Bundle Trust Board Public 5 December 2024

1 OPENING BUSINESS

1.1 10:00 - Staff Story
Presented by Melanie Whitfield
Dee Carson, John Stubbs, Besh Nijhar-Brown, Lucy Blinko, Inez Szczepanska and Rebecca Stark attending
The origin of this work - BSW Retention Lead Besh was working across the South West region on a series of retention interventions. One of these led to her developing a training package to support application writing and interview skills for BAME staff as we know there can be blocks to progression for this group when compared to white staff in the same occupation.
The course was delivered by Besh at Salisbury in the first instance as we were the People Promise Exemplar Site. She worked with our recruitment team to set up 3 training sessions. Feedback from the training was excellent and Besh managed to secure further funding from NHSE to develop the product further into something that could be used regionally and nationally as required. This resulted in the training video and podcast recorded with Besh in partnership with the team here at Salisbury as part of our People Promise activity.

1.2 10:20 - Presentation of SOX certificates
September SOX of the month – Orthotics Team
September Patient Centred SOX – George Cherian and the Day Assessment and Beatrice Maternity Wards
October SOX of the month – Gilly Ansell, Radiology
October Patient Centred SOX – Bethan Warner, Medical Engineering
November SOX of the month –
November Patient Centred SOX –

1.3 Welcome and Apologies
Apologies received from Fiona McNeight

1.4 Declaration of Interests, Fit & Proper / Good Character

1.5 10:30 - Minutes of the previous meeting
Minutes attached from meeting held on 3rd October 2024
For approval
1.5 Draft Public Board mins 3 October 2024

1.6 Matters Arising and Action Log
1.6 Public Trust Board Action Log

1.7 Register of attendance
For information
1.7 Register of Attendance - Public Board 2024-25

1.8 10:35 - Chair's Business
Presented by Ian Green
For information

1.9 10:40 - Chief Executive/Managing Director Report
Presented by Cara Charles Barks and Lisa Thomas
For information
1.9 Chief Executive Report December 2024

2 ASSURANCE AND REPORTS OF COMMITTEES

2.1 10:50 - Integrated Performance Report to include exception reports Month 7 (October)
Presented by Mark Ellis
For assurance
2.1a IPR Cover Sheet - Trust Board 2024-12
2.1b New IPR Nov 2024

2.2 11:20 - Finance and Performance Committee 26th November
Presented by Debbie Beaven
For assurance
2.2 Finance and Performance Escalation Report Nov 2024

2.3 11:25 - Clinical Governance Committee 26th November

Presented by Anne Stebbing
For assurance

2.3 CGC 26Nov 2024

2.4 11:30 - Trust Management Committee 27th November
Presented by Lisa Thomas
For assurance

2.4 TMC escalation report Dec Board

2.5 11:35 - People and Culture Committee 31st October and 28th November
Presented by Eiri Jones
For assurance

2.5a PCC Escalation Report to Trust Board from PCC October 2024 to Board December 2024

2.5b PCC Escalation Report to Trust Board from PCC November 2024 to Board December 2024

3 STRATEGY AND DEVELOPMENT

3.1 11:40 - Annual Digital Plan Update
Presented by Jon Burwell
For assurance

3.1 Digital Plan Update Nov 2024

3.2 External Well-Led Review - 6 monthly update on progress - deferred to January

4 PEOPLE AND CULTURE

4.1 11:50 - Nursing Skill Mix Review
Presented by Judy Dyos
For assurance

4.1a cover sheet skill mix 2024

4.1b Full Bi-annual Safe Staffing Review September 2024

4.2 12:00 - BREAK

5 QUALITY AND RISK

5.1 12:30 - Patient Experience - Patient Feedback Report and National Inpatient Survey Results 2023
Presented by Judy Dyos
For assurance

5.1a Patient Experience - Patient Feedback Report Q2 24-25 v1.0

5.1b National Inpatient Survey 2023 Results - Report Cover Sheet CGC 26.11.24

5.1c National Inpatient Survey 2023 - Results v1

5.2 Incident Reporting and Risk Report - deferred to January

5.3 12:45 - Recommendations in the infected blood enquiry report and the impact on the Trust (from action log)
Presented by Duncan Murray
For assurance

5.3a Infected blood inquiry recommendations TB cover sheet Nov 24

5.3b Recommendations of infected blood inquiry TB

5.4 12:55 - Maternity and Neonatal Quality and Safety Report Quarter 2
Presented by Vicki Marston/Judy Dyos
For assurance

5.4a Front sheet Q and S report Q2 23 24

5.4b Maternity and Neonatal Safety Report Q2 July-Sept 24

5.4c APPENDIX 1 - PMRT Report Q2 Jul-Sept 24

5.4d APPENDIX 2 - Training Report Q2 Jul-Sept 24

5.4e APPENDIX 3 - Patient and Staff Experience Report Q2 Jul-Sept 24

5.4f APPENDIX 4 - Saving Babies Lives Report Q2 Jul-Sept 24

5.4g APPENDIX 5 - Workforce Report Q2 Jul-Sept 24

5.4h APPENDIX 6 - ATAIN TC Report Q2 Jul-Sept 24

5.5 13:05 - Perinatal Culture and Leadership Report

Presented by Vicki Marston/Judy Dyos
For assurance

5.5a Front sheet Perinatal Culture & Leadership Board Report

5.5b Perinatal Culture and Leadership Board Report FINAL SEPT24

5.6 13:10 - Perinatal Quality Surveillance Report October (September data)
Presented by Vicki Marston/Judy Dyos
For assurance

5.6a Front sheet Perinatal Quality Surveillance Report - October (September data)

5.6b Perinatal Quality Surveillance Oct 2024 Slides (Sept data)

5.7 13:15 - Perinatal Quality Surveillance Report November (October data)
Presented by Vicki Marston/Judy Dyos
For assurance

5.7a Front sheet Perinatal Quality Surveillance Report - November (October data)

5.7b Perinatal Quality Surveillance Nov 2024 Slides (Oct data)

7 CLOSING BUSINESS

7.1 13:20 - Agreement of Principal Actions and Items for Escalation

7.2 Any Other Business

7.3 13:25 - Public Questions

7.4 Date next meeting 9th January 2025

8 13:35 - 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 10am on Thursday 3rd October 2024, Boardroom/MS Teams Salisbury NHS Foundation Trust Boardroom

Board Members:

Ian Green (IG)	Chair
Eiri Jones (EJ)	Non-Executive Director
Debbie Beaven (DBe)	Non-Executive Director
David Buckle (DBu)	Non-Executive Director
Michael von Bertele (MVB)	Non-Executive Director
Richard Holmes (RH)	Non-Executive Director
Rakhee Aggarwal (RA)	Non-Executive Director
Judy Dyos (JDy)	Chief Nursing Officer
Mark Ellis (ME)	Interim Chief Finance Officer
Duncan Murray (DM)	Interim Chief Medical Officer
Lisa Thomas (LT)	Interim Chief Executive Officer
Niall Prosser (NP)	Interim Chief Operating Officer
Melanie Whitfield (MW)	Chief People Officer
Anne Stebbing (AS)	Non-Executive Director

In Attendance:

Fiona McNeight (FMc)	Director of Integrated Governance
Alex Talbott (AT)	Director of Improvement
Peter Collins (PCo)	Chief Medical Officer
Kylie Sanders (KS)	Head of Corporate Governance (minutes)
Kirsty Matthews (KM)	Associate Non-Executive Director
Abi Kingston (AK)	Clinical Director, Women and Newborn (items 7.3, 7.4, 7.5, 7.6)
Katherine Barrio (KB)	Head of Maternity & Neonatal Services (items 7.3, 7.4, 7.5, 7.6)
Thalina Wijetung (TW)	Visiting fellow
Jayne Sheppard (JS)	Lead Governor (observer)
Jane Podkolinski (JP)	Governor (observer)
Joanne Bennett (JB)	Governor (observer via Teams)
Angie Ansell (AA)	Deputy Chief Nurse (observer)

ACTION

TB1 3/10/1 **OPENING BUSINESS**

IG referred to the Improving Together Program and noted the Trust is using the approach and methodologies to bring about improvement, IG asked members and attendees to ask appropriate questions as part of the process of seeking assurance and to be present in the room, reminding them to highlight if they needed to step out during the meeting.

IG noted the busy agenda, asking committee chairs to raise items of escalation.

TB1 3/10/1.1 **Welcome and Apologies**

IG welcomed everyone to the meeting and noted that apologies had been received from:

- Paul Cain, Associate Non-Executive Director

TB1 3/10/1.2 **Declarations of Conflicts of Interest, Fit and Proper/Good Character**

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

EJ noted that she had recently been appointed as a joint Non-Executive Director for Dorset County Hospital and Dorset Healthcare.

TB1 3/10/1.3 **Minutes of the Part 1 (Public) Trust Board meeting held on 5th September 2024**

IG presented the public minutes from 5th September 2024 and the following changes were noted:

- There were minor typos which had been amended.

Decision:
Subject to these changes the minutes were approved as an accurate reflection of the meeting.

TB1 3/10/1.4 **Matters Arising and Action Log**

FMc presented the action log and noted that all items were either covered on the agenda, were for a future meeting or had been deferred to the Board Committees. IG referenced the actions which were to be picked up by the Committees and colleagues noted they were content to close them on the Board action log.

It was noted that all other actions were either closed or subject to a future agenda.

TB1 3/10/1.4a **Appendix for action TB1 5/9/2.1**

JDy had provided further information regarding TB1 5/9/2.1 Integrated Performance Report (IPR) (M4) - Patient Deterioration Metric.

This additional information was noted.

TB1 3/10/1.5 **Chair's Business**

IG noted the following key points:

- There had been a CQC inspection in Maternity on Monday (30th September) and acknowledged the work and effort from the maternity division in ensuring the visit went well. IG asked JDy to pass on thanks to the team.

- The three Trust Boards of Salisbury NHS Foundation Trust (SFT), Great Western Hospitals NHS Foundation Trust (GWH) and Royal United Bath Hospital NHS Foundation Trust (RUH) approved the proposal to enter into a group model led by a single Chief Executive Officer (CEO). In terms of next steps, the private Board meeting will discuss and consult on the Joint Committee Terms of Reference which will be coming back to

Board for final approval in the next few months. Additionally, interviews for the Group CEO are taking place tomorrow (4th Oct) with each Board holding a Remuneration Committee and Council of Governors next week to approve this appointment. IG noted that there are a number of internal and system-wide colleagues involved in the assessment and interview process.

- This is MvB's and DBu's last meeting as Non-Executive Directors at SFT. IG paid tribute to their work and commitment as part of the Trust Board over a number of years and thanked them on behalf of the Trust for their expertise and support.

- IG noted that this was also to be PC's last meeting before he moved on to his new role as Chief Medical Officer in Devon. IG noted that PC has been a great addition to the Board and a passionate advocate of Improving Together. IG noted PC will be greatly missed and wished him all the best in his new role.

- IG noted that further to the hopeful appointment of a Group CEO in the next few weeks, this would also be LT's last meeting as SFT CEO. IG thanked LT for her incredible support, tenacity, patience and highlighted her utmost care for the patients SFT serves. IG reflected upon LT's skill in managing the complexity of an NHS Trust, which is an extremely challenging role.

The update was noted.

TB1 3/10/1.6 **Chief Executive's Report**

LT provided an update noting the following key points:

- Earlier this month, the independent investigation into the NHS in England by Lord Darzi was published. The report makes for sobering reading and its findings are reflective of the challenges in access to care we have been experiencing in the Bath Swindon and Wiltshire (BSW) health system. There will be a 10-year plan for the NHS that follows this and references in the upcoming budget which SFT will respond to in the coming months when it is understood what this means for patients and staff.
- September was a very special month for the Trust, celebrating contributions made by our volunteers, partners, and staff to the Trust, which comes together as "thank you" week. Our communications team worked tirelessly to make all the events look seamless so a special thank you to the team and congratulations to all the Staff Award winners.

The update was noted.

TB1 3/10/2 **ASSURANCE AND REPORTS OF COMMITTEES**

TB1 3/10/2.1 **Integrated Performance Report (IPR) (M5)**

MW presented the Integrated Performance Report which provided a summary of Month 5 (August 2024). MW noted the purpose of the report and highlighted the following key points:

- In terms of the Breakthrough Objectives, three out of four are maintaining the correct trajectory.
- The two key challenges are theatre utilisation and No Criteria to Reside (NCTR). These are major drivers regarding inefficiencies.
- Whilst our focus is driving better performance and patient care, the system is looking to manage whole time equivalents (WTE) and to further understand if we have the right staff in the right place.
- MW recognised the success of the recruitment team and the subsequent low vacancy rates. Additionally, MW praised the teams managing short term intermittent absence. There is a need to recognise achievements of staff and this is why it is important for people to have appraisals. IG noted that the People and Culture Committee have oversight of this and are seeking further assurance.

Discussion:
NP reported that the report contained July's cancer performance and August's data. The Trust expects to move out of tiering for cancer services very soon.

Regarding RTT performance, whilst the target of zero 65-week waits by the end of September will not be achieved by any trust, SFT will have only 19 patients exceeding this threshold; a testament to staff efforts in managing complex pathways.

Diagnostic performance remains at 82.8%, with expectations to exceed 90% by year-end.

Challenges were noted regarding ERF performance, which reached 106% in August against a target of 116%, although improvements are anticipated from October.

Emergency Department (ED) performance stands at 72%. There remains significant concern about this metric due to the Trust's NCTR performance. F&P Committee conducted a deep dive into NCTR issues, which has prompted additional work with ICB contribution. Further improvement options are being explored for the coming months, with outcomes to be reported back to F&P.

Despite August being particularly busy and challenging, the hospital has made significant progress in several areas. Where challenges persist, recovery plans are in place. In response to IG's query about NCTR, it was confirmed as a key driver of current issues. F&P has explored various scenarios and is reviewing these again. Internal focus areas and NCTR challenges were discussed, though no additional out-of-hospital capacity is currently planned.

DBe asked if the Trust is identifying actionable steps for bed optimisation. While there is good assurance that issues are identified and reasonable assurance regarding mitigation strategies, implementation remains a challenge. Questions were raised about opportunities for accelerated

improvement and the pace of change. The involvement of ICB in discussions was noted, though system-level assurances remain incomplete.

ME responded to DBe's points, noting that issues largely affect Medicine and contribute to an unaffordable pay bill, primarily due to bed numbers. Despite improvements in Length of Stay (Los), the pace of change is impeded by underlying complexities.

Regarding the new ICB PLACE director's attendance at F&P, RH noted that while immediate assurance wasn't evident, time should be allowed for the new appointment to take effect.

DBu acknowledged the Trust's efforts in cancer care and waiting list management. LT confirmed that inter-trust cooperation exists, particularly when sharing best practice and managing significant patient risks. NP highlighted that cancer improvements have been built on lessons learned from others, noting the Surgery assessment update based on RUH practices.

PC emphasised that NCTR issues should be viewed as a strategic initiative requiring 2-3 years rather than expecting resolution within a year, particularly given the financial context.

EJ raised concerns about the level of pressure ulcers. JDy detailed actions being taken regarding tissue viability and pressure ulcers, including process improvements and training updates.

AS sought assurance about maximising internal opportunities such as hospital at home and virtual wards. IG noted positive assurance from the AGM, particularly regarding the frailty unit's impact on reducing Length of Stay.

In relation to NCTR, DBe proposed a specific project starting with stakeholder mapping to ensure proper focus areas. It was agreed that this will be referred back to F&P for further action. **ACTION: LT to follow up with F&P regarding additional NCTR actions.** **LT**

TB1 3/10/2.2 **Audit Committee – 19th September**

RH presented the report from the Audit Committee and asked for the Board to take it as read, noting the following key points:

- The Committee reviewed the effectiveness of the Board Assurance Framework process and recommends to the Board that the Board Assurance Framework remains effective. The Board agreed that the current BAF should continue to be adopted.

Discussion:
EJ gave thanks to the Information Governance team as the Data Security and Protection Toolkit (DSPT) had provided significant assurance with minor improvement opportunities in line with management expectations.

The Board noted the report.

TB1 3/10/2.3 **Trust Management Committee – 25th September**

LT presented the report which provided a summary of escalation points from the meeting held on 25th September. The report was taken as read.

Discussion:
KM addressed the challenges regarding NCTR in the context of winter planning, noting that whilst summer has been challenging, winter is expected to present even greater difficulties. LT noted that there was robust discussion concerning NCTR and bed occupancy, both of which significantly impact the winter plan. Whilst there is confidence in the actions taken for demand management, it was stressed that a system-wide response is necessary.

NP provided an update on the winter plan, highlighting that SFT plans well through its clinically led Urgent Care Board. The emphasis on clinical and staff leadership was noted as particularly positive. JDy noted that a review had been undertaken of particular Standard Operating Procedures (SOPs) and expressed confidence that appropriate measures are in place for managing patients who are not in optimal placement.

EJ enquired about potential impacts from the LIMS delay. ME responded that whilst this creates some constraints on IT resources, it does not affect current service delivery and actually presents an opportunity for improvement. He also noted that national funding has been secured to address the financial gap.

Regarding the vaccination programme, AS sought assurance on staff coverage. JDy confirmed that under the Deputy CNO, Fiona Hyett's leadership, the Trust ranks first and second for vaccination delivery numbers in the last few years. PC referenced COVID-19 specifically, noting that current vaccines attenuate rather than eliminate symptoms. He emphasised the need to return to pre-pandemic approaches regarding colds and coughs, indicating a shift in thinking.

The Board noted the report.

TB1 3/10/2.4 **Finance and Performance Committee – 24th September**

DBe presented the report which provided a summary of escalation points from the meeting held on 24th September. The report was taken as read with DBe noting that further assurance regarding the Trust's financial position would be provided in the private Trust Board.

In terms of other areas to alert the Board, DBe noted that in relation to estates, without a CAFM system we were alerted that we can't be assured that we are meeting all our statutory obligations. With >£100m of backlog maintenance (based on cost of delivery) the teams are being reactive in dealing with issues, but we see the impact of estate risk on performance.

The Board noted the report.

TB1 3/10/2.5 **Clinical Governance Committee – 24th September**

AS presented the report which provided a summary of escalation points from the meeting held on 24th September. The report was taken as read. IG asked JDy to provide a further update on the Maternity CQC inspection. JDy noted the following:

- The CQC notified the Trust the day before the visit. There were four inspectors on the day and followed up with a request for approx. 100 documents which have all been submitted.
- Subsequently, there was a call with the CQC engagement lead and it was noted that the visit went well. There is no timescale given in relation to receiving the report and SFT is not sure which system we're on. The new system would mean we do not get change in the single word assessment. The engagement manager is looking into this. JDy noted the hard work of the maternity team in responding to the visit.

Discussion:
EJ queried the decision to put intensive support measures in for gastrointestinal services. JDy noted that the issues are related to cultural concerns and safety regarding ERCP. The executives have written to team and will start to meet them in the following weeks. DM reassured the Board that the service is fragile but performance and quality metrics are positive compared to system partners. The risk sits around resilience and fragility and therefore the team have done well to deliver the service. DBu supported DM, noting that individuals have worked hard to make clinical improvements.

The Board noted the report.

TB1 3/10/2.6 **People and Culture Committee – 26th September**

EJ presented the report which provided a summary of escalation points from the meeting held on 26th September 2024. The report was taken as read with EJ briefly highlighting the following points:

- There is an issue in relation to capturing mandatory training data and therefore the Committee have commissioned a deep dive.

Discussion:
- RH referenced the posters around the Trust asking staff to become members of a Staff Council and asked how this feedback circulates back to the Board. MW advised that feedback will go through Organisational Development and People Management Board (OD&PMB) and People and Culture (P&C) Committee via listening events and updates will be included in 'a voice that counts' paper which reports to P&C committee
- RA acknowledged the WRES (Workforce Race Equality Standard) data improvements, noting that the Board have previously questioned validity in terms of improvement. The Board noted it was good to see this positive improvement.

The Board noted the report.

TB1 3/10/3 **STRATEGY AND DEVELOPMENT**

TB1 3/10/3.1 **Improving Together Update Report**

AT presented the report, providing a comprehensive summary of the work undertaken in quarter two of 2024/25. The following key points were noted:

- The key training trajectory target of 50% of teams trained by September 2024 has been met, and at least 50% of clinical speciality triumvirates are set to be trained in each division by the end of October 2024.
- The development of leadership behaviours that support improvement and personal development is fundamental to the success of Improving Together. The rollout and use of our Leadership Behaviours Framework is beginning to show signs of behavioural change and impact.
- Our deployment and alignment of Improving Together across the Group is improving with the development of a Strategic Planning Framework (SPF) for the Group, hosting the Catalysis CEO Summit in Salisbury and increasing collaboration between the three Coach Houses and Transformation teams to help ensure Improving Together remains at the heart of how we run our organisations.
- The Catalysis visit is next week. AT noted the focus in ensuring teams are ready for this. The next report will provide feedback on learning from this visit.
- From a transformation/ improvement team perspective there needs to be focus on prioritising corporate resources regarding NCTR and reviewing what would make the difference to support and help resource this programme of work.

Discussion:
DBe acknowledged the positive £3.3m savings captured and reiterated the need to do more to elevate awareness of the impact of Improving Together on financial performance.

DBe referenced engagement with GPs, asking if and how primary care are engaged in the Improving Together methodology. Could we invite them to be part of solution? AT explained that this is part of the communication workstream and is being built upon. The Board discussed noting that attention needs to be paid and regulatory bodies and system partners need to engage in a similar mindset of improvement. It was noted that SFT has developed and focused on the methodology and it is not as robust in the other Trusts.

The report was noted.

TB1 3/10/4 **GOVERNANCE**

TB1 3/10/4.1 **Register of Seals**

FMc presented the report, asking the Board to note the entries to the Trust's Register of Seals which, while not formally authorised by resolution of the Trust Board, have been authorised through powers delegated by the Trust Board.

- It was noted that there was one entry with no conflicts of interest**.**

The Board noted the report.

TB1 3/10/4.2 **Review of Constitution**

FMc presented the constitution report which asked the Board to consider and support the amendments to the constitution and recommend approval to the Council of Governors.

FMc outlined the changes that were made and approved by the Trust Board in May. It was noted that these amendments were not approved by Council of Governors in May with additional assurance sought regarding joint committees and committees in common. There are now further changes which were outlined on the cover sheet of the report which the Board is asked to consider and to recommend approval to the Council of Governors on 25th November.

FMc further noted that the governors have reinstated the Constitution Group which ensures changes to the constitution are considered prior to formal approval. They will meet prior to CoG in November to go through the necessary changes.

Discussion:
IG commented that it is key governors review the constitution prior to final sign-off at Council of Governors in November.

AS asked for further assurance as to why the constitution had not been approved previously. IG explained that there had been a misunderstanding that attempting to bring the constitution up to date and including reference to joint committees was a method of pre-empting any further decision in relation to the group model.

It was noted that point 36.2 needed to be checked in relation to reference to 'Monitor'.

Decision:
The Board agreed to the updates in principle, noting that engagement with CoG constitution group will be considered prior the CoG in November and any further changes communicated to the Board before then.

The Board noted the report.

TB1 3/10/4.3 **Draft Trust Board and Committee dates 2025/26**

FMc presented the draft dates for 2025/26.

Decision:
The Board approved the dates of the Board and Committees.

TB1 3/10/5 **FINANCIAL AND OPERATIONAL PERFORMACNE**

TB1 3/10/5.1 **Quarterly Strategy Update**

LT presented the report which provided an update on the actions progressed to deliver the Trust strategy under the 3 Pillars Population, People and Partnership. The Trust uses a strategic Planning Framework (SPF) to oversee the delivery of our strategy. To ensure the strategy is progressing the SPF identifies nine metrics to monitor to oversee delivery, these are the Vision Metrics. LT noted she would take the report as read.

Discussion:
RH noted that the strategy finishes in 2026 and asked should the Trust be producing another strategy that takes us 5 years onwards. LT explained there is an alignment piece of work to do with the other two Trusts. GWH are extending theirs so we all end at a point and then a Group Strategy will be developed.

The Board noted the report.

TB1 3/10/5.2 **Estates Technical Service Update**

ME presented the quarterly report and noted he was content to take report as read.

Discussion:
The Board discussed, noting the CAFM system issue which had been discussed at length at F&P.

The Board also discussed the risk regarding the chimneys. ME noted that the chimneys remain as high risk with continual assessments whilst the Trust returns to the market to tender for replacement.

EJ reflected that this report started coming to Board due to the number of extreme risks, a large proportion of which have now been mitigated. Therefore, EJ asked if this report still needed to come to Board. LT noted that there was a Board Assurance Framework (BAF) risk regarding estates so the focus of the report should provide assurance of mitigation of this risk.
ACTION: ME/JoK to work this through. The F&P committee will receive an updated report and decide what should be escalated to the Board. **ME/ JoK**

The Board noted the report.

TB1 3/10/6 **PEOPLE AND CULTURE COMMITTEE**

TB1 3/10/6.1 **Health and Safety Quarter One Report – deferred from September**

MW presented the report which had been through Trust Management Committee (TMC) and noted the following key points:

- There has been a focus on reducing the number of days lost due to injury at work. There has been a healthy check and challenge regarding Datix data updates.
- In terms of violence and aggression reported there is an increasing number of staff who continue to report. This continues to be closely monitored and posters will start going up around the Trust.
- Greater visibility of high risks, looking at what those risks are and the mitigation.

Discussion:
The Board discussed the report and noted that the increased reporting regarding violence and aggression could be reflective of a willingness to report. Additionally, MW was asked if the Trust have a process or policy regarding police involvement. The Board were assured that if a patient assaults staff, there is a policy which sets out a no tolerance approach.

DBe noted that it was positive to hear about increased training and reporting of violence and aggression but asked about in-the-moment aggression and the interventions colleagues are trained in to dissipate. The Board heard that staff do receive de-escalation training, but any reports of aggression should go to the H&S team who will respond immediately. There is also a new follow-up process to make sure the person affected feels like the situation was managed appropriately. Further assurance was provided that the Trust does have emergency preparedness plans to undertake a lockdown on site if required and lessons have been learnt from other organisations. JDy noted the security team who also support in violence and aggression situations.

RH noted the positive increase in reporting regarding near misses but suggested that it would be useful to see the patterns. RH further highlighted that incidents with tugs appear to be a concern, noting this should be acknowledged as a key issue. MW explained that the H&S team have reviewed the issues with tugs, undertaking an extensive investigation and providing further training. MW asked what further assurance the Board required. **ACTION: MW RH suggested further assurance on timescales, i.e., when is the work implemented to improve tug safety likely to bring about change.** **MW**

NP, responding to questions about large casualty event rehearsals, explained that emergency planning guidance requires a live exercise every three years. He confirmed that the Trust is currently meeting this schedule and noted he would confirm the date of the next planned exercise outside of the meeting. It was noted that the Resilience and Strategic Committee maintains oversight of this area.

EJ enquired about preventative measures regarding violence and aggression. The response highlighted that training courses are well-attended and the Trust maintains an active security team. JDy noted the important connection in supporting mental health patients in the Emergency Department.

RA outlined three key areas of focus: prevention, capability, and estate engagement with patients. Whilst considerable training is provided, RA reflected on the need to better stratify training requirements. MW discussed specific considerations for international staff, noting cultural differences and physical size variations among nursing staff. Despite extensive training provision, the importance of timely delivery was emphasised. It was agreed that near-miss incidents should be captured and used to inform targeted training and risk reduction strategies. This information will be reported through the P&C Committee.

AS queried whether Estates and Health & Safety matters were being addressed collaboratively. It was confirmed that both departments work alongside each other, though it was noted this isn't fully reflected in the current report format.

TB1 3/10/6.2 **Organisational Development and People Annual Report**

MW presented noting that the Board is requested to note the breadth of detail contained in the first OD&P Annual Report. The following key points were noted:

- EJ noted that the report had been discussed in detail at P&C Committee and they had noted the breadth of the report and the good performance reported.
- MW noted that since she began at the Trust several people reports had reported to Board and with input from the OD&P team, the way various elements of the people function were reported has been developed, drawing this together in one report.
- MW acknowledged the wide range of work and success completed by the OD&P team.

Discussion:
DBe noted that Appendix 1, achievements and metrics for the People Promise elements, provided an excellent snapshot of work.

The Board noted the report progress made.

TB1 3/10/6.3 **Guardian of Safe Working Annual Report**

DM presented the report which had been to People and Culture Committee. The following key points were noted:

- The trust reviews the title given to our current junior doctors in line with the recent recommendation from the BMA Junior Doctors committee to adopt the term 'Resident Doctors'.
- In terms of exception reporting, the cohort of people who can report is increasing.
- The Trust welcomes the end of industrial action which also comes with a change regarding exception reporting.
- It has recently been suggested that there are plans to stop hospital training posts for GPVTS doctors, with the entirety of the training being undertaken in general practice. This is yet unconfirmed but would have a significant impact on junior medical staffing across SFT.

Discussion:
IG thanked DM for the update noting the positive step forward in relation to the end of industrial action now that that the pay award has been accepted. This will create a more stable condition going forward.

DM referenced the "Framework of Quality Assurance for Responsible Officer and Revalidation" which is an annual Board report including a statement of compliance. This was submitted through NHSE recently but the format of the report has now changed and therefore the Trust has to resubmit before end of October 2024. The new format is nearly the same; however, there is a logistical issue of signing off before 31st October. The Board agreed to delegate responsibility for sign off via Chair's action and it was agreed IG, AS and EJ would be asked to review and approve outside of the meeting.

Post meeting moted: The Designated Body Annual Report and Statement of Compliance was signed off and submitted to NHSE.

TB1 3/10/6.4 **WRES and WDES Annual Report and Action Plan**

IG noted that the Board is asked to note the detail presented in the Annual WRES and WDES reports and approve the reports and associated action plan for publication on the Trust's website by 31st October 202414.

MW presented the report and highlighted the following points:

- The WRES (Workforce Race Equality Standard) papers have been refreshed, showing fantastic progress in international recruitment.
- According to Model Hospital guidance, organisations should aim to have a workforce that reflects their local community. Currently, 26% of our workforce is from overseas, while the local community representation is approximately 6%.
- Additional system-wide workshops are being conducted to develop career pathways, with a particular focus on career progression opportunities.
- The WDES (Workforce Disability Equality Standard) revealed negative experiences from some colleagues regarding bullying and harassment. The Trust's ambition is to address this through the "Leading with Compassion" initiative, supported by education and ongoing work as outlined in the action plans.

Discussion:
EJ noted the progress made in WRES while acknowledging the challenges identified in WDES and welcomed the appointment of a new lead for this area.

IG emphasised that the next steps would focus on understanding staff experiences. The Trust aims to champion inclusivity while avoiding complacency, both internally and in external partnerships.

AS commented on the metrics and concerns, noting that the comparisons in the coversheet were powerful but could have been better highlighted. AS questioned how this information is communicated to colleagues. MW explained that this is addressed through line management and training groups, including discussions about reasonable adjustments. It was noted that not all staff with disabilities may have disclosed their status. The importance of treating everyone with dignity and respect was emphasised to create an environment where people feel safe to declare their disability.

JDy observed that some people are uncomfortable with the term 'disability'.

Decision:
IG confirmed that the report had been discussed through P&C Committee and the Board approved the reports for publication along with the action plan.

TB1 3/10/7 **QUALITY AND RISK**

TB1 3/10/7.1 **Research Annual Report – deferred from July**

DM presented the annual report and highlighted the following points:

- There was an increase in recruitment throughout 2023/24.
- The Trust is working towards more effective collaboration with industry.

- Good progress has been demonstrated across research studies.
- There has been positive engagement with IT training, showing enthusiasm for the programme.
- Feedback is being gathered regarding participants' experiences in studies.

Discussion:
RH queried how we determine if this is the right level of research. DM responded that one cannot do too much research unless it impacts other services. He noted that the Trust has an experienced Head of Research with extensive experience in London Teaching Hospitals who is actively engaged in the research network. DM mentioned that benchmarking data might be available. DM further noted that the RUH is research-active and highlighted opportunities as part of the group.

RA questioned how we translate completed research into measurable impact. DBu noted that patients and staff enjoy being involved in research, which can offer numerous benefits, though proper principles need to be established. AS raised a query about moving to South West Central, DM will confirm whether this includes Swindon.

Regarding Health Innovation Networks (HINs), PC emphasised that service delivery research has impact and stressed the need to develop stronger networks with these HINs.

IG commented on the valuable information generated. RA questioned the 'so what' aspect, specifically how we communicate findings and inform staff. RH asked about nationalisation opportunities.

ACTION: DM In light of the report the Board asked for further assurance about how the outcome of research is disseminated more broadly and how do the communications team get involved. **DM**

JDy highlighted that the Trust is also progressing with non-medical research.

EJ left the meeting.

The Board noted the report.

TB1 3/10/7.2 **Learning from Deaths Q1 Report**

DM presented report to provide assurance to the committee that the Trust is learning from deaths and making improvements. It was noted this report had been reviewed at CGC. DM noted the following key points:

- There is a continued improvement in the Trust's Mortality Statistics. Both the HSMR and SHMI have continued to see a positive decline in recent months.
- 98% of deaths have been reviewed by the Medical Examiner's Office. Of these 27 (7.8%) primary reviews have been requested. From these, 23 learning points, 11 positive points and 12 negative have been generated. Positive and negative learning points are assimilated on the AMAT system.

- From October the medical examiner officer will be reviewing community deaths. The current challenge is the team is constrained by space but this is being picked up via Space Allocation Committee.

Discussion:
AS referenced the review of community deaths and asked if the Trust is being funded. DM confirmed funding was in place but the issue was down to space in the Trust.

IG noted that governor colleagues should be sighted on this report as they had raised concerns regarding mortality and level of deaths and the regional medical director who had carried out an independent review. PC noted that the regional medical director receives mortality data which is discussed at a regional meeting but suggested it would be useful for him to see the full report.

The report was noted.

TB1 3/10/7.3 **Perinatal Quality Surveillance Report August (July data)**

AK and KB joined the meeting.

AK presented the report which asked the Board to note the contents of the monthly Perinatal Quality Surveillance Report. It was noted that this report reflected July's data.

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 6 – Safety Action 9.

AK provided an update of the key points, as summarised in the executive summary of the report. AK noted that this is presented at the divisional governance meetings on a quarterly basis.

Discussion:
EJ noted that from her perspective as NED maternity champion she regularly observed really good triangulation in the department and noted good progress in terms of the maturity matrix.

The Board noted the report.

TB1 3/10/7.4 **Perinatal Quality Surveillance Report September (August data)**

AK presented the report which asked the Board to note the contents of the monthly Perinatal Quality Surveillance Report. It was noted that this report reflected August's data.

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 6 – Safety Action 9.

AK provided an update of the key points, as summarised in the executive summary of the report.

The Board noted the report.

TB1 3/10/7.5 **Maternity Quality and Safety Report Quarter 1**

AK presented asking the Board to note the report and highlighting the requirement for the minutes as per CNST requirements ensuring quarterly oversight of the quality and safety agenda is maintained in addition to the Perinatal Quality Surveillance Model that is reported monthly.

The Board was asked to note:

- The Perinatal Mortality Review Tool (PMRT) review.
- Compliance with labour ward coordinator being supernumerary and women receiving 1:1 care =100%.
- Inclusion of the Trust's claims scorecard and the review of it alongside incident and complaint data.

Discussion:
EJ referenced the PMRT and queried why there would be an occasion where no meeting was held. It was confirmed that a meeting would not be held if deaths did not meet the threshold.

The Board noted the report.

TB1 3/10/7.6 **Maternity and Neonatal Staffing Report**

AK presented the report which asked the Board to note the contents of this report which has been provided for information and assurance processes. In order to demonstrate compliance with the CNST Maternity Incentive scheme Year 6 the Trust Board are asked to note the specific expectations in relation to demonstrating effective Midwifery and Neonatal workforce planning as detailed in the report.

The required standards that SFT have fulfilled for NHS Resolutions Maternity CNST Incentive Scheme are:

- A systematic, evidence-based process to calculate midwifery staffing establishment is completed. SFT is 100%.
- Trust Board to evidence midwifery staffing budget reflects establishment as calculated in a) above.
- The midwifery coordinator in charge of labour ward must have supernumerary status; (defined as having a rostered planned supernumerary co-ordinator and an actual supernumerary co-ordinator at the start of every shift) to ensure there is an oversight of all birth activity within the service. An escalation plan should be available and must include the process for providing a substitute co-ordinator in situations where there is no co-ordinator available at the start of a shift.
- All women in active labour should receive one-to-one midwifery care.
- Submit a midwifery staffing oversight report that covers staffing/safety issues to the Board every 6 months, during the maternity incentive scheme year six reporting period.

Discussion:
The Board noted the contents of the report and compliance to those metrics requiring noting as evidence for CNST compliance.

AK and KB were thanked, and IG asked for thanks to be passed to the maternity team for their response to the CQC inspection earlier in the week.

LT referenced 'Saving Babies Lives' standard asking if there was any support and help to achieve this standard. It was explained that the Local Maternity and Neonatal System (LMNS) sign off SFT's progress. The team have sought guidance from the auditor and will be sharing that back with LMNS. This will come back to a future meeting.

AK and KB left the meeting

TB1 3/10/7.7 **Board Assurance Framework (BAF) and Corporate Risk Register (CRR)**

FMc presented the Board Assurance Framework (BAF) provides the Trust Board with a mechanism for satisfying itself that its responsibilities are being discharged effectively. The following key points were noted:

- The Board had a deep dive of BAF risks at Board Development Day. FMc has looked back over the last 12 months to observe comparison and there has been positive shift.
- The BAF reflects the persistent challenges regarding estates and finance.
- The revised BAF has been to all committees.
- There has been a positive move in the CRR in number of risks and mitigations.

Discussion:
IG reflected on conversation noting the issues discussed in the meeting broadly relate to the BAF risks presented. It was noted that the only risk today's meeting had not focused on is BAF risk 5 regarding IT. The Board noted that the Audit Committee escalated report had provided assurance regarding the Trust's digital agenda and cyber security.

The Board noted the report, accepting the risk profile.

TB1 3/10/7.8 **Risk Appetite**

FMc presented the report, noting each committee had received the risk appetite definitions and categories. The Board was asked to approve the risk category definitions, the risk appetite level descriptors for each risk category, the risk tolerance level proposed for each risk category and the overall risk type tolerance level.

FMc provided context regarding the risk appetite development, noting that GWH had aligned their risk appetite to a similar structure.

FMc outlined the changes to the profile since the Committees discussed in September, noting the risk appetite will be applied to the BAF and CRR if the Board approve the recommendations.

Discussion:
RH noted that the overall consensus was to approve risk appetite and review in six-months' time.

DBe noted the good progress in the evolution of risk appetite with plenty of opportunities to feedback. The next stage will be to review how the risk appetite works in reality when aligned to the BAF.

JDy commented on the positive step forward to work with GWH on aligning this work, although the Board noted they needed to be mindful that different risk appetite across the three Trusts could impact activity in the future.

AS referenced the health and safety risk descriptors, asking for further clarification on. It was agreed this would be clarified outside of the meeting.

LT thanked FMc for a really useful piece of work. FMc noted that a draft risk appetite statement and framework which sets out the approach will be coming back to Board in the near future.

Decision:
The Board approved the recommendations.

IG thanked FMc for her work.

The Board noted the report.

TB1 3/10/7.9 **Patient Experience Report Q1**

JDy presented report which provided a summary and insights drawn from the various methods by which our patients feedback on our services. It was noted that the report had also been reviewed at CGC. JDy took the report as read but noted the following key points:

- JDy noted that one of the appendices presented to CGC, produced by the Head of Patient Experience, outlined the work around co production, co-involvement, and patient partners. JDy wanted the Board to recognise the hard work of the team in supporting this additional work.
- Inpatient surveys have been deferred to November. The delay was externally driven, due to one particular question. Details will come back to the next Board.

Discussion:
AS referenced the debate regarding the amount of information the Board and CGC need to receive. In CGC, AS had asked VA to use the 3 A approach (alert assure and advise) in presenting her reports to keep the discussion more focused. JDy explained that the patient experience report serves the quality contract so paper is lengthy for a specific reason.

The Board discussed reporting and it was acknowledged FMc and LT had been looking at the standard work for Board papers and committees but that this referenced back to the outcome of the well-led report received in 2023. This highlighted that Board and committee papers should have a succinct executive summary and should stand alone. It was agreed there needs to be a consistent approach.

EJ rejoined the meeting.

The Board noted the report

TB1 3/10/7.10 **Q1 Risk Management Report**

JDy presented report to provide an overview of risk management activity in Quarter 1. JDy took the report as read.

The Board noted the report.

TB1 3/10/7.11 **Inpatient Survey Results**

The Board noted the Inpatient Survey Report had been deferred to the December meeting.

TB1 3/10/8 **CLOSING BUSINESS**

TB1 3/10/8.1 **Any Other Business**

There was no further business to discuss.

TB1 3/10/8.2 **Agreement of Principle Actions and Meeting Reflection**

IG referred to the principal items from the meeting and noted the following

- The Board need to ensure they're using the committees effectively to obtain sufficient assurance and focus on the key issues.
- The Board had approved the Risk Appetite categories and definitions to take forward.
- DBe commented regarding NCTR, noting this is not just SFT's issue to solve and should be progressed with system support. It was noted that there is external support but the challenge is around pace. There is an opportunity with stakeholders to map contributions in dealing with this issue and it was noted using the Improving Together methodology would be useful to work out how we navigate this issue together.

TB1 3/10/8.3 **Public Questions**

There were no public questions.

TB1 3/10/8.4 **Date of Next Public Meeting**

The next Public Trust Board meeting will be held on 5th December 2024

TB1 3/10/9 **RESOLUTION**

TB1 3/10/9.1 Resolution to exclude Representatives of the Media and Members of the Public from the Remainder of the Meeting (due to the confidential nature of the business to be transacted)

Master Action Log

1	Deadline passed, Update required
2	Progress made, update required at next meeting
3	Completed
4	Deadline in future

Contact Kylie Nye, kylie.Sanders1@nhs.net for any issues or feedback

Committee	Organiser	Reference Number	Deadline	Owner	Action	Current progress made	Completed Status (Y/N)	RAG Rating
Trust Board Public	Sasha Godfrey	TB1 4/7/2.6 Clinical Governance Committee	~~03/10/2024~~ 5/12/2024	Duncan Murray, DM	Report regarding the recommendations in the infected blood enquiry report and the impact on the Trust	**PC Update 26.9.24 report has been completed and will be taken through CGC in October, December Board, on agenda**	N	2
Trust Board Public	Sasha Godfrey	TB1 5/9/3.1 SIRO Annual Data Security and Protection Assurance Report (includes Toolkit Self-Assessment and Data Protection Annual Report and GDPR)	05/12/2024	Jon Burwell, JB	A deep dive report on cyber security will come to the Board in December.	**On December Board agenda**	N	2
Trust Board Public	Sasha Godfrey	TB1 5/9/6.2 Freedom to Speak Up Guardian Annual Report/ NED MLE	05/12/2024	Ian Green, IG Fiona McNeight, FMc	Statutory and mandatory training for NEDs was discussed mandatory training for Non-Executive Directors will be reviewed, with updated guidance for separate NED training to be provided.		Y	3
Trust Board Public	Sasha Godfrey	TB1 3/10/2.1 Integrated Performance Report (IPR) (M5) NCTR	26/11/2024	Lisa Thomas (LT)	In relation to NCTR, DBe proposed a specific project starting with stakeholder mapping to ensure proper focus areas. It was agreed that this will be referred back to F&P for further action. ACTION: LT to follow up with F&P regarding additional NCTR actions.	**Discussed at November's Finance and Performance Committee meeting.**	N	2
Trust Board Public	Sasha Godfrey	TB1 3/10/5.2 Estates Technical Service Update	09/01/2025	Mark Ellis (ME) John O'Keefe (JoK)	Focus of the report should provide assurance of mitigation of BAF risk. ACTION: ME/JoK to work this through. The F&P committee will receive an updated report and decide what should be escalated to the Board.	**Next report due January 2025**	N	4
Trust Board Public	Sasha Godfrey	TB1 3/10/6.1 Health and Safety Quarter One Report –Tugs	09/01/2025	Melanie Whitfield (MW) Troy Ready (TR)	MW asked what further assurance the Board required re the investigation into tugs. ACTION: MW RH suggested further assurance on timescales, i.e., when is the work implemented to improve tug safety likely to bring about change.	**Next report due January 2025**	N	4
Trust Board Public	Sasha Godfrey	TB1 3/10/7.1 Research Annual Report	**TBC**	Duncan Murray, DM	DM In light of the report the Board asked for further assurance about how the outcome of research is disseminated more broadly and how do the communications team get involved.	**Next report due in July 2025 - ?pick this up on CGC agenda sooner**	N	4

Register of Attendance – Public Board 2024/25

	2 May	4 July	22 July	5 September	3 October	5 December	9 January	6 March	attendance rate
Tania Baker	✓								1/1
Michael von Bertele	✓	✓	✓	✓	✓				5/5
Lisa Thomas	✓	✓	✓	✓	✓				5/5
Judy Dyos	✓	✓	✓	✓	✓				5/5
Melanie Whitfield	✓	✓	✓	✓	✓				5/5
Eiri Jones	✓	✓	✓	✓	✓				5/5
Rakhee Aggarwal	✓	✓	✓	✓	✓				5/5
David Buckle	✓	✓	✓	✓	✓				5/5
Peter Collins	✓	✓	✓	✓	✓				5/5
Mark Ellis	✓	✓	✓	✓	✓				5/5
Debbie Beaven	✓	✓	✓	✓	✓				5/5
Richard Holmes	✓	✓	x	✓	✓				4/5
Ian Green	✓	✓	✓	✓	✓				5/5
Kirsty Mathews		✓	✓	✓	✓				4/4
Paul Cain		✓	✓	✓	x				3/4
Anne Stebbing		✓	✓	✓	✓				4/4
Duncan Murray				✓	✓				2/2
Niall Prosser	✓	✓	✓	✓	✓				5/5

Governor Observer								
Jane Podkolinski	✓	✓	✓	✓	✓			
Jayne Sheppard	✓	✓		✓	✓			
Frances Owen	✓	✓						
Peter Russell								

Attended - ✓

Apologies – X

Report to:	Trust Board (Public)	Agenda item:	1.9
Date of meeting:	5th December 2024		

Report title:	Chief Executive and Managing Director Report			
Status:	Information	Discussion	Assurance	Approval
	X			
Approval Process: (where has this paper been reviewed and approved):	N/A			
Prepared by:	Cara Charles-Barks, Chief Executive Officer Lisa Thomas, Managing Director			
Executive Sponsor: (presenting)	Cara Charles-Barks, Chief Executive Officer Lisa Thomas, Managing Director			
Appendices	N/A			

Recommendation:

The Board is asked to receive and note this paper as progress against the local, regional and national agenda.

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.

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):	

National

1. Evolution of NHS Operating Model

The Chief Executive received a letter (see appendix one) on 13th November 2024 from NHS England Chief Delivery Officer and National Director for System Development outlining plans to evolve the operating model to ensure that the way the NHS works supports delivery of the priorities as well as deliver the neighbourhood health model that will underpin the health and care system that is fit for the future.

Four actions will guide a refresh of the current operating framework which are outlined below:

i) Simplify and reduce duplication, clarifying roles and responsibilities and being clear on the place of performance management.
ii) Shift resources, time and energy to neighbourhood health, creating momentum that makes clear the role of the provider sector in neighbourhood health and how to work with local partners.
iii) Devolve decision-making to those best placed to make changes, clarifying the role of integrated care partnerships (ICPs) and health and wellbeing boards.
iv) Enable leaders to manage complexity at a local level, supporting leaders with new strategic commissioning frameworks to include national best practice.

Achieving this will require everyone in the NHS to work together, alongside it's partners in the wider system, to fully leverage the potential of ICSs, aligned around a clear purpose and each with a distinct role to play.

2. NHS Providers Conference 2024: Secretary of State for Health and Social Care Speech - Key Messages

The Secretary of State for Health and Social Care, Wes Streeting, spoke at the NHS Providers conference on 13th November 2024 where he outlined the Governments ambition to reform the NHS.

The key messages from the speech were:

a) Important to lay down some directions.
b) The NHS is not meeting its promises to patients.
c) Performance of the NHS has deteriorated, which in turn is deteriorating the health of the nation.
d) Biggest barrier - long waiting times.
e) Need to deliver better outcomes and better value for taxpayers.
f) Values and standards should be the same nationally.
g) 5 Key Tasks:
    i. Living within money
    ii. Embedding improvement
    iii. Maintaining quality and safety
    iv. Working with primary care
    v. Optimising Efficiency

3. NHS Management and Leadership Programme

a) Leadership Management Programme

The NHS is one of the largest employers in the world and delivers care and treatment to more than a million people every 24 hours. It impacts everyone's lives and employs over 1.3 million people across more than 350 different careers. The NHS delivers amazing care to patients every single day, but there are times when it falls short, and services aren't what we want them to be which has to change.

Excellent leadership and management are key to delivering that change. We need our colleagues to have the right skills, the right support and the right accountabilities.

The NHS Chief Executive, Amanda Pritchard, has announced a programme to transform NHS leadership and management over the next two years as leaders and managers shape the culture, experience and outcomes across the service for patients and staff.

The aims of the NHS Management and Leadership Programme are to make sure:

- NHS leaders and managers at all levels meet the standards and competencies our staff and patients expect of them
- All leaders and managers have access to professional development and support to meet the expected standards and competencies
- The NHS attracts, develops and retains the best talent
- The public has increased confidence in NHS leaders and managers, who feel a continued sense of pride in their profession

The programme will have three workstreams which will set the right standards, improve its development offer, and nurture and deploy talent across the NHS.

- Workstream 1: Set the right standards for our leaders and managers
- Workstream 2: Develop our leadership and management
- Workstream 3: Talent support and career development

Further information can be found via https://www.england.nhs.uk/leaders/

b) Insightful Board

NHS England have published the Insightful Board for Integrated Care Boards and Provider Boards which will help Boards to consider their approach to handling and acting on the information they receive.

It considers the leadership behaviours and culture of the Board and how these can affect the information it receives and the actions it takes, as well as metrics that can support the Board to better understand the organisation's performance.

Further information can be found via https://www.england.nhs.uk/leaders/insightful-board-guidance/

4. NHS managers' regulations proposal:

A public consultation was launched on 26 November 2024 seeking views on government proposals to regulate health service managers, ensuring they follow professional standards: https://www.gov.uk/government/consultations/leading-the-nhs-proposals-to-regulate-nhs-managers/leading-the-nhs-proposals-to-regulate-nhs-managers

The Department of Health and Social Care has also launched a consultation on 26 November 2024 considering whether to introduce a new professional duty of candour on managers, and in addition to make managers accountable for responding to patient safety concerns.

Amanda Pritchard, Chief Executive of NHS England stated:

"It is right that NHS managers have the same level of accountability as other NHS professionals, but it is critical that it comes alongside the necessary support and development to enable all managers to meet the high-quality standards that we expect.

"We welcome this consultation and already have a range of work underway to boost support for managers in the NHS and to help set them up to succeed – this includes creating a single code of practice, a new induction

process and a new set of professional standards, which will ultimately help drive improvements in productivity and patient care."

BSW Hospitals Group is well-placed to be at the forefront of developments our CEO, Cara Charles-Barks sits on the national CEO working group.

5. NHS Launches Major New Stroke Campaign

Tens of thousands of people who have a stroke could be diagnosed and treated sooner as new data found that the average time between onset of first symptoms and a 999 call being made was nearly an hour and a half.

New analysis of NHS data shows that for 2023/24 of 41,327 patients with a recorded time of symptom onset, the average time between first symptom and a 999 call being made was 88 minutes.

The figures come as the NHS today launches the first major update to the 'Act FAST' campaign since 2009. As part of the campaign launch, a powerful new film has also been released which features stroke survivors listening back to audio recordings of the real 999 calls that saved their lives.

For further information please follow this link: https://www.england.nhs.uk/2024/11/nhs-launches-major-new-stroke-campaign-as-thousands-delay-calling-999-by-nearly-90-minutes/

6. Covid Inquiry:

Module 3 of 10 of the UK Covid 19 Inquiry opened on Tuesday 8 November 2022 with the impact of Covid-19 Pandemic on Healthcare Systems in the 4 Nations of the UK Public Hearings taking place between 9 September – 28 November 2024. It continues to look into the governmental and societal response to Covid-19 as well as dissecting the impact that the pandemic had on healthcare systems, patients and health care workers. This includes healthcare governance, primary care, NHS backlogs, the effects on healthcare provision by vaccination programmes as well as long covid diagnosis and support.

The preceding modules looked at UK's resilience and preparedness for the pandemic (Module 1) and core political and administrative governance and decision-making for the UK (Module 2).

7. Lampard Inquiry

The Lampard Inquiry is a statutory inquiry investigating mental health inpatient deaths in Essex. It is chaired by Baroness Kate Lampard CBE. The Lampard Inquiry will investigate the circumstances surrounding the deaths of mental health inpatients under the care of NHS Trust(s) in Essex between 1 January 2000 and 31 December 2023.

The Lampard Inquiry was preceded by a non-statutory inquiry that was set up to investigate the deaths of mental health inpatients in Essex between 2000 and 2020, launching in November 2021.

In June 2023 the then Secretary of State for Health and Social Care, Steve Barclay, announced that the Inquiry would be granted statutory status under the Inquiries Act 2005.

Following a consultation period and development of the Terms of Reference, the Lampard Inquiry commenced in September 2024.

The Lampard Inquiry is expected to conclude in 2026.

8. Uniting Health Data Report

Professor Cathie Sudlow's independent review of the UK health data landscape, titled 'Uniting the UK's Health Data: A Huge Opportunity for Society', was published on Friday 8 November 2024.

The review's findings set out a bold vision for overcoming the barriers and inefficiencies that currently delay the safe and secure use of health data to improve lives. It also sets out how that can be achieved, with five key recommendations to transform the national health data ecosystem.

1. Major national public bodies with responsibility for or interest in health data should agree a coordinated joint strategy to make England's health data a critical national infrastructure
2. Leading government health and research bodies should establish a national health data service for England with accountable senior leadership
3. The Department for Health and Social Care should oversee and commission a strategy for ongoing, coordinated engagement with patients, public, health professionals, policymakers and politicians
4. The health and social care departments in the four UK nations should set a UK-wide approach for data access processes and proportionate data governance
5. National organisations in the four UK nations should develop a UK-wide system for standards and accreditation of SDEs holding data from the health and care system

Further information can be found via https://www.hdruk.ac.uk/helping-with-health-data/the-sudlow-review/

System:

1. BSW Review of System meeting (H2 – second half of the year):

In November, a meeting held with the ICB and Regional Team to discuss the performance and financial position in the BSW system.

Three key priority areas were agreed for the remainder of 2024/2025 as:

- Year-end financial position
- 65 week waits
- Urgent and emergency care with a key focus on ambulance turnaround

2. South West Region Managing Ambulance Handover Delays in Extremis Standard Operating Procedure update:

An updated Standard Operating Procedure for Managing Handovers in Extremis was implemented on 18 November 2024 in response to the deteriorating position across the Region in relation to delayed ambulance handovers and consequently response times.

It is nationally recognised that unassessed patients in the community (those awaiting an ambulance to attend) pose the greatest level of clinical risk in a system. As such, every effort is being made to prevent any ambulance handover delays.

The new SOP strengthens the response to delays, including how and when handover delays are escalated in the system and Region, ensuring that senior support and input is available.

Group:

1. BSW Hospitals Group Development:

Activities & Achievements

As new Chief Executive BSW Hospitals Group, the first month in-post has seen focus on getting to know the organisations, meeting teams and visiting departments across Great Western, Salisbury and RUH Bath Foundation Trusts. In these first few weeks it has been striking to see the opportunities we have to share excellent practice more widely across BSW Hospitals Group.

We have established a new rhythm of work with the Chairs and interim Managing Directors. We meet locally in each Trust considering local priorities, and also come together weekly to plan the development of BSW Hospitals

Group. Jon Westbrook, Lisa Thomas, Andrew Hollowood, and I have arranged a series of monthly development days, designed to support our group development work and most importantly to establish the behaviours, principles and culture we will aspire to together.

The Trusts have developed a Strategic Planning Framework which outlines the key issues we need to work on collectively. We have been working with the SW Regional team to identify budget required to support our Group development.

Priorities

While work is beginning to establish a governance structure and operating model for our Group, there are a number of issues which need our immediate focus in each Trust. Emphasised in recent announcements from NHS Chief Executive and the Secretary of State, these include:

- Urgent and Emergency Care, particularly improving access for our population across BSW.
- Financial sustainability, including our 24-25 year-end position.
- Digital environment. We will implement a new shared Electronic Patient Record, maximising the opportunity this gives us, using Improving Together, to drive clinical transformation and improvement.

We will work together to develop our responses to these challenges.

Managing Director - Hospital Updates

The Trust welcomed Cara this month as the new Chief Executive, as part of the induction process a briefing session across all three Trust took place offering all staff the opportunity to ask Cara direct questions which will be built into a regular communication event.

Overall performance for the Trust is detailed in the Integrated Performance Report, there has been steady improvement over several metrics. The Trust has exited tiering for cancer performance which will ensure patients have better timely access to services. The Trust is still experiencing increased demand for urgent care and working alongside system colleagues on mitigations.

HCRG won the ICB contract for Adult and Children Community services, the Hospice service is covered as part of the contract. We have been working alongside HCRG to understand the implications for the management of the hospice and any potential satransfers of responsibility.

We have a very successful month with awards and recognition externally, our Ops Managers have collectively won the Proud2bOps Operational Improvement Initiative of the Year. Although they've all only been in post for a relatively short space of time, they have helped to deliver some impressive service improvements.

We are also celebrating being awarded Gold by the National Joint Registry (NJR) for the ninth year running. The NJR Quality Data Provider certificate scheme offers hospitals a blueprint for reaching high quality standards relating to patient safety, and rewards those who have met the registry's high targets in the

achievement of the quality of the data collected about joint replacement patients. Improving patient safety is of the upmost importance to our Trust and something we take very seriously.

Dr William Garrett, one of our Consultant Anaesthetists has won the Evelyn Baker Award recognition from the Association of Anaesthetists of Great Britain and Northern Ireland. This award is given to individuals who set themselves apart from peers by demonstrating excellence in teaching, training and supporting colleagues.

NHS Salisbury NHS Foundation Trust

Report to:	Trust Board (Public)	Agenda item:	2.1
Date of meeting:	05th December 2024		

Report title:	Integrated Performance Report			
Status:	Information	Discussion	Assurance	Approval
			Yes	
Approval Process: (where has this paper been reviewed and approved):	Niall Prosser, Chief Operating Officer			
Prepared by:	Lyndsey Adamek, Operational Performance Lead			
Executive Sponsor: (presenting)	Mark Ellis, Chief Finance Officer Niall Prosser, Chief Operating Officer			
Appendices				

Recommendation:

The Trust Board are asked to note the Trust's operational performance for Month 7 (October 2024).

Executive Summary:

Breakthrough Objectives

- *Time to First OP Appointment* reduced from 135 to 130 days and is now at lowest point since January 2023 and continues below baseline of 139 days since adoption in April 2023.
- *Managing Patient Deterioration* increased from 46.2% to 48.7% and sustains incremental improvement since adoption in April 2024 against the revised target of 60% (from 50%).
- *Staff Turnover* reduced marginally from 18.8% to 18.7% which continues progress and now a total 1.7% improvement since adoption in April 2024 against the target of 15%.
- *Productivity* improved its position for the fourth consecutive month from -15.9% to -15%. The Trust recorded an in-month control total deficit of £0.8m against an original deficit target of £0.4m - an adverse variance of £0.4m.

Deteriorating Performance

- Emergency Department (ED) metrics were alerting for contrasting reasons:
  - *ED 4-hour Performance* improved from 68.6% to 69.2% but remains under trajectory of 77.8%.
  - *Ambulance Handover* time increased from 25 to 26 minutes.
  - *Attendances* increased from 6,608 to 6,879 and comparatively 408 higher than October 2023.
  - *Ambulance Handovers >60 minutes* increased for third month in a row from 78 to 102.
  - *Arrival to Departure >12 hours* decreased for third month in a row from 56 to 45.
- *No Criteria to Reside (NCTR)* continued monthly increase to 108 average patients and is now 5 months of successive growth therefore concern over variance from operational plan trajectory.

- *Income* the Clinical income position is below plan year-to-date with underperformance across all of the main commissioners, with the exception of Specialised commissioning. This is driven by lower Elective Inpatients impacting on the ERF income partially offset by overperformance on Day Cases activity.
- *Referral to Treatment (RTT)* waiting list metrics worsened:
    - Patients waiting *>65 weeks* increased from 19 to 43 with plans being made to clear ahead of revised target: Zero by end of December 2024 (from September).
    - Patients waiting *>52 weeks* increased from 879 to 927 although progress continuing to reduce overall cohort number ahead of target: Zero by end of March 2025.

Alerting Metrics

- Number of *High Harm Falls* increased from 2 to 5 against the target of 0 but is within common cause.
- Diagnostic *DM01 Standard* improved from 84.9% to 86.3% and is now above the trajectory plan for the first time since April 2024.
- Staff *Sickness Absence* saw an increase to 3.8% and the highest point since January 2024 signalling that winter is upon us.
- *Stroke Care* – the percentage of patients arriving on the Stroke Unit within 4 hours remains static at 59% against a target of 90%.
- *Incidents,* there is an increasing trend in the number of high harm incident reports. No themes have emerged from yet and it is possible the increase is as a result of good reporting culture. Reporting is monitored through the daily incident huddle with patient safety reviews (PSR) completed for all incidents where moderate harm is reported to have potentially occurred.

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

Integrated Performance Report

December 2024

(October 2024 data)

Our Strategy 2022-26
IMPROVING together

Summary

Salisbury NHS Foundation Trust

The Trust is expecting to formally exit from the Tiering process for Cancer and Diagnostic performance with acknowledgment of the improvements made. For the last reported month (September) the Trust *28-day FDS* performance continues to remain positive at 75% and the *62-day Standard* at 69.8%, both demonstrate much improved positions from earlier in the year and are expected to continue the strong performance. The number of patients waiting *More than 62 days* for Cancer treatment increased slightly from 69 to 78 patients although sustains a significantly improved position since monitoring began earlier in the year. *Note: Cancer data is one month behind, reporting September in this IPR.*

Attendances within the Emergency Department (ED) remained high at 6,878 total in month and continues to be circa 8% higher than the previous year. The *4-hour performance* demonstrated slight increase at 69.2% for combined performance in October, but below target of 77.85%. *Ambulance Handover* performance has slightly decreased marginally to 26 minutes average, although remains a strong performer in the South-West region. Contributing factors to ED performance included challenges to flow as the average number of patients with *No Criteria to Reside (NCTR)* increased for a fifth consecutive month to 108 against a target of 26. Replacing the previous *Bed Moves* data, for the first time the IPR now includes the use of *Temporary use of Escalation Beds and ED corridor care*.

Diagnostics *6-week Standard (DM01) performance* increased to 86.27% and on trajectory towards a year end performance of 93%. The number of breaches (patients over 6 weeks) increased from 642 to 717, which was expected as overdue surveillance patients are now also reported in this metric giving greater oversight of this group of patients. All modalities improved their performance in month and reduced their number of breaches with the exception of Endoscopy who increased from 252 breaches to 485 due to the inclusion of the surveillance patients.

The Stroke care measure of *Arrival on Stroke Unit within 4 hours* performance reduced slightly from 62% to 59% although a modest decrease whilst maintaining an overall improved position for the last seven months. Key variable in performance continues to be Out of Hours patients and overall acuity in the hospital.

There was further progress in the breakthrough objective of *Wait Time to 1st Appointment* reduced from 135 to 130 days, its lowest point since January 2023. The number of patients waiting longer than 65 weeks for elective treatment increased slightly to 43 against a plan of 0. The year-to-date Elective Recovery Fund (ERF) performance is currently at 112% against plan of 117% (against 100% baseline). Underperformance of elective activity is the top contributor, and the Surgical Division are leading on plans to recover this.

Workforce metrics were contrasting, with Trust *Vacancies* standing at 2.2% in October, well below the 5% target and maintaining a consistent improvement for the third month. The breakthrough objective relating to retention measured by *Staff Turnover* also improved, with another small reduction to 18.7% continuing a 6-month trend. Whereas the *Sickness Absence* rate increased to 3.8% at the 15-month average.

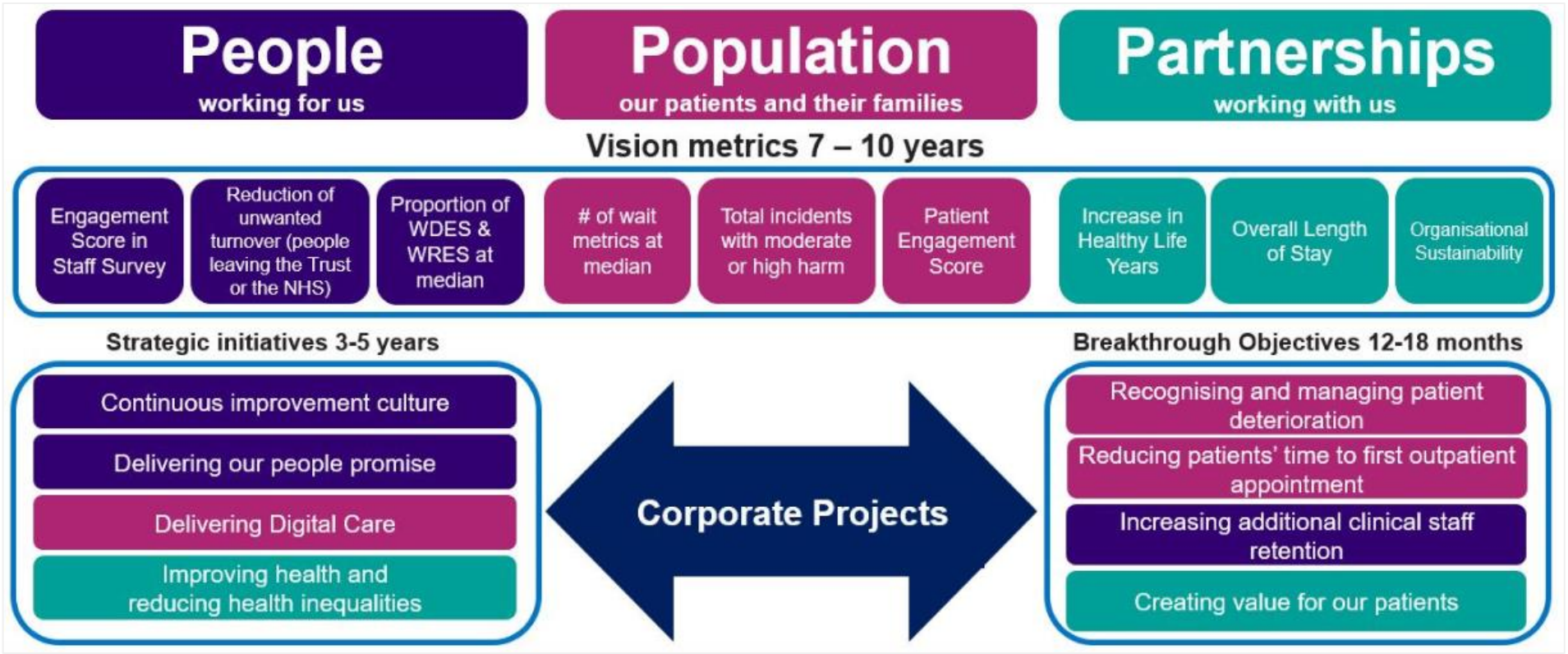
The quality related breakthrough objective of *Managing Patient Deterioration* reported the highest performance since adoption at 48.7% and remains close to the revised target of 60%. The metric has been adjusted to incorporate all NEWS2 observation scores ranging from 3-6 (previously only 5 and above). *Pressure Ulcers* saw a further decrease from its peak in August at 4 down to 2, with the Trust identification of Pressure Ulcers (from the 1st October 2024) seeing an update in practice to follow the national recommendations. The cause of reduction cannot be attributed to this change alone and appears in line natural variation.

The Trust breakthrough objective of Creating value for our Patients improved its position for the fourth consecutive month from -15.9% to -15%. The Trust recorded an in month control total deficit of £0.8m against an original deficit target of £0.4m – an adverse variance of £0.4m.

Strategic Priorities

NHS Salisbury NHS Foundation Trust

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



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. 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	Trust wide area of focus for the next 12-18 months. We are striving for an improvement of more than 30% in the metrics over this period.
Key Performance Indicator (KPI)	Key metric that is monitored as part of the NHS National Operating Framework and 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 address worsening performance or celebrate achievement if 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.

Part 1: Quality of Care, Access and Outcomes

Performance against our Strategic Priorities and Key Lines of Enquiry

Our Priorities

People

Population

Partnerships

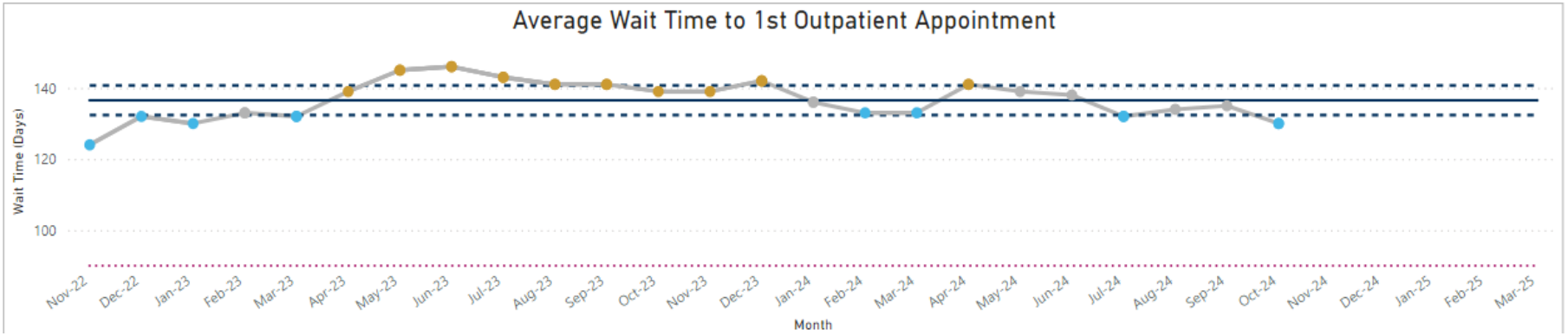
Reducing Patients' Time to First Outpatient Appointment

NHS Salisbury NHS Foundation Trust

Breakthrough Objective

We are driving this measure because… **Baseline: 139 days (April 2023)**	SFT has a growing waiting list with increased numbers of patients waiting longer for their care and has not met the 92% Referral to Treatment (RTT) 18-week 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.

Target: ≤90 days Performance: 130 days Position: Special Cause Improvement



Understanding the Performance

Time to first outpatient reduced to 130 days, the lowest level since December 22 and is now showing a trend of improvement.

Women & Newborn and CSFS have seen a consistent improvement over the last 6 months, Surgery remain in common cause variation but improved in month, however Medicine have increased for the third month in a row.

All 3 focus specialties are showing improvements:
Urology – reduced to 150 from 191 in May 24
Colorectal – improved to 123 from 200 in Oct 23, however fairly static over the last 6 months
Oral Surgery – improved to 145 from peak of 167 in June 24.

Countermeasure Actions	Due Date
• Maintain engagement with stakeholders from Booking and the 3 chosen specialties. Continue to review how they will feed into PCB alongside Stuart Henderson.	Ongoing
• Continue to develop countermeasures with each sub-workstreams and develop the project plan to support this.	30th Nov
• Development of PID to outline what activities we plan to focus on, who needs to be involved, what are the timeframes and how will we measure the impact of these deliverables.	30th Nov

Risks and Mitigations

- Increased waits in specialties other than the 3 focus specialties may cause an increase or slower improvement in the overall Trust time to first outpatient, regardless of impact in the 3 focus areas.
- Staffing levels in the booking teams may prevent pace of work required to achieve sufficient reduction.

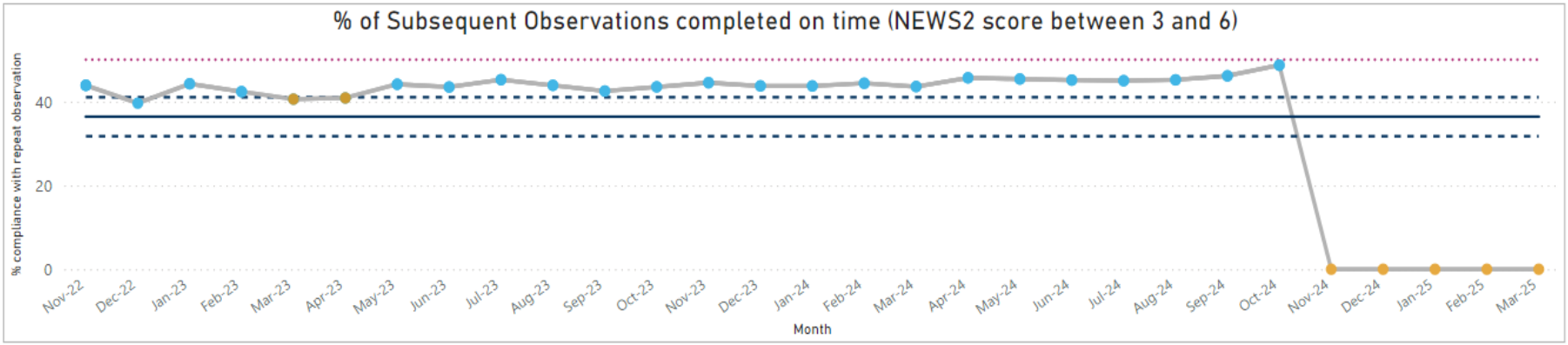
Recognising and Managing Patient Deterioration

Salisbury NHS Foundation Trust

Breakthrough Objective

We are driving this measure because… **Baseline: 45.7% (April 2024)**	Improving the early recognition of patient deterioration is a multidisciplinary team activity and comprises of three recognised steps – **Record, Recognise and Respond.** The first step is regular measurement and recording of clinical observations and in line with recommendations from the *Royal College of Physicians* and *Academy of Medical Royal Colleges*, frequency of these physiological measures is determined by the NEWS2 score. Monitoring trends in both the patient's physiology and NEWS2 score will provide information to the clinical teams to triage workload and to identify potential patients at risk of deterioration. Our aim is to improve upon the current compliance for the recording of these measures with reductions in both mortality, morbidity and late escalations of care.

Target: ≥50% Performance: 48.7% Position: Special Cause Improvement



Understanding the Performance

Please note new measure to incorporate NEWS2 scores of 3 to 6

From April 2024 the divisional teams have been undertaking work to improve the compliance with frequency of undertaking clinical observations – RECORD. Frequency is a nationally set standard which is determined by NEWS2 . This new measure has allowed us to see that there has been a gradual improvement in compliance over time. Performance now sits at 48.7%.

The Escalation group continues to work on elements of RECOGNITION and RESPOND to patient deterioration.

Countermeasure Actions	Due Date
• **RECORD:** Analyse the audit data via Tendable.	January 2025
• **RECOGNISE:** To continue rolling out the training programmes and develop curriculum for 2025. Evaluation of POET review at the daily huddle	February 2025
• **RESPOND:** Carry out a PDSA cycle around the documentation of escalation responses on a surgical ward.	January 2025

Risks and Mitigations

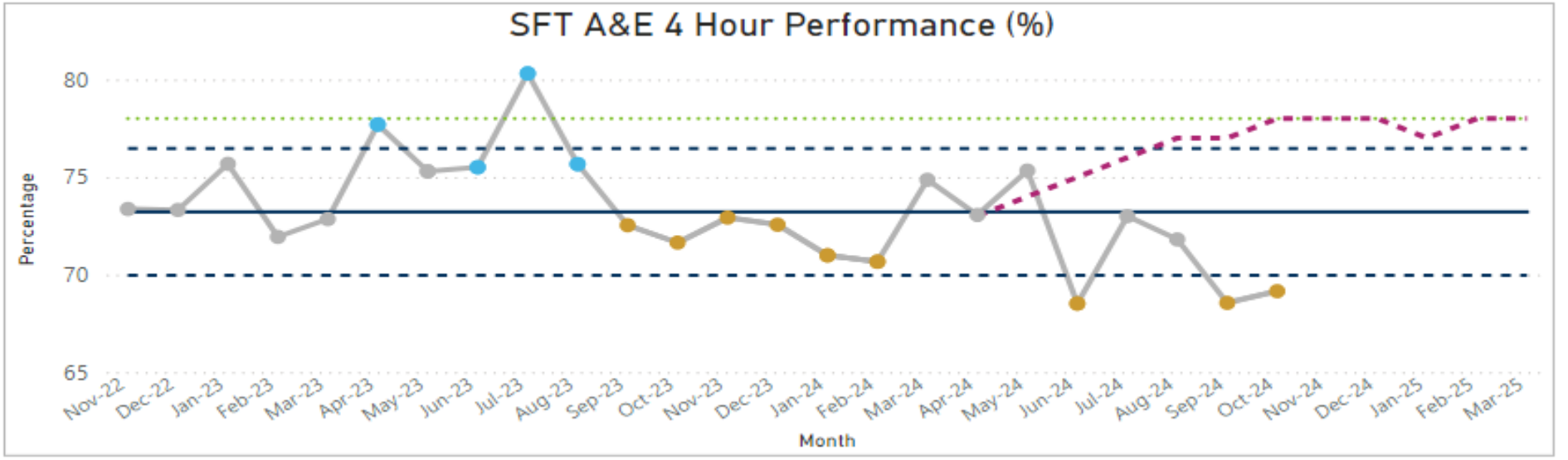
There is still a risk of unrecognised deterioration which may lead to patient harm. However, whilst we continue to learn and improve, other measures allow us to monitor the risk including:

- Overall mortality rates are decreasing.
- Cardiac arrest rates remain low.
- Medical emergency Team calls increasing signaling around earlier recognition.
- Unplanned admissions to ITU from the wards is low.

Emergency Access 4-hour Standard

Salisbury NHS Foundation Trust

Target: ≥78% Performance: 69.1% Position: Special Cause Concern

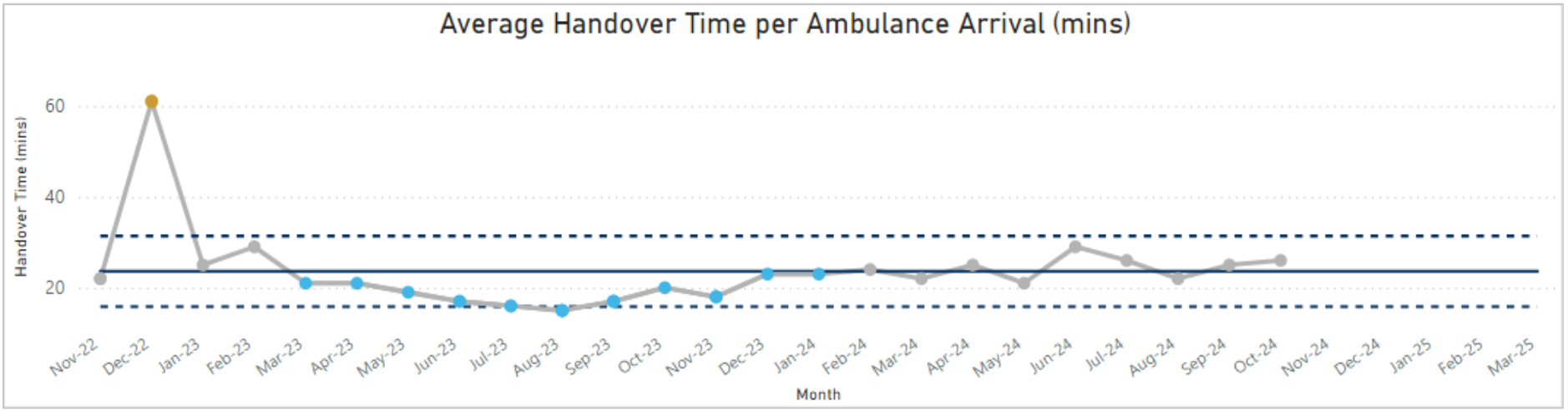


Understanding the Performance	Countermeasure Actions	Due Date	Risks and Mitigations
Trust delivered a small improvement in month. Attendances remained static at an average of 156 patients per day which represents an increase of 5.8% compared to M7 in the previous year. Within the month, the first and second weeks remained in line with the increased trend, however there was a slight reduction in the remaining two weeks, with several days (in isolation) seeing a total of around 130 attendances, in which the department was able to achieve its 4-hour target at >80%. Overall performance remains affected by the number of patients awaiting admission occupying 329 hours of the total 360 which the emergency department have available to clinically assess and treat patients. The average length of stay in the department was 7 hours 50 min, evidencing flow of patients through the department continues to be a contributing factor in the achievement of the 4-hour target.	• Continue to develop the junior workforce with focus on Band 6's and 7's to lead the department efficiently and effectively consistently. • Establish working groups to work on the workstreams identified from the Overcrowding A3. • Continue to explore streaming direct to assessment units and to community services including the WIC • Finalise and plans for the transfer of the Minors service to the current Rapid Assessment Treatment and Triage (RATT) / Ambulatory space. • Finalise business case to support medical staffing following Demand and Capacity modelling with support from ECIST.	Ongoing Dec 2024 Jan 2025 Dec 2024 Dec 2024	• Current medical model unable to meet rising demand. ECIST support creation of correct model and plans in place to mitigate this risk. • Risk also includes entering winter pressures with risk of continuation of deteriorating performance. Winter plan launching to help support front door flow with a dedicated discharge lounge, increased medical ambulatory space and streaming to services outside of the department.

Ambulance Handover Delays

NHS Salisbury NHS Foundation Trust

Target: ≤15 mins Performance: 26 mins Position: Common Cause



Understanding the Performance
Average handover times have risen slightly to 26 minutes with 38.6% of patients were handed over within the target time of 15 minutes. However, patients handed over within 30 minutes improved from 78.1% in M6 to 84% in M7. 92% of patients were handed over within 60 minutes. The number of patients arriving by Ambulance remained static at 1,273 at an average of 41 patients conveyed per day. The continued declining position highlights that processes in the department require review, including the process of off-loading ambulances through RATT and the need for triage of patients conveyed by ambulance.

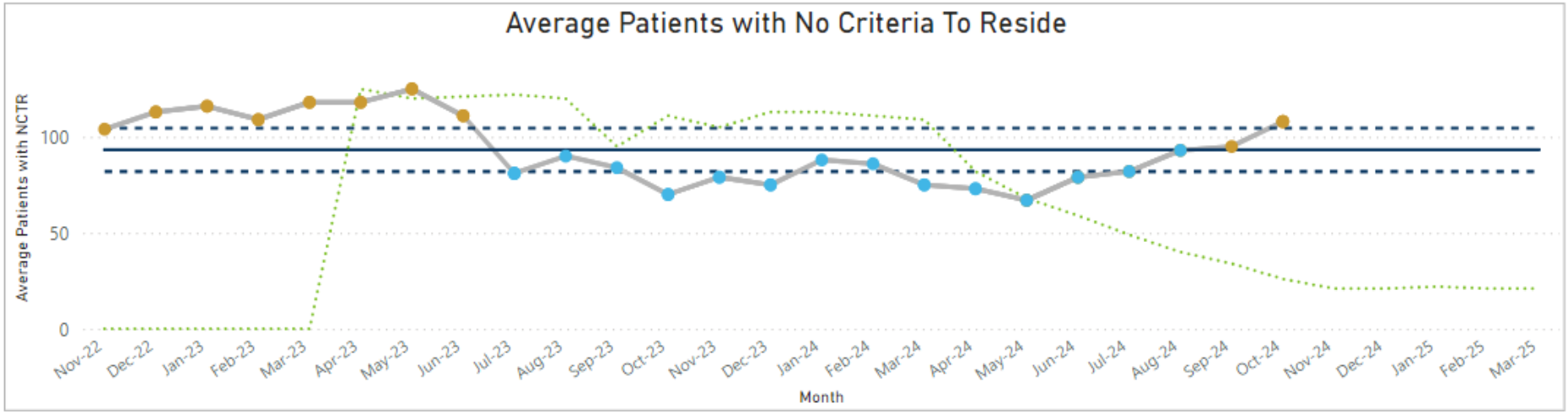
Countermeasure Actions	Due Date
• A review of Streaming within the department will provide opportunities to explore efficiencies for ambulance offloads	Dec 2024
• Finalise and sign off plans for the exchange of the Rapid Assessment Treatment and Triage (RATT) area with the current Minors space. With the aim to provide an additional offload cubicle and address the 'bottleneck' when multiple attendances arrive at the same time.	Dec 2024
• Trial and refine the Rapid Handover SOP which involves Trust wide response to the South-West Ambulance Service (SWAST) SOP of offloading patients (meeting a certain criteria) who have been waiting 75 minutes for handover.	Nov 2024

Risks and Mitigations
• The implementation of W75 on 20/11/24. Mitigated by the implementation of Trust Huddles within the Emergency Department to agree a Trust wide response to the pending rapid offload. • Current agreement with SCAS that SFT will work to the same policy as SWAST and agree W75, although no official timeframe has been specified by SCAS at present.

Optimising Beds

NHS Salisbury NHS Foundation Trust

Target: ≤25 (5%) Performance: 108 Position: Special Cause Concern



Understanding the Performance
The average number of patients with No Criteria to Reside (NCTR) has risen to 108. The internal referral time for patients with NCTR remains static at 1.4 days. Overall Length of Stay (LoS) remains static, with the average LoS to NCTR declaration decreasing slightly. Average delayed LoS has also reduced slightly. Average (of those delayed) bed-day delays by pathway: • P0 – 10 days; P1 – 9 days; P2 – 7.6 days; P3 – 25 days. P0 are being driven primarily by Spinal Patients waiting for housing. P3 delays have decreased in month. Note: ED attendances continue to remain high.

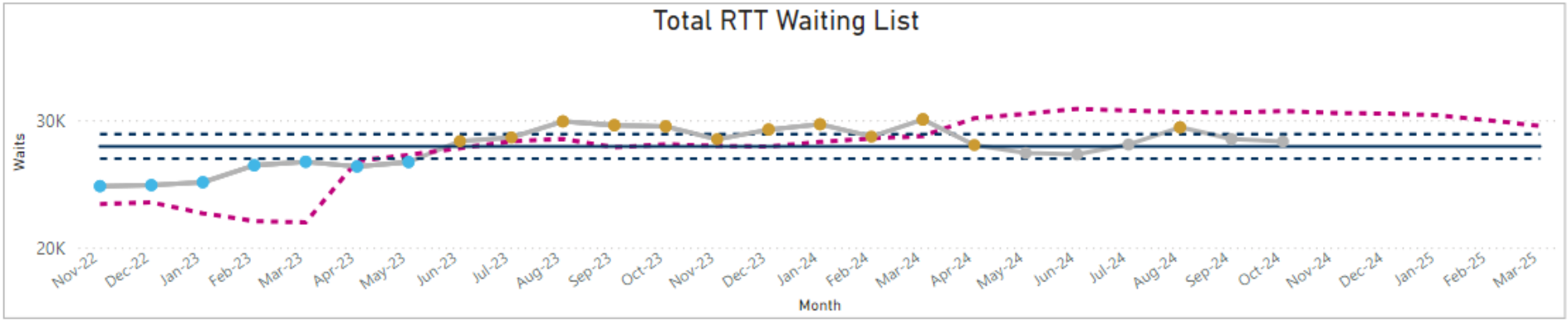
Countermeasure Actions	Due Date
• Ongoing work to reduce time from NCTR to referral, more detailed work being carried out over the next 12 weeks to focus on quality of referral etc	Ongoing Feb 25
• Digitisation of Decision to Admit (D2A) process to go live Jan 25 (delayed due to CMB not meeting in Dec).	Jan 25
• Breamore ward team working to reduce Length of Stay (LoS) and prevent deterioration of patients waiting packages of care.	On going
• External review of ward processes to triangulate with internal improvement program.	Complete
• Ongoing training with ward and clinical staff regarding daily use of whiteboards.	Ongoing
• System working to reduce time for NCTR patients to be allocated beds.	Ongoing

Risks and Mitigations
• External conflicts such as reduction in capacity in local authority social care teams and financial constraints. • Changes to community model. • Clinical capacity and demand conflicts. • Clinical engagement.

Total Elective Waiting List (Referral to Treatment)

Salisbury NHS Foundation Trust

Target: ≤30,503 Performance: 28,332 Position: Common Cause



Balancing Metric	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24	Apr-24	May-24	Jun-24	Jul-24	Aug-24	Sep-24	Oct-24
Longest waiting patient	200	194	153	139	110	94	72	68	73	74	78	83	73	74

Understanding the Performance

The Referral to Treatment (RTT) waiting list reduced for the second consecutive month from 28,519 to 28,332 and maintains position below the trajectory of 30,721. A total 62.4% of patients were under 18 weeks.
The long wait reduction target of zero patients waiting more than 65 weeks by the end of September has been extended to December and the Trust had 43 patients in October, with plans to clear these and any remaining to meet the revised target, before working towards 52 weeks.

Specialties with notable variation to waiting list:
- Oral Surgery (-323)
- Respiratory (-118)
- Ophthalmology (-112)
- Rheumatology (+123)

Countermeasure Actions

Countermeasure Actions	Due Date
• Quantify the work required to validate all patients currently assigned with non-RTT status in surgical waiting list and explore options to resolve.	31/12/2024
• Continue weekly access meeting to focus on reducing long waits of patients in line with national targets: Zero waiting >65 weeks by the end of September 2024, Zero waiting >52 weeks by the end of March 2025 and Zero waiting >78 weeks as standard.	Ongoing
• Work with Trust CCS software to improve waiting list management by enhancing reports (Pre-Op status, Access plan creation date, Duplicate access plans, non-RTT patients).	Ongoing

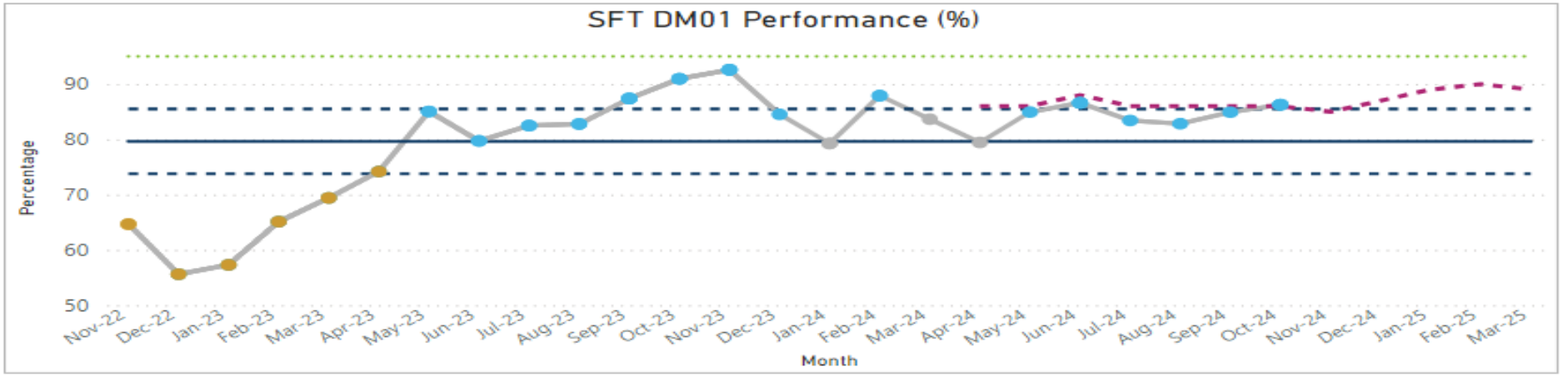
Risks and Mitigations

- Risk of long wait patients having incorrect status (particularly non-RTT) needs full review and action plan to mitigate – Linked to action reference developing Trust CCS software.
- Risk of lost capacity owing to any future industrial action remains – Being monitored.
- Risk of increase to waiting list through IA by GPs and action to stop providing advice and guidance, being replaced with direct referral – Being monitored.
- Weekly Access Meeting continuing with aim to reduce risk of long waiters and drive towards national reduction targets.

Diagnostic Waiting Times

NHS Salisbury NHS Foundation Trust

Target: ≥95% Performance: 86.3% Position: Special Cause Improvement



	%	Over 6 weeks		%	Over 6 weeks		%	Over 6 weeks		%	Over 6 weeks
MRI	92.6%	63	Dexa	100%	0	Colonoscopy	42.3%	303	Urodynamics	52.2%	33
CT	95.0%	29	Neurophysiology	100%	0	Gastroscopy	81.2%	29	Cystoscopy	100%	0
Ultrasound	99.4%	8	Echo	92.3%	23	Flexi Sigmoid	36.5%	153	Audiology	87.2%	76

Understanding the Performance

DM01 performance improved in M7, reporting 86.27% vs a position of 84.92%. Of note the number of breaches (patients over 6 weeks) increased from 642 to 717. Whilst breaches increased, an overall increase in the waiting list size contributed to the improved % compliance. Waiting list size increased due to increases in most modalities but notably in USS and Endoscopy. The former due to the team ensuring a balance between overtime cost and waiting time, sustaining a 4-5 week wait as opposed to 2-3 weeks and Endoscopy due to overdue surveillance patients now reporting into the DM01 position.

All modalities improved their performance in month **and** reduced their number of breaches with the exception of Endoscopy who increased from 252 breaches to 485 (circa 200 of which due to overdue surveillance now being reported).

Countermeasure Actions	Due Date
• Endoscopy insourcing arrangement due to increase capacity from M9.	M8-M12
• Cardiac MRI outsourcing to continue as planned throughout M8 and M9.	M8
• USS CDC capacity online and to be prioritised for booking to ensure capacity is fully utilised.	M8
• Echo Team continue to explore improved capacity for remain TOE breaches.	M8-M12

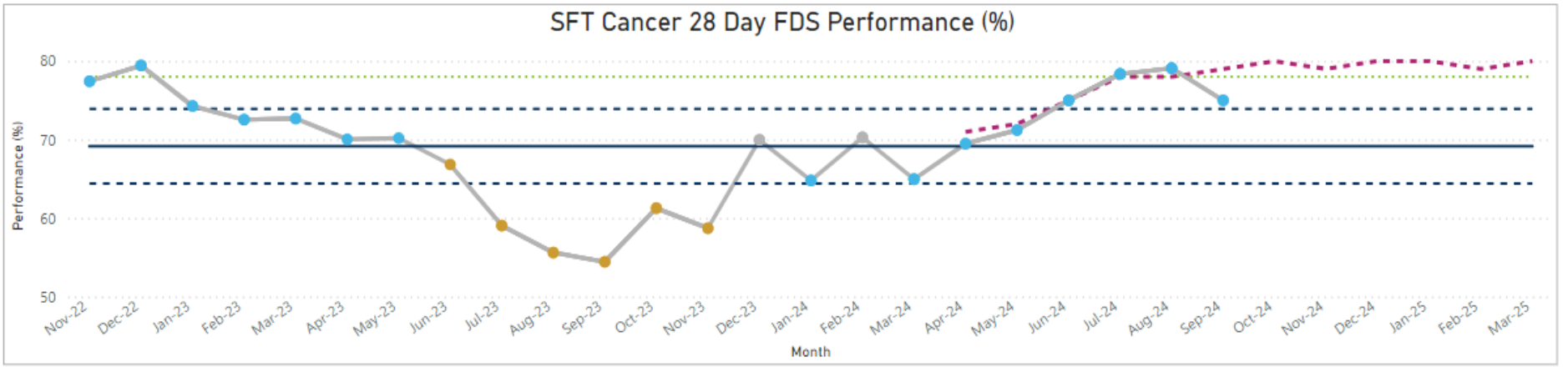
Risks and Mitigations

- Many modalities remain reliant on in / out - sourcing and / or overtime of substantive staff to sustain capacity.
- All other overdue surveillance to be reported from M8 (alongside Endoscopy the other modality of volume is Audiology). Analysis of impact being monitored weekly through Delivery Group.

Cancer 28 Day Faster Diagnosis Standard

NHS Salisbury NHS Foundation Trust

Target: ≥78% Performance: 75.0% Position: Special Cause Improvement:

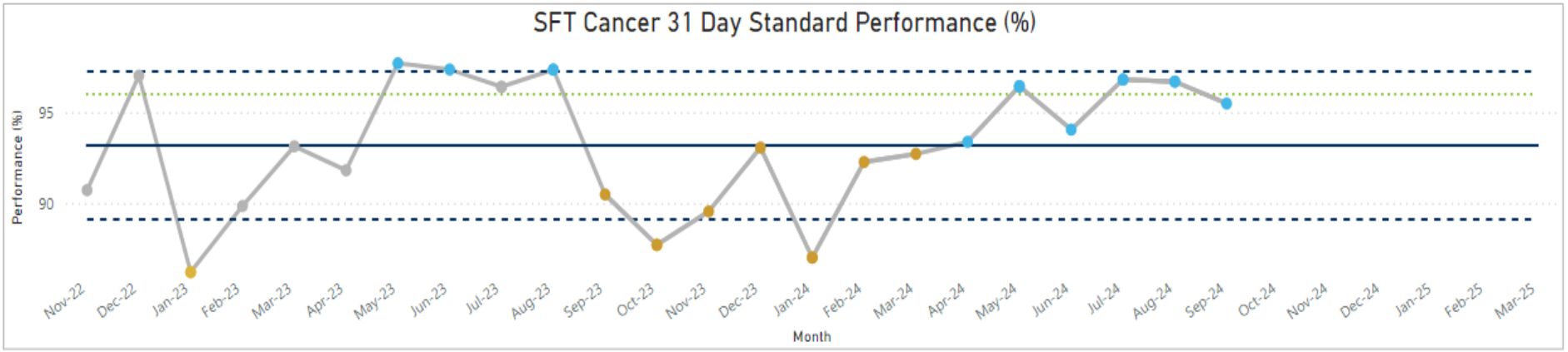


Please note: The performance data is subject to quarterly and six month revisions, this can lead to updates in past reported performance. Changes to shared data at other Trusts can cause variation between the national and internally reported performance.

Understanding the Performance	Countermeasure Actions	Due Date	Risks and Mitigations
28-day performance standard at month-end was a position of 75%. Pathways found not to be achieving the standard as follows: • Lower GI: 48% • Gynaecology: 77.7% • Haematology: 20% • Head & Neck:73.4% • Urology: 58.1% Lower GI continues to be challenged by complex pathways and capacity constraints within the Bowel Cancer Screening pathway. Urology performance predominantly driven by Prostate diagnostic pathway. Early indications are that October performance is expected to recover closer to target and trajectory.	• Maintain regular site-specific 'Faster Diagnosis touch-point' meetings. • Maintain sufficient Breast and Skin capacity for first appointments to support overall Trust delivery of FDS. • Analysis of delivery against 'best practice timed pathway' milestones underway for Lower GI, with BSW-wide analysis anticipated during November '24. • Development of FDS 'A3' in place for Lower GI, Head & Neck, Gynaecology, Skin and Lung completed. Further A3s for Urology and Haematology under development, with discussion via Cancer Improvement Group. • Impact of BSW-wide Bowel Cancer screening pathway alongside LGI FDS performance remains ongoing.	Monthly Monitored weekly Q3 2024/25 Q3 2024/25 Ongoing	• Skin service remains vulnerable to demand and capacity. Additional insourcing capacity in place from November '24. • Breast Cancer Awareness month October '24. Service lead continues to monitor demand vs capacity. • Resource within MDT cancer services team remains challenging in terms of capacity. Transformation Funding bid successful recruit fixed term Assistant MDT Co-ordinator posts; start dates anticipated over November / December '24. • Cancer Escalation Policy routinely in use across all tumour sites. • Cancer Waiting Time Validator post approved (Cancer Transformation Funded), with recruitment underway. Role will support completion of FDS breach validation and in turn data quality.

Cancer 31 Day Standard

Target: ≥96% Performance: 95.5% Position: Special Cause Improvement

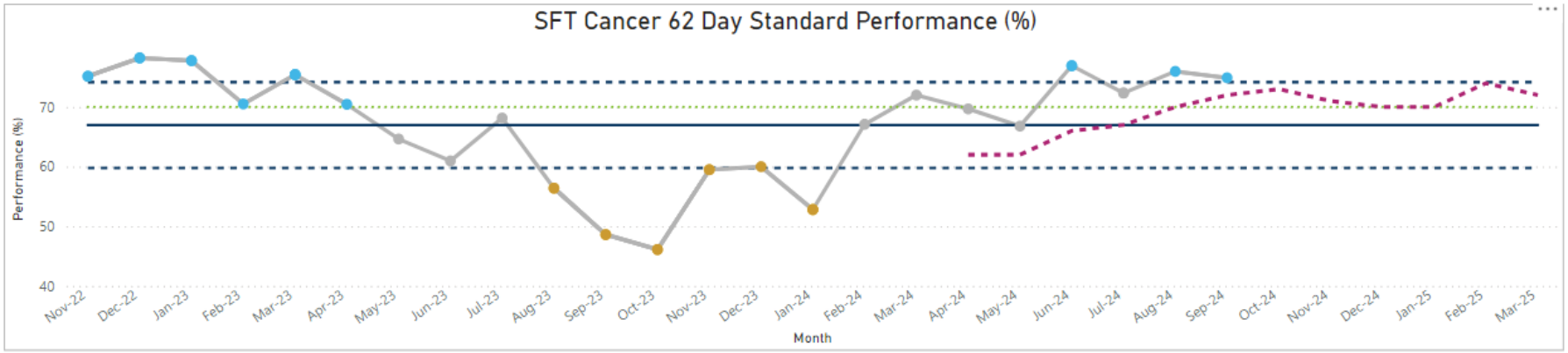


Please note: The performance data is subject to quarterly and six month revisions, this can lead to updates in past reported performance. Changes to shared data at other Trusts can cause variation between the national and internally reported performance.

Understanding the Performance	Countermeasure Actions	Due Date	Risks and Mitigations
31-day performance has deteriorated during M6, with month-end position of 95.5%. This represented 9 breaches of the 212 patients treated. The majority of specialties achieved the standard, with the exception of the following: • Lower GI: 92.3% (1 patient not treated within 31 days of DTT). • Head & Neck: 50% (1 patient not treated within 31 days of DTT). • Urology: 89.5% (4 patients not treated within 31 days of DTT).	• Maintain regular PTL meetings to ensure improved visibility and timeliness of anticipated breaches. • Early escalation of bookings where patient is booked beyond target date. Cancer escalation policy amended to reflect immediate escalation to Divisional Director of Operations.	Daily Ongoing	• Skin service remains vulnerable to demand and capacity issues. • Resource within MDT cancer services team remains challenging in terms of capacity. Transformation Funding bid successful recruit fixed term Assistant MDT Co-ordinator posts; start dates anticipated over November / December '24. • Insufficient capacity within Central Booking department; recruitment ongoing. • Risk of Oncology capacity associated with Aseptics and associated outsourcing, as well as Consultant Oncologist capacity and vacancies.

Cancer 62 Day Standard

Target: >70% Performance: 74.9% Position: Special Cause Improvement:



Patients waiting over 62 days for treatment	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24	Apr-24	May-24	Jun-24	Jul-24	Aug-24	Sep-24
	102	167	119	87	158	145	117	91	73	76	65	61	69	78

Please note: The performance data is subject to quarterly and six month revisions, this can lead to updates in past reported performance. Changes to shared data at other Trusts can cause variation between the national and internally reported performance.

Understanding the Performance

62-day standard in M6 performance was submitted at 69.8% but has been validated up to 74.9% which will be reflected in the next national quarterly report.

135.5 patients were treated in total against the 62-day standard in M6, with 34 patients not meeting the standard. Notable specialty performance as below:

- Lower GI: 66.7% (2.5 breaches / 7.5 patients).
- Gynaecology: 62.5% (3 breaches / 8 patients).
- Head & Neck: 50% (1 breach / 2 patients).
- Lung: 57.1% (4.5 breaches / 10.5 patients).
- Urology: 61.4% (13.5 breaches / 35 patients).

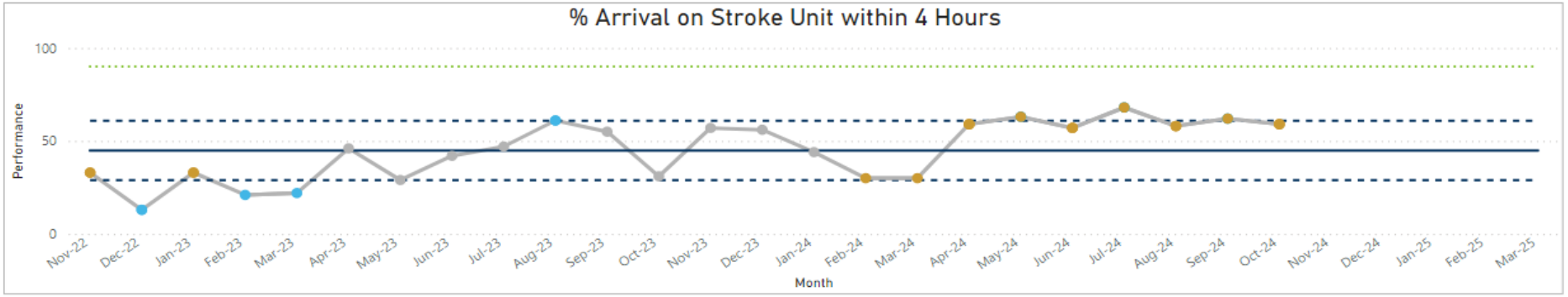
Countermeasure Actions	Due Date
• Sustain robust weekly tracking list meetings, with improved resilience and standardisation across all tumour sites	Weekly
• Backlog trajectories agreed for each tumour site, with stretch target of 6% of overall PTL size >62 days. Aspirational figure provided to each specialty to support focussed delivery of backlog reduction.	Monitored weekly
• Amendment to Cancer Escalation Protocol completed to support facilitation of immediate escalation of patients booked to breach to Divisional Director-level.	Ongoing

Risks and Mitigations

- Whilst there remains focus on reducing 62-day backlog, 62-day compliance will be impacted. Aiming for <6% of PTL size for patients >62 days in their pathway.
- Noted resource within MDT cancer services team remains challenging in terms of capacity.
- Risk associated with Oncology capacity associated with Aseptics and associated outsourcing as well as Consultant Oncologist capacity and vacancies (UHS).
- Insufficient PSMA-PET capacity (via Alliance Medical) detrimentally impacting Urology pathways and backlog; escalation remains ongoing with datix incident reporting where applicable.
- High volume of patients opting for Surgery for treatment of Prostate cancer, resulting in increased demand and insufficient robot capacity at tertiary centre.

Stroke Care

Target: ≥90% Performance: 59% Position: Special Cause Improvement



	2022/23 Q2	2022/23 Q3	2022/23 Q4	2023/24 Q1	2023/24 Q2	2023/24 Q3	2023/24 Q4	2024/25 Q1
SSNAP score	C	C	C	B	A	B	C	C

Understanding the Performance

4 Hour Performance

M7 performance was 59%, which is a 3% decrease on M6. This represents a modest decrease which is within expected variation. Key variable in performance continue to be Out of Hours (OOH) patients and overall acuity in the hospital.

Key Themes from the Data:

- 18 of 32 patient were OOH: of these, 9 failed to make 4-hour performance.
- Of the 4 patients not meeting performance in hours, 1 of these was due to bed capacity issues

Therapy Minutes

New SSNAP changes have now come into effect, which historic data on therapy minutes averages available from next month. Current unvalidated average for October is 32 minutes, down from 47 minutes the previous month due to staff vacancies.

Countermeasure Actions

	Due Date
• **OOH Performance**: Programme for delivering training is well-developed for nursing teams, with a study day taking place at least quarterly. Focus for the coming year is Registrar training for symptom diagnosis in ED. This will be worked on through improving together methodology.	01/01/25
• **Therapy Minutes Driver Metric:** This will now be a driver metric for improving together with an initial target of 2 hours per day per stroke patient with a vision metric of meeting the national target of 3 hours.	01/12/24
• **Therapy Use of Volunteers and Students:** Current initiatives are focused on utilising students and volunteers to support therapy staff. Students will be joining in January for 6 weeks to help with the open gym where patients can complete rehab. A Pilot scheme in the summer showed this boosted intensity of motor minutes. Ward volunteers will help run the group sessions which will free up a member of staff.	01/02/25
• **CT profusion Business Case:** To improve identification of patients a case is being developed to introduce a CT profusion service to the hospital.	01/01/25

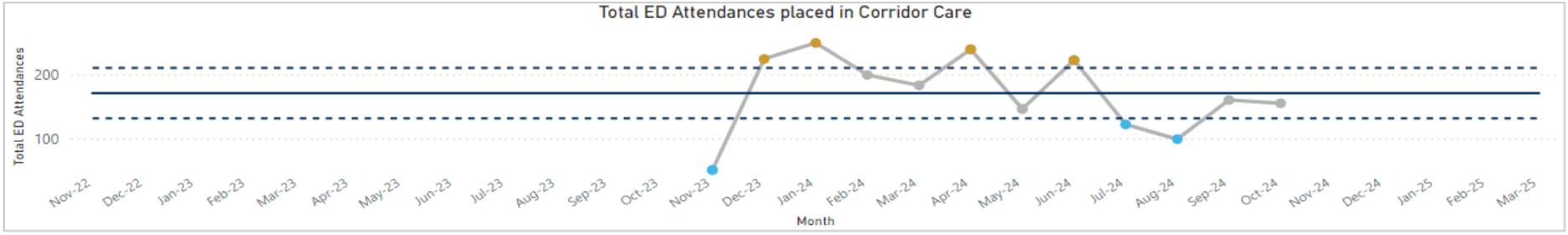
Risks and Mitigations

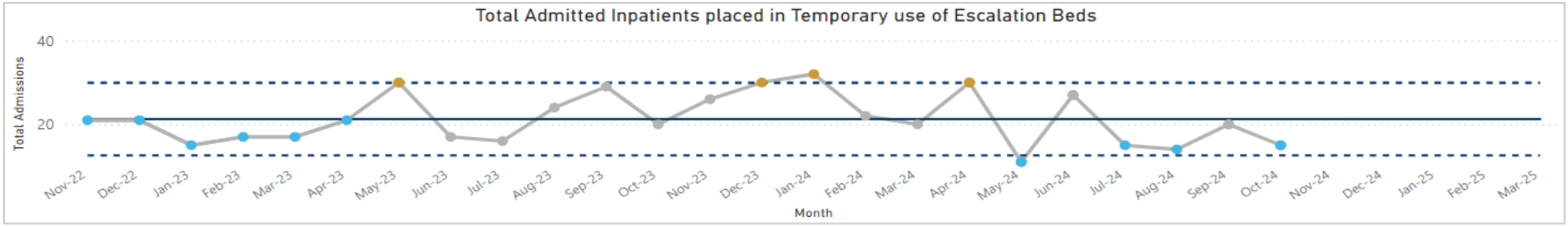
- OOH cover is a continuing risk contributing to the Trust's 4-hour performance, this includes doctor cover (and their ability to deliver reviews in the appropriate timeframe), and B6 Stroke nurse liaison with ED, which is not covered during OOH. Mitigations of communication and education are continuing.
- Bed Flow / LS: the Stroke Unit's LoS is 14 days for August. Driver metrics for the unit are before midday discharges, with a view to improving bed flow. A key driver for performance has been identified as EDS timing. Doctors have been invited to the huddle to identify areas in the process where EDS's have been delayed.

Temporary use of Escalation Beds & ED Corridor Care

Salisbury NHS Foundation Trust

Target: 0 Performance: Position: Common Cause





Understanding the Performance

This is the first month of inclusion within the IPR for Temporary use of escalation beds and ED corridor care. This replaces the Bed Moves data.

M7 remains static from M6, at a total of 155 patients cared for within the emergency department corridor at any time during their time in the department.

Total admitted inpatients placed in temporary escalation beds has decreased to 15 from 20 in M6, with the highest seen totals within the past 12 months at 30 and the lowest at 11 patients. The mean sitting at 20.68 patients.

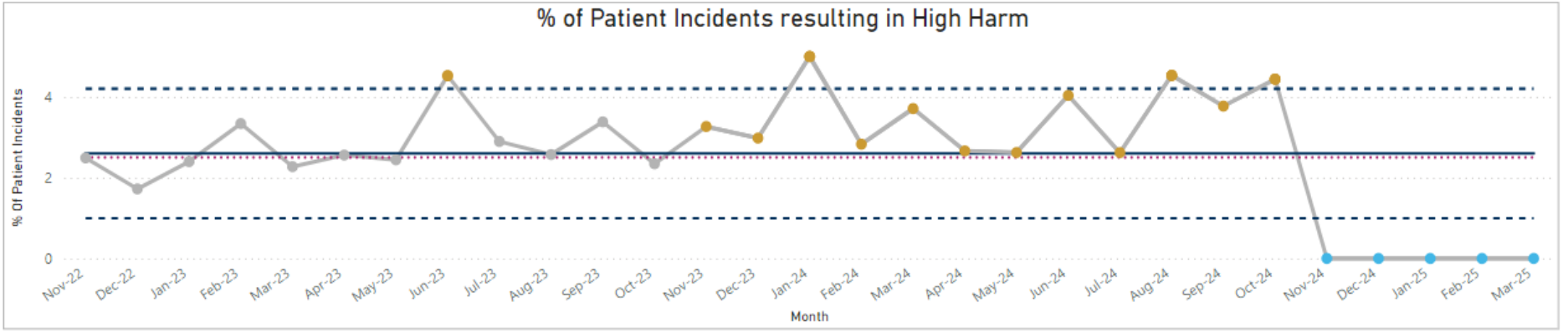
Countermeasure Actions	Due Date
• The inclusion of this data will identify and allow greater monitoring of the use of temporary escalation beds and the impact on overcrowding within the Emergency Department (ED). It will also allow greater understanding of the use of temporary escalation spaces.	Ongoing
• ED continues to progress with their A3, addressing the root causes of overcrowding within the department.	Jan 2025
• The Trust has developed a 'Temporary use of Escalation Beds' Policy which includes reference to the ED corridor care SOP. This document is currently in review at UEC, CMB and CESG. This document will require regular updates as the impact of Wait 75 is felt across the Trust.	Dec 2024

Risks and Mitigations

- Wait 75 is due to be implemented on the 20/11/2024. Trust wide huddles will be held in the Emergency Department to formulate plans to decompress the department and allow for safe ambulance handovers.

Incidents

Target: ≤2.5% Performance: 4.4% Position: Special Cause Concern



Please note the data being presented ends in August 2024 and therefore the markers shown on the x-axis after that point should be ignored.

Understanding the Performance

There were 954 incidents reported in October compared to 919 in September.

In October there were:
32 reported moderate incidents, a decrease of 8 incidents from September (40).

The number of moderate incidents has increased over the last quarter which may be due to the additional vigilance at the morning incident huddle where the previous 24h incidents are reviewed and discussed. This is being closely monitored for any themes in reporting.

There may be a slight fluctuation in the actual % of reported incidents with harm from previous months, due to data validation and conclusions of reviews which occur retrospectively). A patient safety review (PSR) is undertaken for all patient incidents where moderate harm is reported to have potentially occurred.

Countermeasure Actions	Due Date
• Daily morning huddle across all divisions to discuss previous 24 hours incidents and any immediate actions required.	Ongoing
• Weekly Patient Safety Summit (PSS) where all moderate, major and catastrophic graded incidents are discussed.	Weekly
• Patient Safety Reviews (PSR) are undertaken for all cases where moderate or above harm has occurred to patients.	Ongoing
• Consider if information from the PSR immediately identifies an unexpected level of risk or emergent issue/trend and a patient safety incident investigation (PSII) is indicated.	Ongoing
• Learning from incidents forum.	Monthly

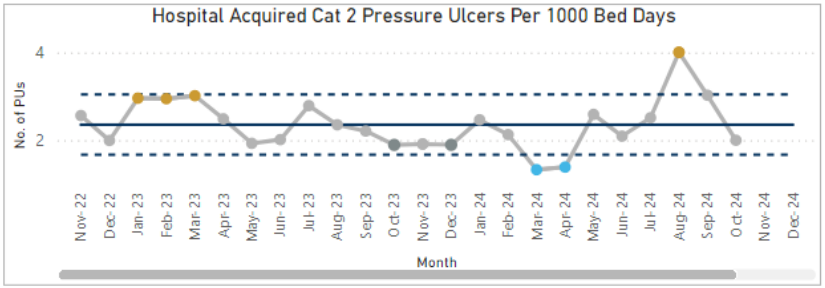
Risks and Mitigations

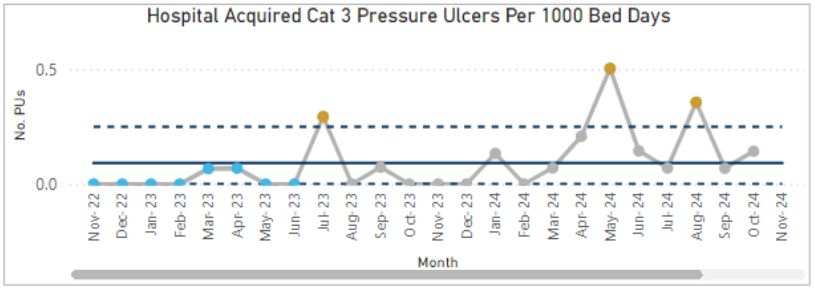
- For CAMHs to be involved earlier with vulnerable adolescents who are under CAMHs care to ensure effective care planning.
- For staff to be vigilant with checking staff members ID badges in all hospital settings.
- An insulin bolus should be a single dose with strict directions for use and should not be on the PRN section of EPMA.

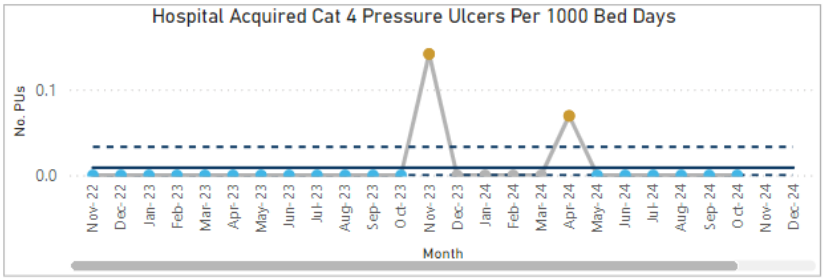
Pressure Ulcers

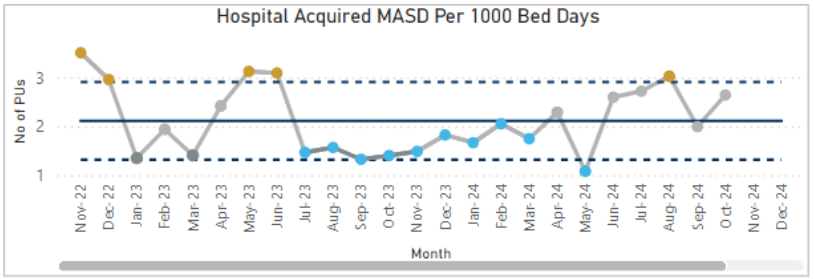
NHS Salisbury NHS Foundation Trust

Target: N/A Performance: 2.0 Position: Common Cause









Understanding the Performance

From the 1st October (2024) the Trust updated practice to follow the national recommendations from the National Wound Care Strategy Programme. The categories Deep Tissue Injury (DTI) and unstageable are no longer referred to. What was known as unstageable will now be identified as a category 3 pressure ulcer. DTIs will continue to be monitored and categorised 1-4 appropriately.

A decrease is seen within all categories of pressure ulcers compared to September.

There was an increase of Hospital Acquired (HA) Moisture Associated Skin Damage (MASD).

71 pressure ulcers were reported as present on admission and 48 incidences of MASD were reported on admission.

Countermeasure Actions	Due Date
• Tissue Viability Nurses (TVN) have reviewed MLE training for pressure ulcers / wounds. The Education department have been contacted with the details of the NHS England eLearning for healthcare program details.	01/01/25
• Second pressure ulcer extraordinary meeting held on the 12th November to review wider concerns with prevention, further meeting TBA.	Ongoing
• MASD Pathway taken for approval to PSSG who recommend pharmacy involvement. TV to arrange this.	01/01/25
• Review of the available wipes/soaps for patient hygiene (TV and Decontamination Leads)	01/01/25
• Suspected deep tissue injury pathway to be completed.	30/11/24

Risks and Mitigations

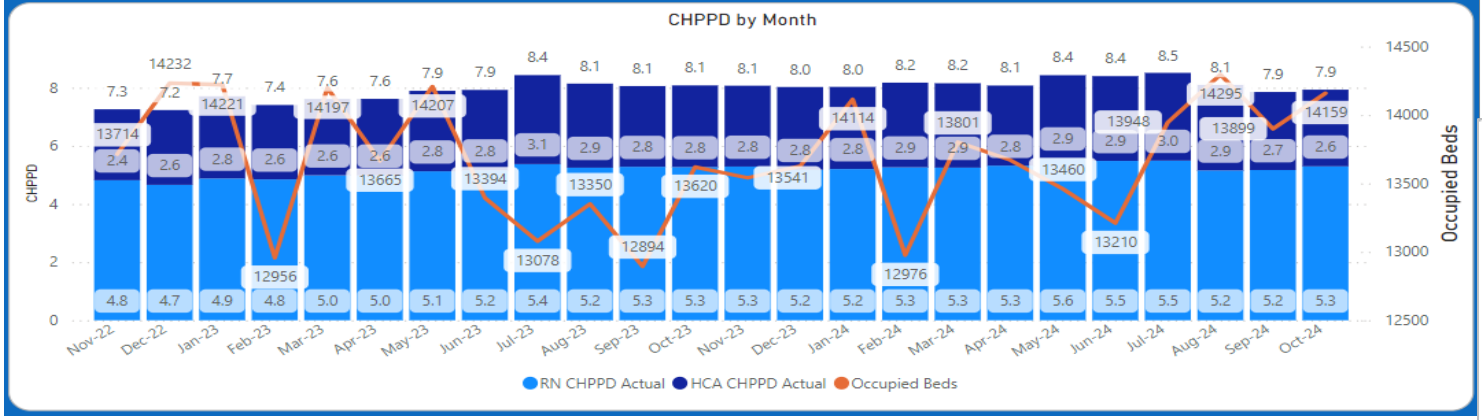
- Current education available on MLE out of date.
- Opportunity on STOP the pressure ulcer day (21st November) to focus on Trust wide review themes.
- Management of suspected deep tissue injurie.

Care Hours Per Patient Per Day (CHPPD)

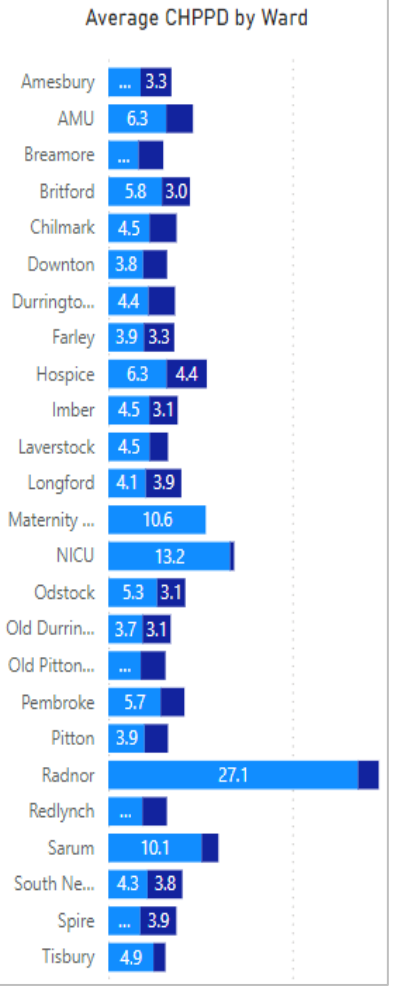
NHS Salisbury NHS Foundation Trust

Target: N/A Performance: 7.9 Position: Common Cause

Latest Month CHPPD	Average CHPPD	Latest Month RN CHPPD	Average RN CHPPD	Latest Month HCA CHPPD	Average HCA CHPPD
7.9	8.0	5.3	5.2	2.6	2.8



Definition: CHPPD measures the total hours worked by RNs and HCAs divided by the average number of patients at midnight and is nationally reported. Note: There is no national target as is a benchmark to review wards.



Understanding the Performance

CHPPD 7.9 in month and 7.4 when excluding critical care and maternity, same as previous month, and continues to sit lower that previous high of 8.5. When reviewed on model hospital (latest data August) we are in quartile 2. We benchmark lower than peers in ICS who are in quartile 3.

Fill rate in month has stayed static except for HCAs day shifts which has decreased to 90% (from 101%). Likely to be reflective of half term which spanned 2 weeks.

Bank temp staffing cost in month increased but actual worked remained static – this is reflective of both pay award for bank. Agency costs increased due to significant RMN demand.

Countermeasure Actions

Countermeasure Actions	Due Date
• SNCT Data collection across all wards in November.	30/11/2024
• Weekly-staffing reviews – focus on additional above establishment.	Ongoing
• Safe Staffing annual review paper to Trust board to align establishments to acuity and demand.	December 2024

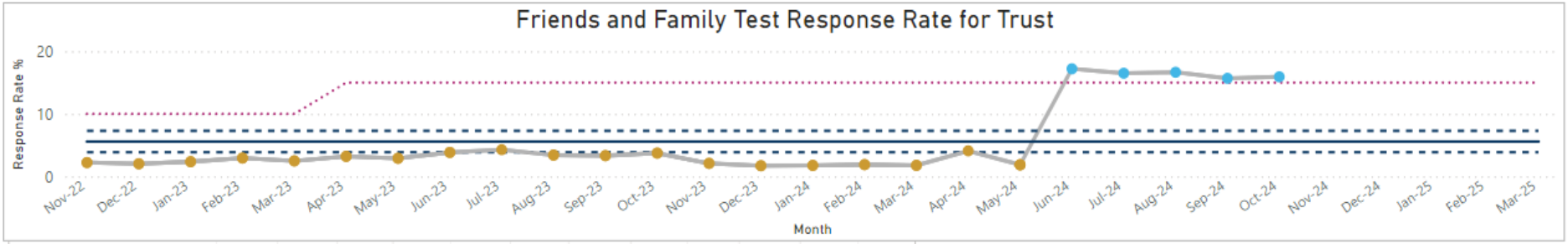
Risks and Mitigations

- Requirement to reduce headcount/temp staffing spend to March 23 position (risk).
- On-going demand for patients requiring RMN support.
- High short-term sickness and on-going unfunded escalation driving temp staff spend (risk).
- OD+P led work on retention, turnover and inclusion (mitigation).
- Successful RN recruitment (mitigation).

Friends and Family Test Response Rate

Salisbury NHS Foundation Trust

Target: ≥15% Performance: 15.9% Position: Special Cause Improvement



Response Rate by Area	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24	Apr-24	May-24	Jun-24	Jul-24	Aug-24	Sep-24	Oct-24
FFT Response Rate - A&E	0.6%	0.9%	0.7%	0.5%	0.5%	0.7%	0.6%	20.6%	20.4%	22.0%	20.7%	21.6%
FFT Response Rate - Day Case	2.4%	2.5%	3.1%	3.2%	3.3%	2.1%	2.9%	3.4%	10.8%	11.2%	6.3%	10.3%
FFT Response Rate - Inpatient	17.2%	10.2%	19.1%	19.7%	17.2%	22.3%	18.5%	10.4%	26.3%	31.8%	21.4%	26.0%
FFT Response Rate - Maternity	0.9%	0.5%	3.8%	0.0%	3.0%	0.5%	0.0%	13.7%	9.7%	10.1%	10.3%	9.5%
FFT Response Rate - Outpatient	1.3%	1.1%	0.9%	1.0%	0.8%	1.0%	0.9%	18.3%	16.4%	16.0%	15.8%	15.6%

Understanding the Performance

Our response rate in October maintained an improved position since the new digital dashboard and SMS message service went live in June, reporting 15.9%.

Our satisfaction rate was 94% so although we met our response rate target, we slightly fell short of our satisfaction rate target of 95%. We don't have full insight on the dissatisfaction at this stage, but we are looking to provide this within future narratives.

Countermeasure Actions	Due Date
• SMS messages are sent to all eligible patients attending our maternity services, Outpatients and ED This has demonstrated a significant improvement to the Trust's response rate. The new online forms have now also gone live and work is underway to advertise these changes through a new poster.	Ongoing
• The installation of the new FFT boards currently in the inpatient areas is currently taking place, with a second phase rollout planned for outpatient areas.	Apr 25
• The patient experience team will be working with individual clinics and services not included in the new hierarchy data structure, to consider alternative data collection methods for informing service Improvements.	Dec 24

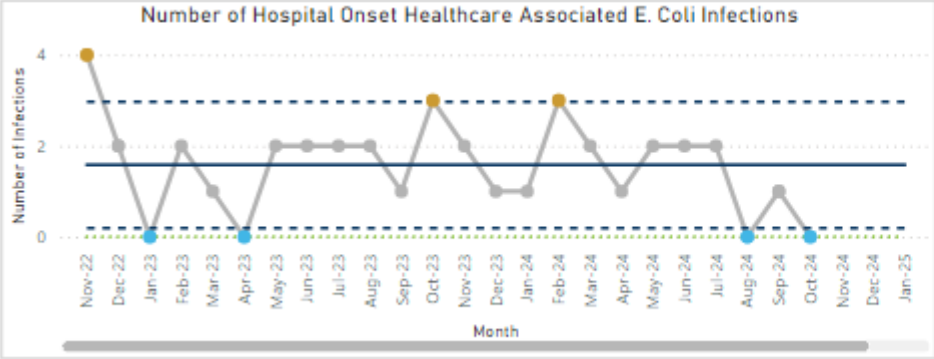
Risks and Mitigations

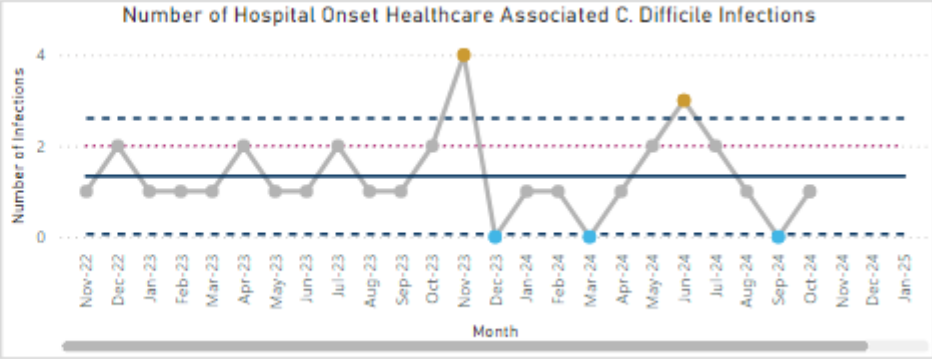
- The new dashboard continues to enable better themes and insight analysis of comments. Going forward we will be able to offer more robust analysis and insights from the feedback received. Implementation of the new system has already demonstrated a successful drive towards the Trust's 15% improving together response rate target set for 2024/25.

Infection Control

Position: Special Cause Improvement

Position: Common Cause





Year	2022-2023	2023-2024	2024-2025
MRSA Bacteraemia Infections: Hospital Onset	0	0	0
MSSA Bacteraemia Infections: Hospital Onset	10	10	5

Understanding the Performance

There has been no hospital onset healthcare associated (HOHA) reportable *E.coli* bacteraemia infections, compared to one case last month. There has been one HOHA reportable *MSSA* bacteraemia infections, compared with one last month.

For HOHA reportable *C.difficile* cases, there has been one case compared to no cases last month. A continued level of diarrhoeal and respiratory activity has been experienced across inpatient areas.

IPC policy review work ongoing, with progress achieved against workplan.

Countermeasure Actions	Due Date
• Completion of required investigations by clinical areas to identify good practice and any new learning continues with identified timeframes.	Monthly
• From reviews completed for *C.difficile,* lapses in care identified includes poor assessment and documentation, and delay in sampling. The divisions continue to monitor those areas that have produced action plans and provide updates to the IPCWG.	Monthly
• The IPC nursing team continue to undertake targeted clinical visits and use educational opportunities with staff.	Ongoing
• IPC representation at preparedness work internally and at BSW ICB convened meetings, including HCID.	Ongoing

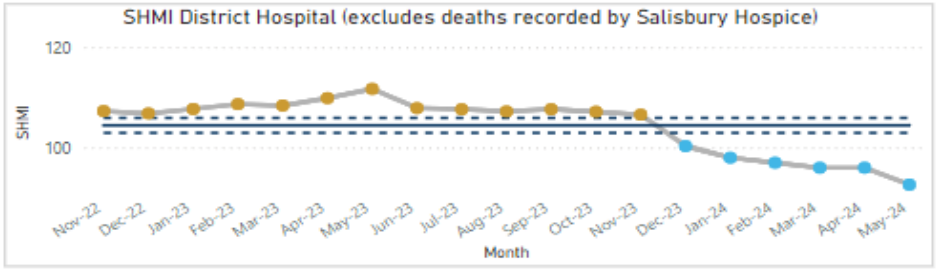
Risks and Mitigations

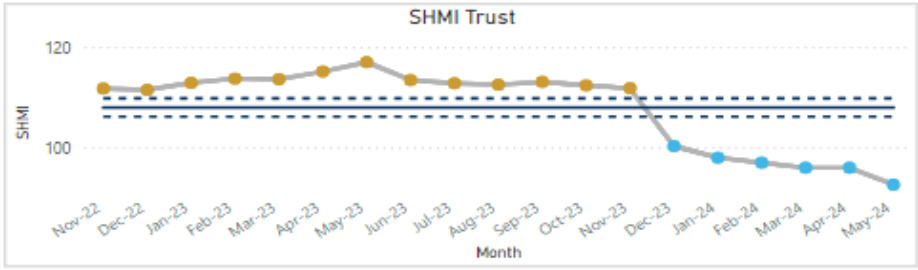
- An underlying risk continues to be a potential increase in incidence of reportable HCAIs with poor patient outcomes. From 1st April 2024, the admission date definition for reporting changed, which **may** lead to an increase in cases classified as HOHA.
- 2024/25 threshold levels set by NHSE: for reportable *C.difficile*, is 21 healthcare associated cases. From 1st April to 31st October, there have been 18 cases (10 HOHA and 8 COHA). For one of the reportable *Gram negative bacteraemias,* the Trust has exceeded the threshold level for healthcare associated cases of *Pseudomonas aeruginosa.* The threshold is set at 7 cases, and the Trust has reported 10 cases to date.

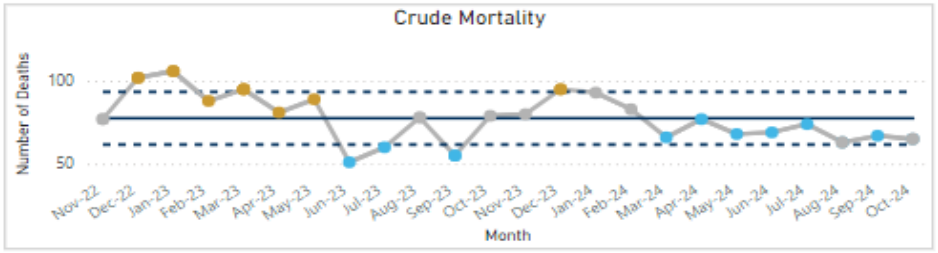
Mortality

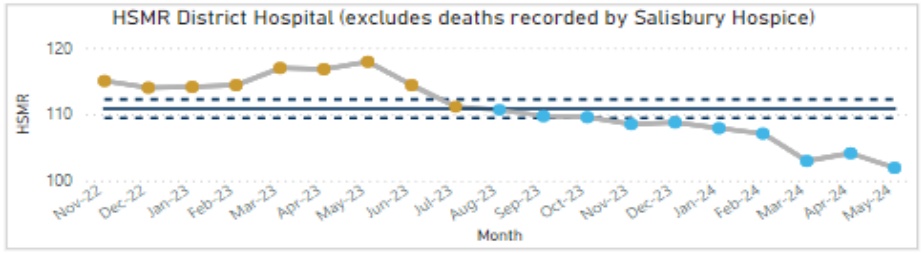
Salisbury NHS Foundation Trust

Target: N/A Performance: N/A Position: N/A









Understanding the Performance	Countermeasure Actions	Due Date	Risks and Mitigations
The Summary Hospital-level Mortality Indicator (SHMI) continues to improve. For the 12-month rolling period ending in May 2024 this is **now 0.94** and remains statistically within the expected range [according to NHSE]. The Hospital Standardised Mortality Ratio (HSMR) for the 12-month rolling period ending in May 2024 for Salisbury District Hospital is **101.92** (rolling 12-month figures that ended in Jan '24 which were > 108 at this time).	• A revision to the methodology for calculating the SHMI came into effect (rolling 12-months from Dec'23 onwards). Prior to this, the Trust had already started to see a positive reduction in the SHMI and HSMR figures. • An online mortality system to support learning from deaths was launched in March. Current activity has been centred on improving reporting outputs from the mortality reviews (primary reviews) and a dashboard is being developed to improve visibility of Trust learning. A new training guide for staff and a supporting video have recently been produced. • Further activity is also underway to improve data quality and specifically rectifying issues of how data currently feeds between the shared EPR and our mortality system.	Ongoing / Bi-Monthly Ongoing / Bi-Monthly Ongoing / Bi-Monthly	• 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 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

NHS Salisbury NHS Foundation Trust

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	78	102		0		Common Cause Variation	X	48
Complaints Closed within agreed timescale %	44.0%	28.0%	30.0%	85.0%			Special Cause Improving - Run Above Mean	X	48
ED 12 Hour Breaches (Arrival to Departure)	104	142	103		0		Special Cause Improving - Run Below Mean	X	48
ED Attendances	6813	6608	6879				Special Cause Concerning - Run Above Mean		
Inpatients Undergoing VTE Risk Assessment within 24hrs %	33.7%	43.5%	32.8%		95%		Special Cause Improving - Two Out of Three High	X	48
Number of High Harm Falls in Hospital	3	2	5	0	0		Common Cause Variation	X	5
Pressure Ulcers Hospital Acquired Cat 2 - Device Related	10	8	6	0				X	7
Pressure Ulcers Hospital Acquired Cat 3 - Device Related	0	1	1	0				X	2
RTT Incomplete Pathways: Total 52 week waits	966	879	927	580	0		Special Cause Concerning - Two Out of Three High	X	22
RTT Incomplete Pathways: Total 65 week waits	83	19	43	0	0		Special Cause Improving - Below Lower Control Limit	X	14

Watch Metrics: Alerting

Salisbury NHS Foundation Trust

Quality of Care, Access and Outcomes

Understanding the Performance

Pressure on the front door demand and flow is evident in the alerting metrics with ED attendances continuing to high and running at 8% above levels in 23/24. Despite the increasing attendances the process changes in the Emergency Department triage are holding ambulance handovers within common cause.

Challenges in reducing the number of patients waiting over 52 and 65 weeks remain, with both above target and increased in comparison to September. Particular areas of challenge are Dermatology, Plastics and Urology. Potential for BSW to enter a shadow tiering process for RTT performance in November with regional NHSE team.

The proportions of complaints closed within agreed timescales and patients undergoing VTE Risk Assessment continue to fluctuate, and although both show improvement over a 2-year trend, they remain some way from target.

Countermeasure Actions

- Current medical model in the Emergency Department unable to meet rising demand. Support provided through Emergency Care Intensive Support Team to help define appropriate staffing model and plans in place to mitigate this risk.
- An insourcing arrangement has been procured for Dermatology with anticipated start date by the end of November 24.
- Additional Plastics capacity for Hand patients is in negotiation with a potential surgeon identified. Subject to approval and pre employment checks capacity should begin from start of December.
- Urology service have a locum in place who is leaving in December so actions underway to locate suitable replacement.

Risk and Mitigations

- Risk of continued increase in Emergency Department attendances as we enter traditional period of Winter Pressures with potential of further deterioration of 4 hour performance. Winter plan launching to help support front door flow with a dedicated discharge lounge, increased medical ambulatory space and streaming to services outside of the department.

Watch Metrics: Non-Alerting

Salisbury NHS Foundation Trust

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
Beds Occupied %	92.1%	92.6%	90.9%	96.0%	92%		Special Cause Improving - Below Lower Control Limit	✓	0
Diagnostics Activity	8164	8200	8871	0			Special Cause Improving - Above Upper Control Limit	✓	0
Mixed Sex Accommodation Breaches	0	0	0	0	0		Special Cause Improving - Run Below Mean	✓	0
Patients referred on a suspected cancer pathway and seen within 2 weeks (%)	78.9%	73.5%	79.0%				Special Cause Improving - Two Out of Three High		
Pressure Ulcers Hospital Acquired Cat 4 - Device Related	0	0	0	0				✓	0
Proportion of patients spending more than 12 hours in an emergency department	0.8%	0.7%	0.6%				Special Cause Improving - Run Below Mean		
RTT Incomplete Pathways: Total 78 week waits	1	0	0	0	0		Special Cause Improving - Below Lower Control Limit	✓	0
Stroke patients receiving a CT scan within one hour of arrival	58.0%	79.0%	63.0%		50%		Common Cause Variation	✓	0
Total Incidents (All Grading) per 1000 Bed Days	77	63	66				Common Cause Variation		
Total Number of Complaints Received	9	7	15				Common Cause Variation		
Total Number of Compliments Received	48	78	56				Special Cause Improving - Run Above Mean		
Total Patient Falls per 1000 Bed Days	7.53	6.82	5.81	7			Special Cause Improving - Below Lower Control Limit	✓	0

Part 2: People

Performance against our Strategic Priorities and Key Lines of Enquiry

Our Priorities

People

Population

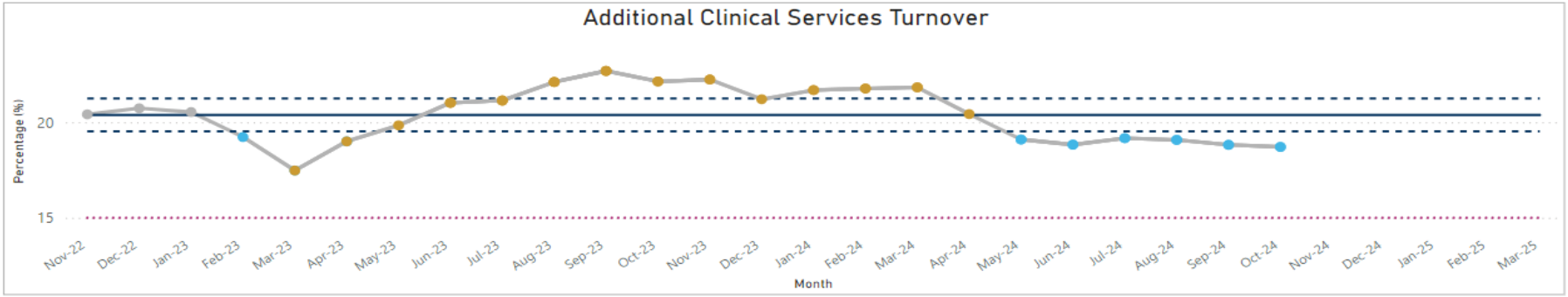
Partnerships

Increasing Additional Clinical Staff Retention

Breakthrough Objective

We are driving this measure because…	The breakthrough is on Retention – focus on Healthcare Assistants (HCA) turnover. HCAs have the highest turnover of any staff group at circa 21%. The breakthrough objective is to improve this to a target of 15% turnover by March 2025. SFT currently measures the highest turnover areas by staff group (HCA), length of service and Age of Leavers.
Baseline: 20.4% (April 2024)	We have developed an A3 approach to focus on improving retention in this staff group due to the significant impact this turnover has on direct patient care. This will enable more direct patient care hours due to more available HCAs working each shift.

Target: ≤15% Performance: 18.7% Position: Special Cause Improvement



Understanding the Performance

The rolling average for Additional Clinical Services (ACS) staff turnover in October was 18.7%, another very small reduction which continues a 5-month downward trend. It remains above the 15% target, with the biggest contributors being Medicine (23.7%), W&NB (20.7%) and Surgery (19.1%). These divisions have the largest proportion of ACS staff.

A total of 10 ACS staff (8.64 WTE) left this month, eight with less than 2 years' service. Only 2 left without no known reason for leaving.

The overall turnover rate for the Trust sits at 12.88% which is the first time turnover has been below 13% for over 18 months. The best performing divisions are CSFS at 10.9% and W&NB at 11.45%.

Countermeasure Actions	Due Date
• Review success of HCA preceptorship prog launched in Jul 24. First cohort completes Dec 24.	Dec 24
• Apprenticeship career development routes identified and implemented.	Dec 24
• R&R retention leads delivering exit interviews to improve leavers data.	Dec 24
• Quarterly HCA learning and celebratory events. (HCA Retention lead).	Mar 25
• Review of current recruitment processes.	Jan 25

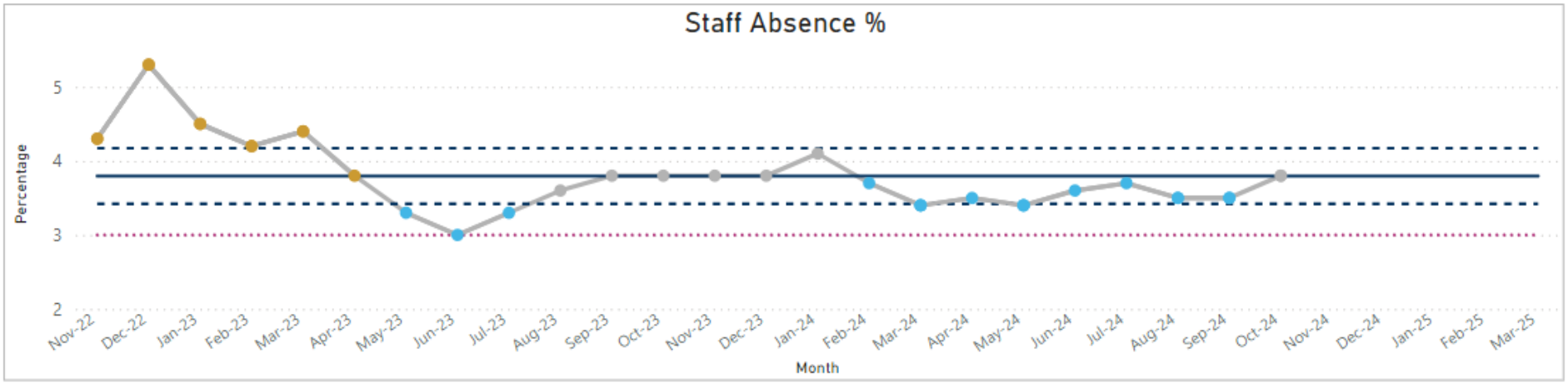
Risks and Mitigations

- New to care staff identified on appointment and provided additional support.
- Care certificate completion rates up to 97%.
- Insufficient leavers data to plan actions.
- HCA role not sufficiently understood by applicants.
- High attrition of staff in first 12 months of appointment.
- HCA opportunities not well understood by line managers and staff.

Sickness Absence

Salisbury NHS Foundation Trust

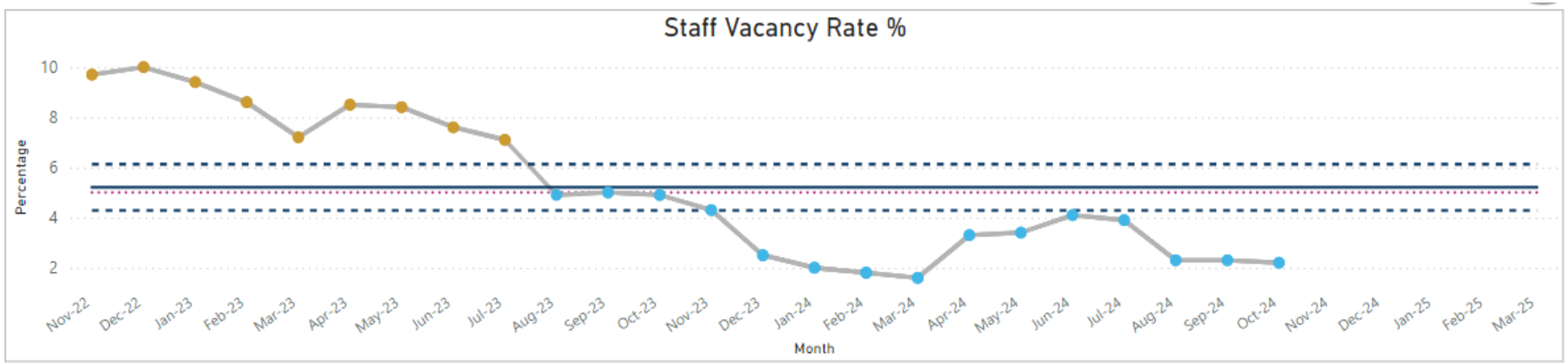
Target: ≤3% Performance: 3.8% Position: Common Cause



Understanding the Performance	Countermeasure Actions	Due Date	Risks and Mitigations
An uptick in sickness absence rate for October with the rate at 3.8%, highest rate for 6 months, but still at the 15-month average. Increases of c20% within the cold/cough/flu and Stress and Anxiety categories were the main causes. W&NB and Surgery remain the highest contributors at 5.8 and 4.4% respectively Additional clinical services remain the highest contributing staff group at 5.9% this month and higher rates of sickness (c6%) are noted on some inpatient areas and the community midwifery team Sickness accounted for 4,744 FTE days lost to the Trust, with a broad 1/3 long term/2/3 short term split remaining. There were fewer sickness occurrences in Oct than Sep, but days lost were higher. Highest absence cause remains Anxiety / Stress / Depression, accounting for 20% of all absence.	• Line Manager (LM) training on Absence Management policy and actions seeking to deliver training opportunities for all LM by year end. sessions programmed through the year, with additional support through breakfast clubs. (Hd ER and Policy). • Reduction of violence and aggression on wards and in ED/AMU, seeking to prevent physical injury and reduce cases of workplace stress and anxiety. 'No excuse for abuse' campaign and training interventions for ward staff planned each month. Excellent feedback so far. • Deep dive of EFM absence causation to generate mitigation actions	Dec 24 Mar 25 Dec 24	• Availability of instructors and advisers to support training interventions and workplace support to LM. Staff are being trained and recruited to fill vacancies in current team. • Availability of LM to attend training. • The ER team has been recruiting to better support the programmed activity but this currently remains a risk until new starters are in post. • Training risks: - Conflict resolution 95% - Moving and handling 70% - Hand hygiene 75% - Infection control 90%

Vacancies

Target: ≤5% Performance: 2.2% Position: Special Cause Improvement



Understanding the Performance	Countermeasure Actions	Due Date	Risks and Mitigations
Trust vacancies stand at 2.18% for M7, well below the 5% target. The highest contributing staff group is infrastructure staff, where there are a total of 127 FTE vacancies. The highest vacancy rates amongst clinical divisions sit within Theatres, Pathology and GI unit. HCA vacancies sit at 73 FTE, adding pressure to the work force in this staff group, which correlates with the high rates of turnover in this group. Reporting to ICS, which includes subsidiaries and hosted services show a total of 178 FTE in Month 7, a vacancy ratio of 4.1%.	• Targeted support to the 13 identified hard to recruit roles, seeking to support attraction campaigns to fill these post which generate high agency back fill costs. • Confirmation that vacancies identified as greater than 10% align accurately to team structures in order to ensure that attraction campaigns are focussed on the areas of most need. • Development of campaigns to attract ACS and Admin and Clerical staff, both groups subject to high levels of turnover.	Dec 24 Dec 24 Dec 24	• DMT and HRBPs working to design and develop attraction packages for hard to recruit roles • Understanding of future resourcing and staff requirements. Workforce trajectory forecasting, seeking to support Divisions and Line Managers with targeted attraction and recruitment campaigns, specifically for hard to fill high value niche posts is a key focus of the recruitment team. • Loss of potential staff through ineffective recruitment and on-boarding processes Implementation of PWC 'overhauling recruitment' programme phase 2 recommendations.

Watch Metrics: Alerting

NHS Salisbury NHS Foundation Trust

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 %	85.2%	85.1%	85.4%	90.0%	85%		Special Cause Concerning - Below Lower Control Limit	X	21
Medical Appraisal Rate %	87.6%	85.4%	83.7%	90.0%			Special Cause Concerning - Below Lower Control Limit	X	3
Non-Medical Appraisal Rate %	76.0%	74.3%	71.8%		90%		Special Cause Improving - Run Above Mean	X	48

Watch Metrics: Alerting Narrative

NHS Salisbury NHS Foundation Trust

People

Understanding the Performance

Mandatory training remains below target at 85% completion rate across the Trust. The best performing area is facilities with 95% completion. The lowest contributors are Corporate at 81.7% and medicine at 84.9%. The c85% completion rate remains a stubborn target as it has moved no more than 1 or % points since early 23. The application of significant oversight from management teams remains the most effective action to increase compliance. .

Medical appraisals continue to fall month on month and now sit at 83.7%. Some encouragement has been seen in the reduction of appraisals that are more than 3 months out of date, this number reducing from 62 in Sep 24 to 53 in October.

Non-medical appraisals rates have fallen back to the same level recorded 12 months ago. This is a worrying trend as the gains made by much effort in Q3 last year have not been consolidated. The main contributors to poor appraisal rates across the Trust are corporate at 60.4% and Medicine at 71%.

Countermeasure Actions

- CSTF courses now live on MLE and available for completion by staff.
- Medical appraisals: Clinical directors to maintain positive oversight of appraisals for medical staff, with a focus on appraisals more than 3 months out of date.
- Non-Medical Appraisals: Monthly reconciliation of appraisals with line managers by business partners will continue, with a focus on those staff who have not had an appraisal for more than 15 months.

Risk and Mitigations

- Loss of Trust in the accuracy and useability of the MLE system may deter staff from completing mandatory training. Work is ongoing to improve accuracy and design course content which is easy to understand and use.
- Completion of appraisals remains patchy, and susceptible to interpretation from staff and line managers, leading to incomplete appraisals and lack of effective recording. Having delivered a new, more succinct form, which improved the rate from Sep 23, further work is now being planned to improve training and oversight of appraisals for line managers.
- Loss of staff due to poor reward and recognition is recognised as a risk in the Trust. Work is underway to mitigate this risk through the identification of an Employee Value Proposition, which will seek to identify a framework to better exploit all elements of reward and recognition within the Trust. First elements of this project will be delivered considered at OD&P MB in Nov 24.

Part 3: Finance and Use of Resources

Performance against our Strategic Priorities and Key Lines of Enquiry

Our Priorities

People

Population

Partnerships

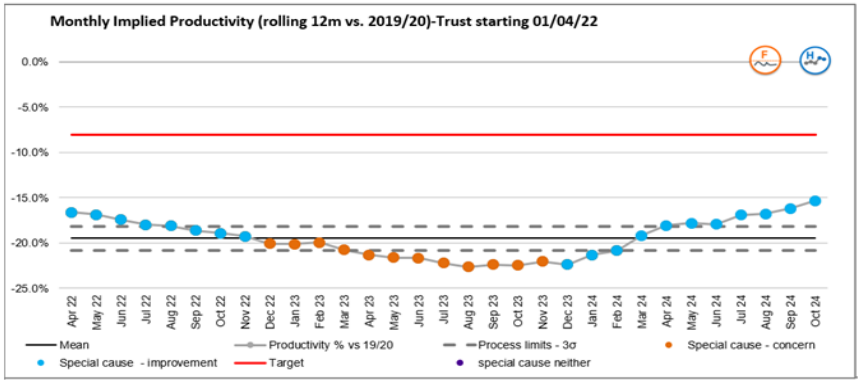
Creating Value for Our Patients

NHS Salisbury NHS Foundation Trust

Breakthrough Objective

We are driving this measure because… **Baseline: -18% (April 2024)**	Productivity is closely linked to the vision metric of financial sustainability. Since 2019/20 SFT's activity per unit cost has deteriorated leading to challenges of financial sustainability and constraining SFT's ability to invest in service developments and quality initiatives. Through Productivity all front line, clinical support areas and back-office services have the opportunity to affect positive change, either through driving additional activity through a given resource base or through the release or redistribution of excess resource. Divisional proposals for key driver metrics have been agreed and are being measured.

Target: -8% Performance: -14.99% Position: Special Cause Improvement



Understanding the Performance	Countermeasure Actions	Due Date
In Month 7 pay pressures due to worked WTE above funded levels, sickness cover and medical agency costs combined with increased drugs and clinical supplies costs, have been mitigated by increased activity, and have driven the 0.9% improvement in productivity delivery. There is an improvement of 4.2% delivery since March and is due to cost increases being mitigated by Non Elective, Day cases and Outpatient Follow up activity increases. The calculation is generated by adjusting Pay and Non Pay costs for cumulative inflation since 2019/20 and activity valued at a standard rate to provide a monthly Implied Productivity % as a comparator to 2019/20.	• FRG task and finish group operating on alternate fortnight basis to review headcount above March 23 levels. • Modernisation and consistency of admin processes • Theatre utilisation and targets • ERF performance, key metrics and coding opportunities • Medical temporary staffing controls	Ongoing Ongoing November November November

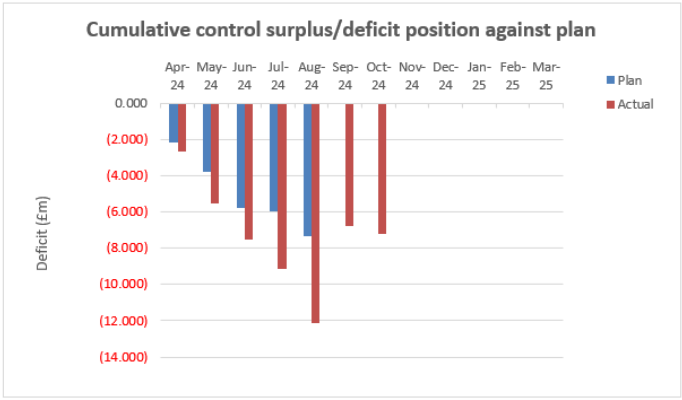
Risks and Mitigations
• The Finance Recovery Group and ERF / Delivery groups support the savings programme and ERF points of delivery.

Income and Expenditure

Salisbury NHS Foundation Trust

Target: N/A Performance: N/A Position: N/A

	October '24 In Month			October '24 YTD			24-25
	Plan £000s	Actual £000s	Variance £000s	Plan £000s	Actual £000s	Variance £000s	Plan £000s
Operating Income							
NHS Clinical income	31,684	32,583	*899*	187,508	184,057	*(3,451)*	320,166
Other Clinical Income	2,583	1,432	*(1,151)*	7,590	7,933	*344*	10,735
Other Income (excl Donations)	3,297	3,327	29	22,947	22,547	(401)	39,359
Total income	**37,564**	**37,341**	**(223)**	**218,045**	**214,537**	**(3,508)**	**370,260**
Operating Expenditure							
Pay	(26,489)	(26,305)	*184*	(144,787)	(148,062)	*(3,274)*	(247,436)
Non Pay	(9,576)	(10,062)	(486)	(68,999)	(70,724)	(1,725)	(117,175)
Total Expenditure	**(36,065)**	**(36,367)**	**(301)**	**(213,786)**	**(218,786)**	**(4,999)**	**(364,611)**
EBITDA	**1,499**	**975**	**(524)**	**4,259**	**(4,249)**	**(8,508)**	**5,649**
Financing Costs (incl Depreciation)	(1,887)	(1,782)	105	(13,212)	(11,911)	1,301	(22,654)
NHSI Control Total	**(388)**	**(807)**	**(419)**	**(8,953)**	**(16,160)**	**(7,207)**	**(17,005)**
Deficit Support Funding	388	388	-	8,953	8,953	-	17,005
Reported Position	**0**	**(419)**	**(419)**		**(7,207)**	**(7,207)**	
Add: impact of donated assets	(81)	97	*178*	(567)	217	*784*	(973)
Add Impact of AME Impairment							(5,000)
Add impact of UK GAAP on PFI	16	(27)	*(43)*	116	(191)	*(307)*	199
Surplus/(Deficit)	***(65)***	***(349)***	***(284)***	***(451)***	***(7,182)***	***(6,731)***	***(5,774)***



Understanding the Performance

The financial plan submitted to NHS England on 12 June shows a £17m deficit position for the year and includes an efficiency requirement of £21.1m. £17m non recurrent deficit support has been funded from October.

In month the Trust recorded an in month control total deficit of £0.8m against an original deficit target of £0.4m - an adverse variance of £0.4m.

The deficit position year to date is driven by income underperformance on Elective recovery and Community diagnostics activity, depreciation funding and overperformance on the block BSW contract, combined with pay and non pay pressures driven by non elective activity volumes and pathways resulting in an increased bed base, additional backfill requirements and medical agency costs plus drugs and clinical supplies costs.

Countermeasure Actions

- Financial recovery group (FRG) in place to review recovery actions with alternate fortnightly workforce group to review headcount.

Due Date

Ongoing

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, staff availability and recruitment.
- The Trust's £21.1m efficiency savings plan includes more than 40% non-recurrent delivery and signals a risk into 25/26.

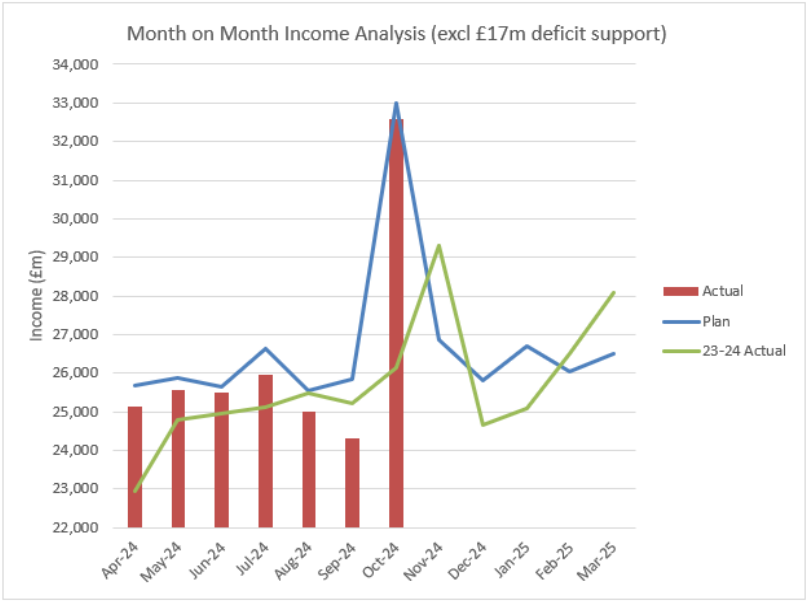
Income and Activity Delivered by Point of Delivery

Target: N/A Performance: N/A Position: N/A

Income by Point of Delivery (PoD) for all commissioners	October '24 YTD		
	Plan (YTD) £000s	Actual (YTD) £000s	Variance (YTD) £000s
A&E	7,203	7,740	537
Day Case	15,535	15,638	103
Elective inpatients	12,736	9,510	(3,226)
Excluded Drugs & Devices (inc Lucentis)	15,879	17,276	1,397
Non Elective inpatients	48,590	51,037	2,447
Other	60,495	56,094	(4,401)
Outpatients	27,070	26,762	(308)
TOTAL	187,508	184,057	(3,451)

SLA Income Performance of Trusts main NHS commissioners	Contract		
	Plan (YTD) £000s	Actual (YTD) £000s	Variance (YTD) £000s
BSW ICB	119,850	118,675	(1,175)
Dorset ICB	18,561	18,046	(515)
Hampshire, Southampton & IOW ICB	16,570	15,762	(808)
Specialist Services	25,315	26,178	863
Other	7,212	5,396	(1,816)
TOTAL	187,508	184,057	(3,451)

	Activity YTD			Activity Last Year Actuals	Variance last year
	Plan	Actuals	Variance		
A&E	43,254	46,326	3,072	43,199	3,127
Day case	16,463	15,963	(500)	13,816	2,147
Elective	2,728	2,079	(649)	1,868	211
Non Elective	16,730	18,019	1,289	16,269	1,750
Outpatients	175,360	174,270	(1,090)	157,621	16,649



Understanding the Performance

The Clinical income underperformance is driven by lower Elective Inpatients and Outpatient First attendances partially offset by overperformance on Day cases activity, underperformance on Community diagnostics activity and pass through depreciation funding, prior year ERF funding which will not be received and overperformance above the block high cost drugs and devices and diagnostics contract for BSW.

The NHS Payment scheme has been uplifted for all pay awards and individuals prices and tariffs have been uplifted to reflect this.

The level of uncoded day cases and inpatient spells is 18% in September and 92% in October at the time the activity was taken for reporting purposes.

Activity across all of the main points of delivery was higher in October than in September.

Countermeasure Actions

- NHS England contracts are now signed and the ICB contract is progressing to signature.

Due Date

December

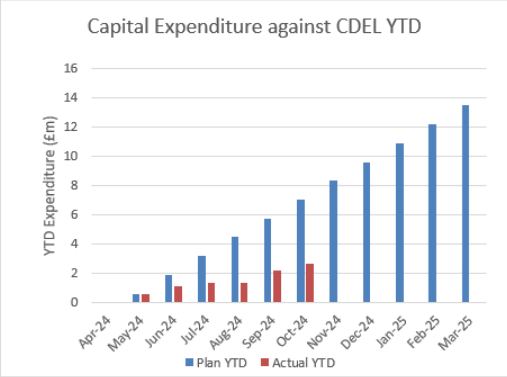
Risks and Mitigations

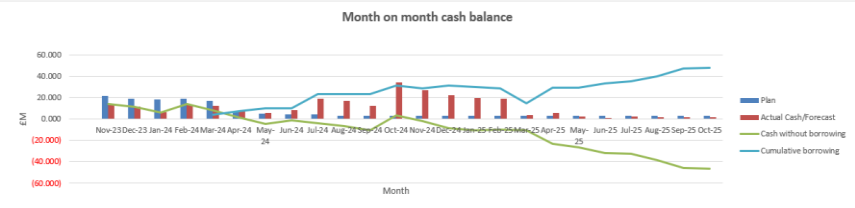
- The NHS England Specialised position for Month 12 23/24 has been published and the full impact of £560k will not be paid.
- The Trust is maximising activity recording opportunities, Advice and Guidance and productivity improvements.

Cash Position and Capital Programme

Target: N/A Performance: N/A Position: N/A

	Closing Balance March 2024 £000s	Current Month Balance £000s	Actual In Year Movement £000s
Inventories (Stock)	7,954	8,630	676
Debtors	24,999	29,343	4,344
Cash	28,891	34,249	5,358
TOTAL CURRENT ASSETS	**61,844**	**72,222**	**10,378**
Creditors	(58,026)	(53,566)	4,460
Borrowings	(641)	(23,369)	(22,728)
Provisions	(474)	(407)	67
TOTAL CURRENT LIABILITIES	**(59,141)**	**(77,342)**	**(18,201)**
TOTAL WORKING CAPITAL	**2,703**	**(5,120)**	**(7,823)**





Position				
	Annual	October '24 YTD		
Schemes	Plan £000s	Plan £000s	Actual £000s	Variance £000s
CDEL Schemes				
Building schemes CIR	3,609	1,839	701	(1,138)
Building projects	2,682	1,567	1,507	(60)
Fire schemes	500	263	22	(241)
IM&T	6,264	3,158	402	(2,756)
Medical Equipment	393	182	20	(162)
Total CDEL schemes	**13,448**	**7,009**	**2,652**	**(4,357)**
National Funding				
Shared EPR - national element	2,231	1,115	655	(460)
Digital Pathology & LIMS	837	439	136	(303)
Community Diagnostic Centre	1,306	655	9	(646)
Total National Funding	**4,374**	**2,209**	**800**	**(1,409)**
IFRS 16 Leases				
Medical Equipment	1,800	300		(300)
Vehicles and transport	850	142	360	218
All other leases including property	350	58	58	-
Total IFRS 16 Leases	**3,000**	**500**	**418**	**(82)**
GRAND TOTAL	**20,822**	**9,718**	**3,870**	**(5,848)**

Understanding the Performance

Capital expenditure on both CDEL and nationally funded projects totals £3.9m driven by Breamore refurbishments, Imber ward, lifts and CT scanner installation costs.

The cash balance at the end of Month 7 was £30.1m above the planned level of £3.1m. The improvement is due to payments relating to the non recurrent deficit support, CDC, ERF and Pay award in advance.

Countermeasure Actions

- Revenue cash support application for February and March

Due Date

December

Risks and Mitigations

- 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 cash support framework and monitoring draws on finance and procurement resources to ensure that payments are made on a timely basis in line with limited cash balances.
- The context of digital modernisation programmes, along with an aging estate and medical equipment means the Trust's five year capital requirement is well in excess of available resources. The Trust seeks to in part mitigate this risk through the proactive bidding for national funds where available.

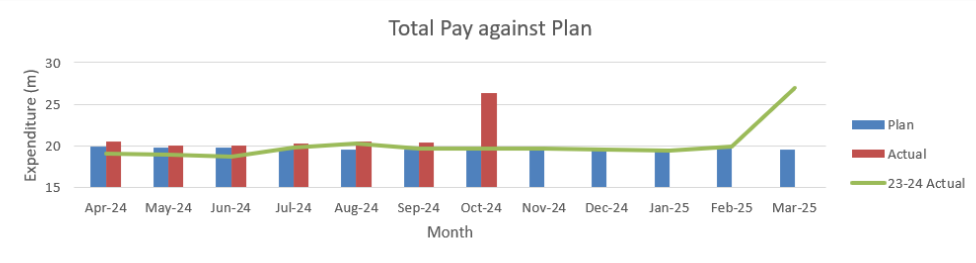
Workforce and Agency Spend

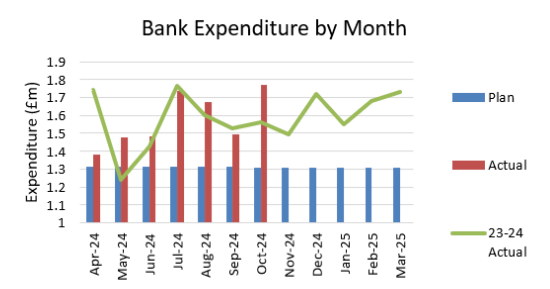
NHS Salisbury NHS Foundation Trust

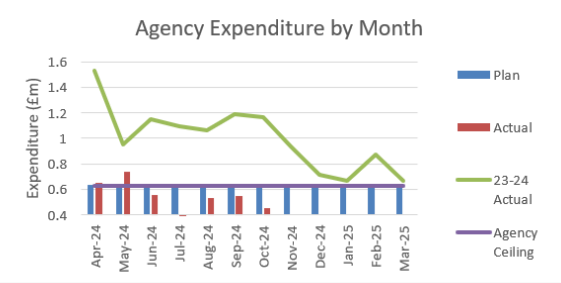
Target: N/A Performance: N/A Position: N/A

	October '24 YTD		
	Plan £000s	Actual £000s	Variance £000s
Pay - In Post	130,473	132,688	(2,216)
Pay - Bank	9,469	11,020	(1,551)
Pay - Agency	4,424	3,806	618
Other (eg apprenticeship levy)	422	548	(126)
TOTAL	**144,787**	**148,062**	**(3,274)**
Medical Staff	37,622	42,357	(4,734)
Nursing	39,404	38,370	1,034
Support to Nursing	14,050	12,164	1,885
Other Clinical Staff	19,415	19,512	(97)
Infrastructure staff	34,060	35,111	(1,051)
Other (eg apprenticeship levy)	237	548	(311)
TOTAL	**144,787**	**148,062**	**(3,274)**

	October '24 YTD		
	Plan WTEs	Actual WTEs	Variance WTEs
Medical Staff	535.1	565.36	30.3
Nursing	1,215.9	1,315.76	99.8
Support to Nursing	444.2	568.58	124.4
Other Clinical Staff	829.9	655.55	(174.3)
Infrastructure staff	1,367.4	1,463.95	96.6
TOTAL	**4,392.5**	**4,569.2**	**176.7**







Understanding the Performance

Pay costs in month were £0.2m below plan with Medical and Agenda for Change pay awards in month driving a £6.3m increase in run rate. The in month variance is driven by reductions in substantive staff, enhancement payments and nursing agency costs offset by unavailability increases due to sickness and enhanced care costs.

After adjusting for the pay award impact, Substantive costs reduced by £0.2m, Bank costs increased by £0.1m and Agency costs reduced by £0.1m.

The pay savings target was £7.2m against which achieved pay savings were £4.4m - an adverse variance of £2.8m, with £1.3m recurrent delivery.

There is an overestablishment of 177 WTE against the 4,393 WTE Workforce trajectory (4,309 WTE at March 25) with the overestablishment across all Pay categories with the exception of Other Clinical Staff.

Countermeasure Actions	Due Date
• Trustwide and Division workforce control panels in place since November 2023.	Ongoing
• Finance recovery groups to review workforce actions (detailed under Creating Value for our Patients)	Ongoing

Risks and Mitigations

- Staff availability initiatives are in train to mitigate workforce gaps and the need for premium agency and bank, although it is likely that the Trust will require both due to operational pressures.

Appendix

Business rules and Statistical Process Control (SPC) chart guidance

Our Priorities

People

Population

Partnerships

Appendix

Business Rules – Driver Metrics

Salisbury NHS Foundation Trust

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

Appendix

Business Rules – Watch Metrics

Salisbury NHS Foundation Trust

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

Appendix

NHS Salisbury NHS Foundation Trust

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 a corss 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 action are suggested depending on hpw 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

Appendix

Reading a Statistical Process Control (SPC) Chart

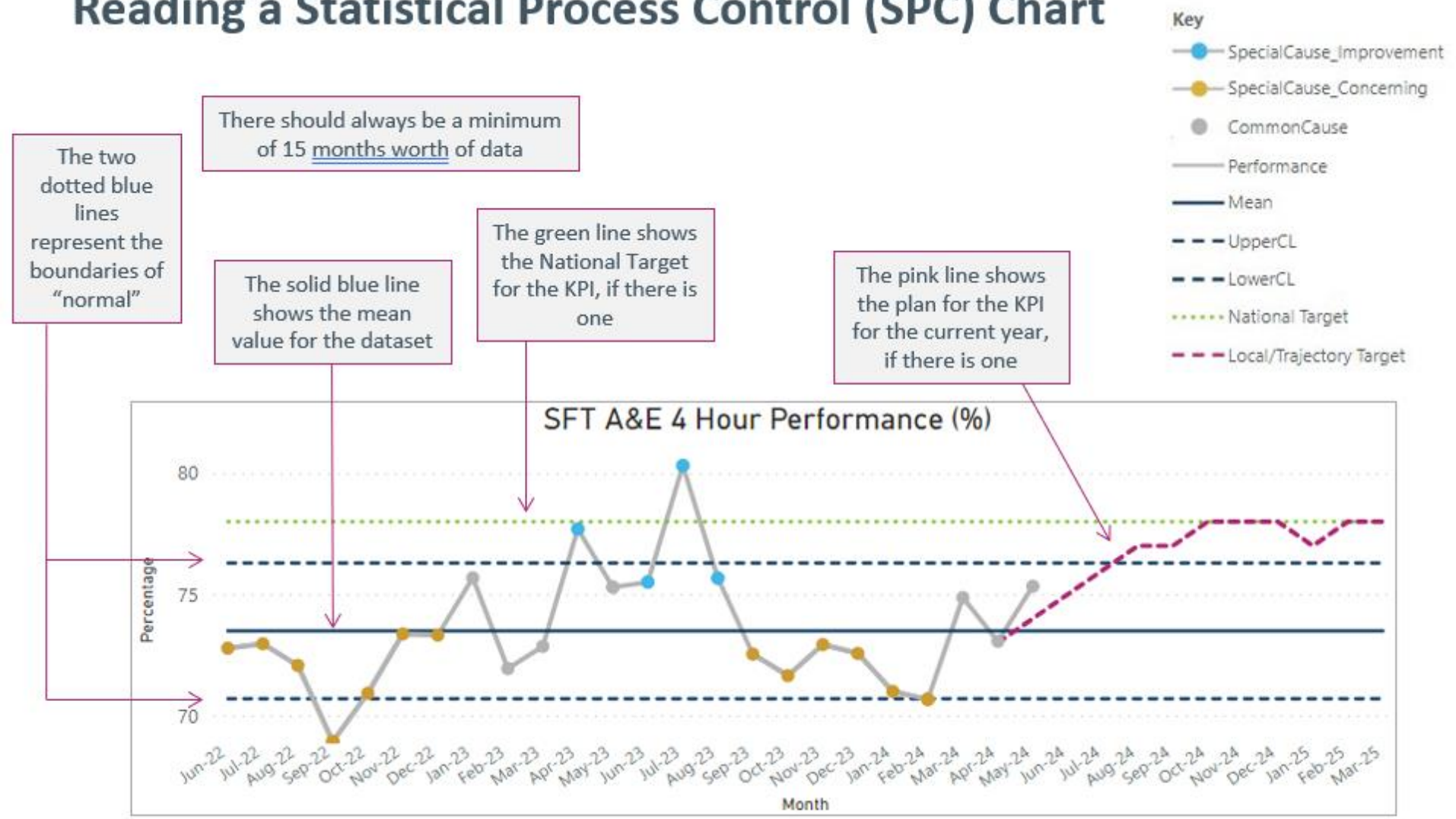
There should always be a minimum of 15 months worth of data

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

The solid blue line shows the mean value for the dataset

The green line shows the National Target for the KPI, if there is one

The pink line shows the plan for the KPI for the current year, if there is one



NHS Salisbury NHS Foundation Trust

Report to:	Trust Public Board	Agenda item:	2.2
	5th December 2024		

Report from (Committee Name):	Finance & Performance Committee		Committee Meeting Date:	26th November 2024
Status:	Information	Discussion	Assurance	Approval
			x	
Prepared by:	Debbie Beaven – Chair of Finance & Performance Committee			
Non-Executive Presenting:	Debbie Beaven			
Appendices (if necessary)	none			

Key discussion points and matters to be escalated from the meeting:

ALERT: Alert to matters that require the board's attention or action, e.g., non-compliance, safety, or a threat to the Trust's strategy.

September's meeting had a strong risk focus. This month's meeting was about "finding the balance". The IPR, H2 forward look, CFO report and a paper on balance were taken together with the key drivers for change and improved performance discussed in more detail, given their influence on the financial outturn for 24/25. The four key topics were NCTR, discharge process, ERF/theatre utilisation and workforce. As a result of the discussions we gained assurance that the right things were being done, although we couldn't be assured that the projected financial impacts would be delivered, with NCTR remaining the most significant risk to the financial outturn.

- **NCTR –** In October the average NCTR beds was 108, with demand continuing to run hot at 10% (against 3% in plan). The finding the balance paper laid out the risks of closing beds to reduce costs in the short term. The impact on quality was the greatest risk, with the associated knock on impacts ultimately having a negative cost impact. The team reminded the Committee that they had done just this in 2022 and understood the consequences. Using improving together methodology over 12 weeks there is an expectation that reductions can be made, focusing on pathway 1 interfaces (as highlighted in the deep dive in September); an example being the reduction of referral days from 7-8 to 2. The committee wasn't fully assured that necessary change would be possible in what remains of the financial year, particularly given the 12-week sprint, but were moderately confident of some improvement.
- **Financial Performance** – The Trust has recorded a control total deficit position year to date of £16.2m against an original deficit target of £9.0m - an adverse variance of £7.2m. Our trajectory to the end of the year, shows some improvement, but not where the system needs us to be. Interventions are expected to improve our most likely position by £3.7m, but both most likely and best-case outcomes have risks as we have seen played out so far this year and as we head into winter.

A summary of the papers, interventions, outturn and risks will be presented by the Executive at the Private Board meeting next week.

The alerts from last escalation report regarding winter plan and the Estates CAFM risk were not discussed in any detail, but remain alerts.

NHS Salisbury NHS Foundation Trust

ADVISE: Advise of areas of ongoing monitoring or development or where there is negative assurance. What risks were discussed and were any new risks identified.

- **Theatre utilisation and ERF –** We are currently at 111% against 116% plan. Theatre utilisation has significantly improved and we are now in top half of trusts as measured by model hospital. List uptake over the summer was 75%, and we have challenged ourselves to get to 90% (model hospital 85%), which requires additional capacity. Actions on advice and guidance are happening, and there is work to do on a retrospective review of coding, which should generate >£1m income. There is a risk around resource availability over Christmas and February half term.

ASSURE: Inform the board where positive assurance has been achieved, share any practice, innovation or action that the Committee considers to be outstanding.

- **CDC** – deep dive. The national prioritisation of CDC investment ends next year, but there continues to be a strong push to go further and faster. There is capital available. We heard of the challenges with the current CDC, and options to improve capacity and facilities to meet future demand.
- **Workforce Controls –** we were assured that resources for theatres and central booking will be secured, despite the enforced controls, as these are key to improving theatre utilisation and ERF income. We were further assured that every request to recruit, including vacancies, are tested for value and contribution to performance and improvement, with team structures challenged for optimisation.
- **Discharge Process –** The aim is to bring forward discharges to pre-midday, through timings of walk-arounds and reviews, improved communication between wards and other interventions, all using improving together methodology. There is a need for the medical team to drive a plan for a discharge lounge, with the new transport contract (approved in September) not having a positive impact until next year.
- **Breakthrough objectives (IPR) –** Productivity continues to improve and we are in the top quartile, despite our significant challenges, demonstrating that the actions being effective. Their value is possibly being "drowned out" by other challenges such as NCTR and financial deficit.
- **Cyber Security Framework –** assurance was given with mitigations in place. A challenge on urgent patches taking 14 days was defended as appropriate in the hospital environment given the planning needed to avoid disruption. Phishing compliance needs to improve through training and awareness as this continues to pose a risk.
- **Committee Effectiveness –** overall positive feedback, although limited in numbers. Intention next time is to extend to all regular attendees.

GOOD NEWS

- **Out of tiering for cancer and diagnostics**
- **£5m capital approved for South Newton** with DD report progressing and completion hoped for within a couple of weeks.
- **Campus and Estates – the local council have adopted the plan** (subject to Public consultation EIP next year) - our plans are progressing.

Approvals: Decisions and approvals made by the Committee/ Any recommendations for further ratification by the Board.

- **S6 molecular diagnostics – 9-year fixed price contract** – Recommended to Board.

NHS Salisbury NHS Foundation Trust

Report to:	Trust Board (Public)	Agenda item:	2.3
Date of meeting:	5th December 2024		

Report from (Committee Name):	Clinical Governance Committee		Committee Meeting Date:	26/11/24
Status:	Information	Discussion	Assurance	Approval
Prepared by:	Anne Stebbing, Non-Executive Director			
Non-Executive Presenting:	Anne Stebbing, Non-Executive Director			
Appendices (if necessary)				

Key discussion points and matters to be escalated from the meeting:

ALERT: Alert to matters that require the board's attention or action, e.g., non-compliance, safety, or a threat to the Trust's strategy.

- Concern regarding safeguarding training compliance. Continued concern re accuracy of data from MLE, and manual checking shows MCA training at 61% and paediatric level 2 training below 80%. Noted that safeguarding training has been prioritised by MLE to obtain greater accuracy on training numbers, and that MLE needs to better provide timely reminders for the need to undertake training.
- Increase in number of allegations against staff noted in Q2 safeguarding adults report. CGC noted this was concerning.

ADVISE: Advise of areas of ongoing monitoring or development or where there is negative assurance. What risks were discussed and were any new risks identified.

- Deep dive on deteriorating patients outlined all the different steps being taken following improving together methodology. Provided evidence that outcome metrics are improving, or satisfactory and stable. Agreed that alternative metric of "time to decision to escalate following NEWS score" could be better for monitoring progress of this breakthrough objective.
- Increased number of complaints have been made regarding staff attitude which is concerning.
- Noted the Dementia Strategy 2022-2024, but asked for more information about how much had been delivered, audit results, including National Dementia Audit outcome. For review in January 2025
- Received update on GIRFT, and requested future reports give an indication of how compliant SFT is with all the recommendations / suggestions for improvement.
- Received Annual End of Life Care Report, and noted the assurance this provided. Concern was raised that there had been continued delays in making an on-line training package available on MLE, but noted considerable other training had continued to take place. CGC also noted the possible impact on the service from the new community contract.
- CNO escalated a concern raised to the maternity safety champions that SFT is not compliant with the British Association of Perinatal Medicine guidance on number of paediatricians. A risk assessment and mitigations paper is to be brought to next CGC to better understand the position.
- Noted the assurance provided by the yearly full skill mix review for safer staffing and how this triangulates with the data from the safer nursing care tool. Noted also that various posts are required to improve the SFT position. A future paper will come to Trust Board
- Agreed to adopt the same approach for committee effectiveness review next year, but including a wider group of committee attendees in the collection of feedback

ASSURE: Inform the board where positive assurance has been achieved, share any practice, innovation or action that the Committee considers to be outstanding.
• Received update on Medicine division governance activity. Agreed divisional reports would benefit from an element of standardisation. • Discussed latest IPR quality and safety aspects. Noted new charts showing number of patients cared for in corridor in ED or in escalation beds. Agreed this provided additional assurance. • Received annual Quality Impact Assessment report. • Discussed the results of the Inpatient Survey performed in 2023 which shows significant improvement in overall scores. • Received the Perinatal Surveillance report for October and November, the Maternity Quality and Safety Report for Q2 and noted that 1:1 care and supernumerary coordinator were maintained throughout. In October, Midwife to birth levels moved to 1:30 as a consequence of expected increased activity, maternity leave and short-term sickness. • Discussed a thematic review of obstetric 3rd and 4th degree tears which had identified the importance of continued education and support, especially for newly qualified midwives, to help prevent harm.

Approvals: Decisions and approvals made by the Committee/ Any recommendations for further ratification by the Board.
•

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:	2.4
Date of meeting:	5th December 2024		

Report from (Committee Name):	Trust management committee TMC		Committee Meeting Date:	27/11/24
Status:	Information	Discussion	Assurance	Approval
	x			
Prepared by:	Interim Managing Director, Lisa Thomas			
Non-Executive Presenting:	Interim Managing Director, Lisa Thomas			
Appendices (if necessary)	N/A			

Key discussion points and matters to be escalated from the meeting:

ALERT: Alert to matters that require the board's attention or action, e.g., non-compliance, safety, or a threat to the Trust's strategy.

- The committee discussed the right to work process compliance challenges and agreed for a structured review to learn and improve the processes going forward.
- The financial position was discussed and the subsequent recruitment controls as part of system trying to achieve financial plans for 2024/25.

ADVISE: Advise of areas of ongoing monitoring or development or where there is negative assurance. What risks were discussed and were any new risks identified.

- An update from Cancer Board updated on progress on the standard operating procedure for "upgrading" of patients from routine pathways to cancer pathways. This is in draft and will be rolled out to clinical teams throughout the last quarter of 2024.
- The Childrens Quality and Safety board highlighted concerns on the configuration of Paeds in ED and the ongoing discussions on best ways to accommodate meeting safeguarding requirements.
- The Committee received an update on the annual Bowel Cancer screening programme, the Trust hosts the programme on behalf of GWH and RUH and challenges in other group Trusts performance was noted. This has a direct impact on SFT's ability to improve the 28 day cancer performance. Discussions were ongoing with the respective Trusts.

ASSURE: Inform the board where positive assurance has been achieved, share any practice, innovation or action that the Committee considers to be outstanding.

- Following the Thames Valley and Wessex Surgery & Children ODN visit SFT in May, a report has been produced and SFT were commended for managing our waiting lists in line with adults. SFT were also flagged were flagged as a best practice example in GIRFT for our collaborative working for children's abdominal pain and the complex plastics MDT.

- An update was provided on the Imber ward project, next steps would be a review and lessons learnt following closure of the project.
- The committee received a quarterly update from facilities where and update on risks were provided and updates on recruitment and cleaning standards. No significant alerts were identified.
- The committee received an update from Estates, where risks continue to reduce in line with the programme work of compliance.

Approvals: Decisions and approvals made by the Committee/ Any recommendations for further ratification by the Board.

- Business case for introduction Paediatric Asthma Nurse was approved as will benefit patient experience and enable a better pathway. Next step is to the ICB finance committee for approval.
- Third party and supply chain policy was approved.
- The Final contract award was agreed for Imber Ward following conversations for some months with the supplier BAM, TMC approved in line with the delegated limits.

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

Report to:	Trust Board (Public)	Agenda item:	2.5
Date of meeting:	5th December 2024		

Report from (Committee Name):	People and Culture Committee		Committee Meeting Date:	31st October 2024
Status:	Information	Discussion	Assurance	Approval
	√		√	
Prepared by:	Miss Eiri Jones, NED, Chair People and Culture Committee			
Non-Executive Presenting:	Miss Eiri Jones, NED, Chair People and Culture Committee			
Appendices (if necessary)				

Key discussion points and matters to be escalated from the meeting:

ALERT: Alert to matters that require the board's attention or action, e.g., non-compliance, safety, or a threat to the Trust's strategy.

- A detailed discussion was held in relation to appraisals. Further understanding is being sought in relation to barriers to improving the position and the importance of appraisals for staff support and development

ADVISE: Advise of areas of ongoing monitoring or development or where there is negative assurance. What risks were discussed and were any new risks identified.

- The following items were presented and discussed at this month's meeting:
  - The People Promise update
  - Workforce operational plan and winter planning
  - The IPR report
  - An update on managing the MLE concerns raised as an alert in the last meeting and escalated to Board in October 2024
  - Freedom to speak up report
  - Staff survey report – early signs of good response rate though variation in response rates by different professional groups
  - Organisational Development and People (OD&P) management Board escalation report

It was Dr Michael Von Bertele's last meeting and he was thanked by the committee for all his input over the years he has been a NED in Salisbury

ASSURE: Inform the board where positive assurance has been achieved, share any practice, innovation or action that the Committee considers to be outstanding.

- The meeting was quorate
- Assurance was provided in relation to the DBS process for staff in high risk areas
- The Trust is making good progress with its People Promise workstreams. A plan on a page was presented which the committee felt would be useful for all Trust Board members to see.
- Under the safe and well domain, work is commencing on the Trauma and Risk Management framework (TRIM)
- Under the recruitment and retention domain it was positive to note that care certificate completion had risen from 25% to 97%

- Work on Martha's Rule has commenced through the Critical Care Outreach Team (CCOT) and is available 24/7
- New system for managing policies to go live early November

Approvals: Decisions and approvals made by the Committee/ Any recommendations for further ratification by the Board.
Nil this month

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:	2.5
Date of meeting:	5th December 2024		

Report from (Committee Name):	People and Culture Committee		Committee Meeting Date:	28th November 2024
Status:	Information	Discussion	Assurance	Approval
	√		√	
Prepared by:	Miss Eiri Jones, NED, Chair People and Culture Committee			
Non-Executive Presenting:	Miss Eiri Jones, NED, Chair People and Culture Committee			
Appendices (if necessary)				

Key discussion points and matters to be escalated from the meeting:

ALERT: Alert to matters that require the board's attention or action, e.g., non-compliance, safety, or a threat to the Trust's strategy.

- No new issues to escalate. Further discussion was held on appraisals improvement actions building on the discussion at October meeting

ADVISE: Advise of areas of ongoing monitoring or development or where there is negative assurance. What risks were discussed and were any new risks identified.

- The following items were presented and discussed at this month's meeting:
  - Turnover in Women and Newborn Division
  - Improving working lives of doctors. Action to be referred to Finance and Performance Committee
  - Committee Effectiveness review
  - 5 year Strategic Workforce plan – this now needs to be discussed across the Trust and triangulated with other planning and financial frameworks
  - OD&P SLA and KPIs – an area to flag is Employee / Employer Relations cases. Due to capacity in OD&P team and training gaps for line managers, there is a risk of delay in cases being concluded with a potential adverse impact on staff wellbeing
  - Workforce operational plan and winter planning
  - The IPR report. Slow downward trajectory continues (positive) re turnover. Appraisals trajectory down 3 consecutive months (adverse)
  - Director of Medical Education's Annual Report
  - Employment Law briefing of impact of new requirements
  - Organisational Development and People (OD&P) management Board escalation report

ASSURE: Inform the board where positive assurance has been achieved, share any practice, innovation or action that the Committee considers to be outstanding.

- The meeting was quorate
- Assurance was received in relation to managing turnover in the Women and Newborn Division – a deep dive had been completed identifying 'good' exits and 'regretful' exits. The midwifery team is now fully staffed
- 63% of OD&P KPIs met fully
- Positive assurance in relation to model of working from occupational health lead

- Phase 1 of temporary staffing project completed
- Positive management of internal audit recommendations
- Positive Director of Medical Education report despite challenges of Industrial Action. External validation from Deanery in the Foundation Year report and positive GMC survey

Approvals: Decisions and approvals made by the Committee/ Any recommendations for further ratification by the Board.
Board to receive the Director of Medical Education's annual report, noting the positive assurance provided

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

Salisbury NHS Foundation Trust

Report to:	Trust Board (Public)	Agenda item:	3.1
Date of meeting:	5th December 2024		

Report title:	Digital Plan Update – Nov 24			
Status:	Information	Discussion	Assurance	Approval
	X		X	
Approval Process: (where has this paper been reviewed and approved):				
Prepared by:	Russell King, Head of Digital Business Management Jon Burwell, Acting Chief Digital Officer			
Executive Sponsor: (presenting)	Jon Burwell, Acting Chief Digital Officer			
Appendices	None			

Recommendation:

Trust Board is asked to note the contents of the report.

Executive Summary:

This report summarises the progress against the Trust's Digital Plan over the last 12 months. The majority of the workstreams expected to commence in 2024/25 are now underway, however the report highlights a couple of workstreams were either due to capacity or a change of strategic direction, the workstream has been paused or stopped.

The report highlights a range of wider programmes of work that have completed over the last 12 months and the programmes that are currently in progress. Where possible the Trust is working with ICS partners, in particular Great Western NHS Foundation Trust, to standardise solutions and ways of working to help build resilience between the digital teams. Over the last 12 months there has been a greater focus on understanding the benefits that technology has enabled and the report covers some examples of this.

All programmes have been prioritised through the Corporate Projects Prioritisation Group. Digital Steering Group still oversees the delivery of Digital Programmes and considers how any new requests fits in with the Digital Plan's priorities and expected outcomes.

Alongside progressing the implementation of the Shared EPR Programme, the next 12 months will see a focus on finalising plans for improving digital literacy, improving digital inclusion and data alignment across the BSW Hospitals Group. The main risks to the plan are available funding and the capacity of staff to engage in the digital agenda.

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):	

Digital Plan Update - November 2024

1 Introduction

This report summarises the progress against the Trust's Digital Plan which was signed off in November 2022. The Plan is split into five priorities:

- Our Electronic Patient Record
- Digitally enabled partnership working
- Supporting the people we serve
- Empowering a digital workforce
- Modern and Secure Infrastructure

The delivery of the activities with the Digital Plan is overseen through the Digital Steering Group. Digital Steering Group monitors progress against existing digital programmes alongside approving that new digital programmes align with the Digital Plan. The governance around prioritising transformation resource for programmes of work is managed through the Corporate Projects Prioritisation Group (CPPG).

The national approval of the Shared EPR Full Business Case in March 2024, originally planned for late 2023. The EPR Programme had now commenced with Oracle Health commencing on the programme in August 2024. The national funding available for the EPR Programme includes funding for enabling infrastructure, is predominantly upgrading the current wireless network to a modern environment. The Digital Steering Group signed off the networked infrastructure improvement plan in 2024 with phase 1 of this being funded through the EPR Programme. The remaining phases of the plan will be completed as capital funding becomes available however the existing wireless network has already been confirmed as EPR ready, the improvements will bring the Trust to industry standard and in line with ICS peers.

To ensure successful EPR delivery, there is an expectation that transformation programmes that are not essential will be paused/stopped unless they are required to deliver breakthrough objectives or key elements of strategic initiatives. Given the delay in EPR approval, 2024/25 has seen some further development with Lorenzo (incumbent EPR) to reduce higher clinical risks. Where new initiatives are progressed, careful planning in conjunction with the EPR programme team to ensure they complement one another, there is no risk introduced without approval and there is sufficient capacity to successfully complete the new initiative.

2 Project and Planned Work Progress

The table below outlines the major workstreams within the Digital Plan that were anticipated to be completed in 2024/25, alongside any workstreams that remained in progress at the last annual report in November 2023. Many programmes of work run over multiple years and have a range of activities and milestones within them as can be seen in the overall plan on a page in Appendix 1.

Workstream	Status	Update
Our Electronic Patient Record		
Shared EPR Programme	In Progress	FBC approved by NHS England, commencement of the programme in August 2024, Go Live is currently planned for October 2026.
Electronic Discharge Summaries in Lorenzo	Complete	

Nursing E documentation – Optimization Revisions and improvements, 6 and 24 hour bundles	Complete	Rollout completed in July 2023. Optimisation of what has already been rolled out will be completed this financial year.
Lorenzo patient context launch of Order Comms (Review)	Stopped	Order Comms cost and timescales from supplier proved inhibitive. Focus now on shared EPR
Digitally enabled partnership working		
ICS Joint data warehousing pilot	Complete	The ICB current hosts their data warehouse in the cloud providing the proof of concept however there was insufficient funding to extend the programme at the end of 2023/24. A review will be undertaken in the remainder of 2024/25 to agree the intended approach to joint data warehousing both at the Hospitals Group level and the potential extension with the ICS.
Adoption of PHM analysis tools	In Progress	The adoption of PHM analysis tools remains at an immature state with some pockets of use across the ICS. The ICS group that oversees PHM has agreed two focus areas for 2024/25 with the intention to agree the wider roll out plan once this phase of development is complete.
Integrated digital care record (ICR), expansion of shared content	Complete / In Progress	The ICR is live and seeing increasing use. There is a rolling programme of sharing additional reports (e.g. endoscopy, cardiology) as part of a roadmap of enhancements, aligned to AHA partners. Digital Respect forms in pilot
Cloud Power BI	Paused	Currently there is no funding to support the implementation of cloud (NHS Tenant) Power BI cloud and therefore this has been paused. A data strategic plan is intended to be developed by March 2025 in conjunction with Hospital Group peer organisations and this will be considered as part of this.
Procurement of archiving solution	In Progress	This is being procured jointly across the Hospitals Group in tandem with the EPR Programme, with procurement commencing in December 2024.
Roll out of advice and guidance software	Complete	
Hospice EPR	Complete	Implementation of new SystmOne Hospice EPR, aligned to Hospice community partners across BSW.
GP order comms replacement	In Progress	A new GP Order Comms solution has been procured however the implementation timeframes are still to be agreed to ensure no risk is introduced to the EPR Programme. This will be agreed over the next two months.
Standards based regional image sharing	In Progress	The West of England procurement of a regional PACS is underway and at preferred supplier stage. The Full Business Case for consideration will be brought forward in Q4 2024/25.

		Alongside this, the PACS consortium that the Trust is part of have successfully onboarded Hampshire Hospitals into the consortium as well as completing a number of upgrades.
Digital Histopathology rollout	In Progress	The programme is progressing well with testing expected to start in Q4 2024/25.
Supporting the people we serve		
Maternity and Cancer PHR pilots	In Progress	The Maternity PHR as part of the approval of the new Maternity EPR procurement. A new Maternity PHR forms part of this procurement. The initial phases of the Cancer PHR has been implemented.
Roll out of virtual consultations solution	Complete	Dr Doctor now being used for virtual consultations.
Virtual appointment rebooking	In Progress	This has been delayed due to supplier capacity to support the work and is delivery timeframes are currently in review.
Electronic patient letters and assessments	Complete	Delivered using the Dr Doctor software – patient letters and assessments shared digitally.
Expansion of home monitoring apps and telehealth	In Progress	The Trust has rolled our new telehealth solutions in some clinical services such as Respiratory over the last 12 months. As the market continues to evolve, business cases will be developed as opportunities for investment arise or through business planning.
Expansion of virtual wards	Complete	Virtual wards have been rolled out and will continue to evolve over the coming year.
Online resources to support patients and wayfinding	Not commenced	Currently this has not been commenced with the focus on rolling out a solution for digital signage and digital communications.
Expansion of Digital Improvement Network to include patients	Not commenced	The Digital Improvement Network will continue to be built upon as part of the EPR Programme. Currently this has not been extended to include patients with the focus on maturing the staff engagement and ownership of the digital agenda.
Patient access to digital devices	In Progress	The Trust has provided access to devices as requested by wards. A review is underway to agree the future model for patient Wi-Fi and entertainment which will better inform the future guidance and approach.
Empowering a digital workforce		
RPA Programme	In Progress	The RPA programme has commenced with first automations delivered. A rolling programme of opportunities being progressed.

Digital Maternity – Badgernet EPR	In Progress	Expecting to complete implementation of new Maternity EPR in Q4 2024/25.
Medical eRostering roll out	In Progress	Deployment is underway, having commenced later the planned.
Online corporate filing structure	Paused	Currently this is paused whilst the ICS awaits further guidance from NHS England on the Shared Tenant access controls to provide greater assurance that the proposed approach is viable. The expectation is that guidance will be provided in 2025/26.
RFID pilot	Complete	The pilot commenced during 2024 with a benefits realisation document being developed to consider wider rollout/investment case.
Build up core digital learning resources on the intranet	Complete	Additional training has been added and will continue to be updated with new content as it is required. Wider approaches to support training and education is to be rolled out as part of the EPR Programme.
Pathology LIMS	In Progress	Implementation of a single shared pathology LIMS system as part of the shared Pathology network continues with completion expected in mid 2025.
Digital literacy support roll out	In Progress	A small working group has been set up to consider how digital literacy can be improved with the initial focus being with staff. A baseline of existing literacy work will be completed with a more detailed plan being developed in Q4 2024/25.
Digital Consenting solution	Not Commenced	Currently this has not been prioritised given the wider demands across the Trust.
Modern and Secure Infrastructure		
Virtual Smartcards/Authentication	In Progress	The national approach to virtual smartcards/authentication have changed since the Digital Plan was written. The new authentication approach being rolled out (CIS2) nationally, currently two services live at the Trust.
Approval of Trust cloud strategy	In Progress	An ICS Cloud Strategy has been agreed outline a “cloud appropriate” approach when developing business cases. Moving to the cloud will be on a case by case basis for applications. A cloud landing platform is in development for the Hospitals Group, expecting completion in March 2025. Initial meetings have commenced in conjunction with peer Trusts to consider wider planning. Discussions are underway with a third party supplier on how best to approach a further joint readiness assessment of data and applications/tools.
Data Warehouse migration complete	In Progress	Complete replacement of legacy data warehouse expected by March 2025. This has been delayed due to competing demands on resource.

Wi-Fi & Network improvements	In Progress	In progress with a number of areas such as Maternity and Imber Ward modernized. Phase 1 of wireless network plan has been approved using national EPR funding. Further roll out beyond this will be subject to capital availability.
Expansion of secure bandwidth capacity	Complete	
Datacentre Hardware Replacement Project	In Progress	Major programme to replace the existing datacentre and managed service provider contract, new service in place (complete), decommission will complete this financial year.
Unsupported Server Programme	In Progress	Close to 500 servers and associated systems & software have been either upgraded or decommissioned since the commencement of the programme. 30 servers remain, which will be actioned by year end.

2.4 Other Project and Planned Work Completed

There are a range of wider projects and planned works in progress across the Trust. The following have also been completed during 2024:

Projects and Programmes completed in 2024
AMat – Mortality Reporting tool
Blood 360 Upgrade
Electronic Documentation Management System upgrade and enhancements
NHS Mail – Set up of Multi factor authentication (5000 users)
Electronic Referrals, Inpatient Bookings and Digitisation of Wessex rehab paper processes through Lorenzo
PACs Active Directory migration
Digital Communication and Signage solution rollout (SnapComms)
Upgrading of Microguide
Teletracking Upgrade – Portering system upgrade
SystmOne Upgrade (GP system) and read/write access for specialist services
Video Conferencing Upgrade for the Board Room
Somerset Cancer Registry Upgrade
Implementation of Care Coordination Solutions (now part of the Federated Data Platform)

2.5 Projects & Planned Work In Progress

The table below summarises the list of planned key activity items/projects that are either already in progress or due to commence in this financial year.

Projects and Programmes
Pathology MES roll out of managed equipment
Windows 11 implementation, roll out & upgrade
Lille (Sexual Health) System upgrade

Theatreman to Aqua system upgrade
Wayfinder – NHS App – Phase 2
GP Order Comms - Replacement
Voice Recognition Software (subject to Business Case approval)
Optimisation of Clinical Digital Administration Processes (letters)
ECGs storage in PACS (subject to Capital availability)
Auditbase (audiology) System upgrade
AOVPN Roll Out
Extension of the use of the Federated Data Platform

3 Benefits realisation

Over the last 12 months there has been improvement in monitoring the benefits from transformation enabled by delivery digital programmes. Some examples are as follows:

Programme	Benefits Realised
Digitisation of Outpatient Appointment Letters via DrDoctor	Achieved in the first 4 months of delivery (May – August 2024): • 33,325 Outpatient appointment letters sent digitally, with 57% of these (19,006 letters) being viewed by patients • This equates to approx. £13,000 of savings, through avoidance of cost associated with physical print. • Reduced carbon emissions emitted by the Trust as a result of decreased paper usage, packaging and postage. Qualitative benefits: • Improved patient experience due to the patient being more likely to receive their appointment letter with digital and paper options being in place. • Bespoke digital process in place for Military patients and military medical centres, improving military patient accessibility.
Digital Assessments	The Digital Assessments project has enabled 6 of our outpatient services to make efficiency improvements in how patients are triaged through waiting lists and how clinic time is spent, as well as enabling the Pre-Op team to meet NHSE requirements around earlier pre-screening and validation of patients added to our surgical waiting lists. Since deployment over May – July 2024, 1,838 forms have been assigned to 1,594 patients. Overall completion rate is currently sitting at 69.2% but individual outpatient services are seeing compliance rates up to 78%. From a performance level, this places the Trust as the 4th highest assigned to completed rate among DrDoctor clients and the highest number of deployed assessments. The measures of success vary for each of the assessment formats. Some examples are included below:

	• Spinal: Looking to improve compliance on national audit measures. Previous paper method saw a completion rate of 29%. DrDoctor completion is currently at 50%. • Respiratory and Wessex: Quicker triage of patients through the waiting list and reduced admin time associated with this (e.g. in respiratory, the 1 day admin time per week to distribute assessments has reduced to around 15 mins) • Paediatric Diabetes: Expect to be able to increase clinic slots by making their current process more efficient - aim to increase to 2 clinics a week. • Gynae and Burns: Expect to be able to use more clinic time for discussing patient needs as data will be collected in advance. Potential scope to increase number of clinic slots for some clinicians. • Pre-Op: Aligns with NHSE requirements around peri-operative screening and validation. Aim is to reduce the number of on the day cancellations through better pre-screening and reduced waiting lists through regular validation every 3 months. Qualitative benefits: • Validation and pre-appointment assessment tools increase the ways that clinicians can remotely review a patient – this means that Digital Assessments will decrease the likelihood of patients having to travel to hospital unless clinically necessary. • Assessments will allow patients to complete the form at their own convenience, including out of office hours, making the service more accessible for patients. Associated benefit of increased patient satisfaction.
Servers Refresh	Our rolling programme to remove unsupported technology has completed a significant number of upgrades and migrations over the last 12 months. This includes: • Upgrading 2 applications to newer versions, increasing resilience, performance, supportability and functionality • Migrating 5 applications to new hardware, increasing resilience and performance • Archiving 4 applications so that they are not in active use but accessible if needed) • Retiring 2 legacy applications The programme as a whole has significantly improved the Trust's cyber security posture and improved staff experience of using the applications that have been retained.
Discharge Summaries	Over 30 wards / clinical areas have moved from EDS onto Lorenzo for completing patients discharge summaries. Benefits of this include: • Improved Medication Management; decision support with the flagging of drug interactions • Improved patient safety through improved availability of drug charts and prescription information • Reduced need to access multiple applications where the patients care records would be stored – sole source of the truth • Reduction in Discharge medication errors due to reduced transcription errors on prescriptions - the new discharge summary removes the risk of any transcribing errors occurring as it will all recorded within the same system so no more transcribing will need to take place.

	• Alignment with the Transfer of Care Standards set out by NHS Digital • Improving Interventional Radiology communications with GPs through their new adoption of a discharge summary, having previously not sent information. • Improved visibility of discharge summary completion using Power BI • Maximising the investment made in our existing EPR application.
Hospice SystmOne Palliative Care implementation	With the Hospice EPR system going live in March 2024, the following benefits have been seen: • Improved Information sharing with our partners (GP practices, community teams, district nurses, ambulance staff, other hospices) now occurring at the point of care, electronically (delays eliminated) • Reduction in delays in care occurring as a result of information being unavailable to care providers external to the Trust • Faster processing and tracking of referrals • Consistent recording of and updates to EOLC (End Of Life Care) preferences • Reduced reliance on clinical and administrative staff to relay messages to partner agencies • Greater visibility of care records for colleagues in the Acute trust through palliative care record in SystmOne viewer • Reduction in use of paper • Increased accuracy of data held, leading to more accurate reporting for local and national strategic purposes, and to support capacity planning • Strategic alignment with National Palliative and EOLC Partnership Ambitions, NICE Guidelines, National EOLC Strategy, Wiltshire EOLC Strategy, SFT Digital Strategy

4 Risks to the Digital Plan

The main risks to the delivery of the Digital Plan remains funding, the availability of resources to support and the overall quantum of change the organisation can sustain.

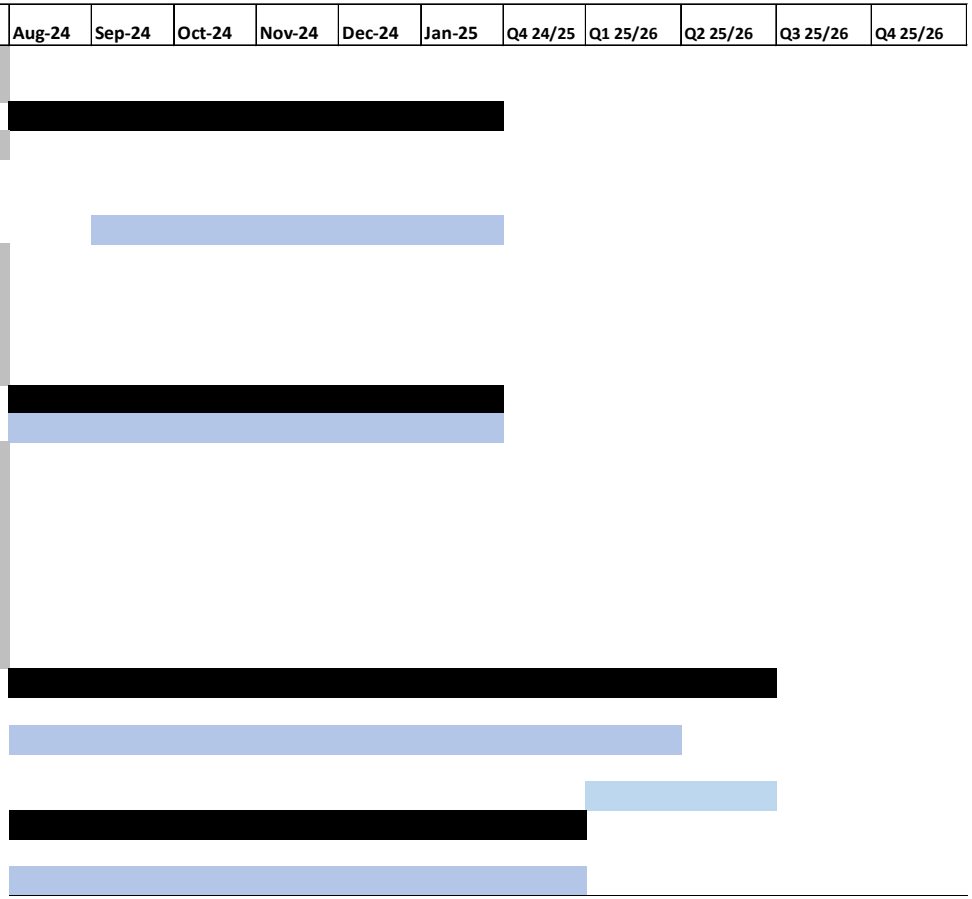
Nationally, funding available continues to be predominantly capital whereas increasingly the requirement is for recurrent revenue funding as solutions move to cloud hosting and/or different licensing models. Further to this, the national funding for digital has been restricted and is expected to be challenging over the coming 12 months. The Trust will continue to proiritise investment in technology through existing governance arrangements. This may slow the pace of some programmes outlined in the Digital Plan if funding is not available or wider strategic directions are required to change (and thus there is a need to focus funds and capacity to different areas).

Over the coming years the Trust will see a step change in support required to implement and optimise the Shared EPR. This will include ensuring the wide impact of releasing staff onto the Shared EPR is closely monitored. Over the last 12 months recruiting into technical roles in areas such as Business Intelligence, Clinical Coding and Infrastructure has continued to be challenging. As the requirements for different technologies including the increased use of cloud evolves, it will be important to continually review the skills needed within technical teams to provide the expected level support. The Trust has focused on upskilling and retaining staff however there will be a requirement to consider how resilience can be built in conjunction with peer organisations in the ICS. This has already successfully happened across Salisbury and Great Western Hospitals in some areas.

NHS Salisbury NHS Foundation Trust

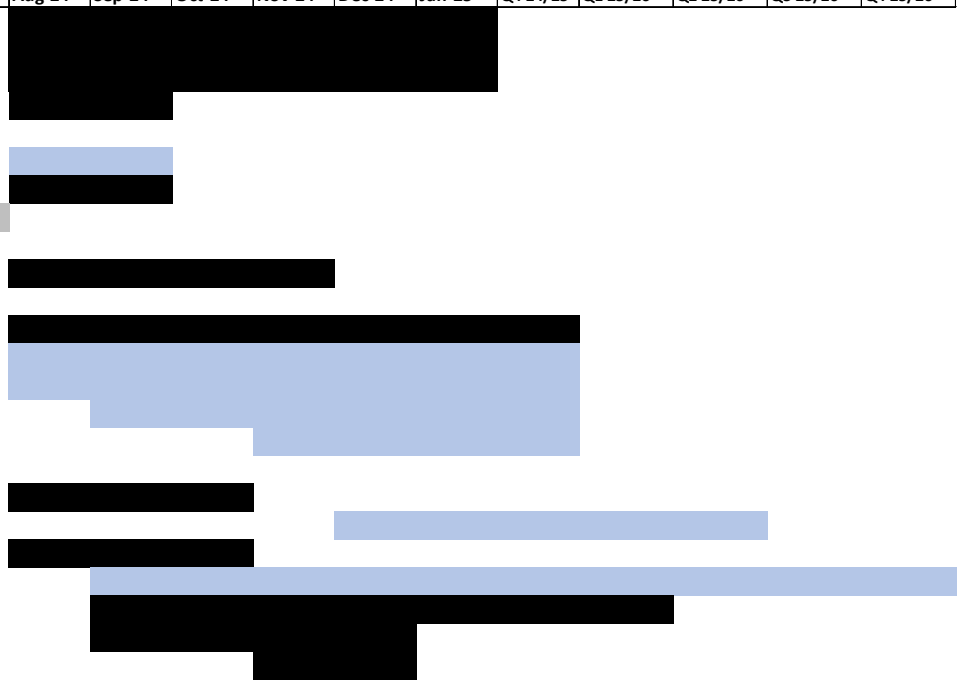
Appendix 1: Digital Plan on a Page

Project	Start Date	End Date	Original End Date	Complexity	Phases
EPMA	Mar-21	Oct-23	Oct-23	High	COMPLETE
					COMPLETE
Paperlite - E Documentation Phase 2/3	Mar-23	Jan-25	Sep-23	High	
					Phase 2 COMPLETE
					Final Phase scoping
					Final Phase Config/Testing
					Final Phase Implementation
Paperlite - Discharges in Lorenzo	Dec-22	Mar-24	Oct-23	High	COMPLETE
					COMPLETE
					COMPLETE
Paperlite - Electronic Bookings	Mar-23	Jan-24	Dec-23	Medium	COMPLETE
					COMPLETE
Paperlite -XIP/Other forms	Jun-23	Jan-25	Mar-24	Low	Implementation
PAC - CRIS Communicator Options	Jan-23	Dec-23	Nov/Dec 23	Medium	PAUSED
					PAUSED
PACS - AD Migration	Jul-23	Mar-24	Nov-23	Low	COMPLETE
					COMPLETE
					COMPLETE
BIGHAND/CITO Migration	Apr-20	Nov-23	Nov-23	Low	COMPLETE
		Jan-24	Nov-23		COMPLETE
					COMPLETE
Pathology LIMS	Jun-21	Jun-25	Jun-24	High	
					Preparation/Plannning
					Configuration/Build
					Testing
					Implementation
Digital Pathology	Jul-22	Dec-24	Apr-24	Medium	
					Hardware Install
					Phase 1 /Phase 2



Project	Start Date	End Date	Original End Date	Complexity	Phases
Shared EPR	**Apr-21**	**Oct-26**	**Mar-26**	High	
					Business Case Approval
					Engagement/Discovery
					Configuration/Testing
					Implementation
GP Order Comms Replacement	**Q1 25/26**	**Q2 25/26**	**Nov-24**	**Medium**	**Detail TBC**
Integrated Care Record - Phase 3	**Aug-23**	**ROLLING**	**Jan-24**	Low	
					Phase 3 Scoping
					Phase 3 Implementation
Doctor Dr - Letters/Assesments	**Jun-23**	**Oct-24**	**Dec-23**	Medium	
					Configuration
					Testing/Training
					Implementation
Cinapsis - Roll Out & Lorenzo integration	**Mar-22**	**May-24**	**Feb-24**	Low	
					COMPLETE
Teletracking Upgrade	**May-23**	**Aug-24**	**Jan-24**	Low	**COMPLETE**
Blood 360 Upgrade	**Apr-23**	**Mar-24**	**Oct/Nov 23**	Low	**COMPLETE**
TPP Viewer Upgrade/Roll out	**Jun-22**	**TBC**	Scope changes	Low	**COMPLETE**
		Nov-24			**Phase 2**
Snapp Comms (Digital Comms)	**Mar-23**	**Ongoing**	**Nov-23**	Low	**Implementation**
NHS MAIL - MFA	**Mar-23**	**Apr-24**	**Dec-23**	Low	**COMPLETE**
AMAT - Audit/Mortality System	**Mar-23**	**Apr-24**	**Oct/Nov 23**	Medium	**COMPLETE**
Audit					**AUDIT COMPLETE**
Mortality					**COMPLETE**
System One - Hospice System	**Feb-23**	**Mar-24**	**Q4 23/24**	Medium	**COMPLETE**
					COMPLETE
					COMPLETE
RPA - Process Automation Pilots	**Dec-22**	**Ongoing**	**Mar-24**	Medium	
					Intial Pilot Live
					Pilot Review and Proposal
					Rolling Implementation

Project	Start Date	End Date	Original End Date	Complexity	Phases
Servers Refresh Programme	**Oct-19**	**Dec-24**	**Jul-23**	High	**Rolling Programme**
BI Transformation	**Apr-19**	**Feb-25**	**Dec-23**	High	
Connectivity	**Dec-20**	**Ongoing**		Medium	
RAPIDS /SAN Replacement	**Jun-21**	**Dec-24**	**Mar-24**	High	
					Migration
					Decommission Old Network
Network Projects	**Sep-20**	**Rolling**	**Apr-24**	High	**Rolling Programme**
Video Conferencing Upgrade	**Feb-23**	**Dec-23**	**Dec-23**	Low	**COMPLETE**
VOIP/Telecoms Projects	**Nov-20**	**Replan**	**Oct-23**	Medium	**Replan**
SCR Upgrade	**May-24**	**Nov-24**	**Jul-24**	Low	**Planning**
Lille Upgrade	**May-24**	**TBC**	**Jul-24**	Low	**Planning**
Badgernet	**Nov-23**	**Feb-25**	**Nov-24**	High	
					Process Design
					Configuration
					Testing
					Training
					Implementation
Theatreman/Aqua Upgrade	**Jun-24**	**Jun-25**	**Jun-25**	Medium	**Planning**
					Implementation
Windows 11	**Sep-24**	**TBC**			**Scoping**
					Implementation
Digitisation of Clinic Letters	**Aug-24**				
Voice Recognition Business Case	**Sep-24**	**Dec-24**			**Buisness Case**
Wayfinder App	**Oct-24**	**Nov-24**			



High - Technically complex, or involves multiple stakeholders/services, and/or significant business change
Medium - medium technical complexity, major business impact is on one service
Low - standard technical work, or impacts small number of stakeholders, or very simple business change

Salisbury NHS Foundation Trust

Report to:	Trust Board (Public)	**Agenda item:**	4.1
Date of Meeting:	05 December 2024		

Report Title:	Bi-Annual Skill Mix review: Full report			
Status:	**Information**	**Discussion**	**Assurance**	**Approval**
	x	x	x	
Approval Process (where has this paper been reviewed and approved)	Clinical Governance Committee 26th November 2024 Safe Staffing Steering Group			
Prepared by:	Fiona Hyett Deputy Chief Nurse, CNO Safe Staffing Fellow			
Executive Sponsor	Judy Dyos, Chief Nurse			
Appendices (list if applicable):	1. Safe staffing data analysis by division 2. Registered Nurse ratios by ward 3. Costed skill mix recommendations, including SNCT analysis			

Recommendation:

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. Of note this year is the additional assurance provided by the triangulation with Safer Nursing Care Tool (SNCT) data alongside quality and HR indicators and professional judgement.

It is recognised that there is a significant funding request at a time of financial challenge, however, there has been underpinning work to fund and manage the headcount of these requests through alignment in e-rostering of shift times with the overlap minimised across all wards.

Executive Summary:

The yearly full skill mix review was undertaken in July and August 2024, reviewing data from June 2023 to July 2024. This period has seen a sustained improvement in nurse staffing levels, achieving a near zero vacancy level for Registered Nurses but very junior skill mix continues as do operational capacity demands such as escalation capacity and boarding of patients.

Corporate risk register ID 7039, initially captured when safe staffing could not be guaranteed has now been closed, following the improvement in vacancy levels.

It should be noted that Care Hours per Patient Day (CHPPD) which alone cannot be seen as a measure of quality and safety have plateaued at an average of 7.4 (when excluding maternity and critical care). SFT is in quartile 2 which is lower than both RUH and Swindon who are in the upper end of quartile 3.

The post Covid pandemic mental health crisis continues to impact in the number of patients admitted who require RMN or general enhanced care support. It is anticipated that investment into the recommendations highlighted would significantly reduce the reliance on additional enhanced care shifts with the exception of RMNs.

As highlighted within the report requests for further funding have been supported by the implementation of SNCT across all wards (except the hospice for which the tool is not designed) with all wards having a minimum of 1 data collection point. The implementation of the tool has been underpinned by a robust training programme and close scrutiny of all data collated.

The reduction of nurse temporary staffing spend should be seen in the context of published research which demonstrates a direct impact on mortality when high levels of temporary staffing exist.

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 whose work for the last year was due to focus on appointing a safe staffing lead to support the work across the 3 acute Trusts with an intended focus for the year on ED, theatres and out-patient staffing. The work has been slow to progress with no appointment made to the lead post, data collection has been done for EDs but recommendations are still to be agreed.

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

1. Purpose

1.1 The report presents the outcomes of the annual review of ward staffing nursing establishments for 2024. The paper focuses specifically on a review of all in-patient wards and the Emergency department and Intensive Care. Theatres and out-patients are not included within this review. Women and newborn, maternity and NICU are reported separately by the Director of Midwifery.

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. It also demonstrates compliance with the Royal College of Nursing (RCN) Workforce Standards 2021[4] alongside on-going compliance with the recommendations made by NICE 2014[5].

1.3 The last full review went to Board in September 2023 and the following recommendations were approved, though due to delays in agreeing funding they were not implemented into budgets until June 2024

WARD	BANDING and WTE	ROLE/SHIFT
AMU	Uplift of 3wte B5 to B6	Provide 24/7 senior support across unit and SDEC
ED	5.3wte B5	Implement triage model/RCEM recommendation
	2.5wte B3	RCEM recommendation
Farley	Uplift 2.6wte B5 to B6	Senior support to 4-hr target
Laverstock	5.3wte B5	Investment in unfunded beds
Spire	2.6 wte B5	Improve ratio of RNs on night shift
Amesbury	2.6wte B5	Improve ratio of RNs on night shift
Britford	Uplift 0.5wte B5 to B6	Leadership in SAU
Downton	2.6wte B5	Improve ratio of RNs on night shift
Sarum	Uplift 2.6wte B5 to B6	Senior cover on night shift

1.4 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 the rating was reduced to 12, and this year has been closed – reflecting the adequacy of the controls in place.

2.0 Background

2.1 National Guidance

In 2013 as part of the response to the Francis Enquiry[6] 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 guidance ensures that safe staffing levels are determined on patient needs, acuity and risks and can be monitored from 'ward to board'. This triangulated approach to reviewing staffing establishments provides evidence for CQC assessment. 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

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.

In January 2018 the NQB published an additional resource 'An improvement resource for the deployment of nursing associates in secondary care'.[7] 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.

CQC Quality Statement

The CQC assessment framework's quality statement relating to staffing is:

We make sure there are enough qualified, skilled and experienced people, who receive effective support, supervision and development. They work together effectively to provide safe care that meets people's individual needs.

2.2 **BSW Acute Hospital Alliance – Safe Staffing**

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 scope for 2024 was to continue to embed the previous priorities and to expand further the work to 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 – no appointment has been made and this work has made slow progress this year. Data collation has been completed for ED, but this has not been further reviewed or any recommendations made.

3.0 Right Staff

3.1 Ward staffing review methodology

3.1.1 Salisbury Foundation Trust (SFT) has an established systematic, evidence-based and triangulated methodological approach to reviewing ward staffing levels on a 6-monthly basis (full review plus 6mth update) and taking proposals for any changes to ward 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 enabling the delivery of efficient, effective and high-quality care.

3.1.2 The approach taken for the full skill mix review utilises the following methodologies and full detail of each ward review is in appendix 1:

- Shelford Safer Nursing Care Tool data.
- Care Hours Per Patient Day.
- Ratios.
- 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).

3.1.3 The full review was carried out with each ward during Q2, reviewing the data from June 2023 – July 2024. The reviews were attended by the Ward Leader, 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, SNCT and professional judgement.

3.2.1 <u>Safer Nursing Care Tool (SNCT)</u>

Since the last safe staffing review the Deputy CNO and Safe Staffing Matron have implemented Shelford Safer Nursing Care Tool (SNCT)[8], the only nationally approved evidence-based tool that enables the evaluation of nurse staffing establishments against patient acuity and dependency.

National guidance recommended that it is carried out a minimum of twice per year, for a period of 30 days each time – data capture is limited to 3 trained staff per ward and these staff have refresh training at each data collection point ensuring good quality of data.

6 initial wards plus ED completed data collection in November 2023 and June 2024 which has been included in the annual reviews, the remaining wards came online in June 2024 meaning they only have 1 data point – the tool recommends 2 to provide full assurance as this enables reviewing the data over time.

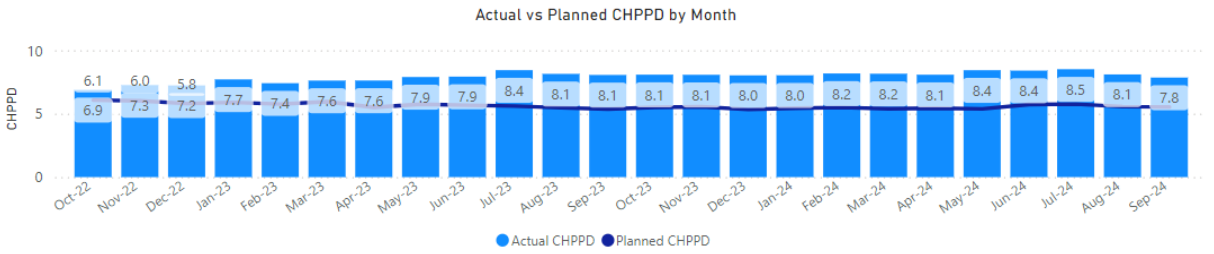
The outcomes from all the data collections are included in appendix 1 and appendix 3 which lists the recommendations for increases to establishment aligned with SNCT outcomes. These recommendations have also been triangulated with quality outcome and HR indicator data as alongside professional judgement.

3.1.4 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.

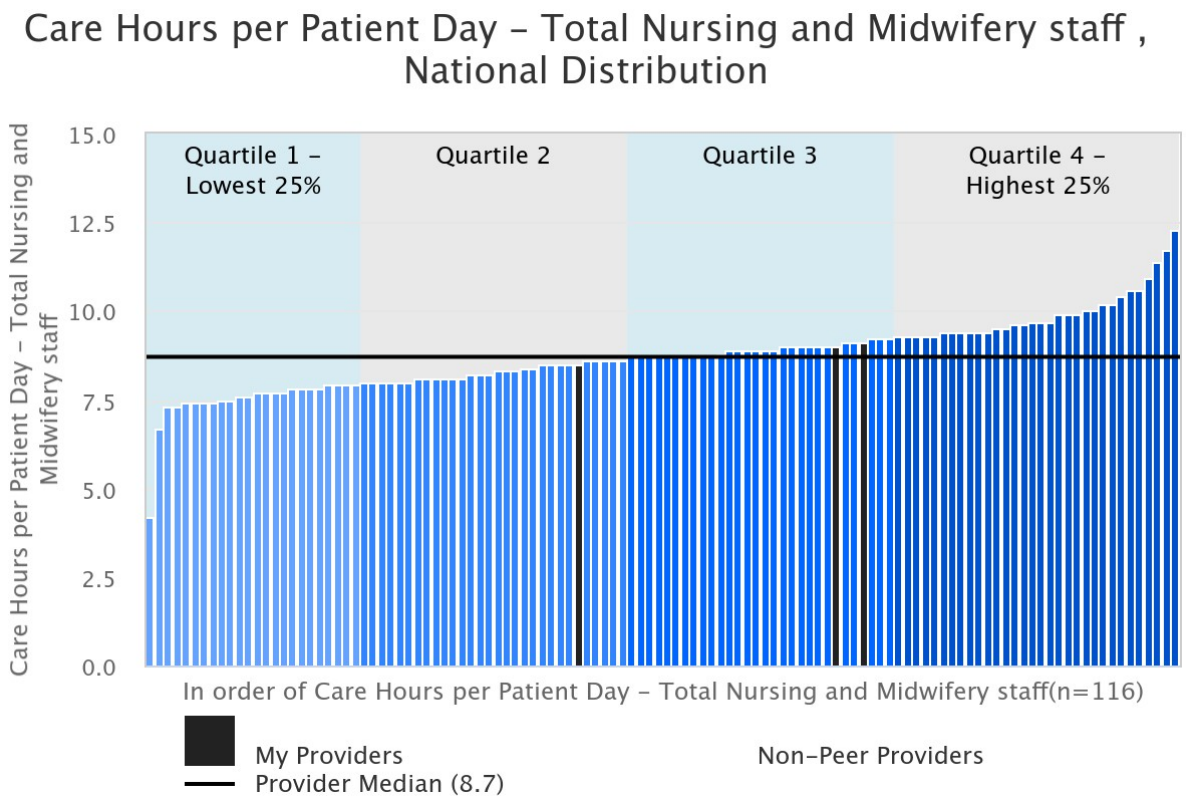
Within Model Hospital comparisons can be seen at both ward and trust level, however, caution is required as the specific configuration of services in any organisation determines the level of staffing required. CHPPD required to deliver safer care can vary in response to local conditions such as the layout of a ward or the dependency and care needs of the patient group it serves. Therefore, higher levels of CHPPD may be completely justifiable and reflect the assessed level of acuity and dependency. Lower levels may reflect organisational inefficiencies or innovative staffing deployment models or patient pathways.
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 sustained the improvement of the previous year across all clinical areas generally at around 8.1– which is driven by the improvement in vacancy levels and reduction in escalation areas that are open. Reduction in September 2024 is due to re-alignment of bed and staff in maternity and the assessment areas in AMU and SAU.
In line with the national guidance when reviewing the data that wards are only compared against themselves over a period of time.



CHPPD Benchmarking

The chart below shows SFT benchmarked nationally against all acute providers and shows comparison against RUH and GWH. Whilst SFT CHPPD has improved we remain in Quartile 2 below the provider median, whilst our BSW partners are comfortably in Quartile 3.



3.1.5 Nurse to patient ratios by registered and total nursing

National guidance (including NICE) recommends patient ratios should not be greater than 1:8 Whilst there are no mandated staffing ratios there is a significant body of evidence that links ratios of greater than 1:8 to higher mortality as well as harm and poor experience.

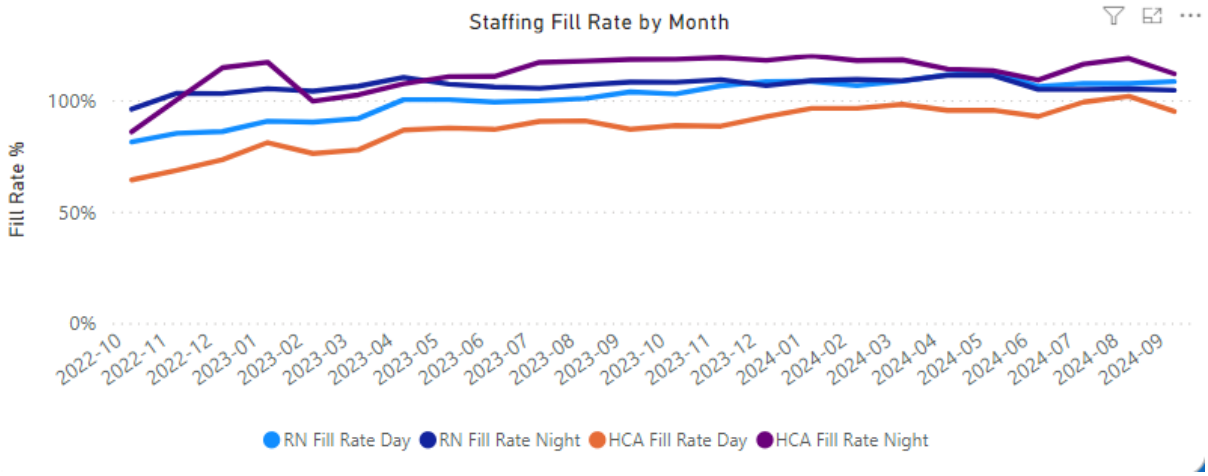
Appendix 2 summarises current RN:Patient ratios which within current establishments range from 1:4 to 1:8 on day shifts and 1:4 to 1:9 at night depending on specialty and overall staffing model, which is an improved position on the previous year. The exception is Breamore which is 1:9.5 day and night but is appropriate to the ward change in designation to holding patients with no criteria to reside.

These ratios do include the nurse in charge (shift co-ordinator), although the intent within the AHA is for ratios not to include this role. 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).
In addition, ward leaders are budgeted to 80% supervisory time with many ward leaders now getting this supervisory time following a period of successful recruitment.

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.

3.1.5 Fill rates – nursing staff planned vs actual (in-patient beds)

As part of the monthly CHPPD submission, the Trust also returns its position with actual hours worked versus planned hours for all in-patient areas. The percentage fill rate for registered nurses and health care assistants for both day and night shifts.
The fill rates have sustained at a position above 100% for RNs – which relates to over-establishment as part of ensuring we sustain minimal vacancies. For HCAs the fill rate is over 100% at night due to enhanced care and less than 100% for day shifts which is due to on-going vacancies.
The graph below shows the trend over time:



4.0 Right Skills

4.1 Recruitment and retention

4.1.1 Registered Nurses

The achievement within RN recruitment has been sustained with a near zero vacancy position throughout the year across the wards for RNs, and with turnover at 10% below the Trust target. Much of the recruitment remains focused in the international space and ward mix of internationally educated nurses is now at around 60% of all ward registered staff.

The NHS long term workforce plan articulated a move away from the reliance on 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. Financial approval has been given for 10 places per year for Nurse Associates to top-up to RN and for 5 places per year for RN degree apprenticeships. Due to the timing of this approval and University application timelines these will not be able to commence until the 2025-26 financial year.

Further development of the Nurse Associate role has continued with partnership of the Trust with Coventry University and Wiltshire College and the approval of a direct entry programme which supports widening participation.

4.1.2 Health Care Assistants

Turnover amongst HCAs has been identified as a key area of focus for the Trust as at 18% is above target and impacts at ward level with an on-going requirement to continually recruit

and train new staff. Focused work has included development of 2-week initial training package, ensuring completion of care certificate by all new starters, a year long preceptorship programme and early work is in progress to utilise an apprenticeship to support their development.

4.1.3 Retention Initiatives

Clinical Practice Educators
The central practice education team increased by 2.0wte to focus on the training and education needs of our internally recruited staff. This enabled the re-aligning of OSCE training back in-house and supports international staff to pass their structured OSCE assessment, with first time pass rates now at over 60%, significantly higher than the national average. The programme has also improved the confidence of these staff, supporting them in transitioning into RN roles and seeing turnover decrease.

Professional Nurse Advocates (PNAs)
PNAs are a national initiative to provide restorative supervision in practice and the Trust had been slow in their implementation. A senior nurse has been working focused in this area which has brought together the current PNAs, enabled a further 4 staff to undertake training and provides a trajectory to meet the national target of 1 PNA to 20 RNs.

Legacy Mentors
The Trust was funded by the ICB to host 1 legacy mentor, which has subsequently been amalgamated into the wider practice education team. Legacy mentors are experienced nurses at the end of their career who provide mentorship and guidance to newly qualified nurses, aiming to prevent them leaving their careers within the first 2years through providing pastoral care as well as career advice and mentorship.

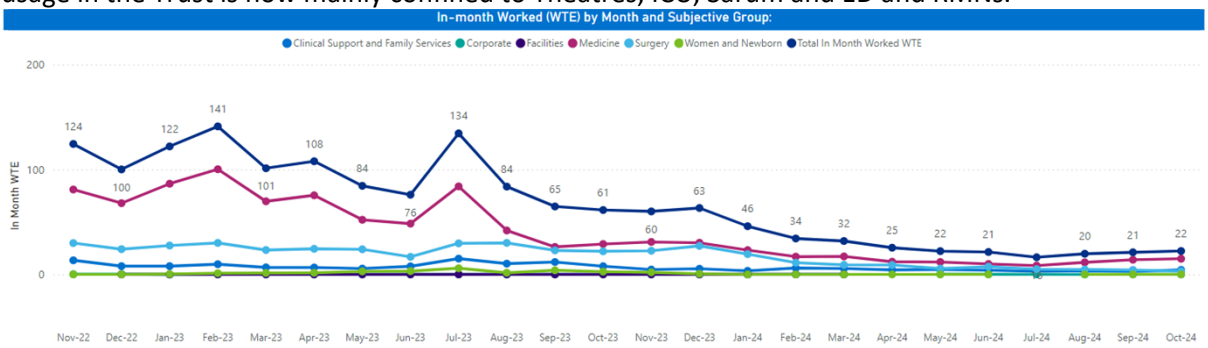
5.0 Right Place and Time

5.1.1 Daily staffing meetings and Safecare
On a daily basis the ward staff continue to record daily acuity and dependency via SafeCare (through the e-rostering system) and record professional judgement on daily staffing levels which supports daily decision making in twice daily staffing meetings, this 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.
The rollout of training in acuity and dependency for SNCT along with a review of how SafeCare is used has seen a significant improvement in the accuracy of scoring related to daily staffing needs.

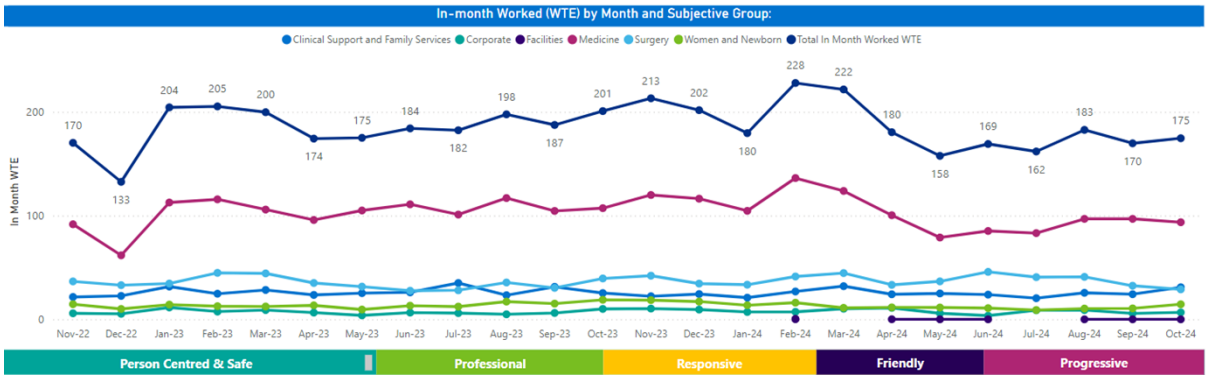
5.1.2 Temporary Staff
The drive to reduce the reliance on temporary workers must be seen in context of quality and safety, recent research by Griffiths et al (2024)[9] showed a statistically significant increase in the risk of death among patients exposed to low nurse staffing or high proportions of temporary staffing, and the presence of senior/experienced staff did not mitigate in either of these groups.

Drivers for temporary staffing (bank and agency) are unfunded escalation beds, ward sickness rates at 8-10% and RMNs.

As the graph below demonstrates, the current financial year has seen on-going success in the reduction of agency to its lowest level and the elimination of off-framework agency. Agency usage in the Trust is now mainly confined to Theatres, ICU, Sarum and ED and RMNs.



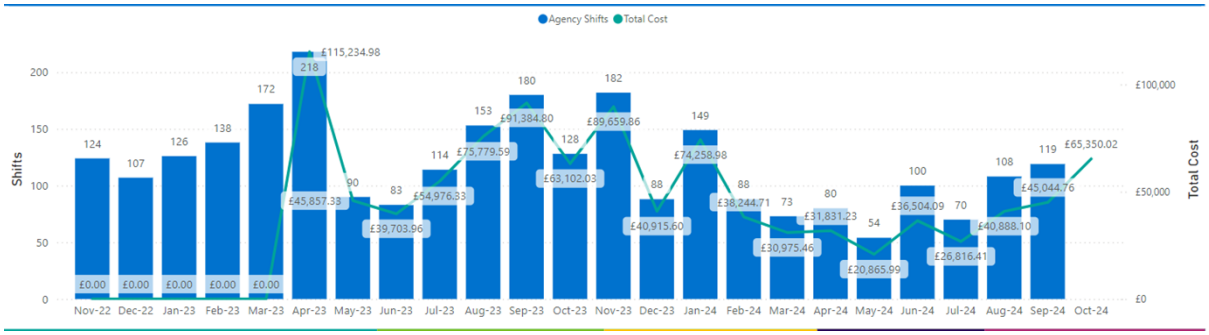
Progress with reduction of bank has been slower than agency despite the improved RN vacancy position due to both vacancy for HCAs and lower CHPPD which means tolerance for managing without a staff member is reduced (alongside the drivers highlighted above). However, work is on-going to further improve this position whilst maintaining quality and safety.



The Deputy CNO has co-chaired a SW regional nurse agency group which has also seen all Trusts across the SW achieve capped rate compliance for nurse agency.

5.1.3 Impact of Mental Health

One of the impacts that has continued since the Covid pandemic is on mental health – whilst compared to 2023 there has been a reduction, there continues to be demand for both paediatric and adult patients admitted requiring specialist mental health input, and we are reliant on agency workers in this space.



5.1.4 Additional Duties

These are shifts created over and above the ward establishment when wards perceive a need for more staff that in the roster template – usually for 1:1 care of patients with enhanced care or mental health needs – this is monitored through acuity and dependency scoring in SafeCare.

Year to date spend on specials (RMNs and general RN/HCAs) at £755k is lower than previous 2 years and if continues at same rate will remain lower as table below shows:

2024-2025	£755k at mth 7 (predict £1.3m end of year
2023-2024	£1.8m
2022-2023	£1.7m
2021-2022	£70,961
2020-2021	£376,242
2019-2020	£622,193

This has been an area of real focus which has driven the reduction seen this year. The Deputy CNO is joining the National Advisory Group for enhanced care as this is seen as an area of challenge across the country.

5.1.5 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 mainly by sickness levels that are running higher than allowance (around 8-10%) and training/supernumerary time for new starters.

- Maternity leave has seen a lower impact this year but remains unpredictable and impacts on staff availability.

- The Trust continues to run a supervisory model for ward sisters/charge nurses equating to 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 sustained from the last review with all areas generally achieving the 80% level.

6.0 Specific Divisional Themes

Outlined below is the detail presented by each division which sets out the rationale for recommendations for increases in establishment.

Appendix 3 sets out the recommendations from the individual ward reviews and shows indicative staffing levels against SNCT.

If all recommendations were supported this would see an investment of £1.7m, with a proposal that the funding could be secured from a change in the shift overlap which would release £2m (detail also included in appendix 3). The Divisions have agreed that this would significantly reduce the reliance on additional staff for enhanced care (with exceptions for RMNs) further driving down run rate.

6.1 **Medicine Division:**

RN staffing levels have continued to improve over the past year however turnover and vacancies in HCAs continue – being addressed through Trust retention focus. Continued demand from patients requiring enhanced care needs although there is ongoing work to ensure wards use the enhanced care policy to assess and identify risk. Within the Division

there has been the continued need for use of escalation areas to manage the demand for medical patients, these have included ED corridor, intentional radiology, use of boarding spaces on Farley, Spire and SDEC, which then impacts on additional use of temporary staffing.

Key areas for priority for the division are:

Durrington AFU - Durrington ward has become the acute frailty unit and as such is now a direct admissions area with increased patient flow and acuity, to manage the demand there is a need to increase of x1 RN on nights, x1 HCA on a late shift and an uplift of 2 x RNs from B5 to B6 to support this change.

Spire – on-going demand of patients with enhanced care needs alongside a ward layout that can be challenging to meet the needs for this cohort of patients. The uplift of x1 RN during the day and an additional HCA overnight would be offset by the removal of additional duties allowing the ward to manage within the increased template.

Emergency Department – Attendance numbers have continued to increase which has resulted in an increase requirement for senior nursing leadership on each shift, to recognise and respond to the ever-changing complexity of the department, this is reflected in RCEM standards. To deliver this requires an uplift to ensure cover by 1 senior sister per shift to oversee whole department, and an additional junior sister to ensure senior leadership in areas within the department.

Redlynch – currently staffing in the afternoon reduces which is not reflective of the workload, an increase of x1 RN and x1 HCA to address the shortfall in the afternoon.

Pembroke – Additional RN 10-6pm; this is acknowledging commencement of the SACT service and the increasing demand and support of the AOS helpline.

Pitton – Additional RN on the long day whilst reducing 1 x HCA on the early shift, this is in line with safer staffing recommendations for registered nurse ratio to HCA.

Farley – Additional RN for the 24-hour period, this is to increase the RN/HCA ratio to ensure safe registered nurse staffing levels.

Whiteparish - currently RN staffing reduces in the afternoon, which is not reflective of the workload, changing an HCA to an RN on the late shift would address this.

AMU – Currently there is a continued pressure of workload into the night shift on AMU, this is reflected by the high numbers of patients being admitted, transferred and discharged into the night, we are requesting an additional HCA on nights to support this.

6.2 **Surgical Division:**

The Division has prioritised 2 areas requiring an uplift in staffing:

Amesbury ward continues to have an increased dependency of post orthopaedic trauma surgery. The acuity of this patient group is hight due to their acute frailty and comorbidities. The area has experienced challenges associated with this in the last 12 months which has been reflected in patient safety incidents namely hospital acquired pressure damage, which resulted in a period of intensive support where the need for an uplift of staffing was an evident theme. Furthermore, there is a need to drive patient flow supporting the NHFD BPT of length of stay and 4-hour admission target. There is a requirement to ensure a senior presence in this area. Our priority is therefore to improve RN to patient ratio by 1x RN on the Long day.

Downton received an RN uplift on the night duty in the last safe staffing review resulting in a 1 to 8 RN to patient ratio enabling the ward to manage enhanced care such as tracheostomy and airway patients. Due to the planned focus on the expansion of SAU and the development of Surgical SDEC there will be further focus on downstream patient flow to this ward. Our second priority is therefore to increase by 1x RN early on weekend shifts to provide consistency over 7 day working increasing the staff to patient ratio for this shift to 1

to 6 as per the Monday to Friday template. This reduction in weekend staffing is not implemented in other areas and stems from the previous short stay patient group that the ward historically accommodated.

6.3 **Clinical Support and Family Services**

Paediatrics

Sarum Ward has seen successful recruitment of paediatric nurses, resulting in the appointment of 6.0 wte nurses, including both newly qualified nurses and experienced nurses from acute paediatric settings.

The current Practice Educators are funded out of the Band 6 budget (1.2 wte) which has been for an extended fixed term period. They have supported clinical work to cover vacancy gaps and improved senior cover when patient acuity has been high, and the recommendation is that this becomes substantive. This is in line with regional paediatric services where practice educators are key to ensuring that nursing staff at all levels have the knowledge, skills, and confidence to ensure the delivery of high-quality care to children and young people across the trust (including ED and DSU).

Spinal

Another positive year of improvement for Longford ward with exceptional recruitment and reduced turnover of staff, leading to a consolidation of skills and spinal nursing experience supported by spinal education team.

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 uplift by 1.74 WTE band 5 staffing to protect patient oversight including medication rounds and controlled drug administration, whilst covering out of hours telephone line.

7.0 Conclusions

The 2024 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 to meet the shortfall demonstrated through data from SNCT triangulated with quality and HR indicator data and professional judgement.

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 but also through the controls it has in place and the use of acuity and dependency tools to articulate need. 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.

Whilst CHPPD can be seen to have improved over the last year as a result of an improved vacancy position the Trust still remains in the lower quartiles. 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.

8.0 **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 implementation of the Safer Nursing Care Tool providing both evidence of required staffing levels with a mechanism 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 3 and noting the proposed work on shift overlap and 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.

References

1. National Quality Board. How to ensure the right people, with the right skills, are in the right place and the right time: A guide to nursing, midwifery and care staffing capacity and capability. NQB. 2013.

2. National Quality Board. Supporting NHS providers to deliver the right staff, with the right skills, in the right place at the right time: London: NQB. 2016.

3. NHS improvement. *Developing workforce safeguards: Supporting providers to deliver high quality care through safe and effective staffing*. NHSi. 2018

4. Royal College of Nursing. Nursing Workforce Standards: Supporting a safe and effective workforce: RCN 2021

5. National Institute for Health and Care Excellence (NICE). *Safe staffing for nursing in adult inpatient wards in acute hospitals*. London: NICE 2014. Available from https://www.nice.org.uk/guidance/sg1/resources

6. Francis R. Independent Inquiry: Report of the Mid Staffordshire NHS Foundation Trust Public Enquiry. London: The Stationary Office, 2013.

7. National Quality Board. Safe, sustainable and productive staffing. An improvement resource for the deployment of nursing associates in secondary care. NQB. 2019.

8. The Shelford Group. Safer Nursing Care Tool; Implementation Resource Pack 2014.

9. Griffiths, Saville, Ball et al *Nursing Team Composition and Mortality Following Acute Hospital Admission 2024* Available from Nursing Team Composition and Mortality Following Acute Hospital Admission | Health Policy | JAMA Network Open | JAMA Network

Report to:	Trust Board (Public)	Agenda item:	5.1
Date of meeting:	05 December 2024		

Report tile:	Patient Experience – Patient Feedback Report – Q2 2024/25			
Status:	Information	Discussion	Assurance	Approval
	Yes	Yes	Yes	Yes
Approval Process: (where has this paper been reviewed and approved):	Clinical Governance Committee 26th November 2024 Scheduled for Patient Experience Steering Group – 27th November 2024. Scheduled for Trust Board – 5th December 2024.			
Prepared by:	Victoria Aldridge - Head of Patient Experience			
Executive Sponsor: (presenting)	Judy Dyos - Chief Nursing Officer			
Appendices (list if applicable):	None.			

Recommendation:
This report is for assurance and noting by the Board.

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 any National surveys reported during Q2 of 2024/25. To summarise the contents of this paper: **Complaints/concerns/compliments and enquiries:** Patient activity across the Trust has decreased this quarter, the total number of complaints and concerns has also decreased. A total of 77 were logged for Q2, compared with 111 in Q1. A total of 435 comments/enquiries were logged by the PALS team in Q2, this is less than the previous quarter. Of these, 66 were not related to any of the clinical divisions and over 50% of these were related to charges for car parking. A total of 171 compliments were recorded on Datix this quarter across the Trust (less than last quarter). The previously noted backlog of approximately 220 compliments for Q1 has now been resolved and reporting has been updated accordingly. Despite the above, PALS capacity remains flagged on the Quality Risk register, but risk has been reduced, following updated status and mitigations in place. For Q2 the top three most prevalent high-level themes for complaints across the Trust were the same as those seen in both Q1. These were in relation to **Patient Care** (44%) and **Communication** (18%). **Values and behaviours of staff** is a new theme this quarter (13%) – see Table 1.2. Within these themes **unsatisfactory treatment, lack** or **insensitive communication** and **attitude of medical staff** were the highest sub-categories (see Tables 1.1a - 1.2c).

Meeting the 85% target for **complaints response within timescale** continues to be a challenge, (see Figure 1.3). The PALS Department have added this to their Improving Together huddles as a driver metric, with "Go Sees" planned for Cardiology and ED to understand factors in these delays and help target improvements.

The number of **reopened complaints/concerns** this quarter is currently estimated to be around 7%. For 2023/24 the Trust has had an average 8% of the total complaints/concerns received, reopen. Patient Experience Quality Priority Targets for 2024/25 would like to see this reduce to less than 5% by the end of the year. CSFS were noted to continue to have 0 reopened complaints and an action is being taken through PESG to understand what learning could be shared with other Divisions.

Friends and Family Test (FFT) Trust wide average response rate for Q2 has seen a peak with the introduction of the new digital solution. In total for Q2 there was a total of 16,123, this is 8,545 more than Q1. This equates to an average response rate of 17% (of eligible population), exceeding the Trust's target. FFT experience ratings have however decreased slightly to 94%, this is below the Trust's target for satisfaction. New FFT boards are currently being rolled out across the Trust.

Local Surveys:

Real-time feedback (RTF) remains a standing item for discussion at the PESG. Overall good satisfaction rates, improvements seen this quarter on Q1. Some issues still noted around noise at night and involvement with discharge plans. High levels of satisfaction related to cleanliness of the ward areas, receiving enough to eat and drink and feeling safe. A total of 100 surveys were completed during this quarter and an average overall satisfaction rating of 87.4% being achieved. The RTF annual report was shared with PESG in September and included actions to triangulate this data with the National Inpatient Survey; and look at how RTF can be improved to provide better insights into safety, noise at night and involvement with discharge plans.

Your Views Matter quarterly report has been replaced with the National Audit for End of Life Care (NACEL) Survey. The Q2 report was presented to the EOLC Steering Group, who were asked to consider whether this report providing enough insight for quality improvements within the hospital. This was to aid their decision on whether NACEL should continue beyond December 2024, or whether the Trust should resume its own quality measures (Your Views Matter). This decision was deferred pending 1the NACEL changes update was announced (scheduled for the end of November 2024).

Annual complaints survey was noted to have had a decreased response rate on comparison to last year's report, with only 15% of these being returned. Insights from this data have resulted in actions to improve:

- The alignment of feedback to each Division
- Improve process to increase volume of surveys received and overall response rates
- Rephrasing of a question to ensure it accurately reflects the current processes
- Improve communication throughout the complaints process with the complainant (this is now a driver metric for the PALS department's improving together huddles)

National Surveys:

National Inpatient Survey 2023

Overall, the Trust received a similar response rate to last year, achieving a return rate of 51% (higher than the national average at 41.7%). The Trust scored better than other trusts in relation to staff explaining the reasons for changing wards during the night in a way in which they could understand. All other 48 questions were scored comparatively with other Trusts. Overall experience was also noted to have increased positively by more than 5%, with experience rating increasing to 8.3 this year (from 8.0 in 2022), placing the Trust amongst the highest scoring within our region.

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
Q2 Report 2024/25

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

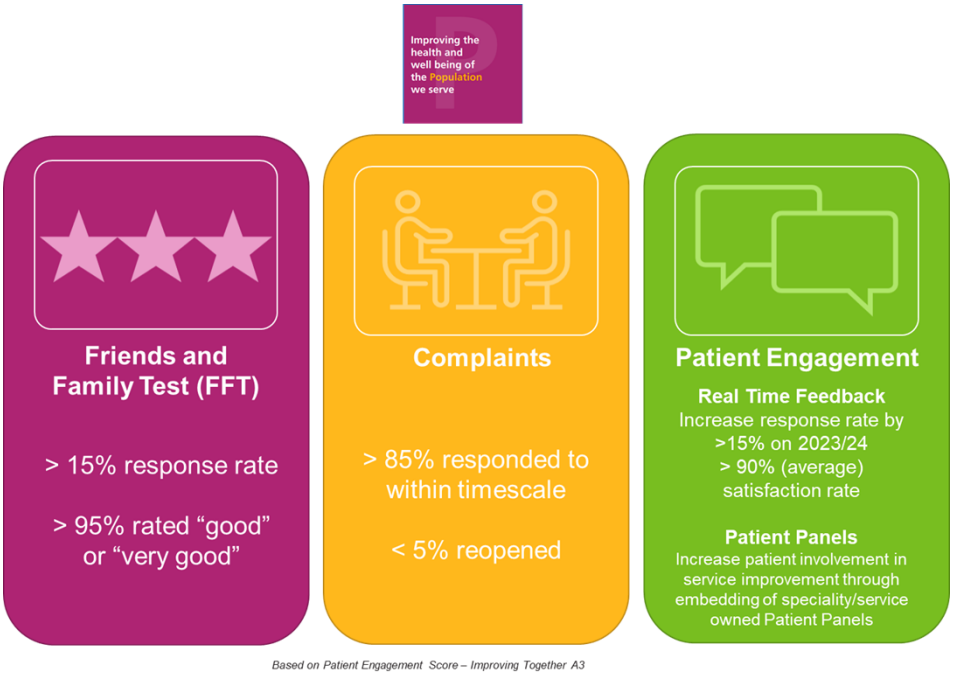
Patient experience is defined as “the sum of all interactions, shaped by an organisation’s culture that influence patient perceptions across the continuum of care”. Nationally, the scrutiny in relation to compassionate healthcare, as well as in engaging with the public, is to understand their voice and 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.

In line with the Trust’s Improving Together Methodology and under the Patient Experience Quality Priorities approved through the Patient Experience Steering Group, the following areas remain the focus for 2024/25. Friends and Family Testing, Complaints and Patient Engagement.

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.

Summary of the performance metrics in relation to these areas is summarised below:



Contents

1. Complaints, Concerns and Compliments - Trust Overview

There were a total of 7 items of feedback posted on the NHS Website* in Q2.

Average rating on responses: ★★★

	Positive	Neutral	Negative	Average star rating
Q2 24/25	**4**	**0**	**3**	★★★
Q1 24/25	3	0	0	★★★★★
Q4 23/24	2	1	0	★★★★★
Q3 23/24	6	1	0	★★★★★
Rolling year Total / Average	**15**	**1**	**3**	★★★★½

*All feedback is available here: Ratings and reviews - Salisbury District Hospital - NHS (www.nhs.uk)

Summary of these comments are demonstrated in this word cloud:

Patient Activity

Table 1.1 shows the breakdown for patient activity across the Divisions and total for the Trust. This is used to calculate feedback on a per 1,000 basis within this report (see Figure 1.1). The Trust is seeing a higher level of patient activity compared with last quarter, and this is noted to be first quarter where there has been an overall drop in activity, however, remains higher than this same period last year.

Table 1.1 – Patient activity

Patient Activity by Division / Quarter	Clinical Support and Family Services	Medicine	Surgery	Women & Newborn	Total
Q2 2024 - 25	36,567	36,800	43,222	5,273	121, 862
Q1 2024 - 25	36,630	38,139	42,344	5,291	122, 404
Q4 2023 - 24	36,547	37,402	41,456	4,576	119,981
Q3 2023 - 24	33,495	35,002	41,789	4,471	114,757
Q2 2023 - 24	33,871	34, 921	39, 997	4,330	113,119

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 formal

recognition. Whilst compliments continue to be retained locally within the department areas, the PALS team have been working to promote the importance of sharing these to allow for more formal reporting. This ensures for more robust reporting and changes to the Datix system now allow for theming of compliments to enable reporting alongside complaints and FFT.

Complaints and Concerns

Figure 1.1 Total Number of Complaints, Concerns, Compliments and FFT per 1,000 of Trust activity

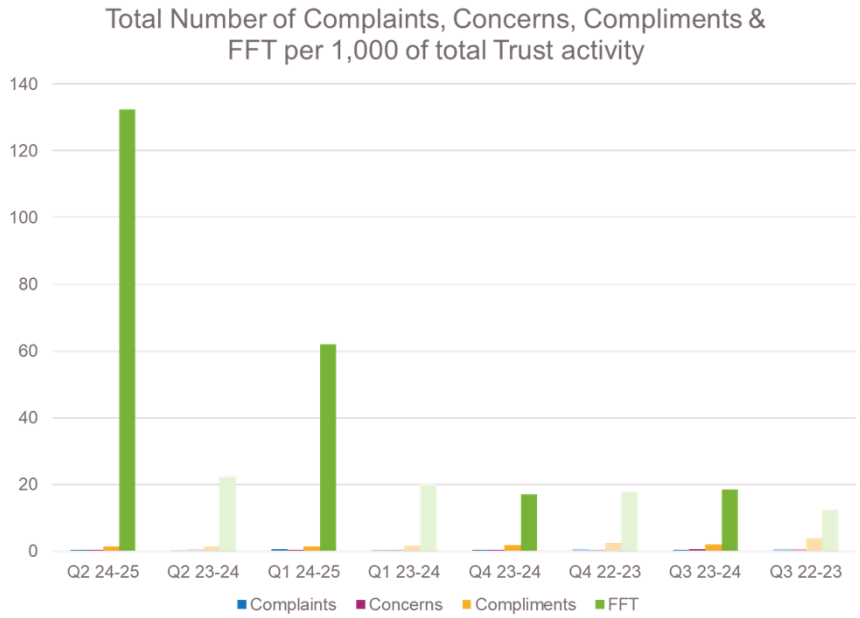


Figure 1.1 shows a slight decrease in the total number of both complaints and concerns received for Q2, in comparison with Q1. These numbers continue to remain overall lower when comparing the same period last year *(opaque graphs show 2023/24 reporting)*.

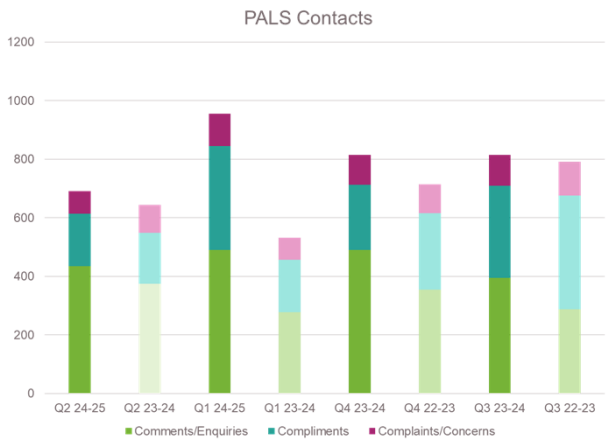
FFT feedback continues to significantly increase this quarter, with an average 94% satisfaction rate.

Compliment numbers have continued to fluctuate, as we balance the continued promotion of formally recording these with PALS and the resources needed to undertake this. At the time of writing this report, there were at total of 171 compliments recorded on Datix for Q2. Last month, there was an estimated 220 still outstanding for logging, these have now been added to Datix. This update for Q1 has been reflected in Fig 1.1a below.

In Q2 the PALS department logged 435 comments/enquiries. 65 less than Q1.

This equates to an average of 3.6 contacts per 1,000 patient activity across the Trust. These contacts are in addition to the complaints, concerns and compliments.

Figure 1.1a Total Number of Complaints & Concerns, Comments/enquiries, and Compliments logged by PALS with quarter comparisons 2022/23 – 2023/24



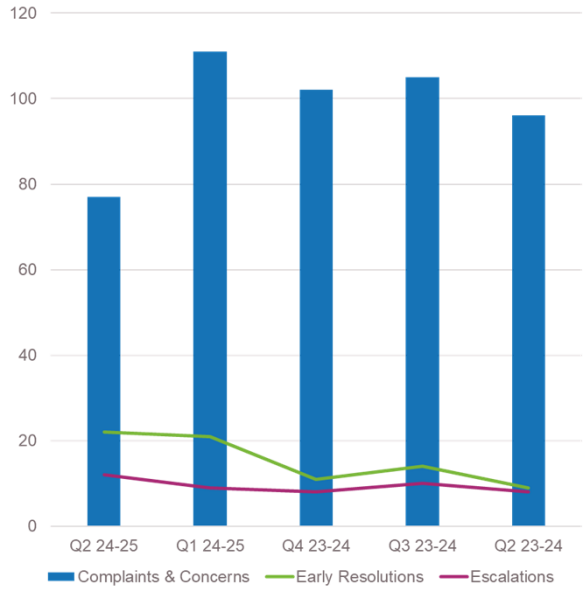
During Q1 there were a total of 77 complaints and concerns logged (111 in Q1).

Figure 1.1a demonstrates the continued steady increase in contacts for the PALS department, particularly for comments and enquiries on comparison with the same period last year.

Complaints and concerns however, have been comparatively lower when compared with the same time periods last year (pink opaque graphs).

Changes to the complaints process over the past 6-12months coupled with targeted work through PALS to adopt the PHSO principles on **early resolution** of complaints continues to be emphasised.

Figure 1.1b Total Number of Complaints & Concerns, Early resolutions, and Escalations



22 of the 77 were considered to achieve an earlier resolution than anticipated in Q2.

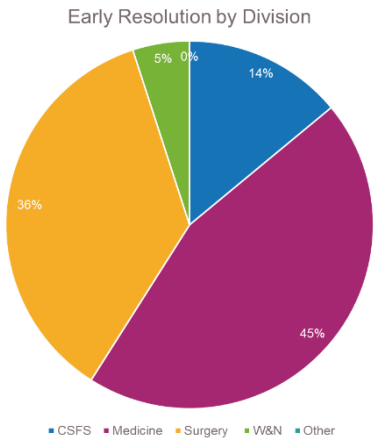
12 of the 77, were noted to have escalated from a comment or enquiry into a concern or complaint.

Figure 1.1b shows how this correlates with previous quarters.

Figure 1.1c shows how the de-escalated complaints/concerns were distributed across the Trust.

Medicine continues to work hard this quarter to adopt the principles around early resolution and de-escalation, and this is evidenced by have the highest proportion of these 22.

Figure 1.1c



Themes from Complaints/concerns

Table 1.2 below shows the themes for complaints and concerns received in Q2 (trust wide).

Highlighted are the top three most prevalent themes. **Patient Care** and **Communication** are consistent themes with the previous quarter, however **values and behaviours of staff** is a new theme for this quarter. These top three themes are further broken down into sub-categories for deeper analysis in Tables 1.2a, 1.2b and 1.2c.

Table 1.2 Raw data - Themes from Q2 Complaints/concerns

	CSFS	Medicine	Surgery	Women & Newborn	Non-clinical	Total by theme	% of total by theme
Access to treatment or drugs			5			5	6.5%
Admissions, discharge and transfers	1	6				7	9.1%
Appointments including delays and cancellations			3			3	3.9%
Clinical Treatment							0.0%
Commissioning Services							0.0%
Communications		7	5	2		14	18.2%
End of Life Care		1				1	1.3%
Facilities Services							0.0%
Other		1		1		2	2.6%
Patient Care	2	10	20	2		34	44.2%
Prescribing errors							0.0%
Privacy, dignity & wellbeing		1				1	1.3%
Values and behaviours (Staff)	1	2	7			10	13.0%
Total by Division	**4**	**28**	**40**	**5**	**0**		
Divisions Total			**77**				

The following tables show a further breakdown for these three themes across the Trust.

Unsatisfactory treatment was the highest sub-category this quarter under **Patient Care** (see Table 1.2a). This was the same for Q1.

Insensitive and lack of communication was again the highest causes for complaints under the **Communications** category (see Table 1.2b).

Values and behaviours of staff is a new theme for Q2. With **attitude of medical staff** featuring as the highest causes under this category (see Table 1.2c).

Table 1.2a

Patient Care	34	44%
Delay in making diagnosis	3	9%
Falls	1	3%
Further complications	9	26%
Inappropriate treatment	4	12%
Neglect	3	9%
Nursing Care	2	6%
Pain management	1	3%

Unsatisfactory treatment	**11**	**32%**

Table 1.2b

Communications	**14**	**18%**
Information not given to patient	2	14%
Insensitive communication	**5**	**36%**
Lack of communication	**5**	**36%**
Wrong information	2	14%

Table 1.2c

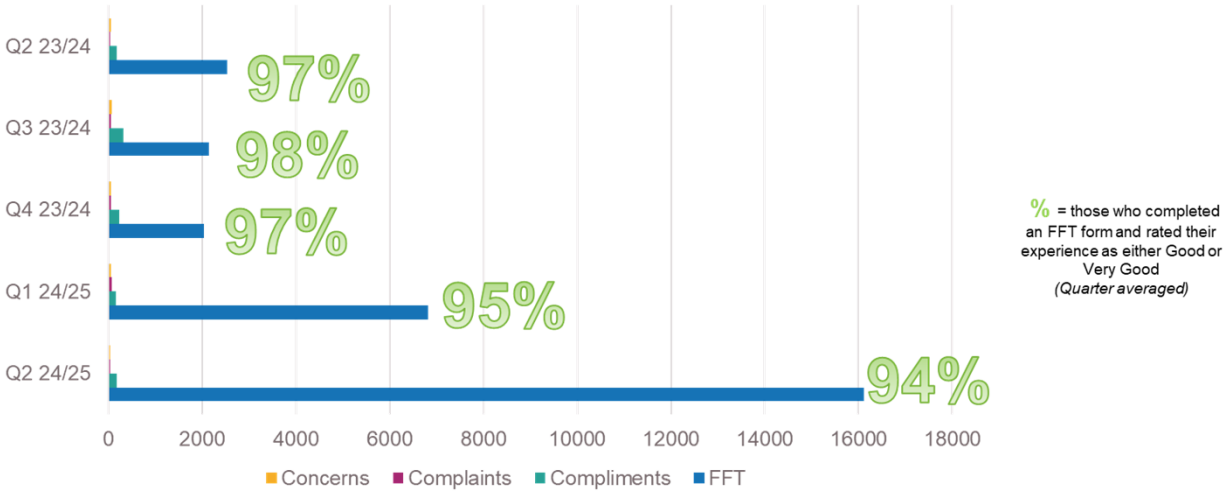
Values and behaviours of staff	**10**	**13%**
Attitude of nursing staff	1	10%
Attitude of staff - medical	**7**	**70%**
Discrimination on the grounds of weight	1	10%
Attitude of staff - other	1	10%

Complaints and concerns continue to be small in number when compared with the number of Friends and Family Test (FFT) feedback received across the Trust and satisfaction rates associated with these. This comparison is demonstrated in Figure 1.2.

This demonstration represents the proportion of good or very good experiences (as rated by our service users) and how vast this is in comparison to the number who have raised a complaint or concern.

We have continued to see a slight decrease in satisfaction this quarter, dropping below the 95% Improving Together target, however it is recognised that this is largely due to the significant increase in quantity of feedback in this period.

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.

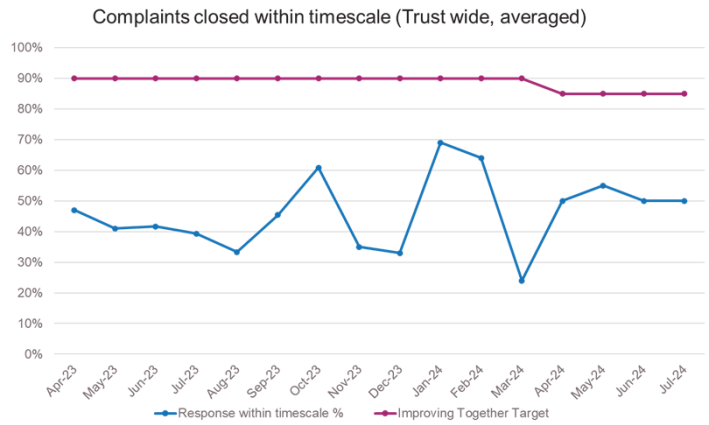


Overdue Complaints

The Trusts Improving Together Target for response to complaints within their agreed timescale for 2024/25 is 85%. As a Trust we continue to struggle to achieve this, despite individual areas regularly achieving this. Overdue complaints will therefore continue to be a focus for the Patient Experience Quality Priorities going into 2024/25.

Monthly live data is also monitored via the Patient Experience Steering Group, and the tracking of this target through this forum is being demonstrated in Figure 1.3.

Figure 1.3 – Complaints closed within timescale (live, in month reporting at PESG)



There are various factors that can influence the inability to achieve the timescale for response.

PALS continue to work with individual areas to understand these challenges and to help improve processes to help mitigate where possible.

This target also continues to be monitored via the Integrated Performance Report (IPR) as a watch metric and has been added to the PALS Department Improving Together huddles as a driver metric.

Reopened Complaints

Figure 1.4 – Number of re-opened complaints or concerns

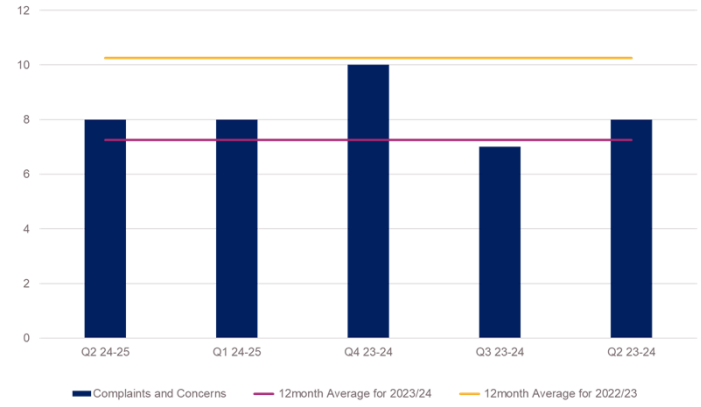


Figure 1.4 shows the number of reopened complaints and concerns (in total), compared with previous quarters.

The yellow lines shows the average for 2022/23.

The pink line is a calculated average for 2023/24 acting as a benchmark for comparison.

The Patient Experience Quality Priorities for 24/25 aims for a less than 5% of total number of complaints/concerns to be reopened. So far, we are estimated to be averaging approximately 7%.

The number of reopened complaints and concerns is the same this quarter and is noted to be marginally higher than the 2023/24 average, there were no clear themes noted for this.

2. Learning from Patient Experience

Patient Stories

September PESG:
Patient story presented by a staff member from Sarum Ward. Story reflected the learning around the complex needs of a 15 year old attending for surgery. Parent had raised concerns following recovery, by the bruises on the young person as a result of restraining in order to keep them safe, as they had become distressed.

Parents were keen to work with the ward to avoid repeated cycles of this and improve the experience for both the patient and staff involved. Work was undertaken with theatres, and lots of ideas were shared on how to improve the experience of the patient. Pre-assessment had worked well and supported by the effective use of the Patient Passport. The passport was used to share information related to the reasonable adjustments needed to ensure a positive hospital experience in future. Examples of the learning shared included: going somewhere more quiet on admission, and consideration of where they were placed on the theatre list (i.e. being seen first or last) to minimise contact with other patients and undue distress.

The parents will be contacted in the future with a view to creating a patient story, of the this learning from their perspective.

Patient Experience Division Presentations

The development of the Patient Experience Steering Group agenda ensuring there are equal opportunities for sharing patient experiences seen through DMT's and Clinical Governance Sessions. Throughout Q2, complaints and FFT data from Q1 was shared at Divisional Governance sessions as an opportunity to share patient experience data with front-line teams and encourage reflections on what mitigations could be considered to change poor experiences and replicate those things which are being done well.

In return, Divisions have been attending the Patient Experience Steering Group to reflect on this data and also provide updates on any areas of focus which they are pursuing informed in part, by this data.

Table 1.3 – Q1 Patient Experience data presented to Divisions during Q2:

Division	Data presented to Division	Division update to PESG
Surgery	*Deferred, scheduled for presentation with Q2 data in December*	31st July 2024
CSFS	*Deferred, date to be confirmed*	25th September 2024
Medicine	13th August 2024	*Deferred to October 2024*
Women & Newborn	16th August 2024	28th August 2024
Facilities (Food & Nutrition /PLACE)	6th August 2024	28th August 2024

Surgical Update to PESG (31st July 2024):

Complaints closure compliance has increased from 31% in June to 43% in July for the Division. This improvement was credited to the changes in the complaints processing, streamlining this and improving accountability and ownership of complaints within the Division.

Work is being undertaken with the five inpatient wards, linking better and sharing learning, this is noted to be a ongoing area for improvement and there are fouses on ensure staff feel confident in verbalising their feedback. Learning from Incident Forums are also continuing to developm with Patient Safety Partners now being included in the invitation list.

Facilities Update to PESG (28th August 2024):

Summary of services and celebtration of SOX's. 1 complaints in last 12 months relating to cleaning. Celebration of the 5 stars awarded to Catering Team for cleanliness from the Environmental Health Team. Comprehensive update on the parking plans and outputs from the Car Parking Working Group.

Women and Newborn Update to PESG (28th August 2024):

Including achievements, compliments, SOX nominations, challenges around maternity, personalised care 'My Maternity Choices Booklet', Gynae challenges, complaints and concerns including themes, planned departmental/ward changes & engagement projects, patient experience surveys, FFT responses and what's next for the Division.

CSFS Division Update to PESG (25th September 2024)

Noted achievements fo the division, including SOX of the year for the Spinal Unit at this year's Staff Awards. Complaints update: 6 cases closed in Q1 and 50% were on time. The team are trying to improve on this. There were noted to be no re-opened cases for the quarter and reflections at PESG were made in reference to 0 reopened complaints for the past 12months. Action taken to understand whether there was any learning that could be shared with other divisions. Impacts of the change in FFT system have seen a significant overall increase in feedback for the Division.

Patient story shared also shared by a member of the team this learning is outlined in the Patient Stories section.

3. Training & Development for Staff

The Patient Experience Team and PALS continue to work with Division leads and staffing groups to ensure staff are understand the complaints process and the role of PALS within this.

Training packages were delivered in July 2024 to Bands 7 and 8 staff as part of the leadership training package offered by the Trust.

Work is currently underway to include PALS and complaints within the Trust's communication course during Q3.

4. CQC & PHSO Complaints Summary

CQC

Concerns raised through the CQC can emit three main types of action/response.

- These can be for information only and no further action.
- These can be general action requests for assurances either related to a specific area of the hospital or particular staff group.
- These can be actions, responses or assurances related to a specific complainants case details.

In Quarter 2 the Trust received 6 concerns from the Care Quality Commission (CQC) – these are summarised below, with outcomes and listed chronologically.

Summary of the requests for this period are shown in Table 4.1:

Table 4.1 Summary of concerns received via the Care Quality Commission (CQC) for Q2

Concern (listed chronologically)	Location / Area related	Request from CQC	Outcome
Concern 1	Laverstock	Request related specifically to the indiviual's care. Request related to policies and procedures concerning; support with eating and drinking, nursing staff levels, senior leadership assurances re: nutrition, hydration and mobilisation of patients	Response submitted on the 16/07/2024, no feedback from CQC at time of writing this report.
Concern 2	Not stated	Request related specifically to the indiviual's care, specifically information in regards to pressure sore assessment and management.	Response submitted on the 06/08/2024, no feedback from CQC at time of writing this report.
Concern 3	Spinal Unit	Request related specifically to the indiviual's discharge plan as discharged to new home address with insufficient care package in place.	Case closed with SFT by CQC as patient was discharged home by Gloucester Hospital.
Concern 4	Not stated	Patient raised concern that they have not received a formal response to their complaint within the timeline quoted.	The timeline quoted was 04/07/2024 but response did not go out until 29/08. CQC were not requesting to see a copy of the response.
Concern 5	Radiology	Request related specifically to the indiviual's care and treatment and also confirmation of receipt, invesgation and response to their complaint.	Complaint response letter sent to patient was shared with CQC 14/08/2024. CQC responded acknowledging that the Trust had worked hard to meet the patients needs, and confirmed they do not require any further information. Case closed.
Concern 6	Imber	Request related specifically to the restraint of an indiviual whilst an inpatient.	Responded to CQC on the 07/10/2024 with completed patient safety review. There is no documented evidence of restraint being used and learning is around understanding what constitutes restraint, documenting hand holding and language used in handovers. Based on the contents of the PSR, CQC have confirmed they have no further queries. Case has been closed.

Table 4.1a Concerns received via the Care Quality Commission (CQC) – quarterly comparison

	Q1 24-25	Q2 24-25		
Across all Directorates	4	6		

Parliamentary Health Service Ombudsman (PHSO)

The Ombudsman investigate complaints about government departments and the NHS in England. They make the final decisions on complaints that have not been resolved by the Trust. Every complainant is advised of their option to take their complaint to the PHSO once they have received their final response from the Trust. The service is free for everyone.

In Quarter 2 the Trust received 0 concerns from the PHSO – these are summarised below, with outcomes and listed chronologically.

Table 4.2 Summary of concerns received via the Ombudsman (PHSO) for Q2

Concern	Location/Area related	Request from PHSO	Outcome
None.			

Table 4.2a Concerns received via the Ombudsman (PHSO) – quarterly comparison

	Q1 24-25	Q2 24-25		
Across all Directorates	0	0		

5. Triangulation of data (Risk, Safety, Experience, Freedom to Speak Up)

This quarter, leads from Risk, Patient Safety, Experience and Freedom to Speak Up held the second data triangulation meeting this year.

This meeting reviewed data from Q2 and Table 5.1 below is a summary of these discussions:

Table 5.1 Triangulating Data – Leads Meeting Summary – Q2 24/25

This was presented to the Clinical Management Board in November as a trial to determine whether this is the appropriate escalation committee for this report.

This escalation report was also presented to the "We Are Safe and Well Committee" in October.

Triangulating Data Leads Meeting
Reporting Period: Q2 2024/25
Summary

ALERT: Alert to matters that require the board's attention or action, e.g., non-compliance, safety, or a threat to the Trust's strategy.
• ED noted to have the highest proportion of total complaints/concerns. Mainly unsatisfied with treatment or related to poor communication. Top three negative themes for FFT related to staff attitude, communication and environment. ED was also noted to be the most prevalent areas for these three themes amongst FFT. Significant proportion of risk incidents related to ED, however the area is known for good reporting practices. Go See scheduled for 4/11/24 with PALS to discuss, understand challenges and seek assurance. Agreed to check displays of F2SU posters/information as part of the visit. • Discharge processes within Medicine noted to be a prevalent theme within Risk and Patient Experience. Deep dive into this theme was included with the Real-Time Feedback Annual Report (Aug 24) following noted correlations with real-time feedback. Further correlations noted with the national inpatient survey (2023). This correlation will be shared at the next Patient Experience Medicine's Governance Meeting. There is noted to be a current PSII running in relation to discharge and also a discharge workstream.
ADVISE: Advise of areas of ongoing monitoring or development or where there is negative assurance. What risks were discussed and were any new risks identified.
• Radiology noted to have correlation with trust wide negative themes within FFT, complaints coordinator weekly huddles have been tasked to include review of Radiology complaints/concerns to consider any other correlations relative to these themes. • Freedom to Speak up noted largest proportion of concerns were related to "elements of inappropriate behaviours" (57%). Potential correlation with new theme for complaints related to "staff attitude and behaviours". • Surgery noted to have the highest number of F2SU cases raised this quarter, considerable correlation with change in leadership. Assurance that these were largely historic issues resurfacing, likely triggered by change in management. Agreed to keep under review for now as no correlation with other areas was noted.
ASSURE: Inform the board where positive assurance has been achieved, share any practice, innovation or action that the Committee considers to be outstanding.
• Freedom to Speak Up data to include further context for staffing groups (proportion of Trust staff) to help determine the significance of the number of cases raised by staff group. Action: ES/ST to update data set for Q3. • No F2SU cases noted from ED, agreed to seek assurance that this is because staff are being effectively supported with the department. Action: ES to follow-up with HR/TS re: support for staff. • Next steps to include legal slides for overview and further comparison. Action VA/JL • Discussed where this escalation report should go for further scrutiny and potential correlation. Clinical Management Board suggested initially. Action VA to follow-up with JD/DM.

Next meeting – Q3 review (23rd January 2025)

6. Triangulation of data – ICB Acute Trusts

The Heads of Patient Experience across the three acute Trusts (Salisbury, Bath and Swindon) are working together to create a format to compare activity and themes across complaints, concerns, compliments and FFT.

A template has been drafted using Q1 and Q2 data, however work in ongoing to ensure that the data is compared relatively, particularly given the differences in patient activity and composition of the patient experience teams. A copy of the proposed draft template has been shared with Clinical Management Board as part of August's action log update.

7. Process reviews, audits and policies

The following Patient Experience policies have now been reviewed, updated and archived this quarter:

- ✓ Copying patient letters
- ✓ Lost Property (management and retention)
- ✓ Accessible information guidance
- ✓ Producing patient information (readership group)

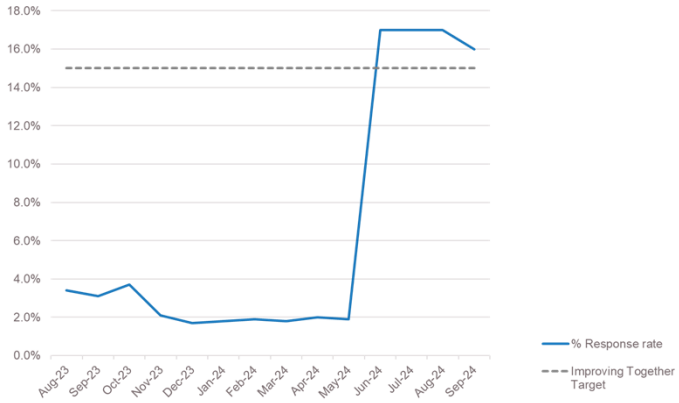
Division Summaries – Complaints, Concerns and Compliments

Content not included in the report for this committee.

8. Friends and Family (FFT)

Response Rates

Fig 9.1 Number of FFT responses, broken down by quarter with Trust response rate target.



A total of **16,123** patients provided feedback through the paper form for the Friends and Family Test (FFT) in Q2. This is 8,545 more than the previous quarter.

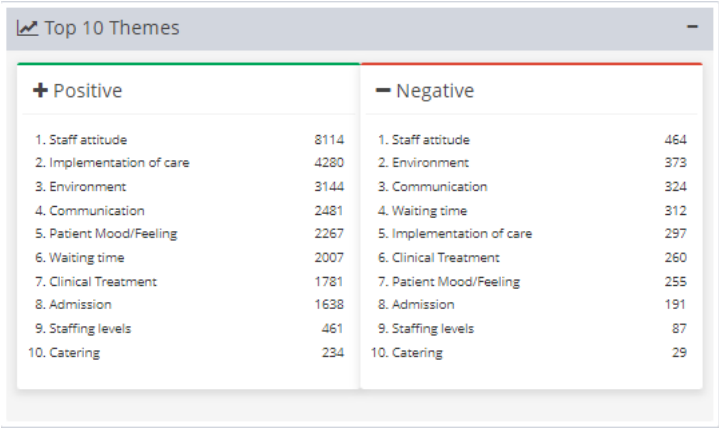
This up surge in June 2024 was owed to the launch of the digital provider. From the 1st June 2024 the Trust commended SMS messaging of the FFT questions for ED and all maternity and outpatient services. The FFT card system remains in place for Daycase and Inpatient areas.

The overall target response rate for the quarter has achieved the Trust target, however the overall satisfaction rate has decreased below the Trust's target of 95%.

94% Of those surveyed rated their experience of our hospital as Good or Very Good (average for Q2 2024-25)

17%* Response rate (*of eligible population and averaged for Q2 2024-25)

The following key words and themes for Q2 are demonstrated here:



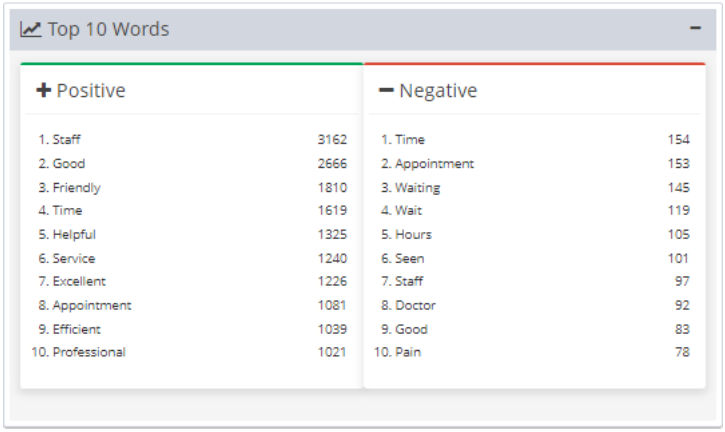


Table 9.1 and 9.1a show the quarterly comparatives for both response rates and satisfaction rates. The satisfaction rate is noted to have dropped below the Trust's target of 95% for the first time since reporting, however, this was anticipated owed to the significant increase in sampling.

Table 9.1 Response rate across the Trust by per 1,000 patient activity – rolling annual comparison

	Q2 24-25	Q1 24-25	Q4 23-24	Q3 23-24	Q2 23-24
Across all Directorates	▲ 132.31 (121, 862)	▲ 61.91 (122, 404)	▼ 17.00 (119, 981)	▼ 18.66 (114, 757)	▲ 22.36 (113, 119)

Table 9.1a Satisfaction rate across the (averaged from responses received)

	Q2 24-25	Q1 24-25	Q4 23-24	Q3 23-24	Q2 23-24
Across all Directorates	▼ 94% (16, 123)	▼ 96% (7, 578)	▼ 97% (2, 042)	▶ 98% (2, 141)	▼ 98% (2, 529)

Friends and Family Test – Digital Go Live

The digital FFT launch on the 1st June 2024. This transition has already demonstrated the following benefits:

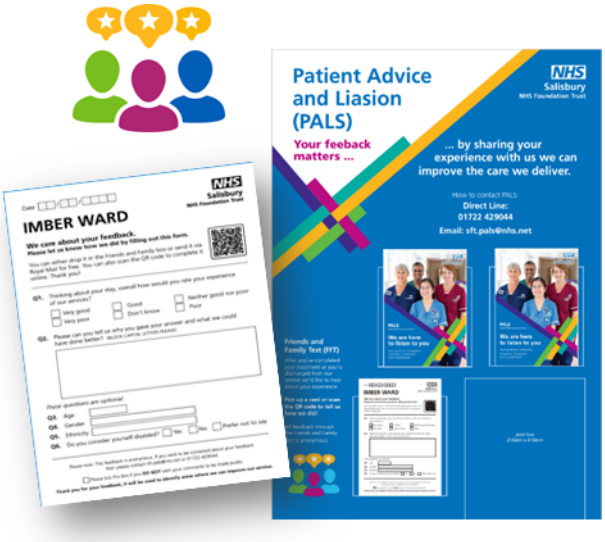
- ✓ Increased response rates to FFT
- ✓ Diversifying methods for access
- ✓ More robust analysis of data for insight
- ✓ More opportunities to triangulate themes

In addition, the Trust website has been updated to reflect the changes to FFT.

There is currently a further project underway to update all FFT boards in the inpatient areas, using the opportunity to align with the PALS services and also bring these on brand. These boards have so far been updated in Pembroke, Britford and Downton.

The FFT cards have also been redesigned to mirror the format of the new SMS system and also include additional demographic information.

Examples shown here.



Speech and Language will be added as new area for FFT feedback, patients attended this clinics from the 1st of September 2024 will be invited to send their FFT feedback by SMS.

9. Patient and Public Feedback – Local Surveys

Real-Time Feedback (RTF)

The aim of RTF is to give a “real-time” view of a patients perspective of their care.

Real-time feedback is not currently undertaken within the maternity inpatient areas or on Sarum ward. Surveys are taken at the patients bedside and results are sent to ward leads within one week of these being completed for reflection.

The survey mirrors the focuses of the National Inpatient survey and includes questions to assess the following areas: Admission to hospital, the ward environment, Doctors & Nurses, care and treatment, operations and procedures, leaving hospital, respect & dignity and overall experience.

A comparison of RTF data with the National Inpatinet Survey can be found in here.

Real-time feedback (RTF) has increased in Q2, due to availability of volunteers, governors and work experience students. In Q2 a total of 100 surveys were completed – achieving an overall average satisfaction rating of 87.4%. This quarter has seen a slight decrease in the number of surveys completed compared with Q1 (n~102), however, an overall increase in satisfaction score from Q1 (81.0%). See Table 10.1 for in month breakdown.

RTF is a standing agenda item presented to the Patient Experience Steering Group.

Table 10.1 Number of inspections and locations visited

Month	Total number of surveys	Number of inpatient areas visited	Wards surveyed	Average Score
July	**27**	**10**	AMU, Breamore, Britford, Chilmark, Downton, Durrinton, Farley, Imber, Pitton, Spire,	86.4%
August	**37**	**9**	AMU, Durrinton, Hospice, Imber,Laverstock, Odstock, Pitton, Redlynch, Tisbury	88.4%
September	**36**	**10**	Amesbury, Britford, Durrington, Farley, Hospice, Laverstock, Longford, Pembroke, Tisbury, Whiteparish	87.1%
Total	**100**	**18**	87.4%	

Table 10.1a Average ratings breakdown by ward (July 2024):

Area	Number of inspections	Average score
Durrington	1	94.29%
Chilmark	4	92.71%
Spire	2	91.43%
Farley	3	90.76%
Downton	3	90.52%
Imber	4	86.71%
Britford	2	84.78%
AMU	3	82.43%
Breamore	4	75.88%
Pitton	1	75%

Table 10.1b Average ratings breakdown by ward (August 2024):

Area	Number of inspections	Average score
Hospice	1	100%
Odstock	5	98.05%
Imber	3	95.42%
Durrington	3	95.24%
AMU	4	92%
Laverstock	5	90.31%
Redlynch	8	85.38%
Pitton	6	76.71%
Tisbury	2	74.31%

Table 10.1c Average ratings breakdown by ward (Sept 2024):

Area	Number of inspections	Average score
Hospice	1	100%
Britford	2	93.68%
Farley	5	92.70%
Durrington	4	90.97%
Whiteparish	5	90.37%
Pembroke	2	90.11%
Tisbury	6	88.24%
Amesbury	3	82.10%
Longford Ward	6	78.43%
Laverstock	2	72.51%

Tables 10.2 and10.3 shows the breakdown of average response to specific questions (highest and lowest).

There is a notable consistency with last quarter in relation to negative themes around noise at night, however these percetanges are noted to be an improvement on last quarter. Invovlement with discharge plans continues to be a negative theme and there has been some correlation with complaint themes also noted in Q2.

Positive themes are also largely consistent, pertaining to the cleanliness of the ward and receiving enough to eat and drink during their stay, privacy and feeling safe.

Table 10.2 highest scoring questions:

Question Text	Answer score (%)	Responded Answers
Do you feel comfortable?	98%	100
Are you receiving enough to eat?	97.94%	97
Have you felt treated with dignity and respect during your stay?	97%	100
Are you receiving enough to drink?	96.94%	98
How would you rate the level of privacy when being examined or treated?	95.60%	100
How would you describe the level of assistance you receive for basic care such as eating, drinking and washing?	95.50%	80
Do you feel safe?	95%	100
How would you rate the cleanliness of the ward you are in?	94%	100
How would you describe the trust and confidence you have in those involved in your care?	92.80%	100

Table 10.3 lowest scoring questions:

Question Text	Answer score (%)	Responded Answers
Is there noise at night from other patients?	57%	100
How would you describe the noise level on the ward at night?	69%	100
Is there noise at night from Equipment or machines?	70%	100
How would you describe your understanding or involvment with your discharge plan?	70.49%	82

Real-Time Feedback (RTF) Annual Report 2023/24 Summary

The Real Time Feedback annual report was presented at PESG in September.

In summary, 334 inspections were carried out from July 2023 to July 2024. Key themes were noted in relation to **cleanliness of the wards**, receiving **enough to eat and drink** and maintaining **privacy and dignity**, consistently scoring highest. The lowest scoring questions themed around **noise levels**, **involvement with discharge planning** and **quality of written information** given for procedures.

A deep dive was agreed by the Patient Experience Steering Group following triangulation of RTF with complaints data through quarters 2, 3 and 4, noting a prevalent theme in relation to hospital discharge. This analysis was also included in this report, outlining a picture of the complex backdrop during this period with hospital pressures requiring initiatives for reactive change. It was noted other factors such as time being taken for these new and great initiatives to embed, with both patients and staff alike will have impacted on the patient's experience.

This examples the Trust's risk appetite in relation to Patient Experience, illustrating that patient experience may at times be compromised in the face of delivering safe and effective care.

Next steps following this report includes actions to triangulate this data with the National Inpatient Survey; and look at how RTF can be improved to provide better insights into safety, noise at night and involvement with discharge plans.

National Audit for End of Life Care (NACEL) Survey Summary – Q2 Report 2024/25

The survey rate has increased this quarter, sampling 60% of bereaved families, compared to 54% in Q1. Return rate was recorded as 36%, a slight increase on last quarter (35%).

There was a total of 44 completed surveys received in Q2.

66% of SFT's respondents described their overall rating of care and support given by the hospital to the dying person as "excellent", compared with 6% who described this as "Poor".

Although, this is a slight increase on the excellent rating for Q1 (65%) there is an overall *decline* in total excellent/good rating for the Trust when comparing Q1 with Q2 – (see Fig 2.2)

n summary, the Trust's comparative performance with our South West peers has improved, taking the Trust from 6th to 5th position in the overall ratings comparisons (see Table 2.1).

Success to note: The following areas the Trust continued to respond well and outperform our peers both locally and nationally are in relation to:

- Explanation to family that the person may die in the next few days
- Hospital's plan for the person's care considered their needs and wishes
- Families were given enough spiritual, religious or cultural support
- Care plans were in place before death
- Staff had the skills to care for the person at the end of their life
- Staff behaved with compassion, care and treated the person with dignity
- Families were kept up to date and had the opportunity to discuss the patient's condition
- Overall care and support given by the hospital to those important to the dying person

Challenges to note: There were several areas in which the Trust's position had changed from Q1, going from outperforming nationally and against peers to becoming an outlier. These were in relation to:

- Supported to receive enough eat and drink
- Involvement with decisions about care and treatment
- Provision of emotional needs and regular checking of person's needs
- Coordinated approach during final admission
- Timely communication of imminent death
- Dying person offered an interpreter or other language support

The Trust has remained an outlier this quarter in relation to:

- The dying person being given enough pain relief

The NACEL survey remains unable to robustly correlate complaint themes by location with this data, changes to the process implemented at the end of Q2 has allowed for location to begin some collection, we hope to use this in the Q3 sampling but acknowledge this has limited capability to be correlated with individual responses.

18 survey participants requested a call-back from PALS, two were unhappy with the care and one of these resulted in a formal complaint being raised. 10 expressed praise and compliment about the care received and the remaining 6 were uncontactable at the time of writing this report.

Full report was presented to the End of Life Care Steering Group on the 4th November 2024 scheduled for the Patient Experience Steering Group on the 27th November 2024.

Complaints Process Survey – Annual Report Summary 2023/24

The annual complaints process survey was prestned to the Patient Experience Group in august 2024 and Clinical Governance Committee in September 2024. This report provided a summary and the insights drawn from the feedback received from complainants who have had a closed complaint between 1st September 2024 and the 10th July 2024.

Response rate was noted to have decreased on comparison to last year's report, with only 15% returned. However, a surge of surveys were retrospectively sent out to eligible closed complaints as resourcing and increased workloads was recognised to have impacted the survey's processing. It is anticipated that this increase in surveys sent (and return rate) will be demonstrable in the next Annual Report.

Insights from this data have resulted in actions to improve:

- The alignment of feedback to each Division
- Improve process to increase volume of surveys received and overall response rates
- Rephrasing of a question to ensure it accurately reflects the current processes
- Improve communication throughout the complaints process with the complainant (this is now a driver metric for the PALS department's improving together huddles)

The feedback from these surveys is routinely reviewed by the PALS Lead to identify improvements within the scope of the PALS team, this report seeks to provide assurance of this continuous improvement.

10. Patient and Public Feedback – National Surveys

National Inpatient Survey 2023

Overall, the Trust received a similar response rate to last year, achieving a return rate of 51% (higher than the national average at 41.7%). The Trust scored better than other trusts in relation to staff explaining the reasons for changing wards during the night in a way in which they could understand. All other 48 questions were scored comparatively with other Trusts.

There was a total of 7 questions where the Trust had improved on its 2022's performance by more than 5%, these were in relation to waiting for a bed on arrival to hospital, getting enough help from staff for washing, eating and drinking. Staffing levels, and being treated with respect and dignity. Overall experience was also noted to have increased positively by more than 5%, with experience rating increasing to 8.3 this year (from 8.0 in 2022), placing the Trust amongst the highest scoring within our region.

Positive themes from comments in relation to:

- Care and general treatment
- Operations/investigations and procedures
- Staff

Negative themes from comments in relation to:

- Discharge process/information
- Continuity of care
- Care after leaving hospital
- Medical
- Noise and disruption

These themes were noted to have some correlations with the Trust's Real-Time Feedback themes captured over the past year. Particularly in relation to noise at night, involvement with discharge planning, ward cleanliness and being treated with dignity and respect.

Scheduled Reporting of Surveys

- Urgent and Emergency Care Survey – will be reported in (Q3) 24/25

- Children and Young People Survey 2023 – will be reported in (Q4) 24/25

NHS Salisbury NHS Foundation Trust

Report to:	Trust Board (Public)	Agenda item:	5.1
Date of meeting:	5th December 2024		

Report tile:	National Inpatient Survey Results 2023			
Status:	Information	Discussion	Assurance	Approval
	Yes	Yes	Yes	Yes
Approval Process: (where has this paper been reviewed and approved):	Clinical Governance Committee 26 November 2024 Scheduled for Patient Experience Steering Group 27th November 2024			
Prepared by:	Victoria Aldridge – Head of Patient Experience			
Executive Sponsor: (presenting)	Angie Ansell – Deputy Chief Nursing Officer			
Appendices (list if applicable):	National Inpatient Survey Results (2023) – Results Report Slide Deck v1			

Recommendation:

This report is for assurance and noting by the Committee.

Executive Summary:

Overall, the Trust received a similar response rate to last year, achieving a return rate of 51% (higher than the national average at 41.7%). The Trust scored better than other trusts in relation to staff explaining the reasons for changing wards during the night in a way in which they could understand. All other 48 questions were scored comparatively with other Trusts.

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- Medical

- Noise and disruption

These themes were noted to have some correlations with the Trust's Real-Time Feedback themes captured over the past year. Particularly in relation to noise at night, involvement with discharge planning, ward cleanliness and being treated with dignity and respect.

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

National Inpatient Survey Results (2023)

Results Report – Oct 2024

Patient Experience Steering Group
27th November 2024

Presented by:
Victoria Aldridge – Head of Patient Experience

Angie Ansell – Deputy Chief Nursing Officer

Salisbury NHS Foundation Trust National Inpatient Survey 2023

Sample: Patients aged 16years+ who had spent at least one night in hospital and discharged during November 2023

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.

Note: There was a delay in the usual publication date of these results due to data collection issues, noted by the survey provider.
The reports were subsequently re-issued on the 14th October 2024.

Full CQC Benchmark Report:

Survey - NHS Surveys

Summary of comparisons with other Trusts

Salisbury NHS Foundation Trust

131 NHS Acute Trusts involved
(133 last year)

63, 573 Total responses received average return rate of 41.7%
(63,224 responses and a return rate of 40.2% last year)

624 Total responses received for SFT (621 last year)

51%* Response rate *same as last year

No. of questions where SFT scored better than other Trusts = 1

No. of questions where SFT scored about the same as other Trusts = 48

No. of questions where SFT scored worse or somewhat worse than other Trusts = 0

Demographic breakdown

Salisbury NHS Foundation Trust

Age

4% were aged 16 - 35

8% were aged 36 - 50

24% were aged 51 - 65

64 % were aged 66+

Sex

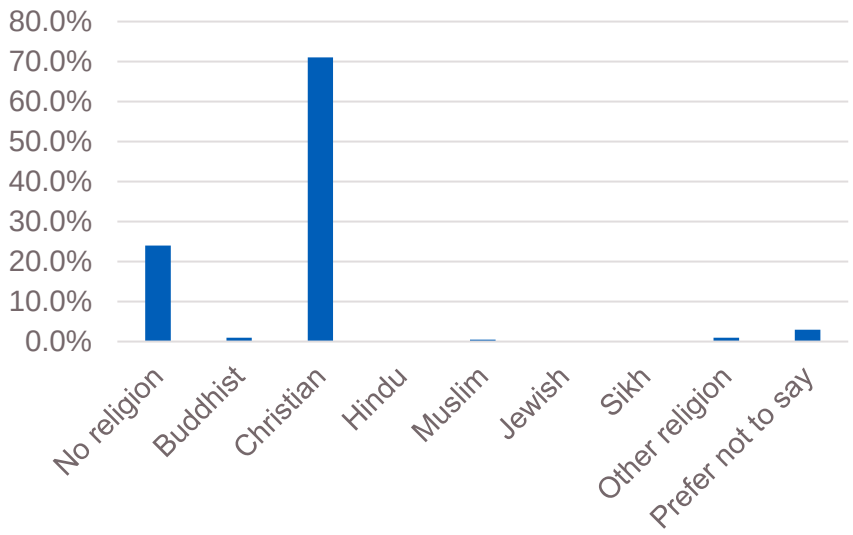
50% of those surveyed identified as female

49% of those surveyed identified as male

1% of those surveyed preferred not to say

0% of participants said their gender is different from the sex they were registered with at birth

Religion



Ethnicity

96% of those surveyed were White

1% were Mixed

<0.5% were Asian or Asian British

<0.5% were Black or Black British

3% were unknown

82%

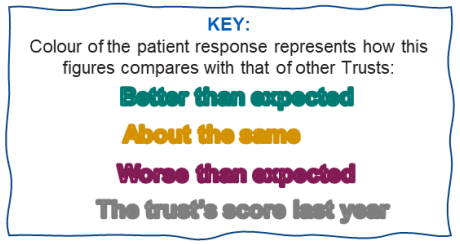
of participants said they have physical or mental health conditions, disabilities or illnesses that have lasted or are expected to last 12 months or more

Comparison with SFT's 2022's survey results

7 questions were scored better by +5%

- Q5 – How long do you feel you had to wait to get to a bed on a ward after you arrived at the hospital?
- Q10 – did you get enough help from staff to wash or keep yourself clean?
- Q16 – During your time in hospital, did you get enough to drink?
- Q23 – In your opinion, were there enough nurses on duty to care for you in hospital?
- Q30 – Were you able to get a member of staff to help you when you needed attention?
- Q48 – Overall, did you feel you were treated with respect and dignity while you were in the hospital?
- Q49 – Overall, how was your experience while you were in the hospital?

Comparison with other Trusts and 2022



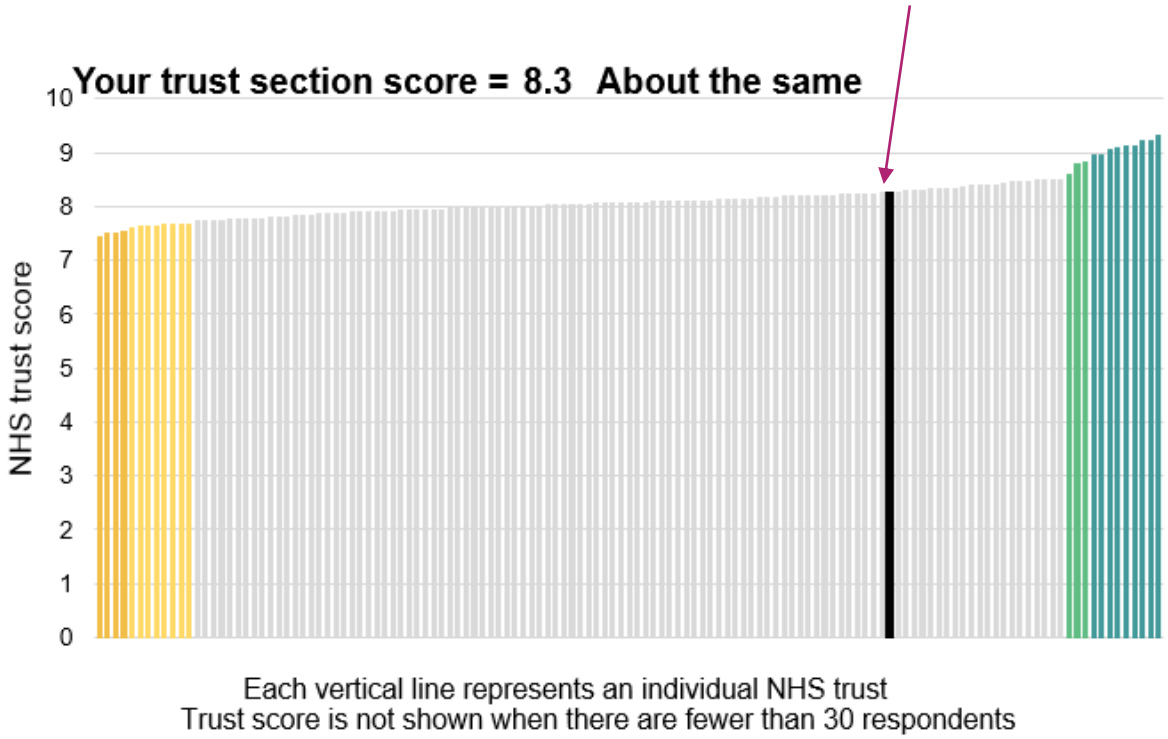
NHS Salisbury NHS Foundation Trust

	2023	2022		2023	2022
Admission to hospital	Patient Response 7.5	Patient Response 7.0	Virtual Wards	Patient Response 7.1	Patient Response *No data available*
Hospital and Ward	Patient Response 7.7	Patient Response 7.7	Leaving hospital	Patient Response 7.1	Patient Response 7.0
Doctors	Patient Response 9.0	Patient Response 9.0	Feedback on quality of care	Patient Response 3.8	Patient Response 1.0
Nurses	Patient Response 8.4	Patient Response 8.1	Kindness and Compassion	Patient Response 9.2	Patient Response *No data available*
Care and treatment	Patient Response 8.3	Patient Response 8.1	Respect and dignity	Patient Response 9.3	Patient Response 9.0

	2023	2022
Overall Experience	Patient Response 8.3	Patient Response 8.0

Salisbury NHS Foundation Trust

**SFT's position is indicated by the black line below*



Comparison with other trusts within your region

Trusts with the highest scores

Royal Devon University Healthcare NHS Foundation Trust	8.6
Royal United Hospitals Bath NHS Foundation Trust	8.4
University Hospitals Bristol and Weston NHS Foundation Trust	8.4
North Bristol NHS Trust	8.3
Salisbury NHS Foundation Trust	8.3

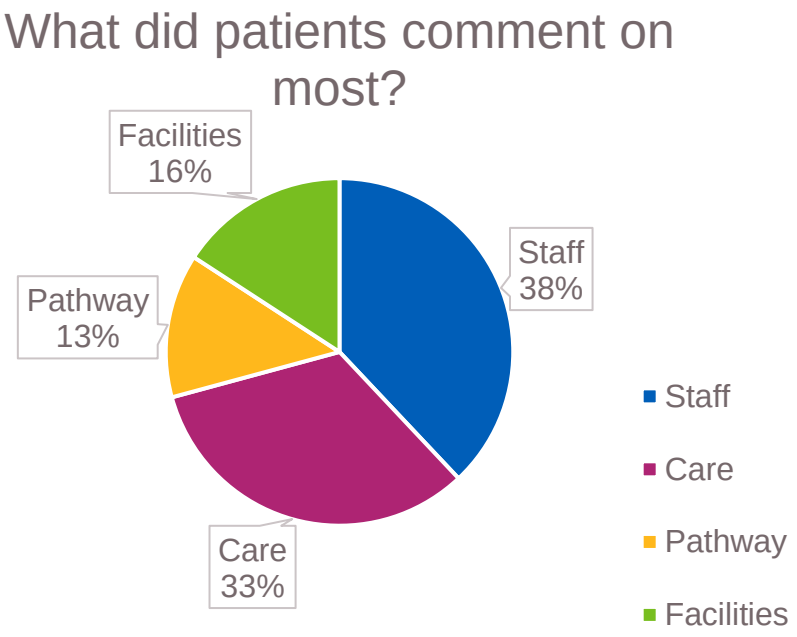
Trusts with the lowest scores

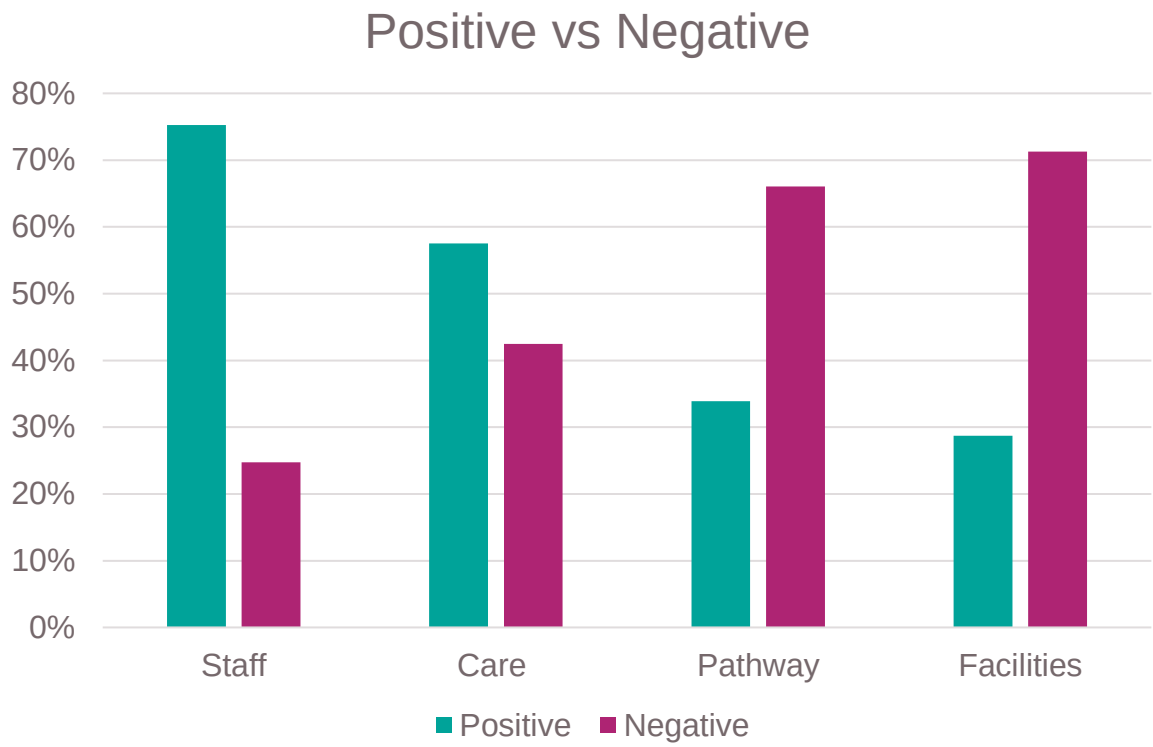
Gloucestershire Hospitals NHS Foundation Trust	7.9
University Hospitals Plymouth NHS Trust	8.0
University Hospitals Dorset NHS Foundation Trust	8.0
Great Western Hospitals NHS Foundation Trust	8.0
Royal Cornwall Hospitals NHS Trust	8.1

Themes from comments

Total comments received: 1,277
(1,509 last year)

Overall positive: 56%
(51% last year)





Person Centred & Safe | Professional | Responsive | Friendly | Progressive

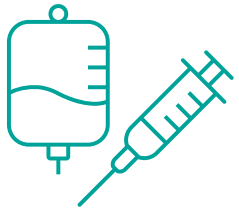
Themes from comments

Salisbury NHS Foundation Trust

Positives

(these themes are noted to be unchanged from 2022)

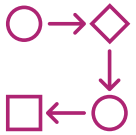
Care and general treatment



Operations/investigations and procedures

Staff (nurses and doctors and generally)

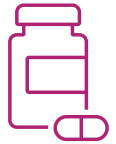
Negatives



Discharge process/information

Continuity of care *(new*)*

Care after leaving hospital *(new*)*



Medication *(new*)*

Noise and disruption *(new*)*

Correlations with Real-Time Feedback (RTF)

Salisbury NHS Foundation Trust

Real-Time Feedback is a face-to-face opportunistic survey undertaken by the patient's bedside whilst they are in hospital. This is usually undertaken by volunteers or governors.

The aim of the feedback to give a "real-time" view of a patient's perspective of their care.

Real-time feedback is currently undertaken in all inpatient areas with the exception of maternity inpatient areas or on Sarum ward.

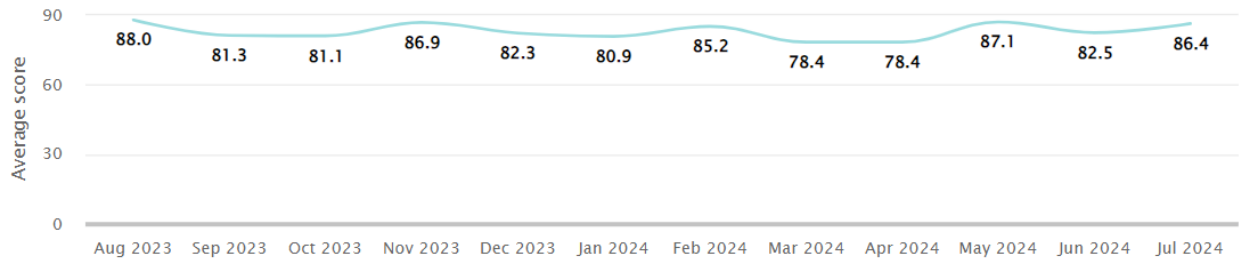
The survey mirrors the focuses of the National Inpatient survey and includes questions to assess the following areas:

- Admission to hospital
- The ward environment
- Doctors
- Nurses
- Care and treatment
- Operations and procedures
- Leaving hospital
- Respect and Dignity
- Overall experience

Aug 2023 – Jul 2024

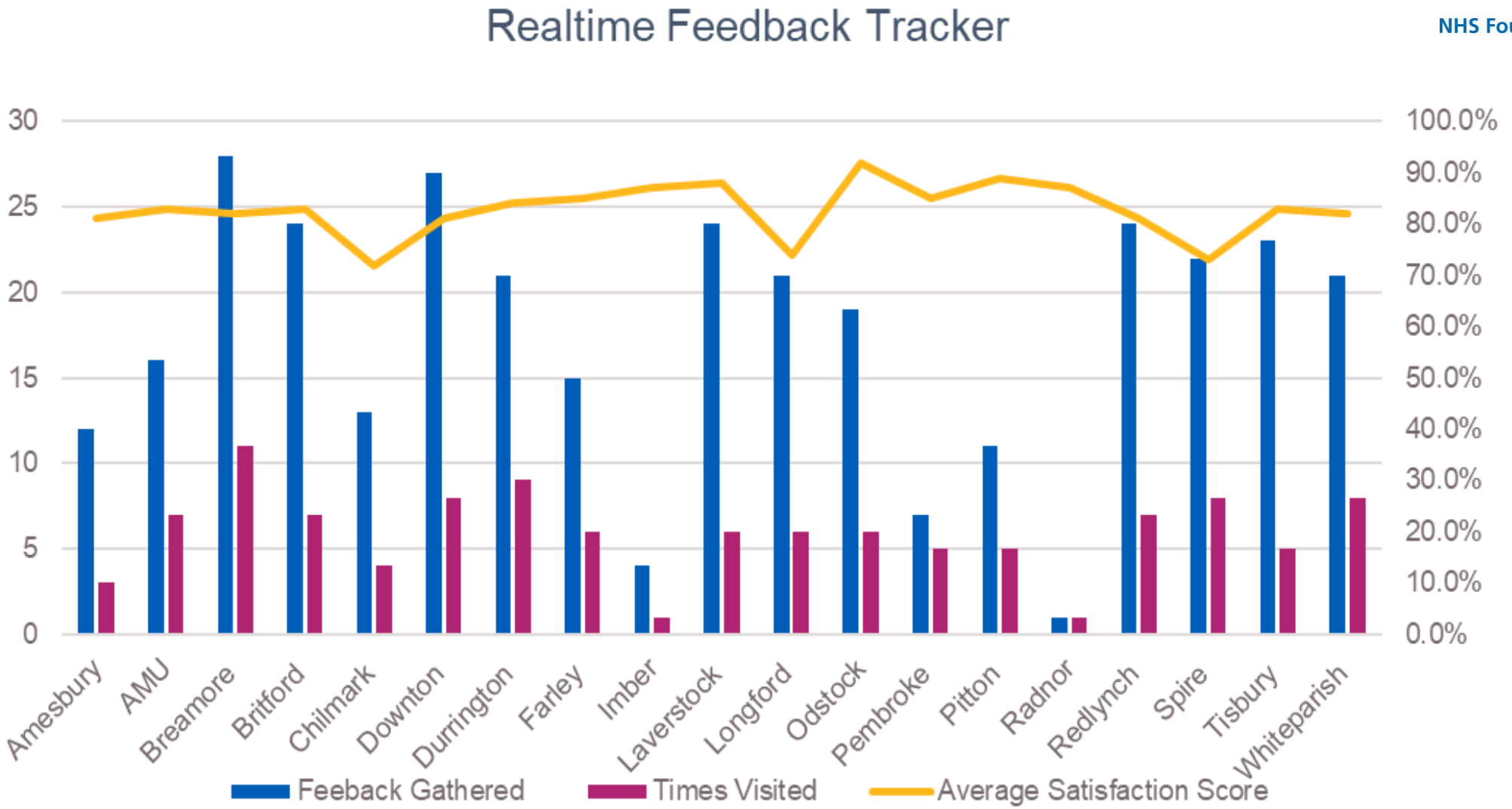
Total surveys undertaken: 344

Average satisfaction rating: 83%



Activity and overall satisfaction ratings

Salisbury NHS Foundation Trust



Person Centred & Safe | Professional | Responsive | Friendly | Progressive

Themes from Real-time Feedback

NHS
Salisbury
NHS Foundation Trust

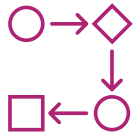
Positives

Cleanliness of the wards

Being treated with respect and dignity, feeling safe and comfortable

Trust and confidence in those involved in their care

Negatives



Understanding and involvement with discharge planning

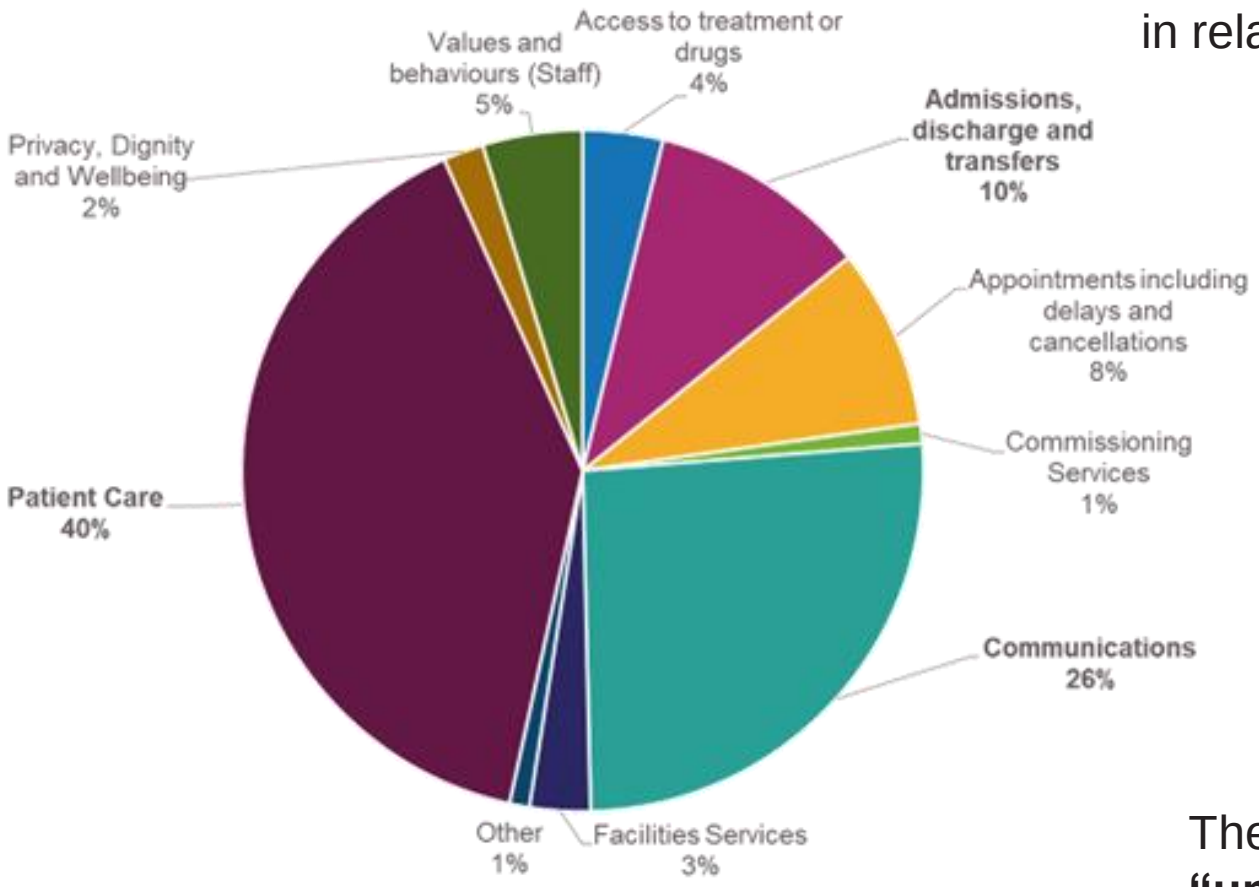
Quality of written information related to procedures and operations

Noise at night

Themes from Complaints

Understanding and involvement with discharge planning

Salisbury NHS Foundation Trust



Data from RTF in Q2 demonstrated low scoring questions in relation to **involvement with discharge plans**.

It was noted to have correlated with themes from complaints later seen in Q3
(of which 10% of complaints were noted to be in relation to admissions, discharges and transfers)

A review of PALS enquiries across Q2 and Q3 highlighted 28 contacts specifically related to Discharge.

9 of these were recorded as a formal complaint or concern.

There were prominent themes noted with patients being **“unhappy with their discharge plan”.**

NHS Salisbury NHS Foundation Trust

Report to:	Trust Board (Public)	Agenda item:	5.3
Date of meeting:	5 December 2024		

Report title:	Recommendations in the Infected Blood Inquiry Report and the impact on the Trust			
Status:	Information	Discussion	Assurance	Approval
		x		x
Approval Process: (where has this paper been reviewed and approved):	Clinical Management Board			
Prepared by:	Duncan Murray			
Executive Sponsor: (presenting)	Duncan Murray			
Appendices				

Recommendation:

The Board is asked to review this summary of the recommendations of the Inquiry into Infected Blood that are most relevant to SFT, and to approve the proposed next steps for this organisation in advance of formal guidance being issued by DHSC/NHSE.

Executive Summary:

Background:

The Infected Blood Inquiry is an independent public statutory inquiry established to examine the circumstances in which patients treated by national health services acquired blood borne viral infections from infected blood and blood products in the 1970's and 80's. Thousands of men, women and children suffered severe health consequences, including chronic illness and death. The inquiry aims to understand what went wrong, who was responsible, and how to address the suffering that was caused, including looking into compensation and support for victims. The inquiry is clear that a series of poor decisions were made throughout the emergent history of transfusion associated hepatitis C and HIV, at every level from individual clinicians to regulators and government departments.

The final inquiry report The Inquiry Report | Infected Blood Inquiry includes a number of important recommendations for the NHS which will be considered by NHSE alongside the Department of Health and Social Care and other relevant bodies. In addition, an Extraordinary Clinical Reference Group is being convened to inform any immediate actions which should be taken.

Purpose:

This document presents an overview of the key recommendations from the Infected Blood Inquiry and their implications for SFT and will inform the initial local response to the inquiry in terms of learning for our organisation and our staff, ahead of further direction from NHSE/DHSC.

Key recommendations:

The high-level recommendations of the inquiry and, where relevant, the initial recommended response by SFT are as follows:

1. **Compensation** – decision for central government

2. **Recognising and remembering what happened to people** – recommendations for central government

3. **Learning from the inquiry** – For GMC: "lessons to be learned" which relate to clinical practice should be incorporated into every doctor's training

4. **Preventing future harm to patients: achieving a safety culture** - Recognising similarities between several high-profile public-sector cases and this inquiry, the report highlights three areas within the NHS that demand action – changing the culture; a more rational approach to regulation and safety management; ensuring a coherent approach to use of patient data to help identify threats and trends, and better inform protection of others

   SFT learning/actions:

   - *Review duty of candour and complaint response policies and training to ensure alignment with principles of the Hillsborough Charter referenced in the report*
   - *Consider whether current accountability arrangements for the recording of and response to concerns and risks are adequate considering the inquiry's recommendations*
   - *Review of the Trust's safety culture and freedom to speak up process to ensure that the identification of risk and harms and the response to it is seen as fundamental to the delivery of our vision to provide an outstanding experience for our population, people and partners*
   - *Review of the risk management policy to identify any gaps in alignment with the Health Services Safety Investigations Body report (October 2023) as recommended by the inquiry, and to aid understanding across the organisation of the importance of timely responses to reported risks/harms*
   - *Review and improve policy and process around maintenance of and patient access to accurate, comprehensive, objective and contemporaneous clinical information, shared safely and securely with partner organisations, timed with the deployment of our electronic patient record shared with our group partners*

5. **Ending a defensive culture in the civil service and government** – for central government and arm's length bodies

6. **Monitoring liver damage for people who were infected with Hepatitis C** – The report details explicit requirements for ongoing monitoring of liver damage for people who were infected with Hepatitis C

   SFT learning/actions:

   - *The Trust should seek assurance through our hepatology service leadership that there is a mechanism to deliver the recommendations about case finding, monitoring and treatment of affected individuals and that ensure any resource gaps are identified to the Trust Board and Integrated Care Board*

7. **Patient safety: Blood transfusions** – The report details several recommendations around improving the safety of blood transfusion practice, specifically with regard to: the appropriate use of tranexamic acid; implementation of the recommendations of the Transfusion 2024 report; transfusion laboratory performance; transfusion education and training; implementation of recommendations of SHOT reports; establishing the outcome of every transfusion

   SFT learning/actions:

   - *The Trust should ask the Transfusion Committee to consider the recommendations and complete a gap analysis and action plan to describe the required steps to achieve compliance (recognising that the SW pathology network have indicated they will be conducting an audit into transfusion services in the next twelve months)*

8. **Finding the undiagnosed –** when doctors become aware that a patient has had a blood transfusion prior to 1996, that patient should be offered a blood test for Hepatitis C; and, as a matter of routine, new patients registering at a practice should be asked if they have had such a transfusion

   SFT learning/actions

   The Trust should look to ensure that front line staff are aware of the importance of taking a transfusion history and that there is a mechanism for the appropriate counselling and testing of individuals identified as having received blood products prior to 1996

9. **Protecting the safety of haemophilia care –** The report details several recommendations regarding peer review of haemophilia centres and the implementation of peer review findings; the resourcing of haemophilia care networks by hospitals Trusts and integrated care boards; preferential use of recombinant coagulation factor products over plasma derived products where appropriate

   SFT learning

   SFT is not a haemophilia centre. However, the Trust should assure itself via the haematology service leadership that the service is part of a peer reviewed multidisciplinary network that has considered the inquiry's recommendations and acted accordingly.

10. **Giving patients a voice –** The report recommends that the patient voice be enabled and empowered by, amongst others: including measures of patient satisfaction and concern into clinical audit as a matter of routine, with reporting of these measures to the board of the body concerned; relevant charities receiving specific finding for patient advocacy; specific consideration as to how best to address the holistic needs of patients with thalassaemia and sickle cell disease

    SFT learning/actions

    The Trust already has a vision metric outlining its ambition to improve our patient engagement. The board will receive assurance that we are including the voice of patients in the work that we do and collecting better and more granular feedback from our patients as our strategic delivery advances in the coming years

11. **Responding to calls for a public inquiry** – for central government

12. **Giving effect to the recommendations of this inquiry** – for central government. The response will give further clarity on which of the recommendations will be taken forward and the mechanisms by which they will be actioned

Conclusion:

The Infected Blood Inquiry produced 12 recommendations which have been put to central government. Whilst the government response is awaited there are a number of recommendations that are pertinent to the Trust and some actions that can be taken in advance of any formal guidance being issued by NHS England.

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):	

Initial learning from the recommendations made by the infected blood enquiry

The UK Infected Blood Inquiry investigated events that occurred primarily during the 1970s and 1980s when thousands of people in the UK were infected with HIV, Hepatitis C and other blood borne viruses through receiving contaminated blood products from unscreened donors. This led to severe health consequences for these patients, including debilitating chronic illness and death. The inquiry aimed to uncover what went wrong, who was responsible, and how to address the suffering caused, including providing compensation and support for the victims and their families.

The inquiry is clear that a series of poor decisions were made throughout the emergent history of the recognition of transfusion associated Hepatitis C and HIV. These decisions were made at every level in the health and health science sector, involving individual clinicians, provider organisations, regulators, and government departments. The inquiry report was submitted to government in May 2024 and is available at [The Inquiry Report | Infected Blood Inquiry].

The inquiry made 12 recommendations which are summarised in this document. The document also outlines potential learning relevant to SFT and proposes actions for our organisation to initiate ahead of direction by DHSC/NHSE in their anticipated response to the inquiry.

The Recommendations

1. **Compensation**

   The decision about compensation is for central government but underlines the importance of recompense for the mistakes made and the need for our teams to ensure we have made every effort to identify those affected.

2. **Recognising and remembering what happened to people**

   The recommendations are for central government although further guidance about formal recognition and remembrance at organisational level may follow.

3. **Learning from the Inquiry**

   i. The General Medical Council, and NHS Education for Scotland, Health Education and Improvement Wales, Northern Ireland Medical and Dental Training Agency and NHS England, should take steps to ensure that those

"lessons to be learned" which relate to clinical practice should be incorporated in every doctor's training.

ii. They should look favourably upon putting together a package of training materials, with excerpts from oral and written testimony, to underpin what can happen in healthcare, and must be avoided in future.

iii. The inquiry website is maintained online.

4. Preventing future harm to patients: achieving a safety culture

The inquiry draws attention to a history of "failing to focus on risk, a failure to put safety first, and a failure to listen to voices advising a different course". It recognises similarities between several different high-profile public inquiry findings and highlights three areas within the NHS that demand action: Changing the culture; a more rational approach to regulation and safety management; and ensuring a coherent approach to data.

For SFT there are several pertinent aspects to this recommendation:

- *Duty of candour*

The enquiry recommendations pay significant attention to the importance of true transparency with citizens when there are errors or potential errors in the delivery of care. The report highlights five of the six key aspects of the Hillsborough Charter it feels relevant:

> *"2. Place the public interest above our own reputation.*
>
> *3. Approach forms of public scrutiny … with candour, in an open, honest and transparent way, making full disclosure of relevant documents, material and facts. Our objective is to assist the search for the truth. We accept that we should learn from the findings of external scrutiny and from past mistakes.*
>
> *4. Avoid seeking to defend the indefensible or to dismiss or disparage those who may have suffered where we have fallen short.*
>
> *5. Ensure all members of staff treat members of the public and each other with mutual respect and with courtesy. Where we fall short, we should apologise straightforwardly and genuinely.*
>
> *6. Recognise that we are accountable and open to challenge. We will ensure that processes are in place to allow the public to hold us to account for the work we do and for the way in which we do it. We do not knowingly mislead the public or the media."*[82]

The importance of aligning a professional duty with a statutory duty of candour is also emphasised, and the need for those in leadership roles to be personally accountable for recording of concerns raised by healthcare staff, and for properly considering these concerns.

SFT Learning: The Trust should look to review its duty of candour and complaint response policies and training to ensure that we are aligned with the principles within the Hillsborough charter. The Trust Board should also consider whether the current accountability arrangements for the recording of and response to concerns and risks are adequate considering the report's recommendations.

- *Cultural change*

  The inquiry report recommendations discuss at length the apparent resistance to departure from the status quo and change/challenge. It discusses the need to move to a proactive rather than reactive safety culture that recognises and attends to potential risks to patient care, and the need to move from a focus on supporting people who speak up/out to a requirement for people to speak up/out if they observe a significant risk or concern.

  SFT Learning: The Trust Board should review its safety culture and its freedom to speak up processes to ensure that the identification of risks and harms and the response to them is seen as a fundamental part of the delivery of the Trust's vision for an outstanding experience for our population, people and partners.

- *Regulation*

  Whilst much of this recommendation is about the complex nature of statutory and other regulation of the health sector, there are relevant discussions of the need to simplify and standardise safety management systems, and it suggests the approach outlined in the October 2023 Health Services Safety Investigations Body ("HSSIB") report:

  > (a) *"**safety policy** – establishes **senior management's commitment** to improve safety and outlines responsibilities; defining the way the organisation needs to be structured to meet safety goals*
  >
  > (b) ***safety risk management – which includes the identification of hazards (things that could cause harm) and risks** (the likelihood of a hazard causing harm) and the assessment and mitigation of risks*
  >
  > (c) ***safety assurance – which involves the monitoring and measuring of safety performance** (eg how effectively an organisation is managing risks), the continuous improvement of the SMS, and evaluating the continued effectiveness of implemented risk controls*
  >
  > (d) *safety promotion – which includes **training, communication and other actions to support a positive safety culture** within all levels of the workforce."*[142]

  SFT Learning: the new Patient Safety Incident Framework we have deployed within the Trust is aligned to the recommendations of the HSSIB report, but the risk management policy should be reviewed in light of the above to identify any potential gaps and to aid understanding at all levels of the organisation of the importance of timely responses to reported risks/harms.

- *Patient records*

  The inquiry recognised that the lack of availability, public accessibility, and interconnectivity of clinical records (particularly historical ones) contributed to a lack of empowerment for individuals to understand and act on their own risk. In an age of digitalisation the inquiry made the following recommendation:

(d) **Patient records**

(i) **Before the end of 2027 there should be a formal audit, publicly reported, of the extent of success of digitisation of patient records in each of the four health jurisdictions of the UK, measuring at least the levels of patient access to their personal records, their ability to identify and correct apparent errors in them, their interoperability, and the confidence of health professionals in the detail, accuracy and timeliness of any record they enter, and that little material which should be recorded has been omitted. Next steps should be identified.**

The inquiry also makes special mention of the need to ensure professionals only record facts and that there is no place for subjective commentary on patients (either positive or negative).

SFT Learning: as the Trust begins its deployment of the Oracle Electronic Patient Record platform it should take the opportunity to review and improve policy and process around patient access and right to correct medical records, the quality, objectivity of and comprehensiveness of clinical information, and look to maximise the safe secure sharing of information to partner organisations.

5. Ending a defensive culture in the Civil Service and government

This recommendation is pertinent to central government and arms-length bodies.

6. **Monitoring liver damage for people who were infected with Hepatitis C**

All patients who have contracted hepatitis via a blood transfusion or blood products should receive the following care:

(i) those who have been diagnosed with cirrhosis at any point should receive lifetime monitoring by way of six-monthly fibroscans and annual clinical review, either nurse-led, consultant-led or, where appropriate, by a GP with a specialist interest in hepatitis
(ii) those who have fibrosis should receive the same care
(iii) where there is any uncertainty about whether a patient has fibrosis, they should receive the same care
(iv) fibroscan technology should be used for liver imaging, rather than alternatives
(v) those who have had Hepatitis C which is attributable to infected blood or blood products should be seen by a consultant hepatologist, rather than a more junior member of staff, wherever practicable
(vi) those bodies responsible for commissioning hepatology services in each of the home nations should publish the steps they have taken to satisfy themselves that the services they are commissioning meet the particular needs of the group of people harmed by NHS treatment

SFT Learning: the Trust should seek assurance through its hepatology service leadership that there is a mechanism to deliver the recommendations about case finding, monitoring and treatment of affected individuals and for any resource gaps to be identified to the Trust and Integrated Care Board.

7. **Patient Safety: Blood transfusions**

a) Tranexamic acid (i) In England, Hospital Transfusion Committees and transfusion practitioners take steps to ensure that consideration of tranexamic acid use be on every hospital surgical checklist; that hospital medical directors be required to report to their boards and the chief executive of their Trust as to the extent of its use; and that the board report annually to NHS England as to the percentage of eligible operations which have involved its use. If the percentage is below 80% or has dropped since the previous year, this report should be accompanied with an explanation for the failure to use more tranexamic acid and thereby reduce the risk to patient safety that comes with using a transfusion of blood or red blood cells. (ii) In Scotland, Wales and Northern Ireland offering the use of tranexamic acid should be considered a treatment of preference in respect of all eligible surgery. (iii) Consideration be given to standardising and benchmarking transfusion performance between hospitals to deliver better patient blood management.
b) Progress in implementation of the Transfusion 2024 recommendations be reviewed, and next steps be determined and promulgated; and that in Scotland the 5 year plan is reviewed in or before 2027 with a view to determining next steps. The responsibility for this in England is that of the NHS, shared with NBTC, the Royal Colleges (as appropriate), and NHSBT.
c) Transfusion laboratories should be staffed (and resourced) adequately to meet the requirements of their functions.
d) Those bodies concerned with undergraduate and postgraduate training across the UK of those people who are, or intend to be, working in the NHS ensure that they are adequately trained in transfusion, that the standards by which sufficiency of training is measured are defined, and accountability for training in transfusion be defined.
e) That all NHS organisations across the UK have a mechanism in place for implementing recommendations of SHOT reports, which should be professionally mandated, and for monitoring such implementation.
f) Establishing the outcome of every transfusion (i) That a framework be established for recording outcomes for recipients of blood components, and that those records be used by NHS bodies to improve transfusion practice (including by providing such information to haemovigilance bodies). Success in achieving this will be measured by the extent to which the SHOT reports for the previous three years show a progressive reduction in incidents of incorrect blood component transfusions measured as a proportion of the number of transfusions given. (ii) To the extent that the funding for digital transformation does not already cover the setting up and operation of this framework, bespoke funding should be provided. (iii) That funding for the provision of enhanced electronic clinical systems in relation to blood transfusion be regarded as a priority across the UK.

SFT Learning: The Trust should ask its transfusion committee to consider the recommendations and complete a gap analysis and action plan to describe the steps that would need to be taken to comply with them (note that the SW pathology

network have indicated that they will be conduction an audit into transfusion services in the coming 12 months).

8. **Finding the undiagnosed**

a) When doctors become aware that a patient has had a blood transfusion prior to 1996, that patient should be offered a blood test for Hepatitis C.
b) As a matter of routine, new patients registering at a practice should be asked if they have had such a transfusion.

SFT Learning: The Trust should look to ensure that front line staff are aware of the importance of taking a transfusion history (including blood products) and that there is a mechanism for the appropriate counselling and testing of any individuals identified who received blood products prior to 1996.

9. **Protecting the safety of haemophilia care**

a) That peer review of haemophilia care should continue to occur as presently practised, with any necessary support being provided by NHS Trusts and Health Boards
b) That NHS Trusts and Health Boards should be required to deliberate on peer review findings and consider implementing the changes identified with a view to ensuring comprehensive, safe, care.
c) A peer review of each centre should take place not less than once every five years.
d) The necessary administrative and clinical resources should be provided by hospital Trusts and boards, integrated care boards, and service commissioners to facilitate multi-disciplinary regional networks to discuss policy and practice in haemophilia and other inherited bleeding disorders care, provided they involve patients in their discussions.
e) Recombinant coagulation factor products should be offered in place of plasmaderived ones where clinically appropriate. Service commissioners should ensure that such treatment decisions are funded accordingly.
f) That the National Haemophilia Database, run by the UKHCDO, merits the support of additional central funding.

SFT Learning: whilst SFT is not a haemophilia treatment centre, the Trust should assure itself via the haematology service leadership that the service is part of a peer reviewed multi-disciplinary network that has considered the inquiry's recommendations and acted accordingly.

10. **Giving patients a voice**

That the patient voice be enabled and empowered by the following measures:
a) clinical audit should as a matter of routine include measures of patient satisfaction or concern, and these should be reported to the board of the body concerned. Success in this will be measured by comparing the

measure of satisfaction from one year to the next, such that the reports to the board concerned demonstrate a trend of improvement by comparing this year's outcomes with the similar outcomes from at least the two previous years.

b) that the following charities receive funding specifically for patient advocacy: the UK Haemophilia Society; the Hepatitis C Trust; Haemophilia Scotland; the Scottish Infected Blood Forum; Haemophilia Wales, Haemophilia Northern Ireland, and the UK Thalassaemia Society.
c) that favourable consideration be given to other charities and organisations supporting people infected and affected that were granted core participant status (as listed on the Inquiry website) to continue to provide support for at least the next 18 months. Further support should be reviewed at that stage with a view to it continuing as appropriate.
d) particular consideration be given, together with the UK Thalassaemia Society and the Sickle Cell Society, to how the needs of patients with thalassaemia or sickle cell disease can best holistically be addressed.
e) steps be taken to give greater prominence to the online Yellow Card system to those receiving drugs or biological products, or who are being transfused with blood components.

SFT Learning: The Trust already has a vision metric outlining its ambition to improve outpatient engagement. The Board will receive assurance that we are including the voice of patients in the work that we do and collecting better and more granular feedback from our patients as our strategic delivery continues over the coming years.

11. Responding to calls for a public inquiry

This recommendation is for central government

12. **Giving effect to Recommendations of this Inquiry**

a) Within the next 12 months, the Government should consider and either commit to implementing the recommendations, or give sufficient reason, in sufficient detail for others to understand, why it is not considered appropriate to implement any one or more of them.
b) During that period, and before the end of this year – the Government should report back to Parliament as to the progress made on considering and implementing the recommendations.
c) This timetable should not interfere with earlier consideration and response to the Recommendations of the Second Interim Report of the Inquiry
d) The Public Administration and Constitutional Affairs Committee ("PACAC") should review both the progress towards responding to the Inquiry's recommendations and, to the extent that they are accepted, implementing those recommendations
e) PACAC should accept the role in respect of any future statutory inquiry of reviewing government's timetable for consideration of recommendations, and of its progress towards implementation of that inquiry's recommendations.

This request/recommendation is for central government – the response will give further clarity on which of the recommendations will be taken forward and the mechanisms by which they will be actioned.

Conclusion

The Infected blood inquiry produced 12 recommendations which have been put to central government. Whilst the response is awaited there are several recommendations that are pertinent to the Trust and some actions that could be taken ahead of any formal guidance being issued by NHS England.

NHS Salisbury NHS Foundation Trust

Report to:	Trust Board (Public)	Agenda item:	5.4
Date of meeting:	5th December 2024		

Report tile:	Maternity & Neonatal Quality and Safety Report for Quarter 2 2024/25.			
Status:	Information	Discussion	Assurance	Approval
	X	x	X	
Approval Process: (where has this paper been reviewed and approved):	Divisional Governance 15.11.24 DMT approval e-mail 8.11.24 CGC 26.11.24			
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 report, and for its content to be minuted as per CNST requirements ensuring that quarterly oversight of the Quality and Safety Agenda is maintained in addition to the monthly Perinatal Quality Surveillance Model that is reported monthly.

CNST requirement for Trust board to minute the following:

1. PMRT reviews as described in report.
2. Compliance with labour ward coordinator being supernumerary and women receiving 1:1 care =100%
3. Feedback from ward to board and board to ward evidenced by Safety Champion meetings and attendance by Executive and Non-executive safety champions.
4. The trust claims scorecard has been reviewed within the report alongside incident and complaint data.
5. Evidence in the minutes that the Trust Board has acknowledged the ongoing Safety Champions meetings, with support implemented as escalated.

Executive Summary:

The Maternity and Neonatal Quality and Safety Report for Q2 demonstrates current position against local and nationally agreed measures to monitor maternity and neonatal safety. The purpose of this report is to inform the Salisbury Foundation Trust Board of present and emerging safety concerns.

It will evidence current compliance with national reporting to include Care Quality Commission (CQC), Maternity Incentive Scheme (MIS) and Ockenden 2020 and 2022 recommendations and work towards the 2023 publication of the Three-Year Delivery plan. It will also demonstrate patient experience and feedback and learning.

This report reflects data from Quarter 2 24/25 with detail highlighted below:

- In Q2 – 0 Stillbirth (Excluding Medical Termination of Pregnancy)
    - Overall rate for last 12 months for SFT is 1.93 per 1000. (National rate 3.9/1000 National ambition 2.5 per 1000)
- 0 reportable Neonatal Deaths.
    - This makes a total of 1 NND > 24 week in the last 12 months which equates to 0.55 per 1000 live births. The national neonatal death rate is 1.65 per 1000 live births.
- 0 reportable cases to Maternity and Newborn Safety Investigations (MNSI) in Q2
- 0 new Maternity PSII commissioned under the new PSIRF framework in Q2.

- 5 Ockenden actions closed in Q2, 14 however remain open as of September 30th, 2024

- Trajectory in place to achieve 90% training compliance by December 2024.

- Executive and Non-Executive safety champion attendance at safety champions meetings and regular walkabouts in progress. You said/We did boards visible to staff to ensure ward to board and board to ward cascade of information and oversight.
- Progress with compliance to Saving Babies Lives Vs 3 remains challenging, and compliance is a risk.
    - 7% compliant October 2023
    - 37% compliant December 2023
    - 40% compliant June 2024
    - 51% complaint September 2024
    - Next submission November 2024 pre CNST MIS submission.
- 1:1 labour care and supernumerary status of labour ward coordinator maintained 100% of the time in Q2.

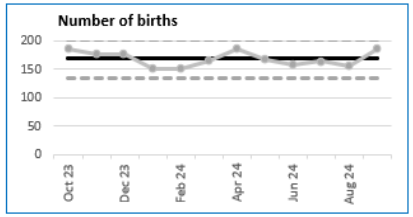
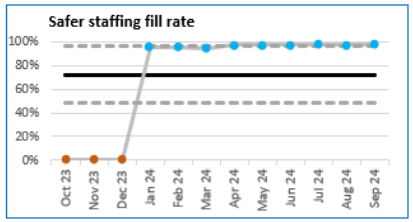
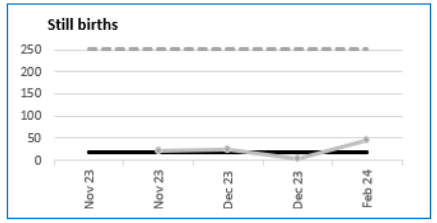
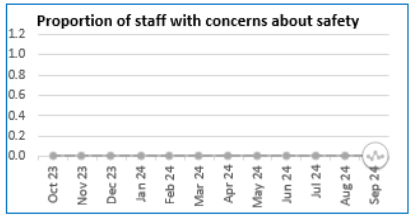
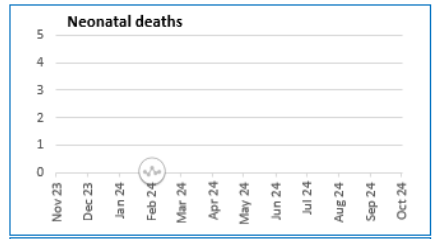
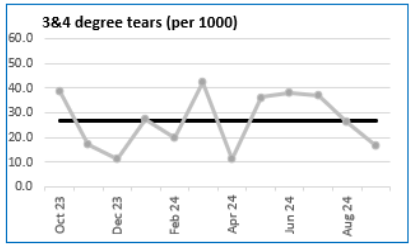
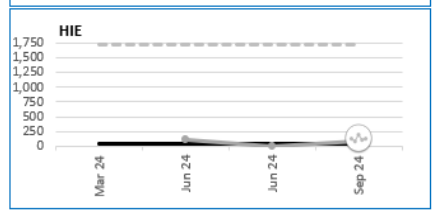
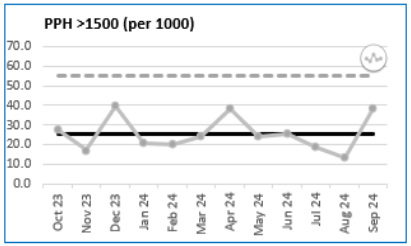
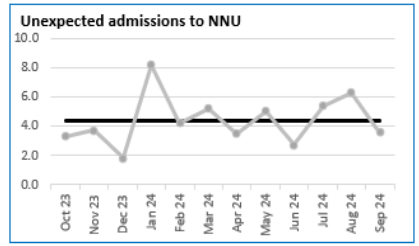
- Feedback received via safety champions, FFT, MNVP. Complaints and concerns actioned and fed back to staff and service users.
- Atain rates for SFT for year to date (end Q2) are 3.9 % against a national ambition of <6% and a network ambition of <5%.
- Significant progress made with the Maternity Safety Support Programme. Exit meeting with National team to be held in Q3.
- Midwifery and Neonatal staffing- Midwifery recruitment positive and vacancy gap minimal. Neonatal nursing staffing – Non-complaint for BAPM for Neonatal Nurses – action plan in progress and due for presentation to Board in December.

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

Maternity and Neonatal Services Quality and Safety Report Q2 2024/25

Women and Newborn Division

SALISBURY NHS FOUNDATION TRUST DATA MEASURES: PERINATAL QUALITY SURVEILLANCE TOOL

Latest month 01/09/24 Number of births 186 No significant change		Latest month 01/09/24 Still birth rate/1000 0.0 Significant Improvement
	Date of last stillbirth 06/02/24 Average days between stillbirths 19.2 No significant change
	
Latest month 01/09/24 Safer staffing fill rate 98% Significant Improvement		Latest month 01/09/24 Neonatal Death rate/1000 0.0 Significant Improvement
	Date of last neonatal death 01/02/24 Average days between deaths No significant change
	
Latest month 01/09/24 Proportion of staff with concerns about 0% No significant change		Latest month 01/09/24 HIE rate/1000 5.4 No significant change
	Date of last HIE 15/09/24 Average days between HIE 46.3 No significant change
	
Latest month 01/09/24 3&4 degree tears (per 1000) 16.4 No significant change		Latest month 01/09/24 PPH >1500 (per 1000) 38.5 No significant change
	Latest month 01/09/24 Unexpected admissions to NNU 3.6 No significant change
	

Trust: **Salisbury NHS Foundation Trust Hospital**

CQC Maternity Inspection Ratings 2021	OVERALL	SAFE	EFFECTIVE	CARING	WELL-LED	RESPONSIVE
	Select Rating:	*Select Rating:*	*Select Rating:*	*Select Rating:*	*Select Rating:*	*Select Rating:*
	Requires Improvement	**Requires Improvement**	**Inspected but not rated**		**Inadequate**	

NHSE Maternity Safety Support Programme	Yes	SFT have exited the MSSP and moved into the sustainability phase of programme

	2024/25											
	Jan	**Feb**	**March**	**April**	**May**	**June**	**July**	**Aug**	**Sep**	**Oct**	**Nov**	**Dec**
1.Findings of review of all perinatal deaths using the real time data monitoring tool	✓	✓	✓	✓	✓	✓	✓	✓	✓			
2. Findings of review of all cases eligible for referral to MNSI	✓	✓	✓	✓	✓	✓	✓	✓	✓			
Report on: 2a. Number of incidents logged graded as moderate or above and what actions are being taken	✓	✓	✓	✓	✓	✓	✓	✓	✓			
2b. Training compliance for all staff groups in maternity related to the core competency framework (CCF) and wider job essential training	On track for MIS Year 6 targets (inc. CCF)	On track for MIS Year 6 targets (inc. CCF)	On track for MIS Year 6 targets (inc. CCF)	On track for MIS Year 6 targets (inc. CCF)	On track for MIS Year 6 targets (inc. CCF)	On track for MIS Year 6 targets (inc. CCF)	On track for MIS Year 6 targets (inc. CCF)	On track for MIS Year 6 targets (inc. CCF)	On track for MIS Year 6 targets (inc. CCF)			
2c. Minimum safe staffing in maternity services to include Obstetric cover on the delivery suite, gaps in rotas and midwife minimum safe staffing planned cover versus actual prospectively	✓	✓	✓	✓	✓	✓	✓	✓	✓			
3.Service User Voice Feedback	✓	✓	✓	✓	✓	✓	✓	✓	✓			
4.Staff feedback from frontline champion and walk-abouts	✓	✓	✓	✓	✓	✓	✓	✓	✓			
5.MNSI/NHSR/CQC or other organisation with a concern or request for action made directly with Trust	✓	✓	✓	✓	✓	✓	✓	✓	✓			
6.Coroner Reg 28 made directly to Trust	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a			
7.Progress in achievement of CNST 10	✓	✓	✓	✓	✓	✓	✓	✓	✓			

8.Proportion of midwives responding with 'Agree' or 'Strongly Agree' on whether they would recommend their trust as a place to work or receive treatment	Reported annually
9.Proportion of speciality trainees in Obstetrics & Gynaecology responding with 'excellent' or 'good' on how they would rate the quality of clinical supervision out of hours	Reported annually

Contents

1. Report Overview

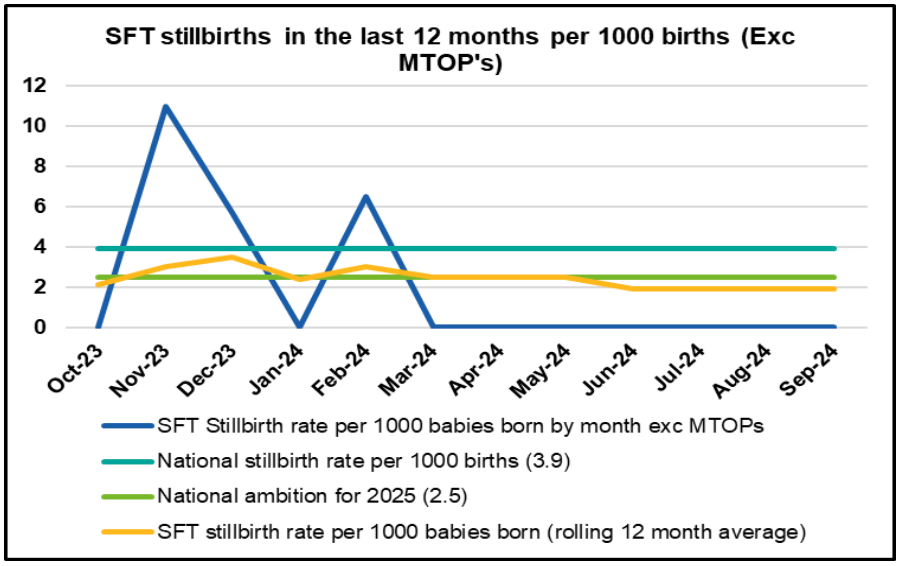
This report outlines locally and nationally agreed measures to monitor maternity and neonatal safety, as outlined in the NHSEI document '*Implementing a revised perinatal quality surveillance model*' (December 2020). The purpose of the report is to inform the Trust Board and LMNS Board of present or emerging safety concerns or activity to ensure safety with a two-way reflection of 'ward to board' insight across the multi-disciplinary, multi-professional maternity services team. The information within the report reflects actions in line with Ockenden and progress made in response to any identified concerns at provider level. Monthly reports will also be shared with Trust Board and LMNS Board via the Perinatal Quality Surveillance Monthly slide set.

2. Perinatal Mortality Rate

The full report is contained in the appendices. The following is a summary of key highlights.

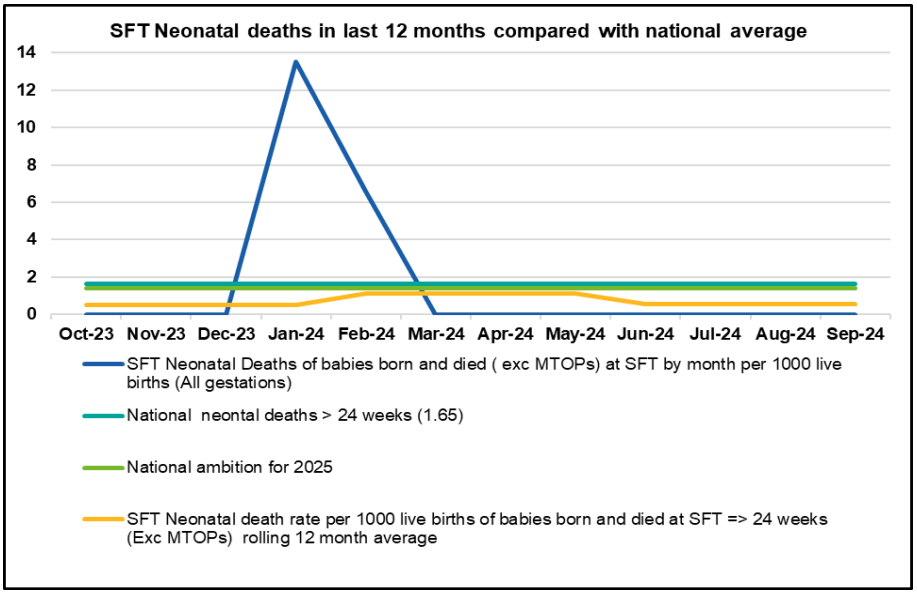
The graphs below demonstrate how Salisbury NHS Foundation Trust is performing against the national ambition.

Figure 1. Monthly Stillbirth rate (per 1000 births excluding MTOP's) for SFT over the last 12 months, compared with national rate and ambition.



In the last completed quarter (Q2), SFT had 0 stillbirth (Excluding MTOP's). This is a total of 4 in the last 12 months, which equates to 1.93 per 1000 births in the last 12 months and is below the national rate is 3.9 per 1000 births and national ambition of 2.5 per 1000 births.

Figure 2. Monthly neonatal death rate per 1000 live births > 24 weeks for SFT compared with national rate



In the last quarter (Q2), SFT had 0 neonatal deaths >24 weeks. This is a total of 1 neonatal death >24 weeks in the last 12 months which equates to 0.55 per 1000 live births and is below the national neonatal death rate of 1.65 per 1000 live births.

There are currently three historic PMRT cases with outstanding actions and are detailed in the full report in the appendices. Two actions relate to guideline development and updating. One action relates to arrangements for ongoing aspirin prescribing in pregnancy. These have been discussed at Safety Champions meetings and work is ongoing to progress these actions to close in Q3.

2.1 Perinatal Mortality Summary for the Quarter (Q2 July-Sept 2024)

Figure 3. Perinatal Mortality summary

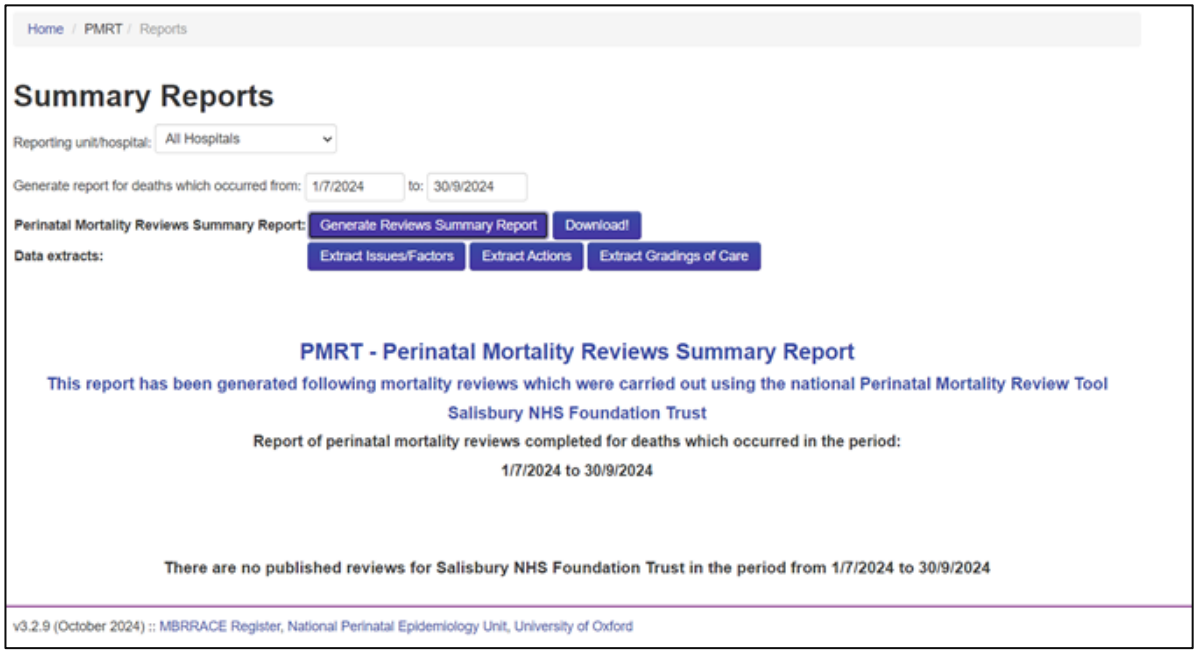
PMRT ID	Cause of Death	Issues/ Actions / learning
There were no PMRT cases to review in Q2.		

2.2 PMRT real time data monitoring tool

At Salisbury NHS foundation Trust, authorised PMRT users generate reports that summarise the results from completed reviews over a period, within the PMRT for user-defined time periods. Reports are accessed directly from the national PMRT reporting portal. They are used as the basis for Trust Board reports and are discussed with Trust Maternity Safety Champions.

It is not possible to embed a copy of the Q2 2024/25 PMRT board report of the perinatal losses reviewed at SFT. This is because it is not possible to generate a report for quarter 2 as there were no perinatal losses within that timeframe (as per previous graphs and screenshot of the MBRRACE reporting tool below).

Figure 4. PMRT Report screenshot showing that there were no published reviews in Q2



2.3 Learning from PMRT reviews

There were 0 cases reviewed under PMRT in Q2.

3. Maternity and Newborn Safety Investigations (MNSI) and Maternity Patient Safety Incident Investigation (PSII's)

3.1 Background

The National Maternity Safety Ambition launched in November 2015 aims to halve the rates of stillbirths, neonatal and maternal deaths, and brain injuries that occur soon after birth, by 2025. This strategy was updated in November 2017 with a new national action plan called Safer Maternity Care, which set out additional measures to improve the rigour and quality of investigations into term stillbirths, serious brain injuries to babies and deaths of mothers and babies. The Secretary of State for Health asked HSIB (now MNSI) to carry out the work around maternity safety investigations outlined in the Safer Maternity Care action plan.

MNSI undertake maternity investigations in accordance with the Department of Health and Social Care criteria (Maternity Case Directions 2018), taken from Each Baby Counts and MBRRACE-UK. In accordance with these defined criteria, eligible babies include all term babies (at least 37 completed weeks of gestation) born following labour who have one of the following outcomes:

Maternal Deaths: Direct or indirect maternal deaths of women while pregnant or within 42 days of the end of pregnancy

Intrapartum stillbirth: where the baby was thought to be alive at the start of labour but was born with no signs of life.

Early neonatal death: when the baby died within the first week of life (0-6 days) of any cause.

Severe brain injury diagnosed in the first seven days of life, when the baby:

- Was diagnosed with grade III hypoxic ischemic encephalopathy (HIE), or,
- Was therapeutically cooled (active cooling only), or,
- Had decreased central tone and was comatose and had seizures of any kind.

To meet the requirements against the 15 Immediate and Essential Actions (IEAs) in the Ockenden 2022 report all SI's concerning maternity services adhere to the Trusts Patient Safety Incident Response (PSIRF) Policy and Plan.

3.2 CNST Compliance as per MIS Year 6 Standards

As part of the Maternity Incentive Scheme, Trusts are required to ensure that there is a robust process for reporting cases that meet the criteria for MNSI and for notification to the NHS Resolution Early Notification Scheme. Information is provided to families about this, and consent obtained for information sharing. Maternity services are required to report quarterly to Trust Boards and for SFT this is fulfilled via this report.

During this quarter one case was referred to MNSI which was rejected. Therefore, there were 0 new cases that qualified for notification to MNSI and subsequent Early Notification Scheme in Q2.

Salisbury NHS Foundation Trust is currently compliant with all eligible standards for MIS CNST Year 6 (safety action 10).

3.3 Investigation progress update (MNSI and PSII cases) for the last Quarter (Q2)

On 8th January 2024, SFT transitioned to the national Patient Safety Incident Response Framework (PSIRF) requirements. The Trust Patient Safety Incident Response Plan (PSIRP) identifies local and nationally mandated PSII responses. Maternity Serious Incidents include both commissioned Patient Safety Incident Investigations (PSII's) and MNSI cases that have been accepted.

During this quarter all cases under the previous incident investigation model (CCR's and SI's) have seen steady progress. At the beginning of Q2 there were 7 investigations in breach of the 60-day investigation target to CRG. At the end of Q2 there is one Commissioned Clinical Review (CCR) in breach of the 60-day target from the previous model.
In addition, there is one MNSI case with an action plan in draft and a PSII. Current ongoing

investigations are summarised below.

Figure 5. Investigation progress update

Investigation Type and Ref	MNSI Ref	Summary of Incident	Date Investigation Commissioned	External Notifications and Other Investigations	Current Investigation Progress
CR 613* (*previous incident investigation model)	n/a	Eclampsia	28.11.23		Draft report received and sent for factual accuracy. For CRG.
PSII-001	n/a	Cooled baby - preterm	6.2.24		Awaiting draft report
MNSI Investigation: STEIS 2024/3982	MI-036889	Cooled baby	5.3.24	MNSI and NHSR Early Notification Scheme	Final report received. Action plan to be drafted and sent to CRG readership panel. Awaiting tripartite meeting

3.4 Coroner Reg 28 made directly to Trust

There has been no coroner regulation 28's and actions being taken in the last quarter.

3.5 Maternity Patient Safety Incident Investigation (PSII) during Q1

During the last quarter there were 0 new maternity PSII's commissioned. These are normally highlighted below for the last quarter.

Figure 6. Commissioned Maternity PSII's

DATIX	Incident Summary	Immediate learning identified
N/a	Nil PSII's commissioned or MNSI cases in Q1.	

All patient safety incidents which have resulted in moderate harm or above require a PSR to support the statutory duty of candour process. This is detailed in section 11 of this report.

4. Midwifery Continuity of Care (MCOC)

The three-year maternity and neonatal delivery plan states that the delivery of personalised care by undertaking regular audits, seeking feedback from women and parents, and acting on the findings. The delivery and roll out of midwifery continuity of carer in line with the principles around safe staffing that NHS England set out in September 2022 should be considered.

At Salisbury NHS Foundation Trust there are no midwifery continuity of carer teams presently. Due to midwifery vacancies and having a less experienced workforce, plans to

implement this model are paused as per recommendation from NHSE and as advised following the publication of the Ockenden report. When staffing and skill mix improves significant consideration will be given to reviewing a team for continuity of care in line with national recommendations.

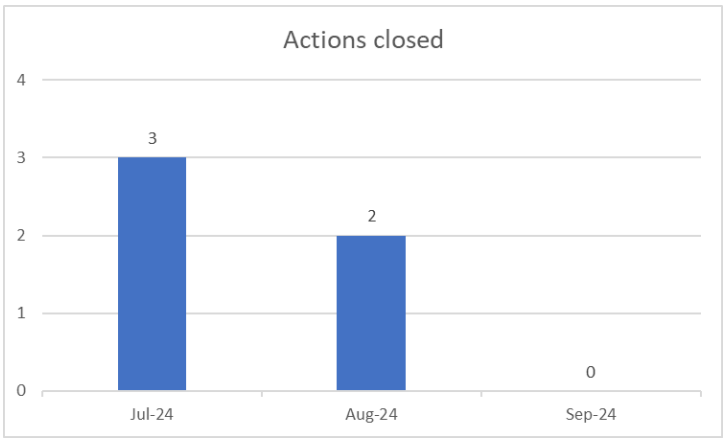
5. Ockenden updates

For the Ockenden Final Actions 2022, there are 15 essential actions, separated into 84 sub actions. The multi-disciplinary Ockenden Working Group meets monthly to drive progress on the immediate and essential actions. Current progress is detailed in the table below.

Figure 7. Current progress with Ockenden 2022 IEAs

OCKENDEN 2022		Immediate and Essential Action	Number of actions under each heading rated			
			RED	AMBER	AWAITING CLOSURE	GREEN
Sep-24	1	Workforce Planning and Sustainability	0	2	0	5
	2	Safe Staffing	0	0	0	10
	3	Escalation and Accountability	0	0	0	5
	4	Clinical Governance - Leadership	0	1	0	7
	5	Clinical Governance - Incident Investigation and Complaints	0	0	0	7
	6	Learning from Maternal Deaths	0	0	0	2
	7	Multidisciplinary Learning	0	0	1	6
	8	Complex Antenatal Care	0	2	1	2
	9	Preterm Birth	0	3	0	1
	10	Labour and Birth	0	1	2	3
	11	Obstetric Anaesthesia	0	1	0	6
	12	Postnatal Care	0	1	0	3
	13	Bereavement Care	0	2	1	1
	14	Neonatal Care	0	1	0	5
	15	Supporting Families	0	0	0	3
			0	14	5	↑ 66

Figure 8. Numbers of actions closed per month in Q2.



The key achievements and next steps to progress the closure of Ockenden 2022 IEAs are listed below.

- **Key Achievements:** Compliance achieved in areas of Postnatal Care, Obstetric Anaesthesia, Complex Antenatal Care, and Safe Staffing.

- **Next Steps for Progressions:** Bereavement Care – agree responsibility outside of Maternity and Neonatal Services for delivery of National Bereavement Care Pathway trust wide, supported as necessary by Bereavement Midwife. Focus resource on directly delivering within Women and Newborn Division only.
  Identify with action holders within more complex actions how momentum can be continued.

6. Three Year Delivery plan

The Three-Year Delivery Plan has been mapped out during Q2. All action holders have been met with (for each of the four elements). Current compliance status and ongoing actions have been identified. Please see embedded document for further details.

Single Delivery Plan
updated 30th July 202

7. Training compliance for all staff groups in Maternity related to the core competency framework and wider job essential training

The full report is contained in the appendices. The following is a summary of key highlights.

Safety Action 8 of the Maternity Incentive Scheme (MIS) requires all maternity units to implement all six core training modules of the Core Competency Framework (CCF) (version 2). This safety action aims to address known variation in training and competency assessment across England and address areas of significant harm. A three-year training plan was developed for maternity and neonatal services (2021-24) and agreed with the quadrumvirate and signed off by the Trust Board and LMNS/ICB. There are six core modules of the CCF:

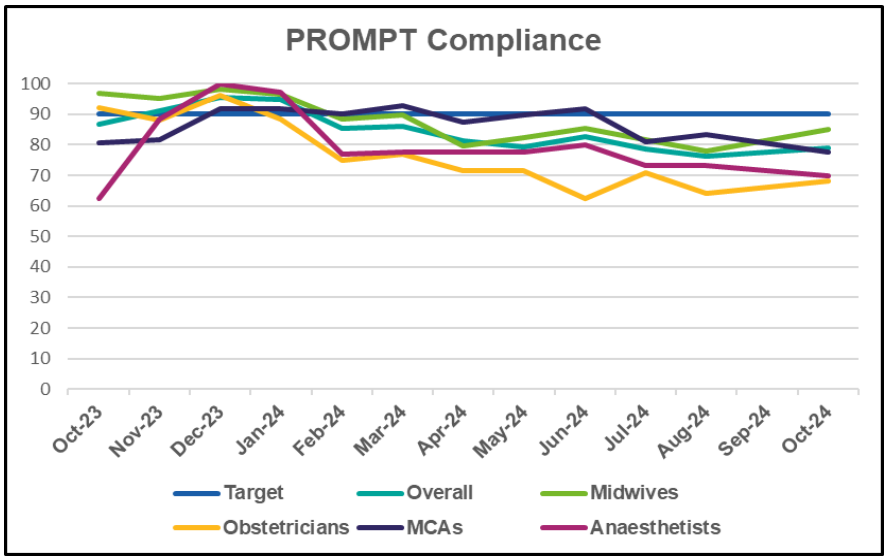
- Saving Babies Lives Care Bundle
- Fetal monitoring and surveillance
- Maternity Emergencies and multi professional training
- Equality/ equity and personalised care
- Care during labour and immediate post-natal period
- Neonatal basic life support

MIS requirements are for 90% attendance for each relevant staff group at fetal monitoring training, multi-professional maternity emergencies training and neonatal life support by 30th November 2024. The other core modules will not the measured within the MIS requirements.

During quarter 2, a drop in training compliance is expected as no training days run in August due to high levels of annual leave among all staff groups.

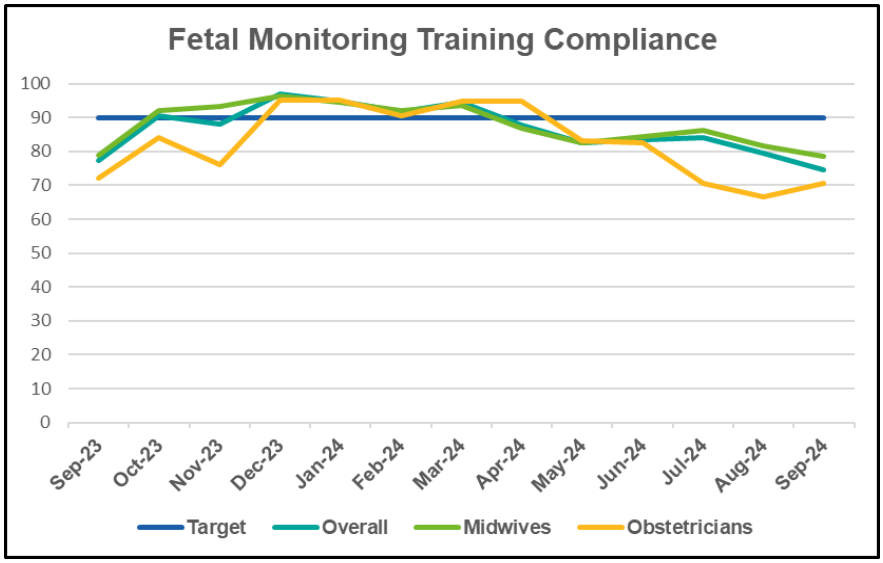
The multi-professional maternity emergencies training (PROMPT) compliance for obstetricians and midwives has improved in quarter 2. However, due to the conflicting demands of the services, anaesthetic attendance has declined due to additional surgical lists and pressure to reduce waiting times. This has been escalated to the relevant divisions and a plan has been created for quarter 3 to improve attendance. An additional training date has also been created in November to allow more anaesthetic attendance prior to the MIS deadline.

Figure 9. PROMPT Training Day Compliance



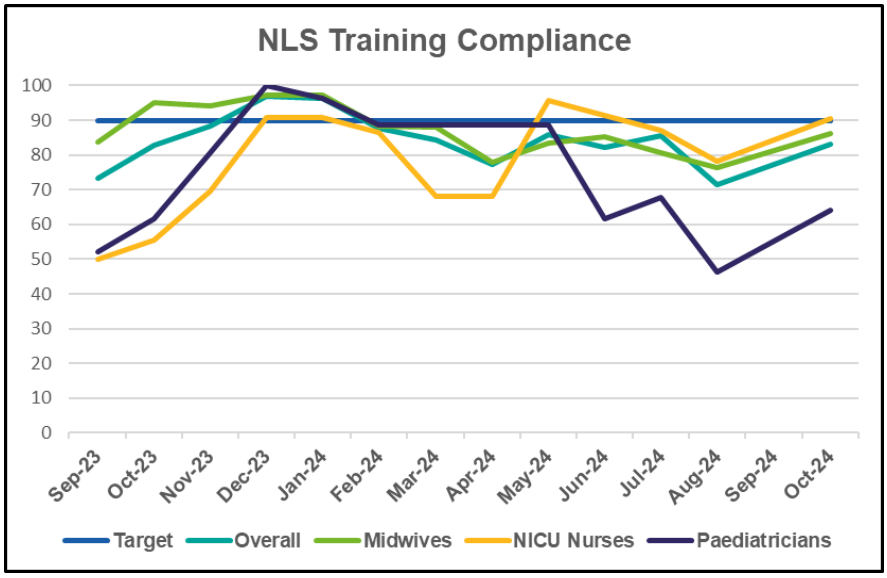
There was a drop in compliance this quarter for fetal monitoring training, this was due to no study day being held in August, avoiding school holidays and increase in annual leave. Obstetric compliance has improved with the incoming rotating resident doctors, as this training can be transferred between Trusts. There are 3 more dates for fetal monitoring training in quarter 3, with a trajectory of achieving >90% for midwives and obstetricians.

Figure 10. Fetal Monitoring Training Compliance



In quarter 2, there has been an improvement in Newborn Life Support training across all staff groups. The upwards trajectory is planned to continue in quarter 3. The neonatal team now plan to hold the training data for the nurses and paediatricians to have improved oversight into the training needs of their teams and target the staff that currently require NLS updates.

Figure 11. NLS Compliance Training



8. Maternity & Neonatal Safety Champions meetings

This section provides evidence of staff and service user feedback from frontline champions and walk-abouts and outline discussions regarding safety intelligence.

The Maternity and Neonatal Safety Champions meetings occur on the third Thursday of each month. Please see below the recently agreed Terms of Reference for further details of the meeting requirements.

MATERNITY SAFETY CHAMPIONS ToR APF

8.1 Maternity and Neonatal Safety Champions meeting attendance by role for Q2

Figure 12. Maternity and Neonatal Safety Champions attendance by role in Q2

Staff groups	July	August	September
Trust Executives	**Meeting cancelled - not quorate.	Chief Nursing Officer Non-Executive Director	Chief Nursing Officer Non-Executive Director
Obstetric		Consultant Obstetrician	Consultant Obstetrician
Midwifery		Director of Midwifery Band 6 Midwife Representative Inpatient Matron Operational Manager	Director of Midwifery Family Experience & Inclusion Midwife Quality & Safety Matron Operational Manager Maternity & Neonatal Independent Senior Advocate Quality & Safety Lead Midwife Community Midwife Bereavement Lead Specialist Midwife
MSW			
Neonatal		NICU Sister	Neonatal Matron Consultant Paediatrician Infant Feeding Lead
MNVP		MNVP Lead for RUH, Bath & NE Somerset, Swindon and Wiltshire (providing temporary maternity cover)	
Secretarial support		Quality & Safety Administrator	Quality & Safety Administrator

8.2 Positive points recognised

Over the course of the Q2 period the following positive points were highlighted:

- Exit meeting from MIP took place on 22/07/2024 - positive feedback given in meeting and Maternity is on track to exit the MIP.

- Patient Experience on Beatrice Maternity Ward survey results were analysed and presented in August 2024. Feedback was generally very positive with small areas of improvement noted. Partners now being able to stay on the ward reported as working well.
- MNVP representative conducted on site visits to get feedback from service users. Feedback was positive, no safety concerns were reported, and issues around translation are already being addressed.
- Separation improvement time project going well – lock boxes have been provided in each room on NICU so new mothers can self-administer; parent grade Oramorph, PPH box and fully motorised trolley are now available on the unit.
- The Infant Feeding Team reported recently undergoing the Baby Friendly Stage 3 Assessment. The feedback was positive especially regarding the facilities on the unit and discussions with parents. Only fell below 80% in two areas and will conduct an internal audit over the next year before applying for gold standard.

8.3 Concerns raised in Q2

Figure 13. Concerns raised in Maternity and Neonatal Safety Champions meetings

Concerns raised	Action and progress
ePMA issues around medications and prescribing reported.	The Trust will be moving to a new ePMA in the next 18 months, but in the meantime education will be provided regarding medications being prescribed by midwives and their remit regarding this, PRN and stat dual prescriptions, and retrospective medication administration times.
GMC survey for junior doctors highlighted red flags around their satisfaction with training, e.g., teaching at handovers and localised teaching.	Action plan in place and this will be included in governance update.
Issues reported around ATAIN – long process and a number of babies are overdue for review.	Neonatal Matron has requested further input from Obstetrics.
No expressing room for staff in NICU - Trust policy around this states they should have an expressing room, but no space/funding to provide this.	Chief Nursing Officer has raised as safeguarding issue and will feed back at Safety Champions meeting. Non-Executive Director will flag this at next People & Culture Committee meeting.
Infant Feeding Team Lead reported difficulties with conducting audits at present due to lack of staff.	New member of staff being recruited which should allow more time to conduct audits.
Anaesthetic room lights broken – this has been reported but there has been a delay to delivery/repair as query around parts needed.	Chief Nursing Officer reported this was flagged during a ‘walk about’ and the Chief Executive Officer is following this up with the Estates Team.
Black spots reported with bleeps.	Issue had been raised previously and bleep testing was conducted. Chief Nursing Officer will check if issue was resolved with either the Estates Team or Communications Team.

Delays to scan reviews on DAU.	Plan for further education around escalation routes - bleeping consultants and reporting to Duty Manager to escalate if Registrar cannot immediately attend. DAU Lead Midwife is also monitoring all delays throughout September to consider themes. If this issue has not progressed by next meeting then this can be escalated via the Trust Board meeting.
Issue around GP's and prescribing for outpatients.	Consultant Obstetrician and Outpatient Matron liaising with GP Liaison Manager to set up meeting with GP Commissioning Group and look into how other Trusts across BSW are managing this.

Maternity and Neonatal Safety Champions action tracker:

Maternity Safety Champions Meeting

8.4 Concerns raised by service users

There have been 3 complaints, and 0 concerns raised in Q2 24/25:

- Historical case - which was initially investigated under the serious incident investigation (SII) framework. The focus of the concern was on an injury sustained during childbirth.
- Management of a retained placenta, and blood loss post the birth.
- Challenges surrounding the accessibility and admission criteria of the Birth Centre, and the management of the patient's blood loss following the birth.

Common theme includes the management of blood loss following the birth. Postpartum Haemorrhage (PPH) over 1.5L are registerable on Datix, as a trigger event. In all cases a review is undertaken by the Quality and Safety team. Any learning from the review will be shared with the workforce, via the newsletters, general communications or safety briefings.

In Q2 there were 3 complaints closed, 2 within target time, offering a 66% compliance rate.

8.5 Additional safety champions intelligence

Both executive and non-executive safety champions conduct regular walk-arounds to seek intelligence regarding safety concerns. The following findings were reported in Q2:

Figure 14. Walk around findings

Area/date visited	Discussion points	Concerns raised	Actions
Non-Executive Director (NED) Safety Champion visit - July 2024 - Antenatal/Postnatal, Labour Ward, Theatres & Anaesthetic Room	Did not speak to women or families but all staff spoken to, including new doctors. Questions raised by two NED's for the Chief Nursing Officer around the use of the White Boards in the Labour Ward Office relating to their	No safety concerns.	Queries to be flagged to Chief Nursing Officer. Next visit will be to NICU.

	purpose and any failsafe mechanisms in place.		
Executive Safety Champion visit - 09/08/2024 - Labour ward/DAU and NICU	Met with several staff who had no staffing concerns. The unit felt calm and under control. Met one midwife from Jamaica who said she felt it was a good unit but felt lonely being away from her family. Also discussed the unit with staff member who joined us 13 months ago from a neighbouring Trust who reported that SFT has good culture.	No safety concerns.	Will feedback at safety champions meeting.

8.6 Culture/SCORE survey findings

The SCORE survey was undertaken in August/September 2023 and reported to the Trust in November 2023. A series of cultural conversations were then undertaken with staff as part of the work of the quadrumvirate. The Perinatal Culture and Leadership programme was commissioned by NHSE to support Maternity Quadrumvirate teams with development and cultural improvements within Maternity Services.

A board report has been drafted and will be presented to the Trust board in Q3 with the suggestion that the Quadrumvirate work is included as a rolling quarterly agenda item to the Maternity & Neonatal Safety Champions meeting.

The cultural conversations with staff formed part of the initial actions by the Quad. The results of these have now developed into a provisional action plan which has been reviewed by the divisional leadership team. One of the actions outlined the need for a follow up culture survey for staff as the data from the Score survey was now recognised to be over a year old, and there have been numerous changes to the service and staffing numbers since then. The results of this will help refine the action plan from the Quad which be implemented from Q3.

9. Saving Babies Lives V3

The Saving Babies Lives Care Bundle version 3 (SBLCBv3) was published on 31st May 2023. The SBLCBv3 represents Safety Action 6 of the Clinical Negligence Scheme for Trusts Maternity Incentive Scheme.

The full report is contained in the appendices. The following is a summary of key highlights.

9.1. Update

The Saving Babies Lives Care Bundle version 3 (SBLCBv3) continues to make slow progress towards full implementation. NHS England produced a national implementation tool in July 2023 that maternity services are continuing to use to track and evidence improvement

and compliance with the requirements set out in Version Three.

Whilst the full report included in the appendices details the specific ongoing action planning and work, as detailed above, trajectory has been slow. SFT's initial assessment was validated at 7%, 37%, 40% and currently sits at 51% with SFT self-assessments largely in-line with LMNS validated assessments. Targeted assistance is being offered to action leads by the newly appointed Quality Assurance Midwife to support ongoing compliance.

10. NHS Resolution Maternity Incentive Scheme

SFT declared compliance with 9 out of 10 safety actions for the year 5 2023/24 MIS submission. SFT were non-compliant with Safety Action 6 Saving Babies Lives. An action plan was submitted to NHSE which outlined the roles and actions needed to move forwards with achieving full compliance.

The new MIS year 6 requirements were published on 2nd April 2024 and SFT is required to be compliant by 30th November 2024. Progress with CNST Maternity Incentive Scheme Year 6 2024/25 has been steady. SFT are presently compliant with 7 of the 10 Safety actions. See table below.

Figure 16. Current compliance with new Maternity Incentive Scheme (MIS) Year 6 2024/25 requirements

NHSR Maternity Incentive Scheme- Year 6 - Position September 2024				
	Description	YR 6 Submission	Comment	Current Assessment
1	Perinatal Mortality Review Tool	Compliant	Compliant at present	
2	Maternity Services Data Set	Compliant	Compliant at present	
3	Transitional Care Services	Compliant	Compliant at present	
4	Workforce	Non-Compliant	Progressing	
5	Midwifery Workforce	Compliant	Compliant at present	
6	Saving Babies Lives Bundle Version 3	Non-Compliant	On track	
7	Patient Experience	Compliant	Compliant at present	
8	Training	Non-compliant	Progressing	
9	Quality and Risk	Compliant	Compliant at present	
10	MNSI and EN	Compliant	Compliant at present	

The areas of non-compliance include Safety actions 4, 6 and 8. It is anticipated that SFT will be compliant with workforce (safety action 4) by 30.11.24. Steady progress is being made with SBL (action 6) and in September SFT were 51% compliant across all elements. It is hoped that with the change in requirements moving from '70% implemented' to

'demonstrating significant improvement' may enable SBL compliance to be achieved. Training (safety action 8) is currently non-compliant. Trajectories have been reviewed and there is a potential risk when new trainee doctors arrive in August and October. Several actions have been taken around this:

- 3 dates for PROMPT in 2024 and 2 dates for FM in 2024 left.
- New obstetric training passport to be sent in advance of new doctors arriving (training is transferrable between Trusts).
-

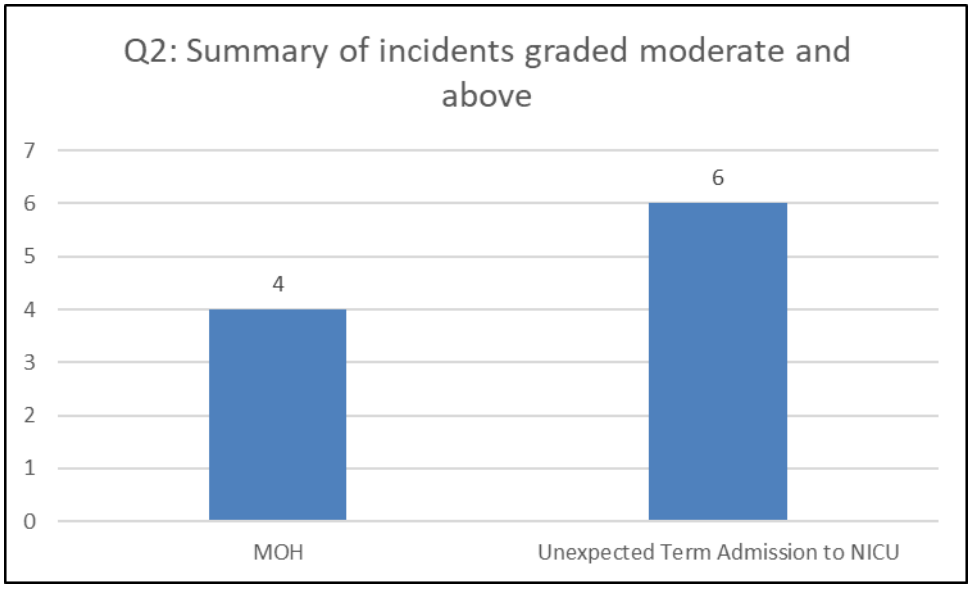
Anaesthetic attendance has been escalated to divisional leads and a plan created.

11. The number of incidents in Q2 and what actions are being taken

A summary of Moderate or above incidents in Q2 are provided below. These numbers were extracted from our reporting system DATIX and a search created using the following data:

Date: 01/07/2024:30/09/2024
Severity: Moderate and above
Directorate: Women and Newborn Division

Figure 17. Summary of Moderate or above incidents



The last quarter noted a rise in unexpected term admissions to NICU and also Massive Obstetric Haemorrhage (MOH) in comparison to last quarter. However, upon further investigation, all cases involved in Fig. 17 have ongoing reviews in to care in accordance with PSIRF. This may lead to a reclassification of harm upon completion of a MDT review meeting, PSR forms and presentation at the Patient Safety Summit meeting.

The Trust Patient Safety Incident Response Plan (PSIRP) outlines nationally and locally mandated responses to incidents. This includes PSII triggers and PSR processes with associated methodology. All moderate harm or above Datix reported incidents and their

outcomes in the last quarter are listed below.

Figure 18. Description of Moderate or above incidents reported in Q2

DATIX Number	Incident Category	Outcome/Learning/Actions
167060	MOH	EMCS. Ongoing investigation from PSR 2: for process mapping of patient journey and risk assessment. For re-presentation of PSR 2 at PSS.
167371	Term Admission to NICU	Attended SFT, booked for care in neighbouring unit. Delay to delivery: Cat 2 EMCS @ 106 minutes from decision. No initial category stated. Meconium aspiration. Actions: • Documentation – All staff reminded about importance of documentation when reviewing patient and inclusion of categorisation of EMCS at decision for delivery. • Escalation delay – RCOG escalation toolkit is a new incentive launched 01/10/24 to aid escalation. Added to ongoing rolling audit.
168531	Term Admission to NICU	Attended SFT, booked for care in neighbouring unit. Fetal monitoring concerns during labour and presence of meconium. Baby transferred to tertiary unit following birth with meconium aspiration. Actions: • Comms have been sent out as a reminder for use of FSE's if any concerns for fetal wellbeing. • Birth gases – added to the daily safety bulletin at each staff handover to ensure everyone is aware of the policy to obtain cord gases in presence of meconium during labour. • Resident Paediatrician to be in attendance for all births involving meconium – added to the daily safety bulletin as a reminder for staff. Added to rolling audit.
168733	MOH	EMCS & PSR 2 due for presentation 25/10/2024
168755	Term Admission to NICU	Meconium Aspiration and PSR 2 due for PSS presentation on 25/10/2024.
168831	Term Admission to NICU	Post delivery collapse of baby around 5 minutes of age. Presented PSR 1 to PSS and awaiting panel for PSR 2. No immediate learning outcomes
168907	Term Admission to NICU	Delay accessing theatre/escalation to 2nd theatre. Immediate Learning/Actions: • Direct feedback for escalation to consultant and opening 2nd theatre. • RCOG escalation toolkit launched 01/10/24. • Fetal monitoring classification – learning being shared directly and also via comms and safety bulletin about importance of re-escalation. Awaiting PSR 2 panel and re-presentation at PSS.
169765	Term Admission to NICU	Awaiting notes and case review. Potential for reclassification and addition to rolling audit.

169773	MOH	Awaiting notes and case review. Potential for reclassification and addition to rolling audit.

12. Safe Maternity Staffing

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 provide safe care at all times to women and babies in all settings. Maternity and Midwifery staffing is reported separately to the Women & Newborn Division and Trust Board biannually to meet the requirements for the maternity incentive scheme.

A full report is contained in the appendices (appendix 5). The following is a summary of key highlights.

12.1 Midwifery Staffing

Planned Versus Actual Midwifery Staffing Levels
The following table outlines percentage Registered Midwife (RM) fill rates for the inpatient areas by month.

Figure 19. Percentage shift fill rates for the inpatient areas by month in Q2

Month	RM Day %	RM Night %
July 2024	97.9	98.5
August 2024	97.3	99.5
September 2024	97.6	96.8

When staffing is less than optimum, the following measures are taken in line with the Maternity Operational Escalation Policy:

- Elective workload prioritised to maximise available staffing.
- Relocate staffing to ensure one to one care in labour and dedicated supernumerary labour ward co-ordinator roles are maintained.
- Utilisation of Bank Midwives.
- Community staff working flexibly in the unit as and when required.
- Non-clinical midwives working clinically to support acuity.
- 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.

- Liaise closely with maternity services at opposite sites to manage and move capacity as required.

All the above actions are designed to maximise staffing into critical functions to maintain safe care for the women and their babies.

12.2 Obstetric staffing

The obstetric consultant team and maternity senior management team should acknowledge and commit to incorporating the principles outlined in the RCOG workforce document: *'Roles and responsibilities of the consultant providing acute care in obstetrics and gynaecology'* into their service. This includes obstetric staffing on the labour ward and any rota gaps.

Trusts should monitor their compliance of consultant attendance for the clinical situations listed in the RCOG document when a consultant is required to attend in person.

Figure 20. Table showing compliance of consultant attendance meeting above criteria

Date	Clinical Situation(s)	Comments
04/07/24	Caesarean birth for women with BMI >50.	Consultant present
11/07/24	PPH 2L where the haemorrhage is continuing, and Massive Obstetric Haemorrhage has been instigated.	Consultant present
28/07/24	Early warning score protocol that suggests critical deterioration where HDU / ITU care is likely to become necessary.	Consultant not present
19/08/24	4th Degree perineal tear repair.	Consultant present
27/09/24	High acuity, second theatre opened.	Consultant present
28/09/24	PPH 2L where the haemorrhage is continuing, and Massive Obstetric Haemorrhage has been instigated.	Consultant present

Table above showing that for Quarter 2 (1st July 2024 – 30th September 2024) there were 6 cases meeting the criteria above. The audit demonstrates 83.3% compliance to the standard. The case where the Consultant was not present was discussed with the Consultant on-call and the case was reviewed in line with the trust process of 72 hour review. There was no harm caused by Consultant non-attendance and the case was appropriately managed.

The medical teams are aware of the expectation of consultant attendance for future cases and continued audits for this Safety Action will be completed monthly by the Maternity service.

12.3 Short Term Locum usage

NHS Trusts/organisations should ensure that the following criteria are met for employing short-term (2 weeks or less) locum doctors in Obstetrics and Gynaecology on tier 2 or 3 (middle grade) rotas:

a. currently work in their unit on the tier 2 or 3 rota
   or
b. have worked in their unit within the last 5 years on the tier 2 or 3 (middle grade) rota as a postgraduate doctor in training and remain in the training programme with satisfactory Annual Review of Competency Progressions (ARCP)
   or
c. hold a certificate of eligibility (CEL) to undertake short-term locums.

An audit of compliance with our Medical HR colleagues was completed for the time period 1st July 2024 – 30th September 2024. The audit demonstrated that during this period, 23 (short term) middle grade locum shifts were required. 6 Doctors completed these shifts, 4 of these Doctors were employed by Salisbury NHS Foundation Trust and 2 Doctors were locums, not employed at Salisbury NHS Foundation Trust at the time of undertaking the shifts. However, both Doctors were working in their local unit (within the Wessex area) on their Tier 2 or 3 rota, therefore the trust is 100% compliant with the criteria described above.

12.4 Long term locum usage

During the time period 1st July 2024 – 30th September 2024 the trust has utilised 4 long term middle grade locum doctors. 1 Doctor has been working in the trust for many months prior to Q1 and therefore standards 1-6 are not applicable during this time period, another doctor was included in Q1 report, therefore standards 1-6 are not applicable. The other doctor commenced employment as a long-term locum in Q2.

For all standards that were applicable the trust was 100% compliant. The compliance can be seen in the table below.

Figure 21. Table below shows 100% compliance with locum standards being met

Standard	Compliance % for Locum 1 (Commenced in Q2)	Compliance % for Locum 2 (in post prior to Q2)	Compliance % for Locum 3 (in post prior to Q2)
Standard 1 Locum doctor CV reviewed by consultant lead prior to appointment	100%	N/A	N/A
Standard 2 Discussion with locum doctor re clinical capabilities by consultant lead prior to starting or on appointment	100%	N/A	N/A
Standard 3 Departmental induction by consultant on commencement date	100%	N/A	N/A
Standard 4 Access to all IT systems and guidelines and training completed on commencement date	100%	N/A	N/A

Standard 5 Named consultant supervisor to support locum	100%	N/A	N/A
Standard 6 Supernumerary clinical duties undertaken with appropriate direct supervision	100%	N/A	N/A
Standard 7 Review of suitability for post and OOH working based on MDT feedback	100%	100%	100%
Standard 8 Feedback to locum doctor and agency on performance	100%	100%	N/A (remains in post)

12.5 Anaesthetic staffing

For Safety Action 4 of the Maternity Incentive Scheme, evidence must be provided to demonstrate that a duty anaesthetist is immediately available for the obstetric unit 24 hours a day and should always have clear lines of communication to the supervising anaesthetic consultant. Where the duty anaesthetist has other responsibilities, they should be able to delegate care of their non-obstetric patients to be able to attend immediately to obstetric patients. (ACSA standard 1.7.2.1).

Figure 22. Compliance with this standard by month

Month	July 2024	August 2024	September 2024
% compliance	100	100	100

The service will continue to audit this standard monthly.

13. Insights from service users and Maternity Voices Partnership Co-production

A full report is contained in the Patient and Staff Experience Report in the appendices (appendix 3). The following is a summary of key highlights.

- There is a 5% decrease in FFT responses this quarter. Further exploration is being undertaken to ensure the validity of these results.
- The number of complaints received has remained consistent with Q1; only receiving 1 more complaint this quarter (total 3 in Q2).
- There have been no reported concerns logged in Q2.
- Work is ongoing to embed the Triangulation meeting into the Divisional Governance structure.
- The 2023 National Patient Experience and the 15 steps assessment action plans are near to completion. The compliance to the National Patient Experience Survey's actions will be monitored by the LMNS.
- In Q2 there was 1 reportable fetal loss. No patient feedback was provided by the family.

- The Neonatal Survey findings are included in the full report. The survey results positive; with a 9.4/10 positive rating score.
- A Health Inequalities Patient Experience Survey was conducted. Full details are included in appendix 3.

  Priorities for next quarter:

  - To undertake listening events with hard-to-reach groups, in order to prioritise the voices from women (birthing peoples) from communities with the poorer maternity outcomes. There are two listening events planned in Q3 RE Family Nurse Practitioner (FNP) and the 'entitled people' (refugees entitled to be residing in the UK) .
  - To develop strong links with Wessex Health Innovation, to continue the ongoing work to secure funding for a new 'at the point of contact' translation device.
  - Review themes from the feedback obtained via FFT, with the focus on increasing patient engagement with the survey.
  - Working with the LMNS Inclusion Lead to align the service with the national agenda relating to reducing health inequalities
  - Review of the data from 2024 National Patient Experience Maternity Survey. It is intended that the development of the action plan will be co-produced with the MNVP.
  - Progress the actions detailed in the Three-year delivery plan and support the work currently ongoing to promote personalisation of care with both patient and staff. It is intended that we will receive the first shipment of the 'My Maternity Choices' booklets, in Q3 which will be disseminated to women upon registering their pregnancy with the Maternity Department.

14. Quality Improvement projects / progress

The Maternity and Neonatal department follow the Trust wide 'Improving Together' methodology which focusses on a programme of continuous improvement underpinned by coaching support and training. The senior leadership have undertaken the training, and it is currently being rolled out to some of the individual teams. The drivers for the QI projects are locally driven being aligned to both divisional and the main trust drivers.

Projects which have been rolled out and, are continuing include:

- Development of flexible working agreements
- MEOWS and fluid balance compliance
- NIPE clinics

Projects planned in the next quarter (Q3)

- RCOG clinical escalation toolkit planned launch 1st October
- New National Maternity Early Warning Score (MEWS) to replace MEOWS

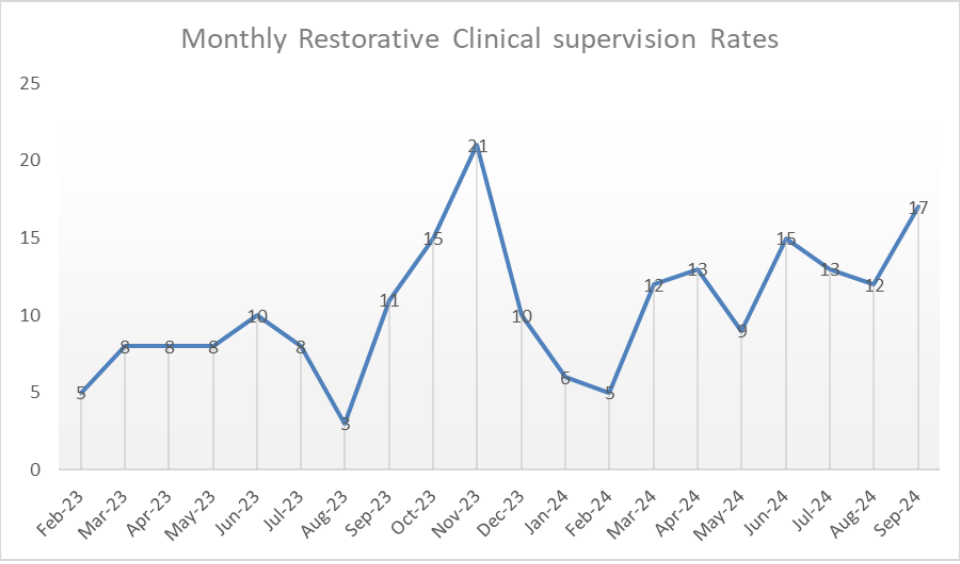
15. Implementation of the A EQUIP model

The Professional Midwifery Advocate (PMA) team are responsible for implementing and deploying the A-EQUIP model (Advocating for Education and Quality Improvement) which supports a continuous improvement process that aims to build personal and professional resilience, enhance quality of care and support preparedness for appraisal and professional revalidation.

15.1 PMA Update

- Restorative Clinical Supervision (RCS): In Q2, all Midwives returning from long term sick or Maternity leave, and all new starters have received an RCS session (see below graph). During Q2, a total of 42 RCS sessions were carried out (incorporating wellbeing and Career conversations). This is a slight increase on the 38 sessions held in Q1.
- RCS support: all NQMW continue to receive this as part of a retention initiative. All current preceptee Midwives have been successfully retained. We currently have a new intake of 8 preceptees starting in September. As per the Preceptee plan, they all receive quarterly teaching to help support them to thrive during their transition from student to qualified Midwife and they each receive quarterly 1:1 restorative supervision from a PMA.
- Anonymous data is kept on themes and numbers of RCS sessions. These are shared with Director of Midwifery for awareness and via appropriate channels to support action and improvement.
- 'Civility and positive workplace culture' training together with 'Active Bystander Training' is no longer being delivered on PROMPT MDT training (due to topic rotation) but has been delivered to all new preceptee midwives.

Figure 23. Restorative Clinical Supervision Rate (p/m)



15.2 Plans and Actions

The structure of the PMA service and the way the service is delivered is changing after Oct 2024. The PMA service will now be sessional, with the 8 currently trained PMA's being given protected time out of their substantive hours each month to carry out restorative supervision, teaching activities and other PMA activity.

The focus and priority over the next quarter is around upskilling and supporting sessional PMA's and ensuring the support offered to Preceptees, and Midwives returning from either long-term sickness or maternity leave is sustained as we move to a sessional PMA model.

16. Avoidable Admission into the Neonatal Unit (ATAIN)

The full report is contained in the appendices. The following is a summary of key highlights.

16.1 The National Ambition

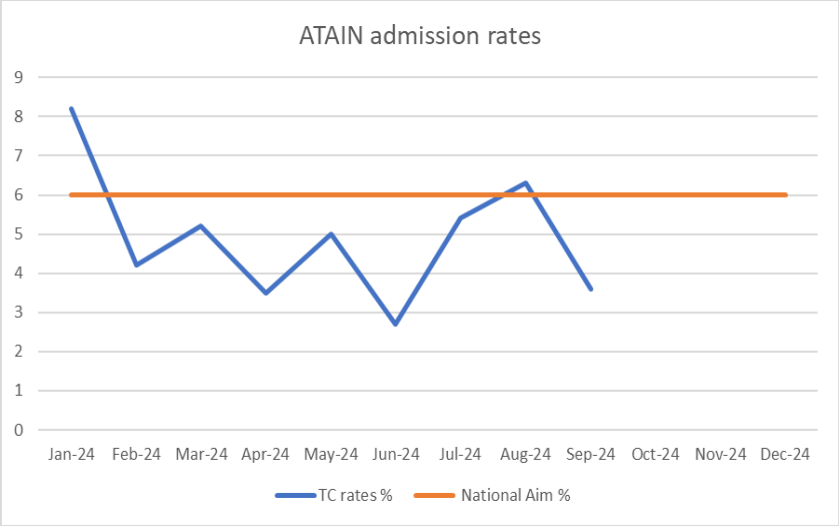
In August 2017 NHSI mandated a Patient safety alert to all NHS Trusts providing maternity care. The safety alert was issued to reduce harm from avoidable admissions to neonatal units for babies born at or after 37 weeks. This fell in line with the Secretary of State for Health's ambition to reduce stillbirth, neonatal brain injury and neonatal death by 50% by 2030. The national ambition for term admissions is below 6%, however Trusts should strive to be as low as possible.
This ambition is also aligned with the vision created within Better Births (2016), which aims to drive forward the NHS England-led Maternity Transformation Programme, with a key focus on:

- Reducing harm through learning from serious incidents and litigation claims
- Improving culture, teamwork and improvement capability within maternity units.

16.2 Why is it important?

There is overwhelming evidence that separation of mother and baby so soon after birth interrupts the normal bonding process, which can have a profound and lasting effect on maternal mental health, breastfeeding, long-term morbidity for mother and child. This makes preventing separation, except for compelling medical reason, an essential practice in maternity services and an ethical responsibility for healthcare professionals.

Figure 24. Monthly ATAIN rates since January 2024 for Salisbury NHSFT Trust



The ATAIN meeting action tracker embedded below contains evidence of actions agreed by both maternity and neonatal leads which address the findings of the reviews to minimise separation of mothers and babies born equal to or greater than 37 weeks.

Figure 25. ATAIN reviews during Q2 (babies equal or >37 weeks gestation)

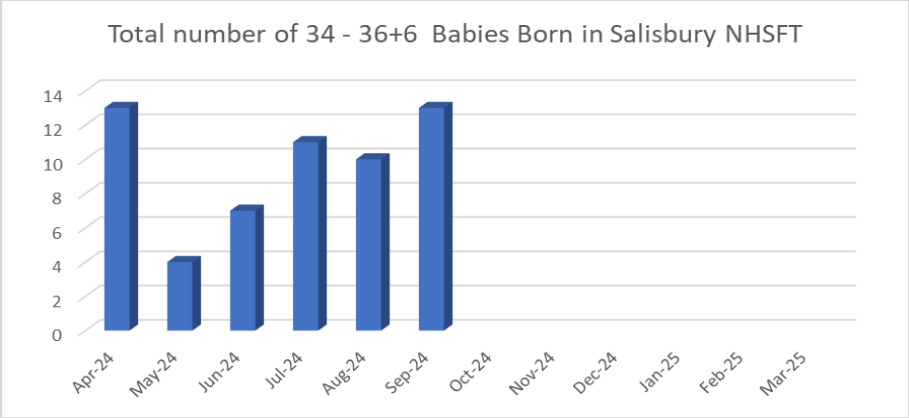
	July 2024	August 2024	September 2024
Total number of admissions in month	8	9	6
Number of babies admitted to the NNU that would have met current TC admission criteria but were admitted to the NNU due to capacity or staffing issues.	0 at present Awaiting further reviews	Awaiting reviews	0 at present Awaiting further reviews
Number of babies that were admitted to or remained on NNU because of their need for nasogastric tube feeding but could have been cared for on TC if nasogastric feeding was supported there.	0 at present Awaiting further reviews	Awaiting reviews	0 at present Awaiting further reviews
	July 2024	**August 2024**	**September 2024**
Total number of case reviews undertaken in month	2	0	1
Total number of case reviews with both maternity and neonatal staff present	2	0	1

16.3 SFT Trust transitional care rates

The number of late pre-term babies (34-36+6 weeks gestation) born that met transitional

care criteria in the last quarter are shown below for Q1 and Q2. Further detail is contained within the appendices.

Figure 26. Total number of 34-36+6 babies born each month since beginning of Q1



All late pre-term babies were cared for on either the Special Care Baby Unit (SCBU) within the neonatal unit or on Beatrice Maternity Ward as outlined in the full report in the appendices.

17. Staff Survey

The most recent annual NHS Staff survey was published in March 2024 (Q4 23/24), with data having been collected in October and November 2023. The questions in the NHS Staff Survey are aligned to the People Promise as well as two themes, staff engagement and morale.

The data below reflects the whole Women and Newborn division which includes nurses working in both the Gynaecology and Fertility departments, as well as nurses and midwives in Maternity and the Neonatal unit.

Figure 27. Proportion of nurses and midwives working in the Women and Newborn Division responding with 'Agree' or 'Strongly Agree' regarding recommending Trust as place to work and for care/treatment

Description	Picker survey national average	Salisbury Foundation Trust average	Women and Newborn
Would recommend organisation as place to work	60.4%	60.3%	**69.6%**
If friend/relative needed treatment would be happy with standard of care provided by organisation	62.6%	63.4%	**72.2%**

There are significantly higher percentages in the Women and Newborn division compared to both the national and main Trust average which is very positive.

Figure 28. Proportion of specialty trainees responding with 'excellent' or 'good' regarding how they would rate the quality of clinical supervision out of hours

Response	Salisbury Foundation Trust trainee %	National average %
Very good (excellent)	0%	26%
Good	75%	47%
Neither good nor poor	25%	18%

The percentages relate to a small number of trainees and reflects a positive experience for the trainees.

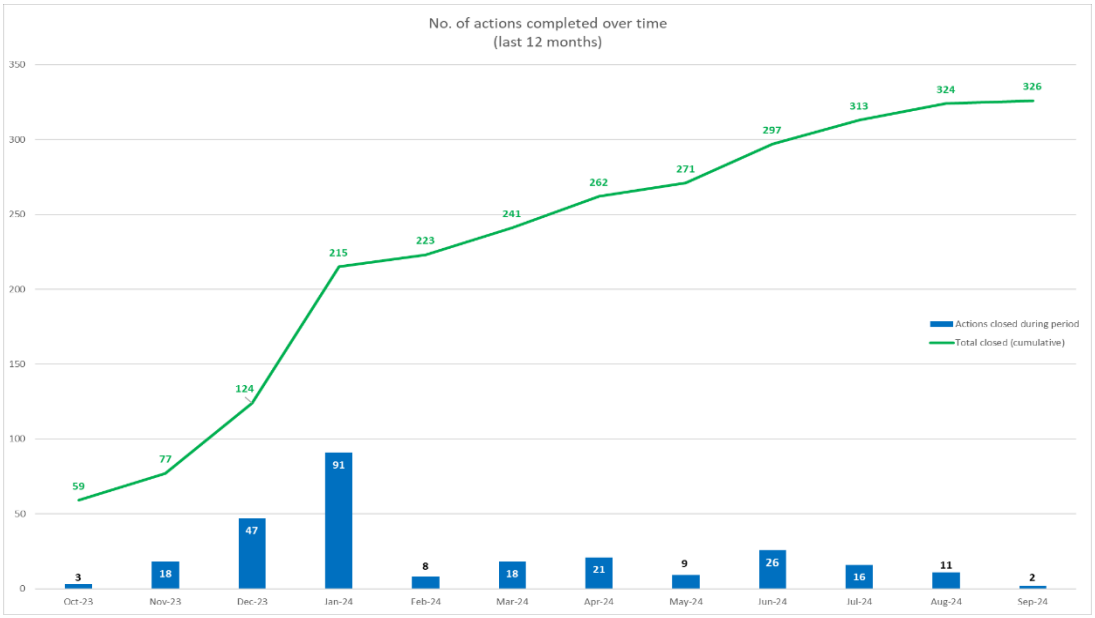
18. Safety Improvement plan

Every Trust is required to develop a bespoke Maternity Safety Improvement Plan which brings together existing and new plans to progress these projects into one place. Salisbury NHS Foundation Trust has been on the NHSE Maternity Safety Support programme since it's CQC inspection in 2021 and an individualised plan was developed in collaboration with the NHSE Maternity Improvement Advisor allocated to Salisbury, to support SFT's progress and improvement journey.

18.1 Progress made over the last quarter

In quarter 2 progress continued with closing actions on the Maternity Improvement Plan, with the highest impact within the governance workstream. More of an 'inch-wide mile-deep' approach is being taken towards the end of Q2 due to the complexity of the actions being tackled, hence a reduced quantity of actions completed in that period. A number of actions within the digital workstream have a dependency on the implementation of the BadgerNet maternity EPR system which is planned to go-live in February 2025.

Figure 29. Progress with Maternity Improvement Plan actions Q2



A meeting to formally present the evidence to move to Exit from the Support programme was held in Q2 2024/25. The board report or application to exit and the sustainability plan were presented to the Trust Board and approved on 5th September 2024. The application to Exit was then approved by the ICB Board (19th September), LMNS Board (23rd September) and Regional PQSSG (23rd September).

The next steps are sign off by Regional Quality Group, Regional Support Group, and National QPC, which should all complete by 19th November 2024.

19. Risk register highlights

The Divisional risk registered is reviewed bi-monthly with leads being encouraged to review and update any risks ahead of this. On 3rd October 2024, the current risks on the risk register can be seen in figures 1-3 below.

Figure 30. Women and Newborn Division - Risk register summary

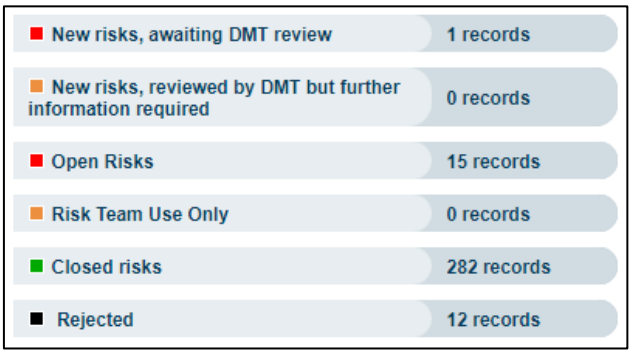


Figure 31. Maternity and Neonatal services 'new risk' awaiting review'.

Title	Opened	Risk Type	Rating (current)	Review date
Maternity Information syastem back and forward copying issue	29/01/2024	Organisational Risk	2	31/10/2024

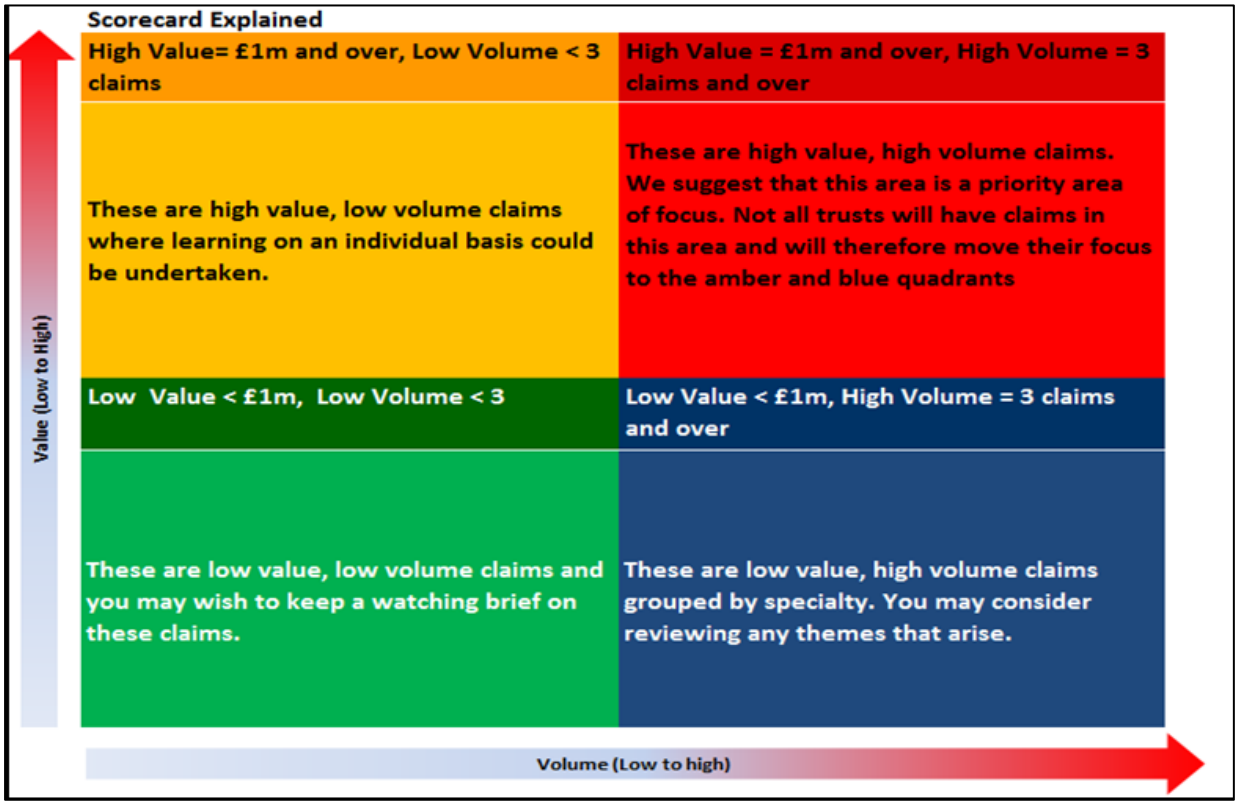
Figure 32. Current 'open risks' in Maternity and Neonatal services

ID	Title	Opened	Risk Type	Rating (current)	Review date
8074	Breaches in 60 day SII and CCR investigation target	30/04/2024	Clinical Risk	6	25/10/2024
6412	Harm to women and babies through lack of dedicated 2nd obstetric theatre	28/04/2020	Clinical Risk	9	02/09/2024
7923	Neonatal unit heating	08/12/2023	Corporate Risk	10	27/12/2024
7860	Neonatal ventilators	04/10/2023	Clinical Risk	3	01/10/2024
7659	Poor uterine vision during a hysteroscopy due to aged flexiscopes	18/04/2023	Clinical Risk	10	30/09/2024
7357	Unable to meet 28 day faster cancer diagnosis	15/06/2022	Organisational Risk	10	02/12/2024
7221	There is a risk of cases with harm not being investigated and escalated due to the large backlog of Datix	14/02/2022	Clinical Risk	8	27/09/2024
8060	Non attendance at essential safeguarding child protection and child in need meetings	17/04/2024	Clinical Risk	6	16/09/2024
8013	No robust system for checking results on review	14/03/2024	Clinical Risk	9	31/10/2024
8141	Unable to meet national guidance for staffing ratios in colposcopy	08/07/2024	Clinical Risk	5	30/08/2024
7623	Neonatal ROP	02/03/2023	Organisational Risk	5	30/03/2026
7109	There is a theorectical risk of infection to women and babies as the Labour Ward birthing pools are over recommended manufactu	15/11/2021	Clinical Risk	5	01/01/2026
7999	No dedicated 24/7 obstetric anaesthetist cover.	02/10/2023	Clinical Risk	4	01/11/2024
7891	No separate consultant rotas for obstetrics and gynaecology	13/11/2023	Clinical Risk	4	30/08/2024
7758	Failure to submit invasive cancer patient details to the national audit leading to missed learning	30/06/2023	Corporate Risk	3	30/09/2024

20. Litigation Scorecard and Triangulation of Incidents and Complaints

The NHSR Litigation Scorecard is updated and published annually for the Trust. It contains 10 years of claims data and is based on incident date. The scorecard is a Quality Improvement Tool for CNST and is a requirement that a quarterly review of incident and complaints data against the annual scorecard themes is reported to Trust Board level Safety champions as part of the Year 6 Maternity Incentive Scheme. The scorecard can be understood within the following table.

Figure 33. NHSR litigation scorecard explained in terms of value and volume of claims

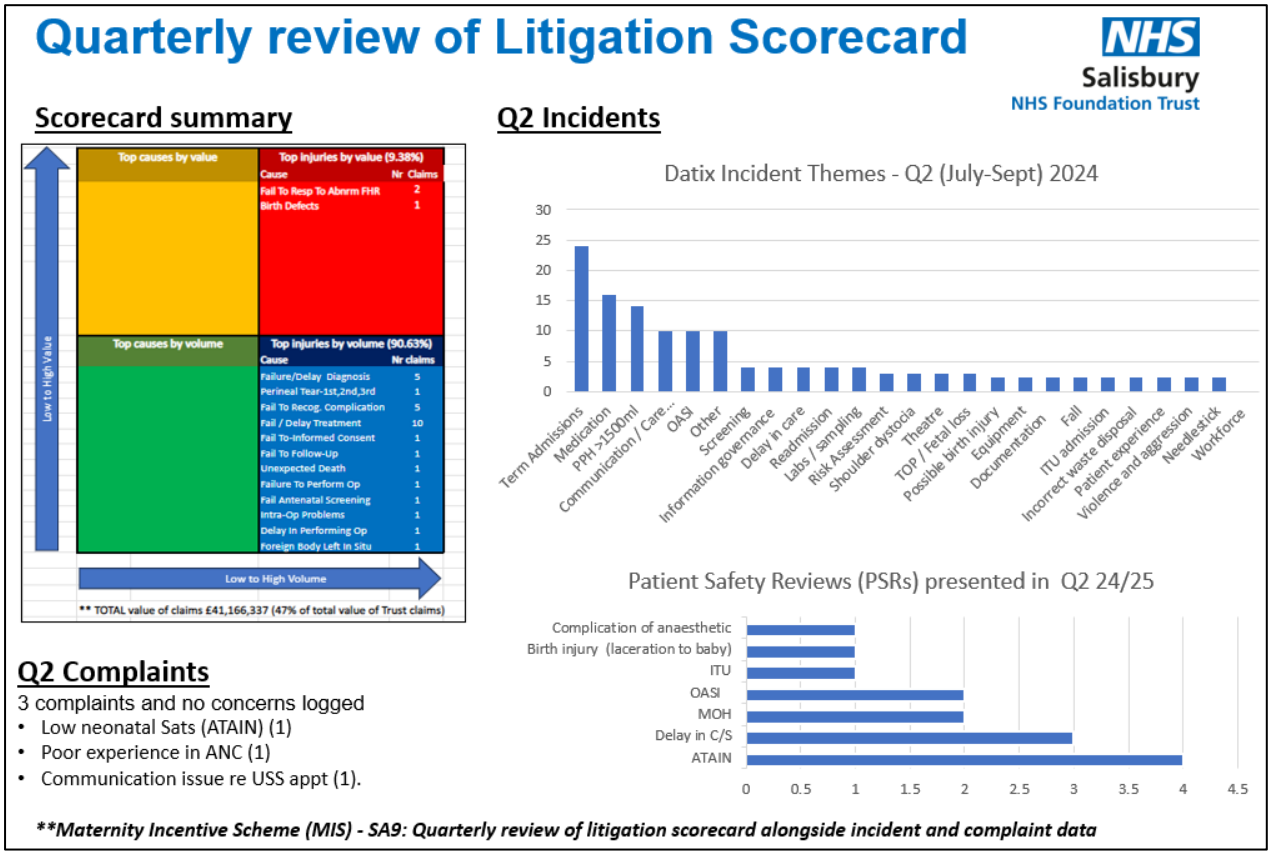


The themes from incidences, claims and complaints are reviewed at the quarterly triangulation meeting and Maternity Governance meeting.

These can be summarised as follows and, in the figure below:

- Legal claims - the top injury claim by value is failure to respond to abnormal fetal heart rate (2) and by volume is failure / delay in diagnoses (5).
- Incidents – the top 3 DATIX including term admissions, medications and postpartum haemorrhage (PPH). Term admissions and PPH are listed on the trigger list, therefore all cases are reviewed in line with the Trust PSIRF plan and learning identified.
- Complaint themes – these include a term admission, poor experience in antenatal clinic and communication issue re appointment.

Figure 34. Litigation scorecard - triangulation of complaints, incidents and legal claims in Maternity and Neonatal services



21. Recommendation

The Board of Directors / Trust Board is asked to receive and discuss the content of the report. They are also asked to record in the Trust Board minutes as requested to provide evidence for the maternity incentive scheme.

Perinatal Mortality & Morbidity Review Group
Perinatal Mortality Review Tool (PMRT) Quarterly Report
Maternity and Neonatal Services
(Quarter 2 2024/25)

1. Introduction

The aim of this quarterly report is to provide assurance to Salisbury NHS Foundation Trust Maternity Safety and Board level Safety Champions and Trust Board that every eligible perinatal death is reported to MBRRACE-UK: Mothers and Babies: Reducing Risk through Audits and Confidential Enquiries across the UK (MMBRACE-UK) via the Perinatal Mortality Reporting Tool (PMRT) and that following this referral the review that is undertaken is robust along with the quality of care provided. The actions and learning will be identified.

1.1 Definitions

The following definitions from MMBRACE-UK are used to identify reportable losses:

- **Late fetal losses** – the baby is delivered between 22^{+0} and 23^{+6} weeks of pregnancy (or from 400g where an accurate estimate of gestation is not available) showing no signs of life, irrespective of when the death occurred.
- **Stillbirths** – the baby is delivered from 24^{+0} weeks gestation (or from 400g where an accurate estimate of gestation is not available) showing no signs of life.
- **Early neonatal deaths** – death of a live born baby (born at 20 weeks gestation of pregnancy or later or 400g where an accurate estimate of gestation is not available) occurring before 7 completed days after birth.
- **Late neonatal deaths** – death of a live born baby (born at 20 weeks gestation of pregnancy or later or 400g where an accurate estimate of gestation is not available) occurring between 7 and 28 completed days after birth.
- **Terminations of pregnancy:** terminations from 22^{+0} weeks are cases which should be notified plus any terminations of pregnancy from 20^{+0} weeks which resulted in a live birth ending in neonatal death. Notification only.

MIS Year 6 requirements to notify:

The following deaths should be notified to MBRRACE and reviewed under PMRT to meet safety action one standards:

- All late miscarriages/ late fetal losses (22+0 to 23+6 weeks' gestation)
- All stillbirths (from 24+0 weeks' gestation)
- Neonatal death from 22 weeks' gestation (or 500g if gestation unknown) (up to 28 days after birth)
- Terminations of pregnancy: terminations from 22+0 weeks are cases which should be notified plus any terminations of pregnancy from 20+0 weeks which resulted in a live birth ending in neonatal death. **Notification only.**

2. Standards

A report has been received by the Trust Executive Board each quarter from Salisbury NHS Foundation Trust Maternity and Neonatal Services that includes details of the deaths reviewed. Any themes identified and the consequent action plans. The report should evidence that the PMRT has been used to review eligible perinatal deaths and that the required standards a), b), c) and d) have been met. For standard b) for any parents who have not been informed about the review taking place, reasons for this should be documented within the PMRT review.

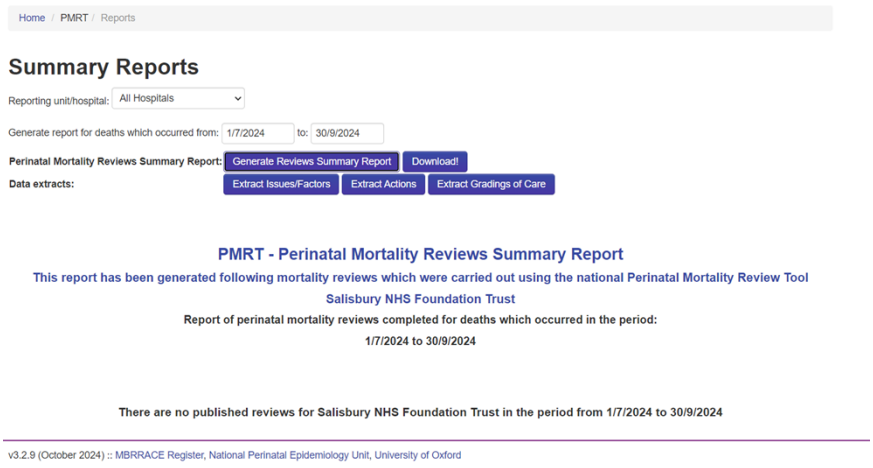
The MIS Year 6 scheme was released in April 2024 and will apply to babies who die between 8th December 2023 until 30th November 2024.

Figure 1. MBRRACE-UK/PMRT standards

MBRRACE-UK/PMRT standards for eligible babies following the PMRT process	Standard
a) Notify all deaths: All eligible perinatal deaths should be notified to MBRRACEUK within seven working days.	**100%**
b) Seek parents' views of care: For at least 95% of all the deaths of babies in your Trust eligible for PMRT review, Trusts should ensure parents are given the opportunity to provide feedback, share their perspectives of care and raise any questions and comments they may have from 8 December 2023 onwards.	**95%**
c) Review the death and complete the review: For deaths of babies who were born and died in your Trust multi-disciplinary reviews using the PMRT should be carried out from 8 December 2023 • 95% of reviews should be started within two months of the death, • minimum of 60% of multi-disciplinary reviews should be completed and published within six months.	**95%** **60%**
d) Report to the Trust Executive: Quarterly reports should be submitted to the Trust Executive Board on an on-going basis for all deaths from 8 December 2023.	**100%**

It is not possible to generate a report for quarter 2 as there were no (zero) perinatal losses within that timeframe (as per screenshot of the MBRRACE reporting tool below).

Figure 2. PMRT Report screenshot showing that there were no published reviews in Q2.



3. Recommendations

3.1 Eligible Incidents in 2024-2025 (appendix A)

There has been a total of 1 incident reported to MBRRACE-UK in Quarter 2. This was a medical termination of pregnancy at 27 weeks which is legally registerable as a stillbirth due to gestation and notified to MBRRACE. This case does not require surveillance and review under PMRT arrangements.

0 PMRT cases have met the threshold for referral to the Maternity and Newborn Safety Investigations programme (MNSI).

No concerns have been raised with the notification and surveillance submission and the current reporting process is to continue.

3.2 Summary of all incidents closed in Quarter 2 (appendix B)

There have been 0 incidents closed in Q2.

For late losses and stillbirths this is broken down into the care provided to the mother and baby before the death of the baby and the care of the mother after the death of the baby.

Grading of care of the mother and baby up to the point that the baby was confirmed as having died:

- 0 cases had no issues with care identified up the point that the baby was confirmed as having died
- 0 cases identified care issues which would have made no difference to the outcome for the baby
- 0 cases identified care issues which may have made a difference to the outcome for the baby
- 0 cases identified care issues which were likely to have made a difference to the outcome for the baby

Grading of care of the mother following confirmation of the death of her baby:

- 0 cases had no issues with care identified for the mother following confirmation of the death of her baby
- 0 cases identified care issues which would have made no difference to the outcome for the mother
- 0 cases identified care issues which may have made a difference to the outcome for the mother
- 0 cases identified care issues which they considered were likely to have made a difference to the outcome for the mother

For neonatal deaths this is broken down into the care of the mother and baby up to the point of birth of the baby, care of the baby from birth up to the death of the baby, care of the mother following confirmation of the death of her baby.

Grading of care of the mother and baby up to the point of birth of the baby:

- 0 case had no issues with care identified up the point that the baby was born
- 0 cases identified care issues which would have made no difference to the outcome for the baby
- 0 cases identified care issues which may have made a difference to the outcome for the baby
- 0 cases identified care issues which were likely to have made a difference to the outcome for the baby

Grading of care of the baby from birth up to the death of the baby:

- 0 case had no issues with care identified from birth up the point that the baby died
- 0 cases identified care issues which would have made no difference to the outcome for the baby
- 0 cases identified care issues which may have made a difference to the outcome for the baby
- 0 cases identified issues which were likely to have made a difference to the outcome for the baby

Grading of care of the mother following the death of her baby:

- 0 case had no issues with care identified for the mother following the death of her baby
- 0 cases identified care issues which would have made no difference to the outcome for the mother
- 0 cases identified care issues which may have made a difference to the outcome for the mother
- 0 cases identified care issues which were likely to have made a difference to the outcome for the mother

Where actions have been identified, appropriate deadlines have been put in place and can be found in appendix 3.

3.3 CNST Compliance as per MIS Year 6 Standards (appendix C)

Salisbury NHS Foundation Trust is currently compliant with all eligible standards for MIS CNST Year 6.

3.4 Learning and Action Logs for Outstanding Cases (appendix D)

Learning and progress against previous actions are included in appendix D.

3.5 Perinatal mortality rate per 1000 births compared to the national average (appendix E)

The graphs in appendix E demonstrate how Salisbury Foundation Trust is performing against the national ambition to reduce rates of stillbirths, neonatal and maternal death by 20 per cent by 2020 and 50 per cent by 2025.

There were 0 stillbirths (excluding MTOP's) in Q2. This makes a total of 4 stillbirths in the last 12 months, which equates to 1.93 per 1000 births in the last 12 months. The national rate per 1000 births is 3.9 per 1000 with a national ambition to reduce to 2.5 per 1000 births.

There were 0 neonatal deaths in Q2. This makes a total of 1 NND >24 weeks in the last 12 months which equates to 0.55 per 1000 live births in the last 12 months. The national neonatal death rate is 1.65 per 1000 live births.

Report Author

Name: Stephanie Thompson

Title: Bereavement Lead Midwife

Date: 17/10/2024

Appendix A - Summary of all Eligible Incidents Reported in Q2 2024/25

	PMRT ID	Reason for entry to MBRRACE/ PMRT	Gestation (weeks)	Date of Birth	Date of Death	Weight (g)	Location of booking / Primary Antenatal Care	Location of Delivery	Location of Death (reporting hospital)	MNSI Case	CIIR /SI	Notify MBRRACE within 7 days	Seek parent's views of care	Start review <2 months	Complete and publish review <6 months	Report to Trust Executive
Q2	**95021**	Medical termination of pregnancy	27+1	31/08/24	29/06/24	NA MTOP	SFT	SFT	SFT	NA	NA	Yes	Not required MTOP	Not required MTOP	Not required MTOP	Yes

Appendix B - Summary of all incidents closed in Q2 2024/25

Case	Cause of Death	Grading of Care	Issues Identified	Actions	Responsible/Date	Update
There were no reviews closed in Q2						

Appendix C - Summary of CNST Compliance as per MIS Year 6 Standards

MBRRACE-UK/PMRT standards for eligible babies following the PMRT process	% Target	From 8 Dec Q3 23/24	Q4 23/24	Q1 24/25	Q2 24/25	To 30 Nov Q3 24/25	Total
Notification of all perinatal deaths eligible to be notified to MBRRACE-UK to take place within 7 working days	100	2 (1 MTOP)	4 (2<22wk)	1 (MTOP)	1 (MTOP)		8
		100%	100%	100%	100%		100%
Seek parents' views of care: For at least 95% of all the deaths of babies in your Trust eligible for PMRT review, Trusts should ensure parents are given the opportunity to provide feedback, share their perspectives of care and raise any questions and comments they may have from 8 December 2023 onwards.	95	1	2	0	0		3
		100%	100%	NA	NA		100%
A PMRT review must be commenced within two months following the death of a baby.	95	1	2	0	0		3
		100%	100%	NA	NA		100%
Minimum of 60% of multi-disciplinary reviews should be completed and published within six months.	60	1	2	0	0		3
		100%	100%	NA	NA		
Report to the Trust Executive: Quarterly reports should be submitted to the Trust Executive Board on an on-going basis for all deaths from 8 December 2023.	100	2	4	1	1		3
		100%	100%	100%	100%		100%

Appendix D - Summary of all Learning and Action Logs for Outstanding Cases

Case IDs	Issue	Action	Responsible / Date	Update / progress
PMRT ID 75880	SID's pathway not available.	NICU team and Bereavement MW to work together to develop a pathway for care of families experiencing SID in the neonatal period.	ST MW BR NN New date 12/24.	SOP completed- in 2022. Delay in being ratified at Neonatal and Sarum governance. Will now need updating- in progress. Update and planned for ratification October Audit and Guidelines meeting
PMRT ID 79097	This mother did not receive preconception care regarding severe pre-eclampsia or HELLP.	To consider postnatal follow up appointment for women with severe pre-eclampsia or HELLP to discuss appropriate pre-conception management and to add to hypertension guideline.	KEB and SE New action holders date put back to 12/24.	Update requested 16/5 To discuss at consultant meeting Sept 2023 for agreement then update policy. Emailed APH 16/2/2024 to add to guideline. KEB- 20/2/24-Currently working with SE to incorporate picking these women up on PN ward and having the referral process clear. Document still in progress. Emailed KEB and SE 17/6/2024.
PMRT ID 88241	This mother did not receive aspirin.	Robust processes are required by the trust to ensure women who need aspirin are provided with it. To talk to staff to discuss the barriers around this and then decide an action plan. To be discussed at the antenatal quality meeting for a plan. NED present at review will take this to the Executive Team for the Trust.	ET- ANC S TR- CMW EJ- Trust New date due to new action holder in post 12/24.	Clinic lead MW is reviewing PGD with pharmacy. Discussed at Maternity Risk and Governance 12/7/24 and Antenatal Quality meeting 5th August 24. Storage logistics and PGD in progress

Appendix E - Perinatal mortality rate

Stillbirths

The graphs below show the monthly and annual stillbirth rates (per 1000 births) at Salisbury.

Figure 1. Monthly Stillbirth rate (per 1000 births excluding MTOP's) for SFT over the last 12 months, compared with national rate and ambition

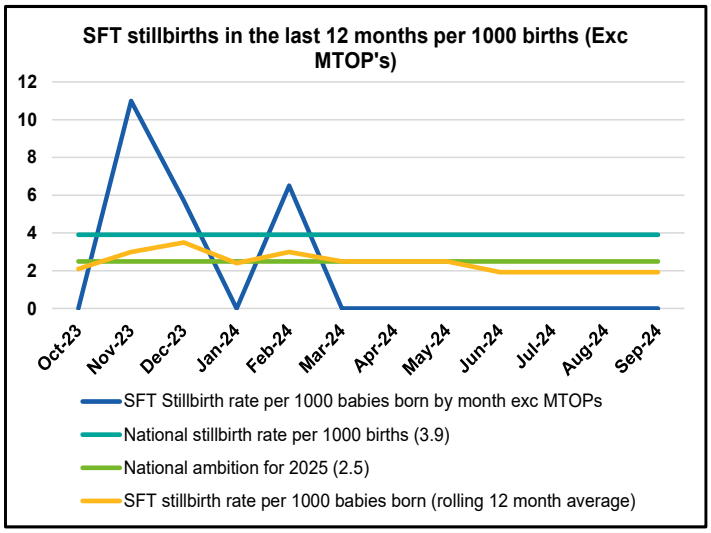
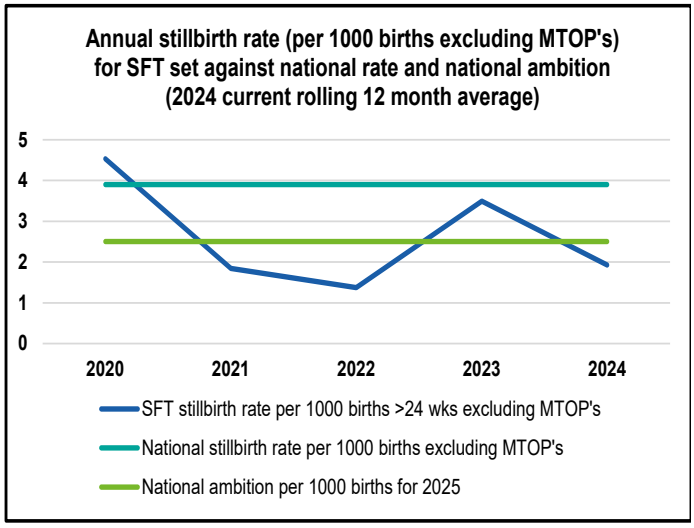


Figure 2. Annual Stillbirth rate (per 1000 births excluding MTOP's) for SFT set against national rate and national ambition (2024 current rolling 12 month average)



Neonatal Deaths

The graphs below show the monthly and annual neonatal death rates (per 1000 live births) at Salisbury.

Figure 3. Monthly Neonatal death rate >24 weeks per 1000 live births for SFT over the last 12 months set against national rate and ambition

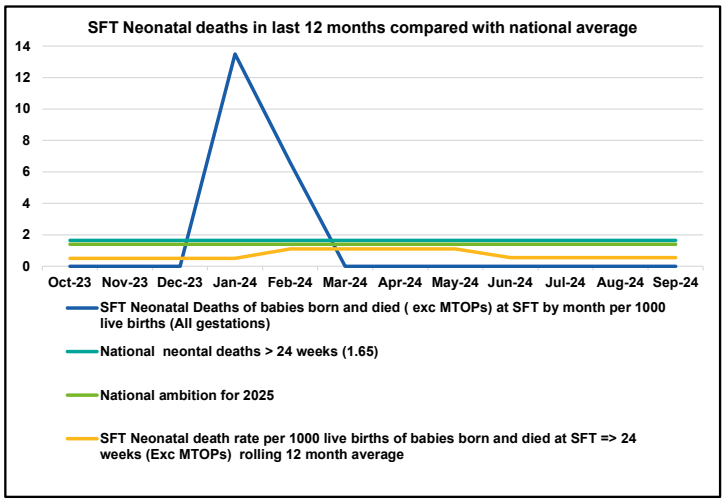
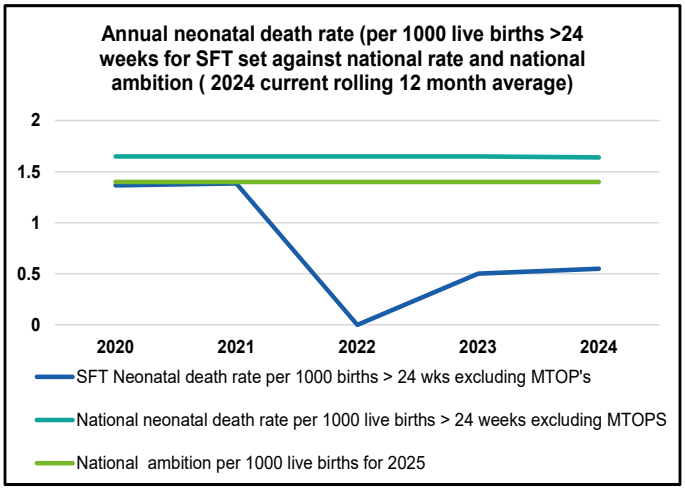


Figure 4. Annual Neonatal death rate per 1000 live births >24 weeks for SFT set against national rate and national ambition (2024 current rolling 12 month average)



Maternity and Neonatal Training Report
Maternity and Neonatal Services
(Quarter 2 2024-25)

The report provides an update on the local training and development that is ongoing within the maternity and neonatal service at SFT, including a response to current CNST Maternity Incentive Scheme action 8. The Maternity and Neonatal service must demonstrate that a local training plan is in place for implementation of the current Core Competency Framework (CCF) and that the plan has been agreed with the quadrumvirate and signed-off by the Trust Board and the LMNS/ICB. The CCF (version 2) sets out clear expectations for all Trusts, aiming to address known variation in training and competency assessment across England. It ensures that training to address significant areas of harm are included as minimum core requirements and standardised for every maternity and neonatal service.

A training plan for the 3-year period of the Core Competency Framework (2021-2024) was submitted on 21/11/23, covering January 2022 – December 2024, as per the CCFv2. This included all training requirements for the multi-disciplinary team within maternity and neonatal services. The plan has been agreed with the quadrumvirate before sign-off by the Trust Board and the LMNS/ICB. The TNA will be reviewed in Quarter 2 and 3 to plan training for 2025-2027.

This report is to demonstrate compliance to the mandatory obstetric and maternity training at the end of each quarter as well as the compliance to the aspects of corporate training that the maternity education team support.

The report aligns to the Maternity Training and Development Policy.

***For noting:** There were **no study days during August** due to high levels of staff annual leave. Data collected for maternity-specific training is norrmally collated by the maternity education team on the 1st working day of the month. Due to conflicting demands, the **September data was not collected** and is therefore missing throughout this report. Data from 1st October has been used to demonstrate trends of compliance for Quarter 2.*

Contents

1.6 Diabetes in pregnancy

2. **Obstetric Emergency Day** (PROMPT) (which includes Human Factors and recognition of the deteriorating patient and newborn)
3. **Neonatal Basic Life Support**
4. **Maternity Update Day** (which includes equality, equity, and personalised care)
5. **MDT safeguarding children level 3**
6. **NIPE**
7. **Adult Basic Life Support**
8. **Blood Transfusion Training**
9. **Simulation Training**
10. **CNST Year 6**
11. **Plans for next quarter**
12. **Action plan**

Compliance

The target compliance for staff attendance is 90% for all elements within the CCF. The compliance is calculated in the number of staff members in each group excluding those on maternity leave or long-term sick (>2months). This provides evidence for safety action 8 of the maternity incentive scheme.

Saving Babies Lives Care Bundle (SBLCB) version 3 minimum compliance with each of the 6 elements is 90% attendance – annual for each element (eLearning is appropriate for some elements on eLfH). There is also an ambition to achieve the stretch target of ≥95% attendance.

For those training modules that are non-compliant, an action plan highlights the plan to gain compliance by the MIS deadline on 30th November 2024.

1. **Saving Babies Lives Care Bundle**

The CCF version 2 introduced training requirements for each element of the Saving Babies' Lives Care Bundle in 2023. However, each element is not currently required for all staff groups. You will see within the compliance graphs which staff groups are required for each element of training.

1.1. Smoking in Pregnancy

Minimum standard:

- All multidisciplinary staff trained to deliver Very Brief Advice to women and their partners (NCSCT eLearning).
- Local opt-out pathways/protocols, advice to give women and actions to be taken.
- CO monitoring and discussion of result.
- Individuals delivering tobacco dependence treatment should be fully trained to NCSCT standards.

For 2024, this training is provided via eLearning for Health (eLfH) online, as part of the national Saving Babies' Lives eLearning package. Compliance is held once certificates of completion are evidenced to the maternity education team.

Midwives are now being provided with paid time to complete the eLearning required for SBL Care Bundle, introduced in January 2024, which is aiding compliance in multiple training elements. This element is currently non-compliant (see figure below) as the training was only introduced in January, with midwives having paid time to complete the eLearning in their maternity study week. There are 10 study weeks throughout the year, therefore it is not expected to meet compliance until November 2024.

There has been a drop in compliance for obstetric staff due to the rotations of new junior doctors into the workforce in August.

Figure 1. Compliance progress with SBL Element 1 eLearning in Quarter 2

	July 2024	August 2024	October 2024
Midwives	54.1%	53.5%	60.9%
Obstetricians	20.8%	24.0%	22.7%

1.2. Fetal Growth Restriction (FGR)

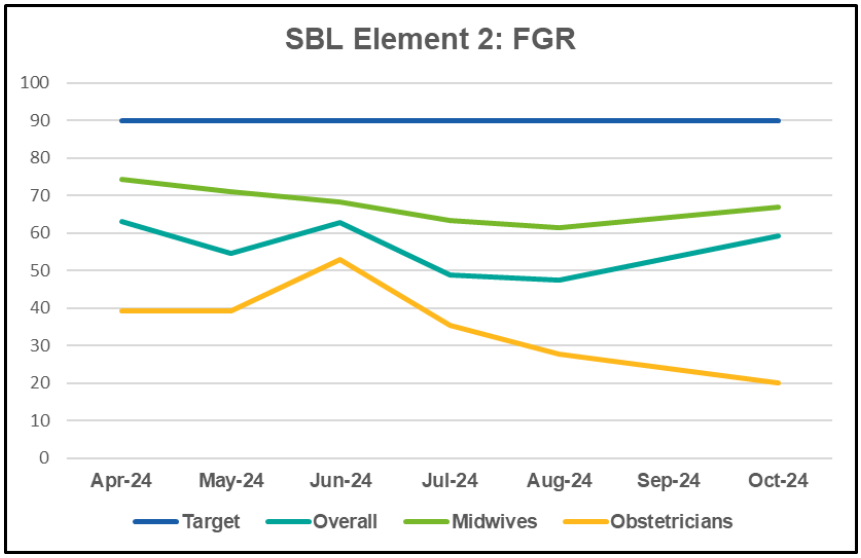
Minimum standard:

- Local referral pathways, identification of risk factors and actions to be taken.
- Evidence of learning from local Trust detection rates and actions implemented.
- Symphysis fundal height measuring, plotting, and interpreting results practical training and assessment, and case reviews from examples of missed cases locally.

From January, FGR detection and surveillance is accessible via the eLfH eLearning website and data of compliance is kept within our Divisional Performance Review on PowerBI and is reported to Trust quarterly. The following table demonstrates overall compliance for the last quarter.

The staff groups required to complete FGR training changed in April 2024, now only required for midwives and obstetricians as per the CCF and SBL Care Bundle. Midwives are now required to complete this during their maternity study week, which is why the compliance is dropping, but will increase towards the end of 2024 when all have attended the week. Obstetric compliance is challenging due to the constant rotations of junior doctors but there is a plan to introduce an obstetric training passport, to help those rotating into SFT to complete all required e-Learning prior to arrival.

Figure 2. FGR compliance (Q2 July-Sept)



1.3. Reduced Fetal Movements

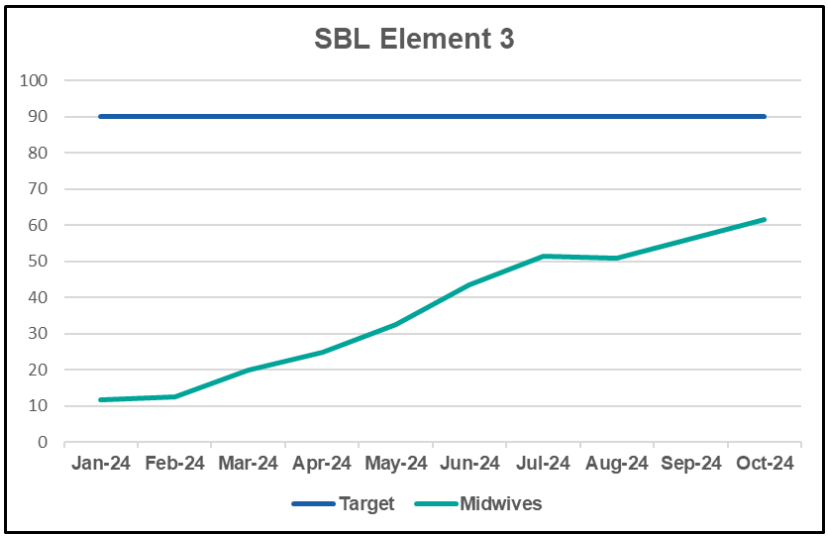
Minimum standard:

- Local pathways/protocols, and advice to give to women and actions to be taken.
- Evidence of learning from case histories, service user feedback, complaints and local audits.

This training element was introduced for the first time in January 2024 as part of Saving Babies' Lives version 3, it was previously being covered as part of the maternity update days. This element is now being taught on the Fetal Monitoring study day as well as the eLearning on eLfH. Compliance for the eLfH module is presented below and fetal monitoring compliance presented within element 4.

This element is currently non-compliant (see figure below) as the training was only introduced in January, with midwives having paid time to complete the eLearning in their maternity study week. There are 10 study weeks throughout the year, therefore it is not expected to meet compliance until November 2024.

Figure 3. SBL training compliance (Q2 July-Sept)



1.4. Fetal Monitoring

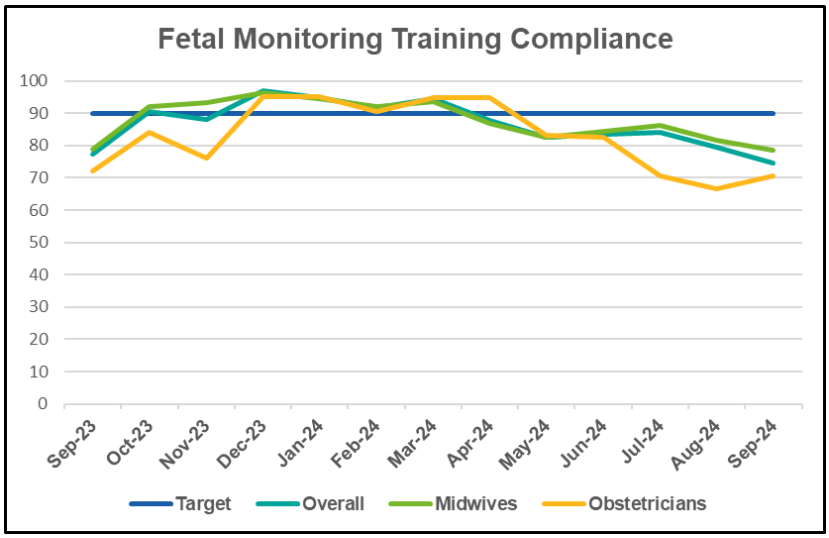
Minimum standard:

- 90% attendance.
- Annual update.
- All staff will have to pass an annual competency assessment that has been agreed by the local commissioner (ICB) based on the advice of the clinical network.
- One full day's training in addition to the local emergencies training day.
- Fetal monitoring lead trainers must attend annual specialist training updates outside of their unit.

For MIS Year 6, the requirement for attendance at fetal monitoring training now excludes GP trainees and Foundation Year doctors, as they will not be interpreting CTGs and fetal wellbeing without supervision.

The following graph demonstrates overall compliance for fetal monitoring over the past 12 months:

Figure 4. Fetal Monitoring training compliance (Q2 July-Sept)



The below data is specific to attendance on the fetal monitoring study day.

Figure 5. Fetal Monitoring Training compliance

Attendance & overall compliance	Midwives	Obstetricians
July attendance	10	3
July % compliance	86.2% ↑	70.6% ↓
August 2024	No training session held	No training session held
September attendance	10	3
September % compliance	84.3% ↓	70.6% ↔

1.5. Preterm birth

Minimum standard:

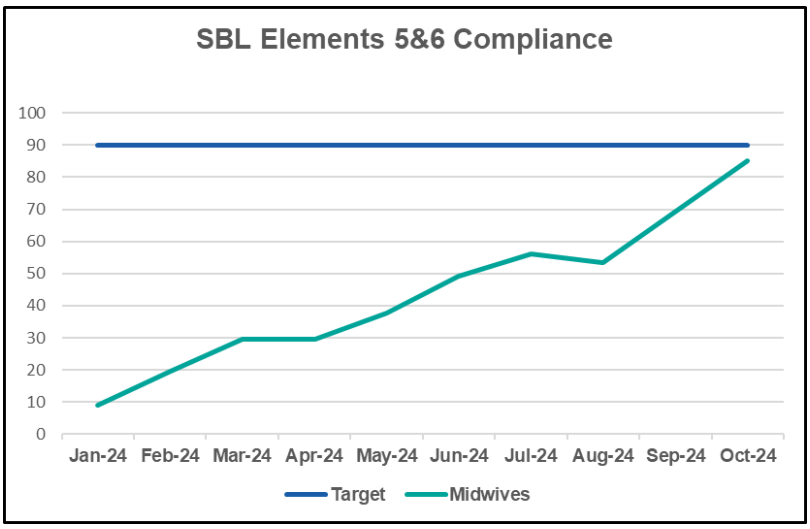
- Identification of risk factors and local referral pathways.
- All elements in alignment with the BAPM/MatNeoSIP optimisation and stabilisation of the preterm infant pathway of care.
- A team-based, shared approach to implementation as per local unit policy.
- Risk assessment and management in multiple pregnancy.

To provide face-to-face teaching on elements 5&6 of the SBL Care Bundle, a new study day was introduced in 2024, which includes face-to-face teaching and time for midwives to complete required eLearning for other elements. This study day is currently only mandatory

for midwives to attend and therefore we have also incorporated other local learning requirements such as blood transfusion.

The below graph demonstrates midwifery compliance with Preterm Birth and Diabetes in Pregnancy. This element is currently non-compliant (see figure below) with midwives attending SBL study day in their maternity study week. There are 10 study weeks throughout the year, therefore it is not expected to meet compliance until November.

Figure 6. SBL Elements 5&6 compliance



1.6. Diabetes in Pregnancy

Minimum standard:

- Identification of risk factors and actions to be taken.
- Referral through local multidisciplinary pathways including Maternal Medicine Networks and escalation to endocrinology teams.
- Intensified focus on glucose management in line with the NHS Long Term Plan and NICE guidance, including continuous glucose monitoring.
- Care of the diabetic woman in labour.
- This training element was introduced for the first time in January 2024 as part of Saving Babies' Lives, it was previously being covered as part of the maternity update days. Please see above training compliance within Element 5 (Preterm Birth).

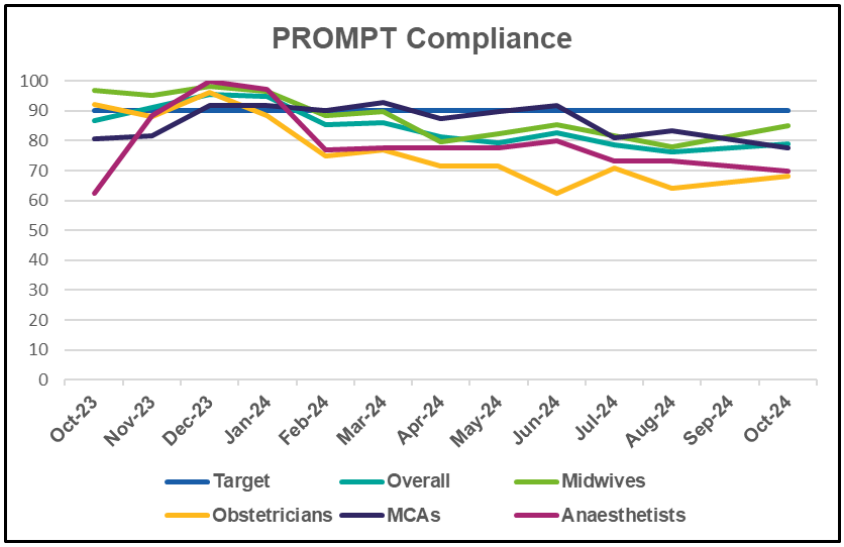
2. Maternity Emergencies and Multi-Professional Training Day (PROMPT)

CNST MIS year 6 minimum standards:

- 90% of each relevant maternity unit staff group has attended an 'in-house' MDT training day which includes a minimum of four maternity emergencies with all scenarios covered over a three-year period and priorities based on locally identified training needs:
    - Antepartum and postpartum haemorrhage
    - Shoulder dystocia
    - Cord prolapse
    - Maternal collapse, escalation, and resuscitation
    - Pre-eclampsia/eclampsia and severe hypertension
    - Impacted fetal head
    - Uterine rupture
    - Vaginal breech birth
    - Care of the critically ill patient
- Annual update.
- Training should be face-to-face (unless in exceptional circumstances such as the covid pandemic).

The following graph demonstrates compliance for the specific staff groups over the past 12 months:

Figure 7. PROMPT training day compliance



The MIS deadline for training compliance was for year 5 was in December 2023. Since then, there have been multiple challenges in achieving consistent MDT attendance at the study day. PROMPT attendance has been affected by junior doctor industrial action and conflict of workload for anaesthetists.

PROMPT has 10 study days throughout 2024 to enable opportunities for attendance, with 2 extra dates being added in October and November 2024 in anticipation for junior doctor

rotations. Current trajectories show that full compliance for all staff will be met by November 2024.

The below data is specific to attendance on the PROMPT study day.

Figure 8. PROMPT study day attendance

Attendance & overall compliance	Midwives	Obstetricians	Anaesthetists	MCAs
July attendance	8	2	5	0
July % compliance	81.7% ↓	70.8% ↑	73.2% ↓	81.1% ↓
August (No session held)	78.1% ↓	64.0% ↓	73.2% ↔	83.3% ↑
September attendance	12	5	6	2
October % compliance	85.2% ↑	68.2% ↑	69.8% ↓	77.5% ↓

3. Neonatal Basic Life Support

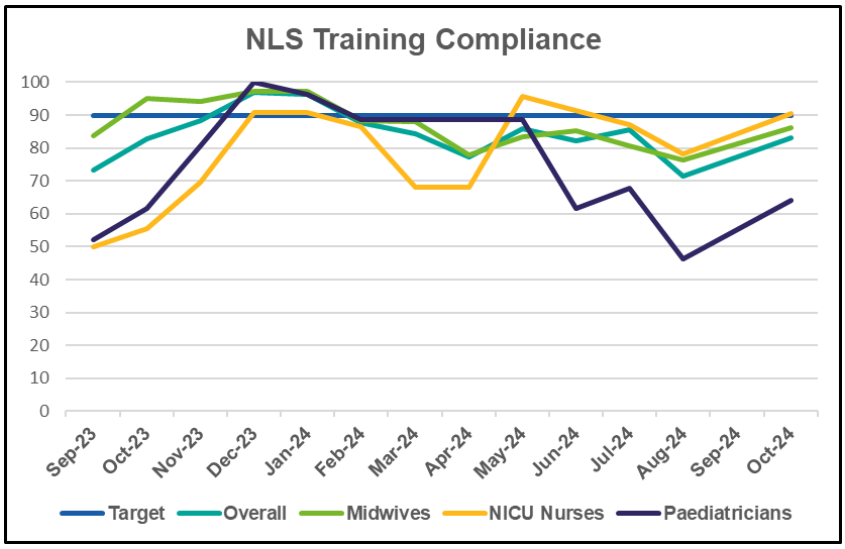
Minimum standard:

- 90% compliance at a neonatal basic life support annual update, either as an in-house neonatal basic life support training or newborn life support (NLS).
- Only registered Resuscitation Council (RC) trained instructors should deliver their local NLS courses and the in-house neonatal basic life support annual updates.

Within maternity and neonatal services, there are 5 RC-trained instructors, with a further 3 midwives that have been invited to become instructors in the future. This has enabled the delivery of in-house updates with RC-trained instructors for all staff groups since 2023.

The following graph demonstrates compliance for the specific staff groups in the past 12 months. A clear trajectory is in place to achieve full compliance with staff training for NLS.

Figure 9. NLS training compliance



**NB: This data includes staff that have completed an Resus Council NLS course.*

4. Maternity Update Day

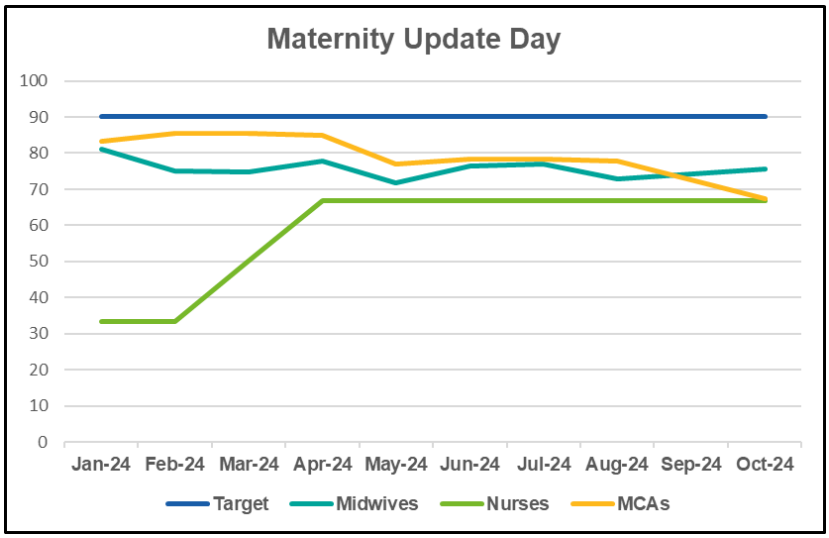
The maternity update day is an annual day for midwives, nurses working in maternity and MCAs and includes training in modules 4 & 5 of the CCFv2 (Equality, equity and personalised care and care during labour and immediate postnatal period). This study day also includes content required locally, such as an epidural care update and learning from patient feedback. A trajectory for 2024 ensures by November 2024 all Midwives, MCA and maternity nurses will have attended and be compliant.

Minimum standard:

- 90% attendance (three yearly programme of all topics)
- Training should cover local pathways and key contacts when supporting women and families
- Training must include learning from incidents, service user feedback, local learning, local guidance, audit reviews, referral procedures and 'red flags.
- Learning from themes identified in national investigations e.g., HSIB
- Include national training resources within local training e.g., OASI Care Bundle, RoBUST
- Be tailored to specific staff groups depending on their work location and role e.g., homebirth or birth centre teams/maternity support worker (MSW).

The following graph outlines attendance data since January 2024:

Figure 10. Maternity Update Day attendance



5. Level 3 Safeguarding Children

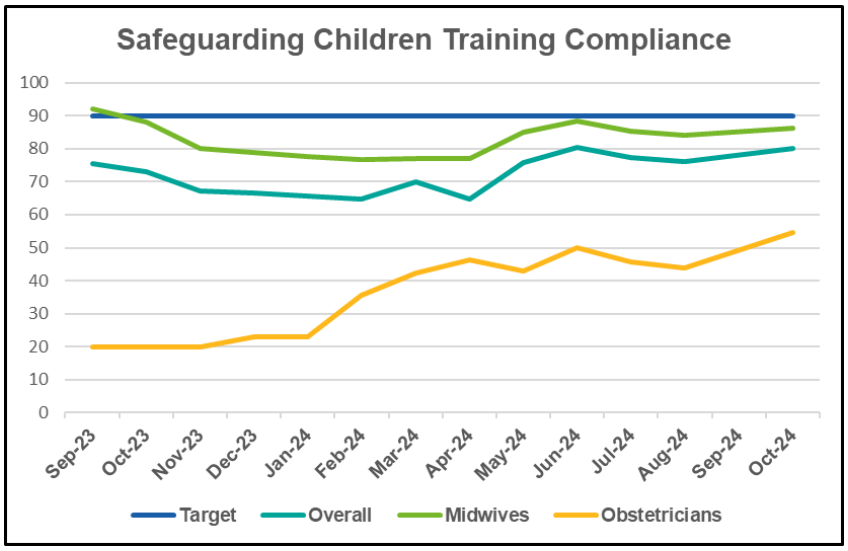
In line with the recommendations from the Safeguarding Children and Young People: Roles and Competencies for Healthcare Staff Fourth edition: Intercollegiate document: All midwives, obstetricians and doctors in training who have posts in these level 3-affiliated specialties, are required to complete level 3 children's safeguarding training.

Initial training: Professionals will complete the equivalent of a minimum of 8 hours education, training and learning related to safeguarding/child protection. Those requiring role specific additional knowledge, skill and competencies should complete a minimum of 16 hours.

Refresher training: Over a three-year period, professionals should be able to demonstrate refresher education, training and learning equivalent to a minimum of eight hours for those requiring Level 3 core knowledge, skills and competencies a minimum of 12-16 hours for those requiring role specific additional knowledge, skills and competencies.

The level 3 training is currently delivered by the named nurse for safeguarding and is mandated for all staff across the Trust who are required to complete this level of training. Currently there is 1 training day (7.5 hours) running each month and there is a waiting list. There have been vacancies within the Trust safeguarding team which has been a challenge to support teaching on the safeguarding Level 3 study day. Recently eLearning for health online training has been introduced for experienced maternity staff who are non-compliant, this was due to the reduced compliance levels within maternity. The overall vision is for all staff to receive this training face to face. Another extra maternity session is planned in Q3 to target newly recruited midwives and rotating junior doctors.

Figure 11. Safeguarding children training compliance



6. Newborn and Infant Physical Examination (NIPE)

The Nursing and Midwifery Council's Standard's of Proficiency for Midwives has included all newly qualified midwives to be able to perform full systemic physical examinations of the newborn (NIPE). This was introduced by the NMC in 2019, increasing the numbers of midwives who are now qualified at SFT to complete NIPEs. In addition, CPD funding is utilised to support midwives to gain this qualification as a post-graduation module, in collaboration with Bournemouth University.

Within the midwifery workforce, there are 34 midwives qualified to perform NIPE. To ensure their knowledge and skills are up to date, it is a requirement for them to complete the NHS NIPE Programme eLearning annually. The current compliance for this eLearning is at 88.2%, with 4 midwives expired. Their NIPE Smart accounts are suspended if they are expired until evidence of eLearning has been sent to the NIPE screening lead midwife. The NIPE lead has contacted all expired midwives and reiterated the importance of this eLearning in the NIPE forums. Due to the small numbers of those qualified, compliance should quickly increase following these contacts.

7. Adult Basic Life Support

Adult Basic Life Support (BLS) training is provided by the Trust's Resuscitation Department. All staff, including non-clinical, require BLS training but at different levels depending on their role.

Midwives are required to attend Level 3 Adult BLS, which is a 3.5-hour training session, every year. Nurses and MCAs are required to annual attend Level 2 Adult BLS, which is a 2.5-hour session.

It has been a challenge to collect the data on BLS compliance for staff groups as LEARN (Trust eLearning platform) does not appear to collect accurate staffing details within the Women and Newborn Division. Therefore, data was also collected from the resuscitation department to ensure the BLS training compliance was accurate.

The following table outlines RAG rated compliance with Adult Basic Life Support training:

Figure 12. Adult Basic Life Support training compliance (data collected 30/09/24)

Midwives	Maternity Nurses	MCAs & MAs
74.1% (112)	33% (3)	74% (35)

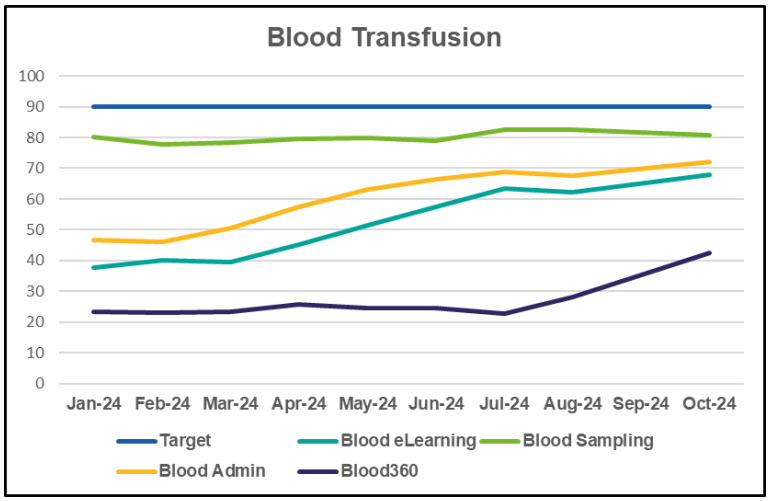
All staff out of date for Adult BLS have been contacted and advised to book via the Trust's LEARN platform.

8. Blood Transfusion Training

The following graph outlines compliance with blood transfusion competency training for midwives. The Trust requires several elements in relation to blood transfusion for registered midwives, including 2 eLearning modules (essential transfusion practice and Anti-D), a blood sampling assessment, blood administration training (1.5 hours) and blood collection (Blood360).

From January, blood transfusion link nurses provide training on the SBL study day and, includes time to complete the eLearning. This has shown an improvement in training compliance and will hopefully achieve over 90% compliance by December 2024 as the link nurses continue to attend the maternity study days.

Figure 13. Blood transfusion training compliance



9. Simulation Training

During Q2 the maternity education team, due to high levels of annual leave and supporting the clinical teams, were unable to support any ad-hoc in-situ simulation training. We did however continue our simulation training on PROMPT and community PROMPT, including pool evacuation, maternal sepsis and newborn life support. Our plan for Q3 would be to run more ad-hoc clinical simulations for staff during shifts, if it is safe and appropriate to do so.

The maternity education team has increased the number of staff faculty trained in delivering effective simulation training. The hope is to continue providing ad-hoc simulations within the clinical area throughout the whole year, with technical and equipment support when required from the Trust Simulation Team.

Figure 14. Simulation training in Q2

	Scenario details	Attendance	Findings	Actions Taken
July	Nil sessions			
August	Nil sessions			
September	Nil sessions			

10. CNST Maternity Incentive Scheme (MIS)

Safety action 8 of the Maternity Incentive scheme compliance is dependent upon an agreed local training plan which demonstrates implementation of Version 2 of the Core Competency Framework. The plan has been agreed with the quadrumvirate before sign-off by the Trust Board and the LMNS/ICB on 17/09/24.

The maternity education team have developed an action plan which in outlined below. This plan will be reviewed and updated quarterly, and any concerns will be escalated to the Senior Management Team at Quality and Safety meetings.

11. Plans for next quarter

The objectives for the team in the next quarter are:

- Ensure rotating junior doctors in October are booked to attend all training requirements as part of their induction.
- Follow Maternity Training and Development pathway for those who were unable to attend training during Q1 and 2 due to sickness – rebook as soon as possible in Q3.
- Liaise with Operational Manager for Gynaecology to ensure all obstetricians are booked to attend required training dates in Q3.

Report Author

Name: Scarlett Leahy

Title: Practice Education Midwife

Date: 10/10/2024

Appendix A

The following action plan includes actions taken to maintain or improve training compliance and any other actions in relation to training and education.

Figure 15. Action plan

Actions to maintain or improve training compliance				
Action	**Responsible person**	**Deadline**	**Progress made**	**Rag rating**
Contact all rotating doctors prior to start date with all training expectations and requirements (obstetric training passport created).	Shelley King and Hannah Rickard	August for SHOs October for SPRs	Emails sent to SHOs in June by HR UHS sent data of PROMPT and FM compliance for our incoming SPRs in July to HR.	Email sent by HR to all new junior doctors in June 2024.
Ensure all obstetricians are booked to attend all required study days before MIS deadline in December.	Scarlett Leahy Helen O'Shea Yazmin Faiza	July	Meeting held in June. All obstetricians now booked to attend, and places reserved for incoming rotating doctors if required on rota.	Review meeting with SK booked 8/10/24 as attendance not as planned in Q2. Ensure all new rotating junior doctors are booked onto mandatory training.
Contact all bank-only staff to ensure attendance at all required study days for 2024.	Scarlett Leahy Justine Wren	August 2024	Bank-only midwives contacted in July by SL.	All bank-only midwives and MCAs contacted by SL in July and booked onto maternity training for 2024.
Offer more PROMPT dates before MIS deadline of 30th November 2024	Scarlett Leahy	October 2024	2 additional PROMPT dates created – one in October and one in November	Dates created and MDT staff allocated to attend
Improve annual update compliance for NIPE qualified practitioners.	Donna Crayden	September 2024	Individual emails sent to those out of date. NIPE Smart accounts suspended until eLearning completed.	Increase from 77% to 88% since previous quarter.

Actions from simulation training				
Action	**Responsible person**	**Deadline**	**Progress made**	**Rag rating**
Disseminate education around performing external manoeuvres before internal manoeuvres in the management of shoulder dystocia to reduce the risk of brachial plexus injury and OASI.	Maternity Education Team	December 2024	To be introduced on PROMPT from September 2024. Scenario on community PROMPT May – July 2024.	New SD in birth pool scenario introduced onto PROMPT in September – including learning as highlighted.
Further Actions				
Action	**Responsible person**	**Deadline**	**Progress made**	**Rag rating**
Create new PROMPT programme to run Sept 2024-25.	Maternity Education Team Yazmin Faiza Q&S Midwife Julia Bowditch/ Juliet Barker	August 2024	New content being created and MDT meeting planned for August 2024.	PROMPT programme created with MDT support and introduced September 2024. Content noted at Maternity Risk and Governance September 2024.

Patient and Staff Experience Report
Maternity and Neonatal Services
(Quarter 2 2024/25)

1.	Purpose of the Report
	The purpose of this report is to provide a quarterly overview of patient and staff experience within the maternity and neonatal service. Any trends and themes are identified and shared not only with those directly involved but the whole team to ensure there is learning and continual improvement of the service. The report also outlines work and co production with the MNVP. Escalation of feedback is shared monthly at the Safety Champions meeting, Maternity Risk and Governance meeting, and via the Perinatal Quality Surveillance slides. Themes from patient are discussed quarterly at the Triangulation meeting. Staff feedback is captured by the annual staff survey and work undertaken by the Perinatal Quadrumvirate which is shared at the Safety Champions meetings and via the Perinatal Quality Surveillance slides.
2.	**Executive Summary**
	• There is a 5% decrease in Friends and Family Test (FFT) responses this quarter. Further exploration is being undertaken to ensure the validity of these results. • The number of complaints received has remained consistent with Q1; only receiving 1 more complaint this quarter (total 3 in Q2). • There have been no reported concerns logged in Q2. • Work is ongoing to embed the Triangulation meeting into the Divisional Governance structure. • The 2023 National Patient Experience and the 15 steps assessment action plans are near to completion. The compliance to the National Patient Experience Survey's actions will be monitored by the LMNS. • In Q2 there was 1 reportable fetal loss. No Patient feedback was provided by the family. • The Neonatal survey findings are included within this report in section 7.0. The survey results positive; with a 9.4/10 positive rating score. • Analysis of the findings from the Health Inequalities Patient Experience Survey can be reviewed in section 8.0. **Key priorities for patient experience and inclusion, next quarter includes:** • To undertake listening events with hard-to-reach groups, to prioritise the voices from women (birthing peoples) from communities with the poorer maternity outcomes. There are two listening events planned in Q3 RE Family Nurse Practitioner (FNP) and the 'entitled people' (refugees entitled to be residing in the UK) .

	• To develop strong links with Wessex Health Innovation, to continue the ongoing work to secure funding for a new 'at the point of contact' translation device. • Review themes from the feedback obtained via FFT, with the focus on increasing patient engagement with the survey. • Working with the LMNS Inclusion Lead to align the service with the national agenda relating to reducing health inequalities • Review of the data from 2024 National Patient Experience Maternity Survey. It is intended that the development of the action plan will be co-produced with the MNVP. • Progress the actions detailed in the Three-year delivery plan and support the work currently ongoing to promote personalisation of care with both patient and staff. It is intended that we will receive the first shipment of the 'My Maternity Choices' booklets, in Q3 which will be disseminated to women upon registering their pregnancy with the Maternity Department.
3.	**Patient Story**
	No patient story presented this quarter. A patient has come forward who is wishing to share their story through a short film in Q3 and for use in local training.
4.	**Patient Surveys – National and Local (including CQC national maternity survey)**
	The National Patient Experience Survey looks at the experiences of women and (pregnant people) who gave birth at SFT between January and February 2023. Questionnaires were sent out between April and August of the same year; responses were received from 170 (59%) people at Salisbury NHS Foundation Trust. The average response rate for all 31 Trusts surveyed was 47%. **3 questions** showed **at least 10% improvement** on the 2022 score, and for **0 questions** the score was **worse by 10%** or more. The Trust were in the top 20% for six questions around the following areas: • Choice and being listened too antenatally. • Not being left alone when worried during labour. • Confidence and trust in midwives after going home. The Trust were in the bottom 20% for seven questions around the following areas: • Feeding in Hospital (action: The Infant Feeding Team offer a feeding service six days a week (including bank holidays) and work is ongoing to raise awareness of the national infant feeding helplines). • Mental Health and changes that might be experienced (action: MNVP to host an online listening event on: families experience of perinatal mental health support).

	• Visiting times (action: as from March 23, there is no restrictions place on visiting for birth partners). • Being treated with kindness and being given information on the ward after birth (action: The PMA lead intends to work with staff on the Behavioural Charter with the focus on kindness and compassionate communication with staff and patients). A comprehensive action plan has been devised in collaboration with the MNVP and leads nominated. As required for CNST the National Patient Experience Survey compliance will be monitored by the LMNS and presented at Safety Champions. The action plan can be viewed below: Action Plan maternity survey 2023 version 3
5.	**Maternity and Neonatal Voices Partnership (MNVP), Staff and Patient Experience - Triangulation**
	In Q1 a new triangulation meeting was introduced with the aim of triangulating insights and feedback from: staff via Datix risks, legal claims, local and national patient feedback surveys, the Birth Reflections Service and through the intelligence obtained by the Maternity and Neonatal Voice Partnership (MNVP). These themes inform and drive the priorities of service development and quality improvement. The action from Q1 meeting was to undertake a detailed analysis and review of the Birth Reflection Service with further consideration given to the referral process. A data analysis of the Birth Reflection Service and theming was discussed in Q2's Triangulation meeting. The expansion of the referral criteria has been agreed, and women are now able to self-refer to the service. The next steps are to ensure a robust referral pathway is agreed and shared widely with Primary care, Maternity staff and women. Points of escalation from Q2 meeting includes. **Actions as below:** • Consistency needed when upholding the uniform policy within certain cohorts of staff. • Staff who racialize as black or brown feel that on occasions women (pregnant person) would react differently to them, once a staff member of white ethnicity enters the room. The conversation would be directed to them, rather than the black or brown midwife who had been caring for them. 'No Excuse for Abuse' posters planned as a Trust wide initiative planned in Q3.

The minutes from Q2's Triangulation meeting action plan is embedded below:

Action Plan - Triangulation meeting

Triangulation Group Meeting Minutes 3.9.2

Work is ongoing to complete the outstanding actions from the 15 steps assessment undertaken by the MNVP October 23. The full action plan can be viewed by the link below:

Final 15 steps action tracker .docx

Communications cascaded to the workforce can be viewed below:

15 Steps v3.pdf

6. Friends and Family Test (FFT)

Friends and Family Test: July - September 2024

Prior to Q1 the Maternity department experienced challenges with FFT response rates, despite a relaunch of the FFT in January 24. Maternity services were chosen to be part of the initial role out of the digital SMS messaging service across the Trust, with the touch points including:

- Maternity Antenatal (at 20 weeks)
- Maternity Birth (at 7 days)
- Maternity Postnatal (at 14 days)
- Maternity Community (at 28 days)

	FFT Q2 2024/25 Data: In Q2 it was identified that 2860 women were eligible to receive the FFT survey request, with a total of 295 responses, offering a 10.3% compliance rate. A summary of Maternity FFT Q2 data is embedded below:  FFT Q2 Survey v3.pdf FFT Priorities for Q3: • Exploration is needed to consider pathways to increase engagement with the survey; the possibility of volunteer support to promote and complete the FFT survey in real-time is an option under consideration. • The FFT data will be presented at the next triangulation meeting and used to inform any learning opportunities or service improvements.
7.	**Feedback from Neonatal and Bereaved Families**
	Neonatal feedback The analysis of the Neonatal Parent Survey was undertaken in Q2. There were over 100 responses to the survey. Overwhelmingly, the response was positive. With parents rating the service provided as 9.4/10. Actions: 1. The Neonatal Unit (NNU) has worked to improve communications within the local NNU network to ensure that families are fully informed about what level of care Salisbury's NNU can provide. It is hoped that this will alleviate any concerns families may have about their babies being repatriated to Salisbury NNU. 2. The Neonatal unit are pleased to offer both parents hot meals during their baby's stay on the Unit. To ensure that parents receive a full menu choice, work is ongoing to secure a designated meal trolley.

	The full survey results are embedded in the link below: NNU Parent Survey A2 draft.pdf **Feedback from bereaved families** Women (birthing person) who have experienced the unexpected loss of a baby from 22 weeks gestation, are asked, as part of the Perinatal Mortality Review Tool (PMRT) to share their feedback with either the Bereavement Lead or the Family Experience Midwife. The aim of the PMRT is to support the standardised perinatal mortality reviews across the NHS maternity and neonatal services in England, Scotland and Wales. The tool supports the multidisciplinary, high-quality review of the circumstances and care leading up to and surrounding the deaths of babies who die in the postnatal period. Active communication with parents is encouraged, therefore parents are asked, prior to the PMRT meeting if they had any questions they would like addressed by the panel. The outcome of the multidisciplinary review together with the family's questions are shared with the family during the (post PMRT meeting) follow up with their named consultant obstetrician. If there are concerns raised by the family which cannot be addressed by the panel, these are then taken forward an investigated through the complaint procedure. In Q2 there was 1 reportable loss: MTOP at 27 weeks which was a registerable stillbirth. SFT notified MBRRACE of MTOP, PMRT review not required.
8.	**Feedback from Black, Asian and Minority Ethnic Backgrounds and Families Living in Areas with High Levels of Deprivation**
	An Inclusion Midwife has been successfully recruited to support the development of this workstream and started in post at the beginning of Q2. A local patient experience survey was conducted with the focus on capturing women's feedback on their pregnancy journey who identify as black or brown (global majority) and/ or service users identified as living in areas of deprivation. **Conclusion and key themes** The results demonstrated some reassuring findings. Women found that they had the right information to enable them to make an informed decision about their care, and this was shared with them in a way that they could understand. However, some of the written response to Q12 would indicate that women would like more information and time with their clinician.

96.1% of women felt listened too and their concerns were taken seriously. However, it would appear that translation services were not offered to all women who may have benefited from this service. Reassuringly, most women felt that their ethnicity did not affect their care.

Continuity in consultant care is something that women have highlighted as important to them, as having that familiarity and knowledge about their medical history and obstetric care provides a level of consistency to information shared with women, particularly those with risk factors.

The full report can be viewed via the link below:

Health inequalities audit report.docx

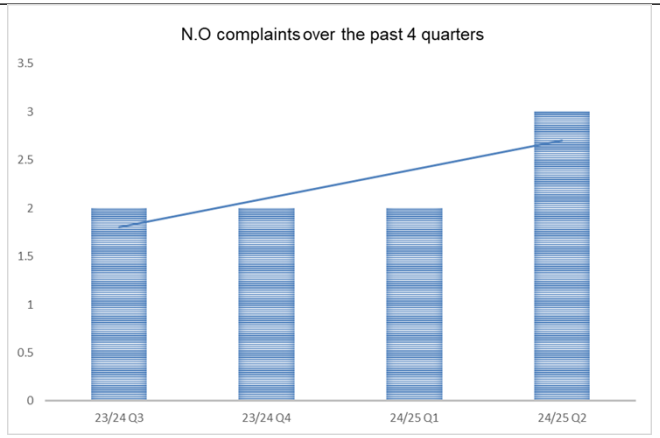
Continued priorities for Q2

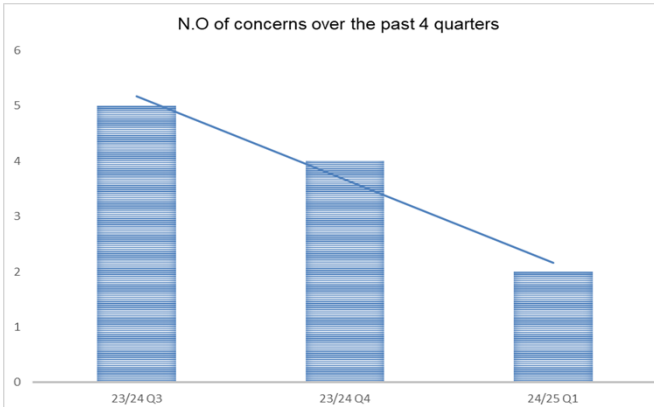
- Collaborative working with the communications team and IT to ensure our Trust website has a translation function.
- To develop strong links with Wessex Health Innovation, to continue the ongoing work to secure funding for a new 'at the point of contact' translation device. Update in Q2, we are looking at funding options to secure 10 translation devices.
- Ensure that patient information leaflets are available in the top 5 commonly requested languages. Update in Q2 - In view of budget restrictions, it is unlikely that all patient information leaflets will be translated. It is hoped that the introduction of the translation tool bar will be a variable solution.
- Listening events planned in Q2 includes: FNP- (Family Nurse Practitioner) and a listening event in Larkhill surgery, to hear the voices of those women from our Afghanistan refugee community.

Please see Three-Year Delivery Plan for full details and updates on the Inclusion priorities:

Single Delivery Plan updated 30th July 202

9.	Compliments
	Thank you cards are collected from both inpatient and outpatient areas, throughout the year and are now added to DATIX by the PALS team. **Actions** • Themes of compliments together with examples of service user's gratitude is shared with the workforce on a quarterly basis. • If a compliment is sent via the PALS department, this is then shared with the individual staff member and a SOX nomination completed. In Q2 2024/25 Maternity and Neonatal Services received 28 compliments, the top 3 themes reported was 'gratitude', 'kindnesses and 'care'. The numbers and themes of compliments and SOX received during Q2 are summarised in the embedded documents below, which have been shared with the workforce.  Compliments Q2 2024.pdf  SOX poster Jul-Sep 24 v2.pdf
10.	**Complaints/PALS Contacts**
	Formal and informal complaints 3 complaints (formal) and 0 concerns (informal complaints) were logged on Datix in Q2 24/25.





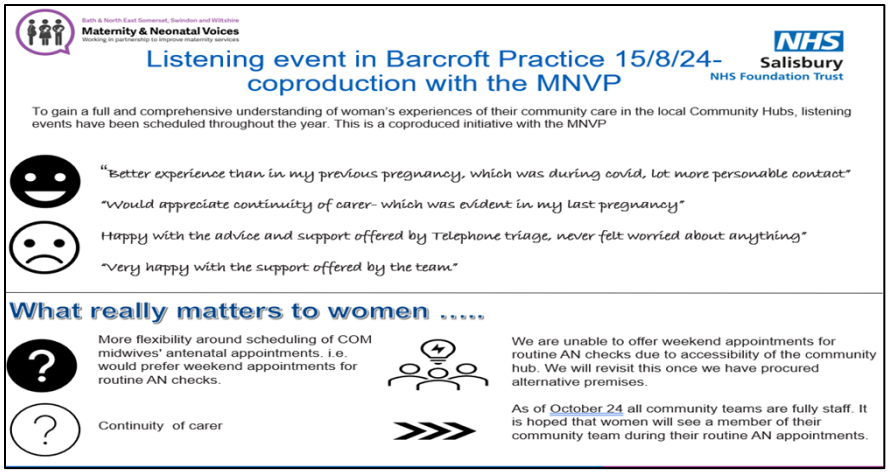
The number of complaints have remained at a consistent number over the last year – 2 or 3 per quarter. Attached is a review of the themes of complaints received, and actions of complaints closed in Q2.

Complaints received & closed Q2 2425.doc

Birth Reflections Service

The Birth Reflections Service aims to provide women and their families with an opportunity to discuss and reflect on their birth experience with a view to nurturing psychological wellbeing in preparation for parenting, and future pregnancies. Birth Reflections sessions can also provide valuable feedback for the maternity service, facilitating change and improvements in the care that is provided. The Birth Reflection Service offers a confidential, one to one midwifery-led listening service for women who have given birth in Salisbury Foundation Trust.

It has been agreed that SFT will expand the referral criteria to include self-referral. Work is ongoing to promote and share this change in process with the primary care setting and increase communication to ensure women have access to the service.

11.	**Matron/ Ward Manager Audits**
	This section is for reporting any findings from Ward Manager / Matron audits, themes and actions taken. It may also include triangulation between different clinical areas. During Q2, antenatal services are undertaking a service review in response to feedback from service users in respect to waiting times in ANC and DAU for obstetric review. As part of the Improving Together Strategy, an audit is scheduled in Q3 to understand waiting times in ANC, and the number of women requiring obstetric reviews following scans on the afternoon that the ANC is not in operation. To explore further feedback, obtain by staff, an additional focus of this audit will be on the start and finish times of the AN clinic, and noting those occasions when the clinic is overbooked. The referral criteria for consultant review will also be reviewed as part of this service review.
12.	**Internal/ External Visits (relating to patient or staff experience)**
	In Q2 several listening events were undertaken in coproduction with the MNVP, results are seen below:   Listening events scheduled for next quarter: • FNP - (Family Nurse Practitioner) hearing the voice of our pregnant teenage population.

	• Visit to Larkhill surgery, to hear the voices of those women from our Afghan refugee community.
13.	**Staff Survey Results**
	The National Annual staff survey was not published in Q2.
14.	**Staff Experience/ Wellbeing**
	Restorative Supervision has been offered and received by all staff returning from sick leave and maternity leave, as well as all new starters. Quarterly 1:1 RCS has been achieved for all preceptee Midwives. There has been 1 significant Potentially Traumatising Event, a hot debrief was facilitated for all staff involved and all staff were offered a TRiM intervention.
15.	**Key Activities in place for both Staff and Patient Experience**
	Themes from complaints and concerns, patient experience surveys and FFT are discussed at the Triangulation meeting and shared with the workforce during the annual maternity study days.
16.	**Sharing of Best Practice**
	Patient and staff experiences are shared as follows: • Friends and Family test (FFT) feedback is shared via email and posters in ward areas • SOX can be seen in inpatient and ward areas • MNVP feedback is shared via email, in team meetings, and through Maternity Governance and Safety Champion meetings. • Compliments • Learning from incidents • New guidelines • Maternity and Neonatal Services Newsletter
17.	**Update on Actions Outlined in the Previous Report**
	The 3 main priorities were previously identified in the last Quality and Safety report: 1. **To develop strong links with Wessex Health Innovation, to continue the ongoing work to secure funding for a new 'at the point of contact' translation device.**

	Update: It is anticipated that Maternity Services will purchase 10 AI translation devices, following approval of charitable funds. **2. Review themes from the feedback obtained via FFT.** Update: Quarterly review of the feedback from FFT is correlated and themes discussed at the Triangulation meeting. **3. Working with the LMNS Inclusion Lead to align the service with the National agenda related to reducing health inequalities.** Update: Work is ongoing to agree clinical outcomes to be monitored across the LMNS, via a collective dashboard.
18.	**Next Steps/ Looking Forward**
	Key priorities for patient experience and inclusion, next quarter includes: • To undertake listening events with hard-to-reach groups, in order to prioritise the voices from women (birthing people) from communities with the poorer maternity outcomes. There are two listening events planned in Q3 RE Family Nurse Practitioner (FNP) and the 'entitled people' (refugees entitled to be residing in the UK). • To develop strong links with Wessex Health Innovation, to continue the ongoing work to secure funding for a new 'at the point of contact' translation device. • Review themes from the feedback obtained via FFT, with the focus on increasing patient engagement with the survey. • Working with the LMNS Inclusion Lead to align the service with the national agenda relating to reducing health inequalities • Review of the data from 2024 National Patient Experience Maternity Survey. It is intended that the development of the action plan will be co-produced with the MNVP. • Progress the actions detailed in the Three-year delivery plan and support the work currently ongoing to promote personalisation of care with both patients and staff. It is intended that we will receive the first shipment of the 'My Maternity Choices' booklets, in Q3 which will be disseminated to women upon registering their pregnancy with the Maternity Department.

Report Author(s)

Name(s): Alison Lambert and Katherine Barrio

Title(s): Family Experience & Inclusion Midwife and Head of Midwifery & Neonatal Services

Date: 19/10/2024

Saving Babies Lives Quarterly Report
Maternity and Neonatal Services
(Quarter 2 2024/25)

1.0 Background

The Saving Babies' Lives Care Bundle (SBLCB) provides evidence-based best practice, for providers and commissioners of maternity care across England to reduce perinatal mortality. The Three-Year Delivery Plan for Maternity and Neonatal Services sets out that providers should fully implement Version Three. SBLCBv3, in line with MIS Year 6, maintains an approach of continuous improvement and comprehensive evaluation of organisational processes and pathways as part of developing an understanding of where improvements can be made.

A national implementation tool was launched in 2023 (as part of the previous MIS year 5 requirements) to help maternity services to track and evidence improvement and, compliance as set out in Version Three. This has been continued for use with MIS Year 6 requirements. The national implementation tool contains a 'Board Report & Progress' and 'LMNS review' sections for monitoring progress on actions. This is part of the quarterly assessment of evidence collated by providers which is reviewed by the LMNS and validated accordingly. This is shared with the Trust Board quarterly via this report as part of MIS Year 6 requirements and with the ICB.

2.0 Introduction

The aim of this report is providing a quarterly update on the implementation, monitoring and training of all six elements of the Saving Babies Lives care bundle v3.

Saving babies lives audits for quarter 1 2024/25 have been completed to provide assurance to the Trust and LMNS that all six elements have been implemented. Maternity services are working towards a consistent high level of compliance to improve care for women and their families which in turn will assist in reducing the still birth and neonatal death rates.

Following an update for Version 3, each organisation will be expected to look at their performance against the outcome measures for each element using the new national implementation tool with a view to understand where improvement may be required. Previously, the Year 5 MIS requirements required providers were required to demonstrate implementation of 70% of interventions across all 6 elements overall, and implementation of at least 50% of interventions in each individual element. The current MIS Year 6 requirements mandate that providers should fully implement Saving Babies Lives Version Three by March 2024. However, where full implementation is not in place, compliance can still be achieved if the ICB confirms it is assured that all best endeavours – and sufficient progress – have been made towards full implementation, in line with the locally agreed improvement trajectory.

Embedded documents: Current (as of August 2024 submission) SFT Implementation Tool & LMNS Validation Tracking Tool


13 09 2024 SBL V3 Implementation Toc


BSW LMNS Validation Tracking

3.0 Progress and LMNS Review Record

Figure 1. Percentage of interventions fully implemented following each LMNS validation.

% of Interventions Fully Implemented (LMNS Validated)	Baseline Assessment	Assessment 1	Assessment 2	Assessment 3
Review Quarter	Initial			
Assurance Review Date	25.10.2023	23.12.2023	24 06 2024	13.09.2024
Element 1	10%	29%	20%	40%
Element 2	5%	50%	50%	70%
Element 3	0%	100%	50%	50%
Element 4	0%	0%	20%	40%
Element 5	11%	37%	48%	52%
Element 6	7%	33%	17%	17%
TOTAL	7%	37%	40%	51%

4.0 Implementation Progress

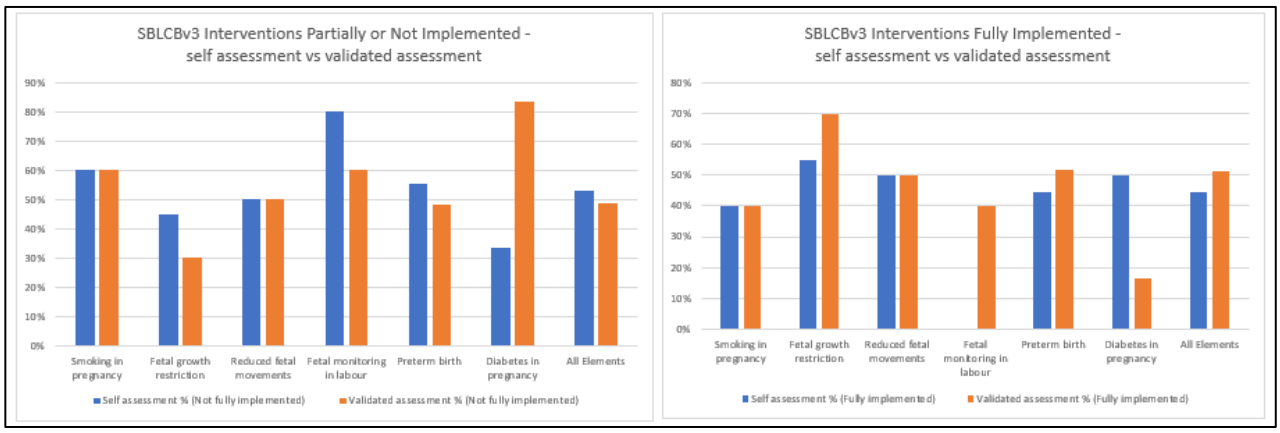
SFT has made minimal progress and has several actions in place to move towards full implementation.

Figure 2. Implementation progress for Q2 2024 self-assessment (44%) and LMNS (51%)

Intervention Elements	Description	Element Progress Status (Self assessment)	% of Interventions Fully Implemented (Self assessment)	Element Progress Status (LMNS Validated)	% of Interventions Fully Implemented (LMNS Validated)	NHS Resolution Maternity Incentive Scheme
Element 1	Smoking in pregnancy	Partially implemented	40%	Partially implemented	40%	CNST Not Met
Element 2	Fetal growth restriction	Partially implemented	55%	Partially implemented	70%	CNST Met
Element 3	Reduced fetal movements	Partially implemented	50%	Partially implemented	50%	CNST Met
Element 4	Fetal monitoring in labour	Not implemented	0%	Partially implemented	40%	CNST Not Met
Element 5	Preterm birth	Partially implemented	44%	Partially implemented	52%	CNST Met
Element 6	Diabetes	Partially implemented	50%	Partially implemented	17%	CNST Not Met
All Elements	TOTAL	Partially implemented	44%	Partially implemented	51%	CNST Not Met

The graphs below show the breakdown for each element of interventions partially or not yet implemented which have been validated by the LMNS and those which have been fully implemented as validated by the LMNS. This shows that the LMNS agree, for the most part, with SFT's self-assessments.

Figure 3. Self-assessment vs LMNS assessment Q1 2024 (40%) and Q2 2024 (51%)



5.0 Care Bundle Elements

An audit and training plan has been developed to continually monitor and identify areas to improve the service and outcomes relating to the care bundles elements:

- **Element 1: Reducing Smoking in Pregnancy**
- **Element 2: Fetal Growth: Risk assessment, surveillance, and management**
- **Element 3: Raising awareness for reduced fetal movements**
- **Element 4: Effective fetal monitoring during labour**
- **Element 5: Reducing pre-term birth and optimising perinatal care**
- **Element 6**: **Management of Pre-existing Diabetes in Pregnancy**

Element 1: Reducing Smoking in pregnancy

Reducing smoking in pregnancy by identifying smokers with the assistance of carbon monoxide (CO) testing and ensuring in-house treatment from a trained tobacco dependence adviser is offered to all pregnant women who smoke, using an opt-out referral process.

Quarter audit %	Actions taken and progress made
	• Meeting with LMNS arranged to provide mutual feedback on current progress and to help identify areas for improvement and any barriers.- Complete • 1:1 meetings arranged with action holders, leads and stakeholders for Element 1- Complete • Maternity Services Dataset (MSDS) Data Quality rating passed and to be submitted as evidence for next submission as previous data now out of date. Complete • Audit numerators and denominators explored and explained in detail to those completing the audits for Element 1 to ensure understanding-good feedback received from these 1:1s so to continue until final submission to provide support. Complete • New audit plan for Element 1 created by action holder to amalgamate recording of audits in one place for ease of reporting, and to ensure that multiple staff members can complete the audits to safeguard against single point of failure. Complete

	• SFT stop smoking strategy and Wiltshire stop smoking service specification previously not included in evidence submission-now collated and ready for next submission. Complete • Acknowledgment of current non-compliance with actions surrounding CO monitoring and 'very brief advice' (VBA) around smoking for Midwives and Maternity Care Assistants (MCAs). Action Plan created and ready for next submission date, with a clear goal to achieve compliance with targeted study days. Ongoing • 'Smoking in pregnancy' guideline has been subject to minor amendments to make it clearer that the guideline and SOP are to be used in conjunction with the Wessex Pathway for smoking in pregnancy. It has also been amended to correctly reflect the amount of support women can expect to receive throughout their pregnancy. Complete **Looking Forward** • Assist in the review of action plans to monitor compliance trajectory. Complete • Utilising non-clinical bank hours to ensure backlog of audit data has been captured. Complete **Update** • Plan to provide training for new B4 PIMS/HiP practitioners for there to be a rolling audit plan for the collation of data. Ongoing • Poster reminders for smoking status disseminated to ante-natal clinic and community midwives to increase compliance around recording of status. Complete.

Element 2: Risk assessment and surveillance for fetal growth restriction

Risk assessment and management of babies at risk of or with fetal growth restriction (FGR).

Quarter audit %	Actions taken and progress made
	• 1:1 meetings arranged with action holders, leads and stakeholders for Element 2. Complete • 23/24 Q3 and 23/24 Q4 data not included in last submission, now completed and collated ready for next submission. Complete • 24/25 Q1 audit data collated and ready for next submission. Complete • Feedback received from LMNS meeting to advise that guideline evidencing aspirin recommendation was not included in evidence folder. The correct guideline has been located to be included in the next submission. Complete • As above but for recommendation of vitamin D-the 'routine booking' guideline has been subject to minor amendments to make the recommendation of Vitamin D supplementation in pregnancy clearer. Complete • Work ongoing with Outpatient Matron to procure and implement the use of digital blood pressure machines validated for use in pregnancy. Only a limited number of machines are validated for use in pregnancy and then also for women with pre-eclampsia. Upon checking the NHS Supply Chain catalogue, one validated BP machine is available, however this is only validated for use in pregnancy, not pre-eclampsia. Another has been discontinued and another is not available through the NHS Supply Chain website. Work is ongoing to reach out to other Trusts within the LMNS to identify the monitors they use and understand their procurement processes. Ongoing • Meeting with Trust medical devices team to identify possible alternative BP machines which are still compliant. Conclusion of this meeting highlighted that

	procurement is a national issue. Discussed with Head of Midwifery who will feed this back in a regional forum for escalation to the national SBL team. Ongoing **Looking Forward:** • Continue to liaise with Outpatient Matron and other Trusts to procure BP monitors validated for use in pregnancy and for women with pre-eclampsia. Procurement plan to be submitted as evidence. Ongoing • Trust Medical Devices Lead to continue to liaise with national Medical Devices teams to try to identify compliant machines. Complete **Update:** • Confirmation received from MSDS Lead, that manufacturer of the VS-900 Dinamaps has advised that those already in circulation in the acute areas are compliant for pregnancy and PET related BP monitoring-no need to procure extra Dinamaps but exploring procurement of community-based BP machines. Awaiting funding process information from LMNS. Ongoing

Element 3: raising awareness for reduced fetal movements

Raising awareness amongst pregnant women of the importance of reporting reduced fetal movements (RFM), and ensuring providers have protocols in place, based on best available evidence, to manage care for women who report RFM.

Quarter audit %	Actions taken and progress made
	• Identified discrepancy between RCOG Green Top Guidance (suggested within SBL technical guidance) which states: 'if ultrasound scan assessment is deemed necessary, it should be performed when the service is next available-preferably within 24 hours.' The reduced fetal movements and fetal surveillance guidelines do not have a fixed timeframe as mentioned above. The Wessex pathway advises to 'arrange ultrasound scan' but with no specific timeframe and the same can be said for the BSOTS triage pathway for women presenting with reduce fetal movements. For women categorised as an 'orange' risk category within BSOTS, the pathway advises 'USS for estimated fetal weight, liquor volume and uterine artery dopplers as per local policy and guidance' however SFT local policy and guideline around timings of ultrasound are ambiguous. LMNS feedback suggested liaising with sonography lead to enquire as to whether there would be capacity and staff availability to provide this, and then to update guidance in collaboration with sonography, stakeholders, and authors of the current guideline. Email communication sent to Lead Sonographer and awaiting their reply. Ongoing • Ongoing meetings with Digital Lead Midwife who has built a report that details the number of women with reduced fetal movements and of those, how many women received a computerised CTG. This should improve the data capture process, making it easier to collate the data on a month-by-month basis. Complete • Updated 24/25 report submitted for evidence by Bereavement Lead detailing no cases of stillbirths with issues associated with management of reduced fetal movements. Complete **Looking Forward:** • Awaiting further Q4 audit data. Complete • To liaise with Digital Lead Midwife to enquire as to whether there are any further reports that can be built into E3 to make data capture more streamlined. Complete **Update:** • Ongoing plan now in place for monthly data collation Complete

Element 4: Effective fetal monitoring during labour

Quarter audit %	Actions taken and progress made
	• Feedback received from LMNS in relation to training compliance around intermittent auscultation and how this is evidenced during fetal monitoring study days. Assurance provided that intermittent auscultation case study and post-study day assessment are still utilised, and snapshot of assessment shown and will be provided as evidence for next submission to provide further assurance. Complete • Element 4 interventions audit data was previously omitted for Q1. Now collated and ready to be submitted as evidence for the next submission date. Complete • Minor amendment to intermittent auscultation guideline to reflect the importance of a buddy system when conducting intermittent auscultation and completing the 'Intermittent Auscultation Wellbeing Proforma'. Complete • Discussions held around the job descriptions relating to the Fetal Surveillance co-leads. Feedback received from LMNS to advise that the job descriptions were un-dated and now x2 job descriptions are to be submitted to reflect the two individuals fulfilling the role. To discuss with the co-leads re: dating job descriptions and WTE contracted hours. Ongoing • To discuss with Clinical Director and Operations Manager evidence for PA time for Obstetrician with responsibility for fetal surveillance as currently insufficient evidence submitted. Ongoing **Update:** • Meeting requested between LMNS and Fetal Surveillance Lead and SBL Lead to provide clarification around certain elements of the required actions. Ongoing

Element 5: Reducing preterm birth and optimising perinatal care

Reducing the number of preterm births and optimising perinatal care when preterm birth cannot be prevented.

Quarter audit %	Actions taken and progress made
	• Feedback received that job descriptions received in relation to point 5.1: 'lead for preterm perinatal optimisation' were not detailed enough to be used as evidence. Discussed with LMNS and Neonatal Matron, and the LMNS willing to accept email confirmation that both the Neonatal Consultant and Neonatal Matron have enough time in their job plans to devote to neonatal optimisation. The same was fed back for the Quality Assurance Midwife role. Request sent to neonatal leads via email to enquire as to whether they are happy that they can fulfil this part of their job description, and a request that they are able to provide their evidence-currently awaiting this. Ongoing • Discussion with Neonatal Matron around new ventilators. Procurement ongoing and as soon as they are acquired, a new SOP will be created and implemented. Ongoing **Update** • Most guidelines are now compliant and awaiting further audit data for next submission. Ongoing • Liaised with neonatal consultant lead for SBL and neonatal nursing lead. Job description confirmation received. Complete • Liaised with neonatal consultant re: x1 outstanding audit-awaiting response. Ongoing

Element 6: Management of Pre-existing Diabetes in Pregnancy

Women with Type 1 and Type 2 diabetes have persistently high perinatal mortality with no improvement over the past 5 years. The recent Ockenden report has highlighted the need for continuity of experienced staff within Diabetes in Pregnancy teams to reduce poor outcomes in women with diabetes. Providing multidisciplinary care in a joined-up way for women with type 1 and type 2 diabetes during pregnancy and harnessing technology (e.g. continuous glucose monitoring) to reduce maternal complications of diabetes, including perinatal morbidity and mortality.

Quarter audit %	Actions taken and progress made
	• In discussion with Antenatal Clinic Lead Midwife. Plan: make minor amendments to guideline as current guidance advises incorrectly that women with Type 1 diabetes are currently not being offered continuous glucose monitoring. Ongoing • Feedback received from LMNS advising that main Trust-wide guideline does not include any guidance or policy on management diabetic ketoacidosis (DKA) specifically in pregnancy. ANC Lead Midwife to liaise with authors of this guideline to collaboratively write a passage/appendix for management of DKA in pregnancy. Ongoing • Exploration of the possibility of a specialist diabetic midwife post/s at SFT. Reached out to Clinic Matron at Great Western Hospital to ask for guidance on how they managed their specialist education requirements and the clinic in general. Discussion with Director of Midwifery and Outpatient Matron where it was identified that a draft job role description already exists, and the Maternity Education Team have secured funding for relevant specialist training for 2 staff members. Meeting to discuss next steps planned for before August submission date. Ongoing • Evidence for referral pathway to regional maternal medicine network for women with complex diabetes previously not included in evidence folder-now collated and ready for next submission date. Complete

Report Author

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Title: Quality Assurance Midwife

Date: 18/10/2024

Midwifery, Maternity and Neonatal Staffing Report
Maternity and Neonatal Services
(Quarter 2 2024/25)

1. Background

It is a requirement that NHS providers 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.

Previously midwifery staffing data has been included in the nurse staffing paper, however, to provide evidence for NHS Resolutions Maternity CNST Incentive Scheme, a separate paper is now provided which also includes staffing data on other key groups, obstetricians, and anaesthetics.

2. 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. It also gives a summary of key workforce measures for obstetricians and anaesthetics to provide evidence for the current maternity incentive scheme year 6.

3. Birthrate Plus Workforce Planning

A formal Birth Rate Plus assessment was completed in 2024, which reviewed the acuity of women who used maternity services at Salisbury NHS Foundation Trust. This review recommended a birth to midwife ratio of 1:24 across the Trust.

NICE (2017) recommend that an assessment is carried out every three years. The 2024 formal Birth rate Plus assessment indicated that an increase of 3.27 WTE was required to the establishment and the midwifery staffing budget has been augmented to reflect this and agreed by the Trust board.

4. Planned Versus Actual Midwifery Staffing Levels

The following table outlines percentage fill rates for the inpatient areas by month.

Figure 1. Percentage fill rates for inpatient areas by month

Month	Day qualified %	Night qualified %
July 2024	97.9	98.5
August 2024	97.3	99.5
September 2024	97.6	96.8

Fill rates are gradually improving month on month due to the increase in available workforce following both successful recruitment and staff returning from maternity leave. SFT do however continue to have 4.42 WTE on maternity leave and some long-term sickness. Staffing is monitored daily, and staff redeployed based on the acuity. There are more new starters, a cohort of preceptee Band 5 midwives, in Quarter 3 which will further improve our position.

When staffing is less than optimum, the following measures are taken in line with the escalation policy:

- Elective workload prioritised to maximise available staffing.
- Relocate staffing to ensure one to one care in labour and dedicated supernumerary labour ward co-ordinator roles are maintained.
- Utilisation of Bank Midwives.
- Community staff working flexibly in the unit as and when required.
- Non-clinical midwives working clinically to support acuity.
- 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.
- Liaise closely with maternity services at opposite sites to manage and move capacity as required.

All the above actions are designed to maximise staffing into critical functions to maintain safe care for the women and their babies.

5. Birth to Midwife Ratio

The birth to midwife ratio is calculated monthly using Birth Rate Plus methodology and the actual monthly delivery rate. Birthrate Plus has calculated an individualised midwife to birth ratio for Salisbury, recommending a rate of 1:24. 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 has now been added to the maternity dashboard so that it can be monitored alongside clinical data. The table outlines the real time monthly birth to midwife ratio.

Figure 2. Birth to Midwife ratio

Month	July	August	September
Birth to midwife ratio	1:25	1:25	1:30

6. Specialist Midwives

Birth Rate Plus recommends a percentage of the total establishment are not included in the clinical numbers. This percentage is tailored to units considering size, acuity and whether units are multi-centred. These roles include management positions and specialist midwives. 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.

Following the birthrate plus review in February 2024 the current percentage for Salisbury is calculated to be 13%.

7. Birth Rate Plus Live Acuity Tool

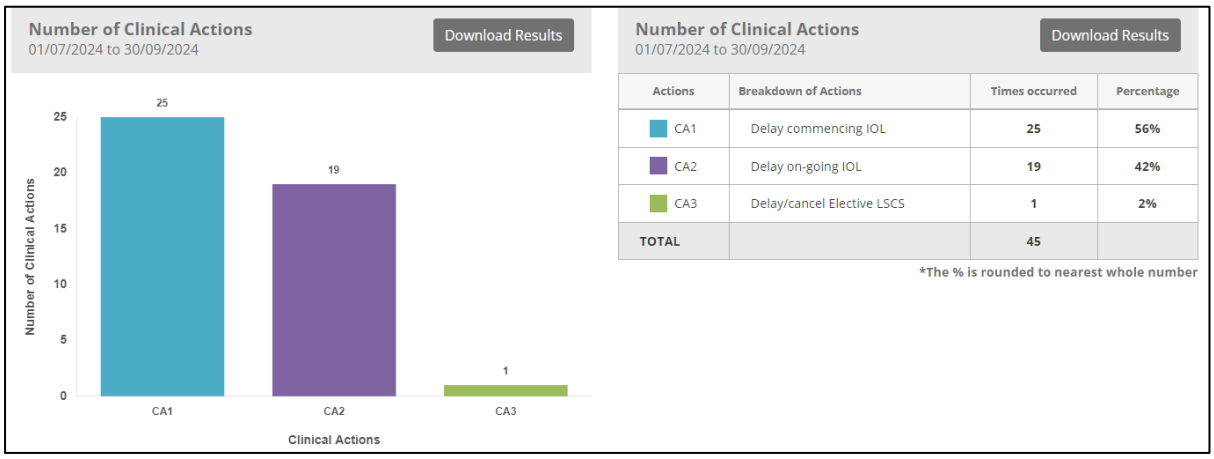
The Birth Rate Plus Live Acuity Tool was introduced in the intrapartum areas on 1st December 2014 and has since gone live in the other inpatient areas. It is a tool for midwives to assess their 'real time' workload arising from the number of women needing care, and their condition on admission and during 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 co-ordinator. 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.

The following provides evidence of actions taken (both clinical and management) to mitigate any shortfalls in staffing or for periods of high acuity.

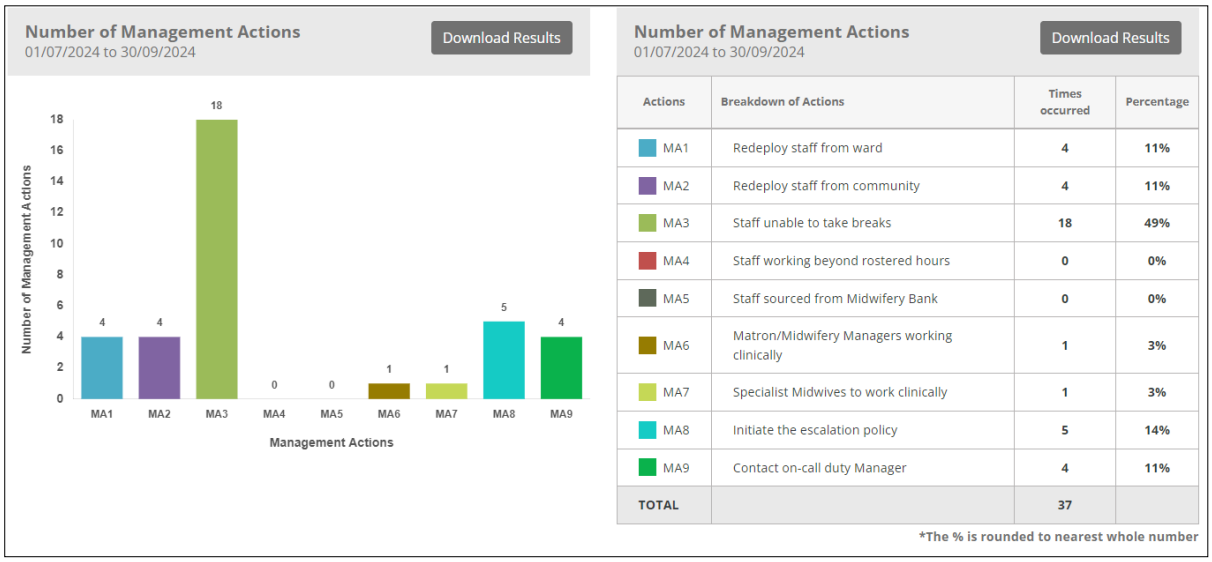
Figure 3. Number and percentage of clinical actions taken



Actions	Breakdown of Actions	Times occurred	Percentage
CA1	Delay commencing IOL	25	56%
CA2	Delay on-going IOL	19	42%
CA3	Delay/cancel Elective LSCS	1	2%
TOTAL		45	

*The % is rounded to nearest whole number

Figure 4. Number and percentage of management actions taken



Actions	Breakdown of Actions	Times occurred	Percentage
MA1	Redeploy staff from ward	4	11%
MA2	Redeploy staff from community	4	11%
MA3	Staff unable to take breaks	18	49%
MA4	Staff working beyond rostered hours	0	0%
MA5	Staff sourced from Midwifery Bank	0	0%
MA6	Matron/Midwifery Managers working clinically	1	3%
MA7	Specialist Midwives to work clinically	1	3%
MA8	Initiate the escalation policy	5	14%
MA9	Contact on-call duty Manager	4	11%
TOTAL		37	

*The % is rounded to nearest whole number

The data above indicates that there is a low incidence of occasions where clinical or management actions are taken to mitigate for high acuity and when needed the escalation process is followed for support. The management of induction of labour (IOL) without any delay is an issue with which all maternity units struggle due to its complex process pathways and unpredictable nature of its management.

Supernumerary Labour Ward Co-ordinator

Availability of a supernumerary labour ward co-ordinator is recommended as best practice to oversee safety on the labour ward. This is an experienced midwife available to provide advice, support, and guidance to clinical staff and able to manage activity and workload through the labour ward. SFT have ensured that rostering reflects this requirement. The Birthrate Plus acuity tool monitors this every 4 hours.

The following table outlines the supernumerary status compliance by month:

Figure 7. Supernumerary status of Labour Ward Co-ordinators by month

	Number of days per month	Number of shifts per month	Compliance
July	31	62	100%
August	31	62	100%
September	30	60	100%

8. One to One 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 co-ordinator to follow the course of actions within the acuity tool. These may be clinical, or management actions taken.

The following table outlines compliance with provision of 1:1 care by Month.

Figure 8. 1:1 care in labour compliance by month

	July	August	September
Birth Centre	100%	100%	100%
Labour Ward	100%	100%	100%

9. 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 3-month period from 1st July 2024 to 30th September 2024. Out of 546 data admissions (confidence factor of 82% recorded) there were red flags entered onto the system with the reasons detailed below:

Figure 9. Number and percentage of red flags recorded during Q2

Number of Red Flags recorded
01/07/2024 to 30/09/2024

Download Results

Red Flags	Breakdown of Red Flags	Times occurred	Percentage
RF1	Delayed or cancelled time critical activity	2	67%
RF2	Missed or delayed care (for example, delay of 60 minutes or more in washing and suturing)	1	33%
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	0	0%
RF5	Delay of 30 minutes or more between presentation and triage	0	0%
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	0	0%
RF8	Delayed recognition of and action on abnormal vital signs (for example, sepsis or urine output)	0	0%
RF9	Any occasion when 1 midwife is not able to provide continuous one-to-one care and support to a woman during established labour	0	0%
RF10	Supernumerary status of labour ward coordinator not achieved	0	0%
TOTAL		3	

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.

10.0 Obstetric staffing

10.1 Consultant Attendance

The obstetric consultant team and maternity senior management team should acknowledge and commit to incorporating the principles outlined in the RCOG workforce document: *'Roles and responsibilities of the consultant providing acute care in obstetrics and gynaecology'* into their service. This includes obstetric staffing on the labour ward and any rota gaps.

Trusts should monitor their compliance of consultant attendance for the clinical situations listed in the RCOG document when a consultant is required to attend in person. Episodes where attendance has not been possible should be reviewed at unit level as an opportunity for departmental learning with agreed strategies and action plans implemented to prevent further non-attendance. Trusts' positions with the requirement should be shared with the Trust board, the board-level safety champions as well as the LMNS.

Clinical situations listed in the RCOG document when a consultant is required to attend in person:

- In the event of high levels of activity e.g., a second theatre being opened, unit closure due to high levels of activity requiring obstetrician input.
- Any return to theatre for Obstetrics or Gynaecology
- Team debrief requested if requested to do so.
- Early warning score protocol or sepsis screening tool that suggests critical deterioration where HDU / ITU care is likely to become necessary.
- Caesarean birth for major placenta praevia/abnormally invasive placenta
- Caesarean birth for women with a BMI >50
- Caesarean birth <28/40
- Premature twins <30/40
- 4th Degree perineal tear repair
- Unexpected intrapartum stillbirth
- Eclampsia
- Maternal Collapse e.g., septic shock, massive abruption
- PPH 2L where the hemorrhage is continuing, and Massive Obstetric Haemorrhage protocol has been instigated.

For Quarter 2 (1st July 2024 – 30th September 2024) there were 6 cases meeting the criteria above. The audit demonstrates 83.3% compliance to the standard.

The case where the Consultant was not present was discussed with the Consultant on-call and the case was reviewed in line with the trust process. There was no harm caused by consultant non-attendance and the case was appropriately managed.
The medical teams are aware of the expectation of consultant attendance for future cases and continued audits for this Safety Action will be completed monthly by the Maternity service.

Figure 10. Table showing compliance of consultant attendance meeting above criteria

Date	Clinical Situation(s)	Comments
04/07/24	Caesarean birth for women with BMI >50.	Consultant present
11/07/24	PPH 2L where the haemorrhage is continuing, and Massive Obstetric Haemorrhage has been instigated.	Consultant present
28/07/24	Early warning score protocol that suggests critical deterioration where HDU / ITU care is likely to become necessary.	Consultant not present
19/08/24	4th Degree perineal tear repair.	Consultant present
27/09/24	High acuity, second theatre opened.	Consultant present
28/09/24	PPH 2L where the haemorrhage is continuing, and Massive Obstetric Haemorrhage has been instigated.	Consultant present

10.2 Short Term Locum usage

NHS Trusts/organisations should ensure that the following criteria are met for employing short-term (2 weeks or less) locum doctors in Obstetrics and Gynaecology on tier 2 or 3 (middle grade) rotas:

a. Currently work in their unit on the tier 2 or 3 rota
   or
b. Have worked in their unit within the last 5 years on the tier 2 or 3 (middle grade) rota as a postgraduate doctor in training and remain in the training programme with satisfactory Annual Review of Competency Progressions (ARCP)
   or
c. Hold a certificate of eligibility (CEL) to undertake short-term locums.

An audit of compliance with Medical HR colleagues was completed for the time period 1st July 2024 – 30th September 2024. The audit demonstrated that during this period, 23 (short term) middle grade locum shifts were required. 6 Doctors completed these shifts, 4 of these Doctors were employed by Salisbury NHS Foundation Trust and 2 Doctors were locums, not employed at Salisbury NHS Foundation Trust at the time of undertaking the shifts. However, both Doctors were working in their local unit (within the Wessex area) on their Tier 2 or 3 rota, therefore the trust is 100% compliant with the criteria described above.

10.3 Long term locum usage

During the time period 1st July 2024 – 30th September 2024, the Trust has utilised 4 long term middle grade locum doctors. 1 Doctor has been working in the trust for many months prior to Q1 and therefore standards 1-6 are not applicable during this time period, another

doctor was included in Q1 report, therefore standards 1-6 are not applicable. The other doctor commenced employment as a long-term locum in Q2.

For all standards that were applicable the Trust was 100% compliant.

Figure 11. Table showing Locum compliance

Standard	Compliance % for Locum 1 (Commenced in Q2)	Compliance % for Locum 2 (in post prior to Q2)	Compliance % for Locum 3 (in post prior to Q2)
Standard 1 Locum doctor CV reviewed by consultant lead prior to appointment	100%	N/A	N/A
Standard 2 Discussion with locum doctor re clinical capabilities by consultant lead prior to starting or on appointment	100%	N/A	N/A
Standard 3 Departmental induction by consultant on commencement date	100%	N/A	N/A
Standard 4 Access to all IT systems and guidelines and training completed on commencement date	100%	N/A	N/A
Standard 5 Named consultant supervisor to support locum	100%	N/A	N/A
Standard 6 Supernumerary clinical duties undertaken with appropriate direct supervision	100%	N/A	N/A
Standard 7 Review of suitability for post and OOH working based on MDT feedback	100%	100%	100%
Standard 8 Feedback to locum doctor and agency on performance	100%	100%	N/A (remains in post)

11. Anaesthetic staffing

For Safety Action 4 of the Maternity Incentive Scheme, evidence must be provided to demonstrate that a duty anaesthetist is immediately available for the obstetric unit 24 hours a day and should have clear lines of communication to the supervising anaesthetic consultant at all times. Where the duty anaesthetist has other responsibilities, they should be able to delegate care of their non-obstetric patients in order to be able to attend immediately to obstetric patients (ACSA standard 1.7.2.1).

The following table demonstrates compliance with this standard by month.

Figure 12. Table showing ACSA standard 1.7.2.1 compliance

Month	July 2024	August 2024	September 2024
% compliance	100	100	100

The service will continue to audit this standard on a monthly basis.

12. Neonatal medical staffing

To meet safety action 4 of the maternity incentive scheme the neonatal unit needs to demonstrate that it meets the British Association of Perinatal Medicine (BAPM) national standards of junior medical staffing. If the requirements had not been met in previous years there should be an action plan with progress against any previously developed action plans.

Salisbury Neonatal unit is designated as a Local Neonatal Unit (LNU). Units designated as LNUs should admit greater than or equal to 25 infants <1500 grams admission weight and perform greater than or equal to 365 respiratory care days (RCDs) annually. In 2023, Salisbury Neonatal unit undertook 943 RCDs and looked after 23 infants weighing less than 1500 grams.

Compliance has never been met for medical staffing against BAPM criteria. However, a trainee ANNP has now been appointed and started their training programme in September 2024. This role will support the medical staffing going forward.

Figure 13. Action plan for medical staffing against BAPM criteria

Action	Owner	Deadline	Rating
Email to SW Specialist Commissioners to request update on any future plans for redesignation of Salisbury LNU to SCU	Mary Pedley-Duncalfe	Completed and awaiting reply	
Write a business case to outline what full BAPM compliance would entail to	Mary Pedley-Duncalfe	October 2024	

allow for Trust level decision making			

The above action plan serves to put in motion a plan to achieve BAPM compliance. Both the LMNS and Neonatal ODN are aware of non-compliance to BAPM and of the above action plan.

13. Neonatal nursing staffing

To meet safety action 4 of the Maternity Incentive Scheme the neonatal unit needs to demonstrate that it meets the service specification for neonatal nursing standards and the Trust is required to formally record to the Trust Board minutes compliance to BAPM Nurse staffing standards annually using the Neonatal Nursing Workforce Calculator (2020). For units that do not meet the standard, the Trust Board should agree an action plan and evidence progress against any action plan previously developed to address deficiencies.

The nursing workforce review was completed in September 2024 using the Workforce calculator seen below. This demonstrates that the unit is partially compliant to the BAPM standards being over funded for registered nurses but under-funded for non-registered nurses. The requirement would be an additional 2.09wte non-registered nurse. There are mitigations in place for increasing the number of nurses who are QIS trained, 1.92wte are now trained & 1.0WTE is now in training. An action plan to review neonatal staffing was shared at Trust Board March 2024, however, it is important to note that activity and acuity are variable, and this consequently means a variation in BAPM neonatal nursing requirements from month to month.

1.92WTE are now on Maternity leave and we have had 2 leavers (0.8WTE in total) Jobs are on TRAC awaiting sign off & awaiting instruction from the board regarding increasing non-registered staff by 2.19WTE and band 5 by 0.7WTE to achieve compliance in this area.

Figure 14. Compliance with BAPM standards for Neonatal Nurses with respect to QIS training (red is staffing shortfall, green is positive to meet BAPM standards)

	Funded September 2024	In post September 2024	BAPM calculated requirement *(from ODN tool, based on NNU activity)*	Variance
Total direct care nurses	24.08	20.07	24.55	-4.01
of which QIS	13.64	13.19	15.16	-0.45
Total Non-QIS	9.64	4.86	6.50	-4.78
Total Non-Reg	0.80	2.02	2.89	-1.22

% Registered Nurses QIS Qualified		73.1%	70.0%	

14. Recommendations

It is recommended for the Board to note the contents of the report and formally record to the Trust Board minutes agreement to the action plan, in place due to non-compliance with BAPM standards for both neonatal nurse staffing and neonatal medical workforce and.

Report Author(s)

Name(s): Katherine Barrio & Shelley King

Title(s): Head of Maternity & Neonatal Services and Operational Manager

Date: 27/10/2024

Avoidable Term Admissions to the Neonatal Unit (ATAIN) and Transitional Care Report

(Quarter 2 2024-25)

1. Report Overview

ATAIN is an acronym for Avoiding Term Admissions into Neonatal units. It is a national programme of work initiated under patient safety to identify harm leading to term neonatal admissions. The current focus is on reducing harm and avoiding unnecessary separation of mothers and babies.

This report outlines the term admission rates at 5.1%, findings from audits of the pathway/ policy, findings from the ATAIN reviews both term and late pre-term babies and provides assurance of actions being taken and progress being made.

2. The national ambition

In August 2017 NHSI mandated a Patient safety alert to all NHS Trusts providing maternity care. The safety alert was issued to reduce harm from avoidable admissions to neonatal units for babies born at or after 37 weeks. This fell in line with the Secretary of State for Health's ambition to reduce stillbirth, neonatal brain injury and neonatal death by 50% by 2030. This ambition is also aligned with the vision created within Better Births (2016), which aims to drive forward the NHS England-led Maternity Transformation Programme, with a key focus on;

- Reducing harm through learning from serious incidents and litigation claims
- Improving culture, teamwork, and improvement capability within maternity units

2.1 Why is it important?

There is overwhelming evidence that separation of mother and baby so soon after birth interrupts the normal bonding process, which can have a profound and lasting effect on maternal mental health, breastfeeding, long-term morbidity for mother and child. This makes preventing separation, except for compelling medical reason, an essential practice in maternity services and an ethical responsibility for healthcare professionals. Collaboration between neonatal and maternity staff at Salisbury NHSFT has seen several positive changes, with a real focus around improving maternity and neonatal care. Several projects have been identified to support the reduction in the unnecessary separation of the mothers and babies that use our service.

Using the 'Improving Together' Methodology SFT are embarking on our 'SIT' project (Separation Improvement Times). This project hopes to slowly move the culture in maternity and Neonatal services to allow as close to immediate access for mothers to visit their infants admitted to the neonatal service. With multidisciplinary working across all stake holders, we would like women to have a seamless experience when their infant requires admission to the

neonatal unit. This project hopes to improve the empowerment & experience of mothers whose infants (>37 weeks gestation) require unexpected neonatal care. Please see below PDF of A3 project.

Seperation Improvment Times (S

QI project introduced this year 'Think 45' project. This project has been running across the TV&W ODN and was adopted in Salisbury to reduce the amount of term respiratory admissions admitted to the unit. Please see below pdf outlining the purpose of the project:

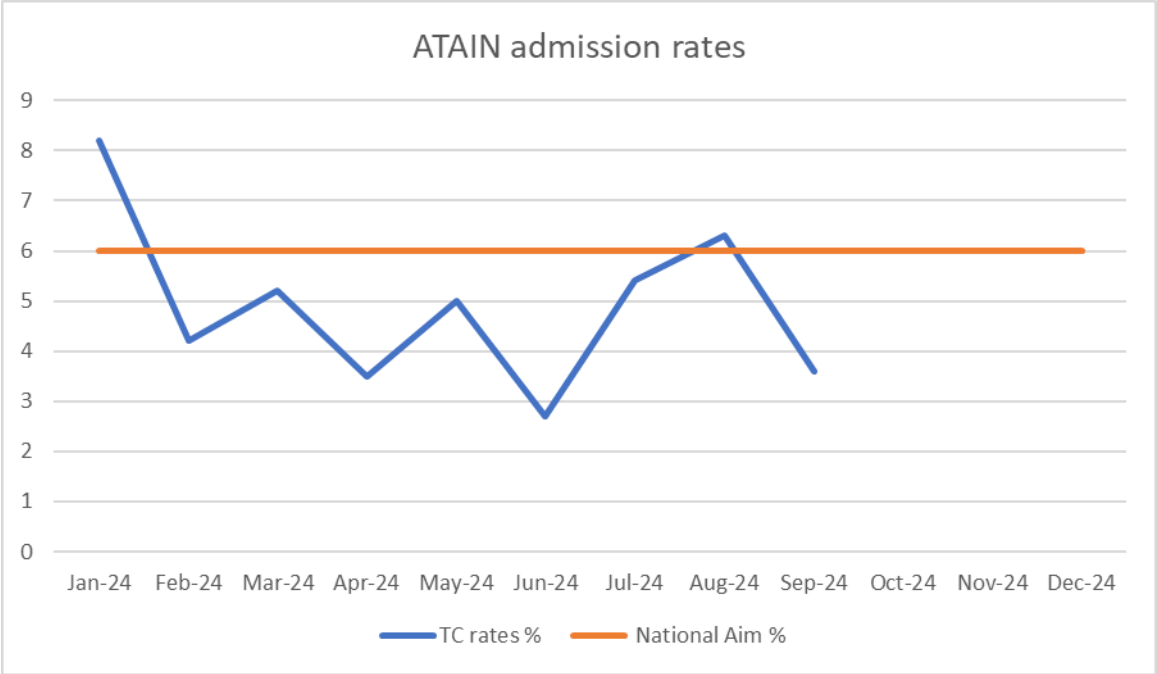
Think 45 minutes!! presentation.pdf

The national aim for term admissions to the neonatal unit is less than 6% of all term babies, however Trusts should strive for this rate to be as low as possible.

3. Trust ATAIN rates

The following graph outlines the rolling calendar year ATAIN rates for Salisbury NHSFT Trust.

Figure 1. Monthly ATAIN rates since January 2024 for Salisbury NHSFT Trust



The action plan below with updates and progress from the last report is included below.

Figure 2. ATAIN reviews (babies equal or >37 weeks' gestation)

	July 2024	August 2024	September 2024
Total number of admissions in month	**8**	**9**	**6**
Number of babies admitted to the NNU that would have met current TC admission criteria but were admitted to the NNU due to capacity or staffing issues.	**0 at present** **Awaiting further reviews**	**Awaiting reviews**	**0 at present** **Awaiting further reviews**
Number of babies that were admitted to or remained on NNU because of their need for nasogastric tube feeding but could have been cared for on TC if nasogastric feeding was supported there.	**0 at present** **Awaiting further reviews**	**Awaiting reviews**	**0 at present** **Awaiting further reviews**
	July 2024	**August 2024**	**September 2024**
Total number of case reviews undertaken in month	**2**	**0**	**1**
Total number of case reviews with both maternity and neonatal staff present	**2**	**0**	**1**

4. Findings and learning from the ATAIN review meetings

4.1 Neonatal

Over the past quarter SFT have found discrepancies in the amount of time that PEEP has been delivered to babies, this was not always 45mins. It has become apparent that it is not always possible to achieve the full recommended time due to the hospital environment of a District General Hospital being smaller and having less staff capacity to support. Paediatrics are thus requesting that PEEP to be delivered between 30-45mins. In the future SFT will be able to fully audit the results of the 'Think 45' project.

4.2 Maternity

Delays in recommended timeframes for decision to delivery have been noted for CAT 2 C-sections. In-patient Matron and Obstetric Risk Lead are in the process of reviewing altered processes to support meeting the nationally recommended timeframes for caesarean sections.

4.3 Learning

In Q2 (in addition to the above themes) we have referred the following learning:

- In Q2 remainder of Q1 ATAIN reviews complete. Findings highlighted one infant deemed to be an avoidable admission to NICU due to lack of adherence to hypoglycaemia guidance. This learning is planned for feedback to individuals and to the wider work force via the perinatal group.
- Currently there is an ATAIN review backlog of cases, this has been raised with DMT and meeting convened to improve compliance with extra ordinary review dates planned.
- DMT backing given for ATAIN process, leads to work with new staff to improve compliance.
- Exceptional meetings added to diaries and improvement in this area will come in November 2024.
- If no improvement seen in the timely completion of reviews this issue will need to be added to the risk register and will be escalated as appropriate.

5. Transitional Care Service (TC)

Please see appendix in below local policy:

Salisbury TC policy 1.6 (2023).pdf

SFT's TC policy was updated in 2023 and includes a clear staffing model for TC. It is recognised that we are not always BAPM compliant with the additional TC work and are working through a business case to increase NICU staffing to 4/shift to offer more standardised care.

6. TC Audit

6.1 How many TC babies did SFT have and how long did they stay for?

The graphs below demonstrate the numbers of babies born each month that fit within the TC gestational criteria and the length of stay.

Figure 3. Total number of 34-36+6 babies born each month since beginning of Q2

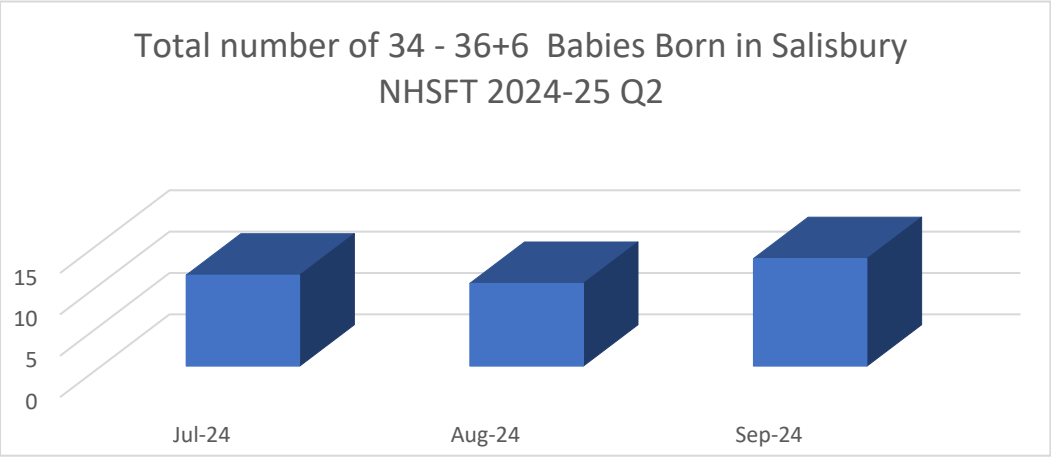
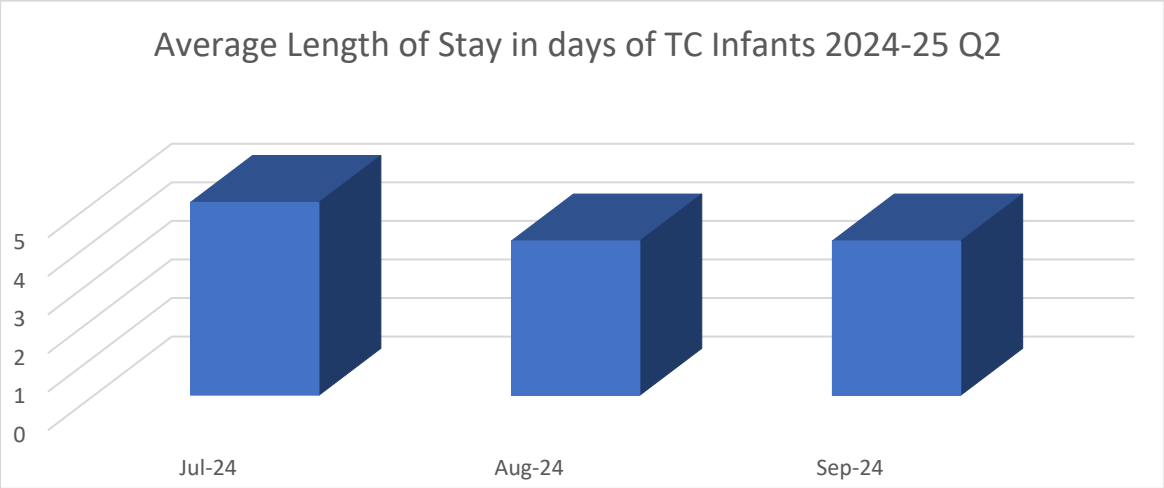


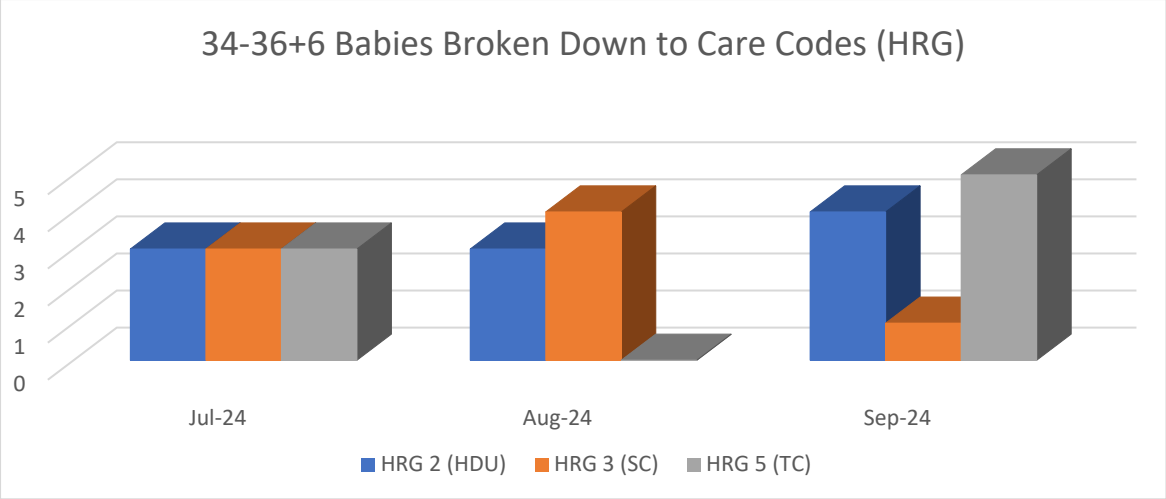
Figure 4. Average length of stay in days for TC infants.



6.2 Did SFT admit the correct babies to TC and SCBU?

This graph below shows that SFT are further interrogating care codes for infants that fall within the Transitional Care gestation. This helps to understand if these are correct for each baby.

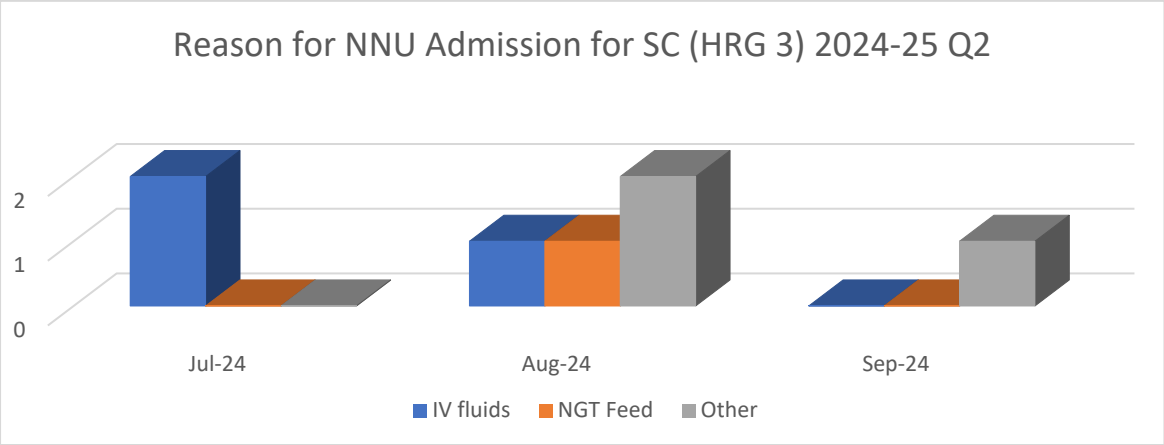
Figure 5. TC babies identified by care codes each month 2024-25 Q2.



It is then possible to drill down further on special care infants (HRG 3) to ascertain if these infants could in-fact be coded as TC infants.

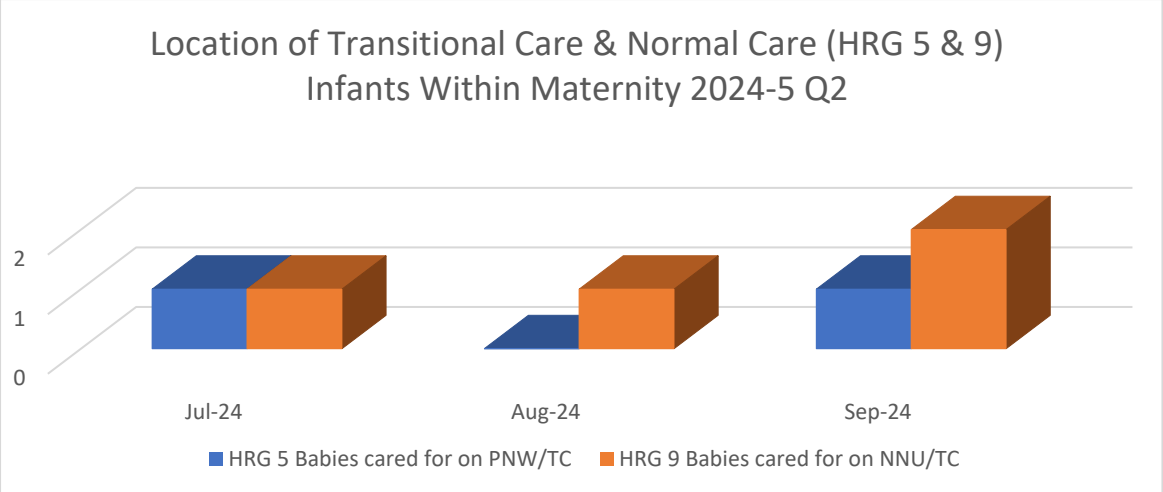
This graph below shows that in Q2 there has been 1 infant that could have been coded as TC. This infant was again one of a twin where the sibling required HDU care. These twins remained together on the neonatal unit and their mother joined when able.

Figure 6. Reason for NNU admission



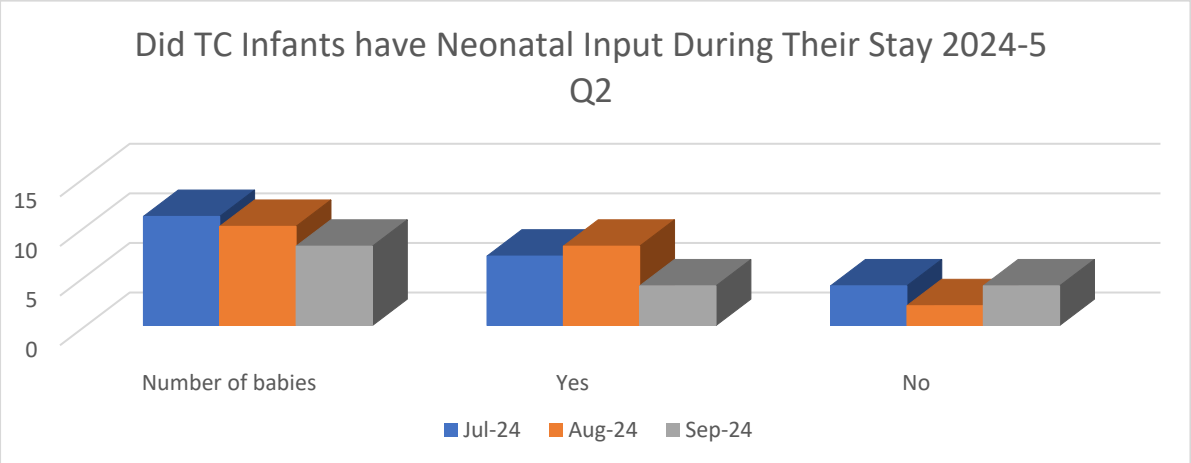
The graph below shows that SFT have cared for babies in the correct setting (BMW/LNU - TC) but during most months we have had 1 or 2 normal care (HRG 9) infants on the neonatal unit. These numbers are monitored monthly via CNST audit. These are very low numbers and can be anything from 'place of safety', a twin that requiring less than a sibling, lack of space on BMWW/TC etc. Due to this monitoring, it will be easy to recognises and act on changes to this number.

Figure 7. Location of care setting



6.3 Did all TC infants have Neonatal involvement?

Figure 8. Babies receiving neonatal input during their stay.



Neonatal input can be any input from neonatal nursing team or medical staff. These results are taken from National Neonatal Audit Programme (NNAP) data showing if they have been seen by a senior medical member of staff.

7. Pre-term babies (34 – 36+6 weeks gestation)

Figure 9. Table showing number of admissions each month during Q2

	July 2024	August 2024	September 2024
Total number of admissions	11	10	13

The TC pathway is now fully integrated and familiar to staff and has become the norm.

The action plan below with updates and progress from the last report.

8. Action Plan

The following combined action plan outlines actions being taken in response to audits of compliance with the pathway / policy and actions being taken in response to ATAIN reviews for both term and late pre-term babies.

The plan includes progress since the last report.

Figure 10. ATAIN and TCU action plan

Actions from TC pathway /policy audits				
Action	**Responsible person**	**Deadline**	**Progress made**	**Rag rating**
Education on the MW study day continues but still struggling for sustained engagement from MW cohort. Due to this we are looking at increase our maternity nurse numbers as part of an options appraisal and subsequently rotate these nurses to the neonatal unit to build up skills so they can care for TC infants on LW until mum & baby can come to NICU TC together for their ongoing care.	GD/SC-O/BR & SL	30/11/24	On going midwifery education continues and is now in a sustaining phase. Maternity nurses have completed a period of supernumerary. Ongoing discussion with DMT regarding staffing model.	
Actions from ATAIN reviews for babies >37 weeks				
Action	**Responsible person**	**Deadline**	**Progress made**	**Rag rating**
Missing Q1 reviews from last report	ATAIN group	Q2	All Q1 reviews now done 1 avoidable admission found learning to go through perinatal group	
Lack of ATAIN reviews for Q2	ATAIN group	Q3	Exceptional dates agreed	
CAT 2 C-section timing audit	BR/SM-G	Q3	Update required (on-going audit)	
Update ATAIN meeting TOR as >3yeas old	ATAIN Group & JB	November 2024	TOR with JB completion end of November	
Actions from TC pathway for late pre-term babies (34 weeks – 36+6 weeks)				
Action	**Responsible person**	**Deadline**	**Progress made**	**Rag rating**
Discussion of splitting of twins if one requires NICU treatment – keeping mum with infant that only requires TC care.	GD/BR/JB/ SM-G	November 2024	To be discussed in November TC meeting.	

9. Recommendations

The Trust Board are asked to note the contents of the report and agree to sign off the action plan.

Report Author(s)

Name(s): Becky Roberts & Geoff Dunning

Title(s): Inpatient Matron and Neonatal Matron

Date: 16/10/2024

NHS Salisbury NHS Foundation Trust

Report to:	Trust Board (Public)	Agenda item:	5.5
Date of meeting:	5th December 2024		

Report tile:	Perinatal Culture & Leadership Board Report			
Status:	Information	Discussion	Assurance	Approval
	x	x	x	
Approval Process: (where has this paper been reviewed and approved):	Divisional Governance 15. 11.2024 Clinical Governance Committee 26.11.24			
Prepared by:	Vicki Marston –Director of Midwifery and Neonatal Services			
Executive Sponsor: (presenting)	Judy Dyos - Chief Nursing Officer			

Recommendation:

The committee are asked to note the contents of the Perinatal Culture & Leadership Board Report and to acknowledge the external and internal demands made of the perinatal quadrumvirate.

This includes the significant national oversight and requirements being made of Maternity & Neonatal Services around assurance and culture and the role of the Trust board and Executive Team in supporting implementation of these external requirements, as well as acknowledging the role of the Trust Board in oversight and support of Maternity and Neonatal services.

For minutes to note the report and the following for CNST Safety action 9 evidence:

- Evidence in the Trust Board minutes that Board Safety Champion(s) are meeting with the Perinatal leadership team at a minimum of bi-monthly (a minimum of three in the reporting period) and that any support required of the Trust Board has been identified and is being implemented.

- Evidence in the Trust Board (or an appropriate Trust committee with delegated responsibility) minutes that progress with the maternity and neonatal culture improvement plan is being monitored and any identified support being considered and implemented.

Executive Summary:

The Perinatal Culture and Leadership programme was commissioned by NHSE to support Maternity and Neonatal Quadrumvirate teams with development and cultural improvements within Maternity Services.

The programme was nationally funded and was designed in direct response to feedback from perinatal colleagues in support of nurturing a positive safety culture. The programme also supported the response to the Immediate and Essential Actions in the Independent Review of Maternity Services at Shrewsbury and Telford Hospitals.

Every Maternity Unit in the country has been asked to support their 'Quadrumvirate' to complete the training package and is supporting the work being completed in Maternity and Neonatal Services. the programme brought together senior leaders from across maternity and neonatal services to improve the quality, safety, and experience of care for women and families.

Due to Salisbury's entry onto the Maternity Safety Support Program (MSSP) our team at SFT joined the first cohort, in November 2022. The in-person development section of the programme, which was completed as a team alongside three other quadrumvirates from other trusts also on the MSSP, was followed by a culture survey (score survey) to provide a benchmark of current culture within Maternity and Neonatal services to enable progress and improvements to be implemented.

As of November 2024, an action plan has been designed following the score survey, feedback sessions and collaboration from staff across the Maternity and Neonatal Services. The actions are being worked through and will be monitored via Maternity and Neonatal Safety Champions meetings which are held monthly, with attendance at these meetings from the Executive and Non-Executive safety champions to ensure oversight.

CNST Maternity incentive Scheme Safety Action 9 (Board Assurance) stipulates the importance of, and requirements for, oversight and support from Board as requested from the Quadrumvirate to continue to develop and progress the Maternity and Neonatal Culture plan.

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):	

Purpose of the Report

To provide the Trust Board with an oversight of the progress, support requirements and improvement plan following the ongoing Perinatal Culture and Leadership Programme which began in November 2022 within Maternity Services.

Background

The Perinatal Culture and Leadership programme was commissioned by NHSE to support Maternity Quadrumvirate teams with development and cultural improvements within Maternity Services.

The nationally funded Perinatal Culture and Leadership Development Programme was designed in direct response to feedback from perinatal colleagues in support of nurturing a positive safety culture. The programme also supported the response to the Immediate and Essential Actions in the Independent Review of Maternity Services at Shrewsbury and Telford Hospitals.

NHSE's aim is to support all perinatal teams in England to create and craft the conditions for a positive culture of openness, safety and continuous improvement. Reviews of maternity services have highlighted cultural and leadership issues as a common theme that contributes to underlying patient safety failures across organisations. Strong and positive leadership creates effective teamwork and therefore improved clinical care.

Co-designed by frontline teams and leadership experts, the programme brought together senior leaders from across maternity and neonatal services to improve the quality, safety, and experience of care for women and families.

Our team at SFT joined the first cohort, in November 2022; it was aimed that all services across the country would be enrolled by March 2024. It took around six months to complete the 'quads' section of the programme and this was followed by a culture survey (including de-briefing and coaching support) - the score survey – which was offered to all perinatal services as part of the programme.

The Perinatal Quad at SFT consists of:

Yazmin Faiza	Obstetric Clinical Lead
Mary Pedley-Duncalfe	Paediatric & Neonatal Clinical Lead
Katherine Barrio	Head of Midwifery & Neonatal Services
Shelley King	Operational Manager, Women & Newborn Division

The Divisional Triumvirate, that supports and works with the Perinatal Quadrumvirate consists of:

Abi Kingston	Clinical Director Women and Newborn Division
Vicki Marston	Director of Midwifery and Neonatal Services
Hannah Boyd	Divisional Director of Operations

Current position

The programme provided a detailed and in-depth programme of leadership development with a focus on supporting cultural improvement. It gave the team the tools and resource to formalise the Quadrumvirate team and its purpose.

It supported the Quadrumvirate to understand what shapes culture, and to develop a culture building toolkit to improve team performance and patient care.

As a Quadrumvirate we discussed which cultural values we felt were important and how we would role model behaviours in line with those values; it was agreed that we wished to lead with transparency, openness, honesty; to be accountable; to lead compassionately and to be encouraging and positive to our teams.

A collective vision and aspiration was discussed and formed:

- To have a happy, satisfied and engaged workforce
- To ensure culture / engagement conversations are a part of how we do business
- That across our services, there is shared accountability and ownership for culture at every level
- That everyone knows our shared aspirations.

The quadrumvirate has supported members of the Midwifery Team to conduct a number of Cultural Conversations with varying staff groups.

Themes and insights from the SCORE Survey and subsequent Cultural conversations are below.

Theme	Observation
Collaboration	• Communication and collaboration could be improved • Communication was a recurring theme within teams and with external teams • Accountability doesn't feel equal across all teams • A sense of them and us across teams.
Psychological Safety	• The behaviour charter is helping but a sense that people could be nicer to each other • Accountability for your own behaviours, being kind to others and supporting the team • A theme around having to deal with difficult colleagues causing burnout.

Leadership	• Lots of changes in leadership which has impacted in a number of ways • Understanding the leadership structure and job roles & responsibilities
Burnout	• Strong sense of burnout, overworked, overwhelm and staffing / resource issues • Impact of National media reports around Maternity & Neonatal care to staff

Moving forward regular check-ins are scheduled for staff and as a Quadrumvirate we would like to focus on creating a Cultural working group, identifying 'Culture Champions' across different roles across our services, we would like to re-launch the Maternity & Neonatal visions and organise different methods of facilitating feedback.

We will also ensure that these workstreams are aligned with other Trust and Regional Surveys and guidance, such as the Staff Survey.

Recommendation and next steps

The Perinatal quadrumvirate have produced an initial action plan following the SCORE survey and in line with CNST; the quadrumvirate will meet for a full day quarterly to continue this work and have monthly check-in sessions.

The Board is required to acknowledge the external and internal demands made of the perinatal quadrumvirate, including the significant national oversight and requirements being made for Maternity & Neonatal Services around assurance and culture. For continued progress and improvement in this work the Quadrumvirate requires protected time and resource to achieve these outcomes. It is expected that there will also be need for resource and support from other areas – OD and L, OD and P, communications team.

The Executive and Non-executive Safety Champions have provided key support and this has enabled the positive progress made thus far, their roles and input will be key in the sustainability of this progress and further improvements.

Any Board member would be welcome to attend one of the Perinatal quarterly meetings for an update.

NHS Salisbury NHS Foundation Trust

Report to:	Trust Board (Public)	Agenda item:	5.6
Date of meeting:	5th December 2024		

Report tile:	Perinatal Quality Surveillance - Salisbury NHSFT Maternity & Neonatal services –**September data 2024**			
Status:	Information	Discussion	Assurance	Approval
	x	x	x	
Approval Process: (where has this paper been reviewed and approved):	Divisional Governance 18.10.24 DMT approval 16.10.24 CGC 26.11.2024			
Prepared by:	Vicki Marston –Director of Midwifery and Neonatal Services			
Executive Sponsor: (presenting)	Judy Dyos - Chief Nursing Officer			

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 6 – 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 September 2024.

The report comprises of a slide pack which has been designed collaboratively across the LMNS, ensuring that Trust Board at SFT, RUH and GWH are receiving the same metrics for review in each provider across BSW

Summary:

Staffing:

- Reduction in Midwifery vacancies, although still significant gap in clinical Midwives.
- Midwife to birth ratio 1:30– SFT recommended ratio 1:24 -Increased for September due to acuity and sickness increases.

- 1:1 care in labour achieved at all times
- Supernumerary status of labour ward maintained 100% time.

Incidences reported as moderate.

- 6 Incidences reported as moderate.
  - 1x OASI – added to thematic review
  - 2 x Term admission to Neonatal Unit. All in process of review at present.
  - 2x Massive Obstetric Haemorrhage – PSR1 complete
  - 1x postnatal readmission on day 3

PMRT

- No cases for review in September.

Training

- Compliance in PROMPT, CTG and NLS training. Target of 90% reached and compliance met as of 1st December 2023. Anticipated compliance of 90% for November 30th, 2024.
- Support from Executive team and anaesthetic trajectory to ensure compliance possible.

Service user and staff feedback

- Feedback received from varying sources including MNVP, safety champions, friends, and family survey and PALS
- Safety Champions meeting well attended and escalation taken for action by Exec and Non-exec safety champion

National Guidance

- CNST compliance 9 out of 10 for 2023. MIS year 6 published in April 2024.
  - ESCALTION: Concerns remain around compliance with Saving Babies Lives. Work ongoing around Saving babies lives Vs 3.
  - Confirmation from LMNS of agreed percentage to be reached to show compliance for NHSR CNST Maternity Incentive Scheme. And agreement with SFT trajectory around 'best endeavours'.

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

Perinatal Quality Surveillance
October 2024 *(September Data)*

Maternity and Neonatal Unit

Salisbury Foundation Hospital

Safe: Maternity & Neonatal Workforce

	Target	Threshold		Apr '24	May '24	Jun 24	Jul '24	Aug '24	Sept '24	Comment
		Green	Red							
Midwife to birth ratio	1:24	1:24	>1:26	1:32	1:28	1:25	1:25	1.25	1:30	Ratio increased this month due to increase in expected births and acuity and short term sickness
Compliance with supernumerary Status of LW Coordinator %	0	0	>1	100%	100%	100%	100 %	100 %	100%	
1:1 care not provided	0	0	>1	0	0	0	0	0	0	
Confidence factor in Birthrate+ recording	60%	>60%	<50%	83.3%	75.8%	75.5 %	80.11 %	84.9 7%	83.33 %	Percentage of possible episodes for which data was recorded. Audit commended December 23.
Consultant presence on LW (hours/week)	40	40		40	40	40	40	40	40	
Daily multidisciplinary team ward round	90%	>90%	<80%	100%	100%	100%	100 %	100 %	100%	
Consultant non-attendance when clinically indicated (in line with RCOG guidance)	0	0	>1	0	0	0	0	0	0	

Table 1. Total WTE vacancy and availability to work - by role

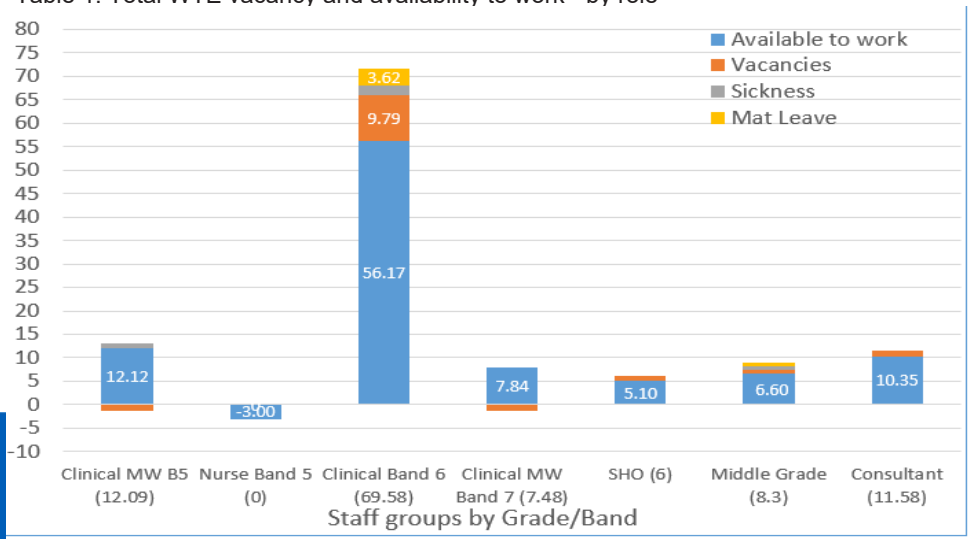


Table 2. Average midwife shift fill rates

		Apr '24	May '24	Jun '24	Jul '24	Au '24	Sept '24
Midwives	Day	97.2	97.2%	97.3%	97.9 %	97. 3%	97.6%
	Nigh t	99.3%	99.3%	98.9% %	98.5 %	99. 5	96.8%
MCA/MSWs	Day	98.6%	98.6%	97.3%	90.8 %	94. 6%	92.8%
	Nigh t	98.9%	98.09 %	91.2%	97.8 %	92. 5%	88.7%

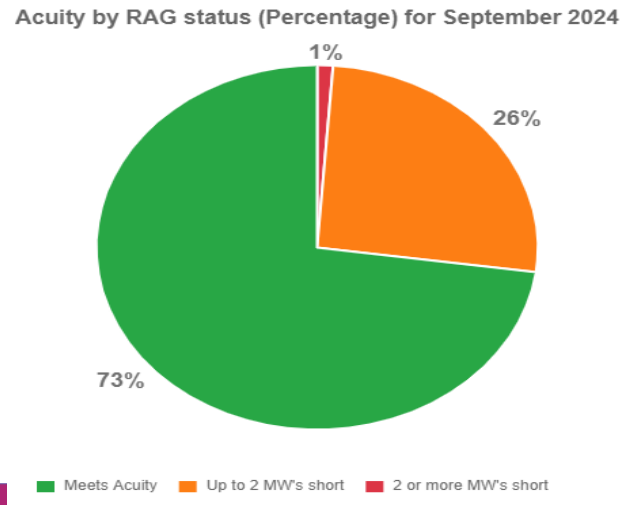
Is the standard of care being delivered?

- Supernumerary Labour Ward coordinator status achieved 100% time
- 1:1 care in labour achieved 100% of time

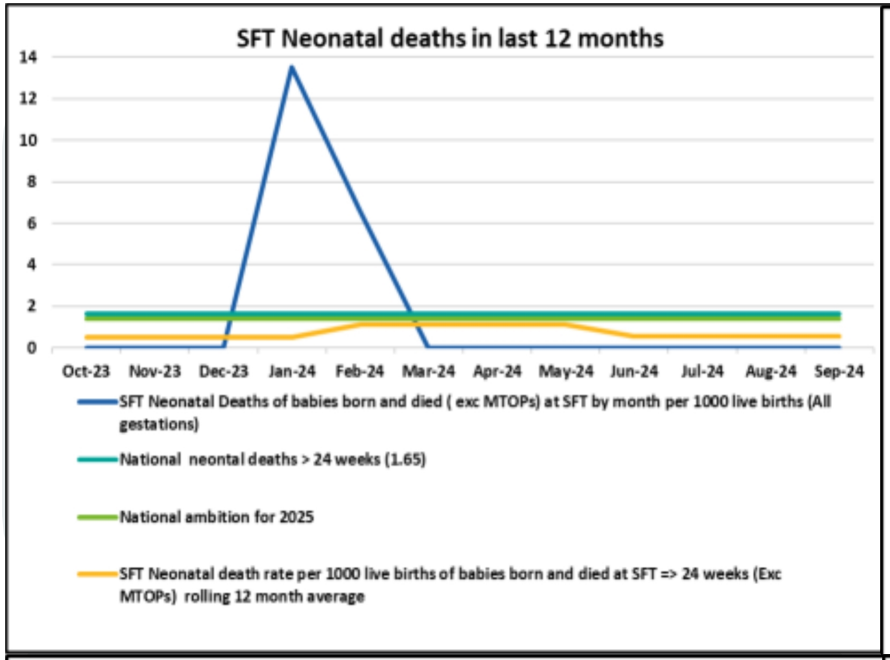
What are the top contributors for under/over-achievement?

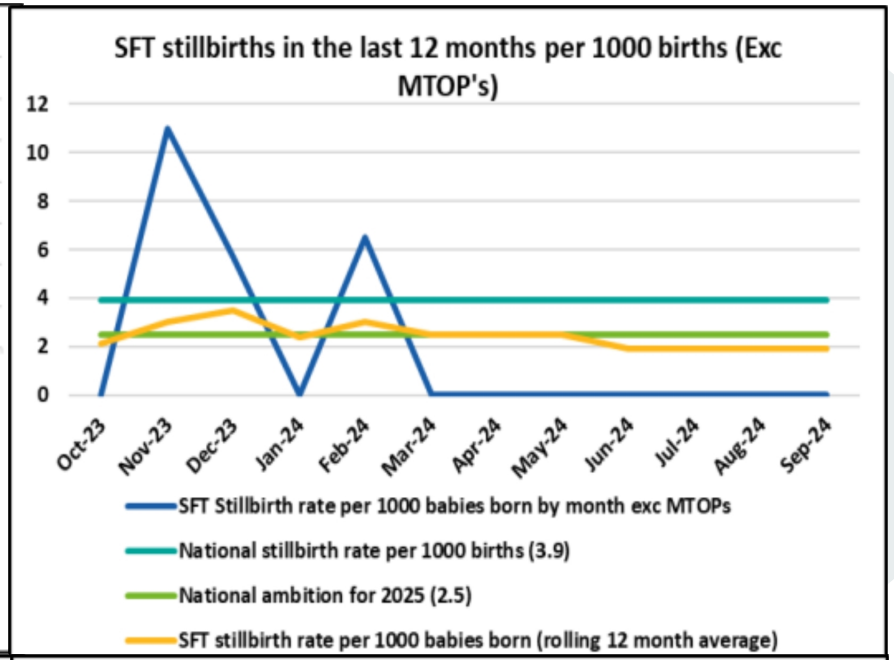
- Available workforce numbers this month show slight increase due to numbers of newly recruited staff.
- The Midwife to Birth ratio increased this month due to increase in expected births and acuity and short term sickness
- Acuity vs staffing data more challenged this month due to higher birth numbers, acuity and short term sickness.

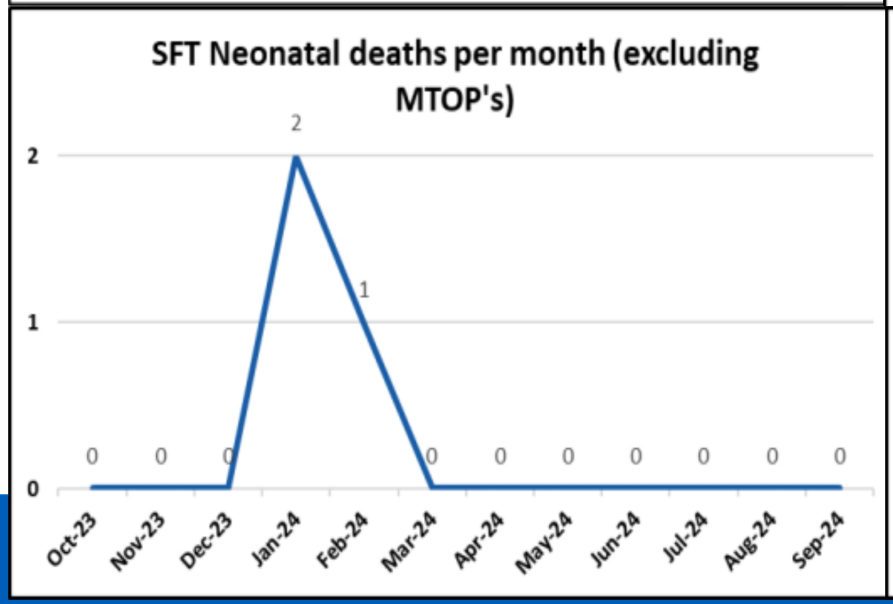
Table 3. Acuity by RAG vs staffing data

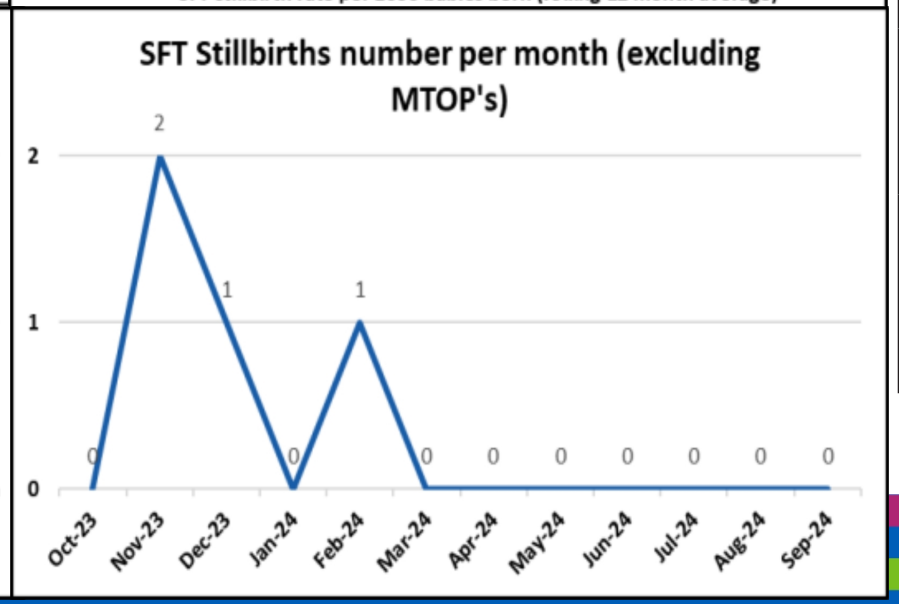


Safe: Perinatal Mortality Review Tool (PMRT)









- All perinatal deaths have been reported using the Perinatal Mortality Review Tool (PMRT). PMRT reporting is mandated by MIS Safety Action 1 for year 6. A quarterly update paper is shared with the board.
- Neonatal deaths of any gestation are a registerable birth and have been included in these numbers.
- Stillbirth rate is presented per 1000 births for national benchmarking, therefore the number presented on the graphs will not automatically correlate to direct numbers per month.
- There was one perinatal loss in September > 12 weeks-
- 1 miscarriage at 17+4 weeks

PMRT Action Plans for Salisbury Foundation Trust – September 2024 review

PMRT case ID	Issue text	Action plan text	Person responsible	Target date
	There were no cases to review under PMRT in September.			

PMRT grading of care – Key

Salisbury NHS Foundation Trust

A - The review group concluded that there were no issues with care identified up the point that the baby was confirmed as having died
B - The review group identified care issues which they considered would have made no difference to the outcome for the baby
C - The review group identified care issues which they considered may have made a difference to the outcome for the baby
D - The review group identified care issues which they considered were likely to have made a difference to the outcome for the baby

A- The review group concluded that there were no issues with care identified for the mother following confirmation of the death of her baby
B - The review group identified care issues which they considered would have made no difference to the outcome for the mother
C - The review group identified care issues which they considered may have made a difference to the outcome for the mother
D - The review group identified care issues which they considered were likely to have made a difference to the outcome for the mother

Case Ref	Date	Category	Incident	Outcome/Learning/Actions	HSIB Reference	SI? Reference
				The were no cases requiring PMRT review in September.		

INCIDENTS: Moderate Incidents and PSRs

Salisbury NHS Foundation Trust

DATIX Incidents classified as moderate harm and above at month end

Case Ref (Datix no)	Date of incident	Category	Incident Summary	Comments	Commissioned Y / N	MNSI ref no.?	PSII ref no.?
168907	01/09/24	Moderate	Unexpected Term Admission to NNU	PSR1 presented 24/09/24, delayed due to obtaining documentation and for PSR 2.	**N**		
169394	17/09/24	Moderate	OASI	For review with potential reclassification	**N**		
169589	21/09/24	Moderate	Postnatal readmission	Case currently awaiting review with potential reclassification	**N**		
169752	28/09/24	Moderate	MOH	Notes received 01/10/24 and awaiting case review	**N**		
169765	29/09/24	Moderate	Unexpected Term Admission to NNU	To be reviewed, however admission was less than 4 hours, therefore likely for reclassification as does not meet ATAIN criteria	**N**		
169773	30/09/24	Moderate	MOH	To be reviewed	**N**		

INCIDENTS: Investigation update

NHS Salisbury NHS Foundation Trust

Ongoing Maternity and Neonatal Reviews

Case Ref (Datix)	Date	Category	Incident	Outcome/Learning/Actions
CCR 580	16/07/2023	Moderate	Term admission to NICU	Final report sent for signature
SII 586	08/08/2023	Moderate	Eclamptic Seizure	Awaiting exit date
CCR 599	19/09/2023	Moderate	Postpartum haemorrhage at home	Awaiting date for report sharing
CCR 613	19/11/2023	Moderate	Eclampsia	Draft report sent to staff for factual accuracy and awaiting changes
PSII 162915	29/01/2024	Moderate	Preterm baby transferred to tertiary unit for cooling	Awaiting draft report.
MNSI 163944	04/03/2024	Moderate	Baby transferred to tertiary unit for cooling	Final report received and awaiting a date for tripartite meeting

Responsive

NHS Salisbury NHS Foundation Trust

MNVP Service User feedback (Sept 24)

Key achievements and feedback:
No feedback provided this month. The MNVP will be sharing the feedback from listening events at the new Triangulation meeting, which is scheduled quarterly.

Next steps for progression:

- Continue to roll out personalised care planning training. Update: We have received the delivery of the 'My Maternity Choice' booklets. Comms will be shared with the workforce in October, and the introduction to the booklets will be added to the maternity website.
- Exploration of translation services- the Maternity Department continues to work with Wessex Health innovation on the application of a new translation device. As a Trust we are working towards adding a translation tool bar to the website.
- Working in collaboration with the MNVP and the Family Nurse Practitioner a listening event has been scheduled in November 24, in order to capture the voices of our younger clients (under 19yrs)

Safety Champions/ Staff Feedback

Items for escalation:

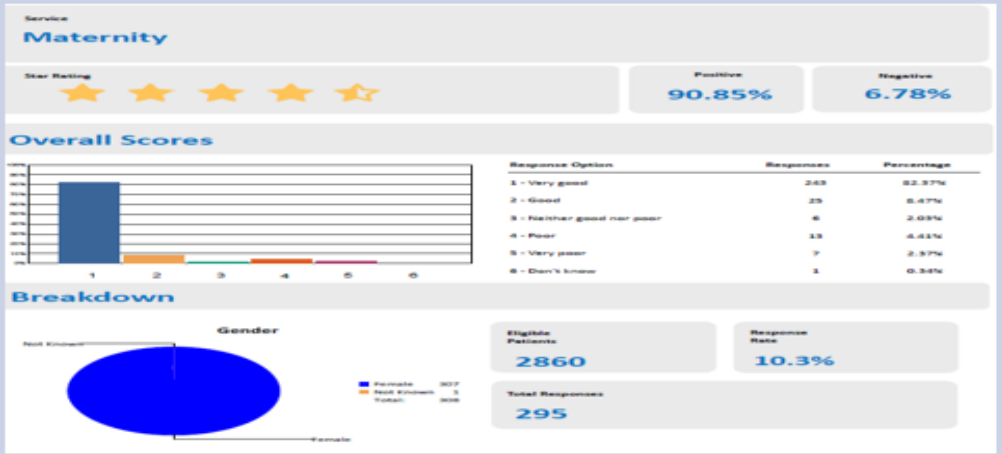
- Scan reviews in DAU- education needed around bleeping the Consultant at times of high acuity.
- Broken lights in the anaesthetic room.- Repair delayed due to waiting for parts.
- DATIX have been submitted regarding bleeps and black spots. It was noted that this has been a previous concern. Plan made to establish if this issue has now been resolved with either Estates Team or Communications Team.
- MNVP – concerns around availability as we don't have a designated lead for SFT currently.

Compliments and Complaints

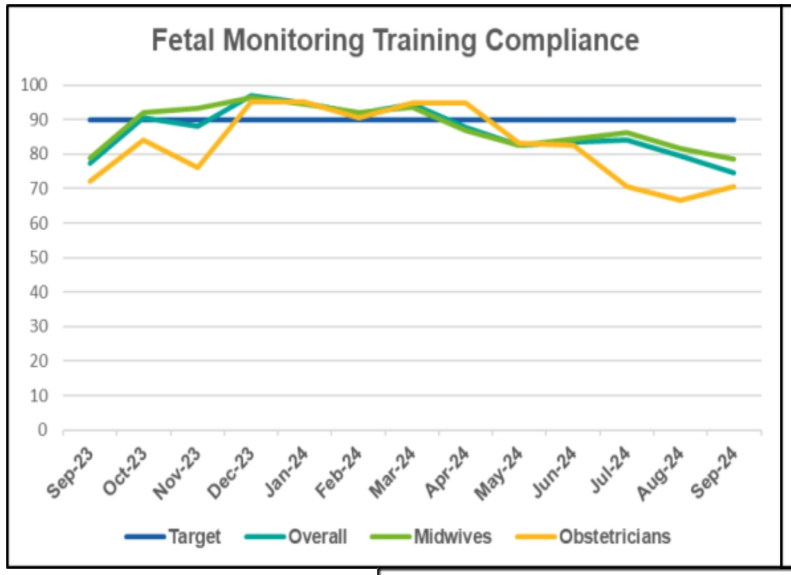
2 complaints and no concerns logged in September 24
7 compliment logged
4 SOX:

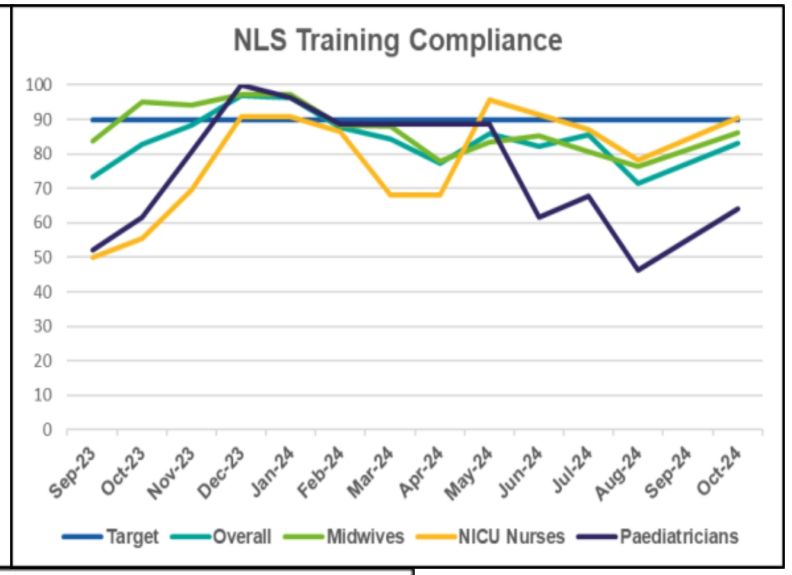
" XX worked relentlessly to secure an intrauterine transfer of one of our mums and baby. She did this with a smile on her face and is a real example of leadership and tenacity and doing what is right for the patient and the unit. She did it all with a smile on her face."

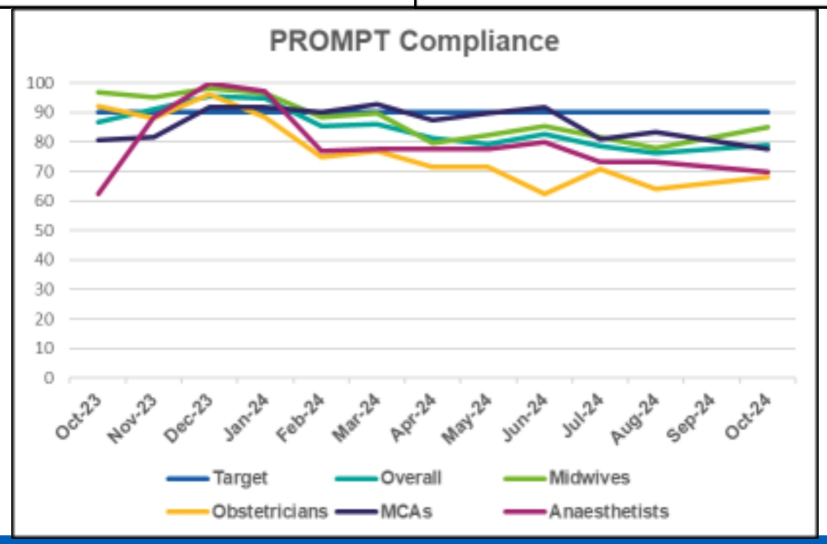
Friends and Family Test



Well-led Training







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Training

September data not collected – please see October data (01/10/2024)

Updated training plan commenced for 2024 to meet new Core Competency Framework Version 2 requirements, including training requirements for Saving Babies' Lives Care Bundle version 3.

Countermeasures/action:

- Maternity "training week" to cover all aspects for CCF version 2 and SBLCB version 3 commenced in January 2024 for midwives, MCAs and obstetricians.
- Additional skills sessions available to newly qualified staff and senior students during induction period.
- 10 training dates for each module booked in over 2024 – not during periods of high rates of annual leave
- Additional PROMPT and fetal monitoring training days created in October due to the ongoing decline of compliance in May for obstetric and anaesthetic groups.
- Rotating obstetric doctors can transfer training compliance of PROMPT and fetal monitoring.
- Additional PROMPT created in November

Risks:

- Influx of new MDT staff in September/October /November.
- Anaesthetic conflicts of priorities to attend training –plan in place from July.
- Challenges in gaining accurate safeguarding children compliance rates for Obstetric registrars, SHO's and GP trainees.

Compliance to National Guidance

Table 1. Ockenden 2022

OCKENDEN 2022		Immediate and Essential Action	Number of actions under each heading rated			
			RED	AMBER	AWAITING CLOSURE	GREEN
Sep-24	1	Workforce Planning and Sustainability	0	2	0	5
	2	Safe Staffing	0	0	0	10
	3	Escalation and Accountability	0	0	0	5
	4	Clinical Governance - Leadership	0	1	0	7
	5	Clinical Governance - Incident Investigation and Complaints	0	0	0	7
	6	Learning from Maternal Deaths	0	0	0	2
	7	Multidisciplinary Learning	0	1	0	6
	8	Complex Antenatal Care	0	3	0	2
	9	Preterm Birth	0	3	0	1
	10	Labour and Birth	0	1	2	3
	11	Obstetric Anaesthesia	0	1	0	6
	12	Postnatal Care	0	1	0	3
	13	Bereavement Care	0	3	0	1
	14	Neonatal Care	0	1	0	5
	15	Supporting Families	0	0	0	3
			0	17	2	66

Ockenden Report

Key Achievements:

- **Complex Antenatal Care –** progressing towards closing action 52, multiple pregnancies.

Next Steps for Progressions:

- Continue work towards Labour Ward Co-Ordinator training module, succession planning programme, and National Maternity self-assessment tool, by ringfencing time.

Table 2. CNST Maternity Incentive Scheme – Year 6

NHSR Maternity Incentive Scheme- Year 6 - Position September 2024				
	Description	YR 6 Submission	Comment	Current Assessment
1	Perinatal Mortality Review Tool	Compliant	Compliant at present	
2	Maternity Services Data Set	Compliant	Compliant at present	
3	Transitional Care Services	Compliant	Compliant at present	
4	Workforce	Non-Compliant	Progressing	
5	Midwifery Workforce	Compliant	Compliant at present	
6	Saving Babies Lives Bundle Version 3	Non-Compliant	On track	
7	Patient Experience	Compliant	Compliant at present	
8	Training	Non-compliant	Progressing	
9	Quality and Risk	Compliant	Compliant at present	
10	MNSI and EN	Compliant	Compliant at present	

Maternity Incentive Scheme (CNST)

Key Achievements:

- Progress being made in all areas.
- Training trajectories clearer.

Next Steps for Progressions:

- NLS in NICU/Paediatrics to be booked in to further improve trajectory.

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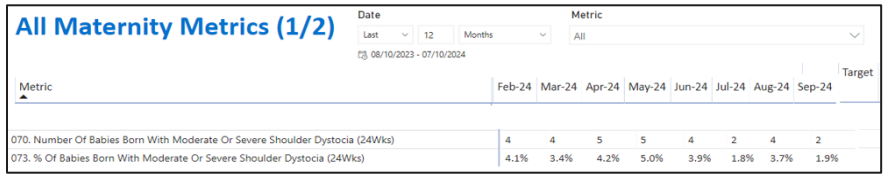
Themes – PSIRF 'continuous audits'

Salisbury NHS Foundation Trust

Shoulder Dystocia



Shoulder Dystocia

Results

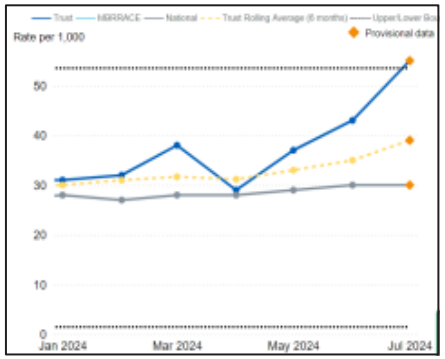
Local rates vary between 1.8% - 5% month on month (PowerBi dashboard) and have steadily been reducing. Shoulder dystocia is not reported on the national maternity dashboard.

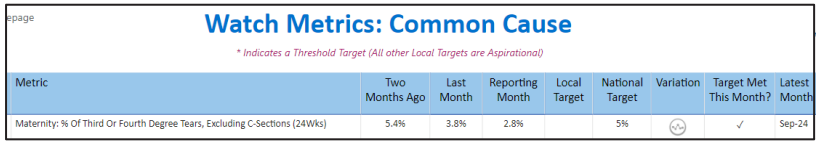
A thematic reivew has been completed of cases from 1.1.24-31.8.24. This identified some health inequalities: locally 20% of shoulder dystocia incidents involved service users of the global majority. SFT population data indicates that 12% of Maternity service users are from the global majority.

Actions

- PROMPT training
- Improve compliance with use of shoulder dystocia emergency proforma
- Datix incident investigation proforma reviewed and updated to improve reviews and audit capability. This will now include social deprivation (IMD) and ethnicity.
- Work with Inclusion Midwife as part of reducing healthcare inequalities
- 6 monthly review of rolling audit and presentation to Maternity Governance meeting.

Obstetric Anal Sphincter Injury (OASI)





Obstetric Anal Sphincter Injury (OASI)

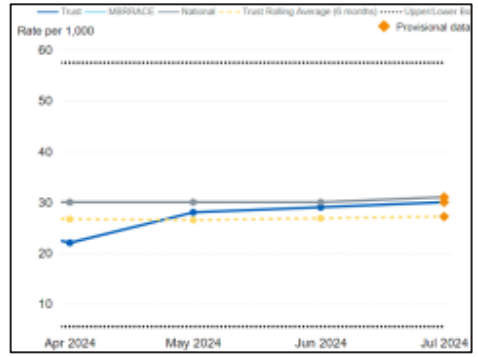
Results

Local OASI rates were above national average and local target from January-July 2024 (as noted in the national dashboard above). A thematic review was previously undertaken and recently repeated. A reduction is noted during August and September and improvement work continues presently.

Actions

- Ongoing education on mandatory study day
- Pelvic Health Specialist Midwife recruited substantively
- Themed workforce updates
- Documentation of OASI care – crib sheet for staff
- Datix incident investigation proforma reviewed and updated to improve reviews and audit capability. This will now include social deprivation (IMD) and ethnicity.

Post Partum Haemhorage ≥1.5l (MOH)



Post Partum Haemhorage ≥1.5l (MOH)

Results

During 2023 local PPH rates were above national average and local target (3%). Work has been ongoing to successful reduce this (as noted in the national dashboard above).

MOH **≥1.5l** is continuously audited as part of the Salisbury 'Patient Safety Incident Response Plan' (PSIRP) a review has been repeated. Improvement work continues as outlined in the actions below.

Actions

- Audit findings continue to be fed back to staff re PPH Risk assessment
- Prompt training
- Improve compliance with use of the PPH emergency proforma
- Implementation of RCOG Clinical Escalation toolkit
- Datix incident investigation proforma reviewed and updated to improve reviews and audit capability. This will now include social deprivation (IMD) and ethnicity.

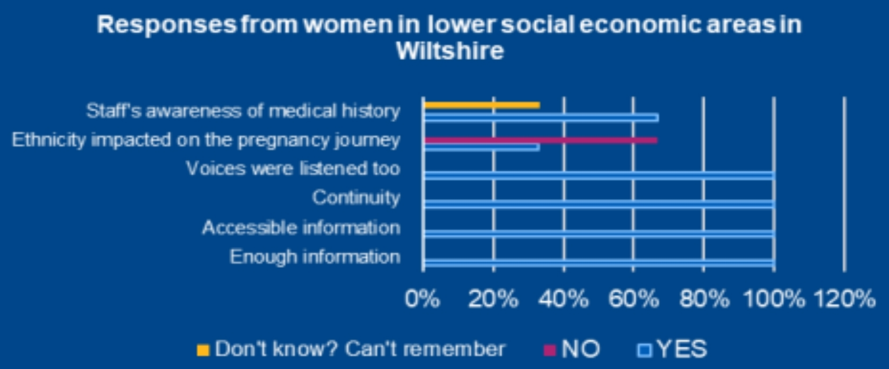
Health Inequalities Priorities

NHS Salisbury NHS Foundation Trust

1. Improving Data Quality

Working with LMNS to ensure data quality adopts a standardised approach.
Locally SFT have begun looking at birth outcomes for the global majority locally.
The Quality and Safety team will be including data as part of incident reviews for Shoulder dystocia, OASI and PPH. This will be reported via governance and triangulation meetings.

2. Local Patient Experience Survey



Action
Explore viable options for at 'the point of contact translation'. Thus, making translation services more accessible
Explore possible translation apps to be added to the website. This will enable women to access information in their preferred language
Introduction of Badger net across the BSW, will negate the need to recall maternity records from other service providers.
Further exploration into local data surrounding birth outcomes for women who racialize as black or brown.
To share the survey findings at the next A/N Quality meeting, with the focus on Translation and continuity of consultant care.

Patient Experience

Listening events:

- FMP - coproduction with the MNVP / listening event to hear the voices of pregnant women under 19 years old.
- Coproduction with the MNVP, on undertaking listening events at the Community Hubs.
- Collaboration with the MNVP on a listening event for entitled people.

Ongoing Projects:

Mapping exercise is to be undertaken in October to explore the possibility of offering women face to face parent education classes

Completed actions:

- Accessibility resource pack is now available in DAU, containing tools such as communication aids , Hospital Passports, 'My Pregnancy My Choice' accessible book.
- Maternity has secured its own designated iPad to support BSL translation.

Perinatal Leadership and Culture Programme

NHS Salisbury NHS Foundation Trust

Aims of the programme:

- To support Perinatal leadership teams to develop the conditions for a positive culture of safety and continuous improvement
- To drive change with a better understanding of the relationship between leadership, safety improvement and safety culture

Current position:

Following the initial support from a culture coach to the Quad in 2023, and several cultural conversations with staff took place in the early part of 2024, the quad have been working on:

- Completion of an initial action plan, using the themes and data from both the SCORE survey and cultural conversations
- Up-to-date Staff Questionnaire around Culture & Leadership distributed in September (due to close 20th October), recognising that some work has already happened since the initial survey, and with a high percentage of new starters in the team, wanted to ensure the themes and concerns were still current

Next steps:

- Next Quad session 25th October, to agree priorities for the action plan, incorporating the most recent questionnaire results

Report to:	Trust Board (Public)	Agenda item:	5.7
Date of meeting:	5th December 2024		

Report tile:	Perinatal Quality Surveillance - Salisbury NHSFT Maternity & Neonatal services –**October data 2024**			
Status:	Information	Discussion	Assurance	Approval
	x	x	x	
Approval Process: (where has this paper been reviewed and approved):	Divisional Governance 15.11.2024 DMT approval 12.11.2024 Clinical Governance Committee 26th November 2024			
Prepared by:	Vicki Marston –Director of Midwifery and Neonatal Services			
Executive Sponsor: (presenting)	Judy Dyos - Chief Nursing Officer			

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 6 – 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 October 2024.

The report comprises of a slide pack which has been designed collaboratively across the LMNS, ensuring that Trust Board at SFT, RUH and GWH are receiving the same metrics for review in each provider across BSW

Summary:

Perinatal Culture and Leadership Programme:

- National programme expecting every Trust in England to send a quadrumvirate team to train with quadrumvirates from other trust to share, learn and develop together

- Aims to support Perinatal leadership teams to develop the conditions for a positive culture of safety and continuous improvement.
- Work in place following score survey for SFT perinatal quadrumvirate
- Action plan to progress improvements and report to Board to ensure Executive and Non-executive team have oversight of the programme and needs of the quad.

Staffing:

- Significant Reduction in Midwifery vacancies, newly qualified midwives starting between October – December.
- Midwife to birth ratio 1:30– SFT recommended ratio 1:24 -Increased for October due to acuity and sickness increases (Newly qualified midwives remain supernumerary in October).
- 1:1 care in labour always achieved in October
- Supernumerary status of labour ward maintained 100% time.

Incidences reported as moderate.

- 7 Incidences reported as moderate.
  - 1x OASI – added to thematic review
  - 1x Undiagnosed anomaly noted during NIPE
  - 2 x Term admission to Neonatal Unit. All in process of review at present.
  - 1x Massive Obstetric Haemorrhage
  - 1x Shoulder Dystocia
  - 1x Incident reporting system not working for 5 days – leading to delay in incident review and oversight.

PMRT

- 1 x stillbirth in October – Being cared for under Fetal Medicine Unit and SFT and will be reviewed as per PMRT process as appropriate
- No cases for review in October

Training

- Anticipated compliance for PROMPT, CTG and NLS training of 90% for November 30th, 2024.

Service user and staff feedback

- Feedback received from varying sources including MNVP, safety champions, friends, and family survey and PALS
- Safety Champions meeting well attended and escalation taken for action by Exec and Non-exec safety champions, You said/We did boards updated monthly on wards.

National Guidance

- CNST compliance 9 out of 10 for 2023. MIS year 6 published in April 2024.
  - ESCALTION: Concerns remain around compliance with Saving Babies Lives. Work ongoing around Saving babies lives Vs 3.
  - Confirmation from LMNS of agreed percentage to be reached to show compliance for NHSR CNST Maternity Incentive Scheme. And agreement with SFT trajectory around 'best endeavours.

-

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

Perinatal Quality Surveillance
November 2024 *(October Data)*

Maternity and Neonatal Unit

Salisbury Foundation Hospital

Safe: Maternity & Neonatal Workforce

Salisbury NHS Foundation Trust

	Target	Threshold		May 24	Jun '24	Jul 24	Aug '24	Sept '24	Oct'24	Comment
		Green	Red							
Midwife to birth ratio	1:24	1:24	>1:26	1.28	1:25	1:25	1:25	1.30	1:30	Ratio increased this month due to increase in expected births and acuity and continued MW sickness
Compliance with supernumerary Status of LW Coordinator %	0	0	>1	100%	100%	100%	100%	100%	100%	
1:1 care not provided	0	0	>1	0	0	0	0	0	0	
Confidence factor in Birthrate+ recording	60%	>60%	<50%	75.8%	75.5%	80.11 %	84.97 %	83.3 %	83.87 %	Percentage of possible episodes for which data was recorded. Audit commended December 23.
Consultant presence on LW (hours/week)	40	40		40	40	40	40	40	40	
Daily multidisciplinary team ward round	90%	>90%	<80%	100%	100%	100%	100%	100%	100%	
Consultant non-attendance when clinically indicated (in line with RCOG guidance)	0	0	>1	0	0	0	0	0	0	

Is the standard of care being delivered?

- Supernumerary Labour Ward coordinator status achieved 100% time
- 1:1 care in labour achieved 100% of time

What are the top contributors for under/over-achievement?

- Available workforce numbers this month show an increase due to numbers of newly recruited staff and Band 5s moving into Band 6 positions.
- The Midwife to Birth ratio increased this month due to increase in expected births and acuity and a rise in some long term sickness continued.
- Midwifery fill rates have been affected by an increase in short term sickness..

Table 1. Total WTE vacancy and availability to work - by role

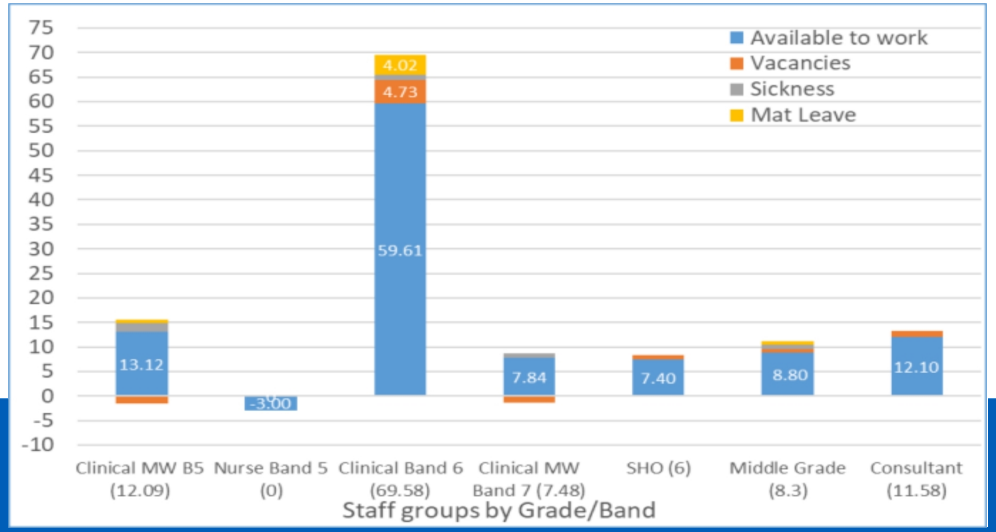
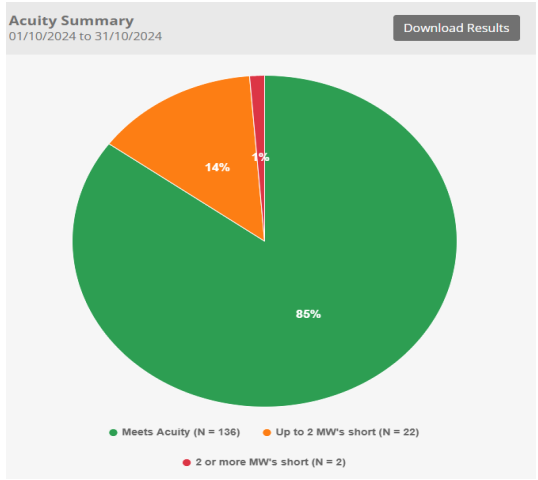


Table 2. Average midwife shift fill rates

		May 24	Jun 24	Jul '24	Aug '24	Se '24	Oct '24
Midwives	Day	97.2	97.3%	97.9%	97.3%	97.6 %	93.95%
	Night	99.3%	98.9%	98.5%%	99.5%	96.8 %	96.50%
MCA/MSWs	Day	98.6%	97.3%	90.8%	94.6%	92.8 %	92.61%
	Night	98.9%	91.2%	97.8%	92.5%	88.7 %	91.84%

Table 3. Acuity by RAG vs staffing data



Safe: Perinatal Mortality Review Tool (PMRT)

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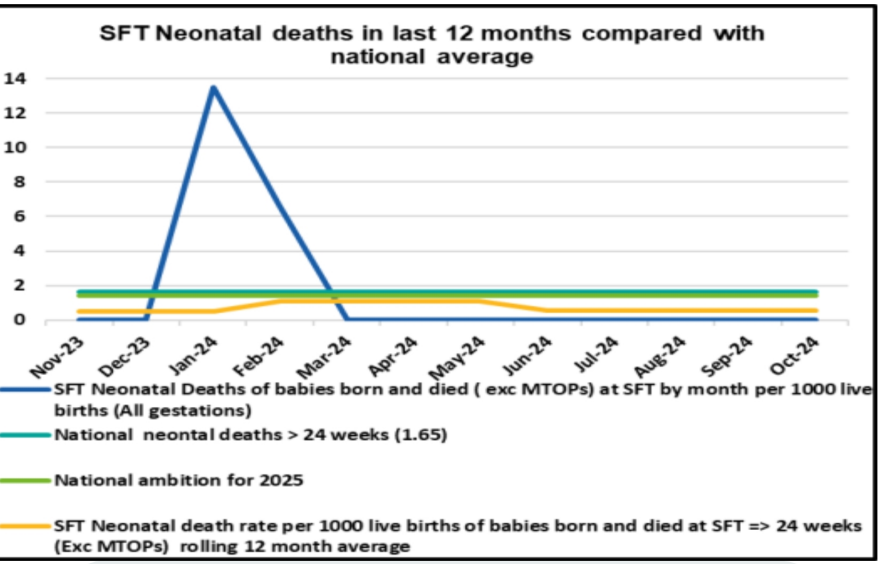

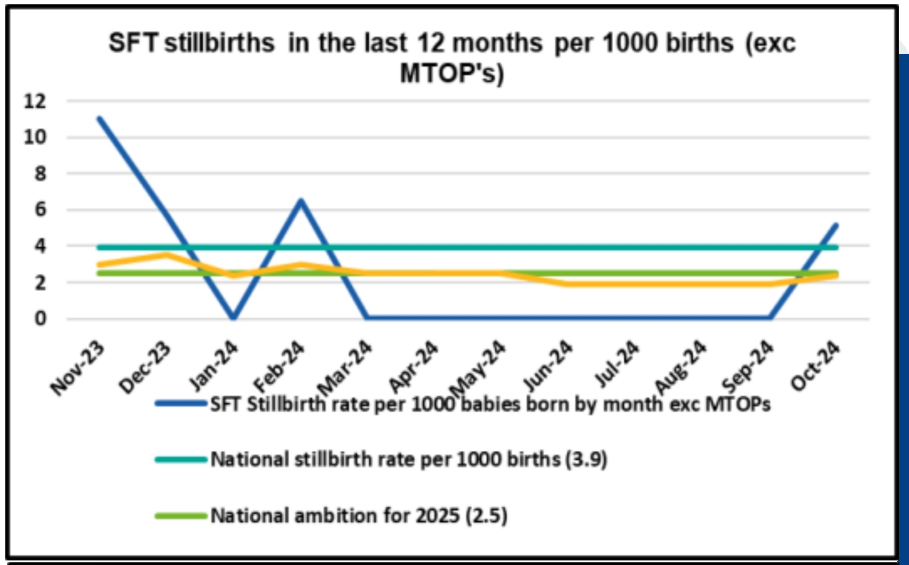

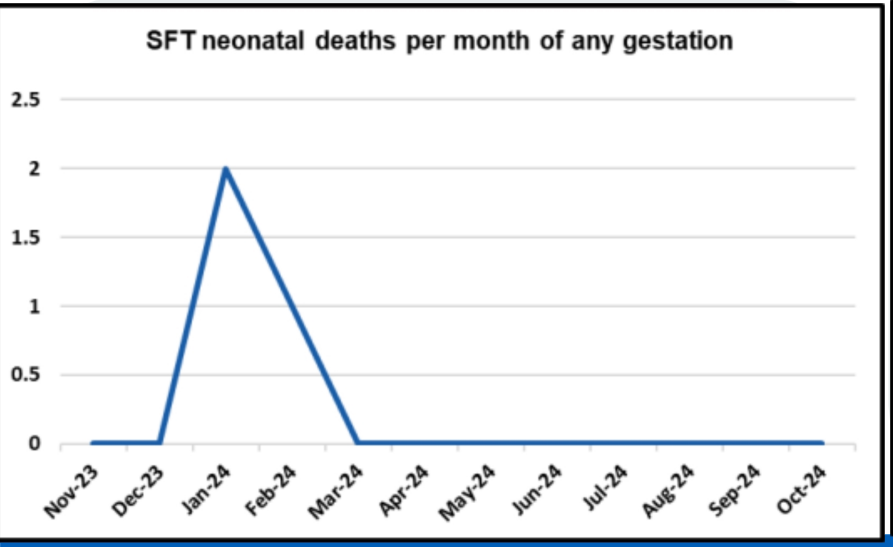

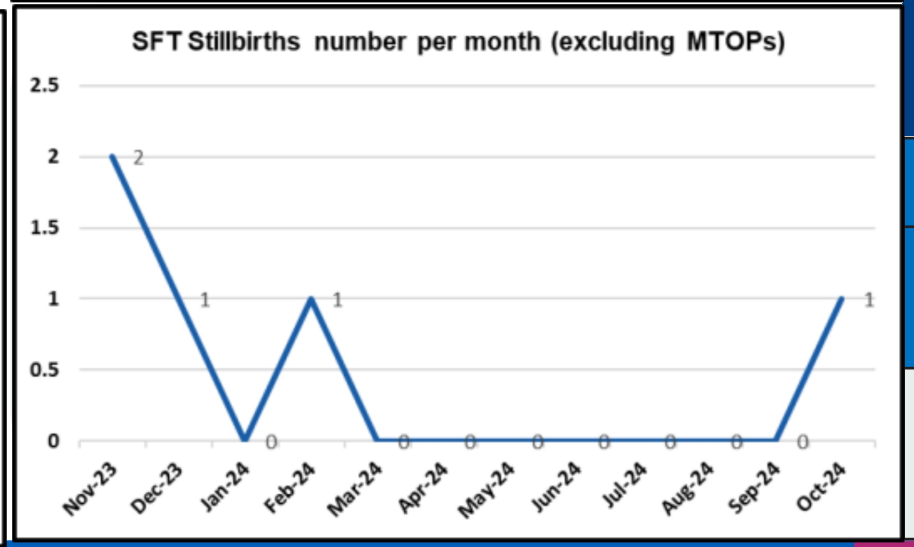

- All perinatal deaths have been reported using the Perinatal Mortality Review Tool (PMRT). PMRT reporting is mandated by MIS Safety Action 1 for year 6. A quarterly update paper is shared with the board.
- Neonatal deaths of any gestation are a registerable birth and have been included in these numbers.
- Stillbirth rate is presented per 1000 births for national benchmarking, therefore the number presented on the graphs will not automatically correlate to direct numbers per month.
- There were 2 perinatal losses in October > 12 weeks-
- 1 MTOP at 24+4 weeks for fetal anomalies, this is a registerable stillbirth by law however not counted in the stillbirth rates shown.
- 1 stillbirth at 25 weeks

PMRT Action Plans for Salisbury Foundation Trust – October 2024 review

PMRT case ID	Issue text		Action plan text	Person responsible	Target date
	There were no cases to review under PMRT in September.				

PMRT grading of care – Key

NHS Salisbury NHS Foundation Trust

A - The review group concluded that there were no issues with care identified up the point that the baby was confirmed as having died
B - The review group identified care issues which they considered would have made no difference to the outcome for the baby
C - The review group identified care issues which they considered may have made a difference to the outcome for the baby
D - The review group identified care issues which they considered were likely to have made a difference to the outcome for the baby

A- The review group concluded that there were no issues with care identified for the mother following confirmation of the death of her baby
B - The review group identified care issues which they considered would have made no difference to the outcome for the mother
C - The review group identified care issues which they considered may have made a difference to the outcome for the mother
D - The review group identified care issues which they considered were likely to have made a difference to the outcome for the mother

Case Ref	Date	Category	Incident	Outcome/Learning/Actions	HSIB Reference	SI? Reference
				The were no cases ready for PMRT review in October.		

INCIDENTS: Moderate Incidents and PSRs

NHS Salisbury NHS Foundation Trust

DATIX Incidents classified as moderate harm and above at month end

Case Ref (DATIX no)	Date of incident	Category	Incident Summary	Comments	Commissioned Y / N	MNSI ref no.?	PSII ref no.?
169941	04/10/24	Moderate	Undiagnosed abnormality identified during NIPE	Clinical review being undertaken by the screening lead midwife	**N**		
170597	25/10/24	Moderate	Unexpected Term Admission to NNU and transferred to Tertiary Unit	Clinical review being undertaken by the screening lead midwife due to undiagnosed abnormality.	**N**		
170630	26/10/24	Moderate	Shoulder Dystocia	Case currently awaiting notes and review with potential reclassification and addition to rolling audit	**N**		
170673	28/10/24	Moderate	MOH 1.6L	Case currently awaiting notes and review with potential reclassification and addition to rolling audit	**N**		
170736	28/10/24	Moderate	Incident reporting system was not working for 5 days	The Q&S have been unable to review or view cases leading to a delay in reviewing incidents.	**N**		
170692	30/10/24	Moderate	Unexpected Term Admission to NNU	Case currently awaiting notes and review with potential reclassification and addition to rolling audit			
170760	31/10/24	Moderate	OASI	Case currently awaiting notes and review with potential reclassification and addition to rolling audit	**N**		

INCIDENTS: Investigation update

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Ongoing Maternity & Neonatal Reviews

Case Ref (DATIX)	Date	Category	Incident	Outcome/Learning/Actions
CCR 613	19/11/2023	Moderate	Eclampsia	Draft report sent to staff for factual accuracy and awaiting feedback. **Next steps**: Finalise report and draft action plan before sending to DMT, CRG and Exit (for approval)
PSII 162915	29/01/2024	Moderate	Preterm baby transferred to tertiary unit for cooling	Draft report received. Factual accuracy replies returned.
MNSI 163944	04/03/2024	Moderate	Baby transferred to tertiary unit for cooling	Final report received and awaiting a date for tripartite meeting. **Next steps:** Action plan to be drafted and sent to DMT, CRG readership panel and exit (for approval).

Responsive

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MNVP Service User feedback (Oct 24)

Key achievements and feedback:
No feedback provided this month. The MNVP will be sharing the feedback from listening events at the new Triangulation meeting, which is scheduled quarterly.

Next steps for progression:

- Continue to roll out personalised care planning training. Update: We have received the delivery of the 'My Maternity Choice' booklets. Comms have been shared with the workforce in October, and the introduction to the booklets are to be added to the maternity website.
- Exploration of translation services- the Maternity Department continues to work with Wessex Health innovation on the application of a new translation device. As a Trust we are working towards adding a translation tool bar to the website.
- Working in collaboration with the MNVP and the Family Nurse Practitioner a listening event has been scheduled in November 24, in order to capture the voices of our younger clients (under 19yrs).

Safety Champions/ Staff Feedback

Items for escalation:

Meal trolley for the NNU.

Compliments and Complaints

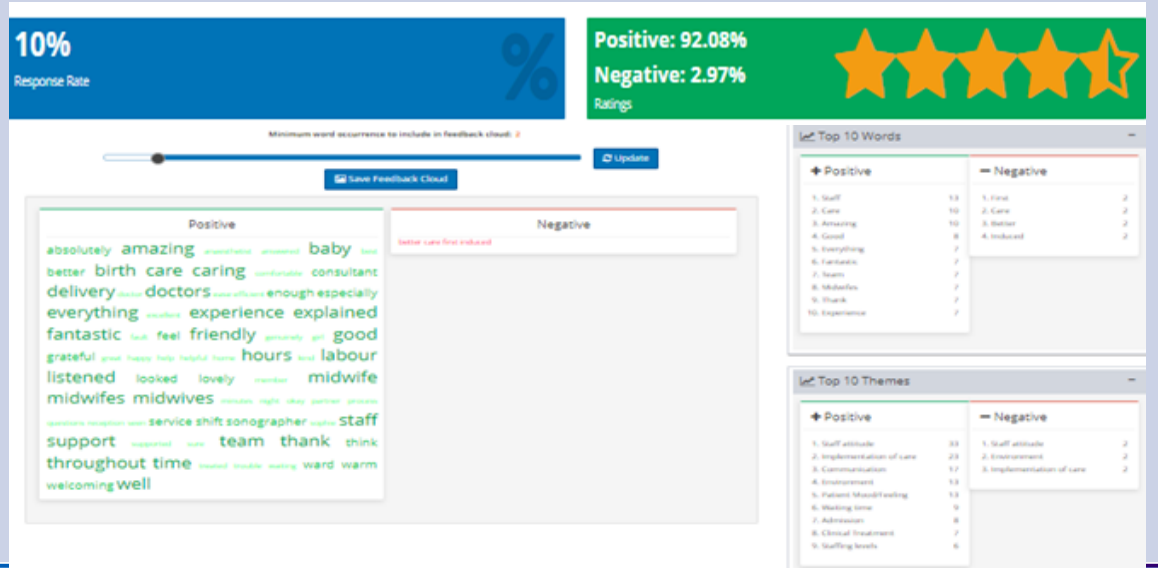
1 complaints and no concerns logged in October 24

2 compliment logged

4 SOX:

"Fran produced a couple of very well written pieces of work within a very short period of time which supported the Maternity team with their work for the CQC. Fran understood what was required and achieved it within the time frame and to a high standard."

Friends and Family Test



Well-led Training

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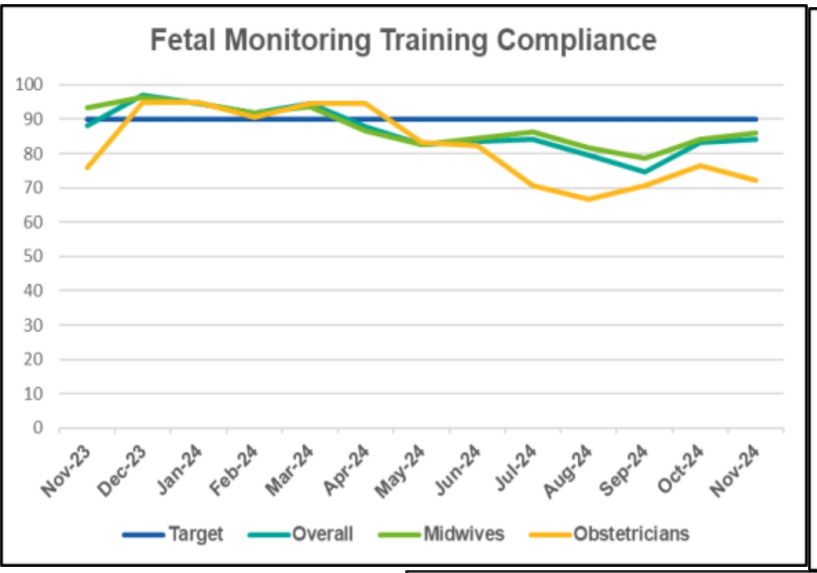

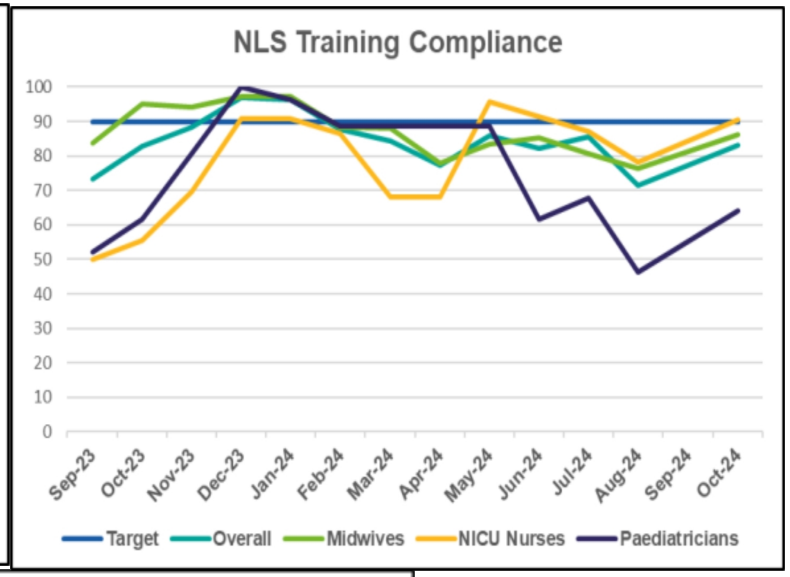

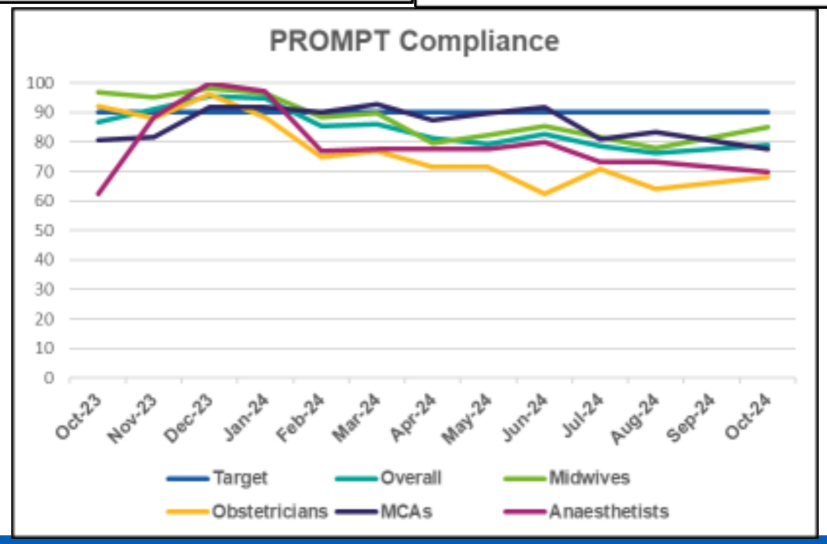

Training

Updated training plan commenced for 2024 to meet new Core Competency Framework Version 2 requirements, including training requirements for Saving Babies' Lives Care Bundle version 3.

Countermeasures/action:

- Maternity "training week" to cover all aspects for CCF version 2 and SBLCB version 3 commenced in January 2024 for midwives, MCAs and obstetricians.
- Additional skills sessions available to newly qualified staff and senior students during induction period.
- 10 training dates for each module booked in over 2024 – not during periods of high rates of annual leave.
- Additional PROMPT and fetal monitoring training days created in November due to the ongoing decline of compliance over the summer for obstetric and anaesthetic groups.
- Rotating obstetric doctors can transfer training compliance of PROMPT and fetal monitoring with sign off of agreed evidence.

Risks:

- Influx of new MDT staff in September/October /November.
- Anaesthetic conflicts of priorities to attend training –plan in place from July.
- Challenges in gaining accurate safeguarding children compliance rates for Obstetric registrars, SHO's and GP trainees.

Compliance to National Guidance

Table 1. Ockenden 2022

OCKENDEN 2022		Immediate and Essential Action	Number of actions under each heading rated			
			RED	AMBER	AWAITING CLOSURE	GREEN
Oct-24	1	Workforce Planning and Sustainability	0	2	0	5
	2	Safe Staffing	0	0	0	10
	3	Escalation and Accountability	0	0	0	5
	4	Clinical Governance - Leadership	0	1	0	7
	5	Clinical Governance - Incident Investigation and Complaints	0	0	0	7
	6	Learning from Maternal Deaths	0	0	0	2
	7	Multidisciplinary Learning	0	0	0	7
	8	Complex Antenatal Care	0	2	1	2
	9	Preterm Birth	0	3	0	1
	10	Labour and Birth	0	1	0	5
	11	Obstetric Anaesthesia	0	1	0	6
	12	Postnatal Care	0	1	0	3
	13	Bereavement Care	0	2	0	2
	14	Neonatal Care	0	1	0	5
	15	Supporting Families	0	0	0	3
			0	14	1	↑70

Ockenden 2022

Key Achievements

- 4 actions closed in October

Next steps for progression

- Work progressing well, the remaining actions are more complex so it is taking longer to see formal closure.
- Decisions required re National Bereavement Care Pathway implementation. Progress is being made with action 52 around complex antenatal care

Table 2. CNST Maternity Incentive Scheme – Year 6

	NHSR Maternity Incentive Scheme- Year 6 - Position October 2024			
	Description	YR 6 Submission	Comment	Current Assessment
1	Perinatal Mortality Review Tool	Compliant	Compliant at present	
2	Maternity Services Data Set	Compliant	Compliant at present	
3	Transitional Care Services	Compliant	Compliant at present	
4	Workforce	Non-Compliant	Progressing	
5	Midwifery Workforce	Compliant	Compliant at present	
6	Saving Babies Lives Bundle Version 3	Non-Compliant	On track	
7	Patient Experience	Compliant	Compliant at present	
8	Training	Non-compliant	Progressing	
9	Quality and Risk	Compliant	Compliant at present	
10	MNSI and EN	Compliant	Compliant at present	

Maternity Incentive Scheme (CNST)

Key Achievements:

- Progress has continued in all areas with any challenges escalated swiftly for support at CNST meetings.
- Additional training dates have been added throughout October and November to increase compliance (SA8)
- It is anticipated that workforce trajectories will support full compliance (SA4)
- SBL is making good progress (SA6)

Next Steps :

- Evidence to be submitted 30th November.

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Themes

PSIRF ‘continuous audits & DATIX

Salisbury NHS Foundation Trust

Previous Report: current SFT data and actions were presented in October for Shoulder Dystocia, OASI and PPH ≥1500mls. All are monitored continually as part of the Trust PSIRP 'continuous rolling audits'. There has been a reduction in rates of PPH, OASI and Shoulder dystocia.

Future Plans: there is currently thematic work around medication errors and VTE risk assessments which will be reported in December.

Health Inequalities Priorities

NHS Salisbury NHS Foundation Trust

Equality Data:

We continue to wait for directions from the LMNS on what equality data is required, in order to maintain a standardised approach to data reporting across the BSW. However, we are starting to look at our local data around birth outcomes for women from the global majority groups , and ethnicity data from maternity services such as Bereavement, mental health, PSR/ PSIR, and pelvic health.

Translation service:

At a Trust level we are working towards the implementation of a translation bar to the Trust website. It was anticipated that all patient information leaflets would be translated into the top 5 requested languages, however, this was unsustainable due to the translation costs.

We continue to explore 'at the point of contact' translation services. We hope to purchase 10 PocketTalk translation devices (following positive feedback from trials undertaken in Nottingham and Southampton primary care).

Patient Experience

Listening events:

- FMP - coproduction with the MNVP / listening event to hear the voices of pregnant women under 19 years old. This is to be held in November 2024.
- Coproduction with the MNVP, on undertaking listening events at the Community Hubs.
- Collaboration with the MNVP regarding a listening event for 'entitled people'.

Ongoing Projects:

Mapping exercise is to be undertaken in October to explore the possibility of offering women face to face parent education classes. Work is ongoing to establish a pathway to enable all Hubs to offer in person education classes.

Perinatal Leadership and Culture Programme

NHS Salisbury NHS Foundation Trust

Aims of the programme:

- To support Perinatal leadership teams to develop the conditions for a positive culture of safety and continuous improvement.
- To drive change with a better understanding of the relationship between leadership, safety improvement and safety culture.

Current position:

Following the initial support from a culture coach to the Quad in 2023, and several cultural conversations with staff took place in the early part of 2024. Since the quad have been working on:

- Completion of an action plan, using the themes and data from both the SCORE survey, cultural conversations and up to date staff questionnaire developed by the Quad around Culture & Leadership which closed on 20th October. The Quad met on 25th October to prioritise actions developed from themes from these.
- Trust staff survey currently in progress - Quad to review results and align with current work.

Next steps:

- Complete top priority actions identified from Quad meeting on 25th October (including a pre-Christmas engagement event).
- Present actions and progress at November Safety Champions meeting.