Bundle Trust Board Public 5 October 2023

1 OPENING BUSINESS

1.1 10:00 - Presentation of SOX certificates
Jane Dickinson – presentation of Shadow Board certificate
September SOX of the month – Isaac Rooney, Lou Figures, Maddie Herridge and Chloe Farley, Spinal Treatment Centre
September Patient Centred SOX – Anne MacRae, Gastroenterology

1.2 10:10 - Staff Story
Presented by Melanie Whitfield
Jon Thorne and Elizabeth Swift attending

1.3 Welcome and Apologies
Apologies received from -
Rakhee Aggarwal, Ian Green, Richard Holmes

1.4 Declaration of Interests, Fit & Proper / Good Character

1.5 10:30 - Minutes of the previous meeting
Minutes attached from meeting held on 7 September 2023
For approval
1.5 Draft Public Board mins 7 September 2023

1.6 10:35 - Matters Arising and Action Log
1.6 Public Trust Board Action Log

1.7 Register of Attendance
1.7 Register of Attendance - Public Board 2023-24

1.8 10:40 - Chair's Business
Presented by Eiri Jones
For information

1.9 10:45 - Chief Executive Report
Presented by Stacey Hunter / Lisa Thomas
For information
1.9 CEO October Trust Board
1.9 AHA Aug September 23 Briefing 021023 V1.0

2 FINANCIAL AND OPERATIONAL PERFORMANCE

2.1 10:55 - Winter Plan
Presented by Lisa Thomas/Jane Dickinson
For assurance
2.1a WINTER PLAN cover sheet
2.1a WINTER PLAN

2.2 Review of Trust Strategy Progress Report - deferred to December

3 ASSURANCE AND REPORTS OF COMMITTESS

3.1 11:05 - Clinical Governance Committee - 26 September
Presented by Eiri Jones
For assurance
3.1 Upward Report from September 2023 CGC to October 2023 Trust Board

3.2 11:10 - Finance and Performance Committee - 26 September
Presented by Debbie Beaven
For assurance
3.2 September Escalation Report from F^L0P

3.3 11:15 - Trust Management Committee - 27 Septmeber
Presented by Lisa Thomas
For assurance
3.3 TMC September Escalation Report

3.4 11:20 - People and Culture Committee - 28 September
Presented by Eiri Jones
For assurance

3.4 Upward Report from September 2023 PCC to October 2023 Trust Board

3.5 11:25 - Audit Committee - 21 September
Presented by Richard Holmes
For assurance

3.5 Audit Committee Escalation Report

3.6 11:30 - Integrated Performance Report to include exception reports
Presented by Mark Ellis
For assurance

3.6a IPR Cover Sheet - Trust Board 2023-09
3.6b Integrated Performance Report Oct 23 v4

4 STRATEGY AND DEVELOPMENT

4.1 12:00 - Improving Together Quarterly Update Report Q2
Presented by Peter Collins / Alex Talbott
For assurance

4.1 Improving Together Quarterly Trust Board Report Oct 2023

4.2 Review of Trust Strategy Progress Report (deferred to December)

4.3 12:10 - BREAK - 30 MINUTES

5 QUALITY AND RISK

5.1 12:40 - Board Assurance Framework and Corporate Risk Register
Presented by Fiona McNeight
For assurance

5.1a Trust Board BAF report October 2023
5.1b Board Assurance Framework September 2023 V1 Draft
5.1c Corporate Risk Register 080923
5.1d CRR tracker v1 September Board Committees 2023

5.2 12:50 - Patient Experience Report Q1
Presented by Judy Dyos
For assurance

5.2a Patient Experience - Patient Feedback Report Q1 23-24 v3.0
5.2b APPENDIX 2 HWW Survey Feedback - Action Plan v5
5.2c ii APPENDIX 3 SFT 23-24 Patient Complaints Audit ToR FINAL
5.2d APPENDIX 4 Friends and Family Feedback all Divisions Q1
5.2e APPENDIX 5 YVM - Bereavement Survey Report Q1 2023-24 v3
5.2f APPENDIX 6 National UEC Survey 2022 - CQC Results v3

5.3 13:00 - Quarterly Learning from Deaths Report Q1
Presented by Peter Collins
For assurance

5.3a Learning from Deaths Report cover sheet
5.3b Learning from Deaths Report

5.4 13:10 - Perinatal Quality Surveillance Monthly Report (CGC)
Presented by Judy Dyos
For assurance

5.4a Front sheet Perinatal quality surveillance September (August Data)
5.4b Perinatal Quality Surveillance monthly report to board September 2023

5.5 13:20 - Maternity Safer Staffing Paper (CGC)
Presented by Judy Dyos
For assurance

5.5a Front Sheet Maternity Neonatal Staffing Report September 2023
5.5b Staffing Report Sept 23
5.5c NICU Staffing paper September 23

5.6 13:30 - Quarterly Risk Report Card Q1
Presented by Judy Dyos
For assurance

5.6 RMRC and risk report Q1

5.7 In-Patient Survey Results – deferred to December

6 PEOPLE AND CULTURE

6.1 13:40 - Guardian of Safe Working Annual Report – deferred from September
Presented by Peter Collins
For assurance
6.1 GoSW annual report 2023

6.2 13:50 - Nursing Skills Mix Review – deferred from September
Presented by Judy Dyos
For assurance
6.2a Safer Staffing Cover Sheet i
6.2b Staffing Report Sept 23
6.2c Appendix 1 CSFS Skill Mix Analysis 2023
6.2d Appendix 2 Skill Mix 2023 Medicine Analysis
6.2e Appendix 3 Skill Mix 2023 Surgery Analysis
6.2f Appendix 4 Costed recommendations Skill Mix 2023
6.2g Appendix 5 ECIST Salisbury supplementary staffing ED Skill mix 2023

6.3 14:00 - Freedom to Speak Up Guardian Board Self-Assessment Tool Kit
Presented by Melanie Whitfield
For approval
6.3a Cover sheet for Public Board Sept 23
6.3b
B1245_iii_Freedom-To-Speak-Up-A-reflection-and-planning-tool_060422.docx-RC_RW_Final_Arial12 (3)

6.4 14:05 - WRES and WDES Report
Presented by Melanie Whitfield
For approval
6.4a Cover Sheet - WRES_WDES 2022-23 AR and Action Plan Trust Board 05.10.23
6.4b WRES AR and Action Plan 2022-23 Final - Board 05.10.23
6.4c WDES AR and Action Plan 2022-23 Final Board 05.10.23

7 GOVERNANCE

7.1 Register of Seals Q2 - no new seals since last report

7.2 14:10 - Approve Board and Committee dates for next year
Presented by Fiona McNeight
For approval
7.2a Board and Committee Dates 2024_25
7.2b 2024_25 Trust Board and Committee Dates v2

8 CLOSING BUSINESS

8.1 14:15 - Agreement of Principal Actions and Items for Escalation

8.2 Any Other Business

8.3 14:20 - Public Questions

8.4 Date next meeting

9 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 7 September 2023, Boardroom/MS Teams
Salisbury NHS Foundation Trust
Boardroom

Board Members:

Ian Green (IG)	Chair
Rakhee Aggarwal (RA)	Non-Executive Director
Debbie Beaven (DBe)	Non-Executive Director
Eiri Jones (EJ)	Non-Executive Director
David Buckle (DBu)	Non-Executive Director
Tania Baker (TB)	Non-Executive Director
Michael von Bertele (MVB)	Non-Executive Director
Richard Holmes (RH)	Non-Executive Director
Stacey Hunter (SH)	Chief Executive Officer
Judy Dyos (JDy)	Chief Nursing Officer
Mark Ellis (ME)	Chief Finance Officer
Peter Collins (PC)	Chief Medical Officer
Melanie Whitfield (MW)	Chief People Officer
Lisa Thomas (LT)	Chief Operating Officer

In Attendance:

Kylie Nye (KN)	Head of Corporate Governance (minutes)
Naginder Dhanoa (ND)	Chief Digital Officer
Jayne Sheppard (JS)	Lead Governor (observer)
Jane Podkolinski (JP)	Governor (observer)
William Holmes (WH)	Governor (observer)
Abi Kingston (AK)	Clinical Director, Women and Newborn (for agenda item 5.6)
Vicky Marston (VM)	Interim Director of Midwifery (for agenda item 5.6)
Michelle Sadler (MS)	Shadow Board (observer)
Kate Jenkins (KJ)	Shadow Board (observer)

ACTION

TB1 07/09/1 OPENING BUSINESS

TB1 070/09/1.1 Presentation of SOX (Sharing Outstanding Excellence) Certificates

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

July SOX of the month – Richard Pearce, Facilities
July Patient Centred SOX – Jenny Smith, PALS and Andrea Pearson and Jordon Beresford, Hospice
August SOX of the month – Graham Castle, Estates
August Patient Centred SOX – Katy Preedy, Maternity

IG congratulated all the staff that had been recognised in July and August on behalf of the Board and also thanked all the staff that had been nominated for their hard work and innovation.

SH before staff awards the poignance that we see and feel and hear about these every day and it's a good reflection on the contributions that most staff are making all day every day.

TB1 07/09/1.2 **Patient Story**

VA introduced the patient story which came from a patient who had received a kidney transplant some years ago. The story described her experience, receiving ongoing treatment and how having a transplant had completely transformed her life.

Discussion:

- DBu noted that, as a member of the organ donation committee, he was happy to see a positive organ donation story at the Board. DBu explained the difference organ donation can make to people's lives and that the story was a reminder of the shortage of donors nationally.
- Kate Jenkins noted, as the clinical psychology lead for intensive care, that in her experience the relatives of donors really feel a positive impact knowing that other people have benefitted from organ donation.
- EJ referenced the difficulties there can be when people have signed up to be donors but the family are not content to move forward with donation. Often, clinical teams will go with the relatives wish. PC noted that all clinical staff can do is have the conversation as it is sensitive and difficult when families do resist. All the staff can do is open up the possibility of change and understand it's a personal decision.
- SH noted that it's about being as clear as possible around the benefits but this is best done by the people who are benefitting. SH further noted that staff should be aware of the right teams to get hold of and are directed in the right place when they feel less equipped to have the conversation.
- JDy explained that when there is a potential transplant, the transplant teams are skilled do this work. PC agreed noting that for areas where the conversations need to happen, staff should be linked to support from organ transplant services.
- IG noted that the story was a great reminder for everyone to ensure their families were aware of their wishes to be a donor. IG thanked VA and asked her to send the patient his thanks for sharing her story.

VA left meeting.

TB1 07/09/1.3 **Welcome and Apologies**

IG welcomed everyone to the meeting apologies were received from:

- Fiona McNeight, Director of Integrated Governance

TB1 07/09/1.4 **Declarations of Conflicts of Interest**

There were no declarations of conflict of interest pertaining to the agenda. However, the following items were noted:

- SH noted her standing declaration in relation to being an Integrated Care Board (ICB) Member, noting that there was no conflict of interest with any of the agenda items at the meeting.

TB1 07/09/1.5 **Minutes of the Part 1 (Public) Trust Board meeting held on 6th July 2023**

IG presented the public minutes from 6th July 2023 and the minutes were approved as an accurate record of the meeting.

- EJ noted on pg. 13, the first bullet point should say "the Trust is moving to a new system PSIRF".
- DBu noted that pg. 6. re the point on HSMR, should read "there was no evidence that high HSMR was the result of a patient safety concern".
- On pg. 11, JDy noted that the wording in the patient experience report relating to nutrition and hydration being part of complaint needed updating.

Subject to these amendments, the minutes were agreed as a correct record of the meeting.

TB1 07/09/1.6 **Matters Arising and Action Log**

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

TB1 6/4/3.6 Integrated Performance Report (IPR) (M10)/ Stroke
TB1 4/5/2.5 Integrated Performance Report (IPR) (M11) – The stroke improvement slides were presented at July's F&P Committee but were not discussed due to timing issues. It is on September's agenda. EJ noted that the work around stroke is a good example of triangulation where performance reports to F&P committee, quality outcomes are considered at CGC too.

TB1 06/07/6.2 Health and Safety Annual Report – The report to include near misses' data in future reports to come to Board from Q2 report onwards.

TB1 06/07/7.1 Non-Executive Responsibilities and Committee Composition – IG noted this would be covered under his report to the Board. Item closed.

It was noted that all other matters arising were either closed or to be considered on a future agenda.

TB1 07/09/1.7 **Chair's Business**

IG noted the following key points:

- An updated Fit and Proper Person Test framework was published on 2nd August with proposed changes effective from 30 September. In summary there are implications on how references are sought, provided, and held centrally and through appraisal process. There is also particular obligation of chair to effectively

implement and give assurances to NHSE on annual basis. Regulation of senior leaders in NHS. SH noted that it is right and proper for people at Board level to be regulated. SH explained that there are some technicalities and further guidance will be issued around these.

- The Trust commissioned an external well led developmental review earlier in the year which ended in June. The Board have seen the report which is a fair and honest assessment. An additional session of the Board has been scheduled for early October to discuss. The report reflects areas of development and executives will have time in the development session next week to discuss and once this has been discussed collectively as a Board, the report will be socialised with leadership teams.

- A report came to the last meeting around the requirements to have NED champions for doctors' disciplinary procedures which DBe has agreed to take on. RH has also agreed to be the NED champion for Security Management. IG asked if the Board were content with this and they confirmed their support.

TB1 07/09/1.8 **Chief Executive's Report**

SH presented her CEO report and highlighted the following key points:

- Industrial action is having a profound impact on medical staff and it is getting harder due to the persistent nature. There has been a huge impact on waiting list and leadership capacity. The outcome of the recent ballot revealed that there will be strikes with consultants and junior doctors striking on the same day. SH noted that this industrial action has to be bought to an end as it impacts the Trust's recovery. SH gave thanks to all staff who are supporting the industrial action work.
- Financially, the Trust is focused on delivery of the plan this year which has seen some expected challenges. This is a challenging plan compounded by the impact of industrial action. SH noted that the Board would be discussing the medium-term financial plan in the private session.
- SH noted that the Trust was in the middle of its 'thank you' week, with a variety of events and felt very privileged event to be part of.
- A letter has been received from NHS England (NHSE) in relation to the outcome of the Lucy Letby case. SH explained that there will likely to be wider implications and learning as a result of this case but wanted to take the opportunity to acknowledge the huge amount pain caused and the likely impact on confidence in the NHS due to one person's actions. SH extended her support to the Trust's paediatric nurses who do an incredible job, working and caring for vulnerable babies. JDy noted that the Trust already have a supported plan around some additional work in NICU. SH noted that the Board should take some time to discuss what SFT would have done in a similar situation. SH noted that the NHS has become so reliant on data but from a safety perspective can the Trust be confident in identifying the signal from the noise. The Board was conscious that October is Freedom to Speak up month

in October but this is in place as a last resort. The goal is to enable a speak-up culture for all staff.

Discussion:
RH noted the importance of acknowledging the Lucy Letby case and demonstrating learning and action taken in the short term, i.e., in the next 6 months. SH agreed but suggested that Trusts could be too reactive and not focus on the right actions. There will be a public enquiry and therefore there are aspects of the case that no one is aware of yet. Therefore, the appropriate reflection time is required to ensure the correct action is taken. It was agreed that when more is known this will be a topic for discussion and consideration at a future development session. This will be added to the items for Board development session in 2024. **ACTION: KN** **KN**

DBe suggested that as part of this the Board should consider and discuss the utlisation of data science. DBu also noted the importance of the relevant information and intelligence coming through Clinical Governance Committee. IG noted these points, acknowledging that there is a broader, national piece of work ongoing and further guidance is anticipated.

RA explained that a lot of information has been embargoed and there should be consideration around the impact on workforce and the challenge this creates in terms of recruitment and retention.

JDy agreed that at this point the Trust do not know enough to gain any clear learning. However, from the details we do know, data was not the problem. Ultimately this is about organisational culture.

TB1 07/09/2 **ASSURANCE AND REPORTS OF COMMITTEES**

TB1 07/09/2.1 **Audit Committee – 20 July**

RH presented the report, providing a summary of escalation points from the meeting held on 20th July 2023. RH asked for the report to be taken as read and highlighted the key points as follows:

- We now have newly appointed auditors and a meeting is being organised with senior partners in the Autumn to support collaborative working and effective communication.

The report was noted.

TB1 07/09/2.2 **Clinical Governance Committee – 25th July**

EJ presented the report, providing a summary of escalation points from the meeting held on 25th July 2023. EJ asked for the report to be taken as read and highlighted the key points as follows:

- Ongoing assurance was sought in relation to veno-thrombo embolus performance. This will come back to the Committee in September.
- The Committee have requested further assurance in relation to Mortality and Stroke outcomes.

- EJ noted that this was her last Committee as chair and it had been a privilege to undertake this role.

Discussion:
SH noted that the Trust have asked for some additional support externally around mortality. EJ noted that this a good example of an issue that the Committee and Board have kept a focus on

IG thanked EJ for all her hard work as chair of CGC.

The report was noted.

TB1 07/09/2.3 **Finance and Performance Committee - 25th July**

DBe presented the report, providing a summary of escalation points from the meeting held on 25th July 2023. DBe asked for the report to be taken as read and highlighted the key points as follows:

- There are some improvements in the IPR metrics, e.g., bed occupancy as a result of Same Day Emergency Care (SDEC).
- There has been no significant progress on the Stroke metric which saw a slight improvement in May but does not reveal any consistent improvement.
- The Committee was assured that there had been progress in relation to trajectories, noting that it would be helpful to express these in financial and performance terms. This will be picked by ME and LT.
- The finance report highlighted one of the Trust's biggest challenges in terms of delivery against target. More detail is being worked through to establish an updated forecast for the year.
- The Committee received an update on CIPs. Actions are underway to identify additional schemes and the Committee acknowledged the risks and need for system interventions to the ned occupancy of NCTR patients.
- The Committee discussed the medium- term financial plan and challenges around breakeven within 3-5 years, including what is required from a system perspective. IG noted that there is a role we have to play but SFT cannot do this in isolation.

Discussion:
SH noted that the Trust has not made the expected progress required on outpatient work. LT is doing work at the Planned Care Board, but there may be some additional support required to accelerate this work. IG asked about the full impact of this in terms of patients and finance. LT noted that this will be triangulated for the next IPR. **ACTION: LT** **LT**

DBe agreed that being able to articulate the impact both financially and clinically is important. ME noted that the reporting period was up to June and Industrial Action has increased since then. This has materially impacted activity and the Trust is able to quantify what was cancelled and what was not booked as a result.

TB1 07/09/2.4 **Trust Management Committee – 26th July**

SH presented the report which provided a summary of escalation points from the meeting held on 26th July 2023. SH asked for the report to be taken as read and highlighted the following key points:

- The Trust have reverted back to having a normal TMC every month to keep on top of Trust business. The bi-monthly leadership discussions will be scheduled in separately.
- SH summarised the outcome of the business cases detailed in the paper.
- In terms of the escalation reports TMC received there was a better opportunity to discuss and there was an interesting conversation regarding the Helipad and a Health and Safety Executive (HSE) notice following an incident at another Trust. Assurance work is being led by Ian Robinson with further updates to come back to the committee in the near future.

Discussion:
The Board had a discussion around support for teams in the art of developing business cases. It was noted that this was part of the development work with senior managers. ME noted that he had been working on a new business case template with the Associate Director of Strategy to ensure it followed a measure approach, utilising baseline data and working through the rationale methodically. IG noted that business planning needs to be consistent with the Improving Together methodology.

KJ noted that writing business cases is a very daunting task but the shadow board is helping enormously, and going to committees and listening to priorities helps to streamline the thought process. It is helpful to have the experience, but workshops or mentoring would also help.

EJ expressed her disappointment that the Registered Nurse Degree Apprenticeship (RNDA) business case couldn't be supported. JDy noted the challenges as aspects of the business case were taken apart from the original one submitted. The outcome was that ME, JDy, and FH need to develop an approach to put forward something in the pipeline over time. There needs to be a further look at trajectories to support robust planning going forwards.

SH noted her support but that the Trust was not reducing agency spend in nursing with the current plan. There needs to be a strategic route through to achieve this.

The report was noted.

TB1 07/09/2.5 **People and Culture Committee 27th July**

MvB gave a verbal update from the meeting held on 27th July 2023. MvB highlighted the following key points:

- The Committee discussed the long-term workforce plan, including new ways of working, potential new professions, the People Promise and ultimately, an effective workforce strategy. What is

clear in terms of the workforce strategy is that is not a one size fits all scenario.

- The Committee discussed the Winter Plan, bed occupancy, the staff needed and potential recruitment support. This was highlighted as an area of risk.
- The Committee received the IPR and the outcome of the discussion pointed to more granularity to understand weak areas in the metrics, e.g., the lag time in recruitment. However, there was good detail in terms of challenges at a divisional level.
- The Committee received the standard EDI reports which somewhat fail to take account of SFT's unique circumstances. The focus of the Board is to understand why SFT is different and take the right steps to support all staff. MvB pointed to generational differences and the differences in how people approach work, mental health challenges etc. which should be in diversity plan.

Discussion:
SH noted that the Winter Plan will come to board and it's not a plan that will encourage widescale recruitment. LT provided an update noting that the urgent and emergency board and planned care board were both focused on programmes of work that support the Winter Plan.

MW further highlighted the discussion around encouraging a greater contribution and completion of the Trust's Pulse Surveys. Action plans are Trust and division wide.

IG noted that this was MvB's last People and Culture Committee as chair and thanked him for his support and work in the Committee over the last few years.

TB1 07/09/2.6 **Integrated Performance Report (IPR) (M4)**

MW presented the Integrated Performance Report which provided a summary of July 2023 performance metrics.

MW noted that a lot of the key highlights had already been discussed as part of the Committee escalation reports but noted the following:

- There has been success as part of the breakthrough objectives in terms of falls and length of stay.
- MW recognised the work around recruitment and absence management. However, noted that retention of staff is still proving challenging.
- Industrial action continues to have an impact across the Trust and this will be even more so in the coming weeks with both junior Drs and consultants planning strike action at the same time.

Discussion:
IG noted that at the recent chief executive and chairs conference, Amanda Pritchard had made it clear that the ongoing Industrial Action has to be resolved. SH noted that there will be a huge impact on activity in September with both groups of staff striking.

TB noted the positive improvement as part of the focused breakthrough objectives and the fact that we are building them through a methodology that is robust and will have more benefits over time.

TB further raised that the Mortality metrics are flagging concerns and, as a public document, the commentary should tie back to the external review as part of the mitigating actions.

TB referenced the waiting times for appointments and that the impact is forcing people to utilise private healthcare in some instances. This can cause patients to dip in and out of NHS care and TB suggested a heightened awareness of how the Trust communicates with its patients and colleagues around the rules. SH noted that the Access Policy is clear from an internal viewpoint. This is about public communication and individual clinical behaviour but it is assumed people are acting with integrity. It was suggested that the Access Policy could be published on the Trust's website (*post meeting note: Microguide, the Trust's document system, is available to the public).* PC noted the longer-term implications around equity, access of healthcare and inequalities.

EJ referenced the cover sheet which noted the sections had been approved by the responsible committee. Governance-wise each committee doesn't approve their section but they receive and seek further assurance. Therefore, future cover sheet needs to be updated. **ACTION: LD/LT** **LD/ LT**

The Board discussed the mortality data, with the lag time in reporting discussed again. PC noted that he would be happy to reappraise the Board or CGC with the rationale behind the delay in reporting and noted the key benefits of accurate coding and ensuring the Trust does not respond reactively. This reasoning was acknowledged with suggestion that this detail really did belong in the narrative in the IPR. Additionally, IG suggested that this should perhaps be included as part of the external review and if there are any recommendations as a result in terms of reporting.

The Board further discussed waiting times with further assurance sought around additional action to improve this position and sustain improvements. LT noted that this will be picked up in F&P. However, the outpatient wating times will take some months to address due to the deep-rooted cultural ways of working that need to be addressed. SH noted that the countermeasure to waiting times is clinical validation which is also impacted by industrial action.

KJ noted that mortality had been discussed at the Shadow Board and suggested she follow up on the actions suggested and conversation at Board to feedback through to Shadow Board and review how each group interpreted.

TB1 07/09/3 **FINANCIAL AND OPERATIONAL PERFORMANCE**

TB1 07/09/3.1 **SIRO Annual Data Security & Protection Assurance Report (includes Toolkit Self-Assessment and Data Protection Annual Report and GDPR) – deferred from July.**

ND presented the quarterly SIRO report, providing an update on progress made, highlighting areas of improved compliance with statutory and regulatory standards overseen by the Information Commissioners Office (ICO). ND highlighted the following key points:

- The Trust's Freedom of Information compliance consistently exceeds the 90% set by the ICO.
- The Trust achieved the 2022/23 DSPT assessment. Whilst the 95% was achieved, ND urged everyone to continue encouraging the DPST training, accessed via the MLE Learn system.
- Whilst the Trust's FOI compliance consistently exceeds the 90% set by the ICO, the IG team often struggle to get information back from the divisions, largely due to the pressure of work and the current industrial action.
- GWH and SFT IG teams continue to work well together. There is work on developing a business case to support the growth of coders.
- Everyone has now transitioned to Windows 10 from Windows 7.
- ND thanked those who have supported compiling the reports which contained further detail. Internal audits provide a significant level of assurance.

Discussion:
SH noted that either her or FMc sign off the FOI requests with a majority coming from different companies.

MW referred to corporate services, noting that within those departments there are difficulties in terms of access to data. MW suggested it would be useful to have corporate services data separated to get more of an idea of themes within departments.

DBu queried if there are any cyber security concerns. There was one recent cyber-attack last month, of which the outcome was not significant. However, ND noted that cyber security is always concerning but the Trust is currently mitigating the risk well. RH challenge cyber-attack, there is ongoing cyber-attacks (successful cyber-attacks) Most likely circumstance that results in an attach is human error. Continual training to encourage people to be sensible. ND spam link. E.g., NHS E email. Send to IT.

Approve recommendations in report.

TB1 07/09/3.2 **Protecting and expanding elective capacity**

LT presented the report asking the Board to note the draft completions and delegate final sign off for submission to September's Finance and Performance Committee. LT noted the following key points:

- The Trust received a national letter on the 4th August focusing on protecting and expanding elective capacity during winter. Boards have been asked to consider several questions regarding outpatient activity namely:

  - Identifying more opportunities for outpatient transformation

- Set an ambition that no patient in the 65-week cohort will be waiting for a first outpatient appointment after 31st October 2023.
- Maintain an accurate and valid waiting list, by ensuring that at least 90% of patient waiting over 12 weeks are contacted and validated by 31st October 2023.

The Board need to sign off the self-certification process by 30th September 2023.

Discussion:
EJ PIFU, most deprived group without tech then you will not be aware of PIFU and lost in the system. Happy to note in draft and this will be EJ which will sign off.

Decision:
The Board were content to note the draft and delegate authority to F&P in September for final sign off.

TB1 07/09/4 **QUALITY AND RISK**

TB1 07/09/4.1 **Risk Management Strategy 3 yearly report – deferred from May**

JDy presented the report which sets out the strategic direction for Risk Management. It provides a framework for the Trust, specifying the direction of travel with objectives, responsibilities and monitoring mechanisms.

JDy noted that there may be some adjustments in relation to the outcome of the external well-led review and the Lucy Letby case. However, the team have worked hard to get the strategy to this stage, tying in PSRIF and Improving Together. The plan is to organise staff briefings to take forward the strategy and also work through with divisional teams.

Discussion
IG thanked JDY and the team, noting it was a welcome document and sets out a clear approach.

DBe noted that it was an excellent, detailed document but she would feedback outside of the meeting regarding some language that could be updated.

TB1 07/09/4.2 **Quarterly Maternity Quality and Safety Report**

This item was taken after agenda item 6.3.

JD introduced Vicky Marston who was now the substantive Director of Maternity and Neonatal Services. JD asked VM to update the Board on recent neonatal data and plans put in place.

VM referred to the Lucy Letby case and work which was ongoing with neonatal matrons and staff. VM noted a listening event had been arranged for staff in the Maternity Department to talk through how they feel and gauge the support they require.

VM noted a review of all neonatal deaths over the last five years had been carried out, the data showed one neonatal death due to incompatible with life had occurred, neonatal deaths would continue to be reviewed quarterly. IG asked if there was anything in the data for the Board to be concerned about. VM confirmed there was not and the baby that died had received palliative care.

EJ noted her attendance at the monthly peri natal heath review board and added each case is looked at in detail and a consensus opinion agreed with those present.

SH noted her attendance at a recent national NHS event which had focused on the early reflections of the Lucy Letby case. SH added this case could have happened anywhere, but the Trust needed to reflect how it could have been detected sooner. SH reflected small teams developed close relationships with each other which made it hard to raise difficult issues.

PC provided assurance in the governance process and noted the reporting had changed and perinatal and neonatal deaths now get reported to the Learning from Deaths Committee which gave an extra layer of scrutiny.

VM highlighted the following points from the report:

- There had been one still birth in quarter 1.
- There had been one neonatal death, the baby had received palliative care.
- Correction to report which stated the number of still births so far this year had been 1.8 per 1000, this should read 3.8 but this was still below the national expectation of 4.1.
- Only 3 still births so far in 2023.
- One outstanding PMRT case.
- Progress made with Ockendon since Q1

SH expressed concern that Salisbury was the only Trust in the ICS that had not completed the Ockendon recommendations. VM noted there had been no specific ask as to what evidence should be presented but Salisbury would try to be transparent and present good evidence, hopefully with completion in this quarter.

VM gave a summary of the progress made with training, the maternity safety champion and recruitment and noted midwifery staffing was still a challenge but still able to maintain safety and 1:1 care at all times. VM gave an update on the use of steroids in caesarean sections and the birth centre.

MS noted this report had been discussed at the Shadow Board. The Shadow Board had expressed concern regarding an outstanding action of over a year in the report, VM noted the Professional Midwifery Advocate had been launched to support staff and enable staff to express concerns regarding serious incidents. JD added a caveat to the staffing as reaching the establishment did not include any additional continuity of care models.

VM noted the Birth Rate Plus assessment had been redone due to some of the information collected not being accurate. VM added collecting data would take until the end of November and that may well change the establishment and increase non-clinical roles.

SH asked if there were any material concerns that would not come through in the data, VM noted the geography of the hospital and the nature of the site were both challenging, in an ideal world post-natal care and neonatal care would be located together with transitional care in the middle. VM added from a cultural perspective there had been a lot of changes in leadership and a restructure with new individuals in roles who need support. SH suggested the next Women and Newborn Executive Performance Review look at the estates challenge and consider if there is sufficient mitigation in place.

EJ referred to CQC reports from other trusts and asked where we were with implementing a total triage model. VM noted Salisbury used the Birmingham specific model, patients ring in and are assessed as green, amber or red and quickly triaged, then guidance used to work out how quickly they are seen. VM noted the system worked well but sometimes times were breached. EJ noted the Birmingham Obstetric Triage System was the recommended triage model.
JD noted triage was a challenge in terms of the documentation required but that would improve after badger net had been introduced.

The Board noted the report.

TB1 07/09/4.3 **Perinatal Quality Surveillance Monthly Report**

VM presented the Perinatal Quality Surveillance Monthly report which the board received monthly for oversight. VM noted the following key points:

- Staffing is noted and recognised that there are challenges in establishment.
- Midwife ratio is 1:30 recommended ratio is 1:26.
- Achieved 1:1 care in labour at all times.
- Two Datix related to workforce action.
- PMRT no outstanding actions.
- Six moderate incidents occurred.

IG thanked VM and congratulated her on her new role. IG asked VM to provide feedback to the board in a few months' time on the cultural piece. **ACTION VM** **VM**

The Board noted the report.

TB1 07/09/5 **PEOPLE AND CULTURE**

TB1 07/09/5.1 **Nursing Skills Mix Review – deferred to October**

The Board noted the Nursing Skills Mix Review had been deferred to the October Trust Board meeting.

TB1 07/09/5.2 **Guardian of Safe Working Annual Report – deferred to October**

The Board noted the Guardian of Safe Working Annual Report had been deferred to October.

TB1 07/09/5.3 **Freedom to Speak Up Guardian Annual Report**

MW introduced Elizabeth Swift, the Freedom to Speak Up Guardian and asked her to present the report. ES noted the following points:

- Cases were increasing.
- Since the Letby case senior leaders had been written to by NHSE to ask for assurance that staff had access to Freedom To Speak Up (FTSU).
- FTSU now well-known across the organisation with cases coming from all staff groups.
- Some cases were not appropriate for FTSU and should be dealt with through line management.
- Working on board self-reflection tool which should be completed by January 2024.
- Policy ratified and would be launched in October.
- Data was currently triangulated with patient experience, risk and litigation, it was proposed to widen this triangulation to include occupational health, health and safety and employee relations.
- Concern regarding lack of contact with agency staff and contractors who could be difficult to manage and transient.

Discussion:

RH referred to table 6.1 and noted the high figures relating to inappropriate attitude and behaviours. ES noted this usually related to a breakdown of relationships within a team which lead to the member of staff being unable to go to their line manager.

IG noted this report had been discussed at Shadow Board the day before and asked MS to feedback. MS asked if the number of concerns raised had gone up due to staff knowing about FTSU or because incidences had increased. ES noted it was hard to tell but FTSU was well known in the organisation and she made sure to meet every new starter and all international recruits.

MS referred to the report and noted 20% of cases reported were attributed to BAME staff, MS asked if line managers could do more to support staff. ES noted her work with equality and diversity but added staff from BAME backgrounds just didn't want to come forward.

MS referred to MLE and noted the increase from the previous year with half of staff completing the mandatory training, MS noted previously the trust had 10-12 mediators that had gone through ACAS training but now there were only 2 mediators, MS asked if more mediators would help to stop issues escalating and resolve problems quicker. ES noted this could be an option but at present did not want to offer mediation in case there was no mediator available.

RA reflected on the triangulation work and added it would be good to extend the triangulation to leadership training and the staff survey to see if themes were similar. RA added this could assess the impact of leadership training and staff expectations of their leaders. ES noted she ran a session for transformational leaders and aspiring leaders to let them know what the expectations are of them.

SH reflected on the Letby case and noted Salisbury had an established Freedom to Speak Up culture but added the focus of the role must be on safety and not a catch all for all issues.

MW referred to unacceptable behaviour and noted her work on a behaviour charter which promoted civility, respect, and kindness.

DBu noted the bench marking in the report which showed that Salisbury was not out of kilter and the numbers of cases were going up nationally.

IG noted the Board's responsibilities regarding Freedom to Speak Up and the Board agreed the recommendations in the report.

EJ noted the action for the Board to sign of the self-reflection tool and added it would be on the People and Culture Committee agenda in October/November. IG noted the Trust Board would then receive it in December.

TB1 07/09/5.4 **Health and Safety Annual Report and Q1**

This item was taken after agenda item 4.1.

MW noted the report had previously been received at the Health and Safety Committee and the Trust Management Committee. MW highlighted the following points:

- Ongoing work on the health and management system to include making staff aware of their responsibilities regarding health and safety.
- Report now includes a schedule and plan of work.
- Considerable increase in data showing violence and aggression towards staff, Health and Safety Officer now chairs the Violence and Aggression Committee.

Discussion:

IG expressed concern regarding the number of cases of violence and aggression towards staff and noted it was important to provide support to staff who had been the subject to violence and aggression.

SH noted the recent publicity regarding RAAC concrete in public sector buildings. SH noted the Director of Estates had confirmed there was no RAAC on site. NHSE had asked for further assurance and the Director of Estates would lead this work on behalf of board.

LT referred to her recent 'go and see' visit to Security and added a number of measures had been put in place to support teams but extra

support had been provided to Security as the team was often involved in incidents of violence and aggression due to the nature of their work. LT acknowledged there was more work to do to support staff but as an organisation progress had been made. IG requested the next report contain more details on the support available to staff and added a trajectory showing if incidents were getting better or worse would also be helpful. **ACTION MW** **MW**

DBe expressed concern regarding the number of injuries to head and face and asked if mental as well as physical support was offered to staff following patient attacks. MW explained analysis had shown a number of the head and face injuries were accidents caused by staff bumping into furniture and things falling from a height but there had been incidents of staff being hit by patients.

EJ noted the report cover sheet had a good executive summary and the report contained good detail, EJ asked for the next report to contain more information on what the Trust was doing to improve.

JDy noted the report indicated a possible link to dementia management being a factor in cases of violence and aggression and added mental care processes were being reviewed with the Dementia Lead Nurse.

IG referred to a recent 'go and see' visit to Sarum Ward and noted the damage caused by patients with mental health issues.

RH asked if there was different expertise represented on the Health and Safety Committee, MW noted a number of specialist sub committees reported into the committee and both operational and management staff were members.

The Board noted the report.

TB1 07/09/6 **GOVERNANCE**

TB1 07/09/6.1 **Remuneration Committee Terms of Reference Review**

This item was taken after agenda item 5.4.

IG presented the report and noted Rakhee Agarwal was now the Chair of the Remuneration Committee. IG added the terms of reference had been reviewed and set against best practice from other trusts.

Discussion:

EJ asked if Non-Executive Directors who were not formal members of the committee could attend. IG noted all Trust Non-Executive Directors were welcome to attend the Remuneration Committee.

MW noted paragraphs 3.5 and 3.6 were repetitive and made the same point, MW suggested the two paragraphs could be one.

Subject to this amendment the Board approved the Terms of Reference.

TB1 07/09/6.2 **Annual Report and Accounts**

IG presented the report and noted the Annual Report and Accounts had been previously approved by the Trust Board and had now been submitted to parliament.

Discussion:

SH noted the work that had gone into compiling the Annual Report and Accounts SH added it was a well written document and thanked KN. (and SG for her pdf skills ha ha) SH noted the report was an important document as it gave members of public who were interested in their local hospital information on how hospital is run.

RH asked for confirmation of the work to coalesce the annual report into an easier document to read. SH noted a more accessible version of the Annual Report and Accounts would be ready in time for the AGM.

The Trust Board noted the report.

TB1 07/09/6.3 **Annual Review of Board and Committee Effectiveness**

This item was taken after agenda item 6.2.

IG presented the report which reviewed the effectiveness of the committees and noted there was not a review of the Charitable Funds Committee due to timing issues. IG confirmed the Charitable Funds Committee had been operating effectively and robustly and would be included in the review next year. IG added board site with trustees separate conversation.

EJ noted her thanks to KN for compiling the report.

The Board noted the report.

TB1 07/09/7 **CLOSING BUSINESS**

TB1 07/09/7.1 **Any Other Business**

There was no other business.

TB1 07/09/7.2 **Agreement of Principle Actions and Items for Escalation**

IG summarised the board's discussion.

- The Winter plan would be on the September Finance and Performance Committee agenda and a further report to the Board in October.
- The medium-term financial plan discussion would continue in the Private session.

- The impact of the Letby case had been discussed the Board would pick up again when there was more information and respond with the appropriate focus on culture.
- The Well Led review would be discussed further at a future public board meeting.
- Separate work on mortality commissioned.
- Ockendon compliance and trajectory needed more understating on what is required to comply.

IG thanked the Shadow Board colleagues for their feedback.

TB1 07/09/7.3 **Public Questions**

William Holmes asked if the Board were aware of the recent Terence Higgins secret shopper into Sexual Health. IG noted the challenge for patients to access sexual health services but explained the responsibility sat with the local authority to fund the service and the NHS to provide the service, IG added he was sighted. PC noted his recent 'go and see' to Sexual Health and added access to the department had been discussed.

TB1 07/09/7.4 **Date of Next Public Meeting**

The next Public Trust Board meeting will be held on 5th October 2023, in the Board Room, Salisbury NHS Foundation Trust

TB1 07/09/8 **RESOLUTION**

TB1 07/09/8.1 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

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

1	Deadline passed, Update required
2	Progress made, update required at next meeting
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	TB1 07/09/1.8 Chief Executive's Report	05/10/2023	Kylie Nye, KN	It was agreed that when more is known on the outcome of the Lucy Letby case this will be a topic for discussion and consideration at a future development session. This will be added to the items for Board development session in 2024.	**On the list of discussion topics on the Board development schedule**	Y	3
Trust Board Public	Sasha Grandfield	TB1 07/09/2.3 Finance and Performance Committee - 25th July	05/10/2023	Lisa Thomas, LT	LT will ensure that the financial and patient impact of outpatients performance would be triangulated in the IPR. .		N	2
Trust Board Public	Sasha Grandfield	TB1 07/09/2.6 Integrated Performance Report (IPR) (M4)	05/10/2023	Lisa Thomas, LT	Coversheet of IPR mentions that Board Committees approve their section of the IPR. This does not take place and therefore the coversheet should be amneded to reflect that the Committees receive the IPR to gain assurance. - they do not approve.	**Cover sheet updated**	Y	3
Trust Board Public	Sasha Grandfield	TB1 07/09/4.3 erinatal Quality Surveillance Monthly Report	11/01.2023	Vicky Marston, VM	IG asked VM to provide feedback to the board in a few months' time on the cultural piece in maternity.		N	4
Trust Board Public	Sasha Grandfield	TB1 07/09/5.4 Health and Safety Annual Report and Q1	11/01.2023	Melanie Whitfielf, MW	IG requested the next report contain more details on the support available to staff and added a trajectory showing if incidents were getting better or worse would also be helpful.		N	4

Register of Attendance – Public Board 2023/24

	6 April	4 May	6 July	7 September	5 October	7 December		attendance rate
Tania Baker	✓	✓	✓	✓				4/4
Michael von Bertele	✓	✓	✓	✓				4/4
Stacey Hunter	✓	✓	✓	✓				4/4
Lisa Thomas	x	✓	✓	✓				3/4
Judy Dyos	✓	✓	✓	✓				4/4
Melanie Whitfield	✓	✓	✓	✓				4/4
Eiri Jones	✓	✓	✓	✓				4/4
Rakhee Aggarwal	✓	✓	✓	✓				4/4
David Buckle	✓	✓	✓	✓				4/4
Peter Collins	✓	✓	✓	✓				4/4
Mark Ellis	✓	✓	✓	✓				4/4
Debbie Beaven	✓	✓	✓	✓				4/4
Richard Holmes	✓	✓	✓	✓				4/4
Ian Green	✓	✓	✓	✓				4/4

Governor Observer							
Lucinda Herklots		✓					
Jane Podkolinski	✓		✓	✓			
Jayne Sheppard			✓	✓			
Frances Owen			✓				
William Holmes				✓			

Attended - ✓

Apologies – X

NHS Salisbury NHS Foundation Trust

Report to:	Trust Board (Public)	Agenda item:	1.9
Date of meeting:	5 October 2023		

Report title:	Chief Executive's Report			
Status:	Information	Discussion	Assurance	Approval
	x		x	
Approval Process: (where has this paper been reviewed and approved):	None			
Prepared by:	Lisa Thomas, Chief Operating Officer			
Executive Sponsor: (presenting)	Stacey Hunter, Chief Excutive			

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

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 in September 2023.

1.0 Our Population

1.1 Operational Context

The detailed performance is shared in the Integrated Performance Report which, similar to last month shows sustained progress in some of the urgent care improvements and positive progress in two out of our four breakthrough objectives (Falls and LOS).

There are more pressures and challenges in meeting our planned care improvement targets, partly driven by the continued industrial action. In September Consultant medical staff were on strike from the 19th of September to the 22nd of September and Junior Doctors 20th September to the 22nd of September, this was the first month the action meant both groups of medical staff were striking at the same time.

Our clinical, operational and EPRR colleagues once again did a fantastic job in the oversight of the activities during that week and in the preparation before. I continue to be grateful to all colleagues who are involved, both recognising the significant time requirement placed on leadership teams who plan to mitigate the action and those colleagues who cover during the striking periods.

In the last few weeks of September, the Trust has been operationally very busy with an increase in Covid cases, greater number of ambulances and an increase in staff sickness placing the hospital in its highest escalation level (OPEL 4). This has given the organisation a glimpse of what challenges the winter period may hold.

The seasonal Flu vaccination and Covid vaccination programme has started with over 1,000 staff booking their appointments in the first week which is a fantastic start to helping us mitigate the challenges which may lay ahead.

2. **Our People**

The Trust held its annual staff awards, long service awards, staff party and family day starting on the 7th September in the beautiful Cathedral grounds, all of these were fantastic events and real opportunity to celebrate the success of the extraordinary people that work and support the Trust.

Firstly, I know the Board will want me to thank the communications team and all those wider Trust colleagues that step forward to help in organising such a brilliant few days. The feedback from all the events as ever is outstanding, and a real testament to the discretionary effort displayed by all involved.

There were 17 winners in 14 categories:

- **Patient Experience Award** Dr Chris Anderson, Consultant, Children's Outpatients
- **Sustainability Award** Jane Websdale, Head of Service, Waste Grounds and Recycling Team & Tom Sneddon, Compliance and Energy Conservation Manager, Estates
- **SOX of the Year Award** Alex Beck, Physiotherapist, Child Health – Physiotherapy
- **Continuous Improvement, Education and Research Award** Urology Cancer Patient Tracking List (PTL) Team
- **Leadership Award** Katie Ransby, Matron, Chilmark Ward
- **Team of the Year Award** (Clinical) Longford Ward
- **Team of the Year Award** (Non Clinical) Patient Advice and Liaison Service (PALS) Team
- **Unsung Contribution Award** (Clinical) Mark Docksey, HCA Recruitment and Retention Facilitator, Education
- **Usung Contribution Award (Non Clinical**) Lucian Gaca, Cleaning Assistant, Housekeeping
- **Outstanding Partner of the Year Award** Hospital Ambulance Liaison Officer (HALO) Team, South Western Ambulance Service NHS Foundation Trust (SWASFT)
- **Rising Star of the Year Award** Dr Hazel Woodland, Consultant Gastroenterologist, Gastroenterology
- **Lifetime Contribution Award** Louise Kettle, Therapy Assistant, Odstock Ward
- **Chair's Award** Dr Alex Crick & Radio Odstock
- **Chief Executive's Aw**ard Nic Summerill & Laurence Arnold

3. Our Partnerships

The focus of discussions in the last month have centred around the medium-term financial recovery plan. The BSW system is under significant financial pressure and in line with NHS England guidance, working on a recovery plan to return the system to financial balance within a three-year period.

A key component part is ensuring the Trust and other system partners return to productivity levels seen in 2019/20 pre Covid. The Trust is developing a recovery plan looking at opportunities to increase elective capacity and reduce the number of patients waiting for onward care. The Board will receive more information in coming months as financial controls increase to mitigate the financial pressures.

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

Meeting of Board of Directors

Report Summary Sheet

Report Title	Acute Hospital Alliance Briefing, August-September 2023.						Agenda item	
Date of meeting	October / November 2023							
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	• Stacey Hunter, CEO SFT, Senior Responsible Owner • Cara Charles-Barks, CEO RUH • Kevin McNamara, CEO GWH							
Executive summary	This briefing provides an update on the activities of the Acute Hospital Alliance (AHA) in August and September 2023, as well as a description of priorities for the forthcoming period. The following areas are covered in the briefing: 1. Delivery of Priority Projects 2. Developmental Governance Review 3. National Provider Collaboratives Innovator Programme 4. Programme Resources and Risks The next AHA Board briefing will be issued in December 2023. 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 2023-26 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. Service users will be involved in service design activities as the AHA Clinical Strategy is implemented.							
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 AHA is in line with national policy and strategic direction on provider collaboration. The AHA Programme Board, 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's 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 hosting the core AHA budget. The programme leadership ensures 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, October 2023 Briefing

Introduction

This briefing summarises the activities of the Acute Hospital Alliance (AHA) in August and September 2023, and priorities for the forthcoming period. The following contents are included in each monthly briefing:

1. Committees in Common & Programme Board Activities; Delivering Core Projects
2. AHA Developmental Governance Review
3. National Provider Collaboratives Innovator Programme
4. Programme Resources and Risks

1. Committees in Common & Programme Board Activities

- The Committees in Common (CIC) sets strategic direction for the AHA. At its meeting on 18th August, CIC members discussed a *Compact for the BSW Integrated Care Board & the Acute Hospital Alliance*. The Compact, commissioned by the CIC and ICB Chair and Chief Executive, describes how we will work as partners, affirming the AHA's role in BSW ICS as a delivery partner testing new collaborative ways of working, underpinned by a shared understanding of system priorities, objectives, opportunities and expectations. The Compact will be finalised and shared widely by the end of 2023.
- The next CIC meeting is planned for 20th October, when the group will review the proposed *single capital programme* and *corporate services collaboration* proposals.
- The Programme Board met on 22nd September, approving Terms of Reference, reviewing progress of priority projects and considering a proposal to embed use of Improving Together methodology in the Programme.
- *Executive Team Coaching Sessions.* The coaching programme for the Executive Teams to support our collaborative development is well underway. Recognising the challenge and ambiguity that system-wide working brings, sessions with groups of Executive Leads are progressing well, and planning for the next in a series of larger-scale development sessions bringing together the three Executive Teams is underway.
- Updates on the recent activities and next steps for *core AHA activities – Clinical Strategy, Single Capital Plan, EPR Programme and Corporate Services Programme* follow.

Acute Clinical Services Strategy

- *CEO Sponsor:* Cara Charles-Barks, RUH*; Executive Lead*: Peter Collins, Chief Medical Officer, SFT.
- *Recent Activities*: The *Clinical Strategy Programme Board* met on 18th September and saw discussion on the AHA's *Clinical Programme refresh* – which will see specialty teams from *Orthopaedics, Gastroenterology, Urology and Dermatology* working together to identify and implement service improvements in response to the Clinical Strategy and BSW Care Model. A standardised framework has been adopted to support teams to identify opportunities, their vision for services, and improvement measures. September also saw clinical and management leaders from across BSW meet in Devizes for the AHA Clinical Summit #5, *AHA Clinical Strategy and Inequality Reduction in BSW*. This was the first

of two planned workshops exploring the acute sector's potential role in reducing inequalities in BSW. The next workshop will be held in early 2024 and will be planned with Local Authority Public Health leads.

- *Next Steps:* On 18th October the *Clinical Strategy Programme Board* will hold its next session and will confirm its resourcing approach for the next 12 months.

Single Capital Priorities Plan

- *CEO Sponsor:* Cara Charles-Barks, RUH*; Executive Lead:* Simon Wade, Chief Finance Officer, GWH.
- *Objective:* Project aims for AHA Trusts: To work together to maximise available capital resources flowing into BSW/ AHA by having a coherent, strategic plan for capital investment within the AHA; to advocate consistently for each-other's schemes and the collective capital development priorities; to establish clear principles guiding how we will collectively respond to national requests to bid for funding.
- *Recent Activities:* August and September saw a core team working with Trust and BSW ICB colleagues to review capital investment proposals grouped in five workstreams (Elective Care, Urgent & Emergency Care, Infrastructure, Women & Children's services & Digital). Desktop analysis was followed by workshop sessions in Chippenham, Devizes and online, which will inform a strategic plan for capital investment within the acutes as part of a wider BSW capital programme.

EPR Alignment Programme

- *CEO Sponsor:* Stacey Hunter, SFT*; Executive Lead:* Jon Westbrook, Chief Medical Officer, GWH.
- *Objective:* Procurement and deployment of a single EPR platform.
- *Recent Activities:* Full Business Case passed to SW Region for detailed review before national EPR Investment Board consideration.
- *Milestones:* NHSE FBC approval anticipated early December 2023.

Corporate Services Collaboration Programme Development

- *Objective:* Against the background of latest national policy, available benchmarking, and best practice guidance, Executive Teams have begun developing plans for corporate service collaboration over the next five years, identifying opportunities to work at scale to enhance service quality, user experience, career pathways and resilience, and improve efficiency and productivity.
- *Recent activities:* The following services have been asked to develop collaboration plans: People, Digital, Finance, Estates & Facilities, Governance & Legal, Communications, Research & Innovation.
- *Milestones:* End October: Executive Leads present initial proposals to CIC. November: Final plans to AHA Programme Board and CIC. December onwards: Implementation begins, plans embedded consistently in core 2024-2026 planning round assumptions.

2. AHA Developmental Governance Review

Following the programme's developmental *governance review* carried out early in 2023, programme leads have continued working on a series of changes designed to ensure the AHA has strong governance arrangements in place as it embarks on the next phase of its work. Recently developments have included:

- Changes to our programme oversight arrangements including establishment of a new Programme Board, with membership balanced between executive professional portfolios (CEOs x 3 plus 1 x CNO, CMO, COO, Strategy, People, Finance, Digital, Estates, Governance and Communications leads; and an ICB lead). The focus of the Programme Board will be on delivery of major milestones and effective programme resourcing.
- Establishment of All Trusts Executive Group (ATEG), meeting in person six times annually to support executive engagement in and awareness of the AHA. The focus of ATEG sessions will be on project deep dives and collaborative leadership development. The ATEG has met once and convenes next on 27th October.
- As referenced in section one above, a Compact has been developed describing how the AHA and ICB will work as partners in BSW ICS.
- AHA Engagement Strategy. Over the Summer, a refreshed AHA Engagement Strategy was released.
- Finally, work has also begun to streamline decision-making in our single EPR Programme.

3. AHA Participation in National Provider Collaboratives Innovator scheme 2023-2024

Through participation in the Provider Collaboratives Innovator Scheme, the AHA aims to maximise opportunities for collaborative working, enable delivery of our core programme, and cement the AHA's role in BSW ICS as a central delivery partner. Since the May launch, we have primarily benefitted from the Peer Innovator Support offer – that is active sharing of innovation and troubleshooting of issues with the other provider collaboratives in the scheme. Most notably, our Programme has held a series of sessions with leads from the Foundation Group (South Warwickshire, Wye Valley, & George Eliot NHS Trusts), learning from their experiences in pharmacy, digital services, and clinical service improvement.

Emerging themes from the Innovator Scheme are being collated in Q3 2023-24 with a view to being shared nationally in Q4.

4. Programme Resources

The AHA brings together clinical and corporate services experts from across the three Trusts to design and deliver the work programme. Executive leads are in place for all priority activities. The programme is funded by balanced contributions from the three Trusts. A small core team is in post, with roles being hosted by all three Trusts. During the period covered by this report:

- AHA Nursing and Midwifery Lead. Interviews have been arranged on 13th October to appoint an AHA Nursing and Midwifery Lead, to support workforce and Clinical Strategy projects working alongside the Associate Medical Directors.
- Analytical Support. The national Innovator Scheme has allocated funding for analytical support through the scheme. Support is being sourced from SCW Commissioning Support Unit. Access to GIRFT Clinical Leads and a range of other subject matter experts has been secured.

- BSW Support. The AHA Virtual Clinical Teams work (including Dermatology and Ophthalmology) has continued to receive programme and project management support from BSW ICB.

5. Risks & Issues

A range of risks and issues continue to be managed by the programme team. A risk register is held centrally, risk management responses are reviewed monthly, with significant items being reported to the Programme Board and Committees in Common. No new and significant risks have emerged in this reporting period.

6. AHA Forward Meeting Cycle

Table one below sets out the dates of our CIC meetings, Programme Board and Clinical Summits for 2023-2024. A detailed meeting planner, providing a clear view of key decision points and milestones has been developed by the programme team and is used by the Programme Board and Committees in Common.

Table 1. 2023-2024 Meeting Cycle: Key Dates

	Q2		Q3			Q4			Q1			Q2	
	Aug-23	Sept-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24	Apr-24	May-24	Jun-24	Jul-24	Aug-24
AHA Programme Board		22nd		24th		26th		22nd		24th		26th	
All Trust Executive Group			27th		15th		23rd		26th		28th		30th
Committee in Common	18th		20th		4th		15th		19th		21st		16th
Clinical Strategy Programme Board	31st	28th	18th	15th	20th	17th	21st	20th	17th	15th	19th	17th	21st
EPR Programme Board	31st	28th	26th	30th	28th	25th	29th	28th	25th	30th	27th	25th	29th
Clinical Summit			TBC			TBC			TBC			TBC	

Finally, the next AHA Board briefing will be issued in December 2023.

Close

Drafted by Programme Director, Ben Irvine

2nd October 2023

Salisbury NHS Foundation Trust

Report to:	Trust Board (Public)	**Agenda item:**	2.1
Date of Meeting:	26 September 2023		

Report Title:	Winter Plan and UEC Recovery Update			
Status:	**Information**	**Discussion**	**Assurance**	**Approval**
	✓			
Approval Process	Finance and Performance Committee 26 September 2023			
Prepared by:	Jane Dickinson Deputy Chief Operating Officer			
Executive Sponsor (presenting):	Lisa Thomas, Chief Operating Officer			
Appendices (list if applicable):				

Recommendation:
The committee is asked to note this first draft of the SFT 2023/24 Winter plan in conjunction with an assessment of where the organisation is against the Urgent and Emergency Care Recovery Plan.

Executive Summary:

The 2023/24 Winter Plan has been pulled together working on the asks of the NHSE Recovery of UEC services and 'Delivering a resilient winter'.
The focus remains on the 10 high impact interventions for all ICS throughout both documents.
 	
The focus for SFT will be:
 	
➢ **SDEC** – reducing variation in SDEC provision by operating a variety of SDEC services.
➢ **Frailty** – providing a robust frailty service with pathways designed to recognize those who would benefit for AFU.
 	
➢ **Inpatient Flow and length of stay.**
  ➢ Improving In hospital efficiencies, bringing forward discharge processes for those on a simple discharge pathway.
  ➢ Improvements in Ambulance handover times.
 	
➢ **Bed productivity and Flow:**
  ➢ Ensure that all beds are available as per operating plan.

- Improving the 4hr standard for type 1 attendances to consistently achieve the 76%.
- Minimizing number of patients spending over 12 hrs in ED.
- Clear discharge arrangements, processes for the more complex patients.
- Ensure that sufficient capacity is in place to protect the elective programme for adults, young people and children.
- Ensure that there are process in place so there is full understanding and visibility of pressures across the totality of the UEC pathways.
- Robust workforce plans are in place to respond to increase demand over the winter period; AL planning must ensure that there is sufficient clinician cover over the festive and NY period. This must include planning for possible staff sickness due to a rise in winter illness such as C19 and Flu.
- Ensure that there is a robust vaccination plan in place for staff, volunteers, and patients.
- Compliance with new national OPEL framework and reporting.

The slides draw attention to the following risks anticipated by the organisation:

- Demand exceeds capacity for inpatient beds.
- Staffing pressures.
- Industrial Action
- Weekend working
- Infectious diseases
- Increasing demand for mental services across adults and children

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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Virtual Meeting Etiquette:

- Mute microphones when not speaking (to minimise background noise)
- Turn cameras off – unless speaking (to maximise call quality)
- Please use the *Raise Your Hand* to ask a question
- Please note, this event will be recorded

Winter Plan 2023/24

Finance and Performance Committee

26th Sept 2023.

Content

Salisbury NHS Foundation Trust

- Overview
- SFT plan on a page
- Section 1: National expectations
- Section 2: SFT Capacity & Demand
- Section 3: Progress against national expectations
- Section 4: System plans
- Section 5: Elective Care
- Section 6: Risks

Overview

Salisbury NHS Foundation Trust

This document outlines SFT's *draft* plan for winter 2023/24. It is anticipated that pressures on the NHS this winter will be significant. The combination of services managing significant patient backlogs associated with the pandemic, on going industrial action by the BMA affecting junior and consultant medical workforce, other staffing challenges which are exacerbated by the economic climate (for both health and care services). Urgent care services are under increasing demand from an increasingly elderly and frail population and those with mental health challenges.

It will recognize the seasonal recommendations set out in the NHSE winter guidance comment, on the SFT position in relation to the NHSE ask and provide mitigation plans where there are gaps.

Central to the plan is supposition that all actions and plans are in line with the Trusts vision to deliver an outstanding experience for all our people, population and partners, with improving together quality improvement methodology pivotal to delivering our service. The overarching challenge is to ensure that we are delivering outstanding urgent and emergency care services in addition to increasing our planned care services so that we continue to reduce those waits.

The potential for on-going and additional industrial action across the unions is an added concern and challenge.

Areas discussed:

- National expectations
  - Current SFT provision, gap and mitigation plans
- SFT pressures
- SFT Elective plans
- SFT priorities
  - Staffing
  - Flow and OPEL framework
  - IPC Plans
- BSW plans (TBC)

SFT Winter plan on a page

Salisbury NHS Foundation Trust

1. **Length of Stay**: Continue to reduce LoS ensuring the minimum number of escalation beds are open.
   - ❑ SDEC continued development
   - ❑ Acute Frailty Unit (AFU) moving from Pitton to Durrington to benefit from SDEC alignment.
   - ❑ Timely discharge (particularly for pathway P0 patients) with improved focus on ward processes/staffing.
   - ❑ Discharge Hub (started July) continue to support discharge for those requiring P1-P3 pathways.
2. **Protect Elective Capacity**
   - ❑ Convert downstairs in DSU to space for 9 recliner chairs to support planned care work in DSU in lieu of capacity being used for escalation.
3. **ED Flow**
   - ❑ Implement ECIST recommendations to support reduction in Ambulance handover delays.

1. National Expectations

Salisbury NHS Foundation Trust

The national expectations for the winter period thus far build on documents released earlier in the year providing guidance on recovery of urgent and emergency care and the elective programme; for the purpose of winter planning they are called “high-impact interventions”.

They are spilt into expectations of ICB’s, Acute trusts and all health and care providers.

Specific asks of Acute trusts:

- **SDEC** (Same Day Emergency Care)
  - Reducing variation in SDEC provision by operating a variety of SDEC services for at least 12hrs a day 7 days a week.
- **Frailty**
  - providing a robust frailty service with pathways designed to recognize those who would benefit for Acute Frailty Service (AFS) and ensuring referrals to avoid admission.
- **Inpatient Flow and length of stay.**
  - Improving In hospital efficiencies, bringing forward discharge processes for P0 patients.
  - Improvements in Ambulance handover times.
  - IPS in place for specialty in-reach to ED 24/7.
- **Bed productivity and Flow:**
  - Ensure that all General & Acute beds are available as per operating plan.
  - Improving the 4hr standard for type 1 attendances to consistently achieve the 76% (80% target from Oct).
  - Minimizing number of patients spending over 12 hrs in ED.
  - Clear discharge arrangements, processes for P1-P3.

1. National Expectations Cont'd

Salisbury NHS Foundation Trust

- **Bed Productivity and Flow.**

  - Ensure that Sufficient capacity is in place to protect the elective programme for adults, young people and children. With clear triggers in place to open additional NEL capacity as required.
  - Ensure that there are process in place so there is full understanding and visibility of pressures across the totality of the Urgent and Emergency Care (UEC) pathways.
  - Robust workforce plans are in place to respond to increase demand over the winter period; AL planning must ensure that there is sufficient clinician cover over the festive and New Year period. This must include planning for possible staff sickness due to a rise in winter illness such as C19 and Flu.
  - Ensure that there is a robust vaccination plan in place for staff, volunteers and patients.
  - Compliance with new national OPEL framework and reporting.

2. SFT position

In developing the winter plan for 2023/24 the Trust has reviewed mitigations taken during winter 2022/23 with associated outcomes (outlined below). Together with the identification of roles and responsibilities described by NHSE across the ICB, SFT has recognised several key elements that will impact on effective service delivery and have developed an approach that will be realistic to supporting the mitigation of these elements.

The plan does not assume a significant respiratory outbreak in terms of modelling bed capacity, if such event were to occur then the comprehensive infection control planning is instigated, and patients are prioritised following this guidance.

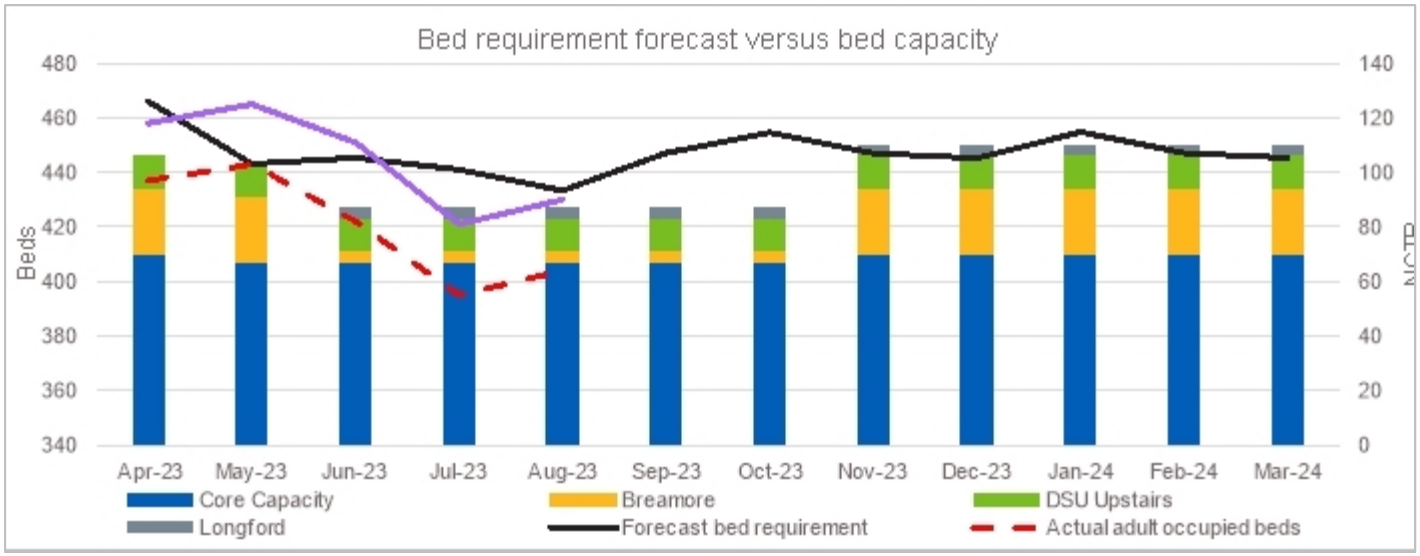
Whilst the nursing staffing position is much improved from September last year (as evidenced in an improvement in Care Hours Per Patient moving from Quartile 1 to Quartile 2 in Model Hospital), we have a significant gaps in Consultant posts in Medical Specialities (Elderly Care, Acute Medicine, Stroke and Respiratory).

When bed occupancy rises, this gap impacts the ability for senior decision makers to review patients in a timely way and places a significant increase in workload of existing staff.

This ultimately places risk to increasing Length of Stay.

Area	Lesson 2022/23	Recommended Action 2023/24
SWIC (Walk in centre)	Additional capacity at Walk in centre prevented high numbers of child ED attendances	Similar additional capacity required through winter with uplift to specific weekends were we saw peak attendances last year. In place for 2023/24.
Trust	Opening of additional bedded escalation areas impact on Clinical Support Services.	Consider staffing and financial impact on facilities, radiology, therapies and pharmacy especially.
Trust	Significant outliers and open escalation areas has a negative effect on LoS and bed occupancy.	Focus at each capacity meeting on ↓ outliers and closing escalation areas where possible.
Trust	Capacity meetings can be a challenge, role and responsibilities need defining.	Piece of work under way to define roles and responsibilities across divisions and site team, including DCOO etc.
Trust	Transport processes not aligned to support prompt discharge.	Explore how the gap can be closed.
Trust	Annual leave across some staff groups needs more scrutiny during the festive period.	OD&P team to support with oversight of annual in less visible staff groups.

2. Bed Modelling



The Trust has undertaken modelling for anticipated bed requirements based on 2022/23, planned elective activity. Based on the analysis, this forecasts an Adult bed requirement of around 445-455 across M6-12. This assumption is based on an average and doesn't show the full impact of the range of requirements (for example January last year beds peaked at 490 and the lowest day was 448).

There has been improvement against the plan in June, July and August with correlation against improvement in the number of NCTR, there has also been improvement in LoS as a direct result of SDEC, Acute Frailty unit and overall reduction in number of beds open.

Core capacity is 432 adult beds once Whiteparish ward reopens in Q3, with a gap of around 13-23 beds on average. M6 and M7 represent a bigger gap (circa 40) until Whiteparish is back online.

What this means is we are likely to be fully escalated into Day Surgery Unit and puts risk to the elective programme for winter 2023/24. The position will improve into next financial year with the new ward opening. However the winter programme has to concentrate on improvements to LoS and bed occupancy to mitigate the impact on the elective programme.

3. NHSE vs SFT gap analysis

Salisbury NHS Foundation Trust

The comparison of SFT's position to the NHSE Urgent and Emergency Care expectations is outlined below:

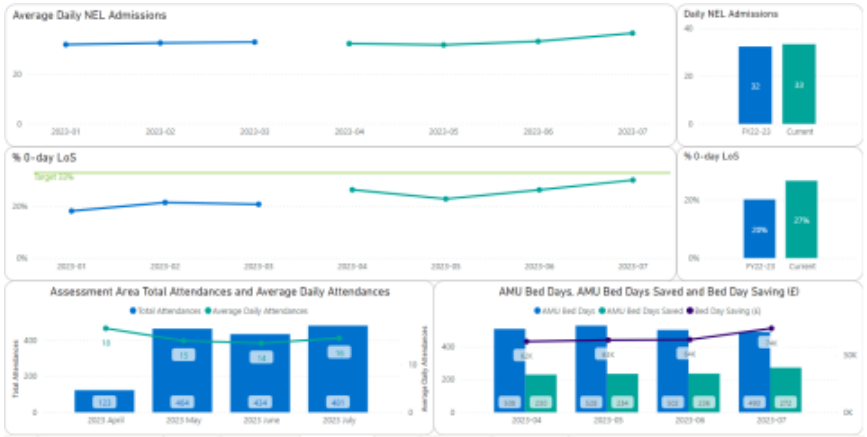
NHSE Exp.	SFT position
SDEC provision 12hrs a day 24/7	Good provision cross medicine 6 days a week; SAU in place and performance improving, long term location not yet agreed.
Frailty service that is consistent and provides admission avoidance.	AFU becoming more established, reduction in LoS need to 'watch' re-admissions. Work with site team to provide appropriate ward placement first time where possible or 'flag' for AFU.
Inpatient flow and LoS improvement. 1. Bringing forward P0 discharges 2. Improving ambulance handover times. 3. Improved compliance with IPS 24/7	1. P0 discharges before midday remain low 2. Ambulance handover delays have improved but more work needs to be done to manage surge. 3. No IPS in place hence no holding to account for long speciality delays.
Bed productivity and flow. 1. All G&A beds open as per plan. 2. Improving the ED performance for type 1 (overall 76%). 3. ↓ Patients in ED over 12 hrs. 4. 7 day working for transfer hubs. 5. Plans in place to protect elective capacity. 6. Workforce plans to ensure sufficient cover over seasonal holidays. 7. Plans in place for vaccination of staff/patients	1. *LD to provide narrative* 2. Overall ED performance is improving, however much is reliant on Type 3&4 via the SWIC. Type1 performance needs to be improved as part of the ED programme. 3. Closely linked to ED improvement and IP flow. 4. 7 day Discharge hub is in place, improvements being made to communication from each provider 5. Plans to ring fence some DSU space and create a chair recovery area. 6. Divisional oversight of leave to be supported by OD&P in areas with limited electronic solutions. 7. Vaccination programme in place from October

a) National expectation : SDEC provision 12hrs a day 24/7

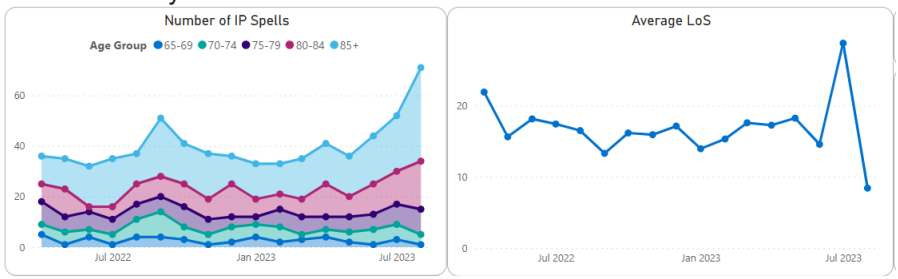
Medical SDEC is currently provided 12 hrs a day 6 days a week.
The Acute Frailty Unit is already demonstrating reduced LoS, the unit will be co-located with AMU/SDEC from November which in turn is expected to bring further benefits.

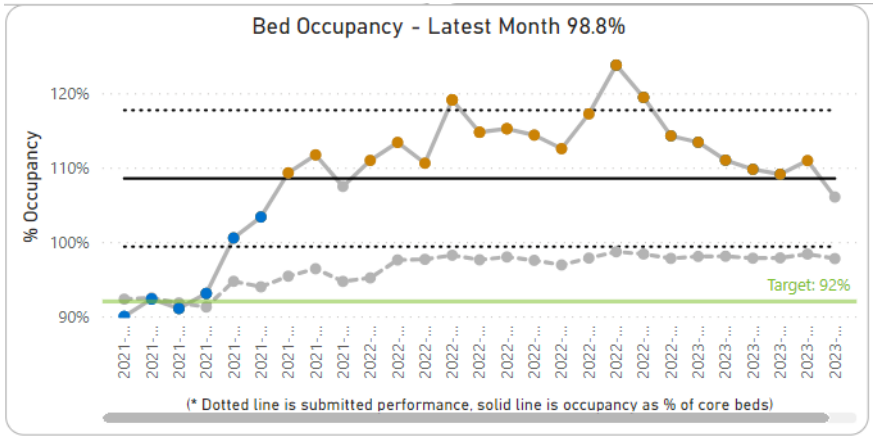
NHS Salisbury NHS Foundation Trust

Medical SDEC



Acute Frailty Unit





Medical SDEC services are well established and we can now demonstrate just under 30% of all patients on the pathway have a zero length of stay.

Acute Frailty Unit processes are becoming embedded and working well. It is anticipated that closer working with SDEC will bring improvements getting patients to the right ward on admission so leading to greater reductions in LoS and bed occupancy.

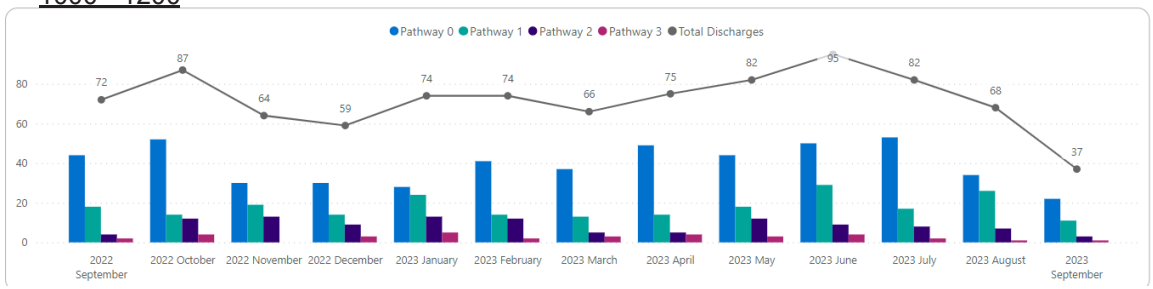
Surgery have an established surgical assessment unit, however work is starting to explore some key speciality pathways in which patients often wait in ED for extended times waiting to be see such as T/O and head and neck. This will involve patients being navigated to a more appropriate space to be seen and assessed.

B) Inpatient flow and LoS improvement

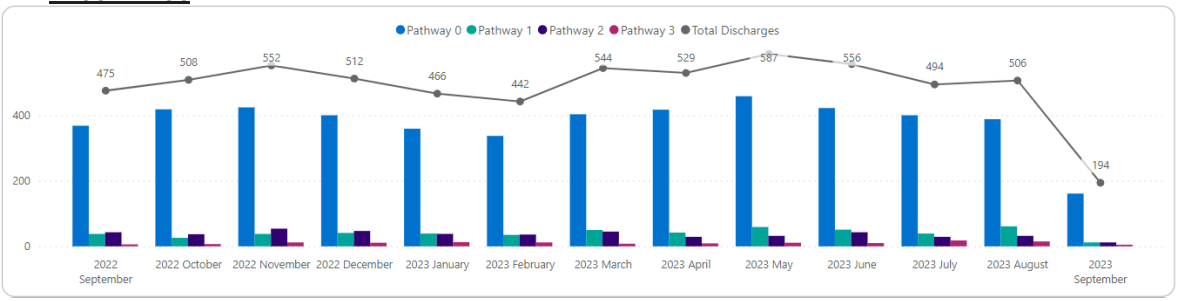
Salisbury NHS Foundation Trust

Bring forward P0 discharges.

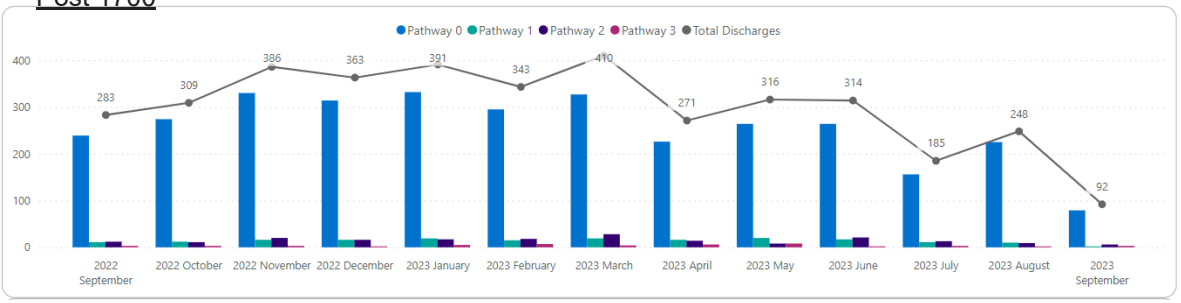
1000 - 1200



1200 - 1700



Post 1700



Increasing the P0 discharges to earlier in the day is a national challenge. This has been the case for many years and is not necessarily a pandemic ‘effect’. The majority of discharges at SFT take place between midday and 1700, with high numbers after 1700 too.

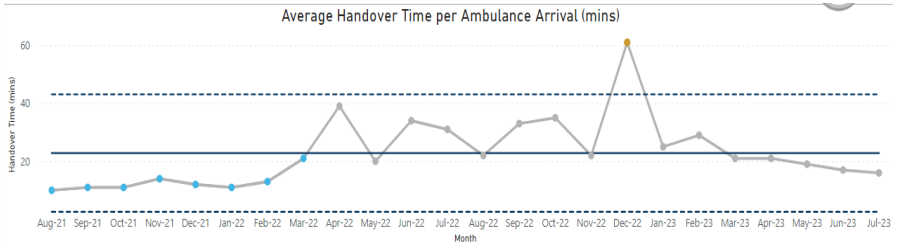
There is much anecdotal narrative what causes this from low prioritisation for doing EDS and TTO needed for discharge to patients who can go home before 1000 generally go home the night before.

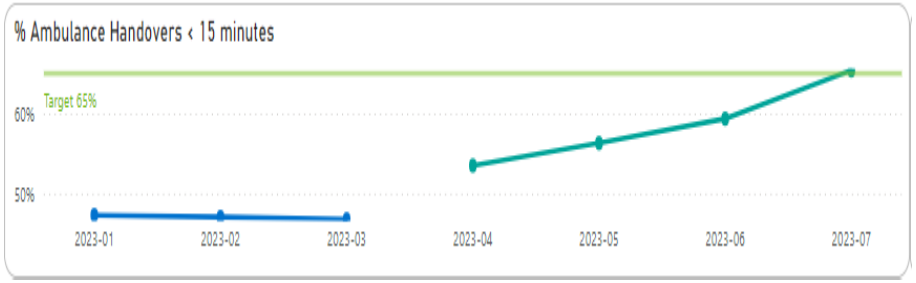
As part of the UEC improving together work ward processes are being reviewed across various wards to establish where efficiencies and improvements can be made.

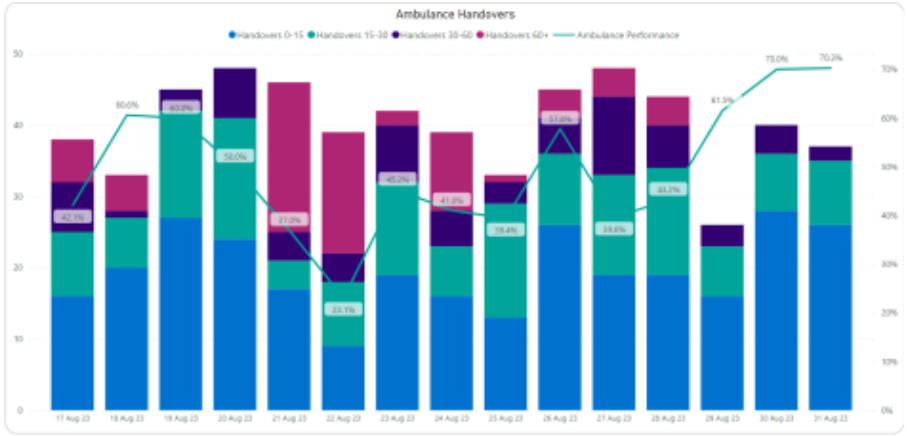
B) Inpatient flow and LoS improvement 2

Salisbury NHS Foundation Trust

Improving ambulance handover times







Ambulance handover delays have improved over quarter 1 of 2023.

Whilst we are in an overall improved picture of average handover times compared to Q1 in 2022 we were seeing an improving picture then and we need to make sure we have triggers and actions in place to address the inevitable deterioration come the winter period.

HALO's are in place but we need to ensure that we have internal queuing resourced 24/7 and have clear triggers.

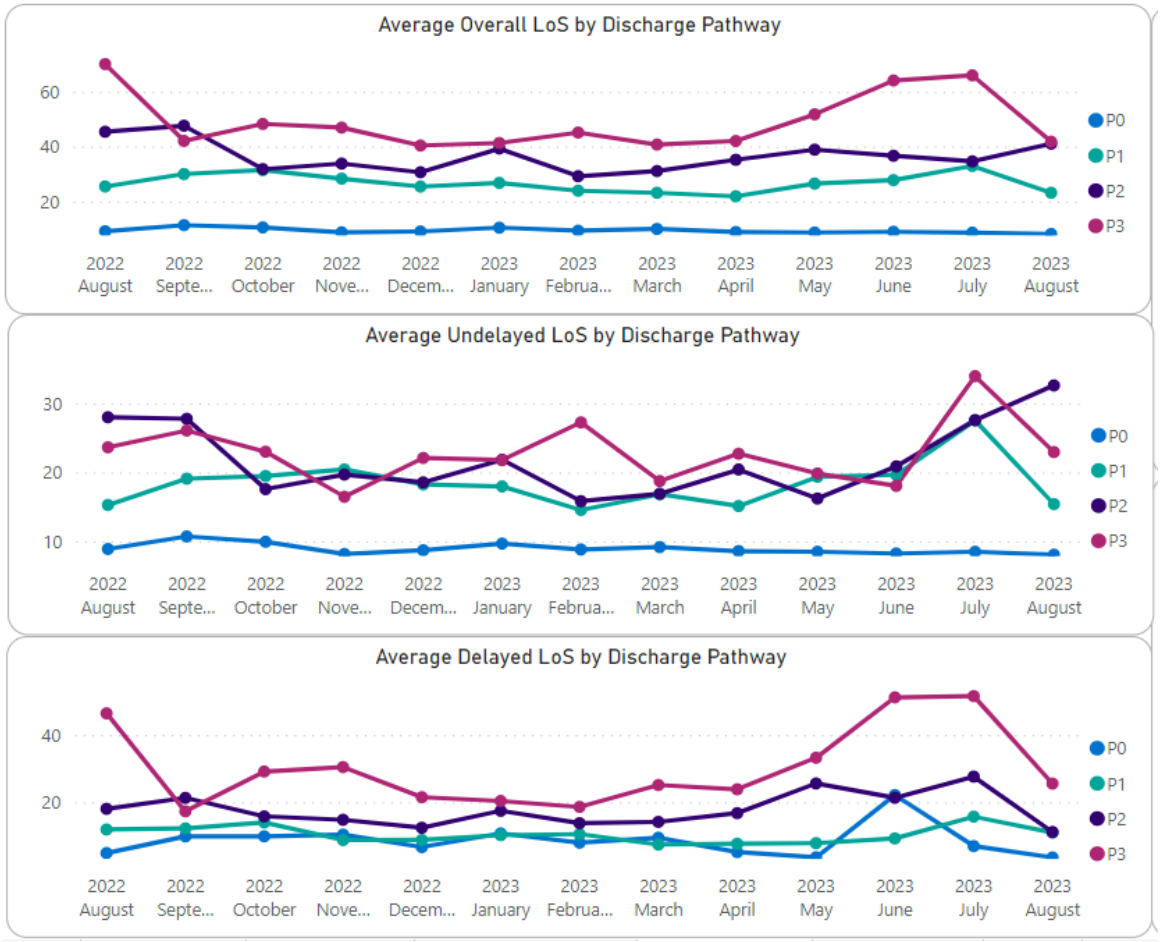
We currently make decisions on using additional capacity such as reverse boarding when we are in extremis positions, this needs to become more pro active to help avoid queuing with internal triggers to enact so there is less reliance on capacity call discussions.

A review of the use of ED space is being explored following an ECIST visit which may support space to provide ambulatory and ambulance RAT.

C) Bed Productivity and Flow

Salisbury NHS Foundation Trust

Clear Discharge arrangements and processes for P1-3.



Integrated Discharge Service (IDS) was not meeting the post covid need for supporting flow through SFT. In collaboration with Partners from Wiltshire, IDS was redesigned and 3 distinct functions were identified as the optimum service.

This was launched 26th July 2023

It aims to and has achieved:

Reduce the post NC2R decision bed days

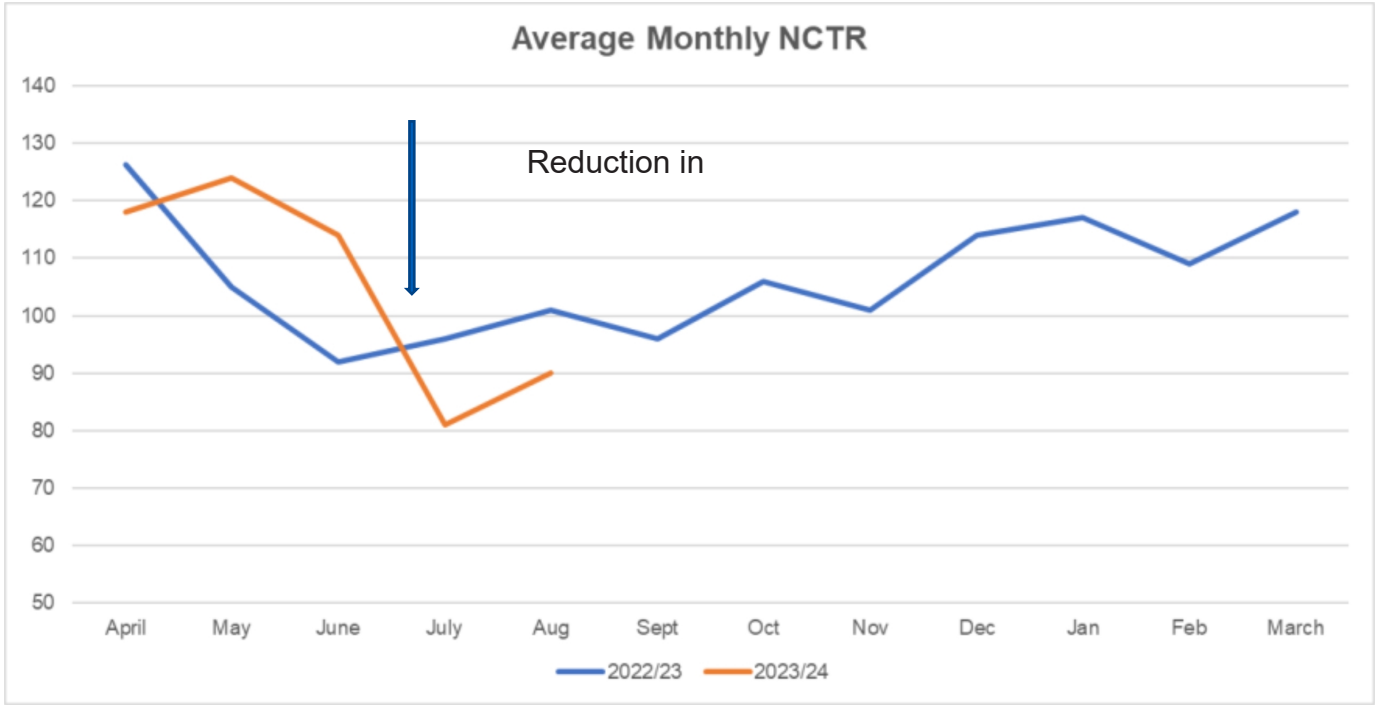
Increase the number of people returning to their own homes

Maximise the use of community services from front door

Provide a bespoke support service to the most complex discharges across adult inpatients

The benefits can be seen in the increase in patients on pathway 1 compared to pathway 2/3, and overall numbers of NCTR have reduced by 10-15 since inception.

C) Patients waiting for care packages – NCTR.



An additional piece of work that has recently happened is that AGEUK are supplying 'parsley boxes' (food that can be stored at ambient temperature) which will support a safer discharge for some patients. Food safety has been checked.

New project – Virtual Transfer of Care with care homes; more details when care homes for pilot have been identified and IG closed off.

Significant improvements have been achieved with the new discharge hub and integrated discharge team in the support and management of more complex patients and their families.

However although the work done internally means that the time waited for pathway decisions has decreased significantly the time taken to move patients out of SFT remain high.

C. Discharge Lounge.

Salisbury NHS Foundation Trust

Background

Delayed access to inpatient beds for admitted patients contributes significantly to emergency department (ED) boarding and crowding, which have been associated with deleterious patient safety effects. To expedite inpatient bed availability, many acute hospitals have implemented discharge lounges, allowing discharged patients to depart their inpatient rooms while awaiting completion of the discharge process or transportation.

Overall, discharge lounges are widely endorsed as a mechanism to accelerate access to inpatient beds, yet the limited available evidence indicates wide variation in design and performance. The purpose of this paper is to examine the model of discharge lounge that was established at SFT in 2022, detailing pros and cons to the model and provide recommendations regarding it future.

As part of the winter plan last year (winter 2022/23) in response to the anticipated patient flow challenge that was expected.

From daily discussions and experience on site and capacity meetings it was well known that daily discharges peaked at between 15:00 – 17:00hrs (at this time there little central data collection on discharge times) with less than 15% being before midday.

Implementation and model of Care.

As the Covid pandemic operational challenges subsided we were able to re-evaluate the use of Breamore ward.

Being a nightingale style ward and being remote to the main hospital medical and surgical template it is not suitable to house acutely unwell patients or those with infection concerns.

At this time the hospital was also accommodating a high number of patients not requiring acute medical in put but waiting for on going care such as residential care or social care support (no criteria to reside or NCTR)

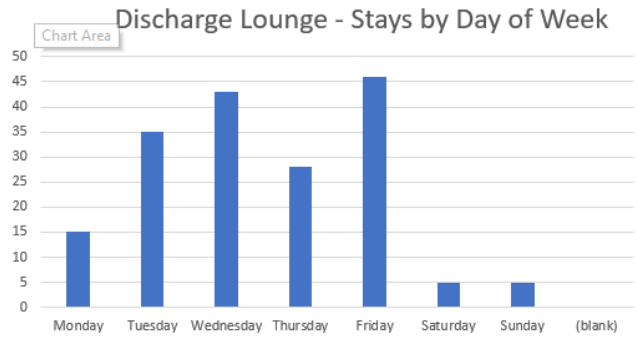
After discussion with the divisional medical team and significant work with the senior nursing team especially it was decided to split the foot print of Breamore into a 13 bedded area for NCTR patients who would not need intense medical.

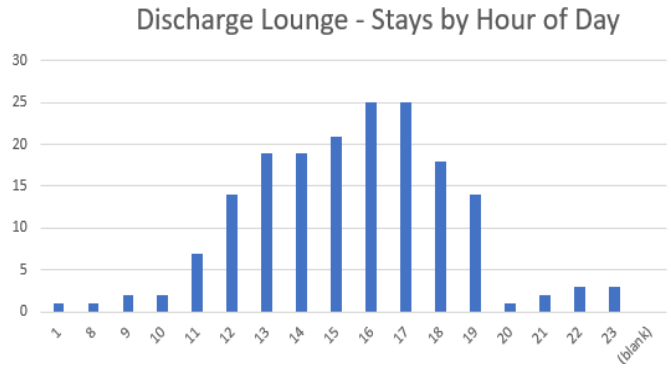
The 6 beds in the annex area would be for discharge lounge patients who needed to remain on a bed and 4 chairs in the corridor space for seated patients for discharge.

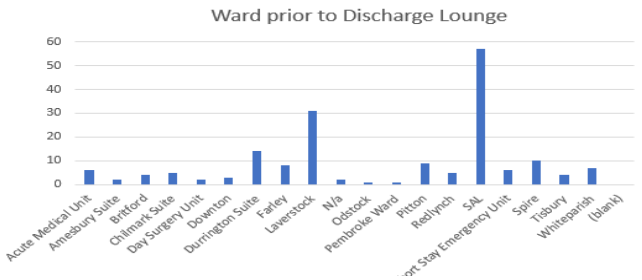
There was also a side room facility that could be used should and patient need isolation.

c. Discharge Lounge

The general feedback were that the concept of having a discharge lounge is a good idea, however there are several areas that we need to consider to decide what the appropriate model of care for discharge is for SFT. The data below provides information on the originating ward, the time of discharge from the lounge and the patient activity by day of the week.







What went well?

- having an area with a clinical team to discharge from.
- Having a lead nurse in the area to identify early on the wards who could come to the discharge lounge and provide names ahead.
- Freed up beds quicker in the day to enable teams to admit from ED/AMU and other areas earlier in the day.
- The lounge supported improved flow.

What did not go so well?

- The discharge processes on the wards are not efficient, nor do they appear to be the medical teams priority, this needs to improve if the discharge lounge is to realise its potential. This is a separate piece of work that will feed into the reduction in length of stay project.
- The slow ward handover process is an on-going challenge which affects all the back wards including Breamore.
- The above is also linked to a transport process which is not aligned to the operational flow of the hospital.
- Staffing on Breamore was at times sub optimal, if the area is to stay open the staffing needs to be substantive.

What could have been done differently?

- Need to educate staff more regarding its use, eligibility criteria.
  - If there are beds and chairs available it should not be an option to use or not if the patient has a robust home plan that day.
- Review flow model to a pull model.
- If we keep the area as a discharge lounge we need to consider the environment, such as:
  - TV, Availability of tea and coffee, Newspapers.
- Consider how we use the area more stringently when there are capacity pressures.
  - Stop escalating bedded patients into the corridor area.
- Consider how we separate the ward area to the discharge lounge area, this should include some minor refurbishment, signage.
- Communication to patients and relatives regarding it use could have been improved with social media.

C. OPEL Framework and scoring. (Operational Pressures Escalation Levels)

NHS Salisbury NHS Foundation Trust

The OPEL framework provides a unified, systematic and structured approach to detection and assessment of acute hospital UEC operating pressures, achieved through standardisation of parameters and assessment within acute trusts.

Along side the framework there is an associated action card corresponding to each OPEL status that details considerations that should be worked through though not exhaustive.
The new framework is based on quantitative date rather than qualitative, this will facilitate more standardisation across acute facilities.

OPEL Parameters and scoring range

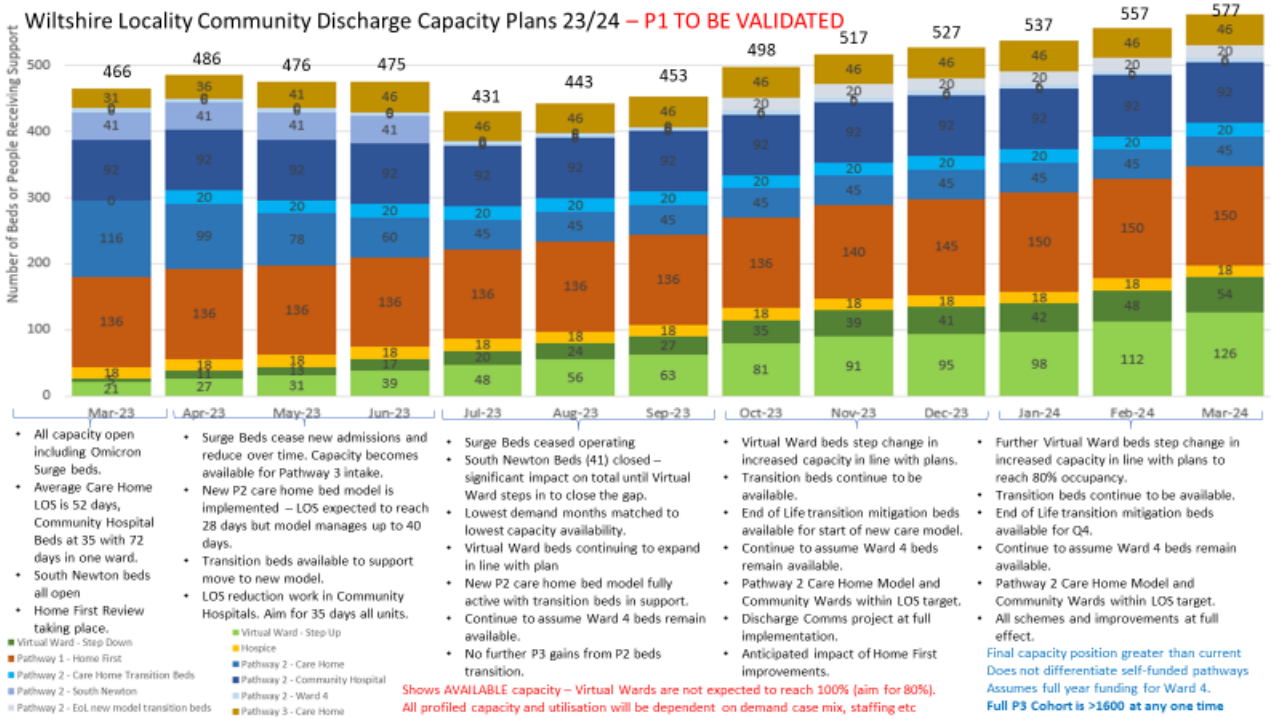
OPEL Parameter	SFT baseline	Score						
		0	1	2	3	4	5	6
Mean ambulance handover time		<15 min		15-30 min		30-60 min		>60 min
ED all type 4 hr performance		>95%	76-95%	60-76%		<60%		
ED all type attendances	120	<2%	2-10%	10-20%		>20%		
Majors and resus occupancy (adult)	22	<80%		80-100%		100-120%		>120%
Median time to treatment		<60 min	60-90 min	90-120 mins		>120mins		
% of patients spending >12 hrs in ED		<2%	>2-5%	>5-10%		>10%		
% G&A bed occupancy		<92%		>92-95%		>95-98%		>98%
% of open beds that are escalation beds		<2%	2-4%	4-6%		>6%		
% of beds occupied by NCTR patients		<10%		>10-13%		>13-15%		>15%

Aggregated OPEL Score	OPEL	Clinical Risk
0-11	1	Low
12-22	2	Medium
23-33	3	High
34-44	4	Very High

4) Wider system partner actions

Salisbury NHS Foundation Trust

- Hospital @home (virtual wards), Wiltshire locality plans for 2023/24 assumed an increase in capacity for virtual wards for both step up beds (avoiding admission) and step down beds (reducing SFT LoS). The SFT team and WH&C Community team are working together to facilitate increased step down capacity with a working group established supporting pathway changes.
- To date capacity for South Wiltshire has been 11 spaces (for both step up and down) with variable occupancy. As the teams develop a closer working relationship there is scope for improvement.



5. Elective Care in Winter

Salisbury NHS Foundation Trust

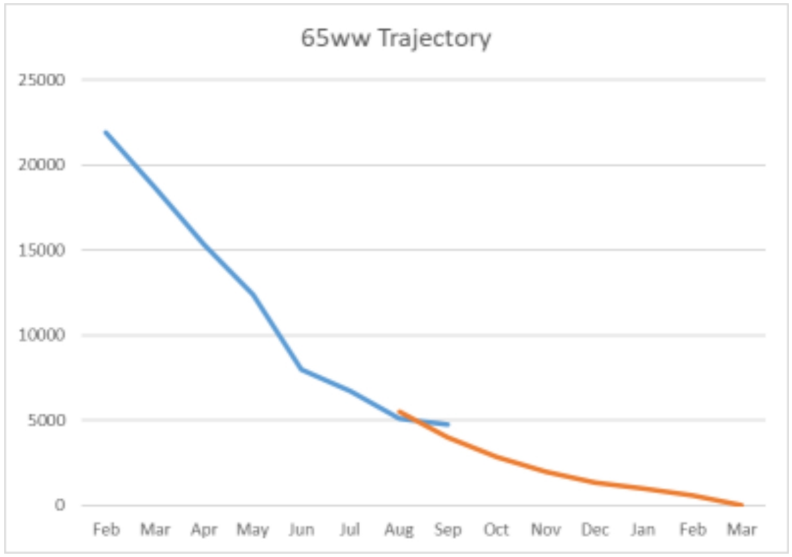
NHSE/I has set ambitious targets for activity and elective recovery for 2023/24, with an expected elimination of all over 65wweek waits, coupled with working towards the 2024/25 target of eliminating all over 52week waits. Whilst the expectation is that patients are still treated in line with clinical priority, there is an expectation that transformation across outpatient services continues in line with GIRFT recommendations, and theatre efficiency and productivity is improved further through the reduction in late starts, improved booking and use of HV/LC (High Volume/Low Complexity) principles.

Delivery of these targets is predicated on an value base ERF (Elective Recovery Fund) system with the reduction of OPD follow ups without a procedure being key to freeing up clinical capacity to address the additional activity required to reduce waiting lists sizes, eliminated long waits and ensuring every clinical ‘touchpoint’ adds maximum value.

In order to meet these exacting targets Trusts are expected to attribute the same level of importance to elective care as emergency, with an expectation that ring fenced surgical capacity is maintained throughout the year including winter.

Whilst the SFT has been successful in securing the funding for the development of a new ward (currently under construction) this will not be operational and able to provide additional bed capacity until April 2024, and as such the protection of elective capacity will be of paramount importance for the winter of 2023/24.

Elective Care in Winter



Current Position

SFT currently has 235 over 65week waits, a subset of the overall 'at risk' cohort (those that if not treated would breach 65w at or before March 31st 2024) of 4793 patients, across 97% of the at risk cohort sit however within 14 specialties (11 Surgery, 2 Medicine, 1 Woman and New Born)

3895 currently sit on a non-admitted pathway, with 898 on an admitted.

Surgical specialties currently account for 78% of all at risk patients, 79% of all the non-admitted pathways, and 74% of admitted pathways . Whilst clearly not all non-admitted patients convert to surgery the need to protect and ring-fence elective capacity is of paramount importance if the Trust to meet this nationally mandated target of zero >65ww by the end of March.

The above graph is an aggregate position, which at this point of the year can be deceptive. It should be noted however there are a number of specialities have specific operational challenges that are, as such then, disproportionately affected by strike action, and consequently more sensitive to loss of capacity from winter pressures.

This achievement of this target has been materially impacted upon by the success rounds of industrial action over the course of this financial year. At the graph below illustrates there has been an increasing and cumulative effect of the on going IA upon the clearance rate; the line has markedly flattened as clinical priority patients affected by IA take precedent over less clinically urgent, long waiting patients.

In terms of progress in September, SFT has now fallen behind where it needs to be with a recovery by month end unlikely given the strike action this week.

Further impact owing to winter pressures and escalation into elective capacity will further place the achievement of this target at risk.

Day Surgery Unit mitigation

NHS Salisbury NHS Foundation Trust

When the Trust is in a period of escalation Day Surgery Unit (12 beds upstairs, 18 beds downstairs) is used for inpatient stays. This compromises the level of theatre activity that can take place significantly and significantly compromises patient experience.

The Day surgery beds upstairs do not have washing facilities which also gives a poorer patient experience.

To be able to continue the elective programme in the context of the NCTR position and expected bed occupancy, a mitigation plan has been developed to generate a discharge space.

- On the ground floor, a discharge facility within DSU and two additional consulting rooms
- On first floor, some minor amendments to the waiting area

The discharge facility would provide nine recliner spaces and supporting space. This space will not accommodate inpatient beds, allowing the lounge to be maintained for planned care and subsequent discharge of patients.

This discharge area is imperative to the Trust being able to maintain a higher level of safe and efficient surgery even during period of high bed demand.

In the period December to February in 2022/23 approximately 800 theatre slots were not taken up for a variety of reasons, but mostly related to the availability of ward space on DSU due to bed pressures. It is estimated that this would be reduced by about three quarters in 2024 with the availability of the discharge lounge and subject to availability of bed spaces downstairs in DSU. This would equate to approximately 200 additional patients per month in January and February having their surgery at a time when emergency pressures are most challenging.

The capital cost is c£0.5m. The implications for staffing are being developed in response to the bed model.

6. Risks and mitigations

NHS Salisbury NHS Foundation Trust

Anticipated risk	Mitigation
Demand for IP beds exceeds capacity.	Plans in place to move AFU to Durrington ward. This creates a joint assessment and admission space for general medical and frail elderly patients which will facilitate more efficient processes and shared learning across both teams. **Hospital@Home** project has identified patients needing IV Abx as a group that could utilise the step down virtual ward model of care. Work is being done to establish this pathway, starting with shadow working between acute and community colleagues. The aim is to have move 10 patients out using this model by November and then review and agree next steps.
Staffing across all groups.	Historically escalation areas have been covered by existing medical teams which leads to fatigue and does not address the staffing gaps in the AHP and pharmacy teams. Any additional funds this year will focus on covering gaps in medical, nursing, AHP and pharmacy teams. Ideally outling patients will be seen by specific outling teams rather than from existing staff. However find individual will be a challenge.
On going Industrial Action by the BMA with the risk of additional unions doing similar.	On going IA is proving a drain on everyone resource, inducing fatigue and taking up valuable time when activity that has more added value could be pursued. However the divisions are becoming more ‘slick’ at pulling together rotas as providing assurance to the exec team. The impact on the elective pathway is significant, looking at the trajectory in slide 10 it is likely that our 65 week position will deteriorate significantly as there is no end to the IA in sight.
Weekend working	From the data it is clear that a lack of senior decision makers seeing patients at the weekends and OOH stalls discharges and often creates a back log in assessment areas and ED each morning that takes hours to unpick. A number of options are being explore to address this.
Infectious disease outbreak (C19,Flu,Noro) increasing the need for protected bed capacity.	The current IPC policy for Covid needs a review. The need for POC testing is clear, the service worked well last year. The process for de-escalation of C19 patients needs to be communicated regularly. C19 Cohorting policy still as per winter 2022/23.
Increasing demand for mental health services across adults and children.	Work being done across the ICS with adult and children's MH providers to ensure robust escalation processes in place. This will be communicated with SFT staff to ensure all staff working on OOH rotas are fully briefed as this is often when challenges arise.

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Appendix 1

update on progress against the National plan (published January 2023) – Recovering urgent and Emergency Care

NHS
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Urgent and Emergency Care Recovery Update

Finance and Performance Committee

26th Sept 2023.

Overview

Salisbury NHS Foundation Trust

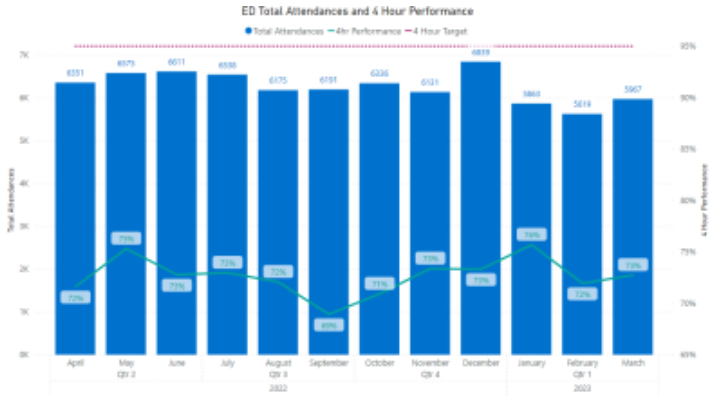
In January 2023 NHSE published a plan for the recovery of urgent and emergency care services across England. At the time of publication bed occupancy was at an all time high with most acute Trusts reporting over 95% of beds filled on average, this picture had been sustained throughout 2022.

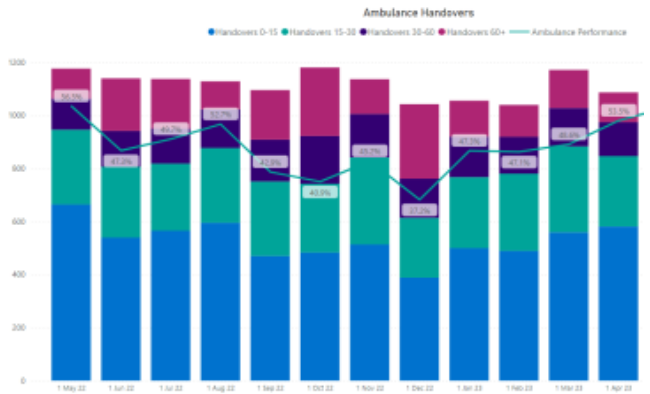
This was recognized as a key driver of worsening ED performance which in turn had a direct impact on ambulance handover delays and subsequent community response times.

Challenges in community settings and social care compounded this situation with high numbers of patients who were fit to move to their next place of care or rehabilitation staying in acute hospitals for extended periods of time (NCTR patients).

Nationally this was on a backdrop of an aging population, emerging from the Covid pandemic with an NHS workforce often working to the limits of their endurance.

This was the scenario that was played out at SFT, the winter period of 2022/23 we unfortunately saw some very long ambulance handover delays and patients experiencing long waits in ED, with our numbers of patients without criteria to reside (NCTR) reaching 25-30% of our bed base.





National Expectations

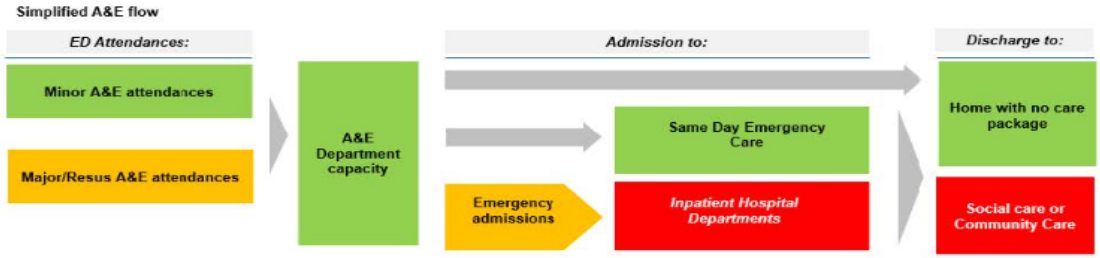
Salisbury NHS Foundation Trust

It is recognized that the challenge does not lie solely with acute hospitals and that recovery relies on solutions from a number of providers and stakeholders.

To support the recovery a number of ambitions were described, this document will provide information on where SFT is with each of those areas of improvement, gaps and plans to address the gaps, these include:

1. Patients being seen more quickly in ED - 76% of patients being admitted, transferred or discharged within 4 hours by March 2024, increasing to 80% in 2024/25.
2. Ambulances getting to patients quicker - ambulance response times for category 2 incident to average 30 minutes for lower over 2023/24, further improvement in 2024/25 expected.
3. Increasing capacity – to support reduction in bed occupancy, with an emphasis on Same Day Emergency Care (SDEC) services.
4. Grow the workforce – the modern workforce shows innovative thinking in addition to the traditional medical model of care to support in population demand.
5. Improving and speeding up discharge – to support reduction in bed occupancy in the NCTR group.
6. Expanding and joining up health and social care – admission avoidance, step down facilities, better use of the virtual ward model of care.
7. Easier to access the right care – 111, mental health support

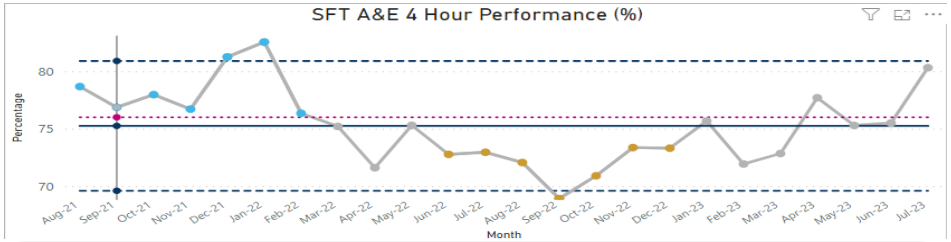
Figure 1: provides a simple patient flow picture highlighting current constraints.

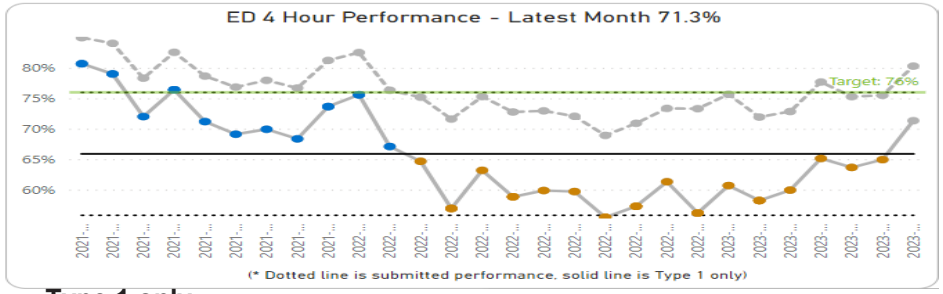


SFT Position – 4 hr standard

Salisbury NHS Foundation Trust

Patients being seen more quickly in ED - 76% of patients being admitted, transferred or discharged within 4 hours by March 2024, increasing to 80% in 2024/25.





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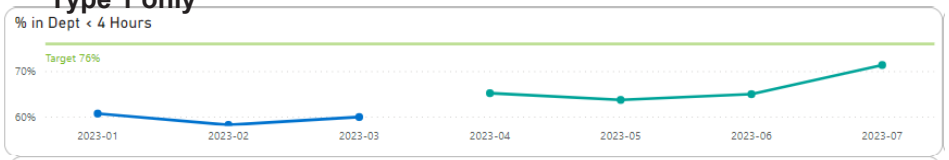
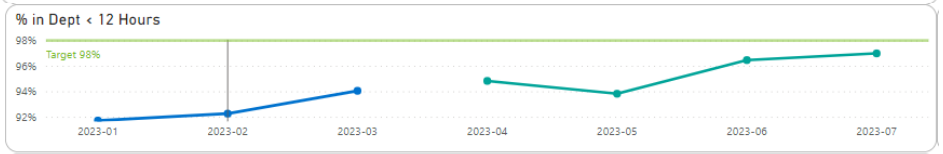
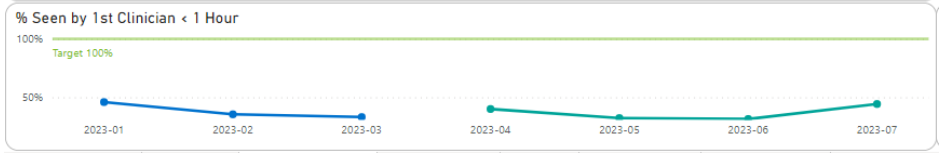






Current 4 hrs performance has improved recently; however the combined type 1-3 performance average is being driven significantly by type 3 performance through the SWIC and we need to see an

Admitted breaches are primarily driven by congestion downstream. Work is underway to speed up discharges and patient flow.

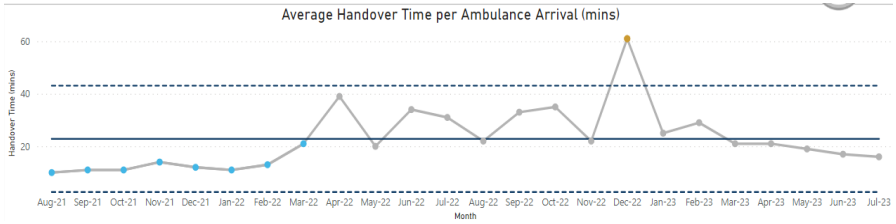
Work is being done in ED to reduce breaches in patients on a non- admitted pathway, this includes monitoring compliance with internal professional standards and divisional escalation processes.

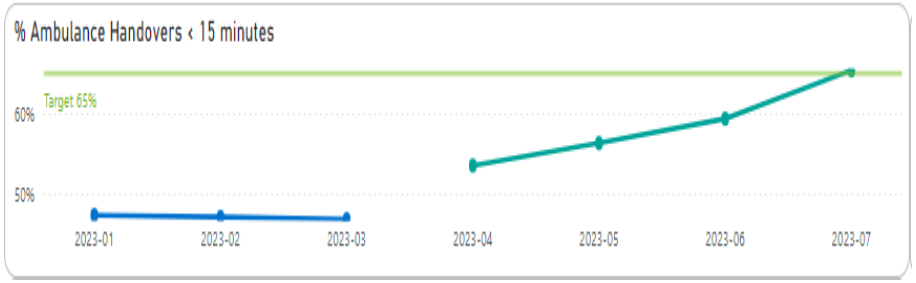
In addition internal processes in ED are under review to improve efficiencies such as the triage process and managing surge.

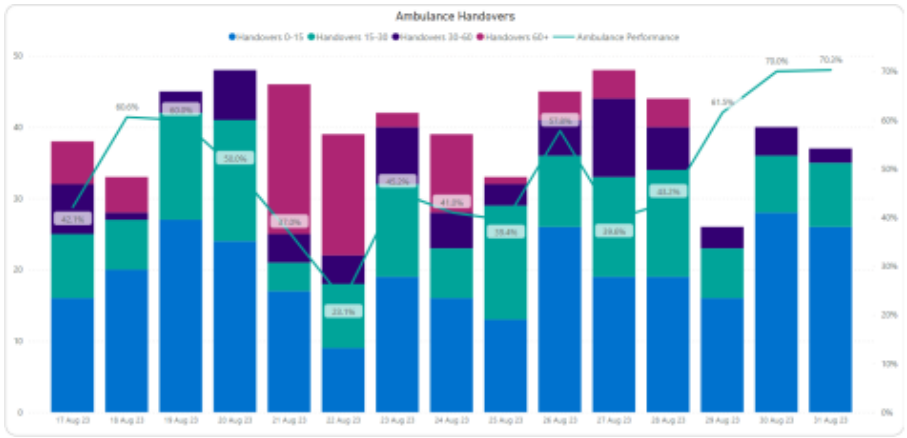
SFT Position – ambulance handover

Salisbury NHS Foundation Trust

Ambulances getting to patients quicker - ambulance response times for category 2 incident to average 30 minutes for lower over 2023/24, further improvement in 2024/25 expected.







Ambulance handover delays have improved over quarter 1 of 2023.

Whilst we are in an overall improved picture of average handover times compared to Q1 in 2022 we were seeing an improving picture then and we need to make sure we have triggers and actions in place to address the inevitable deterioration come the winter period.

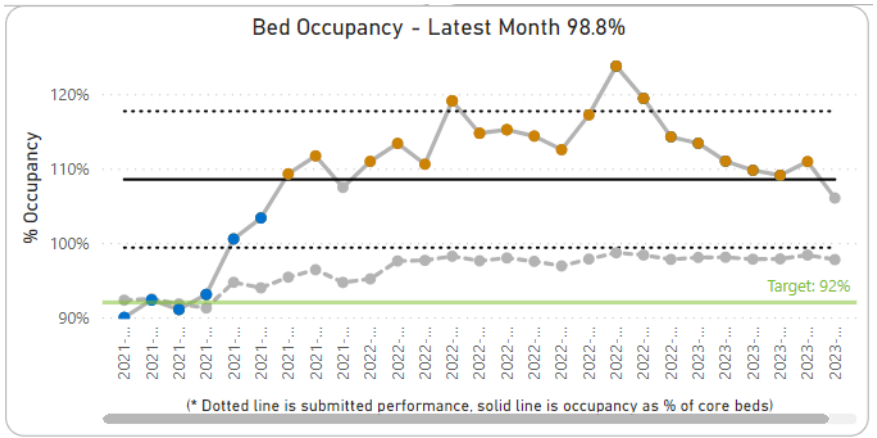
HALO's are in place but we need to ensure that we have internal queuing resourced 24/7 and have clear triggers.

We currently make decisions on using additional capacity such as reverse boarding when we are in extremis positions, this needs to become more pro active to help avoid queuing with internal triggers to enact so there is less reliance on capacity call discussions.

A review of the use of ED space is being explored following an ECIST visit which may support space to provide ambulatory and ambulance RAT.

SFT Position - Capacity

Increasing capacity – to support reduction in bed occupancy, with an emphasis on Same Day Emergency Care (SDEC) services.



SDEC has be successfully rolled out in medicine, frailty and is being established in surgery. Some pathways exist in surgery but there is a need to explore T/O and head and neck pathways out of ED

The protection of assessment areas is a significant contributor to reduction in LoS, by way of ensuring patients are allocated the correct bed/team at the start of their IP treatment.
It also supports hospital flow mitigating bottle necks in ED.

The use of Virtual wards will support the care of step down patients who can be safely care for in their own homes such as patients on IV Abx.

Ward processes are being reviewed by peer review with the emphasis on standardisation and lean methodology removing all steps that do not have added value.

SFT Position – Grow the workforce

NHS Salisbury NHS Foundation Trust

Grow the workforce – the modern workforce shows innovative thinking in addition to the traditional medical model of care to support in population demand.

CREATING A SUSTAINABLE WORKFORCE

Problem Statement: Our capability and capacity to deliver care depends upon having a sustainable workforce.

Analysis shows our current workforce is not sustainable, creating a risk that SFT will be unable to provide the care and support to staff and patients that is expected and measured.

Current Situation: SFT employs over 3500 WTE substantive staff, supplemented by bank workers and agency where required. Our specialist workforce is becoming harder to both recruit and retain and more generalist staff, required in numbers are the same. Financial conditions require is to reduce our reliance on temporary agency staff.

Staff survey results indicate nearly a third of staff intend to leave and fewer are recommending SFT as a great place to work. A high proportion of staff in Bands 2-4 leave in the first 2 years, whilst the average age of the clinical workforce is high.

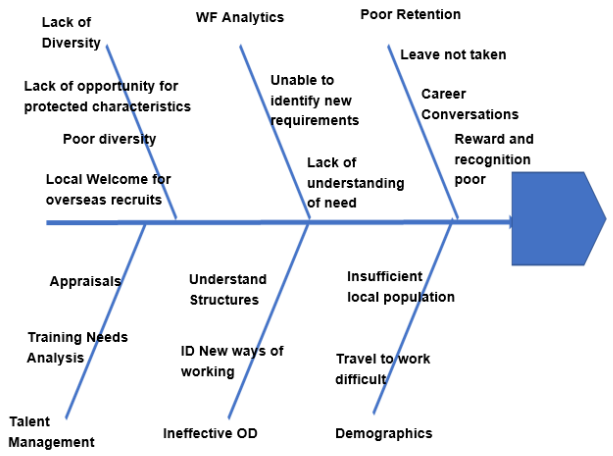
The local demographics in Salisbury are insufficient to satisfy the demand for staff, particularly Medical staff.

Vision: SFT understands the skills mix required to manage service now and in the future, with a resourced plan to maintain new and existing workforce requirements and manage talent appropriately. **Goals**. SFT is attractive to skilled staff, maximising retention rates. Accurate workforce analytics enable us to plan to respond to everchanging service and workforce needs.
Our workforce is affordable, increasingly productive and agile.
We have a pipeline of talent wanting to work at SFT.

People feel welcome and included with all kinds of diversity being perceived as an asset.

Owner(s): OD&P – Melanie Whitfield and Ian Crowley

Root Causes Analysis



Benefits:

Strategic capability increases

Happy staff deliver better care

Reduction in agency spend

Efficiency through reduced recruitment activity.

Risks:

Employment market falling

Increased demand outstripping supply

Time pressure vicious circle

Delays to people promise implementation driven by: - effort reg'd Vs time available, lack of investment, lack of knowledge/ skill to implement, return of pandemic conditions, leadership and political changes of priority.

Countermeasures – Plan, Do, Study, Act Cycle

Concern	Cause	Countermeasure	Owner	Due Date	Status	Outcome	Next Step
WF Analytics	Ineffective Strat WF Planning	Cross Trust mechanisms to address strategic WF planning capacity	OD&P	Aug 23	Green	Estb Baselined	24/25 WF Plan developed
Retention	LM lack confidence and understanding	Deliver across People Promise workplan elements	OD&P / LMs	Apr 24	Amber	Improved Retention to 12%	Report end Mar 24
Talent Man	No forward plans	LM Training Talent Management strategy	OD&L	tbc	Amber	Effective Line Managers, talent managed	Strategy approved
Inclusion	See Equity Watch metric A3	Adopt SW Inclusion plans	OD&P	Apr 24	Green	Improved WRES/WDES metrics	Report end Apr

NHS Salisbury NHS Foundation Trust

Report to:	Trust Board (Public)	Agenda item:	3.1
Date of meeting:	5th October 2023		

Report from (Committee Name):	Clinical Governance Committee		Committee Meeting Date:	26th September 2023
Status:	Information	Discussion	Assurance	Approval
	X	X	X	
Prepared by:	Miss Eiri Jones NED			
Executive Sponsor: (presenting)	Miss Eiri Jones NED			
Appendices	Nil			

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 26th September 2023. The report both provides assurance and identifies areas where further assurance has been sought and / or is required.

Executive Summary:

- Key information / issues / risks / positive care to escalate to the Board are as follows:
  - ADVISE - The following subjects were discussed on the agenda:
    - Divisional Governance report from CSFS
    - Deep Dive from the Intensive Care Unit
    - Safer Staffing review
    - Maternity report (included in the safe staffing report)
    - Integrated Performance Report
    - Risk report
    - Board Assurance Framework
    - Safeguarding annual reports
    - PSIRF update
    - Research report
    - Clinical Management Board
- ALERT - areas for highlighting to the Board for consideration and discussion and where further assurance is being sought:
  - Ongoing focus on stroke, VTE and mortality. Stroke had been discussed at F&P committee earlier in the day and noting the progress being made re the SNAPP audit, a query was raised at CGC in relation to ongoing assurance relating to quality of care. Further reports are expected in relation to VTE and mortality in forthcoming meetings. Verbal updates were provided in the September in relation to ongoing work in both these areas though further assurance reports are required.

- The CFSF Division highlighted the number of CAMHS patients using acute care services. This can cause additional pressure on the service in relation to admitting physically acutely ill children. Whilst the committee is aware that this is a national issue, the service regularly escalates to the relevant mental health provider and the system. Other areas alerting from the Division include violence and aggression towards staff and blood kiosk function
- The Intensive Care Unit presentation highlighted the following areas for improvement – time to discharge with the resultant impact on single sex accommodation, datix management and staffing
- The safer staffing 6 month report was presented. Recognising that good progress has been made in recruiting registered nurses, ongoing areas of alert include agency spend, maternity staffing and the skill mix / experience levels of new staff (See assurance section below for assurance gained)
- Whilst maternity services continue to provide 1:1 care in labour and supernumerary status for the coordinator, staffing remains pressured due to vacancies. The monthly report was received and will also be presented at the next Board meeting as per national reporting requirements.
- The risk report was presented noting that all Divisional deep dives with executives were planned to be completed by the end of October. A query around line of sight from ward through to CGC and Board was raised, and this will be the subject for the next report, also noting the implementation of PSIRF and LFPSE (new safety incident processes)
- The alerts from the safeguarding reports related to CAMHS workload, MASH referrals and DBS checking (repeats and new starters)
- The impact of industrial action is being felt across the organisation including on the waiting list/elective care and recruitment to research trials. Further assurance will be sought re full quality impact at a future date.
- A new concern has been raised in relation to the sustainability of the gastroenterology service. The Chief Medical Officer is liaising with the service and providing support. An action for further update has been placed on the action log.

- ASSURE - the following areas of assurance were received:
  - The CSFS Divisional report highlighted good performance in relation to risk management and complaints with good escalation processes within the Division.
  - The deep dive presentation from the intensive care unit highlighted good performance in relation to national standards (GPICS 2015).
  - The required processes have been followed for the safer staffing review and the Chief Nursing Officer and her team are working closely with finance and operations teams to ensure that the correct nursing resource is a focus for annual business planning.
  - The patient experience team noted a reduction in the number of formal complaints and the number of complaints reopened. This is in positive response to the improvements made in the management of informal concerns and PALS queries.
  - In the discussion on the IPR, it was flagged that the number of patients meeting the no criteria to reside remained over the expected trajectory. Assurance was provided that the impact was being reviewed from a quality perspective.
  - The new version of the BAF was reviewed, noting the alignment with the ICS BAF. Thanks was given to the Director of Corporate Governance and to the teams involved for this work in keeping the BAF a relevant and live document.
  - Progress is being made across the system in relation to PSIRF implementation and two patient safety specialists have been identified by the Trust.

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

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

NHS Salisbury NHS Foundation Trust

Report to:	Trust Board	Agenda item:	3.2
Date of meeting:	21 September 2023 (Extraordinary), 26 September 2023		

Report from (Committee Name):	Finance & Performance Committee		Committee Meeting Date:	21 September (extraordinary) 26 September 2023
Status:	Information	Discussion	Assurance	Approval
			x	
Prepared by:	Debbie Beaven (NED)			

Recommendation:

The Finance and Performance Committee met twice in September. There was an extraordinary session on 21 September dedicated to considering the submission for the Medium-Term Financial Plan; the escalation points are covered in this section below. The full meeting was on 26 September 2023, in which the Committee considered the following business cases and contracts:

1. **Volumetric Pumps -** The Committee was asked to approve a 7-year lease for 250 Volumetric Infusion Pumps including consumables. This equipment is critical for the provision of safe patient care, with the current fleet depleted and unreliable. Following some challenge regarding the involvement of nursing staff in the process, we were assured that they were party to the decision through representation at the MDC. The procurement method, via lease, was questioned. The Committee noted that there is no capacity in the capital budget for this expenditure and that a lease option would not, in this case, be treated as capital under FRS17, because the capital element of the lease was immaterial. The cost pressure highlighted in the paper does not include training, and the Committee were assured that this would be delivered internally with no additional cost pressure. Total costs over the 7 years are within the approval levels for F&PC; ***The Committee, therefore, approved the recommendation.***

2. **CT Scanner Lease and Revised works -** The Committee considered the request to approve a 7-year lease for 2 CT Scanners. With a compelling case based on sustaining a reliable and effective provision of service, and the detrimental impact on patient safety if the scanners are not replaced, ***this case was supported by the Committee and is recommended to the Board***. It is, however, subject to obtaining "lease funding", which we hope to hear about imminently. In the event that the funding is not available, urgent and alternative funding will need to be sought.

3. **Improving Together Business Case** – The proposal presented to the Committee received significant scrutiny as it presents an additional cost pressure. Whilst it will be funded from an investment budget, taking 20% of the budget, meaning it is fully allocated at M5. The Committee were mindful that there may be other critical needs for which the funding will be required, and wanted more assurance that there are significant benefits in bringing forward the timescale for the implementation whether that be the confidence level in delivering our challenging CIPs target or improving the value of the CIPs this year and/or next year and beyond. The Committee acknowledged the significant progress being made as a result of the programme and how it is being embedded into the culture and felt that it would potentially be damaging to our ability to continue with

our "improving together" if we did not invest in the resources that will create the capacity for "change agents". ***The Committee agreed to support the recommendation but*** requested that the paper comes back next month detailing the benefits and identifying the "hot spots" where the investment will be focussed on to drive the most needed improvements.

4. **Day Surgery Discharge lounge** – The Committee received a recommendation from Strategic Capital Committee to reallocate funds from the Trust's capital programme to undertake works to create a discharge lounge within the day surgery unit to improve patient flow, maintain elective activity and improve patient experience. ***The Committee approved.***

Executive Summary:

The Board is asked to note the following items from the F&P meeting on 26th September and reference to the extraordinary meeting on 21 September in the Medium Term Financial Strategy section:

Performance and Risk:

1. **Integrated Performance Report** – The following themes were drawn out from the IPR for M5:
   - ***a. Alert***
     - i. Industrial action (IA) is preventing recovery for elective activities and continues to impact resource costs and waiting times for treatment. The Committee was advised that it is hard to predict the impact of IA on resourcing plans, as the number striking is not known until the action commences. The Finance Report included an appendix detailing the impact of IA. There has been a cost of approx. £1.8m so far, with a forecast of £5.6m by the end of the year, which after funding, could leave a £1m hole in our finances. Nearly 1,500 activities have been rescheduled at M5.
     - ii. A report on Elective Priorities and assurance was received by the Committee, who took ***some assurance*** from the transparency of the paper, but questioned whether the Committee could be sighted on where the "hot spots" are. The Executive will consider how to bring a strategic service review, considering finance, workforce and performance of service areas to provide more oversight for assurance.
     - iii. Despite a good winter plan (see later) recovering the position on elective, while dealing with the winter pressures will add to the challenge and we are unlikely to catch up.
     - iv. There are some areas where outsourcing is helping to improve performance and trajectories, such as dermatology, however the results won't show for another 2 months. Nationally there is recognition of the lack of capacity to meet demand in this speciality.
   - ***b. Assure***
     - i. The ongoing improvements in SDEC and new frailty service is helping to reduce the length of stay and occupied beds.
   - ***c. Advise***
     - i. Breast patients now included in the RTT waiting times (over 104 week waits).
     - ii. Theatre timetable revised for October with more capacity.

2. **Cancer Faster Diagnosis -** the Board is ***alerted*** to the issue of data reporting quality. The paper presented to the Committee highlighted the root cause as being a difference between internal and external reporting but was ***assured*** that the external reporting was correct and that the mitigation by clarifying roles and responsibilities should improve quality. However, the error in internal reporting is cause for concern and disappointment, given that the Cancer 28-day Faster Diagnosis standard, showed our performance appearing to be near or above target for the last 6 months, when in fact they were below target by some way. As a result of this and some other examples where data input,

processing, quality or reporting have been mentioned in reports, the Committee is recommending that an internal audit of data will be planned by the DoF, liaising with the Audit Chai and ***advise*** the Board.

3. **Winter Plan –** The Committee were ***assured*** of the winter planning, which was well presented and thought through and acknowledged that IA will continue to have a major impact. The use of a discharge lounge is key to keeping flow working more effectively.

4. **Stroke Performance** – The Committee received an ***assuring*** update on the improving stroke performance, with the % of patients admitted direct to the Stroke Unit within 4 hours improving up to 42%, but were reminded that protecting beds will be done as long as is possible and until there is absolute pressure to make them available.

5. **Electronic Patient Pathway Management** – The Committee were ***assured*** that since the roll out there has been good engagement, but that for it to provide full benefit and enable effective bed management there will be a need for cultural change. We will receive a further update later in the roll out process – 9-12 months' time.

6. **Finance Report** – The Committee was asked to note the financial position to M5, which shows a continuing deficit; £5.1m, £3m worse than plan. Payroll costs continue to run higher than plan with an additional £1.6m over plan spent in M5. The impact of industrial action was detailed for the Committee, particularly bank costs for locums who have been used to fill gaps during periods of industrial action. Whilst there is some funding to cover the impact of IA, it does not acknowledge the significant impact on management time spent planning for safe care during IA, which detracts from time to drive the improvement agenda. There remain many pressure points, with mental health being an issue with interventions impacting negatively on costs. Non-Pay costs are £1.5m above budget with inflation being a major contributing factor.

7. **CIPs –** The performance on CIPs is nearing closer to target, with £4.8m of savings delivered against a target of £6.4m year to date. It is acknowledged that pace needs to increase to reduce the run rate. The Committee acknowledged that there is still no progress with unlocking a new approach to NCTR patients, enabling their discharge from hospital beds and reducing the costs, which are estimated to be approx. £3m for the full year. The Board are ***advised*** that this is a financial pressure that will be extremely hard to mitigate.

8. **Medium Term Financial Strategy (MTFS)–** An Extraordinary meeting of the committee held on 21 September considered the modelling of the MTFS prepared for submission to the ICB. The Committee considered the timescale to breakeven, with the scale and pace of improvement being a key risk. The Board are ***advised*** that, after much discussion, the Committee supported a breakeven plan over a 5-year period and proposed that this was submitted together with a "side letter" that described the plan as a "statement of ambition" and detailed any material assumptions beyond those prescribed.

   In the meeting on 26 September the Committee were advised that there was a minor change, which improved the position and that the draft letter was being reviewed by the Trust solicitors. The Committee requested that they be advised of any changes to the MTFS.

9. **Q2F –** The Committee received draft forecast figures for Q2F, which they were asked to note, showing a deteriorating position, and were advised that all 3 BSW Trusts are in the same position, which will present challenges and likely consequences around our rating. There is no date for the submission yet.

10. **Estates Update –** The Committee were ***assured*** through a comprehensive update that the Estate's activity is being managed well, with ***further assurance*** given that the 5 remaining extreme risks will

be mitigated by the end of the year. However, the Board are ***alerted*** to the continuing significant maintenance backlog and the risk that there will be insufficient capital next year to improve the position. The Estates Strategy is being prepared and will be ready for March 2024, with the Committee hopeful to see a draft before then.

11. **Procurement & Commercial Services Annual Report –** The Committee ***took assurance*** through the paper and discussion that there are good procurement processes and engagement in place, although there are pressures on resourcing and conflicting priorities across the 3 Trusts served in BSW. We heard that there has been training in Improving together and that an away day is planned in November to explore ways of improving the effectiveness of procurement across BSW.

Wrap up on Governance and Controls:

1. ***Advise:*** With the feedback Well Led review in mind and the challenges the Committee experience in preparing for meetings, the following improvements were agreed:
    a. Executive summaries need to provide clarity on the purpose of the accompanying papers. They should be clear on what forums they have been through and where they need to go, if anywhere, after F&PC. Where approval is sought to commit finances or enter into contracts where there is a financial risk/liability the papers should clearly show the rationale, how it aligns with strategic and operational objectives of the Trust and/or the System, whether the spend is in plan, how it is funded, the key benefits (financial and non-financial) and the significant risks that the Committee should be aware of.
    b. All business cases and contracts should, ideally, be presented by the business owner in the Committee with Procurement colleagues available to give assurance of compliant processes.
    c. All business cases should have the support of the Executive team.
2. ***Advise:*** To ensure compliance with SIs and clarity on approval levels these should be added as an appendix to the Terms of Reference.
3. ***Assure:*** Lessons learned from the payroll issues in August have been taken and addressed. Their effectiveness will be reviewed later through an internal audit.
4. ***Advise:*** The financial impact of the deficit in Wiltshire Health and Care, of which SFT, owns 1/3 is currently held as a cost by the ICB and is not in SFT's financial forecast.

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

NHS Salisbury NHS Foundation Trust

Report to:	Trust Board (Public)	Agenda item:	3.3
Date of meeting:	5 October 2023		

Report from (Committee Name):	Trust Management Committee		Committee Meeting Date:	27th September 2023
Status:	Information	Discussion	Assurance	Approval
	x		x	
Prepared by:	Chief Operating Officer			
Executive Sponsor: (presenting)	Chief Operating Officer			
Appendices	None			

Recommendation:
The Board is asked to note the report.

Executive Summary:

The Trust Management Committee was held on 26th September

The committee reviewed a number of business cases

1) Gastroenterology: working with Primary Care

This Committee considered a case related to a proposal for investment in insourcing gastroenterology resource by local GP partnership funded by income generated through ERF for admitted new patients into Hepatology or Gastroenterology pathways:

Gastro has been under significant pressure for a number of years with an inability to recruit both substantive and locum capacity to meet demand. This partnership arrangement allows greater capacity and reduction in referrals for secondary care. The initial scheme is for 30 patient appointments per week for new and follow up patients on an abnormal LFT pathway. The expected cost is £206k per annum against income of £266k.

The committee approved subject to all clinical governance documentation being finalised.

2) The New ward business case

The Trust approved the original business case as part of the bid for capital funding 18 months ago. This case was the final revenue model associated with opening the theatres from 13 to 16 and the staffing for the ward. The case highlighted higher costs for staffing than originally proposed. The committee approved the amount to the original costings but wanted to scrutinize the additional spend identified namely in Anaesthetics and clinical support functions.

3) MCA apprenticeship Programme

This case considered investment in supporting Maternity Care Assistants complete a two year apprenticeship in Midwifery via Winchester university. Women and Newborn Division have been offered two places on the programme starting January 2024. The apprenticeship university fees are provided via the apprenticeship levy, SFT will be required to fund the
salaries of the successful applicants.

The committee approved as the short term funding had been identified through national funding. There is still a requirement to identify funding to support investment and training in all nursing apprenticeship programs at SFT.

Other items to note:

- There remains a concerted focus on ensuring policies are updated with an ongoing oversight at TMC to ensure the number due for ratification are expedited.
- The new Elective Patient Access booking and Choice policy was approved, it has been updated to reflect the latest NHS England guidance.
- The committee reviewed the corporate risk register and BAF with some discussion on reviewing Divisional risk registers ensuring full alignment.

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

NHS Salisbury NHS Foundation Trust

Report to:	Trust Board	Agenda item:	3.4
Date of meeting:	5th October 2023		

Report from (Committee Name):	People and Culture Committee		Committee Meeting Date:	28th September 2023
Status:	Information	Discussion	Assurance	Approval
	X	X	X	
Prepared by:	Miss Eiri Jones, Chair PCC			
Executive Sponsor: (presenting)	`Miss Eiri Jones, Chair PCC			
Appendices	Nil			

Recommendation:

Trust Board members are asked to note and where relevant, discuss the items escalated from the People and Culture Committee (CGC) meeting held on the 28th September 2023. The report both provides assurance and identifies areas where further assurance has been sought and / or is required.

Executive Summary:

- Key information / issues / risks / positive care to escalate to the Board are as follows:
  - ADVISE - The following subjects were discussed on the agenda:
    - Equality, Diversity and Inclusion (EDI) workstream
    - PCC Work plan
    - Board Assurance Framework
    - FTSU Board self-reflection toolkit
    - Long Term Workforce Plan (LTWP) – this month's focus on Retain
    - Operational Performance WF&P teams
    - Internal Audits and Counter fraud audits
    - Integrated Performance Report
    - Guardian of Safe Working annual report
    - WRES and WDES action plans
    - OD and P Management Board upward report
- ALERT - areas for highlighting to the Board for consideration and discussion and where further assurance is being sought:
  - Areas flagged at the start of the meeting included the risk and impact of reduced capacity in the hospital, gastroenterology workforce (cross referenced with CGC) and flexible working considering the Trust demographics (from staff survey feedback)
  - Risk areas relating to the BAF included digital with a focus on technology changes and the impact on our workforce, achievement of timelines and the challenge between processes and outcomes.

- The committee is focussing on each chapter of the LTWP in turn and has identified the need to improve the focus on being a learning organisation. There is a continued focus on the turnover rates which remain over target. The retain actions are expected to improve this and will be monitored through the committee according to the workplan.
- Whilst the GOSW annual report provided good assurance for the last year (see below), the Guardian raised the following emerging themes for this year – low morale (impacted by industrial action) increase in exception reports, flexible working and the sexual harm concerns reported nationally. These will be considered and addressed through the year and reported back to PCC.
- The draft action plans for WRES and WDES were received, discussed and feedback given noting that the actions remain more transactional than transformational at present. It was confirmed that it was important to focus on the fundamentals at this stage noting that a three-year strategy is in development. The final draft action plan will be presented at October Board ready for submission at the end of the month. 3 key themes for actions are recruitment, working of the networks and cultural awareness. Noting progress in place, the committee acknowledged that there is more to do in relation to ensuring people from all protected characteristics are supported in the workplace.
- Work is ongoing to reconcile the financial ledger with the ESR, noting that a delay has occurred.

- ASSURE - the following areas of assurance were received:
  - The new version of the BAF was reviewed, noting the alignment with the ICS BAF. Thanks was given to the Director of Corporate Governance and to the team for this work in keeping the BAF a live document.
  - The FTSU Board self-reflection toolkit was reviewed, and it was noted that it demonstrates good performance. There is strong leadership in this area and the Trust is recognised as a leader in this field. The committee was assured that there was no complacency and still work to do. The toolkit will also be presented at Board in the October meeting
  - A good dashboard is in place in relation to the operational management of the OD&P service. 36 of the 53 metrics are on target or within 5% of the target.
  - Good assurance is now in place in relation to progress against internal audit and counter fraud audit action plans. Where actions have previously been delayed, a clear plan is in place to achieve and these will report back to this committee in November (2023) and January (2024) after the relevant deadlines
  - Progress was noted in the IPR this month in relation to sickness absence and vacancies.
  - The GOSW report was presented and noted the improvements in relation to increased Deanery posts filled over the last year. There was also an increase in Foundation Doctor posts by 6. The number of fines re breaches and exception reports remained low for the year. Actions to support junior doctors, review the gender pay gap and flexibility requests are in train for this year (see Alert issue above)

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

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

NHS Salisbury NHS Foundation Trust

Report to:	Trust Board (Public)	Agenda item:	3.5
Date of meeting:	5 October 2024		

Report from (Committee Name):	Audit Committee		Committee Meeting Date:	21 September 2023
Status:	Information	Discussion	Assurance	Approval
	X		X	
Prepared by:	Richard Holmes (Audit Committee Chair)			
Executive Sponsor: (presenting)	Richard Holmes			
Appendices				

Recommendation:

Amongst other matters discussed at the Audit Committee, the Board is asked to **NOTE** the key escalation items below, and **APPROVE** those items recommended to it:

Executive Summary:

Key Items for Escalation:

Deep Dive – Electronic Outcome Forms (EOFs), presented by Annalise McNair, Clinical CIO

A new Electronic Outcome Form has replaced the previously existing Paper Outcome Form as a tool to record and communicate next steps in a patient's treatment, specifically to ensure follow on appointments are arranged within appropriate timescales, to record RTT status effectively and to improve procedure coding.

The results have been very encouraging; as an example, complaints from patients regarding delays and lack of follow up by the Hospital following treatment have reduced by 75% in the 15 months to July 2023 compared with the 10 months to January 2021.

Some challenges still remain to embed the use of EOFs across the Trust; it will form the basis of new functionality in the recently approved EPR system.

The new business process solution was developed in conjunction with Clinical and Non-Clinical staff and is a good example of an effectively implemented IT and process solution to a business problem.

Internal Audit and Counter Fraud Audit

The Committee was joined by representatives of KPMG, the newly appointed Internal and Counter Fraud auditors. Both teams reported successful handovers from the previous incumbents, and subjectively reported feeling welcomed and embedded into the Trust, with good engagement with Trust staff.

Both teams have been appointed as auditors to the wider AHA including GWH and RUH, and as such will be ensuring, where agreed with Clients, that good practice and lessons learned from audits across the AHA are shared.

Internal Audit

The Internal Auditors presented their progress against plan, with no major issues to report. Two audits are under way and will be reported to the next Audit Committee. 40 management actions have been cleared since the previous Audit Committee. Of the 20 management actions that remain open from previous internal audits, two are outstanding as being overdue with no agreed extension. The Committee required that work is undertaken to clarify this position such that all audit actions are current with none being overdue at the next Audit Committee. Neither overdue action presents a material risk to the Trust. The majority of the remaining open actions relate to workforce design, planning and management.

It is the intention of the Audit Committee to explore the value of planning at least one common audit across the three AHA trusts for the 24/25 financial year.

KPMG reported that their initial opinion was that the Trust's approach to Risk Management tracking and associated management focus is "thorough and impressive" when compared to other organisations.

Counter Fraud audit

The Counter Fraud Auditors presented their progress report, which highlighted no significant findings at this stage of their engagement. They are under way with two Counter Fraud audits to be reported to a subsequent Audit Committee meeting.

Five issues were referred to the Auditors to investigate from within the Trust, of which one remains ongoing. In particular, the Committee considered the case where an agency member of staff was alleged to be working without the relevant qualifications. That individual is not currently and will not in future be engaged by SFT, and hence the local risk is mitigated, but the Committee was assured that local, regional and national scrutiny would prevent that individual from working at the same level in a different Trust, and vice versa.

External Audit

Following the appointment of Deloitte as the Trust's external auditors, initial audit planning meetings have taken place. The Audit Committee required that the full plan be completed and submitted to the Audit Committee at its December meeting. This is an accelerated timetable compared to that of previous years.

Action Tracking

In conjunction with KPMG and Deloitte, the Trust has now developed a comprehensive mechanism for recording and tracking Audit Actions centrally which will improve visibility of matters raised during Audits.

Board Assurance Framework review

The Committee reviewed the Boad Assurance Framework and recommends to the Board that the Committee's view is that it remains effective and proportionate to manage the risk horizon facing the Trust.

Reports for noting – the Committee noted the Payroll Overpayments report, and the Register Of Losses and Compensation reports with no substantive issues of concern.

John Parker and Barry Bull, Governors, observed the meeting.

Board Assurance Framework – Strategic Priorities	Select as applicable:
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People: Supporting our People to make Salisbury NHS Foundation Trust the Best Place to work	Yes
Other (please describe):	N/a

NHS Salisbury NHS Foundation Trust

Report to:	Trust Board (Public)		Agenda item:	3.6
Date of meeting:	5th October 2023			
Report tile:	Integrated Performance Report			
Status:	Information	Discussion	Assurance	Approval
			Yes	
Approval Process: (where has this paper been reviewed and approved):	Sections received by the responsible committee: - Operational performance and resources: Finance and Performance Committee - Quality and care: Clinical Governance Committee - Workforce: People and Culture Committee			
Prepared by:	Adam Parsons, Operational Performance Lead			
Executive Sponsor: (presenting)	Mark Ellis, Chief Finance Officer			

Recommendation:

The Trust Board are asked to note the Trust's performance for Month 5 (August 2023)

Executive Summary:

The Trust has experienced a downturn in flow capacity, impacting on relative performance metrics and particularly highlighted through Emergency Department (ED) 4-hour performance dropping to 75.7% (from 80.3%) and 12-hour breaches increasing from 16 to 47 despite having fewer attendances in month (6,320 compared to 6,527). Directly contributing are an increase in bed occupancy to 99% (from 97%), NCTR patients averaging at 89 daily and a reduction in total discharges. Despite this, ED has again improved ambulance handover performance to an average of 18 minutes, making SFT the 2nd best performing acute trust in the country against this metric.

The Same Day Emergency Care (SDEC) pilot introduced to AMU continues to have a positive impact, diverting appropriate patients away from ED and showing early potential of reducing LoS through protected, targeted treatment areas (AMU average pre-pilot 33 hours compared to current 25 hours).

Breakthrough Objective relating to average time to first outpatient appointment remained static above target (132 days against 87 days) and the overall RTT waiting list (WL) increased (from 28,649 to 29,909), however the overall long wait clearance rates remain slightly ahead of plan. Significant addition to WL is a cohort of Breast patients due to a change in recording and management from NHSE, which has resulted in a small number (15) of patients waiting longer than 78 weeks, a standard that the Trust has achieved since March '23.

Quality related metrics were similarly opposing, with Breakthrough Objective of patient falls increasing back above target for the first time in 3 months, although only marginally (7.3 against 7), bed moves also increased with escalation areas opening, whereas stroke 4-hour performance increased to highest level since Sep '21 (61%).

Cancer performance is in a worsening position with both 2WW and 28-day performance deteriorating to lowest levels since Sep '21. Skin patients account for a large proportion of this and demand and capacity modelling support is being provided internally along with Dermatology outsourcing initiative to urgently address. A discrepancy in external and internal reporting in relation to the 28-day standard has resulted in a change to our previously reported performance in this report from January '23. The 28-day standard has not been achieved since January '23.

Workforce relating to Breakthrough Objective of Staff Availability saw a further decrease in agency spend aligned with an improvement in vacancy rates to lowest levels since March '22, with turnover rates remaining static.

Finance recorded a YTD control total deficit of £5.141m against a target of £2.151m - an adverse variance of £2.990m. The position is driven by the costs of Industrial action, the costs of provided enhanced care to patients and the residual gap on pay awards.

Board Assurance Framework – Strategic Priorities	Select as applicable:
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Partnerships: Working through partnerships to transform and integrate our services	Yes
People: Supporting our People to make Salisbury NHS Foundation Trust the Best Place to work	Yes
Other (please describe):	N/A

Integrated Performance Report

NHS
Salisbury
NHS Foundation Trust

August 2023

Summary

August 2023

Salisbury NHS Foundation Trust

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Vision

To provide an outstanding experience for our patients, their families and the people who work for and with us.

NHS Salisbury NHS Foundation Trust

People
working for us

Population
our patients and their families

Partnerships
working with us

Vision metrics 7 – 10 years

- Engagement Score in Staff Survey
- Reduction of unwanted turnover (people leaving the Trust or the NHS)
- Proportion of WDES & WRES at median
- # of wait metrics at median
- Total incidents with moderate or high harm
- Patient Engagement Score
- Increase in Healthy Life Years
- Overall Length of Stay
- Matrix Measure

Strategic initiatives 3-5 years

- Continuous improvement culture
- Delivering our people promise
- Delivering Digital Care
- Improving health and reducing health inequalities

Corporate Projects

Breakthrough Objectives 12-18 months

- Reducing Falls
- Reducing time to first outpatient appointment
- Staff Availability
- Bed Occupancy

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.

Business Rules - Driver Metrics

Rule No	Rule	What It means	Suggested Action for Metric Owner	Rationale
1	Driver does not meet target for a single month	Performance outside of expected range for a single month	Give Structured Verbal Update	Understanding required as to whether adverse performance will be due to a consistent issue or a one off event
2	Driver does not meet target for 2 or more months in a row	Performance outside of expected for multiple months in a row	Prepare Countermeasure Summary	Showing signs of continued difficulty meeting the target and need understanding of root cause.
3	Driver meets or exceeds target for a single month	Performance outside of expected range for a single month	Share top contributing reason	Showing early signs of improvement but not yet sustained
4	Driver meets or exceeds target for 2 or more months in a row	Performing above target for multiple months in a row	Share success and move on	Showing signs of continued improvement but not yet assured that the target will always be met
5	Driver meets or exceeds target for 4 or more months in a row	Performing above target for a sustained length of time	Consider swapping out for a Concerning Watch metric/increase target of Driver	Assess Watch metrics and consider switching out this high performing Driver metric for an underperforming Watch metric, or increasing target of Driver metric
6	Driver is orange	Performance outside of expected range in a negative/deteriorating direction	Refer to rules 1-4 above and act accordingly	Driver metrics are being deliberately targeted and therefore SPC rules are not strict enough for monthly performance assurance purposes
7	Driver is grey	Performance is in line with expectations (no special cause)	Refer to rules 1-4 above and act accordingly	Driver metrics are being deliberately targeted and therefore SPC rules are not strict enough for monthly performance assurance purposes
8	Driver is blue	Performance outside of expected range in a positive /improving direction	Refer to rules 1-4 above and act accordingly	Driver metrics are being deliberately targeted and therefore SPC rules are not strict enough for monthly performance assurance purposes

Business Rules - Watch Metrics

Rule No	Rule	What It means	Suggested Action	Rationale
9	Watch has one point out of control limits – orange	Concerning performance	Share top contributors and move on	**SPC logic** – Orange means special cause variation causing adverse performance. Understanding required as to whether adverse performance will be due to a consistent issue or a one off event
10	Watch has 2 out of 3 points low – orange	Worsening performance	Give Structured Verbal Update (includes top contributors)	**SPC logic** – Orange means special cause variation causing adverse performance. Understanding required as to whether adverse performance will be due to a consistent issue or a one off event
11	Watch has 4 points below mean or 4 points deteriorating - orange	Worsening performance	Consider: - Upgrading to a Driver and which driver to downgrade to a watch (include on Slide 4)	**SPC logic** – Row of orange dots means special cause variation causing adverse performance. Discussion required around whether this requires promotion to driver and replace current focus.
12	Watch has one point out of control limits - blue	Improving performance, not yet sustained	Do not discuss	**SPC logic** – achieving our stretch target. Sustained improvement, not natural variation. Blue dots = showing sustained improvement
13	Watch has 2 out of 3 points high - blue	Improving performance	Do not discuss	**SPC logic** – achieving our stretch target. Sustained improvement, not natural variation. Blue dots = showing sustained improvement
14	Watch has 6 points above mean or 6 points increasing - blue	Improving performance	Do not discuss	**SPC logic** – achieving our stretch target. Sustained improvement, not natural variation. Blue dots = showing sustained improvement
15	Watch is grey (no special cause)	Performance is as expected	Do not discuss	**SPC logic** – nothing special is going on, performance is within normal variation

Business Rules - Statutory/Mandatory Metrics

These are additional rules only applied to certain metrics that are statutory or mandatory to be monitored at Trust level.

Whether or not a metric has met its target each month will be indicated by a tick or cross icon in the "Target Met This Month?" column. The number to the right of that indicates how many months in a row the metric has **NOT** met its target for. Any metric that has met the target in the current reporting month will therefore show a 0 in this column. Different actions are suggested depending on how many months the target has not been met for.
These metrics are assessed against their improvement target, or their national target where no improvement target exists.

Rule No	Rule	What It means	Suggested Action for Metric Owner	Rationale
16	Mandatory does not meet target for a single month	Performance outside of expected range for a single month	Note performance Give structured verbal update by exception	Understanding required as to whether adverse performance will be due to a consistent issue or a one off event
17	Mandatory does not meet target for 2 or more months in a row	Performance outside of expected for multiple months in a row	Give structured verbal update, agree if counter measure summary required	Showing signs of continued difficulty meeting the target and need understanding of root cause.
18	Mandatory does not meet target for 4 or more months in a row	Performing below improvement target for a sustained length of time	Consider applying improvement target	Showing signs of continued difficulty meeting the target despite understanding of root cause. Current performance known and acknowledged.
19	Mandatory with improvement target meets or exceeds target for 4 or more months in a row	Performing above improvement target for a sustained length of time	Consider increase target of Mandatory	Assess Mandatory metrics and ensure performance culture is maintained.
20	Mandatory is orange	Performance outside of expected range in a negative/deteriorating direction	Refer to rules 16-17 above and act accordingly	Mandatory metrics are being deliberately monitored and therefore SPC rules are not strict enough for monthly performance assurance purposes

NHS
Salisbury
NHS Foundation Trust

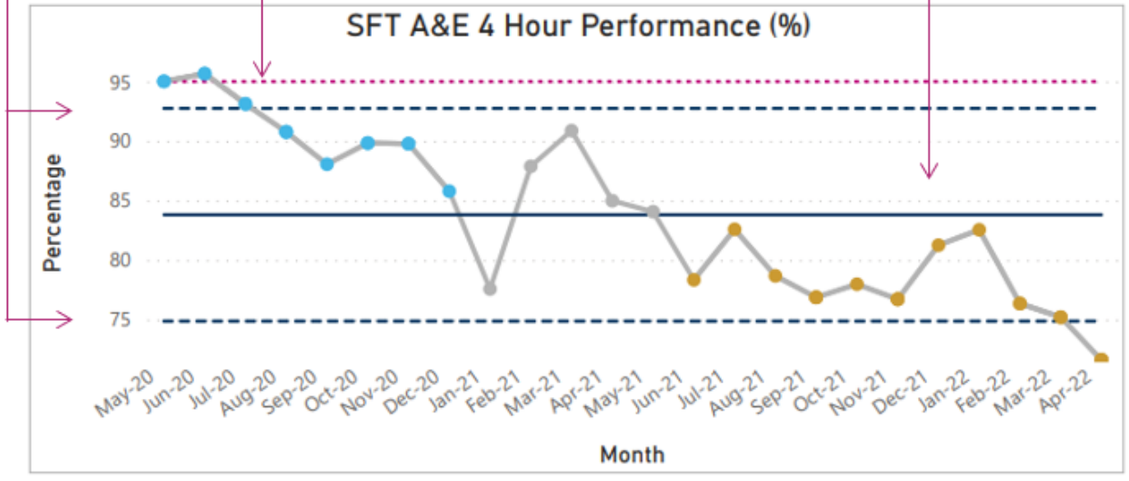
Reading a Statistical Process Control (SPC) Chart

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

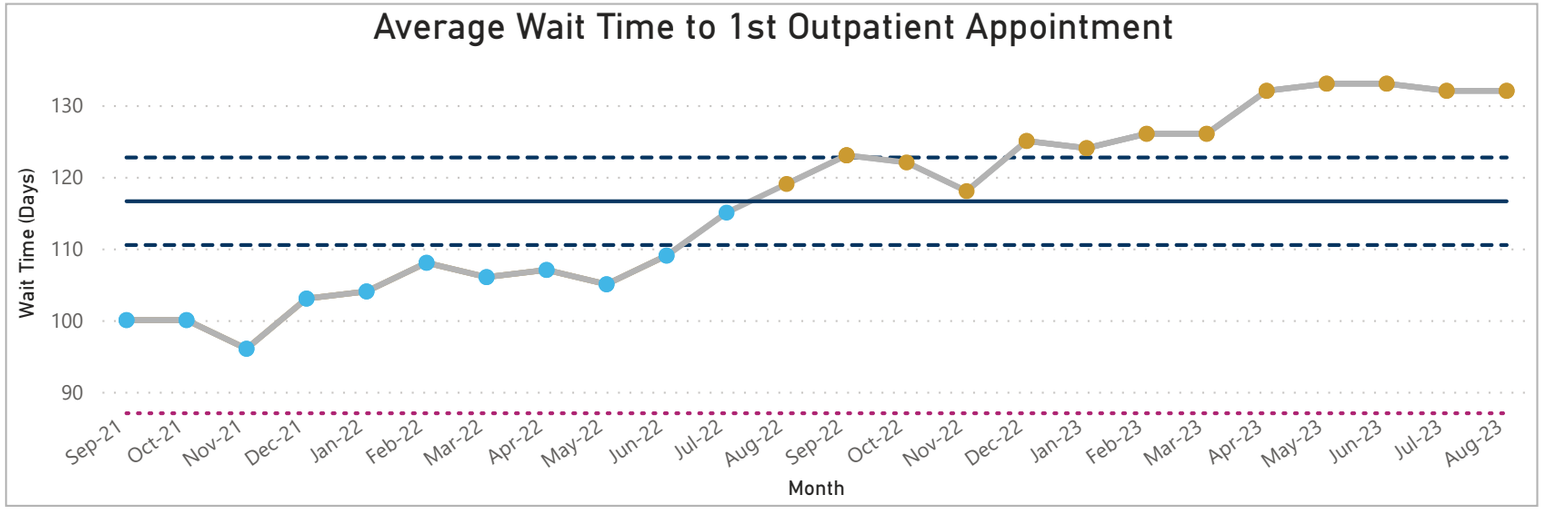
Partnerships

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

The performance data shows a static position in performance between July and August's position, at 132 days. Given the monthly loss of capacity/activity from the ongoing Industrial Action (now including Consultant IA) this is not entirely disappointing.
Performance does remain, however, significantly behind the local target of 87 days, but is month on month being compromised by reduced capacity owing to this ongoing IA.
Whilst there were improvements in Surgery and CSFS of 2 days and 0.7 days respectively, both Women and Newborn and Medicine had deteriorations of 2 and 6 days respectively. However, whilst Surgery improved its overall position, the longest waits to 1st Appointment remain in this Division at 141 days. The requirement to consistently re-provide capacity to priority patients on both non-admitted and admitted pathways as a result of IA is precluding any material improvement across the board.
The Trust continues to focus on seeing patients in line with clinical need, referral type, e.g. Cancer 2 week wait and Urgent referrals, and by longest wait, in line with NHSE requirements. The impact of the reduced capacity affects those patients carrying the least clinical risk and therefore most significantly the longest waiting patients. Increased levels of 2WW and urgent referrals in some areas is compounding the tension between clinical priority and longest waits.
The Dermatology insourcing initiative went live in August and has made an immediate impact, however, whilst overall numbers long waiting patients <52 weeks has reduced, this is broadly due to this individual initiative and the Trust's underlying numbers of >52 week waits continue to grow albeit at a significantly slower rate.

Actions (SMART)

Weekly review at Delivery Group of undated longest waiting patient by specialty with specific review on those patients awaiting 1st Appointment.

ICB to investigate disparity of waiting times profile of IS activity to ensure equity of access for patients across both IS and NHS providers – awaiting outcome.

Trust progress against long waiting patients including those awaiting 1st Appointment to continue to be monitored weekly and to be reported to the CEO and COO via weekly summary updates.

Patients to continue to be booked in line with NHSE recommendations, with weekly validation of long waiting patients. Specialty Managers and DDO's of challenged key specialties have been supplied with historic trajectories and booking performance to assist forward planning.

Demand and Capacity software tool to be reviewed with view to procurement and rollout across Divisions.

Risks and Mitigations

Limitations continue in relation to the Trust's ability to comprehensively map demand and capacity at a subspeciality/pathway level, however the performance team are supporting this work with the Divisions and specialities.

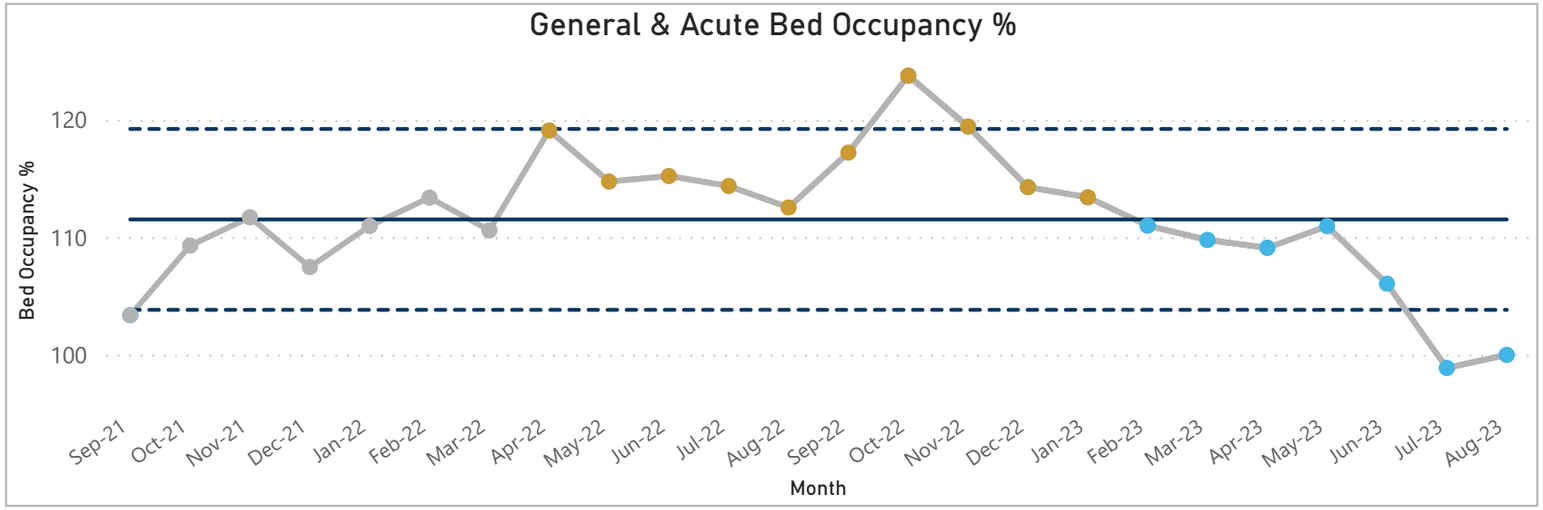
Staffing pressures exist across a number of specialities, not least Dermatology and Plastics which present a potential individual speciality pressure into next financial year. The Division of Surgery has an approved business case currently under mobilisation to provide insourcing support, with Dermatology live as noted. Plastics have recruited in the interim to a Micro Plastics Fellow and Locum Consultant post.

Ongoing IA presents significant risk to maintaining levels of capacity, with mitigations options limited.

Optimising Beds

Target 92%

Breakthrough Objective



We are driving this measure because...

Bed occupancy is used as a driver metric as it is closely linked to length of stay.

Lower bed occupancy generally is associated to optimised clinical practice and lower lengths of stay, the combination of the two are known to demonstrate good outcomes and patient experience. An additional positive consequence is also lower temporary staffing costs.

Understanding the performance

Bed occupancy has risen slightly on M5 to 99% which has coincided with a deterioration in ED performance including ambulance handover delays and % of patients waiting in ED over 12 hours. Total numbers of discharges have decreased very slightly in M5, similar to M4 which will also be a contributor to increased bed occupancy. The numbers of emergency admissions has remained fairly static over M4 -5 with NEL LoS continuing to improve. The improving LoS picture is a positive indicator and the bed occupancy position needs to be watched closely.

Actions (SMART)

- SDEC methodology and process rolled out across surgery now needs focus. Cinapsis roll out is now complete.
- Meeting with Radiology regarding increasing need for appointments to align with SDEC has taken place and requirements actioned.
- Full roll out of new eWhiteboard software is complete and complinace is being actively monitored
- FAcute Frailty Unit has gone live and early data demonstrates a decrease in Los in that group of patients.
- Discharge Hub and Integrated Discharge team - This has now gone live and turn around times for pathway allocation have come down significantly, however allocation of resource from system partners is unchanged hence there has been only a small imporvement in the number of NCTR patients on the P1-P3 pathways and are similar to the same time last year,
- LoS and Bed occupancy workstreams set up focusing on ward discharge process; Managing staff and patients expectations and support services, this is looking at setting up a robust standardised vascular access pathway that will reduce the LoS for patients needing a PICC line etc.

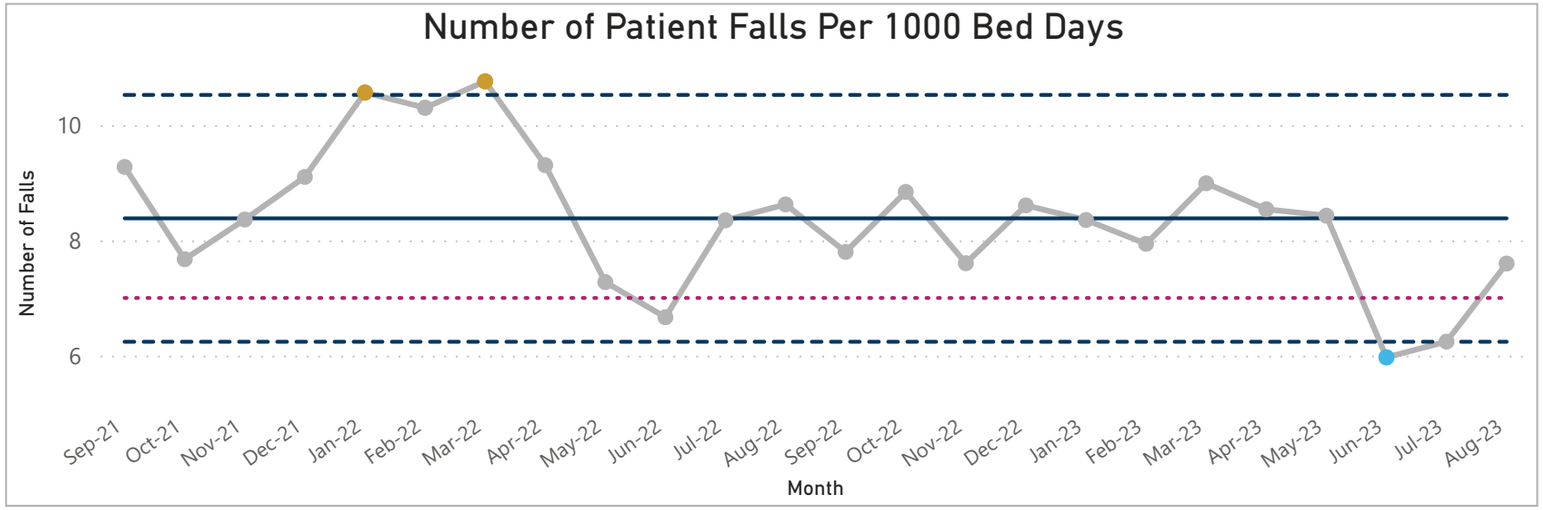
Risks and Mitigations

An increase in Infection Prevention Control challenges such as COVID or other will impact the ability to keep escalation areas closed.
As winter approaches, operational challenges related to capacity are expected to increase - winter planning is under way.
Ongoing IA from various professional groups and unions reduces staff capacity to focus on the QI work.

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

In August, falls rose slightly to 7.3 per 1000 bed days against target of 7. The Trust had higher attendance with escalation areas open, plus a higher rate of staff on annual leave. This may have had an impact on the figures.
There were 3 inpatient falls with moderate or above harm, plus 1 in the Emergency Department:
x 1 neck of femur fracture
x 1 fractured nose
x 1 fractured wrist
The ED patient fell in the department and fractured his humerus.
Falls audit data continues to show improvements from the majority of wards with lying and standing BP monitoring compliance improving month on month with 3 medical wards performing at 100% compliance.

Actions (SMART)

SWARM investigations for falls to be completed as per Trust policy.
The new Falls Workstream met at the end of August for their second monthly meeting with terms of reference circulated to the PSS group for approval.
A capital bid for crash mats for every ward has been presented.
Adjustments to the falls ward audit (monthly) and Intentional Rounding document have been circulated for adjustments as thought to be “not fit for purpose”.
The Falls risk assessment including eye test is being explored by the EDOC team for trial on Amesbury and Downton wards when available.
Ultra low beds have commenced to be electronically tagged by the Medical Devices Team.
Bay watch continues to be in use on Amesbury, Farley and Spire wards with a reduction in falls prominent for Amesbury in particular, with falls being 5, 7 and 7 respectively for the past 3 months since commencing bay watch (previous figures were consistently in double figures). There is still work to be done on promotion of MDT involvement, therefore senior members of the DMTs and executive team will be asked to do 30 minutes of bay watch in FALLS WEEK 18-24TH of September.

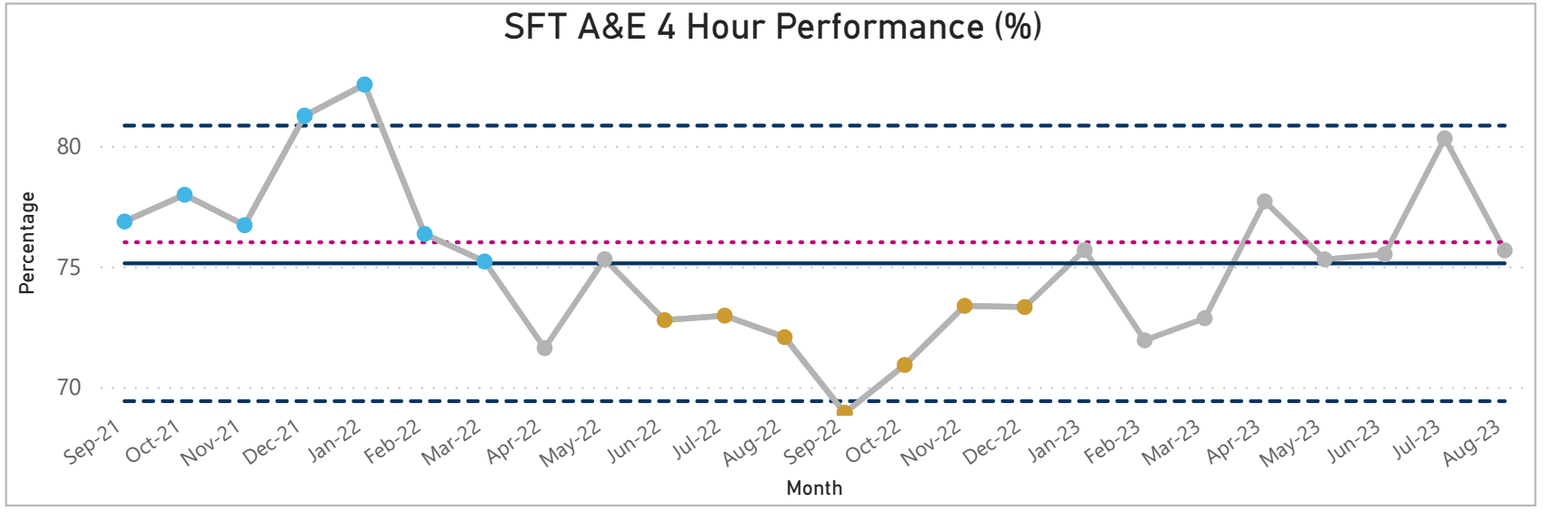
Risks and Mitigations

The winter months have consistently shown a rise in falls and the workstream and especially the elderly care therapy team are exploring mitigation for this with concentration in September and October on planning
Interviews for a falls facilitator at 15 hours per week will be at the beginning of September with hopes that the vacancy will be filled in October.

Emergency Access (4hr) Standard

Target 76%

National Key Performance Indicators



Performance Latest Month:	75.7%
Attendances:	6320
>12 hrs in ED Breaches:	47

Understanding the performance

M5 4 hour standard performance has seen a big decrease in performance of 4.6% to 75.7% compared to M4 of 80.3%. Overall attendances also saw a decrease in M5 with 6,320 attendances compared to 6,527 in M4, this equates to circa 7 patients per day. Conversion rates also decreased by 2.5% to 26.7% in M5 compared to that of 29.2% in M4. This change is explained by the decrease in Category 2 attendances in month although there was a slight increase in Category 1 attendances.

M5 has seen a large increase in the number of 12 hour breaches, 47 compared to 16 in M4. This decline was expected given the difficulties the Trust experienced in M5 relating to flow, with all Trust escalation areas at periods of the month. This is further illustrated when stripping back to just type 1 4 hour performance. The performance saw a 7% decrease to 63% from 70% in M4.

The equivalent of 5.5 spaces were lost per day to patients with a DTA in M5 compared to 4.3 spaces in M4, this is the first time since being recorded that this has increased, the lost spaces amount to 66 patients per day. As articulated by this figure, flow out of the department continues to be the biggest contributory factor to the failure of the 4 hour standard performance.

Average time to initial assessment has continued to improve and the average time is now 20 minutes in M5 compared to 22 minutes in M4. This remains a high priority on the ED breakthrough objectives. This work is being supported by ECIST who are due to reattend the Trust in M6 to support some pathway redesign.

Actions (SMART)

The Emergency Department continue to push recruitment and in M4 have successfully recruited to all vacant B3&5 posts from M7. However the majority of these Nurses are newly qualified or have no ED experience so support will be required with education to ensure they are trained in ED Core Skills.

Working group ongoing to help improve handover times out of the Emergency Department and generate faster flow. This has now been allocated project management time to support the delivery.

Risks and Mitigations

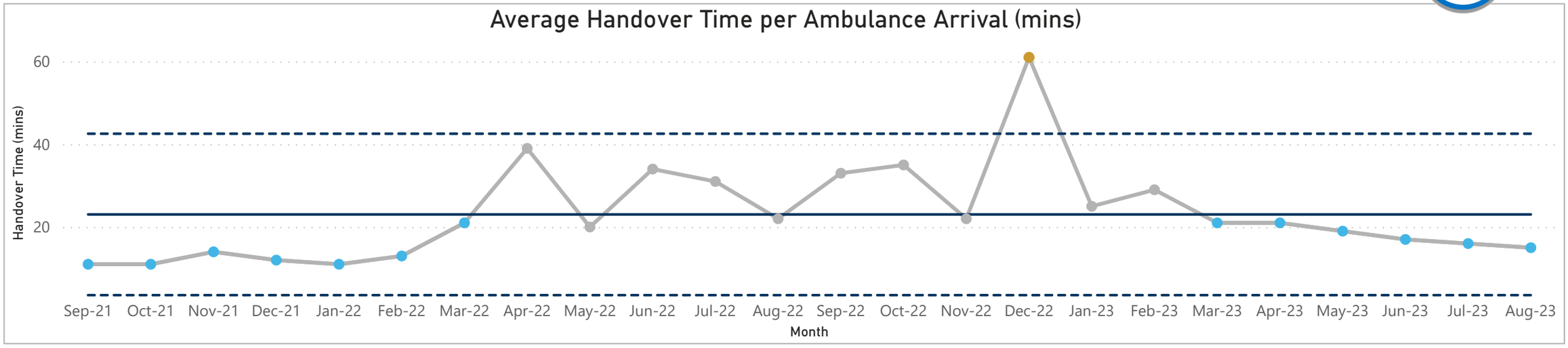
Timely flow out of the Department continues to impact 4 and 12 hour standard performance targets with high bed occupancy levels across the Trust continuing. This has been further hindered with the loss of 24 beds at the end of M4 with the Closure of South Newton along with the loss of 23 beds in M2 with the closure of Whiteparish Ward for refurbishment. – this is being managed at Trust executive level

There are significant gaps in the medical workforce also with 3.2 WTE Consultant Gaps. The Senior Leadership Team continue to work on recruiting into these vacancies with National Advert for Nursing Workforce gaps and in reach to the Deanery with upcoming newly qualified Consultants. A Physician Associate started in M4 and Paediatric SHO commenced in M5. Both have been a positive impact to the clinical workforce.

Further IA planned for M6 and alternative rota planning are ongoing to support the Department through this period.

Ambulance Handover Delays

National Key Performance Indicators



Understanding the performance

There was a significant increase in the number of ambulances presenting in M5 of 73 to 1,246, compared to 1,173 in M4. There has also been a shift in the time of day ambulances are presenting with peaks at 18:00 and 23:00. This is being driven by an increase in SWAST OOH staffing to 115%. This has been raised as a concern across the whole ICB. The agreement to protect Medicine SDEC from escalation which started in M12 continues to have a positive impact, enabling fewer medical patients being diverted to ED, minimising delays to offload at the Front Door. The Emergency Department has seen its first decrease in Ambulance Handover performance for the first time in 6 months.

- 83% of patients off loaded <15 minutes in M5 compared to that of 63.1% in M4
- 87.3% of patients off loaded <30 minutes in M5 compared to that of 90.5% in M4
- 93.2% of patients off loaded <60 minutes in M5 compared to that of 98.2% in M4

Actions (SMART)

The Emergency Department Matron and senior nursing staff have been making continuous improvement to the Ambulance Handover and have developed a new Handover process to be initiated at the end of M4, to continue to make improvements for Ambulances presenting to SFT.

Risks and Mitigations

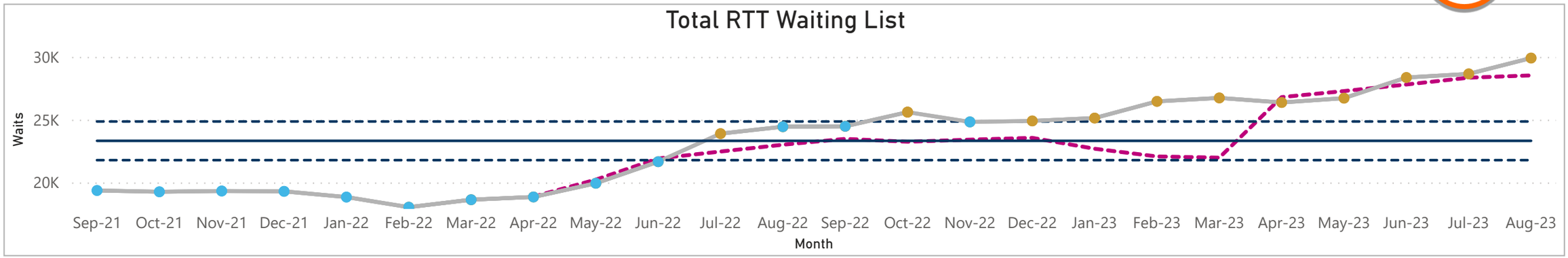
As reported in M1, the HALO service is currently compromised at SFT with a 70% vacancy with only 1 WTE permanent HALO currently provided by SWAST. SWAST continue to work through alternative ways to recruit into this position. SWAST will provide HALO support at times of surge when there is not a permanent HALO present, and the Emergency Department continues to work collaboratively with SWAST partners.

ECIST visit took place in M5 to look at the handover process and flow through the department. Awaiting formal report.

High bed occupancy levels and staffing challenges across the Trust, continues to result in poor timely flow out of the department, hindering capacity within the Emergency Department, with a loss of an average of 5.5 spaces per day in M5. This continues to be the biggest challenge in being able to offload patients swiftly and safely into the department. Medicine SDEC remains beneficial in generating earlier flow out of the department and enabling SWAST to convey patients to the most appropriate area.

Total Elective Waiting List (Referral to Treatment)

National Key Performance Indicators



Month	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23	Apr-23	May-23	Jun-23	Jul-23	Aug-23
Longest Waiting Patient (Weeks)	94	95	87	83	85	73	75	76	75	76	77	243

Understanding the performance

The Total RTT Waiting List size position at the end of August stood at 29,909, an increase of 1,260 from July (28,649) and remains behind plan.

There continues to be a small number of specialties that account for a disproportionate percentage of the Waiting List (WL) increase since April 2022. The top five specialties with the greatest increase in their respective waiting list are: ENT (1st), Urology (2nd), Gynaecology (3rd), General Surgery (4th) and Gastroenterology (5th). They collectively account for 51% of the increase in waiting list size since April 2022.

The Dermatology insourcing initiative commences as scheduled and is working well with immediate benefit as planned.

Plastics recruitment has been successful but remains a challenged specialty.

However, whilst there is ongoing IA on a monthly basis the ability to mitigate lost capacity will remain limited, and this has been reflected by the 4 month consecutive increase in the WL number. Whilst to date long waits have been managed and the impact has been mitigated the pressure upon the maintenance of the 78WW waits is challenging, with two specialties recording isolated month end breaches (Dermatology and Plastics).

To note: Owing to a NHSE diktat a small cohort of breast patients have been added to the RTT WL at the end of August (previously recorded and managed via the planned WL). As such, the Trust is now registering a number of >104WW with the longest wait being 243 weeks. Regular meetings with regional NHSE colleagues taken place and plan implemented to address agreed.

Information will be included to F&P Committee monthly on number of patients validated as part of the RTT reported position (currently approx. 4000 per week validated, of which 1700 are long waiters).

Actions (SMART)

The largest proportion of the waiting lists remains within the non-admitted pathways. There are a number of specialities with large increases in waiting list size over the last year, including a number of specialities with considerable operational and staffing pressures, e.g. Plastics and Dermatology.

A number of actions planned for August onwards are either planned or to continue including:

- Monitoring of Long Waits to continue with a mirrored process for the 65WW target as was implemented for the 78WW in 2022/23, with the Trust's clearance rate marginally remaining ahead of plan.
- Focused speciality support to the most challenged specialties in the form of weekly huddles supported by the Transformation Team ongoing.
- Breast DIEP WLreduction, incorporating noted additions
- Dermatology insourcing to continue as per business case.

The need to better understand the demand and capacity by specialty, which is currently being developed by the performance and BI teams. The procurement of an established electronic tool is being considered for rollout across all Divisions. Demonstration for which planned for early Sept.

Risks and Mitigations

The risk of lost capacity owing to the industrial action remains, not least that lost to ongoing monthly Jnr Doctor strikes, now being compounded by consultant IA. Whilst mitigations are in place to support safety for those most clinically urgent patients, the volume of activity affected cannot usually be entirely mitigated, and many plans have now been stretched beyond that for which they were designed.

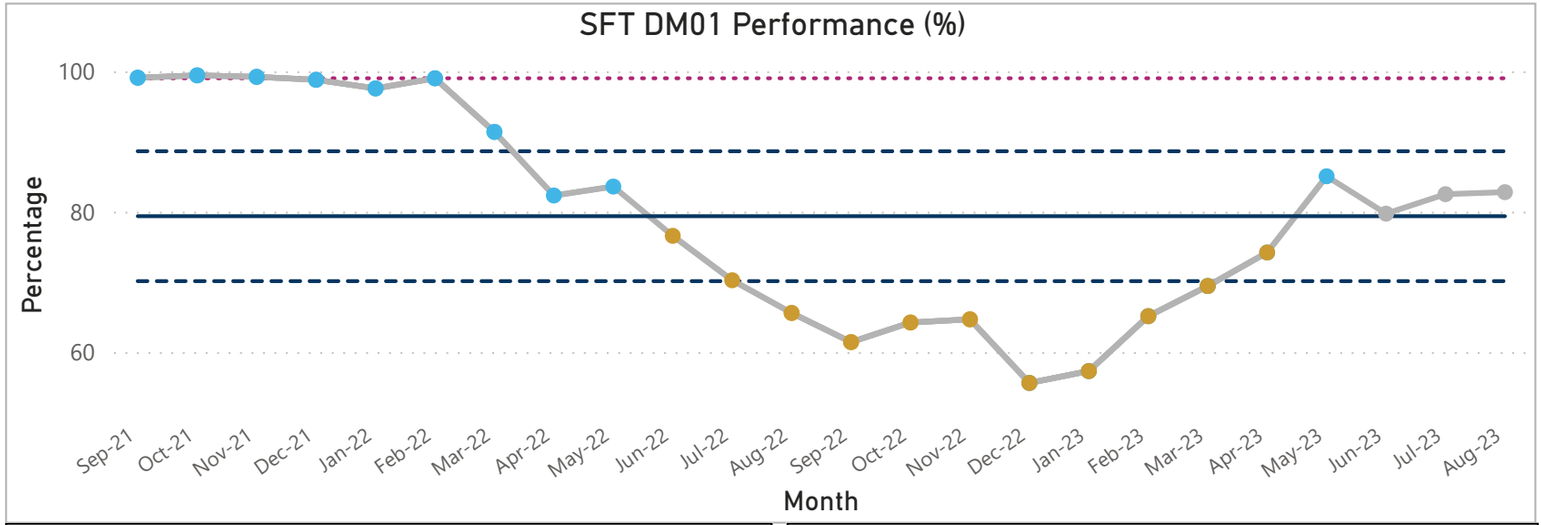
Support into operational teams to enhance level of focus on the non-admitted pathways, through further OPD workshop and weekly huddles in line with Improving Together Methodology throughout to continue through Quarter 2.

The ICB is to begin analysis of workload currently being undertaken by the IS to ensure there is equity across both IS and NHS provider delivery.

Diagnostic Wait Times Performance (DM01)

Target 99%

National Key Performance Indicators



Performance Latest Month: 82.8%

Diagnostic Activity: 7482

	Performance	Breaches		Performance	Breaches
MRI	92.5%	27	CT	98.9%	7
US	97.2%	30	DEXA	100.0%	0
Audio	50.0%	530	Cardio	85.1%	36
Neuro	100.0%	0	Colon	76.4%	49
Flexi Sig	60.3%	25	Gastro	93.9%	7

Understanding the performance

DM01 performance improved slightly in M5, increasing to 82.78% from 82.49% in M4. The position reflects 711 breaches as opposed to 743 in M4.

Continued reduction in the number of patients waiting beyond 6 weeks are reported in MRI (reducing from 34 to 27), USS (reducing from 51 to 3) and audiology (reducing from 576 to 530). CT remains stable with minimal breaches of 7 (complex patients), Endoscopy remains relatively stable and on trajectory plan of 81 patients, and Cardiology Echo reported an increased number of breaches (36 in month compared to 0 in M4) due to a validation adjustment made. As a result of the latter the Head of CIU will provide focus to the long waiters identified to ensure the breach numbers improve.

Actions (SMART)

1) Continue with insourcing provision in USS (circa 100 scans per month) until contract ends in December 2023. Present new proposal for extension of insourcing and potential impact to COO by end of September 2023.

2) Continue with incentivised overtime rates in Audiology to ensure modality stays on trajectory position (predictor position for M6 indicates further improvement is being made). Overtime to continue throughout Q3.

3) Review Endoscopy points capacity for M6 and M7 to ensure sufficient capacity to retain trajectory position and/or react where needed if looking off track.

4) Continue to utilise CDC mobile scanner resource (CT and MRI) as much as possible to maximise activity and reduce waiting lists.

Risks and Mitigations

USS, Echo and Audiology remain heavily dependent on overtime, agency and/or insourcing arrangements.

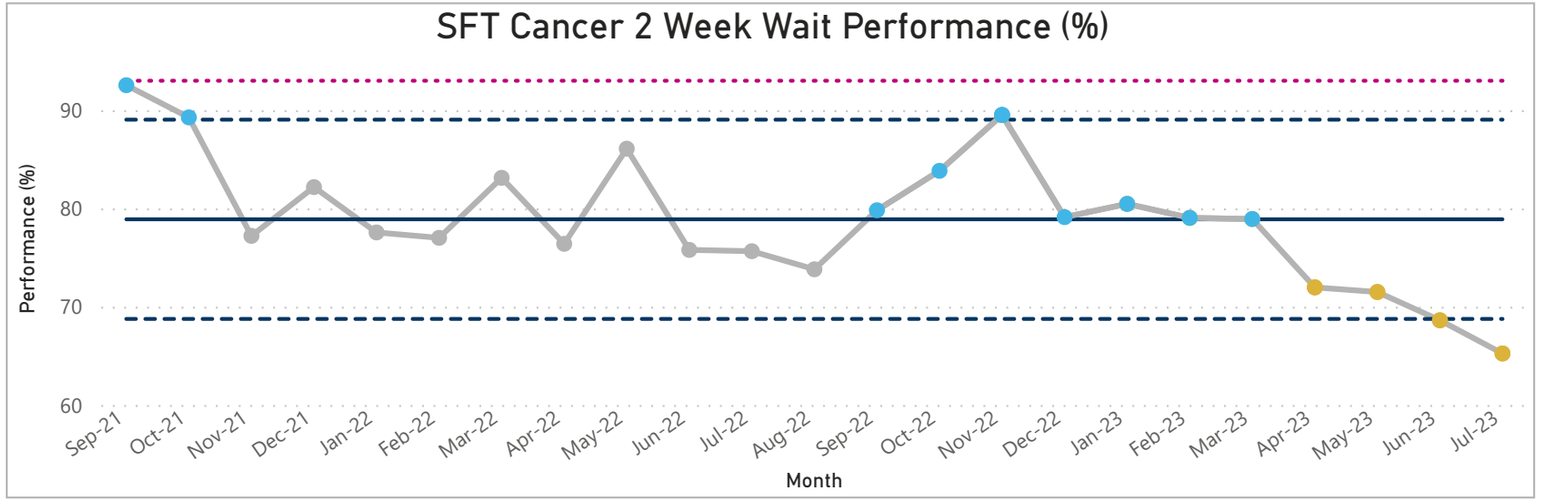
Achieving zero breaches in MRI and CT will be challenging due to capacity constraints within Cardiac. CSFS working with Medicine Team re proposal for increased lists and how to mitigate possible loss of UHS support for outsourced provision.

Endoscopy capacity is variable and remains locum dependent. Clinical Lead is validating waiting list to ensure capacity is used as most appropriately as possible.

Cancer 2 Week Wait Performance

Target 93%

National Key Performance Indicators



	Performance	Num	Den	Breaches
Two Week Wait Standard:	65.2%	672	1030	358
Two Week Wait Breast Symptomatic Standard:	90.0%	18	20	2

Understanding the performance

The Trust continues to be challenged against the 2WW Peformance in July. This position has been steadily decreasing since March as we have had challenges within the 2WW Suspected Skin Cancer Pathway. In June the reported performance for Skin was sat at 0.6% with 173 2WW Breaches. This has seen the Trusts overall performance drop to 65.6%. The next lowest performing tumour site was Colorectal with a total of 95 2WW Breaches which resulted in their overall performance being sat at 54.5%. The main reasons across both specialites was inadequate outpatient capacity which resulted in a total of 269 breaches.

Actions (SMART)

The Trusts 2WW position is monitored weekly within Cancer Improvement Group. We continue to enagage with services to understand their plans for recovery and to gain oversight into the operational challenges.

Skin are currently in the process of appointing additional clinical staff to help support the 2WW challenges which are due to start in October. There is currently 400 + patients awaiting a first 2WW Suspsected Skin Cancer appointment, currently a triage protocol is being developed by the Plastics / Dermatology service to ensure high risk patients are prioritised out of this backlog. We have also asked the service to put together comms to primary care and patients about the increased wait to first seen.

Colorectal have successfully recruited an additional CNS for Early Diagnosis which will help support the front end of the pathway. This funding is for 2 years and will help support triage of referrals and management of IDA patients. As well as this an Endoscopy pathway navigator which has had agreed funding to support the management of Endoscopy for 2WW patients to increase utilisation and oversight for Suspected Cancer patients.

Risks and Mitigations

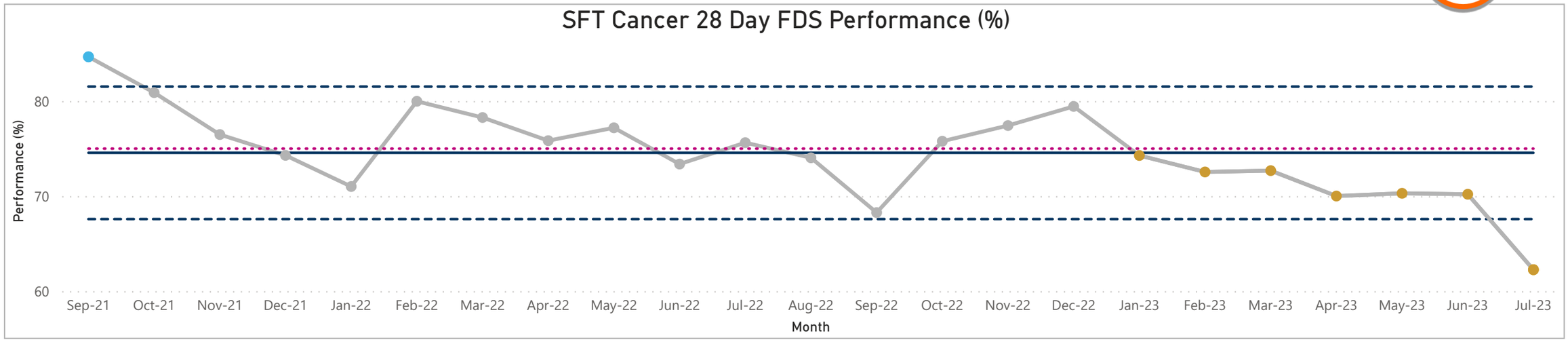
The Trusts 28 day FDS target has been effected due to the delays in patients being seen for patients within the Suspected Skin Cancer pathway. This has been caused by patients waiting beyond 28 days to be given a decision to treat. The knock on effect of this will be shown in August and September performance as Skin are regularly one of the tumour sites which are able to meet the FDS standard in previous months. We have asked at Delivery group if Skin will be able to pull the first seen date within 28 days as a priority as this is currently sat around day >46.

There is a short gap between the Rapid referral administrator and colorectal early diagnosis nurse being in post which will have potential issues with the admin led triage and ERMA requesting of diagnostics. The GI team are currently in the process of supporting the gap until the early diagnosis nurse is appointed and a more formalised process is expected in the coming weeks.

Cancer 28 Day Faster Diagnosis Standard Performance

Target 75%

National Key Performance Indicators



Understanding the performance

The Trust did not meet the 28 day FDS Standard in July reporting just below the expected 75% at 62.27%. The Trusts position has declined since June due to the overhaul of the Urology Cancer PTL, which had seen a large proportion of patients removed and making Urology one of the smallest proportion of patients within the Backlog. However the challenges noted with the current Dermatology / Plastics are having a negative impact on the Trusts overall 28 day performance. Currently Skin is sat at 4.0% which is approximately 90% dip in performance. Gynaecology, Urology and Colorectal's position against this standard improved in July, however the size of the Skin denominator overshadows the good performance in other tumour sites at Trust level.

Actions (SMART)

Both the Urology and Gynaecology performance against FDS are have improved July / August due to the service improvements of both the roll-out of template letters for benign patients and the implementation of the clinical PTL for Urology. We have just implemented a clinically led PTL within Gynaecology with support of the CNS / Consultant, this will enable us to have clinical support when making decisions on patients during the PTL and enable us to progress next steps at an expedited timeframe.

The FDS Performance is monitored during the weekly cancer improvement group and performance is discussed at the bi-monthly cancer board and SLT, the last one being held in August.

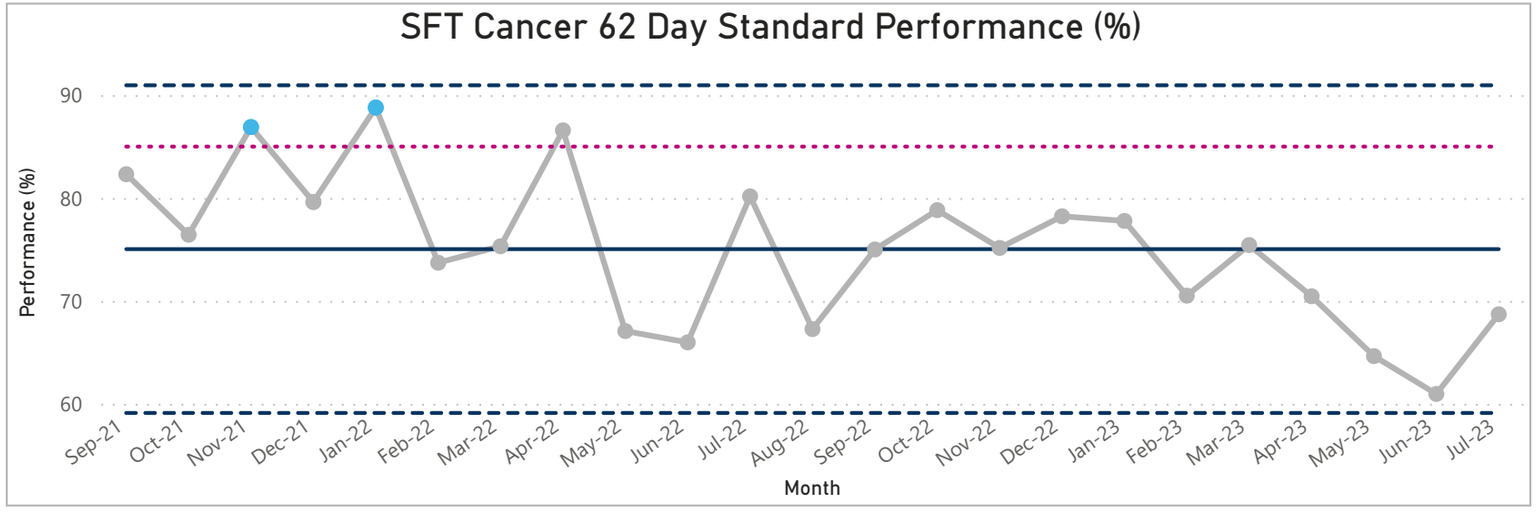
Risks and Mitigations

Skin FDS Performance continues to be a risk to the Trusts overall FDS compliance. Skin usually achieve 95% compliance against the faster diagnosis standard, this is due to patients being listed for surgery as a clock stop for faster diagnosis. Due to the capacity challenges within Plastics and the 2WW - the average wait to first seen is exceeding 28 days and slipping week-on-week. We are anticipating their performance to be around 5% in August - this will have a massive impact on the Trusts compliance. This has been escalated in delivery group, cancer board and to the skin DMT. Cancer Services have asked Skin to try and pull the first seen date to before day 28 to help support the Trusts performance. There is currently a review of the large backlog of referrals being undertaken by the Derm / Plastics team and discussions with the ICB on how to manage this, there is plans for a further staff grade to join the Trust in October as well as the recent appointment of a Locum with interest in Skin Cancer.

Cancer 62 Day Standard Performance

Target 85%

National Key Performance Indicators



	Performance	Num	Den
62 Day Standard:	68.7%	45	66
62 Day Screening:	75.0%	2	2

Understanding the performance

The Trusts performance against the 62 day standard was reported at 68.7% the break down of breaches are shown below:

Urology - 9.0 Breaches Breaches
Colorectal - 2.0 Breaches
Gynaecology - 2.0 Breaches
Lung - 2.0 Breaches
Upper GI - 1.0 Breaches
Haematology - 3.0 Breaches

The main themes for breach reasons were:
Complex diagnostic pathway - 11 breaches
Healthcare delay to diagnostic - 5.5 breaches
Elective capacity inadequate - 2.0 Breaches
Patient initiated delays - 2.0 Breaches

Actions (SMART)

The large proportion of Urology breaches have resulted in the work that has been undertaken on working on the over 62 day PTL Backlog position. In previous months Urology have remained at around 50 patients sat within the backlog which was approximately 50% of our Trust position. Since the implementation of the Clinical PTL we have been able to remove patients off which has resulted in an increased number of Urology breaches. As a forward look we are predicting an improved performance for Urology across August / September

Colorectal's number of breaches has grown due to challenges within consultant availability due to annual leave / unavailability, as well as this challenges with industrial action have increased the number of breaches. The planned recruitment of the endoscopy business pathway navigator and early diagnosis nurse should help support the front end of the pathway which will support the back-end pathway allowing for additional time for clinical follow-up.

We have been sharing the breach reasons with operational teams through the Cancer Improvement group after the monthly validation. Trying to draw themes from the breaches, this is ongoing and we will continue to monitor this at Cancer Improvement Group.

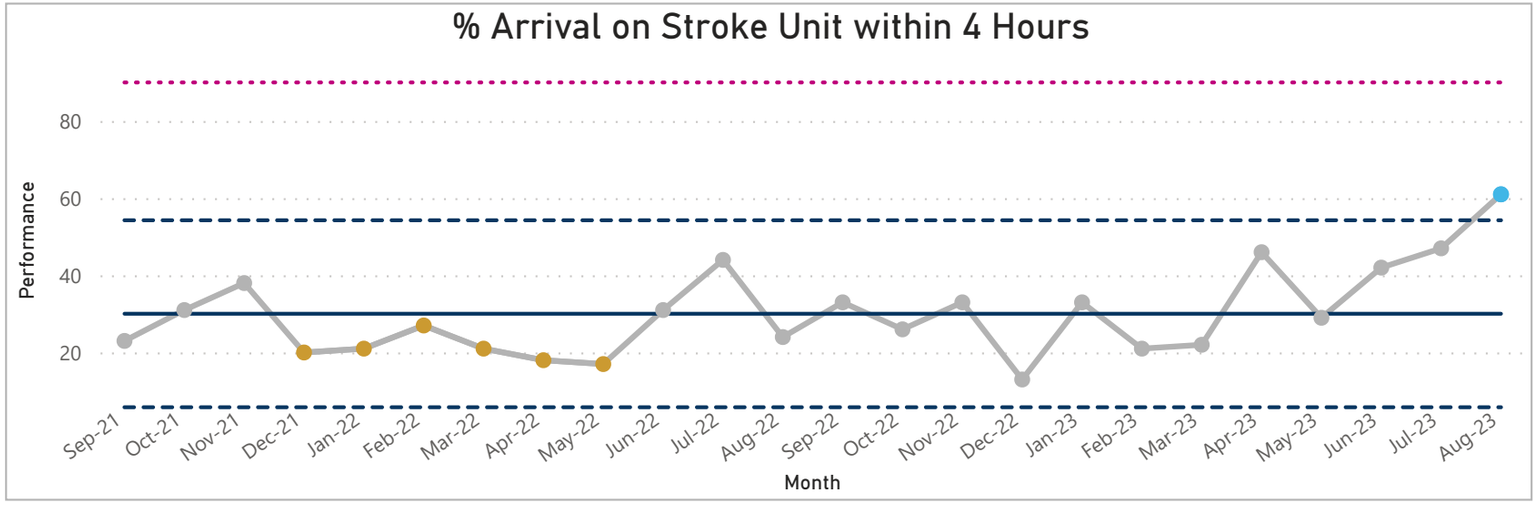
Risks and Mitigations

There is a risk to the Trusts 62 day performance as per above with the challenges within Skin. Patients are waiting longer for their first OPA which will subsequently delay their ability to provide a treatment within 62 days and put additional burden on MDT and Histopathology. We are likely to see this in August / September and beyond as above the insourcing and additional recruitment are planned to help support and mitigate this challenge however there is significant risk in the large backlog cohort.

Radiology outsourcing is a risk due to the waiting times for outsourced imaging and the ongoing impact on MDT discussion and Post-MDT follow-up. We have been discussing with Radiology on how we can try and provide support by giving as much oversight on patients with a high risk of a cancer diagnosis and escalating appropriate to their turn around times for the external reporting companies. We are expecting this position to improve into September as the challenges with annual leave / summer holidays are less prevelant.

Stroke Care

National Key Performance Indicators



SSNAP Case Ascertainment Grade

Highest Level = Grade A
Lowest Level = Grade E

Fyear	Q1	Q2	Q3	Q4
2021-2022		C	C	C
2022-2023	D	C	C	C
2023-2024	B			

Understanding the performance

The national target for patients admitted to the stroke unit within 4 hours is 90%
August end of month performance is at 61% which is a 14% improvement on last month and is indicative of the work the team have been implementing and shows continual improvement. This has now achieved a SSNAP score B from April- June 2023
August data shows 23 patients were admitted to the stroke unit with 9 out of target, the main cause of this was:
- 2 delayed transfers from ED due to late diagnosis/late communication
- 3 waiting for bed due to ward being at full capacity and needing to create beds.
- 4 awaiting speciality doctors due to weekend and out of hours admissions
Concerted efforts have been made to ring fence a bed to accommodate overnight stroke admissions and the GP assessment room, clinic room and boarding has also been considered to meet demand.

Actions (SMART)

From October the 4 hour target will be introduced as an improving together driver metric to ensure issues are routinely discussed within ward huddles.
A Root cause analysis will be commenced in view this and identifying issues raised.
Concentrate on Ambulance stroke pathway as out of the 9 patients that did not make it to the ward within target in August, 5 were bought in by ambulance which would have improved the score by 21.7%
Arrange a "Go and See" in Bath due to their continued high performance, share practice and pinch with pride.

Risks and Mitigations

The average length of stay for August has improved by 2% on last month, on closer analysis this is due to a reduction patient acuity and less rehabilitation requirements The collaborative working with stroke stakeholders and teams continue to be monitored and a date is being arranged for the stroke operational working group to commence.
The nursing skill mix within the team has proved beneficial with return of redeployed staff and the WTE vacancy for B5 is 2.99. There is a varying skill mix at times and a request through the skill mix reviews identified B6 cover over night. This will be reflected within the October rota to improve focus on national stroke targets.

Maternity

Are We Safe?

01/08/2023 <- Reporting Month (Input the first of the REPORTING month)

	SFT Assurance Dashboard	Guidance	Standard	RAG rating Red	RAG rating Green	Improvement Direction	Rolling 6 months Mar-23	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Rolling 6m average
Perinatal Morbidity and Mortality (M&M)	Number of late fetal losses (22+0 to 23+6 weeks excl TOP)			>= 2	= 0	Down	0	0	0	0	0	0	0
	Number of stillbirths (>+ 24 weeks excl TOP)			NA	NA	Down	1	0	0	1	0	0	0
	Number of neonatal deaths : 0-28 days			NA	NA	Down	0.0	0.0	0.0	1.0	0.0	0.0	0.2
	Number of neonatal deaths : 0-28 days per 1,000 Live (Reg) Births	ONS	2.7 per 1000 live births	>= 2.8	<= 2.6	Down	0.0	0.0	0.0	6.3	0.0	0.0	1.0
	Medical termination over 24 +0 registered			NA	NA	Down	0	0	0	0	0	0	0
Maternal M&M	Number of Maternal Deaths			NA	NA	Down	0	0	0	0	0	0	0
	Number of Maternal Deaths per 100,000 Maternal Deaths	ONS	9.1 per 100,000 women who	>= 9.2	<= 9	Down	0.0	0.0	0.0	0.0	0.0	0.0	0.0
	Number of women requiring admission to ITU	6 month SFT rolling		>= 2	= 0	Down	0	0	0	1	0	1	0.3
Insight	Datix incidence SII	6 month SFT rolling		>= 1	= 0	Down	1	0	0	2	0	2	0.8
	HSIB referrals	6 month SFT rolling		>= 1	= 0	Down	1	0	0	0	0	1	0.3
	HSIB/NHSR/CQC or other organisation with a concern or request	6 month SFT rolling		>= 1	= 0	Down	0	0	0	0	0	0	0.0
	Coroner Reg 28 made directly to trust	6 month SFT rolling		>= 1	= 0	Down	0	0	0	0	0	0	0.0
Workforce	Obstetric cover - labour ward	RCOG guidence		<= 39	>= 40	Up	40	40	40	40	40	40	40
	Midwife to Birth ratio	RCM;NHSR;BR +	1:26	>= 1:28	<= 1:26	Down	1:31	1:25	1:31	1:29	1:30	1:30	NA
	Midwifery vacancy rate (black= over establishment; red =under establishment)			>= 1	NA	Down	21.9	21.9	23.2	23.0	23.9	23.3	NA
	Provision of 1 to 1 care in established labour (%)	NICE, RCM, MIS	100%	<= 94	>= 100	Up	100	100	100	100	100	100	NA
	Datix relating to workforce	6 month SFT rolling		>= 2	= 0	Down	2	3	1	1	2	3	2
	Compliance with supernumery status of the LW coordinator - %	NICE;RCM;NHSR	100% rostered	<= 94	>= 100	Up	100	100	100	100	100	100	NA
	Numbers of times maternity unit on divert	6 month SFT rolling		>= 2	= 0	Down	0	0	0	0	0	1	0.2
Involvement	Service user feedback : Number of Compliments	6 month SFT rolling		NA	>= 18	Up	25	31	22	3	1	0	14
	Service user feedback : Number of Complaints	6 month SFT rolling		NA	NA	Down	1	0	2	0	1	0	0.7
	Number of SOX	6 month SFT rolling		NA	>= 7	Up	17	2	12	7	9	10	10

Understanding the performance

3 datix relating to workforce.
Rolling 6month averages for mortality remain below national average.
Neonatal death of a baby in June* with a congenital abnormality that was incompatible with life (*NB artificially inflated rate as figure per 1,000 births).
Maternity service diverted once in August following the birth of 30 week triplets utilizing all available equipment and maximum capacity. Triplets transferred to neighboring NICU with available capacity and service re-opened.
Two SIIs this month: An eclampsia case and a term admission and transfer for cooling

Actions (SMART)

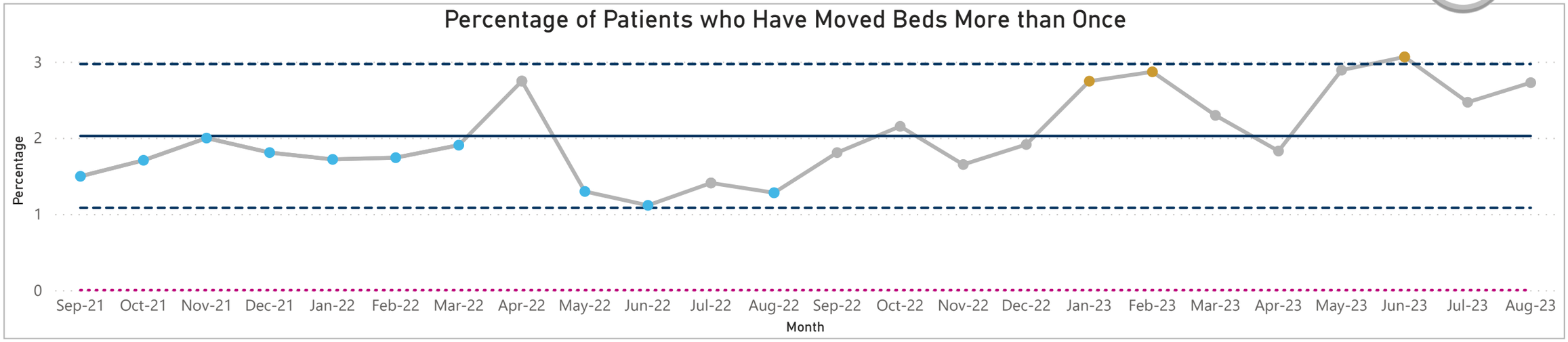
Targeted recruitment drive in place with welcome incentive.
Escalation policy followed as required to ensure maintenance of one to one care in labour and supernumerary status of labour ward coordinator.
SIIs to be investigated as per Trust policy.

Risks and Mitigations

Midwifery staffing remains a risk, mitigated by long line agency usage until qualification and employment of band 5 midwives.
Escalation policy followed to ensure one to one and safe care maintained.
Maternity care assistants supporting with non midwifery care.
Registered nurses employed within maternity services, supporting with non midwifery specific roles, e.g., working alongside midwives in postnatal care.

Patients Who Have Moved Beds More Than Once

Are We Safe?



Understanding the performance

The percentage of patients moved more than once has increased once again this month and is significantly higher than reported percentage for the same month last year. Throughout August the Trust saw a rise in escalation beds and medical outlier patients into the surgical division to accommodate the increased operational pressures on the Trust's capacity. The closure of Whiteparish ward for refurbishment has had an impact on patients transferring from Tisbury to downstream wards to provide cardiac capacity, but also has resulted in the outlier numbers increasing. The ward is aiming to reopen in October.

Actions (SMART)

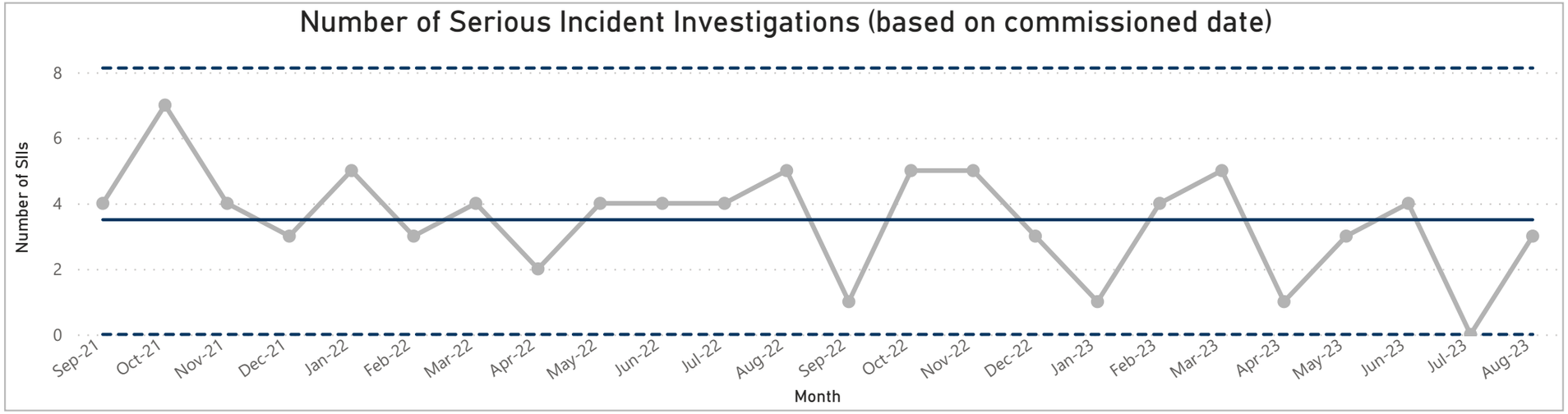
Throughout August, Pitton has been working as an 'AFU' which has seen an increased admission number through the unit. There has been positive work with the teams to ensure downstream movement of the patients after 1-2 day stay on the AFU to the appropriate ward. There is ongoing work with the medical teams for early identification of the patient suitable for AFU, to ensure patients are admitted directly to Pitton, aiming to reduce the number of bed moves per patient. Staffing pressures have continued throughout the Trust across all MDT's, which has impacted patient flow. The Trust escalation status and use of escalation beds is related to the number of bed moves that a patient experiences. To accommodate patients needs in clinical speciality when the hospital is full requires prioritisation and movement.

Risks and Mitigations

There is ongoing work with the AFU/medical teams to ensure that patients are triaged at point of admission to a speciality, to ensure that long stay patients are sent to the right speciality ward area, aiming to reduce the length of stay. Ongoing work to ensure that all ward areas are engaged with eWhiteboards.

Incidents

Are We Safe?



Fyear	Never Events
2021-2022	3
2022-2023	0
2023-2024	2

Understanding the performance

3 SIIs commissioned:
SII 582- Mouth prop left insitu post dental extraction (NEVER EVENT)
SII 586- management of woman with eclampsia.
SII 587- Therapeutic cooling of a baby (HSIB case).

Actions (SMART)

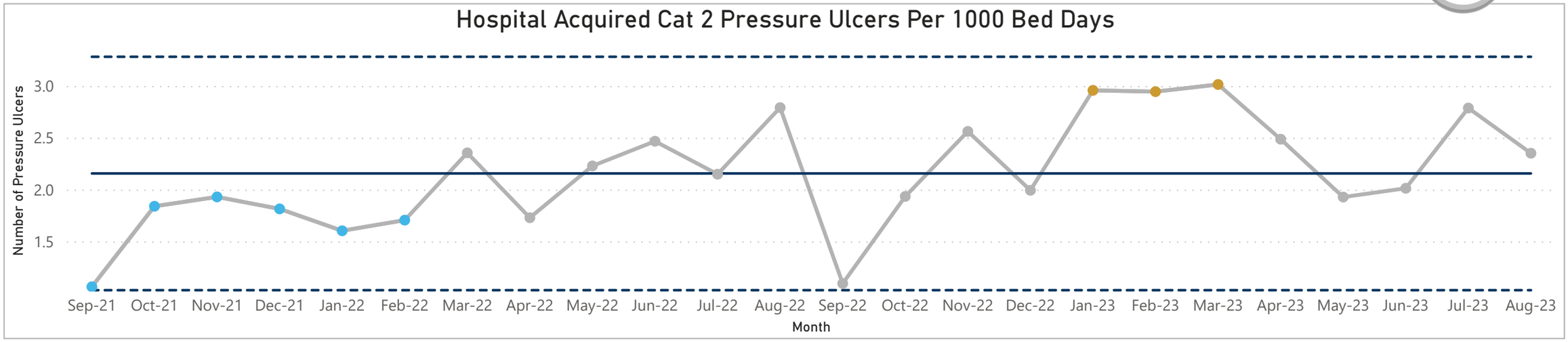
Following the commissioning of an SII, the incident will be investigted as per Trust Policy.

Risks and Mitigations

Once an incident has been identified and a 72 hour report completed, it is established whether there are any immediate safety actions that need to be implemented or escalated straight away. On completion of the report, learning is cascaded through the intranet, Clinical Governance sessions, Patient Safety Steering group and dissemination to staff via area leads.

Pressure Ulcers

Are We Safe?



Understanding the performance

The process for collecting the pressure ulcer and MASD data was completed differently for the month of August.
Each individual datix was reviewed and compared to the TV Pressure ulcer spread sheet and where possible medical photographs.

The data shows a slight decrease in pressure ulcers for August compared with July.

The HA category 2 pressure ulcers have slightly decreased from 38 in July to 33 in August. There have been zero CAT 3 pressure ulcers this month compared to the 4 that were reported in July and only 1 Unstageable pressure ulcer this month compared to the 3 from July. This shows an overall decrease in pressure ulcers.

One of the category 2 pressure ulcers (present on admission) had deteriorated, this has been counted in the Trusts numbers and re-categorised as a 3.

There has been a decrease in Hospital acquired moisture associated skin damage (MASD) and work has been continues to support with further reducing these incidences.

Actions (SMART)

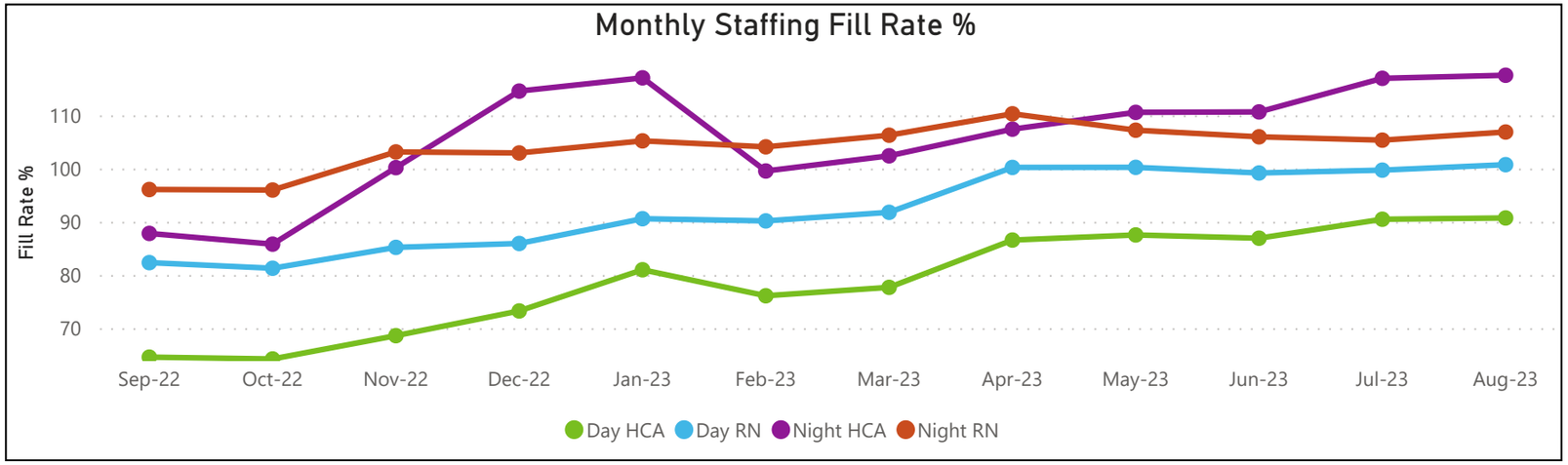
The team have been reviewing the current pressure ulcer prevention documentation.
An application has been sent to the STARS appeal for consideration of additional pressure ulcer prevention equipment.
Work has commenced on reviewing products/consumables available within the Trust that supports with MASD prevention.
Share and Learn group continues and are currently agreeing the escalation of ward themes and learning across the Trust for Hospital Acquired Pressure Ulcers.
The new Pressure ulcer prevention and management policy is currently in Draft.

Risks and Mitigations

Tissue Viability team have had to reduce the amount of pressure ulcer prevention and management teaching to staff in response to leave in the team. However, continue to review patients requiring specialist input. The team is currently reviewing the service. Work towards heel offloading devices is still undergoing. The prevention and management of MASD is being reviewed.

Nurse Staff Fill Rate

Are We Safe?



Ward	Day RN	Night RN	Day HCA	Night HCA
Amesbury	102%	101%	103%	131%
AMU	98%	104%	80%	104%
Britford	100%	100%	105%	111%
Chilmark	101%	102%	86%	99%
Downton	131%	204%	117%	140%
Durrington	104%	103%	81%	110%
Farley	101%	107%	92%	137%
Hospice	94%	100%	99%	99%
Laverstock	127%	135%	79%	123%
Longford	104%	118%	89%	100%
Maternity	81%	94%		
NICU	104%	101%	78%	
Odstock	103%	96%	100%	101%
Pembroke	105%	101%	103%	119%
Pitton	106%	103%	92%	154%
Radnor	89%	98%	51%	81%
Redlynch	110%	117%	87%	100%
Sarum	125%	125%	93%	
Spire	104%	120%	106%	181%
Tisbury	95%	99%	76%	104%
Whiteparish	113%	108%	94%	98%

Understanding the performance

All 4 markers remain broadly static, normal variation. HCA rate still under 100% - is driven in part by areas such as critical care who only have 1 HCA which they do not replace if unfilled but also due to unfilled additional duties added for specials at ward level. If unfilled on roster they remain to demonstrate need was required but shift not filled.
CHPPD 8.1 in month (down 0.3 on last month) and 7.7 (0.2 down) when excluding critical care and maternity excluded – this shift in CHPPD is then seen in the increased staff costs as less shifts go unfilled. NICU has returned to normal CHPPD for the unit this month as occupied bed days back to normal levels. The slight reduction in CHPPD will be driven in part by change in NICU and closure of South Newton and return of staff to medicine footprint.

Actions (SMART)

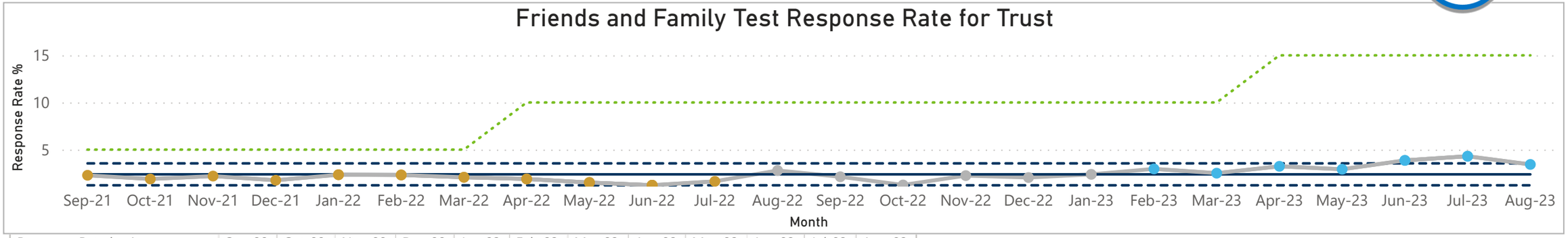
Band 3 bank pay implemented in August and HCA banding project closed down.
Ward assistant project – KPIs from matrons awaited (data being collated)
IEN Recruitment – visit to Sri Lanka now planned for September which is scoping and interviewing combined.
Business cases for RNDA, Nurse associate to RN business cases approved in principle but being taken to system financial recovery group. Return to Practice business case approved for 10 nurses .
Trailers obtained to use as training hub to bring OSCE training back in house (saving £800 per candidate) – expected launch in October.
Work on A3 for enhanced care and RMNs – meeting dates planned for September.
On-going work with partners on opportunity for mental health support worker to replace some RMNs – led by AWP.
Process flow implemented to ensure IENs being utilised in staffing numbers in consistent approach.

Risks and Mitigations

On-going turnover for HCAs and RNs exceeds starters (risk)
Increase demand for patients requiring RMN support (risk)
Additional beds utilised which are reliant on temporary workforce and not in establishment (risk)
Domestic and international recruitment campaigns (mitigation)
OD+P led work on retention, turnover and inclusion (mitigation and risk)

Friends and Family Test Response Rate

Our Care



Response Rate by Area	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23	Apr-23	May-23	Jun-23	Jul-23	Aug-23
FFT Response Rate - A&E	0.4%	0.3%	1.1%	0.3%	0.8%	1.6%	1.0%	0.6%	0.6%	0.8%	1.1%	0.8%
FFT Response Rate - Day Case	6.8%	3.1%	2.5%	1.4%	0.3%	2.0%	2.5%	3.4%	4.2%	6.4%	6.6%	3.5%
FFT Response Rate - Inpatient	11.4%	5.1%	10.5%	5.8%	11.5%	13.0%	3.2%	14.5%	12.9%	17.1%	28.4%	20.5%
FFT Response Rate - Maternity	1.1%	1.2%	0.0%	2.6%	2.2%	3.7%	1.4%	0.0%	0.5%	0.0%	0.0%	0.9%
FFT Response Rate - Outpatient	0.9%	0.9%	1.6%	2.0%	2.0%	2.2%	2.1%	2.5%	2.3%	2.6%	2.2%	2.2%

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 response figures have started to increase now. Staff are still being encouraged and reminded to offer FFT through the PALS outreach services although we appreciate that this sole method of obtaining response will inevitably mean fluctuations in activity consequent to pressures.

New cards have gone to all areas and offer free postage. Gender options have also now been extended in line with national guidance

Actions (SMART)

Delay in the rollout of digital provider (see below risk/mitigations) will now require interim actions to be developed, such as:

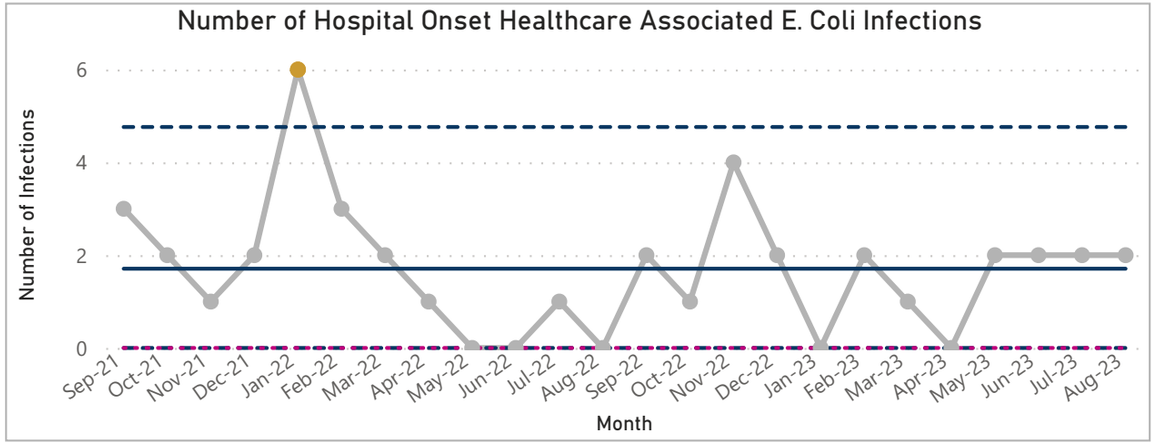
1. Use of QR codes on posters, outpatient letters and within discharge packs – this has been held back as we may be adopting the online form earlier which will change any QR codes we put on posters.
2. Text messaging via Dr Doctor – this has also been held as the process is more complex than anticipated and this would effectively be an interim solution.
3. More volunteers to input cards – this was considered as a mitigation for the potential impact of the above two plans. Responses are increasing steadily (owed to increased profiling of the FFT through mitigations 4 and 5), but remains manageable with current resources.
4. Promotion in inpatient areas through PALS Outreach services – ongoing and now part of BAU.
5. Regular presentation of feedback and response rates at Divisional Governance meetings – ongoing and now part of BAU

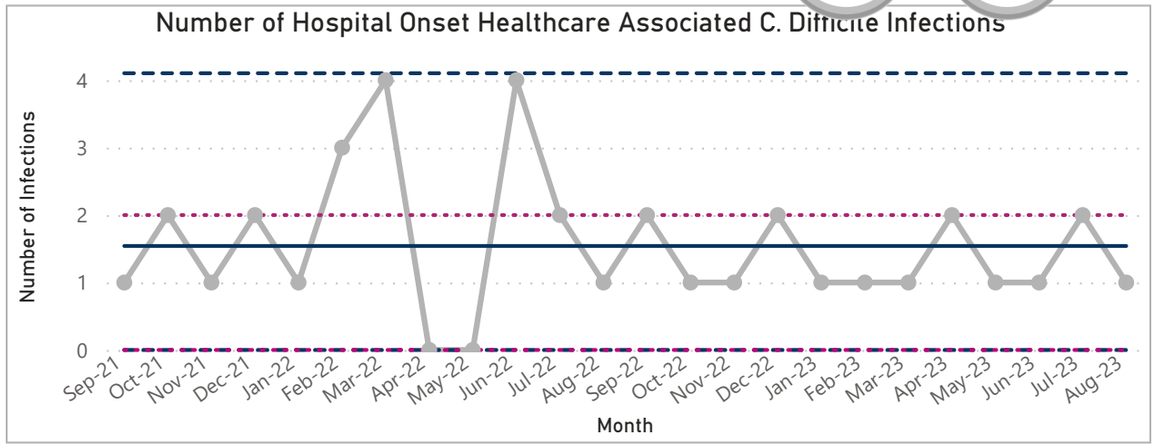
Risks and Mitigations

In June 2023 we saw the highest response rate across Inpatient, Day case and Outpatient areas in the past 12months, demonstrating that mitigations 4 + 5 may be helping to demonstrate to staff the importance of promoting this to patients as a way to hearing their views and gathering feedback on their services. We anticipate that the dashboard will further increase this as we will be in a position to draw themes and insights from the comments. We are currently working with the new digital provider on the data analysis dashboard and we hope to be in a position to analyse and theme the comments we collected during Q1 and Q2 of this year and plan to showcase this through the Divisional Governance structures and PALS Outreach Services in the meantime. These mitigations may not have any dramatic impact on responses rates but will significantly improve our data quality and therefore the insights we draw from this feedback. We hope to have the dashboard populated and begin extractions from this, this Autumn, and plan to introduce this reporting within the Patient Experience Report from Q3.

Infection Control

Are We Safe?





Understanding the performance

There have been two hospital onset healthcare associated reportable E.coli bacteraemia infections, and one hospital onset healthcare associated reportable C.difficile cases this month. There has been no hospital onset healthcare associated MSSA bacteraemia infections this month.
The Infection Control Nurses (ICNs) continue to undertake targeted ward visits and use educational opportunities with different staff groups.

Year	2021-2022	2022-2023	2023-2024
MSSA Bacteraemia Infections: Hospital Onset	12	10	3
MRSA Bacteraemia Infections: Hospital Onset	0	0	0

Actions (SMART)

Advancement with an alternative approach for staff in ward areas to complete hand hygiene education and assessments continues within the surgical unit, with positive feedback from the division. Commencement within the medical division is being facilitated by one of the Divisional Matrons.
Completion of required case investigations by clinical areas to identify good practice and any new learning continues. SFT IP&C team facilitate this process so that areas can take ownership and progress any actions or identified learning (including sharing good practice).
Of the reviews completed, lapses in care have been identified but no action plans developed. This continues to be followed up by the divisions. New format for 'Share & Learn' meetings to be relaunched next month.
Involvement with BSW collaborative workstreams related to IPC and Gram-Negative Bloodstream Infections: Any feedback communicated from the sessions to identified individuals in the organisation is to be shared at the SFT Infection Prevention & Control Working Group as part of a standing agenda item. There have been no HCAI collaborative meetings held this month.

Risks and Mitigations

Ongoing clinical and non-clinical workload for existing IPC nursing team continues to have an impact on ability to progress other HCAI prevention work e.g. policy reviews/development, and innovation activities.
Band 6 nurse interviews held last month, with successful candidate offered position pending references.
An underlying risk continues to be a potential increase in incidence of reportable healthcare associated infections with poor patient outcomes. (Of note: Trust trajectories for 2023/24 were published in May 2023).

Mortality

Are We Safe?

Metric Name	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	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23	Apr-23	May-23	Jun-23	Jul-23	Aug-23
Crude Mortality	65	64	79	94	86	84	84	88	84	77	88	82	73	75	77	102	106	88	95	81	89	51	60	78
HSMR District Hospital (excludes deaths recorded by Salisbury Hospice)	102.85	103.49	106.41	105.02	99.28	102.37	104.12	108.04	108.88	110.44	112.17	113.58	113.85	115.15	114.97	113.95	113.98	113.43	115.10					
HSMR Trust	112.07	114.35	116.13	118.21	106.53	108.89	110.50	113.70	113.97	116.03	117.54	119.24	119.50	121.17	121.04	120.67	121.26	120.88	122.08					
SHMI District Hospital (excludes deaths recorded by Salisbury Hospice)	102.61	102.69	102.81	102.70	104.38	105.48	107.66	106.81	106.05	106.48	106.90	106.98	107.03	106.65	107.29	106.83	107.71	108.68	108.40					
SHMI Trust	107.07	106.90	106.67	106.77	108.47	109.13	111.34	110.43	109.56	110.01	110.87	111.16	111.41	111.08	111.79	111.52	112.92	113.77	113.65					

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. Please also be aware that historical data can change month on month due to updated figures in Telstra Health as a result of latent coding.

***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 12month rolling period ending in March-23 for Salisbury District Hospital is 108.40.

The HSMR for the 12month rolling period ending in March-23 for Salisbury District Hospital is 115.10.

Actions (SMART)

The Trust Board have commissioned a review of our mortality governance processes to ensure that we are taking all reasonable steps to understand and act on the significant and sustained change seen in the Trust's statistical mortality model benchmarking.
Low coding of comorbidities may be resulting in a higher-than-expected number of deaths. We are prioritising coding of patients who die and improving coding of patients' comorbidities.

A data insight report is provided by Dr Foster and reviewed at each Mortality Surveillance Group (MSG) meeting and contains peer comparison data. There have been no obvious patterns or themes suggesting significant deficiencies in care from recent reviews although a general increased in patient frailty at the point of admission has been noted. A regional mortality summit is being established to help provide us with further context in regards to our mortality data. Data suggests that there is a lower overall mortality rate for the region as a whole when compared to national figures.

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	Target Met This Month?	Consecutive Months Target Failed
Ambulance Handovers 60+ mins	61	24	84		0		Common Cause Variation	X	29
Cancer 62 Day Screening Performance	80.0%	50.0%	75.0%		90%		Common Cause Variation	X	11
Complaints Acknowledged within agreed timescale %	40.0%	45.0%	24.0%	90.0%		H		X	29
ED 12 Hour Breaches (Arrival to Departure)	28	16	47		0	L	Special Cause Improving - Run Below Mean	X	29
ED Attendances	6589	6527	6320			H	Special Cause Concerning - Run Above Mean		
Inpatients Undergoing VTE Risk Assessment within 24hrs %	13.5%	22.4%	37.1%		95%	H		X	29
Mixed Sex Accommodation Breaches	16	12	12	0	0	L	Special Cause Improving - Two Out of Three Low	X	12
Number of High Harm Falls in Hospital	2	1	4	0	0		Common Cause Variation	X	13
RTT Incomplete Pathways: Total 52 week waits	1273	1367	1290	940	0	H	Special Cause Concerning - Above Upper Control Limit	X	8
RTT Incomplete Pathways: Total 78 week waits	0	0	15	0	0	L	Special Cause Improving - Below Lower Control Limit	X	1
Trust Performance RTT %	61.8%	62.5%	61.3%		92%	L	Special Cause Concerning - Below Lower Control Limit	X	29

Watch Metrics: Alerting Narrative

Quality of Care, Access and Outcomes

Understanding the performance

Statistical process charts (SPC) are used for monitoring of the watch metrics, these should always have at least 15 months of data feeding them to enable the variation detail which is generated when viewing performance over the whole reporting period. A number of metrics this month are showing to be alerting due to improvement when viewed over the total period, but may actually have deteriorated in the most recent months. Notably, the number of patients reported to be waiting over 78 weeks was 15 in M5, this has been zero since March 23 so represents a deterioration when compared to the previous month. 13 of the patients are on Breast pathways that were previously managed as planned pathways, at the request of NHSE these have been added to the WL. In addition, there was also 1 Dermatology and 1 Plastic patient that waited longer than 78 weeks due to the ongoing and cumulative impact of the Industrial action with combined junior and consultant strike action in M5. This also had an effect on progress towards eliminating the number of patients waiting over 65 weeks, whilst a reduction was achieved, the number remains above the target level of where we planned to be.

Similarly, the number of patients spending longer than 12 hours in the Emergency Department, waiting longer than 60 minutes with ambulance crews on arrival at the Emergency Department or experiencing mixed sex accommodation has increased in comparison to the last month, but overall are showing a reduction when viewed as a trend over a longer period. The interdependencies of flow related metrics with bed occupancy is well recognised, bed occupancy in M5 rose slightly supporting the picture of a more operationally flow challenged month.

Actions (SMART)

Monitoring of long waits for Elective treatment continues with focused specialty support where appropriate. Regular meetings with NHSE regarding breast pathways with a plan for reduction agreed.

As we approach Winter operational challenges related to capacity are expected to increase, a Winter plan is being developed to mitigate against this focusing on optimising Same Day Emergency Care pathway and decreasing length of stay. The Discharge Hub and Integrated Discharge Team has been implemented with improved times for pathway allocation, an increase in allocation resource from system partners is required to see further improvement in the number of patients in hospital that no longer meet the criteria to reside.

Further detail in relation to the Referral to Treatment and Cancer metrics can be found on the relevant key performance indicator page earlier in this report.

Risks and Mitigations

The risk of lost capacity owing to the industrial action remains. Whilst mitigation is in place to protect urgent activity, the total volume of activity cannot usually be entirely mitigated resulting in potential reduction of routine activity able to be undertaken.
Unknown impact of Covid-19 or other respiratory viruses over Winter.

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	Target Met This Month?	Consecutive Months Target Failed
Average Patients with No Criteria to Reside	111	86	89	120		L	Special Cause Improving - Below Lower Control Limit	✓	0
Cancer 2 Week Wait Breast Performance	97.1%	97.6%	90.0%		90%	H	Special Cause Improving - Run Above Mean	✓	0
Cancer 31 Day Performance Overall	97.7%	97.4%	96.3%		96%		Common Cause Variation	✓	0
Cancer Patients with a decision to treat waiting > 62 days	89	78	102	112				✓	0
Diagnostics Activity	8176	7673	7482	6812		H	Special Cause Improving - Run Above Mean	✓	0
Neonatal Deaths Per 1000 Live Births	6	0	0		0		Common Cause Variation	✓	0
Pressure Ulcers Hospital Acquired Cat 2	28	38	33				Common Cause Variation		
Pressure Ulcers Hospital Acquired Cat 3	0	4	0				Common Cause Variation		
Pressure Ulcers Hospital Acquired Cat 4	0	0	0			L	Special Cause Improving - Run Below Mean		
Proportion of patients spending more than 12 hours in an emergency department	0.6%	0.4%	1.1%			L	Special Cause Improving - Run Below Mean		
RTT Incomplete Pathways: Total 65 week waits	235	236	225	250	0		Common Cause Variation	✓	0
Serious Incident Investigations	4	0	3				Common Cause Variation		
Stillbirths Per 1000 Total Births	6	0	0				Common Cause Variation		
Stroke patients receiving a CT scan within one hour of arrival	58.0%	63.0%	65.0%		50%	H	Special Cause Improving - Two Out of Three High	✓	0
Total Incidents (All Grading) per 1000 Bed Days	62	58	59				Common Cause Variation		
Total Incidents Resulting in High Harm (Mod/Maj/Cat) %	4.4%	3.3%	2.7%				Common Cause Variation		
Total Number of Complaints Received	12	12	9				Common Cause Variation		
Total Number of Compliments Received	34	51	86				Common Cause Variation		

Part 2: People

Performance against our Strategic Priorities and Key Lines of Enquiry

Salisbury NHS Foundation Trust

Our Priorities

Population

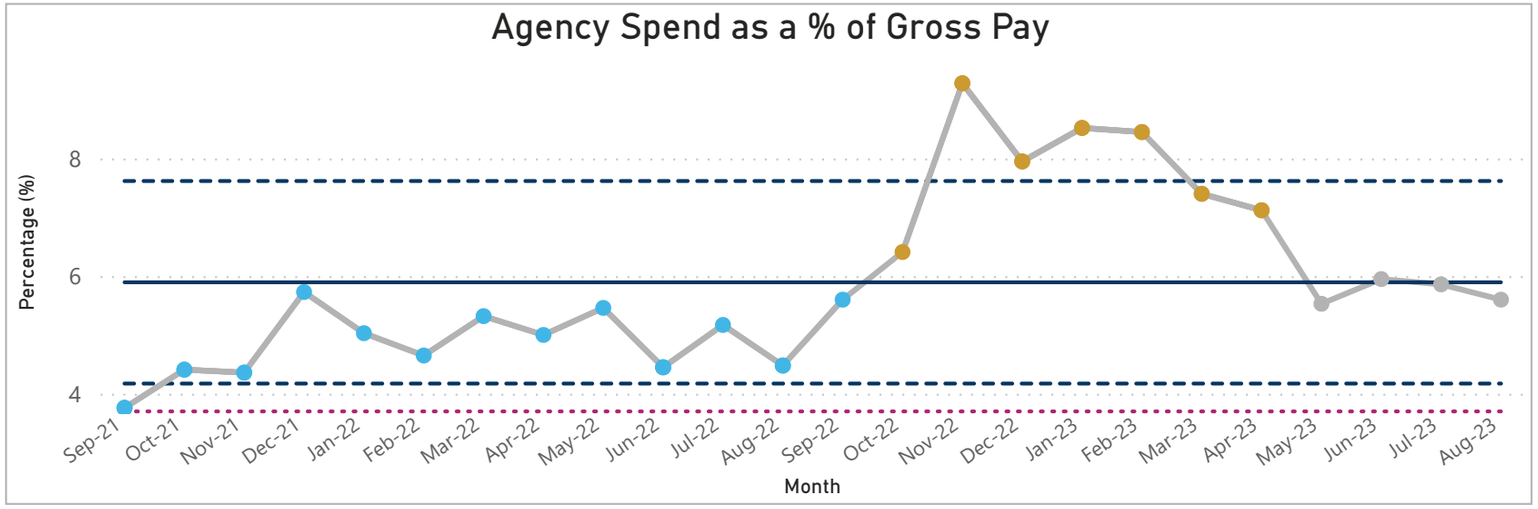
Partnerships

People

Staffing Availability

Target 3.7%

Breakthrough Objective



We are driving this measure because...

Insufficient substantive clinical staff are available to meet safe staffing levels. The Trust is currently unable to consistently meet Green staffing levels across all shifts and for a significant number of shifts has to resort to the use of expensive agency staff, which has led to an unsustainable overspend. Agency spend against total staff pay costs is currently averaging 5.9% against a 3.7% target and rising.

Understanding the performance

August saw a further small reduction in the agency spend percentage from 5.86% to 5.6% of the total pay bill, which represents a total spend of £1.037M. This is encouraging, but remains higher than the comparable period in 2022 by c0.5% and still above target. The proportion of spend on nursing has dropped below 60%, with Medical staffing rising to 27%. These two staff types remain the largest contributors to Agency spend accounting for £889K of the £1.037M spend this month.

Medicine continue to dominate Agency spend at 10.9% of their pay bill. Emergency Medicine and Theatres remain the highest departments for Agency spend accounting for 20% of total agency spend between them. The Emergency department is also the highest user of Bank staff accounting for nearly twice as much spend as the second highest user.

Actions (SMART)

Temp Staffing Deep Dive into Medicine and Surgery. Work has commenced to identify the break down of Agency and Bank spend in Medicine and Surgery, seeking to better understand the process levers that can reduce spend, where unestablished positions generate spend, and how operational factors impact spend. This study will report in late September.

Establishment Control: NHS BSA team has started work on the implementation of ESR Establishment Control modules. This work has take longer than planned due to significant data cleansing challenges. The project now aims to complete a reconciliation of finance ledger with organisational design on ESR by end Dec 23.

Temporary staffing: Weekly management meetings initiated by the Deputy CNO provide a forward look at temp staffing controls and demand.

Risks and Mitigations

Corporate Risk – Sustainable Workforce
Mitigations:

Line Managers insufficiently trained to support people promise and absence management initiatives – Leaders training now established at 2 levels, with management training interventions designed and in place.

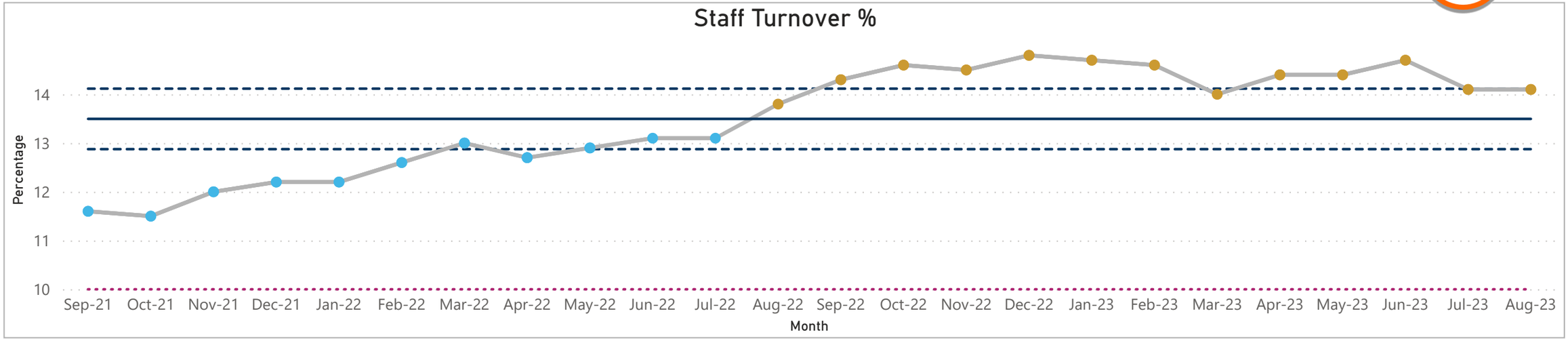
Temp staffing 5 point plan seeks to address weaknesses in the process and controls of temp staffing, as well as managing Agency costs through improve Bank staff numbers and new Agency contracts.

Estb Control project timelines are tight and require detailed engagement from DMT, Fin BP and HR BP. The new timetable has just been released seeking to establish a reconciled position by Dec 23.

Workforce - Turnover

Target 10%

People



Understanding the performance

Turnover rates have remained static at 14.1% this month. In Aug 23, 34.24(FTE) left the Trust, with 40.25 (FTE) new staff starting work, a gross gain of 6 FTE. Staff leavers remain high with turnover metrics stubbornly difficult to move.

All Divisions remain above the Trust target of 10%. Women & New Born (17.95%) remain the division with the highest turnover for the fourth month. Understanding the position in relation to midwives is urgent work for the division. Total nursing and midwifery turnover is low at 11.78%, but this month saw a net loss of 12 FTE leavers within the nursing and midwifery staff group.

A total of 42 staff left the Trust in July, of which over a third were in their first 2 years of service and a quarter under 30. Reasons for leaving this month were more varied than in recent months, although relocation and not known remain the highest reasons.

Actions (SMART)

AD HR Ops has reviewed the turnover A3 and identified a need to focus countermeasures on why staff remain, with particular focus on those in their first 2 years of service and under 30. This work is complemented by 100 day and 1 year sessions for staff organised by OD&P

The new appraisals form and process was launched on 31st May providing a streamlined and simpler method of completing the key elements of the appraisal, supporting staff in recognising their performance, setting effective objectives and understanding career development aspirations and training requirements.

People promise actions, designed to support staff retention and improve welfare and wellbeing continue to be rolled out, with an increased focus on communicating the positive interventions available for all staff. A wellbeing survey will be launched in Sep to identify areas of concern amongst staff.

Risks and Mitigations

Corporate Risk – Sustainable Workforce.

Improved toolkits to support Line Managers to deliver appraisals and other conversations have been delivered.

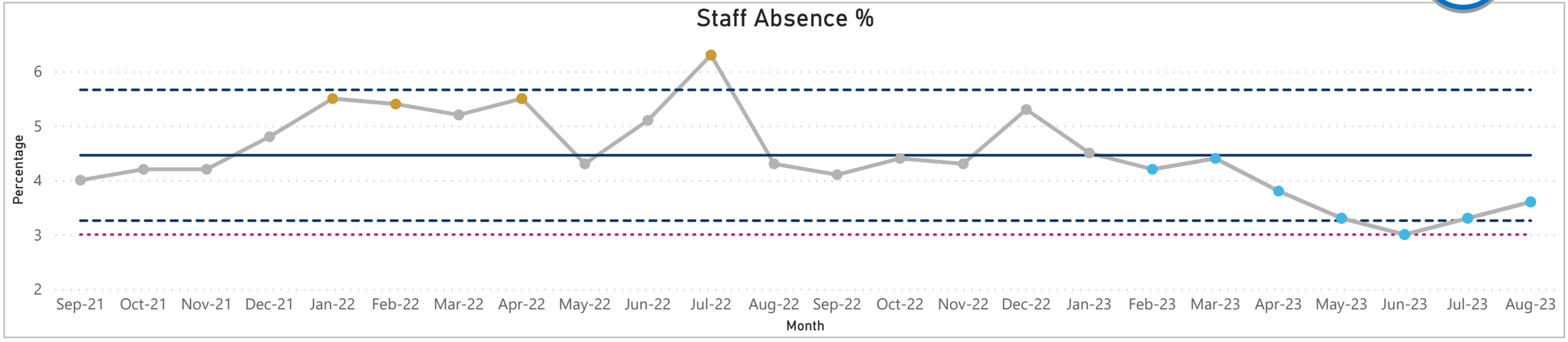
Divisional Staff Survey Action Plans

Line Manager Training interventions

Workforce - Sickness

Target 3%

People



Understanding the performance

Sickness absence in August rose slightly to 3.62%, the second monthly rise following a record low in Jun 23. The 6 month average is 3.57%.

CSFS and women and new born are the best performers of the clinical divisions at 3.1%, with Medicine and surgery at 4.39 and 4.26% respectively. Staff from Additional Clinical Services remain the staff group with the highest absence rate, rising this month above 6%. This group includes HCAs, Therapy assistants and Radiography helpers.

Sickness accounted for 4,216 FTE days lost to the Trust, of which 2528 were for short term absence. Anxiety and stress continues to be the major reason for absence accounting for over 25% of all absence in the month. Over 60 staff have had 10 or more periods of absence in the calendar year and will be identified as priority for case work to support them.

Actions (SMART)

Absence Management: Following correlation of OH Data and Absences, it has been identified that some areas of the Trust are less likely to be able to manage reasonable adjustments for staff to return to role. Work has been initiated to understand the reasons why, and support line managers to understand the process and rules around reasonable adaptations in the workplace.

Work is underway following publication of the Annual H&S report to develop the Health Intelligence Capability in the Trust, seeking to focus on MSKI in the Spinal area and Stress and Anxiety prevention in Medicine, particularly the Elderly Medicine wards.

A focus on the prevention of violence and aggression within the Trust will seek to reduce instances of physical and verbal assault and thus reduce both physical and mental health injury for staff.

Risks and Mitigations

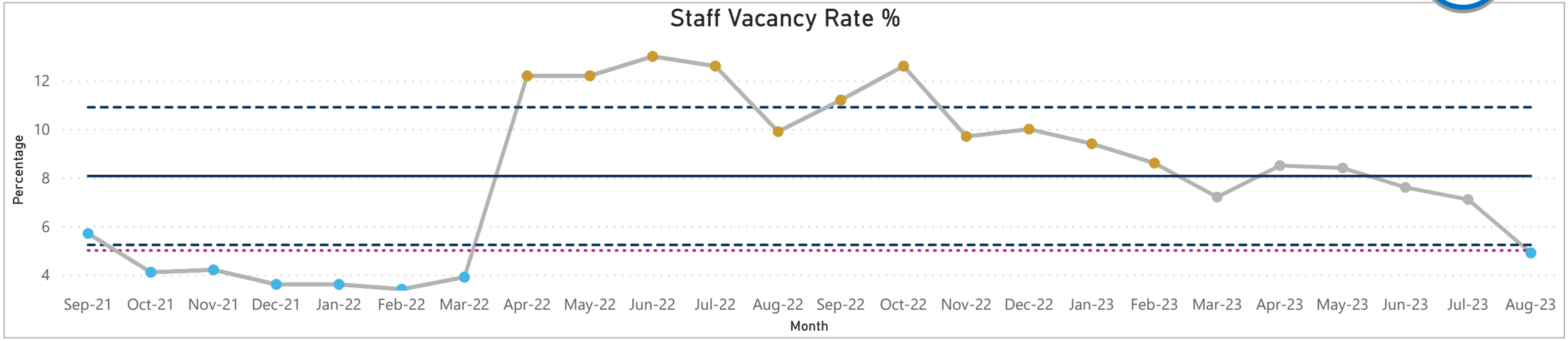
Corporate Risk – Delivery of OH service
Increased counselling and physio hours have been agreed and staff recruited for the counselling post. Delivery of an initial health intelligence capability is planned for Summer 23.

Corporate Risk – Sustainable Workforce
The HRA team has been reduced by 50% (4 FTE) due to promotion, resignation and maternity leave – this will generate a short term impact on outputs for the Team.

Workforce - Vacancies

Target 5%

People



Understanding the performance

The downward trend within vacancy rates has continued with the graph showing a marked improvement in performance for the first time since Mar 22. The rate was measured at 4.90% in Aug against the target of 5%.

At 125 FTE, nursing staff remain the staff group with the highest number of vacancies and this correlates with the largest agency spend by staff group. This gap is being targeted through the international recruitment campaign this year and agreement has been reached on additional funding to manage nurses seeking to return to practice.

Theatres have reduced their vacancies from 80 to 31 this month which represents a significant drop in this department. Elderly Medicine (30) have the highest number of vacancies in medicine. These areas both still correlate with high agency spend.

Actions (SMART)

The focus of Advertisement campaigns remains Theatres, The Emergency Department, Maternity, HCA and Housekeeping.

Work to reconcile vacancies through Finance ledger and ESR is ongoing as part of the ESR Establishment Control project.

Workforce trajectory forecasting work is ongoing, seeking to support Divisions and Line Managers with targeted attraction and recruitment campaigns.

Business cases have been submitted to support degree apprenticeships for nursing and to enable additional training to allow those overseas staff with nursing qualifications to practice in the UK.

Toolkits have been completed and are awaiting sign off before being deployed to support line managers with recruitment.

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	Target Met This Month?	Consecutive Months Target Failed
Mandatory Training Rate %	89.7%	89.5%	88.6%	90.0%	85%		Special Cause Improving - Run Above Mean	X	7
Non-Medical Appraisal Rate %	60.1%	60.2%	61.0%	86.0%			Special Cause Concerning - Below Lower Control Limit	X	29

Watch Metrics: Alerting Narrative

People

Understanding the performance

Mandatory training activity remains close to the improvement target of 90%, sitting at 88.6% in Jul and noting the national target of 85%. The corporate area at 84.9% completion is the area which causes the greatest reduction in the Trust average. A refresh of the MLE, linked with ESR is underway to ensure that data is accurately captured, this activity takes time and is aligned with reconciling ESR to the finance ledger as part of the establishment control project.
Medical appraisals data was not available at the time of submitting the report.
Despite the launch of the modified appraisal form, the completion rate for non-medical appraisals has only increased by 0.8% in the last month. Completion rates were 61% against the 86% improvement target in August. Ineffective management of appraisals remains a key area of concern in Staff Survey and Pulse survey data, leading to low morale amongst staff. Time to complete and complexity of the process, including managing data on ESR, are the most common challenges put forward to explain the challenges to correct this reducing completion rate.

Actions (SMART)

Mandatory Training: At the core of ensuring that statutory and mandatory training are improved is the ability for Line Managers to remind staff of their responsibility and enable the time to complete activity. Trust wide comms will continue to remind all staff of their responsibilities, alongside specific updates to line managers from the MLE system, identifying staff who are out of date. The corporate HRBP has been tasked to support corporate teams (less Facilities, which are at 97%) in understanding the demand and enabling the time to complete training.

Appraisals: Work to identify and support managers with a large number of outstanding appraisals has been conducted. Instructions on how to record appraisals on ESR has been published and training offered to line managers to support data capture.

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	Target Met This Month?	Consecutive Months Target Failed
Medical Appraisal Rate %	94.7%	95.4%	91.5%	90.0%			Special Cause Improving - Above Upper Control Limit	✓	0

Part 3: Finance and Use of Resources

Performance against our Strategic Priorities and Key Lines of Enquiry

Salisbury NHS Foundation Trust

Our Priorities

Population

Partnerships

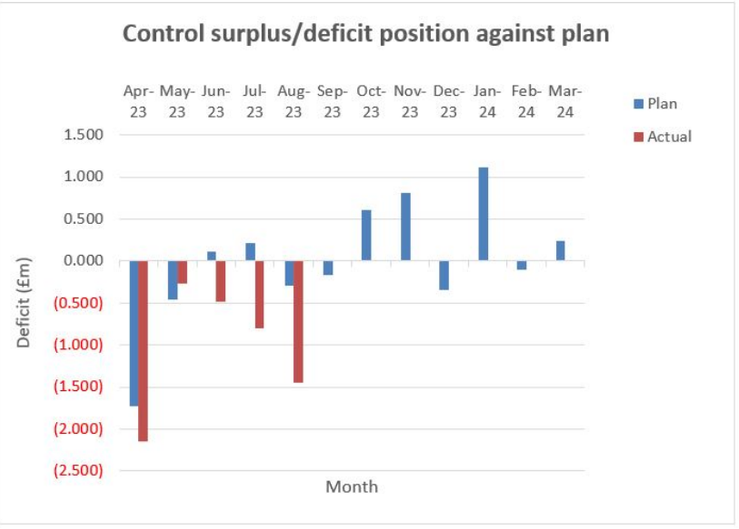
People

Income and Expenditure

Income & Expenditure:

Finance and Use of Resources

	August '23 In Month			August '23 YTD			23-24 Plan
	Plan £000s	Actual £000s	Variance £000s	Plan £000s	Actual £000s	Variance £000s	Plan £000s
Operating Income							
NHS Clinical income	25,151	25,466	315	122,792	123,297	505	275,490
Other Clinical Income	794	1,619	825	3,993	7,942	3,949	9,478
Other Income (excl Donations)	3,273	3,455	182	14,144	16,940	2,796	70,426
Total income	**29,218**	**30,541**	**1,322**	**140,929**	**148,179**	**7,251**	**355,394**
Operating Expenditure							
Pay	(18,590)	(20,229)	(1,639)	(88,512)	(96,784)	(8,272)	(212,809)
Non Pay	(9,333)	(10,109)	(776)	(46,630)	(48,132)	(1,502)	(123,527)
Total Expenditure	**(27,923)**	**(30,339)**	**(2,415)**	**(135,142)**	**(144,916)**	**(9,774)**	**(336,336)**
EBITDA	**1,295**	**202**	**(1,093)**	**5,787**	**3,263**	**(2,524)**	**19,058**
Financing Costs (incl Depreciation)	(1,588)	(1,644)	(56)	(7,938)	(8,404)	(466)	(19,058)
NHSI Control Total	**(293)**	**(1,442)**	**(1,149)**	**(2,151)**	**(5,141)**	**(2,990)**	**0**
Add: impact of donated assets	232	364	132	460	2,340	1,880	9,989
Surplus/(Deficit)	**(61)**	**(1,078)**	**(1,017)**	**(1,691)**	**(2,800)**	**(1,109)**	**9,989**



Understanding the performance

The financial plan submitted to NHS England on 4 May shows a breakeven control total position for the year. The 2023/24 financial arrangements have moved to the 2023/25 NHS payment scheme with fixed and variable elements of an Aligned Payment Incentive (API) arrangement following the transitional arrangements from COVID block payments in 2022/23. Although the majority of the Trust's NHS contractual income base is fixed, the guidance allows for additional income to be earned through the variable element of the API and the Elective Recovery Fund (ERF) from commissioners. SFT has not assumed any ERF income within the 2023/24 plan, or the year to date position in line with national guidance, as the Trust's planned activity levels do not meet the thresholds for payment. In Month 5 the Trust recorded a YTD control total deficit of £5.141m against a target of £2.151m - an adverse variance of £2.990m. The position is driven by the costs of Industrial action, the costs of provided enhanced care to patients and the residual gap on pay awards.

Actions (SMART)

The 2023/24 plan includes an efficiency requirement of £15.3m and the Financial recovery group was established in April, as a sub committee of the Finance and Performance committee, to provide scrutiny and support to the savings programme.

Risks and Mitigations

Pressure on emergency care pathways, particularly in relation to continued levels of patients with no clinical right to reside, as the efficiency plan assumes significant length of stay reductions which will not be realised in full without effective system working. Delivery of productivity increases which are contingent on both length of stay reductions and the recruitment of staff. The Trust's forecast of £15.3m efficiency savings includes more than 29% non recurrent delivery and signals a risk if further recurrent efficiencies cannot be idenitifed. Actions are ongoing to identify additional schemes. Impacts of Industrial action which drives the increased costs of cover and constrains the elective programme, introducing risk to income, with additional Junior doctors and Consultant action planned in September and October.

Income & Activity Delivered by Point of Delivery

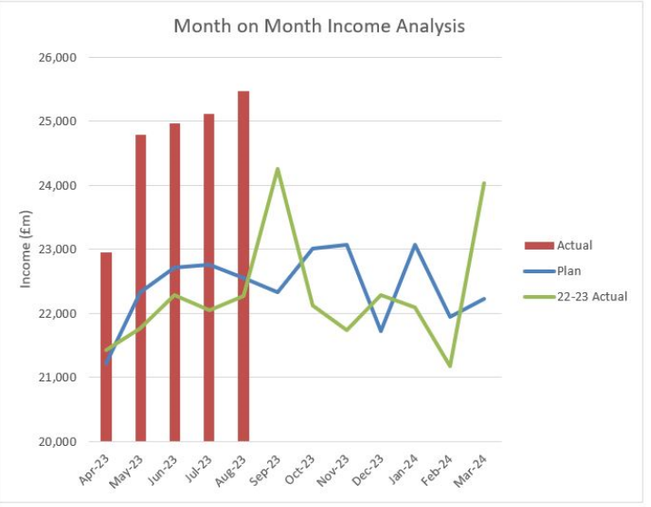
Clinical Income:

Finance and Use of Resources

Income by Point of Delivery (PoD) for all commissioners	Aug 23 Year to Date (YTD) Plan (YTD) £000s	Actual (YTD) £000s	Variance (YTD) £000s
A&E	4,388	4,718	330
Day Case	8,748	8,592	(156)
Elective inpatients	5,697	5,937	240
Excluded Drugs & Devices (inc Lucentis)	10,053	10,783	730
Non Elective inpatients	32,345	32,052	(293)
Other	46,916	45,410	(1,506)
Outpatients	14,645	15,805	1,160
TOTAL	122,792	123,297	505

SLA Income Performance of Trusts main NHS commissioners	Contract Plan (YTD) £000s	Actual (YTD) £000s	Variance (YTD) £000s
BSW ICB	75,613	76,307	694
Dorset ICB	12,096	11,551	(545)
Hampshire, Southampton & IOW ICB	10,437	10,142	(295)
Specialist Services	16,754	16,994	240
Other	7,892	8,303	411
TOTAL	122,792	123,297	505

	Activity YTD Plan	Actuals	Variance	Activity Last Year Actuals	Variance last year
A&E	30,893	30,804	(89)	30,948	(144)
Day case	9,521	9,927	406	9,292	635
Elective	1,344	1,346	2	1,465	(119)
Non Elective	11,523	11,590	67	11,106	484
Outpatients	103,908	110,147	6,239	101,428	8,719



Understanding the performance

The Clinical income position is above plan year to date due to BSW ICB overperformance on High cost drugs and devices, Advice and Guidance and Radiology from the use of independent sector providers for MRI and CT activity, Specialist services overperformance on High cost drugs and devices and Other commissioners overperformance due to Cross border patient flows and Cystic Fibrosis drugs recharges.

The level of uncoded day cases and inpatient spells is 35% in July and 92% in August at the time the activity was taken for reporting purposes. June's activity was fully coded at the SUS submission.

Activity was higher in August than in June across the majority of points of delivery with the exception of A&E attendances.

Actions (SMART)

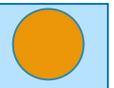
The contracts with ICBs and NHS England remain under negotiation at this stage. Several contract schedules have been agreed with ICB commissioners and discussions are progressing around the finance schedules with BSW and Dorset ICBs. Further guidance is anticipated around Dental commissioning arrangements including revised ICB allocations.

Risks and Mitigations

The impact of industrial action constrains the elective programme, introducing risk to income. Additional guidance has been received which reduces the ERF target by 2% across all commissioners. The impact of this on the Trust is being confirmed with BSW ICB and the regional team as the Trust was not planning to achieve the ERF target. All commissioner contracts outside BSW are required at 101% of 2019/20 Elective activity levels. The Trust is seeking to mitigate the impact by maximising activity recording opportunities and via the contract negotiations.

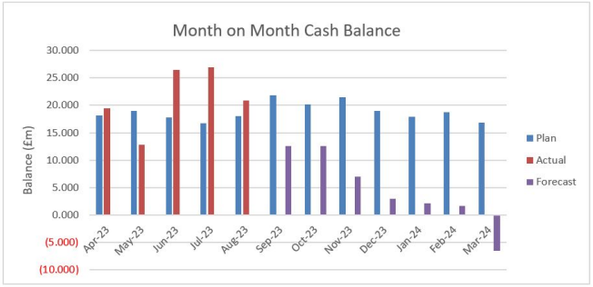
Cash Position & Capital Programme

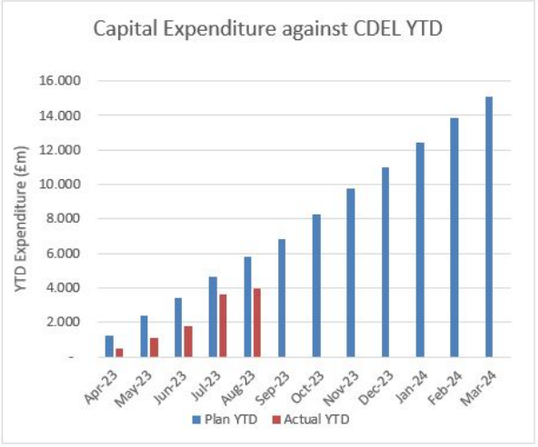
Capital Spend: 

Cash & Working: 

Finance and Use of Resources

	Closing Balance March 2023 £000s	Current Month Balance £000s	Actual In Year Movement £000s
Inventories (Stock)	7,954	8,585	631
Debtors	24,999	25,248	249
Cash	28,891	20,873	(8,018)
TOTAL CURRENT ASSETS	**61,844**	**54,706**	**(7,138)**
Creditors	(58,026)	(56,028)	1,998
Borrowings	(641)	(637)	4
Provisions	(474)	(470)	4
TOTAL CURRENT LIABILITIES	**(59,141)**	**(57,135)**	**2,006**
TOTAL WORKING CAPITAL	**2,703**	**(2,429)**	**(5,132)**





Payables age profile	Total Payables £'000	0-30 days £'000	31-60 days £'000	61-90 days £'000	90+ days £'000
Aug-23	**6,684**	5,666	246	239	533
Jul-23	**9,501**	8,470	238	174	619
Jun-23	**8,446**	7,306	231	379	530
Movement vs prev mth	*(2,818)*	*(2,804)*	*8*	*65*	*(86)*

Schemes	Annual Plan £000s	August '23 YTD Plan £000s	August '23 YTD Actual £000s	August '23 YTD Variance £000s
CDEL Schemes				
Building schemes CIR	2,800	1,167	393	774
Building projects	6,235	2,598	2,387	211
IM&T	3,451	1,207	1,017	190
Medical Equipment	2,713	1,130	194	936
Total CDEL schemes	**15,199**	**6,102**	**3,991**	**2,111**
National Funding				
New Elective Ward TIF	*11,952*	*1,375*	*1,375*	0
Salix Decarbonisation	*10,005*	*3,213*	*3,213*	0
Shared EPR - national element	*3,760*	*0*	*0*	0
Digital Pathology	*1,053*	*307*	*307*	0
Pathology LIMS	*310*	*39*	*39*	0
SW Imaging (ATVS)	*174*	*2*	*2*	0
Total National Funding	**27,254**	**4,936**	**4,936**	**0**
GRAND TOTAL	**42,453**	**11,038**	**8,927**	**2,111**

Understanding the performance

In month 5 there has been further significant expenditure on the Salix project (£762k) and the Whiteparish refurbishment (£808k). Forecast expenditure by capital sub group continues to be reviewed each month at the Trust Capital Control Group to ensure full allocations will be spent by the year end. Forecast expenditure by capital sub group will be reviewed each month at the Trust Capital Control Group to ensure full allocations will be spent by the year end. Specific projects, including Salix, do have expenditure profiles weighted towards the end of the year and actions will to taken to maximise the funding in year and manage any slippage. Cash reserves are now c£2m above plan following the reduction in payables c£3m, lower income levels in month and the year to date deficit of c£5.1m which is c£3.0m adverse to plan.

Actions (SMART)

The Trust will be actively seeking opportunities for additional capital funds as they arise. Regular engagement with the regional capital team is taking place on the availability of Leases funding so that this can be fully utilised within year. Additional cash funds have been paid by BSW ICB in June to mitigate any adverse impact of the June pay award payments on the Trust's cash position. Monthly review of the cash position and forecast to ensure that sufficient funds are available to meet payments as they arise and that capital funding is in place as early as possible to mitigate working capital requirements.

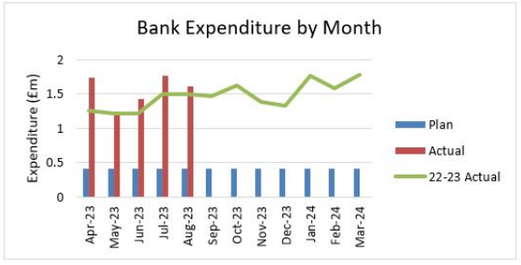
Risks and Mitigations

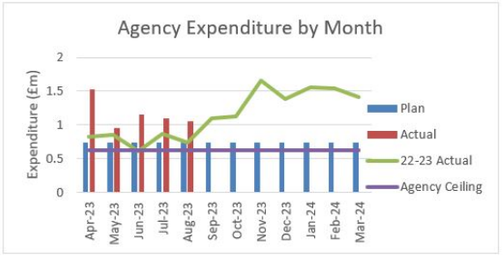
Additional capital pressures are emerging in year and such risks will have to be managed within the overall capital envelope if additional funding cannot be secured. Following the resubmission of financial plans on 4th May 2023 the Trust is awaiting confirmation from NHS England of the Capital leases funding of £5m. This funding is expected to be used to purchase CT scanners and C-arm equipment on a leased basis. 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. 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.

Workforce and Agency Spend

Pay:

Finance and Use of Resources





	August '23 YTD		
	Plan £000s	Actual £000s	Variance £000s
Pay - In Post	82,574	82,900	326
Pay - Bank	2,118	7,776	5,658
Pay - Agency	3,820	5,789	1,970
Other (eg apprenticeship levy)		319	319
TOTAL	**88,512**	**96,784**	**8,272**
Medical Staff	23,325	25,052	1,728
Nursing	23,236	26,177	2,942
Support to Nursing	6,356	8,875	2,520
Other Clinical Staff	12,566	12,634	68
Infrastructure staff	23,030	23,726	697
Other (eg apprenticeship levy)		319	319
TOTAL	**88,512**	**96,784**	**8,272**

	August '23 YTD		
	Plan WTEs	Actual WTEs	Variance WTEs
Medical Staff	474.7	580.7	106.0
Nursing	1,136.3	1,174.8	38.5
Support to Nursing	508.3	614.9	106.5
Other Clinical Staff	640.8	619.7	(21.2)
Infrastructure staff	1,462.7	1,428.4	(34.3)
TOTAL	**4,222.9**	**4,418.4**	**195.6**

Understanding the performance

Month 5 saw the highest monthly pay costs of the year so far, totalling c£20.2m, leading to an adverse variance to plan in month of c£1.6m and c£8.3m YTD. Pay costs increased by c£0.45m on the Month 4 run rate with all clinical divisions exceeding planned levels of Pay year to date. The pay position includes the cumulative pay savings target at month 5 of c£3.8m of which c£2.0m has been delivered to date. Substantive costs increased by c£0.6m in month, while bank and agency costs fell by c£0.16m and c£0.03m respectively. Pressure on pay budgets has continued in month due to a further decrease in staff availability in month with availability 108 WTE lower in August than July linked to both sickness and annual leave. The average unavailability was 24.3% which is seen at higher levels within clinical teams and wards. The costs of patients requiring specialling has reduced across the majority of areas within month with the only exception within Child Health.

Substantive vacancies across the Trust have decreased from 5% to 4% overall in August with the highest proportion of vacancies remaining within the Consultant and Nursing and midwifery groups. The unfilled rate has increased to June levels of 3%, mainly across AHPs and Infrastructure groups.

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 establishment, recruitment, temporary staffing and sickness.

Risks and Mitigations

Staff availability initiatives are in train to mitigate workforce gaps and the need for premium agency and bank, although in the short term it is likely that the Trust will require both. The impact of Industrial action which drives the costs of increased cover and Time off in lieu (TOIL).

Data Sources: Narrative and Breakthrough Objectives

Understand the Data

Metric Type	Metric Name	Data Source	Executive Lead	Data Quality Rating
Breakthrough Objective	Beds Occupied %	Lorenzo via Trust Data Warehouse	Lisa Thomas	Medium
Breakthrough Objective	Staffing Availability	Oracle	Melanie Whitfield	High
Breakthrough Objective	Total Patient Falls per 1000 Bed Days	DATIX Team	Judy Dyos	High
Breakthrough Objective	Wait time to first OPA (non-admitted)	Lorenzo via Trust Data Warehouse	Lisa Thomas	High
Narrative	Ambulance Handover Delays >30 mins as a % of all handovers	Lorenzo via Trust Data Warehouse	Lisa Thomas	High
Narrative	Average Ambulance Handover Time	Lorenzo via Trust Data Warehouse	Lisa Thomas	High
Narrative	C Difficile Hospital onset Healthcare associated	Infection Control Team	Judy Dyos	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	Infection Control Team	Judy Dyos	High
Narrative	DM01 Performance	Trust Data Warehouse	Lisa Thomas	High
Narrative	E Coli Hospital onset Healthcare associated	Infection Control Team	Judy Dyos	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	Judy Dyos	High
Narrative	Patients moved more than once %	Lorenzo via Trust Data Warehouse	Judy Dyos	High
Narrative	Staff Sickness Absence %	Health Roster	Melanie Whitfield	High
Narrative	Staff Turnover	ESR	Melanie Whitfield	High
Narrative	Stroke: % Arrival on Stroke Unit within 4 hours	Stroke Team	Peter Collins	Medium
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	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	MSSA Bacteraemia Infections: Hospital Onset	Infection Control Team	Judy Dyos	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 patients receiving a CT scan within one hour of arrival	Stroke Team	Peter Collins	Medium
Watch	Stroke: % Bedside Swallow Assessment within 4 hours	Stroke Team	Peter Collins	Medium

Data Sources: Watch Metrics (2)

Understand the Data

Metric Type	Metric Name	Data Source	Executive Lead	Data Quality Rating
Watch	Cancer 31 Day Performance Overall	Cancer Services	Lisa Thomas	High
Watch	Inpatients Undergoing VTE Risk Assessment within 24hrs %	Lorenzo via Trust Data Warehouse	Peter Collins	High
Watch	Mandatory Training Rate %	MLE	Melanie Whitfield	High
Watch	Medical Appraisal Rate %	ESR	Melanie Whitfield	High
Watch	Mixed Sex Accommodation Breaches	Site Team	Judy Dyos	Low
Watch	Neonatal Deaths Per 1000 Live Births	E3 via Trust Data Warehouse	Peter Collins	High
Watch	Non-Medical Appraisal Rate %	ESR	Melanie Whitfield	High
Watch	Number of High Harm Falls in Hospital	DATIX	Judy Dyos	High
Watch	Pressure Ulcers Hospital Acquired Cat 2	Infection Control Team	Judy Dyos	High
Watch	Pressure Ulcers Hospital Acquired Cat 3	Infection Control Team	Judy Dyos	High
Watch	Pressure Ulcers Hospital Acquired Cat 4	Infection Control Team	Judy Dyos	High
Watch	Proportion of patients spending more than 12 hours in an emergency department	Lorenzo via Trust Data Warehouse	Lisa Thomas	High
Watch	Serious Incident Investigations	DATIX	Judy Dyos	High
Watch	Stillbirths Per 1000 Total Births	E3 via Trust Data Warehouse	Peter Collins	High
Watch	Total (Excess) Bed Days from NC2R to Discharge - Internal Reasons only	e-whiteboards	Lisa Thomas	Medium
Watch	Total Incidents (All Grading) per 1000 Bed Days	DATIX	Judy Dyos	High
Watch	Total Incidents Resulting in High Harm (Mod/Maj/Cat) %	DATIX	Judy Dyos	High
Watch	Total Number of Complaints Received	PALS Team	Judy Dyos	High
Watch	Total Number of Compliments Received	PALS Team	Judy Dyos	High
Watch	Trust Performance RTT %	Lorenzo via Trust Data Warehouse	Lisa Thomas	High

Data Sources: Other Metrics (1)

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 Breaches: Audio	Trust Data Warehouse	Lisa Thomas	High
Other	DM01 Breaches: Cardio	Trust Data Warehouse	Lisa Thomas	High
Other	DM01 Breaches: Colon	Trust Data Warehouse	Lisa Thomas	High
Other	DM01 Breaches: CT	Trust Data Warehouse	Lisa Thomas	High
Other	DM01 Breaches: DEXA	Trust Data Warehouse	Lisa Thomas	High
Other	DM01 Breaches: Flexi Sig	Trust Data Warehouse	Lisa Thomas	High
Other	DM01 Breaches: Gastro	Trust Data Warehouse	Lisa Thomas	High
Other	DM01 Breaches: MRI	Trust Data Warehouse	Lisa Thomas	High
Other	DM01 Breaches: Neuro	Trust Data Warehouse	Lisa Thomas	High
Other	DM01 Breaches: US	Trust Data Warehouse	Lisa Thomas	High
Other	DM01 Performance: Audio	Trust Data Warehouse	Lisa Thomas	High
Other	DM01 Performance: Cardio	Trust Data Warehouse	Lisa Thomas	High
Other	DM01 Performance: Colon	Trust Data Warehouse	Lisa Thomas	High
Other	DM01 Performance: CT	Trust Data Warehouse	Lisa Thomas	High
Other	DM01 Performance: DEXA	Trust Data Warehouse	Lisa Thomas	High
Other	DM01 Performance: Flexi Sig	Trust Data Warehouse	Lisa Thomas	High
Other	DM01 Performance: Gastro	Trust Data Warehouse	Lisa Thomas	High
Other	DM01 Performance: MRI	Trust Data Warehouse	Lisa Thomas	High
Other	DM01 Performance: Neuro	Trust Data Warehouse	Lisa Thomas	High
Other	DM01 Performance: US	Trust Data Warehouse	Lisa Thomas	High
Other	Longest Waiting Patient (Weeks)	Lorenzo via Trust Data Warehouse	Lisa Thomas	High
Other	Day HCA	Health Roster	Melanie Whitfield	High
Other	Day RN	Health Roster	Melanie Whitfield	High

Data Sources: Other Metrics (2)

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	Judy Dyos	Medium
Other	Maternity: Coroner Red 28 made directly to trust	Maternity Dept	Judy Dyos	Medium
Other	Maternity: DATIX incidents moderate harm (not SII)	Maternity Dept	Judy Dyos	Medium
Other	Maternity: DATIX incidents SII	Maternity Dept	Judy Dyos	Medium
Other	Maternity: DATIX relating to workforce	Maternity Dept	Judy Dyos	Medium
Other	Maternity: HSIB referrals	Maternity Dept	Judy Dyos	Medium
Other	Maternity: HSIB/NHSR/CQC or other organisation with a concern or request	Maternity Dept	Judy Dyos	Medium
Other	Maternity: Midwifery vacancy rate	Maternity Dept	Judy Dyos	Medium
Other	Maternity: Minimum safe staffing in maternity services; Obstetric cover	Maternity Dept	Judy Dyos	Medium
Other	Maternity: Minimum to birth ratio	Maternity Dept	Judy Dyos	Medium
Other	Maternity: Number of DATIX incidents - moderate or above	Maternity Dept	Judy Dyos	Medium
Other	Maternity: Number of SOX	Maternity Dept	Judy Dyos	Medium
Other	Maternity: Number of times maternity unit on divert	Maternity Dept	Judy Dyos	Medium
Other	Maternity: Number of women requiring admission to ITU	Maternity Dept	Judy Dyos	Medium
Other	Maternity: Progress in achievement of 10 safety actions (CNST)	Maternity Dept	Judy Dyos	Medium
Other	Maternity: Provision of 1 to 1 care in established labour (%)	Maternity Dept	Judy Dyos	Medium
Other	Maternity: Service user feedback: number of complaints	Maternity Dept	Judy Dyos	Medium
Other	Maternity: Service user feedback: number of compliments	Maternity Dept	Judy Dyos	Medium
Other	Maternity: Training compliance - MDT Prompt %	Maternity Dept	Judy Dyos	Medium
Other	Maternity: Medical termination over 24+0 registered	E3 via Trust Data Warehouse	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 stillbirths (>+24 weeks excl TOP)	E3 via Trust Data Warehouse	Peter Collins	Medium
Other	SSNAP Case Ascertainment Audit	Stroke Team	Peter Collins	High

Data Sources: Other Metrics (3)

Understand the Data

Metric Type	Metric Name	Data Source	Executive Lead	Data Quality Rating
Other	Crude Mortality	Medical Examiners	Peter Collins	High
Other	FFT Response Rate - A&E	Trust Data Warehouse	Judy Dyos	High
Other	FFT Response Rate - Day Case	Trust Data Warehouse	Judy Dyos	High
Other	FFT Response Rate - Inpatient	Trust Data Warehouse	Judy Dyos	High
Other	FFT Response Rate - Maternity	Trust Data Warehouse	Judy Dyos	High
Other	FFT Response Rate - Outpatient	Trust Data Warehouse	Judy Dyos	High
Other	HSMR Trust	Telstra Health	Peter Collins	High
Other	MRSA Bacteraemia Infections: Hospital Onset	Infection Control Team	Judy Dyos	High
Other	Never Events	DATIX	Judy Dyos	High
Other	SHMI Trust	Telstra Health	Peter Collins	High

Data Sources: Other Metrics (4)

Understand the Data

Metric Type	Metric Name	Data Source	Executive Lead	Data Quality Rating
Other	Add: impact of donated assets	Finance Division	Mark Ellis	High
Other	Financing Costs	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	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	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
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	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 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 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	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

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
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: Medical Equipment Actual	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 total pay Actual	Finance Division	Mark Ellis	High
Other	Month on Month total pay Plan	Finance Division	Mark Ellis	High

NHS Salisbury NHS Foundation Trust

Report to:	Trust Board (Public)	Agenda item:	4.1
Date of meeting:	05 October 2023		

Report tile:	Improving Together Quarterly Report to Trust Board			
Status:	Information	Discussion	Assurance	Approval
	Yes	Yes	Yes	No
Approval Process: (where has this paper been reviewed and approved):	Reviewed and approved by Peter Collins, Chief Medical Officer.			
Prepared by:	Alex Talbott, Associate Director of Improvement			
Executive Sponsor: (presenting)	Peter Collins, Chief Medical Officer			

Recommendation:

The board is asked to note

1. The progress on delivery of the improving together programme and its impact
2. The current maturity assessment of key elements of continuous improvement across the Trust

Executive Summary:

In March 2023 the Improving Together programme roadmap was developed to achieve a reduction in the original 10 year training timeline to closer to five years. This was in recognition a 10 year timeline would not catalyse the Trust-wide culture change the Trust is seeking to achieve with the programme.

As a result of this roadmap a business case was developed setting out the investment options to deliver such an accelerated programme. The preferred option within this case was approved at Trust Management Committee in July 2023. With the subsequent approval of the business case at September's Finance and Performance (on condition of a further benefits paper going to F&P in October), this report assesses the training trajectory against the roadmap for the accelerated programme.

Seven out of nine workstreams are on-track against the roadmap. Two are off-track: leadership behaviours, and the Coach House. Both have identified actions and mitigations to bring them back on track over the next quarter.

The core training programme is on-track across Improver Standard and Improver Advanced. Improver Leader's trajectory is off track with the top contributor and countermeasure well understood. There is evidence of growth in demand for training, with forecasts into Q4 predicting high fill rates. This represents a year-on-year improvement compared to Q4 of 22/23 when demand and fill rates were low.

The clinical divisions have completed their quarterly Improving Together maturity self-assessments. This routine is increasing the coordination and prioritisation of who is trained. Over the next two quarters this will

help drive alignment between teams attending training and the top contributors to improved performance in our breakthrough objectives. The levels of maturity shown are as expected at this time of the programme.

As teams and individuals begin to embed our improvement approach, benefit delivery is beginning to be seen. A selection of benefits from across the Trust are included in appendix 2. The headlines include significant improvements in reducing falls and bed occupancy in the past quarter, as well as £326,000 YTD savings from the medical Same Day Emergency Care (SDEC) service.

Moving into the annual planning cycle, this paper highlights the linkage between the Improving Together programme and how the Trust and Acute Hospital Alliance will approach business planning for 24/25. This includes plans to review and refresh the Trust's strategic planning framework ahead of setting the breakthrough objectives for 24/25.

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

1.1 Purpose

The purpose of this paper is to provide the Trust Board with a summary of the current position and performance of the Improving Together programme so the board can seek understanding and assurance of the progress to date.

1 Background

The Improving Together programme is the how of how we will achieve our strategy. It links together improvement tools, with the behaviours needed to support a culture of continuous improvement and an operational management system (OMS) to form a golden thread from ward to board.

It is the shared improvement approach used across the Acute Hospital Alliance in the BSW system.

2 NHS Impact: Trust and system self-assessments

The Trust has submitted the first of two self-assessments to the national NHS Impact team.

The second self-assessment[1] is being coordinated across the BSW ICB to ensure each organisation uses a consistent set of interpretations of the scoring scale. Partner organisations from the third and social care sectors are also being invited to submit their self-assessments to enrich the learning we can draw from this work.

The results of the self-assessments will be reviewed along with the findings of NHS Quest's quality improvement questionnaires as part of the BSW improvement community of practice.

The programme team and SRO for Improving Together are working with the NHS Impact team to draw out lessons learnt and benefits delivered to support learning across the NHS. This particularly focuses on championing the roll of continuous improvement in smaller district general hospital (DGH) trusts.

3 Training rollout: Numbers and fill rates

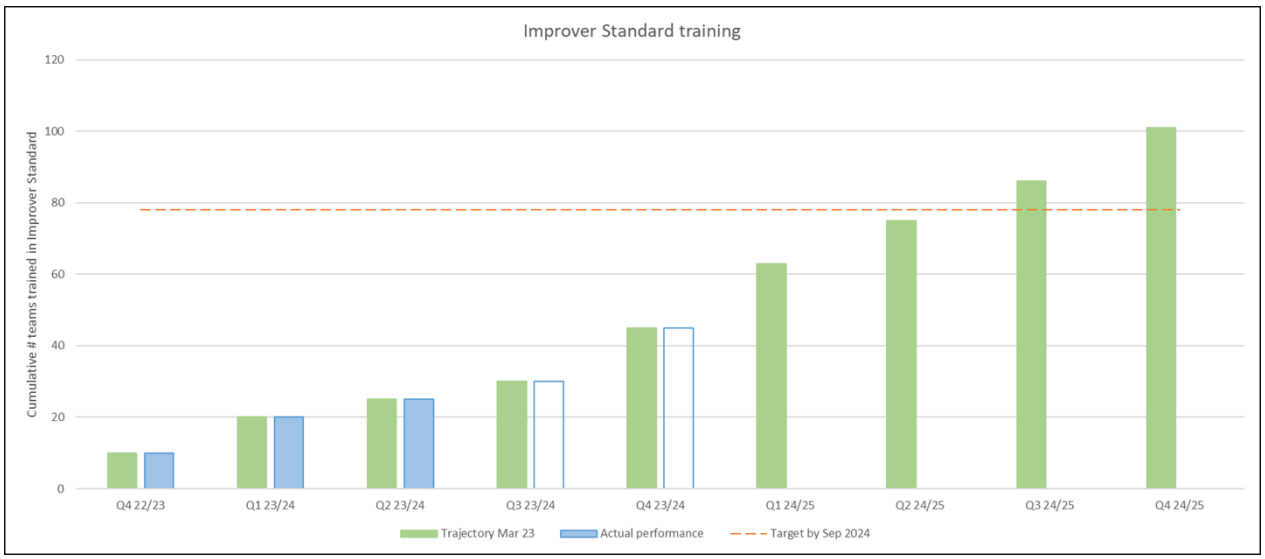
The table and charts below set out the training and numbers for 23/24 Q2 and forecasts for Q3 and Q4. There is a high demand for Improver Standard training, and we are almost fully booked through to January 2024. Improver Advanced training in October is impacted by low numbers of eligible teams with availability. This will improve as the high numbers in Standard come through to Advanced in 24/25.

Course	Individuals trained to date	Teams trained to date	Percentage fill rate of next course (25 places per course)	Number of teams represented at next course
Improver Standard	166	25	November: 144%	November: 9 (5 new)
Improver Advanced	51	12	October: 44%	October: 3 (2 new)

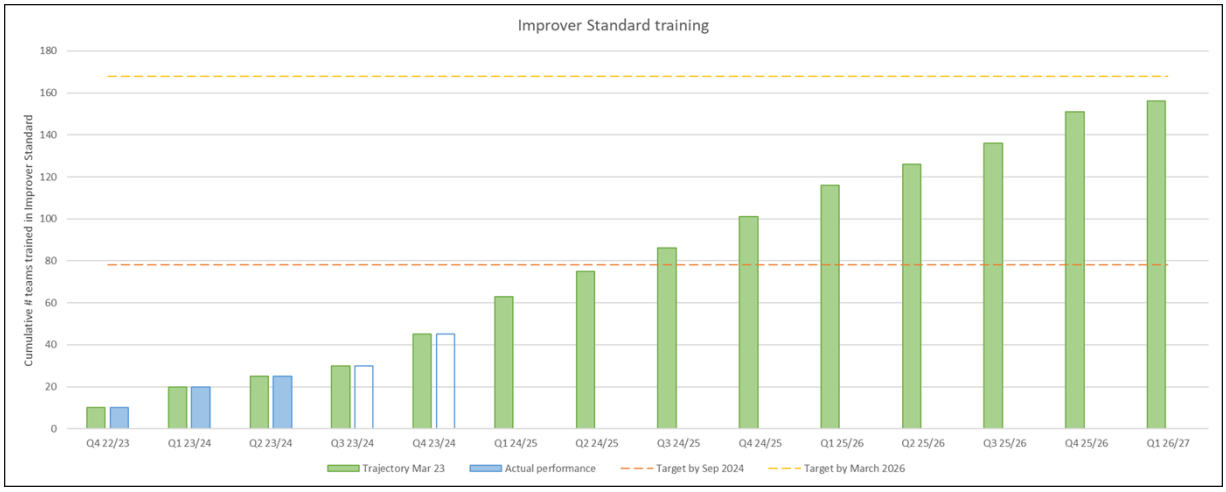
[1] (https://www.england.nhs.uk/nhsimpact/self-assessment/acute-and-mental-health-trust-questions/)

Improver Leader	93	32	October: 72%	October: 10 (2 new)

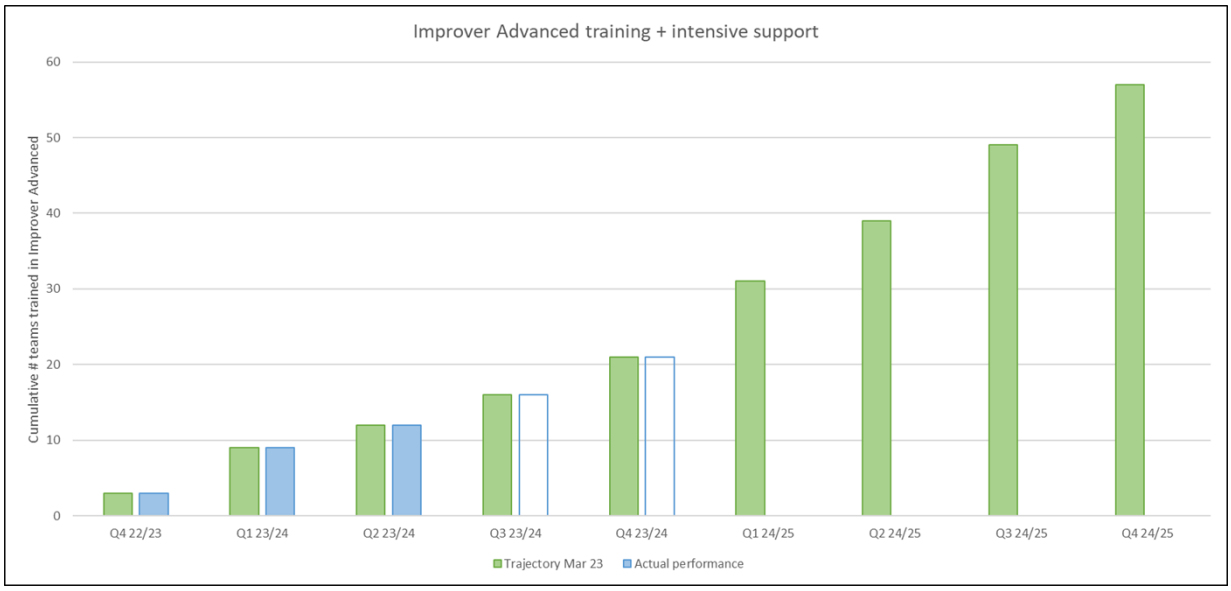
The following charts show the performance against the roadmap trajectory for each course (the unfilled bars reflect our projected performance for the next two quarters).



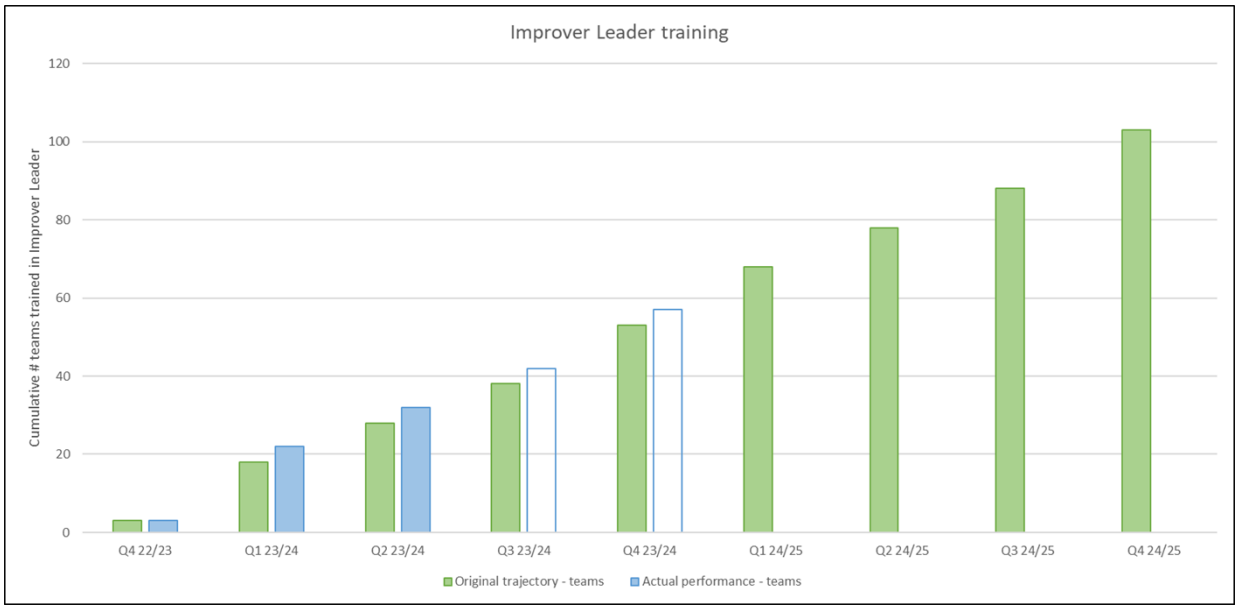
The forecast outturn for July 2024 is 69 teams trained, which is on-track with our trajectory.



The current trajectory is for representatives of 100% of teams to have attended Improver Standard by end of Quarter 1, 2026.



Improver Advanced remains on track. The current trajectory is for representatives of 100% of teams to have attended Improver Advanced by end of Quarter 1, 2028.



Improver Leader training remains on track. This course is for leaders of teams and specialties, with a particular focus on teams who are undertaking the Improver Standard training. Representatives from 19 teams were trained during Q2 23/24.

Against the target of 16 speciality triumvirates being trained in Improver Leader by the end of November we are off track, with 11 on trajectory by the end of November. Conversations with divisional colleagues are being prioritised to ensure clinical leads can attend training to achieve the 16 specialities target. Nineteen specialities have two members trained.

	Number of the triumvirate trained (out of 3)			
Specialty tris trained to date	**3/3**	**2/3**	**1/3**	**0/3**
Medicine division	1	4	4	0
Surgery division	0	12	7	0
CSFS division	4	2	3	3
Women & Newborn division	3	1	0	0

Total	**8**	**19**	**14**	**3**

4 Developing maturity in the use of improving together methodology

This quarter the new maturity assessment has been used by the divisions to self-assess their maturity. The timing of the quarterly reviews will now match that of this report to ensure we can report the freshest assessments to Trust Board.

A new teams maturity assessment has been developed by the Coach House and is being tested in two clinical and one non-clinical teams, prior to a process for completion and feedback being presented to the Programme Board.

Key	
Level 0 - Not started	Level 3 – Maturing
Level 1 – Aware	Level 4 - Mastering
Level 2 – Developing	

The maturity assessment is not a 'marking of your homework'. It represents a structured reflection on where our teams are strongest and where we should focus our energies to develop our understanding and use of the Improving Together approach.

	Framework	Tool	Behaviour	Execs (Sep 23)	Divisions (Sep 23)	Specialty	Frontline (8 teams, Jun 23)
September	Align	Scorecard	Focus	2	3	0	2
		Strategic Filter and SDM		2	1	0	NA
	Enable	Monthly routines (Performance/Executive Review Meeting + A3 Summary)	Humility Curiosity A3 thinking, Go & See, Willingness, Self-discipline, Perserverance, Civility, Inclusivity, Compassion	3	3	0	1
		Weekly Routines (Weekly Driver meetings, Go & See, OMS Exec routines, weekly Exec huddles)		2	2	0	NA
		Daily routines (Improvement Huddles, Performance and improvement boards)		N/A	N/A	N/A	2
		Process and Leader Standard Work		2	2	0	2
		Process Confirmation		1	1	0	1
		Structured Conversation		1	2	0	1
	Improve	A3 thinking	Scientific thinking	3	3	1	2

Where areas of development are identified they will then be focused on at the 'Sharing It' sessions with divisions, specialities and teams.

Key areas to note from the divisions' self-assessments:

- A3 thinking is becoming embedded across the divisions. It is actively being used to approach issues and challenges – focusing on the problem, use of data and root cause analysis. This is helping the language of Improving Together to become more familiar with teams across the Trust.
- Driver meetings are taking place but are not yet routinely embedded across all divisions. This impacts routine focus on the divisions' drivers and subsequent EPR routines.
- While the EPRs are maturing the divisions and executives are working on how to further strengthen the accountability and escalation routes within them.

- Process standard work and process confirmation across all divisions are recognised as less understood elements or embedded tools. The impact of this is the continuation of non-standardised processes within the divisional teams.
- Leader standard work is being considered and applied more frequently in the divisional triumvirates. This is beginning to create a habit of personal reflection on how colleagues go about their work.

Key areas of focus for Q3:

- New operational managers start in Q3 and will undertake Improving Together training collectively. These roles will further support the roll out of Improving Together across the specialities and teams.
- Commitment to increase frequency and protected time to undertake Go & See
- Continue to increase the use of A3 thinking to respond to problem solving

The number of improvement huddles has increased from eight to eleven teams using huddles on a regular basis. To enable colleagues who work from home to participate, two teams have adopted a virtual improvement board, following the same standard work as a physical board.

5 Benefits realisation from using Improving Together across the Trust

The use of Improving Together across the Trust has a leading role in the delivery of the Trust's 23/24 financial plan (see table in appendix 2).

As seen in the Integrated Performance Report, the tracking metrics for three out of four of the breakthrough objectives are showing improvement because of deployment of the Improving Together approach. Outpatients (Time to 1st outpatient appointment) remains off-track and work is now underway to draw collective focus and effort from across the Trust to this breakthrough objective.

Appendix 2 provides a selection of quantified examples of the improvements teams are delivering using the Improving Together approach.

6 April 2023 to September 2024: 18-month roadmap for the programme

Seven out of nine workstreams are on-track against the roadmap. Two are off-track: leadership behaviours, and the Coach House. Both have identified actions and mitigations to bring them back on track over the next quarter. The approval of the preferred option in the Improving Together business case at the Finance and Performance Committee (26th September) is a key step to bringing these workstreams back on-track as it enables the teams to increase capacity across both workstreams.

7 Linking business planning and Improving Together for 24/25

Work is ongoing between the Associate Director of Strategy and Associate Director of Improvement to ensure Improving Together's methodology is interwoven to our business planning round for 24/25. This will include a review and update to the Strategic Planning Framework (SPF) and consideration of what the Trust's breakthrough objectives should be in 24/25.

In turn this will feed into the scorecard agreements with the divisions whereby their drivers (key areas of focus) are confirmed for the year ahead.

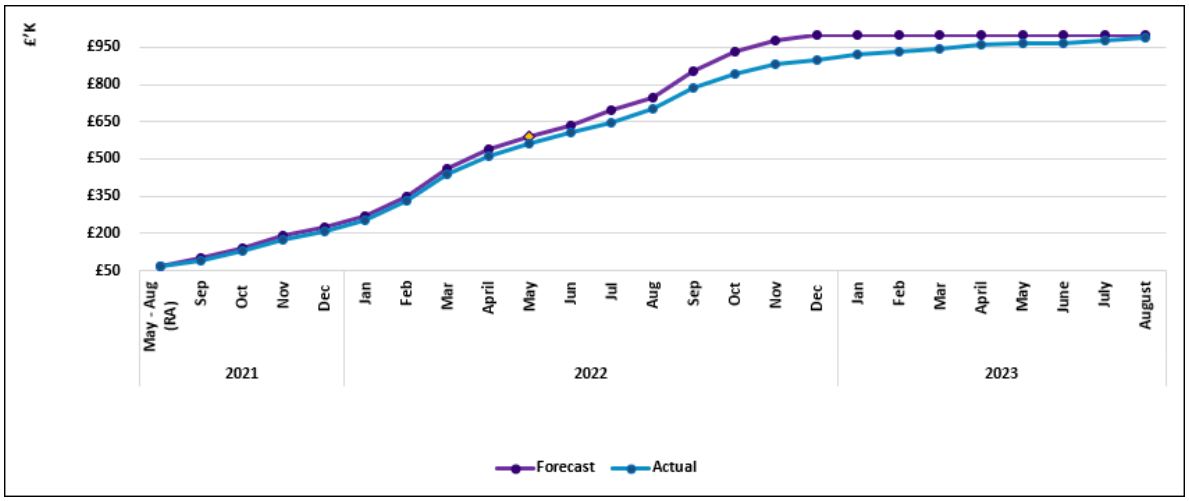
To learn how best to deploy this part of the Operational Management System (OMS) into the specialities and teams a model cell approach will be taken. A division, speciality and team will be chosen to model how the scorecard agreement cascade should work. Learnings from this will then be used in rolling out the approach across the divisions during 24/25.

8 Finance

KMPG consultancy budget tracker

The below graph shows the spend against the budget for the consultancy support from KPMG. The last of the KPMG supported board development day is planned for November. This represents the end of the original budget.

A case for investment in KPMG's support in 24/25 and 25/26 is currently with the regional team for review. Approval of this will provide support to our work across the AHA and BSW on how we build our shared improvement approach and continue to deliver the critical friend support to teams and individuals in the Trust to aid delivery of the roadmap.



9 Recommendations

The board is asked to note:

1. The progress on delivery of the improving together programme and its impact
2. The current maturity assessment of key elements of continuous improvement

Alex Talbott
Associate Director of Improvement

Appendix 2: Improving Together (Operational Excellence) is core to our financial plan for 23/24 and beyond.

		Oversight forum	Responsible officer	Target %	Target £'k
Housekeeping	Procurement	AHA procurement review	CFO	0.3%	1,000
	Medicines Management	Divisional EPRs	CPh	0.1%	200
	Divisional CIP (incl waste reduction)	Divisional EPRs	Divs	0.8%	2,500
	Income generation	Divisional EPRs	Divs	0.5%	1,500
	N/R vacancy	Divisional EPRs	Divs	0.8%	2,500
Operational Excellence	Bed occupancy	Unscheduled care board	COO	0.5%	1,600
	Elective productivity	Planned care board	COO	0.3%	1,000
	Staff availability	OD&P management board	CPO	0.6%	2,000
AHA/BSW collabroration	Discharge processes	Unscheduled care board	COO	1.0%	3,000
	Non-tariff prescribing				
	Non clinical support service collaboration				
	AHA clinical strategy				
				4.9%	**15,300**

Housekeeping	2.5%	7,700
Operational Excellence	1.5%	4,600
AHA/BSW collabroration	1.0%	3,000

Deployment of our Improving Together approach (aka operational excellence) is the driver of at least £4.6m of our £15.3m savings target in 23/24.

The growing collaboration and shared improvement approach across the AHA and BSW is also linked to this case as we work to develop and deploy our shared improvement approach at the AHA level.

The increase in capacity and capability this investment case delivers underpins making Improving Together our default way of working as we build towards a culture of continuous improvement across SFT, the AHA and BSW as a whole.

Examples of where the deployment of Improving Together is already generating benefits to our people, population and partners include:

Medical SDEC (Same Day Emergency Care)

Average monthly AMU bed days pre-trial = 740

April = 508 bed days saving 230 beds and saving the Trust £62k

May = 528 bed days saving 234 beds and saving the Trust £63k

June = 502 bed days saving 236 beds and saving the trust £64k

July = 490 bed days saving 272 beds and saving the trust £74k

August = 529 bed days saving 233 beds and saving the trust £63k

Total Saving since go live on 27/03/23 = £326k.

Expected full year effect = £780k

- Average LOS hours on AMU- Pre Trial 33 hours now 25 hours – **Improvement of 8 hours**
- Percentage zero day LOS for medical NEL admissions (all hours), pre-trial = 20.0% post go live = 27.8%. **Improvement of +7.8 points**
- Time to Junior Doctor Assessment, pre-trial 161 mins now 95 mins – **Improvement of 66 mins**
- Time to 8-hour Consultant review, pre-trial 278 mins now 236 mins – **Improvement of 42 mins**

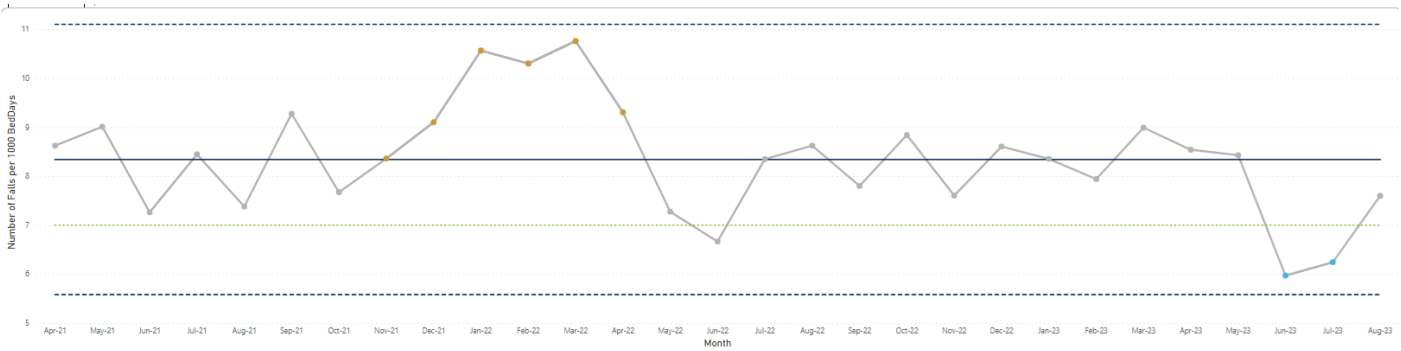
Surgical SDEC

- Time from ED arrival to SAU 2022/23 - 715 Mins 2023/24 - 481 Mins - **Improvement of 234 mins**
- Time to First Clinician to SAU 2022/23 - 581 Mins 2023/24 - 410 Mins – **Improvement of 171 mins**
- Time from DTA to SAU 2022/23 - 449 mins 2023/24 255 Mins – **Improvement of 194 mins**
- Average weekly referrals to SAU 2022/23 - 77 2023/24 83 – **Increase of 6 per week.**
- Average Los (Hours) 2022/23 - 7.6 hours 2023/24 6.5 hours - **Improvement of 1.1 hours or 14%**

Emergency Department Quality, Safety and Performance Improvements

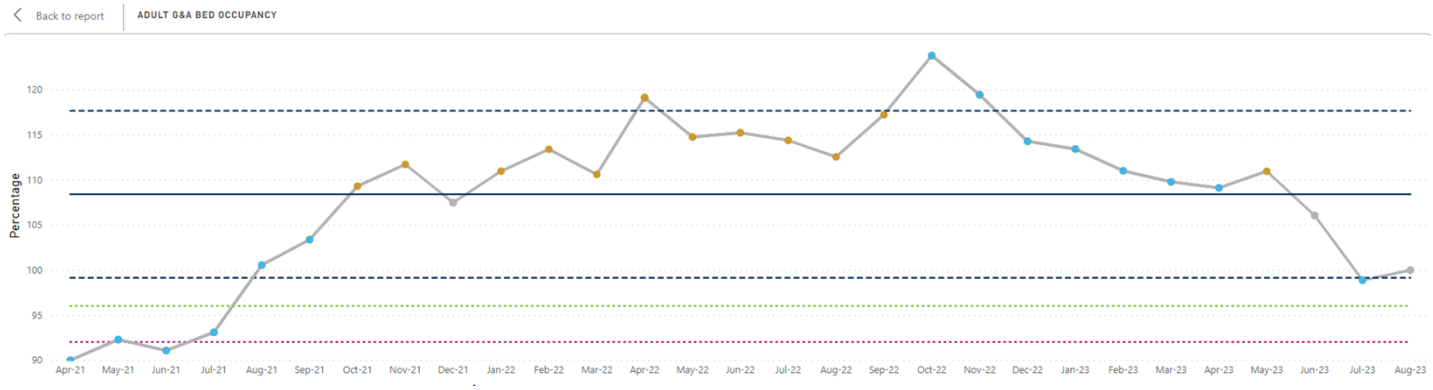
- Average Time to Triage Pre SDEC 51 Mins – Since SDEC Go Live 32 mins – **Improvement of 19 mins**
- Average Time DTA to Admission Pre SDEC 246 Mins – Since SDEC Go Live – 199 Mins – **Improvement of 47 mins**
- Average time to 1st Clinician Pre SDEC 119 Mins – Since SDEC Go Live 101 Mins **Improvement of 18 mins**
- % Seen by 1st Clinician within an hour – Pre SDEC - 30% - Since SDEC Go Live 38% - **Improvement of 8 points**
- Average time in Department Pre SDEC 310 mins – Since SDEC Go Live 266 Mins – **Improvement of 44 mins**
- % Ambulance Handovers < 15Mins Pre SDEC - 47% - Since SDEC Go Live 58% -
- **Improvement of 11 points**
- % In Department < 4 hours Pre SDEC - 59% - Since SDEC Go live 65% **Improvement of 6 points**
- % DTA to Admission < 12 hours Pre SDEC – 97% - Since SDEC Go Live 99% - **Improvement of 2 points.**
- % In Department <12 hours Pre SDEC – 92% - Since SDEC Go Live 95% - **Improvement of 3 points.**
- Collectively this has meant that in September 2023 our Trust is currently in the top ten for the shortest ambulance waiting times nationally and top of the list in the South West.

Reducing patient falls



- A reduction to under our breakthrough objective target of 7 falls per 1,000 bed days in June and July 2023, with August 2023 at 7.6 falls per 1,000 bed days. This improvement has been driven by the focus on the top contributors to falls on our top contributing wards.

Reducing bed occupancy



- A statistically significant reduction in our overall bed occupancy was achieved in July 2023 as a result of work across the trust focusing on the top contributors to high bed occupancy. This has supported the closure of Whiteparish ward for redecoration and the ringfencing of SDEC space.

Report to:	Trust Board (Public)	Agenda item:	5.1
Date of meeting:	5 October 2023		

Report title:	Board Assurance Framework (BAF) and Corporate Risk Register (CRR) Report			
Status:	Information	Discussion	Assurance	Approval
		Yes		
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:	Board Assurance Framework September 2023 Summary CRR Tracker v1 September 23 Corporate Risk Register September 23			

Recommendation:

The 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.
- Discuss how target dates can be incorporated
- Discuss alignment with the BSW ICB Board Assurance Framework.
- Agree escalation points for the Trust Board, to include any emerging risk/s or control concerns.

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.

A recommendation from the AQUA external well led review was to split out the controls and assurances on the BAF template as these describe different things. The template has been amended accordingly. Of particular note, there is limited assurance on BAF risk 10 that the controls are effective.

A further recommendation from the review was to consider target dates for risk mitigation. This has been discussed previously however, the Board are advised to discuss this further and agree the approach to be taken.

The 5 strategic risks out with tolerance are unchanged since June 2023 although BAF risk 5 has had a third consecutive score decrease. 2 BAF risks have been closed.

There has been alignment of the Trust BAF with the ICB BAF. The Trust BAF risks 5, 7, 8, 9, 10 and 12 align to the ICB risks in relation to staff resource, finance, operational performance and partnership working. There do not appear to be any risks on the ICB BAF which would impact on the Trust which the Trust is not sighted on. Whilst the ICB has a strategic role in health promotion, the Board may want to further consider the ICB risks relating to this and health outcomes and whether these have any bearing on the Trust BAF.

There have been several changes to the corporate risk profile with a positive shift noted.

There has been a positive shift in the overall risk profile since June 2023. Recommendations from the External Auditors and the AQUA well-led review have been implemented. The changes noted to the BAF and CRR demonstrate that this is a dynamic process and one of continuous improvement.

Feedback from Board Committees

The Board Committees noted the response to external recommendations. The alignment to the ICB BAF was noted and it was acknowledged that the ICB BAF is in development with a view to move to a system focussed BAF and therefore further consideration will be given to this going forward by the Committees. A recommendation to review the BAF risk descriptions was accepted. The Director of Integrated Governance is in the process of scheduling a meeting with the new Internal Auditors to discuss this who offered to support on this. There was a continued view that the risk profile is reflective of the organisational risks.

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

Salisbury NHS Foundation Trust

Board Assurance Framework (BAF) and Corporate Risk Register (CRR) Report

Purpose

1.1 The purpose of the report is to provide an updated BAF and CRR providing all relevant information to the Board on the risks to achievement of the strategic objectives and their management.

2 Background

2.1 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. The provision of healthcare involves risks and being assured is a major factor in successfully controlling risk.

3 Summary Strategic Risk Profile

3.1 BAF summary

A recommendation from the AQUA external well led review was to split out the controls and assurances on the BAF template as these describe different things. The template has been amended accordingly. Of particular note, there is limited assurance on BAF risk 10 that the controls are effective.

A further recommendation from the review was to consider target dates for risk mitigation. This has been discussed previously however, the Board are advised to discuss this further and agree the approach to be taken.

3.2 BAF Risks Out with Tolerance

The 5 strategic risks out with tolerance are unchanged since June 2023:

- BAF 4 - Risks associated with critical plant and building infrastructure that may result in utility or system failure impacting on service delivery. Score unchanged at 16.
- 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. This risk score has decreased to 16 which is the third score decrease since January 23.
- 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. Score unchanged at 16.
- BAF 8 - Demand for services that outweighs capacity, resulting in an increased risk to patient safety, quality, and effectiveness of patient care. Score unchanged at 16.
- BAF 9 - An irreversible inability to reduce the scale of financial deficit. Score unchanged at 16.

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. 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.

3.3 **BAF Risk Profile Changes**

Two BAF risks have been closed in August 2023:

- BAF 1: The impact on service delivery as a result of respiratory viruses, impacting on the ability to delivery activity to pre-19/20 levels. Risk of delay to treatments, impact on quality of care and performance. The risk of disruption from respiratory viruses is now business as usual and the risk has been at target score since June 23.
- BAF 6: Lack of a National clear model for small rural DGH services places future strategic planning uncertainty at SFT. This risk is now covered by BAF risks 2 and 9.

3.4 **Alignment to BSW Integrated Care Board BAF**

There was a recommendation from the Trust External Auditors as part of their annual report and also from AQUA as part of their Well-Led review, that the Trust considers how risks in the ICB BAF impact on and align with the Trust.

The ICB BAF is in its infancy and currently focusses on risks to achieving the strategic objectives from an ICB perspective. The aim is to develop the BAF into a system focussed BAF which articulates risks to achieving the BSW Integrated Care Strategy from a system perspective.

For this report, there has been consideration of the 7 ICB BAF risks, which are as follows:

- BSW ICS is unable to create the right conditions and incentives for all BSW residents to stay healthy.
- BSW ICB does not put reducing inequalities at the heart of all its activities.
- BSW ICB is unable to meet the additional healthcare demands and deliver our operational plan.
- BSW ICS is unable to recruit and retain suitably qualified staff.
- BSW ICB and partner health and care organisations in BSW do not work more effectively in partnership.
- BSW ICS is unable to reduce its expenditure to address its underlying financial deficit.
- BSW ICB and partner health and care organisations in BSW do not focus on those things that impact most on health outcomes.

The Trust BAF risks 5, 7, 8, 9, 10 and 12 align to the ICB risks in relation to staff resource, finance, operational performance and partnership working. There do not appear to be any risks on the ICB BAF which would impact on the Trust which the Trust is not sighted on. Whilst the ICB has a strategic role in health promotion, the Board may want to further consider the ICB risks relating to this and health outcomes and whether these have any bearing on the Trust BAF.

3.4 **CRR summary**

The risk type, risk appetite and risk tolerance is now applied to all CRR risks. There are 19 risks on the CRR compared to 20 in June 2023. There are 8 risks out with tolerance compared to 9 as reported in June 23. Risk 7039 is now within tolerance, risk 6954 is closed and risk 7807 is a new risk:

- Risk 5704: Inability to provide a full gastroenterology service due to a lack of medical and nursing workforce. Score 15. There has been ongoing oversight of this service through Clinical Governance Committee and upward reporting to Board.
- Risk 7807: As a result of a lack of mental health provision there is a risk that patients with specialist mental health needs are being managed in the acute setting. This may result in sub-optimal care with less therapeutic value than if undertaken in the right setting with appropriately trained staff. Score 20. **New risk.**

- Risk 5751: Risk of patient harm caused by a delayed discharge from hospital. The score has reduced to 15 from 20.
- Risk 7573 (Population) - The risk of sustained use of escalation bed capacity (e.g. DSU, Discharge lounge, intervention radiology) has an impact on patient safety due to not enough substantive staff for increased bed capacity, patients not always placed initially in most appropriate ward. The more beds the Trust has open the impact on operational effectiveness, e.g. ward rounds, clinical support services. Score reduced to 15 from 20.
- Risk 7574 (Population) - The continued pressure from urgent care flow alongside the increases in length of stay, compromises the ability for the Trust to undertake planned care. Score unchanged at 15.
- 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. Score unchanged at 16.
- Risk 7308 (Partnership) - 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 unchanged at 20.
- Risk 6229 (Population) - The DSU building is 'end of life' and has been identified as priority for replacement. Score is unchanged at 20.

New risks since June 2023

There are 2 new risks:

- 7807 (Population): As a result of a lack of mental health provision there is a risk that patients with specialist mental health needs are being managed in the acute setting. This may result in sub-optimal care with less therapeutic value than if undertaken in the right setting with appropriately trained staff. Score 20.
- 7809 (Population): There is a risk that the Trust has an unidentified gap in effective clinical care may be the cause of the sustained deterioration in HSMR and SMR. There is a current failure to provide adequate assurance that the change in statistics is not a result of avoidable harm. Score 8.

Risks removed:

- 6570 (Population): As a result of the fact that the highly contagious Covid, Flu and RSV variants are still circulating within the community, there is a risk that an outbreak of one of these could occur either for staff and/or patients. This may result in patient and/or staff sickness and potential mortality. This risk has been at target score since June 23 and is now managed as business as usual.
- 7516 (Population): As a result of demand outweighing capacity and the impact on patient flow there is a risk of boarding and the potential impact of this on patient care.
- 6954 (People): 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. This risk is being revised by the Chief Operating Officer as no longer specific to nurses.

Risks with an increased score:

- 7078 (People): As a result of competing priorities and deliverables there is a risk of slippage of the Improving Together Programme deadlines

Risks with a decreased score:

- 5751 (Population): Risk of patient harm caused by a delayed discharge from hospital. Score 20 to 15.
- 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 15 to 12. Now within tolerance.
- 6143 (Population): Risk that inadequate medical staffing in the oeganisation will impact on the ability of the Trust to maintain safe and effective services across 7 days. Score 9 to 6. Now at target score.
- 7573 (Population): The risk of sustained use of escalation bed capacity (e.g. DSU, Discharge lounge, intervention radiology) has an impact on patient safety due to not enough substantive staff for increased bed capacity, patients not always placed initially in most appropriate ward. The more beds the Trust has open the impact on operational effectiveness, e.g. ward rounds, clinical support services. Score 20 to 15.

4 Summary

4.1 There has been a positive shift in the overall risk profile since June 2023. Recommendations from the External Auditors and the AQUA well-led review have been implemented. The changes noted to the BAF and CRR demonstrate that this is a dynamic process and one of continuous improvement.

5 Recommendations

5.1 The Board Committees 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 Committee 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.
- Discuss how target dates can be incorporated
- Discuss alignment with the BSW ICB Board Assurance Framework.
- Agree escalation points for the Trust Board, to include any emerging risk/s or control concerns.

Salisbury NHS Foundation Trust

Director of Integrated Governance

Salisbury NHS Foundation Trust

Board Assurance Framework

V1 September 2023

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

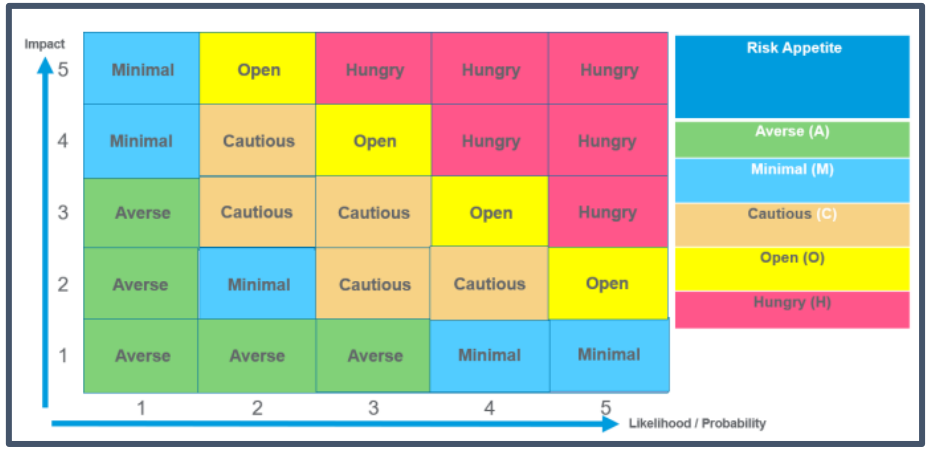
The core values and behaviours to support the achievement of the Trust vision:

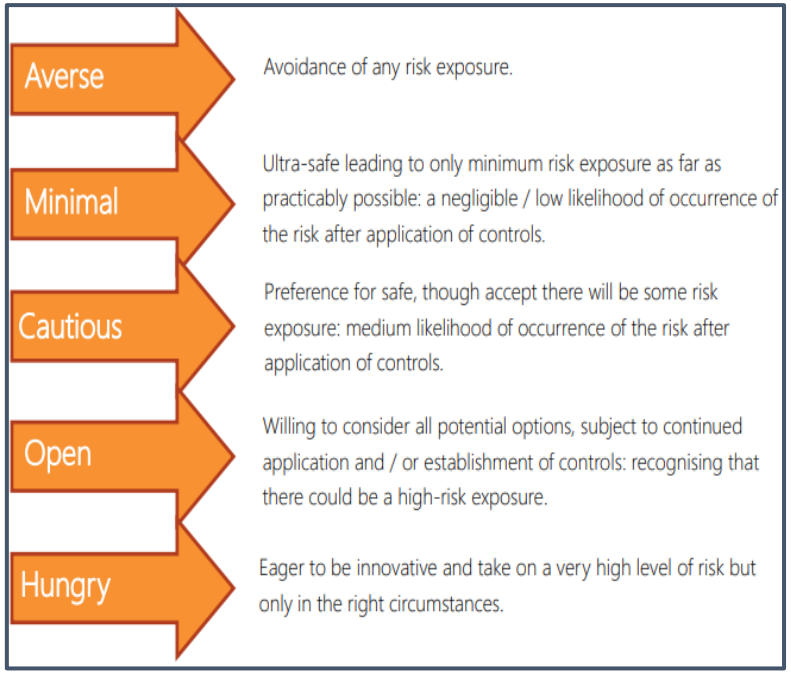
Strategic Priorities

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

Strategic Risk	Risk Title	Exec Lead	Initial Score	Jan-22	Apr-22	Jul-22	Oct-22	Jan-23	Jun-23	Sep-23	Target
Risk Detail			Score Trend								
POPULATION - Improving the health and wellbeing of the population we serve											
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	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	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	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	20	20	16	16	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	Jan-22	Apr-22	Jul-22	Oct-22	Jan-23	Jun-23	Sep-23	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	25	20	16	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	20	16	16	9
PARTNERSHIPS - Working through partnerships to transform and integrate our services											
BAF 9	An irreversible inability to reduce the scale of financial deficit	Chief Finance Officer	12			12	16	16	16	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 Operating Officer	9			9	9	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	12	12	12	9
BAF 12	Risk of sustained deterioration across key performance metrics (new risk)	Chief Operating Officer	16				16	16	12	12	9

Risk Score Key

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

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 2023/24

Initial Score	Sept 21	Jan 22	April 22	July 22	Oct 22	Jan 23	June 23	Sept 23	Target Score
15	10	10	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 most vulnerable specialties include GI, dermatology and the sleep service.

Controls

Trust contribution into the AHA clinical strategy moved to implementation phase with set up of oversight Board chaired by the CMO.
Dermatology mutual aid agreement with RUH
GI bleed service being managed in partnership with Bournemouth (UHD)
Reconfiguration of sleep services across BSW – agreed clinical model presented to the AHA Programme Executive. Agreement to proceed to full business case.
External Medical workforce and model of care commissioned work completed- workforce model now feeding into divisional operational planning

Assurance

Internal assurance through service performance and outcome measures.

External assurance through GIRFT and the AHA clinical strategy review monitoring

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 developed specifically looking at small for scale services and the opportunity for cross organisational working or service reconfiguration to support sustainability	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. GI bleed service being managed in partnership with Bournemouth (UHD) Trust leading on Reconfiguration of sleep services across BSW. Dermatology and sleep services are subject to working groups as part of the AHA clinical strategy implementation. Commissioned Deputy CMO to undertake review of a sustainable partnership model for GI services (6 month delivery)

BAF Risk 3	Non delivery of programmes within the Digital Plan could result in poor quality services, reputational damage and inability to attract and retain high quality staff		
Strategic Priority	Population		
Linked Corporate Risks	5360 (Cyber) – current score 10		
Executive Lead	Chief Digital Officer		
Lead Committee	Finance and Performance		
Risk Type	Infrastructure	**Risk Appetite / tolerance**	**Open**

Risk Score 2023/24

Initial Score	Sept 21	Jan 22	April 22	July 22	Oct 22	Jan 23	June 23	Sept 23	Target Score
16	12	12	12	12	12	12	12	12	9

Context

The Trust is digitally immature when benchmarked nationally. The Trust's digital plan 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. Anticipated to meet the target score of 9 from January 2024.

Controls

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.
Joint CDO, CIO and Deputy CIO roles across SFT & GWH.

Assurance

Digital Steering Group minutes.
Prioritised digital plan for the year agreed
Regular Digital Plan updates to Board committees.
Regular minutes from BSW shared EPR programme board.

Progress

What is going well/ Future Opportunities?

EPMA implementation on track for completion by Sept 2023.
Refreshed Digital Plan approved at Trust Board in November 2022.
Shared EPR OBC approved, Preferred Bidder selected in December 2022. FBC approved by Trusts and ICB, submitted for national approval Aug 2023.
Digital Services Review being commissioned as part of AHA corporate services review.

What are the current challenges including future risks?

1. Some infrastructure hardware procurement delays remain globally.
2. Funding for new shared EPR not confirmed until Full Business Case 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. Lack of funding to deliver full Digital Plan including removing all unsupported technologies.
6. Clinical engagement is limited due to operational pressures.

How are these challenges being managed?

1. Reprioritisation of existing infrastructure stock usage to help deliver programmes as 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. Discussion planned to consider impact EPR programme will have on wider transformation plans.
4. Programmes are rebased as part of existing programme governance & strong PMB challenge on delivering against this rebased targets in place. Risk mitigations put in place where appropriate.
5. Seeking opportunities for national funding to support programmes
6. Clinical leads supporting identifying champions for key activities (Shared EPR, implementation activities). Implementing 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	7573, 6229		
Executive Lead	CEO/ Director of Estates		
Lead Committee	Finance and Performance		
Risk Type	Infrastructure	Risk Appetite/Tolerance	Open

Risk Score 2023/24

Initial Score	Sept 21	Jan 22	April 22	July 22	Oct 22	Jan 23	June 23	Sept 23	Target Score
12	16	16	16	16	16	16	16	16	8

Context

SFT has a substantial estates backlog (£75.2m – 2023) which impacts service delivery, quality of estate and public/patient experience. Limitations via CDEL and lack of investment capital impact the Trust ability to reduce the estates backlog and creates a corresponding increase in Trust risks; costs to operate and maintain the existing estate, likelihood of future infrastructure and estate failures, compromised service delivery and patient care. Equally environmental sustainability investment is limited reducing the Trust ability to achieve net carbon zero.
Whilst National and/or targeted funding may become available, careful planning and prioritisation of requirements is essential yet remains consistently insufficient to make any marked progress in the reduction of long term risks, or exceed the inflationary rate of change to the backlog value. The clinical strategy and the estates strategy are key long term plans for the Trust evolution and delivery of effective and reliable services over the next 10 years (and beyond), but require significant investment to achieve.

Controls

A 6 Facet survey of the whole site was completed in 2022, providing an up to date and independent assessment of the campus in accordance with National guidance (NHS Estate Code).
The 6-facet data is reviewed annually and adjusted to reflect capital investment made in year and increases due to inflation. Last annual update May 2023 (revised data submitted to NHSEI for ERIC)
Quarterly estates reporting to Trust Board. Annual capital plan reviewed via Strategic Capital committee.
Internal audit on management of backlog maintenance completed in 2023 and recommendations being followed through.

Assurance

Significant improvements in estates governance and risk management introduced in last 12 months, including the 10 year capital programme compiled, with investment forecasts for estates backlog.
Estates compliance status clearly recorded. 2022-23 targets achieved. Continued progress to mitigate and conclude compliance actions for 2023-24 year end.

Progress

What is going well/ Future Opportunities?

- 10 year capital programme compiled, includes investment forecast for estates backlog. Program subject to annual prioritisation process
- Additional elective ward mobilised (replaces poor condition estate)
- Estates strategy renewal, mobilised with procurement underway, Target completion May 2024.
- Estates strategy update will incorporate Campus project for long term development
- Successful bid for national investment to begin decarbonisation of energy infrastructure, £10m for 2023/24, further bids to be submitted for future years.
- Completion of DAC refurbishment to increase space available and permit wider Trust decants

What are the current challenges including future risks?

- Insufficient capital. Inflation pressures alone continue to significantly increase backlog value year-on-year
- Competing demands for Trust capital each year.
- Estates backlog value (£75.2m) is not actual cost to deliver (due to Estate code national reporting methodology). Likely value £120.3m
- Limited electrical infrastructure on campus impacting future redevelopment opportunities
- Current decarbonisation (Salix) investment does not encompass whole site. Further investment required to realise decarbonisation. Decarbonisation strategy reduces fossil fuel use but increases electrical demand which is a higher cost, Trust utility costs will rise as we become more environmentally sustainable.
- Lack of adequate investment means infrastructure continues to degrade – level of backlog maintenance increases. Cost to maintain Trust estates and infrastructure increases.
- Day surgery unit remains Trust highest priority, with no funding source available.
- Aged areas of the Estate are not fit for purpose or occupation (SFT South and central) but require investment for continued use and are at higher risk of failure.
- Trust 'space' is in high demand and appetite to remove poor quality buildings challenged with space use.
- Clinical strategy limitations inhibit the estates strategy.
- National targeted resources do not address key resilience issues
- Patient environment quality being compromised e.g., spinal unit
- Quality of on-site residential accommodation poor with little investment

How are these challenges being managed?

- Categorisation and prioritisation of Trust capital. Review and prioritisation within Trust framework (alongside digital, medical equipment etc)
- Continued lobbying for major service developments – DSU
- Funding applications made for environmental sustainability and energy decarbonisation (e.g. Salix)
- Estate's strategy procurement documents mobilised
- Board paper planned to present options for on-site residential accommodation
- Investigations into strategic partnership models to allow development and investment of the estate.
- Monthly meetings with regional NHSEI colleagues to highlight priorities and risks
- Continued review of poor quality accommodation use, identifying opportunities to vacate (e.g remove and dispose archive material) with potential to demolish and remove risk
- Increased scrutiny of estate requests via space allocation committee. Management of space utilisation 'creep'

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, 7573, 7472,
Executive Lead	Chief Nursing Officer
Lead Committee	People and Culture Committee
Risk Type	Capability and skills
Risk Appetite / tolerance	Open

Risk Score 2023/24

Initial Score	Sept 21	Jan 22	April 22	July 22	Oct 22	Jan 23	June 23	Sept 23	Target score
20				20	20	25	20	16	9

Context

Due to the number of RN vacancies, and overall unavailability, staffing levels are challenging at times. This is contributing to an overall poor experience for staff and patients, contributing to increased sickness and increased turnover. Potential ongoing strike action will impact this further.
CHPPD has improved. This position overall has improved due to significant HCA recruitment however, this poses ongoing skillmix challenges given the RN vacancies and new to care HCAs.
Maternity leave is high
Heavy reliance on RMN due to MH needs and unavailability of specialised MH beds. In addition, use of specials for complex patients
NCTR high on avg >80 patients
Agency spend remains a financial challenge in relation to RMN and RN usage
OSCE nurses taking longer to convert since the change to external training provider (from internal provision)

Controls

3 x daily staffing meetings and early escalation to agency
Monthly safer staffing meeting
Recruitment events
Block booking and use of bank staff
Apprenticeship to Registered Nurse in place (limited funding)
Successful overseas and HCA recruitment
HCA away days to boost retention
HCA rebanding completed
Revised HCA induction and competencies
Risk assessments and SOP in place for boarding
Successful NHSE bid for 40 additional RNs
Approved OSCE support business case

Assurance

CHPPD improved position to 7.7
% of actual vs planned hours at 99%
Significant HCA recruitment
RN vacancy for wards reduced from 14.5% in May to 10% in July
HCA vacancy reduction to 3-6%
Sickness reduction from 9% in December to 6% in July

Progress

What is going well/ Future Opportunities?

Registered nurse recruitment ongoing. HCA Apprenticeships including Maths and English to attract staff with low educational attainment.
HCA support workers in place to support wellbeing and education
Partnership working to review future workforce requirements and further opportunities

What are the current challenges including future risks?

Overall vacancy rate for RNs and HCAs
Sickness absence rate 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
Recruiting to cover new ward

How are these challenges being managed?

Recruitment events ongoing
Revised induction for RNs
Utilising Improving Together methodology to focus on improvement areas.
Active sickness management deep dive underway
Ongoing focus on tissue viability and falls prevention management
New to Care HCA Programme
Medicine Division managing plans for new ward including recruitment

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, 7039, 6143, 7573, 7472
Executive Lead	Chief People Officer
Lead Committee	People and Culture Committee
Risk Type	Capability and Skills
Risk Appetite / tolerance	Open

Risk Score 2023/24

Initial Score	Sept 21	Jan 22	April 22	July 22	Oct 22	Jan 23	June 23	Sept 23	Target Score
20				20	20	20	16	16	12

Context

12-month rolling average turnover is 14.74% against Trust target of 10% and is the highest in BSW.
A month on month improving vacancy position, reducing to 7.1% in July.
A continued reduction in sickness absence achieving 2.98% in June against a Trust target of 3%.
Maintaining Trust compliance for staff mandatory training with 89.7% in July (target 85%).
Continued poor compliance with non-medical appraisal rates – 60.1%
On-going industrial action for medical workforce when other professional groups have agreed a National settlement
Quarterly pulse survey is indicating an improving perception from staff against all People Promise elements
Exemplar site for the People Promise
There is a National shortage of workforce across a range of professions and BSW mirror the National picture. Attraction to geographical area through recruitment and retention premia, Golden Handshake welcome payment, offer of relocation payment and re-launched 'Refer a friend scheme'.

Controls

Workforce Control Panel overseeing vacancies
Financial recovery programme includes 6 workforce interventions including establishment control
Exit interview process re-established
International RN and Midwife recruitment
HCA recruitment and retention facilitator in post
Staff availability now a breakthrough objective with clear focus
Appointment of a Health and wellbeing facilitator
All OD&P policies reviewed
Workstreams for all 7 elements of the People Promise benchmarked against staff survey
Newly established leadership development programme plus a proposed people management skills modular programme
Newly appointed Wellbing Specialist
Lifted all Band 2 hourly rate to real living wage rate
All clinical HCAs Band 2 moved to Band 3

Assurance

Improving vacancy and attendance position – as a result of attraction incentives
Improving pulse survey responses
Maximum take up on the leadership development, wellbeing and appraisal training courses
Time to hire recruitment process – significant reduction in days

Progress

What is going well/ Future Opportunities?	What are the current challenges including future risks?	How are these challenges being managed?
Recruitment & attraction process and practices overhaul in conjunction with PWC – implementation phase completed and imminent launch Student reservist campaign Reviewing approach to training needs analysis – appointed to Head of Clinical Learning Launching wellbeing survey Development of a strategic workforce plan	Increasing retention and reducing turnover Line managers capacity to manage exit interviews and complete appraisals Non-Medical Appraisal compliance – remains at 60% Manager's capacity to manage staff absence due to operational pressures. Lack of Strategic workforce planner	A comprehensive improvement programme against all 7 elements of the People Promise Introduced a simplified appraisal form for managers Exploring interim opportunity for both workforce planning and Associate Director of OD Design and partial implementation of people management skills for line managers

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, 7573, 7574		
Executive Lead	Chief Operating Officer		
Lead Committee	Finance and Performance		
Risk Type	Capacity	Risk Appetite / tolerance	Open

Risk Score 2023/24

Initial Score	Sept 21	Jan 22	April 22	July 22	Oct 22	Jan 23	June 23	Sept	Target score
20				20	20	20	16	16	9

Context

Our operational context remains challenging with escalation beds , 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. The continued use of escalation capacity compromises efficiency and effectiveness of the operational flow and compromises patient care.

The underlying constraint is insufficient capacity in respect of the skilled workforce required alongside system wide change to respond to an aging population . The ongoing level of patients in the hospital who are medically fit for discharge impact on available beds to see and treat planned care patients.

Controls

SFT Urgent Care Board
BSW Urgent Care Board
BSW Urgent Care Tactical
Wiltshire Alliance

Assurance

BSW Virtual ward and care co-ordination centre in place reducing demand on SFT beds and admissions
SDEC model reducing bed occupancy requirements for SFT
Acute Frailty model started August 23 – decreased LOS
Overall bed escalation and bed occupancy has decreased since Q4.

Progress

What is going well/ Future Opportunities?	What are the current challenges including future risks?	How are these challenges being managed?
Trust internal programme to reduce bed occupancy including implementation of SDEC, Developing new Acute frailty pathways and unit on Pitton to reduce length of stay Improving discharge processes through a new discharge hub supporting a reduction in NCTR and length of stay. ED improvement work ongoing with ECIST support to identify new opportunities to improve workforce offer.	The time it takes for Patients to flow out of ED due to bed occupancy remaining higher than national target of 92%. Relatively high NCTR bed occupancy as a result of insufficient community care provision and pathway reconfiguration. Continued escalation into DSU compromising surgery rates and recovery of 2019/20 activity levels	Recruitment into vacant nursing, medical and admin posts in ED ongoing. Daily focus on site flow to maximise bed efficiency Urgent care Board to oversee transformation programme Winter plan including UEC Recovery plan to manage flow being developed.

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

Risk Score 2023/24

Initial Score	Sept 21	Jan 22	April 22	July 22	Oct 22	Jan 23	June 23	Sept 23	Target Score
12				12	16	16	16	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 particularly due to high numbers of patients waiting for onward packages of care. 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

Ongoing discussions to agree the distribution of centrally held ICB funding by system Directors of Finance
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.

Assurance

3 year financial plan will act as assurance mechanism

Staff availability breakthrough measurement

Monthly reporting on performance and forecast

Breakthrough objective measurement via Engine Room

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 opportunities. LOS reductions having favourable impact on bed base. Work on longer stays on-going.	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 Oversight on delivery of CIP through the Financial Recovery Group 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 Operating Officer		
Lead Committee	Finance and Performance		
Risk Type	Integration & Partnership	**Risk Appetite / tolerance**	Open

Risk Score 2023/24

Initial Score	Sept 21	Jan 22	April 22	July 22	Oct 22	Jan 23	June 23	Sept 23	Target Score
9				9	9	9	9	9	6

Context

The Integrated Care Alliance continues to develop and respond to changing national guidance on role and functions. 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 Community services tender has been delayed with the contract due to be awarded in which has a strategic impact on the ability to develop integrated services locally for SFT.

Controls

ICB and Wiltshire PLACE with SFT representation
Established AHA with SFT representation
SFT executive representation within ICS workstreams

Assurance

Limited

Progress

What is going well/ Future Opportunities?	What are the current challenges including future risks?	How are these challenges being managed?
Work with the Acute Hospital Alliance continues to develop and gather momentum. Acute Alliance Clinical strategy Elective and Urgent care well established forums	Place based working still in infancy, further work to progress placed based strategy for integrated care, particularly with community services. Challenge to develop relationships across multiple partners at place, including the capacity to influence and support the wide range of groups.	The Trust is represented at appropriate meetings at PLACE, Acute Providers and the ICS. Exec team members developing relationships with professional colleagues, attending stakeholder events.

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

Risk Score 2023/24

Initial Score	Sept 21	Jan 22	April 22	July 22	Oct 22	Jan 23	June 23	Sept 23	Target score
12				12	12	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 2 years. 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

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

Assurance

Use of Datix to track risks and use of Trello to track ongoing issues and updates. Lead times of certain products in excess of the normal

Supply chain monitoring through procurement systems – current supply issues with Stryker products (although improving)

Progress

What is going well/ Future Opportunities?	What are the current challenges including future risks?	How are these challenges being managed?
Supply Disruption meeting 3 times a week with NHS Supply chain to give early warning of issues Clinical procurement Specialists building comprehensive list of alternatives. Clinical teams working with procurement to approve and support finding alternatives Management of key issues via Datix to track risk	Non availability on areas where we do not dual source and are predominantly reliant on one supplier (i.e. Stryker trauma and elective Hip and knee) – currently supply issues with Stryker products but availability is now improving. Lead times of certain products being far in excess of the normal and poor communication from suppliers when there is a shortage of supply	Procurement managing product substitutions and maintaining a list of alternatives Use of Datix to track risks and use of Trello to track ongoing issues and updates 3 times per week meeting of supply chain teams across region to share intel and meet Supply Chain Introduction of dual sourcing where appropriate to mitigate risk Regular Supplier review meetings with high risk suppliers Supply chain monitoring through procurement systems Appropriate 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, 7573, 7574, 7039, 7807		
Executive Lead	Lisa Thomas, Chief operating Officer		
Lead Committee	Finance and Performance		
Risk Type	Covid Recovery	Risk Appetite / tolerance	Open

Risk Score 2023/24

Initial Score	Sept 21	Jan 22	April 22	July 22	Oct 22	Jan 23	June 23	Sept 23	Target score
16					16	16	12	12	9

Context

There is a risk that all performance targets (Cancer, planned Care, Diagnostic targets) are not improving due to significant gaps in workforce and ongoing industrial action.

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.

Slow improvement in DM01, cancer, theatre productivity and less occupied beds showing some improvement since January 2023.

The ongoing impact of industrial action is a significant risk to meeting performance targets due to the level of cancellations.

Controls/ Assurance

Planned care and urgent Care boards for transformation
BSW Planned Care Board and Elective Recovery group
Delivery group monitors performance weekly
Cancer improvement group

52/78 week performance is on trajectory although there are emerging risks following further Industrial Action

Outsourcing arrangement for additional capacity in Radiology which has improved DMO1 performance significantly in Ultrasound, MRI and CT.

Progress

What is going well/ Future Opportunities?	What are the current challenges including future risks?	How are these challenges being managed?
BSW Virtual ward and care co-ordination centre improving bed occupancy and reduced escalation Outsourcing arrangement for additional capacity in Pathology, Theatres and Radiology. Theatres improvement plans	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 Industrial action impacting Significant issue with Plastic breast reconstruction services due to Consultant capacity. Outpatient waits not reducing in line with expectations – further improvement work targeted to reduce follow up's increase PIFU and improve pathways for patients	Improved governance processes for oversight of performance (delivery group. Cancer improvement group) Hard to recruit plan in place linked to People Plan. Planned Care and Urgent Care SFT Boards in place to support transformation BSW Urgent care and Planned care boards well established to help support delivery.

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	Controls in place	Gaps in Control	Assurance on Controls	Gaps in Assurance
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	31/07/2024	2	Population	Trust Board (Corporate Risk Register)	Chief Medical Officer	Kingston, Miss Abigail	24/02/2021	Current NICU provision is continuing pending final decision through the neonatal intensive care network.	Decision likely to be made at a regional rather than organisational level.	Data on quality of NICU service. Data on patient numbers.	Patient numbers not sufficient to support sustainable NICU service.
										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.	31/07/2023		Kingston, Miss Abigail												
6143	Medicine	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.	Do not expect it to happen again but it is possible	Moderate	6	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	30/12/2023	6	Population	Trust Board (Corporate Risk Register)	Chief Medical Officer	Collins, Peter	02/01/2020	Additional Junior Doctor posts secured from the Deanery. Use of Locum Doctors to fill critical gaps. Acting Down Policy in place to ensure safe cover of unexpected workforce gaps. Division of Medicine workforce review to ensure right sizing of junior and senior Doctor numbers. Training programme commenced E-roster system currently being implemented. Physician associate training programme commenced September 2021 and first graduates expected to be offered posts within the Trust in 2023. Update 17/11/22. Increase in LED's has taken medical establishment to 85 however increase in demand has resulted in risk remaining. Internal recruitment processes are now improved for LED's with additional roles and PDT being iuncluded. ED remains a separate risk as rota was increased to permit 1:3 weekends however this has now resulted in a 5 WTE shortfall which has to be filled with agency. Update 09/06/23: Medical workforce group is now well established Clear real-time data on medical workforce gaps and hard-to-recruit posts External strategic workforce review for Medicine and Surgery has been completed and an action plan developed	Some of the vacant posts are in difficult to recruit to specialties. There are gaps in community and primary care services at the weekends. Poor recording of sickness and absence in Medical workforce. Inconsistency in the supply of Doctors in training from HEE results in increased pressure on local recruitment processes.	There has not been an increase in the number of Serious Incidents occurring at the weekend. Performance of 7 day services monitored via CGC Weekend HSMR has reduced to expected levels. Monitoring of exception reporting through the guardian of safe working.	Nil
										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	09/06/2023	Cole, Zoe												
										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.	30/09/2023	17/08/2023	Murray, Dr Duncan												
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	30/08/2024	8	Partnerships	Trust Board (Corporate Risk Register)	Director of Finance	Ellis, Mark	12/03/2021	budgetary controls internal control procedures in built into financial systems between purchasing and paying training to all staff on induction publicity on Counter Fraud service workforce controls & payroll Counter Fraud Champion Role - Director of Integrated Governance Central management of all fraud alerts looking at prevention of Fraud- wellbeing financial health packages	Standard operating procedures across the Whole Trust inconsistently applied	Counter Fraud reports budget monitoring reports fraud investigations low level reporting Risk assessment	investigative fraud allegations show sporadic gaps in procedures.
										Address the drivers of fraud- financial wellbeing of staff	30/06/2022	21/06/2022	Thomas, Lisa												
7809	Quality Directorate	Trustwide	17/08/2023	Clinical Governance	8	There is a risk that the Trust has an unidentified gap in effective clinical care may be the cause of the sustained deterioration in HSMR and SMR. There is a current failure to provide adequate assurance that the change in statistics is not a result of avoidable harm. This may result in reputational risk if unresolved	Do not expect it to happen again but it is possible	Major	8	Chair and CEO have requested external review from Regional CMO to provide further assurance of mortality oversight	30/11/2023		Collins, Peter	Trust Board	30/11/2023	4	Population	Trust Board (Corporate Risk Register)	Chief Medical Officer	Collins, Peter	17/08/2023	Internal mortality surveillance group External reporting and scrutiny by Telstra (Dr Foster) Mortality data reported monthly through IPR Learning from Deaths Report to Board quarterly. Further assurance papers through CGC and Board, shared with Governors	Nil to note	No consistent concerns in any one diagnostic group. No consistent themes of inadequacy of clinical care from structured judgment mortality reviews All cause mortality (from public health data) suggests a low rate of mortality in SFT catchment area	Unexplained deterioration in HSMR and HSR which whilst in keeping with a National picture of lack of confidence in current statistical modelling, does not fully explain the sustained SFT trend
										SFT mortality lead to lead work to set up BSW wide mortality meeting to provide further peer learning and assurance	30/11/2023		Browne, Ben												
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	30/11/2023	6	Partnerships	Trust Board (Corporate Risk Register)	Chief Operating Officer	Thomas, Lisa	12/03/2021	Pulse newsletters Wiltshire alliance attendance key members on ICS development groups (population health, SALSA) white paper published Acute Alliance member	ICB leading the system development work therefore not always sighted on national or regional development.	System working reported to Board Transformation programme aligned with ICA in Wiltshire Acute Alliance work programme and reporting to Board.	Speed in which changes to patient pathways and models of care is currently slow.
										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	13/06/2023	Thomas, Lisa												

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. The impact of this would be a delay in the pace and scale of the rollout of our shared continuous improvement approach across the Trust and within the AHA. This could result in the Trust not being able to improvement performance as far as it could have if the programme had stayed on track.	May recur occasionally	Moderate	9	Use of existing PMB groups to address issues on A3 content	22/11/2021	14/01/2022	Cox, Emma	Executive Director Meeting	30/11/2023	6	People	Trust Board (Corporate Risk Register)	Chief Medical Officer	Talbott, Alex	13/10/2021	Responsibility for delivery sitting with Associate Director of Improvement. Executive oversight of delivery through the monthly Improving Together Board chaired by CEO. Reporting includes progress against the April 2023 to September 2024 roadmap and case studies from across the organisation on the benefit and impact of Improving Together. The Trust Board receive a quarterly board report from the programme board. In preparation for the monthly programme board report and quarterly Trust Board report each of the nine workstreams are reviewed and update by each of the workstream leads (Exec and manager leads). Risks relating to the programme are reviewed on a monthly basis by the Associate Director of Improvement and the Head of the Coach House. This generates new and refresh mitigations as the risk and resultant issues develop month-by-month. E.g. Coach House staffing changes.	None.	- Monthly reviews in preparation for the Improving Together Programme Board between the Associate Director of Improvement and the Head of the Coach House. - Reviews of the workstreams against the overall roadmap at the monthly Improving Together Programme Board and the programme board minutes. - Quarterly reports to Trust Board. - Monthly Engine Room reviews led by the Executives, including quarterly Engine Rooms taking in progress across the four boards: vision metrics, strategic initiatives, breakthrough objectives and corporate projects. -Training continues to be on-trajectory with the Coach House team prioritising training delivery while staffing capacity is constrained. - Of off-track workstreams (OMS Frontline, Leadership Behaviours and Coach House) the actions to bring them back on-track are known as detailed in the programme board papers.	none identified
										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	31/10/2022	Provins, Esther (Inactive User)																		
										Commence recruitment for Programme Director.	30/08/2022	29/12/2022	Collins, Peter																		
										Sustainability workshop completed with Execs and KPMG. Produced roadmap and key area of priorities and assumption in the next 18 months. Detailed roadmaps and requirements to be presented to the Improving Together Programme Board in March 2023.	20/03/2023	09/06/2023	Cox, Emma																		
										Recruitment to coach house to cover maternity leave (B6 improvement practitioner) for 6 months	29/09/2023		Cox, Emma																		
										Recruitment of the three B7 rotational Senior Improvement Practitioner roles into the Coach House. Await final approval of the business case at F&P on 26th September 2023.	31/10/2023		Cox, Emma																		
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	30/11/2023	6	Population	Trust Board (Corporate Risk Register)	Director of Finance	Ellis, Mark	13/08/2019	SFI's standard operating procedures corporate policies (e.g. HR) Governance assurance map risk register	-Education and training on management of risk across the organisation. -working with OD to encompass risk management/controls in leadership development programme.	-Low levels of reported Fraud -low volume of litigation - head of internal audit opinion	-Internal audit reports highlighting weaknesses in controls and processes.
										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	06/01/2023	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	04/05/2023	Ellis, Mark																		
										Development of a standard budgetary management and control training pack for leaders and managers	29/12/2023		Ellis, Mark																		

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, effective and sustainable way. 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.	May recur occasionally	Moderate	9	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	31/10/2023	6	Population	Clinical Governance Committee, Trust Board (Corporate Risk Register), Workforce Committee	Chief Medical Officer	Talbott, Alex	23/08/2019	- Individual professional responsibility to seek best practice - Programme Management / Delivery Boards - People and Culture Committee - Clinical Governance Committee - F&P Committee - Research governance framework - NHS OD / cultural diagnostic work - New style Executive performance meetings commenced which provide new focus on improvement priorities - GIRFT programme - Improving together programme - Executive sponsors in place - Clinical Directors & Deputy Medical Directors in place - Acute alliance discussions - Improving Together programme roll out with strategic partner KPMG completed initial phase) - Elective Recovery Programme Management Board - Patient Flow Improvement Management Board - Newly agreed breakthrough objectives and strategic initiatives - Engine room walk about providing Exec oversight of all improving together delivery metrics occurs monthly.	- Evolving but immature continuous improvement improvement culture - Plans for newly agreed priorities are maturing at divisional level. However these are not yet in place or are in an immature state with speciality and frontline teams - Transition arrangements from one operational management system to another are in progress but not yet fully embedded - Governance and the scorecard agreement processes alignment with the business planning round for 24/25	- Innovation and good practice identified in pockets of the Trust (CQC inspection Nov 2018) - Model hospital benchmarking - Staff survey - GIRFT programme - People and Culture committee minutes and reports - Improving together board meetings and reports to Trust board - Programme Management Boards reports - Vison metrics - Committee effectiveness review - Acute alliance minutes - Corporate objectives (and measurements of) agreed - Quarterly report on progress formerly reported to Trust Board planned for 2023. - Improving performance now being seen in our breakthrough objectives, especially Falls and Bed Occupancy.	- Not all A3s for breakthrough objectives and strategic initiatives complete, or routinely updated with our latest understanding of the problem. - Teams requiring intensive support where standard improvement approaches have not been effective. - Inconsistent and variable leadership behaviours that do not support sustainable improvement remain evident
										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	29/12/2022	Provins, Esther (Inactive User)												
										Executive to commence monthly improvement huddle on all breakthrough objectives.	30/08/2022	29/12/2022	Provins, Esther (Inactive User)												
										Train the specialty triumvirates in Improving Together (16 by November 23)	30/11/2023		Cox, Emma												
										Roll out of the leadership behaviour framework	29/03/2024		Talbott, Alex												
										Integration of business planning and scorecard agreement processes, at Trust and AHA level.	31/10/2023		Talbott, Alex												
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.	May recur occasionally	Moderate	9	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	31/03/2024	6	Population	Trust Board (Corporate Risk Register)	Director of Organisational Development and People	Ready, Troy	06/04/2022	Adequate Health & Safety management system is now in place, with an appropriate system of audit & inspection. Policies and standards are in place with a work programme to ensure they are updated where required by the end of the financial year. All staff trained at induction and further training is in place. Individual department specialist training. A process that requires health and safety risk assessments is in place. Health and Safety Manager and Adviser are in place, plus a Manual Handling Adviser. A mechanism of governance is in place through the H&S Committee, which receives reports from relevant officers plus 19 sub-committees. Interim actions are being taken by the Interim H&S Manager to highlight priorities against this risk and to undertake a small number of activity audits to assess compliance. Adverse event reporting and subsequent analysis/investigation. Health and Safety Committee meetings reporting to board. Health and Safety sub-committees reporting to the Health and safety Committee. Controls Assurance. Health and Safety inspections. Union Health and Safety reps in place.	Some policies not yet up-to-date with current legislation, work programme in place as identified in the H&S management system programme of work.	Observations of behaviours and standards across the publicly accessible parts of the site indicate a H&S culture that is in need of improvement. Independent reports have highlighted areas for improvement which are being addressed at a senior level. An agreed programme of audit and inspection overseen by the H&S committee.	Absence of assurance from divisions and departments giving visibility of H&S issues via the H&S committee. Insufficient near-miss reporting on Datix, for example, multiple examples across the campus of lack of control of premises (e.g. loading bay gates left open, fire doors propped open, safety equipment obstructed by inappropriate storage, trip hazards & obstacles in public areas etc). Ensuring compliance with policy & procedures.
										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 (Inactive User)												
										5/5/22 Recruit permanent H&S Manager.	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 (Inactive User)												
										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	30/12/2022	07/06/2023	Ready, Troy												
										Review gaps in current H&S procedures and policies and update where required	30/12/2022		Ready, Troy												

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	21/10/2023	8	Population	Trust Board (Corporate Risk Register)	Director of Finance	Dhanoa, Naginder	11/02/2020	- Information Security Specialist overseeing CareCERT compliance - Advanced Threat Protection (ATP) has been installed to monitor the Microsoft Windows operating system on a PC or laptop to identify any abnormalities and take immediate action to stop issues identified spreading - NESSUS vulnerability scanning has been implemented - New industry standard firewalls have been installed (Watchguard) - Cyber essentials plan in place - Strong password policy in place and all users now compliant. All functional password with the exception of 3 improved (all three on risk register) - File shares containing "everyone" access have nearly all been removed (recent pen test only shows 90 files accessible compared to 100000 before). - IT Health Assurance Dashboard procured to provide compliance monitoring, in particular CareCERT compliance. Implementation underway. - SIEM, Password monitoring solution and PAM products procured. - All devices on supported version of Windows (windows 10 version 21H2).	- Some windows 7 devices cannot be replaced without significant funding which currently is not available. - A number of outstanding devices for Critical CareCERT. Log4j critical careCERT is a significant wide ranging risk that is considered. - A number of MDE alerts in last 12 months of staff clicking on phishing emails	SFT Informatics Care CERT Alert Dashboard created for the Trusts SIRO. Informatics Tech Group oversees progress in CareCERT compliance, patching monitored by tech group. IT Health dashboard in place and reviewed Tech Group using this operationally Quarterly digital update to F&P. Board agreed moderate risk appetite for cyber security risk. IG, DP and Cyber related Policies updated with external supported, signed off and ratified.	cc.
										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	22/05/2023	Gibson, Richard													
										Implement Privileged Access Management solution	30/09/2023		Gibson, Richard													
										Rollout of SpecOps	16/12/2022	16/12/2022	Gibson, Richard													
										Procure a solution to monitor networked medical devices	31/03/2023	22/05/2023	Gibson, Richard													
										Undertaken awareness of Metacompliance training, focusing on Phishing	30/10/2023		Gibson, Richard													

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 probably recur, but is not a persistent issue	Moderate	12	Communication and reporting of red flag for staffing regionally to NHSI/E	02/08/2021	02/08/2021	Merrifield, Tracey (Inactive User)	Directorate Management Team Meeting	31/12/2023	4	Population	Trust Board (Corporate Risk Register)	Director of Nursing	Hyett, Fiona	01/07/2022	Thrice daily staffing meeting to review allocation of resources and escalation to off cap agencies Rotas completed at six weeks with automatic access to nurse bank and subsequent escalation to nursing agencies at 3 weeks (Tier A) and 3 days (Tier B). Use of nurse bank and temporary staffing Use of supervisory time to support wards Use of RAG safe staffing to guide and inform staffing deployments Availability of matron until 20.00 to support and manage staffing deployments/late sickness calls Use of specialist nurses to support wards	Reduced training and development opportunities. Safe staffing RAG does not account for enhanced care needs. Unpredictable demand for mental health or CAMHS enhanced care leading to use of high cost agency. OSCE nurses are taking a longer time to pass leading to extended supernumerary periods.	Significant reduction in HCA gap. Reduction in RN vacancy for ward areas. Reduction in Falls with Harm. Improving position in relation to tissue damage. Maintenance of Allocate and safecare data. Use of red flags and professional judgement to escalate and capture concerns and mitigations. Daily staffing summaries shared with operational team Datix reporting	Complaints received regarding to care provision. Sickness above target of 3%. Agency spend (although reducing significantly).
												Explore use of agencies (including off cap) to support block booking	09/08/2021	09/08/2021	Wilding, Mr Henry (Inactive User)														
												Explore use of agency HCAs to support wards	20/09/2021	13/12/2021	Wilding, Mr Henry (Inactive User)														
												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 (Inactive User)														
												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 (Inactive User)														
												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 (Inactive User)														
												Extension of winter incentive scheme until 02/04/22 to support ongoing escalation and acuity	04/03/2022	04/03/2022	Wilding, Mr Henry (Inactive User)														
												Develop specific Easter holiday incentive scheme to support and encourage additional shift coverage	08/04/2022	08/04/2022	Wilding, Mr Henry (Inactive User)														
												Ongoing use of golden incentive to support short notice sickness/gap	01/09/2022	05/10/2022	Wilding, Mr Henry (Inactive User)														
												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	13/12/2022	Wilding, Mr Henry (Inactive User)														
												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	06/01/2023	14/06/2023	Hyett, Fiona														
												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	06/01/2023	13/12/2022	Osman, Laura														
												Recruitment of discharge coordinators to support specific wards, releasing nursing time and availability	30/06/2023	14/08/2023	Dickinson, Jane														
												Temporary staffing winter incentive scheme approved by execs. To go live from 30/12/22	30/12/2022	21/12/2022	Ashley, Simon														
												Implement counter measures that came from the A3 on enhanced care management.	31/10/2023		Hyett, Fiona														
												Work in partnership with AWP to reduce the use of Mental Health RMNs and improve continuity of care.	31/12/2023		Hyett, Fiona														
7573	Operations Directorate	Trustwide	16/01/2023	Bed meeting	20	The risk of sustained use of escalation bed capacity (e.g. DSU, Discharge lounge, intervention radiology) has an impact on patient safety due to not enough substantive staff for increased bed capacity, patients not always placed initially in most appropriate ward. The more beds the Trust has open the impact on operational effectiveness, e.g. ward rounds, clinical support services.	Will undoubtedly recur, possibly frequently	Moderate	15	Urgent and Emergency Care Board established to hold transformation programmes to reduce bed occupancy	29/09/2023	07/09/2023	Thomas, Lisa	Trust Board	30/11/2023	12	Population	Trust Board (Corporate Risk Register)	Chief Operating Officer	Thomas, Lisa	16/01/2023	site report, clinical safety huddle patient safety meeting nurse staffing meetings x2 daily urgent care board	system plans for reduction in NCTR including use of additional bedded capacity	Bed occupancy has started to reduce whiteparish ward closed to enable refurbishment Number of patients in ED waiting for bed overnight reducing	Number of beds open still higher than core bed footprint NCTR remains higher than expected Turnover of staff increasing
												expansion of SDEC to surgery and Gynae specialities to further prevent admissions and need for beds	29/12/2023		Thomas, Lisa														
												work with BSW on NCTR reduction plan - particularly those waiting for care Act assessment in beds	29/12/2023		Thomas, Lisa														
												finalise winter plan to optimise flow, including OPEL levels, escalation protocols	31/10/2023		Thomas, Lisa														
7574	Operations Directorate	Trustwide	16/01/2023	Service Delivery Plan	15	The continued pressure from urgent care flow alongside the increases in length of stay, compromises the ability for the Trust to undertake planned care.	Will undoubtedly recur, possibly frequently	Moderate	15	Outpatient transformation programme request for additional support - to ensure progress in reducing patients waiting, reduction in follow ups and increased in PIFU	29/09/2023	07/09/2023	Thomas, Lisa	Weekly Delivery Group	29/12/2023	12	Population	Trust Board (Corporate Risk Register)	Chief Operating Officer	Thomas, Lisa		delivery Group IPR EPR meetings with Divisions Planned care board Theatre productivity programme BSW Elective Care Board	New ward being built- lead time to completed (23/24) Impact of NCTR patients on available bed capacity no real reduction in time to first outpatient appointment risking 78 WW	Longer waits over 78 weeks 104 week waits on trajectory growth in waiting list fairly stable	some specialities under pressure for 52 benchmark lower for productivity that comparable Trusts can't achieve 2019/20 levels of activity due to bed capacity
												Work with Wiltshire Alliance to reduce NCTR impacting on elective beds through the development of virtual wards, discharge hub and pathway changes for non bedded capacity.	29/09/2023	07/09/2023	Thomas, Lisa														
												planned care board to focus on outpatients for the next three months in line with NHS letter 2/8	30/12/2023		Thomas, Lisa														
												winter plan includes expansion within DSU for chairs to mitigate against winter escalation	29/12/2023		Thomas, Lisa														

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.	Will undoubtedly recur, possibly frequently	Moderate	15	Ongoing recruitment drive.	30/09/2019	25/04/2019	Clarke, Lisa	Intensive Support Meeting	30/11/2023	6	Population	Trust Board (Corporate Risk Register)	Chief Medical Officer	Collins, Peter	31/01/2019	Sustainable provision of service through use of long-term locums provided by ID Medical. Ongoing recruitment efforts for specialist nursing and unfilled medical posts. May 2023 - New Fixed term gastroenterologist starting end of May 23 August 23 - Deputy CMO commissioned to provide oversight of the service and to describe road map to sustainability through partnership with neighbouring acute Trusts. External support from senior gastroenterologist providing elements of IBD service	Unsuccessful recruitment to specialist Nurse roles, which has a particular impact on Hepatology and IBD service provision. Until substantive recruitment is complete, off site provision of GI Bleed on-call service will continue. May 2023 - Substantive consultant has handed in notice - leaving end of July 2023. Fixed term consultant going on Mat leave in mid June 2023. Clinical leadership of GI Unit changing hands. June 23 - Resignation of substantive consultant. August 23 - long term capacity and demand planning remains challenging due to non substantive medical workforce	Regular contract monitoring meetings with ID Medical. Monitoring of Key Quality Indicators demonstrating a safe service. 3 new substantive GI Consultants in post and providing oversight and assessment of current service performance. Additional service development time has been job planned for the new consultants to support development of the service and increased governance May 2023 - Reduction in Endoscopy long waiters. August 23 - endoscopy performance remains above peer average in BSW. external quality data does not suggest the Trust is an outlier.	Service is not meeting all required performance standards but this is understood and related to post-Covid elective recovery challenges. No service specific concerns identified currently. New consultants are uncovering new risks as they explore the service but action plans are being developed and will be raised as new specific risks. May 2023 - With fluctuation in staffing levels in endoscopy and gastro over the last 6 months there has been an impact on waiting list levels. Mitigations are in place to regain control June 23 - Risk to service provision around ERCP, inflammatory bowel disease, and nutrition. August 23 - as June update. All subject to ongoing work overseen by Deputy CMO
										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 (Inactive User)														
										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.	29/09/2023		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														
										Develop joint governance meeting between medicine and surgery	31/08/2023		East, Rachael														
										Recruitment of new clinical lead for GI Unit	31/05/2023	22/06/2023	Stephens, Mr Paul														
										CMO to report outcome of GI services review once complete.	29/02/2024		Collins, Peter														
										Surgical division to provide assurance report on oversight of operational delivery and any impacts to quality to CGC on 27th June 2023.	27/06/2023	13/07/2023	East, Rachael														
										Intensive support meetings to commence fortnightly from 24th July.	24/07/2023	17/08/2023	East, Rachael														

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 social care services.	Will undoubtedly recur, possibly frequently	Moderate	15	Winter director managing Trustwide ECIST actions.	01/05/2019	12/06/2019	Hyett, Andy (Inactive User)	Trust Board	31/10/2023	12	Population	Trust Board (Corporate Risk Register)	Chief Operating Officer	Thomas, Lisa	11/03/2019	Daily discharge meeting. Daily reporting and monitoring. System escalation plan revised and approved. Patient flow score card monitoring delivery of KPIs. Expert panel which reviews stranded patients recommencing from July. Weekly system discharge meeting which our head of integrated discharge is now joining. Monthly urgent care board which the COO attends. A system wide winter plan including council and community providers. The BSW system appointed a Director of Urgent Care. Targeting of patient for review by the Medical Director has been implemented as an ongoing process. Discharge Project Team meeting weekly to drive forward improvements. Improved dataset for daily monitoring. Development of Transformation programme for 2021/22. Project Initiation Document has been developed for Patient Flow including KPIs. Weekly system flow meetings attended by new Head of Flow role. Deputy Chief Operating Officer role in place. No right to reside is an approved breakthrough objective as part of the Improving Together Programme Improved data quality	- system trajectory for reduction in NCTR patients not met - capacity gap in Council for domiciliary care which means significant shortage of available care hours -	There is currently increased system visibility. Good visibility of patients waiting on different pathways which is recognised by all across the system. Wiltshire flow hub to manage all patients waiting care new care co-ordination hub being put in place for winter	The number of patients without a right to reside is not reducing. Bed occupancy is high - with escalation areas in use flow through the hospital is poor with delays in ambulance handovers increasing and patient care/quality metrics have deteriorated. Bed capacity mitigation plans identified at BSW level did not materialise as planned - therefore increasing pressure on bed occupancy at SFT.
										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	28/12/2022	Thomas, Lisa																		
										Trust developing winter plan for implementation focusing on pathway 0 patients to maximise available bed capacity	31/10/2022	28/12/2022	Thomas, Lisa																		
										Discharge Hub being established at SFT to support efficient and effective discharge process and improve partner working	29/09/2023	14/08/2023	Cavill, Emma																		
										SFT to complete bed modelling and potential pathway improvements with Wiltshire Place colleagues	30/11/2023		Thomas, Lisa																		

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.	31/03/2024		Crowley, Ian	Trust Board	30/11/2023	6	People	Trust Board (Corporate Risk Register)	Director of Organisational Development and People	Whitfield, Melanie	12/10/2022	Monthly analysis of Workforce Data against Staffing Availability levels People Promise elements delivered to improve retention Targeted attraction and recruitment campaigns against identified priority vacancies. Line management training to support delivery of Career and well being conversations.	Effective resource planning and strategic workforce management. Clinical strategy to meet long term NHS workforce plan targets Resources to deliver the NHS Widening participation agenda. Ineffective targeting of Health and Well-being offers to be reviewed ensure employee's needs are met.	The IPR monthly reporting which includes sickness absence, vacancies, and turnover. Quarterly nursing safe staffing meetings. Nursing skills mix bi-annual reviews.	Lack of alignment between budgeted FTE and the establishment recorded per service function and/or division - this is one of six improvement projects in our financial recovery. Number of days absence/time lost due to short intermittent periods of absence being effectively managed. Control and effective management of temporary staffing numbers.
										Mechanism to manage career pathways and career conversations delivered.	14/01/2023	07/06/2023	Crowley, Ian											
										Delivery of the widening participation initiative.	31/03/2024		Crowley, Ian											
										Recruitment processes optimised (pwc recommendations implemented).	30/04/2023	07/06/2023	Crowley, Ian											
										Movers and leavers project delivered.	31/03/2024		Crowley, Ian											
										People Promise actions for this year to be delivered.	31/03/2024		Crowley, Ian											
										Health and Well-being plan delivered.	30/09/2023		Crowley, Ian											
6229	Surgery	Day Surgery Unit	04/03/2020	Access targets, Complaints, Departmental risk assessment, External audit reports, Incident reports, Other assurance not listed, Service Delivery Plan, Waiting times	12	[07/07/2023 12:00:42 Laurence Arnold] he DSU building is 'end of life' and has been identified as priority for replacement. The fabric of the building is problematic and leads to numerous rook leaks and delayed / cancelled procedures. Failure of the air handling unit is becoming a regular occurrence, this in turn affects the overall environment, prevents activity from taking place owing to infection control policies and results in cancellations of elective procedures. Incidents relating to the building condition are increasing and impacting on patient safety, care and experience. Regular problems with maintaining temperatures safely - theatre F particularly difficult. Air handling plant is sub-optimal for the needs of the facilities. Poor environment for staff - lack of wellbeing facilities. Results in inconvenience for patients - cancellations, and being moved to main theatres. The DSU building is 'end of life' and has been identified as priority for replacement. The fabric of the building is problematic and leads to numerous rook leaks and delayed / cancelled procedures. Failure of the air handling unit is becoming a regular occurrence, this in turn affects the overall environment, prevents activity from taking place owing to infection control policies and results in cancellations of elective procedures. Incidents relating to the building condition are increasing and impacting on patient safety, care and experience.	Will undoubtedly recur, possibly frequently	Major	20	DSU risk escalated to wider stakeholders to ensure remains priority scheme for BSW and South West Region	13/06/2023	13/06/2023	Arnold, Laurence	Trust Board	31/10/2023	4	Population	Trust Board (Corporate Risk Register)	Chief Operating Officer	O'Keeffe, John	13/01/2023	[07/07/2023 12:00:42 Laurence Arnold] None ad hoc nature of issues results in limitations around mitigations. Staff manage individual cases and issues None ad hoc nature of issues results in limitations around mitigations.	[07/07/2023 12:00:42 Laurence Arnold] Substantial capital investment is required - the whole facility needs to replacing, necessitating national capital funding. Funding for new DSU.	None Constant lobbying being undertaken to attempt to secure funding.	[07/07/2023 12:00:42 Laurence Arnold] Problems persist - Roof leaks, heating failures and significant investment identified in the critical plant survey (2020). Regular failure in AHU's resulting in patient cancellations Roof leaks, heating failures and significant investment identified in the critical plant survey (2020). Regular failure in AHU's resulting in patient cancellations
7807		Trustwide	16/08/2023	Incident reports, Trustwide risk assessment, Violence and Aggression	20	As a result of a lack of mental health provision there is a risk that patients with specialist mental health needs are being managed in the acute setting. This may result in sub-optimal care with less therapeutic value than if undertaken in the right setting with appropriately trained staff. This also impacts on staff morale and staff retention.	Will undoubtedly recur, possibly frequently	Major	20	Complete review of requirements for Mental Health Support Workers in conjunction with AWP.	31/12/2023		Hyett, Fiona	Trust Board	31/12/2023	12	Population	Trust Board (Corporate Risk Register)	Director of Nursing	Murray, Dr Duncan	16/08/2023	Daily review of mental health needs across the organisation and identify staffing requirements. 2 long line RMNs 24/7. Use of agency RMNs. Twice weekly meetings with key agencies to discuss current patients. Risk Assessments and care planning in conjunction with AWP and Oxford Health. Partnership working to mitigate risk. Use of security staff to ensure safety of staff and patients. Mental Health Steering Group. Mental Health Liaison Service. Formal escalation to ICS Chief Nursing Officer.	Availability of tier 4 CAMHS beds. Inconsistent standards of agency RMN skills and knowledge.	Improved partnership working leading to better therapeutic input.	Long length of stay for mental health patients requiring community or MH inpatient facilities. Increase number of incidents reported in relation to mental health patients. Impact on estates having to be adapted to maintain safety.
										Ongoing collaboration with partners at ICS and regional level related to Mental Health Provision.	31/12/2023		Murray, Dr Duncan											
7308	Finance and Procurement	Trustwide	19/04/2022	Trusts Objectives, Trustwide risk assessment	15	The financial plan for 2023/24 is for an underlying deficit plan with assumed 5% 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. Ongoing industrial action is affecting both activity levels and management capacity to deliver required improvement programmes. Therefore there is a risk that the financial plan will not be delivered and cash balances will deplete during 2023.	Will undoubtedly recur, possibly frequently	Major	20	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	30/11/2023	9	Partnerships	Finance Committee, Trust Board (Corporate Risk Register)	Director of Finance	Ellis, Mark	19/04/2022	Cash flow forecasting -- monitoring reports to F&P - SFI's ensuring strong financial governance - budget signed off for April 2023/24 based on internal assumptions - ICB surplus distribution to providers agreed. - Weekly agency usage monitoring - Monthly financial recovery group chaired by CEO	- Delivery of 5% CIP dependent on external action - Uncertain impact of winter pressures, staffing gaps, and effects of industrial action	Gaining traction on key improvement programmes leading to closure of beds and reduced agency costs but run rate remains higher than planned Activity is ahead of plan	Ongoing agency bookings Pay overspend
										Deployment of winter plans.	30/11/2022	15/12/2022	Ellis, Mark											
										Seeking support for unfunded pressures from the ICB and SpecCom.	31/01/2023	31/03/2023	Ellis, Mark											
										Review of agency booking process.	31/01/2023	31/03/2023	Whitfield, Melanie											
										3-year forecast being undertaken in Q1, including risks and impact on cash flow.	29/09/2023		Ellis, Mark											
										Identification of additional savings opportunities managed through Divisions with oversight from FRG.	30/09/2023		Ellis, Mark											

Corporate Risk Register Summary - September 2023 v1

Risk (Datix) ID	Risk Title	Exec Lead	Date Risk Added	Initial Score	Apr-22	Jul-22	Oct-22	Jan-23	Jun-23	Sep-23	Target	Risk Type	Risk Appetite
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	12	12	9	9	15	15	6	Capability	Open
5751	Risk of patient harm caused by a delayed discharge from hospital.	Chief Operating Officer	11-Mar-19	16	20	20	20	20	20	15	12	Capacity	Open
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	15	15	12	4	Capability	Open
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	10	8	Infrastructure	Open
5955	Insufficient organisation wide robust management control procedures	Chief Finance Officer	13-Aug-19	15	9	9	9	9	9	9	6	Governance	Cautious
5972	Risk that improvement and transformation is not delivered in a timely manner	Chief Medical Officer	23-Aug-19	16	12	12	12	12	9	9	6	Improvement & Innovation	Open
6143	Risk that inadequate medical staffing in the oeganisation will impact on the ability of the Trust to maintain safe and effective services across 7 days	Chief Medical Officer	02-Jan-20	16	9	12	12	12	9	6	6	Capacity	Open
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	9	15	12	12	9	9	6	Governance	Cautious

6229	The DSU building is 'end of life' and has been identified as priority for replacement. The fabric of the building is problematic and leads to numerous rook leaks and delayed / cancelled procedures. Failure of the air handling unit is becoming a regular occurrence, this in turn affects the overall environment, prevents activity from taking place owing to infection control policies and results in cancellations of elective procedures. Incidents relating to the building condition are increasing and impacting on patient safety, care and experience	Chief Operating Officer	02-Jan-23	12				20	20	20	4	Capacity	Open
7573	The risk of sustained use of escalation bed capacity (e.g. DSU, Discharge lounge, intervention radiology) has an impact on patient safety due to not enough substantive staff for increased bed capacity, patients not always placed initially in most appropriate ward. The more beds the Trust has open the impact on operational effectiveness, e.g. ward rounds, clinical support services.	Chief Operating Officer	16-Jan-23	20				20	20	15	12	Capacity	Open
7574	The continued pressure from urgent care flow alongside the increases in length of stay, compromises the ability for the Trust to undertake planned care.	Chief Operating Officer	16-Jan-23	15				15	15	15	12	Capacity	Open
7807	As a result of a lack of mental health provision there is a risk that patients with specialist mental health needs are being managed in the acute setting. This may result in sub-optimal care with less therapeutic value than if undertaken in the right setting with appropriately trained staff. **New risk**	Chief Nursing Officer	16-Aug-23	20						20	12	Capacity	Open
7809	There is a risk that the Trust has an unidentified gap in effective clinical care may be the cause of the sustained deterioration in HSMR and SMR. There is a current failure to provide adequate assurance that the change in statistics is not a result of avoidable harm. **New risk**	Chief Medical Officer	17-Aug-23	8						8	4	Capacity	Open

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 - T**olerated risk**	Chief Medical Officer	24-Feb-21	12	5	5	5	5	5	5	2	Capacity	Open
People - Supporting our people to make Salisbury NHS Foundation Trust the best place to work														
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	Chief People Officer	12-Oct-22	16			16	16	16	16	6	Capability	Open
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	9	15	12	9	6	9	6	Improvement & Innovation	Open
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	8	8	8	8	8	8	Finance	Open
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 Operating Officer	12-Mar-21	9	9	9	9	9	9	9	6	Integration & Partnership	Open
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	16	20	20	9	Finance	Open

Risk Score Key

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

Risk Appetite

Outwith tolerance

Within tolerance

NHS Salisbury NHS Foundation Trust

Report to:	Trust Board (Public)	Agenda item:	5.1
Date of meeting:	05 October 2023		

Report tile:	Patient Feedback Report – Q1 2023/24			
Status:	Information	Discussion	Assurance	Approval
	Yes	Yes	Yes	Yes
Approval Process: (where has this paper been reviewed and approved):	Scheduled for presentation at Patient Experience Steering Group – 27th September 2023 CGC 26 September 2023			
Prepared by:	Victoria Aldridge - Head of Patient Experience			
Executive Sponsor: (presenting)	Judy Dyos - Chief Nursing Officer			
Appendices (list if applicable):	APPENDIX 1: Datix Compliments Categories APPENDIX 2: Complaints Process Review – Action Plan Progress APPENDIX 3 - KPMG Complaints Internal Audit Terms of Reference APPENDIX 4: Friends and Family Test Comments – Q1 2023/24 APPENDIX 5: Your Views Matter – Bereavement Survey Report Q1 23/24 APPENDIX 6: National UEC Survey Results (2022)			

Recommendation:

This report is for assurance and noting by the Committee.

Executive Summary:

This report provides summary and insights drawn from the various methods by which our patients feedback on our services. This includes analysis of complaints, concerns, compliments, Friends and Family Testing and National surveys reported during Q1 of 2023-24. To summarise the contents of this paper:

Complaints/concerns/compliments and enquiries:

The number of formal complaints made in Q1 has significantly reduced when compared with the previous quarters of 2022/23. 35 complaints were formally logged in Q1 (57 in Q4, 56 in Q3 and 59 in Q2).

There were 41 concerns logged in Q1, a continued decrease on Q4 (42) and significantly lower than quarters 2 and 3 (68 and 60 respectively). New reporting has now been enabled to demonstrate where early resolution and descalation of complaints/concerns are occurring, the early data around this is very positive and suggests a contribution to the reductions in numbers of logged complaints we are seeing.

A total of 277 comments/enquiries logged by the PALS team in Q1, a significant decrease to the number see in Q4 which peaked at 354.

179 compliments were recorded on Datix this quarter across the Trust. We are now able to breakdown this reporting to show which areas are receiving these compliments, further updates to Datix planned in Q2 should also enable us to report themes for compliments going forward.

For Q1 the most common high-level theme for complaints noted across the Trust were largely the same as those seen in Q4. These were in relation to Patient Care (34%) and Communication at (20%). A new

theme noted however was in relation to Values and Behaviours of Staff (14%) – this was also noted to be a common prevalent theme for all four clinical divisions.

Overdue complaints continue to be a challenge for the Trust as a whole, we are falling short of the 90% Improving Together target set. PALS continue to work closely with the divisions on closing this gap and the focus on early resolution and de-escalation is anticipated to help reduce the backlog in some areas over time.

The number of reopened complaints/concerns in Q1 is the lowest we have seen in this rolling 12month period (n~4). This is a two-third reduction on the number reopended in Q4.

New content to note for this quarter: Division Leads have been invited to respond to their section of the report prior to publication, focusing on their complaints and compliments data. This has been trialled with the Medicine's Division this quarter (see Medicine). The Board are invited to comment on this new addition to the report and if favourable, the approach will look to include the same process with the other Divisions going forward.

Friends and Family Test: The Trust wide average response rate for Q1 is the highest seen to date with 2,301 responses received. The response rate has also peaked at 3.3% (of eligible population), and although this is below the new Improving Together target for 2023/24 of 15%, we are on a positive upward trajectory. Friends and Family Test experience ratings have also increased this quarter with 98% of those surveyed rating their expereince as Good or Very Good. Digital provider rollout remains delayed until December 2023, however interim work is well underway to develop the data insights dashboard with plans for Q1 and Q2 restospective FFT data to be add to this to allow for themeing and analysis inclusion in future reports in the interim.

National Surveys: Urgent and Emergency Care Survey (2022) results will be released by CQC in July 2023. Response rate was 33% and a total of 397 responses were received. This was noted to be a higher response rate than averaged. In summary the Trust scored better than others in 19 questions and about the same in the remaining 18 questions. There were no questions where the Trust scored worse than other Trusts.

Key comparisons from our 2020 survey were that the overall experience rating had *reduced* from 85% in 2020 to 80.2%. However, comparison to other Trusts nationally, saw us in the top upper quadrant of "same as expected".

Local Surveys: Real-time feedback (RTF) has been sporadic during Q1, this was complicated with technical issues with the Ipads and the availability of volunteers. There were no presentations of RTF to the Patient Expereince Steering Group during this time as a consequence. This will be reinstated for Q2 reporting.

The Bereavement Survey for Q1 is summarised within this report and the full report can be found in appendix 5. Overall a positive survey with increased satisfaction ratings and decreased disatifcation rates, when compated with the Q4 report. Lowering response rates are noted as a concern and mitigations are in place to increase the uptake. There were no noted correlations with complaints, but themes were noted around the access to the bereavement service out of hours and continued comments in relation to the facilities have instatigated a new targeted themeing process as we go into Q2.

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

Patient Experience - Patient Feedback
Q1 Report 2022/23

Purpose of paper

To provide assurance that the Trust is responding appropriately to complaints and demonstrate that learning and actions are being taken to improve services in response to feedback.

This paper will also outline the other methods of patient feedback that the Trust collects, and as these processes develop will seek to triangulate these various data sets to provide balanced insight to how patients experience our hospital.

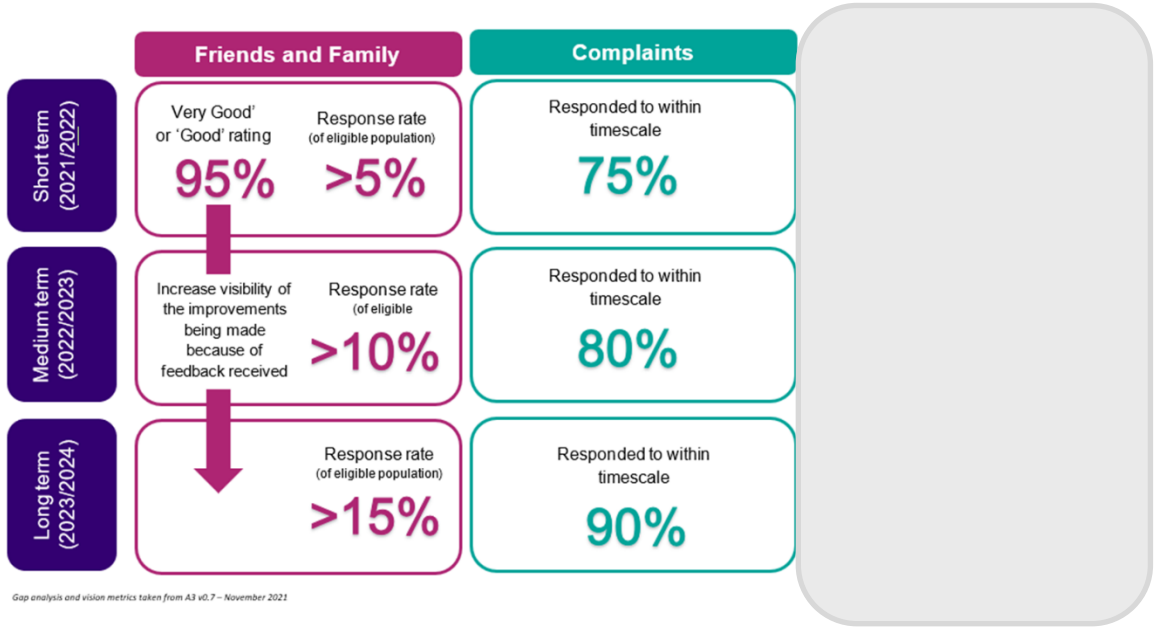
Background

Patient experience is defined as “the sum of all interactions, shaped by an organisation’s culture that influence patient perceptions across the continuum of care”. Nationally, the scrutiny in relation to compassionate healthcare, as well as in engaging with the public, is to understand their voice and feedback is an imperative. This includes learning from feedback and in transparency and honesty on when healthcare goes wrong.

Concerns and complaints can surface, and the quality of the investigation, response and actions allow improvements in the safety and quality of care delivery. We strive to create an open culture where concerns and complaints are welcomed and learnt from. This can also be said of the many compliments received that far outweigh these complaints and concerns. Compliments can also help improve practice by allowing good practice to be disseminated and shared where possible.

Below is a summary of the Improving Together metrics originally developed in 2021 with a 3-year plan. Friends and Family Testing and Complaints are covered in this Patient Experience report. Progress against the Patient Engagement objectives are covered separately under the Patient Engagement annual report.

Patient Experience – Improving Together Summary



Contents

1. Complaints, Concerns and Compliments - Trust Overview

There were a total of 4 items of feedback posted on the NHS Website* in Q1.

Average rating on responses: ★★★★★

	Positive	Negative	Average star rating
Q1 223/24	**4**	**0**	★★★★★
Q4 22/23	2	2	★★★
Q3 22/23	4	0	★★★★★
Q2 22/23	3	2	★★★★

*All feedback is available here: Ratings and reviews - Salisbury District Hospital - NHS (www.nhs.uk)

Patient Activity

Table 1.1 shows the breakdown for patient activity across the Divisions and total for the trust and this is used to calculate this feedback on a per 1,000 basis (see Figure 1.1). The Trust is seeing its highest level of patient activity in this rolling 12month period.

Table 1.1 – Patient activity

Patient Activity by Division / Quarter	Clinical Support and Family Services	Medicine	Surgery	Women & Newborn	Total
Q1 2023 - 24	35,540	34, 554	40, 495	4, 206	114, 795
Q4 2022-23	34,107	28,406	35,310	3,795	101,618
Q3 2022-23	31,906	29,040	35,374	4,802	101,122
Q2 2022-23	29,779	28,414	34,493	4,526	97,212

Compliments

Compliments are sent directly to the Chief Executive, PALS or via the SOX inbox and are acknowledged and shared with the staff/teams named. Where individual staff members are named in a compliment the PALS team complete a SOX which is sent to the SOX administrator for forwarding onto the individual and their line manager. Compliments continue to be recorded (in their numbers) through cards, letters, gifts sent received directly to these areas.

We continue to work with the Divisions to ensure that all compliments are logged with PALS and recorded as a Datix entry for more robust reporting. We are still in the process of making changes to the Datix system to allow for theming of compliments so that these can reported alongside complaints and FFT. This is being facilitated through PALS.

From August 2023 compliments will be themed and categorised on Datix and Appendix 1 demonstrates the new categories which have been added. From Q2 reporting onwards we will include this breakdown along with the themes for complaints and concerns.

Complaints and Concerns

Figure 1.1 Total Number of Complaints, Concerns, Compliments and FFT per 1,000 of Trust activity

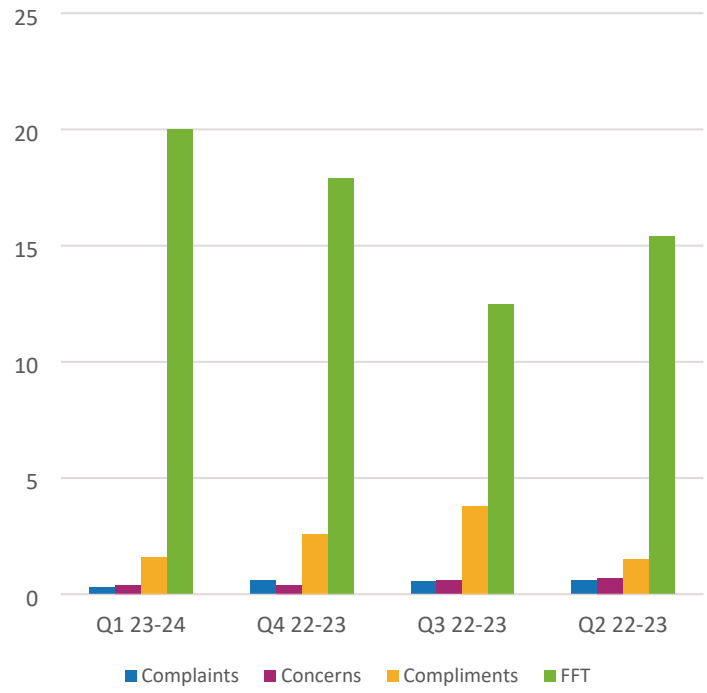


Figure 1.1 continues to show a steady decrease in the total number of both complaints and concerns for Q1, this is against the landscape of an increase in patient activity when compared with previous quarters. FFT feedback also continues to increase, though it is noted that compliment numbers have reduced again slightly in Q1. We do however believe that this is still an impact from the transition of how compliments are recorded (no longer based on numbers but on actual Datix records).

In Q1 the PALS department logged 227 comments/enquiries. This is significantly lower than Q4.

This equates to an average of 2.4 contacts per 1,000 patient activity across the Trust.

During Q1 there were a total of 76 complaints and concerns logged. Changes to the complaints process over the past 6-12months coupled with targeted work through PALS to adopt the PHSO principles on **early resolution** and **descalation** of complaints are being trialled.

Changes to the Datix system implemented in Q1 now enables us to report on the number of complaints/concerns that have been deescalated following early intervention and resolution. 22 of these were considered descalated in Q1.

1 of the 76 total above, was noted to have escalated from a comment to a complaint.

Figure 1.1a shows how the de-escalated complaints/concerns were distributed across the Trust.

Surgery have worked hard this quarter to adopt the principles around early resolution and deescalation.

This has been a focus with the support of PALS to help alleviate the backlog of overdue complaints they currently have.

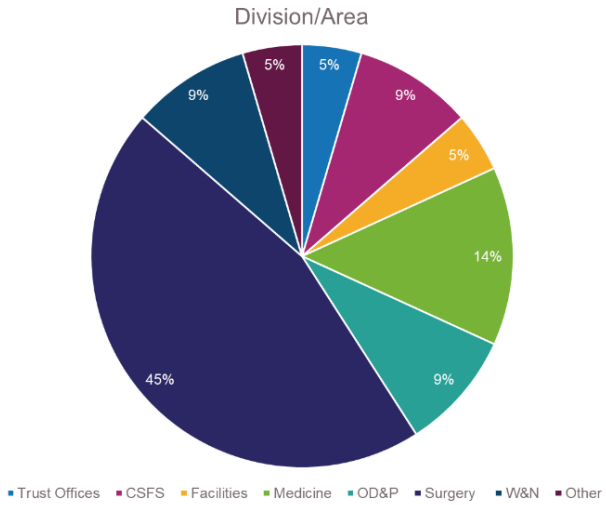


Table 1.2 shows the themes for complaints received in Q1. Highlighted are the top three most prevalent themes. Two of these themes are consistent with Q4 in relation to patient care and communications. **Values and behaviours of staff** however is noted to be a new theme for Q1 replacing **access to treatment/drugs**.

Table 1.2 Raw data - Themes from Q1 Complaints/concerns

	CSFS	Medicine	Surgery	Women & Newborn	% of total by theme
Access to treatment or drugs		1	2	1	5%
Admissions, discharge and transfers excluding delayed discharge due to absence of care package		2	1		4%
Appointments including delays and cancellations			3		4%
Clinical Treatment	1	3	5		12%
Communications		6	9		20%
End of Life Care		1			1%
Facilities Services		2			3%
Other		1			1%
Patient Care including Nutrition / Hydration		9	14	3	34%
Prescribing errors	1				1%
Values and behaviours (Staff)	2	4	3	2	14%
Total by Division	**4**	**29**	**37**	**6**	
Divisions Total	**76**				

The following tables show a further breakdown for the three most prevalent themes across the Trust.

Delay in making diagnosis and further complications came out as the highest sub-category for complaints (see Table 1.2a)

In regards to communication - insensitive communication came out again as the highest cause for complaints (see Table 1.2b)

Values and Behvaiours of staff is a new theme, not consistent with previous quarters and has not been a prevalent theme since Q1 of 2022/23. It is also the only theme to have been noted across all four clinical divisions.

Medical staff have the highest proportion of these types of complaints (see Table 1.2c)

Table 1.2a

Patient Care including Nutrition / Hydration	26	34%
Delay in making diagnosis	7	27%
Further complications	5	19%
Unsatisfactory treatment	4	15%
Correct diagnosis not made	2	8%
Falls	2	8%
Harm	1	4%
Inappropriate treatment	1	4%
Neglect	1	4%
Nursing Care	1	4%
Poor quality of food	1	4%
Ward moves	1	4%

Table 1.2b

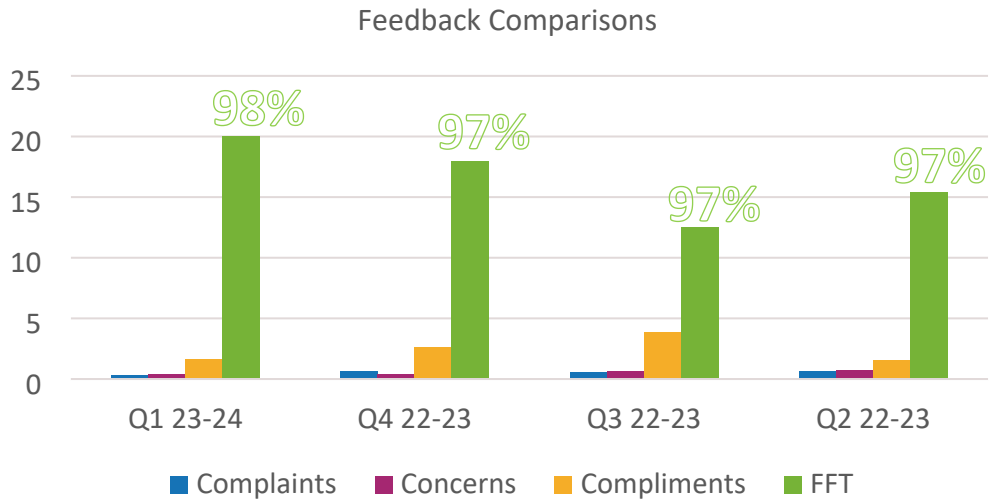
Communications	15	20%
Insensitive communication	7	47%
Lack of communication	3	20%
Wrong information	2	13%
Information not given to family	2	13%
Information not given to patient	1	7%

Table 1.2c

Values and behaviours (staff)	11	14%
Attitude of staff - medical	7	64%
Attitude of nursing staff	3	27%
Attitude of staff - admin	1	9%

Complaints and concerns continue to be small in numbers when compared with the numbers of Friends and Family Test (FFT) feedback received across the Trust. The response rate in this continues to increase as does the overall satisfaction rating. This comparison is demonstrated in Figure 1.2.

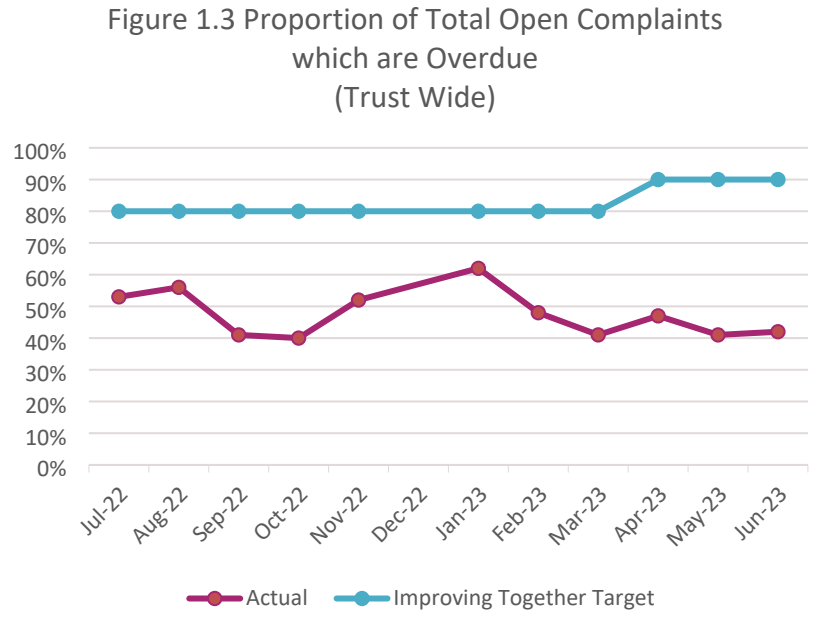
Figure 1.2 – Reiterates the FFT feedback rates compared with complaints, concerns and compliments (based on a per 1,000 patient activity) but also demonstrates the patient experiences rates obtained from these.



% = those who completed an FFT form and rated their experience as either Good or Very Good

(Quarter averaged)

Overdue Complaints



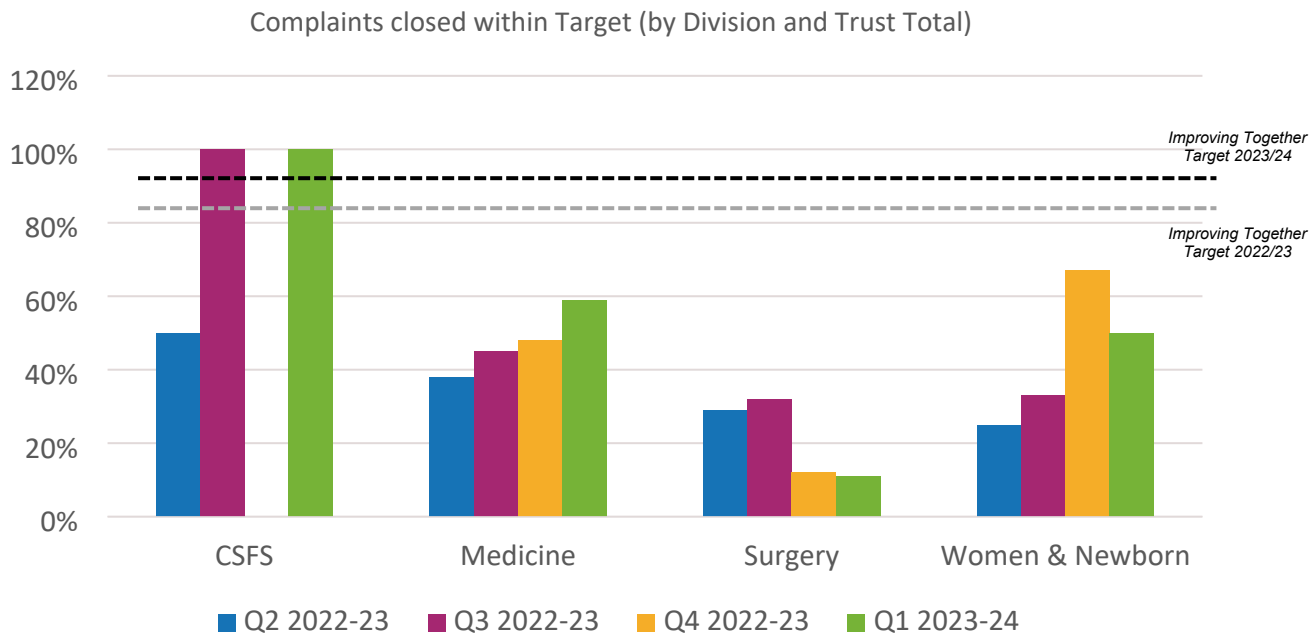
In April 2023 the Improving Together Target was set to change from 80% to 90% of all complaints to be responded to within the agreed timescale. As a Trust we are still struggling to achieve this.

See Figure 1.3.

Update to the Integrated Performance Report (IPR) effective from June 2023 means that this target will form part of this report's watch metrics and it will continue to be scrutinised through the Patient Experience Steering Group, with escalation to the Clinical Management Board (CMB) where appropriate.

At individual Division levels, we are seeing on the whole a steady increase in the number of complaints being closed within the target timeframe.

Figure 1.4 – Complaints closed within Target (by Division and Trust Total)



CSFS were able to close all of their complaints on target for Q1, which was a significant shift from their position in Q4. We continue to see a steady improvement with Medicine and Women & Newborn.

Surgery continue to work closely with the PALS team on their backlog and are engaged with new ways of working to address this. The DMT now have fortnightly meetings to review outstanding complaints and operational teams are realigning their structures to work within specialties which is hoped to improve ownership of complaints and subsequently improve response times.

Training on complaints for the new Band 6's and Band 7 nursing staff are scheduled for July and August 2023 and this has been targeted with the Surgical Division initally.

(see Section 3 Division Summaries – Complaints, Concerns and Compliments) for more detailed breakdowns for each Division.

Figure 1.5 – Number of re-opened complaints or concerns

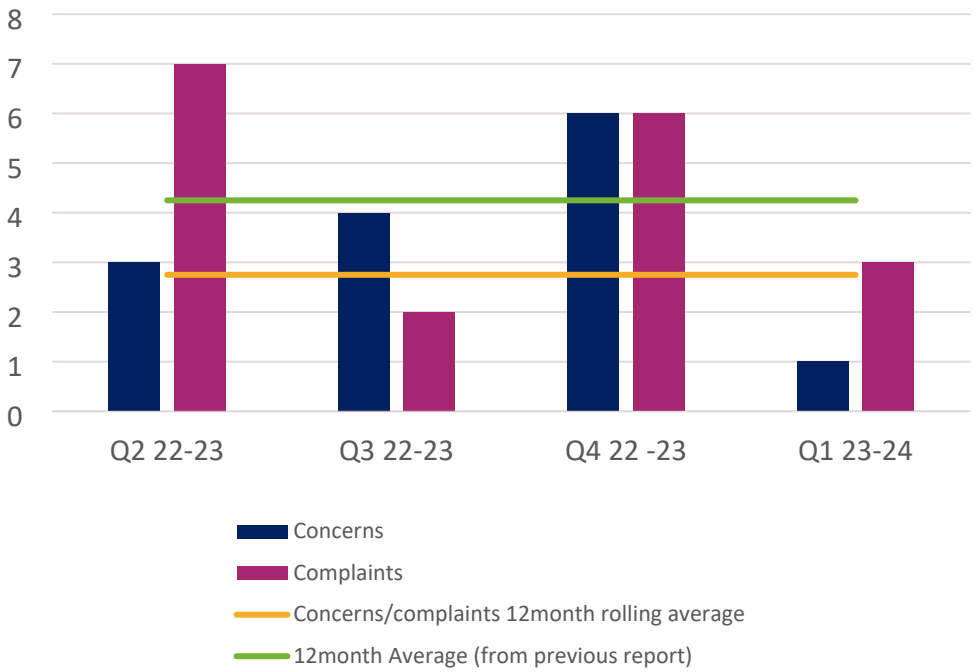


Figure 1.5 shows the number of reopened complaints and concerns, compared with previous quarters.

The yellow lines shows a calculated rolling average and the green a comparison to the previous report to demonstrate how this is fairing.

The number of reopened complaints and concerns have decreased on Q4 and is the lowest we have seen in this rolling 12month period.

For those which have reopend the reasons were varied and in some cases unavoidable as the complainant had further questions. The PALS team and the Division Leads continue to work hard to realise the benefits of concluding investigations with complaint meetings and where written responses were required ensuring these address all the points, contain empathetic apologies and demonstrate lessons learnt.

2. HWW Complaints Project Action Plan progress update

The PALS and Patient Experience team continue to work through the Action Plan (see Appendix 2) developed following the outcomes of the HWW complaints process project (here).

A key milestone for this work was the redevelopment of the PALS complaints leaflet. This is on track for finalisation and will be going to the Patient Experience Steering Group in September for final approvals. This has been reviewed by HWW and our readership panel and will be the first SFT publication to carry the new readership group "patient reviewed" stamp.

From May 2023 the complaints process survey used to undertake this project has become an integral part of the follow-up with all closed complaints and concerns. The analysis from these surveys is scheduled for presentation at Clinical Governance Committee in September 2023.

Internal Complaints Audit 2023

In September 2023 the complaints process will be subject to an internal audit with KPMG. The terms of reference for this audit can be found in Appendix 3. The outcome of the audit including recommendations will be included in the Patient Experience Q3 report.

3. Division Summaries – Complaints, Concerns and Compliments

Non-Clinical Divisions (Facilities, Trust Offices, Corporate etc.)

0 Complaints/concerns were recorded for **non-clinical** divisions in Q1.

There were a total of 33 comments/enquiries logged of which 36% were related to the car park. This is highlighted due to this being a theme noted during Q4 of 2022/23.

Compliments – Non-Clinical Divisions (Facilities, Trust Offices, Corporate etc.)

There were a total of 6 compliments for non-clinical divisions across Q1 and all have been logged on Datix. This is a new reporting for this so no comparisions from previous quarter.

Figure 3.0 shows a breakdown of where the compliments were received:

Figure 3.0 – Non-clinical Compliments breakdown

Clinical Support and Family Services (CSFS)

- There were a total of 4 complaints and concerns received during Q1
- The division was able to achieve a 100% response rate within target
- 0 complaints/concerns were reopened.
- 8 compliments were formally logged on Datix.

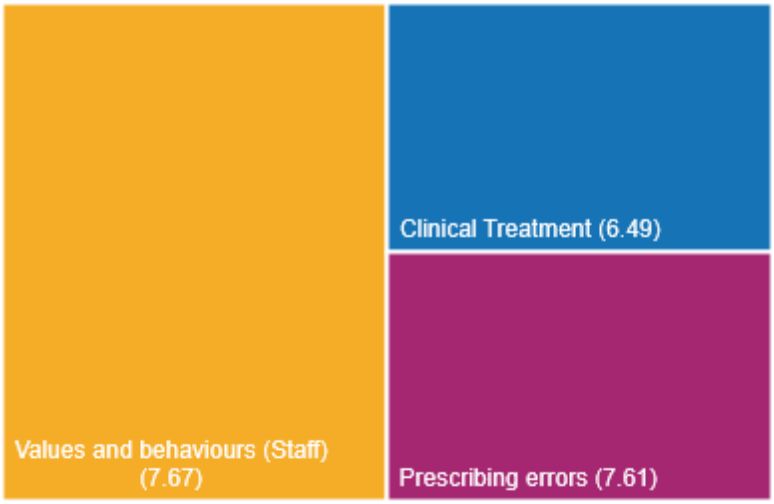
Table 3.1 Summary of number of received, reopened and response within timeframe – annual comparison and quarterly averages.

- Positive downward trajectory on previous quarter
- Negative downward trajectory on previous quarter
- No change on previous quarter
- Positive upward trajectory on previous quarter
- Negative upward trajectory on previous quarter

	Q2 22-23	Q3 22-23	Q4 22-23	Q1 23-24
Complaints	▼ 2	▲ 5	▼ 1	▲ 2
Concerns	▼ 6	▼ 5	▶ 5	▼ 2
Compliments	▼ 3	▲ 6	▲ 21	▼ 8
FFT Responses	▲ 93	▲ 206	▲ 349	▲ 403
Re-opened complaints/concerns	▼ 0	▲ 1	▼ 0	▶ 0
% closed complaints responded to within agreed timescale	▼ 50%	▲ 100%	▼ 0%	▲ 100%
Complaints closed in this quarter	2	4	2	1
Complaints by Division activity (per 1,000)	▼ 0.1 (29,779)	▲ 0.2 (31,906)	▼ 0.0 (34,107)	▼ 0.06 (35,540)
Concerns by Division activity (per 1,000)	▶ 0.2 (29,779)	▶ 0.2 (31,906)	▼ 0.1 (34,107)	▼ 0.06 (35,540)
Compliments by Division activity (per 1,000)	▶ 0.1 (29,779)	▲ 0.2 (31,906)	▲ 0.6 (34,107)	▲ 0.23 (35,540)

Figure 3.1 demonstrates the most prevalent high-level themes for opened complaints during Q1.

Figure 3.1 – Summary of themes for CSFS Complaints and Concerns – Q1 2023/24



50% = Values and Behaviours (staff)

25% = related to Clinical Treatment

25% = related to Prescribing errors

Within these theme(s), the following shows a sub-category breakdown for further context of the themes of these complaints:

Table 3.1a

Values and Behaviours of Staff	2	50%
Attitude of staff (medical)	2	100%

Table 3.1b

Clinical Treatment	1	25%
Clinical treatment	1	100%

Table 3.1c

Prescribing errors	1	25%
Drug error	1	100%

Compliments – Clinical Support and Family Services

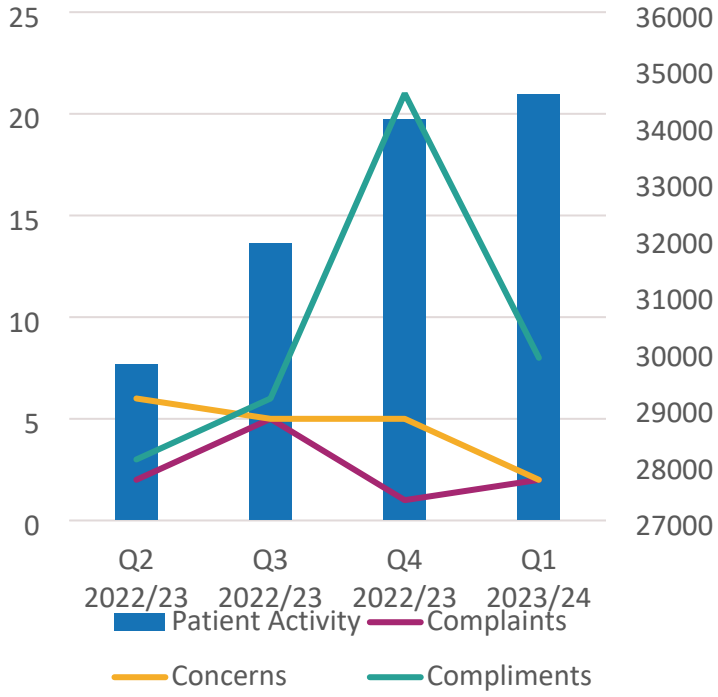
There were a total of 8 compliments for CSFS across Q1. This is fewer than previous quarters and all have been logged on Datix. Figure 3.2 shows a breakdown of where the compliments were received:

Figure 3.2 – CSFS Compliments breakdown

Figure 3.3 shows

correlation of number of complaints, concerns and compliments by patient activity for Clinical Support & Family Services.

Figure 3.3 – CSFS patient activity correlation with feedback



The Division continues to see an increasing number of patients and despite this increase the number of logged concerns and complaints appear to be on a downward trajectory.

Compliments recored this quarter are significantly lower than previous quarter and further work may be needed to ensure departments are sharing these with the PALS team for recording on Datix.

As mentioned previously, from Q2 we hope to be able to theme compliments in the same way we do complaints so that we can celebrate our success and provide equal weight to the learning and insight we gain from these with that of our complaints.

Women and Newborn

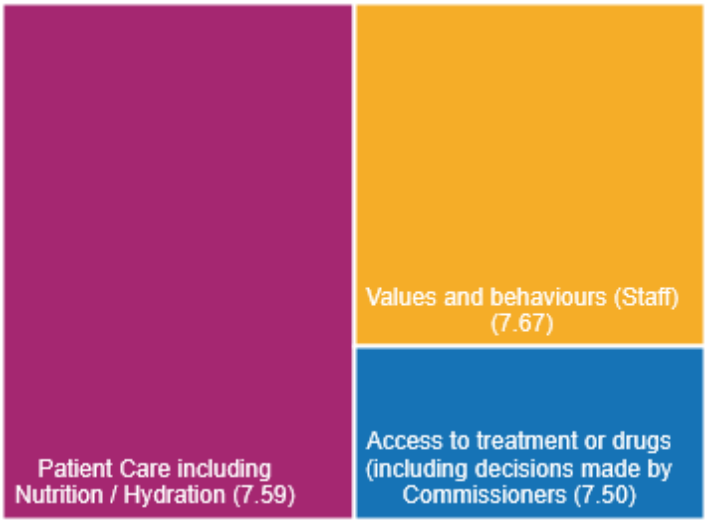
- There were a total of 6 complaints and concerns for Q1 – almost half that seen in Q4
- 4 complaints were closed in Q1; with 50% being responded to within the agreed timescale. This is a slight reduction onf the 67% achieved in the previous quarter.
- 0 complaints was reopened.
- 58 compliments were formally logged on Datix.

Table 3.2 Summary of number of received, reopened and response within timeframe – annual comparison and quarterly averages.

- Positive downward trajectory on previous quarter
- Negative downward trajectory on previous quarter
- No change on previous quarter
- Positive upward trajectory on previous quarter
- Negative upward trajectory on previous quarter

	Q2 22-23	Q3 22-23	Q4 22-23	Q1 23-24
Complaints	▲ 8	▼ 7	▲ 8	▼ 3
Concerns	▼ 5	▶ 5	▼ 3	▶ 3
Compliments	▲ 21	▼ 19	▲ 34	▲ 68
FFT Responses	▼ 42	▼ 19	▲ 114	▼ 50
Re-opened complaints/concerns	▶ 1	▼ 0	▲ 1	▼ 0
% closed complaints responded to within agreed timescale	▼ 25%	▲ 33%	▲ 67%	▼ 60%
Complaints closed in this quarter	4	9	6	4
Complaints by Division activity (per 1,000)	▲ 1.8 (4,526)	▼ 1.5 (4,802)	▲ 2.1 (3,795)	▼ 0.71 (4, 206)
Concerns by Division activity (per 1,000)	▼ 1.1 (4,526)	▼ 1.0 (4,802)	▼ 0.8 (3,795)	▼ 0.71 (4, 206)
Compliments by Division activity (per 1,000)	▲ 4.6 (4,526)	▼ 4.0 (4,802)	▲ 9.0 (3,795)	▲ 13.7 (4, 206)

Figure 3.4 – Summary of themes for W&N Complaints and Concerns – Q1 2023/24



50% = Patient Care

33% = related to Values and Behaviours of Staff

17% = related to Access to Treatment or Drugs

Patient care remains the highest theme for complaints this quarter, consistent with Q4. Values and Behaviours of staff is also a consistent theme carried from Q4.

Within these theme(s), the following shows a sub-category breakdown for further context of the themes of these complaints:

Table 3.2a

Patient Care	**3**	**50%**
Further complications	2	66%
Unsatisfactory treatment	1	33%

Table 3.2b

Values and Behaviours (staff)	**2**	**33%**
Attitude of nursing staff	1	50%
Attitude of medical staff	1	50%

Table 3.2c

Access to Treatment or Drugs	**1**	**17%**
Delay in receiving treatment	1	100%

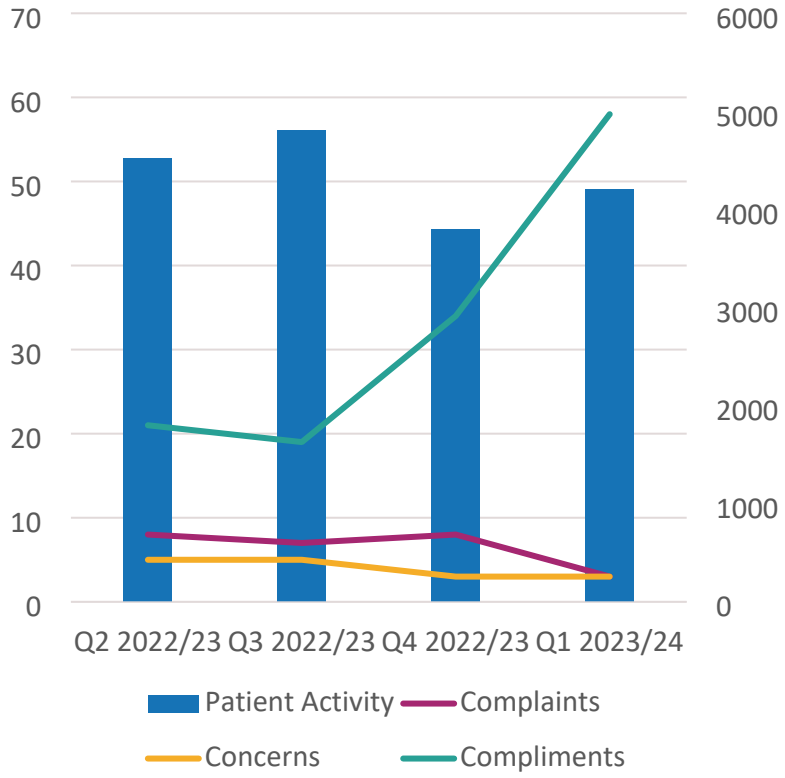
Compliments – Women & Newborn

There was a total of 58 recorded compliments for W&N across Q1, these were all formally recorded on Datix. Figure 3.5 shows a breakdown of where the compliments were received:

Figure 3.5 – W&NB Compliments breakdown

Figure 3.6 shows correlation of number of complaints, concerns and compliments by patient activity for Clinical Support & Family Services.

Figure 3.6 – W&NB patient activity correlation with feedback



The Division saw an increased number of patients this quarter compated with Q4. Despite this increase, the number of logged concerns and complaints is at its lowest for the rolling 12month period.

Compliments recored this quarter are also significantly higher than previous quarters.

As mentioned previously, from Q2 we hope to be able to theme compliments in the same way we do complaints so that we can celebrate our success and provide equal weight to the learning and insight we gain from these with that of our complaints.

Medicine

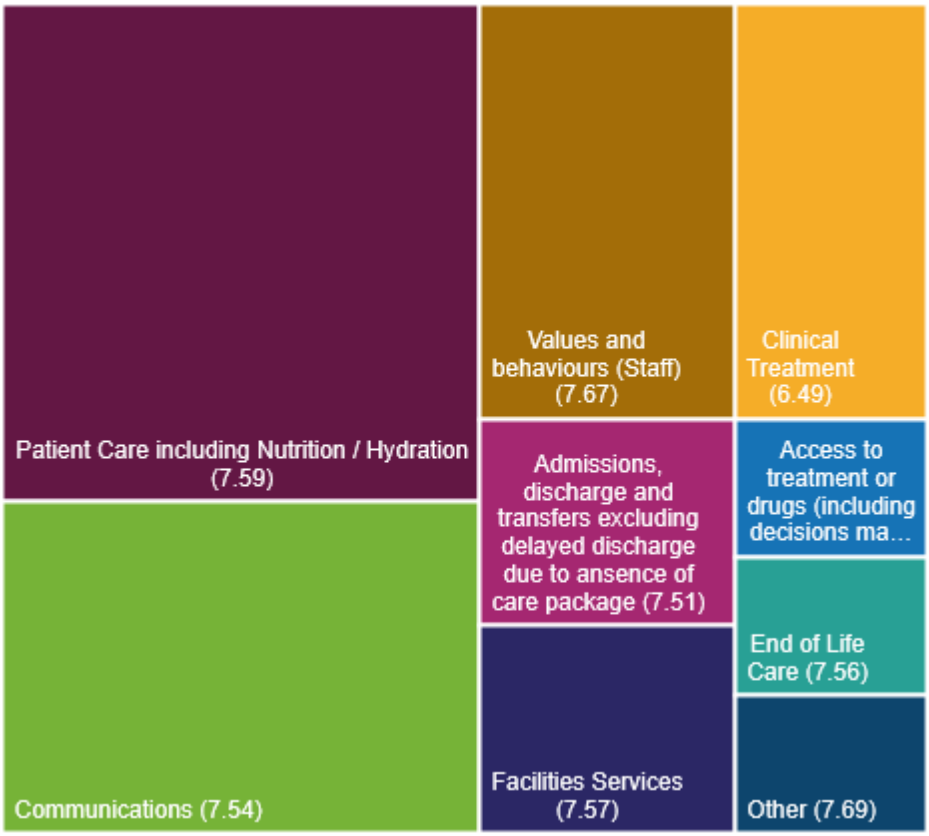
- There were a total of 29 complaints and concerns for Q1, this is a significant reduction on the number seen in Q4 (n~49).
- 51 compliments were formally logged on Datix.
- 22 complaints were closed in Q1; with 59% being responded to within the agreed timescale. This is a notable continued improvement towards the 90% Improving Together Target.
- 2 complaints were reopened this quarter.

- Positive downward trajectory on previous quarter
- Negative downward trajectory on previous quarter
- No change on previous quarter
- Positive upward trajectory on previous quarter
- Negative upward trajectory on previous quarter

Table 3.3 Summary of number of received, reopened and response within timeframe – annual comparison and quarterly averages.

	Q1 22-23	Q2 22-23	Q3 22-23	Q4 22-23	Q1 23-24
Complaints	▲ 20	▲ 24	▼ 18	▲ 31	▼ 12
Concerns	▲ 32	▼ 31	▼ 24	▼ 18	▼ 17
Compliments	▼ 139	▼ 85	▲ 251	▼ 134	▼ 51
FFT Responses	320	▲ 649	▼ 383	▲ 482	▲ 573
Re-opened complaints/concerns	▼ 2	▲ 5	▼ 2	▲ 5	▼ 2
% closed complaints responded to within agreed timescale	▼ 23%	▲ 38%	▲ 45%	▲ 58%	▲ 59%
Complaints closed in this quarter	13	24	29	19	22
Complaints by Division activity (per 1,000)	▼ 0.7 (29,026)	▲ 0.8 (28,414)	▼ 0.6 (29,040)	▲ 1.1 (28,406)	▼ 0.35 (34, 554)
Concerns by Division activity (per 1,000)	▼ 1.1 (29,026)	▶ 1.1 (28,414)	▼ 0.8 (29,040)	▼ 0.6 (28,406)	▼ 0.49 (34, 554)
Compliments by Division activity (per 1,000)	▲ 4.8 (29,026)	▼ 3.0 (28,414)	▲ 8.6 (29,040)	▼ 4.7 (28,406)	▼ 1.45 (34, 554)

Figure 3.7 – Summary of themes for Medicine Complaints and Concerns – Q4 2022/23



31% = Patient Care

21% = related to Communication

14% = related to Values and Behaviours of Staff

For comparison, the top themes common for Q4 were still in relation to **communication, patient care** and **access to treatment and admissions** and **discharge**.

Further breakdown of the top three sub-themes show a new theme in relation to falls (patient care) and insensitive communication was more prevalent than lack of communication (change from Q4). There is a new theme for **staff values and behaviours**, and this is equally split across both medical and nursing staff.

Within these three most prevalent theme(s), the following shows a sub-category breakdown for further context of the themes of these complaints:

Table 3.3a

Patient Care including Nutrition / Hydration	**9**	**31%**
Correct diagnosis not made	1	11%
Delay in making diagnosis	1	11%
Falls	2	22%
Harm	1	11%
Neglect	1	11%

Nursing Care	1	11%
Poor quality of food	1	11%
Unsatisfactory treatment	1	11%

Table 3.3b

Communications	**6**	**21%**
Insensitive communication	4	67%
Lack of communication	2	33%

Table 3.3c

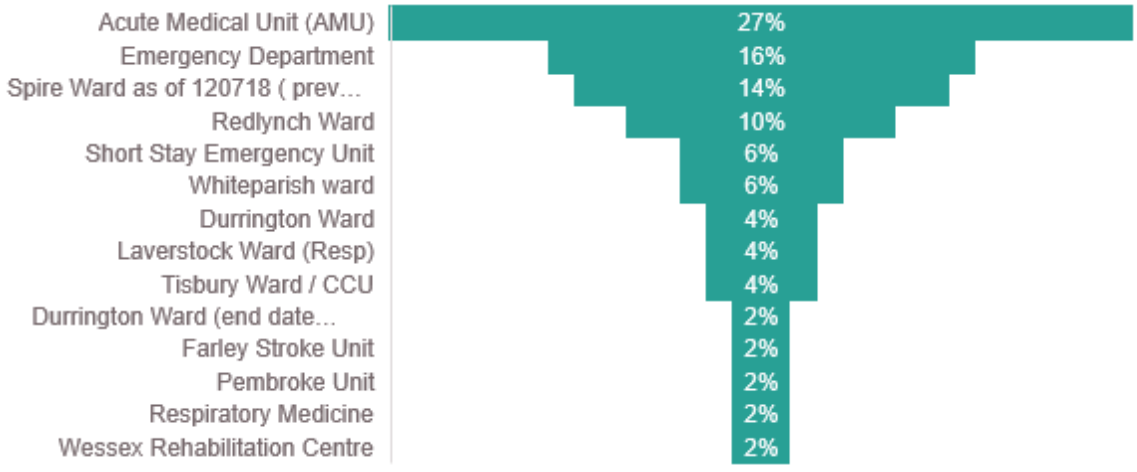
Values and Behaviours of Staff	**4**	**14%**
Attitude of nursing staff	2	50%
Attitude of staff - medical	2	50%

Compliments - Medicine

There was a total of 51 compliments logged for Medicine on Datix for Q1, this was noted to be lower than previous quarters and more work within the Division to ensure that compliments are sent to PALS is likely to be the cause of this.

Figure 3.8 shows a breakdown of where the compliments were received:

Figure 3.8 – Medicine Compliments breakdown



AMU have the most compliments logged on Datix this quarter, this breakdown is new for this quarters reporting and will be used to help determine which areas might need more reminding about submitting their compliments to PALS.

Figure 3.9 shows correlation of number of complaints, concerns and compliments by patient activity for Medicine.

Fig 3.9 Activity compared with Complaints, Concerns and compliments

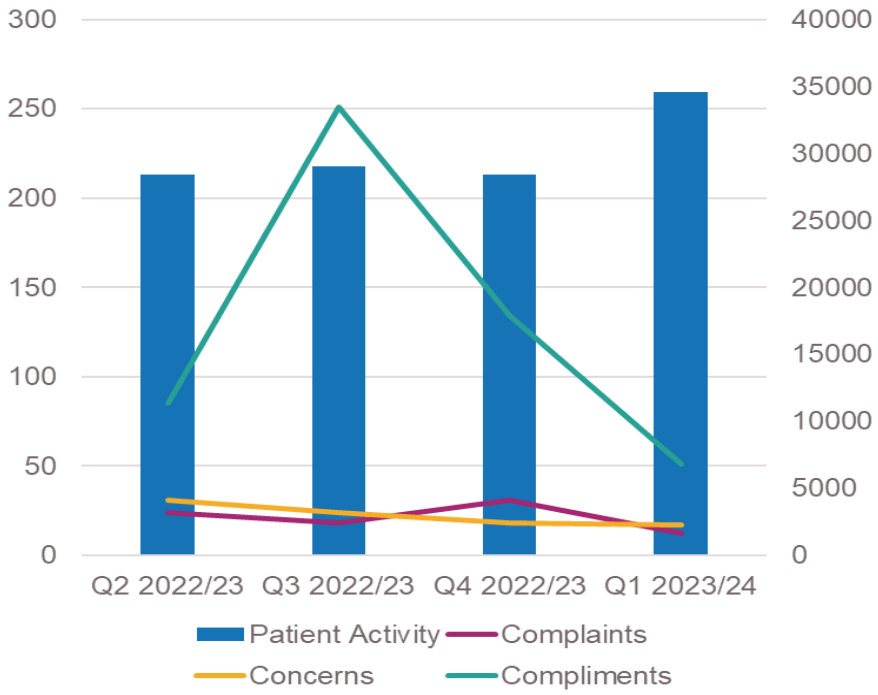


Figure 3.9 is demonstrating an overall decline in the number of recorded complaints and concerns, despite increases in patient activity.

Complaints numbers have decreased bon Q4.

This division has been actively engaged since in trialling new processes and department leads have demonstrated commitment to changing the culture of how complaints are managed - adopting the PHSO principles of early resolution and meaningful apology.

Figure 3.9 shows how the compliments are apportioned (by area). This is new to this reporting and we hope to be able to triangulate this with FFT feedback in due course.

NEW: Response to Report from Divisional Management Team:

Kirsty Bendfield - Interim Head of Nursing, Medicine Division
Sarah Needle - Divisional Director of Operations

Within the division there has been increased focus and scrutiny over complaints/concerns that have come with the content to ensure the appropriate level of investigation is instigated, in relation to allegations against staff.

There is a continued trend in completing in a timely manner and the number of concerns/complaints coming in. The division is actively encouraging more phone calls, meet and great and face to face meetings. There is drive to complete responses quicker and support given to ward teams to provide appropriate responses and investigation timelines to be detailed and effective.

Patients and relatives are gradually being invited to the divisional governance meetings to share experiences and share wider learning and this has already proved helpful and reassuring to family members in their healing process to see the work that the division is doing in response.

Although communication is one of the top three themes this has changed in terms of poor communication to insensitive communication and would be linked to the staff attitudes and behaviours across the medical and nursing staff, this is reflective of the number of allegations against staff that the division has seen.

Through the learning from incidents forum these concerns are shared with all levels of teams and SIM training is due to take place, acting out scenarios, provoking discussions and understanding the barriers that staff face.

Compliments and friends and family feedback are improving, and work is still required to ensure the ward teams are sharing this with PALS and that this shared in ward areas for reflective learning.

The divisional 48-hour review templates are not routinely filled out and the action plans are not returned. This is an area of improvement for the next quarter.

Surgery

- There were a total of 37 complaints and concerns for Q1, a slight increase on Q4.
- 27 complaints were closed in Q1, 10 more than Q4. However 11% of these were on target compared with 12% in Q4.
- 1 concern1s and 1 complaint1s were reopened this quarter, a significant reduction on previous quarters.
- 62 compliments were logged this quarter.

- Positive downward trajectory on previous quarter
- Negative downward trajectory on previous quarter
- No change on previous quarter
- Positive upward trajectory on previous quarter
- Negative upward trajectory on previous quarter

Table 3.4 Summary of number of received, reopened and response within timeframe – annual comparison and quarterly averages.

	Q2 22-23	Q3 22-23	Q4 22-23	Q1 23-24
Complaints	▲ 25	▲ 26	▼ 17	▲ 18
Concerns	▲ 26	▶ 26	▼ 16	▲ 19
Compliments	▼ 39	▲ 112	▼ 72	▼ 62
FFT Responses	▲ 771	▼ 661	▲ 877	▲ 1,275
Re-opened complaints/concerns	▼ 4	▼ 3	▲ 6	▼ 2
% closed complaints responded to within agreed timescale	▶ 29%	▲ 32%	▼ 12%	▼ 11%
Complaints closed in this quarter	17	19	17	27
Complaints by Division activity (per 1,000)	▲ 0.7 (34,493)	▶ 0.7 (35,374)	▼ 0.5 (35,310)	▼ 0.44 (40,495)
Concerns by Division activity (per 1,000)	▲ 0.8 (34,493)	▼ 0.7 (35,374)	▼ 0.5 (35,310)	▼ 0.47 (40,495)
Compliments by Division activity (per 1,000)	▼ 1.1 (34,242)	▲ 3.2 (35,374)	▼ 2.0 (35,310)	▼ 1.53 (40,495)

Figure 3.10 – Summary of themes for Surgery Complaints and Concerns – Q1 2023/24

38% = related to Patient Care

34% = related to Communications

14% = related to Clinical treatment

For comparison, the top themes common for Q4 22/23 were consistent with above with **Patient Care** and **Communications** featured during that quarter. **Clinical Treatment** is new for Q1.

Within these three most prevalent theme(s), the following shows a sub-category breakdown for further context of the themes of these complaints:

Table 3.4a

Patient Care	**14**	**38%**
Delay in making diagnosis	6	43%
Further complications	3	21%
Unsatisfactory treatment	2	14%
Correct diagnosis not made	1	7%
Inappropriate treatment	1	7%
Ward moves	1	7%

Table 3.4b

Communications	**9**	**34%**
Insensitive communication	3	33%
Information not given to family	2	22%
Wrong information	2	22%
Information not given to patient	1	11%
Lack of communication	1	11%

There was no further sub-categorisation data available for the 5 complaints related to Clinical Treatment.

Compliments – Surgery

There was a total of 62 compliments for Surgery for Q1, this was noted to be slightly lower than last quarter and may indicate that further work could be needed to ensure these are being logged with PALS.

Figure 3.11 shows a breakdown of where the compliments were received:

Figure 3.11 – Surgery Compliments breakdown

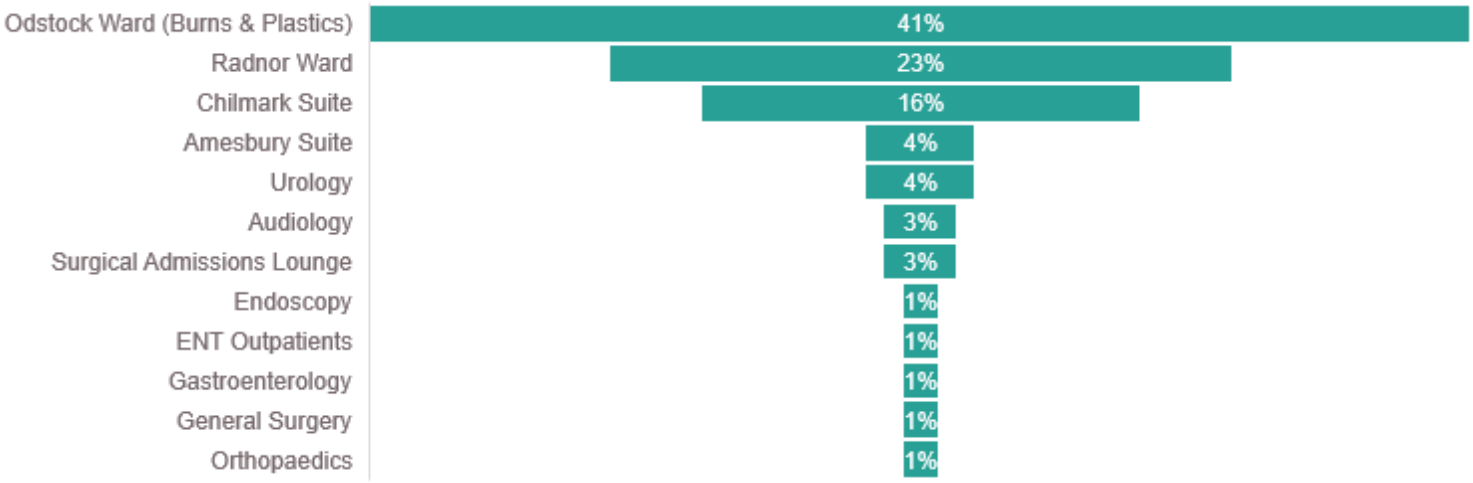


Figure 3.12 shows correlation of number of complaints, concerns and compliments by patient activity for Surgery. Fig 3.12 Activity compared with Complaints, Concerns and compliments

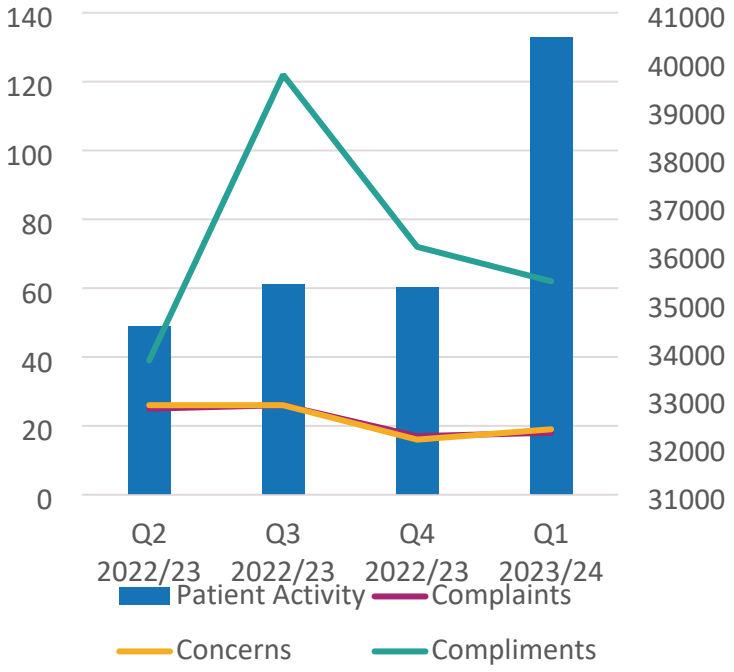


Figure 3.12 is demonstrating an overall decline in the number of recorded complaints and concerns, despite signficant increases in patient activity.

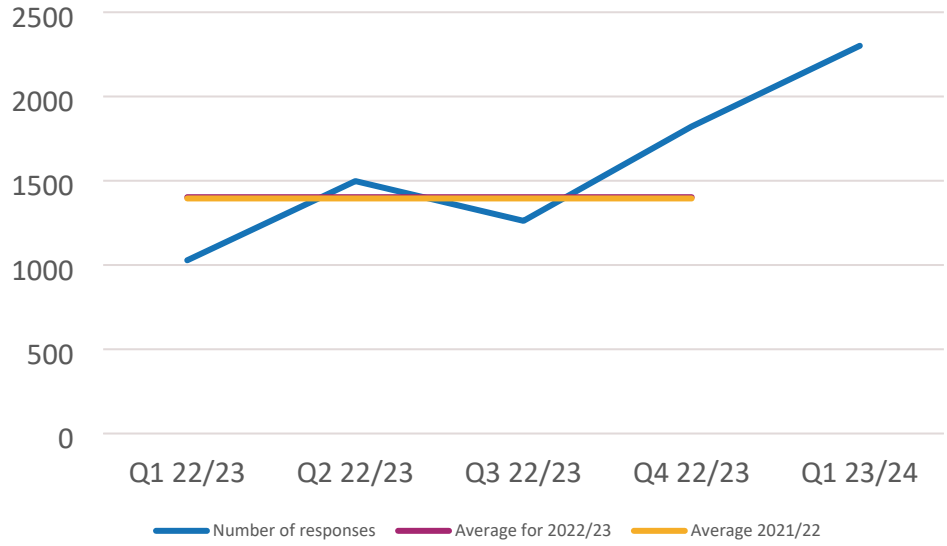
Complaints numbers have increased slightly on Q4, but overall appear to be on a downward trajectory.

This division has been actively engaged in adopting the principles for descalation of complaints and utilising opportunities for earlier resolution. This work will continue with an aim that these approaches will eventually impact on the response with timescale challenges that the Division currently faces.

4. Friends and Family (FFT)

Response Rates

Fig 4.1 Number of FFT responses, broken down by quarter with historic averages



A total of **2,301** patients provided feedback through the paper Friends and Family Test (FFT) in Q1 of 23/24. This continues to be the highest number of responses we have seen to date.

The orange and pink lines show the calculated quarter averages for those time periods.

We are still unable to delve into these data sets without using a time consuming and subjective interpretation of the comments to produce any reliable theming. This was a Board decision to delay rollout of the digital system until December 2023, however the Patient Expereince team have been working closely with the provider to adopt the reporting dashboard early and apply this to data sets from Q1 2022/23. The aim is for the dashboard to be operational by end of Q2 and begin development of the reporting systems, early designs of this are due to be incoprated in the Q2 report pending successful completion of this work.

98% Of those surveyed rated their experience of our hospital as Good or Very Good (average for Q1 2023-24)

3.3%* Response rate (*of eligible population and averaged for Q1 2023-24)

A selection of the comments received from both inpatient and outpatient areas across the Trust can be found in Appendix 4.

The target response rate continues to be significantly below our Improving Together target of >15% of eligible patients for 2023/24, however this is increasing despite the increased patient activity and subsequent elible population. There has also been an increase from 97% to 98% of those surveyed rating their experiences at our hospital as Good or Very Good.

We continue to rely primarily on the use of the FFT cards and this subsequently means that our inpatient areas tend to perform better with response rates compared with outpatients or day cases. This will continue to be a challenge until the full rollout of the digital solution which will include the use of QR codes for online options and targeted SMS messages.

Table 4.1 summarises the response rates in accordance with patient activity.

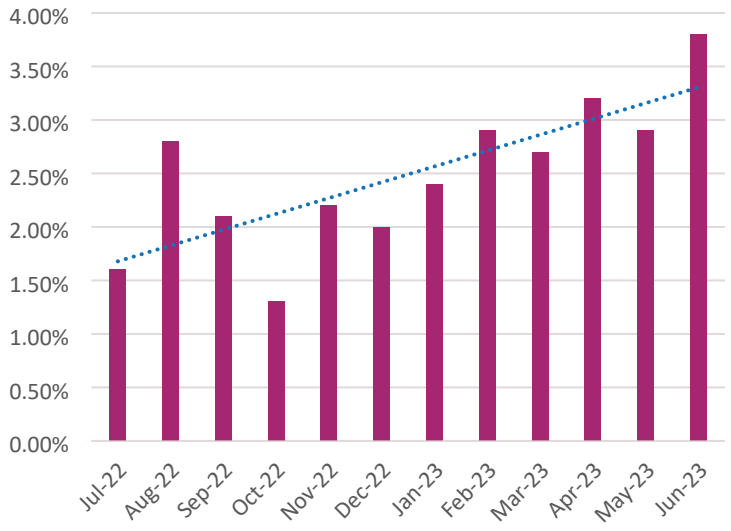
Table 4.1 Response rate across the Trust by per 1,000 patient activity – rolling annual comparison

	Q2 22-23	Q3 22-23	Q4 22-23	Q1 23-24
Across all Directorates	▲ 15.4 (97,212)	▼ 12.5 (101,122)	▲ 17.9 (101,618)	▲ 20.0 (114, 795)

Benchmarking against Improving Together Targets

In April 2023 the Improving Together Targets for the Friends and Family Test increased from 10% of the eligible population to 15% and we recongise this to be a challenge as we go into 2023/24.

Figure 4.1 – Response rate (based on eligible population) – Trust wide



As Figure 4.1 demonstrates - we continue to be far from our **Improving Together** targets as we go into 2023/24.

15%

Response rate target

(2023/24)

However, the response rates continue to be on upward trajectory and this is without any radical changes to the accessibility of the feedback forms.

We continue to regularly promote positive feedback received via FFT through weekly social media plugs under "*#ThankyouThursday*" and "*#FeedbackFriday*" hashtags. Most recent examples below from April to June 2023:

5. Patient and Public Feedback – Local Surveys

Real-Time Feedback

Real-time feedback (RTF) has been sporadic during Q1, this was complicated with technical issues with the Ipads and the availability of volunteers. There were no presentations of RTF to the Patient Expereince Steering Group during this time as a consequence. This will be reinstated for Q2 reporting.

Your Views Matter – Bereavement Survey – Q1 Report Summary

Background The Your Views Matter Bereavement survey was established in 2019 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 thanked 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 teamThis report will be presented to the Patient Experience Steering Group in May 2023 and elements are also included with the quarterly Learning from Deaths Report.

Summary of analysis: Overall, there has been a slight increase in positive experience and subsequent satisfaction ratings that were previously noted in the Q4 report. 70% of those surveyed rated their overall experience as Good or Very Good, compared with 68% last quarter. Poor experience ratings have decreased on last quarter going from 21% down to 15%.

Response rates have decreased slightly from Q4, going down to 31% this quarter from 33% in Q4. However, this response rate is still higher than the average response rate seen for 2022/23 (28%)

3 survey participants requested a call-back from PALS, 2 of these went on to record a formal complaint or concern. This is an increase on what we saw in Q4.

There continues to be negative themes around facilities and appropriateness of the room or ward where someone dies. More robust reporting on this has now commenced to understand where specific improvements are needed. There continued to be a many positive comments in relation to both the bereavement office and medical examiners office this quarter. However, there was a negative theme noted around access to these services out of hours and the use of answer machine facilities. There were no notable correlations with complaint themes this quarter.

The report includes a response to these findings from the End of Life Care leadership team.

Extracts from this report will be presented at the Mortality Surveillance Group on the 12th September and the full report will be presented to the End of Life Steering Group on the same day. The Patient Experience Steering Group will be presented with this report on the 27th September.

Full report can be found in Appendix 5.

6. Patient and Public Feedback – National Surveys

Urgent & Emergency Care 2022

The results from the Urgent and Emergency Care due to be released by CQC in July 2023.

Response rate was 33% and a total of 397 responses were received.

Summary of findings:

- Scoring better than other Trusts in 19 questions
- Scoring the same as other Trusts in 18 questions
- There were no questions where the Trust scored worse than other Trusts.

Key comparisons from the 2020 survey were that the overall experience rating had *reduced* from 85% in 2020 to 80.2%.

Areas in which the Trust had made improvements since 2020:

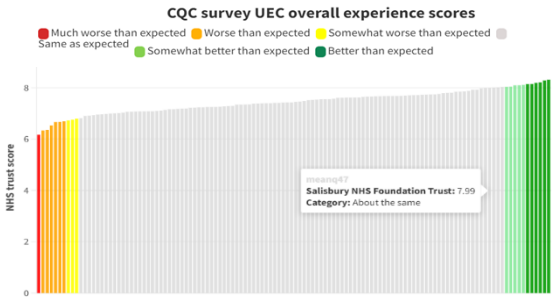
- ✓ Availability of suitable food and drinks was an area of declining experience noted in 2020 – this has seen notable improvement for 2022.
- ✓ Opportunities to discuss what needs may be required, on leaving ED
- ✓ Care and support availability once left ED
- ✓ Feeling that staff listened to what they had to say
- ✓ Given opportunities to discuss anxieties and concerns with nurses and doctors
- ✓ Quality of information given on treatment or condition and communication on symptoms to watch out for
- ✓ Fewer experiences of patients experiencing differing opinions or instructions from health professionals

Areas that have declined and may require further work:

- × Privacy when discussing condition
- × Wait time before first medical contact and first examination
- × Help with condition and symptoms (during wait) and pain control
- × Overall length of visit to ED
- × Cleanliness of the area
- × Communication around side effects of medication
- × Communication related to transport from ED

The BMJ published a report from the CQC benchmarking all Trusts. Data from the CQC survey of more than 36,000 people who used urgent and emergency care services in September 2022 shows a total of 10 trusts who performed poorly on patients' overall experience.

SFT was noted to have ranked in the higher quadrant of "same as expected" under this same data set (see below).



CQC names worst trusts for experience in A&E | News | Health Service Journal (hsj.co.uk) (note: article requires subscription to access)

Full report can be found in Appendix 6.

Scheduled Reporting of Surveys

National Inpatient Survey 2022 – will be reported in (Q2) 2023

Children and Young People Survey 2023 – will be reported in (TBC) 2024

National Inpatient Survey 2023 – will be reported in (TBC) 2025

APPENDIX 1: Datix Compliments Categories

Care
Compassion
Professionalism
Reassurance
Kindness
Friendly
Exceptional
Positive
Support
Help
Gratitude
Sensitivity
Sympathetic
Outstanding

NHS Salisbury NHS Foundation Trust

APPENDIX 2: Complaints Process Review – Action Plan Progress

Recommendation	Actions taken	Responsibility	By when	Status	Evidence to demonstrate actions have been completed
Disseminate information about the complaints process across all Trust departments and ensure all staff can explain the role of PALS.	PALS Outreach Service	PALS team	Ongoing since August 2022 – make BAU	Complete	Now business as usual, fully embedded with the PALS team. Each member has 3-4 inpatient wards they visit on a recurring 6weekly basis. These visits review complaints, FFT, and general discussions related to patients experiences i.e. lost property etc. (example attached) PALS Outreach Ward Visit Tisbury W Friends and Family Feedback February :
	Regular attendance at DMT meetings	PALS Lead / Head of Patient Experience	Ongoing since August 2022	Complete	Now business as usual, quarterly presentations at all divisional governance meetings (patient experience focus, covering complaints, compliments and FFT) Surgical Governance - Patien W&N - Patient Experience Update 1 CSFS - Patient Experience Update - Medicine DMT - Patient Experience L
	PALS leaflet currently being developed Posters to be designed and audit undertaken as where these need to be located	PALS Lead / Head of Patient Experience	~~March 2023~~ ~~June 2023~~ October 2023	In Progress – near finalisation	Work continues to collate content and also working with external design agency to bring this resources into line with the Trusts new branding . Various reviews now completed, Healthwatch Wiltshire, Patient Readership Group and RNIB for accessibility recommendations. Final artwork scheduled for completion end of August 2023. Final draft now received – planned for approval at PESG September 2023. PALS Complaints, Concerns, Comments

	Opportunities for shadowing PALS enquiries	PALS Lead	Ongoing since November 2022 – make BAU	Complete	Now business as usual, so far 8 staff members have shadowed the PALS team since November 2022. This shadowing has been undertaken by a mixture of clinical and non-clinical colleagues from Radiology, information governance, catering, clinical psychology, and ward clerks. We will continue to facilitate this as part of our business as usual. We have developed a feedback form to help us to continue to maximise the benefit of what staff can get from this exposure
	Staff development – F2 doctor training, B7 development days, Admin Training Collaboration with Mentor4Leaders. Consideration with standard Trust Induction timetable	Head of Patient Experience	January 2023 March 2023 *TBC*	Complete Complete **Not started**	PALS Services - Admin Presentation Consultants Programme - Comm Patient Experience - F2 Core Teaching Pr Patient Experience - Staff Development F
Provide regular updates to complainants and inform them of revised timescales as appropriate.	Weekly meetings between PALS Lead and complaints co-ordinators for escalation and ensure regular communications	PALS Lead and complaints co-ordinators	January 2023	Complete	Cycle of meetings added – format continues to develop with focuses on overdue and complex complaints, escalation and communication/update to complainants
	Review of holding letter timescales. Change to acknowledgement letters to be clearer on timescales, reference numbers and who is overseeing their complaint.	PALS Lead / Head of Patient Experience	January 2023	Complete	Updated acknowledgement letters. Acknowledgement letter 25 working da
Identify potential communication barriers with complainant at first contact.	Record of discussion re-designed to include: Summary of the key points to address	PALS Lead / Head of Patient Experience	January – March 2023 ~~January – March 2023~~	Complete	Updated Record of Discussion template to incorporate 48hour review process – and launched with Divisions. Changes to Complaints Process Division 48-hour Initial Complaints Re Record of discussion v2 Dec 2(

	Introduction of a new standard to response letters which bullet point/summarise actions being taken Embedding cultures for following up closed complaints with "you said, we did".	PALS Lead / Head of Patient Experience	January 2023 March 2023	Complete In Progress	Updated process with Divisions and use of examples.   FW_ Changes to complaint response Example letter.pdf
Continued monitoring	Complaints process feedback, survey to be updated to reflect this project and continued monitoring. Use of survey monkey and SOP for completion will also be drafted.	PALS Lead / Complaints Coordinators	May 2023	Complete	Survey monkey created and draft SOP due to be approved at PESG in May 2023. New feedback survey will be launched with all closed complaints from the 9th May 2023. Presentation of analysis scheduled for CGC in September 2023.
additional support e.g., advocacy services.	Building links with local advocacy services	Patient Experience	Extended to Summer 2023		Talk at team meeting 14th June 2023.
Publicise and celebrate improvements made to services as a direct result of complaints raised e.g., you said, we did.	Review of FFT Boards (location, information etc.) Implementation of new digital provider to allow for insightful analysis of feedback and meaningful triangulation with complaints.	PALS Lead / Head of Patient Experience / Engagement Lead	January – March 2023 ~~April 2023~~ December 2023 October 2023	Complete Not started – hold. In Progress	Orders for new and replacement FFT boards currently underway. Requirements presented to PESG on March 2023.  Bi-Annual FFT Update - PESG Marc Digital provider rollout delayed until December 2023. Interim actions to continue to drive response rates included in the above presentation. Digital dashboard now in place, historic FFT data for Q1 (and Q2 once finalised) is planned to begin development of the theming and analysis of comments in the interim. This is planned to be operational by end of Q2.
	Reporting on outputs and learning from complaints – exploring the use of the actions recording and reporting function on Datix	PALS Lead / Head of Patient Experience	Ongoing	In Progress	Limited with exploration due to changes to Datix being limited as new system is anticipated under the PSIRF project.

Salisbury NHS Foundation Trust

APPENDIX 3 - KPMG Governance, Risk & Compliance Services – Complaints Internal Audit Terms of Reference

SFT 23-24 Patient Complaints ToR FINAl

NHS Salisbury NHS Foundation Trust

APPENDIX 4: Friends and Family Test Comments – Q1 2023/24

Medicine Inpatient Comments Q1


Whiteparish
Staff have been so kind and caring. I would like to commend Chidi and Neethu for how they have been to me and other patients, such good nurses and Gemma the sister who is amazing. It's clear to see why she is sister, a step ahead and totally above and beyond with help and care to patients.
Spire
The staff are all so busy but always have time for you and nothing is too much trouble. Nursing staff or the army of other staff are all brilliant.
Pembroke
Staff are extremely dedicated and professional and amazing at putting you at ease, explaining everything you need to know and what to expect. Saw an incredible amount of the MDT who are skilled to make your stay the best it can be. They take away all the stress and worries you come in with.
Tisbury
All staff are very friendly and very helpful. They show a total amount of respect, consideration and are completely dedicated to the job in hand. They are a credit to their profession

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NHS Foundation Trust

Medicine Outpatient Comments Q1

NHS
Salisbury
NHS Foundation Trust

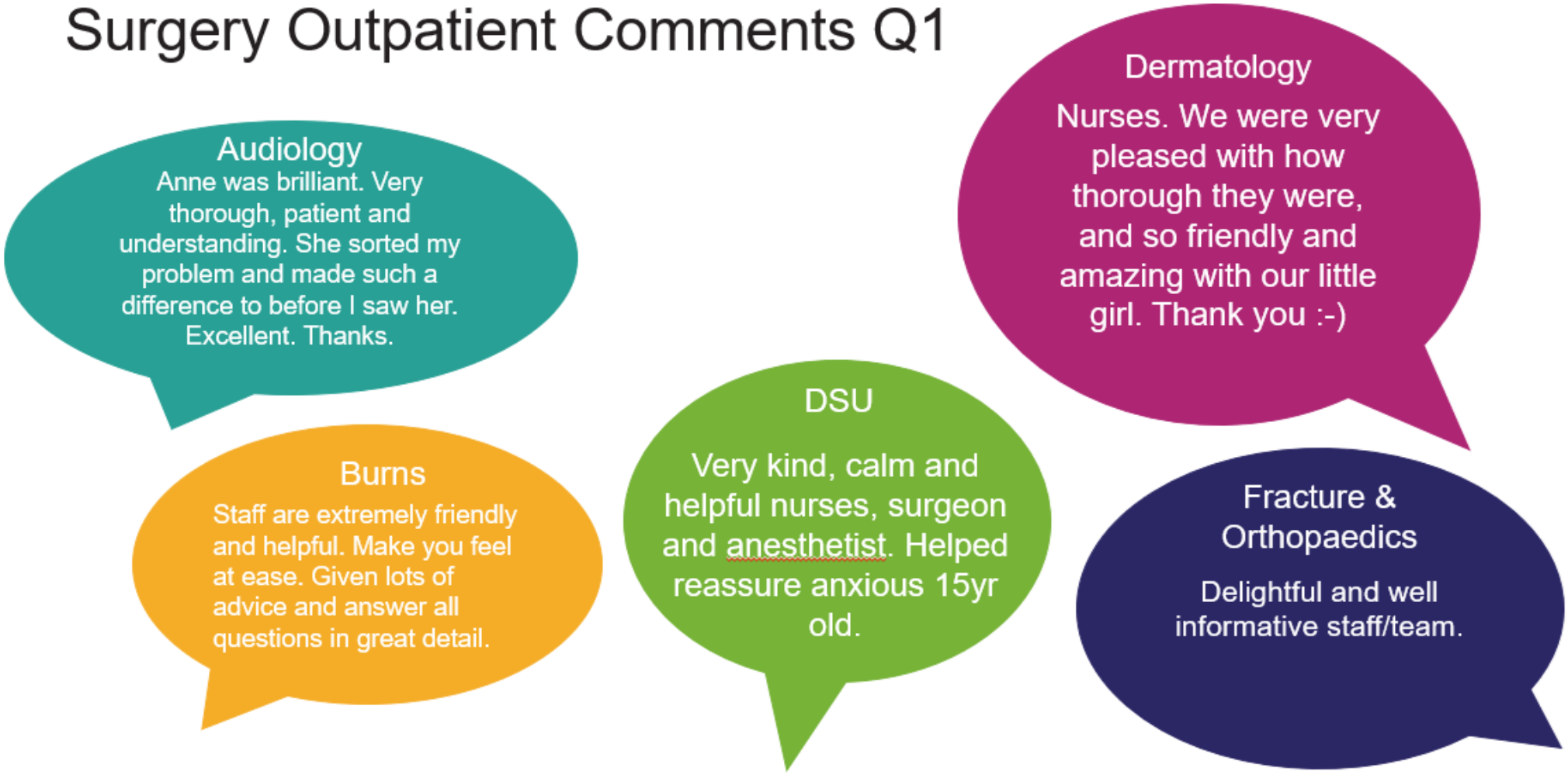
CSFS & W&N Comments Q1

NHS Salisbury NHS Foundation Trust

Surgery Inpatient Comments Q1

NHS
Salisbury
NHS Foundation Trust

Surgery Outpatient Comments Q1




Rheumatology
Prompt delivery of a very professional service by all staff involved. Efficient, speedy, very competent and compassionate. Thank you.
Preoperative
I was not waiting too long. The entire team was ready and we were able to talk over the plans so I know what to do next. It was a friendly team.
Oral Surgery
Professional, informed, compassionate, efficient, kind, humour, skilled. Thank you.
Laser
Excellent! Friendly staff, swift service, ability and willing to answer direct questions. Thank you.
Med/Surg OP
Calm and efficient staff and environment. I felt very much at ease. Thank you all.
Plastic Surgery
Everything was explained really well about my options and everyone was very kind and friendly.
Main Theatres
Everyone here was amazing and friendly - Ashleigh, Dez, John the three of those are very kind and caring.

NHS Salisbury NHS Foundation Trust

APPENDIX 5: Your Views Matter – Bereavement Survey Report – Q1 2023/24

Your Views Matter - Bereavement Survey F

APPENDIX 6: National Urgent & Emergency Care Survey Results (2022) – Results Report

National UEC Survey 2022 - CQC Results v:

Action Plan from HWW survey report – version 5

Recommendation	Actions taken	Responsibility	By when	Status	Evidence to demonstrate actions have been completed
Disseminate information about the complaints process across all Trust departments and ensure all staff can explain the role of PALS.	PALS Outreach Service	PALS team	Ongoing since August 2022 – make BAU	**Complete**	Now business as usual, fully embedded with the PALS team. Each member has 3-4 inpatient wards they visit on a recurring 6weekly basis. These visits review complaints, FFT, and general discussions related to patients experiences i.e. lost property etc. (example attached) PALS Outreach Ward Visit Tisbury W Friends and Family Feedback February 2
	Regular attendance at DMT meetings	PALS Lead / Head of Patient Experience	Ongoing since August 2022	**Complete**	Now business as usual, quarterly presentations at all divisional governance meetings (patient experience focus, covering complaints, compliments and FFT) Surgical Governance - Patien W&N - Patient Experience Update 1 CSFS - Patient Experience Update - Medicine DMT - Patient Experience U
	PALS leaflet currently being developed Posters to be designed and audit undertaken as where these need to be located	PALS Lead / Head of Patient Experience	~~March 2023~~ ~~June 2023~~ October 2023	**In Progress – near finalisation**	Work continues to collate content and also working with external design agency to bring this resources into line with the Trusts new branding . Various reviews now completed, Healthwatch Wiltshire, Patient Readership Group and RNIB for accessibility recommendations. Final artwork scheduled for completion end of August 2023. Final draft now received – planned for approval at PESG September 2023. PALS Complaints, Concerns, Comments

	Opportunities for shadowing PALS enquiries	PALS Lead	Ongoing since November 2022 – make BAU	**Complete**	Now business as usual, so far 8 staff members have shadowed the PALS team since November 2022. This shadowing has been undertaken by a mixture of clinical and non-clinical colleagues from Radiology, information governance, catering, clinical psychology, and ward clerks. We will continue to facilitate this as part of our business as usual. We have developed a feedback form to help us to continue to maximise the benefit of what staff can get from this exposure
	Staff development – F2 doctor training, B7 development days, Admin Training Collaboration with Mentor4Leaders. Consideration with standard Trust Induction timetable	Head of Patient Experience	January 2023 March 2023 *TBC*	**Complete** **Complete** **Not started**	 PALS Services - Admin Presentation  Consultants Programme - Commi  Patient Experience - F2 Core Teaching Pr  Patient Experience - Staff Development F
Provide regular updates to complainants and inform them of revised timescales as appropriate.	Weekly meetings between PALS Lead and complaints co-ordinators for escalation and ensure regular communications	PALS Lead and complaints co-ordinators	January 2023	**Complete**	Cycle of meetings added – format continues to develop with focuses on overdue and complex complaints, escalation and communication/update to complainants
	Review of holding letter timescales. Change to acknowledgement letters to be clearer on timescales, reference numbers and who is overseeing their complaint.	PALS Lead / Head of Patient Experience	January 2023	**Complete**	Updated acknowledgement letters.  Acknowledgement letter 25 working da
Identify potential communication barriers with complainant at first contact.	Record of discussion re-designed to include: Summary of the key points to address	PALS Lead / Head of Patient Experience	January – March 2023 ~~January – March 2023~~	**Complete**	Updated Record of Discussion template to incorporate 48hour review process – and launched with Divisions.  Changes to Complaints Processi  Division 48-hour Initial Complaints Re  Record of discussion v2 Dec 2(

	Accessibility needs i.e. larger font letters or translation services etc.		Extended to Summer 2023 to coincide with other accessibility workstreams	In Progress	Input on the new PALS leaflet has been requested from the RNIB (Royal National Institute for the Blind) to help develop guidance alongside use of the Trusts branding. Successful bid with Cancer Services for health inequalities funds to purchase widget software to expand communications for those with learning disabilities.
	Embedding the 48hr review template to highlight challenges from department/divisions	PALS Lead / Head of Patient Experience	January – March 2023	Complete	As above.
Improve signposting to additional support e.g., advocacy services.	Acknowledgement letters, leaflets amendments Building links with local advocacy services	PALS Lead / Head of Patient Experience	~~January – March 2023~~ Extended to Summer 2023	Complete	Talk from Local Advocacy Services – PALS Team Meeting – February 2023. Talk postponed as speaker is currently unwell. Rescheduled talk date to be confirmed. Talk at team meeting 14th June 2023.
Publicise and celebrate improvements made to services as a direct result of complaints raised e.g., you said, we did.	Review of FFT Boards (location, information etc.) Implementation of new digital provider to allow for insightful analysis of feedback and meaningful triangulation with complaints.	PALS Lead / Head of Patient Experience / Engagement Lead	January – March 2023 ~~April 2023~~ December 2023 October 2023	Complete Not started – hold. In Progress	Orders for new and replacement FFT boards currently underway. Requirements presented to PESG on March 2023. Bi-Annual FFT Update - PESG Marc Digital provider rollout delayed until December 2023. Interim actions to continue to drive response rates included in the above presentation. Digital dashboard now in place, historic FFT data for Q1 (and Q2 once finalised) is planned to begin development of the theming and analysis of comments in the interim. This is planned to be operational by end of Q2.
	Reporting on outputs and learning from complaints – exploring the use of the actions recording and reporting function on Datix	PALS Lead / Head of Patient Experience	Ongoing	In Progress	Limited with exploration due to changes to Datix being limited as new system is anticipated under the PSIRF project.

	Introduction of a new standard to response letters which bullet point/summarise actions being taken Embedding cultures for following up closed complaints with “you said, we did”.	PALS Lead / Head of Patient Experience	January 2023 March 2023	**Complete** **In Progress**	Updated process with Divisions and use of examples. FW_ Changes to complaint response Example letter.pdf
Continued monitoring	Complaints process feedback, survey to be updated to reflect this project and continued monitoring. Use of survey monkey and SOP for completion will also be drafted.	PALS Lead / Complaints Coordinators	May 2023	**Complete**	Survey monkey created and draft SOP due to be approved at PESG in May 2023. New feedback survey will be launched with all closed complaints from the 9th May 2023. Presentation of analysis scheduled for CGC in September 2023.

Terms of Reference: Patient Complaints

Salisbury NHS Foundation Trust

KPMG Governance, Risk & Compliance Services

—

August 2023

Patient Complaints

01

Background

Formal complaints provide an important mechanism by which management can assess the quality of services provided. Effective complaints handling is a foundation of the patient experience and can also provide enhancements to patient safety and clinical effectiveness if lessons are learned and necessary action taken. This review will evaluate the Trust's processes for managing and responding to complaints, including a review of the policy and procedures and sample testing of individual complaints received and associated correspondence, to provide assurance that the Trust's policies are being complied with.

Complaints can span multiple clinical divisions. Therefore, it is important that effective mechanisms are in place for monitoring the response times of complaints and sharing lessons learnt with all areas of the Trust that are affected, and that these lessons are cascaded to the wider Trust where appropriate. We will review governance arrangements surrounding the management and reporting of complaints across the Trust and consider how lessons learnt are captured and shared. We will also review the Trust's approach to complaints management and backlog reduction, looking for process improvement as part of that work.

Scope of internal audit

The scope of this review will include the consideration of:

- Policies and procedures relating to patient complaints and the extent to which they are adhered to in a timely manner in different divisions (Key Risks 1 & 2);
- Analysis of the number of complaints which are re-opened, and how this varies across divisions (Key Risk 3);
- Monitoring and reporting of complaints activity through governance structures (Key Risk 4); and
- How lessons learnt are captured and shared across the Trust (Key Risk 5).

Our Approach

Our work will involve the following activities:

- Meetings with the key staff involved in patient complaints processes;
- Walkthroughs of key patient complaints processes;
- Consideration of alignment of the Trust's policy and procedures with the NHS Complaints Standards and best practice where appropriate;
- Desktop review of documentation supporting the internal controls; and
- Sample testing where appropriate.

The approach will include sample checks to determine whether the key controls are being effectively and consistently operated. In cases where we note controls do not exist, we will raise this as a finding.

An escalation process will be agreed with Management for instances where documentation, meetings or interview note confirmations are not provided in a timely manner.

Out of scope

We will not provide an assessment on the quality of the responses for the complaints sampled. Our work does not provide an absolute assurance that material error, loss or fraud does not exist.

Key risks identified

1	**Policies and procedures** Policies and procedures for patient complaints are not sufficiently documented or communicated to staff which may result in inconsistent and/or inappropriate practices being applied throughout the Trust.

Patient Complaints

Key risks identified

2	**Timeliness of responses** There is no mechanism for identifying complaints at risk of breaching set targets and complaints are not handled with in a timely manner, negatively impacting patient experience.
3	**Re-opened complaints** Patient complaints are not responded to effectively, increasing the workload for staff involved through the re-opening of complaints, and negatively impacting patient experience.
4	**Monitoring and reporting** There is insufficient oversight at a senior level of complaint trends and complaint handling performance, reducing accountability for those involved and impacting the ability for informed decisions to be made.
5	**Lessons Learnt** Emerging themes and lessons learnt from patient complaints are not shared widely across the Trust, preventing learning opportunities.

Anticipated assurance

Management anticipates that this review will be given a 'partial assurance with improvements required' (AMBER-RED) rating, recognising that the control environment is well designed but improvements are likely to be required in the operation of controls across the Trust.

Assistance required

We require assistance to deliver this review on time, in particular we need: prompt agreement of these terms of reference; staff required for interview to ensure their reasonable availability; and access to relevant records.

Key contacts

In order to undertake this work we will require meetings with:

- Judy Dyos, Chief Nursing Officer (Executive Sponsor);
- Angie Ansell, Deputy Chief Nursing Officer;
- Victoria Aldridge, Head of Patient Experience; and
- Sophie Brookes, PALS Lead.

This list is not exhaustive and we may require additional meetings as our work progresses.

Documentation request

We provide below details of documentation we would like to review if available. This list is not exhaustive and if there are other documents that we feel would be useful to review we will request these whilst onsite. Similarly if you feel there are other documents that would assist us which are not listed please provide them.

- Policies and procedures relating to patient complaints;
- Organisation structure;
- Training material provided on complaints processes;
- A list from Datix of all complaints received since 1 January 2023, detailing timestamps for all key actions in the complaint handling process;
- A list from Datix all re-opened complaints since 1 January 2023;
- Relevant papers on patient complaints activity and/or compliance that have been reported to Board/Sub-Committees/Executive in the last 12 months; and
- Evidence to demonstrate the capturing and sharing of lessons learnt from complaints in the last 12 months.

Patient Complaints

Outputs

We will present our findings in a report. The report will be agreed with Judy Dyos, as the Executive sponsor for this review, before it is presented to the Audit Committee for approval.

Timetable

The timetable for this review is shown below

Due date	Task	Responsibility	
		SFT	KPMG
August 2023	Prepare and agree terms of reference	✓	✓
Fieldwork			
06 September 2023	Start fieldwork	✓	✓
19 September 2023	Complete fieldwork		✓
22 September 2023	Closure meeting	✓	✓
Reporting			
06 October 2023	Issue draft report		✓
20 October 2023	Provide management responses	✓	
27 October 2023	Final report issued		✓
14 December 2023	Presentation to Audit Committee		✓

Resourcing

This review forms part of our 2023/24 internal audit plan. Staff will be drawn from your core audit team as follows

Name	Position
Neil Thomas	Partner
Tiffany Irwin	Manager
Kallie Beasley	Internal Auditor

kpmg.com/uk

This terms of reference is provided pursuant to the terms of our engagement letter dated April 2023. Nothing in this report constitutes a valuation or legal advice. We have not verified the reliability or accuracy of any information obtained in the course of our work, other than in the limited circumstances set out in our engagement letter. This report is for the sole benefit of Salisbury NHS Foundation Trust. In preparing this report we have not taken into account the interests, needs or circumstances of anyone apart from the Trust, even though we may have been aware that others might read this report. This report is not suitable to be relied on by any party wishing to acquire rights against KPMG LLP (other than Salisbury NHS Foundation Trust) for any purpose or in any context. Any party other than the Trust that obtains access to this report or a copy (under the Freedom of Information Act 2000, the Freedom of Information (Scotland) Act 2002, through the Trust's Publication Scheme or otherwise) and chooses to rely on this report (or any part of it) does so at its own risk. To the fullest extent permitted by law, KPMG LLP does not assume any responsibility and will not accept any liability in respect of this report to any party other than the Trust. Any disclosure of this report beyond what is permitted under our engagement letter may prejudice substantially our commercial interests. A request for our consent to any such wider disclosure may result in our agreement to these disclosure restrictions being lifted in part. If Salisbury NHS Foundation Trust receives a request for disclosure of the product of our work or this report under the Freedom of Information Act 2000 or the Freedom of Information (Scotland) Act 2002, having regard to these actionable disclosure restrictions the Trust should let us know and should not make a disclosure in response to any such request without first consulting KPMG LLP and taking into account any representations that KPMG LLP might make.

This report has been prepared solely for Salisbury NHS Foundation Trust in accordance with the terms and conditions set out in our engagement letter dated April 2023. We do not accept or assume any liability or duty of care for any other purpose or to any other party. This report should not be disclosed to any third party, quoted or referred to without our prior written consent.

Friends and Family Feedback
Medicine Inpatient Comments Q1

NHS Salisbury NHS Foundation Trust

AMU

Compassionate, polite, respectful, good communication, professional, well informed, calm and caring.

ED

Neil's communication and compassion skills outstanding. He treated the patient not the ailment. Tiana was professional and caring plus a wonderful communicator. Brilliant!!

Farley

Staff very attentive, knowledgeable and friendly. Nothing ever too much trouble. Comfortable, clean, generally nice ward and staff. Meals super and always hot :-)

Breamore

All the staff were so nice and helpful which made my stay so much more pleasant. Also the food was excellent.

Durrington

Had every available attention given to me from start to finish. Nurse's Evans, Armstrong and Muma, as the saying goes, "worked their socks off" Nothing was too much trouble.

Laverstock

Felt safe that the NCAs were knowledgeable. Felt listened to and cared for. The food was of a good standard. The therapists were positive, supportive and encouraging. The specialist nurses made a huge difference. Access to parish priest was essential and comforting

Friends and Family Feedback
Medicine Inpatient Comments Q1

NHS Salisbury NHS Foundation Trust

Whiteparish

Staff have been so kind and caring. I would like to commend Chidi and Neethu for how they have been to me and other patients, such good nurses and Gemma the sister who is amazing. It's clear to see why she is sister, a step ahead and totally above and beyond with help and care to patients.

Spire

The staff are all so busy but always have time for you and nothing is too much trouble. Nursing staff or the army of other staff are all brilliant.

Pembroke

Staff are extremely dedicated and professional and amazing at putting you at ease, explaining everything you need to know and what to expect. Saw an incredible amount of the MDT who are skilled to make your stay the best it can be. They take away all the stress and worries you come in with.

Tisbury

All staff are very friendly and very helpful. They show a total amount of respect, consideration and are completely dedicated to the job in hand. They are a credit to their profession

Friends and Family Feedback
Medicine Outpatient Comments Q1

Salisbury NHS Foundation Trust

Outstanding rehab program. Very professional and friendly staff Knowledgeable and helpful. Great venue. Recommend for all cardio patients

My appointment was conducted by kind friendly staff. They helped with my disability and explained procedures

Please don't change. The calm relaxed approach is excellent. Approachable staff is excellent. Thank you

I was seen on time. Everyone, receptionist, HCAs, consultant and especially nurses were polite, friendly and efficient

Friends and Family Feedback
CSFS & W&N Comments Q1

NHS Salisbury NHS Foundation Trust

Sarum

All staff were very polite and attentive. Kept usefully informed throughout and really cared. Best care anyone could ask for! Thank you.

Wessex Rehab

Team really invest in the individual, both in emotional and physical support. Very friendly and just a fantastic team.

Postnatal

No comments available

Labour

No comments available

DSU

All the staff were very helpful and kind. Nothing was too much trouble and they really listened to any concerns etc. Can not fault the wonderful supportive and friendly atmosphere. Thank you to all involved.

Patient Centred & Safe | Professional | Responsive | Friendly | Progessive

Surgery Inpatient Comments Q1

Salisbury NHS Foundation Trust

Amesbury

The nurses had enough time for my well being and with the help of them I am feeling very good now.

Chilmark

Exceptional care from cleaning staff to the operating team. You have given what is beyond what is required of you. I am deeply grateful and thankful.

Britford

All staff incredible, caring and proactive. Made my unexpected stay feel safe and in amazing hands. Thanks so much :-)

Downton

Very clued up on my complex care needs. All the staff were delightful, professional and caring.

Odstock

All the staff were amazing and so kind. Happy to answer all questions.

Surgery Outpatient Comments Q1

NHS Salisbury NHS Foundation Trust

Audiology

Anne was brilliant. Very thorough, patient and understanding. She sorted my problem and made such a difference to before I saw her. Excellent. Thanks.

Dermatology

Nurses. We were very pleased with how thorough they were, and so friendly and amazing with our little girl. Thank you :-)

Burns

Staff are extremely friendly and helpful. Make you feel at ease. Given lots of advice and answer all questions in great detail.

DSU

Very kind, calm and helpful nurses, surgeon and anesthetist. Helped reassure anxious 15yr old.

Fracture & Orthopaedics

Delightful and well informative staff/team.

Rheumatology

Prompt delivery of a very professional service by all staff involved. Efficient, speedy, very competent and compassionate. Thank you.

Preoperative

I was not waiting too long. The entire team was ready and we were able to talk over the plans so I know what to do next. It was a friendly team.

Oral Surgery

Professional, informed, compassionate, efficient, kind, humour, skilled. Thank you.

Laser

Excellent! Friendly staff, swift service, ability and willing to answer direct questions. Thank you.

Med/Surg OP

Calm and efficient staff and environment. I felt very much at ease. Thank you all.

Plastic Surgery

Everything was explained really well about my options and everyone was very kind and friendly.

Main Theatres

Everyone here was amazing and friendly - Ashleigh, Dez, John the three of those are very kind and caring.

Report to:	End of Life Care Steering Group	**Agenda item:**	TBC
Date of Meeting:	12 September 2023		

Report Title:	**Q1 2023/24 Your Views Matter – Bereavement Survey Report**			
Status:	**Information**	**Discussion**	**Assurance**	**Approval**
	x	x	x	
Approval Process (where has this paper been reviewed and approved)	Mortality Surveillance Group (12th September 2023) - (extract included in Learning from Deaths Report)			
Prepared by:	Victoria Aldridge - Head of Patient Experience Emma Gravestock – End of Life Care Lead			
Executive Sponsor (presenting):	Angie Ansell – Deputy CNO			
Appendices (list if applicable):	None.			

Recommendation:
This report is asked to be noted by the steering group and feedback on the contents and focuses of the report. For note - elements of this report are extracted for inclusion within the quarterly Learning from Deaths Report, presented to the Mortality Surveillance Group.

Executive Summary:
Overall, there has been a slight increase in overall experience and subsequent satisfaction ratings previously noted in the Q4 report. 70% of those surveyed rated their overall experience as Good or Very Good, compared with 68% last quarter. Poor experience ratings have decreased on last quarter going from 21% down to 15%. Response rates have noted to have decreased slightly from Q4, going down to 31% this quarter from 33% in Q4. However, this response rate is still higher than the average response rate seen for 2022/23 (28%) 3 survey participants requested a call-back from PALS, 2 of these went on to record a formal complaint or concern. This is an increase on what we saw in Q4. There continues to be negative themes around facilities and appropriateness of the room or ward where someone dies. More robust reporting on this has now commenced to understand where specific improvements are needed. There continued to be a many positive comments in relation to both the bereavement office and medical examiner's office this quarter. However, there was a negative theme noted around access to these services out of hours and use of answer machine facilities. There were no notable correlations with complaint themes this quarter.

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) -	☐

Your Views Matter (Bereavement Survey) Analysis
Q1 2023/24

Background

The Your Views Matter Bereavement survey was established in 2019 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 thanked 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.

Metric Data

During Q1 of 2023-24 the Trust saw 221 deaths (68 less than Q4 22/23), of which 48% (n~105), were sent a bereavement survey after follow-up with the Medical Examiner's Office. This is the noted to be a significant increase on the % of surveys sent in Q4 (29%). In 2022/23, on average 41% of bereaved families were sent the YMV survey.

Response rate for Q1 is down on Q4 but still higher than the average response rate for 2022/23. We are currently reviewing the time interval and process for sending out these forms to understand if this may be a factor in the return rate. Its acknowledged that return rates may be affected as surveys are sent to families within a week of their loved ones death. For many this will be a very difficult time as they are also likely to be sorting affairs and making funeral preparations.

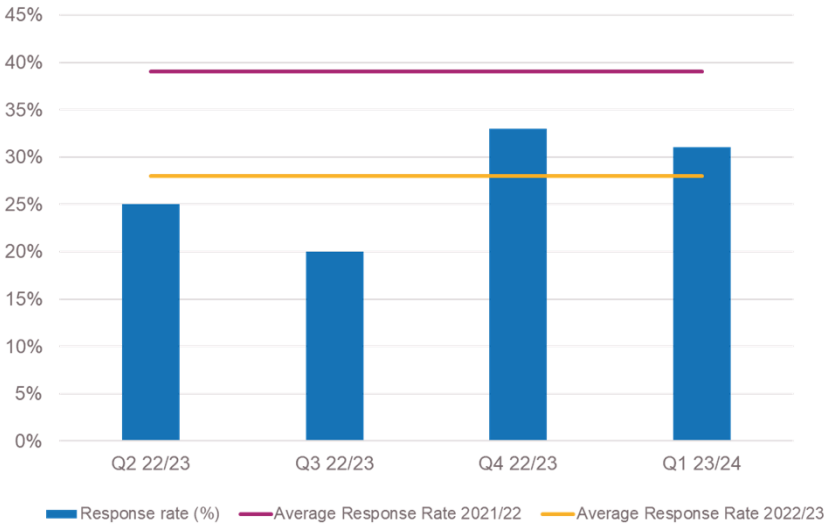


Figure 1.1 Response rates

In Q1 **70%** of those surveyed rated their overall experiences with end of life care as **good/very good**. This is an increase on Q4, and consistent with the annual average for 2022/23.

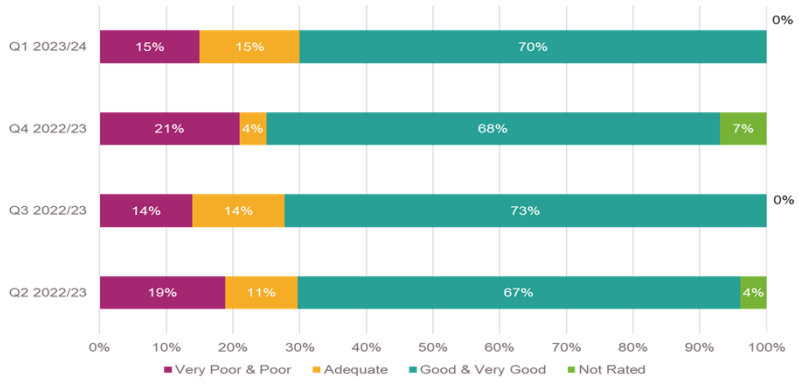


Figure 1.2 Satisfaction rating

However, this remains lower than the average 2021/22 where this was 79%.

15% rated their overall experience as **poor/very poor**, this is lower than we saw in Q4 and higher than the annual average for2022/23 which was 13%, it is also an increase on the average 2021/22, where this was 10%.

Insights and Analysis

70% of those surveyed rated their experience as **good or very good** (n~23).

Of those who rated their experience as good or very good – the following further breakdowns are noted:

- **17/23** felt that on reflection the hospital was the right place for your loved one to be [noted that the remaining 6 left this answer blank]
- **14** out of the **17** who felt hospital was the right place for their loved also felt that the room in which they spent their last days or hours was appropriate
- **18/23** said that if they had any questions or concerns that they able to talk to someone about their loved one's care. The remaining **5** noted this question as not applicable.
- **12/23** received support from the chaplaincy services. These services were rated as either good or very good – [noted that 3 left this blank].
- **1** requested further contact by PALS, this was in relation to missing property

Figure 1.2a Satisfaction rating ward breakdown (Good/Very Good)

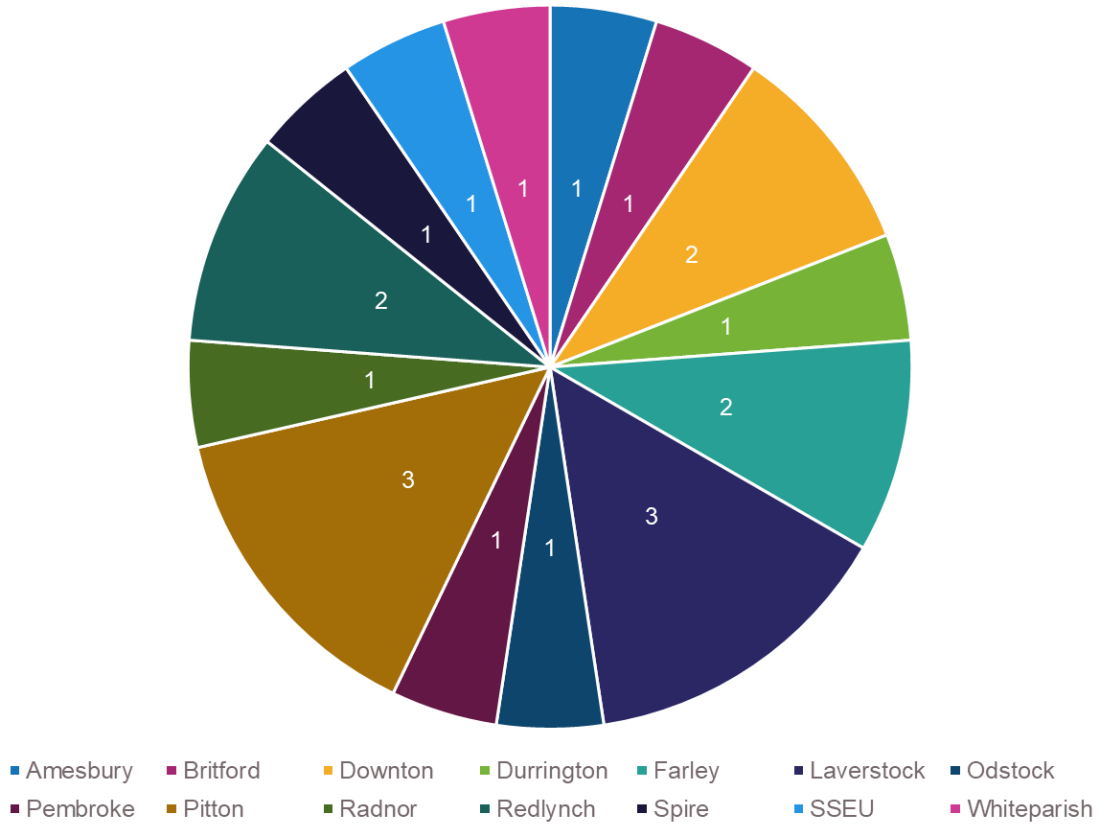
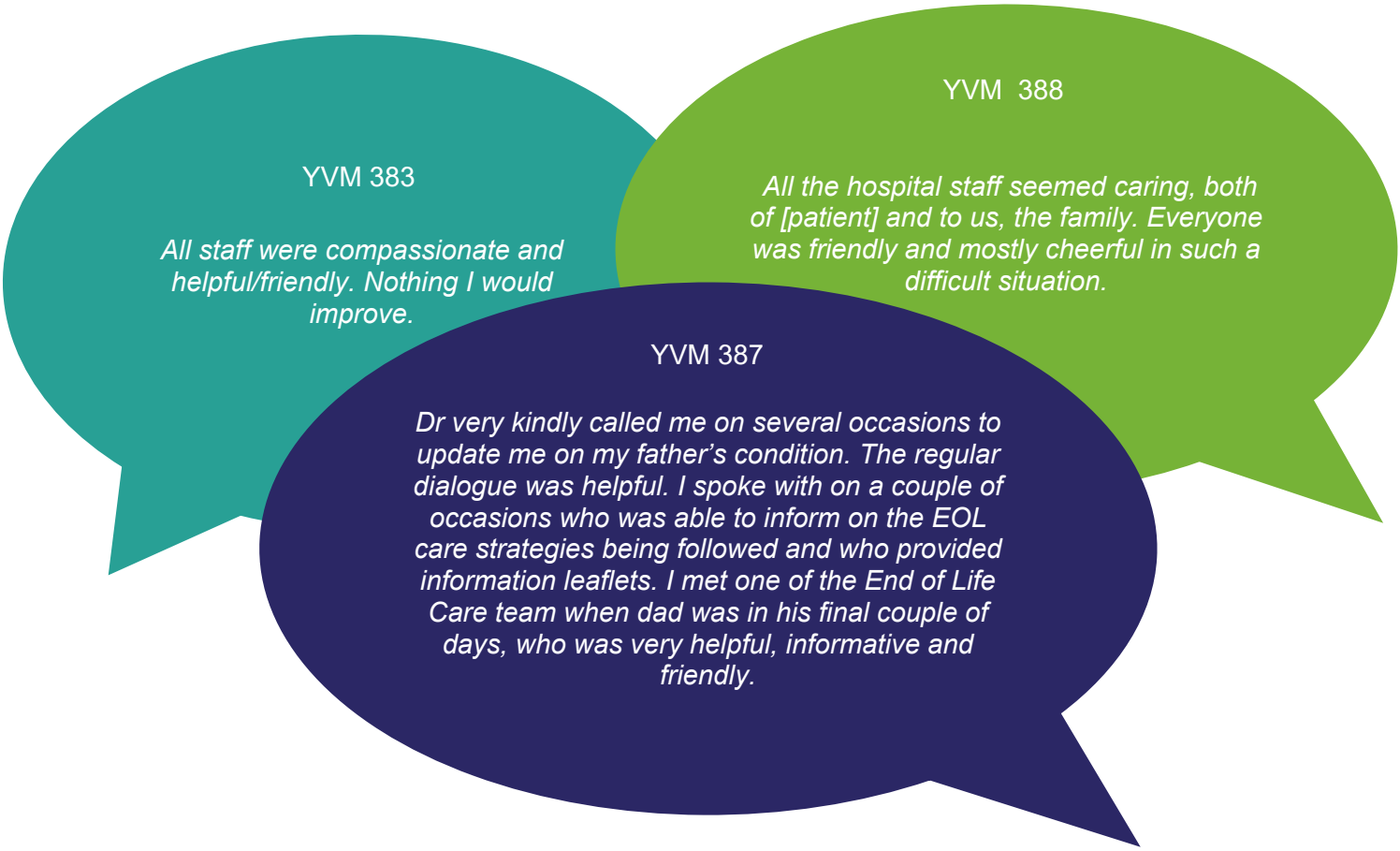


Figure 1.2a shows the satisfaction rating (good/very good) by ward area. Laverstock and Pitton are noted to have higher proportions of these positive ratings.

Below are some of the comments taken from the surveys who rated their experiences as good or very good:



15% of those surveyed rated their experience as **poor or very poor** (n~5).

Of those who rated their experience as poor – the following further breakdowns are noted:

- **3/5** either did not have an advanced care plan in place.
- **2/5** had an advanced care plan in place, but **1** did not know whether this was taken into account when their loved one was admitted and the other left this response blank.
- **4/5** felt that the hospital was not the right place for their loved one to be
- **3/5** did not feel that the room/ward in which they spent their last days or hours was appropriate.
- **1/5** received support from the hospital chaplaincy team in the days before or after their loved ones death. This was rated as Good. [noted that the remaining 4 left this answer blank]
- **1/5** didn't feel able to talk to someone about further questions they had [noted that the 1 left this answer blank]
- **2/5** requested further contact by PALS, **both** has since raised a concern/complaint. There are no noted commonalities with complaint theme or location for these two complaints.

Figure 1.2b Satisfaction rating ward breakdown (poor/very poor)

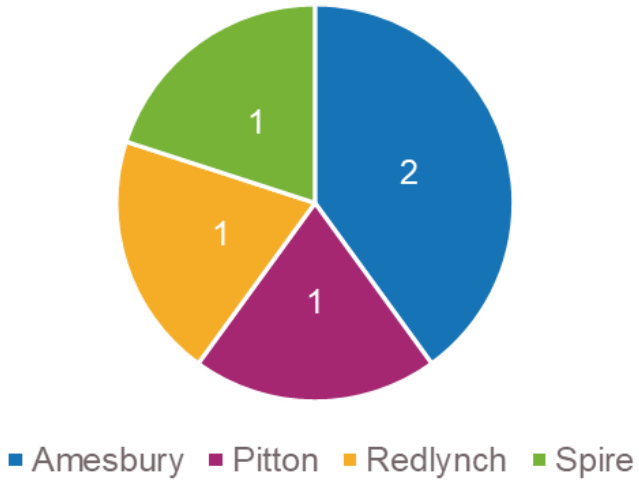


Figure 1.2b shows the wards where there was an overall rating of poor or very poor recorded for Q1. Amesbury hard marginally higher negative ratings that the other 3 wards.

During Q1 there were a total of 10 recorded complaint/concern across the same period.
Only one of these were directly related to death or end of life care (Spire).

The breakdown and themes from these are detailed in Table 1.1 below.

Table 1.1 summarises complaints/concerns logged by PALS during Q1 where the location is the same as those wards in Figure 1.2b. For context, these concerns were not related to end-of-life care necessarily and this is being tested as another means by which to triangulate our feedback to see if there were any common themes related which may be relatable to the bereavement survey experiences. No clear correlations this quarter and specially, Amesbury were noted to have had no complaints or concerns raised during this quarter.

Table 1.1 Summary of complaints/concerns for Q1 by ward

Ward	Number of complaints/concerns	Summary of themes
Spire	5	Hydration, ward moves, deterioration, death and poor EOLC
Redlynch	3	Falls, discharge, staffing challenges
Pitton	2	Deterioration, poor communication, patient care (treatment, supervision)
Total		**10**

Below are some of the comments taken from the surveys who rated their experiences as poor or very poor:

YVM 366

I felt there was very little care or support. A 90-year-old who suffered a catastrophic fall by clung on for nearly 3weeks – he deserved better. We haven't even been given his nightshirt back. He was just left in an old hospital gown.

YVM 376

Be clear don't shy away. Don't try and give hope when there really is little or none. Don't try and fix someone who is old and worn out and more than ready to go. It is not kind or compassionate. Listen to the family, they know the patient too.

Figures 1.3 to 1.6 show the overall ratings in the key areas of patient experience:

- Relief of symptoms
- Communication
- Compassion and Dignity
- Support for loved ones

All four areas have a significant proportion of the overall good/very good rating. Relief of symptoms are noted received more poor ratings overall when compared with Q4. Communication still remains good, with less responses rating this as poor. Compassion and dignity still remains consistent with ratings since in Q4, whilst support for loved ones is overall improved. June saw the highest peak of very good rating, in all four areas.

Figure 1.3 Relief of Symptoms

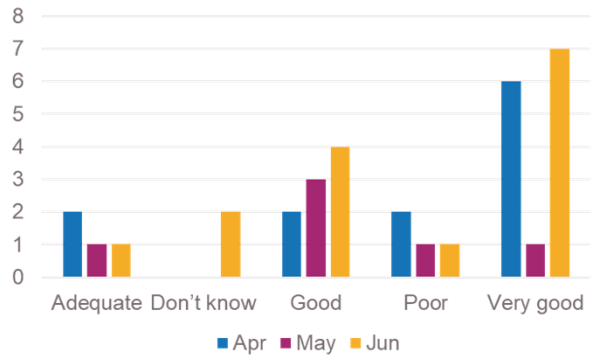


Figure 1.4 Communication

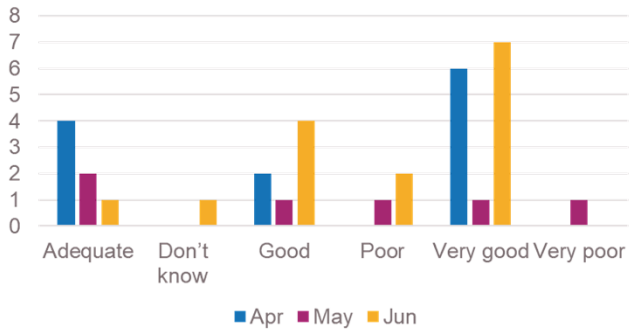


Figure 1.5 Compassion and dignity

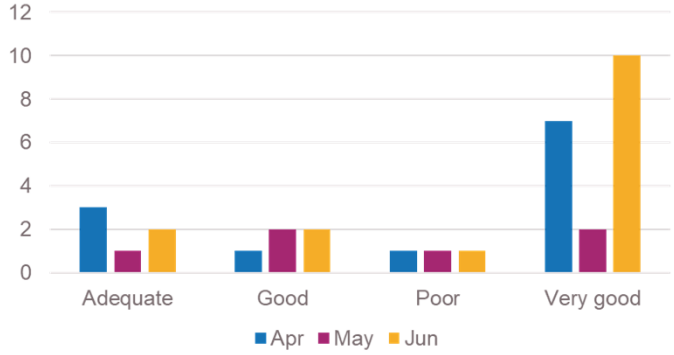
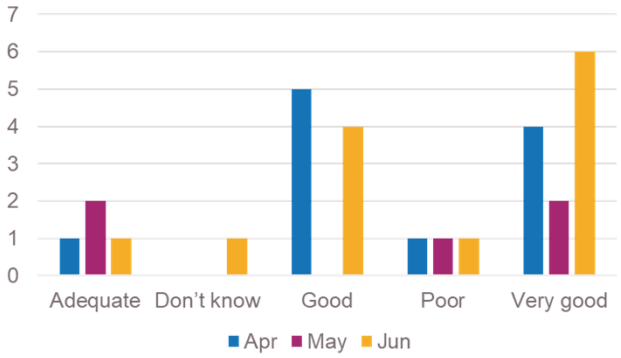


Figure 1.6 Support for loved ones



Medical Examiners Office and Bereavement Office

In Q4, several comments were made in relation to the experiences with the bereavement office and medical examiner's office. None of these comments were negative.

There was a total of 27 individual comments related to these areas and positive comments largely continued into Q1 (see Figures 1.7a & b).

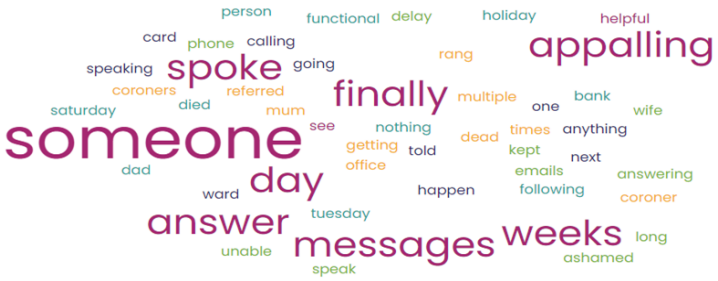
These are depicted on the word cloud opposite. The size of the word indicates how many times this word was used within these comments:

Figure 1.7a Comments on Medical Examiner's Office

Figure 1.7b Comments on Bereavement Office

However, there was a total of 8 negative comments made, themes noted around access to both of these offices out of hours and poor experiences associated with initial contact being through answer machines (depiction of most prevalent words used in the negative comments are show in Fig 1.7c)

Figure 1.7c Negative comments made on both the Bereavement Office and Medical Examiner's Office.



Correlation with Complaints:

In Q1 there were no clear correlations to be drawn from the complaints made in relation to end of life care. Two complaints in total were received. these were from different Divisions and themes were different. One of these complaints involved a patient with a learning disability. The other complaint was themed as poor communication as loved one was not contacted in time and patient subsequently died alone.

Other noted themes

It was noted that there were quite a few surveys returned that were not fully completed where these would have been expected to be. This is a new theme for these surveys, not previously

noted since reporting began at the beginning of 2022/23. This has raised some questions about the length (whether all these questions continue to be valid) and timing of the survey. The Patient Engagement and EOLC teams are now reviewing the survey to consider if this may need to be condensed and also whether the time interval between death and receiving the survey could be a factor in both the full completion and also the response rate.

In Q4 of 2022/23 there were a total of 6 comments made in relation to the room where their loved one died, these comments all referenced the lack of privacy and dignity of both the patient and the grieving families.

This quarter we continue to see this theme, but numbers have doubled. There were a total of 12 comments in relation to facilities, this was in response to the question “was the room/ward in which they spent their last days or hours appropriate?”. 2 of these comments were positive and 3 were neutral and 7 were negative.

As this theme continues to reoccur each quarter, The Patient Experience Team responsible for collating these surveys will now be collecting data in relation to facilities formally in an attempt to identify where approvements are most needed and can be made.

Next steps and response from End of Life Care Lead:

The quality of EOLC received for the dying person can have a profound effect on their loved one/s and could affect their bereavement process. Therefore, we value every survey response and carefully analyse each one to help us gain insight to ensure lessons are learned and good practice is shared. This can be instrumental to continuing to make improvements in care at the EOL, “*we only have one chance to get it right*.”

We recognise the significant value of feedback and should be pleased with receiving 70% of those surveyed rated their overall experience as Good or Very Good. The report response rates have noted a slight decline from Q4, going down to 31% this quarter from 33% in Q4. However, this response rate is still higher than the average response rate seen for 2022/23 (28%) which is positive. In response to this, the aim is to increase the response rate, currently, the bereavement service is asking for the NOK address when they make their initial phone call. Unfortunately, the bereavement service cannot obtain an address for 100% of the deceased patients due to how busy the service is. Therefore, the EOLC team has added the deceased patient's NOK address to the Nurses Record of Death form, the bereavement service can then send out the bereavement information and the survey to everyone.
For future discussions, we have acknowledged the timing of sending out the survey potentially is too early, and the survey could be too lengthy which could be contributing to the low response rate of return and full completion of the survey. This will be revisited later. Data will continue to be checked monthly.

Poor experience ratings have decreased in the last quarter going from 21% down to 15%, this is positive, however in response to the 15% of complaints/concerns an action plan has been started focusing on the following areas: Advance Care Planning (ACP), poor communication,

facilities, and EOLC for someone who has Learning difficulties, we have also acknowledged a reduced number of patients who have had support from our Chaplaincy service.
Education is the core foundation to build an effective, well-equipped workforce to have the tools and competence to care for someone who is dying. Having a well-established EOLC education program available for everyone who works in the Trust is imperative and will reduce complaints in the identified areas. Working collaboratively with the EOLC Clinical lead (Palliative Consultant) the aim is to capture the right education needs for all healthcare professionals. There is already a strong education program in place for Junior doctors, however, further education is needed on identifying the uncertainty/deteriorating/dying patient and better communication around this.
Documentation on ACP requires improvement and better-completed Respect forms as well as documentation of a patient's preferred place of care and death. The EOLC Lead Nurse will work closely with specialist palliative doctor who has a specialist interest in ACP to improve this within the Trust.
As we continue to learn from the survey feedback to improve our practice, using feedback quotes that have been anonymised to remain confidentiality, is a powerful teaching method to get the point across and we plan to use them in future reports.
The EOLC Lead Nurse has had discussions with the education department, and we plan to develop an online EOLC teaching program for nurses on MLE, this will be three yearly mandatory training, and there will also be an online program for the preceptorship nurses. The EOLC Lead nurse has liaised with other regional Trusts to explore their online education packages, to share learning and to align EOLC education. EOLC link nurses for every ward will be re-introduced to provide representation for their wards. Study days will be arranged by the EOLC team to enable the EOLC link nurses to cascade information back to the wards.
The well-attended Communication Course will hopefully continue indefinitely, there has been an improvement in communication complaints.

In repose to the specific communication comment about the relative feeling there was no one to answer her questions, the EOLC team will work closely with the wards to ensure the allocated nurse caring for the EOL patient introduces themselves to the family/NOK and states … *"Hi I am …… I am the nurse looking after …… the nursing assistant/HCA is …… if you need anything, have any questions, or concerns I will try my best to answer them but if I can't, I will find someone who can*". This will hopefully help to alleviate any fears or concerns the family/NOK may have.

From the report, there have been fewer EOLC patients who have received support from the chaplaincy service. Correct communication when offering Chaplaincy support is important and ensuring the families/NOK understand the diverse levels of support they offer and is not just around religion.
The EOLC team continues to update the Chaplaincy on patients they are involved with.
The Chaplaincy team participate for half an hour on the HCA education session and the nurse's induction program. Here, they discuss what they do, and what they can offer, they also go through the What Matters to You form and offer support and guidance on any questions about death, dying, and bereavement.
The EOLC Lead Nurse will consult with the Chaplaincy team about other ideas to improve the above.

Figure 7.1a Medical Examiner's Office (MEO) shows there were 8 negative comments made, themes noted around access to both offices out of hours and poor experiences associated with initial contact being through answer machines. In Figure 7.1a prevalent words used in the negative comments are shown. In response to this, on the **"information for recently bereaved families and carers"** card that is handed out by the ward after death, states *"Please call the Bereavement Team at the hospital after 10am the next working day on 01722 425150. Please* ***leave your details and the details of the person who has died on their 24hr answerphone, and they will endeavour to call you back as soon as possible".*** If this continues to be an issue further education with the wards will be needed.
There was also an increased number of Bank Holidays during this time could have had an effect which reduced OOH provision for the service.

On a positive note, 2 additional staff members have joined the team since, which will enable a safer, more effective, and robust service. We are confident that this data will improve and return to receiving mostly positive comments and feedback. However, we will continue to closely monitor.

In response to the increasing number of complaints regarding facilities, managing where someone dies can be challenging, and sometimes we cannot get it right! We have acknowledged every concern and as a Trust are aware that a person dying in a bay may not be the right place, as the environment can be noisy, and there could be a lack of privacy and dignity. The EOLC team, HPCT, Chaplains, and ward staff will endeavour to make the situation as good as it can be, and if the family/NOK or the patient requests a side room this will be escalated to the nurse in charge, though we acknowledge this may not be guaranteed.
If a patient is dying in a side room this can be more manageable to meet expectations for the patient and the family and would encourage the family/NOK to bring in familiar items pillow, blanket, pictures, and smells, to make the patient as comfortable as possible.
EOLC Lead is participating in the new ward meetings and has discussed the increased number of complaints regarding facilities at the end of life.

Everyone has the right to access high quality EOLC, joint working and education with the Specialist Palliative Care Team and Learning Disability CNS has started and this will continue. The EOLC lead nurse, and SPC team will continue to work closely with Learning Disabilities CNS to discuss how can we do better when someone is dying with Learning Disabilities.

Report written by Victoria Aldridge - Head of Patient Experience
Report reviewed and contributed to by Emma Gravestock – End of Life Care Lead Nurse

National Urgent & Emergency Care Survey Results (2022)

Results Report

Salisbury NHS Foundation Trust

Presented by:
Victoria Aldridge – Head of Patient Experience

Angie Ansell – Deputy Chief Nursing Officer

Salisbury NHS Foundation Trust National Urgent and Emergency Care Survey 2022

Sample: Patients were eligible for the survey if they were aged 16years or older and had attended UEC services during September 2022.

Scoring: Each question in the survey that can be scored are converted into scores on a scale of 0 to 10.
Scores of 10 are assigned to the most positive and scores of 0 are assigned to the least positive.
The UEC survey is standardised by age and gender.

Comparisons: Redevelopment work carried out on this survey means results are comparable with those results received in 2020, 2018 and 2016 only.

Full CQC Benchmark Report:

Salisbury NHS Foundation Trust - Care Quality Commission (cqc.org.uk)

Summary of comparisons

122 NHS Acute Trusts involved with a Type 1 accident and emergency department

29, 357 Total responses received (return rate of 23%)

397 Total responses received for SFT

33% Response rate

No. of questions where SFT scored better than other Trusts = 19

No. of questions where SFT scored about the same as other Trusts = 18

No. of questions where SFT scored worse or somewhat worse than other Trusts = 0

Demographic breakdown

Salisbury NHS Foundation Trust

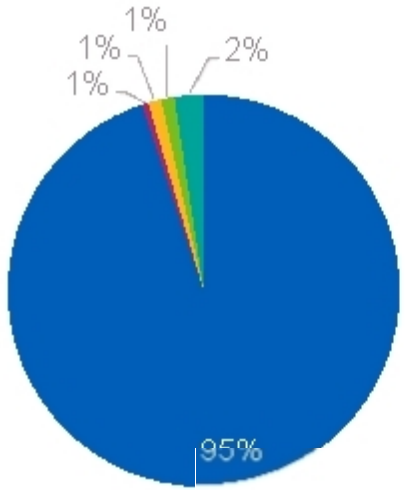
Age

6.8% were aged 16 - 35

12.1% were aged 36 - 50

23.2% were aged 51 - 65

57.9 % were aged 66+



Sex

54.9% of those surveyed identified as female

45.1% of those surveyed identified as male

0.0% of those surveyed identified as intersex

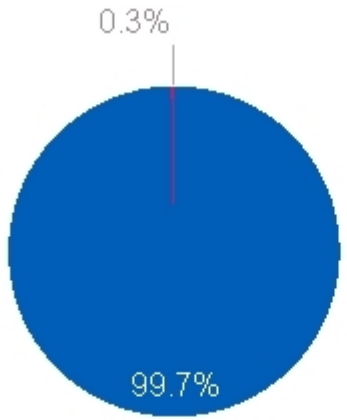
0.0% preferred not to say

Ethnicity

94.2% of those surveyed were White

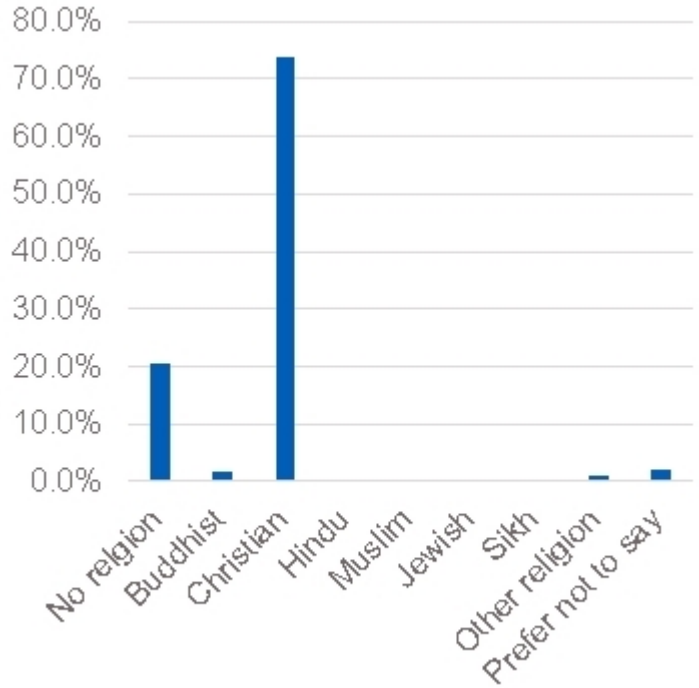
1.0% were from multiple ethnic groups
1.3% were Asian or Asian British
0.3% were Black or Black British

3.3% were unknown



Gender

Religion



Comparison with SFT's 2020's survey results

Salisbury NHS Foundation Trust

9 questions were scored worse by 5%+

- Privacy when discussing condition with receptionist
- Wait before speaking to nurse or doctor
- Wait before being examined by a nurse or doctor
- Help with condition or symptoms whilst waiting
- Overall length of visit to ED
- Pain control
- Cleanliness of the department
- Understanding of medication side effects
- Discussions about transport arrangements prior to discharge

3 questions were scored better by 5%+

- Availability of suitable food and drinks
- Discussions on further health or social care services that may be needed following discharge
- Availability of care and support expected after leaving ED

Overall experience rating had reduced* to 80.2%

*(*when compared with SFT's 2020 results of 85%)*

Improvements from our 2020 survey results

Salisbury NHS Foundation Trust

Comparison from survey results:

		2020	2022	
Q33	Were you able to get suitable food or drinks when you were in A&E?	62.9%	74.1%	Better by 5% +
Q43	Did hospital staff discuss with you whether you may need further health or social care services after leaving A&E (e.g. services from GP, physiotherapist or community nurse, or assistance from social services or the voluntary sector)?	63.5%	81.4%	Better by 5% +
Q44	After leaving A&E, was the care and support you expected available when you needed it?	78.2%	84.4%	Better by 5% +

- ✓ Availability of suitable food and drinks was an area of declining experience noted in 2020 – this has seen notable improvement for 2022.
- ✓ Opportunities to discuss what needs may be required, on leaving ED
- ✓ Care and support availability once left ED

Other improvements from our 2020 survey results

NHS Salisbury NHS Foundation Trust

The following areas are also noted to have improved*

*(but there was a less than 5% change):

- ✓ Feeling that staff listened to what they had to say
- ✓ Given opportunities to discuss anxieties and concerns with nurses and doctors
- ✓ Quality of information given on treatment or condition and communication on symptoms to look out for
- ✓ Fewer experiences of patients experiencing differing opinions or instructions from health professionals

Decreases from our 2020 survey results

Salisbury NHS Foundation Trust

Extract from survey results:

		2020	2022	
Q6	Were you given enough privacy when discussing your condition with the receptionist?	77.3%	70.8%	Worse by 5% +
Q7	How long did you wait before you first spoke to a nurse or doctor? This does not include staff screening for coronavirus at the entrance to A&E.	67.4%	45.4%	Worse by 5% +
Q8	Sometimes, people will first talk to a doctor or nurse and be examined later. From the time you arrived, how long did you wait before being examined by a doctor or nurse?	68.1%	51.1%	Worse by 5% +
Q11	While you were waiting, were you able to get help with your condition or symptoms from a member of staff?	59.1%	47.4%	Worse by 5% +
Q12	Overall, how long did your visit to A&E last?	76.0%	57.6%	Worse by 5% +
Q30	Do you think the hospital staff did everything they could to help control your pain?	80.8%	74.9%	Worse by 5% +
Q31	In your opinion, how clean was the A&E department?	91.8%	82.5%	Worse by 5% +
Q38	Did a member of staff tell you about medication side effects to watch for?	58.9%	46.9%	Worse by 5% +
Q42	Before you left the hospital, did a member of staff discuss your transport arrangements for leaving A&E?	53.9%	44.9%	Worse by 5% +

- Privacy when discussing condition
- Wait time before first medical contact and first examination
- Help with condition and symptoms (during wait) and pain control
- Overall length of visit to ED
- Cleanliness of the area
- Communication around side effects of medication
- Communication related to transport from ED

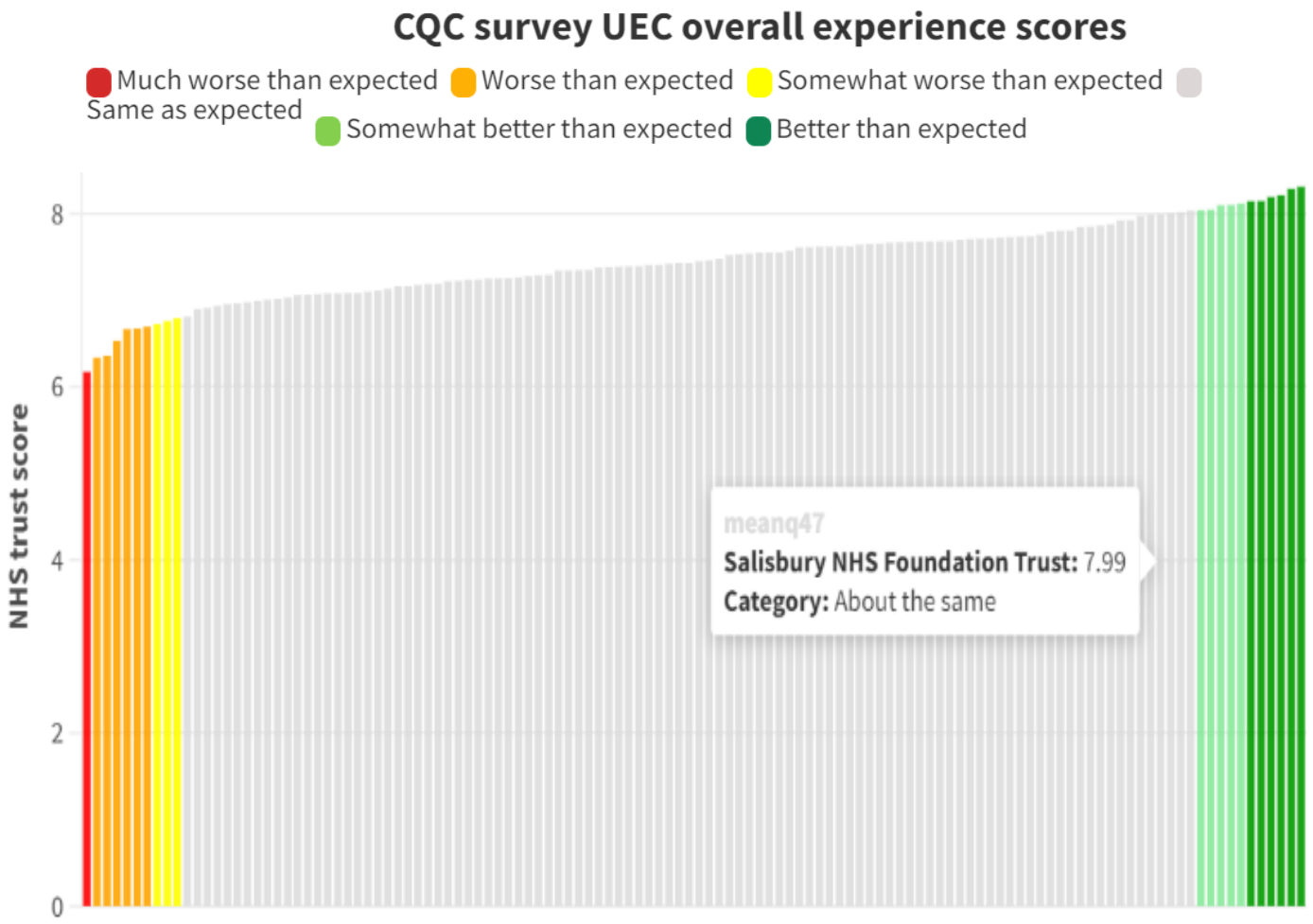
Comparison with other Trusts

NHS Salisbury NHS Foundation Trust

Arrival	Patient Response 7.1/10	About the same
Waiting times	Patient Response 4.3/10	About the same
Doctors and nurses	Patient Response 8.4/10	Better than expected
Care and treatment	Patient Response 8.2/10	Better than expected

	Patient Response	
Tests	8.4/10	Better than expected
Hospital environment and facilities	8.5/10	About the same
Leaving A&E	7.3/10	Better than expected
Respect and dignity	9.2/10	Better than expected
Experience overall	8.0/10	About the same

NHS Salisbury NHS Foundation Trust



Data from the CQC survey of more than 36,000 people who used urgent and emergency care services in September 2022 shows a total of 10 trusts who performed poorly on patients' overall experience.

SFT was noted to have ranked in the higher quadrant of "same as expected" under this same data set.

CQC names worst trusts for experience in A&E | News | Health Service Journal (hsj.co.uk) (note: article requires subscription to access)

Actions and next steps

NHS
Salisbury
NHS Foundation Trust

NHS Salisbury NHS Foundation Trust

Report to:	Trust Board (Public)	Agenda item:	5.3
Date of meeting:	5 October 2023		

Report tile:	Q1 Learning from Deaths Report 2023-24			
Status:	Information	Discussion	Assurance	Approval
	Yes	Yes	Yes	
Approval Process: (where has this paper been reviewed and approved):	Mortality Surveillance Group CGC 26 September 2023			
Prepared by:	Dr Ben Browne, Head of Clinical Effectiveness			
Executive Sponsor: (presenting)	Peter Collins, Chief Medical Officer			

Recommendation:

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

Executive Summary:

The Trust MSG met on 11th April and 20th June 2023 in Quarter 1 (Q1), where learning, improvement themes and actions arising from mortality diagnosis group alerts and individual case reviews were discussed. Please refer to the Q1 **Summary of Learning** (outlined on pages 3-5 of this report).

There were 221 inpatient deaths in Q4 (inclusive of patients who died in either the Emergency Department or Hospice).

During Quarter 1 there was/were:

- 5 deaths where COVID-19 was the primary cause of death (recorded as 1a on the death certificate)
- 1 stillbirth
- No maternal deaths
- 4 deaths reported in patients with a learning disability
- 0 deaths in patients considered to have a serious mental illness

A total of 203 deaths were scrutinised by the Medical Examiners in Quarter 1 (92% of all inpatient deaths) and 15 Structured Judgement Reviews (SJRs) were requested.

End of Life Care

The Your Views Matter Bereavement survey aims to capture the views and experience of bereaved families.

During Quarter 1:

- 105 families gave consent for the Trust's Your Views Matter bereavement survey to be posted.
- A response rate of 31% (n~ 33) was achieved.

- 70% of respondents rated the overall end of life care as good or very good.

National Benchmarks

Latest SHMI (as reported by NHS Digital at the time of publication):

- The Trust SHMI is 1.1365 for the twelve-month period ending in March 2023 and is statistically higher than expected. When comparing SHMI by site, Salisbury District Hospital is 1.0840 and Salisbury Hospice is 2.3287.
- The SHMI is within the expected range when our hospice data is removed.

HSMR:

A two-month time lag continues to be applied to the HSMR data to improve the accuracy of our data reporting for the 12-month period (allowing for any potential coding delays). Therefore, the latest HSMR is for the 12-month rolling period ending in March 2023.

- The HSMR (relative risk) for the Trust for the twelve-month period ending in March 2023 is 122.1 and is statistically higher than expected (113.7 – 131.0, 95% confidence limits).
- The HSMR (relative risk) for Salisbury District Hospital (excludes hospice data) for the twelve-month period ending in March 2023 is 115.1 and is statistically higher than expected (106.4 – 124.3).
- Weekday HSMR is 116.5 and weekend HSMR is 140.3. For Salisbury District Hospital (excludes hospice data) this is 110.4 and 132.9 respectively. These are both statistically higher than expected.

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

NHS
Salisbury
NHS Foundation Trust

QUARTER 1 2023/24 LEARNING FROM DEATHS REPORT

September 2023

A summary document outlining the learning from deaths at Salisbury NHS Foundation Trust during the first financial quarter of 2023/24

Mr Richard Cole - Trust Mortality Lead
Dr Ben Browne - Head of Clinical Effectiveness

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 based on 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.

Salisbury NHS Foundation Trust

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.

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 11th April and 20th June 2023 in Quarter 1 (Q1), where learning, improvement themes and actions arising from mortality diagnosis group alerts and individual case reviews were discussed. Further work is underway to introduce a new Mortality review platform alongside the Trust's Clinical Audit system (AMaT), itself due to go live in September 2023. The output from any mortality reviews included in this platform has an emphasis on learning points and actions taken as a result, all of which will be in a categorised format for the purpose of future interrogation, for example if a new Alert is received from Dr Foster / Telstra UK. It is expected that the Mortality module will go live about three months after the Audit one.

3.1. SJRs and The Medical Examiner System

In Q1 there were 221 deaths (inclusive of the hospice and ED). Of these, 203 cases were scrutinised by the MEs (92%) with 15 Structured Judgement Reviews (SJRs) requested by the MEs. This was a similar percentage (7%) to that observed during Q1 in 2022/2023 (8%), the majority being indicated for issues in the "other" category. The categorisation of Type of problem triggering the SJR is being addressed in the new Audit management platform whereby any learning or actions arising from Checklist reviews or SJRs will be categorised more precisely.

To enhance the SJR process for Learning Disabled (LD) and Autism mortality cases (approximately 4 per year) it is proposed that these are in future set up as Panel reviews, coordinated by the LD & Autism Lead nurse and the Mortality audit facilitator, ensuring as far as possible that these are completed together with a key specialist or their deputy, and also within the six month period allowed for submission following death.

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

Several SIIs were reviewed leading to identification of learning points and actions proposed for discussion in the relevant groups.

Potassium infusions for hypokalaemia: as a result of a case where the patient received a potassium intravenous infusion based on an old result (the new result had not been reported yet) it was proposed that documentation as part of the infusion prescription of the time & date of the test report of the measurement which had triggered the infusion should be mandatory as part of the prescription itself, alongside documentation of the relevant potassium level.

A patient was subjected to CPR despite having withdrawn consent for this; it was proposed that case notes should make DNACPR obvious without having to open them, for example by using a different coloured folder, or large label on the front, alternatively a discreet wrist band.

A patient at a facility for convalescent SFT outliers was not challenged when wandering away from the ward despite having been recognised as having limited mobility and being at risk of falls; there were missed opportunities to help the patient to return to the safety of the ward. It was proposed that these at-risk patients should have coloured wrist bands indicating that they always require assistance or supervision.

The Deputy Head of Risk has agreed to take forward proposals arising from these SII and Case Review discussions.

3.3. Bereavement

Your Views Matter Bereavement survey were posted to 105 families in Q1 with their consent, 31% responding. This was a lower % response rate compared to the previous two years, but satisfaction was reported as good or very good in 70%, which is consistent with findings observed from Q2-4 in 2022/2023. Learning of areas for improvement in this process included the nature of facilities and appropriateness of the room or ward where someone passed away.

3.4. Formal Alerts and Reports

As a result of a review by the Coding team of Pneumonia mortality cases (a diagnosis group which had triggered a Dr Foster Telstra UK Alert which incorporates the patients' Charlson comorbidity scores as part of the case-mix calculation) it was identified that seven of these cases, from a total of 22 which had been attributed to the zero-comorbidity group, should have been coded as having comorbidities. Actions arising from this learning include the need to establish improved training and a quarterly audit; furthermore, an education session on the importance of scrutinising all available documentation including ED records.

Pneumonia as an admission diagnosis is no longer Alerting according to Dr Foster / Telstra UK data.

A further key action arising from this review of Coding of co-morbidities has been to allow increased access to records for coders, whereby it will be the local policy at SFT to use the Integrated Care Record (ICR) within the Electronic Patient Record (EPR) to extract information regarding patient co-morbidities. Clinical coders will access the ICR within the EPR when recording comorbidities and will access the active problems, past problems, medication, and lifestyle sections to determine appropriate codes; the ICR is updated frequently to provide the most relevant information which will help to ensure accurate data and improve depth of coding.

The attribution of Charlson co-morbidities is one of the three case-mix factors which are provided directly by SFT for the Dr Foster / Telstra UK mortality model. It is important that these co-morbidities are coded as accurately as possible because they influence our "expected" mortality, and, if our cases are being allocated to zero co-morbidities because some are being missed in the coding process, there is a risk of SFT mortality metrics being moved towards or into the statistical outlier levels or intervals.

Learning opportunities from the significant accumulation of mortality review Checklists (the level of review scrutiny below formal SJRs) have led to further improvements, including the addition of Delayed Discharge as a data-item, proposed by the public governor in MSG. Another upgrade has been the inclusion of the initials of a second consultant, as well as the original admitting one. This is relevant if during the admission most of the Care occurs under a second or principal consultant who is not the admitting one. Learning from the review of AKI mortality cases triggered by the recent Dr Foster / Telstra UK Alert confirmed that during the care of the 27 cases, there were 20 different admitting consultants, but some cases were subsequently handed over. This can also occur with cases transferred to the palliative care team and admitted to the hospice after a brief period under the initial admitting consultant. This more detailed identification of the principal consultant will facilitate allocation of any future Higher level or M&M meeting reviews to the most appropriate consultants and improve efficiency of this process. These amendments will be also included in the Initial review section of the new Mortality online platform.

A Higher-level review was carried out by the Trust Mortality Lead (TML) together with the Trust Acute Kidney Injury (AKI) Lead, of those cases which triggered a Dr Foster / Telstra UK Alert. The initial review of 27 cases had already been presented to the MSG, revealing no patterns of concern and good adherence to best practice in end-of-life care. This higher-level review was of the case-notes available of the ten patients who died within 72 hrs of admission, leading to several actions. It was agreed that a new audit of AKI care was due (previous one in 2020). It was proposed that consideration should be given to recording data, time and potassium level for those cases receiving prescription for hyperkalaemia management, potentially via EPMA, but it was unclear if this would have prevented the inappropriate infusion in one case. Further deficiencies were noted in completion of fluid charts and food charts. It was agreed to escalate these issues, with further training considered to be essential for all staff. A further action is to review the accuracy of Charlson co-morbidity scoring in the early mortality subgroup.

In the most recent Dr Foster / Telstra report on the six key diagnosis risk groups, the rolling 12-month trends in SFT's relative risk for all six lie within the normal range (95% confidence intervals). These highest risk groups which MSG has asked Dr Foster / Telstra UK to monitor include Acute and unspecified renal failure, Pneumonia, non-hypertensive Congestive cardiac failure, Acute cerebrovascular disease, Fractured neck of femur and Septicaemia (non-labour).

4. Mortality Data

Categories	Quarter 1 2023/24			
	April	May	June	Q1 Total
All inpatient Deaths (inc. ED and Hospice)	81	89	51	**221**
Deaths Reviewed/Scrutinised by the ME	74	80	49	**203 (92%)**
SJRs requested by ME	6	8	1	**15**
ED Deaths	3	3	0	**6**
Hospice Deaths	17	15	9	**41**
Covid-19 as Primary cause of death (recorded as Covid 1a)	3	2	0	**5**
Stillbirths (>37+0 weeks)	0	0	0	**0**
Stillbirths (>24+0 weeks – 36+6 weeks)	0	0	1	**1**
Late Miscarriage (22+0 weeks – 23+6 weeks)	0	0	0	**0**
Neonatal Deaths	0	0	1	**1**
Maternal Deaths	0	0	0	**0**
Learning Disability Deaths*	0	4	0	**4**
Serious Mental Illness*	0	0	0	**0**

**as reported/identified 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.

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

The requests (identified through ME screening) are categorised into problem themes and stage of care (see table below). Please note that some requests may occasionally fall into multiple categories. Where requests do not fit into any of the categories below, this may be because the ME has requested a review for a specific group of patients, e.g., where a serious mental illness or learning disability has been identified, but no obvious problems in care were identified during their initial screening.

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	**2023/24 YTD**	**2022/23 YEAR TOTAL**	***2021/22 YEAR TOTAL***
Problem in assessment, investigation or diagnosis (including assessment of pressure ulcer risk, venous thromboembolism (VTE) risk, history of falls)							***0***	***7***	***17***
Problem with medication / IV fluids / electrolytes / oxygen							***0***	***5***	***3***
Problem related to treatment and management plan (including prevention of pressure ulcers, falls, VTE)						*2*	***2***	***8***	***7***
Problem with infection control							***0***	***0***	***0***
Problem related to operation/invasive procedure (other than infection control)							***0***	***2***	***4***
Problem in clinical monitoring (including failure to plan, to undertake, or to recognise and respond to changes)		*1*				*1*	***2***	***7***	***13***
Problem in resuscitation following a cardiac or respiratory arrest (including cardiopulmonary resuscitation (CPR))							***0***	***0***	***0***
Problem of any other type not fitting the categories above						11	***11***	***26***	***24***
2023/24 YTD	*0*	*1*	*0*	*0*	0	14			
2022/23 YEAR TOTAL	***6***	***15***	***0***	***0***	***5***	***30***			
2021/22 YEAR TOTAL	***9***	***24***	***3***	***3***	***4***	***25***			

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 can 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.

- In Q1, 105 families gave consent for the Trust's Your Views Matter bereavement survey to be posted. Achieving a response rate of 31% (n~ 33). Although an improvement on previous quarters, this is noted to be lower, than the average response rate seen for 2022-2023 (41%). Average response rate for 2021/22 was 39%.

Figure 1.1 Response rates

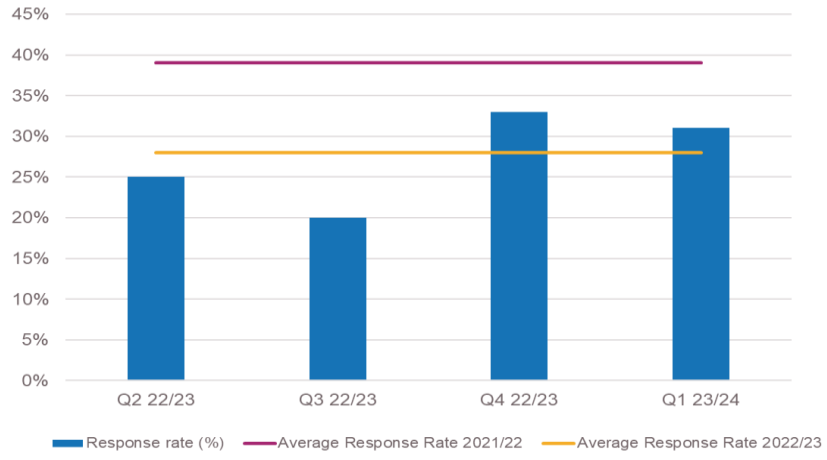
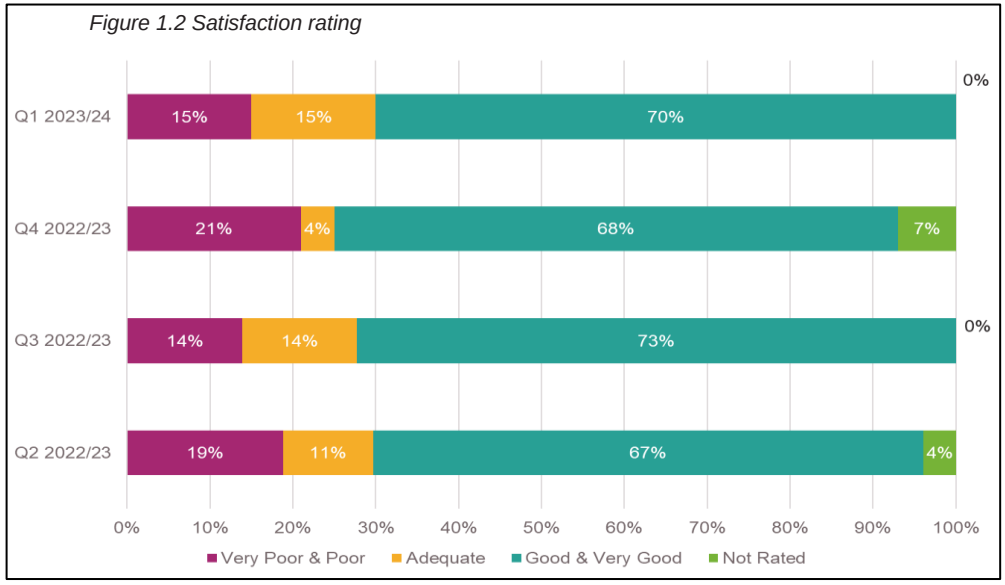


Figure 1.2 Satisfaction rating



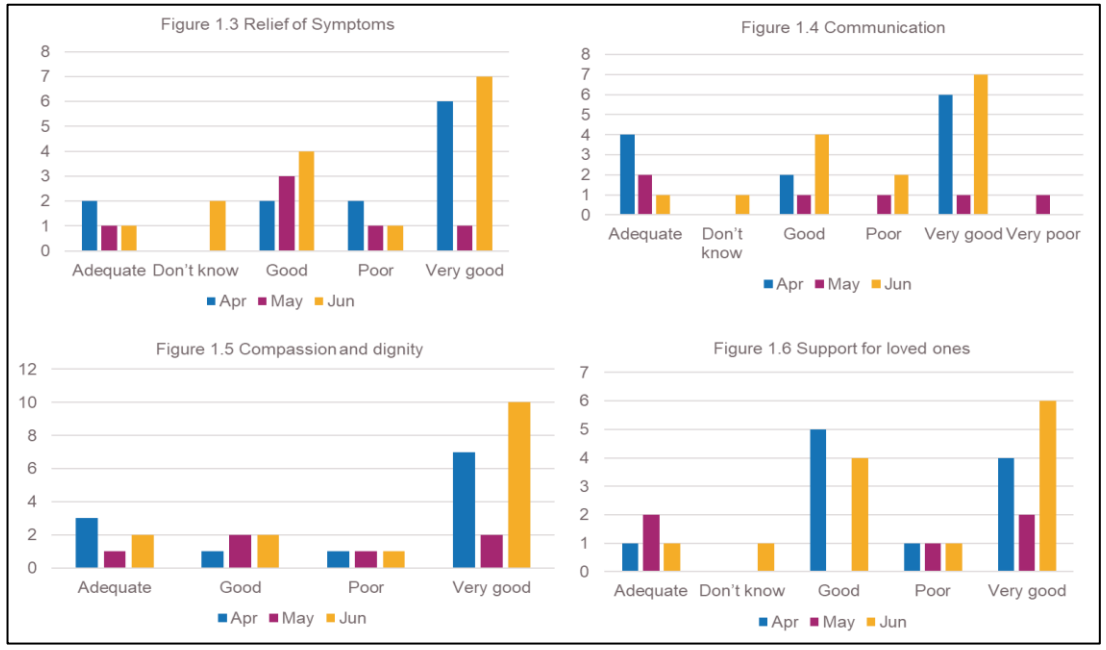
- 70% of respondents rated the overall end of life care as good or very good.

- **Figures 1.3 to 1.6** (below) show the overall ratings in the key areas of patient experience (Relief of symptoms, Communication, Compassion and Dignity, Support for loved ones)

- 3 survey participants requested a call-back from PALS, 2 of these went on to record a formal complaint or concern. This is an increase on what we saw in Q4. There were no notable correlations with complaint themes this quarter.

- There continues to be negative themes around facilities and appropriateness of the room or ward where someone passes away. More robust reporting on this has now commenced to understand where specific improvements are needed.

- There continued to be a many positive comments in relation to both the bereavement and medical examiner's office this quarter. However, there was a negative theme noted around access to these services out of hours and the use of answer machine facilities.



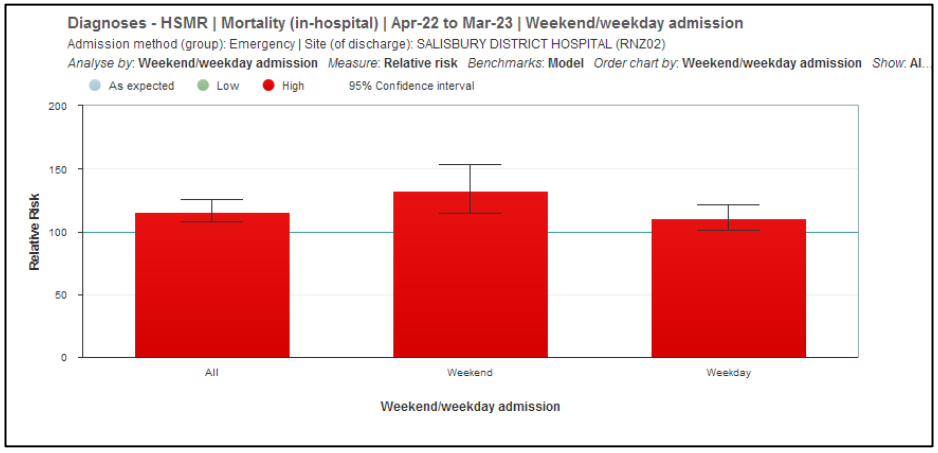
7. Mortality Benchmarking

A two-month time lag has been applied to the HSMR data to improve the accuracy of data for the 12-month period. This is due to a potential coding backlog for the two most recent months of discharge data. Therefore, the latest HSMR is for the 12-month rolling period ending in March 2023.

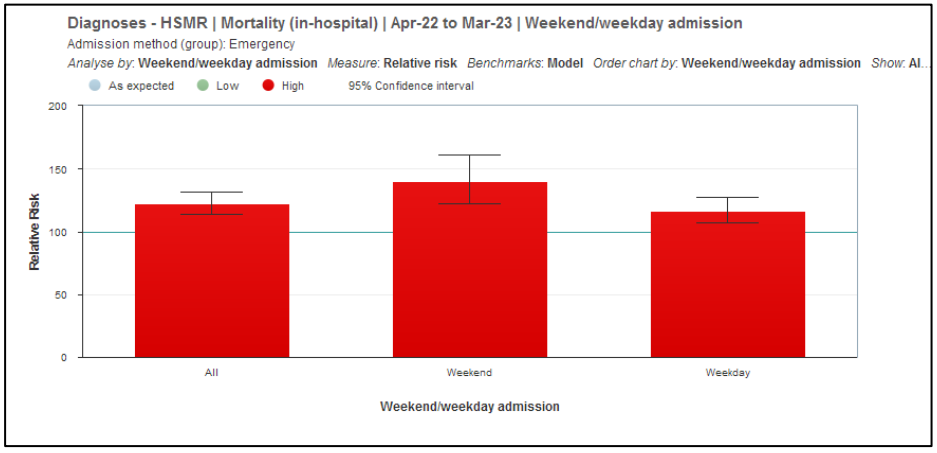
7.1. Summary - HSMR rolling 12-month trend to March '23

- The HSMR (relative risk) for the Trust for the twelve-month period ending in March 2023 is **122.1** and is statistically higher than expected (113.7 – 131.0, 95% confidence limits).
- The HSMR (relative risk) for Salisbury District Hospital (excludes hospice data) for the twelve-month period ending in March 2023 is **115.1** and is statistically higher than expected (106.4 – 124.3).
- Weekday HSMR is **116.5** and weekend HSMR is **140.3**. For Salisbury District Hospital (excludes hospice data) this is **110.4** and **132.9** respectively. These are both statistically higher than expected.

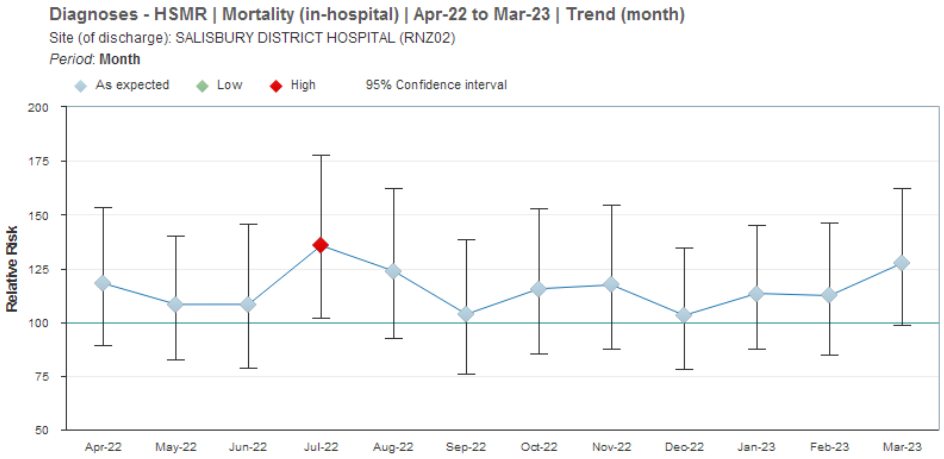
Weekend/Weekday HSMR [Excluding Hospice Data]



Weekend/Weekday HSMR [Inclusive of Hospice Data]



Salisbury District Hospital HSMR [Excludes Hospice Data] – Monthly Trend

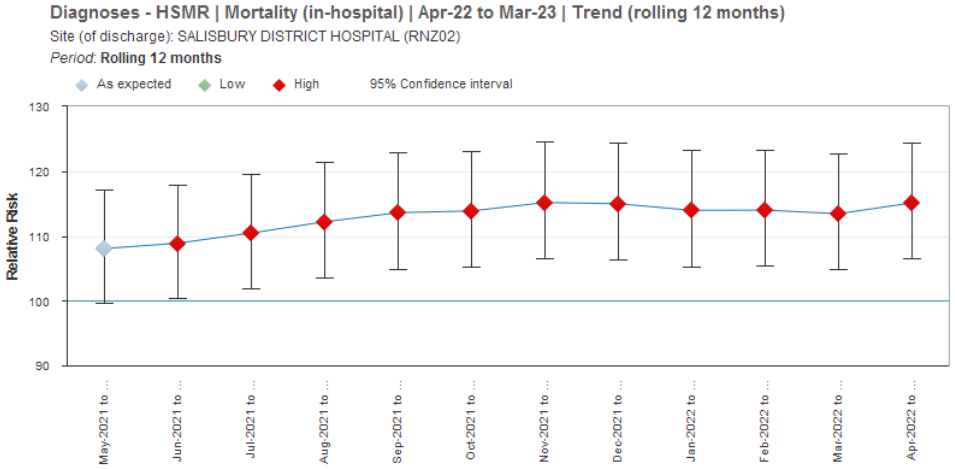


Monthly HSMR Figures

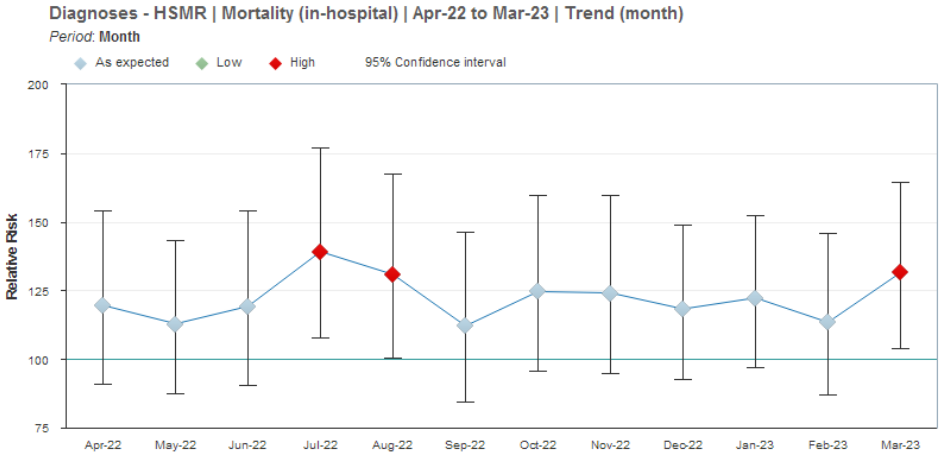
When reviewing the previous 12-month's data monthly, July-22 is the only month where the mortality figures were statistically higher than expected.

With the hospice data included the months of August '22 and March '23 is also statistically high (see page 12).

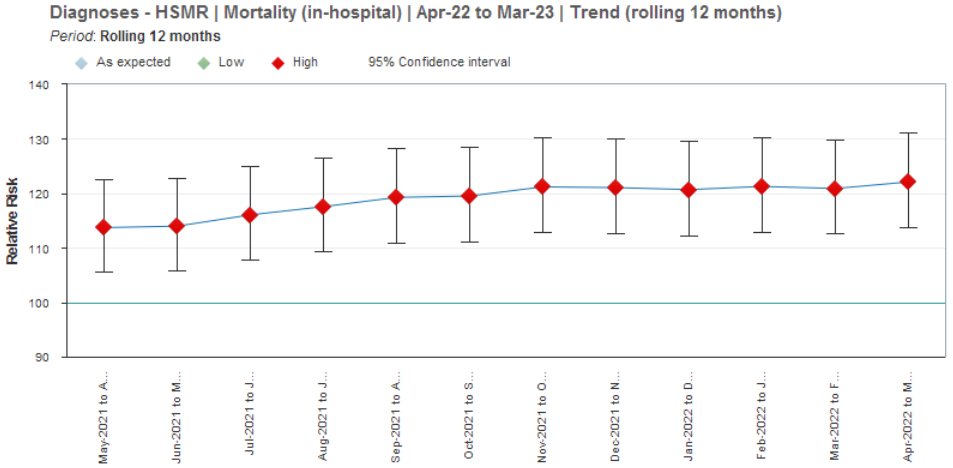
Salisbury District Hospital HSMR [Excludes Hospice Data] – Rolling 12-Month Trend



Trust HSMR [Includes Hospice Data] – Monthly Trend

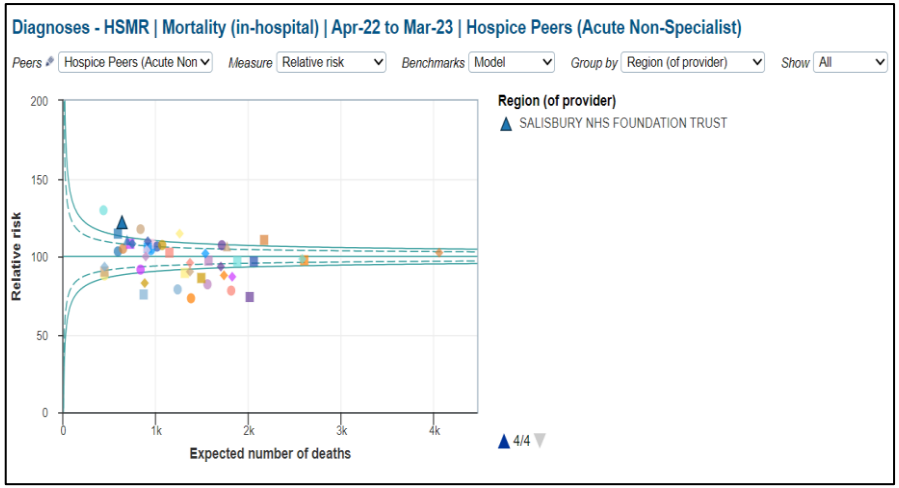


Trust HSMR [Includes Hospice Data] – Rolling 12-month Trend

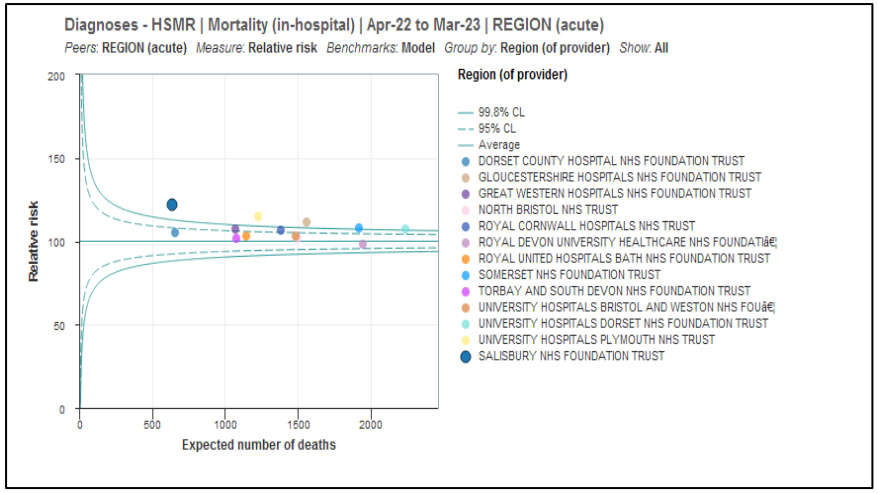


Trust HSMR [Includes Hospice Data] Peer Comparison Rolling 12-month Trend

Hospice Peers



Regional Acute Trusts



Region (of provider)

99.8% CL
95% CL
Average
AIREDALE NHS FOUNDATION TRUST
BARNSLEY HOSPITAL NHS FOUNDATION TRUST
BEDFORDSHIRE HOSPITALS NHS FOUNDATION TRUST
BOLTON NHS FOUNDATION TRUST
BRADFORD TEACHING HOSPITALS NHS FOUNDATION TRUST
CAMBRIDGE UNIVERSITY HOSPITALS NHS FOUNDATION TRUST
CHELSEA AND WESTMINSTER HOSPITAL NHS FOUNDATION TRUST
CHESTERFIELD ROYAL HOSPITAL NHS FOUNDATION TRUST
CROYDON HEALTH SERVICES NHS TRUST
DORSET COUNTY HOSPITAL NHS FOUNDATION TRUST
EAST CHESHIRE NHS TRUST
FRIMLEY HEALTH NHS FOUNDATION TRUST
GREAT WESTERN HOSPITALS NHS FOUNDATION TRUST
GUY'S AND ST THOMAS' NHS FOUNDATION TRUST
HAMPSHIRE HOSPITALS NHS FOUNDATION TRUST
HARROGATE AND DISTRICT NHS FOUNDATION TRUST
HOMERTON HEALTHCARE NHS FOUNDATION TRUST
IMPERIAL COLLEGE HEALTHCARE NHS TRUST
JAMES PAGET UNIVERSITY HOSPITALS NHS FOUNDATION TRUST
KING'S COLLEGE HOSPITAL NHS FOUNDATION TRUST
LEWISHAM AND GREENWICH NHS TRUST
LIVERPOOL UNIVERSITY HOSPITALS NHS FOUNDATION TRUST
MID CHESHIRE HOSPITALS NHS FOUNDATION TRUST
MILTON KEYNES UNIVERSITY HOSPITAL NHS FOUNDATION TRUST
NORFOLK AND NORWICH UNIVERSITY HOSPITALS NHS FOUNDATION TRUST
NORTH WEST ANGLIA NHS FOUNDATION TRUST
NORTHAMPTON GENERAL HOSPITAL NHS TRUST
ROYAL BERKSHIRE NHS FOUNDATION TRUST
ROYAL SURREY COUNTY HOSPITAL NHS FOUNDATION TRUST
ROYAL UNITED HOSPITALS BATH NHS FOUNDATION TRUST
SOUTH WARWICKSHIRE UNIVERSITY NHS FOUNDATION TRUST
ST GEORGE'S UNIVERSITY HOSPITALS NHS FOUNDATION TRUST
ST HELENS AND KNOWSLEY TEACHING HOSPITALS NHS TRUST
TAMESIDE AND GLOSSOP INTEGRATED CARE NHS FOUNDATION TRUST
THE QUEEN ELIZABETH HOSPITAL, KING'S LYNN, NHS FOUNDATION TRUST
THE ROTHERHAM NHS FOUNDATION TRUST
THE ROYAL WOLVERHAMPTON NHS TRUST
THE SHREWSBURY AND TELFORD HOSPITAL NHS TRUST
UNIVERSITY HOSPITAL SOUTHAMPTON NHS FOUNDATION TRUST
UNIVERSITY HOSPITALS BIRMINGHAM NHS FOUNDATION TRUST
UNIVERSITY HOSPITALS OF NORTH MIDLANDS NHS TRUST
UNIVERSITY HOSPITALS PLYMOUTH NHS TRUST
WEST SUFFOLK NHS FOUNDATION TRUST
WHITTINGTON HEALTH NHS TRUST
WIRRAL UNIVERSITY TEACHING HOSPITAL NHS FOUNDATION TRUST
WYE VALLEY NHS TRUST
YORK AND SCARBOROUGH TEACHING HOSPITALS NHS FOUNDATION TRUST

7.2. Summary Hospital-Level Mortality Indicator (SHMI) for April 2022 – March 2023

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.

- The Trust SHMI is **1.1365** for the twelve-month period ending in March 2023 and is statistically higher than expected. When comparing SHMI by site, Salisbury District Hospital is **1.0840** and Salisbury Hospice is **2.3287.**
- The SHMI is within the expected range when our hospice data removed.

Site code	Site name	Provider spells	Observed deaths	Expected deaths	SHMI value
RNZ02	Salisbury District Hospital	32,000	970	895	1.0840
RNZ78	Salisbury Hospice	125	90	40	2.3287

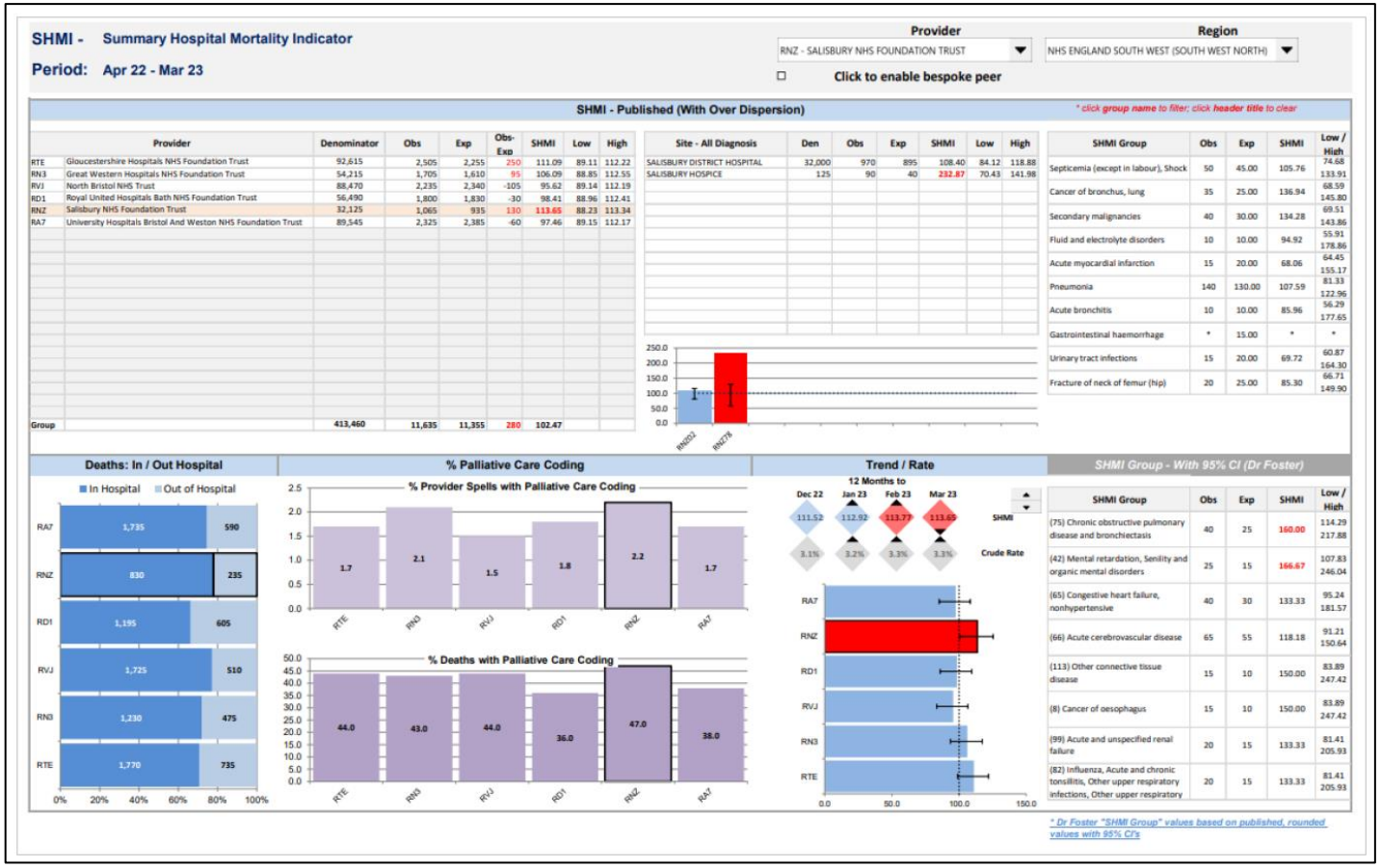
- The tables in the supplementary data pack show additional data for SFT as a breakdown for specific conditions for the twelve-month period ending in March 2023.

7.3. Alerts

- All new alerts continue to be discussed at the Trust MSG meeting where a further review or investigation into deaths may be requested. A representative from Telstra Health U.K (Dr Foster) attends and provides a regular report of our mortality data and all new alerts. A member of the Trust Information Services team and/or coding department have been attending to help further our understanding of the data.

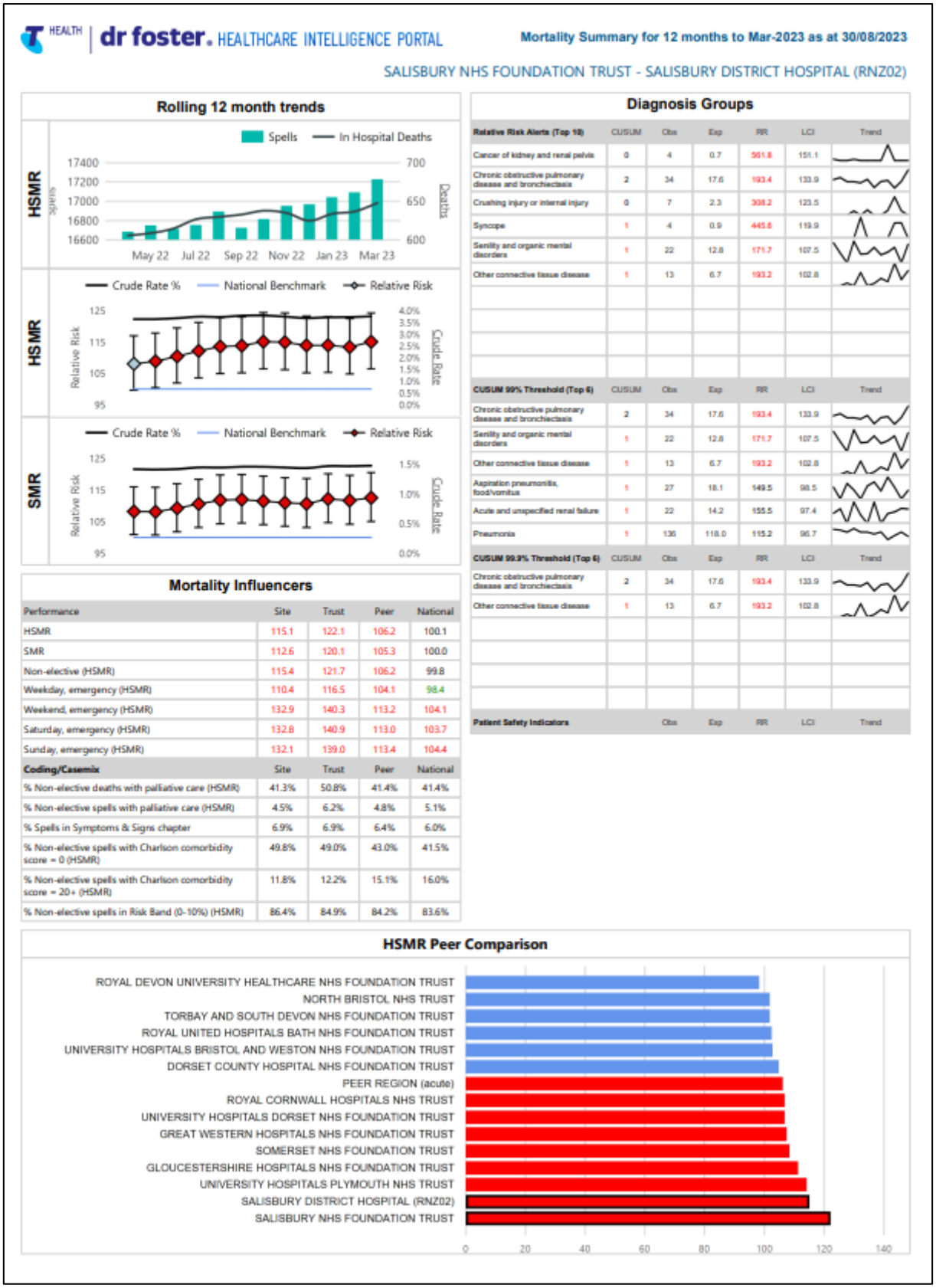
8. Supplementary Data

SHMI Data for the 12 Month Period Ending in March 2023



Salisbury NHS Foundation Trust

HSMR for the 12 Month Period Ending in March 2023 for Salisbury District Hospital [Excludes Hospice Data]



HEALTH | dr foster. HEALTHCARE INTELLIGENCE PORTAL

Mortality Summary for 12 months to Mar-2023 as at 30/08/2023

SALISBURY NHS FOUNDATION TRUST - SALISBURY DISTRICT HOSPITAL (RNZ02)

Rolling 12 month trends

HSMR — Spells / In Hospital Deaths

HSMR — Crude Rate % / National Benchmark / Relative Risk

SMR — Crude Rate % / National Benchmark / Relative Risk

Diagnosis Groups

Relative Risk Alerts (Top 10)	CUSUM	Obs	Exp	RR	LCI	Trend
Cancer of kidney and renal pelvis	0	4	0.7	561.8	151.1	
Chronic obstructive pulmonary disease and bronchiectasis	2	34	17.6	193.4	133.9	
Crushing injury or internal injury	0	7	2.3	308.2	123.5	
Syncope	1	4	0.9	445.6	119.9	
Senility and organic mental disorders	1	22	12.8	171.7	107.5	
Other connective tissue disease	1	13	6.7	193.2	102.8	

CUSUM 99% Threshold (Top 6)	CUSUM	Obs	Exp	RR	LCI	Trend
Chronic obstructive pulmonary disease and bronchiectasis	2	34	17.6	193.4	133.9	
Senility and organic mental disorders	1	22	12.8	171.7	107.5	
Other connective tissue disease	1	13	6.7	193.2	102.8	
Aspiration pneumonitis, food/vomitus	1	27	18.1	149.5	98.5	
Acute and unspecified renal failure	1	22	14.2	155.5	97.4	
Pneumonia	1	136	118.0	115.2	96.7	

CUSUM 99.9% Threshold (Top 6)	CUSUM	Obs	Exp	RR	LCI	Trend
Chronic obstructive pulmonary disease and bronchiectasis	2	34	17.6	193.4	133.9	
Other connective tissue disease	1	13	6.7	193.2	102.8	

Patient Safety Indicators	Obs	Exp	RR	LCI	Trend

Mortality Influencers

Performance	Site	Trust	Peer	National
HSMR	115.1	122.1	106.2	100.1
SMR	112.6	120.1	105.3	100.0
Non-elective (HSMR)	115.4	121.7	106.2	99.8
Weekday, emergency (HSMR)	110.4	116.5	104.1	98.4
Weekend, emergency (HSMR)	132.9	140.3	113.2	104.1
Saturday, emergency (HSMR)	132.8	140.9	113.0	103.7
Sunday, emergency (HSMR)	132.1	139.0	113.4	104.4
Coding/Casemix	**Site**	**Trust**	**Peer**	**National**
% Non-elective deaths with palliative care (HSMR)	41.3%	50.8%	41.4%	41.4%
% Non-elective spells with palliative care (HSMR)	4.5%	6.2%	4.8%	5.1%
% Spells in Symptoms & Signs chapter	6.9%	6.9%	6.4%	6.0%
% Non-elective spells with Charlson comorbidity score = 0 (HSMR)	49.8%	49.0%	43.0%	41.5%
% Non-elective spells with Charlson comorbidity score = 20+ (HSMR)	11.8%	12.2%	15.1%	16.0%
% Non-elective spells in Risk Band (0-10%) (HSMR)	86.4%	84.9%	84.2%	83.6%

HSMR Peer Comparison

Salisbury NHS Foundation Trust

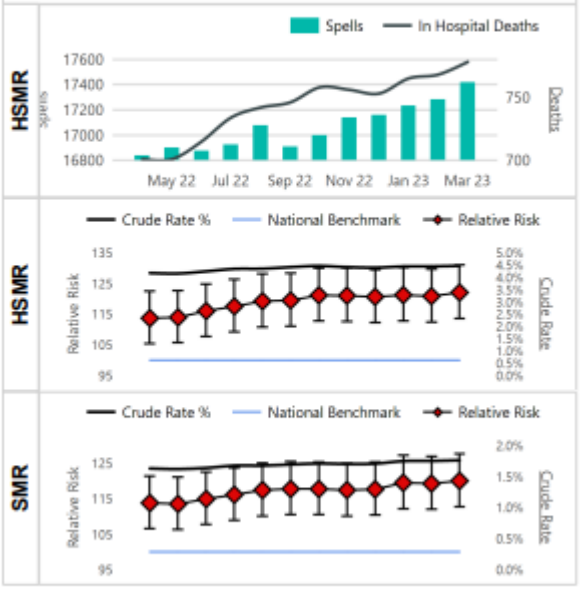
HSMR for the 12 Month Period Ending in March 2023 for SFT [Includes Hospice Data]

HEALTH | dr foster. HEALTHCARE INTELLIGENCE PORTAL

Mortality Summary for 12 months to Mar-2023 as at 30/08/2023

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	35	18.2	192.5	134.0	
Crushing injury or internal injury	0	7	2.3	308.2	123.5	
Secondary malignancies	2	31	17.3	178.8	121.5	
Syncope	1	4	0.9	445.6	119.9	
Cancer of kidney and renal pelvis	0	4	1.0	403.6	108.6	
Other connective tissue disease	1	14	7.1	198.0	108.2	
Senility and organic mental disorders	1	22	12.8	171.7	107.5	
Cancer of colon	0	18	10.6	169.4	100.3	

CUSUM 99% Threshold (Top 6)	CUSUM	Obs	Exp	RR	LCI	Trend
Chronic obstructive pulmonary disease and bronchiectasis	2	35	18.2	192.5	134.0	
Secondary malignancies	2	31	17.3	178.8	121.5	
Other connective tissue disease	1	14	7.1	198.0	108.2	
Senility and organic mental disorders	1	22	12.8	171.7	107.5	
Pneumonia	1	140	120.2	116.5	98.0	
Acute and unspecified renal failure	1	22	14.2	155.5	97.4	

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Patient Safety Indicators	Obs	Exp	RR	LCI	Trend

Mortality Influencers

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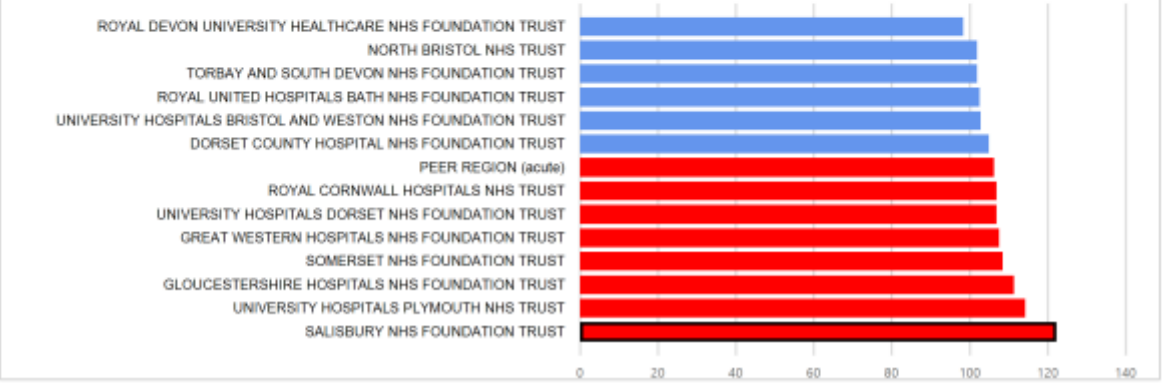
% Non-elective spells in Risk Band (0-10%) (HSMR)		84.9%	84.2%	83.6%

HSMR Peer Comparison

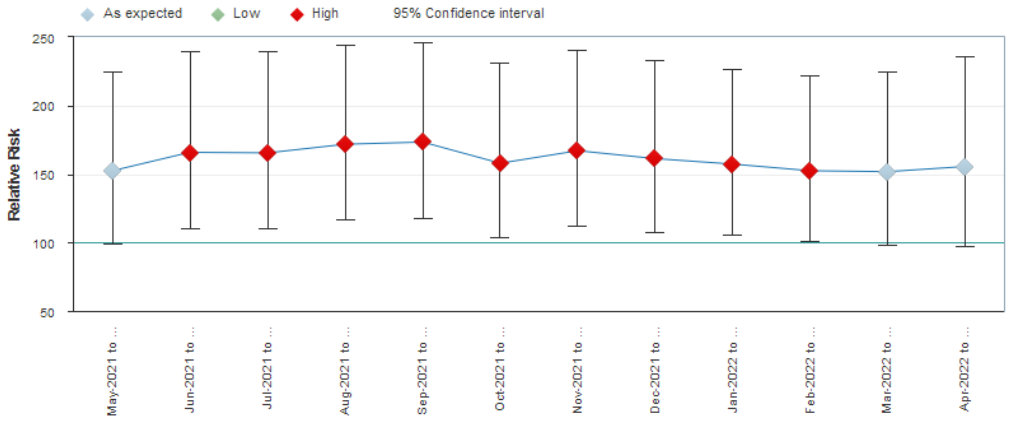


12-Month Trends in Relative Risk for High-Risk Diagnosis Groups

Acute and unspecified renal failure | Mortality (in-hospital) | Apr-22 to Mar-23 | Trend (rolling 12 months)

Diagnosis group: Acute and unspecified renal failure

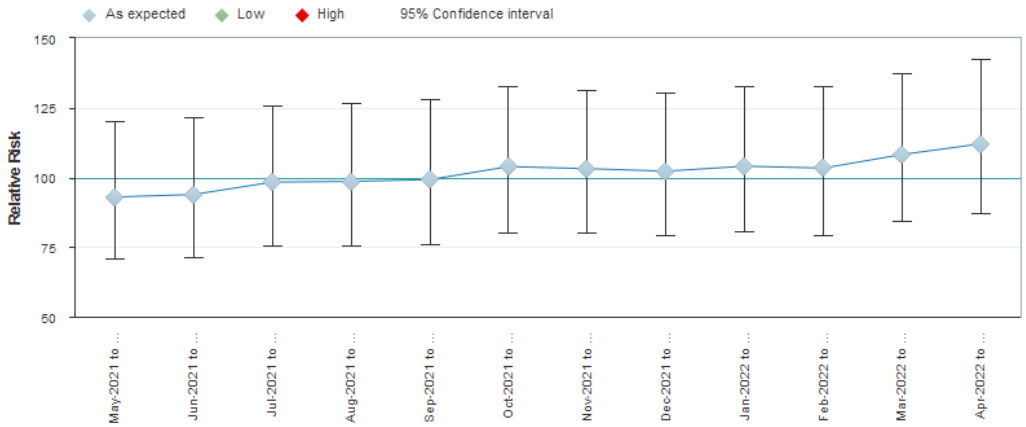
Period: **Rolling 12 months**



Acute cerebrovascular disease | Mortality (in-hospital) | Apr-22 to Mar-23 | Trend (rolling 12 months)

Diagnosis group: Acute cerebrovascular disease

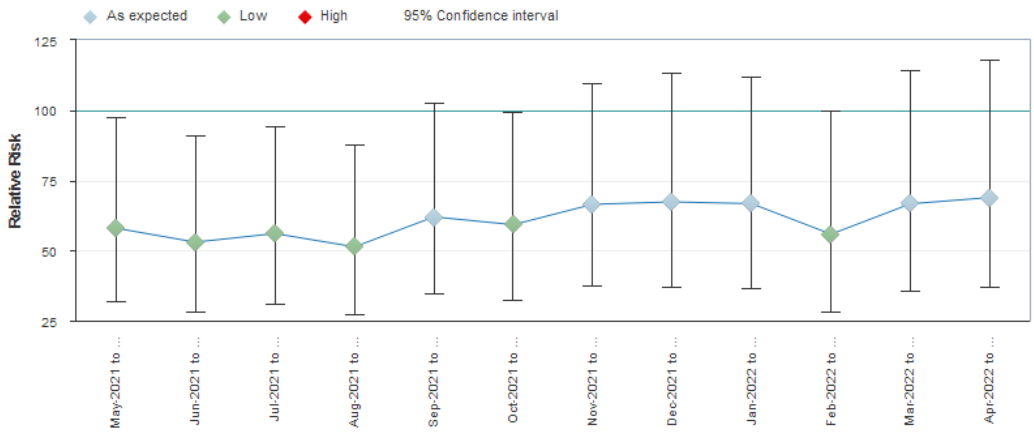
Period: **Rolling 12 months**



Acute myocardial infarction | Mortality (in-hospital) | Apr-22 to Mar-23 | Trend (rolling 12 months)

Diagnosis group: Acute myocardial infarction

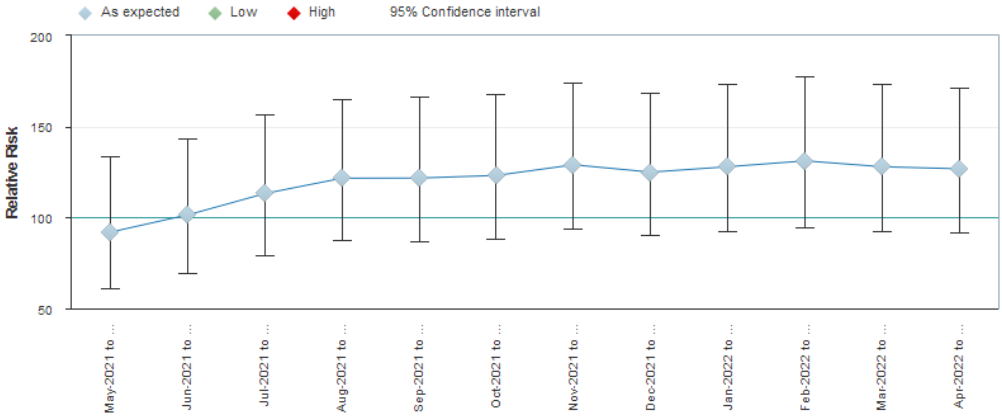
Period: **Rolling 12 months**



Congestive heart failure, nonhypertensive | Mortality (in-hospital) | Apr-22 to Mar-23 | Trend (rolling 12 months)

Diagnosis group: Congestive heart failure, nonhypertensive

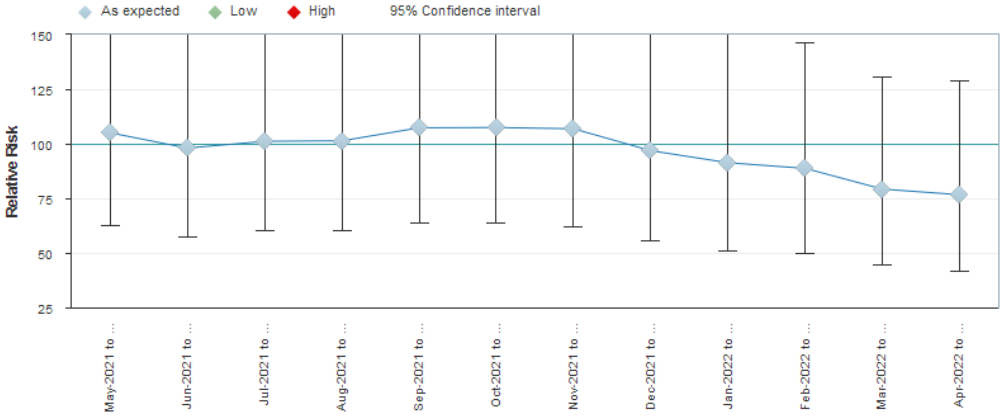
Period: **Rolling 12 months**



Fracture of neck of femur (hip) | Mortality (in-hospital) | Apr-22 to Mar-23 | Trend (rolling 12 months)

Diagnosis group: Fracture of neck of femur (hip)

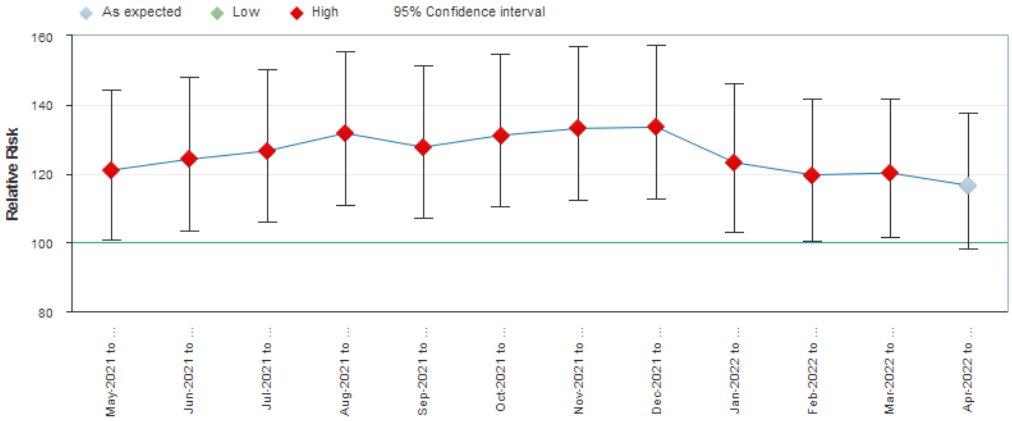
Period: **Rolling 12 months**

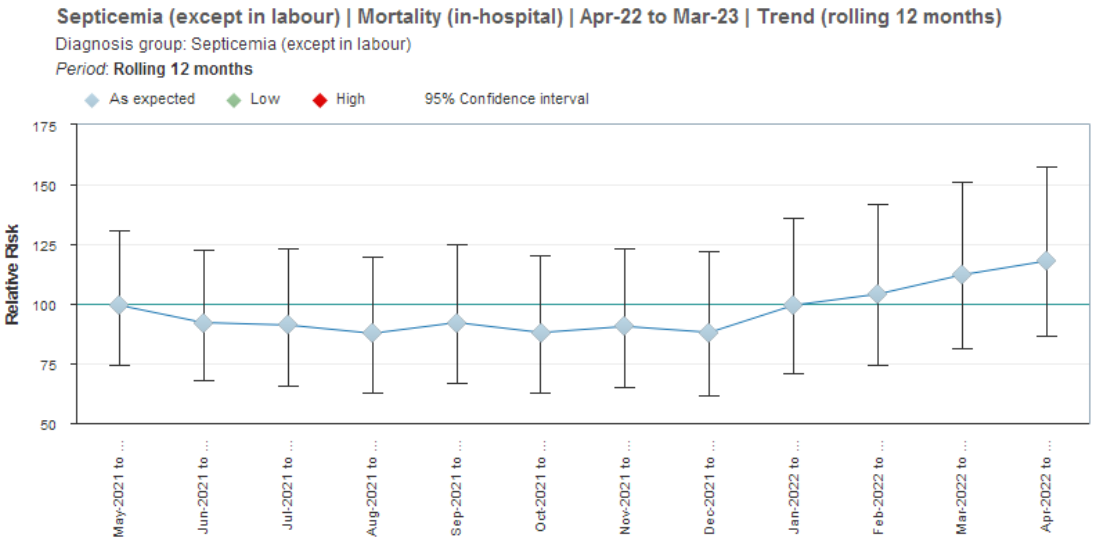


Pneumonia | Mortality (in-hospital) | Apr-22 to Mar-23 | Trend (rolling 12 months)

Diagnosis group: Pneumonia

Period: **Rolling 12 months**





* * * * * * END OF REPORT* * * * * *

Report to:	Trust Board	Agenda item:	5.4
Date of meeting:	5th October 2023		

Report tile:	Perinatal Quality Surveillance - Salisbury NHSFT Maternity & Neonatal services			
Status:	Information	Discussion	Assurance	Approval
	x	x	x	
Approval Process: (where has this paper been reviewed and approved):	Approved by DMT remotely on 19.09.23 following Divisional Governance on 15.09.23 Clinical Governance Committee 26th September 2023			
Prepared by:	Vicki Marston –Director of Midwifery and Neonatal Services			
Executive Sponsor: (presenting)	Judy Dyos			

Recommendation:

The Trust Board are asked to note the contents of the monthly Perinatal Quality Surveillance Report. This report is prepared to demonstrate assurance to the board on Maternity and Neonatal Quality and Safety issues as required by Maternity Incentive Scheme – year 5 – Safety Action 9.

As per CNST Maternity Incentive Scheme requirements this will be a monthly report to Trust Board and will require noting in minutes.

Executive Summary:

The Maternity Incentive Scheme (safety action 9) states an expectation that discussions regarding safety intelligence, including the number of incidents reported as serious harm, themes identified, and actions being taken to address any issues; staff and service user feedback; minimum staffing in maternity services and training compliance take place at Board level monthly. The perinatal Quality Surveillance Models sets out a model to report this and the information required is shared in the Perinatal Quality Surveillance report for SFT for August 2023.

Summary:

Staffing:

- Staffing noted as a challenge and remains a driver for improving together.
- Midwifery vacancies and maternity leave mitigated by bank and long line agency usage.
- Midwife to birth ratio 1:30
- 1:1 care in labour achieved at all times
- Supernumerary status of labour ward maintained 100% time

- Datix relating to workforce 3

PMRT

- No outstanding actions

Incidences reported as moderate.

- 6 – 3 x relating to Post Partum Haemorrhage – thematic review in progress
  No themes with other 3

Training

- Compliance shows slight decrease in PROMPT and NLS training, Plan in place to address this and improve compliance.

Service user and staff feedback

- As detailed and actions taken forward to address any concerns or areas for improvement.

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

NHS
Salisbury
NHS Foundation Trust

Virtual Meeting Etiquette:

- Mute microphones when not speaking (to minimise background noise)
- Turn cameras off – unless speaking (to maximise call quality)
- Please use the *Raise Your Hand* to ask a question
- Please note, this event will be recorded

Perinatal Quality Surveillance

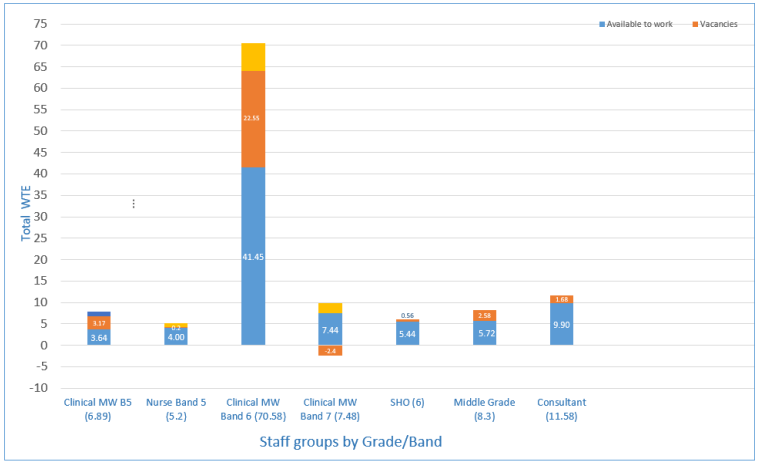
Salisbury NHSFT Maternity & Neonatal services

September 2023 (August data)

Safe - workforce

Salisbury NHS Foundation Trust

Stratified Data
Active Available Workforce M 5



Is the standard of care being delivered?

- 1:1 care in labour was achieved 100% of the time
- Supernumerary status of Labour Ward coordinator maintained 100% of time in July
- Midwife to birth ratio is stable
- -23.32 WTE clinical midwifery vacancy rate

What are the top contributors for over/under achievement?

- Vacancy rate
- Maternity leave
- Successful recruitment campaign x 15 B5/6 MW starting Oct/Nov 23.
- Accuracy in data capture for fill rates

Active Available Workforce

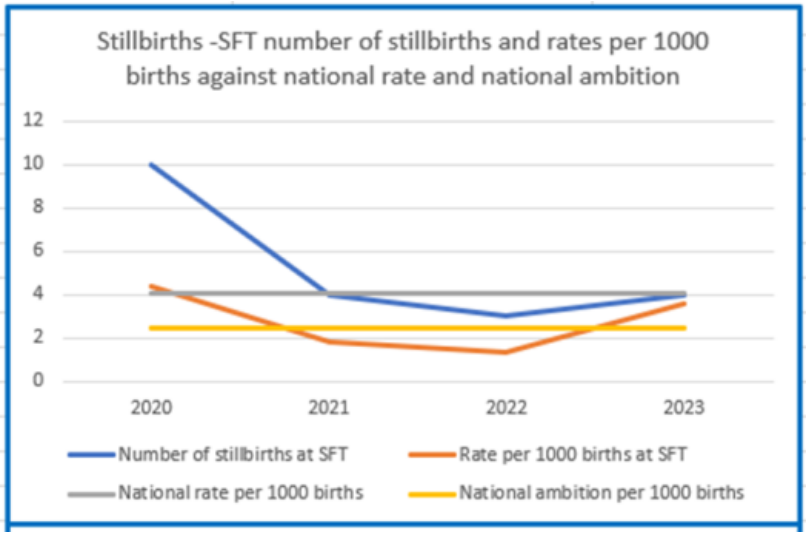
Concern	Cause	Countermeasure	Owner	Due Date
Recruitment of MW's	International recruitment	Update: • 7 International Midwives commenced in service • 4 completed and passed OSCE (2 have NMC PIN and commenced work – 2 awaiting pin) • 2 taking OSCE in July • 1 recruited and commenced in June.	Vicki M/International Recruitment lead	Ongoing
	Development opportunities	2 x places secured on Nurse to Midwife conversion course. Commencing Jan '24, training funded by HEE, completion Jan'26. 2 x places secured for Midwifery apprenticeship which will be open to current MSW with appropriate education (education fees funded by apprenticeship levy). 3 year apprenticeship starting Jan '24. Business case in progress to support payment of salaries	VM SL	Ongoing
	Workforce Total	Birthrate plus team meet in June 23. Data collection started in August 23, report expected November to December 2023. This will inform workforce numbers based on current activity and acuity and align with MIS requirement for workforce review.	VM	Nov 23
Retention of MW and MCAs	Education and Training	Medled human factors training bespoke to MCA's agreed, planning call September. Briefing discussed and feedback from MCA re MDT training, MDT included and training booked for October 23.	VM	ongoing
Middle Grade Doctors		Deanery confirmation of posts Additional Registrar starting September SAS Doctor – recruitment in progress	Shelley King Shelley King	Complete In progress

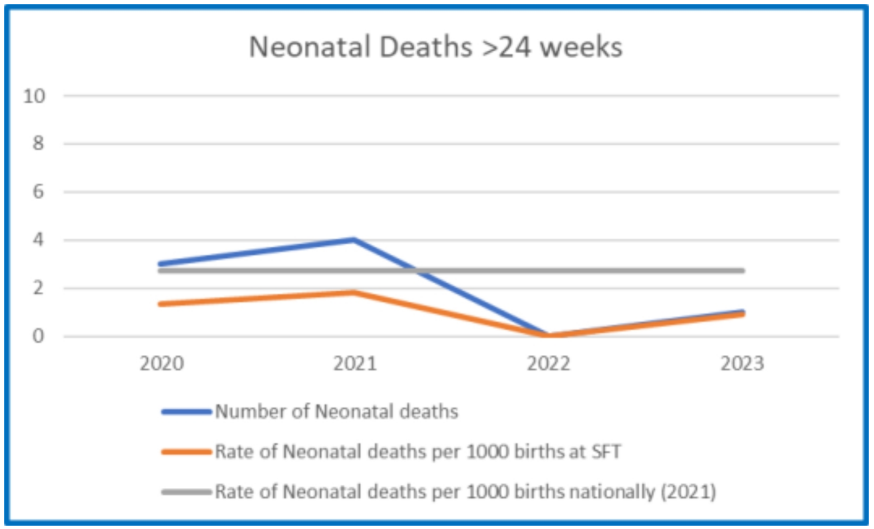
Safe – workforce M5

Salisbury NHS Foundation Trust

01/08/2023	<- Reporting Month (Input the first of the REPORTING month)											
				RAG rating			Rolling 6 months					
SFT Assurance Dashboard		Guidance	Standard	Red	Green	Improvement Direction	Mar-23	Apr-23	May-23	Jun-23	Jul-23	Aug-23
Workforce	Obstetric cover - labour ward	RCOG guidence		<= 39	>= 40	Up	40	40	40	40	40	40
	Midwife to Birth ratio	RCM;NHSR;BR +	1.26	>= 1.28	<= 1.26	Down	1.31	1.25	1.31	1.29	1.30	1.30
	Midwifery vacancy rate (black= over establishment; red =under establishment)			>= 1	NA	Down	21.9	21.9	23.2	23.0	23.9	23.3
	Provision of 1 to 1 care in established labour (%)	NICE, RCM, MIS	100%	<= 94	>= 100	Up	100	100	100	100	100	100
	Datix relating to workforce	6 month SFT rolling		>= 2	= 0	Down	2	3	1	1	2	3
	Compliance with supernumery status of the LW coordinator - %	NICE;RCM;NHSR	100% rostered	<= 94	>= 100	Up	100	100	100	100	100	100
	Numbers of times maternity unit on divert	6 month SFT rolling		>= 2	= 0	Down	0	0	0	0	0	1

Safe – perinatal mortality review





August 23		
Stillbirths	0	
Neonatal Deaths	0	

PMRT action plans update				
Case ID	Action plan	Responsible person	Target date	completion
No outstanding actions				

Incidents and review update

Salisbury NHS Foundation Trust

SIIs, CRs and LRs In Progress						
ID	Directorate / Ward / Dept	Summary of incident	Incident date	Date commissioned	CRG	Date Due to CCG / 60 days target
SII 554	w and NB/Gynae	Delayed Ca Diagnosis	25/11/2022	21/03/2023		08/06/2023
SII 555 (HSIB)	Maternity/W&NB	Intrapartum stillbirth - HSIB	16/03/2023	21/03/2023		08/06/2023
CR 565	Maternity/W&NB	Uexpected admission to neonatal unit	18/05/2023	30/05/2023		22/08/2023
CR 569	Maternity	Uncrossmatchable Blood	02/06/2023	13/06/2023		08/09/2023
SII 570	Maternity	Retained Swab	09/06/2023	13/06/2023		08/09/2023
SII 571	Maternity	Placenta Acreta	25/05/2023	20/06/2023		14/09/2023
SII 574	Maternity	Stillbirth		27/06/2023		21/09/2023
CR 578	W and NB/Gynae	Delay in diagnosis (Ca)		11/07/2023		02/10/2023
CR 579	WNB	Term admission to NICU	20/04/2023	18/07/2023		09/10/2023
CR 580	WNB	Term admission to NICU	16/07/2023	01/08/2023		23/10/2023
CR 584	Maternity	OASI	3.7.23	8.8.23		30/10/2023
SII586	Maternity	Eclampsia and GA	8.8.23	22.8.23		13/11/2023
SII 587 (HSIB)	Maternity/W&NB	Term baby admitted to NICU and transferred to tertiary unit for cooling	12.8.23	22.8.23		13/11/2023
CR 588	Maternity	Antenatal Pulmonary Embolism at 15 weeks pregnant	31.7.23	29.08.23		20/11/2023
Reports for EXIT						
ID	Directorate / Ward / Dept	Summary of incident	Date commissioned	CRG	Date Due to CCG	Within 60 day target?
SII 548	Maternity/W&NB	Term admission to NICU	23/02/2023	28/02/2023		26/05/2023
SII 492	Maternity/W&NB	baby fitted in first 24 hrs - not HSIB - fitting was due to metabolic disorder	13/07/2022	19/07/2022		12/10/2022
SIIs, CRs and LRs Signed off - share (Stage 3) duty of candour						
ID	Directorate / Ward / Dept	Summary of incident	Incident date	Date Signed Off	Duty of Candour Update	Report share

Incident moderate or above

Date	Grading	Detail
02/08/2023	Moderate	Major Obstetric Haemorrhage and return to theatre
12/08/2023	Moderate	Unexpected Term Admission to Neonatal Unit
13/08/2023	Moderate	Major Obstetric Haemorrhage
14/08/2023	Moderate	4th Degree tear (Obstetric Anal Sphincter Injury)
18/08/2023	Moderate	Major Obstetric Haemorrhage requiring additional treatment (blood transfusion) and return to theatre
23/08/2023	Moderate	Failure in booking system

Incidents – actions

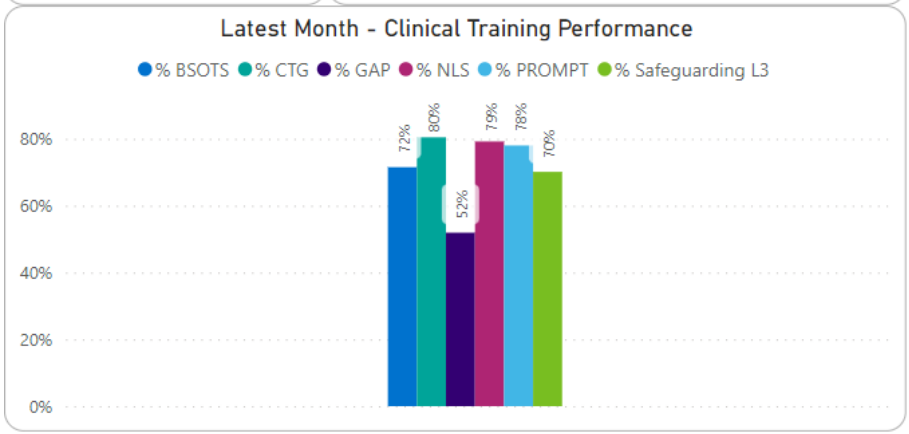
Salisbury NHS Foundation Trust

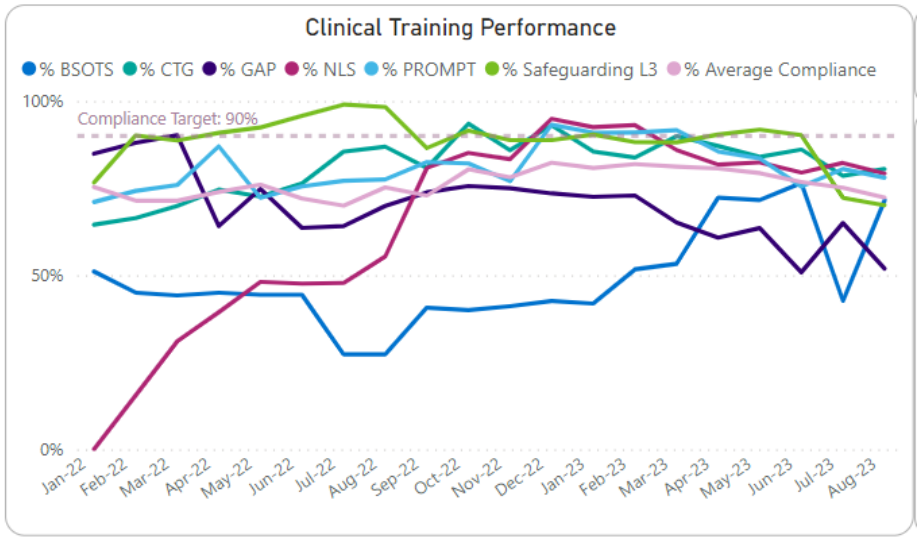
SII/CR No.	Link to Sheet	Directorate	Incident Date	Recommendation RAG Rating (Green = Completion Date, Amber/Red: Target Date)										
				1	2	3	4	5	6	7	8	9	10	11
SII 432	Click	W&NB	September 2021	Q3 21-22	June 22	Q2 22-23	Q2 22-23	Q2 22-23	Q2 22-23	Q2 22-23				
CR 454	Click	W&NB	December 2021	Q2 23-24	Q2 23-24	Oct 22	Q4 22-23							
SII 472	Click	W&NB	February 2022	Q1 22-23	Oct 22	Oct 22	Q3 22-23	Q3 22-23						
SII 477	Click	W&NB	April 2022	Q1 22-23	Q2 23-24	Jan 23	Q4 22-23	Q4 22-23	Q4 22-23	Q3 22-23	Q4 22-23	Q1 23-24		
SII 489	Click	W&NB	May 2022	Q1 22-23	Dec 22	Q4 22-23	Q4 22-23	Q3 22-23	Q3 22-23					
SII 497	Click	Surgery	July 2022	Surg	Q1 23-24	Q2 23-24	Med	Apr 23						
SII 506	Click	W&NB	March 2021	CSFS	Jun 23	Q1 23-24	CSFS							
CR 509	Click	W&NB	July 2022	Q2 22-23	Oct 23	Aug 23	Oct 23	Aug 23						
SII 510	Click	W&NB	August 2022	Q1 23-24	Q1 23-24	Feb 23	Feb 23	Feb 23	Jan 23	Jan 23	Q1 23-24	Jan 23		
CR 512	Click	W&NB	September 2022	Sept 23	Jul 23									
CR 514	Click	W&NB	September 2022	Q3 22-23	Jan 23	Q1 23-24	Dec 22	Feb 23	Q2 23-24	Q1 23-24				
CR 527	Click	W&NB	October 2022	Q1 23-24	Q1 23-24	Jun 23	Q2 23-24							
SII 537	Click	W&NB	December 22	Jul 23	Jul 23	Jul 23								
CR 540	Click	W&NB	November 2022	Jul 23	Jun 23	Sep 23	Jul 23	Jun 24						

Training Compliance August 2023

NHS Salisbury NHS Foundation Trust

Latest Month	90.0%	72.3%
Aug-23	% Compliance Target	% Compliance Average





Training-

Decrease in overall compliance in training in August – no training for PROMPT or CTG this month. Sessions allocated for September and October should ensure compliance exceeding 90%.

New training database in place to support allocation of all required maternity training, with oversight by divisional workforce lead to ensure staff are appropriately allocated study leave to improve training compliance.

Trajectory for BSOT's training completed with extra sessions in September to reach 90%

Fetal monitoring team and PDM to create a sustainability plan for keeping compliance at or around 90%

Service user and Staff Feedback

NHS Salisbury NHS Foundation Trust

Feedback from families

Positive from the MVP:

Waiting on the publication of a new patient experience survey.
Last survey Feb 23.

Neonatal unit (NNU) parent questionnaire,
Aug 23 -some highlights:
Did your baby/ babies admission to the unit go smoothly?
96.9% stated YES!

" *We were made to feel very welcome and everything that was happening to our babies was communicated very clearly"*

On the scale of 1-10 (where 1 is worst and 10 is best) how would you rate the neonatal unit at SFT?
Score 9/10

"Communication & treated with dignity and respect not felt to just be a patient but treated by nurses and doctors who care"

Areas for improvement:

Focus on postnatal care
Care in the latent phase of labour
Meal trolleys on the NNU

Feedback from staff

Feedback

Concerns over staffing levels

Concerns over study leave and time to complete mandatory training

Actions:

Findings from flexible working focus group and changes formalised

Incentive and recruitment drive in place – 15 midwifery roles offered and accepted to start Sept/Oct

Whilst Vacancies remain high to support payment of study as bank if staff wish to do it as extra hours

Compliments	Concerns	Complaints
0	0	0

NHS
Salisbury
NHS Foundation Trust

Report to:	Trust Board (Public)	Agenda item:	5.5
Date of meeting:	5th October 2023		

Report tile:	Maternity and Neonatal bi-annual Staffing report – September 2023			
Status:	Information	Discussion	Assurance	Approval
	Yes		Yes	
Approval Process: (where has this paper been reviewed and approved):	Approved by Women and Newborn Divisional Management Team 19.9.23 CGC – 26th September			
Prepared by:	Vicki Marston - Director of Maternity and Neonatal Services			
Executive Sponsor: (presenting)	Judy Dyos - Chief Nursing officer			

Recommendation:

The Trust Board are asked to note the contents of this report which has been provided for information and assurance processes.

In order to demonstrate compliance with the Maternity Incentive scheme the committee is asked to note the specific expectations in relation to demonstrating effective midwifery workforce planning as detailed in the report and that this is noted in the minutes of the meeting.

Executive Summary:

This report provides a bi-annual Midwifery staffing report as per Maternity Incentive Scheme (Year 5) – Safety Action 5.
It also includes a bi-annual staffing report relating to the neonatal nursing workforce.

For the Trust Board to note and minute the following required standards as set out in the report:

a) A systematic, evidence-based process to calculate midwifery staffing establishment is completed.
b) Trust Board to evidence midwifery staffing budget reflects establishment as calculated in a) above.
c) The midwifery coordinator in charge of labour ward must have supernumerary status; (defined as having no caseload of their own during their shift) to ensure there is an oversight of all birth activity within the service.
d) All women in active labour receive one-to-one midwifery care.
e) Submit a midwifery staffing oversight report that covers staffing/safety issues to the Board every 6 months, during the maternity incentive scheme year five reporting period.

In addition to note the challenges and mitigations in Midwifery staffing over the 6 month period this covers, and to acknowledge that the required standards as set out above have been met and are evidenced in the report.

To note that to meet Safety action 4 of CNST a Neonatal Staffing action plan (covering nursing and medical workforce) will be reported in November alongside Obstetric and Anaesthetic medical staffing in addition to this bi-annual report as per CNST requirement for this safety action.

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

BI-ANNUAL MIDWIFERY, MATERNITY AND NEONATAL STAFFING REPORT SEPTEMBER 2023

1. Purpose

The aim of this report is to provide assurance to the Trust Board that there was an effective system of midwifery workforce planning and monitoring of safe staffing levels from April 2023 to September 2023. This is a requirement of the NHSLA Maternity Incentive Scheme and relates to Safety Action 5

2. Background

It is a requirement that as NHS providers we continue to have the right people with the right skills in the right place at the right time to achieve safer nursing and midwifery staffing in line with the National Quality Board (NQB) requirements.

Organisational requirements for safe midwifery staffing for maternity settings (NICE 2017) states that midwifery staffing establishments develop procedures to ensure that a systematic process is used to set the midwifery staffing establishment to maintain continuity of maternity services and to always provide safe care to women and babies in all settings.

In addition, the Maternity Incentive Scheme, (MIS Clinical Negligence Scheme for Trusts), Year 5, sets out clear expectations in relation to demonstrating an effective system of midwifery workforce planning.
To provide evidence for NHS Resolutions Maternity CNST Incentive Scheme, this paper provides staffing data on Midwifery and Neonatal Nursing Staffing. The required standards are as below:

a) A systematic, evidence-based process to calculate midwifery staffing establishment is completed.

b) Trust Board to evidence midwifery staffing budget reflects establishment as

calculated in a) above.

c) The midwifery coordinator in charge of labour ward must have supernumerary status; (defined as having no caseload of their own during their shift) to ensure there is an oversight of all birth activity within the service.

d) All women in active labour should receive one-to-one midwifery care.

e) Submit a midwifery staffing oversight report that covers staffing/safety issues to the Board every 6 months, during the maternity incentive scheme year five reporting period.

3.Executive Summary

This report gives a summary of all measures in place to ensure safe midwifery staffing; including workforce planning, planned versus actual midwifery staffing levels, the midwife to birth ratio, specialist hours, compliance with supernumerary labour ward coordinator, one to one care in labour and red flag incidents.

4. Birthrate Plus Workforce Planning and staffing levels.

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 coordinator 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.

NICE (2017) recommend that an assessment is carried out every three years, as of August 2023 we are in the process of repeating our assessment and are currently in the data collection stage with the team from Birthrate Plus. We expect to complete this by end of September and to receive a new report in late Autumn 2023

Birth-rate plus recommendation May 2021

Total Births	**2193**
Core Hospital Services	
Delivery Suite	33.86
Postnatal Ward	20.95
Maternity DAU	7.56
Community Inc. Homebirth provision	27.83
Total Clinical wte Band 3-7	**90.15**

Our substantive funded establishment reflects the birthrate plus recommendation for staffing levels. However, recruiting to our funded establishment has been challenging over recent months and maintaining staffing levels is a constant challenge.

This has been escalated to Board level and is being managed accordingly, as detailed later

in the report.

We recognise that there is a need to balance the junior workforce with experienced staff and in particular the recruitment into senior Band 6 positions is a challenge for Salisbury. Although challenges in recruitment are not just isolated to Salisbury, the military population, lack of city lifestyle and size of the maternity service are all contributory factors to recruitment challenges.

The recruitment team are currently providing focused individual support, including weekly meetings with the Director of Maternity and Neonatal Services, 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.

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 being piloted to aid recruitment. We have adapted to look at several varying processes to attract staff, including supporting return to practice midwives, financial incentives, and varying contracts. From a flexible working perspective, we have trialed 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 well-received by staff and supports our work around retention.

Our collaborative work with Gloucester and GWH to recruit international midwives has been successful, we have 7 international midwives working within the service now. Two are working at band 5 having completed their OSCE and received their NMC Pin, the remaining 5 midwives are at varying stages in the education and OSCE process and remain in supernumerary posts. We are anticipating all will have taken OSCE by the end of September 2023 and on receipt of NMC registration will be moving into band 5 preceptee positions.

We have also been working on a forecast trajectory, looking at vacancies rates against budgeted establishment and factoring in predicted starters (including OSCE qualified international midwives and newly qualified midwives), leavers, agency staff and maternity leave. This has enabled forward planning and in particular, a clear approach and timeframe around recruiting long line agency midwives to support vacancies until substantive staff move into posts.

We are anticipating a significant reduction in vacancies in October 2023 as shown below:

Banding	Clinical Budgeted Establishment	Actual Clinical Headcount (WTE) August 2023	Variance (WTE) Establishment vs staff in post August 2023	Anticipated Staffing October 2023
Band 5 Nurses	0	4	+4	4
Band 5 Midwives	12.09	3.64	-8.45	18.64 (New starters – Preceptee and International Midwives)
Band 6 Midwives	70.58	48.03	-22.55	57.87 (New Starters and B5 MW moving to B6 MW)
Band 7 Midwives	7.48	10.68	+3.2	9.68
Total	**90.15**	**66.35**	**- 23.8**	90.19 (includes nurses) **86.19 Clinical Midwives**

Maternity leave has been consistently high amongst midwives and as of August 2023 we have 8.98 WTE midwives on maternity leave which does put further pressure on fill rates.

When staffing is less than optimum, the following measures are taken in line with the escalation policy:

- Utilisation of Bank Midwives.
- Community staff working flexibly in the unit as and when required.
- Non-clinical midwives working clinically to support acuity.
- Use of long line Agency Midwives to cover vacancies (February to October 2023).
- Support of Maternity and Neonatal 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.
- Recruitment of nurses to the maternity Services.

All the above actions are designed to maximise staffing into critical functions to maintain safe care for the women and their babies.

It is important to recognise staff wellbeing is impacted with the shortfall of staff within the service and staff are feeling the pressure of vacancies. It is recognised that although staff have undertaken Bank work to close day to day gaps this is not a sustainable long-term solution.

From a pastoral support perspective, we have a retention Professional Midwifery advocate (PMA) in post and have recently received LMNS money to support funding a retention lead for MSW. The PMA post has proved valuable in supporting staff and understanding the reasons they may be considering leaving the service and helping them to find solutions to

remaining with us i.e., flexible working for example.

5. Midwife to Birth Ratio

Birthrate Plus has calculated an individualised midwife to birth ratio for Salisbury, recommending a rate of 1:26. Following review of individualised data 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.

The table outlines the real time monthly birth to midwife ratio for the past 6 months.

Month	February23	March 23	April 23	May 23	June 23	July23
Midwife to birth ratio	1:27	1:31	1:25	1:31	1:29	1:30

6. Specialist Midwives

Birth Rate Plus recommends that 8-11% of the total establishment are not included in the clinical numbers, with a further recommendation of this being 11% for multi-sited Trusts. This includes management positions and specialist midwives. 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 at SFT 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 amongst others.

Since our assessment in 2019/21 birthrate plus has been reviewing the standard percentage and is adapting it depending on unit size, recognizing that the national ask is the same despite the number of births and therefore smaller units may expect to require a higher percentage of non-clinical. They have indicated that the percentage applicable to SFT is likely to move upwards to 12% in our next assessment.

7. Birth Rate Plus Live Acuity Tool

The Birth Rate Plus Live Acuity Tool is used in the intrapartum areas and in the other inpatient areas. It is a tool for midwives to assess their 'real time' workload arising from the number of women needing care, and their condition, admission and during the processes of labour, delivery and postnatally. It is a measure of 'acuity', and the system is based upon an adaption of the same clinical indicators used in the well-established workforce planning system Birth Rate Plus.

The Birth Rate Plus classification system is a predictive/prospective tool rather than the retrospective assessment of process and outcome of labour used previously. The tool is completed four hourly by the labour ward coordinator. An assessment is produced on the number of midwives needed in each area to meet the needs of the women based on the minimum standard of one-to-one care in labour for all women and increased ratios of midwife time for women in the higher need categories. This provides an assessment on admission of where a woman fits within the identified Birth Rate Plus categories and alerts midwives when events during labour move her into a higher category and increased need of midwife support.

This safe staffing tool kit supports most of the components in the NICE Guidance (and is endorsed by NICE) on safe midwifery staffing for maternity settings necessary for the determination of maternity staffing requirements for establishment settings. It provides evidence of what actions are taken at times of higher acuity and use of the escalation policy when required.

8. Supernumerary Labour Ward 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 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 100% of the measured occasions in the 6 months this report relates to.

The following table outlines the compliance against this action by month:

	Number of days per month	Number of shifts per month	Compliance
February 23	28	56	100%
March 23	31	62	100%
April 23	30	60	100%
May 23	31	62	100%
June 23	30	60	100%
July 23	31	62	100%

9. One to One care in Established Labour

Women in established labour are required to have one to one care and support from an assigned midwife. Care will not necessarily be given by the same midwife for the whole labour, but it is expected that the midwife caring for a woman in established labour will not have any other cases allocated to her.

If there is an occasion where one to one care cannot be achieved, then this will prompt the labour ward coordinator to follow the course of actions within the acuity tool and the escalation policy. These may be clinical, or management actions taken.

The following table outlines compliance with provision of 1:1 care by Month.

	February	March	April	May	June	July
Birth Centre	100%	100%	100%	100%	100%	100%
Labour Ward	100%	100%	100%	100%	100%	100%

10. Red Flag Incidents

A midwifery red flag event is a warning sign that something may be wrong with midwifery staffing (NICE 2015). If a midwifery red flag event occurs, the midwife in charge of the service is notified. The midwife in charge will then determine whether midwifery staffing is the cause and the action that is needed. Red flags are collected through the live Birth Rate Plus acuity tool.

The following tables demonstrate red flag events for the 6-month period from 1st February 2023 to 31st July 2023. Out of 659 data admissions there were 7 red flags entered onto the system with the reasons detailed below:

Number & % of Red Flags Recorded

From 01/02/2023 to 31/07/2023

RF1	Delayed or cancelled time critical activity e.g.Delay EL LSCS >4 hours	0	0%
RF2	Missed or delayed care (for example, delay of 60 minutes or more in washing and suturing) e.g waiting for suturing >60 mins	0	0%
RF3	Missed medication during an admission to hospital or midwifery-led unit (for example, diabetes medication)	0	0%
RF4	Delay of more than 30 minutes in providing pain relief	1	13%
RF5	Delay of 30 minutes or more between presentation and triage	1	13%
RF6	Full clinical examination not carried out when presenting in labour	0	0%
RF7	Delay of 2 hours or more between admission for induction and beginning of process	5	63%
RF8	Delayed recognition of and action on abnormal vital signs (for example, sepsis or urine output)	0	0%

Each red flag is recorded on the acuity tool and reported via datix, this ensures timely review and action planning to reduce repeat incidents and maintain safety.

11. Safety and Overview

In order for the service to demonstrate safe staffing on a daily basis 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 missed breaks via Datix 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 (as an Improving together divisional driver) and is discussed with the Board level Safety Champions monthly. The reporting mechanisms ensure clear escalation and visibility of staffing challenges.

12. 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 carer 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.

The table below 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 90.16 WTE clinical midwives to be fully recruited into, and with the current vacancy rate this is not currently feasible.

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**	

13. 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. Next steps are detailed:

- Continue with the recruitment campaign work utilising all options available to the Trust for recruitment and retention incentives.
- 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.
- Continue with retention work and input from PMA to support staff.
- Continued consideration of any exit interview themes and actions associated with them.

Neonatal Staffing report – September 2023

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),

This report has been written following review of Neonatal Nurse staffing in line with the recommendations and standards outlined in the above documents by the Director of Midwifery and Neonatal Services and Neonatal Matron.

2. Neonatal Services staffing review methodology.

2.1 The department has been in escalation for 10 days from April 1st 2023 to the end of August 2023. The service had a mixture of higher acuity and cot capacity against plan in this time because a rise in the number of overall admissions. Safe staffing was maintained by use of escalation policy and NICU and Maternity staff covering shortfalls in acuity, and the use of bank nurses.

2.2 All units within the local Neonatal network are utilising a recognised acuity tool (Badger). This enables staff to consider the staffing, capacity and activity in real time and activate escalation when necessary. This real time data ensures that there is a clear pathway around escalation and activity which is being followed in times of high activity.

Additionally, the Neonatal Matron further reviews the data monthly around performance and activity against acuity to ensure we are meeting the service demands and providing safe and appropriate levels of staffing.

2.3 Within the budgeted establishment 70% of RNs/RCNs are expected to be Qualified in speciality (QIS). Current levels locally at SFT are at 68.7% although will be above 70% in October due to further training being completed.

QIS training is now being delivered by the neonatal network with the backing of Health Education England (HEE). 1 to 2 places on the QIS course are allocated to SFT annually to ensure we meet national targets on specific neonatal nurse training and have a clear trajectory around succession planning for these specialist roles. At present 1.0 WTE nurses has just completed their QIS training, and a further 1.53 WTE commence QIS training in September 2023. This rolling training programme supports succession planning to ensure there are staff with correct skills working in the NICU.

2.4 Central funding was allocated in August 2023 from the Operational Delivery Network (ODN) of £12,129/year. These additional funds are to support leadership in the Neonatal team.

2.4.1 Additional posts in 2023:

Band 7 Psychotherapist 0.2WTE employed to support mothers requiring psychological input following trauma from birth or following their babies admissions and stay on Neonatal Unit. It is recognised that birth and the subsequent Neonatal journey for mothers can be challenging, and this role shared across maternity and NICU will allow support for this.

Audit lead 0.2WTE. With both the local and National requirement to be benchmarking our services and care provision, particularly around CNST and Ockenden this will enable increased hours for audit to ensure oversight and continuous improvement.

3. Challenges:

- Sickness Absence

- Sickness absence is currently at 3.2%.

  Absence is challenging in what is a small and specialist team, however it has been mitigated successfully with the use of bank staff and the continued use of an ad hoc on call system. Flexibility across post-natal and Sarum ward to support when the neonatal service goes into escalation further reduces the need for agency staff. Securing last minute agency is challenging with a requirement for QIS however the Trust incentive of 'super enhanced shifts' has supported filling last minute absence.

- The national initiative (ATAIN), to reduce the number of babies admitted to a neonatal service, 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.

  - Funding (£40,000) secured following our submission last year will support recruitment of 1.0WTE maternity nurse to enhance the TC model and partially support financing attendance at Transitional Care study days (provided by SE neonatal network).

  - As of November 2023, we will commence a rotation for the maternity nurses working on postnatal ward to the neonatal unit to further enhance their skills.

  - This will be done with a long-term goal in mind to utilise these nurses for TC staffing.

- 2.0 WTE jobs currently advertised following promotion of current nurses. This will ensure that we remain, as current position, at full establishment.

- Band 5 maternity leave (1.0WTE) from November 2023 - mitigated by rotating the maternity nurses to NICU.

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:

- Educational opportunities to support retention e.g. QIS and New-born Life Support (NLS) training.

- Monthly assessment of staffing and effective forecasting.

- Recruitment of Audit lead 0.2WTE

- Opportunities for development by shadowing senior nursing staff and focussing on succession planning and educational opportunities.

- Supporting flexible working to enable improved work/life balance for staff

5.0 Recommendations

- As per CNST safety action 4 an action plan of Neonatal Medical and Nursing staffing, alongside Obstetric and Anaesthetic Medical staffing will be presented alongside a report to demonstrate the compliance with this standard in November 2023.

- We will continue to closely monitor a sustained increase in cot numbers and acuity since the pandemic through our BAPM nursing staffing tool. If the increase in numbers is sustained consideration will be given to the possibility of expanding 1 ITU cot and recruiting further band 5 nurses to comply with BAPM standards. Admissions are continuing to be closely monitored and all are reviewed by the MDT.

- 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.

CLASSIFICATION:

Salisbury NHS Foundation Trust

Report to:	Trust Board	Agenda item:	
Date of meeting:	July 2023		

Report tile:	Quarter 1 2023/24 Risk Management Report			
Status:	Information	Discussion	Assurance	Approval
	X	X	X	
Approval Process: (where has this paper been reviewed and approved):	Clinical management board			
Prepared by:	Kim Melbourne Deputy Risk Manager			
Executive Sponsor: (presenting)	Judy Dyos Chief Nurse			

Recommendation:

Information - To note the themes and trends identified in the Executive Summary.

Discussion – To note the report and identify any areas requiring further clarity or focus.

Assurance – To note the numbers of reported incidents with associated low levels of harm.

Executive Summary:

Monitoring of incidents to highlight trends and areas requiring further investigation/action.

All patient safety incidents classified as moderate harm or above are reviewed at the weekly Patient Safety Summit. A total of 18 reviews were commissioned in Quarter 1. Of these, 8 were Serious incidents and 10 were clinical reviews.

In addition, there were 17 SWARMs for falls resulting in moderate and above harm completed. One of these SWARMs progressed to an SII.

13 SII/CRs have been completed and closed during quarter 1. None of these were completed within the 60-day time frame. However, the ICB are now looking at whether progress is being consistently made rather than a strict adherence to the previously recommended 60 days.

48 SII/CRs remain open. 18 of these are within the original 60-day timeframe, the other 30 have breached the 60-day timeframe.

SII/CR recommendations compliance

Recommendations and learning continue to be extrapolated from reviews. There are currently just short of 175 open actions which have breached their specified time frame. These compliance reports are addressed in the divisional deep dive meetings that are held with the executives. 50% of the divisions are within the recommended time frame of a deep dive every 3-6 months. Barriers lie with the availability of quorate members to attend.

Embedding risk management at all levels of the organisation – embedding a just culture

Each Department and Division continues to maintain a comprehensive risk register. Divisional risk registers are formally reviewed in Divisional Governance Meetings and through Executive Performance reviews, in addition to a risk deep dive as described above.

Promoting reporting

There has been an overall increase of 8.1% in the reporting of incidents from Q1 22/23 (2323) to 2513 in Q1 23/24. From Q4 22/23 to Q1 23/24 there is a 2% decrease in the reporting rate. The largest reporting group continues to be nursing and allied health professionals.

The NRLS system will be replaced by the Learning from Patient Safety Events (LFPSE) in September 2023. This is a large ongoing piece of work within the risk department at present to ensure the Trust is ready to go live by the specified national date.

Ensuring there is appropriate provision of datix incident training.

An issue has come to light regarding the initial MLE mandatory training that was thought to be included on everybody's learning tree. This has fallen off and work is ongoing with the education department to reinstate this.

Training will change shortly in order to reflect the upcoming LFPSE launch.

Ensure compliance of 'duty of candour' reports.

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

Quarter 1 2023/24 Risk Management Report

Introduction

The Trust recognises that risk management must be fully embedded for the organisation to function safely and effectively. Robust risk management processes must be in place for the Trust Board to be assured on performance and standards. To achieve this, the Trust Board needs to be confident that the systems, policies and staff it has put in place are operating in a way that is effective, focused on key risks, and driving the delivery of the corporate objectives.

To monitor the effectiveness of the risk management processes and policies the following strategic objectives have been set:

- Monitoring of incidents to highlight trends and areas requiring further investigation/action.
- Embedding risk management at all levels of the organisation – embedding a just culture
- Promoting reporting
- Ensuring there is appropriate provision of datix incident training.
- Ensure compliance of 'duty of candour' reports.

1. Monitoring of incidents to highlight trends and areas requiring further investigation/action

1.a *Weekly review of all moderate, major, and catastrophic patient safety incidents through the weekly Patient Safety Summit.*

The weekly Patient Safety Summit (PSS) provides a means of systematically reviewing and managing patient safety incidents within the organisation. The main purpose of the group is to ensure incidents are managed effectively and consistently, and any quality or safety themes can be identified and escalated to the required governance channels as appropriate. This also includes the sharing and communication of best practice. Assurance is sought to understand what has been put in place to mitigate a repeated incident / what still needs to be done and what learning for the team involved and wider learning can be drawn upon. Prior to the meeting the Head of Nursing / Divisional Matron will have arranged for a 72-hour report to have been completed.

Using the Serious Incident / Adverse Incident reporting guidance, the meeting will agree whether the incident is:

- A Serious Incident, requiring external reporting to our commissioners and an investigation and delivery of a report within 60 working days that is presented to CRG.
- A high-risk incident requiring a clinical review and a report presented to CRG.
- An incident requiring local investigation and management (Recorded on Datix)
- For an external agency/organisation to undertake a review.
- A potential joint investigation with another organisation(s)

Through the PSS, 18 reviews were commissioned in quarter 1 2023/24. Of these, 8 were Serious Incidents and 10 were clinical reviews.

The table below gives a snapshot of the last **2** months of quarter 1 in relation to how many cases were brought through PSS and the outcomes of these cases.

Quarter 1	Division	Cases	Bring Back	Swarm	LR	CR	SII	Attain	Reclassified	Themes
May	Med	23	6	5	6	1	2		1	Falls
	Surg	15	4	2	3				6	
	CSFS	11	6			1	1			
	WNB	10	3		2	1		2		
		59	19	7	11	3	3	2	7	
June	Med	31	7	1	9	3			5	Falls
	Surg	11	4	1		1	1		4	
	CSFS	11	2		4				4	
	WNB	15	6				3			
		68	19	2	4	4	4	0	13	
May/June total		127	38	9	15	7	7	2	20	

In addition, there were 17 SWARMs for falls resulting in moderate and above harm completed, 8 in April 7 in May and 2 in June

The main theme remains at risk assessments being incomplete/late, hence interventions not utilised correctly.

From presentation and thorough discussion at the weekly Patient Safety Summit meeting 1 incident in April was commissioned for an SII.

There was a patient who unfortunately fell twice in May sustaining life changing head injuries, which have also been commissioned as SII's.

The rest of the SWARM investigations have remained with actions at local level.

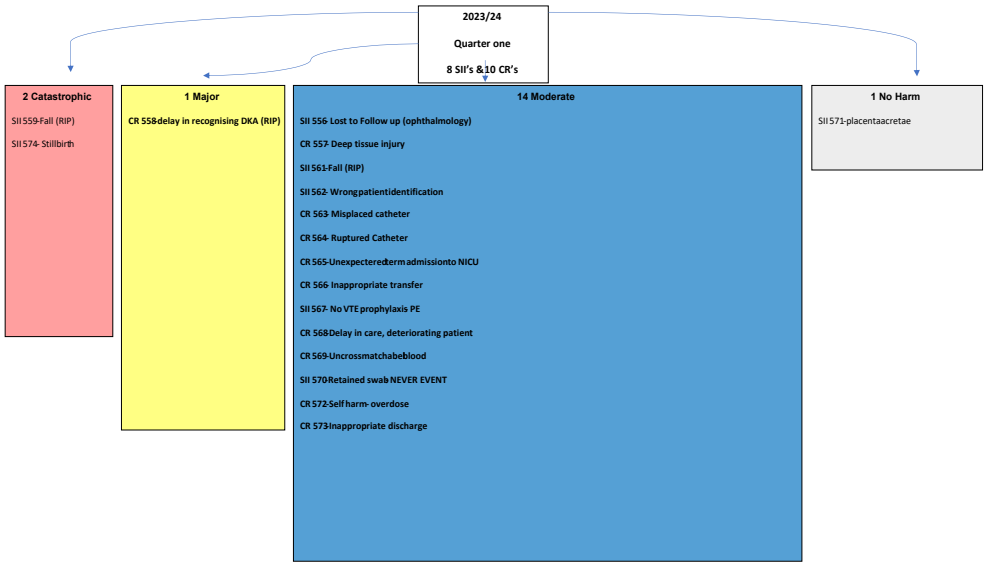
The overall falls fell dramatically in June. Some speculative reasons for this are:

Bed days have decreased hence wards are better staffed this is reflected in CHPPD .

Staffing levels on the ward have mainly been "green" with a decrease in sickness and vacancy absences.

Bay Watch has been in use in some high-risk areas e.g., Amesbury who have decreased their falls rate by 60% in June with no harm to those patients who did fall.

Since May there has been a greater focus from senior nurses who have been assisting at ward level with Improvement projects.

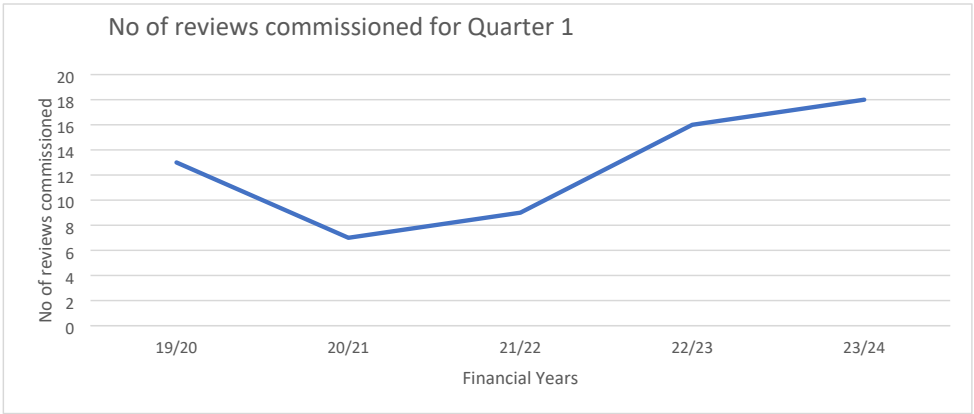


Whilst the themes of the reviews commissioned this quarter are broad there are a number of reviews where the overarching themes have been raised in previous SII/CRs. Examples of these are:

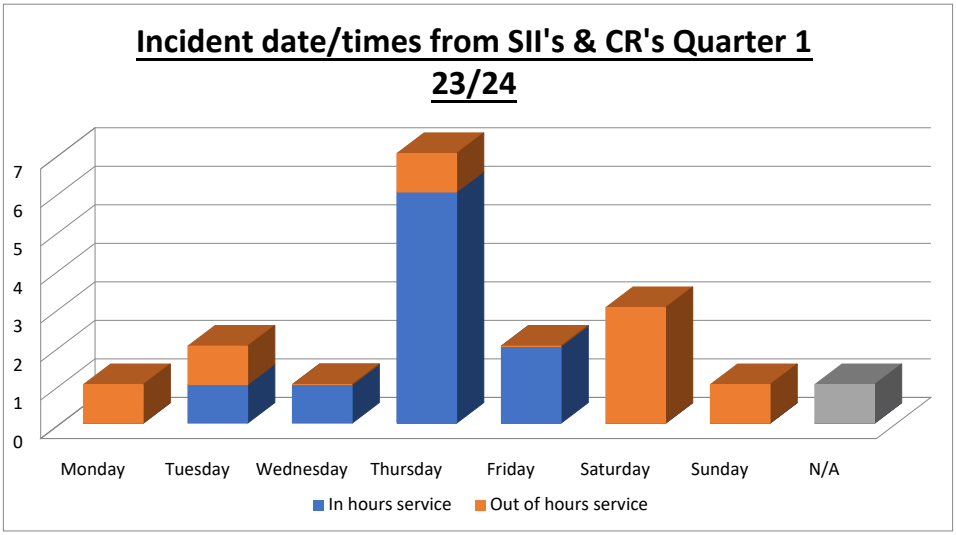
- Term admission to NICU
- Falls
- Delay in care for the deteriorating patient
- Lost to follow up.

There has been **one Never Event** in Quarter one which involved a retained swab following an emergency cesarean section.

The chart below indicates the trend over the last 5 financial years of commissioned reviews. Following the introduction of the weekly patient safety summit (PSS), in December 2020, there has been a steady increase in the number of reviews commissioned.



The chart below identifies the timings of incidents. Overall, there is a slightly higher occurrence of incidents within '9-5' hours (10) as opposed to out of hours (7). This appears to reflect the findings from the annual report 22/23



1.b Compliance against SI/CR KPI timeframes

Looking at the SII/CR data for Quarter 1

13 SII/CRs have been completed and closed during Quarter 1.

None of these were completed within the 60-day time frame. However, the ICB are now looking at whether progress is being consistently made rather than a strict adherence to the previously recommended 60 days.

48 SII/CRs remain open.

- 18 of these are within the original 60-day timeframe, the other 30 have breached the 60-day timeframe

Members of the Quality Team within the ICS have attended the weekly PSS and are in receipt of timely progress updates of SII's.

Processes are constantly being reviewed to identify and address where the delays are and how these can be minimised.

Compliance report for SII/CR open actions

The next table illustrates the number of actions within the reviews that remain open and have breached their completion date. Alongside the risk registers, the compliance reports are discussed within the deep dives that are held between the divisional leads and the execs. The table below also demonstrates when each division last had their deep dive meeting. The surgery directorate has not participated in a deep dive for 2 years. Numerous attempts have been made by the risk department to coordinate dates with the directorate with no success. CSFS have their next meeting booked in for 03/08/2023.

Directorate	Breached (Red)	Breached but work in progress (Amber)	Total breached	last deep dive
Medicine	61	31	**92**	22/06/2023
Surgery	18	23	**41**	09/06/2021
CSFS	11	8	**19**	21/11/2022
W and NB	9	12	**21**	16/06/2023

The table below illustrates the frequency of these deep dive meetings and barriers as to why they have been cancelled.

Division	Date Booked In	Cancelled?	Reason for cancellation
CSFS	20/05/2021	No	
	14/10/2022	Yes	DMT unavailability
	21/11/2022	No	n/a
	02/06/2023	Yes	DMT unavailability
Medicine	28/06/2021	Yes	
	11/11/2023	Yes	DMT unavailability
	12/04/2023	Yes	DMT unavailability
	22/06/2023	No	
Surgery	09/06/2021	No	
	31/05/2022	Yes	DMT unavailability
	24/04/2023	Yes	Clash with Exec Gold for industrial action
W & NB	28/7/2021	No	
	18/11/2022	No	
	21/04/2022	Yes	
	16/06/2023	No	

Attendance at Clinical Risk Group (CRG) and Patient Safety Steering Group (PSSG).

As part of the governance process, SIIs and CRs are presented at CRG for approval prior to being presented to the executives for final sign off.

An overall review of all completed reviews alongside the RMRC are presented monthly at the PSSG.

Twice monthly meetings have been consistently held during quarter 1 for CRG and attendance records are maintained.

Monthly PSSG meetings have continued to run consistently.

1.c Provision of monthly incident report card at the Patient Safety Steering Group to support theming of all incidents and monitoring of high harm incidents.

The Risk Report Card is reviewed monthly by the Patient Safety Steering Group and quarterly through the Clinical Governance Committee. Key themes and trends are identified along with feedback on work streams being taken forward to improve patient safety and reduce risk. An example for this quarter is the workstream regarding SBAR and handover of patient care between areas.

There has been an overall decrease of 2% in the reporting of incidents in Q1 23/24 (2513) compared to 2569 in the previous quarter (4 22/23).

The top 5 incident categories for this quarter are:

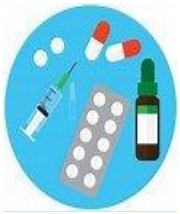
Implementation of care or ongoing monitoring/review

574 incidents fall in this category
444 relate to pressure sores/decubitus ulcers.
A small increase from 3 to 7 in safeguarding concerns relating to inpatient care.
A 22% increase in a possible delay or failure to monitor. (51 in Q4 as opposed to 62 in Q1)

Accident that may result in personal injury.

409 incidents fall into this category
353 of these incidents relate to slips, trips and falls, of these 19 affected staff members.
A 55% decrease in needlestick or other sharps related incidents (31 in Q4 compared to 14 in Q1)
An increase in Exposure to electricity, hazardous substance, infection, etc (5 to 13) (to note, this category includes spills to patients from hot drinks, inappropriate imaging as well as estate based incidents)

Medication



252 incidents in this category, a 28% decrease in the number of medication incidents from Q4 to Q1(346 in Q4 to 252 in Q1)
An increase in recording error is noted (from 2 to 7)

Access, appointment, admission, transfer, discharge

210 incidents in this category, a similar number to quarter 4
A small increase in problem with referral from primary to secondary care (2 to 7)
An increase in failure in booking process (13 to 21)

Consent, confidentiality, and communication

140 incidents in this category, an increase from quarter 4.
Predominantly related to inadequate handover of care (from 4 to 28)
(A workstream has been established to look at handover of care, including use of SBAR)

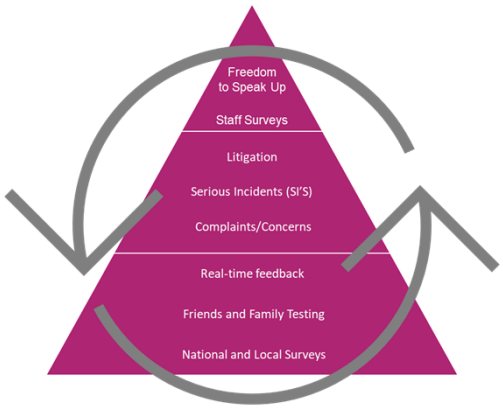
Learning from completed reviews.

The following are a small number of areas of learning that have been extrapolated from SII/CRs.

- The importance of maintaining situational awareness within the multidisciplinary team on the Labour Ward.
- The importance of using the Sepsis Six Screening Tool to aid clinical decision making.
- The need to review how paediatric and adult patients are triaged and risk assessed within the ED department. Work is now currently under way in relation to development/updating of a peadiatric pathway in ED
- The need to follow the paediatric escalation protocol when the ED is over capacity or a where a delay in triage is anticipated.
- On going to allow for greater confidence of Labour Ward Coordinators to contact the on call obstetric consultant if they have concerns about care provided by a member of the medical team.
- Junior doctors need to understand their responsibilities in relation to informing on call obstetric consultants of the changing clinical picture on Labour ward.
- SBAR not being used for handover of patient.
- Evidence escalation within the Division when identified 1:1 support not available.
- Recognition of ease in which patients and staff can exit via a fire door in a secure ward environment.
- When anticoagulation is started there needs to have been a clear discussion re possible timing of delivery so that the most appropriate drug is given.

***1.d** Triangulation with PALS, Freedom to Speak Up and the legal Team to look at broader themes and learning.*

At the time of writing this report, the data for Q1 has not yet been pulled together.



2. Embedding risk management at all levels of the organisation – creating a safety culture

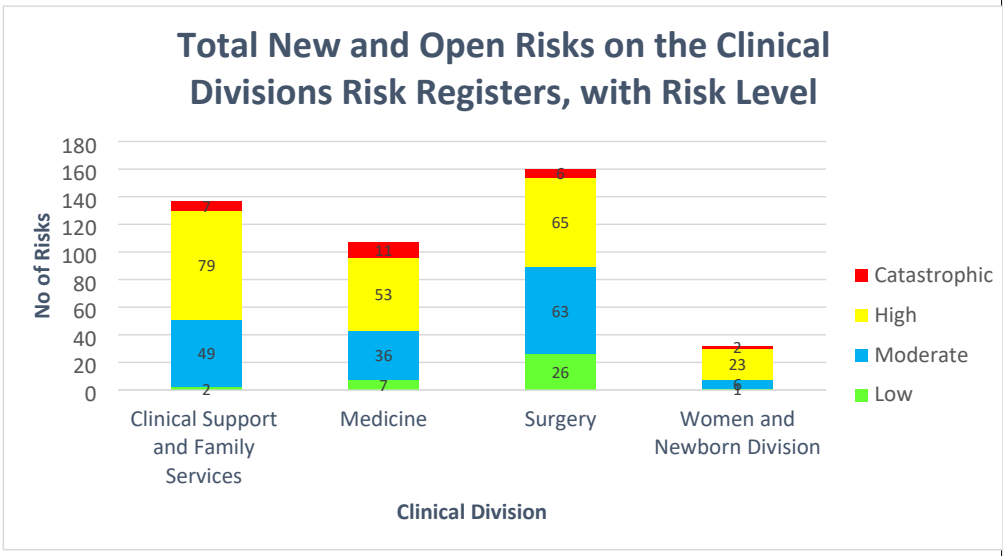
2.a Ownership of risks at a local level

Each Department continue to carry out risk assessments which are held on Datix. A single framework for the assessment, rating, and management of risk is used throughout Datix to ensure a consistent approach. An additional 17 members of staff have undertaken training in Quarter 1 in order for them to have access and utilise the risk register.

2.b Enhance the use of risk registers at Departmental and Divisional level.

Each Department and Division continues to maintain a comprehensive risk register. Divisional risk registers are formally reviewed in Divisional Governance Meetings and through Executive Performance reviews. Additionally quarterly divisional deep dives are undertaken with the CMO and/or CNO where all risk are reviewed not just high and new risks.

The below table demonstrates the current open risks for each directorate, alongside the grading. There are a total of 436 risks open between the four divisions.



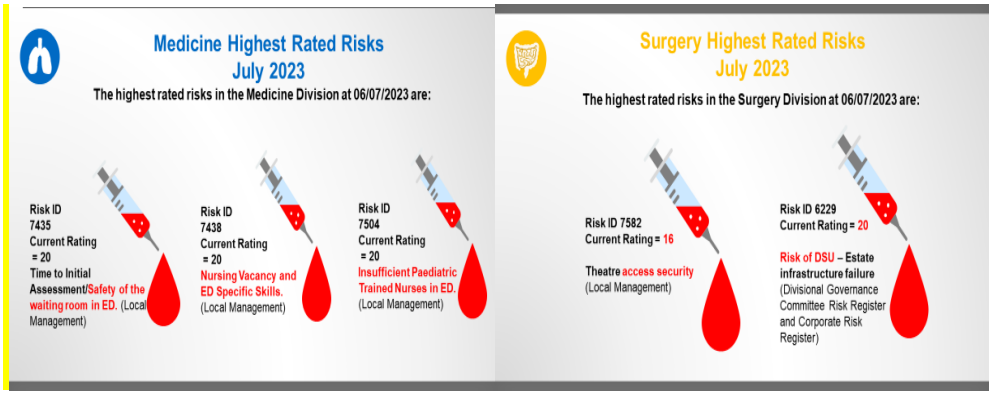
2.c Evidence that dynamic risk registers are held within all departments covering key risks.

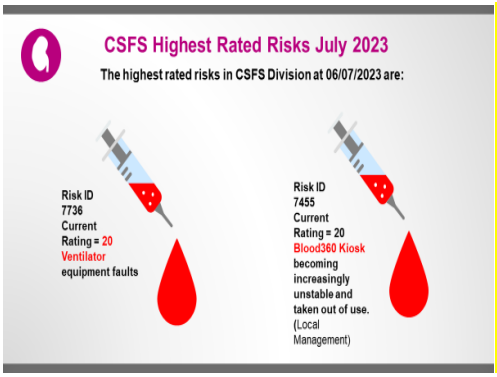
Any new risk is flagged to the risk owner, monitored and compliance reported to each of the Divisions monthly. Email reminders are sent to risk owners to remind them to review risks that are overdue for review.

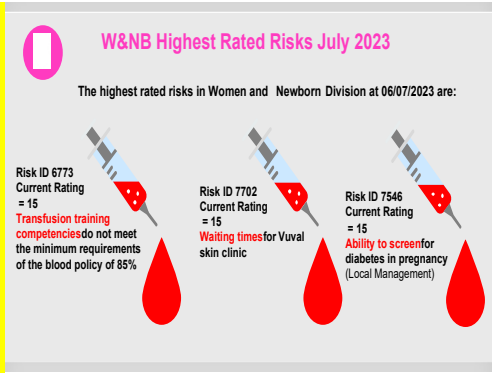
2.d Ensuring a transparent system for aggregation and escalation between departmental and Divisional risk registers with the Corporate Risk Register and Assurance Framework.

All Divisions have risk registers, which include high risks (10+) and any lower scoring risks that require DMT oversight. Those that require executive support are escalated and monitored via the executive performance meetings.

The below tables demonstrate the top risks by Division.







3. Promoting Reporting

3.a Ensure all staff are aware of their responsibility for reporting incidents.

There has been an overall decrease of 2% in the reporting of incidents in Q1 2023/24 (2513) compared to 2569 in Q4 2022/232. There has been an overall increase of 8.1% in the reporting of incidents from Q1 22/23 (2323) to 2513 in Q1 23/24. This is seen as a positive reporting culture.

Job Type	Q4 22-23	% of total	Q1 23-24	% of total
Administration/Clerical/Secretarial	111	4.31	102	4.03
Allied Health Professional	361	14.02	255	10.08
Ancillary	56	2.18	50	1.98
Bank/Agency/Locum	95	3.69	92	3.64
Clinical Assistant	105	4.08	91	3.60
External	30	1.17	31	1.23
Manager	37	1.44	51	2.02
Medical	88	3.42	119	4.71
Nursing/Midwifery	1667	64.76	1731	68.45
Unknown	24	0.93	7	0.28
Total	**2574**	**100**	**2529**	**100**

The new National Learning From Patient Safety Events (LFPSE) is replacing the current national reporting and learning system (NRLS). Our local datix system needs to be upgraded to be compatible, to report patient safety incidents which will then automatically be uploaded directly to the national system. IT are engaged to provide the necessary support. The commencement date of this has nationally been extended from April 2023 to September 2023. LFPSE will play an important role within the PSIRF agenda and identifying themes, trends and areas for learning.

3.b Participation in local meetings, M and M meetings and Clinical governance sessions.

The risk management team continue to work closely with local teams and alongside the Divisions to support the risk management agenda ensuring that there is representation at the appropriate governance forums to support the learning and reinforce key messages.

3.c Facilitation of Board Safety walk rounds to support staff to raise safety concerns within their areas.

There were 15 Board Safety Walks scheduled between April 2023 and June 2023 (quarter 1) –4 were cancelled due to reasons which are illustrated below. The walk arounds allow the Executives, Non-Executives and Quality Leads to meet with Ward/Department Team members to see first-hand all the good work happening throughout the Trust and to hear firsthand of safety concerns from staff. Although there has been significant delays in minutes and action plans being submitted to the risk team, the meetings enable issues to be raised and solved quickly and for new initiatives to be introduced.

Some examples of issues raised for further actions include:

- Highlight potential income generated from additional clinician/cost of part time Dental nurse. (proposed business case) to move forward more swiftly
- Link with Risk Management and Food & Nutrition Steering re set-up of additional category for Datix to show reporting of swallow-related incidents.
- Ask IT to compare number of patients with diagnosis of pneumonia with number of patients referred to SaLT for swallowing.

Quarter 1	Scheduled	Complete	Cancelled	Reasons for cancellation
	15	11	4	Laverstock- No exec on site
				Site team- No exec on site
				Radnor- Cancelled by directorate manager
				Wessex rehab- double booked

4. Ensuring there is appropriate provision of training in line with:

4.a Datix Incident Module training (NB these sessions were only held from September 2022)

Course:	**Datix Incident Reporting**
Description:	This training covers how to report an incident on Datix and the purpose and importance of incident reporting.
Training Method:	MLE package
Staff Group:	All staff on induction
Assessment:	Multiple choice questions at end of MLE package
No of staff completed MLE package Quarter 1	**55**

It has become evident that although this datix module can be accessed by all staff, it does not sit as compulsory on each staff members learning tree now. It is unclear as to why this has happened, and conversations are ongoing with the risk dept and the education team. Due to changes required anyway to reflect LFPSE, the package will need to be amended so work is ongoing.

4.b Datix Incident Investigation training

Course:	**Datix Incident Investigation /Management**
Description:	This training provides an overview of the Datix Incident Module and instructs staff on how to complete a Datix Incident Investigation. This training is a pre-requisite to obtaining a Datix log for access to the Incident Module.
Training Method:	Microsoft Teams Session (45 minutes)

Staff Group:	Staff (generally band 6 or above) who are required to complete incident investigations on Datix.
Assessment:	None
No of training sessions held in Quarter 1	5
No of staff who booked this training and did not attend in Quarter 1	3
No of staff who completed this training in Quarter 1	28

4.c Datix risk module training

Course:	**Datix Risk Register Module**
Description:	This course trains staff on how to use the Risk Module on datix for submission and ongoing management of Risk's on the Trust's Risk Register
Training Method:	MLE package
Staff Group:	Staff who need to add, review and manage risks on the Trust Risk Register. Generally managers and department leads, but can also be a nominated individual who has been given responsibility to manage and maintain theirs department's Risk Register. Band 6 or above.
Assessment:	Multiple choice questions at end of MLE package
No of staff completed MLE package 22-23:	**17**

5 Ensuring compliance with 'Duty of Candour' requirements

5.a Ensure all staff are aware of their responsibilities through cascade of the Duty of Candour and Being Open Policy.

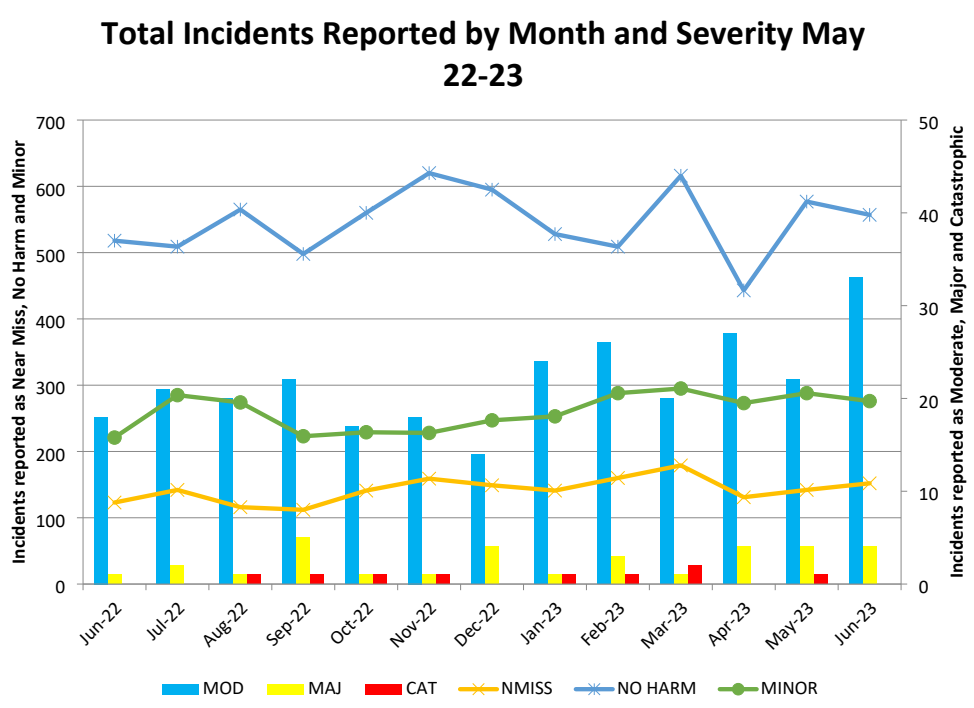
As part of our ongoing commitment to promoting a learning culture we continue to monitor Duty of Candour compliance when patients suffer moderate, major or serious harm and report it monthly to the Patient Safety Summit to drive and monitor further improvement. Whilst our staff have complied with their professional duty of candour, the statutory duty requires clear documentation of our explanation and an apology followed up by a letter. This requirement is now embedded within the Datix web reporting form so that compliance can be monitored at all 3 stages of the incident process, these measures that are in place then assist to understand when compliance fails to identify where the gaps are.
Patients (or other relevant persons) were informed about 'notifiable safety incidents' and support was provided to that person. The investigations into incidents graded them to include any that invoked the duty of candour.

The table below outlines the Trust as a wholes current position with duty of candour across the four divisional groups. The data for this is obtained via the Datix system. Compliance in stage 2 is notably low and after discussion with divisional leads, they feel confident that the required letters have been sent to patients and families but have not been uploaded to Datix. The 60-day timeframe and subsequent delays in the completion of SIIs being completed and consequently being able to share with families, does have an impact on compliance at stage 3.

Following the production of last year annual report, the duty of candour compliance became a focus for the divisions. The data below was drawn from 01/04/2023-09/06/2023 and has shown compliance improvement in all three stages.

Stage 1 increase from 83.63% to 89.8%
Stage 2 increase from 61.43% to 72.3%
Stage 3 increase from 47.28% to 61.5%

5.b Monitoring of incidents through the weekly Patient Safety Summit to ensure appropriate grading.



The below table illustrates the number of incidents of moderate and above broken down into the four divisions

	moderate incident	major incident	catastrophic incident	Total
Clinical Support and Family Services	5	0	0	5
Medicine	44	8	1	53
Women and Newborn Division	7	1	0	8
Surgery	9	2	0	11

5.c Where Duty of Candour triggered liaison with clinicians to ensure they are aware of the correct notification and follow up procedures, feeding back to DMC's and teams where gaps identified.

In the event of a high harm incident Risk Management provides oversight and support with the DoC. A report is subsequently pulled monthly from the risk management team which highlights any incidents with remaining outstanding DoC compliance. These are sent directly to the Divisional Heads of Nursing to follow up specific outstanding cases within their divisions. These are also discussed on a monthly occurrence at the Weekly Patient Safety Summit.

5.d Monitoring of duty of Candour compliance
The outstanding DoC compliance is updated monthly and is monitored through the Patient Safety Summit

Moving forward in 2023/24 the priority areas going forward are :

- Patient safety Incident response Framework (PSIRF)
- LFPSE
- Establishment of Learning from Incidents Forums.
- Setting up regular Datix drop-in Clinics.

Patient safety Incident response Framework (PSIRF) Update

- Progress with identifying response leads to undertake Level 3 HSIB training remains a challenge. Training completion is a key risk currently in terms of meeting the requirements of the new framework in responding to safety incidents.
- PSIRF communications plan has commenced.
- There has been good progress with the Patient Safety Incident Response Plan and the first draft is near completion.
- A local task and finish group has been established to look at recruitment of Patient Safety Partners which forms part of the National Patient Safety Strategy.
- The Trust is engaged with the development of an ICS PSIRF Policy. The aim is to have an overarching ICS Policy with appendix for each Acute Trust in the system.
- The ICS has shared two flowcharts. One for the Serious Incident Framework closure process and the other detailing the ICB PSIRF response plan sign off process.

Learning from Patient Safety Incidents

In line with the roll out of LFPSE at the end of September, the current datix system is due to have a datix test upgrade mid-august. A full communication plan has been devised to ensure staff have an

understanding of the changes this presents. Teaching and drop-in sessions will be made available as well as feeding into Trust meetings i.e., Nursing and Midwifery forum to introduce the idea.

Learning from Incidents forum

The Learning from Incidents Forum is a new forum that is being piloted in the Medicine division, this forum aims to adopt a PSIRF approach to looking for and sharing learning via our reported incidents. The forum is aimed at the frontline members of staff who will be integral in supporting the changes and challenges brought about by learning from incidents.

Currently this is a monthly meeting that has an informal style , there are two main focuses of the meeting. The first are the incidents that have caused moderate harm and have been discussed at the patient safety summit but have been commissioned as a Local review. The second topic that is discussed are the trends and themes from the divisional incidents as a whole for the past month, this includes no harm, near misses and minor harm incidents. The group will then share how their working area feels and what trends and themes are apparent to them, hoping to ascertain if there are any trends and themes that are not reported as well.

There has been good engagement at these meetings so far, with a wide range of staff including student nurses and nursing assistants. The teams welcome all the attendants to share any learning they have had in their personal practice to share with the group. The group is a safe environment to share and learn from each other and hopefully bring about learning and improvements that will help prevent the high harm incidents happening.

Quarterly Comparison Infographic Summary – Q1 23/24 vs Q4 22/23

NHS Salisbury NHS Foundation Trust

REPORTED INCIDENTS

Major / Catastrophic Reported Incidents

9 – Q4 22/23

13 – Q1 23/24

44%

Near Miss Reported Incidents

481 – Q4 22/23

426 – Q1 23/24

11%

Total Number of Reported Incidents

2569 – Q4 22/23

vs

2513 – Q1 23/24

2%

New SII/CR

16 – Q4 22/23

18 – Q1 23/24

36%

Abusive, violent, disruptive or self-harming behaviour	Q4 22/23	**Q1 23/24**	% change
	142	**154**	8%

Abuse etc of patient by patient

6 – Q4 22/23

8 – Q1 23/24

33%

!

Self-harm during 24-hour care

12 – Q4 22/23

28 – Q1 23/24

133%

Access, Appointment, Admission, Transfer, Discharge	Q4 22/23	**Q1 23/24**	% change
	212	**210**	1%

Appointment

48 – Q4 22/23

51 – Q1 23/24

6%

Discharge

93 – Q4 22/23

90 – Q1 23/24

3%

Accident that may result in personal injury	Q4 22/23	**Q1 23/24**	% change
	443	**409**	8%

Needlestick Injury or other incident connected with sharps

55%

31 – Q4 22/23

14 – Q1 23/24

10%

Slips, trips, falls & collisions

391 – Q4 22/23

353 – Q1 23/24

Anaesthesia	Q4 22/23	**Q1 23/24**	% change
	7	**3**	57%

Commented [DJ(NFT1]: What does this mean

Clinical assessment (investigations, images and lab tests)	Q4 22/23	**Q1 23/24**	% change
	135	**122**	10%

Laboratory investigations

97 – Q4 22/23

72 – Q1 23/24

26%

Images for diagnosis (scan / x-ray)

31%

16 – Q4 22/23

21 – Q1 23/24

Consent, confidentiality, or communication	Q4 22/23	**Q1 23/24**	% change
	95	**140**	47%

Communication between staff, teams or departments

34 – Q4 22/23

70 – Q1 23/24

106%

Communication with the patient

5 – Q4 22/23

4 – Q1 23/24

20%

Diagnosis, failed or delayed	Q4 22/23	**Q1 23/24**	% change
	13	**12**	8%

Implementation of care or ongoing monitoring / review	Q4 22/23	**Q1 23/24**	% change
	539	**574**	7%

Possible delay or failure to Monitor

51 – Q4 22/23

62 – Q1 23/24

22%

Infection Control

18 – Q4 22/23

24 – Q1 23/24

33%

Infrastructure or resources (staffing, facilities, environment)	Q4 22/23	**Q1 23/24**	% change
	165	**152**	8%

Environmental matters

40 – Q4 22/23

41 – Q1 23/24

3%

Adverse events that affect staffing levels

60 – Q4 22/23

50 – Q1 23/24

17%

Medication	Q4 22/23	**Q1 23/24**	% change
	346	**252**	28%

Preparation of medicines / dispensing in pharmacy
45 – Q4 22/23
34 – Q1 23/24
24 %

Administration or supply of a medicine from a clinical area
161 – Q4 22/23
128 – Q1 23/24
20%

Patient information (records, documents, test results, scans)	Q4 22/23	**Q1 23/24**	% change
	75	**64**	15%

27%
Electronic Patient Record
11 – Q4 22/23
14 – Q1 23/24

Patient's case notes or records
50 – Q4 22/23
39 – Q1 23/24
22%

Treatment, procedure	Q4 22/23	**Q1 23/24**	% change
	154	**139**	10%

Skin
63 – Q4 22/23
61 – Q1 23/24
3%

Arteries and veins
2 – Q4 22/23
2 – Q1 23/24
0%

NHS Salisbury NHS Foundation Trust

Report to:	Trust Board (Public)	Agenda item:	6.1
Date of meeting:	5th October 2023		

Report title:	Guardian of Safe Working Annual Report 2022/23			
Status:	Information	Discussion	Assurance	Approval
	x			
Approval Process: (where has this paper been reviewed and approved):	People and Culture 28 September 2023			
Prepared by:	Rowena Staples			
Executive Sponsor: (presenting)	Peter Collins			

Recommendation:

The Committee are asked to note the annual Guardian of Safe working report for 2022/23 and its recommendations.

Executive Summary:

The Trust expect to be allocated around 168 doctors in training by the deanery who are subject to the conditions of the 2016 contract. Doctors 'exception report' breaches of their contracted working hours to allow the trust to monitor and act on recurrent themes around work load and rightsizing of the work force.

The majority of exception reports relate to overtime and comment on inadequate staffing. This is in part due to unfilled training posts, and less than full time working. The trust looks to mitigate this and fill unallocated rota slots with locally employed doctors (LEDs).

The process of transitioning LEDs to 2016 T&Cs was commenced in spring 2023. This gives LEDs the same access to exception reporting as their deanery appointed peers.

All work schedules for doctors in training are now compliant with 2016 T&Cs.

Ongoing industrial action by doctors since March 2023 impacts on our patients and the entire healthcare team. In general, morale amongst junior doctors is low.

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	X
Other (please describe):	

Purpose

The 2016 Junior doctor contract introduced the role of the Guardian of Safe Working and requires that the guardian reports to the board (or via a committee) every quarter and produces a consolidated annual report, which is included as a statement in the Quality Account

Background

The Trust is allocated trainees (including LTFT) by the Deanery to fill 168 deanery training posts. There is an overall shortfall in the number of doctors provided by the deanery with respect to the required number to fill the spaces. This results in gaps in the medical workforce rotas. Some of these spaces are filled with locally employed doctors, or locums.

Numbers of trainees in deanery training programmes across the region are controlled and limited by the General Medical Council and Health Education England. The junior doctors' contract was negotiated in 2016 but not formally adopted until 2019 at which time additional restrictions on hours, consecutive long shifts and weekend working were introduced, with the aim of protecting junior doctors from overwork and protecting their training opportunities.

Since 2016 trainees have been required to report any instance that they work beyond the hours in their work schedule (national and local guidance gives a leeway of up to 15 minutes), any missed training opportunities and "immediate safety concerns" when they believe patients are being put at risk by excessive hours or insufficient doctors. Excess hours can arise for reasons including:

- Rota gaps resulting in fewer doctors than planned – for example due to the Deanery failing to recruit trainees, less than full time trainees, maternity leave, sick leave or poor annual leave planning.
- Unrealistic work schedules that do not meet the needs of the service
- Junior doctor factors including capability, organisational skills and clinical experience
- Supervision factors including lack of support, unrealistic expectations
- Infrastructure issues particularly IT, but also bleeps and telephones
- Lack of support from other health care professionals including nurses, pharmacists and admin staff.

We also employ locally employed doctors (LEDs) at junior and senior trainee level to fill deanery gaps, provide additional staffing required by the clinical services and enable rotas compliant with the 2016 'rota rules'. Many of these doctors will be on the same or similar work schedules as the deanery trainees. In Spring 2023 the process of moving LEDs to the 2016 T&Cs began. In general, this change has been undertaken at the end of a fixed term contract. There are currently 21 LEDs still on 2002 T&Cs. These doctors do not have access to exception reporting. The aim of changing to 2016 T&Cs is that this will give the trust a much clearer view of hours worked by its medical workforce and better highlight gaps and issues. It will also give a degree of parity between deanery and LED doctors and a 'voice' to those who might otherwise feel unheard.

NHS Salisbury NHS Foundation Trust

Rota Gaps

The rota gaps in this report occurred between August 22 and July 23

Number of doctors / dentists in training (total): 168

For context, approximately 2/3 of these posts are at junior level and 1/3 are at senior level. Thus, for a given number of WTE gap, the senior rota is disproportionately affected. LEDs are often more difficult to recruit at a senior level.

Junior Trainees (F1-CT2) WTE Gaps by Specialty and Grade

Specialty/grade	Aug 22	Sept	Oct	Nov	Dec	Jan 23	Feb	Mar	Apr	May	Jun	Jul
Elderly care F2									1	1	1	1
ED F2	0.4	0.4	0.4	0.4					1	1	1	1
ED GPVTS							0.2	0.2	0.2	0.2	0.2	0.2
ACCS ED ST2							1	1	1	1	1	1
Anaesthetics CT1/2	1	1	1	1	1	1	1	1	1	1	1	1
ACCS Anaesthetics ST2	1	1	1	1	1	1						
Anaesthetics ST2	0.2	0.2	0.2	0.2	0.2	0.2						
ITU F2	0.2	0.2	0.2	0.2								
ACCS ST1	0.25	0.25	0.25	0.25	0.25	0.25	0.25	0.25	0.25	0.25	0.25	0.25
Endocrine GPVTS	0.2	0.2	02	0.2	0.2	0.2	1	1	1	1	1	1
ENT CST 1									0.2	0.2	0.2	0.2
ENT GPVTS	0.4	0.4	0.4	0.4	0.4	0.4						
Palliative GPVTS							0.4	0.4	0.4	0.4	0.4	0.4
Palliative F2					0.2	0.2	0.2	0.2				
O&G GPVTS	1	1	1	1	1	1	2	2	2	2	2	2
O&G GPVTS	0.7	0.7	0.7	0.7	0.7	0.7						
O&G F2					1	1	1	1				
T&O CST2	1	1	1	1	1	1	1	1	1	1	1	1
Paeds GPVTS	0.2	0.2	0.2	0.2	0.2	0.2	0.8	0.8	0.8	0.8	0.8	0.8
Plastics CST2	1	1	1	1	1	1	1	1	1	1	1	1
Surgery CST1	0.2	0.2	0.2	0.2							0.2	0.2
Ophthalmology GPVTS	0.4	0.4	0.4	0.4	0.4	0.4						
Stroke F2									0.2	0.2	0.2	0.2
WTE unfilled gap	**8.15**	**8.15**	**8.15**	**8.15**	**8.55**	**8.55**	**10.85**	**10.85**	**11.05**	**11.05**	**10.25**	**10.25**

Senior Trainees ST3-7 WTE Gaps by Specialty and Grade.

Specialty/grade	Aug 22	Sept	Oct	Nov	Dec	Jan 23	Feb	Mar	Apr	May	Jun	Jul
ED	1.2	1.2	1.2	1.2	1.2	1.2	0.8	0.8	0.8	0.8	0.8	0.8
Acute medicine	1	1	1	1	1	1						
ENT	1	1										
Cardiology	1	1	1	1	1	1			1	1	1	1
Gastro	1											
Respiratory	0.4	0.4	1	1	1	1	1	1	1	1	1	1
Elderly Care	1	1	1	1	1	1	1	1	1	1	1	1
Elderly Care	0.8	0.8	0.8	0.8	0.8	0.8						
O&G	1.2	1.2										
Paeds	0.4											
Palliative	0.4	0.4	0.4	0.4	0.4	0.4	0.4	0.4	0.4	0.4	0.4	0.4
Histopath	0.2	0.2	0.2	0.2	0.2	0.2						
Haematology	0.2											
Urology	1	1	1									
WTEGap total	**10.8**	**9.2**	**7.6**	**6.6**	**6.6**	**6.6**	**3.2**	**3.2**	**4.2**	**4.2**	**4.2**	**4.2**

Yellow indicates LTFT working.
Red indicated an unfilled gap.

Issues arising

Ongoing staff shortages from deanery gaps, sickness, and other forms of leave (study, annual, parental) result in very slim staffing on the wards quite regularly. Even a ‘filled’ rota can become unworkable very easily with little slack in the system.

Over the past 12 months the deanery fill rate has improved slightly, particularly at senior level.

The trust is lead employer for 39 GPVTS doctors. Recent changes to the GP curriculum have resulted in GPVTS doctors spending less time in hospital training posts and more time in community GP placements. This change has impacted doctor posts at a junior level.

Numbers of foundation programme doctor posts in the trust have been expanded.

Industrial action by doctors since March 2023 has had wide reaching effects. The morale of junior doctors is low, with an impression that this is felt more by the most junior doctors.

Actions taken to resolve issues

- Significant numbers of rota gaps have been filled with LEDs, across all specialties and grades. Obtaining a clear picture of the numbers of LEDs is challenging as the numbers change frequently in line with unfilled deanery posts, LTFT working and clinical service demands.

- Changes have been made to work schedules in response to previous exception reports and feedback. Recently this has improved night shift cover in medicine with an increased number of F1 doctors. To achieve this change, the number of daytime weekend F1s has decreased, something that has concerned the foundation programme doctors. There is ongoing monitoring of exception reports and feedback (including Junior doctor forum and Datix) in relation to the weekend daytime junior medical cover.

- All work schedules for the doctors in deanery or LED posts are now compliant.

- Junior doctor forum meetings (JDF) have been held in advance of all periods of industrial action to ensure that our doctors are fully informed of arrangements and the trust position on industrial action. JDF meetings not focused on strike action continue as normal.

Summary

There remain rota gaps across all specialties at both junior and senior grades. These gaps are filled with LEDs where possible. The gaps are as a result of the deanery not supplying a doctor to a post, less than full time working and a smaller number of other reasons. There has been a slight improvement in the number of gaps over the past 12 months, particularly at senior level.

There is reliance on locums to cover unexpected absence or changeover periods to allow for induction and compliance with the ‘rota rules’

Information on the number of locally employed doctors remains difficult to obtain.

Recommendations

That the trust continues to employ LED to fill deanery rota gaps and support the service.

Alongside the study leave arrangements already in place for LEDs, the trust considers other opportunities to further develop this group of doctors over a longer period to enable training locally to achieve career grade status or completion of training via the CESR route.

The trust continues to focus on being an attractive place to work and train.

Dr Rowena Staples
Guardian for Safe Working Hours
Consultant Paediatrician
September 2023

Salisbury NHS Foundation Trust

Appendix

Locum spend August 22- July 23

NHS Salisbury NHS Foundation Trust

Report to:	Trust Board (Public)	Agenda item:	6.2
Date of meeting:	26th September 2023		

Report title:	Bi-Annual Skill Mix review: Full report including Maternity and Neonatal bi-annual Staffing report – September 2023			
Status:	Information	Discussion	Assurance	Approval
	X		X	
Approval Process: (where has this paper been reviewed and approved):	Safe Staffing Steering Group Women and Newborn Divisional Management Team 19.9.23 CGC 26 September 2023			
Prepared by:	Fiona Hyett, Deputy Chief Nurse Vicki Marston - Director of Maternity and Neonatal Services			
Executive Sponsor: (presenting)	Judy Dyos, Chief Nurse			

Recommendation:

Nursing

The Clinical Governance Committee are asked review and note the yearly full skill mix review. The paper provides detailed analysis of current nurse staffing position reviewed as per the requirement of NHS guidance Developing Workforce Safeguards and NQB guidance for safer staffing.

It is recognised that there is a significant funding request at a time of financial challenge and so the recommendations for investment have been stratified into those most urgent based on risk and it is anticipated that a focus on reducing additional staffing requirements would in part fund the required investment to deliver safe staffing levels.

Midwifery and Neonatal Services

In order to demonstrate compliance with the Maternity Incentive scheme the committee is asked to note the specific expectations in relation to demonstrating effective midwifery workforce planning as detailed in the report.

Executive Summary:

Nursing

The yearly full skill mix review was undertaken in July and August 2023, reviewing data from June 2022 to July 2023. This period has seen an improvement in nurse staffing levels in terms of reduction in vacancy levels but with a very junior skill mix and operational capacity demands, strike action and requirement to recover elective activity.

Corporate risk register ID 7039, which was captured as at times, safe staffing could not be guaranteed has now been reduced to a rating of 12, following the improvement in vacancy levels and staff unavailability.

It should be noted that Care Hours per Patient Day (CHPPD) which whilst alone cannot be seen as a measure of quality and safety has improved from a low figure of 5.7 in September 2022 to 7.3 in August 2023.

There has been a significant increase in numbers of patients admitted who are impacted by the mental health crisis post the Covid pandemic and who require RMN or general enhanced care support. It is anticipated that investment into the recommendations highlighted would be partially funded by changing the authorization process for creation additional shifts in excess of ward establishments.

As highlighted within the report requests for further funding are made to specific areas such ED where Safer Nursing Care Tool analysis has been undertaken, plus wards where staffing ratios are higher than the recommended minimum of 1:8 RN:patient ratios.

Whilst CGC will not offer or approve this funding, the committee is asked to note the reports findings and offer its own considerations through the lens of quality and patient safety.

The committee is also asked to note the on-going collaborative work across the ICS which has agreed some initial recommendations of minimum 1:7 ratios, fully supervisory ward sister and shift coordinator being caseload free to be developed over a 3-year period. Further work is due to commence in ED, theatres and out-patient staffing.

Midwifery and Neonatal Services

This report provides a bi-annual Midwifery staffing report as per Maternity Incentive Scheme (Year 5) – Safety Action 5.

It also includes a bi-annual staffing report relating to the neonatal nursing workforce.

For the Committee to note and minute the following required standards as set out in the report:

a) A systematic, evidence-based process to calculate midwifery staffing establishment is completed.
b) Trust Board to evidence midwifery staffing budget reflects establishment as calculated
c) The midwifery coordinator in charge of labour ward must have supernumerary status; (defined as having no caseload of their own during their shift) to ensure there is an oversight of all birth activity within the service.
d) All women in active labour receive one-to-one midwifery care.
e) Submit a midwifery staffing oversight report that covers staffing/safety issues to the Board every 6 months, during the maternity incentive scheme year five reporting period.

In addition to note the challenges and mitigations in Midwifery staffing over the 6 month period this covers, and to acknowledge that the required standards as set out above have been met and are evidenced in the report.

To note that to meet Safety action 4 of CNST a Neonatal Staffing action plan (covering nursing and medical workforce) will be reported in November alongside Obstetric and Anaesthetic medical staffing in addition to this bi-annual report as per CNST requirement for this safety action

Board Assurance Framework – Strategic Priorities	Select as applicable:
Population: Improving the health and well-being of the population we serve	Yes
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	Yes
Other (please describe):	N/a

Salisbury NHS Foundation Trust

(Insert Title)

Purpose

1.1 State the purpose of the report.

2 Background

2.1 Provide sufficient background to inform the reader of the history to the content of the paper and prepare them for the recommendation.

3 Use headings to separate the report

3.1 Complete the report using appropriate headings and sections.

3.2 Link your report to the Trust's Strategy or Assurance Framework as appropriate

4 Summary

4.1 Summarise the content and bring report to a close.

5 Recommendations

5.1 State the recommendation to the group [This should mirror the recommendation on the covering paper]

[Insert name of author(s)]
[Insert Job title of author(s)]

Safe Staffing Skill Mix Review 2023

1. Purpose

1.1 The purpose of this paper is to report the outcomes of the annual review of ward staffing nursing establishments for 2023. The paper focuses specifically on a review of all in-patient wards, Intensive Care and the Emergency department. Theatres and out-patients are not included within this review. Women and newborn, maternity and NICU are subject to their own separate report.

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 2022 and the following recommendations were approved:

WARD	BANDING and WTE	ROLE/SHIFT
ED	B7 1.0 wte	Practice Educator
	B7 1.0 wte	Paediatric Lead
	Uplift of 4.5 wte B5 to B6	Creation of second B6 on LD and N shift to provide safety, oversight and leadership
	B6 1.11 wte	Headroom uplift 24% to 27%
AMU	B5 3wte	Ensure minimum standard of 1:6 ratio maintained 24/7
Amesbury	B5 to B6 1.0 we	Allow B6 allocation 24/7
Longford	B6 1.96wte	Would allow for additional RN on late and night and senior leadership presence across ward footprint.

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 (ED only).

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 1.1 evidence-based workforce planning 1.2 professional judgement 1.3 compare staffing with peers	**Right Skills** 2.1 mandatory training, development and education 2.2 working as a multi-professional team 2.3 recruitment and retention	**Right Place and Time** 3.1 productive working and eliminating waste 3.2 efficient deployment and flexibility 3.3 efficient employment and minimising agency

2.2.2 There are 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 assessed 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 is now available within the e-rostering system.

However, it requires a ward to have an established templates specifically listing the NA role and currently no wards have sufficient numbers in post to develop required template. This remains an active conversation with ward and E-Roster leads.

2.3 **BSW Acute Hospital Alliance – Safe Staffing**

2.3.1 With the formal inception of the ICS, the collective CNOs from the three acute Trust's commissioned a wider review of safe staffing levels across the system. The agreed output from the initial scope to be implemented over 3 years was:

- Move towards minimum RN to patient ratio of 1:8
- No caseload for shift co-ordinator
- Full supervisory ward leader
- Ensure sufficient training allowance within headroom

In addition to the above, this year's priorities include appointment of a BSW Safe Staffing Lead who will work with the Trusts to ensure consistent approach and to review workforce requirements in Emergency Department, theatres and Out-patients.

2.3.2 Appendix 1 includes the current ratios by ward, within the recommendations for investment are wards where current ratios are above 1:10. Current RN:Patient ratios do include the shift co-ordinator and Ward leaders are budgeted to 80% supervisory time with many ward leaders now getting this supervisory time following a period of successful recruitment. Over the coming year full analysis will be completed on the impact of achieving all of these aims over a 3-year time period as investment will be required to implement.

2.4 Ward Staffing Review

2.4.1 The full review was carried out with each ward during Q2, reviewing the data from June 2022 – July 2023. The reviews were attended by the Ward Sister, Divisional Head of Nursing and/or Matron and Deputy Chief Nurse. 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 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.

2.4.4 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.]
In the last review it was indicated that Safer Nurse care Tool (SNCT) had been utilised in Longford, Sarum and ED. However, the data from these reviews is not available with the exception of ED which had some incorrect data submitted. In July 2023 SNCT was undertaken within ED giving a second triangulation point and ECIST have supported an analysis of the findings and impact which has been included within the recommendations. Sarum have undergone training but did not complete data collection in July 2023. The use in the Spinal Unit (Longford) needs further work as the tool has not been developed for use in areas such as these. A full and sustainable rollout programme has been developed which will commence in November 2023, with 50% of the wards included, followed by all wards completing the data collection twice yearly from June 2024, the outputs of which will be included in future reviews.
The Trust 2 data collection points per year will be in November and June. The use of the tool is seen as gold standard to support the annual skill mix process but should be used in triangulation with other data sets such as NSIs and professional judgement and not in isolation.

2.4.3 <u>Nurse to patient ratios by registered and total nursing</u>

- One of the elements of collaboration with BSW has been to agree to move to a minimum ratio level of 1RN : 7patients (NICE recommendation was minimum of 1:8) over the next

3years. It should be noted that whilst there are no mandated staffing ratios in the UK, there is sufficient evidence to show that higher RN levels are associated with lower levels of harm.

- RN:Patient ratios within current establishments range from 1:5 to 1:10 depending on specialty and overall staffing model. These ratios include the nurse in charge (shift co-ordinator). 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).

- 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.The recommendations within this year seek to address the ratios at night in Amesbury, Downton and Spire where additional duties have been used to address a shortfall to maintain patient safety.

- Total number of nurses i.e. RNs and HCAs:Patient ratios offer similar variation depending on speciality.

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 implementation of the Nurse Associate role.

- Several wards have actively implemented the use of Nurse Associate (spinal, elderly care and orthopaedics). The Trust is still unable to report CHPPD for the Nurse Associate role as despite the role being embraced there are insufficient Nurse Associates in any single ward area to be able to create a separate template to report against.
  Further development of the Nurse Associate role will continue with partnership the Trust is developing with Coventry University providing a career development route for non-registered staff.

- As would be anticipated a few wards have higher than 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).

2.4.5 Assessment against HealthRoster SafeCare Tool

- The Safe Care Tool (acuity/dependency model) is used in daily practice and assesses staffing against the acuity and dependency of the patients in the moment to enable decisions to be made for redeployment of staff. The data that is then held has been used as a proxy to review staffing in context of the skill mix reviews.

- The use of professional judgements enables staff to record whether staffing levels meet their needs on that shift and also extends to the recording and capture of red flags when staffing does not meet the required demand, with an escalation of concerns to the matron. A mixed pattern is seen in staff ability to accurately record acuity and dependency, and a system upgrade will enable matrons to add any action they have taken as well as approve the rating given. Some ward consistently raise red flags which potentially 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).

- A risk was added to the corporate risk register (7039) initially in 2021, with the risk rating being escalated to 20 to vacancy, extended escalation, sickness and unavailability. Given the improvement in vacancy rates and improvement in CHPPD over the last year the rating has been reduced to 12 – reflecting the improvement but noting this is not yet on a sustained footing.

- Analysis of SafeCare data is included within the reviews.

2.4.6 Allowance for additional headroom requirements and supervisory ward leader

- Headroom is set within budgeted establishment at 24% plus 3% for maternity which is centrally funded. Headroom for the last year has been averaging at around 30% for most wards –driven in the main by sickness levels that are running higher than allowance and training/supernumerary time for new starters, including internationally educated nurses. Focused work has taken place in the last 2-3 months to ensure that international nurses have clear programme of supernumerary time and when it is expected for them to be rostered into staffing numbers.

- Maternity leave has seen a lower impact this year but remains unpredictable and impacts on staff availability.

- Sickness whilst reducing (11% in July 2022 to 6% in July 2023) is still above the 4% within headroom and in some wards is much higher eg Pitton and Laverstock who are 12%. Short notice sickness has very direct impact on safe staffing on the day. 3 wards are engaged in a project with OD+P to reduce this but it will be time before full impact is seen.

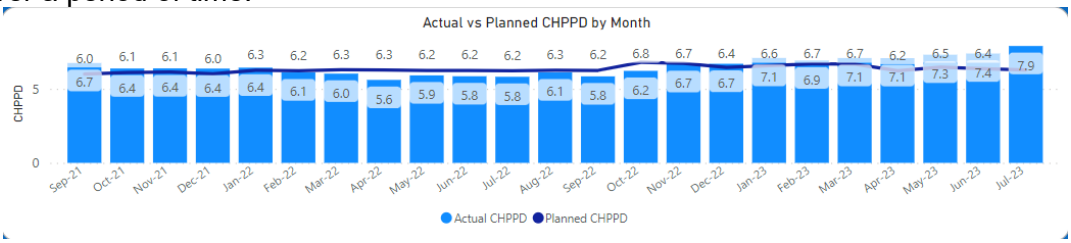
- The Trust continues to run a supervisory model for ward sisters/charge nurses, in which they are given 0.8wte of their working week for this, with 0.2wte clinically rostered into numbers. In this review the average amount of supervisory time ward leaders had improved significantly from the last review and many areas were achieving the 80% level. The use of a ward managers assistant role was more evident across many wards which had been funded using HCA vacancies although there had not been a correlating reduction in HCA shifts thus roster templates not impacted but may result in overspend where wards fully established.

2.5 Care Hours per Patient Day (CHPPD)

- Trusts are required to report 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. 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 but this is not possible until we have a sufficient cohort of Nursing Associates.

- Since the last review CHPPD can be seen to have improved across all clinical areas with a low of 5.4 (actual) in the summer of 2022 to 7.9 this year– which is driven by the improvement in vacancy levels and reduction in escalation areas that are open.
  It is important when reviewing the data that wards are only compared against themselves over a period of time.



2.6 Specific Divisional Themes

Outlined below is the detail presented by each division which sets out the rationale for recommendations for increases in establishment. Appendix 2 sets out the recommendations from the reviews and gives them a rag rating for investment in this year. If all recommendations were supported this would see an investment of £1.9m and if only the highest priority areas were supported the required investment would be £1.1m. The detail and priorities are outlined by Division below:

2.6.1 Medicine Division:

Whilst the period of assessment (July 2022 – June 2023) staffing within the division has improved with the impact of a more stable workforce starting to be seen. The division continues to be impacted, particularly during the winter periods, of escalation beds being open which whilst funded do not have an associated substantive staff model thus impacting on overspends through the use of temporary staffing. This year included supporting escalation into South Newton which the division embraced despite the challenges of being an offsite provision. Nurse staffing also continues to have higher sickness absence rate than the Trust target and has undertaken some focused work on 3 wards with OD+P – outputs from this are not expected to impact for several months. Along with the other divisions an increase of patients requiring RMN support and general patients with enhanced care needs has created a pressure across all areas.

Key areas for priority for the division are:

The Emergency Department has had support over the last year from ECIST to review both staffing levels and ways of working within the department. SNCT has been completed and analysis alongside triangulation of professional judgement sees this review recommending an increase in their establishment. Numbers attending ED rose sharply in 2021/22 and whilst there was a small drop on 22/23 the numbers remain significantly higher, which when coupled with occupancy in the department supports the increase staffing requirement. In addition, ECIST identify opportunities to reduce initial assessment time and note that in a small department there is an inevitably of a higher cost base. The detail of their staffing analysis, which incorporates SNCT data, can be seen in appendix 3.

When Pitton ward was relocated to Laverstock as an acute respiratory ward during COVID, bed capacity was reduced from 27 to 20 beds to accommodate 4 patients from ICU, staffing decreased to reflect loss of beds. Laverstock are now running at 24 acute respiratory beds and either an additional RN across the 24hr period is required to meet the required ratios for acute respiratory or the beds should be closed.

Spire ward is a large 30-bedded ward with high number of cubicles and has high use of additional duties for enhanced care and at night has a ratio of 1:10 RN:Patients. The ward is seeking increase or 1 RN and 1 HCA at night, plus additional RN on an early shift. The priority for this year would be the RN on night shift.

Redlynch as an acute gastroenterology ward experiences patients with significant additional needs and the impact is seen into the evening when the ward has higher levels of falls and incidents and at night the ward has a ratio of 1:10. The ward has requested RN on night shift and a twilight HCA. The priority for this year would be the RN on night shift.
Farley and AMU are both requesting to uplift B5 RN roles to B6 Junior sister – in both instances this supports senior presence on the wards 24/7 to help drive patient flow, supporting 4-hr target

2.6.2 Surgical Division:

The Surgical Division nurse staffing position has remained relatively stable over the last year, with an improved vacancy position in orthopaedics and sickness whilst above Trust target is at lower levels than other wards.

Downton accommodates a high number of ENT and airway patients in addition to complex urology patients who require specialist surgery, including patients with a spinal injury.
The ward has identified the need for an additional RN on the night, this would then move from a 1:12 RN:Patient ratio to 1:8. This would enable the ward to accommodate tracheostomy patients without always requiring additional duties. Downton continues to support a high number of medical outliers during the year, average 10-12 at any one time, it is anticipated with the new ward coming on line in medicine would see a reduction.

Amesbury continues to have an increased dependency of patients post orthopaedic trauma surgery and the acuity of this patient group is high due to their acute frailty and co morbidities. The ward would benefit from an additional RN on the night shift to reduce the ratio from 1:10 to a 1:8 nurse patient ratio.

Chilmark continues as an elective surgery ward with supporting the elective recovery programme and increased theatre activity, with some activity also going through Britford and Odstock as well as day surgery unit. Britford have requested a modest uplift of 0.5wte to support 7-day leadership in SAU which is seeing much higher activity levels. Odstock have requested and additional RN on a late shift to support ward co-ordination – and it is recommended this is reviewed as part of the wider work on non-caseload for shift co-ordinators.

2.6.3 Clinical Support and Family Services

Paediatrics:
Sarum ward has seen on-going increase in admissions of children and young people requiring specialist care from children and adolescent mental health services (CAMHS). Due to continued limited appropriate placements for these patients, extended lengths of stay have significantly increased pressure on the paediatric team and required use of agency registered mental health nurses (RMN).
A fixed term band 6 secondment (0.2wte) focusing on mental health care, training and support for the team has been appointed to address increasing complex mental health needs and liaise with CAMHS team.
In line with regional paediatric services addressing junior work forces , increased patient acuity and respiratory surges, fixed term band 6 education roles 1.2 WTE appointed to support training and development across all areas in the hospital where children may be admitted (including ED and DSU).
Recruitment of paediatric trained nurses remains a national challenge and therefore adult trained nurses have been appointed to work alongside paediatric educational team to achieve paediatric competencies and increase number of substantive nurses with paediatric skills within the trust.
New experienced paediatric matron in post has reviewed staffing skill mix with acknowledgment of paediatric needs across the whole trust.
To ensure patient safety the Sarum ward minimal shift allocations are as follows : 4 RN and 1 HCA rostered to Sarum ward on long day (Monday to Sunday) and 2 RNs on day assessment unit (DAU) to support GP admissions, planned treatments and were appropriate emergency

department. The night shift has 4 RNs rostered all week. These shift allocations require utilisation of band 4 roles within RN numbers and are achievable within current budget.

To address above challenges and changing needs within paediatrics the request is to uplift 2.6 WTE band 5 posts to band 6 ensuring Senior paediatric nurse cover across both inpatient ward and day assessment unit (DAU) 24/7. The band 6 education roles and band 6 with mental health focus to be included as part of the band 5 to band 6 uplift.

Spinal Services:
A positive year of improvement for Longford ward with a new matron in post working alongside triumvirate colleagues to steer the team successfully through a period of intensive support from MDT and the executive team.
To address development concerns specifically invasive respiratory and spinal care skills, the education team has expanded to include an additional 1 WTE band 6 and 1 WTE band 4. Whilst these posts are currently not agreed within substantive budget a business case will be written to support the need for these posts to become part a permanent of the establishment.
Request for additional RN to co-ordinate late shift, support with goal planning, case conferences and discharges to be covered with education band 6's and supervisory band 7.

Hospice:
10 bedded specialist palliative care inpatient ward continues to support community team to provide specialist care for short term admission and where possible avoid admission to hospital for those patients wishing to remain at home.
Request to uplift staffing to include band 4 on early shift Monday to Friday and additional band 2 on late shift Saturday and Sunday. This will support 2 RNs to provide enhanced care needs and patient oversight during periods of heightened activity including medication rounds and controlled drug administration.

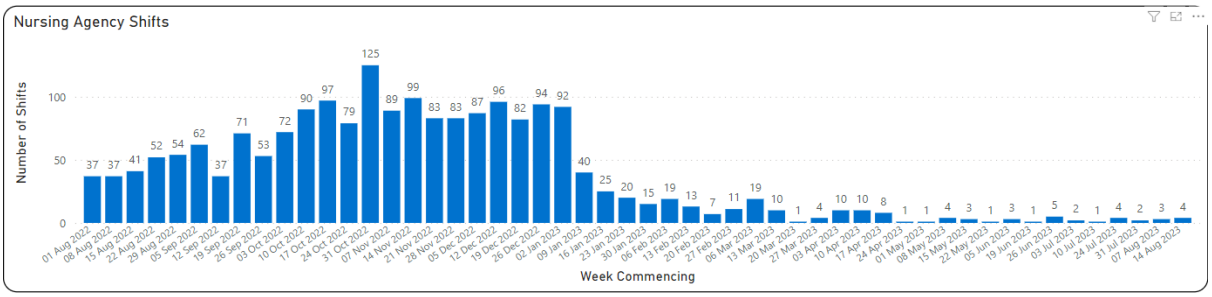
3.0 Trust wide risks and issues considered in the review:

3.1 Vacancies and temporary staffing

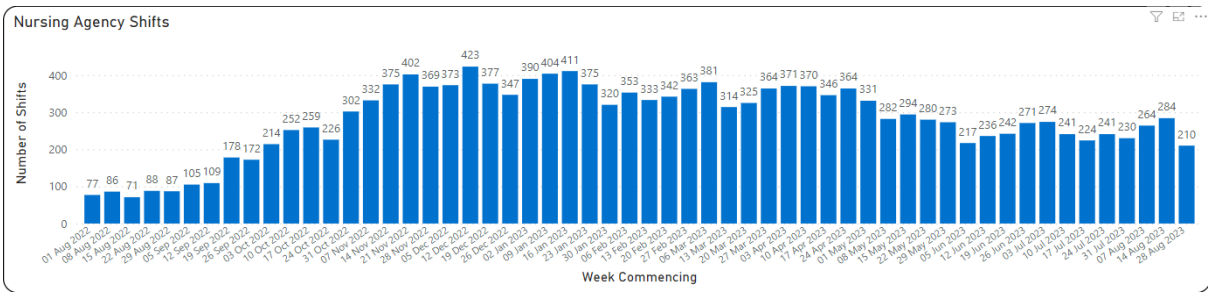
Nationally RN vacancies remain high with various recruitment and retention strategies in place. The Trust is fully engaged with all recommended approaches and closely working with NHS England with regards to targeted international recruitment and HCA recruitment programs and improvements in recruitment of RNs and HCAs can be seen, though retention needs continued focus.

The focus on nurse retention has remained and linked into wider Trust work such as Best Place to Work initiative. The recent release of NHS Longterm workforce plan sees a focus on growing, retaining and reforming the wider workforce of which nursing will have a crucial part. The development of roles through the use of apprenticeships for nursing will be critical and 2 business cases have been submitted but not yet funded for the growth of Registered Nurse degree apprenticeship and apprenticeship to support Nursing Associates to transition to RNs. Both cases have support of the Executive Committee but require system wide support for the backfill costs for implementation.
Nursing associate development is the first step with our partnership with Coventry University with a programme expected to run from September 2024.
The NHS long term workforce plan also sees a reduction in the reliance of international recruitment and the use of apprenticeships to train nurses who do not wish to enter a traditional nursing route will be key and support widening participation in the local community and support retention.

Since January 2022 the Deputy CNO has driven work to eliminate the use of agency for HCAs and longline agency and virtually eliminated the use of off framework agency Thornbury as per graph below

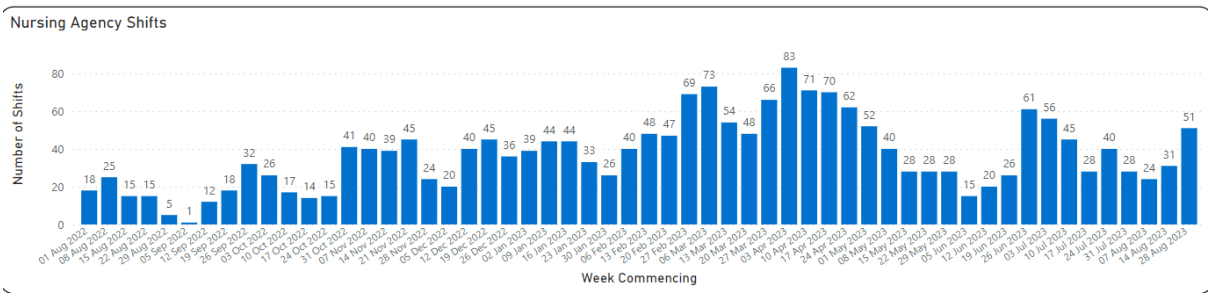


Alongside this is an on-going drive to reduce the reliance on agency nurses as this impacts on the quality of care provision. The graph below shows a slow reduction but progress being made. Varied drivers for agency include RMNs, escalation areas being open and short notice sickness



3.2 Impact of Mental Health

One of the impacts that has been seen since the Covid pandemic is on mental health – with a rise in both paediatric and adult of patients admitted requiring specialist mental health input. This has resulted in an increase in agency expenditure as can be seen below in terms of shifts requiring RMN.



Work is undergoing with partners to look at the use of mental health support workers and at a risk assessment approach to reducing reliance on RMNs.

3.3 Additional Duties

In addition to RMNs there has been a significant increase in year in additional duties, which are shifts created over and above the ward budgeted template and used when wards perceive a need for more staff then rostered – usually for 1:1 care of patients with mental health or enhanced care needs such as dementia. Year to date spend on specials (RMNs and general RN/HCAs) is nearly £1m at end of mth 5. Table below shows expenditure over previous years:

2023-2024	£929,546 at mth 5
2022-2023	£1.7m
2021-2022	£70,961
2020-2021	£376,242
2019-2020	£622,193

Work has commenced using Improving Together methodology to understand the root cause for the spike and ensure actions to enable management of those requiring general RN/HCA within

ward establishments. Investment in the recommendations within the review would drive this usage down. From the middle of October, it is intended to remove the ability for additional duties to be created at ward level, with the responsibility and oversight being sat at Divisional Head of Nursing, which is in line with action many other Trusts are taking.

4. Conclusions

The 2023 safe staffing review has demonstrated that whilst several areas have sufficient resource to achieve safe staffing levels there are areas which would benefit from investment in establishment to reduce reliance on creating additional shifts and a prioritised approach has been outlined and address shortfalls in RN:Patient ratios, with clear research based evidence on reduction of harm with higher RN input. Some areas require small modest uplifts to Junior sister roles which as well as providing leadership for a workforce which currently has a very junior skill mix also provides an opportunity for career development and progression within SFT supporting the retention agenda.

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. The improvement in vacancy position means nursing continues to meet the requirements of the national publications on nurse staffing and the responsibilities in Developing Workforce Safeguards.

The planned roll out of SNCT to all areas over the coming year will provide a supported evidence base to staffing establishments across the wards in future reviews.
Whilst CHPPD can be seen to have improved over the last year as a result of an improved vacancy position. By itself, CHPPD does not reflect the total amount of care provided on a ward nor does it directly show whether care is safe, effective or responsive. It should therefore be considered alongside measures of quality and safety which is demonstrated by the triangulation with other data in this review.

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
- 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 sustain the improved vacancy position and focus on retention to continue to drive down the reliance on temporary staffing.
- To adopt the recommended increase in establishment as per Appendix 2 and noting the proposed work on reducing additional duties to offset the funding required
- To discuss the report at CGC, TMC and open Trust Board as an ongoing requirement of the National Quality Board expectations on safe staffing assurance.

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BI-ANNUAL MIDWIFERY, MATERNITY AND NEONATAL STAFFING REPORT SEPTEMBER 2023

1. Purpose

The aim of this report is to provide assurance to the Trust Board that there was an effective system of midwifery workforce planning and monitoring of safe staffing levels from April 2023 to September 2023. This is a requirement of the NHSLA Maternity Incentive Scheme and relates to Safety Action 5

2. Background

It is a requirement that as NHS providers we continue to have the right people with the right skills in the right place at the right time to achieve safer nursing and midwifery staffing in line with the National Quality Board (NQB) requirements.

Organisational requirements for safe midwifery staffing for maternity settings (NICE 2017) states that midwifery staffing establishments develop procedures to ensure that a systematic process is used to set the midwifery staffing establishment to maintain continuity of maternity services and to always provide safe care to women and babies in all settings.

In addition, the Maternity Incentive Scheme, (MIS Clinical Negligence Scheme for Trusts), Year 5, sets out clear expectations in relation to demonstrating an effective system of midwifery workforce planning.
To provide evidence for NHS Resolutions Maternity CNST Incentive Scheme, this paper provides staffing data on Midwifery and Neonatal Nursing Staffing. The required standards are as below:

a) A systematic, evidence-based process to calculate midwifery staffing establishment is completed.

b) Trust Board to evidence midwifery staffing budget reflects establishment as calculated in a) above.

c) The midwifery coordinator in charge of labour ward must have supernumerary status; (defined as having no caseload of their own during their shift) to ensure there is an oversight of all birth activity within the service.

d) All women in active labour should receive one-to-one midwifery care.

e) Submit a midwifery staffing oversight report that covers staffing/safety issues to the Trust Board every 6 months, during the maternity incentive scheme year five reporting period.

3.Executive Summary

This report gives a summary of all measures in place to ensure safe midwifery staffing; including workforce planning, planned versus actual midwifery staffing levels, the midwife to birth ratio, specialist hours, compliance with supernumerary labour ward coordinator, one to one care in labour and red flag incidents.

4. Birthrate Plus Workforce Planning and staffing levels.

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 coordinator 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.

NICE (2017) recommend that an assessment is carried out every three years, as of August 2023 we are in the process of repeating our assessment and are currently in the data collection stage with the team from Birthrate Plus. We expect to complete this by end of September and to receive a new report in late Autumn 2023

Birth-rate plus recommendation May 2021

Total Births		**2193**
Core Hospital Services		
Delivery Suite		33.86
Postnatal Ward		20.95
Maternity DAU		7.56
Community Inc. Homebirth provision		27.83
Total Clinical wte	Band 3-7	**90.15**

Our substantive funded establishment reflects the birthrate plus recommendation for staffing levels. However, recruiting to our funded establishment has been challenging over recent months and maintaining staffing levels is a constant challenge.

This has been escalated to Board level and is being managed accordingly, as detailed later in the report.

We recognise that there is a need to balance the junior workforce with experienced staff and in particular the recruitment into senior Band 6 positions is a challenge for Salisbury. Although challenges in recruitment are not just isolated to Salisbury, the military population, lack of city lifestyle and size of the maternity service are all contributory factors to recruitment challenges.

The recruitment team are currently providing focused individual support, including weekly meetings with the Director of Maternity and Neonatal Services, 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.

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 being piloted to aid recruitment. We have adapted to look at several varying processes to attract staff, including supporting return to practice midwives, financial incentives, and varying contracts. From a flexible working perspective, we have trialed 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 well-received by staff and supports our work around retention.

Our collaborative work with Gloucester and GWH to recruit international midwives has been successful, we have 7 international midwives working within the service now. Two are working at band 5 having completed their OSCE and received their NMC Pin, the remaining 5 midwives are at varying stages in the education and OSCE process and remain in supernumerary posts. We are anticipating all will have taken OSCE by the end of September 2023 and on receipt of NMC registration will be moving into band 5 preceptee positions.

We have also been working on a forecast trajectory, looking at vacancies rates against budgeted establishment and factoring in predicted starters (including OSCE qualified international midwives and newly qualified midwives), leavers, agency staff and maternity leave. This has enabled forward planning and in particular, a clear approach and timeframe around recruiting long line agency midwives to support vacancies until substantive staff move into posts.

We are anticipating a significant reduction in vacancies in October 2023 as shown below:

Banding	Clinical Budgeted Establishment	Actual Clinical Headcount (WTE) August 2023	Variance (WTE) Establishment vs staff in post August 2023	Anticipated Staffing October 2023
Band 5 Nurses	0	4	+4	4
Band 5 Midwives	12.09	3.64	-8.45	18.64 (New starters – Preceptee and International Midwives)
Band 6 Midwives	70.58	48.03	-22.55	57.87 (New Starters and B5 MW moving to B6 MW)
Band 7 Midwives	7.48	10.68	+3.2	9.68
Total	**90.15**	**66.35**	**- 23.8**	90.19 (includes nurses) **86.19 Clinical Midwives**

Maternity leave has been consistently high amongst midwives and as of August 2023 we have 8.98 WTE midwives on maternity leave which does put further pressure on fill rates.

When staffing is less than optimum, the following measures are taken in line with the escalation policy:

- Utilisation of Bank Midwives.
- Community staff working flexibly in the unit as and when required.
- Non-clinical midwives working clinically to support acuity.
- Use of long line Agency Midwives to cover vacancies (February to October 2023).
- Support of Maternity and Neonatal 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.
- Recruitment of nurses to the maternity Services.

All the above actions are designed to maximise staffing into critical functions to maintain safe care for the women and their babies.

It is important to recognise staff wellbeing is impacted with the shortfall of staff within the service and staff are feeling the pressure of vacancies. It is recognised that although staff have undertaken Bank work to close day to day gaps this is not a sustainable long-term solution.

From a pastoral support perspective, we have a retention Professional Midwifery advocate (PMA) in post and have recently received LMNS money to support funding a retention lead for MSW. The PMA post has proved valuable in supporting staff and understanding the reasons they may be considering leaving the service and helping them to find solutions to remaining with us i.e., flexible working for example.

5. Midwife to Birth Ratio

Birthrate Plus has calculated an individualised midwife to birth ratio for Salisbury, recommending a rate of 1:26. Following review of individualised data 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.

The table outlines the real time monthly birth to midwife ratio for the past 6 months.

Month	February23	March 23	April 23	May 23	June 23	July23
Midwife to birth ratio	1:27	1:31	1:25	1:31	1:29	1:30

6. Specialist Midwives

Birth Rate Plus recommends that 8-11% of the total establishment are not included in the clinical numbers, with a further recommendation of this being 11% for multi-sited Trusts. This includes management positions and specialist midwives. 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 at SFT 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 amongst others.

Since our assessment in 2019/21 birthrate plus has been reviewing the standard percentage and is adapting it depending on unit size, recognizing that the national ask is the same despite the number of births and therefore smaller units may expect to require a higher percentage of non-clinical. They have indicated that the percentage applicable to SFT is likely to move upwards to 12% in our next assessment.

7. Birth Rate Plus Live Acuity Tool

The Birth Rate Plus Live Acuity Tool is used in the intrapartum areas and in the other inpatient areas. It is a tool for midwives to assess their 'real time' workload arising from the number of women needing care, and their condition, admission and during the processes of labour, delivery and postnatally. It is a measure of 'acuity', and the system is based upon an adaption of the same clinical indicators used in the well-established workforce planning system Birth Rate Plus.

The Birth Rate Plus classification system is a predictive/prospective tool rather than the retrospective assessment of process and outcome of labour used previously. The tool is completed four hourly by the labour ward coordinator. An assessment is produced on the number of midwives needed in each area to meet the needs of the women based on the minimum standard of one-to-one care in labour for all women and increased ratios of midwife time for women in the higher need categories. This provides an assessment on admission of where a woman fits within the identified Birth Rate Plus categories and alerts midwives when events during labour move her into a higher category and increased need of midwife support.

This safe staffing tool kit supports most of the components in the NICE Guidance (and is endorsed by NICE) on safe midwifery staffing for maternity settings necessary for the determination of maternity staffing requirements for establishment settings. It provides evidence of what actions are taken at times of higher acuity and use of the escalation policy when required.

8. Supernumerary Labour Ward 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 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 100% of the measured occasions in the 6 months this report relates to.

The following table outlines the compliance against this action by month:

	Number of days per month	Number of shifts per month	Compliance
February 23	28	56	100%
March 23	31	62	100%
April 23	30	60	100%
May 23	31	62	100%
June 23	30	60	100%
July 23	31	62	100%

9. One to One care in Established Labour

Women in established labour are required to have one to one care and support from an assigned midwife. Care will not necessarily be given by the same midwife for the whole labour, but it is expected that the midwife caring for a woman in established labour will not have any other cases allocated to her.

If there is an occasion where one to one care cannot be achieved, then this will prompt the labour ward coordinator to follow the course of actions within the acuity tool and the escalation policy. These may be clinical, or management actions taken.

The following table outlines compliance with provision of 1:1 care by Month.

	February	March	April	May	June	July
Birth Centre	100%	100%	100%	100%	100%	100%
Labour Ward	100%	100%	100%	100%	100%	100%

10. Red Flag Incidents

A midwifery red flag event is a warning sign that something may be wrong with midwifery staffing (NICE 2015). If a midwifery red flag event occurs, the midwife in charge of the service is notified. The midwife in charge will then determine whether midwifery staffing is the cause and the action that is needed. Red flags are collected through the live Birth Rate Plus acuity tool.

The following tables demonstrate red flag events for the 6-month period from 1st February 2023 to 31st July 2023. Out of 659 data admissions there were 7 red flags entered onto the system with the reasons detailed below:

Number & % of Red Flags Recorded

From 01/02/2023 to 31/07/2023

RF1	Delayed or cancelled time critical activity e.g.Delay EL LSCS >4 hours	0	0%
RF2	Missed or delayed care (for example, delay of 60 minutes or more in washing and suturing) e.g waiting for suturing >60 mins	0	0%
RF3	Missed medication during an admission to hospital or midwifery-led unit (for example, diabetes medication)	0	0%
RF4	Delay of more than 30 minutes in providing pain relief	1	13%
RF5	Delay of 30 minutes or more between presentation and triage	1	13%
RF6	Full clinical examination not carried out when presenting in labour	0	0%
RF7	Delay of 2 hours or more between admission for induction and beginning of process	5	63%
RF8	Delayed recognition of and action on abnormal vital signs (for example, sepsis or urine output)	0	0%

Each red flag is recorded on the acuity tool and reported via datix, this ensures timely review and action planning to reduce repeat incidents and maintain safety.

11. Safety and Overview

In order for the service to demonstrate safe staffing on a daily basis 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 missed breaks via Datix 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 (as an Improving together divisional driver) and is discussed with the Board level Safety Champions monthly. The reporting mechanisms ensure clear escalation and visibility of staffing challenges.

12. 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 carer 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.

The table below 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 90.16 WTE clinical midwives to be fully recruited into,

and with the current vacancy rate this is not currently feasible.

Continuity of Carer modelling from Birthrate Plus® report (May 2021)

SALISBURY NHS TRUST	24% uplift	Version date: 13/05/2021		DRAFT							
TOTAL BIRTHS	2193										
TOTAL COMMUNITY CASES	2756	**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.									
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 *includes home births*	0.00		11.24		19.67		28.66		42.15		56.19	
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**	

13. 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. Next steps are detailed:

- Continue with the recruitment campaign work utilising all options available to the Trust for recruitment and retention incentives.
- 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.
- Continue with retention work and input from PMA to support staff.
- Continued consideration of any exit interview themes and actions associated with them.

Neonatal Staffing report – September 2023

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),

This report has been written following review of Neonatal Nurse staffing in line with the recommendations and standards outlined in the above documents by the Director of Midwifery and Neonatal Services and Neonatal Matron.

2. Neonatal Services staffing review methodology.

2.1 The department has been in escalation for 10 days from April 1st 2023 to the end of August 2023. The service had a mixture of higher acuity and cot capacity against plan in this time because a rise in the number of overall admissions. Safe staffing was maintained by use of escalation policy and NICU and Maternity staff covering shortfalls in acuity, and the use of bank nurses.

2.2 All units within the local Neonatal network are utilising a recognised acuity tool (Badger). This enables staff to consider the staffing, capacity and activity in real time and activate escalation when necessary. This real time data ensures that there is a clear pathway around escalation and activity which is being followed in times of high activity.

Additionally, the Neonatal Matron further reviews the data monthly around performance and activity against acuity to ensure we are meeting the service demands and providing safe and appropriate levels of staffing.

2.3 Within the budgeted establishment 70% of RNs/RCNs are expected to be Qualified in speciality (QIS). Current levels locally at SFT are at 68.7% although will be above 70% in October due to further training being completed.

QIS training is now being delivered by the neonatal network with the backing of Health Education England (HEE). 1 to 2 places on the QIS course are allocated to SFT annually to ensure we meet national targets on specific neonatal nurse training and have a clear trajectory around succession planning for these specialist roles. At present 1.0 WTE nurses has just completed their QIS training, and a further 1.53 WTE commence QIS training in September 2023. This rolling training programme supports succession planning to ensure there are staff with correct skills working in the NICU.

2.4 Central funding was allocated in August 2023 from the Operational Delivery Network (ODN) of £12,129/year. These additional funds are to support leadership in the Neonatal team.

2.4.1 Additional posts in 2023:

Band 7 Psychotherapist 0.2WTE employed to support mothers requiring psychological input following trauma from birth or following their babies admissions and stay on Neonatal Unit. It is recognised that birth and the subsequent Neonatal journey for mothers can be challenging, and this role shared across maternity and NICU will allow support for this.

Audit lead 0.2WTE. With both the local and National requirement to be benchmarking our services and care provision, particularly around CNST and Ockenden this will enable increased hours for audit to ensure oversight and continuous improvement.

3. Challenges:

- Sickness Absence

    - Sickness absence is currently at 3.2%.

      Absence is challenging in what is a small and specialist team, however it has been mitigated successfully with the use of bank staff and the continued use of an ad hoc on call system. Flexibility across post-natal and Sarum ward to support when the neonatal service goes into escalation further reduces the need for agency staff. Securing last minute agency is challenging with a requirement for QIS however the Trust incentive of ‘super enhanced shifts’ has supported filling last minute absence.

- The national initiative (ATAIN), to reduce the number of babies admitted to a neonatal service, 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.

    - Funding (£40,000) secured following our submission last year will support recruitment of 1.0WTE maternity nurse to enhance the TC model and partially support financing attendance at Transitional Care study days (provided by SE neonatal network).

    - As of November 2023, we will commence a rotation for the maternity nurses working on postnatal ward to the neonatal unit to further enhance their skills.

    - This will be done with a long-term goal in mind to utilise these nurses for TC staffing.

- 2.0 WTE jobs currently advertised following promotion of current nurses. This will ensure that we remain, as current position, at full establishment.

- Band 5 maternity leave (1.0WTE) from November 2023 - mitigated by rotating the maternity nurses to NICU.

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:

- Educational opportunities to support retention e.g. QIS and New-born Life Support (NLS) training.

- Monthly assessment of staffing and effective forecasting.

- Recruitment of Audit lead 0.2WTE

- Opportunities for development by shadowing senior nursing staff and focussing on succession planning and educational opportunities.

- Supporting flexible working to enable improved work/life balance for staff

5.0 Recommendations

- As per CNST safety action 4 an action plan of Neonatal Medical and Nursing staffing, alongside Obstetric and Anaesthetic Medical staffing will be presented alongside a report to demonstrate the compliance with this standard in November 2023.

- We will continue to closely monitor a sustained increase in cot numbers and acuity since the pandemic through our BAPM nursing staffing tool. If the increase in numbers is sustained consideration will be given to the possibility of expanding 1 ITU cot and recruiting further band 5 nurses to comply with BAPM standards. Admissions are continuing to be closely monitored and all are reviewed by the MDT.

- 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.

WARD STAFFING REVIEW
July/Aug 23

NB All these indicators are for period of 01/06/22 - 31/05/23

		Completed by Healthroster team			Completed by healthroster						Completed by Healthroster team								
					Sisters/Charge Nurses		Vacancies (as of 20.06.2023)				Total Number of staff per shift (roster template)								
Wards/department	Beds	Total Ward Establishment (WTE)	Average maternity leave for review period in WTE	Average % uplift during July 22-23 (from Allocate)	No Band 7	No Band 6	Band 6 Vacancy WTE	Band 5 RN Vacancy WTE	Band 4 NA or AP vacancy WTE	Band 3 HCA vacancy WTE	E- Registered Nurse	E - Band 4 (NA or AP)	E - Band 3 (HCA)	L -Registered Nurse	L -Band 4 (NA or AP)	L -Band 3 (HCA)	N - Registered Nurse	N - Band 4 (NA or AP)	N - Band 3 (HCA)
Hospice	10	24.27	0	34.10%	1	2.00	-0.01	1.94	0.64	2.22	2	0	2	2	0	2	2	0	1
Longford	39	84.1	1.04	29.80%	2	6	-1.44	11.37	-9.00	13.41	7	0	10	6	0	6	5	0	5
Sarum	16	38.96	2.6	35.40%	1	7	-0.89	5.94	1.59	-0.36	4	0	1	4	0	1	3	0	0

	Ward Sister	Completed by Healthroster team			Completed by Healthroster										Ward Sister			
	Admin support (WTE)		Skill mix as a proportion of total staff RCN note national benchmark of RN 65%		Registered (RN + NA) staffing relative to patients (early / day shift)		Registered (RN+NA)staffing relative to patients (late shift)		Registered (RN+NA) staffing relative to patients (night shift)		Staffing per occupied bed (NPOB) on a early/day shift		Staffing per occupied bed (NPOB) on a Night Shift		HR Indicators			
Wards/department	Ward managers Assistant - Y/N	Ward Siser/Charge Nurse supervisory - average % of contracted hours	Registered %	Non-registered %	RN and NA/AP	No Patients	RN and NA/AP	No of patients	RN and NA/AP	No Patients	Nurses (RN & HCA)	No. beds	Nurses	No beds	% Staff Turnover (average)	% Sickness absence (average from e-	% Compliance Appraisals	% Compliance Stat and Mand training
Hospice	N	70 - 80%	62.20%	37.80%	1	5	1	5	1	5	1	2.5	1	3.33		8.90%	79.00%	85.00%
Longford		80%	51.60%	48.40%	1	6	1	7	1	8.4	1	2.47	1	4.2		6.70%	?	91.00%
Sarum		80%	83.60%	16.40%	1	3.00	1	3	1	4	1	2.4	1	4		5.40%		

	Ward Sister from Power BI													Healthroster - Power BI								
	Nursing Sensitive Indicators 01/06/22 - 31/05/23													Workforce utilisation 01/06/22 - 31/05/2023								
	Number of PUs per 1000 bed days			Number of falls per 1000 bed days			medication incidents per 1000 bed days			Number of complaints	No of MRSA Bacteraemia	No of MSSA Bacteraemias	No of C-diff (reportable and non-reportable)	Total CHPPD		RN CHPPD		Fill Rate		Staffing concerns on risk register	Red Flags (Reported via Safecare)	SNCT undertaken
Wards/department	High	Low	Average	High	Low	Average	High	Low	Average					Average	Last mth	Average	Last mth	RN	HCA			
Hospice	17.2	4.5	8.2	25	13.5	12.2	8.1	3,4	4.7	0	0	0	0	9.7	12.8	6.1	8.1	95%	85%	N	35	N
Longford	11.6	2	6.7	11.8	1	6.4	5.9	1	3.6	3	0	1	3	8.2	8.4	4.2	4.2	94.50%	81.50%	N	116	Y
Sarum	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	2	0	0	0	11.6	10.6	9.6	8.4	103.70%	89.60%	N	11	Y

WARD STAFFING REVIEW
July/Aug 23

NB All these indicators are for period of 01/06/22 - 31/05/23

Wards/department	Beds	Total Ward Establishment (WTE)	Average maternity leave for review period in WTE	Average % uplift during July 22-23 (from Allocate)	Sisters/Charge Nurses: No Band 7	Sisters/Charge Nurses: No Band 6	Vacancies (as of 20/06/2023): Band 6 Vacancy WTE	Band 5 RN Vacancy WTE	Band 4 NA or AP vacancy WTE	Band 3 HCA vacancy WTE
		Completed by Healthroster team			Completed by healthroster					
AMU	19	51.95	4.13	42.20%	1	6.00	0.16	5.79	-8.66	3.08
	8									
Durrington	21+2	37.68	1.91	31.30%	1	4	-1	2.63	0	3.26
ED	8	81.01	3.95	32.50%	6	11.00	5.87	13.19	-2.00	12.16
Farley	30	45.96	0.32	29.20%	1	5	-2	7.37	-3.92	6.07
Laverstock	24	31.01	4.23	42.30%	1	3	0	-2.88	0	5.71
Pembroke Ward	10	16.91	0.8	29.30%	1	4	-0.56	-1.75	0.00	1.31
Pitton	27	33.75	1.43	38.10%	1	3	0	4.82	-3	2.99
Redlynch	27	39.75	1.1	37.70%	1	3	1	0.24	0	7.81
Spire	30	45.16	3.05	33.70%	1	5	-2	4.53	-1	7.23
Tisbury	23	35.1	2.94	35.60%	2	4	0.08	2.74	-1.61	1.75
Whiteparish	23	35.17	0.83	31.30%	1	4	-2	4.2	2.65	5.59

Wards/department	Total Number of staff per shift (Roster Template): E- Registered Nurse	E - Band 4 (NA or AP)	E - Band 3 (HCA)	L -Registered Nurse	L -Band 4 (NA or AP)	L -Band 3 (HCA)	N - Registered Nurse	N - Band 4 (NA or AP)	N - Band 3 (HCA)	Admin support (WTE): Ward Clerk (Y/N)	Ward managers Assistant (Y/N)	Ward Siser/Charge Nurse supervisory time - average % of contracted work hours	Skill mix as a proportion of total staff RCN note national benchmark of RN 65%: Registered %	Non-registered %
	Completed by Healthroster team									Ward Sister		Completed by Healthroster team		
AMU	4	0	3	5	0	3	4	0	2	Y	Y	100%	70.30%	29.70%
	2		1	2		1								
Durrington	4	0	5	4	0	4	3	0	2	Y	Y	100%	57%	43%
ED	9	0	5	9	0	6	7	0	3		Shared by B7s - ap		74.30%	25.70%
Farley	5	0	5	5	0	4	4	0	3	Y	Y	80%	61.60%	38.40%
Laverstock	4	0	3	4	0	2	3	0	2	Y	Y	50%	63%	37%
Pembroke Ward	2	0	1	2	0	1	2	0	1	Y	N	80%	78.70%	21.30%
Pitton	4	0	4	4	0	3	3	0	2	Y	Y	100%	56.80%	43.20%
Redlynch	5	0	4	4	0	2	3	0	3	Y	N	100%	62.20%	37.80%
Spire	4	0	6	4	0	4	3	0	3	Y	Y	100%	50.20%	49.80%
Tisbury	6	0	2	6	0	2	4	0	1	Y	Y	100%	80%	20%
Whiteparish	4	0	3	3	0	3	2	1	2	Y	Y	100%	60%	40%

Wards/department	Registered (RN + NA) staffing relative to patients (early / day shift): RN and NA/AP	No Patients	Registered (RN+NA)staffing relative to patients (late shift): RN and NA/AP	No of patients	Registered (RN+NA) staffing relative to patients (night shift): RN and NA/AP	No Patients	Staffing per occupied bed (NPOB) on a early/day shift: Nurses	No. beds	Staffing per occupied bed (NPOB) on a Night Shift: Nurses	No beds	HR Indicators: % Staff Turnover (average)	% Sickness absence (average from e-roster da	% Compliance Appraisals	% Compliance Stat and Mand training
	Completed by Healthroster										Ward Sister			
AMU	1	4.75	1	3.8	1	4.75	1	2.7	1	3.1		11.70%	76.00%	86.00%
Durrington	1	5.75	1	5.75	1	7	1	2.5	1	4.6		5.60%	57.00%	89.40%
ED		N/A		N/A		N/A		N/A		N/A	16.7%	6.70%	62.00%	87.40%
Farley	1	5.2	1	5.2	1	6.5	1	2.6	1	3.71		8.70%	79.00%	81.00%
Laverstock	1	4.25	1	4.25	1	5.66	1	2.42	1	3.4		8.30%	62%	92%
Pembroke Ward	1	5	1	5	1	5	1	3.33	1	3.33		6.50%	59.00%	92.00%
Pitton	1	5.25	1	5.25	1	7	1	2.62	1	4.2		11.90%	39%	89%
Redlynch	1	5.4	1	6.75	1	9	1	3	1	4.5	0	11.10%	74%	63%
Spire	1	7.5	1	7.5	1	10	1	3	1	5		7.80%	43%	88%
Tisbury	1	3.83	1	3.83	1	5.75	1	3	1	4.8		7.20%	91%	97%
Whiteparish	1	5.75	1	7.66	1	7.66	1	3.28	1	3.28		9%	81%	94%

Wards/department	Nursing Sensitive Indicators 01/06/22 - 31/05/23: Number of PUs per 1000 bed days – High	Low	Average	Number of falls per 1000 bed days – High	Low	Average	medication incidents per 1000 bed days – High	Low	Average	Number of complaints	No of MRSA Bacteraemias	No of MSSA Bacteraemias	No of C-diff (reportable and non-reportable)	Workforce utilisation 01/06/22 - 31/05/2023: Total CHPPD – Average	Last mth	RN CHPPD – Average	Last mth	Fill Rate – RN	HCA	Staffing concerns on risk register	Red Flags (Reported via Safecare)	SNCT undertaken
	Ward Sister from Power BI													Healthroster - Power BI								
AMU	6.5	1.3	2.7	14.7	5.1	9.5	15.5	6.5	10.2	6	1	0	3	7.6	9.8	5.2	6.7	89.00%	79.00%	Y	53	N
Durrington	8.5	1.5	3.8	17.5	3	10.9	16.4	1.5	6.3	1	0	2	+ period	5.8	7.1	3.1	3.8	78.30%	81.60%	N	220	N
ED	N/A			N/A			N/A			22				N/A		N/A		N/A		3	15	Y
Farley	12.6	2.3	7.1	11.6	1.1	7.8	5.5	1.1	3.3	6	1	2		5.9	6.5	3.6	3.9	89.70%	75.30%	N	333	N
Laverstock	20.7	1.4	6.1	14.10%	3.1	7.3	5.5	1.4	2.9	1	1	0	1	5.2	5.6	3.2	3.7	84.20%	82.80%	N	66	N
Pembroke Ward	23.6	3.2	9.4	18.3	3.3	8.4	19	3.3	4.3	0	0	0	1	8	9	5.8	6.4	97.20%	79.00%	N	79	N
Pitton	8.8	1.2	4.9	20.7	4.9	11.4	7.3	2.4	14.9	3				5.6	6.4	3.2	3.4	101.80%	95.70%	N	153	N
Redlynch	6.4	1.2	2.8	16.2	6.2	10.8	8.7	1.2	2.8	6	0	0	1	5.3	5.7	3.2	3.4	90.40%	78.10%	2	36	N
Spire	11.1	2.3	5.7	22.8	8.4	15.2	6	1.1	2.7	5	0	0	5	6.1	7	3	3.4	103.40%	90.30%	N	221	N
Tisbury	5.6	1.4	2.6	8.6	1.4	4.9	1.5	5.6	4.5	2				5.4	5.9	4.3	4.8	83.00%	71.30%	N	473	N
Whiteparish	11.8	1.4	5.6	17.7	3.1	9.01	7.4	2.8		1		1	3	6.1	11	3.6	6.6	98.70%	89.00%	N	19	N

WARD STAFFING REVIEW
July/Aug 23

NB All these indicators are for period of 01/06/22 - 31/05/23

Wards/department	Beds	Completed by Healthroster team: Total Funded Establishment WTE (not inc A&C)	Average maternity leave for review period in WTE	Average % uplift during July 22-23 (from Allocate)	Completed by healthroster: Sisters/Charge Nurses: No Band 7	No Band 6	Vacancies (As of 20/06/2023): Band 6 Vacancy WTE	Band 5 RN Vacancy WTE	Band 4 NA or AP vacancy WTE	Band 3 HCA vacancy WTE	Completed by Healthroster team: Total Number of staff per shift (Roster Template): E- Registered Nurse	E - Band 4 (NA or AP)	E - Band 3 (HCA)	L -Registered Nurse	L -Band 4 (NA or AP)	L -Band 3 (HCA)	N - Registered Nurse	N - Band 4 (NA or AP)	N - Band 3 (HCA)
Amesbury	32	50.55	0.96	31.50%	1	3.00	0.00	1.13	-0.94	9.91	4	1	5	4	1	5	3	0	4
Britford	20 + 6	42.95	2.1	31.10%	1	3	-0.12	1.33	0.00	-2.12	5	0	2	4	0	2	3	0	2
(SAU)	Funded establishment is within Britford Ward - along with Maternity & Avg % Uplift and vacancies										2	0	1	2	0	1	0	0	0
Chilmark	24	39.08	1.73	39.20%	1	3.00	0.39	3.96	0.00	3.08	4	0	3	4	0	3	3	0	2+twi
Downton	24	31.9	2.95	37.40%	1	3	0	1.41	-2.53	2.46	4	0	3	3	0	2	2	0	2
Odstock	17	35.97	0.43	30.40%	1	4	0	1.28	0.00	1.67	4	0	2	3	0	2	3	0	2
Radnor	10	66.94	1.96	32.80%	6	10	2.02	9.99	0.00	1.77	9	0	1	9	0	1	9	0	1

Wards/department	Ward Sister: Admin support (WTE): Ward managers Assistant (Y/N)	Completed by Healthroster team: Ward Siser/Charge Nurse supervisory - average %	Skill mix as a proportion of total staff RCN note national benchmark of RN 65%: Registered %	Non-registered %	Completed by Healthroster: Registered (RN + NA) staffing relative to patients (early / day shift): RN and NA/AP	No Patients	Registered (RN+NA)staffing relative to patients (late shift): RN and NA/AP	No of patients	Registered (RN+NA) staffing relative to patients (night shift): RN and NA/AP	No Patients	Staffing per occupied bed (NPOB) on a early/day shift: Nurses	No. beds	Staffing per occupied bed (NPOB) on a Night Shift: Nurses	No beds	Ward Sister: HR Indicators: % Staff Turnover (average)	% Sickness absence (average from e-roster data)	% Compliance Appraisals	% Compliance Stat and Mand training
Amesbury	N	100% (2 Clinical shifts	54.00%	46.00%	1	6.4	1	6.4	1	10.66	1	3.55	1	4.57	22.0%	8.10%	43.00%	87.00%
Britford	Y	100%	64.80%	35.00%	1	4.25	1	5.25	1	7	1	3	1	3.5	?	5.20%	74.00%	81.20%
(SAU)					SAU not included in above figures													
Chilmark	N	90%	61.21%	38.79%	1	6	1	6	1	8	1	3.42	1	4		10.80%	20.00%	60.00%
Downton		90%	59.90%	40.10%	1	6.5	1	8.66	1	13	1	3.71	1	6.5		8.50%		
Odstock	0.4	60%	65.30%	34.70%	1	4.25	1	5.66	1	5.66	1	2.83	1	3.4		9.50%	67.00%	91.00%
Radnor		N/A	94.00%	6.00%	Crit care	Crit care	Crit care	Crit care	Crit care	Crit care	Crit care	Crit care	Crit care	Crit care		8.50%	78.00%	89.30%

Wards/department	Ward Sister from Power BI: Nursing Sensitive Indicators 01/06/22 - 31/05/23: Number of PUs per 1000 bed days: High	Low	Average	Number of falls per 1000 bed days: High	Low	Average	medication incidents per 1000 bed days: High	Low	Average	Number of complaints	No of MRSA Bacteraemia	No of MSSA Bacteraemias	No of C-diff (reportable and non-reportable)	Healthroster - Power BI: Workforce utilisation 01/06/22 - 31/05/2023: Total CHPPD: Average	Last mth	RN CHPPD: Average	Last mth	Fill Rate: RN	HCA	Staffing concerns on risk register	Red Flags (Reported via Safecare)	SNCT undertaken
Amesbury	21.3	2.2	13.79	21.9	9.6	13.67	15.3	0	5.07	4	0	1	1	6.3	8.5	3.2	4.9	102.10%	89.00%	2	61	N
Britford	6.5	1.5	2.8	9.6	1.6	4.8	12.8	1.6	6.5	2	0	0	1	8.6	8.6	5.7	5.5	92.80%	94.20%	N	2	N
(SAU)																						
Chilmark	11.6	1.6	6.6	10.2	1.6	5.9	10	3.2	5.4	1	0	0	1	5.3	6.9	3	4	83.40%	74.00%	N	7	N
Downton														6	5.9	3.5	3.6	122.40%	102.40%		4	
Odstock	5.9	1.9	3.7	10.2	2.1	9.8	11.8	1.9	5.3	0	0	0	4	7.4	7.6	4.8	4.8	99.40%	93.20%	1	15	N
Radnor	44.8	13.2	25.6	8.7	4.4	1.5	62.5	8.2	24.8	0	0	1	0	26.7	28.9	25.1	26.7	86.00%	53.90%	1	37	N

Division	Ward	Recommendation	Rationale	Financial Impact/costs	Comments
Medicine		Uplift 3wteB5 to B6	2 x B6 per shift support SDEC	36,050	Required to provide senior support to SDEC - proven to improved LOS
	AMU	2 x ACP trainee posts uplift to 8a	ACPs should be 8a	-	Outside skill mix review - shuld have been in business case for ACP roles - cost £12,705
	Durrington	NIL		0	
	ED	1 wte B7	Facilitate supervisory time for B7s	66,751	Defer as have dedicated matron role, review next year
		5.3wte B5	Additional triage 24/7	263,316	RCEM / ECIST recommendations
		HCA	Additional 2.5 wte Band 3	92,680	RCEM / ECIST recommendations
		B4 Nurse associate	2wte for now	78,762	Specific ED NA funding received for training, which supports different ways of working in department
	Farley	Uplift 2.6wte B5 to B6	Support 4-hr target through senior cover at night	31,243	Support to achieve SNAP
	Laverstock	1 x RN day and night shifts (5.3wte)	Achieve 1:6 ratio and the 4-beds not staffed	263,316	Invest or close beds
	Pitton	1 x HCA night shift (2.6wte)	Currently 2 HCAs on night - falls risk, high user fof additional duties	94,846	Do have 3 RNs so 5 staff for 24 pts but using additional duties
	Redlynch	1 x RN night shift (2.6wte)	Procedures and discharges in afternoon, changes ratio from 1:9 to 1: 6.75	129,174	Defer until SNCT review complete
		1 x HCA twilight (1.4wte)	Incidents show pattern of afternoon	51,071	1 RN but make twilight
		1 x RN on night shift (2.6wte)	Current ratio 1RN:10pts - would get to 1:7.25	129,174	Lean ratio means any increase in acuity leads to additional duties thus spending in run rate
		1 x RN Early shift (1.4wte)	Allow co-ordinator and give ratio 1:6 - currently 1:7.25	69,555	Review next skill mix review - impact of night being put in and SNCT complete
	Spire	1 x HCA on night shift (2.6wte)	Incidents on night shift/additional duties	94,846	Using additional duties
	Tisbury	NIL		0	
	Whiteparish	1 x RN late shift (1.4wte)	Changing case mix would change ratio from 1:7.66 to 1:5.75	69,555	Defer and review impact once ward established following refurbishment
	New ward				
Surgery	Amesbury	1 x RN night shift (2.6wte)	32- bed ward takes from ratio of 1:10 to 1:8	129,174	Lean ratio means any increase in acuity leads to additional duties thus spending in run rate
	Britford	Uplift 0.5wte B5 to B6	Support 7-day leadership SAU	6,008	
	Chilmark	Nil		0	Night ratio is 1:8 but- is elective and often empty beds
	Downton	1 x RN night shift (2.6wte)	Meet ratio of minimum 1:7 (currently 1:13)	129,174	Lean ratio means any increase in acuity leads to additional duties thus spending in run rate
	Odstock	1 x RN late shift Mon - Fri (1wte)		50,241	Defer and review with analysis of moving all wards to shift co-ordinator being non-caseload
	Radnor (ICU)	Nil		0	
CSFS	Hospice	B4 E Mon-Fri Late weekend (1wte)		38,828	Only need 1wte as some coverage in budget
	Pembroke	1 RN Mon-Fri (1.9wte)	To support SACT therapy as reintroduce from UHS not in b/case	95,458	Needs to be subject to business case as bringing work back from UHS
	Longford	Late co-ordinator		0	24/7 B6 was approved in last year review (1,96wte) so query why needed plus 2 supernumerary B7
	Sarum	Uplift 2.6wte B5 to B6	Support senior cover at night	31,243	Increase in mental health, complex patients needing senior support

Total (all recommendations invested in green red and amber)	1,950,465
Total (red and amber only)	1,379,832
Total (red only)	1,190,141

NHS England

Emergency Care Improvement Support Team (ECIST)

ED Nurse staffing supplementary staffing summary

Salisbury NHS Trust

September 2023
Richard Brownhill RN

Background summary

Slide excerpts have been supplied which reflect the different Monday, Saturday and Sunday staffing deployment model vs the Tuesday, Wednesday and Thursday model. I note there is a 2- hour additional RN and HCSW complement between the two for the busier days (MSS).

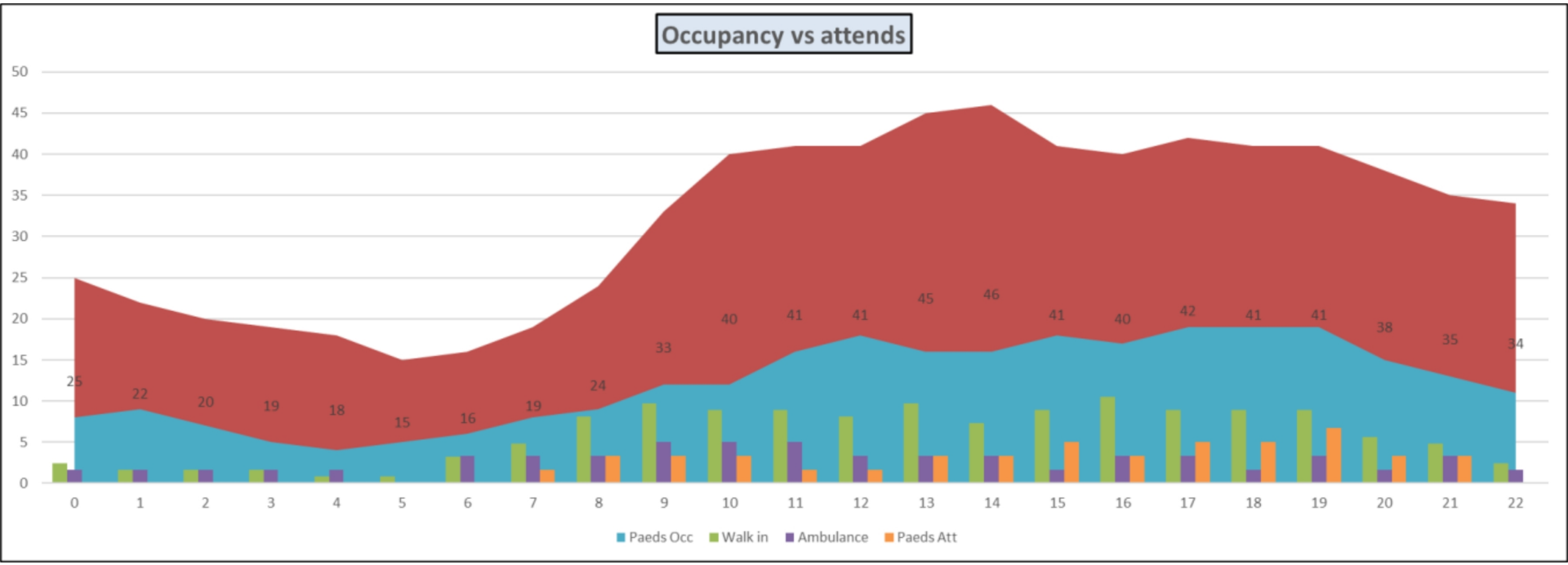
The overall staffing when breaks are not included aligns well with a range of parameters including the ED SNCT, though when looking at the allocations of staff, there is currently only one nurse allocated for initial assessment. This means that the staff currently trade off the use of a nurse between assessment and other core functions risking extended waits for undifferentiated risky patients. The team need to protect this function on their allocation. Due to economy of scale and size of the department the allocation currently being undertaken on a shift basis merely serves all core functions of an ED and is therefore not possible to reduce staffing without adding delay/risk to the clinical model. If the second nurse for assessment cannot be allocated from the current establishment (without destabilising other areas) this will require additional staff hours. Recognising that staff are currently using some u

Due to complexity of only using occupancy, acuity and dependency, there are likely other factors, e.g. support services, access to other facilities which will further impact upon staff time.

The current allocation of staff (funded or unfunded) doesn’t match from midnight until 3am and the team should consider what the impact/controls to this might be.

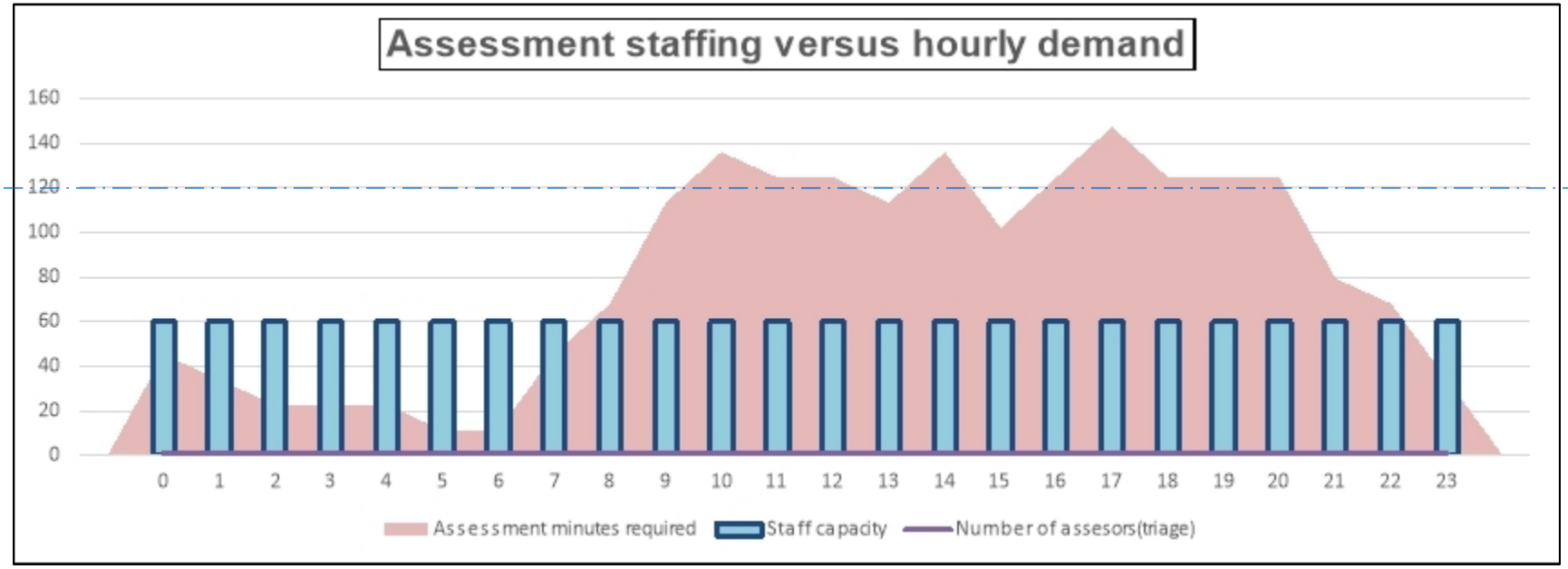
ED patient occupancy in relation to attendances (80th percentile)

This slide demonstrates that there is a limited relationship between the number of patients attending the ED and the high occupancy of the department. Factors include poor exit from the ED, limited space to see patients and constraints in consultation.



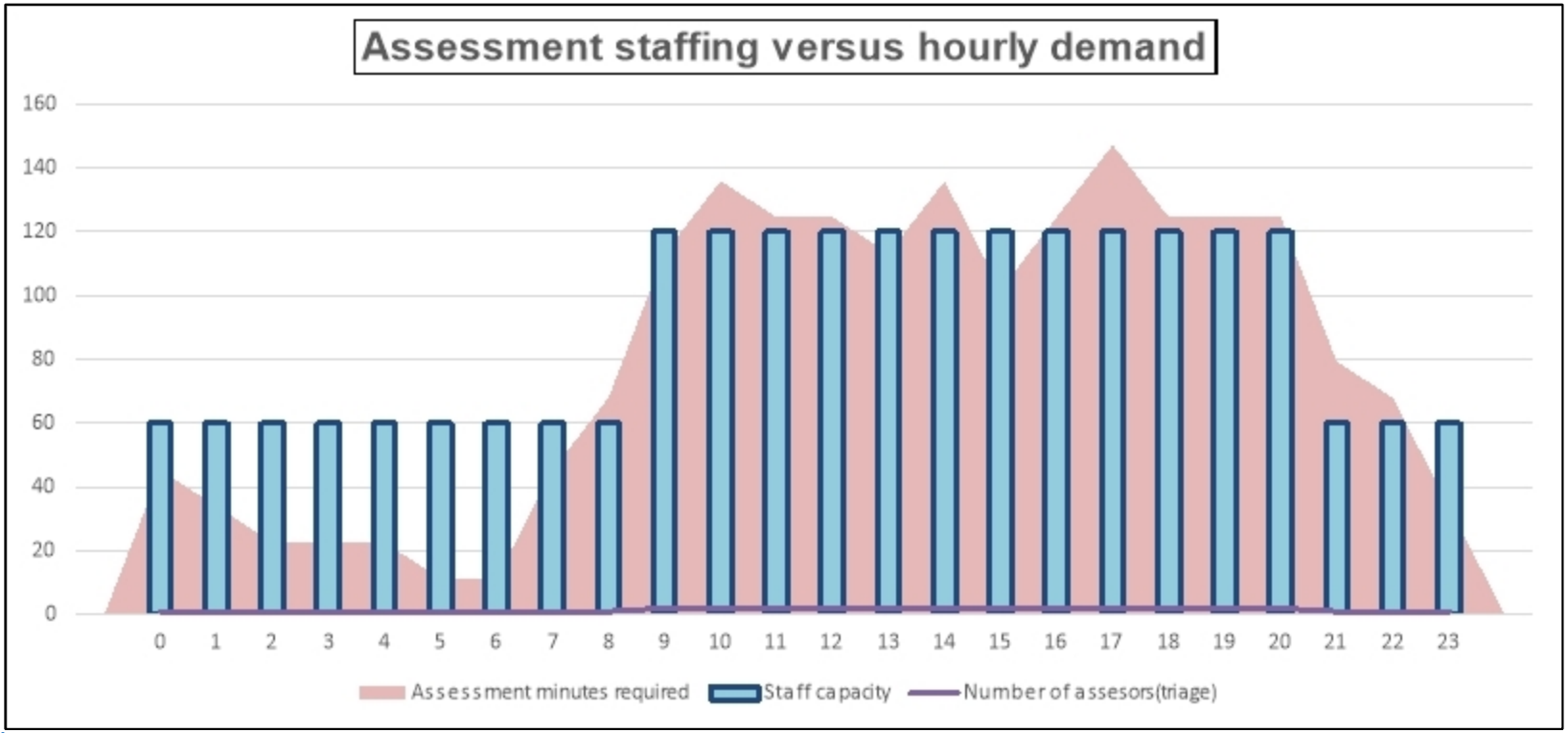
Walk in assessment (one nurse)

Using one registered nurse to conduct an initial assessment including the formal recording of triage in the current process suggests that the nurse will be unable to meet the demand from walk in patients and will lead to a significant delay in detecting potentially deteriorating patients as well as delaying opportunities for streaming/redirection.



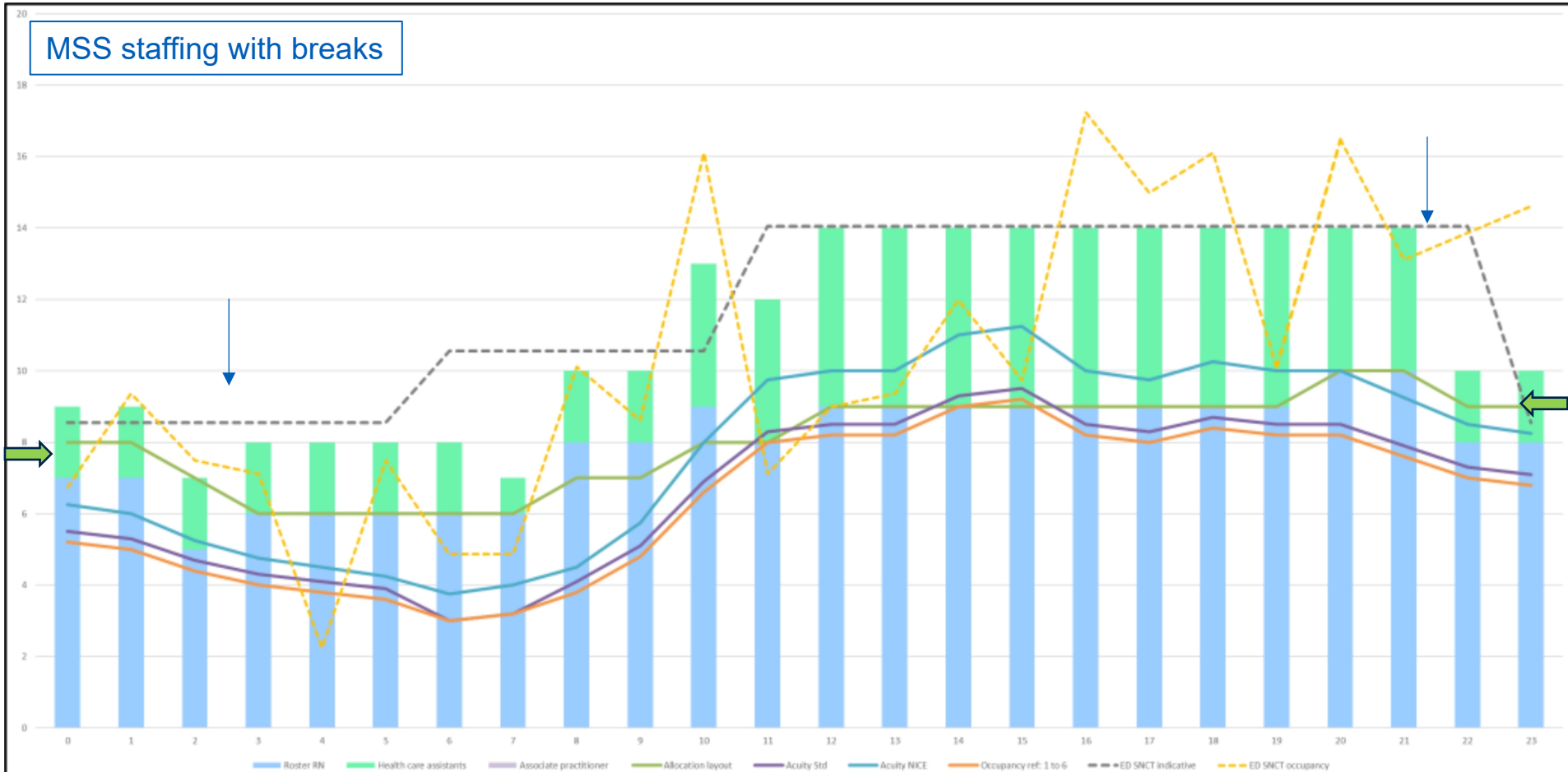
Walk in assessment (two nurses)

Using 120 mins representing two two nurses conducting this process. This would still mean that there would be a mismatch between 0900 and 2000 if this process was to be continued. The process could be redesigned to make up this shortfall potentially as it the mismatch is smaller.



Overall staffing MSS

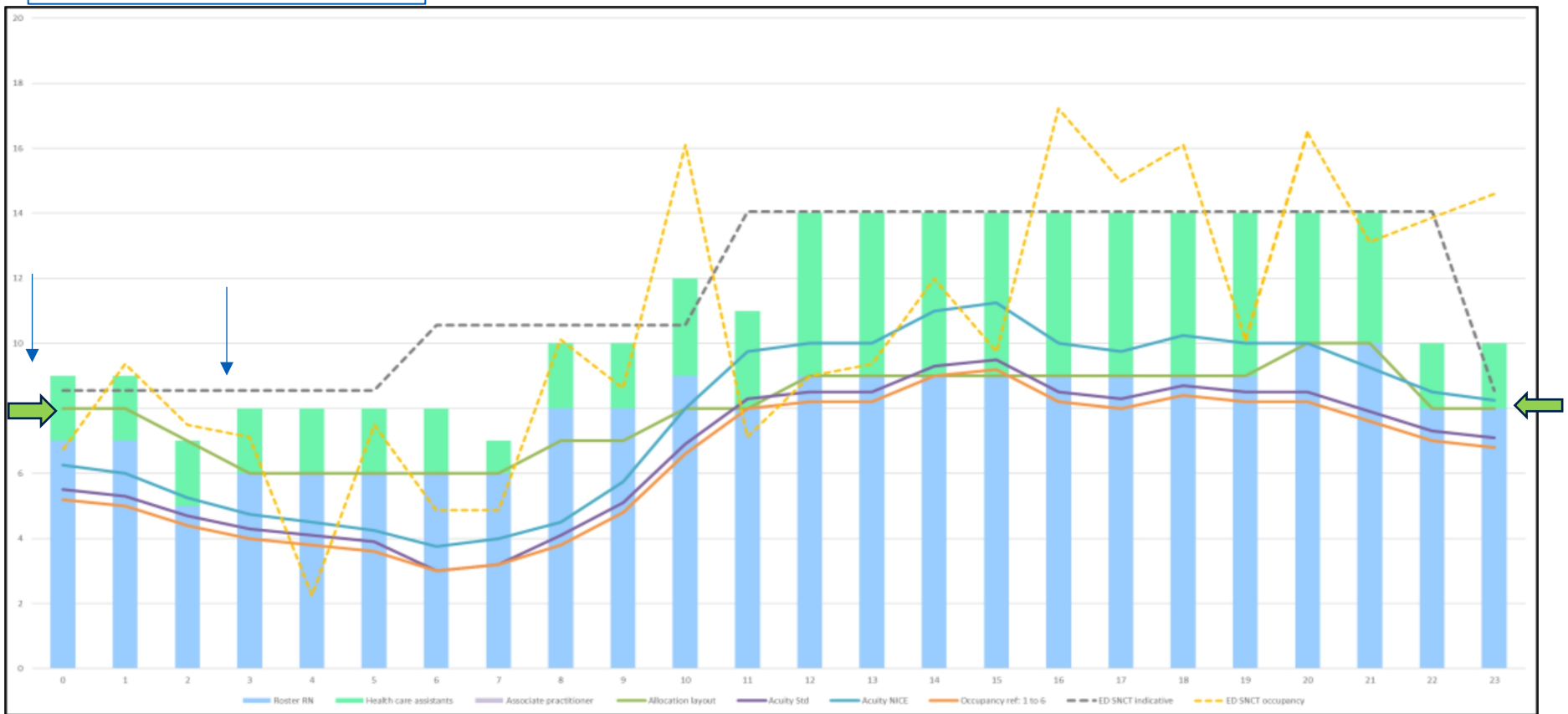
Current ED staffing (incorporating breaks) shows a mismatch between registered staffing and demand from 2100 until 0300 when compared with the daily staffing allocation (see arrows). This suggests that care demand is unlikely to be met across the busiest part of the day using existing staffing allocation. The SNCT spikes indicate that this period is particularly vulnerable to high workload demand. This is also the time when staff have their breaks, and the numbers below take account of that. This is likely to lead to delays in patients receiving medication and other care delivered by RN's.



Overall staffing TWTF

Current ED staffing (incorporating breaks) shows a mismatch between registered staffing and demand from midnight until 0300 when compared with the daily staffing allocation (see arrows). This suggests that care demand is unlikely to be met across the busiest part of the day using existing staffing allocation. The SNCT spikes indicate that this period is particularly vulnerable to high workload demand. This is also the time when staff have their breaks, and the numbers below take account of that. This is likely to lead to delays in patients receiving medication and other care delivered by RN's.

TWTF staffing with breaks



NHS Salisbury NHS Foundation Trust

Report to:	Trust Board (Public)	Agenda item:	6.3
Date of meeting:	5th October 2023		

Report tile:	FTSU – Board Self-Reflection Toolkit, draft FTSU Strategy and Protocol			
Status:	Information	Discussion	Assurance	Approval
		✓		✓
Approval Process: (where has this paper been reviewed and approved):	Monday Executives Meeting:18th September OD and P Management Board:19th September People Committee: 28th September			
Prepared by:	Chief People Officer, Freedom to Speak Up Guardian – Lizzie Swift			
Executive Sponsor: (presenting)	Chief People Officer – Melanie Whitfield			

Recommendation:

The Board Self Reflection Toolkit has been reviewed and agreed by Execs on Monday 18th September. Both OD&P Management Board and People Committee reviewed and confirm they are content with the completed Toolkit and accept the recommendations in the Executive Summary.
The Board are asked to confirm if they are both content with the self-assessment and recommendations for action.

Executive Summary:

The FTSU Board Self Reflection Toolkit is required by NHSE to be signed off alongside the refreshed FTSU Policy by the end of January 2024.
The Trust remains on track to provide strong evidence against all eight principles. The seven areas and actions for improvement over a 6–24-month period are in the tables pages 25 /26 and refer to required training, access and time for Ambassadors and ensuring ongoing cultural development to address any determine when colleagues speak up.
The Policy has been refreshed and reviewed by the Joint Consultative Committee and OD and P management Board.
Board Self Reflection Tool and FTSU Policy to be launched in October 2023 as part of Speak Up Month.

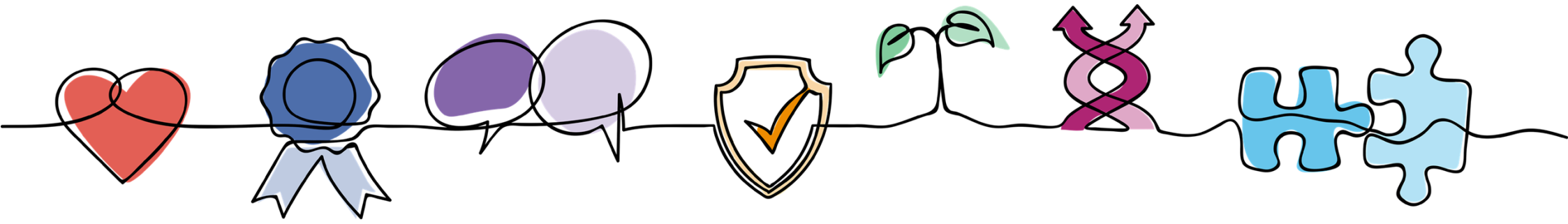
Board Assurance Framework – Strategic Priorities	Select as applicable:
Population: Improving the health and well-being of the population we serve	x
Partnerships: Working through partnerships to transform and integrate our services	x
People: Supporting our People to make Salisbury NHS Foundation Trust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

National Guardian
Freedom to Speak Up

NHS

Freedom to Speak up

A reflection and planning tool



Introduction

The senior lead for FTSU in the organisation should take responsibility for completing this reflection tool, at least every 2 years.

This improvement tool is designed to help you identify strengths in yourself, your leadership team and your organisation – and any gaps that need work. It should be used alongside Freedom to speak up: A guide for leaders in the NHS and organisations delivering NHS services, which provides full information about the areas addressed in the statements, as well as recommendations for further reading.

Completing this improvement tool will demonstrate to your senior leadership team, your board or any oversight organisation the progress you have made developing your Freedom to Speak Up arrangements.

You may find that not every section in this tool is relevant to your organisation at this time. For this reason, the tool is provided in Word format to allow you to adapt it to your current needs, retaining the elements that are most useful to you.

If you have any questions about how to use the tool, please contact the national FTSU Team using england.ftsu-enquiries@nhs.net

The self-reflection tool is set out in three stages, set out below.

Stage 1

This section sets out statements for reflection under the eight principles outlined in the guide. They are designed for people in your organisation's board, senior leadership team or – in the case of some primary care organisations – the owner.

You may want to review your position against each of the principles or you may prefer to focus on one or two.

Stage 2

This stage involves summarising the high-level actions you will take over the next 6–24 months to develop your Freedom to Speak Up arrangements. This will help the guardian and the senior lead for Freedom to Speak Up carry out more detailed planning.

Stage 3

Summarise the high-level actions you need to take to share and promote your strengths. This will enable othersin your organisation and the wider system to learn from you.

Stage 1: Review your Freedom to Speak Up arrangements against the guide

What to do

- Using the scoring below, mark the statements to indicate the current situation.

  1 = significant concern or risk which requires addressing within weeks

  2 = concern or risk which warrants discussion to evaluate and consider options

  3 = generally applying this well, but aware of room for improvement or gaps in knowledge/approach

  4 = an evidenced strength (e.g., through data, feedback) and a strength to build on

  5 = confident that we are operating at best practice regionally or nationally (e.g., peers come to use for advice)

- Summarise evidence to support your score.
- Enter any high-level actions for improvement (you will bring these together in Stage 2).
- Make a note of any areas you score 5s in and how you can promote this good practice (you will bring these together in Stage 3).

Principle 1: Value speaking up

For a speaking-up culture to develop across the organisation, a commitment to speaking up must come from the top.

Statements for the senior lead responsible for Freedom to Speak Up to reflect on	Score 1–5 or yes/no
I am knowledgeable about Freedom to Speak Up	5 - yes
I have led a review of our speaking-up arrangements at least every two years	5 - yes
I am assured that our guardian(s) was recruited through fair and open competition	5 - yes
I am assured that our guardian(s) has sufficient ringfenced time to fulfil all aspects of the guardian job description	5 - yes
I am regularly briefed by our guardian(s)	5 - yes
I provide effective support to our guardian(s)	5 - yes
Enter summarised commentary to support your score. **Familiar with NGO guidance and communications on FTSU developments at a national level.** **Attended NGO Conference in London with FTSUG** **Guardian was recruited fairly and openly. Guardian is employed full time. Review resourcing on a regular basis.** **Formal monthly 1:1 with Guardian, but in reality has much more frequent contact for support if and when needed.** **Ensure Guardian's wellbeing is supported effectively.**	
High-level actions needed to bring about improvement (focus on scores 1, 2 and 3)	
1	
2	

Statements for the non-executive director lead responsible for Freedom to Speak Up to reflect on	Score 1–5 or yes/no
I am knowledgeable about Freedom to Speak Up	5
I am confident that the board displays behaviours that help, rather than hinder, speaking up	5
I effectively monitor progress in board-level engagement with the speaking-up agenda	4
I challenge the board to develop and improve its speaking-up arrangements	4
I am confident that our guardian(s) is recruited through an open selection process	5
I am assured that our guardian(s) has sufficient ringfenced time to fulfil all aspects of the guardian job description	5
I am involved in overseeing investigations that relate to the board	2
I provide effective support to our guardian(s)	4
Enter summarised evidence to support your score Undertook FTSUG training and maintain familiarity with developments. Board discusses FTSU regularly and is committed to enabling all staff to raise concerns through LM or Guardian. Board supported recruiting additional Ambassadors. Executive leads on Board understand and engage well – less so for members with less direct oversight. All board members, included NEDS, understand the concept and principles well. The Board narrative can veer towards conflating whistleblowing with FTSU. The guardian was recruited fairly and openly while I was in place. The Guardian is full time. I do not actively participate in investigation but the Guardian keeps me informed of concerns. Our Guardian is well supported by the executive an keeps me fully informed but there can be long periods when I am not on site.	
High-level actions needed to bring about improvement (focus on scores 1, 2 and 3)	
1 I will schedule regular meetings to give prominence to our updates and make a point of asking about ongoing investigations of concern.	
2 It is not the role of a NED to be too involved in routine operational activity.	

Principle 2: Role-model speaking up and set a healthy Freedom to Speak up culture

Role-modelling by leaders is essential to set the cultural tone of the organisation.

Statements for senior leaders	Score 1–5 or yes/no
The whole leadership team has bought into Freedom to Speak Up	Yes - 4
We regularly and clearly articulate our vision for speaking up	Yes - 4
We can evidence how we demonstrate that we welcome speaking up	Yes - 4
We can evidence how we have communicated that we will not accept detriment	No - 2
We are confident that we have clear processes for identifying and addressing detriment	No - 2
We can evidence feedback from staff that shows we are role-modelling the behaviours that encourage people to speak up	Yes - 4
We regular discuss speaking-up matters in detail	Yes - 5
Enter summarised evidence to support your score. FTSU Policy agreed at JCC and published Investing in and introducing a RJLC approach which will encourage learning and minimise detriment to those who speak up Regular communication sent out from CEO and CPO stating that detriment will not be tolerated and signposting to refreshed guidance Regular discussion with FTSUG regarding detriment within the organisation with targeted support	
High-level actions needed to bring about improvement (focus on scores 1 ,2 and 3)	
1 – People related policies to be reviewed to address detriment – RJLC focus. AHA currently reviewing across BSW to align.	
2 – Leadership development currently includes what is detriment, how to manage detriment and how to create a culture that does not tolerate detriment in any form.	

Statements for the person responsible for organisational development	Score 1–5 or yes/no
I am knowledgeable about Freedom to Speak Up	Yes - 3
We have included creating a speaking-up culture (separate from the Freedom to Speak Up guardian process) in our wider culture improvement plans	Yes - 3
We have adapted our organisational culture so that it becomes a just and learning culture for our workers	In Progress - 2
We support our guardian(s) to make effective links with our staff networks	
We use Freedom to Speak Up intelligence and data to influence our speaking-up culture	Yes - 3

Enter summarised evidence to support your score.

I (Head of OD and Leadership) work closely with our FTSU manager to understand the themes and issues that are being raised across our Trust to make sure the content of our internal leadership programmes are not only current but also impactful for our delegates. Civility and Respect and the wider RJLC are a key discussion topic in all programmes linking to the 4 pillars of building psychological safety and building high performing teams. This helps our leaders understanding of the importance of compassionate leadership as an essential tool to team and organisational performance and how this leads to a great passionate experience.

SFT have just delivered a 2-day Leadership Festival (Tent Talks) where Civility and Respect were at the core of every discussion. We also rolled out our new Leadership Behaviours Framework where Civility and Compassion are a key element, and this is being built out into a Leadership behaviours self-assessment tool and then a broader 360-degree feedback tool where leaders will be assessed on how they model live these behaviours.

We still have a way to go in adapting our culture and we are aware of the steps that we need to take. Our HR policies are being looked at but will take time to change as well as changing the processes and behaviours around this.

High-level actions needed to bring about improvement (focus on scores 1, 2 and 3)
1 HR polices, processes and behaviours.
2 Accountability of leaders/managers through building knowledge and understanding.

Statements about how much time the guardian(s) has to carry out their role	Score 1–5 or yes/no
We have considered all relevant intelligence and data when making our decision about the amount of ringfenced time our guardian(s) has, so that they are able to follow the National Guardian's Office guidance and universal job description and to attend network events	Yes - 5
We have reviewed the ringfenced time our Guardian has in light of any significant events	Yes - 5
The whole senior team or board has been in discussions about the amount of ringfenced time needed for our guardian(s)	Yes - 5
We are confident that we have appropriate financial investment in place for the speaking-up programme and for recruiting guardians	Yes -4
Enter summarised evidence to support your score. The Guardian is employed substantively and is full time. The 10 Ambassadors have ringfenced time to support the FTSU programme. Discussions held regularly to review resource. To ensure resilience and development within the team, the FTSU Guardian has been asked to write a business case to propose an Associate Guardian role.	
High-level actions needed to bring about improvement (focus on scores 1, 2 and 3)	
1	

2

Principle 3: Make sure workers know how to speak up and feel safe and encouraged to do so

Regular, clear and inspiring communication is an essential part of making a speaking-up culture a reality.

Statements about your speaking-up policy	Score 1–5 or yes/no
Our organisation's speaking-up policy reflects the 2022 update	Yes - 5
We can evidence that our staff know how to find the speaking-up policy	Yes - 4
Enter summarised evidence to support your score. 1 Policy has been reviewed, been through JCC, staff networks and published 2 Comms during speak up month to ensure staff know how to find speaking up policy, and monthly thereafter. FTSU Ambassadors signpost. All new starters meet with FTSUG and given credit card with contact details.	
High-level actions needed to bring about improvement (focus on scores 1, 2 and 3)	

Statements about how speaking up is promoted	Score 1–5 or yes/no
We have used clear and effective communications to publicise our guardian(s)	Yes - 4
We have an annual plan to raise the profile of Freedom to Speak Up	Yes - 3
We tell positive stories about speaking up and the changes it can bring	No -2
We measure the effectiveness of our communications strategy for Freedom to Speak Up	Yes - 4

Enter summarised evidence to support your score.

Daily Communication Bulletin references FTSU, it's purpose and contact details. Comms use social media to further publicise. Newly launched intranet with easy access to FTSU information. Posters updated and displayed across the organisation. Further visual displays needed in newly refurbished areas – Douglas Arter Centre. Focussed Comms from CEO and CPO during the year and speak up month.
FTSUG receives concerns from all departments and staff groups, therefore Comms is effective.

High-level actions needed to bring about improvement (focus on scores 1, 2 and 3)

1 Action required to communicate positive staff stories. FTSUG to work with Comms. This is a gap in the People Promise Plan – to address.

2 Continue to review comms on a regular basis to ensure FTSU is promoted trust-wide.

Principle 4: When someone speaks up, thank them, listen and follow up

Speaking up is not easy, so when someone does speak up, they must feel appreciated, heard and involved.

Statements about training	Score 1–5 or yes/no*
We have mandated the National Guardian's Office and Health Education England training	Yes – 3
Freedom to Speak Up features in the corporate induction as well as local team-based inductions	Yes - 4
Our HR and OD teams measure the impact of speaking-up training	Yes - 3
Enter summarised evidence to support your score. Speaking up training mandated, yet to mandate Listen up and Follow Up training FTSU attends every corporate induction, and follows up with OSCE training, NA training, preceptee training. Varying quality of local team based inductions being addressed by 90 day follow up meetings.	
High-level actions needed to bring about improvement (focus on scores 1, 2 and 3)	
1 FTSUG to take paper through OD&P, then P&C to get Listen Up training mandated. It is a requirement for staff who attend Transformational Leaders course to complete Listen up training to fully complete the competencies.	
2 Work with HR/ER and OD to measure impact of FTSU training – such as types of concerns and grievances, managers skill set	

Statements about support for managers within teams or directorates	Score 1–5 or yes/no
We support our managers to understand that speaking up is a valuable learning opportunity and not something to be feared	Yes -4
All managers and senior leaders have received training on Freedom to Speak Up	Yes - 3
We have enabled managers to respond to speaking-up matters in a timely way	Yes - 3
We are confident that our managers are learning from speaking up and adapting their environments to ensure a safe speaking-up culture	Yes - 3
Enter summarised evidence to support your score. Positive messaging about responding in a timely and restorative way with learning opportunities. Speak Up training is mandated and captured on MLE. Managers are required to complete Listen Up training in order to complete Aspirational/Transformational Leaders course.	
High-level actions needed to bring about improvement (focus on scores 1, 2 and 3)	
1 Mandated Listen Up training to be introduced. Aspiring and Transformational Leadership programmes have element of FTSU.	
2 Resource issues have been challenging both with management and HR – being resolved with recruiting and retaining staff 3 Managers frequently ask for support from FTSUG to ensure that their departments are a safe and restorative area to raise concerns.	

Principle 5: Use speaking up as an opportunity to learn and improve

The ultimate aim of speaking up is to improve patient safety and the working environment for all NHS workers.

Statements about triangulation	Score 1–5 or yes/no
We have supported our guardian(s) to effectively identify potential areas of concern and to follow up on them	Yes - 5
We use triangulated data to inform our overall cultural and safety improvement programmes	Yes -5
Enter summarised evidence to support your score. Quarterly meetings with FTSU/Risk/Patient experience/Litigation where data is triangulated and areas of concern identified and action plan agreed. This is escalated as appropriate, discussed at CCG and PCC. FTSUG meets CQC representative on a regular basis to discuss any areas of concern or areas that have improved. FTSU advises on RJLC for PSIRF implementation programme.	
High-level actions needed to bring about improvement (focus on scores 1, 2 and 3)	
1	
2	

Statements about learning for improvement	Score 1–5 or yes/no
We regularly identify good practice from others – for example, through self-assessment or gap analysis	Yes - 5
We use this information to add to our Freedom to Speak Up improvement plan	Yes - 4
We share the good practice we have generated both internally and externally to enable others to learn	Yes - 5
Enter summarised evidence to support your score. Regular gap analysis done on any reviews or recommendations from NGO These influence improvements to the organisations FTSU offer FTSU meets regularly with regional team and also BSW Guardians. Other OD & FTSU teams invited to share learnings (RUH). FTSUG shares good practice with other NHS Trusts.	
High-level actions needed to bring about improvement (focus on scores 1, 2 and 3)	
1	
2	

Principle 6: Support guardians to fulfil their role in a way that meets workers' needs and National Guardian's Office requirements

Statements about how our guardian(s) was appointed	Score 1–5 or yes/no
Our guardian(s) was appointed in a fair and transparent way	Yes - 5
Our guardian(s) has been trained and registered with the National Guardian Office	Yes - 5
Enter summarised evidence to support your score. FTSUG applied for role that was advertised externally. Shortlisted and interviewed by CEO and CPO.	
High-level actions needed to bring about improvement (focus on scores 1, 2 and 3)	
1	
2	

Statements about the way we support our guardian(s)	Score 1–5 or yes/no
Our guardian(s) has performance and development objectives in place	Yes -5
Our guardian(s) receives sufficient one-to-one support from the senior lead and other relevant executives or senior leaders	Yes - 5
Our guardian(s) has access to a confidential source of emotional support or supervision	Yes - 4
There is an effective plan in place to cover the guardian's absence	Yes - 4
Our guardian(s) provides data quarterly to the National Guardian's Office	Yes - 5
Enter summarised evidence to support your score. Guardian has one-to-one support on a regular basis with CPO and CEO and other execs as required. Also meets with NEDs on a regular basis including the Chairman. Ambassador covers guardian's absence with CPO being available if required. Data submitted quarterly to NGO and PCC. Annual appraisal highlights areas for personal development and objectives.	
High-level actions needed to bring about improvement (focus on scores 1, 2 and 3)	
1	
2	

Statements about our speaking up process	Score 1–5 or yes/no
Our speaking-up case-handling procedures are documented	Yes - 5
We have engaged with managers and other key stakeholders on the role they play in handling speaking-up cases	Yes -3
We are assured that confidentiality is maintained effectively	Yes - 4
We ensure that speaking-up cases are progressed in a timely manner within the teams or directorates we are responsible for	Yes - 3
We are confident that if people speak up within the teams or directorates we are responsible for, they will have a consistently positive experience	Yes - 4

Enter summarised evidence to support your score.

All cases are documented and stored securely in line with GDPR and input from IG. Ambassadors are trained accordingly.
Guardian attends Divisional Management Team meetings to discuss responsibilities around handling concerns raised. Response to the way concerns are handled through feedback from those who raise concerns is improving.
In nearly all cases, confidentiality is maintained by those handling the concern. Where this does not happen support and training is given to prevent recurrence.
Due to resource issues not all concerns are progressed in a timely manner, but this is improving with more resource being sought.
Feedback suggest that speaking up is a positive experience for those raising the concern and those handling the concern, as we start to adopt a RJLC approach.

High-level actions needed to bring about improvement (focus on scores 1, 2 and 3)

1 Cases that are not addressed in a timely manner often escalate or the person raising the concern withdraws as they don't see the point and don't feel listened to, or that the concern is not deemed important enough to respond to. Guardian and ER acknowledge this area needs some attention and are working together.

2

Principle 7: Identify and tackle barriers to speaking up

However strong an organisation's speaking-up culture, there will always be some barriers to speaking up, whether organisation wide or in small pockets. Finding and addressing them is an ongoing process.

Statements about barriers	Score 1–5 or yes/no
We have identified the barriers that exist for people in our organisation	Yes - 4
We know who isn't speaking up and why	Yes - 4
We are confident that our Freedom to Speak Up champions are clear on their role	Yes - 3
We have evaluated the impact of actions taken to reduce barriers?	Yes - 4

Enter summarised evidence to support your score.

Guardian works closely with the staff networks to identify the additional barriers that exist for them. This approach appears to be successful as proportionally staff from protected backgrounds speak up. Guardian meets with all overseas nurses 2-3 times in the first 6 months of arrival. Guardian attends Network Chairs meeting, EDI committee and has completed the NGO WRES training.
Guardian gives development sessions to Ambassadors, coaching, mentoring, conflict, bystander training etc, with refresher on role responsibilities.
Staff feel able to come forwards and speak about concerns, whatever their background. Wide reach across the organisation, with Ambassadors from protected backgrounds to support this.

High-level actions needed to bring about improvement (focus on scores 1, 2 and 3)

1 More visibility about FTSU for contractors and agency staff required. Work with temporary staffing to develop plan.

2 Ensure that Ambassadors are given the time required to fulfil their role. Reminder sent to line managers. Look at an Ambassador being linked to a Staff Network to offer support and guidance about speaking up and having a deeper understanding of barriers to speaking up.

Statements about detriment	Score 1–5 or yes/no
We have carried out work to understand what detriment for speaking up looks and feels like	Yes – 3
We monitor whether workers feel they have suffered detriment after they have spoken up	Yes -4
We are confident that we have a robust process in place for looking into instances where a worker has felt they have suffered detriment	Yes - 3
Our non-executive director for Freedom to Speak Up is involved in overseeing how allegations of detriment are reviewed	Yes - 3
Enter summarised evidence to support your score. Deep dive done for FTSU with OD&P Division People Promise activity – Compassionate and Inclusive Leadership, We have a Voice that Counts focus on valuing the learning from speaking up. RJLC approach, reducing the blame culture which plays a big part in detriment. Cases are reviewed by CEO,CPO & NED where detriment is alleged.	
High-level actions needed to bring about improvement (focus on scores 1, 2 and 3)	
1 Continue to work on People Promise Plan to enable workers to speak up with no adverse consequences	
2 Create an environment where detriment is identified, action is put in place to support the individual concerned, and action plan for learning with the management team. This work to be done by ER.	

Principle 8: Continually improve our speaking up culture

Building a speaking-up culture requires continuous improvement. Two key documents will help you plan and assess your progress: the improvement strategy and the improvement and delivery plan.

Statements about your speaking-up strategy	Score 1–5 or yes/no
We can evidence that we have a comprehensive and up-to-date strategy to improve the speaking-up culture	Yes - 5
We are confident that the Freedom to Speak Up improvement strategy fits with our organisation's overall cultural improvement strategy and that it supports the delivery of related strategies	Yes - 5
We routinely evaluate the Freedom To Speak Up strategy, using a range of qualitative and quantitative measures, and provide updates to our organisation	Yes - 5
Our improvement plan is up to date and on track	Yes -5
Enter summarised evidence to support your score. Strategy been updated and presented to P & C in October 2023. The strategy fits with the organisation vision and improvement strategy and is supported by the work being carried out for the People Promise. FTSU is routinely evaluated, strategy and improvement plans updated using a range of measures – themes and trends, triangulated data from Patient Experience, Risk, Litigation and FTSU.	
High-level actions needed to bring about improvement (focus on scores 1, 2 and 3)	
1	
2	

Statements about evaluating speaking-up arrangements	Score 1–5 or yes/no
We have a plan in place to measure whether there is an improvement in how safe and confident people feel to speak up	Yes - 4
Our plan follows a recognised 'plan, do, study, act' or other quality improvement approach	Yes - 4
Our speaking-up arrangements have been evaluated within the last two years	Yes - 5
Enter summarised evidence to support your score. Staff survey results, focus groups, GMC survey results We follow the Improving Together methodology, A3 thinking and working together on the People Promise Speaking up is continually evaluated and improvement plans put in place. Regular 1:1 with CEO and CPO, Chair and NED. Resourcing is discussed regularly at People and Culture.	
High-level actions needed to bring about improvement (focus on scores 1, 2 and 3)	
1	
2	

Statements about assurance	Score 1–5 or yes/no
We have supported our guardian(s) to structure their report in a way that provides us with the assurance we need	Yes - 5
We have we evaluated the content of our guardian report against the suggestions in the guide	Yes - 5
Our guardian(s) provides us with a report in person at least twice a year	Yes - 5
We receive a variety of assurance that relates to speaking up	Yes - 5
We seek and receive assurance from the relevant executives/senior leaders that speaking up results in learning and improvement	Yes - 4
Enter summarised evidence to support your score. FTSU reports are structured following NGO guidance and gives additional assurance from qualitative and quantitative data. The reports are well socialised for comment prior to submission. The National Guardian has read the most recent annual report and commented on the excellent quality of the report, the structure, the readability and flow, that captures the comprehensive aspects of FTSU. Reports are presented 4 times a year in person by the Guardian. Exec lead follows up with senior leaders in speaking up cases to seek learning and improvement.	
High-level actions needed to bring about improvement (focus on scores 1, 2 and 3)	
1	
2	

Stage 2: Summarise your high-level development actions for the next 6 – 24 months

Development areas to address in the next 6–12 months	Target date	Action owner
1 People related policies to be reviewed to address detriment – RJLC focus. AHA currently reviewing across BSW to align	Oct 2024	Jackie Mosley/ Mark Robinson - ER
2 Action required to communicate positive staff stories. FTSUG to work with Comms. This is a gap in the People Promise Plan – to address.	April 2024	Dave Roberts – Ass.Dir Comms
3 FTSUG to take paper through OD&P, then P&C to get Listen Up training mandated. It is a requirement for staff who attend Transformational Leaders course to complete Listen up training to fully complete the competencies.	April 2024	FTSUG/CPO
4 Matters raised need to be addressed in a more timely manner, which is addressed in the People Policies and FTSU Policy	Jan 2024	Jackie Mosley/Mark Robinson- ER
5 aEnsure that Ambassadors are given the time required to fulfil their role. Reminder sent to line managers. 5b Linking Ambassadors to a Staff Network, as the Chaplains have done, to offer support and guidance about speaking up and having a deeper understanding of barriers to speaking up.	April 2024	FTSUG/CPO
6 More visibility about FTSU for contractors and agency staff required. Work with temporary staffing to develop plan.	October 2024	FTSUG/Sharon Holt – Resourcing
7 Improving the learning and feedback loop to show what changes have been implemented as a result of staff raising concerns to give assurance that the organisation learns and improves as a result of concerns being raised.	October 2024	FTSUG/Employee Relations

Development areas to address in the next 12–24 months	Target date	Action owner
1 Leadership development currently includes what is detriment, how to manage detriment and how to create a culture that does not tolerate detriment in any form.	Oct 2025	Carl Lewin – Head of OD& Leadership
2 We are confident that the Freedom to Speak Up improvement strategy fits with our organisation's overall cultural improvement strategy and that it supports the delivery of related strategies	Oct 2025	FTSUG/CPO
3		
4		
5		
6		
7		
8		

Stage 3: Summary of areas of strength to share and promote

High-level actions needed to share and promote areas of strength (focus on scores 4 and 5)	Target date	Action owner
1 We have identified the barriers that exist for people in our organisation and will continue to work with the staff networks to ensure that all staff feel confident to speak up	Oct 2024	FTSU/EDI
2 Assurance given by many different methods, and this will continue to expand to include Health & Safety Data, OH data and ER data to give a broader overview of potential areas of concern	Oct 2024	Heads of H&S, Risk, Pals, ER, FTSU, Litigation & OH
3 We share the good practice we have generated both internally and externally to enable others to learn – Guardian to continue to work with external partners sharing best practice to enable learning. Internal learning continues to be shared across the Divisions and also FTSU national and regional networks	Oct 2024	FTSU/CPO
4		
5		
6		
7		
8		

Report to:	Trust Board	Agenda item:	6.4
Date of meeting:	5 October 23		

Report tile:	Workforce Race Equality Standard (WRES) AR and Action Plan & Workforce Disability Equality Standard (WDES) AR and Action Plan 2022/23			
Status:	Information	Discussion	Assurance	Approval
			x	x
Approval Process: (where has this paper been reviewed and approved):	• OD&P – 19.09.23 • People & Culture Committee – 28.09.23			
Prepared by:	Harjinder Bahra, Head of Inclusion and Wellbeing			
Executive Sponsor: (presenting)	Melanie Whitfield, Chief People Officer			

Recommendation:

The Trust Board is asked to note the detail of the WRES & WDES 2022/23 Annual Reports and the recommended Action Plans and approve them for publication on the SFT public website by 31 October 2023.

Executive Summary:

1. WRES ANNUAL REPORT AND ACTION PLAN

The WRES is mandated by the NHS Standard Contract as an evidence-based standard that aims to help improve the experiences of Black and Minority Ethnic (BME) staff in the NHS. See **Annex A** of the main report for definitions of ethnicity and the people covered by the WRES. There are nine WRES metrics to enable NHS organisations to compare the workplace and career experiences of BME and White staff. Data for metrics 5 to 8 is sourced from SFT's national NHS staff survey 2022. The WRES is designed to help foster a better understanding of the issues faced by BME staff and the inequalities they experience compared to White colleagues.

Workforce race equality data

This report presents data on the workforce race equality of the Southwark Foundation Trust (SFT) for the year 2022/23. The data was collected on a snapshot date of 31 March 2023.

Overall workforce (metric 1)

The total number of staff at SFT has increased from 4041 in 2022 to 4166 in 2023. This is an increase of 125. The total Black and Minority Ethnic (BME) workforce has also increased, from 810 in 2022 to 957 in 2023.

Progression of BME staff

The progression of BME staff from lower to the upper pay bands continues to be a challenge. The WRES disparity index, which measures the difference in progression rates between BME and white staff, has

increased again in 2023. This means that White staff are **15.62** times more likely to progress from lower to the upper employment bands than BME staff.

BME staff in key senior roles

In the non-clinical workforce, there are no BME staff at Band 8A, Band 8D, Band 9 or at very senior manager positions. Similarly, In the clinical (non-medical) workforce, there are no BME staff at Band 8B, Band 8C, Band 8D, Band 9 or at very senior manager positions. This remains a concern if SFT is to become an inclusive and equitable employer and meet the Model Employer Goals.

Model Employer Goals

The Model Employer Goals set ambitious targets for Trusts to ensure that all roles above Band 6 are representative of the workforce by 2025. SFT revised these goals last year to reflect the increase in the AfC BME staff from 15.7% to 18.7% for the year 2021/22. However, the AfC BME staff has now **increased** to **21.7%,** so SFT will need to revise these goals again in 2023.

Appointment from shortlisting (metric 2)

Relative likelihood of White staff being appointed from shortlisting is **X1.55 times c**ompared to BME staff. In 2021 it was **X2.78 times,** however, we now know that this figure was an error in the calculation. The figure of **X1.55** is similar across other Trusts in the BSW region and to the national average of **X1.54**

Entering formal disciplinary process (metric 3)

BAME staff were **X0.98 less likely** (national average X1.4) to enter the formal disciplinary process compared to White staff. This appears to have significantly reduced from 2021 when BME staff were X1.7 times more likely to enter the formal disciplinary process then White staff.

Staff accessing non-mandatory training and CPD (metric 4)

At the present time the Trust does not have a method for collecting staff accessing non-mandatory training and CPD. Work is in progress to identify a mechanism for identifying the uptake of non-mandatory training by BME staff.

Metrics 5 to 8 are sourced from SFT's national NHS staff survey 2022 (1881 respondents)

The staff survey shows BME staff experiencing **increased (28.9%)** (2021 27.7%) harassment, bullying or abuse from patients, relatives or the public relatives or the public in last 12 months, but **slight less (19.2%)** (2021 19.9%) from managers/team leaders, but **more (25.5%)** (2001 22%) from staff. There is an **increase (44.2%)** (2021 39.1%) in BME staff believing the trust provides equal opportunities for career progression or promotion

Progress on 2021/22 WRES action plan

Good progress has been made on all the action plan activities planned in 2021/22

Action plan 2022/23

The Trust is dedicated to fostering a diverse and inclusive workforce, offering equal opportunities for all staff. Our action plan outlines tangible steps to enhance the experiences and career progression of BME staff over the next 12 months. We believe this initiative will substantially benefit our BME staff and enrich our organisational culture.

Previous SFT's WRES annual reports for 2017, 2018, 2019, 2020, 2021 and 2022 can be found here.

2. WDES ANNUAL REPORT AND ACTION PLAN

Similarly, the Workforce Disability Equality Standard is mandated by the NHS Standard Contract as an evidence-based standard that aims to help improve the experiences of disabled staff in the NHS. See **Annex A** of the main report for definitions of disability. There are ten WDES metrics to enable NHS organisations to compare the workplace and career experiences of disabled and non-disabled staff. Data for metrics 4 to 9a is sourced from SFT's national NHS staff survey 2022. The WDES is designed to help foster a better understanding of the issues faced by disabled staff and the inequalities they experience compared to non-disabled colleagues. The WDES has been in place since 2019, and the 2023 metrics, have been built on progress achieved in the first four years to improve the workplace and career experiences of disabled staff working in, or seeking employment in the NHS.

Workforce disability equality data

This report presents data on the workforce race equality of the Southwark Foundation Trust (SFT) for the year 2022/23. The data was collected on a snapshot date of 31 March 2023.

Overall workforce (metric 1)

On 31 March 2023, SFT had a total of 4171 (excluding Bank staff) staff in the workforce (131 disabled, 3831 non-disabled and 209 with disability unknow).

Appointment from shortlisting (metric 2)

Relative likelihood of **non-disabled staff** compared to disabled staff being appointed is **X1.47 times higher.** Comparison with 2021 is not feasible due to variations in the methodologies employed.

Entering formal capability process (metric 3)

Relative likelihood of **disabled staff** entering formal capability compared to non-disabled staff is **X2.92 times** higher (2-year average). Comparison with 2021 is not feasible due to variations in the methodologies employed.

Metrics 4 to 9a are sourced from SFT's national NHS staff survey 2022 (1881 respondents)

Staff with LTC or illness experiencing harassment, bullying or abuse from patients/service users, their relatives or the public **(25.2%)** is a slight decrease from 2021 (27.4%)

Staff with LTC or illness experiencing harassment, bullying or abuse from managers **(13.9%)** this is a decrease from 2021 (18.95)

Staff with LTC or illness experiencing harassment, bullying or abuse from colleagues **(26.2%).** This is an increase from 2021 (15.1%)

Staff with LTC or illness experiencing harassment, bullying or abuse from patients/service users, saying that the last time they experienced harassment, bullying or abuse at work, they or a colleague reported it **(49.7%).** This is an increase from 2021 (42%)

51% of staff with LTC or illness who believe that their organisation provides equal opportunities for career progression or promotion

29.4% of staff with a LTC or illness said that they felt pressure to come to work. This is an increase from 2021 (25.6%)

29.0% of staff with a LTC or illness felt satisfied with the extent to which their organisation values their work This is a decrease from 2021 (39%)

70.8% of staff with a LTC or illness said their employer has made reasonable adjustment(s) to enable them to carry out their work. This a decrease from 2021(71.8%)

The staff engagement score for staff of staff with a LTC or illness was **6.5** (Trust average 6.7)

Progress on 2021/22 WDES action plan

Good progress has been made on all the action plan activities in 2021/22

WDES Action plan 2022/23

The Trust is committed to creating a more inclusive and equitable workplace for all staff, regardless of their background. The action plan sets out several concrete steps that will be taken over the next 12 months to improve the experiences of Disabled staff, ensure their representation at all levels throughout the organisation, and identify and remove any barriers that stand in the way of their career progression. We are confident that this action plan will make a real difference to the lives of our disabled staff and help us to create a more diverse and inclusive workforce.

Previous SFT's WDES annual reports for 2019, 2020, 2021 and 2022 can be found here.

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	x
Other (please describe):	

Salisbury NHS Foundation Trust

Workforce Race Equality Standard (WRES)

Annual Report and Action Plan

2022/23

Final (05.10.2023)

Introduction and Background to WRES 2022/23

The Workforce Race Equality Standard is mandated by the NHS Standard Contract as an evidence-based standard that aims to help improve the experiences of Black and Minority Ethnic (BME) staff in the NHS.

See **Annex A** below for definitions of ethnicity and the people covered by the WRES. There are nine WRES metrics to enable NHS organisations to compare the workplace and career experiences of BME and White staff.

The WRES is designed to help foster a better understanding of the issues faced by BME staff and the inequalities they experience compared to White colleagues.

The WRES was first made available to the NHS in 2015, and the 2023 metrics have been built on progress achieved since 2017 to improve the workplace and career experiences of BME staff working in, or seeking employment in the NHS.

The WRES 2023 resources for NHS organisations can be found here.

The national WRES annual report 2022 is the seventh national WRES report to be published and provides key findings and trends highlighting inequalities between the experiences of BME staff and White staff across all nine metrics.

This demonstrates the case for trusts to continue in 2023 to take urgent action to create an inclusive and diverse leadership; reduce bullying and harassment; improve recruitment of a diverse workforce; and improve the retention of BME staff. Moreover, the WRES complements the commitments made in the People Plan and the People Promise for a more inclusive and compassionate NHS.

In addition, for 2023, Trusts have been asked to report separately on their BANK staff (BWRES) and their Medical staff (MWRES). Provider trusts are mandated to publish a WRES annual report and action plan (2023/24) on their website by 31 October 2023, which should contain:

- A report that sets out the organisation's data for each metric.
- A WRES action plan, which should set out how they will address the differences highlighted by the metrics data in the forthcoming 12 months.
- A narrative on what progress has been made in delivering the objectives detailed in their 2022 WRES action plan.
- An outline of the steps the organisation will take to improve the experiences of BME staff in their 2023 WRES action plan.
- An outline of the steps the organisation will take to ensure BME staff representation at all levels throughout the organisation and identify any barriers that stand in the way of career progression.

Previous SFT's WRES annual reports for 2017, 2018, 2019, 2020, 2021 and 2022 can be found here.

Executive Summary

Workforce race equality data

This report presents data on the workforce race equality of the Southwark Foundation Trust (SFT) for the year 2022/23. The data was collected on a snapshot date of 31 March 2023.

Overall workforce (metric 1)

The total number of staff at SFT has increased from 4041 in 2022 to 4166 in 2023. This is an increase of 125. The total Black and Minority Ethnic (BME) workforce has also increased, from 810 in 2022 to 957 in 2023.

Progression of BME staff

The progression of BME staff from lower to the upper pay bands continues to be a challenge. The WRES disparity index, which measures the difference in progression rates between BME and white staff, has **increased** again in 2023. This means that White staff are **15.62** times more likely to progress from lower to the upper employment bands than BME staff.

BME staff in key senior roles

In the non-clinical workforce, there are no BME staff at Band 8A, Band 8D, Band 9 or at very senior manager positions. Similarly, In the clinical (non-medical) workforce, there are no BME staff at Band 8B, Band 8C, Band 8D, Band 9 or at very senior manager positions. This remains a concern if SFT is to become an inclusive and equitable employer and meet the Model Employer Goals.

Model Employer Goals

The Model Employer Goals set ambitious targets for Trusts to ensure that all roles above Band 6 are representative of the workforce by 2025. SFT revised these goals last year to reflect the increase in the AfC BME staff from 15.7% to 18.7% for the year 2021/22. However, the AfC BME staff has now **increased** to **21.7%,** so SFT will need to revise these goals again in 2023.

Appointment from shortlisting (metric 2)

Relative likelihood of White staff being appointed from shortlisting is **X1.55 times c**ompared to BME staff. In 2021 it was **X2.78 times,** however, we now know that this figure was an error in the calculation. The figure of **X1.55** is similar across other Trusts in the BSW region and to the national average of **X1.54**

Entering formal disciplinary process (metric 3)

BAME staff were **X0.98 less likely** (national average X1.4) to enter the formal disciplinary process compared to White staff. This appears to have significantly reduced from 2021 when BME staff were X1.7 times more likely to enter the formal disciplinary process then White staff.

Staff accessing non-mandatory training and CPD (metric 4)

At the present time the Trust does not have a method for collecting staff accessing non-mandatory training and CPD. Work is in progress to identify a mechanism for identifying the uptake of non-mandatory training by BME staff.

Metrics 5 to 8 are sourced from SFT's national NHS staff survey 2022 (1881 respondents)

The staff survey shows BME staff experiencing **increased (28.9%)** (2021 27.7%) harassment, bullying or abuse from patients, relatives or the public relatives or the public in last 12 months, but **slight less (19.2%)** (2021 19.9%) from managers/team leaders, but **more (25.5%)** (2001 22%) from staff. There is an **increase (44.2%)** (2021 39.1%) in BME staff believing the trust provides equal opportunities for career progression or promotion

Progress on 2021/22 WRES action plan

Good progress has been made on all the action plan activities planned in 2021/22

Action plan 2022/23

The Trust is dedicated to fostering a diverse and inclusive workforce, offering equal opportunities for all staff. Our action plan outlines tangible steps to enhance the experiences and career progression of BME staff over the next 12 months. We believe this initiative will substantially benefit our BMEstaff and enrich our organisational culture.

Key Findings – National NHS WRES Report 2022

In February 2023, the national WRES team published its annual WRES report based on data from 31 March 2022.

The figures on the right represent the key findings across England and Wales.

There has been a big jump in the number of BME staff. An increase of **over 27,500** was seen in the last year, with BME representation in the workforce increasing from **22.4% to 24.2%**.

Since 2018 the number of BME staff has increased by **over 100,000** (with BME representation increasing from **19.1% to 24.2%**). An increase in internationally educated nurses (IENs) and international medical graduates (IMGs) is likely to be a significant contributor to this. Although BME representation increased by **1.8%** percentage points from **22.4% to 24.2%**.

+ 3.3%

As at 31 March 2021, **22.4%** (309,532) of staff working in NHS trusts in England were from a BME background. This is an **increase from 19.1%** in 2018. There were 74,174 more BME staff and 71,296 more white staff in 2020 compared to 2018.

+69.7%

The total number of BME staff at very senior manager level has increased by **69.7%** since 2018 from **201 to 341**.

93.5%

The proportion of trusts, where a higher proportion of BME staff compared to white staff experienced harassment, bullying or abuse from staff in the last 12 months.

+38.1%

The number of BME board members in NHS trusts increased by **128 (38.1%)** between 2020 and 2022.

x1.14

BME staff were **1.14 times** more likely to enter the formal disciplinary process compared to white staff. This is the same as in 2021. There is a significant improvement from 2016 when the likelihood ratio was **1.56**. BME staff were more than **1.25 times** more likely to enter the formal disciplinary process at just under half of trusts.

1 in 4

staff experienced abuse or harassment from the public, and as many from other staff.

The difference is that the abuse or harassment from the public affects both white and BME staff (this varies by region).

Abuse or harassment from other staff is mostly a problem of harassment for BME staff (and is seen in all regions).

x1.54

White applicants were **1.54 times** more likely to be appointed from shortlisting compared to BME applicants; this is lower than 2021. There has been year-on-year fluctuation but no overall improvement over the past seven years.

42.8%

of women from a white Gypsy or Irish Traveller background experienced harassment, bullying or abuse from patients, relatives or the public in the last 12 months.

Women from a black background **(19.8%)** and women from an Arabic background **(18.4%)**, experienced high levels of discrimination from a manager/team leader or other colleagues in the last 12 months.

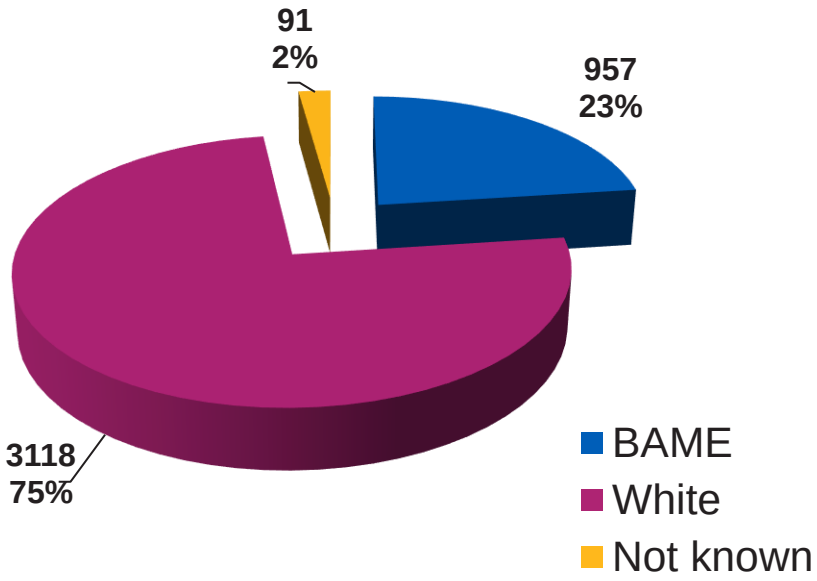
35.4%

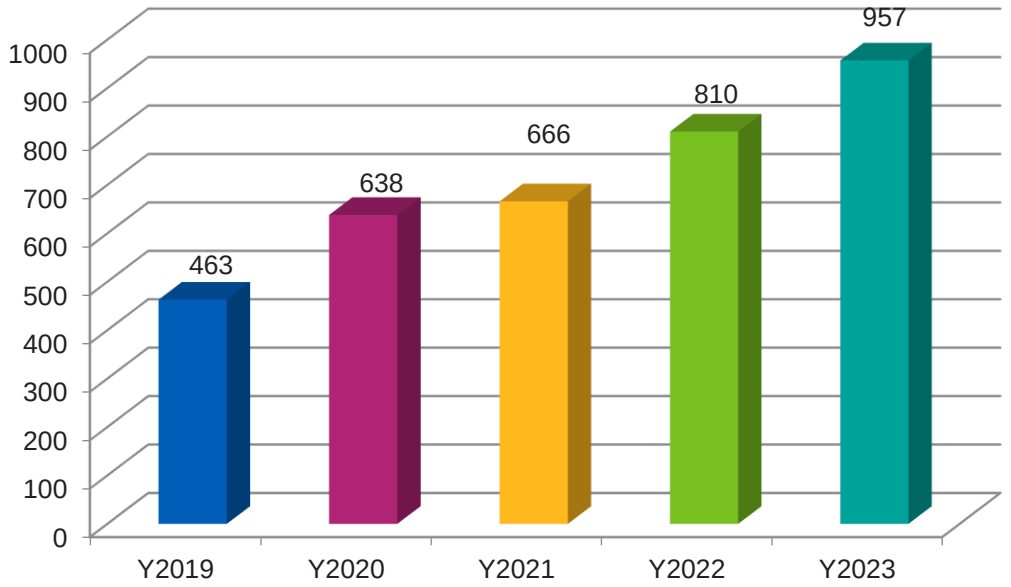
of staff from a black background believed their trust provides equal opportunities for career progression or promotion, with levels below those of other ethnic groups since at least 2015, irrespective of gender.

SFT Workforce 31 March 2023 (Metric 1)

+3% BME

On 31 March 2023, SFT had a workforce of 4166 (excluding Bank staff) of which, 3188 were White, 91 had unknow ethnicity and **23% (957)** of staff were from a Black, and Minority Ethnic (BME) background. This is an increase from **20% (810)** in 2022.



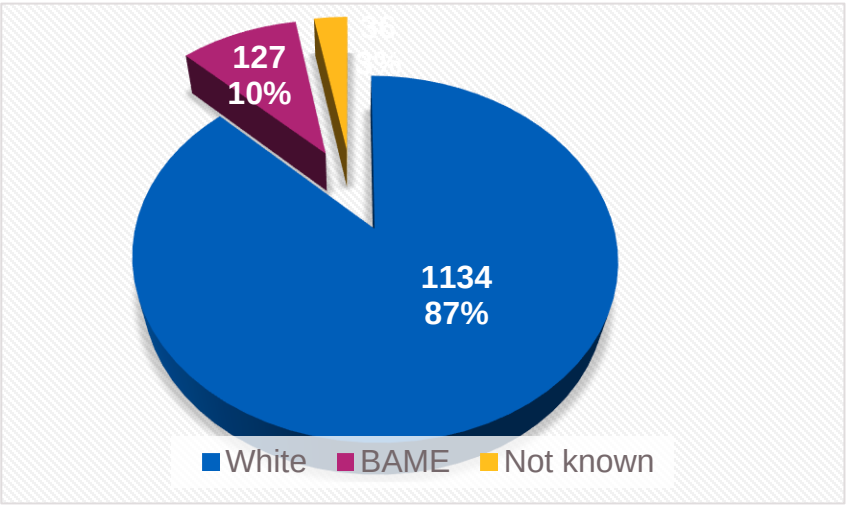


There has been a steady increase in the number of people from a BME background employed by the Trust as can be seen in the graph above. This has been boosted by international recruitment of nurses.

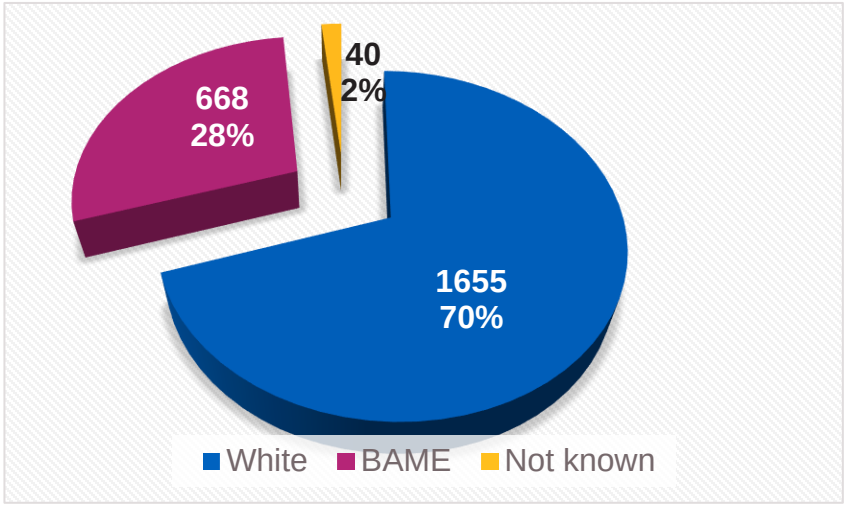
SFT Workforce 31 March 2023 (Metric 1)

The following pie charts show the percentage of BAME staff in clinical and non-clinical roles compared with White staff.
2874 (69%) of our staff are clinical, compared to **1297 (31%)** non-clinical.

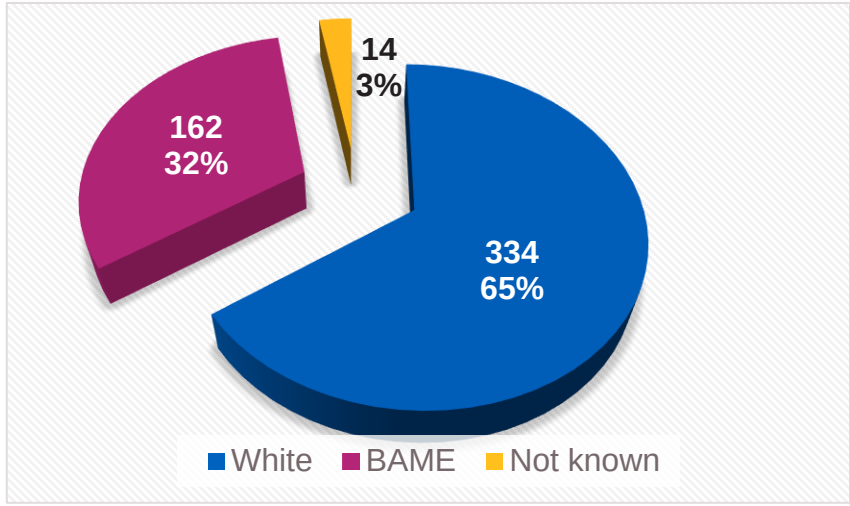
Non-clinical



Clinical (non medical)



Medical & Dental



SFT Workforce 31 March 2023 – Non-clinical (Metric 1)

On the 31 March 2023, SFT had a total of 4166 staff (excluding Bank Staff). The table below represents the breakdown of the non-clinical workforce.

In the non-clinical workforce, there are no BME staff at Band 8A, Band 8D, Band 9 or at very senior manager positions

1a) Non-clinical workforce	White	BME	Ethnicity unknown
	Headcount	Headcount	Headcount
Under Band 1	0	0	0
Band 1	2	0	0
Band 2	322	56	9
Band 3	328	36	11
Band 4	153	17	4
Band 5	102	5	3
Band 6	85	8	3
Band 7	53	2	1
Band 8A	41	0	2
Band 8B	21	2	2
Band 8C	10	1	0
Band 8D	10	0	1
Band 9	6	0	0
VSM	1	0	0
Total non-clinical	1134	127	36

SFT Workforce 31 March 2023 – Clinical (non medical) (Metric 1)

On the 31 March 2023, SFT had a total of 4166 staff (excluding Bank Staff). The table below represents the breakdown of the clinical (non-medical) workforce.

In the clinical (non medical) workforce, there are no BME staff at Band 8B, Band 8C, Band 8D, Band 9 or at very senior manager positions

1b) Clinical workforce (non-medical)	White	BME	Ethnicity unknown
	Headcount	Headcount	Headcount
Under Band 1	0	0	0
Band 1	0	0	0
Band 2	76	26	0
Band 3	383	86	12
Band 4	101	71	1
Band 5	284	354	13
Band 6	417	106	11
Band 7	273	20	2
Band 8A	77	5	1
Band 8B	28	0	0
Band 8C	8	0	0
Band 8D	6	0	0
Band 9	1	0	0
VSM	1	0	0
Total clinical (non-medical)	1655	668	40

SFT Workforce 31 March 2023 – Medical & Dental (Metric 1)

On the 31 March 2023, SFT had a total of 4166 staff (excluding Bank Staff). The table below represents the breakdown of the medical and dental workforce.

1b) Medical & Dental	White	BME	Ethnicity unknown
	Headcount	Headcount	Headcount
Consultants	174	35	10
Of which Senior medical manager	5	0	0
Non-consultant career grade	40	47	2
Trainee grades	114	80	3
Other	1	0	0
Medical & Dental	334	162	15

The Model Employer Targets 2023

Excluding Medical & Dental grades, the percentage of BME people across all AfC pay bands is **21.7%** at 31 March 2023. This is an increase from **18.7%** in 2022.

The Workforce Race Equality Standard Model Employer paper, published in January 2019, sets out an ambition to increase black and minority ethnic representation at all levels of workforce by 2028. This ambition has been expedited by the NHS People Plan 2020 to increase senior leader representation by 2025 to equate to either the organisational or community percentage, whichever is highest.

In May 2021 NHS WRES National Team circulated details of an updated approach to the Model Employer Goals. The basis of the change is a more ambitious plan for organisations to be representative across all AfC Pay Bands from Band 6 to VSM by 2025

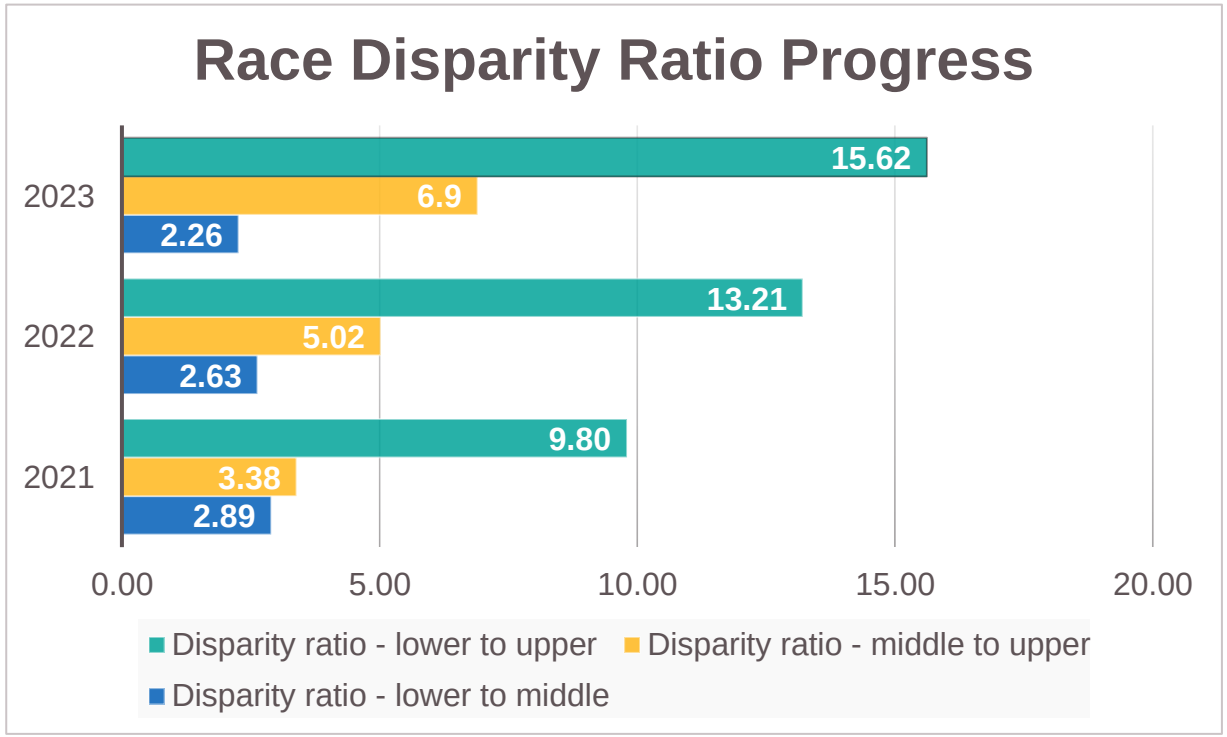
The following table shows the revised 2025 SFT target for AfC Bands 6 to VSM based on the current **21.7% BME** workforce

2023	Total staff	BME Staff (Actual)	BME Target 21.7% by 2025	Actual % 2023
Band 6	502	114	0	22.4
Band 7	326	22	71	7
Band 8a	118	5	26	6
Band 8b	49	2	11	4
Band 8c	18	1	4	5
Band 8d	16	0	3	0
Band 9	7	0	1	0
VSM	2	0	0	0

The Race Disparity Ratio

The WRES Disparity ratio helps us to review how our staff are represented in career progression to more senior roles, it looks at the difference in the proportion of BAME staff across Agenda for Change bands compared to the proportion of White staff in those bands in three tiers:

- Bands 5 and below (‘lower’);
- Bands 6 and 7 (‘middle’)
- Bands 8a and above (‘upper’)



The Race Disparity Ration of 1.00 would indicate equity in the progression of White and BME staff groups. For example, a disparity ration of 15.62 means that White staff are 15.62 times more likely to progress from lower to the upper employment bands than BME staff

Appointment from shortlisting 31 March 2023 (Metric 2)

Relative likelihood of staff being appointed from shortlisting across all posts.

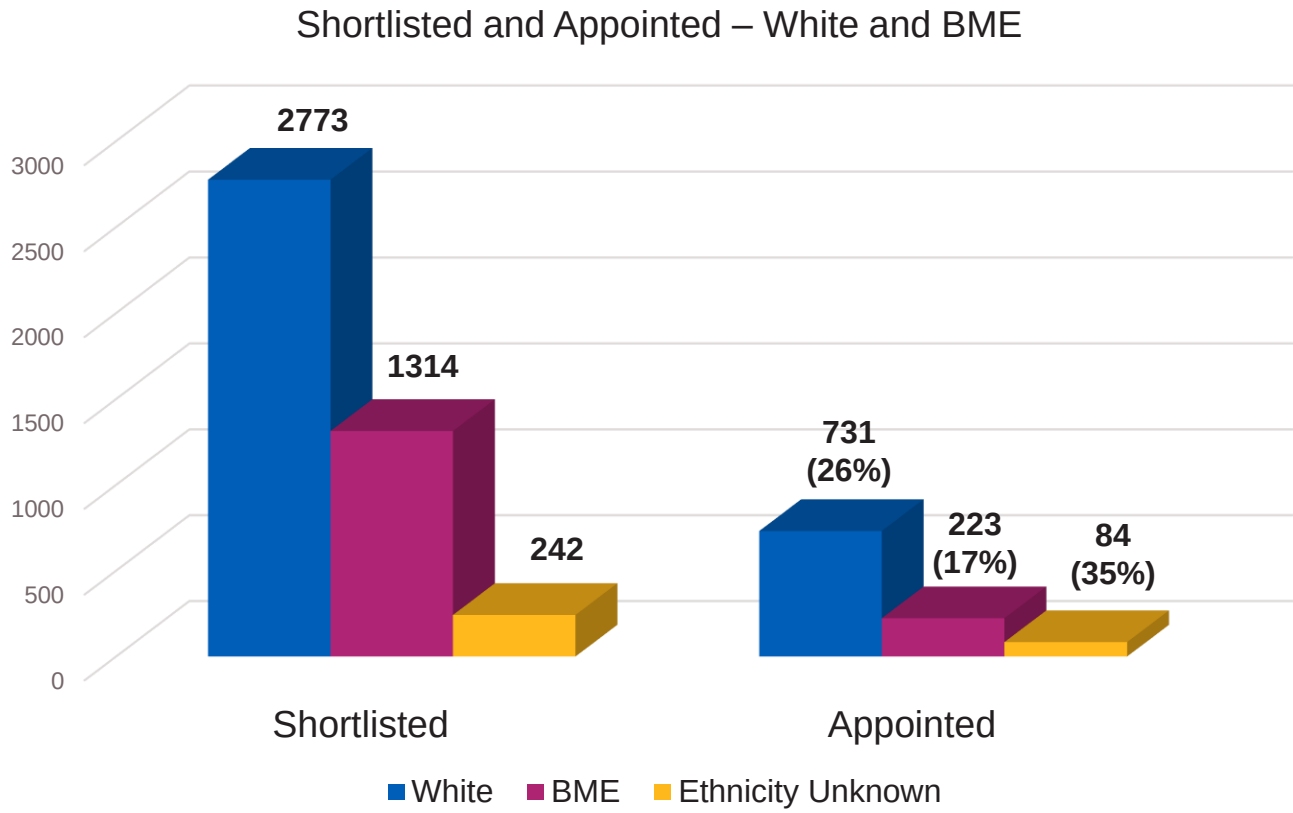
X1.55

Relative likelihood of White staff being appointed from shortlisting compared to BME staff.

The figure of **X1.55** is similar to the national average of **X1.54.**

Relative likelihood of appointment from shortlisting is also shown in percentage in the graph.

Note: This figure does not include directly recruited international staff.



SFT WRES 31 March 2023 (Metric 3)

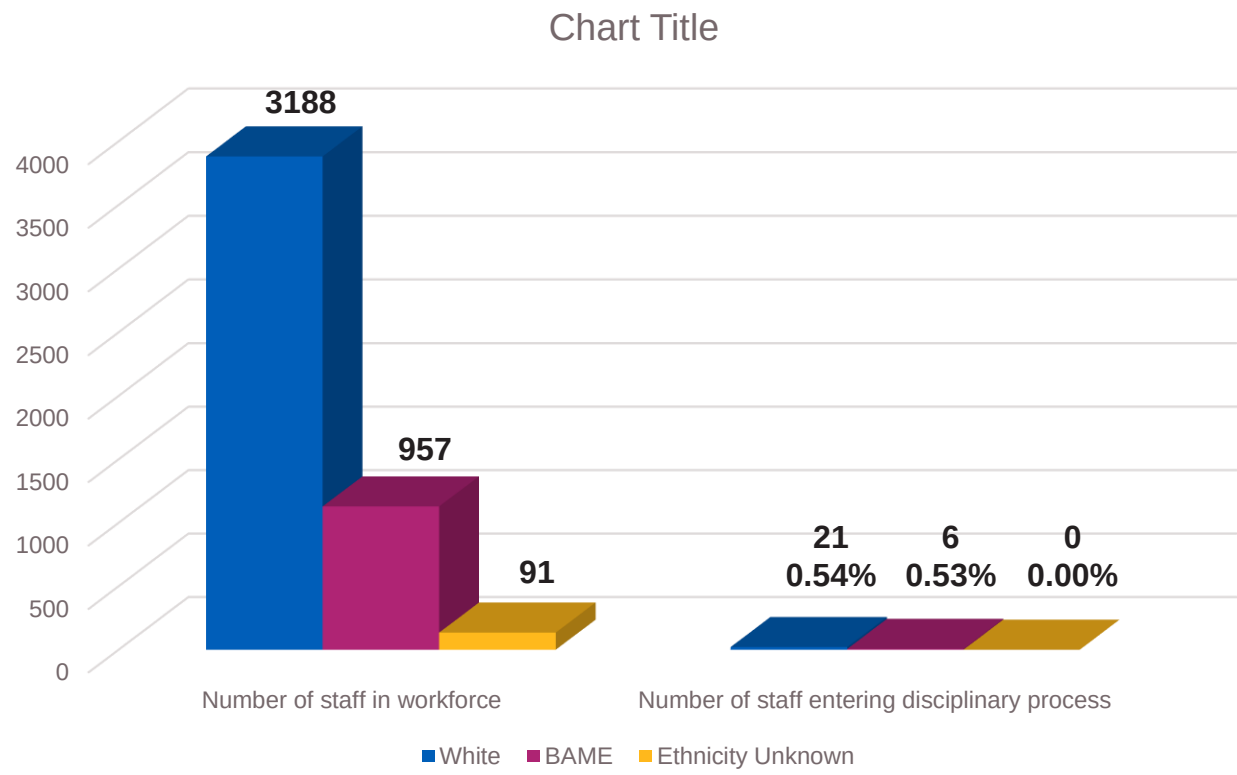
Relative likelihood of staff entering the formal disciplinary process, as measured by entry into a formal disciplinary investigation.

X0.98

BAME staff were **X0.98 less likely** to enter the formal disciplinary process compared to white staff.

This appears to have significantly reduced from 2022 when BME staff were **X1.7** times more likely to enter the formal disciplinary process compared to white staff.

The national average is **X1.14**

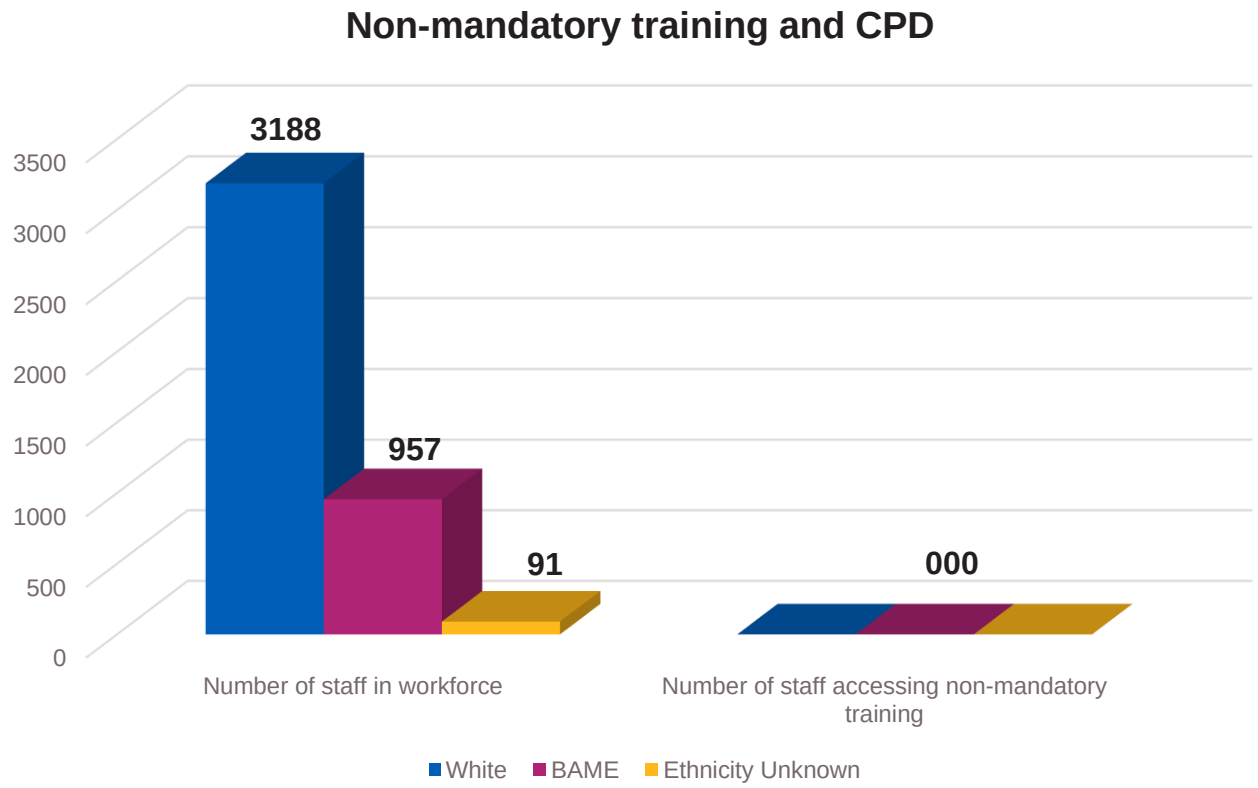


SFT WRES 31 March 2023 (Metric 4)

Relative likelihood of staff accessing non-mandatory training and CPD

NOTE: At the present time the Trust does not have a method for collecting staff accessing non-mandatory training and CPD.

Work is in progress to identify a mechanism for identifying the uptake of non-mandatory training by BME staff.



SFT Staff Survey 2022 (Metric 5)

NOTE: Metrics 5 to 8 are sourced from the SFT's national NHS staff survey 2022

1861 people in the Trust responded to the 2022 staff survey. The following Staff Survey questions are recorded within our WRES data:

Metrics 5: Percentage of staff experiencing harassment, bullying or abuse from patients, relatives or the public in last 12 months out of those who answered the question

28.9% of Black, Asian and Minority Ethnic staff stated they had experience harassment, bullying or abuse. This is an **increase** from 2021 (27.7%)

24.7% of White staff stated they had experience harassment, bullying or abuse. This is an **increase** from 2021 (22.4%)

SFT Staff Survey 2022 (Metric 6)

NOTE: Metrics 5 to 8 are sourced from the SFT's national NHS staff survey 2022

1861 people in the Trust responded to the 2022 staff survey. The following Staff Survey questions are recorded within our WRES data:

Metrics 6: Percentage of staff experiencing harassment, bullying or abuse from staff in last 12 months out of those who answered the question

25.5% of Black, Asian and Minority Ethnic staff stated they had experience harassment, bullying or abuse. This is an **increase** from 2021 (22%)

22.6% of White staff stated they had experience harassment, bullying or abuse. This is an **increase** from 2021 (17.2%)

SFT Staff Survey 2022 (Metric 7)

NOTE: Metrics 5 to 8 are sourced from the SFT's national NHS staff survey 2022

1861 people in the Trust responded to the 2022 staff survey. The following Staff Survey questions are recorded within our WRES data:

Metrics 7: Percentage of staff believing that the trust provides equal opportunities for career progression or promotion

44.2% of Black, Asian and Minority Ethnic staff said **Yes.** This is a slight **increase** from 2021 (39.1%)

55.1% of White staff said **Yes**. This is a slight **increase** from 2021 (53.5%)

SFT Staff Survey 2022 (Metric 8)

NOTE: Metrics 5 to 8 are sourced from the SFT's national NHS staff survey 2022

1861 people in the Trust responded to the 2022 staff survey. The following Staff Survey questions are recorded within our WRES data:

Metrics 8: Percentage of staff experiencing discrimination at work from manager/team leader or other colleagues in the last 12 months out of those who answered the question

19.2% of Black, Asian and Minority Ethnic staff said **Yes.** This is a slight **decrease** from 2021 (19.9%)

6.3% of White staff said **Yes**. This is slight decrease from 2021 (6.6%)

SFT Staff Survey 2022 (Metric 9)

NOTE: Metrics 5 to 8 are sourced from the SFT's national NHS staff survey 2022

1861 people in the Trust responded to the 2022 staff survey. The following Staff Survey questions are recorded within our WRES data:

Metric 9: Trust Board Membership – snapshot on 31 March 2023

Board voting membership	White	BME	Ethnicity unknown
Total Board members	11	1	2
of which: Voting Board members	11	1	2
Non-voting Board members	0	0	0
of which: Exec Board members	4	0	2
Non-executive Board members	7	1	0

Progress on WRES 2021/22 Action Plan

	Action	Status
1	The Trust Board to engage in a Reciprocal/Reverse Mentoring Program, initially with members of the Trust's BME Forum.	Piloted reverse mentoring pilot with CEO/BME staff network chair Proposed Mentor/Mentee programme as part of the Race Equality Wellbeing Project - **this work is carried over to 2022/23**
2	Trust Board to discuss and consider having an open seat on the Trust Board for a representative from the BME Forum.	The CEO is the exec sponsor of the Culture and Equity Staff Network. Monthly meeting with all staff networks take place with the CPO.
3	A program of support to be provided to BME Forum Members to prepare them for attendance at Board meetings.	The CEO is the exec sponsor of the Culture and Equity Staff Network
4	Nominate and support a member of staff to take part in the 2022 national WRES expert program.	There is a WRES expert in the Trust
5	Research and review how the Trust collects data on the progress of individuals from application to appointment. This to include the comparison between applicants who are from White or BME communities.	This is ongoing work as part of the overhauling of recruitment and career progression taking place at the Trust - **this work is carried over to 2022/23**

	Action	Status
6	Regular Starter and Leaver reports to include a comparison of white and BAME staff.	This is ongoing work as part of the overhauling of recruitment and career progression taking place at the Trust - **this work is carried over to 2022/23**
7	Trust adopts and engages with the NHSE/I inclusive recruitment and promotion practices Six Point action plan	Six Points adopted with creation of an action plan to embed EDI into recruitment and career progression – **this work is carried over to 2022/23**
8	To agree the recording process of the uptake of non-mandatory training by BME staff.	Scoping work on MLE - **this work is carried over to 2022/23**
9	EDI Committee to work with the BME forum to monitor these actions to drive the WRES agenda forward	WRES is part of the A3 Thinking action plan on SFT becoming am inclusive and equitable employer
10	Ensure our people are confident to share up to date, relevant and accurate equality data through our ESR self-reporting process. Ensuring that they understand the benefits of doing so.	Regular promotion in comms and other media to encourage staff to update ESR with personal and demographic data - **this work is carried over to 2022/23**

Recommended WRES 2022/23 Action Plan

	Cultural Development Objective	Action	Lead	Deadline
1	To seek a downward trend in the percentage of BME staff experiencing harassment, bullying, abuse or discrimination at work **Metric 5, 6 and 8 (staff survey)**	• Review and refresh training interventions for all staff with a focus on civility and respect to support recognition and prevention of race discrimination. • Develop and rollout an inclusive leadership programme that enhances the ability of managers and team leaders to foster and effectively manage diverse teams and promote inclusivity.	Head of Inclusion & Wellbeing Head of Organisation Development & Leadership	Q2 2024
2	To seek an upwards trend in the percentage of BME staff believing that the trust provides equal opportunities for career progression or promotion. **Metric 7 (staff survey)**	• Design and establish a programme to support the career development and advancement of BME staff, including workshops to enhance knowledge and skills for job applications and interviews. • Develop and test the BME Mentor/Mentee initiative within the framework of the Race Equality Wellbeing Project.	Head of Inclusion & Wellbeing - Head Resources - Head of Employee Relations Race Equality Wellbeing Project Lead Culture and Equality Staff Network	Q2 2024
	Networks and Communication Objective	**Action**	**Lead**	**Deadline**
3	To develop a robust method to measure the relative likelihood of staff accessing non-mandatory training and CPD. **Metric 4 (staff survey)**	Identify and establish a procedure for documenting (e.g., MLE) the participation of staff in non-mandatory training and CPD, including details on the demographic backgrounds of the participants.	Head of Education	Q1 2024
4	To enhance the reach and impact of the Culture and Equity Staff Network to improve the experience of BME staff across the Trust.	Support and develop the Culture and Equity Staff Network in celebrating and commemorating events, as well as in identifying and reporting on prevalent themes and issues concerning BME staff at the Trust.	Head of Inclusion & Wellbeing - Culture and Equality Staff Network	Q2 2024
5	To improve personal and demographic data on ESR	Encourage all staff and Board execs to update their personal and demographic status on ESR.	Head of Inclusion & Wellbeing - ESR Team	Q2 2024
	Recruitment Objective	**Action**	**Lead**	**Deadline**
6	To seek equity on appointment from shortlisting for BME applicants compared to white applicants. **Metric 2 (staff survey)**	Incorporate the principles of EDI from the NHSE/I's Six Point plan into the Trust's recruitment and promotion overhaul to foster inclusivity for BME staff.	Head of Resources	Q3 2023

Annex A – Definitions of ethnicity: people covered by the WRES

	Ethnic Categories 2021 – Definitions of 'Black and Minority Ethnic' and 'White'
2	WHITE
	1 – White –British / Welsh / Scottish / Northern Irish / British 2 – White –Irish 3 – Gypsy or Irish Traveller 4 – Any other White background
3	**MIXED/MULTIPLE ETHNIC GROUPS**
	5 – White and Black Caribbean 6 – White and Black African 7 – White and Asian 8 – Any other mixed / multiple ethnic background please describe
4	ASIAN / ASIAN BRITISH
	9 – Asian or Asian British –Indian 10 – Asian or Asian British –Pakistani 11 – Asian or Asian British – Bangladeshi 12 – Asian or Asian British – Chinese 13 – Any other Asian background please describe

	Ethnic Categories 2021 – Definitions of 'Black and Minority Ethnic' and 'White'
5	BLACK / AFRICAN / CARIBBEAN / BLACK BRITISH
	14 – Black or black British – African 15 – Black or black British – Caribbean 16 – Any other black background please describe
6	ANY OTHER ETHNIC GROUP
	17 – Arab 18 – Any other ethnic group please describe
7	NOT STATED OR UNKNOWN
	19 – Not stated 20 – Do not wish to state 21 – Unknown

Salisbury NHS Foundation Trust

Workforce Disability Equality Standard (WDES)

Annual Report and Action Plan

2022/23

Final (05.10.2023)

Introduction and Background to WDES 2022/23

The Workforce Disability Equality Standard is mandated by the NHS Standard Contract as an evidence-based standard that aims to help improve the experiences of disabled staff in the NHS. See **Annex A** below for definitions of disability.

There are ten WDES metrics to enable NHS organisations to compare the workplace and career experiences of disabled and non-disabled staff.

The WDES is designed to help foster a better understanding of the issues faced by disabled staff and the inequalities they experience compared to non-disabled colleagues.

The WDES has been in place since 2019, and the 2023 metrics, have been built on progress achieved in the first four years to improve the workplace and career experiences of disabled staff working in, or seeking employment in the NHS. The WDES 2023 resources for NHS organisations can be found here.

The national WDES annual report 2021 provides key findings highlighting inequalities between the experiences of disabled and non-disabled staff across all 10 metrics. This demonstrates the case for trusts to continue in 2023 to take urgent action to create an inclusive and diverse leadership; reduce bullying and harassment; improve recruitment of a diverse workforce; and improve the retention of disabled staff. Moreover, the WDES complements the commitments made in the People Plan and the People Promise for a more inclusive and compassionate NHS and the best place to work.

Provider trusts are mandated to publish a WDES annual report and action plan (2023/24) on their website by 31 October 2023, which should contain:

- A report that sets out the organisation's data for each metric.
- A WDES action plan, which should set out how they will address the differences highlighted by the metrics data in the forthcoming 12 months.
- A narrative on what progress has been made in delivering the objectives detailed in their 2022 WDES action plan.
- An outline of the steps the organisation will take to improve the experiences of disabled staff in their 2023 WDES action plan.
- An outline of the steps the organisation will take to ensure disabled staff representation at all levels throughout the organisation and identify any barriers that stand in the way of career progression.

Previous SFT's WDES annual reports for 2019, 2020, 2021 and 2022 can be found here.

Executive Summary

Workforce disability equality data

This report presents data on the workforce race equality of the Southwark Foundation Trust (SFT) for the year 2022/23. The data was collected on a snapshot date of 31 March 2023.

Overall workforce (metric 1)

On 31 March 2023, SFT had a total of 4171 (excluding Bank staff) staff in the workforce (131 disabled, 3831 non-disabled and 209 with disability unknow).

Appointment from shortlisting (metric 2)

Relative likelihood of **non-disabled staff** compared to disabled staff being appointed is **X1.47 times higher.** Comparison with 2021 is not feasible due to variations in the methodologies employed.

Entering formal capability process (metric 3)

Relative likelihood of **disabled staff** entering formal capability compared to non-disabled staff is **X2.92 times** higher (2-year average). Comparison with 2021 is not feasible due to variations in the methodologies employed.

Metrics 4 to 9a are sourced from SFT's national NHS staff survey 2022 (1881 respondents)

Staff with LTC or illness experiencing harassment, bullying or abuse from patients/service users, their relatives or the public **(25.2%)** is a slight decrease from 2021 (27.4%)

Staff with LTC or illness experiencing harassment, bullying or abuse from managers **(13.9%)** this is a decrease from 2021 (18.95)

Staff with LTC or illness experiencing harassment, bullying or abuse from colleagues **(26.2%).** This is an increase from 2021 (15.1%)

Staff with LTC or illness experiencing harassment, bullying or abuse from patients/service users, saying that the last time they experienced harassment, bullying or abuse at work, they or a colleague reported it **(49.7%).** This is an increase from 2021 (42%)

51% of staff with LTC or illness who believe that their organisation provides equal opportunities for career progression or promotion

29.4% of staff with a LTC or illness said that they felt pressure to come to work. This is an increase from 2021 (25.6%)

29.0% of staff with a LTC or illness felt satisfied with the extent to which their organisation values their work This is a decrease from 2021 (39%)

70.8% of staff with a LTC or illness said their employer has made reasonable adjustment(s) to enable them to carry out their work. This a decrease from 2021(71.8%)

The staff engagement score for staff of staff with a LTC or illness was **6.5** (Trust average 6.7)

Progress on 2021/22 WDES action plan

Good progress has been made on all the action plan activities in 2021/22

WDES Action plan 2022/23

The Trust is committed to creating a more inclusive and equitable workplace for all staff, regardless of their background. The action plan sets out several concrete steps that will be taken over the next 12 months to improve the experiences of Disabled staff, ensure their representation at all levels throughout the organisation, and identify and remove any barriers that stand in the way of their career progression. We are confident that this action plan will make a real difference to the lives of our disabled staff and help us to create a more diverse and inclusive workforce.

National NHS WRES Report 2022

Key findings

Workforce Representation

2022 data shows that **2.5%** of Trust staff have declared a disability.

Compared to the staff survey where **17.0%** of respondents stated they had a disability, leaves a disparity of **14.5%**.

Recruitment

Disabled applicants are more likely than non-disabled applicants to be appointed in the Trust's recruitment processes. **(relatively likelihood 0.84).**

Using the rule of 4/5ths, it does not suggest a statistical adverse impact.

Capability

Disabled staff are **nearly 2 ½ times more likely** to enter the formal capability process.

(Please note this is based on a two-year rolling average involving 9 capability cases).

Bullying, harassment and abuse

More Disabled staff have consistently reported experiencing bullying, harassment and abuse compared to non-disabled staff from patients and staff.

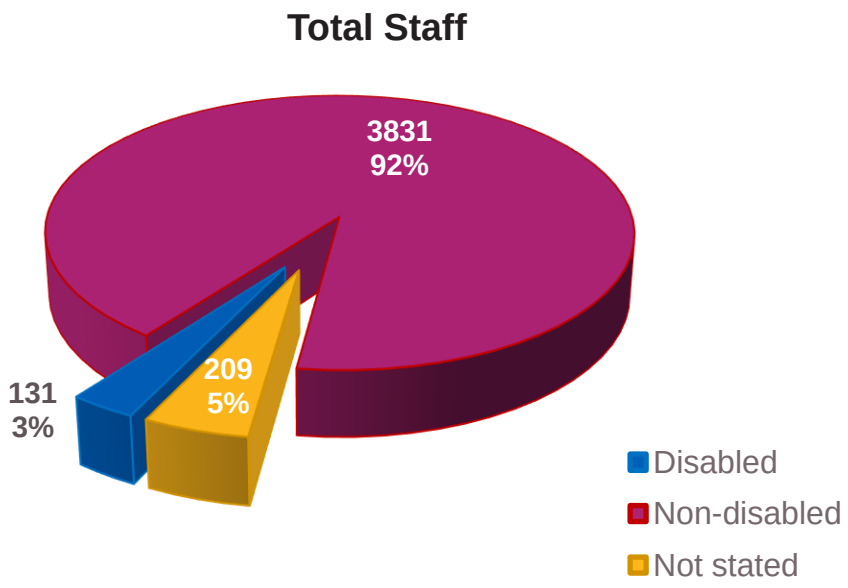
Presenteeism

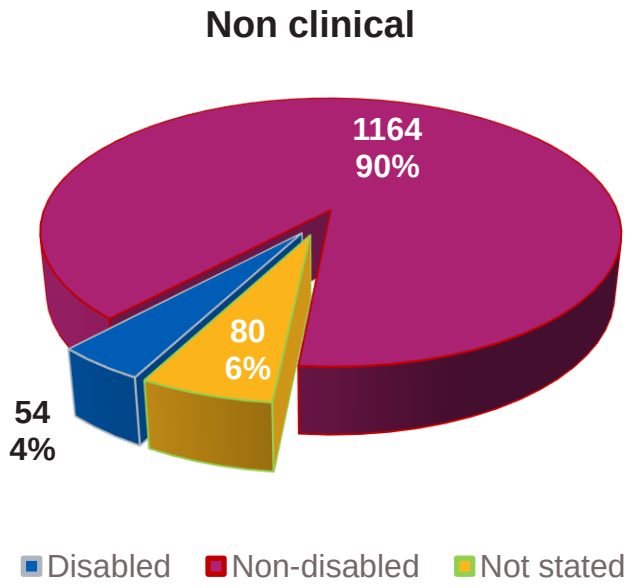
Nearly a third of disabled staff felt pressure to attend work when not feeling well enough. However, the gap in experience for disabled and non-disabled staff is getting smaller.

Reasonable Adjustments

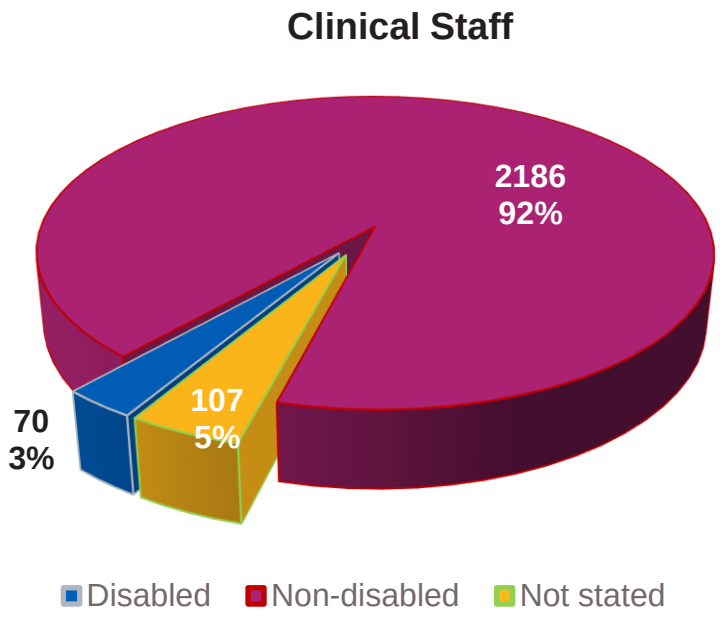
62.3% of Disabled staff report that they have the adjustments necessary to perform their duties effectively, a **decrease of 4.7** percentage points from 2021.

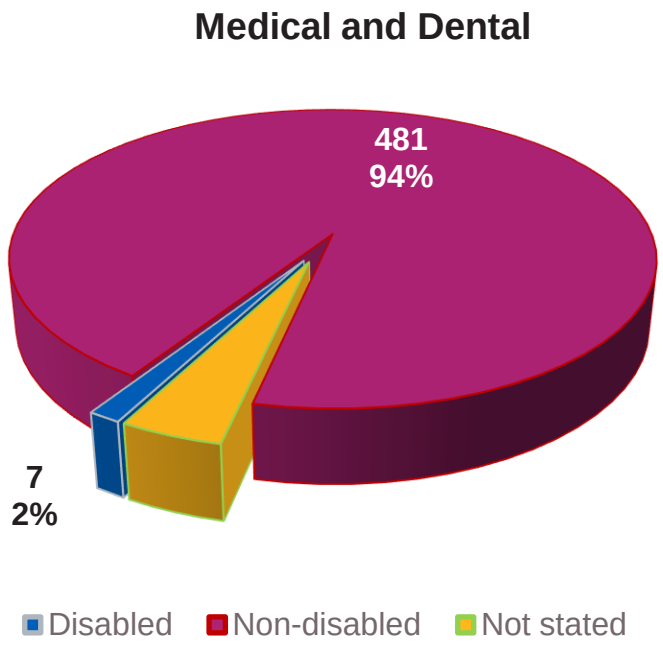
SFT Workforce 31 March 2023 (Metric 1)





SFT Workforce 31 March 2023 (Metric 1)





SFT Workforce 31 March 2023 – Non-clinical (Metric 1)

On the 31 March 2023, SFT had a total of 4171 (excluding Bank staff) staff in the workforce (131 disabled, 3831 non-disabled and 209 with disability unknow)

1a) Non-clinical workforce	Disabled	Non-disabled	Disability unknown
	Headcount	Headcount	Headcount
Under Band 1	0	0	0
Band 1	0	2	0
Band 2	16	349	22
Band 3	17	336	22
Band 4	4	156	14
Band 5	3	98	9
Band 6	7	85	4
Band 7	2	50	4
Band 8A	2	39	2
Band 8B	1	22	2
Band 8C	1	9	1
Band 8D	1	10	0
Band 9	0	6	0
VSM	0	1	0
Total non-clinical	54	1164	80

SFT Workforce 31 March 2023 – Clinical (Metric 1)

On the 31 March 2023, SFT had a total of 4171 (excluding Bank staff) staff in the workforce (131 disabled, 3831 non-disabled and 209 with disability unknow)

1b) Clinical workforce	Disabled	Non-disabled	Disability unknown
	Headcount	Headcount	Headcount
Under Band 1	0	0	0
Band 1	0	0	0
Band 2	8	89	5
Band 3	18	432	31
Band 4	0	165	8
Band 5	14	605	32
Band 6	18	500	16
Band 7	8	275	12
Band 8A	3	78	2
Band 8B	1	26	1
Band 8C	0	8	0
Band 8D	0	6	0
Band 9	0	1	0
VSM	0	1	0
Total Clinical	70	2186	107

SFT Workforce 31 March 2023 – Medical and Dental (Metric 1)

On the 31 March 2023, SFT had a total of 4171 (excluding Bank staff) staff in the workforce (131 disabled, 3831 non-disabled and 209 with disability unknow)

1b) Medical & Dental	Disabled	Non-disabled	Disability unknown
	Headcount	Headcount	Headcount
Consultants	3	212	9
Non-consultants career grade	2	83	4
Medical & Dental trainee grade	2	186	9
Total Medical and Dental	7	481	22

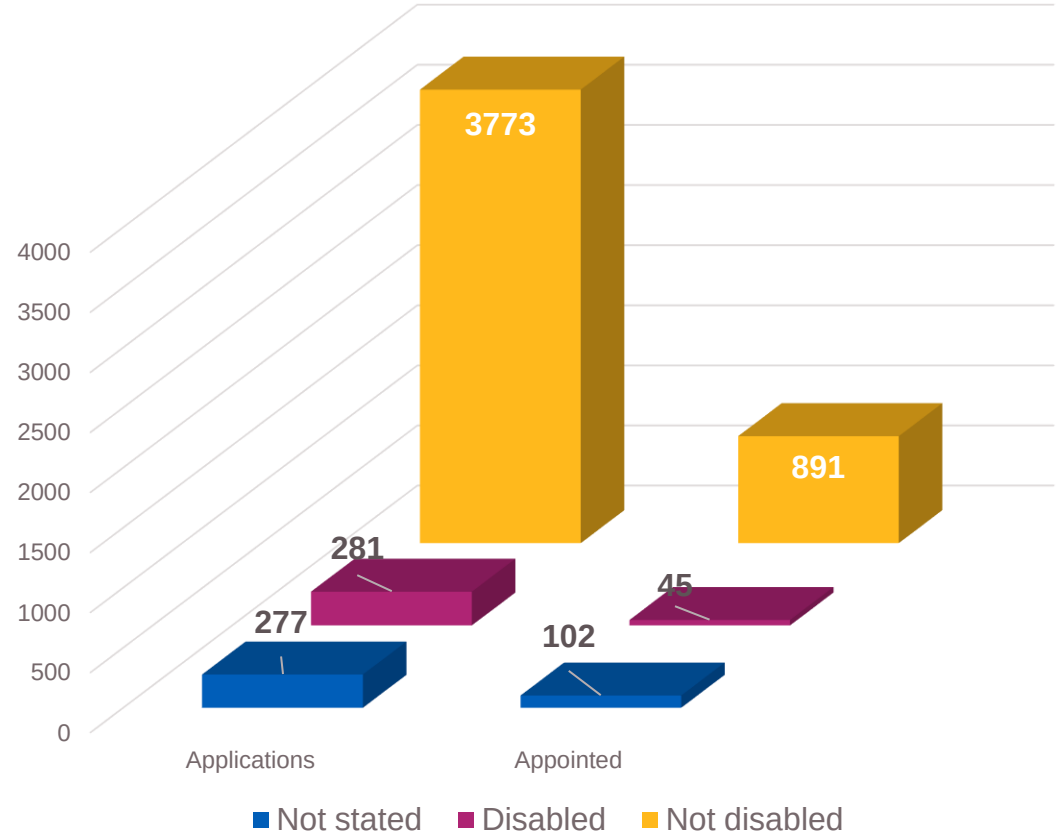
Appointment from shortlisting 31 March 2023 (Metric 2)

Relative likelihood of staff being appointed from shortlisting across all posts.

X1.47

The relative likelihood of non-disabled staff compared to disabled staff being appointed

Note: This figure does not include directly recruited international staff. Additionally, a comparison with 2021 is not feasible due to variations in the methodologies employed.



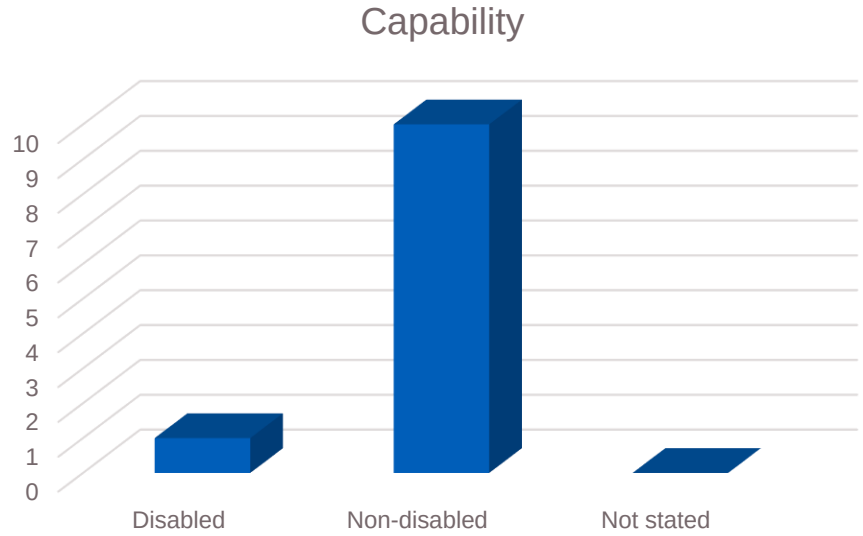
SFT WRES 31 March 2023 (Metric 3)

Relative likelihood of staff entering the formal disciplinary process, as measured by entry into a formal disciplinary investigation.

Metric 3: Relative likelihood of disabled staff compared to non-disabled staff entering the formal capability process, as measured by entry into a formal capability procedure.

Note: This indicator will be based on data from a two-year rolling average of the current year and the previous years (April 2021 to March 2022 and April 2022 to March 2023)

Formal capability process	Disabled	Non-disabled	Disability Unknown
	Headcount	Headcount	Headcount
Average number of staff entering the formal capability process over the last 2 years for any reason	1	10	0
Of these how many were on the grounds of ill-health	0	0	0
Relative likelihood of disabled staff entering formal capability compared to non-disabled staff	2.92		



X2.92

The relative likelihood of disabled staff entering formal capability compared to non-disabled staff.

Note: Comparison with 2021 is not feasible due to different methodologies employed.

SFT Staff Survey 2022 (Metric 4a)

NOTE: Metrics 4 to 9a are sourced from the SFT's national NHS staff survey 2022

1861 people in the Trust responded to the 2022 staff survey. The following Staff Survey questions are recorded within our WDES data:

Metric 4a: Staff experiencing harassment, bullying or abuse from patients/service users, their relatives, the public, managers or other colleagues in the last 12 months

Percentage of staff experiencing harassment, bullying or abuse from patients/service users, their relatives or the public in the last 12 months out of those who answered the question

25.2% of staff with a LTC or illness experienced harassment, bullying or abuse. This is a slight decrease from 2021 (27.4%)

25.3% of staff without a LTC or illness experienced harassment, bullying or abuse. This is a slight increase from 2021 (22.1%)

SFT Staff Survey 2022 (Metric 4b)

NOTE: Metrics 4 to 9a are sourced from the SFT's national NHS staff survey 2022

1861 people in the Trust responded to the 2022 staff survey. The following Staff Survey questions are recorded within our WDES data:

Metric 4b: Staff experiencing harassment, bullying or abuse from patients/service users, their relatives, the public, managers or other colleagues in the last 12 months

Percentage of staff experiencing harassment, bullying or abuse from managers in the last 12 months out of those who answered the question

13.9% of staff with a LTC or illness experienced harassment, bullying or abuse. This is a slight decrease from 2021 (18.9%)

7.9% of staff without a LTC or illness experienced harassment, bullying or abuse. This is a slight decrease from 2021 (10%)

SFT Staff Survey 2022 (Metric 4c)

NOTE: Metrics 4 to 9a are sourced from the SFT's national NHS staff survey 2022

1861 people in the Trust responded to the 2022 staff survey. The following Staff Survey questions are recorded within our WDES data:

Metric 4c: Staff experiencing harassment, bullying or abuse from patients/service users, their relatives, the public, managers or other colleagues in the last 12 months

Percentage of staff experiencing harassment, bullying or abuse from other colleagues in the last 12 months out of those who answered the question

26.2% of staff with a LTC or illness experienced harassment, bullying or abuse. This is a **large increase** form 2021 (15.1%)

17.7% of staff without a LTC or illness experienced harassment, bullying or abuse. This is a **large decrease** from 2021 (28%)

SFT Staff Survey 2022 (Metric 4d)

NOTE: Metrics 4 to 9a are sourced from the SFT's national NHS staff survey 2022

1861 people in the Trust responded to the 2022 staff survey. The following Staff Survey questions are recorded within our WDES data:

Metric 4d: Staff experiencing harassment, bullying or abuse from patients/service users, their relatives, the public, managers or other colleagues in the last 12 months

Percentage of staff saying that the last time they experienced harassment, bullying or abuse at work, they or a colleague reported it out of those who answered the question

49.7% of staff with a LTC or illness reported it. This is an increase from 2021 (42%)

46.6 % of staff without a LTC or illness reported it. This is a slight decrease from 2021 (47%)

SFT Staff Survey 2022 (Metric 5)

NOTE: Metrics 4 to 9a are sourced from the SFT's national NHS staff survey 2022

1861 people in the Trust responded to the 2022 staff survey. The following Staff Survey questions are recorded within our WDES data:

Metric 5: Percentage of staff who believe that their organisation provides equal opportunities for career progression or promotion out of those who answered the question

51.0% of staff with a LTC or illness said yes. In 2021 (47%)

54.2% of staff without a LTC or illness said yes. In 2021 (53%)

SFT Staff Survey 2022 (Metric 6)

NOTE: Metrics 4 to 9a are sourced from the SFT's national NHS staff survey 2022

1861 people in the Trust responded to the 2022 staff survey. The following Staff Survey questions are recorded within our WDES data:

Metric 6: Percentage of staff who have felt pressure from their manager to come to work, despite not feeling well enough to perform their duties out of those who answered the question

29.4% of staff with a LTC or illness said that they felt pressure to come to work. This is a increase from 2021 (25.6%)

21.5% of staff without a LTC or illness said that they felt pressure to come to work. This is a decrease from 2021 (32%)

SFT Staff Survey 2022 (Metric 7)

NOTE: Metrics 4 to 9a are sourced from the SFT's national NHS staff survey 2022

1861 people in the Trust responded to the 2022 staff survey. The following Staff Survey questions are recorded within our WDES data:

Metric 7: Percentage of staff satisfied with the extent to which their organisation values their work out of those who answered the question

29.0% of staff with a LTC or illness said Yes. This is a decrease from 2021 (39%)

37.3% of staff without a LTC or illness said Yes. This is an increase from 2021 (28%)

SFT Staff Survey 2022 (Metric 8)

NOTE: Metrics 4 to 9a are sourced from the SFT's national NHS staff survey 2022

1861 people in the Trust responded to the 2022 staff survey. The following Staff Survey questions are recorded within our WDES data:

Metric 8: Percentage of staff with a long lasting health condition or illness saying their employer has made reasonable adjustment(s) to enable them to carry out their work out of those who answered the question.

70.8% of staff with a LTC or illness said Yes. In 2021 (71.8%)

SFT Staff Survey 2022 (Metric 9)

NOTE: Metrics 4 to 9a are sourced from the SFT's national NHS staff survey 2022

1861 people in the Trust responded to the 2022 staff survey. The following Staff Survey questions are recorded within our WDES data:

Metric 9a: The staff engagement score (0-10) for disabled staff, compared to non-disabled staff.

- The overall average staff engagement score at the Trust was 6.7
- The staff engagement score for staff of staff with a LTC or illness was 6.5
- The staff engagement score for staff without a LTC or illness was 6.8

SFT Staff Survey 2022 (Metric 9)

NOTE: Metrics 4 to 9a are sourced from the SFT's national NHS staff survey 2022

1861 people in the Trust responded to the 2022 staff survey. The following Staff Survey questions are recorded within our WDES data:

Metric 9b: Has your Trust taken action to facilitate the voices of Disabled staff in your organisation to be heard? (yes) or (no)

- Yes. A new Ability Confident Staff Network has been established with Judy Dyos, Chief Nursing Officer, as the Executive Sponsor.

SFT Staff Survey 2022 (Metric 9)

Metric 10: Trust Board Membership – snapshot on 31 March 2023			
Board	**Disabled**	**Non-disabled**	**Disability unknown**
	Headcount	**Headcount**	**Headcount**
Total Board members	0	10	4
Of which: Voting Board members	0	10	4
Non-voting Board members	0	0	0
Of which: Exec Board members	0	4	2
Of which: Non Exec Board members	0	5	3

Progress on WDES 2021/22 Action Plan

	Action	Status
1	Support the Disability Diversity Champion to establish and develop a Trust wide Disability Staff Network.	The Ability Confident Staff network is well established and meeting monthly
2	Support the Disability Diversity Champion to engage with similar staff networks across BSW ICS to facilitate the development of the Disability Staff Network and share best practice	BSW has established a monthly Staff networks support and development group
3	Ensure our people are confident to share up to date, relevant and accurate equality data through our ESR self-reporting process. Ensuring that they understand the benefits of doing so.	This is ongoing work. We know that there is a huge discrepancy between self-declared disability on ESR (3% of workforce) and the anonymous declaration on the national staff survey (20% of respondents) - **this work is carried over to 2022/23**
4	Identify the number of Reasonable Adjustments which have been agreed and implemented within the Trust. Calculate the cost of implementing these Reasonable Adjustments.	This is ongoing work. The Trust has implemented A3 methodology for reasonable adjustments to become business as usual over the next 12 months - **this work is carried over to 2022/23**
5	Review the “Working with people with disabilities policy” and the culture of the Trust concerning the treatment of people who identify with a disability.	This is ongoing work. The Ability Confident Staff network is now well established and meeting monthly with a wider reach and impact on policy and culture within the Trust - **this work is carried over to 2022/23**

	Action	Status
6	Complete the Disability Confident Self-Assessment to achieve Level 3 Disability Confident Lead status	**This work is carried over to 2022/23**
7	Research and review how the Trust collects data on the progress of individuals from application to appointment. This to include the comparison between applicants who identify with a disability and those who do not.	**This work is carried over to 2022/23**
8	Regular Starter and Leaver reports to include a comparison of people who identify with a disability and those who do not.	The is ongoing work as part of embedding EDI into recruitment and promotion (6 Point Plan) - **this work is carried over to 2022/23**

Recommended WDES 2022/23 Action Plan

	Cultural Development Objective	Action	Lead	Deadline
1	To seek a downward trend in the percentage of disabled staff experiencing harassment, bullying, abuse or discrimination and an upward trend **Metric 4 (staff survey)**	• Review and refresh training interventions for all staff with a focus on civility and respect to support recognition and prevention of discrimination. • Develop an inclusive leadership programme that enhances the ability of managers and team leaders to understand OH processes and to make reasonable adjustments	Head of Organisation Development & Leadership Head of Employee Relations - Head of OH	Q2 2024
2	To seek validation for SFT to become a Disability Confident Scheme Leader (Level 3)	• Complete the Disability Confident Employer Level 3 Self-Assessment and apply for validation	Head of Inclusion & Wellbeing - Ability Confident Staff Network Lead	Q3 2024
	Networks and communications objective	**Action**	**Lead**	**Deadline**
3	To seek an upward trend in the percentage of staff saying that the last time they experienced harassment, bullying or abuse at work, they or a colleague reported. **Metric 4d (staff survey)**	• Discuss experiences of harassment, bullying or abuse with disabled staff, ensuring that there is a safe space for people to report and speak up.	Head of Inclusion & Wellbeing - Ability confident network lead	Q2 2024
4	To seek an upward trend in the percentage of disabled staff satisfied with the extent to which their organisation values their work **Metric 7 (staff survey)**	• Develop a communications campaign focused on the benefits of employing disabled people, aligning these with the NHS People Promise values including the activities that support disability as an asset.	Head of Inclusion & Wellbeing - People Promise Manager - Comms Team - Ability Confident Staff Network	Q2 2024
5	To seek an upward trend in the disabled staff engagement score. **Metric 9 (staff survey)**	• Continue to support the Ability Confident Staff Network in identifying and reporting on prevalent themes and issues concerning disabled staff.	Ability Confident Staff Network	Q2 2024
6	To improve self-declared disability data on ESR	• Encourage all staff and Board execs to update their personal status on ESR	Head of Inclusion & Wellbeing - ESR Team	Q2 2024
	Recruitment and Promotion Objective	**Action**	**Lead**	**Deadline**
7	To achieve equity on appointment from shortlisting for disabled applicants compared to non-disabled applicants. **Metric 2 (staff survey)**	• Collect insights from disabled applicants who were not selected after the shortlisting stage to improve selection	Head of Resources	Q2 2024
8	To seek an upward trend in the percentage of disabled staff who believe that their organisation provides equal opportunities for career progression or promotion. **Metric 5 (staff survey)**	• Incorporate the principles of EDI from the NHSE/I's Six Point plan into the Trust's recruitment and promotion overhaul to foster inclusivity for disabled staff.	Head of Resources	Q4 2023

Annex A - Definitions of disability – Equality Act 2010, NHS Staff Survey, NHS Jobs & ESR

A	Equality Act 2010 – Legal definition of disability
	A person (P) has a disability if— (a) P has a physical or mental impairment, and (b) the impairment has a substantial and long-term adverse effect on P's ability to carry out normal day-to-day activities

B	NHS Staff Survey disability monitoring question
	Q28a. Do you have any physical or mental health conditions or illnesses lasting or expected to last for 12 months or more? If YES, please answer part b below; if NO, go to Question 29 Q28b. Has your employer made adequate adjustment(s) to enable you to carry out your work? 1 Yes 2 No 3 No adjustment required

C	NHS Jobs disability monitoring question
	The Equality Act 2010 protects Disabled people – including those with long term health conditions, learning disabilities and so called "hidden" disabilities such as dyslexia. If you tell us that you have a disability, we can make reasonable adjustments to ensure that any selection processes – including the interview – are fair and equitable. * Do you consider yourself to have a disability? 1. Yes 2. No 3. I do not wish to disclose this information. Please state the type of impairment which applies to you. People may experience more than one type of impairment, in which case you may indicate more than one. If none of the categories apply, please mark 'other'. • Physical impairment • Learning Disability/Difficulty • Sensory impairment • Long-standing illness • Mental health condition • Other If you have a disability, do you wish to be considered under the guaranteed interview scheme if you meet the minimum criteria as specified in the person specification? 1. Yes 2. No

D	Disability categories on ESR are:
	• Learning disability/difficulty • Long-standing illness • Mental Health Condition • No • Not Declared • Other • Physical Impairment • Sensory Impairment • Prefer Not to Answer • Yes – Unspecified

NHS Salisbury NHS Foundation Trust

Report to:	Trust Board Public	Agenda item:	7.2
Date of meeting:	5th October 2023		

Report title:	Draft Board and Committee Dates 2024/25			
Status:	Information	Discussion	Assurance	Approval
				x
Approval Process: (where has this paper been reviewed and approved):	N/A			
Prepared by:	Kylie Nye, Head of Corporate Governance Sasha Godfrey, Board Support Officer			
Executive Sponsor: (presenting)	Fiona McNeight, Director of Integrated Governance			

Recommendation:

To review the Board dates and approve for 2024/25.

To decide if we should increase F&P and CGC Committees to ten a year (currently nine) and agree on the two months the meetings are not held (either May, July, Aug, Dec).

Executive Summary:

In February 2023 it was agreed that the structure of Board and Committee meetings would be updated to have eight full Board meetings a year and reduce F&P and CGC to nine times a year. There have been some issues with reporting scheduling, long agendas and in some cases the need for extraordinary meetings held outside the normal schedule. Additionally, there has not been enough Board development time.

Therefore, the new meeting schedule attached proposes increasing CGC and F&P to ten times a year. If this is agreed then the Board must choose two of the months highlighted in yellow to not schedule an F&P and CGC. Currently, there are no meetings in May, Aug and Dec. However, it has been observed that not having an August meeting has meant Q1 reports are being received in Committees in September which some have commented is too late.

The Board Development sessions have been increased from four to five sessions in the year. The number of Board meetings (eight) remains' the same but with June's meeting being held after Audit Committee to fit in with the approval of the Annual Report and Accounts.

2025 Jan-Mar dates have also been added to align to financial year reporting.

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

Trust Board, Committees and Council of Governors – Meetings 2024/25

	Financial Month	Public & Private Trust Board Thursday Week 1 or 2 All day	OD & People Management Board Tuesday Week 3 9 - 11	Clinical Management Board Wednesday Week 3 10.30-12.30	Audit Committee Thursday Week 3 9.30 - 12	Charitable Funds Committee Thursday Week 3 3 – 5	Trust Management Committee Wednesday Week 4 or 5 10 - 12	Clinical Governance Committee Tuesday Week 4 or 5 13:00-15:30	Finance and Performance Committee Tuesday Week 4 or 5 09:30 – 12:00	People and Culture Committee last Thurs 10 - 12	Council of Governors Monday (CoG) 16:00-18:30	Non-Exec/ Governor informal Monday 16:00-17:30
Chair		Ian Green	Melanie Whitfield	Peter Collins	Richard Holmes	Ian Green	Stacey Hunter	David Buckle	Debbie Beaven	Eiri Jones	Ian Green	Ian Green
Admin		Sasha Godfrey	Rebecca Falletta	Rebecca Hawtin	Fiona McNeight	Marcia Hocking	Gemma O'Brien	TBC	Marcia Hocking	Rebecca Falletta	Isabel Cardoso	Isabel Cardoso
Jan M10	M9	11	16	17	-	-	24	30	30	25	-	-
Feb M11	M10	8 (Dev Day)	20	21	-	-	28	27	27	29	26	12
Mar M12	M11	7	19	20	21	21	27	26	26	28 (sch hol)	-	-
Apr M1	M12	4 (Dev Day)	16	17	-	-	24	30	30	25	-	22
May M2	M1	2	-	15		-	29 (sch hol)	28 (sch hol)	28 (sch hol)	-	20	-
June M3	M2	6 (Dev Day) 20 (AR and Accounts & Rem Com)	18	19	20	20	26	25	25	27	-	-
Jul M4	M3	4	16	17	18	-	24 (sch hol)	30 (sch hol)	30 (sch hol)	25 (sch hol)	22	1
Aug M5	M4	8 (Dev Day)	-	21	-	-	28	27 (sch hol)	27 (sch hol)	-	-	-
Sept M6	M5	5	17	18	19	19	25	24	24	26	-	-
Oct M7	M6	3	15/22	16/23	-	-	23 (30 half term)	29 (half term)	29 (half term)	31 (half term)	AGM-7	21
Nov M8	M7	7 (Dev Day)	19	20	-	-	27	26	26	28	25	-
Dec M9	M8	5 (Rem Com)	-	18	12	12	18	17	17	-	-	-
2025												
Jan M10	M9	9	21	22	-	-	22	28	28	30	-	-
Feb M11	M10	6 (Dev Day)	18	19	-	-	26	25	25	27	17	10
Mar M12	M11	6	18	19			26	25	25	27	-	-

Trust Board, Committees and Council of Governors – Meetings 2024/25

Bank Holidays:
Monday 1st Jan
Friday 29th March
Monday 1st April
Monday 6th May
Monday 27th May
Monday 26th August
Monday 25th Dec
Tuesday 26th December

Notes:

- Trust Board – Always book the Boardroom 9:00-17:00. Public Board starts at 10:00
- Always include a Teams link for those joining virtually.
- All meetings – book room 30 minutes either side of start/finish times
- NEDS/Governors – Ensure Boardroom is available.
- CoG – If not virtual, book the Boardroom from 2:30pm (Set-up plus 15:00 pre-meet)