 30 | 27 | 21 | 13 | 20 | 25 | 25 | |
| Safety | S4 | Healthcare acquired infection (HCAI) measure - MSSA | No target set | M | 0 | n/a | 77 | | 2 | 8 | 6 | 13 | 6 | 10 | 6 | 3 | 9 | 6 | 6 | 10 | 10 | |
| Safety | S5 | Healthcare acquired infection (HCAI) measure - *Pseudomonas aeruginosa* | No target set | M | 0 | n/a | 0 | | | | | | | | | | | | | 0 | 0 | |
| Safety | S6 | Healthcare acquired infection (HCAI) measure - *Klebsiella* spp. | No target set | M | 0 | n/a | 0 | | | | | | | | | | | | | 9 | 9 | |
| Safety | S7 | Bed Days closed due to infection outbreak (e.g. Noro Virus) | No target set | TBC | To be determined | n/a | 632 | | 0 | 26 | 12 | 4 | 4 | 15 | 59 | 142 | 176 | 117 | 71 | 16 | 16 | |
| Safety | S8 | Number of Never Events (CCG) | Number of events = 0 | M | 0 | n/a | 4 | | 1 | 0 | 0 | 0 | 0 | 1 | 0 | 0 | 0 | 2 | 0 | 0 | 0 | |
| Safety | S9 | Number of Serious Incidents reported for Wiltshire patients. | Number of reported serious incidents | M | n/a | n/a | 148 | | 20 | 17 | 12 | 13 | 10 | 13 | 14 | 7 | 11 | 14 | 7 | 11 | 11 | |
| Safety | S10 | NHS Patient Safety Thermometer - Venous Thromboembolism (VTE) | VTE -% | M | 0.40% | n/a | 0.7% | | 0.6% | 0.7% | 0.7% | 0.6% | 0.6% | 0.7% | 0.7% | 0.4% | 0.7% | 0.2% | 2.5% | 0.6% | 0.6% | |
| Safety | S11 | Midwife:Birth Ratio | | M | 1.27 | n/a | 1.30 | | 1.30 | 1.29 | 1.30 | 1.30 | 1.31 | 1.32 | 1.33 | 1.28 | 1.30 | 1.28 | 1.29 | | | |
| Safety | S12 | Over 52 Week Waits | | M | To be determined | n/a | 57 | | 1 | 9 | 2 | 4 | 4 | 1 | 2 | 5 | 5 | 7 | 13 | 18 | 18 | |
| Experience | Ex1 | Staff Friends and Family Test Score (Work) | Score => National average | Q | 67.0% | 63% | 60.2% | | | 64% | | | 62% | | | | | | 54% | | | |
| Experience | Ex2 | Staff Friends and Family Test Score (Care) | Score => National average | Q | 84.0% | 80% | 81.6% | | | 84% | | | 82% | | | | | | 79% | | | |
| Experience | Ex3 | Friends and Family Test Score Mental health | Score => National average | M | 93.0% | 89% | 88.1% | | 89% | 88% | 88% | 86% | 90% | 88% | 88% | 88% | 88% | 89% | 88% | 90.0% | 90% | |
| Experience | Ex4 | Friends and Family Test Score GPs | Score => National average | M | N/A | 89% | 90.3% | | 91% | 92% | 88% | 90% | 90% | 91% | 91% | 89% | 92% | 89% | 90% | 88.0% | 88% | |
| Experience | Ex5 | Mixed sex accommodation (MSA) Breaches (rate per 1000 episodes) | Number of breaches = 0 | M | 0 | 1.0 | 1.1 | | 0.3 | 0.3 | 0.6 | 0.4 | 0.5 | 0.2 | 0.2 | 0.1 | 4.0 | 2.4 | 3.1 | | | |
| Experience | Ex6 | Number of Complaints Received (to the CCG) | Total number of complaints received | M | N/A | n/a | 66 | | 3 | 4 | 4 | 4 | 4 | 7 | 9 | 4 | 8 | 6 | 9 | 10 | 6 | |
| Effectiveness | Ef1 | 12 Hr Trolley Breaches in the ED | | M | 0 | n/a | 28 | | 4 | 5 | 5 | 0 | 0 | 0 | 0 | 6 | 0 | 1 | 1 | | | |
| Effectiveness | Ef2 | Fractured Neck of Femur | % in theatre within 36 hours | M | 80% | 73% | 80.6% | | 71% | 75% | 79% | 83% | 76% | 91% | 86% | 84% | 80% | 77% | 84% | 72.4% | 72% | |

1 – Data is available monthly (M), quarterly (Q) or annually (A). 2 – Nationally available benchmark indicators are in purple, regional (South West or more local) are in orange. 3 – 2017/18 average figures appear without underline, total figures appear in an underlined format. Colour of the number indicates overall performance. 4 – Indicators marked with a flag are reported in further detail below the dashboard (blue flags indicate that this has already been reported as an exception so will be covered in the Ongoing Exceptions Table). 5 - This data is only for Salisbury Foundation Trust.

## CCG Level Indicators Reported by Exception

| Indicator: | Healthcare acquired infection (HCAI) measure - C.difficile (Post 72 hours) |
|---|---|
| Issue: | 2018/19 trajectory 101 in comparison to 2017/18 trajectory of 103. |
| Assurances and Next Steps: | 2017/18 has seen a reduction in the reported cases of C. difficile; total number of cases for WCCG for 2017/18 is 98, in comparison to 101 for 2016/17. The CCG threshold of 103 cases has been decreased to 102 for 2018/19.<br>The WCCG Quality Team will continue to seek assurance from providers to ensure mitigating action is aligned across Wiltshire services, and provide support to reduce C. difficile rates.<br>The split of cases between hospital onset and community onset for 2017/18 has seen the larger proportion of cases originate within the community.<br>WCCG plan on commencing a task and finish group in order to review these cases to look at possible themes, trends and root causes, and take action on these appropriately.<br>Themes of the RCA that have been reviewed to date are predominantly related to use of antibiotics, in particular over the winter period for chest infections. Any associated learning has been shared with Primary Care and focuses on the vigilance of previous antibiotic prescribing. Of note, there are no significant prescribing outliers within Wiltshire. |

| Indicator: | Healthcare acquired infection (HCAI) measure – MRSA |
|---|---|
| Issue: | Increase in acute care MRSA cases |
| Assurances and Next Steps: | There have been two reported cases of MRSA bacteraemia at the RUH for May 2018. Both cases are currently under a post infection review by the provider. Further detail will be provided in the next version of this report. |

| Indicator: | Healthcare acquired infection (HCAI) measure - E. coli |
|---|---|
| Issue: | 10% reduction in E-coli Bacteraemia cases not achieved |
| Assurances and Next Steps: | 2017/18 has seen a reduction in the reported cases of E-Coli blood stream infections (BSI) of 6%. The 2017/18 Quality Premium 'Reduction in Urinary Tract Infections and Gram Negative Blood Stream infections' called for a reduction of at least 10% in gram-negative blood stream infections. Unfortunately, WCCG did not achieve the 10% reduction, this is in line with national performance and that of the STP.<br>WCCG are working in collaboration with Swindon and BANES CCGs to develop specific and targeted actions to reduce this across the whole health economy.<br>For 2018/19, the reduction trajectory will remain the same against the 16/17 figures. |

| Indicator: | S8 Number of Never Events (CCG)<br>S9 Number of Serious Incidents reported for Wiltshire patients |
|---|---|
| Issue: | During the month of April 2018, 11 Serious Incidents (SI) were reported on STEIS. |
| Assurances and Next Steps: | The incidents, providers and types of incidents were as follows: |

| Provider and Incident type | April 2018 |
|---|---|
| **AWP** | **4** |
| Abuse/alleged abuse of adult patient by staff | 1 |
| Apparent/actual/suspected self-inflicted harm | 1 |
| Pending review (a category must be selected before incident is closed) | 1 |
| Treatment delay | 1 |
| **RUH** | **2** |
| HCAI/Infection Control incident | 1 |
| Medication incident | 1 |
| **SFT** | **3** |
| Abuse/alleged abuse of adult patient by staff | 1 |
| Diagnostic incident including delay (inc failure to act on test results) | 1 |
| Maternity/Obstetric incident: baby only (this includes foetus, neonate and infant) | 1 |
| **WCCG** | **2** |
| Medication incident (CCG reported on behalf of Primary Care) | 1 |
| Pressure ulcer (CCG reported on behalf of Prospect Hospice) | 1 |

These incidents are now in the investigation phase. Providers have 60 days under the Serious Incident Framework (2015) to carry out an investigation and submit the report to the CCG for review. The medication incident raised by the CCG for Primary Care was logged to STEIS following initial review of an NRLS incident raised by the practice. From this review, the CCG requested an additional review by RUH regarding their elements of the patient pathway. This was logged to STEIS, by RUH, in May. There were no Never Events raised regarding Wiltshire patients during April 2018.

In April 2018, 4 SI closure panels were held, and 10 SI were reviewed. The outcomes of these reviews are as follows:

| Row Labels | Count of Status |
|---|---|
| **AWP** | **4** |
| Awaiting closure by third party with additional assurances required from the Provider | 3 |
| Awaiting Provider response to queries raised at panel | 1 |
| **RUH** | **2** |
| Awaiting Provider response to queries raised at panel | 1 |
| Closed Assurance Required | 1 |
| **WCCG** | **3** |
| Awaiting Provider response to queries raised at panel | 1 |
| Removed from STEIS (requested and actioned by NHS England) | 1 |
| Return to CCG Quality Leads for agreement of content of SI closure form | 1 |
| **WHC** | **1** |
| Closed Assurance Required | 1 |
| **Grand Total** | **10** |

For each RCA reviewed, the Panel notes SI themes, recommendations, lessons learned and associated action plans. The main themes identified at April's SI Panels related to; reflection/shared learning and a need for clearer monitoring/auditing. A continuing trend and commonality between RCAs was the need for improvement in action planning to ensure that these reflect the lessons learned and recommendations identified within the RCA and that the actions are SMART. The CCG SI Manager will provide feedback to the risk leads in the Trusts to ensure this is acted on for subsequent reports.

AWP were issued with a contract performance notice (CPN) in December 2017 for their serious incident management (relating to timely completion of root cause analyses). This remains in place and a detailed update is included later in the report.

| Indicator: | S12 52 Week Incomplete Waits |
|---|---|
| Issue: | 18 x 52 week wait breaches reported in April 2018 (latest data available). |
| Assurances and Next Steps: | 5 RUH (3 General Surgery & 2 Ophthalmology), 7 GWH (1 Gynaecology, 3 Ophthalmology, 2 Trauma and Orthopaedics & 1 Ear, Nose and Throat), 6 others (NBT: 2 Plastic surgery, 1 Trauma and Orthopaedics, Oxford: 1 Gynaecology. UHB: 1 Cardiology & 1 Other).<br><br>The RUH have reported the following 52 week breaches by month for the last 4 months:<br>• January 6 breaches<br>• February 6 breaches<br>• March 13 breaches<br>• April 18 breaches<br><br>During February and March RUH recorded the first breaches caused by capacity constraints and non-elective pressures following increased demand and reduced elective activity over the Winter period. Deferring elective activity was supported at a national level by NHS Improvement. Oversight and monitoring of RUH RTT (Referral to Treatment) pathways and actions is undertaken via the RTT Steering group (internal RUH) and through the RTT Delivery Board (CCG meeting) . All patients have had a clinical harm review completed and to date no patients have come to harm as a result of the delay in treatment. Letters have been sent to patients apologising for the delays and explaining how they can contact the Trust if they have any concerns. To date an initial 16 RCA have been reviewed and no patients have come to harm as a result in the delay for treatment.<br><br>The RCA for the NBT and UHB breaches have been requested from the coordinating commissioner, NBT and UHB usually complete aggregated RCA by speciality rather than per patient breach . WCCG have been advised by Oxford CCG that there are a large number of breaches in Gynaecology at Oxford Hospital (OUH). OUH do not complete individual RCA for each breach however, if harm is caused to a patient as a result of a breach, an incident is reported and the relevant CCG is informed. WCCG have not been informed that any harm has come to a Wiltshire patient that has experienced a longer wait for their treatment.<br>WCCG has requested the GWH RCA and will review when these have been received.<br>GWH have implemented an Ophthalmology recovery plan to address the RTT breaches in this speciality. |

| Indicator: | Fractured Neck of Femur – operated on within 36 hours |
|---|---|
| Issue: | Performance has deteriorated to 72% overall |
| Assurances and Next Steps: | Analysis of the data shows that this drop in performance is predominantly attributable to Salisbury Hospital whose performance has dropped to 60% (RUH dropped from 81.8 to 72.7% and GWH from 86.5 to 84.6%). The Trust have already identified this issue and have taken steps to put actions in place to improve performance against this target. SFT have reported on concern regarding a reduction in the number of hip fracture patients being operated on within 36 hours mitigated by an orthopaedic trauma only list commenced in April 2018 and the golden patient initiative. The Quality Team will monitor the effectiveness of these improvements. |

## Provider Cohort Indicators

### Quality Dashboard; Provider Cohort Level Indicators

NHS Wiltshire Clinical Commissioning Group

| Outcomes Framework Domain (1) | Indicator | Indicator (Yellow Indicates IAF / Constitutional Target) | Measure | Data Frequency (1) | Target / Threshold | Benchmark National / Regional (2) | 2017/18 TOTAL / AVERAGE (3) | 2017/18 Sparkline | May-17 | Jun-17 | Jul-17 | Aug-17 | Sep-17 | Oct-17 | Nov-17 | Dec-17 | Jan-18 | Feb-18 | Mar-18 | 2019/18 TOTAL / AVERAGE (3) | Apr-18 | Exception Identified? (4) |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | **Urgent Care** | **111 SWAST Medvivo** | | | | | | | | | | | | | | | | | | | |
| Safety | U1a | Ambulance Handover Delays > 30mins (Wiltshire) | | M | N/A | n/a | 745 | | 42 | 69 | 60 | 49 | 61 | 55 | 43 | 100 | 91 | 59 | 63 | | | |
| Safety | U1b | Ambulance Handover Delays > 30mins (SFT only) (5) | | M | N/A | n/a | 326 | | 23 | 23 | 26 | 20 | 24 | 21 | 19 | 47 | 52 | 29 | 26 | | | |
| Experience | U2a | Call Audits Compliance (111) (%) | | M | 83% | 88% | 75.1% | | 100% | | 100% | 100% | 100% | 100% | 100% | 40% | 30% | 40% | 16% | | | |
| Experience | U2b | Call Audits Compliance (SWASFT) (%) | | M | 85% | 90% | 72.1% | | | 57% | 67% | 68% | 49% | 106% | 129% | 61% | 49% | 64% | | | | |
| Safety | U3a | >16 Hour ED Stays (Waits) (Wiltshire) | | M | N/A | n/a | 373 | | 20 | 26 | 24 | 16 | 24 | 9 | 24 | 62 | 65 | 23 | 54 | | | |
| Safety | U3b | >16 Hour ED Stays (Waits) (SFT) (5) | | M | N/A | n/a | 4 | | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 1 | 0 | 1 | 2 | | | |
| Effectiveness | U4 | CQUIN performance (NHS 111 and SWAST) | | Q | N/A | n/a | 100.00% | | | 100% | | | 100% | | | 100% | | | | #DIV/0! | | |
| | | **Mental Health** | **AWP and CHAMS** | | | | | | | | | | | | | | | | | | | |
| Effectiveness | M1 | s. 136 Length of Stay Breaches (of 72 hours) | | M | N/A | n/a | 1 | | | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | |
| Effectiveness | M2 | CQUIN performance (AWP and CAMHS) | | Q | N/A | n/a | 100.00% | | | 100% | | | 100% | | | 100% | | | | | | |
| | | **Planned Care** | **Acutes and Independents** | | | | | | | | | | | | | | | | | | | |
| Experience | P1 | 104-day Cancer Target Breaches | | M | N/A | n/a | 14 | | 3 | 1 | 2 | 4 | 0 | 2 | 0 | 0 | 0 | 0 | 0 | | | |
| Safety | P2 | Pressure Ulcers (Grade III & IV Pressure Ulcers: Hospital Acquired) | | M | N/A | n/a | 63 | | 2 | 8 | 6 | 8 | 6 | 7 | 6 | 7 | 5 | 3 | 4 | | | |
| Safety | P3 | Falls resulting in fracture or major harm | | M | N/A | n/a | 137 | | 9 | 13 | 8 | 16 | 6 | 10 | 14 | 12 | 18 | 14 | 8 | 1 | 1 | |
| Experience | P4 | Patient Moves within thresholds | | M | N/A | n/a | 58 | | 4 | 6 | 1 | 12 | 13 | 4 | 1 | 5 | 9 | 3 | 0 | | | |
| Safety | P5 | Mortality Ratios - SHMI | (GWH, RUH and SFT only) | M | N/A | 100 | 99.8 | | 99.0 | 99.7 | 100.0 | 106.0 | | | 102.0 | 91.4 | 98.3 | 102.3 | | | | |
| Safety | P6 | Mortality Ratios - HSMR | (GWH, RUH and SFT only) | M | N/A | 100 | 103.1 | | 105.7 | 105.7 | 109.0 | 115.4 | 108.7 | 90.2 | 98.6 | 101.0 | 101.0 | 101.0 | | | | |
| Effectiveness | P7a | CQUIN performance (acutes) | | Q | N/A | n/a | 79.5% | | | 87% | | | 88% | | | 64% | | | | | | |
| Effectiveness | P7b | CQUIN performance (others) | | Q | N/A | n/a | 76.8% | | | 83% | | | 73% | | | 74% | | | | | | |
| Safety | P8 | Number of patients moved over night | | Q | N/A | n/a | 58 | | | 10 | | | 26 | | | 10 | | | 12 | | | |
| Safety | P9 | Unplanned Transfers to Acute Services from Independent Providers | | Q | N/A | n/a | 3 | | | 2 | | | 1 | | | 0 | | | | | | |

1 – Data is available monthly (M), quarterly (Q) or annually (A). 2 – Nationally available benchmark indicators are in purple, regional (South West or more local) are in orange. 3 – 2017/18 average figures appear without underline, total figures appear in an underlined format. Colour of the number indicates overall performance. 4 – Indicators marked with a flag are reported in further detail below the dashboard (blue flags indicate that this has already been reported as an exception so will be covered in the Ongoing Exceptions Table). 5 - This data is only for Salisbury Foundation Trust.

## Quality Dashboard; Provider Cohort Level Indicators

NHS Wiltshire Clinical Commissioning Group

| Outcomes Framework Domain (1) | Indicator | Indicator (Yellow Indicates IAF / Constitutional Target) | Measure | Data Frequency (1) | Target / Threshold | Benchmark National / Regional (2) | 2017/18 TOTAL / AVERAGE (3) | 2017/18 Sparkline | May-17 | Jun-17 | Jul-17 | Aug-17 | Sep-17 | Oct-17 | Nov-17 | Dec-17 | Jan-18 | Feb-18 | Mar-18 | 2019/18 TOTAL / AVERAGE (3) | Apr-18 | Exception Identified? (4) |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | **Adult Community Services** | | WHC | | | | | | | | | | | | | | | | | | |
| Safety | A1 | Pressure Ulcers | | M | N/A | n/a | 1.7 | | 0 | 2 | 2 | 3 | 2 | 2 | 0 | 1 | 1 | 1 | 1 | | | |
| Safety | A2 | Falls with Harm | | M | N/A | n/a | 4.2 | | 1 | 0 | 2 | 7 | 4 | 5 | 6 | 4 | 6 | 6 | 4 | | | |
| Safety | A3 | Clinical Incidents per Month | | M | N/A | n/a | 218.6 | | 244 | 236 | 210 | 225 | 190 | 239 | 213 | 211 | 183 | 231 | 204 | | | |
| Effectiveness | A4 | CQUIN Performance | | Q | N/A | n/a | 1.0 | | | 100% | | | 94% | | | 100% | | | | | | |
| | | **Childrens Community Services** | | Virgin | | | | | | | | | | | | | | | | | | |
| Safety | C1 | Clinical Incidents per Month | | M | N/A | n/a | 131 | | 27 | 29 | 13 | 0 | 5 | 0 | 4 | 11 | 7 | 3 | 7 | 0 | | |
| Effectiveness | C2 | CQUIN Performance | | Q | N/A | n/a | | | | N/A | | | 100% | | | N/A | | | | | | |
| | | **Primary Care Community Services** | | GPs | | | | | | | | | | | | | | | | | | |
| Effectiveness | PC1 | CQC Results (# RI or below) | % good or above overall (of inspected practices) | M | N/A | n/a | 98% | | 93% | 95% | 98% | 100% | 100% | 100% | 100% | 100% | 100% | 100% | 98% | 98% | 98% | |
| Effectiveness | PC2 | CQC Safety Domain | % good or above overall (of inspected practices) | M | N/A | n/a | 100% | | 93% | 95% | 100% | 100% | 100% | 100% | 96% | 96% | 96% | 96% | 96% | 93% | 96% | |
| Safety | PC3 | Number of NRLS incidents raised | | M | N/A | n/a | 35 | | 2 | 2 | 0 | 0 | 0 | 0 | 4 | 1 | 1 | 4 | 20 | 5 | 5 | |
| Safety | PC4 | Number of STEIS incidents raised | | M | N/A | n/a | 1 | | 0 | 1 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 1 | 1 | |
| Experience | PC5 | GP Friends and Family Test | Recommend Rate | M | N/A | 89% | 90% | | 91% | 92% | 88% | 90% | 90% | 91% | 91% | 89% | 92% | 89% | 90% | 88% | 88% | |
| Experience | PC6 | GP Ipsos Mori Results - Overall experience of GP surgery | | A | N/A | 85% | 90% | | | | 90% | | | | | | | | | | | |

1 – Data is available monthly (M), quarterly (Q) or annually (A). 2 – Nationally available benchmark indicators are in purple, regional (South West or more local) are in orange. 3 – 2017/18 average figures appear without underline, total figures appear in an underlined format. Colour of the number indicates overall performance. 4 – Indicators marked with a flag are reported in further detail below the dashboard (blue flags indicate that this has already been reported as an exception so will be covered in the Ongoing Exceptions Table). 5 - This data is only for Salisbury Foundation Trust.

## Provider Cohort Indicators Reported by Exception

| Indicator: | U2a & U2b Call Audits Compliance (111 & SWASFT) |
|---|---|
| **Issue:** | Call Audits Compliance; NHS111 16% in March 2018, SWASFT 64% in February 2018 (latest data- no update since last report) |
| **Assurances and Next Steps:** | The dashboard shows an audit performance which has again decreased significantly for another month for Care UK 111 from 40% in February 2018 to 16% in March 2018. Care UK audit performance for April however, was recovered to the required position. If this continues, the Recovery Action Plan will be closed. This provider no longer delivers 111 services to Wiltshire patients as of 1 May 2018.<br>The new IUC contract with Medvivo went live on 1 May 2018 and will be reporting against defined and specific KPIs for audit and assurance, these are being monitored and will be reported in the next edition of this report.<br><br>SWASFT report that call audit compliance for Clinicians and Non-Clinicians remains a challenge, a plan for improvement has been agreed by SWASFT which will be shared with commissioners. The joint commissioners have made a number of recommendations to SWASFT regarding audit performance improvement.<br><br>The Trust has given assurance that audits are risk stratified and prioritised for new staff and those with a need to monitor performance, for which the Trust is reporting 100% compliance. |

| Indicator: | P5 & P6 – Mortality Ratios - SHMI & HSMR (acutes) |
|---|---|
| **Issue:** | Mortality Ratios – SHMI & HSMR Acutes (latest data – no update since last report) |
| **Assurances and Next Steps:** | The data regarding Mortality ratios is published with a considerable time lag. There is no new data to report since the previous edition of this report. The CCG is able to access unverified data on an ongoing basis which indicates that the improving trend in the SFT data is continuing.<br><br>The RUH Medical Director has presented assurance to the Clinical Outcomes and Quality Assurance meeting. The Quality team has sought additional assurance regarding patients belonging to specific diagnosis groups and variations in weekend performance. The RUH response will be reviewed at the next COAQ meeting in August. |

## Provider Workforce Cohort Level Indicators

### Quality Dashboard; Provider Workforce Cohort Level Indicators

NHS Wiltshire Clinical Commissioning Group

| Outcomes Framework Domain (1) | Indicator | Indicator (Yellow Indicates IAF / Constitutional Target) | Measure | Data Frequency (1) | Target / Threshold | Benchmark National / Regional (2) | 2017/18 TOTAL / AVERAGE (3) | Sparkline | May-17 | Jun-17 | Jul-17 | Aug-17 | Sep-17 | Oct-17 | Nov-17 | Dec-17 | Jan-18 | Feb-18 | Mar-18 | 2018/19 TOTAL / AVERAGE (3) | Apr-18 | Exception Identified? (4) |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | **Urgent Care** | **111 SWAST Medvivo** | | | | | | | | | | | | | | | | | | | |
| Effectiveness | U5 | Staff Turnover (NHS 111, SWAST & Medvivo) | Staff turnover rate - % | M | Provider set these targets average = 5% | n/a | **8.8%** | | 8.2% | 8.0% | 9.1% | 8.1% | 5.9% | 8.2% | 6.0% | 7.3% | 9.3% | 13.7% | 13.4% | **13.1%** | 13.1% | |
| Effectiveness | U6 | Sickness Absence (NHS 111, SWAST & Medvivo) | Sickness absence rate against provider target - % | M | | n/a | **4.8%** | | 4.9% | 4.1% | 4.9% | 4.9% | 4.0% | 4.8% | 3.4% | 5.2% | 6.2% | 4.6% | 5.0% | **4.6%** | 4.6% | |
| Effectiveness | U7 | Vacancies (NHS 111, SWAST & Medvivo) | Vacancy rates -% | M | | n/a | **16.3%** | | 11.7% | 18.8% | 20.4% | 18.0% | 12.7% | 18.0% | 19.5% | 13.2% | 19.3% | 21.5% | 1.4% | | | |
| Effectiveness | U8 | Agency staffing (NHS 111, SWAST & Medvivo) | Agency staff - % | M | | n/a | **6.5%** | | 6.8% | 7.0% | 6.8% | 6.7% | 4.9% | 5.2% | 5.4% | 7.0% | | 8.6% | 10.0% | | | |
| Effectiveness | U9 | Appraisal Rate (NHS 111, SWAST & Medvivo) | Staff with an annual appraisal - % | M | 75% | n/a | **90.4%** | | 90% | 89% | 91% | 87% | 87% | 90% | 97% | 97% | 91% | 91% | 89% | **92.4%** | 92% | |
| Effectiveness | U10 | Mandatory Training Compliance (NHS 111, SWAST & Medvivo) | Compliance with all mandatory training - % | M | 85% | n/a | **95.8%** | | 98% | 98% | 98% | 97% | 98% | 98% | 96% | 96% | 94% | 96% | 84% | | | |
| | | **Mental Health** | **AWP and CHAMS** | | | | | | | | | | | | | | | | | | | |
| Effectiveness | M3 | Supervision rates within threshold | | M | 85% | 85% | **85.9%** | | 85% | 90% | 85% | 87% | 87% | | | | | 83% | 83% | **83.1%** | 83% | |
| Effectiveness | M4 | Staff Turnover (AWP) | Staff turnover rate - % | M | Provider set these targets average = 5% | n/a | **13.4%** | | | 14.0% | 13.0% | 14.0% | 13.0% | 13.0% | 13.0% | 13.0% | 13.0% | 13.0% | 12.0% | **13.0%** | 13.0% | |
| Effectiveness | M5 | Sickness Absence (AWP) | Sickness absence rate against provider target - % | M | | n/a | **4.7%** | | | 4.7% | 3.9% | 4.1% | | 5.1% | 4.4% | 4.4% | 4.4% | 5.7% | 5.7% | **4.8%** | 4.8% | |
| Effectiveness | M6 | Vacancies (AWP) | Vacancy rates -% | M | | n/a | **20.2%** | | | 22.0% | 22.0% | 22.0% | 21.0% | 19.0% | 20.0% | 20.0% | 20.0% | 18.0% | 18.0% | **18.0%** | 18.0% | |
| Effectiveness | M8 | Appraisal Rate (AWP) | Staff with an annual appraisal - % | M | 75% | n/a | **94.2%** | | 95% | 95% | 94% | 93% | 92% | 92% | 93% | 96% | 94% | 95% | 95% | **95.0%** | 95.0% | |
| Effectiveness | M9 | Mandatory Training Compliance (AWP) | Compliance with all mandatory training - % | M | 85% | n/a | **89.4%** | | 89% | 89% | 90% | 89% | 89% | 89% | 89% | 90% | 90% | 89% | 89% | **89.0%** | 89% | |

1 – Data is available monthly (M), quarterly (Q) or annually (A). 2 – Nationally available benchmark indicators are in purple, regional (South West or more local) are in orange. 3 – 2017/18 average figures appear without underline, total figures appear in an underlined format. Colour of the number indicates overall performance. 4 – Indicators marked with a flag are reported in further detail below the dashboard (blue flags indicate that this has already been reported as an exception so will be covered in the Ongoing Exceptions Table). 5 - This data is only for Salisbury Foundation Trust.

# Quality Dashboard; Provider Workforce Cohort Level Indicators

NHS Wiltshire Clinical Commissioning Group

| Outcomes Framework Domain (1) | Indicator | Indicator (Yellow Indicates IAF / Constitutional Target) | Measure | Data Frequency (1) | Target / Threshold | Benchmark National / Regional (2) | 2017/18 TOTAL / AVERAGE (3) | 2017/18 Sparkline | May-17 | Jun-17 | Jul-17 | Aug-17 | Sep-17 | Oct-17 | Nov-17 | Dec-17 | Jan-18 | Feb-18 | Mar-18 | 2018/19 TOTAL / AVERAGE (3) | Apr-18 | Exception Identified? (4) |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | **Planned Care** | **Acutes and Independents** | | | | | | | | | | | | | | | | | | | |
| Effectiveness | **P10a** | Staff Turnover (acutes) | Staff turnover rate - % | M | Provider set these targets average = 5% | n/a | **11.7%** | | 11.7% | 11.5% | 11.0% | 11.5% | 11.6% | 11.4% | 11.5% | 11.8% | 11.9% | 12.0% | 12.0% | **12.0%** | 12.0% | |
| Effectiveness | **P10b** | Staff Turnover (others) | Staff turnover rate - % | M | | n/a | **3.3%** | | | 4.6% | | | 2.8% | | | 3.4% | | | 2.2% | | | |
| Effectiveness | **P11a** | Sickness Absence (acutes) | Sickness absence rate against provider target - % | M | | n/a | **3.9%** | | 3.6% | 3.5% | 3.5% | 3.7% | 3.7% | 3.6% | 3.8% | 4.2% | 4.6% | 4.2% | 4.6% | **4.1%** | 4.1% | |
| Effectiveness | **P11b** | Sickness Absence (others) | Sickness absence rate against provider target - % | M | | n/a | **4.2%** | | | 4.6% | | | 3.7% | | | 4.9% | | | 3.7% | | | |
| Effectiveness | **P12a** | Vacancies (acutes) | Vacancy rates -% | M | | n/a | **7.5%** | | 8.7% | 8.1% | 9.8% | 8.5% | 7.6% | 7.0% | 6.6% | 6.0% | 6.6% | 6.6% | 6.8% | **6.7%** | 6.7% | |
| Effectiveness | **P12b** | Vacancies (others) | Vacancy rates -% | M | | n/a | **4.6%** | | | 5.3% | | | 4.4% | | | 3.9% | | | 4.9% | | | |
| Effectiveness | **P13a** | Agency staffing (acutes) | Agency staff - % | M | | n/a | **2.2%** | | 2.0% | 1.7% | | 2.5% | 2.6% | 2.8% | 3.8% | 2.5% | 1.5% | 1.3% | 1.7% | **2.4%** | 2.4% | |
| Effectiveness | **P13b** | Agency staffing (others) | Agency staff - % | M | | n/a | **5.1%** | | | 6.0% | | | 5.5% | | | 5.3% | | | 3.5% | | | |
| Effectiveness | **P14a** | Appraisal Rate (acutes) | Staff with an annual appraisal - % | M | 75% | n/a | **82.1%** | | 82% | 83% | 83% | 84% | 83% | 82% | 82% | 85% | 81% | 81% | 81% | **81.1%** | 81% | |
| Effectiveness | **P14b** | Appraisal Rate (others) | Staff with an annual appraisal - % | M | 75% | n/a | **94.3%** | | | 94% | | | 94% | | | 93% | | | 96% | | | |
| Effectiveness | **P15a** | Mandatory Training Compliance (acutes) | Compliance with all mandatory training - % | M | 85% | n/a | **84.8%** | | 86% | 83% | 84% | 86% | 84% | 86% | 86% | 87% | 87% | 87% | 87% | **87.6%** | 88% | |
| Effectiveness | **P15b** | Mandatory Training Compliance (others) | Compliance with all mandatory training - % | M | 85% | n/a | **86.7%** | | | 89% | | | 84% | | | 85% | | | 89% | | | |
| | | **Adult Community Services** | **WHC** | | | | | | | | | | | | | | | | | | | |
| Effectiveness | **A5** | Sickness Absence | Sickness absence rate against provider target - % | M | Provider set these targets average = 5% | n/a | **4.2%** | | 4.0% | 4.4% | 4.5% | 4.0% | 3.1% | 4.4% | 3.7% | 4.8% | 5.2% | 3.7% | 3.6% | | | |
| Effectiveness | **A6** | Vacancies | Vacancy rates -% | M | | n/a | **12.4%** | | | 16.4% | 13.9% | 12.9% | 12.3% | 12.9% | 11.2% | 11.3% | 11.5% | 11.5% | 10.5% | | | |
| Effectiveness | **A7** | Agency staffing | Agency staff - % | M | | n/a | **7.2%** | | 5.7% | 6.7% | 6.4% | 6.1% | 4.5% | 4.8% | 7.3% | 10.2% | 7.6% | 11.1% | 11.1% | | | |
| Effectiveness | **A8** | Appraisal Rate | Staff with an annual appraisal - % | M | 75% | n/a | **80.0%** | | 86% | 85% | 83% | 80% | 79% | 79% | 77% | 76% | 78% | 77% | 76% | | | |
| Effectiveness | **A9** | Mandatory Training Compliance | Compliance with all mandatory training - % | M | 85% | n/a | **83.5%** | | 88% | 80% | 83% | 84% | 82% | 82% | 83% | 83% | 83% | 83% | 83% | | | |
| | | **Childrens Community Services** | **Virgin** | | | | | | | | | | | | | | | | | | | |
| Effectiveness | **C4** | Sickness Absence | Sickness absence rate against provider target - % | M | Provider set these targets average = 5% | n/a | **1.5%** | | | 1.8% | 2.0% | 1.2% | 0.3% | 0.9% | 1.0% | 0.1% | 2.8% | 1.6% | 1.2% | **1.9%** | 1.9% | |
| Effectiveness | **C5** | Vacancies | Vacancy rates -% | M | | n/a | **12.8%** | | | 6.0% | 4.4% | | 12.0% | 0.0% | 14.6% | 25.6% | 22.6% | 14.3% | 2.6% | **10.0%** | 10.0% | |
| Effectiveness | **C6** | Agency staffing | Agency staff - % | M | | n/a | **4.1%** | | | | | | | | 14.9% | 1.8% | 1.0% | 1.4% | 1.4% | **1.4%** | 1.4% | |
| Effectiveness | **C7** | Appraisal Rate | Staff with an annual appraisal - % | M | 75% | n/a | **84.9%** | | 84% | 84% | 87% | 87% | 87% | 87% | 87% | 87% | 81% | 81% | 81% | **81.0%** | 81% | |
| Effectiveness | **C8** | Mandatory Training Compliance | Compliance with all mandatory training - % | M | 85% | n/a | **84.7%** | | 87% | 90% | 89% | 80% | 87% | 84% | 81% | 87% | 79% | 83% | 82% | **89.0%** | 89% | |

1 – Data is available monthly (M), quarterly (Q) or annually (A). 2 – Nationally available benchmark indicators are in purple, regional (South West or more local) are in orange. 3 – 2017/18 average figures appear without underline, total figures appear in an underlined format. Colour of the number indicates overall performance. 4 – Indicators marked with a flag are reported in further detail below the dashboard (blue flags indicate that this has already been reported as an exception so will be covered in the Ongoing Exceptions Table). 5 - This data is only for Salisbury Foundation Trust.

## Provider Workforce Cohort Indicators Reported by Exception

| Indicator: | U7 – Staff Vacancies (NHS 111, SWASFT & Medvivo) |
|---|---|
| Issue: | Staff Vacancies (NHS 111, SWASFT & Medvivo) |
| Assurances and Next Steps: | The current vacancy rate for SWASFT for March (latest data) is at 1.4% this is an improvement from November and December where it was 2.5% and 3.5% respectively. SWASFT are currently completing an extensive staffing consultation and review.<br><br>1 May 2018 saw the CCG's newly commissioned Integrated Urgent Care service go live. This includes the former individual 111 and GP Out of Hours services. This service has been through an extensive internal and NHS England assurance process. The CCG is sighted on staffing levels across the whole service and will begin to report this in the next version of this report. |

| Indicator: | U8 Agency Staff (NHS 111, SWASFT & Medvivo) |
|---|---|
| Issue: | Agency Staff (NHS 111, SWASFT & Medvivo) |
| Assurances and Next Steps: | Agency staff usage at NHS 111 increased to 10% in March 2018 from 9% in February 2018. This provider no longer delivers 111 services to Wiltshire patients. Medvivo and SWASFT have reported zero agency usage in January – March 2018.<br><br>As per the previous indicator, the Medvivo Integrated Urgent Care service data will be reported from the date of the appropriate reporting period for May 2018 (the July version of this report). The CCG is sighted on staffing levels hour by hour across the service. |

| Indicator: | M3 - Supervision rates within threshold (AWP) |
|---|---|
| Issue: | Target 85%: Reporting 83% |
| Assurances and Next Steps: | AWP have reported below target for supervision rates at 83%. This has been related to sickness however AWP are reporting an improvement in April. The CCG will continue to monitor supervision rates through the monthly CQRM |

| Indicator: | M4 & M6 - Staff Turnover and Vacancies (AWP) |
|---|---|
| Issue: | Turnover and Vacancies |
| Assurances and Next Steps: | Whilst staff turnover and vacancies continue to be a concern for AWP and WCCG, the Trust are reporting increased retention rates and are leading the 'reshaping the workforce' STP transformation work stream. There is an 18% vacancy rate reported in April'18 for Wiltshire. The turnover rate remains at 12% (March data latest data). A more detailed update is included further in the report. |

| Indicator: | P10a - Staff Turnover (acutes) & P12a – Vacancies (acutes) |
|---|---|
| Issue: | 12% average turnover & 6.7% average vacancy rate for April 2018 (all acutes) |
| Assurances and Next Steps: | SFT: Staff turnover for the Trust was 10.24% in February 2018, slightly decreased from 10.27% in January 2018. SFT have Recruitment and retention plans in place, these are discussed at each CQRM. Hotspot areas for SFT include the Corporate Department (13.32%), Medicine (10.34%) and Clinical support and Family Services (10.14%).<br><br>GWH: In February 2018 (latest data for GWH), GWH's turnover level increased slightly to 13.74% from 13.38% in January 2018. This remains below the national rate of 14.08% but above the Trust target of 13%. GWH's vacancy rates increased marginally to 8.90% in March 2018 from 8.58% in February 2018. This is above the Trust's 8% target for vacancy rate.<br><br>51 staff left the Trust in February 2018; this is a decrease from the 62 staff that left in January 2018. Top 3 reasons for leavers in February 2018 are:<br>1. Voluntary resignation – other/ not known (9.82 WTE)<br>2. Work life balance (8.55 WTE)<br>3. Relocation (5.96 WTE)<br><br>Departmental Recruitment & Retention Plans continue across each Division at GWH. The Trust's strategy to improve retention for 18/19 for the older workforce includes actions around; a myth buster guide for older employees and their line managers, a review of the retirement policy to promote flexible working and retire and return to work and retirement workshops.<br><br>RUH: April 2018 indicated a variance of 11.59% in surgical and medical divisions with a further 0.65% in women's and children's division giving a total variance of 12.24%. A programme of overseas recruitment is in place and the first cohort of Assistant Practitioners are established with a second cohort planned for September 2018. |

| Indicator: | A6 –Vacancies (Wiltshire Health & Care) |
|---|---|
| Issue: | 10.5% March 2018 (latest data) |
| Assurances and Next Steps: | The vacancy data has decreased slightly from 11.45% in February to 10.5% in March which equates to 96.83 WTE vacancies. This remains above WHC own target of 8%. The WHC HR team are monitoring the recruitment pipeline which includes 30.11 WTE undergoing pre-employment checklists. |

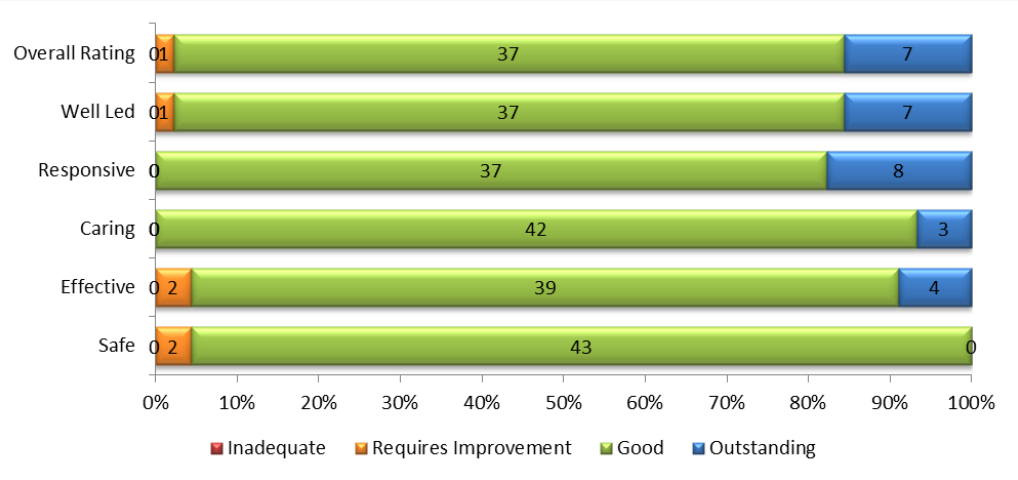
| Indicator: | A7 – Agency Staffing Spend (Wiltshire Health & Care) |
|---|---|
| Issue: | 11.12% agency usage for February 2018 (last available data) |
| Assurances and Next Steps: | The agency staff spend has increased in February. WHC continue to report significant vacancies in some areas, particularly Ailesbury ward (31% vacancy rate). These vacancies are filled with temporary staff, predominantly agency staff, to ensure patient safety is maintained. |

## Primary Care – update

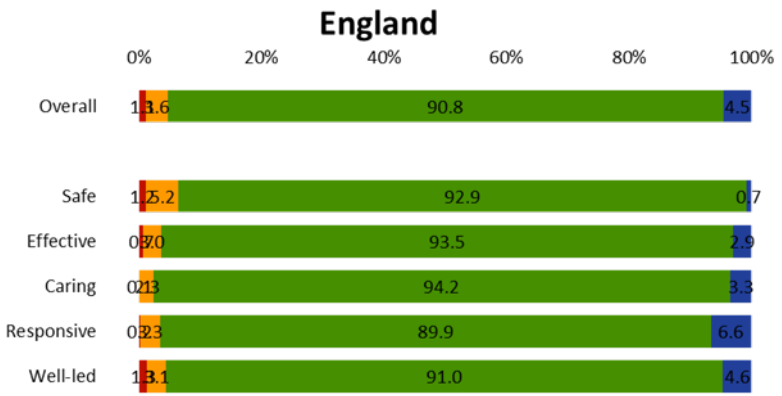
The breakdown of GP Practice CQC inspection results is shown in the charts below. As of 1 June 2018, there remain no practices rated in any domain or overall as 'Inadequate'. The rate of 'Requires Improvement' at domain level has increased to 4 practices with one of these practices having an overall rating of 'Requires Improvement'. There are currently 3 practices that have yet to be inspected following practice mergers.

Wiltshire practices have worked hard to deliver these inspection outcomes and are performing above national average CQC inspection ratings. The CCG continues to support practices with inspection preparation and the further development of a continuous improvement quality and safety culture.

**Current Wiltshire Practice Overall CQC Ratings as at 1 June 2018**




**National GP Practice Ratings as at January 2018.**




Further information around Primary Care assurance and quality improvement work is available in the Primary Care Quality Report (Current issue: Report number 7, March 2018).

## National Reporting and Learning System – Update

The most recent data published on the National and Reporting Learning System (NRLS) relates to incidents reported in England that occurred between 1 April 2017 and 30 September 2017, and were submitted to NRLS by 30 November 2017. The information outlined below focuses on the following providers which are commissioned by Wiltshire CCG (WCCG):

- Salisbury Foundation Trust (SFT)
- Royal United Hospital Bath Foundation Trust (RUH)
- Great Western Hospital Foundation Trust (GWH)
- Avon and Wiltshire Mental Health Partnership NHS Trust (AWP)

*Please note; WHC are not included within the data release as they are not an NHS Foundation Trust. WHC upload NRLS data monthly, which is available via NHS Improvement.*

The type of health care setting where most reported incidents occur is the acute/general hospital setting.

There is always scope to improve safety culture. Evidence for potential under-reporting and reporting rate are indirect indicators of potential problems with culture or reporting. They can be affected by many factors - for example, the services provided, populations served, and local safety issues and concerns. Increased reporting over time **may** indicate an improved reporting culture

The report identifies that none of WCCG's acute care providers (GWH, RUH and SFT) have evidence that is suggestive of potential under-reporting and all three acute care providers are advised to continue to assure staff that incident reporting is worthwhile and maintain a positive reporting culture.

All three acute trusts demonstrated a slight decrease in incidents reported per 1000 bed days from 2016 to 2017 with AWP reporting an increase, there has also been a decline in the timeliness of reporting for all providers except SFT:

| Acute Trusts | 2016: reported incidents per 1000 bed days: | 2017: reported incidents per 1000 bed days: | 2016: 50% of reports submitted after X days of reported incident date: | 2017: 50% of reports submitted after X days of reported incident date: |
|---|---|---|---|---|
| **SFT** | 57.68 | 41.99 ↓ (worse) | 17 days | 13 days ↑ (better) |
| **RUH** | 30.60 | 29.30 ↓ (worse) | 14 days | 34 days ↓ (worse) |
| **GWH** | 38.44 | 33.84 ↓ (worse) | 24 days | 27 days ↓ (worse) |
| **AWP** | 52.06 | 54.33↑ (better) | 16 days | 42days ↓(worse) |

Reporting patterns must always be interpreted alongside other information such as NHS Staff Survey results on reporting culture and practice and also reported Serious Incidents on STEIS. The Quality team will be triangulating this data and seeking assurance from providers through the CQRM process to ensure appropriate reporting and learning.

Across all three acute providers the most frequently reported Type 1* incident is “patient accident” accounting for: 20.2% at GWH, 19.1% at RUH and 22% at SFT. The most frequently reported Type 2* incidents are “slips, trips and falls” accounting for 18.4% at GWH, 17.3% at RUH and 20.3% at SFT. AWP report the most frequent Type 1 incident as disruptive, aggressive behaviour at 42.1%, for type 2 incidents it is ‘Physical’ at 35.5%.

**Type 1 incidents refer to the categorisation of incidents within NRLS reporting system and include:* *Patient accident, Infrastructure, Medication, Implementation of care, Access, admission, transfer, discharge, Treatment, procedure, Clinical assessment, Consent, communication, confidentiality, Documentation, Medical device / equipment*
**Type 2 incidents refer to sub categories of incidents within the NRLS reporting system*
The NRLS reports do not give a comparison to the 2016 data.Please see link below for further details.
https://improvement.nhs.uk/resources/national-patient-safety-incident-reports-september-2017/

## Update of Exceptions Identified in Previous Reports and On-going Work

This section includes information on previously reported exceptions as appropriate and if the identified issue is not resolved and reported in the dashboard within the anticipated time frame. These will be indicated with a blue flag on the dashboard to indicate where indicators are included within this section.

| Indicator | Provider | Action | Target Date | Responsibility | Expected Outcome | Progress to date | Date Completed |
|---|---|---|---|---|---|---|---|
| Healthcare acquired infection (HCAI) – E.coli Reduction in Urinary Tract Infections and Gram Negative Blood Stream infections | Across STP | Collection, and analysis of E-Coli BSI data inform next steps of project steps | March 2019 | STP CCG and all Providers | Reduction of at least 10% in gram-negative blood stream infections and urinary tract infections | • Data review on-going to ensure all cases up to the end of March 2018 are captured.<br>• Acute trust individual working groups have commenced to tackle HCAI GNBSI.<br>• Hydration messages going out across STP through Public Health.<br>• 'Plans on a page' being worked on in collaboration with BANES and Swindon CCGs for 18/19.<br>• 10% reduction not achieved. 6% reduction achieved.<br>• HCAB meeting occurring on 19 June 2018 where further actions will be decided across STP<br>• Hydration messages being coordinated across the STP by Local Authority colleagues. | Ongoing |

| Indicator | Provider | Action | Target Date | Responsibility | Expected Outcome | Progress to date | Date Completed |
|---|---|---|---|---|---|---|---|
| Healthcare Acquired Infection (HCAI) – *C. difficile* (post 72 hrs) 2017/18 year end reported rate is less than 2016/17. Reduction in cases. | Across Wiltshire health economy | 2017/18 has seen a reduction in the reported cases of C. difficile; total number of cases for WCCG for 2017/18 is 98, in comparison to 101 for 2016/17. The WCCG Quality Team will continue to seek assurance from providers to ensure mitigating action is aligned across Wiltshire services, and provide support to reduce C. difficile rates. | March 2019 | CCG and all providers | C.diff cases remain under new reduced threshold of 101 for 18/19 | • Assurance sought on an on-going basis from acute providers<br>• Primary care C.diff cases to be reviewed as required<br>• Antimicrobial stewardship work in collaboration with medicines management team to continue<br>• The WCCG Quality Team will continue to seek assurance from providers to ensure mitigating action is aligned across Wiltshire services, and provide support to reduce C. *difficile* rates.<br>• Decision for WCCG task and finish group to be commenced to review CDI in Primary care. | On-going |
| U3a >16 Hour ED Stays (Waits) (Wiltshire)<br><br>U3b - >16 Hour ED Stays (Waits) (SFT) (5) | GWH, RUH and SFT | The Quality Team is working towards agreeing with acute providers a process of assurance around reporting 16-hour waits in ED. The CCG has commissioned a new report from the Analytics Team giving the number of patients who waited in the Emergency Department for more than 16 hours (a combination of the 4 hour Decision to Admit Target and the 12 – hour Trolley Wait. | May 2018 | Main providers (Planned Care Quality Lead) | The reports will be shared with the ED Delivery Board on a monthly basis. | There was a data issue identified within the new CSU report. This was corrected in both the provider data for SFT and the CSU data for GWH and RUH. A re-run of the data that took place for month 7 identified that there are still some anomalies. The CSU are continuing to work directly with all the providers to resolve the issue. The Quality Team have escalated the slow progress in developing this report to the CCG Associate Director of Informatics. | Ongoing |

| Indicator | Provider | Action | Target Date | Responsibility | Expected Outcome | Progress to date | Date Completed |
|---|---|---|---|---|---|---|---|
| | | This new report is designed to capture these cases and to support the providers to investigate and identify outcomes and learning from them. | | | | Following the last GWH FIG sub-group in February 18, the CSU shared the search criteria with the Trust so that they can identify the patients. The Trust has been tasked with reviewing the data to identify the data issues.<br><br>The national implementation of ECDS is also affecting the A&E data quality and this is being investigated and the CSU is still working with the Providers to improve the quality of the data. | |
| Serious Incidents | AWP | A Serious Incident (SI) Contract Performance Notice (CPN) was issued to AWP on 12 December 2017. | | AWP and all CCGS (Bristol, North Somerset, South Gloucestershire (BNSSG) and BANES, Swindon and Wiltshire (BSW)) | | This CPN remains in place and all Commissioners are working with AWP to ensure that the trajectories included within the Remedial Action Plan (RAP) are suitable, include short, medium and long term actions, and work towards meeting the Trusts' contractual obligations.<br>• The Trusts' revised trajectory for meeting the 60 day RCA timeframe is August'18. Commissioners receive monthly updates on performance against trajectory. | |

| Indicator | Provider | Action | Target Date | Responsibility | Expected Outcome | Progress to date | Date Completed |
|---|---|---|---|---|---|---|---|
| Staff Turnover and Vacancies | AWP | Recruitment and Retention plan (RAP) | | | | Recruitment remains a priority and an area of focus for AWP in Wiltshire. The annual objective remains of reducing both staff turnover and the vacancy rate by 2% in 2018/19.<br>WCCG will continue to seek assurance at the monthly BSW CQPM to ensure that there is a continued focus on the specific Wiltshire workforce concerns.<br>. A recruitment and retention workshop was held in April to think about the next stage of the locality's recruitment and retention improvement work. Work undertaken to date has seen the turnover rate move from 20%-12% and the vacancy rate move from 24%-18% over the past 18 months. Recruitment of qualified registered staff continues to be an ongoing challenge.<br>Bank and agency usage has increased slightly over the last month. The primary reasons for temporary staff use are the levels of vacancy and sickness within the locality. | |

# Quality Dashboard Glossary: 2017/18

| Dashboard | Detailed Measure | Source of indicator definition | Reference in Contract | Detailed definition | Source |
|---|---|---|---|---|---|
| Quality | Mixed Sex Accommodation (MSA) Breaches | Everyone Counts 2013/14 | E.B.S.1 | The number of breaches of mixed-sex accommodation (MSA) sleeping accommodation | Published on NHS England website: https://www.england.nhs.uk/statistics/statistical-work-areas/mixed-sex-accommodation/msa-data/ |
| Quality | Number of Never Events | Quality | Quality Schedule | Never Events are serious, largely preventable patient safety incidents that should not occur if the available preventative measures have been implemented. | Reported as Serious Incidents on the Strategic Executive Information System (STEIS) |
| Quality | % of all adult inpatients who have had a VTE risk assessment | Quality | Quality Schedule | Every patient admitted to hospital for medical reasons should have a documented risk assessment to identify those at risk of Venous Thromboembolism (VTE). | Published on NHS England website: https://www.england.nhs.uk/statistics/statistical-work-areas/vte/ |
| Quality | WHO Surgical Safety Checklist completed for 100% of procedures | Quality | Quality Schedule | This is a surgical checklist that the surgery team completes with listed tasks before it proceeds with the operation. | From provider submissions to Contract Review Meetings |
| Quality | Fracture Neck of Femur - % in theatre within 36 hours | Quality | Quality Schedule | The best practice for Fractured Neck of Femur is the time to surgery within 36 hours from arrival in an emergency department, or time of diagnosis if an inpatient, to the start of anaesthesia. | From provider submissions to Contract Review Meetings |
| Quality | Healthcare acquired infection (HCAI) measure (MRSA) | Everyone Counts 2013/14 | E.A.S.4 | Number of cases of Methicillin-resistant Staphylococcus aureus (MRSA) bacteraemia | Health Protection Agency Healthcare Aquired Infections website https://nww.hpanw.nhs.uk |
| Quality | Healthcare acquired infection (HCAI) measure (c. difficile) | Everyone Counts 2013/14 | E.A.S.5 | Number of Clostridium difficile infections, for patients aged 2 or more on the date the specimen was taken | Health Protection Agency Healthcare Aquired Infections website https://nww.hpanw.nhs.uk |
| Quality | Friends and family test score | Everyone Counts | Schedule 6e | The proportion of people who reported that they were either 'extermely likely' or 'likely' to recommend the service to their friends and family, out of the total number of people who responded to the survey. Score is displayed as a percentage. | NHS England website. http://www.england.nhs.uk/statistics/statistical- work-areas/friends-and-family-test/friends-and- family-test-data/ |
| Quality | Patient Safety Thermometer | NHS Contract (National Quality Requirements) | Quality Schedule | The number of instances of each type of harm reported in a month. This is a point prevelance audit, captured on one day per month. | Health & Social Care Information Centre. http://www.hscic.gov.uk/thermometer |
| Quality | Complaints | Quality | Quality Schedule | The combined number of formal complaints raised by patients and by MP's on behalf of patients in the month | From provider submissions to Contract Review Meetings |
| Quality | Mortality ratios | The Department of Health (Commissioned from the HSCIC) | Quality Schedule | The Summary Hospital-level Mortality Indicator (SHMI) is an indicator which reports on mortality at trust level across the NHS in England using a standard and transparent methodology. It is produced and published quarterly as an official statistic by the Health and Social Care Information Centre (HSCIC) with the first publication in October 2011.<br><br>The SHMI is the ratio between the actual number of patients who die following hospitalisation at the trust and the number that would be expected to die on the basis of average England figures, given the characteristics of the patients treated there.<br><br>The Hospital Standardised Mortality Ratio (HSMR) is an indicator of healthcare quality that measures whether the mortality rate at a hospital is higher or lower than you would expect. Like all statistical indicators, HSMR is not perfect. If a hospital has a high HSMR, it cannot be said for certain that this reflects failings in the care provided by the hospital. However, it can be a warning sign that things are going wrong. HSMR does not measure deaths post discharge. | For SHMI:From the Healtha nd Social Care Information Centre Website: http://www.hscic.gov.uk/SHMI<br><br>For HSMR: http://www.nhs.uk/NHSEngland/Hospitalmortalityrates/Documents/090424%20MS(H)%20-%20NHS%20Choices%20HSMR%20Publication%20-%20Presentation%20-%20Annex%20C.pdf |
| Quality | Maternity Indicators (Stillbiths, Midwife to bith ratio, Breast Feeding Rates at Discharge) | Better Births National Maternity Review: https://www.england.nhs.uk/wp-content/uploads/2016/02/national-maternity-review-report.pdf | Quality Schedule | Following the National Maternity Review and the resulting Better Births Report, Maternity quality indicators are measured to ensure continuous improvement and consistency across all providers. The CCG measures these indicators via the contract quality schedule and through the South West Stretgic Clinical Network Maternity Dashboard | http://www.swscn.org.uk/networks/maternity-children/maternity-group/ |
| Quality | Workforce Indicactors | Quality | Quality Schedule | The CCG monitors a wide range of workforce indicators within in each provider. These indicators are triangulated with other data and information to form part of an 'early alert' trigger to emerging concerns. | Provider submissions to contract review meetings. |
| Quality | Call Audit Indicators | Quality | Quality Schedule | Providers commissioned to deliver services to patients via telephone are required to audit a proportion of the calls that they receive or make to patients. These calls can be made / received by both clinically trained and non-clinical staff. One of the ways that the CCG monitors quality of service to patients by these providers is to ensure that calls are audited and learning and improvements are identified to ensure safety and appropraiteness of call handling. | Provider submissions to contract review meetings, and CCG attendance at Call Reviews. |
| Quality | CQC Status | Quality | Quality Schedule | The providers are required to register with CQC under their contract with the CQC. The CCG works with partner organisations, including the CQC, to share intelligence about providers and identify and address providers in need of support. The CCG monitors CQC compliance and ensures action plans developed following inspection results are comprehensive and completed by providers. | http://www.cqc.org.uk/ |

# Section 2: Finance and Information

| FINANCE AND ACCESS DASHBOARD | | | |
|---|---|---|---|
| **Target** | **Responsible Director** | **Where will performance and assurance be sought** | **RAG status** |
| Delivery of in-year surplus £198k | Steve Perkins | Finance committee and group performance review | |
| Running costs within allocation | Steve Perkins | Finance committee | |
| Operating within cash limit | Steve Perkins | Finance committee | |
| Better payment performance | Steve Perkins | Finance committee | |
| Non elective activity on plan | Jo Cullen | Finance committee and group performance review | |
| Non elective & urgent care QIPP plan delivery | Jo Cullen | Finance committee and group performance review | |
| Planned care activity on plan | Lucy Baker | Finance committee and group performance review | |
| Outpatient targets are being delivered | Lucy Baker | Finance committee and group performance review | |
| Planned care QIPP plan delivery | Lucy Baker | Finance committee and group performance review | |
| Other activity targets are being delivered | Multiple | Finance committee and group performance review | |
| A&E 4 Hour wait (SFT) | Jo Cullen | Finance committee, group performance review and Local Delivery Board | |
| A&E 4 Hour wait (GWH) | Jo Cullen | Finance committee, group performance review and Local Delivery Board | |
| A&E 4 Hour wait (RUH) | Jo Cullen | Finance committee, group performance review and Local Delivery Board | |
| Cancer waiting times | Lucy Baker | Finance committee, group performance review and RTT Assurance Group | |

## Summary

In line with NHS England (NHSE) planning requirements, the CCG is required to deliver a cumulative 1% surplus against its available resources including its brought forward surplus. The CCG is monitored on the in-year element of this, £198k, and is not expected to draw down the brought forward balance. The CCG is required to hold a contingency of 1%, and has also set aside a 1% reserve to pump prime and support service redesign. The CCG's plan control totals for 2018/19 are set out below:

| | £m |
|---|---|
| Revenue Resource Limit | (676.807) |
| Applications | 692.429 |
| QIPP | (15.820) |
| **Net In-year (surplus) / deficit** | **(0.198)** |

For month 2, the CCG is forecasting delivery of the planned surplus position.

The CCG only has one month of activity data from providers to support month 2 reporting. Some data quality issues, including high volumes of uncoded activity at two NHS providers, have been observed and are being investigated. One month of data is not sufficient to be able to produce meaningful forecasts, however, no significant areas of over or underperformance have been identified at this stage.

The CCG is operating within its available resources (both cash and income and expenditure) and has achieved its better payment performance requirements on a year to date basis.

## Resources

At month 2, resources received were in line with plan, and there has been no change to the CCG's revenue resource limit.

## Income and expenditure movements

There are no forecast outturn variances in month 2.

## Key financial performance issues

There are no financial performance issues to report in month 2.

## Financial risks

The CCG identified a number of financial risks as part of the planning process for 2018/19.

While the CCG has agreed contract sums for acute services provision, these have been calculated on the basis of forecast activity at M8 of the 2017/18 financial year, adjusted for known changes in provider capacity and estimated growth rates. While every effort has been made to contract on a realistic basis, there is always a risk that activity and therefore cost are understated. There are also a number of QIPP schemes associated with acute contracts, most of which are expected to deliver, but some of which are new in 2018/19 and also carry a degree of risk. The risk value reported below is consistent with that reported to NHS England during the planning process, and will be adjusted as more robust actual activity information begins to flow to the CCG.

The CCG identified the risk of underfunding in relation to further patients in the Daisy, based on what our understanding is of the funding likely to be provided for these patients versus the costs associated with provision at the Daisy.

Risks associated with CHC disputes were identified during the planning round; the value of these has been increased to reflect the further possibility of backdated costs, and to reflect the risk associated with continuing care QIPP.

A risk has been recognised in relation to prescribing QIPP in month 2. While schemes have been identified which meet the target QIPP for prescribing, there are some uncertainties around deliverability of some of these schemes.

The CCG has identified a potential cost pressure in Delegated Primary Care commissioning budgets, in relation to GMS and PMS contracts, which exceed the expected budget when probable list size growth is taken into account. The CCG is working with NHS England to develop a further understanding of the likelihood of this risk materialising.

The CCG has reported a risk in relation to Quality Premium in month 2, which is planned to contribute to the CCG’s QIPP target.

The CCG recognised a residual VAT risk in relation to the Integrated Urgent Care contract as part of its planning submission, and is awaiting further clarification around whether this element of VAT will be payable on the new contract.

The financial risks at month 12 are summarised in the table below:

| Area | | Risk £m | Comment |
|---|---|---|---|
| Risk issues | Acute services | 2.34 | Overperformance and QIPP risk |
| | Daisy unfunded patients | 0.50 | New Daisy patients not already funded |
| | Continuing care services | 0.90 | Costs and prior year payments relating to legal challenges; QIPP risk £0.1m |
| | Prescribing | 0.33 | Prescribing QIPP risk |
| | Delegated primary care | 0.40 | Cost pressure arising from increased list sizes |
| | Quality Premium | 0.13 | QIPP risk arising from possible non-achievement of Quality Premium |
| | Integrated Urgent Care | 0.10 | VAT risk |
| | | 4.70 | |
| Mitigations | Contingency | -3.07 | Reserves balances |
| | Other reserves | -1.63 | Reserves balances |
| | | -4.70 | |
| **Net risk position after mitigations** | | **0.00** | |

## Key access issues

### RTT Incomplete Pathways

In April 2018, the CCG did not deliver the 92% Referral to Treatment (RTT) target achieving 90.6%, this was 0.4% up on the previous month. SFT achieved the standard with 93.4%, however there was underperformance at both GWH (87.5%) and RUH (87.8%). Performance continues to be monitored monthly at dedicated RTT steering groups. Winter elective plans are being developed and will be finalised by mid July 2018. There are current pressures in ophthalmology and urology across providers and pre-referral redirection continues to reduce impact on patients and performance risk. Performance trajectories have been agreed with SFT with continued delivery of the 92% target. RUH and GWH trajectories are being reviewed.

### Total Waiting List Size

There has been a national drive to ensure the waiting list size does not increase in 2018/19 with the March 2019 waiting list to be no greater than at March 2018. The table below shows the waiting list size movements for April 2018.

| | Mar-18 | Apr-18 | Shift |
|---|---|---|---|
| GWH | 5,704 | 5,974 | 270 |
| RUH | 7,195 | 7,338 | 143 |
| SFT | 10,080 | 10,361 | 281 |
| Others | 5,611 | 5,821 | 210 |
| CCG Total | 28,590 | 29,494 | 904 |

| | |
|---|---|
| CCG Plan | 28,600 |
| Un-planned Variance | 894 |

**Over 52 Week RTT Waits**
There were 18 breaches in April; 7 at GWH (3 in Ophthalmology, 2 T&O, 1 ENT, and 1 Gynae), 5 at RUH (3 in General Surgery, and 2 Ophthalmology), 3 at North Bristol (2 in Plastic Surgery, and 1 T&O), 2 at University Hospital Bristol (1 in Cardiology, and 1 Other), and 1 at Oxford University Hospitals (Gynae). The GWH ophthalmology long waiting patients now all have dates and are being operated on by an SFT consultant in Swindon. RUH are continuing to outsource long waiters in General Surgery for Wiltshire and this is being monitored weekly.

**Diagnostic Waits**
The CCG breached the 99% within 6 week standard for April with 95.5%. SFT achieved the standard (99.3%) but GWH and RUH breached at 83.9% and 97.9% respectively. RUH continue to recover their position and the focus remains on cardiology diagnostics. GWH position continues to deteriorate. The main area of concern remains imaging. A dedicated director and clinical task and finish group continues. A mobile unit is now on site and will be undertaking 800 diagnostics in June. Clinical pathways are being reviewed with Wiltshire GP involvement starting with ultrasound. SFT have offered capacity from 1 July 2018 for imaging. Additional recruitment continues with a number for newly qualified clinical staff commencing in September.

**Cancer Access (Data not yet available for April)**
The NHS has decommissioned the former Cancer reporting system and there has been a national delay in the availability of April cancer waiting times performance data from the new replacement system. NHS Digital has advised they aim to have prioritised aggregate reports by 14 June 2018 and work will then begin on development work to build metrics. A timetable will be provided once the extract has been assessed.

GWH performance is likely to dip due to issues with urology two week waits and capacity at tertiary providers for robotic surgery. This is being monitored through the Cancer Steering Group.

**Mixed Sex Accommodation (March, data not yet available for April)**
There were 41 breaches in March 2018; 40 at SFT, 1 at GWH. All the SFT breaches occurred in the Ambulatory Care Bay on AMU. The CCG has undertaken a visit to the AMU at SFT to review the management of MSA breaches. In times of increased activity within the Trust, and particularly in the AMU ambulatory care bay, there are occasions when MSA breach occurs. When this does happen, the bay is flexed to ensure that each end of the bay is designated as ‘male’ or ‘female,’ with separate toilet facilities at each end of the bay. The bay also has ‘Quick Screens,’ which are used to separate the male/female end of the bay to maintain patients’ privacy and dignity. On review of the bay and the mitigations the Trust puts in place when MSA occurs, we have agreed that the Trust will report each breach to commissioners, but that the breach will not be counted in the Trusts’ numbers, as there are mitigations in place.

**A&E <4 Hour waits**
All three Acute Trust breached the 95% standard in April. RUH 83.2%, SFT 90.6% and GWH 86.5%.

Across the whole system there is increasing focus on patients with extended length of stay (21 days or more), and the correlation with 4 hours A&E performance; and for the three system A&E Local Delivery Boards in June, we are developing and presenting a Wiltshire Action Plan focussed on pre hospital pathways through the Integrated Urgent Care service; and discharge Pathways with specific metrics and actions to deliver.

**Ambulance Response**
There was some improvement in performance for SWAST in April, but both standards continue to breach the 7 minute and 15 minute standards.
The Category 1 Response Mean for SWAST was 8.5 minutes (90th Percentile was 15.8 minutes).

A joint plan has been collaboratively developed between SWASFT and commissioners from across the south west. There is joint commitment to achieving the Ambulance Response Programme (ARP) standards and to maintaining clinical safety and patient experience during and beyond the period of performance recovery. There are a number of key components to the plan; and as part of the commissioner action plan six work-streams have been identified:

- Falls and frailty
- NHS111 activity
- Handover delays
- Health care professional calls
- Mental health
- Frequent callers

The CCG is working closely with other commissioners to ensure the plan reflects the requirements in improvement for Wiltshire, and aligns with other work programmes and the implementation will be supported through the three A&E Local Delivery Boards.

**Community Services**
Adult Health (WH&C) for April 2018, WH&C average length of stay now stands at 26 days reducing from an average of 28.2 days for 17/18 which is 6 days more than target but one of the lowest lengths of stays reported during the previous 12 months. DToC has also reduced following a consistent downward trend and has decreased to 11% (target 20%) which is the lowest since April 2017. The availability of domiciliary packages of care remains the main reason for the delays.

**Dementia Diagnosis**
The April rate was 64.2%, Target is 66.7%.

## Appendices

- Annex 1 Summary I&E position M2 2018/19
- Annex 2 Summary Statement of Financial Position M2 2018/19
- Annex 3 Cash Position M2 2018/19
- Annex 4 Better Payment Practice Code Performance M2 2018/19
- Annex 5 Movement between budgets and resources M2 2018/19
- Annex 6 Performance against constitution targets M1 2018/19

## Annex 1 – Summary Income and expenditure position M2 2018/19

| CCG Income and Expenditure summary | Year to date | | | Forecast outturn | | | Prior Month Forecast Variance | Movement |
|---|---|---|---|---|---|---|---|---|
| | Plan £m | Actual £m | Variance £m | Plan £m | Actual £m | Variance £m | £m | £m |
| Acute services | 57.853 | 57.551 | 0.302 | 349.374 | 349.374 | - | - | - |
| Mental health services | 8.667 | 8.667 | - | 51.999 | 51.999 | - | - | - |
| Community health services | 9.975 | 9.658 | 0.317 | 59.849 | 59.849 | - | - | - |
| Continuing care services | 4.906 | 4.748 | 0.158 | 29.361 | 29.361 | - | - | - |
| Primary care services | 15.475 | 14.842 | 0.633 | 92.276 | 92.276 | - | - | - |
| Primary care delegated commissioning | 10.922 | 10.770 | 0.152 | 63.070 | 63.070 | - | - | - |
| Other programme services | 1.386 | 1.322 | 0.063 | 8.166 | 8.166 | - | - | - |
| Contingency | 0.511 | - | 0.511 | 3.069 | - | 3.069 | 3.069 | - |
| Other CCG reserves | 0.117 | 2.389 | (2.272) | 9.398 | 12.467 | (3.069) | (3.069) | - |
| **Total commissioning services** | **109.811** | **109.946** | **(0.135)** | **666.562** | **666.562** | **-** | - | - |
| Running costs | 1.583 | 1.448 | 0.135 | 10.046 | 10.046 | - | - | - |
| **Total CCG net expenditure** | **111.394** | **111.394** | **-** | **676.609** | **676.609** | **-** | - | - |
| | | | | | | | | |
| **Revenue resource limit (in year)** | 111.427 | 111.427 | - | 676.807 | 676.807 | - | | |
| **In year underspend (deficit)** | **0.033** | **0.033** | **-** | **0.198** | **0.198** | **-** | | |
| Add back brought forward surplus | 2.531 | 2.531 | - | 15.186 | 15.186 | - | | |
| **Cumulative underspend / (deficit)** | **2.564** | **2.564** | **-** | **15.384** | **15.384** | **-** | | |

**Supplementary information**

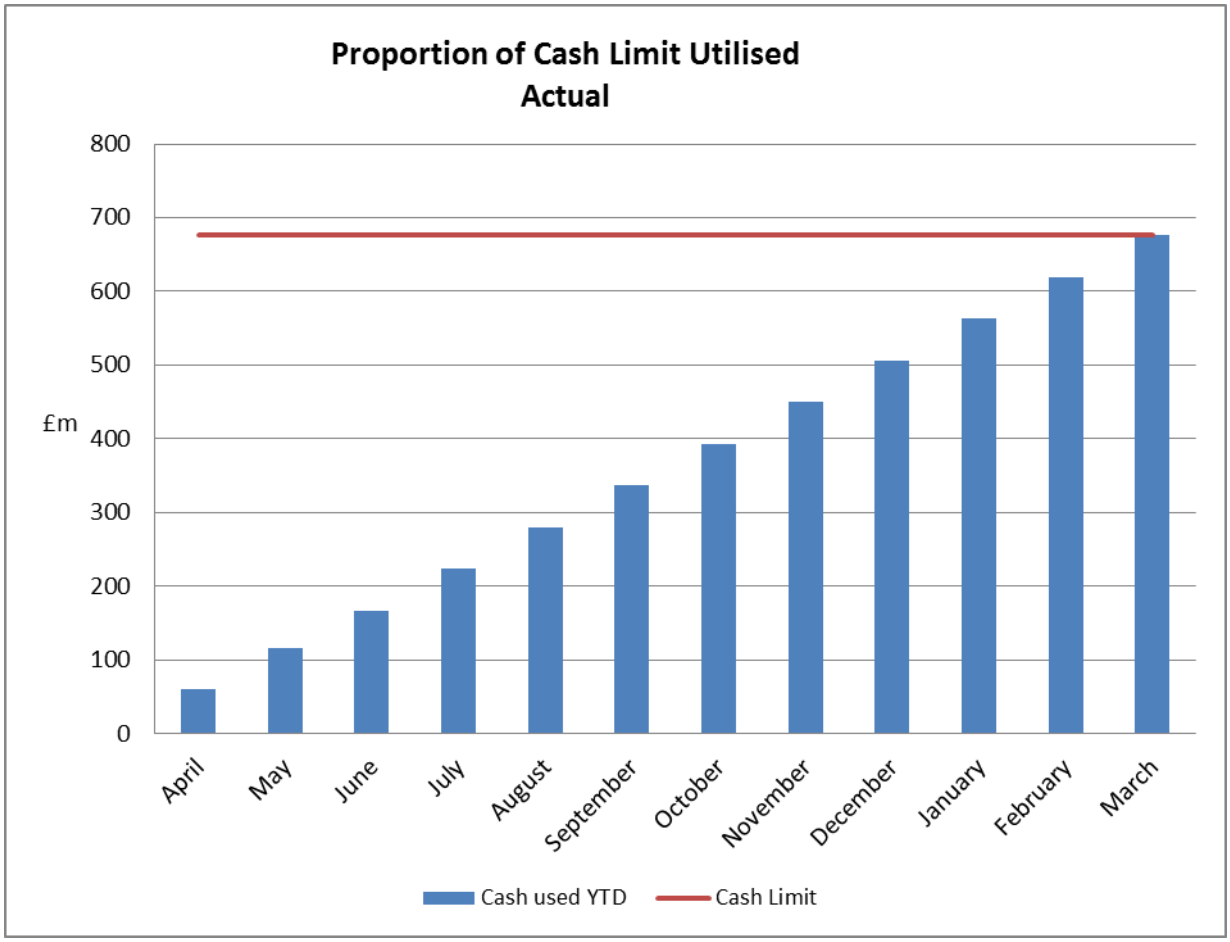
| | Year to Date Net Expenditure | | | Forecast Net Expenditure | | | Prior Month Forecast Variance | Movement |
|---|---|---|---|---|---|---|---|---|
| | Plan £m | Actual £m | Variance £m | Plan £m | Actual £m | Variance £m | £m | £m |
| **Prescribing budget** | | | | | | | | |
| Prescribing (included within primary care services above | 12.506 | 12.086 | 0.420 | 74.987 | 74.987 | - | - | - |
| | | | | | | | | |
| **Analysis of BCF expenditure included within commissioning services above** | | | | | | | | |
| BCF direct contribution to Wiltshire Council | 3.233 | 3.267 | (0.034) | 19.396 | 19.396 | - | - | - |
| Within - Mental Health | 0.035 | 0.035 | - | 0.208 | 0.208 | - | - | - |
| Within - Urgent Care | 0.004 | - | 0.004 | 0.027 | 0.027 | - | - | - |
| Within - Commissioning Schemes | 0.208 | 0.202 | 0.006 | 1.246 | 1.246 | - | - | - |
| Within - Community Services | 1.788 | 1.788 | - | 10.727 | 10.727 | - | - | - |
| **Total BCF expenditure** | **5.268** | **5.292** | **(0.024)** | **31.604** | **31.604** | **-** | - | - |

## Annex 2 – Summary Statement of Financial Position M2 2018/19

| Summary Statement of Financial Position | £'m Opening position 1st April 2018 | Closing position 31st May 2018 | Forecast position at 31st March 2019 |
|---|---|---|---|
| Non-Current Assets: | | | |
| Premises, Plant, Fixtures & Fittings | 0.00 | 0.00 | 0.00 |
| IM&T | 0.00 | 0.00 | 0.00 |
| Other | 0.01 | 0.01 | 0.01 |
| Long-term Receivables | 0.00 | 0.00 | 0.00 |
| TOTAL Non-Current Assets | 0.01 | 0.01 | 0.01 |
| Current Assets: | | | |
| Inventories | 0.00 | 0.00 | 0.00 |
| Prepayments | 2.02 | 1.87 | 2.02 |
| Trade and Other Receivables | 2.79 | 2.18 | 2.79 |
| Bad debt impairment | -0.53 | -0.53 | -0.53 |
| Cash and Cash Equivalents | 0.03 | 5.33 | 0.03 |
| TOTAL Current Assets | 4.31 | 8.85 | 4.31 |
| | | | |
| **TOTAL ASSETS** | **4.32** | **8.86** | **4.32** |
| Non-Current Liabilities: | | | |
| Long-term payables | 0.00 | 0.00 | 0.00 |
| Provisions | 0.00 | 0.00 | 0.00 |
| Borrowings | 0.00 | 0.00 | 0.00 |
| TOTAL Non-Current Liabilities | 0.00 | 0.00 | 0.00 |
| Current Liabilities: | | | |
| Trade and Other Payables | 41.91 | 42.46 | 42.99 |
| Other Liabilities | 0.00 | 0.00 | 0.00 |
| Provisions | 1.04 | 1.03 | 0.20 |
| Borrowings | 0.00 | 0.00 | 0.00 |
| Total Current Liabilities | 42.95 | 43.49 | 43.19 |
| | | | |
| **TOTAL LIABILITIES** | **42.95** | **43.49** | **43.19** |
| | | | |
| **ASSETS LESS LIABILITIES (Total Assets Employed)** | **-38.63** | **-34.63** | **-38.87** |
| Financed by taxpayers' equity: | | | |
| General fund | 38.63 | 34.64 | 38.87 |
| Revaluation reserve | 0.00 | 0.00 | 0.00 |
| Other reserves | 0.00 | 0.00 | 0.00 |
| Total taxpayers' equity: | **38.63** | **34.64** | **38.87** |

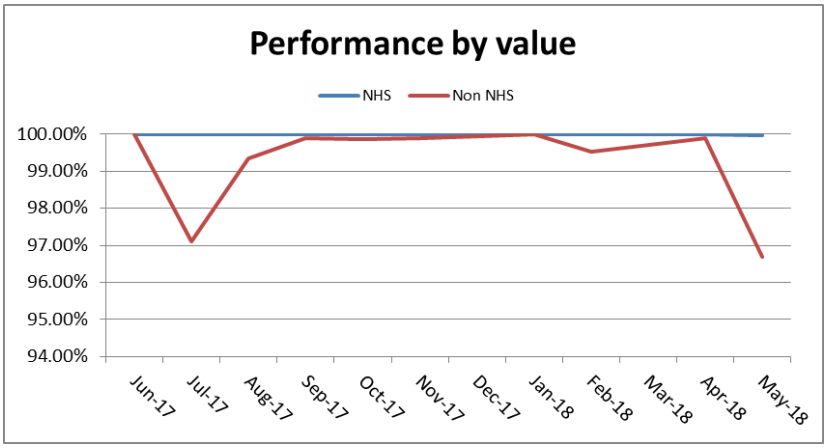
## Annex 3 – Cash Position M2 2018/19

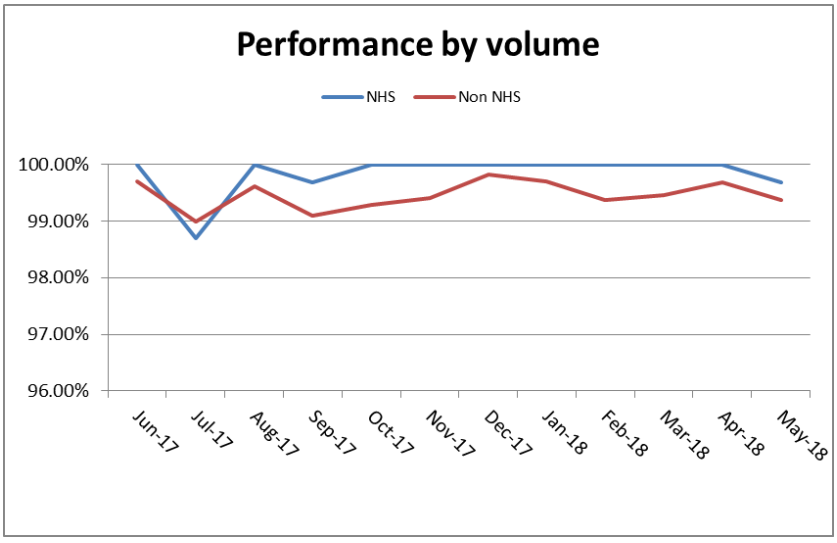
| | £'m Year to date | FOT |
|---|---|---|
| Assumed revenue resource limit / £'m | 115.33 | 691.99 |
| Assumed revenue cash limit / £'m | 112.60 | 675.60 |
| | | |
| Cash drawn down / £'m | 106.06 | 618.17 |
| Cash top sliced for CHC risk pool prescribing and home oxygen / £'m | 9.32 | 57.43 |
| Effective total cash drawn down / £'m | 115.38 | 675.60 |
| | | |
| Cash drawn down as % of total | 17.1% | 100.0% |
| Expected cash draw down as % | 16.7% | 100.0% |
| | | |
| Cash utilised / £'m | 110.09 | 675.60 |
| Balance in account / £'m | 5.33 | 0.03 |
| Balance in account as % of total cash limit | 0.79% | 0.01% |



## Annex 4 – Better Payment Practice Code Performance M2 2018/19

| | | Performance vs 30 days BPP ytd May 2018 | | | |
|---|---|---|---|---|---|
| | | In Month | | YTD | |
| | | Nos. | £'m | Nos. | £'m |
| NHS | | | | | |
| | Total bills paid | 313 | 29.40 | 645 | 60.43 |
| | Total bills paid within time | 312 | 29.39 | 644 | 60.42 |
| | % of bills paid within target | 99.7% | 100.0% | 99.8% | 99.9% |
| Non-NHS | | | | | |
| | Total bills paid | 643 | 10.13 | 1,289 | 19.80 |
| | Total bills paid within time | 639 | 9.79 | 1,283 | 19.46 |
| | % of bills paid within target | 99.4% | 96.7% | 99.5% | 98.3% |
| ALL | | | | | |
| | Total bills paid | 956 | 39.53 | 1,934 | 80.23 |
| | Total bills paid within time | 951 | 39.18 | 1,927 | 79.87 |
| | % of bills paid within target | 99.5% | 99.1% | 99.6% | 99.6% |



## Annex 5 - Movement between M1 and M2 budget 2018/19

| Budget movemets | M2 £m | M1* £m | Change £m | Explanation of movement |
|---|---|---|---|---|
| Acute services | 349.374 | 326.510 | 22.864 | NHSE mapping of direct BCF (£19.4m), resilience (£3.1m) and OOH (0.5m) to acute services. Query with NHSE. Offset by reduction of £0.2m in relation to SWAST contract value. |
| Mental health services | 51.999 | 51.641 | 0.358 | Mental health contracts reclassified from other programme services. |
| Community health services | 59.849 | 54.648 | 5.201 | ICES and continence reclassified from other programme services. |
| Continuing care services | 29.361 | 29.362 | - | |
| Primary care services | 92.276 | 92.674 | (0.398) | Correction of overstated TCOP and GPIT budgets to reserves. |
| Primary care delegated commissioning | 63.070 | 63.070 | - | |
| Other programme services | 8.166 | 36.592 | (28.426) | Mapping difference re acute services, and community and MH adjustments |
| Contingency | 3.069 | 3.069 | - | |
| Other CCG reserves | 9.398 | 8.996 | 0.402 | Correction of TCOP and GPIT budgets, and reduction of SWAST budget to contract value as outlined above. |
| **Total commissioning services** | **666.562** | **666.562** | **-** | |
| Running costs | 10.046 | 10.046 | - | |
| **Total CCG net expenditure** | **676.609** | **676.609** | **-** | |
| **Revenue resource limit (in year)** | 676.807 | 676.807 | - | |
| **In year underspend (deficit)** | **0.198** | **0.198** | **-** | |
| Add back brought forward surplus | 15.186 | 15.186 | - | |
| **Cumulative underspend / (deficit)** | **15.384** | **15.384** | **-** | |

*** As reported to Finance and Performance Committee**

## Annex 6 – Performance against constitution targets M1 2018/19

**NHS WILTSHIRE CCG**
**Are patient rights under the NHS Constitution being promoted?**

| Indicator | Org. | 2017/18 | 2018/19 | | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| **Referral To Treatment waiting times for non-urgent consultant-led treatment** | | | Target | Apr-18 | May-18 | Jun-18 | Jul-18 | Aug-18 | Sep-18 | Oct-18 | Nov-18 | Dec-18 | Jan-19 | Feb-19 | Mar-19 |
| E.B.3 RTT % Incomplete Pathways within 18 Weeks | CCG | 90.2% | 92% | 90.6% | | | | | | | | | | | |
| Total number of patients waiting | CCG | 28,590 | 28,600 | 29,474 | | | | | | | | | | | |
| Number of patients waiting more than 52 weeks | CCG | 57 | 0 | 18 | | | | | | | | | | | |
| **Diagnostic test waiting times** | | | | | | | | | | | | | | | |
| E.B.4 Diagnostic Test Waiting Times (%<6 week waits) | CCG | 96.3% | ≥99% | 95.5% | | | | | | | | | | | |
| **Cancer waits – 2 week wait** | | | | | | | | | | | | | | | |
| Maximum two-week wait for first outpatient appointment for patients referred urgently with suspected cancer by a GP | CCG | 94.1% | ≥93% | | | | | | | | | | | | |
| Maximum two-week wait for first outpatient appointment for patients referred urgently with breast symptoms (where cancer was not initially suspected) | CCG | 91.3% | ≥93% | | | | | | | | | | | | |
| **Cancer waits – 31 days** | | | | | | | | | | | | | | | |
| Maximum one month (31-day) wait from diagnosis to first definitive treatment for all cancers | CCG | 97.2% | ≥96% | | | | | | | | | | | | |
| Maximum 31-day wait for subsequent treatment where that treatment is surgery | CCG | 96.4% | ≥94% | | | | | | | | | | | | |
| Maximum 31-day wait for subsequent treatment where that treatment is an anti-cancer drug regimens | CCG | 100.0% | ≥98% | | | | | | | | | | | | |
| Maximum 31-day wait for subsequent treatment where the treatment is a course of radiotherapy | CCG | 98.7% | ≥94% | | | | | | | | | | | | |
| **Cancer waits – 62 days** | | | | | | | | | | | | | | | |
| Maximum two month (62-day) wait from urgent GP referral to first definitive treatment for cancer | CCG | 83.1% | ≥85% | | | | | | | | | | | | |
| Maximum 62-day wait from referral from an NHS screening service to first definitive treatment for all cancers | CCG | 93.9% | ≥90% | | | | | | | | | | | | |
| Maximum 62-day wait for first definitive treatment following a consultant's decision to upgrade the priority of the patient (all cancers) | CCG | 89.6% | ≥85% | | | | | | | | | | | | |
| **Mixed Sex Accommodation Breaches** | | | | | | | | | | | | | | | |
| Breaches of Mixed-Sex Accommodation | CCG | 163 | 0 | | | | | | | | | | | | |
| PROVIDER BASED INDICATORS | | | | | | | | | | | | | | | |
| **A&E waits** | | | | | | | | | | | | | | | |
| Patients should be admitted, transferred or discharged within 4 hours of their arrival at an A&E department (A&E and MIUs) | RUH | 82.6% | ≥95% | 80.7% | | | | | | | | | | | |
| | SFT | 92.3% | | 93.1% | | | | | | | | | | | |
| | GWH | 87.2% | | 90.0% | | | | | | | | | | | |
| | SWIC | 100.0% | | 100.0% | | | | | | | | | | | |
| **Category Red Ambulance Responses** | | | | | | | | | | | | | | | |
| Category 1 Mean Response Duration (Mins) | SWAST | 9.7 | <7 | 8.5 | | | | | | | | | | | |
| Category 1 90th Percentile Response Duration (Mins) | SWAST | 17.7 | <15 | 15.8 | | | | | | | | | | | |
| **Cancelled Operations** | | | | | | | | | | | | | | | |
| All patients who have operations cancelled, on or after the day of admission (including the day of surgery), for non-clinical reasons to be offered another binding date within 28 days. | RUH | 15 | 0 | | | | | | | | | | | | |
| | SFT | 0 | | | | | | | | | | | | | |
| | GWH | 7 | | | | | | | | | | | | | |

NHS WILTSHIRE CCG

| Other CCG KPIs | Org. | 2017/18 | Target | 2018/19 Apr-18 | May-18 | Jun-18 | Jul-18 | Aug-18 | Sep-18 | Oct-18 | Nov-18 | Dec-18 | Jan-19 | Feb-19 | Mar-19 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| HCAI measure (C.Difficile infections) | CCG | 98 | 102 | 11 | 6 | | | | | | | | | | |
| HCAI measure (MRSA infections) | CCG | 4 | 0 | 0 | 1 | | | | | | | | | | |
| DTOC Total Days Delayed (Wiltshire) | RUH | 305 | 175 | 225 | | | | | | | | | | | |
| | SFT | 379 | 225 | 366 | | | | | | | | | | | |
| | GWH | 320 | 100 | 429 | | | | | | | | | | | |

| Mental Health | Org. | 2017/18 | Target | 2018/19 Apr-18 | May-18 | Jun-18 | Jul-18 | Aug-18 | Sep-18 | Oct-18 | Nov-18 | Dec-18 | Jan-19 | Feb-19 | Mar-19 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Dementia Diagnosis (March 2017 Target) | CCG | 64.7% | 66.7% | 64.2% | 64.7% | | | | | | | | | | |
| IAPT Access Rate (2017/18 target = >4.2% per Qtr) | CCG | 5.3% | 4.20% | | | | | | | | | | | | |
| IAPT Recovery Rate (2017/18 Quarter 4 target = >50%) | CCG | 53.0% | ≥50% | | | | | | | | | | | | |
| IAPT <6 Weeks Access (National Target >=75%) | CCG | 91.6% | ≥90% | | | | | | | | | | | | |
| IAPT <18 Weeks Access (National Target => 95%) | CCG | 99.9% | ≥96% | | | | | | | | | | | | |
| EIP - Psychosis treated with a NICE approved care package within two weeks of referral (National Target >=50%) | CCG | 100.0% | ≥97.7% | 88.9% | 100.0% | | | | | | | | | | |
| Care Programme Approach (CPA): The proportion of people under adult mental illness specialties on CPA who were followed up within 7 days of discharge from psychiatric in-patient care during the period. | CCG | 98.3% | ≥95% | | | | | | | | | | | | |

| Wiltshire Health & Care Community Performance<br>Indicator | 2017/18 | Target | 2018/19 Apr-18 | May-18 | Jun-18 | Jul-18 | Aug-18 | Sep-18 | Oct-18 | Nov-18 | Dec-18 | Jan-19 | Feb-19 | Mar-19 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| RTM incomplete Pathways - % waiting under 18 weeks at month end | 96.5% | ≥95% | 97% | 98% | | | | | | | | | | |
| Average length of stay - Mean (Ailesbury, Cedar, Longleat) | 28.2% | <=20 | 26.0 | 26.6 | | | | | | | | | | |
| DToCs (% of occupied beds) | 24.7% | <=20% | 11.0% | 13.0% | | | | | | | | | | |
| % End of Life patients dying in preferred place | 92.0% | ≥90% | 92% | 100% | | | | | | | | | | |
| Minor Injury Units - Arrival to discharge time within 4 hours | 99.0% | 95% | 99% | 99% | | | | | | | | | | |
| Average Length of Stay on the Home First Pathway (Days) | | <10 | 7 | 6 | | | | | | | | | | |
| % of patients discharged from the Home First Pathway who required no further support | | N/A | 49% | 55% | | | | | | | | | | |