Bundle Trust Board Public 3 November 2022

1 Opening Business

1.1 10:00 - Presentation of SOX certificates

Presentation of SOX certificates
September SOX of the month – Debra Polat, Pembroke Unit and Natasha Machin, Britford Ward
September Patient Centred SOX – Avril Smith and Nikki Boydcamps, Britford Ward
October SOX of the month – Emma Nellis, Facilities
October Patient Centred SOX – Suzie Dukes, Stoma Care and Anne Phillimore, Audiology

1.2 10:10 - Patient Story

1.3 Welcome and Apologies

No apologies received

1.4 Declaration of Interests

1.5 10:25 - Minutes of the previous meeting

Minutes attached from meeting held on 8th September 2022
For approval

1.5 V2 Draft Public Board mins 8 September 2022.docx

1.6 10:30 - Matters Arising and Action Log

1.6 Public Board Action Log Nov 2022.pdf

1.7 10:35 - Chairman's Business

Presented by Nick Marsden
For information

1.8 10:40 - Chief Executive Report

Presented by Stacey Hunter
for information

1.8a CEO Board Report october for November Board.docx

1.8b AHA_October_Briefing_241022_ V1.0.pdf

1.9 10:50 - Feedback from Shadow Board

Verbal update by Eiri Jones and Rakhee Aggarwal
For information

1.10 Register of Attendance

Presented by Nick Marsden

1.10 Register of Attendance - Public Board 2022-23.docx

2 ASSURANCE AND REPORTS OF COMMITTEES

2.1 10:55 - Clinical Governance Committee - 25 October

Presented by Eiri Jones
For assurance

2.1 Escalation report - from October 2022 CGC to November Board 2022.docx

2.2 11:00 - Finance and Performance Committee - 25 October

Presented by Eiri Jones
For assurance

2.2 Finance and Performance Committee escalation paper 25th October 2022.docx

2.3 11:05 - Trust Management Committee - 26 October

Presented by Stacey Hunter
For assurance

2.3 TMC Escalation Report for Board.docx

2.4 11:10 - People and Culture Committee - 27 October

Presented by Rakhee Aggarwal
For assurance

2.5 11:15 - Integrated Performance Report to include exception reports

Presented by Peter Collins
For assurance

2.5a IPR Trust Board cover sheet 031122.docx

2.5b Integrated Performance Report Nov_22 FINAL.pdf

3 PERFORMANCE AND RISK

3.1 11:45 - Digital Plan 2022-26

Presented by Naginder Dhanoa
For approval

- 3.1a TB 202226 Digital Plan cover sheet Nov 2022.docx
- 3.1b 202226 Digital Plan final.pdf

3.2 11:55 - Improving Together Highlight Report

Presented by Peter Collins
For assurance

- 3.2a Improving together october report - Front cover sheet.docx
- 3.2b Improving Together Report October 2022.pptx

4 QUALITY AND RISK

4.1 12:05 - Board Assurance Framework and Corporate Risk Register

Presented by Fiona McNeight
For assurance

- 4.1a Trust Board BAF cover sheet November 2022.docx
- 4.1b Board Assurance Framework October 2022.pptx
- 4.1c Corporate Risk Register October 2022.pdf
- 4.1d CRR tracker v1_October Board Committees 2022.pdf

4.2 Patient Experience Report Q1 - deferred to January

4.3 12:15 - Learning from Deaths Report Q1

Presented by Peter Collins
For assurance

- 4.3a Cover Sheet Q1 LFD Report 2022-23.docx
- 4.3b Learning from Deaths Report Q1 2022-23.pdf

4.4 12:25 - East Kent Maternity Report

Presented by Judy Dyos
For assurance

- 4.4a East Kent cover sheet.docx
- 4.4b East Kent Maternity Review.pptx

4.5 12:35 - BREAK - 15 MINUTES

5 PEOPLE AND CULTURE

5.1 12:50 - Nursing Skill Mix Review - deferred from September

Presented by Judy Dyos
For assurance

- 5.1a cover sheet skill mix trust Baord Nov 22.docx
- 5.1b Skill mix review Sept 2022 final.docx
- 5.1c Appendix 1 safe staffing data.pdf
- 5.1d Appendix 2 Requested uplift 2022.docx
- 5.1e Appendix 3 W+NB safe staffing review.docx
- 5.1f Appendix 4 ward designations.docx
- 5.1g Appendix 5 Safe staffing RAG purple and black.docx
- 5.1h Appendix 6 RAG impact on CHPPD.pdf
- 5.1i Appendix 7 NICU Staffing paper 2022.docx

5.2 Education and Development Annual Report - deferred

6 GOVERNANCE

6.1 13:00 - Register of Seals Q2

Presented by Fiona McNeight
For information

- 6.1 Register of seals.docx

7 CLOSING BUSINESS

7.1 13:05 - Agreement of Principle Actions and Items for Escalation

7.2 13:10 - Any Other Business

7.3 13:15 - Public Questions

7.4 Date next meeting

12 January 2022

8 RESOLUTION

Resolution to exclude Representatives of the Media and Members of the Public from the Remainder of the Meeting (due to the confidential nature of the business to be transacted)

Salisbury NHS Foundation Trust

Draft
Minutes of the Public Trust Board meeting held at 10:00am on Thursday 8th September 2022, MS Teams
Salisbury NHS Foundation Trust
Boardroom

Board Members:

Nick Marsden (NM)	Chairman
Paul Kemp (PK)	Non-Executive Director
Eiri Jones (EJ)	Non-Executive Director
Tania Baker (TB)	Non-Executive Director
Rakhee Aggarwal (RA)	Non-Executive Director
Michael von Bertele (MVB)	Non-Executive Director
Lisa Thomas (LT)	Chief Operating Officer
Judy Dyos (JD)	Chief Nursing Officer
Stacey Hunter (SH)	Chief Executive
Melanie Whitfield (MW)	Chief People Officer
Peter Collins (PC)	Chief Medical Officer
Mark Ellis (ME)	Chief Finance Officer

In Attendance:

Kylie Nye (KN)	Head of Corporate Governance (minutes)
Fiona McNeight (FMc)	Director of Integrated Governance
Jane Podkolinski (JP)	Governor (observer)
Peter Kosminsky (PK)	Governor (observer)
Jayne Shepperd (JS)	Lead Governor (observer)
Juliet Barker (JB)	Guardian of Safe Working
Troy Ready (TR)	Health and Safety Manager
Jeremy Hill (JH)	Consultant Anaesthetist (observer)
Venetia Field (VF)	Associate Director OD & Learning (observer)
Ian Crowley (IC)	Deputy Chief People Officer (observer)

ACTION

TB1 8/9/1 OPENING BUSINESS

TB1 8/9/1.1 Presentation of SOX (Sharing Outstanding Excellence) Certificates

NM noted the following members of staff had been awarded a SOX Certificate and details of the nominations were given:

- **July SOX of the month – Lauren Jackson and Farley Ward**
- **July Patient-centered and Safe SOX – The Early Supported Discharge Team.**
- **August SOX of the month – Katie McKernan, Porter**
- **August Patient centered and Safe SOX – Joe Walsgrove, Hilary Smith and Yvonne Browning, ED.**

SH noted the positive feedback about Farley Ward and noted that whilst SSNAP performance was not where the Trust would want it to be, it was good to hear the positive feedback from service users.

NM noted the wide variety of nominations that are put forward each month and the great work underway during extremely challenging times.

NM and the Board congratulated the members of staff who had received a SOX award.

TB1 8/9/1.2 **Staff Story**

MW introduced a member of staff to the Board, who had joined the meeting to discuss their experience of identifying as gender fluid and their journey in terms of expressing their gender fluidity at work.

The member of staff explained the long journey of working towards being in a place where they felt supported and happy to embrace who they were. The prospect of telling work colleagues that, at times, they felt like they wanted to express themselves as female was daunting. However, joining the Transformation Team at Salisbury NHS Foundation Trust in August 2020 saw a turning point. After some time and during pride month in 2021, they decided to tell colleagues about their gender fluidity and bravely attended the 2021 SFT Staff Awards as a female.

Still feeling insufficiently confident this person confided in their line manager, Louise Arnett. Louise was supportive and adamant that this member of staff should feel free to express themselves at work. To this member of staff Louise demonstrated a genuine example of a supportive line manager, upholding the key values of the Trust. This approach allowed this member of staff to feel confident enough to attend the Christmas party as female and, on 17th August 2022, they came into the office for the very first time as a female, which three years ago would have been inconceivable. This member of staff has encountered no negative responses and explained that they are proud to work in an organisation where people are free to express themselves and welcomes diversity in all forms.

However, the member of staff noted that whilst diversity is embraced at SFT, many other staff have faced forms of discrimination and explained that having more supportive managers who truly demonstrated the key value of the organisation would help this.

The key issues they have personally faced is still having to display their male identity badge when walking around the Trust. It was noted that this reflects the lack of policy relating to gender expression.

Discussion:
NM thanked the member of staff for sharing their story and noted the positive experience they had since joining the Trust. NM acknowledged that progress on diversity and inclusion in the Trust has been slow but this story demonstrates progress in the right direction.

TB echoed NM's thanks and noted that this member of staff had been very brave and courageous in being able to now express themselves but also sharing the story with the Board. TB noted that there is no easy path and it requires support mechanisms in and outside of work. The more the Trust encourages people to come to work as themselves will result in better outcomes from those people.

JD thanked the member of staff and noted how useful it is to hear firsthand experience and understand the emotions behind their experience at work.

EJ noted that the story had been really moving and has a great impact on the Board in terms of understanding diversity and inclusion at work.

LT asked that in terms of coming to work has it changed how the person had contributed and felt about work. They described feeling more relaxed and freer to express themselves, which is likely to have impacted their happiness at work. LT further asked if there was one thing that made their decision easier. People have to know they're going to be supported.

PC noted that whilst this story highlighted a personal struggle the staff member was in fact a trailblazer and that another person who is struggling will now struggle a bit less.

SH thanked the member of staff and noted the importance of staff having a sense of belonging and being supported in the workplace.

TB1 8/9/1.3 **Welcome and Apologies**

NM welcomed everyone to the meeting and noted the following apologies:

- Lucinda Herklots, Lead Governor (observer)
- David Buckle, Non-Executive Director

TB1 8/9/1.4 **Declarations of Conflicts of Interest**

There were no declarations of conflict of interest pertaining to the agenda.

TB1 8/9/1.5 **Minutes of the part 1 (public) Trust Board meeting held on 7th July 2022.**

NM presented the public minutes from 7th July 2022.

EJ noted that on pg. 5 under the Finance and Performance Committee Escalation report she had presented the report.

Subject to this amendment, the minutes were approved as a correct record of the meeting.

TB1 8/9/1.6 **Matters Arising and Action Log**

NM presented the action log and noted the following key updates:

- **TB1 10/3/2.4, TB1 7/4/1.6 IPR/ Maternity dashboard –** JD noted that the Trust is still awaiting the Local Maternity System (LMS) dashboard which might be some time. Therefore, in the interim, Tania Baker is going to meeting with the senior leadership team in maternity to work on the current dashboard and ensure it is more useful. Item closed.

- **TB1 7/4/3.2 - Outcome focus at the Board/Learning from Death Report Q3 –** PC has been thinking about current governance

arrangements. There may not be one forum that collectively describe outcomes. However, the focus on patient related outcome measures has been strengthened through patient experience steering group; clinical outcomes report through the clinical effectiveness steering group, audits and GIRFT (Getting it Right First Time) to Clinical Management Board (CMB) and Clinical Governance Committee (CGC). As part of Improving Together (IT) the vision metrics will come through more as the organisation starts to get a grip on this new way of working.

PC noted that learning from care of those people who have died comes through the learning from deaths report. PC noted that he was keen to seek further guidance on how this could be improved. TB explained that there is an imbalance, as the Board gets the mandated data, which is important and required, but the Board does not see much of the other outcome data. TB noted that this is not an urgent request but a high performing organisation should be able to provide outcome data. PC noted the focused work underway around vision metrics and reporting on those. TB explained the importance of the balance of data and use of the data as a management tool to improve performance. PC noted that the Head of Clinical Effectiveness is working hard with teams to work through this. PC assured the Board that the audits that go through Clinical Effectiveness provide a lot of information about the services we provide and the actions that should be taken forward.

SH noted that the discussion regarding outcomes was well timed as there are active conversations as to how the organisation balances transparent communication re waiting times and performance data and the good outcomes. SH noted the current political environment and the need of balance for the public in terms of messaging.

PK raised a point around the focus of IT and noted that if this is a focal mechanism for improvement, the Board need to see some further detail on progress coming through the Board Committees. The Board noted that governance arrangements of IT were under review. PC reported that an IT Board would start which will oversee the delivery of programme and reports will come to F&P Committee. PC reminded the Board that the benefits of this work will take a number of years to recognise. The Strategic Deployment Room will be a manifestation of what the Trust is doing and how. PK noted that further information about the implementation of IT is required going forward.

EJ fully supported TB’s point in relation to an outcome focus. EJ noted that CGC had discussed how the Trust can demonstrate outcomes and noted the positive outcomes in relation to the falls reduction in F&P and CGC. Additionally, staff have been observed discussing the IT methodology when attending Board safety walks which is positive.

RA referred to learning from deaths and asked if the Trust report on how it operationalises the learning from this process. PC explained that in terms of thematic learning, there are key themes reported from the Structured Judgement reviews. A lot of work has been done in

terms of learning which does not come through in the reports to Board.

JD noted the need for more of a focus on outcomes rather than the SII process itself. JD explained that learning in somewhat shared in silo but this has not been demonstrated to the Board. FMc suggested that there is something about how the Trust uses the Quality Account to demonstrate learning and outcomes.

It was noted that all other business was either closed, covered on a future agenda or was to be discussed as part of the meeting agenda.

TB1 8/9/1.7 **Chairman's Business**

NM noted the volatile political environment and the degree of uncertainty with another new Secretary of State. However, NM noted that from the government's perspective, the NHS is still a top priority.

In terms of progress in relation to system working and the Integrated Care Board (ICB), there is still a lot of work underway to integrate new roles and ways of working and therefore, it is unlikely in the short term that there will be any meaningful action.

NM noted that with winter approaching it is useful for the Trust's staff and the wider public to understand positive work that is progressing and where the Trust is going to be challenged to provide some transparent context in the current environment.

Discussion:
PC noted that the last module of IT for divisional teams was held yesterday and a focus of that was a peer reflection of moving this methodology forward whilst also trying to maintain a business-as-usual approach. PC noted that IT is not the entire answer but it will help people to understand where we can focus on a few things and do them well.

EJ noted the opportunity to focus on what is going well and share this at public boards, not in terms of benchmarking but sharing learning of how we are able to achieve and progress in certain areas.

TB1 8/9/1.8 **Chief Executive's Report**

SH presented her report and highlighted the following key points:

- A formal welcome to LT and ME in their new roles as Chief Operating Officer and Chief Finance Officer. SH noted her gratitude to both for stepping into those roles noting that the stability in leadership will continue to provide continuity and structure.
- Operationally the context has been challenging for some time. There is nothing new to draw attention to and the detail of the impact is seen in the Integrated Performance Report (IPR).
- Positively, the Trust has achieved some of the requirements of the elective recovery programme which is a testament to the hard work of staff across the Trust.

- The Trust is currently in an intense period of preparation and activities for winter planning. There are concerns about the potential challenges of winter and it should be noted that internally, routes to provide more capacity are not there. Plans are being worked up, alongside partners, which will come through F&P Committee and Board in October. Some financial support has been confirmed but there is more support required to ensure service delivery over winter.
- Despite the ongoing challenges in the Organisational Development and People team, the Trust is an exemplar site for the People Plan. The national team have recently visited and were impressed with the work and progress. Given how important recruitment and retention of staff is, this was good to observe.
- Stacey referenced the Trust's Thank you week (w/c 5th September), celebrating the work our colleagues do, including volunteers. SH extended her thanks to the Communications Team, who work tirelessly to deliver and always do so with such enthusiasm. These events encourage positive feelings back into the organisation and boost staff morale (*post meeting note: several events in Thank You week were postponed to October due to the Queen's passing*).

The report was noted.

TB1 8/9/1.9 **Register of Attendance**

The register of attendance was noted.

TB1 8/9/2 **ASSURANCE AND REPORTS OF COMMITTEES**

TB1 8/9/2.1 **Clinical Governance Committee (CGC) 30th August 2022**

EJ presented the report, providing a summary of escalation points from the meeting held on 30th August. EJ asked for the report to be taken as read and noted the pertinent points for the Board's attention:

- The Committee discussed the Clinical Governance Annual Report and it was decided that the information in this report is duplicated and therefore, it was felt that it was no longer needed. EJ asked for the Board's support as this item was also on the Board cycle of business. The Board supported the removal of this item from both CGC and Trust Board.
- The Committee discussed palliative care coding and the CMO presented a paper in response to a concern raised by one of the Trust governors. PC provided assurance that the approach is based on national coding guidance and there is specific data in relation to the percentage of coding and mortality which indicated we are not an outlier. The Committee felt that the assurance provided was sufficient.
- EJ noted that the maternity services report is appended so the Board can see the great work being undertaken. Their biggest challenge is workforce and they are aware further improvement work is required but progress has been good.

Discussion:

PK referred to coding and a historical external audit of coding undertaken some years ago, which was quite useful and a series of actions were agreed as a result. PK asked if this was to be repeated in the future. PC explained that external assurance into the coding process is completed regularly but an audit would provide a deep dive on processes.

NM noted that in relation to the coding query a written response has been sent and this matter is now closed. The board supported this.

The report was noted.

TB1 8/9/2.2 **Finance and Performance Committee (F&P) 30th August 2022**

EJ provided a summary of escalation points from the Finance and Performance Committee held on 30th August. EJ asked for the report to be taken as read highlighting the key points as detailed in the report.

Discussion:
PK referred to the digital update and noted his concerns about the state of the estate and the number of system outages. PK noted that the Trust is layering in sophisticated systems but the underlying infrastructure is challenged. SH noted that when reviewing the digital strategy, the Trust needs to look at where there are interdependencies and if the estate is fit for purpose. This has been picked up by the Chief Information Officer.

The report was noted.

TB1 8/9/2.3 **Trust Management Committee (TMC) 24th August 2022**

SH presented the escalation report from TMC held on 24th August. SH asked for the report to be taken as read and noted the key points detailed in the report, including the business cases which were considered.

Discussion:
PK referred to the South West Spinal Network and asked what commitment a 'Network' involved. ME explained that the Trust expenditure for its component is £180k and other regional connections will recruit their own people. However, management and funding will flow through the Trust. The Board discussed if this should have come to Board before a final decision had been made given the strategic context. However, ME confirmed that TMC has authority to approve up to £2m for contracting of NHS services. EJ supported this decision and noted that this was part of core business, with the added element of being host for the region. The good opportunities were noted.

TB1 8/9/2.5 **Integrated Performance Report (IPR) (M4)**

JD presented the Integrated Performance Report which provided a summary of July 2022 performance metrics. JD highlighted a few key points from the report:

Discussion:

- This is the new version IPR which aligns to the vision metrics and breakthrough objectives which have been implemented as part of IT.
- The performance in the IPR reflects some of the challenges experienced regarding No Criteria to Reside (NCTR).
- Positively, falls are in a better position than they were during peaks of COVID cases. Falls are a specific focus as part of the breakthrough objectives.
- Staffing remains a challenge which has had a detrimental impact on agency spend.
- In relation to turnover, there is a 2% increase in comparison to last year which is challenging alongside a reduced availability in staff.

Discussion:
PK noted his support for the new format IPR. However, PK suggested as it evolved staff needed further guidance and training around SMART, as a number of actions detailed in the report were not measurable or focused enough. SH agreed that the new IPR was a good step in the right direction but there was further education in terms of achievable actions. This reflects the recent executive discussions around adopting coaching to support this learning. LT acknowledged the work that is required.

JD noted her support for the new IPR but explained that further practice is required in how the new metrics are presented.

The new format had been discussed in both CGC and F&P, both felt it was better but required a level of increased specificity. EJ noted that diagnostics were a concern and a deep dive was coming to September's F&P.

SH noted the continued challenge in the ambulance handover position which is directly linked to NCTR. This will be covered more in Private Board.

TB referred to the mortality data and asked if the SHMI data separated hospice and hospital deaths. It was confirmed that this was the case. TB noted her concerns in separating the numbers out, noting that there are a multitude of differences across a number of hospitals. PC explained that he is hoping to include benchmarking data of hospitals which include their hospices within their mortality figures.

TB1 8/9/3 **QUALITY AND RISK**

TB1 8/9/3.1 **Research Annual Report**

PC presented the Research Annual Report and highlighted the key points as detailed in the report:

- Performance has remained relatively strong and the research department ranks well compared to other trusts.
- A number of research grants show the breadth of research across the organisation. There are also opportunities for portfolio expansion in terms of partnership working and non-medical research.

- The team have been part of a cultural review, recognising potential to restructure in terms of leadership. PC noted that Zoe Cole had clinical oversight of the research portfolio with support from the Head of Clinical Effectiveness, which will strengthen the leadership structure.
- There is an intention to move SFT from the Wessex Research Network to the South West Network. There is a national restructuring and will align to Bath, and North East Somerset, Swindon, and Wiltshire (BSW).
- There are no real concerns or areas of escalation other than the impact of COVID-19 on staffing.

Discussion:
The Board noted the positive report acknowledging that research active organisations generally have better patient outcomes. New specialist nurse positions will provide an opportunity to widen research portfolios. JD noted she was part of a group looking at non-medical research within the regional team and progress on this would be reported when further work had occurred.

MW referenced the lack of funding income and the contracts having to be closed for research staff. MW asked if this had been forecast as a risk and if so where does the Board receive this information. PC noted that part of the consideration when looking at the department has been introducing a Research Board. There has been an arrangement of having a non-clinician research lead without much strategic leadership. PC explained that the team need to understand how it benchmarks and spends resource. PC further noted that it has been difficult to predict loss of activity and funding during the pandemic. However, following review there is a greater understanding of the department and progress is reviewed via CMB and CGC.

RA referred to non-medical workforce and asked if there is an ambition to have principal investigators. Additionally, RA asked if the Trust benefits from the learning from those undertaking other research as part of a master's or PHD. PC noted that this can be challenging as research is tightly constrained and it's acknowledged that as the strategy is refreshed this needs to reflect other portfolios of research. The Board discussed that research is driven through individual projects which could contribute successfully to population health.

MvB referred to the change in network and asked if this will affect education links which are currently in Wessex. PC noted there will be a change in focus towards the west.

TB1 8/9/4 STRATEGY AND DEVELOPMENT

TB1 8/9/4.1 Estates Technical Services – Sept 2022

BJ not on the attendance list presented the ETS report and noted the following key points:

- Good progress has been made on the compliance action plan and there are plans to tackle the key areas of focus by the end of the financial year.
- The Trust has successfully submitted the Estates Return Information Collection (ERIC) by 30th June. NSHEI have made some queries which are currently being worked through. The Trust is working towards a bid for decarbonisation funding. Work progressing well. We are currently working with CEF to develop a c£10m bid for the next round of funding due in September 2022.
- There is an increased focus on the Estates Strategy, which will consider the Trust's sustainability approach, focusing on the estates element and what this means for the Trust. It is hoped this will outline a move towards electrification of the estate with a move away from gas. The NHS deadline is 2050 but the work should start now. The Trust will need support in delivering these plans and this is currently being worked through.
- In relation to the energy cost crisis the team are working to forecast what the impact might be this year and finance are involved in these discussions.

Discussion:
PK referred to estates maintenance, noting the increased reliance on IT systems whilst experiencing infrastructure related challenges. PK asked if the contributing factors had been flagged as risks e.g., server rooms which have recurring cooling problems, rats chewing cables and other low-level issues which have a high impact. BJ explained that there is now a better understanding of the cooling systems with an in- depth review undertaken. Additionally, there has been work to identify areas where there could be opportunities for infestations before they occur.

SH noted that the Trust is currently setting out strategic questions around staff accommodation and further to a visit there are clear challenges. EJ noted that some organisations in more expensive areas are managing to recruit because of good accommodation offers.

MW referred to the close working relationship with the Health and Safety Team and thanked BJ for his support recognised the shared learning from RUH Bath to help the backlog.

TB1 8/9/5 **GOVERNANCE**

TB1 8/9/5.1 **Annual Review of Board and Committee Effectiveness**

FMc presented the report noting that she would take it as read and asked the Board if they supported the outcome of the paper and is there anything the Board felt it could do differently.

FMC explained that an external Well-Led assessment is currently being tendered jointly with Royal United Hospitals Bath NHS Foundation Trust (RUH) and Great Western Hospital NHS Foundation Trust (GWH) for winter 2022/23.

Discussion:
The Board discussed the delayed external well-led tender and FMc noted that each Trust had delayed the review for COVID-related reasons. SH

noted that it was preferable to have the new chair in post prior to the start of the process. FMc explained that the tender process could take up to 12 weeks so the new chair would be in post.

MW referenced the committee effectiveness report for People and Culture Committee which was out of sync with the other Committees. She noted the Committee would discuss in September and would then align to the other Committees from 2023 onwards.

The Board supported the content of the annual review of Board and Committee effectiveness.

TB1 8/9/5.2 **Approve Board and Committee Dates for 2023**

FMC presented the Board and Committee dates for 2023 and the following key points were noted:

- There has been discussion about how often the Board meets and this will be progressed when the new Chair and NEDs are appointed and in post. Therefore, there is opportunity for the Board dates to slightly change as a result of this.

Discussion:
LT noted that the Committees always fall in half term which does not provide the members of those groups much flexibility. SH noted that in these circumstances deputies should be able to step in during periods of leave.

EJ asked for as much notice as possible considering the other responsibilities the NEDs might have.

MW noted that there would not be an OD & P Committee in May as per the normal schedule and it was agreed the dates would be amended.

Decision:
The dates were approved.

TB1 8/9/6 **PEOPLE AND CULTURE**

TB1 8/9/6.1 **Guardian of Safe Working Hours Annual Report**

PC and JB presented the report which asked the Board to note the annual Guardian of Safe-working report. PC noted the following key points:

- This was JB's last GoSW report as she had decided to step down from the role. The Trust is currently identifying a new guardian of safe working. PC gave thanks to JB for the progress she had made in this role and for her ongoing support to the junior doctor workforce.
- The gaps that arise because of deanery provision are somewhat mitigated by locally employed doctors. The mitigated fill rate position is 82-98%.
- The non-fill rate is particularly high in senior training posts which can impact a smaller hospital disproportionately.

- Positively, non-compliant rotas in ED and palliative care are now fully compliant.
- The Trust is working on adding locally employed doctors to the exception reporting system, however a decision is yet to be made on whether this is a data gathering exercise or if this will also be a mechanism for overtime payment. The aim is to achieve a much better understanding of hours worked by the medical workforce and provide a degree of parity between deanery and locally employed doctors.
- The number of junior doctors now wanting to work less than full time (LTFT) has significantly increased and therefore further thought is required about how different ways of working are accommodated.

Discussion:
MvB echoed PC's thanks to JB for her hard work as GoSW. He referred to the locally employed doctors and asked if the employment offer included training. PC noted that this has been discussed with medical education. The future workforce for small-medium Trusts cannot rely on deanery posts to provide a full substantive workforce. There needs to be further cultural work undertaken to balance the experience of our temporary workforce vs medical trainees.

SH referred to the alternative roles that have emerged to support medical staffing, e.g., physician associates. SFT is somewhat behind in accelerating this in comparison to its peers and therefore the implementation of these roles is critical.

JB noted that junior doctor trainees come and go but the more permanent members of staff become integrated and have a greater commitment to the organisation. Therefore, they should be offered the advantage of training to help retainment.

EJ asked what feedback we receive from the junior doctors. JB referred to the exception reports and noted that the feedback is mostly about junior doctors staying late as there are not enough staff on the wards to manage acuity and the number of patients. JB is having conversations with senior staff around what can be done differently.

NM thanked JB for her contribution during her time as GOSW. JB noted that she has felt hugely supported in her role and when there have been things that could be changed, they have been.

TB1 8/9/6.2 **Freedom to Speak Up Guardian**

LS presented the report which provided an overview of the work of Freedom to Speak Up (FTSU) Guardian over the year, including the number of cases, a thematic analysis and any learning gained.

- A new National Guardian Lead was appointed and now the FTSU system has been established across multiple organisations, and there is now further work to be done to streamline processes across the system. LS has been appointed as a National Guardian Mentor and is looking to introduce a training model linking to Equality Diversity and Inclusion (EDI).

- The Trust is working closely with RUH Bath and GWH to gain learning and understand how processes can be improved.
- This year 89 concerns have been raised. Positive action has been taken to mitigate these concerns.
- The division with the highest number of FTSU concerns raised is Medicine, which is not unexpected due to the high amount of pressure experienced in the past year.
- Several of the concerns relate to problems with line management which are escalated via the FTSU route, especially if staff feel they are unable to raise their concerns via management.
- In terms of proportionality of concerns raised, data suggests that staff from protected backgrounds do speak up. The FTSU team worked closely with staff networks and it is worth noting that people across all areas have raised concerns.
- The FTSU route is widely communicated and there has been a lot of work done to highlight this to staff at induction.
- Themes that have arisen generally relate to poor behaviour, harassment and bullying and patient safety in terms of redeployment.
- There have been concerns raised around perceived detriment, which is a national issue. This is being picked up as part of the People Promise.

Discussion:
SH asked if it is possible that good news stories could be publicised without breaking confidentiality. MW noted that the team would think about different methods in how this could be achieved.

MW referred to the theme around line management and noted that manager development and training is essential. The Trust wants its staff to feel like they can raise concerns with their line managers and not have to escalate to the FTSU Guardian. The key focus for the team in October will be to recruit ambassadors.

SH thanked LS for her work in progressing the FTSU movement in the Trust. LS thanked the Board for their support, noting that the Trust is moving in the right direction and this work is progressing in a positive way. LS left the meeting.

TB1 8/9/6.3 **Formal Update on Equality, Diversity, and Inclusion Progress**

MW introduced RxW to the meeting to provide an update on the Trust's progress in terms of the improvements around EDI. MW took the opportunity to thank RxW for his hard work noting that his penultimate day in the Trust.

In August 2021 PwC produced an audit report which highlighted six recommendations in relation to the Trust's EDI progress. The progress is as follows:

1. A formal EDI Strategy is in draft for consultation.
2. The EDI action plan has been revised to include measures of success in response to the new strategy. This is in draft as part of our People Promise Strategy.

3. In terms of EDI metrics, the Trust is monitoring data of new starters and leavers, promotion applications and those under formal review.
4. In terms of EDI governance, the EDI Committee and staff network groups have been re-established.
5. There has been a review of senior objectives and a review of refreshed policies and procedures to ensure there are further opportunities for embedding EDI practices across the Trust.
6. The Trust has created the role of Head of Wellbeing and Inclusion with a supporting specialist recently advertised for recruitment. Additionally, with RxW retiring from his part time post, the Trust will look to employ a full-time head of EDI to support this work.

Discussion:
SH thanked RxW for his work and support and noted the encouraging feedback which had been highlighted as part of the staff story earlier in the meeting. SH noted the Trust's ambition to be an open and inclusive employer and felt that the staff story was a reminder to the Board of the commitment of ensuring a great experience for all staff who come to work.

MvB also reflected on staff story and noted that all staff should be encouraged to ensure everyone in their teams can contribute to the workplace in a positive way. RA explained that people with protected characteristics should not be considered as being in deficit but their knowledge and experience should be used for learning as they have a useful skill set to offer.

TB noted the importance of Staff Networks and asked MW why she thought it had been a challenge to re-initiate some of these groups. MW explained that most of these people are doing this aside from their day jobs and it has proved challenging. However, work has progress and each Network now has an executive lead to support. SH noted that this will hopefully reinforce the Board's intent and commitment to improve EDI across the Trust.

JD noted that she was exec lead for the disability network and some of the discussions raise some interesting challenges about the expectations of people who may have a physical or mental disability but would not describe themselves as disabled. There is further work required to learn more about this to support staff in the best way possible.

FMc noted that she was the executive lead for the Carers Network and acknowledged the opportunities for mutual learning across the networks. FMc noted that the high-level support in place will ensure the required work in each group will pick up pace.

RxW thanked the Board for their support and noted that it had been a pleasure to work for an organisation which is on the path to change and is now attracting people with protected characteristics as they recognise this as a place they would like to work.

NM thanked RxW on behalf of the Board and wished him well in his retirement. RxW left the meeting.

TB1 8/9/6.4 **Health and Safety Annual Report**

MW presented the annual Health and Safety report and noted that TR, the new substantive Head of Health and Safety, had joined the meeting. MW noted the following key points:

- The report is a formal record of issues and performance in health and safety which lead to the aims and objectives for the year ahead, in support of an organisational culture in which a positive and proactive approach is taken to health and safety management.
- MW noted that Peter Adams, Interim Head of Health and Safety, had completed this report before he left the organisation and noted the 18-month period where the department had been led by interim managers.
- There has been some positive work in the last year including the improved reporting of risks, the emergence of a structured Health and Safety Management System and greater collaboration with Estates to address health and safety concerns.
- There is a substantial governance infrastructure beneath the Health and Safety Committee, with the numerous groups under review by TR.
- There have been concerns around health and safety policies and how staff take responsibility for health and safety in their areas and this is being addressed.
- MW noted that the Health and Safety Committee continues to meet bi-monthly and with the help of FMc governance and escalation routes to the Board have improved.

Discussion:
EJ thanked MW and the team for being transparent about the ongoing concerns and risks. EJ noted that it would be helpful, once TR has settled into his new role, to get a trajectory of focus in health and safety and the expected outcome.

PK asked if Health and Safety should be an item on every Board agenda as he had experienced in the commercial sector, noting the risks highlighted in the report. SH explained that normally this report would come to an executive-led Committee, with escalation points to Board. SH suggested that a proportionate way of keeping the Board appraised of gaps in assurance and mitigations. SH asked MW and FMC to discuss a quarterly update from Health and Safety to TMC and add to the workplan. Escalation points could then be included as part of the escalation report to Board. **ACTION: MW/FMC** **MW/ FMc**

TB1 8/9/6.5 **Nursing Skill Mix Review – Deferred to November**

TB1 8/9/7 **FINANCE AND PERFORMANCE**

TB1 8/9/7.1 **EPRR NHSE Framework – Accountability and Responsibility**

LT presented the report ensuring our changed and revised accountabilities and responsibilities are noted following the revision of the NHS Emergency Preparedness Resilience and Response Framework. Following the resignation of Andy Hyett as Chief Operating Officer (COO)

and Accountable Emergency Officer (AEO) from 31st August 2022, Lisa Thomas will take over the roles of both the COO and AEO from 1st September 2022.

Additionally, LT noted a significant change in the framework to be noted by Trust Board. What the Non-executive Directors (NEDs) bring is essential to being able to hold the AEO to account, but responsibility for EPRR sits with the whole board and all NEDs should assure themselves that requirements are being met.

The Board noted the report.

TB1 8/9/8 CLOSING BUSINESS

TB1 8/9/8.1 Agreement of Principle Actions and Items for Escalation

NM noted the key points from the meeting as follows:

- In terms of the coding issue that was raised by a governor the Board has agreed that assurance has been given and this matter is now closed.
- The IPR is a much-improved report and will only become more powerful as a performance management tool when people get used to the new format.

The key areas of escalation were noted.

TB1 8/9/8.2 Any Other Business

PC noted that the Board should have received the Medical Revalidation and Appraisal Annual Report and including Statement of Compliance to sign off prior to the end of July. PC apologised for the oversight but noted that the cycle of business would be updated for 2023.

Decision
The Board discussed and agreed that they would delegate responsibility for sign off to Nick to avoid any further delay.

TB1 8/9/8.3 Public Questions

There were no public questions.

TB1 8/9/8.4 Date of Next Public Meeting

Thursday 3rd November 2022, Board Room, Salisbury NHS Foundation Trust

TB1 8/9/9 RESOLUTION

TB1 8/9/9.1 Resolution to exclude representatives of the media and members of the public from the remainder of the meeting (due to the confidential nature of the business to be transacted).

Master Action Log
Open Actions

Contact Kylie Nye, kylie.nye1@nhs.net for any issues or feedback

1	Deadline passed
2	Progress made, please detail
3	Completed
4	No progress made/ Deadline in future

Committee	Organiser	Reference Number	Deadline	Owner	Action	Current progress made	Completed Status (Y/N)	RAG Rating
Trust Board Public	Sasha Grandfield	TB Public 08/09/2022 - Health and Safety Annual Report	03/11/2022	Melanie Whitfield, MW Fiona McNeight, FMc	SH asked MW and FMC to discuss a quarterly update Health and Safety to TMC and add to the workplan. Escalation points could then be included as part of the escalation report to Board.	Agreed that Health and Safety reports to TMC and then upward to Board. Annual Report is presented at TMC and at Board with any requests for further assurance from the Board to be managed through People and Culture Committee as and when required. Item closed.	Y	3

NHS Salisbury NHS Foundation Trust

Report to:	Trust Board (Public)	**Agenda item:**	1.8
Date of Meeting:	03 November 2022		

Report Title:	Chief Executive's Report			
Status:	**Information**	**Discussion**	**Assurance**	**Approval**
	X			
Approval Process (where has this paper been reviewed and approved)	N/A			
Prepared by:	Stacey Hunter, Chief Executive Officer			
Executive Sponsor (presenting):	Stacey Hunter, Chief Executive Officer			
Appendices (list if applicable):	Appendix 1) AHA Programme update.			

Recommendation:
The Board is asked to receive and note this paper as progress against the local, regional and national agenda and as an update against the leadership responsibilities within the CEO portfolio.

Executive Summary:
The purpose of the Chief Executive's report is to highlight developments that are of strategic and significant relevance to the Trust and which the Board of Directors needs to be aware of. This report covers the period since the last public board meeting on the 8th September 2022.

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

1. Our Population

1.1 Operational Context

Our services and teams remain under considerable pressure with the Trust reporting the highest levels of escalation OPEL 4 on 42 occasions and responding to 4 critical incidents (2 related to capacity, 1 fire and 1 IT outage) since our last public board meeting in September 2022.

The Board are well sighted on the factors driving the OPEL levels which are outlined in the Winter plan the Board will consider in our meeting today.

The Board will note this is giving rise to increased risks detailed in the Board Assurance Framework and on the corporate risk register and continued pressure in some of our performance and quality metrics captured in our Integrated Performance Report.
I know the Board will want to join me in acknowledging that this impacts on our ability to provide a consistent outstanding experience for our patients and staff.

I would like to thank all our colleagues who continue to provide the best care possible to our patients and acknowledge that working under this level of intensity is challenging.
The Board will want to note that despite the pressures the teams have sustained progress in respect of those patients with the longest waits (over 78 weeks) and remain on trajectory with this key indicator.

Our leadership teams with support from the Executives have focused on what additional areas of improvement we want to prioritise to increase our resilience for the winter months. This will supplement the work already agreed during our annual planning round for Winter and is to mitigate some of the current capacity constraints. This plan has been socialised via the Board sub-committees and due to be considered by the Board today.

The numbers of patients needing hospital care for COIVD-19 in this latest wave has started to reduce albeit our Infection Prevention Control team continue to oversee and manage several outbreaks within the hospital.

1.2 Vaccination

Our vaccination team are supporting both the COVID booster programme and the annual Flu vaccination. It is a key priority for us to be able to offer this to our colleagues over the next month and I would like to thank the team who provide and excellent service at City Hall. They have offered sessions at the hospital too and will continue to be flexible in this approach to make it as easy as possible for colleagues to access their vaccinations.

1.3 Financial sustainability

We remain on trajectory with our financial plan the detail of which is overseen by the finance and performance board sub-committee. Whilst this is positive the position is supported by a high level of nonrecurrent schemes and the vacancies.

2.0 Our People

2.1 Staffing

Our staffing situation has slightly improved but remains a concern. Turnover remains consistently above the target of 10% and staff sickness, whilst having dropped over the last few months still remains above the 3% target. This continues to impact staffing levels.

Our vacancy rate is high however it did drop to under 10% in August, its lowest level this financial year. We continue to prioritise recruitment and continuous improvement work to our recruitment processes is ongoing with a significant project group working on this over the coming months. There are ongoing campaigns in place for the recruitment of HCAs which includes twice weekly interview panels (maternity and nursing), admin and clerical staff and theatres. A recent Admin recruitment fair yielded very positive results with over 30 job offers made on the spot.

We are on track to welcome 55 internationally recruited nurses by the end of the year, with eight arriving in September alone and a further 7 due in October.

2.2 Retention of staff

The People directorate are developing ways to best capture how colleagues are experiencing work life in the Trust. Wellbeing offer is continuing to develop with the introduction of wellbeing conversations, regular health and wellbeing committee meetings, expanding the financial wellbeing offer to include wellbeing website signposting to sources of advice on financial support, pensions seminars, financial education sessions, low-cost meal option on site.

Staff ED&I networks continue to be developed and a new ED&I Specialist has been recruited. A Health and Well-being lead is also being recruited to push forward this agenda.

The annual NHS Staff survey has launched and runs until late November. This is a crucial tool in capturing feedback from our workforce and we can then promote activity that has taken in response to this. At the time of writing this report uptake of the survey is low which is a concern. The Chief People Officer is continuing to work with colleagues on ways to incentivise and make it easy to contribute to the staff survey.

OD & People are continuing to develop processes and policies that incorporate the principles of Just and Learning culture and also to identify opportunities to support management capability and confidence with coaching and training in people management processes. There is also a significant focus on increasing available staffing levels through positive attendance management.

One of the OD&P projects expected to deliver positive impact on staffing includes a banding review of our 500 plus Health Care assistants. There is scope for formalising differentiated roles for a Band 2 and 3 and we are expecting this to enable us to recruit and retain more effectively, reducing vacancies in these important clinical support roles in both bands 2 & 3. The project was launched in August and we anticipate that more Health care Assistants will be able to achieve the higher grade and therefore offer greater support to our nursing staff in giving patient care. Reviews are likely to be completed before Christmas, which we hope will begin to impact recruitment and retention for our winter plan.

Our appraisal process and form are being fine-tuned to make them as streamlined and user friendly as possible while also developing the scope and content of appraisal reviews to

assist with signposting conversations about wellbeing and career development opportunities, two areas highlighted strongly in last years' employee survey.

Members of the OD&P team are reviewing how we align absence management processes and management training to identify potential for a more effective response to long- and short-term absences.

2.3 Staff Wellbeing

The long-awaited *Staff Thank You Week* held in the Cathedral Close was impacted by the death of the late Queen Elizabeth 2nd. The news of her death was announced after the Staff Awards had begun, therefore the event continued after a suitable period of reflection led by Chaplain Frances Canham and with the agreement of The Dean of the Cathedral.

The planned Staff Party and Family Fun Day were delayed until after the period of mourning and the Long Service Awards, Volunteers thank you and AGM were also rearranged. Feedback from the *Thank You* events has been extremely positive. 94% of respondents said they would apply for tickets to The Awards next year and 78% approved of the Family Fun Day activities.

In response to our Women's Network suggestion, we recently held a number of workshops for men with the White Ribbon Campaign to discuss violence against women and on World Menopause Day launched a menopause policy for the Trust.

October is Freedom to Speak Up month and Black History Month, both of which have been marked by videos and talks. It was great to welcome the ABF The Soldiers Charity to the Trust this month to take a look at the work the Trust is doing to support veterans.

And finally, I am pleased that our staff are gaining recognition by their peers. Teams have been successful in three recent Awards
Our Paediatric Team won big at the Wessex PAFTAs (Paediatric Awards for Training Achievements) with Dr Chris Anderson winning the Consultant Unsung Hero of the Year. This is the first time Salisbury has won this award and is down to the hard work and positivity from the entire Paediatric and neonatal MDT. Artcare with our CAHM service from Oxford Health have won the national NHS Forest Award for Successful Ways to Support Biodiversity.

And you may remember that last month I announced our Reflection on a Pandemic project was a finalist in the national NHS Communicate Awards for best internal communications and engagement – well they went and won it - with the judges saying they were "blown away" by this "inspirational" project.

3.0 Our Partnerships

There is nothing to escalate to the Board from BSW ICB with much of the focus being on ensuring their governance and ways of working are aligned to the priorities. There is a significant amount of work across the partnership to ensure we are as prepared as feasible to respond to Winter. This includes the work Lisa Thomas is leading in relation to the additional capacity the system has secured at the South Newton site.

The Acute Hospital Alliance priorities are progressing well. Further detail is provided in Appendix one.

There is continued progress in relation to the Campus Project which I will provide a verbal update about in our private session.

Meeting of Board of Directors

Report Summary Sheet

Report Title	Acute Hospital Alliance Briefing, October 2022.						Agenda item	
Date of meeting	September/ October 2022							
Purpose	Note X		Agree		Inform		Assure	
Author, contact for enquiries	Ben Irvine, Programme Director (ben.irvine@nhs.net)							
Appendices	Appendix 1. AHA Briefing							
This report was reviewed by	• Cara Charles-Barks, CEO RUH, Senior Responsible Owner • Kevin McNamara, CEO GWH • Stacey Hunter, CEO SFT							
Executive summary	This briefing provides an update on the activities of the Acute Hospital Alliance (AHA) in September and October 2022, as well as a description of priorities for the forthcoming period. Work of the AHA Committees in Common of the three Trusts, and the AHA Programme Executive is described. The following areas are covered in the briefing: 1. Committees in Common Update 2. Programme Executive, Delivering Five Core Projects: i. Acute Clinical Services Strategy Development ii. Consistent Methodology for Staff Modelling iii. Open Book Finances & Use of Resources Assessments iv. Single Capital Priorities Plan v. EPR Alignment Programme 3. Further updates are provided on Programme Resources, Risks & Issues, Communications plans, the role of AHA in BSW Integrated Care System and the AHA Forward Meeting Cycle. The next AHA Board briefing will be issued in November. For further information on the AHA Programme please contact Programme Director Ben Irvine (ben.irvine@nhs.net).							
Equality Impact Assessment	An AHA Programme Equality Impact Assessment [EIA] has been completed. The EIA will be refreshed as the three-year AHA Programme 2022-25 matures.							
Public and patient engagement	Our AHA Clinical Strategy work is closely linked with the BSW Care Model which has been through a significant public engagement exercise. Q4 2022-							

	23 will see detailed engagement activities with service users and representative groups. Service users will be involved in service design activities.							
Recommendation(s)	To note the AHA briefing.							
Risk (associated with the proposal / recommendation)	High		Medium		Low X		N/A	
Key risks	The development of the BSW Acute Hospital Alliance is in line with national policy and strategic direction on provider collaboration. The AHA Programme Executive, SRO and Programme Director identify and manage risks associated with programme delivery.							
Impact on quality	The AHA maintains a strong focus on quality and patient safety and assumes continuous focus on quality improvement – the Improving Together programme is one of the AHA core activities. The AHA clinical strategy and staffing methodology workstreams are designed to improve clinical service effectiveness, patient experience and quality. The corporate workstreams aim to deliver value for money, quality, and resilience of corporate services.							
Resource implications	A cost centre has been established at GWH to host the core AHA budget. SFIs are being developed by the Directors of Finance to maintain balance in financial contributions between the three Trusts.							
Conflicts of interest	None known.							
This report supports the delivery of the following BSW System Priorities:	☒ Improving the Health and Wellbeing of Our Population ☒ Developing Sustainable Communities ☒ Sustainable Secondary Care Services ☒ Transforming Care Across BSW ☒ Creating Strong Networks of Health and Care Professionals to Deliver the NHS Long Term Plan and BSW's Operational Plan							

Appendix One.

Acute Hospital Alliance, September - October 2022 Briefing

Introduction

This briefing provides an update on the activities of the Acute Hospital Alliance (AHA) in September and October 2022, as well as description of priorities for the forthcoming period. The following contents are included in each monthly briefing:

1. Committees in Common: Update
2. Programme Executive Activities, Delivering Five Core Projects
3. Decisions Taken
4. AHA in BSW Integrated Care System
5. Resources Update
6. Risks & Issues
7. Communications
8. AHA Forward Meeting Cycle

1. Committees in Common: Update

The AHA Committees in Common (CIC) sets strategic direction and provides oversight of the AHA programme. The CIC has arranged a series of away days, to support AHA development. The latest of these sessions was held on 30th September and saw discussion on the AHA's principles and objectives – *Equity, Sustainability, and Improvement*. A summary of the definitions developed by the CIC will be included in next month's AHA Briefing. The group had also planned to spend time reflecting on difficult subjects where there may be points of tension between the three Trusts. The availability of capital funding in BSW is one such area, where the bids for funding significantly outstrip availability.

In discussion, CIC agreed on the importance of maximising capital funds into BSW. Members asked whether we understand where the risk lies across the system, for example in relation to the balance between urgent repairs and investment in new projects.

It was agreed that there is a clear requirement to link revenue and capital in prioritisation, and to assess each scheme in terms of implications on revenue, activity and workforce. Finally, members noted the need for more detailed knowledge of each organisation's capital needs, to be able to advocate for one another and reach an informed collective position regarding priorities. To address this need, the CIC resolved to arrange site visits for its members.

The next of the CIC away days will be held on 5th December while the next regular CIC meeting is planned for 9th December.

2. Programme Executive Activities – Delivering Five Core Projects

The Programme Executive drives programme delivery, meeting monthly. In September and October, Sponsors and Executive leads have continued progressing our five core areas of work. The team now has a clearly-defined 3-year AHA Programme – see figures 1 and 2 below.

Figure 1 AHA Programme 2022-2025

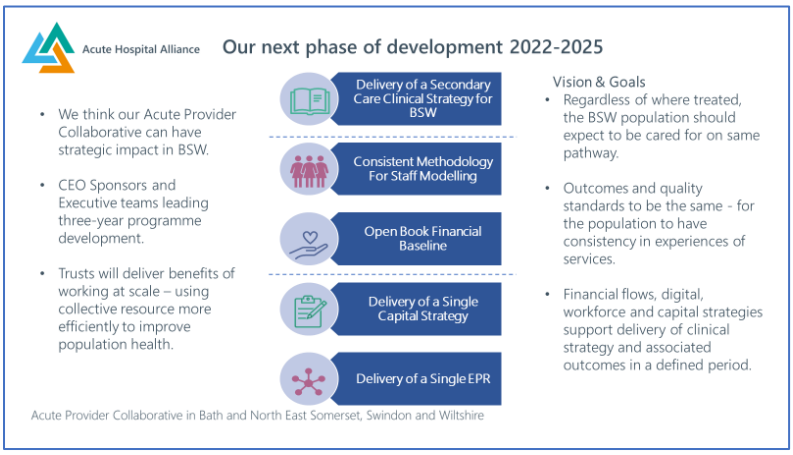
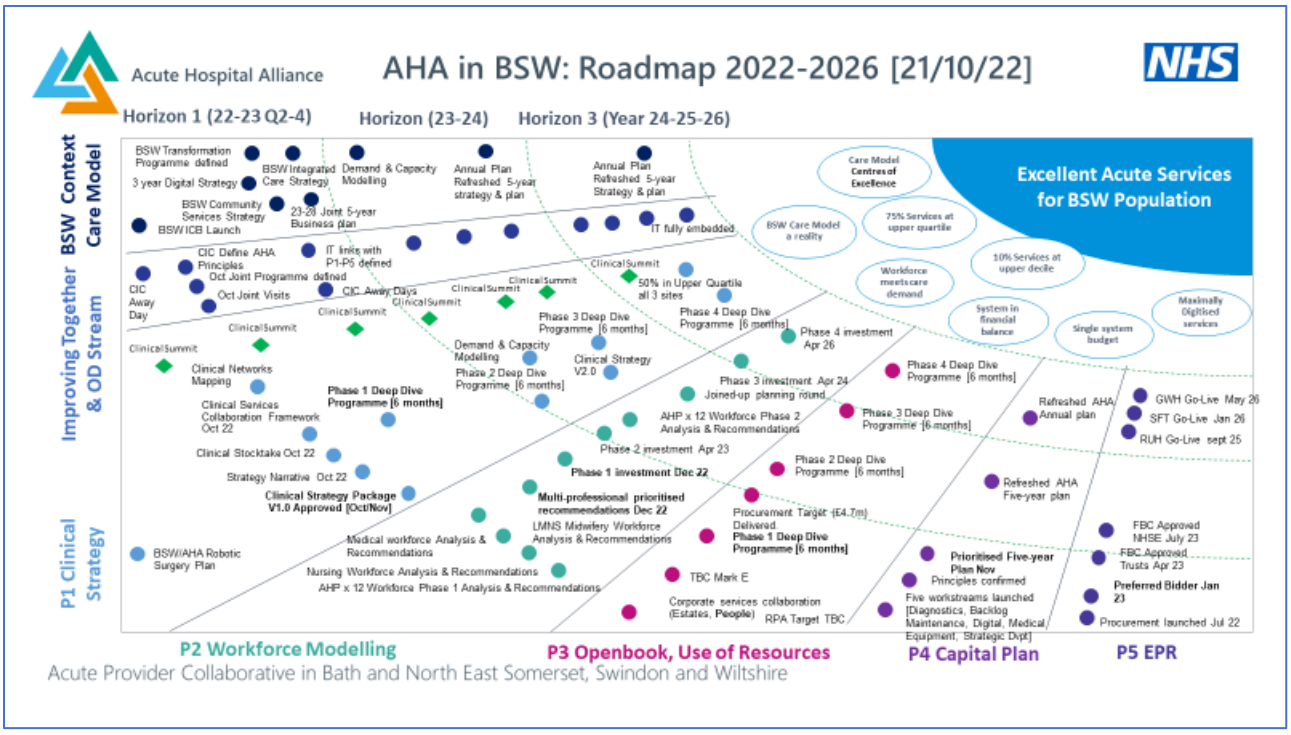


Figure 2. AHA in BSW Roadmap 2022-2026



Updates on the delivery of the five core AHA projects follow.

Project One: Acute Clinical Services Strategy Development

- *CEO Sponsor:* Cara Charles-Barks, *Executive Lead*, Peter Collins; Programme Management, Geoff Underwood & Alicia Wyer.

- *Objective:* Creation of a joined-up acute clinical services strategy. This project aims to support transformational change across our health and care system, so that as three acute hospitals we deliver excellent care and focus on the work that only we can do. The strategy will set a clear ambition for our

services – for example to achieve at least upper-quartile performance against a group of measures, compared to similar services nationally.

- *Recent Activities:* A multi-disciplinary team from the three Trusts has continued development of the strategy closely linked to the BSW care model. A working group meets fortnightly and has planned a series of six Acute Alliance Clinical Summit sessions to bring together clinical leaders from the three Trusts. Recent weeks have seen finalisation of the draft *Clinical Strategy Narrative*, and completion of a high-level AHA *Clinical Stocktake* designed to identify areas of notable strength, and others that might need support. The initial membership of a new Clinical Strategy Programme Board has been confirmed.

- *Next Steps:* November will see completion of a detailed *Clinical Networks Mapping* exercise and further development of a *Clinical Service Collaboration Framework*, establishment of a *Programme of Specialty Deep Dives*, and the development of a *Clinical Strategy public engagement plan*. A third AHA Clinical summit will be held on 23rd November, and on 2nd December our Clinical Strategy Programme Board will hold its first session, chaired by Peter Collins. This group will oversee the strategy implementation.

- *Forthcoming Milestones:*
    - Summit 3: The Clinical Summit on 23rd November will receive the finalised *Clinical Strategy narrative*, *Clinical Stocktake and Clinical Services Collaboration Framework*. Attendees will begin to develop their responses to these products. We will also confirm the first wave of specialties/ services that will be involved in piloting the *Clinical Services Collaboration Framework*.
    - Summit 4: The fourth summit on 1st March will focus on learning from the specialties / services and teams involved in piloting the *Clinical Services Collaboration Framework*.

Project Two: Consistent Methodology for Staff Modelling

- *CEO Sponsor:* Kevin McNamara, *Executive Leads:* Melanie Whitfield & Antonia Lynch; Programme Management, Alicia Wyer
- *Objectives:* This project is closely linked to our Clinical Strategy work. Its objectives are:
    - To achieve safe staffing levels across the AHA supported by agreed principles and variance.
    - To deliver best in class patient outcomes. Creating an environment where staff feel psychologically safe, supported, developed and have sufficient resource to do their job.
    - To support the Acute Trusts ambition to achieve a rating of 'outstanding'. To encourage new staff models designed to support delivery of Clinical Strategy and BSW Care Model.
    - Finally, to achieve financially sustainable high-quality services.

- *Recent Activities*: A small working group has continued to meet weekly to drive the project and its four workstreams – Nursing, Midwifery, AHP, Medical Staffing. Trust professional leads, HR and Business Intelligence teams are supporting data collection. To avoid duplication of effort, the project is working closely with the BSW Local Maternity and Neonatal System group (LMNS), and the BSW Academy.

- *Next Steps:* In late October and November four workstreams will complete data collection, analysis & benchmarking. Teams from the three Trusts will meet in mid-late November to develop staffing principles and risk-based recommendations.

- *Milestone: End November/ Mid December 2022* – Risk-based, prioritised and phased investment plan completed, in readiness for inclusion in the annual planning round.

Project Three: Open Book Finances & Use of Resources Assessments

- *CEO Sponsor:* Kevin McNamara, *Executive Lead:* Mark Ellis.

- *Objectives:*
    - First, creation of an 'Open Book' BSW ICS Finance report. To understand the collective risk of the three Trusts, looking ahead proactively to plan mitigations. To demonstrate partnership working in instigating mitigating actions and a collective approach to risk.
    - Second, Use of Resources (UOR) assessments, to allow AHA to prioritise and systematically identify opportunities for collective improvement; Identify opportunities for learning and best practice to be shared amongst the alliance to deliver improvements; and to support the development of the Acute Alliance Clinical strategy.

- *Recent Activities:* BSW ICS Finance report completed and circulated M04 & M05; Initial high-level Use of Resources Assessment (UOR) drafted for all three Acute Hospitals; Pilot: Urology UOR assessment completed. Leads have been planning analytical and project support resources required to complete UOR assessments.

- *Next Steps:* Develop a programme of deep dives for 2022/23 based on UOR assessment. Secure resources to enable project delivery.

- *Milestones:* Confirmation of Use of Resources Deep Dives Programme – Anticipated November/ December. Monthly open book finance reporting.

Project Four: Single Capital Priorities Plan

- *CEO Sponsor:* Stacey Hunter, *Executive Lead:* Simon Wade.

- *Objective/ Vision:* Project aims for AHA Trusts to:
    - Work together to maximise available capital resources into BSW/ AHA by having a coherent, strategic plan for capital investment within the AHA
    - Create a workstream-based approach to prioritisation that balances different types of capital investment.
    - Consistently advocate for each-others' schemes and the collective capital development priorities.

- Establish a focused capital strategy development framework including clear principles guiding how we will collectively respond to national requests for funding
- Confirm a coherent plan working towards net zero carbon sustainability standards across AHA.

- *Recent Activities:* Work in September and October saw planning of workstreams (Strategic Redevelopment, Backlog Maintenance, Medical Equipment, Diagnostics, Digital).

- *Next Steps:* Late October and November will see workstreams established and confirmation of detailed workstream plans and priorities, a Capital Working Group will be established to oversee the project.

- *Milestones:*
  - End November 2022: Principles defined, and collective view of capital priorities developed; agreed 5-year AHA wide capital strategy.

Project Five: EPR Alignment Programme

- *CEO Sponsor:* Stacey Hunter, *Executive Lead:* Jon Westbrook. Programme Director: Pamela Gordon.

- *Objective:* Procurement and deployment of a single EPR platform. The programme will provide a common digital platform between the Trusts that can enable standardised care pathways, mutual aid models, single consistent data flows and economies of scale.

- *Recent Activities:*
  - EPR procurement is progressing on plan. Supplier responses have been reviewed. Demonstrations have been undertaken, and site visits have been scheduled
  - Key stakeholders across the three organisations have been involved in scoring and moderation sessions. There continues to be a good balance of engagement by colleagues from the three Trusts.
  - Work on improving programme controls, governance and detailed planning and resourcing for next stages has continued. Recruitment is underway to bring in key roles required now to support the Programme.

- *Next Steps:*
  - *Procurement.* The procurement process will continue to involve expert Trust stakeholders over the next period. *November* will see the close of procurement and invitation of final tenders. Tenders to be submitted. *December* sees selection of preferred supplier. *January* will see start of contract finalization activities.
  - *Full Business Case Timetable. December* - commence drafting of FBC.
  - *January to February* – Briefing sessions for Trust committees. *March 2023* – Finalise FBC document.

- *Milestones:*
  - March & April 2023 – Full Business Case (FBC) to Trust Boards for consideration.
  - NHSE FBC approval anticipated in July/ August 2023

- Go-live plans for each Trust will be determined during contract negotiations with the suppliers.

Other Programme Activities

- Corporate Back-Office Programme – Finance team: good progress continues to be made in procurement collaboration. The team is focused on delivering the 2022-23 programme. Procurement lead Rob Webb has produced a lessons learnt report, describing experiences of developing the single AHA Procurement team. Learning from this work is likely to be of interest across AHA and more widely in BSW. The report will be presented to AHA Executive on 28th October then shared.
- Improving Together– rollout continues across the three Trusts of the Improving Together, common improvement methodology. Where possible Improving Together approach will be used in delivering the Five Core AHA Priorities.

3. Decisions Taken – September – October 2022-23

None to report.

4. AHA in BSW Integrated Care System

The AHA contributes to system stability, modelling the benefits of collaboration. With strong relationships between Trust leadership teams built over the past years, the AHA intends to play a full role as an effective provider collaborative, maximising opportunities to work together at scale to the benefit of the population we serve.

5. Resources Update

The Acute Alliance has a small core team in-post. The AHA Programme is funded by equal contributions from the three Trusts. Posts are hosted by all three Trusts. The AHA Virtual Clinical teams work (eg Dermatology and Ophthalmology) also receives programme and project management support from the ICB Strategy & Transformation Directorate – acute commissioning team. During the period covered by this report:

- AHA Programme Manager, Alicia Wyer, joined the Programme on 30th September.
- Opportunities for Trust staff to take part in collaborative project teams are being identified. A wide range of clinical and non-clinical staff have completed/ are embarked on training and leadership development programmes – often requiring project/ improvement work. A proposal on how this capability could be coordinated is being developed.

6. Risks & Issues

A range of risks and issues continue to be managed by the programme team. A risk register is held centrally, with significant items being reported to Programme Executive. The risk register was reviewed and fully refreshed in early October. No new and significant risks have emerged through this review exercise. The following risks & issues were reported to the Programme Executive over the last three months.

1. *Capacity constraint; delay to delivery:* Response: Recognise need to balance between short-medium & long-term priorities; capacity for both operational and transformation work required. Prioritisation of AHA activities required.

2. *Leadership Transition in BSW*. Establishment of new ICB leadership team creates destabilising effect. Response: Core team and executive leads develop effective relationships with new ICB executive team members. Maintain focus on effective delivery by AHA, contributing to system stability, modelling impact of collaboration.
3. [Project 5] Access to EPR Funding restricted (Capital & Revenue). Response: CIC support will be required over next 12 months to ensure require funds are secured. £21m capital support confirmed by NHSE. Revenue budget for the next phases to be confirmed. Budget planning for 23-24 and 24-25 underway.
4. [Project 2] *Staffing Methodology*. Note: The clinical staffing establishment baseline work has potential cost implications. The team has developed a draft investment decision timeline that assumes risk-based phasing of investment will be required.

7. Communications

An AHA Communications strategy is in place, created by Communications lead, Tim Edmonds (GWH), with internal and external strands including:

- *Monthly Board Briefings*, a *Monthly Newsletter* for wider dissemination through Trusts and BSW, and a monthly *AHA Highlight Report* – for CIC, Programme Executive and BSW Integrated Care Board/ Executive.
- *AHA branding* has been developed and is now in use [refer logo on this briefing] and a series of *videos on our five priority projects* involving Trust leads is being created.
- *Engagement activities* in relation to AHA Clinical Strategy work are being planned with Healthwatch leads and Voluntary sector representative groups.

8. AHA Forward Meeting Cycle

The table below sets out the dates of our CIC meetings, CIC Away Days, Programme Executive and Clinical Summits for 2022-23. A detailed meeting planner, providing a clear view of key decision points and milestones is being developed by the programme team and will be shared via the Programme Executive and Committees in Common.

Table 2. Forward Meeting Cycle: Key Dates

AHA Committees in Common Dates 2022								
8th April		*10th June*		21st October		9th December		
Committees in Common Away Days 2022/23								
11th July 2022		*30th September 2022*		5th December 2022		TBC Feb 2023		TBC May/July/Oct 2023
AHA Programme Executive Dates 2022								
29th April	*27th May*	*24th June*	*29th July*	*26th August*	*30th September*	28th October	25th November	16th December
AHA Clinical Summit Dates 2022/23								
20th May 2022		*2nd September 2022*		23rd November 2022		1st March 2023	25th May 2023	28th September 2023

Finally, the next AHA Board briefing will be issued in late-November.

Close

Drafted by Programme Director, Ben Irvine

24th October 2022

Register of Attendance – Public Board 2022/23

	7 April	5 May	7 July	8 September	3 November	January 2023	March 2023	attendance rate
Nick Marsden	✓	✓	✓	✓				4/4
Tania Baker	✓	✓	✓	✓				4/4
Michael von Bertele	x	✓	✓	✓				3/4
Paul Kemp	✓	✓	✓	✓				4/4
Paul Miller	✓	✓						2/2
Stacey Hunter	✓	✓	✓	✓				4/4
Lisa Thomas	✓	✓	✓	✓				4/4
Andy Hyett	✓	✓	x					2/3
Judy Dyos	✓	✓	✓	✓				4/4
Melanie Whitfield	✓	✓	✓	✓				4/4
Eiri Jones	✓	✓	✓	✓				4/4
Rakhee Aggarwal	✓	✓	✓	✓				4/4
David Buckle	✓	✓	✓	x				3/4
Peter Collins	x	✓	✓	✓				3/4

Governor Observer							
John Mangan							
Lucinda Herklots	✓	x	✓	x			

Attended - ✓

Apologies – X

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Report to:	Trust Board (Public)	**Agenda item:**	2.1
Date of Meeting:	3rd November 2022		

Report from: (Committee Name)	Clinical Governance Committee		**Committee Meeting Date:**	25th October 2022
Status:	**Information**	**Discussion**	**Assurance**	**Approval**
	X	X	X	
Prepared by:	Miss Eiri Jones, Chair CGC			
Board Sponsor (presenting):	Miss Eiri Jones, Chair CGC			

Recommendation

Trust Board members are asked to note and where relevant, discuss the items escalated from the Clinical Governance Committee (CGC) meeting held on the 25th October 2022. The report both provides assurance and identifies areas where further assurance has been sought and is required.

Key Items for Escalation

- Key information / issues / risks / positive care to escalate to the Board are as follows:
  - A hot topic presentation was received on Monkey Pox, with assurance provided in relation to the immunisation programme for this. It was also outlined how one of the staff networks had supported communication in this area.
  - The emerging system clinical strategy was presented. This has been co-produced by partners. A plan of further engagement and development was included in the strategy and further updates will come to CGC in due course.
  - As at F&P, a detailed presentation and discussion was held in relation to the latest iteration of the winter plan. The latest critical incident re flow was also noted and that the current position had been escalated to the ICS. The clinical safety concerns were flagged and are escalated to Board. One of the proposed actions relates to a continuous flow model. This will require both a quality impact and a risk assessment.
  - An update on the pressure area work across the Trust was presented. The team are using the Improving Together methodology to continue the focus on improvement. It was noted that pressure ulcers have increased during the last 2 years and that this triangulates with the reduction in care hours per patient day (CHPPD). The Executives confirmed that focussed work on staffing is underway.

- The BAF and CRR were reviewed and correlate with the risks presented in relation to both the IPR metrics and the winter plan. It was felt to be a realistic review.
- Positive progress against the patient experience plan was provided in the mid year report. Whilst response numbers of family and friends test are low, the feedback is very positive.

The Board is asked to note and discuss the content of this report, in particular the current pressures impacting on safety and quality.

Salisbury NHS Foundation Trust

Report to:	Trust Board (Public)	**Agenda item:**	2.3
Date of Meeting:	3rd November 2022		

Committee Name:	Finance and Performance		**Committee Meeting Date:**	25th October 2022
Status:	**Information**	**Discussion**	**Assurance**	**Approval**
			X	
Prepared by:	Eiri Jones, Non-Executive Director			
Board Sponsor (presenting):	Eiri Jones, Non-Executive Director			

Recommendation
To note and discuss key aspects of the Finance and Performance (F&P) Committee meeting held on the 25th October 2022

Items for Escalation to Board
(1) Approvals Three cases were presented to the committee 1. The first was in relation to the minor injuries provider in Salisbury. The provider has been in place for some time and the committee was asked to support the extension for a further 2 years to be backdated to April 2022. A detailed discussion was held in relation to governance, performance and management of the contract. Assurance was provided in relation to the procurement with the contract being tested with Beechcroft. It was acknowledged that the management of the contract requires further work and this is in hand. The extension is limited to a maximum of 2 years to allow for future options as the system becomes more established. It was agreed that the process would be considered by the audit committee in due course. The F&P committee recommends to Board that they support this case.

2. The second case related to replacement back-up generators. The product has been reviewed by a mechanical engineer re quality and it was confirmed that these generators were more environmentally friendly than the current ones. The committee approved this bid.
3. The third case was in relation to orthopaedic trauma implants. The contract is across the Acute Hospital Alliance and outlined savings for all three providers. The committee approved the bid.

(2) Procurement updates.

An update was provided on the Capital Prioritisation Criteria. This was felt to be a good tool. An update was also provided following the recent court case in relation to the Consultant Connect contract. The learning has been shared widely with the procurement team and will also be included in management training. The committee were assured that tests are now in place to prevent a repeat of this issue.

(3) Winter planning

A detailed presentation and discussion was held on the Trust and system plans. The current safety challenges and pressures were flagged for escalation and triangulated with the data in the integrated performance report. Three priorities for action are underway, namely staffing, discharges and protection of assessment space. Actions were outlined to address these challenges though it was acknowledged that some of the actions would take time to establish, especially with the staffing challenges which could worsen due to Covid and flu. The committee were informed that there had been formal escalation to the system due to the concerns raised about safety. It was felt that a further discussion was required at the Board.

(4) Quarterly estates update

The report outlined that the plan to manage risks was on trajectory. Continued progress against the improvement plan was noted. The risk score requires review. It was noted that internal audit are undertaking an audit in relation to backlog maintenance.

(5) BAF and CRR

The BAF and CRRs were reviewed and discussion confirmed that the current position outlined an organisation under pressure as per the winter plan discussion. Both documents will be discussed at the Board.

The Board is asked to note and, where relevant, discuss the content of this upward report.

NHS Salisbury NHS Foundation Trust

Report to:	Trust Board (Public)	**Agenda item:**	2.3
Date of Meeting:	03 November 2022		

Report Title:	Trust Management Committee Escalation Report			
Status:	**Information**	**Discussion**	**Assurance**	**Approval**
	X		X	
Approval Process (where has this paper been reviewed and approved)	Reviewed and signed off by Stacey Hunter Chief Executive Officer.			
Prepared by:	Gavin Thomas, Executive Services Manager			
Executive Sponsor (presenting):	Stacey Hunter Chief Executive Officer			
Appendices (list if applicable):				

Recommendation:
The Board is asked to note the report from the Trust Management Committee.

Escalation Summary:
The Trust Management Committee was held on Wednesday 26th October and was a full committee this month following the Senior Leadership Meeting being held last month. The committee reviewed several business cases this month including the Digital plan and an update paper on the additional ward. In respect of the Digital plan the committee heard that the plan was an update to the Digital Strategy which was written in 2019 and how the strategy builds on foundations laid over the last three years, and the 5 priority areas which the strategy will focus on, namely our Electronic Patient Record, digitally enabled partnership working, supporting the people we serve, empowering a digital workforce and modern and secure infrastructure, whilst recognising this has been significantly disrupted due to Covid. The committee heard that the strategy whilst ambitious, needed to be mindful of the financial challenges, we are going to face over the next 5 years. The committee were all agreed that moving forward, digital will be a key factor in Salisbury NHS Foundation Trust delivering its strategy and vision of an outstanding experience for every patient. This paper was supported. In relation to the additional ward, the committee were asked to support the proposal in that the upper floor above the new ward be designated for use by the cleft and speech therapy teams, enabling ENT to move into the space vacated which would in turn support expansion of the cancer services on level 3.

The committee heard that following an initial shortlisting process, three options for the use of the space were assessed against agreed criteria and that following this process it was felt that the option to see a combined cleft and speech therapy unit be established in the space above the new ward, which would allow ENT services to be consolidated in level 3, close to the maxilla-facial and plastic surgery departments complementing the head and neck provision at the Trust and improve ENT support to ED would be the best option, as in turn this would be followed by cancer services being able to extend out into the space left by the move of the ENT department and continue the development of cancer services at level 3 in line with the cancer strategy proposals. This was approved.

There was a business case from OD and P for additional investment to support the deployment of e rostering for all staff and to strengthen our capacity and capabilities in workforce strategy. This work responds to the PWC audit report that the Board have been sighted on. TMC supported the business case in principle recognising that approval for this needs to be via F and P board sub-committee. Colleagues feedback that the case would benefit from an implementation plan and clarity in respect of the ongoing oversight of such if it is approved. T

The committee received all the escalation reports from the subgroups that report in. There is nothing to escalate to Board colleagues that isn't already covered in the IPR and the Board sub-committee reports.

The committee also received the Business Continuity Policy and the EPPR Policy for their annual review. Both noted and approved.

Lastly the committee received the Board Assurance Framework (BAF) and heard that following the Risk Appetite session at the Trust Board Development Day in May 2022, the Board Assurance Framework has been completely revised to apply the risk appetite. The same process has now been applied to the corporate risk register which allows colleagues to focus on those areas that are out with the tolerance level and agree whether there is any further mitigation that could be delivered.

The committee noted the amount of work which had gone into amending the BAF and were keen to show their appreciation as it supports a more focused and effective dialogue and decisions.

The next committee meeting is scheduled for November and will be Senior Leadership session.

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

Salisbury NHS Foundation Trust

Report to:	Trust Board (Public)	**Agenda item:**	2.5
Date of Meeting:	03 November 2022		

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

Recommendation:
The Trust Board are asked to note the Trust's performance for Month 6 (October 2022).

Executive Summary:
The average wait to first appointment has increased to 108 days (15 weeks), this is in part due to the successes in reducing the backlog of urgent referrals waiting for 1st appointment. The Trust continues to deliver ahead of the trajectory for reducing the number of patients waiting over 52 and 78 weeks, and no patients waiting over 104 weeks. The growth seen in the total waiting list size over the 7 months reduced with the waiting list size in M6 static in comparison to M5. The number of excess bed days associated with internal reasons for delays to discharging patients no longer meeting the criteria to reside remains static increased in M6 to 432 (260 in M5). Progress is affected by staffing levels to perform assessments and follow up enquiries for patients on pathways 1-3 (patients that require some level of support for safe discharge). The use of escalation areas without substantive staff contributes further to the delays. The availability of workforce to deliver the operational priorities of the organisation remains extremely challenging. Turnover of staff has increased consistently for 18 months, and has peaked in M6 at 14%, and vacancy levels increased to 11%. A Task group has been set up led by Deputy Chief Nursing Officer to explore and consider all possible actions and incentives to increase fill rate and retention to nursing ward support.

Work to reduce the number of patient falls continues as part of the Improving Together program, and the number of falls decreased to 7.52 per 1000 bed days in M6. This is just above the target of 7.0 and a significant improvement from the peak of 10.32 in March.

Flow throughout the organisation remains challenging with occupancy levels throughout the month of 96.2%. The number of patients in the organisation not meeting the criteria to reside is static at 126 (127 in M5). Both factors contribute towards the delivery of the Emergency Access standards – 68.9% of patients were admitted or discharged within 4 hours and 116 patients spent longer than 12 hours in the Emergency Department. Flow out of the department was constrained, and the average time in the department for patients requiring admission was 8 hours and 49 minutes. Consequently, the average number of hours lost to ambulance handover delays per day rose from 13 in M5 to 20 in M6.

There was further deterioration of the 6-week diagnostic standard, falling to 61.4% of patients receiving a diagnostic within 6 weeks of referral. MRI, Ultrasound, Echocardiogram and Audiology are the modalities with increased waiting times. Difficulties in recruiting staff is the factor with the biggest impact and opportunities are being pursued with expanding roles, insourcing and additional roles.

The proportion of patients referred on a suspected cancer referral that were seen within 14 days reduced to 73.9%. Performance against the Breast Symptomatic standard was high at 94.4%, and the 28 Day Faster Standard of 75% was achieved. Delays in the first outpatient part of the suspected cancer pathway contributed towards 62 Day referral to treatment standard, with the standard achieved for only 64.7% of patients (target 85%).

There was some improvement in the Stroke standards with a score of C for Q1 in the SSNAP standards. 33% of patients reached the stroke unit within 4 hours, the national target is 90%.
There was a decrease in both the number of incidents and the number of pressure ulcers reported in M6, due to the operational pressures there is potential that this may not be a true representation due to under reporting. M7 figures will be closely monitored to review if this trend continues.

In M6 the trust recorded a control total deficit of £1.512m against a target of £0.601m, an adverse variance of £0.871m. Pressure on emergency care pathways which results in increased costs associated with the Trusts bed base, reductions of elective inpatients care and premium costs of bank and agency to cover vacancies and unavailability.

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

Integrated Performance Report

NHS
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September 2022

Summary

September 2022

Salisbury NHS Foundation Trust

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The availability of workforce to deliver the operational priorities of the organisation remains extremely challenging. Turnover of staff has increased consistently for 18 months, and has peaked in M6 at 14%, and vacancy levels increased to 11%. A Task group has been set up led by Deputy Chief Nursing Officer to explore and consider all possible actions and incentives to increase fill rate and retention to nursing ward support.
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What we are measuring – our Strategic Priorities

Improving the health and well being of the Population we serve

Working through Partnerships to transform and integrate our services

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

Our focus – Breakthrough Objectives and Strategic Initiatives

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

What is an Integrated Performance Report (IPR)?

NHS Salisbury NHS Foundation Trust

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

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

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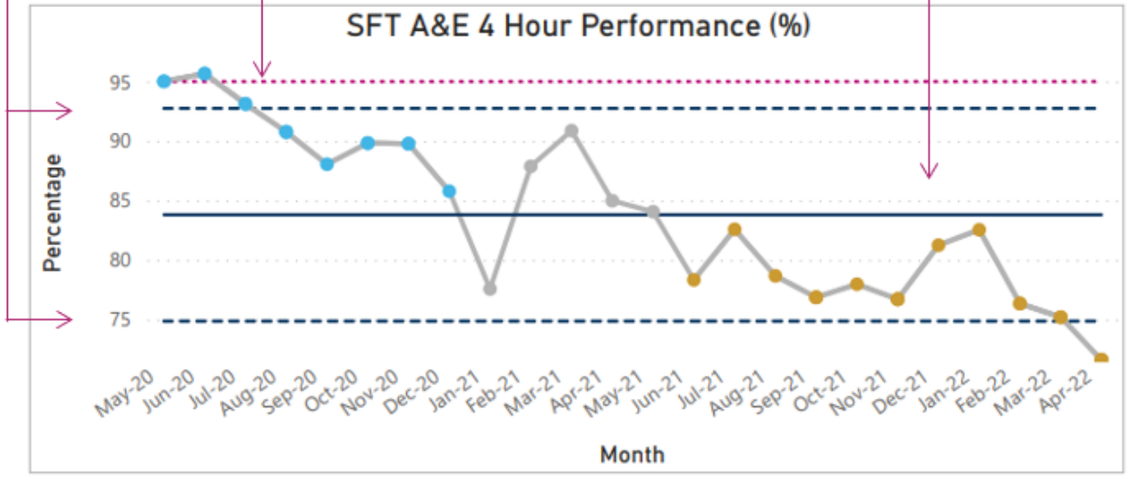
Reading a Statistical Process Control (SPC) Chart

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

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

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

The solid grey line shows the mean value for the dataset



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

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

Grey markers show normal behaviour with no significant cause for variation

Part 1: Quality of Care, Access and Outcomes

Performance against our Strategic Priorities and Key Lines of Enquiry

Salisbury NHS Foundation Trust

Our Priorities

Population

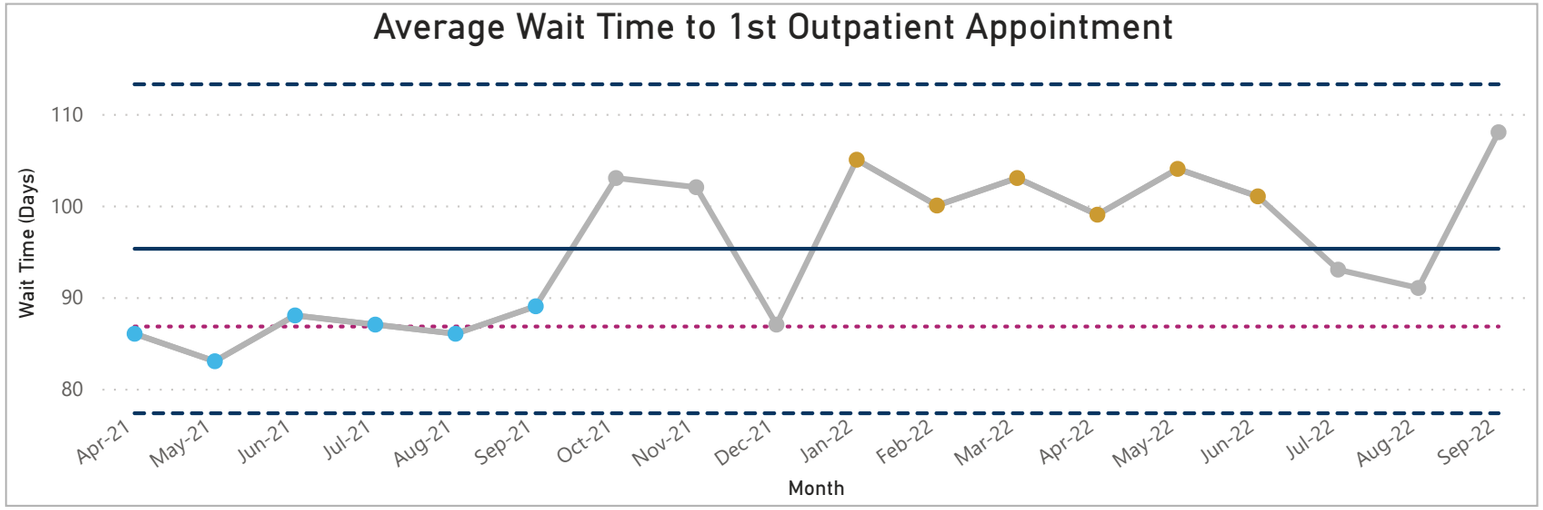
Partnerships

People

Reducing Patient Waiting Times

Target 87 days

Breakthrough Objective



We are driving this measure because…

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

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

Understanding the performance:

-Sept saw a marked increase in Average Time to 1st Appointment. This was driven by successes over recent months in reducing the backlog in urgent referrals waiting for 1st appt. The booking teams are able to book increasing numbers of routine patients.
-The average wait is 15weeks for those attending OPD appointments.
-The Trust continues to have no >104week waits, is delivering ahead of trajectory for both >78ww and >52ww, and continues to make progress against the >78w 'at risk' cohort of patients for the March 2023 target. Numbers down from circa 1700 - 412 at end of Month 6.
-No patients >78weeks awaiting 1st out-patient appointment.
-178 patients wait over 52 weeks for 1st appt, 138 of these are booked.
-As the number of long waits is reduced the capacity given over to these patients is consistently used to provide appt for shorter waiting patients, assisting in the reduction in average time to 1st appt.

Actions (SMART):

Regular and frequent focus, analysis and action planning continues via a weekly meeting to establish and progress actions supporting the reduction in our longest waiting patients, in line with national expectations.

Weekly monitoring of non-admitted patients on non-admitted pathways over 52 weeks with no 1st appointment.

Waiting list review and patient pathway analysis with the objective of converting increased numbers of follow up activity to alternative pathways such as PIFU to free up additional capacity for First Appointments.

Risks and mitigations:

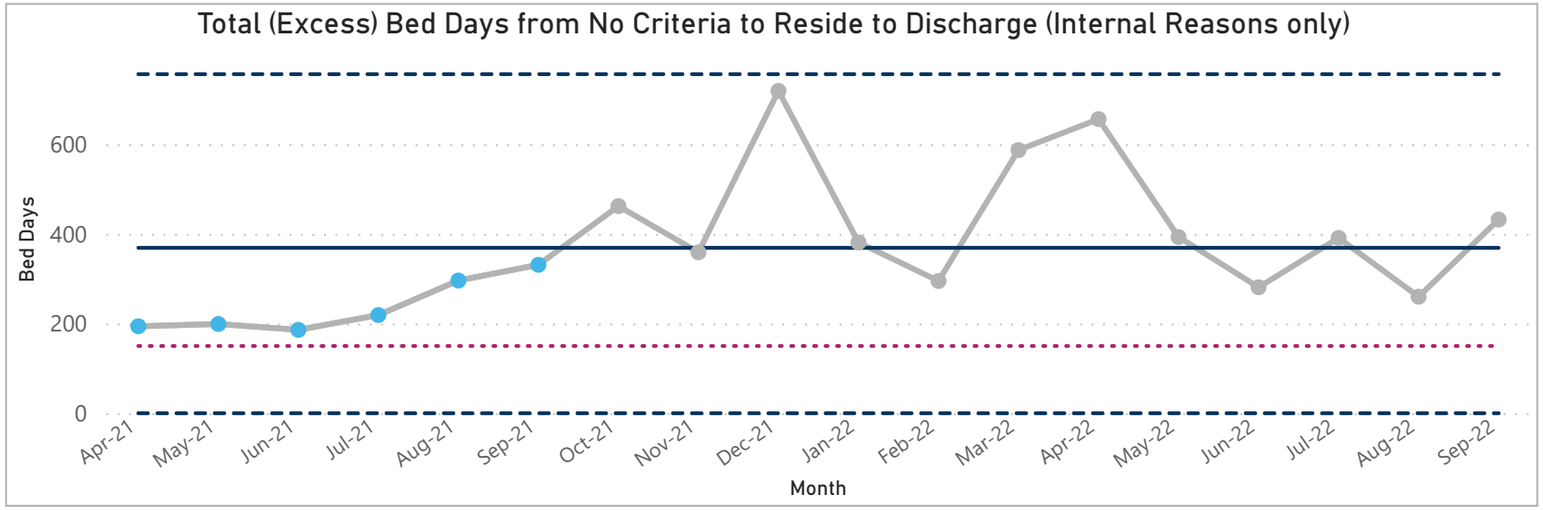
Limitations continue in relation to the Trust's ability to comprehensively map demand and capacity at Specialty and Sub Specialty/Pathway Level. This is currently being worked through with support provided from the EPR Meetings.

Resource limitations at both DMT and Specialty Level continue to challenge for Divisional Teams.

Optimising Beds

Target 150 days

Breakthrough Objective



We are driving this measure because…

Patients are in hospital for longer than they need to be due to delays with their discharge. These excess bed days (EBDs; i.e. days where a patient is in hospital, with no criteria to reside (NC2R) and waiting for discharge) cause the condition of the patient to potentially deteriorate, cause delays with patient flow into, around and out of the hospital and have a negative impact of patient and staff experience. This impacts the ability of the Trust to meet its operational targets around Elective Recovery and is potentially unsafe for patients.

Understanding the performance:

Bed days lost for internal reasons is steady at an elevated rate from this time last year.

Staffing is a significant contributing factor to this – the ability to perform the assessments and produce the documentation and follow up enquiries for patients on pathway 1-3 has been affected by the challenges in numbers, skill mix and MDT availability.

The requirement to outline patients and use areas of escalation without substantive staff has also contributed to internal delays –teams are prioritising where possible in terms of support to facilitate flow.

Actions (SMART):

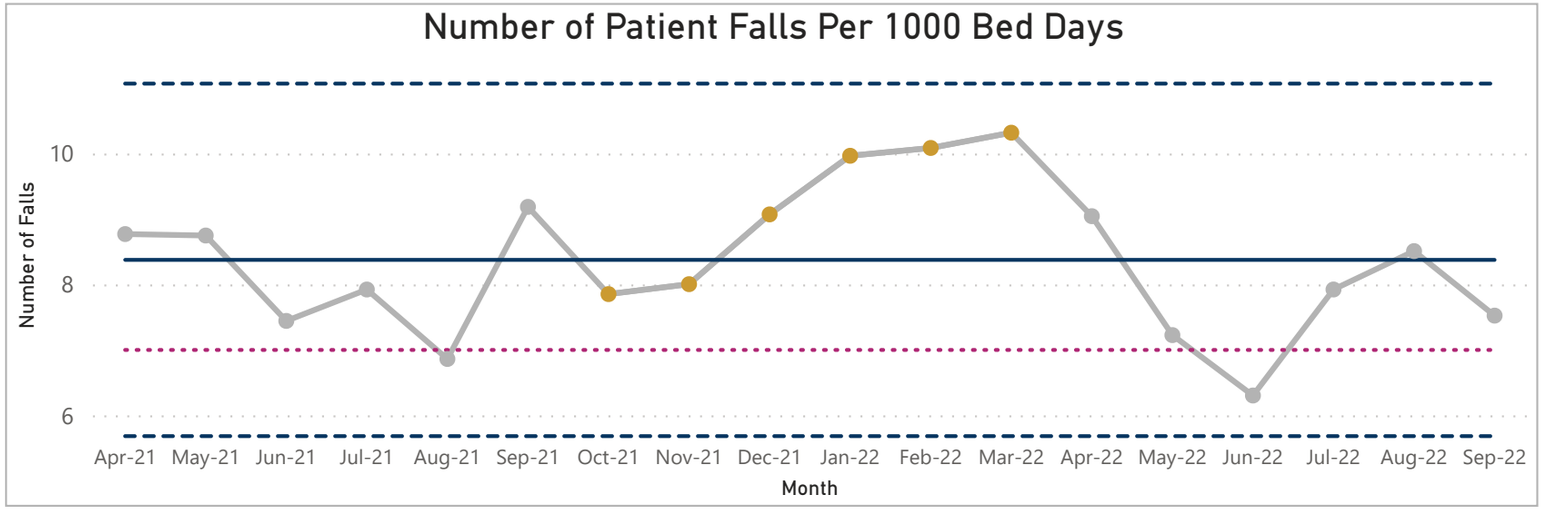
Efforts continue to maximise the use of the e whiteboard system to support the prioritisation of work for patients who are outstanding referrals. There is a whiteboard group that meets to discuss purpose, reporting and engagement. Trust focus remains facilitating flow where possible, reducing the use of outlying or escalation facilities.

Risks and mitigations:

Reducing Patient Harm

Target 7

Breakthrough Objective



We are driving this measure because...

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

Understanding the performance:

-217 members of nursing and therapy staff have received training. Collaboration with education department to deliver training at induction for HCAs and RNs from overseas commencing in Oct.
-The eLearning module has had no participants as of Sept.
-Support from The Coach House team to deliver Improving Together modules. Data collection commenced in July.
-Redesigned with assistance from the falls group. Trial one ward in Nov.
-Capital bid has been raised for 20 more ultra-low beds.
-The falls per 1000 bed days for September decreased slightly from Aug and is at 7.39 with a target of 7.00.
-There were 5 patients who fell with moderate or above harm in Sept.
-Major-below knee stump wound dehiscence requiring surgery.
-Moderate-x3 #distal radius. Lacerations/fractures 4th and 5th toes.

Actions (SMART):

-Formal training programme being delivered at ward level. Also, on the spot training and advice at the bed side. New overseas and HCA induction training finalised.
-eLearning national module available on Kallidus.
-Improving Together Falls reduction breakthrough drivers for Pitton Ward and Farley Ward. Lying and Standing compliance is a breakthrough target for the Orthopaedic wards.
-Revision of bed rails assessments and falls risk assessment to include visual test.
-Review of equipment availability including ultra-low beds, falls sensor alarms and crash mats
-Concentrating on lying and standing BP compliance and roll out of “Bay watch” on the wards.

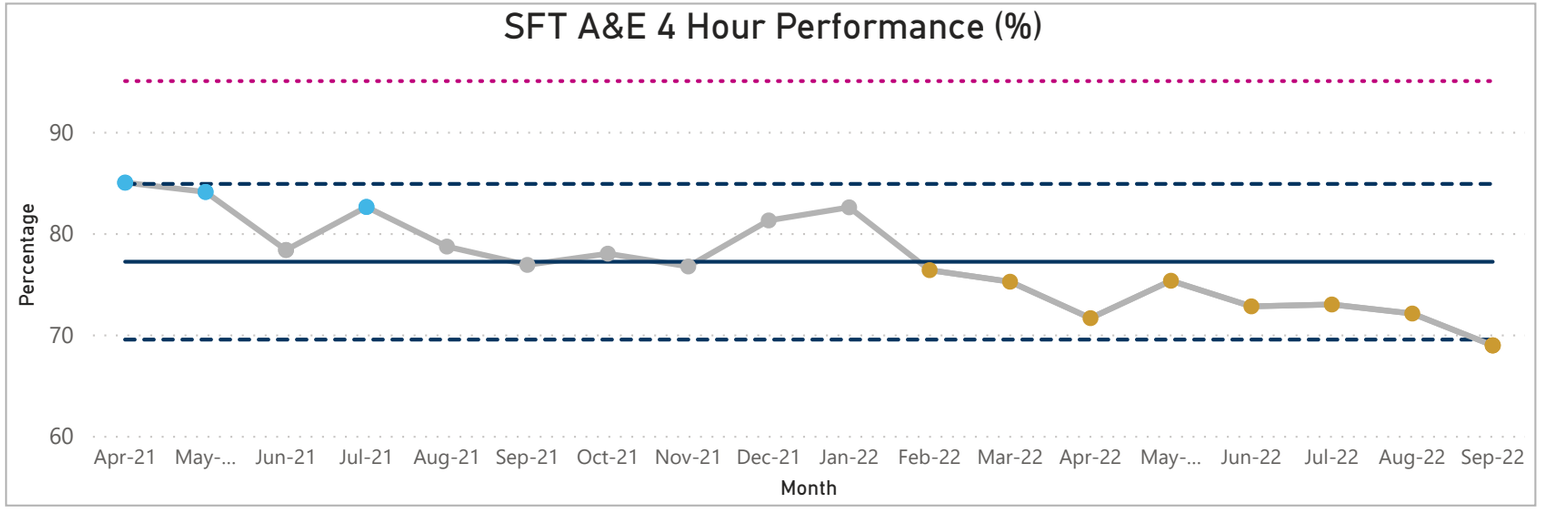
Risks and mitigations:

-Staff availability for training has gradually declined. There is a direct correlation with vacancies/sickness and available care hours. Dates have been given to wards for face to face training on a programme.
-Pitton huddles commenced. Farley have embraced the Improving Together aims. Ortho are collecting data on compliance with lying/standing BP and have well led huddles. They've done cycles of change regarding when to collect L&S BP data. Audits show compliance on Chilmark-83%. Progress on Amesbury at 79%.
-Redesigned falls/bed rails risk assessments will be trialed on Farley with PDSA cycles to produce final documents by the end of the year. Farley will be piloting “bay watch” prior to the new trial.
-Capital bid for 13 ultra-low beds was successful-in hope 13 falls sensor alarms will be available later in the year.
-Potential collab with MDMS for 2 crash mats.

Emergency Access (4hr) Standard

Target 95%

National Key Performance Indicators



Performance Latest Month:	68.9%
Attendances:	6191
>12 hrs in ED Breaches:	116

Understanding the performance:

-Performance against 4 hour standard deteriorated further in M6 to 68.9% (72.1% in M5). Attendances remained broadly static and in line with attendance levels seen pre-covid. 33% of patients had an initial assessment within 15 minutes, and the average time to initial assessment was 48 minutes.
-Flow out of the department was significantly challenged. The average time in the department for patients not admitted was 3 hours and 58 minutes and the average for patients that were admitted into the hospital was 8 hours and 49 minutes (increased from 7 hours 51 in M5).
-There were 9 patients that waited longer than the 12 hour standard for time from decision to admit to admission into the hospital.
-Covid escalation plan agreed If Covid presentations exceed capacity of current covid ward area.

Actions (SMART):

-Agency bookings have been agreed for ED, with interviews for a practice educator planned for M7.
-Additional med staff overnight agreed to mitigate impact of higher numbers of patients in the department waiting for admission to wards.
-Agreement to protect at least 2 spaces in the AMU assessment bay in M7 to support flow at the start of day. Additional junior/middle grade medical staff agreed to support weekend discharges from wards.
-ED Escalation tool developing with clear actions. To be agreed by end of M7.
-ED/AMU leadership team developing options for creating an SDEC area. This will present at a DMT meeting in M7.
-Development of tracker role to assist Nurse in Charge and ED consultant with tracking of patients in the department and escalation of delays/requests for help. Role agreed/advertised by end of M7.

Risks and mitigations:

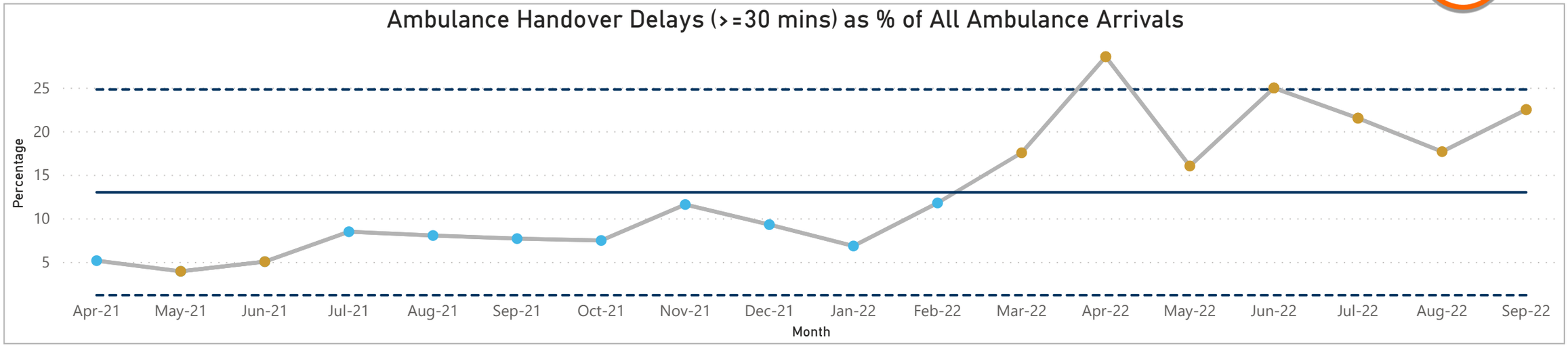
High occupancy levels in the Trust remain the biggest factor affecting flow in the Emergency Department.

Workforce gaps in medical, nursing and admin. Re-banding on reception post agreed, recruitment at higher level to start.

Agency long line agreed to support nursing gaps. Appointment of practice educator to prioritise uplifting the skill mix in the department. Successful recruitment into middle grade vacancies, candidates currently in the pre employment process.

Ambulance Handover Delays

National Key Performance Indicators



Understanding the performance:

The proportion of patients waiting longer than 30 minutes to be handed over to the Emergency Department increased in M6 to 22% (17% in M5).

There was an average of 20 hours lost per day, (13 per day in M5). The number of patients that waited longer than 60 minutes increased from 106 in M5 to 187 in M6.

The number of patients arriving by ambulance remained static.

Actions (SMART):

ED escalation tool developed with clearly defined actions when triggers are hit, delays in offloading ambulances are part of this.
Hospital Ambulance Liaison Officers (HALO) support with managing safety of the queue when there are fluctuations in the number arriving, or the department are unable to offload.
If patients are held in a queue the medical team will review patients in the back of the ambulance where possible to start assessment or investigations, or if acuity is low then move the patient to the waiting room to release the crew.

Agreement to protect 2 assessment spaces in AMU assessment area in order to allow some flow, and reduce the likelihood of the GP take being diverted to ED increasing the number of spaces in the department that are blocked.

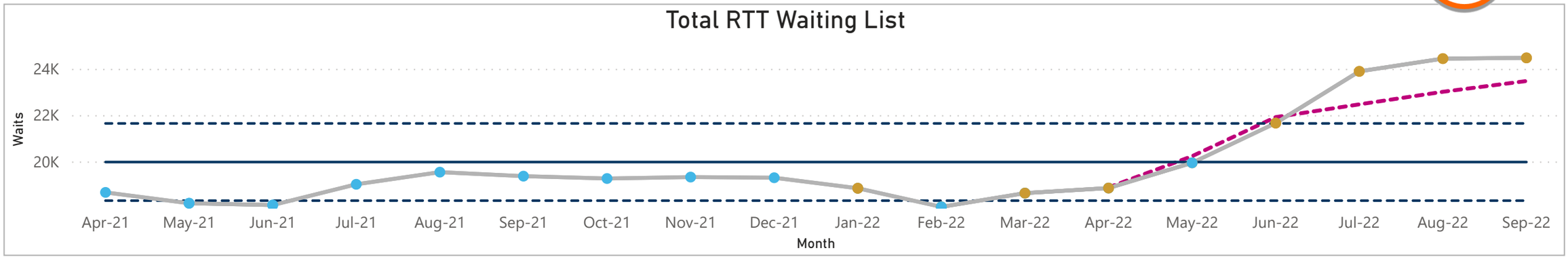
Risks and mitigations:

Flow into the hospital is the biggest risk to offloading ambulances quickly – the development of an SDEC area with protected assessment space remains the focus, and a proposal is in development to be presented to the DMT in M7.

Increase in covid or flu presentations – where possible lateral flow tests are undertaken on arrival by ambulance crews so isolation requirements can be quickly identified or excluded.

Total Elective Waiting List (Referral to Treatment)

National Key Performance Indicators



Month	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22
Longest Waiting Patient (Weeks)	110	110	107	111	116	116	120	99	99	95	98	94

Understanding the performance:

-The national expectation is that throughout Covid Recovery there will be a growth in the size of waiting lists across the country before any reduction is seen.
-Referral rates in quarter 2 whilst remaining broadly in line with the average over Qtr. 1, have stabilised. In Qtr. 1. the greatest monthly variance from quarter average was 657 with a total range of 1160 from lowest monthly to the greatest number of monthly, whereas the greatest variance from quarter average for Qtr 2 was only 18 with a total range of 37 from highest month to lowest month. As, such, managing capacity has been significantly easier.
-Total clock stops increased in September to 5035 an increase of 470 from the previous month, and the highest figure this year since May.
-Admitted clock stops increase from 926 to 1050 (21% of all stops), with non-admitted stops increasing from 3639-3985(79% of all stops).

Actions (SMART):

Analysis of performance demonstrated a number of contributory factors including:-
Ongoing impact of non-elective pressures and NC2R above and beyond forecast for SFT and across the System, and escalation into DSU.
Theatre Workforce.

Further actions include:
Ongoing support for weekend operating lists, including high volume specialties such as Plastics.
Focused and dedicated OD and Recruitment support for Theatres, including weekly task and finish group established to drive recruitment.
Analysis of non-admitted OPD clock stops.

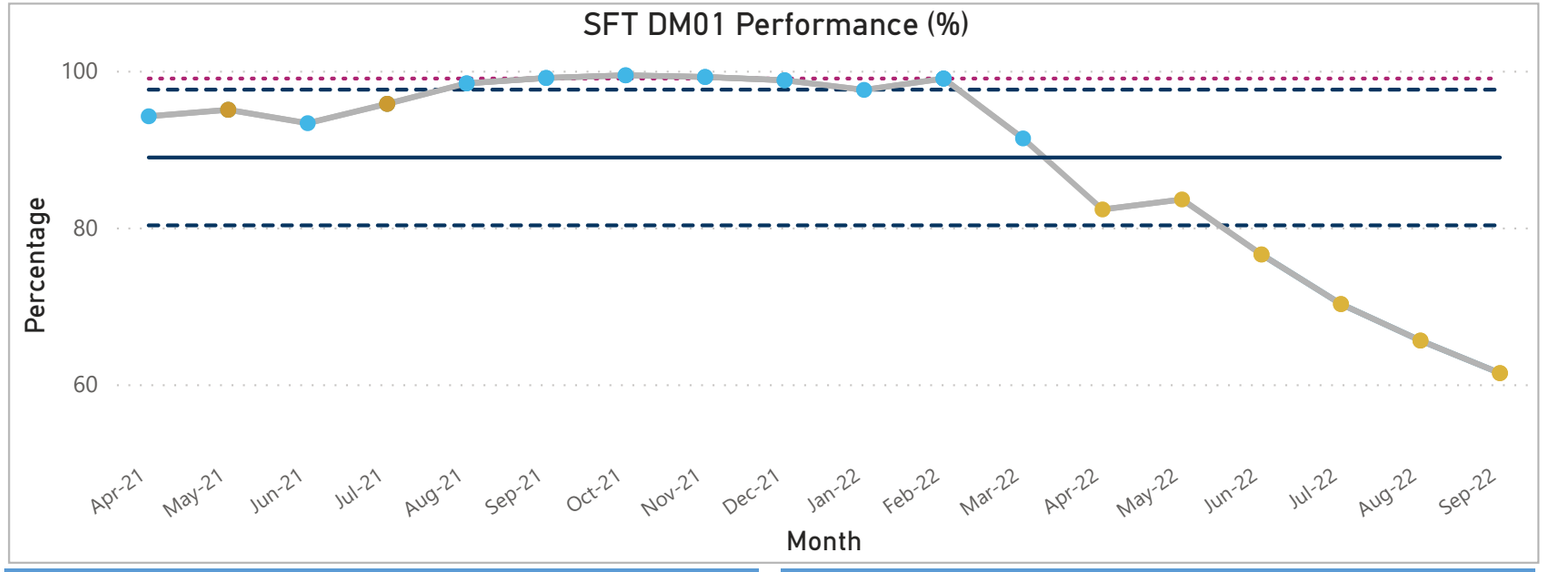
Risks and mitigations:

-Non elective flow continues to place significant pressure on elective programme, not least Day-case/Elective activity, and is increasingly a risk to the Trust meeting its national plan requirements at year end.
-Challenges across the workforce continue to present challenges, with mitigation balancing the tensions between financial prudence and target achievement, in sourcing locum cover and/or agency staff to cover gaps in staffing.
-Management of Covid related absence continues in line with Trust guidance, however SFT is experiencing higher volumes of Covid positive patients.
-Planning for winter continues, including acquisition of capacity at South Newton, in order to mitigate the effects of increased non-elective demand upon the elective recovery programme and any additional Covid-19 wave.

Diagnostic Wait Times Performance (DM01)

Target 99%

National Key Performance Indicators



Performance Latest Month: 61.4%

Waiting List Volume: 3283

MRI	52.5%	CT	92.4%
US	51.1%	DEXA	100.0%
Audio	29.3%	Cardio	48.9%
Neuro	100.0%	Colon	92.5%
Flexi Sig	84.8%	Gastro	94.9%

Understanding the performance:

-Performance in M6 reduced compared to M5. A total of 2530 patients breached the performance target, which represents an increase from 2060 breaches in M5. Key modalities that continue to have high numbers of breaches are MRI, USS and Echo with 538, 1465 and 294 breaches respectively. However for Echo this does represent a reduction in the number of breaches (reduced from 335 in M5.) USS continues to be a key area of concern with breaches increasing by 31% in month, having seen a 64% increase in M5. Activity overall increased in M6 from 6672 to 6922 patients. Modalities with activity reductions in month were Endoscopy 43, from 69 in M5, due to Endoscopy Nurse Practitioner sickness.

Actions (SMART):

-Incentivised overtime rates in MRI and USS continue to be in place to sustain core activity and to increase weekend elective lists where possible. This will continue for at least the next 6 months whilst longer term solutions are identified.
-Successful recruitment in Audiology, new starter expected in Dec.
-Revision of roles in Echo to increase banding of senior Echo Physiology roles and vacancies advertised.
-Business case for Echo Support roles being pursued although expect at least 4-6 month timeframe for this to realise capacity (if approved).
-Mini competition placed by procurement for insourcing USS options, closing end October.
- Performance update paper presented to F&P committee 27/9/22.

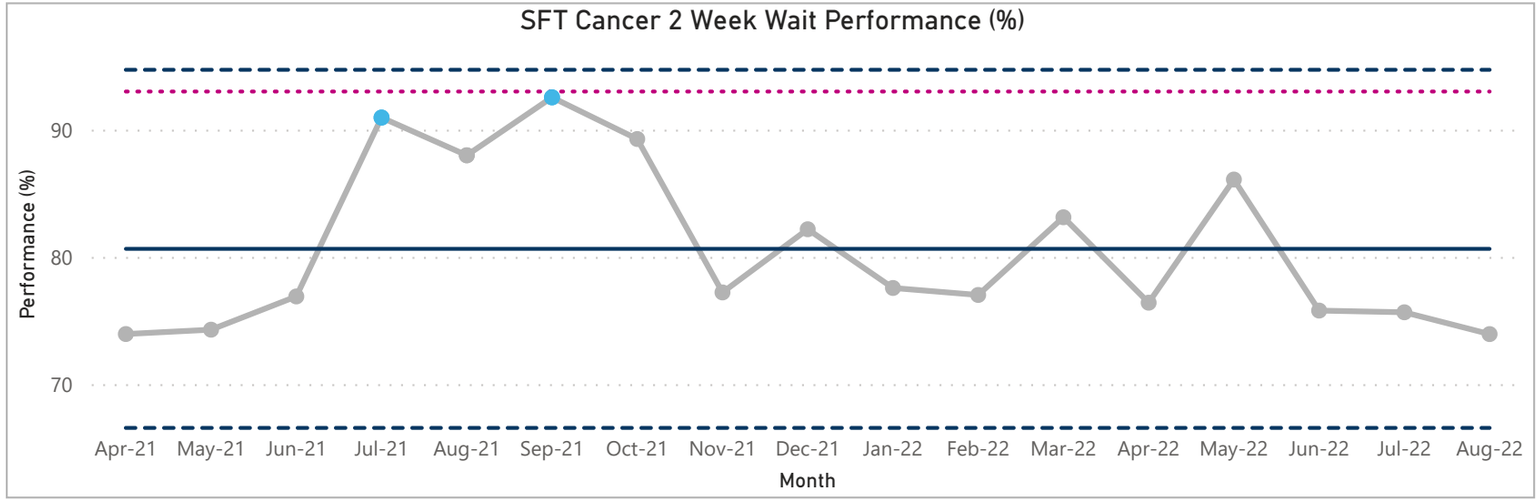
Risks and mitigations:

-Improvements in the overall Trust performance are all dependent on resourcing temporary staff and/or on overtime for existing workforce.
-Unable to appoint new substantive staff.
-Filling vacancies, Out/insource options, internal overtime, incentivised rates, RRP for current staff.
-Inability to identify out/insource options for USS and Echo.
-Redesign service spec to encourage responses from other providers.
-Vetting/audit of referrals, Communication with primary care, increase to establishment/temporary staffing etc. to increase capacity.
-Reduction of scanners - unable to increase capacity.
-MRI mobile van replaced with more reliable scanner to be able to use for full amount of sessions. MRI1 replacement project.

Cancer 2 Week Wait Performance

Target 93%

National Key Performance Indicators



	Performance	Num	Den	Breaches
Two Week Wait Standard:	73.9%	834	1128	294
Two Week Wait Breast Symptomatic Standard:	94.4%	34	36	2

Understanding the performance:

There have been challenges within the organisation around the 2WW Performance for some months. Unfortunately, the month of August was shown as a non-compliant month – this is mainly due to two key areas: Lower GI and Skin. These are by far two of our busiest tumour sites at the trust and there are current challenges within the STT (Straight-to-test) pathway within - Colorectal due to staffing issues within Endoscopy. We are also currently challenged with the Skin Cancer Pathway due to a rise in number of referrals and issues with capacity for first appointments with the Plastics team. In comparison to August 2021 the trust has seen a 12% increase in the number of suspected cancer referrals for the same period in 2022. The pressures with both these pathways are also felt across some of our neighbouring trusts as well as nationally.

Actions (SMART):

Skin is looking to increase capacity and are currently in the process of recruitment for a locum consultant, they have also managed to extend a plastic surgeon who started in September which should enable the team free up capacity.

An additional 3 Gastroenterologists have been appointed and started in September which will enable additional capacity within Endoscopy.

Regular Cancer Improvement group has been set-up to enable oversight of potential risks and challenges within services.

Risks and mitigations:

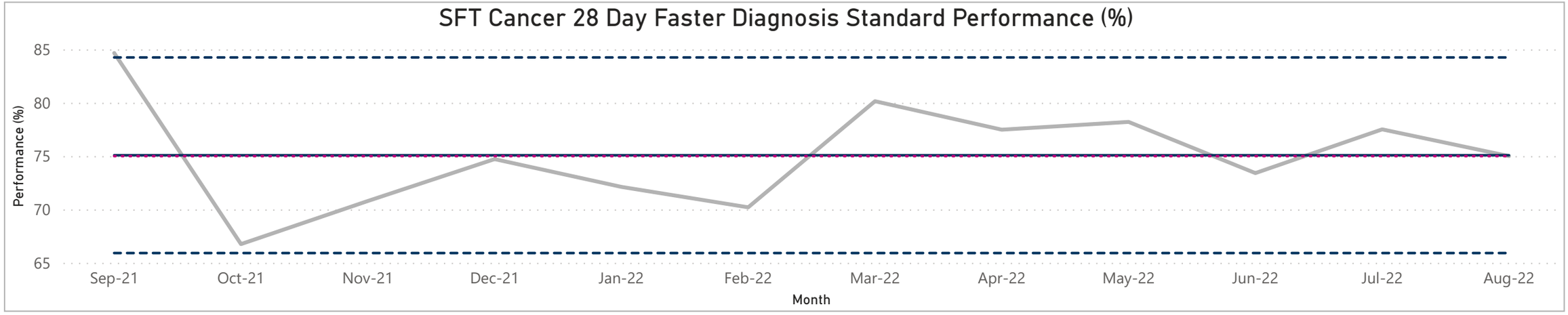
Overall increase in referrals for rapid access suspected skin cancer but service exploring tele dermatology to provide additional support as well as additional clinics

Anticipating this will see a reduction in the number of 2WW breaches attributed to Endoscopy capacity but may take some time to recover.

Anticipating this will see a reduction in the number of 2WW breaches attributed to Plastics OPA capacity but may take some time to recover.

Cancer 28 Day Faster Diagnosis Standard Performance — Target 75%

National Key Performance Indicators



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

Understanding the performance:

Our 28 day performance is being supported by the fantastic work being done within the Breast and Dermatology team in being able to inform the patients of their diagnosis within the 28 days of receipt of referrals. We are currently seeing challenges within Urology and Colorectal with Prostate Biopsy capacity being a major bottleneck of the pathway.

We are also facing challenges within support services / diagnostics such as Radiology and Histopathology mainly around reporting times which adds valuable time onto a patient's pathway ensuring this is rectified is essential to our ability to achieve the 28d FDS Standard. We are anticipating more challenges with these services going forward which may have an ongoing effect on our ability to achieve the FDS Standards.

Actions (SMART):

A piece of work is being done by Cancer Services around the Prostate Pathway in conjunction with the service to try and improve the pathway and to model on the best practice timed pathway.

New consultant is due to start at the end of October within Urology which should increase the capacity of template biopsy as well as a nurse being trained to complete template biopsies.

Work is being done to obtain mobile PET-CT scanner on site at Salisbury which will give our patients access to a scanner which will increase capacity and enable patients to have access to this being done at Salisbury which is more accessible for our patients. This is awaiting sign off in November TMC.

Risks and mitigations:

Histopathology will continue to be challenged with news that our outsourced pathology service has had cease excepting any Skin pathology due to staff shortages. Histopathology at Salisbury will still prioritise Cancer pathway patients via MDT escalation whilst alternative options are being explored.

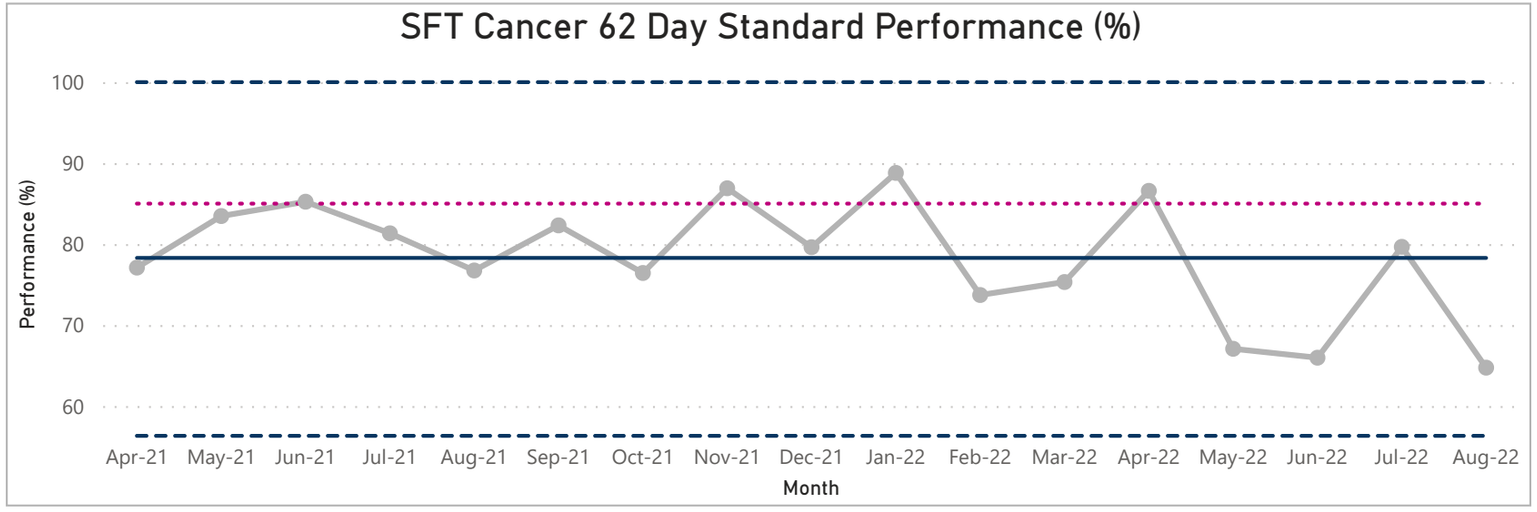
Training of nurses to do template biopsies will take time, and new Consultant not due to start until end of October. Triage processed has been changed and MRI scans being requested at point of triage which will help with wait times.

PET-CT is under the alliance so will be used not solely by Salisbury Hospital patients. This is additional capacity so should decrease the current waiting times for PET-CT.

Cancer 62 Day Standard Performance

Target 85%

National Key Performance Indicators



	Performance	Num	Den
62 Day Standard:	64.7%	51	78
62 Day Screening:	100.0%	4	4

Understanding the performance:

Our 62 day Performance will reflect the challenges we face within 2WW and 28d standards and the challenges with Radiology, Histopathology as well as Urology and Colorectal are reflected as they received the larger proportion of breaches for August.
We do not have a huge margin for error with 85% compliance and we received almost double the number of breaches than we would like in order to be compliant.

We are aware of challenges within the sector for Surgery / RT dates, but we also must ensure we are working up our patients within a timely manner to transfer their care by day 38 to the tertiary centres. We are also aware of challenges with our ability to deliver chemotherapy at present due to staff shortages within the Chemo suite.

Actions (SMART):

A regular Cancer Improvement group has been set-up to enable oversight of potential risks and challenges within services / radiology and histopathology. This enables us to support services and escalate as appropriate internally.

Agency staff have been recruited to help the delivery of Chemotherapy and Oncology are exploring longer term options to ensure there are adequate staffing levels in chemo suite.

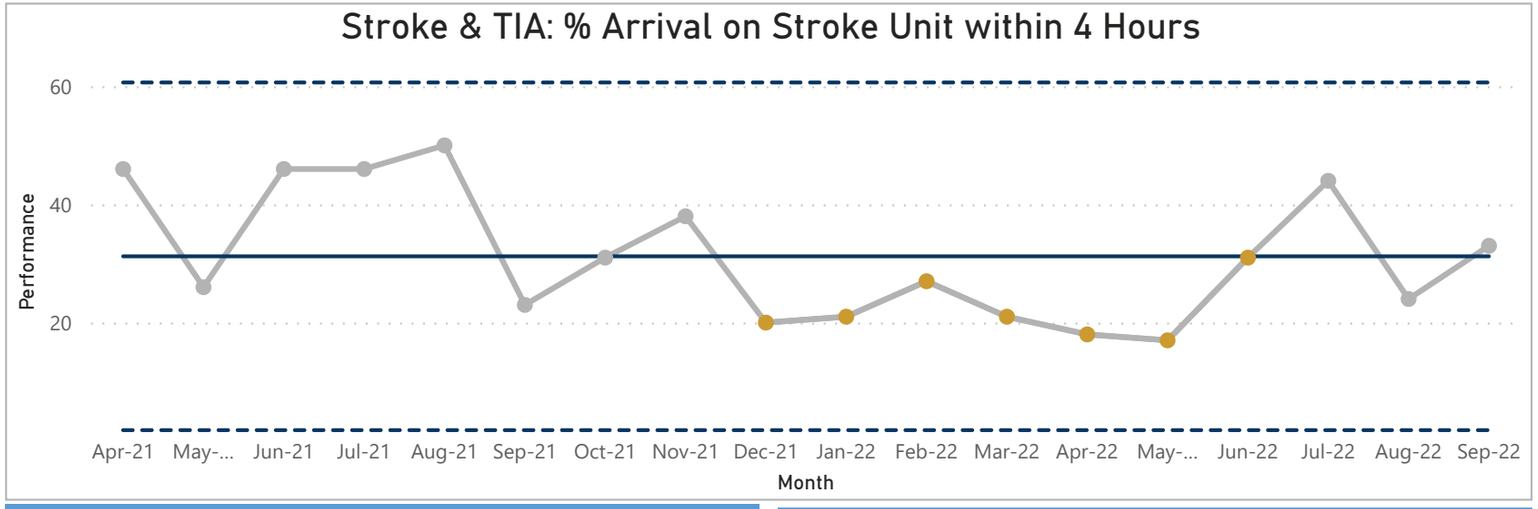
Risks and mitigations:

Histopathology will continue to be challenged with news that our outsourced pathology service has had cease excepting any Skin pathology due to staff shortages. Histopathology at Salisbury will still prioritise Cancer pathway patients via MDT escalation whilst alternative options are being explored.

PET-CT is under the alliance so will be used not solely by Salisbury Hospital patients. This is additional capacity so should decrease the current waiting times for PET-CT.

Stroke Care

National Key Performance Indicators



SSNAP Case Ascertainment Grade

Highest Level = Grade A
Lowest Level = Grade E

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

Understanding the performance:

The national target for arrival on stroke unit within 4 hours is 90%.

Patients arriving within the 4 hours will improve all other SSANP targets giving patients the appropriate care needed.

Ongoing challenges include bed pressures, with general medicine patients in stroke beds and moving the nursing staff to other wards often means that Farley does not have the appropriate staff numbers.

Actions (SMART):

Understanding the priority transfers from ED to Farley-Future simulation training for ED staff in recognising stroke symptoms.

Prioritise bed moves out of Farley to facilitate stroke patients transferring in.

Future meeting with ED Matron to create a plan going forward to help improve future targets.

To avoid moving nurses off the stroke unit.

Risks and mitigations:

Hyperacute stroke patients are at currently risk of worsening outcomes without access to specialist care in the appropriate time frame, which in turn increases length of stay.

To help improve this, meetings with medicine matrons and bed managers to discuss importance of a stroke patient arriving on the stroke unit within 4 hours
Weekly updates with SITE managers to discuss arising issues of transferring patients and staffing issues

To have beds allocated for stroke patients to improve transfer time.

Maternity

Are We Safe?

SFT Assurance Dashboard		Guidance	Standard	Aim For	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22
Perinatal Morbidity and Mortality (M&M)	Number of late fetal losses (22+0 to 23+6 weeks excl TOP)			-	0	0	0	0	0	0
	Number of stillbirths (> + 24 weeks excl TOP)	ONS	3.8 per 1000 live births	-	0	0	0	1	0	0
	Number of neonatal deaths : 0-28 days	ONS	2.7 per 1000 live births	-	0	1	0	0	0	0
	Medical termination over 24 +0 registered			-	0	0	1	0	0	0
Maternal M&M	Number of Maternal Deaths	ONS	9.1per 100,000 women who delivered	-	0	0	0	0	0	0
	Number of women requiring admission to ITU	6 month SFT rolling		-	0	0	2	0	0	0
Insight	Number or Datix incidents - moderate or above	6 month SFT rolling		-	1	2	3	1	4	2
	Datix incidents moderate harm (not SII)	6 month SFT rolling		-	0	1	3	3	4	1
	Datix incidence SII	6 month SFT rolling		-	0	1	0	3	0	0
	HSIB referrals	6 month SFT rolling		-	0	0	0	0	0	1
	HSIB/NHSR/CQC or other organisation with a concern or request	6 month SFT rolling		-	0	0	0	0	0	0
	Coroner Reg 28 made directly to trust	6 month SFT rolling		-	0	0	0	0	0	0
Workforce	Minimum safe staffing in maternity services :Obstetric cover - hours	RCOG guidence		-	40	40	40	40	40	40
	Midwife to Birth ratio	RCM;NHSR;BR +	1.28	-	1.31	1.32	1.32	1.32	1.33	1.35
	Midwifery vacancy rate (black= over establishment; red =under			up	17.2	17.4	18.8	20	19.64	19.65
	Provision of 1 to 1 care in established labour (%)	NICE, RCM, MIS	100%	-	100	100	100	100	100	100
	Datix relating to workforce	6 month SFT rolling		-	3	1	0	2	1	1
	Compliance with supernumery status of the LW coordinator - %	NICE;RCM;NHSR	100% rostered	-	100	100	100	100	100	100
	Numbers of times maternity unit on divert	6 month SFT rolling		-	0	0	0	0	0	0
Involvement	Service user feedback : Number of Compliments	6 month SFT rolling		-	27	27	31	31	21	31
	Service user feedback : Number of Complaints	6 month SFT rolling		-	2	0	1	1	4	2
	Number of SOX	6 month SFT rolling		-	8	7	6	5	2	7
Assurance	Progress in achievement of 10 safety actions(CNST)	NHSR	10	-	5	5	5	5	5	5
	Training compliance - MDT PROMPT %	NHSR	90%	-	72.3	83.6	86.5	86.2	77.0	77.0
	Term babies admitted to NNU unexpectedly %	NMPA	<5.8%	-	1.82%	4.73%	2.31%	4.62%	6.10%	5.82%
	Term babies admitted to NNU unexpectedly			-	3	8	4	8	10	11

Understanding the performance:

1 x HSIB referral. Baby collapsed post birth and subsequently transferred to tertiary unit and received therapeutic cooling. This fitted HSIB criteria and thus being investigated.

Midwifery vacancies remain high impacting midwife to birth ratio.

Actions (SMART):

We have received the external audit for year 4 MIS and a plan is in place to review this and address outstanding safety actions.
Midwifery staffing vacancies being addressed. Involved in international recruitment collaboration and awaiting the start of seven international midwives. Four newly qualified midwives commencing at the trust in October. When these staff are in post midwife to birth ratio should fall inline with national recommendations. Further advertising for nurses to support postnatal care for women and to complete some postnatal midwifery roles.
Extra Prompt session in October.

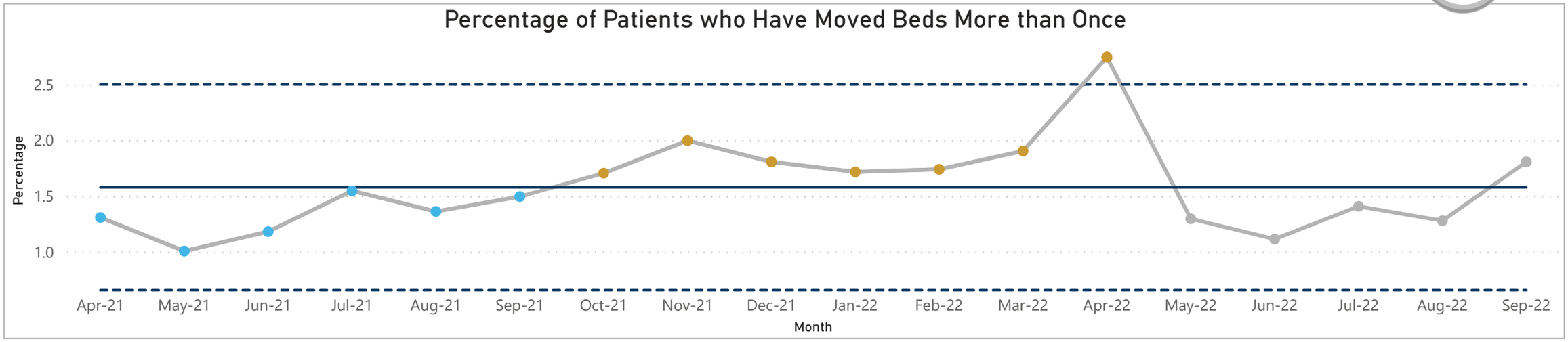
Risks and Mitigations:

Escalation policy being followed to ensure appropriate midwifery staffing on shifts, and ensuring women receive 1:1 care, whilst staffing vacancies are high.

International recruitment through collaboration proceeding. 1 x midwife commenced employment in September and 3 starting in November, they will be working as band 4s until OSCE completed and will then move onto the rota to become part of midwifery numbers.

Patients Who Have Moved Beds More Than Once

Are We Safe?



Understanding the performance:

Patients being moved more than once has crept up since the summer and is increased on this time last year.

Trust capacity due to demand, restricted flow, staffing and the requirement to provide specialism appropriate care to acute patients has been a factor in this area. Additionally the Trust has begun to see an increase in the number of covid positive patients requiring isolation either in the covid unit or in a sideroom in a specialty.

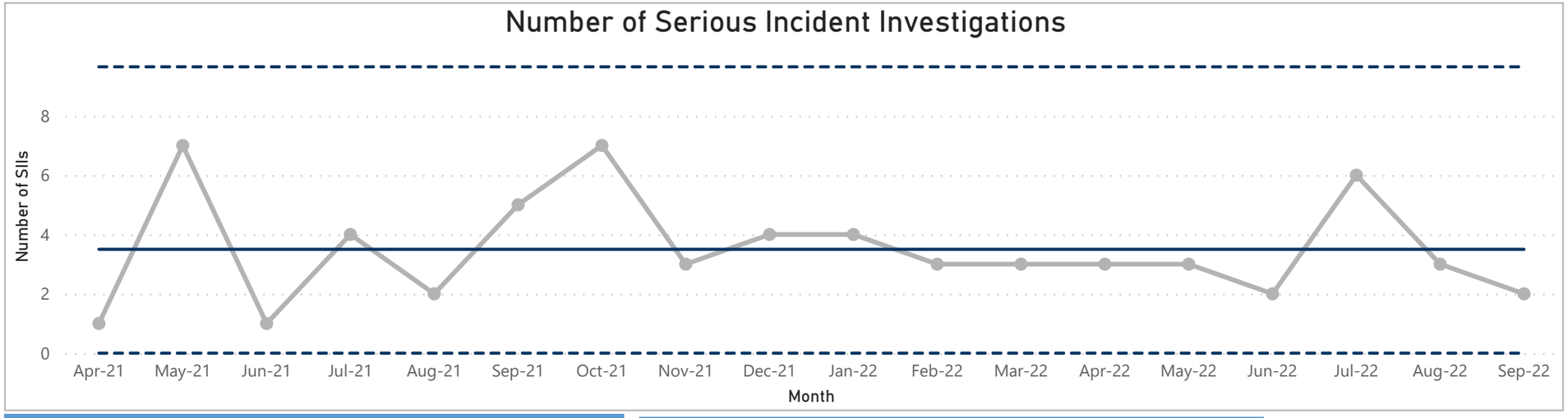
Actions (SMART):

Risks and mitigations:

All efforts regarding flow, safe patient placement and good quality patient experience continue, and is an area of constant consideration in the operational delivery of inpatient services at SFT. Capacity that increases as a result of this will allow for fewer moves.

Incidents

Are We Safe?



Year	2021-2022	2022-2023
Never Events	3	0

Understanding the performance:

There was one SII commissioned in September -
SII 510 (women and newborn)- Term admission to NICU.

There were no never events in September.

Actions (SMART):

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

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

Risks and mitigations:

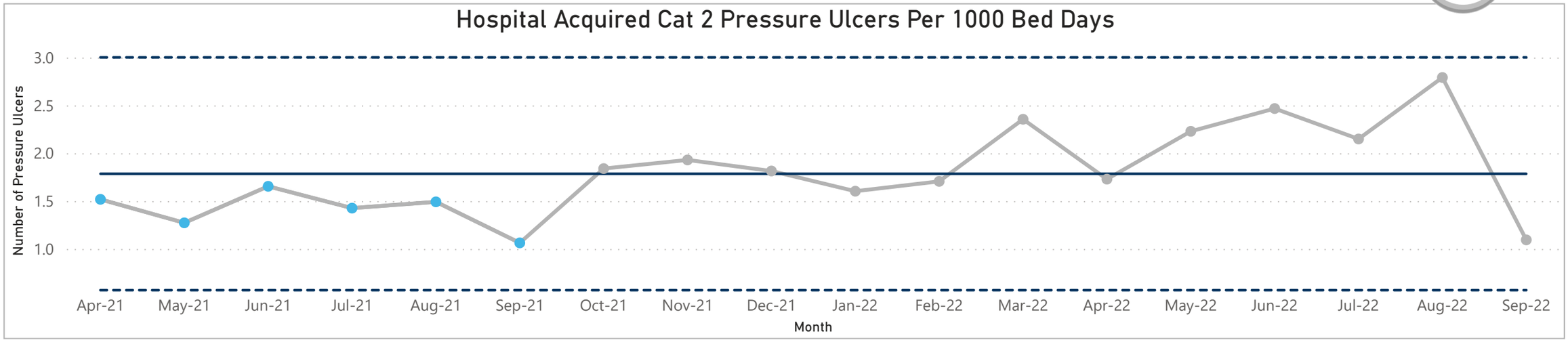
Once an incident has been identified and a 72 hour report completed, it will be established as to whether there are immediate safety actions that need to be implemented or escalated immediately.

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

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

Pressure Ulcers

Are We Safe?



Understanding the performance:

21 Hospital acquired PUs in September:

· 16 Cat 2 PU's- This is a significant decrease of 25 PUs (41 cat 2 PUs in August) Significant decrease in PUs on Amesbury ward after commencing bitesize teaching sessions and involvement from senior ward team to improve practice.
· 5 DTI's- This is a decrease from August 2022 (10 DTIs in August) Reduction in heel DTIs likely due to increased preventative orthotic boot use.
· No Unstageable PU's in September 2022
· No Cat 3 or 4 PUs in September 2022
· 25 Present on admission Cat 2 PUs in September 2022

Actions (SMART):

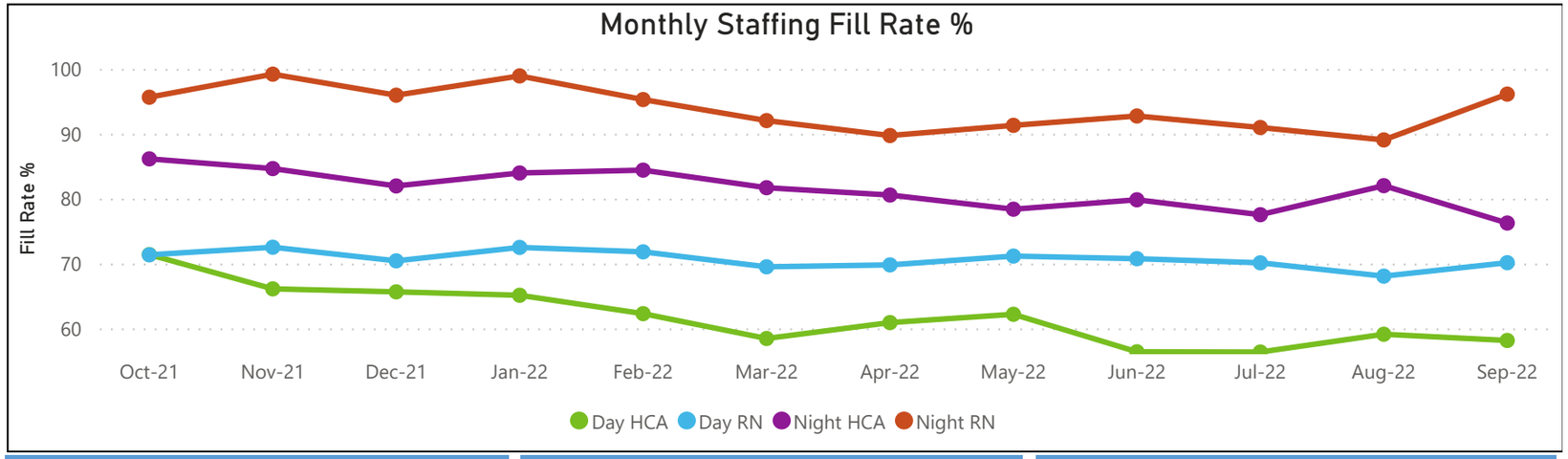
-Continue bitesize ward education (several wards arranging dates as their operational pressures allow)
-Upcoming change in Share and Learn reporting and investigation process for hospital acquired PUs starting November 2022 to improve compliance and gain more insight into themes of PUs and ward actions.
-Upcoming change in Safety Thermometer reporting; form now includes MASD and ALL categories of PU for more accurate reporting and validation.
-Review of pressure relieving mattress delivery to wards completed and showed no delay in delivery. This review was undertaken as an action from Share and Learn after Ward reports of delays. This will be taken back to Share and Learn in October for further discussion with ward leads.

Risks and mitigations:

-Due to the current operational pressures across the Trust, there is potential that September PU figures may not be a true representation of the data as there may have been missed PU identification or unreported PUs. October PU figures will allow us to review if this downward trend continues.
-Ongoing staffing concerns mean potential for delays in pressure area care for patients, poor uptake in education and training and delays/barriers to conducting ward based education.
-Mini RCA documents are not being completed for all hospital acquired Cat 2 PUs despite clear time frame for completion.
-Lack of ward lead engagement in PU investigation process.

Nurse Staff Fill Rate

Are We Safe?



Ward	Day RN	Night RN	Day HCA	Night HCA
Amesbury	80%	102%	65%	110%
Breamore	53%	85%	40%	64%
Britford	100%	99%	83%	74%
Chilmark	85%	124%	59%	75%
Downton	118%	121%	68%	114%
Durrington	72%	89%	58%	101%
Farley	78%	88%	51%	89%
Hospice	99%	101%	69%	111%
Longford	75%	108%	71%	86%
Maternity	90%	96%		
NICU	101%	101%	0%	
Odstock	98%	98%	80%	84%
Pembroke	91%	101%	37%	83%
Pitton	91%	116%	75%	90%
Radnor	80%	81%	57%	65%
Sarum	88%	95%	69%	
Spire	74%	98%	75%	90%
Tisbury	70%	91%	56%	79%
Whiteparish	81%	87%	66%	93%

Understanding the performance:

-Whilst it appears there is encouraging sharp increase in RN coverage at night, and slight improvement in RN day time coverage, when reviewing this figure with Sept planned CHPPD, the number actually fell from 8.2 (M5) to 7.7 (M6) which has the effect of negating any evident increase. (less planned/required RN hours creates an apparent proportionate fill rate).

-Decline in HCA fill rate is linked to ongoing vacancy gap and anticipate some impact due to the end of the summer incentive scheme. Allocation on Arrival incentive remains in place (£5 per hour uplift for AOA).
-M6 CHPPD 6.3 (M5 6.9) broken down as RN 4.3 (M5 4.5) and HCA 2.1 (M5 2.4)

Actions (SMART):

-Task and Finish action group commissioned by CEO led by DCNO to explore and consider all possible actions and incentives to increase fill rate, retention and alternatives to ward support 26/09/22.
-Plans to feed back in to winter planning meetings 05/10/22.
-COO, DCNO, CPO to work through, cost and implement plans during October.
Although not all confirmed, current plans:
-Increase basic rate of B2 pay to top of band
-Recruit to B2 non clinical support/housekeeper role and discharge coordinators to wards.
-Develop B3 senior HCA role.
-Winter incentive payment scheme.

Risks and mitigations:

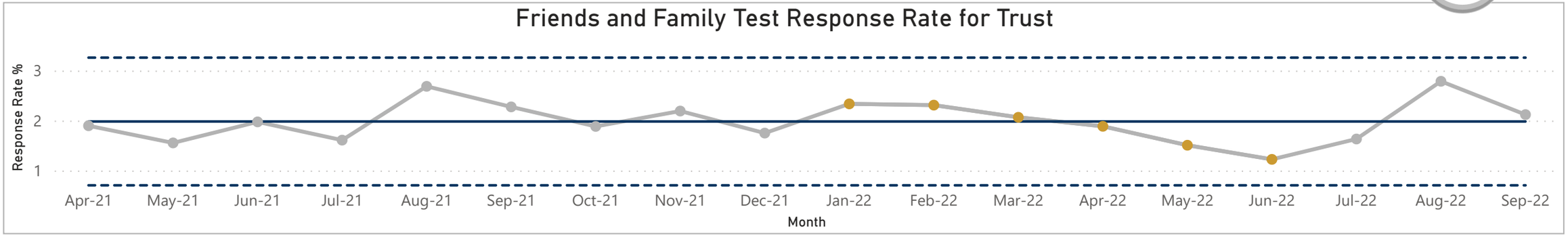
-Ongoing high turnover rate and vacancy gap Competitive market for recruitment of lower banded unregistered roles with restrictions of Agenda for Change terms and conditions and competing supermarkets.

-Weekly HCA recruitment events with twice monthly boarding needing established induction program (in hand but on site space limited so sourced external options).

-International recruitment ongoing with 55 planned by end of December and bidding for further 40 in Q4 in partnership with NHSE.

Friends and Family Test Response Rate

Our Care



Response Rate by Area	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22
FFT Response Rate - A&E	0.3%	0.0%	0.0%	0.1%	0.1%	0.0%	0.2%	0.0%	0.2%	0.1%	0.3%	0.4%
FFT Response Rate - Day Case	5.8%	7.1%	6.9%	10.1%	5.3%	5.0%	4.8%	4.6%	3.3%	4.6%	8.9%	6.8%
FFT Response Rate - Inpatient	8.0%	11.2%	6.9%	13.4%	9.5%	7.1%	5.7%	7.1%	6.8%	7.5%	10.9%	11.5%
FFT Response Rate - Maternity	2.4%	6.6%	10.8%	0.9%	2.5%	5.9%	11.5%	0.9%	0.4%	1.6%	7.8%	1.1%
FFT Response Rate - Outpatient	1.1%	1.1%	0.8%	0.9%	1.6%	1.6%	1.3%	0.8%	0.6%	0.9%	1.5%	0.9%

Understanding the performance:

-The NHS Friends and Family Test (FFT) was created to help service providers and commissioners understand whether patients are happy with the service provided, or where improvements are needed. It's a quick and anonymous way to give views after receiving NHS care or treatment Areas are encouraged to offer feedback forms to patients at discharge or during their stay. Weekly emails are sent to leads showing feedback received in the previous week, allowing them to pick up any immediate causes for concern and mitigate these where possible.
-Negative feedback is review by the ward and PALS, twice a year.
-FFT responses we slightly lower that last month but still a big improvement on what has been received lately. Staff are being encourage to offer FFT by the PALS outreach service.

Actions (SMART):

Long-term action: Securing a provider to gather patient feedback via SMS will be key to moving towards achievement of our objectives under the Improving Together Programme over the next 6-12months:
Aims:
-Increase overall response rates to FFT
-Diverse methods for completion (including, online, SMS, over the phone)
-Increased accessibility and options for inclusivity (sight impairments, languages and additional demographic options)
-Robust analysis of data for insight and meaningful
-comparison/benchmarking via a real-time dashboard
-Opportunity to align our processes in FFT across the ICS.

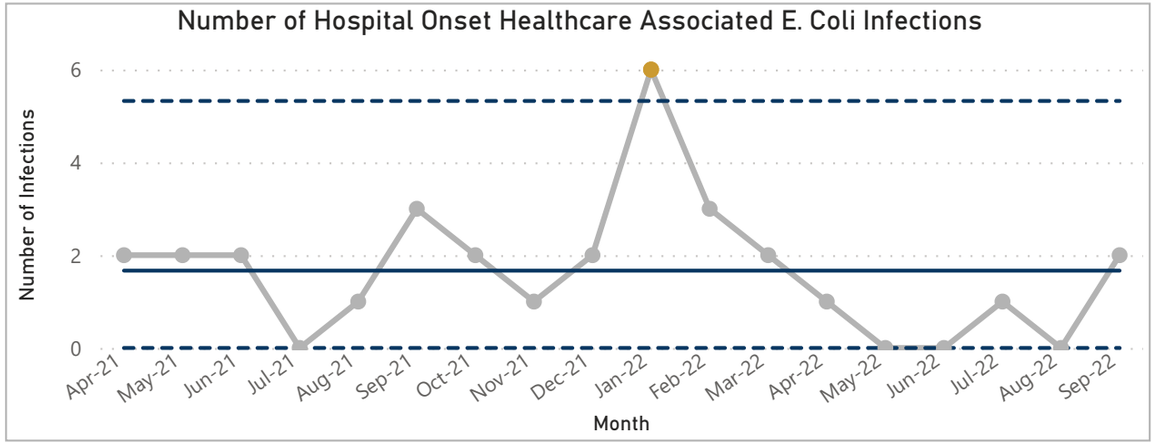
Risks and mitigations:

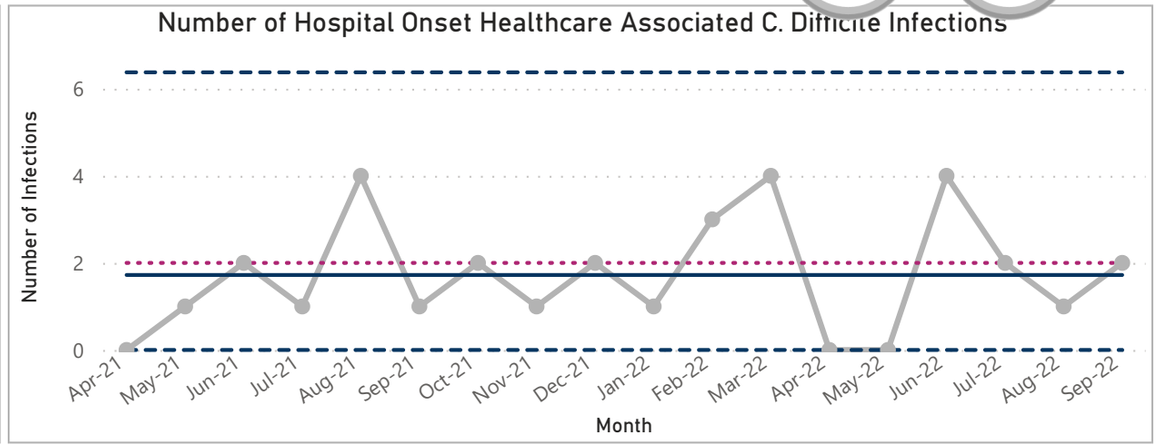
Continued low response rate, due to limited methods for accessibility and the reliance on staff to promote completion of a physical card, this is directly impacted when there are staff shortages and operational pressures. The current method requires manual input and theming, which there is limited resource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

-Procurement have secured a suitable provider to address both risks (as per the Actions). The provider currently works with Great Western hospital and will also be joining Bath. Implementation planned for Autumn 2022 .

Infection Control

Are We Safe?





Year	2021-2022	2022-2023
MSSA Bacteraemia Infections: Hospital Onset	12	5
MRSA Bacteraemia Infections: Hospital Onset	0	0

Understanding the performance:

-There were two hospital onset healthcare associated reportable E.coli bacteraemia infections and two hospital onset healthcare associated reportable C.difficile cases this month. We are not exceeding set trajectories for 2022/23 for these specific reportable cases.
-The previously reported period of increased incidence of C.difficile declared for an inpatient area within the surgical division has been closed. There were no links identified from the ribotyping of the samples sent to the external reference laboratory.
-The Infection Control Nurses (ICNs) continue to undertake targeted ward visits and utilise educational opportunities with different staff groups.
-Small practice improvements with infection prevention and control compliance noted from individual staff interactions undertaken, with the aim of sharing information with their colleagues.

Actions (SMART):

-Completed trial of alternative approach for staff in ward areas to complete hand hygiene education and assessments. Process for evaluation and review required by the division to ensure full compliance to enable roll out to another ward area to be progressed.
-Completion of required case investigations by clinical areas to identify good practice and any new learning.
-Feedback required by clinical areas at 'Share & Learn' meeting to enable agreement of actions moving forward from any themes/trends identified from all cases.
-Involvement with BSW collaborative workstreams related to IPC and Gram-Negative Bloodstream Infections (GNBSIs).

Risks and mitigations:

-Increased clinical workload for IPC nursing team including managing COVID-19 outbreaks, impacting focus on other HCAI prevention work.
-Ongoing nursing vacancy within the IPC team which has delayed the ability for the service to undertake additional educational activities and policy practice reviews. Secondment plan for position initiated.
-An underlying risk continues to be a potential increase in incidence of reportable healthcare associated infections with poor patient outcomes and Trust exceeds agreed trajectories.
-Variable staffing levels reported by clinical areas affecting ability to facilitate learning in ward environment.
-Poor return of completed case investigation documentation by relevant clinical areas, therefore no evidence of learning.
-Limited evidence of IPC practice assurance by the clinical divisions due to operational challenges/workload pressures for teams.
-No progress on IPC collaboratives with BSW colleagues.

Mortality

Are We Safe?

Metric Name	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22
HSMR District Hospital (excludes deaths recorded by Salisbury Hospice)	100	102	100	101	102	102	103	106	105	101	104	107	109					
HSMR Trust	111	108	109	108	108	109	110	110	113	113	109	111	116					
SHMI District Hospital (excludes deaths recorded by Salisbury Hospice)	98	100	101	101	101	102	102	102	102	104	105	107	106					
SHMI Trust	103	105	106	106	106	107	107	107	107	108	109	111	110					
Total Mortalities	63	76	62	68	69	65	64	79	94	86	84	84	88	84	77	88	82	73

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

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

Understanding the performance:

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

The SHMI for the 12-month rolling period of May 2021 to April 2022 for Salisbury District Hospital is 1.0680.

The HSMR for the 12-month rolling period of May 2021 to April 2022 for Salisbury District Hospital is 109.9416.

Actions (SMART):

N/A

Risks and mitigations:

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

A representative from our Partner organisation, Telstra Health UK (Dr Foster), is invited to attend in order to help us to interpret and analyse our mortality data and identify variations in specific disease groups.

Where alerts are generated, these are discussed and a further review of the patient's records may be undertaken.

Watch Metrics: Alerting

Quality of Care, Access and Outcomes

Metric	Two Months Ago	Last Month	This Month	Improvement Target	National Target	Variation	Variation Detail	Assurance
% Beds Occupied	96.7%	95.5%	96.2%				Special Cause Concerning - Run Above Mean	
% of Total Incidents Resulting in High Harm (Mod/Maj/Cat)	27.0%	29.0%	32.0%				Special Cause Concerning - Run Above Mean	
Ambulance Handovers 30-<60 mins	132	145	157				Special Cause Concerning - Run Above Mean	
Ambulance Handovers 60+ mins	187	106	187		0		Special Cause Concerning - Two Out of Three High	
Average hours lost to Ambulance Handover delays per day	19	13	20				Special Cause Concerning - Two Out of Three High	
Average Patients with No Criteria to Reside	128	127	126	35			Special Cause Concerning - Two Out of Three High	
DM01 Waiting List Volume	5647	5984	6558				Special Cause Concerning - Above Upper Control Limit	
ED 12 Hour Breaches (Arrival to Departure)	86	68	116		0		Special Cause Concerning - Above Upper Control Limit	
ED Attendances	6538	6175	6191				Special Cause Concerning - Run Above Mean	
Proportion of patients spending more than 12 hours in an emergency department	1.9%	1.6%	2.7%				Special Cause Concerning - Above Upper Control Limit	
Total Number of Compliments Received	10	0	4				Special Cause Concerning - Run Below Mean	
Trust Performance RTT %	62.5%	62.4%	62.2%		92%		Special Cause Concerning - Below Lower Control Limit	

Watch Metrics: Alerting Narrative

Quality of Care, Access and Outcomes

Understanding the performance:

Metrics relating to the Emergency Department, DM01 and Ambulance handovers are related to the detail on dedicated slide earlier in the report.

Bed occupancy levels remain high as the level of operational pressure has been sustained across the year and likely to continue throughout the Winter months. There has been no improvement in the number of patients in the hospital not meeting the criteria to reside which drives increased occupancy levels.

Actions (SMART):

Winter planning is focused on Discharge, Supporting ED and Workforce. As part of this the Trust is developing options to create a Same Day Emergency Care (SDEC) unit, which will protect assessment capacity for rapid assessment and treatment of patients referred to the Acute Medical Unit. This will enable patients to receive treatment more quickly and increase the number that are able to be discharged on the same day.

Risks and Mitigations:

The trust continues to work with partner organisations to reduce delays in discharging patients who no longer need to be in an acute environment, if reductions are not able to be delivered this this will remain a significant risk to the delivery and recovery of operational standards.

Watch Metrics: Non-Alerting

Quality of Care, Access and Outcomes

Metric	Two Months Ago	Last Month	This Month	Improvement Target	National Target	Variation	Variation Detail	Assurance
Ambulance Arrivals	1140	1133	1099				Special Cause Improving - Run Below Mean	
Ambulance Handovers 15-<30 mins	253	282	281				Common Cause Variation	
Cancer 31 Day Performance Overall	94.5%	98.1%	94.3%		96%		Common Cause Variation	
Cancer 62 Day Screening Performance	28.6%	66.7%	100.0%		90%		Common Cause Variation	
Neonatal Deaths Per 1000 Live Births	0	0	0				Special Cause Improving - Run Below Mean	
Number of High Harm Falls in Hospital	0	0	0	0	0		Common Cause Variation	
Pressure Ulcers Hospital Acquired Cat 2	32	41	16				Common Cause Variation	
Pressure Ulcers Hospital Acquired Cat 3	0	0	0				Common Cause Variation	
Pressure Ulcers Hospital Acquired Cat 4	0	0	0				Common Cause Variation	
RTT Incomplete Pathways: Total 104 week waits	0	0	0		0		Common Cause Variation	
RTT Incomplete Pathways: Total 52 week waits	509	453	433				Special Cause Improving - Below Lower Control Limit	
RTT Incomplete Pathways: Total 78 week waits	66	48	46				Special Cause Improving - Below Lower Control Limit	
Serious Incident Investigations	6	3	2				Common Cause Variation	
Stroke & TIA: % CT'd within 1 hour	42.0%	44.0%	44.0%				Common Cause Variation	
Total Incidents (All Grading) per 1000 Bed Days	54	59	50				Common Cause Variation	
Total Number of Complaints Received	15	18	26				Common Cause Variation	

Watch Metrics: Non-Alerting

Quality of Care, Access and Outcomes

Metric	Two Months Ago	Last Month	This Month	Improvement Target	National Target	Variation	Variation Detail	Assurance
% of Inpatients Undergoing VTE Risk Assessment	99.1%	99.2%	99.3%		95%		Common Cause Variation	
Mixed Sex Accommodation Breaches			89	0	0		Common Cause Variation	
Outpatient follow-up activity levels compared with 2019/20 baseline	%	%	%					
Performance against relevant metrics for the target population cohort and five key clinical areas of health inequalities	%	%	%					
Pressure Ulcers Hospital Acquired Cat 2	32	41	16				Common Cause Variation	
Proportion of acute or maternity inpatient settings offering smoking cessation services	%	%	%					
Stillbirths Per 1000 Total Births	5	0	0				Common Cause Variation	
Total diagnostic activity undertaken compared with 2019/20 baseline	%	%	%					
Total elective activity undertaken compared with 2019/20 baseline	%	%	%					
Total patients treated for cancer compared with the same point in 2019/20	%	%	%					
Total patients waiting over 62 days to begin cancer treatment compared with baseline	%	%	%					

Part 3: People

Performance against our Strategic Priorities and Key Lines of Enquiry

Salisbury NHS Foundation Trust

Our Priorities

Population

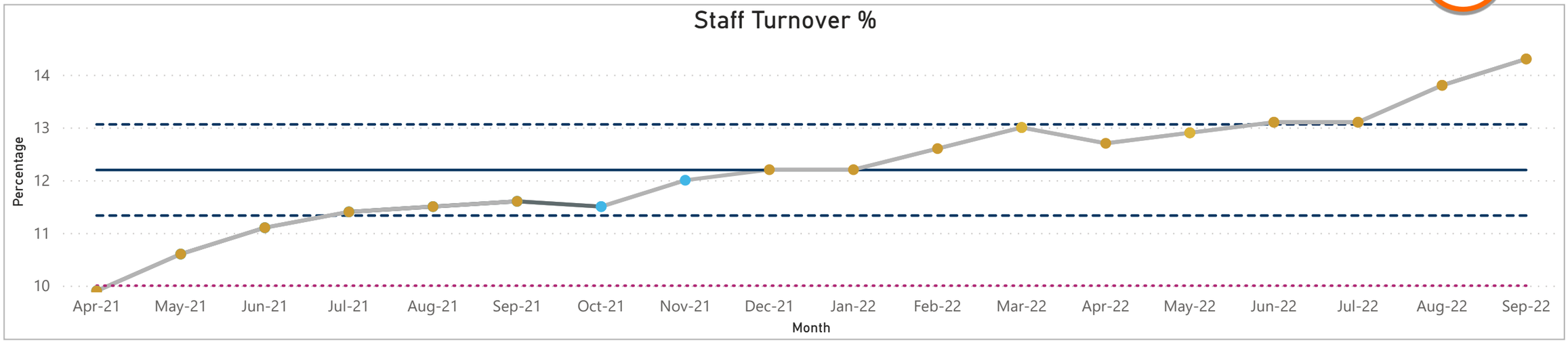
Partnerships

People

Workforce - Turnover

Target 10%

People



Understanding the performance:

For a second successive month the rolling 12-month turnover data sees a rise, reaching 14.32% for September. All Divisions are now rated red against the KPI target, with Women and Newborn at 19.91% the division with highest turnover and Surgery (12.71%) the lowest.
Despite the increase in turnover, the number of starters was higher than leavers by a little under 7 FTE, a small indicator of progress overall.

Of the 561 leavers in the 12 month rolling period, only 20% completed the exit survey, and just under 10% of the total leavers indicated they would be joining another NHS organisation, thus 90% of staff are lost to the NHS. The main underlying themes for leaving remain retirement, flexible working and promotion.

Actions (SMART):

Women and Newborn have started a number of initiatives to improve retention. Staff have requested greater flexible working options and work patterns to accommodate this desire are being identified. Maternity department have improved induction, including new buddy system for new starters to support MCA, a high turnover area and there is a new retention lead in the Division.

Career conversations in CSFS have picked up pace and Surgery are targeting Admin and Clerical Staff (a key turnover area) initially. 'Go and See' events have been targeted with Central Booking staff to continue to support retention in this high turnover staff area.

Risks and mitigations:

Corporate Risk – Sustainable Workforce. Action plans include: Delivery of wellbeing website and financial planning sessions

Appraisal Project is nearer its completion milestone, final meeting held 13 Oct.

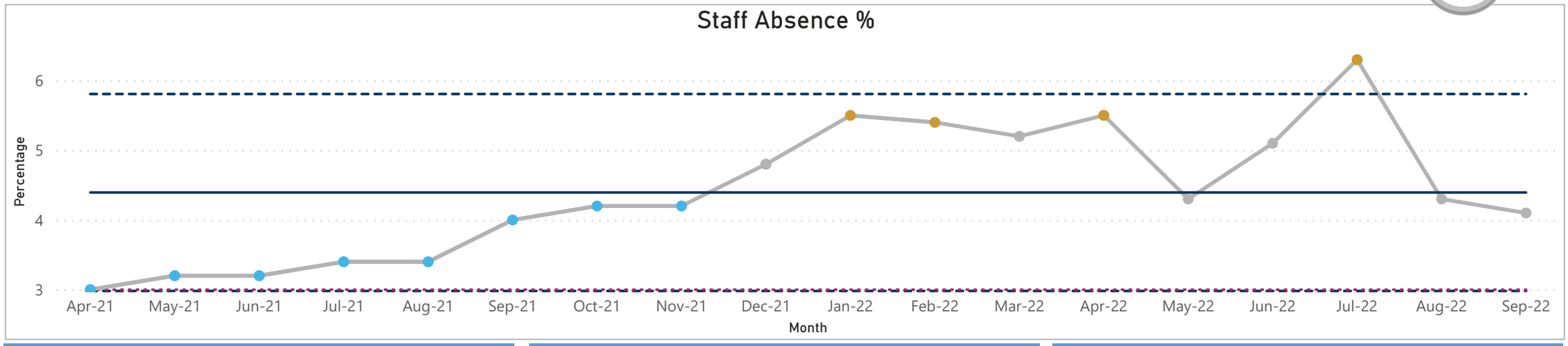
Movers and Leavers project will seek to improve processes and outcomes from exit interviews and work to encourage staff movement within the Trust.

Implementation of work to improve the Just and Learning Culture in the Trust and compassionate leadership modules for middle managers, aimed at improving this key area of management.

Workforce - Sickness

Target 3%

People



Understanding the performance:

Sickness absence has shown a modest reduction again this month, although there are some indicators that COVID infections are rising again, combined with some increase in gastro-intestinal complaints.

Mental Health illnesses remain the leading cause of absence from work.

Actions (SMART):

-Comms have gone out via the BPs to Divisions signposting the training now available on LEARN and Wellbeing Conversations resources available on the Trust Intranet. To date, 15 staff have attended 2x online training sessions and there are 2 further sessions now available to book.
-A 10% 'dip test' of absence cases is being conducted to seek options to increase the speed with which cases are dealt, options include contracting out some of the work, which in turn will allow a broader HR advisory service to support DMTs with absence management.
-Further work is in hand to identify where staff have breached Trust policy triggers to seek to generate early interventions to support health initiative and improve workforce availability.

Risks and mitigations:

Corporate Risk – Delivery of OH service

Occupational Health remains short staffed. Services are being prioritised, with compliance and recruitment support the highest priority. Two temporary OHA have been engaged to support the recruitment on boarding process.

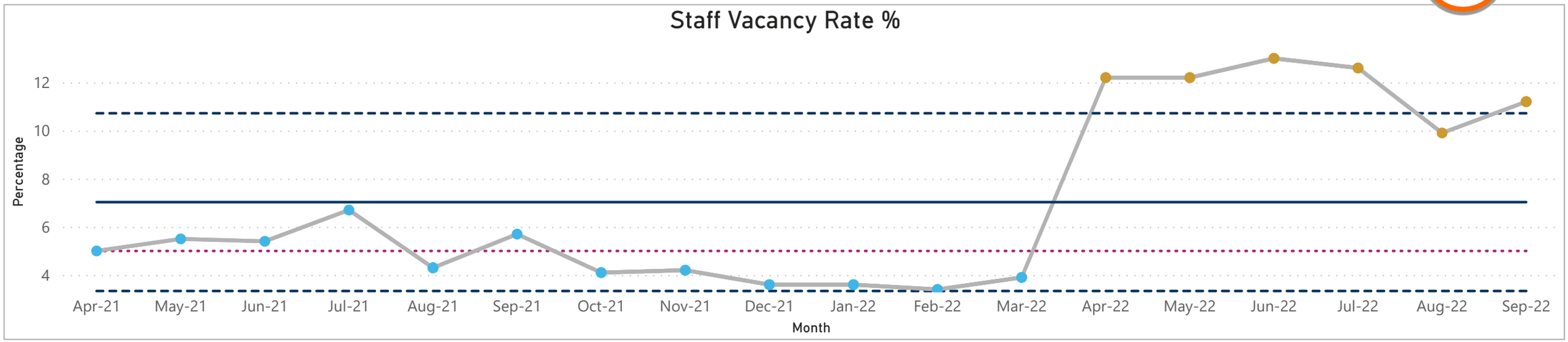
Corporate Risk – Sustainable Workforce

Absence management actions are not effective. Weekly workforce cell will review data on short term and long-term absences, target systemic absence management practices and reinforce staff alerts surrounding absence.

Workforce - Vacancies

Target 5%

People



Understanding the performance:

The vacancy rate has risen above 10% this month, despite significant effort and some success from the Resourcing teams in conjunction with DMTs and Line Managers.

Actions (SMART):

Successful bulk event for Admin staff signed up over 20 staff on the night for various Admin and Clerical posts.

14 MCSa have been offered roles in W&NB, aiming for start dates in early November.
53 position have been offered to international nurses, of which 16 will have arrived by End Sep.

A landing page with staff testimonials and videos is due to go live in October to mark the next phase of the Theatres recruitment campaign, coupled with Twitter, Facebook and Linked in advertising and forthcoming InStream radio publicity. A similar campaign is being designed for the additional elective ward to recruit extra nursing, therapist and theatre practitioners.

Risks and mitigations:

Corporate Risk – Sustainable Workforce.

Resourcing Plans delivered.

Implementation of PWC 'overhauling recruitment' recommendations to generate more efficient processes.

Recruitment campaigns are being refreshed.

Communication of single version of recruiting picture across the Trust.

Creation of career pathways and improved career structures to better advertise roles and opportunities.

Watch Metrics: Alerting

People

Metric	Two Months Ago	Last Month	This Month	Improvement Target	National Target	Variation	Variation Detail	Assurance
Non-Medical Appraisal Rate %	67.0%	63.4%	63.2%	86.0%			Special Cause Concerning - Below Lower Control Limit	

Watch Metrics: Alerting Narrative

People

Understanding the performance:

Non-Medical appraisals remain red against the target of 85%, with a month on month reduction for the 4rd consecutive month to a 63.2% completion rate.

They are at their lowest level since January, with the 4 worst performing areas (Finance, Redlynch, Day Surgery and Portering) all siting below 30% completion.

Ineffective management of appraisals remains an area of concern in Staff Survey and Pulse survey data, leading to low morale amongst staff.

Actions (SMART):

The Appraisals project held its final meeting on 13th Oct and should roll out the new, simplified process in the next few weeks.

Line Managers must take responsibility to then engage with the process, and report on ESR that appraisals have been completed.

Risks and Mitigations:

Corporate Risk - Sustainable Workforce.

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

Watch Metrics: Non-Alerting

People

Metric	Two Months Ago	Last Month	This Month	Improvement Target	National Target	Variation	Variation Detail	Assurance
Mandatory Training Rate %	92.1%	91.2%	91.3%	90.0%	85%		Special Cause Improving - Two Out of Three High	
Medical Appraisal Rate %	87.1%	84.7%	82.0%	90.0%			Common Cause Variation	

Part 4: Finance and Use of Resources

Performance against our Strategic Priorities and Key Lines of Enquiry

Salisbury NHS Foundation Trust

Our Priorities

Population

Partnerships

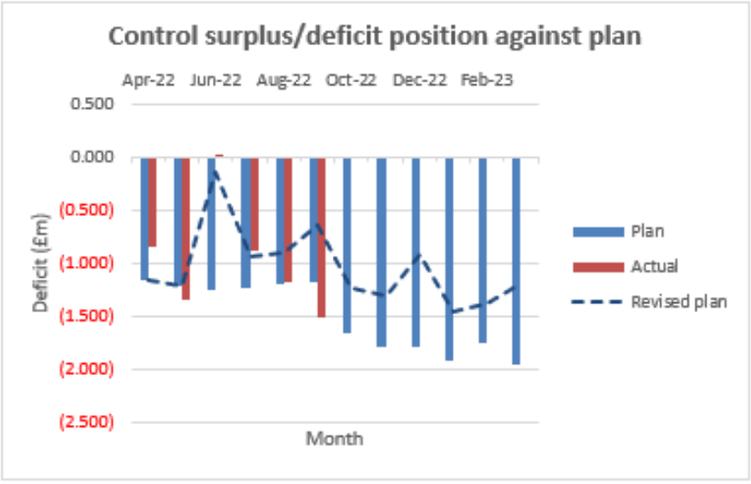
People

Income and Expenditure

Income & Expenditure:

Finance and Use of Resources

	Sept '22 In Month			Sept '22 YTD			22-23 Plan
	Plan £000s	Actual £000s	Variance £000s	Plan £000s	Actual £000s	Variance £000s	Plan £000s
Operating Income							
NHS Clinical income	21,731	24,256	2,525	(130,388)	134,073	264,461	260,775
Other Clinical Income	715	769	54	265,063	4,952	(260,110)	8,573
Other Income (excl Donations)	2,991	4,149	1,158	17,570	20,029	2,459	34,540
Total income	**25,437**	**29,174**	**3,737**	**152,245**	**159,054**	**6,809**	**303,888**
Operating Expenditure							
Pay	(16,506)	(19,761)	(3,255)	(99,119)	(102,936)	(3,817)	(199,429)
Non Pay	(7,903)	(9,164)	(1,261)	(48,095)	(51,682)	(3,587)	(96,646)
Total Expenditure	**(24,409)**	**(28,925)**	**(4,516)**	**(147,214)**	**(154,618)**	**(7,404)**	**(296,075)**
EBITDA	**1,028**	**249**	**(779)**	**5,031**	**4,436**	**(595)**	**7,813**
Financing Costs (incl Depreciation)	(1,669)	(1,761)	(92)	(9,988)	(10,147)	(159)	(20,213)
NHSI Control Total	**(641)**	**(1,512)**	**(871)**	**(4,957)**	**(5,711)**	**(754)**	**(12,400)**
Add: impact of donated assets	(68)	(71)	(3)	(408)	(424)	(16)	(816)
Surplus/(Deficit)	(709)	(1,583)	(874)	(5,365)	(6,135)	(770)	(13,216)



Understanding the performance:

-In month 6 the Trust recorded a control total deficit of £1.512m against a target of £0.641m -an adverse variance of £0.871m.
-September saw the backdated payment of the 2022/23 pay award, provision had been made for costs in line with the national guidance and further funding has been received to contribute towards the excess cost of the award. The impact of the award has been found to be £0.7m (FYE) greater than the national assumption, and non-recurrent 2022/23 funding has been agreed with BSW to cover gap.
-'Pass through' non pay costs continue to run in excess of those planned, accounting for 70% of costs above plan. A spike in gas wholesale prices in Aug-Sept, and the lease of decant space to allow for ward maintenance are driving pressures in excess of Trust plans.

Actions (SMART):

Verbal agreement has now been reached on the distribution of the BSW ICB planned surplus (£12.4m for SFT). This income will be received in Q3.
-People workstreams are focusing on retention of staff, with planned interventions discussed at an October winter summit. A short list of interventions has been agreed for final analysis t be put in place in Q3.
-SFT is engaged in a SW wide analysis on the impact of the pay award, all eleven Trusts to have returned analysis to date are showing a similar order of pressure to SFT.
-The BSW-wide procurement 2022/23 workplan levers the ICS spending power to mitigate the impact of inflation.

Risks and mitigations:

-Pressure on emergency care pathways which results in increased costs associated with the Trust's bed base, reductions of elective inpatient care and premium costs of bank and agency to cover vacancies and unavailability.
-Estates works on Breamore have necessitated the reprovision of space in South Newton: additional costs have been included as part of the Trust's winter plan. An ongoing requirement for provision of these additional beds represent a financial risk to the Trust if unfunded.
-The Trust has a target of £9.7m efficiency savings with a forecast delivery of £8.9m, split 50:50 between recurrent and non-recurrent schemes. This signals a significant risk if further recurrent efficiencies are not identified.

Income & Activity Delivered by Point of Delivery

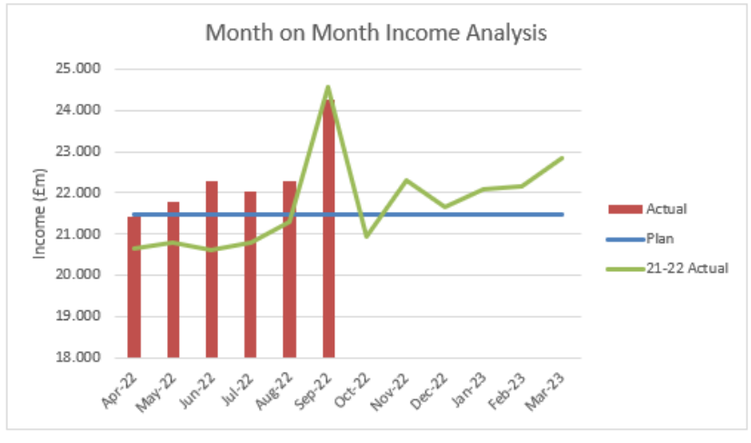
Clinical Income:

Finance and Use of Resources

Income by Point of Delivery (PoD) for all commissioners	September '22 YTD Plan (YTD) £000s	Actual (YTD) £000s	Variance (YTD) £000s
A&E	5,418	5,224	(194)
Day Case	10,089	9,637	(452)
Elective inpatients	6,447	6,937	490
Excluded Drugs & Devices (inc Lucentis)	11,066	12,095	1,029
Non Elective inpatients	35,285	36,474	1,189
Other	43,818	46,441	2,623
Outpatients	18,265	17,265	(1,000)
TOTAL	130,388	134,073	3,685

SLA Income Performance of Trusts main NHS commissioners	Contract Plan (YTD) £000s	Actual (YTD) £000s	Variance (YTD) £000s
BSW ICB	78,278	78,598	320
Dorset ICB	13,148	13,113	(35)
Hampshire, Southampton & IOW ICB inc Portsmouth	10,721	10,721	-
Specialist Services	20,403	21,535	1,132
Other	7,838	10,106	2,268
TOTAL	130,388	134,073	3,685

	Activity Plan	Activity Actuals	Activity Variance	Activity Actuals	Variance last year
A&E	35,380	36,876	1,496	34,917	1,959
Day case	11,507	11,173	(334)	10,147	1,026
Elective	1,593	1,684	91	1,421	263
Non Elective	14,458	13,247	(1,211)	14,322	(1,075)
Outpatients	126,359	123,356	(3,003)	133,815	(10,459)



Understanding the performance:

-Trust is ahead of the Clinical income plan. Plans remain consistent with the submitted plans and have not been increased for the pay award. Dorset ICB income reduced this month by £35k, reflecting the agreement around sleep service. NHS specialised services continues to be above plan for the cost and volume drugs/devices by £1.1m.
-A&E activity higher in September than in August with attendances at A&E department. Less at the walk in centre activity in month. Day case activity in Sept was 600 less cases than Aug and lower than plan by 631 cases. It remains behind plan year to date. Activity in elective inpatients fell below plan by 87 cases. Most specialities reporting less activity.
-Non Elective activity was higher than Aug mainly within Obs (53) and Gen Surgery (50). Outpatient higher than Aug within Gynae/T&O/Oral.

Actions (SMART):

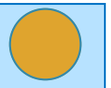
The NHS E standard contract with BSW ICB is expected to be signed week commencing 10th October. Further work is required on reviewing the contract documents shared to date by NHS England. A new tariff is also now expected to reflect the changes proposed around national insurance.

Risks and mitigations:

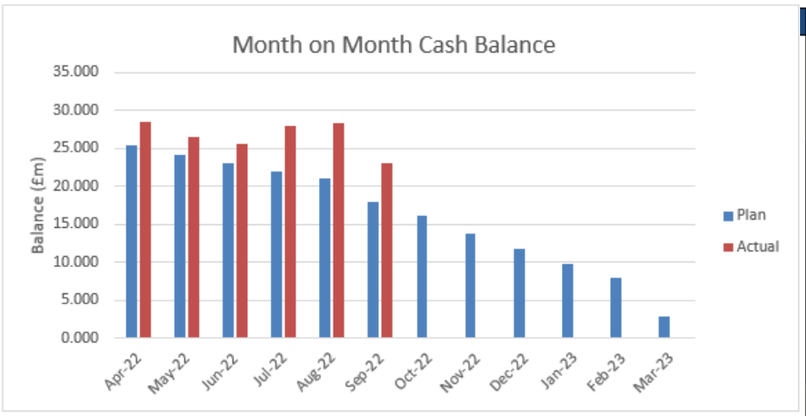
Pay award funding has been allocated to ICB systems on a fair shares basis and additional funding of 1.66% including pay arrears was paid in September. Most commissioners have paid the pay award funding as required. There has been a shortfall in the pay award allocation compared with costs incurred and an additional £350k above the 1.66% funding is expected from BSW ICB.

Cash Position & Capital Programme

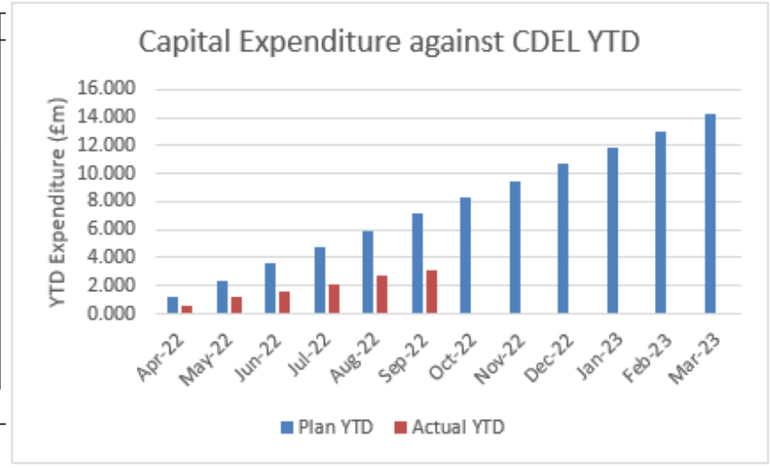
Capital Spend: 

Cash & Working: 

Finance and Use of Resources



Position				
	Annual	September '22 YTD		
	Plan	Plan	Actual	Variance
Schemes	£000s	£000s	£000s	£000s
CDEL Schemes				
Building schemes CIR	3,758	1,842	542	1,300
Building projects	2,740	1,524	1,222	302
IM&T	4,106	1,914	699	1,215
Medical Equipment	2,207	1,626	482	1,144
Other	1,414	212	274	(62)
GRAND TOTAL	**14,225**	**7,118**	**3,220**	**3,898**



Understanding the performance:

-Capital expenditure is significantly behind plan, particularly within Building Projects. A revised forecast has been agreed at Trust Board which fully utilises the capital funding by year end. Forecast includes refurbishment of the DAC as part of the decant for the additional ward scheme together with further agreed investment in med equipment.
-The Trust cash balance is currently healthy, partly due to slippage in the 22-23 capital plan. The cash balance has reduced by £5.2m in month 6. This is due to the payment of the six monthly instalment on PDC £2.2m and the timing of payments to suppliers given the Aug BH. Due to the size of the deficit planned for 22-23 the cash balance had been planned to reduce significantly over the year. The expectation is this will be mitigated by the distribution of BSW funding held by ICB.

Actions (SMART):

The capital plan has been reviewed in the context of known supply chain restraints. Alternative projects initially planned for 2023/24 which can be brought forward to 2022/23 have been identified to mitigate the risk of further slippage.
The unallocated of BSW capital allocation has now been released, with Trust Board agreeing to an increase in the SFT 2022/23 capital plan of £795k in October. A prioritised list or requests has been agreed though Capital Control Group in October and will now proceed to final approval.
The additional ward project is now progressing to the final stage of approval, with the full business case panel review scheduled for 3rd November 2022.

Risks and mitigations:

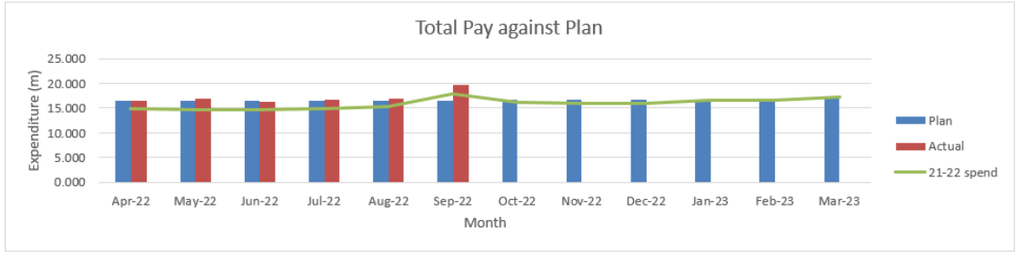
Supply chain disruption and inflationary pressures remain a significant draw of time on the procurement team. This gives rise to a risk in both lead times and overall procurement capacity.

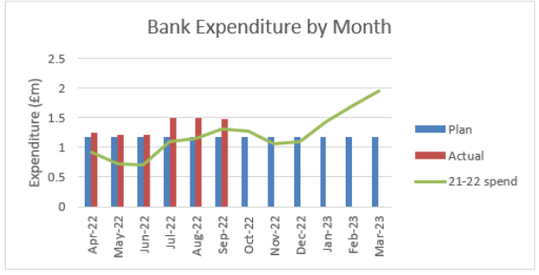
The constraint of both available cash and system capital expenditure limits gives rise to both a mid and long term risk to the Trust. The context of digital modernisation programmes, along with an aging estate and medical equipment means the Trust's five year capital requirement is well in excess of available resources. The Trust seeks to in part mitigate this risk through the proactive bidding for national funds where available.

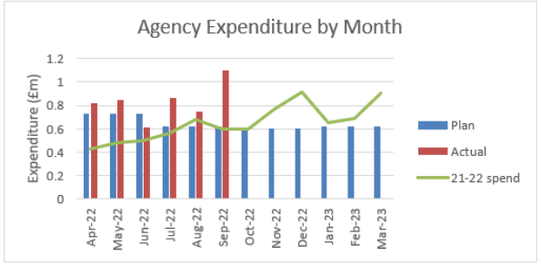
Workforce and Agency Spend

Pay:

Finance and Use of Resources







Position	September '22 YTD		
	Plan £000s	Actual £000s	Variance £000s
Pay - In Post	87,445	89,432	(1,987)
Pay - Bank	7,018	8,142	(1,124)
Pay - Agency	4,062	4,985	(923)
Other (eg. Apprenticeship Levy)	594	376	218
TOTAL	**99,119**	**102,936**	**(3,817)**
Medical Staff	26,204	26,539	(335)
Nursing	23,475	26,160	(2,685)
Support to Nursing	7,177	8,053	(876)
Other Clinical Staff	16,127	15,632	495
Infrastructure staff	25,542	26,175	(633)
Other (eg. Apprenticeship Levy)	594	376	218
TOTAL	**99,119**	**102,936**	**(3,817)**

Position	September '22		
	Plan WTEs	Actual WTEs	Variance WTEs
Medical Staff	490.6	469.61	21.0
Nursing	1,103.6	1084.51	19.1
Support to Nursing	515.1	496.54	18.6
Other Clinical Staff	689.8	651.44	38.3
Infrastructure staff	1,461.1	1424.8	36.3
TOTAL	**4,260.2**	**4,126.9**	**133.3**

Understanding the performance:

Pay expenditure increased by £2.9m in month 6, bringing the year to date adverse variance against plan to £3.8m. Most increase is by backdated pay, the total value which was £3.3m. £1.2m of this was accrued during months 1-5 based on national guidance, with the balance offset by additional income, £0.7m (FYE) of this is self-funded on a non-recurrent basis from BSW.
Increase in agency expense of £347k (47%) from previous month - Nursing/Medical. Nursing agency spend increased by £234k reflects the increased availability of agency/shift fill rate. Med agency increased by £77k - most clinical areas. Bank staff decreased in month (by £20k), and were seen in all areas except Infrastructure/Support to Nursing. Infrastructure spend concentrated in Housekeeping/Portering.

Actions (SMART):

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

The Trust is engaged in a SW review of the cost of the pay award over and above the national assumptions

Risks and mitigations:

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

Unions are currently balloting on industrial action, in the event that they decide to proceed workforce disruption and additional costs to mitigate are likely.

Data Sources: Narrative and Breakthrough Objectives

Understand the Data

Metric Type	Metric Name	Data Source	Executive Lead	Data Quality Rating
Breakthrough Objective	Total (Excess) Bed Days from NC2R to Discharge - Internal Reasons only	e-whiteboards	Lisa Thomas	Medium
Breakthrough Objective	Total Patient Falls per 1000 Bed Days	DATIX Team	Peter Collins	Medium
Breakthrough Objective	Wait time to first OPA (non-admitted)	Lorenzo via Trust Data Warehouse	Lisa Thomas	High
Narrative	% of patients moved more than once	Trust Data Warehouse	Peter Collins	High
Narrative	C Difficile Hospital onset Healthcare associated	Infection Control Team	Peter Collins	High
Narrative	Cancer 2 Week Wait Performance	Cancer Services	Lisa Thomas	High
Narrative	Cancer 28 Day Faster Diagnosis Standard	Cancer Services	Lisa Thomas	High
Narrative	Cancer 62 Day Standard Performance	Cancer Services	Lisa Thomas	High
Narrative	Cat 2 Pressure Ulcers per 1000 Bed Days	DATIX Team	Peter Collins	High
Narrative	DM01 Performance	Trust Data Warehouse	Lisa Thomas	High
Narrative	E Coli Hospital onset Healthcare associated	Infection Control Team	Peter Collins	High
Narrative	ED 4 Hour Performance	Lorenzo via Trust Data Warehouse	Lisa Thomas	High
Narrative	Friends and Family Test Response Rate - All Trust	Trust Data Warehouse	Peter Collins	High
Narrative	Staff Sickness Absence %	Health Roster	Melanie Whitfield	High
Narrative	Staff Turnover	ESR	Melanie Whitfield	High
Narrative	Stroke & TIA: % Arrival on Stroke Unit within 4 hours	Trust Data Warehouse	Peter Collins	High
Narrative	Total Ambulance Handover Delays	Lorenzo via Trust Data Warehouse	Lisa Thomas	High
Narrative	Total Waiting List	Lorenzo via Trust Data Warehouse	Lisa Thomas	High
Narrative	Vacancies	ESR	Melanie Whitfield	High

Data Sources: Watch Metrics (1)

Understand the Data

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

Data Sources: Watch Metrics (2)

Understand the Data

Metric Type	Metric Name	Data Source	Executive Lead	Data Quality Rating
Watch	Mixed Sex Accommodation Breaches	Site Team	Judy Dyos	Low
Watch	% of Inpatients Undergoing VTE Risk Assessment	Quality Team	Peter Collins	High
Watch	Total Number of Complaints Received	PALS Team	Peter Collins	High
Watch	Total Number of Compliments Received	PALS Team	Peter Collins	High
Watch	Mandatory Training Rate %	MLE	Melanie Whitfield	High
Watch	Proportion of patients spending more than 12 hours in an emergency department	Lorenzo via Trust Data Warehouse	Lisa Thomas	High
Watch	Trust Performance RTT %	Lorenzo via Trust Data Warehouse	Lisa Thomas	High
Watch	MSSA Bacteraemia Infections: Hospital Onset	Infection Control Team	Peter Collins	High
Watch	Medical Appraisal Rate %	ESR	Melanie Whitfield	High
Watch	Non-Medical Appraisal Rate %	ESR	Melanie Whitfield	High
Watch	Neonatal Deaths Per 1000 Live Births	E3 Maternity System	Peter Collins	High
Watch	Stillbirths Per 1000 Total Births	E3 Maternity System	Peter Collins	High
Watch	% of Total Incidents Resulting in High Harm (Mod/Maj/Cat)	DATIX Team	Peter Collins	Medium
Watch	Number of High Harm Falls in Hospital	DATIX Team	Peter Collins	Medium
Watch	Pressure Ulcers Hospital Acquired Cat 2	DATIX Team	Peter Collins	High
Watch	Pressure Ulcers Hospital Acquired Cat 3	DATIX Team	Peter Collins	High
Watch	Pressure Ulcers Hospital Acquired Cat 4	DATIX Team	Peter Collins	High
Watch	Serious Incident Investigations	DATIX Team	Peter Collins	Medium
Watch	Total Incidents (All Grading) per 1000 Bed Days	DATIX Team	Peter Collins	High
Watch	Cancer 31 Day Performance Overall	Cancer Services	Lisa Thomas	High
Watch	Total patients waiting over 62 days to begin cancer treatment compared with baseline	Cancer Services	Lisa Thomas	High

Data Sources: Other Metrics (1)

Understand the Data

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

Data Sources: Other Metrics (2)

Understand the Data

Metric Type	Metric Name	Data Source	Executive Lead	Data Quality Rating
Other	Day HCA	Health Roster	Melanie Whitfield	High
Other	Day RN	Health Roster	Melanie Whitfield	High
Other	Night HCA	Health Roster	Melanie Whitfield	High
Other	Night RN	Health Roster	Melanie Whitfield	High
Other	FFT Response Rate - A&E	Trust Data Warehouse	Peter Collins	High
Other	FFT Response Rate - Day Case	Trust Data Warehouse	Peter Collins	High
Other	FFT Response Rate - Inpatient	Trust Data Warehouse	Peter Collins	High
Other	FFT Response Rate - Maternity	Trust Data Warehouse	Peter Collins	High
Other	FFT Response Rate - Outpatient	Trust Data Warehouse	Peter Collins	High
Other	HSMR Trust	Telstra Health	Peter Collins	High
Other	Maternity Clinical Dashboard: Apgar less than 6 @ 5 min %	E3 via Trust Data Warehouse	Peter Collins	Medium
Other	Maternity Clinical Dashboard: Babies (incl non reg)	E3 via Trust Data Warehouse	Peter Collins	Medium
Other	Maternity Clinical Dashboard: Elective caesarean sections %	E3 via Trust Data Warehouse	Peter Collins	Medium
Other	Maternity Clinical Dashboard: Emergency caesarean sections %	E3 via Trust Data Warehouse	Peter Collins	Medium
Other	Maternity Clinical Dashboard: Homebirth Rate	E3 via Trust Data Warehouse	Peter Collins	Medium
Other	Maternity Clinical Dashboard: Inductions %	E3 via Trust Data Warehouse	Peter Collins	Medium
Other	Maternity Clinical Dashboard: Instrumental deliveries %	E3 via Trust Data Warehouse	Peter Collins	Medium
Other	Maternity Clinical Dashboard: PPH >= 1, 500 %	E3 via Trust Data Warehouse	Peter Collins	Medium
Other	Maternity Clinical Dashboard: Term babies admitted to NNU unexpectedly %	E3 via Trust Data Warehouse	Peter Collins	High
Other	Maternity Clinical Dashboard: Total CS rate (planned & unscheduled)	E3 via Trust Data Warehouse	Peter Collins	Medium
Other	Maternity: Training compliance - MDT Prompt %	Maternity Dept	Peter Collins	Medium
Other	MRSA Bacteraemia Infections: Hospital Onset	Infection Control Team	Peter Collins	High
Other	Never Events	DATIX Team	Peter Collins	Medium
Other	SHMI Trust	Telstra Health	Peter Collins	High
Other	Total Mortalities	Medical Examiners	Peter Collins	High

Data Sources: Other Metrics (3)

Understand the Data

Metric Type	Metric Name	Data Source	Executive Lead	Data Quality Rating
Other	Cancer 2 Week Wait Breaches	Cancer Services	Lisa Thomas	High
Other	Cancer 2 Week Wait Den	Cancer Services	Lisa Thomas	High
Other	Cancer 2 Week Wait Num	Cancer Services	Lisa Thomas	High
Other	DM01 Performance: Audio	Trust Data Warehouse	Lisa Thomas	Medium
Other	DM01 Performance: Cardio	Trust Data Warehouse	Lisa Thomas	Medium
Other	DM01 Performance: Colon	Trust Data Warehouse	Lisa Thomas	Medium
Other	DM01 Performance: CT	Trust Data Warehouse	Lisa Thomas	Medium
Other	DM01 Performance: DEXA	Trust Data Warehouse	Lisa Thomas	Medium
Other	DM01 Performance: Flexi Sig	Trust Data Warehouse	Lisa Thomas	Medium
Other	DM01 Performance: Gastro	Trust Data Warehouse	Lisa Thomas	Medium
Other	DM01 Performance: MRI	Trust Data Warehouse	Lisa Thomas	Medium
Other	DM01 Performance: Neuro	Trust Data Warehouse	Lisa Thomas	Medium
Other	DM01 Performance: US	Trust Data Warehouse	Lisa Thomas	Medium
Other	Longest Waiting Patient (Weeks)	Lorenzo via Trust Data Warehouse	Lisa Thomas	High
Other	Add: impact of donated assets	Finance Division	Mark Ellis	High
Other	Financing Costs	Finance Division	Mark Ellis	High
Other	NHS Clinical income	Finance Division	Mark Ellis	High
Other	NHS Clinical income Plan	Finance Division	Mark Ellis	High
Other	Non Pay	Finance Division	Mark Ellis	High
Other	Other Clinical income	Finance Division	Mark Ellis	High
Other	Other Clinical income Plan	Finance Division	Mark Ellis	High
Other	Other income (excl donations)	Finance Division	Mark Ellis	High
Other	Other income (excl donations) Plan	Finance Division	Mark Ellis	High
Other	Pay	Finance Division	Mark Ellis	High
Other	Share of Gains on Joint Ventures	Finance Division	Mark Ellis	High

Data Sources: Other Metrics (4)

Understand the Data

Metric Type	Metric Name	Data Source	Executive Lead	Data Quality Rating
Other	Activity by PoD: A&E	Finance Division	Mark Ellis	High
Other	Activity by PoD: Day case	Finance Division	Mark Ellis	High
Other	Activity by PoD: Elective	Finance Division	Mark Ellis	High
Other	Income by PoD: A&E Actual	Finance Division	Mark Ellis	High
Other	Income by PoD: A&E Plan	Finance Division	Mark Ellis	High
Other	Income by PoD: Daycase Actual	Finance Division	Mark Ellis	High
Other	Income by PoD: Daycase Plan	Finance Division	Mark Ellis	High
Other	Income by PoD: Elective IP Actual	Finance Division	Mark Ellis	High
Other	Income by PoD: Elective IP Plan	Finance Division	Mark Ellis	High
Other	Income by PoD: Excluded Drugs & Devices Actual	Finance Division	Mark Ellis	High
Other	Income by PoD: Excluded Drugs & Devices IP Plan	Finance Division	Mark Ellis	High
Other	Income by PoD: Non Elective IP Actual	Finance Division	Mark Ellis	High
Other	Income by PoD: Non Elective IP Plan	Finance Division	Mark Ellis	High
Other	Income by PoD: Other Actual	Finance Division	Mark Ellis	High
Other	Income by PoD: Other Plan	Finance Division	Mark Ellis	High
Other	Income by PoD: Outpatients Actual	Finance Division	Mark Ellis	High
Other	Income by PoD: Outpatients Plan	Finance Division	Mark Ellis	High
Other	Month on month I&E Surplus/(Deficit) Actual	Finance Division	Mark Ellis	High
Other	Month on month I&E Surplus/(Deficit) Plan	Finance Division	Mark Ellis	High
Other	SLA Income: BSW CCG	Finance Division	Mark Ellis	High
Other	SLA Income: Dorset CCG	Finance Division	Mark Ellis	High
Other	SLA Income: Hampshire, Southampton and IoW CCG	Finance Division	Mark Ellis	High
Other	SLA Income: Other	Finance Division	Mark Ellis	High
Other	SLA Income: Specialist Services	Finance Division	Mark Ellis	High
Other	Surplus/(Deficit)	Finance Division	Mark Ellis	High

Data Sources: Other Metrics (5)

Understand the Data

Metric Type	Metric Name	Data Source	Executive Lead	Data Quality Rating
Other	Activity by PoD: A&E	Finance Division	Mark Ellis	High
Other	Activity by PoD: Day case	Finance Division	Mark Ellis	High
Other	Activity by PoD: Elective	Finance Division	Mark Ellis	High
Other	Activity by PoD: Non Elective	Finance Division	Mark Ellis	High
Other	Activity by PoD: Outpatients	Finance Division	Mark Ellis	High
Other	Bank total Actual	Finance Division	Mark Ellis	High
Other	Capital Expenditure: Additional funds approved in year Actual	Finance Division	Mark Ellis	High
Other	Capital Expenditure: Additional funds approved in year Plan	Finance Division	Mark Ellis	High
Other	Capital Expenditure: Building Projects Actual	Finance Division	Mark Ellis	High
Other	Capital Expenditure: Building Projects Plan	Finance Division	Mark Ellis	High
Other	Capital Expenditure: Building Schemes Actual	Finance Division	Mark Ellis	High
Other	Capital Expenditure: Building Schemes Plan	Finance Division	Mark Ellis	High
Other	Capital Expenditure: IM&T Actual	Finance Division	Mark Ellis	High
Other	Capital Expenditure: IM&T Plan	Finance Division	Mark Ellis	High
Other	Capital Expenditure: Medical Equipment Actual	Finance Division	Mark Ellis	High
Other	Capital Expenditure: Medical Equipment Plan	Finance Division	Mark Ellis	High
Other	Capital Expenditure: Other Actual	Finance Division	Mark Ellis	High
Other	Capital Expenditure: Other Plan	Finance Division	Mark Ellis	High
Other	Month on Month CAPEX Actual	Finance Division	Mark Ellis	High
Other	Month on Month CAPEX Plan	Finance Division	Mark Ellis	High
Other	Month on month cash balance	Finance Division	Mark Ellis	High
Other	Month on month Income Analysis Actual	Finance Division	Mark Ellis	High
Other	Month on month Income Analysis Plan	Finance Division	Mark Ellis	High
Other	Month on Month total pay Actual	Finance Division	Mark Ellis	High
Other	Month on Month total pay Plan	Finance Division	Mark Ellis	High

Data Sources: Other Metrics (6)

Understand the Data

Metric Type	Metric Name	Data Source	Executive Lead	Data Quality Rating
Other	Agency total Actual	Finance Division	Mark Ellis	High
Other	Agency Total Plan	Finance Division	Mark Ellis	High
Other	Bank total Actual	Finance Division	Mark Ellis	High
Other	Bank total Plan	Finance Division	Mark Ellis	High

NHS Salisbury NHS Foundation Trust

Report to:	Trust Board (public)	**Agenda item:**	3.1
Date of Meeting:	03 November 2022		

Report Title:	Digital Plan 2022-26			
Status:	**Information**	**Discussion**	**Assurance**	**Approval**
				X
Approval Process (where has this paper been reviewed and approved)	Reviewed and approved at Digital Steering Group Approved at Trust Management Committee on 26th Oct 2022			
Prepared by:	Jon Burwell, Chief Information Officer			
Executive Sponsor	Naginder Dhanoa, Chief Digital Officer			
Appendices (list if applicable):	Digital Plan 2022-26			

Recommendation:

Trust Board is asked to:

- Approve the Digital Plan
- Note that the intent for the level of programmes to be vastly reduced by October 2023 to focus all efforts on the Shared EPR implementation
- Note that the associated delivery of the Digital Plan will be overseen by the Digital Steering Group

Executive Summary:

The Digital Plan is an update from the previous Trust Digital Strategy written in 2019. The Digital Plan responds and complements the recent revision of the Trust Strategy.

The Digital Plan builds on the foundations laid over the last three years, recognising this has been significantly disrupted due to Covid. Examples of what has been achieved during this time includes:

- Upgrading key systems such as PACS, our EPR, Blood tracking systems, cardiology system and the Trust's websites
- Expansion of the functionality of our Electronic Patient Record with the introduction of EPMA from November 2022 and making a number of other processes such as Outpatient appointment outcoming electronic.
- Rollout of Mobile Device Management on our smart phones and tablets
- Reducing the Trusts cyber risk exposure through replacing c.3500 aged laptops and PCs (95% of the Trust's devices) with new equipment and upgrading to Windows 10.
- Commencing a programme to remove all end of support servers (from a position of being the worst in the country). The current plan will see the vast majority completely removed by March 2023

- ICS (nee STP) wide collaboration in joint system procurements such as endoscopy, virtual appointment booking and single sign on, joint contracts for device procurement and standardisation of policies/principles around cloud first, cyber and technology refreshes.
- Introduction of a range of new policies and standardised procedures to ensure we have strong underpinning internal controls and up to date guidance for staff and patients.

The principles underpinning the new Digital Plan remain largely consistent with the 2019 strategy, with collaboration, interoperability, reducing repetition and duplication, maximising value of investment and maintaining high quality data being fundamental to all the work we do.

The Digital Plan is split into five priority areas which will collectively support delivery of the Digital Plan's vision ***to provide our citizens and staff with an outstanding experience of using technology and information, when and wherever they need it***.

The five priority areas are as follows:

1) **Our Electronic Patient Record**: the journey to an ICS wide solution, interacting with health and care partners seamlessly
2) **Digitally enabled partnership working**: maximising the potential of closer working with ICS peers and clinical networks
3) **Supporting the people we serve**: systems and support to improve how people interact with our service digitally
4) **Empowering a digital workforce**: tools to help staff work effectively and use data to make informed decisions
5) **Modern and Secure Infrastructure**: maintaining the technology that means we can work digitally. Reducing cyber attack risks

The Digital Plan is designed to provide a realistic programme of activities. There is now mature governance for the digital agenda. Programme management boards are set up as appropriate to oversee programmes and provide escalation reports to Digital Steering Group, which will provide overall assurance on delivery of the Digital Plan.

Where there is capacity and/or funding available to introduce additional or emerging technologies, this will be carefully considered through the relevant prioritisation processes and governance. We will continue to collaborate with both ICS and clinical network partners to help streamline our practices, use resources most effectively and build resilience across our digital teams.

There are a number of risks identified in the Digital Plan, in particular around ownership and capacity for change, the availability of both capital and revenue funding and market supply challenges. Mitigating actions have been outlined, some of which will require decisions through governance (for example where there is a financial cost pressure or increased resources needed).

Board Assurance Framework – Strategic Priorities	**Select as applicable**
Population: Improving the health and well-being of the population we serve	☒

Partnerships: Working through partnerships to transform and integrate our services	☒
People: Supporting our People to make Salisbury NHS Foundation Trust the Best Place to work	☒
Other (please describe) -	☐

NHS
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Our Digital Plan

2022-26

Executive Summary

Salisbury NHS Foundation Trust

The Digital Plan looks to build on the progress made over the last three years of our Digital Strategy and refreshes our focus, factoring in the changes in the environment we live and work. The Trust's Strategy highlights three priority areas in Population, Partnerships and People, all of which have a dependence on interacting with technology and other digital areas such as the use of high quality information and having a progressive digital culture.

The Digital Plan will continue to take a clinically led 'digital first' approach on our journey to working paperless. Fundamental to this is the introduction of a new shared acute Electronic Patient Record (EPR) across our Integrated Care System (ICS), capable of interacting with wider specialist systems. This objective is to provide a platform that can digitise patient interactions and processes, deliver on the need for high quality information at the point of care and create a solution to empower clinicians and ICS partners to transform the way we work now to support the future needs of our population. For this Digital Plan to be successful a strong digital culture and engagement alongside a resilient and modern underlying technical infrastructure will be required. These are therefore core priorities.

How we collaborate and innovate with our ICS partners and peer networks is vital to ensure we progress in reducing variation and increasing standardisation of practice. Alongside the implementation of a Shared EPR, we will look to increase the standardisation and convergence of systems and technology where possible and maximise the collective technical skills and knowledge across the ICS in areas such as Cyber Security and Business Intelligence, applying the "do once share many" principle both within the Trust, across the ICS and beyond boundaries.

The digital plan will also seek to deliver the most appropriate technologies to enable patients to co-own their care through the use of technology and information, recognising the increasing desire for virtual interactions with health professionals and informed decision making.

Naginder Dhanoa
Chief Digital Officer

Stacey Hunter
Chief Executive Officer

Our strategic context

Since we published our Digital Strategy in 2019, the landscape in which we work has shifted significantly towards a focus on working approaches that cross organisational boundaries. The recent national Digitise, connect, transform: Digital transformation in health and social care strategy builds upon the NHS Long Term Plan and reviews such as the Watcher Report (Making IT Work). The national strategy has a series of policies and guidance coverings aspects such as using the NHS App the front door for NHS services, standardising on good practice activities to empower citizens and using data to inform care planning. There is a particular emphasis on local heath and care integration, working as one across the ICS geography. Digital will also play a part in how we respond to wider national strategies, such as the NHS People Plan to improve the experience of people that work in the NHS and our responsibilities within the Green Plan 2022-26. Some of the key documents are below:

The Digital Plan seeks to respond to the asks set out in the national strategies whilst ensuring the primary focus is supporting the delivery of our Trust Strategy. The Trust Strategy highlights the importance of collective responsibility with the ICS to improve the health and care of our population. We work closely with our ICS partners to challenge how we can collectively support the improvement journey through providing consistent digital services across the ICS, ensuring all people across the ICS have the same positive experience using systems and data platforms. The three strategic priorities to help realise the Trust Strategy are:

- Improving the health & well being of the Population we serve
- Working through Partnerships to transform and integrate our services
- Supporting our People to make Salisbury NHS Foundation Trust the Best Place to Work

Our Digital Vision and Priorities

Salisbury NHS Foundation Trust

Our Digital Vision is:

To provide our citizens and staff with an outstanding experience of using technology and information, when and wherever they need it

There are five priority areas that will collectively help make this vision a reality. Each priority responds to at least one of the Trust's strategic priorities.

Priority Areas and how they align with the Trust Strategy	Population	Partnerships	People
1) Our Electronic Patient Record: the journey to an ICS wide solution, interacting with health and care partners seamlessly	✓	✓	✓
2) Digitally enabled partnership working: maximising the potential of closer working with ICS peers and clinical networks		✓	✓
3) Supporting the people we serve: systems and support to improve how people interact with our service digitally	✓		✓
4) Empowering a digital workforce: tools to help staff work effectively and use data to make informed decisions			✓
5) Modern and Secure Infrastructure: maintaining the technology that means we can work digitally. Reducing cyber attack risks	✓	✓	✓

What the plan will mean to people

NHS Salisbury NHS Foundation Trust

The Digital Plan will benefit people in different ways depending on your role if a member of staff and/or how you interact with our services if you are a member of the public. Here are some examples of what we aim to achieve through delivering the Digital Plan:

Doctors

I will be able to access electronically all the relevant information on my patients collated both inside and outside the hospital. This will enable me to deliver the best possible continuity of care. Having electronic notes will reduce the time I spend behind a desk, allowing me to interact better with patients and families both face to face and virtually.

Nursing/AHPs

Having patient observations alongside information such as care plans and allied health professional assessments will help team working, reducing delays and ensure patients have a safe and enjoyable experience with us. Getting alerts and prompts when prescribing drugs alongside seeing key information from primary care will reduce the risk of incorrect prescribing.

Patients and Carers

Having control of my own health and care records, monitoring my health issues using apps at home and speaking to clinical professions about my care without the need for face to face appointments will help me manage my health concerns more effectively. Supporting me to use technology and understand my health information will help me make better decisions about myself.

Admin and Management

I will have the skills and confidence to use the systems I require to undertake my role, removing printing needs, freeing my time to undertake to complete more useful tasks. I will have access to information electronically enabling me to answers patient and clinical queries more quickly and help make quicker and more informed decisions.

Underlying Principles

Salisbury NHS Foundation Trust

There is an expectation for all activities being undertaken to deliver the digital vision, that they will continue to comply with the underlying principles originally agreed in 2019. These principles are used to challenge our thinking when developing, implementing or optimising systems and processes. Adherence to the principles through our work will ensure our systems work together to streamline working practices, we spend money on tools we truly need and that fit into our overall systems plan and everyone will understand the importance of timely and high quality data entry.

High data quality	Maximising Value	Do once share many	Interoperability	Collaboration
Maintain compliance with national data definitions and set consistent local definitions where appropriate. Ownership of data quality compliance by the clinical teams	Maximising investments in digital including the full use of system functionality with staff effectively trained. Ensure systems are stable and available whenever required	Reducing duplicate data entry and where possible enable information to be shared between systems securely	Adherence to the national expectations around interoperability, ensuring procurement and contracts support this agenda	Wherever possible consider opportunities for collaboration to ensure solutions work at scale locally and regionally. Ensure legislation is an enabler for this (e.g. UK GDPR)

1) Our Electronic Patient Record

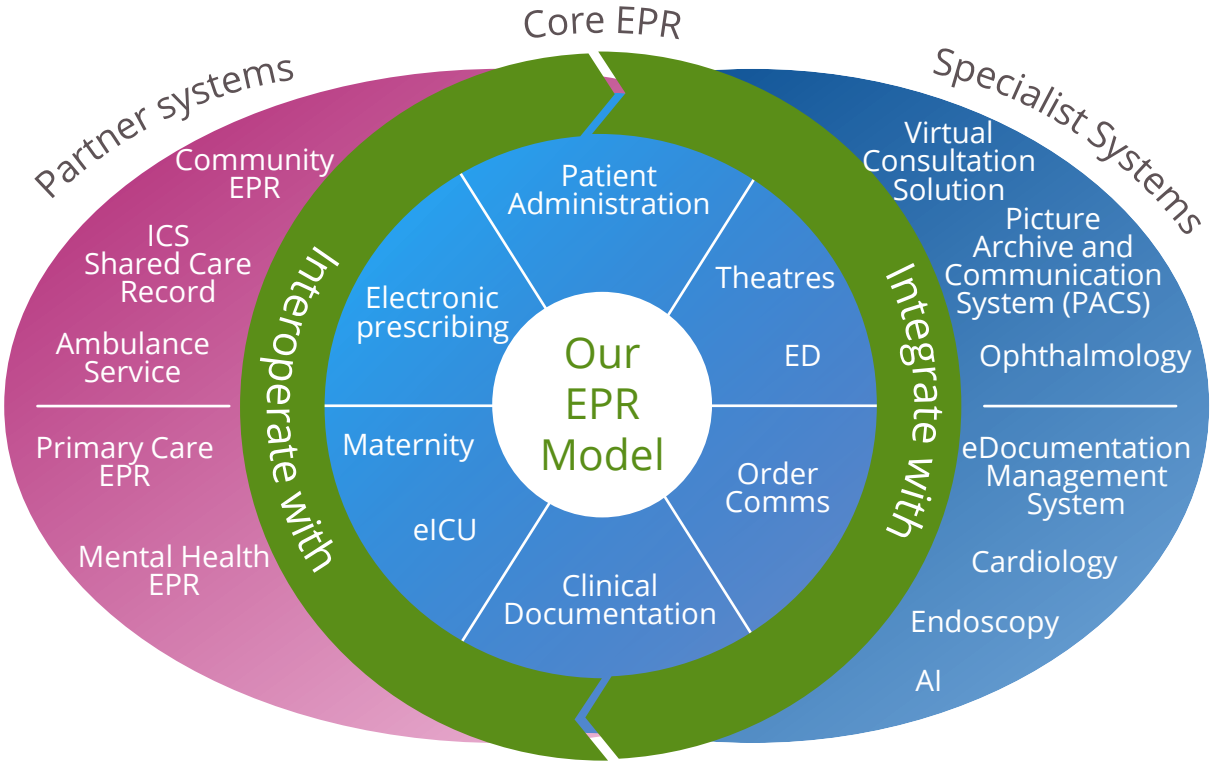
Salisbury NHS Foundation Trust

Over the next three years we will be procuring and implementing a new Electronic Patient Record (EPR), replacing the current version of Lorenzo and a number of standalone systems with go live expected in early 2025. This is a pivotal programme which will see us migrate away from our dependency on paper based working, significantly increasing the Trust's digital maturity. Being a shared procurement with the two other acute Trusts, this will provide the opportunity to consider how we can work differently with the systems provided both locally and across the ICS, aligning our working practices with our ICS acute partners where appropriate.

We aim to integrate key specialist systems into our new EPR, creating a more seamless experience for our staff. We will also work with our clinical network peers, mental health, primary, community and social care partners to ensure appropriate sharing of information with improved decision support.

The Shared EPR will provide the platform to build upon established pathways of care, standardising processes and improving the equitability of outcomes across our ICS. It will provide the opportunity to consider different workforce models across both the ICS and more widely with regional peers through creating a solution that staff can engage with remotely.

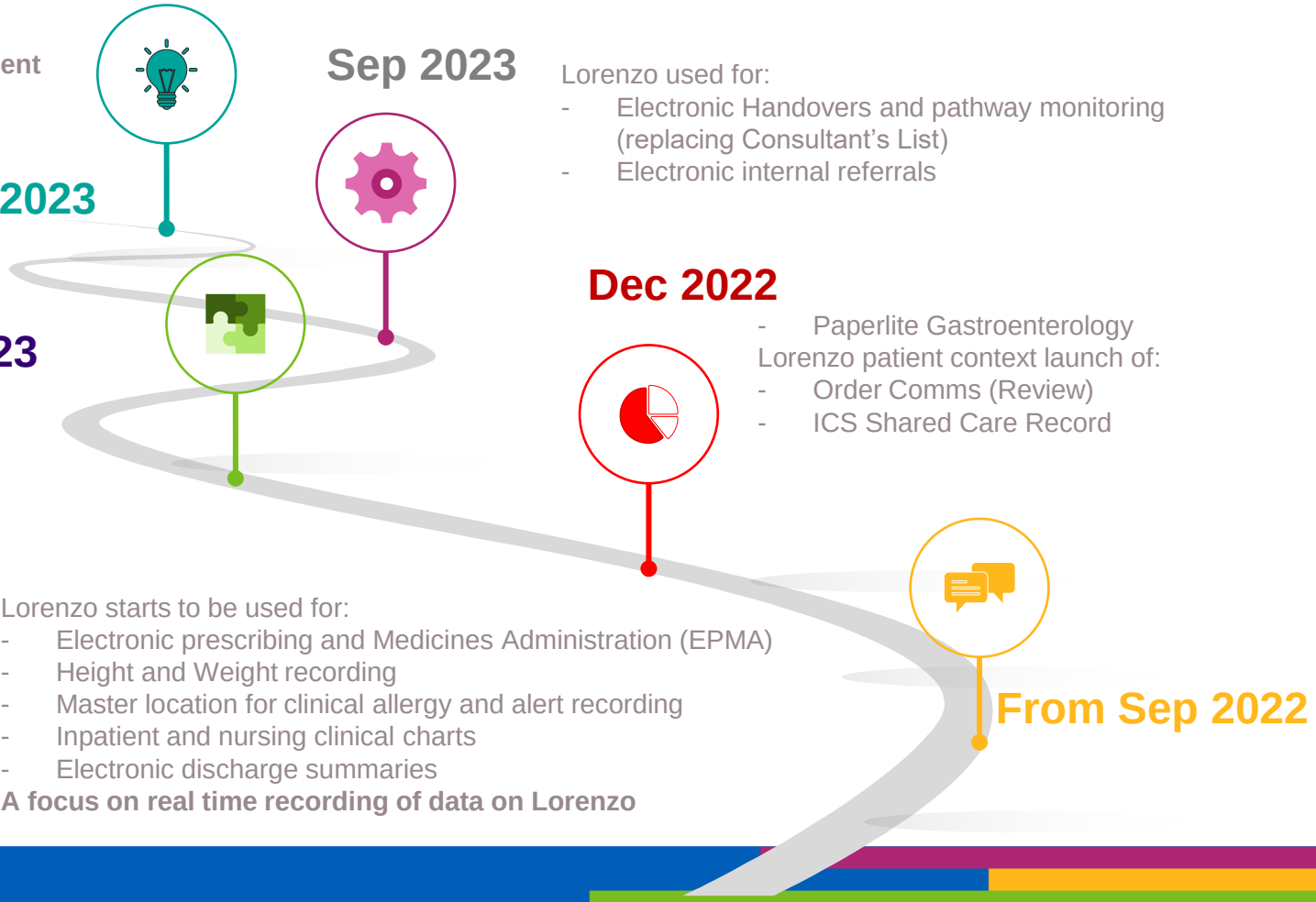
Moving to a new EPR provides us with an opportunity to reflect on the appropriateness of current inhouse developed applications. We will no longer build clinical applications, focusing on amalgamating appropriate applications into the new EPR or other existing solutions. This will then enable our skilled staff to focus on interoperability and integration of our systems and data.



Improving the use of Lorenzo

NHS Salisbury NHS Foundation Trust

Our longer term focus on successfully implementing our Shared EPR procurement and the benefits this will bring means that from October 2023 any developments on Lorenzo will stop. From now until that point however we still plan to help improve our working practices through increasing the use of Lorenzo, including the implementation of EPMA. Below describes what we aim to achieve before October 2023.



2) Digitally enabled partnership working

Salisbury NHS Foundation Trust

Both national and local strategies highlight the importance of partnership working in furthering the patient experience and improving outcomes. This can be seen through our ICS Health and Care Model and ICS Digital Strategy.

We will continue to expand the close working relationships with our ICS digital partners, considering how we can collectively create an environment where partnership working can flourish. This may be through joint procurements, improved information sharing or ensuring there is visibility of data. The most high profile programme is our Shared EPR procurement however this is only one strand of partnership working planned. In 2022 we will go live with our ICS Integrated Digital Care Record (IDCR), having Health and Social Care partners all contributing to provide clinicians with a single access point for key patient information such as care plans.

We will provide technology to help staff get the advice and guidance they require for effective decision making on treatments and onward care requirements.

The ICS Business Intelligence (BI) strategy sets out a vision of a single data warehouse and aligned reporting using cloud Power BI software to aid more effective planning. The roll out of our Shared EPR will see increased adoption of SNOMED CT coding improving standardisation across care settings. Our BI team will also support the use of population health management (PHM) tools across the ICS, helping clinicians to prioritise and coordinate care.

Through engagement with clinical networks, we will support finding technological solutions to key challenges such as rolling out digital pathology enabling our pathology network to share results and reporting capacity. Image sharing is a priority across the South West. We will work to implement solutions that are vendor neutral, providing clinicians with a single approach to requesting images and seeing results, reducing duplication of diagnostics for patients.

Some key deliverables are as follows:

2026
- Extending Shared EPR interoperability and Integration with Heath and Social Care partners

2025
- Adoption of SNOMED CT via Shared EPR implementation
- ICS BI reporting portal
- Shared EPR Go Live

2024
- Migration to an ICS standard GP order comms solution
- Standards based regional image sharing
- Digital Histopathology rollout

2023
- ICS Joint data warehousing pilot
- Adoption of PHM analysis tools
- Expansion of IDCR content
- Cloud Power BI
- Procurement of archiving solution

2022
- Go live of integrated digital care record
- Roll out of advice and guidance software

3) Supporting the people we serve

Salisbury NHS Foundation Trust

The expectations of people to be able to manage their healthcare and interact with professionals at the point of need continues to grow. We do however need to remember that whatever solutions we provide to respond to this ask considers those less digitally aware or within access to supportive technology.

The NHS App is now used by over 27 million people. The NHS App has a vision to be the single access point for people for NHS services in the future, therefore our objective is to ensure appropriate applications will link seamlessly with this application.

There are several programmes already underway which will help improve patient self care and virtual interactions. These include the development of personal held records for cancer and maternity, virtual consultations and virtual wards. We are working with ICS partners on creating a comprehensive personal held record and patient portal for patients to see their patient record, update key personal information and use this platform to communicate with clinicians regarding their care. This will include the option to receive previously written communication digitally.

Virtual wards and home monitoring applications have increasing uses to support patient self management and keep people out of hospital. We will seek to expand how we use these approaches in our clinical services, integrating them where possible with our patient portal future.

To ensure our population can all have equal opportunity to access services digitally, we will work with the ICS to understand and remove any barriers to inequality such as access to a mobile device. We will increase online guidance and training materials to improve utilisation of the online tools on offer. We will also look to expand our internal Digital Improvement Network to include citizen champions to help us hear the voice of our community to digital development and aid our local communities to support one another.

Some key deliverables are as follows:

2026

2025
- Expansion of PHR and patient portal linked to Shared EPR

2024
- Online resources to support patients and wayfinding
- Expansion of Digital Improvement Network to include patients
- Patient access to digital devices

2023
- Virtual appointment rebooking
- Optional electronic patient letters
- Expansion of home monitoring apps and telehealth
- Expansion of virtual wards

2022
- Maternity and Cancer PHR pilots
- Roll out of virtual consultations solution

4) Empowering a digital workforce

Salisbury NHS Foundation Trust

The electronic patient record is the principal IT system the majority of our staff use and will be the main focus of our resources in the coming years. However our staff undertake a range of other activities which often are either paper based or are digital but how we use the technology needs optimising.

The introduction of Microsoft 365 and the use of Microsoft Teams has provided us with the opportunity to increase our virtual communication and collaboration. These programmes will allow us to securely collaborate on documents seamlessly across organisations, access our corporate filing from any device and increase efficiency on joint improvement programmes.

Our use of Artificial Intelligence (AI) has increased in areas such as imaging and stroke. Over the lifetime of the digital plan, we will assess the benefits of piloting and/or rolling out new AI solutions to ensure we progress with those that have the greatest impact in the work we do. In 2022 we will commence the use of robotic process automation (RPA) to help reduce the routine repetitive activities so our staff can focus on areas that improve patient care.

Over the next three years we will continue to ensure we increase the use of existing systems such as ESR, eRostering and education solutions. We will continue to support key priority upgrades of systems in particular the replacement of the pathology management information system and the piloting of technology (RFID) to help track and trace items like medical devices.

We must ensure our staff feel confident in using technology at work and make it easy for them to undertake their roles effectively. We will provide simple to use education material to help build up knowledge. Our recent launch of the Digital Improvement Network aims to provide our staff with support local to where they work from people in similar roles or teams. This will help create ownership to expand the use of technology and adhere to agreed best practice in using these.

Ultimately we will aim to remove the use of paper records within the lifetime of this Digital Plan.

Some key deliverables are as follows:

2026
- Scanning of remaining paper records post Shared EPR implementation

2025
- Expansion of RFID

2024
- eRostering roll out complete
- Pathology LIMS implemented
- Digital literacy support roll out
- Digital Consenting solution

2023
- Digital Maternity
- Phase 1 of eRostering roll out complete
- Online corporate filing structure
- RFID pilot

2022
- Self Service BI for staff
- Intranet refresh
- Commencement of RPA programme
- Digital Improvement Network Launched

Digital Literacy

Salisbury NHS Foundation Trust

Our Digital Literacy programme builds on the Health Education England work and is aimed to:

- Ensure every role has the basic training necessary to use the systems and technology required to successfully undertake their role.
- Support staff in feeling confident to use systems and data in the ways they should be used, asking questions where there is any confusion
- Ensure all staff have parity of access to equipment and training materials to be able to develop
- Provide a network of like minded people to help proactively drive and encourage the use of technology

The programme has four main strands of focus. These will evolve as the programme builds up momentum, in particular as we look to implement the Shared EPR. The intent is to have a mature programme that supports the successful implementation of any new EPR in 2025. The four focus areas are:

Training and Education

Build up core digital learning resources (DLR) accessible through the DLR intranet page supplementing the Managed Learning Environment (MLE) training

Digital Improvement Network

Creating a network of digital champions and superusers to support staff in the use of core systems and build understanding of the digital agenda

Access to Training

Enabling staff to have the time and tools to undertake essential training through equipment provision and effective job planning

Digital Capability Assessments

Providing staff with digital capability self-assessments to help inform areas for professional and personal development as part of appraisals and job planning

5) Modern and Secure Infrastructure

Salisbury NHS Foundation Trust

There has been significant progress made in improving core infrastructure over the last 3 years, bringing increased stability and new technology such as single sign on. We will build on this, working on programmes such as virtual smartcards and a Wi-Fi network which will be able to cope with the networking of medical devices, the use of RFID technology, patients streaming online and more. By the end of the Digital Plan the objective is to have removed all legacy software and hardware.

We remain committed to a cloud first strategy and will be developing our cloud strategy with ICS partners over the next 12 months. In the interim, we have commenced the replacement of our core infrastructure with a more modern, fit for purpose solution which will enable us to better migrate to cloud over the next 5 years.

It is important we are able to technically support both the increasingly flexible and mobile workforce as well as ensure there is swift access to the cloud based systems we use. We will increase our broadband capacity to support future working practices and continue to invest in our rolling replacement programme for devices, providing staff with the right equipment to undertake their roles. With bleep technology becoming increasingly dated, we will work with peers to consider options around secure clinical communication and the enabling infrastructure to support this.

We are nearing completion of our local data warehouse and BI platform. This will provide us with a strong platform to work with our ICS partners to develop the next stage of shared working whilst ensuring we can maintain essential statutory reporting requirements and facilitate the self service BI and BI convergence plans.

Some key deliverables are as follows:

2026
- Cloud Strategy implemented
- Removal of all legacy equipment
- Clinical comms/bleep replacement
- Phase 3 Wi-Fi improvement

2025
- Phase 2 Wi-Fi improvement

2024
- Migration to new Infrastructure platform complete
- Phase 1 Wi-Fi improvement

2023
- Approval of Trust cloud strategy
- Data Warehouse migration complete
- Wi-Fi improvements pilot rolled out in Spinal services
- Expansion of secure bandwidth capacity

2022
- Virtual Smartcards/Authentication

Keeping SFT Secure

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The biggest threat to the NHS is cyber attacks which we are now well versed in both monitoring potential threats and dealing with cyber risks as they arise. However, as the cyber landscape is constantly evolving it is imperative that we continue to develop our threat monitoring, management and response approaches.

We have expanded on the core set of solutions we have in place to protect us such as anti-virus and industry standard firewalls to introduce modern mobile device management, privileged access management and event logging products. These will help us better control access to our devices and network as well as investigate potential threats. We have also integrated with national security solutions to ensure that national bodies such the National Cyber Security Centre can support us in monitoring risks and dealing with any issues we might have. Our programmes to replace out of support hardware and software means we can apply new patches aimed at stopping any vulnerabilities identified.

Our greatest defense to cyber attacks is people's education, awareness and vigilance. We already undertake routine awareness activities to help with this. In 2022/23 we are introducing more targeted online education material to help breakdown and focus education into threats and what individuals can do to help reduce the risk of cyber attack.

Over the last 12 months we have refreshed all our policies relating to information governance, data security and cyber security to help improve and simplify the guidance to staff in a bid to keep us safe. With the increasing move to cloud-based systems and working from home, we will be considering how best to develop an appropriate bring your own device policy (BYOD) in the coming year with the aim to allow people to access our networks and systems in a more flexible and safe manner.

We will continue to consider other technologies to improve in this area and by achieving Data Security and Protection Toolkit (DSPT) compliance annually, we will meet the minimum standards expected of the NHS.

Emerging digital opportunities

NHS Salisbury NHS Foundation Trust

The digital plan looks to introduce a range of new technologies and systems alongside building on what we have now. This includes a new Shared EPR, robotic process automation, telehealth and population health management. There will always be potential solutions not directly covered in our existing plans and/or can be expanded beyond the existing intended scope of use. Where funding and resources allow, we will consider which products could further our digital maturity, reduce emerging risks or provide added benefits. The table below outlines some areas which we know are evolving but are not currently in our strategy to give a flavour of opportunities which we may look at on a case by case basis:

Clinical Solution	Opportunity	How evolved is the market?	Benefits	Capital or Revenue
Infrastructure	Virtual Desktops Infrastructure	Mature	Less administrative overhead • Increased productivity • Cost savings	Capital & Revenue
	Use of drones	Immature	Swift transportation of organ transplants, small medical devices, medicines and vaccines and time sensitive diagnostic samples.	Capital & Revenue
Data Availability	AI supported advanced analytics	Growing	Undertake analytics or large datasets, providing insight and predicative analytics • Proactive scenario modeling based on trends/insights through machine learning	Revenue
Clinical Solutions	Secure Clinical Messaging	Growing	Significant time savings • Cessation of legacy bleep systems • Expedited communications enabling earlier discharge • UK GDPR compliance	Revenue
	Virtual Reality	Immature	Improving medical education • Delivering Chronic Pain Management • Supporting mental health therapy	Revenue
Patient Engagement	Remote Patient Monitoring	Growing	Improve quality of care • Timely interventions, reducing cost further down	Revenue
	Digital therapeutics	Immature	Prevent, manage, or treat behaviour-modifiable conditions such as diabetes, obesity and Alzheimer's disease.	Capital & Revenue
	Telehealth	Growing	Access to real time patient readings • Patients are not bound to NHS hours • Changes in treatment can happen sooner rather than later.	Revenue
Other Areas	Artificial Intelligence use in various services	Growing	Early detection of diseases such as cancer • Augments clinicians in their diagnosis process • Staff productivity	Capital & Revenue
	IoT Wearables	Growing	Accurate diagnoses at the point of care • More data collected for analytics purposes • Timely interventions	Revenue

Delivering the plan

Salisbury NHS Foundation Trust

Delivering the Digital Plan will require efforts from all staff as the majority of the plan requires ownership from clinical or operational staff to be successful. Our Digital Improvement Network is designed to help improve engagement, provide an initial point of contact with someone local who has the necessary training to support on some of the key systems such as Lorenzo. This will be expanded upon as we develop our plans to implement our new EPR. The launch of our Digital Care microsite will provide a platform for staff to understand the programmes underway, how they can be part of them alongside what the business as usual teams do and how to access training materials.

All of our programmes will continue to follow the Trust's programme management approach which has been in place for a number of years and has successfully delivered a range of projects. This includes a clear governance approach for programmes with escalation to Digital Steering Group. This includes ensuring we comply with our commitments relating to the clinical safety of digital transformation, led by our Clinical Safety Officer.

We have worked closely with procurement and our Digital Clinical Safety Officer to improve the processes around procuring digital tools, ensuring we undertake all due diligence up front to keep us safe and compliance with UK GDPR. The intent is to continue with central procurement of all technology and systems enabling a single oversight of requests which provides the opportunity to check alignment with the Digital Plan's priorities.

Wherever possible our Digital Plan will be delivered against however, like Covid has shown, there are sometimes reasons why plans need to be reviewed and changed as it is difficult to predict what will impact our Digital Plan over the next 5 years. Alongside Improving Together, we will ensure we have an effective prioritisation process for new requests as part of annual planning. This will make sure our resources are used most effectively and redirected where emerging clinical risk needs responding to. We will not commence or continue any programme where there is insufficient resource to successfully deliver the required objectives.

With a joint Chief Digital Officer across our Trust and Great Western Hospitals NHS Foundation Trust, it provides an opportunity for closer working by Digital departments. We already work closely as part of the ICS on joint procurements and strategic planning however we will look to expand on this to help improve resilience and remove duplication where possible.

Recruitment of fixed term staff within Informatics is often difficult. We have successfully recruited and developed bank staff over the last few years, many of whom have become substantive staff. We will continue with this model alongside considering apprenticeships, joint partnership working and/or finding resource externally. Projects will consider any training/upskilling that staff require to successful support the successfully deliver at the outset.

Strategic risks

Salisbury NHS Foundation Trust

The following have been identified as potential risks to delivery of the Digital Plan with proposed mitigating actions

Risk	Rating	Mitigating Actions to be taken
Delays in programmes due to the unavailability of hardware could delay delivery of programmes in the Digital Plan	High	Consideration of using different technology with reduced lead in times. Rearrange the use of existing network kit stock to support the more high risk programmes across the Trust (including estates builds). Engagement with suppliers and national NHS teams to provide influence in NHS organisations getting priority.
Insufficient commitment across the organisation to own the delivery of the digital agenda and associated benefits	High	Agreement from Board, executive team and senior management to champion the Digital Plan and adhere to consistent message. Improved engagement with staff on digital agenda (e.g. Digital Improvement Network). CIG to help ensure benefits identified are owned.
Insufficient commitment from ICS partners to deliver collaboration across the digital agenda to deliver potential benefits	Medium	Engagement on digital through ICS governance by CDO and CIO. CDO representation on ICS. Clinical pathway transformation agenda to support prioritisation of digital programmes, digital representation through ICS governance to support discussions. Joint procurements of systems/technology across the ICS.
Insufficient funding available to deliver Digital Plan	High	Strategy structured to be as realistic as possible. Bids to be put in for any available external funding where appropriate. Consideration of further funding options should external funding not be available for large programmes. FBC to clearly articulate the full resource needs for successful implementation to limit financial “surprises”.
Increased revenue costs associated with movement to cloud based technology	High	Cloud Strategy to be developed for Board consideration in Year 1 of Digital Plan. Maximise nationally procured cloud based products (e.g. Microsoft 365). National guidance around use of capital for cloud based system purchases available (where Trust has a preferred appetite for capital purchase).
Skill set and capacity within Informatics insufficient to deliver programmes in the Digital Plan	Medium	Work to align and/or converge key teams across SFT and GWH. Some structures as part of Shared EPR procurement to be reviewed. 3rd party partnerships with key suppliers in place for Infrastructure and networking. Upskilling of existing staff through professional development. Where appropriate seek partners to provide managed support (e.g. ICS cloud partner). Shared EPR programme developing resource plan for coming years including seating arrangements to ensure there is an effective approach to resourcing the programme successfully.
Trust unable to introduce emerging technology	Medium	Trust prioritisation process to be finalised for possible future investments from external funding streams and/or potential opportunities of funding for pilots. Connectivity improvement programme within Digital Plan a key enabler for networking medical devices, etc.

NHS Salisbury NHS Foundation Trust

Report to:	Trust Board (Public)	**Agenda item:**	3.2
Date of Meeting:	03 November 2022		

Report Title:	Improving Together highlight report			
Status:	**Information**	**Discussion**	**Assurance**	**Approval**
	X	X	X	
Approval Process (where has this paper been reviewed and approved)	n/a			
Prepared by:	Emma Cox, Head of Quality Improvement and Coach House			
Executive Sponsor (presenting):	Peter Collins, Chief Medical Officer and Exec Sponsor for Improving Together			
Appendices (list if applicable):				

Recommendation:
That the Board note this report.

Executive Summary:
The purpose of this report is to provide the Board with a monthly progress update of the Improving Together programme. In line with feedback provided in September Trust Board, mitigations are now included for workstreams off track. One workstream has been RAG rated red as a result of having delayed sessions to deliver content to Executive team. This is being mitigated through use of 1:1 sessions to introduce the content where appropriate while a new date is fixed for the session, at which point the workstream will return to amber, then green once session is delivered. Other workstreams remain amber as a result of mitigations still being worked on. Recruitment has been successfully completed to the Associate Director for Strategy (start date December) and Associate Director Improvement (start date January) roles. KPMG resource to provide support are being agreed to ensure a successful handover to both new starters. The Coach House are now developing a programme of continued support and coaching with divisions to ensure sustainability and embedding of tools. However, there continue to be challenges in divisional teams being able to actively engage in sessions due to the continual operational pressures faced by the Trust. Execs have agreed to a joint meeting to hear and

discuss concerns and agree way forward. In addition a gap analysis for our Exec Deputies will also be undertaken to ensure that they can adopt and introduce new ways of working effectively and consistently.

Our Front-line teams continue to experience operational staffing pressures, which is therefore impacting on their ability to attend training and coaching sessions and therefore learn new tools and implement within their working area. Opportunities are being explored with teams on how to 'bring them up to speed' on the tools taught to date.

The review of vision metrics is will be completed by the end of October and as a result, other actions can be achieved.

The Improving Together internal budget is currently underspent by £127,555. Identification of what is driving this underspend is being explored by the Head of Quality Improvement/Coach House. Areas who have Fixed Term Contracts (FTC's) will be discussing options and way forward with their finance BP as part of upcoming budget setting discussions.

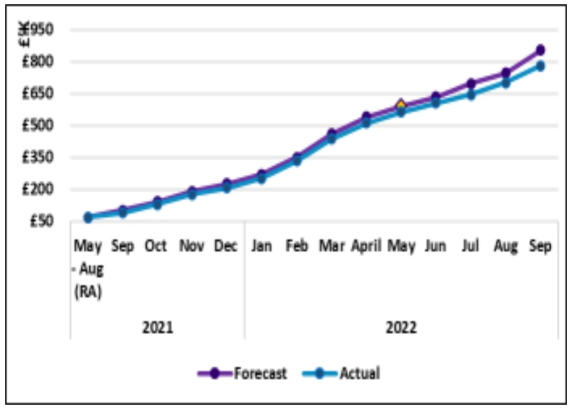
Board Assurance Framework – Strategic Priorities	Select as applicable
Population: Improving the health and well-being of the population we serve	☒
Partnerships: Working through partnerships to transform and integrate our services	☒
People: Supporting our People to make Salisbury NHS Foundation Trust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

Programme Report - October

Date of report: October 2022	Programme Overall RAG	

Salisbury NHS Foundation Trust

Financial update – Monthly fees KPMG



SFT Trust YTD Position

Project Code	YTD Budget	YTD Actual	YTD Variance
Improving Together (Non-pay)	50,196	4,834	-45,362
Improving Together (Pay)	283,978	201786	-82,192
Total Budget	**334,174**	**206,619**	**-127,555**

Success Stories

- First 2 day boot camp, undertaken independently by Coach House completed with a variety of clinical and non-clinical colleagues

- IPR into the third month of new process
- Divisional EPRs also BAU and now moving on to specification designing for Specialty Scorecards
- Release of Peter's first blog and video
- Microsite Analytics now in place
- All Execs completing personal A3 and working with KPMG coach
- Programme SRO attended Lean Healthcare Transformation Summit in Geneva
- Accountability Framework and Integrated Governance Framework have been combined into one document and updated to reflect IT methodology. Further work required to reflect changes in the EPR process". To be presented to TMC in November and Trust Board December.
- The tender process for a joint external Well-Led review has begun. SFT, RUH Bath and GWH have agreed the specification and work will now commence on finding the most appropriate provider to facilitate. SFT is leading on this.
- Rapid Improvement Events socialisation session with KPMG to begin planning for future events

Programme Risks / Mitigation

ID	Risk	Mitigated Score
1	There is a risk that the programme does not 'land' well with colleagues across the Trust.	12
2	There is a risk that the Coach house team do not have the required skills or experience to sustain the approach going forwards.	12 **(increased from 6)**
3	There is a risk that operational and severe staffing pressures result in an inability to support the current planned training dates or a significant lack of attendance.	15
4	There is a risk that the Trust will not fully realize value for money from KPMG support.	12 **(increased from 9)**
5	Insufficient leadership capacity to support the programme delivery.	9

Key for workstream RAG	On track	Off track – mitigation in place	Off track – requires mitigation

Workstream		Upcoming milestones – Q3	Escalation	Mitigation
Strategy Deployment		New Associate Director for Strategy in place and upskilled. Strategy Deployment Room routines started.	Assistant Director for Strategy in post in December, Board reporting to commence in Q4	Confirmed start date for Dec. Exec SRO driving work in the interim.
Leadership Behaviours		Board (inc. NED) development work is upcoming. Internal Leadership training started in Sept.	Workstream Project Initiation Document revised and updated for Board on 17.10 – scope includes management and leadership development across all staff groups –for example Best Place to Work (BPTW) / Breakfast club/ Shadow Board. Organisational Development team scheduling the core 3 culture and leadership modules for cohort 1 to complete prior to Christmas / positioning core modules alongside coach house offer for 2nd cohort and developing introduction to coaching for front line staff (may use intro to coaching on Managed Learning Environment). OD&L are currently running 2x cohorts of BPTW and have delivered 4 sessions for 42 delegates during Sep 22. Further to continued consultation proposed SFT Leadership behaviours framework requires further revision – next iteration to Board 21.11	New Associate Director and Head of OD increasing familiarity with Improving Together behaviours/ leadership curriculum / revisions and consultations to be carried out
Board & Exec Leadership Behaviours		Leadership Behaviour work with full Board in the new year.	Decision made to defer start of workstream until the new year due to changes in NED positions and Chairman change. Topics outstanding (“Go and See”, “Structured Conversation” and “Leader Standard Work”) to be delivered with no forum to do this.	Exec 1:1 sessions covering topics as needed for personal development in the interim.
Transformation		Commence planning for Rapid Improvement Events. Exec Corporate Projects deep dive (deferred from 3.10.22)	Decision needed on ownership of Corporate Project Prioritisation Group (CPPG) or link with Trust Investment Group(TIG) vs shadow board. Chair for CPPG required. Divisional representation requires discussion. Projects are continuing to emerge without coming through Corporate Priorities Filter process Dependency exists with A3s (for Strategic Initiatives and Breakthrough Objectives) and link to potential corporate projects (linked to escalation point above) – gap in understanding current governance/oversight)	Chief Finance Director in place to own decision making of CPPG going forward. Strategy Deployment Room routine to provide oversight of project status.
OMS – Divisions		Consistent use of driver metrics through weekly driver meetings as well as use of A3 thinking Divisional support roadmap in place and signed off with Coach House Development of full Specialty level implementation plan.	Divisional engagement / time to attend coaching sessions to embed new ways of working, following completion of the formal training is variable. Finalising watch metrics in line with good governance of the organisation is outstanding.	Development of additional role in Coach House to support better Divisional engagement. Further iteration of the Executive Performance Review standard work to create pull on management system routines.
OMS - Frontline		Huddles continuing to embed within ward / department Formal module training and coaching to be completed with KPMG.	Operational & staffing pressures impacting all team coaching and implementation of Improving Together tools this month. Limit new attendees to module training and coaching at this stage of the programme. Senior Ward staff are supporting the E-docu rollout on Farley and Spire, this is impacting on the support available to Farley staff for Improving Together.	Training for future cohorts redesign to be more flexible. Additional catch up sessions to be built in for teams that are behind. Development of additional role in Coach House to support better engagement.
Comms & Engagement		Fine-tuning comms activities to reflect change in formal training approach. Progression of physical space branding. In-person events planning (subject to Coach House resources): HiMP, Springs and Hedges drop-ins, Pizza evening and Champions takeover MS Teams (subject to approval). Materials for Induction and ongoing engagement.	Budget. Lack of budget limiting what can be created to help further build colleague awareness of Improving Together. Costs currently being subsidised by Communications budget but not sustainable. Chief People Officer looking into options.	Ongoing discussions on budget review for in year and future budget. Improving Together non-pay under spend budget considered for use to alleviate pressure on comms budget
Business Intelligence		Integrating Finance reporting , incorporating SOF into watch metrics and aligning cross divisional reporting.	Consideration needed for upcoming specialty workload based on resources in the team. Confirmation of process to change definitions of Breakthrough Objectives and subsequent methodology changes, if approved.	
Coach House		Full mapping of new training strategy delivery. Staffing Review. Upcoming 2 day bootcamp. Improver Standard pilot to be undertaken with transformation team.	Front line staffing challenges/changes to team representatives at this stage of the programme impact on methodology being understood/introduced and embedded. Divisional engagement/time to attend coaching sessions to embed new ways of working, following completion of the formal training is variable.	New roles in Coach House will add capacity for delivery and development of internal capability.
Governance		Work on Board subcommittee papers alignment to Vision and methodology Updating governance structures to reflect the IT methodology, including finalising the Framework to match Executive Performance Review process.	Breakthrough Objectives governance pending subject to Vision Metric review that is ongoing.	Review of the Vision Metrics by 31st October.

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Report to:	Trust Board (Public)	**Agenda item:**	4.1
Date of Meeting:	03 November 2022		

Report Title:	Board Assurance Framework (BAF) and Corporate Risk Register (CRR)			
Status:	**Information**	**Discussion**	**Assurance**	**Approval**
		x	x	
Approval Process (where has this paper been reviewed and approved)	N/A			
Prepared by:	Fiona McNeight, Director of Integrated Governance			
Executive Sponsor (presenting):	Fiona McNeight, Director of Integrated Governance			
Appendices (list if applicable):	Revised Board Assurance Framework October 2022 (draft) Draft Summary CRR tracker v1 October 2022 Corporate Risk Register October 2022 v1			

Recommendation:

The Trust Board are asked to review, discuss and make any recommendations to the following:

- Board Assurance Framework (BAF)
- Corporate Risk Register
- The Corporate Risk Tracker

Specifically, the Board is required to:

- Review the overall risk profile for each strategic priority and agree this reflects all current and future risks.
- Review the risks out with tolerance and request any further assurance required in respect of risk mitigation.
- Review the principle strategic risks (BAF) and any associated gaps in control or assurance

Executive Summary:

The Board Assurance Framework (BAF) provides the Trust Board with a mechanism for satisfying itself that its responsibilities are being discharged effectively. It identifies through assurance where aspects of service delivery are being delivered to internal and external requirements. It informs the Board where the delivery of principal objectives is at risk due to a gap in control and/or assurance.

Following the Risk Appetite session at the Trust Board Development Day in May 2022, the Board Assurance Framework has been completely revised and presented in July 2022. Further changes to note:

- The risk theme, risk appetite and tolerance level has been applied to each risk on the CRR and included on the CRR tracker.
- The BAF risk template has also been amended slightly to include the controls and assurance for each strategic risk together with the risk tolerance level as requested in the July Board Committees.

The overall risk profile reflects an organization under pressure with key risks associated with staffing and the impact on patient care provision and service delivery, the estate, the financial position and deterioration in key performance metrics.

Board Committee Feedback

There is consensus that the focus on the strategic and corporate risk profile and associated application of the risk themes and appetite is appropriate and that the current risk profile is reflective of the key organization risks. There was detailed discussion regarding the risks out with risk tolerance and a collective view and understanding of risk mitigation, acknowledging what was within the Trust control and the challenge to bringing these risks back within tolerance.

Summary Strategic Risk Profile

- 12 strategic risks have been identified by the Executives compared to 11 reported in July.
- BAF risk 1: The impact on service delivery as a result of Covid, impacting on the ability to recover activity to pre-Covid levels. Risk of delay to treatments, impact on quality of care and performance is now within tolerance with a reduction in score from 20 to 12.
- BAF risk 8: Demand for services that outweighs capacity, resulting in an increased risk to patient safety, quality, and effectiveness of patient care is now within tolerance with a reduction in score from 20 to 12.
- BAF risk 9: An irreversible inability to reduce the scale of financial deficit is now out with tolerance with an increase in score from 12 to 16.
- BAF risk 12: Risk of sustained deterioration across key performance metrics is a new risk with a score of 16 and is out with tolerance.

There are 5 strategic risks out with tolerance:

- BAF 4 - Risks associated with critical plant and building infrastructure that may result in utility or system failure impacting on service delivery.
- BAF 5 - As a result of inadequate nursing staff and additional open capacity there is a risk of poor quality of care and poor patient experience.
- BAF 7 - Inability to effectively plan for, recruit and retain staff with the right skills which will impact staff experience, morale and well-being which can result in an adverse impact on patient care.
- BAF 9 - An irreversible inability to reduce the scale of financial deficit
- BAF 12 - Risk of sustained deterioration across key performance metrics

All of the above risks have a score greater than 15. These all fall within an open risk appetite and therefore any score over 12 is out with tolerance. This is a change in risk profile from the previous report in July and reflects the key focus of the identification and assessment of risks by the Board and the Board Committees. The risk tolerance has not identified any unexpected

risks out with tolerance and reflect the challenges discussed at Board and Board Committees and evidenced through the Integrated Performance Report metrics and individual reports.

Summary Corporate Risk Profile

The risk type, risk appetite and risk tolerance has been applied to all CRR risks. This has identified that the following 6 risks are out with tolerance:

- Risk 5751: Risk of patient harm caused by a delayed discharge from hospital.
- Risk 7039: The Trust is currently experiencing increased demand and patient acuity across all in-patient areas, at a time of increased nursing sickness, maternity leave, leavers and retirement and reduced recruitment. This causes a shortfall in Care Hours per Patient day (CHPPD), increases risk of burnout for remaining staff, causes delay to flow and discharges and inability to provide required care for all patients
- Risk 508: The absence of a comprehensive Health and Safety Management System for the Trust runs the risk that legislative requirements will not be embedded into the Trust standards to which departments are expected to work. Without those standards, we cannot expect the Trust be compliant, so the consequences of non-compliance with health and safety law results in Staff and all persons on site at risk of harm and the Trust at risk of prosecution and claims.
- Risk 7276 (People) - Risk to Occupational Health Service provision.
- Risk 7430 (People) – As a result of the 2022 National pay award there is a risk of industrial action across a number of staff groups. This may compromise patient safety and quality of care provision.
- Risk 7472 (People) - As a result of unmanageable staff absences, poor retention of existing staff and ineffective recruitment activity to fill vacancies, there is a risk that SFT is unable to manage service provision and operate in a safe hospital.

As with the BAF, the corporate risks out with tolerance have been key topics for discussion both at Board and the Board Committees in relation to patient flow and staffing impacting on patient care provision and service delivery. Health and Safety governance is progressing and the risk score has reduced since July. A new Health and Safety Manager is in post and is assessing areas for improvement in the management systems. The Board agreed a cautious risk appetite for governance hence why this risk is out with tolerance with a score of 12.

Extreme risks

- 5751 (Population) - Risk of patient harm caused by a delayed discharge from hospital (Score 20).
- 7039 (Population) - The Trust is currently experiencing increased demand and patient acuity across all in-patient areas, at a time of increased nursing sickness, maternity leave, leavers and retirement and reduced recruitment. This causes a shortfall in Care Hours per Patient day (CHPPD), increases risk of burnout for remaining staff, causes delay to flow and discharges and inability to provide required care for all patients (Score 20)
- 7276 (People) - Risk to Occupational Health Service provision (Score 16).
- 7430 (People) – As a result of the 2022 National pay award there is a risk of industrial action across a number of staff groups. This may compromise patient safety and quality of care provision (Score 16)

- 7472 (People) - As a result of unmanageable staff absences, poor retention of existing staff and ineffective recruitment activity to fill vacancies, there is a risk that SFT is unable to manage service provision and operate in a safe hospital (Score 16)

New risks since July 2022

- 7039 (Population) - The Trust is currently experiencing increased demand and patient acuity across all in-patient areas, at a time of increased nursing sickness, maternity leave, leavers and retirement and reduced recruitment. This causes a shortfall in Care Hours per Patient day (CHPPD), increases risk of burnout for remaining staff, causes delay to flow and discharges and inability to provide required care for all patients. (Score 20)
- 7430 (People) – As a result of the 2022 National pay award there is a risk of industrial action across a number of staff groups. This may compromise patient safety and quality of care provision (Score 16)
- 7472 (People) - As a result of unmanageable staff absences, poor retention of existing staff and ineffective recruitment activity to fill vacancies, there is a risk that SFT is unable to manage service provision and operate in a safe hospital (Score 16)

Risks removed

- 6471 (Partnerships) - Shortfall in funding available (locally and nationally) for capital programme, leading to potential risk to safety and availability of buildings and equipment to deliver services (Score 15). This is reflected within BAF risk
- 6834 (People) - As a result of Covid-19 pandemic there is a significant risk that a large proportion of the workforce could suffer from significant mental and physical wellbeing consequences. This may result in a large number of staff resignations and retirements as well as increased staff absence due to sick leave.
- 7081 (People) - As a result of vacant roles which are defined as hard to recruit to posts, there is a risk that there becomes a reliance on covering the vacancy with costly Agency/Locums and/or outsourcing and/or discontinue services. Risk of impact on services. The workforce risks (6834 and 7081) have been removed and replaced with risk 7472 as an overarching staffing risk.

Risks with an increased score

- Nil to note

Risks with a decreased score

- 5704 (Population) - Inability to provide a full gastroenterology service due to a lack of medical and nursing workforce (Score 12 to 9).
- 7283 (Population) - Covid Testing and patient pathway management (Score 12 to 9)
- 508 (Population) - The absence of a comprehensive Health and Safety Management System for the Trust runs the risk that legislative requirements will not be embedded into the Trust standards to which departments are expected to work. Without those standards, we cannot expect the Trust to be compliant, so the consequences of non-compliance with health and safety law results in Staff and all persons on site at risk of harm and the Trust at risk of prosecution and claims (Score 15 to 12).
- 7078 (People) - As a result of competing priorities and deliverables there is a risk of slippage of the Improving Together Programme deadlines (Score 15 to 12).
- 7308 (Partnerships) - The financial plan for 2022/23 is a deficit plan with assumed 2.2% savings. There is a material risk that the deficit will be larger than planned due to the operational constraints, inability to achieve financial savings and ongoing pressures

related to patients with no criteria to reside. Therefore, there is a risk that cash flow is challenged during the year resulting in the Trust having to take emergency cash measures (Score 15 to 12).

Deep Dive
The Board approved the criteria for the initiation of a deep dive of a risk on the corporate risk register in February 2020. The criteria are set out below:

- A corporate risk of 16 and above for a period of 6 months will initiate a deep dive
- A corporate risk score <16 unchanged for 12 months will initiate a deep dive
- An escalating risk score over a 3-month period will initiate a Board Committee discussion

2 risks currently meet the threshold for a deep dive:

Risk 5751 (Population): Risk of patient harm caused by a delayed discharge from hospital. This risk has scored 15 to 20 for over 12 months. A deep dive was presented to Finance and Performance Committee in February 2022. Monthly updates are provided through the Integrated Performance Report.

Risks 5360 (cyber), 5955 (management control processes), 5972 (transformation and improvement delivery), 6143 (7 day services) and 6858 (BSW partnership working) have scored <16 for over 12 months and require review as they meet the threshold for a deep dive.

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

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Board Assurance Framework

V1 October 2022

Our Vision is to provide an outstanding experience for our patients, their families and the people who work for and with us.

An outstanding experience for every patient

Board Assurance Framework

The Board Assurance Framework (BAF) provides the Trust Board with a mechanism for satisfying itself that its responsibilities are being discharged effectively. It identifies through assurance where aspects of service delivery are being delivered to internal and external requirements. It informs the Board where the delivery of principal objectives is at risk due to a gap in control and/or assurance.

Trust Values

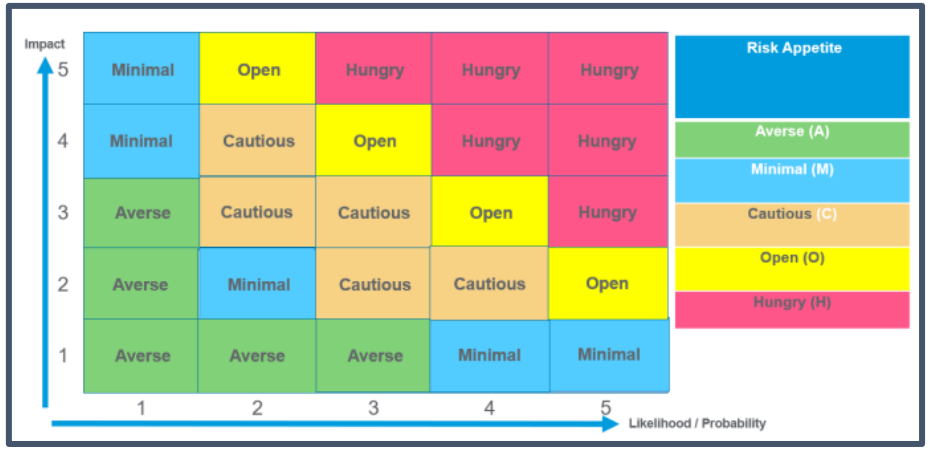
The core values and behaviours to support the achievement of the Trust vision:

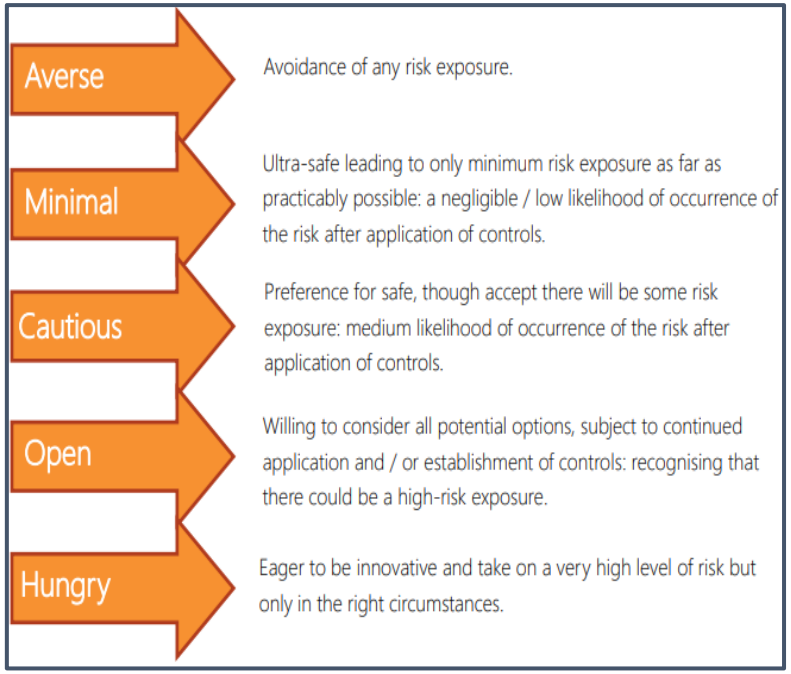
Strategic Priorities

Risk Matrix

Risk Matrix					
Likelihood/ Frequency ↓	Consequence/Impact →				
	Insignificant 1	Minor 2	Moderate 3	Major 4	Catastrophic 5
5 Almost Certain	Moderate 5	High 10	Significant 15	Significant 20	Significant 25
4 Likely	Moderate 4	High 8	High 12	Significant 16	Significant 20
3 Possible	Low 3	Moderate 6	High 9	High 12	Significant 15
2 Unlikely	Low 2	Moderate 4	Moderate 6	High 8	High 10
1 Rare	Low 1	Low 2	Low 3	Moderate 4	Moderate 5

Risk Appetite





Risk Scores	Risk Appetite Level
15+	Hungry
10-12	Open
6-9	Cautious
4-5	Minimal
1-3	Averse

Risk Tolerance	
within tolerance	
outwith tolerance	

Board Assurance Framework Dashboard

Board Assurance Framework 2022/2023 October 2022

Strategic Risk	Risk Title	Exec Lead	Initial Score	Sep-21	Jan-22	Apr-22	Jul-22	Oct-22	Target
Risk Detail			Score Trend						
POPULATION - Improving the health and wellbeing of the population we serve									
BAF 1	The impact on service delivery as a result of Covid, impacting on the ability to recover activity to pre-Covid levels. Risk of delay to treatments, impact on quality of care and performance	Chief Operating Officer	15	12	12	20	20	12	8
BAF 2	The scale of and demand for certain Specialist or Sub-Specialty services provided at SFT are not compatible with long-term sustainability. This confers a risk that patients will not have access to either a quality service or a local service.	Chief Medical Officer	15	10	10	10	10	10	8
BAF 3	Lack of capability and capacity to deliver the digital strategy, resulting in poor quality services, reputational damage and inability to attract and retain high quality staff.	Chief Digital Officer	16	12	12	12	12	12	9
BAF 4	Risks associated with critical plant and building infrastructure that may result in utility or system failure impacting on service delivery.	Chief Executive Officer / Director of estates	12	16	16	16	16	16	8
BAF 8	Demand for services that outweighs capacity, resulting in an increased risk to patient safety, quality, and effectiveness of patient care.	Chief Operating Officer	20				20	12	9

Risk Score Key

Low Risk 1-3
Moderate Risk 4-6
High Risk 8-12
Extreme Risk 15-25

Board Assurance Framework Dashboard Cont.

Strategic Risk	Risk Title	Exec Lead	Initial Score	Sep-21	Jan-22	Apr-22	Jul-22	Oct-22	Target
People - Supporting our people to make Salisbury NHS Foundation Trust the best place to work									
BAF 5	As a result of inadequate nursing staff and additional open capacity there is a risk of poor quality of care and poor patient experience.	Chief Nursing Officer	20				20	20	9
BAF 7	Inability to effectively plan for, recruit and retain staff with the right skills which will impact staff experience, morale and well-being which can result in an adverse impact on patient care.	Chief People Officer	20				20	20	9
PARTNERSHIPS - Working through partnerships to transform and integrate our services									
BAF 6	Lack of a National clear model for small rural DGH services places future strategic planning uncertainty at SFT.	Chief Finance Officer	12	8	8	8	8	8	6
BAF 9	An irreversible inability to reduce the scale of financial deficit	Chief Finance Officer	12				12	16	9
BAF 10	Failure to establish and maintain effective partnerships to support the Integrated Care System with the potential to impact the Trust at PLACE level.	Chief executive Officer/ Chief Finance Officer	9				9	9	6
BAF 11	Significant failure of supply chain which could result in substantial or prolonged disruption to services.	Chief Finance Officer	12				12	12	9
BAF 12	Risk of sustained deterioration across key performance metrics (new risk)	Chief Operating Officer	16					16	9

Risk Score Key

Low Risk 1-3
Moderate Risk 4-6
High Risk 8-12
Extreme Risk 15-25

BAF Risk 1	The impact on service delivery as a result of Covid, impacting on the ability to recover activity to pre-Covid levels. Risk of delay to treatments, impact on quality of care and performance									
Strategic Priority	**Population**			**Risk Score 2021/22**						
Linked Corporate Risks	7283			Initial Score	July 21	Sept 21	Jan 22	April 22	July 22	Oct 22	Target score
Executive Lead	Chief Operating Officer									
Lead Committee	Finance and Performance			15	16	12	12	20	20	12	8
Risk Type	Covid Recovery	**Risk Appetite/Tolerance**	Open							

Context	Controls/ Assurance
Following de-escalation from a Level 4 National incident, the Trust has an increased number of patients waiting for elective procedures. Trajectories have been agreed and the Trust is monitoring against these Our operational context remains challenging with escalation beds still open, demand for urgent services consistently pressurised, the on-going need to deliver elective recovery and staff availability day to day creating significant pressure for the teams. Despite the challenges our elective recovery is currently on track in respect of delivering the headline requirements for waiting times.	Vaccination programme Low levels of Covid +ve patients

Progress

What is going well/ Future Opportunities?	What are the current challenges including future risks?	How are these challenges being managed?
South Newton capacity Recruitment campaign to increase theatre capacity No patients waiting over 104 weeks for care by end of July Continued reduction in those waiting over 78 and 52 weeks respectively	Failure in infrastructure resulting in loss of capacity e.g. day surgery unit Workforce constraints due to recruitment, retention and sickness Increasing numbers of NCTR Lack of resources (contractors and supplies). Increasing community infection rates. Lack of capacity of discharge pathway providers. Increase in referrals and referrals late in the disease pathway. Follow-up and non-first procedure waiting times. Not assured that the insource provider will deliver the contract. Lack of recruitment and retention plan	Delivery of the estates plan as per BAF Risk 4 On-going recruitment Staffing task and finish group established Escalated to GOLD level at BSW for mitigations for external capacity to address NCTR Trust reviewing options to commission capacity directly

BAF Risk 2	The scale of and demand for certain Specialist or Sub-Specialty services provided at SFT are not compatible with long-term sustainability. This confers a risk that patients will not have access to either a quality service or a local service.		
Strategic Priority	Population		
Linked Corporate Risks	5704, 6836		
Executive Lead	Chief Medical Officer		
Lead Committee	Finance and Performance		
Risk Type	Innovation	**Risk Appetite / tolerance**	Open

Risk Score 2021/22

Initial Score	July 21	Sept 21	Jan 22	April 22	July 22	Oct 22	Target Score
15	10	10	10	10	10	10	8

Context

Increasing public professional and regulatory requirements resulting in sub-specialisation which is resource intensive and difficult to provide in a Trust of this size.

The 3 concern specialties include GI, dermatology and the sleep service

Controls/Assurance

Trust contribution into the AHA clinical strategy stocktake
Dermatology mutual aid agreement with RUH
GI bleed service being managed in partnership with Bournemouth (UHD)
Reconfiguration of sleep services across BSW

Progress

What is going well/ Future Opportunities?	What are the current challenges including future risks?	How are these challenges being managed?
Acute Hospital Alliance clinical strategy is under development specifically looking at small for scale services and the opportunity for cross organisational working or service reconfiguration to support sustainability Recruitment of an Associate Director of Strategy successful	Pace of change required for large scale reconfiguration Current fragile services could be at risk of regulatory enforcement action. Risk that patients will not have access to state of the art services Current substantive workforce gap in GI Medicine precludes on site GI bleed service. Lack of capacity in the sleep service to meet demand	Clinical governance processes ensure minimum safe standards are maintained. AHA clinical strategy work being led by Chief Medical Officer. External medical workforce and model of care commissioned for completion by end of January 2023. GI bleed service being managed in partnership with Bournemouth (UHD) Trust leading on Reconfiguration of sleep services across BSW

BAF Risk 3	Lack of capability and capacity to deliver the digital strategy, resulting in poor quality services, reputational damage and inability to attract and retain high quality staff.		
Strategic Priority	Population		
Linked Corporate Risks	5360 (Cyber)		
Executive Lead	Chief Digital Officer		
Lead Committee	Finance and Performance		
Risk Type	Infrastructure	**Risk Appetite / tolerance**	Open

Risk Score 2021/22

Initial Score	July 21	Sept 21	Jan 22	April 22	July 22	Oct 22	Target Score
16	16	12	12	12	12	12	9

Context

The Trust is digitally immature when benchmarked nationally. The Trust's digital strategy sets out a significant agenda to improve integration of systems, maximise the existing Electronic Patient Record (EPR) whilst working towards a more sustainable longer term joint approach across the ICS, expanding the use of data and ensuring we have infrastructure that enables us to effective use technology and stay safe.
As technology touches on most transformation programmes, there is insufficient capacity and funding to deliver all that is asked with our appropriate prioritisation. This constraint risks the Trust not being able to maintain all desired level of improvements alongside participating in all local and regional initiatives with peers.

Controls/ Assurance

Digital Steering Group in place with robust digital governance below this, including programme governance.
BSW shared EPR programme board in place.
Clinical digital leadership in place including CCIO, CNIO, MIOs and Digital Midwife.
Digital Innovation Launched to increase digital profile including digital champions and digital superusers to support change and ownership.
Cyber security team set up within IT Operational to manage cyber risk mitigation activities.

Progress

What is going well/ Future Opportunities?	What are the current challenges including future risks?	How are these challenges being managed?
Programme to replace all unsupported servers progressing, majority expected to be removed by March 2023 EPMA Go Live planned for Q3 2022/23 Refreshed Digital Plan intended going through October 2022 governance for final approval at November 2022 Trust Board EPR OBC approved, procurement for new Shared EPR commenced 18th July 2022, expecting to have preferred supplier by December 2022.	1. Infrastructure hardware seeking significant delays globally (c.7 months) due to chip shortage. 2. Funding for new shared EPR not confirmed until Full Business Case is developed and approved. 3. There remains a large agenda of projects with a digital component which are not resourced, funded or prioritised. 4. Some digital programmes are behind original plans 5. The current Informatics leadership is not fully resilient and there is a single point of failure. 6. Lack of funding to deliver full Digital Plan including removing all unsupported technologies 7. Clinical engagement is limited due to operational pressures	1. Reprioritisation of existing infrastructure stock usage to help deliver programmes as re-quickly as possible. 2. Informal funding commitment from NHSE/I. Routine updates with NHSE/I region to resolve emerging concerns. 3. Prioritisation of programmes through Corporate Projects Prioritisation Group. 4. Programmes are rebased as part of existing programme governance and strong PMB challenge on delivering against this rebased targets in place. 5. Structure across GWH and SFT being reviewed with CDO. 6. Seeking opportunities for national funding to support programmes, carefully considering the revenue impact and resource availability to implement. 7. Clinical leads supporting identifying champions for key activities (Shared EPR, implementation activities). Procuring new communication software to support different digital communication methods.

BAF Risk 4	Risks associated with critical plant and building infrastructure that may result in utility or system failure impacting on service delivery.		
Strategic Priority	Population		
Linked Corporate Risks			
Executive Lead	CEO/ Director of Estates		
Lead Committee	Finance and Performance		
Risk Type	Infrastructure	Risk Appetite / tolerance	Open

Risk Score 2021/22							
Initial Score	July 21	Sept 21	Jan 22	April 22	July 22	Oct 22	Target Score
12	16	16	16	16	16	16	8

Context

With a large, in some parts dated, estate, SFT has a substantial backlog of investment required to maintain standards and deliver on emerging expectations, e.g., sustainability.

There is equally a requirement to keep technologies up to date, investing in replacement medical equipment and modernising digital capabilities. The availability of CDEL capital funds is largely fixed and the projections suggest that it will be insufficient to meet the demands faced. Whilst targeted funding may become available, the picture is such that careful planning and prioritisation of requirements will be essential. The plan sets out how the Trust should develop a revised estates strategy, have a plan for decarbonisation of the estate and review how the estate will evolve over the next three to five years in line with the Trust strategy. Similarly, the digital strategy and need for medical equipment replacement will influence priorities for investment in these areas.

Controls/ Assurance

Prioritised capital programme assessed against critical need.
Estates risk register and action plan reporting to Trust Board demonstrating progress

Progress

What is going well/ Future Opportunities?	What are the current challenges including future risks?	How are these challenges being managed?
Prioritised capital programme assessed against critical need. Campus project to address longer term estates. Funding bid approved for additional ward. Significant improvement in compliance Monitoring to identify key risk areas.	Core infrastructure continues to degrade – level of backlog maintenance increases Inflationary pressures increase costs of necessary improvements Long lead in times due to supply chain issues National targeted resources do not address key resilience issues Resilience of day surgery unit Patient environment in a number of inpatient areas, e.g., spinal unit, Breamore Quality of on-site, staff accommodation worsens Insufficient progress made on digital initiatives limits productivity improvements and increased interoperability with other health and care organisations Increasingly challenged position medical equipment replacement Failures of medical equipment require immediate, unplanned replacement Insufficient progress on sustainability initiatives limits delivery of nationally mandated target.	Engagement on fair shares for capital allocations. Planning for system approach to capital plans. Lobbying for major service developments (e.g., DSU) stressing of wider, placemaking benefits. Assess potential for emergency capital bid or bids. Estate's strategy renewal – to develop a three-year estates plan. Estate sustainability strategy. Review staff accommodation offering. Look for alternative sources of funding. Regular review of digital priorities. Medical equipment group review of clinical priorities

BAF Risk 5	As a result of inadequate nursing staff and additional open capacity there is a risk of poor quality of care and poor patient experience.		
Strategic Priority	People		
Linked Corporate Risks	5704, 7039, 6143, 7472, 6954		
Executive Lead	Chief Nursing Officer		
Lead Committee	People and Culture Committee		
Risk Type	Capability and skills	**Risk Appetite / tolerance**	Open

Risk Score 2021/22

Initial Score	July 21	Sept 21	Jan 22	April 22	July 22	Oct 22	Target score
20					20	20	9

Context

Due to the number of vacancies, levels of Covid absence and overall unavailability, staffing levels are running at Red, Black and Purple levels on a regular basis. This is contributing to an overall poor experience for staff and patients, contributing to low morale, increased sickness and increased turnover.
CHPPD shows SFT is in the bottom decile and materially worse than BSW partners. This is predominately driven by HCA lower workforce.
Covid numbers are increasing for staff absence
Maternity leave is high
Morale is low, with exhausted teams
Agency fill is poor
Heavy reliance on RMN due to MH needs, use of specials for complex patients
NCTR high on avg >100 patients

Controls/ Assurance

3 x daily staffing meetings and early escalation to agency
Staffing task and finish group established
Recruitment events
Block booking and use of bank staff
Apprenticeship to Registered Nurse in place

Progress

What is going well/ Future Opportunities?	What are the current challenges including future risks?	How are these challenges being managed?
Registered nurse vacancy and there is a pipeline to close the gap with overseas nurses by Dec 2022. HCA Apprenticeships including Maths and English to attract staff with low educational attainment. HCA away days to boost retention Falls improvement following Improving Together focus	Overall vacancy rate for RNs and HCAs (80 HCA vacancies) Sickness absence rate increasing across RN and HCA. Staffing demand is likely to increase based on levels of NCTR and Bed capacity modelling which will increase required number of HCA and RN's Retention of current staff Deterioration in key quality metrics Inability to release staff for training	Recruitment events monthly Allocation on arrival & Buy back A/L Run HCA Recruitment event HCA banding review Band 4 Ward Movement Retention bonus for HCAs and Band 5s Revised induction New to Care HCA programme Staffing task and finish group established Utilising Improving Together methodology to focus on improvement areas. A3 assessment for tissue viability planned

BAF Risk 6	Lack of a National clear model for small rural DGH services places future strategic planning uncertainty at SFT.		
Strategic Priority	Partnership		
Linked Corporate Risks	6858		
Executive Lead	Chief Finance Officer		
Lead Committee	Finance and Performance		
Risk Type	Integration & Partnership	Risk Appetite / tolerance	Open

Risk Score 2021/22

Initial Score	July 21	Sept 21	Jan 22	April 22	July 22	Oct 22	Target score
12	8	8	8	8	8	8	6

Context

There is a risk that smaller non specialist acute providers operate at too small a scale to be financially sustainable - whilst providing a high quality of care. International policy changes have seen attempts to rationalise care, consolidating services at larger hospitals which serve more densely populated areas.

Without a national policy recognising specifically the challenges of smaller hospitals there is a risk that a one size all fits payment regime and policy approach (particularly clinical standards) fails to recognise the significant challenges in achieving high quality service delivery at scale, addressing sub specialty challenges and meeting recruitment and retention challenges.

Controls/ Assurance

Partnership working with Acute Alliance on shared back-office functions to reduce cost.

Working with partners on wider partnerships e.g., Pathology south Six, radiology network.

Working in hub and spoke models for clinical services to mitigate risk.

Progress

What is going well/ Future Opportunities?	What are the current challenges including future risks?	How are these challenges being managed?
Move of specialist commissioning services to ICB will allow more flexible approach to service delivery models. Looking at technology to enable recruitment and retention e.g. robotic surgery.	Cost of 7 day a week services shows high cost for level of patient numbers. National work on small hospitals paused due to Covid, more policy direction now at ICB level. Lack of fully developed ICB financial recovery plan addressing underlying deficit. Lack of national change in funding regime to reflect rurality and size of organisation. further work required to influence tariff developments.	Partnership working with Acute Alliance on shared back-office functions to reduce cost. Working with partners on wider partnerships e.g., Pathology south Six, radiology network. Working in hub and spoke models for clinical services to mitigate risk. Use of technology to support service delivery

BAF Risk 7	Inability to effectively plan for, recruit and retain staff with the right skills which will impact staff experience, morale and well-being which can result in an adverse impact on patient care.		
Strategic Priority	People		
Linked Corporate Risks	5704, 7206, 7039, 6143, 7276, 6954, 7430,7472		
Executive Lead	Chief People Officer		
Lead Committee	People and Culture Committee		
Risk Type	Capability and Skills	Risk Appetite / tolerance	Open

Risk Score 2021/22							
Initial Score	July 21	Sept 21	Jan 22	April 22	July 22	Oct 22	Target Score
20					20	20	9

Context

12-month Turnover of 13.8% against 10% target (August)
Vacancy rate 9.9% (August) including 60.08 wte HCA vacancies.
Sickness absence 4.28% (August) with a 30%+ increase on Q4 in absence management.
Trust compliance is 91.2% (August) for staff training.
Non-medical appraisal rate is 63.4% / medical appraisal rate 84.7% (August)
60% increase on Q4 in employee relations case management.
Long Covid case management.
Lack of capacity to effectively undertake workforce planning, including development of alternative workforce models.
National Pay award and negative impact on specific staff groups

Controls/ Assurance

Weekly workforce cell
Workforce Control Panel overseeing vacancies
WTE costed budget
Exit interview process re-established
Workforce task and finish group
International RN recruitment
HCA recruitment and retention facilitator in post

Progress

What is going well/ Future Opportunities?	What are the current challenges including future risks?	How are these challenges being managed?
Interviews weekly through the BSW agency collaborative Recruitment & attraction process and practices overhaul in conjunction with PWC. International midwife's recruitment initiative. Reservist programme 43 expressions of interest received. Review of 36 OD&P Policies and Procedures to ensure legal compliance Well-being pilots successful – adopting dynamic conversations including appraisal, development and well-being	Workforce gaps within OD & People function Understanding reasons for staff leaving Manager's capacity to manage staff absence due to operational pressures. Lack of management time from operational pressures to undertake appraisals. Depleted resources in recruitment team due to recent resignations.	Recruitment of critical posts in progress Exit interview process relaunched through ESR. Large scale recruitment activities focussed on HCAs, administration and housekeeping. Targeted campaigns for theatres and RNs

BAF Risk 8	Demand for services that outweighs capacity, resulting in an increased risk to patient safety, quality, and effectiveness of patient care.		
Strategic Priority	Population		
Linked Corporate Risks	5751, 6143		
Executive Lead	Chief Operating Officer		
Lead Committee	Finance and Performance		
Risk Type	Capacity	Risk Appetite / tolerance	Open

Risk Score 2021/22

Initial Score	July 21	Sept 21	Jan 22	April 22	July 22	Oct 22	Target score
20					20	12	9

Context

Our operational context remains challenging with escalation beds still open, demand for urgent services consistently pressurised, the on-going need to deliver elective recovery and staff availability day to day creating significant pressure for the teams. Despite the challenges our elective recovery is currently on track in respect of delivering the headline requirements for waiting times i.e., no patients waiting over 104 weeks for care by end of July, continued reduction in those waiting over 78 and 52 weeks respectively. There has been a deterioration in our performance against the 6-week diagnostic standard which is a concern. The detail is within the IPR and those modalities that are failing to deliver are working on their recovery plans. The underlying constraint is insufficient capacity in respect of the skilled workforce required. The number of people with Covid in the community and the associated hospitalisations has increased.

Controls/ Assurance

- 52/78 week performance is on trajectory
- BSW Virtual ward and care co-ordination centre
- Outsourcing arrangement for additional capacity in pathology, theatres and radiology.

Progress

What is going well/ Future Opportunities?	What are the current challenges including future risks?	How are these challenges being managed?
Successful pilot of a Wiltshire Health & Care ACP based at the front door to provide rapid frailty response (admission avoidance). The senior management team are working on joint case with WH&C to try to make the service a permeant addition to SFT ED. HALO present in times of escalation – to be made permanent New minors rebuild completed. 5 week SAFER event May/June	Patient flow out of ED Ambulance handovers delays Same Day Emergency Care (SDEC) ambulatory area within AMU continues to be escalated into overnight. The impact of this often means the medical take is diverted to ED and adds pressure to the ambulance conveyance performance overall. Increasing NCTR patient numbers as a result of insufficient community care provision	Recruitment into vacant nursing, medical and admin posts in ED ongoing. Recommendations from SAFER event to inform work programme

BAF Risk 9	An irreversible inability to reduce the scale of financial deficit		
Strategic Priority	Partnership		
Linked Corporate Risks	6857, 7308, 6858		
Executive Lead	Chief Finance Officer		
Lead Committee	Finance and Performance		
Risk Type	Finance	**Risk Appetite / tolerance**	Open

Risk Score 2021/22							
Initial Score	July 21	Sept 21	Jan 22	April 22	July 22	Oct 22	Target Score
12					12	16	9

Context

The Trust has had an underlying deficit greater than 5% of turnover for a number of years. This has led the Trust to be disadvantaged in terms of capital spend due to managing cash flows. Restricted capital expenditure limit is compounded by GWH PFI impact on system allocation.
The financial position emerging from Covid remains with SFT being in material deficit. This position has deteriorated and despite increased funding, SFT remains challenged.
The Trust is not alone with BSW ICS reporting an underlying deficit relative to allocation funding.
The inability to deliver a breakeven position risks the ability to deliver safe and effective care and or regulatory action associated with breach of license conditions.

Controls/ Assurance

Ongoing discussions to agree the distribution of centrally held ICB funding by system Directors of Finance and People workstreams are focusing on retention of staff, with planned interventions ranging from the onboarding process through to retire and return conversations.
The BSW-wide procurement workplan levies the ICS spending power to mitigate the impact of inflation.
Breakthrough objective initiatives focus on patients no longer clinically requiring an acute hospital bed, as well as fall reduction, in order to reduce the demand on the Trust's bed base.

Progress

What is going well/ Future Opportunities?	What are the current challenges including future risks?	How are these challenges being managed?
Focus on increase in productivity to mitigate further decline in financial position and maximise opportunities for ERF. Acute Alliance programme of benchmarking to identify.	Identifying CIP plans in context of significant operational challenges. Increasing proportion of savings programme will have to be delivered through clinical service transformation. Adequate cash reserves to service capital programme Medium term financial outlook is uncertain Long term capital programme needs to be assessed against available CDEL and additional funding sources. BSW transformation programme immature and not fully developed.	Improving together programme improving a structured approach to change. Working with ICS to develop BSW sustainability programme. Development of CIP teams within corporate and divisional teams (opportunity checklist & Grip and control checklist) Cash flow monitoring and NHSE support in place if required.

BAF Risk 10	Failure to establish and maintain effective partnerships to support the Integrated Care System with the potential to impact the Trust at PLACE level.		
Strategic Priority	**Partnership**		
Linked Corporate Risks	6858		
Executive Lead	Chief Executive Officer/ Chief Finance Officer		
Lead Committee	Finance and Performance		
Risk Type	Integration & Partnership	**Risk Appetite / tolerance**	Open

Risk Score 2021/22

Initial Score	July 21	Sept 21	Jan 22	April 22	July 22	Oct 22	Target Score
9					9	9	6

Context

The Integrated Care Alliance is in early stages of development alongside recruitment of new members to the ICB. In turn this places risk to how quickly trusted successful partnership working can enable service integration and delivery.

Without partnership working one of SFT's strategic aims of integrating care and partnership working is compromised leading to disjointed services for patients.

The plans to develop formal arrangements for place-based governance are continuing to progress. The Wiltshire place-based leadership team has agreed draft terms of reference that will need to be ratified by the ICB in due course.

Controls/ Gaps in Assurance

Nil to note

Progress

What is going well/ Future Opportunities?	What are the current challenges including future risks?	How are these challenges being managed?
ICB board now recruited and permanent members of team now in place. ICB for BSW met on July 1st 2022 for the first meeting of the newly created ICB. Work with the Acute Hospital Alliance continues to develop and gather momentum. The committee in common are due to meet in a strategy session in July to consider how to build on the current work programme over the coming 12-24 months.	The immaturity of the ICB and ICB policies and strategy could result in a lack of understanding of roles and responsibilities and response to critical operational challenges	The Trust is represented at appropriate meetings at PLACE, Acute Providers and the ICS

BAF Risk 11	Significant failure of supply chain which could result in substantial or prolonged disruption to services.		
Strategic Priority	Population		
Linked Corporate Risks			
Executive Lead	Chief Finance Officer		
Lead Committee	Finance and Performance		
Risk Type	Covid Recovery	Risk Appetite / tolerance	Open

Risk Score 2021/22							
Initial Score	July 21	Sept 21	Jan 22	April 22	July 22	Oct 22	Target score
12					12	12	9

Context

The Supply Chain service at SFT has been disrupted from global supply issues which have led to considerable challenges across various product ranges over the past 12 months, particularly in the past 6 -9 months since a number of global ports were shut down due to the pandemic. These global issues of supply are against a back drop of the UK exiting from the EU and commodity pricing increasing and global economic challenges with currency.

There are significant risks to service delivery due to a shortage and/or distribution challenges, with a large number of clinical and digital supplies. This currently is manifesting through a global shortage of digital component parts impacting digital project lead in times of over six months. This is impacting services like sleep apnoea where distribution of machines is severely disrupted leaving longer patient waiting times.

Controls/ Assurance

Focus on inventory management
Reallocation of procurement staff to work on supply disruption
Investment in niche solutions to digitise aspects of the supply chain increasing resilience

Progress

What is going well/ Future Opportunities?	What are the current challenges including future risks?	How are these challenges being managed?
Procurement monitoring of supply chain and alerting early to significant issues.	Patient waiting times increasing due to equipment shortfalls Lead in times for digital projects delayed due to component parts delayed	Procurement managing product substitutions Project planning identifying key digital infrastructure inputs. Supply chain monitoring through procurement systems Communication to staff where supply chain is disrupted

BAF Risk 12	Risk of sustained deterioration across key performance metrics		
Strategic Priority	**Population**		
Linked Corporate Risks	5751		
Executive Lead	Lisa Thomas, Chief operating Officer		
Lead Committee	Finance and Performance		
Risk Type	Covid Recovery	**Risk Appetite / tolerance**	Open

Risk Score 2021/22						
Initial Score	Sept 21	Jan 22	April 22	July 22	Oct 22	Target score
16					16	9

Context

Due to significant gaps in workforce across a number of functions (e.g Theatres, Diagnostics, central booking) alongside demand being greater than capacity, key performance and quality metrics are showing sustained deterioration.

Controls/ Assurance

- 52/78 week performance is on trajectory
- BSW Virtual ward and care co-ordination centre
- Outsourcing arrangement for additional capacity in pathology, theatres and radiology.

Progress

What is going well/ Future Opportunities?	What are the current challenges including future risks?	How are these challenges being managed?
- BSW plan for 57 additional beds in community - BSW Virtual ward and care co-ordination centre - Outsourcing arrangement for additional capacity in pathology, theatres and radiology.	• Increase in patient demand in winter in the event of Covid, or spike in flu/ respiratory infections. • Increased turnover of staff compounding vacancies • Cost of living rises impacting recruitment • Financial position of Councils impacting on out of hospital/care capacity. • Lack of specialist skilled staff to reduce patient waiting times in specific specialities (e.g cardiac Echo) Number of Patients waiting for planned treatment is increasing • Cancer performance targets (particularly 62 day standard) is deteriorating • ED performance has significantly deteriorated (handover delays, time to triage) • No reduction in NCTR (reduction expected from system plans) • Quality metrics e.g. Stroke, pressure ulcers deteriorating • Bed occupancy is increasing (beyond efficient bed base)	- Winter plan being finalised- task and finish group includes, staffing, discharge and focus on assessment areas. - Improved governance processes for oversight of performance (OMB, delivery group. Cancer improvement group) - Hard to recruit plan

4.1c Corporate Risk Register October 2022

ID	Directorate	Location (exact)	Opened	Source of Risk	Rating (initial)	Description	Likelihood (current)	Consequence (current)	Rating (current)	Actions	Action Due Date	Action Done Date	Action Lead	Source of Review	Review Date	Rating (target)	Assurance Framework link (AF Risk Ref)	Assurance Committee	Executive Lead	Risk Owner	Date Escalated to Corporate Risk
6836	Women and Newborn Division	Neonatal Unit	24/02/2021	Directorate risk assessment	12	There is a risk that the re-designation of the neonatal intensive care unit will result in families needing to receive intensive care (or any care when the baby is under a specific gestation) in Neonatal units across the region and not local to Salisbury or Wiltshire. This will have an impact on quality and safety for families.	Will undoubtedly recur, possibly frequently	None	5	SFT NICU Service designation strategy to be completed to ensure patient safety following re-designation.	26/02/2021	01/09/2021	Boyd, Hannah	Trust Board	01/07/2023	2	Care	Trust Board (Corporate Risk Register)	Medical Director	Kingston, Miss Abigail	24/02/2021
										Finance review of re-designation NICU. To include 3 scenarios. 27 week's, 32 week and 34 weeks gestation To include income related to births.	30/09/2021	28/09/2021	Boyd, Hannah								
										Review of impact to clinical Income to the organisation if redesignation process proceeds with the DoF.	21/01/2022	25/03/2022	Boyd, Hannah								
										Division to work on scenario options to help Trust better understand the implications to local population of any proposed changes.	30/03/2023		Kingston, Miss Abigail								
6857	Finance and Procurement	Trustwide	12/03/2021	Financial management	6	There is a risk that weaknesses in controls give rise to an opportunity for fraud, in turn meaning the Trust incurs financial losses.	Will probably recur, but is not a persistent issue	Minor	8	continue programme of fraud awareness and prevention with Counter Fraud team	31/03/2022	13/04/2022	Thomas, Lisa	Departmental Team meeting	31/03/2023	6	Resources	Trust Board (Corporate Risk Register)	Director of Finance	Ellis, Mark	12/03/2021
										Address the drivers of fraud- financial wellbeing of staff	30/06/2022	21/06/2022	Thomas, Lisa								
6954	Trustwide	Trustwide	22/06/2021	Union Activity	8	As a result of the National Pay Award for nurses not being accepted by the Royal College of Nursing, there is a risk of industrial action by members of the RCN. This could result in staffing shortages or staff working to rule.	Do not expect it to happen again but it is possible	Major	8	Active monitoring of National Outcomes.	01/10/2021	13/12/2021	Dyos, Judy	Trust Board	31/10/2022	4	People (Care)	Trust Board (Corporate Risk Register)	Director of Nursing	Dyos, Judy	22/06/2021
										Active monitoring of National outcomes.	31/07/2022	01/07/2022	Dyos, Judy								
7283	Chief Executive	Trustwide	06/04/2022	COVID-19/Coronavirus	12	The Trust is implementing local variation to the National Covid testing guidance to improve patient flow and mitigate associated risks. Patients will be tested on admission or if symptomatic only. There is a risk that Covid positive patients will go undetected which may result in unidentified outbreaks and potentially patients with significant symptoms which require ICU admission.	May recur occasionally	Moderate	9	Set up task and finish group to oversee implementation	29/04/2022	27/06/2022	Dyos, Judy	Executive Director Meeting	29/12/2022	6	Population	Trust Board (Corporate Risk Register)	Medical Director	Collins, Peter	06/04/2022
										Continue to monitor and understand the impact of Covid through IMT and VBR.	29/12/2022		Dyos, Judy								
6858	Finance and Procurement	Trustwide	12/03/2021	Trusts Objectives	9	There is a risk as new guidance and models of working emerge the immaturity of partnerships between SFT and wider BSW organisations will impact on progress to achieve key objectives. With the delay to the ICS formal start date and a double running with ICB's this may delay progress in system transformation.	May recur occasionally	Moderate	9	Executive team participate in Place based leadership development within the ICS to help shape collaborative arrangements. workshop 13th July	31/08/2021	12/10/2021	Thomas, Lisa	Trust Board	31/03/2023	6		Trust Board (Corporate Risk Register)	Director of Finance	Ellis, Mark	12/03/2021
										Trust developing committee in common with Acute Alliance - progress towards provider collaborative in line with national guidance	31/12/2021	11/01/2022	Thomas, Lisa								
										Trust to work in partnership with new emerging leadership structure to develop transformation plans to meet national operating targets.	31/03/2023		Thomas, Lisa								

4.1c Corporate Risk Register October 2022

5955	Finance and Procurement	Trustwide	13/08/2019	Trustwide risk assessment	15	Insufficiently robust management control procedures across the organisation which pose a financial, reputational, legal and operational/clinical risk.	May recur occasionally	Moderate	9	Reviewing Trust wide risk training, aiming to roll out programme to all middle managers	31/03/2020	17/06/2020	Thomas, Lisa	Trust Board	31/01/2023	9	Resources	Trust Board (Corporate Risk Register)	Director of Finance	Ellis, Mark	13/08/2019
										Process mapping underway for business critical controls	31/12/2019	16/12/2019	Thomas, Lisa								
										Trust identifying additional procurement training for those areas of non compliance across the organisation. New process targeting individuals starts in November 2019.	29/03/2020	17/06/2020	Willoughby, Kelly								
										Trust developed draft risk training specification for additional support for directorates- view to tender and award before December 2019.	31/12/2020	07/01/2021	Thomas, Lisa								
										Introduce a monthly informatics department management committee that feeds into monthly executive performance reviews	31/10/2019	18/10/2019	Burwell, Jonathan								
										Approval of IT General Controls plan at Informatics DMC and ratify at exec performance review	31/01/2020	02/03/2020	Scott, Andy								
										Approach to testing of backups agreed	20/03/2020	02/03/2020	Cowling, Andrew (Inactive User)								
										All IT system contracts reviewed with IAA and IAO confirmed and delivery of duties being monitored	31/12/2020	15/12/2020	Burwell, Jonathan								
										Full review of informatics standard operating procedures including putting in place monitoring processes	30/06/2022		Scott, Andy								
										Full implementation of IT general controls framework	31/12/2021	12/03/2021	Scott, Andy								
										Complete a stocktake of all IT operational infrastructure	31/01/2020	02/03/2020	Burwell, Jonathan								
										Implement a robust asset management system	30/10/2020	01/07/2020	Burwell, Jonathan								
										Implement a centralised rolling replacement programme for computers, laptops and iPads	01/04/2020	28/04/2020	Burwell, Jonathan								
										Complete review of IT security policies	30/10/2021	09/12/2021	Burwell, Jonathan								
										Review of existing storage locations of Informatics SOPs to centralise and improve searchability though using modern software such as CITO or Sharepoint	31/08/2021	16/08/2021	Burwell, Jonathan								
										Embed improving together methodology in performance review reporting structure.	31/01/2023		Ellis, Mark								

4.1c Corporate Risk Register October 2022

5704	Surgery	Trustwide	31/01/2019	Directorate risk assessment	16	A risk that the current lack of substantive Gastroenterology medical and nursing workforce will impact on the ability of the service to deliver sustainable comprehensive safe and effective care to patients.	May recur occasionally	Moderate	9	Ongoing recruitment drive.	30/09/2019	25/04/2019	Clarke, Lisa	Intensive Support Meeting	30/03/2023	6	Local Services (Care, People)	Trust Board (Corporate Risk Register)	Medical Director	Collins, Peter	31/01/2019
										Continual clinical prioritisation to ensure that high risk areas are covered.	01/04/2019	17/04/2019	Clarke, Lisa								
										Continuing insourcing of private provider to endoscopy.	30/06/2019	25/04/2019	Vandyken, Mrs Ali								
										Quantification and mitigation of the risk to bowel scope.	01/04/2019	17/04/2019	Vandyken, Mrs Ali								
										Tender for elements of the Gastroenterology service.	01/04/2019	17/04/2019	Stagg, Andrew								
										Monthly update to F&P Committee and CGC.	10/05/2019	25/04/2019	Hyett, Andy (Inactive User)								
										Presentation of gastro strategy to Finance and Performance Committee.	31/05/2019	12/06/2019	Hyett, Andy (Inactive User)								
										Put together a workshop with CDs and Clinical Leads to discuss options for service provision.	01/10/2019	22/10/2019	Hyett, Andy (Inactive User)								
										Continue conversations and meetings with alternative NHS providers for likely future joint partnership for delivery of service	30/09/2019	29/08/2019	Henderson, Dr Stuart								
										Medical Director to link with other STP partners around system wide solution.	31/12/2019	21/02/2020	Blanshard, Dr Christine (Inactive User)								
										Case for change to develop a GI unit to be completed	31/12/2019	04/03/2020	Hyett, Andy (Inactive User)								
										New GI unit to be launched on 1st April	01/04/2020	07/05/2020	Hyett, Andy (Inactive User)								
										To recruit medical and nursing staff for the GI Unit.	31/10/2022		East, Rachael								
										Confirm Southampton will be able to take over full responsibility for the GI Bleed out of hours service.	23/04/2021	23/04/2021	Branagan, Mr Graham								
										Secure support for existing junior doctors	30/07/2021	31/08/2021	Branagan, Mr Graham								
										Ongoing regular review of workforce strategy in GI unit	01/12/2021	20/12/2021	East, Rachael								
										Recruitment to Nutrition Service Vacancy required.	31/01/2022	28/03/2022	East, Rachael								

4.1c Corporate Risk Register October 2022

5360	Transformation & IM&T	Information Technology	28/02/2018	Data Protection	15	Risk of a cyber or ransomware attack, resulting in the potential loss of IT systems, compromised patient care and financial loss.	Do not expect it to happen again but it is possible	Catastrophic	10	02/10/18 IT Technical group on 8/10/18 to discuss what Anti virus software should be purchased	10/10/2018	14/12/2018	Noble, Bob (Inactive User)	Information Governance Steering Group	21/11/2022	6	Resources	Trust Board (Corporate Risk Register)	Director of Finance	Dhanoa, Naginder	11/02/2020
										Technical Group made decision to extend current product. Quotes being obtained for 1, 2 and 3 year extension.	28/02/2019	20/02/2019	Noble, Bob (Inactive User)								
										Review of practicalities of getting ransomware with financial controller.	24/07/2019	09/09/2019	Burwell, Jonathan								
										Development of Cyber Essentials plus plan to support achievement of the standard by 2021	17/01/2020	03/02/2020	Carman, Mr Stephen								
										Review of options for SIEM automated logging and impact of this on resource	31/03/2020	28/04/2020	Carman, Mr Stephen								
										Business case to TMC for agreement of option, associated resources an risk management	18/03/2020	28/04/2020	Carman, Mr Stephen								
										Windows 10 migration complete	31/03/2022	13/04/2022	Arnold, Jon								
										Cyber essentials plus accreditation achieved	30/06/2021	09/07/2021	Carman, Mr Stephen								
										Completion of outstanding penetration test actions prior to moving into cyber essentials plus plan	28/02/2020	17/03/2020	Burwell, Jonathan								
										Implementation of SIEM solution with regional leads	30/06/2020	10/07/2020	Carman, Mr Stephen								
										ATP to be installed on Servers	31/12/2020	08/01/2021	Gibson, Richard								
										External CORS review to be undertake to support progress review	31/01/2021	24/02/2021	Burwell, Jonathan								
										Test implementation of IT Health Assurance Dashboard	31/05/2021	09/07/2021	Burwell, Jonathan								
										Review of proposed actions outlined by NHSD cyber team and CORS assessment to develop a 2021/22 updated cyber plan.	30/07/2021	12/10/2021	Gibson, Richard								
										Implementation of offline backup storage	21/12/2021	12/01/2022	Gibson, Richard								
										Completion of KPI report for Cyber	17/09/2021	12/10/2021	Badham, Gareth								
										Completion Log4j Critical CareCERT mitigations that are currently available.	30/03/2023		Gibson, Richard								
										Implement Privileged Access Management solution	30/10/2022		Gibson, Richard								

4.1c Corporate Risk Register October 2022

508	Organisational Development and People	Trustwide	21/11/2002	Other assurance not listed	8	The absence of a comprehensive Health and Safety Management System for the Trust runs the risk that legislative requirements will not be embedded into the Trust standards to which departments are expected to work. Without those standards, we cannot expect the Trust be be compliant, so the consequences of non-compliance with health and safety law results in Staff and all persons on site at risk of harm and the Trust at risk of prosecution and claims.	Will probably recur, but is not a persistent issue	Moderate	12	Trust compliance is assessed on an add hoc basis by Health & Safety. Yearly corporate and self assessment audits are conducted in 2 clinical and 2 non-clinical areas. Compliance results are reported to the H&S Committee, the Workforce Committee and then onto the board.	01/10/2019	08/02/2021	Knight, Paul (Inactive User)	Health and Safety Committee	04/11/2022	3	People	Trust Board (Corporate Risk Register)	Director of Organisational Development and People	Ready, Troy	06/04/2022
										Reviewed the scope of the risk assessment and have not found any significant gaps in our provision of health & safety instruction, training and baseline support.	20/07/2022	06/10/2022	Adams, Peter								
										5/5/22 Recruit permanent H&S Manager. Transparent escalation and communication of the risk in the first instance is intended to draw attention to the work required to create a comprehensive H&S Management System. Recruitment of a permanent H&S Manager is underway whose task it will be to determine the long-term resources required to deliver and maintain (i) the polices and standards that define how the Trust will address H&S compliance, and (ii) the form of the audit system that will measure the gaps between the legal requirements and the Trust's policies and standards; and the gaps between those policies & standards and their implementation by divisions and directorates. In addition the H&S Management system requires support of divisions and directorates in activities such as: H&S Training; risk assessment; and accident investigation; and the administration and contribution to corporate governance activity through the provision of data dashboards, performance reports, attendance and contribution to H&S committee & sub-committees and escalation reports	01/08/2022	07/09/2022	Adams, Peter								
										The polices and standards required by H&S legislation have been identified and a plan of work is being drawn up to resource their implementation, estimated 47 documents requiring 70 days' work. Auditing of activities to assess implementation of legislative requirements is underway and upon the arrival of the new H&S Manager on 1/8/22 a long-term scheme of audit will be devised. Recruitment of a H&S Adviser is underway and consideration of how to resource policy and audit workload in the long term will be led by the H&S Manager.	30/12/2022	06/10/2022	Adams, Peter								
										7 policies approved by OMB 19/7/22	19/07/2022	19/07/2022	Adams, Peter								
										Create a H&SMS that provides measurement, audit and assurance to the Trust Board	04/11/2022		Ready, Troy								
										Review gaps in current H&S procedures and policies and update where required	04/11/2022		Ready, Troy								

4.1c Corporate Risk Register October 2022

5972	Transformation & IM&T	Trustwide	23/08/2019	Trusts Objectives	16	As a result of deeply rooted historic ways of working, resistance to change and the absence of a mature continuous improvement culture, there is a risk that improvement and transformation is not delivered in a timely manner. This may result in poor quality services, reputational damage, financial impact, ineffectiveness, an inability to attract and retain high quality staff and non-delivery of strategic and or corporate priorities.	Will probably recur, but is not a persistent issue	Moderate	12	Review of role and purpose of Innovation Committee; develop a clear approach for innovation	13/12/2019	21/02/2020	Provins, Esther (Inactive User)	Trust Board	31/10/2022	6	Innovation (Resources)	Clinical Governance Committee, Trust Board (Corporate Risk Register), Workforce Committee	Director of Transformation	Collins, Peter	23/08/2019
												Introduce a Dragon's Den event to inspire, promote and reward innovation	30/07/2020	19/08/2020	Provins, Esther (Inactive User)							
												Develop a comms and engagement plan to promote innovation, linked to QI and continuous improvement	31/12/2019	11/12/2019	Provins, Esther (Inactive User)							
												Review effectiveness of Quality Improvement plan.	01/06/2020	19/08/2020	Provins, Esther (Inactive User)							
												Implement Quality Improvement plan (see also risk 6138).	31/03/2021	22/06/2021	Provins, Esther (Inactive User)							
												Finalising procurement of external support to develop a QI coach network.	31/10/2019	06/11/2019	Provins, Esther (Inactive User)							
												Develop a business case and procurement approach for an OD/Trust transformation intervention jointly with GWH.	31/03/2021	20/04/2021	Provins, Esther (Inactive User)							
												Strengthen capability and capacity of theatres operational staff; review benefits of this and whether it has mitigated the current risk	28/08/2020	03/09/2020	Hyett, Andy (Inactive User)							
												Escalate discussions with system partners regarding levels of DToCs. *Action covered by Corporate Risk 5751. Please see risk 5751*	31/12/2019	04/03/2020	Hyett, Andy (Inactive User)							
												Provide increased oversight of flow programme and links to Trust KPIs, in particular length of stay, as per GIRFT data pack received 10/12/19	28/08/2020	19/08/2020	Provins, Esther (Inactive User)							
												Review workforce transformation programme progress for 19/20 and provide support to develop the programme for 20/21	31/01/2020	21/02/2020	Provins, Esther (Inactive User)							
												Undertake a CIP assurance exercise for 19/20	11/01/2020	21/02/2020	Provins, Esther (Inactive User)							
												Delivery of Best Place to Work programme.	31/03/2021	22/06/2021	Lane, Lynn (Inactive User)							
												Delivery of phase 1 of NHS Improvement Cultural Leadership Programme.	31/07/2020	18/08/2020	Lane, Lynn (Inactive User)							
												Delivery of 20/21 Transformation Priorities.	31/03/2022	11/04/2022	Provins, Esther (Inactive User)							
												Development of the Operational Excellence Workplan.	31/12/2021	11/01/2022	Wood, Paul							
												Implement a benefits realisation tracking approach to understand the impact of Improving Together	30/08/2022		Provins, Esther (Inactive User)							
												Executive to commence monthly improvement huddle on all breakthrough objectives.	30/08/2022		Provins, Esther (Inactive User)							

4.1c Corporate Risk Register October 2022

6143	Quality Directorate	Trustwide	20/12/2019	Trustwide risk assessment	16	Risk that inadequate medical staffing in the organisation (due to insufficient budgeted workforce and/or failure to recruit and retain staff) will impact on the ability of the Trust to maintain safe and effective services across 7 days.	Will probably recur, but is not a persistent issue	Moderate	12	Weekend safety and effectiveness action plan reported to Board on a quarterly basis.	01/04/2020	28/04/2020	Blanshard, Dr Christine (Inactive User)	Trust Board	30/03/2023	6	Care	Trust Board (Corporate Risk Register)	Medical Director	Collins, Peter	02/01/2020
										Report containing triangulation of all relevant information and associated action plan to be submitted to Clinical Governance Committee.	30/06/2020	07/07/2020	Blanshard, Dr Christine (Inactive User)								
										Reinstate the weekend working Task and Finish Group.	31/03/2021	24/02/2021	Collins, Peter								
										The work reviewing the weekend working arrangements to be carried out as part of the Medical Division workforce review and overseen by new Medical workforce group.	30/03/2023		Henderson, Dr Stuart								
										Physicians Associates training programme to be commenced.	01/09/2021	31/08/2021	Murray, Dr Duncan								
										Medical e-roster business case to be refreshed by Medical Director and reconsidered by TIG and TMC.	29/10/2021	20/12/2021	Collins, Peter								
										Medical Workforce recruitment and retention strategy to be developed through Medical Workforce Group.	30/03/2023		Collins, Peter								
7308	Finance and Procurement	Trustwide	19/04/2022	Trusts Objectives, Trustwide risk assessment	15	The financial plan for 2022/23 is a deficit plan with assumed 3% savings. There is a material risk that the deficit will be larger than planned due to the operational constraints, inability to achieve financial savings and ongoing pressures related to patients with no criteria to reside. Therefore there is a risk that cash flow is challenged during the year resulting in the Trust having to take emergency cash measures.	May recur occasionally	Major	12	Grip and Control processes reviewed in all Divisions to ensure robust financial governance	29/07/2022	11/10/2022	Thomas, Lisa	Finance and Performance Committee	31/12/2022	9		Finance Committee, Trust Board (Corporate Risk Register)	Director of Finance	Ellis, Mark	19/04/2022
										Divisions asked to identify full CIP and or productivity plans to ensure they manage within Budget for 2022/23	29/07/2022	11/10/2022	Thomas, Lisa								
										Deployment of winter plans.	30/11/2022		Ellis, Mark								
7206	Clinical Support and Family Services	Pharmacy	02/02/2022	Departmental risk assessment	16	Due to a lack of adequately qualified staff (two key staff members are working their notice) the unit may have to close. This will result in an inability to manufacture chemotherapy and some trial medicines which our patients need.	May recur occasionally	Major	12	Backfill from another Salisbury pharmacy staff member with a decrease in their ability to perform their actual role.	23/03/2022	14/04/2022	Raynes, Alastair	Departmental Team meeting	28/11/2022	4	Population	Trust Board (Corporate Risk Register)	Chief Operating Officer	Raynes, Alastair	06/04/2022
										Business case to put staffing on a sustainable footing	25/04/2022	30/05/2022	Raynes, Alastair								
										Looking as sharing a post holder across the ICS	31/05/2022	27/05/2022	Raynes, Alastair								
7078	Transformation & IM&T	Trust Offices	12/10/2021	Trusts Objectives	12	As a result of competing priorities and deliverables there is a risk of slippage of the Improving Together work programme deadlines	Will undoubtedly recur, possibly frequently	Moderate	12	Use of existing PMB groups to address issues on A3 content	22/11/2021	14/01/2022	Cox, Emma	Executive Director Meeting	31/10/2022	6	People	Trust Board (Corporate Risk Register)	Director of Transformation	Collins, Peter	13/10/2021
										SRO leads to prioritise the work and engage with specific task and finish groups	30/11/2021	14/01/2022	Cox, Emma								
										Executive to agree new road map by end of July.	31/07/2022	01/10/2022	Provins, Esther (Inactive User)								
										Commence recruitment for Programme Director.	30/08/2022	01/10/2022	Collins, Peter								

4.1c Corporate Risk Register October 2022

7276	Organisational Development and People	Occupational Health Department	30/03/2022	Specialty Risk assessment	16	As a result of resignations and retirements the Occupational Health service is operating with cc.7WTE against an establishment of 11.5WTE. This impacts on our ability to provide health monitoring and to deal with any increased demand for pre-employment or management referrals. This presents 2 threats: lack ability to understand the health impact of people working in high risk areas and; could delay recruitment and return to work following long term absence	Will probably recur, but is not a persistent issue	Major	16	Complete process maps for recruitment referrals and management referrals	30/11/2022		Holt, Sharon	Executive Workforce Committee	29/07/2022	6	People	Trust Board (Corporate Risk Register)	Director of Organisational Development and People	Crowley, Ian	06/04/2022
										To recruit an interim Head of Occupational Health	31/05/2022	27/05/2022	Lillis, Quentin								
										Recruitment to all vacant posts	30/06/2022		Lillis, Quentin								
										Review and extend formal contract with outsource provider.	30/04/2022	12/10/2022	Lillis, Quentin								
7430	Organisational Development and People	Trustwide	13/09/2022	National guidance	16	As a result of the 2022 national pay award there is a risk of industrial action across a number of staff groups. This may compromise patient safety and quality of care provision	Will probably recur, but is not a persistent issue	Major	16	Undertake a table top exercise to coordinate potential workforce planning to mitigate resource risk	30/09/2022		Crowley, Ian	Executive Director Meeting	17/10/2022	3	People	Trust Board (Corporate Risk Register)	Director of Organisational Development and People	Crowley, Ian	13/09/2022
7472	Organisational Development and People	Organisational Development & People Department	12/10/2022	Trustwide risk assessment	16	As a result of unmanageable staff absences, poor retention of existing staff and ineffective recruitment activity to fill vacancies, there is a risk that SFT is unable to manage service provision and operate a safe hospital.	Will probably recur, but is not a persistent issue	Major	16	Staff resource plans identified and agreed with Divisional Management Teams.	30/11/2022		Crowley, Ian	Trust Board	30/11/2022	6	People	Trust Board (Corporate Risk Register)	Director of Organisational Development and People	Crowley, Ian	12/10/2022
										Mechanism to manage career pathways and career conversations delivered.	30/11/2022		Crowley, Ian								
										Delivery of the widening participation initiative.	01/07/2023		Crowley, Ian								
										Recruitment processes optimised (pwc recommendations implemented).	30/04/2023		Crowley, Ian								
										Movers and leavers project delivered.	01/04/2023		Crowley, Ian								
										People Promise Strategy delivered.	01/04/2023		Crowley, Ian								
										Health and Well-being plan delivered.	30/11/2022		Crowley, Ian								

4.1c Corporate Risk Register October 2022

7039	Trustwide	Trustwide	13/09/2021	Bed meeting, Departmental risk assessment, Incident reports, Trustwide risk assessment	15	The Trust is currently experiencing increased demand and patient acuity across all in patient services, at a time of increased nursing sickness, maternity leave, leavers and retirements, and reduced recruitment. This causes a shortfall in CHPPD, increases risk for patient harm, increases risk of burnout for remaining staff, causes delay to flow and discharges, and inability to provide the required care for all patients.	Will undoubtedly recur, possibly frequently	Major	20	Communication and reporting of red flag for staffing regionally to NHSI/E	02/08/2021	02/08/2021	Merrifield, Tracey	Directorate Management Team Meeting	31/10/2022	4	People	Trust Board (Corporate Risk Register)	Director of Nursing	Wilding, Mr Henry	01/07/2022
										Explore use of agencies (including off cap) to support block booking	09/08/2021	09/08/2021	Wilding, Mr Henry								
										Explore use of agency HCAs to support wards	20/09/2021	13/12/2021	Wilding, Mr Henry								
										Establish HCA recruitment event - webinar and associated interview dates	30/09/2021	13/09/2021	Holt, Sharon								
										Use of Specialist Nurses/Out patient Nursing to support ward areas	01/11/2021	04/03/2022	Dyos, Judy								
										Development of B2 non-clinical support worker role (housekeeper) to support wards	13/12/2021	13/12/2021	Wilding, Mr Henry								
										Request for use of volunteers from non-patient facing teams to support wards with delivery of meals, answering phone, runner, drink round	01/01/2022	04/03/2022	Wilding, Mr Henry								
										Develop winter incentive scheme for bank workers	01/01/2022	13/12/2021	Ashley, Simon								
										Explore of use of short, fixed term use of over time payments for part time staff.	27/12/2021	04/03/2022	Wilding, Mr Henry								
										Extension of winter incentive scheme until 02/04/22 to support ongoing escalation and acuity	04/03/2022	04/03/2022	Wilding, Mr Henry								
										Develop specific Easter holiday incentive scheme to support and encourage additional shift coverage	08/04/2022	08/04/2022	Wilding, Mr Henry								
										Ongoing use of golden incentive to support short notice sickness/gap	01/09/2022	05/10/2022	Wilding, Mr Henry								
										Revise incentive scheme framework with established triggers and values, and process of sign off	01/08/2022	05/07/2022	Ashley, Simon								
										Review action card/BCP regarding deployment of available resources in times of extemis	31/10/2022	05/10/2022	Cox, Emma								
										Commission task and finish group to explore all options and opportunities to recruit, retain and incentivise additional nursing hours and support	28/10/2022		Wilding, Mr Henry								
										Recruit substantively to 'allocation on arrival' team to support wards/areas as required	30/11/2022	10/10/2022	Ashley, Simon								
										Develop and recruit to non-clinical support worker role	30/11/2022		Wilding, Mr Henry								
										Commission development of and recruitment to the use of a discharge lounge, supporting earlier discharge on the day and release of current nursing hours on wards facilitating TTOs, transport, collections	30/11/2022		Osman, Laura								
										Recruitment of discharge coordinators to support specific wards, releasing nursing time and availability	30/11/2022		Benfield, Helen								

4.1c Corporate Risk Register October 2022

5751	Operations Directorate	Discharge Team	11/03/2019	Directorate risk assessment	16	Risk of patient harm caused by patients remaining in hospital when their clinical need does not require this (no right to reside). This risk is caused by lack of capacity within the community and delay in internal and external processes.		Will undoubtedly recur, possibly frequently	Major	20	Winter director managing Trustwide ECIST actions.	01/05/2019	12/06/2019	Hyett, Andy (Inactive User)												
											Winter Director coordinating trajectory for delivery of DTOC target.	01/05/2019	12/06/2019	Hyett, Andy (Inactive User)												
											Trust actions being led by COO and Medicine CD and managed through weekly delivery meeting and monthly PMB.	01/05/2019	12/06/2019	Hyett, Andy (Inactive User)												
											Weekly expert panel meeting to challenge discharge pathways chaired by CCG director of quality.	01/05/2019	12/06/2019	Hyett, Andy (Inactive User)												
											Trust implementing discharge PTL	01/07/2019	04/09/2019	Hyett, Andy (Inactive User)												
											Escalation to EDLDB non delivery of trajectory	01/07/2019	04/09/2019	Hyett, Andy (Inactive User)												
											Mitigation actions being prepared to mitigate lack of capacity in the community.	01/08/2019	04/09/2019	Hyett, Andy (Inactive User)												
											All providers required to present their winter plans to EDLDB in September.	30/09/2019	22/10/2019	Hyett, Andy (Inactive User)												
											Business case to expand ESD service going to TMC in September and COO and DoF meeting Wiltshire Health and Care to align services	30/11/2019	10/12/2019	Hyett, Andy (Inactive User)												
											CEO DOF and COO representing SFT at system wide winter summit on 25th October 2019.	31/10/2019	10/12/2019	Hyett, Andy (Inactive User)												
											COO representing Trust at Regional Workshop w/b 9th December	14/12/2019	04/03/2020	Hyett, Andy (Inactive User)												
											System wide actions to be monitored through the ED local delivery board.	01/04/2020	28/04/2020	Hyett, Andy (Inactive User)												
											COO escalating the need for an ED LDB risk log reflecting the risks carried by each provider organisation.	19/12/2019	04/03/2020	Hyett, Andy (Inactive User)												
											Risk to be captured on newly developed ED Local Delivery Board Risk Register.	31/03/2020	28/04/2020	Hyett, Andy (Inactive User)												
											Action plan to be developed for 2021 by Urgent Care Board.	31/03/2021	04/05/2021	Hyett, Andy (Inactive User)												
											Reinstate the challenge of stranded patients by the Medical Director by the end of October.	01/11/2020	20/10/2020	Hyett, Andy (Inactive User)												
											Development of Transformation Programme for improved Discharge processes.	31/05/2021	28/06/2021	Hyett, Andy (Inactive User)												

										Agreement of system escalation triggers.	31/05/2021	28/06/2021	Hyett, Andy (Inactive User)								
										Review of bed modelling in light of increased urgent and elective activity.	31/05/2021	30/06/2021	Humphrey, Kieran (Inactive User)								
										Agreement of Improvement Trajectory with system partners.	30/07/2021	08/10/2021	Hyett, Andy (Inactive User)								
										Delivery of the Transformation Improvement Plan.	30/11/2021	30/12/2021	Wood, Paul								
										Delivery of the BSW Urgent Care Board discharge improvement plan which the Trust is contributing to	31/10/2022	11/10/2022	Thomas, Lisa								
										Trust working with BSW on delivery of 57 additional community beds at South newton from November.	30/11/2022		Thomas, Lisa								
										Trust developing winter plan for implementation focusing on pathway 0 patients to maximise available bed capacity	31/10/2022		Thomas, Lisa								

Corporate Risk Register Summary - October 2022 v1

Risk (Datix) ID	Risk Title	Exec Lead	Date Risk Added	Initial Score	Sep-21	Jan-22	Apr-22	Jul-22	Oct-22	Target
Risk Detail				Score Trend						
POPULATION - Improving the health and wellbeing of the population we serve										
5704	Inability to provide a full gastroenterology service due to a lack of medical and nursing workforce	Chief Medical Officer	31-Jan-19	16	9	15	12	12	9	6
5751	Risk of patient harm caused by a delayed discharge from hospital.	Chief Operating Officer	11-Mar-19	16	15	15	20	20	20	12
7206	Risk of Pharmacy Aseptic Unit closure due to a lack of adequately qualified staff impacting on provision of an aseptic service	Chief Operating Officer	06-Apr-22	16			16	12	12	4
7283	Covid Testing and patient pathway management	Chief Medical Officer	06-Apr-22	12			12	12	9	6
7039	The Trust is currently experiencing increased demand and patient acuity across all in-patient areas, at a time of increased nursing sickness, maternity leave, leavers and retirement and reduced recruitment. This causes a shortfall in Care Hours per Patient day (CHPPD), increases risk of burnout for remaining staff, causes delay to flow and discharges and inability to provide required care for all patients	Chief Nursing Officer	01-Jul-22	15				20	20	4
5360	Risk of a cyber or ransomeware attack resulting in the potential loss of IT systems, compromised patient care and financial loss	Chief Finance Officer	11-Feb-20	15	10	10	10	10	10	6
5955	Insufficient organisation wide robust management control procedures	Chief Finance Officer	13-Aug-19	15	9	9	9	9	9	9

5972	Risk that improvement and transformation is not delivered in a timely manner	Chief Medical Officer	23-Aug-19	16	12	12	12	12	12	6
6143	Risk to the ability of SFT to provide the same quality of service 24 hours a day, 7 days a week, with a potential impact to patient care. Difficulties in recruiting vacant posts, funding for new posts and restrictive medical contracts contribute to this risk.	Chief Medical Officer	02-Jan-20	16	9	9	9	12	12	6
508	The absence of a comprehensive Health and Safety Management System for the Trust runs the risk that legislative requirements will not be embedded into the Trust standards to which departments are expected to work. Without those standards, we cannot expect the Trust be compliant, so the consequences of non-compliance with health and safety law results in Staff and all persons on site at risk of harm and the Trust at risk of prosecution and claims.	Chief People Officer	30-Jun-21	16	16	16	9	15	12	6
6836	There is a risk that the re-designation of the Neonatal Intensive Care Unit (NICU) will result in restricted access to neonatal intensive care for women in Wiltshire with the impact on quality and safety - **tolerated risk**	Chief Medical Officer	24-Feb-21	12	4	5	5	5	5	2
People - Supporting our people to make Salisbury NHS Foundation Trust the best place to work										
7430	As a result of the 2022 National pay award there is a risk of industrial action across a number of staff groups. This may compromise patient safety and quality of care provision **(New risk)**	Chief People Officer	13-Sep-22	16					16	3
7276	Risk to Occupational Health Service provision	Chief People Officer	06-Apr-22	16			16	16	16	6

7472	As a result of unmanageable staff absences, poor retention of existing staff and ineffective recruitment activity to fill vacancies, there is a risk that SFT is unable to manage service provision and operate in a safe hospital **(New risk)**	Chief People Officer	12-Oct-22	16					16	6
6954	As a result of the national pay award for nurses not being accepted by the Royal College of Nursing, there is a risk of industrial action by members of the RCN. This could result in staffing shortages or staff working to rule	Chief Nursing Officer	22-Jun-21	8	8	8	8	8	8	4
7078	As a result of competing priorities and deliverables there is a risk of slippage of the Improving Together Programme deadlines	Chief Medical Officer	13-Oct-21	12	12	9	9	15	12	6
PARTNERSHIPS - Working through partnerships to transform and integrate our services										
6857	There is a risk that weaknesses in controls give rise to an opportunity for fraud, in turn resulting in the Trust incurring financial losses **Risk tolerated**	Chief Finance Officer	12-Mar-21	6	6	6	6	8	8	4
6858	There is a risk as new guidance and models of working emerge, the immaturity of partnerships between the Trust and wider BSW organisations will impact on progress to achieve key objectives	Chief Finance Officer	12-Mar-21	9	9	9	9	9	9	6

7308	The financial plan for 2022/23 is a deficit plan with assumed 2.2% savings. There is a material risk that the deficit will be larger than planned due to the operational constraints, inability to achieve financial savings and ongoing pressures related to patients with no criteria to reside. Therefore there is a risk that cash flow is challenged during the year resulting in the Trust having to take emergency cash measures.	Chief Finance Officer	12-Mar-21	15			15	15	12	9

Risk Score Key

Low Risk 1-3
Moderate Risk 4-6
High Risk 8-12
Extreme Risk 15-25

Risk Appetite

NHS Salisbury NHS Foundation Trust

Report to:	Trust Board (Public)	**Agenda item:**	4.3
Date of Meeting:	03 November 2022		

Report Title:	Q1 Learning from Deaths Report 2022 - 2023			
Status:	**Information**	**Discussion**	**Assurance**	**Approval**
			x	
Approval Process (where has this paper been reviewed and approved)	Mortality Surveillance Group/ Clinical Effectiveness Steering Group Clinical Governance Committee September 2022			
Prepared by:	Dr Ben Browne, Head of Clinical Effectiveness			
Executive Sponsor (presenting):	Dr Peter Collins, Chief Medical Officer			
Appendices (list if applicable):				

Recommendation:
The paper is to provide assurance that the Trust is learning from deaths and making improvements.

Executive Summary:

Summary:
There were 249 inpatient deaths in Q1. This figure is inclusive of patients who died in either the Emergency Department or the Hospice.

During Q1:

- There were 8 deaths where COVID-19 was identified as the primary cause of death (most occurring in April).
- There was 1 stillbirth and 1 neonatal death in Q1.
- There were 0 maternal deaths in Q1.
- There were 2 deaths reported in patients with a learning disability in Q1.
- There were no deaths identified in a patient with serious mental illness in Q1.

- Key themes identified by the medical examiners in Q1 were related to inpatient falls and communication of end-of-life care.
- The Trust's 'Improving Together' programme continues to focus on supporting with falls reduction. As a result of this work the number of falls per 1,000 bed days has reduced from 9.96 in April to 6.97 in June.

- 126 families gave consent for the Trust's Your Views Matter bereavement survey to be posted and 44 completed surveys were returned.
    - 73% of respondents rated the overall end of life care as good or very good.
    - There was a higher overall satisfaction in April when compared to May and June. This variation may be attributable to a spike in COVID-19 cases seen amongst staff at this time.

- The HSMR for the twelve-month period ending in May 2022 is 119.2 and is statistically higher than expected.
- Weekday HSMR is 117.0 and weekend HSMR is 129.5. Both are statistically higher than expected.
- The SHMI for Salisbury District Hospital for the twelve-month period ending in March 2022 is 1.0766. This is within the expected range.

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	☐
Other (please describe) -	☐

Quarter 1 2022/23 Learning from Deaths report

September 2022

GLOSSARY OF TERMS

CUSUM
A cumulative sum statistical process control chart plots patients' actual outcomes against their expected outcomes sequentially over time. The chart has upper and lower thresholds and breaching this threshold triggers an alert. If patients repeatedly have negative or unexpected outcomes, the chart will continue to rise until an alert is triggered. The line is then reset to half the starting position and plotting of patients continues. The CQC monitor CUSUM's at a 99.9% threshold to determine outliers.

HSMR
The Hospital Standardised Mortality Ratio (HSMR) is the ratio of observed deaths to expected deaths for a basket of 56 diagnosis groups, which represent approximately 80% of in hospital deaths. It is a subset of all and represents about 35% of admitted patient activity.

ME
Medical examiners (MEs) are senior medical doctors who are contracted for a number of sessions a week to undertake medical examiner duties, outside of their usual clinical duties. They are trained in the legal and clinical elements of death certification processes. The purpose of the medical examiner system is to provide greater safeguards for the public by ensuring proper scrutiny of all non-coronial deaths, ensure the appropriate direction of deaths to the coroner, provide a better service for the bereaved and an opportunity for them to raise any concerns to a doctor not involved in the care of the deceased, improve the quality of death certification, and improve the quality of mortality data. The Medical Examiner (ME) system was introduced in April 2020 and was established in the Trust by August 2020.

MSG
The Mortality Surveillance Group (MSG) meets bi-monthly and is responsible for reviewing deaths to identify problems in care and commissioning improvement work, to reduce unwarranted variation and improve patient outcomes. To identify the learning arising from reviews and improvements needed.

PALS
The Patient Advice and Liasion Service (PALS) offers confidential advice, support and information on health-related matters and they provide a point of contact for patients, their families and their carers. A complaint is an expression of dissatisfaction made to an organisation, either written or spoken, and whether justified or not, which requires a formal response from the Chief Executive. A concern is a problem raised that can be resolved/responded to by the clinical or non-clinical teams concerned. Concerns include issues where the patient/family member has said that they don't want to make a formal complaint.

SFT
Salisbury NHS Foundation Trust.

SHMI
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. It covers in-hospital deaths and deaths that occur up to 30 days post discharge for all diagnoses excluding still births. The SHMI is an indicator which reports on mortality at trust level across the NHS in England and it is produced and published as an official statistic by NHS Digital.

SII
Serious Incident requiring Investigation.

SJR
The Structured Judgement Review (SJR) is a process for undertaking a review of the care received by patients who have died.

SMR
A calculation used to monitor death rates. The Standardised Mortality Ratio (SMR) is the ratio of observed deaths to expected deaths, where expected deaths are calculated for a typical area with the same case-mix adjustment. The SMR may be quoted as either a ratio or a percentage. If the SMR is quoted as a percentage and is equal to 100, then this means the number of observed deaths equals that of expected. If higher than 100, then there is a higher reported mortality ratio.

SOX
Sharing Outstanding Excellence (SOX) is a method of paying a compliment to a team or a member of staff. It is a way of learning from when things go well.

QUARTER 1 (Q1) LEARNING FROM DEATHS MORTALITY REPORT 2022/23

1. *Purpose*

To comply with the national requirements of the Learning from Deaths framework, Trust Boards must publish information on deaths, reviews and investigations via a quarterly report to a public board meeting.

2. *Background*

The Learning from Deaths initiative aims to promote learning and improve how Trusts support and engage bereaved families and carers of those who die in our care.

3. *Summary of Learning in Q1*

The Trust MSG met on 04th May 2022 in Q1, where learning, improvement themes, and actions around in-hospital deaths were discussed. Some of the key learning and themes discussed are summarised below.

3.1. SJRs and The Medical Examiner System

The requirement for non-coronial deaths to be scrutinised by a ME will soon become statutory (revised deadline of April 2023). This will be for all deaths – in hospital and the community. It will require a substantial expansion of the ME service that currently exist in all hospitals. Work is currently underway to meet this requirement at SFT. Adverts are going out to GPs to apply to become a community ME and recent internal publicity has resulted in multiple expressions of interest from clinicians within the Trust to become a hospital ME. Concurrent to this, there has been a 'pilot' with a local GP practice, which has been very useful and CCG meetings continue fortnightly. There is a visit planned to University Hospitals Dorset (UHD) to gain process information on community roll-out – UHD were early adopters of the ME system and are ahead of most within the region. Falls continues to be an area of concern and reduction of this is being prioritised at the highest level through the Hospital's *Improving Together* programme. Other key areas of focus has been to improve documentation surrounding death certification and communication of ward visiting arrangements, e.g. where COVID-19 has continued to impact services.

3.2. Serious Incidents Requiring Investigation (SIIs) / Case Reviews

The recommendations from two reviews were discussed – both cases were regarding individuals who had injuries attributed to an inpatient fall. In one case key learning centred on reviewing methods for alerting staff who attempt to mobilse unaided, e.g. falls mat alarms or ultralow beds. Examples of good communication with the family (and documentation of this) was identified and intentional rounding was appropriately completed by a range of clinical teams. As a result of this review, improvements will now be made to increase eduction of falls for staff and to increase the stock of ultralow beds so that more patients will be cared for at floor level where risks are identified. In the other case there were also several positive findings. The patient was quickly assessed following their fall, there were prompt discussions with specialist neurosurgeons regarding treatment options, and the family were also kept well informed. Learning and improvements were identified which will focus on improving adherence to Trust policy regarding the undertaking of patient observations and improving staff recognition of the deteriorating patient in the future.

3.3. Bereavement

The majority of bereaved families continue to rate the end of life care as being good or very good. Overall satisfaction appears to have been higher in April when compared with May and June. This may be related to an increase in the numbers of staff off sick or isolating following a spike in COVID-19. Further information can be found in section 6 of this report.

3.4. Formal Alerts and Reports

All new alerts are discussed at the MSG meeting and a further review or investigation into these deaths may be requested.
The following reports were received and discussed at the MSG meeting in May:

- Mortality Report – Provided by Telstra Health UK.
- Perinatal Mortality Review Tool of Stillbirths
- National Heart Failure Audit 2020/21
- Prevention of Future Deaths Report in Inquests

4. Summary of Mortality Data for Q1

- There were 249 inpatient deaths during Q1 (2022/23). This figure is inclusive of patients who died in either the Emergency Department or the Hospice.
- There were 8 deaths where COVID-19 was identified as the primary cause of death (most occurring in April).
- There was 1 stillbirth and 1 neonatal death in Q1.
- There were 0 maternal deaths in Q1.
- There were 2 deaths reported in patients with a learning disability in Q1.
- There were no deaths identified in a patient with serious mental illness in Q1.

2022/23	April	May	June	Quarter 1
All Inpatient Deaths including Emergency Department (ED) and Hospice	88	84	87	249
Deaths Reviewed/Scrutinised by the Medical Examiner	79	72	65	216
SJRs requested by ME	6	6	5	17
ED Deaths	5	4	5	14
Hospice Deaths	9	12	17	38
SFT Nationally Reported COVID-19 Deaths*	31	6	5	42
COVID-19 as Primary Cause of Death (Recorded as '1a' on the Death Certificate)	6	1	1	8
Stillbirth	0	0	1	1
Neonatal Deaths	0	1	0	1
Maternal Deaths	0	0	0	0
Learning Disability Deaths**	0	0	2	2
Serious Mental Illness**	0	0	0	0

indicates where an individual has either died within 28-d of a positive swab result and/or COVID-19 has been reported on the death certificate

****as reported by the Medical Examiner***

5. Medical Examiner (ME) and Structured Judgement Reviews (SJR)

The ME system was introduced to ensure excellence in care for the bereaved and learning from deaths to drive improvement. The Medical Examiners aim to scrutinise all acute hospital deaths, and a local network of MEs exists to share learning and provide an independent review facility if needed.

- **17 Structured Judgement Reviews were requested by the Medical Examiners in Q1.**

The reasons for each requested review has been outlined and categorised into problem themes and stage of care below (see Table 1)

Table 1: Reasons for SJR Requests and Themes–Quarter 1, 2022-23

Type of problem	*Stage of Care* →							
	Admission and initial assessment (first 24 hours)	Ongoing care	Care during a procedure	Perioperative/procedure care	End of life care (or discharge care)	Concerns about over all care	**2022/23 (Q1)**	***2021/22 YEAR TOTAL***
Problem in assessment, investigation or diagnosis (including assessment of pressure ulcer risk, venous thromboembolism (VTE) risk, history of falls)							***0***	*17*
Problem with medication / IV fluids / electrolytes / oxygen						*1*	***1***	*3*
Problem related to treatment and management plan (including prevention of pressure ulcers, falls, VTE)						*2*	***2***	*7*
Problem with infection control							***0***	*0*
Problem related to operation/invasive procedure (other than infection control)							***0***	*4*
Problem in clinical monitoring (including failure to plan, to undertake, or to recognise and respond to changes)							***0***	*13*
Problem in resuscitation following a cardiac or respiratory arrest (including cardiopulmonary resuscitation (CPR))							***0***	*0*
Problem of any other type not fitting the categories above					3	11	***14***	*24*
2022/22 (Q1)	***0***	***0***	***0***	***0***	***3***	***14***		
2021/22 YEAR TOTAL	*9*	*24*	*3*	*3*	*4*	*25*		

Summary of Reviews Requested in Q1

- ***Key themes identified by the medical examiners in Q1 were related to inpatient falls and communication of end of life care (see also section 6).***
- ***The Trust's 'Improving Together' programme continues to focus on supporting with falls reduction. As a result of this work the number of falls per 1,000 bed days has reduced from 9.96 in April to 6.97 in June.***

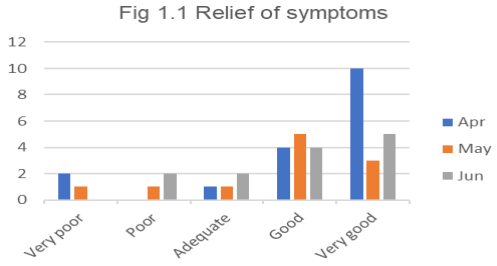
6. Your Views Matter Survey & End of Life Care

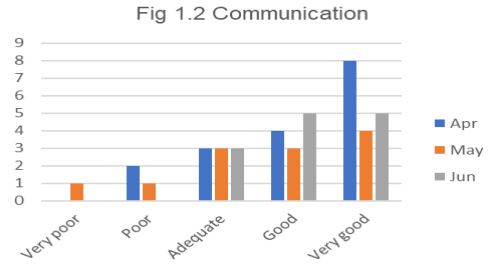
The Your Views Matter Bereavement survey was established in 2020 and was created to capture the views and experiences of bereaved relatives. This is an opportunity for families to feedback their experiences about the support they themselves received and the end of life care their loved one was given during their last days of life in Salisbury Hospital. Whilst the feedback is anonymous, relatives are able to name individuals they would like to acknowledge and thank for making a difference. Likewise, where the experience was less than satisfactory those completing the survey also have the option to enclose their contact details and be followed up by the PALS team.

Overall rating of experience for Q1 2022-23

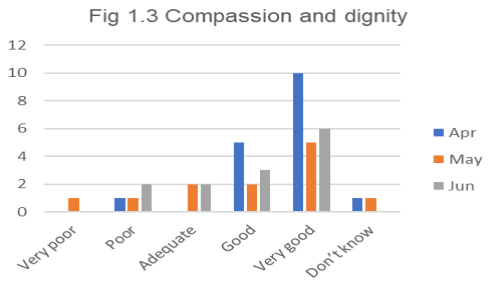
Very poor & Poor	Adequate	Good & Very good	Not rated
7% (n~3)	16% (n~7)	73% (n~32)	5% (n~2)

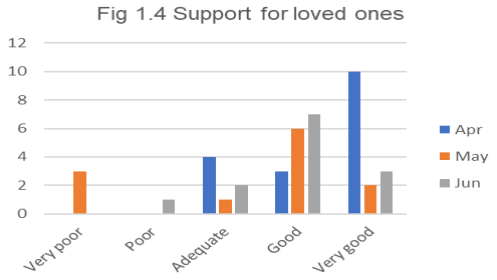
- In Q1, 126 families gave consent for the Trust's Your Views Matter bereavement survey to be posted and 44 completed surveys were returned. The response rate was 35% (average response rate for 2021/22 = 39%).
- 73% of respondents rated the overall end of life care as good or very good.





There was a higher overall satisfaction in April when compared to May and June. This variation may be attributable to a spike in COVID-19 cases seen amongst staff at this time. Staff off sick and /or isolating is likely to have had a negative impact on patient experience.





There were no common themes identified where the rating of experience was considered to be poor or very poor in Q1. However, the outcomes of these surveys will continue to be monitored by the Trust patient experience team and PALS.

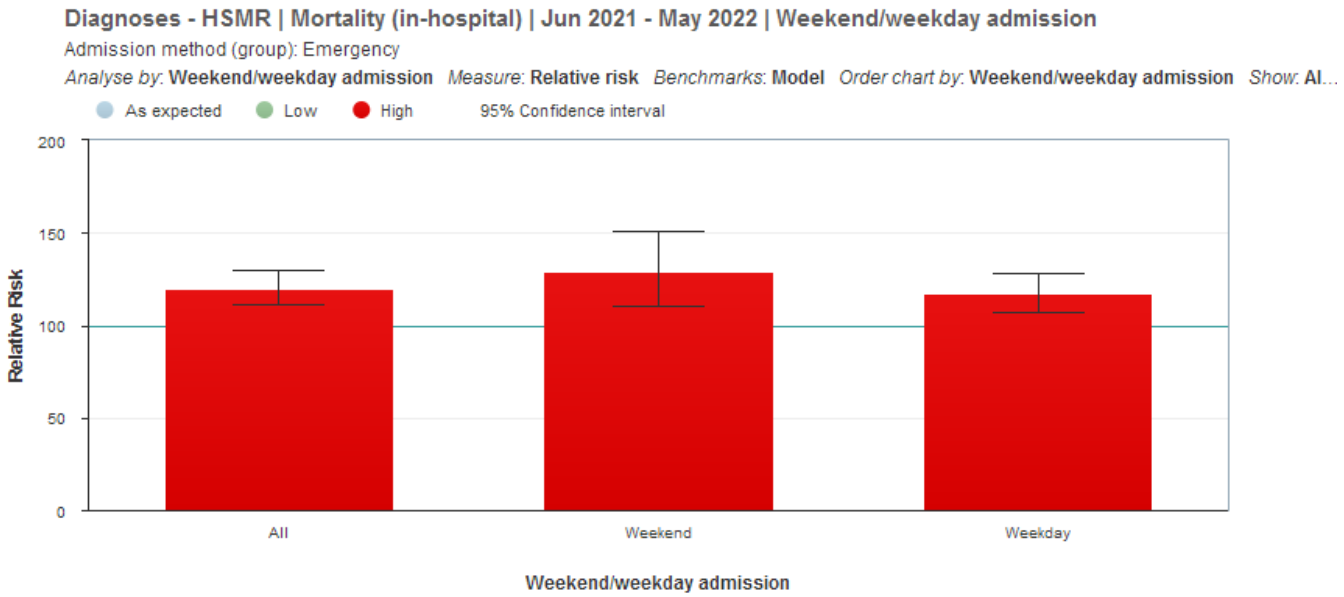
7. Mortality Benchmarking

7.1. *HSMR rolling 12-month trend to May '22*

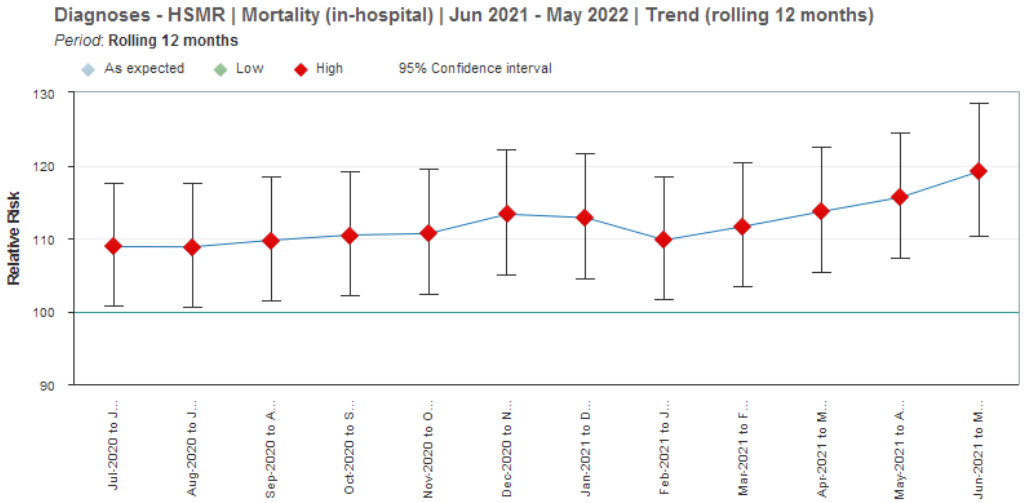
- **The HSMR (relative risk) for the twelve month period ending in May 2022 is 119.2 and is statistically higher than expected (110.3 – 128.5, 95% confidence limits).**

- **Weekday HSMR is 117.0 and weekend HSMR is 129.5. Both are statistically higher than expected.**

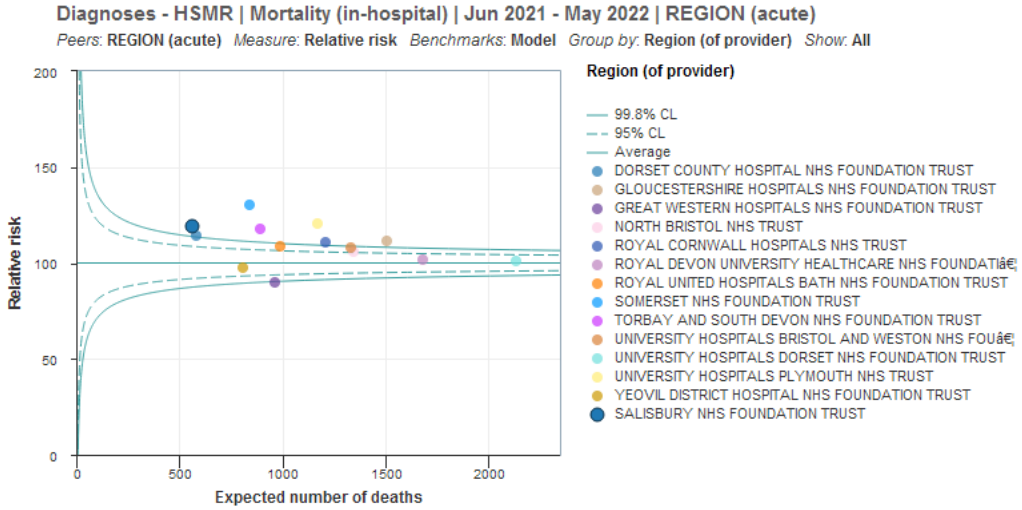
Weekend/weekday HSMR



HSMR (Rolling 12-month trend to year-end May 2022)



Peer comparison of HSMR (Rolling 12-month trend to year-end May 2022)



7.2. Summary Hospital-Level Mortality Indicator (SHMI) for April 2021 – March 2022

The SHMI is an indicator which reports on mortality at Trust level across the NHS in England and it is published as an official statistic by NHS Digital. The latest available data is published in this report.

- **SHMI is 1.1134 for the twelve month period ending in March 2022 for SFT. When comparing SHMI by site, Salisbury District Hospital is 1.0766 and Salisbury Hospice is 2.3559.** When compared with regional peers, the Trust has a SHMI within the expected range.

Site code	Site name	Provider spells	Observed deaths	Expected deaths	SHMI value
RNZ02	Salisbury District Hospital	34,260	990	920	1.0766
RNZ78	Salisbury Hospice	100	65	25	2.3559

- The tables in the supplementary data pack show the SHMI data for SFT as a breakdown for specific conditions for the twelve month period ending March 2022.

7.3. Alerts

- All new alerts are discussed at the Trust MSG meeting where a further review or investigation into these deaths may be requested. The relative risk is higher than expected in two new high risk diagnosis groups (outlined in the appendix of this report, p14&15 - 'acute and unspecified renal failure' and 'pneumonia'.)

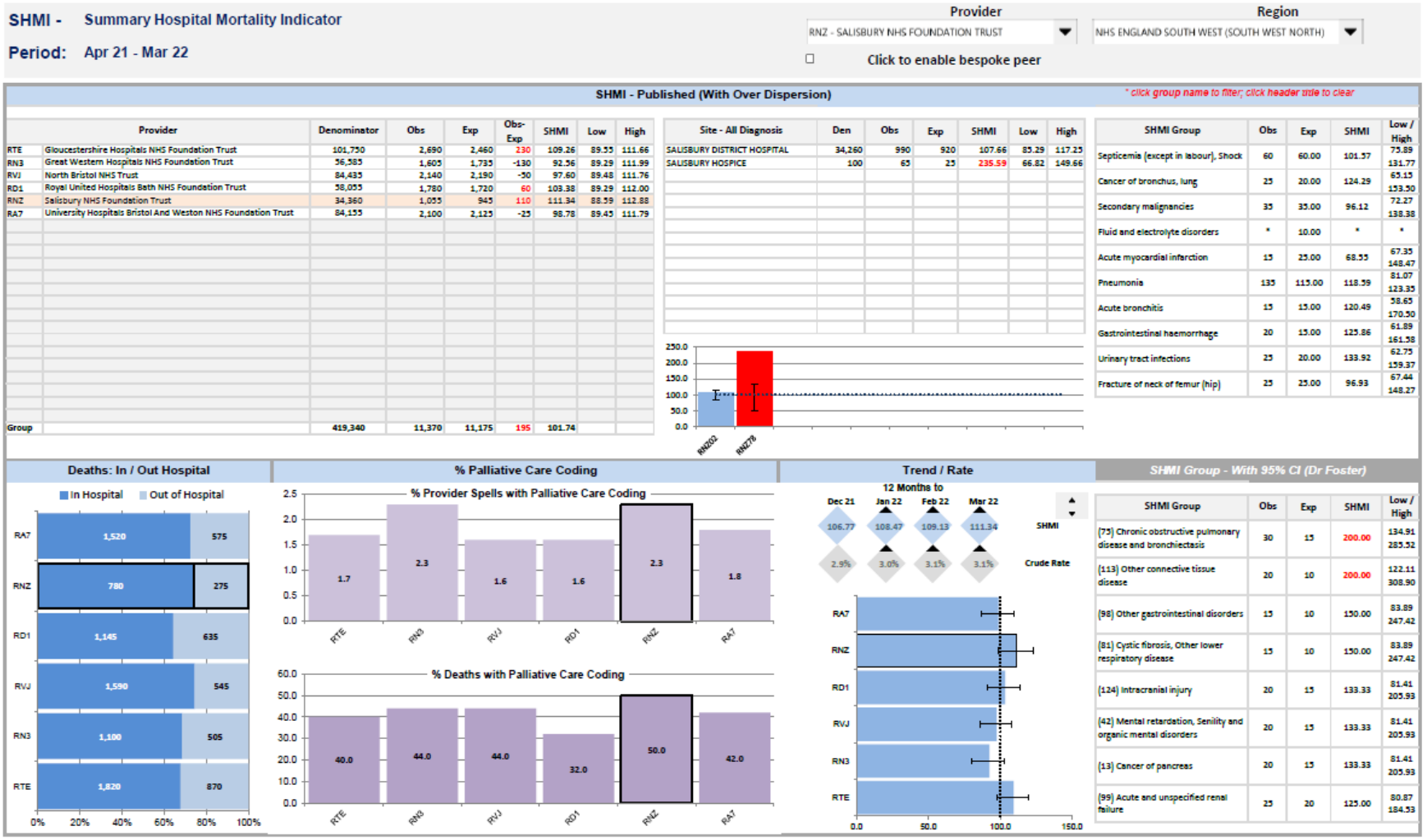
8. Recommendations

The report is provided for assurance that the Trust is learning from deaths and making improvements.

Author:
Dr Ben Browne, Head of Clinical Effectiveness, 5th September 2022
Approved by Dr Peter Collins
Chief Medical Officer, September 2022

9. *Supplementary Data*

SHMI Data for the 12 Month Period Ending March 2022



SHMI_Apr21_Mar22_master

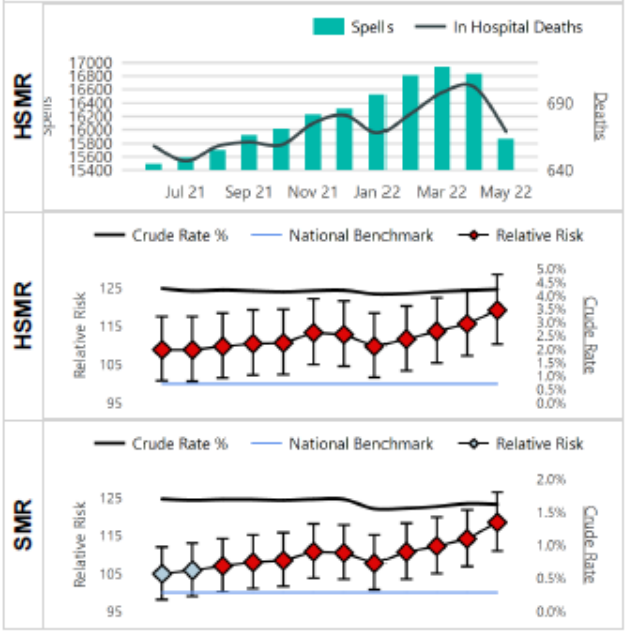
HSMR Data for 12 month period to May 2022 for SFT (Inclusive of Hospice Data)

dr foster. HEALTHCARE INTELLIGENCE PORTAL

Mortality Summary for 12 months to May-2022 as at 07/09/2022

SALISBURY NHS FOUNDATION TRUST - All Sites

Rolling 12 month trends



Diagnosis Groups

Relative Risk Alerts (Top 10)	CUSUM	Obs	Exp	RR	LCI	Trend
Chronic obstructive pulmonary disease and bronchiectasis	2	25	12.4	202.0	130.7	
Secondary malignancies	1	30	16.7	179.3	120.9	
Acute and unspecified renal failure	1	28	15.4	181.6	120.7	
Residual codes, unclassified	1	51	32.0	159.3	118.6	
Urinary tract infections	0	20	11.7	170.9	104.4	
Pneumonia	0	121	96.6	125.2	103.9	

CUSUM 99% Threshold (Top 6)	CUSUM	Obs	Exp	RR	LCI	Trend
Chronic obstructive pulmonary disease and bronchiectasis	2	25	12.4	202.0	130.7	
Secondary malignancies	1	30	16.7	179.3	120.9	
Acute and unspecified renal failure	1	28	15.4	181.6	120.7	
Residual codes, unclassified	1	51	32.0	159.3	118.6	
Other connective tissue disease	1	18	9.5	167.6	95.7	
Respiratory failure, insufficiency, arrest (adult)	1	9	6.4	140.1	83.9	

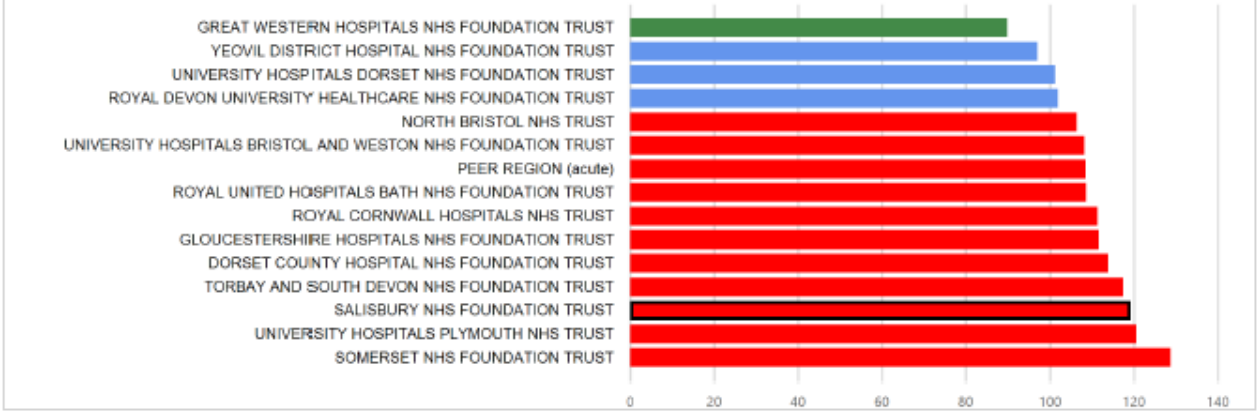
CUSUM 99.9% Threshold (Top 6)	CUSUM	Obs	Exp	RR	LCI	Trend
Chronic obstructive pulmonary disease and bronchiectasis	1	25	12.4	202.0	130.7	
Other connective tissue disease	1	18	9.5	167.6	95.7	

Patient Safety Indicators	Obs	Exp	RR	LCI	Trend

Mortality Influencers

Performance	Site	Trust	Peer	National
HSMR		119.2	108.6	102.0
SMR		118.5	108.0	101.0
Non-elective (HSMR)		119.8	108.5	101.6
Weekday, emergency (HSMR)		117.0	106.5	100.1
Weekend, emergency (HSMR)		129.5	115.3	106.0
Saturday, emergency (HSMR)		134.0	114.1	106.0
Sunday, emergency (HSMR)		122.4	116.3	105.9
Coding/Casemix	**Site**	**Trust**	**Peer**	**National**
% Non-elective deaths with palliative care (HSMR)		52.5%	41.0%	39.8%
% Non-elective spells with palliative care (HSMR)		6.2%	4.7%	4.9%
% Spells in Symptoms & Signs chapter		11.8%	8.0%	7.2%
% Non-elective spells with Charlson comorbidity score = 0 (HSMR)		47.7%	42.9%	41.5%
% Non-elective spells with Charlson comorbidity score = 20+ (HSMR)		13.6%	15.0%	15.8%
% Non-elective spells in Risk Band (0-10%) (HSMR)		84.9%	85.1%	84.7%

HSMR Peer Comparison



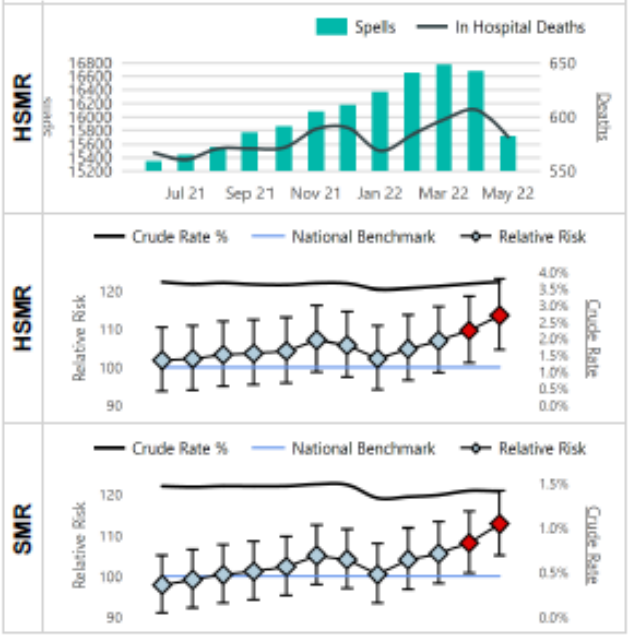
HSMR Data for the 12 month period to May 2022 for SFT (Excluding Hospice Data)

dr foster. HEALTHCARE INTELLIGENCE PORTAL

Mortality Summary for 12 months to May-2022 as at 31/08/2022

SALISBURY NHS FOUNDATION TRUST - SALISBURY DISTRICT HOSPITAL (RNZ02)

Rolling 12 month trends



Diagnosis Groups

Relative Risk Alerts (Top 10)	CUSUM	Obs	Exp	RR	LCI	Trend
Chronic obstructive pulmonary disease and bronchiectasis	2	25	12.4	202.0	130.7	
Acute and unspecified renal failure	1	27	15.0	180.5	119.0	
Residual codes, unclassified	1	41	25.1	163.3	117.2	
Pneumonia	0	113	91.2	123.9	102.1	

CUSUM 99% Threshold (Top 6)	CUSUM	Obs	Exp	RR	LCI	Trend
Chronic obstructive pulmonary disease and bronchiectasis	2	25	12.4	202.0	130.7	
Acute and unspecified renal failure	1	27	15.0	180.5	119.0	
Residual codes, unclassified	1	41	25.1	163.3	117.2	
Pathological fracture	1	3	0.7	454.1	91.3	
Other connective tissue disease	1	14	8.4	165.9	90.6	
Respiratory failure, insufficiency, arrest (adult)	1	9	6.4	140.1	83.9	

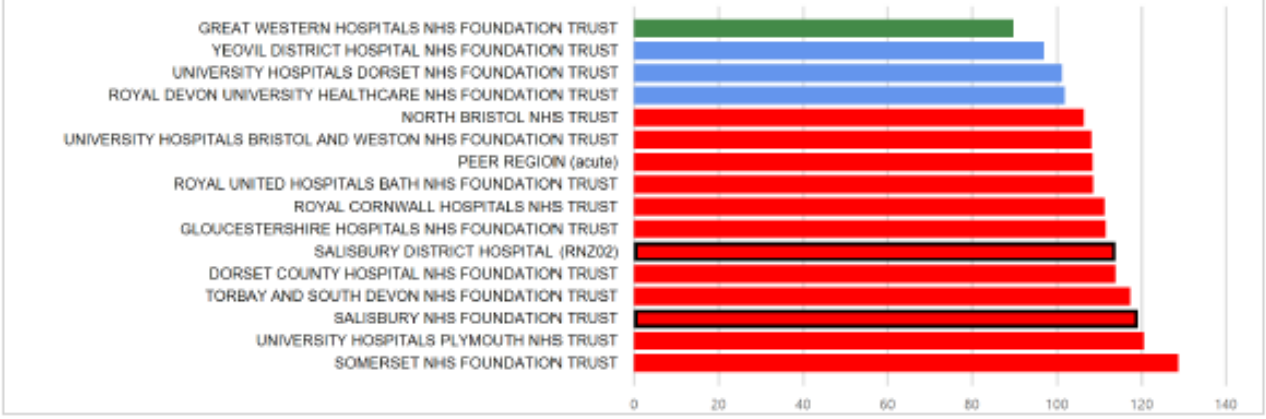
CUSUM 99.9% Threshold (Top 6)	CUSUM	Obs	Exp	RR	LCI	Trend
Chronic obstructive pulmonary disease and bronchiectasis	1	25	12.4	202.0	130.7	

Patient Safety Indicators	Obs	Exp	RR	LCI	Trend

Mortality Influencers

Performance	Site	Trust	Peer	National
HSMR	113.7	119.2	108.6	102.0
SMR	112.9	118.5	108.0	101.0
Non-elective (HSMR)	114.4	119.8	108.5	101.6
Weekday, emergency (HSMR)	111.7	117.0	106.5	100.1
Weekend, emergency (HSMR)	123.1	129.5	115.3	106.0
Saturday, emergency (HSMR)	127.9	134.0	114.1	106.0
Sunday, emergency (HSMR)	115.2	122.4	116.3	105.9
Coding/Casemix	**Site**	**Trust**	**Peer**	**National**
% Non-elective deaths with palliative care (HSMR)	45.4%	52.5%	41.0%	39.8%
% Non-elective spells with palliative care (HSMR)	4.8%	6.2%	4.7%	4.9%
% Spells in Symptoms & Signs chapter	11.8%	11.8%	8.0%	7.2%
% Non-elective spells with Charlson comorbidity score = 0 (HSMR)	48.3%	47.7%	42.9%	41.5%
% Non-elective spells with Charlson comorbidity score = 20+ (HSMR)	13.2%	13.6%	15.0%	15.8%
% Non-elective spells in Risk Band (0-10%) (HSMR)	86.1%	84.9%	85.1%	84.7%

HSMR Peer Comparison

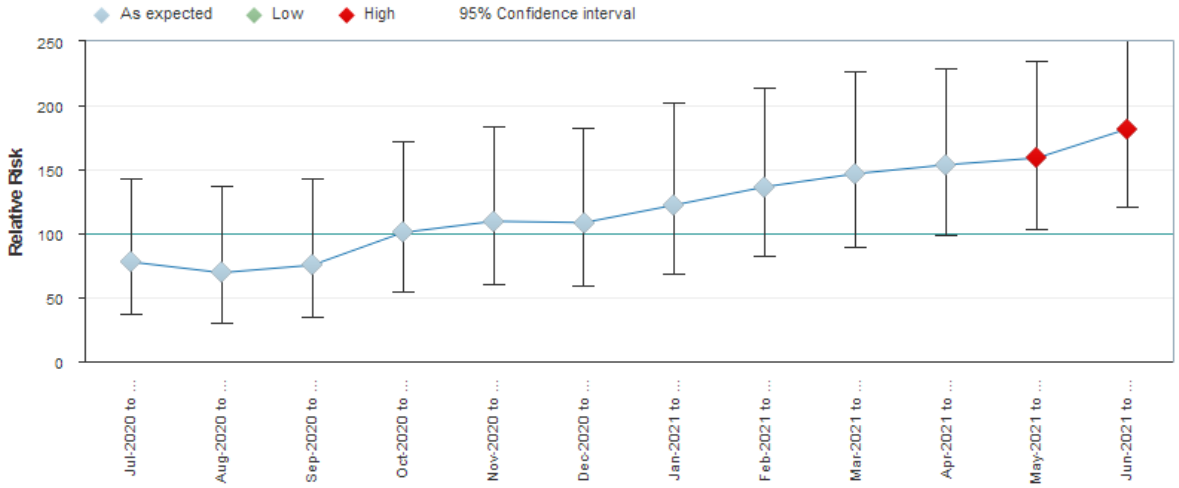


12-Month Trends in Relative Risk for High Risk Diagnosis Groups

Acute and unspecified renal failure | Mortality (in-hospital) | Jun 2021 - May 2022 | Trend (rolling 12 months)

Diagnosis group: Acute and unspecified renal failure

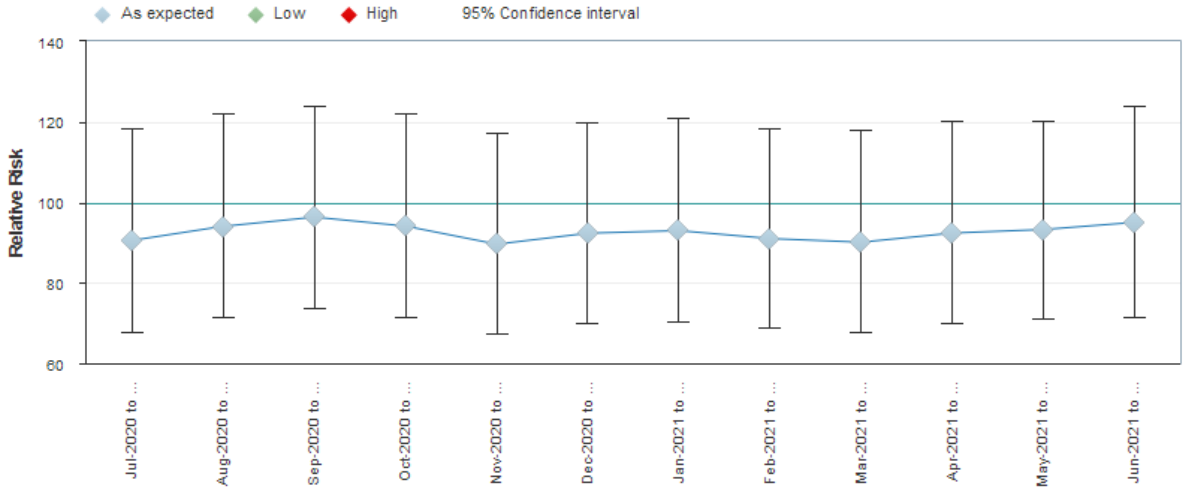
Period: **Rolling 12 months**



Acute cerebrovascular disease | Mortality (in-hospital) | Jun 2021 - May 2022 | Trend (rolling 12 months)

Diagnosis group: Acute cerebrovascular disease

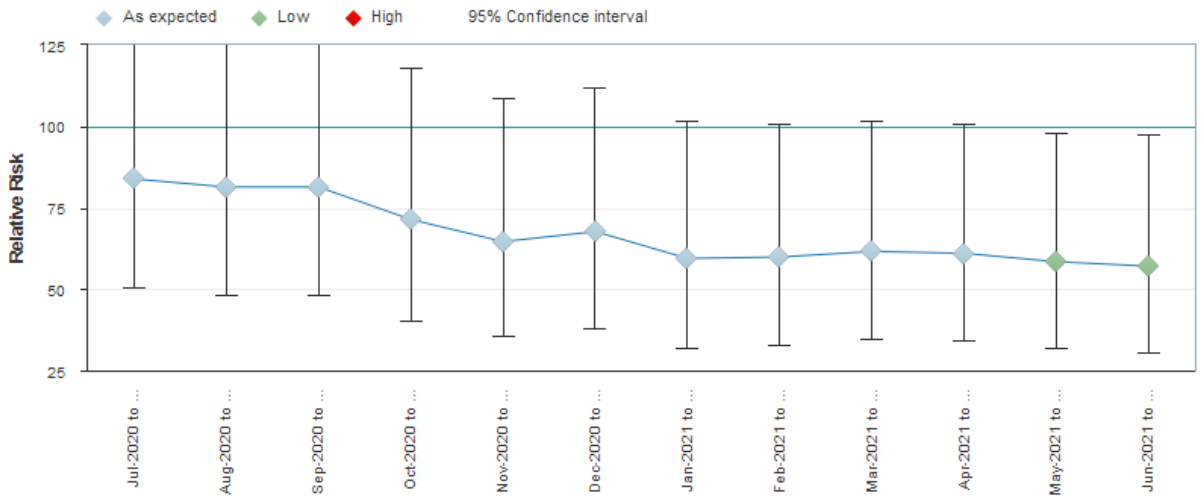
Period: **Rolling 12 months**



Acute myocardial infarction | Mortality (in-hospital) | Jun 2021 - May 2022 | Trend (rolling 12 months)

Diagnosis group: Acute myocardial infarction

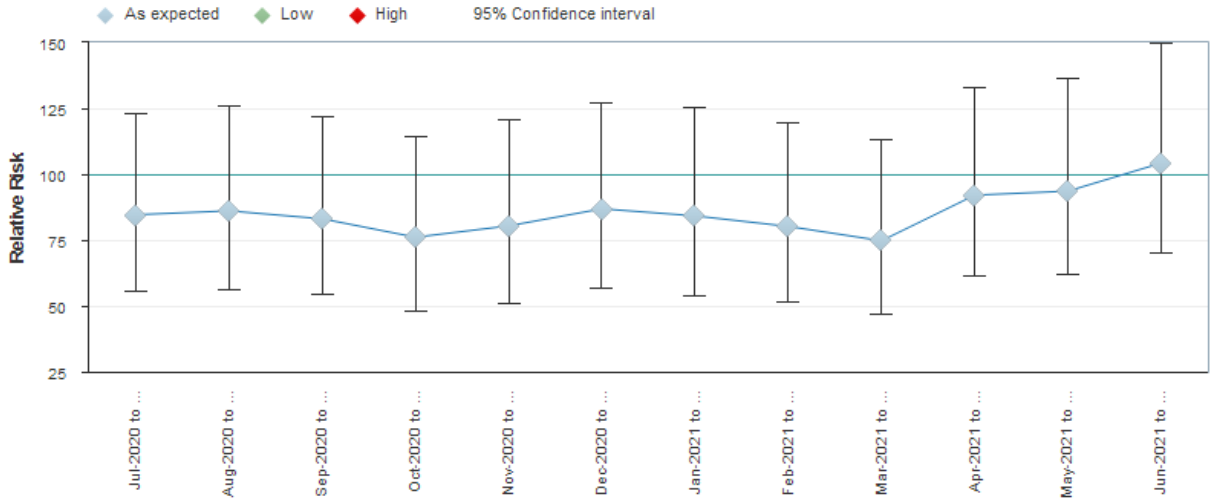
Period: **Rolling 12 months**



Congestive heart failure, nonhypertensive | Mortality (in-hospital) | Jun 2021 - May 2022 | Trend (rolling 12 months)

Diagnosis group: Congestive heart failure, nonhypertensive

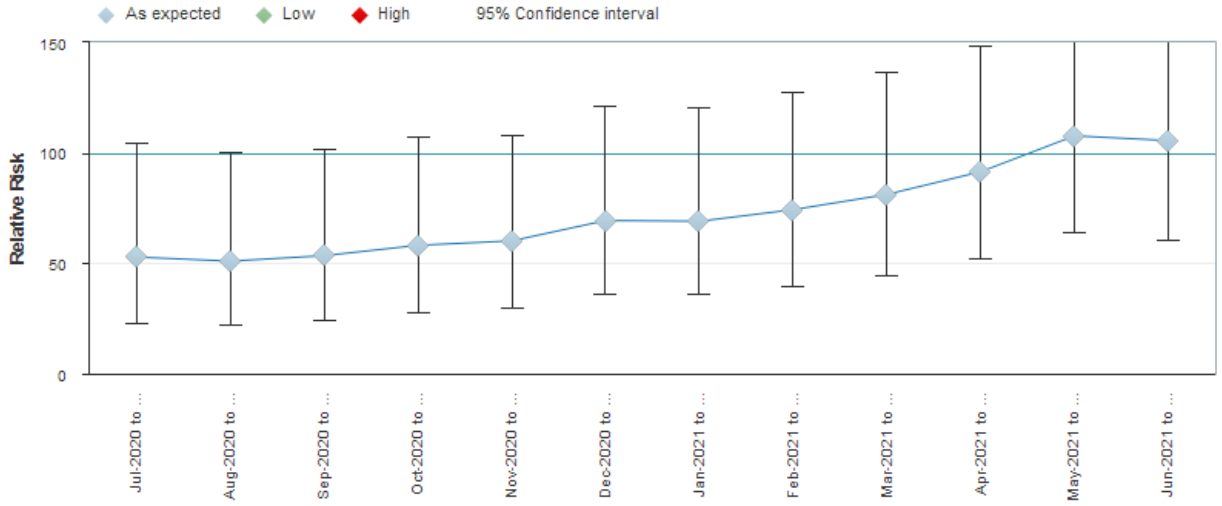
Period: **Rolling 12 months**



Fracture of neck of femur (hip) | Mortality (in-hospital) | Jun 2021 - May 2022 | Trend (rolling 12 months)

Diagnosis group: Fracture of neck of femur (hip)

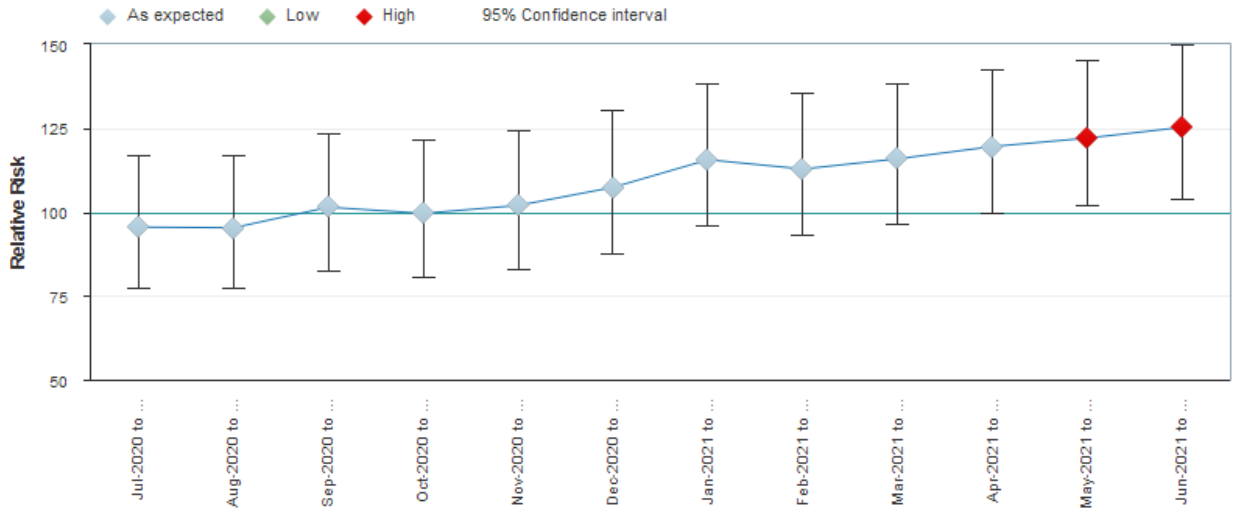
Period: **Rolling 12 months**

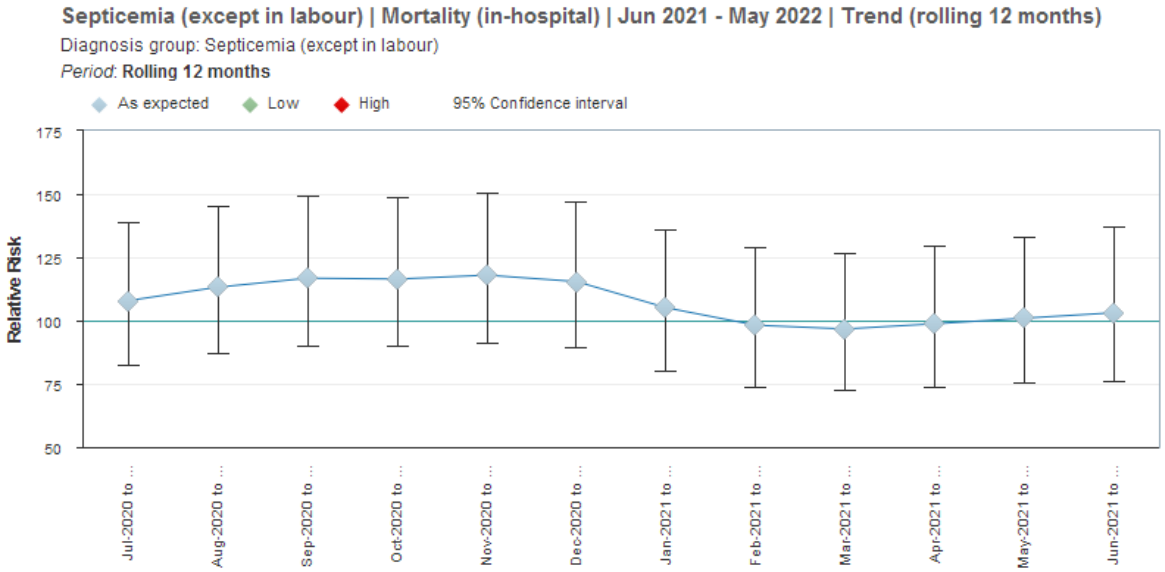


Pneumonia | Mortality (in-hospital) | Jun 2021 - May 2022 | Trend (rolling 12 months)

Diagnosis group: Pneumonia

Period: **Rolling 12 months**




Septicemia (except in labour) | Mortality (in-hospital) | Jun 2021 - May 2022 | Trend (rolling 12 months)
Diagnosis group: Septicemia (except in labour)
Period: Rolling 12 months
As expected
Low
High
95% Confidence interval
Relative Risk
175
150
125
100
75
50
Jul-2020 to ...
Aug-2020 to ...
Sep-2020 to ...
Oct-2020 to ...
Nov-2020 to ...
Dec-2020 to ...
Jan-2021 to ...
Feb-2021 to ...
Mar-2021 to ...
Apr-2021 to ...
May-2021 to ...
Jun-2021 to ...

NHS Salisbury NHS Foundation Trust

Report to:	Trust Board (Public)	**Agenda item:**	4.4
Date of Meeting:	03 November 2022		

Report Title:	Board and Committee Effectiveness Annual Report			
Status:	**Information**	**Discussion**	**Assurance**	**Approval**
	x			
Approval Process (where has this paper been reviewed and approved)	Committee Effectiveness is reviewed at each Board Committee			
Prepared by:	Judy Dyos, Chief Nursing Officer			
Executive Sponsor (presenting):	Judy Dyos, Chief Nursing Officer			
Appendices (list if applicable):				

Recommendation:

For the Trust Board to note the information provided on the outcomes of the East Kent maternity review by Dr Kirkup. This prestation will be followed with a "true to us" assessment for Salisbury NHS Foundation Trust at a later date, the report was only published on the 18th October so the maternity team have not had time to undertake this assessment at the time of the Public Board.

Executive Summary:

This slide deck provides the board with an overview of the findings of the East Kent maternity review undertaken by Dr Bill Kirkup.

The review looked at 202 cases including 65 baby deaths from 2009-2020 at East Kent NHS Foundation Trust. The Kirkup panel found that in 95 of the 202 cases outcomes could have been different. Furthermore, the outcome could have been different in 45 of the 65 baby deaths if recognised standards of care had been met

The report identified that no one person or action was the cause of these outcomes but problems were identified at every level from ward to board and beyond to NHSE and other regulators.

The findings are broken into 5 key themes

- Failure in team work
- Failure in professionalism
- Failures in compassion
- Failure to listen
- Failure of the Trust Board
-

Recommendations from the report are included and strongly link with recommendations from previous national reports into failing maternity services.

A “true to us” assessment for Salisbury NHS Foundation Trust will be undertaken once the Maternity team have had the time to work through the findings in full.

However, the Chief Nursing Officer has included detail of work already in progress at Salisbury NHS Foundation Trust to prevent common safety issues in maternity services that are linked with the themes identified in the East Kent report.

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

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East Kent Maternity Report

Judy Dyos

Chief Nursing Officer

Background

Salisbury NHS Foundation Trust

Dr Bill Kirkup led a review into the maternity services at East Kent NHS Trust , which included two hospitals the Queen Elizabeth The Queen Mother Hospital and the William Harvey Hospital between 2009-2020

202 cases reviewed

Had care been given to the nationally recognised standards, the outcome could have been different in 97, or 48%, of the 202 cases assessed by the Panel, and the outcome could have been different in 45 of the 65 baby deaths

Report published 18th October 2022

Problems were identified at every level within the service and described as:

- What happened to women and babies under the care of the maternity units within the two hospitals
- The Trust's response, including at Trust Board level, and whether the Trust sought to learn lessons
- The Trust's engagement with regulators, including the Care Quality Commission (CQC), and the actions and responses of the regulators, commissioners and the NHS, regionally and nationally

Findings - 5 key themes

Salisbury NHS Foundation Trust

- They did not find that a single clinical shortcoming explains the outcomes. Nor should the pattern of repeated poor outcomes be attributed to individual clinical error, although clearly a failure to learn in the aftermath of obvious safety incidents has contributed to this repetition
- They acknowledge there were staffing and infrastructure shortcomings but did not feel this was a factor in the poor outcomes

Broken into 5 key themes

- Failure in team work
- Failure in professionalism
- Failures in compassion
- Failure to listen
- Failure of the Trust Board

Failures in team work at East Kent

Salisbury NHS Foundation Trust

They identified

- A series of problems between the midwives, obstetricians, paediatricians and other professionals involved in maternity and neonatal services
- Some staff have acted as if they were responsible for separate fiefdoms, cultivating a culture of tribalism
- There had also been problems within obstetrics and within midwifery, with factionalism, lack of mutual trust, and disregard for other points of view
- They found clear instances where poor teamwork hindered the ability to recognise developing problems, and escalation and intervention were delayed
- Poor teamworking was raised as a prominent feature by many of those we interviewed. Some obstetricians had “challenging personalities … big egos … huge egos”. Midwives showed “cliquey behaviour” and there was an in-group, “the A-team”
- We have found that midwives and obstetricians did not always share common goals, and that this damaged the safety of patient care. One mother, who asked a paediatrician why her baby had died, was told that “if you want to look for blame, you should be looking at the obstetricians not me”.

<u>SFTs actions to date</u>

- Cultural review
- Midwifery development programme
- Fresh eyes with new team members
- Matron development programme starting this month
- Consultant coaching
- Change maker cultural programme
- Maternity improvement programme
- Insights visits

Next steps- to bring paediatricians into change maker approach

Failure in professionalism at East Kent

Salisbury NHS Foundation Trust

- Staff were disrespectful to women and disparaging about the capabilities of colleagues in front of women and families
- Others sought to deflect responsibility when something had gone wrong. A staff member visited a mother the day after a significant problem with her baby had been missed at birth
- In other cases, women themselves were blamed for their own misfortune. A woman admitted to hospital to stabilise her type 1 diabetes pointed out to antenatal ward staff that they were not adjusting her insulin correctly. She was told that “we’re midwives not nurses and we don’t deal with diabetes … it’s not our issue and you don’t fit in our box”
- A family member heard a consultant describe the unit they were in as “unsafe” to a colleague in the corridor, which was hardly the way to raise any legitimate concerns they may have had

<u>SFTs actions to date</u>

- Midwifery development programme
- Matron development programme starting this month
- Consultant coaching
- Change maker work
- Safety walk abouts
- Maternity safety champions
- Maternity improvement programme and assessor
- Insights visit

Failures in compassion at East Kent

- Technical competence alone is not sufficient for good care, if it is delivered without compassion and kindness. Uncompassionate care can be devastating for the wellbeing and mental health of the recipients
- They heard many examples of uncompassionate care that shocked us. A woman who asked for additional information on her condition during an antenatal check was dismissively told to look on Google
- A mother who was anxious about her baby's clavicle, fractured during a difficult delivery, was told that "collar bones break all the time because they are built to do that to get them out easier"
- Another, who asked why an additional attempt at forceps delivery was to be made, was brusquely told that it was "in case of death"

<u>SFT actions to date</u>

- Working close with Maternity voices partners to understand the experience of our users
- Increased engagement between trust patient experience lead and the maternity team
- Maternity patient survey
- Patient experience midwife appointed
- Midwifery development programme
- Fresh eyes from new team members
- Matron development programme starting this month
- Consultant coaching
- Change maker cultural programme

Failure to listen, and to learn from safety incidents in East Kent

Salisbury NHS Foundation Trust

- They have found that this failure to listen contributed to the clinical outcome
- A pattern of dismissing what was being said, which contributed significantly to the poor experience of the families within our Investigation
- Aspects of the families' experiences have been extremely damaging and have had a significant effect on the outcome for them
- They found that the same patterns of dysfunctional teamworking and poor behaviour marred the response by staff after safety incidents, including those incidents that led to death or serious damage
- Where things went wrong, clinical staff, managers and senior managers often failed to communicate openly with families about what had happened
- Safety investigations were often conducted narrowly and defensively, if at all, and not in a way designed to achieve learning. The instinct was to minimise what had happened and to provide false reassurance, rather than to acknowledge errors openly and to learn from them
- Where the nature of the safety incident made this impossible, a junior obstetrician or midwife was often found who could be blamed

SFT Actions to date

- Shared learning focus at governance meetings
- Shared learning focus for all staff
- Working close with Maternity voices partners
- Maternity patient survey
- Patient experience midwife appointed
- Midwifery development programme
- Consultant coaching
- Change maker cultural programme

Failure of the Trust Board at East Kent

Salisbury NHS Foundation Trust

- The problems among the midwifery staff and the obstetric staff were known but not successfully addressed. The failure to confront these issues further damaged efforts to improve maternity services and exposed critical weaknesses in the Human Resources (HR) function
- When bullying and divisive behaviours among midwives were challenged, the staff involved began a grievance procedure, following which, it appears to us, the Head of Midwifery was obliged to leave and not speak out. The bullying and divisive behaviours were not addressed
- One critical weakness was the lack of control that could be exercised in relation to consultants. We have found that experience in East Kent demonstrates the problems that occur when some consultants stubbornly refuse to change unacceptable behaviour.
- We have found that the Trust Board itself missed several opportunities to properly identify the scale and nature of the problems and to put them right
- The Trust Board was faced with other challenges. Some of these concerned other hospital services, particularly the Accident and Emergency department, and the failure to meet targets
- The repeated turnover of staff at many levels, including Chief Executive, served to encourage this cycle; each time it was believed that this time things really would get better
- Where issues have been brought into public focus by the efforts of families or through the media, too often the Trust has focused on reputation management, reducing liability through litigation and a “them and us” approach. Again, this has got in the way of patient safety and learning

<u>Actions at SFT to date</u>

- A number of reviews undertaken and actions brought to Trust Board and CGC in more detail
- Executive Maternity safety Champion in place
- NED Maternity safety champions in place
- Safety walkabouts undertaken
- Maternity insight visit said staff felt they knew how to access maternity safety champions
- PMRT process attended by safety champions
- MIA feedback positive and working towards exit from MIA programme in December
- Maternity insights recommending our structure to other trusts

Next step : Full “True to us” assessment

Recommendations from the report

Salisbury NHS Foundation Trust

The prompt establishment of a Task Force with appropriate membership to drive the introduction of valid maternity and neonatal outcome measures

For undergraduate, postgraduate and continuing clinical education be commissioned to report on how compassionate care can best be embedded into practice and sustained through lifelong learning

Relevant bodies, including Royal Colleges, professional regulators and employers, be commissioned to report on how the oversight and direction of clinicians can be improved, with nationally agreed standards of professional behaviour and appropriate sanctions for non-compliance

Relevant bodies, including the Royal College of Obstetricians and Gynaecologists, the Royal College of Midwives and the Royal College of Paediatrics and Child Health, be charged with reporting on how teamworking in maternity and neonatal care can be improved, with particular reference to establishing common purpose

Relevant bodies, including Health Education England, Royal Colleges and employers, be commissioned to report on the employment and training of junior doctors to improve support, teamworking and development

The Government reconsider bringing forward a bill placing a duty on public bodies not to deny, deflect and conceal information from families and other bodies

Trusts be required to review their approach to reputation management and to ensuring there is proper representation of maternity care on their boards

NHSE reconsider its approach to poorly performing trusts, with particular reference to leadership

The Trust accept the reality of these findings; acknowledge in full the unnecessary harm that has been caused; and embark on a restorative process addressing the problems identified

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Questions

NHS Salisbury NHS Foundation Trust

Report to:	Trust Board (Public)	**Agenda item:**	5.2
Date of Meeting:	03 November 2022		

Report Title:				
Status:	**Information**	**Discussion**	**Assurance**	**Approval**
	X	X	X	X
Approval Process (where has this paper been reviewed and approved)	Written by DepCNO, supported by Safe Staffing Steering Group and Divisional teams. Discussed at CGC as part of governance route. Discussed at F+P given financial request and investment			
Prepared by:	Henry Wilding, Dep CNO			
Executive Sponsor (presenting):	Judy Dyos/Henry Wilding			
Appendices (list if applicable):	1. Safe staffing data 2. Requested uplift to staffing numbers 3. W+NB staffing review 4. Ward designations and specialism 5. Safe staffing RAG, purple/black 6. RAG impact on CHPPD 7. NICU staffing review			

Recommendation:
The committee are requested to review the safe staffing paper and consider the recommended uplift in staffing resource for our in-patient environments (Appendix 2).

Executive Summary:
The yearly full skill mix review was undertaken in August and September 2022, reviewing data from July 2021 to June 2022. This period saw subsequent waves of covid infection that brought us our most challenging position yet with regards to operational capacity demands, concurrent outbreaks, staff unavailability and ultimately Care Hours Per Patient Day (CHPPD). As has been reported separately and captured within the corporate risk 7039, this meant at times, safe staffing could not be guaranteed as the available resources were deployed on a risk assessment basis to the areas of greatest and emerging need.

This has resulted in the highest number of staffing escalations, red flags and Datix with regards to nursing shortfall and a falling Care Hours Per Patient Day position, with the Trust's lowest figure of 6.4 (April 2022) to date.

Whilst it is correct that such acknowledgement is made, the skill mix review also focuses on the funded establishment and provision that is made available, which for the majority of wards and services is sufficient to meet the needs of the patients and their relevant acuity - the challenge being recruitment, retention and any provision of temporary workforce in the interim.

As highlighted within the report (appendix 2), a request for further funding is made to specific areas such ED, AMU and cancer care to ensure the appropriate skill mix, supervision training and support is achieved, which in turn will ultimately add to recruitment and retention.

The committee is also asked to note the collaborative work underway across the ICS with a sperate workforce and skill mix review being undertaken across the three acute Trust. Data analysis is currently underway and anticipate further updates to follow at the October Acute Hospital Alliance meeting, and subsequent skill mix review of February 2023.

The paper has previously been discussed at CGC (September) with suggested amendments made regarding apparent omission of NICU review (now included in appendix 7) and discussion at Finance and Performance (undertake 25/10/22).

Whilst valuable discussion and oversight from F&P, no definitive funding approval reached, deferring to anticipated Board discussions with concurrent winter staffing plans.

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	☒
Other (please describe) -	☐

1. Purpose

1.1 The purpose of this paper is to report the outcomes of the annual review of ward staffing nursing establishments. Due to the impact of the pandemic the frequency and rhythm of skill mix reviews had fallen out of its standard bi-annual frequency of February/September, but this reports sees the established rhythm return with a full cycle of reports (September 2021, February 2022 and now September 2022).

1.2 The report fulfils expectation 1 and 2 of the NQB requirements[1,2] for trusts in relation to safe nurse staffing, and the most recent guidance Developing Workforce Safeguards[3] which requires Boards to be fully sighted on the staffing requirements.

2. Specific Detail

2.1 Ward staffing review methodology

2.1.1 In 2012 SFT (Salisbury Foundation Trust) established a systematic, evidence-based and triangulated methodological approach to reviewing ward staffing levels on a 6-monthly basis and taking proposals for changes to establishment to the Board to be approved and implemented via a budget setting process. The aim of this process is to provide safe, competent and fit for purpose staffing to ensure delivery of efficient, effective and high quality care.

2.1.2 This process has been adapted to include a full annual skill mix review presented to Board (this paper), followed up by an update review 6 months later to ensure plans are still appropriate and to review the impact of any investment. The last full review went to Board in September 2021 which included financial provision to increase the establishment of midwives, development of B4 Nursing Associate role for the Hospice and provision to enable Band 6 sister/charge nurse presence 24 hours a day on Tisbury CCU. These recommendations were successfully embedded and whilst aspects of recruitment remain on going for some areas (midwifery) the targeted uplift has been successful in achieving the required aims in addressing the specific aspects of safe staffing and acuity needs of patients.

2.1.3 The approach taken for the full skill mix review utilises the following methodologies:

- Safecare module of Allocate as a proxy for Shelford Safer Nursing Care Tool.
- Care Hours Per Patient Day.
- Professional judgement.
- Peer group validation.
- Benchmarking and review of national guidance.
- Review of e-rostering data.
- Review of ward nurse sensitive indicator data.
- Review of HR indicators and finance metrics.
- INSIGHTs data (from Allocate E-Roster data).
- Safer Nurse Care Tool.

2.2 National Guidance

2.2.1 In 2013 as part of the response to the Francis Enquiry[4] the National Quality Board (NQB) published a guide to nursing, midwifery and care staffing capacity and capability (2013) 'How to ensure the right people, with the right skills, are in the right place, at the right time'. This guidance was refreshed and broadened to include all staff groups and re-issued in July 2016

to include the need to focus on safe, sustainable and productive staffing. The expectations outlined in this guide are offered below.

Safe, Effective, Caring, Responsive and Well-Led Care		
Measure and Improve -Patient outcomes, people productivity and financial sustainability – Report, investigate and act on incidents (including red flags) - Patient, carer and staff feedback		
- Implementation Care Hours per Patient Day (CHPPD) - Develop local quality dashboard for safe sustainable staffing		
Expectation 1	**Expectation 2**	**Expectation 3**
Right Staff	**Right Skills**	**Right Place and Time**
1.1 evidence-based workforce planning	2.1 mandatory training, development and education	3.1 productive working and eliminating waste
1.2 professional judgement	2.2 working as a multi-professional team	3.2 efficient deployment and flexibility
1.3 compare staffing with peers	2.3 recruitment and retention	3.3 efficient employment and minimising agency

2.2.2 There is now available a suite of improvement resources developed and designed to support the approved NQB guidance on safe, sustainable and productive staffing. The resources applicable to the Trust are:

- In-patient Wards for Adult Acute Hospitals - is aimed at wards that provide overnight care for adult in-patients and excludes intensive care, high dependency, acute admissions and assessment units.
- Urgent and Emergency Care.
- Maternity Services.
- Children's Services.
- Deployment of nursing associates in secondary care.

These resources have been included within the process for the skill mix reviews and assessing compliance against them.

2.2.3 In July 2014 NICE published clinical guideline Safe Staffing for nursing in adult in-patient wards in acute hospitals.[5] This guideline is made up of 38 recommendations. The Trust remains compliant with these guidelines.

2.2.4 In October 2018 NHSI published 'Developing Workforce Safeguards – Supporting providers to deliver high quality care through safe and effective staffing'. The document moves forward from the NQB Guidance as described above and from April 2019 NHSI will assess Trusts compliance with the triangulated approach to deciding staffing requirements described in the NQB guidance – the Trust is compliant with this through the staffing review process. The Trust is also required to include a specific workforce statement in its annual governance statement.

2.2.5 In January 2018 the NQB published an additional resource 'An improvement resource for the deployment of nursing associates in secondary care'.[6] The Trust remains compliant with the recommendations, the deployment of Nursing Associates has not resulted in a substantial change to the RN establishment (a full EQIA would need to be undertaken if this approach changed). The guidance indicates that Care Hours Per Patient Day (CHPPD) needs to be reported separately for Nursing Associates (NA), this requirement was due to be met with a planned e-rostering update early 2020, and whilst the erostering system has since been upgraded to facilitate this, wards are required to develop established templates specifically listing the NA role, to which currently no wards have sufficient numbers to develop such a fixed pattern. SFT are in a similar position to BSW colleagues with regard to this aspect and remains an active conversation with ward and E-Roster leads.

2.3 **BSW Regional Skill Mix Review**

2.3.1 With the formal inception of the ICS, the collective CNOs from the three acute Trust's have commissioned a wider review of safe staffing levels across the system. The three Deputy CNOs have been working together over the past 4 months confirming a data set which provides consistency amongst us, and together with colleagues from Southampton University anticipate we will be able to peer review, benchmark against national guidance, apply consistency and rigour to future skill mix reviews and share equally any available finances, initiatives and focus to the areas of collective greatest need for the benefit of the ICS as a whole.

2.3.2 The combined ICS skill mix review is currently in the data analysis stage, and due to be shared and discussed at the next Acute Hospital Alliance meeting in October 2022. It is anticipated it will form part the skill mix review undertaken and reported to Board February 2023.

2.4 Ward Staffing Review

2.4.1 The full review was carried out with each ward during Q2, reviewing the data from June 2021 – July 2022. The reviews were attended by the Ward Sister, Head of Nursing and/or Matron and Deputy Director of Nursing. Business Partners and Finance Managers were invited to attend, along with education. The same triangulated methodology was used as in previous reviews – review of nurse sensitive indicators, HR and finance metrics, headroom data, nurse-patient ratios, Safecare data and professional judgement.

2.4.2 The detailed spreadsheets with ward by ward findings are included in Appendix 1. This provides detailed information on the current establishment levels for each ward and vacancies at time of ward reviews; registered to unregistered ratios; nurse to patient ratios by registered and total nurse staffing by shift; nurse sensitive quality and HR outcome data and detailing acuity and dependency information from the Safe Care Tool reviewed by ward.

2.4.3 With the development of Power BI and establishment of Ward Performance Reviews, the provision of nurse sensitive, quality and infection data is now much more robust, consistent and offers an accepted 'one version of the truth'. The data now available also allows us to

clearly track trends month by month, and review peaks in greater detail along with concurrent markers.

2.4.4 As indicated and referenced in previous skill mix reviews, the formal Safer Nurse care Tool (SNCT) has now been able to be utilised. Licenses for its use have been secured and we have been able to get underway introducing its formal adoption. To date three areas have utilised the tool – Longford, Sarum and ED. As local expertise grows, it is anticipated that further roll out will develop at pace, as the availability of Deputy CNO and Safe Staffing Lead has been compromised by concurrent operational and competing priorities. Whilst the tool itself is regarded as gold standard, it's recommended use requires twice yearly assessments before any fundamental adjustment to skill mix review should be undertaken.

2.4.3 Nurse to patient ratios by registered and total nursing

- The ward establishments allow for registered nurse to adult patient ratios during the day across SFT to range from 1:5 to 1:10 depending on specialty and overall staffing model. These ratios do not include the nurse in charge. In some areas where there has been active implementation of the band 4 role these ratios can vary on specific shifts, although the underlying establishment ratio is not altered. These ratios are set against establishment and can regularly increase when wards are not fully staffed (vacancy/sickness etc) as we have over past 12 months.

- Planned staffing ratios at night require constant oversight to ensure the model is sufficient to provide the required support for patients out of hours. Ratios range from 1:5 to 1:12; all areas with higher ratios have been reviewed to ensure the registered nurse ratio is appropriate for the acuity of the ward and is offset by higher total staff to patient ratios, and will also form part of the combined ICS skill mix and staffing review.

- Total number of nurses offer similar variation depending on speciality, ranging from 1:2.3 (Longford) to 1:3.4 (Laverstock) during the day, and 1:3 (AMU) to 1:6 (Downton) during the night.

2.4.4 Registered to unregistered ratios

- The wards have been reviewed against the benchmark of 60:40 registered to unregistered ratios as the planned model of care. Again this ratio varies across ward and speciality ranging from 36:64 (Spire) to 70:30 (Britford) when excluding bespoke environments such as Tisbury, ED and Radnor.

- Overall the Trust average of registered to unregistered workforce is 56:44, however, the registered:unregistered ratio does not account for the presence and application of the B4 role and the extent of their role and remit offsetting the apparent lack of registered nurses.

- Several wards have actively implemented the use of band 4's (spinal, elderly care and orthopaedics) and the ratios have been reviewed as registered: band 4: unregistered. This will be further supported when we are able to report CHPPD for the Nursing Associate role. The band 4 role continues to be developed as part of models of care and utilisation of the role continues to be a theme for review for each skill mix review to identify further opportunities - particularly linked to the development of apprenticeships nationally and providing a career development route for unregistered staff.

- As the adoption, development of appointment of B4 Nursing Associates takes place, there is some variation as to how the B4 role is represented within ward budgets with some assumptions that funding for the role is allocated from unregistered staff, and some wards funding taken from a shortfall in registered staff. However, local management and financial support ensure these roles, and the funding of, are tracked and managed in their inception, development and application.

- There are ward areas where the acuity and intensity of patients has increased and treatment and medication regimes are complex and so an overall reduction in registered to unregistered ratios would not be appropriate to maintain safe staffing levels. Focus will continue on reviewing the overall registered to unregistered ratios to ensure reductions are linked to planned model of care changes.

- A few wards are significantly above the 60:40 ratios and this tends to be where the intensity of patient needs requires a higher ratio of registered staff (intensive care, cancer care, cardiology, Acute Medical Unit).

- Ratios of registered and unregistered staff will also be a focus of the ICS skill mix review to ensure consistency across all three trust and how B4 NAs are applied and utilised.

2.4.5 Assessment against SafeCare Tool

- The Safe Care Tool (acuity/dependency model) has been used to review the staffing. This is integrated into the Healthcare roster system and provides information on the acuity/dependency levels and corresponding staffing levels on a real-time basis. When predicted levels differ from established numbers, professional judgement has been used to assure that the levels set are appropriate for the specialty and number of beds. The data is reviewed at each skill mix review as well as being used to review staffing levels on a daily basis.

- The use of professional judgements extends to the recording and capture of red flags both within the Trusts datix system and within the Allocate rostering system. These have also been included within the reviews with some wards consistently raising red flags almost daily (Redlynch, Durrington, Pitton, Breamore specifically). These 'red flags' highlight significant shortfalls in nursing care where the most basic of nursing premises are unable to achieved (shortfall in nurse-to-patient acuity needs, omission in medication, delay in provision of analgesia, staff unable to take breaks, delayed/omitted intentional rounding/SKIN bundle).

- Whilst wards have varying approaches, compliance and consistency to the raising/reporting of red flags, this skill mix review period has seen the highest numbers of red flags raised which reflect the documented shortfall in available care hours and associated corporate risk (7039) due to vacancy, extended escalation, sickness and unavailability.

- Analysis of SafeCare data is included within the reviews.

- In line with the NHSI Developing Workforce Safeguards, updated licences have been obtained from Imperial Innovations to allow the use of the Shelford Safer Nursing Care Tool (SNCT).[7.]

- Specific SNCT analysis has now been undertaken on Longford, Sarum and ED which has been considered within any offered adjustments, although in line with SNCT guidance a series of twice-yearly assessments should be undertaken before any fundamental adjustments undertaken to ensure consistency and validity.

2.4.6 Allowance for additional headroom requirements and supervisory ward leader

- As a result of previous skill mix review the headroom allowance was increased from 19% to 24% across all inpatient wards and roles. This was applied to ward budgets from April 2021. In the main across the wards, this has been well adhered to and monitored as part of the senior sign off and approval of rosters, and the Safe Staffing Steering Group. Unfortunately, due to high sickness levels seen across the year caused directly or indirectly by the pandemic, unavailability has reached in excess of 30% at times and within smaller teams, much higher still.

- Whilst maternity leave continued to be funded centrally and is managed outside of the 24% headroom, a higher rate of maternity leave has compromised staffing availability further with some wards seeing up to 8 members of the team on maternity leave at any one time, which in turn also impacts annual leave allocation due to accrued leave which is then frequently added on to the end of any maternity leave.

- The Trust continues to run a supervisory model for ward sisters/charge nurses, in which they are given 0.8wte of their working week for this, with 0.2wte clinically rostered into numbers. In this review the average amount of supervisory time ward leaders were currently able to access had deteriorated to an average of 20% in Medicine and 60% in Surgery and 55% in CS&FS. This is a deterioration of 10-15% from the previous year across all three divisions. Surgery have previously utilised a Ward Managers Assistant post which has proved successful in releasing ward sisters from administrative duties, and medicine are now looking to adopt a similar model, sharing between wards and utilising available B2 monies.

2.5 Care Hours per Patient Day (CHPPD)

- The national reporting requirements for safe staffing has changed from the planned vs actual hours' methodology to reporting on care hours per patient day. This metric provides a single comparable metric for recording and reporting nursing and care staff deployment. It's a simple calculation which divides the number of actual nursing/midwifery (registered and non-registered) hours available on the ward per day, by the number of patients on the ward at midnight. It represents the average number of hours that are nominally available to each patient that day.

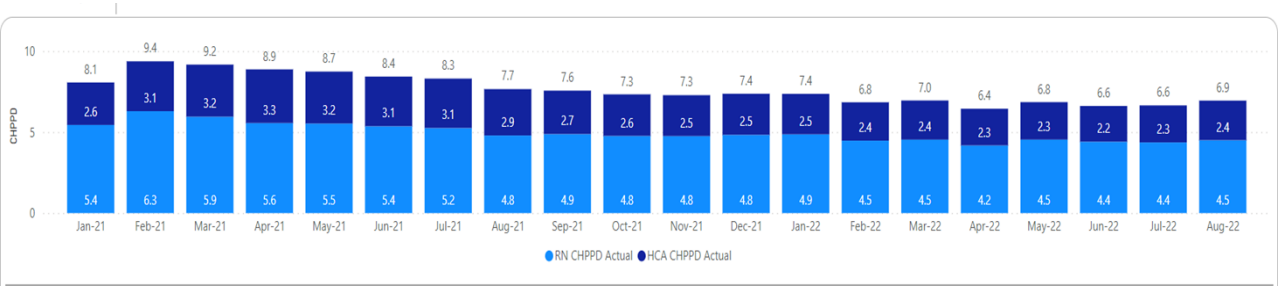
- Within Model Hospital comparisons can be seen at both ward and trust level, however, caution is required as the specific configuration of services in any organisation determines the level of staffing required. The data in the model hospital provides the opportunity to review staffing levels through another lens, ask questions and challenge and evaluate whether staffing levels are safe. As previously highlighted, going forward Nursing Associates (but not Assistant Practitioners) will be shown separately to RNs and HCAs, and will provide a more accurate review and assessment of CHPPD.

- As referenced previously, CHPPD will also form a key part of the ICS skill mic review as direct comparison can be undertaken amongst the same specialisms.

- At the time of completing this report as a Trust we continue to report regionally a red flag regarding current nursing levels driven primarily by annual leave, sickness, maternity leave and reduced bank and agency coverage. During the course of year this 'red flag' has been deployed in line shortfall in available staff, and includes all aspects of front-line staff (medical, nursing, midwifery, AHP etc). However, this review focuses on skill mix and financial establishment to support the safe deployment of resources, and broadly we have staffing levels that can be seen to be safe, however, there are areas where an increase in staffing is recommended (see appendix 2).

- Whilst the skill mix review focuses on the availability of financial establishment to support a skill mix resource that is regarded as safe and sufficient for the specialism and acuity of patients, it would be remiss not to reference the challenges the Trust has faced in actually delivering safe staffing resources, regardless of funding establishment within the period of review itself. This interplays with sickness, recruitment, retention, operational pressures, escalation and ability to provide onward community care for our medically fit patients amongst many other regional and national factors and trends.

- This is highlighted within our CHPPD figures, where our nadir of April 2022 saw our lowest figure of 6.4 CHPPD. Since then we have seen an albeit slow, but steady recovery in line with recruitment and retention efforts, and reduction in sickness and unavailability.



- As referenced in 3.2, as a result of Covid pandemic varying tolerance levels of staffing numbers was developed in the form of red, amber and green rating (appendix 5). To help provide context with regards to the impact of these staffing numbers on CHPPD Appendix 6 offers what these staffing number represent when applied to the average number of patients. Whilst this demonstrates that green (normal staffing establishment) offers a CHPPD of 7.1, amber 6.2, red 4.9 – some caution is offered, as this would not include enhanced care needs, specials, escalation areas.

2.6 Specific Divisional Themes

Outlined below is the detail by division which describes where there are opportunities to review efficiencies, effectiveness, patient experience and any recommendation for increases in establishment.

2.6.1 Medicine Division:

Whilst the period of assessment (July 2021 – June 2022) offered a period of increasing stability from the initial period of pandemic for Medicine, its effect still rumbles on impacting on

availability of staffing, requirement for further flexibility and evolutions of environments and deployment of resources. This includes the adoption of Spire ward as currently cohort environment for Covid-19 confirmed and suspected patients, and Breamore ward establishing itself as destination for our non-criteria to reside patients.

Durrington and Breamore ward are still regarded as escalation wards but have been fully open and deployed in their entirety for the duration of the year.

Emergency Department

The Emergency Department continues to operate differently and settle into its new norm, with the extension of majors cubicles (11-15) and displacement of minors. ED minors has been able to fully establish itself in its new home with the development of the previous Orthopaedic outpatient clinic environment. To coincide with this and in response to the significant and sustained shift in type and number of attendances, the ED and Medicine Division are currently preparing a business case to support an additional ENP role along with relevant nursing support roles.

However, separate to the business case to increase ENP support, and in keeping with the remit of safe staffing review, the Emergency Department continues to highlight aspects of their staffing that are not compliant with Royal College of Emergency Medicine (RCEM) standards. Of the 96 standards SFT are fully compliant with 22 standards, partially compliant with 44 standards and not compliant with 30 standards. The recommendations listed in appendix 2 aims to address the most the pressing and impactful standards for patient care and in line with our own service priorities.

AMU

The AMU department itself has struggled during the year to achieve its planned CHPPD. This has been as a result of its persistent vacancy gap and high sickness which has been reported elsewhere, and the persistent occupancy of the ambulatory environment overnight due to concurrent capacity issues. This has been further compounded by the overflow of ambulatory patients numbers at times with up to 17 patients (total of 36 patients) requiring care and assessment within the same footprint, by the same team.

With the arrival of the newly appointed ED/AMU matron, a deeper dive in to AMU staffing and skill mix is planned for winter 2022, but in reviewing AMU current staffing model against Society Acute Medicine position of a minimum of ratio of 1:6 RNs, an immediate uplift of 3 RNs is requested to ensure this minimum requirement is maintained 24/7.

Staff turnover

Recruitment across the Division of Medicine was generally steady but over the past 12 months the division has continued to struggle with increased staff turnover ranging from 9% to 23%, a sickness rate ranging from 5% to 13% and an increased maternity leave. The impact of retention is also posing a challenge within specialist services such as cardiology, emergency medicine and oncology. With OD&P and line managers undertaking exit interviews, rationale and reasoning for leaving is regarded as regular and reasonable with onward progression, geographical move or known retirements. However, the impact of covid is often cited and current demands and pressures is often referenced as causative factors of sickness, with reduced interest picking up additional bank shifts. Within lower banded staff, the cost-of-living crisis is now an increasing theme with leavers achieving higher rates of pay within the community or agency work, or more worryingly, leaving the healthcare profession altogether.

In terms of additional staffing needs as a result of skill mix reviews, appendix 2 details the requests, assessment and recommendation of the DCNO as part of the review process.

2.6.2 Surgical Division:

The Surgical Division has remained relatively static in the past year in comparison to the displacement and repurposing at the height of the pandemic. Chilmark ward remains the elective ward but in line with 'Living with Covid' and subsequent easing of restrictions, all surgical environments have been utilised to their full potential in line with guidance and to ensure maximum efficacy as part of the elective recovery efforts.

Downton

Downton ward has continued to experience a high number of medical outliers during the year, average 10-12 at any one time. This together with the displacement of elective patients to Chilmark ward has meant a higher acuity of patient for their establishment in an environment that can pose a challenge for infection control and observation – namely the 10 bedded bay of bay one. As a result, further uplift in staffing is requested to ensure adequate and safe provision to implement bay watch, and address the acuity needs of patients.

Britford SAU

Whilst there is ongoing Divisional assessment and review of SAU, given its increasing numbers and referrals, adjustments to staffing can currently be made through existing budgets.

2.6.3 Clinical Support and Family Services

Paediatrics

The number of paediatric patients requiring support from Children and Adolescent Mental Health Services (CAMHS) has become an increasing staffing challenge, there is limited access to suitable placement for some of these patients which has resulted in extended periods of time on Sarum ward. Caring for young people in crisis has been a significant pressure on the team and required the use of agency Paediatric Mental Health Nursing support. The Head of Nursing is working with partner organisations to increase knowledge of how best to support these patients with our own staffing group with the appointment of a paediatric mental health lead role.

Sarum staffing numbers have remained static with 3 Paediatric RNs on shift for many years now. The last previous uplift in staffing establishment was to support the POST (Paediatric Outreach Support Team) approximately 4 years ago. This has since been renamed to PASS (Paediatric Assessment Service) to more effectively describe its role and extent of interaction with services across the Trust. Over the past year, the role of PASS team/nurse has been to predominantly support Sarum acknowledging their increased acuity and change in patient type (increased CaMHS attendances). This has limited how effective the PASS team can be in fulfilling their original brief, and has to some extent masked the changing needs and acuity to Sarum ward itself, with the need for all four RNs to be predominantly based on Sarum ward.

The RCN (2013) guidance states that a paediatric trained nurse must be available at all times when children are admitted for Day Case Surgery (DSU). DSU currently employ 1.0 wte

Paediatric RN directly, with support offered from the PASS or Sarum ward team as required. Unfortunately due to concurrent demands and acuity this is not always achievable. In these circumstances, following a review of bank options with the sisters from Sarum and NICU ward, a paediatric agency nurse may be requested to work on DSU. It is also to be noted that there has been intensive work to ensure that the DSU staff undergo their paediatric competencies.

Longford

Longford ward now sits within CS+FDS Division but for the period of assessment remained within Medicine. It has been a challenging year for Longford as it has continued to work towards the previous CQC actions and recommendations and addressed concerns and complaints stemming from staff and patients. This has culminated in intensive support from the executive team and bespoke action plan which is monitored separately via the executive team and Clinical Governance Committee.

In part of addressing some of the concerns and developments for Longford ward, an increase in senior nurse provision is requested to provide leadership and senior oversight 24/7 with the availability of a B6 nurse on each shift covering the 42 bedded ward.

2.6.4 **Women and Newborn Division**

The Women and Newborn have undertaken their own review and are included in Appendix 3, and NICU staffing report in Appendix 7. In summary, no specific ask or request for additional resources is made, and the team continue to recruit to their previously awarded uplift of 2021 with following summarised plan.

- Work with the national, regional, and local teams to develop an action plan modelling the rollout of Continuity of Carer.
- Continue with the recruitment campaign work utilising all options available to the Trust for recruitment and retention incentives.
- Complete a workforce review of all staff groups in the service to ensure flexibility is explored for all clinical roles; this will include NICU, Maternity Care Assistants and Maternity Assistants working in the community.
- Utilise Bank and Agency staff.
- Review working patterns and flexibility models within the current service.
- Monitor staffing monthly through staffing dashboard and escalate concerns accordingly.
- Where opportunities to over recruit become an option ensure this is available to the team.
- Review the Maternity Care Assistant competency framework with the LMNS to ensure their role is included in workforce planning and skill mix – ultimately reducing midwifery staffing in the postnatal ward environment.

3.0 Trust wide risks and issues considered in the review

3.1 Vacancies and temporary staffing

Nationally RN vacancies remain high with various recruitment and retention strategies in place. The Trust is fully engaged with all recommended approaches and closely working with

NHS England with regards to targeted international recruitment and HCA recruitment programs.

The focus on nurse retention has remained and linked into wider Trust work such as Best Place to Work initiative. The release of the People Plan sees nursing as a core element and work continues across Divisional leads and representatives with regards to flexible working pattern systems. The Trust is part of a national collaborative with Allocate piloting team-rostering (Britford and Odstock) as part of a wider piece of work on improving flexibility for staff – a requirement within the People Plan.

Focused recruitment campaigns continue for HealthCare Assistants to increase the numbers of substantive staff with the intention of eliminating agency expenditure in this area which is a national requirement.

3.2 Impact of Covid on Safe Staffing

The period of the skill review covers July 2021 to June 2022. This period covered subsequent waves of covid infection resulting in a number of ward outbreaks, and increased staff absence.

As a result, and in anticipation of reduced staffing numbers, a planned change in ratios was previously developed and agreed via the Executive Gold forum (See appendix 4). The table below demonstrates the planned actions for green, amber and red staffing as wards and teams are impacted as a result of leave and sickness.

The purpose was to facilitate an informed approach to reducing staffing during any shortfall. During the year in question, the Trust reached the point where the teams were unable to achieve red levels, and as a result of this, the Trust actioned additional resource requests in the form of implementation of the Ward Buddy programme, and was forced to develop and contemplate further reductions in staffing numbers with the development of purple and black staffing numbers (appendix 4).

Whilst the feared mass casualty did not materialise to its full extent with those proposed and potential repurposing of Springs restaurant to accommodate in-patients, the Trust was tested to its limits with regard to capacity and the resulting stretch on nursing resources.

Rating	Trigger/Impact	Action	Authorisation
Green	**Staffing levels:** staffing levels match with agreed roster plan **Patient acuity & dependency**: is within usual expected range for the area **Situation**: "business as usual"	All planned care and routine tasks will be carried out	None
Amber	**Staffing levels:** A shortfall has occurred between 'We have' and	Some non-essential activities may be postponed or cancelled until	Matron – in hours Duty manager - out of hours

	'We planned' e.g. due to staff absence and/or vacancy **Patient acuity & dependency:** is increased from that usually expected e.g. requiring increased clinical observation levels or other staff intensive interventions **Situation:** A short term solution resolved by short term provision of additional resources	situation is resolved as determined by the Nurse in Charge Matron seeks redeployment of staff from other areas or where this is unsuccessful may request additional Bank cover as required	
Red	**Staffing levels:** A shortfall has occurred between 'We have' and 'We planned' that cannot be met in the short term by redeployment of staff from other areas or by Bank staffing **Patient acuity & dependency:** risk assessment and professional judgement indicates that risks presented by a measurable increase in patient acuity/dependency necessitates a shift to be covered	All non-essential tasks are suspended – specifics agreed by Nurse in Charge Matron escalates red rated shift to HoN for consideration/approval for agency cover. Off framework agency to be approved by DoN or Deputy (Exec on-Call out of hours) Nurse in Charge reports a patient safety incident on DATIX if shift is unable to be partially/completely covered and patient safety is at risk of being compromised	Agency - Matron or Divisional Head of Nursing to Deputy Director of Nursing in hours On call manager and exec on call out of hours DoN or Deputy for non-framework requests (exec on call out of hours) Below red Ward buddies and military support was sought

4. Conclusions

Whilst the safe staffing review has demonstrated that the vast majority of services and ward have sufficient budgetary resources to achieve safe staffing levels, the unfortunate reality and deployment of resources day to day, has meant at times staffing numbers have been insufficient, and in line with the corporate risk 7039, meant that we could not guarantee safe staffing levels for all our patients for all of the time. This does not mean that all attempts of shift coverage, agency, incentive, redeployment have not or were not exhausted, but the unfortunate reality of the lowest points of the staff year seen in the CHPPD nadir of April/May 2022.

Whilst nobody regards these shortfalls in nursing care and provision as satisfactory, it has provided aspects of clarity as to priorities for immediate and medium term with recruitment, retention, and well-being initiatives at heart of our approach. Overseas and HCA recruitment

programmes have seen consistent engagement with wards along with the revision of induction program, new to care models and flexibility for our colleagues.

Nursing continues to demonstrate effectiveness in deploying workforce as efficiently as possible which is demonstrated in both INSIGHTs data which is reviewed monthly at the Safe Staffing Group, and in utilisation of the Covid staffing plan.

Good progress has been made against ensuring nursing continues to meet the requirements of the national publications on nurse staffing and the responsibilities in Developing Workforce Safeguards, although as referenced specific areas of imminent focus include ED, AMU and cancer care services.

The review itself and ongoing work between the nursing team and the Finance team has led to an improved understanding of the current and required staffing position. The roll out of SNCT will continue to engage ward leads and the proposed use of daily CHPPD figures to inform staffing discussions, deployments and escalations will ensure greater clarity and consistency in demonstrating safe care for our patients.

The Chief Nursing Officer on acceptance of the recommendations considers the funded nurse staffing model to be safe, effective and sustainable, and will be subject to ongoing bi-an annual review.

5. Recommendations

- To note the findings of the full ward establishment review and the Trust position in relation to adherence to the monitored metrics on nurse staffing levels, specifically:
    - SFT nursing establishments are set to achieve an average of ratio 1:6.9 (excluding ITU) in Surgery and 1:7.1 (excluding ED) in Medicine of registered nurses to patients during the day, which does not include the nurse charge role.
    - Wards are staffed on average 55:45 registered/unregistered ratio, with exceptions linked to the implementation of the band 4 role.
- To note the on-going progress with compliance with the guidance from the National Quality Board on safe, sustainable and productive staffing including Developing Workforce Safeguards.
- To note the requirement to implement the Safer Nursing Care Tool to provide additional assurance that nurse staffing levels are safe.
- To continue momentum on actions to fill vacancies in a timely manner and improve retention and to continue the reduction on the reliance on high cost agency.
- To discuss the report at both TMC and open Trust Board as an ongoing requirement of the National Quality Board expectations on safe staffing assurance.
- To recognise that ongoing Covid activity and elective recovery may require an agile response to maintain safe nursing care.
- To adopt the recommended increase in establishment as per Appendix 2

References

1. National Quality Board. How to ensure the right people, with the right skills, are in the right place and the right time: A guide to nursing, midwifery and care staffing capacity and capability. NQB. 2013.

2. National Quality Board. Supporting NHS providers to deliver the right staff, with the right skills, in the right place at the right time: London: NQB. 2016.

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4. Francis R. Independent Inquiry: Report of the Mid Staffordshire NHS Foundation Trust Public Enquiry. London: The Stationary Office, 2013.

5. National Institute for Health and Care Excellence (NICE). *Safe staffing for nursing in adult inpatient wards in acute hospitals*. London: NICE 2014. Available from https://www.nice.org.uk/guidance/sg1/resources

6. National Quality Board. Safe, sustainable and productive staffing. An improvement resource for the deployment of nursing associates in secondary care. NQB. 2019.

7. The Shelford Group. Safer Nursing Care Tool; Implementation Resource Pack 2014.

8. NHSI .Advice on acute sector workforce models during COVID-19 Dec 2020

9. https://digital.nhs.uk/data-and-information/publications/statistical/nhs-vacancies-survey/april-2015---september-2020

Column	Descriptor	Definition
B	Beds	Number of funded beds on ward
C-I	Funded establishment	The establishment on the ward for all ward based posts ie nurses, nursing assistants, ward clerks etc
J	% Establishment uplift	The actual headroom on the ward to cover annual leave, sickness, maternity etc - this will be provided by the E-roster team and will be an average for the year
M-Q	Vacancies	Inlcude all current vacancies at time of skill mix
R-AC	Staff on shift	Number of registered and unregistered on the early, late and night shift. If long days please indicate the numbers of staff who are on the ward at these times
AD	Shift pattern	Identify whether 2-shift (LD) or 3-shift (E/L/N) pattern. Where use a combination please choose the option most used.
AE-AF	Admin support	Identify any additional roles on the ward which are not in the daily nursing requirements but that are funded from the ward budget
AG	Supervisory	Identify whether using supervisory shifts and how much time given to this ie 2 days per week = 0.4, 4 days = 0.8. This will be calculated from e-roster and will be percentage of the 0.8 that is funded.
AH-AJ	Skill mix	The percentage of RNs and NA's based on establishment
AL-AQ	RN staff relative to patients	If you have a 28-bed ward and you have 4 TN on the early shift then this would be 1RN to 7 patients. Exclude any nurse in charge role routinely without patient case load
		As above but for late shift so may be you have 3RN on the late shift so this would be 1RN to 9 patients
AR-AU	Staffing relative to population served	Same as above but count all RNs and NA's so if you have 7 on an early shift and is 28-bed ward this would be 1 nurse to 4 patients
		As above for late shift ie if you drop to 5 on the late shift then would be 1 nurse to 5.6 patients
AV	Turnover / absence	Overall percentage for the specified time period - HR business partners can provide
AW	Sickness	Will be provided by E-roster as part of unavailablity/headroom data
AX -AY	Appraisal and MLE Compliance	Check Power BI ward performace data (Safe and Well led)
AZ-BB	Number of PUs per 1000 bed days within t	Check Power BI ward performace data summary page. Record highest, lowest and average
BC-BE	Number of falls per 1000 bed days	Check Power BI ward performace data summary page. Record highest, lowest and average
BF-BH	Number of medication incidents per 1000 bed days	Check Power BI ward performace data summary page. Record highest, lowest and average
BI	Number of datix red flag incidents	Check datix for number occuring within time period period
BJ-BL	Number of infections	Data to be provided by DCNO (will be Powerr BI in future)
BM	Risk register	Please bring any risk register entries related to nurse staffing
BN	% Actual of planned hours	percetnage of actaul nurse resource achived against planned staffigb template.Check Power BI ward perfromance data (well led)
BO	CHPPD	Numner of care hours achieved in proiportion to number of patients on ward. Check Power BI ward performance data (efffective)
BP	SNCT review?	DCNO to complete

Date: **Ward:Amesbury**

Present:

Section 1: Review of Current Position

	Themes/Concerns/Good Practice from Data	Comments
1.1	Quality/Outcome Data	Continued high incidence of falls and continued increase volume of pressure sore, evidence of higher volume of aggression towards staff . Prevalence of safeguarding requiring investigation cof complex discharge management requiring incraese focus on long staying patients
1.2	HR Indicators	Low level compliance due to high level operational activity . Retention challenges due to workload, persistent stressed and challenging environment . High sickness level due to msk and anxiety and stress . Well being session done with staff. Poor compliance with MLE due to unavailability of time allocated to staff due to ongoing staffing pressure .Limited opportunity for training staff to upskill or update . Training arrange but staff gets pulled out due to staffing gaps . Constantly engage in recruitment but like 'dripping tap'
1.3	Finance	Increased in requirement with agency nurse and band 2 temporary staffing due to sickness
1.4	Current establishment / Vacancies	Amesbury needs RN 2.7 WTE and 8 HCA WTE
1.5	Supervisory	Supervisory hours are 20%
1.6	Professional judgement of staffing ratios	Professional Judgment persistently red , mitigation is sort with support from other areas , persistent gap with care hours requirement and availability . Supernumerary time not protected to mitigate the risk
1.7	Safe Care Data	Safe care shows short due to increased acuity and dependency as most Amesbury patients would be in level 1a,1b and 2 even there are no staffing issues
1.8	Other supporting evidence to any proposed changes to skill mix	

Section 2: Recommendations/Considerations

	Recommendations/Actions from Review	By Who	By When
2.1			
2.2			
2.3			
2.4			

All actions reviewed from Skill Mix Review 2021:

SafeCare Data

Date: **Ward: AMU**

Present:

Section 1: Review of Current Position

	Themes/Concerns/Good Practice from Data	Comments
1.1	Quality/Outcome Data	
1.2	HR Indicators	
1.3	Finance	
1.4	Current establishment / Vacancies	
1.5	Supervisory	
1.6	Professional judgement of staffing ratios	
1.7	Safe Care Data	
1.8	Other supporting evidence to any proposed changes to skill mix	Nil proposals at this review-however we need to establish a robust process to capture no of patients on AMU at any one time to evidence our actual RN:Patient Ratio. Currently this can be an additional 9 patients not in our bed base-however this is anecdotal. Society of Acute Medicine current guidance is 1:6 RN:Patient and supports a Practice Educator within template. There should be an unlift of x% to support the additional training required for acute medical nurses. I would like to consider Nunton budget Skill Mix Reviews and template to sit seperate to AMU.

Section 2: Recommendations/Considerations

	Recommendations/Actions from Review	By Who	By When
2.1			
2.2			
2.3			
2.4			

All actions reviewed from Skill Mix Review 2021:

SafeCare Data

Date: **Ward:**

Present:

Section 1: Review of Current Position

	Themes/Concerns/Good Practice from Data	Comments
1.1	Quality/Outcome Data	2 complaints for Breamore in the past year, quite a few concerns dealt with before they progress to formal complaints, mostly around the facilities on Breamore and the staffing levels. Fall's per 1000 bed days have been high with 13.1 in July. Blue screens have just been taken doen on Breamore so this will hopefully help. Pressure ulcers have been low on Breamore. Outstanding Datix's are currently about 100 but trying to reduce these.
1.2	HR Indicators	Sickness is currently at 4.2%, this did peak at 29.5% in April. Appraisal rates are currently at 43%, discusions with ward leads of the areas from where the staff are redeployed from to see who will be doing the appraisal.
1.3	Finance	
1.4	Current establishment / Vacancies	All staff currently on Breamore are seconded, 1 WTE B2 is due to start in the next couple of weeks from pre op and 1 WTE B2 was recruited at the last recruitment event but awaiting a start date.
1.5	Supervisory	Very little supervisory time taken by B6's.
1.6	Professional judgement of staffing ratios	Since being I charge of Breamore I have not worked there whilst it has been fully staffed, so I think the day time staffing can remain the same, however I feel a 3rd band 2 is needed overnight due to the dependency of the patients.
1.7	Safe Care Data	Safe care data is inputed in the system 3x daily, the majority of the patients on breamore are a 1B due to the dependency.
1.8	Other supporting evidence to any proposed changes to skill mix	

Section 2: Recommendations/Considerations

	Recommendations/Actions from Review	By Who	By When
2.1			
2.2			
2.3			
2.4			

All actions reviewed from Skill Mix Review 2021:

SafeCare Data

Date: **Ward:** Britford

Present:

Section 1: Review of Current Position

	Themes/Concerns/Good Practice from Data	Comments
1.1	Quality/Outcome Data	Last Skill mix staff, staff to be divided between SAU and Trial for ring fencing ward bed for SAU. This was unable to be actioned as When staff moved in
1.2	HR Indicators	Band 2 LT sickness now returned, still having episodes of sickness and has reduced hours. Band 5 LT sickness leaving in October 2 x RN phased return with referrals to Occ health and Manual Handling
1.3	Finance	Budget not to bad some bank used for SAU admin
1.4	Current establishment	At current time over recruited by October we will be under due to satff leaving and 2 band 4 seconded to education for 18 months to top up to band 5 we have no budget for band 4. Band 3 TNA in staffing numbers but employed by education, On her placement majority of time. Junior skill mix with osce nurses and nurses who have returned needing to work nights for family reasons
1.5	Supervisory	I manage most of the time to have my supervisory role, spending time in SAU and on the ward, I have found recently I am having to support staff while on other wards due to high anxiety. I have 3 nurses developing for senior staff nurse, so trying to support them and the reshaping of the team with some LT SAU team members leaving
1.6	Professional judgement of staffing ratios	When the skill mix is junior or staff moved I tend to go in the numbers prioritising patient care. SAU professional judgement not captured.
1.7	Safe Care Data	SAU isnt on Safe care so no way of capturing
1.8	Other supporting evidence to any proposed changes to skill mix	SAU is been used for escalation

Safecare Data

Section 2: Recommendations/Considerations

	Recommendations/Actions from Review	By Who	By When
2.1	With an average of 14.56 patients coming through SAU change the band 2 on safecare to Admin support and use the current staffing budget to move 2nd band 5 RN Monday to Friday		
2.2	Concentrate on getting staff feeling that they are confident in SAU		
2.3			
2.4			

All actions reviewed from Skill Mix Review 2021:

Allocate and Eroster advise that SAU now undertakes SafeCare (as per AMU) to accurately reflect stats

Date: **Ward: Chilmark**

Present:

Section 1: Review of Current Position

	Themes/Concerns/Good Practice from Data	Comments
1.1	**Quality/Outcome Data**	Increase in pressure sores and medication errors, Lack of training opportunities as study days are cancelled to staff wards when staffing critical.
1.2	**HR Indicators**	Sickness no work related sickness
1.3	**Finance**	Within budget currently
1.4	**Current establishment / Vacancies**	fully established for RN's, however 3 staff on maternity leave, 1 due back October. Unable to recruit directly into B4 vacancy, therefore permanent short fall of B4's. Current vacancy band 2 4.11. attending B2 recruitment days
1.5	**Supervisory**	always complete 1 clinical shift per week, some months 2 - 3 clinical shifts per week, this impacts on ability to release B6's to complete essential training and appraisals with the ward staff
1.6	**Professional judgement of staffing ratios**	staffing ratios adequate
1.7	**Safe Care Data**	shortfall of 961.90 CHPPD hours due to staffing shortages over the last year, short fall in B2 establishment
1.8	**Other supporting evidence to any proposed changes to skill mix**	Continuous shortfall in recruiting into B4, propose exchanging if possible a B4 to a B5

Section 2: Recommendations/Considerations

	Recommendations/Actions from Review	By Who	By When
2.1			
2.2			
2.3			
2.4			

All actions reviewed from Skill Mix Review 2021:

SafeCare Data

Date: **Ward:** Downton

Present:

Section 1: Review of Current Position

	Themes/Concerns/Good Practice from Data	Comments
1.1	**Quality/Outcome Data**	period of increased activity of infection currently due to high numbers of Cdiff, 1x noro virus and currently still in COVID outbreak, increased number of falls with harm in the last year due to acuity and dependency of non speciality patients (medical/confused). increased patient acuity due to loss of elective surgery and increased emergency admissions. DMT increased staffing levels to address critical incidents with positive outcomes to patient safety this further reinforces the need for changing current establishment to meet patient safety needs.
1.2	**HR Indicators**	fluctuating levels of sickness - no long term sickness currently, staff turnover doesn't appear to be a problem a few leavers last year due to going to university for nurse training. Some Sickness associated with MSK injury's. Appraisal compliance low due to limited time availability for both staff and line managers to complete. limited training opportunities due to critical staffing levels meaning study days often cancelled to support patient safety. recruitment of band 2 staff is a persistent problem.
1.3	**Finance**	over spent due working outside funded establishment due to patient safety. Also over recruited by band 5 nurses.
1.4	**Current establishment**	band 5 over established by 3.98 1 on M/L, band 2 under by 0.93 with 1 on M/l and 1 due to go on M/L October, due to over establishment B5 able to increase late by x1 B5 7/7
1.5	**Supervisory**	70% supervisory time used to support new staff, band 2 and band 5 to facilitate study leave and admin time for band 6's
1.6	**Professional judgement of staffing ratios**	high acuity and dependency at times due to increased levels of medical patients, high numbers of patients requiring specials and on intentional rounding, also with MCA and DOLS
1.8	**Safe Care Data**	often shows shortage of care hours
1.9	**Other supporting evidence to any proposed changes to skill mix**	Geographical layout of ward is challenging particularly bay 1 due to having 11 beds and SR 2 + 3 are out of the way and can be difficult if patient needs close observation. on nights particular if you are with patients in bay 1 and bay 2 patietns in bay 3 can be unobserved. I feel that the ward would benefit from increasing by 1 x band 2 for nights and 1 x band 5 for late shifts to continue to ensue patient safety standards are met.

Safecare Data

Section 2: Recommendations/Considerations

	Recommendations/Actions from Review	By Who	By When
2.1			
2.2			
2.3			
2.4			

All actions reviewed from 2021 Skill Mix Review:

Date: **Ward: Durrington**

Present:

Section 1: Review of Current Position

	Themes/Concerns/Good Practice from Data	Comments
1.1	Quality/Outcome Data	July falls per 1,000 bed days = 10.2, this has undoubetdly gone up with 11 falls in August July PA's per 1,000 bed days = 5.0 this will have increased with five in August. IPC Study hours - only mandatory training taking place. Complaints - have received several in last 8 months, one serious complaint about a patient who was reusitated with a valid respect form. Datex currently 136 outstanding, in July this was only 44.
1.2	HR Indicators	sickness - one long term sickness, a part-time B2, she returns September on reduced hours. Maternity leave - one B6 who returns March but will transfer to Farley ward. One B2 returns March. One B5 pregnant will start mat leave ealry 2023 Turnover, three B2's resigned or reduced hours in August as unable to cope with the staffing numbers. Disciplinary / PIPs - no staff on disciplinary Appraisals only 62% this will be my priority in next few mothns
1.3	Finance	
1.4	Current establishment / Vacancies	Band 7 / WTE budget 1.0, fixed term 12-month contract untill Dec 22 Band 6 / WTE budget 2.0 - in post 2.0 with a third on maternity leave when she returns she is moving to Farley Band 5 Nurse / WTE budget 13.78 in post 9.0 vacancy rate 4.95 Band 4 AP(Q) no budget - in post 2.0 with 2 more expected Band 5 A+C / WTE 1.0 in post 0.0 - no plans to fill this post Band 2 A+C / WTE budget 2.0 in post 0.0 - new staff member apponted awaiting start date. Band 2 HCA / WTE budget 12.39 in post 7.44 vacancy rate 4.95 with 1.0 WTE on maternity
1.5	Supervisory	Ward Manager spending approximately 75% of time clinical - Band 6 Sisters have one 7.5 hour shift per month as management this I feel is not enough for their development. Ward not meeting audit targets due to lack of supervisory time. Ward has welcomed six new staff members in last month WM has prioritised working with them to help them become familliar with ward routine. The 2 x B4 AP(Q)s are often used as HCA as we are so short of HCA's
1.6	Professional judgement of staffing ratios	The acuity of Durrington can vary but at times can be very high. We have a growing nursing team who are all from overseas and require a lot of supervision I would like to have a third band six to try to maintain a B6 on every day shift. Our staffing ratio is based on 21 beds, however, for the last nine months we have used the two escalation beds 100%, could our staffing mix be changed to reflect this.
1.7	Safe Care Data	
1.8	Other supporting evidence to any proposed changes to skill mix	Durrington is an escalation ward, the ward team, its therapists medical team would all like for it to be a substantive ward.

Section 2: Recommendations/Considerations

	Recommendations/Actions from Review	By Who	By When
2.1			
2.2			
2.3			
2.4			

All actions reviewed from Skill Mix Review 2021:

SafeCare Data

Date: **Ward:**

Present:

Section 1: Review of Current Position

	Themes/Concerns/Good Practice from Data	Comments
1.1	Quality/Outcome Data	
1.2	HR Indicators	
1.3	Finance	
1.4	Current establishment / Vacancies	
1.5	Supervisory	
1.6	Professional judgement of staffing ratios	
1.7	Safe Care Data	
1.8	Other supporting evidence to any proposed changes to skill mix	

Section 2: Recommendations/Considerations

	Recommendations/Actions from Review	By Who	By When
2.1			
2.2			
2.3			
2.4			

All actions reviewed from Skill Mix Review 2021:

SafeCare Data

Date: **Ward:**

Present:

Section 1: Review of Current Position

	Themes/Concerns/Good Practice from Data	Comments
1.1	**Quality/Outcome Data**	According to KQI, the amount of falls increased by 0.6 with a higher rate during winter period. One of the reasons that had been indentified is Farley RCU with 6 side rooms,also stroke patients there are in higher risk of falls because of mobility and cognitive impairment and the lack of staff to provide 1:1 enhanced care when needed. Action plans to mitigate the risk (i.e.staff rota to provide for 1h enhanced care) were in place when operational and staffing pressures allowed it. 3 SWARMS completed for falls with harm which identified that there was not harm from the falls but pre existing medical history, lessons to be learnt cascaded to the team and falls training arranged. Pressure ulcers grade 2 or above have increased by 0.3, mini RCA completed and presented, and new lessons and
1.2	**HR Indicators**	Sickness abscene year to date is 6.7% which is a decrease of 2.2% from last year.Several staff members on S1 and managed accordingly and with longer monitoring period,1 staff members on S2 with HR involvement and X2 staff on long term sickness. X1 staff member retire and return. X1 staff member under stage 2 performance review. LEARN is up to 83% and it is an increase of 8% from last year and appraisals sits at 67% with room for improvement and action plans in place..
1.3	**Finance**	Year To Date Total Pay & Non Pay Budget £845,710 Actual £843,713 Adverse Variance £1,997 High spend in sercurity needs and agencies in order to support other wards in the Trust. Covering Breamore until March with Farley staff and since
1.4	**Current establishment / Vacancies**	Currently 3.92 WTE band 6 and I am funded for 3 WTE band 6, 2.92 they are on secondments that agreed while we were Laverstock and Breamore and continued because of RCU acuity. X1 B5 WTE on maternity leave. Vacancies: 5 WTE B5 and 3,5 WTE B2
1.5	**Supervisory**	30% supervisory time with Senior Sister covering Farley/ Farley RCU/ CMDU and Breamore ward in total 54 beds capacity. From March 2022 when Breamore stroke moved back to Farley template was covering the same without RCU. From middle of June 2022 onwards overseeing Spire ward plus Farley ward and CMDU.
1.6	**Professional judgement of staffing ratios**	Staffing during the day is managed well within the nursing skill mix and adapted accordingly to match acuity and dependency of the unit. Thrombolysis/Haemorrhagic stroke care also effectively managed during the day. All stroke patients require intensive observation and are considered level 2 patients for the first 72 hours post admission due to the increased risk of neurological deterioration. Thrombolysis patients require 1:1 trained nurse support for the first 24 hours and longer if condition dictates. Intracerebral bleeds also require 1:1 due to managing high BP and administration of medication to manage with regular BP checks every 15 mins. With this in mind, the daily staffing is adequate and well managed. However, acuity of patients has been higher on Farley template as we have accommodated the RCU side as well that is for 10 patients and all of them, they have acuity 2 with close observation and high risk of deterioration. The acuity varies depending on both day and night in bays. Due to the template being spread across the corridor is a
1.7	**Safe Care Data**	Safe Care data reflects the Farley Stroke Unit and the RCU side until March 2022, with high acuity and dependency. Professional judgement completed on each shift by the staff and they are getting to the routine to raise red flags when needed.
1.8	**Other supporting evidence to any proposed changes to skill mix**	ANP role to complete the business case until the end of September and present to DMT. Repurpose of band 5 to a band 6 for SSNAP data collection officer. Also, stroke unit to be included to the business case for the band 3 discharge co-ordinator.

SafeCare Data

Section 2: Recommendations/Considerations

	Recommendations/Actions from Review	By Who	By When
2.1			
2.2			
2.3			
2.4			

All actions reviewed from Skill Mix Review 2021:

Date: **Ward: Hospice**

Present:

Section 1: Review of Current Position

	Themes/Concerns/Good Practice from Data	Comments
1.1	**Quality/Outcome Data**	Complaints related to the IPU have reduced this last rolling 12mths
1.2	**HR Indicators**	Band 5 establishment is the most filled it has been for a while, however there are a number of staff whom are likely to have some degree of longer term sickness management. Sickness levels had improved however increasing for a multitude of reasons. Difficulty in recruiting suitable band 2's. A number of band 2's have left the trust or applied to other areas- i.e Hospice at Home due to reduction in chance of redeployment into acute trust + higher pay grade.
1.3	**Finance**	
1.4	**Current establishment / Vacancies**	Total is 24.27, Vaccancy of 7.17. Band 5- 1.62. Band 4- 0.64. Band 2- 4.81
1.5	**Supervisory**	Band 7 currently uses 0.8 supervisory. With other day as a WD(Tuesday, Hospice meetings, clinical gov, MDT) .Band 7 also has role in oversight of operational management of whole Palliative care services when other management team off duty(5 services plus therapy, volunteers) including strategic planning involement.
1.6	**Professional judgement of staffing ratios**	Due to vacancy in band 2 and multiple short term/longer term unavailabilities (including band 6) the staffing ratio remains lower than desired to deliver the expected high standard of Palliative Care. During Covid and even now we are constantly planning admissions prior to an empty bed being actually available (ie the patient is still in it, with a hope that this will be discharged that day) to help improve patient outcomes and flow from the acute trust. There is a new 'early shift coordinator role' Monday- Friday- agreed at the last skill mix review but only very recently implemented due to staffing resource issues in the the Hospice and across the trust. This role can be a band 6/5 and this role has to be covered with a Band5/6 when a band 4 is working as they are unable to carry out the administration of controlled drugs delivered by the injectable administration routes and complex care .(Current post holder working a 22.5hr week , MON-FRI early shifts only as this is when the service need it) with a plan to review this at at 6 months) This role is still evolving- the additional
1.7	**Safe Care Data**	Safe Care does not reflect the level of acuity and dependency of Hospice Patients accurately. Patients are more complex and the care hours needed to treat dying pre and post death is a high. We would like to explore this further and had started discussions with Fiona Hyett and Catherine Moore in the past but have not moved this on further. Current plan is to establish benchmarking with the other hospices in BSW and also look to utilise the Establishment Genie System as used by other Hospice nationally, again for benchmarking.
1.8	**Other supporting evidence to any proposed changes to skill mix**	B2 HCAs are leaving the Hospice due to lack of career progression opportunities on the ward. There is option for Hospice at Home B3 progression but not all would wish to work in the community setting. Frequent comments heard by B2 IPU based HCAs are if they dont want to do B4 training then they are "stuck" and have to consider leaving and other workplace opportunites elsewhere.

SafeCare Data

Section 2: Recommendations/Considerations

	Recommendations/Actions from Review	By Who	By When
2.1	Aim: HCA's keen to progress. Many would be keen to work towards band 3 and have training on extended skills- i.e catheters and bowel care improving retention, staff satisfaction and avoiding delays in patient care/flow. Currently band 4 role difficult to fit into daily processes as cannot be in replacement of a band 5. Registered band 4 trialing early shifts as the only shift with agreed 'coordinator'. However this makes it more difficult to attract other band 4's in line with flexible working. ? Aim to have band 4 on late shift also but not in replacement of HCA?		
2.2			
2.3			
2.4			

All actions reviewed from Skill Mix Review 2021:

Date: **Ward:**

Present:

Section 1: Review of Current Position

	Themes/Concerns/Good Practice from Data	Comments
1.1	Quality/Outcome Data	0 hospital acquired C Diffs. 0 Hospital acquired MRSA. 1 x fall with harm 2022. MQAR 62.4%. Falls for July 5.6 % (decreased from last year) have falls reduction project running on the ward. PU's 2.8%, decreased from last year. Sickness 8.9% decreased from earlier in the year, still high.
1.2	HR Indicators	Sickness is increased to 11.10% multiple short term sickness. 3 x LTS under review with HR. 3 x stage 2. 3 x stage 1. High pregnancy sickness, 3 x staff who are currently pregnant. High % of staff on MH adjustments, I have added on the risk register. 2 x B5's on reduced clinical time for extended period of time. MLE compliance: 89%. Appraisals: 79%.
1.3	Finance	This quarter we are over budget by £15,000 this is bank and agency, due to high levels of sickness and covering mat leave.
1.4	Current establishment / Vacancies	RN: Budget: 14.63 Actual: 18.13 = +3.91 B2 Budget: 12.38 Actual: 5.66 = - 6.72. 4 x staff currently on mat leave. 3 x staff to go on mat leave. 2 x staff redployed - have requested one back. 1 x B5 LTS. 2 x B5 reduced clinical.
1.5	Supervisory	Low % supervisory time for B7 and B6's. Efficient use non clinical x 2 B5's. Current B7 supernumery time this year is approx 5%.
1.6	Professional judgement of staffing ratios	When fully staffed, staffing ratios are adequate. We should be 4+3, 4+2, 3+2. Allowing for level 2 patients. Currently we can be left on critical numbers which are 2+2 or 3+1.
1.7	Safe Care Data	Improving compliance with submitting safe care data. Latest data: % of temp staff 40%. Hours short 22.5 -30 per shift. 67 red flags over the last year.
1.8	Other supporting evidence to any proposed changes to skill mix	

Section 2: Recommendations/Considerations

	Recommendations/Actions from Review	By Who	By When
2.1			
2.2			
2.3			
2.4			

All actions reviewed from Skill Mix Review 2021:

SafeCare Data

Date: **Ward: Longford**

Present:

Section 1: Review of Current Position

	Themes/Concerns/Good Practice from Data	Comments
1.1	**Quality/Outcome Data**	KQI from June2021 to June 2022. **CR,SII &LR - 2** All investigated and 1closed. **Falls-** 72 **Complaints-3(2** closed and 1 investigated) **Cdiff**-2 **MSSA**-1(All closed) **Hand Hygeine assessment**-100% **PU2** and above- 115 **Blood transfusion**- **Nursing red flags-147 Sickness-09.6% Incident report being investigated-84 Lack of the education team hours was a challenge to give staff and patient education in the last year. 2 xB4 is currently on the band 5 programme and a band 2 is currently doing associate training.**
1.2	**HR Indicators**	**Sickness** rate 4.2%-9.7% Have few ACM 1 and ACM 2 monitoring .ACM 2 is managed with HR.Due to the vacancy rate on the ward Band 6s are not getting admin hours and manging sickness on time is a challenge.Only 3 band 6s are currently on the unit and 1 band 6 is on long term sick leave..**MLE** compliance is 90%.**Appraisal** compliance is 77%.Staff gets their increment automatically.
1.3	**Finance**	Total Band7/8 (3)which2xB7 is covered and **B8A** vacancy to fill. **Band6** 5.40 All vacancy is covered.Out of the this 1xWTE band 6 is covering the Education on the ward and 1xB6 is long term sick.**Band5**-29.20 (23.51)**Band 4**(2)not qualified.**Band 3**-28.62(18.26)**Band 2**(12.45(5.40) There are increase in use of bank and agencies due to the vacancies , sickness and maternity leave. Currently B8X1 is appointed. B5 vacancy to be completed.B4 No vacancies.B3x10 WTE vacacy to fill.B2x3 WTE to cover. 1xWTE band 2 budget is covered by Ward clerk.1.50 x band 3 budget is Rehab recreational assistant.
1.4	**Current establishment / Vacancies**	Currently on the ward 11.5XWTE HCA vacancy and 5.7XWTE RN vacancy present. B8x1 vacancy is filled.1xWTE is waiting to start.2x WTE band 2 non clinical post are advertised .Longford elective is managed by Longford staff and the additional staffing is not in place.
1.5	**Supervisory**	B7 supervisory time are not protected most of the days due to the shortages on the ward. Most of the sup shift for the B6 are moved on to clinical due to the high demands on to the ward.Audits and RCA are uptodate most of the month..Datix investigation are very behind due to the lack of supervisory time.400 datix to investigate.Sickness management not completed on time or gaps in it
1.6	**Professional judgement of staffing ratios**	Most of the shifts are working on amber staffing or below and concerns raised on the safe care and the professional judgement added.All the short fall shifts are escalated to the staffing.There was 2 patient complaints raised to CQC regarding the staffing ratio/Staff and patient training.Staff sickness and retention was challenging due to the heavy work load and unhappy patients
1.7	**Safe Care Data**	Safe care data was missing in many occassions due to the high work load and lack of band 6 on the ward.This data was allocated retrospectively in the system.
1.8	**Other supporting evidence to any proposed changes to skill mix**	Over the last year there was only 5.4 B6s on the unit as per the budget. 1xB6 WTE is long term sick which makes 4.4 B6 together with 2B7s on the unit to cover the staff and patient education, Audits,complaints,datix investigations and to cover the clinical demands on the ward.This makes a huge delay in investigating the datixs and also have huge impact on the education.Insufficient Spinal/Respiratory competent staff delay in taking admissions to the unit and relay on respiratory competent staff to do additional shift to make the ward safe.

SafeCare Data

Section 2: Recommendations/Considerations

	Recommendations/Actions from Review	By Who	By When
2.1			
2.2			
2.3			
2.4			

All actions reviewed from Skill Mix Review 2021:

Date: **Ward: Odstock**

Present:

Section 1: Review of Current Position

	Themes/Concerns/Good Practice from Data	Comments
1.1	**Quality/Outcome Data**	Overall audits are strong. Some months in Amber, but management plans in place to support this and evidence improvement. Falls with harm very low. X3 cidif cases but only one found to be attributed to ward and learning evidenced fom this.
1.2	**HR Indicators**	Apprasail complinace has dropped since introduction of ESR, but team working hard to overcome. Some Stage 2 sickness- all supported with HR. High turnover attributed with encouragement to undertake higher education, logistics (long distance and pertol costs) and HR performance.
1.3	**Finance**	2K overspend on Bank B2- to cover the BDC Lone worker
1.4	**Current establishment / Vacancies**	Fully established with trained staff. Slight over-recuitement, to start BDC secondment for B5 to encourgae personal growth and to ensure back up skill set if clinic nurse off and reduce requirment for bank B2. 10 leavers in last 12 months.x3 to university. HCA leavers to better paid positions either in care homes/community or leaving care.
1.5	**Supervisory**	Succifient supervisory time aloocated. Current redployment to DSU and apprenticeship has made this difficult. All B6's allloacted admin day each month, but not always able to take if shortages on the ward.
1.6	**Professional judgement of staffing ratios**	Effective ratio. Late shifts run much smoother and greater capacity to accept thetare returns and new admissions when four staff are on the late.
1.7	**Safe Care Data**	Often showing an excess, but this is not comparable to feel of the ward.
1.8	**Other supporting evidence to any proposed changes to skill mix**	

SafeCare Data

Section 2: Recommendations/Considerations

	Recommendations/Actions from Review	By Who	By When
2.1			
2.2			
2.3			
2.4			

All actions reviewed from Skill Mix Review 2021:

Date: **Ward:**

Present:

Section 1: Review of Current Position

	Themes/Concerns/Good Practice from Data	Comments
1.1	Quality/Outcome Data	•Systemic Anti Cancer Treatment (SACT) is being administered on Pembroke Ward without SACT competent registered nurses (RN) being present for the duration of treatment, this is unsafe practice. •SACT is being administered on Pembroke Suite without appropriate scheduling (patient: staff ratio •Pembroke Ward bed base is not able to accommodate the demand of patients resulting in some Haematology patients and a large number of Oncology patients outlying on medical wards. •The Hotline is not consistently answered by a trained and competent RN and adds additional workload to the suite and ward.
1.2	HR Indicators	•Staff are missing their breaks as 2 RN on ward when HCA redeployed •Appraisals are 73% compliant due to the Senior Sister not being supernumerary. •Mandatory training is 92% compliant as staff are not being released to undertake training due to the clinical workload. •Leavers have fed back that they are leaving to lack of job satisfaction, feeling undervalued and do not see career progression. The last 3 leavers have left the organisation without promotions in their new role •There is a lack of clear career development opportunities across the workforce.
1.3	Finance	It is difficult to see the funded establishment by area (Ward, Suite, Outpatients, AOS, CNS teams). These are sub services and have their own requirements. Having the budgets separated into cost centres with the agreed budgets will make the management of budgets simple, easy to see vacancy and where investment has gone/needed in future business planning.
1.4	Current establishment / Vacancies	•Current funded establishment for the Suite, Ward and Outpatients is band 6 RN- 3.00 WTE, band 5 RN- 17.16 WTE, band 2 HCA- 10.56 WTE •Mobile Cancer Care Unit (MCCU):- 4 chair mobile SACT infusion service. Current funded establishment band 6 RN- 1.00, band 5 RN- 1.00 WTE and band 3 driver •There are 5.81 working time equivalent (WTE) RN vacancies. •There are only 11.43/ 22.39 if all staff were SACT trained nurses. •There are 4.41 WTE Health Care Assistant (HCA) vacancies.
1.5	Supervisory	•The Senior Sister is fundamental to the safety, quality, nursing standards and setting the culture of compassionate care and team working across Pembroke. The senior sister has 21% supernumerary time due to working on the suite. •The Sister and band 6 team cover 4 areas, ward, suite, MCCU and outpatients •Propose 75% supervisory with 25% clinical to allow band 6 to be supervisory. •As a specialist area the education and development of our workforce is critical to the safe delivery of SACT.
1.6	Professional judgement of staffing ratios	The skill mix for the ward should be 2 RN, one at band 6 and a band 3 HCA. This skill mix reflects the specialist care, additional nursing needs and that Pembroke ward layout with mainly SW means patients cannot be easily visualised. •Although the ward has a small bed base the patients residing have high nursing requirements. As per Nice, 2014 safe staffing for nursing in adult inpatient wards in acute hospitals individual patient nursing needs are the main factor for calculating nursing staff requirements. •Increased risk of clinical deterioration •Personalised care planning •Ward layout due to visibility and number of patients in isolation
1.7	Safe Care Data	Need to upskill whole unit trained staff to utilise safe care, currently only ward staff and several new staff members that need to understand the benefits of Safe care. The data entered has not been consistent and does not reflect the acuity of the ward. Patients post stem cell transplant and having chemo should be coded as a 2. Red flags due to redeployment of HCA
1.8	Other supporting evidence to any proposed changes to skill mix	See SBAR for:- •National guidelines to support skill mix •References to support skill mix •Benchmarking to other providers

Section 2: Recommendations/Considerations

	Recommendations/Actions from Review	By Who	By When
2.1	Adopt skill mix suggested in appendix 1 within SBAR. Depending on option can be within budget.		
2.2	Introduce a Practice Educator funded 22.5 hours band 7 for 3 years by Macmillan with ongoing funding from the Trust to support onboarding of new SACT nurses and outreach to the wards providing education to upskill our workforce.		
2.3	Minimum staffing to stay at 2 RN and 1 HCA on ward especially if SACT running or acuity is high		
2.4	Introduce a band 3 Senior HCA within the suite with a level 3 qualification to manage PICC line care, bloods and phlebotomy on the day unit releasing RN to administer SACT. Bringing line care on Nunton back into Pembroke.		

Band 7 Senior Sister should be released from numbers to support junior RN workforce and support a recruitment drive new starters in competency sign off to ensure fast tracked training.

Review the repatriation of Stem Cell reinfusion and the impact on the nursing team funded establishment and training needs. There will need to be an increase in nursing hours as 2 RN will be allocated to 1 patient for 2 hours over the infusion period, with increased observation and monitoring following.

Consider a buddy ward where Haematology and Oncology patients outlie to ensure targeted education and increased presents of Oncology and Haematology medical and nursing staff. Audit the bed base requirements for Pembroke ward to avoid outliers

Schedule to chairs allowing appropriate set up time and be clinically signed off by Senior Sister weekly.

Analyse data and scope a same day assessment service in conjunction with AMU Matron and team. Ideally this would be based in the offices

SafeCare Data

Date: **Ward:**

Present:

Section 1: Review of Current Position

	Themes/Concerns/Good Practice from Data	Comments
1.1	Quality/Outcome Data	**CR, SII & CR:** 3 CR & 1 SII. **Falls:** 132 for the last financial year. **Complaints & Concerns:** 10 complaints & 4 Concerns. **C-Diff:** 3 **Nursing Red Flag:** 16 (should be a lot more but lack of reporting to evidence). **Absence:** 14.2%, extremely high. Nil staff on LTS or restricted duties. **Datix Outstanding:** 30 incidents. Staff very limited on training within the last year due to staffing pressures.
1.2	HR Indicators	**Sickness: 14.2% (**but I believe this to be higher still now) Short term sickness is a serious problem currently and hard to manage. Due to a lack of SUP time many staff members not on correct sickness stage. Not any obvious recurring themes and no staff member off on LTS. Staff that need to be seen by occupational health have referrals in. Staff extremely burnt-out ++ and morale at an absolute all time low. Morale boxes to gauge staff attitudes and feelings out on ward currently as part of improvement project. **MLE Compliance:** 90.9%**. Appraisal Compliance:** 70%.
1.3	Finance	Pay - £9k underspent.
1.4	Current establishment / Vacancies	No vacancy for B7 (1 WTE) or B6 (3 WTE). We currently have 3.50 WTE vacancies @ B5, with x2 RN's currently on maternity leave with no back-fill. We also have x2 B4 WTE in our registered numbers. X1 B4 is completing her uplift to RN starting 18th October for 18 months (off ward) - with no backfill. x1 B4 is awaiting her PIN, following several years of failing ILET's exams. Experienced B5 was due to start following success at interview but ward unable to offer set night shifts so candidate dropped out. 3.31 WTE B2 vacancies but x1 B2 1 WTE has been working as our discharge co-ordinator for the last 8 months - awaiting official job description and banding agreement. x1 B2 currently training to become Nursing Assosciate. x3 NA's in the process of leaving so we will have over 6 WTE vacancies within the next couple of months. x1 WTE ward clerk post not currently filled. Interviewing to take place 16/09. x0.8 ward managers assistant to be appointed also.
1.5	Supervisory	B6's are allocated at least 7.5hrs a month of supervisory time but this is not protected. This time is for managing datixs, auditing, teaching and staff management ie; appraisals etc... Within the last year each of the x3 B6's have had no supervisory time as they have had to cover the ward due to short staffing and re-deployment. B7 gets some supervisory time but due to ward shortages is usually expected on the ward and therefore admin jobs are being completed without full care and attention.
1.6	Professional judgement of staffing ratios	In my professional opinion I feel our ward staffing ratios are not sufficient currently. Registered staffing numbers are sufficient at x4RNS E, x4 RNS L, x3 RNS N to meet patient demand and acuity. Un-registed staffing numbers should, in my opnion be uplifted. We currently have x4NAs E, x2NAs L & 2NAs N. Patient demand and monitoring does not decrease througouht the day and therefore I feel it appropriate that we have the same number of NAs rostered for both the E & L shift. We have at least x2 enhanced care shifts out most day and by increasing the NA ratio we would therefore mitigate the need for enhanced care shifts as we could utilise the staff we have in order to meet that demand. I would ideally like x5 NAs E, x5 NAs L & x3 NA's N. This would ensure an NA is allocated to each of the 4 bays with the an extra NA on duty to fufill any enhanced care need demands.
1.7	Safe Care Data	
1.8	Other supporting evidence to any proposed changes to skill mix	Ward layout template. All bays non-vsible unless staff in bay therefore enhancing need for uplift of nursing assistants to ensure spread across ward template for monitoring.

Section 2: Recommendations/Considerations

	Recommendations/Actions from Review	By Who	By When
2.1			
2.2			
2.3			
2.4			

All actions reviewed from Skill Mix Review 2021:

SafeCare Data

Date: **Ward:** Radnor

Present:

Section 1: Review of Current Position

	Themes/Concerns/Good Practice from Data	Comments
1.1	**Quality/Outcome Data**	Radnor Quality dashboard and outcome, ICNARC data collection in addition to CCOT and H@nt data. H@nt Medical Assisstant working activity data collection
1.2	**HR Indicators**	Sickness absence has averaged at 7.27% During this period there has been some long term sickness. Themes are stress and anxiety, non work related MSK. 1 staff member currently being managed on a formal Stage 3. 1 staff member being managed on a formal Stage 3 perfermonce management. - now on LT sick 3.0 WTE on maternity leave. 3 out 4 resignations due to redeployment.
1.3	**Finance**	£26K overspent (averge 4.3 WTE monthly) on agency staff. Not always required for ICU specifically. Budget report- Month 1 2022 Band 5 WTE funded 38.28 (as has been historically), however now WTE funded for Band 5 is
1.4	**Current establishment**	RN's - WTE overrecruited 2.93. Currently 2.0 WTE on maternity leave, up to 3 band 6 vacancies, (adert put) planning 1 b6 secondment to CCOT, CCA vacancy - difficult to recruit into. CCOT diffiuclt to recruit into (interviews on the 8/9/22) CCOT DM post advert in progress
1.5	**Supervisory**	Matron's , Band 6&7 Clinical Educator - 0.8 , NIC case load free each shift
1.6	**Professional judgement of staffing ratios**	recently started using safecare
1.7	**Safe Care Data**	
1.8	**Other supporting evidence to any proposed changes to skill mix**	

Section 2: Recommendations/Considerations

	Recommendations/Actions from Review	By Who	By When
2.1			
2.2			
2.3			
2.4			

All actions reviewed from 2021 Skill Mix Review:

Date: **Ward:**

Present:

Section 1: Review of Current Position

	Themes/Concerns/Good Practice from Data	Comments
1.1	Quality/Outcome Data	
1.2	HR Indicators	
1.3	Finance	
1.4	Current establishment / Vacancies	
1.5	Supervisory	
1.6	Professional judgement of staffing ratios	
1.7	Safe Care Data	
1.8	Other supporting evidence to any proposed changes to skill mix	

Section 2: Recommendations/Considerations

	Recommendations/Actions from Review	By Who	By When
2.1			
2.2			
2.3			
2.4			

All actions reviewed from Skill Mix Review 2021:

SafeCare Data

Date: **Ward:**

Present:

Section 1: Review of Current Position

	Themes/Concerns/Good Practice from Data	Comments
1.1	**Quality/Outcome Data**	1. Good FFT feedback, 2. Quality metrics demonstrate poor documentation plus there is a recurring theme of families not being listened to across child health. 3. CAMHs patients , sectioned and requiring Tier 4 beds, on risk register 4. One Never event occurance involving naso gastric tubes over the course of the year
1.2	**HR Indicators**	Sick leave 9.3% including long term sickness being appropriately managed via HR, appraisal compliance 75%
1.3	**Finance**	Significant Overspend owing to long term mental health patients requiring RMN and security,
1.4	**Current establishment / Vacancies**	1. Band 5: Vacancy 5.26 wte, Appointed 3.4 wte - awaiting start dates, Remaining vacancy 1.86 of whch 1.0wte transferred to band 6 for nely appointed 1.2 wte Practice Educator. Band 6: 1.06 wte vacancy - advertised, Band 4 vacancy, still to advertise
1.5	**Supervisory**	Band 7 supervisory shifts undertaken, 20% clinical, 80% supervisory
1.6	**Professional judgement of staffing ratios**	Patient number fluctuate and acuity and dependancy has increased with more complex patients curtesy of RSV surge and mental health patients as well as safeguarding/child protection.
1.7	**Safe Care Data**	
1.8	**Other supporting evidence to any proposed changes to skill mix**	1

Section 2: Recommendations/Considerations

	Recommendations/Actions from Review	By Who	By When
2.1			
2.2			
2.3			
2.4			

All actions reviewed from Skill Mix Review 2021:

SafeCare Data

Date: **Ward:**

Present:

Section 1: Review of Current Position

	Themes/Concerns/Good Practice from Data	Comments
1.1	Quality/Outcome Data	According to KQI, the number of falls decreased by 2.1, but it is still a high rate of 11.4 per 1000 beds. One of the reasons that had been identified is that Spire has 10 side rooms, also the nature of the patients that nursed on Spire are in higher risk of falls because of mobility and cognitive impairment. 3 SWARMS completed for falls with harm and one clinical review for a catastrophic fall. Lessons to be cascaded to the team and training arranged. Pressure ulcers grade 2 or above have decreased by 0.8, mini-RCA in the process of completing them and new lessons and action plans to be cascaded to the team. Medication errors increased by 4,3. IPC: we had 3 C-diff cases, SWARMS to be completed, and an outbreak of Norovirus CR in progress. No MRSA or MSSA cases. Number of incidents
1.2	HR Indicators	Sickness absence year to date is 5.7% which is a decrease of 1.1% from last year. Several staff members on S1 and managed accordingly and with longer monitoring period,2 staff members on S2 with HR involvement. X3 staff member on maternity leave. x1 staff retire and return. LEARN is up to 88% and it is a decrease of 5% from last year and appraisals sits at 64% with room for improvement and action plans in place.
1.3	Finance	
1.4	Current establishment / Vacancies	Vacancies: 2,8 WTE B2, 0,4 WTE B3 and 1,5 WTE B5
1.5	Supervisory	20% Supervisory time.
1.6	Professional judgement of staffing ratios	At the moment Spire ward has Covid patients, so it has high acuity and dependency.The staffing ratios are safe if they are staying to their numbers. A lot of times staffing is pulling the 3rd B5 from the night shift and that means that there is 1:15 patients, that it's unsafe and puts at risk patients and staff.
1.7	Safe Care Data	Safe Care data reflects the Spire ward, with high dependency patients. Professional judgement started completing on each shift by the staff and they are getting to the routine to raise red flags when needed.
1.8	Other supporting evidence to any proposed changes to skill mix	

Section 2: Recommendations/Considerations

	Recommendations/Actions from Review	By Who	By When
2.1			
2.2			
2.3			
2.4			

All actions reviewed from Skill Mix Review 2021:

SafeCare Data

Date: **Ward:**

Present:

Section 1: Review of Current Position

	Themes/Concerns/Good Practice from Data	Comments
1.1	**Quality/Outcome Data**	KQI from July 2021 - June 2022: **CR, SII & LR:** 2; **Falls total**: 45; **Complaints:** 1 - solved; **C-Diff:** 1, numbers of infection continue low although there were outbreaks declared for Covid-19 - mostly associated with asymptomatic patients -, there is a strict plan with cleaning task lists; **Hand Hygiene Assessment:** 87% (average of June 22 audits); **PUG2 or above:** 14; **Blood Transfusion:** struggling to get figures with new elearning system as there is no reporting system. No updated data since April as Blood Transfusion Specialist Nurse has been unavailable. last figures collected showed that 96.9% of staff had Opt-Out form, 69.7% Comp 1 completed (New OSCE trained Nurses - 12% of staff - not signed off yet for the competency of collecting blood), 78.8% Comp 2 completed (some
1.2	**HR Indicators**	**Sickness:** Occasional stage 1's that were reviewed according to policy, there were x3 LT sickness (x2 for programmed surgery + x1 MSK), of which one required redeployment to a different role but stayed on the ward, one staff member having his management reviews taken by Rheumatology Department (only has 11.5h contracted with Tisbury and the remaining to achieve full time with Rheumatology department) who is currently on LT sick leave. There were spikes of sickness (as shown above on absence section) mainly at peaks of Covid-19 absence. In general, sickness has been higher than previous years (also due to mandatory isolation when covid-19 positive) but the ward manages within own staff to cover gaps. **MLE compliance:** 92%; **Appraisals:** 76% since new system to be completed on
1.3	**Finance**	No overspending on B6, as currently have x3 1 WTE, but advert is currently out to cover this position. At the moment this is not allowing us to cover every single day with a B6, specially at times of annual leave, and rarely the nights are covered by a band 6. Due to increased numbers of RNs on Maternity Leave and sickness during this year it was difficult, not only to maintain 2 senior nurses covering both LDs and Nights, but also to fullfill all the rota and not allocate shifts to bank as soon as the off duty was completed. There was definitely a higher spending on bank work due to the reasons above, but mostly covered by staff from the ward, which supported the skill mix on each shift. All RN's now booked or trained on Immediate Life Support to be in accordance with the British Cardiovascular
1.4	**Current establishment / Vacancies**	There was an adjustment after last year's skill mix review meeting to reduce by 1 WTE the B5 numbers to allocate 1 WTE to B6 numbers, which brought up to a total of 4 WTE B6 and 21.11 WTE B5. During the year, due to the need of allocation of TNA (Band 4s) on the ward it was reinstated the previous vacancies for B4's but these were removed from the B2 vacancies, whichhas led to B2 vacancies dropping from 7.99 WTE to 5.99 WTE. Referring that the B4 TNA role is now different from the previous B4 HCSW role I believe these x2 B4 vacancies should be reallocated from the B5 numbers (as TNA will count on RN numbers on the shift), dropping B5 WTE to 19.11 and return 2 WTE to B2 numbers. With current B2 budget WTE there is no capacity to cover the off duty, which could be done with previous budget of 7.99 WTE. Currently B7 1 WTE with secondment post, with no defined end date at the moment (covering further secondment), current secondment position holder going on Maternity Leave in November. There is currently x1 WTE B6 vacancy
1.5	**Supervisory**	Supervisory time is not maintained most of the times, with a maximum of 20% supervisory time being protected. B6's unable to take admin time most of the times due to staffing pressures. The supervisory time is used to complete appraisals, answer incident investigations, completion of off duty, sickness reviews, audits and perform other investigations. Due to x1 WTE B6 vaccancy and reduced supervisory time, it was noticeable over the last year that some KQI's like appraisal compliance have also had a drop on the compliance.
1.6	**Professional judgement of staffing ratios**	Due to maternity leave, sickness, vacancies and staff shortages accross the division (with staff required to cover other areas), there have been significant gaps on the shifts, with the ward not being fully staffed for several months and leaving several shifts with minimal numbers to provide safe care, frequently day shift left with 4 RNs + 1 HCA and night shifts with 3 RNs + 1 HCA, this has also been noted by the increase of red flags raised over the last 12 months (194 between July 21 and June 22). Despite increased acuity on some shifts, staff is still required to be redeployed to cover other more critical areas, which has led to shifts been particularly challenging and workload pressure has had a direct impact on staff morale, especially when redeployed to other departments. One of the SII's was related to lack of skill mix on a particular shift that had a direct impact on patient care with a catastrophic outcome in the end. Concerns are escalated afterwards to Matrons/B7 covering the staffing bleep and red flag raised to the shift discovered.
1.7	**Safe Care Data**	Safe Care data is input on the system x3 times a day, with professional judgement being added to each shift. This is then escalated to Matrons/B7 covering staffing bleep and a red flag raised if adequate. When staffing levels are extremely concerning a datix is also completed for that shift. This data is completed most of the days by the B6/B7 on duty.
1.8	**Other supporting evidence to any proposed changes to skill mix**	

Section 2: Recommendations/Considerations

	Recommendations/Actions from Review	By Who	By When
2.1			
2.2			
2.3			
2.4			

All actions reviewed from Skill Mix Review 2021:

SafeCare Data

Date: **Ward:**

Present:

Section 1: Review of Current Position

	Themes/Concerns/Good Practice from Data	Comments
1.1	Quality/Outcome Data	Complaints have been slightly higher in the past year, they have mostly been very complex cases. Falls are reducing, the team have been working hard to improve compliance with L&S BP's and this is also now on our admission checklist. We are still working to reduce pressure ulcers, the ward staff are having regular training and they also have an education board in place. Sickness has peaked at 14% for the last 2 months, partilly due to 1xLTS, also due to COVId sickness, Lowest sickness was 3.4% in March. trying to reduce DATIX's for both Whiteparish and Breamore.
1.2	HR Indicators	Sickness levels are high, mainly due to recent COVID and 1 person being on LTS, who is then due to retire in October. Appraisal rates are down on the previous year and are currently at 72% in June. Meetings are planned and in diaries but do not always happen. statuatory training is good at 96%. 1x staff member on a stage 2 and 7 on a stage 1.
1.3	Finance	
1.4	Current establishment / Vacancies	our last OSCE nurse has just passed which means we are almost fully recruited for band 5's, howerev we do have 2xWTE on maternity leave and 1xB5 redeployed to breamore currently. B4's is showing that we are over recruited however 0.92 is on LTS and will then retire and 0.8 is leaving to go to cardiac rehab. We also have 1x B4 on Breamore 0.77WTE. We are currently 4 WTE b2's under recruited, but with 2 WTE going through recruitment checks, 1 should start the 5th September and 1 awaiting a start date.
1.5	Supervisory	Supervisory time has been notibaly lower the past 12 months with B6's getting very limited admin time. Appraisals are notibly lower recently.
1.6	Professional judgement of staffing ratios	I would ideally like to ncrease to 4x RN on the late shift so that the NIC can continue to co-ordinate and support the junior staff on the ward, 1 of these can be a band 4. When the night shift is fully staffed it works much better having a 3rd RN or band 4 on shift and staff have reported that it is much less stressful for them.
1.7	Safe Care Data	Safe care data has been inputted 3x a day, normally by the NIC, this is on the NIC checklist to help remind people to do it.
1.8	Other supporting evidence to any proposed changes to skill mix	

Section 2: Recommendations/Considerations

	Recommendations/Actions from Review	By Who	By When
2.1			
2.2			
2.3			
2.4			

All actions reviewed from Skill Mix Review 2021:

SafeCare Data

Appendix 2

Requested changes to establishment – see page 3 for focused priority items

WARD	BANDING and WTE	ROLE/SHIFT	COST	COMMENTS OF DepCNO
MEDICINE				
ED	B7 1.0 wte	Practice Educator	£63,932	Lead training and development of ED competencies, supporting retention, skills and confidence.
	B7 1.0 wte	Paedciatric Lead	£63,932	Lead peadiatric provsion, education, trainging and development, supporting retention, skills and confidence/competence
	Uplift of 4.5 wte B5 to B6	Creation of second B6 on LD and N shift	£52,002	Increase in senior RN presence and availability 24/7, supporting supervision, education, leadership, retention..
	B6 1.11 wte	Headroom uplift 24% to 27%	£64,980	Increase in headroom allowance to support educational, development and supervision needs of specialist environment.
	B5 1.4 wte	Second resus nurse overnight	£66,523	Adjust current twilight shift to full night shift to allow for second resus nurse availability
Whiteparish	B5 0.5wte	Support 4th late RN shift	£23,758	Increase in complex unstable diabetic patients, theatre involvement, VAC therapy, pressure ulcer management
Durrington				Current escalation ward, but to date no respite of current use. Current cost pressure as not currently funded to previously agreed staffing numbers (shortfall approximately 2.85 B5/6 and 2.66 B2). To be confirmed within budget setting.
Pitton	B2 3.59wte	Creation of 4th HCA on long day, and 3rd HCA night shift	£114,248	Challenges with outbreak (noro and covid) during past 12 months. High falls environment, with additional HCA required to ensure bay watch implemented 24/7.
Spire				Request to move current twilight shift to late shift. Can be accommodated within budget. Regarded as better use of time by staff and for patients needs.
Laverstock				No specific ask at this time, but await SNCT review, impact of NIV acuity and comparsion with ICS acute respiratory wards
Redlynch	B2	Late shift 7/7	nil	Can be accommodated by moving 3rd HCA from night shift in line with tracked incidents and timing of greatest need. Also creates some flexability within budget to allow for 5th RN on late shift as acuity requires.
Farley	B2 2.66wte	Additional B2 LD	£84,651	Supporting recovery of SSNAP, falls and PU management, and ongoing use of Farley RN team in managing CMDU requirments.
Breamore	B2 1.5wte	Allowing for 3rd HCA on night	£47,736	Currently partially covered by twilight shift, but request to increase in full night in view of patient acuity/complexities/ dependencies
Tisbury				No specific ask. Good progress and outcome of previous B6 increase with training and development within speciciality

Pembroke	Uplift B5 to B6	Support B6 on shift 24/7	£11,556	Upift in senior nurse presence to provide oversight, chemo support, training and education, promote rentention, support phone line, and increase stem cell transfers.
AMU	B5 3wte	Ensure minimum standard of 1:6 ratio maintained 24/7	£142,551	Further deep dive and SNCT review planned for winter 2022, but uplift reflects minimum staffing ratios for environment
SURGERY				
Amesbury	B5 to B6 1.0 we		£11,556	Request to increase existing B5 role to B6, thus allowing option of senior nurse cover 24/7 across 32 bedded ward.
Chilmark				Adjustment of current establishment usage creating HCA twilight shift to support post op recovery and increase day case/turnaround of patients, and option of additional admin/ward managers assistant. Within budget utilising previous B4 night shift monies.
Odstock				No specific ask, have been successfully working budget flexiably to support Burns Dressing Clinic with addiotnal B2 support and 4th RN on late shift as acuity requires.
Downton	B5 2.66 B2 2.66	4th RN on late shift 3rd HCA on night shift		To support increased acuity and ENT, trache care patients. Electives now on Chilmark, so reduced number of 'simpler' turnaround pts. Average of 10/12 medical outliers at any one time.
Britford				Creation of second B5 on early within SAU in view of increasing demand/acuity. Accomodated within budget.
Radnor				Nil to add. Continue 9RN+1HCA 24/7 in view of commissioned 10 ITU beds (assuming x6 level 3, x4 level 2 patients)
CS&FS				
Sarum				No specific ask at this time, but plans to utilise and ensure HCA coverage of long day 7 days a week within available budget.
Longford	B6 1.96wte	Suport additional RN on late and night.	£115,783	Request for B6 would allow for for senior nurse cover 24/7 offering supervision, training, support and leadership – in keeping with plans to address recent CQC, intensive support and complaint outcomes
Hopsice	B2 1.74 wte	B2 Twilight 7/7	£55,373	Request for additional B2 twilight shift reflecting complexities for patients, complex discharge, and risk of falls in to evening.
W&NB				
Maternity				No specific ask
NICU				No specific ask
TOTAL COST			£918.581	

Whilst an element of rationalisation of requests is made at time of skill mix discussions, the list above offers the full details of requests for consideration.

Given the antipcated limits and concurrent financial demands, should a focused/prioritised approach be required the following are offered as the minimum to achieve and maintain safe care with the evolving needs, acuity and demands on our in-patient environments.

WARD	BANDING and WTE	ROLE/SHIFT	COST
ED	B7 1.0 wte	Practice Educator	£63,932
	B7 1.0 wte	Paediatric Lead	£63,932
	Uplift of 4.5 wte B5 to B6	Creation of second B6 on LD and N shift to provide safety, oversight and leadership	£52,002
	B6 1.11 wte	Headroom uplift 24% to 27%	£64,980
AMU	B5 3wte	Ensure minimum standard of 1:6 ratio maintained 24/7	£142,551
Amesbury	B5 to B6 1.0 we	Allow B6 allocation 24/7	£11,556
Longford	B6 1.96wte	Would allow for additional RN on late and night and senior leadership presence across ward footprint.	£115,783
		TOTAL	**£514,736**

Maternity and Neonatal Staffing Report - SFT September 2022

This report provides a summary of key midwifery staffing standards within the maternity service at Salisbury NHS Foundation Trust to assure that safe staffing levels are in line with National guidance.

Introduction and purpose

The maternity workforce is reviewed utilising National published responses to maternity staffing:

- Safer Childbirth: Minimum standards for the organisation and the delivery of care in labour (RCOG, RCM 2007, NICE2019).
- Birthrate Plus (Salisbury assessment 2021).
- National Quality Board (2018). Safe, sustainable, and productive staffing - An improvement resource for maternity services.
- National Maternity Review: - 'Better Births' (2016) – A five year forward view for maternity care.
- Maternity Workforce Strategy- Transforming the Maternity Workforce HEE March 2019.
- Safer Midwifery Staffing for Maternity Settings (NICE 2015).

In addition, the Maternity Incentive Scheme, (MIS Clinical Negligence Scheme for Trusts), Year 4, sets out clear expectations in relation to demonstrating an effective system of midwifery workforce planning. The required standards are as follows:

a) A systematic, evidence-based process to calculate midwifery staffing establishment is complete.

b) Trust Board to evidence midwifery staffing budget reflects establishment as calculated in as above

c) The Midwifery Coordinator in charge of Labour Ward must have supernumerary status (defined as having no caseload of their own during a shift) to ensure there is an oversight of all birth activity within the service.

d) All women in active labor receive one-to-one care.

e) Submit a bi-annual midwifery staffing oversight report that covers staffing / safety issues to the Board.

Following the cultural and safety reviews that were commissioned within the Trust in 2020 into Maternity services, and reported at the beginning of 2021, a review into the midwifery workforce has been completed. Both reviews recommended a significant change to the leadership structure within the service. A revised Maternity structure was agreed in March 2021 and new posts have now been recruited into in. The new structure ensures an increase in leadership roles within the service to meet demand from the regional and national work streams and to ensure clear accountability and responsibility at all levels in the service.

The National Maternity Transformation programme details a particular focus around an increase in continuity of care and personalisation for women alongside the national ambition to reduce the stillbirth, neonatal and maternal death and neonatal brain injury by 50% by 2025. We recognise and embrace the need to make our service as safe as possible for women and babies and are keenly embracing and implementing the recommendations from our safety review, along with acknowledging and actioning the recommendations and points raised in the cultural survey. It was highlighted in both reports the significant impact that appropriate staffing levels have on both safety and staff wellbeing.

Alongside this work, we acknowledge the current media attention around safety as being a high priority agenda within the maternity service and especially in light of the Final report of the Ockenden Review which was published in early 2022. We are keenly embracing and working towards the recommendations set out by Ockenden.

Methodology

The current midwifery establishment at SFT was calculated using a midwife/birth ratio of 1:26 as recommended by the SFT Birthrate Plus® report in December 2019. Birthrate Plus® is the national workforce tool recommended by NICE (2014). Current funded establishment is based upon a projected total of 2200 births per annum. To monitor the safety of this approach we also use the Birthrate Plus® acuity tool, inputting precise data detailing risk and acuity of inpatients on Labour Ward 4 hourly, and Postnatal 8 hourly. This gives us up to date feedback on the level of safe staffing against the acuity and activity of the day. The tool also measures by exception where 1:1 care is not possible for labouring women, and when the labour ward co-ordinator is not able to maintain supernumerary status.

Birthrate Plus® is the only recognised national tool for calculating midwifery staffing levels and provides a robust and proven methodology for determining midwifery staffing establishments. It was recognised that the figures of current clinical establishment presented to Birthrate Plus® in Summer 2019 that informed the report published in December 2019, included some non-clinical roles within the variance report, and was therefore, inaccurate in this calculation and subsequent recommendations.

Following liaison with Birthrate Plus® in May 2021 and a recalculation of the service requirements using 2019 clinical data, Birthrate Plus® recalculated our staffing requirements. Table 1 is the updated report from Birthrate Plus® May 2021.

Birth-rate plus recommendation May 2021

Total Births	**2193**
Core Hospital Services	
Delivery Suite	33.86
Postnatal Ward	20.95
Maternity DAU	7.96
Community Inc. Homebirth provision	27.83
Total Clinical wte Band 3-7	**90.60**

Table 1

In addition to the clinical workforce recommendations from Birthrate Plus® the non- clinical workforce is calculated based on a standard % of 9%. This would mean that the non-clinical wte should be 8.15wte. These roles include Named Midwife for Safeguarding Children, Antenatal and Postnatal Screening Leads, Perinatal Mental Health Lead Midwife, Birth Environment Lead, Practice Educator, Fetal Surveillance Lead and Midwifery Matrons.

The recommendations for clinical staffing for clinical midwives and the budgeted establishment versus current staffing levels are shown in Table. 2:

Banding		Clinical Budgeted Establishment Midwivesband 5-7 89.15 (wte)	Actual clinical Headcount (wte) August 2022	Maternity Leave (wte) January 2022	Variance (wte) budget vs actual	Variance (wte) **actual available to work (incl mat leave)** vs Birthrate Plus® 2021 report
Band 5		12.09	9.72	0	-2.37	-2.37
Band 6		70.58	54.51	3.61	-16.07	-19.68
Band 7		6.48	6.16	0	-0.32	-0.32

Table 2

Midwife to Birth Ratio

Although NICE 2019 recommends a midwife to birth ratio of 1:25 for a DGH service, Birthrate Plus has adjusted this for Salisbury and recommends a rate of 1:26, this takes into account anticipated levels of risk and safeguarding which both affect the amount of time and care required for women and their families. This rate is reached via calculations between monthly birth numbers and available numbers of midwives. The ratios are analysed monthly and are affected by fluctuating birth numbers and variations in establishment month to month.

Midwives to Births Ratio
(excluding HOM & non clinical time)

Month	Budgeted Establishment	Actual Establishment (minus mat leave, sickness and vacancy)	Total Births	Midwife to Birth ratio (rounded) Actual establishment	Midwife to Birth ratio (rounded) budgeted establishment	12 Month average actual
Sep-21	88.64	64.55	217	1:40	1:29	32.7
Oct-21	88.64	77.16	198	1:31	1:27	32.6
Nov-21	88.64	77.16	187	1:29	1:25	32.4
Dec-21	88.64	77.16	149	1:23	1:20	31.5
Jan-22	88.64	74.82	166	1:27	1:22	31.2
Feb-22	88.64	72.38	190	1:32	1:26	31.4
Mar-22	89.16	72.38	190	1:32	1:26	31.5
April	89.16	73.47	178	1:29	1:24	31.4
May-22	89.16	73.47	184	1:30	1:25	36.4
June	89.16	71.87	195	1:33	1:26	36.7
July	89.16	72.47	201	1:33	1:27	37.3

Table 3

1:1 Care in Labour

The NICE clinical standards dictate that each woman should receive 1:1 care during established labour and childbirth by a trained Midwife or a Trainee Midwife under direct supervision. This is audited monthly and demonstrates excellent compliance as the care of labouring women is always the priority and escalation is utilised when needed to ensure this. Between July and December 2021 compliance with this standard was 100%.

February 2021	100%
March 2021	100%
April 2021	100%
May 2021	100%
June 2021	100%
July 2021	100%

Supernumerary Status of Coordinator

One of the safety standards mandated by CNST is the need to have a supernumerary Labour Ward Coordinator leading on every Labour Ward 24-hours a day. We have ensured that our rostering reflects this requirement.

The Birthrate Plus acuity tool monitors this, alongside other red flags, every 4 hours. It also takes into account risk factors, acuity and dependency of women, environmental factors and skill mix enabling the co-ordinator to flex staffing to the need of the service within a shift by redirecting staff and prioritising care. A detailed escalation policy also ensures the coordinator retains this supernumerary status enabling oversight of activity. Supernumerary status of the coordinator was maintained over 99% of the measured occasions in the 6 months this report relates to (Table 4). Detail has been obtained to understand the times this wasn't achieved to ensure we are striving to maintain supernumerary status 100% of the time.

Number of episodes measured via birthrate plus acuity tool between 1/2/2022 – 31/7/2022	Supernumerary status of Labour Ward coordinator not maintained
1086	3

Table 4

Recruitment

Recruitment to Band 5 and Band 6 clinical posts has been variable in the last 12 months, we recognise that there is a need to balance the junior workforce with experienced staff and the recruitment into senior Band 6 positions is a challenge for Salisbury. Although this is not just isolated to Salisbury, the military population, lack of city lifestyle and size of the maternity service are all contributory factors.

The recruitment team are currently providing focussed individual support, including weekly meetings to the Deputy Director of Maternity responsible for workforce, to ensure recruitment is advertised and promoted as widely as possible and that new starters are assisted into positions in the most efficient timeframes possible.

In recent months there has been a need for a more flexible approach to working across the entire midwifery workforce. An example of this has been to reduce Community Midwifery staffing levels at a weekend to meet acuity demands within the hospital environment – using staff flexibly across areas to meet service needs.

The concept of flexible working across the maternity pathway rather than having fixed areas of working, as an alternative approach to providing maternity care, is seen as not only a more

cost-effective way of working but supports the future vision for continuity of carer. Their preceptorship programme has been redesigned to encompass a more holistic approach to providing care to women and their families by working more flexibly across the maternity service and includes experience in both inpatient and outpatient areas. We have also adapted to look at varying processes to attract staff, including supporting return to practice midwives. From a flexible working perspective, we have trialled an increase in requesting for staff, stepping out of the policy dictating numbers of request and doubling them to allow staff more opportunity to balance work and home life. This has been received very positively and aided retention of staff.

In October 2022 the preceptor midwives will have the opportunity to progress to a Band 6 position, following completion of all clinical competencies.

We have been involved in a collaborative with GWH and Gloucester around recruitment of international midwives, this is a new approach nationally and we have been allocated 5 midwives who will be starting with us in early Autumn. Leading on from this we have also recruited 2 overseas midwives independently of the collaborative who will join this cohort and be support through their midwifery OSCEs. These two midwives will join us in September.

In considering the workforce and national shortage of midwives we have considered how we can utilise other clinicians to work within maternity services. We have now employed four nurses to assist in caring for women within maternity. Two commenced employment in August and a further two will start in November. They will be caring for women post operatively and will be able to support with many of the tasks that the midwives complete yet are not midwifery specific.

Safety and Overview

In order for the service to demonstrate safe staffing on a daily basis the role of the Maternity Duty Manager plays a fundamental role in responding to the constant changing clinical situations within maternity, both in the building and in the community environment. The Duty Manager is available to provide a 24/7 support to the Maternity and Neonatal Service, providing a helicopter view across all areas and maintaining safety at every level. The Maternity Duty Manager rota is covered by Band 7 and Band 8 midwifery leaders and provides visible responsive leadership to Maternity and Neonatal Services.

Maternity Services continue to report via Datix missed breaks and when the coordinator is unable to maintain their supernumerary status. At such a time the involvement of the Duty Manager and use of the Maternity Escalation Policy ensures oversight and transparency when staffing and incidents occur. Additionally, Red Flag reporting is discussed monthly at the Maternity Risk meeting, with any themes being fed into the Trust Clinical Risk Group.

Staffing is discussed at Maternity Risk monthly, forms part of the Executive Performance Review monthly meetings and is discussed with the Board level Safety Champions monthly. The reporting mechanisms ensure clear escalation and visibility of staffing challenges. A

staffing dashboard is currently being developed by the Deputy Director of Maternity responsible for workforce.

Challenges and Mitigations

Maternity Leave
Maternity leave has consistently been high in the Maternity Department year on year, and over the past 2-3 years is consistently around 8-10 WTE at any one time. This has impacted on the ability to staff the department on a daily basis. Rates are currently low at however they are due to rise again later in the Autumn.

Staffing Levels
With the recalculated Birthrate Plus assessment of the recommended safe staffing levels, maintaining staffing levels is a constant challenge.

This has been escalated to Board level and is being managed accordingly, through a sharing of staffing resources across the midwifery pathways. In addition, we have:

- Utilised Bank Midwives.
- Community staff working flexibly in the unit as and when required.
- Use of Agency Midwives when available (June to September 2022).
- Support of Duty Manager day and night as required to coordinate the escalation process ensuring coordination of staff and work as acuity dictates necessary.
- The daily staffing/safety huddle involving clinical leaders across all areas of maternity services, to ensure a team approach to day to day working also contributes to ensuring staff are assigned to clinical areas according to fluctuating activity levels.
- Involved in a programme to internationally recruit midwives, working with other Trusts across the South-West.
- Recruitment of nurses to the maternity Service.

These measures have provided assurance of safety for all women and babies in our care.

It is important to recognise staff wellbeing is impacted with the shortfall of staff within the service and are feeling the pressure of this. It is recognised that although staff have undertaken Bank work to close day to day gaps this is not a sustainable long-term solution.

Risks

Delivery of Continuity of Carer Model

In February 2016 Better Births, the report of the National Maternity Review, set out the Five Year Forward View for NHS Maternity Services in England to become safer and more personal. At the heart of its vision is a recommendation that there should be Continuity of Carer to ensure safe care based on a relationship of mutual trust and respect in line with the woman's decisions. In Salisbury a pilot study for Continuity of Carer was established in 2019 and the

'Ivy Team' offered midwives and women the opportunity to foster the recommended pathway of care for certain cohorts of women (birth trauma and previous caesarean birth). The pilot ended in March 2021 due to concerns around entire midwifery workforce skill mix and vacancy rates at Salisbury. When moving towards the continuity model, it is recognised nationally that this will require an increased number of midwives as opposed to the traditional working model. In addition, in the Ockenden report (2022) there was clear guidance advising that if adequate staffing levels were not in place then continuity of career should be paused until full establishment of staff was reached. With our vacancy rates we have followed this advice and paused our rollout of continuity at present.

Table 5 demonstrates the required staffing levels needed to achieve Continuity of Carer using SFT data and staffing establishment figures.

It is clear within the report that in order to develop Continuity of Carer to 35% of women the service requires the establishment of 89.16 WTE clinical midwives to be fully recruited into, and with the current vacancy rate this is not currently feasible.

NHS Salisbury NHS Foundation Trust

Table 5. Continuity of Carer modelling from Birthrate Plus® report (May 2021)

SALISBURY NHS TRUST	24% uplift	Version date: 13/05/2021		DRAFT							
TOTAL BIRTHS	2193	**The figures are an indication only and should be reviewed as more caseload teams are set up**. The staffing totals assume the annual births, community exports and imports remain as in the baseline and there are no other changes to services. The CoC staffing is based on a caseload ratio of 36 cases to 1wte. Factored into core staffing is that 20% of CoC women will require care from core staff on D/S and that 90% of women will require transfer to the p/n ward for maternal and/or fetal reasons. The % may reduce as CoC becomes established. It is advisable to consider minimum staffing on D/S and Maternity Ward as higher % of women are allocated to a CoC team.									
TOTAL COMMUNITY CASES	2756										
ELIGIBLE FOR COC	2023										
Minimum Staffing 24/7 x 1 m/w	**Baseline exc CoC**	*Core Staffing Nos. per Shift*	**CoC 20%**	*Core Staffing Nos. per Shift*	**CoC 35%**	*Core Staffing Nos. per Shift*	**CoC 51%**	*Core Staffing Nos. per Shift*	**CoC 75%**	*Core Staffing Nos. per Shift*	**CoC 100%**	*Core Staffing Nos. per Shift*
5.56												
Core Hospital Services												
Delivery Suite	33.86	*6.09*	30.85	*5.55*	27.86	*5.01*	24.67	*4.44*	19.88	*3.58*	14.90	*2.68*
Maternity Ward	20.95	*3.77*	20.91	*3.76*	20.27	*3.65*	19.59	*3.52*	18.58	*3.34*	17.52	*3.15*
OPD/MAU	7.96		7.96		7.96		7.96		7.96		7.96	
Core Community	25.45		21.99		18.75		15.29		10.10		4.70	
Home births	2.38											
Caseload Teams	0.00		11.24		19.67		28.66		42.15		56.19	
includes home births												
Total Clinical wte PN Band 3s to Band 7/8s	**90.60**		**92.94**		**94.51**		**96.17**		**98.67**		**101.28**	
Variance from BR+ baseline in CLINICAL WTE	0.00		2.35		3.91		5.57		8.07		10.68	
Incremental Variance in Clinical wte			2.35		1.56		1.67		2.50		2.60	
TOTAL CLINICAL, SPECIALIST, MANAGEMENT WTE	**98.75**		**101.31**		**103.01**		**104.83**		**107.55**		**110.39**	
Variance from BR+ baseline in TOTAL WTE			**2.56**		**4.26**		**3.52**		**4.54**		**5.56**	

Inability to Recruit

If we continue to have difficulty recruiting, we will continue to utilise Agency and Bank staff, and looking at working creatively across all areas of maternity to utilise Community Midwives working in inpatient areas, as and when required. Use of an incentive scheme for Bank work in Summer 2022 was successful in maintaining safe levels of staff until the newly qualified midwives start in October 2022, we have four newly qualified midwives joining us at this point. This is a scheme which was well received, and we would look to re-implement if staffing levels dictated a need for it.

Conclusion and Next Steps

The paper demonstrates the current staffing establishment in the maternity service, challenges, risks, and mitigations in place. The ongoing work to recruit and retain is key to the long-term staffing within the service and in order to deliver Continuity of Carer across the service. Next steps are detailed:

- Work with the national, regional, and local teams to develop an action plan modelling the rollout of Continuity of Carer.
- Continue with the recruitment campaign work utilising all options available to the Trust for recruitment and retention incentives.
- Complete a workforce review of all staff groups in the service to ensure flexibility is explored for all clinical roles; this will include NICU, Maternity Care Assistants and Maternity Assistants working in the community.
- Utilise Bank and Agency staff.
- Review working patterns and flexibility models within the current service.
- Monitor staffing monthly through staffing dashboard and escalate concerns accordingly.
- Where opportunities to over recruit become an option ensure this is available to the team.
- Review the Maternity Care Assistant competency framework with the LMNS to ensure their role is included in workforce planning and skill mix – ultimately reducing midwifery staffing in the postnatal ward environment.

Appendix 4.

Ward Specialities

DIVISION	WARD	SPECIALITY	NOTES
Medicine	AMU	Acute Medicine Unit	
	Breamore	Stroke rehab	Escalation ward. Currently accommodating NCTR patients
	Durrington	Acute medicine	Escalation ward
	ED	Emergency Department	
	Farley	Acute Stroke	
	Laverstock	Respiratory Medicine	
	Pitton	Elderly care	
	Redlynch	Gastroenterology	
	Spire	Elderly care/rehab	Currently Covid cohort ward
	Tisbury	Cardiology	
	Whiteparish	Endocrinology	
Surgery	Amesbury	Trauma	
	Britford	Acute Surgery	
	Chilmark	Elective Surgery	Incorporates both general surgery and orthopaedic electives
	Downton	Acute Surgery	
	Odstock	Burns and plastics	
	Radnor	Intensive Care Unit	
CS+FS	Sarum	Paediatrics	
	Longford	Spinal Rehabilitation	Moved to CS+FS 05/09/22
	Hospice	Hospice	Moved to CS+FS from 01/04/22

												Total beds	SD beds
	RN	B4	HCA		RN	B4	HCA		RN	B4	HCA		
MEDICINE													
AMU												19	0
Early	6		4		5		4		4		3		
Late	6		4		6		3		4		3		
Night	4		2		4		2		3		2		
Durrington												21	2
Early	4		4		3		3		2		2		
Late	4		3		3		2		2		2		
Night	3		2		2		2		2		1		
Farley Stroke (but currently includes RCU) (Note increased staffing levels when ward functioning with high number of COVID)												30	0
Early	5		5		5		3		4		3		
Late	5		4		5		3		4		3		
Night	4		3		4		3		4		3		
Hospice												10	0
Early	2		2		2		1		2		0		
Late	2		2		2		0		2		0		
Night	2		1		2		1		2		0		
Pembroke												10	0
Early	2		1		2		1		2		0		
Late	2		1		2		1		2		0		
Night	2		1		2		1		2		0		
Pitton (Elderly Care)												25	2
Early	4		4		3		4		3		2		
Late	4		3		3		3		3		2		
Night	3		2		3		2		2		2		
Redlynch												24	3
Early	5		4		4		3		3		2		
Late	4		2		3		2		3		2		
Night	3		3		3		2		3		2		
Spire												30	0
Early	4		6		4		5		3		4		
Late	4		3		3		3		3		3		

Updated 06/07/22 - HW

Night	3		3 +tw		3		2 +tw		2		3 tw		
Laverstock (Resp)												19	1
Early	4		3		3		3		3		2		
Late	4		2		3		2		3		2		
Night	3		2		3		1		2		2		
Breamore												20	4
Early	3		4		3		3		2		2		
Late	3		3		3		2		2		2		
Night	2		2 +tw		2		2		2		1 +tw		
Tisbury/CCU												23	0
Early	6		2		5		2		4		1		
Late	6		2		5		2		4		1		
Night	4		1		3		1		3		1		
Whiteparish												23	0
Early	4		3		3		2		2		2		
Late	3		3		3		2		2		2		
Night	2	1	2		2		2		2		1		
Longford @42/47 beds												39	0
Early	7/8		10/11		6/7		8/9		5/6	1	6/8		
Late	6		6		5		6		5	1	4		
Night	5/6		5/6		4/5		5		4/5		4		

Updated 06/07/22 - HW

												Total beds	SD beds
SURGERY													
	RN	B4	HCA		RN	B4	HCA		RN	B4	HCA		
Britford												20	1
Early	5		2		4		2		3		2		
Late	4		2		4		2		3		2		
Night	3		2		3		2		2		2		
Downton												24	2
Early	4		3		3		2		2	1	2		
Late	3		2		3		2		2	1	2		
Night	2		2		2		2		2		2		
Odstock												17	0
Early	4		2		3		2		2	1	2		
Late	3		2		3		2		2	1	2		
Night	3		2		2		2		2		2		
Amesbury												32	0
Early	4	1	5		4		4		3	1	3		
Late	4	1	5		4		4		3	1	3		
Night	3		4		3		3		3		3		
Chilmark – Elective												8	0
Early	2		2		2		1		2		1		
Late	2		2		2		1		2		1		
Night	2		2		2		1		2		1		
Chilmark - Trauma												16	0
Early	2		1		2		1		2		0		
Late	2		1		2		1		2		0		
Night	2		1		2		1		2		0		

Updated 06/07/22 - HW

Addition – Red/Purple/Black

In light of the evolving pandemic and omicron variant expected to impact nationally from early January 2022, further review, evaluation and preparation required as to how further deterioration in nursing resource coupled with increased demand can be managed and accommodated.

NOTE: Whilst obvious, it is worth noting, that these measures represent an extreme event, and must only be applied in the context offered (overwhelming patient numbers and significant staffing absence caused by the pandemic).

The risk this represents is well understood by the executive team, Trust Board and our regional and national counterparts. Risk 7039 (current score of 20) features on the corporate risk register, with the organisation carrying the burden of this risk. Whilst individuals will understandably be impacted by the notion and delivery of care in this manner, this is a collective and shared response to these unprecedented times.

Indemnity and regulation

- NHS Resolution has confirmed additional indemnity arrangements that cover healthcare workers who are supporting the COVID-19 response, including those who have been asked to undertake duties outside of their usual role.
- It is recognised that at times staff might need to act outside their normal role or places of work/scope of practice. With any request a risk-based approach is used to mitigate emerging risks using available resources effectively and responsibly.
- The Nursing and Midwifery Council (NMC) and the four chief nursing officers in the UK have written to all registrants reminding all of the importance of working in partnership with people receiving care and their fellow professionals; and of using professional judgement to assess risk, informed by the values and principles set out in NMC professional standards.

A note on the numbers

- The offered numbers represent the very basic core minimum numbers of Registered and Un-Registered Nurses conceivable, and does not reference or include additional ward support roles that would be utilised to bolster and support ward teams
- Additional support roles would include and termed ‘other’
    - students
    - volunteers
    - non-patient facing staff
    - military
    - floating matron/senior nurse to undertake drug checks (FM)

PURPLE Further deterioration of 'red' staffing numbers. Significant risk and omissions in care, documentation, ability to protect and maintain patient safety. Bare minimum of essential tasks undertaken (medication, meal time support)

BLACK Surge ++. Demand far exceeding capacity needing to open novel mass patient accommodation

MEDICINE	TOTAL BEDS	SD BEDS	RN	B4	HCA		RN	B4	HCA		RN	B4	HCA	Other
AMU	19	0												
Early			4		3		3		2		2		1	2
Late			4		3		3		2		2		1	2
Night			3		2		3		2		2		1	2
Durrington	21	2												
Early			2		2		2		1		1+FM		1	2
Late			2		2		2		1		1+FM		1	2
Night			2		1		2		1		1+FM		1	2
Farley (+RCU)	30	0												
Early			4		3		3		2		2		1	2
Late			4		3		3		2		2		1	2
Night			4		3		3		2		2		1	2
Hospice	10	0												
Early			2		0		1	1			1+FM		0	1
Late			2		0		1	1			1+FM		0	1
Night			2		0		1	1			1+FM		0	1
Pembroke	10	0												
Early			2		0		1	1			1+FM		0	1
Late			2		0		1	1			1+FM		0	1
Night			2		0		1	1			1+FM		0	1
Pitton	25	2												
Early			3		2		2		2		1+FM		1	2
Late			3		2		2		2		1+FM		1	2
Night			2		2		2		2		1+FM		1	2
Redlynch	24	3												
Early			3		2		2		2		2+FM		1	2
Late			3		2		2		2		2+FM		1	2
Night			3		2		2		2		2+FM		1	2
Spire	30	0												
Early			3		4		2		3		2		1	2
Late			3		3		2		3		2		1	2
Night			2		3+tw		2		3		2		1	2

Updated 06/07/22 - HW

Laverstock	19	1													
Early			3		2		2		2		1+FM		1	2
Late			3		2		2		2		1+FM		1	2
Night			2		2		2		2		1+FM		1	2
Breamore	20	4													
Early			2		2		2		1		1+FM		1	2
Late			2		2		2		1		1+FM		1	2
Night			2		1+tw		2		1		1+FM		1	2
Tisbury/CCU	23	0													
Early			4		1		3		1		2+FM		1	2
Late			4		1		3		1		2+FM		1	2
Night			3		1		3		1		2+FM		1	2
Whiteparish	23	0													
Early			2		2		2		1		1+FM		1	2
Late			2		2		2		1		1+FM		1	2
Night			2		1		2		1		1+FM		1	2
Longford	39	0	Alternative numbers represent when 42 beds/47 beds in use												
Early			5/6	1	6/8		4/5		4/6		3/4		2/4	2
Late			5	1	4		4		4/5		3		2/3	2
Night			4/5		4		4		4		3		2/3	2

Please note, that staffing numbers reflect opportunity for neighbouring wards to support each other, eg Redlynch may have additional nurse to Pitton, but expectation that Redlynch third RN float and support with medications, drug checks etc on both Redlynch and Pitton ward.

Tisbury + Whiteparish

Redlynch + Pitton

Britford + Downton

Updated 06/07/22 - HW

SURGERY	TOTAL BEDS	SD BEDS	RN	B4	HCA		RN	B4	HCA		RN	B4	HCA	Other
Britford	20	1												
Early			3		2		2	1	2		2+FM		1	2
Late			3		2		2	1	2		2+FM		1	2
Night			2	1	2		2		2		2+FM		1	2
Downton	19	5												
Early			2	1	2		2		2		1+FM		1	2
Late			2	1	2		2		2		1+FM		1	2
Night			2		2		2		2		1+FM		1	2
Odstock	17	0												
Early			2	1	2		2		2		1+FM		1	2
Late			2	1	2		2		2		1+FM		1	2
Night			2		2		2		2		1+FM		1	2
Amesbury	32	0												
Early			3	1	3		2		3		2		1	2
Late			3	1	3		2		3		2		1	2
Night			3		3		2		3		2		1	2
Chilmark – Elective	24	0												
Early			3	1	1		2		2		2		1	2
Late			3	1	1		2		2		2		1	2
Night			2	1	1		2		2		2		1	2

Escalation and mass casualty

	TOTAL BEDS	SD BEDS	RN	B4	HCA		RN	B4	HCA		RN	B4	HCA	Other
DSU	11 up	1												
Early			2		0		1		1		1		0	1
Late			2		0		1		1		1		0	1
Night			2		0		1		1		1		0	1
DSU	18 down	0												
Early			2		1		2		1		2		0	1
Late			2		1		2		1		2		0	1
Night			2		1		2		1		2		0	1
Endoscopy	10	0												
Early			2		0		1		1		1		0	1
Late			2		0		1		1		1		0	1
Night			2		0		1		1		1		0	1
Clarendon Spinal Gym	6 10	2 0												
Early											2		1	
Late											2		1	
Night											2		1	
Pembroke Suite	6	2												
Early											1		1	
Late											1		1	
Night											1		1	
Nunton	6													
Early											1	1		
Late											1	1		
Night											1	1		
Springs	25	0												
Early											2		2	
Late											2		2	
Night											2		2	

Staffing numbers offered reflecting number of beds, location and access to neighbouring support, and the environment itself.

Updated 06/07/22 - HW

CHPPD Triggers

		Green								Amber								Red							
Ward	Type	RNs	RN Hours	HCAs	HCA Hours	Total Staff	Total Hours	CHPPD Total Beds	CHPPD Average Occupancy	RNs	RN Hours	HCAs	HCA Hours	Total Staff	Total Hours	CHPPD Total Beds	CHPPD Average Occupancy	RNs	RN Hours	HCAs	HCA Hours	Total Staff	Total Hours	CHPPD Total Beds	CHPPD Average Occupancy
AMU	Day	6	69	4	46	10	115	**6.1**	**4.8**	6	65	4	42	10	107	**5.6**	**4.5**	4	46	3	34.5	7	80.5	**4.2**	**3.4**
AMU	Night	4	46	2	23	6	69	**3.6**	**2.9**	4	46	2	23	6	69	**3.6**	**2.9**	3	34.5	2	23	5	57.5	**3.0**	**2.4**
AMU	Total	10	115	6	69	16	184	**9.7**	**7.7**	10	111	6	65	16	176	**9.3**	**7.3**	7	80.5	5	57.5	12	138	**7.3**	**5.8**
Durrington	Day	4	46	4	42	8	88	**4.2**	**4.2**	3	34.5	3	30.5	6	65	**3.1**	**3.1**	2	23	2	23	4	46	**2.2**	**2.2**
Durrington	Night	3	34.5	2	23	5	57.5	**2.7**	**2.7**	2	23	2	23	4	46	**2.2**	**2.2**	2	23	1	11.5	3	34.5	**1.6**	**1.6**
Durrington	Total	7	80.5	6	65	13	145.5	**6.9**	**6.9**	5	57.5	5	53.5	10	111	**5.3**	**5.3**	4	46	3	34.5	7	80.5	**3.8**	**3.8**
Farley Stroke	Day	5	57.5	5	53.5	10	111	**3.7**	**4.1**	5	57.5	3	34.5	8	92	**3.1**	**3.4**	4	46	3	34.5	7	80.5	**2.7**	**3.0**
Farley Stroke	Night	4	46	3	34.5	7	80.5	**2.7**	**3.0**	4	46	3	34.5	7	80.5	**2.7**	**3.0**	4	46	3	34.5	7	80.5	**2.7**	**3.0**
Farley Stroke	Total	9	103.5	8	88	17	191.5	**6.4**	**7.1**	9	103.5	6	69	15	172.5	**5.8**	**6.4**	8	92	6	69	14	161	**5.4**	**6.0**
Hospice	Day	4	30	4	30	8	60	**6.0**	**6.7**	4	30	1	7.5	5	37.5	**3.8**	**4.2**	4	30	0	0	4	30	**3.0**	**3.3**
Hospice	Night	2	23	1	11.5	3	34.5	**3.5**	**3.8**	2	23	1	11.5	3	34.5	**3.5**	**3.8**	2	23	0	0	2	23	**2.3**	**2.6**
Hospice	Total	6	53	5	41.5	11	94.5	**9.5**	**10.5**	6	53	2	19	8	72	**7.2**	**8.0**	6	53	0	0	6	53	**5.3**	**5.9**
Pembroke	Day	2	23	1	11.5	3	34.5	**3.5**	**4.3**	2	23	1	11.5	3	34.5	**3.5**	**4.3**	2	23	0	0	2	23	**2.3**	**2.9**
Pembroke	Night	2	23	1	11.5	3	34.5	**3.5**	**4.3**	2	23	1	11.5	3	34.5	**3.5**	**4.3**	2	23	0	0	2	23	**2.3**	**2.9**
Pembroke	Total	4	46	2	23	6	69	**6.9**	**8.6**	4	46	2	23	6	69	**6.9**	**8.6**	4	46	0	0	4	46	**4.6**	**5.8**
Pitton	Day	4	46	4	42	8	88	**3.5**	**3.5**	3	34.5	4	42	7	76.5	**3.1**	**3.1**	3	34.5	2	23	5	57.5	**2.3**	**2.3**
Pitton	Night	3	34.5	2	23	5	57.5	**2.3**	**2.3**	3	34.5	2	23	5	57.5	**2.3**	**2.3**	2	23	2	23	4	46	**1.8**	**1.8**
Pitton	Total	7	80.5	6	65	13	145.5	**5.8**	**5.8**	6	69	6	65	12	134	**5.4**	**5.4**	5	57.5	4	46	9	103.5	**4.1**	**4.1**
Redlynch	Day	5	53.5	4	38	9	91.5	**3.8**	**3.7**	4	42	3	30.5	7	72.5	**3.0**	**2.9**	3	34.5	2	23	5	57.5	**2.4**	**2.3**
Redlynch	Night	3	34.5	3	34.5	6	69	**2.9**	**2.8**	3	34.5	2	23	5	57.5	**2.4**	**2.3**	3	34.5	2	23	5	57.5	**2.4**	**2.3**
Redlynch	Total	8	88	7	72.5	15	160.5	**6.7**	**6.4**	7	76.5	5	53.5	12	130	**5.4**	**5.2**	6	69	4	46	10	115	**4.8**	**4.6**
Spire	Day	4	46	6	57	10	103	**3.4**	**3.8**	4	42	5	49.5	9	91.5	**3.1**	**3.4**	3	34.5	4	42	7	76.5	**2.6**	**2.8**
Spire	Night	3	34.5	4	41	7	75.5	**2.5**	**2.8**	3	34.5	3	29.5	6	64	**2.1**	**2.4**	2	23	4	41	6	64	**2.1**	**2.4**
Spire	Total	7	80.5	10	98	17	178.5	**6.0**	**6.6**	7	76.5	8	79	15	155.5	**5.2**	**5.8**	5	57.5	8	83	13	140.5	**4.7**	**5.2**
Laverstock	Day	4	46	3	30.5	7	76.5	**4.0**	**3.5**	3	34.5	3	30.5	6	65	**3.4**	**3.0**	3	34.5	2	23	5	57.5	**3.0**	**2.6**
Laverstock	Night	3	34.5	2	23	5	57.5	**3.0**	**2.6**	3	34.5	1	11.5	4	46	**2.4**	**2.1**	2	23	2	23	4	46	**2.4**	**2.1**
Laverstock	Total	7	80.5	5	53.5	12	134	**7.1**	**6.1**	6	69	4	42	10	111	**5.8**	**5.0**	5	57.5	4	46	9	103.5	**5.4**	**4.7**
Breamore	Day	3	34.5	4	42	7	76.5	**3.8**	**3.5**	3	34.5	3	30.5	6	65	**3.3**	**3.0**	2	23	2	23	4	46	**2.3**	**2.1**
Breamore	Night	2	23	3	28	5	51	**2.6**	**2.3**	2	23	2	23	4	46	**2.3**	**2.1**	2	23	2	16.5	4	39.5	**2.0**	**1.8**
Breamore	Total	5	57.5	7	70	12	127.5	**6.4**	**5.8**	5	57.5	5	53.5	10	111	**5.6**	**5.0**	4	46	4	39.5	8	85.5	**4.3**	**3.9**
Tisbury	Day	6	69	2	23	8	92	**4.0**	**4.2**	5	57.5	2	23	7	80.5	**3.5**	**3.7**	4	46	1	11.5	5	57.5	**2.5**	**2.6**
Tisbury	Night	4	46	1	11.5	5	57.5	**2.5**	**2.6**	3	34.5	2	23	5	57.5	**2.5**	**2.6**	3	34.5	1	11.5	4	46	**2.0**	**2.1**
Tisbury	Total	10	115	3	34.5	13	149.5	**6.5**	**6.8**	8	92	4	46	12	138	**6.0**	**6.3**	7	80.5	2	23	9	103.5	**4.5**	**4.7**
Whiteparish	Day	4	42	3	34.5	7	76.5	**3.3**	**3.5**	3	34.5	2	23	5	57.5	**2.5**	**2.6**	2	23	2	23	4	46	**2.0**	**2.1**
Whiteparish	Night	2	23	2	23	4	46	**2.0**	**2.1**	2	23	2	23	4	46	**2.0**	**2.1**	0	0	0	0	0	0	**0.0**	**0.0**
Whiteparish	Total	6	65	5	57.5	11	122.5	**5.3**	**5.6**	5	57.5	4	46	9	103.5	**4.5**	**4.7**	2	23	2	23	4	46	**2.0**	**2.1**
Longford	Day	7	76.5	10	99	17	175.5	**4.5**	**5.0**	6	65	8	84	14	149	**3.8**	**4.3**	5	57.5	6	61	11	118.5	**3.0**	**3.4**
Longford	Night	5	57.5	5	57.5	10	115	**2.9**	**3.3**	5	57.5	5	57.5	10	115	**2.9**	**3.3**	5	57.5	4	46	9	103.5	**2.7**	**3.0**
Longford	Total	12	134	15	156.5	27	290.5	**7.4**	**8.3**	11	122.5	13	141.5	24	264	**6.8**	**7.5**	10	115	10	107	20	222	**5.7**	**6.3**
Britford	Day	5	53.5	2	23	7	76.5	**3.8**	**4.3**	4	46	2	23	6	69	**3.5**	**3.8**	3	34.5	2	23	5	57.5	**2.9**	**3.2**
Britford	Night	3	34.5	2	23	5	57.5	**2.9**	**3.2**	3	34.5	2	23	5	57.5	**2.9**	**3.2**	2	23	2	23	4	46	**2.3**	**2.6**
Britford	Total	8	88	4	46	12	134	**6.7**	**7.4**	7	80.5	4	46	11	126.5	**6.3**	**7.0**	5	57.5	4	46	9	103.5	**5.2**	**5.8**
Downton	Day	4	42	3	30.5	7	72.5	**3.0**	**3.5**	3	34.5	2	23	5	57.5	**2.4**	**2.7**	2	23	2	23	4	46	**1.9**	**2.2**
Downton	Night	2	23	2	23	4	46	**1.9**	**2.2**	2	23	2	23	4	46	**1.9**	**2.2**	2	23	2	23	4	46	**1.9**	**2.2**
Downton	Total	6	65	5	53.5	11	118.5	**4.9**	**5.6**	5	57.5	4	46	9	103.5	**4.3**	**4.9**	4	46	4	46	8	92	**3.8**	**4.4**
Odstock	Day	4	42	2	23	6	65	**3.8**	**4.1**	3	34.5	2	23	5	57.5	**3.4**	**3.6**	2	23	2	23	4	46	**2.7**	**2.9**
Odstock	Night	3	34.5	2	23	5	57.5	**3.4**	**3.6**	2	23	2	23	4	46	**2.7**	**2.9**	2	23	2	23	4	46	**2.7**	**2.9**
Odstock	Total	7	76.5	4	46	11	122.5	**7.2**	**7.7**	5	57.5	4	46	9	103.5	**6.1**	**6.5**	4	46	4	46	8	92	**5.4**	**5.8**
Amesbury	Day	4	46	5	57.5	9	103.5	**3.2**	**3.6**	4	46	4	46	8	92	**2.9**	**3.2**	3	34.5	3	34.5	6	69	**2.2**	**2.4**
Amesbury	Night	3	34.5	4	46	7	80.5	**2.5**	**2.8**	3	34.5	3	34.5	6	69	**2.2**	**2.4**	3	34.5	3	34.5	6	69	**2.2**	**2.4**
Amesbury	Total	7	80.5	9	103.5	16	184	**5.8**	**6.3**	7	80.5	7	80.5	14	161	**5.0**	**5.6**	6	69	6	69	12	138	**4.3**	**4.8**
Chilmark	Day	4	46	3	34.5	7	80.5	**3.4**	**3.8**	4	46	2	23	6	69	**2.9**	**3.3**	4	46	1	11.5	5	57.5	**2.4**	**2.7**
Chilmark	Night	4	46	3	34.5	7	80.5	**3.4**	**3.8**	4	46	2	23	6	69	**2.9**	**3.3**	4	46	1	11.5	5	57.5	**2.4**	**2.7**
Chilmark	Total	8	92	6	69	14	161	**6.7**	**7.7**	8	92	4	46	12	138	**5.8**	**6.6**	8	92	2	23	10	115	**4.8**	**5.5**

CHPPD Triggers

	Green		Amber		Red	
Ward	CHPPD Total Beds	CHPPD Average Occupancy	CHPPD Total Beds	CHPPD Average Occupancy	CHPPD Total Beds	CHPPD Average Occupancy
AMU	9.7	7.7	9.3	7.3	7.3	5.8
Durrington	6.9	6.9	5.3	5.3	3.8	3.8
Farley Stroke	6.4	7.1	5.8	6.4	5.4	6.0
Hospice	9.5	10.5	7.2	8.0	5.3	5.9
Pembroke	6.9	8.6	6.9	8.6	4.6	5.8
Pitton	5.8	5.8	5.4	5.4	4.1	4.1
Redlynch	6.7	6.4	5.4	5.2	4.8	4.6
Spire	6.0	6.6	5.2	5.8	4.7	5.2
Laverstock	7.1	6.1	5.8	5.0	5.4	4.7
Breamore	6.4	5.8	5.6	5.0	4.3	3.9
Tisbury	6.5	6.8	6.0	6.3	4.5	4.7
Whiteparish	5.3	5.6	4.5	4.7	2.0	2.1
Longford	7.4	8.3	6.8	7.5	5.7	6.3
Britford	6.7	7.4	6.3	7.0	5.2	5.8
Downton	4.9	5.6	4.3	4.9	3.8	4.4
Odstock	7.2	7.7	6.1	6.5	5.4	5.8
Amesbury	5.8	6.3	5.0	5.6	4.3	4.8
Chilmark	6.7	7.7	5.8	6.6	4.8	5.5

Bed Numbers			
CHPPD Total Beds	Number of Beds	SD Beds	Average Occupancy (past 6 months)
Amesbury	32	0	29
AMU	19	0	24
Breamore	20	4	22
Britford	20	1	18
Chilmark	24	0	21
Downton	24	2	21
Durrington	21	2	21
Farley Stroke	30	0	27
Hospice	10	0	9
Laverstock	19	1	22
Longford	39	0	35
Odstock	17	0	16
Pembroke	10	0	8
Pitton	25	2	25
Redlynch	24	3	25
Spire	30	0	27
Tisbury	23	0	22
Whiteparish	23	0	22

Neonatal Staffing report 2022

Neonatal Staffing

1. Purpose

- The review has been undertaken utilising National published recommendations for Neonatal staffing:
- British Association of Perinatal Medicine (BAPM) June 2018
- National Quality Board (2016). Safe, sustainable and productive staffing - An improvement resource for neonatal care Supporting NHS providers to deliver the right staff with the right skills, in the right place at the right time- Safe, sustainable and productive staffing.
- National Institute for Health and Care Excellence (NICE) quality standard (QS4) for neonatal specialist care (2010),

The senior neonatal nurse and the head of maternity and neonatal services reviews the service and workforce in line with the recommendations and standards outlined in the above documents on a monthly basis.

2. Neonatal Services staffing review methodology

2.1 The department has been in escalation on 22 days from January 2022 to August 2022. The service has had a mixture of higher acuity and cot capacity against plan in this time because of a rise in the number of overall admissions. This was successfully mitigated by NICU staff, Maternity staff, and the use of bank nurses, despite the ongoing high sickness rates and COVID isolation periods. Only 3 of these days were unsuccessfully mitigated as staff were not found to cover the shifts despite all avenues (including agency) be explored.

2.2 All units within the local Neonatal network are utilising a recognised acuity tool (Badger) which enables staff to consider the staffing, capacity and activity in real time and activate escalation when necessary. The senior nurse produces a monthly acuity report to there is clarity around activity.

2.3 Within the staffing numbers 70% of RNs are expected to be Qualified in speciality (QIS) and the unit is currently at 73%. This is a slight decrease from 80% in 2021. The QIS training has come out of the university set-up and is being delivered by the neonatal network with the backing of Health Education England (HEE). We will continue to secure 1 to 2 places on the QIS course each year to ensure we continue to meet national targets on specific neonatal nurse training. This year we have 1.0WTE equivalent nurse taking on this training.

2.4 The service received a significant uplift in funding in April 2022. This funding is central funding allocated to us from the National Clinical Care Review (NCCR) fund. £128,809/year. This extra money is for investment into practice education & patient facing care and has been invested and recruitment is complete. Please see link below for breakdown of spending:

3 **Challenges**:

2022.23 neonatal funding tracker - Sa

- Key challenges within the neonatal unit have been a mixture of medium term, short term sickness and the ongoing coronavirus pandemic and all of the changes that go with this. Sickness has been up to 5.3% which has been a small rise from 4.8% in 2021. This has been hard to mitigate this year but has successfully been achieved with the use of bank staff and using an adhoc on call system when acuity low. Flexibility across post-natal and Sarum ward to support when the neonatal service goes into escalation further reduces the need for agency staff, although agency has been utilized on a few occasions this year (approx. 3 shifts).
- There is a national initiative (ATAIN) to reduce the number of babies admitted to a neonatal service. This demands a transitional care provision which was developed within SFT in 2018 and the neonatal nurses are providing an outreach service to the postnatal ward for transitional care babies. The neonatal unit has been able to continue this service despite the challenges of the last year.
- Going forward there are going to be gaps in the rota created for a few differing reasons:
    - Band 5 maternity leave (2.63WTE) we have 0.4WTE returning later this year.
    - Higher rates of medium- & short-term absences continue to remain high as a result of the pandemic coupled with unclear messaging in regard to self-isolation, quarantine restrictions and the awaiting coronavirus swab results for staff.

4. Strategies in place for maintaining recruitment and retention of staff

4.1 The following strategies are being utilised to maintain the recruitment and retention across the maternity workforce:

- 1 staff member (1.0WTE) undertaking QIS training 2022-23.
- Continue drive in getting staff trained in New-born life support. We have sent 2 staff this year and have another 4 places secured
- With the increased funds we have recruited 2.0WTE band 5 development nurses to protect continuity of staffing around maternity leave.
- Practice educator has been employed 0.6WTE (Band 7) this will ensure that we will be able to continue to deliver our internal training days and ongoing nurse training and development will be protected.
- Monthly assessment of staffing and effective forecasting.
- The infant feeding continues under neonatal management. This change has aided us in getting central funding to roll out baby friendly standards within NICU to mirror the certification that maternity has already gained. We now have an infant feeding team that can cover 6 days/week continuously despite AL etc. which is more robust – please see neonatal funding tracker for out line.

5.0 Recommendations

- To note the improvements and the on- going progress in recruitment.
- To note and continue to support the plan to maintain the current staffing to manage maternity leave and sickness.
- **Introduce on-call payments for staff when acuity low to be able to manage the unit more cost effectively. This would reduce bank payments but give incentive and flexibility to react to the needs of the service.**

Salisbury NHS Foundation Trust

Report to:	Trust Board (Public)	**Agenda item:**	6.1
Date of Meeting:	03 November 2022		

Report Title:	Register of Seals – Quarter 2			
Status:	**Information**	**Discussion**	**Assurance**	**Approval**
	✓			
Approval Process (where has this paper been reviewed and approved)	Approved by Lisa Thomas, Director of Finance and Stacey Hunter, Chief Executive			
Prepared by:	Sasha Grandfield, PA and Board Support Officer			
Executive Sponsor (presenting):	Fiona McNeight, Director of Corporate Governance			
Appendices				

Recommendation:
The Board is asked to note the entries to the Trust's Register of Seals which, while not formally authorised by resolution of the Trust Board, have been authorised through powers delegated by the Trust Board.

Executive Summary:
To report entries in the Trust's Register of Seals since the last report to Board in July 2022. None of the signatories who witnessed the fixing of the seal of Salisbury NHS Foundation Trust had an interest in the transactions they witnessed.

Register of Seals entries

No.	Date signed in Register	Approval Details	Held on file with:	Signature one:	Signature Two:
370	23 August 2022	Lease relating to new health care centre, Westbury, between (landlord) Leighton Health Ltd and SFT (tenant)	Laurence Arnold	Lisa Thomas	Stacey Hunter

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