Bundle Trust Board Public 3 October 2024

1 OPENING BUSINESS

1.1 Welcome and Apologies

1.2 Declaration of Interests, Fit & Proper / Good Character

1.3 10:00 - Minutes of the previous meeting held on 5th September 2024
For approval
1.3 Draft Public Board mins 5 September 2024 v2

1.4 10:05 - Matters Arising and Action Log
1.4 Public Trust Board Action Log
1.4a Action Log Appendix TB1 5_9_2.1 deteriorating patients JDy

1.5 10:10 - Chair's Business
Presented by Ian Green
For information

1.6 10:15 - Chief Executive Report
Presented by Lisa Thomas
For information
1.6 October CEO Board paper

2 ASSURANCE AND REPORTS OF COMMITTEES

2.1 10:25 - Integrated Performance Report to include exception reports
Presented by Melanie Williams
For assurance
2.1a IPR Cover Sheet - Trust Board 2024-10
2.1b Integrated Perfomance Report - October 2024 FINAL

2.2 10:50 - Audit Committee 19th September 2024
Presented by Richard Holmes
For assurance
2.2 240919 Audit Committee Escalation Report

2.3 10:55 - Trust Management Committee 25th September 2024
Presented by Lisa Thomas
For assurance
2.3 TMC escalation report Oct Board

2.4 11:00 - Finance and Performance Committee 24th September 2024
Presented by Debbie Beaven
For assurance
2.4 Finance and Performance Escalation Report Sept 2024

2.5 11:05 - Clinical Governance Committee 24th September 2024
Presented by Anne Stebbing
For assurance
2.5 CGC escalation report 24 Sept 2024

2.6 11:10 - People and Culture Committee 26th September 2024
Presented by by Eiri Jones
For assurance
2.6 PCC Escalation Report to Trust Board from PCC September 2024 to Board October 2024

3 STRATEGY AND DEVELOPMENT

3.1 11:15 - Improving Together Update Report Q2
Presented by Alex Talbott
For assurance
3.1a Cover sheet Improving Together Quarterly Trust Board Report Oct 2024 V2
3.1b Improving Together Quarterly Trust Board Report Oct 2024 V2

4 GOVERNANCE

4.1 11:25 - Register of Seals

Presented by Fiona McNeight
For assurance

4.1 Register of Seals

4.2 11:30 - Review of Constitution
Presented by Fiona McNeight
For assurance

4.2a Cover Sheet Constitution Review 2024
4.2b NEW - Draft Constitution 2024 V2

4.3 11:35 - 2025 Trust Board and Committee dates
Presented by Fiona McNeight
For assurance

4.3a cover sheet Board and Committee Dates 2025_6
4.3b 2025_26 Trust Board and Committee Dates

5 FINANCIAL AND OPERATIONAL PERFORMANCE

5.1 11:40 - Quarterly Strategy Update
Presented by Lisa Thomas
For assurance

5.1 2024-10-03_Quarterly-Strategy-Update

5.2 11:50 - Estates Technical Service Update
Presented by Mark Ellis
For assurance

5.2 Estates Report Sept 2024

5.3 12:00 - BREAK 30 MINUTES

6 PEOPLE AND CULTURE

6.1 12:30 - Health and Safety Quarter One Report - deferred from September
Presented by Melanie Whitfield
For information

6.1a H&S report cover sheet - Q1 Public Board
6.1b HS Report Q1 FY25

6.2 12:40 - Organisational Development and People Annual Report - deferred from September
Presented by Melanie Whitfield
For assurance

6.2a 20240926-ODP Annual Report-IC
6.2b 20240915-ODP Annual Report FY2324-FINAL

6.3 12:50 - Guardian of Safe Working Annual Report
Presented by Duncan Murray
For assurance

6.3 GoSW annual report 2024 version 2

6.4 13:00 - WRES and WDES Annual Report and Action Plan
Presented by Melanie Whitfield
For assurance

6.4a 20240926-WRES & WDES 2023-24 AR and Action Plan Cover Sheet
6.4b 20240926-WRES Annual Report and Action Plan 2023-24 Final
6.4c 20240926-WDES Annual Report and Action Plan 2023-24 Final

7 QUALITY AND RISK

7.1 13:10 - Research Annual Report - deferred from July
Presented by Duncan Murray
For assurance

7.1a Research Annual Report Cover Sheet Sep2024 (002) (002)
7.1b Research Annual Report_TK27092024 (2)

7.2 13:20 - Learning from Deaths Report Q1
Presented by Duncan Murray
For assurance

7.2a Cover Sheet - Sept 24 LfD CGC

7.2b 202412 Q1 LFD Report 2024-25v1.1

7.3 13:30 - Perinatal Quality Surveillance Report August (July data)
Presented by Abi Kingston and Katherine Barrio
For assurance
7.3a Front sheet Perinatal quality surveillance August 2024 (July 2024 data)
7.3b Perinatal Quality Surveillance AUGUST 2024 Slides (July data)

7.4 13:35 - Perinatal Quality Surveillance Report September (August data)
Presented by Abi Kingston and Katherine Barrio
For assurance
7.4a Front sheet Perinatal quality surveillance Sept (Aug data)
7.4b Perinatal Quality Surveillance Sept 2024 Slides (Aug data)

7.5 13:40 - Maternity Quality and Safety Report Quarter 1
Presented by Abi Kingston and Katherine Barrio
For assurance
7.5a Front sheet Q and S report Q1 23 24
7.5b FINAL Maternity and Neonatal Safety Report Q1 Apr-June 24 v1.1
7.5c APPENDIX 1 - PMRT Report Q1 Apr-June 24
7.5d APPENDIX 2 - Training Report Q1 Apr-June 24
7.5e APPENDIX 3 - Patient and Staff Experience Report Q1 Apr-June 24
7.5f APPENDIX 4 - Saving Babies Lives Report Q1 Apr-June 24
7.5g APPENDIX 5 - Workforce Report Q1 Apr-June 24
7.5h APPENDIX 6 - ATAIN TC Report Q1 Apr-June 24

7.6 13:45 - Maternity and Neonatal Staffing Report
Presented by Abi Kingston and Katherine Barrio
For assurance
7.6a Front Sheet Bi-annual Maternity Neonatal Staffing Report September 2024
7.6b Midwifery and Neonatal Nursing Staffing Report September 24

7.7 13:50 - Board Assurance Framework and Corporate Risk Register
Presented by Fiona McNeight
For assurance
7.7a Board BAF report October 2024
7.7b Board Assurance Framework Sept 2024 V2
7.7c Corporate Risk Register September 2024
7.7d Corporate Risk Tracker September 2024 v1

7.8 14:00 - Risk Appetite
Presented by Fiona McNeight
For assurance
7.8a Trust Board Risk Appetite Cover Sheet Oct 2024
7.8b Risk Appetite Definitions September 2024 V2 KN

7.9 14:10 - Patient Feedback Report Q1
Presented by Judy Dyos
For assurance
7.9 Patient Experience - Patient Feedback Report Q1 24-25 v1.0

7.10 14:20 - Q1 Risk Management Report
Presented by Judy Dyos
For assurance
7.10a Q 1 Risk management Report for TB
7.10b Q1 Risk Management Report

7.11 Inpatient Survey Results - deferred to December

8 CLOSING BUSINESS

8.1 14:30 - Agreement of Principal Actions and Items for Escalation

8.2 14:35 - Any Other Business

8.3 14:40 - Public Questions

8.4 Date next Public meeting: 5th December 2024

9 Resolution

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

Salisbury NHS Foundation Trust

Draft
Minutes of the Public Trust Board meeting held at 11:15am on Thursday 5th September 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
Paul Cain (PCa)	Associate Non-Executive Director
Vicki Marston (VM)	Clinical Director, Women and Newborn (for item 4.1)
Abi Kingston (AK)	Director of Midwifery (for items 4.2 and 4.3)
Philip Rhoades (PR)	Chaplain (for item 1.2)
Thalina Wijetung (TW)	Visiting fellow
Jayne Sheppard (JS)	Lead Governor (observer)
Jane Podkolinski (JP)	Governor (observer)
Susan Snoxall (SS)	Governor (observer via Teams)

ACTION

TB1 5/9/1 **OPENING BUSINESS**

IG referred to the Improving Together Program and noted the Trust used 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.

TB1 5/9/1.1 **Presentation of SOX (Sharing Outstanding Excellence) Certificates**

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

July SOX of the month –

- Kelly Hogan and Liam Gondelle, Emergency Department

- Helen Thake, IT

July Patient Centred SOX –

- Laura Pollard, Plastic Outpatients

August SOX of the month –

- Emergency Department, Critical Care Outreach, Security
- Sarum Ward

August Patient Centred SOX –

- Louise Morris, Laverstock Ward
- James Johnstone, Housekeeping

IG congratulated all the staff that had been recognised in July and August on behalf of the Board and also thanked all the staff that had been nominated for their hard work, diligence, and innovation. The SOX presented reflected the genuine care delivered in the Trust.

TB1 5/9/1.2 **Staff Story**

MW introduced Philip Rhoades (PR), Trust Chaplain, to the meeting. He leads a team of 9 part time chaplains, who alongside their work in their local communities, provide a 24 hour, 7 days a week service to both patients and staff at the hospital. The Chaplaincy team are funded partly by the Trust and the Stars Appeal. PR has sought to broaden the remit of team to ensure inclusivity and enhanced support, providing valuable insights and wellbeing support to our staff.

PR described the work he and his team provide to staff. This has been a particular focus over the last two years and over a 12-month period the chaplaincy team made contact with 7115 members of staff. These include active support on wards, everyday catch ups, discussions in corridors etc.

There are lots of visits to the chapel by different faiths and there has been an increase of referrals through staff The chaplaincy has tried to make the service inclusive and not just for the religious. The team has worked to share end of life training and bereavement training with all HCAs and nurses. There is an assigned chaplain to every ward to enhance relationships and with each staff network. PR felt that earlier input in induction would be useful to highlight the service to new staff.

The team observe the stresses and challenges from staff working in hospital and particularly for those international staff who miss their home and family.

PR described the broad depth of support provided and shared some specific stories of support provided to different members of staff.

Discussion:
The Board discussed the important service offered and thanked PR and the team for their ongoing work to support the Trust, the additional capacity and focus of the Chaplaincy team was evidently of considerable psychological and spiritual wellbeing.

TB1 5/9/1.3 **Welcome and Apologies**

IG welcomed everyone to the meeting and noted no apologies had been received.
DM and AT were welcomed to the public Board in their new roles of Interim CMO and Director of Improvement.

TB1 5/9/1.4 **Declarations of Conflicts of Interest, Fit and Proper/Good Character**

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

TB1 5/9/1.5 **Minutes of the Part 1 (Public) Trust Board meeting held on 4th and 22nd July 2024**

IG presented the public minutes from 4th July 2024 and the following changes were noted:

- On p12. there is reference to IG making comments but not present in the meeting at that point. KN to check and amend.

IG presented the public minutes from 22nd July 2024 and they were agreed as a correct record of the meeting.

Decision:
Subject to these changes the minutes were approved.

TB1 5/9/1.6 **Matters Arising and Action Log**

FMc presented the action log and noted the following update:

- **TB1 4/7/2.5 Finance and Performance Committee 25 June -** Paper setting out key financial risks, mitigation, and controls, including cash flow forecast went to F&P 30/07. H2 cash requirements to be set out in paper to board Oct'24.
- **TB1 4/7/2.6 Clinical Governance Committee –** The report regarding the recommendations in the infected blood enquiry report and the impact on the Trust is due back at the next Board.
- **TB1 4/7/3.1 Quarterly Maternity and Neonatal Quality and Safety Report Q4 -** Deep dive regarding severe tears to September Clinical Governance Committee.

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

TB1 5/9/1.7 **Chair's Business**

IG noted that further to the Group Model decision to be taken later in the meeting and the potential leadership changes this was likely to be LT's last meeting in her formal CEO role. IG gave thanks to LT for her ongoing support and commitment to the Trust, noting her outstanding leadership in the last 8 months.

The update was noted.

TB1 5/9/1.8 **Chief Executive's Report**

LT provided an update noting the following key points:

- The Trust is in its 'Thank you week' celebrating Trust staff. LT gave thanks to the communications team for their hard work organising all the events taking place this week.
- LT reflected on the forthcoming Darzi Review. The focus is likely to be on integration and care in terms of the prevention agenda and this is what NHS care should be centred on.

The Board noted the update.

TB1 5/9/2 ASSURANCE AND REPORTS OF COMMITTEES

TB1 5/9/2.1 Integrated Performance Report (IPR) (M4)

NP presented the Integrated Performance Report which provided a summary of Month 2 (May 2024). NP noted the purpose of the report and highlighted the following key points:

- The improvement in retention is holding steady, and there are improvements in divisions' driver metrics related to BT objectives.
- Patient deterioration shows a range of improvements across key safety and quality metrics. The team is exploring how to report this BT objective more effectively.
- Value for patients, measured on a 12-month rolling average, is starting to show improvements. However, it's noted that these don't necessarily align with financial improvements.
- The target of having no patients waiting over 65 weeks for treatment by September is close to being achieved, with only about 21 patients remaining.
- The Elective Recovery Fund (ERF) target is at 113%, and year-to-date averages are at 107%. Theatre utilisation requires significant work and focus.
- For urgent care, the team is reviewing the A3 for ED to explore different ways of working. A new slide on No-Criteria to Reside (NCTR) patients shows an average of 82 in July. A deep dive on NCTR is scheduled at the Finance and Performance Committee in September.
- The cancer target was 70%, and current performance is at 78%, with August reaching 79.8%, showing significant improvement. The region is recommending that the Trust come out of tiering for cancer.
- Overall, while there are still challenges, there is a general direction of improvement.

Discussion:
IG queried the NCTR position, seeking to understand the measures in place.

NP explained that internal delays in getting referral data out of the hospital have improved. Continued shifting of capacity has led to a series of changes, resulting in reduced average pathway times. However, there are still opportunities to further reduce these times. More patients are coming through the system, and much of the work is focused on BSW (Bath, Swindon and Wiltshire), although many waiters are not in BSW at the moment. There has been significant uptake in system ownership, with weekly conversations in

place to drive improvements. DBe noted that F&P has requested an articulation of what is going well and where the Trust would be without some of the current challenges.

It was noted that the four-hour stroke target has been subject to significant focus, with hopes to see a continuation of the positive trajectory.

AS queried whether the admitted conversion rate is increasing. NP confirmed that the Trust is still using escalation beds and seeing 11% more patients attending ED than last year. Whilst improvements have helped, the increase in patients has placed more demand on beds.

RH focused on the patient deterioration metric, where the target is 50%, and questioned why the target is low and what actions are being taken to change this narrative. JDy explained that the data is not fully reflective of the improvements, as staff have not yet seen the full capability of the POET system. The focus is on training staff to use POET effectively and on a greater number of patients to see the impact. The time when a patient is recognised as deteriorating and the number of unexpected admissions to ICU have both decreased. **ACTION: JDy suggested bringing back additional data on improvements, including the number of arrests.** **JDy**

EJ requested further assurance on the approach to prevention of harms. JDy explained that there is a responsive approach to taking immediate action and conducting daily reviews of incidents. Each division has a shared learning forum, which is shared across the organisation periodically. **ACTION: EJ suggested a further conversation at the CGC regarding the details of this process.** **JDy**

PCa questioned whether sufficient work has been done and if the Trust is waiting for improvements to show in the performance data, or if further work is needed. PC explained that there has been a shift from traditional improvement methodologies. The focus is now on describing problems well and encouraging teams to come up with small, incremental improvements. PC described the process of improvement through engine room discussions and PRMs (Performance Review Meetings). PCa inquired about resources to continue this work, to which PC responded that they are able to channel resources while reviewing if there are more efficient ways to work. IG noted that the BT objectives have been collectively agreed by the Board, emphasising that they have approved the objective, not the specific metric.

AS emphasised that the Board needs assurance from evidence and triangulation, suggesting that one metric might not be the best way to evidence patient deterioration. AS encouraged further transparency, recommending annotating the chart and being open to changing measurables in the spirit of Improving Together.

IG discussed the financial plan regarding income and expenditure, emphasising the need for an approach to return to a more sustainable position. Work on triangulation and metrics creating value for patients was highlighted. ME noted the importance of ensuring focus on the right areas, including delivering against elective recovery, managing the number of open beds, and addressing medical agency use. It was noted that if current trends

continue without further intervention, the Trust would be £12m off plan at year-end, with the biggest risk being the bed base.

DBe emphasized the need for focused deep dives in areas that will have the biggest impact, acknowledging the risk. DBe suggested that the Cost Improvement Programme (CIP) could provide opportunities. IG inquired about less palatable options for recovery, to which ME provided assurance that options are under review, including technical opportunities and addressing high-cost areas like agency spend.

There was a system request to support understanding of drivers of demand to determine if there is a system-wide approach to manage demand. NP noted that the BSW system is experiencing demand growth across the whole system and that further analysis is needed.

LT mentioned that the executive team has reviewed the top contributors to financial challenges, but difficult discussions regarding cash flow will be necessary. The threat of SOF 4 (System Oversight Framework level 4) was noted. **ACTION: To have a broader discussion through the Finance and Performance Committee to review the financial position. ME**

ME

AS inquired about how ED and non-elective admissions compare with other providers. NP explained that while the situation is more acute at SFT, similar trends are seen across the region. **ACTION: NP to provide regional comparison data for ED and non-elective admissions.**

NP

TB1 5/9/2.2 **Trust Management Committee – 24th July and 28th August**

LT presented the report asking for the Board to take it as read. LT highlighted that further to TMC there had been a policy summit on Tuesday. Significant progress has been made with less than 10 policies outstanding and the directive is to review and complete these by the end of September.

The Board noted the report.

TB1 5/9/2.3 **Clinical Governance Committee – 30th July**

DBu presented the report which provided a summary of escalation points from the meetings held on 30th July. The report was taken as read.

The Board noted the report.

TB1 5/9/2.4 **Finance and Performance Committee – 30th July**

DBe presented the report which provided a summary of escalation points from the meeting held on 30th July. The report was taken as read.

The Board noted the report.

TB1 5/9/2.5 **People and Culture Committee – 25th July 2024**

EJ presented the report which provided a summary of escalation points from the meeting held on 25th July 2024. The report was taken as read with EJ briefly highlighting the following points:

- Concerns re maternity turnover were discussed. It was acknowledged that small numbers can have impact in smaller teams. Work is underway to review this and check for any themes.

- P&CC had a leaner agenda which enabled good discussion time. IG noted the balance between conducting committee business and having the time to have those in-depth strategic discussions.

The Board noted the report.

TB1 5/9/3 FINANCIAL AND OPERATIONAL PERFORMANCE

TB1 5/9/3.1 SIRO Annual Data Security and Protection Assurance Report (includes Toolkit Self-Assessment and Data Protection Annual Report and GDPR)

JB presented the report, providing an update on progress made by the organisation over the last 12 months. It highlights areas of improved compliance, and areas of concern within the Trust's compliance with statutory and regulatory standards overseen by the Information Commissioner's Office (ICO). The following key points were noted:

- Cyber controls remind in place and programmes to improve the Trust's cyber posture around areas such as unsupported technology continue. The Trust is fully engaged with the planned changes for the DSPT in 2024/25 as it becomes aligned to the Cyber Assurance Framework. It is acknowledged that Cyber is a key risk and a broader paper will be coming to the Board at a later date.
- Performance remains strong in compliance for FOIs and requests. The report confirms that the Trust has successfully submitted the 2023/24 DSPT assessment which included an internal audit on a subset of evidence. This audit reported a 'Significant assurance with minor improvement opportunities', with one medium and five low findings all having been responded to.

Discussion:
IG noted that in terms of the cyber risks the Trust has its own processes but it does rely on external providers and their processes. IG queried the checks undertaken by SFT to gain assurance from our partners on their processes. JB explained the national controls and processes in place that we must align and adhere to. The Trust is compliant with national security guidance but there is a piece of work to do with suppliers regarding learning from recent incidents and how are they assuring us on security of sub-contractors. Work is underway with procurement to assess what additional actions are needed. IG thanked JB for the update, noting that the Trust is being proactive in managing these risks.

DBe queried the value in undertaking an independent audit. JB explained that the Trust do have the opportunity to audit to certain level. However, the issue is around capacity and time to complete those audits.

AS referred to IG training compliance of which the target is a minimum of 85% compliance. Referring to the table on p.8 of the report, AS queried the adjustments mentioned in relation to reaching compliance. JB explained that the Trust have to complete a lot of the IG training via paper-based methods for those who do not always have access to a computer/laptop. The adjustments are also made for those on maternity leave and long-term sickness. The Board suggested that this be made clearer in the narrative in future reports.

JB

ACTION: A deep dive report on cyber security will come to the Board in December.

TB1 5/9/4 QUALITY AND RISK

TB1 5/9/4.1 Women and Newborn Divisional Governance Report

AK and VM joined the meeting. AK presented the report to provide assurance to the Board of the Women and Newborn Governance processes.

- AK noted the key successes including significantly reducing out of date guidelines, review of scorecard in triangulation of quality and safety themes and the use of alert, assure, advise escalation from services.
- The division plan to daft a new 12-month plan for W&N divisional governance.

Discussion:
The Board discussed the quoracy of meetings and AK noted the team do strive hard to ensure good attendance but would rather meetings go ahead than cancel if one person is unable to attend. AS asked if the team had reflected on the frequency of meetings. AK confirmed, explaining that on occasion the reflections indicate that longer meetings are necessary as the team finds them really valuable.

AT referenced the litigation triangulation and queried if this is replicated across with other services. The Board discussed that they are sighted more on maternity as it is mandated the reports come to Board. JDy explained that there is alot other departments can learn from the work in maternity but it is well-resourced in comparison to the other divisions.

The Board noted the report.

AK left the meeting.

TB1 5/9/4.2 Perinatal Quality Surveillance Report July 2024 (June Data)

VM joined the meeting to present the Perinatal Surveillance Report. The Trust Board is 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.

VM referred to the cover sheet which summarised the key points.

Discussion:
JDy noted that the team are doing a good job of monitoring and managing any concerns robustly. IG noted transformational work that has been ongoing in the division.

JDy summarised that the team have been working collaboratively across Acute Hospital Alliance (AHA) and relationships have been forged which have allowed better benchmarking opportunities. VM noted that the perinatal slide sets are designed collaboratively as reporting the same metrics make it easier to learn and benchmark from each other.

PC summarised that the Trust had a service that was fragile and delivering poor outcomes and through a staged series of interventions, as an organisation and system, we have learnt what the possibilities are. It highlights the importance of leadership time, development, and robust governance. The challenge is how this is applied elsewhere.

The Board noted the report.

TB1 5/9/4.3 **Application to exit the Maternity Safety Support Programme**

VM presented the report summarising the journey through the Maternity Safety Support Programme.

- Following a CQC inspection, areas for improvement were highlighted. The Trust has worked with a Maternity Improvement Supervisor over the last few years.
- A set of exit criteria was established, and the Trust has met all of the requirements. VM, along with JDy, NP, and PC, presented the exit criteria and discussed the sustainability plan.
- The Board was asked to approve the exit so that wider external approval could be sought.

Discussion:
EJ supported the proposal and reflected on the positive comments from those in the exit meeting. EJ assured the Board on the wider processes for sustainability.

The Board thanked JDy for her leadership and maternity colleagues for their resilience.

AS inquired about the rigour applied in assessing the criteria. JDy explained that their Maternity Improvement Supervisor was forensic in assessing the risks, resulting in an initial improvement plan with over 500 actions. The criteria for exit have been assessed several times at different forums. The Local Maternity and Neonatal System (LMNS) has also been involved in this process. JDy reassured the committee of her confidence in the process, noting that when they did a table-top exercise with the CQC, every request was addressed.

There was a reflection on the process, suggesting it would be beneficial to share the slide deck with the Board when looking at other areas. It was noted that there is a need to tread carefully if the Trust finds itself in this process with other services in the future, as the wide-scale review had a significant impact.

It was noted that the process is run externally by the LMNS, who would raise concerns via the Integrated Care Board (ICB). Updates on sustainability will come back via the monthly report, through CGC to the Board. The sustainability action plan will be submitted to the CQC.

Decision:
Board supported the recommendations and asked VM to pass on thanks to team.

VM left the meeting.

TB1 5/9/4.4 **Research Annual Report**

The Board noted the Research Annual report had been deferred to October.

TB1 5/9/5 GOVERNANCE

TB1 5/9/5.1 **Annual Report and Accounts**

KS presented the report and noted the following key points:

- The Trust's Annual Report and Accounts was approved at the Audit Committee on 20th June 2024.
- The report was laid before parliament in July and can therefore be published in the Trust's public Board papers and on the website.
- The communications team is producing an 'Annual Review' which summarises the key highlights from the Annual Report and this will be shared with staff, governors, and members prior to the Annual General Meeting on 30th September.

Discussion:
The Board noted that the 2024/25 annual report will have to reflect the community services work if SFT is successful.

KS thanked FMc for finalising the Annual Report, including audit comments in her absence.

The Board noted the report.

TB1 5/9/5.2 **Consideration of establishing formal group with RUH and GWH**

This item was taken as part of TB1 5/9/1.7.

LT presented the report which recommended approval of a group model by Great Western Hospitals NHS Foundation Trust (GWH), Royal United Hospitals Bath NHS Foundation Trust (RUH) & Salisbury NHS Foundation Trust. LT noted that this had been discussed in the private meeting earlier in the day and highlighted the following points:

The process of establishing a formal group was paused to allow governors to seek further assurance. LT thanked the governors for their tone and approach in bringing concerns forward and for engaging over the summer in

opportunities to seek additional assurance. There have been several sessions to provide additional assurance, including an extraordinary Council of Governors (CoG) meeting with Sue Harriman, a meeting with David Dalton, and a group meeting of lead and deputy lead governors from all three Trusts.

An email from the deputy lead and lead governor indicated they are content with the approach and grateful for the opportunity to go through the process. It was noted that their views are important and have been considered. The pause has been constructive in allowing the Trust's journey to move forward. The report recommended, as part of the Acute Hospital Alliance (AHA), to enter into a formal arrangement with RUH and GWH as the next step in the journey. LT stressed that this does not change the legal status of the Trust and Board. The Trust will remain a sovereign organisation, agreeing to collaborate with partners to resolve system challenges, deliver more sustainable care, and ensure financial resilience.

The proposal includes changes around collective leadership, but this does not alter the status of the organisation. Governors are keen for the process to appoint a Group CEO to be a joint one, which is the responsibility of the Non-Executive Directors (NEDs).

LT noted that there have been extensive discussions at the Board, and reaching this point allows the Trust to shape the new operating model. LT asked the Board to consider the report and the eight recommendations set out. It was noted that the Joint Committee terms of reference are still in draft and would come back for approval at a later date.

Discussion:
DBe noted that the timelines set out will need to shift slightly due to the delay. It was noted that no action has been taken in terms of implementation until this paper had been considered. Further work over the next six months will determine the implications and benefits.

NP queried whether there would be more detail between now and January when the operating model is set to come back to the Board. It was clarified that this will be an iterative process, and the Board will be involved throughout. The whole Board will receive updates and be required to make decisions. The Board noted that some constitutional changes are also required.

AS suggested incorporating measures of success into the initial terms of reference.

Decision:
Further to the acknowledgement that the timelines in the paper would need to be adjusted the Board approved the recommendations set out in the report in relation to entering into a group model with GWH and RUH.

DBu maintained that, consistent with earlier conversations, he would abstain from the decision.

TB1 5/9/6 PEOPLE AND CULTURE

TB1 5/9/6.1 **Organisational Development and People Annual Report (to include Equality and Diversity Annual Report, Education and Development Annual Report)**

The Board noted the Organisational Development and People Annual Report had been deferred to October.

TB1 5/9/6.2 **Freedom to Speak Up Guardian Annual Report**

MW introduced LS to the Board and presented the FTSU annual report which noted the and highlighted the following points:

- There has been an uptake in staff confidence regarding managers listening to people, as reflected in the staff survey. The Trust is working with managers at all levels to appreciate how staff feel at work.
- Themes and trends from the report feed into the leadership and management training offer. In the full financial year, there were 163 concerns raised, of which 103 had elements related to line management competencies and behaviours. This may suggest a lack of confidence in managing responses to staff. There is a healthier interest in how the Trust supports concerns.
- The number of staff from diverse backgrounds coming forward is positive. This was reflected in an earlier staff story from a member of staff who had moved from overseas and had a poor experience when they first joined the Trust.
- There is a focus on preventing detriment for people who speak up, to ensure a restorative learning culture.
- There is a need to refresh the Board toolkit, and all members are invited to participate.

Discussion:

MvB reflected on the development of the FTSU culture, noting that it has enabled the Trust to understand the deficit in training for line managers. They questioned how to develop the role, emphasising that it cannot be undertaken in isolation.

IG asked whether the Trust is setting the tone and culture where people are encouraged to speak up. They compared the number of cases at RUH and GWH, expressing encouragement that people are speaking up.

DBe thanked LS and queried whether the data means that 28% of staff don't feel safe speaking up in the organisation. They asked if there are hotspots or cultural reasons for this. LS explained that over the last 12 months, they have been triangulating data from PALS, risk, and exit data to identify themes and trends and to determine what support services might need. MW noted that Carl Lewin Head of OD analyses data form staff survey, turnover, absence and triangulates this to focus on services which might need further support.

LT expressed concern that the staff survey shows some BAME colleagues have a less positive experience, emphasising that these colleagues need to feel safe to raise issues.

RA raised a wider question about detriment, noting it's difficult to measure. She asked what has been done to look at national data on detriment and how

it can be more easily spotted. LS explained that leadership courses discuss these responsibilities, but it remains a work in progress and is subjective. IG suggested it would be useful to see if there's anything further the Board needs to be sighted on. EJ noted that while three-quarters of staff feel secure, they're not as confident that action would be taken on their concerns. They suggested this is a key responsibility for the People and Culture Committee to discuss, noting that Improving Together has helped boost people's confidence in raising concerns. **ACTION: EJ will discuss at the People and Culture Committee how to assess detriment and what the consequences should be.** **EJ/ LS**

AT encouraged Board members to reflect on their own reactions when someone raises a concern.

AS queried the resources in the FTSU team. LS confirmed the team is well-resourced with 10 ambassadors who have protected time, which is rare. AS suggested including this information in the report as it provides assurance to the Board. AS also raised concerns about the low percentage of staff who have completed mandatory speak-up training, noting system faults that prevent completion. **ACTION: The issue with the mandatory speak-up training system will be escalated.**

MvB suggested incorporating feedback from complaints into the appraisal process to promote learning.

ACTION: 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. **IG /KS**

The Board noted the report.

TB1 5/9/6.3 **Health and Safety Quarter One Report – Deferred**

The Board noted the Quarter One Health and Safety Report had been deferred to October.

The Board noted the report.

TB1 5/9/7 **CLOSING BUSINESS**

TB1 5/9/7.1 **Any Other Business**

The Board discussed approval routes for Trust Board reports and asked for future reports to contain more details on what happens to the report once it has been approved.

There were queries over why H&S report had been deferred. The last Board meeting had received the end of year report. Q1 will come to October's Board.

DBe reminded the Board of the approach to risk appetite review which are going through committees in September with the intention is to send the slides out with notice to allow time for feedback.

MW referenced a point in the legal report regarding health and safety and manual handling. The Head of Health and Safety has confirmed manual handling training is in excess of 90%. The lowest performing area on manual handling is corporate functions.

There was no further business to discuss.

TB1 5/9/7.2 **Agreement of Principle Actions and Meeting Reflection**

IG referred to the principal actions from the meeting and noted there were several referrals back to the Committees which would be picked up via the action log.

The Board noted that a key decision had been taken to enter into Group Model with RUH and GWH. IG to contact other the other Trusts to let them know of the Board's decision today.

TB1 5/9/7.3 **Public Questions**

There were no public questions.

TB1 5/9/7.4 **Meeting Reflection**

The Board reflected on the meeting and the following was discussed:

- There was general agreement that the discussion had been productive, and it was noted that the quality of papers is improving.
- PCa raised a concern about resourcing, pointing out that the Trust may not yet have brought all the elements together. He questioned whether there is a comprehensive, pan Trust view of the problem.
- KM acknowledged that they will need to step up to respond, stating that they are genuinely beginning to have joined-up conversations. She noted the regular discussions regarding bandwidth and capacity are taking place.
- PC reflected on the Group discussion, noting that similar themes were heard in different conversations relating to various entities. He suggested it would be worth being mindful of what constitutes 'the group' and the language used around it.
- MW questioned if the Trust might have a forum to discuss the level of organisational change and enable visibility of these changes.
- MvB observed that the Integrated Performance Report (IPR) at the beginning of the meeting sets the narrative for the rest of the discussion.
- There was a discussion about capacity and bandwidth, with it being noted that this is now a new risk on the Board Assurance Framework (BAF). It was agreed that the BAF is working effectively.
- AT commended the humility shown regarding the Electronic Patient Record (EPR) and community initiatives, as well as the willingness to learn about how to put these into action. This is challenging the Board to change the way it works going forward.
- DM reflected that while there are clearly big issues confronting the Trust, it was reassuring to see that the right questions are being asked. He highlighted the importance of considering resource and capacity issues, and beneath that, the need for kindness and acknowledgement of the challenges faced by staff.

- RH raised a question for the Non-Executive Directors (NEDs), asking whether they are challenging the executive team enough.

TB1 5/9/7.5 **Date of Next Public Meeting**

The next Public Trust Board meeting will be held on 3rd October 2024

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 4/7/2.5 Finance and Perforamcne Committee 25 June	03/10/2024	Mark Ellis, ME	Item on the next Trust Board agenda to give assurance and more clarity to the Board on the Trust's financial resilience and the mitigations required to maintain a positive cash position.	**Paper setting out key financial risks, mitigation, and controls, including cash flow forecast went to F&P 30/07. H2 cash requirements to be set out in paper to board Oct'24.**	N	2
Trust Board Public	Sasha Godfrey	TB1 4/7/2.6 Clinical Governance Committee	~~03/10/2024~~ 5/12/2024	Peter Collins, Pco	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**	N	4
Trust Board Public	Sasha Godfrey	TB1 4/7/3.1 Quarterly Maternity and Neonatal Quality and Safety Report Q4	24/09/2024	Vicki Marston, VM and David Buckle, DBu	Deep dive regarding severe tears to September Clinical Governance Committee	**VM to give update on 3rd October under agenda item 6.2 Perinatal Quality Surveillance Report**	N	2
Trust Board Public	Sasha Godfrey	TB1 5/9/2.1 Integrated Performance Report (IPR) (M4) - **Patient Deterioration Metric**	03/10/2024	Judy Dyos, JDy	JDy suggested bringing back additional data on improvements, including the number of arrests.	**Updated included on 3rd October agenda**	Y	3
Trust Board Public	Sasha Godfrey	TB1 5/9/2.1 Integrated Performance Report (IPR) (M4) - **Prevention of Harms**	26/11/2024	Judy Dyos, JDy	EJ requested further assurance on the approach to prevention of harms. EJ suggested a further conversation at the CGC regarding the details of this process.	**Provisionally added date for 26/11 CGC**	N	4
Trust Board Public	Sasha Godfrey	TB1 5/9/2.1 Integrated Performance Report (IPR) (M4) - **Financial Performance**	26/11/2024	Mark Ellis, ME	To have a broader discussion through the Finance and Performance Committee to review the financial position in light of SOF position.	**Provisionally added date for 26/11 F&P**	N	4
Trust Board Public	Sasha Godfrey	TB1 5/9/2.1 Integrated Performance Report (IPR) (M4) - **Non-elective admission**	03/10/2024	Niall Prosser, NP	NP to provide regional comparison data for ED and non-elective admissions.	**Completed shared at F&P in September.**	Y	3
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.	**December Board**	N	4
Trust Board Public	Sasha Godfrey	TB1 5/9/6.2 Freedom to Speak Up Guardian Annual Report/ Detriment	28/11/2024	Eiri Jones, EJ Melanie Whitfield Lizzie Swift	EJ will discuss at the People and Culture Committee how to assess detriment and what the consequences should be.	**Provisionally added for 28/11 People and Culture Committee**	N	4
Trust Board Public	Sasha Godfrey	TB1 5/9/6.2 Freedom to Speak Up Guardian Annual Report/ FTSU MLE issue	03/10/2024	Melanie Whitfield, MW Ian Crowley, IC	The issue with the mandatory speak-up training system will be escalated.	**Wider issues in relation to MLE reporting have been raised in September's Committees. As P&C chair EJ has requested OD&P team bring a paper to October's Committee to understand the issues with MLE reporting and the current mitigations.**	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 Kylie Sanders, KS	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.	**December Board**	N	4

NHS Salisbury NHS Foundation Trust

Report to:	Trust Board Public	Agenda item:	1.4
Date of meeting:	3 October 2024		

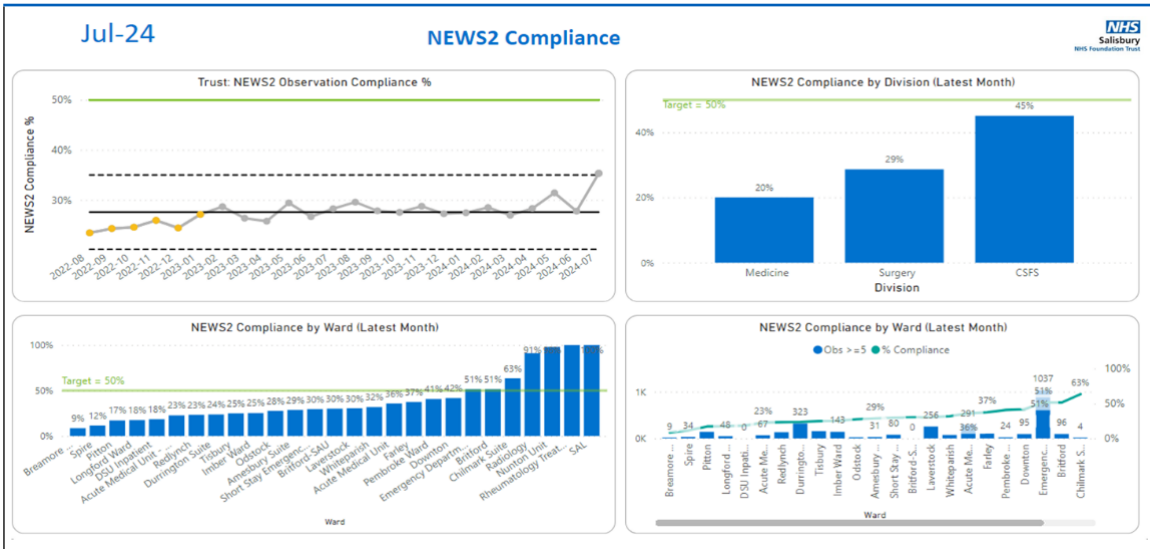
Report title:	Trust Board Action Response. Recognition of patient deterioration Breakthrough Objective additional data.			
Status:	Information	Discussion	Assurance	Approval
			x	
Approval Process: (where has this paper been reviewed and approved):	N/A			
Prepared by:	Judy Dyos, Chief Nursing officer			
Executive Sponsor: (presenting)	Judy Dyos, Chief Nursing officer			
Appendices	N/A			

Recommendation:

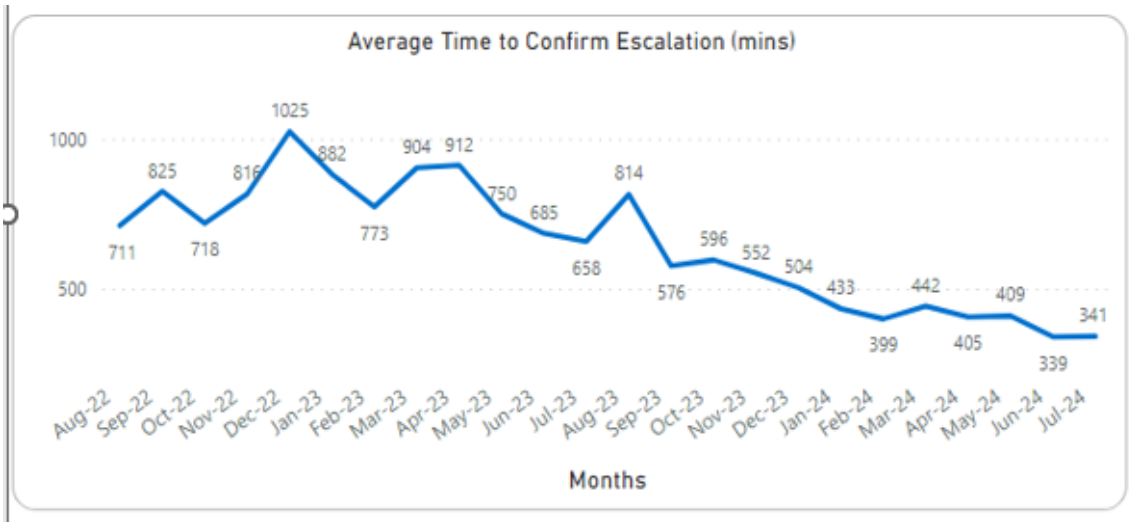
This short paper is to provide additional data related to recognition of the deteriorating patient. This was agreed as an action due to the NEWS 2 POETS based data being challenging and not showing the improvement we are seeking, despite this issue other data is showing positive trending in relation to the recognition and management of patients that have increased acuity. Counter measures were commenced in late April 2024 including experiments such an educational programme, morning safety huddle review of POETS system to review any patients scoring 2 or above, Nurse in Charge POETS review as leader standard working and Matron daily review.

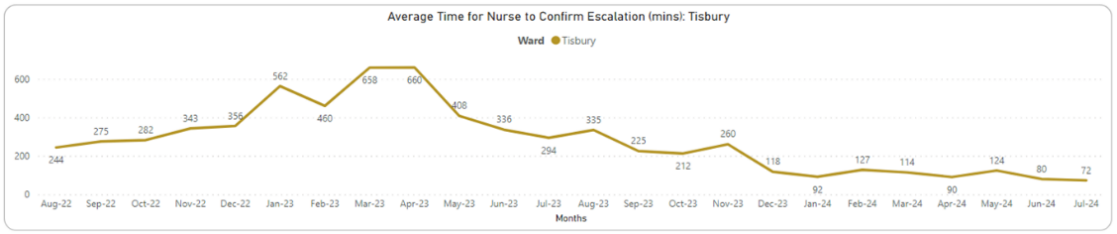
Executive Summary:

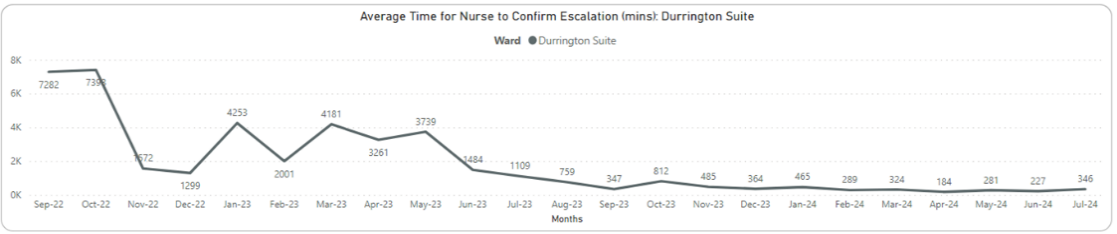
Compliance with observations in correct timeframes for news 5 and above remains below the target. Following discussion, it has been agreed that for purposes of quality improvement, a different measure is required. The rationale for this decision is because the sample size is small resulting in large monthly variation, and it is contaminated with extraneous data in relation to the Glasgow Coma Scale (GCS).

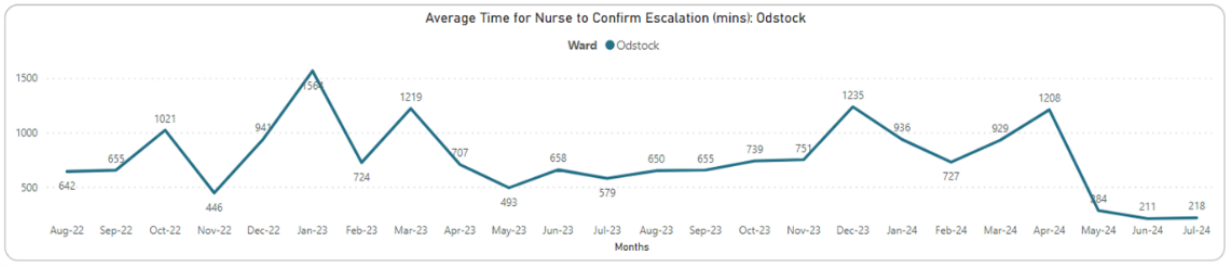


Time taken to escalate from raised NEWS 2 has reduced across all wards

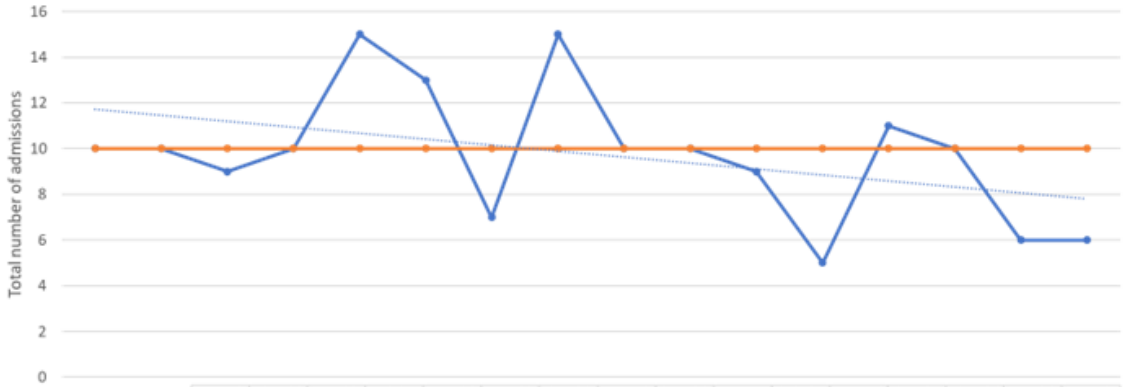






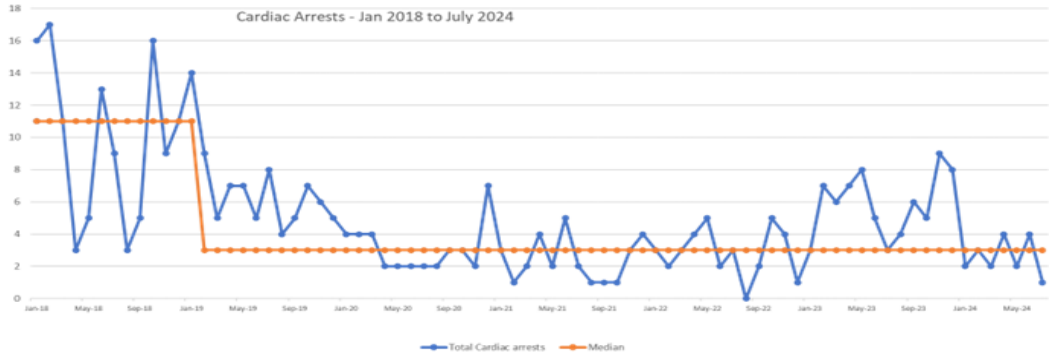


Unplanned admission to ICU has reduced

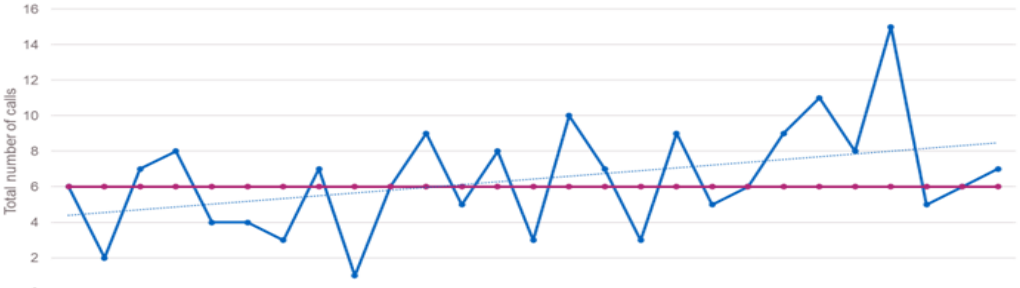


	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24	Apr-24	May-24	Jun-24	Jul-24
Unplanned admissions	10	10	9	10	15	13	7	15	10	10	9	5	11	10	6	6
Median	10	10	10	10	10	10	10	10	10	10	10	10	10	10	10	10

Cardiac Arrest rates- ward areas. Initial reduction in Jan 19 was introduction of NEW2 but more consistent picture is emerging since April 2024



Medical Emergency Team calls increasing means early recognition and escalation



	May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24	Apr-24	May-24	Jun-24	Jul-24
Total	6	2	7	8	4	4	3	7	1	6	9	5	8	3	10	7	3	9	5	6	9	11	8	15	5	6	7
Median	6	6	6	6	6	6	6	6	6	6	6	6	6	6	6	6	6	6	6	6	6	6	6	6	6	6	6

Next steps

- Educational video on the POETS system
- Matha's rule roll out
- Daily patient wellbeing check added to POETS observations

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	
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:	1.6
Date of meeting:	3rd October 2024		

Report title:	Chief Executive Report			
Status:	Information	Discussion	Assurance	Approval
	x			
Approval Process: (where has this paper been reviewed and approved):	N/A			
Prepared by:	Lisa Thomas, Interim Chief Executive			
Executive Sponsor: (presenting)	Lisa Thomas, Interim Chief Executive			
Appendices	N/A			

Recommendation:

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

Executive Summary:

The purpose of the Chief Executive's report is to highlight developments that are of strategic and significant relevance to the Trust and which the Board of Directors needs to be aware of.

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):	

1. Population

Operational Context

National updates

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. The key drivers of these challenges around performance are described as: funding austerity and capital funding being low, the impact of the Covid-19 pandemic and its aftermath; lack of patient voice and staff engagement; and management structures and systems.

The new Secretary of State for Health, Wes Streeting, has announced that there will be a new ten-year plan for the NHS forthcoming and no doubt references in the upcoming October budget to the future funding for the NHS. We will respond to both in the coming months when we understand what that will mean for our hospital and staff.

Local Context

The hospital remains busy, overall activity has increased significantly this year with more patients using our urgent and emergency services and we are treating more patients through our planned care services. However, in this context the Trust is showing improvements across a range of performance metrics including Cancer and diagnostics access targets and we remain focused on reducing long waiting times for surgery. More detailed information is contained within the Integrated Performance Report (IPR).

All of this is against a backdrop of the difficult financial situation facing our Trust and the wider BSW system which in turn is under greater scrutiny. We continue to work with our partners to ensure our collective financial controls are in place and work across the system to look at what opportunities we collectively have to become more efficient.

2. Our People

September is a very special month for the Trust in that we celebrate the contributions made by our volunteers, partners, and staff to the Trust, which comes together as “thank you” week. The events held in the grounds of Salisbury Cathedral took place and encompassed our staff awards, volunteers thank you lunch, long service awards, comedy night and staff family fun day. Our communications team work tirelessly to make all the events look seamless so a special thank you to the team.

Our awards evening saw more than six hundred staff coming together to celebrate across a range of categories, the winners were:

Rising Star - Andrea Robson, *Paediatric Matron and Trust Lead for Children*

Outstanding Partner - Dr Nicola Wray & Defence Primary Healthcare (DPHC)

Patient Experience - Lizzie Goodyear, *Speech and Language Therapy Assistant*

Lifetime Contribution - Annie Colmer, *Staff Nurse, Salisbury Hospice*

SOX of the Year - Spinal Unit

Team of the Year (Non-Clinical) - Health and Safety Team, including Fit Testing

Continuous Improvement, Education - Cardiology Team

Unsung Contribution (Clinical) - Dr Stephen Jukes, *Consultant Anaesthetist, Radnor Ward*

Team of the Year (Clinical) - Acute Frailty Unit

Leadership - Sarah Howells, *Team Lead, Early Supported Discharge Therapy Team*

Unsung Contribution (Non- Clinical) - Angie Down, *IBD Pathway Navigator* and
- Amelia Mifsud, *Hepatology, Pathway Navigator, IBD/Hepatology*

Contribution from Overseas Colleague - Analiza Maramo, *Staff Nurse, Tisbury Ward*

Chair's Award - Imber Project Team
- Chaplaincy

Chief Executive's Award - Victoria Aldridge, *Head of Patient Experience*
- Dr Aazzalrahman Alghoul, *Elderly Care*

Governors' Volunteer of the Year – Kevin Noble

Thank you, week highlighted, much which is great about our Trust and the focus this year was on inclusion. We could not run our services without the help of those who have come here from more than eighty different countries.

The obvious benefits we draw from our international workforce was just one of the many reasons why the racism, xenophobia and Islamophobia that was on display during the recent riots was so troubling. It has been a difficult and distressing time for many colleagues, and we will continue to look out for them and support them.

We've been working on improving our response to violence and aggression to staff, there has been an active working group – violence prevention and reduction working group which continues to develop and implement plans. New posters have been placed across the Trust as part of the campaign.

Dr Peter Collins, who has been our Chief Medical Officer for the past four years is leaving in October for new challenges in NHS Devon. I want to thank Peter for his enormous contribution and pay particular homage to Peter in his role leading and championing Improving Together across the Trust. The adoption of Improving

Together and his personal commitment to embedding new processes and thinking has meant the Trust has really seen a step change in improving care for patients and staff. We wish him well for his next challenge.

3 Our Partnerships

Our Annual Public Meeting takes place on Monday 30th September in Salisbury Guildhall, refreshments will be available from 17.15pm and the meeting will start at 18.00pm. It will include presentations from our clinical teams in Frailty and Cardiology sharing the improvements in patient pathways made this year. Everyone is welcome to attend.

We took the decision to form a group with Great Western Hospitals (GWH) and Royal United Hospitals (RUH) Bath as a Board in September. Work is underway to continue building on our partnerships and expedite improvements in care. We came to together for the launch of the new Electronic Patient Record (EPR) in month where both executives and non-executive directors had an opportunity to look at the timetable ahead as we work to upgrade our digital systems. This is a truly exciting opportunity to make a step change at SFT improving digital maturity and enabling our clinical teams to work more effectively.

Finally, this is my last report as the interim Chief Executive. I wanted to express my formal thank you to all colleagues for their support during the last eight months. It has been a privilege to lead SFT, I have been lucky enough to meet so many colleagues across the Trust and meet lots of patients and families. This is an incredible organisation and I look forward to the new chapters ahead.

NHS Salisbury NHS Foundation Trust

Report to:	Trust Board (Public)	Agenda item:	2.1
Date of meeting:	03rd October 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)	Melanie Whitfield, Chief People Officer			
Appendices				

Recommendation:

The Trust Board are asked to note the Trust's operational performance for Month 5 (August 2024).

Executive Summary:

Breakthrough Objectives

- *Time to First OP Appointment* increased slightly from 132 to 134 days although remains consistent with lowest points since April 2023 when baseline was 139 days.
- *Managing Patient Deterioration* reduced slightly from 32.8% to 32.5% although maintained improvement of 2.5% since April 2024 against the target of 50%.
- *Staff Turnover* also continued progress by reducing marginally from 19.2% to 19.1% and a total 1.3% reduction since April 2024 against the target of 15%.
- *Productivity* maintained improved position at -16.3% implied productivity against the 2019/20 equivalent period and an overall 1.7% improvement since April 2024.

Deteriorating Performance

- Cancer performance, whilst continuing to improve within the Trust, remains under national monitoring across the BSW system, where all Trusts are collectively in Tier 2 Cancer oversight for the *28-day Faster Diagnosis Standard (FDS)* and *62-day Referral to Treatment Standards.* Performance was again positive across all metrics:
  - *28-day Faster Diagnosis Standard (FDS)* from 75% to 82.4% (above plan)
  - *62-day Standard* from 76.9% to 77.6% (above plan)
  - Number of patients waiting *>62 days* for Cancer treatment reduced further from 63 to 61.

  The criteria to exit national tiering is to achieve ≥70% performance against the *28-Day FDS Standard* and ≥60% performance against the *62-day Standard* and is a collective target for all BSW Trusts, requiring all to achieve this to exit tiering arrangements.

Note: Cancer data is one month behind, reporting July in this IPR.

Alerting Metrics

- Hospital acquired *Pressure Ulcers* category 2 and 3 both increased from 36 to 45 and 1 to 4 respectively.
- Emergency Department (ED) metrics:
  - *Attendances* remain high despite decrease from 7,251 to 6,813.
  - *Ambulance Handovers >60 minutes* reduced from 92 to 61.
  - *Arrival to Departure >12 hours* increased from 27 to 39.
- *Referral to Treatment (RTT)* related metrics deteriorated as challenges continued and seasonal reduction in activity a likely contributor:
  - Total *RTT waiting list* increased from 28,094 to 29,443.
  - Patients waiting *>52 weeks* increased from 901 to 966 although overall cohort number is below clearance plan ahead of target: Zero by end of March 2025.
  - Patients waiting *>65 weeks* increased from 70 to 83 although most have plans to clear, it is unlikely we will hit target: Zero by end of September 2024.
  - Patients waiting *>78 weeks* reported one breach after discovery of administrative error regarding RTT clock start date. Target: Zero as standard.

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

October 2024

(August 2024 data)

Our Strategy 2022-26
IMPROVING together

Summary

NHS Salisbury NHS Foundation Trust

The Trust continues to operate well within a challenging period with this demonstrated within the Trusts performance within the latest period.

Cancer performance remains under national monitoring across the BSW system, where all Trusts are collectively in Tier 2 Cancer oversight for the *28-day Faster Diagnosis Standard (FDS)* and *62-day Referral to Treatment Standards*. Performance at SFT continues to improve, with the *28-day FDS* increasing for the fourth month in a row from 75% to 82.4% and now above trajectory of 78%. The *62-day Standard* also increased again from 76.9% to 77.6% and is above the trajectory of 67%. The number of patients waiting *over 62 days* for Cancer treatment reduced again from 63 to 61 patients and continues steady reduction overall since monitoring began. *Note: Cancer data is one month behind, reporting July in this IPR.*

Diagnostics *6-week Standard (DM01)* saw a slight reduction to 82.8% overall against the trajectory of 86% with Endoscopy and Audiology remaining top contributors. However, this sustains improvement compared to the previous 12 months average. And for the fifth consecutive month, the Stroke care measure of *Arrival on Stroke Unit within 4 hours* maintained an overall improved position at 58%.

Waiting list related metrics were challenged, with the breakthrough objective of *Wait Time to 1st Appointment* increasing slightly to 134 days from 132 in July and the total Referral to Treatment (RTT) waiting list increased again to 29,443 patients, although remains below the trajectory. The year-to-date Elective Recovery Fund (ERF) performance is currently at 106% against a target of 116% with Month 5 performance as of the 16th 104% with 51% of patients uncoded at present.

Attendances within the Emergency Department remained high at 6,813 in month, continuing the trend of year to date of circa 10% higher than in 2023/24. *4-hour performance* demonstrated a slight decrease at 71.8%, however *Ambulance Handover* time improved by reducing to 22 minutes.

The number of patients with *No Criteria to Reside (NCTR)*, increased to 93 patients across the Trust, a rise for the third consecutive month. However, whilst the numbers of patients with NCTR is increasing, the internal referral time has reduced, and the average LoS for patients with NCTR has dropped for the 4th month consecutively to 7.43 days. Therefore, whilst internal processes appear to be improving, the numbers overall continue to increase due to growing demand for community care provision.

Workforce metrics were again varied, with the breakthrough objective relating to retention measured by *Staff Turnover* seeing a slight decrease to 19.08% maintaining its improved position since May. *Staff Absence* saw a minor increase to 3.5% and *Vacancies* a significant decrease from 3.9% in July to 2.3% in August, with achievement of the 5% consistently demonstrated across the past 12 months.

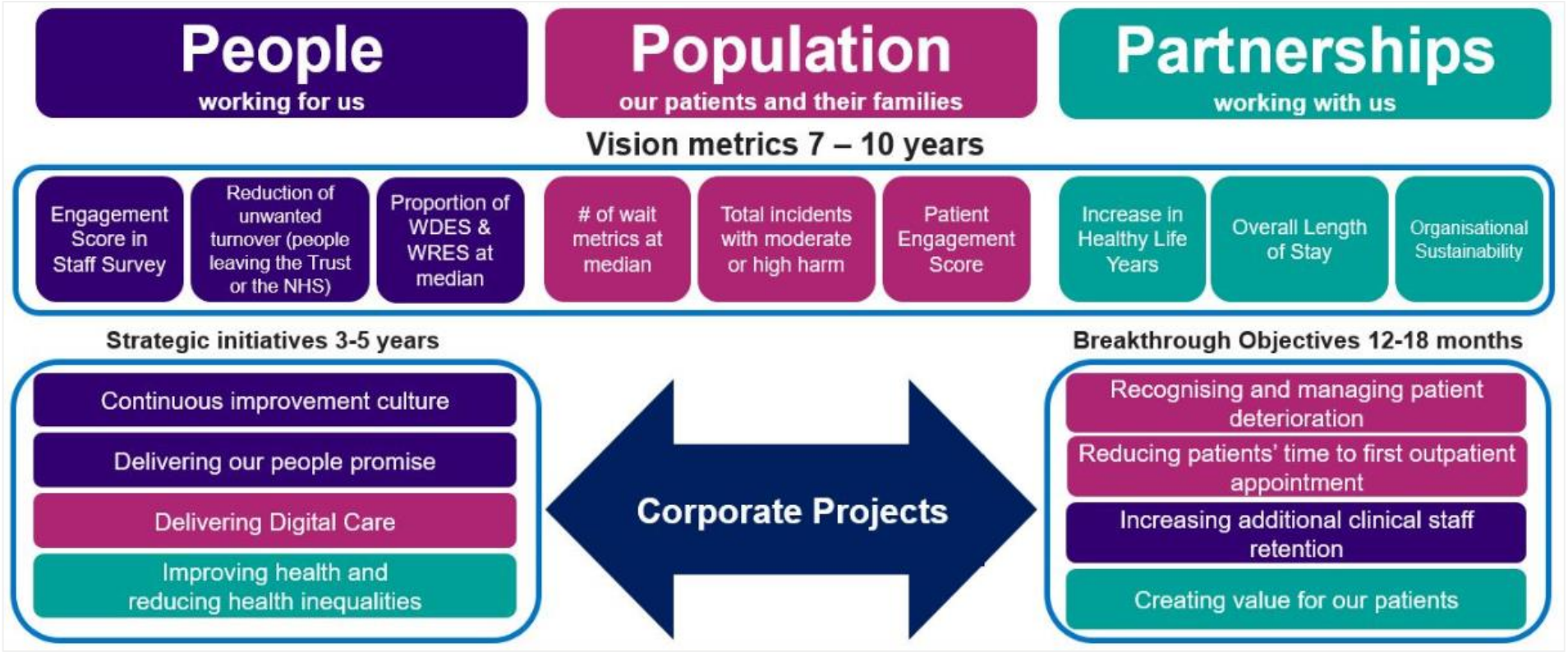
The quality related breakthrough objective of *Managing Patient Deterioration* maintained incremental improvement, holding at 32.5% of subsequent observations completed on time. Wider quality metrics saw varied performance, as *Pressure Ulcers* per 1,000 bed days increased from 2.5 to 4 although improvement was seen in *Infection Control with C-Difficile* and *EColi* reduced to 0 and to 1 respectively.

The finance breakthrough objective of *Productivity* also maintained its improved position for a second month at -16.3%. The Trust recorded an in-month control total deficit of £3.0m against an original deficit target of £1.4m - an adverse variance of £1.6m.

Strategic Priorities

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

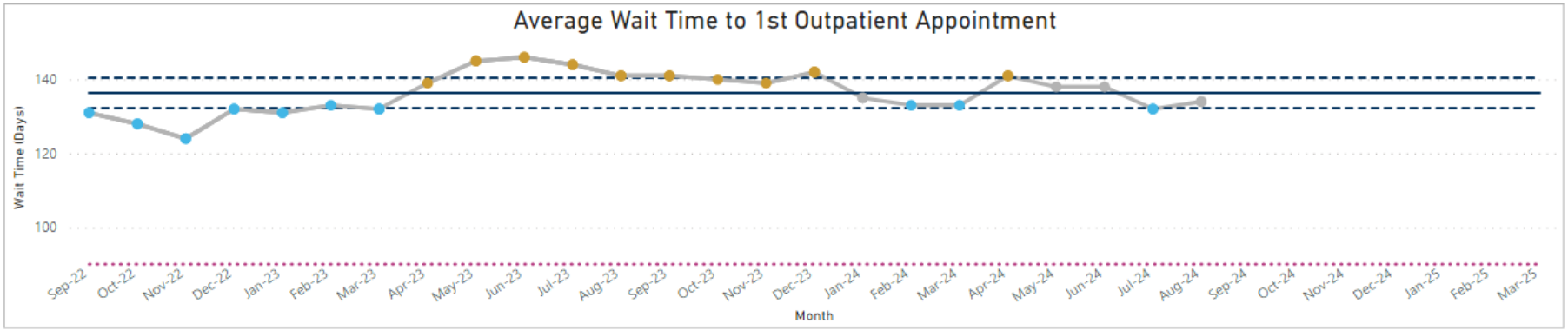
Reducing Patients' Time to First Outpatient Appointment

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: 134 days Position: Common Cause



Understanding the Performance

The average time to first outpatient increased slightly in August to 134 days. All divisions reported a small increase perhaps reflecting the lower level of outpatient activity in this month due to the holiday period.

The three focused specialties are:
Oral surgery – remained static at 164 days.
Colorectal – increased from 102 in August to 122, but remains in a static trend following a reduction from a peak of 200 days in Oct 23.
Urology – decreased from 187 days to 176 days.

Countermeasure Actions	Due Date
Continue engaging stakeholders from the 3 chosen specialties and establish their regular involvement within the TT1OP weekly meetings.	19th Oct (next reporting period)
Complete A3 sessions with sub-workstreams to focus on the management of waiting lists and clinic templates at both the booking and specialty level.	19th Oct
Complete a review of the TT1OPA A3 to ensure alignment with current work.	19th Oct
Continue to develop the project documentation to support the emerging project plan. Begin to define 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.	19th Oct

Risks and Mitigations

- To drive improvement in the 3 chosen specialties, engagement and resource will be required from clinical colleagues within these teams.
- There is a risk that improvements to the overall TT1OPA metric will not be realised if there is significant declining performance in the TT1OPA metric of other individual specialties (e.g., dermatology).

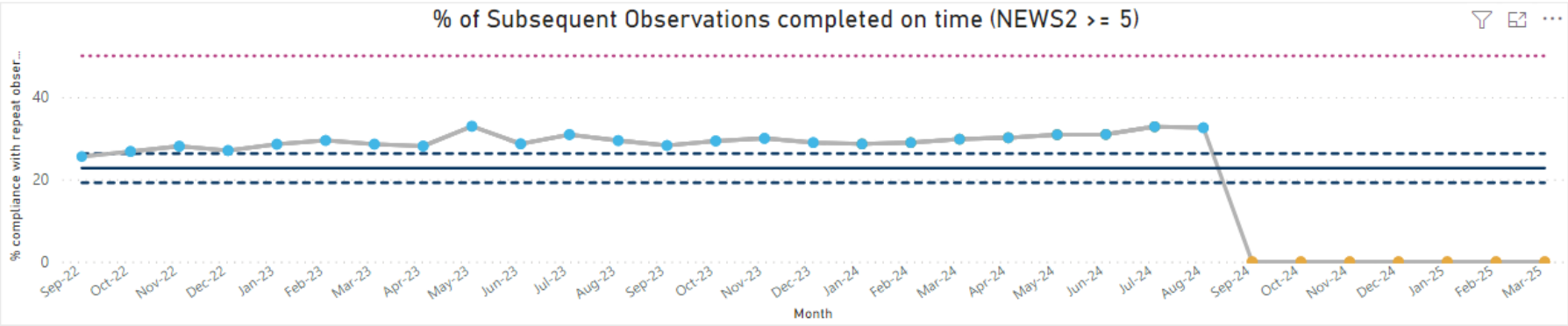
Recognising and Managing Patient Deterioration

Salisbury NHS Foundation Trust

Breakthrough Objective

We are driving this measure because… **Baseline: 30.1% (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: 32.5% Position: Special Cause Improvement



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

M5 performance remained consistent.

The current measure records the frequency of observations of those patients scoring a NEWS2 of 5 and above. It also includes other data unrelated to NEWS2

Analysis of the data has revealed that this represents only 5-7% of the total observations in the pilot ward areas. For purposes of the work around quality improvement, it has now been agreed that a different measure is required as the small sample size is not representative, making interpretation challenging.

Countermeasure Actions	Due Date
• Extend the sample size to include NEWS2 scores of 3 and above whilst excluding scores of 7 and above. This will be shown as all wards, and available as stratified data. Continue A3 work through the divisions.	Oct 2024
• Continue rolling out the training programmes.	Oct 2024
• Set up meeting to benchmark our ability to meet the Royal College of Physicians *National Early Warning Score (NEWS) 2 Standardising the assessment of acute-illness severity in the NHS.*	

Risks and Mitigations

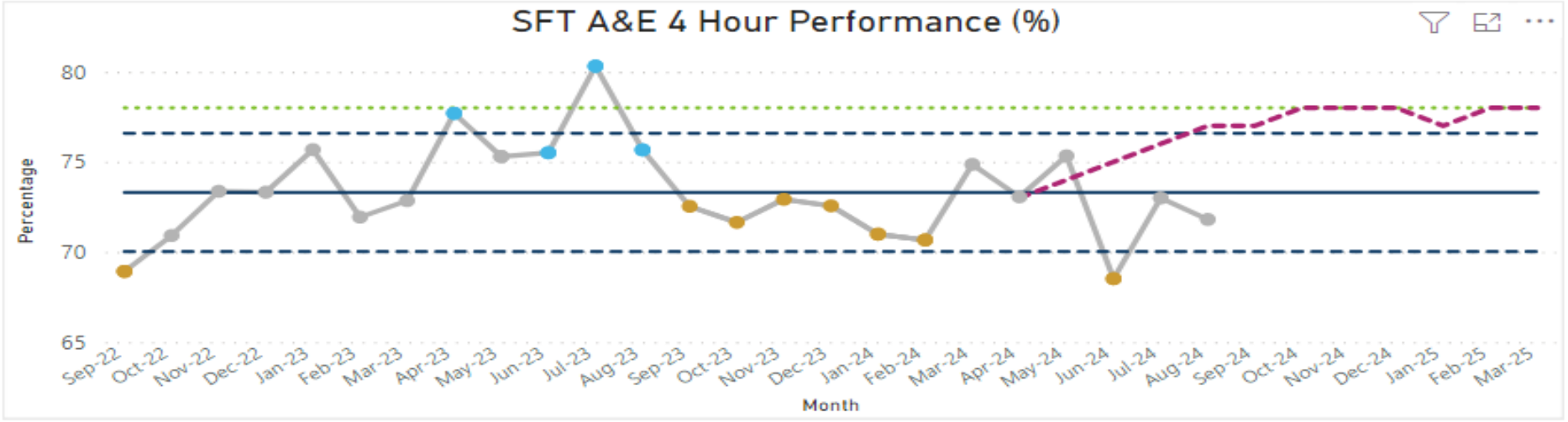
There is still a risk of unrecognised deterioration which may lead to patient harm. However other measures allow us to monitor the risk.

- Overall mortality rates are decreasing.
- Cardiac arrest rates remain low.
- Medical emergency Team calls increasing signalling earlier recognition.
- Unplanned admissions to ITU low.

Emergency Access 4-hour Standard

Salisbury NHS Foundation Trust

Target: ≥78% Performance: 71.8% Position: Common Cause



Understanding the Performance
SFT 4hr performance remains within standard variation at 71.8% in M5 compared with 73% in M4. Attendances dropped by an average of 14 patients a day and Type 1 attendances (ED), although reduced, remain high at 150 attendances on average a day which continues to exceed staffing establishment. There was a high intensity of Mental Health attendances over M5 which absorb significant resource and lead to an increased length of stay. Waits for specialty referred patients and expected patients have also had a detrimental effect on length of stay in the Department. M5 historically has always been a difficult month with the rotation of new Junior Doctors requiring more supervision.

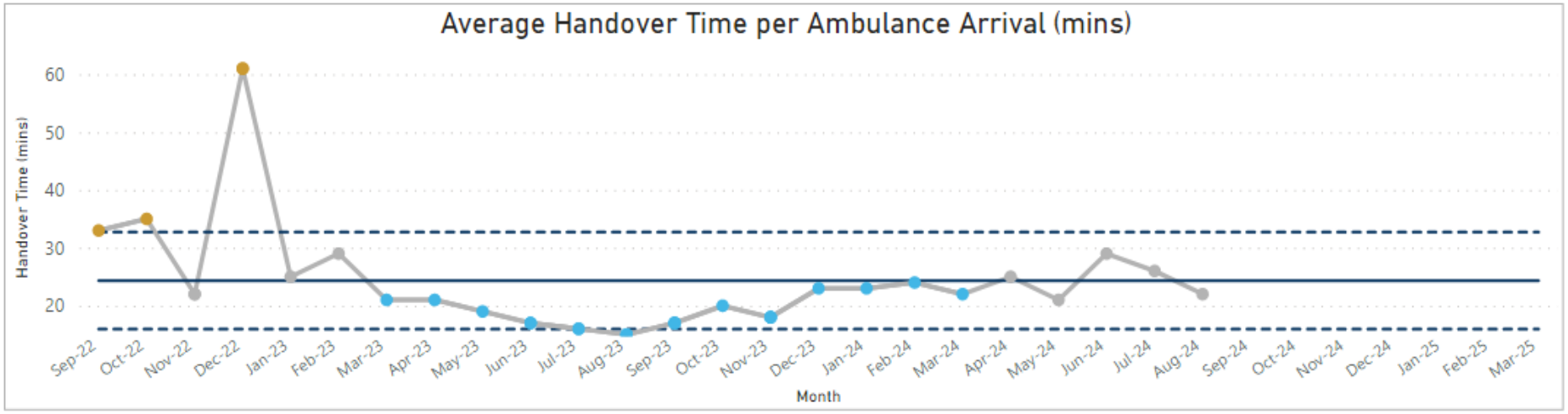
Countermeasure Actions	Due Date
• The 'Streaming' initiative at the front door continues and has improved the percentage target for patients seen within 15 minutes to 90% in M5. This is a significant improvement against 34.70% in M3.	Ongoing
• A meeting has taken place with the Lead Clinician and ECIST to discuss demand and capacity analysis and a paper is due to be presented with the findings.	Sept 2024
• Analysis to evidence whether specialty waits in the department have an adverse effect on performance, limiting capacity to see and treat patients remains challenging as the data is not captured in the data warehouse and will have to be a manual collation of data. Analysis to follow.	Oct 2024
• Work on standardisation of the roles of the Emergency Physician in Charge (EPIC) and Nurse in Charge (NIC) and aim to eliminate variation between staff members.	Nov 2024

Risks and Mitigations
• Senior leadership team meetings are planned in M6 to establish roles and planed improvement. • A3 remains outstanding for non-admitted patients.

Ambulance Handover Delays

NHS Salisbury NHS Foundation Trust

Target: ≤15 mins Performance: 22 mins Position: Common Cause

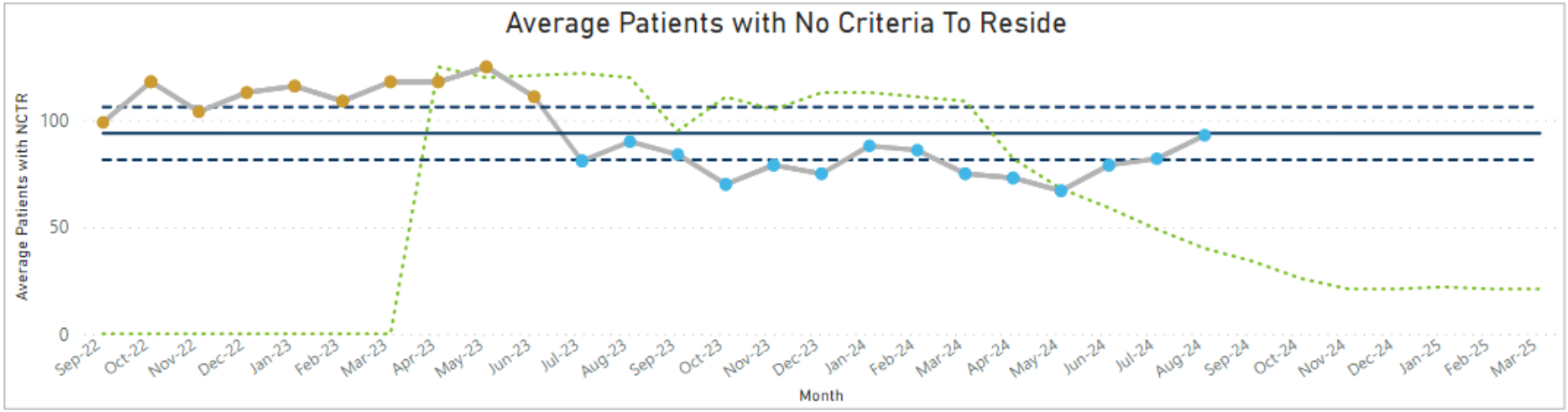


Understanding the Performance	Countermeasure Actions	Due Date	Risks and Mitigations
The percentage of ambulance handovers occurring within 15 minutes has increased to 44.6% in M5 compared to 41.25% in M4 and 35.71% in M3. Patients handed over within 30 minutes and 60 minutes stands at 83.1% and 95.1% respectively. Number of patients arriving by Ambulance remained static at 1,239 in M5 compared to 1,292 in M4.	• Monthly meetings with the Southwestern Ambulance Services (SWAS) Operational Officers continue to improve collaborative working between the teams. Focus remains on the handover process and SFT support of corridor nursing vs SWAS cohort patients. • 'Go and See' planned for M6 by the Operational Performance Lead to observe the RATT handover process and hopefully identify areas for potential improvement. • Rapid Assessment Treatment and Triage (RATT) paper to support investment to deliver Medical led RATT 12 hours per day is part of the Medical Workforce paper.	Ongoing 30/09/2024 30/10/2024	• Occasional bottleneck in Rapid Assessment Ambulatory (RAMBO) when multiple attendances arrive consecutively – mitigated by ensuring ambulances offloaded to any available space when RAMBO is full will be further addressed by the countermeasures above in the event that there is no available space.

Optimising Beds

NHS Salisbury NHS Foundation Trust

Target: ≤25 (5%) Performance: 93 Position: Special Cause Improvement



Understanding the Performance

The average number of patients with No Criteria to Reside (NCTR) has risen for the 3rd month in a row to 95. The internal referral time for patients with NCTR was reduced to an average of 1.4 days from 1.6 days in July. The average LoS to patients being NCTR has dropped for the 4th month in a row to 7.43 days.

Average bed day delays by pathway:

P0 – 0 days; P1 – 7 days; P2 – 8 days; P3 – 12 days.

Note: ED attendances continue to remain high (>300 more compared to Aug 23) with no decline in conversion rate hence the number of patients being admitted is also higher.

Countermeasure Actions	Due Date
• Ongoing work to reduce time from NCTR to referral.	Ongoing
• Digitisation of Decision to Admit (D2A) process to go live sept 24.	Sept 24
• Greater use of Hospital at Home (H@H) (% to be agreed).	Nov 24
• Breamore ward team working to reduce Length of Stay (LoS) and prevent deterioration of patients waiting packages of care.	On going
• Detailed codes providing details on reasons for delays in discharge.	Sept
• 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

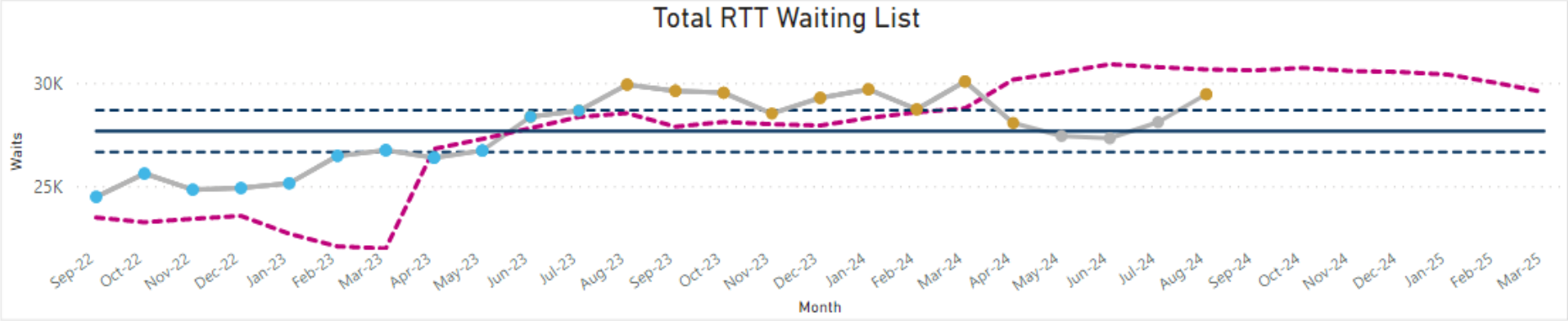
Risks and Mitigations

- 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: 29,443 Position: Special Cause Concern



Balancing metric	Jul-23	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
Longest waiting patient	77	243	200	194	153	139	110	94	72	68	73	74	78	83

Understanding the Performance

August saw the Referral to Treatment (RTT) waiting list grow again for the second consecutive month to 29,443 as further progress was made processing a backlog of referrals. The long wait position also increased slightly to 83 patients waiting more than 65 weeks, however almost all of these have plans to treat before the end of September and meet the target of zero at month end.

Top 3 specialties with increases in month:

- Plastic Surgery (+316)
- Ophthalmology (+258)
- Trauma and Orthopaedics (+108)

Top 3 specialties with decreases in month:

- ENT (-114)
- Gynaecology (-41)
- Pain Management (-24)

Countermeasure Actions

	Due Date
• 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 improving reports (Pre-Op status, Access plan creation date, Duplicate access plans, non-RTT patients).	30/09/2024
• Work with internal colleagues and external providers to improve surgical waiting list Pre-Op process and ensure all patients are being actively monitored electronically.	31/10/2024

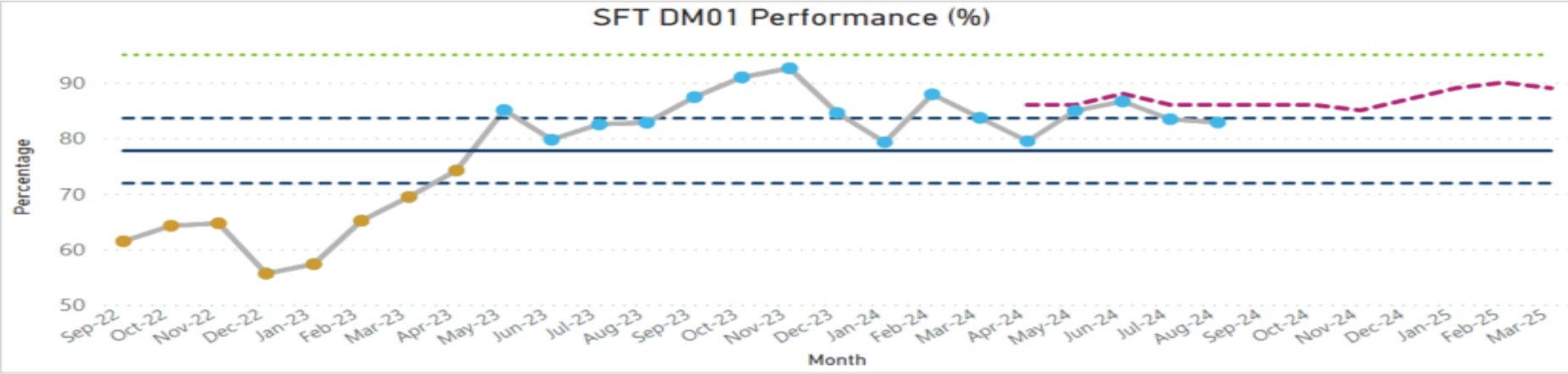
Risks and Mitigations

- 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 continue drive towards national reduction targets.

Diagnostic Waiting Times

NHS Salisbury NHS Foundation Trust

Target: ≥95% Performance: 82.8% Position: Special Cause Improvement



	%	Over 6 weeks		%	Over 6 weeks		%	Over 6 weeks		%	Over 6 weeks
MRI	78.8%	132	Dexa	99.6%	1	Colonoscopy	46.3%	176	Urodynamics	29.4%	60
CT	87.1%	69	Neurophysiology	91.7%	18	Gastroscopy	91.2%	13	Cystoscopy	100%	0
Ultrasound	98.5%	15	Echo	89.5%	29	Flexi Sigmoid	29.6%	60	Audiology	76.4%	167

Understanding the Performance

6 week diagnostic performance in M5 deteriorated from 83.41% in M4 to 82.83% but this was against a backdrop of a reducing waiting list size (due to the earlier than planned recovery of USS waiting list backlog). Waiting list size reduced by circa 500 patients overall and so whilst performance overall reduced, there were less patients impacted by breach (reduced from 789 in M4 to 737 in M6).

Trust trajectory position for M5 was 86.13%. Early predictions for M6 show an improved predicted position of circa 85%.

All modalities except for endoscopy and urodynamics reduced the numbers of patients impacted by a > 6 week wait for diagnostic. Endoscopy breaches increased from 196 to 246 and urodynamics from 27 to 60.

Countermeasure Actions	Due Date
• Additional nurse led urodynamics capacity to restore wait time to < 6 weeks.	Oct 24
• Endoscopy 4th room and weekend capacity in M6 to increase number of lists.	Sept 24
• Finalise insourcing arrangement for Endoscopy for further additional capacity to be online from M7.	Sept 24
• New CT scanner operational from late M6, will allow for restoration of some Cardiac CT and CTC capacity to support reduction of their circa 70 backlog.	Oct 24
• Cause of audiology backlog unclear, data analysis to understand key contributors required.	Sept 24

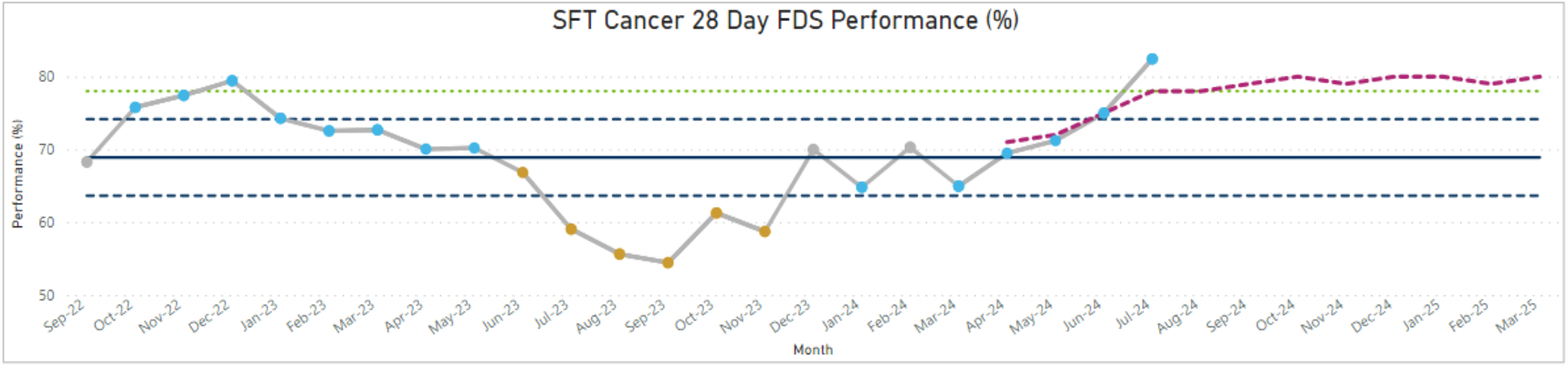
Risks and Mitigations

- Endoscopy surveillance overdue position risks the DM01 position from M7 if the additional capacity does not meet demand. Trajectory is being finalised with mitigations regarding additional capacity being mobilised
- Future second CT scanner replacement will reduce Cardiac CT and CTC capacity again

Cancer 28 Day Faster Diagnosis Standard

Salisbury NHS Foundation Trust

Target: ≥78% Performance: 82.4% Position: H 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

28-day performance standard achieved in M4, with month-end position of 82.4%. Performance is above trajectory of 78%.
Improvement across the majority of pathways, with pathways not achieving including:

- Lower GI : 58%
- Haematology: 63.6%
- Head & Neck: 77.3%
- Urology 41.1%

Lower GI continues to be challenged by complex pathways and capacity constraints within the Bowel Cancer Screening pathway.
Urology performance is predominantly driven by Prostate diagnostic pathway.

Countermeasure Actions	Due Date
• Maintain regular site-specific 'Faster Diagnosis touch-point' meetings.	Monthly
• Maintain sufficient Breast and Skin capacity for first appointments to support overall Trust delivery of FDS.	Monitored weekly
• Analysis of delivery against 'best practice timed pathway' underway for Lower GI and Urology (Prostate and Bladder).	Q3 2024/25
• Development of FDS 'A3' for Lower GI, Head & Neck, Gynaecology, Lung, Urology and Haematology underway.	Q3 2024/25
• Impact of BSW-wide Bowel Cancer Screening pathway alongside LGI FDS performance ongoing.	Q4 2024/25

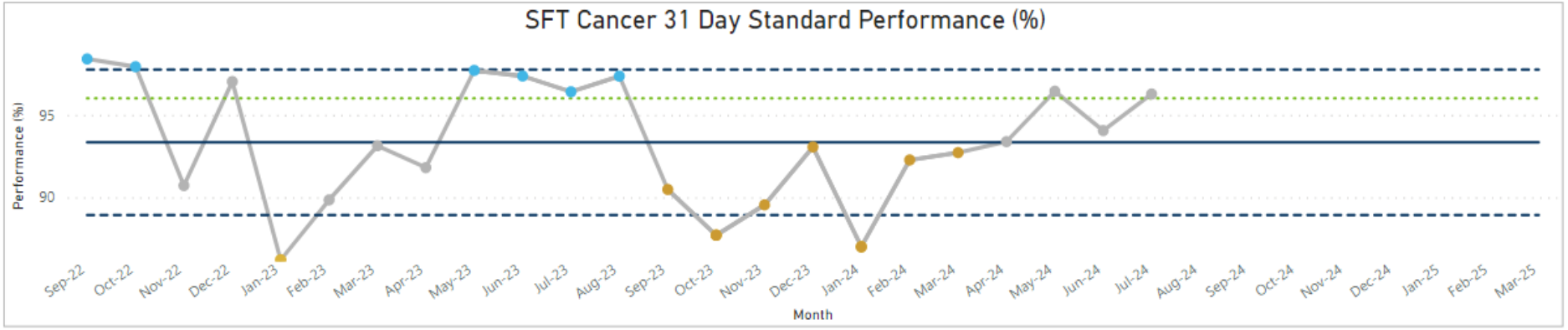
Risks and Mitigations

- Skin service remains vulnerable to demand and capacity issues. Bid approved by NHS England to support further insourcing capacity; surgery are working through procurement processes ahead of utilisation.
- Resource within MDT cancer services team remains challenging in terms of capacity, with vacancy within Urology post. Cancer Transformation Funding bid successful to recruit fixed-term Assistant MDT co-ordinator posts; recruitment underway
- Cancer escalation policy routinely in use across all tumour sites

Cancer 31 Day Standard

Salisbury NHS Foundation Trust

Target: ≥96% Performance: 96.2% Position: Common Cause:

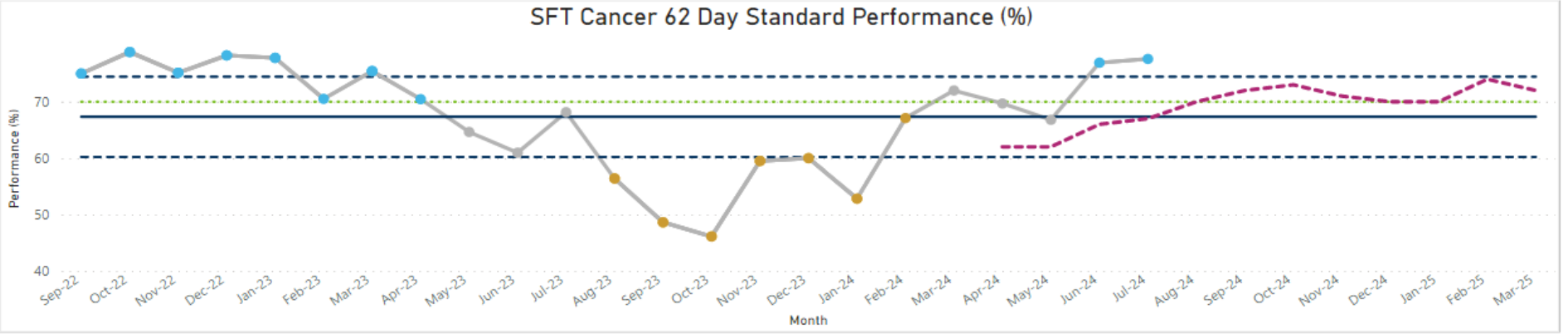


Please note: The performance data is subject to quarterly and six month revisions, this can lead to updates in past reported performance. Changes to shared data at other Trusts can cause variation between the national and internally reported performance.

Understanding the Performance	Countermeasure Actions	Due Date	Risks and Mitigations
31-day performance has incrementally improved since January 2024, with M4 position of 96.2%. This represented 8 breaches of the 241 treated. All specialties achieved the standard, excluding the following: • Skin: 93.9% (5 patients not treated within 31 days of DTT). • Urology: 95.5% (2 patients not treated within 31 days of DTT).	• Maintain regular site-specific 'Faster Diagnosis Touch-point' meetings. • Early escalation of booking where the patient is booked beyond target date; increased visibility of upcoming breach dates within weekly PTL meetings established. Further consideration underway in relation to awareness and visibility of breach dates within booking teams.	Monthly Q3 2024/25	• Skin service remains vulnerable to demand and capacity issues • Resource within MDT cancer services team remains challenging in terms of capacity, with vacancy within Urology post. Cancer Transformation Funding bid successful to recruit fixed-term Assistant MDT co-ordinator posts; recruitment underway • Insufficient capacity within Central Booking department. Recruitment ongoing • Risk of Oncology capacity associated with Aseptics and associated outsourcing.

Cancer 62 Day Standard

Target: >70% Performance: 77.6% Position: H Special Cause Improvement:



Patients waiting over 62 days for treatment	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24	Apr-24	May-24	Jun-24	Jul-24
	89	78	102	167	119	87	158	145	117	91	73	76	65	61

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

Incremental improvement in 62-day performance since April '24, with month 4 end position of 77.6%. Performance is above trajectory of 67.39%.

Data is subject to change upon receipt of post-op histology and confirmed cancer diagnosis treatments recorded after the monthly submission. Data will be updated within quarterly submission.

180.5 patients were treated in total against the 62-day standard in M4, with 43.5 patients not meeting the standard. Notable specialty performance as below:

- Lower GI: 51.6% (7.5 breaches/15.5 patients)
- Gynaecology: 61.5% (2.5 breaches/6.5 patients)
- Head & Neck: 40% (3 breaches/5 patients)
- Urology: 61.5% (15 breaches/43 patients)

Countermeasure Actions

Due Date

Countermeasure Actions	Due Date
• Sustain robust patient tracking list meetings, with improved resilience and standardisation across all tumour sites.	Weekly
• Backlog trajectories scoped by Cancer Services and agreed by Operational Management teams, 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

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 over 62 days in their pathway

Resource within MDT cancer services team remains challenging in terms of capacity, with vacancy within Urology post. Cancer Transformation Funding bid successful to recruit fixed-term Assistant MDT co-ordinator posts; recruitment underway

Risk of Oncology capacity associated with Aseptics and associated outsourcing, alongside general Oncology OPA capacity.

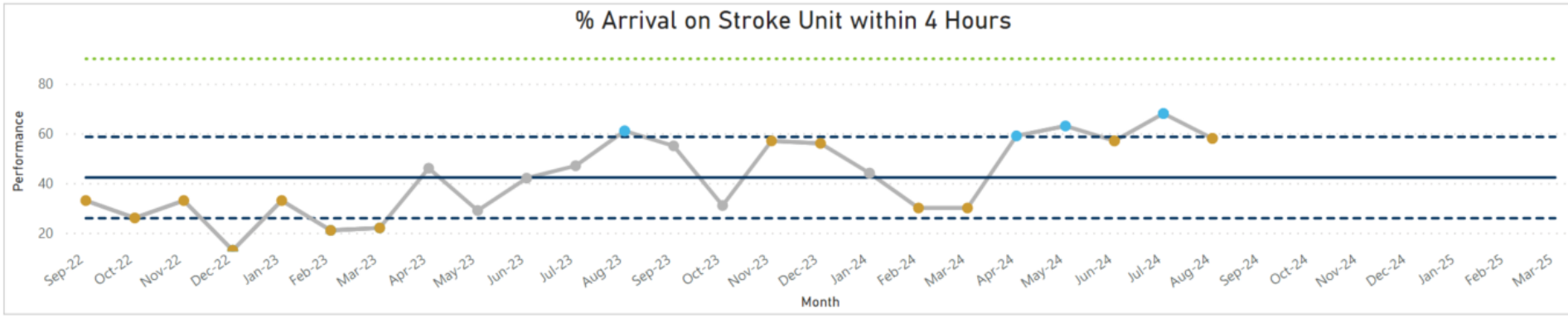
Cancer escalation policy routinely in use across all tumour sites.

Insufficient PSMA PET capacity (via Alliance Medical) detrimentally impacting Urology pathways and backlog; escalation remains ongoing with datix incident reporting where applicable

Stroke Care

NHS Salisbury NHS Foundation Trust

Target: ≥90% Performance: 58% 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

M5 performance was 58%, which is a 10% decrease on M4. This is a return to M3 performance and is felt to be reflective of expected variation due to bed pressures affecting performance.

Key themes from the data:

- Bed capacity in the hospital impacted the ability of the unit to deliver SSNAP standards. Without bed capacity issues, the Stroke unit would have achieved the same performance as the previous month (68%).
- Improvement in Education: The number of patients failing to reach the unit due to late diagnosis remained low at 2 this month.
- Communication / Staffing Out of Hours (OOH): of the 6 breaches OOH, all can be attributed to communication issues, transfer delays or waiting for doctors reviews.

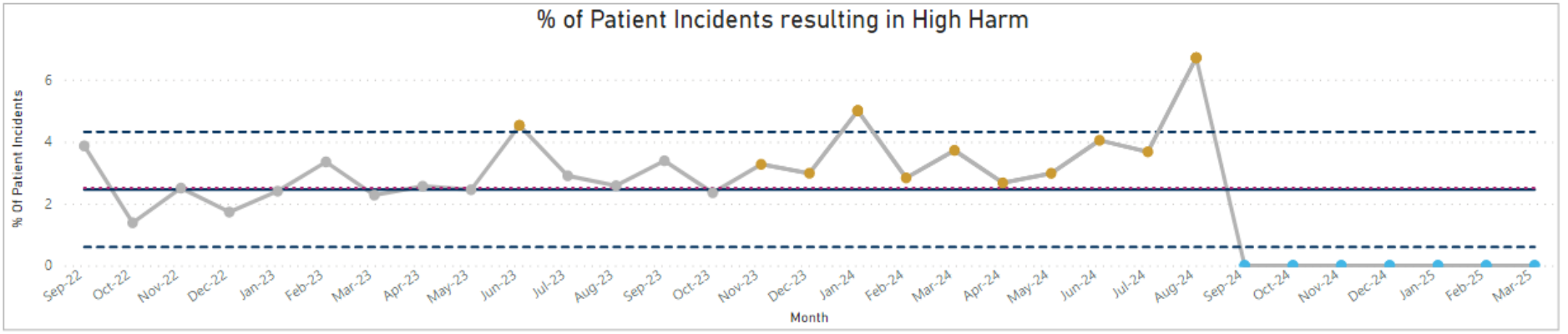
Countermeasure Actions	Due Date
• OOH performance: Action plan developed with an A3 looking at root causes, including relaunching huddles. A diagram on triaging / escalating is to be produced and sent to ED. Expected outcomes are a decrease in patients breaching due to communication issues.	Dec 24
• Training on non-specific stroke symptoms: Outcomes from sessions are positive, with improved performance with recognisable stroke symptoms. A plan for continuing education has been developed to embed these changes.	Oct 24
• Stroke B6 nurse liaison with ED: rota change has been reviewed and positive impact, continue monitoring.	Oct 24
• CT Profusion Business Case: To improve identification of patients a case is being developed to introduce a CT Profusion service to the hospital.	Oct 24

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 / LoS: 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.

Incidents

Target: ≤2.5% Performance: 6.7% Position: Special Cause Concern



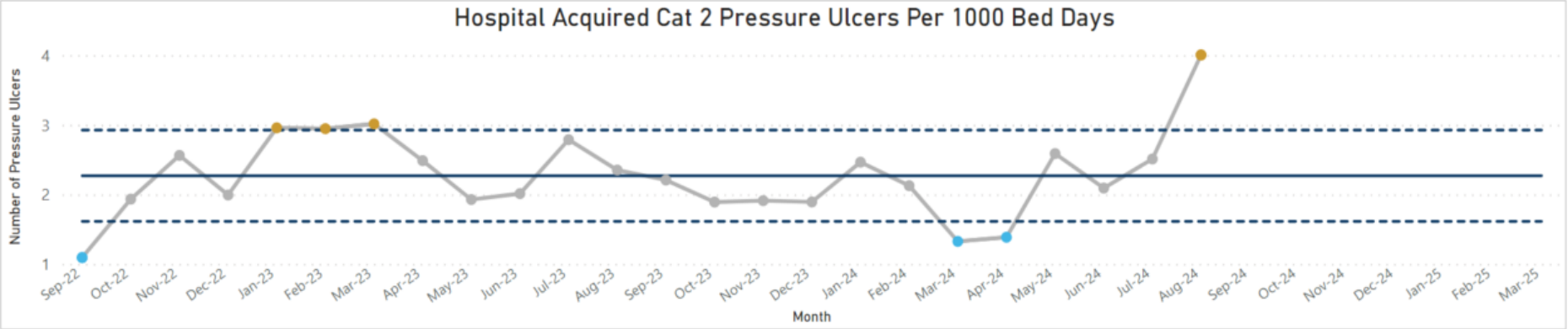
Please note the data being presented ends in August 2024 and therefore the markers shown on the x-axis after that point should be ignored.

Understanding the Performance	Countermeasure Actions	Due Date	Risks and Mitigations
There were 890 incidents reported in August. This was a decrease compared to 968 reported in July . In August there were: • 42 reported moderate harm incidents, (an increase of 9 incidents from July). • 2 major incidents reported. (1x fall and 1x disruption of service in Cath Lab due to power supply issue). • 2 catastrophic incidents reported (1 fall, 1 rapid deterioration following admission to ED). *(To note 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*).	• Daily morning huddle across all divisions to discuss previous 24 hours incidents and any immediate actions required. • Weekly Patient Safety Summit (PSS) where all moderate, major and catastrophic graded incidents are discussed. • Patient Safety Reviews (PSR) are undertaken for all cases where moderate or above harm has occurred to patients. • 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. • Learning from incidents forum.	Daily / Ongoing Weekly / Ongoing Ongoing Ongoing Monthly / Ongoing	There were no Patient Safety Incident Investigations (PSII's) commenced in August.

Pressure Ulcers

NHS Salisbury NHS Foundation Trust

Target: N/A Performance: 4.0 Position: Special Cause Concern



Understanding the Performance
The number of pressure ulcers across the Trust has remained the same for August (59) when compared to July. The most significant comparison from is a 8% increase of category 2 pressure ulcers and 23% decrease in DTIs. An increase from 1 to 4 Category 3s, and 6 from 5 unstageable pressure ulcers. The number of medical device related pressure ulcers was 11 compared to 10 in July. The total number of pressure ulcers identified on admission was 51. MASD (moisture associated skin damage) hospital incidence had decreased from 39 to 34. The MASD identified on admission was 28 reduced from 48 in July.

Countermeasure Actions	Due Date
• Tissue viability service review.	Oct 24
• Review current pressure ulcer divisional working groups.	Sept 24
• Ward leaders to ensure TV Link Workers attend the TV study days.	Ongoing
• Wards to utilise TV link workers to support with wound care management and prevention of skin tissue injury.	Ongoing
• Plaster Team to review education/information around plaster casts and pressure ulcer prevention.	Nov 2024
• Trust wide audit to review the compliance of aSSKKINg Care Plan.	Nov 24

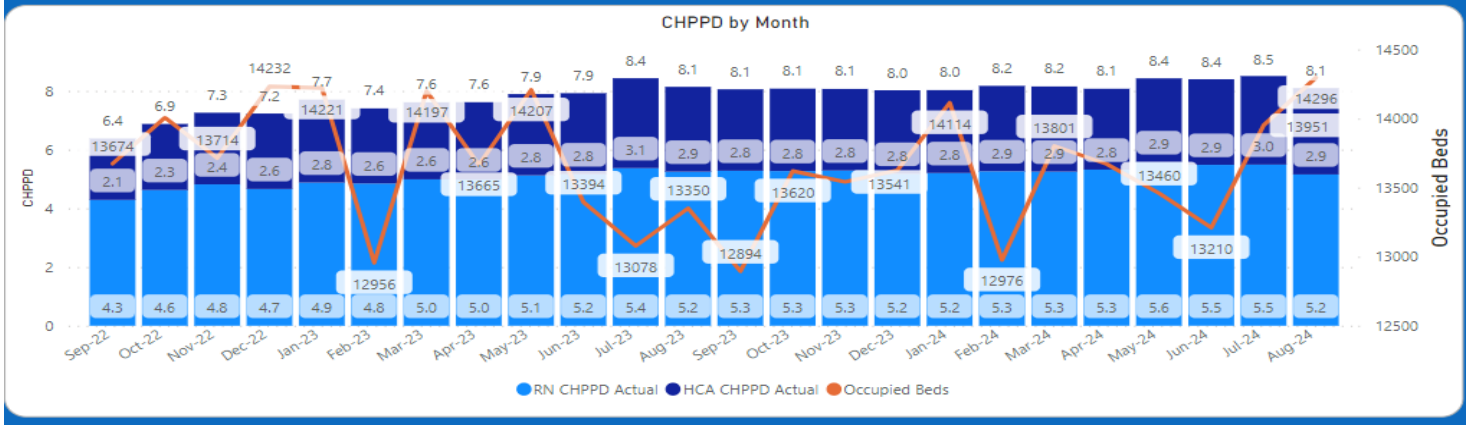
Risks and Mitigations
• Wards to utilise Link workers to support with wound care management and prevention of skin tissue injury. • Capital bid for additional 30 dynamic air mattresses submitted • Extraordinary meeting arranged for senior divisional nurses • Patients in plaster casts who are identified to be at risk of PU to have red casts.

Care Hours Per Patient Per Day (CHPPD)

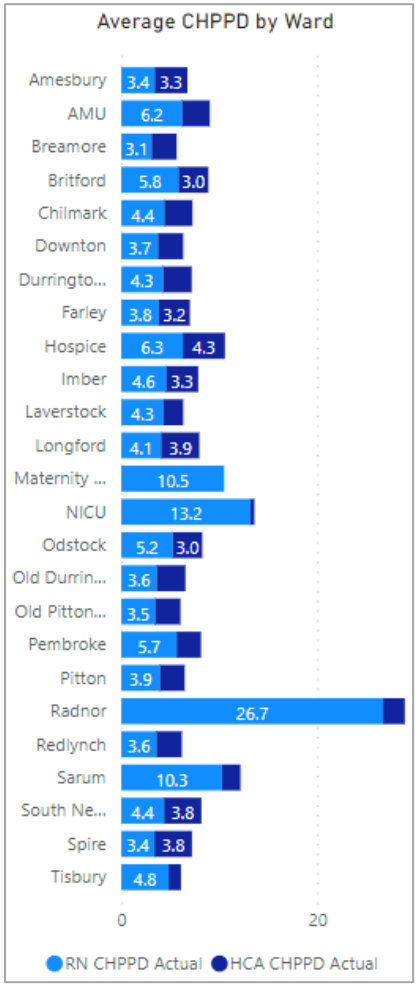
NHS Salisbury NHS Foundation Trust

Target: N/A Performance: 8.1 Position: Common Cause

Latest Month CHPPD	Average CHPPD	Latest Month RN CHPPD	Average RN CHPPD	Latest Month HCA CHPPD	Average HCA CHPPD
8.1	7.9	5.2	5.1	2.9	2.7



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 8.1 in month and 7.5 when excluding critical care and maternity, both are a small decrease on previous months. Change made in month to remove assessment units (SAU,SDEC) which has contributed small reduction.

Fill rate remains broadly consistent month on month.

Agency spend on nursing is £55k which is in part due to a credit paid in July but remains low and continues to be driven predominantly by Theatres, ED, ICU and Paediatrics plus RMNs. Bank spend has increased in month - mainly in Medicine and CSFS.

Countermeasure Actions	Due Date
• Detailed safe staffing reviews completed across all wards – will inform final paper.	Nov 24
• On-going weekly staffing reviews currently focussed on additional duties.	Ongoing
• Trailers due to arrive 20/09/24 - Potential education space for IENs/ new HCAs.	Oct 24
• Review of staffing and beds contributing to maternity CHPPD to ensure accurate data - will be reflected in next month's data.	Sept 24

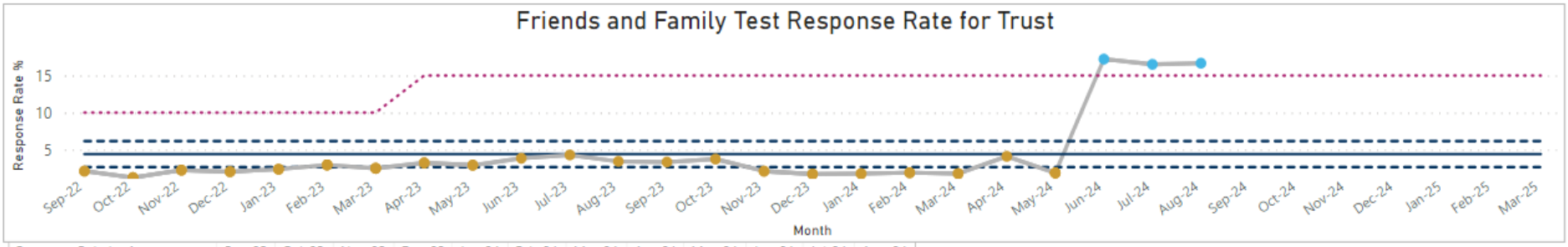
Risks and Mitigations

- Business case for RNDA and Nursing Associate top-up – approved at Sept execs (risk).
- Requirement to reduce headcount impacting safe staffing review requirements (risk).
- On-going demand for patients requiring RMN support (risk).
- Domestic and international recruitment campaigns (mitigation).
- OD+P led work on retention, turnover and inclusion (mitigation).

Friends and Family Test Response Rate

Salisbury NHS Foundation Trust

Target: ≥15% Performance: 16.6% Position: Special Cause Improvement



Response Rate by Area	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24	Apr-24	May-24	Jun-24	Jul-24	Aug-24
FFT Response Rate - A&E	0.6%	1.0%	0.6%	0.9%	0.7%	0.5%	0.5%	0.7%	0.6%	20.6%	20.4%	22.0%
FFT Response Rate - Day Case	5.8%	4.1%	2.4%	2.5%	3.1%	3.2%	3.3%	2.1%	2.9%	3.4%	10.8%	11.2%
FFT Response Rate - Inpatient	33.7%	24.0%	17.2%	10.2%	19.1%	19.7%	17.2%	22.3%	18.5%	10.4%	26.3%	31.8%
FFT Response Rate - Maternity	1.0%	2.9%	0.9%	0.5%	3.8%	0.0%	3.0%	0.5%	0.0%	13.7%	9.7%	10.1%
FFT Response Rate - Outpatient	2.1%	2.3%	1.3%	1.1%	0.9%	1.0%	0.8%	1.0%	0.9%	18.3%	16.4%	16.0%

Understanding the Performance

Response rate in August maintained improved position since the new digital dashboard and SMS message service went live in June, reporting 16.6%.

The NHS Friends and Family Test (FFT) was created to help service providers and commissioners understand whether patients are happy with the service provided, or where improvements are needed. It's a quick and anonymous way to give views after receiving care.

NHS care or treatment Areas are encouraged to offer feedback forms to patients at discharge or during their stay. Feedback reports are sent to leads showing feedback received in a given time frame allowing them to pick up any immediate causes for concern and mitigate these where possible.

Countermeasure Actions

- SMS messages are now being 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. Redesign of the FFT boards currently in the inpatient areas are also close to finalisation, with a second phase rollout planned for outpatient) areas.
- 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.

Due Date

Ongoing

Oct 24

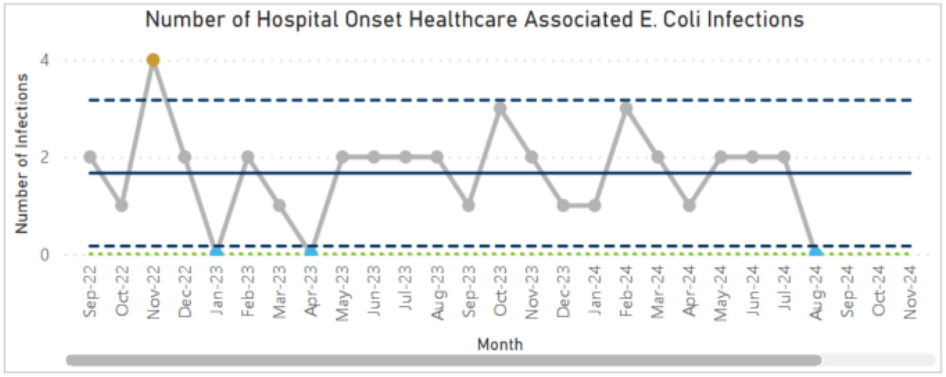
Risks and Mitigations

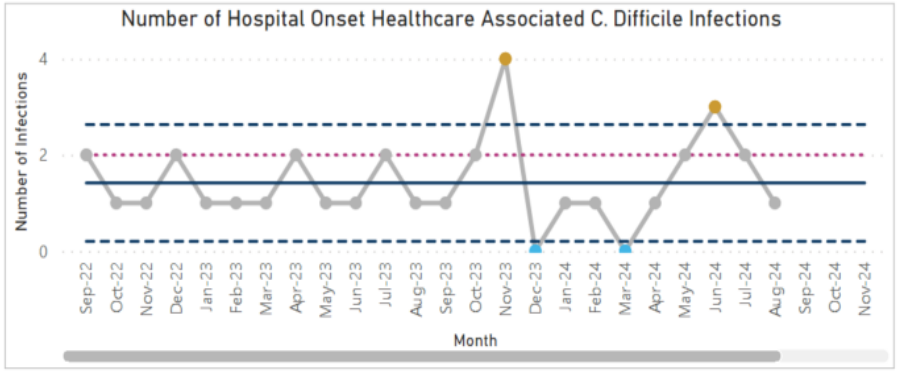
- The new dashboard is already enabling better theming and insights analysis of comments. Going forward we will be able to offer more robust analysis and insights from the feedback received. Implementation of the new system has already demonstated a successful drive towards the Trust's 15% improving together response rate target set for 2024/25. For August our response rate was 17% with a satisfaction rate of 94.5% therefore we exceeded our response rate target for August but slightly fell short of our satisfaction rate target of 95%

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	4

Understanding the Performance

There have been no hospital onset healthcare associated (HOHA) reportable *E.coli* bacteraemia infections, compared to 2 cases last month. There have been 2 HOHA reportable *MSSA* bacteraemia infections, compared to no cases last month.

For HOHA reportable *C.difficile*, there has been 1 case compared to 2 cases last month. For the period of increased incidence of *C.difficile* declared in July for Durrington AFU, the ribotyping results were all different, and the cases not considered to be linked.

A continued level of diarrhoeal and respiratory activity has been experienced across inpatient areas.

A paper prepared for CGC for the reportable *C.difficile* cases identified for 2024/25 to date and classified as healthcare associated (includes community onset healthcare associated (COHA) and HOHA cases).

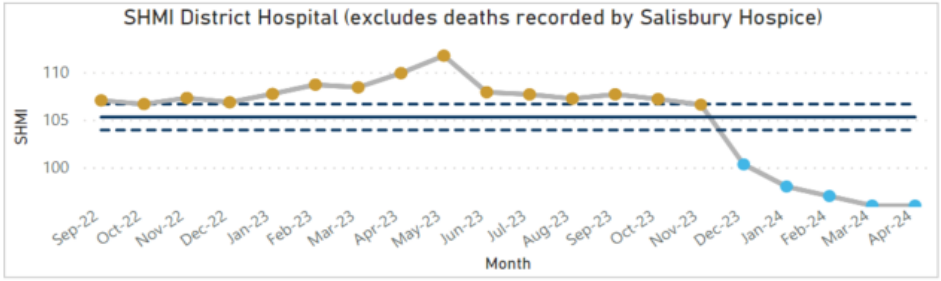
Countermeasure Actions	Due Date
• Completion of required case investigations by clinical areas to identify good practice and any new learning continues within identified timeframes.	Monthly
• From the reviews completed for *C.difficile,* lapses in care have been identified relating to timely escalation of symptoms, prompt isolation of patients, and delays in sampling. The divisions continue to monitor those areas that have produced action plans and provide updates to the Infection Prevention & Control Working Group (IPCWG).	Monthly
• The IPC nursing team continue to undertake targeted ward visits and use educational opportunities with different staff groups.	Ongoing
• IPC representation at preparedness work internally and at BSW ICB convened meetings, including Winter Planning and Mpox.	Ongoing

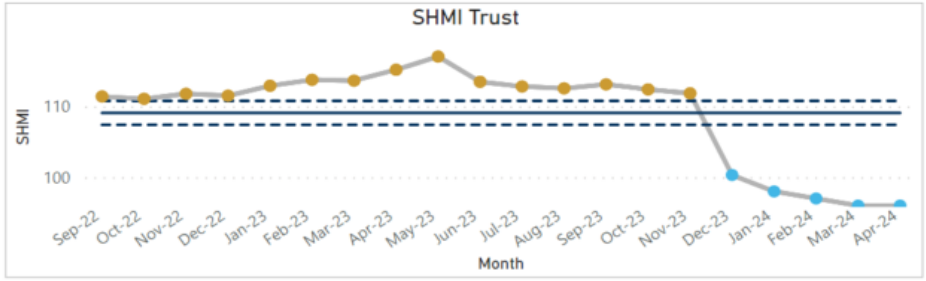
Risks and Mitigations

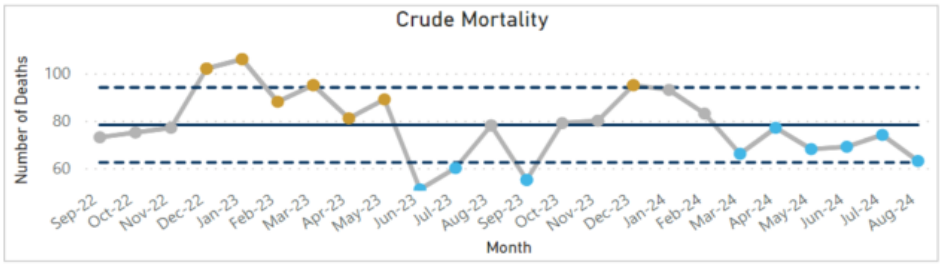
- Ongoing clinical workload for IPC nursing team continues to have an impact on progression with policy reviews and other HCAI prevention work.
- An underlying risk continues to be a potential increase in incidence of reportable healthcare associated infections with poor patient outcomes. As of 1st April 2024, the admission date definition for reporting HCAIs has changed, which **may** lead to an increase in cases classified as HOHA.
- NHS Standard Contract 2024/25: minimising *C.difficile* and Gram-negative bloodstream infections received, outlining the threshold levels set by NHSE. For reportable *C.difficile*, the threshold is set at 21 healthcare associated cases. So far, from 1st April to 31st August, there have been 15 cases (9 HOHA and 6 COHA).
- New soap and gel installation work recommenced this month as planned.

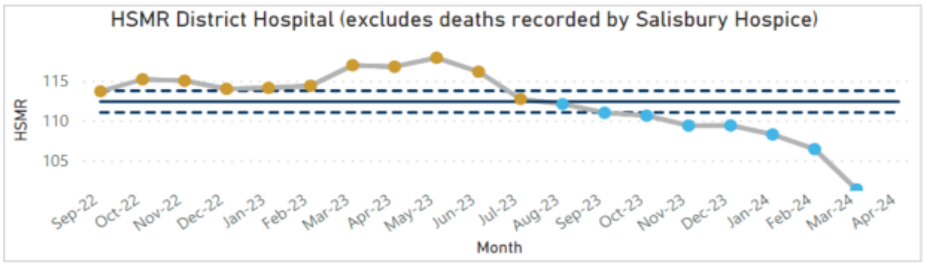
Mortality

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









*Data and narrative remain unchanged from August due to there being no updated available data for HSMR. SHIMI value also remains unchanged.

Understanding the Performance	Countermeasure Actions	Due Date	Risks and Mitigations
The Summary Hospital-level Mortality Indicator (SHMI) for the 12-month rolling period ending in March 2024 for Salisbury District Hospital has significantly improved and is now 0.96.* The Hospital Standardised Mortality Ratio (HSMR) for the 12-month rolling period ending in March 2024 for Salisbury District Hospital is 101.35 (a further reduction to the 12-monthly rolling figures seen ending in Jan '24, which were > 108 at this time). Mortality statistical models compare across all acute hospital Trusts (the majority of which will not contain hospice services), therefore the number of expected deaths at Salisbury NHS Foundation Trust is likely to sit above expected levels.	• A revision to the methodology for calculating the SHMI has come into effect (rolling 12-months from December '23). Prior to this, the Trust had already started to see a positive reduction in the SHMI and HSMR figures. • Actions related to a Board requested mortality visit continue to be progressed through the Trust's Mortality Surveillance Group (MSG). However, a recommendation has been made to formally close the visit process following positive improvement in the Trust's benchmarking figures. • An online mortality system to support learning from deaths was launched in March with focus on engagement of our new processes at M&M meetings.	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	129	92	61		0		Common Cause Variation	X	48
Complaints Closed within agreed timescale %	47.0%	48.0%	44.0%	90.0%			Special Cause Improving - Above Upper Control Limit	X	48
ED 12 Hour Breaches (Arrival to Departure)	53	27	39		0		Special Cause Improving - Run Below Mean	X	48
ED Attendances	7166	7251	6813				Special Cause Concerning - Run Above Mean		
Inpatients Undergoing VTE Risk Assessment within 24hrs %	41.9%	42.0%	33.7%		95%		Special Cause Improving - Above Upper Control Limit	X	48
Number of High Harm Falls in Hospital	2	2	4	0	0		Common Cause Variation	X	3
Pressure Ulcers Hospital Acquired Cat 2	29	36	45				Special Cause Concerning - Above Upper Control Limit		
Pressure Ulcers Hospital Acquired Cat 3	2	1	4				Special Cause Concerning - Above Upper Control Limit		
RTT Incomplete Pathways: Total 52 week waits	923	901	966	750	0		Special Cause Concerning - Above Upper Control Limit	X	20
RTT Incomplete Pathways: Total 65 week waits	96	70	83	26	0		Special Cause Improving - Run Below Mean	X	12
RTT Incomplete Pathways: Total 78 week waits	0	1	1	0	0		Special Cause Improving - Below Lower Control Limit	X	2
Total Incidents (All Grading) per 1000 Bed Days	59	62	76				Special Cause Concerning - Above Upper Control Limit		
Total Patient Falls per 1000 Bed Days	6.11	6.65	7.53	7			Common Cause Variation	X	1

Watch Metrics: Alerting

Salisbury NHS Foundation Trust

Quality of Care, Access and Outcomes

Understanding the Performance

Attendances to the Emergency Department remain above plan at 10% year to date above levels seen in the same period last year. The number of patients spending over 12 hours in the Department remains fairly static despite the increase in attendances. Ambulance handover delays over 60 minutes improved further in August and remain stable

Metrics in relation to Referral to Treatment times are alerting due to number of patients waiting for treatment higher than target, but the 18-month trend is an improving picture with a consistent reduction. The number of patients waiting over 65 weeks for treatment in August was 83, which is higher than the plan of 26. The expectation from NHSE is that there are zero patients waiting over 65 weeks by the end of September 24, current expectation is that SFT will have a small number of patients waiting over 65 weeks at this point.

The number of pressure ulcers and incidents both are alerting with a slight increasing trend, no key contributor has been identified yet but remain under close observation.

The number of Falls continues to remain within expected common variation.

Countermeasure Actions

- Daily review of patients waiting over 65 weeks on an elective pathway by Performance lead and operational teams. Clear escalation to Delivery Group where capacity constraints cannot be unblocked.
- GP practices with the highest increase in the number of patients attending the Emergency Departments have been identified. Deputy Clinical Director for Medicine and GP Liaison making contact to understand what is driving it and what opportunity there is to provide access to advise in a different way that might avoid patients attending the Emergency Department.
- Pressure ulcers and incidents to remain under observation to identify if any cause for increasing trend.

Risk and Mitigations

- Increases in attendances to the Emergency Department and non-elective admissions continue to remain above plan which leads to high occupancy levels
- Risk of increase to waiting list through IA by GPs and action to stop providing advice and guidance, being replaced with direct referral
- Weekly Access Meeting and now daily touchpoint continuing with aim to reduce risk of long waiters and continue drive towards national reduction targets

Watch Metrics: Non-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
Beds Occupied %	94.0%	89.9%	92.1%	96.0%	92%		Special Cause Improving - Below Lower Control Limit	✓	0
Diagnostics Activity	8443	9318	8164	0			Special Cause Improving - Run Above Mean	✓	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 (%)	86.0%	79.4%	%		0%		Common Cause Variation	✓	0
Patients referred on a suspected cancer pathway and seen within 2 weeks (%)	84.7%	86.0%	79.4%		0%		Common Cause Variation	✓	0
Pressure Ulcers Hospital Acquired Cat 4	0	0	0				Common Cause Variation		
Proportion of patients spending more than 12 hours in an emergency department	1.1%	0.5%	0.8%				Special Cause Improving - Run Below Mean		
Stroke patients receiving a CT scan within one hour of arrival	67.0%	74.0%	58.0%		50%		Common Cause Variation	✓	0
Total Number of Complaints Received	17	17	9				Common Cause Variation		
Total Number of Compliments Received	74	49	48				Common Cause Variation		

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

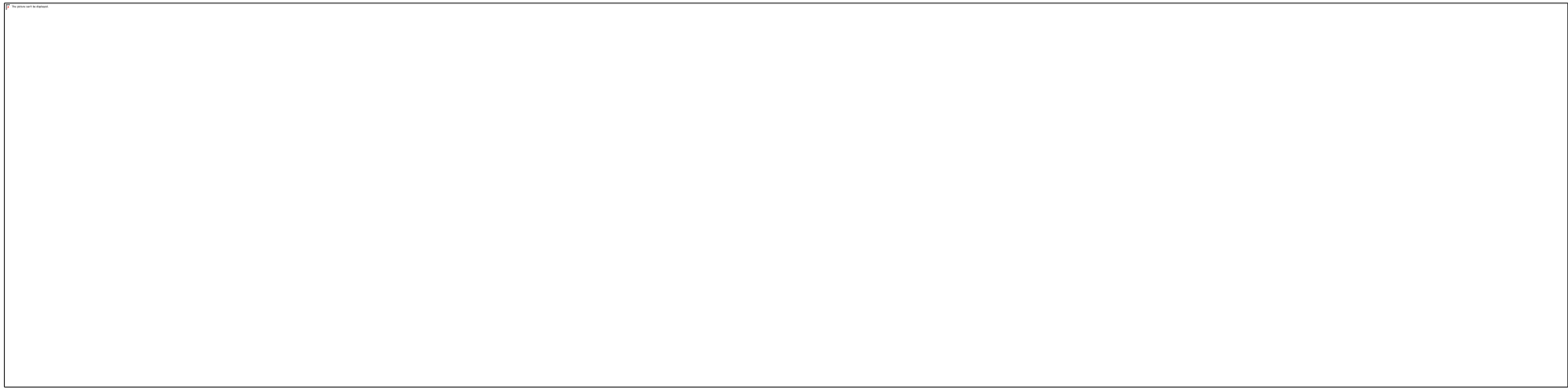
We are driving this measure because…	The breakthrough is on Retention – focus on Healthcare Assistants (HCA) turnover. HCAs have the highest turnover of any staff group at circa 21%. The breakthrough objective is to improve this to a target of 15% turnover by March 2025. SFT currently measures the highest 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: 19.1% Position: Special Cause Improvement

Understanding the Performance	Countermeasure Actions	Due Date	Risks and Mitigations
The rate of turnover for Additional Clinical Services (ACS) staff was 19.08% in August (down slightly from 19.17% July) continuing the general reduction trend since adoption as a breakthrough objective. The Trust turnover rate sits at 13.39% (second month in a row this has gone up slightly since June). Against the divisions, Estates have the highest turnover at 16.93%. Only CSFS is under the 12% Trust target. 11 staff (9.24 FTE) left the Trust in June 2024, this represents a slight reduction compared to the previous month.	• Launch and review success of HCA Preceptorship to improve training/induction experience. First cohort due to complete in December 2024 (HCA retention lead). • New to care HCA tagged at Induction, shadow shifts provided in first 3 months of employment. (HR / HCA retention leads). • Lack of development of HCA colleagues. Apprenticeship / career development routes. HCAs onboarded directly onto “apprenticeship route”. Other HCAs have option to step on to route. Completes higher development award (HCA Retention lead).	Jul 24 (launch) May - Sep 24 Q2 2024	• Impact of raise of national living wage and delay of pay review body announcement risks loss of staff to other roles. Mitigation to ensure all staff move to Band 3 provision as quickly as possible. Approved at July TMC for immediate implementation. New pay award implemented August 2024. • Demand for ACS staff outstrips local supply. Staff at lower pay levels cannot travel. Wider engagement through local schools, colleges and job centres to attract individuals new to care.

Sickness Absence

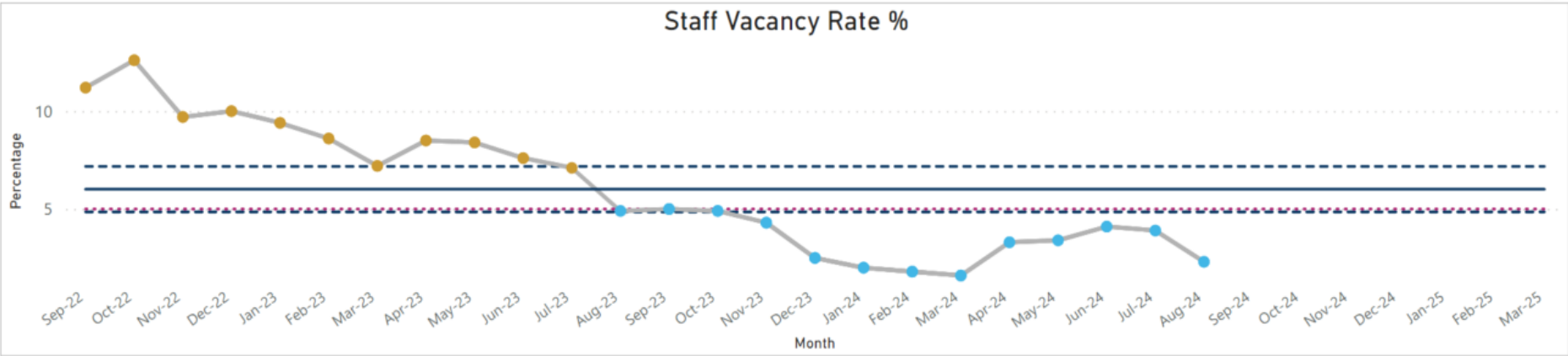
Target: ≤3% Performance: 3.5% Position: Special Cause Improvement



Understanding the Performance	Countermeasure Actions	Due Date	Risks and Mitigations
Sickness absence has stabilised over the last 3 months and gone down slightly to 3.5%, the lowest since May. Corporate and CSFS are both under the target 3% with EFM the highest at 4.5%. Additional clinical services at 5.51% (down from 5.62%), remain the worst performing staff group, which triangulates with high turnover rates as well. Sickness accounted for 4,313 FTE days lost to the Trust, of which c2/5 were for long term and c3/5 short term absence. Highest absence rate remains Anxiety / Stress / Depression, accounting for c.1 in 5 absence days.	• Line Manager 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.	Dec 24 Mar 25	• Low availability of instructors and advisers to support training interventions and workplace support to LM due to ongoing vacancies in HR team. • The HR team has been recruiting to better support the programmed activity but this currently remains a risk until new starters are in post. As of September 2024 the HR team has one substantive WTE HRA in post and is reliant on temp staff (currently 1.8 WTE in post). • B7 team manager role being covered part-time by HR BP. • 1.6 B6 HRA on maternity leave. 2.2 WTE vacancies. 0.5 B5 vacancy. B4 currently FTC cover for Maternity leave has also now resigned.

Vacancies

Target: ≤5% Performance: 2.30% Position: Special Cause Improvement



Understanding the Performance	Countermeasure Actions	Due Date	Risks and Mitigations
A drop of c.63 FTE (159 FTE to 96 FTE vacancies) in the Trust saw the headline rate fall again from 3.87% to 2.32% in M5, consistently below the Trust target of 5% for over 12 months running. The highest FTE vacancy rates are in Theatres (39 FTE), followed by Pathology and Informatics (both 19 FTE). Theatres is in the top 5 for Temporary staff spend (£26k Agency and £62k Bank).	• Focus attraction campaigns to meet high vacancy and hard to recruit areas. Current focus is Theatres, Emergency Department, Maternity, HCAs and Housekeeping. A campaign has also been launched to attract consultant staff in hard to recruit posts. • Hard to Recruit roles: Job offers in progress/ready to start for Clinical Coding, Respiratory Physiologist and Consultants in Stroke, Endocrinology and Respiratory. • Identification of new areas for apprenticeships through Coventry Programme. Nursing Associate Degree Apprenticeships initial focus.	Aug 24 Sep 24 Sep 24	• 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 onboarding processes. Implementation of PWC 'overhauling recruitment' programme phase 2 recommendations. • Successful appointment and induction ongoing of new Recruitment manager.

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 %	85.0%	85.4%	85.2%	90.0%	85%		Special Cause Concerning - Below Lower Control Limit	X	19
Medical Appraisal Rate %	90.9%	92.5%	87.6%	90.0%			Common Cause Variation	X	1
Non-Medical Appraisal Rate %	78.1%	78.4%	76.0%		90%		Special Cause Improving - Above Upper Control Limit	X	48
Staff Turnover (Trust overall)	13.3%	13.3%	13.4%	13.0%			Special Cause Improving - Below Lower Control Limit	X	48

Watch Metrics: Alerting Narrative

NHS Salisbury NHS Foundation Trust

People

Understanding the Performance

Mandatory training remains below target at 85.2% completion. This has been falling throughout the current financial year and is almost 4% below the 90% target. Only Facilities at 96% have consistently met this target, through the application of significant oversight from their management team.

Medical appraisals are below the 90% target with appraisals in August at 87.6%. This is the first drop since April. The number of medical appraisals out of date continues to gradually increase, sitting at 100 out of date and a further 45 (up from 27) > 3 months out of date.

The trend for non-medical appraisals since the start of FY 24/25 has seen a drop in completion rates, now down to 76% in August. The application of significant oversight is required to reverse this trend moving forward.

Turnover trends at the Trust in the last 4 months have plateaued and is just under.13.4%, from last years' high of 14.5% average.

Countermeasure Actions

• A review of Mandatory training requirements, aligned to the core skills training framework, and national guidance seeks to better understand the mandated training environment and the time required to complete training. On completion this review will identify any changes to the provision and need for statutory and mandatory training in different roles and professions. The review was due to report in July 24, awaiting confirmation of outcome from Head of Education.

• 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. Further analysis of organisational structure to support those managers with a high appraisal burden is ongoing and due to report in Aug 24. This report is still outstanding.

• Turnover: Training and education to improve exit conversations will support further work across the Trust to better investigate the negative reasons for leaving and target these areas to mitigate negative reasons for leaving the Trust.

Risk and Mitigations

• The ability to accurately record and assign statutory and mandatory training to staff is a key function in understanding risk to the Trust from training gaps. A programme of work is underway to improve the MLE system in assigning and identifying staff gaps in training.

• 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. This training and revision to the guidance has been delayed due to significant/ongoing vacancies in the HR Operations team.

• 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 in Q2 and these are being led by the Associate Director for Communication & Engagement.

Part 3: Finance and Use of Resources

Performance against our Strategic Priorities and Key Lines of Enquiry

Our Priorities

People

Population

Partnerships

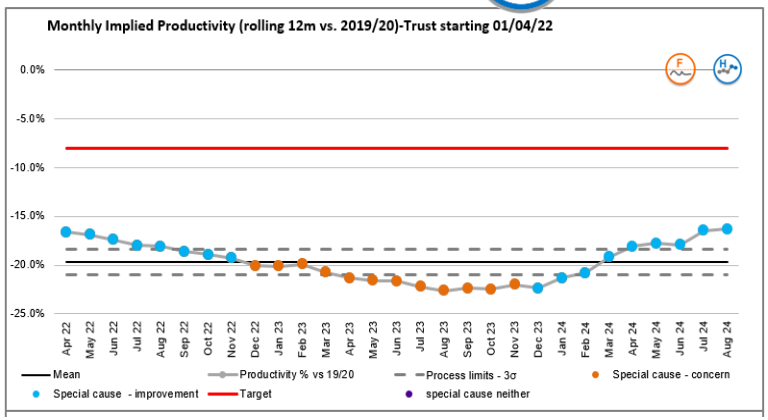
Creating Value for Our Patients

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: -16.3% Position: Special Cause Improvement



Understanding the Performance
In Month 5 pay pressures due to annual leave and bank holidays cover and medical agency costs combined with increased drugs and clinical supplies costs, and lower levels of activity across all points of delivery, have driven the 0.1% improvement in productivity delivery. There is an improvement of 2.4% delivery since March and is due to cost being mitigated by Day cases and Outpatients 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.

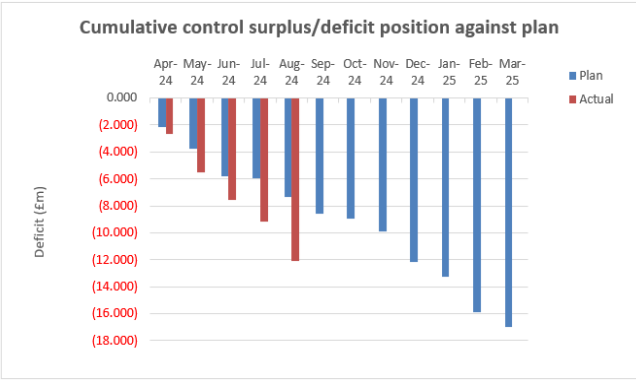
Countermeasure Actions	Due Date
• FRG task and finish group operating on alternate fortnight basis to review headcount above March 23 levels	Ongoing
• Modernisation and consistency of admin processes	Ongoing
• Further analysis of Workforce utilisation modelling to consider annual leave, study leave, sickness and roster overlaps	October
• CDC Improvement trajectory	October

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

Income and Expenditure

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

	August '24 In Month			August '24 YTD			24-25
	Plan £000s	Actual £000s	Variance £000s	Plan £000s	Actual £000s	Variance £000s	Plan £000s
Operating Income							
NHS Clinical income	25,561	25,012	(549)	129,382	127,157	(2,225)	311,071
Other Clinical Income	952	1,046	94	4,813	5,320	507	10,794
Other Income (excl Donations)	3,275	3,825	550	16,375	16,079	(296)	39,300
Total income	**29,788**	**29,883**	**95**	**150,570**	**148,556**	**(2,014)**	**361,165**
Operating Expenditure							
Pay	(19,579)	(20,494)	(915)	(98,743)	(101,369)	(2,626)	(236,139)
Non Pay	(9,706)	(10,668)	(962)	(49,709)	(50,916)	(1,207)	(119,377)
Total Expenditure	**(29,285)**	**(31,162)**	**(1,877)**	**(148,452)**	**(152,285)**	**(3,833)**	**(355,516)**
EBITDA	**503**	**(1,279)**	**(1,782)**	**2,118**	**(3,729)**	**(5,847)**	**5,649**
Financing Costs (incl Depreciation)	(1,887)	(1,686)	201	(9,436)	(8,397)	1,039	(22,654)
NHSI Control Total	**(1,384)**	**(2,965)**	**(1,581)**	**(7,318)**	**(12,126)**	**(4,808)**	**(17,005)**



Understanding the Performance	Countermeasure Actions	Due Date	Risks and Mitigations
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. In month the Trust recorded an in month control total deficit of £3.0m against an original deficit target of £1.4m - an adverse variance of £1.6m. The deficit position year to date is driven by underperformance on Elective Recovery Funding (ERF) points of delivery, with higher level of non elective activity volumes and pathways than planned driving an increased bed base, additional backfill requirements and medical agency plus drugs and clinical supplies costs.	• Financial recovery group (FRG) in place to review recovery actions with alternate fortnightly workforce group to review headcount.	Ongoing	• 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.

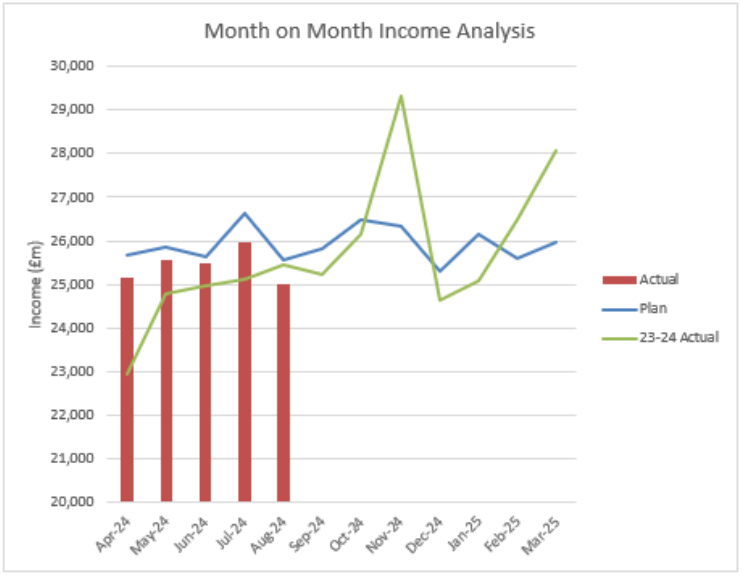
Income and Activity Delivered by Point of Delivery

Salisbury NHS Foundation Trust

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

Income by Point of Delivery (PoD) for all commissioners	August '24 YTD		
	Plan (YTD) £000s	Actual (YTD) £000s	Variance (YTD) £000s
A&E	5,007	5,372	365
Day Case	10,533	10,833	300
Elective inpatients	8,909	6,314	(2,595)
Excluded Drugs & Devices (inc Lucentis)	11,417	12,570	1,153
Non Elective inpatients	33,629	33,822	193
Other	41,950	40,139	(1,811)
Outpatients	17,937	18,107	170
TOTAL	129,382	127,157	(2,225)

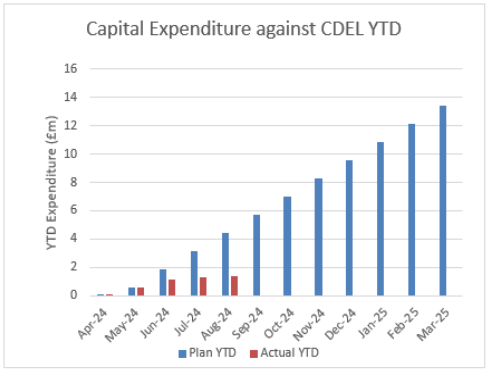
	Contract		
	Plan	Actual	Variance



Understanding the Performance	Countermeasure Actions	Due Date	Risks and Mitigations
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. The level of uncoded day cases and inpatient spells is 24% in July and 94% in August at the time the activity was taken for reporting purposes. This is a slight improvement on the July position of 31% in June and 94% in July. Activity across all of the main points of delivery was lower in August than July.	• Contract values have been agreed with all commissioners and issues remain outstanding by exception. Contracts are progressing to signature.	Ongoing	• The Month 12 23/24 and in year ERF positions have not yet been published by NHS England. • 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



Understanding the Performance	Countermeasure Actions	Due Date	Risks and Mitigations
Capital expenditure on both CDEL and nationally funded projects totals £1.8m driven by Imber ward, the decarbonisation scheme and CT2 scanner installation costs. The cash balance at the end of Month 5 was £14.9m above the planned level of £4.4m. The improvement is due to the BSW ICB contract payment which was doubled in month to mitigate short term cash issues. Daily cash monitoring is in place and supplier payments are being actively managed to reflect supplier payment terms.	• Capital cash support application • Revenue cash support application	September November	• 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 constraint of both available cash and system capital expenditure limits gives rise to both a mid and long term risk to the Trust. The context of digital modernisation programmes, along with an aging estate and medical equipment means the Trust's five year capital requirement is well in excess of available resources. The Trust seeks to in part mitigate this risk through the proactive bidding for national funds where available.

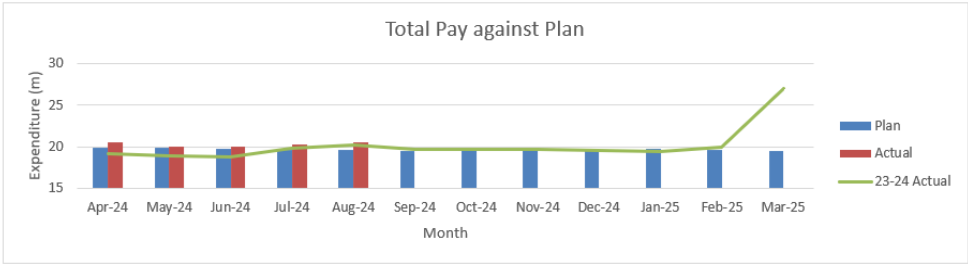
Workforce and Agency Spend

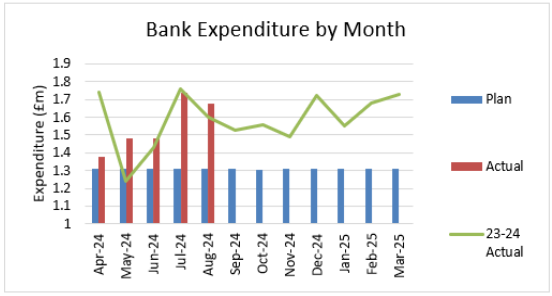
NHS Salisbury NHS Foundation Trust

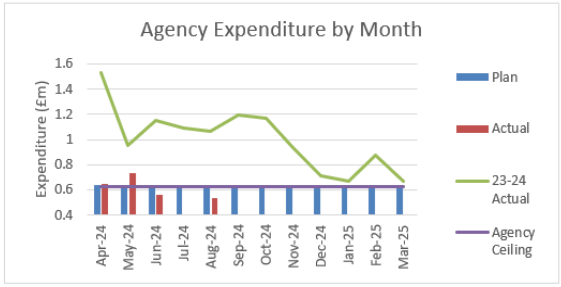
Target: N/A Performance: N/A Position: N/A

	August '24 YTD		
	Plan £000s	Actual £000s	Variance £000s
Pay - In Post	88,705	90,417	(1,712)
Pay - Bank	6,560	7,754	(1,194)
Pay - Agency	3,176	2,802	374
Other (eg apprenticeship levy)	302	396	(94)
TOTAL	**98,743**	**101,369**	**(2,626)**
Medical Staff	24,453	27,958	(3,505)
Nursing	27,267	26,463	804
Support to Nursing	9,723	8,515	1,208
Other Clinical Staff	13,372	13,575	(203)
Infrastructure staff	23,626	24,463	(837)
Other (eg apprenticeship levy)	302	396	(94)
TOTAL	**98,743**	**101,369**	**(2,626)**

	August '24 YTD		
	Plan WTEs	Actual WTEs	Variance WTEs
Medical Staff	533.7	614.73	81.0
Nursing	1,226.2	1,276.19	50.0
Support to Nursing	453.9	596.57	142.7
Other Clinical Staff	838.6	646.74	(191.9)
Infrastructure staff	1,383.9	1,453.92	70.1
TOTAL	**4,436.3**	**4,588.2**	**151.8**







Understanding the Performance

Pay costs in month were £0.9m above plan and driven by unavailability increases for annual leave and bank holidays, medical agency costs and increased substantive staff.

Substantive costs increased by £0.1m, bank costs reduced by £0.1m each and Agency costs increased by £0.2m.

The pay savings target was £4.7m against which achieved pay savings were £3.3m - an adverse variance of £1.4m, with £1.1m recurrent delivery.

Substantive staff have increased in month by 94 WTE which will be impacted by up to 82 WTE for the Junior Doctors August rotation. There is an overestablishment of 70 WTE (adjusted by 82 WTE for the Junior Doctors rotation) against the 4,436 WTE Workforce trajectory (4,309 WTE at March 25). The over establishment is across all Pay categories with the exception of Other Clinical Staff.

Countermeasure Actions	Due Date
• Trust wide and Division workforce control panels in place since November 23	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 in the short term it is likely that the Trust will require both.

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

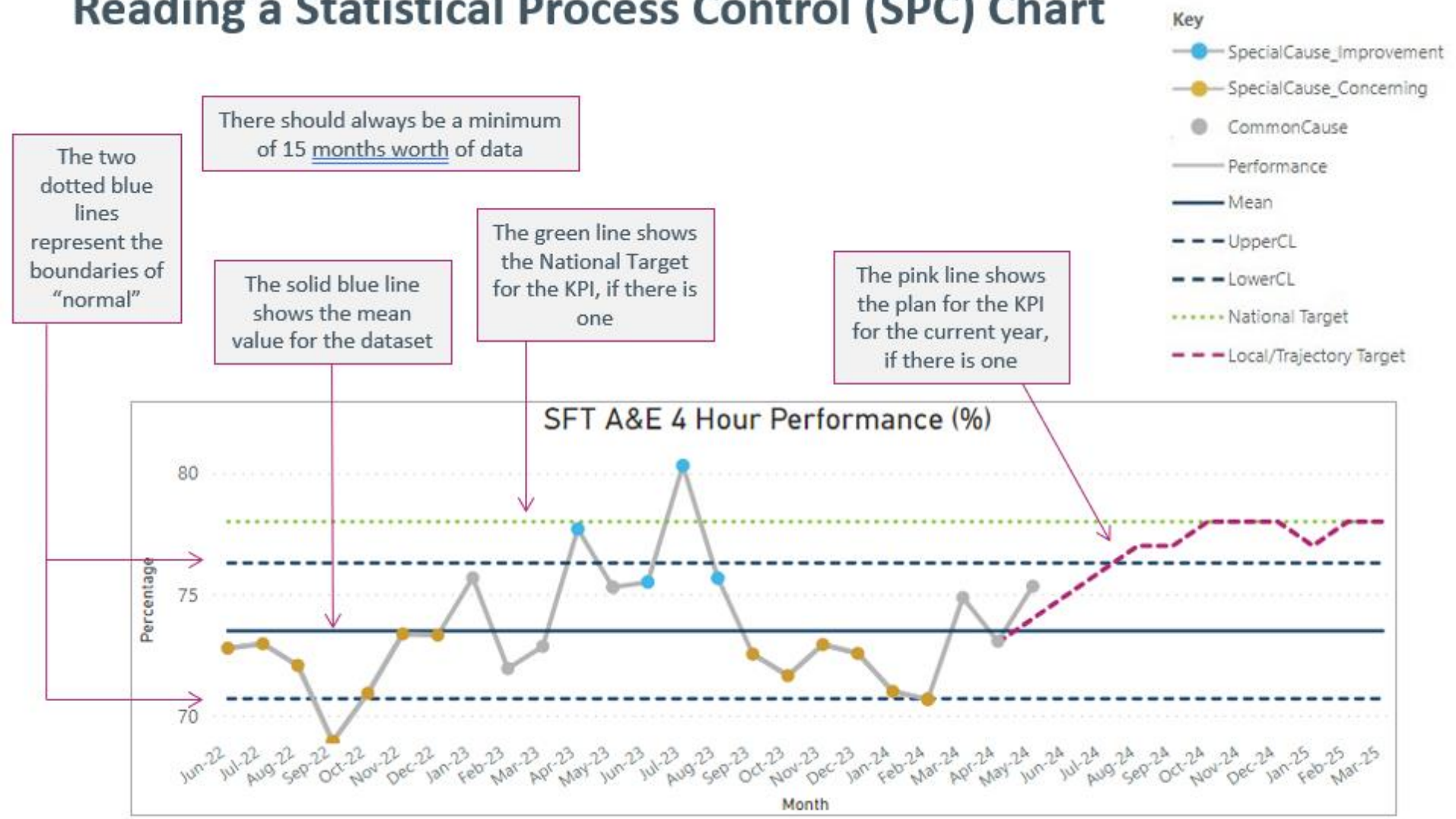
There should always be a minimum of 15 months worth of data

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 Board (Public)	Agenda item:	2.2
Date of meeting:	3 October 2024		

Report from (Committee Name):	Audit Committee		Committee Meeting Date:	19 Sept 2024
Status:	Information	Discussion	Assurance	Approval
	X		X	
Prepared by:	Richard Holmes (Audit Committee Chair)			
Non-Executive Presenting:	Richard Holmes			
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.

- There are no alerting matters to raise to the Board.

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 Committee received a Deep Dive covering the process of obtaining theatre consent prior to procedures being carried out. Other than for certain emergency procedures, it is a requirement that full consent for all procedures planned is obtained prior to the patient arriving in theatre so that voluntary, informed and unpressurised consent can be given beforehand and in discussion with clinicians.

  In all cases consent is required to be reaffirmed immediately prior to the procedure.

  On ten occasions in the last 24 months there have been incidents where consent had been obtained in the operating theatre and not beforehand. The Executive therefore raised this to be considered as a Deep Dive by the Audit Committee.

  The Team has completed an A3 using Improving Together methodology and identified a number of actions. These are primarily associated with reinforcing learning and behaviours as distinct from process redesign.

  The Committee was assured that the action plan in place was appropriate, requested an update on progress in the Spring, and recommended the discussion be considered as part of CGC business.

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

- The ongoing programme of Internal and Counter Fraud Audits continues. The first joint internal audit covering Cyber Security across both SFT and GWH has been completed, which as provided Amber/Green 'significant assurance with minor improvement opportunities', in line with management expectations.

  KPMG, the Local Counter Fraud auditors for the Trust, continue to receive and deal with referrals from within the Trust, none of which are significant. They are working with the Director of Integrated Governance to design and deliver a series of events to staff during National Fraud Awareness Week taking place during the week of 12 – 18 November.

  The Data Security and Protection Toolkit (DSPT) Certificate review was completed by the SIRO which provided 'Significant assurance with minor improvement opportunities' in line with management expectations. This is the last year that the DSPT will exist in this form, being replaced by a more comprehensive Cyber Assurance Framework next year.

- Systems that are rated at SOF 4 are required to undertake additional scrutiny to determine if each of the organisations within it operate within appropriate levels of financial and other governance. The Checklist covers Finance, Workforce, Procurement and Estates processes and controls. In anticipation, SFT has undertaken its own pre-assessment of the 'Grip and Control' checklist issued in November 2023 and this was reviewed by the Audit Committee. The Trust has reviewed each of the 44 measures within the checklist and prepared an action plan for seven areas that SFT considers that additional controls could be effected.

  Progress against self-assessed actions will be presented to Audit Committee in December 2024

- The Audit Committee received the regular Register of Losses and Compensation, and the Payroll Overpayments report with no material losses reported.

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

- The Committee reviewed the effectiveness of the Board Assurance Framework process and recommends to the Board that the Board Assurance Framework remains effective. The newly considered definitions of Risk Appetite is nearing completion following reviews at Board sub-committees and will be presented to the Board for approval in October.

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:	2.3
Date of meeting:	3rd October 2024		

Report from (Committee Name):	Trust management committee TMC		Committee Meeting Date:	25/09/2024
Status:	Information	Discussion	Assurance	Approval
	x			
Prepared by:	Interim Chief Executive, Lisa Thomas			
Non-Executive Presenting:	Interim Chief Executive, 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 underlying challenge to both the operational and financial plan is the high number of patients currently who are medically fit for discharge, this in turn has meant more beds open than planned. The committee received a presentation on the actions to mitigate but recognised the risk entering winter.
- Winter planning is showing significant bed challenges without further actions, the Chief operating officer is working with system partners on a mitigation plan. The Committee agreed further discussions needed to take place as to the first draft winter plan and escalation plans.
- The Financial position remains a challenge, the committee discussed what further controls should be put in place and work was underway in the coming weeks to discuss at Trust Board.
- The Pathology LIMs replacement programme is behind plan due to wider system working across the pathology network. There is a replanning exercise on the 24th September to understand resource implications.

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 urgent care Board outlined the improvement in metrics on ED 4 hour performance, bed occupation, say day discharges and reduced ambulance waiting times. Focus on is on the culture flow and discharge processes across the Trust.

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

- The committee received an update from Health and Safety committee showing the targeted work was focused on the use of TUGs in the hospital and reducing violence and aggression particularly from patients and relatives.

Approvals: Decisions and approvals made by the Committee/ Any recommendations for further ratification by the Board.
• Business case for introduction of Mohs Surgery was approved as will benefit patient experience and enable a better pathway. Next step is to the ICB finance committee for approval. • Approved the terms of reference and annual workplan for TMC.

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:	2.4
	3 October 2024		

Report from (Committee Name):	Finance & Performance Committee		Committee Meeting Date:	24 September 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.

- **NCTR -** Numbers are still too high at an August average of 93, despite actions have been taken to improve the position at SFT; increased zero days, more patients through pathway 0 & 1, Breamore ward, and improved clinical engagement. There is an urgent need to shift position, through a better understanding of demand and capacity models, discharge processes and behaviours, getting Hospital at Home to work more effectively and to understand ICS actions that will make a difference. If NCTR increases through winter, it will jeopardise our elective recovery plans and winter planning. We have asked for some principles (how we balance the tensions of quality, finance and operations), key metrics and short-term actions to be tabled.
- **Winter Plan –** Without an improvement in NCTR the winter plan will be under significant pressure, however actions being taken will help; Imber (24 extra beds), Breamore "home is best" model, expansion and increased direct streaming to SDEC, and the planned increase in discharge space in Pitton.
- **Financial Performance** – we are off plan by £4.8m and need to explore every opportunity to get back to plan of £17m deficit, acknowledging the challenges of improving NCTR (impact £5.6m), and unidentified CIPs (impact £4.1m). There are a number of uncertainties drawn out in the CFO paper, which will be covered in a short paper to Private Board.
- **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.

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.

- **National Cancer reporting error** – whilst assurance that internal reporting is accurate an error in the upload of data for national reporting was flagged, with additional controls added to ensure no future repeat.

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

- **Digital and Cyber –** good progress with our server replacements, with only 34 unsupported servers left to replace by the end of year. Confirmation that our infrastructure is EPR ready, although EPR timelines have slipped a bit, which has provided some resource and funding capacity to LIMS and the CAFM system to address the highest risk in estates. Assurance on 14-day turnaround on "high risks" and resolution of penetration test issues by end of September.
- **Cancer performance (IPR) –**The regional team are recommending that we come out of tiering.
- **Breakthrough objectives (IPR) –** Productivity and managing patient deterioration continue to improve. There has been good progress in other metrics too – RTT and diagnostics, with an A3 session on ED performance.
- **Subsidiary Governance and performance –** performing close to play with plans to bring each back with a commercial evaluation around strategic role and contribution in SFT.
- **Procurement & Commercial Services –** good assurance, including CIPs of £3.8m (£1.2m).

Approvals: Decisions and approvals made by the Committee/ Any recommendations for further ratification by the Board.
• **Risk Appetites for Financial and Operational** – Recommended to Board. • **Primary Care Minor Injuries and Illness Managed Service –** Recommended to Board • **Non-Emergency Patient Discharge Service** – Recommended to 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):	

Report to:	Trust Board (Public)	Agenda item:	2.5
Date of meeting:	3 October 2024		

Report from (Committee Name):	Clinical Governance Committee		Committee Meeting Date:	24/9/24
Status:	Information	Discussion	Assurance	Approval
			x	
Prepared by:	Anne Stebbing			
Non-Executive Presenting:	Anne Stebbing			
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.

- Continued concern about accuracy of training data. Noted to be discussed further at People and Culture committee.
- Unannounced visit from CQC to Maternity on day of CGC 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.

- Review of 5 recent never events has identified that relevant policies were in date at the time of 4 out of 5 events. For the 5th policy there had been no change to clinical practice or guidance.
- Highest risk for CSFS - Lloyds pharmacy notice of intention to novate pharmacy
- Increase in high harm incidents in August. No new risks identified.
- Pressure sores remain a concern. There is still an education need across the Trust.
- CGC to receive deep dive into managing patient deterioration in November to better understand the data behind this breakthrough metric.
- Intensive support is to be provided for gastroenterology, recognising the impact of BAF risks 2 and 7 on this service.
- Complaints closed within target remains challenging.
- BAF 10 - effective partnerships at PLACE - the committee questioned whether this should be reconsidered to include wider partnership context. CEO to review
- Future CGC to consider how to improve assurance regarding shared learning and how the Trust triangulates the sources of information.

ASSURE: Inform the board where positive assurance has been achieved, share any practice, innovation or action that the Committee considers to be outstanding.
• Noted from CSFS divisional governance review -improved position of number of in date policies • Good participation in governance meetings in CSFS. • Review of recent C. diff cases in acute frailty unit has shown cases were not linked, and good IPC guidance was followed. A new SOP has been introduced to describe processes around decontamination **and** maintaining unit flow. • Improved response rate for FFT has been maintained. • CGC agreed risk category definitions, risk appetite descriptors, and following discussion agreed risk tolerances for the clinical risks. To be proposed to the board. • Improvement in mortality statistics noted and assurance provided by 98% of deaths being reviewed by medical examiner. • Review of external agency visits and subsequent action plans showed good progress. • Annual reports for 2023 - 2024 on both adults and children's safeguarding both noted to provide assurance. • Perinatal surveillance data report for July and August, Maternal Safer Staffing, and Maternal quality and Safety report Q1 were all received and continue to provide good assurance. The challenges of delivering Savings Babies lives bundle were discussed. The committee was assured of the progress being made. • MSSP Exit paper has now been approved at ICB board and SW regional group.

Approvals: Decisions and approvals made by the Committee/ Any recommendations for further ratification by the Board.
None.

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:	2.6
Date of meeting:	3rd October 2024		

Report from (Committee Name):	People and Culture Committee		Committee Meeting Date:	26th September 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.

- The key issue to escalate relates to the MLE platform used by the Trust. Both Audit Committee and the Clinical Governance Committee have raised concerns, the first in relation to recording of training in theatres and the second in relation to recording safeguarding training. The committee have commissioned a deep dive in response to these concerns.

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 revised Board Assurance Framework (BAF) - see assure below
  - The OD&P annual report – see assure below. A detailed discussion was held in relation to supporting managers to manage through effective training. This followed the announcement by Amanda Pritchard at the NHS Confederation about training managers
  - IPR / Key Performance Indicators (KPIs) noting strong performance and areas of risk / mitigation
  - Internal Audit reports, noting a new report relating to agency staff management
  - WRES and WDES reports (these are also on the Board agenda)
  - The Guardian of Safe Working (GOSW) report
  - On call payments recommendations (this is also on the private Board agenda)
  - The GMC survey was noted and a further report will come back to a future meeting with relevant actions

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

- There was a discussion about the risk appetite documentation previously circulated. The team were thanked for their work on this and it was approved, noting that as a live document there may need to be changes in year
- The first OP&P annual report was presented by the Deputy Chief People's Officer. The report provided strong assurance in relation to the positive work undertaken by the team whilst being realistic about the ongoing challenges
- All actions from previous audits completed

- A WDES lead is now in post
- At the end of the meeting, as part of Improving Together discussion, it was felt that there was good triangulation between committees

Approvals: Decisions and approvals made by the Committee/ Any recommendations for further ratification by the Board.
• WRES and WDES reports • Guardian of Safe Working report • On call payments (private 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):	

Report to:	Trust Board	Agenda item:	3.1
Date of meeting:	3rd October 2024		

Report title:	Improving Together Quarterly Report (Q2 2024/25)			
Status:	Information	Discussion	Assurance	Approval
			✓	
Prepared by:	Alex Talbott, Director of Improvement			
Executive Presenting:	Alex Talbott, Director of Improvement			
Appendices (if necessary)				

Executive Summary:

Over the latest quarter (Q2 24/25) we have seen continued and sustained growth in the use of the Improving Together methodology across the Trust. 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. These are seen as tipping points in the deployment of Improving Together.

This has led to a deepening of the Operational Management System in divisions through an increasing use of scorecard agreements and performance review meetings with specialities and teams. This has the effect of increasing strategic alignment across the improvement work going on across the Trust.

The rollout and use of our Leadership Behaviours Framework is beginning to show signs of behavioural change and impact. Teams with higher levels of engagement and completion of the Leadership and Management programmes and courses are showing stronger performance in the staff survey, while the use of leadership behaviour charters is growing across the Trust. The development of leadership behaviours that support improvement and personal development is fundamental to the success of Improving Together. The evidence shows continued strengthening of the collaboration and therefore overall effectiveness of the OD&L, Coach House and Transformation teams.

Our deployment and alignment of Improving Together across the Group is increasing in momentum 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.

In summary, a review of the next steps listed in May 2024's quarterly update shows:

1. Build out and resource via Corporate Projects Prioritisation Group (CPPG) our programme of improvement for 24/25 – completed and now progressing in to business planning for 25/26
2. Focus on connecting the Operational Management System up by coaching and supporting scorecard agreements and instigating the routines of daily/weekly improvement huddles and monthly performance review meetings (PRMs) for every team trained in 24/25 – A doubling of active improvement huddles since May (15 to 38), 23 scorecards and 19 PRMs live.
3. Work on ways to further align our OD&L and Improving Together training programmes – Improver Leader nested as part of the Transformational Leadership Programme

4. Work with our AHA and system colleagues to develop an AHA Strategic Planning Framework – First draft completed and discussed at the All Trust Executive meeting in September.
5. Roadmap the next phase (October 2024 to March 2026) of Improving Together at SFT to ensure we sustain and continue to deepen our us of the approach. – Completed across the summer, with desired outcomes described in appendix 1.

Below we have used the Alert, Assure, Advise approach to help inform the Board of our levels of assurance in the deployment and development of Improving Together at SFT.

Key discussion points and matters to be escalated:

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.

- None escalated from Improving Together Board.

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.

- Conversion of Improver Standard training to active use of improvement huddles is around 30%. This remains lower than we would need for us to get the most from of our collective investment in training. The Coach House has adopted this metric as one of their drivers in their performance review meeting. A key driver of improving this is thought to be clarity of leadership support for use of improvement huddle boards.

- Masterclass utilisation – low attendance on the courses (1.5-3hrs long). The Coach House is reviewing the structure, promotion and balance between bespoke workshops for teams versus booking teams onto masterclasses. The review will identify next steps, which may include a re-design of the masterclass offer.

- Members of the Transformation team have been successful in their applications to join the shared Electronic Patient Record programme team This is a positive outcome for the individuals and the programme. However, this will reduce the availability of overall project resource as we seek to recruit new starters or decide not to backfill the roles. A review of current and future workplans is undertaken each month to map resources via CPPG and we have identified improved triangulation with the EPR programme is required. Colleagues from the EPR programme have joined our Corporate Projects Prioritisation Group to support the triangulation.

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

- We have achieved our target of training 50% of teams at Improver standard level by September 2024. The rotational roles have enabled this to happen alongside increases in the level of improvement coaching delivered to trained teams.

- Utilisation of the Improver Standard training remains high, with a strong pipeline of bookings into 2025 and consistently positive feedback on the effectiveness of training delivery.

- Improver Leader: 50% of speciality triumvirates will be trained by the end of Oct 2024.

- Improver Leader: from November 2024 piloting bringing it into the modules of the transformational leader programme to better align the two programmes.
- Through the consistent and quality work of the OD&L team, awareness and use of the leadership behaviours framework and charters are growing.
- Clinical Division maturity self-assessments show continued development of knowledge, skill and confidence in the methodology.

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):	

Improving Together Quarterly Roadmap Progress Report – October 2024

1. Training update

1.1. Current situation

Improver Standard and Improver Leader: In September 2024 we achieved our target of training 50% of teams at Improver Standard level. This will shortly be followed by having at least 50% of speciality triumvirates trained at Improver Leader level by the end of October 2024. Based on the experience of organisations who have deployed Operational Excellence (aka Improving Together) before, these are seen as tipping points in the deployment of Improving Together. Training participant feedback, utilisation rates and the pipeline of bookings all remain strong. The addition of three rotational Improvement Practitioner roles has enabled the delivery of the target.

The development of **Introducing It** as part of the My First 90 Days induction programme has been particularly successful with 96 representatives from over 47 areas across the hospital in attendance. The Introducing It session for existing staff has been delivered to over 500 members of staff since its inception at the end of March 2024. It has received positive feedback, with an average 4.3/5 delivery score (both for new starters and existing staff).

Improver Advanced and Masterclasses have seen lower levels of utilisation as awareness of the new approach and dates grows across teams.

1.2. Next steps

Improver Standard: Continue to meet quarterly with divisional management teams and OD&L to prioritise the training pipeline. Review which trained teams require re-training due to staff turnover.

Improver Leader: Starting in November, formalise more collaborative working between OD&L and the Coach House by piloting Improver Leader becoming part of the Transformational Leadership programme. *Note:* the OD&L team already provide a half day of Improver Standard.

Improver Advanced and Masterclasses: This is an area of focus for the Coach House team over the next quarter as they seek to ensure the new training structure and offer meets the needs of our teams. In the meantime, the Coach House continue to support teams on an ad-hoc basis with workshops focusing on tools such as A3s, process standard work, and in preparing teams for their scorecard agreement and first performance review meeting.

2. Operational Management System (OMS) update

The Operational Management System is how the strategic focus of the organisation cascades up and down from Board to division, speciality and team, and back again. The goal of training teams is to give them the knowledge, skills and confidence to use the OMS. We monitor the depth and breadth of the OMS via the number of active improvement huddle boards, the number of scorecard agreements and performance review meetings across the divisions and the alignment of a team's drivers with the strategy.

2.1. Current situation

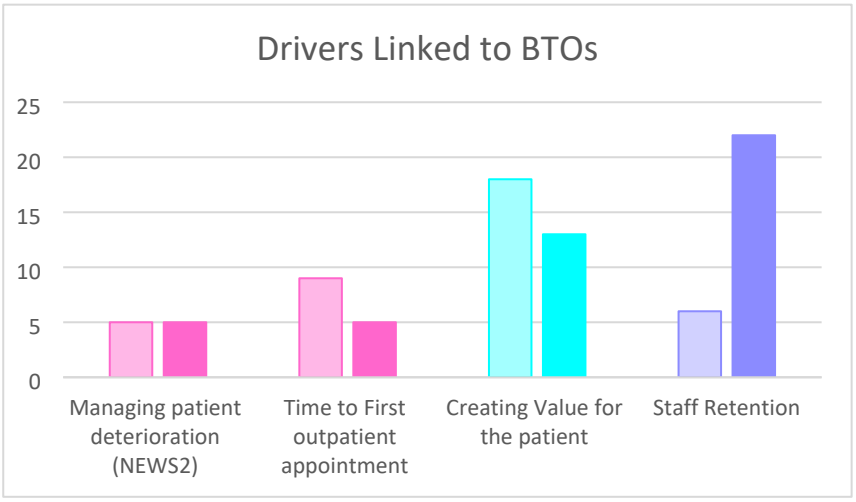
Improvement Huddles: We have 38 active improvement huddles across the Trust, up from 15 in May 2024. The conversion rate from training to an active improvement huddle is 30%. The Coach House are actively focusing on improving this figure as one of their driver metrics.

Scorecard agreements and Performance Review Meetings (PRMs):

	CSFS	W&NB	Medicine	Surgery	Corporate	Total
Scorecard	6	3	10	1	3	23
PRMs	6	3	5	2 (at ward level)	3	19

Alignment of drivers: Teams and specialities chose their drivers – the areas they are focusing on to improve – as they begin to use the improvement huddle and performance boards. The chart over the page shows how they map to the breakthrough objectives at team and speciality level. The most popular breakthrough objective is creating value for our patients (productivity).

Project delivery and Corporate Project Prioritisation Group (CPPG): Alignment of our corporate resources to the strategy is a key part of the operational management system. It enables us to allocate resources to the most important programmes and projects in pursuit of achieving our strategy and vision. Examples of the benefits delivered via our projects and programme in Q2 are shown in Appendix 1.



Number of drivers aligned to each breakthrough objective. Coloured by Vision Domain, with lighter columns relating to Team drivers and darker columns Specialty drivers.

2.2. Next steps

Improvement Huddles: Our current understanding of the top contributor to not using improvement huddles is limited engagement with the team's leaders. Therefore, the Coach House will work to engage divisional and speciality leaders in promoting, recognising and rewarding the use of improvement huddles post-training. Supporting this is the use of Go & See by members of the Board, divisional management teams and heads of service to join teams at their improvement huddles to show the importance of the work and listen and learn from the improvement huddle.

Scorecard agreements and performance review meetings: Continue to support divisional, speciality and team colleagues as requested in the preparation for scorecards, including the promotion of the corresponding masterclasses

CPPG: Continue to map into 2025/26 so we can make informed resourcing decisions as the EPR programme and Group develop draws on more resources.

3. Leadership behaviours

3.1 Background & Context

The NHS Institute for Innovation and Improvement highlight in their Improvement Leaders' Guide - Leading Improvement that Leadership is about setting direction, opening up possibilities, helping people achieve, communication and delivering.

It is with this understanding that Salisbury NHS Trust introduced its new Leadership Behaviours Framework (LBF) in Q1 2023.

The OD and Leadership team have socialised the LBF across the Trust to over 590 people through varying means to create dialog, understanding and reflection as well as creating opportunities in how to apply and embed the framework in teams.

3.2 Qualitative impact data

The OD and Leadership teams continued work across our Trust (although still very early within its journey) we are already starting to see signs of behavioural change and impact.

According to our annual staff survey, a high performing team such as Transformation and Coach House, not only scored highly on the staff survey in all areas, with on average low staff turnover and sickness rates, they've also shown zero HR and FTSU interventions. What the data also shows is that the Transformation and Coach House Team have a 46% attendance rate on our internal leadership development programmes (with more booked on) which include a deep dive into our LBF. Their managers have attended 33 management workshops and the team invest in quarterly team development session with a focus on Leadership Behaviours. They also have an appraisal compliance rate of 85.7%.

In contrast when we look at the lowest performing team according to the Staff survey data, who have a 25.7% turnover rate, 7.7% sickness rate and a 47.1% appraisal compliance rate. The data also shows that only 4% of this team have attended one of our internal leadership programmes and only 2 management workshops.

The OD&L team will continue to deliver and add the LBF to its widening portfolio of work to ensure it is embedded and lived throughout our Trust.

4. Roadmap for Improving Together - October 2024 to March 2026

September 2024 saw the end of the first Improving Together 18 month Roadmap. The roadmap is how we track the nine workstreams that support Improving Together via monthly workstream meetings, which feed into the monthly Improving Together Board.

The roadmaps have been developed by Executive workstream leads and members of the Improving Together Board. The overarching objectives for each shown in appendix 2. At a high level these objectives are focused on the further alignment and embedding of the following across the Trust: the leadership behaviours needed for continuous improvement, the Improving Together methodology and the Operational Management System (OMS).

A key area of focus for the next 18 months is the increasing the visibility of the improvements teams are delivering. The introduction of a 'pink ticket' will create a standard process to recognise teams in corporate and local communications.

5. Wider System working

5.1. Coach House compare and contrast

Coach House Leads at SFT, RUH and GWH have undertaken a compare and contrast review of Improving Together across the AHA. This review has identified areas of further improvement and collaboration notably; simplifying the language, sharing of training

across the AHA, sharing of case studies/learning and increasing consistency/commonality of the material and collateral used.

A presentation with the recommendations from the report is scheduled in early October with the improvement leads at SFT, GWH and RUH. This will build on the work and start to design the next steps as part of the development of how closer working and collaboration between the Coach Houses can support the deployment and use of Improving Together at Group and as a Group.

5.2. Group level Strategic Planning Framework (SPF)

A draft SPF for the AHA/Group has been developed with the Trust CEOs. It will next be presented and discussed with all Trust Executives on the 27th September. Subsequently this SPF will help inform and guide the work of the Group as its strategy is built and connected to the ICB's strategy and the three Trust strategies.

This is a key step to holding Improving Together at the heart of how the Group will run and how work will be aligned at each Trust and influence the wider system.

5.3. Catalysis CEO Summit

On the 9th and 10th of October 2024, SFT will host the Catalysis CEO Summit. The summit involves 20+ CEO and Improvement Senior Responsible Officer colleagues from across Northern Europe and the UK visiting SFT to learn from our and the Group's work on Operational Excellence (Improving Together). This bi-annual summit, visits healthcare providers using Operational Excellence, and we are proud to be hosting this Autumn's event in recognition of the strides we have made over the past three years.

During the summit, visitors will go & see teams across our organisation. Our visitor's insight and experience of deploying Operational Excellence in their organisations will help us continue to improve. A communications plan has been developed to support the summit and celebrate the visit with our staff and local population.

6. Next steps

To continue to support the maturity of the OMS and build on the success of Improving Together at a Trust level we will focus on the following during the next quarter:

- Increase our sharing of successes and improvements across the organisation (including the pink ticket process)
- Host a successful CEO Summit on behalf of the Group, and reflect on our learning as a result
- Continue to improve the maturity of our OMS by increasing the number of PRMs and improvement huddles that are sustained over time
- Identify opportunities for collaboration across the Group within our Coach House teams and as part of the Group SPF being developed
- Continue to align Improvement and Leadership training programmes
- Plan and implement the review of the SPF and our breakthrough objectives in line with business planning and the formation of the Group SPF.

Salisbury NHS Foundation Trust

Appendix 1:

Some of the benefits delivered in the last quarter are outlined below;

Urgent Emergency Care projects: Bed occupancy Breakthrough objective - Creating value for the patient (productivity)

SDEC Bed Day Cost avoidance since go live on 27/03/23 to 31/03/24 - £760,000 From March 2024 to July 2024 Year on year savings £23,000 in bed day cost avoidance. Total £783,000

Zero-day length of stay for medical admission – 50% improvement [Pre SDEC 20.3% now running at 30.9%] SDEC zero-day LOS 47.3%

Acute Frailty Unit launch August 2023 - Bed Day Cost avoidance to End June 2024 - £2,543,832 – Average length of stay reduced by 12 days [from 16 days to 4 days].

ED improvements: Time to triage 51 mins to 32 mins improvement 19 mins – Streaming started in July 2024 and Triage time now at 7 mins against a Target of 15 mins.

% seen by a clinician with 1 hour 30% to 34% improvement 4 points. % in department less than 4 hours 59% to 62% improvement 3 points. % in department less than 12 hours 92% to 94% improvement 2 points.

Total Bed Day Saving across AMU and AFU - £3,326,832.

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.

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.

Expected benefits;

Reduction in on the day cancellations (Pre-op)

Improved compliance on national audit measures (Spinal) – completion already increased from 29% to 50%

Quicker triage of patients through waiting lists/reduced admin time (Respiratory and Wessex)

Planned Care projects: Breakthrough objective – Time to First Outpatients -Vision Metric timely access to care

Digitalisation of Appointment Letters 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

Dr Doctor digital assessments -

Enabled 6 outpatient services to make efficiency improvements.

Since deployment from May – July 2024, 1,838 forms have been assigned to 1,594 patients. **Overall completion rate is at 69.2%** but individual outpatient services are seeing compliance rates up to 78%. This places SFT the 4th highest completed rate among DrDoctor clients and the highest number of deployed assessments.

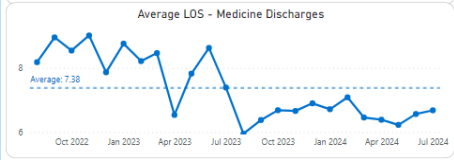
In pre-operative assessment – digital assessments decreases the rate at which patients need to travel to hospital (unless clinically advised) and increases accessibility for patients

NHS Salisbury NHS Foundation Trust

Vision Metric: timely access to care;

Successful opening of Imber Ward (new Medical ward) as part of the wider programme of elective recovery.

Benefits realised within Medicine division; Early indication is that LOS overall has reduced.



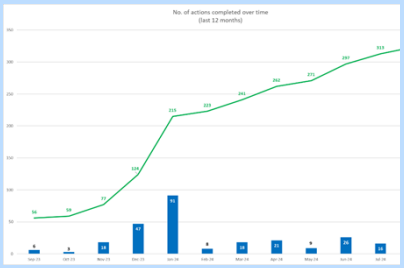
Benefits realised within Surgical division

Forecast to achieve targeted increase in elective day cases. Elective cases undertaken to YTD is 961 (BI dashboard). Extrapolated over 12months, forecasts an end of year position of 2883 against a baseline target of 2573.

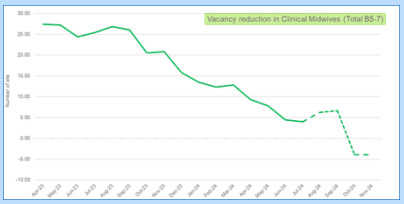
Surgery LOS reporting LOS has come in under target. Position for M4 meets Divisional Watch metric target. Elective 2.1 days (against target 2.6 days) AND Non Elective 3.5 days (against target 3.9 days)

Mandated time sensitive projects: Maternity Safety Support Programme (MSSP) – increase compliance with NHSE requirements to support exit

In the last quarter we have seen a further increase in compliance from 62% to 86% compliant. Eligibility for formal Exit from MSSP agreed at Exit meeting by Trust, LMNS, ICB, Region, and National representatives.



Improvements in leadership, safety, training, and development pathways have had a positive impact on midwifery vacancy rate, with trajectory to be fully recruited by October 2024



Strategic Initiative: Digital Care

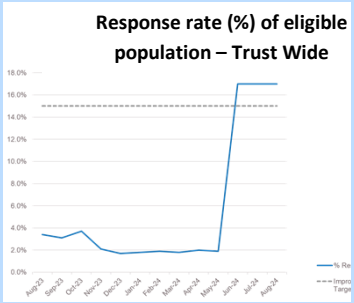
Officially entered the 'Planning' stage of the **Shared EPR** programme, working with our chosen supplier Oracle Health to baseline the programme plan. This will provide a reference point and schedule, from planning through to deployment in 2026.

The Shared EPR will create a single care record for patients replacing several of our current clinical systems.

Vision Metric: Patient Engagement

Friends and Family Test (FFT)

SFT have implemented a new digital provider for FFT which targets our service users via SMS messages. Following a six month project, the new service launched on the 1st June 2024.



This change has; significantly increased the FFT response rate – from a pre-change 2-4% up to 17% now exceeding the Trust 15% target; diversified methods of access; increased accessibility; and offers robust analysis of data and opportunity to triangulate feedback themes with complaints, incidents, compliments, RTF and national surveys

Breakthrough Objective: Time to First Outpatients

Focusing on three top contributing specialities; Oral Surgery, Colorectal and Urology. Fully process mapped the booking processes pathway to identify variances, pressure points, data gaps and potential improvements. Areas in scope for improvement;

- Increased engagement with patients at the point of booking to ascertain changes since referral and manage expectations and support waiting list validation
- Implementation of standard work routines to improve the management of waiting lists and clinic slot utilisation - to effectively triage all referral pathways (2WW, Urgent and routine)
- Increased efficiencies in the practice of re-booking of cancelled appts which will also reduce the significant time taken by admin teams.
- Real time tracking of improvements is now facilitated by a new weekly divisional and specialty level process and additional dashboards have been established to breakdown metrics aligned to the mapped pathway to ascertain improvements and areas of focus.

NHS
Salisbury
NHS Foundation Trust

Appendix 2: Overarching desired outcomes per workstream in the 18-month roadmap

Strategy Deployment and Transformation	Exec and Board Leadership	Leadership Behaviours
Aligned SPF refresh, business planning and CPPG resource plan	Board behaviours and actions align to Improving Together and our leadership behaviours framework	There is a 'Centre of Excellence' Model of deployment and delivery
SFT is an integrated organisation (Acute and Community Provider	Board members practice and role model continuous improvement personally	SFT has a positive, just and improving culture
At least 80% of the organisation feel involved in delivering our strategy	Board members are confident in coaching their teams and colleagues in Improving Together	Our leadership culture supports outstanding experience at SFT
Mature approach to vision metric tracking in place	An embedded training approach in place for Board members and NED's	Our people know our leadership behaviours
All specialties have responded to Trust master strategy		Improver Leader and Transformational Leader are conjoined
Overarching AHA Transformation Plan		Our leadership behaviours are aligned across the BSW Provider Group
Rapid Improvement Events will be in place and scoped by 2026		Our leaders regularly self-assess their behaviours and seek feedback from their team
Organisational education on corporate project prioritisation is embedded into training programmes		
The project management industry standards will be embedded in SFT and socialised across the AHA		

Coach House	OMS Divisions and Specialities	OMS Teams
Teams can describe the golden thread and how their work aligns/contributes to the Trust strategy	Embedded Improving Together Methodology across all Divisional and Speciality structures (Confident in coaching their teams	Monthly spotlight and case study available to share successes
There is a Centre of Excellence Model of deployment and delivery	All Corporate Functions have a minimum of one team trained	Nursing strategy aligned to Trust Strategy and cascaded throughout the organisation and within training
The Coach House is mature in their skills of Improving Together	100% specialities are running PRM's with their DMT's	All teams trained to Improver Standard level across SFT (as per original baseline figure)
Standardised approaches to deploying Improving Together across the AHA	Performance delivery of our Breakthrough Objectives and Vision Metrics	Every team has a Performance Review Meeting structure in place
The Improving Together Board provides routine and focused time for personal practice of the Improving Together approach.	Assurance process – We have clearly reviewed and agreed tolerance and reporting processes in place for our watch metrics at Corporate and clinical	Standard work alongside senior management escalation, support and attendance in place for those teams who are not sustaining improvement huddles.
Sustained continuous improvement is at the heart of the organisation and across all corporate and clinical services	Standardisation of reporting (e.g. IPR) across the AHA	A daily management system with processes is evolving
Our people are skilled and experienced and adopting improving together methodology		

Business Intelligence	Governance	Comms
OMS Scorecard reporting in place across all clinical and corporate divisions	An effective governance framework in place to support a culture of continuous improvement or	Comms plan approval process in line with financial timetable
Establish SFT as a data led organisation to operationalise Improving Together methodology and the OMS system fully	Our governance systems and processes support a culture of continuous improvement	Aware of vision
Our colleagues and teams are confident in how to use data to inform service improvements	Regular Team, SLT and DPR meetings demonstrate that performance oversight	CECR team involved in Quality Accounts much earlier
Standardisation of reporting (e.g. IPR) across the AHA	Risk appetite roll out at DPR level working consistently	Aware of 3P's and Breakthrough objectives. Leadership behaviours and personal development gains
		Patient/visitor targeted comms underway
		Partnership event offered/held

NHS Salisbury NHS Foundation Trust

Report to:	Trust Board (Public)	Agenda item:	4.1
Date of meeting:	03 October 2024		

Report title:	Register of Seals			
Status:	Information	Discussion	Assurance	Approval
	✓			
Approval Process: (where has this paper been reviewed and approved):	Approved by Lisa Thomas, Chief Executive			
Prepared by:	Sasha Godfrey, EA and Board Support Officer			
Executive Sponsor: (presenting)	Fiona McNeight, Director of Integrated Governance			

Recommendation:
The Board is asked to note the entries to the Trust's Register of Seals which, while not formally authorised by resolution of the Trust Board, have been authorised through powers delegated by the Trust Board.

Executive Summary:
To report entries in the Trust's Register of Seals since the last report to Board in July 2024. None of the signatories who witnessed the fixing of the seal of Salisbury NHS Foundation Trust had an interest in the transactions they witnessed.

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):	N/a

No.	Date signed in Register	Approval Details	Held on file with:	Signature one:	Signature Two:
377	10 September 2024	Contract of sale and transfer of title 12 Owlswood, Salisbury SP2 8DN	Laurence Arnold	Lisa Thomas	Not required

NHS Salisbury NHS Foundation Trust

Report to:	Trust Board (Public)	Agenda item:	4.2
Date of meeting:	3 October 2024		

Report tile:	Trust Constitution Updates 2024			
Status:	Information	Discussion	Assurance	Approval
		✓		✓
Approval Process: (where has this paper been reviewed and approved):	Initial updates re joint committees approved at Trust Board in May.			
Prepared by:	Kylie Nye - Head of Corporate Governance Fiona McNeight- Director of Integrated Governance			
Executive Sponsor: (presenting)	Fiona McNeight - Director of Integrated Governance			

Recommendation:

The Trust Board is asked to consider and support the amendments to the constitution and recommend approval to the Council of Governors.

Executive Summary:

The constitution is reviewed and approved by the Trust Board and Council of Governors. As a reminder in May 2024, the Trust Board approved the following amendments:

- Paragraph 1 – updated to reflect the Health and Social Care Act 2022.
- Paragraph 4 - Powers updated to recognise joint committees and the 2006 Act (revised 2022).
- Paragraph 4.5 - added as specified in the Health and Care Act 2022.
- Paragraph 17 - updated to recognise joint committees.
- Annex 4 - updated to reflect changes to 'partnership organisations' in relation to Appointed Governors.
- Annex 8 - paragraph 5.9 added to reflect the establishment of Joint Committees and Committee-in Common.

However, these amendments were not approved by Council of Governors in May with additional assurance sought regarding joint committees and committees in common. Therefore, further approval will be sought in November's meeting for the above amendments alongside the most recent changes outlined below. The Governors have reinstated their Constitution Group to ensure that future changes to the constitution are considered prior to formal approval.

The Board is asked to review the amendments outlined below and recommend approval to the Council of Governors on 25th November.

The following sections (in yellow in the document) have been updated

- Paragraph 21 – Board Composition has been updated and aligns with Great Western Hospitals NHS Foundation Trust.
- Paragraph 23 – Updated to include the associate NED reference.
- Paragraph 25 – Updated to reflect the Fit and Proper Persons (FPPR) regulations.

- Paragraph 26 – New section added reflecting the latest Code of Governance relating to the appointment and removal of the Company Secretary.
- Paragraph 31 – Updated wording for terms of office for Chair and Non-Executive Directors to reflect the latest Code of Governance. Ultimately, any decision to extend a NED term of office beyond 6 years should be subject to rigorous review.
- Paragraph 42 – The wording around significant transactions has been strengthened following feedback from the Council of Governors.

Once these changes are supported at both Board and Council of Governors the constitution will be published on the Trust's website.

Please note formatting and numbering will be completed once changes have been approved.

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

CONSTITUTION

Post Holder Responsible for Policy:	Director of Integrated Governance
Directorate Responsible for Policy:	Chief Executive's
Contact Details:	Ext: 2774
Date Written:	2005
Date Revised:	April 2024
Approved by:	Council of Governor's/ Trust Board
Date Approved:	
Next Due for Revision:	April 2025 (Annual Review)
Date Document Becomes Live:	

Version No.	Updated By	Updated On	Description of Changes
1.0	Director of Corporate Governance	See amendment history below	
1.1	Director of Corporate Governance	April 2020	Annex 9 Updated
2.0	Director of Corporate Governance	October 2020	Complete revision
2.1	Corporate Governance Manager/ Membership Manager	December 2020	Further amendments as per amendment history below agreed at CoG.
2.2	Head of Corporate Governance	January 2022	Small amendments to wording to provide consistency in document
2.3	Head of Corporate Governance	March 2022	Further small amendments following CoG.
2.4	Head of Corporate Governance / Membership Manager	January/ February 2023	Amendments to NED terms of office, nominated governor categories and nominations Committee composition and Annex 4
2.5	Head of Corporate Governance	April 2024	Annual Review - Further amendments reflected in amendment history 2024.
2.6	Director of Integrated Governance/ Head of Corporate Governance/ Membership Manager	Sept 2024	Amendments summarised in the amendment history. Complete re-format.

Introduction

Salisbury NHS Foundation Trust, Royal United Hospitals Bath NHS Foundation Trust and Great Western Hospitals NHS Foundation Trust approved arrangements to establish a group model to support increased joint working and collaboration between the three organisations and wider system, in line with the powers set out in the Health and Care Act 2022 and with approval from NHS England and Bath and North-East Somerset, Swindon and Wiltshire Integrated Care Board (BSW ICB)

In line with current legislation all three trusts remain as individual statutory organisations with individual constitutions. Therefore, for the purposes of this document references to the chief executive will remain singular and not 'joint' or 'group'.

Table of Contents:

Amendment History:

Year	Amendment
2014	• The addition of paragraph 21 of the Council's Standing Orders was approved by the Council on 21 July 2014
2016	• Amendment of paragraph 37 of the Constitution was approved by the Board of Directors on 29 February 2016 and by the Council of Governors on 11 April 2016. • The new Model Election Rules were issued by the former Foundation Trust Network (NHS Providers) in August 2014 and formally adopted by the trust on 29 February/11 April 2016 • Amendment of paragraph 16 of the Council's standing orders was approved by the Council on 16 May 2016
2018	• April 2018 minor amendments to Board Standing Orders • Addition of Standing Financial Instructions – approved February 2018
2019	• Amendment of Annex 1 to a) insert the area covered by the West Wiltshire constituency into the South Wiltshire Rural constituency; (b) delete West Wiltshire as a constituency; (c) increase the number of governors for the South Wiltshire Rural Constituency from 5 to 6. – approved November 2019
2020	• Annex 8 Standing Orders of the Board of Directors has been completely revised and is included as an appendix to the Constitution. • The wards and constituencies have been updated. This includes merging West Wiltshire into South Wiltshire Rural. North Dorset and East Dorset constituencies have also been updated based on the electoral ward. • Within Annex 2 the Hotel and Property Class in the Staff Constituency is merged with the Clerical, Administrative and Managerial staff class. The name has been amended to "Administrative, Facilities and Managerial". • The unused paragraphs have been removed and the document renumbered and reformatted to reflect this.
2021	• Wiltshire Clinical Commissioning Group (CCG) is now called Bath and North-East Somerset, Swindon and Wiltshire (BSW)
2022	• Amendments to Annex 6 and Annex 9 to update Governor and Board disqualification criteria. • Document renumbered.
2023	• Minor formatting updates. • Item 32.3 updated to reflect NED terms of office (2 x 3-year terms plus 1 x 2-year term). • Annex 4 – Composition of the Appointed Governors updated to reflect the distinction between local authority and partnership organisations. • Annex 7 – Item 11.3 updated to include 'external stakeholder' in the composition of future Nominations Committees
2024	• Updating para 1 to reflect the Health and Social Care Act 2022. • Para 4 – Powers updated to recognise joint committees and the 2006 Act (revised 2022). • Para 4.5 added as specified in the Health and Care Act 2022. • Para 17 updated to recognise joint committees. • Annex 4 updated to reflect changes to 'partnership organisations' in relation to Appointed Governors. • Annex 8, para 5.9 added to reflect the establishment of Joint Committees and Committee-in Common. • Para 21 – Board Composition has been updated and aligns with Great Western Hospitals NHS Foundation Trust. • Para 23 – updated to include the associate NED reference. • Para 25 – Updated to reflect the Fit and Proper Persons (FPPR) regulations.

	• Para 26 – new section added reflecting the latest Code of Governance relating to the appointment and removal of the Company Secretary. • Para 31 – Updated wording for terms of office for Chair and Non-Executive Directors to reflect the latest Code of Governance. Ultimately, any decision to extend a NED term of office beyond 6 years should be subject to rigorous review. • Para 42 – The wording around significant transactions has been strengthened following feedback from the Council of Governors

1. Interpretation and definitions

1.1 Unless otherwise stated, words or expressions used in this constitution have the same meaning as in the National Health Service Act 2006 as amended by the Health and Social Care Act 2012 and the Health and Social Care Act 2022.

1.2 Words importing the masculine gender only shall include the feminine gender. Words importing the singular shall import the plural and vice versa where it is appropriate that they do so.

1.3 The 2006 Act is the National Health Service act 2006 as amended at any time, and the 2012 Act is the Health and Social Care Act 2012 as amended at any time.

1.4 The Health and Care Act 2022 has merged "Monitor" and the Trust Development Authority (TDA) into NHS England and removed legal barriers to collaboration and integrated care, ensuring providers adopt greater responsibility for service planning and putting Integrated Care Systems (ICSs) on a statutory footing. NHS England

1.5 Constitution means this constitution and its annexes (save that the standing orders set out for convenience in annexes 7 and 8 are not part of the constitution). It comes into effect when it has been approved both by more than half of the members of the Council of Governors voting, and by more than half of the Board of Directors voting.

1.6 The Accounting Officer is the person who discharges the functions specified in paragraph 25(5) of Schedule 7 to the 2006 Act.

1.7 The Code of Conduct is the Code of Conduct as set out in the Standing Orders of the Council of Governors.

2. Name

2.1 The name of the foundation trust is the Salisbury NHS Foundation Trust, and the Trust means that trust.

3. Principal purpose

3.1 The principal purpose of the Trust is the provision of goods and services for the purposes of the health service in England.

3.2 The Trust does not fulfil its principal purpose unless, in each financial year, its total income from the provision of goods and services for the purposes of the health service in England is greater than its total income from the provision of goods and services for any other purposes.

3.3 The Trust may provide goods and services for any purposes related to–

3.3.1 the provision of services provided to individuals for or in connection with the prevention, diagnosis or treatment of illness, and

3.3.2 the promotion and protection of public health.

3.4 The Trust may also carry on activities other than those mentioned in this paragraph for the purpose of making additional income available in order better to carry out its principal purpose.

3.5 The Trust may carry out research in connection with the provision of health care and may make facilities and staff available for the purposes of education, training or research carried on by others.

4. Powers

4.1 The powers of the Trust are set out in the 2006 Act, updated in the 2012 Health and Social Care Act and the 2022 Health and Care Act.

4.2 All the powers of the Trust shall be exercised by the Board of Directors on behalf of the Trust.

4.3 Any of these powers may be delegated to a committee of directors or to an executive director.

4.4 The Trust may arrange for any functions exercisable by it to be exercised by or jointly with any one or more of the bodies set out in section S 65Z5(i) of the 2006 Act. Where such a function is exercisable jointly the bodies may arrange for the functions to be exercised by joint committees as set out in S5 65Z6 of the 2006 Act.

4.5 In exercising its powers, the Trust will have regard to:

- S.63A of the 2006 Act (revised 2022) (duty to have regard to wider effect of decisions), also referred to as the "Triple Aim".
- 3.7.2 S.63B of the 2006 Act (revised 2022) (duties in relation to climate change).

5. Membership and constituencies

5.1 The Trust shall have members, each of whom shall be a member of one of the following constituencies:

5.1.1 A public constituency

5.1.2 A staff constituency

6. Application for membership

6.1 An individual who is eligible to become a member of the Trust shall become a member on his application to the Trust to become a member or by being invited by the Trust to become a member of the staff constituency in accordance with paragraph 9.

7. Public Constituency

7.1 The public constituencies are the areas specified in Annex 1 and individuals living within them may become members of the Trust.

7.2 The individuals who live in the areas so specified are referred to collectively as a Public Constituency.

7.3 An individual who ceases to live in the areas specified in Annex 1 shall cease to be a member of the Trust. A member who moves from one such area to another shall continue to be a member but shall have a right to vote in any election of governors in accordance with the new area.

7.4 The minimum number of members in each Public Constituency is specified in Annex 1, and if the number of members does not equal or exceed the minimum the area shall not be treated as a Public Constituency for the purpose of electing governors.

8. Staff Constituency

8.1 An individual who is employed by the Trust under a contract of employment with the Trust may become or continue as a member of the Trust provided:

8.1.1 They are employed by the Trust under a contract of employment which has no fixed term or has a fixed term of at least 12 months; or

8.1.2 They have been continuously employed by the Trust under a contract of employment for at least 12 months.

8.2 Individuals who exercise functions for the purposes of the Trust other than under a contract of employment with the Trust, may become or continue as members of the staff constituency provided that they have exercised these functions continuously for a period of at least 12 months.

8.3 Individuals eligible for membership of the Trust under this paragraph are referred to collectively as the Staff Constituency.

8.4 The Staff Constituency shall be divided into 5 classes of individuals as set out in Annex 2

8.5 The minimum number of members in each class of the Staff Constituency is specified in Annex 2, and if the number of members in a class does not equal or exceed the minimum number that class shall not be treated as a class for the purpose of electing governors.

9. Automatic Membership by default – Staff

9.1 An individual who is:

9.1.1 Eligible under paragraph 8.1 to become a member of the Staff Constituency, and

9.1.2 invited by the Trust to become a member of the Staff Constituency, shall become a member of the Staff Constituency and in the appropriate staff class without an application being made, unless they inform the Trust that they do not wish to do so.

10. Patients' Constituency

There is no Patients' Constituency

11. Restrictions on Membership

11.1 An individual, who is a member of a constituency, or of a class within a constituency, may not while such membership continues be a member of any other constituency or class.

11.2 An individual who satisfies the criteria for membership of the Staff Constituency may not become or continue as a member of any other constituency.

11.3 An individual must be at least 16 years old to become a member of the Trust.

11.4 An individual may not become or remain a member of the Trust if they have been convicted of any offence involving violent, threatening or abusive behaviour on Trust property or in connection with receiving services from the Trust.

11.5 A member of the Trust shall inform the Secretary of the Trust of any circumstances which may affect their entitlement to be a member.

11.6 Where the Trust has reason to believe that a person may be disqualified from becoming a member or no longer entitled to be a member, the Secretary may give the member 14 days written notice to show why he should not become or remain a member. On receipt of such response as may be made by the member, or failing any response, the Secretary may, if he considers it appropriate, refuse the application to become a member or remove the member from the register of members. If the person wishes to dispute a decision of the Secretary not to admit him to membership or to remove him, he may refer the issue to the Council of Governors, whose decision by a majority of the governors voting shall be final.

11.7 A member may resign by written notice to the Secretary of the Trust.

12. Annual Members' Meeting

12.1 The Trust shall hold an annual meeting of its members, 'the Annual Members Meeting'. It shall be open to the public. This should be held no later than 30th September.

13. Council of Governors – Composition

13.1 The Trust is to have a Council of Governors comprising both elected and appointed governors.

13.2 The composition of the Council of Governors is specified in Annex 4.

13.3 The members of the Council of Governors, other than the appointed members, shall be chosen by election by their constituency or, where there are classes within a constituency, by their class within that constituency. The number of governors to be elected by each constituency or class is specified in Annex 4.

13.4 No person may stand for election as a governor or be appointed as a governor unless he will be at least 18 years old when he becomes a governor.

14. Council of Governors – Election of Governors

14.1 Elections for the elected members of the Council of Governors shall be conducted in accordance with the Model Election Rules current at the time of the election.

14.2 The Model Election Rules are those as published from time to time by the Department of Health, and form part of this Constitution. The Rules current at the time of the coming into effect of this constitution are set out in Annex 5.

14.3 A subsequent variation of the Model Election Rules by the Department of Health does not constitute an amendment of the constitution for the purpose of paragraph 48 hereof (amendment of the constitution).

14.4 An election, if contested, shall be by secret ballot.

14.5 In the event of an elected governor ceasing to hold office, if there are then more than 15 months of his term of office left after his resignation, ceasing to hold office or death, then an

election shall be held for his replacement. The person elected shall hold office for the remainder of the period for which the governor he is replacing was last elected.

15. Council of Governors – Tenure

15.1 Subject to 14.5 and 15.2, an elected governor may hold office for a period of up to three years.

15.2 An elected governor may stand for re-election but may not stand for re-election when, if re-elected, he might serve for more than nine years in all.

15.3 An appointed governor may hold office for a period of up to three years and may then be re-appointed but shall not hold office for more than nine years in all. He shall cease to hold office if his appointing organisation withdraws its appointment of him by notice in writing to the Trust or if the appointing organisation ceases to exist.

15.4 A governor may resign by giving notice in writing to the Chair of the Trust.

15.5 In the event of an appointed governor ceasing to hold office, the body appointing him may make a further appointment.

15.6 The limits of nine years in sub-paragraphs 15.2 and 15.3 shall in the case of an elected governor include any time served as an appointed governor, and in the case of an appointed governor include any time served as an elected governor.

16. Council of Governors – Disqualification and Termination of Office

16.1 The following may not stand for election or continue as a member of the Council of Governors:

16.1.1 a person who has been adjudged bankrupt or whose estate has been sequestrated and (in either case) has not been discharged.

16.1.2 a person who has made a composition or arrangement with, or granted a trust deed for, his creditors and has not been discharged in respect of it.

16.1.3 a person who within the preceding five years has been convicted in the British Islands of any offence if a sentence of imprisonment (whether suspended or not) for a period of not less than three months (without the option of a fine) was imposed on them.

16.1.4 The further persons set out in Annex 6.

16.2 An elected governor shall cease to hold office if he ceases to be a member of the constituency or class by which he was elected.

16.3 If a governor fails to attend 3 consecutive scheduled meetings of the Council of Governors, he shall cease to be a governor unless a voting majority of the other governors are satisfied that:

16.3.1 the failure was in their opinion due to a reasonable cause or causes, and

16.3.2 he will be able to, and will, start attending meetings of the Council within such period as they consider reasonable.

16.4 A governor shall cease to be a governor if he is adjudged by not less than 75% of the remaining Council of Governors to have:

16.4.1 acted in a manner inconsistent with the core principles set out in the Trust's authorisation, or with the Constitution, or with the Code of Conduct, in such a way that he should cease to be a governor, or

16.4.2 failed to declare a material interest pursuant to paragraph 21 below and participated in a meeting where that interest was relevant, in such a way that he should cease to be a governor.

16.5 Where circumstances arise which give rise to an issue as to a governor's ability to remain a governor (other than those referred to in paragraphs 16.3 and 16.4 above), the governor shall give written notice of the circumstances to the Secretary of the Trust and shall state whether he is resigning.

16.6 In the event of a notice being given under sub-paragraph 16.3 which states that the governor is not resigning, or where no such notice is received but circumstances as to a governor's ability to remain a governor (other than those set out in paragraphs 16.3 and 16.4 above) come to the notice of the Trust, the issue shall be considered by the other governors at a meeting and if 75% of the remaining Council of Governors consider that the governor is disqualified from continuing as a governor, he shall cease to be a governor.

16.7 A governor shall not exercise any function as a governor (including attending any meeting of the Council as a governor) if he has not signed and delivered to the Secretary a statement in the form required by the Council confirming that he accepts the Code of Conduct.

16.8 If a governor who is an employee of the Trust is suspended as an employee as a part of a disciplinary process, the Chair of the Trust may suspend the governor from acting as a governor while the governor remains suspended as an employee.

17. Council of Governors – Duties of Governors, Equipping Governors, Lead Governor and Deputy Lead Governor

17.1 The general duties of the Council of Governors are–

17.1.1 to hold the non-executive directors individually and collectively to account for the performance of the Board of Directors, and

17.1.2 to represent the interests of the members of the Trust as a whole and the interests of the public.

17.2 The Trust must take steps to secure that the governors are equipped with the skills and with the knowledge that they require in their capacity as governors.

17.3 The governors shall choose a Lead Governor and a Deputy Lead Governor as set out in the Council's standing orders. The Lead Governor and the Deputy Lead Governor shall have the functions set out in the standing orders.

18. Council of Governors – Meetings of Governors

18.1 The Chair of the Trust, that is the Chair of the Board of Directors, or in his absence, the Deputy Chair or, in his absence, the Lead Governor (or Deputy Lead Governor), shall preside at meetings of the Council of Governors.

18.2 Where it is inappropriate by reason of the subject matter of a meeting that it should be chaired by the Chair, the Deputy Chair may preside unless it is also inappropriate that the Deputy Chair preside, in which case the Lead Governor or in his absence the Deputy Lead Governor may preside.

18.3 Meetings of the Council of Governors shall be open to members of the public, but the public may be excluded from all or any part of the meeting by resolution of the Council for special reasons, namely that publicity would be prejudicial to the public interest by reason of the confidential nature of the business to be transacted or for other special reasons stated in the resolution and arising from the nature of the business or proceedings.

18.4 The Council of Governors shall meet at least 4 times a year, including an annual meeting no later than 31 October when the Council shall receive and consider the annual accounts, any report of the Auditor on them, and the Trust's annual report. The meetings shall be called by the Secretary after consultation with the Lead Governor.

18.5 The Lead Governor (or in the case of the Lead Governor's unavailability the Deputy Lead Governor) or at least 10 governors may, by written notice to the Secretary stating the business to be considered, requisition a meeting of the Council, and the Secretary shall arrange for a meeting to be held as soon as practicable after notice has been given to the governors.

18.6 For the purpose of obtaining information about the Trust's performance of its functions or the ~~directors~~ director's performance of their duties (and deciding whether to propose a vote on the Trust's or directors' performance), the Council of Governors may require one or more of the directors to attend a meeting.

18.7 The Council of Governors may appoint committees consisting wholly ort partly of its members to assist it in carrying out its functions ~~will establish statutory committees to carry out such functions~~ as are required by law and to carry out such functions as the Council specifies.

18.8 The Council of Governors may appoint members to serve on joint committees with the Board of Directors of committees thereof.

18.9 The Council of Governors will establish working groups to carry out such functions as the Council specifies.

18.10 These committees, sub-committees or joint committees may call upon outside advisers to help them in their tasks, provided that the financial and other implications of seeking outside advisers have been discussed and agreed by the Board of Directors. Any conflict arising

between the Council of Governors and the Board of Directors under this paragraph will be determined in accordance with para 44 (Dispute Resolution).

19. Council of Governors – Standing Orders

19.1 The Council of Governors shall adopt standing orders for the practice and procedure of the Council. Those in force as at the date of the adoption of this constitution are set out in Annex 7. They may be amended as provided in them.

20. Council of Governors – Referral to the Panel

20.1 In this paragraph the Panel means a panel of persons appointed by NHS England to which a governor of an NHS foundation trust may refer a question as to whether the trust has failed or is failing –

20.1.1 to act in accordance with its constitution, or

20.1.2 to act in accordance with provision made by or under Chapter 5 of the 2006 Act.

20.2 A governor may refer a question to the Panel only if more than half of the members of the Council of Governors voting approve the referral.

21. Council of Governors – Conflicts of Interest of Governors

21.1 If a governor has a pecuniary, personal or family interest, whether that interest is actual or potential and whether that interest is direct or indirect, in any proposed contract or other matter which is under consideration or is to be considered by the Council of Governors, the governor shall disclose that interest to the members of the Council of Governors as soon as they ~~he~~ become aware of it. The Standing Orders for the Council of Governors shall make provision for the disclosure of interests and arrangements for the exclusion of a governor declaring any interest from any discussion or consideration of the matter in respect of which an interest has been disclosed.

21.2 For the avoidance of doubt a governor has a personal interest where the governor or a person close to the governor has had a personal experience which might be considered to affect the governor's view of the matter in question.

22. Council of Governors – Travel Expenses

22.1 The members of the Council of Governors are not entitled to remuneration, but the Trust shall on application pay travelling and other expenses incurred by a member for the purpose of his duties at rates to be decided by the Trust.

23. Board of Directors – Composition

23.1 The Trust is to have a Board of Directors, which shall comprise both executive and non-executive directors.

23.2 The Board of Directors is to comprise:

23.2.1 a non-executive Chair

23.2.2 a ~~maximum~~ minimum of 5 ~~7~~ other non-executive directors

23.2.3 a ~~maximum~~ minimum of 5 ~~6~~ executive directors ~~(subject to 23.4 below),~~ to include:

~~23.2.4 a chief Executive who shall be the Accounting Officer~~

~~**23.2.5** a finance Director~~

23.2.4 One of the Executive Directors shall be the Chief Executive.

23.2.5 The Chief Executive shall be the Accounting Officer.

23.2.6 One of the Executive Directors shall be the Chief Finance Officer

23.3 One of the executive directors must be a qualified medical practitioner or a registered dentist (within the meaning of the Dentists Act 1984) and one must be a registered nurse or midwife.

23.4 The number of non-executive directors including the Chair must always exceed the number of executive directors. At any meeting where there is parity of non-executive and executive directors the Chair, or in his absence the Deputy Chair, shall have a casting vote.

23.5 Only a member of a public constituency or the patients' constituency is eligible for appointment as a non-executive Director.

24. Board of Directors – General Duty

24.1 The general duty of the Board of Directors and of each director individually is to act with a view to promoting the success of the Trust so as to maximise the benefits for the members of the Trust as a whole and for the public.

25. Board of Directors – Appointment and removal of Chair and Non-Executive Directors, including Associate Non-Executive Directors

25.1 The Council of Governors at a general meeting of the Council of Governors shall appoint or remove the Chair of the Trust and the other non-executive directors, including Associate Non-Executive Directors.

25.2 Removal of the Chair or any other non-executive director, including Associate Non-Executive Directors shall require the approval of 75% of the members of the Council of Governors.

25.3 The Standing Orders of the Council shall provide for nomination committees to identify appropriate candidates for appointment as Chair and as non-executive directors.

26. Board of Directors – Deputy Chair

26.1 After consultation with the Council of Governors the Board of Directors shall appoint one of the non-executive directors to be the Deputy Chair. The Deputy Chair shall also have the functions previously exercised by the Senior Independent Director, namely in particular to act as a means of communication between the non-executive directors and the governors.

27. Board of Directors – Appointment and removal of the Chief Executive and Executive Directors

27.1 The non-executive directors shall appoint or remove the Chief Executive. All appointments must satisfy the requirements of Regulation 5: Fit and Proper Persons: Directors of the Health and Social Care Act 2008 (Regulated Activities Regulations 2014 including all future amendments to the regulation.

27.2 The appointment of the Chief Executive shall require the approval of the Council of Governors.

27.3 A committee consisting of the Chair, the Chief Executive and the other non-executive directors shall appoint or remove the other executive directors. All appointments must satisfy the requirements of Regulation 5: Fit and Proper Persons: Directors of the Health and Social Care Act 2008 (Regulated Activities Regulations 2014 including all future amendments to the regulation.

28. Board of Directors – appointment and removal of the Company Secretary

28.1 The whole Board shall appoint or remove the Company Secretary (Director of Corporate Governance)

29. Board of Directors – Disqualification

29.1 The following may not be appointed or continue as a member of the Board of Directors:

29.1.1 a person who has been adjudged bankrupt or whose estate has been sequestrated and (in either case) has not been discharged.

29.1.2 a person who has made a composition or arrangement with, or granted a trust deed for, his creditors and has not been discharged in respect of it.

29.1.3 a person who within the preceding five years has been convicted in the British Islands of any offence if a sentence of imprisonment (whether suspended or not) for a period of not less than three months (without the option of a fine) was imposed on him.

29.1.4 The persons referred in Annex 9.

30. Board of Directors – Meetings

30.1 Before holding a meeting, the Board of Directors must send a copy of the agenda of the meeting to the Council of Governors.

30.2 As soon as practical after holding a meeting the Board of Directors must send a copy of the minutes of the meeting to the Council of Governors.

30.3 Meetings of the Board of Directors shall be open to members of the public.

30.4 Members of the public may be excluded from all or any part of a meeting by a resolution of the Board for special reasons, namely that publicity would be prejudicial to the public interest by reason of the confidential nature of the business to be transacted or for other special reasons stated in the resolution and arising from the nature of the business or proceedings.

31. Board of Directors – Standing orders

31.1 The standing orders for the practice and procedure of the Board of Directors are attached at Annex 8. They may be amended as provided in them.

32. Board of Directors – Conflicts of Interest of Directors

32.1 The duties that a director of the Trust has by virtue of being a director include in particular–

32.1.1 a duty to avoid a situation in which the director has (or can have) a direct or indirect interest that conflicts (or may possibly conflict) with the interests of the Trust.

32.1.2 a duty not to accept a benefit from a third party by reason of being a director or by reason of doing or not doing anything in that capacity.

32.2 The duty referred to in sub-paragraph 31.1.1 is not infringed if the situation cannot reasonably be regarded as likely to give rise to a conflict of interest.

32.3 The duty referred to in sub-paragraph 31.1.2 is not infringed if acceptance of the benefit cannot reasonably be regarded as likely to give rise to a conflict of interest.

32.4 In sub-paragraph 31.1.2 'third party' means a person other than the Trust or a person acting on its behalf.

32.5 If a director of the Trust has in any way a direct or indirect interest in a proposed transaction or arrangement with the Trust, the director must declare the nature and extent of that interest to the other directors before the Trust enters into the transaction or arrangement.

32.6 If a declaration under this paragraph proves to be, or becomes, inaccurate or incomplete, a further declaration must be made.

32.7 Any declaration required by this paragraph must be made before the trust enters into the transaction or arrangement.

32.8 This paragraph does not require a declaration of an interest of which the director is not aware, or where the director is not aware of the transaction or arrangement in question.

32.9 A director need not declare an interest –

32.9.1 if it cannot be reasonably regarded as likely to give rise to a conflict of interest.

32.9.2 if, or to the extent that, the directors are already aware of it.

32.9.3 if, or to the extent that, it concerns terms of the director's appointment that have been or are to be considered by a meeting of the Board of Directors, or by a committee of the directors appointed for the purpose under the constitution.

33. Board of Directors – Remuneration and Terms of Office

33.1 The Council of Governors shall decide at a general meeting of the Council the remuneration and allowances, and the other terms and conditions of office, of the Chair and the other non-executive directors.

33.2 The Trust shall establish a committee of non-executive directors to decide the remuneration and allowances, and the other terms of office, of the Chief Executive and the other executive directors.

33.3 The Chair and other non-executive directors ~~may be appointed for an initial term of up to three years, which may be renewed by the Council for a further term of up to three years, and may be renewed thereafter for a two year term, which will bring the total length of service to eight years. Where a director has served eight years, his appointment may be renewed for a further one year provided that exceptional circumstances exist in relation to the renewal.~~ should not remain in post beyond nine years from the date of their first appointment to the board of directors and any decision to extend a term beyond six years should be subject to rigorous review. To facilitate effective succession planning and the development of a diverse board, this period of nine years can be extended for a limited time, particularly where on appointment a chair was an existing non-executive director. The need for all extensions should be clearly explained and should have been agreed with NHS England. A NED becoming chair after a three-year term as a non-executive director would not trigger a review after three years in post as chair.

34. Registers

34.1 The Trust shall have a register of members, showing in respect of each member, the constituency to which the member belongs and, where there are classes within it, the class to which he belongs.
34.2 a register of members of the Council of Governors.
34.3 a register of interests of Governors.
34.4 a register of interests of directors.
34.5 and a register of directors.

35. Registers – Inspection and copies

35.1 The Trust shall make the registers specified in paragraph 33 above available for inspection by members of the public, except in the circumstances set out in the next sub-paragraph or as otherwise prescribed by regulations.
35.2 The Trust shall not make any part of its registers available for inspection by members of the public which shows details of:
35.2.1 any member of the Rest of England Constituency; or
35.2.2 any other member of the Trust if the member so requests.
35.3 So far as the registers are required to be made available:
35.3.1 They are to be available for inspection free of charge at all reasonable times; and
35.3.2 A person who requests a copy or extract from the registers is to be provided with a copy or extract.
35.4 If the person requesting a copy or extract is not a member of the trust, the Trust may impose a reasonable charge for doing so.

36. Documents available for public inspection

36.1 The Trust shall make the following documents available for inspection by members of the public free of charge at all reasonable times:
36.1.1 A copy of the current constitution.
36.1.2 A copy of the latest annual accounts and of any report of the auditor on them; and
36.1.3 A copy of the latest annual report
36.2 The Trust shall also make the following documents available for inspection by members of the public free of charge at all reasonable times:
36.2.1 A copy of any order made under section 65D (appointment of special trust administrator), 65J (power to extend time), 65KC (action following Secretary of State's rejection of final report), 65L (trusts coming out of administration) or 65LA (trusts to be dissolved) of the 2006 Act.
36.2.2 A copy of any report laid under section 65D (appointment of trust special administrator) of the 2006 Act.
36.2.3 A copy of any information published under section 65D (appointment of special trust administrator) of the 2006 Act.
36.2.4 A copy of any draft report published under section 65F (administrator's draft report) of the 2006 Act.
36.2.5 A copy of any statement provided under section 65F (administrator's draft report) of the 2006 Act.
36.2.6 A copy of any notice published under section 65F (administrator's draft report), 65G (consultation plan), 65H (consultation requirements), 65J (power to extend time), 65KA (Monitor's decision), 65KB (Secretary of State's response to Monitor's decision), 65KC (action following Secretary of State's rejection of final report) or 65KD (Secretary of State's response to re-submitted final report) of the 2006 Act.
36.2.7 A copy of any statement published or provided under section 65G (consultation plan) of the 2006 Act.
36.2.8 A copy of any final report published under section 65I (administrator's final report) of the 2006 Act.

36.2.9 A copy of any statement published under section 65J (power to extend time), or 65KC (action following Secretary of State's rejection of final report) of the 2006 Act.

36.2.10 A copy of any information published under section 65M (replacement of trust special administrator) of the 2006 Act.

36.3 Any person who requests a copy or extract from any of the above documents is to be provided with a copy.

36.4 If the person requesting an extract or copy is not a member of the Trust, the Trust may impose a reasonable charge for doing so.

37. Auditor

37.1 The Trust shall have an auditor.

37.2 The Council of Governors shall appoint or remove the auditor at a general meeting of the Council.

37.3 The auditor must be qualified to act as auditor in accordance with paragraph 23 of schedule 7 to the 2006 Act.

37.4 The auditor shall comply with schedule 10 of the 2006 Act and shall have the rights and powers there set out.

37.5 The Trust shall provide the auditor with every facility and all information which he may reasonably require for the purpose of his functions.

38. Audit Committee

38.1 The Trust shall establish a committee of non-executive directors as an audit committee to perform such monitoring, reviewing and other functions as are appropriate.

39. Accounts

39.1 The Trust must keep proper accounts in such form as NHS England may with the approval of the Treasury direct and proper records in relation to those accounts.

39.2 NHS England may, with the approval of the Secretary of State for Health, give directions to the Trust as to the content and form of its accounts.

39.3 the accounts are to be audited by the Trust's auditor.

39.4 The following documents will be made available to the Comptroller and Auditor General for examination at his request:

39.4.1 the accounts.

39.4.2 the records relating to them; and

39.4.3 any report of the Auditor on them

39.5 The Trust (through its Chief Executive and accounting officer) is to prepare in respect of each Financial Year annual accounts in such form as NHS England may with the approval of the Secretary of State for Health direct.

39.6 NHS England may with the approval of the Secretary of State for Health direct the Trust:

39.6.1 to prepare accounts in respect of such period or periods as may be specified in the direction; and/or

39.6.2 that any accounts prepared by it by virtue of sub-paragraph 38.6.1 above are to be audited in accordance with such requirements as may be specified in the direction.

39.7 In preparing its annual accounts or in preparing any accounts by virtue of sub-paragraph 44.6.1 above, the Trust is to comply with any directions given by NHS England with the approval of the Secretary of State for Health as to:

39.7.1 the methods and principles according to which the annual accounts are to be prepared; and/or

39.7.2 the content and form of the annual accounts

39.8 The Trust must –

39.8.1 lay a copy of the annual accounts, and any report of the Auditor on them, before Parliament; and

39.8.2 send copies of the annual accounts, and any report of the Auditor on them to NHS England within such a period as NHS England may direct

39.9 The Trust must send a copy of any accounts prepared by virtue of paragraph 38.6 above and a copy of any report of the Auditor to NHS England within such a period as NHS England may direct.

39.10 The functions of the Trust referred to in this paragraph 38 shall be delegated to the accounting officer.

40. Annual Report, Forward Plans and Non-NHS work

40.1 The Trust shall prepare an annual report and send it to NHS England.

40.2 The annual report must give:

40.2.1 information on any steps taken by the Trust to secure that (taken as a whole) the actual membership of any public constituency and of the patients' constituency is representative of those eligible for membership.

40.2.2 information on any occasions in the period to which the report relates on which the council of governors exercised its power to require one or more of the directors to attend a meeting as provided by paragraph 18.5 here of

40.2.3 information on the corporation's policy on pay and on the work of the committee established under paragraph 32(2) hereof and such other procedures as the corporation has on pay.

40.2.4 information on the remuneration of the directors and on the expenses of the governors and the directors

40.2.5 any other information that NHS England or requires.

40.3 The Trust shall give information as to its forward planning in respect of each financial year to NHS England

40.4 the document containing the information with respect to forward planning (referred to above) shall be prepared by the directors.

40.5 In preparing the document, the directors shall have regard to the views of the governors, and the directors shall provide the governors with information appropriate for them to be able to form their views.

40.6 Each forward plan must include information about:

40.6.1 the activities other than the provision of goods and services for the purposes of the health service in England that the Trust proposes to carry on, and

40.6.2 the income it expects to receive from doing so.

40.7 Where a forward plan contains a proposal that the trust carry on an activity of the kind mentioned in sub-paragraph 39.6.1, the Council of Governors must:

40.7.1 determine whether it is satisfied that the carrying on of the activity will not to any significant extent interfere with the fulfilment by the Trust of its principal purpose or the performance of its other functions, and

40.7.2 notify the directors of the Trust of its determination.

40.8 If the Trust proposes to increase by 5% or more the proportion of its total income in any financial year attributable to activities other than the provision of goods and services for the purposes of health service in England, the Trust may implement the proposal only if more than half of the members of the Council of Governors of the Trust voting approve its implementation.

41. Presentation of the Annual Accounts and Reports to the Governors and Members

41.1 The following documents are to be presented to the Council of Governors at a general meeting of the Council:

41.1.1 the annual accounts

41.1.2 any report of the auditor on them

41.1.3 the annual report.

41.2 The documents shall also be presented to the members of the Trust at the Annual Members' Meeting by at least one member of the Board of Directors in attendance.

41.3 The Trust may combine a meeting of the Council of Governors convened for the purposes of sub-paragraph 40.1 with the Annual Members' Meeting.

42. Instruments

42.1 The Trust shall have a seal.
42.2 The seal shall not be affixed except under the authority of the Board of Directors

43. Amendment of the Constitution

43.1 The Trust may make amendments of its constitution only if –
- **43.1.1** more than half of the members of the Council of Governors of the Trust voting approve the amendments, and
- **43.1.2** more than half of the members of the Board of Directors of the Trust voting approve the amendments.

43.2 Amendments made under paragraph 42.1 take effect as soon as the conditions in that paragraph are satisfied, but the amendment has no effect in so far as the constitution would, as a result, not accord with Schedule 7 of the 2006 Act.

43.3 Where amendment is made to the constitution in relation to the powers or duties of the Council of Governors (or otherwise with respect to the role that the Council of Governors has as part of the Trust) –
- **43.3.1** at least one member of the Council of Governors must attend the next Annual Members' Meeting and present the amendment, and
- **43.3.2** the Trust must give the members an opportunity to vote on whether they approve the amendment.

43.4 If more than half of the members voting approve the amendment, the amendment continues to have effect. Otherwise, it ceases to have effect and the Trust must take such steps as are necessary as a result.

43.5 Amendments by the Trust of its constitution are to be notified to NHS England. For the avoidance of doubt, NHS England's functions do not include a power or duty to determine whether or not the constitution, as a result of the amendments, accords with Schedule 7 of the 2006 Act.

44. Mergers etc. and Significant Transactions

44.1 The Trust may only apply for a merger, acquisition, separation or dissolution, as referred to in sections 56,56A, 56B, and 57A of the 2006 Act with the approval of more than half of the members of the Council of Governors.

44.2 The Trust may only enter a significant transaction only if more than half of the members of the Council of Governors of the Trust voting approve entering into the transaction. The threshold for a significant transaction differs depending upon whether the transaction relates to UK or non-UK healthcare investment or disinvestment.

~~**44.3** A 'significant transaction' is a transaction which, if entered into by the Trust:~~
- ~~43.3.1 would increase or reduce the turn-over of the Trust (in a financial year relative to the previous financial year) by £20 million or by 10%, whichever is the greatest.~~
- ~~43.3.2 would involve a receipt of or capital expenditure of £10 million or more; in the case of expenditure, this is after the deduction of any grant or gift which specifically relates to the expenditure in question.~~
- ~~43.3.3 would involve a service contract, asset rental or lease running for period of 3 years or more with a planned income or cost over its duration of £10 million or more.~~
- ~~43.3.4 would be likely to put at risk the Trust's ability to provide its services as a whole, or a significant part of its services, to the appropriate regulatory standard.~~
- ~~43.3.5 would be likely to put at risk the Trust's ability to maintain the minimum required financial risk rating/ continuity of service risk rating.~~
- ~~43.3.6 Where it might reasonably be considered that a transaction falls within paragraph 43.3 the Board shall inform the Council of the transaction at the earliest Opportunity.~~
- ~~43.3.7 The Board shall in any event inform the Council of a transaction which it is considering, and which may involve a sum which is greater than 2% of the Trust's income in the previous year, but the Board need not so inform the Council of any such transaction if the transaction has been clearly identified in the Annual Estimate, the Capital Programme or the Annual Plan~~

44.3 There are three types of transactions that may trigger the significant transaction threshold:

44.3.1 investment/disinvestment in income – Where the income attributable to the asset or the contract associated with the transaction is greater than 25% when divided by the income of the trust. (For non-healthcare/international transactions the threshold is reduced by 50% for investments only).

44.3.2 acquisition or disinvestment of assets of the business – Where the gross assets subject to the transaction is greater than 25% when divided by the gross assets of the trust.

44.3.3 investment of a capital nature - Where the gross capital of the company or business being acquired/divested is greater than 25% when divided by the total capital of the trust following completion of the effects on the total capital of the trust resulting from the transaction.

44.4 In deciding whether to approve a proposed significant transaction the Council will:

44.4.1 act in accordance with its judgment of the best interests of the Trust; and

44.4.2 have regard to the risks the transaction might entail and the adequacy of steps proposed to mitigate those risks, and to the risks which not entering into the transaction might entail.

44.5 If the Council votes not to approve a significant transaction, the reasons advanced in the course of the Council's discussion of the transaction for and against approval shall be recorded in the minutes.

44.6 The Board shall inform the Council of transactions not featuring in the annual estimates, capital programme or annual plan for the year which the Board is considering which involve a sum which is greater than 2% of the Trust's income or capital in the previous year.

45. Indemnity

45.1 Members of the Council of Governors and of the Board of Directors who act honestly and in good faith will be indemnified by the Trust against any civil liability which is incurred in the execution or purported execution of their functions relating to the Trust, save where they have acted recklessly. The Trust shall take out insurance against liability under this indemnity.

46. Dispute Resolution

46.1 In the event of a dispute arising between the Board of Directors and the Council, the Chair shall take the advice of the Secretary and such other advice as he sees fit, and he shall confer with the Vice-Chair and the Lead Governor and shall seek to resolve the dispute.

46.2 If the Chair is unable to do so, he shall appoint a committee consisting of an equal number of directors and governors to consider the matter and to make recommendations to the Board and Council with a view to resolving the dispute.

46.3 If the dispute is not resolved, the Chair may refer the dispute to an external mediator appointed by the Centre for Dispute Resolution, or by such other organisation as he considers appropriate.

ANNEX 1 – THE PUBLIC CONSTITUENCIES

Public Constituency (paragraph 7)

Class/Constituency	Number of Governors	Minimum numbers of members
North Dorset	2	50
Kennet	1	50
New Forest	1	50
Salisbury City	3	50
South Wiltshire Rural	6	50
East Dorset	1	50
Rest of England	1	50
Total	**15**	

Class/ Constituency	Area
North Dorset	Part of the area formerly covered by North Dorset District Council, comprising the following electoral wards: ▪ Beacon ▪ Blandford ▪ Cranborne Chase ▪ Gillingham ▪ Hill Forts & Upper Tarrants ▪ Shaftesbury Town ▪ Stalbridge & Marnhull (Marnhull parish) ▪ Sturminster Newton
Kennet	The area formerly covered by Kennet District Council comprising the following electoral wards: • Bromham, Rowde & Potterne • Devizes East • Devizes North • Devizes & Roundway South • Ludgershall & Perham Down • Pewsey • Pewsey Vale • Roundway • Summerham & Seend • The Lavingtons & Erlestoke • The Collingbournes & Netheravon • Tidworth • Urchfont & The Cannings
New Forest	The following electoral wards within New Forest District Council: ▪ Downlands & Forest ▪ Fordingbridge ▪ Forest Northwest ▪ Ringwood East & Sopley ▪ Ringwood North ▪ Ringwood South

Salisbury City	The following electoral wards formerly covered by Salisbury District Council: • Salisbury Bemerton • Salisbury Fisherton & Bemerton Village • Salisbury Harnham • Salisbury St. Edmund's & Milford • Salisbury St. Francis & Stratford • Salisbury St. Marks & Bishopdown • Salisbury St. Martin's & Cathedral • Salisbury St. Paul's
South Wiltshire Rural	The following electoral wards • Alderbury & Whiteparish • Amesbury East • Amesbury West • Bourne & Woodford Valley • Bulford, Allington & Figheldean • Downton & Ebble Valley • Durrington & Larkhill • Ethandune • Fovant & Chalke Valley • Laverstock, Ford & Old Sarum • Mere • Nadder & East Knoyle • Redlynch & Landford • Till & Wylye Valley • Tisbury • Warminster Broadway • Warminster Copheap & Wylye • Warminster East • Warminster West • Warminster Without • Westbury East • Westbury North • Westbury West • Wilton & Lower Wylye Valley • Winterslow
East Dorset	The following electoral wards within the area formerly covered by East Dorset District Council: • Cranborne & Alderholt • St. Leonards & St. Ives • Stour & Allen Vale (Horton, Holt, Hinton, & Charbury parishes • Verwood • West Moors & Three Legged Cross
Rest of England	All other areas of England not covered above

ANNEX 2 – THE STAFF CONSTITUENCY

(See paragraph 6)

The Staff Constituency is divided into 5 classes as set out below and the classes shall contain the groups set out by each.

STAFF CLASSES	SUBGROUPS WITHIN EACH CLASS
Registered Medical and Dental Practitioners	
Nurses and Midwives	All Nurses and Nursing Auxiliaries Health Care Assistants (Nursing)
Scientific, Therapeutic and Technical Staff	Occupational Therapists and Helpers Orthoptists Physiotherapists and Helpers Art/Music/Drama Therapists Speech and Language Therapists and Helpers Psychologists and Psychology Technicians Psychotherapists Medical Physicists and Technicians Pharmacists and Pharmacy Technicians Dental Technicians Operating Department Practitioners Social Workers Chaplains Clinical Scientists Biomedical Scientists and Technical Staff Geneticists and Technicians Audiology Staff Cardiographers and Support Staff
Administrative, Facilities and Managerial Staff	Ancillary Staff Works and Maintenance Staff Ambulance Staff
Voluntary Staff	

1. The minimum number of members of each class shall be 10.
2. The Secretary to the Trust shall assign persons to the classes set out above in accordance with the groups set out by each. In case of any difficulty the Secretary shall have discretion to allocate the person to the class which is in his opinion the most appropriate.
3. The Secretary shall maintain a register of volunteer schemes designated for the purposes of membership of the Trust.
4. A volunteer is a person who carries out functions on behalf of the Trust on a voluntary basis under a scheme on the register referred to in paragraph 4 above.
5. Where a person is eligible to be included both in the volunteers class and another class, the Secretary shall assign the person to that other class.

ANNEX 3 – THE PATIENTS' CONSTITUENCY

The Trust has no Patients' Constituency

ANNEX 4 - COMPOSITION OF COUNCIL OF GOVERNORS

(See paragraph 13)

Public Governors

1. There shall be 15 public governors as set out in Annex 1.

Staff Governors

2. There shall be 5 staff governors, one to be elected by the members of each class set out in Annex 2 from the members of the class in question.

Appointed Governors

3. There shall be 4 ~~6~~ appointed governors:

- **Local Authority**

3.1 As stated in paragraph 9(4) of the Schedule 7 of the 2006 Act, Wiltshire Council may appoint one governor by notice in writing to the chair, signed by the senior executive of the Council. For the avoidance of doubt, the person appointed shall be a councillor of Wiltshire Council.

- **Partnership Organisations**

3.2 There shall be ~~five~~ three partnership organisations (or successor organisations) who may appoint one governor by notice in writing, signed by the chief executive (or equivalent) of that organisation and delivered to the chair. These partnership organisations are decided by the Board of Directors and Council of Governors. There is currently one partnership organisation as detailed below. The other vacant partnership organisations positions are currently under review.

3.2.1 ~~There shall be one governor appointed by Wessex Community Action~~

3.2.1 There shall be one governor appointed by the Commander of 1 Artillery Brigade or the Officer holding a position nearest to that position to represent local army interests.

3.2.2 ~~Bath and North East Somerset, Swindon and Wiltshire (BSW) Integrated Care Board~~

3.2.3 ~~NHS Dorset Integrated Care Board~~

3.2.4 ~~Hampshire and Isle of Wight Integrated Care Board~~

ANNEX 5 - THE MODEL ELECTION RULES

[See paragraph 14]

PART 1: INTERPRETATION

1. Interpretation

PART 2: TIMETABLE FOR ELECTION

2. Timetable
3. Computation of time

PART 3: RETURNING OFFICER

4. Returning officer
5. Staff
6. Expenditure
7. Duty of co-operation

PART 4: STAGES COMMON TO CONTESTED AND UNCONTESTED ELECTIONS

8. Notice of election
9. Nomination of candidates
10. Candidate's particulars
11. Declaration of interests
12. Declaration of eligibility
13. Signature of candidate
14. Decisions as to validity of nomination forms
15. Publication of statement of nominated candidates
16. Inspection of statement of nominated candidates and nomination forms
17. Withdrawal of candidates
18. Method of election

PART 5: CONTESTED ELECTIONS

19. Poll to be taken by ballot
20. The ballot paper
21. The declaration of identity (public and patient constituencies)

Action to be taken before the poll

22. List of eligible voters
23. Notice of poll
24. Issue of voting information by returning officer
25. Ballot paper envelope and covering envelope
26. E-voting systems

The poll

27. Eligibility to vote
28. Voting by persons who require assistance
29. Spoilt ballot papers and spoilt text message votes
30. Lost voting information
31. Issue of replacement voting information
32. ID declaration form for replacement ballot papers (public and patient constituencies)
33 Procedure for remote voting by internet
34. Procedure for remote voting by telephone

PART 1: INTERPRETATION

1. Interpretation

1.1 In these rules, unless the context otherwise requires:

- **"*2006 Act*"** means the National Health Service Act 2006;
- "***corporation***" means the public benefit corporation subject to this constitution;
- **"*council of governors*"** means the council of governors of the corporation;
- **"*declaration of identity*"** has the meaning set out in rule 21.1;
- **"*election*"** means an election by a constituency, or by a class within a constituency, to fill a vacancy among one or more posts on the council of governors;
- "*e-voting*" means voting using either the internet, telephone or text message;
- "*e-voting information*" has the meaning set out in rule 24.2;
- "*ID declaration form*" has the meaning set out in Rule 21.1; "internet voting record" has the meaning set out in rule 26.4(d);
- "*internet voting system*" means such computer hardware and software, data other equipment and services as may be provided by the returning officer for the purpose of enabling voters to cast their votes using the internet;
- "*lead governor*" means the governor nominated by the corporation to fulfil the role described in Appendix B to The NHS Foundation Trust Code of Governance (Monitor, December 2013) or any later version of such code.
- "*list of eligible voters*" means the list referred to in rule 22.1, containing the information in rule 22.2;
- "*method of polling*" means a method of casting a vote in a poll, which may be by post, internet, text message or telephone;
- "*Monitor*" means the corporate body known as Monitor as provided by section 61 of the 2012 Act;
- "*numerical voting code*" has the meaning set out in rule 64.2(b)
- "*polling website*" has the meaning set out in rule 26.1;
- "*postal voting information*" has the meaning set out in rule 24.1;
- "*telephone short code"* means a short telephone number used for the purposes of submitting a vote by text message;
- "*telephone voting facility*" has the meaning set out in rule 26.2;

- "*telephone voting record*" has the meaning set out in rule 26.5 (d);
- "*text message voting facility*" has the meaning set out in rule 26.3;
- "*text voting record*" has the meaning set out in rule 26.6 (d);
- "*the telephone voting system*" means such telephone voting facility as may be provided by the returning officer for the purpose of enabling voters to cast their votes by telephone;
- "*the text message voting system*" means such text messaging voting facility as may be provided by the returning officer for the purpose of enabling voters to cast their votes by text message;
- "*voter ID number*" means a unique, randomly generated numeric identifier allocated to each voter by the Returning Officer for the purpose of e-voting,
- "*voting information*" means postal voting information and/or e-voting information

1.2 Other expressions used in these rules and in Schedule 7 to the NHS Act 2006 have the same meaning in these rules as in that Schedule.

PART 2: TIMETABLE FOR ELECTIONS

2. Timetable

2.1 The proceedings at an election shall be conducted in accordance with the following timetable:

Proceeding	Time
Publication of notice of election	Not later than the fortieth day before the day of the close of the poll.
Final day for delivery of nomination forms to returning officer	Not later than the twenty eighth day before the day of the close of the poll.
Publication of statement of nominated candidates	Not later than the twenty seventh day before the day of the close of the poll.
Final day for delivery of notices of withdrawals by candidates from election	Not later than twenty fifth day before the day of the close of the poll.
Notice of the poll	Not later than the fifteenth day before the day of the close of the poll.
Close of the poll	By 5.00pm on the final day of the election.

3. Computation of time

3.1 In computing any period of time for the purposes of the timetable:

a) a Saturday or Sunday;
b) Christmas day, Good Friday, or a bank holiday, or
c) a day appointed for public thanksgiving or mourning, shall be disregarded, and any such day shall not be treated as a day for the purpose of any proceedings up to the completion of the poll, nor shall the returning officer be obliged to proceed with the counting of votes on such a day.

3.2 In this rule, "bank holiday" means a day which is a bank holiday under the Banking and Financial Dealings Act 1971 in England and Wales.

PART 3: RETURNING OFFICER

4. Returning Officer

4.1 Subject to rule 69, the returning officer for an election is to be appointed by the corporation.
4.2 Where two or more elections are to be held concurrently, the same returning officer may be appointed for all those elections.

5. Staff

5.1 Subject to rule 69, the returning officer may appoint and pay such staff, including such technical advisers, as he or she considers necessary for the purposes of the election.

6. Expenditure

6.1 The corporation is to pay the returning officer:
(a) any expenses incurred by that officer in the exercise of his or her functions under these rules,
(b) such remuneration and other expenses as the corporation may determine.

7. Duty of co-operation

7.1 The corporation is to co-operate with the returning officer in the exercise of his or her functions under these rules.

PART 4: STAGES COMMON TO CONTESTED AND UNCONTESTED ELECTIONS

8. Notice of election

8.1 The returning officer is to publish a notice of the election stating:
a) the constituency, or class within a constituency, for which the election is being held,
b) the number of members of the council of governors to be elected from that constituency, or class within that constituency,
c) the details of any nomination committee that has been established by the corporation,
d) the address and times at which nomination forms may be obtained;
e) the address for return of nomination forms (including, where the return of nomination forms in an electronic format will be permitted, the e-mail address for such return) and the date and time by which they must be received by the returning officer,
f) the date and time by which any notice of withdrawal must be received by the returning officer
g) the contact details of the returning officer
h) the date and time of the close of the poll in the event of a contest.

9. Nomination of candidates

9.1 Subject to rule 9.2, each candidate must nominate themselves on a single nomination form.

9.2 The returning officer:

a) is to supply any member of the corporation with a nomination form, and

b) is to prepare a nomination form for signature at the request of any member of the corporation,

but it is not necessary for a nomination to be on a form supplied by the returning officer and a nomination can, subject to rule 13, be in an electronic format.

10. Candidate's particulars

10.1 The nomination form must state the candidate's:

a) full name,

b) contact address in full (which should be a postal address although an e-mail address may also be provided for the purposes of electronic communication), and

c) constituency, or class within a constituency, of which the candidate is a member.

11. Declaration of interests

11.1 The nomination form must state:

a) any financial interest that the candidate has in the corporation, and

b) whether the candidate is a member of a political party, and if so, which party,

and if the candidate has no such interests, the paper must include a statement to that effect.

12. Declaration of eligibility

12.1 The nomination form must include a declaration made by the candidate:

a) that he or she is not prevented from being a member of the council of governors by paragraph 8 of Schedule 7 of the 2006 Act or by any provision of the constitution; and,

b) for a member of the public or patient constituency, of the particulars of his or her qualification to vote as a member of that constituency, or class within that constituency, for which the election is being held.

13. Signature of candidate

13.1 The nomination form must be signed and dated by the candidate, in a manner prescribed by the returning officer, indicating that:

a) they wish to stand as a candidate,

b) their declaration of interests as required under rule 11, is true and correct, and

c) their declaration of eligibility, as required under rule 12, is true and correct.

13.2 Where the return of nomination forms in an electronic format is permitted, the returning officer shall specify the particular signature formalities (if any) that will need to be complied with by the candidate.

14. Decisions as to the validity of nomination

14.1 Where a nomination form is received by the returning officer in accordance with these rules, the candidate is deemed to stand for election unless and until the returning officer:

a) decides that the candidate is not eligible to stand,

b) decides that the nomination form is invalid,

c) receives satisfactory proof that the candidate has died, or

d) receives a written request by the candidate of their withdrawal from candidacy.

14.2 The returning officer is entitled to decide that a nomination form is invalid only on one of the following grounds:

a) that the paper is not received on or before the final time and date for return of nomination forms, as specified in the notice of the election,

b) that the paper does not contain the candidate's particulars, as required by rule 10;

c) that the paper does not contain a declaration of the interests of the candidate, as required by rule 11,

(d) that the paper does not include a declaration of eligibility as required by rule 12, or
(e) that the paper is not signed and dated by the candidate, if required by rule 13.

14.3 The returning officer is to examine each nomination form as soon as is practicable after he or she has received it and decide whether the candidate has been validly nominated.

14.4 Where the returning officer decides that a nomination is invalid, the returning officer must endorse this on the nomination form, stating the reasons for their decision.

14.5 The returning officer is to send notice of the decision as to whether a nomination is valid or invalid to the candidate at the contact address given in the candidate's nomination form. If an e-mail address has been given in the candidate's nomination form (in addition to the candidate's postal address), the returning officer may send notice of the decision to that address.

15. Publication of statement of candidates

15.1 The returning officer is to prepare and publish a statement showing the candidates who are standing for election.

15.2 The statement must show:
a) the name, contact address (which shall be the candidate's postal address), and constituency or class within a constituency of each candidate standing, and
b) the declared interests of each candidate standing, as given in their nomination form.

15.3 The statement must list the candidates standing for election in alphabetical order by surname.

15.4 The returning officer must send a copy of the statement of candidates and copies of the nomination forms to the corporation as soon as is practicable after publishing the statement.

16. Inspection of statement of nominated candidates and nomination forms

16.1 The corporation is to make the statement of the candidates and the nomination forms supplied by the returning officer under rule 15.4 available for inspection by members of the corporation free of charge at all reasonable times.

16.2 If a member of the corporation requests a copy or extract of the statement of candidates or their nomination forms, the corporation is to provide that member with the copy or extract free of charge.

17. Withdrawal of candidates

17.1 A candidate may withdraw from election on or before the date and time for withdrawal by candidates, by providing to the returning officer a written notice of withdrawal which is signed by the candidate and attested by a witness.

18. Method of election

18.1 If the number of candidates remaining validly nominated for an election after any withdrawals under these rules is greater than the number of members to be elected to the council of governors, a poll is to be taken in accordance with Parts 5 and 6 of these rules.

18.2 If the number of candidates remaining validly nominated for an election after any withdrawals under these rules is equal to the number of members to be elected to the council of governors, those candidates are to be declared elected in accordance with Part 7 of these rules.

18.3 If the number of candidates remaining validly nominated for an election after any withdrawals under these rules is less than the number of members to be elected to be council of governors, then:
a) the candidates who remain validly nominated are to be declared elected in accordance with Part 7 of these rules, and
b) the returning officer is to order a new election to fill any vacancy which remains unfilled, on a day appointed by him or her in consultation with the corporation.

PART 5: CONTESTED ELECTIONS

19. Poll to be taken by ballot

19.1 The votes at the poll must be given by secret ballot.
19.2 The votes are to be counted and the result of the poll determined in accordance with Part 6 of these rules.
19.3 The corporation may decide that voters within a constituency or class within a constituency, may, subject to rule 19.4, cast their votes at the poll using such different methods of polling in any combination as the corporation may determine.
19.4 The corporation may decide that voters within a constituency or class within a constituency for whom an e-mail address is included in the list of eligible voters may only cast their votes at the poll using an e-voting method of polling.
19.5 Before the corporation decides, in accordance with rule 19.3 that one or more e-voting methods of polling will be made available for the purposes of the poll, the corporation must satisfy itself that:
a) if internet voting is to be a method of polling, the internet voting system to be used for the purpose of the election is:
i. configured in accordance with these rules; and
ii. will create an accurate internet voting record in respect of any voter who casts his or her vote using the internet voting system.
b) if telephone voting to be a method of polling, the telephone voting system to be used for the purpose of the election is:
i. configured in accordance with these rules; and
ii. will create an accurate telephone voting record in respect of any voter who casts his or her vote using the telephone voting system.
c) if text message voting is to be a method of polling, the text message voting system to be used for the purpose of the election is:
i. configured in accordance with these rules; and
ii. will create an accurate text voting record in respect of any voter who casts his or her vote using the text message voting system.

20. The ballot paper

20.1 The ballot of each voter (other than a voter who casts his or her ballot by an e-voting method of polling) is to consist of a ballot paper with the persons remaining validly nominated for an election after any withdrawals under these rules, and no others, inserted in the paper.
20.2 Every ballot paper must specify:
a) the name of the corporation,
b) the constituency, or class within a constituency, for which the election is being held,
c) the number of members of the council of governors to be elected from that constituency, or class within that constituency,
d) the names and other particulars of the candidates standing for election, with the details and order being the same as in the statement of nominated candidates,
e) instructions on how to vote by all available methods of polling, including the relevant voter's voter ID number if one or more e-voting methods of polling are available,
f) if the ballot paper is to be returned by post, the address for its return and the date and time of the close of the poll, and
g) the contact details of the returning officer.
20.3 Each ballot paper must have a unique identifier.
20.4 Each ballot paper must have features incorporated into it to prevent it from being reproduced.

21. The declaration of identity (public and patient constituencies)

21.1 The corporation shall require each voter who participates in an election for a public or patient constituency to make a declaration confirming:
a) that the voter is the person:
i. to whom the ballot paper was addressed, and/or
ii. to whom the voter ID number contained within the e-voting information was allocated,
b) that he or she has not marked or returned any other voting information in the election, and

c) he particulars of his or her qualification to vote as a member of the constituency or class within the constituency for which the election is being held,

("declaration of identity")

and the corporation shall make such arrangements as it considers appropriate to facilitate the making and the return of a declaration of identity by each voter, whether by the completion of a paper form ("ID declaration form") or the use of an electronic method.

21.2 The voter must be required to return his or her declaration of identity with his or her ballot.

21.3 The voting information shall caution the voter that if the declaration of identity is not duly returned or is returned without having been made correctly, any vote cast by the voter may be declared invalid.

Action to be taken before the poll

22. List of eligible voters

22.1 The corporation is to provide the returning officer with a list of the members of the constituency or class within a constituency for which the election is being held who are eligible to vote by virtue of rule 27 as soon as is reasonably practicable after the final date for the delivery of notices of withdrawals by candidates from an election.

22.2 The list is to include, for each member:

a) a postal address; and,
b) the member's e-mail address, if this has been provided to which his or her voting information may, subject to rule 22.3, be sent.

22.3 The corporation may decide that the e-voting information is to be sent only by e-mail to those members in the list of eligible voters for whom an e-mail address is included in that list.

23. Notice of poll

23.1 The returning officer is to publish a notice of the poll stating:

a) the name of the corporation,
b) the constituency, or class within a constituency, for which the election is being held,
c) the number of members of the council of governors to be elected from that constituency, or class with that constituency,
d) the names, contact addresses, and other particulars of the candidates standing for election, with the details and order being the same as in the statement of nominated candidates,
e) that the ballot papers for the election are to be issued and returned, if appropriate, by post,
f) the methods of polling by which votes may be cast at the election by voters in a constituency or class within a constituency, as determined by the corporation in accordance with rule 19.3,
g) the address for return of the ballot papers,
h) the uniform resource locator (url) where, if internet voting is a method of polling, the polling website is located.
i) the telephone number where, if telephone voting is a method of polling, the telephone voting facility is located,
j) the telephone number or telephone short code where, if text message voting is a method of polling, the text message voting facility is located,
k) the date and time of the close of the poll,
l) the address and final dates for applications for replacement voting information, and
m) the contact details of the returning officer.

24. Issue of voting information by returning officer

24.1 Subject to rule 24.3, as soon as is reasonably practicable on or after the publication of the notice of the poll, the returning officer is to send the following information by post to each member of the corporation named in the list of eligible voters:

a) a ballot paper and ballot paper envelope,

b) the ID declaration form (if required),
c) information about each candidate standing for election, pursuant to rule 61 of these rules, and
d) a covering envelope.
("postal voting information").

24.2 Subject to rules 24.3 and 24.4, as soon as is reasonably practicable on or after the publication of the notice of the poll, the returning officer is to send the following information by e-mail and/ or by post to each member of the corporation named in the list of eligible voters whom the corporation determines in accordance with rule 19.3 and/ or rule 19.4 may cast his or her vote by an e-voting method of polling:
a) instructions on how to vote and how to make a declaration of identity (if required),
b) the voter's voter ID number,
c) information about each candidate standing for election, pursuant to rule 64 of these rules, or details of where this information is readily available on the internet or available in such other formats as the Returning Officer thinks appropriate,
d) contact details of the returning officer,
("e-voting information").

24.3 The corporation may determine that any member of the corporation shall:
a) only be sent postal voting information; or
b) only be sent e-voting information; or
c) be sent both postal voting information and e-voting information.
for the purposes of the poll.

24.4 If the corporation determines, in accordance with rule 22.3, that the e-voting information is to be sent only by e-mail to those members in the list of eligible voters for whom an e-mail address is included in that list, then the returning officer shall only send that information by e-mail.

24.5 The voting information is to be sent to the postal address and/ or e-mail address for each member, as specified in the list of eligible voters.

25. Ballot paper envelope and covering envelope

25.1 The ballot paper envelope must have clear instructions to the voter printed on it, instructing the voter to seal the ballot paper inside the envelope once the ballot paper has been marked.

25.2 The covering envelope is to have:
a) the address for return of the ballot paper printed on it, and
b) pre-paid postage for return to that address.

25.3 There should be clear instructions, either printed on the covering envelope or elsewhere, instructing the voter to seal the following documents inside the covering envelope and return it to the returning officer –
a) the completed ID declaration form if required, and
b) the ballot paper envelope, with the ballot paper sealed inside it.

26. E-voting systems

26.1 If internet voting is a method of polling for the relevant election, then the returning officer must provide a website for the purpose of voting over the internet (in these rules referred to as "the polling website").

26.2 If telephone voting is a method of polling for the relevant election, then the returning officer must provide an automated telephone system for the purpose of voting by the use of a touch-tone telephone (in these rules referred to as "the telephone voting facility").

26.3 If text message voting is a method of polling for the relevant election, then the returning officer must provide an automated text messaging system for the purpose of voting by text message (in these rules referred to as "the text message voting facility").

26.4 The returning officer shall ensure that the polling website and internet voting system provided will:
a) require a voter to:
i. enter his or her voter ID number; and
ii. where the election is for a public or patient constituency, make a declaration of identity;
in order to be able to cast his or her vote;
b) specify:

i. the name of the corporation,
ii. the constituency, or class within a constituency, for which the election is being held,
iii. the number of members of the council of governors to be elected from that constituency, or class within that constituency,
iv. the names and other particulars of the candidates standing for election, with the details and order being the same as in the statement of nominated candidates,
v. instructions on how to vote and how to make a declaration of identity,
vi. the date and time of the close of the poll, and
vii. the contact details of the returning officer.

c) prevent a voter from voting for more candidates than he or she is entitled to at the election.
d) create a record ("internet voting record") that is stored in the internet voting system in respect of each vote cast by a voter using the internet that comprises of-
i. the voter's voter ID number.
ii. the voter's declaration of identity (where required).
iii. the candidate or candidates for whom the voter has voted; and
iv. the date and time of the voter's vote,
e) if the voter's vote has been duly cast and recorded, provide the voter with confirmation of this; and
f) prevent any voter from voting after the close of poll.

26.5 The returning officer shall ensure that the telephone voting facility and telephone voting system provided will:

a) require a voter to
i. enter his or her voter ID number in order to be able to cast his or her vote; and
ii. where the election is for a public or patient constituency, make a declaration of identity.
b) specify:
i. the name of the corporation,
ii. the constituency, or class within a constituency, for which the election is being held,
iii. the number of members of the council of governors to be elected from that constituency, or class within that constituency,
iv. instructions on how to vote and how to make a declaration of identity,
v. the date and time of the close of the poll, and
vi. the contact details of the returning officer.
c) prevent a voter from voting for more candidates than he or she is entitled to at the election.
d) create a record ("telephone voting record") that is stored in the telephone voting system in respect of each vote cast by a voter using the telephone that comprises of:
i. the voter's voter ID number.
ii. the voter's declaration of identity (where required).
iii. the candidate or candidates for whom the voter has voted; and
iv. the date and time of the voter's vote
e) if the voter's vote has been duly cast and recorded, provide the voter with confirmation of this.
f) prevent any voter from voting after the close of poll.

26.6 The returning officer shall ensure that the text message voting facility and text messaging voting system provided will:

a) require a voter to:
i. provide his or her voter ID number; and
ii. where the election is for a public or patient constituency, make a declaration of identity;
in order to be able to cast his or her vote;
b) prevent a voter from voting for more candidates than he or she is entitled to at the election;
c) create a record ("text voting record") that is stored in the text messaging voting system in respect of each vote cast by a voter by text message that comprises of:
i. the voter's voter ID number;
ii. the voter's declaration of identity (where required);
iii. the candidate or candidates for whom the voter has voted; and
iv. the date and time of the voter's vote
d) if the voter's vote has been duly cast and recorded, provide the voter with confirmation of this;
e) prevent any voter from voting after the close of poll.

The poll

27. Eligibility to vote

27.1 An individual who becomes a member of the corporation on or before the closing date for the receipt of nominations by candidates for the election, is eligible to vote in that election.

28. Voting by persons who require assistance

28.1 The returning officer is to put in place arrangements to enable requests for assistance to vote to be made.

28.2 Where the returning officer receives a request from a voter who requires assistance to vote, the returning officer is to make such arrangements as he or she considers necessary to enable that voter to vote.

29. Spoilt ballot papers and spoilt text message votes

29.1 If a voter has dealt with his or her ballot paper in such a manner that it cannot be accepted as a ballot paper (referred to as a "spoilt ballot paper"), that voter may apply to the returning officer for a replacement ballot paper.

29.2 On receiving an application, the returning officer is to obtain the details of the unique identifier on the spoilt ballot paper, if he or she can obtain it.

29.3 The returning officer may not issue a replacement ballot paper for a spoilt ballot paper unless he or she:

a) is satisfied as to the voter's identity; and
b) has ensured that the completed ID declaration form, if required, has not been returned.

29.4 After issuing a replacement ballot paper for a spoilt ballot paper, the returning officer shall enter in a list ("the list of spoilt ballot papers"):

a) the name of the voter, and
b) the details of the unique identifier of the spoilt ballot paper (if that officer was able to obtain it), and
c) the details of the unique identifier of the replacement ballot paper.

29.5 If a voter has dealt with his or her text message vote in such a manner that it cannot be accepted as a vote (referred to as a "spoilt text message vote"), that voter may apply to the returning officer for a replacement voter ID number.

29.6 On receiving an application, the returning officer is to obtain the details of the voter ID number on the spoilt text message vote, if he or she can obtain it.

29.7 The returning officer may not issue a replacement voter ID number in respect of a spoilt text message vote unless he or she is satisfied as to the voter's identity**.**

29.8 After issuing a replacement voter ID number in respect of a spoilt text message vote, the returning officer shall enter in a list ("the list of spoilt text message votes")**:**

a) the name of the voter, and
b) the details of the voter ID number on the spoilt text message vote (if that officer was able to obtain it), and
c) the details of the replacement voter ID number issued to the voter.

30. Lost voting information

30.1 Where a voter has not received his or her voting information by the tenth day before the close of the poll, that voter may apply to the returning officer for replacement voting information.

30.2 The returning officer may not issue replacement voting information in respect of lost voting information unless he or she:

a) is satisfied as to the voter's identity,
b) has no reason to doubt that the voter did not receive the original voting information,
c) has ensured that no declaration of identity, if required, has been returned.

30.3 After issuing replacement voting information in respect of lost voting information, the returning officer shall enter in a list ("the list of lost ballot documents"):

a) the name of the voter
b) the details of the unique identifier of the replacement ballot paper, if applicable, and
c) the voter ID number of the voter.

31. Issue of replacement voting information

31.1 If a person applies for replacement voting information under rule 29 or 30 and a declaration of identity has already been received by the returning officer in the name of that voter, the returning officer may not issue replacement voting information unless, in addition to the requirements imposed by rule 29.3 or 30.2, he or she is also satisfied that that person has not already voted in the election, notwithstanding the fact that a declaration of identity if required has already been received by the returning officer in the name of that voter.

31.2 After issuing replacement voting information under this rule, the returning officer shall enter in a list ("the list of tendered voting information"):
a) the name of the voter,
b) the unique identifier of any replacement ballot paper issued under this rule;
c) the voter ID number of the voter.

32. ID declaration form for replacement ballot papers (public and patient constituencies)

32.1 In respect of an election for a public or patient constituency an ID declaration form must be issued with each replacement ballot paper requiring the voter to make a declaration of identity.

Polling by internet, telephone or text

33. Procedure for remote voting by internet

33.1 To cast his or her vote using the internet, a voter will need to gain access to the polling website by keying in the url of the polling website provided in the voting information.

33.2 When prompted to do so, the voter will need to enter his or her voter ID number.

33.3 If the internet voting system authenticates the voter ID number, the system will give the voter access to the polling website for the election in which the voter is eligible to vote.

33.4 To cast his or her vote, the voter will need to key in a mark on the screen opposite the particulars of the candidate or candidates for whom he or she wishes to cast his or her vote.

33.5 The voter will not be able to access the internet voting system for an election once his or her vote at that election has been cast.

34. Voting procedure for remote voting by telephone

34.1 To cast his or her vote by telephone, the voter will need to gain access to the telephone voting facility by calling the designated telephone number provided in the voter information using a telephone with a touch-tone keypad.

34.2 When prompted to do so, the voter will need to enter his or her voter ID number using the keypad.

34.3 If the telephone voting facility authenticates the voter ID number, the voter will be prompted to vote in the election.

34.4 When prompted to do so the voter may then cast his or her vote by keying in the numerical voting code of the candidate or candidates, for whom he or she wishes to vote.

34.5 The voter will not be able to access the telephone voting facility for an election once his or her vote at that election has been cast.

35. Voting procedure for remote voting by text message

35.1 To cast his or her vote by text message the voter will need to gain access to the text message voting facility by sending a text message to the designated telephone number or telephone short code provided in the voter information.

35.2 The text message sent by the voter must contain his or her voter ID number and the numerical voting code for the candidate or candidates, for whom he or she wishes to vote.

35.3 The text message sent by the voter will need to be structured in accordance with the instructions on how to vote contained in the voter information, otherwise the vote will not be cast.

Procedure for receipt of envelopes, internet votes, telephone votes and text message votes

36. Receipt of voting documents

36.1 Where the returning officer receives:
a) a covering envelope, or
b) any other envelope containing an ID declaration form if required, a ballot paper envelope, or a ballot paper,

before the close of the poll, that officer is to open it as soon as is practicable; and rules 37 and 38 are to apply.

36.2 The returning officer may open any covering envelope or any ballot paper envelope for the purposes of rules 37 and 38, but must make arrangements to ensure that no person obtains or communicates information as to:
a) the candidate for whom a voter has voted, or
b) the unique identifier on a ballot paper.

36.3 The returning officer must make arrangements to ensure the safety and security of the ballot papers and other documents.

37. Validity of votes

37.1 A ballot paper shall not be taken to be duly returned unless the returning officer is satisfied that it has been received by the returning officer before the close of the poll, with an ID declaration form if required that has been correctly completed, signed and dated.

37.2 Where the returning officer is satisfied that rule 37.1 has been fulfilled, he or she is to:
a) put the ID declaration form if required in a separate packet, and
b) put the ballot paper aside for counting after the close of the poll.

37.3 Where the returning officer is not satisfied that rule 37.1 has been fulfilled, he or she is to:
a) mark the ballot paper "disqualified",
b) if there is an ID declaration form accompanying the ballot paper, mark it "disqualified" and attach it to the ballot paper,
c) record the unique identifier on the ballot paper in a list of disqualified documents (the "list of disqualified documents"); and
d) place the document or documents in a separate packet.

37.4 An internet, telephone or text message vote shall not be taken to be duly returned unless the returning officer is satisfied that the internet voting record, telephone voting record or text voting record (as applicable) has been received by the returning officer before the close of the poll, with a declaration of identity if required that has been correctly made.

37.5 Where the returning officer is satisfied that rule 37.4 has been fulfilled, he or she is to put the internet voting record, telephone voting record or text voting record (as applicable) aside for counting after the close of the poll.

37.6 Where the returning officer is not satisfied that rule 37.4 has been fulfilled, he or she is to:
a) mark the internet voting record, telephone voting record or text voting record (as applicable) "disqualified",
b) record the voter ID number on the internet voting record, telephone voting record or text voting record (as applicable) in the list of disqualified documents; and
c) place the document or documents in a separate packet.

38. Declaration of identity but no ballot paper (public and patient constituency)[1]

38.1 Where the returning officer receives an ID declaration form if required but no ballot paper, the returning officer is to:

[1] It should not be possible, technically, to make a declaration of identity electronically without also submitting a vote

a) mark the ID declaration form “disqualified”,
b) record the name of the voter in the list of disqualified documents, indicating that a declaration of identity was received from the voter without a ballot paper, and
c) place the ID declaration form in a separate packet.

39. De-duplication of votes

39.1 Where different methods of polling are being used in an election, the returning officer shall examine all votes cast to ascertain if a voter ID number has been used more than once to cast a vote in the election.

39.2 If the returning officer ascertains that a voter ID number has been used more than once to cast a vote in the election he or she shall:
a) only accept as duly returned the first vote received that was cast using the relevant voter ID number; and
b) mark as “disqualified” all other votes that were cast using the relevant voter ID number.

39.3 Where a ballot paper is disqualified under this rule the returning officer shall:
a) mark the ballot paper “disqualified”,
b) if there is an ID declaration form accompanying the ballot paper, mark it “disqualified” and attach it to the ballot paper,
c) record the unique identifier and the voter ID number on the ballot paper in the list of disqualified documents.
d) place the document or documents in a separate packet; and
e) disregard the ballot paper when counting the votes in accordance with these rules.

39.4 Where an internet voting record, telephone voting record or text voting record is disqualified under this rule the returning officer shall:
a) mark the internet voting record, telephone voting record or text voting record (as applicable) “disqualified”,
b) record the voter ID number on the internet voting record, telephone voting record or text voting record (as applicable) in the list of disqualified documents;
c) place the internet voting record, telephone voting record or text voting record (as applicable) in a separate packet, and
d) disregard the internet voting record, telephone voting record or text voting record (as applicable) when counting the votes in accordance with these rules.

40. Sealing of packets

40.1 As soon as is possible after the close of the poll and after the completion of the procedure under rules 37 and 38, the returning officer is to seal the packets containing:
a) the disqualified documents, together with the list of disqualified documents inside it,
b) the ID declaration forms, if required,
c) the list of spoilt ballot papers and the list of spoilt text message votes,
d) the list of lost ballot documents,
e) the list of eligible voters, and
f) the list of tendered voting information

and ensure that complete electronic copies of the internet voting records, telephone voting records and text voting records created in accordance with rule 26 are held in a device suitable for the purpose of storage.

PART 6: COUNTING THE VOTES

---

41. -[NOT USED]

42. Arrangements for counting of the votes

42.1 The returning officer is to make arrangements for counting the votes as soon as is practicable after the close of the poll.

42.2 The returning officer may make arrangements for any votes to be counted using vote counting

software where:

a) the board of directors and the council of governors of the corporation have approved:
   i. the use of such software for the purpose of counting votes in the relevant election, and
   ii. a policy governing the use of such software, and
b) the corporation and the returning officer are satisfied that the use of such software will produce an accurate result.

43. The count

43.1 The returning officer is to:

a) count and record the number of:
   iii. ballot papers that have been returned; and
   iv. the number of internet voting records, telephone voting records and/or text voting records that have been created, and
b) count the votes according to the provisions in this Part of the rules and/or the provisions of any policy approved pursuant to rule 42.2(ii) where vote counting software is being used.

43.2 The returning officer, while counting and recording the number of ballot papers, internet voting records, telephone voting records and/or text voting records and counting the votes, must make arrangements to ensure that no person obtains or communicates information as to the unique identifier on a ballot paper or the voter ID number on an internet voting record, telephone voting record or text voting record.

43.3 The returning officer is to proceed continuously with counting the votes as far as is practicable.

PP44. Rejected ballot papers and rejected text voting records

FPP44.1 Any ballot paper:

a) which does not bear the features that have been incorporated into the other ballot papers to prevent them from being reproduced,
b) on which votes are given for more candidates than the voter is entitled to vote,
c) on which anything is written or marked by which the voter can be identified except the unique identifier, or
d) which is unmarked or rejected because of uncertainty,

shall, subject to rules FPP44.2 and FPP44.3, be rejected and not counted.

FPP44.2 Where the voter is entitled to vote for more than one candidate, a ballot paper is not to be rejected because of uncertainty in respect of any vote where no uncertainty arises, and that vote is to be counted.

FPP44.3 A ballot paper on which a vote is marked:

a) elsewhere than in the proper place,
b) otherwise, than by means of a clear mark,
c) by more than one mark,

is not to be rejected for such reason (either wholly or in respect of that vote) if an intention that the vote shall be for one or other of the candidates clearly appears, and the way the paper is marked does not itself identify the voter and it is not shown that he or she can be identified by it.

FPP44.4 The returning officer is to:

a) endorse the word “rejected” on any ballot paper which under this rule is not to be counted, and
b) in the case of a ballot paper on which any vote is counted under rules FPP44.2 and FPP 44.3, endorse the words “rejected in part” on the ballot paper and indicate which vote or votes have been counted.

FPP44.5 The returning officer is to draw up a statement showing the number of rejected ballot papers under the following headings:

a) does not bear proper features that have been incorporated into the ballot paper,
b) voting for more candidates than the voter is entitled to,

c) writing or mark by which voter could be identified, and
d) unmarked or rejected because of uncertainty,

and, where applicable, each heading must record the number of ballot papers rejected in part.

FPP44.6 Any text voting record:

a) on which votes are given for more candidates than the voter is entitled to vote,
b) on which anything is written or marked by which the voter can be identified except the voter ID number, or
c) which is unmarked or rejected because of uncertainty,

shall, subject to rules FPP44.7 and FPP44.8, be rejected and not counted.

FPP44.7 Where the voter is entitled to vote for more than one candidate, a text voting record is not to be rejected because of uncertainty in respect of any vote where no uncertainty arises, and that vote is to be counted.

FPP448 A text voting record on which a vote is marked:

(a) otherwise than by means of a clear mark,
(b) by more than one mark,

is not to be rejected for such reason (either wholly or in respect of that vote) if an intention that the vote shall be for one or other of the candidates clearly appears, and the way the text voting record is marked does not itself identify the voter and it is not shown that he or she can be identified by it.

FPP44.9 The returning officer is to:

(a) endorse the word "rejected" on any text voting record which under this rule is not to be counted, and
(b) in the case of a text voting record on which any vote is counted under rules FPP44.7 and FPP 44.8, endorse the words "rejected in part" on the text voting record and indicate which vote or votes have been counted.

FPP44.10 The returning officer is to draw up a statement showing the number of rejected text voting records under the following headings:

(a) voting for more candidates than the voter is entitled to,
(b) writing or mark by which voter could be identified, and
(c) unmarked or rejected because of uncertainty,

and, where applicable, each heading must record the number of text voting records rejected in part.

[PARAGRAPHS 45-50 NOT USED]

FPP51. Equality of votes

FPP51.1 Where, after the counting of votes is completed, an equality of votes is found to exist between any candidates and the addition of a vote would entitle any of those candidates to be declared elected, the returning officer is to decide between those candidates by a lot, and proceed as if the candidate on whom the lot falls had received an additional vote.

PART 7: FINAL PROCEEDINGS IN CONTESTED AND UNCONTESTED ELECTIONS

FPP52. Declaration of result for contested elections

FPP52.1 In a contested election, when the result of the poll has been ascertained, the returning officer is to:

(a) declare the candidate or candidates whom more votes have been given than for the other candidates, up to the number of vacancies to be filled on the council of governors from the constituency, or class within a constituency, for which the election is being held to be elected,
(b) give notice of the name of each candidate who he or she has declared elected:
(i) where the election is held under a proposed constitution pursuant to powers

conferred on the [insert name] NHS Trust by section 33(4) of the 2006 Act, to the Chair of the NHS Trust, or

(ii) in any other case, to the Chair of the corporation; and

(a) give public notice of the name of each candidate whom he or she has declared elected.

FPP52.2 The returning officer is to make:

(a) the total number of votes given for each candidate (whether elected or not), and

(b) the number of rejected ballot papers under each of the headings in rule FPP44.5,

(c) the number of rejected text voting records under each of the headings in rule FPP44.10,

available on request.

53. Declaration of result for uncontested elections

53.1 In an uncontested election, the returning officer is to as soon as is practicable after final day for the delivery of notices of withdrawals by candidates from the election:

(a) declare the candidate or candidates remaining validly nominated to be elected,

(b) give notice of the name of each candidate who he or she has declared elected to the Chair of the corporation, and

(c) give public notice of the name of each candidate who he or she has declared elected.

PART 8: DISPOSAL OF DOCUMENTS

54. Sealing up of documents relating to the poll

54.1 On completion of the counting at a contested election, the returning officer is to seal up the following documents in separate packets:

(a) the counted ballot papers, internet voting records, telephone voting records and text voting records,

(b) the ballot papers and text voting records endorsed with “rejected in part”,

(c) the rejected ballot papers and text voting records, and

(d) the statement of rejected ballot papers and the statement of rejected text voting records,

and ensure that complete electronic copies of the internet voting records, telephone voting records and text voting records created in accordance with rule 26 are held in a device suitable for the purpose of storage.

54.2 The returning officer must not open the sealed packets of:

(a) the disqualified documents, with the list of disqualified documents inside it,

(b) the list of spoilt ballot papers and the list of spoilt text message votes,

(c) the list of lost ballot documents, and

(d) the list of eligible voters,

or access the complete electronic copies of the internet voting records, telephone voting records and text voting records created in accordance with rule 26 and held in a device suitable for the purpose of storage.

54.3 The returning officer must endorse on each packet a description of:

(a) its contents,

(b) the date of the publication of notice of the election,

(c) the name of the corporation to which the election relates, and

(d) the constituency, or class within a constituency, to which the election relates.

55. Delivery of documents

55.1 Once the documents relating to the poll have been sealed up and endorsed pursuant to rule 56, the returning officer is to forward them to the chair of the corporation.

56. Forwarding of documents received after close of the poll

56.1 Where:

(a) any voting documents are received by the returning officer after the close of the poll, or

(b) any envelopes addressed to eligible voters are returned as undelivered too late to be resent, or

(c) any applications for replacement voting information are made too late to enable new voting information to be issued,

the returning officer is to put them in a separate packet, seal it up, and endorse and forward it to the Chair of the corporation.

57. Retention and public inspection of documents

57.1 The corporation is to retain the documents relating to an election that are forwarded to the chair by the returning officer under these rules for one year, and then, unless otherwise directed by the board of directors of the corporation, cause them to be destroyed.

57.2 With the exception of the documents listed in rule 58.1, the documents relating to an election that are held by the corporation shall be available for inspection by members of the public at all reasonable times.

57.3 A person may request a copy or extract from the documents relating to an election that are held by the corporation, and the corporation is to provide it, and may impose a reasonable charge for doing so.

58. Application for inspection of certain documents relating to an election

58.1 The corporation may not allow:

(a) the inspection of, or the opening of any sealed packet containing –

(i) any rejected ballot papers, including ballot papers rejected in part,

(ii) any rejected text voting records, including text voting records rejected in part,

(iii) any disqualified documents, or the list of disqualified documents,

(iv) any counted ballot papers, internet voting records, telephone voting records or text voting records, or

(v) the list of eligible voters, or

(b) access to or the inspection of the complete electronic copies of the internet voting records, telephone voting records and text voting records created in accordance with rule 26 and held in a device suitable for the purpose of storage,

by any person without the consent of the board of directors of the corporation.

58.2 A person may apply to the board of directors of the corporation to inspect any of the documents listed in rule 58.1, and the board of directors of the corporation may only consent to such inspection if it is satisfied that it is necessary for the purpose of questioning an election pursuant to Part 11.

58.3 The board of directors of the corporation's consent may be on any terms or conditions that it thinks necessary, including conditions as to –

(a) persons,

(b) time,

(c) place and mode of inspection,

(d) production or opening,

and the corporation must only make the documents available for inspection in accordance with those terms and conditions.

58.4 On an application to inspect any of the documents listed in rule 58.1 the board of directors of the corporation must:

(a) in giving its consent, and

(b) in making the documents available for inspection

ensure that the way in which the vote of any particular member has been given shall not be disclosed, until it has been established –

(i) that his or her vote was given, and

(ii) that NHS England has declared that the vote was invalid.

PART 9: DEATH OF A CANDIDATE DURING A CONTESTED ELECTION

FPP59. Countermand or abandonment of poll on death of candidate

FPP59.1 If at a contested election, proof is given to the returning officer's satisfaction before the result of the election is declared that one of the persons named or to be named as a candidate has died, then the returning officer is to:

(a) countermand notice of the poll, or, if voting information has been issued, direct that the poll be abandoned within that constituency or class, and

(b) order a new election, on a date to be appointed by him or her in consultation with the corporation, within the period of 40 days, computed in accordance with rule 3 of these rules, beginning with the day that the poll was countermanded or abandoned.

FPP59.2 Where a new election is ordered under rule FPP59.1, no fresh nomination is necessary for any candidate who was validly nominated for the election where the poll was countermanded or abandoned but further candidates shall be invited for that constituency or class.

F**PP59.3** Where a poll is abandoned under rule FPP59.1(a), rules FPP59.4 to FPP59.7 are to apply.

FPP59.4 The returning officer shall not take any step or further step to open envelopes or deal with their contents in accordance with rules 38 and 39, and is to make up separate sealed packets in accordance with rule 40.

FPP59.5 The returning officer is to:

(a) account and record the number of ballot papers, internet voting records, t telephone voting records and text voting records that have been received,

(b) seal up the ballot papers, internet voting records, telephone voting records and text voting records into packets, along with the records of the number of ballot papers, internet voting records, telephone voting records and text voting records and

ensure that complete electronic copies of the internet voting records telephone voting records and text voting records created in accordance with rule 26 are held in a device suitable for the purpose of storage.

FPP59.6 The returning officer is to endorse on each packet a description of:

(a) its contents,

(b) the date of the publication of notice of the election,

(c) the name of the corporation to which the election relates, and

(d) the constituency, or class within a constituency, to which the election relates.

FPP59.7 Once the documents relating to the poll have been sealed up and endorsed pursuant to rules FPP59.4 to FPP59.6, the returning officer is to deliver them to the Chair of the corporation, and rules 57 and 58 are to apply.

PART 10: ELECTION EXPENSES AND PUBLICITY

Election expenses

60. Election expenses

60.1 Any expenses incurred, or payments made, for the purposes of an election which contravene this Part are an electoral irregularity, which may only be questioned in an application made to NHS England (previously Monitor) under Part 11 of these rules.

61. Expenses and payments by candidates

61.1 A candidate may not incur any expenses or make a payment (of whatever nature) for the purposes of an election, other than expenses or payments that relate to:

(a) personal expenses,
(b) travelling expenses, and expenses incurred while living away from home, and
(c) expenses for stationery, postage, telephone, internet(or any similar means of communication) and other petty expenses, to a limit of £100.

62. Election expenses incurred by other persons

62.1 No person may:

(a) incur any expenses or make a payment (of whatever nature) for the purposes of a candidate's election, whether on that candidate's behalf or otherwise, or
(b) give a candidate or his or her family any money or property (whether as a gift, donation, loan, or otherwise) to meet or contribute to expenses incurred by or on behalf of the candidate for the purposes of an election.

62.2 Nothing in this rule is to prevent the corporation from incurring such expenses, and making such payments, as it considers necessary pursuant to rules 63 and 64.

Publicity

63. Publicity about election by the corporation

63.1 The corporation may:

(a) compile and distribute such information about the candidates, and
(b) organise and hold such meetings to enable the candidates to speak and respond to questions,

as it considers necessary.

63.2 Any information provided by the corporation about the candidates, including information compiled by the corporation under rule 64, must be:

(a) objective, balanced and fair,
(b) equivalent in size and content for all candidates,
(c) compiled and distributed in consultation with all of the candidates standing for election, and
(d) must not seek to promote or procure the election of a specific candidate or candidates, at the expense of the electoral prospects of one or more other candidates.

63.3 Where the corporation proposes to hold a meeting to enable the candidates to speak, the corporation must ensure that all of the candidates are invited to attend, and in organising and holding such a meeting, the corporation must not seek to promote or procure the election of a specific candidate or candidates at the expense of the electoral prospects of one or more other candidates.

64. Information about candidates for inclusion with voting information

64.1 The corporation must compile information about the candidates standing for election, to be distributed by the returning officer pursuant to rule 24 of these rules.

64.2 The information must consist of:

(a) a statement submitted by the candidate of no more than 250 words,
(b) if voting by telephone or text message is a method of polling for the election, the numerical voting code allocated by the returning officer to each candidate, for the purpose of recording votes using the telephone voting facility or the text message voting facility ("numerical voting code"), and
(c) a photograph of the candidate.

65. Meaning of "for the purposes of an election"

65.1 In this Part, the phrase "for the purposes of an election" means with a view to, or otherwise in connection with, promoting or procuring a candidate's election, including the prejudicing of another candidate's electoral prospects; and the phrase "for the purposes of a candidate's election" is to be construed accordingly.

65.2 The provision by any individual of his or her own services voluntarily, on his or her own time, and free of charge is not to be considered an expense for the purposes of this Part.

PART 11: QUESTIONING ELECTIONS AND THE CONSEQUENCE OF IRREGULARITIES

66. Application to question an election

66.1 An application alleging a breach of these rules, including an electoral irregularity under Part 10, may be made to NHS England (previously Monitor) for the purpose of seeking a referral to the independent election arbitration panel (IEAP).

66.2 An application may only be made once the outcome of the election has been declared by the returning officer.

66.3 An application may only be made to NHS England (previously Monitor) by:

(a) a person who voted at the election or who claimed to have had the right to vote, or

(b) a candidate, or a person claiming to have had a right to be elected at the election.

66.4 The application must:

(a) describe the alleged breach of the rules or electoral irregularity, and

(b) be in such a form as the independent panel may require.

66.5 The application must be presented in writing within 21 days of the declaration of the result of the election. NHS England (previously Monitor) will refer the application to the independent election arbitration panel appointed by NHS England (previously Monitor).

66.6 If the independent election arbitration panel requests further information from the applicant, then that person must provide it as soon as is reasonably practicable.

66.7 NHS England (previously Monitor) shall delegate the determination of an application to a person or panel of persons to be nominated for the purpose.

66.8 The determination by the IEAP shall be binding on and shall be given effect by the corporation, the applicant and the members of the constituency (or class within a constituency) including all the candidates for the election to which the application relates.

66.9 The IEAP may prescribe rules of procedure for the determination of an application including costs.

PART 12: MISCELLANEOUS

67. Secrecy

67.1 The following persons:

(a) the returning officer,

(b) the returning officer's staff,

must maintain and aid in maintaining the secrecy of the voting and the counting of the votes, and must not, except for some purpose authorised by law, communicate to any person any information as to:

(i) the name of any member of the corporation who has or has not been given voting information or who has or has not voted,

(ii) the unique identifier on any ballot paper,

(iii) the voter ID number allocated to any voter,

(iv) the candidate(s) for whom any member has voted.

67.2 No person may obtain or attempt to obtain information as to the candidate(s) for whom a voter is about to vote or has voted, or communicate such information to any person at any time, including the unique identifier on a ballot paper given to a voter or the voter ID number

allocated to a voter.

67.3 The returning officer is to make such arrangements as he or she thinks fit to ensure that the individuals who are affected by this provision are aware of the duties it imposes.

68. Prohibition of disclosure of vote

68.1 No person who has voted at an election shall, in any legal or other proceedings to question the election, be required to state for whom he or she has voted.

69. Disqualification

69.1 A person may not be appointed as a returning officer, or as staff of the returning officer pursuant to these rules, if that person is:

(a) a member of the corporation,
(b) an employee of the corporation,
(c) a director of the corporation, or
(d) employed by or on behalf of a person who has been nominated for election.

70. Delay in postal service through industrial action or unforeseen event

70.1 If industrial action, or some other unforeseen event, results in a delay in:

(a) the delivery of the documents in rule 24, or
(b) the return of the ballot papers,

the returning officer may extend the time between the publication of the notice of the poll and the close of the poll by such period as he or she considers appropriate.

ANNEX 6 - ADDITIONAL PROVISIONS – COUNCIL OF GOVERNORS - DISQUALIFICATION

(See paragraph 16)

In addition to the cases set out in paragraph 17, the following may not stand for election or continue as a governor:

1. A person who is the subject of a sexual offences order under the Sexual Offences Act 2003 or any subsequent legislation.
2. A person who is disqualified from being a company director under the laws of England and/or Wales.
3. A person who is a director of the Trust, Chair or chief executive of another NHS Foundation Trust or NHS Trust; However, a governor (other than the lead governor) may be a governor or non-executive director (other than Chair) of another NHS Foundation trust or NHS trust, save where there is a real risk of conflict of interest arising as a result of the two governorships or directorship and governorship.
4. A person whose physical or mental wellbeing is such that their ability to act as a governor of the Trust is materially affected.
5. A person who occupies the same household as an existing governor or a director of the Trust.
6. In the case of a public or patient governor, a person who has been employed by the Trust within 12 months prior to election or becomes employed by the Trust.
7. A person who has had his name removed from a list maintained under regulations pursuant to Sections 91, 106, 123, or 146 of the 2006 Act, or the equivalent lists maintained by Local Health Boards in Wales under the National Health Service (Wales) Act 2006, and he has not subsequently had his name included in such a list and, due to the reason(s) for such removal, he is considered by the Trust to be unsuitable to be a Governor.

ANNEX 7 - STANDING ORDERS FOR THE PRACTICE AND PROCEDURE OF THE COUNCIL OF GOVERNORS

(See paragraph 19)

CONTENTS

1. Introduction

1.1 Paragraph 14 of Schedule 7 to the National Health Service Act 2006 provides that the constitution of an NHS foundation trust must make provision for the practice and procedure of the Council of Governors. The Council made such provision in its standing orders adopted in 2006. Paragraph 3.13 of those orders provided that they might be amended as there set out. At a meeting of the Council on 25 February 2013 in accordance with paragraph 3.13, these standing orders as set out herein were adopted in substitution of those orders.

2. Interpretation

2.1 The expressions and terms used herein shall have the same meaning as in the Trust's Constitution.

2.2 'The Constitution' means the constitution of the Trust.

2.3 'The Council' means the Council of Governors.

2.4 A 'motion' means a formal proposition to be considered and voted on at a meeting of the Council.

2.5 An 'item for the agenda' means a matter to be considered at a meeting of the Council.

2.6 'The Secretary' means the person appointed as the Secretary to the Trust.

2.7

3. Meetings of the Council

3.1 Paragraph 18.3 of the Constitution provides that meetings of the Council shall be open to members of the public but that the public may be excluded as there set out.

3.2 The dates, times and venues of meetings of the Council shall be arranged by the Secretary in consultation with the Chair and the Lead Governor. There shall be at least 4 meetings in any year, in respect of which the dates and times shall be arranged, and notice given to the governors, before December of the previous year. At least 4 days clear notice of other meetings must be given

3.3 If the Lead Governor (or in case of the Lead Governor's unavailability the Deputy Lead Governor), or at least 10 governors, give notice to the Secretary requiring a meeting stating the proposed agenda, the Secretary shall arrange a meeting as soon as practicable.

3.4 Notice of meetings of the Council shall be given to the governors by email (or post where a governor so requests).

3.5 Notice of meetings of the Council will be posted on the Trust's website, as soon as practical after notice has been given to the governors.

4. Agenda Items and Motions

4.1 Save as provided in 3.3 above and 4.2 below, the agenda for meetings shall be arranged by the Secretary in consultation with the Chair and the Lead Governor.

4.2 A governor wishing to have an item included in the agenda for a meeting of the Council or to propose a motion at a meeting shall give notice of the item or motion to the Secretary 10 clear days before the meeting unless the circumstances relating to the item make necessary a shorter period. In the case of a motion the notice shall name a governor who is prepared to second the motion and shall otherwise be treated as invalid. The Secretary shall include in the agenda for the meeting all items and motions which have been duly notified. The Chair of the meeting may, at his discretion, permit an item to be raised or a motion proposed where due notice has not been given.

4.3 A motion may be withdrawn at any time by the proposer with the agreement of the seconder and the consent of the Chair of the meeting.

4.4 No motion shall be proposed to amend or rescind any resolution, or the substance of any resolution, passed by the Council within the preceding 6 months unless it is signed by the proposer and seconder and by 4 other governors. Once such motion has been disposed of no motion to a similar effect may be proposed for 6 months without the consent of the Chair of the Trust.

4.5 The proposer of a motion shall propose it and shall have a right to speak before a vote is taken.

4.6 During the consideration of a motion a governor may move:

4.6.1 an amendment to the motion;

4.6.2 that the consideration of motion be adjourned to a subsequent meeting;

4.6.3 that the motion be summarily dismissed and the meeting to proceed to the next

business;

4.6.4 that the motion be voted on immediately.

4.7 No amendment to a motion may be submitted if its effect would be to negate the substance of the motion as determined by the Chair of the meeting.

4.8 Save where the Chair of a meeting permits otherwise, the agenda and any papers for the meeting shall be provided to the governors not less than 5 working days before the meeting.

5. Quorum

5.1 No business may be transacted at a meeting of the Council of Governors unless more than half of the governors are present.

6. Relevance and Concision

6.1 Statements made by governors at a meeting of the Council must be concise and relevant to the matter under discussion at the time.

6.2 The Chair of the meeting shall have power to rule on the relevance and regularity any statement, and to determine any issue arising as to the conduct of the meeting.

6.3 In any matter relating to the interpretation of the Constitution and Standing Orders the Chair of the meeting shall consider the advice of the Secretary.

7. Voting

7.1 Save where it is otherwise provided by the constitution, or these orders any matter on which a vote is taken shall be determined by a majority vote of the governors present and voting.

7.2 In the case of an equality of votes the person presiding shall have a vote to decide the matter (if that person is a governor, a second vote).

7.3 At the discretion of the Chair of the meeting, the vote may be taken orally, or by show of hands. If a majority of governors present so request, it shall be by secret paper ballot.

7.4 Save in the case of a secret paper ballot, if at least one third of the governor's present request, the voting for and against of each governor shall be minuted.

7.5 If a governor requests, his vote shall be minuted.

7.6 No one may vote unless physically present: there shall be no votes by proxy.

8. Minutes

8.1 Minutes of meetings shall be drawn up and circulated in draft as soon as practical after the meeting. They shall be submitted for approval at the next meeting.

8.2 The minutes shall record the names of those attending.

9. Suspension of Standing Orders

9.1 Except where to do so would contravene any statutory provision, the terms of the Trust's authorisation or the Constitution, the Chair of any meeting of the Council may suspend any one or more of the Standing Orders.

9.2 A decision to suspend standing orders shall be recorded in the minutes.

9.3 A separate record of matters while the orders were suspended shall be made, and shall be provided to the governors with the minutes.

10. Committees

10.1 The Council may set up committees (with sub-committees) or working groups to consider aspects of the Council's business. They shall report to the Council.

10.2 The powers of the Council may be delegated to a committee for a specific purpose if the law and the Constitution permit, but otherwise the power of any committee is limited to making recommendations to the Council.

10.3 The powers of the Council shall be exercised in general meeting.

10.4 The Council shall approve the membership of committees, sub-committees and working groups, and may appoint persons with specialised knowledge or expertise useful to the committee on such terms as the Council may determine.

10.5 Meetings of the Council's committees, sub-committees and working groups shall be private. Their proceedings shall remain confidential until reported in public to a meeting of the Council.

11. Nominations Committee

11.1 Paragraph 27 of the Constitution provides for the appointment and removal of the Chair of the Trust and the other non-executive directors by the Council. Paragraph 27.3 provides that the Council's standing orders shall provide for there to be a Nominations Committee or Committees to put forward persons for the Council to consider for appointment.

11.2 For the appointment of the Chair, the Nominations Committee shall consist of:

- 2 public governors, one of whom will chair the Committee
- 1 staff governor
- 1 appointed governor
- 1 non-executive director
- 1 external stakeholder

11.3 For the appointment of non-executive directors, the Nominations Committee shall consist of:

- the Chair (or, at the Chair's request the Deputy Chair)
- 2 public governors
- 1 staff governor
- 1 appointed governor
- the Chief Executive
- 1 external stakeholder

11.4 When the formation of a Nomination committee is required the Secretary shall:

11.4.1 ask governors to put themselves forward as members within 10 days of his request, and if more governors put themselves forward than are places for particular categories of governor shall conduct an election or elections for each category with each governor having one vote in respect of each governor place on the committee.

11.4.2 In the case of a nomination for Chair invite the non-executive directors to appoint a non-executive director to serve on the committee.

11.5 If a majority of the governors present at a meeting of the Council of Governors decide that the circumstances of a particular situation require the membership of a Nominations Committee to differ from that set out in paragraph 2 or 3 above, the membership of that Committee shall be as determined by that majority.

12. Declarations and Register of Interests

12.1 Paragraph 21 of the Constitution provides for declarations of interest. It states:

- **21.1** *If a governor has a pecuniary, personal or family interest, whether that interest is actual or potential and whether that interest is direct or indirect, in any proposed contract or other matter which is under consideration or is to be considered by the Council of Governors, the governor shall disclose that interest to the members of the Council of Governors as soon as he becomes aware of it. The Standing Orders for the Council of Governors shall make provision for the disclosure of interests and arrangements for the exclusion of a governor declaring any interest from any discussion or consideration of the matter in respect of which an interest has been disclosed.*
- **21.2.** *For the avoidance of doubt a governor has a personal interest where the governor or a person close to the governor has had a personal experience which might be considered to affect the governor's view of the matter in question***.**

12.2 Interests should be declared to the Secretary within 28 days of appointment, or, if arising later, within 7 days of the governor becoming aware of the interest.

12.3 If a governor only becomes aware of an interest at a meeting of the Council (or at a meeting of any committee, sub-committee or working group) he must declare it immediately.

12.4 Subject to the exceptions below, material interests include:

12.4.1 any directorship of a company;

12.4.2 any interest held in any firm, company or business, which, in connection with the matter, is trading with the Trust, or is likely to be considered as a potential trading partner with the Trust;

12.4.3 any interest in an organisation providing health and social care services to the National Health Service;

12.4.4 a position of authority in a charity or voluntary organisation in the field of health and social care;

12.4.5 any other interest which, in the opinion of a reasonable bystander would be liable to prejudice the ability of the governor to consider the matter before the Council fairly.

12.5 The exceptions are:

12.5.1 shares not exceeding 2% of the total shares in issue held in any company whose shares are listed on any public exchange;

12.5.2 an employment contract with the Trust held by a staff governor;

12.5.3 an employment contract held with the appointing body by an appointed governor;

12.6 If a governor has any uncertainty as to an interest, he should discuss it in advance of any meeting with the Secretary. In case of doubt the interest should be declared.

12.7 The Secretary shall keep a record in a Register of Interests of all interests declared by governors. Any interest declared at a meeting shall also be recorded in the minutes of the meeting

12.8 The Register shall be open to inspection by members of the public free of charge. A copy of any part will be provided on request and a reasonable charge for it may be made to persons who are not members of the Trust.

12.9 If a question arises at a meeting of the Council whether or not an interest of a governor is such that he should not be present when a matter is considered and should not vote on it, the Chair of the meeting shall rule on the question having taken the advice of the Secretary.

12.10 A governor who has an interest in a matter under consideration by the Council shall not be present during such consideration and shall not take part in any vote in connection with it.

12.11 A failure to comply with any of the provisions of this paragraph may be considered by the Council as grounds for removal under paragraph 16.4 of the Constitution.

13. Code of Conduct

13.1 Governors shall agree to, and shall upon appointment sign a copy of, the Code of Conduct set out in the Appendix to these orders and shall at all times comply with the Code.

14. Confidentiality

14.1 It is the duty of a governor not to divulge any information which he receives in confidence, whether that confidence is expressed or arises from circumstances relating to the information.

14.2 Governors must keep secure all confidential matter recorded on paper or electronically and must ensure that their NHS mail and forum details are not disclosed.

14.3 Agendas and minutes and information relating to those parts of meetings of the Board of Directors, or of meetings of the Council, which are not open to the public, are confidential.

14.4 The proceedings of committees and working groups which take place in private are confidential until reported to the Council at a meeting open to the public.

14.5 A governor should keep confidential any information which may come into his possession concerning a patient, a person associated with a patient, or a member of staff or a person associated with a member of staff, unless the information has entered the public domain.

14.6 Any matter which the Council has resolved shall be treated as confidential shall be so treated.

15. Expenses

15.1 Paragraph 22 of the Constitution provides that the Trust shall on application pay travelling and other expenses of governors incurred for the purpose of his duties at rates to be decided by the Trust.

15.2 Payment shall be made by the Secretary following receipt of a signed expenses form backed by receipts.

15.3 The total of the expenses paid to governors will be published in the Annual Report.

16. Lead and Deputy Lead Governor's Appointment

16.1 The Lead Governor and the Deputy Lead Governor must be elected governors. A staff governor may only be appointed as Lead or Deputy in a situation where he will serve with a publicly appointed governor. Thus a staff governor may stand for election as Deputy only if the Lead is a publicly elected governor.

16.2 A person shall be elected as Lead Governor Elect.

a) He will serve for one year as Deputy Lead Governor.
b) Subject to a vote of approval by a majority of the governors present at a meeting of the Council towards the end of the year he will then become the Lead Governor for one year and if similarly approved may serve a second year.
c) At the end of the second year as Lead, if similarly approved, he may serve as Deputy Lead Governor for one year.

16.3 Thus a person may serve two years as Lead Governor supported in their first year by the former Lead Governor acting as Deputy and supported in their second year by the new Deputy.

16.4 3 months before a Lead Governor Elect is needed the Secretary shall ask for nominations within 21 days.

16.5 If more than one governor is nominated, a secret ballot will be arranged by the Secretary with each governor having one vote. If only one candidate is nominated, that person is chosen.

16.6 Where there is a ballot the candidate securing the most votes will be elected. The Secretary will announce the winner but not the votes cast - which shall remain confidential to him.

16.7 In the event that the Deputy Lead Governor stands down or is unable to continue, a new Deputy shall be chosen by the process set out above, and shall serve as Deputy until the Lead Governor reaches the end of his term. He will then become lead governor if approved as set out in 16.3(b) above.

16.8 In the event that the Lead Governor stands down or is unable to continue, if the Deputy has not served as Lead Governor, subject to a vote of approval as above he shall become Lead Governor and shall serve an initial term consisting of the unexpired term of the departing Lead Governor plus one year and then subject to such a vote of approval may serve a second year.

16.9 If the Deputy has served as Lead Governor, then subject to such a vote of approval he may act as Lead Governor for the remainder of the departing Lead Governor's term, and the Secretary shall initiate the process for choosing a new Deputy Lead Governor.

16.10 In the event that a Deputy Lead Governor does not secure the approval of the Governors to become Lead Governor, the Secretary shall immediately initiate the process of choosing a new Lead Governor by the process set out in paragraphs 16.4 to 16.7.

16.11 In the event that the Lead Governor does not secure approval for a second year, the person chosen as Deputy shall become Lead Governor.

16.12 Where a need arises to choose a Lead Governor or a Deputy Lead Governor In any circumstances not covered above, the Secretary shall take such steps as may be necessary following the principles set out in so far as applicable to the situation.

16.13 Where the Lead Governor is a staff governor, in any situation where the Lead Governor's position as an employee of the Trust gives rise to a position of potential conflict or embarrassment, the Deputy Lead shall act as Lead until the next meeting of the Council, when the situation shall be considered and a decision made as to how it shall be handled.

17. Lead Governor and Deputy Lead Governor – Roles

17.1 The role of the Lead Governor is:

17.1.1 to chair meetings of the Council which cannot for any reason be chaired by the Chair or the Deputy Chair;

17.1.2 to consult routinely with the governors regarding the planning and preparation of the agendas for Council meetings and work programme, and to agree them with the Chair;

17.1.3 to communicate regularly with the Chair, to receive reports, as appropriate, on matters considered by the Board at closed meetings, and to provide updates/information to all governors as may be appropriate in the circumstances and respecting the confidentiality of matters of which he has been informed on a confidential basis.

17.1.4 to be a point of contact for NHS England when appropriate;

17.1.5 to provide input into the appraisal of the Chair;

17.1.6 to take an active role in the activities of the Council;

17.1.7 to be a point of contact for governors when they have concerns;

17.2 The role of the Deputy Lead Governor is to support and assist the Lead Governor, and to deputise for the Lead Governor when the Lead Governor is not available to act.

18. Lead and Deputy Lead Governors – Vote of No Confidence

18.1 If 8 governors sign a motion of no confidence in the Lead Governor or Deputy lead Governor

and present it to the Chair, the Chair shall call an emergency meeting of the Council to be held within no more than 4 weeks from his receipt of the motion.

18.2 The Chair will inform the Lead Governor (or Deputy Lead Governor) of his receipt of the motion but not of the names of the signatories, and he shall be invited to attend the meeting.

18.3 The meeting shall not proceed unless at least two thirds of the governors are present, and if they are not the motion will lapse.

18.4 At the meeting the Chair will present the reasons for the motion, and it will be debated. The Lead Governor (or Deputy Lead Governor) may address the meeting.

18.5 A secret ballot shall be taken (in which the Lead Governor - or Deputy Lead Governor - shall be entitled to vote). If more than half of the governor's present support the motion, then the Lead Governor (or Deputy Lead Governor) shall stand down.

18.6 A Lead Governor or a Deputy Lead Governor against whom a motion of no confidence succeeds shall not be eligible to be Lead Governor or Deputy Lead Governor for 2 years.

19. Directors' Attendance

19.1 Paragraph 18.6 of the Constitution provides that the Council may require the attendance of one or more of the directors to attend a meeting for the purposes set out in the paragraph, which include the purpose of obtaining information about the Trust's performance of its functions.

19.2 The attendance of a director pursuant to paragraph 18.6 of the Constitution shall be obtained by request of the Lead Governor made to the Chair. The Lead Governor may make a request at his discretion but shall make one if 5 governors sign a notice requiring the attendance of a named director or directors stating the reason why the request is made.

20. Forward Plan

20.1 Paragraph 39.5 of the Constitution provides that in preparing the Trust's forward plan the directors must have regard to the views of the governors, and that the directors shall provide the governors with information appropriate for them to be able to form their views.

20.2 The Trust's Strategic Development Working Group shall consider aspects of the proposed plan as they become available.

20.3 The proposed plan shall be considered at a joint meeting of the directors and the governors. It shall be provided to the governors, with the information required to form their views, in good time, at least 7 days, for the governors to consider it in advance of the meeting.

21. Amendment of Standing Orders

21.1 Paragraph 19.1 of the Trust's Constitution provides that the standing orders of the Council may be amended as provided in the standing orders.

21.2 The Standing Orders of the Council of Governors may be amended at a meeting of the Council by a vote of the majority of governors (not a majority of governors present, but a majority of the governors).

21.3 No such vote shall be taken unless the proposed amendment has been included in an agenda for the meeting circulated to governors not less than 7 days before the meeting (for example, for a meeting on 27 January no later than 20 January). But the Council may vote to make an amendment the substance of which has been so included but which has been altered at the meeting.

APPENDIX 7.1

CODE OF CONDUCT

Governors will:

1. Actively support the purpose and aims of Salisbury NHS Foundation Trust;
2. Act in the best interests of the Trust at all times, with integrity and objectivity, recognising the need for corporate responsibility, without expectation of personal benefit;
3. Contribute to the work of the Council of Governors so it may fulfil its role, in particular attending meetings of the Council and training events, serving on the committees and working groups of the Council, and attending members meetings, on a regular basis;
4. Recognise that the Council exercises collective decision-making on behalf of patients, public and staff;
5. Acknowledge that, other than when carrying out their duties as governors, they have no rights or privileges different from other members of the Trust;
6. Recognise that the Council has no managerial role within the Trust other than as provided by statute;
7. Respect the confidentiality of all confidential information received by them as governors as more particularly set out in paragraph 15 of the Council's Standing orders;
8. Conduct themselves in a manner to reflect positively on the Trust and not to conduct themselves so as to reflect badly on the Trust;
9. Recognise that the Trust is a non-political organisation.
10. Recognise that they are not, save in the case of appointed governors and their appointing body, representing any trade union, political party or other organisation to which they may belong, or its views, but are representing the constituency which elected them;
11. Seek to ensure that no one is discriminated against because of their religion, race, colour, gender, marital status, sexual orientation, age, social or economic status, or national origin;
12. Comply with the Council's Standing Orders;
13. Not make, or permit to be made, any statement concerning the Trust which they know or suspect to be untrue or misleading;
14. Recognise the need for great care in making public pronouncements, in particular any statement to the media, and will recognise the harm that ill-judged statements can cause to the Trust and to the patients and public the Trust and its governors serve. To this end:
    a) advice of the Trust's press officer and of the Lead Governor, and take their observations into account;
    b) any request by the media for comment should be forwarded to the Trust's press officer;
    c) if a governor considers that a media story requires a response, he will communicate his concern to the Lead Governor and the Trust's press officer rather than responding himself;
    d) it is not the role of a governor to speak in public on operational matters or matters concerning individual patients or staff;
15. Uphold the seven principles of public life as set out by the Nolan Committee, namely:

Selflessness:

Holders of public office should take decisions solely in terms of the public interest. They should not do so in order to gain financial or other material benefits for themselves, their family, or their friends.

Integrity:

Holders of public office should not place themselves under any financial or other obligation to outside individuals or organisations that might influence them in the performance of their official duties.

Objectivity:

In carrying out public business, including making public appointments, awarding contracts, or recommending individuals for rewards and benefits, holders of public office should make choices on merit.

Accountability:

Holders of public office are accountable for their decisions and actions to the public and must submit themselves to whatever scrutiny is appropriate to their office.

Openness:

Holders of public office should be as open as possible about all the decisions and actions they take. They should give reasons for their decisions and restrict information only when the wider public interest clearly demands.

Honesty:

Holders of public office have a duty to declare any private interests relating to their public duties and to take steps to resolve any conflicts arising in a way that protects the public interest.

Leadership:

Holders of public office should promote and support these principles by leadership and example

Governor's undertaking

I,_____, of ,
undertake as a Governor of Salisbury NHS Foundation Trust to abide by the above Code of Conduct including the obligations as to confidentiality and as to dealing with the media there set out.

Signed:_____ Date:_____

ANNEX 8 - STANDING ORDERS FOR THE PRACTICE AND PROCEDURE OF THE BOARD OF DIRECTORS

(see paragraph 30)

1. Interpretations and Definitions

1.1. Save as otherwise permitted by law, at any meeting the Chair of the Trust shall be the final authority on the interpretation of Standing Orders (on which he should be advised by the Chief Executive).

1.2. All references in these Standing Orders to the masculine gender shall be read equally applicable to the feminine gender.

1.3. Any expression to which a meaning is given in the Health and Social Care Act 2012, or any legislation or any regulations made under this Act, shall have the same meaning in these standing orders and in addition:

1.3.1 **"Accounting officer"** means the person responsible and accountable for funds trusted to the Trust. The Officer shall be responsible for ensuring the proper stewardship of public funds and assets. For this Trust, this shall be the Chief Executive;

1.3.2 **"Board"** means the Board of Directors, consisting of the Chair, the independent non-executive directors and the executive directors;

1.3.3 **"Audit Committee"** means a committee whose functions are concerned with providing the Trust Board with a means of independent and objective review and monitoring financial systems and information, quality and clinical effectiveness, compliance with law, guidance and codes of conduct, effectiveness of risk management, the processes of governance and the delivery of the Board assurance framework;

1.3.4 **"Commissioning"** means the process for determining the need for and for obtaining the supply of healthcare and related services by the Trust within available resources;

1.3.5 **"Committee"** means a committee or sub-committee appointed by the Trust;

1.3.6 **"Committee Members"** shall be persons formally appointed by the Trust to sit on or to chair specific committees;

1.3.7 **"Contracting and Procuring"** means the systems for obtaining the supply of goods, materials, manufactured items, services, building and engineering services, works of construction and maintenance and for disposal of surplus and obsolete assets;

1.3.8 **"Council"** means the Council of Governors, formally constituted in accordance with the constitution and presided over by the Chair;

1.3.9 **"Director of Finance"** means the chief financial officer of the Trust;

1.3.10 **"Executive Director"** means a member of the board who is an officer of the Trust;

1.3.11 **"Motion"** means a formal proposition to be discussed and voted on during the course of a meeting;

1.3.12 **"Nominated Officer"** means an Officer charged with the responsibility for discharging specific tasks within Standing Orders and Standing Financial Instructions;

1.3.13 **"Officer"** means an employee of the Trust or any other person holding a paid appointment or office with the Trust;

1.3.14 **"SFIs"** means standing financial instructions;

1.3.15 **"SOs"** means Standing Orders.

1.3.16 **"Trust"** means Salisbury NHS Foundation Trust

2. THE BOARD OF DIRECTORS: COMPOSITION OF MEMBERSHIP AND ROLE OF MEMBERS

2.1 Composition of the Board of Directors

The composition of the Board of Directors shall be in accordance with paragraph 23 of the Constitution.

2.2 Role of Members of the Board of Directors

The Board of Directors will function as a corporate decision-making body. Executive Directors and Non-Executive Directors will be full and equal members. Their role will be to consider the key strategic and managerial issues facing the Trust in carrying out its statutory and other functions with a view to promoting the success of the Trust so as to maximise the benefits for the members of the Trust as a whole and for the public.

Executive Directors

Executive Directors shall exercise their authority within the terms of these Standing Orders and Standing Financial Instructions and the Scheme of Delegation.

Chief Executive

The Chief Executive shall be responsible for the overall performance of the executive functions of the Trust. The Chief Executive is the Accounting Officer for the Trust and shall be responsible for ensuring the discharge of obligations under Financial Directions and in line with the requirements of the NHS Foundation Trust Accounting Officer Memorandum.

Director of Finance

The Director of Finance shall be responsible for the provision of financial advice to the Trust and to its members and for the supervision of financial control and accounting systems. The Director of Finance shall be responsible along with the Chief Executive for ensuring the discharge of obligations under relevant Financial Directions.

Non-Executive Directors

The Non-Executive Directors shall not be granted nor shall they seek to exercise any individual executive powers on behalf of the Trust. They may; however, exercise collective authority when acting as members of or when chairing a committee of the Trust which has delegated powers.

Chair

The Chair shall be responsible for the operation of the Board of Directors and Chair all Board meetings when present. The Chair has certain delegated executive powers. The Chair must comply with the terms of employment and with these Standing Orders.

The Chair shall take responsibility either directly, or indirectly, for the induction, portfolios of interests and assignments, and the performance of Non-Executive Directors.

The Chair shall work in close conjunction with the Chief Executive and shall ensure that key and appropriate issues are discussed by the Board of Directors in a timely manner with all the necessary information and advice being made available to the Board of Directors to inform the discussion and ultimate resolutions.

Senior Independent Director

The Board of Directors should in consultation with the Council of Governors, appoint a Non-Executive Director to be the Senior Independent Director. Any Non-Executive Director so appointed may at any time resign from the office of Senior Independent Director by giving notice in writing to the Chair. The Board of Directors may thereupon, in consultation with the Council of Governors, appoint another Non-Executive Director as Senior Independent Director.

2.3 Corporate role of the Board of Directors.

2.3.1 All business shall be conducted in the name of the Trust.

2.3.2 All funds received in trust shall be held in the name of the Trust as corporate trustee.

2.3.3 The powers of the Trust established under statute shall be exercised by the Board except as otherwise provided for under Section 4 of this annex.

2.3.4 The Board has resolved that certain powers and decisions may only be exercised by the Board of Directors in formal session. These powers and decisions are set out in the

'Schedule of Matters reserved to the Board' and Scheme of Delegation and have effect as if incorporated into the Standing Orders.

3. MEETINGS OF THE BOARD

3.1 Admission of the Public and the Press

3.1.1 The meetings of the Board of Directors shall be open to members of the public and press unless the Board decides otherwise in relation to all of the meeting for reasons of confidentiality, or on other proper grounds, or for other special reasons. Matters to be dealt with by the Board following the exclusion of members of the public and/or press shall be confidential to the members of the Board. Directors and any employees of the Trust in attendance shall not reveal or disclose the contents of papers marked 'In Confidence' or minutes headed 'Items Taken in Private' outside of the Trust, without the express permission of the Trust.

3.1.2 In the event that the public and press are admitted to all or part of a Board meeting by reason of SO 3.1 above, the Chair (or Vice Chair) shall give such directions as he thinks fit in regard to the arrangements for meetings and accommodation of the public and representatives of the press such as to ensure that the Board's business shall be conducted without interruption and disruption and the public will be required to withdraw upon the Board resolving "that in the interests of public order the meeting adjourn for (the period to be specified) to enable the Board to complete business without the presence of the public".

3.2 Observers at Board Meetings

3.2.1 The Trust may make such arrangements from time to time as it sees fit with regards to the extending of invitations to observers to attend and address any of the Board meetings.

3.2.2 Nothing in these Standing Orders shall be construed as permitting the introduction by the public or press representatives of recording, transmitting, video or small apparatus into meetings of the Board or Committees. Such permission shall be granted only upon resolution of the Trust.

3.3 Calling of Meetings

3.3.1 Ordinary meetings of the Board shall be held at such times and places as the Board determines. Board meetings shall be held in public but the whole or any part of a meeting may be held in private if the Board of Directors so resolves for special reasons.

3.3.2 The Chair of the Trust may call a meeting of the Board at any time. If the Chair refuses to call a meeting after a requisition for that purpose, signed by at least one-third of the whole number of Directors, has been presented to him/her, or if, without so refusing, the Chair does not call a meeting within seven days after such requisition has been presented to him at the Trust's Headquarters, such one third or more Directors may forthwith call a meeting.

3.4 Notice of Meetings

3.4.1 Before each meeting of the Board, a written notice of the meeting, specifying the business proposed to be transacted at it shall be delivered to every Director, or sent by post to the usual place of residence of such Director, so as to be available to him at least five clear days before the meeting.

3.4.2 In the case of a meeting called by Directors in default of the Chair, the notice shall be signed by those Directors and no business shall be transacted at the meeting other than that specified in the notice, or emergency motions permitted under SO 3.10 below

3.4.3 Agendas will normally be sent to members of the Board seven calendar days before the meeting and supporting papers, whenever possible, shall accompany the agenda, but will certainly be despatched no later than five clear days before the meeting, save in emergency.

3.4.4 Before any meeting of the Board which is to be held in public, a public notice of the time and place of the meeting, and the public part of the agenda, shall be displayed on the

Trust's website at least five clear days before the meeting.

3.5 Agendas and supporting papers

3.5.1 The Board may determine that certain matters shall appear on every agenda for a meeting and shall be addressed prior to any other business being conducted.

3.5.2 A Director desiring a matter to be included on an agenda shall make his/her request in writing to the Chair at least 12 clear days before the meeting. The request should state whether the item of business is proposed to be transacted in the presence of the public and should include appropriate supporting information. Requests made less than 12 days before a meeting may be included on the agenda at the discretion of the Chair.

3.6 Petitions

3.6.1 Where a petition has been received by the Trust, the Chair of the Board shall include the petition as an item for the agenda of the next Board meeting.

3.7 Chair of Meeting

3.7.1 At any meeting of the Board, the Chair of the Board, if present, shall preside. If the Chair is absent from the meeting the Vice Chair, if there is one and he/she is present, shall preside. If the Chair and Vice Chair are absent, such Non-Executive as the Directors present shall choose shall preside.

3.7.2 If the Chair is absent temporarily on the grounds of a declared conflict of interest the Vice Chair, if present, shall preside. If the Chair and Vice Chair are absent, or are disqualified from participating, then the remaining non-executive directors present shall choose which non-executive director shall preside.

3.8 Notices of Motion

3.8.1 A Director of the Board desiring to move or amend a motion shall send a written notice thereof at least 12 clear days before the meeting to the Chief Executive, who shall ensure that it is brought to the immediate attention of the Chair. The Chair shall include in the agenda for the meeting all notices so received, subject to the notice being permissible under the appropriate regulations. This Standing Order 3.8.1 shall not prevent any motion being withdrawn or moved without notice on any business mentioned on the agenda.

3.8.2 Withdrawal of Motion or Amendments

A motion or amendment once moved and seconded may be withdrawn by the proposer with the concurrence of the seconder and the consent of the Chair.

3.8.3 Motion to Rescind a Resolution

Notice of motion to amend or rescind any resolution (or the general substance of any resolution) which has been passed within the preceding six calendar months shall bear the signature of the Director who gives it and also the signature of three other Board Directors and, before considering any such motion, the Board may refer the matter to any appropriate Committee or the Chief Executive for recommendation. When any such motion has been disposed of by the Board, it shall not be competent for any Director other than the Chair to propose a motion to the same effect within six months; however the Chair may do so if he/she considers it appropriate. This Standing Order shall not apply to motions moved in pursuance of a report or recommendations of a Committee or the Chief Executive.

3.9 Motions – procedure at and during meetings

3.9.1 Who may propose?

A motion may be proposed by the Chair or any Director present at the meeting. Such motion must also be seconded by another Director.

3.9.2 Contents of Motions

The Chair may (at his discretion) refuse to admit any motion of which notice was not given in accordance with SO 3.8, other than a motion relating to:

(a) the reception of a report;

(b) consideration of any item of business before the Trust Board;
(c) the accuracy of minutes;
(d) that the Board proceed to next business;
(e) that the Board adjourn;
(f) that the question be now put.

3.9.3 Amendments to Motions

A motion for amendment shall not be discussed unless it has been proposed and seconded. Amendments to motions shall be moved relevant to the motion and shall not have the effect of negating the motion before the Board.

If there are a number of amendments, they shall be considered one at a time. When a motion has been amended, the amended motion shall become the substantive motion before the meeting, upon which any further amendment may be moved.

3.9.4 Rights of reply to motions

Amendments: The mover of a motion shall have a right of reply at the close of any discussion on the motion or any amendment thereto.

Original motion: The member who proposed the substantive motion shall have a right of reply at the close of any debate on the motion.

3.9.5 Motions Once Under Debate

When a motion is under debate, no motion may be moved other than:

- an amendment to the motion;
- the adjournment of the discussion or the meeting;
- that the meeting proceed to the next business;
- the appointment of an ad hoc committee to deal with a specific item of business;
- that the motion be now put;
- that a Director be not further heard;
- a motion resolving to exclude the public, including the press.

In those cases where the motion is either that the meeting proceeds to the 'next business' or 'that the question be now put' in the interests of objectivity these should only be put forward by a Director of the Board who has not taken part in the debate and who is eligible to vote.

If a motion to proceed to the next business or that the question be now put is carried, the Chair should give the mover of the substantive motion under debate a right of reply, if not already exercised. The matter should then be put to the vote.

3.10 Emergency Motions

Subject to the agreement of the Chair and SO 3.9 above, a Director may give written notice of an emergency motion after the issue of the notice of meeting and agenda, up to one hour before the time fixed for the meeting. The notice shall state the grounds of urgency. At the Chair's discretion, the emergency motion shall be declared to the Board at the commencement of the business of the meeting as an additional item included on the agenda. The Chair's decision to include the item shall be final.

3.11 Chair's Ruling

Statements of Directors made at meetings of the Board shall be relevant to the matter under discussion at the material time and the decision of the Chair of the meeting on questions of order, relevancy, regularity (including procedure on handling motions) and any other matter shall be final.

3.12 Voting

3.12.1 Save as provided in SO 3.15 Suspension of Standing Orders, every question at a meeting shall be determined by a majority of the votes of the Chair of the meeting and

Directors present and voting on the question and, in the case of the number of votes for and against a motion being equal, the Chair of the meeting (or any other person presiding in accordance with the terms of these Standing Orders) shall have a second or casting vote.

3.12.2 All questions put to the vote shall, at the discretion of the Chair of the meeting, be determined by oral expression or by a show of hands. A paper ballot may also be used if the Chair so directs or it is proposed and seconded by any of the Directors present.

3.12.3 If at least one-third of the Directors present so request, the voting (other than by paper ballot) on any question may be recorded to show how each Director present voted or abstained.

3.12.4 If a Director so requests, his/her vote shall be recorded by name upon any vote (other than by paper ballot).

3.12.5 In no circumstances may an absent Director vote by proxy. Absence is defined as being absent at the time of the vote.

3.12.6 An Officer who has been appointed formally by the Board to act up for an Executive Director during a period of incapacity or temporarily to fill an Executive Director vacancy, shall be entitled to exercise the voting rights of the Executive Director. An Officer attending the Board to represent an Executive Director during a period of incapacity or temporary absence without formal acting up status may not exercise the voting rights of the Executive Director. An Officer's status when attending a meeting shall be recorded in the minutes.

3.13 Minutes

3.13.1 The Minutes of the proceedings of a meeting shall be drawn up and submitted for agreement at the next ensuing meeting.

3.13.2 No discussion shall take place upon the minutes except upon their accuracy or where the Chair considers discussion appropriate. Any amendment to the minutes shall be agreed and recorded at the next meeting.

3.14 Quorum

3.14.1 The quorum of a meeting will be at least half of the whole number of members of the Board of Directors (including at least one Non-Executive Director and one Executive Director).

3.14.2 An officer in attendance for an Executive Director but without formal acting up status may not count towards the quorum.

3.14.3 If the Chair or member has been disqualified from participating in the discussion on any matter and/or from voting on any resolution by reason of a declaration of a conflict of interest that person shall no longer count towards the quorum. If a quorum is then not available for the discussion and/or the passing of a resolution on any matter, that matter may not be discussed further or voted upon at that meeting. Such a position shall be recorded in the minutes of the meeting. The meeting must then proceed to the next business.

3.15 Suspension of Standing Orders

3.15.1 Except where it would contravene any statutory provision or any provision in the Constitution, any one or more of the Standing Orders may be suspended at any meeting, provided that at least two-thirds of the Board are present, including one Executive Director and one Non-Executive Director, and at least two-thirds of those present votes in favour of suspension.

3.15.2 A decision to suspend Standing Orders shall be recorded in the minutes of the meeting.

3.15.3 A separate record of matters discussed during the suspension of Standing Orders shall be made and shall be available to the Chair and Directors of the Board.

3.15.4 No formal business may be transacted while Standing Orders are suspended.

3.15.5 The Audit Committee shall review every decision to suspend Standing Orders.

3.16 Record of Attendance

The names of the Chair and Directors present at the meeting shall be recorded in the minutes.

4. ARRANGEMENTS FOR THE EXERCISE OF FUNCTIONS BY DELEGATION

4.1 Subject to the Constitution, or any relevant statutory provision, the Board may make arrangements for the exercise, on behalf of the Board, of any of its functions:

4.1.1 by a committee, sub-committee or,

4.1.2 appointed by virtue of Standing Order 5.1 or 5.2 below or by an Officer of the Trust,

4.1.3 or by another body as defined in Standing Order 4.2 below,

in each case subject to such restrictions and conditions as the Trust thinks fit.

4.2 Where a function is delegated to a third party, the Trust has responsibility to ensure that the proper delegation is in place. In other situations, i.e. delegation to committees, sub committees or Officers, the Trust retains full responsibility.

4.3 Emergency Powers

The powers which the Board has retained to itself within these Standing Orders may in emergency be exercised by the Chief Executive and the Chair after having consulted at least two Non-Executive Directors. The exercise of such powers by the Chief Executive and Chair shall be reported to the next formal meeting of the Board in public or private session (as appropriate) for ratification.

4.4 Delegation to Committees

The Board shall agree from time to time to the delegation of executive powers to be exercised by committees, or sub-committees, or joint-committees, which it has formally constituted. The constitution and terms of reference of these committees, or sub-committees, or joint committees and their specific executive powers shall be approved by the Board in respect of its sub-committees.

4.5 Delegation to Officers

Those functions of the Trust which have not been retained as reserved by the Board or delegated to a committee or sub-committee or joint-committee shall be exercised on behalf of the Trust by the Chief Executive. The Chief Executive shall determine which functions he/she will perform personally and shall nominate Officers to undertake the remaining functions for which he/she will still retain accountability to the Trust.

4.6 Scheme of Delegation

The Chief Executive shall prepare a Scheme of Delegation identifying his/her proposals which shall be considered and approved by the Board, subject to any amendment agreed during the discussion. The Chief Executive may periodically propose amendment to the Scheme of Delegation that shall be considered and approved by the Board as indicated above.

4.7 Discharge of the Direct Accountability

Nothing in the Scheme of Delegation shall impair the discharge of the direct accountability to the Board of the Finance Director to provide information and advise the Board in accordance with statutory or NHS England requirements. Outside these requirements the roles of the Finance Director shall be accountable to the Chief Executive for operational matters.

4.8 The arrangements made by the Board as set out in the Schedule of Matters reserved to the Board and Scheme of Delegation shall have effect as if incorporated in these Standing Orders.

4.9 Overriding Standing Orders

If for any reason these Standing Orders are not complied with, full details of the non-compliance and any justification for non-compliance and the circumstances around the non-compliance, shall be reported to the next formal meeting of the Board for action or ratification. All Directors of the Board and staff have a duty to disclose any non-compliance with these Standing Orders to the Chief Executive as soon as possible.

5. COMMITTEES

5.1 Appointment of Committees

Subject to the Constitution, (and to any guidance issued by the Department of Health applicable to Foundation Trusts or as may be given by NHS England), the Board of Directors may appoint committees of the Trust

5.2 Applicability of Standing Orders and Standing Financial Instructions to committees

The Standing Orders and Standing Financial Instructions of the Trust, as far as they are applicable, shall apply with appropriate alteration to meetings of any committees established by the Trust. In which case the term “Chair” is to be read as a reference to the Chair of the committee as the context permits, and the term “member” is to be read as a reference to a member of the committee also as the context permits. (There is no requirement to hold meetings of committees established by the Trust in public).

5.3 Terms of Reference

Each such committee shall have such terms of reference and powers and be subject to such conditions (as to reporting back to the Board), as the Board shall decide and shall be in accordance with any applicable legislation and regulation or direction. Such terms of reference shall have effect as if incorporated into the Standing Orders.

5.4 Delegation of Powers

The Board of Directors may appoint committees consisting wholly or partly of persons who are not Executive Directors or Non-Executive Directors of the Trust for any purpose that is calculated or likely to contribute or assist it in the exercise of its powers. It may delegate powers to such committees only if the membership consists wholly of Directors.

5.5

Where committees are authorised to establish sub-committees, they may not delegate executive powers to the sub-committee unless expressly authorised by the Board.

5.6 Approval of appointments to committees

The Board shall approve the appointments to each of the committees which it has formally constituted. Where the Board determines, and regulations permit, that persons, who are neither Directors nor Officers, shall be appointed to a committee the terms of such appointment shall be within the powers of the Board. The Board shall define the powers of such appointees and shall agree allowances, including reimbursement for loss of earnings, and/or expenses in accordance where appropriate with national guidance.

5.7 Appointments for Statutory Functions

Where the Board is required to appoint persons to a committee and/or to undertake statutory functions, and where such appointments are to operate independently of the Board, such appointment shall be made in accordance with the Constitution, the Terms of Reference and any applicable regulations and directions.

5.8 Committees established by the Board of Directors

The Trust Board of Directors shall establish an Audit Committee and Remuneration and Nomination Committee, as standing Committees of the Trust Board of Directors. In addition, the

Trust Board of Directors shall establish such other Committees as it deems necessary and appropriate from time to time.

5.9 Joint Committees

Joint committees may be established by the Trust, by joining together with one or more other trusts, consisting of wholly or partly of the Chair and Directors of the Trust or other health service bodies, or of Directors of the Trust with non-directors of other health bodies in question.

Any Committee-in-Common or Joint Committee established under standing orders may, subject to such directions or guidance as may be given by NHS England or the Trust or any other health bodies in question, appoint sub-committees consisting wholly or partly of directors sitting on the Committee or Joint Committee (whether or not they are directors of the other health bodies in question) or wholly of persons who are not directors of the other health bodies in question provided that the Trust is always represented by an Executive Director (or deputy nominated by the Executive Director) on such Committees, Joint Committees or sub committees.

6 DECLARATIONS OF INTERESTS AND REGISTER OF INTERESTS

6.1 Disclosure of Interests

The Constitution, the 2006 Act and the Foundation Trust Code of Governance requires Board Directors to declare interests which are relevant and material to the NHS board of which they are a director. All existing Board Directors should declare such interests. Any Board Directors appointed subsequently should do so on appointment.

6.2 Interests which should be regarded as "relevant and material" are:

- **6.2.1** directorships, including non-executive directorships held in private companies or public limited companies (with the exception of those of dormant companies);
- **6.2.2** ownership or part-ownership of private companies, businesses or consultancies likely or possibly seeking to do business with the NHS;
- **6.2.3** majority or controlling shareholdings in organisations likely or possibly seeking to do business with the NHS;
- **6.2.4** a position of trust in a charity or voluntary organisation in the field of health and social care;
- **6.2.5** any connection with a voluntary or other organisation contracting for NHS services;
- **6.2.6** any connection with an organisation, entity or company considering entering into or having entered into a financial arrangement with the Trust including but not limited to, lenders or banks;
- **6.2.7** interests in pooled funds that are under separate management;
- **6.2.8** research funding/grants that may be received by an individual or their department;
- **6.2.9** any other commercial interest in the decision before the meeting.

6.3 Declaring interests

- **6.3.1** At the time Board Directors' interests are declared, they should be recorded in the Board minutes. Any changes in interests should be declared at the next Board meeting following the change occurring and recorded in the minutes of that meeting.
- **6.3.2** Board Directors' directorships of companies likely or possibly seeking to do business with the NHS should be published in the Board's Annual Report. The information should be kept up to date for inclusion in succeeding annual reports.
- **6.3.3** During the course of a Board meeting, if a conflict of interest is established, the Director concerned should withdraw from the meeting and play no part in the relevant discussion or decision.
- **6.3.4** If Board Directors have any doubt about the relevance of an interest, this should be discussed with the Chair or the Company Secretary.
- **6.3.5** Financial Reporting Standard (issued by the Accounting Standards Board) specifies that influence rather than the immediacy of the relationship is more important in assessing the relevance of an interest. The interests of partners in professional partnerships

including general practitioners should also be considered.

6.3.6 This standing order applies to a committee or sub-committee and to a joint committee as it applies to the Trust and applies to a Director of any such committee or sub-committee (whether or not he is also a Director of the Trust) as it applies to a Director of the Trust.

6.4 Register of Interests

6.4.1 The Chief Executive will ensure that a Register of Interests is established to record formally declarations of interests of Board Directors. In particular, the Register will include details of all directorships and other relevant and material interests which have been declared by both Executive and Non-Executive Directors, as defined in Standing Order 6.2.

6.4.2 These details will be kept up to date by means of an annual review of the Register in which any changes to interests declared during the preceding 12 months will be incorporated.

6.4.3 The Register will be available to the public in accordance with the Constitution and the Chief Executive will take reasonable steps to bring the existence of the Register to the attention of the local population and to publicise arrangements for viewing it.

6.4.4 All senior managers and clinicians have a duty to ensure that declaration of interests are made which could materially affect the outcome of decisions made by them. Where in doubt, all senior managers and clinicians should contact their respective Directors for clarification.

6.5 Exclusion of Chair and Members in proceedings on account of pecuniary interests

6.5.1 Subject to the following provisions of this Standing Order, if the Chair or a Director has any pecuniary interest, direct or indirect, in any contract, proposed contract or other matter and is present at a meeting of the Trust at which the contract or other matter is the subject of consideration, he shall at the meeting and as soon as practicable after its commencement disclose the fact and shall not take part in the consideration or discussion of the contract or other matter or vote on any question with respect to it.

6.5.2 The Board of Directors may exclude the Chair or a Director of the Board from a meeting of the Board while any contract, proposed contract or other matter in which he has a pecuniary interest, is under consideration.

6.5.3 Any remuneration, compensation or allowances payable to the Chair or a Director by virtue of the 2006 Act shall not be treated as a pecuniary interest for the purpose of this Standing Order.

6.5.4 For the purpose of this Standing Order the Chair or a Director shall be treated, subject to SO 6.6, as having indirectly a pecuniary interest in a contract, proposed contract or other matter, if:

- he, or a nominee of his, is a director of a company or other body, not being a public body, with which the contract was made or is proposed to be made or which has a direct pecuniary interest in the other matter under consideration; or
- he is a partner / associate of, or is in the employment of, a person with whom the contract was made or is proposed to be made or who has a direct pecuniary interest in the other matter under consideration;
- and in the case of persons living together as partners, the interest of one partner shall, if known to the other, be deemed for the purposes of this Standing Order to be also an interest of the other.

7 STANDARDS OF BUSINESS CONDUCT POLICY

7.1 All staff and members must comply with the Trust's Standards of Business Conduct, the Regulatory Framework and the National guidance contained in HSG 1993/5 "Standards of Business Conduct for NHS Staff".

7.2 Interest of Officers in Contracts

7.2.1 If it comes to the knowledge of an Officer of the Trust that a contract in which he has any

pecuniary interest not being a contract to which he is himself a party, has been, or is proposed to be, entered into by the Trust he shall, at once, give notice in writing to the Chief Executive or the Secretary of the fact that he is interested therein. In the case of persons living together as partners, the interest of one partner shall, if known to the other, be deemed to be also the interest of that partner.

7.2.2 An Officer should also declare to the Chief Executive any other employment or business or other relationship of his, or of a cohabiting spouse, that conflicts, or might reasonably be predicted could conflict with the interests of the Trust.

7.3 The Trust requires interests, employment or relationships declared, to be entered in a register of interests of staff.

7.4 Canvassing of and Recommendations by, Directors in Relation to Appointments

7.4.1 Canvassing of Directors of the Trust or of any Committee or joint committee of the Trust directly or indirectly for any appointment under the Trust shall disqualify the candidate for such appointment. The contents of this paragraph of Standing Order 7 shall be included in application forms or otherwise brought to the attention of candidates.

7.4.2 A Director of the Board shall not solicit for any person any appointment under the Trust or recommend any person for such appointment, but this paragraph of this Standing Order 7 shall not preclude a Director from giving written testimonial of a candidate's ability, experience or character for submission to the Trust.

7.4.3 Informal discussions outside appointments panels or committees, whether solicited or unsolicited, should be declared to the panel or committee.

7.5 Relatives of Directors or Officers

7.5.1 Candidates for any staff appointment under the Trust shall, when making application, disclose in writing to the Trust whether they are related to any Director or the holder of any office under the Trust. Failure to disclose such a relationship shall disqualify a candidate and, if appointed, render him liable to instant dismissal.

7.5.2 The Chair and every Director and Officer of the Trust shall disclose to the Chief Executive any relationship between himself and a candidate of whose candidature that Director or Officer is aware. It shall be the duty of the Chief Executive to report to the Board any such disclosure made.

7.5.3 On appointment, Directors (and prior to acceptance of an appointment in the case of Executive Directors) should disclose to the Board whether they are related to any other Director or holder of any office in the Trust.

8 CUSTODY OF SEAL, SEALING OF DOCUMENTS AND SIGNATURE OF DOCUMENTS

8.1 Custody of Seal

The Common Seal of the Trust shall be kept by the Chief Executive or designated Officer in a secure place.

8.2 Sealing of Documents

8.2.1 The seal of the Trust shall not be fixed to any documents unless the sealing has been authorised by a resolution of the Board or of a committee thereof, or where the Board has delegated its powers. Where it is necessary that a document be sealed, the seal shall be affixed in the presence of two Directors; OR, one Director and the Trust Secretary; OR two senior managers (not being from the originating department) duly authorised by the Chief Executive, and shall be attested by them.

8.2.2 Before any building, engineering, property or capital document is sealed it must be approved and signed by the Finance Director (or an Officer nominated by him) and authorised and countersigned by the Chief Executive (or an Officer nominated by him who shall not be within the originating directorate).

8.3 Register of Sealing

8.3.1 An entry of every sealing shall be made and numbered consecutively in a book provided for that purpose and shall be signed by the persons who shall have approved and authorised the document and those who attested the seal. A report of all applications of the Trust seal shall be made to the Board at least quarterly.

(The report shall contain details of the seal number, a description of the document and the date of sealing).

8.4 Signature of documents

8.4.1 Where the signature of any document will be a necessary step in legal proceedings involving the Trust, it shall be signed by the Chief Executive, unless any enactment otherwise requires or authorises, or the Board shall have given the necessary authority to some other person for the purpose of such proceedings.

8.4.2 The Chief Executive or nominated Officer(s) shall be authorised, by resolution of the Board, to sign on behalf of the Trust any agreement or other document not requested to be executed as a deed, the subject matter of which has been approved by the Board or any committee, sub-committee or standing committee with delegated authority.

ANNEX 9 – Additional Provisions - Directors – DISQUALIFICATION

(See Paragraph 28)

The following may not be appointed or continue as a director:

1. A person who is the subject of a sexual offences order under the Sexual Offences Act 2003 or any subsequent legislation.
2. A person who is disqualified from being a company director under the law of England and/or Wales.
3. A person who is a governor of the Trust, or a governor, director, Chair or chief executive of another NHS Foundation trust or NHS trust. However, a non-executive director (other than the Chair) may be a non-executive director or a governor of another NHS Foundation trust or NHS trust, save where there is a real risk of conflict of interest arising as a result of the two directorships or directorship and governorship.
4. A person whose physical or mental wellbeing is such that their ability to act as a director of the Trust is materially affected.
5. A person who occupies the same household as an existing director of the Trust or a governor.
6. A person who has had their name removed from a list maintained under regulations pursuant to Sections 91, 106, 123, or 146 of the 2006 Act, or the equivalent lists maintained by Local Health Boards in Wales under the National Health Service (Wales) Act 2006, and they have not subsequently had their name included in such a list and, due to the reasons(s) for such removal, they are considered by the Trust to be unsuitable to be a Director.

Report to:	Trust Board Public	Agenda item:	4.3
Date of meeting:	3rd October 2023		

Report title:	Draft Board and Committee Dates 2025/26			
Status:	Information	Discussion	Assurance	Approval
				x
Approval Process: (where has this paper been reviewed and approved):	N/A			
Prepared by:	Kylie Sanders, Head of Corporate Governance Sasha Godfrey, Board Support Officer			
Executive Sponsor: (presenting)	Fiona McNeight, Director of Integrated Governance			

Recommendation:

To review and approve the dates for Trust Board and Committees for 2025/26, keeping the same structure as this year.

Executive Summary:

It is proposed to keep the meeting structure the same as this year:

- Eight full Board meetings.
- Nine Finance & Performance Committees, Clinical Governance Committees and People and Culture Committees.
- Five Board Development sessions 6th February, 3rd April 5th June, 7th August and 6th November.

The number of Board meetings (eight) includes June's meeting being held after Audit Committee to fit in with the approval of the Annual Report and Accounts.

2026 January - March dates have been added to align to financial year reporting.

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

Trust Board, Committees and Council of Governors – Meetings 2025/26

	Financial Month	Public & Private Trust Board Thursday Week 1 or 2 All day	OD & People Management Board Tuesday Week 3 9 - 11	Clinical Management Board Wednesday Week 3 10.30-12.30	Audit Committee Thursday Week 3 9.30 - 12	Charitable Funds Committee Thursday Week 3 3 – 5	Finance and Performance Committee Tuesday Week 4 or 5 09:30 – 12:00	Clinical Governance Committee Tuesday Week 4 or 5 13:00-15:30	Trust Management Committee Wednesday Week 4 or 5 10 - 12	People and Culture Committee last Thurs 10 - 12	Council of Governors Monday (CoG) 16:00-18:30	Non-Exec/ Governor informal Monday 16:00-17:30
Chair		**Ian Green**	**Melanie Whitfield**	**Peter Collins**	**Richard Holmes**	**Ian Green**	**Debbie Beaven**	**David Buckle**	**Lisa Thomas**	**Eiri Jones**	**Ian Green**	**Ian Green**
Admin		**Sasha Godfrey**	**Rebecca Falletta**	**Rebecca Hawtin**	**Fiona McNeight**	**Marcia Hocking**	**Marcia Hocking**	**Jo Underwood**	**Christina Steele**	**Rebecca Falletta**	**Isabel Cardoso**	**Isabel Cardoso**
Jan M10	**M9**	**9**	21	22	-	-	28	28	22	30	-	-
Feb M11	**M10**	**6 (Dev Day)**	18 SH	19 SH	-	-	25	25	26	27	24	10
Mar M12	**M11**	**6** (Charitable Trustees)	18	19	20	20	25	25	26	27	-	-
Apr M1	**M12**	**3 (Dev Day)**	15	16 SH	-	-	29	29	23	24	-	21
May M2	**M1**	**1**	-	21	-	-	-	-	28 SH	-	19	-
June M3	**M2**	**5 (Dev Day)** **19** (AR /Accounts & Rem Com)	17	18	19	19	24	24	25	26	-	23
Jul M4	**M3**	**3**	15	16	17	-	29	29	23	31 SH	21	-
Aug M5	**M4**	**7 (Dev Day) SH**	-	20	-	-	-	-	27 SH	-	-	-
Sept M6	**M5**	**4** (Charitable Trustees)	16	17	18	18	30	30	24	25	**AGM** 29	-
Oct M7	**M6**	**2**	21	15	-	-	-	-	29 SH	30 SH	-	20
Nov M8	**M7**	**6 (Dev Day)**	18	19	-	-	25	25	26	27	24	-
Dec M9	**M8**	**4** (Rem Com)	-	17	11	11	23 SH	23 SH	17	-	-	-
2026												
Jan M10	**M9**	**8**	20	21	-	-	27	27	28	29	-	-
Feb M11	**M10**	**5 (Dev Day)**	17	18	-	-	24	24	25	26	23	9
Mar M12	**M11**	**5 (Charitable Trustees)**	17	18	19	19	31	31	25	26	-	-

Trust Board, Committees and Council of Governors – Meetings 2025/26

***** hold for additional Board meeting to sign off Annual Planning submission

SH = School Holiday

Bank Holidays:
Wednesday 1st January 2025
Friday 18th April 2025
Monday 21st April 2025
Monday 5th May 2025
Monday 26th May 2025
Monday 25th August 2025
Thursday 25th Dec 2025
Friday 26th December 2025
Thursday 1st January 2026
Friday 3rd April 2026
Monday 6th April 2026

Notes:

- Trust Board – Always book the Boardroom 9:00-17:00. Public Board starts at 10:00
- Always include a Teams link for those joining virtually.
- All meetings – book room 30 minutes either side of start/finish times
- NEDS/Governors – Ensure Boardroom is available.
- CoG –book the Boardroom from 2:30pm (Set-up plus 15:00 pre-meet)

NHS
Salisbury
NHS Foundation Trust

Report to:	Trust Board (Public)	Agenda item:	5.1
Date of meeting:	3rd October 2024		

Report title:	Quarterly Strategy Update			
Status:	Information	Discussion	Assurance	Approval
	x			
Approval Process: (where has this paper been reviewed and approved):	N/A			
Prepared by:	Tony Mears, Associate Director of Strategy			
Executive Sponsor: (presenting)	Lisa Thomas, Chief Executive			
Appendices	N/A			

Recommendation:
The Board is asked to note the report

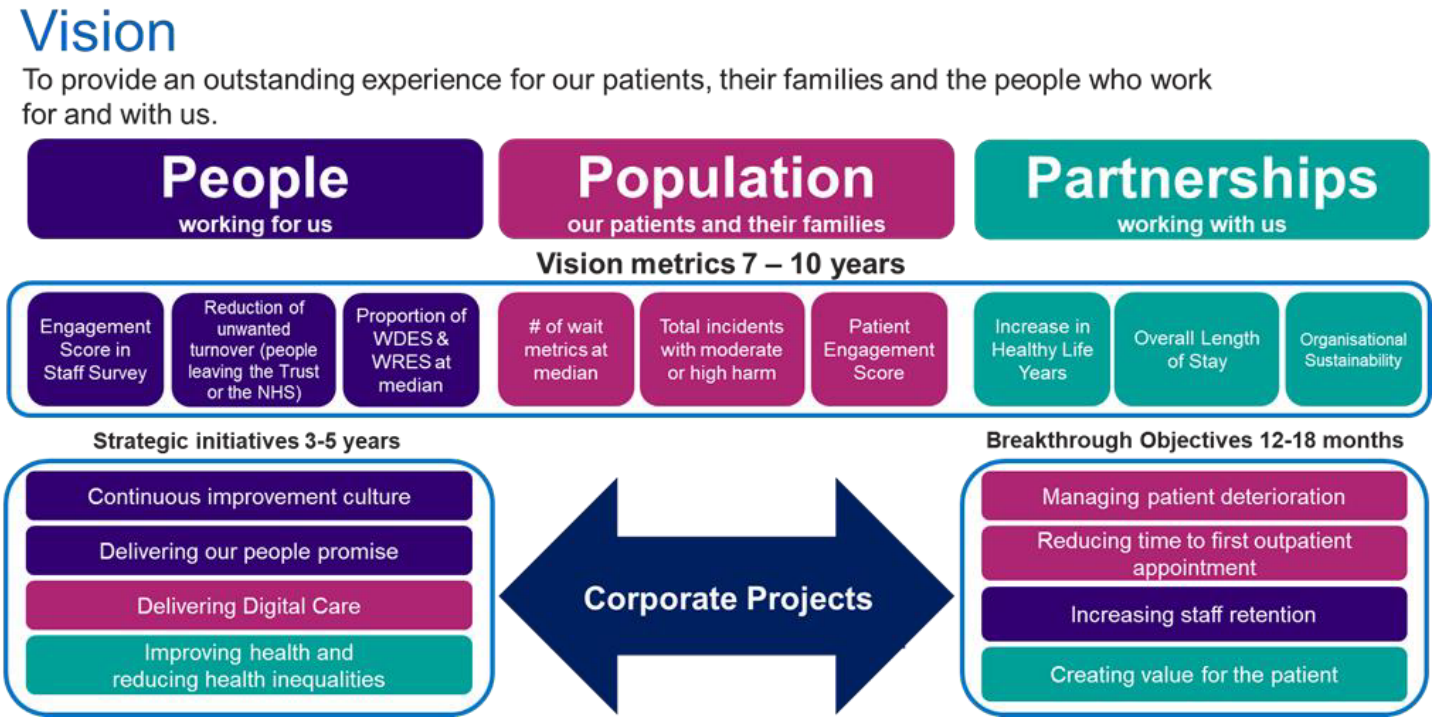
Executive Summary:
This paper is an update on the actions progressed to deliver the Trust strategy under the 3 Pillars- Population, People and Partnership. The Trust uses a strategic Planning Framework (SPF) to oversee the delivery of our strategy[1]. To ensure the strategy is progressing the SPF identifies nine metrics to monitor to oversee delivery, these are the Vision Metrics. The paper shows progress in most of the vision metrics, there are a number where metrics and monitoring is still maturing, however progress in terms of input actions are outlined for the Board to consider. The most significant risk to delivery of the five-year strategy remains the financial sustainability of the organisation and the need to work with system partners to develop a financial plan that ensures services can be delivered within a sustainable resourcing 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):	

[1] salisbury.nhs.uk/media/5gwpjffv/ourstrategy_2022-2026.pdf

Introduction

The organisation's strategy is overseen through the Strategic Planning Framework (SPF), the three areas of focus People, Population and Partnerships all have assigned vision metrics which allow the organisation to track progress over a longer time frame.



To complement the vision metrics the Trust also has strategic initiatives which are programmes of work we consider 'must do, can't fail'; these deliver over a 3 –5 year timeframe.

This paper is an outline of progress against our vision metrics as the principal means by which we track the delivery of our vision and the longest time horizon of our strategy (7-10 years).

1. Population

The focus of the population pillar is to improve the health and wellbeing of the local population. This underpins a focus on good quality patient care and improving on how services are shaped and developed through public engagement.

Progress is measured through a combination of metrics:

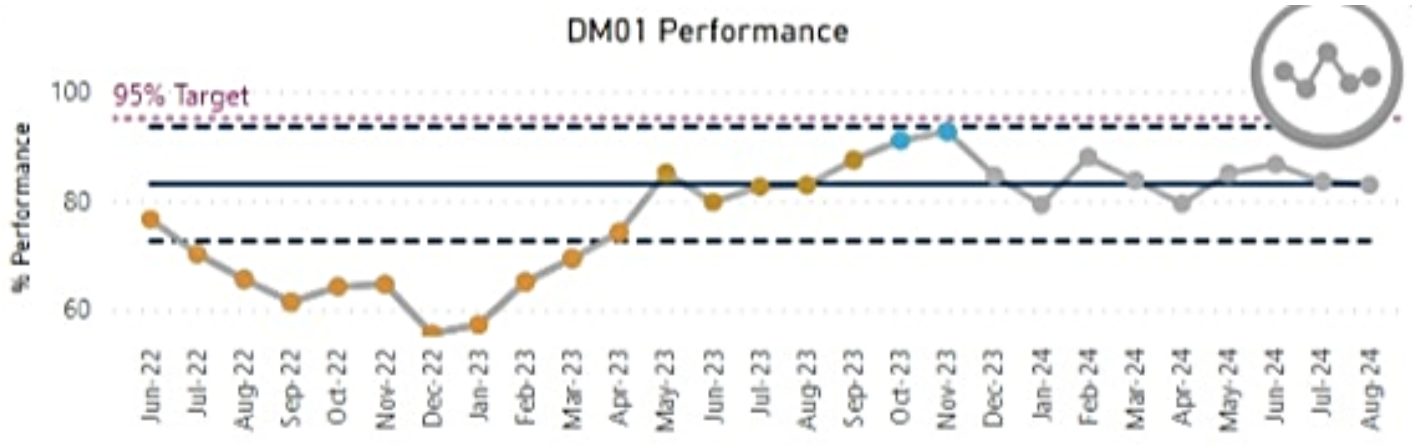
- A combined metric looking at ED performance, Cancer performance, Diagnostic standard DM01 and 18 week RTT performance.
- Reducing patient harm
- Patient engagement score.

The combined performance metric is a way to measure whether patients are receiving timely access to care covering both planned and emergency care. The immediate challenges to recover waiting times even four years on from the Covid Pandemic remains a central focus for the Trust.

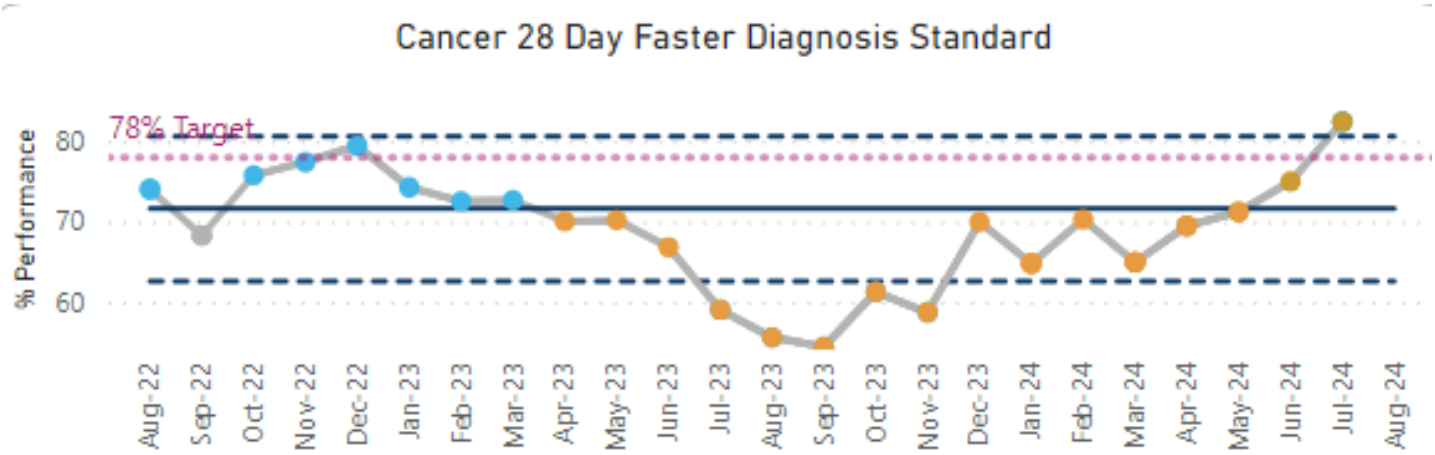
The longer-term strategic aim of replacing the day surgery unit is not only about addressing infrastructure risks, but also creating an environment which will maximise efficiency and opportunities to reduce waiting times. The ability to attract national capital funding remains a significant challenge. The Campus redevelopment programme which DSU is a significant part, remains a focus and working is ongoing with regular updates to Board. The age and environment of the estate remain a significant risk and is reflected in the BAF.

Analysis suggests our population is ageing, with a 40% increase in over 85s projected in the years ahead, a demographic shift that will put enormous pressure on health services across our system. As a result, the models of care will need to change to meet a frail elderly population with ever more complex co-morbidities.

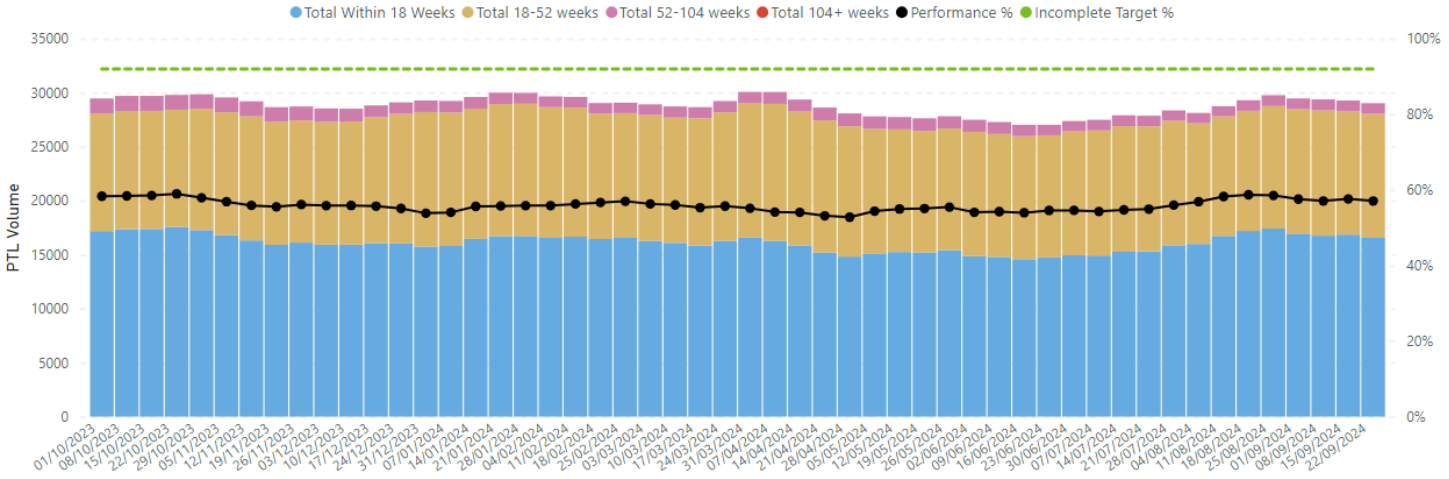
Diagnostics (DM01) has improved steadily over the past 24 months but have fallen from close to target in November 2023 (92%) to a steady state run at the 83% mean. The Trust is part of the Community Diagnostics Centre (CDC), where an increase in diagnostics capacity in the community will improve cancer diagnostic rates in the local population. The Trust is an integral part of providing the service and working with primary care to ensure timely access. Operational logistical challenges have slowed progress in establishing CT and MRI capacity in the community over the last year although these are being resolved to establish services at Central Health Clinic. In the longer term the establishment of CDC capacity will help improve outcomes for the local population and help reduce acute demand.



Cancer performance remains under national monitoring across the BSW system, where all Trusts are collectively in the 28-day Faster Diagnosis Standard (FDS) and 62-day Referral to Treatment Standards. Performance at SFT continues to improve, with the 28-day FDS increasing for the fourth month in a row from 75% to 82.4% and now above trajectory of 78%. The 62-day Standard also increased again from 76.9% to 77.6% and is above the trajectory of 67%. The number of patients waiting over 62 days for Cancer treatment reduced again from 63 to 61 patients and continues steady reduction overall since monitoring began. In the medium term the focus on diagnostics and improved networked pathways will improve outcomes. The Trust will need to continue to develop pathways with University Hospital Southampton but also will look to what opportunities across the AHA may present, particularly any sub specialisation. There is a continued focus on pathway improvements aligned to best practice and system work is progressing regarding colorectal and endoscopy. For the maintenance of our improved position, we retain weekly focus and oversight via cancer improvement group and specialty A3s.



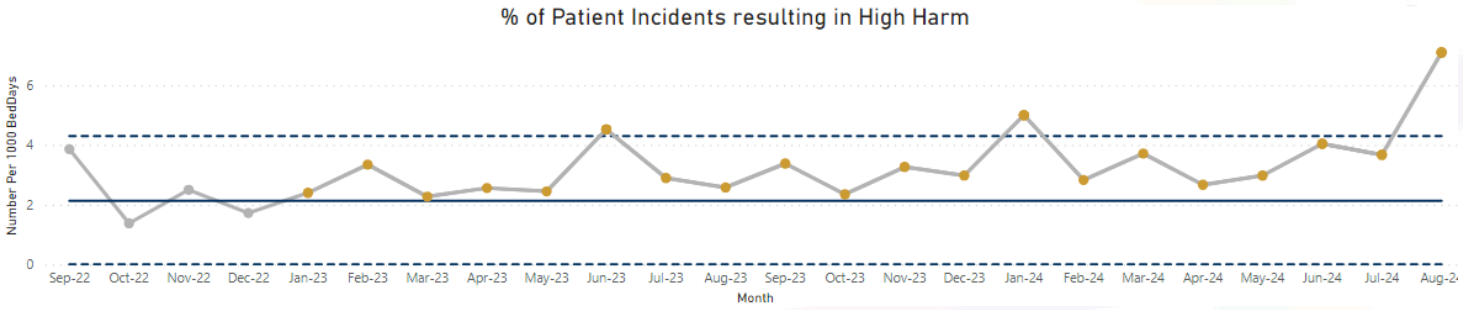
RTT waiting times remain in excess of 18 weeks. The Trust has reduced the number of over 65 weeks and is working towards reducing 52 week waits but reducing the waits will be a multiyear recovery programme. As outlined already in the paper the medium-term focus will be on ensuring access to diagnostics, improving theatre environment to maximise experience and efficiency.



Patient harm

The focus on quality improvement is outlined in the quality accounts which illustrate the range of improvements for the last year. The metric used to monitor the vision metric is 'patient incidents resulting in high harm'. The in-year breakthrough objective linked was reducing patient falls, where progress has been significant, the executive team have now switched focus to reducing patient deterioration (while keen a watch metric for falls).

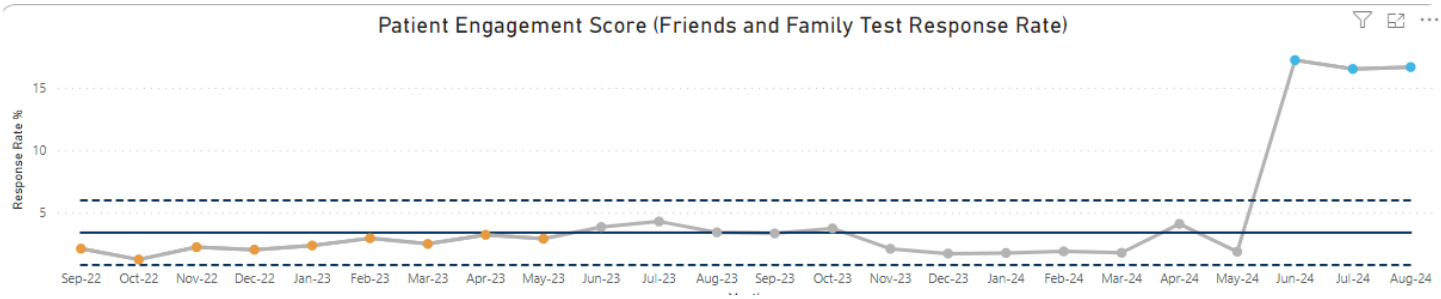
The uptick in the data presented below is due to unvalidated reporting and is likely to reduce once assessed.



Patient Engagement Score

The Trust had identified a need to improve patient engagement to develop services that are responsive to the population need. The most objective way to measure engagement has been through Friends and Family Test (FFT). Due to the FFT being historically an inaccessible method of gathering insight (for example main feedback was from inpatient wards only, and on paper) we have implemented a digital solution (go-live 1st June 2024) that has increased impacting response rates from ~3% to upward of 15%.

PALs have been developing a strategy effectively improving patient co-production over the last twelve months. Regular progress has been reported through the clinical governance committee. Whilst the FFT remains the best way to measure progress it is not the only on emphasis for the team and doesn't reflect the progress made. Additionally the PALS team have been working to understand and triangulate patient experience information across our acute alliance partners, establishing a quarterly meeting from October 2024 and trialling peer benchmarking / review methods.



2) Partnerships

Our partnership work has centred around the Acute Hospital Alliance and our maturing group model. Now all three hospitals are further on in their development with improving together, we have worked toward an SPF that can sit 'at group'. The challenges of ensuring the AHA collective strategy is responsive to the overall ICS strategy published last year, whilst also reflective of the three individual organisations focus is complex. However, it is anticipated this will be completed by the end of Quarter 3 in 2024/25. All three organisations, as expected, have very similar themes and aims. Whilst this work is underway there are three immediate priorities we have focused on as an AHA, are the development of the joint Electronic Record (EPR), the development of our approach to deeper working with community and primary care, and maximising productivity opportunities across the AHA.

The Trust continues to work in partnership at Place. The ICB have recently completed their change programme, reducing staffing levels by 30%. The implications of this are not fully understood yet, but it is anticipated the ICB will not have the same level of resource to invest in Place to support joint working. This presents both a risk and an opportunity for the Trust to develop place-based delivery partners to ensure the shared aim of integration moves forward.

The importance of our tertiary networks with University Hospitals Southampton remains central to delivering high quality services. Our work continues to establish a partnership board with CMO and COO representation. There are obvious operational benefits of continuing to improve services and access for our patients (oncology, plastics, cancer pathways in particular urology and respiratory) but in addition there are opportunities to improve SFT's scale of planned care services.

The metrics monitored for progress against our Partnership pillar are:

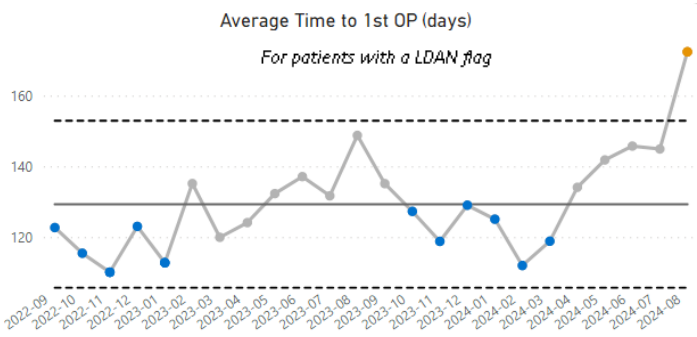
- Increase in healthy life years.
- Overall length of stay.

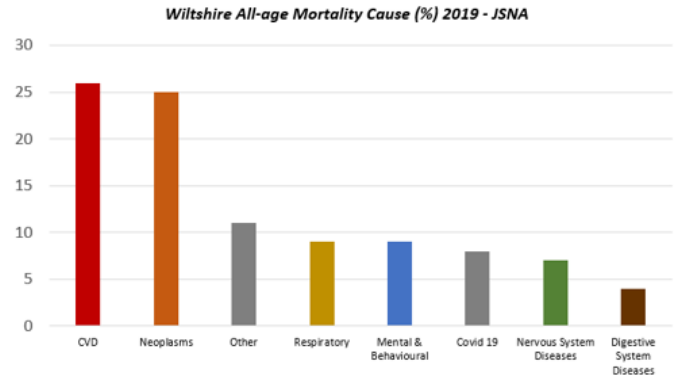
- Organisational sustainability.

Increase in healthy life years

The ability to monitor this metric at the Trust is still being developed. The information which underpins this metric currently sits within the system population health architecture and national data is only available every 5-10 years. As such we are developing watch and balance metrics that we expect to act as proxies for progress against the headline healthy life expectancy measure. There are several system working groups underpinning the programme to influence the wider determinants of health. Our Strategic Initiative 'Improving health and reducing health inequalities' is derived from this vision metric.

Our A3 analysis shows cardiovascular disease (CVD) as the top contributor to excess mortality for Wiltshire. The next steps being developed include focusing on the actions SFT can take to help improve CVD, for example reducing DNA rates for cardiology outpatients which are higher for people from the most socially disadvantaged postcodes. There is also work ongoing to determine what action can be taken to address 'quick win' issues – for example increasing the clinical priority of patients with a learning disability which the below graph demonstrates is a worsening issue.

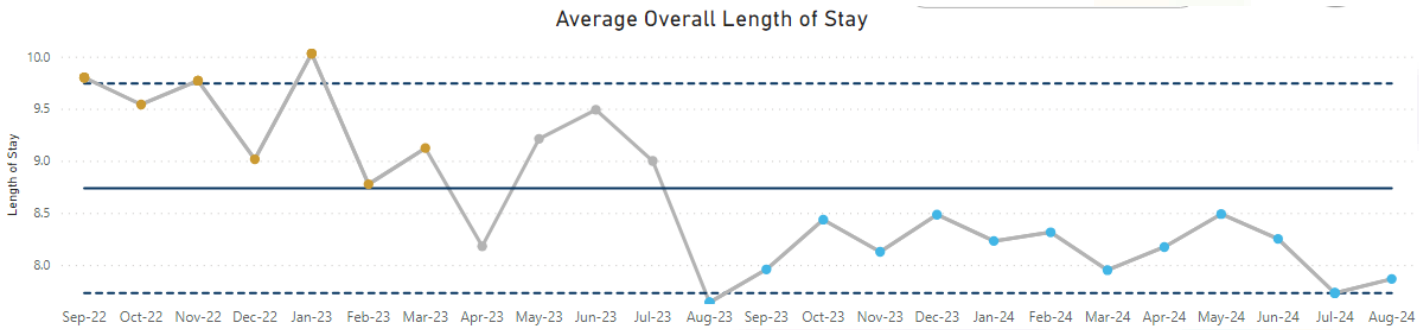




Overall Length of stay

The focus on length of stay recognises there has been an increase in length of stay over the last four years with patients not achieving optimum pathways from both a patient experience and outcome basis. With patients waiting for onward care (no criteria to reside NCTR) increasing from c40 in 2019/20 to over 125 in January 2023. To improve integrated care and ensure patients return to their usual place of residence the Trust has been working closely with partners to improve pathways.

In the last 18 months this has meant the length of stay has reduced by 1 day across the whole Trust. This has been driven through Trust wide initiatives such as Same Day Emergency Care (SDEC) and Acute Frailty Unit. The system work has focused on increasing capacity to support patients in their own homes with a move away from bedded capacity (move to increase pathway 1 and reduce pathway 2). This has enabled a reduction in NCTR closer to 70 on average. This has had a significant impact on flow and capacity. The plans for 2024/25 continue to focus on this metric with an aim of reducing NCTR to being maximum of 10% of occupied beds with a stretch target of 5%. *(The below data excludes the Spinal Unit.)*



Organisational Sustainability

The key elements which underpin this priority include: financial sustainability, having an infrastructure that reflects the needs of a modern hospital (including environmental sustainability), and our role as an anchor institution. The metric used to measure our progress is our deficit as a percentage of turnover, validation of this metric is currently underway.

SFT has been working closely in recent months with system colleagues to refresh the medium-term financial plan and the corresponding system wide transformation plan that underpins this multi-year planning. The cross system working group continues to meet fortnightly to track the progress of our medium-term planning. The underpinning assumptions at a system level is to address the expected future demand include a move of resources from secondary care to prevention and out of hospital provision.

3) People

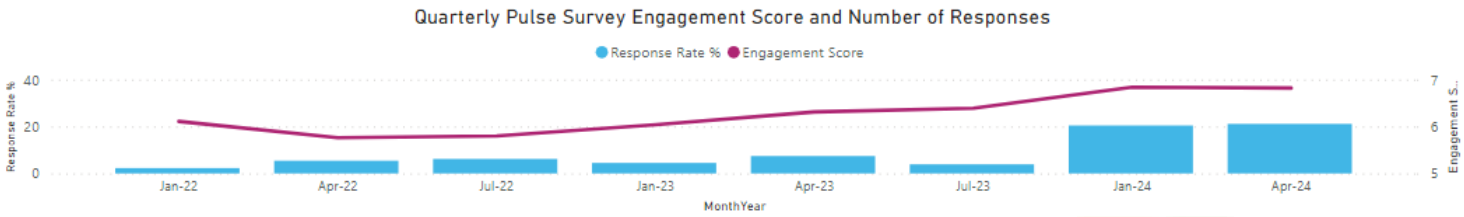
Recognising the workforce of SFT is paramount to delivering safe and effective care. The national people plan was published in 2020 which outlined the expectations of NHS organisations to ensure the NHS has a compassionate, inclusive, and positive culture for staff. The SFT strategy reflects the national ambition with focus on specific improvements for the SFT workforce. The People and Culture Committee oversee delivery of the People strategy with regular updates to Board. To measure progress 3 vision metrics are being monitored:

- Engagement score in the staff survey
- Reduction in turnover
- Proportion of WDES and WRES at median

Engagement score in the staff survey

Engaged staff are critical to delivering our vision. NHS England run the annual staff survey and the previous report showed significant improvement for among SFT staff regarding both response rate and the positivity of those responses.

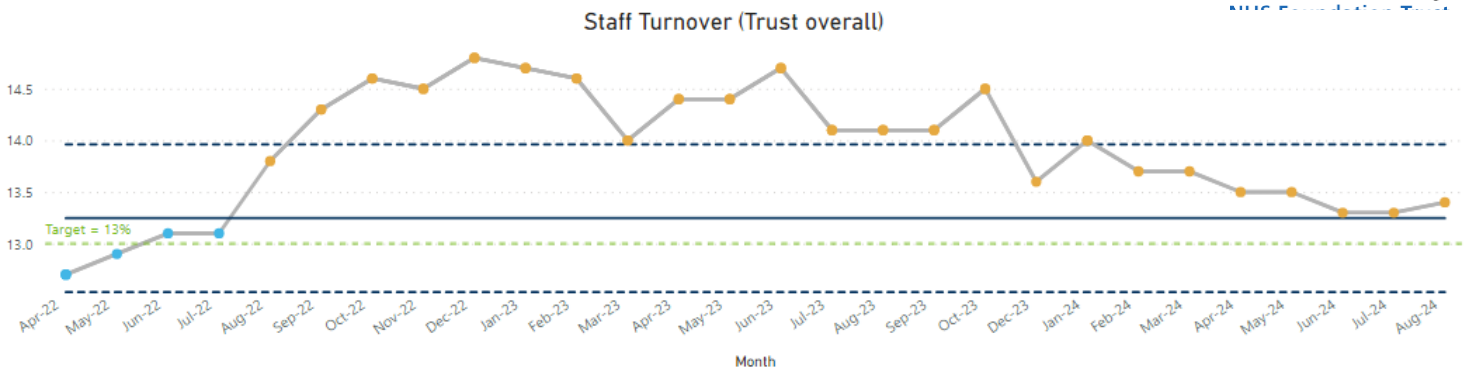
In addition to the national staff survey, which has not updated since the last report, we also run our own quarterly ‘pulse’ survey, and the below data demonstrates increased engagement among staff.



Reducing unwanted turnover

Our ‘increasing staff retention’ short term breakthrough objective is derived from this vision metric to reduce unwanted turnover.

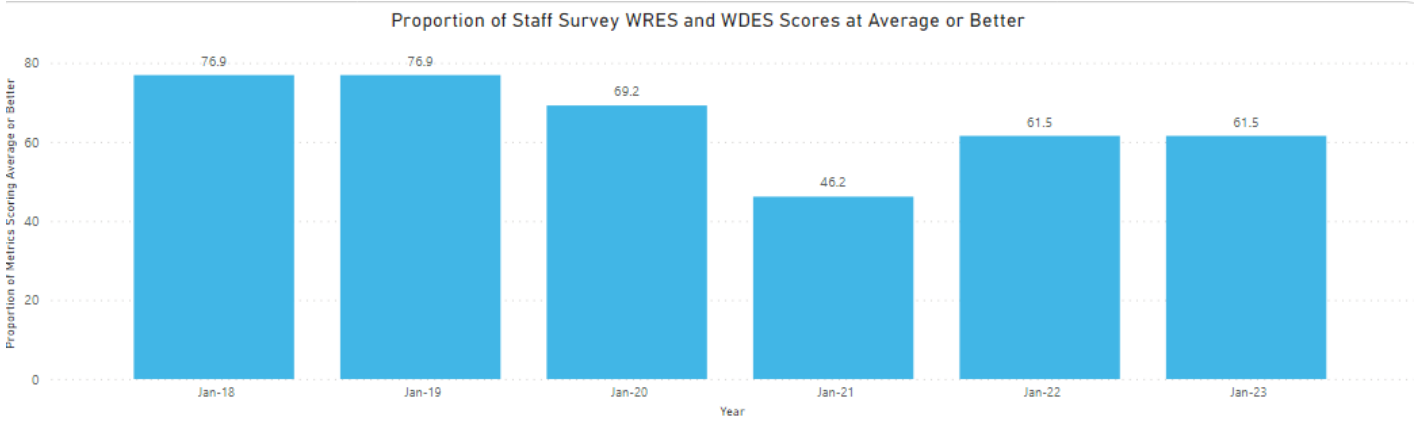
The metric for turnover showed improvement throughout 2023 and the data suggests this improvement has embedded throughout 2024. In the shorter term there is a focus on HCA roles and overall staff under 30 who have much higher turnover rates relative to the wider workforce, and this more targeted approach will continue to evolve as we seek to improve the headline measure.



Proportion of staff survey scores at median for - Workforce Disability workforce standard (WDES) and Race Equality workforce standard (WRES)

Over the past quarter our EDI Long Term Plan has been re-written and published, this encompasses the SW Leading for inclusion work, implements the NHSE six high impact actions and sets the long-term operational milestones to move the culture of the Trust in a positive direction and enable a sense of belonging for all.

Staff survey results have demonstrated a number of areas where our people are less positive, including Black African Staff, Disabled staff, those who identify as bisexual or are unwilling to state their identity in the survey and our youngest staff members. Immediate actions include improving the culture through training interventions to educate staff and provide support tool for managers, creating EDI objectives in our senior managers, and improved interventions to ensure appointment panels are diverse, inclusive and fair for all staff. Finally, work has taken place to support international staff with training for CV writing, interviews and professional development bids.



Conclusion

Overall, the Trust is making progress in implementing its 2022-2026 strategy, and long-term vision for 2032. A number of the vision metrics show positive progress and those less well developed have action plans to ensure metrics become embedded. Oversight of progress by the executive team is through the engine room and regular updates will continue to be provided to Board. The next steps include:

- Finalising monitoring and data collection for all nine-vision metrics for oversight in the Engine room. Including watch and balance metrics where appropriate.
- Continue refining alignment of the progress against the vision metrics with the BAF to ensure risks to delivery are well articulated and understood.
- Finalise the system medium term financial plan to ensure organisational sustainability through the medium term.

NHS Salisbury NHS Foundation Trust

Report to:	Trust Board (Public)	Agenda item:	5.2
Date of meeting:	3rd October 2024		

Report title:	Estates Department Quarterly Update – September 2024			
Status:	Information	Discussion	Assurance	Approval
	x		x	
Approval Process: (where has this paper been reviewed and approved):	Finance and Performance Committee, 24th September 2024			
Prepared by:	John O'Keeffe – Head of Estates Edmund Ellert – Head of Estates Capital Tom Sneddon – Deputy Head of Estates			
Executive Sponsor: (presenting)	Mark Ellis – Chief Financial Officer			
Appendices	Appendix A – Estates Report June 2024 Appendix B – CAFM value for money Appendix C – PAM submission 2024			

Recommendation:

Finance and Performance Committee are asked to note the content of the paper summarising the of the Esta Estates Department, consisting of Estates Technical Services (ETS) and Capital ects teams during the last quar,quarter including current and ongoing risk positions.

Executive Summary:

Staff position two vacancies and one position on hold until justified as required.

Our work on compliance and estates risks continues to reduce both volume and classification of risks. We now have one extreme risk (Estates CAFM System) and six high risks remaining, which have continued beyond our target of the end of the 2023/24 financial year due to funding and volume of works. We are now targeting closure and removal of the high risks by December 2024 by means of mitigating and reducing risks so that only medium and low remain. At this stage we will cease reporting and continue as business as normal.

Overall, we have now reduced the total number of estates risks from 383 to 116. (- 267)

		Extreme		High		Moderate		Low		Total	
This Period	**Remaining** (by **Current** Risk Score)	1	⟺	6	-5 ↓	104	-2 ↓	5	⟺	116	-7 ↓

Previous Period	**Remaining** (by **Current** Risk Score)	1		11		106		5		123	

The chimneys structural integrity continues to be monitored while investigating methods to stabilise and also returning to the market to tender for replacement.

Our MLE compliance has remained above 90%, we are confident our compliance rates will remain in this area. While Our department appraisal rates are currently 87%

Estates have started the Improving Together journey with the senior team having completed the introducing it session and booked on the two-day Improver Standard in September. The rest of the department will then commence training.

The capital team have been allocated £6.791k of CDEL in 24/25; as well as going some way to reduce the backlog maintenance position, it provides budgets to conclude The Elizabeth Building/Imber Ward as well as the decarbonisation project, including the geothermal feasibility.

The decarbonisation project final commissioning has been delayed due to electrical infrastructure issues.

Progress on the new Estates strategy has slipped but a final draft has just been issued for trust approval.

Imber Ward successfully handed over and occupied. Capital team proud of the finished building and very pleased to be part of the team receiving the Chairs staff award.

Replacement of CT 1 & 2 Works and installation of CT2 are complete with applications training starting WC 16th Sept and first patient scans WC 23rd Sept ; Radiology have asked for a 2 month period before CT1 enabling works commence. Structural strengthening has begun with the CT scanner works starting in November. CT1 is due to be operational for patients in late January 25

Estates CAFM System - NHS Estate management involves adhering to numerous and complex laws, regulations and standards, from health and safety to environmental compliance. A CAFM / IWMS system helps organisations reach and maintain compliance by tracking regulatory requirements, managing documentation, and scheduling inspections, supported by an appropriate and readily available audit trail. This reduces the risk of non-compliance issues and enhances overall safety and security within any given building or the wider estate. The Estates CAFM system is our one outstanding extreme risk due to not being able to meet the above criteria on a consistent basis. Therefore, we cannot assure Board and the Trust Duty Holders that we are carrying out our statutory and mandatory tasks, that they are recorded correctly or able to report with conviction that the task are complete. This along with general user frustrations with the system failing and reverting to manual printing of work tickets, which is estimated to be costing around 16 hours per day of admin and trades time increases the requirement to replace it. Data in the main report under section 4.0 shows that currently we are showing as completing 54% of reactive jobs out of 1828 where we would normally be around 85% and 60% compared to 78% of planned jobs.

PAM 2024 – Our PAM submission was completed and returned on time. Again we have seen that the Trust's Estates and Facilities staff have largely maintained a high level of compliance. The Trust has

increased its overall ratings, with significantly more "Good" and "Outstanding" assessments, particularly when considering the change in approach to costed action plans.

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): Long term strategic and sustainable benefits for the SFT campus, supporting the effective delivery of health services.	x

Appendix A – Estates Report – Sept 2024

1.0 Introduction

This is a quarterly update to Trust Board for activity within the Estates Technical Services (ETS) and Capital Project teams from 1st June 2024 – 31st August 2024.

2.0 Staff

Our staffing levels are similar to the last report. We have recruited to the mechanical assistant position, but interviews failed to secure a multi skilled position, so the role is back out to advert. We have had a carpenter resign but an offer has been made following interviews. We currently have had to bring in some bank/contractor support to ensure we meet minimum requirements. Our aim is to maintain a core team of internal resources and therefore reduce our requirement to use external contractors, who are approximately twice as expensive.

We continue meetings with our people business partner and recruitment team to discuss vacancies which currently stand at 2.6 WTE role. We attend the Weekly Divisional Workforce Control Panel (Corporate) meetings as required to discuss and manage vacancies appropriately.

Our latest staff position is below.

August 2024	No.	Notes
Estates Posts	**40.1**	**Includes vacancies.**
Vacancies	**2.6**	**B5 Mechanical Multi Skilled – Being Advertised** **B4 Multi skilled Carpenter – In Offer** **B3 Accommodation Craft Person (0.6WTE) – On Hold**
Sub Total	**37.5**	
Bank Staff	3	**2 x Flushers** **1 x Admin**
Agency/Contractors	**2**	**Agency Cover Jacques Knotter** **LST Contractor Carpentry Cover - Antony Whelan**

Our MLE compliance remains over 90% Whilst our compliance position remains high, there has been a reduction in several mandatory training areas, many are the result of training now becoming due. Staff are

being reminded the importance of mandatory training and supported to undertake their training in reasonable time.

Top Level by Training Title

KEY: 0-79% | 80-84% | 85-100%

Report database last refreshed on 13/09/2024 at 03:41:28

Training Title	Number complete	Number incomplete	Number in target group	Compliance
Adult Basic Life Support 122014	0	1	1	%
Data Security Awareness 122014	35	3	38	92%
Equality and Diversity 122014	36	2	38	95%
Fire Safety 122014	35	3	38	92%
Hand Hygiene Assessment 122014	35	3	38	92%
Infection Control 122014	34	4	38	89%
Moving and Handling 122014	35	3	38	92%
Prevent - 122014	37	1	38	97%
Safeguarding Adults Level 2 - 122014	2	1	3	67%
Safeguarding Children Level 1 122014	27	3	30	90%
Safeguarding Children Level 2 122014	1		1	100%
Overall:	277	24	301	92%

3.0 Compliance

We continue our trajectory of closing and mitigating risks from the Estates compliance report. The table below indicates we are now reduced to one (1) extreme risk, although as previously highlighted some of our mitigation actions do transfer risks into lower rating categories as we work toward concluding them. There has also been a further reduction of three (3) high risk and six (6) overall closures in this period. We have seen an overall reduction in risks and continue toward our target which was to close all extreme and the majority of high risks while converting the remaining moderate and low risks to *business as usual*, which will follow by the closure of the compliance report. However, some high risks will remain until late 2024.

		Extreme	High	Moderate	Low	Total
Initial Risks	**Initial Risks**	286	95	2	0	383
	Closed (by **Initial** Risk Score)	192	74	1	0	267
	Remaining (by **Initial** Risk Score)	94	21	1	0	116
Risk Changed/Moved	**Risk Mitigated** (+/-) due to mitigation in place	-285	-89	102	5	-267
This Period	**Added** in this reporting period.	0	0	0	0	0
	Remaining (by **Current** Risk Score)	1	6	104	5	116
At last report	**Remaining (by Current Risk**	1	11	106	5	123

	Score) at last report					
	Change during reporting period	0	-5	-2	0	-7

We have extracted the final extreme and high risks from the compliance report to the table below and provided a narrative previously.

ID	Source of Risk Data	Risk
197	PAM Audit	Estates and Facilities Operational Management/ Maintenance: CAFM and PPM regime's inadequate

Risk 197

Estates CAFM system not fit for purpose – **1x risk**

Update to last report: The bids received on the CAFM procurement have been assessed and moderated. Concerto came out as the preferred platform. The recommendation report has been shared to seek the capital funding to implement the platform with the preference to place orders and start within this financial year. Work is also being done now the cost is understood how to absorb the ongoing cost into the Estates budget. A bid has been submitted to the Informatics team.

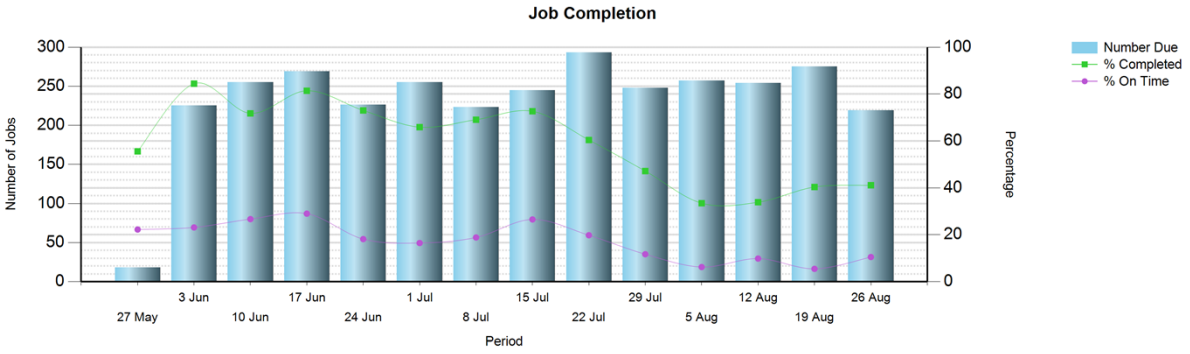
Although we are on track to close or mitigate the bulk of the high-risk actions, there are six actions that will still be outstanding until late-2024 . They are:

ID	Source of Risk Data	Risk	Update
56	AE Audit	Fire Damper maintenance	With the survey work now finished and remediation of faulty dampers in progress, completion of the action is anticipated by Dec 2024 as there was a delay with the procurement process. **Closure Target – December 2024**

87	Other	HTM 06-23 Periodic Inspection and Testing - New contract in place, but not yet used, last undertaken 2013, reports of outstanding C1 and C2 from then	Fixed wiring testing is complete in the residence's south and most central areas. While some testing has begun in the north block, approximately 30% of the site remains untested. This will be completed within the current financial year, as progress awaits confirmation of the capital budget allocation. Additionally, any code FL, C1, or C2 remediation is being addressed as encountered. **Closure Target – December 2024**
106	Other	32-09 Hot Water Cylinders - No Practice in place	Progress on this action has been delayed due to higher-risk actions taking priority. The preventive maintenance plan (PPM) is currently being developed and implemented, however, resource availability for its execution depends on estates operations capacity. **Closure Target – October 2024**
134	Other	102-04 Window Restrictors - No Practice in place	All survey work complete, remediation of identified non-compliances will be undertaken. Procurement process underway. **Closure Target – December 2024**
150	Other	44-08 Electrical Installation – Generally - No practice in place - RCD and AFDD	Pending completion of fixed wiring inspection - see ID 87 **Closure Target – December 2024**
151	Other	44-09 Three Phase Circuits - No practice in place - RCD and AFDD	Pending completion of fixed wiring inspection - see ID 87 **Closure Target – September 2024**

4.0 Estates Maintenance

The data for June – August 2024 is shown below. (Data is shown for full month activity).



This quarter

Previous quarter

Job Type Summary

	Due	Cancelled	Completed	On Time
ECO	225	0	221	214
HELPDESK	1828	39	994	260
IMPROVEMENT	1	0	0	0
PFI	1	0	0	0
PPM	1207	4	719	84
Total	3262	43	1934	558

Job Type Summary

	Due	Cancelled	Completed	On Time
ECO	231	0	230	227
HELPDESK	2112	30	1801	1703
PPM	1149	5	902	805
Total	3492	35	2933	2735

The data shows a continued high volume of helpdesk jobs raised (logged calls for maintenance actions across the estate) although data for planned maintenance (PPM) and Helpdesk are consistent with previous 3-month reporting periods The data shows we carry out more reactive than planned works and we should be aiming for the opposite situation. **What we can see from this data is that we are carrying out more manual processes relating to the helpdesk, this is shown by a severe drop in works completed and completed on time as admin staff are manually printing tickets, trades staff are writing actions on the tickets and then admin staff collate and manually upload in the system , it is estimated that a minimum of 8 hours per day admin time is currently lost across the team of four and a minimum of 8 hours across the trades teams.**

During this period the number of emergency call outs was 225. As with previous report periods, some analysis of the increased numbers is in progress, although given the estates backlog continues to increase at a rate faster than it can be reduced, the failure rate of the estate is equally likely to increase particularly whilst the Trust resources to maintain the estate remain constant or potentially reduce.

5.0 Capital Delivery

The capital team have been allocated £6.791k of CDEL in 24/25; as well as going some way to reduce the backlog maintenance position, it provides budgets to conclude The Elizabeth Building/Imber Ward as well as the decarbonisation project, including the geothermal feasibility.

Imber Ward

Sectional completion of Imber Ward was achieved on 17th June with practical completion of The Elizabeth Building on 5th July 2024. A major cause of the delay was connection of the incoming mains electrical supply; however, the new HV substation went live on 6th June facilitating commissioning of the building. The final account is in the process of being agreed, which will allow a total cost for the project to be verified. Budget pressures mean it's unlikely that an enhanced external landscape design can be implemented, so discussions continue to secure alternative funding which will see this delivered under a separate contract.

Salix decarbonisation

The £10m Salix funded decarbonisation scheme has enabled various net zero carbon works to be carried-out across the estate, including photo voltaic panels, replacement glazing and thermal upgrades to building fabric. The main elements of equipment are the air source heat pumps (ASHP) which although installed, continue to be commissioned. There are electrical supply issues with the ASHP's installed close to the chillers serving SDH North, we are currently exploring options but a new substation may be required.

The Trust's 12% capital contribution to the Salix funding has gone towards commissioning a geothermal feasibility study; the supplier GT Energy have completed the seismic surveys and are now processing the data which will allow completion of the feasibility study in October. The financial offer will be submitted once the study is complete and the Trust is working-up a business case which will include the strategy for installing a district heat network.

Estates Strategy

The consultant team appointed to undertake the Estates Strategy have finalised their Stage 3 report; including an executive summary which is being reviewed by the Trust.

Multi-flue Chimneys

Having previously reported the condition of the energy centre chimneys present associated risks, work associated with the long-term replacement, as well as short, to medium term strengthening is taking place. The decarbonisation project and potential geothermal could reduce the number of gas-fired boilers required on the estate, thereby reducing the number of boiler flues. It is hoped there will only be a need for a single chimney rather than the two currently in situ. Regular monitoring of the condition of the chimneys is ongoing and a specialist consultant has been appointed who will provide advice for re-tendering their replacement, as well as extending their life.

Replacement of CT1 & CT2 scanners

The Trust has taken delivery of CT1 & CT2 scanners which are being stored on site until enabling works have been completed. Structural strengthening works are required to the Level 3 floor slab due to the increased weight of the latest scanners. Works and installation of CT2 are complete with applications training starting WC 16th Sept and first patient scans WC 23rd Sept ; Radiology have asked for a 2 month period before CT1

enabling works commence. Structural strengthening has begun with the CT scanner works starting in November. CT1 is due to be operational for patients in late January 25

Replacement of Lifts 3 & 4

The Trust has appointed a lift contractor to replace the existing hydraulic lifts with electric traction units which should be more reliable. Both lifts 3 & 4 are programmed to be installed by the end of the financial year. The contract value allows part of the project budget to be assigned to the early procurement of lifts 1 & 2, specifically the design and purchase of equipment, with installation planned in the subsequent year.

24/25 Capital Allocation

The following funding has been allocated to the Building and Infrastructure Group:

CDEL	£'000's
Imber Ward	£1,500
Energy Centre Flues	£1,219
CDEL Salix – seismic studies	£930
CT building works	£404
Installation of Fluoroscopy C Arm	£200
Other <£100k	£180
Lift Refurbishment	£700
Fire compartmentation	£300
Other <£300k	£1,358
Total BIG	**£6,791**

National Funding	£'000's
Community Diagnostic Centre	£1,306
Total BIG	**£1,306**

6.0 Governance and Risks

As noted previously the BSW commitment to invest in the EPR system over the next 3-years has resulted in significantly reduced capital availability. Whilst our requirements for 5-year (and beyond) capital investment are now well documented (and tabled regularly via the relevant committees) we expect a combination of reduced investment for 2024-2027 and a resulting very high demand for capital allocation in 2027-28, alongside IT and Medical Equipment requirements, to increase the Trust risks further and the backlog maintenance position to worsen.

The chimneys structural integrity continues to be monitored while investigating methods to stabilise and returning to the market to tender for replacement.

We cannot currently assure Board and the Trust Duty Holders that we are carrying out our statutory and mandatory tasks, that they are recorded correctly or able to report with conviction that the task are complete due to the failings of the Estates CAFM system.

New risks identified within this report.

	Risk	Action
	None	

Report Title: Appendix B	Replacement of Estates Facilities Management (CAFM) Software and implementing an Integrated Works Management System (IWMS)			
Status:	**Information**	**Discussion**	**Assurance**	**Approval**
	x	x		

Executive Summary:

NHS Estate management involves adhering to numerous and complex laws, regulations, standards and HTM's, from health and safety to environmental compliance. Managing the actions required to comply with these laws is managed through a Computer Aided Facilities Management (CAFM) system. A CAFM system is designed to help the Trust reach and maintain compliance by tracking regulatory requirements, managing the documentation of expected and completed works and scheduling inspections that is readily auditable.

The current CAFM acts as a database of work and is not fit for the purpose of planning, tracking or managing preventative maintenance work. It cannot log work against mandatory and statutory actions or routine maintenance requirements that extend the life of plant, equipment and structures. Estates cannot assure the Board, and the Trust Duty Holders, that we are carrying out our statutory and mandatory tasks. Much of the

usability of the CAFM relies upon manually printed work tickets that utilise an estimated additional daily 16 hours of administration and trades time better suited performing maintenance works.

Ensuring all assets are included within the CAFM, and subject to planned maintenance, is a work in progress. Many of the hazards within estates such as confined spaces, asbestos, water, fire, working at heights and pressure systems have actions assigned, and form the basis of many of the tasks on the estates action log, but not all assets are identified and therefore not subject to PPM, inspection or audit. Because there are unknown and unallocated assets that are available on the CAFM there are not assigned planned maintenance, inspection or audited significant risk within ETS. For this reason the CAFM remains on extreme risk on the Trust risk register.

What we are proposing to do:

To replace our current computer aided facilities management (CAFM) system with a modern integrated works management system (IWMS) tailored specifically for our requirements with the ability to expand the planned maintenance of assets, automate the logging of jobs once complete and track maintenance requirements. An IWMS features the online helpdesk for incoming requests as well as integration with property and location management, visual drawing resources, asbestos management, high level detailed report functionality or any project management functionalities.

A replacement system will enable planned maintenance for all assets across the Trust, reduce the amount of administration time of works, improve the way Estates manages its workload, increase maintenance works and provide greater transparency on what is outstanding.

The cost of the IWMS is estimated at £ 85,536 capital implementation cost and £65,000 revenue costs against approximately £10,000 for the CAFM revenue costs.

However, the current lost time is calculated at approximately £72,124 (two off B4 WTE).

The value of this additional expense is seen within:

Improved Compliance

The software will provide a more robust system for documenting compliance across our properties and assets. It will provide a single central source for managing all statutory and mandatory compliance requirements, providing a repository for evidence, with improved automated compliance reporting.

Efficient Resource Management

The software enables Estates to optimise the use of its physical assets and services. By efficiently managing resources we can maximise their utilisation and reduce waste.

Patient-Centric Care

IWMS software can help ensure that facilities are well-maintained, safe, and conducive to patient care.

Data-Driven Decision Making

The software provides valuable data and analytics on facility usage, maintenance/service needs, and asset performance. This data can inform strategic decisions related to resource allocation and long-term planning.

Sustainability and Environmental Goals

The software can help monitor and optimise energy usage, reduce waste, and support the NHS in achieving its sustainability goals by ensuring that facilities are operated in an environmentally responsible manner.

Cost Control

Efficient Estates and facilities management can lead to cost savings in the long run. By using the software to schedule maintenance and services, monitor equipment performance, and track expenses, Estates can monitor costs effectively.

"An IWMS is used by an organisation looking for greater efficiency, transparency, flexibility, and customer satisfaction in their facilities management processes. Research from Research & Markets states that the deployment of an IWMS solution leads to a reduction in facility maintenance costs of 14%, an improvement in workspace management by up to 40% and an increase in facility usage efficiency of 42%" (IWMS Marketplace: IWMS Platforms, Software, and Solutions Market Outlook and Forecasts 2018 – 2023, 2018).

Although the main objective of this project focuses on compliance assurance, it will also recognise efficiency savings in return for the investment.

1.1 Case for change

The current software exclusively caters to the reactive and planned maintenance (PPM) needs within the Estate's teams. While alternative modules exist, they are plagued by the same cumbersome issues afflicting the Estates modules. Regrettably, the current software provider has expressed no intention of implementing significant updates to their product, resulting in the system lagging behind its competitors.

The software's user-friendliness is severely lacking, often necessitating the use of free text fields or workarounds to facilitate workflow processes. The lack of cohesion in its database tables poses challenges for the Estates team when generating clean reports. Consequently, there is a notable lack of confidence in the system, compelling staff to resort to external duplications or disregarding existing information. Moreover, Estates employs different software programs to record data, compounding the risk of errors and duplications, which subsequently impacts reporting across all subjects. These issues have led to a diminished reputation for the platform among teams, eroding trust in the current system.

Furthermore, the system encounters frequent ad-hoc errors, involuntarily logging users out for periods ranging from 5 to 20 minutes daily, sometimes periods of days occur. Despite collaborative efforts with both IT and MRI (CAFM provider), a resolution to this issue remains elusive. In response, operatives have resorted to manual paper-based processes due to mounting frustrations with the existing CAFM software.

While a mobile app is available, it exhibits similar drawbacks as the main platform, characterised by sluggish performance and usability challenges. Concerns have arisen regarding mobile device functionality, although it remains unclear whether these issues stem from software, or connectivity/Wi-Fi problems. Currently, there are no plans to replace the mobile devices as we cannot evidence any problem with the hardware, but this decision could be re-evaluated if similar issues persist with a new software solution in place.

The customer application within the existing system is very limited with free text location fields causing unnecessary issues. IWMS will allow Trust users to see existing work requests both from themselves and colleagues and be able to link jobs if more than one user reports the same defects, giving all the same update to resolution. Currently, the first person to log a call gets updates and others receive a duplicate notice with no further involvement. This increases the calls to the helpdesk and wastes valuable clinical time. To further improve the user experience, there can be single sign on, automatic pre population of user and location details

or scanning of equipment QR/barcodes. There is also the ability to view locational requests and track jobs in a particular area no matter the originator. It will also allow two-way communication between reporter and Estates helpdesk, status updates and an escalation option reducing the traffic on the help desk and reducing the time needed for the customer to report jobs and keep track of progress over the phone.

Strategic alignment

In line with most Digital Strategies this improvement project mirrors the strategic drivers of: improved experience, efficiency, innovation, safety and outcomes as well as supporting strategic themes of using innovation for supporting work force capacity and stress by reducing the administration burden. The core principles of access to open data alongside build/buy software module have been a fundamental part of the specification written for this replacement project. This will increase reporting capabilities in readiness for future integration with data warehouse/BI, establishing the data required for any future "Use of Technology".

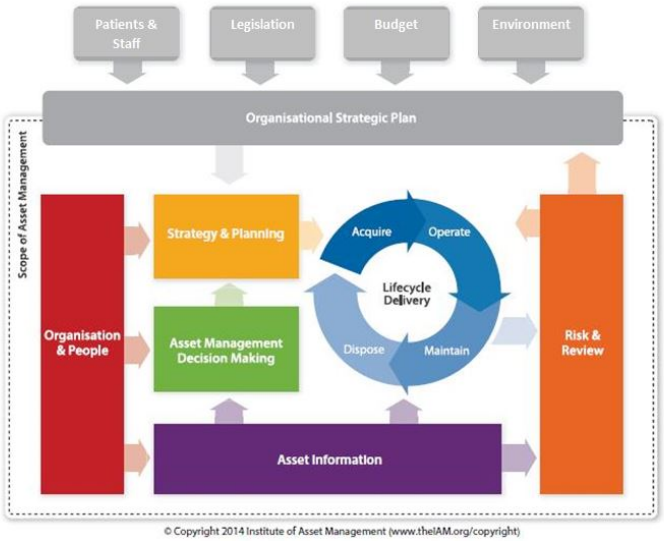
The system offered is cloud based, and all data held in purpose-built warehouses with relevant industry standards, accreditation and encryptions. This reduces the need for the current on-site server requirements. Tender responses regarding this section have been checked by the Informatics team.

IWMS is integral to Estates to remove fragmented and silo-based working and has the scope to extend to other departments as we progress.

It will offer one portal via either a mobile app or desktop for the Trust to report issues for multiple teams across Estates.

NHS England

Working with NHS England and NHS Improvement guidance, we will target the software architecture by applying interoperable standards and future proofed designs with NHS owned data. This project delivers on these principles using full asset lifecycle management.



Evidence/rationale for change

The current trajectory will lead to reduced data quality as manual interactions continue. This will impede any planned automation and audited practices among Estates teams. Inefficiencies continue as valuable time is spent on information finding, resulting in decreased morale among staff members, attributable to the frustrations stemming from the inadequacies of our present software infrastructure.

The existing software exhibits significant limitations in terms of future planning capabilities, as well as the future utilisation of cutting-edge technologies such as smart technologies, IoT (Internet of Things), and Business Intelligence (BI) reporting. Since the Trust update to Microsoft 365, there have been further limitations of the current software due to it remaining a 32bit platform.

The process of accessing the underlying compliance evidence remains laborious and susceptible to human error, potentially leading to unwarranted delays and errors.

To enhance the Estates' performance and effectiveness, it is vital that we establish a more robust system for documenting compliance across our properties and assets. Likewise, we must prioritise the compilation and smooth sharing of data with our partners at SFT. This commitment to modern technology will empower us to make informed decisions and provide our leaders with the tools they need to steer our business towards the optimal path.

1.2 Top 3 Objectives (SMART)	• Procurement of IWMS System. • Build Workflows aligned to Estates. • Integrate existing software data in one platform.
1.3 Top 3 Outcome Measures (key success factors/KPIs)	• Increase compliance reporting capabilities. • Improve efficiency through better resource planning. • Integrate Estates departments via managed workflows for better staff, customer and patient experience.

1. Economic Case	
2.1 **Options Appraisal**	
Option 1 – Business As Usual – No Change	
Advantages	• No additional financial resources required.
Disadvantages	• Increased effort due to ongoing departmental procurement and isolated software usage. • Limited data collection and support for business decision making and strategic planning. • Persistent time-consuming processes. • Insufficient location and asset information • Inability to evidence compliance through a single source • Lack of preparation for emerging technologies
Option 2 – Extend RUH system to cover SFT	
Advantages	• Improved collaboration. • Known system. • Less work involved in implementation
Disadvantages	• Increased effort due to ongoing departmental procurement and isolated software usage. • Limited data collection and support for business decision making and strategic planning. • Disruption throughout implementation phase • RUH system also of the older CAFM style with reduced functionality

	• Inability to evidence compliance through a single source • Lack of preparation for emerging technologies • Revenue requirement
Option 3 – Procure and Implement IWMS software	
Advantages	• Enhanced asset data and tracking capabilities. • Improved communication. • Ability to identify workforce requirements. • Effective management of a centralised help desk/control room, leading to improved customer service • Enhanced functionality accessible via mobile devices for all staff attending to work duties. • Structured workflows and prioritised task management. • Efficient use of clinical time for reporting issues: single sign-on, task visibility within departments, and a one-stop shop for Estates services with options for others. • Open platform for integration with SFT data warehouses • BIM integrations • Establishment of audit trails and provision of compliance evidence. • Integration potential with our third-party contractors for streamlined processes, documentation management, and compliance evidence. • Anticipated opportunities for future development, including IoT enhancements. • Opportunity to roll out across the wider AHA/Group.
Disadvantages	• Disruption throughout implementation phase • Learning a new system • Revenue requirement
2.2 Preferred option	• Option 3 is preferred because IWMS software plays a critical role in supporting the objectives of Estates by improving operational efficiency, enhancing patient care, supporting our clinical colleagues, ensuring compliance, and contributing to the broader goals of sustainability and cost-effectiveness. It forms an essential part of the infrastructure required to deliver high-quality services to SFT.
2.3 Impact on Performance Standards and Waiting List	• N/A
2.4 Impact on Quality and Patient Safety	• Improved efficiency will ultimately improve the quality of the environment and patient care

Efficiency Savings

"An IWMS is used by an organisation looking for greater efficiency, transparency, flexibility, and customer satisfaction in their facilities management processes. Research from Research & Markets states that the deployment of an IWMS solution leads to a reduction in facility maintenance costs of 14%, an improvement in workspace management by up to 40% and an increase in facility usage efficiency of 42%" (IWMS Marketplace: IWMS Platforms, Software, and Solutions Market Outlook and Forecasts 2018 – 2023, 2018).

Although the main objective of this project focuses on compliance assurance, it will also recognise efficiency savings in return for the investment.

Report to:	Mark Ellis – Chief Finance Officer John O'Keeffe – Head of Estates
Date of Report:	25/08/2024
Title of Report:	**NHS Premises Assurance Review 2023-2024**
Status:	For Record
Request:	Approval to Submit the 2023- 2024 PAM self-assessment results as shown below.
Author:	Thomas Sneddon - Deputy Head of Estates
Appendices:	PRN01238_NHS_PAM_SAQ vff.xlsx

It is estimated that the staff hours saved across several posts is identified as a non-cash releasing saving. Due to the fragmented allocation of these hours across multiple staff positions, it is not expected that this project will result in a reduction of the workforce; rather, it is intended to enable greater concentration on their respective areas of expertise.

Appendix C – PAM Report – Sept 2024

Executive Summary:

The Trust's Estates and Facilities staff have largely maintained a high level of compliance or made significant improvements in the Premises Assurance Method submission for the 2023-2024 reporting period. The Trust has increased its overall ratings, with significantly more "Good" and "Outstanding" assessments, particularly when considering the change in approach to costed action plans.

Although some higher risks and lower gradings have emerged in this reporting period, these risks were already present, and the division has proactively identified and is now working to address them.

Some of the most notable changes include:

- Outstanding achievement in Helipad domain compliance within 12 months
- Continued improvement across the board of Hard FM Domains
- Continued high compliance in Soft FM domains, with improved analysis of shortcomings for the purpose of resolution
- The addition of new domains: Anti-ligature and FM Maturity 1

Over the reporting period, higher-level governance has moved to a "Good" position across the board. Future work will focus primarily on maintenance, BCPs, and developing robust costed action plans.

Overall, Salisbury NHS Foundation Trust has made significant progress in its Premises Assurance Method submission for 2023-2024. The departments and domain leads are committed to continuous improvement and are confident that these improvements will further enhance the safety and security of its premises.

Overview:

This marks the fourth year of reporting through the Premises Assurance Model (PAM). The Trust has again seen significant improvements across the board.

Key Changes in PAM for this Year

Several additional sub-domain questions have been added to PAM this year. Key changes applicable to SFT include:

- **Hard FM:**
  - Helipad - question restructured to provide more evidence examples
  - SH14 - Fire Safety - two additional subset questions
  - SH21 - Anti Ligature - new section with multiple subset questions added
  - SH4 - Health and Safety - addition on consideration of Mental Health Patient considerations to A&E and other applicable areas
  - SH19 - Contractor Management - question added around contract expiry control
  - SH20 - Around new medical gas framework, added last year for use this year - now removed due to delays of pending framework implementation
- **Soft FM:**
  - SS4 - Cleanliness and Infection Control - three additional questions added
- **Efficiency:**
  - F3 - question added around Capital Project Management
  - F4 - question added around board reporting and contracting
- **Effectiveness:**
  - E4 - question added around Transport
- **Maturity:** Second set of Maturity framework questions added

Other Changes

- SS10 - Subset changed to specifically focus on PSTN (Old analogue phone lines). As the area the Trust is located has already turned off this service, it is not applicable to the Trust.

The full detail of changes can be found later in this report.

Trust's Progress

As illustrated in the comparison below, the Trust's position has been steadily improving over the last four years. However, some areas within Soft FM and Patient experience have been downgraded to requiring moderate improvement and rated as inadequate. This is largely due to the new food standards guidance, which will be a focus of improvement this year.

Another important consideration is around the costed action plans. In previous years, as per PAM guidance, the results of the six facet survey were used to formulate the costed action plans for each applicable domain. On internal review, this method was found not to create meaningful and accurate costed action plans. Consequently, many sub-domain questions answered as 'good' last year are now reported as requiring minimal improvement or not applicable where the outcome is already good or outstanding across the results of that sub-domain. In the coming years, work will be done to create a better method of capturing these figures for both Capital and Revenue spend.

Considering the above, this reporting year has seen the most subset questions rated as either good or outstanding, with a significant increase in the self-assessment of 'outstanding'. This reflects the many work streams undertaken in estates and facilities, with the bulk of improvement coming from the work done around Helipad and Cap 1264 guidance compliance.

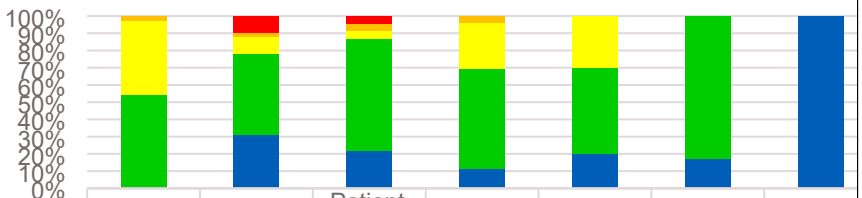
PAM Submission Growth

In the 2022-2023 reporting period, there were 341 questions in the core domains with 19 questions not applicable to the Trust, plus one maturity framework domain. For this reporting period (2023-2024), there have been 376 questions over the core domains with 55 not applicable to the trust. Of these, 27 N/A are due to fully compliant sub-domains that do not require costed action plans, which would have been previously reported as good. There are now also two domains around the FM Maturity framework.

The charts below track the progression across the domains over the last four years. As you can see, the progression from year one to year three has been significant. Work will be targeted this year to bring all subset questions back to at least a 'required minimal improvement' self-assessment. You will also note that the PAM submission has grown significantly over the past four years. As this is used as one of the division's key drivers for compliance, this presents a challenge within department capacity, not only for the submission but also for the progression of non-compliant areas.

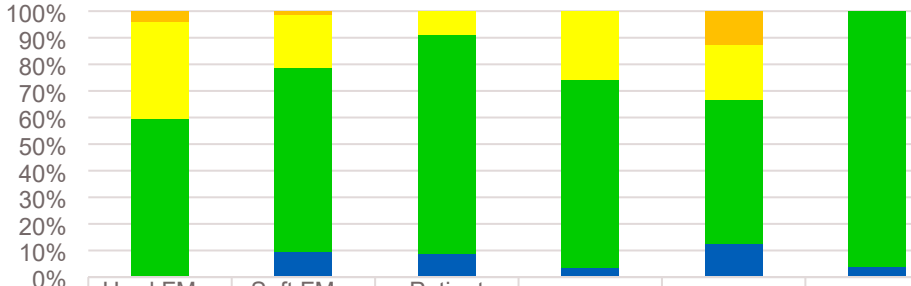
Salisbury NHS Foundation Trust

Domains by SAQ Rating 2023/2024 (THIS reporting year)

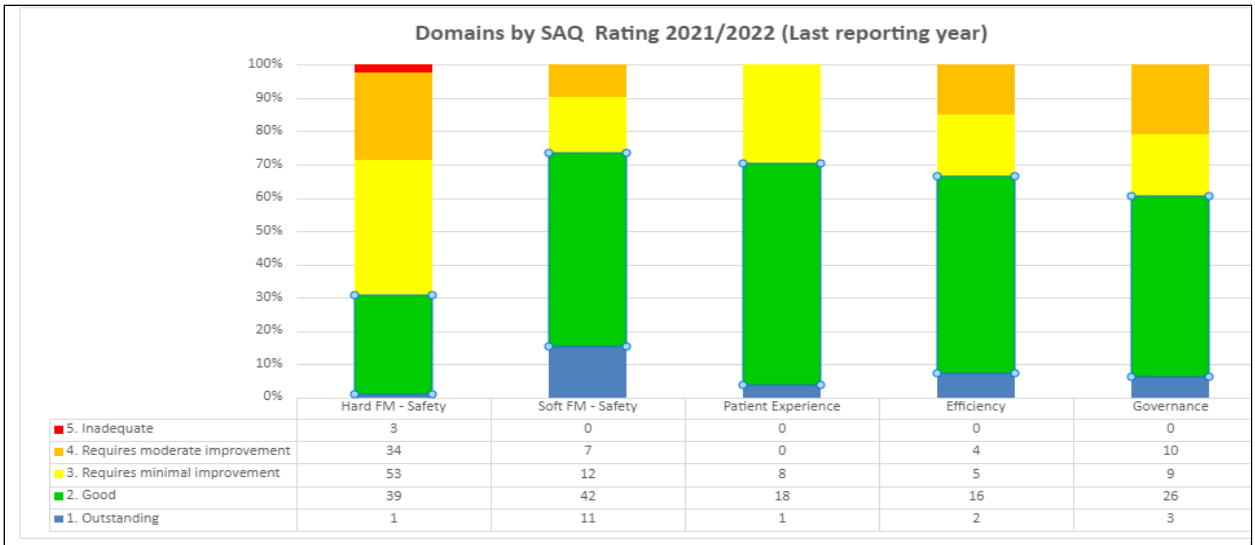


	Hard FM - Safety	Soft FM - Safety	Patient Experience	Efficiency	Effectiveness	Governance	Helipad
5. Inadequate	0	7	1	0	0	0	0
4. Requires moderate improvement	4	2	1	1	0	0	0
3. Requires minimal improvement	63	7	1	7	6	0	0
2. Good	79	35	15	15	10	19	0
1. Outstanding	1	23	5	3	4	4	8

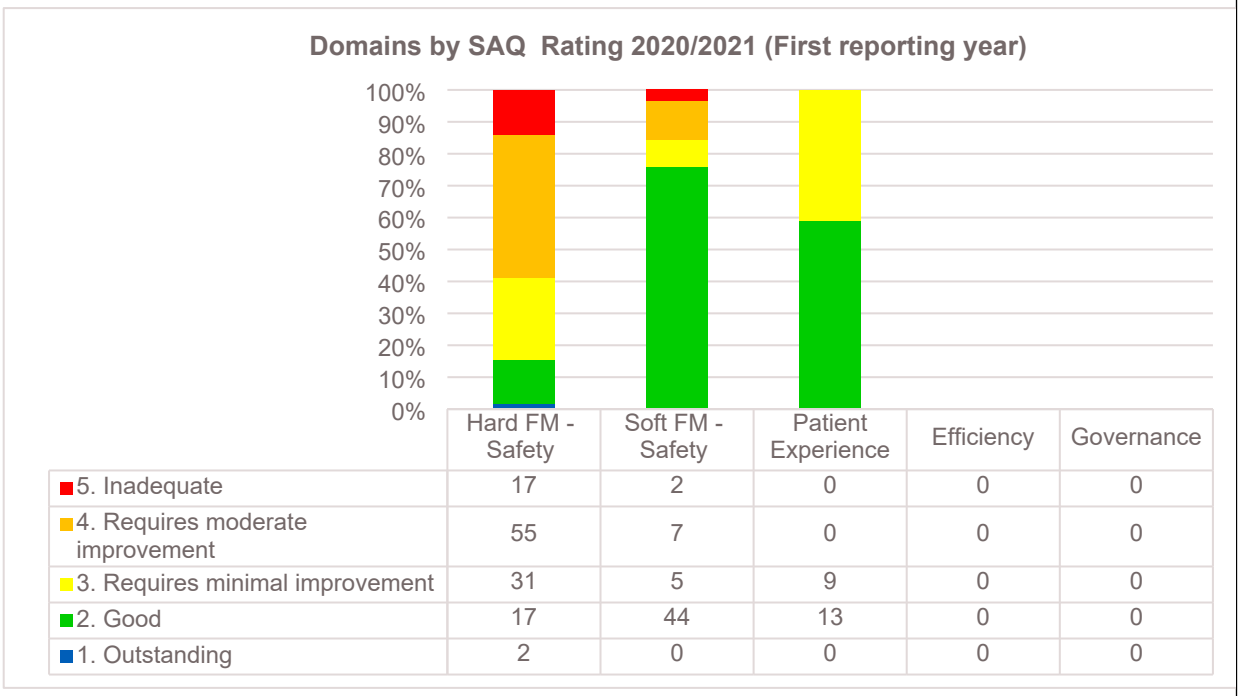
Domains by SAQ Rating 2022/2023



	Hard FM - Safety	Soft FM - Safety	Patient Experience	Efficiency	Effectiveness	Governance
5. Inadequate	0	0	0	0	0	0
4. Requires moderate improvement	5	1	0	0	3	0
3. Requires minimal improvement	48	17	2	7	5	0
2. Good	78	58	19	19	13	25
1. Outstanding	0	8	2	1	3	1



	Hard FM - Safety	Soft FM - Safety	Patient Experience	Efficiency	Governance
5. Inadequate	3	0	0	0	0
4. Requires moderate improvement	34	7	0	4	10
3. Requires minimal improvement	53	12	8	5	9
2. Good	39	42	18	16	26
1. Outstanding	1	11	1	2	3



	Hard FM - Safety	Soft FM - Safety	Patient Experience	Efficiency	Governance
5. Inadequate	17	2	0	0	0
4. Requires moderate improvement	55	7	0	0	0
3. Requires minimal improvement	31	5	9	0	0
2. Good	17	44	13	0	0
1. Outstanding	2	0	0	0	0

The 2023/2024 PAM review demonstrates significant improvement over last year, with more areas rated as 'outstanding' and 'good'. This reflects the effort and focus the Estates and Facilities departments have dedicated to compliance and governance systems. We anticipate further improvement for next year's submission, as some completed actions fell outside of this reporting period.

The division is committed to open, critical, and honest self-assessment. While this may have led to an increase in identified non-compliance in some areas this year, it will enable resolution and improvement in the coming periods, leading to a safer and better-managed Estate.

We expect to see additional improvements in next year's submission as some completed actions were finalised after the reporting period.

Summary and further actions:

The PAM review for 2023/2024 highlights the Trust's progress, with more areas achieving 'outstanding' and 'good' ratings. As this is the fourth year of submission, areas requiring improvement are already integrated into each department's PAM review process. Any new areas will be added to this plan following this submission; actions will be risk-rated and assigned to domain leads for improvement over the next year.In previous years, we utilised information from the six facet survey to generate some of the costed action plan figures that is a self assessed question found on all sub domain question sets. However, this has not been an effective way of forecasting the cost of achieving full compliance. For this reason we have moved our response for the costed action plan sections from good to requires minimal improvement as further work has been identified to develop meaningful costed action plans to achieve full compliance ratings of good or above.

This year, we will develop and populate a new template to formulate costs associated with each domain subset question to achieve compliance. The six facet survey's compliance section will still inform the costed action plans, but other audits, such as Authorised Engineers and professional assessments, will also be used to create more meaningful cost forecasts. Domains rated from 'Good' to 'outstanding' do not require a costed action plan.

A program of improvement has been initiated within Safety Hard domain leads, and the PAM results will be used to further support and clarify this program. This has been an effective driver for improving compliance, as evidenced by the progress over the last three years.

The Senior Management of E & F has provided appropriate resources and support to the PAM team and has reviewed the process at key points, providing additional resources and input as necessary to address any deficiencies in responses from other staff, where capacity allows. The current structure presents ongoing challenges in achieving dedicated roles for all subset areas, and some areas are currently being addressed on an ad-hoc basis as capacity permits.

Key Stake holders that undertook this collection and review are:
Thomas Sneddon – Deputy Head of Estate and PAM collection lead.
Laurance Arnold – Director of Corporate Development
John O'Keeffe – Head of Estates
Ian Robinson – Head of Facilities & Sustainability Lead
Terry Cropp – ETS Technical Services Manager
Jerry Henderson – Senior Estates Officer: Mechanical
Joel Lobo - Estates Officer: Mechanical
Jon Thorne - Estates Officer: Electrical
Michelle Sadler - Facilities General Manager
Richard Pearce – Switchboard & NUPT Manager
Alan Foss – Estates Operation Manager
Debbie Wall – ETS General Manager
Pete Dovey – Fire Officer

Clare Goodyear – Decontamination Lead
Jane Websdale – Waste Manager
Sue Biddle – Capital Project and Space Allocation Manager
Fiona Hyett – Deputy Director of Nursing
Troy Ready – Health and Safety Manger
Gerry Morpeth – AE (working at height) and AE(Confined Spaces)
Racheal Wye – AE(Asbestos)

Introduction:

The NHS Premises Assurance Model (PAM), developed by the English Department of Health, assists Trusts in consistently reviewing their management structures and processes. In response to the challenges highlighted in the Mid Staffordshire NHS Foundation Trust Public Inquiry, the Model and associated notes were updated and re-issued in May 2014 and January 2016.

PAM provides a Board-level overview of the Trust's organisational management, divided into six domains (with the Safety Domain further split into Hard and Soft). This review of SFT utilises the 2018 model and reflects the Trust's position as of March 31st, 2024, focusing on the preceding 12 months.

Review Methodology

As with any internal review, the grading is subjective and depends on the assessor's perspective. While time constraints during this reporting year limited stakeholder engagement, we consulted a wide range of leads to coordinate input into their respective domains. The appointment of Authorising Engineers (AE) to key Hard FM disciplines and consultation with steering groups where PAM is an agenda item also facilitated a broader approach.

This process continues to evolve. We aim to further improve stakeholder engagement and implement a more continuous assessment throughout the reporting year, rather than the post-year assessment conducted this year.

Once all the 'self-assessment questions' (SAQs) were collated, they were reviewed, and a value judgment was made on the grade to be allocated to each SAQ element. This was manually entered into the PAM toolkit.

The Process:

small working group was established to initiate the Evidence file, populating it with key names, contact details for each SAQ, and, where relevant, the elemental questions. The objective was to target the most senior managers and domain leads directly responsible for each SAQ area, thus avoiding fragmentation of evidence collection across too many staff members.

Auditing directly against PAM elements was included in the Authorising Engineers' contract. Additionally, making PAM an agenda item for all Estates subcommittees enabled a diverse cross-section of internal and external stakeholders to contribute to the process.

One-to-one support and training sessions were offered to staff undertaking the task. In some cases, commentary and evidence were generated during extended sessions. Key staff were also required to make assessments and apply the appropriate RAG rating to each area.

Once the Evidence file was deemed complete, a final review was conducted with the PAM lead, the Head of Estates, and the Head of Facilities. The full assessment was also made available to all stakeholders for review and feedback. Each SAQ element was scored within the predetermined rating system.

As meaningful costs have yet to be ascertained, the rating applied to costed action plans was either 'minor' or 'moderate improvements required', depending on the assessed level of compliance and the work needed to achieve full compliance in all areas showing non-compliance.

The final commentary and RAG rating will be submitted to the online submission portal once approval is granted.

What Constitutes Evidence?

PAM requires documented evidence of robust policies and procedures. Instead of collecting a large volume of physical documents that could become outdated, we opted to accept evidence of their existence. Within the Evidence file, staff could submit links to the Trust micro guide or Shared Drive locations. Additionally, approval, review, and expiry dates were requested, and some sensibility checks were conducted using the Evidence file's features.

Due to staff workload, further work is needed to fully complete details around evidence location and commentary. This element is not submitted to the PAM portal.

The Report:

The reporting features of PAM, as provided by the Department of Health, are somewhat limited. Due to the complexity of the spreadsheet containing the responses, adding custom reports is challenging. This report for SFT utilises the available PAM reports, with commentary provided by the PAM team involved in the exercise.

Full changes to PAM submission for 2023-2024

The below is the full extract from the PAM SAQ Annual changes section

Changes for 2024:

There has been several updates to the HBN and HTM guidance, the links within the spreadsheet remain up to date, but please familiarise yourself with the latest publications:

https://www.england.nhs.uk/estates/complete-list-of-publications-related-to-nhs-estates/

Please also note there has been some technical bulletins published this year these can be found: https://www.england.nhs.uk/estates/netb/

Safety Hard

Legislation & guidance updated.

SH16, SH17, SH18 and G2 evidence: 'The organisation demonstrates that it undertakes process to identify lessons from events and incidents, with a robust process for implementing the learning into new or amended organisational policy, procedure or ways of working'

SH4 H&S - MH wording added - (cell E47)

Mental Health (MH) service Providers (and Trusts who may treat MH patients such as A&E) should consider:

- *Ligature Reduction*
- *Barricade Reduction ironmongery*
- *Absconding Reduction*
- *Windows/Falls from Height*
- *Ceiling Height*
- *Air Locks*
- *Fence heights*
- *Bolt down Fixed Furniture and Equipment*
- *Non Pick Mastic*
- *Reduced breakable glass/plastic/fabric*
- *MH court yards and Garden/furniture*

SH4 H&S - MH wording added (cell E45)

4. The ability to report on the regulatory requirements regarding safer wards (ligature).

5. Demonstrate clear ability to report on never events relating to estates and facilities items (window restrictors/non collapsible rails/surface temperature) particularly when in relation to Mental health facilities and A&E wards.

SH10 - wording updated

•SH14 - Fire safety guidance added (cell F147)

18. Approved Document B

19. Equality Act 2010

20. Regulation 38 – operating within the building on Fire Safety.

SH19 - Safety Hard added - SH19.3 'contract expiry' and updated wording SH19.2

Previous SH20 - regarding medical gasses (Framework TBC) - removed - will be added next year if the guidance is available on this)

SH20 - removed

SH21– Added separate question regarding ligature

Safety Soft

Legislation and guidance updated

Cleanliness and infection control

Legislation and guidance updated

SS1.sub questions 15-21 wording updated slightly

SS4 - Cleanliness and infection control - Sub questions 9,10,11 added

SS4.8&9 wording added: (Although the mandatory requirement is to display in patient facing areas however a trust may choose to display in other areas so this is capturing evidence where trusts are improving standards for staff) also guidance note 'Consider ambulance cleaning supplement'

SS9 - Portering services - wording added within the guidance (cell f114):

To note we are working on guidance for portering which will be available for reference next year, covering:

- Service strategy (workforce)

- Technology and equipment

- Policy

- Working with clinical teams

SS10 - PSTN - added sub question SS10.7 - updated

Efficiency

Evidence updated:

F3 Improved efficiencies in capital procurement, refurbishments and land management guidance and evidence updated (Cell E30 and F25)

F3 Efficiency - added F3.2. 'Capital project Management' (also updated wording for F3.1)

F4 Efficiency - added F4.3. 'Board reporting and contracting'

'health system' updated, Procure 23 added - 10. NHS Net Zero Building Standard, 11. Estates Net Zero Carbon Delivery Plan (NZCDP), evidence wording updated to 'site level' 2. The organisation considers the NHS Net Zero Building Standard when undertaking construction and refurbishment projects

Effectiveness

Evidence updated (Cell E33-39)

Guidance legislation updated.

-New Transport question proposed in E4.5

- Updated E4.7 regarding procurement

-Recently published Net Zero Travel & Transport strategy added to 'relevant guidance & legislation'

Helipad - This question has been restructured to provide more evidence examples

(cell B7-9) wording added to sub questions

1.-The Trust should have a responsible person able to demonstrate and documented evidence/policy in relation to Downwash helipad factors and considerations within the Trust.

2. -The Trust should have a responsible person able to demonstrate and documented evidence/policy in relation to general helipad factors and considerations within the Trust.

3. - In addition - The Trust should have a responsible person able to demonstrate and documented evidence/policy in relation to Fire risk regarding helipad factors and considerations within the Trust.

4- Added evidence and updated questions

Maturity Tab '001' added

Overview of the outcome:

PAM Distribution of SAQ Ratings

The PAM Distribution of SAQ Ratings demonstrates a significant improvement for SFT. Last year, we reported on 350 subset questions across 50 domains. This year, we reported on 376 subset questions across 51 domains, with the addition of Anti-Ligature and a second FM maturity domain.

The following chart illustrates the change in percentage split over self-assessment grading across the four years of reporting. The arrows indicate the direction of change in this reporting period: green represents a positive change, red a negative change, and black indicates a none reporting change.

Rating	April 2020 – March 2021 Total per rating	April 2020 – March 2021 %	April 2021 – March 2022 Total per rating	April 2021 – March 2022	April **2022** – March **2023** Total per rating	April **2022** – March **2023**	April **2023** – March **2024** Total per rating	April **2023** – March **2024**	
Outstanding	2	1%	18	5%	15	4%	48	13%	↑
Good	75	22%	142	43%	215	61%	173	46%	↓
Min Improvement	46	14%	86	26%	80	23%	84	22%	↓
Mod Improvement	58	17%	55	16%	10	3%	8	2%	↓
Inadequate	18	5%	3	1%	3	1%	8	2%	↑
Not Applicable	135	40%	30	9%	27	8%	55	15%	↑
TOTAL	334	100%	334	100%	350	100%	376	100%	

While the shift is largely positive, it's important to note that the majority of the movement—both from 'Good' to 'Requires Minimal Improvement' and from 'Good' to 'Not Applicable'—is due to the revised approach to costed action plans. Nevertheless, some areas have seen a reduction in score and, consequently, an increased risk rating.

A summary of the key changes are as follows:

SH1	Estates and Facilities Operational Management
Overall, the position has improved, with the exception of a negative change in the maintenance subset questions. These have been downgraded from 'Requires Minimal Improvement' to 'Moderate'. This is primarily due to the continued use of a poorly functioning CAFM system, which leads to a lack of assurance and monitoring of the overall condition of the estate. Currently, monitoring is a manual and ad-hoc process, lacking clarity and assurance due to limited staff availability. The implementation of a new CAFM system will significantly improve this situation, and we hope to secure funding for this within the current financial year.	

SH5	Asbestos
Significant improvement has been made across the discipline, with policy and procedure moving to Outstanding.	

SH14	Fire Safety
Significant improvement has been made across the discipline, although Resilience, Emergency & Business Continuity Planning being downgraded to a Moderate improvement required. The Organisation has resilience, emergency, business continuity and escalation plans which have been reviewed by the EPRR and Fire Safety Team this year with a view to re-write and implement more robust exercising procedures with the FRS and senior management for the next year. This is planned to be back to ‘good’ by next years submission.	

SH19	Contractor Management for Soft and Hard FM services
Significant improvements have been achieved across the discipline, although Resilience, Emergency & Business Continuity Planning has been downgraded to "Moderate improvement required." The organisation has resilience, emergency, business continuity, and escalation plans that were reviewed this year by the EPRR and Fire Safety Team. The goal is to rewrite and implement more robust exercising procedures with the FRS and senior management for the next year. We anticipate a return to a "good" rating by next year's submission.	

SH20	HSIB
Healthcare Safety Investigation Branch: Once the new qualifications Medical Gas Pipeline System (MGPS) framework is published. . This was added last year with the attention it would be used from this reporting year, due to the delay in the frame work this has been removed.	

SH21	Reducing harm by ligature in practice
This sub-domain was newly added for this reporting period. Our response has been minimal, both because it's new and because it focuses on mental health trusts. However, we still have responsibilities in this area, and a responsible person within the Trust needs to be identified to advance progress in this sub-domain.	

SS1	Catering services
With the latest revision of this subset, the Trust is required to have an appointed dietician, which is not currently the case. Furthermore, the food standards stipulate that a 24/7 food service offering should be available to staff if the trust operates 24/7 services, even if food provision currently only operates during daytime hours. This area is under review to determine if and how compliance can be achieved within the Trust's operational and budgetary constraints. Consequently, this has led to a downgrade in several areas related to specific food standards, in some cases to "inadequate."	

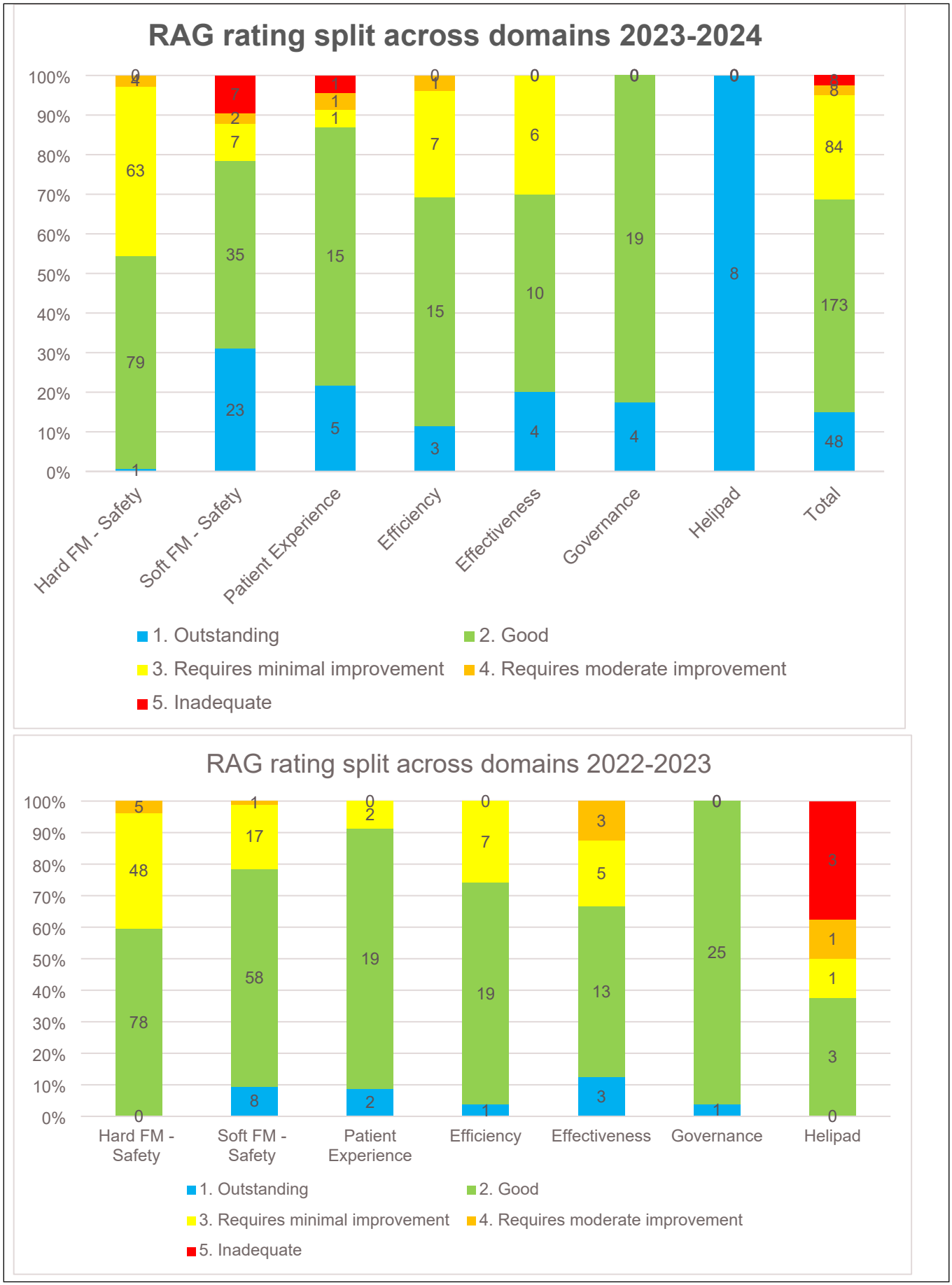
SS4	Cleanliness and Infection Control
This year has witnessed significant fluctuations within this sub-domain. Four of the subset questions have seen substantial improvement, now rated as "outstanding." However, there has also been a downgrade to "inadequate" for both Policy and Procedures and the star rating of cleanliness, as the latter is not displayed in patient areas. This is currently under review, and work is underway to improve the position before the next reporting window. Note though new mandated cleaning standards came into force on 1st May 2022, the Trust received derogation (from NHSE) against these. Whilst the team have progressed with a Trust approved implementation plan, derogation has expired and compliance has reduced to reflect this.	

P6	Catering services

This year has witnessed a significant shift in both directions within this sub-domain. Four of the subset questions have seen substantial improvement, now rated as "outstanding." However, there have also been downgrades: Policy and Procedures is now rated as "inadequate," and Regulation Compliance has been downgraded to "moderate improvement required." This situation is under review, and work is underway to improve the position before the next reporting window.

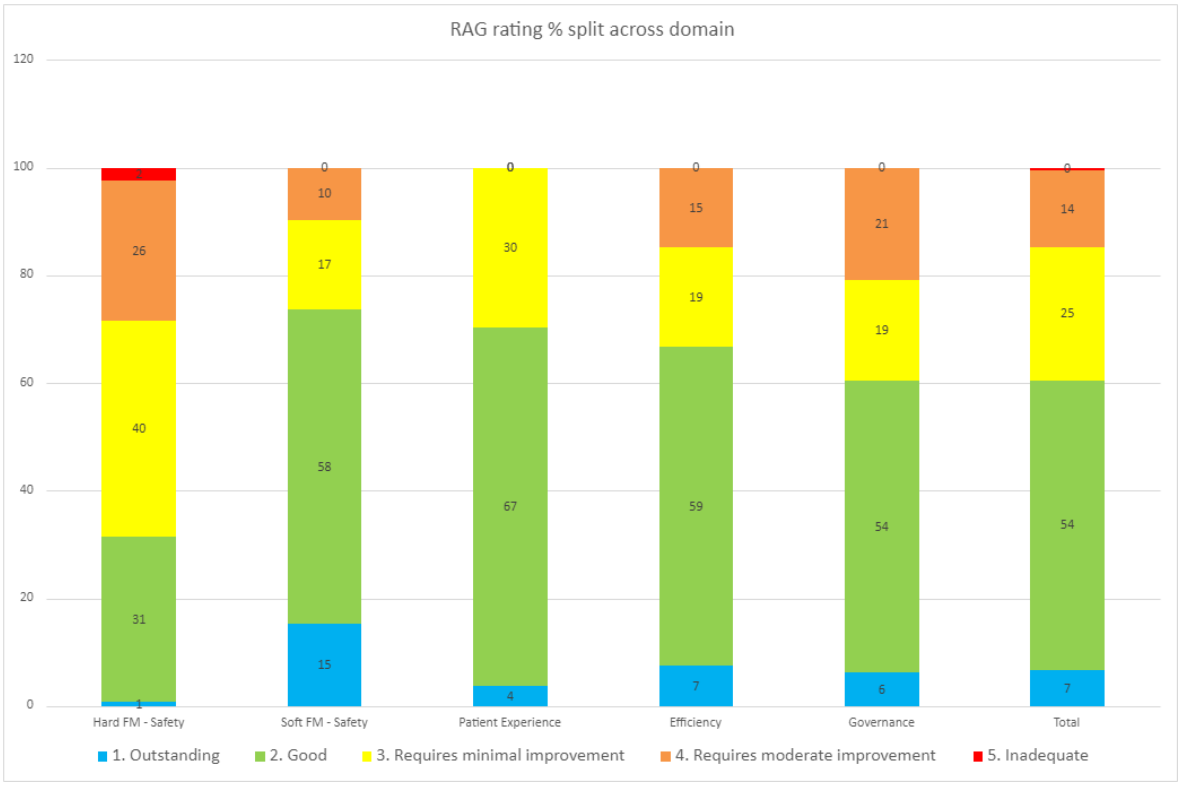
H1	FM01
This new section focuses on the central government FM maturity framework. It's acknowledged that this framework requires focused attention to fully comprehend its requirements and implications. A significant portion of the framework is designed for public sector organisations that outsource their E&F provisions, making it not directly applicable to the Trust.	

The following chart presents the breakdown of assessed domains and the overall trust performance for the 2023-2024 reporting year. Notably, the Helipad, highlighted last year as an area needing attention, now stands out with an outstanding rating across its sub-domain. In general, compliance across all domains has shown improvement.

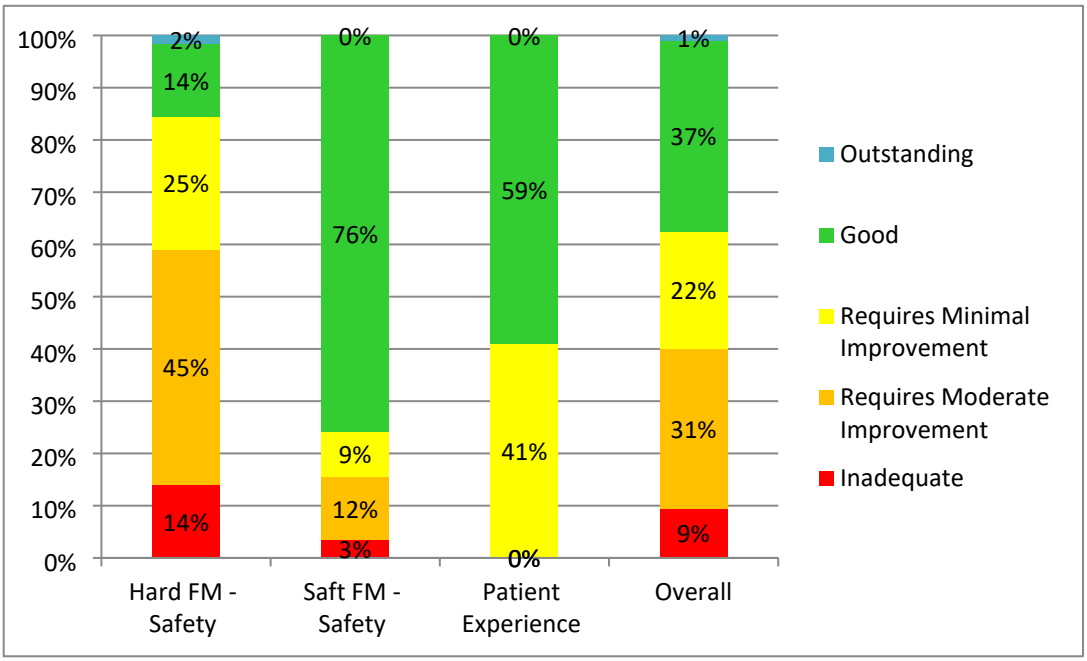

RAG rating split across domains 2023-2024
100%
90%
80%
70%
60%
50%
40%
30%
20%
10%
0%
Hard FM - Safety
Soft FM - Safety
Patient Experience
Efficiency
Effectiveness
Governance
Helipad
Total
1. Outstanding
2. Good
3. Requires minimal improvement
4. Requires moderate improvement
5. Inadequate

RAG rating split across domains 2022-2023
100%
90%
80%
70%
60%
50%
40%
30%
20%
10%
0%
Hard FM - Safety
Soft FM - Safety
Patient Experience
Efficiency
Effectiveness
Governance
Helipad
1. Outstanding
2. Good
3. Requires minimal improvement
4. Requires moderate improvement
5. Inadequate

Next are the previous two years charts for comparison:



Compared to the below chart from last reporting year (2020-2021).



Conclusion:

The Trust's Estates and Facilities staff have largely maintained a high level of compliance or made significant improvements in the Premises Assurance Method submission for the 2023-2024 reporting period. The Trust has increased its overall ratings, with significantly more "Good" and "Outstanding" assessments, particularly when considering the change in approach to costed action plans.

Although some higher risks and lower gradings have emerged in this reporting period, these risks were already present, and the division has proactively identified and is now working to address them.

Some of the most notable changes include:

- Outstanding achievement in Helipad domain compliance within 12 months
- Continued improvement across the board of Hard FM Domains
- Continued high compliance in Soft FM domains, with improved analysis of shortcomings for the purpose of resolution
- The addition of new domains: Anti-ligature and FM Maturity 1

Over the reporting period, higher-level governance has moved to a "Good" position across the board. Future work will focus primarily on maintenance, BCPs, and developing robust costed action plans.

Overall, Salisbury NHS Foundation Trust has made significant progress in its Premises Assurance Method submission for 2023-2024. The departments and domain leads are committed to continuous improvement and are confident that these improvements will further enhance the safety and security of its premises.

NHS Salisbury NHS Foundation Trust

Report to:	Trust Board Meeting in Public	Agenda item:	6.1
Date of meeting:	3 October 2024		

Report tile:	Health and Safety Report – Q1			
Status:	Information	Discussion	Assurance	Approval
	X			
Approval Process: (where has this paper been reviewed and approved):	H&S Committee and Trust Management Committee			
Prepared by:	Troy Ready – Health and Safety Manager			
Executive Sponsor: (presenting)	Melanie Whitfield – Chief People Officer			

Recommendation:

The Trust Board is asked to note the Q1 H&S performance for the 2025FY and the continued improvements in H&S performance measures against Q1 FY24 and previous quarters.

Executive Summary:

There continues to be a significant reduction in the number of lost time injuries and the amount of time lost compared to Q1 last year and Q4. A Q1 comparison with FY24 shows:

- A fall in the number of lost time injuries reported from 12 (Q1 FY24) to 4 (Q1 FY25).
- A fall in the number of days lost due to work related injuries from 76 days (Q1 FY24) to 32 (Q1FY25).
- The frequency of lost time injuries against hours worked continues to track lower from 40 to 5.
- The amount of time lost against hours worked is also tracking lower from 22 to 8.

There were significantly less incidents reported in Q1 last year (54) compared to the 127 reported in FY25. The H&S team has strengthened search criteria on Datix to ensure increased awareness of all incidents and responds to incidents in a timely manner. Staff now expect a response to a datix report and as a result there is an increase in reports – a trend that continued throughout last year.

The H&S Manager remains apprehensive about considerable improvements in H&S performance over the past 12 – 18 months, yet there is no information available to suggest results are incorrect. All time lost reported in the H&S report has been cross referenced with absence data, datix reports and anecdotal information available for ward managers to corroborate work related absences. There remains evidence of late reported injuries but these are captured within each quarter or reported in subsequent quarterly reports.

Exposure to violence, aggression and anti social behaviour remains the most reported incident. The H&S team continue to focus on actions to manage this risk as much as is reasonably practicable. Violence prevention and breakaway training continues and is well attended, the Violence Prevention and Reduction Policy was ratified, the No Excuse for Abuse Campaign is almost finalised, risk assessments have been completed by the H&S team and clinical staff undertake dynamic patient assessments where a risk of violence is identified. Lastly, the Design Council initiatives to reduce violence and aggression in ED have been installed. Where violence and aggression is reported, the H&S team escalate all reports of violence and aggression to divisions and respond directly to staff who have reported such acts against them. A number of yellow cards have been issued by Divisions in response to patient and relative behaviour.

The H&S team continue to facilitate ward inspections and risk assessments, conduct task analysis and audit departments as scheduled. The H&S schedule is due to be completed towards the end of 2024 and will be updated for the next 24 months.

The H&S report also includes an overview of all risks that have an element of H&S with a risk score of 8 or above (high risk). Although each Division has a responsibility for ensuring all risks are appropriately graded with sufficient actions in place, the purpose of identifying high risks in the H&S report is to provide further oversight of the risks that pose an increased liability to the Trust should harm occur, as a result of the greater consequence, or likelihood of harm, that comes with high risks.

On a final note, the H&S Manager continues to consult with internal stakeholders to reduce the movement of tugs within internal corridors. A final paper with agreed actions is expected to be finalised at the next H&S committee in December.

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

HEALTH AND SAFETY PERFORMANCE REPORT
FY25 - QUARTER 1

Salisbury NHS Foundation Trust

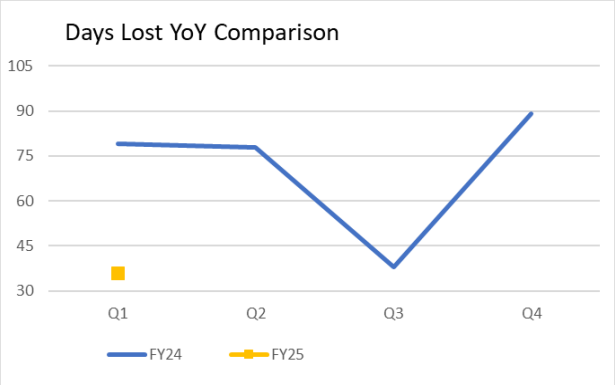
1. Performance Measures

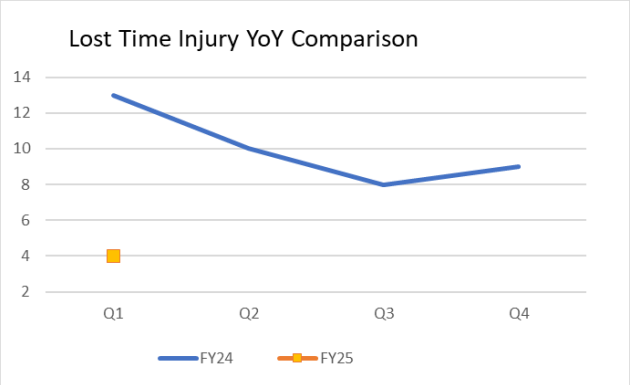
The ongoing downward trend of lost time injuries and the volume of time lost continues. A number of injuries reported did not result in time lost as staff where not rostered to work the following days and returned to work as rostered. Of the 4 lost time injuries reported in Q1, 2 were reportable (RIDDOR) to the Health and Safety Executive (HSE). At the time of reporting, there has been no formal follow up, request for further information, or notice of intention to inspect the site. This is not surprising given the nature of the injuries reported, and the actions taken by the Trust, before and after the injury, to reduce the risk of harm.

Injury and Frequency Rates by Division

	Days Lost	YTD	LTI	YTD	LTIFR	YTD	LTFR	YTD	Near Miss	YTD	RIDDOR	YTD
Estates & Facilities	21		1		5.2		8.2		1		1	
Surgery	7		1		1.3		0.7		6		1	
Medicine	4		2		3.4		0.5		5			
W&N	-		-		-		-					
CSFS	-		-		-		-		6			
Corporate	-		-		-		-					
Total	**32**		**4**		**1.5**		**0.9**		**18**		**2**	

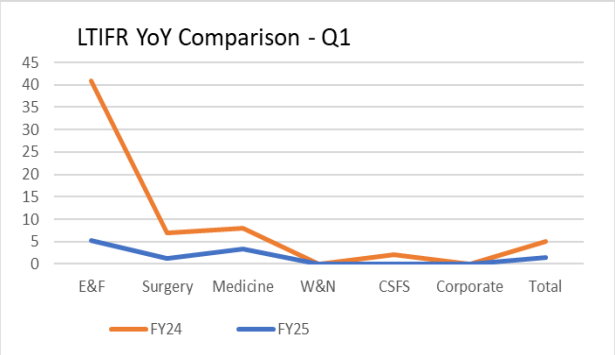
Definitions:
Days lost are the accumulated total of days lost because staff are unfit to work due to work related injury reported in that quarter.
Lost Time Injury Frequency Rate (LTIFR) measures work related hours lost per 1,000,000 hours.
Lost Time Frequency Rate (LTFR) measures work related hours lost per 10,000 hours.
RIDDOR is an incident that must be reported to the Health and Safety Executive
Near Miss is an incident that did not result in harm to staff.

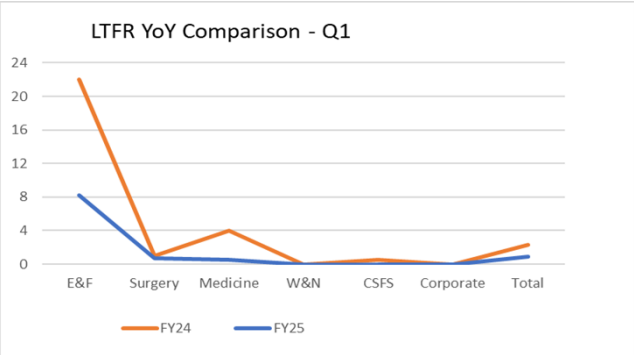


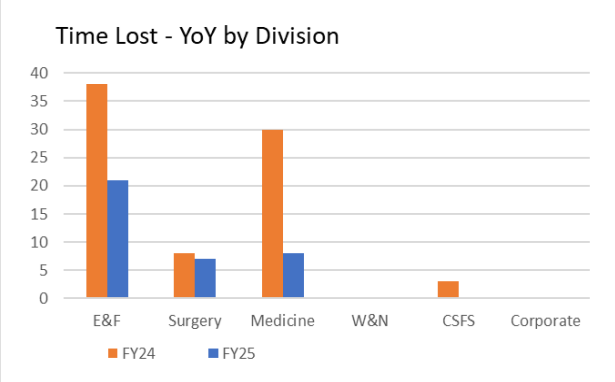


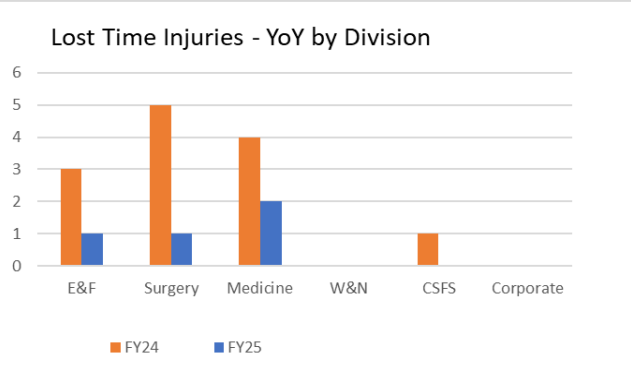
As seen above, days lost across the Trust fell from 78 in Q1 FY24, to 33 in Q1 FY25 and the number of lost time injuries reported fell from 13 to 4. The reduction in frequency rates (as seen in the graphs below) show a reduction across all Divisions and stem from the reduction in injuries and against a modest increase in hours worked in Q4 last FY.

Whilst Facilities saw the highest amount of lost time, this is the result of 1 injury and is still down on this time last year.









As noted in the Annual Health and Safety Report FY24, there is no specific reason the author of the report can point to explain such a significant reduction in injury rates, or consequences. The coming quarters will act as an indicator of whether sustained reductions in injuries across the Trust are being achieved or if there are fluctuations in performance that suggest otherwise there is work still to be done.

2.1 Injury Statistics

As noted in the table below, violence and aggression remains the most reported incident and injury type, and whilst the number of incidents reported is significantly higher than this time last year, performance in Q1 this year is more consistent with the overall quarterly pattern in FY24.

Datix Reports by Type	**Q1**		**YTD**	
	FY24	**FY25**	**FY24**	**FY25**
Violence and aggression	26	33		
• Antisocial behaviour	-	(11)		
• Violence and Aggression – mental health	-	(16)		
• Violence and Aggression – confusion and delirium	-	(6)		
Manual handling	3	11		
Struck an object	2	3		
Near miss	-	23		
Damage, broken equipment and Infrastructure failure		10		
Slip and trips	6	14		
Struck by a moving object	8	11		
Other		8		
Exposure to sharps	3	11		
Biological exposure		4		
Radiation exposure		1		
Chemical exposure	3	-		
Lacerations		8		
Total	**54**	**127**		

2.1.1 Violence and Aggression

Patterns to violence and aggression are becoming clearer as more data is received and assessed. The number of incidents reported as disturbances without elements of violence and aggression have been removed and with this the number of injuries and incidents associated with confusion and dementia has fallen as an overall proportion of incidents and mental health is now the most prevalent. There is no consistency in these results but does show the need to provide a tailored response to each type of violence.

The H&S Team, divisional nursing teams and Violence Prevention and Reduction Working Group continue to develop and implement actions to reduce the risk of violence and manage the consequences should events occur. Actions include:

2.1.2 Staff Follow Up

As outlined in the Guidance on Managing Behaviour Flowchart within the Violence Prevention and Reduction Policy, staff exposed to violence and aggression can expect to be contacted by the H&S team and senior nursing staff. The H&S team is involved in a daily huddle with senior nursing staff to ensure there is communication and follow up of incidents, especially related to violence and aggression. For the most part the H&S team and divisional nursing teams respond to staff in the day following an injury report. Whilst there is evidence of an immediate response to violence and aggression in some areas, the response is not uniformly implemented. The concept of the hot debrief, that involves senior divisional managers or on call before staff leave has received positive feedback and is well received. Doing so as a standard response, at the time of an act of violence and aggression, is the next step in the continued maturity of H&S management.

2.1.3 External Training

Q1 saw a reduction in attendees at the externally facilitated Positive Management of Violence and Aggression and Breakaway training, with the course scheduled in June cancelled due to insufficient numbers.

There are only 2 courses scheduled in Q2 due to the popularity of leave during the summer period. Discussions with ward leaders, Matrons and Divisional Heads of Nursing have seen attendance increase and courses are oversubscribed. The 6 courses scheduled in Q3 are all over subscribed with strong attendance from Sarum, Radnor, ED, Durrington, Redlynch and Farley Wards.

2.1.4 Violence Prevention and Reduction Policy

The Violence Prevention and Reduction Policy has been approved by the Violence Prevention and Reduction Working Group, Health and Safety Committee and the Organisational Development and People Management Board. The policy has now been released and is in use across the Trust.

2.1.5 No Excuse for Abuse

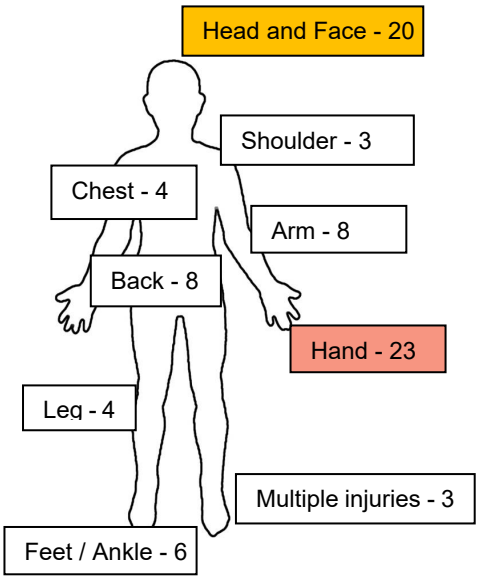
June TMC agreed a number of Trust employees would have their photos taken for the No Excuse for Abuse Campaign. The template poster and wording has been agreed and the Communications Team are coordinating images with respective individuals.

2.1.6 Design Council Project

Q1 saw the installation of the Design Council's Reducing Violence and Aggression in A&E Through a Better Experience Scheme. The basis of the Design Councils approach is to improve the arrival, and waiting experience, for patients and carers through the provision of information about the ED journey. By communicating what to expect at each step of the ED journey, the Design Council found user anxiety fell and with that anxiety and the escalation of anxiety and stress towards violence and anti social behaviour.

It should be noted, this scheme is not a panacea for all acts of violence and aggression but is instead part of the overall Trust strategy to reduce violence and aggression towards staff.

2.2 Injuries by Body Location



Of the 20 injuries sustained to the head and face, 10 were the result of violence and aggression from confused patients.

Of the 23 hand injuries sustained 11 were the result of needlestick injuries to doctors, nurses and students.

2.3 Management and Internal Movement of Tugs

The Health and Safety Executive outlines actions to reduce the risk from moving traffic in the Health and Safety Guide to Workplace Transport Safety (HSG136). Actions that include, but are not limited to, one way systems and the separation of pedestrians and vehicles. When considering the majority of tugs travel past Sarum Ward (children), Maternity (new parents), Breamore Ward (the elderly) and towards the eye clinic (vision impaired), the lack of distance between moving vehicles and presence of high risk pedestrians suggests the Trust must consider reasonable means of segregation, and steps to reduce the use of tugs where possible to demonstrate controls that reduce the risk of injury.

There have been a number of tug related incidents reported that have caused damage to doors, medical equipment and vending machines, there has been near misses with pedestrians and 1 incident where a staff member was struck by a tug whilst walking from a doorway. All incidents occurred in the link bridge, leading to the link bridge, the corridors of Maternity Hill and towards Victoria Drive East. The repairs for which have been estimated by the Estates Team to be around £40,000 per year and are adjacent to those high risk patients listed above.

There is no immediate alternative available to eliminate the use of tugs on site without introducing other risks to health and safety. But there is considerable scope to determine the purpose for which tugs are used, or more importantly, not used.

During May and June the H&S team has been reviewing the use of tugs, incidents involving tugs and held discussions with tug user groups to understand the impact of changing the routes tugs travel. Two key changes are recommended as part of these discussions.

First, the use of tugs as an efficient means to travel across the site is not a sufficient reason to operate a tug in internal corridors and should be prohibited. Examples of tugs used for convenience witnessed include delivering:

- pharmacy supplies.
- boxes of cereal, milk and bread.
- individual serves of jelly.
- an oxygen cylinder.

If tugs are to be used for convenient purposed, their use should be limited to external spaces, in much the same way security, or the postal team, use tugs.

Second, where tugs are required, changes to the direction of travel by way of a one way system that avoids travel down Maternity Hill for the majority of tugs, rerouting travel paths onto external roads where practical and utilising the Level 2 carousel entrance to access Levels 3 and 4 is expected to significantly reduce the volume of tugs travelling in those high risk pedestrians areas between Sarum Ward and the Executive offices.

The one department most affected by this change is the waste team who expect to see an increase in time taken for the completion of internal waste collection services. The team could not estimate how much of an increase this would be and this impact would need to be monitored but when weighing the risk to the H&S of staff and patients or efficiency of a service on a balance of what is reasonable, the risk to the H&S of staff and patients takes precedence.

The exceptions to the above rules would be:

1. Kitchen tugs delivering food services trolleys to Imber, Maternity, Breamore and Spinal, who would be expected to travel up and down Maternity Hill,
2. Grounds and Waste Team emptying waste whilst traveling up Maternity Hill corridor.

All tug using departments have voiced a degree of concern about the impact this may have and there are ongoing discussions on routes and the impact of changes. It is expected that a formal traffic plan with mapped out routes, the impact of changes and the costs of any additional manual handling equipment such as trolley movers will be available in Q2.

Of greatest significance to the Trust is the decision when balancing efficiency of a service and the risk to the safety of pedestrians. Prioritising efficiency over safety would, in a court of competent jurisdiction, fall short of the actions of a person exercising reasonable care and expose individuals to personal liability.

2.4 Auditing

During Q1 the H&S team audited Odstock Ward, Amesbury Ward and the Medical Engineering Department.

Another frequent action identified during audits is the lack of specific risk assessments. In response to this the H&S team has created a number of sessions in Q1 with ward sisters to complete risk assessments for ward specific risks and documenting the actions taken to reduce the risk to staff. 11 ward risk assessments have been completed in Q1 and more are scheduled for Q2 with the H&S team.

2.5 Ward Inspections

The H&S team coordinated the completion of annual ward inspections at the latter part of the 24FY. Inspections continued during Q1 with 30 inspections completed and more scheduled for Q2.

2.6 Lone Working Policy

There are a number of departments that have staff working remotely either in a patient home, in a satellite space or in isolation. Some departments have local procedures to manage the risk of lone working but there is no trust policy on the management of risks to the H&S of staff in this situation.

A draft Lone Working Policy has been developed and presented to the H&S Committee for discussion and approval.

2.7 Nitrous Oxide

In preparation of pressure testing of nitrous oxide, the H&S Team identified a significant leak of nitrous oxide on Theatre 1 in the early hours before theatres were operational. Subsequent testing was conducted during theatre hours and no leak was identified. Further testing out of hours showed the leak was present again.

The out of hours leak was communicated to anaesthetic and surgical staff and surgery continued whilst out of hours works were undertaken to engage a contractor to repair the leak.

2.8 Trust H&S Risks

Triangulation of Data
The triangulation of information between the H&S team and specific departments / divisions continues. Specifically, the Estates and H&S team formally review risks and discuss action plans where there is a H&S element to estates risks.

Freedom to Speak Up Guardian

As H&S audits continue, non H&S related topics are often raised. During the Amesbury audit the H&S Manager spoke to staff undertaking bay watch of confused patients. Discussions picked up themes around inexperienced staff in charge of a ward, challenges between staff and evidence of staff performing task based care rather than patient oriented care. As an example, a patient was woken 3 times during 90 minutes for individual tasks that could have been done at the same time (sheets changed and went to sleep, woken up to sit out of bed only to realise a hoist and physio was needed, woken again for observations and a drink). It is on this background that confused patients get frustrated and subsequently lash out at staff.

Another issue was raised about the information made available to staff when recruited from overseas. Staff communicated concerns about the staff accommodation, accommodation in Salisbury and isolation within the community. During the audit staff were asked if being aware of such issues would prevent them coming to work at Salisbury. Staff responded by saying no, but they could have prepared and saved more to enable a better transition when they arrive.

The H&S Manager continues to raise any themes identified with the F2SU Guardian who then escalates any shared themes through the F2SU Guardian reporting structure. There is also separate reporting to the We are Safe and Healthy Group (WASAH) where issues raised are presented by the chair of the WASAH Group to the Organisational Development and Organisation Management Committee.

Risk Register

Although each Division has a responsibility for ensuring all risks are appropriately graded with sufficient actions in place, the H&S Committee has asked for guidelines on what risks, listed on the Trust Risk Register, will be elevated to the H&S Committee.

Each H&S report will focus on identifying high risks (with a score of 8 or more, and where there is a H&S element described. The exception to this rule is where risks are beyond the control of the Trust to manage, or do not have a direct H&S risk. The focus on high risks stems from the greater consequence, or increased likelihood, of harm and therefore the greater liability to the Trust should harm occur.

The risks currently on the Trust Risk Register that meet the above guidelines are **attached** as Appendix A with those highlighted in yellow beyond their review date.

Report written by

Troy Ready

Health and Safety Manager

August 2024

HEALTH AND SAFETY PERFORMANCE REPORT

FY25 - QUARTER 1

Salisbury NHS Foundation Trust

Appendix A –Risks with a H&S Element on Trust Risk Register

Cells highlighted in yellow are risks with an overdue review date

Risk ID	Directorate	Location	Description	Current Rating	Review date	Controls in place
7066	Operations	Trustwide	On 23rd of September 2021, The Trust in conjunction with Wiltshire Counter Terrorism Police held a Marauding Terrorist Attack (MTA) Table Top Exercise which brought to light a Lack of a Robust Real Time Mass Notification System in case of an Emergency within the Hospital. This may result in lack of proper response and resilience which could cause loss of lives due to lack of situational awareness on the part of the occupants.	10	01/03/2024	Currently The Trust relies on Comms to broadcast messages via email Bleeps can be used to send urgent messages Desk Phones and Mobile phones can be used to pass urgent notification
3129	Surgery	Vascular Assessment & Diabetes Unit	Risk of RSI to sonographers due to job role.	12	24/04/2024	[26/03/2015 14:27:40] Incident reporting of RSI. Ergonomic beds in place, adjustable chairs in place, multiskilling of staff and assessment / training screeners as well as Sonography. Variable appointment system, appointments mixed whenever possible. Breaks allocated in appointment system. Feedback from staff meetings. Manual handling equipment hoist and slide sheets at SDH.
7802	Medicine	MHLT	Office space suitable for maximum of 5 people being used for a team of 13 people plus students.. No storage space so items stored under desks preventing suitable leg space. No wall space for monitoring patient caseload and plans impacting on information governance. Unsuitable workstation space impacting on staff health. General over crowding impacting on staff wellbeing in a very stressful role with an increased risk of staff absence.	10	03/06/2024	Liaising with space management at SFT for more suitable office space. Currently using break out rooms within the department separating the team however limited computer and telephone access. Staff working from library, other available office space and home when no available space within office.

6955	Facilities	Waste	Vehicles enter the area between the Waste Transfer Store and Procurement Store / Estates Store where staff are moving goods and bins around. There is a risk that a member of staff is struck by a passing vehicle or that Trust or Contractor Assets are damaged.	8	01/08/2024	Procurement Team put a sign across the road hanging from 2 hazard cones which reads "Fork Lift Trucks Operate in this Area". TWO CCTV cameras were installed and finally went live in June 2022 providing cover of the area between Waste Store & Procurement Store, with supporting warning signage re CCTV. Barrier still used.
7931	Surgery	Main Theatres	The inadequate availability of sockets for medical equipment poses a concern, further compounded by the absence of dedicated IPS/UPS sockets. These shortcomings may compromise the reliability and safety of critical healthcare infrastructure, warranting attention to mitigate potential hazards and ensure functionality of medical equipment.	16	01/08/2024	Updated 18.06.24 - Weekly PPM visual check of power points and extension leads to check no broken points.
7778	CSFS	Radiology	Theatre scheduling dictates a need to move these x-ray units between main theatres and DSU. There have been multiple reports from Radiology staff of theatres staff moving the x-ray equipment with less than the agreed minimum of 3 members of staff. Should loss of control of the equipment on the link corridor hill occur this is a significant health and safety risk. A comparatively minor secondary concern is that frequent moving of the x-ray equipment on un even ground can cause damage to the equipment which would be classed as accidental damage and so be outside the scope of maintenance agreements.	9	30/08/2024	Agreement in place to only move the kit with at least 3 people.
7959	Surgery	Odstock Ward	As part of the on-going water safety checks due to still having pseudomonas counts from the ward template, Odstock is not sufficiently evidencing adherence to daily flushing of outlets.	8	04/09/2024	Daily check sheet to evidence daily flushing. This is expected to be complete by Odstock ward staff. Ward clerks send off monthly completed sheets to estates to evidence this has been completed

5875	Medicine	Medicine Directorate	Potential or actual risk of harm to patients and/or staff members caused by violent or aggressive patients on the hospital site. For the Medicine Directorate this is a particular risk on Farley Stroke Unit, Whiteparish, Spire, AMU, ED Durrington and Pitton Wards. The main source of violence and aggression directed at staff and patients is from patients themselves and in the main is from those patients who are suffering from dementia/mental health/substance, alcohol/abuse.	15	20/09/2024	Trust security team responding immediately to incidents of violence and aggression and who can also help to de-escalate situations. Identified high risk areas with risk assessments/directorate level risk assessment. The Trust has an identified training provider for physical intervention, training has commenced with the security dept and individuals in high risk areas. Violence and aggression sub group monitor all incidents. Debriefs available following moderate or severe incidents. 24/7 security guard VERA process, Datix reporting encouraged when appropriate, Patient risk assessments completed for high risk patients, dementia training, MCA training, joint working with AWP, escalation to clinical site teams and duty managers out of hours Patient 'specials' arranged. Trust wide violence and aggression working group now in place. Mental operational group also has a section to discuss V&A.
7841	Medicine	Emergency Department	ED has not provided CBRN training for >18 months leaving a deficit in this skill within ED. As a result ED and SFT will not meet requirements set by NHSE EPRR Core Standards. There is a risk of patient and staff harm and delay to treatment if a CBRN incident were to occur this may also result in a loss of reputation at SFT	8	01/10/2024	Audit of CBRN Equipment, training within the department and protected admin time for Band 7 with CBRN in portfolio
7927	Surgery	Odstock Ward	Odstock ward historically nurses a high volume of patients and extending families with challenging behaviours. Staff are therefore at a higher risk of experiencing violence and aggression. There is a risk staff could be injured, or traumatized by this, leading to time off from work.	8	02/10/2024	Low tolerance of abuse to staff Behavioural contracts Security support
7993	Facilities	Accomodation	The accommodation waste compound is continually abused by the residents who throw their domestic waste on the floor of the compound, even when there is room in the council operated bins. This has meant over the years that the W & G Team have had to clean it up as the Council's waste contractor team will not empty the bins when there is a mess. The issue has exacerbated year on year and communication efforts by Accommodation management have failed to get compliance from the residents.	10	28/10/2024	Fly Tipping: There is a CCTV camera opposite which has caught some fly tippers. Use of Compound & Carts: Accommodation management email residents requesting them to use the waste carts to no avail. Posters on fences are ignored.
8207	W&N	Fertility Centre	External inspection carried out by the HEFA in the fertility centre. Concerns were raised about the nitrogen generator room and the potential of a fire hazard due to the size of the room and the storage of multiple cardboard boxes.	8	31/10/2024	Trust health and safety inspection requested, they will do an inspection with the fire officer 06/09/2024. Current controls will be updated post inspection

7917	Surgery	Main Theatres	As a result of the storage of equipment in corridors. Hazards to staff/patients and visitors should they need to evacuate. Restricted egress in an emergency, fire doors being restricted from closing due to racking, fire extinguishers being obscured, emergency exit signage being obscured. Potential hazards to the Fire & Rescue Service should they be required to fight a fire within the area due to equipment and cylinder storage. Risk that staff will have difficulty transferring patients into theatres.	15	27/11/2024	Areas cleared as best as possible so that a theatre trolley can be evacuated out of all the theatres using all designated routes. All fire doors and extinguishers cleared of obstructions. Fire Team to conduct a weekly walk round as a minimum. Designated Fire Safety keyworker(s). Fire Safety and Arson Policy Training for all band 6's and 7's in process and for next year.
6492	Surgery	Day Surgery Unit	Due to the lack of required structural integrity in theatre A and B, there is a risk that the Trust is non compliant with Laser legislation, which may result in the failure of a laser safety inspection.	8	01/01/2025	Non fixed mobile screen, which is not laser compliant, is moved to and placed between between the theatres A and B when laser is operational in Theatre A. Safety signs are in place on doors when laser is in use. Mobile screen with Laser notice in situ, is at the layup entrance to theatre A. Limited access to theatres.
7981	CSFS	Wessex Rehabilitation Centre	A risk assessment has been completed for the use of paraffin candle wax at Wessex Rehab. Numbering of risk elements and their corresponding controls will follow though this form.	10	03/02/2025	To mitigate the risk, the wax bath undergoes regular inspection by staff and PAT tests as per Trust arrangements. The bath is kept in an area separate to the workshop with minimal other equipment and fire doors. The bath is well ventilated and appropriately positioned in this room. Patients are warned that the wax will be hot, and tooling is sharp before participating. Temperature checks are carried out of the molten wax prior to each use as needs to be heated to 95' then cooled down to 65' before using. Spillages to clothing do not result in permanent stain or damage. Staff have time allocated to ensure the wax area is kept clean. All staff who deal with the wax are trained in how to manage to avoid any spillages down drains.

NHS Salisbury NHS Foundation Trust

Report to:	Trust Public Board	Agenda item:	6.2
Date of meeting:	3rd October 2024		

Report title:	OD&P Annual Report FY 23/24			
Status:	Information	Discussion	Assurance	Approval
			Yes	Yes
Approval Process: (where has this paper been reviewed and approved):	OD&P Management Board 17 Sep 24 People and Culture Committee 26 Sep 24			
Prepared by:	Ian Crowley, Deputy Chief People Officer			
Executive Sponsor: (presenting)	Melanie Whitfield, Chief People Officer			

Recommendation:

The Trust Board is requested to **Note** the breadth of detail contained in the first OD&P Annual Report and **approve** the report.

Executive Summary:

The OD&P Annual Report summarises the achievements of the OD&P Directorate in Financial Year 23/24 and will be published on the Trust intranet site after ratification at Trust Board.

This annual report provides a synopsis of the achievements of the Organisational Development and People Directorate in FY23/24 against the SFT People Plan 22-27. Progress has been positive, and it is particularly pleasing to see that SFT was the most improved Trust in the 2023 Staff Survey results published in March 24. The decision to bid to be an NHS People Promise exemplar site for 22-24 has driven positive outcomes and enabled SFT to look across all seven elements of the People Promise in both our routine service delivery, and within our continuous improvement projects.

The directorate has expended significant energy and enthusiasm to drive forward new initiatives in each element of the people promise, achieving its ambitions in all but one area, that of 'we are always learning'. The score for this element of the people promise improved this year, but not to the planned level and remains below the national average. It should be noted that the questions relating to this element are dominated by the impact of appraisals in the Trust and this is an area already identified for further work next year as the Trust appraisal rates are below average.

The report is structured into two sections, the first covers people promise achievements, whilst the second deals with the areas of the directorate which provide a service for the trust daily.

Driving much of the effort of the directorate in FY 23/24 was work to support delivery of the trust's breakthrough objective relating to staff availability and it is pleasing to see that Agency Spend was much reduced in year, through a combination of initiatives and work which reduced our vacancies to below the 5% target, improved sickness absence rates by over 1%, made modest inroads into our retention figures and supported management of agency spend through improved an temporary staffing service.

The Directorate has suffered a number of longer-term sickness absences and some vacancies which have hampered our ability to deliver at pace across the broad range of specialities in the Directorate, and priorities have had to be adjusted to maintain momentum in critical areas. Notwithstanding these challenges, significant progress has been made against our people plan ambition, and this report identifies a solid base from which to progress further in the next 2 years.

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

Organisational Development and People Directorate

Annual Report 2023/24

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

1.0 Executive Summary

This annual report provides a synopsis of the achievements of the Organisational Development and People Directorate in FY23/24 against the SFT People Plan 22-26. Progress has been positive, and it is particularly pleasing to see that SFT was the most improved Trust in the 2023 Staff Survey results published in March 24. The decision to bid to be an NHS People Promise exemplar site for 22-24 has driven positive outcomes and enabled SFT to look across all seven elements of the People Promise in both our routine service delivery, and within our continuous improvement projects.

The directorate has expended significant energy and enthusiasm to drive forward new initiatives in each element of the people promise, achieving its ambitions in all but one area, that of 'we are always learning'. The score for this element of the people promise improved this year, but not to the planned level and remains below the national average. It should be noted that the questions relating to this element are dominated by the impact of appraisals in the Trust and this is an area already identified for further work next year as the Trust appraisal rates are below average.

The report is structured into two sections, the first covers people promise achievements, whilst the second deals with the areas of the directorate which provide a service for the trust daily.

Driving much of the effort of the directorate in FY 23/24 was work to support delivery of the trust's breakthrough objective relating to staff availability and it is pleasing to see that Agency Spend was much reduced in year, through a combination of initiatives and work which reduced our vacancies to below the 5% target, improved sickness absence rates by over 1%, made modest inroads into our retention figures and supported management of agency spend through improved an temporary staffing service.

The Directorate has suffered a number of longer-term sickness absences and some vacancies which have hampered our ability to deliver at pace across the broad range of specialities in the Directorate, and priorities have had to be adjusted to maintain momentum in critical areas. Notwithstanding these challenges, significant progress has been made against our people plan ambition, and this report identifies a solid base from which to progress further in the next 2 years.

2.0 Delivering the People Promise

2.1 **Introduction**. Salisbury NHS Foundation Trust is an NHSE sponsored People Promise Exemplar site, receiving funding to support a people promise manager role between April 2022 and March 2024.

"*The purpose of an exemplar site is to test the assumption that optimum delivery of all NHS People Promise interventions delivered in one place simultaneously can deliver improved staff experience and retention outcomes, beyond the sum of the individual components."*

Delivery of the People Promise was woven into the 5-year People Plan for OD&P from the outset. The Deputy Chief People Officer (DCPO) and Associate Directors (AD) hold oversight of specific People Promise elements and each Head of Department has People Promise improvement activities and projects included within their work portfolio. Activity is monitored and coordinated by the People Promise Manager (PPM) and overseen by the Chief People Officer (CPO). During Financial Year 2022/23 (FY 22/23) we laid foundations for 47 project areas or activities to be carried out against all seven elements of the People Promise. In FY 23/24 we began to see the outcomes of those workstreams and the impact that they had on the experiences of Staff at SFT. The People Promise is regularly reported to OD&P Management Board and People and Culture Committee with individual workstreams or projects that require financial approval taken through Trust management Committee, Finance and Audit committee or the Executive Directors meetings.

SFT has been unusual in the scale and depth of the wide programme approach we have taken to delivering the people promise elements within the Trust. We identified multiple activities against each element of the People Promise (rather than single issues or a couple of activities against some of the areas). This approach has borne fruit seeing SFT achieve the most improved performance across Acute and Community trusts within the Staff Survey 2023 results.

Our achievements and the associated metrics from are illustrated in the table at Appendix 1 to this report.

2.2 **People Promise Activity**. At a programme level we set ourselves year on year ambitions against the NHS Survey which provides an annual picture of how staff perceive their experiences at the Trust. Figure 1 (below) shows that we met all but one of the ambitions we set for the 2023 survey.

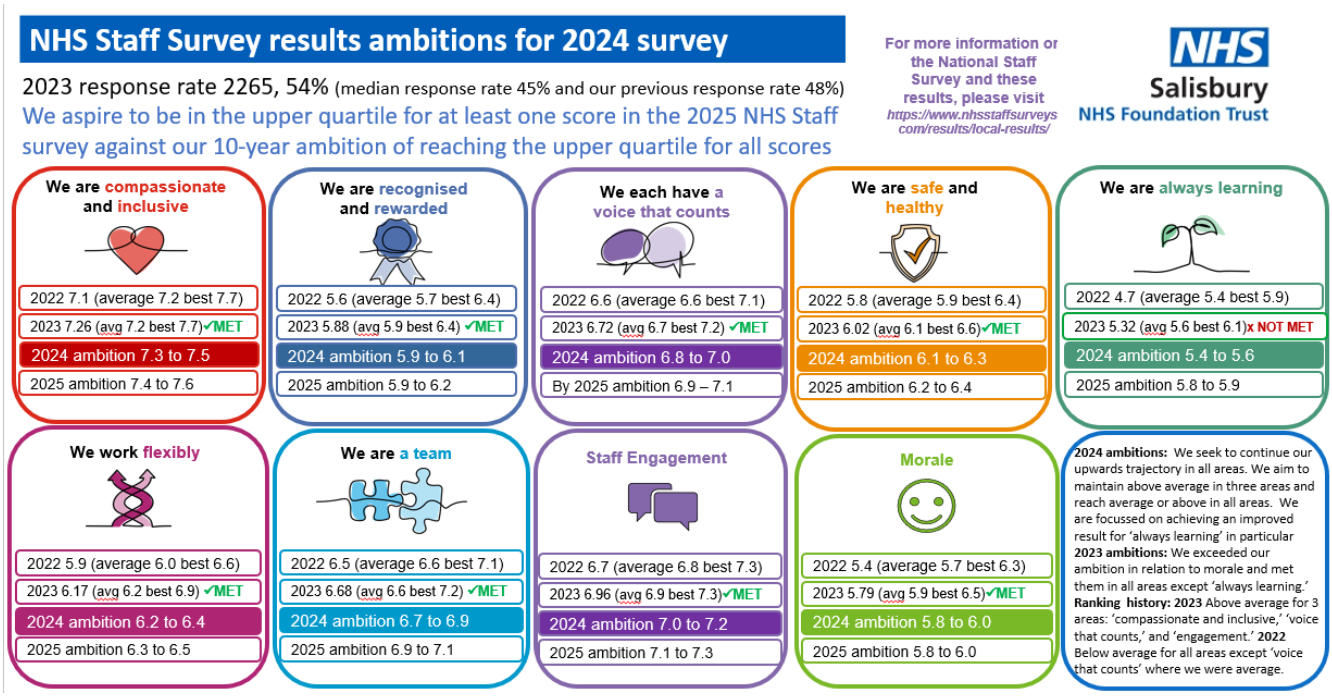


Figure 1: SFT People Promise Ambitions

Overall, SFT moved to above average in three people promise element areas, shown below in Figure 2.

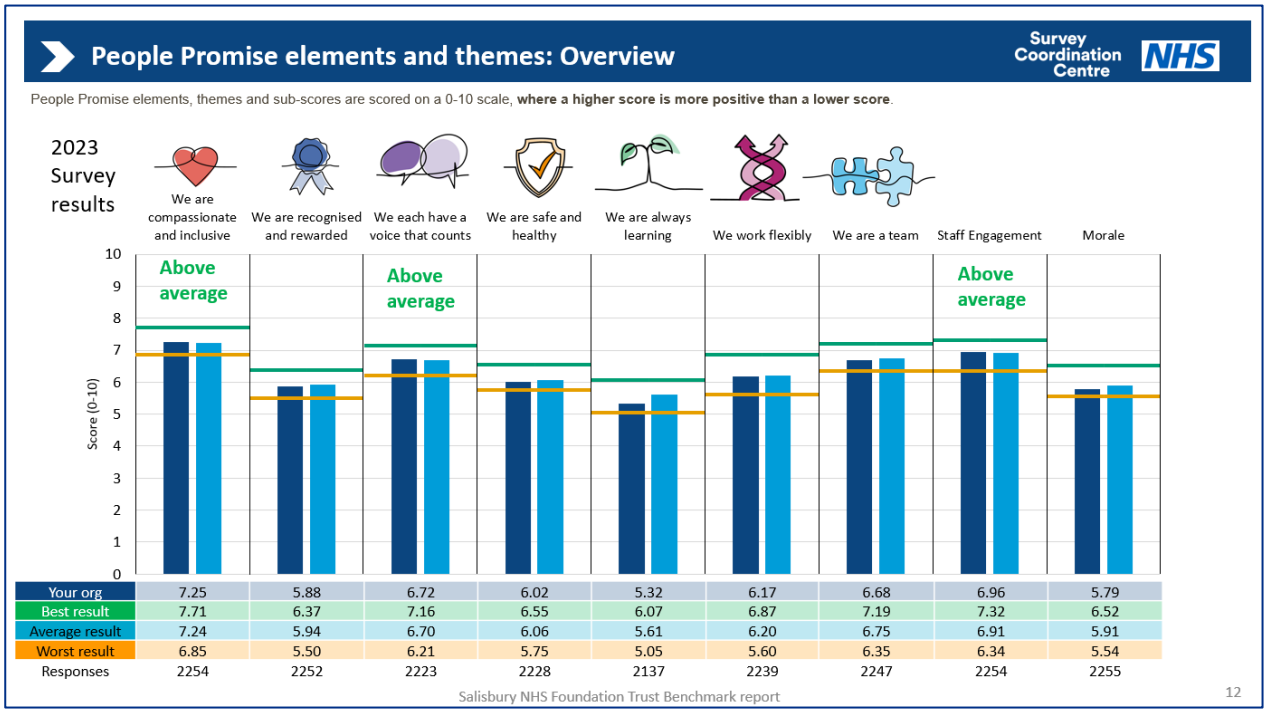


Figure 2: SFT Staff Survey Results Overview

SFT hosted an Exemplar Site Visit from Ronke Akerele, Director of Culture Transformation NHSE and Louise Pramas, Culture Transformation Lead who came to hear about our progress and to share learning from other exemplar sites across the country. The CPO and PPM continue to support NHSE and other colleagues in the region, offering advice, guidance, presentations and coaching to the new network of People Promise Managers that NHSE are sponsoring during 2024/2025.

We launched a section on SALI for all staff to access and find out more about the People Promise and we produced a series of case studies that are held on the national Futures site as well as on our local intranet pages. *http://intranet/about-us/our-people-promise/*

The programme continues into FY24/25 where we are building on the previous work and adding new and refreshed workstreams. Over 30 activities or projects have been identified that will be taken forward during the next 2 years (to March 2026). As before each AD and Head of department have People Promise improvement activities identified in their objectives.

As a result of the successes during the exemplar site period and with the loss of NHSE funding as the exemplar period ends SFT have now funded a substantive post of Widening Participation and People Promise manager, seeking to maintain the momentum generated in the last two years.

Although no longer sponsored by NHSE, we remain committed to the principles of the People Promise Exemplar sites and aim to the upper quartile for NHS Trust by the 2025 NHS Staff Survey.

2.3 **We are Compassionate and Inclusive.** SFT is a vibrant, diverse trust of over 85 nationalities where the expertise and experiences of our internationally educated staff significantly enriches our healthcare approach to better serve our local community. We are proud that 27% of our workforce hails from Black and Minority Ethnic communities. We celebrate this diversity and believe it strengthens us.

Progress with our six staff networks[1] has been steady. We have developed activities and information to support their members and increase a sense of belonging and wellbeing within the Trust for those staff groups. Network chairs have been supported with protected time and financial support to launch events for their networks. By way of example, the Women's network held a very successful Menopause summit which marked the beginning of our journey to ensure all SFT staff receive the comprehensive support they need during this important life transition. The Armed Forces Network has continued to host breakfast events for the veteran community, our reservists and those with serving family members. We have also continued to support a range of initiatives through routine communications and signposting of information, advice and guidance for all our staff, as such we've created a comprehensive inclusion and wellbeing calendar. This calendar highlights key events and celebrations throughout the year, like the highly successful conference on neurodiversity - "Unlock the Potential: Who Are We Really?: Neurodiversity in Action" - hosted in April 24.

The Trust's long-term Equality, Diversity and Inclusion (EDI) Plan (2024/27) was updated this year. This plan aligns with the NHS EDI improvement plan, incorporating its six high-impact actions and the South-West region's 'Leading for Inclusion' framework. Focusing on Leadership, Culture, Policy, and Accountability, a series of projects and workstreams have been launched to address key issues identified in our Workforce Race Equality Standard (WRES) and Workforce Disability Equality Standard (WDES) reports, as well as our Gender Pay Gap action plan. Aligning immediate projects on some of the key areas identified in our staff survey results has enabled us to focus on a roll out of EDI objectives for senior staff, work to ensure that recruitment panels are qualified and diverse, such that they provide a balanced view to our recruitment activity and finally training interventions to support staff from our international community in managing applications and interviews for promotion. An updated version of our EDI policy has also been ratified by the Trust, providing clearer guidance and a simpler approach to this important subject.

We're committed to fostering a workplace where everyone feels valued, respected, and truly belongs and this year we invested in over 109 of our international nurses, providing them with dedicated cultural awareness workshops. These workshops not only improve their cultural competency but also create a positive ripple effect, enhancing the experiences of their colleagues and the patients they care for.

As part of our system work with Bath and North-East Somerset, Swindon, and Wiltshire (BSW) Integrated Care System (ICS), we have co-hosted inspiring events for Black History Month, LGBT History Month, and Women's History Month, featuring speakers who've overcome obstacles and become beacons of hope for others.

We have invested significantly in the design and socialisation of our new Trust Leadership Behaviours Framework (LBF). Our Organisational Development and Learning (OD&L) team have designed a set of leadership behaviours which are aligned to the 'NHS Leadership Way' our Trust values and Catalysis's 13 Continuous Quality Improvement behaviours. Three other key behaviours have been embedded which link into NHS wide strategic initiatives. These are Compassion (linked to Michael West's research); Inclusion (linked to the NHS People Plans 6 High Impact Actions); and Civility (linked to Mersey Care's RJLC research).

The LBF is now being socialised through a number of interventions including *inter alia*:

[1] Ability Confident, Armed Forces, Carers, Culture & Equity, LGBTQ+ Alliance, and Women's

- Breakfast Clubs -1x session delivered per month since Nov 22.
- Twelve cohorts on new internal leadership programmes (240 Delegates) have been introduced to our new behaviours.
- Improving Together courses - with tools being aligned to support the application of each behaviour and highlight the importance in underpinning Improving Together success.
- A Clinical Leadership programme has been launched which has the LBF threaded throughout the content.
- 360° feedback tool - The Exec team have piloted our new LBF 360 feedback tool, but budget for a wider roll out needs to be agreed.
- Behaviours Charter - OD&L have created a team behaviours charter template to support teams in building their own charter which is aligned with our LBF.
- Appraisals & 1-2-1's - OD&L are also creating a managers conversation guidance note that will accompany our appraisal form and support 1-2-1 conversations, enabling managers to engage in conversations around behaviours in a productive way.
- Interview Question Set - OD&L have also created some interview questions to accompany our values-based question that managers can use to ensure our new LBF is threaded into all that we do.

As part of the behaviours charter work, Theatres senior leadership sought support with Cultural change in their service. Theatres have recruited many international staff in a short period of time to quickly fill gaps in their workforce. Any new employees joining a team impact the dynamic of that team and an influx of international staff whose first language is not English can add further complication. A team was formed to support the Theatres leadership which included OD&L, the EDI team and an external consultant.

During this supporting intervention the OD&L team have helped the Team Leader/Managers understand the fundamentals of leadership by identifying their roles as leaders within the team. Commitment has been patchy at times due to operational commitments, but the motivation was to attend, when possible, learn and apply their knowledge. This was evidenced in the collaborative design and creation of a Behaviours Charter which was rolled out by the team in April 24. As can be seen from the two Staff Survey results 2022 and 2023 (Figure 3), significant improvements in the 'My Team' area of the Staff Survey have been achieved. Some question areas have positively increased by as much as 20%.

YOUR TEAM	q7a	Team members have a set of shared objectives	55.2%
	q7b	Team members often meet to discuss the team's effectiveness	36.2%
	q7c	Receive the respect I deserve from my colleagues at work	46.6%
	q7d	Team members understand each other's roles	55.2%
	q7e	Enjoy working with colleagues in team	70.7%
	q7f	Team has enough freedom in how to do its work	36.2%
	q7g	Team deals with disagreements constructively	37.9%
	q7h	Feel valued by my team	41.4%
	q7i	Feel a strong personal attachment to my team	43.1%

YOUR TEAM	q7a	Team members have a set of shared objectives	69.6%
	q7b	Team members often meet to discuss the team's effectiveness	50.6%
	q7c	Receive the respect I deserve from my colleagues at work	64.6%
	q7d	Team members understand each other's roles	65.8%
	q7e	Enjoy working with colleagues in team	80.8%
	q7f	Team has enough freedom in how to do its work	48.1%
	q7g	Team deals with disagreements constructively	44.3%
	q7h	Feel valued by my team	68.4%
	q7i	Feel a strong personal attachment to my team	65.8%

Figure 3: Theatres Staff Survey results for 2022 (Left) and 2023 (Right)

2.4 **We are a Team.** It has been evident that management skills across the NHS and within SFT have needed significate development in places. The Charted Management Institute's (CMI) recent 'Better Managed Britain' research demonstrated that 82% of managers who enter a management role have not had any formal management or leadership training. OD&L have done a lot of work in

this area over the past year, resulting in the SFT management development skills offer rising from 3 workshops to 15 at the end of FY23/24. The team have aligned the suite of programmes to the NHS's new 'Expectations of a Line Manager in Managing People' policy to ensure we are delivering within the national standards framework. In only 6 months we have seen 506 current and future managers attend one or more workshops to support their personal development. 2023 Staff Survey results have shown an increase in scores against the questions '*My immediate manager takes effective action to help me with any problems I face*' and '*My immediate manager works together with me to come to an understanding of my problems*'

OD&L have been working closely with the Improving Together team to support building a culture of continuous improvement within the Trust. Work has included supporting the development of the Coach House through coaching, mentoring and team development sessions. Support has also been provided for teams going through their Improvement courses through interventions on the Improver Standard course 'Leading Self' and team dynamics.

2.5 **We are Always Learning.** This element of the people promise has seen the lowest response from the staff survey and was the only element where the Trust did not meet its ambition. We remain committed to supporting the development of a highly skilled workforce, which has been delivered through several approaches this year.

Mandatory, statutory, and additional core training is delivered via our on-line Managed Learning Environment (MLE) LEARN. The system, provided by Kallidus was subject to contract extension this year to extend the system out to Apr 25, and enable negotiation for a BSW system wide approach to managing core training elements. Detailed work has been undertaken to review the reporting of completed courses to provide assurance on the level of training completed particularly within our nationally reportable areas of safeguarding and data awareness. Alongside this work we have also aligned our mandatory and statutory training with the Corse Skill Training Framework (CSTF) at the direction of NHSE and implemented additional statutory training provided through our BSW Academy of the Oliver McGowan Tier 1 and Tier 2 training. There is a target of 3 years to get all staff trained in this important work.

Core clinical skills and targeted situational clinical event management is delivered through our Practice Education Team and our clinical Simulation Team. Highlights in year include:

- Achieving the National Preceptorship for Nursing Quality Mark for 24-26 whilst supporting 139 nurses on the current preceptorship programme.
- Supporting all Internationally trained nurses through their OSCE programme leading to 155 nurses now working as Band 5 Registered Nurses across the Trust, with a further 14 either waiting for their NMC pin or in transition from a Band 4 with supervised practice.
- Developing the cohorts of Trainee Nursing Associate Apprenticeships.
- SIM team expanded following successful business case to deliver more focus on multi-disciplinary team training.

Additional training for continued professional development (CPD) has this year been provided through two routes, both coordinated by the Education Team. Firstly, the distribution of the NHSE CPD fund targeting Nurses, Midwives and Allied Health Professionals (AHPs), and secondly through an SFT provided fund aimed at other staff groups that traditionally have no access to the NHSE CPD funds.

Funding source	Amount distributed	Total Number of staff who

		accessed funds
NHSE CPD fund	£429,333.33	441
SFT Trust funded CPD	£99,000	65

Apprenticeship coordination is led in Education and utilises the nationally directed levy. An apprenticeship combines practical training in an occupation with study. It can be accessed by people in entry-level jobs right through to those in senior clinical, scientific, or managerial roles.

SFT currently offer apprenticeships to 160 people in 29 different occupations including: Nursing Associate, Mortuary Technician, Occupational Therapist, Sustainability Manager, Project Manager, Health Play Technician, Carpentry & Joinery, Registered Nurse, Physiotherapist, Pharmacy Technician, Diagnostic Radiographer, Senior Healthcare Support Worker, Associate Project Manager, Business Administration, Clinical Coder and more. We are proud to say that 20 of our apprentices successfully completed their apprenticeships in 2023/24.

	2021/2022	**2022/23**	**2023/24**
Total Number of apprentices	153	143	160
Current Funds	£1,481,729.00	£1,575,253	£1,788,691
Total Spent to Date	£1,265,125.39	£1,972,717.77	£2,513,451.77
Total Spend in Year	£432,724.28 Of which £6,918.43 (1.6%) was transferred to other organisations	£579,197.20 Of which £71,377.58 (12.32%) was transferred to other organisations	£608,083 Of which £67,349 (11.1%) was transferred to other organisations
Annual Expired Levy	£112,685.57	£136,370.30	£148,666

The Medical Education Team have continued to provide outstanding support to its medical learners throughout the year. These learners come from a range of career stages from undergraduate (years 4-5) to Post Graduate Foundation years 1 and 2 and include physician associates.

The quality of training provision has been evidenced in a successful Foundation School Quality Assurance visit, SAS end of year review and the NHSE / Wessex Deanery Education Contract review. The medical education team are supporting the hospital to take increasing numbers of trainees and supporting the region through hosting several regional events including ‘Understanding neurodiversity’ study days, Regional IMT exam preparation training pilot (PACES) and an Ophthalmology regional training event.

The Education Centre has benefitted this year from a SFT corporate re-branding at its front entrance, new flooring in the main corridor and an upgrade to the men’s facilities. The lecture theatre was also upgraded with a state-of-the-art communication and presentation system – all aimed at improving the learner experience whilst in the Centre.

The Education Admin Team has adapted and overcome staffing and service capacity issues with a growing stability in its core team. They have been instrumental in implementing the new My First 90 days SFT Trust induction programme, and are working towards an Education Centre Behaviours Charter.

Other services based in the Centre continue to provide high quality staff and learner support and include the Freedom to speak up Guardian, Head of Equality, Diversity, Inclusion and Wellbeing,

the Dementia Training Team, the Manual Handling Team; the Resuscitation Team and the Organisational Development and Leadership team.

2.6 **We Each have a voice that Counts.** In the 2023 Staff Survey our response rate rose by 6% and the Staff Engagement score rose from 6.70 in 2022 to 6.96 in 2023. Staff morale also rose from 5.43 to 5.79. Across all seven people promise elements the Trusts overall score showed a significant increase as shown in Figure 4 below.

Statistical significance helps quantify whether a result is likely due to chance or to some factor of interest. The table below presents the results of significance testing conducted on the theme scores calculated in both 2022 and 2023*.

People Promise elements	2022 score	2022 respondents	2023 score	2023 respondents	Statistically significant change?
We are compassionate and inclusive	7.07	1857	7.25	2254	Significantly higher
We are recognised and rewarded	5.57	1855	5.88	2252	Significantly higher
We each have a voice that counts	6.56	1842	6.72	2223	Significantly higher
We are safe and healthy	5.75	1846	6.02	2228	Significantly higher
We are always learning	4.67	1763	5.32	2137	Significantly higher
We work flexibly	5.87	1846	6.17	2239	Significantly higher
We are a team	6.47	1855	6.68	2247	Significantly higher
Themes					
Staff Engagement	6.70	1859	6.96	2254	Significantly higher
Morale	5.43	1859	5.79	2255	Significantly higher

* Statistical significance is tested using a two-tailed t-test with a 95% level of confidence.

139

Figure 4: Staff Survey Comparative Scores - 2022 to 2023

The Cake podcast continued to develop through guest hosts and eventually a new host. The series was recognised nationally for its contribution to understanding protected characteristics and why staff do what they do. The podcast was a finalist at the CommsHero Awards and the prestigious HSJ Awards. The series now has 4939 downloads.

A series of events to listen to staff was introduced. These *Hearing IT* sessions are led by the Chief Executive Officer and the Chief People Officer and allow both invited groups of staff and those that walk up to ask any question they want. The Executives will also ask staff members why they work at the Trust and what they enjoy about their work. Issues of concern raised have covered line management, car parking, uniforms and accommodation. Staff consistently say the best and worst thing about their work is their close team. The *Hearing It* sessions are complimented by similar sessions led by the senior OD&P leadership team after staff have completed 100 days in post and 1 year.

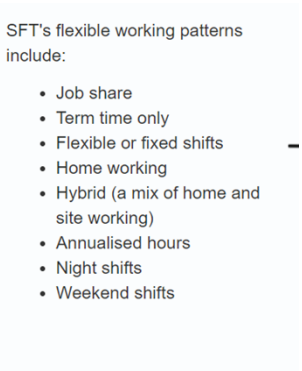
The impact of these listening events has been seen in physical action as a result of the event (for example the Hopper bus and increased line Management training events, focussed at different times to support all staff) and also in increased engagement, one member of staff in a 100 days event stated *"It's nice to be invited to this and be acknowledged as important. Being heard and being listened to is so important. That's why I left the last trust because I wanted to be valued".*

The combined sessions have released a rich spectrum of comments, both positive and critical which has enabled the Trust to calibrate actions to make improvements and sustain the good that is already in pace. The recommendations we are taking forward are to continue to broaden the scope of engagement through on-line sessions for remote workers and a roadshow for those who cannot get away from clinical areas to attend in Springs, the implementation of a Staff Council and wider publication of the outcomes of the sessions for staff to understand the impact their voice has.

2.7 **We work Flexibly.** Work-life balance is frequently cited as one of the top reasons for people leaving the Trust. The requirement to support round the clock operational services is paramount to deliver safe and effective patient care, however the need to recognise individuals' rights to request to work flexibly is a key element in our drive to retain our staff and improve their wellbeing. The fact that the Trust does operate around the clock means that there is scope for people to find a suitable shift pattern to fit in with their other commitments and lifestyle. Key developments over the last 12 months have been:

- Flexible working group established.
- Update and relaunch of the Flexible working Policy.
- Introduction of the right to apply for flexible working from day 1 of employment.
- Introduction and launch of Home working policy.
- Communication plan and development of Flexible working dashboard.
- Introduction of training for Line Managers to support Flexible working applications.
- Introduction of flexible working being offered on every vacancy advertised.

The launch of the flexible working policy was accompanied by communications including the development of the SALi 'Flexible Working' pages which has seen an increase in applications of circa 475% (37 applications in 9 months prior to relaunch and 174 applications in the 9 months following relaunch)



Manager training has also been launched and several cohorts of managers have been trained, leading to more consistent and equitable responses to flexible working requests, evidenced by the increase of scores on the 2023 staff survey questions: "Satisfied with opportunities for flexible working patterns" score (56.6%) and "Can approach immediate manager to talk openly about flexible working" score (70.3%).

2.8 **We are Safe and Healthy.** The combined engagement of the Occupational Health Team, the Health and Safety Team, Wellbeing Team and others has helped support the delivery of a number of workstreams within the we are safe and healthy element of the people promise which has ensured that our ambition metrics were met. Key areas of development have included a project to refurbish rest rooms in our clinical areas, providing a more accessible and comfortable place for staff to take their breaks; the installation of 2 huts to provide space for on-site staff to socialise; ratification of a new menopause policy; the launch of financial offers such as the 'beyond blue light' scheme; and progress towards accreditation for a Safe, Effective, Quality Occupational Health Service which will enable greater breadth of delivery for our OH service.

There has been good progress on bringing together a number of elements of the trust to seek to triangulate data to better support the safety and health of our staff. This has seen themes drawn

from data including the patient experience, employee relations, freedom to speak up guardian, Datix reporting and absence reporting. This data enabled support to be targeted to identified wards to help with sickness absence management. This pilot was successful and ward staff were appreciative of the help received.

The launch of line manager training to support wellbeing conversations with staff has seen an increase in reported conversations due to greater confidence of our line managers having received the training. Over 50 managers received training in this financial year.

2.9 **We are recognised and Rewarded.** The major recognition event is the annual Thank You Week which is supported by the Stars Appeal and the League of Friends. The week features the Staff Awards, Staff Party, Long Service Awards, Volunteers Lunch and Family Fun Day. The venue is the prestigious Marsh Close within the Cathedral Close. The theme for the Staff Awards night was our history and featured dances through the ages provided by local dance company Panthera, a performance by the Salisbury Plain Military Wives Choir and a reading by Saili Katebe of his poem reflecting on diversity within the NHS.

The Awards night seated 650 people, there was 100 plus attendees at the staff party, 130 volunteers came to the thank you lunch and in excess of 750 family, staff and friends enjoyed the fun day.

3.0 Service Delivery

3.1 **Chaplains.** The chaplaincy team have continued to provide an excellent level of service for our patient population, providing a reassuring and supportive presence on the wards for inpatients and on call 24/7 to react to patient needs. The team have met all call out requests throughout the year, despite a number of vacancies in the team and some long-term sickness. The chaplaincy have re-organised the way in which they support the very sensitive issue of baby deaths, both pre-term and post term and the new service has been very well received by families.

Equally positively has been the capacity of the team to provide pastoral support to our staff and provide a multi-faith space available to those of faith and those with none in the trust chapel. For the first time this year a service was conducted for our hindu staff, and space is regularly made available for Muslim prayer. The engagement of the chaplaincy team in our networks and in support of wellbeing initiative is a welcome addition to the support the trust provides for our staff's wellbeing.

3.2 **Occupational Health.** Triage of referrals within 2 working days and OHA first appointment within 10 working days has been achieved this year. However there have been ongoing challenges with the KPI for practice nurse appointments within 5 days of clearance of a Pre-Placement Questionnaire (PPQ) and for physiotherapy first appointment being offered within 10 working days.

Practice nurse appointments are based on pre-placement clearances, we have 1 full time practice nurse doing this role. Whilst this KPI has not been achieved due to staff availability, no impact has been felt on employee's being able to start with the Trust. Staff availability has been affected by sickness and supporting the trust with infection control outbreaks and look back vaccination exercises, as well as peak weeks in recruitment increasing demand.

Our physiotherapists do case management and treatment physiotherapy. Employees can be offered up to 6 sessions of physiotherapy. Whilst we have increased the resource this year, this is a well utilised service and the numbers of employees accessing the service continue to climb.

Musculo Skeletal Injuries continue to account for a high percentage of sickness absence within the Trust.

Occupational health Physician appointments are being supported by Southampton Occupational health as we have been unable to recruit to the role, whilst ideally, we would prefer this to be in house, this is working relatively well. They have supported with some complex cases and ill health retirements.

All service delivery is impacted by Did not Attend (DNA) levels. More stringent processes have been put in place this year to inform line managers and prevent further appointment booking for self-referrals.

The Head of OH has been actively involved with supported the trust in attendance management training and increasing knowledge of OH and what support we can offer staff and managers. We have launched an advice line for managers and staff to enable them to get timely OH advice.

3.3 **Health and Safety.** The H&S function of OD&P provides an assurance, response and technical support role for each Division. The first function is the implementation of a formal H&S management system, supported by a published schedule of risk and audit activity. During FY24 audits were conducted by the H&S Team in Estates Technical Services, Emergency Department, Acute Medical Unit, Longford Ward, Pitton Ward, Theatres and Radnor Wards. The Health and Safety Executive (HSE) attended the Trust premises to conduct an audit of Pathology services with no significant findings made against the Trust. Task analysis activity to undertake a formal review of the risk and the management of risks were conducted in the kitchens, fitness centres, medical engineering, portering service and pathology.

The H&S team was tasked with responding to 90% of work-related injuries reported on Datix within 1 working day. Of the 329 work related injuries reported on Datix in FY24, the H&S team responded to just over 300 within this timeframe (91%). There is also a legal obligation imposed on the Trust to report all reportable injuries (RIDDOR's) to the HSE within a prescribed timeframe. RIDDOR's, of the type recorded at the Trust (incapacity greater than 7 days) must be reported to the HSE within 14 days. The H&S team has committed to reporting within 10 days. In FY24, the Trust had 6 RIDDOR's and all were reported within 10 days of being reported on Datix.

Finally, the H&S team provides a fit test function to ensure respiratory protection is provided to staff exposed to, or likely to be exposed to infections transmitted via respiratory route. Standard practice for named pathogens is to provide an FFP3 mask and to ensure staff have an FFP3 mask that is fitted to the size and shape of an individuals face. Fit testing can be done by way of smell and taste testing or computerised testing. The Fit Test Team use both methods. In FY24 the Fit Test Team booked 2636 appointments and fit tested 1713 individuals and used 5881 masks to identify the correct masks for these 1713 individuals. Where staff had an outbreak of disease that requires an FFP3 mask, the Fit Test Team completed bulk testing on wards, or where staff work weekends and nights, clinics were set up to test staff during these times to ensure all relevant staff have access to a correctly fitted mask.

3.4 **Workforce Informatics.** The Infomatics team has focussed its work this year on three areas. Firstly the roll out of the Establishment Control module of ESR, aligning the ESR hierarchy to the oracle financial ledger and reconciling the two. This was achieved in Apr 24, and as part of the project the ESR new starters process was successfully taken over by the team which recruited two

new staff members to manage ESR position and assignment changes - 488 new starters have been input by the team since October 2023.

Secondly, the team have designed and maintained 12 Power BI builds as requested by the Trust, with data updates managed on time. Data analysis has been provided with Professional Registration, licensing and revalidation checked for 2,700 clinical staff on a monthly basis, 559 workforce information requests have been completed promptly and to a high standard, 141 Freedom of Information requests were answered within the statutory deadline and requests for information from NHSE including regular Agency, PWR and daily Covid returns were completed promptly and on time.

Finally, the team have provided an effective ESR support service for the Trust which saw 100% of ESR manager and employee self-service queries responded to within 2 days. Approx 300 ESR training sessions, workshops and induction sessions were delivered to managers and staff with personalised training for ESR appraisals/flexible working and Manager self service as part of the leadership training and support available for managers new and old in the trust.

This activity saw the team win a number of awards at the Annual Staff Awards night in Sep 23.

3.5 **E-Roster Team.** The e-roster team moved across the OD&P in Apr 23 and have focussed their activity on rolling out the e-roster system to medic and the remaining non-medical teams not on the system, providing effective support to the trust's managers to support their use of the system and finally providing the data needed to inform workforce plans.

The roll out of e-roster to the medical community has been a challenge due ti the capacity of the team, which has been beset by sickness absence, the capability of the system to meet the needs of the medical community and the ability of the Trust to absorb these changes in a busy operational period. The roll out fell behind schedule, but progress is being made in making up the lost ground before the project closure date of Jun 2025.

e-Roster manager monthly training has been initiated and four sessions delivered, which have been well received and are improving the efficiency of staff using the system. Employee online training has supported staff to book annual leave, see shifts and book bank shifts enabling better work life balance. Enabling the staff to request specific shifts allows improved levels of staff happiness as they have an increased autonomy about when they are scheduled to work. Training has also seen an increase in roster approval time for inpatient units, reducing the need for agency cover for shifts on inpatient units. Increasing visibility of available shifts will support staff who want to book bank shifts as part of the work life balance.

3.6 **Recruitment.**

During FY 23/24 Recruitment have been able to continue to improve and embed recommendations from the Overhauling Recruitment Project which commenced in 2022. The objective of the project was to enable the Trust to become a fairer and more equitable employer in all stages of recruitment. A significant amount of work has been undertaken which includes a revamp of the recruitment process to improve candidate and recruiting managers experience and time taken to hire someone. A relaunch of the SFT Recruitment website and branding promoting the many benefits of working at SFT.

In December 2023 a review of recruitment KPI's were undertaken, due to one particular KPI continually remaining red - time taken for Managers to shortlist. This KPI was changed from 3 to 4

days to reflect the reality of a line managers ability to access the system and shortlist candidates. Since the change, KPIs are all tracking green, as Figure 5 shows below.

Month	Average days from vacancy authorisation to posting	Average days to shortlist by RM	Average days to send out interview invitations	Average days for recruiting manager to update interview outcomes	Average days to send offer to successful candidate
KPI	**2 days**	**4 days**	**1 day**	**2 days**	**2 days**
Jan-24	1.08	3.18	0.33	2.31	1.81
Feb-24	1.57	3.26	0.24	2.39	1.62
Mar-24	1.76	3.20	0.34	2.06	0.98
Apr-24	1.42	3.48	0.39	2.00	1.13

Figure 5: Recruitment KPIs

The team have embraced the Improving Together methodology and through having weekly huddles they are able to continually seek ways to improve recruitment activity and processes.

Key milestones achieved in FY23/24 include:

- Introduction of the Recruiting Managers Toolkit to promote a fair, transparent, equitable process, ensuring the best candidate is recruited for the post regardless of background, race or other protected characteristics. Intranet
- Introduction of diverse panels and the monitoring of these.
- Introduction of recruitment and selection training (all interview panels will be chaired by someone who has attended recruitment and selection training).
- Guidance documents to support Recruiting Managers through the recruitment process eg interview guidance and template, how to make reasonable adjustments for candidates to attend interview, how to make a job offer and how to check references.
- Improving the candidate experience eg new joiners get a telephone call from the Recruitment Team just before their pre-employment paper is issued to take them through the documents being sent and answer any questions they may have at this stage
- Introduced different ways to recruit into job roles where there is high volume required eg Cleaning Assistants and Healthcare Assistants; candidates pre-screened prior to being booked for interview, interview assessment undertaken in groups and offers made on the day, contributing to a more efficient recruitment process increasing the number of successful hires to interviews ratio.
- The Trust were awarded the NHS Pastoral Care Quality Award for the international recruitment of nurses and midwives.
- Welcomed 90 international nurses to the Trust which includes providing them with enhanced pastoral support pre and post arrival, an improved induction and OSCE programme; courtesy of the International Practice Education Team.
- Successfully recruited the full complement of nursing ward staff for the Trust's new ward, Imber, opening in Jul 24.
- Building on the success from 2022/23 the Trust vacancy position continued to improve during 2023/24, from 4.68% in April 2023 to 1.62% in March 2024.

3.7 **Temp Staffing.** At the beginning of 2023 an improvement project was established to improve the Temporary Staffing Service. The objective of the temporary staffing review was to provide grip and control over temporary staffing through having central visibility over the deployment of

temporary staff moving away from the current model of multiple 'spoke' units with services managing their own bank and agency use. This would then:

- Reduce agency spend
- Provide managers that need temporary staff with a consistent, easy to use, responsive service which meets patient needs
- Ensure that SFT has the right temporary staffing service to meet the Trusts' needs, handling all bank and agency bookings.
- Ensure that bank workers have a good experience when working for SFT encouraging more staff to work through the bank rather than via agencies.

Over the course of 23/24 the Temporary Staffing Team have revised current processes and redesiged process flows, proactively managing agency contracts with the input from Procurement and the involvement of the Team in other staff groups eg agency for Medical, AHP and HCS. The working hours of the team were extended during the winter months and additional resource has been recruited into the shift co-ordinator role.

In February 2024 the Trust implemented a new managed service provider for direct engagement for agency workers in Medical, AHP and HCS. This includes a revised booking process which now requires the Temporary Staffing Team to add the new request to a vendor management system to instigate cascade to the managed service provider. During 23/2024 the Temporary Staffing Team re-engaged with its agency suppliers to increase fill and to realign charge rates and in January 2024 the new contract and PSL went live.

KPI's for the Nurse Agency Bank and Agency have been finalised and will be used to manage performance of the Temporary Staffing Team through the Nurse Bank and Agency Performance Review Meetings.

A small change has been made to the way the Trust uses Locums Nest with the introduction of a 2nd level approver being added to the system. This means that any shift added now requires 2nd line approval. By introducing 2nd level approver this provides better oversight for the Divisions on the number of shifts being sent out via Locums Nest for fill.

The SW Pan Regional work for both nurse and medical agency and bank has also been a key feature of this improvement project. As a result, the Trust will be at agency cap rates for general nursing from 1 June with specialist areas (Theatres, ED, ITU and Paediatrics) planning to be at cap from 1 July 2024. Medical agency and bank rates are currently being worked through as a region and are likely to be implemented during 2024/25.

Bank and Agency spend has reduced for the Trust when comparing the position in April 2023 to 2024. Acknowledgement on the reduction of agency spend for nursing agency needs to be given to the Deputy Chief Nursing Officer who has worked with the wards to continue to drive down the number of shifts required to be filled either by bank or agency. This also includes the requirement on reducing the Trust's off framework use for nurse agency.

3.8 **Employee Relations.** A busy year in the Employee Relations Team with 129 employee relations cases brought to a satisfactory conclusion across a range of categories. The largest percentage of cases were Grievance, Informal Conversations and Disciplinary.

A significant amount of time has also been spent on proactive work that the team has undertaken to support managers managing staff who are absent from work due to sickness. This activity has

helped support the reduction of absence levels to less than 4% per annum, improving staff availability in line with out breakthrough objective. The highest reason for sickness absence continues to be stress/anxiety/mental health issues closely followed by muscular skeletal however with support from the Occupational Health and Health & Safety teams on early interventions supporting staff to return to work more quickly and making workplace adaptions where necessary has had a positive impact on these figures.

Work has also focussed on supporting Managers to resolve employee relations cases as quickly as possible and advising on restorative processes and practices wherever possible, focusing on lessons learnt rather than blame. This has been supported by the re-introduction of Line Managers breakfast Clubs focusing on sickness absence management, managing performance and tackling grievance and disciplinary matters. New policies supporting a just and restorative learning culture in the Trust have been developed.

Formal Job Evaluation panels have been re-introduced following a hiatus since COVID. This now means panels made up of 3 staff side/management representatives meet on a weekly basis to evaluate any new or changes to roles. Following the training of additional staff this will be increased to panels of 4 in 24/25 in line with best practice guidelines.

3.9 **Volunteers.** Volunteer numbers have increased during FY2324 reaching 430 in Jun 24, above the target of 420. These volunteers provide on average of 2300 hours each month to 48 different areas within the hospital. All volunteers were invited to join the Staff Christmas Lunches, and a special lunch was held during Awards week to recognise the commitment to the Trust of our volunteers. Volunteers helped at our first Hospital Open Day, and a small number attended the first Tent Talks.

We have launched NHS Ambassadors with approx. 30 staff coming forward to be an ambassador. Ambassadors visit schools promoting ALL roles within the trust, not just the clinical roles. They also reach out to local community groups showcasing SDH and promoting the Trust as a place to work and a place to be treated as a patient.

Voluntary Services have attended school career events at Bishop Wordsworth School, Trafalgar School, Burgate School and others. We also attended Marlborough College and an event held in Calne for Home Educated children. This visit highlighted that we are missing a large group of children who may not receive the same career advice as school pupils, and therefore plan to connect with Home Educated children via their Social Media groups in the next year.

Work Experience has really taken off this year after being on hold for 3 years due to Covid. We have offered 90+ placements to students from 25 different educational organisations visiting over 30 different locations within the Trust. There is a barrier to schools to send their students out on Work Experience, and this is the fee they must pay for all the checks on the companies and organisations who provide these placements. Therefore, schools pass this fee on to the parents and unfortunately schools who do not have high achievers are unable to ask parents to cover this cost. We hope to bridge this gap by offering them an NHS Ambassador to visit.

3.10 **Communications**

The communication team lead the Trust relationship with the media, all people communications to staff and the branding of the hospital environment. The team specifically supports the digital transformation project and the Trust Improving Together programme. The team manage the Trust website, the new intranet (SALi) and all digital channels.

The hospital continues to punch above its weight with national media having featured on 5 News, ITV News, Radio 4, BBC news and Channel 4 news in addition to local print and broadcast media. A short BBC documentary about our spinal unit is due for release in 2024.

To celebrate the NHS 75th anniversary the team delivered a Cathedral service featuring newly commissioned poetry and launched the first in a generation Hospital Open Day. 2023 saw the introduction of SFT Tent Talks, a two-day festival of learning wellbeing and fun. The festival had 750 pre-bookings with staff enjoying speakers on strategy, delivering under pressure, speaking up and more. The festival included a night of comedy and a recording of the Trust podcast *The Cake*. In 2024 Tent Talks is focussed on *Leadership in a Diverse World* and has exceeded expectations with over 1200 advanced bookings.

3.11 **Freedom to Speak Up.** In response to last year's Staff survey, in relation to the People Promise, the FTSUG with the wider OD&P team has worked to improve 'We are Compassionate and Inclusive' and 'We Each have a Voice that Counts' scores. Actions included refreshing and publishing FTSU Policy and Strategy, clear communications plan promoting FTSU service, expert data triangulated to create thematic analysis to inform interventions and work alongside staff networks to identify barriers to speaking up.

The FTSUG also delivers training at the Aspiring and Transformational Leaders Course, focusing on how leadership behaviours influence the creation of psychological safety in order that colleagues can raise concerns with confidence and assurance that they will be listened to and acted upon.

The Trust's Guardian has direct access to all senior leaders including the Chief Executive and all Board members. Themes and trends are reported quarterly to Board for assurance and to highlight lessons learned from concerns that have been raised. In the year 2023-24 163 concerns have been raised to the Freedom to Speak Up Guardian, a 22% increase on the previous year following the national trajectory. Of these, 52 had an element of patient safety and quality, these concerns are escalated immediately to senior leaders for appropriate action.

Information on how to access the Freedom to Speak Up service is readily available via daily communication on the Staff Bulletin email, posters are displayed in prominent areas, business cards are handed to every new member of staff.

3.12 **Library Services.** The services's vision is utilising knowledge and evidence for outstanding care. Our mission is to deliver an outstanding knowledge and library service that empowers evidence-based decision making, underpins a culture of learning and development, and contributes to an outstanding experience for all. A summary of Library Services for 23/24 is provided in figure 6, below:

Literature and evidence searches	**The number of searches completed by the Library Service was up by 25% on the previous year.**
We are always learning	"Thank you so much, this will help challenge us on the future of these services and no doubt many of them will be far better for it."
Library staff search the evidence to answer clinical questions and find best practice evidence that teams can use to inform patient care, complete CPD and	"This is one of the most useful documents I have seen to date. Many

<table>
<tr><td>research and work on service improvements.</td><td>thanks for sharing”</td></tr>
<tr><td>Current awareness bulletins and resource lists

Library staff collate articles on specific topics to ensure staff are kept up to date in their area of clinical or professional interests.

Each staff network has a dedicated resource list to support their members and allies.

We also created a resource list collating all the book and article recommendations from Tent Talks and have produced resource lists to support different clinical and non-clinical departments.</td><td>We produce a bulletin for the Cleft department and this bulletin is also shared nationally across the NHS.

“Awesome bulletin with some great articles - such a valuable resource”

‘These bulletins have a HUGE impact on my practice - it is such a helpful way of accessing current research. It is such a valuable resource and very grateful for it. Thank you!!”</td></tr>
<tr><td>Staff publications bulletin

We are recognised and rewarded

The Healthcare Library set up a staff publications bulletin which searches and collates all research publications with an author from SFT and these are produced twice yearly.

We also purchased BMJ Case Reports in consortium with BSW and received a discounted rate and our subscription also provides a fellowship code so our staff can publish for free in BMJ Case Reports.</td><td>This is a brand-new service and the first time these publications have been collated and shared.

“Thanks you so much for circulating this. Its an amazing long list for an organisation of this scale and really worthy of celebrating more widely.”</td></tr>
<tr><td>Article requests and resource usage

We are always learning

The Healthcare Library source books and articles that are not available via our subscriptions.

Ascending order by number of item investigations
<table><tr><th>Trust Name</th><th>Total item investigations</th><th>Price</th></tr><tr><td>Oxford Health NHS Foundation Trust</td><td>154</td><td>£616</td></tr><tr><td>Royal Berkshire NHS Foundation Trust</td><td>1195</td><td>£12,049</td></tr><tr><td>Portsmouth Hospitals NHS Trust</td><td>1244</td><td>£15,902</td></tr><tr><td>Medway NHS Foundation Trust</td><td>1325</td><td></td></tr><tr><td>Hampshire Hospitals NHS Foundation Trust</td><td>1596</td><td>£16,809</td></tr><tr><td>Oxford University Hospitals NHS Fdn Trust</td><td>1746</td><td>£25,775</td></tr><tr><td>University Hospitals Dorset NHS Foundation Tr</td><td>1763</td><td>£18,235</td></tr><tr><td>Buckinghamshire Healthcare NHS Trust</td><td>1801</td><td>£15,176</td></tr><tr><td>Milton Keynes University Hospital NHS Fnd Tru</td><td>3069</td><td>£7,081</td></tr><tr><td>Salisbury NHS Foundation Trust</td><td>3162</td><td>£7,234</td></tr></table></td><td>Over 1000 searches are conducted on our clinical decision making tool – UpToDate – each month.

We purchase a collection of journal articles via OVID and our usage was the highest across the consortium – even with some Trusts having a much higher staff count than SFT.</td></tr>
<tr><td>Literature search training and 1-2-1s and Library inductions

We are always learning

he Library supports staff and students who are undertaking CPD, courses, apprenticeships, writing for publication and those wanting to complete their</td><td>223 people received 1-2-1 and group training from the Library an increase of more than 50% on the previous year.

“I just would like to thank you very much for the time dedicated to deliver your session on study skills. Your session was</td></tr>
</table>

own literature or systematic review. Throughout 23/24 the Library was asked to deliver inductions to all overseas nurses as part of their induction programme.	enlightening to all. Furthermore, this knowledge is extremely beneficial for their present but also any future academic work."
Two SOX awards Awarded for our EDI work and for conducting literature search and article requests.	Taken from our Sox award: "Absolutely fabulous team who go above and beyond every time! we need to look after this wonderful service!

Figure 6: Library Services Achievements

3.14 **Wellbeing.** At SFT, Just as we prioritise patient-centred care, we are equally committed to a person-centred approach for our staff through a comprehensive range of wellbeing initiatives.

Our Approach seeks to foster open communication. We have implemented well-being conversation training for our managers, aiming for each staff member to have at least one such conversation annually with their line manager.

Understanding staff needs to better tailor our support is essential and we conducted a staff wellbeing survey with 370 respondents. The NHS wellbeing baselining exercise undertaken in late 2023 evaluates SFT against various aspects of the framework, such as personal health, relationships, fulfilment at work, and professional support. The main areas of need and our actions this year are identified below:

Financial Support and Advice. A significant development this year was the launch of our 'Exclusive Local Discount Scheme'. This initiative, in partnership with the Salisbury & District Chamber of Commerce and Salisbury Business Improvement District, offers substantial discounts from over 60 local businesses to all SFT staff. Additionally, we continue to provide a 40% discount on local buses, referrals to the Food Bank and the SFT Hub and also webinars and information on financial management.

Mental health remains the greatest area of sickness absence in the Trust and we have supported our staff through a new one stop triage service to access counselling and clinical psychology support, we provide Trauma Risk Management (TRiM) support, and maintain a psychology-focused YouTube channel. Our expanding network of Wellbeing Champions plays a crucial role in ensuring staff are aware of the full range of available well-being resources. This is further complemented by over 103 Mental Health First Aiders and our Chaplaincy service.

A new set of processes have been devised to support staff affected by violence and aggression in their area of work. Alongside the launch of a ne excuse for abuse campaign, support mechanisms have been refined for staff who have been subjected to verbal or physical violence.

Finally, Accessible via a QR code our Staff Well-being Portal provides a wealth of external resources for psychological, physical, financial, and social support.

Appendix:

1. Achievements and Metrics for the People Promise Elements

Appendix 1. Achievements and Metrics for the People Promise Elements.

Achievements as at March 2024

- ✓ 6 Staff Networks
- ✓ Protected time for chairs & named Executive Sponsor
- ✓ Inclusion calendar of events
- ✓ Leadership Behaviours Framework launch
- ✓ New Leadership and coaching offer
- ✓ 360 Exec team
- ✓ Tent Talks Event
- ✓ CLP in Theatres
- ✓ Inclusive recruitment policy, process and toolkit
- ✓ BAME interview and application training and podcast BSW
- ✓ Leading for inclusion Board development day.
- ✓ Cultural Awareness Training pilot
- ✓ RJLC training for key staff
- ✓ Inclusion annual objective for Execs
- ✓ Breakfast clubs
- ✓ Supporting improving together

Recognition including:

- ✓ Staff Awards, Party and Family fun day
- ✓ Anniversary events and activities
- ✓ SOX and small thank you's eg ice creams, pizzas , hampers, and more
- ✓ OD&P End of year celebration

Reward information sharing including

- ✓ Pension seminars
- ✓ Financially fitter workshops
- ✓ Refreshed web pages explaining staff benefits.
- ✓ Bus subsidies
- ✓ Local staff discounts
- ✓ Free parking and shuttle bus
- ✓ Band 2 to 3 pay uplift to real living wage
- ✓ Pay award updates
- ✓ Free porridge daily, free fruit, food for fuel week
- ✓ Birthday leave once in trust for 1 year+
- ✓ Long service awards refreshed

- ✓ FTSU policy, protocol for raising concerns and line manager training
- ✓ Network events and celebrations including international food, Transgender day of remembrance, Armistice, Carer's café, Black history, women's history & more
- ✓ Poetry celebrating diversity
- ✓ Podcast series exploring who we are and what we do
- ✓ People Promise section added to SALI
- ✓ Listening events: divisional, 100-day, 1 year and CEO led Hearing It
- ✓ Poster campaigns reflecting the People Promise and Trust objectives
- ✓ Quarterly pulse survey launched
- ✓ Increased Staff Survey completion
- ✓ Hello and history videos

- ✓ Wellbeing portaland survey launched
- ✓ WB conversation training & resources
- ✓ Menopause pledge and policy
- ✓ Rest room upgrades
- ✓ Relaxation space for international staff
- ✓ Refreshed OH service, SEQOHS PID approved
- ✓ The Hub to support cost of living
- ✓ Improved data collection and triangulation
- ✓ In ward support for reducing absence
- ✓ Mental Health First Aiders network
- ✓ Sleep workshops
- ✓ Psychological interventions and counselling self-refer
- ✓ Breastfeeding event
- ✓ Schwartz rounds
- ✓ White Ribbon campaign
- ✓ No excuse for abuse campaign and strategy

- ✓ Refreshed appraisal process
- ✓ Launch of Preceptorship, Quality Mark achieved
- ✓ HCA retention programme and induction
- ✓ TNA refresh
- ✓ Increased spend against the Levy
- ✓ NAW celebrations and apprenticeship graduation ceremony
- ✓ Coventry Partnership launched
- ✓ Launch Direct Entry Nursing Associate programme
- ✓ International nurse induction improved
- ✓ Career conversations RNs aged 45+
- ✓ OSCE boxes for home practice
- ✓ Shadow Board
- ✓ Legacy mentor in post with BSW
- ✓ Transfer to updated Kallidus MLE system

- ✓ Senior Nurse Champion for Flexible Working
- ✓ Flexible working policy launched
- ✓ Homeworking policy and fund for ergonomic equipment launched
- ✓ Flexible working dashboard
- ✓ All jobs advertised as flex and flex requests accepted from day one
- ✓ Flexible working training for managers
- ✓ Flex resources to support line managers and staff
- ✓ Team based rostering in 3 areas
- ✓ E-job planning and E-rostering projects started
- ✓ Agreement with Patchwork for medical staff bank

- ✓ Manager skills training package developed and improved
- ✓ OD&P Lunch and Learns
- ✓ OD&P Conference
- ✓ Team support triage process developed
- ✓ Team training offered by Sim and Education depts
- ✓ My first 90 days induction proposed and planned
- ✓ Talent development proposal taken to board
- ✓ Recruited additional volunteers for the trust
- ✓ Ran international recruitment campaigns (primarily for nurses)
- ✓ Launched People Promise section of SALI

Metrics as at March 2024

- ✓ 144 completed and 232 on leadership programmes in '24
- ✓ Grown from 7 to 11 leadership cohorts
- ✓ 403 coaching upskilling recipients
- ✓ 23 fully qualified coaches and 26 in training
- ✓ Coach to Lead rated 4.8 (of 5)
- ✓ 60 attended cultural awareness pilot
- ✓ 4 action learning set facilitators trained
- ✓ 13 Train the Trainer attendees
- ✓ 150+ breakfast club attendees
- ✓ 9 of exec team took part in Leadership Behaviours 360
- ✓ 15-day faster recruit to hire time
- ✓ Vacancy rate down to below 2%
- ✓ Theatres FTSU cases reduced from 6 to 2 and turnover reduced from 13.5% to 11.9 (Q1 to Q2)

- ✓ 21 Pension seminars hosted
- ✓ 1013 attended pension training with 72% take up on average
- ✓ 86 attended planning for a positive retirement
- ✓ 40% increased bus subsidies
- ✓ Over 450 staff and bank workers included in the HCA band to Band 3 uplift
- ✓ 437 people nominated for staff awards
- ✓ 245 hampers sponsored by Stars Appeal delivered to colleagues at Christmas
- ✓ 2800 Festive meals served and 22 live entertainment performances
- ✓ 1100 staff took part in thank you week

- ✓ 32+network events and celebrations
- ✓ 4 new FTSU ambassadors
- ✓ 29% FTSU concerns are raised by BAME (which is proportionally representative)
- ✓ 6% increased response rate staff survey and improved representation
- ✓ Engagement score in pulse survey risen from 5.56 Apr 22 to 6.89 Jan 24
- ✓ Steadily increasing number of responses to Pulse Survey
- ✓ 2 Podcast series, 20+ episodes and 4300+ downloads
- ✓ 750 places booked at Tent Talks, 35+ events
- ✓ 45+ attendees at CEO led Hearing it

Highlights

- ✓ FTSUG appointed mentor to other FTSUGs
- ✓ Finalists for Comms Hero and HSJ awards

- ✓ 50+ managers trained in wellbeing conversations
- ✓ 100% sickness absence recorded on e-roster
- ✓ 200+ staff received 1:1 therapy
- ✓ 90% would recommend the service to colleagues
- ✓ 37 out of 41 users rated the Occupational Health Service as excellent
- ✓ OH health clearance reduced from 14 to 2 days
- ✓ 20% decrease in absence rate in medicine following in-ward HR support
- ✓ 2 social huts installed
- ✓ 18 staff room upgrades complete, in progress or planned

- ✓ 305 45+ nurses had career conversations
- ✓ 156 apprentices on programme currently
- ✓ 18 apprenticeship applications in already for 2024
- ✓ 20% improved appraisal compliance in 6 months (from 60% to 80%)
- ✓ 600+ CPD applications approved in 3 years
- ✓ Apprenticeship levy spend at 55.7% against 65% target

Awards

- ✓ Mark Docksey (HCA Recruitment and Retention Lead) and team won National Chief Nursing Officer (England) award for Innovation and Excellence in the value and recognition provided to support workers
- ✓ SFT awarded Defence Employers Recognition Scheme Gold Award

- ✓ 56% new starters employed on part-time contracts
- ✓ 100% roles advertised as open to flexible working
- ✓ 163 new Flexible working agreements logged on ESR
- ✓ 13+ attendees at Flexible working training
- ✓ 65% leavers agree or strongly agree that there are opportunities for flexible working at SFT

Improving Together metrics as at Jan 2024

- ✓ Agency spend as % gross pay 4.02% against target of 3.7%
- ✓ Turnover at 13.95% against target of 10%
- ✓ Sickness absence 4.1% against target 3%
- ✓ Vacancies at 2% against 5% target

- ✓ 34 teams / depts took part in the Open Day
- ✓ 13 Management skills workshops live on MLE
- ✓ 12 People promise case studies shared
- ✓ 2 site visits from NHSE hosted

Projects designed to address

- ✓ 1000+ new starters in 2022/3
- ✓ 495 people left within first year 2022/23
- ✓ It costs in the region of £7000 to recruit a new nurse
- ✓ 178 of our 696 supervisors were new to post in last 2 years
- ✓ 35% of nurses at SFT have held their NMC pin for 5 years or less

NHS Salisbury NHS Foundation Trust

Report to:	Trust Board (Public)	Agenda item:	6.3
Date of meeting:	3rd October 2024		

Report title:	Guardian of Safe Working Annual Report 2023/24			
Status:	Information	Discussion	Assurance	Approval
			x	
Approval Process: (where has this paper been reviewed and approved):	People & Culture Committee, 26th September 2024			
Prepared by:	Rowena Staples, Guardian of Safe Working			
Executive Sponsor: (presenting)	Duncan Murray, Chief Medical Officer			

Recommendation:

The Committee are asked to note the annual Guardian of Safe working report for 2023/24 and its recommendations.

Executive Summary:

The Trust expect to be allocated around 170 doctors in training by the deanery who are subject to the conditions of the 2016 contract. Doctors 'exception report' breaches of their contracted working hours to allow the trust to monitor and act on recurrent themes around workload and rightsizing of the work force.

In 2023/24 the pattern of exception reporting followed previous years, with most reports coming from our most junior doctors and reporting frequency high in the period from August to January, reducing from February to July.

The majority of exception reports relate to overtime at the end of the normal working day. Some exception reports comment on gaps in medical staffing which are in part due to unfilled training posts, and less than full time working (LTFT). The trust looks to mitigate this and fill unallocated rota slots with locally employed doctors (LEDs). The process of transitioning LEDs to 2016 T&Cs was commenced in Spring 2023. This gives LEDs the same access to exception reporting as their deanery appointed peers.

All work schedules for doctors in training are compliant with 2016 T&Cs.

Industrial action taken by junior doctors during 2023/24 appears to have contributed to low morale amongst junior doctors. The proposed pay offer from the government is subject to a referendum which closes on 15th September 2024. The pay offer includes some significant changes to exception reporting, including a shift from clinical or educational supervisors overseeing reporting, to medical HR overseeing exceptions reports for less than 2 hours overtime. The underlying ethos is to empower and trust junior doctors, whilst simplifying processes related to exception reporting.

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

Purpose

The 2016 Junior doctor contract introduced the role of the Guardian of Safe Working and requires that the guardian reports to the board (or via a committee) every quarter and produces a consolidated annual report, which is included as a statement in the Quality Account

Background

The Trust is allocated trainees (including LTFT) by the Deanery to fill circa 170 deanery training posts. There is an overall shortfall in the number of doctors provided by the deanery with respect to the required number to fill the spaces. This results in gaps in the medical workforce rotas. Some of these spaces are filled with locally employed doctors.

Numbers of trainees in deanery training programmes across the region are controlled and limited by the General Medical Council and Health Education England. The 2016 junior doctors' contract placed additional restrictions on hours, consecutive long shifts and weekend working, with the aim of protecting junior doctors from overwork and protecting their training opportunities.

Since 2016 trainees have been required to report any instance that they work beyond the hours in their work schedule (national and local guidance gives a leeway of up to 15 minutes), any missed training opportunities and "immediate safety concerns" when they believe patients are being put at risk by excessive hours or insufficient doctors. Excess hours can arise for reasons including:

- Rota gaps resulting in fewer doctors than planned – for example due to the Deanery failing to recruit trainees, less than full time trainees, maternity leave, sick leave or poor annual leave planning.
- Unrealistic work schedules that do not meet the needs of the service
- Junior doctor factors including capability, organisational skills and clinical experience
- Supervision factors including lack of support, unrealistic expectations
- Infrastructure issues particularly IT, but also bleeps and telephones
- Lack of support from other health care professionals including nurses, pharmacists and admin staff.

We also employ locally employed doctors (LEDs) at junior and senior trainee level to fill deanery gaps, to provide additional staffing required by the clinical services and enable rotas compliant with the 2016 'rota rules'. Many of these doctors will be on the same or similar work schedules as the deanery trainees. In Spring 2023 the process of moving LEDs to the 2016 T&Cs began. In general, this change has been undertaken at the end of a fixed term contract. There are a small number of LEDs remaining on 2002 T&Cs. These doctors do not have access to exception reporting. The aim of changing to 2016 T&Cs is that this will give the trust a much clearer view of hours worked by its medical workforce and better highlight gaps and issues. It will also give a degree of parity between deanery and LED doctors and a 'voice' to those who might otherwise feel unheard.

Summary of Exception Reports Aug 23 – July 24

Total number of exception reports = 364

Reason for ER	Number
Overtime	**344**
Missed breaks	**3**
Inadequate rest	**2**
Missed Educational Opportunities	**7**
Pattern of work	**6**
Service Support	**2**

2 ER due to immediate safety concerns
1 due to sickness absence in medicine
1 due to weekend working in medicine

Rota Gaps

Expected rota gaps August 24 – July 2025

Number of doctors / dentists in training (total): 170

For context, approximately 2/3 of these posts are at junior level and 1/3 are at senior level. Thus, for a given number of WTE gap, the senior rota is disproportionately affected. LEDs are often more difficult to recruit at a senior level.

Junior Trainees (F1-CT2) WTE Gaps by Specialty and Grade Aug 24 – July 25

Specialty/grade	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul
Elderly care F2									1	1	1	1
Elderly care CMT 3	0.2	0.2	0.2	0.2	0.2	0.2	1	1	1	1	1	1
Elderly care CMT 1/2	0.2	0.2	0.2	0.2					1	1	1	1
ED GPVTS	0.4	0.4	0.4	0.4	0.4	0.4	0.4	0.4	0.4	0.4	0.4	0.4
ACCS ED ST2							1	1	1	1	1	1
Anaesthetics ST2	0.2	0.2	0.2	0.2	0.2	0.2						
ACCS ST1	0.2	0.2	1	1	1	1	1	1	1	1	1	1
Intensive care CMT 1/2					0.2	0.2	0.2	0.2				
Endocrine GPVTS							1	1	1	1	1	1
Endocrine CMT 1/2	1	1	1	1								
Endocrine CMT 3	0.2	0.2	0.2	0.2	0.2	0.2						
Gastro CMT 3	0.2	0.2	0.2	0.2	0.2	0.2	0.4	0.4	0.4	0.4	0.4	0.4
Cardiology CMT 3	1	1	1	1	1	1						
Resp CMT 3							0.2	0.2	0.2	0.2	0.2	0.2
Medical Oncology CMT 1/2	1	1	1	1	1	1	1	1	1	1	1	1
Palliative GPVTS	0.4	0.4	0.4	0.4								
O&G F2					0.2	0.2	0.2	0.2				
O&G GPVTS	1	1	1	1	1	1	1	1	1	1	1	1
O&G ST 1/2	0.2	0.2	0.6	0.6	0.6	0.6	0.6	0.6	0.6	0.6	0.6	0.6
T&O F2	0.3	0.3	0.3	0.3								
Paeds GPVTS							0.4	0.4	0.4	0.4	0.4	0.4
Plastics CST 1/2	1	1	1	1	1	1	1	1	1	1	1	1
Dental	2	2	4	4	4	4	4	4	4	4	4	4
WTE unfilled gap	**9.5**	**9.5**	**12.7**	**12.7**	**11.2**	**11.2**	**13.4**	**13.4**	**15.0**	**15.0**	**15.0**	**15.0**

Senior Trainees ST3-7 WTE Gaps by Specialty and Grade Aug 24 – July 25

Specialty/grade	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul
ED	0.4	0.4	0.2	0.2	0.2	0.2						
Endocrine	0.2	0.2	0.2	0.2	0.2	0.2						
Respiratory	0.2	0.2	0.2	0.2	0.2	0.2	0.2	0.2	0.2	0.2	0.2	0.2
Elderly Care	0.2	0.2	0.2	0.2	0.2	0.2	0.2	0.2	0.8	0.2	0.2	0.2
O&G	1	1										
Paeds	0.4	+0.1	+0.1	+0.1	+0.1	+0.1	+0.1	0.1	0.1	0.1	+0.6	+0.6
Histopathology	1	1	1	1	1	1	1	1	1	1	1	1
Haematology	+0.2	+0.2	+0.2	+0.2	+0.2	+0.2	+0.2	+0.2	+0.2	+0.2	+0.2	+0.2
WTEGap total	**3.4**	**3.0**	**1.8**	**1.8**	**1.8**	**1.8**						

Yellow indicates LTFT working.
Red indicated an unfilled gap.

Locum Spend August 23 – July 24

Division	Aug	Sept	Oct	Nov	Dec	Jan
CSFS	22059	31085	45753	21404	21333	15597
Medicine	343797	222612	243308	261547	239569	260921
Surgery	104225	66910	117296	115463	92698	94725
Women and Newborn	34151	88427	30349	21481	27765	6720
Total £	504,232	409,034	436,706	419,895	381,365	377,963

Division	Feb	Mar	Apr	May	Jun	Jul
CSFS	16354	19834	17891	29078	16595	13267
Medicine	288445	268600	206776	189401	189837	359968
Surgery	83082	77976	65911	55791	84672	75690
Women and Newborn	15666	29872	40199	19222	31139	29282
Total £	403,547	396,282	330,777	293,492	322,243	478207

Total Locum spend Aug 23 – July 24 = £4,747,244

Issues arising

Ongoing staff shortages from deanery gaps, sickness, and other forms of leave (study, annual, parental) result in very slim staffing on the wards quite regularly. Even a 'filled' rota can become unworkable very easily with little slack in the system.

Over the past 12 months the deanery fill rate has continued to improve slightly, particularly at senior level. LTFT working is becoming increasingly common including within the most junior doctors (foundation programme).

The trust is lead employer for 39 GPVTS doctors. Recent changes to the GP curriculum have resulted in GPVTS doctors spending less time in hospital training posts and more time in community GP placements. This change has impacted doctor posts at a junior level. 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.

Numbers of foundation programme doctor posts in the trust have been expanded. With further expansion of 3 F1 doctors in August 2024.

Industrial action by doctors since March 2023 has had wide reaching effects. The morale of junior doctors has been low, with an impression that this is felt more by the most junior doctors. The referendum relating to the most recent pay offer closes on 15th September 2024. This offer includes some significant changes to exception reporting, as follows

- Doctors should be enabled and encouraged to exception report.

- They should not suffer any detriment as a result of exception reporting.
- None of these changes should undermine the Guardian of Safe Working Hours ability to undertake their roles and identify unsafe working practices.
- As with all claims for overtime / additional working, there needs to be a sign-off process, but challenges should be exception rather than the norm.
- The system for reporting should be clear and straightforward.
- In reference to exception reports asserting a doctor worked additional hours of 2 hours or less in one occurrence, the only determination the employer will seek to reach when deciding whether to pay the doctor is whether or not the additional hours were indeed worked; the perceived retrospective merits of the doctor's decision to work the additional hours should not be considered when determining whether to make payment for the additional hours.
- Exception report arising from a doctor having worked more than 2 hours in one occurrence should be investigated to ensure safe staffing is maintained and could be subject to a locally determined process which must be agreed upon with the BMA LNC.
- Claims should be based upon clear agreed criteria for what constitutes additional working for example theatre overruns.
- All educational exception reports to go to DME for approval.
- All other exception reports to go to HR or Medical Workforce HR for approval.
- Review the contractual deadlines to ensure that they are sufficient for exception report submission to remove the burden from doctors and replace with timeframes that empower doctors to manage exception reporting when convenient to them as professionals.
- The underlying ethos to this change should be to empower and trust junior doctors to conduct themselves professionally, and remove wherever possible, and minimise wherever not, the time-consuming aspects of the process.

Whilst the referendum results are not known at the time of drafting this report the above would have a significant impact on exception reporting processes in our trust. There would be less involvement from clinical or educational supervisors, greater onus on Medical Workforce HR and more streamlined systems for claiming overtime payments would require development.

Actions taken to resolve issues

- Significant numbers of rota gaps have been filled with LEDs, across all specialties and grades. Obtaining a clear picture of the numbers of LEDs is challenging as the numbers change frequently in line with unfilled deanery posts, LTFT working and clinical service demands.

- Changes continue to be made to work schedules and rotas to improve junior doctors working lives, alongside training opportunities, and address the 'balance' of seniority in medical teams out of hours. Following a review of acute and general medical out of hours rotas, changes were brought in during the Summer of 2024. The feedback from the changes has been extremely positive.

- Junior doctor forum meetings (JDF) have been held in advance of all periods of industrial action to ensure that our doctors are fully informed of arrangements and the trust position on industrial action. JDF meetings not focused on strike action continue as normal. The attendance at JDF meetings from junior doctors has generally been poor and thus different approaches are being trialled from August 2024 with the aim of improving engagement.

- Alongside the trust employing a significant number of LEDs, the Medical Education Team have developed better systems to support this group and prevent the 'lost tribe' of doctors. This has included for formal CESR support / training and funded study leave.

Summary

It has been a difficult and unsettling year for our junior doctors, in the main due to industrial action. Despite this over the last year exception reporting has followed expected patterns.

If the junior doctors accept the government pay offer there will need to be changes to exception report processes in SFT.

There remains reliance on locums to cover unexpected absence, changeover periods and some rota gaps to allow for induction and compliance with the 'rota rules'.

Recommendations

That the trust continues to employ LED to fill deanery rota gaps and support the service, continued focus on how we support these doctors to further develop.

GoSW continues to work with our junior doctors, medical education team and clinical specialities / supervisors to ensure our doctors have a good training experience, in a well-supported environment and are not required to regularly breech their contracted hours.

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’.

Once the outcome of the referendum is known, there is a review of exception reporting processes across the trust led by the GoSW. This is likely to require increased resource in Medical HR.

The trust continues to focus on being an attractive place to work and train.

GoSW to attend National Guardian conference on 8th Oct 2024.

Dr Rowena Staples
Guardian of Safe Working Hours
Consultant Paediatrician
September 2024

Report to:	Public Trust Board	Agenda item:	6.4
Date of meeting:	3rd October 2024		

Report title:	(1) Workforce Disability Equality Standard (WDES) Annual Report and Action Plan 2023/24 Final (2) Workforce Race Equality Standard (WRES) Annual Report and Action Plan 2023/4 Final			
Status:	Information	Discussion	Assurance	Approval
			x	x
Approval Process: (where has this paper been reviewed and approved):	04 Sep 24 – OD Culture and Learning Working Group 17 Sep 24 – OD & People Management Board 26 Sep 24 – People and Culture Committee			
Prepared by:	Harjinder Bahra, Head of Inclusion and Wellbeing			
Executive Sponsor: (presenting)	Melanie Whitfield, Chief People Officer			

Recommendation:

The Trust Board is asked to **Note** detail presented in the Annual WRES and WDES reports, which highlight SFT's progress in these two NHSE mandated reports and **Approve** the reports and associated action plan for publication on the Trust's public website by 31 October 2024.

Executive Summary:

WORKFORCE DISABILITY EQUALITY STANDARD (WDES) ANNUAL REPORT AND ACTION PLAN FOR 2023/24

This report presents Salisbury NHS Foundation Trust's Workforce Disability Equality Standard (WDES) annual report for 2023/24 and action plan. The WDES, a mandatory requirement of the NHS Standard Contract, is an evidence-based framework designed to enhance the experiences of disabled staff within the NHS. See **Annex A** for definitions of disability. The WDES metrics allow NHS organisations to compare the workplace and career experiences of disabled and non-disabled staff, fostering a deeper understanding of the issues and inequalities faced by disabled staff. Introduced in 2019, the WDES has evolved over six years, with the 2024 metrics building on the progress made towards improving the experiences of disabled staff working in, or seeking employment with, the NHS.

The aggregated National WDES annual report 2023 provides key findings highlighting inequalities between the experiences of disabled staff and non-disabled staff across all ten metrics, emphasising the need for

urgent action by NHS Trusts in 2023. This includes cultivating inclusive leadership, reducing bullying and harassment, improving recruitment and selection and enhancing the retention of disabled staff. The WDES aligns with the People Promise commitments for a more inclusive, compassionate, and desirable NHS workplace.

Provider trusts must publish a WDES annual report and action plan (2023/24) on their website by 31 October 2024. This report should include:

- The organisation's data for each metric.
- A WDES action plan detailing how the organisation will address the differences highlighted by the metrics data over the next 12 months.
- A summary of progress made in achieving the objectives outlined in their 2022 WDES action plan.
- Steps the organisation will take to improve the experiences of disabled staff, as outlined in their 2023/24 WDES action plan.
- Steps to ensure disabled staff representation at all levels, identifying any barriers to career progression.

Previous SFT's WDES annual reports for 2019, 2020, 2021, 2022, 2023 can be found here

Workforce disability equality data

This report presents data on the Workforce Disability Equality Standard (WDES) of the Salisbury NHS Foundation Trust (SFT) for the year 2023/24. Data for metrics 1 to 3 and 9b are collected from the Trust's Electronic Staff Records (ESR) on 31 March 2024. Data for metrics 4 to 9a are collected from the 2023 staff survey. Results represented in **Red** text represent a deterioration in performance compared to last year and those in **green** text represent an improved performance against that metric.

Overall workforce (metric 1)

On 31 March 2024, SFT had a total of 4498 staff in the workforce (excluding Bank staff). Of which, 150 (3%) are disabled, 4145 (92%) are non-disabled and 203 (5%) have disability unknown. There is a big discrepancy between the ESR data (3% disabled) and the 2023 staff survey, where **24.5%** of those who responded (2217) declared themselves as having a physical or mental health conditions or illnesses lasting or expected to last for 12 months or more. The discrepancy rate is similar nationally in the NHS.

Disabled job applicants appointed from shortlisted (metric 2)

The purpose of this metric is to achieve equity between disabled job applicants and non-disabled job applicants. In 2024, the relative likelihood of non-disabled applicants compared to disabled applicants being appointed from shortlisted was **x1.17.** This is a **decrease** from 2023 (x1.47). A figure below 1:00 indicates that disabled applicants are more likely than non-disabled applicants to be appointed from shortlisting.

Note: This figure excludes directly recruited international staff not using Trac. Recent surge in international applicants on Trac has created a considerable challenge for recruiting managers in time and resources to efficiently sift and shortlist those eligible to work in the UK, meet the essential criteria and are guaranteed an interview under the Disability Confident Scheme.

Disabled staff entering formal capability process (metric 3)

In 2024, the relative likelihood of disabled staff entering formal capability process compared to non-disabled staff was more than twice at **x2.86.** This is a **decrease** from 2023 (x2.92). Although x2.86 looks very high,

the actual headcount (3 disabled staff) v (29 non-disabled staff) is low in relative terms. A figure below 1:00 indicates that disabled staff are less likely than non-disabled staff to enter the formal capability..

Metrics 4 to 9a are sourced from SFT's national NHS staff survey 2023 (2265 respondent, 54% of the total workforce). LTC = Long Term Condition.

Metric 4a: Harassment, bullying or abuse from patients, relatives or public
30.0% of staff with a LTC or illness experienced harassment, bullying or abuse from patients/service users, their relatives or the public in the last 12 months out of those who answered the question. This is an **increase** from 2022 (25.2%)

Metric 4b: Harassment, bullying or abuse from managers
14.8% of staff with a LTC or illness experienced harassment, bullying or abuse from managers in the last 12 months out of those who answered the question. This is an **increase** from 2022 (13.9%)

Metric 4c: Harassment, bullying or abuse from other colleagues
27.8% of staff with a LTC or illness experienced harassment, bullying or abuse from other colleagues in the last 12 months out of those who answered the question. This is an **increase** from 2022 (26.2%)

Metric 4d: Reporting harassment, bullying or abuse
50.8% of staff with a LTC or illness said that the last time they experienced harassment, bullying or abuse at work, they or a colleague reported it out of those who answered the question reported it. This is an **increase** from 2022 (49.7%). **51.0%** of staff without a LTC or illness reported it. This is an **increase** from 2022 (46.6%)

Metric 5: Equal opportunities for career progression or promotion
51.9% of staff with a LTC or illness believed that SFT provides equal opportunities for career progression or promotion out of those who answered the question. This is an **increase** from 2022 (51.0%)

Metric 6: Pressure from their manager to come to work
31.8% of staff with a LTC or illness said that they felt pressure from their manager to come to work, despite not feeling well enough to perform their duties out of those who answered the question. This is an **increase** from 2022 (29.4%)

Metric 7: Work is valued
31.02% of staff with a LTC or illness said that SFT values their work out of those who answered the question. This is an **increase** from 2022 (29%)

Metric 8: Making reasonable adjustment(s)
74.8% of staff with a LTC or illness said that SFT made reasonable adjustment(s) to enable them to carry out their work out of those who answered the question. This is an **increase** from 2022 (70.8%) and **above average** compared to other NHS organisations (73.4%)

Metric 9a: Staff engagement score
The staff engagement score for staff with a LTC or illness was **6.51**. This is an **increase** from 2022 (6.46). The staff engagement score for staff without a LTC or illness was **7.07**. This is an **increase** from 2022 (6.78). The staff engagement score range is between 0 and 10.

Progress against WDES 2022/23 action plan
Slides 18 to 21 sets out the Trust has made good progress against the eight WDES 2022/23 action plan on our journey to make SFT an inclusive and equitable employer and workplace for disabled staff. Activities are grouped around three objectives: Cultural Development, Networks and Communications, and Recruitment and Promotion.

Action Plan 2024/25

Slide 22 sets out WDES actions for 2024/25 grouped under Cultural Development, Networks and Communications, and Recruitment and Promotion.

WORKFORCE RACE EQUALITY STANDARD (WRES) ANNUAL REPORT AND ACTION PLAN FOR 2023/24.

About this Annual Report and Action Plan

This report presents Salisbury NHS Foundation Trust's (SFT) Workforce Race Equality Standard (WRES) annual report and action plan for 2023/24. The WRES, a mandatory requirement of the NHS Standard Contract, is an evidence-based framework designed to improve the experiences of Black and Minority Ethnic (BME) staff within the NHS. (Please refer to **Annex A** for definitions of ethnicity and the individuals covered by the WRES.)

Nine WRES metrics allow NHS organisations to compare the workplace and career experiences of BME and White staff, fostering a deeper understanding of the issues and inequalities faced by BME staff. Introduced to the NHS in 2015, the WRES has evolved, with the 2023 metrics building on the progress made since 2017 towards improving the experiences of BME staff working in, or seeking employment with, the NHS.

The WRES resources for NHS organisations can be found here.

Executive Summary

Workforce race equality data

This report presents data on the Workforce Race Equality Standard (WRES) of the Salisbury NHS Foundation Trust (SFT) for the year 2023/24. Data for metrics 1 to 4 and 9 are collected from the Trust's Electronic Staff Records (ESR) as at 31 March 2024. Data for metrics 5 to 8 are collected from the 2023 staff survey.

Metric 1: Overall workforce

On 31 March 2024, SFT had a total workforce of 4,498, excluding bank staff. 3127 (70%) of our staff are clinical, compared to 1371 (30%) non-clinical. Of these, 3,195 (71%) were White, 1,205 (27%) were from Black and Minority Ethnic (BME) backgrounds, and 98 (2%) were of unknown ethnicity. The number of BME staff increased significantly in 2024, rising by 26% (248) compared to 2023. This growth, from 957 to 1,205 staff is in part due to a steady increase in the recruitment of internationally educated nurses over the past two years.

Equity in career progression at SFT – Race Disparity Ratio (AfC Bands)

Equity in career progression for BME staff compared to White staff continues to be a challenge. For non-clinical roles, BME staff are **2.15** times less likely to progress equally from lower to middle pay bands, **1.41** times less likely from middle to upper pay bands and **3.03** times less likely from lower to upper pay bands: Clinical BME staff are **4.17** times less likely from lower to middle pay bands, **2.35** times less likely from middle to upper pay bands and **9.83** times less likely from lower to upper pay bands:

BME staff in key senior roles

In our non-clinical workforce, there are no BME staff at Band 8A, 8D, Band 9 or at very senior manager

(VSM). Similarly, in the clinical (non-medical) workforce, there are no BME staff at Band 8B, Band 8C, Band 8D, Band 9 or VSM.

NHS Model Employer BME representation target

Excluding medical and dental grades, the percentage of BME people across all AfC pay bands is **26%** on 31 March 2024 (21.7% in 2023). Recognising the recruitment of BME staff, particularly for leadership roles, is a challenge for SFT due to the limited pool of potential candidates in the Salisbury area, which has a BME population of about **6%,** the trust is fully committed to promoting and developing career opportunities for BME staff that have joined across all grades **.** SFT is actively implementing initiatives and leadership programmes to improve BME representation within the Trust.

Metric 2: Appointment from shortlisting

In 2024, the relative likelihood of White applicants being appointed from shortlisting compared to BME applicants was **x1.25**. This is a **decrease** from 2023 (x1.54). A figure below 1:00 indicates that BME applicants are more likely than White applicants to be appointed from shortlisting. **Note:** This figure excludes directly recruited international staff not using Trac. Recent surge in international applicants on Trac has created a considerable challenge for recruiting managers in time and resources to sift and shortlist those eligible to work in the UK and meet the essential criteria.

Metric 3: Entering formal disciplinary process

In 2024, the relative likelihood of BME staff entering formal disciplinary process compared to White staff was **x1.03.** This is an **increase** from 2023 (x0.98). Note: A figure below 1:00 indicates that BME staff are less likely than White staff to enter the formal disciplinary process.

Metric 4: BME Staff accessing non-mandatory training and CPD

At the present time, the Trust does not have a method for collecting staff accessing non-mandatory training and CPD. Work is in progress to identify a mechanism for identifying the uptake of non-mandatory training by BME staff.

Metrics 5 to 8 are sourced from SFT's national NHS staff survey 2023 (2265 respondent, 54% of total workforce).

Metrics 5: Harassment, bullying or abuse from patients, relatives or public

21.9% of Black, Asian and Minority Ethnic staff stated they had experience harassment, bullying or abuse from patients, relatives or the public. This is a **decrease** from 2022 (28.9%)

Metrics 6: Harassment, bullying or abuse from staff

24.8% of Black, Asian and Minority Ethnic staff stated they had experience harassment, bullying or abuse from other staff. This is a slight **decrease** from 2022 (25.5%)

Metrics 7: Equal opportunities for career progression or promotion

51.8% of Black, Asian and Minority Ethnic staff said that SFT does provide equal opportunities for career progression or promotion. This is an **increase** from 2022 (44.2%)

Metrics 8: experiencing discrimination at work from manager/team leader or other colleagues

16.0% of Black, Asian and Minority Ethnic staff said they experiencing discrimination at work from manager/team leader or other colleagues. This is a **decrease** from 2022 (19.2%)

Progress against WRES 2022/23 action plan

Slides 18 to 20 demonstrate that the Trust has made some progress against the six WRES 2022/23 actions on our journey to make SFT an inclusive and equitable employer and workplace for our BME staff. A

Action Plan 2024/25 Slide 21 sets out WRES actions for 2024/25 grouped under Cultural Development, Networks and Communications, and Recruitment and Promotion.

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

Salisbury NHS Foundation Trust

Workforce Race Equality Standard (WRES)

Annual Report and Action Plan

2023/24

Introduction and Background to WRES 2023/24

About this Annual Report and Action Plan

This report presents Salisbury NHS Foundation Trust's (SFT) Workforce Race Equality Standard (WRES) annual report and action plan for 2023/24.

The WRES, a mandatory requirement of the NHS Standard Contract, is an evidence-based framework designed to improve the experiences of Black and Minority Ethnic (BME) staff within the NHS. Please refer to **Annex A** for definitions of ethnicity and the individuals covered by WRES.

Nine WRES metrics allow NHS organisations to compare the workplace and career experiences of BME and White staff, fostering a deeper understanding of the issues and inequalities faced by BME staff. Introduced to the NHS in 2015, the WRES has evolved, with the 2023 metrics building on the progress made since 2017 towards improving the experiences of BME staff working in, or seeking employment with, the NHS.

The WRES resources for NHS organisations can be found here.

The national WRES annual report 2023 provides key findings and trends highlighting inequalities between the experiences of BME staff and White staff across all nine metric.

This demonstrates the case for trusts to continue in 2024 to take urgent action to create an inclusive and diverse leadership; reduce bullying and harassment; improve recruitment of a diverse workforce; and improve the retention of BME staff. Moreover, the WRES complements the commitments made in the People Promise for a more inclusive and compassionate NHS.

Provider trusts must publish a WRES annual report and action plan (2023/24) on their website by 31 October 2024. This report should include:

- The organisation's data for each metric.
- A WRES action plan detailing how the organisation will address the differences highlighted by the metrics data over the next 12 months.
- A summary of progress made in achieving the objectives outlined in their 2023 WRES action plan.
- Steps the organisation will take to improve the experiences of BME staff, as outlined in their 2023/24 WRES action plan.
- Steps to ensure BME staff representation at all levels, identifying any barriers to career progression.

Previous SFT's WRES annual reports for 2017, 2018, 2019, 2020, 2021, 2022 and 2023 can be found here.

EXECUTIVE SUMMARY

Workforce race equality data

This report presents data on the Workforce Race Equality Standard (WRES) of the Salisbury NHS Foundation Trust (SFT) for the year 2023/24. Data for metrics 1 to 4 and 9 are collected from the Trust's Electronic Staff Records (ESR) on 31 March 2024. Data for metrics 5 to 8 are collected from the 2023 staff survey.

Metric 1: Overall workforce

On 31 March 2024, SFT had a total workforce of 4,498, excluding bank staff. 3127 (70%) of our staff are clinical, compared to 1371 (30%) non-clinical. Of these, 3,195 (71%) were White, 1,205 (27%) were from Black and Minority Ethnic (BME) backgrounds, and 98 (2%) were of unknown ethnicity. The number of BME staff increased significantly in 2024, rising by 26% (248) compared to 2023. This growth, from 957 to 1,205 staff is in part due to a steady increase in the recruitment of internationally educated nurses over the past two years.

Equity in career progression at SFT – Race Disparity Ratio (AfC Bands)

Equity in career progression for BME staff compared to White staff continues to be a challenge. For non-clinical, BME staff are **2.15** times less likely to progress equally from lower to middle pay bands, **1.41** times less likely from middle to upper pay bands and **3.03** times less likely from lower to upper pay bands: Clinical BME staff are **4.17** times less likely from lower to middle pay bands, **2.35** times less likely from middle to upper pay bands and **9.83** times less likely from lower to upper pay bands:

BME staff in key senior roles

In non-clinical workforce, there are no BME staff at Band 8A, 8D, Band 9 or at very senior manager (VSM). Similarly, in the clinical (non-medical) workforce, there are no BME staff at Band 8B, Band 8C, Band 8D, Band 9 or VSM.

NHS Model Employer BME representation target

Excluding medical and dental grades, the percentage of BME people across all AfC pay bands is **26%** on 31 March 2024 (21.7% in 2023). While the NHS Model Employer target aims to boost BME representation at all levels, particularly in leadership (Band 6 to VSM), SFT is currently falling short of these targets. Although this is an improvement from the previous year, it is still below the target set by the NHS Model Employer. Recruiting and retaining BME staff, particularly for leadership roles, is a challenge for SFT due to the limited pool of potential BME candidates in the Salisbury area, which has a BME population of about **6%.** Despite this, SFT is actively implementing initiatives and leadership programme to improve BME representation within the Trust.

Metric 2: Appointment from shortlisting

In 2024, the relative likelihood of White applicants being appointed from shortlisting compared to BME applicants was **x1.25**. This is a **decrease** from 2023 (x1.54). A figure below 1:00 indicates that BME applicants are more likely than White applicants to be appointed from shortlisting. **Note:** This figure excludes directly recruited international staff not using Trac. Recent surge in international applicants on Trac has created a considerable challenge for recruiting managers in time and resources to sift and shortlist those eligible to work in the UK and meet the essential criteria.

Metric 3: Entering formal disciplinary process

In 2024, the relative likelihood of BME staff entering formal disciplinary process compared to White staff was **x1.03.** This is an **increase** from 2023 (x0.98). Note: A figure below 1:00 indicates that BME staff are less likely than White staff to enter the formal disciplinary process.

Metric 4: BME Staff accessing non-mandatory training and CPD

At the present time, the Trust does not have a method for collecting staff accessing non-mandatory training and CPD. Work is in progress to identify a mechanism for identifying the uptake of non-mandatory training by BME staff.

Metrics 5 to 8 are sourced from SFT's NHS staff survey 2023 (2265 respondent, 54% of total workforce).

Metrics 5: Harassment, bullying or abuse from patients, relatives or public

21.9% of Black, Asian and Minority Ethnic staff stated they had experience harassment, bullying or abuse from patients, relatives or the public. This is a **decrease** from 2022 (28.9%)

Metrics 6: Harassment, bullying or abuse from staff

24.8% of Black, Asian and Minority Ethnic staff stated they had experience harassment, bullying or abuse from other staff. This is a slight **decrease** from 2022 (25.5%)

Metrics 7: Equal opportunities for career progression or promotion

51.8% of Black, Asian and Minority Ethnic staff said that SFT does provide equal opportunities for career progression or promotion. This is an **increase** from 2022 (44.2%)

Metrics 8: experiencing discrimination at work from manager/team leader or other colleagues

16.0% of Black, Asian and Minority Ethnic staff said they experiencing discrimination at work from manager/team leader or other colleagues. This is a **decrease** from 2022 (19.2%)

Progress against WRES 2022/23 action plan

Slides 18 to 20 sets out the Trust has made good progress against the six WRES 2022/23 action plan on our journey to make SFT an inclusive and equitable employer and workplace for our BME staff. Activities are grouped around three objectives: Cultural Development, Networks and Communications, and Recruitment and Promotion.

Action Plan 2024/25

Slide 21 sets out five WRES actions for 2024/25 grouped under Cultural Development, Networks and Communications, and Recruitment and Promotion.

National NHS WRES Report 2023 – Key Findings

NHS England's 2023 NHS Workforce Race Equality Standard (WRES) report was published on 18 March 2024, providing a valuable insight into the working and career experiences of staff from Black and minority ethnic (BME) background.

Workforce representation

In March 2023, 26.4% (380,108) of the workforce across NHS trusts in England were BME. This is an increase of 13% (43,070) from 2022.

Appointment from shortlisting

At 76% of NHS trusts, white applicants were significantly more likely than BME applicants to be appointed from shortlisting, higher than the 71% in 2022.

BME representation by pay bands

The total number of BME staff at very senior manager (VSM) level has increased by 61.7% since 2018 from 201 to 325. The percentage representation of BME staff at VSM level has increased from 10.2% to 11.2% over the past year

BME representation by pay bands

White Gypsy or Irish Traveller women (39.0%) and men (45.7%) experienced the highest levels of harassment, bullying or abuse from other staff

Harassment, bullying or abuse

In 2022, the percentage of staff experiencing harassment, bullying or abuse from other staff in the last 12 months was higher for BME staff (27.7%) than for white staff (22.0%). Although disparities between the experiences of BME and white staff persist, harassment, bullying and abuse from staff has followed a largely downward trend since 2018

Equal opportunities

In 2022, a lower percentage of BME staff (46.4%) than white staff (59.1%) felt that their trust provides equal opportunities for career progression or promotion

Career progression

Just 39.3% of staff from a Black background believed their trust provides equal opportunities for career progression or promotion, with levels below those of other ethnic groups since at least 2015.

Discrimination from other staff

In 2022, a higher percentage of BME staff (16.6%) than white staff (6.7%) experienced discrimination from other staff; a pattern that has been evident since at least 2015.

SFT Workforce 31 March 2024 (Metric 1)

SFT Workforce Diversity as of 31 March 2024

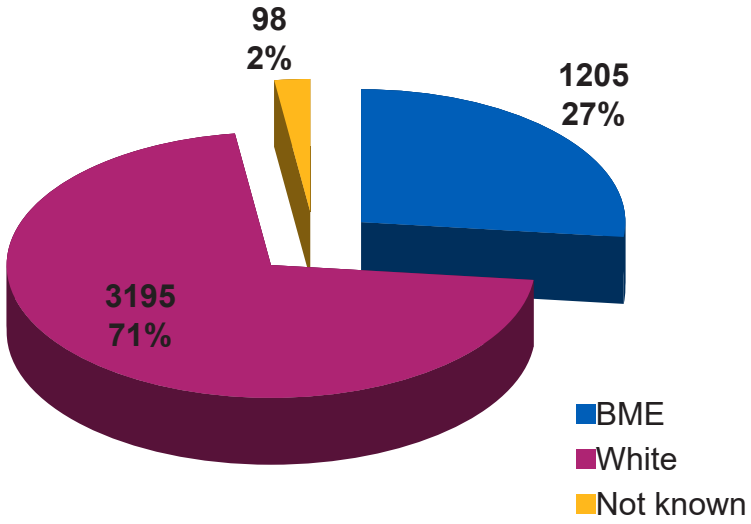
Total Employees: 4,498 (excluding bank staff)

White: 3,195 (71%)

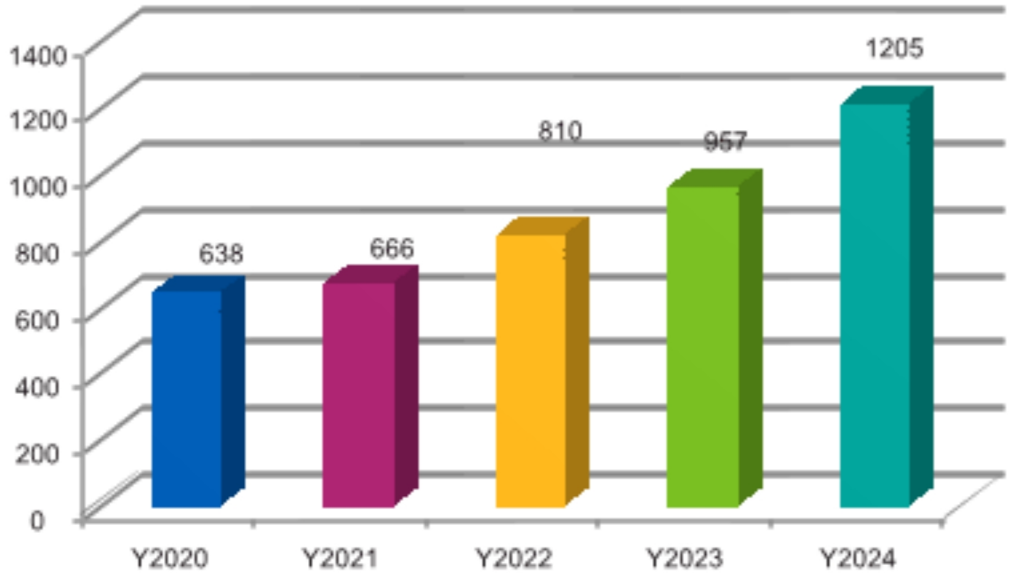
Unknown Ethnicity: 98 (2%)

Black and Minority Ethnic (BME): 1,205 (27%)

The number of BME staff significantly increased by 26% in 2024 compared to the previous year, growing from 957 to 1,205.



BME Workforce over last five years



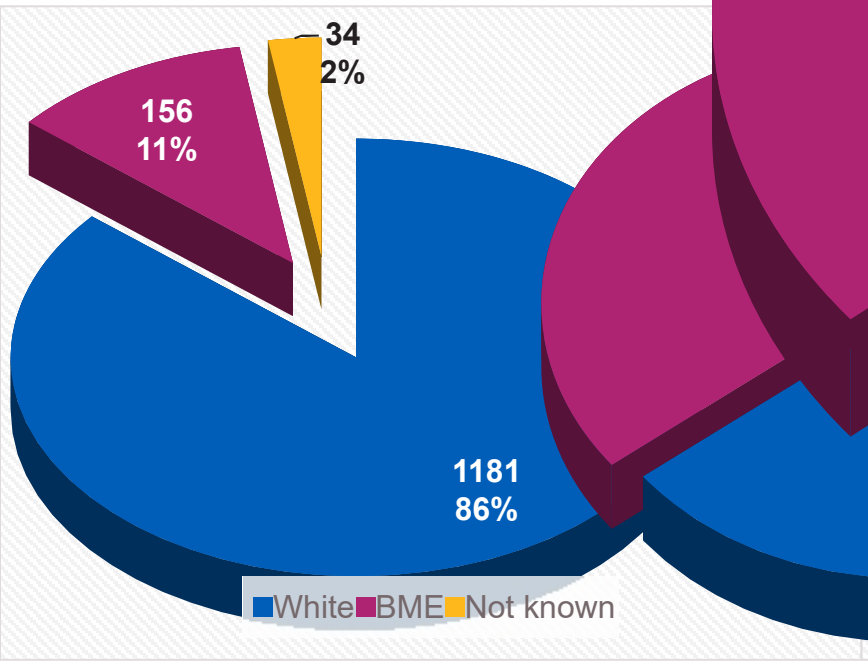
There has been a steady increase in the number of people from a BME background employed by the Trust as can be seen in the graph above. This has been boosted by international recruitment of nurses.

SFT Workforce 31 M ch 2024 (Metric 1)

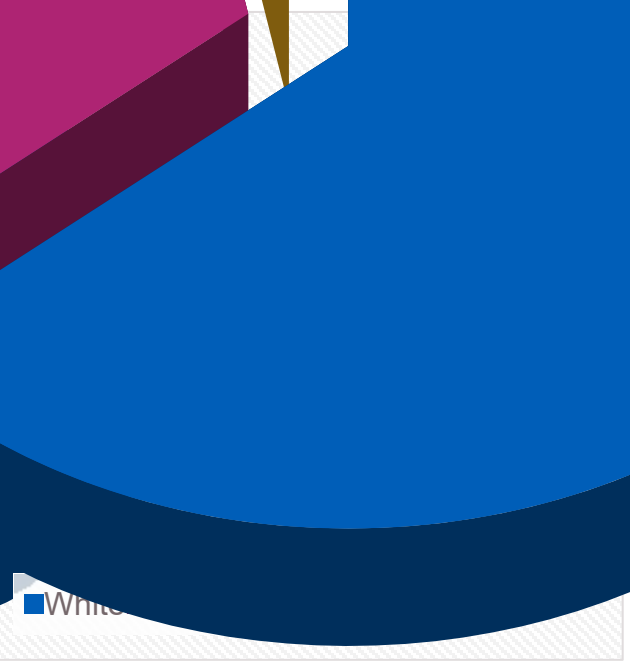
The following pie charts show the perce f clin compared with White staff.

3127 (70 ed t

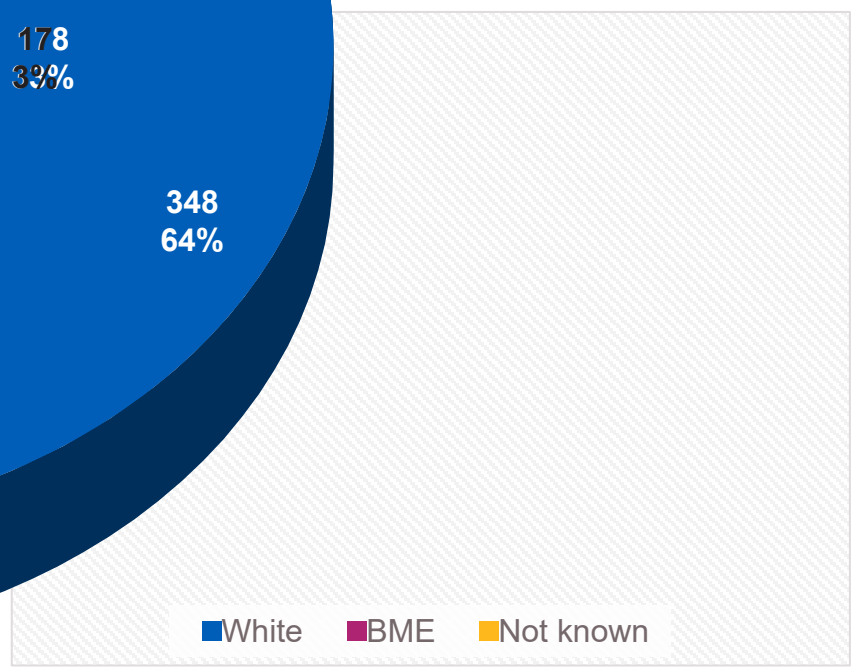
Non-clinical



ned



edical & Dental



Metric 1: SFT Workforce 31 March 2024 – Non-clinical

On the 31 March 2024, SFT had a total workforce of 4498 (excluding Bank Staff). The table below represents the breakdown of the non-clinical workforce.

1a) Non-clinical workforce	White (2023)	White (2024)	BME (2023)	BME (2024)	Ethnicity unknown (2023)	Ethnicity unknown (2024)
	Headcount	Headcount	Headcount	Headcount	Headcount	Headcount
Under Band 1	0	0	0	0	0	0
Band 1	2	1	0	0	0	0
Band 2	322	317	56	63	9	9
Band 3	338	335	36	47	11	13
Band 4	163	165	17	21	4	4
Band 5	107	107	5	9	3	1
Band 6	85	84	8	8	3	1
Band 7	53	72	2	3	1	1
Band 8A	41	39	0	2	2	2
Band 8B	21	24	2	2	2	1
Band 8C	10	10	1	0	0	0
Band 8D	10	9	0	0	1	2
Band 9	6	7	0	0	0	0
VSM	1	11	0	1	0	0
Total non-clinical	1159	1181	127	156	36	34

Metric 1: SFT Workforce 31 March 2024 – Clinical (non-medical)

On the 31 March 2024, SFT had a total workforce of 4498 (excluding Bank Staff). The table below represents the breakdown of the clinical (non-medical) workforce.

1b) Clinical workforce (non-medical)	White (2023)	White (2024)	BME (2023)	BME (2024)	Ethnicity unknown (2023)	Ethnicity unknown (2024)
	Headcount	Headcount	Headcount	Headcount	Headcount	Headcount
Under Band 1	0	0	0	0	0	0
Band 1	0	0	0	0	0	0
Band 2	76	66	26	43	0	2
Band 3	393	375	86	118	12	10
Band 4	101	111	71	67	1	3
Band 5	284	270	354	483	14	14
Band 6	427	423	106	122	11	10
Band 7	273	296	20	27	2	6
Band 8A	77	78	5	7	1	1
Band 8B	28	28	0	3	0	1
Band 8C	8	10	0	1	0	0
Band 8D	6	7	0	0	0	0
Band 9	1	0	0	0	0	0
VSM	1	2	0	0	0	0
Total clinical (non-medical)	1675	1666	668	871	41	47

Metric 1: SFT Workforce 31 March 2024 – Medical & Dental

On the 31 March 2024, SFT had a total workforce of 4498 (excluding Bank Staff). The table below represents the breakdown of the medical and dental workforce.

1b) Medical & Dental	White (2023)	White (2024)	BME (2023)	BME (2024)	Ethnicity unknown (2023)	Ethnicity unknown (2024)
	Headcount	Headcount	Headcount	Headcount	Headcount	Headcount
Consultants	174	179	35	35	10	13
Of which Senior medical manager	5	5	0	0	0	0
Non-consultant career grade	50	43	47	53	2	1
Trainee grades	124	126	80	90	2	3
Other	1	0	0	0	0	0
Medical & Dental	354	348	162	178	14	17

Equity in Career Progression – Race Disparity Ratio in 2024

The NHS Race Disparity Ratio is a tool used to measure the difference in career progression between White staff and BME staff. It looks specifically at the Agenda for Change (AfC) pay bands. in simple terms, imagine a ladder representing the different AfC pay bands. The Race Disparity Ratio tells us if there are any differences in how White staff and BME staff are climbing this ladder. A ratio of 1 means both groups are progressing equally. However, a ratio higher than 1 suggests BME staff face barriers in moving up to higher pay bands compared to White staff.

Non-clinical (SFT)

BME progression ratios

Lower to middle	140	/	11	=	12.73
Middle to upper	11	/	5	=	2.20
Lower to upper	140	/	5	=	28.00

White progression ratios

Lower to middle	925	/	156	=	5.93
Middle to upper	156	/	100	=	1.56
Lower to upper	925	/	100	=	9.25

Disparity ratios	BME		White		
Lower to middle	12.73	/	5.93	=	**2.15**
Middle to upper	2.20	/	1.56	=	**1.41**
Lower to upper	28.00	/	9.25	=	**3.03**

- Lower to middle pay bands: BME staff are **2.15** times less likely to progress equally from lower pay bands (such as Band 5) to middle pay bands (such as Band 6 or 7).
- Middle to upper pay bands: BME staff are **1.41** times less likely to progress from middle pay bands to upper pay bands (such as Band 8a or above).
- Lower to upper pay bands: Taking both steps into account, BME staff are **3.03** times less likely to progress equally from lower pay bands all the way to upper pay bands compared to white staff.

Clinical (SFT)

BME progression ratios

Lower to middle	711	/	149	=	4.77
Middle to upper	149	/	11	=	13.55
Lower to upper	711	/	11	=	64.64

White progression ratios

Lower to middle	822	/	719	=	1.14
Middle to upper	719	/	125	=	5.75
Lower to upper	822	/	125	=	6.58

Disparity ratios					
Lower to middle	4.77	/	1.14	=	**4.17**
Middle to upper	13.55	/	5.75	=	**2.35**
Lower to upper	64.64	/	6.58	=	**9.83**

- Lower to middle pay bands: BME staff are **4.17** times less likely to progress equally from lower pay bands (such as Band 5) to middle pay bands (such as Band 6 or 7).
- Middle to upper pay bands: BME staff are **2.35** times less likely to progress equally from middle pay bands to upper pay bands (such as Band 8a or above).
- Lower to upper pay bands: Taking both steps into account, BME staff are **9.83** times less likely to progress equally from lower pay bands all the way to upper pay bands compared to white staff.

NHS Model Employer BME Representation Target

The NHS Model Employer targets are ambitious goals set by NHS England to increase BME representation at all levels of the workforce, especially in leadership.

These targets aim to address existing racial disparities in career progression and create a more diverse and inclusive NHS. The core principle is to achieve leadership diversity that reflects the overall workforce composition within a set timeframe. Each NHS organization is expected to set its own target for BME representation across all levels, aligning with the national ambition.

In May 2021, the NHS WRES National Team introduced a more ambitious plan, aiming for organisations to achieve representative BME proportions across all AfC Pay Bands from Band 6 to VSM by 2025.

During 2023/24 the overall number of BME staff at SFT has grown significantly from 957 in 2023 to 1,205 in 2024.

Excluding medical and dental grades, the percentage of BME people across all AfC pay bands is 26% on 31 March 2024 (21.7% in 2023). The NHS Model Employer target aims to boost BME representation at all levels, particularly in leadership.

SFT has implemented three leadership development programmes accessible to all staff from Band 2 to Band 8. Additionally, SFT is committed to developing further initiatives, building on recent interview skills workshops over the next 12 months specifically aimed at enhancing career progression opportunities for BME staff.

The following table shows the BME representative figures.

Recruiting and retaining BME staff, particularly for leadership roles, is a challenge for SFT due to the limited pool of potential BME candidates in the Salisbury area, which has a BME population of about 6%. Our focus is to develop and promote career opportunities for BME staff across the organisation.

2024	Total staff	BME Staff	Actual % against 26% of BME staff representation
Band 6	648	130	**20%**
Band 7	405	30	**7%**
Band 8a	129	9	**7%**
Band 8b	59	5	**8.5%**
Band 8c	21	1	**5%**
Band 8d	18	0	**0%**
Band 9	7	0	**0%**
VSM	14	1	**7%**

Metric 2: Appointment from shortlisting 31 March 2024

Relative likelihood of staff being appointed from shortlisting across all posts.

X1.25

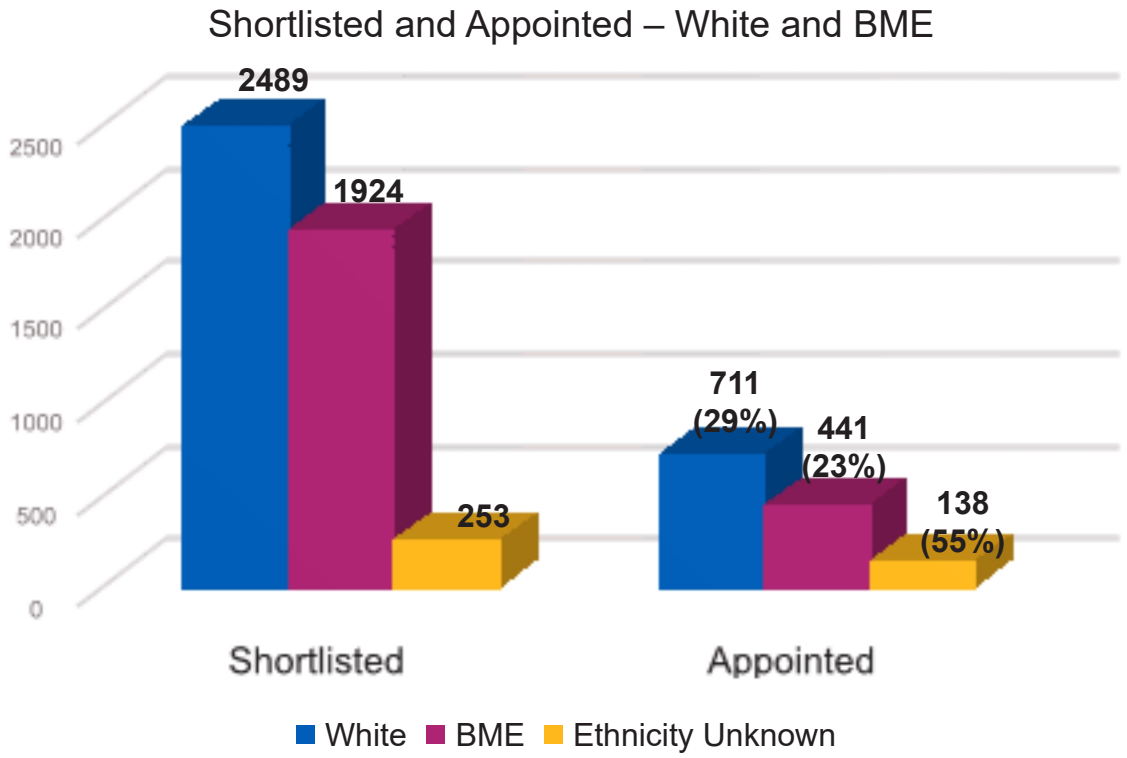
The purpose of this metric is to achieve equity between BME job applicants and White job applicants.

In 2024, the relative likelihood of White applicants being appointed from shortlisting compared to BME applicants was **x1.25**. This is a **decrease** from 2023 (x1.54)

A figure below 1:00 indicates that BME applicants are more likely than White applicants to be appointed from shortlisting.

This figure does not include directly recruited international staff as they do not come through the Trac recruitment process.

Note: Recent surge in international applicants on Trac has created a considerable challenge for recruiting managers in time and resources to sift and shortlist those eligible to work in the UK and meet the essential criteria



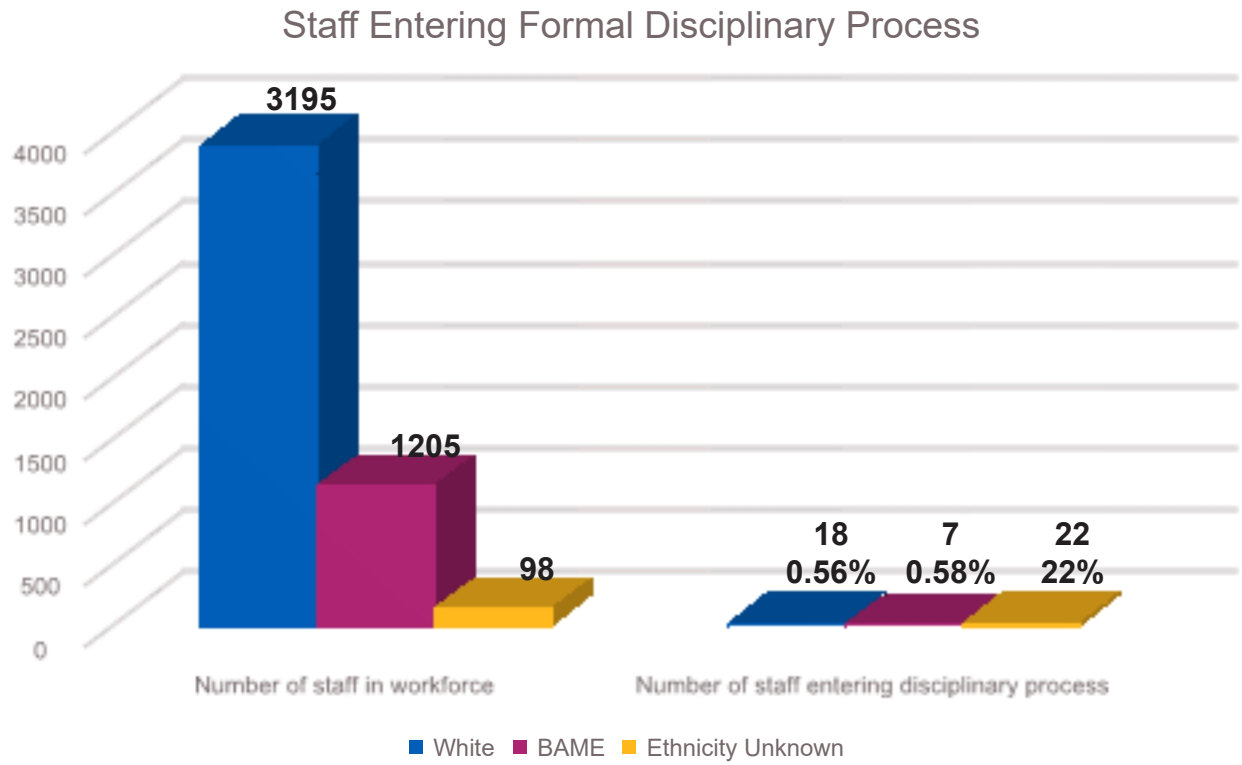
Metric 3: SFT WRES 31 March 2024

Relative likelihood of staff entering the formal disciplinary process, as measured by entry into a formal disciplinary investigation.

X1.03

In 2024, the relative likelihood of BME staff entering formal disciplinary process compared to White staff was **x1.03.** This is an **increase** from 2023 (x0.98).

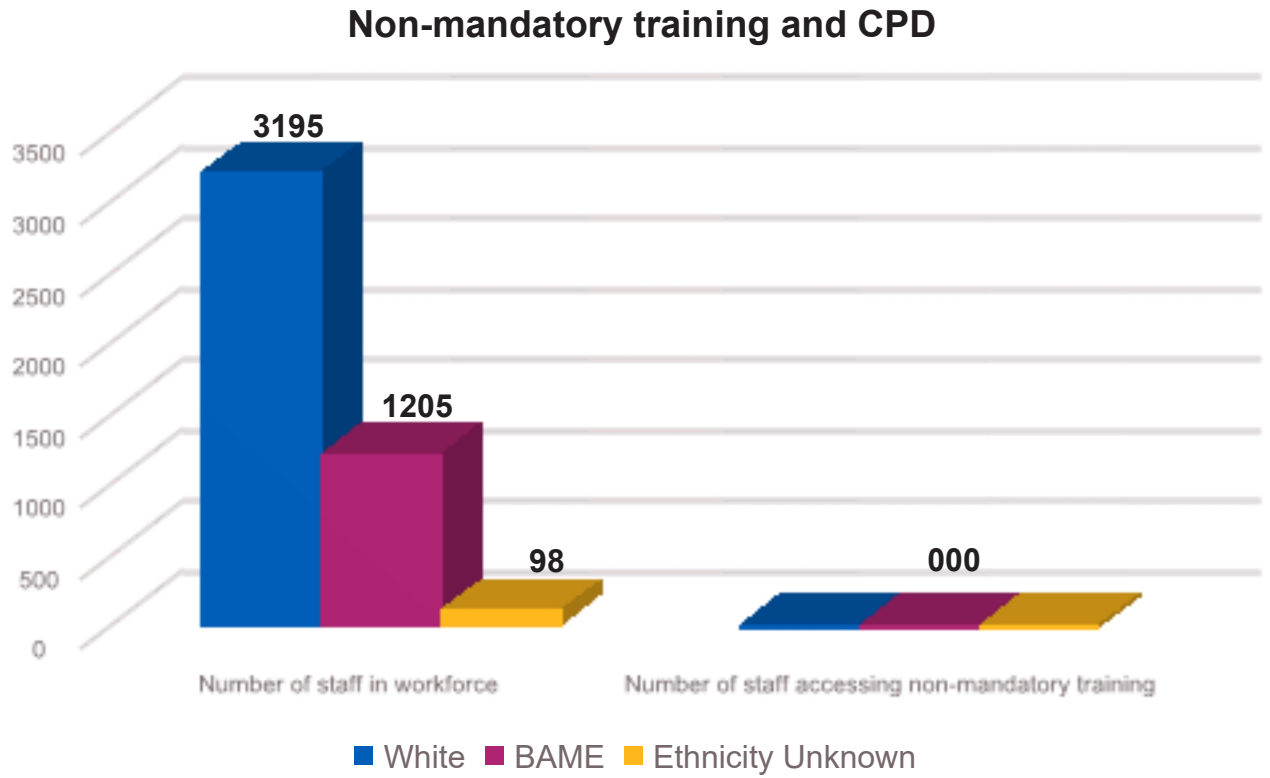
Note: A figure below 1:00 indicates that BME staff are less likely than White staff to enter the formal disciplinary process.



Metric 4: SFT WRES 31 March 2024

Relative likelihood of staff accessing non-mandatory training and CPD

NOTE: Currently, the Trust lacks a centralised system to track who has participated in non-mandatory training, but work is underway to identify ways of collecting this data.



Metric 5 & 6: SFT Staff Survey 2023

NOTE: Metrics 5 to 8 are sourced from the SFT's national NHS staff survey 2023

2265 people in the Trust responded to the 2023 staff survey (response rate of 54%). The following Staff Survey questions are recorded within our WRES data:

Metrics 5: Percentage of staff experiencing harassment, bullying or abuse from patients, relatives or the public in last 12 months out of those who answered the question

21.9% **o**f Black, Asian and Minority Ethnic staff stated they had experience harassment, bullying or abuse. This is a **decrease** from 2022 (28.9%)

20.7% of White staff stated they had experience harassment, bullying or abuse. This is a **decrease** from 2022 (24.7%)

Metrics 6: Percentage of staff experiencing harassment, bullying or abuse from staff in last 12 months out of those who answered the question

24.8% of Black, Asian and Minority Ethnic staff stated they had experience harassment, bullying or abuse. This is a slight **decrease** from 2022 (25.5%)

20.9% of White staff stated they had experience harassment, bullying or abuse. This is a **decrease** from 2022 (22.6%)

Metric 7 & 8: SFT Staff Survey 2023

NOTE: Metrics 5 to 8 are sourced from the SFT's national NHS staff survey 2023

2265 people in the Trust responded to the 2023 staff survey (response rate of 54%). The following Staff Survey questions are recorded within our WRES data:

Metrics 7: Percentage of staff believing that the trust provides equal opportunities for career progression or promotion

51.8% of Black, Asian and Minority Ethnic staff said **Yes.** This is an **increase** from 2022 (44.2%)

56.9% of White staff said **Yes**. This is a slight **increase** from 2022 (55.1%)

Metrics 8: Percentage of staff experiencing discrimination at work from manager/team leader or other colleagues in the last 12 months out of those who answered the question

16.0% of Black, Asian and Minority Ethnic staff said **Yes.** This is a **decrease** from 2022 (19.2%)

7.2% of White staff said **Yes**. This is an **increase** from 2022 (6.3%

Metric 9: Trust Board Membership 2024

Metric 9: Trust Board Membership – snapshot on 31 March 2024						
Board voting membership	**White (2023)**	**White (2024)**	**BME (2023)**	**BME (2024)**	**Ethnicity unknown (2023)**	**Ethnicity unknown (2024)**
Total Board members	11	13	1	1	2	0
of which: Voting Board members	11	13	1	1	2	0
Non-voting Board members	0	0	0	0	0	0
of which: Exec Board members	4	6	0	0	2	0
Non-executive Board members	7	7	1	1	0	0

Progress against WRES 2022/23 Action Plan

	Cultural Development Objective	Action	Progress	Workstreams carried over to 2024/25
1	To seek a downward trend in the percentage of BME staff experiencing harassment, bullying, abuse or discrimination at work **Metric 5, 6 and 8 (staff survey)**	• Review and refresh training interventions for all staff with a focus on civility and respect to support recognition and prevention of race discrimination. • Develop and rollout an inclusive leadership programme that enhances the ability of managers and team leaders to foster and effectively manage diverse teams and promote inclusivity.	• Two Legacy Mentors have been providing pastoral support to BME staff including Internationally Educated Nurses (IENs) • Leadership Behaviours Charter workshops have been successfully piloted and rolled out across all divisions. • A new 30-minute induction focusing on inclusion, wellbeing, and personal/professional boundaries has been launched for all new staff. • A 2-hour "Leading for Inclusion and Wellbeing" module has been integrated into the Transformational and Aspiring Leadership Programmes. • A successful Neurodiversity summit with over 100 staff was held on 4 April 2024 with a focus on making reasonable adjustments for neurodiverse staff **Metrics 5: Harassment, bullying or abuse from patients, relatives or public** **21.9%** of Black, Asian and Minority Ethnic staff stated they had experience harassment, bullying or abuse from patients, relatives or the public. This is a **decrease** from 2022 (28.9%) **Metrics 6: Harassment, bullying or abuse from staff** **24.8%** of Black, Asian and Minority Ethnic staff stated they had experience harassment, bullying or abuse from other staff. This is a slight **decrease** from 2022 (25.5%) **Metrics 8: experiencing discrimination at work from manager/team leader or other colleagues** **16.0%** of Black, Asian and Minority Ethnic staff said they experiencing discrimination at work from manager/team leader or other colleagues. This is a **decrease** from 2022 (19.2%)	• Rollout Leadership Behaviours Charter programme across all divisions. • Develop neurodiversity awareness and support resources to empower staff and managers with knowledge about the impact of neurodiversity, self-awareness, and behaviours, fostering a more inclusive workplace.. • Managers' Wellbeing Conversations training to be refreshed to incorporate duty of care onto support staff on mental wellbeing related to discrimination/exclusion. • Wellbeing Champions training and peer network are being refreshed to raise awareness of the link between mental wellbeing and discrimination/exclusion.

Progress against WRES 2022/23 Action Plan

	Cultural Development Objective	Action	Progress	Workstreams carried over to 2024/25
2	To seek an upwards trend in the percentage of BME staff believing that the trust provides equal opportunities for career progression or promotion. **Metric 7 (staff survey)**	• Design and establish a programme to support the career development and advancement of BME staff, including workshops to enhance knowledge and skills for job applications and interviews.	Job application and interview skills workshops in place **Metrics 7: Equal opportunities for career progression or promotion** **51.8%** of Black, Asian and Minority Ethnic staff said that SFT does provide equal opportunities for career progression or promotion. This is an **increase** from 2022 (44.2%)	• Consolidate job application and interview skills workshops throughout 2024
	To seek an upwards trend in the percentage of BME staff believing that the trust provides equal opportunities for career progression or promotion. **Metric 7 (staff survey)**	• Develop and test the BME Mentor/Mentee initiative within the framework of the Race Equality Wellbeing Project.	• Programme at scoping stage	• Pilot BME Mentoring Programme

	Recruitment Objective	Action	Progress	Workstreams carried over to 2024/25
3	To seek equity on appointment from shortlisting for BME applicants compared to white applicants. **Metric 2 (staff survey)**	Incorporate the principles of EDI from the NHSE/I's Six Point plan into the Trust's recruitment and promotion overhaul to foster inclusivity for BME staff.	• Full overhaul of recruitment and selection processes in place including diverse interview panels • **Metric 2: Appointment from shortlisting** In 2024, the relative likelihood of White applicants being appointed from shortlisting compared to BME applicants was **x1.25**. This is a **decrease** from 2023 (x1.54). • A figure below 1:00 indicates that BME applicants are more likely than White applicants to be appointed from shortlisting.	• Continue to embed best practice in recruitment and selection processes to achieve par on equity between BME and White job applicants. • Continue to develop diverse interview panels

Progress against WRES 2022/23 Action Plan

	Networks and Communication Objective	Action	Progress	Workstreams carried over to 2024/25
4	To develop a robust method to measure the relative likelihood of staff accessing non-mandatory training and CPD. **Metric 4 (staff survey)**	Identify and establish a procedure for documenting (e.g., MLE) the participation of staff in non-mandatory training and CPD, including details on the demographic backgrounds of the participants.	**Metric 4: BME Staff accessing non-mandatory training and CPD** At the present time, the Trust does not have a method for collecting staff accessing non-mandatory training and CPD. Work is in progress to identify a mechanism for identifying the uptake of non-mandatory training by BME staff. • This is ongoing work in the education department on MLE	• This is ongoing work in the education department on MLE
5	To enhance the reach and impact of the Culture and Equity Staff Network to improve the experience of BME staff across the Trust.	Support and develop the Culture and Equity Staff Network in celebrating and commemorating events, as well as in identifying and reporting on prevalent themes and issues concerning BME staff at the Trust.	• A new Multicultural Staff Network has been created with a mission to build an inclusive workplace where everyone belongs and has a voice that counts.	• Multicultural Staff Network relaunched on 18 July • Develop the leadership team with meaningful succession planning • Hold high visibility and impactful events (e.g.. Black History Month, Tent Talks Inclusion Day, Staff awards, Inclusion week, South Asian Heritage Month)
6	To improve personal and demographic data on ESR	Encourage all staff and Board execs to update their personal and demographic status on ESR.	**SFT Workforce Diversity as of 31 March 2024** Total Employees: 4,498 (excluding bank staff) White: 3,195 (71%) **Unknown Ethnicity: 98 (2%)** Black and Minority Ethnic (BME): 1,205 (27%) Board ethnicity now 100% known (9 White and I BME)	• Business as usual

WRES Action Plan 2023/24

	Cultural Development Objective	Action	Lead	Deadline
1	To seek a downward trend in the percentage of BME staff experiencing harassment, bullying, abuse or discrimination at work **Metric 5, 6 and 8 (staff survey)**	• Implement Leadership Behaviours Charter workshops across all divisions. • Update Managers' Wellbeing Conversation training to include addressing mental wellbeing concerns related to discrimination and exclusion. • Provide Inclusion Masterclass training for all staff. • Run 'nip in the bud' workshops to empower staff to confidently address discriminatory behaviours at the outset	Head of Inclusion & Wellbeing Head of Organisation Development & Leadership	Q3 2025/26
2	To seek an upwards trend in the percentage of BME staff believing that the trust provides equal opportunities for career progression or promotion. **Metric 7 (staff survey)**	• Consolidate job application and interview skills workshops throughout 2024	Head of Inclusion & Wellbeing Head of Resources	Q3 2025/26
3	To seek an upwards trend in the percentage of BME staff believing that the trust provides equal opportunities for career progression or promotion. **Metric 7 (staff survey)**	• Pilot BME Mentoring Programme	Head of Inclusion & Wellbeing Head of Resources	Q3 2025/26

	Networks and Communication Objective	Action	Lead	Deadline
4	To develop a robust method to measure the relative likelihood of staff accessing non-mandatory training and CPD. **Metric 4 (staff survey)**	• Develop a method for updating MLE via ESR on staff accessing non-mandatory training and CPD by demographics	Head of Education Head of Data Analysis	Q3 2025/26
5	To enhance the reach and impact of the Multicultural Staff Network to improve the experience of all staff, but with a spotlight on BME staff across the divisions/services/teams	• Develop the leadership team with meaningful succession planning • Hold high visibility and impactful events (e.g.. Black History Month, Tent Talks Inclusion Day, Staff awards, Inclusion week, South Asian Heritage Month)	Head of Inclusion & Wellbeing Deputy Head of Nursing (Surgery) Multicultural Staff Network	Q4 2024/25

Annex A – Definitions of Ethnicity: Workforce Race Equality Standard

	Ethnic Categories 2021 – Definitions of 'Black and Minority Ethnic' and 'White'
1	WHITE
	1 – White –British / Welsh / Scottish / Northern Irish / British 2 – White –Irish 3 – Gypsy or Irish Traveller 4 – Any other White background
2	**MIXED/MULTIPLE ETHNIC GROUPS**
	5 – White and Black Caribbean 6 – White and Black African 7 – White and Asian 8 – Any other mixed / multiple ethnic background please describe
3	ASIAN / ASIAN BRITISH
	9 – Asian or Asian British –Indian 10 – Asian or Asian British –Pakistani 11 – Asian or Asian British – Bangladeshi 12 – Asian or Asian British – Chinese 13 – Any other Asian background please describe

	Ethnic Categories 2021 – Definitions of 'Black and Minority Ethnic' and 'White'
4	BLACK / AFRICAN / CARIBBEAN / BLACK BRITISH
	14 – Black or black British – African 15 – Black or black British – Caribbean 16 – Any other black background please describe
5	ANY OTHER ETHNIC GROUP
	17 – Arab 18 – Any other ethnic group please describe
6	NOT STATED OR UNKNOWN
	19 – Not stated 20 – Do not wish to state 21 – Unknown

Salisbury NHS Foundation Trust

Workforce Disability Equality Standard (WDES)

Annual Report and Action Plan

2023/24

Introduction and Background to WDES 2023/24

About this annual report and action plan

This report presents Salisbury NHS Foundation Trust's Workforce Disability Equality Standard (WDES) annual report and action plan for 2023/24.

The WDES, a mandatory requirement of the NHS Standard Contract, is an evidence-based framework designed to enhance the experiences of disabled staff within the NHS. See **Annex A** for definitions of disability.

The WDES metrics allow NHS organisations to compare the workplace and career experiences of disabled and non-disabled staff, fostering a deeper understanding of the issues and inequalities faced by disabled staff.

Introduced in 2019, the WDES has evolved over four years, with the 2024 metrics building on the progress made towards improving the experiences of disabled staff working in, or seeking employment with, the NHS.

The WDES resources for NHS organisations can be found here.

The National WDES annual report 2023 provides key findings highlighting inequalities between the experiences of disabled staff and non-disabled staff across all ten metrics. emphasising the need for urgent action by NHS Trusts in 2023.

This includes cultivating inclusive leadership, reducing bullying and harassment, improving recruitment and selection plus enhancing the retention of disabled staff.

The WDES aligns with the People Promise commitments for a more inclusive, compassionate, and desirable NHS workplace.

Provider trusts must publish a WDES annual report and action plan (2023/24) on their website by 31 October 2024. This report should include:

- The organisation's data for each metric.
- A WDES action plan detailing how the organisation will address the differences highlighted by the metrics data over the next 12 months.
- A summary of progress made in achieving the objectives outlined in their 2022 WDES action plan.
- Steps the organisation will take to improve the experiences of disabled staff, as outlined in their 2023/24 WDES action plan.
- Steps to ensure disabled staff representation at all levels, identifying any barriers to career progression.

Previous SFT's WDES annual reports for 2019, 2020, 2021, 2022, 2023 can be found here.

EXECUTIVE SUMMARY

Workforce disability equality data

This report presents data on the Workforce Disability Equality Standard (WDES) of the Salisbury NHS Foundation Trust (SFT) for the year 2023/24. Data for metrics 1 to 3 and 9b are collected from the Trust's Electronic Staff Records (ESR) on 31 March 2024. Data for metrics 4 to 9a are collected from the 2023 staff survey.

Overall workforce (metric 1)

On 31 March 2024, SFT had a total of 4498 staff in the workforce (excluding Bank staff). Of which, 150 (3%) are disabled, 4145 (92%) are non-disabled and 203 (5%) have disability unknown. There is a big discrepancy between the ESR data (3% disabled) and the 2023 staff survey, where **24.5%** of those who responded (2217) declared themselves as having a physical or mental health conditions or illnesses lasting or expected to last for 12 months or more. The discrepancy rate is similar nationally in the NHS.

Disabled job applicants appointed from shortlisted (metric 2)

The purpose of this metric is to achieve equity between disabled job applicants and non-disabled job applicants. In 2024, the relative likelihood of non-disabled applicants compared to disabled applicants being appointed from shortlisted was **x1.17.** This is a **decrease** from 2023 (x1.47). A figure below 1:00 indicates that disabled applicants are more likely than non-disabled applicants to be appointed from shortlisting. **Note:** This figure excludes directly recruited international staff not using Trac. Recent surge in international applicants on Trac has created a considerable challenge for recruiting managers in time and resources to efficiently sift and shortlist those eligible to work in the UK, meet the essential criteria and are guaranteed an interview under the Disability Confident Scheme.

Disabled staff entering formal capability process (metric 3)

In 2024, the relative likelihood of disabled staff entering formal capability process compared to non-disabled staff was more than twice at **x2.86.** This is a **decrease** from 2023 (x2.92). Although x2.86 looks very high, the actual headcount (3 disabled staff) v (29 non-disabled staff) is low in relative terms. A figure below 1:00 indicates that disabled staff are less likely than non-disabled staff to enter the formal capability..

Metrics 4 to 9a are sourced from SFT's NHS staff survey 2023 (2265 respondent, 54% of the total workforce). LTC = Long Term Condition.

Metric 4a: Harassment, bullying or abuse from patients, relatives or public

30.0% of staff with a LTC or illness experienced harassment, bullying or abuse from patients/service users, their relatives or the public in the last 12 months out of those who answered the question. This is an **increase** from 2022 (25.2%)

Metric 4b: Harassment, bullying or abuse from managers

14.8% of staff with a LTC or illness experienced harassment, bullying or abuse from managers in the last 12 months out of those who answered the question. This is an **increase** from 2022 (13.9%)

Metric 4c: Harassment, bullying or abuse from other colleagues

27.8% of staff with a LTC or illness experienced harassment, bullying or abuse from other colleagues in the last 12 months out of those who answered the question. This is an **increase** from 2022 (26.2%)

Metric 4d: Reporting harassment, bullying or abuse

50.8% of staff with a LTC or illness said that the last time they experienced harassment, bullying or abuse at work, they or a colleague reported it out of those who answered the question reported it. This is an **increase** from 2022 (49.7%). **51.0%** of staff without a LTC or illness reported it. This is an **increase** from 2022 (46.6%)

Metric 5: Equal opportunities for career progression or promotion

51.9% of staff with a LTC or illness believed that SFT provides equal opportunities for career progression or promotion out of those who answered the question. This is an **increase** from 2022 (51.0%)

Metric 6: Pressure from their manager to come to work

31.8% of staff with a LTC or illness said that they felt pressure from their manager to come to work, despite not feeling well enough to perform their duties out of those who answered the question – an **increase** from 2022 (29.4%)

Metric 7: Work is valued

31.02% of staff with a LTC or illness said that SFT values their work out of those who answered the question. This is an **increase** from 2022 (29%)

Metric 8: Making reasonable adjustment(s)

74.8% of staff with a LTC or illness said that SFT made reasonable adjustment(s) to enable them to carry out their work out of those who answered the question. This is an **increase** from 2022 (70.8%) and **above average** compared to other NHS organisations (73.4%)

Metric 9a: Staff engagement score

The staff engagement score for staff with a LTC or illness was **6.51**. This is an **increase** from 2022 (6.46). The staff engagement score for staff without a LTC or illness was **7.07**. This is an **increase** from 2022 (6.78). The staff engagement score range is between 0 and 10.

Progress against WDES 2022/23 action plan

Slides 18 to 21 sets out the Trust has made good progress against the eight WDES 2022/23 action plan on our journey to make SFT an inclusive and equitable employer and workplace for disabled staff. Activities are grouped around three objectives: Cultural Development, Networks and Communications, and Recruitment and Promotion.

Action Plan 2024/25

Slide 22 sets out three WDES actions for 2024/25 grouped under Cultural Development, Networks and Communications, and Recruitment and Promotion

National NHS WDES Report 2023 – Key Findings

NHS England's 2023 NHS Workforce Disability Equality Standard (WDES) report was published on 18 March 2024, providing a valuable insight into the working and career experiences of disabled people.

Workforce representation

4.9% of the workforce declared a disability through the NHS electronic staff record (ESR) in 2023, an increase of 0.7 percentage points since 2022. The number of people declaring a long-term condition or illness anonymously in the NHS Staff Survey has also increased, from 22.4% in 2021 to 23.4% in 2022.

Workplace adjustments

73.4% of disabled staff reported they had the reasonable adjustment(s) required to perform their duties.

Capability

The relative likelihood of a disabled colleague being in capability is 2.17. This means that disabled staff are more than twice as likely to be in the capability process on the grounds of performance.

Feeling valued

35.2% of disabled staff reported that they felt valued for their contribution..

Presenteeism

27.7% of disabled staff experienced presenteeism. We continue to observe steady improvements in this metric since 2020.

Harassment, bullying or abuse

33.2% of disabled staff reported having experienced bullying, harassment or abuse from patients, service users or the public, 16.1% from managers and 24.8% from other colleagues.

Recruitment

The relative likelihood of a disabled job applicant being appointed through shortlisting has improved from 1.18 in 2019 to 0.99 in 2022. This national average suggests disabled and non-disabled applicants are equally likely to be recruited, but experience varies at trust level.

Board representation

5.7% of board members declared a disability through ESR in 2023, an increase of 1.1 percentage points since 2022.

Staff engagement

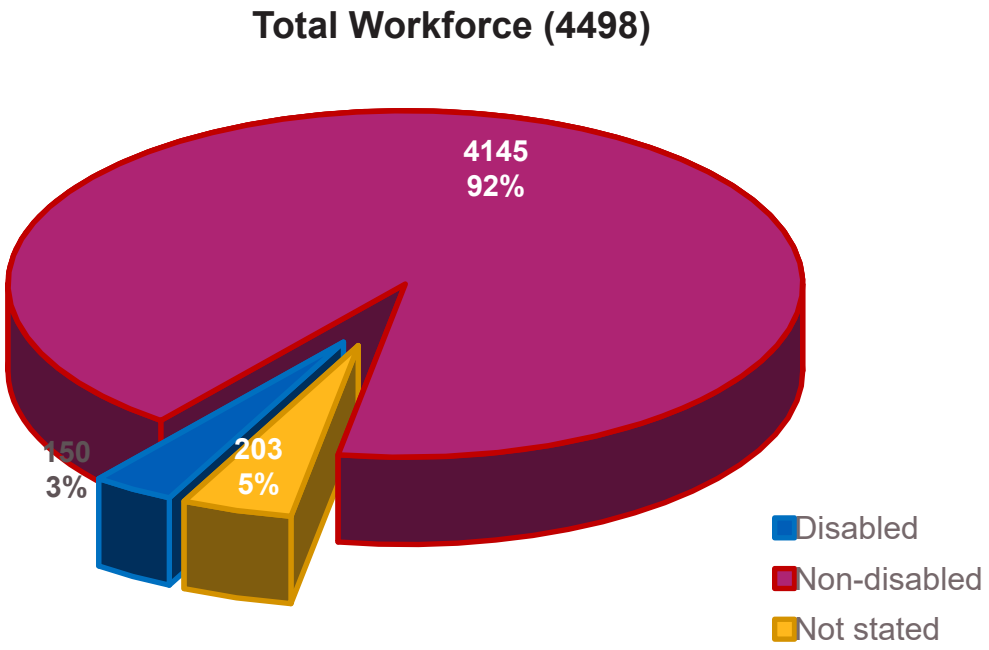
The staff engagement score for disabled staff was 6.4, the third consecutive year it has fallen. 100% of trusts said that they had facilitated the voices of disabled staff to be heard..

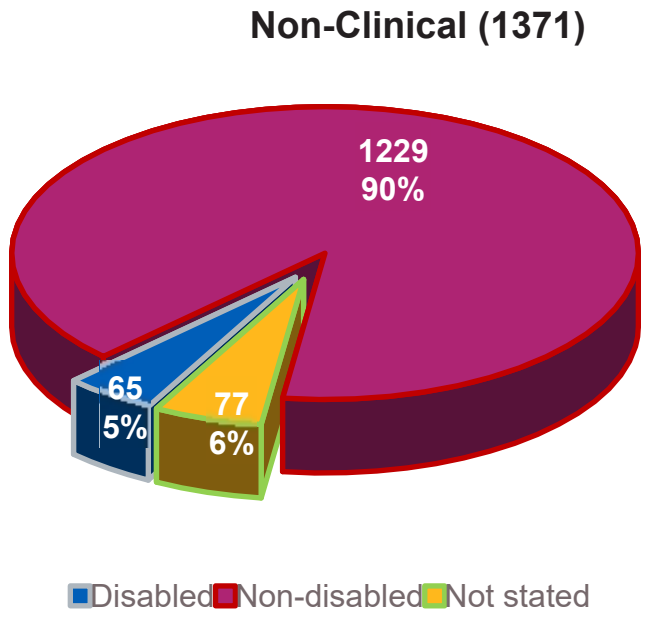
Career progression

52.1% of disabled staff believed they had equal opportunities for career progression or promotion. This is an increase from 51.3% in 2022.

SFT Workforce 31 March 2024 (Metric 1)

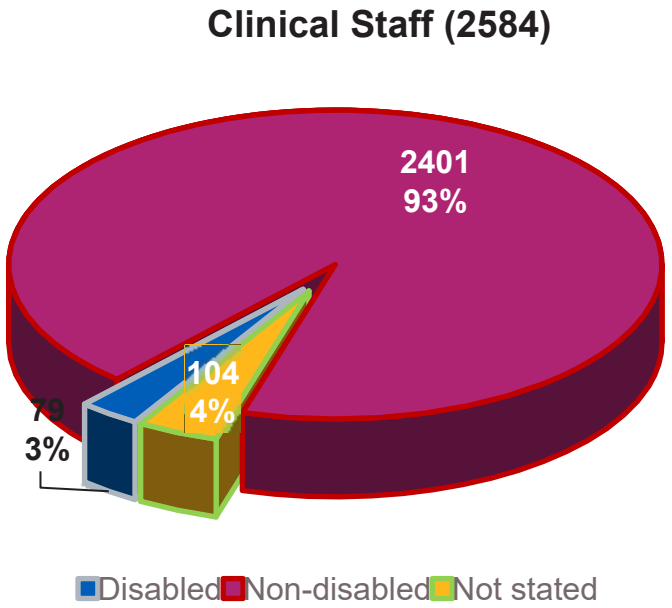
On 31 March 2024, SFT had a total of 4498 staff in the workforce (excluding Bank staff). Of which, 150 (3%) are disabled, 4145 (92%) are non-disabled and 203 (5%) have disability unknown.

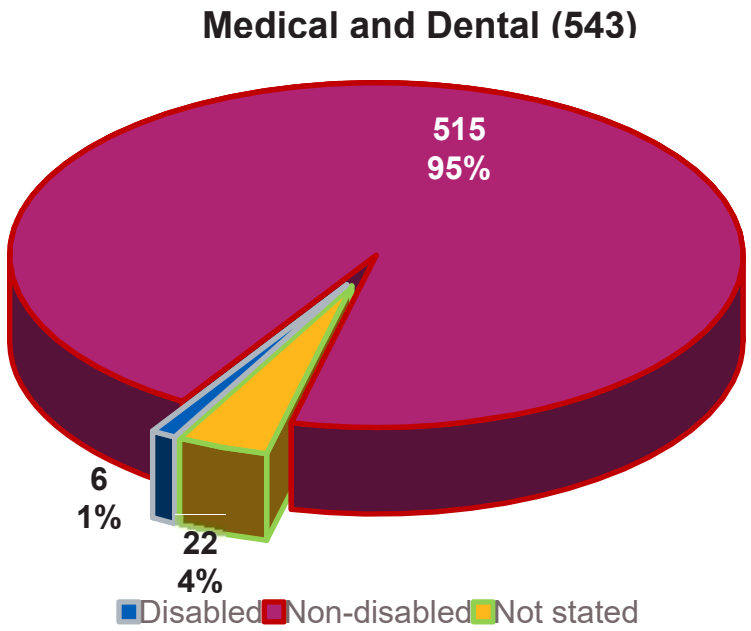




SFT Workforce 31 March 2024 (Metric 1)

On 31 March 2024, SFT had a total of 4498 staff in the workforce (excluding Bank staff). Of which, 150 (3%) are disabled, 4145 (92%) are non-disabled and 203 (5%) have disability unknown.





SFT Workforce 31 March 2024 – Non-clinical (Metric 1)

On 31 March 2024, SFT had a total of 4498 staff in the workforce (excluding Bank staff). Of which, 150 (3.33%) are disabled, 4145 (92.15%) are non-disabled and 203 (4.51%) have disability unknown.

1a) Non-clinical workforce	Disabled (2023)	Disabled (2024)	Non-disabled (2023)	Non-disabled (2024)	Disability unknown (2023)	Disability unknown (2024)
	Headcount	Headcount	Headcount	Headcount	Headcount	Headcount
Under Band 1	0	0	0	0	0	0
Band 1	0	0	2	1	0	0
Band 2	16	23	349	349	22	17
Band 3	17	15	346	358	22	22
Band 4	4	8	166	167	14	15
Band 5	3	5	98	104	9	8
Band 6	7	6	85	84	4	3
Band 7	2	4	50	68	4	4
Band 8A	2	2	39	39	2	2
Band 8B	1	1	22	25	2	1
Band 8C	1	0	9	9	1	1
Band 8D	1	1	10	9	0	1
Band 9	0	0	6	7	0	0
VSM	0	0	1	9	0	3
Total non-clinical	54	65	1184	1229	80	77

SFT Workforce 31 March 2024 – Clinical (Metric 1)

On 31 March 2024, SFT had a total of 4498 staff in the workforce (excluding Bank staff). Of which 150 (3.33%) are disabled, 4145 (92.15%) are non-disabled and 203 (4.51%) have disability unknown.

1b) Clinical workforce	Disabled (2023)	Disabled (2024)	Non-disabled (2023)	Non-disabled (2024)	Disability unknown (2023)	Disability unknown (2024)
	Headcount	Headcount	Headcount	Headcount	Headcount	Headcount
Under Band 1	0	0	0	0	0	0
Band 1	0	0	0	0	0	0
Band 2	8	9	89	100	5	2
Band 3	18	11	437	461	31	31
Band 4	0	4	165	174	8	3
Band 5	14	10	615	723	32	34
Band 6	18	25	510	512	16	18
Band 7	8	16	275	302	12	11
Band 8A	3	2	78	81	2	3
Band 8B	1	2	26	29	1	1
Band 8C	0	0	8	11	0	0
Band 8D	0	0	6	7	0	0
Band 9	0	0	1	0	0	0
VSM	0	0	1	1	0	1
Total Clinical	70	79	2211	2401	107	104

SFT Workforce 31 March 2024 – Medical and Dental (Metric 1)

On 31 March 2024, SFT had a total of 4498 staff in the workforce (excluding Bank staff). Of which 150 (3.33%) are disabled, 4145 (92.15%) are non-disabled and 203 (4.51%) have disability unknown.

1b) Medical & Dental	Disabled (2023)	Disabled (2024)	Non-disabled (2023)	Non-disabled (2024)	Disability unknown (2023)	Disability unknown (2024)
	Headcount	Headcount	Headcount	Headcount	Headcount	Headcount
Consultants	3	3	212	215	9	9
Non-consultants career grade	2	2	93	91	4	4
Medical & Dental trainee grade	2	1	196	209	9	9
Total Medical and Dental	7	6	501	515	22	22

Appointment from shortlisting 31 March 2024 (Metric 2)

Relative likelihood of disabled job applicants being appointed from shortlisting across all posts.

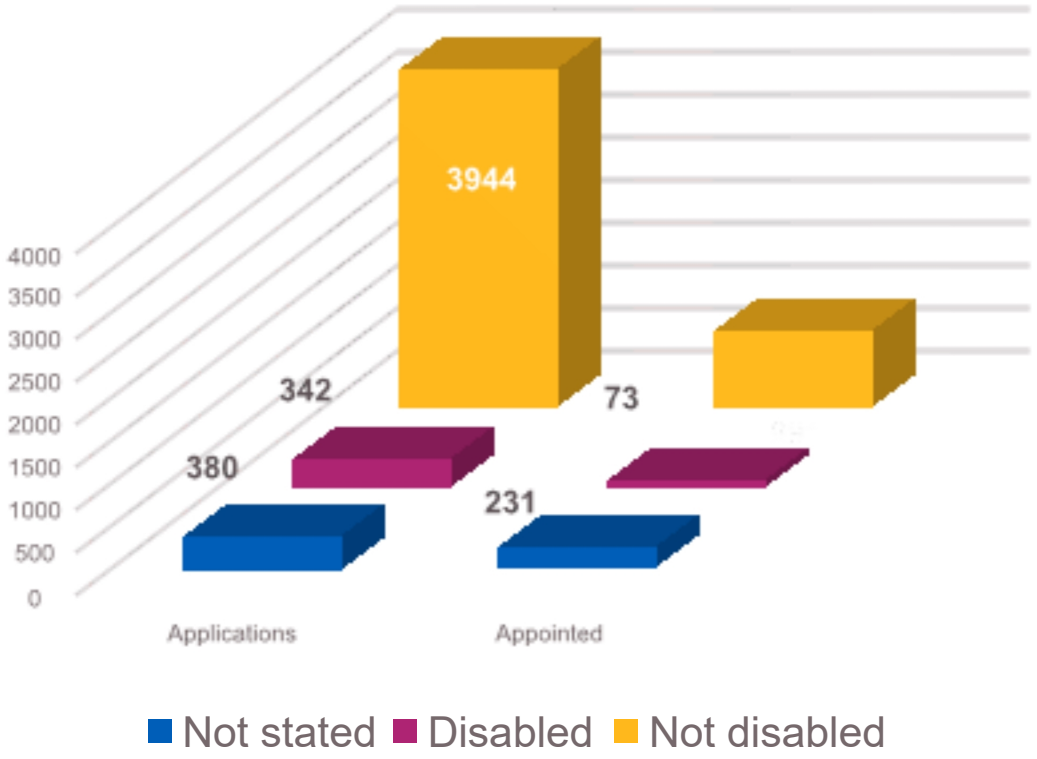
x1.17

The purpose of this metric is to achieve equity between disabled job applicants and non-disabled job applicants.

In 2024, the relative likelihood of non-disabled applicants compared to disabled applicants being appointed from shortlisting was **x1.17**. This is a **decrease** from 2023 (x1.47)

A figure below 1:00 indicates that disabled applicants are more likely than non-disabled applicants to be appointed from shortlisting.

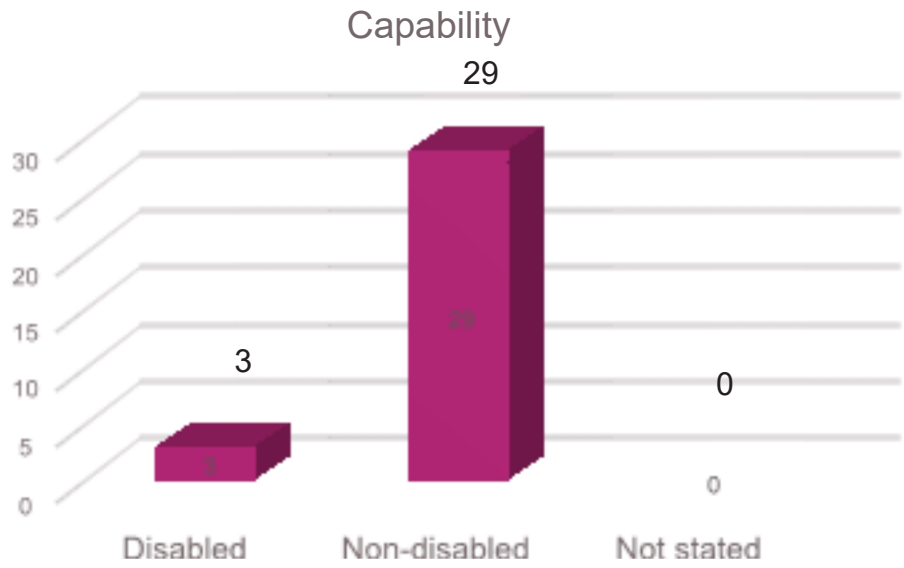
Note: This figure excludes directly recruited international staff not using Trac. Recent surge in international applicants on Trac has created a considerable challenge for recruiting managers in time and resources to efficiently sift and shortlist those eligible to work in the UK, meet the essential criteria and are guaranteed an interview under the Disability Confident Scheme.



SFT WDES 31 March 2024 (Metric 3)

Relative likelihood of disabled staff compared to non-disabled staff entering the formal capability process, as measured by entry into a formal capability procedure.

Metric 3: Relative likelihood of disabled staff compared to non-disabled staff entering the formal capability process, as measured by entry into a formal capability procedure. Note: This indicator will be based on data from a two-year rolling average of the current year and the previous years (April 2022 to March 2023 and April 2023 to March 2024)			
Formal capability process	Disabled	Non-disabled	Disability Unknown
	Headcount	Headcount	Headcount
Average number of staff entering the formal capability process over the last 2 years for any reason	3	29	0
Of these how many were on the grounds of ill-health	0	0	0
Relative likelihood of disabled staff entering formal capability compared to non-disabled staff	2.86		



x2.86

In 2024, the relative likelihood of disabled staff entering formal capability process compared to non-disabled staff was **x2.86.** This is a **decrease** from 2023 (x2.92). Although **x2.86** looks very high, the actual headcount (3 disabled staff) v (29 non-disabled staff) is low in relative terms.

Note: A figure below 1:00 indicates that disabled staff are less likely than non-disabled staff to enter the formal capability process.

SFT Staff Survey 2023 (Metric 4a & 4b)

NOTE: Metrics 4 to 9a are sourced from the SFT's national NHS staff survey 2023

2265 people in the Trust responded to the 2023 staff survey (response rate of 54%). The following Staff Survey questions are recorded within our WDES data:

Metric 4a: Percentage of staff experiencing harassment, bullying or abuse from patients/service users, their relatives or the public in the last 12 months out of those who answered the question

30.0% of staff with a LTC or illness experienced harassment, bullying or abuse. This is an **increase** from 2022 (25.2%)

18.1% of staff without a LTC or illness experienced harassment, bullying or abuse. This is a **decrease** from 2022 (25.3%)

Metric 4b: Percentage of staff experiencing harassment, bullying or abuse from managers in the last 12 months out of those who answered the question

14.8% of staff with a LTC or illness experienced harassment, bullying or abuse. This is an **increase** from 2022 (13.9%)

6.96% of staff without a LTC or illness experienced harassment, bullying or abuse. This is a **decrease** from 2022 (7.92%)

SFT Staff Survey 2023 (Metric 4c & 4d)

NOTE: Metrics 4 to 9a are sourced from the SFT's national NHS staff survey 2023

2265 people in the Trust responded to the 2023 staff survey (response rate of 54%). The following Staff Survey questions are recorded within our WDES data:

Metric 4c: Percentage of staff experiencing harassment, bullying or abuse from other colleagues in the last 12 months out of those who answered the question

27.8% of staff with a LTC or illness experienced harassment, bullying or abuse. This is an **increase** from 2022 (26.2%)

15.5% of staff without a LTC or illness experienced harassment, bullying or abuse. This is a **decrease** from 2022 (17.7%)

Metric 4d: Percentage of staff saying that the last time they experienced harassment, bullying or abuse at work, they or a colleague reported it out of those who answered the question

50.8% of staff with a LTC or illness reported it. This is an **increase** from 2022 (49.7%)

51.0% of staff without a LTC or illness reported it. This is an **increase** from 2022 (46.6%)

SFT Staff Survey 2023 (Metric 5 & 6)

NOTE: Metrics 4 to 9a are sourced from the SFT's national NHS staff survey 2023

2265 people in the Trust responded to the 2023 staff survey (response rate of 54%). The following Staff Survey questions are recorded within our WDES data:

Metric 5: Percentage of staff who believe that their organisation provides equal opportunities for career progression or promotion out of those who answered the question

51.9% of staff with a LTC or illness said YES. This is an **increase** from 2022 (51.0%)

56.9% of staff without a LTC or illness said YES. This is an **increase** from 2022 (54.2%)

Metric 6: Percentage of staff who have felt pressure from their manager to come to work, despite not feeling well enough to perform their duties out of those who answered the question

31.8% of staff with a LTC or illness said that they felt pressure to come to work. This is an **increase** from 2022 (29.4%)

17.9% of staff without a LTC or illness said that they felt pressure to come to work. This is a **decrease** from 2022 (21.5%)

SFT Staff Survey 2023 (Metric 7 & 8)

NOTE: Metrics 4 to 9a are sourced from the SFT's national NHS staff survey 2023

2265 people in the Trust responded to the 2023 staff survey (response rate of 54%). The following Staff Survey questions are recorded within our WDES data:

Metric 7: Percentage of staff satisfied with the extent to which their organisation values their work out of those who answered the question

31.02% of staff with a LTC or illness said YES. This is an **increase** from 2022 (29%)

44.5% of staff without a LTC or illness said YES. This is an **increase** from 2022 (37.3%)

Metric 8: Percentage of staff with a long-lasting health condition or illness saying their employer has made reasonable adjustment(s) to enable them to carry out their work out of those who answered the question.

74.8% of staff with a LTC or illness said YES. This is an **increase** from 2022 (70.8%)

This is **above average** compared to other NHS organisations (73.4%)

SFT Staff Survey 2023 (Metric 9a & 9b)

NOTE: Metrics 4 to 9a are sourced from the SFT's national NHS staff survey 2023

2265 people in the Trust responded to the 2023 staff survey (response rate of 54%). The following Staff Survey questions are recorded within our WDES data:

Metric 9a: The staff engagement score (0-10) for disabled staff, compared to non-disabled staff.

- The overall average staff engagement score at the Trust was **6.95**. This is an **increase** from 2022 (6.71)
- The staff engagement score for staff with a LTC or illness was **6.51**. This is an **increase** from 2022 (6.46)
- The staff engagement score for staff without a LTC or illness was **7.07**. This is an **increase** from 2022 (6.78)

Metric 9b: Has your Trust taken action to facilitate the voices of Disabled staff in your organisation to be heard? (yes) or (no)

YES. The Trust fosters an inclusive environment through its active staff network, Ability Confident, which is dedicated to supporting disabled staff. The network, with the Chief Nursing Officer as its Executive Sponsor, holds monthly meetings to actively engage with disabled staff and amplify their voices within the organization. To ensure staff concerns are heard at the highest levels, all staff network chairs, including the chair of Ability Confident, meet with the Chief People Officer every six weeks to discuss and address issues raised by their members. Additionally, the staff networks contribute valuable insights to the quarterly Organisational Development Culture & Learning Working Group, further amplifying the voices of disabled staff into the Trust's decision-making processes.

Trust Board Membership 2024 (Metric 10)

Metric 10: Trust Board Membership – snapshot on 31 March 2024						
Board	**Disabled (2023)**	**Disabled (2024)**	**Non-disabled (2023)**	**Non-disabled (2024)**	**Disability unknown (2023)**	**Disability unknown (2024)**
	Headcount	**Headcount**	**Headcount**	**Headcount**	**Headcount**	**Headcount**
Total Board members	0	0	10	10	4	4
Of which: Voting Board members	0	0	10	10	4	4
Non-voting Board members	0	0	0	0	0	0
Of which: Exec Board members	0	0	4	4	2	2
Of which: Non Exec Board members	0	0	5	6	3	2

Progress against WDES 2022/23 Action Plan

	Cultural Development Objective	Action	Progress	Workstreams carried over to 2024/25
1	To seek a downward trend in the percentage of disabled staff experiencing harassment, bullying, abuse or discrimination **Metric 4a, 4b & 4c (staff survey)** To seek an upward trend in the percentage of staff disabled staff saying SFT has made reasonable adjustment(s) to enable them to carry out their work. This is above average compared to other NHS organisations (73.4%)	• Review and refresh training interventions for all staff with a focus on civility and respect to support recognition and prevention of discrimination. • Develop an inclusive leadership programme that enhances the ability of managers and team leaders to understand OH processes and to make reasonable adjustments	• Behaviours Charter workshops have been successfully piloted and are now being implemented across all divisions. • A new 30-minute induction focusing on inclusion, wellbeing, and personal/professional boundaries has been launched for all new staff. • A 2-hour "Leading for Inclusion and Wellbeing" module has been integrated into the Transformational and Aspiring Leadership Programmes. • Successful Neurodiversity summit (over 100 staff attending) held on 4 April 2024 with a focus on making reasonable adjustments for neurodiverse staff • Successful Menopause Summit (over 95 staff attending) held on 31 May 2024 with a focus on making reasonable adjustments for staff going through menopause • **Metric 4a:** In 2023, **30.0%** of staff with a LTC or illness experienced harassment, bullying or abuse from patients/service users, their relatives or the public. This is an **increase** from 2022 (25.2%) • **Metric 4b:** In 2023, **14.8%** of staff with a LTC or illness experienced harassment, bullying or abuse from managers. This is an **increase** from 2022 (13.9%) • **Metric 4c:** In 2023, **27.8%** of staff with a LTC or illness experienced harassment, bullying or abuse from other colleagues. This is an **increase** from 2022 (26.2%) • **Metric 8:** In 2023, **74.8%** of staff with a LTC or illness said SFT made reasonable adjustments for the. This is an **increase** from 2022 (70.8%)	• Leadership Behaviours Charter workshops are being rolled out across all divisions. • Neurodiversity awareness and support resources are being developed and will be made available for all staff. • Menopause awareness and support resources are being developed and will be made available for all staff. • Managers' Wellbeing Conversations training to be refreshed to incorporate the duty to make reasonable adjustments. • Wellbeing Champions training and peer network are being refreshed to raise awareness of making reasonable adjustments and a culture of leading for wellbeing.

Progress against WDES 2022/23 Action Plan

	Cultural Development Objective	Action	Progress	Workstreams carried over to 2024/25
2	To seek validation for SFT to become a Disability Confident Scheme Leader (Level 3) to support the Trust in becoming an inclusive and equitable employer of choice for disabled staff	• Complete the Disability Confident Employer Level 3 Self-Assessment and apply for validation	• A gap analysis has been conducted to identify the specific differences between our current Level 2 (L2) capabilities and the desired Level 3 (L3) capabilities.	• A Task and Finish with relevant members to be set-up to support the elimination of the gaps and preparation for the L3 self-assessment and elevate any gaps • L3 self-assessment be submitted for approval in Q2 (2024/5)

	Networks and communications objective	Action	Progress	Workstreams carried over to 2024/25
3	To seek an upward trend in the percentage of disabled and non-disabled staff saying that the last time they experienced harassment, bullying or abuse at work, they or a colleague reported it. **Metric 4d (staff survey)**	• Discuss experiences of harassment, bullying or abuse with disabled staff, ensuring that there is a safe space for people to report and speak up.	• The Freedom to Speak Up Guardian (F2SU) and F2SU Ambassadors continue to place a pivotal role in creating a safe space for staff to report and speak up on a range of issues • Several 'listening' events have been held by the CPO and F2SU Guardian • Several 'listening' events have been held by the Chief Nursing Officer and the Deputy Head of Nursing (Surgery division) • **Metric 4d:** In 2023, **50.8%** of staff with a LTC or illness reported it. This is an **increase** from 2022 (49.7%)	• Promote further 'listening' events

Progress against WDES 2022/23 Action Plan

	Networks and communications objective	Action	Progress	Workstreams carried over to 2024/25
4	To seek an upward trend in the percentage of disabled staff satisfied with the extent to which their organisation values their work **Metric 7 (staff survey)**	• Develop a communications campaign focused on the benefits of employing disabled people, aligning these with the NHS People Promise values including the activities that support disability as an asset.	• A successful Neurodiversity summit with over 100 staff was held on 4 April 2024 with a focus on making reasonable adjustments for neurodiverse staff • A successful Menopause Summit with over 95 staff was held on 31 May 2024 with a focus on making reasonable adjustments for staff going through menopause • **Metric 7:** In 2023, **31.02%** of staff with a LTC or illness said YES. This is an **increase** from 2022 (29%)	• Celebrate with a big 'Thank You' to the contribution disabled staff make in the care of patients and carers during Disability History Month 2024 • Neurodiversity awareness and support resources are being developed and will be made available for all staff. • Menopause awareness and support resources are being developed and will be made available for all staff.
5	To seek an upward trend in the disabled staff engagement score. **Metric 9 (staff survey)**	• Continue to support the Ability Confident Staff Network in identifying and reporting on prevalent themes and issues concerning disabled staff.	• **Metric 9a:** In 2023, the staff engagement score for staff of staff with a LTC or illness was **6.51**. This is an **increase** from 2022 (6.46)	• Promote further 'listening' events
6	To improve self-declared disability data on ESR	• Encourage all staff and Board execs to update their personal status on ESR	• In 2023 ESR self-declared disability showed 150 staff as disabled (3%). • The 2023 staff survey, however, had 24.5% of those who responded (2217) declaring themselves as having a physical or mental health conditions or illnesses lasting or expected to last for 12 months or more. • Board members: 6 non-disabled and 4 disability unknown	• Continue to encourage all staff and board members to update their personal status on ESR via comms bulletin and managers weekly newsletter

Progress against WDES 2022/23 Action Plan

	Recruitment and Promotion Objective	Action	Progress	Workstreams carried over to 2024/25
7	To achieve equity on appointment from shortlisting for disabled applicants compared to non-disabled applicants. **Metric 2 (staff survey)**	• Collect insights from disabled applicants who were not selected after the shortlisting stage to improve selection	• Full overhaul of recruitment and selection processes in place including diverse interview panels • **Metric 2:** In 2023, the relative likelihood of non-disabled staff compared to disabled staff being appointed from shortlisting is **x1.17.** This has **decreased** from 2022 (x1.47). This takes SFT **above the national average on equity.** • A figure below 1:00 indicates that disabled staff applicants are more likely than non-disabled applicants to be appointed from shortlisting	• Continue to embed best practice in recruitment and selection processes to achieve par on equity between disabled and non-disabled job applicants. • Continue to develop diverse interview panels
8	To seek an upward trend in the percentage of disabled staff who believe that their organisation provides equal opportunities for career progression or promotion. **Metric 5 (staff survey)**	• Incorporate the principles of EDI from the NHSE/I's Six Point plan into the Trust's recruitment and promotion overhaul to foster inclusivity for disabled staff.	• Appraisal system streamlined and line managers regularly prompted to conduct appraisal • Managers encouraged to hold wellbeing conversations with their staff • **Metric 5** In 2023, **51.9%** of staff with a LTC or illness said YES. This is an **increase** from 2022 (51.0%)	• Promote meaningful appraisals that focus on professional development plans • Promote wellbeing conversations that eliminate inclusion and wellbeing barriers to career progression

WDES Action Plan 2023/24

	Cultural Development Objective	Action	Lead	Deadline
1	To seek a downward trend in the percentage of disabled staff experiencing harassment, bullying, abuse or discrimination and an upward trend **Metric 4 (staff survey)**	• Rollout Leadership Behaviours Charter workshops across all divisions. • Develop neurodiversity awareness and support resources to empower staff and managers with knowledge about the impact of neurodiversity, self-awareness, and behaviours, fostering a more inclusive workplace.. • Managers' Wellbeing Conversations training to be refreshed to incorporate duty of care onto support staff on mental wellbeing related to discrimination/exclusion. • Wellbeing Champions training and peer network are being refreshed to raise awareness of the link between mental wellbeing and discrimination/exclusion. • Rollout Inclusion Masterclass training for all staff. • Run active bystander 'nip in the bud' workshops to support staff to be confident to address discriminatory behaviours at the outset	Head of Inclusion & Wellbeing Head of Organisation Development & Leadership	Q3 2025/26

	Cultural Development Objective	Action	Lead	Deadline
2	To seek validation for SFT to become a Disability Confident Scheme Leader (Level 3) to support the Trust in becoming an inclusive and equitable employer of choice for disabled staff	• A Task and Finish with relevant members to be set-up to support the elimination of the gaps and preparation for the L3 self-assessment and elevate any gaps • L3 self-assessment be submitted for approval in Q2 (2024/5)	Head of Inclusion & Wellbeing	Q3 2025/26

	Networks and Communications Objective	Action	Lead	Deadline
3	To improve self-declared disability data on ESR	• Encourage all Continue to encourage all staff and board members to update their personal status on ESR via comms bulletin and managers weekly newsletter • Staff and Board execs to update their personal status on ESR	• Head of Inclusion & Wellbeing • ADC&E	Q3 2025/26

Annex A - Definitions of disability – Equality Act 2010, NHS Staff Survey, NHS Jobs & ESR

A	Equality Act 2010 – Legal definition of disability
	A person (P) has a disability if— (a) P has a physical or mental impairment, and (b) the impairment has a substantial and long-term adverse effect on P's ability to carry out normal day-to-day activities

B	NHS Staff Survey disability monitoring question
	Q28a. Do you have any physical or mental health conditions or illnesses lasting or expected to last for 12 months or more? If YES, please answer part b below; if NO, go to Question 29 Q28b. Has your employer made adequate adjustment(s) to enable you to carry out your work? 1 Yes 2 No 3 No adjustment required

C	NHS Jobs disability monitoring question
	The Equality Act 2010 protects Disabled people – including those with long term health conditions, learning disabilities and so called "hidden" disabilities such as dyslexia. If you tell us that you have a disability, we can make reasonable adjustments to ensure that any selection processes – including the interview – are fair and equitable. * Do you consider yourself to have a disability? 1. Yes 2. No 3. I do not wish to disclose this information. Please state the type of impairment which applies to you. People may experience more than one type of impairment, in which case you may indicate more than one. If none of the categories apply, please mark 'other'. • Physical impairment • Learning Disability/Difficulty • Sensory impairment • Long-standing illness • Mental health condition • Other If you have a disability, do you wish to be considered under the guaranteed interview scheme if you meet the minimum criteria as specified in the person specification? 1. Yes 2. No

D	Disability categories on ESR are:
	• Learning disability/difficulty • Long-standing illness • Mental Health Condition • No • Not Declared • Other • Physical Impairment • Sensory Impairment • Prefer Not to Answer • Yes – Unspecified

NHS Salisbury NHS Foundation Trust

Report to:	Trust Board (Public)	Agenda item:	7.1
Date of meeting:	3 October 2024		

Report title:	Research Annual Report			
Status:	Information	Discussion	Assurance	Approval
			Assurance	
Approval Process: (where has this paper been reviewed and approved):	This paper has been presented to the Clinical Effectiveness Steering Group (CESG)on the **10 July 2024** and The Clinical Governance Committee (CGC) on the **30th July 2024**			
Prepared by:	Tumi Kaminskas, Head of Research			
Executive Sponsor: (presenting)	Dr Duncan Murray, Interim CMO			
Appendices				

Recommendation:

The attached paper to the Board is for assurance purposes. The paper has been prepared to provide a comprehensive overview of the Research Department annual performance highlighting performance against higher level objectives, funding acquired and participant experience.

Executive Summary:

The report provides an overview of the Research Departments performance, funding opportunities and priorities over the past year. It is highlighting the achievements and strategic initiatives as well as providing assurance to the board.

Since April 2024, there has been a notable increase in the number of industry studies acquired, with three studies currently open and an additional three in the setup phase. This growth reflects our ongoing efforts to expand our research portfolio and strengthen industry partnerships.

The Salisbury Research Facility has also formed a strategic partnership with University Hospital Southampton (UHS) as a Spoke facility, as part of a funding application submitted to the National Institute for Health Research (NIHR) Clinical Research Development Collaboration (CRDC). The results of this funding application are expected to be available in autumn 2024.

In line with the recent changes in the Clinical Research Networks (CRNs), Salisbury will be transitioning to become part of the South West Central Regional Research Delivery Network

(RRDN) and will no longer be under CRN Wessex, effective October 1st. This change is expected to enhance our regional collaboration and access to broader research opportunities.

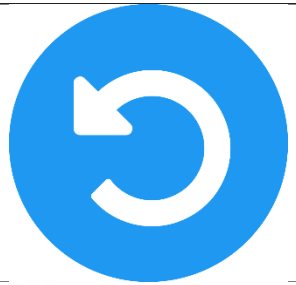
Board Assurance Framework – Strategic Priorities	Select as applicable:
Population: Improving the health and well-being of the population we serve	√
Partnerships: Working through partnerships to transform and integrate our services	√
People: Supporting our People to make Salisbury NHS Foundation Trust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

Salisbury
NHS Foundation Trust

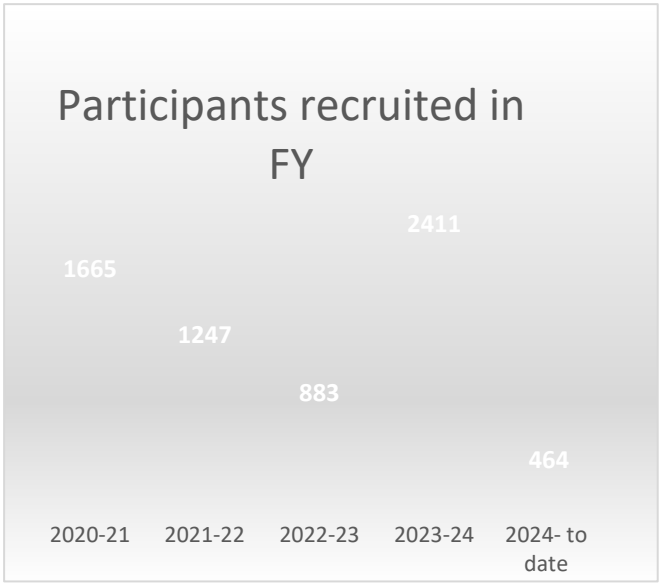
Research Performance Report 2023/24

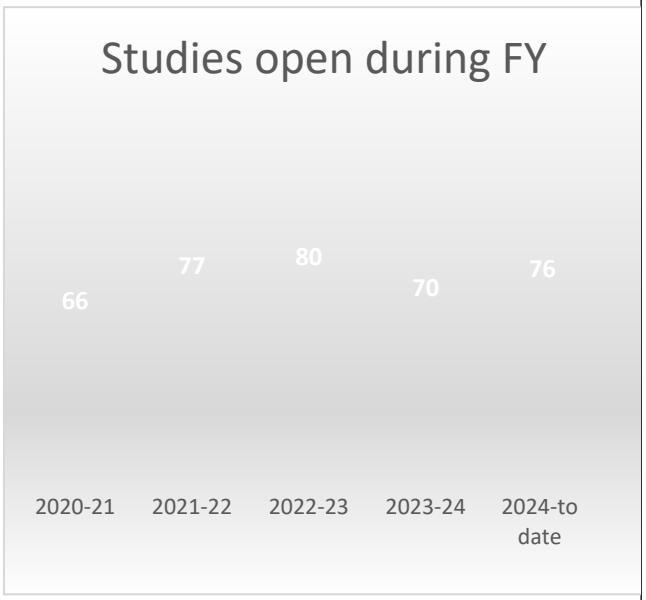
Contents

1. Summary

	**Recruitment had decreased during and after Covid. This was a trend across Wessex.** **We are hitting the targets we have negotiated with Sponsors**		**Feedback from the patient research experience survey at site is overwhelmingly positive**
 **Part 1**	**£2,234,988.61 research funding secured for ongoing research grants**		**NIHR Reset:** **Funding for our sponsored studies is safe as we are hitting our target recruitment or sufficient remedial action has been taken**
 **Part 2**	**£249,548 to fund equipment to support research**		**Research Culture review published by Ben Browne, Zoe Cole and Fiona McKneight** **Recommendations made by Ian Robinson - 100% of recommendations met** **Positive feedback from staff about changes**
	We have achieved so much this year by coming together as a team! See culture Review update		**Key priorities for the future:** • **Research to be aligned with local and national strategic objectives.** • **Establishment of research and innovation board** • **Establishing the Salisbury Research Hub** • **Establishment of research and innovation board** • **Establishing the Salisbury Research Hub**

2. High Level Objectives HLO - Trust recruitment of Patients to Research studies





The graphs indicate recruitment of participants over the past 5 years. 2411 participants were recruited during 2023/24; 464 participants in the last quarter of 2023/2024. This is a marked improvement compared to the preceding years.

The department of research is now focusing on increasing the portfolio and accepting new commercial and non-commercial studies. We have six studies open since October 2023; 3 commercial studies open since April 2024 and an additional 2 commercial studies in set up. This is the same number of commercial studies open to recruitment last year however, we expect to have a total of 5 new commercial studies open by the end of 2024.

Ordinarily CRN: Wessex use a funding formulae and performance against targets to allocate funds to NHS Organisations. In the absence of Trust targets for 2023/24, the Trust is received flat funding from the network of £643,101 plus an uplift for cost pressures. It is unclear if we will return to an activity-based model or what this will look like.

A new research funding model will be implemented following the full establishment of the new Regional Research Delivery Networks (RRDN) in October 2024. After which a revised model will be announced by the NIHR for the coming financial years.

High Level Objectives (HLOs)

Table 1 Wessex Performance

Salisbury Performance on Time to Target (graphs produced by CRN Wessex) Open24

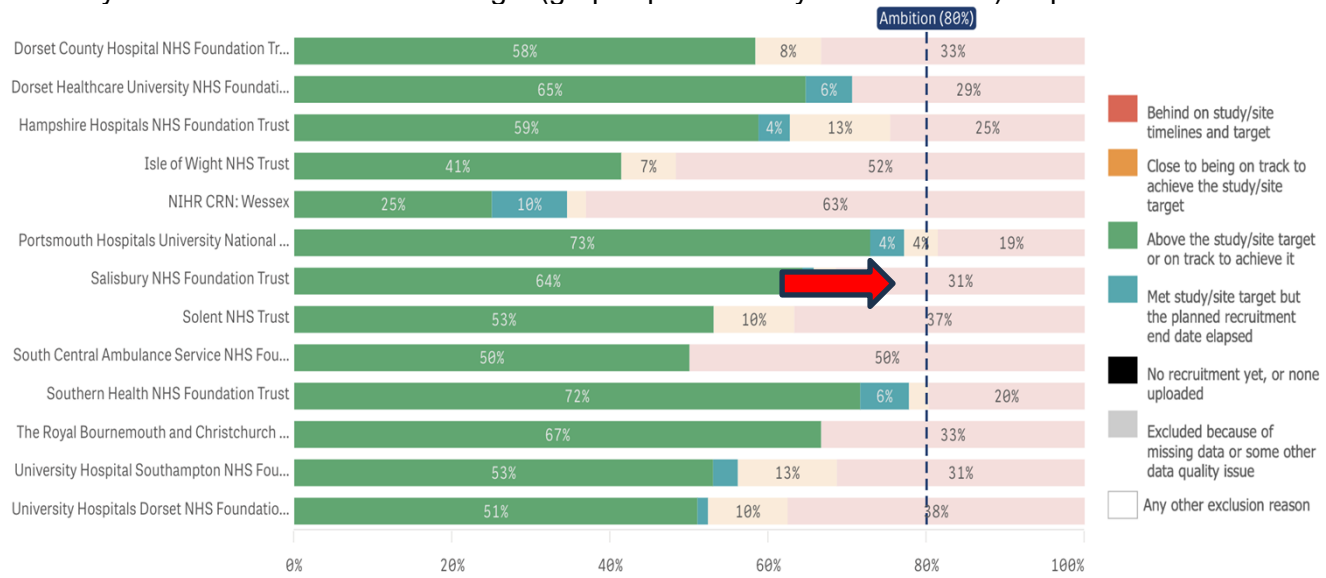


Table 1 shows Salisbury performance on achieving negotiated targets for non-commercial studies. Salisbury achieved 64% of studies recruiting to time and target so far against a national ambition of 80%. Salisbury NHS FT is likely to achieve and exceed the 80% yearly ambition as we have already recruited over 50% of our ambition in year.

High level objectives are monitored by Wessex-led studies (CI, lead site within region)

2024/25 year to date performance on HLOs set in 2023/24.
The HLOs for 2024/25 have not yet been confirmed.

Table 2

Objective		Measure	Ambition	Wessex	England
Study delivery	Support sponsors to deliver NIHR CRN Portfolio studies to recruitment target	Percentage of open to recruitment commercial contract studies which are predicted to achieve their recruitment target	80%	68% (27/40 open Wessex-led studies)	70%
		Percentage of open to recruitment non-commercial studies which are predicted to achieve their recruitment target	80%	75% (93/124 open Wessex-led studies)	82%
Participant experience	Demonstrate to participants in NIHR CRN supported research that their contribution is valued through collecting their feedback and using this to inform improvement in research delivery	Number of NIHR CRN Portfolio study participants responding to the Participant Research Experience Survey	1,237	174 (14%)	18,000 ambition

High Level Objectives are currently measured at CRN level.

Table 2 shows Wessex performance year to date and High-Level Objectives set in 2023/24.

.

2023/24 Year end performance (data cut data) Data cut is a period where data was extracted from the CRN Central Portfolio Systems

Objective		Measure	Ambition	Wessex	England
Study delivery	Support sponsors to deliver NIHR CRN Portfolio studies to recruitment target	Percentage of open to recruitment commercial contract studies which are predicted to achieve their recruitment target	80%	65% (26/40 open Wessex-led studies)	71%
		Percentage of open to recruitment non-commercial studies which are predicted to achieve their recruitment target	80%	78% (100/129 open Wessex-led studies)	82%
Participant experience	Demonstrate to participants in NIHR CRN supported research that their contribution is valued through collecting their feedback and using this to inform improvement in research delivery	Number of NIHR CRN Portfolio study participants responding to the Participant Research Experience Survey	1,237	1,622 (131%)	18,000 ambition (total national responses TBC)
	Study site performance on closed studies				

3.Patient Research Experience Survey (PRES)

This is an NIHR Tool designed to gather feedback from research participants. The aim is to improve experiences by collective participants views on various aspects of research processes. The standard procedure is to invite participants yearly to participate in the Patient Research Experience Survey. Until the final quarter the response rate to this survey was low at Salisbury NHS Foundation Trust. We have changed this to enhance recruitment and participation by implementing a monthly mail drop on selected one to two 2 studies whose participants have either finished their research journey or they may have a long follow up period and are nearing the end. Effectively a personalised Thank you letter from us thanking patients for their participation and asking for their feedback to help us develop and improve how we deliver research at SFT.

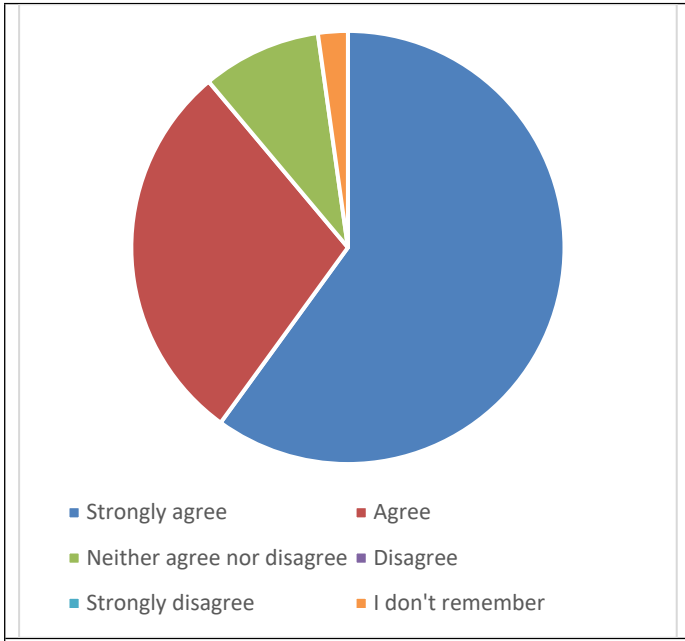
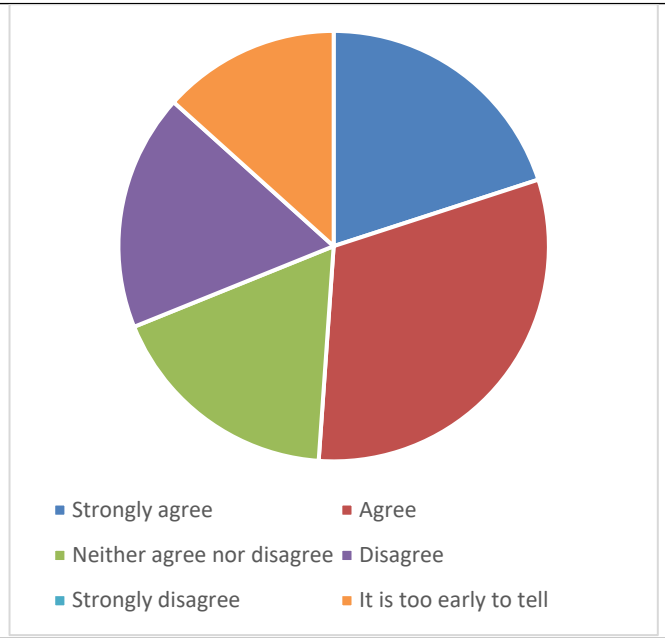
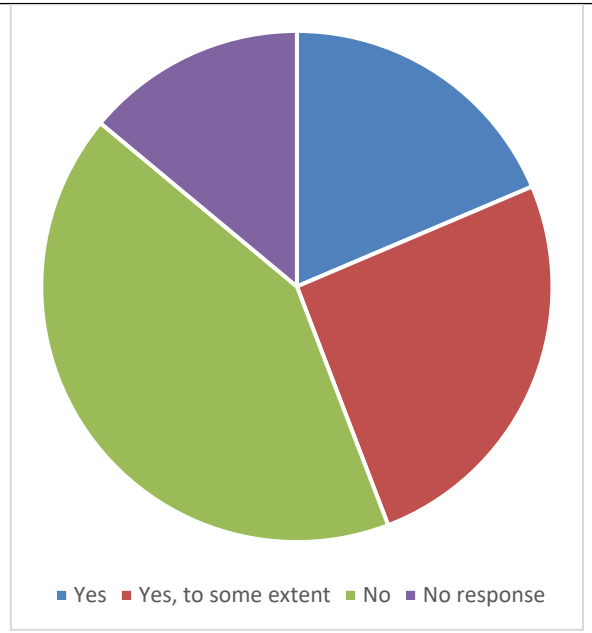
This has increased the response rate markedly putting Salisbury third in the region during 2023/24 the response rate markedly. Salisbury NHS Trust has scored particularly low at 21% on informing patients about the results of the study.

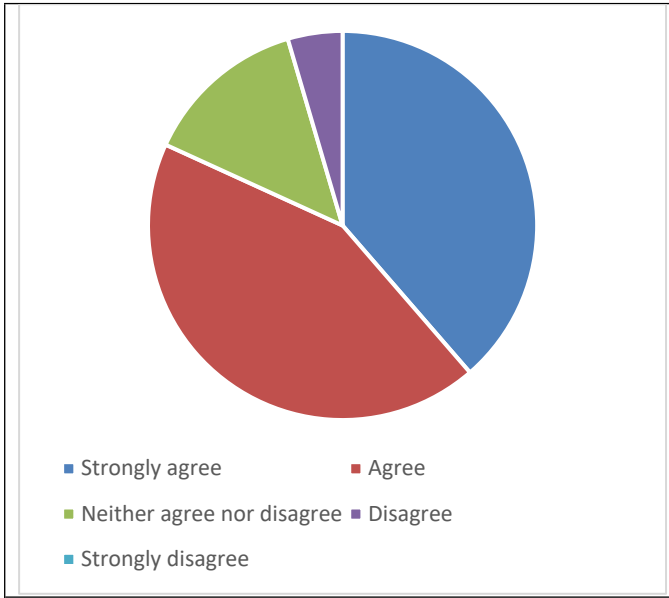
As a next step, we have moved to addressing the issues raised by participants in their feedback and we are providing information of the Study results where possible or directing participants to clinicaltrials.gov or to the locations specified by the sponsors for results publications.

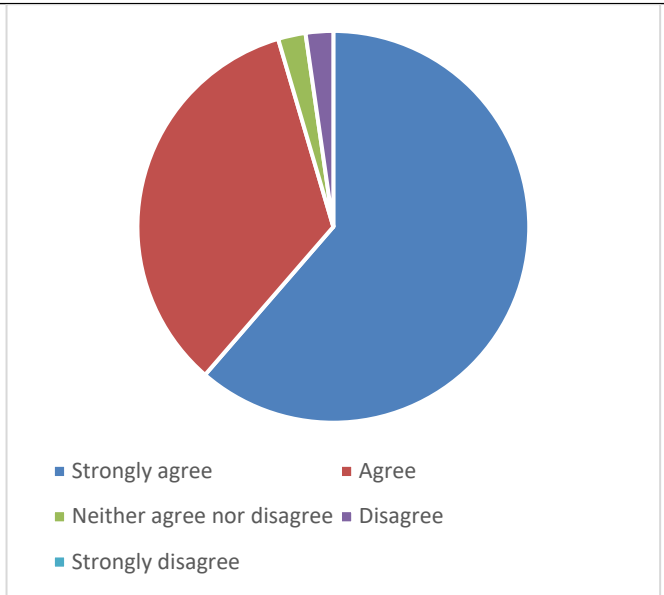
The graphs below, derived from responses collected during the last financial year, indicate positive feedback.

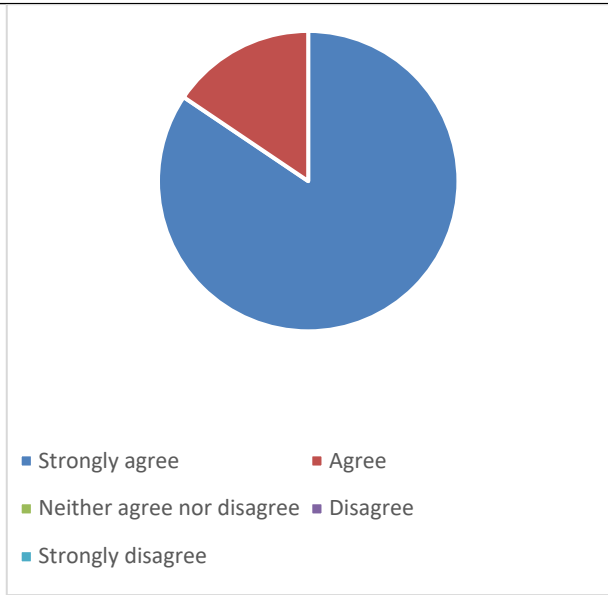
The feedback is relevant not only to research staff but the staff in the departments where the research took place.

1) The information that I received before taking part prepared me for my experience on the study	**2) I feel I have been kept updated about this research study / the research**	**3) I know how I will receive the results of this research study / the research**

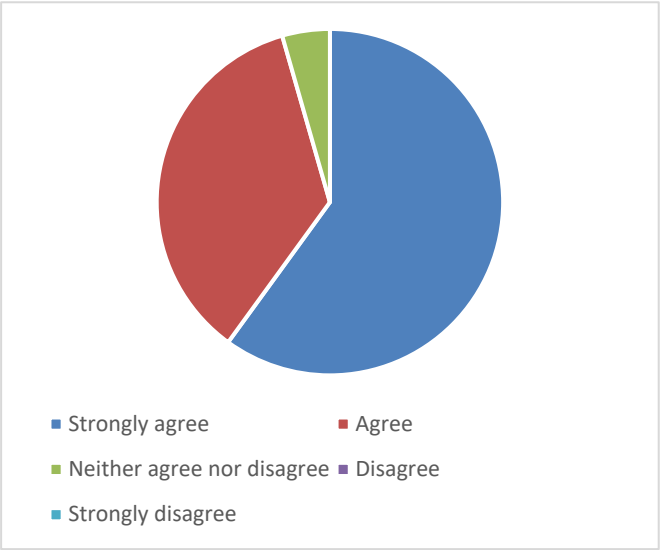
		
4) I know how to contact someone from the research team if I have any questions or concerns	**5) I feel research staff have valued my taking part in this research study / The researchers have valued my taking part in the research**	**6) Research staff have always treated me with courtesy and respect**







7) I would consider taking part in research again



What People said: Positive

These are the themes and an example quote:

- Felt valued: “I felt valued. Empathetic behaviour from researcher. Boost in confidence on how I was coping with my treatment.”
- Felt they were contributing to understanding of condition/treatment: “Very glad to provide data which may help in finding even better treatments, prevention or even cures for bowel cancer”
- Explained well and listened to: “Explained clearly and listened to what I had to say.”
- Friendly, empathetic kind staff: “Pleasant, helpful manner of research assistant. Seen immediately on arrival.”

What People said: Could do better …

These are the themes and an example quote:

- Location of clinics/location of hospital “Having a dedicated space, not the fault of the researcher but not sure if the research is supported by the Breast Unit enough?”
- More information at start and throughout “I couldn't think of anything until I saw the question about receiving the results. Maybe I was told in the very beginning? I assumed that I wouldn't get any results. However, I am most interested in receiving the results!”

4. Research Grants Secured

Grants secured & recruiting in 2022/23 and the grants still open in 2024			
ELABS Early Laser for Burn Scars – A prospective randomised controlled trial to study the effectiveness of the treatment of hypertrophic burn scars with Pulsed Dye Laser and standard care compared to standard care alone PI: Dr Mark Brewin Funding: NIHR RfPB £348,209 over 36 months Design: interventional This study has now ended.	**HIIT** A Feasibility Study of High Intensity Interval Training to Reduce Cardio-metabolic Disease Risks in Individuals with Acute Spinal Cord Injury PI: Prof James Bilzon- Uni Bath Funding: NIHR RfPB £250,000 over 27 months Design: interventional This study has now ended and the final report submitted on the 29th February 2024	**BOWMAN** A Randomised, Sham-Controlled, Proof of Principle Study of Abdominal Functional Electrical Stimulation for Bowel Management in Spinal Cord Injury PI: Dr Tamsyn Street Funding: Inspire Foundation £107,111 over 36 months Design: interventional This study has been extended and further recruitment sites added to maximise recruitment	3 research projects worth a total of £705,320 external grant funding and were recruiting in 2022/23 (ELABS ,BOWMAN and HIIT). In 2024, there are two Research studies sponsored by Salisbury NHS Foundation Trust, STEPS II, and BOWMAN. BOWMAN has recently added more national sites to bolster recruitment, the total recruitment to be achieved is 36. STEPS II now also open to recruitment and has two further sites that have expressed an interest to take part. This is multi-centre study. Research Capacity Funding (RCF) is awarded to research active NHS Organisations that

STEPS II The Efficacy of Peroneal Nerve Functional Electrical Stimulation for the Reduction of Bradykinesia in Parkinson's Disease: An Assessor Blinded Randomised Controlled Trial PI: Prof Paul Taylor Funding: NIHR EME £1,529,668.61 over 44 months Design: interventional				recruit >500 participants (£20k) OR received NIHR income in the previous calendar year (0.28 of income), whichever is greater. The Trust received £20k RCF funding for both 2020/21 and 2021/22. The grant income secured should provide a RCF income of around £50k for 2023/24 This has now increased to £100k in 2024/25 with the success of STEPS II grant application. This funding will be used to increase the research capacity..

5.Sponsor Engagement and Data- Cut: Sponsored studies

During the Research Recovery period – a period during which organisations were recovering their research portfolios post COVID - NIHR took strategic steps to consider which studies continue to be viable. Reset was a major part of this strategy. Sponsored studies are currently monitored according to their ability to recruit to timelines specified in their grant applications. Those studies that fall behind in their recruitment schedules must take remedial action. As part of reset if there is insufficient evidence of remedial action or the actions described are deemed insufficient to recover recruitment to the study, then those studies may be forced close. This has been replaced by the NIHR Sponsor Engagement Tool which operates under the same principles.

This is how it affects our studies:

BOWMAN:
This study fell behind recruitment but was granted an extension by the funding body. The study end date has been extended and further recruitment sites have been included increase recruitment.

Wessex sponsors such as SFT are bound by the terms and conditions for NIHR Clinical Research Network support for studies on the CRN Portfolio. These include maintaining a minimum dataset for the organisation's sponsored studies (e.g. amending the study details when it has passed the planned closure date, exceeding its sample size etc.) and ensuring timely and accurate recruitment data reporting and oversight. Otherwise, sponsors will be in breach of the NIHR Portfolio terms and conditions, and risk studies being removed from the NIHR CRN Portfolio without the option to appeal. There are quarterly deadlines imposed and sponsors are required to have the information accurately recorded on the NIHR Portfolio Management Systems.

6.Research Equipment Funding Secured (Capital Bid Funding)

Equipment to be purchased in 2023/24:

-80 Freezer
£12,255

The Research Department has now procured a -80 Freezer which is stored on site.

Capital Investment Call for NIHR Infrastructure saw total funding awarded being £1,711,501 across Wessex. Salisbury NHS Foundation Trust was successful in funding all the equipment it applied for to a total of £249,548. This equipment will be used to increase our success in attracting commercial income and grant income.

Equipment to be purchased in 2024/25:

Ophthalsuite £43,920 An integration platform for Ophthalmology that connects all devices to a centralised database regardless of the manufacturer, increasing efficiency and minimising risk. While this benefits all research studies, it will be an asset for a new HCQ Study in set up. Discussions are currently underway to assess if this software is compatible with EPR.	**Portable ultrasound** £58,463 This will increase the number of FES grants that we can apply for and increase ease of setting up commercial research	**Magstim Super Rapid +1 Transcranial Magnetic Stimulator (TMS)** £55,000 High specification TMS research equipment would open up a number of interesting opportunities to support research to improve the quality of life for people with neurological conditions such as spinal cord injury, stroke, multiple sclerosis, cerebral palsy and Parkinson's disease.	**Brainbox Neuronavigation System** £55,000 A Brain Navigation System is required for a high level of accuracy in research studies. Repetitive TMS paired with functional electrical stimulation is currently being explored as a potential treatment intervention for motor rehabilitation in people with neurological conditions.	**Portable echocardiogram** £24,910 A portable echocardiogram would help ensure timely echocardiograms for research and allow greater flexibility in location. We currently use clinical echocardiograms, but this resource is under intense pressure which means guaranteeing timely procedures can be difficult

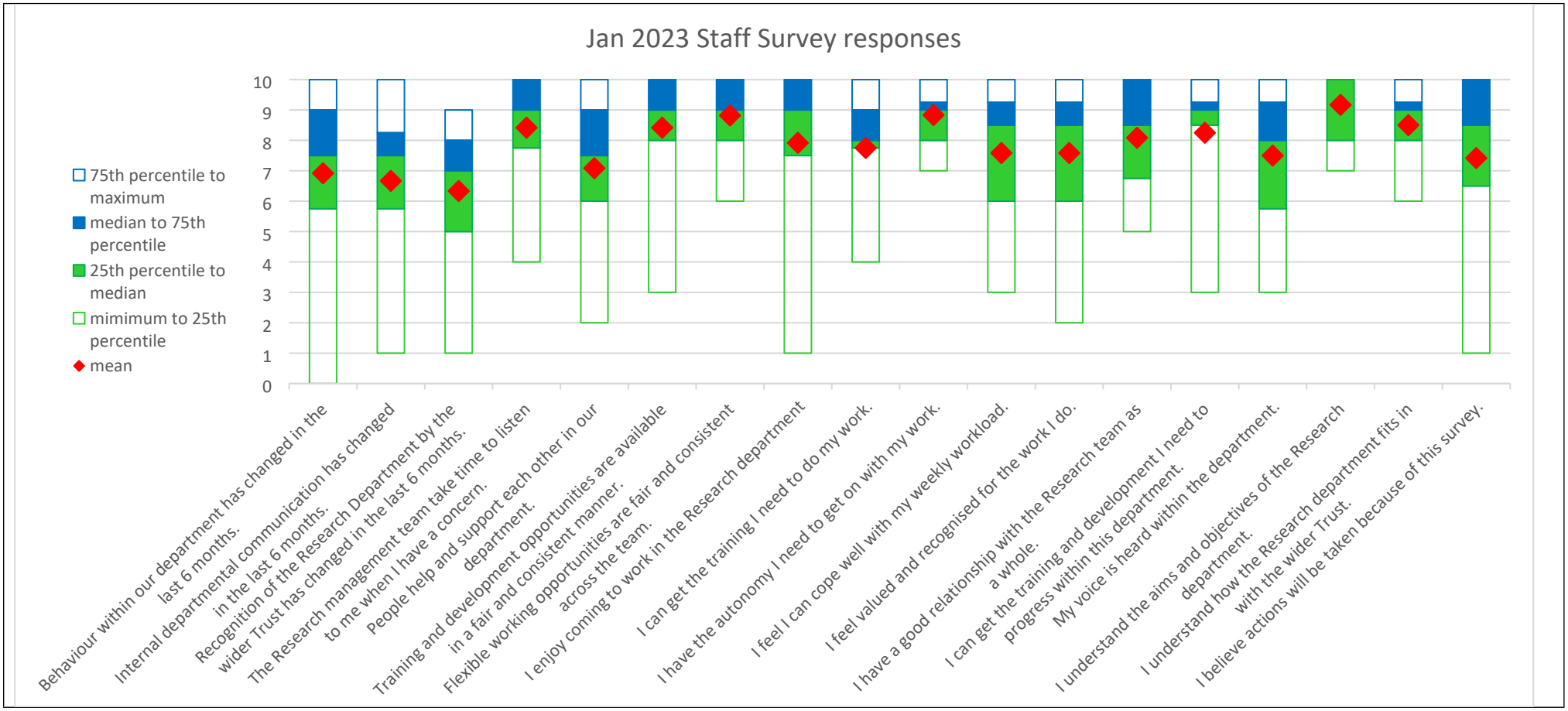
7.The Culture Review

Following a comprehensive culture review conducted in May 2022, the Research department formed a number of Working Groups to advance key issues in the service including raising awareness on Research, enhancing well-being, improving behaviour and conduct, and strengthening training and development.
Regular clinical governance sessions are held where the various projects including those led by the Working Groups are reported.

Some team members have attended two national research conferences in April and May 2024, The EDGE Conference and RD24, respectively. The research team have taken part in various other conferences and National research activities between May and September 2024 which are not in the reporting period but all of which have boosted morale and indicate ongoing improvement.

All the management team including some of the Research staff have attended the Improving Together Training May and June during 2024. The team is working closely with the Improving Together coach and has had three “go & see’s” attended by the coach to ensure that the Trust Strategy and objectives are delivered from a Trust and Research context.

By and large, the team feels empowered to suggest changes, which have been carefully considered and implemented where appropriate. Each team member has signed the behavioural charter to demonstrate commitment. Overall, staff morale has improved, and departmental goals and objectives are communicated regularly. Despite slight staff reductions due to one retirement, a pharmacy technician vacancy, and a reduction in R&D staff from 1 WTE to 0.5 WTE, we have maintained positive staff morale. We are currently recruiting a full-time Research Manager position. While this is not relevant for the reporting period it is added for context following the extensive work undertaken to review the culture and boost the teams morale.



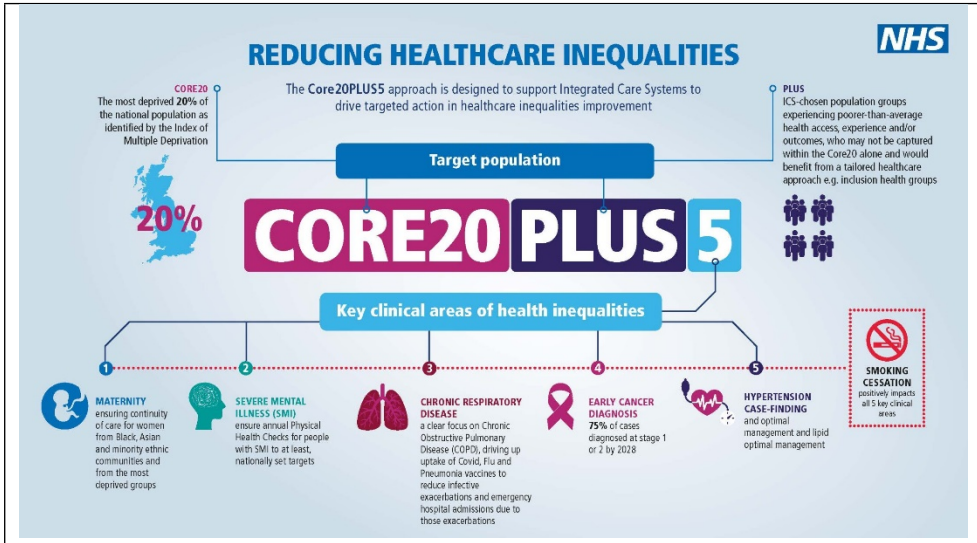
8. Other Key Achievements 2023/24

	In some areas we have excelled expectations: • Funding from successful CRN bid for our staff to work more flexibly and provide an out of hours service. • Link nurse role established to provide more communication with clinical teams, with further opportunities through associated PI scheme.

	• Comms regarding funding opportunities to develop own ideas has led to an increase in interest in research. • Establishment of a research board to improve the visibility of research, alignment with Trust strategies and maximise responses to external opportunities. • First enrolment and obtained in CRP pathway registration. This is a chance for our admin staff to progress to Clinical Trials Practitioner with a professional registration. • The first issue of the Research newsletter due on the 1st September 2024 • Salisbury NHS FT is one of the top recruiters of the SMA Trail (First UK Pilot study of newborn screening for spinal muscular atrophy) and have been approached by BBC Wiltshire for an interview.

9. Strategic Plan for 2023/24

NIHR  	**Integrating research** In order, for research to flourish it should be embedded within clinical practice. The research department will be key to support this. In order to emphasise the value of research, the department should increase its alliance with key national regional and local strategic priorities. Examples include: Decreasing health inequalities and promoting inclusion and diversity Core20plus5 shows areas where health inequalities could be improved. Research can influence these areas and studies that address these areas could be prioritised within the Trust. We are establishing links with EDI teams to improve integration of research locally. Promoting research is a legal obligation for ICS.



The research department will be represented at an ICB group discussing strategic priorities for research. We can then use these discussions to decide the best way to implement these aims in Salisbury. This will also allow us to explore possibilities for collaboration.

Increasing commercial research in the NHS

As per the O'Shaughnessy report, Commercial clinical trials in the UK: the Lord O'Shaughnessy review - GOV.UK (www.gov.uk)recovery of our commercial portfolio is a priority. We now have two open commercial trials in Salisbury and 3 in set up.

Developing the NHS workforce

We have launched the link person role. We are keen to further develop in these areas with an emphasis on NMAHP roles and more junior medical staff.

We have now acquired the space for the Salisbury Research Hub which will support commercial research. This will increase both our commercial portfolio and contribute to health prevention.

Appendix A: Trust recruitment per trial, Update recruitment 2023/4

NIHR Portfolio Study ID	Main Speciality	Project Short title	Recruited FY 2023/24	COVID Study?
55533	Anaesthesia, Perioperative Medicine and Pain Management	PANDOS	30	
55968	Anaesthesia, Perioperative Medicine and Pain Management	The POPPY Study	83	
12255	Cancer	OPTIMA	4	
17006	Cancer	IMPRESS.	1	
17059	Cancer	SERENADE	1	
20443	Cancer	TRACC - Tracking mutations in cell free tumour DNA to predict Relapse in Early Colorectal Cancer	18	
35640	Cancer	COMET (Previous title Crumpet)	4	
37613	Cancer	OnCoRe	3	
41941	Cancer	RAINBOW	3	
42281	Cancer	Myeloma XIV (FiTNEss)	1	
44010	Cancer	Body composition and chemotherapy toxicity in breast cancer (CANDO-3)	18	
45002	Cancer	The EMBED Study: Early Markers for Breast Cancer Detection	27	
47994	Cancer	TRACC C	8	
51104	Cancer	CITRuS Stage 1; Feasibility	3	
51460	Cancer	ELECTRIC: qualitative observational study in UK patients with CLL	2	
52879	Cancer	STATIC	1	
53300	Cancer	CHElsea II Trial	3	
53310	Cancer	QLG Survivorship 4	33	
38382	Cardiovascular Disease	ORION-4	31	
43791	Cardiovascular Disease	ORBITA-2	1	
16436	Children	Identification of factors associated with speech disorder-cleft palate	7	

47485	Children	SLUMBRS2	1	
49271	Children	Covid impact on RSV Emergency Presentations: BronchStart	15	yes
30540	Critical Care	GenOMICC	3	
18437	Dementias and Neurodegeneration	Parkinson's and Movement Disorders Families Project (PFP)	1	
57258	Dementias and Neurodegeneration	STEPS II	4	
10646	Dermatology	Biomarkers and Stratification To Optimise outcomes in Psoriasis (BSTOP)	11	
49143	Dermatology	Early Laser for Burn Scars (EL4BS)	5	
56171	Dermatology	PRO-SCALP Study	5	
8090	Dermatology	BADBIR	5	
9689	Diabetes	DRN 552 (Incident and high risk type 1 diabetes cohort – ADDRESS-2)	1	
20664	Gastroenterology	IBD Bioresource	178	
43148	Gastroenterology	Ustekinumab Real World Evidence Study	8	
8630	Genetics	Molecular Genetics of Adverse Drug Reactions (MOLGEN)	4	
14145	Haematology	UK Childhood ITP Registry	1	
53026	Health Services Research	REINFORCE	59	
54820	Health Services Research	SEISMIC-R	15	
43503	Hepatology	NAFLD BioResource	3	
52724	Infection	Development of Improved Methods for the Diagnosis of Wound Infections	12	
44431	Musculoskeletal Disorders	IMID BioResource	100	
52908	Musculoskeletal Disorders	Flexor tendon repairs - FIRST Study	29	
44971	Neurological Disorders	BOWMAN V. 12.0	8	
14362	Reproductive Health and Childbirth	The Cleft Collective Cohort Studies	85	
42795	Reproductive Health and Childbirth	LOCI: Letrozole Or Clomifene for Ovulation Induction	16	
46123	Reproductive Health and Childbirth	Premature Ovarian Insufficiency Study of Effectiveness of hormonal therapy (POISE)	1	
47078	Reproductive Health and Childbirth	Giant PANDA	10	
51281	Reproductive Health and Childbirth	Newborn screening for SMA	894	
56469	Reproductive Health and Childbirth	Chapter Cohort Study	39	
51339	Respiratory Disorders	REDUCE- Carbon	50	
40836	Stroke	OPTIMAS Trial	2	
40430	Surgery	Short or Long Antibiotic Regimes in Orthopaedics (SOLARIO)	1	

52006	Surgery	Reconstruction in Extended MArgin Cancer Surgery (REMACS)	3	
52135	Surgery	The MANGO Trial	3	
41515	Trauma and Emergency Care	Surgery or Cast for Injuries of the EpicoNdyle in Children's Elbows	1	
49972	Trauma and Emergency Care	Collar or no collar for peg fracture	2	
52042	Trauma and Emergency Care	ASPIRED	11	
53789	Trauma and Emergency Care	ACS:ED	63	
56625	Trauma and Emergency Care	DIDACT – DIsplaced DistAl Clavicle	1	
		SIREN 2.0	16	yes

Appendix B: Research to time and target 2023/24 (compare with preceding years)

SFT Directorate	**Specialty**	FY2223 Recruitment	%	FY2324 Recruitment	%2	FY24 – June 2024 Recruitment	%3
Clinical support & family services	Children	191	6.19%	123	2.09%	2	0.18%
Clinical support & family services	Genetics	0	0.00%	4	0.07%	1	0.09%
Clinical support & family services	Infection	96	3.11%	15	0.25%	3	0.27%
Clinical support & family services	Reproductive Health and Childbirth	432	14.00%	1885	31.98%	590	52.68%
Medicine	Ageing	23	0.75%	0	0.00%	1	0.09%
Medicine	Cancer	329	10.66%	324	5.50%	34	3.04%
Medicine	Cardiovascular Disease	110	3.57%	146	2.48%	13	1.16%
Medicine	Dementias and Neurodegeneration	67	2.17%	90	1.53%	23	2.05%
Medicine	Gastroenterology	161	5.22%	361	6.12%	61	5.45%
Medicine	Haematology	15	0.49%	8	0.14%	1	0.09%
Medicine	Hepatology	6	0.19%	18	0.31%	5	0.45%
Medicine	Respiratory Disorders	35	1.13%	169	2.87%	15	1.34%

Medicine	Stroke	36	1.17%	106	1.80%	10	0.89%
Medicine	Trauma and Emergency Care	221	7.16%	248	4.21%	14	1.25%
MSK	Dermatology	41	1.33%	32	0.54%	3	0.27%
MSK	Musculoskeletal Disorders	96	3.11%	232	3.94%	23	2.05%
MSK	Neurological Disorders	301	9.76%	680	11.54%	132	11.79%
Other	Diabetes	46	1.49%	13	0.22%	0	0.00%
Other	Health Services Research	50	1.62%	254	4.31%	7	0.63%
Other	Mental Health	91	2.95%	80	1.36%	9	0.80%
Other	Metabolic and Endocrine Disorders	47	1.52%	41	0.70%	2	0.18%
Other	Primary Care	4	0.13%	0	0.00%	0	0.00%
Surgery	Anaesthesia, Perioperative Medicine and Pain Management	367	11.90%	610	10.35%	88	7.86%
Surgery	Critical Care	112	3.63%	106	1.80%	15	1.34%
Surgery	Ophthalmology	6	0.19%	35	0.59%	8	0.71%
Surgery	Surgery	202	6.55%	314	5.33%	60	5.36%
Total		**3,085**	**100.00%**	**5894**	**100.00%**	**1120**	**100.00%**

NHS Salisbury NHS Foundation Trust

Report to:	Trust Board (Public)	Agenda item:	7.2
Date of meeting:	3rd October 2024		

Report tile:	Q1 Learning from Deaths Report 2024-25			
Status:	Information	Discussion	Assurance	Approval
	Yes	Yes	Yes	
Approval Process: (where has this paper been reviewed and approved):	Mortality Surveillance Group Clinical Governance Committee, 24 September 2024			
Prepared by:	Mr Charles Ranaboldo, Trust Mortality Lead Ben Browne, Associate Medical Director			
Executive Sponsor: (presenting)	Duncan Murray, Interim Chief Medical Officer			

Recommendation:

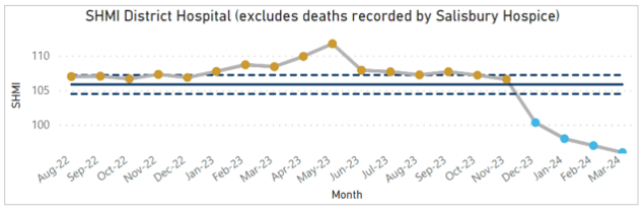
The paper is to provide assurance to the committee that the Trust is learning from deaths and making improvements.

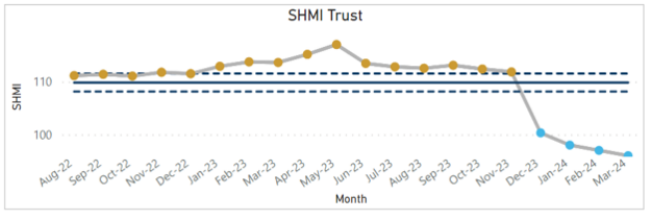
Executive Summary:

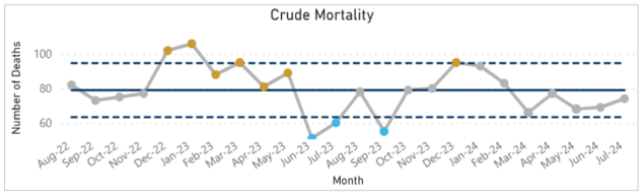
Summary:

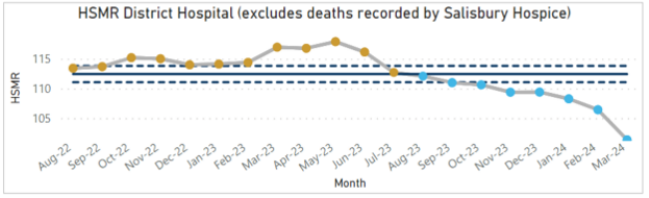
- The hospital mortality group (MSG) met twice during Quarter 1 (Q1), on 16th April 2024 and 11th June 2024, where learning, improvement themes and actions arising from mortality diagnosis group alerts and individual case reviews were discussed.
- There is a continued improvement in the Trust's Mortality Statistics. Both the HSMR and SHMI have continued to see a positive decline in recent months. A national revision to the modelling of the SHMI came into effect from the 12-month rolling period ending in December 2023 onwards.
- 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.
- Staff feedback suggests that space for medical staff to complete this work in the bereavement suite or close by remains a cause for lower completion rates. A request to space allocation has been made.
- In addition to the initial review by the Medical Examiner, 15% of all recorded deaths were also subject to a primary review.
- Most actions from a Board requested mortality insight visit undertaken by NHSE have now been completed. Due to the improved position in our mortality benchmarking figures and improvements made, the visit process will now be formally closed.
- A new training video has been created to emphasise the ease and speed of process for completion of reviews within the mortality module in AMaT.

Salisbury
NHS Foundation Trust









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

NHS
Salisbury
NHS Foundation Trust

QUARTER 1 2024/25 LEARNING FROM DEATHS REPORT

September 2024

A summary document outlining the learning from deaths at Salisbury NHS Foundation Trust during the first financial quarter of 2024/25. Data correct as of 02.09.2024 [unless otherwise stated in the report]

GLOSSARY OF TERMS

CHARLSON COMORBIDITY INDEX (CCI) SCORE
The Charlson Comorbidity Score is a method of measuring comorbidity. It is a weighted index that predicts the risk of death based on the number and severity of 19 comorbid conditions.

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

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

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

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

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

PSIRF
Patient Safety Incident Response Framework

RESPECT
The Recommended Summary Plan for Emergency Care and Treatment (ReSPECT) provides a personalised recommendation for an individual's clinical care in emergency situations whether they are not able to make decisions or express their wishes.

SFT
Salisbury NHS Foundation Trust.

SHMI
The SHMI is the ratio between the actual number of patients who die following hospitalisation at the trust and the number that would be expected to die based on average England figures, given the characteristics of the patients treated there. It covers in-hospital deaths and deaths that occur up to 30 days post discharge for all diagnoses excluding still births. The SHMI is an indicator which reports on mortality at trust level across the NHS in England and it is produced and published as an official statistic by NHS Digital.

SII
Serious Incident requiring Investigation.

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

Salisbury NHS Foundation Trust

SMR

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

SOX

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

NHS Salisbury NHS Foundation Trust

Learning from Deaths Report – Quarter 1

Purpose and Background

To comply with the national requirements of the Learning from Deaths framework, Trust Boards must publish information on deaths, reviews, and investigations via a quarterly report to a public board meeting. The Learning from Deaths initiative aims to promote learning and improve how Trusts support and engage bereaved families and carers of those who die in our care.

Executive Summary

- 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. A national revision to the modelling of the SHMI came into effect from the 12-month rolling period ending in December 2023 onwards.
- 98% of deaths have been reviewed by 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.
- The expectation is that a primary review will be completed by the last responsible team for all deaths with a further review being requested when last responsible team are not equipped to complete.
- Staff feedback suggests that space for medical staff to complete this work in the bereavement suite or close by remains a cause for lower completion rates. A request to space allocation has been made and members of the executive board are aware of the ongoing challenges.
- In addition to the initial review by the Medical Examiner, 15% of all recorded deaths were also subject to a primary review.
- Most actions from a Board requested mortality insight visit undertaken by NHSE have now been completed. Due to the improved position in our mortality benchmarking figures and improvements made, the visit process will now be formally closed.
- A new training video has been created to emphasise the ease and speed of process for completion of reviews within the mortality module in AMaT.

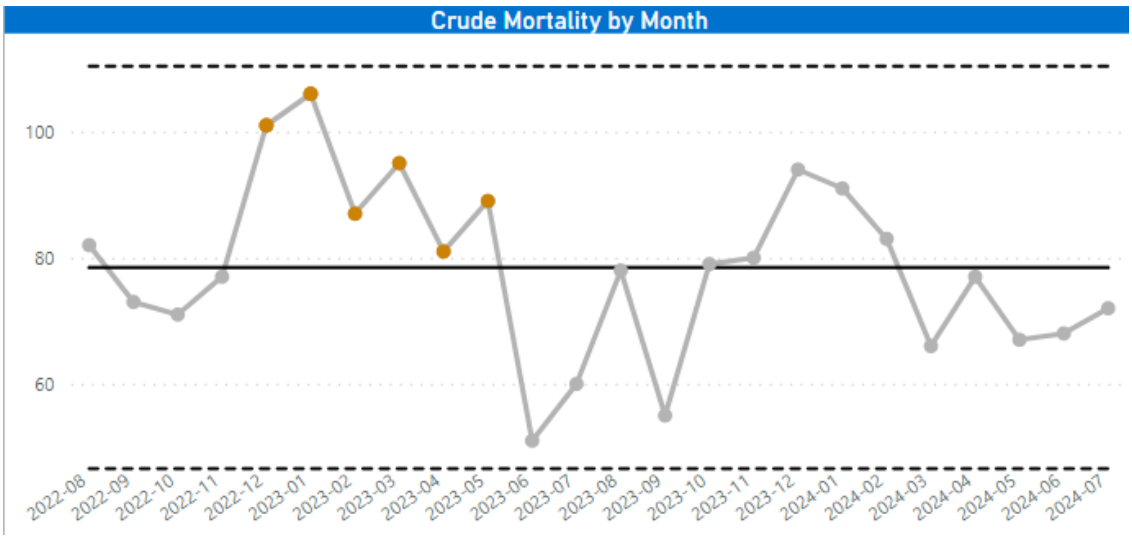
.

Salisbury NHS Foundation Trust

1. Learning from Deaths in Q1

The hospital mortality group (MSG) met twice during Quarter 1 (Q1), on 16th April 2024 and 11th June 2024, where learning, improvement themes and actions arising from mortality diagnosis group alerts and individual case reviews were discussed. The learning outlined in this report reflects a summary of the key highlights, and the information reviewed and discussed at the MSG.

1.1. Data Overview



1.1.1. The graph above has been obtained from the Trust Power-Bi data dashboard. It shows the number of deaths occurring in SFT, as reported monthly, with below average numbers continuing to be observed during each month of Q1. The graph and table on the next page provide a more detailed breakdown of these figures.

Salisbury NHS Foundation Trust

Mortality Overview

Salisbury NHS Foundation Trust

Total Deaths as Reported by the Medical Examiner: Sep-22 - Jul-24

Mortality Overview: Sep-22 - Jul-24

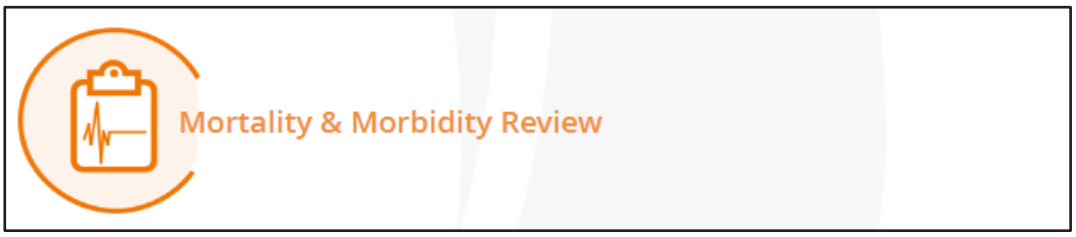
Year-Month	Total Deaths as Reported by the ME	Deaths Reviewed by the ME	SJRs Requested by the ME	ED Deaths	Hospice Deaths	Covid19 as Primary Cause of Death (1a)	Total Stillbirth Deaths	Late Miscarriage 22 - 23+6 Weeks	Stillbirths >24+0 - 36+6	Stillbirths >37+0	Total Neonatal Deaths	Total Maternal Deaths	Total Learning Disability Deaths	Total Serious Mental Illness Deaths
2024-07	74	72	5	5	17	1	0	0	0	0	0	0	2	0
2024-06	69	67	5	3	12	4	0	0	0	0	0	0	0	2
2024-05	68	67	5	2	14	0	0	0	0	0	0	0	1	1
2024-04	77	76	7	5	6	0	0	0	0	0	0	0	1	1
2024-03	66	66	4	2	9	1	0	0	0	0	0	0	0	0
2024-02	83	82	4	6	15	0	1	0	1	0	1	0	2	0
2024-01	93	93	2	6	11	3	0	0	0	0	2	0	1	0
2023-12	95	92	4	7	16	0	1	0	1	0	0	0	0	0
2023-11	80	78	10	4	10	4	2	0	2	0	0	0	1	1
2023-10	79	78	6	3	12	3	0	0	0	0	0	0	1	3
2023-09	55	54	1	2	15	1	0	0	0	0	0	0	0	1
2023-08	78	75	6	2	17	1	0	0	0	0	0	0	0	2
2023-07	60	58	5	1	13	0	0	0	0	0	0	0	1	1

Person Centred & Safe | Professional | Responsive | Friendly | Progressive

1.2. Summary of Learning and Actions Taken in Q1

1.2.1. **Insight Visit from NHSE:** This has been reviewed under the following domains: Strategy, Systems & Process, Training, Data and Governance. One action has been removed (*The Trust should ensure that activity is captured accurately from SystemOne*) as it has been agreed that community deaths will be looked at BSW level and this is beyond our current scope. A BSW mortality group has already been established to support this work.

1.2.2. Of the 27 action points which are now recorded in AMaT following primary reviews (SJRs), 19 items have been completed and 8 are in progress. Most of these are reflected in Trust wide projects. As these actions start to be generated and recorded (which was a recent improvement made through the introduction of the new online mortality module), these will be reviewed and discussed at the Trust MSG to ensure themes are addressed and workstreams are in place to support improvements where needed.



1.2.3. **MaMR (Mortality and Morbidity Review)**: This is our platform which was launched in March 2024 and is supporting our learning from deaths (module within AMaT). This is being utilised for recording the outcomes of ME reviews, triggered primary reviews (SJRs) and incorporates the capacity to include all other mortality reviews using the online Trust checklist, which includes data-fields compatible with the primary review output for overall assessment of care, quality of end-of-life care (EoLC), and the learning points and actions arising from them. Learning point categories are also now compatible with the new patient safety incident response framework (PSIRF), allowing overall learning form adverse events and mortality to use the same parameters. Key elements are as follows:

- 97% of deaths have been reviewed by Medical Examiner's Office. Of these 27 (7.8%) primary reviews have been requested.
- 15% of all recorded deaths have had a primary review completed. The expectation is that this figure will increase as staff become more familiar with the mortality module, and ongoing support and feedback is being provided/collated at M&M meetings to improve uptake and familiarise staff with the recent policy changes.
- From the 23 learning points, 11 positive points and 12 negative have been generated (further information in section 1.2.4.)

1.2.4. 40% (23/57) of primary reviews have generated a learning point with a spectrum of issues are identified. No clear themes have surfaced at this stage.

Domain	Negative	Positive
Assessment, investigation or diagnosis GOOD		2
Clinical monitoring GOOD		1
Clinical monitoring POOR	1	
Communication - with relatives/carers GOOD		2
Communication - with relatives/carers POOR	1	
Communication with clinical colleagues GOOD		2
Communication with clinical colleagues POOR	1	
Communication with patients GOOD		1
Documentation GOOD		1
Documentation POOR	1	
EoLC support or delivery GOOD		1
Falls Management POOR	1	
Medical Device or Equipment Management POOR	1	
Resuscitation following cardiac or respiratory arrest POOR	1	
Service Provision/Staffing POOR	2	
Transfers (internal/external); Patient flow POOR	2	
Treatment and management plan GOOD		1
Treatment and management plan POOR	1	
Total	12	11

1.2.5. In addition, three secondary (higher level) reviews were undertaken in the period where concerns had been escalated (see 1.2.6. – 1.2.8.). Recognition of the deteriorating patient was a theme and has already been identified as an important area of improvement for the Trust. As such, this has already been identified as one of this year's 12–18-month breakthrough objectives for the Trust, and improvement work in relation to this remains ongoing.

1.2.6. There was one case in which the reviewer felt that the probability of death and recognition of deterioration in the terminal phase could have been recognised and acted on sooner. A failure to ensure that family could be contacted was lamentable. A further diagnosis of the underling pathology might have explained some of their symptoms and allowed clarity as to the future prognosis but is unlikely to have influenced the eventual outcome. Overall, the case was adjudged as poor care with slight evidence of avoidability. This has been feedback to the team, who will collectively review and reflect.

1.2.7. Another case was a complex clinical picture with considerable and timely input from many clinicians. There was no recorded cause of death. Quality of care was deemed to be good with slight evidence of avoidability.

1.2.8. In the third case there was deemed to have been a tardy performance by responsible clinicians with poor (or non-existent handover), with the receiving ward thereby failing to recognise the deteriorating patient in timely fashion. The quality of care was deemed to be poor and probably avoidable (more than 50:50). This case was thereby escalated to SSRI review via Datix report. The reports and learning from serious incident reviews resulting in death are shared at subsequent Trust mortality meetings once the investigation has been completed.

1.2.9. **Septicaemia alert**: This was a new alert triggered in 2024 and a case note review is being undertaken. Mortality linked to sepsis may be flagging a wider problem within the Trust for the recognition and prompt treatment of patients with suspected sepsis, and therefore a review of these cases will help to inform learning. Recognition of the deteriorating patient has been selected as one of the Trust's breakthrough objectives for next year as part of the Improving Together programme.

1.3. End of Life Care

1.3.1. From 1st April 2024 the NACEL survey replaced the Trust's Your Views Matter (YVM) survey for 9-months to allow for national benchmarking to take place for this period.

1.3.2. The National Audit of Care at the End of Life (NACEL) is a national comparative audit of the quality and outcomes of care experienced by the dying person and those important to them during the last admission leading to death in acute hospitals, community hospitals and mental health inpatient providers in England, Wales and Jersey. NHS Benchmarking Network is commissioned by Health Quality Improvement Partnership (HQIP) on behalf of NHS England and the Welsh Government. NACEL is featured on NHS England's Quality Accounts list for 2024/25.

NACEL collects data from four sources:

1.3.3. **Quality Survey:** This is an online survey completed by relatives, carers and those important to the person who died in hospital, to report their experiences of the care and support received at the end of life.

1.3.4. **Case Note Review:** This is data collected from patient notes about the care they received during their final admission to hospital. It focusses on 10 indicators of care, including recognition of dying, timely review of the dying and deceased patient, etc.

1.3.5. **Hospital/ Site Overview:** questions focus on the specialist palliative care workforce, staff training, anticipatory prescribing and quality and outcomes within the hospital/site.

1.3.6. **Staff Reported Measure:** this survey is completed by staff who are most likely to encounter dying patients and their loved ones. The survey asks questions about staff confidence and experience in delivering care at the end of life, the support they receive and the culture of their workplace. This is not a staff satisfaction survey such as the NHS staff survey. About NACEL — National Audit of Care at the End of Life

1.3.7. The NACEL bereavement survey focuses on the insights taken from the Quality Survey.

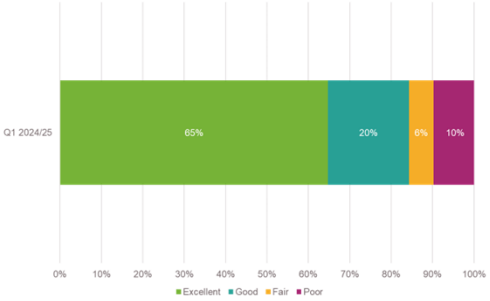
1.3.8. This report contains no comparisons to previous quarter's performance, with the exception of response rates. These were noted to have decreased slightly on Q4 (going down from 38% to 35% this quarter). However, this is slightly higher than the average seen for 2023/24 (32%).

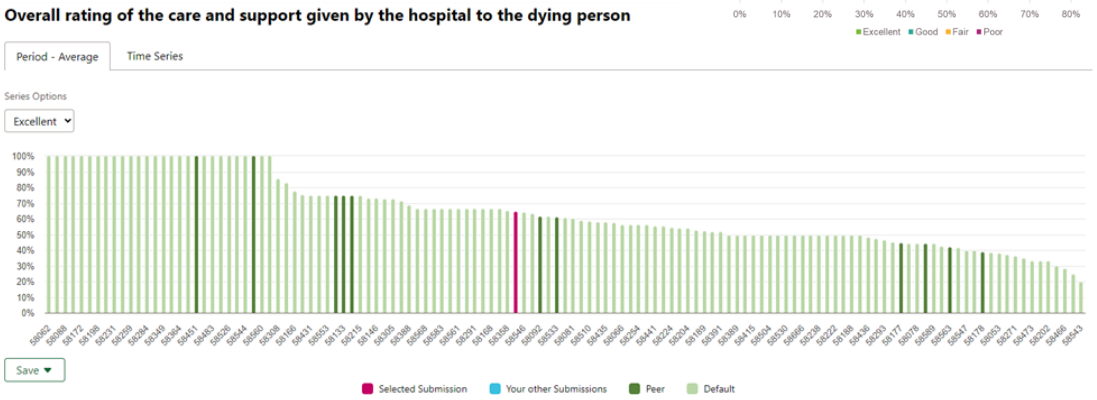
1.3.9. This is also against a decreased survey rate, of 54% of bereaved families agreeing to receiving this survey, compared with 69% in Q4.

1.3.10. 65% of those surveyed described their overall experience as “Excellent”, compared with 10% who described this as “Poor”. Comparisons for previous quarters cannot be made, as the rating scales are different under NACEL.

1.3.11. 65% of SFT’s respondents described their overall rating of care and support given by the hospital to the dying person as “excellent” (shown in pink). Compared with 10% describing this as “Poor”.

The graph below shows this ranking in comparison to our peers across the South West (shown in dark green).





1.3.12. 7 survey participants requested a call-back from PALS, none of these resulted in a formal complaint or concern being raised.

Figures 4.1 to 4.4 show the overall ratings in the key areas of patient experience.

1.3.13. SFT was noted to have outperformed both nationally and against our South West peers in relation to 3 out of the 4 of the Trusts core focuses (dignity for the dying person, communication, and support for family/others of the dying person). However, the Trust was outperformed in relation to symptoms relief both nationally and by our SW peers.

Figure 4.1 The person had enough relief of symptoms other than pain (such as nausea, breathlessness or restlessness)

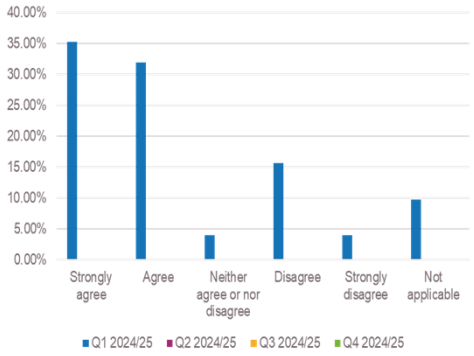


Figure 4.2 Families and others were kept updated and had enough opportunity to discuss the person's condition and treatment with staff

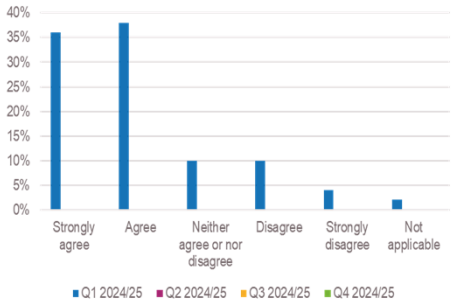


Figure 4.3 Staff looking after the person treated them with dignity

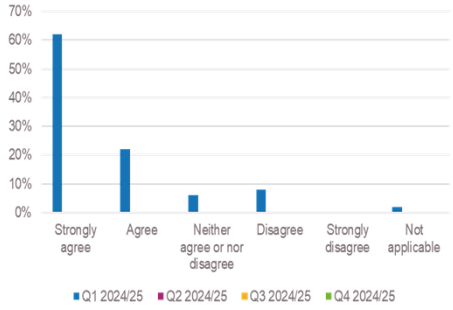
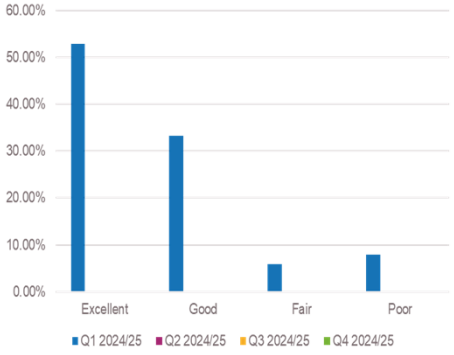


Figure 4.4 Overall rating of the care and support given by the hospital to those important to the dying person



EOL Care – Correlation with Complaints

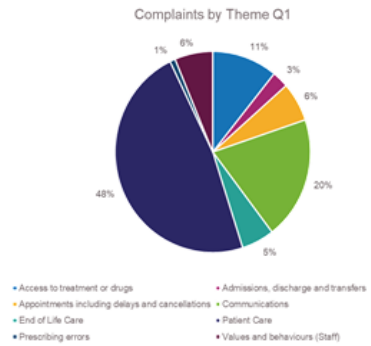
1.3.14. Figure 5.1 shows the themes for complaints for Q1.

1.3.15. There was a total of 111 complaints/concerns logged during this period, of which 5% were related to end-of-life care.

1.3.16. The NACEL survey is unable to be used to correlate complaint themes by location with this data as this is not collected as part of the audit.

1.3.17. PALS are working with Medical Examiners to look at how we may be able to supplement this data in the interim.

Figure 5.1 Complaint themes for Q1 2023/24



1.4. Medical Examiners (MEs)

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

1.4.2. 17 Structured Judgement Reviews were requested by the Medical Examiners in Q1 out of a total of 210 patients cases reviewed. Overall, 98.1% of all patients who died whilst under the care of SFT were subject to a Medical Examiner review during Q1.

1.4.3. A small number of reviews were requested under our mandated categories of patients with a learning disability/autism (no. =2) in Q1. As per recent changes (to improve scrutiny and learning from these case types), these cases will be subject to a mortality review (using the validated SJR method) and will also be reviewed by our learning disability/autism nurse for a specialist review of potential learning. This is in addition to the learning disability /autism cases that continue to be submitted to the national LeDer programme (NHS England » Learning from lives and deaths – People with a learning disability and autistic people (LeDeR) .

1.5. Litigation

New Enquiries from the Coroner During Q1

1.5.1. During this reporting period, there were four new enquiries from the coroner concerning the deaths of patients known to SFT.

1.5.2. Statements have been requested in 3 of those cases, and the final case was a request for the SII only at this stage.

Inquests Concluded in Q1 from Previous Reporting Periods

1.5.3. Four inquests were concluded in this quarter.

1.5.4. Statements were provided by SFT in all three cases - one case was dealt with as read only (no witnesses called) and witnesses from SFT were called in the other three. SFT was an interested party in three of the four cases.

1.5.5. There were no jury cases. One Prevention of Future Death report was issued to the Department of Health & Social Care.

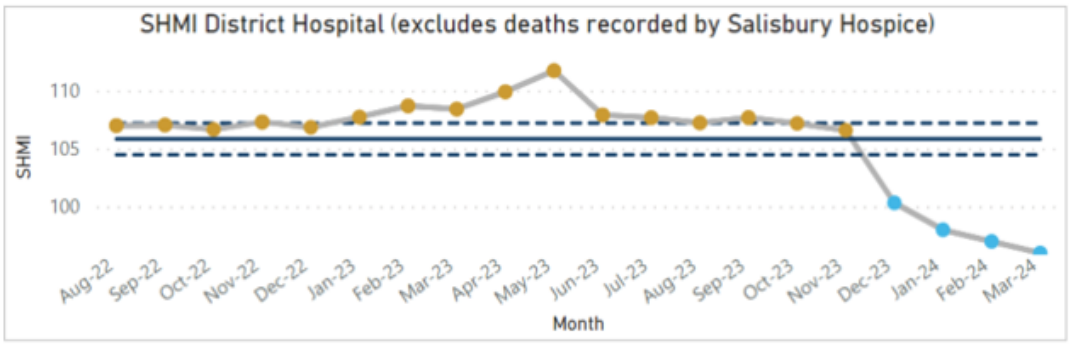
NHS
Salisbury
NHS Foundation Trust

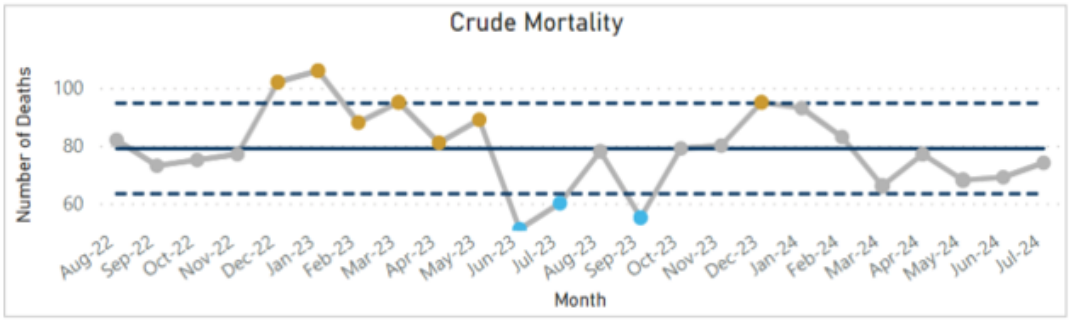
Salisbury NHS Foundation Trust

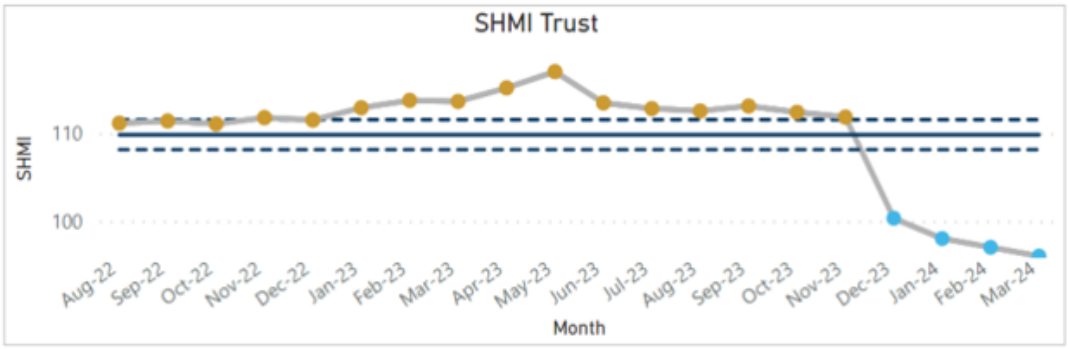
APPENDICES – Mortality Supplementary Data

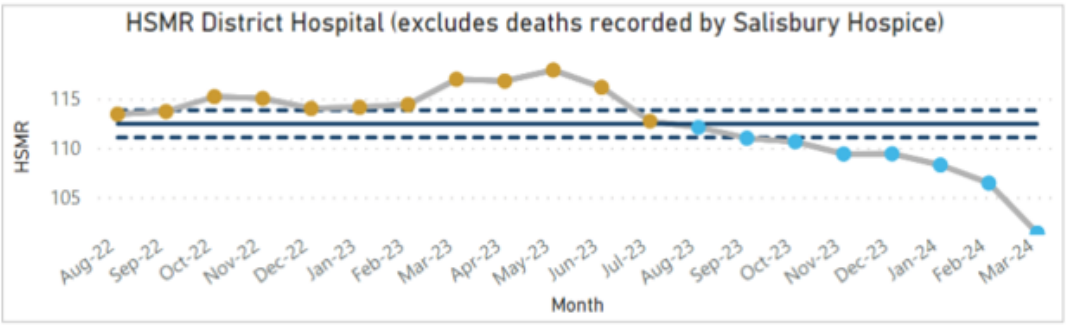
1. HSMR and SHMI Rolling 12-month Trends

1.1. A two-month time lag has been applied to the HSMR data to improve the accuracy of data for the 12-month period. This is due to a potential coding backlog for the two most recent months of discharge data. Therefore, the latest published HSMR is for the 12-month rolling period ending in March 2024. Both the HSMR and SHMI have continued to see a positive decline in recent months. A national revision to the modelling of the SHMI came into effect from the 12-month rolling period ending in December 2023 onwards.

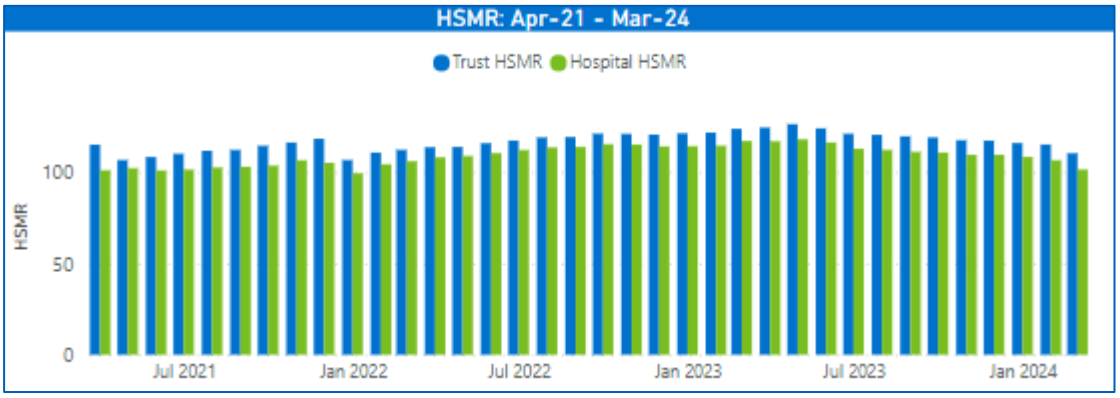


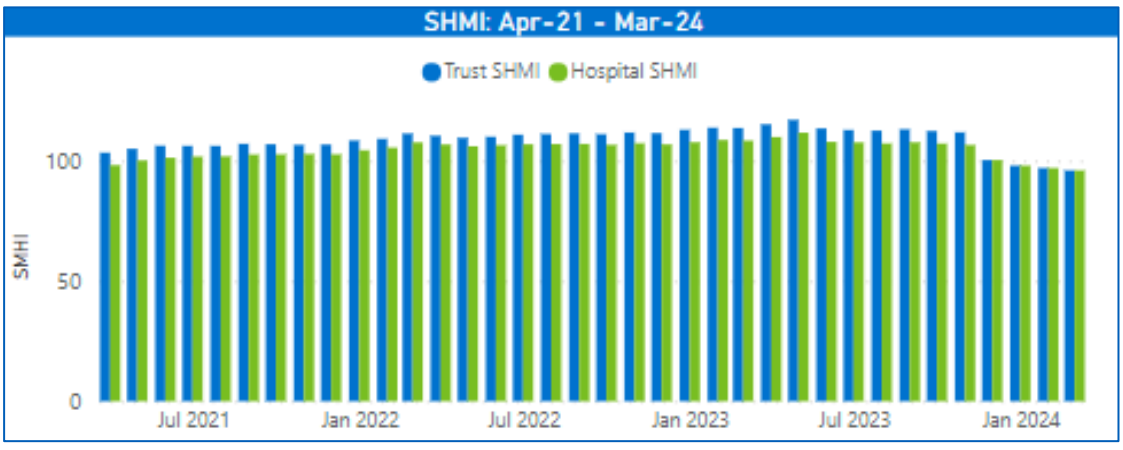






1.2. HSMR and SHMI Reported as Bar Charts





Salisbury NHS Foundation Trust

Latest SHMI data supplied by Telstra U.K. (Dr Foster) - 12 Month Period Ending in March 2024

SHMI - Summary Hospital Mortality Indicator

Period: Apr 23 - Mar 24

Provider: RNZ - SALISBURY NHS FOUNDATION TRUST

Region: SOUTH WEST

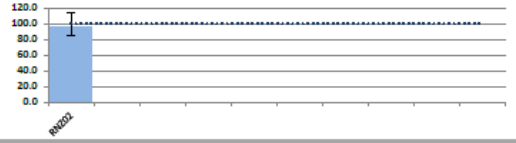
Click to enable bespoke peer

SHMI - Published (With Over Dispersion)

** click group name to filter; click header title to clear*

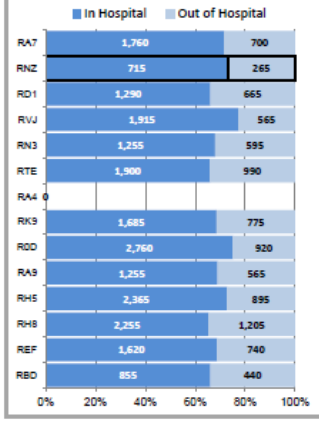
	Provider	Denominator	Obs	Exp	Obs-Exp	SHMI	Low	High
RBD	Dorset County Hospital NHS Foundation Trust	31,895	1,295	1,170	125	110.57	88.52	112.96
REF	Royal Cornwall Hospitals NHS Trust	65,160	2,360	2,255	105	104.70	89.12	112.21
RH8	Royal Devon University Healthcare NHS Foundation Trust	98,380	3,460	3,570	-110	96.90	89.36	111.91
RH5	Somerset NHS Foundation Trust	82,205	3,260	3,200	60	101.93	89.31	111.97
RA9	Torbay And South Devon NHS Foundation Trust	41,945	1,815	1,880	-65	96.53	88.99	112.38
R0D	University Hospitals Dorset NHS Foundation Trust	97,940	3,680	4,215	-535	87.35	89.43	111.82
RK9	University Hospitals Plymouth NHS Trust	77,185	2,460	2,215	245	111.12	89.10	112.23
RA4	Yeovil District Hospital NHS Foundation Trust	0	0	0	0	0.00	0.00	0.00
RTE	Gloucestershire Hospitals NHS Foundation Trust	101,135	2,885	2,495	390	115.78	89.18	112.13
RN3	Great Western Hospitals NHS Foundation Trust	62,775	1,850	1,840	10	100.43	88.97	112.40
RVJ	North Bristol NHS Trust	95,540	2,485	2,600	-115	95.57	89.20	112.10
RD1	Royal United Hospitals Bath NHS Foundation Trust	61,905	1,955	2,105	-150	92.94	89.07	112.27
RNZ	Salisbury NHS Foundation Trust	32,870	980	1,025	-45	95.59	88.36	113.18
RA7	University Hospitals Bristol And Weston NHS Foundation Trust	108,595	2,460	2,685	-225	91.65	89.22	112.08
Group		957,530	30,945	31,255	-310	99.01		

Site - All Diagnosis	Den	Obs	Exp	SHMI	Low	High
SALISBURY DISTRICT HOSPITAL	32,870	980	1,025	95.59	86.45	115.68

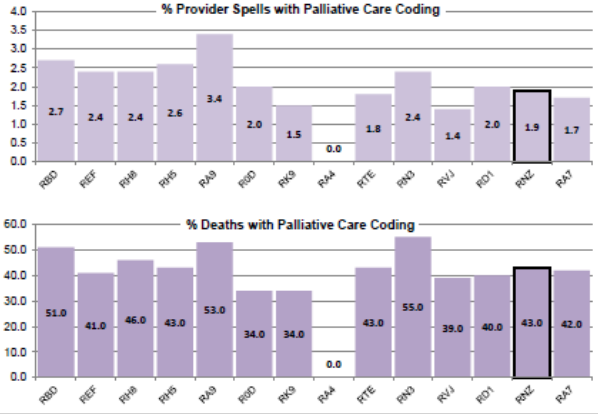


SHMI Group	Obs	Exp	SHMI	Low / High
Septicemia (except in labour), Shock	55	45.00	123.51	72.79 137.39
Cancer of bronchus, lung	25	25.00	108.72	66.45 150.49
Secondary malignancies	10	25.00	44.27	66.27 150.89
Fluid and electrolyte disorders	15	15.00	83.56	58.53 170.84
Acute myocardial infarction	15	25.00	63.95	68.33 146.34
Pneumonia	140	145.00	96.27	82.04 121.89
Acute bronchitis	10	15.00	59.38	58.81 170.05
Gastrointestinal haemorrhage	15	15.00	109.62	58.87 169.87
Urinary tract infections	20	20.00	93.76	62.05 161.17
Fracture of neck of femur (hip)	25	25.00	102.13	68.31 146.40

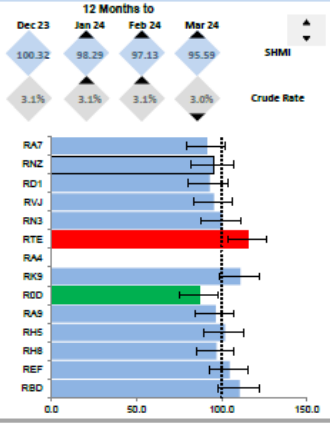
Deaths: In / Out Hospital



% Palliative Care Coding



Trend / Rate



SHMI Group - With 95% CI (Dr Foster)

SHMI Group	Obs	Exp	SHMI	Low / High
[75] Chronic obstructive pulmonary disease and bronchiectasis	35	25	140.00	97.50 194.71
[113] Other connective tissue disease	15	10	150.00	83.89 247.42
[92] Biliary tract disease	15	10	150.00	83.89 247.42
[42] Mental retardation, Senility and organic mental disorders	20	15	133.33	81.41 205.93
[77] Aspiration pneumonitis, food/vomitus	25	20	125.00	80.87 184.53
[66] Acute cerebrovascular disease	60	65	92.31	70.44 118.82
[63] Congestive heart failure, nonhypertensive	35	35	100.00	69.64 139.08
[123] Joint disorders and dislocations, trauma-related, Spinal cord injury, Skull and face fractures,	15	15	100.00	55.93 164.95

** Dr Foster "SHMI Group" values based on published, rounded values with 95% CIs*

HMI_Apr23_Mar24

HEALTH | dr foster

Salisbury NHS Foundation Trust

Blank Page

Salisbury NHS Foundation Trust

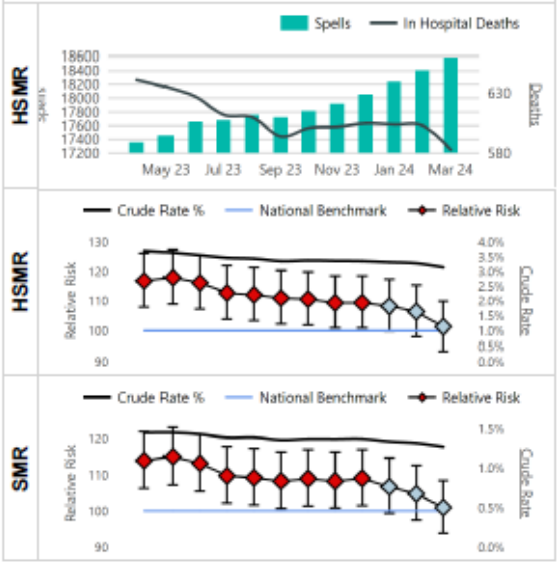
HSMR for the 12 Month Period Ending in March 2024 for Salisbury District Hospital [Excludes Hospice Data]

dr foster. HEALTHCARE INTELLIGENCE PORTAL

Mortality Summary for 12 months to Mar-2024 as at 27/08/2024

SALISBURY NHS FOUNDATION TRUST - SALISBURY DISTRICT HOSPITAL (RNZ02)

Rolling 12 month trends



Diagnosis Groups

Relative Risk Alerts (Top 10)	CUSUM	Obs	Exp	RR	LCI	Trend
Systemic lupus erythematosus and connective tissue disorders	0	2	0.1	2574.5	269.1	
Cancer of kidney and renal pelvis	2	4	1.0	406.6	109.4	
Senility and organic mental disorders	1	17	9.6	177.6	103.4	
Septicaemia (except in labour)	1	50	36.8	136.0	100.9	

CUSUM 99% Threshold (Top 6)	CUSUM	Obs	Exp	RR	LCI	Trend
Cancer of kidney and renal pelvis	2	4	1.0	406.6	109.4	
Senility and organic mental disorders	1	17	9.6	177.6	103.4	
Septicaemia (except in labour)	1	50	36.8	136.0	100.9	
Chronic obstructive pulmonary disease and bronchiectasis	1	26	19.3	134.8	88.1	
Aspiration pneumonitis, food/vomitus	1	20	17.8	112.6	68.7	
Phlebitis, thrombophlebitis and thromboembolism	1	1	0.3	326.5	4.3	

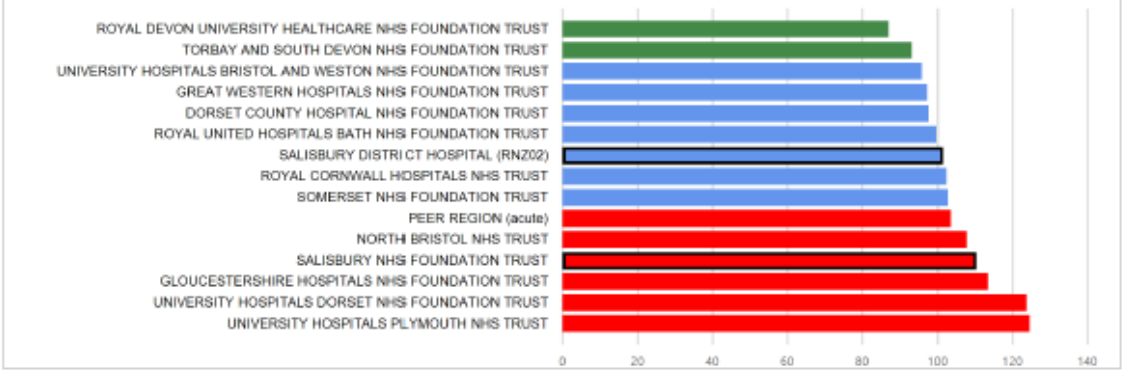
CUSUM 99.9% Threshold (Top 6)	CUSUM	Obs	Exp	RR	LCI	Trend
Senility and organic mental disorders	1	17	9.6	177.6	103.4	
Septicaemia (except in labour)	1	50	36.8	136.0	100.9	

Patient Safety Indicators	Obs	Exp	RR	LCI	Trend

Mortality Influencers

Performance	Site	Trust	Peer	National
HSMR	101.3	110.2	103.6	98.8
SMR	100.9	109.6	104.0	98.8
Non-elective (HSMR)	101.7	109.8	103.6	98.4
Weekday, emergency (HSMR)	99.6	108.2	101.9	97.1
Weekend, emergency (HSMR)	108.6	114.9	109.1	102.4
Saturday, emergency (HSMR)	105.7	108.1	109.1	102.2
Sunday, emergency (HSMR)	111.7	123.3	109.4	102.6
Coding/Casemix	**Site**	**Trust**	**Peer**	**National**
% Non-elective deaths with palliative care (HSMR)	46.5%	55.6%	44.9%	44.7%
% Non-elective spells with palliative care (HSMR)	4.2%	5.5%	4.8%	5.0%
% Spells in Symptoms & Signs chapter	6.8%	6.8%	7.2%	6.3%
% Non-elective spells with Charlson comorbidity score = 0 (HSMR)	47.2%	46.6%	43.6%	41.8%
% Non-elective spells with Charlson comorbidity score = 20+ (HSMR)	13.3%	13.6%	14.9%	16.1%
% Non-elective spells in Risk Band (0-10%) (HSMR)	87.9%	86.7%	86.9%	85.9%

HSMR Peer Comparison



Salisbury NHS Foundation Trust

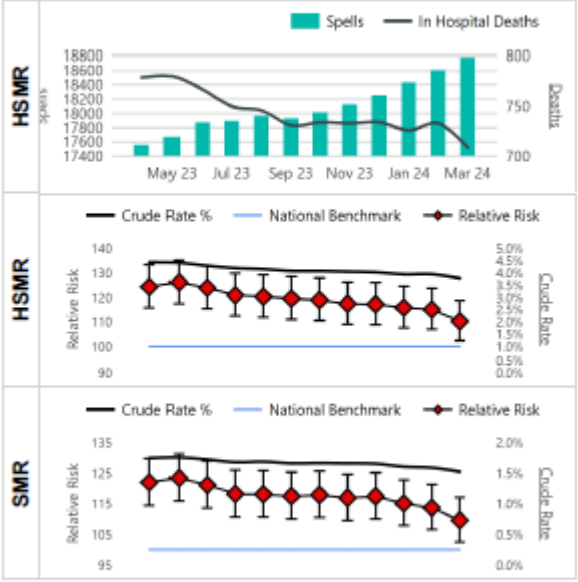
HSMR for the 12 Month Period Ending in March 2024 for SFT [Includes Hospice Data]

HEALTH | dr foster. HEALTHCARE INTELLIGENCE PORTAL

Mortality Summary for 12 months to Mar-2024 as at 27/08/2024

SALISBURY NHS FOUNDATION TRUST - All Sites

Rolling 12 month trends



Diagnosis Groups

Relative Risk Alerts (Top 10)	CUSUM	Obs	Exp	RR	LCI	Trend
Systemic lupus erythematosus and connective tissue disorders	0	2	0.1	2574.5	269.1	
Cancer of brain and nervous system	0	4	1.0	396.6	106.7	
Senility and organic mental disorders	1	18	10.4	173.0	102.5	
Septicaemia (except in labour)	1	51	37.5	136.0	101.3	

CUSUM 99% Threshold (Top 6)	CUSUM	Obs	Exp	RR	LCI	Trend
Senility and organic mental disorders	1	18	10.4	173.0	102.5	
Septicaemia (except in labour)	1	51	37.5	136.0	101.3	
Other lower respiratory disease	1	16	9.3	172.4	98.5	
Chronic obstructive pulmonary disease and bronchiectasis	1	27	20.0	135.2	89.0	
Cancer of colon	1	11	7.8	141.7	70.7	
Cancer of kidney and renal pelvis	1	4	1.5	262.2	70.5	

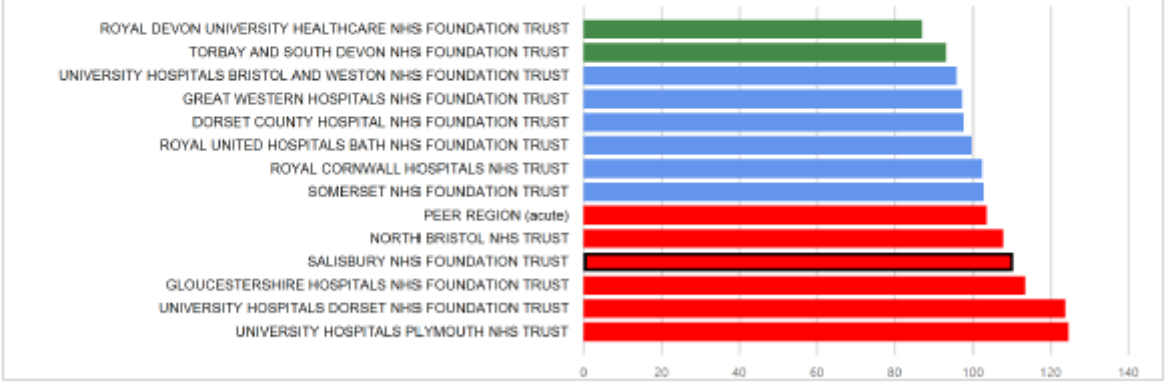
CUSUM 99.8% Threshold (Top 6)	CUSUM	Obs	Exp	RR	LCI	Trend
Senility and organic mental disorders	1	18	10.4	173.0	102.5	
Septicaemia (except in labour)	1	51	37.5	136.0	101.3	
Chronic obstructive pulmonary disease and bronchiectasis	1	27	20.0	135.2	89.0	
Other connective tissue disease	1	9	6.9	130.7	59.7	

Patient Safety Indicators	Obs	Exp	RR	LCI	Trend

Mortality Influencers

Performance	Site	Trust	Peer	National
HSMR		110.2	103.6	98.8
SMR		109.6	104.0	98.8
Non-elective (HSMR)		109.8	103.6	98.4
Weekday, emergency (HSMR)		108.2	101.9	97.1
Weekend, emergency (HSMR)		114.9	109.1	102.4
Saturday, emergency (HSMR)		108.1	109.1	102.2
Sunday, emergency (HSMR)		123.3	109.4	102.6
Coding/Casemix	**Site**	**Trust**	**Peer**	**National**
% Non-elective deaths with palliative care (HSMR)		55.6%	44.9%	44.7%
% Non-elective spells with palliative care (HSMR)		5.5%	4.8%	5.0%
% Spells in Symptoms & Signs chapter		6.8%	7.2%	6.3%
% Non-elective spells with Charlson comorbidity score = 0 (HSMR)		46.6%	43.6%	41.8%
% Non-elective spells with Charlson comorbidity score = 20+ (HSMR)		13.6%	14.9%	16.1%
% Non-elective spells in Risk Band (0-10%) (HSMR)		86.7%	86.9%	85.9%

HSMR Peer Comparison



Salisbury NHS Foundation Trust

* * * * * * END OF REPORT* * * * * *

NHS Salisbury NHS Foundation Trust

Report to:	Trust Board (Public)	Agenda item:	7.3
Date of meeting:	3rd October 2024		

Report tile:	Perinatal Quality Surveillance - Salisbury NHSFT Maternity & Neonatal services –July 2024			
Status:	Information	Discussion	Assurance	Approval
	x	x	x	
Approval Process: (where has this paper been reviewed and approved):	Tri Divisional Governance CGC		8th August 2024 16th August 2024 24th September 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 July 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 1:25– SFT recommended ratio 1:24
- 1:1 care in labour achieved at all times

- Supernumerary status of labour ward maintained 100% time.

Incidences reported as moderate.

- 7 Incidences reported as moderate.
    - Epidural Top up for caesarean section, resulting in total spinal leading to GA and brief ITU admission
    - 3 x 3rd Degree Tears
    - 2 x term admissions to Neonatal Unit
    - Massive Obstetric Haemorrhage following LSCS with Bicornuate Uterus

PMRT

- No cases for review in July

Training

- Compliance in PROMPT, CTG and NLS training. Target of 90% reached and compliance met as of 1st December 2023. Work continues to improve compliance with other mandatory training.
- Challenge with obtaining anaesthetic trajectory to ensure compliance reached December 2024

Service user and staff feedback

- Feedback received from varying sources including MNVP, friends, and family survey and PALS
- No safety champions meeting this month.

National Guidance

- CNST compliance 9 out of 10 for 2023. MIS year 6 published in April 2024. Current compliance at 7 out of 10
- Work ongoing to improve compliance with Ockenden 2022 IEA, 20 actions ongoing, 1 awaiting closure, 63 actions closed.

○

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
AUGUST *2024 (JULY DATA)*

Maternity and Neonatal Unit

Salisbury Foundation Hospital

Safe: Maternity & Neonatal Workforce

	Target	Threshold			Feb '24	Mar '24	Apr '24	May '24	June '24	Jul '24	Comment
		Green	Amber	Red							
Midwife to birth ratio	1:24	1:24		>1:26	1:27	1:30	1:32	1:28	1.25	1:25	Improved ratio due to increase in available workforce
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 %	79.89	41.67 %	83.3%	75.8%	75.56	80.11%	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	

NHS Salisbury NHS Foundation Trust

Is the standard of care being delivered?

- Supernumerary Labour Ward coordinator status achieved 100% time

What are the top contributors for under/over-achievement?

- Available workforce numbers static this month as newly recruited staff and staff returning from maternity leave off set by leavers
- The Midwife to Birth ratio is very close to target at 1:25 in July due to increased available workforce
- Acuity vs staffing data improved this month due to improved staffing levels

Table 1. Total WTE vacancy and availability to work - by role

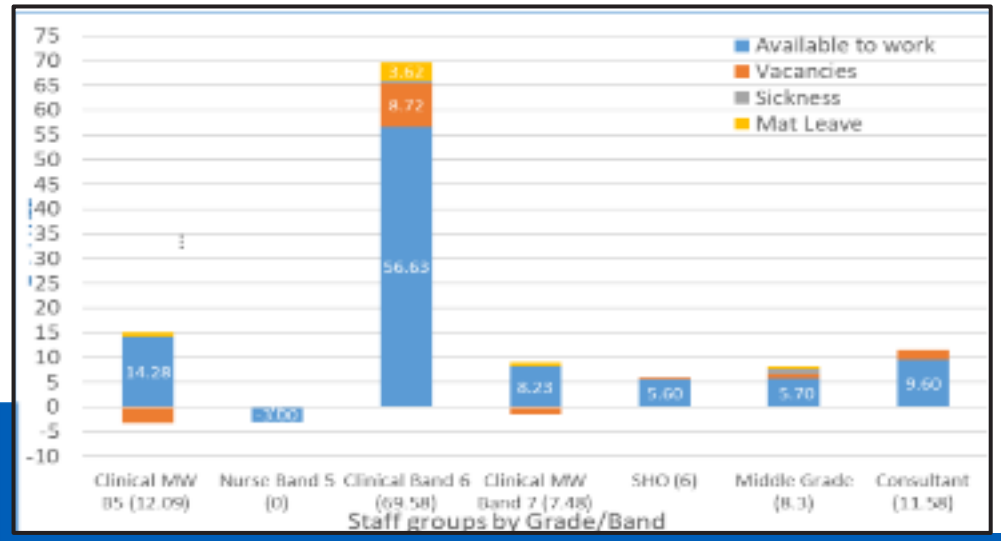
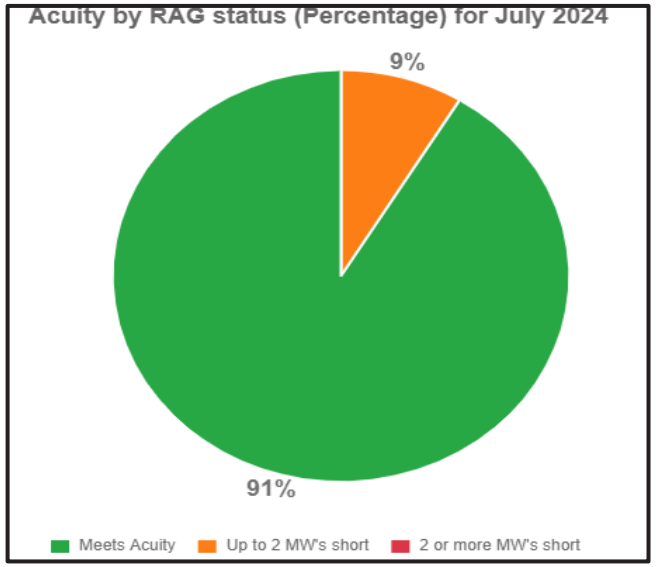
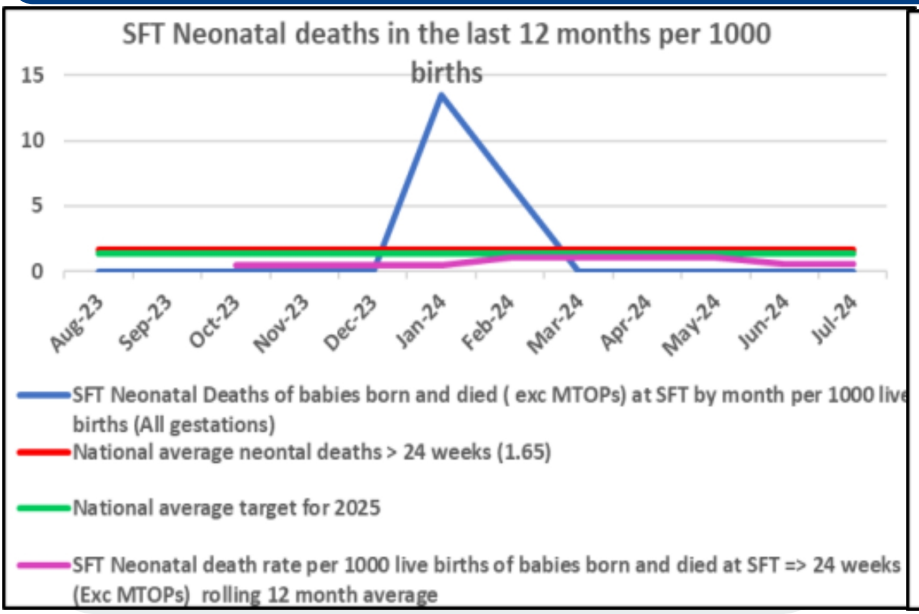


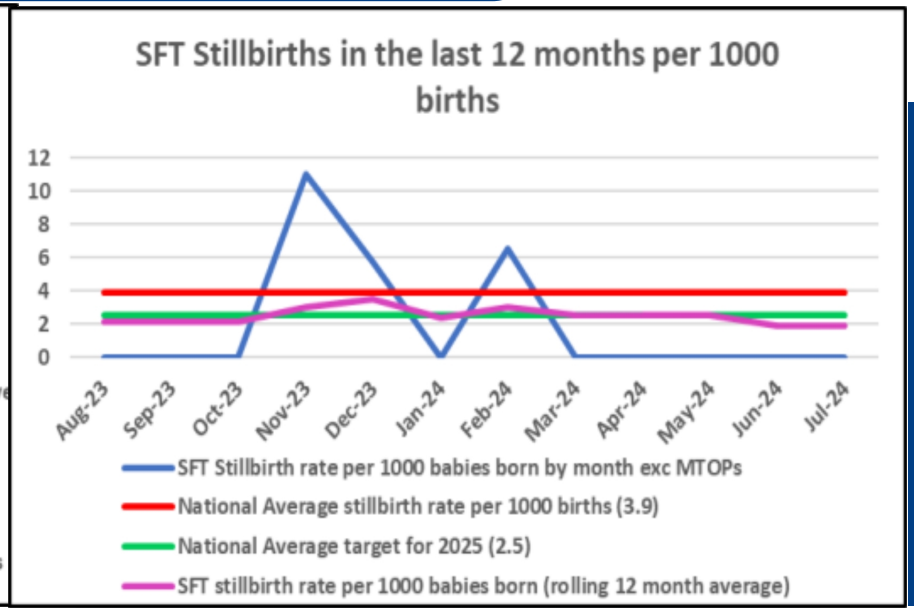
Table 2. Average midwife shift fill rates

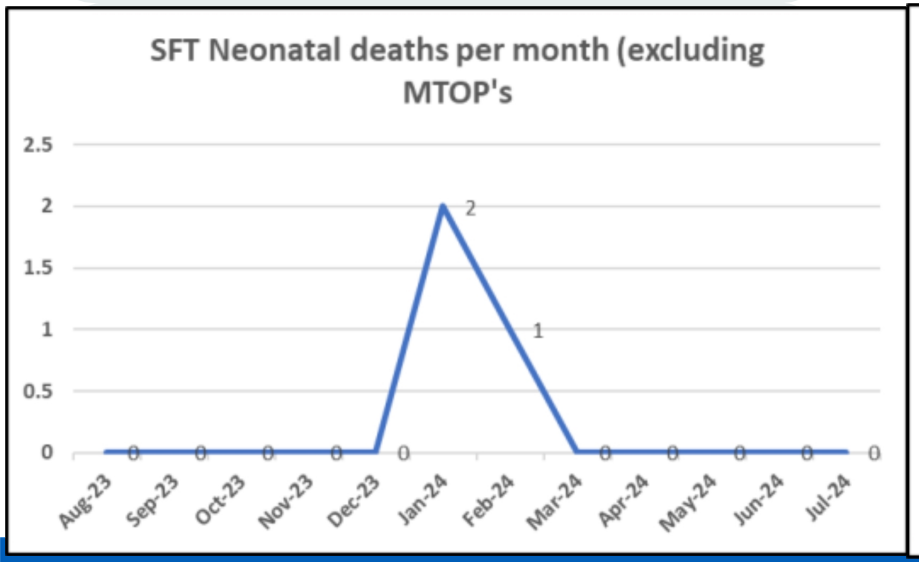
		Feb '24	Mar '24	Apr '24	May '24	Jun '24	JUL '24
Midwives	Day	95.2	94.2 %	97.2%	97.1 %	97.3 %	97.9 %
	Night	97.8%	97.9 %	99.3%	98.6 %	98.9 %	98.5 %
MCA/MSWs	Day	93.6%	97%	98.6%	93%	97.3 %	90.8 %
	Night	87.2%	98.4 %	98.09 %	93%	91.2 %	97.8 %

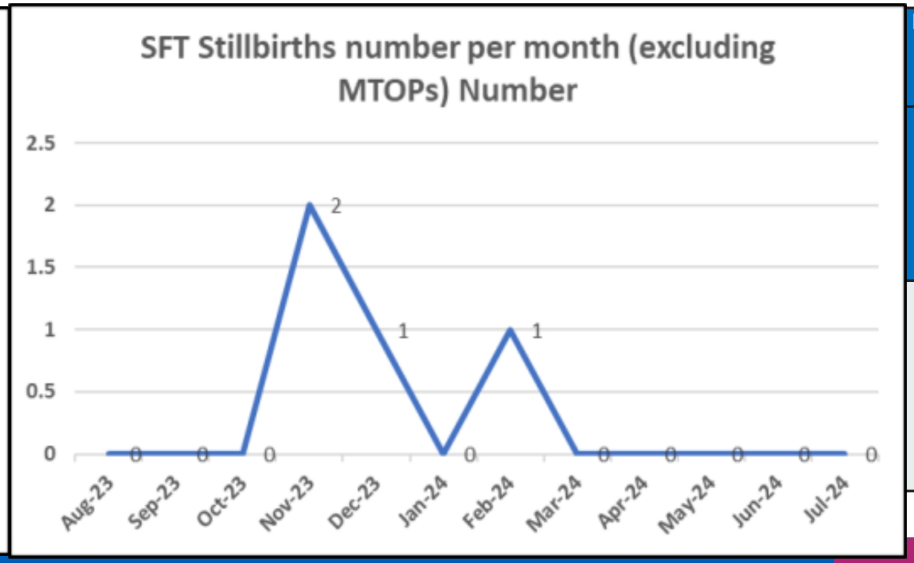


Safe: Perinatal Mortality Review Tool (PMRT) - data as of 25/7/2024









NHS Salisbury NHS Foundation Trust

- 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 loses in July > 12 weeks- neither of these were reportable to MBRRACE
- 1 MTOP for fetal anomalies at 20+5
- 1 miscarriage at 15+6

PMRT Action Plans for Salisbury Foundation Trust – July 2024 review

PMRT case ID	Issue text	Action plan text	Person responsible	Target date
	There were no cases to review under PMRT in July.			

PMRT grading of care – Key Data as of 25/7/2024

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 July		

INCIDENTS: DATIX ≥ Moderate Incidents and PSRs

Salisbury NHS Foundation Trust

DATIX Reported Incidents in July
(moderate harm and above)

Case Ref (Datix no)	Date of incident	Category	Incident Summary	Comments	Commissioned Y / N	MNSI ref no.?	PSII ref no.?
167891	28/7/24	Moderate	Epidural top up for caesarean section, resulting in total spinal so had GA. Brief ITU admission	For PSR due to ITU admission. Awaiting PSR 2	**For review**		
167634	21/7/24	Moderate	3a tear, shoulder dystocia and MROP	Added to rolling OASI audit. Awaiting clarification regarding reclassification	**N**		
167615	21/7/24	Moderate	3b tear following spontaneous vaginal birth	Added to rolling OASI audit. Awaiting clarification regarding reclassification	**N**	**N/A**	**N/A**
167371	12/7/24	Moderate	Term baby to NICU.	For initial review, awaiting documentation			
167369	8/7/24	Moderate	Term baby to NICU: APGAR 3@5	Awaiting PSR 2			
167088	3/7/24	Moderate	3C tear following spontaneous vaginal delivery	Awaiting further clarification from documentation with potential for reclassification.	**N**	**N/A**	**N/A**
167060	2/7/24	Moderate	Bicornuate uterus Cat 2 CS ?decision over instrumental 1.7L MOH	Further information required in order to complete PSR 2 regarding decision making			

INCIDENTS: Investigation update

Ongoing Maternity and Neonatal Reviews

NHS Salisbury NHS Foundation Trust

Case Ref (Datix)	Date	Category	Incident	Outcome/Learning/Actions
156876 **SII 574**	20/06/2023	Moderate	IUD	Presented at CRG: Awaiting amendment and final report
CCR 584	03/07/2023	Moderate	3rd degree tear.	Draft report with panel and staff for factual accuracy. To book CRG.
CCR 580	16/07/2023	Moderate	Term admission to NICU	Presented at CRG: Awaiting amendment and final report
CCR 588	31/07/2023	Moderate	Antenatal pulmonary embolism	Presented at CRG: Awaiting update
158202 **SII 586**	08/08/2023	Moderate	Eclamptic Seizure	Presented at CRG: Awaiting amendments and final report
158301 **SII 587** (HSIB/MNSI)	12/08/2023	Moderate	Term Admission to NICU	Presented at CRG: Awaiting tripartite meeting with family and MDT for report sharing
CCR 599	19/09/2023	Moderate	Postpartum haemorrhage at home	Draft report with panel to send to staff involved for factual accuracy.
CCR 613	19/11/2023	Moderate	Eclampsia	Draft report sent to staff for factual accuracy.
162915 New Process **PSI**I	29/01/2024	Moderate	Preterm baby transferred to tertiary unit for cooling	Investigation ongoing-staff meetings complete and awaiting draft final report.
163944 Awaiting **SII (MNSI)**	04/03/2024 4	Moderate	Baby transferred to tertiary unit for cooling	Investigation ongoing-currently arranging/holding meetings with staff involved.

Responsive

Salisbury NHS Foundation Trust

MNVP Service User feedback (July 24)

Key achievements and feedback:
No further updates.

Identified Areas of Improvement:
MNVP has completed a real-time feedback session within the NNU and ANC.
The focus of the feedback includes:

- Long waits in ANC
- Delays in obstetric review post USS
- Lack of translation, resulting in limited understanding of care events and clinical decision making.
- Lack of information regarding the IOL procedure.

Next steps for Progression:

- Continue to roll out of personalised care planning training.
- Exploration of translation services- the Maternity department continues to work with Wessex Health innovation on the application of a new translation device.
- Progress the IOL patient information leaflet through the Governance process.

Safety Champions/ Staff Feedback

No Safety Champion meeting this month

Compliments and Complaints

1 complaints and 0 concern logged in July 24.
2 compliments logged and 2 SOX.

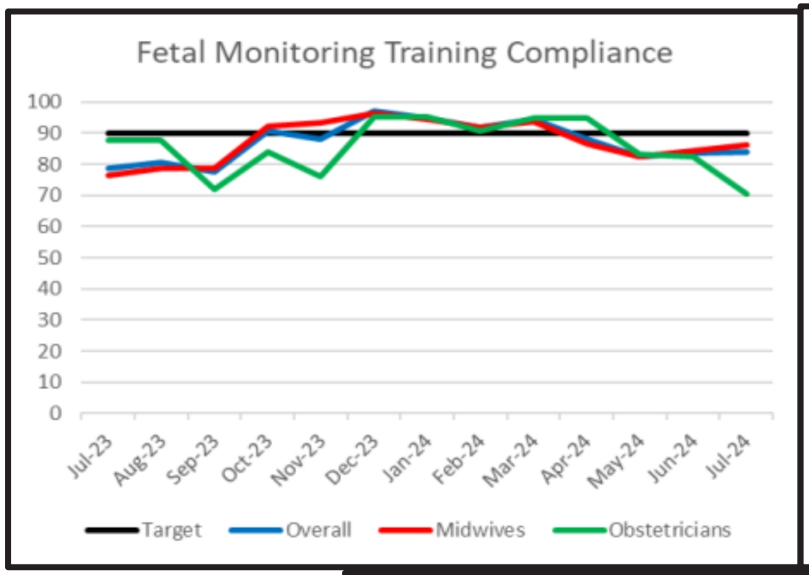
SOX : *I would like to extend my deepest gratitude to the midwives and labour ward staff for their extraordinary dedication and compassion in a recent challenging situation. Your unwavering commitment and exceptional care have not gone unnoticed. Thank you for going above and beyond to provide support and professionalism in every moment. Your efforts are deeply appreciated and valued.*

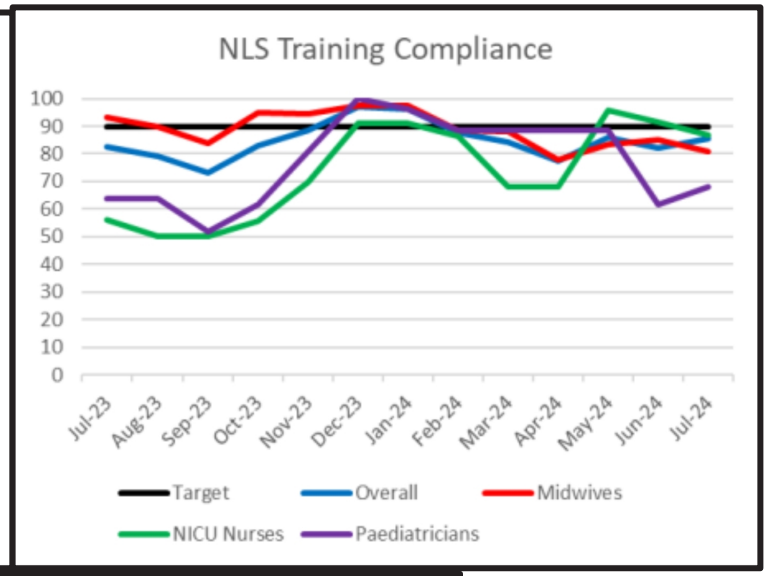
Friends and Family Test

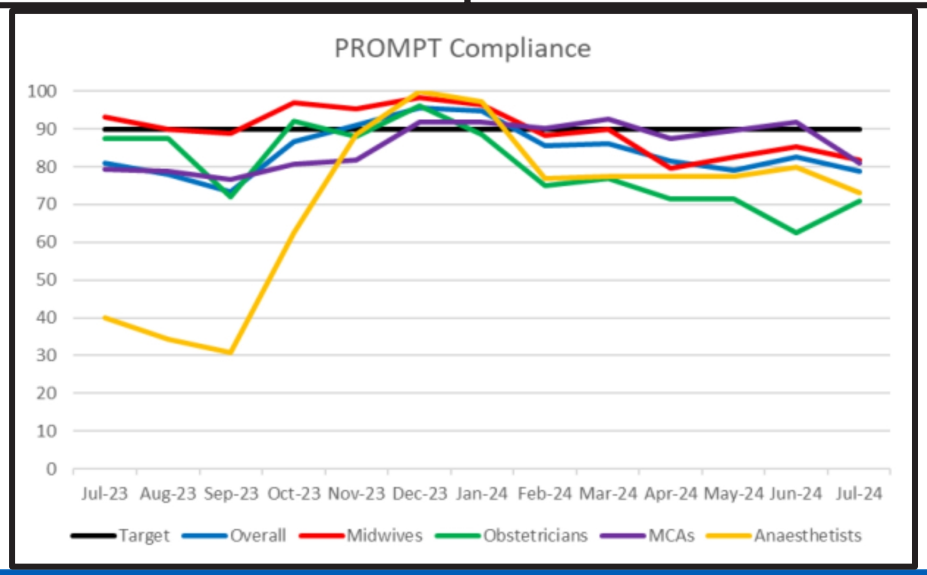
Top 3 Themes

+ positive:	- Negative
1. Staff attitudes	1. Admission
2. Implementation of care	2. Communication
3. Patient mood/feeling	3. Environment

Well-led Training







NHS
Salisbury
NHS Foundation Trust

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 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.

Risks:

- Influx of new MDT staff in September /October /November.
- Anaesthetic conflicts of priorities to attend training –plan in place from July.
- Please note - No study week in or August due to school holidays.
- 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 rate			
			RED	AMBER	AWAITING CLOSURE	GREEN
Jul-24	1	Workforce Planning and Sustainability	0	2	0	5
	2	Safe Staffing	0	0	1	9
	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	3	0	3
	11	Obstetric Anaesthesia	0	2	0	5
	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	20	1	↑64

Ockenden Report

Key Achievements:

1 action closed in Complex Antenatal Care with progress made toward others.

Actions closed in postnatal care

Next Steps for Progressions:

- Focus leaning into Workforce Planning and Sustainability outstanding actions

Table 2. CNST Maternity Incentive Scheme – Year 6

NHSR Maternity Incentive Scheme- Year 6 - Position July 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	Progress begun	
5	Midwifery Workforce	Compliant	Compliant at present	
6	Saving Babies Lives Bundle Version 3	Non-Compliant	Progress begun	
7	Patient Experience	Compliant	Compliant at present	
8	Training	Non-compliant	Progress begun	
9	Quality and Risk	Compliant	Compliant at present	
10	MNSI and EN	Compliant	Compliant at present	

NHS Salisbury NHS Foundation Trust

Maternity Incentive Scheme (CNST)

Key Achievements:

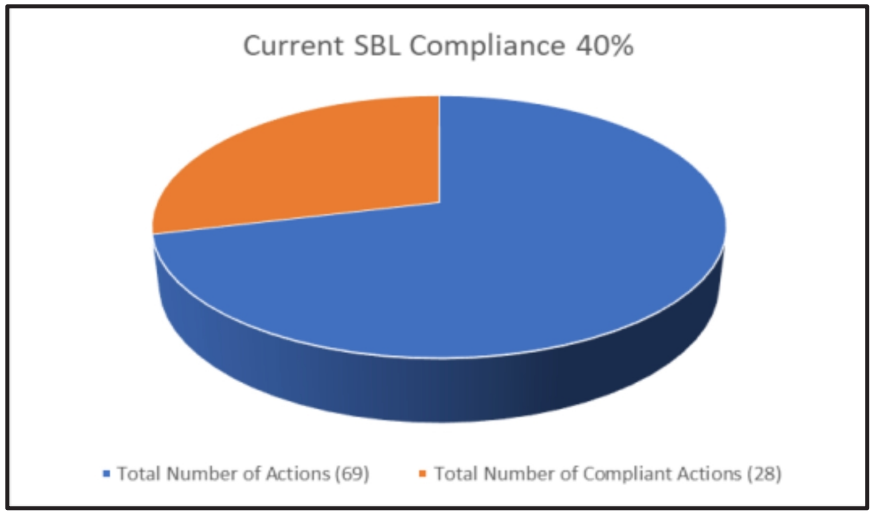
- PMRT no concerns raised
- Training - Good progress in Midwifery

Next Steps for Progressions:

- Review at regular touchpoint meetings

Compliance to National Guidance Continued

NHS Salisbury NHS Foundation Trust



Three year delivery plan for maternity and neonatal services

March 2023

Saving Babies Lives v3

Key Achievements:

- Appointment of full-time Quality Assurance Midwife to focus on SBL compliance as a priority.
- Dedicated 1:1 time with action leads to offer targeted support and identify barriers and solutions.
- Recent meeting with LMNS Lead to identify 'quick-wins' and focus areas to increase compliance.

Next Steps for Progressions:

- QA Midwife to act upon detailed feedback from the LMNS and to disseminate to the action leads for further targeted support as we move towards the next submission date end August.
- To utilise bank hours against vacancy to support completion of audits specific to SBL ask.

Three Year Delivery Plan (3YDP)

Key Achievements:

- Appointment of full-time Quality Assurance Midwife to provide support for action holder mapping of the 3YDP alongside other workstreams.
- Action mapping of the whole of the 3YDP has been completed, additionally action leads have been identified.
- Many of the recommended workstreams within the 3YDP are already ongoing within the Division.

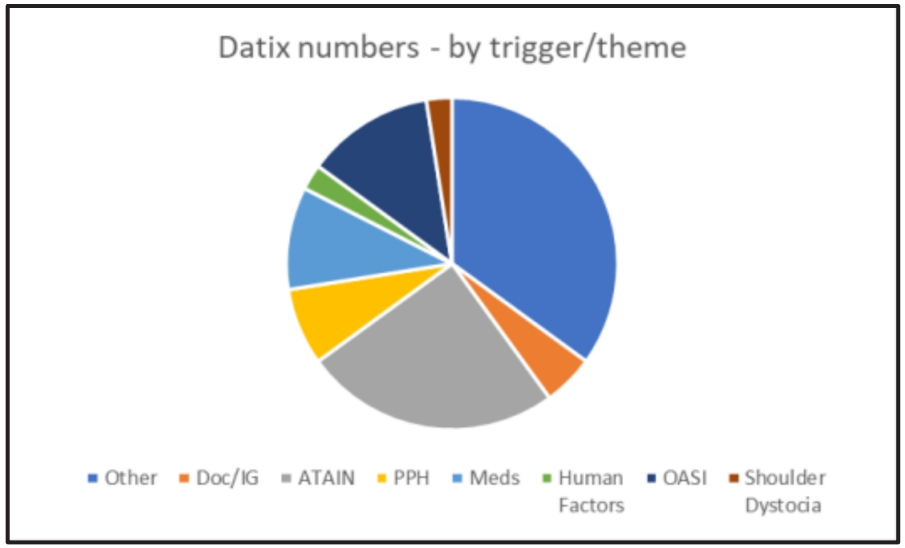
Next Steps for Progressions:

- 1:1 meetings to take place with action leads to introduce the 3YDP, assess ongoing workstreams and identify any future focus points to achieve compliance-meetings planned for early September.

Themes

Over the last 6 months we have conducted thematic reviews on Obstetric Anal Sphincter Injuries (OASI) (3rd and 4th degree tears), post-partum haemorrhage, low apgars (<7 at 5 minutes of age), stillbirth and neonatal deaths. We continue to review these as appropriate at the Maternity Governance and Risk meeting.

Under the new PSIRF framework, we are now reviewing all DATIX's received within the month by theme (to include no harm and low harms). We will work with leads in the coming months to review and align actions around some of the common themes.



Health Inequalities

NHS
Salisbury
NHS Foundation Trust

Maternity 3 Year Delivery Plan covers Health Inequalities

- Inclusion Midwife appointed

Workstream starting within LMNS to work through collaborative plan.

Next steps:

- Continue with patient experience engagement surveys.
- Explore further opportunities for listening events with 'hard-to-reach' groups.
- Continue the collaboration with Wessex Health Innovation RE enquiring a new translation device.

NHS Salisbury NHS Foundation Trust

Report to:	Trust Board (Public)	Agenda item:	7.4
Date of meeting:	3rd October 2024		

Report tile:	Perinatal Quality Surveillance - Salisbury NHSFT Maternity & Neonatal services –August data 2024			
Status:	Information	Discussion	Assurance	Approval
	x	x	x	
Approval Process: (where has this paper been reviewed and approved):	Divisional Governance 20. 09.2024 DMT approval 19.9.2024 CGC 24.9.2024			
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 August 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 1:25– SFT recommended ratio 1:24
- 1:1 care in labour achieved at all times

- Supernumerary status of labour ward maintained 100% time.

Incidences reported as moderate.

- 8 Incidences reported as moderate.
  - NT Screening documentation Error – SIAF, RCA in progress at present.
  - 5 x Term admission to Neonatal Unit. All in process of review at present.
  - 1x Massive Obstetric Haemorrhage – PSR1 complete
  - 1x postnatal readmission on day 3

PMRT

- No cases for review in June

Training

- Compliance in PROMPT, CTG and NLS training. Target of 90% reached and compliance met as of 1st December 2023. Work continues to improve compliance with other mandatory training.
- Support from Executive team and anaesthetic trajectory to ensure compliance reached December 2024 now in place.

Service user and staff feedback

- Feedback received from varying sources including MNVP, safety champions, friends, and family survey and PALS
- Outcome from the first Triangulation meeting was discussed. The focus being on the birth reflection service. Exploration is ongoing into how we can extend the referral process to this service.

National Guidance

- CNST compliance 9 out of 10 for 2023. MIS year 6 published in April 2024.
  - Work ongoing around Saving babies lives Vs 3. Discussion with NHSR and NHSR, awaiting confirmation from LMNS of agreed percentage to be reached to show compliance for NHSR CNST Maternity Incentive Scheme.
- Work ongoing to improve compliance with Ockenden 2022 IEA, 17 actions amber, 2 awaiting closure, 66 actions closed.

-

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
September *2024 (August Data)*

Maternity and Neonatal Unit

Salisbury Foundation Hospital

Safe: Maternity & Neonatal Workforce

	Target	Threshold		Mar '24	Apr '24	May'24	June '24	Jul '24	Aug '24	Comment
		Green	Red							
Midwife to birth ratio	1:24	1:24	>1:26	1:30	1:32	1:28	1:25	1.25	1:25	Improved ratio due to increase in available workforce
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%	41.67 %	83.3%	75.8%	75.56 %	80.11%	83.97%	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	

NHS Salisbury NHS Foundation Trust

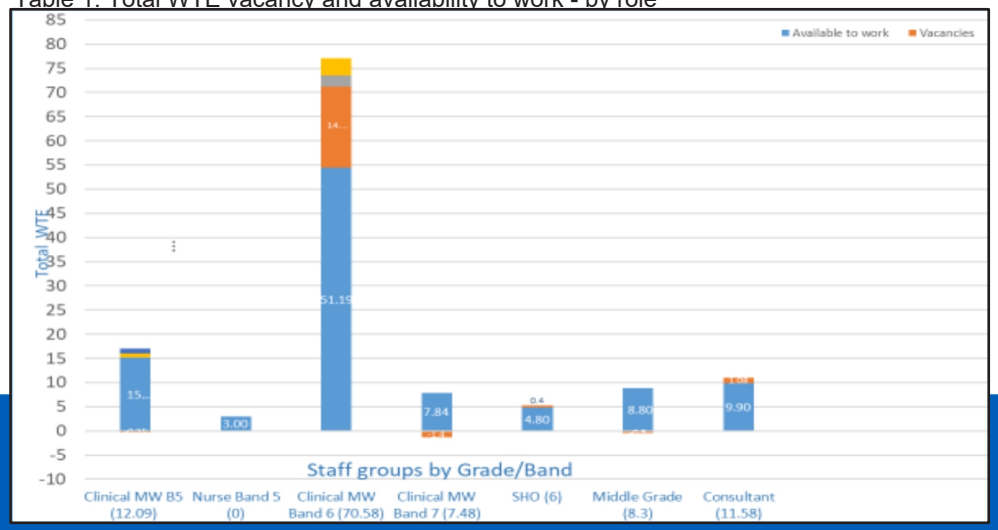
Is the standard of care being delivered?

- 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?

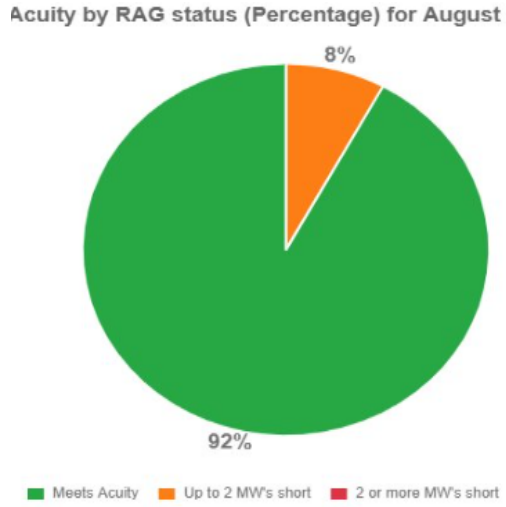
- Available workforce numbers static this month as newly recruited staff and staff returning from maternity leave off set by leavers
- The Midwife to Birth ratio iclose to target at 1:25 in August due to increased available workforce
- Acuity vs staffing data improved this month due to improved staffing levels

Table 1. Total WTE vacancy and availability to work - by role



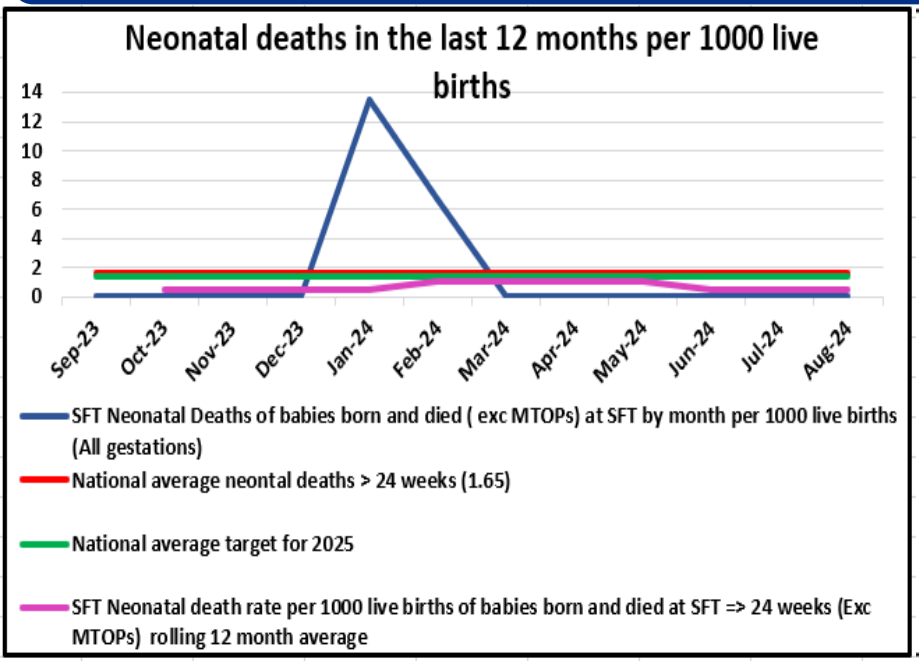
		Mar '24	Apr '24	May '24	Jun '24	Jul '24	Aug '24
Midwives	Day	94.2%	97.2 %	97.2%	97.3 %	979 3%	97.3 %
	Night	97.9%	99.3 %	99.3%	98.9 %	98. 5 %	99.5 %
MCA/MSWs	Day	97%	98.6 %	98.6%	97.3 %	90. 8%	94.6 %
	Night	98.4%	98.09 %	98.09 %	91.2 %	97. 8%	92.5

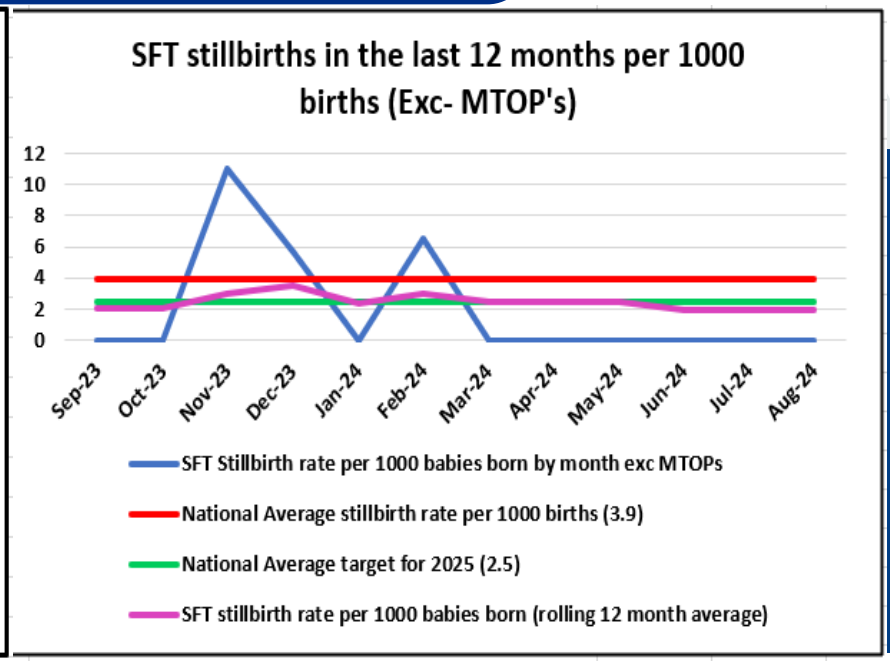
Table 3. Acuity by RAG vs staffing data



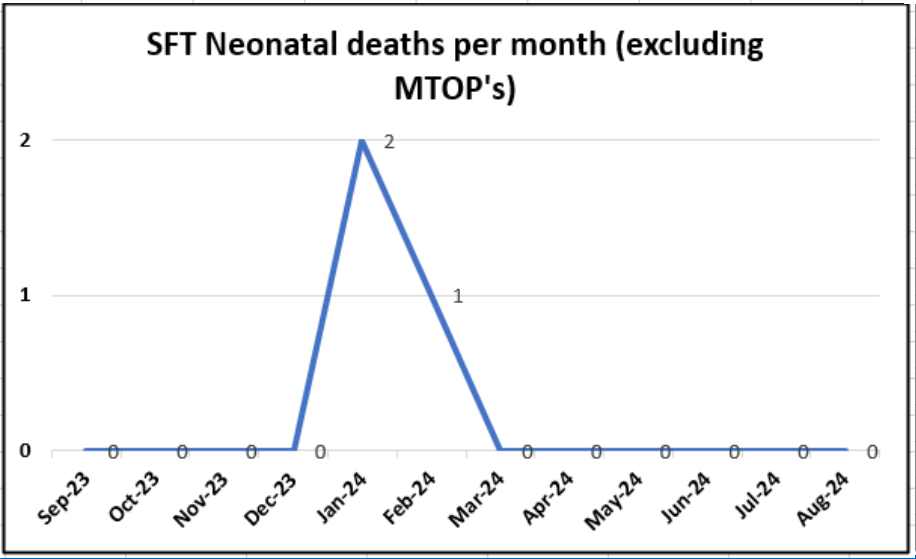
Safe: Perinatal Mortality Review Tool (PMRT)

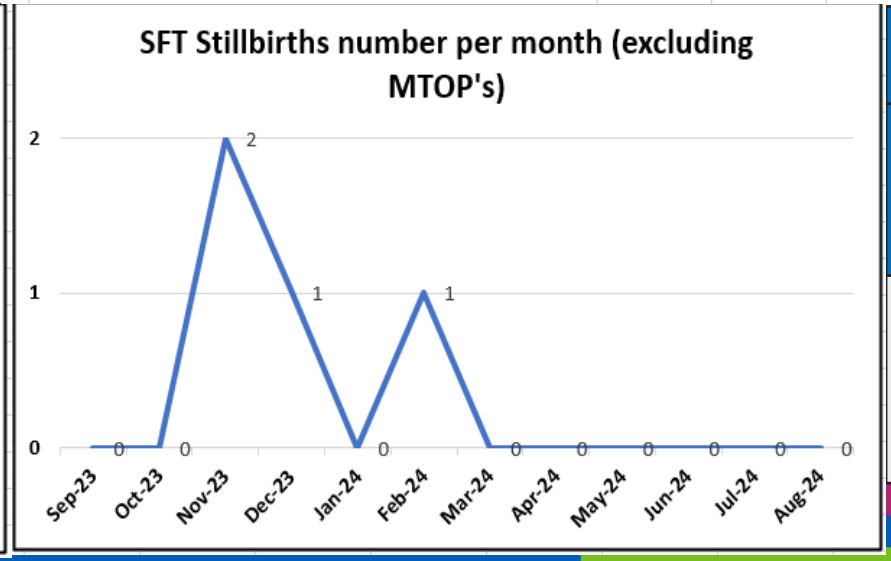
Salisbury NHS Foundation Trust





- 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 3 perinatal loses in August > 12 weeks-
- 1 miscarriage at 14+5 weeks
- 1 misacrriage at 12 weeks
- 1 MTOP resulting in a stillbirth at 27 weeks- Notified to MBRRACE





PMRT Action Plans for Salisbury Foundation Trust – August 2024 review

PMRT case ID	Issue text	Action plan text	Person responsible	Target date
	There were no cases to review under PMRT in August.			

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 August		

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.?
168324	07/08/24	Moderate	NT screening, documentation error	SIAF, RCA in progress			
168378	13/08/24	Moderate	Unexpected term admission to NICU	Added to rolling term admission audit and ATAIN. Awaiting clarification regarding reclassification			
168416	14/08/24	Moderate	Unexpected term admission to NICU	Notes received 2/9/24 and awaiting review			
168531	19/08/24	Moderate	Unexpected term admission to NICU	PSR1 due for presentation. Baby transferred to tertiary unit.			
168733	26/08/24	Moderate	MOH 1300ml (pt below 50kg) and difficult delivery of baby	PSR1 in draft process.			
168755	27/08/24	Moderate	Unexpected term admission to NICU	Meconium Aspiration. PSR 1 due for presentation			
168831	29/08/24	Moderate	Unexpected term admission to NICU	Awaiting notes to enable review			
168883	30/08/24	Moderate	Post natal readmission on day 3	Awaiting notes to enable review			

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	Awaiting exit date
SII 586	08/08/2023	Moderate	Eclamptic Seizure	Awaiting changes post CRG, then for exit.
CCR 599	19/09/2023	Moderate	Postpartum haemorrhage at home	For exit on 2/9
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	Draft report received.

Responsive

NHS Salisbury NHS Foundation Trust

MNVP Service User feedback (August 2024)

Key achievements and feedback:

The Family experience midwife and the MNVP collaborated on a listening event in the Community Hub.

Very positive feedback was received. The importance of flexibility of appointments and continuity of care was a theme throughout the discussions.

Next steps for progression:

- Continue to roll out personalised care planning training. Update: We are expecting our first delivery of the 'My Maternity Choices' booklets on 28th Sept.
- Exploration of translation services- the Maternity Department continues to work with Wessex Health innovation on the application of a new translation device.
- Progress the IOL patient information leaflet through the Governance process. Update: the leaflet was approved at MGG, and it is anticipated that it will be finalized and available on Microguide by the end September 24 24.

Safety Champions/ Staff Feedback

Items for escalation:

- EPMA issue
- Clarity around translation service for NICU.
- Noise at night on the BMW- further exploration is needed around this.
- Red flags highlighted in Junior Doctors GMC survey results around satisfaction with training.

Compliments and Complaints

0 complaints and 0 concern logged in Aug 24.
1 compliments logged and 6 SOX.

SOX : **We wanted to personally thank XX for all her hard work during our stay at the maternity ward . She was amazing during my wife's labour and was the only one who managed to calm her down and take her through the process.**
Without her kindness and patience with us our stay would have looked very different, and we wanted to personally thank her / make sure she is recognised.

Friends and Family Test

Top 3 Themes

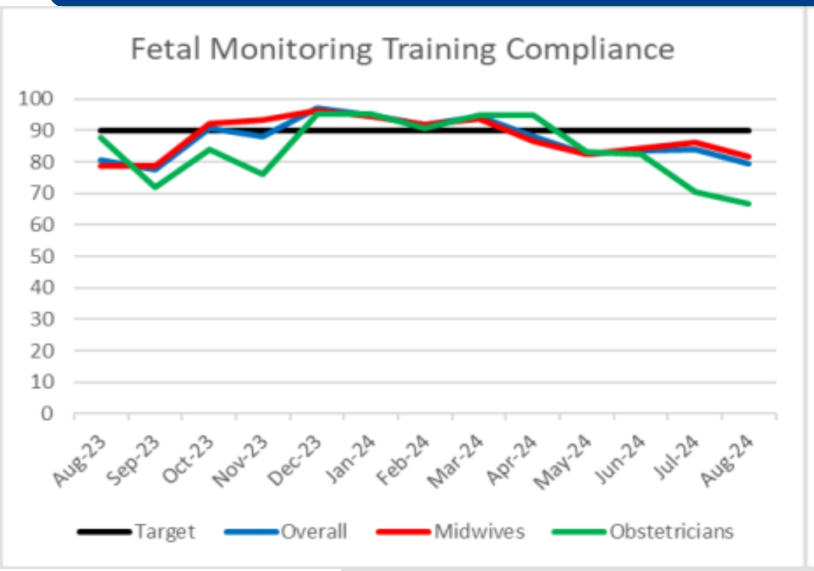
+ Positive:

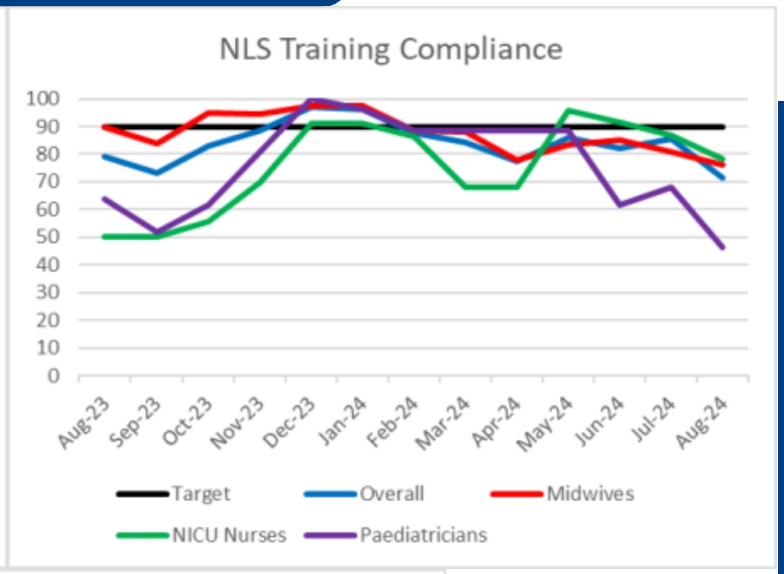
1. Staff attitudes
2. Implementation of care
3. Environment

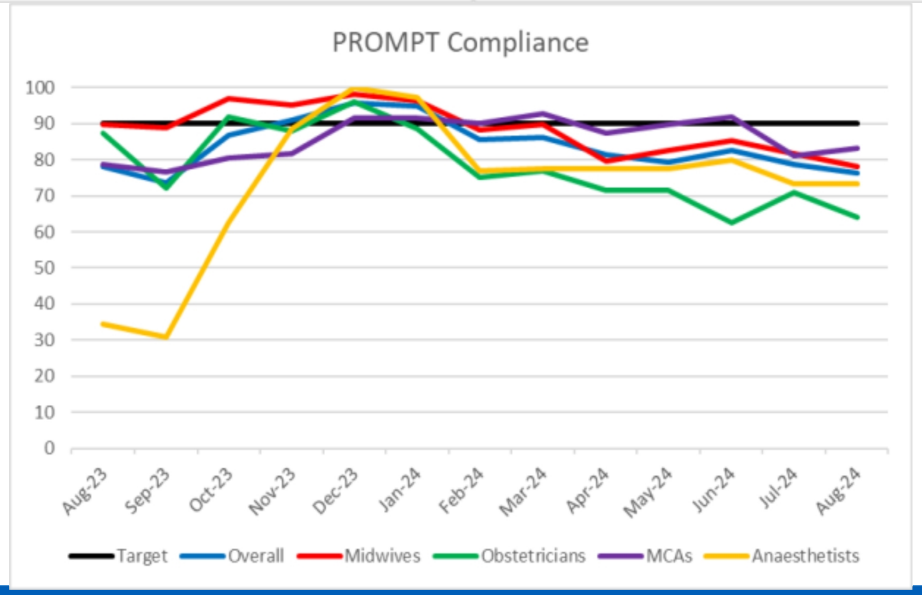
- Negative

1. Staff attitudes
2. Environment
3. Communication

Well-led Training







Salisbury NHS Foundation Trust

Training
Please note - No study week in or August due to school holidays.

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.

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
Aug-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 Cor	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	2	1	1
	10	Labour and Birth	0	2	1	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:

- 2 Actions closed – Safe Staffing and Obstetric Anaesthesia areas.

Next Steps for Progressions:

- Update on position of Bereavement Care actions and forward plan for National Bereavement Care Pathway.
- Decisions to be made to facilitate Complex Antenatal Care actions.

Table 2. CNST Maternity Incentive Scheme – Year 6

NHSR Maternity Incentive Scheme- Year 6 - Position August 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	Progress begun	
5	Midwifery Workforce	Compliant	Compliant at present	
6	Saving Babies Lives Bundle Version 3	Non-Compliant	Progress begun	
7	Patient Experience	Compliant	Compliant at present	
8	Training	Non-compliant	Progress begun	
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.

Next Steps for Progressions:

Themes

NHS
Salisbury
NHS Foundation Trust

There has been an emerging theme identified through Datix notifications surrounding medication prescriptions, for example:

- Inaccurate documentation on EPMA including VTE assessment
- Incorrect prescription doses of prophylactic VTE medication
- TTO prescription delays and incorrect prescriptions
- Delay in stopping medication on EPMA leading to confusion with drug administration

In the coming months, plans are being made to complete a thematic review of medication prescriptions to help identify any common themes and to better understand how improvements can be made.

Under the new PSIRF framework, we are now reviewing all DATIX's received within the month by theme (to include no harm and low harms). We will work with leads in the coming months to review and align actions around some of the common themes.

Health Inequalities

NHS
Salisbury
NHS Foundation Trust

Maternity 3 Year Delivery Plan covers Health Inequalities

- Inclusion Midwife appointed

Workstream starting within LMNS to work through collaborative plan.

Next steps:

- Continue with patient experience engagement surveys. Explore further opportunities for listening events with 'hard-to-reach' groups.
- In collaboration with the MNVP, we hope to undertake a listening event with client supported by the Family Nurse Practitioners (under 18 years).
- Continue to explore ‘at the point of contact’ translation options.

NHS Salisbury NHS Foundation Trust

Report to:	Trust Board (Public)	Agenda item:	7.5
Date of meeting:	3rd October 2024		

Report tile:	Maternity Quality and Safety Report for Quarter 1 2024/25.			
Status:	Information	Discussion	Assurance	Approval
	X	x	X	
Approval Process: (where has this paper been reviewed and approved):	Divisional Governance 20.09.24 DMT approval e-mail 18.09.24 CGC 24th September 2024			
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 requirements board minutes to note the following:

1. PMRT review to be noted in board minutes.
2. Compliance with labour ward coordinator being supernumerary and women receiving 1:1 care =100%
3. Inclusion of the Trust's claims scorecard and the review of it alongside incident and complaint data

Executive Summary:

This report will highlight achievements and demonstrate 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.

Clinical outcomes will be reviewed against local and national benchmarks to demonstrate safety in maternity and key improvements and service development will be identified.

This report reflects data from Quarter 1 24/25 with detail highlighted below:

- In Q1 – 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 weeks 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 Q1
- 0 new Maternity PSII commissioned under the new PSIRF framework in Q1.

- 13 Ockenden actions closed in Q1, 22 however remain open as of June 30th, 2024

- Trajectory in place to achieve 90% compliance by December 2024. Concerns escalated around Anaesthetic attendance at PROMPT and impact of non-compliance on safety and CNST submission/compliance.

- 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
    - Next submission August 2024 and November 2024 pre CNST MIS submission. Extra resource to support the roles and actions that would need to be taken and put into place to move forwards towards compliance received and Assurance midwife commence on 30th June 2024.
- 1:1 labour care and supernumerary status of labour ward coordinator maintained 100% of the time in Q1.
- 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 Q1) are 4.8 % against a national ambition of <6% and a network ambition of <5%.
- Good progress made with the Maternity Safety Support Programme. Exit meeting to be held in Q2.
- Triangulation of the claims scorecard and review alongside incident and complaint data.

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

Salisbury NHS Foundation Trust

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	Moving to exit MSSP and into 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)						
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						
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

1.0 Report Overview

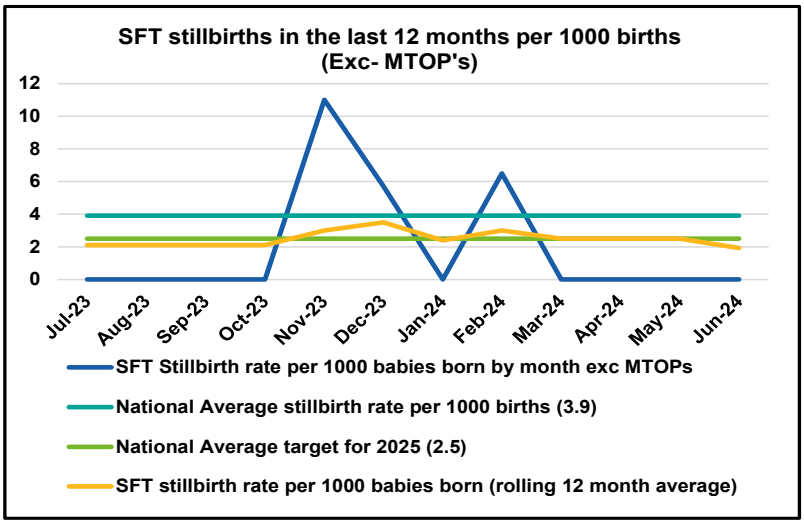
This report outlines locally and nationally agreed measures to monitor maternity and neonatal safety, as outlined in the NHSEI document '*Implementing a revised perinatal quality surveillance model'* (December 2020). The purpose of the report is to inform the Trust Board and LMNS Board of present or 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.

2.0 Perinatal Mortality Rate

The full report is contained in the appendices. The following is a summary of key highlights.

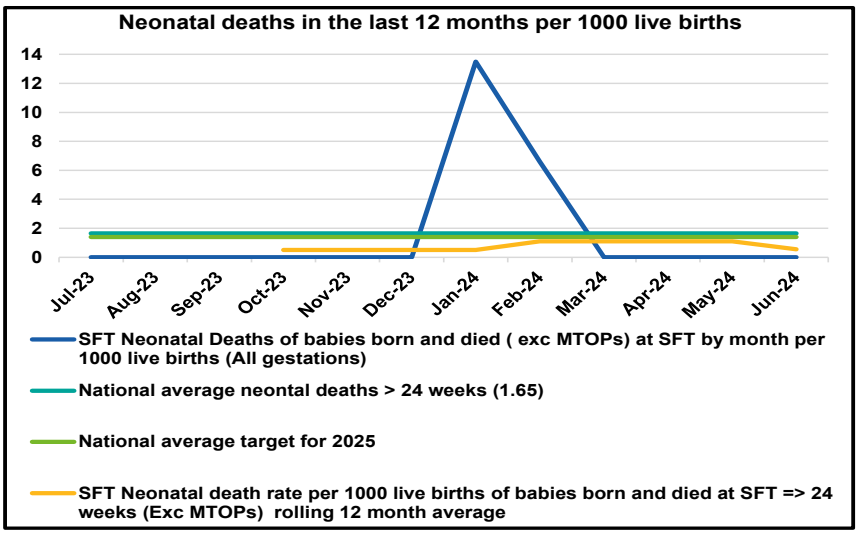
The graphs below demonstrate how Salisbury NHS Foundation Trust is performing against the national ambition.

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 (Q1), 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 (Q1), 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 Q2 and Q3.

2.1 Perinatal Mortality Summary for the Quarter (Q1 Apr-June24)

Figure 3. Perinatal Mortality summary

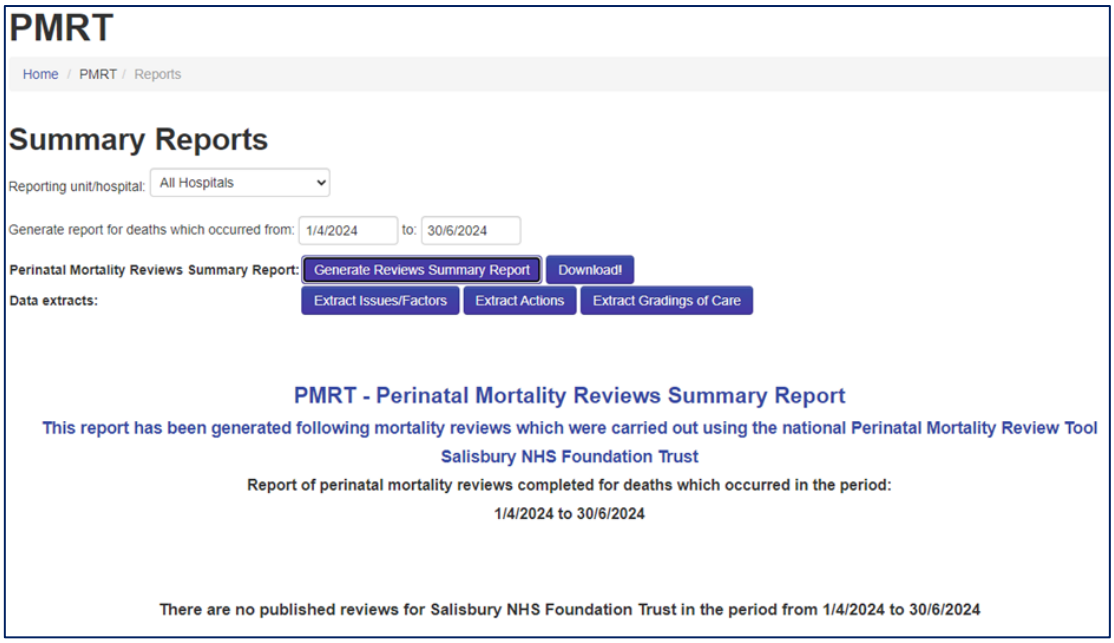
PMRT ID	Cause of Death	Issues/ Actions / learning
Case number 91811 Antepartum Stillbirth 36+2 weeks	Undetermined	The review group concluded that there were: • **No issues with care identified** up the point that the baby was confirmed as having died. • **No issues with care** identified for the mother following confirmation of the death of her baby. No actions identified
Case number 91810 Neonatal death Born at 32+3 weeks Died 2 days of age	1. Hypoplastic left heart 2. Prematurity	The review group concluded that there **were:** • **No issues with care identified** up the point that the baby was born. • **No issues with care identified** from birth up the point that the baby died. • **No issues with care identified** for the mother following the death of her baby. No actions identified

2.2 PMRT real time data monitoring tool

At Salisbury NHS foundation Trust authorised PMRT users generate reports, summarising 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. Below is an embedded copy of the Q1 2024/25 PMRT board report of the perinatal losses reviewed at SFT.

It is not possible to generate a report for quarter 1 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 Q1.



The Q1 PMRT Board Report is embedded below and covers the perinatal losses that were **reviewed** in Q1. Further detail is provided in Appendix 1.

PDF
Feb 24
PMRT_BoardReport_S

2.3 Learning from PMRT reviews

There were 2 cases reviewed under PMRT in Q1.

Issues
No issues raised.

Actions
No action(s) generated.

3.0 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. There is also a robust process for reporting cases that meet the criteria for MNSI.

There were 0 new cases that qualified for notification to MNSI in the last completed quarter (Q1)

3.2 Investigation progress update (MNSI and PSII cases) for the last Quarter (Q1)

On 8th January 2024 SFT moved over 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.

There are currently 10 ongoing investigations that are at various stages of progress and

breaches of the 60-day investigation target to CRG. Investigation breaches are on the risk register and these cases have been escalated for support within the division and Trust risk team. During this quarter all cases under the previous model (CR's and SI's) are seeing progress and are planned for presentation to the Trust Clinical Risk Group in Q2 in order to close. Current 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
SII 574	n/a	Stillbirth	27.6.23		Exit Date Scheduled 23/9/24
CR 580	n/a	Term Admission	1.8.23		Presented at Exit 16/9/24
CR 584	n/a	OASI	8.8.23		Awaiting report share date
SII 586	n/a	Eclampsia and GA	22.8.23		Slight amendment required on report prior to circulation.
STEIS 2023/16049	MI-031767	Cooled baby	22.8.23	MNSI and NHSR Early Notification Scheme	Awaiting tripartite meeting.
CR 588	n/a	Antenatal Pulmonary embolism	29.8.23		For report sharing
CR 599	n/a	PPH at home	3.10.23		Report sent for signing
CR 613	n/a	Eclampsia	28.11.23		Awaiting factual accuracy of draft report
PSII 162915	n/a	Preterm cooled baby	6.2.24		Awaiting final report
STEIS 2024/3982	MI-036889	Cooled baby	5.3.24	MNSI and NHSR Early Notification Scheme	MNSI report returned, awaiting tripartite meeing

3.3 Coroner Reg 28 made directly to Trust

There has been no coroner regulation 28's and actions being taken in the last quarter.

3.4 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.

4.0 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.

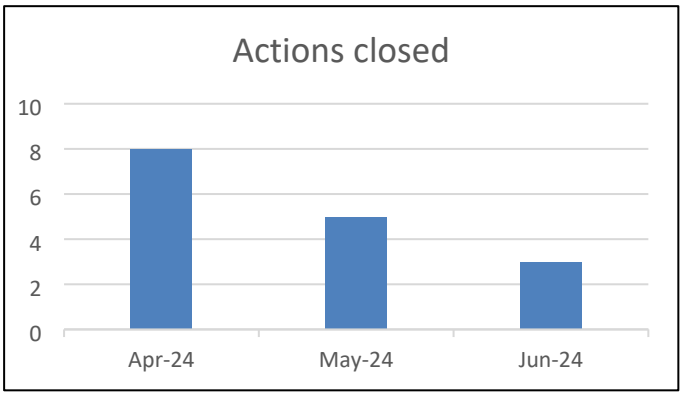
5.0 Ockenden updates

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	umber of actions under each heading rate			
			RED	AMBER	AWAITING CLOSURE	GREEN
Jun-24	1	Workforce Planning and Sustainability	0	2	0	5
	2	Safe Staffing	0	1	0	9
	3	Escalation and Accountability	0	0	0	5
	4	Clinical Governance - Leadership	0	1	0	7
	5	Clinical Governance - Incident Investigation and Cor	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	4	0	1
	9	Preterm Birth	0	3	0	1
	10	Labour and Birth	0	3	0	3
	11	Obstetric Anaesthesia	0	2	0	5
	12	Postnatal Care	0	1	2	1
	13	Bereavement Care	0	3	0	1
	14	Neonatal Care	0	1	0	5
	15	Supporting Families	0	0	0	3
			0	22	2	↑61

Figure 8. Numbers of actions closed per month in Q1



The key achievements and next steps to progress the closure of Ockenden 2022 IEAs are:

- **Key Achievements:** Bereavement added to Maternity Risk & Governance agenda for action tracking, progress and escalations.
- **Next Steps for Progressions:** Complex Antenatal Care working group to meet – attendance of key stakeholders a challenge, work ongoing to resolve.

6.0 Three Year Delivery plan

The Three-Year Delivery Plan has recently been mapped, with action holders identified for each element. The current priority for SFT has been increasing compliance with Saving Babies Lives (SBL) v3, with the next submission date for SBL 30th August 24.

After the next submission date, and whilst awaiting feedback from the LMNS, time will be dedicated to meeting delivery plan action holders in order to set out the ask, explore current compliance and identify any challenges or barriers to compliance.

7.0 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 (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:

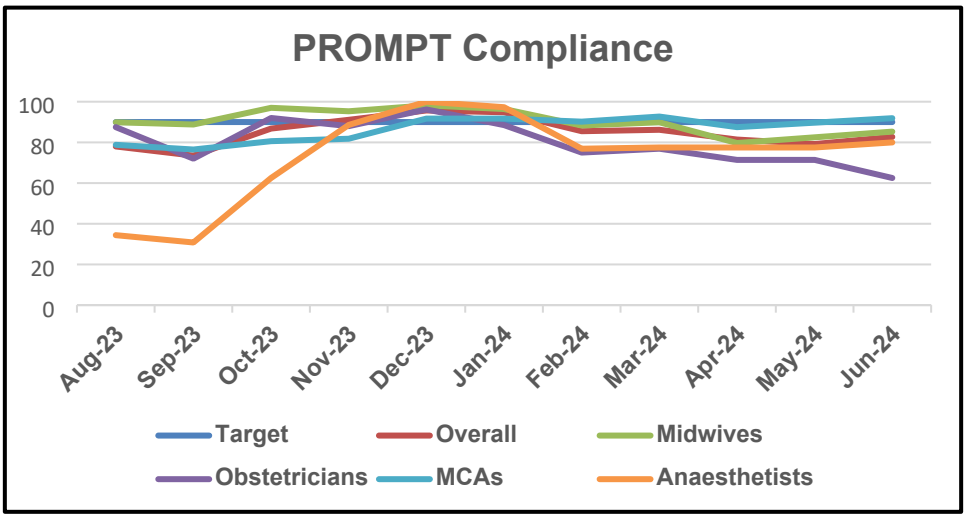
- Saving Babies Lives Care Bundle
- Fetal monitoring and surveillance
- Maternity Emergencies and multi professional training
- Equality/ equity and personalised care

- 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.

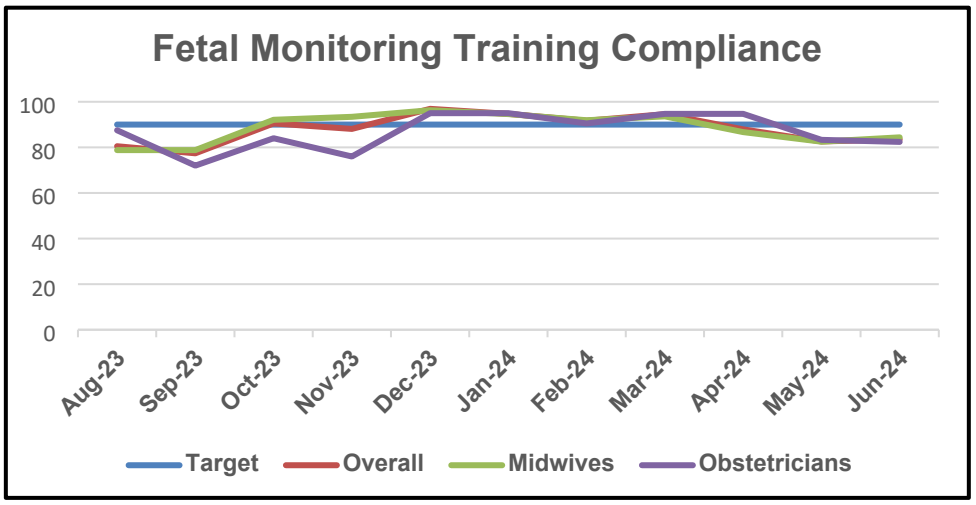
In quarter 1, it has been difficult to maintain compliance for the multi-professional maternity emergencies training for medical staff, as shown below. This is due to the conflicting demands of the services, with additional surgical lists and pressure to reduce waiting times. This has been escalated to the relevant divisions and a plan has been created for quarter 2 to improve attendance.

Figure 9. PROMPT Training Day Compliance



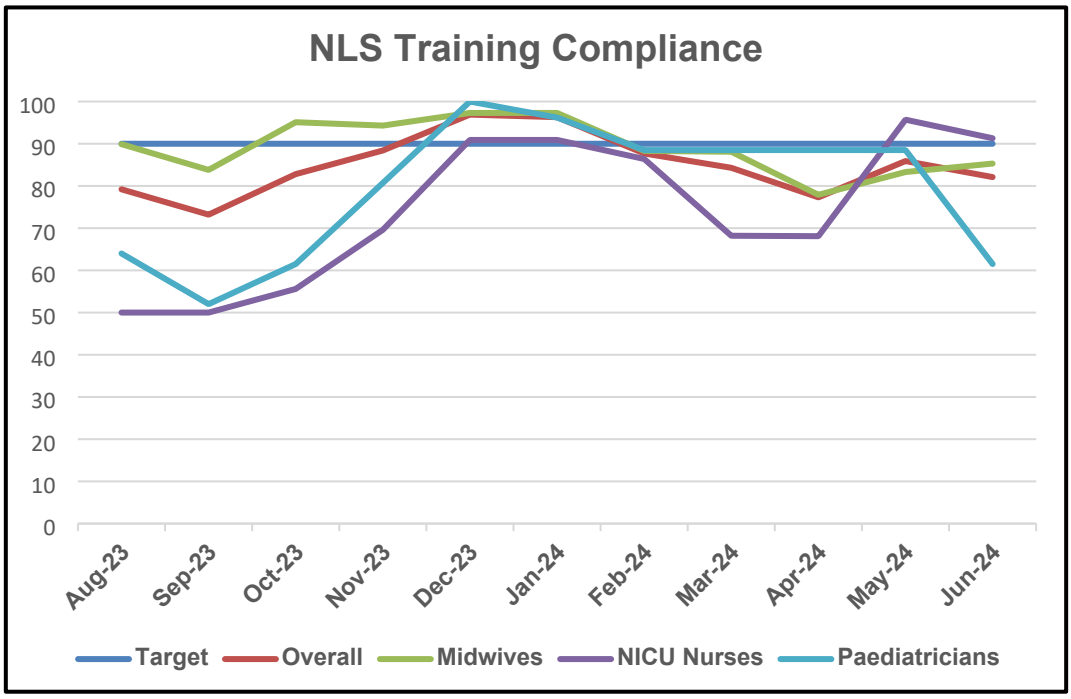
Fetal monitoring training has managed to maintain compliance at a steadier rate than previous years. The was a drop in compliance this quarter, this was due to no study day being held in May, avoiding school holidays and increase in annual leave. There is an upwards trajectory in compliance for quarter 2.

Figure 10. Fetal Monitoring Training Compliance



In quarter 1, there has been a fall in Newborn Life Support training across all staff groups. This has been escalated to Neonatal clinical lead and the neonatal practice educator. Due to small numbers of paediatricians and neonatal nurses, compliance will be achievable following 1-2 more training sessions in 2024.

Figure 11. NLS Compliance Training



8.0 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 Q1

Figure 12. Maternity and Neonatal Safety Champions attendance by role in Q1

Staff groups	April	May	June
Trust Executives	Chief Nursing Officer	Chief Nursing Officer Non-Executive	
Obstetric		Consultant Obstetrician	Consultant Obstetrician
Midwifery	Director of Midwifery Family Experience Midwife Quality & Safety Matron	Director of Midwifery Head of Midwifery Family Experience Midwife Quality & Safety Matron Band 6 Midwife Representative	Director of Midwifery Family Experience Midwife Quality & Safety Matron
MSW	MSW	MSW	
Neonatal		Neonatal Matron	Neonatal Matron Consultant Paediatrician
MNVP	MNVP	MNVP	MNVP
Secretarial support	Admin Manger Quality & Safety Administrator	Operational Manager Quality & Safety Administrator	Operational Manager Quality & Safety Administrator

8.2 Positive points recognised

Over the course of the Q1 period the following positive points were highlighted:

- Staffing levels on the Neonatal Unit reported as good with 2 nurses completing their neonatal course by June 2024.
- NIPE clinic staffing levels have improved.
- *My Maternity* booklets have been created to provide advice and information around birth choices and personalised care planning.
- Maternity Survey 2023 action plan was reviewed and a lot of actions surrounding patient information provided on the Labour Ward have been completed.
- A 'walk around' was undertaken in June and reported as positive.
- It was noted that the first Triangulation meeting took place in Q1, allowing for more in-depth discussions around providing a robust Birth Reflections Service to take place.

8.3 Concerns raised in Q1 have been:

Figure 13. Concerns raised in Maternity and Neonatal Safety Champions meetings

Concerns raised	Action and progress
18/04/2024 - Concerns surrounding delays to Paediatricians arriving on the ward reported. Consultant Paediatrician previously escalated to CD. DoM to provide update on outcome of this.	16/05/2024 - Ongoing issue, Lead Paediatrician working on changing job plans to include clinical time on postnatal ward for Consultant Paediatricians. DoM and lead Paediatrician to discuss outside of meeting re. putting on Risk Register.

Maternity and Neonatal Safety Champions action tracker:

Maternity Safety Champions Meeting

8.4 Concerns raised by service users

There has been 1 complaint and 0 concerns raised in July 24. During Q1 there have been multiple concerns raised regarding the service user's pregnancy journey; ranging from the attitude of medical staff, lack of continuity in community, fundal height measurements, unsupported with birth preferences and concerns raised regarding intrapartum care. Appropriate action plans have been developed.

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 Q1:

Figure 14. Walk around findings

Area/date visited	Discussion points	Concerns raised	Actions
09/04/2024 - meeting with community midwives	Follow up meeting with community midwives. Still waiting for the rota consultation outcomes.	The meeting felt much better on this occasion with agreement of using the behaviour charter. The main issue remains the shift pattens and the outcomes of the staffing consultation. Patient information leaflets were discussed as many out of date and poor quality. Access to equipment much improved.	Staffing consultation due to come out in next few weeks. DoM to look at the leaflets and documents of concern.
07/06/2024 - Labour Ward/DAU and NICU	No immediate safety issues raised. Staffing all okay for the day. Adequate cover in all areas and low numbers of women in labour. Birthing pool checked and limescale not present.	DAU midwives raised a concern about the availability of the registrar in the afternoon in DAU. They said they might have women that had injured themselves being kept for long periods before scans can be reviewed.	For feedback by Exec at Trust Board meeting and Maternity Safety meeting. Raised immediately with DoM and CD.

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 Q2 with the suggestion that the Quadrumvirate work is included as a rolling quarterly agenda item to the Maternity & Neonatal Safety Champions meeting.

Figure 15. Initial findings from the SCORE survey

The findings of the SCORE survey are illustrated below. 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 is currently under review by the divisional leadership team.

9.0 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%, then 37% and currently sits at 40% with 28 compliant interventions against the total 69 interventions across all elements, 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.

10.0 NHS Resolution Maternity Incentive Scheme update in month

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 July 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	Progress begun	
5	Midwifery Workforce	Compliant	Compliant at present	
6	Saving Babies Lives Bundle Version 3	Non-Compliant	Progress begun	
7	Patient Experience	Compliant	Compliant at present	
8	Training	Non-compliant	Progress begun	
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 the workforce safety action by 30.11.24.

It is not possible to provide expected compliance for SBLCBv3 at this point (end of Q1). It is hoped that with the change in requirements moving from '70% implemented' to 'demonstrating significant improvement' may enable SBL compliance to be achieved. It will be possible to provide more accurate commitment closer to the submission dates (30.11.24).

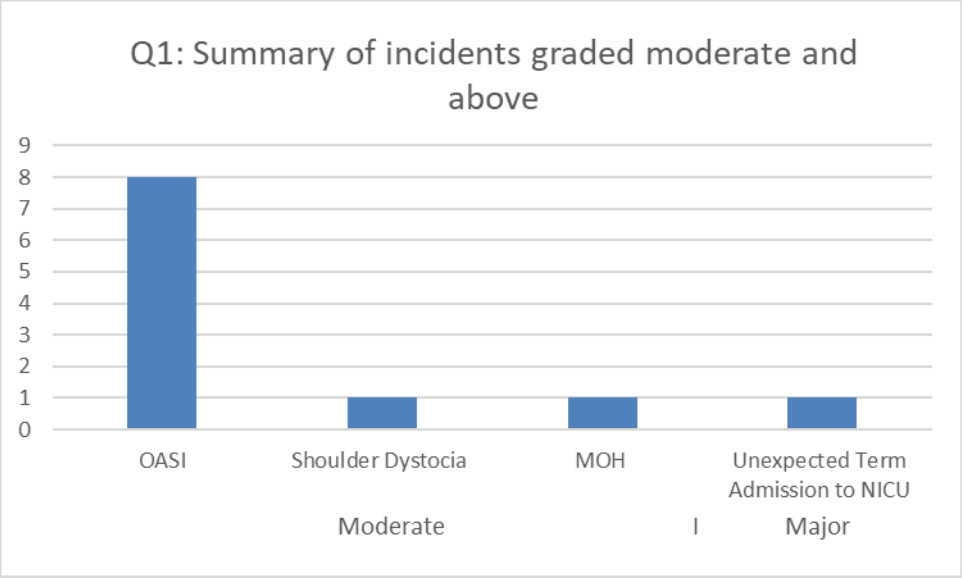
At present SFT are non-compliant with Safety Action 8 due to Anaesthetic attendance for Prompt. This has been escalated to Divisional Clinical Directors and the Trust Executives for support and the team are working through an action plan.

11.0 The number of incidents in Q1 and what actions are being taken

A summary of Moderate or above incidents in Q1 are provided below. These numbers were extracted from our reporting system Datix and a search created using the following data:

Date: 01/04/2024:30/06/2024
Severity: Moderate and above
Directorate: Women and Newborn Division

Figure 17. Summary of Moderate or above incidents



The last quarter noted a rise in Obstetric Anal Sphincter Injury (OASI) or 3rd and 4th degree perineal tear rates. This is a divisional watch metric and is currently 6 % which is above the national target of 5 % and national rate per 1000 births. A thematic review took place identifying actions for improvement. This report has been shared with clinical leads and OASI data shared with staff via the quarterly maternity newsletter, risk updates and daily communications board. The Q&S team and pelvic health Midwife are working with leads.

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 Q1

Datix Number	Incident Category	Outcome/Learning/Actions
165183	3b tear and 1.7L MOH	Delay transferring to theatre resulting in increased blood loss. Escalation for use of 2nd theatre (already noted on the risk register). For weekly obstetric roster to be available on Labour Ward to aid prompt escalation.
165313	3c tear	Trauma following birth in water and therefore limitations present for perineal protection. No omission in care identified.
165583	3a tear	Precipitate birth. No omission in care identified.
166149	3a tear	Trauma following birth in water and therefore limitations present for perineal protection. No omission in care identified.
165936	3b tear	OASI fully discussed and clear documentation of perineal protection. No omission in care identified.
166085	3a tear	OASI fully discussed and clear documentation of perineal protection. No omission in care identified.
166364	3a tear	Extremely precipitate birth. No omission in care identified.
166507	3a tear	Instrumental delivery. OASI fully discussed and clear documentation of perineal protection. No omission in care identified.
166508	Shoulder dystocia and 3a tear	OASI fully discussed and clear documentation of perineal protection. McRoberts procedure used successfully. No omission in care identified.
165965	Term Admission to NNU	Congenital abnormality identified at birth, extremely rare event. Additional training opportunities for the sonography team.

12.0 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 fill rates for the inpatient areas by month in Q1

Month	RM Day %	RM Night %
April 2024	97.2	99.3
May 2024	97.1	98.6
June 2024	97.6	98.9

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 the 8 cases meeting the above criteria and 100% compliance achieved

Date	Clinical Situation(s)	Comments
2/04/24	**PPH 2L where the haemorrhage is continuing, and Massive Obstetric Haemorrhage has been instigated.**	Consultant present.
3/04/24	**PPH 2L where the haemorrhage is continuing, and Massive Obstetric Haemorrhage has been instigated.**	Consultant present.
2/05/24	**PPH 2L where the haemorrhage is continuing, and Massive Obstetric Haemorrhage has been instigated.**	Consultant present.
1/06/24	**PPH 2L where the haemorrhage is continuing, and Massive Obstetric Haemorrhage has been instigated.**	Consultant not present. Consultant aware when MOH call put out, not requested to attend. Total amount 2L.
3/06/24	**Caesarean birth for women with BMI >50**	Consultant present.
9/06/24	**Maternal collapse and Early warning score protocol that suggests critical deterioration where HDU / ITU care is likely to become necessary.**	Consultant present.
9/06/24	**Caesarean birth for major placenta praevia / abnormally invasive placenta**	Consultant present.
7/06/24	**PPH 2L where the haemorrhage is continuing, and Massive Obstetric Haemorrhage has been instigated.**	Consultant present.

Short and long-term locum usage

NHS Trusts/organisations should ensure that the following criteria are met for employing short-term (2 weeks or less) and long-term locum doctors in Obstetrics and Gynaecology. Full details are contained in the appendix. The table below shows compliance with the locum standards.

Figure 21. Table shows 100% compliance with locum standards being met

Standard	Compliance % for Locum 1 (Commenced in Q1)	Compliance % for Locum 2 (in post prior to Q1)
Standard 1 Locum doctor CV reviewed by consultant lead prior to appointment	100%	N/A
Standard 2 Discussion with locum doctor re clinical capabilities by consultant lead prior to starting or on appointment	100%	N/A
Standard 3 Departmental induction by consultant on commencement date	100%	N/A
Standard 4 Access to all IT systems and guidelines and training completed on commencement date	IT / microguide 100%	N/A
Standard 5 Named consultant supervisor to support locum	100%	N/A
Standard 6 Supernumerary clinical duties undertaken with appropriate direct supervision	100%	N/A
Standard 7 Review of suitability for post and OOH working based on MDT feedback	N/A	100%
Standard 8 Feedback to locum doctor and agency on performance	N/A	100%

Anaesthetic and neonatal workforce is detailed in the full workforce report in the appendices.

13.0 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 5). The following is a summary of key highlights.

- Digital Friends and Family Test (FFT) feedback implemented in Q1.
- The number of complaints received has remained consistent with the previous quarter.
- Decline in concerns logged in Q1. Themes include waiting times and miscommunication with scan appointments.
- Increase in comments and enquiries logged with PALS this quarter. The top themes being, 'unsatisfactory treatment' and 'information required'.
- A Patient story was shared, at the family's request, at the perinatal meeting as an opportunity for learning.
- A new Triangulation meeting was introduced, where the feedback from the MNVP was shared and discussed in a multidisciplinary forum. An identified action from this meeting was the need to undertake a data analysis of the Birth Reflection Service, considering the recently published Parliamentary Inquiry into birth trauma.
- The 2023 National Patient Experience and the 15 steps assessment action plans are progressing towards completion. Compliance to the National Patient Experience Survey's actions will be monitored through the LMNS and Safety Champions.
- In Q1 there were no reportable fetal losses, therefore no patient experience feedback was received relating to bereavement care.
- A patient survey was conducted for Beatrice Maternity Ward (BMW). This is detailed in the full report.
- The MNVP has been unable to appoint to the Local MNVP lead role. (to cover maternity leave). This has impacted on the frequency in which we receive feedback via the MNVP.

Priorities for next quarter:

- Finalise the Neonatal unit (NNU) patient experience survey.
- Undertake a detail analysis of the findings from the health inequalities patient experience survey.
- 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.

14.0 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 include:

- Development of flexible working agreements
- MEOWS and fluid balance compliance
- NIPE clinics

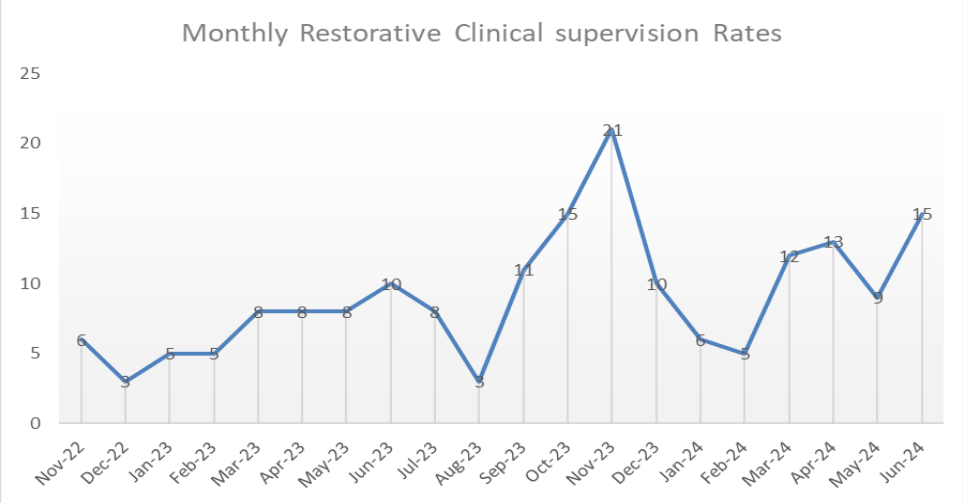
15.0 Implementation of the A EQUIP model

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): all Midwives returning from long term sick or Maternity leave, and all new starters have received an RCS session in Q1 (see below graph).
- RCS support: all NQMW and international midwives continue to receive this as part of a retention initiative. All current preceptee Midwives have been successfully retained.
- 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.
- Teaching continues around Civility and respect. 'Civility and positive workplace culture' training together with 'Active Bystander Training' has been included in PROMPT MDT training. This is to support and promote a positive culture.

Figure 22. Restorative Clinical Supervision Rate (p/m)



15.2 Plans and Actions

- PMA training: 2 band 6 Midwives have successfully completed their PMA training bring the total number of qualified PMAs within Maternity to 8.
- PNA/PMA collaborative working: The 'PMA/PNA plan to deliver the a-equip model at Salisbury NHS Trust' was successfully approved through the NMAHP meeting and will shortly be available on Microguide. This joint plan forms the basis of collaborative working between the PMA's and PNA's within the wider trust so that each service can benefit from the experiences of the other.

16.0 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

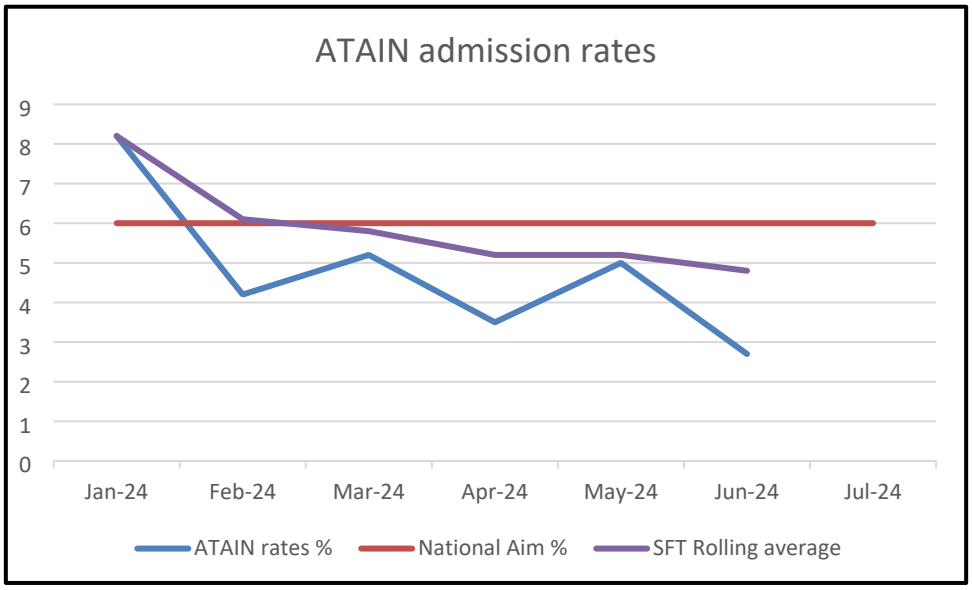
In August 2017 NHSI mandated a Patient safety alert to all NHS Trusts providing maternity care. The safety alert was issued to reduce harm from avoidable admissions to neonatal units for babies born at or after 37 weeks. This fell in line with the Secretary of State for Health's ambition to reduce stillbirth, 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 23. 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.

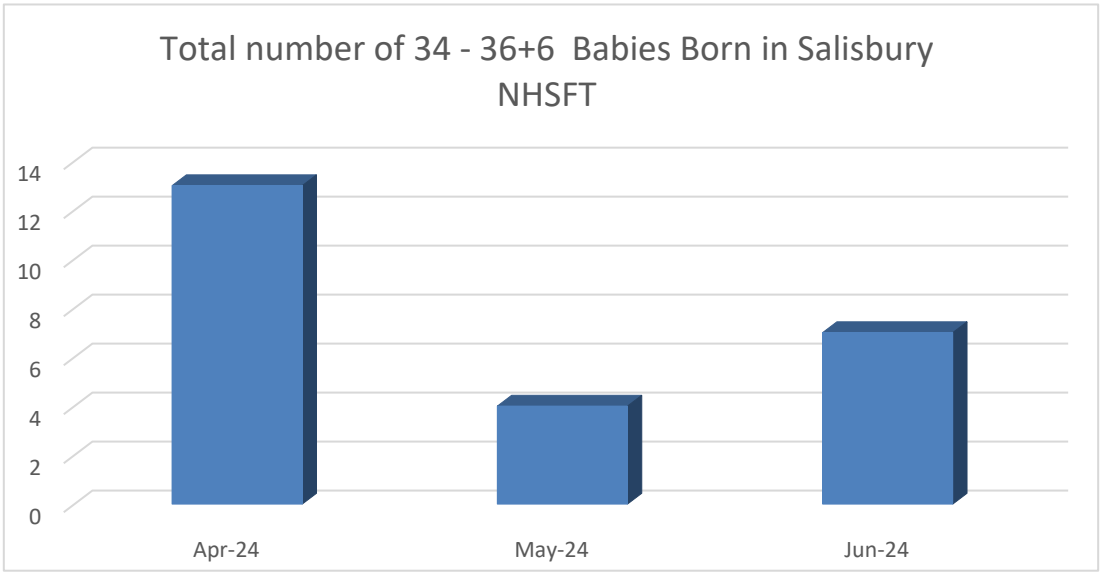
Figure 24. ATAIN reviews during Q1 (babies equal or >37 weeks gestation)

	April 2024	May 2024	June 2024
Total number of admissions in month	**6**	**7**	**4**
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.	**1**	**0 @ present, dept. behind with ATAIN**	**0 @ present, dept. behind with ATAIN reviews 2 outstanding**
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.	**1 – This was a bilious vomiting infant**	**0 @ present**	**0 @ present**
	April 2024	**May 2024**	**June 2024**
Total number of case reviews undertaken in month	**6**	**7**	**2**
Total number of case reviews with both maternity and neonatal staff present	**6**	**4 – 3 remain outstanding**	**2 – 2 remain outstanding**

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 the last quarter and preceding 12 months. Further detail is contained within the appendices.

Figure 25. 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.

17.0 Staff Survey

The most recent annual NHS Staff survey was published in March 2024, 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 26. 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 27. 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.

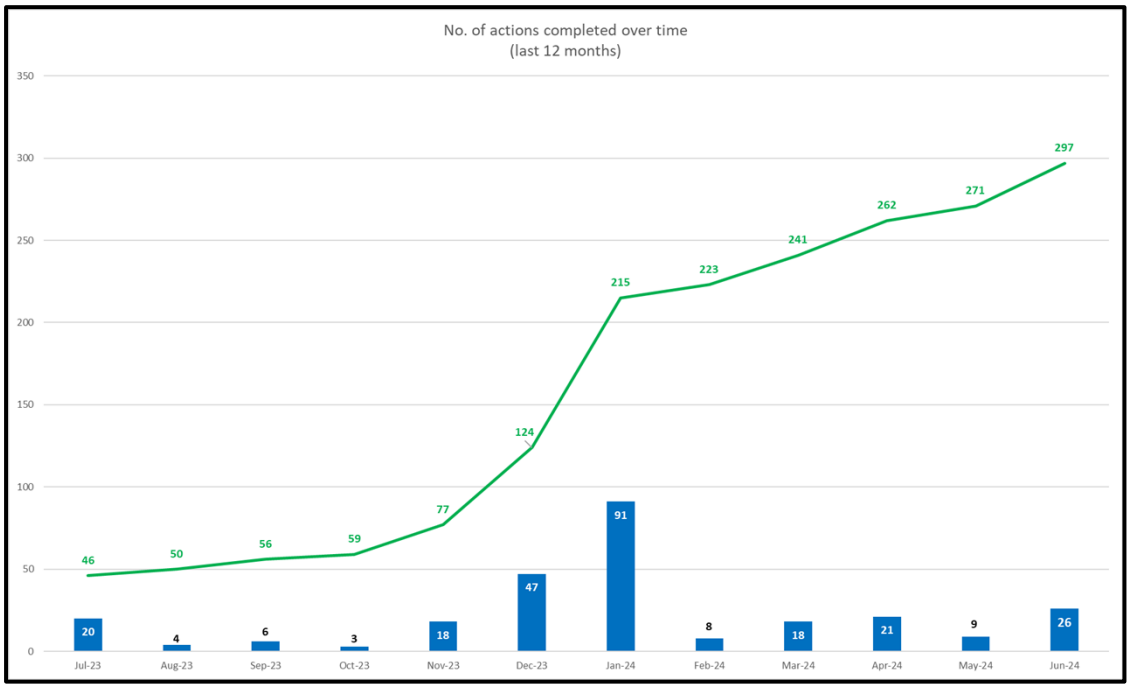
18.0 Safety Improvement plan

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 1 significant progress was made with closing actions on the Maternity Improvement Plan.

Figure 28. Progress with Maternity Improvement plan Actions Q1



In March 2024 (Q4 2023/24) a meeting was held with SFT, LMNS, regional and National stakeholders in which it was agreed that SFT had made the progress required to move to Exit from the Support programme. A meeting to formally present the evidence will be held in Q2 2024/25.

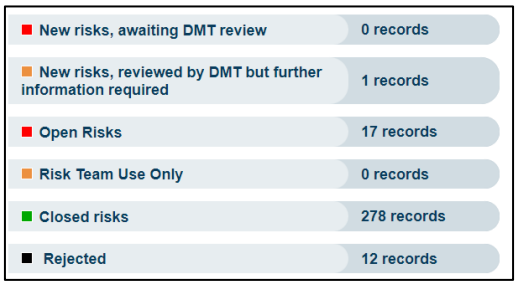
As of end of Q1 2024:

- All CQC actions now complete
- Further completions in Governance workstream
- MSSP Exit meeting date agreed
- Board report in progress

19.0 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 5.7.24 the current risks on the risk register can be seen in figures 1-3 below.

Figure 29. Women and Newborn Division - Risk register summary



New risks, awaiting DMT review	0 records
New risks, reviewed by DMT but further information required	1 records
Open Risks	17 records
Risk Team Use Only	0 records
Closed risks	278 records
Rejected	12 records

Figure 30. Maternity and Neonatal services 'new risks, reviewed by DMT but further information required.'

ID	Title	Opened	Risk Type	Rating (current)
8060	Non attendance at essential safeguarding child protection and child in need meetings	17/04/2024	Clinical Risk	6

Figure 31. Current 'open risks' in Maternity and Neonatal services

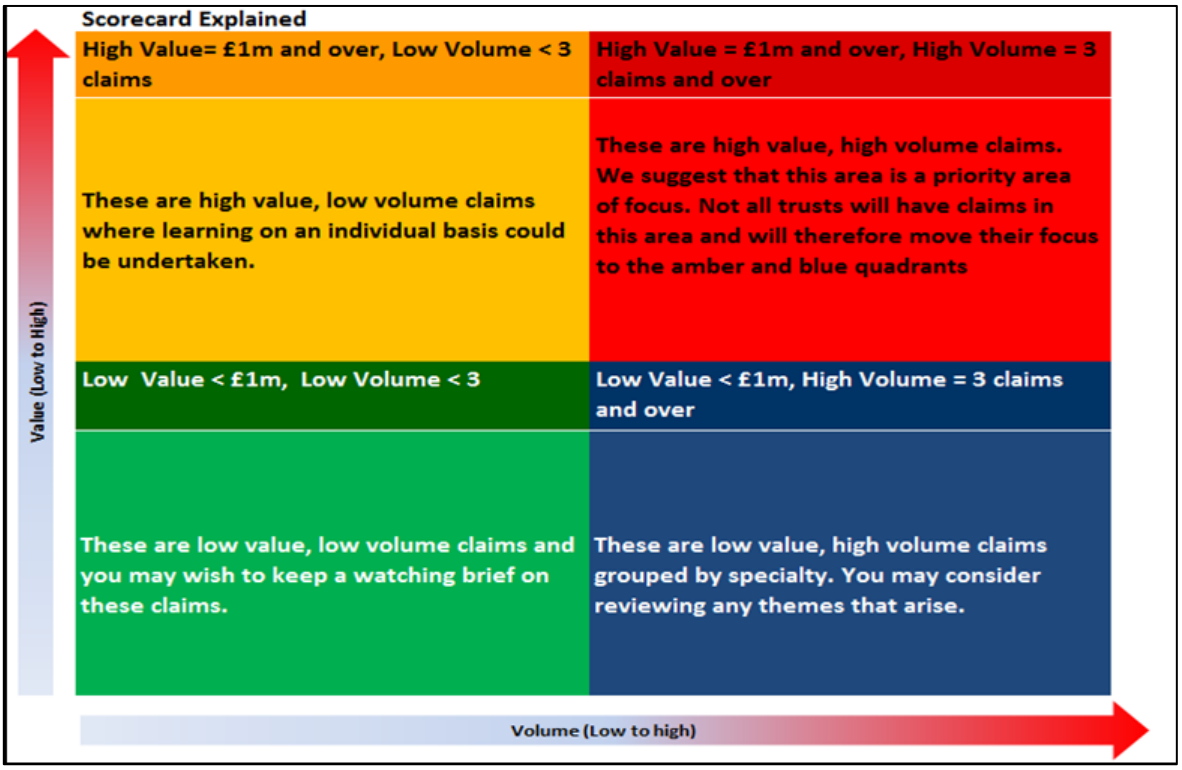
ID	Title	Opened	Risk Type	Rating (current)
7894	Delay in first trimester screening bloods reaching the lab in Portsmouth	14/05/2024	Clinical Risk	9
7733	Lack of Service for Abnormal Placentation	15/06/2023	Clinical Risk	8
8074	Breaches in 60 day SII and CCR investigation target	30/04/2024	Clinical Risk	9
6836	Risk of re-designation of neonatal intensive care service	24/02/2021	Clinical Risk	5
6412	Harm to women and babies through lack of dedicated 2nd obstetric theatre	28/04/2020	Clinical Risk	9
8013	No robust system for checking results on review	14/03/2024	Clinical Risk	5
7923	Neonatal unit heating	08/12/2023	Corporate Risk	10
7860	Neonatal ventilators	04/10/2023	Clinical Risk	3
7221	There is a risk of cases with harm not being escalated due to the large backlog of Datix	14/02/2022	Clinical Risk	10
8049	Maternity Information syastem back and forward copying issue	29/01/2024	Organisational Risk	2
7623	Neonatal ROP	02/03/2023	Organisational Risk	5
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
7999	No dedicated 24/7 obstetric anaesthetist cover.	02/10/2023	Clinical Risk	4
7891	No separate consultant rotas for obstetrics and gynaecology	13/11/2023	Clinical Risk	4

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 32. the NHSR litigation scorecard explained in terms of value and volume of claims

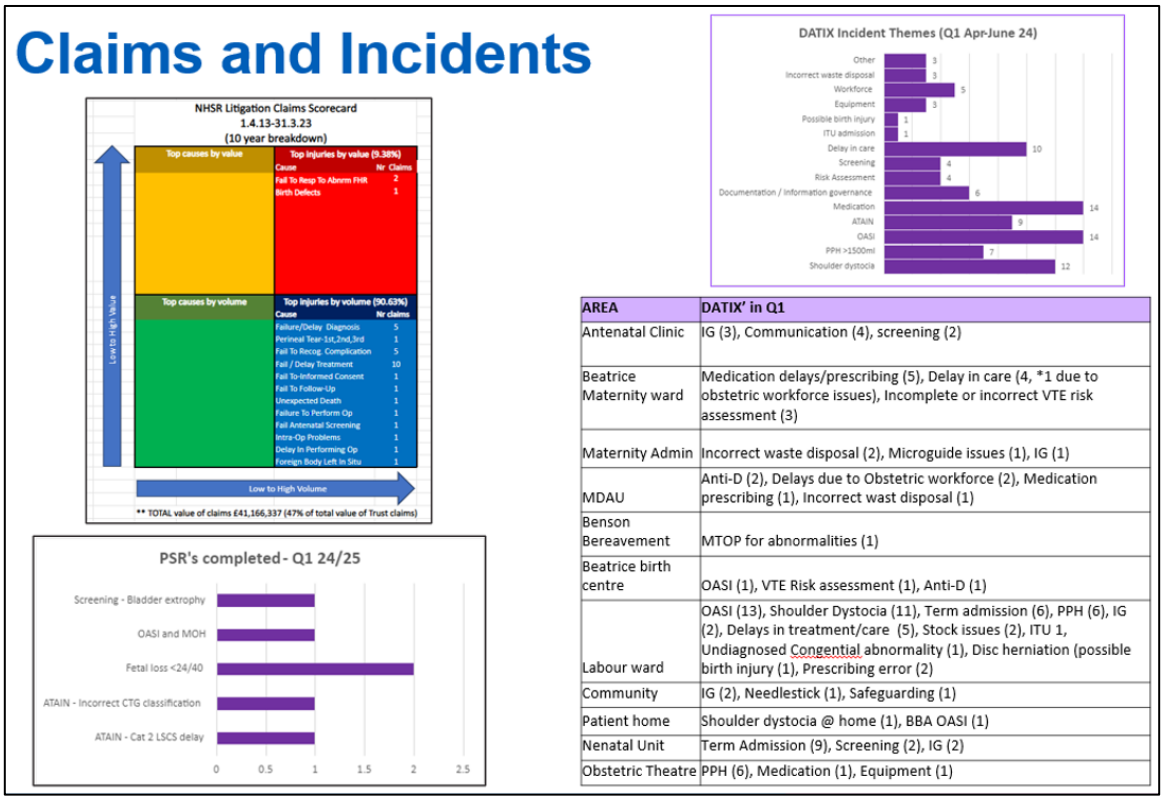


The themes from incidences, claims and complaints are reviewed at the quarterly triangulation meeting.

These can be summarised as follows and in the images below:

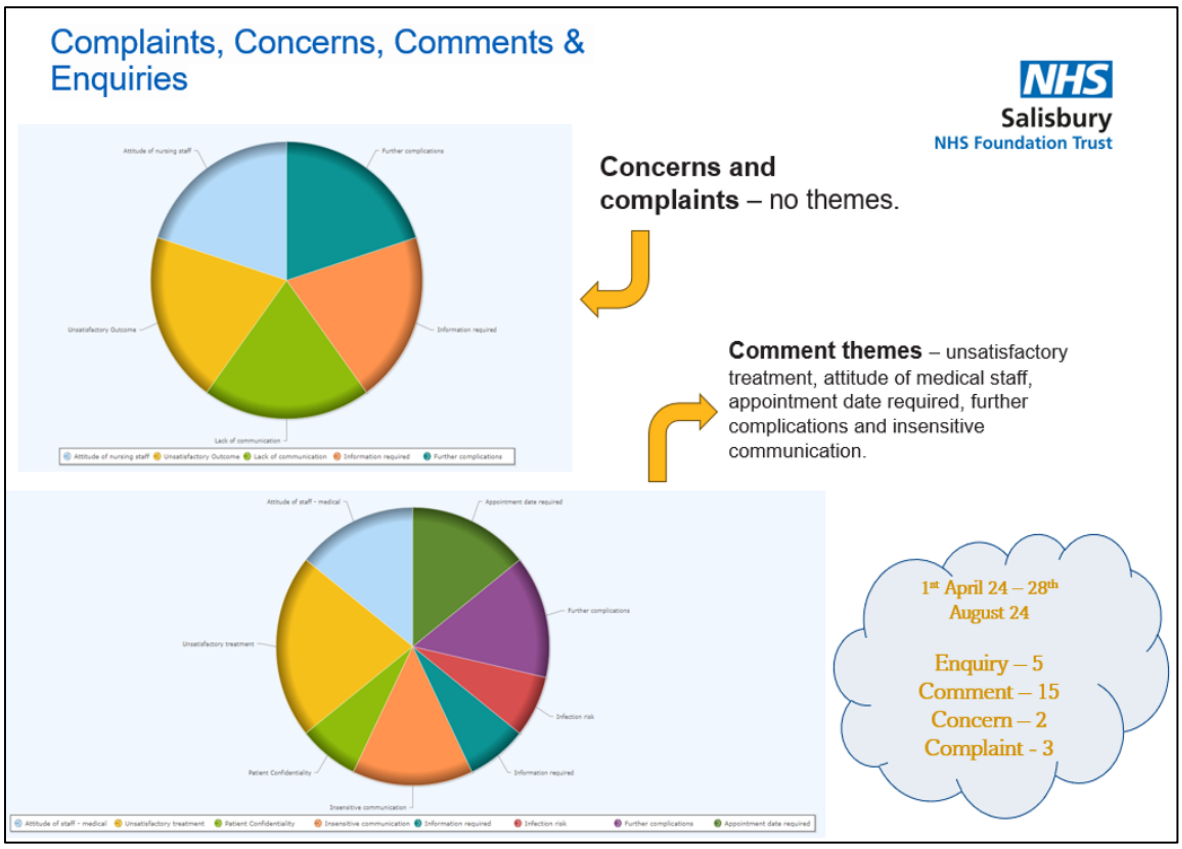
- Legal claims - the top injury claim by value is failure to respond to abnormal fetal heart rate (2) and by volume is failure / delay in diagnoses (5) .
- Incidents - top 3 Datix these include medications, OASI and shoulder dystocia. OASI and shoulder dystocia are listed on the trigger list, therefore all cases are reviewed in line with the Trust PSIRF plan and learning identified.
- Complaint themes – these include unsatisfactory treatment, attitude of medical staff. Appointments date required, further complications and insensitive communication.

Figure 33. Current 'open risks' in Maternity and Neonatal services



AREA	DATIX' in Q1
Antenatal Clinic	IG (3), Communication (4), screening (2)
Beatrice Maternity ward	Medication delays/prescribing (5), Delay in care (4, *1 due to obstetric workforce issues), Incomplete or incorrect VTE risk assessment (3)
Maternity Admin	Incorrect waste disposal (2), Microguide issues (1), IG (1)
MDAU	Anti-D (2), Delays due to Obstetric workforce (2), Medication prescribing (1), Incorrect wast disposal (1)
Benson Bereavement	MTOP for abnormalities (1)
Beatrice birth centre	OASI (1), VTE Risk assessment (1), Anti-D (1)
Labour ward	OASI (13), Shoulder Dystocia (11), Term admission (6), PPH (6), IG (2), Delays in treatment/care (5), Stock issues (2), ITU 1, Undiagnosed Congential abnormality (1), Disc herniation (possible birth injury (1), Prescribing error (2)
Community	IG (2), Needlestick (1), Safeguarding (1)
Patient home	Shoulder dystocia @ home (1), BBA OASI (1)
Nenatal Unit	Term Admission (9), Screening (2), IG (2)
Obstetric Theatre	PPH (6), Medication (1), Equipment (1)

Figure 34. Current 'open risks' 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 1 2024-25)

1.0 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.**

2.0 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.

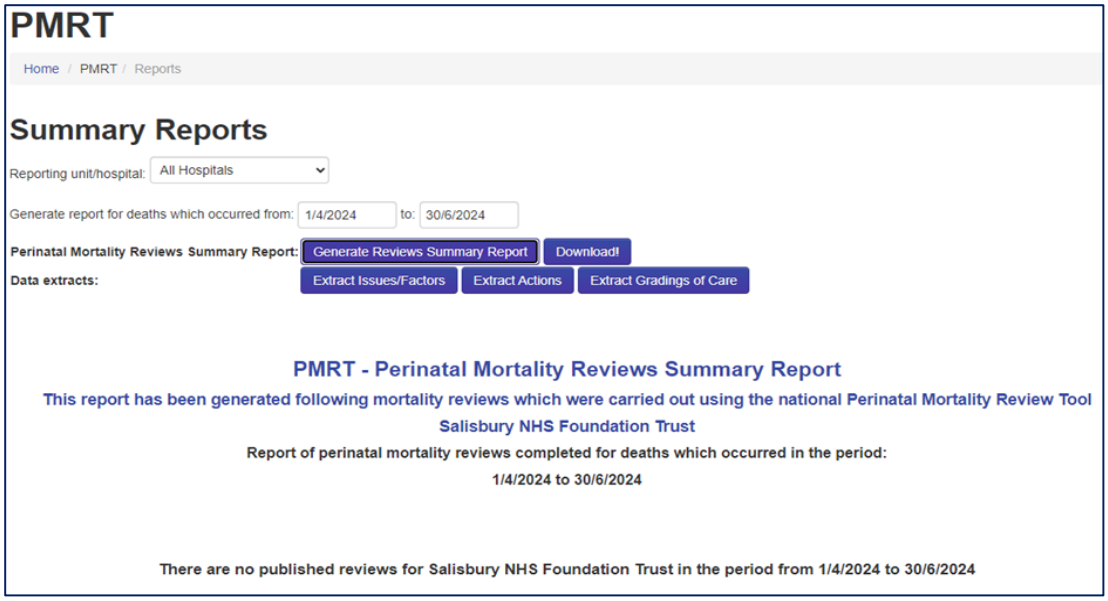
The MIS Year 6 scheme was released in April 2024 and will apply to babies who die between 8th December 2023 until 30th November 2024.

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 1 as there were no perinatal losses within that timeframe (as per previous graphs and screenshot of the MBRRACE reporting tool below).

Figure 2. PMRT Report screenshot showing that there were no published reviews in Q1.



The Q1 PMRT Board Report is embedded below and covers the perinatal losses that were **reviewed** in Q1. Further detail is provided in Appendix 1.

Feb 24
PMRT_BoardReport_S

3.0 Recommendations

3.1 Eligible Incidents in 2024-2025 (appendix A)

There has been a total of 1 incident reported to MBRRACE-UK in Quarter 1.

0 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 1 (appendix B)

There have been 2 incidents closed in Q1.

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:

- 1 case 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:

- 1 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:

- 1 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:

- 1 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:

- 1 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 in Q1. 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 Q1. 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: 15/08/2024

Appendix A - Summary of all Eligible Incidents Reported in Q1 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	CII R/SI	Notify MBRRACE within 7 days	Seek parent's views of care	Start review <2 mths	Complete and publish review < 6mth	Report to trust executive
Q1	**93916**	Medical termination of pregnancy	23+6	20/06/2024	18/06/2024	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 Q1 2024-25

Case	Cause of Death	Grading of Care	Issues Identified	Actions	Responsible/Date	Update
Case number **91811** **Antepartum Stillbirth** **36+2 weeks**	Undetermined	The review group concluded that there were **no issues with care identified** up the point that the baby was confirmed as having died. The review group concluded that there were **no issues with care** identified for the mother following confirmation of the death of her baby.	No issues were identified.	No actions identified.		
Case number **91810** **Neonatal death** **Born at 32+3 weeks** **Died 2 days of age**	1. Hypoplastic left heart 2. Prematurity	The review group concluded that there **were no issues with care identified** up the point that the baby was born. The review group concluded that there were **no issues with care identified** from birth up the point that the baby died. The review group concluded that there were **no issues with care identified** for the mother following the death of her baby.	No issues were identified.	No actions identified.		

Appendix C - Summary of CNST Compliance as per MIS Year 6 Standards

MBRRACE-UK/PMRT standards for eligible babies following the PMRT process	%	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)			7
		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			3
		100	100	100			100%
A PMRT review must be commenced within two months following the death of a baby.	95	1	2	0			3
		100	100	100			100%
Minimum of 60% of multi-disciplinary reviews should be completed and published within six months.	60	1	2	0			3
		100	100	100			
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			3
		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.	Steph Thompson Bonnie Randell New date 12/24.	SOP completed- in 2022. Delay in being ratified at Neonatal and Sarum governance. Will now need updating- in progress.
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 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 TRibb- 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.

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

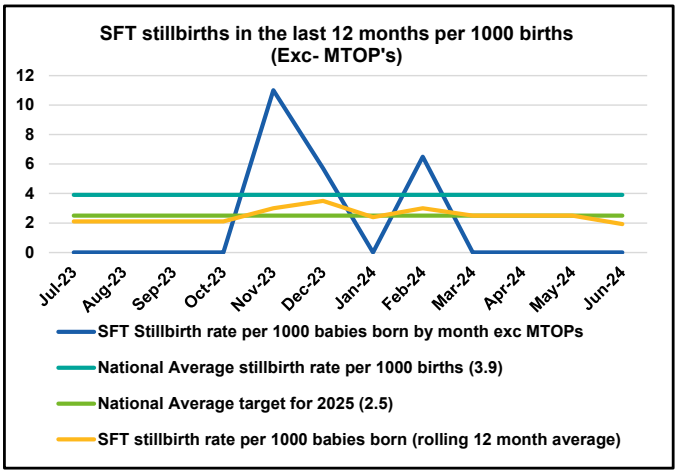
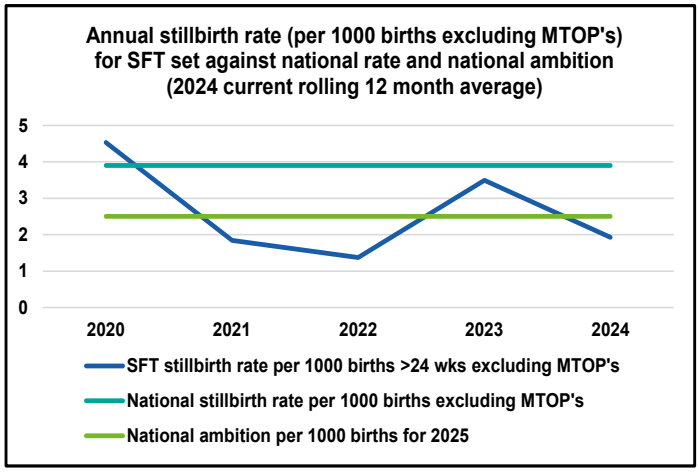


Figure 2. Annual Stillbirth rate (per 1000 births excluding MTOP's) for SFT set against national rate and national ambition (2024 current rolling 12 month average)



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 per 1000 live births > 24 weeks for SFT compared with national rate

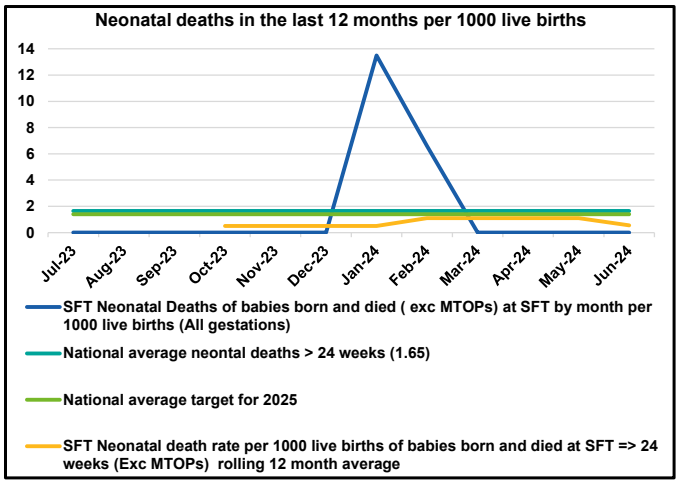
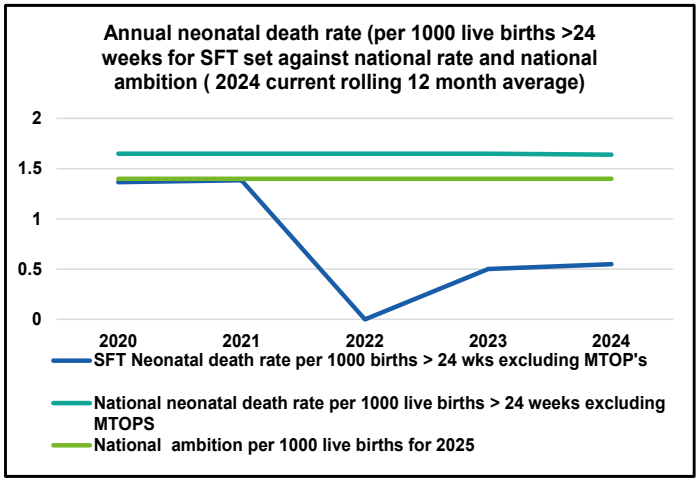


Figure 4. Annual Neonatal death rate per 1000 live births > 24 weeks for SFT set against national rate and national ambition (2024 current rolling 12 month average)



Maternity and Neonatal Training Report
Maternity and Neonatal Services
(Quarter 1 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.

Contents

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 (>3months). 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 ambition to achieve stretch target ≥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.

Figure 1. Compliance with SBL Element 1 eLearning in Quarter 1

	April 2024	May 2024	June 2024
Midwives	**31%**	**37.7%**	**48.2%**
Obstetricians	**20%**	**17.9%**	**16.7%**

1.2. Fetal Growth Restriction (FGR)

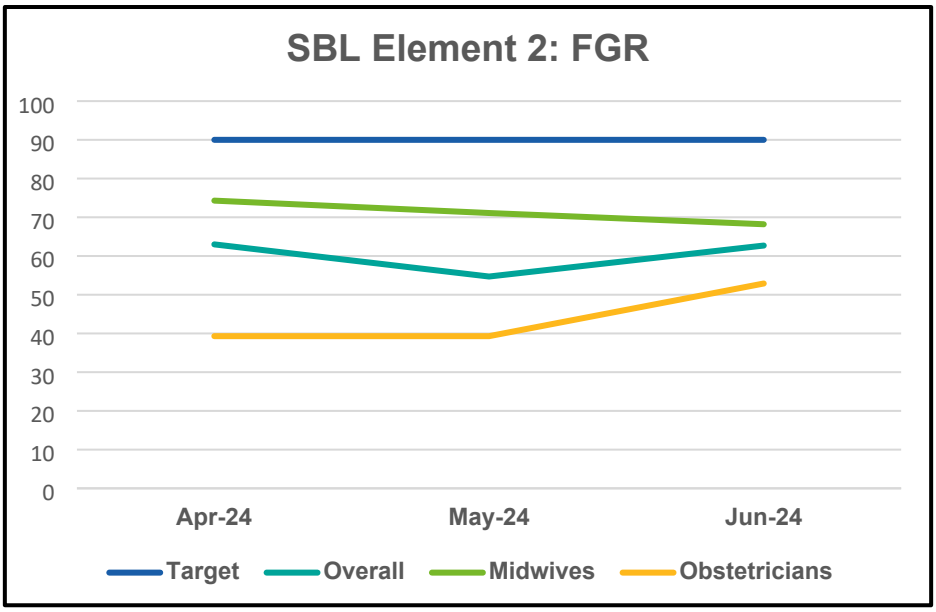
Minimum standard:

- 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. 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 increasing and there is a plan to introduce an obstetric training passport, to help those rotating in to SFT to complete all required eLearning prior to arrival.

Figure 2. FGR compliance (Q1 April-June)



1.3. Reduced Fetal Movements

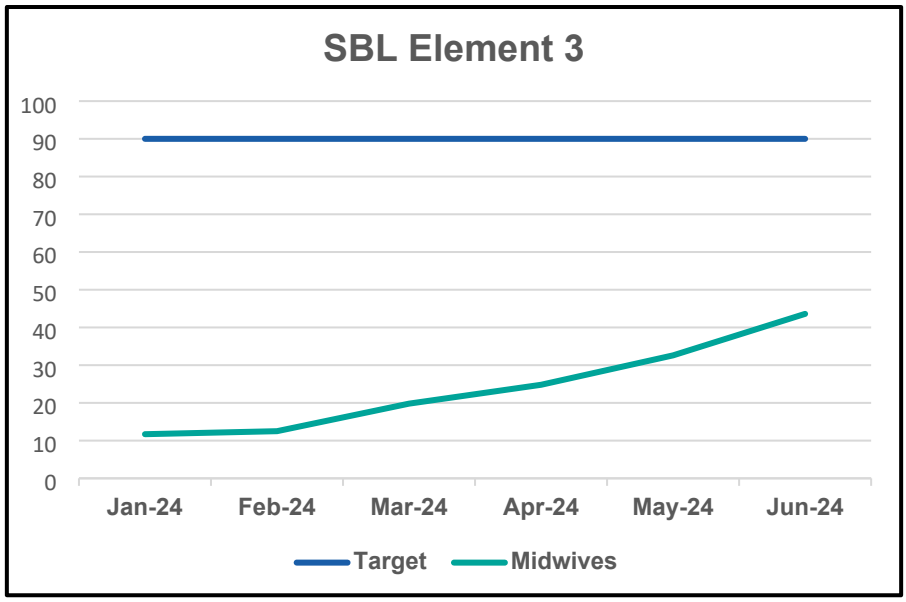
Minimum standard:

- 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 (Q1 April-June)



1.4. Fetal Monitoring

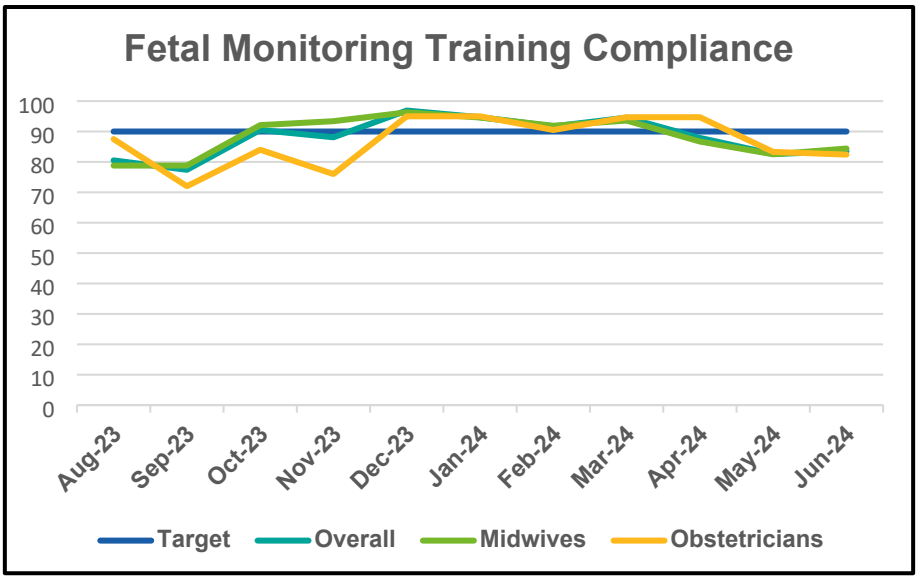
Minimum standard:

- 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 (Q1 April-June)



The below data is specific to attendance on the fetal monitoring study day.

Figure 5. Fetal Monitoring Training compliance

Attendance & overall compliance	Midwives	Obstetricians
April attendance	14	0
April % compliance	86.7% ↓	94.7% ↔
May 2024	No training session held	No training session held
June attendance	18	1
June % compliance	83.6% ↓	82.4% ↓

1.5. Preterm birth

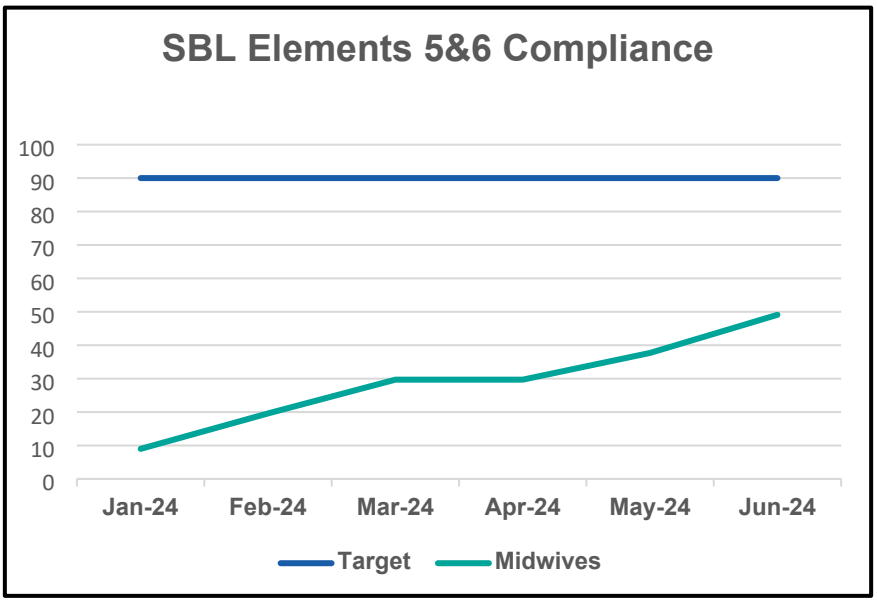
Minimum standard:

- 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).

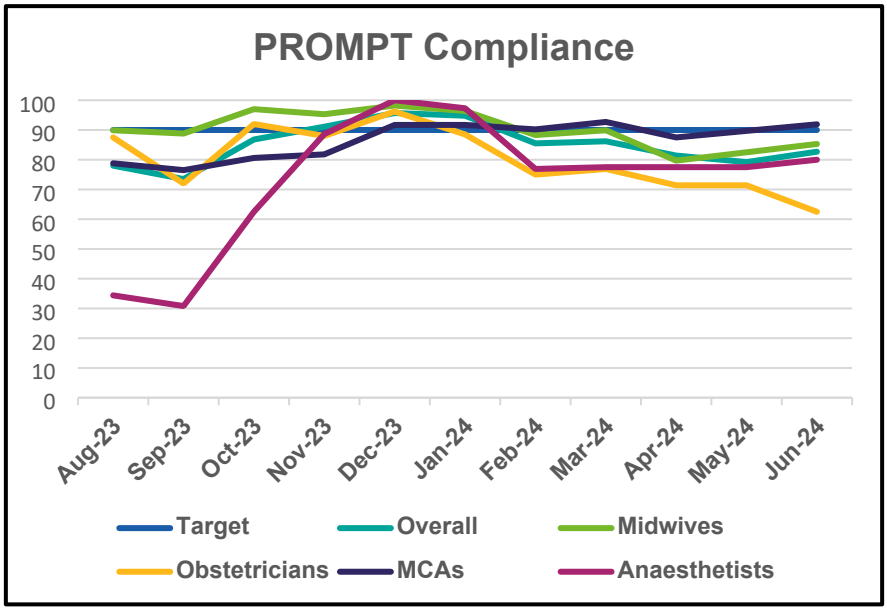
2. Maternity Emergencies and Multi-Professional Training Day (PROMPT)

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 an extra date being added in October 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
April % compliance (No session held)	89.9% ↑	76.9% ↑	77.5% ↑	92.7% ↑
May attendance	12	2	1	2
May % compliance	82.5% ↓	71.4% ↓	77.5% ↔	89.7% ↓
June attendance	13	2	1	3
June % compliance	85.5% ↑	62.5% ↓	80% ↑	91.9% ↑

3. Neonatal Basic Life Support

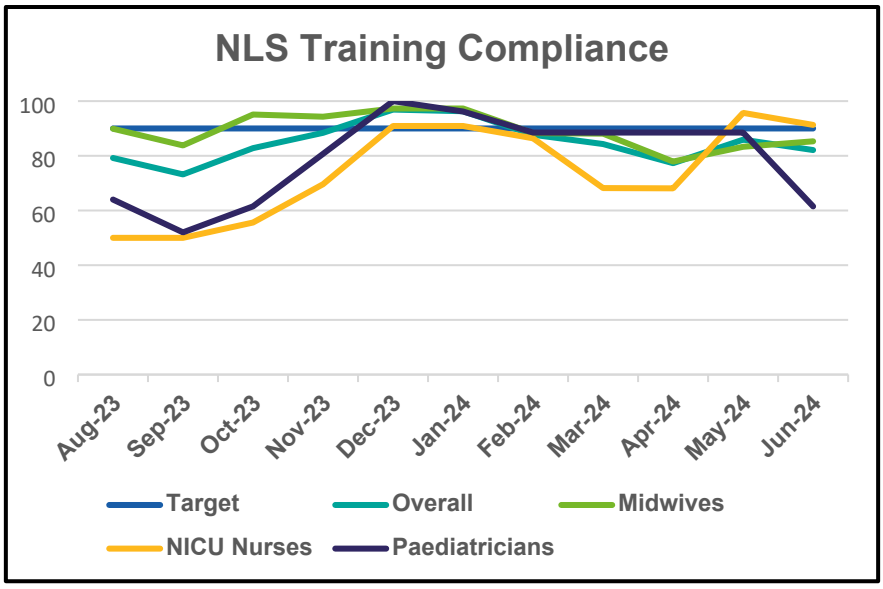
Minimum standard:

- 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

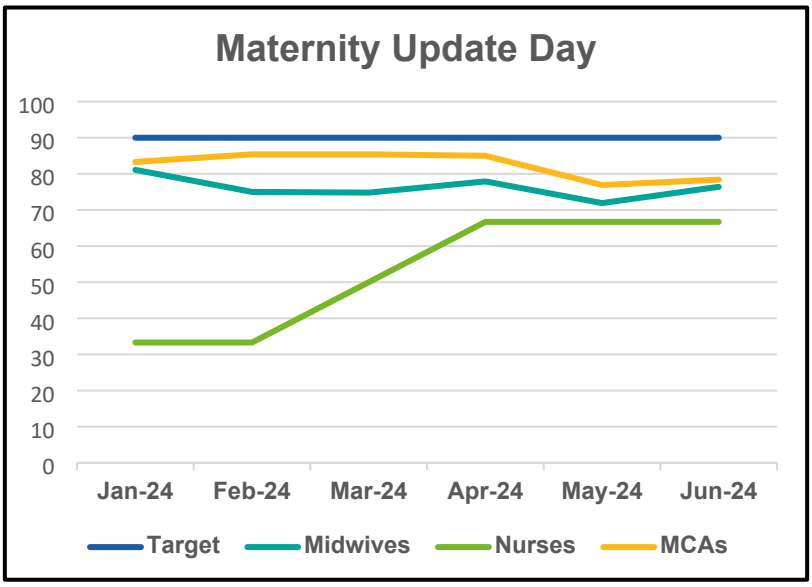
The maternity update day is an annual day for midwives, nurses working in maternity and MCAs and includes training in modules 4 & 5 of the CCFv2 (Equality, equity and personalised care and care during labour and immediate postnatal period). This study day also includes content required locally, such 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

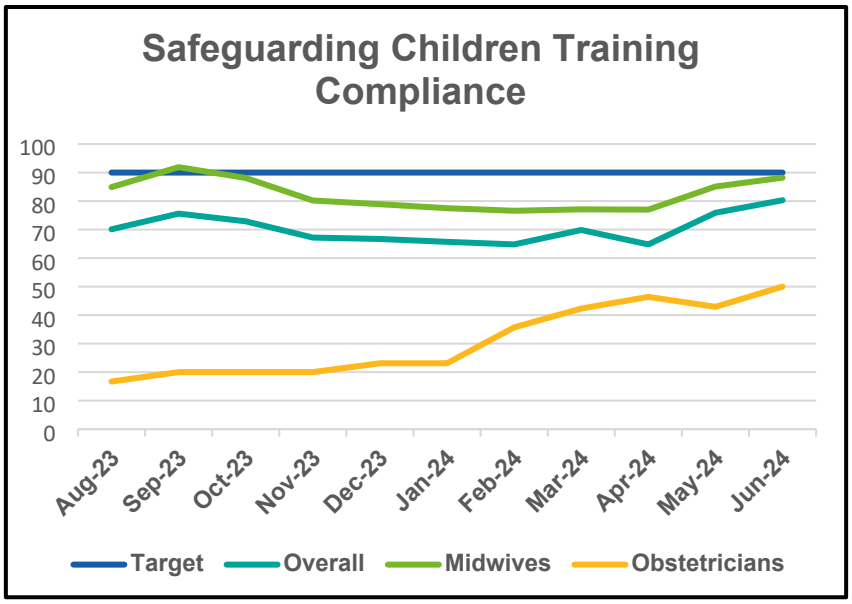
In line with the recommendations from the Safeguarding Children and Young People: Roles and Competencies for Healthcare Staff Fourth edition: Intercollegiate document: All midwives, obstetricians and doctors in training who have posts in these level 3-affiliated specialties, are required to complete 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 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 Q2/3 to target newly recruited midwives.

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 35 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 77%, being held and monitored by 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

Midwives	Maternity Nurses	MCAs & MAs
82% (111)	33% (3)	86% (35)

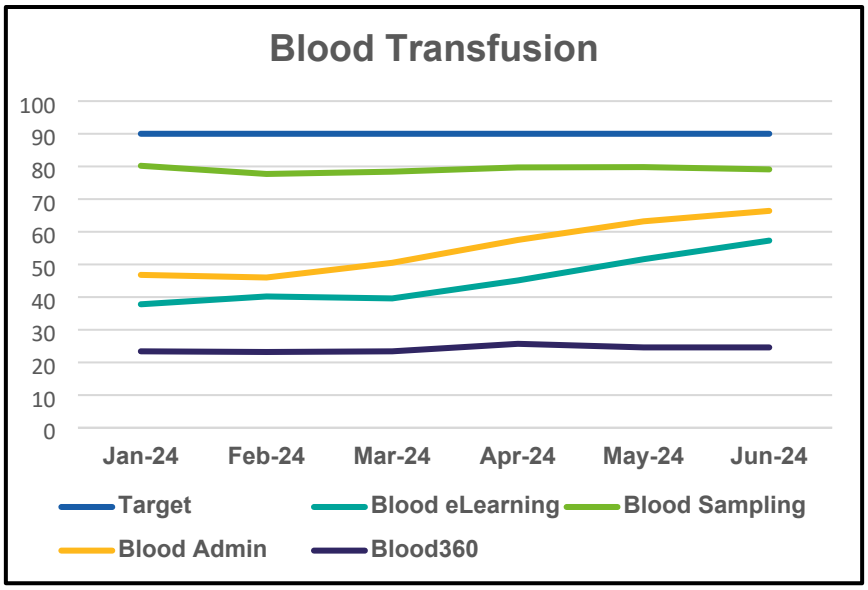
All staff out of date for Adult BLS have been contacted and advised to book via the Trust's LEARN platform.

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 Q1 the maternity education team, with support from labour ward co-ordinators, planned 3 multi-professional in-situ simulations. These were evacuation of the birth pool, shoulder dystocia and newborn life support.

Figure 14. Simulation training

	Attendance	Findings	Actions Taken
Shoulder Dystocia	6 midwives 1 student midwife 1 obstetric trainee 1 obstetric consultant	Discussed importance of performing non-invasive manoeuvres prior to internal manoeuvres to reduce risk of brachial plexus injury	Shoulder dystocia introduced to PROMPT from September 2024
Evacuation of the Birth Pool (two simulations)	7 midwives 2 MCAs 1 student midwife	Understanding of the woman's perspective	SOX for student midwife involved – learning from excellence

Newborn Life Support (two simulations) **Ran by RC-trained instructor** (NN Nurse)	12 midwives 1 student midwife 1 obstetric consultant	6 scenarios covered Effective use of i-Gel	Annual in-house NLS update achieved

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.

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 21/11/23.

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 August 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 due to sickness – rebook as soon as possible in Q2.
- Liaise with Operational Manager for Gynaecology to ensure all obstetricians are booked to attend required training dates in Q2 and Q3.
- Introduce the new PROMPT programme to run September 2024 – September 2025 as per our local training plan and the Core Competency Framework Version 2.

Salisbury NHS Foundation Trust

Report Author

Name: Scarlett Leahy

Title: Practice Education Midwife

Date: 22/08/2024

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.	New action
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.	New action
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.	New action
Improve annual update compliance for NIPE qualified practitioners.	Donna Crayden	September 2024	Individual emails sent to those out of date.	New action
Actions from simulation training				
Action	**Responsible person**	**Deadline**	**Progress made**	**Rag rating**
Disseminate education around performing external manoeuvres before internal manoeuvres in the	Maternity Education Team	December 2024	To be introduced on PROMPT from September 2024.	Action in progress

management of shoulder dystocia to reduce the risk of brachial plexus injury and OASI.			Scenario on community PROMPT May – July 2024.	

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.	New action

Patient and Staff Experience Report
Maternity and Neonatal Services
(Quarter 1 2024-25)

1.0	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 and staff feedback are discussed quarterly at the Triangulation meeting.
2.0	**Executive Summary**
	• Digital Friends and Family Test (FFT) feedback has been implemented in Q1. This will offer women an alternative option to the FFT cards. • The number of complaints received has remained consistent with the previous quarter. • There has been a decline in concerns logged in Q1. The themes of concerns relate to waiting times and miscommunication associated with scan appointments. In both cases this required the appointments being rescheduled. • There has been a significant increase in comments and enquiries logged with PALS this quarter. The top themes being, 'unsatisfactory treatment' and 'information required'. • A Patient story was shared, at the family's request, with the hope that this would be an opportunity for learning. • A Triangulation meeting was introduced, where the feedback from the MNVP was shared and discussed in a multidisciplinary forum. • 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 through the LMNS and Safety Champions. • In Q1 there were no reportable fetal losses, therefore no patient experience feedback was obtained this quarter. • The findings from the Beatrice Maternity Ward (BMW) patient survey are discussed in this appendix. **Key priorities for patient experience and inclusion, next quarter includes:** • Finalise the Neonatal unit (NNU) patient experience survey. • Undertake a detail analysis of the findings from the Health Inequalities Patient Experience Survey due to be completed in Q2 2024/25.

	• 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. • Establish links with our teenage service users (to include listening events- co-produced with MNVP and FNP). • Ensure the completion of the 15 steps action plan. • Working with the LMNS Inclusion Lead to align the service with the National agenda related to reducing health inequalities ***
3.0	**Patient Story**
	A patient story was presented at the Perinatal meeting in May 24. It was the family's wishes to share their experience of the care they received in labour, and the initial moments following the birth. The baby was born in poor condition and required specialist neonatal support in a neighbouring tertiary referral unit. This prompted a detailed and thorough review by the Maternity and Neonatal Safety Investigation (MNSI) programme, as the baby met the criteria for cooling. The patient's main concern was around not feeling listened to, and a reluctance from staff to acknowledge that she was in established labour. Once the baby was born, she felt there was a lack of recognition that her baby's poor condition. This left the family feeling distrust in staff and the Service. After having several months of worry about whether their baby had suffered any neurological damage, the family are pleased that their baby seems to have made a full recovery and is meeting their current milestones. The family's very candid experience was discussed in the multidisciplinary forum and learning noted.
4.0	**Patient Surveys – National and Local (including CQC national maternity survey)**
	The National Patient Experience Survey looks at the experiences of women and other 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. • **Labour and birth** **Patient Response: 8.2 / out of 10** **Compared with other trusts: About the same**

- **Staff caring for you**

Patient Response: 8.4 / out of 10
Compared with other trusts: About the same

- **Care in hospital after the birth**

Patient Response: 6.8 / out of 10
Compared with other trusts: About the same

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 IFT 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

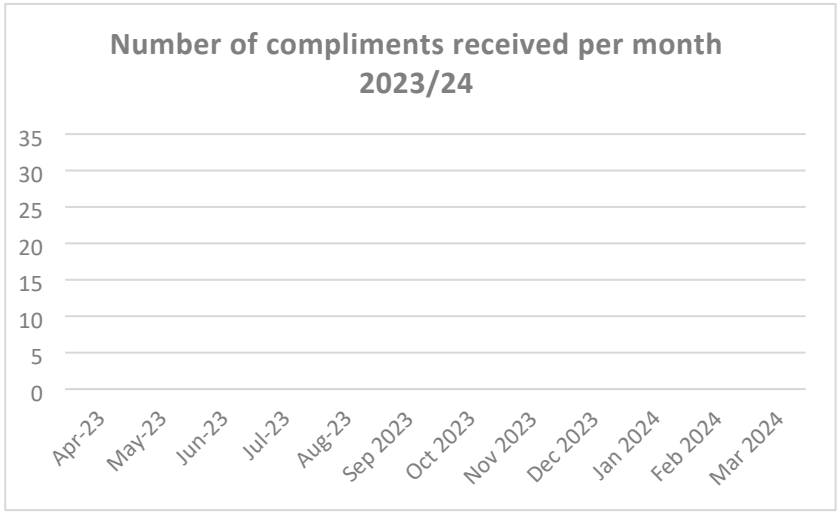
With the introduction of the mixed antenatal and postnatal ward - renamed Beatrice Maternity ward (BMW), a patient survey was undertaken to establish women's experience of their stay on the ward. The finding suggested that overall women were happy with their inpatient stay on Beatrice Maternity Ward. Improvement opportunities include ensuring a robust discharge process is embedded, inclusive of a designated Newborn Examination NIPE clinic. The full survey results can be viewed via the embedded document below:

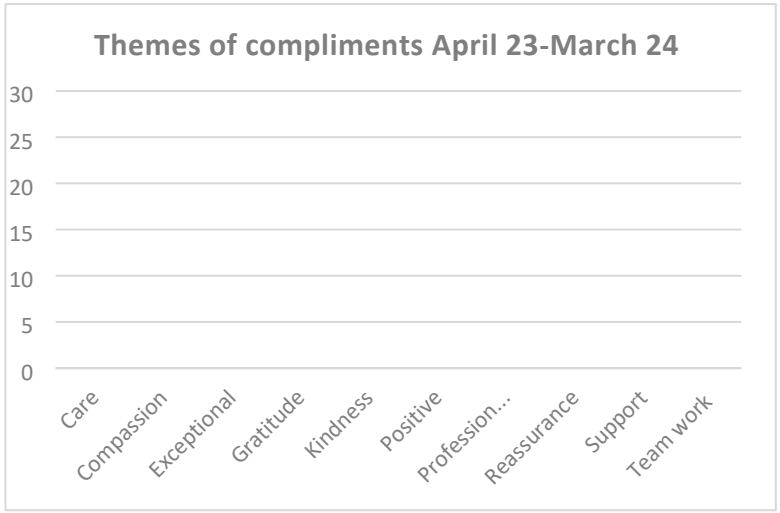
	PatExp Survey on A2.pdf Final.pdf The findings of the survey will be reported at July's Safety Champions meeting with a suggestion that further scrutiny is needed around women's experience of the noise levels on the ward.
5.0	**Maternity and Neonatal Voices Partnership (MNVP), Staff and Patient Experience - 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 are then be used to inform and drive the priorities of service development and quality improvement. The Terms of Reference for this group are embedded below. SFT Triangulation meeting ToR - May 2 During the first meeting, MNVP Patient feedback from real time survey's (undertaken by the MNVP) was shared and included. • Rise in induction rates. • Lack of privacy offered to women undertaking intermate examinations (one woman's account only). • Women feeling pressured to discuss contraception prior to discharge from the BMW. It was clear from the multidisciplinary discussion that a detailed analysis and review of the Birth Reflection Service was required, and further consideration was to be given to the referral process. The minutes from this meeting and action plan are embedded below: Triangulation Group Meeting Min Action Plan - Triangulation meeting 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
6.0	**Friends and Family Test (FFT)**
	Friends and Family Test – July 24 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 28days) **Q1 Data:** There was limited feedback collected in April and May whilst SFT moved to SMS messaging. It is hoped that with the introduction of a digital option, it will increase the response rates. FFT results are shared weekly with the clinical leads and themes are shared monthly with staff. The figures below show the FFT response rate for June 24. Response Rate: 14% **Positive: 91.89%** **Negative: 6.31%**

	Top 3 Themes: Positive: 1. Staff attitude 2. Implementation of care 3. Environment Negative: 1. Staff attitude 2. Clinical Treatment 3. Communication RATING 
7.0	**Feedback from Neonatal and Bereaved Families**
	Neonatal feedback The Neonatal Patient Experience Survey will be a continuous audit. Survey results are scheduled to be analysed in July 24. **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 Q1 there were no reportable fetal losses and therefore there is no feedback from bereaved families.

8.0	**Feedback from Black, Asian and Minority Ethnic Backgrounds and Families Living in Areas with High Levels of Deprivation**
	An inclusion midwife has been successful recruited to support the development of this workstream and starts in post at the beginning of Q2. The ambition is that a local patient experience survey will be 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. Other priorities have been identified as: • Collaborative working with Coms 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. • Ensure that poignant patient information leaflets are available in the top 5 commonly requested languages.
9.0	**Compliments**
	Thank you cards are collected from both in/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 sited and is then nominated for a SOX. The graphs below demonstrate the number of compliments received and the themes for the last financial year:





***NB/ Data has been taken from DATIX reporting and locally held spreadsheet*

Although there appears to be a decrease in compliments logged over the latter quarter of 2023/24, this is noted to be largely dependent upon on when the compliments are collected and logged on DATIX as this is not live data.

The 2 themes of compliments in 2023/24 relate to support provided to the women (birth person) and or their family and the quality of care offered.

In Q1 2024/25 the Maternity Department and Neonatal Unit received 17 compliments, the top theme reported was ‘gratitude’.

Infographics are developed and shared with the workforce. The embedded document below is an example used to show case and celebrate exemplary care:

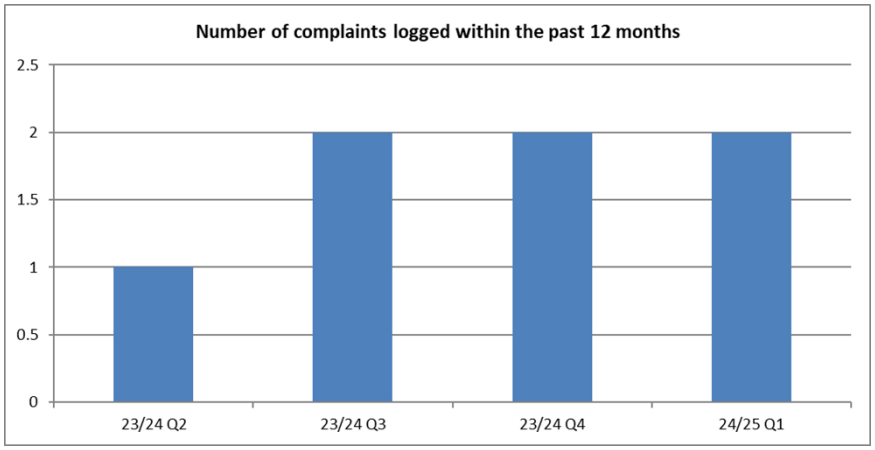
Compliments 2023-24 v2.pdf

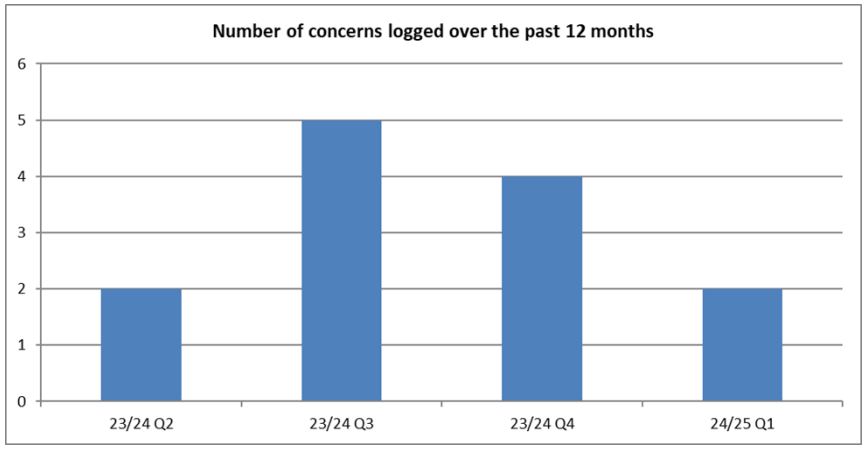
10.0	Complaints/PALS Contacts

Formal and informal complaints

2 complaints (formal) and 2 concerns (informal complaints) were logged on Datix in Q1 24/25. There were 16 comments/and enquiries logged with PALS in Q1.

The number of complaints (formal) and concerns (informal complaints) over the last 12 months are:





Actions:

Full analysis of PALS cases can be viewed in the document embedded below including associated action plan.

COMPLAINTS.docx

	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. Annual analysis of the birth reflection data 23/24 can be viewed in the embedded document below:  Annual analysis of the birth reflection service
11.0	**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 Q1 there were no matron/ward manager audits related to patient or staff experience, however, these are planned for Q2.
12.0	**Internal/ External Visits (relating to patient or staff experience)**
	There were no external visits in Q1, however the MNVP has scheduled real-time engagement sessions in the Antenatal Clinic (ANC), Neonatal unit and Barcroft Surgery in Q2 (July and August 24). A further date in September has been secured.
13.0	**Staff Survey Results**
	The National Annual staff survey was not published in Q1.
14.0	**Staff Experience/ Wellbeing**
	No staff wellbeing events were held in Q1; however, restorative clinical supervision (RCS) support has been offered to all newly qualified and international midwives. To date, all current preceptee Midwives (including those internationally recruited) have been successfully retained. There is a planned 'Maternity Picnic' for staff in Q2.

15.0	**Key Activities in place for both Staff and Patient Experience**
	Themes from complaints and concerns, patient experience surveys and FFT are shared with the workforce during the annual maternity study days.
16.0	**Sharing of Best Practice**
	Patient and staff experiences are shared as follows: • Friends and Family test (FFT) feedback are shared via email and posters in ward areas • SOX are shared in 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 (see embedded below)  Maternity & Neonatal Newsletter -
17.0	**Update on Actions Outlined in the Previous Report**
	3 main priorities were previously identified in the last Quality and Safety report: 1. **Progress the 15 steps action plan** and monitor the compliance to the national patient experience 2023 work stream. **Update:** Compliance is being continuously monitored by the Family Experience Midwife. Pending action relates to the user guide for the Birth Centre and staff boards for the inpatient and outpatient areas. The identified barriers to the completion of the actions relates to the lack of administrative time to complete the tasks and the embargo placed on requests to the Art care department. 2. **Audit experience of women** identifying as black or brown and those from lower social economic groups.

	Update: The Health inequalities Patient Experience Survey is due to be completed in July 24, however, it is expected that the completion date will be extended to ensure the reliability of the results, due to small sample size. 3. **Promote and support the newly formed Triangulation group** for identifying themes for patient feedback, claims and risks. **Update:** This has been introduced in Q1 and is a quarterly meeting. The next meeting is scheduled for 3rd September 2024.
18.0	**Next Steps/ Looking Forward**
	Key priorities for patient experience and inclusion, next quarter: • Finalise the Neonatal Unit (NNU) Patient Experience Survey. • Undertake a detailed analysis of the findings from the Health Inequalities Patient Experience Survey. • 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. • Establish links with our teenage service users (listening events- co-produced with MNVP and FNP). • Ensure the completion of the 15 steps action plan. • Ensure that patient information leaflets are available in the top 5 commonly requested languages.

Report Author(s)

Name(s): Alison Lambert and Katherine Barrio

Title(s): Family Experience & Inclusion Midwife and Head of Midwifery & Neonatal Services

Date: 19/08/2024

Saving Babies Lives Quarterly Report
Maternity and Neonatal Services
(Quarter 1 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 May Submission) SFT Implementation Tool & LMNS Validation Tracking Tool


SBL Version 3 SFT Implementation Too


BSW-SFT LMNS Validation Tracking

3.0 Progress and LMNS Review Record

Figure 1. Percentage of interventions fully implemented following each LMNS validation.

	Baseline Assessment	Assessment 1	Assessment 2
Review Quarter	**Initial**		
Assurance Review Date	**25.10.2023**	**23.12.2023**	**24 06 2024**
Element 1	10%	29%	20%
Element 2	5%	50%	50%
Element 3	0%	100%	50%
Element 4	0%	0%	20%
Element 5	11%	37%	48%
Element 6	7%	33%	17%
TOTAL	7%	37%	40%

% of Interventions Fully Implemented (LMNS Validated)

4.0 Implementation Progress

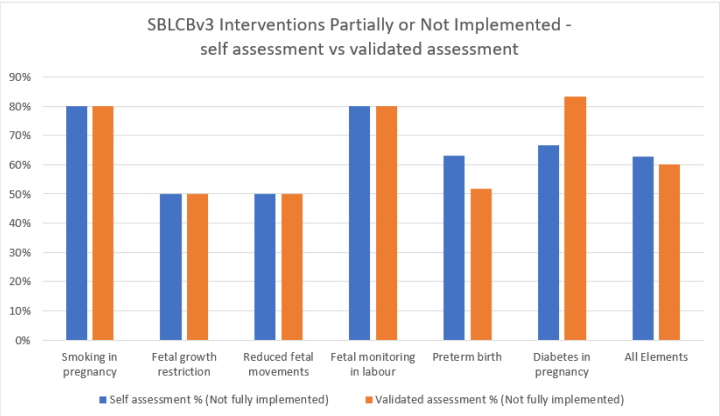
SFT has made minimal progress and has a number of actions in place to move towards full implementation.

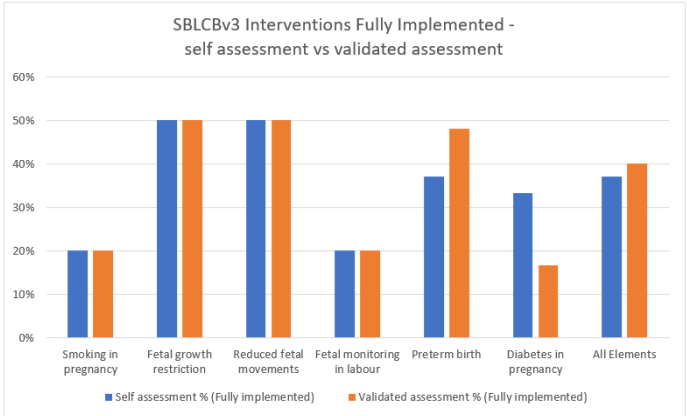
Figure 2. Implementation progress between Q3 2023 (37%) and Q4 2023/24 (40%)

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	20%	Partially implemented	20%	CNST Not Met
Element 2	Fetal growth restriction	Partially implemented	50%	Partially implemented	50%	CNST Met
Element 3	Reduced fetal movements	Partially implemented	50%	Partially implemented	50%	CNST Met
Element 4	Fetal monitoring in labour	Partially implemented	20%	Partially implemented	20%	CNST Not Met
Element 5	Preterm birth	Partially implemented	37%	Partially implemented	48%	CNST Not Met
Element 6	Diabetes	Partially implemented	33%	Partially implemented	17%	CNST Not Met
All Elements	TOTAL	Partially implemented	37%	Partially implemented	40%	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 validated assessments for interventions Q3 2023 and Q4 2023/24





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. • 1:1 meetings arranged with action holders, leads and stakeholders for Element 1. • Maternity Services Dataset (MSDS) Data Quality rating passed and to be submitted as evidence for next submission as previous data now out of date. • 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. • 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. • SFT stop smoking strategy and Wiltshire stop smoking service specification previously not included in evidence submission-now collated and ready for next submission. • 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. • '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. **Looking Forward** • Assist in the review of action plans to monitor compliance trajectory. • Utilising non-clinical bank hours to ensure backlog of audit data has been captured.

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. • 23/24 Q3 and 23/24 Q4 data not included in last submission, now completed and collated ready for next submission. • 24/25 Q1 audit data collated and ready for next submission. • 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. • 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. • 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. • 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. **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. • Trust Medical Devices Lead to continue to liaise with national Medical Devices teams to try to identify compliant machines.

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 our 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 meetings with Digital Lead Midwife who has built a report into our MIS 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. • Updated 24/25 report submitted for evidence by Bereavement Lead detailing no cases of stillbirths with issues associated with management of reduced fetal movements. **Looking Forward:** • Awaiting further Q4 audit data. • 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.

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. • Element 4 interventions audit data was previously omitted for Q1. Now collated and ready to be submitted as evidence for the next submission date. • 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'. • 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. • To discuss with Clinical Director and Operations Manager evidence for PA time for Obstetrician with responsibility for fetal surveillance as currently insufficient evidence submitted.

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.

	• Discussion with Neonatal Matron around new ventilators. Procurement ongoing and as soon as they are acquired, a new SOP will be created and implemented.

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 to: make minor amendments to guideline as current guidance advises incorrectly that women with Type 1 diabetes are currently not being offered continuous glucose monitoring. • 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. • 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 we identified a draft job role description already exists, and our Education Team have secured funding for relevant specialist training for 2 staff members. Meeting to discuss next steps planned for before August submission date. • 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.

Report Author

Name: Bess Hadfield

Title: Quality Assurance Midwife

Date: 23/08/2024

Midwifery, Maternity and Neonatal Staffing Report
Maternity and Neonatal Services
(Quarter 1 2024-25)

1. Background

It is a requirement that as NHS providers we continue to have the right people with the right skills in the right place at the right time to achieve safer nursing and midwifery staffing in line with the National Quality Board (NQB) requirements.

Organisational requirements for safe midwifery staffing for maternity settings (NICE 2017) states that midwifery staffing establishments develop procedures to ensure that a systematic process is used to set the midwifery staffing establishment to maintain continuity of maternity services and to always provide safe care to women and babies in all settings.

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 maternity incentive scheme year 5.

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

	Day qualified %	Night qualified %
April 2024	97.2	99.3
May 2024	97.1	98.6
June 2024	97.6	98.9

Fill rates are gradually improving month on month due to the increase in our available workforce following both successful recruitment and staff returning from maternity leave. We do however continue to have 5.61 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 and staff returning from maternity leave in Quarter 2 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	April	May	June
Birth to midwife ratio	1:32	1:28	1:25

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 our 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. Graph showing percentage of occasions when a clinical action was recorded

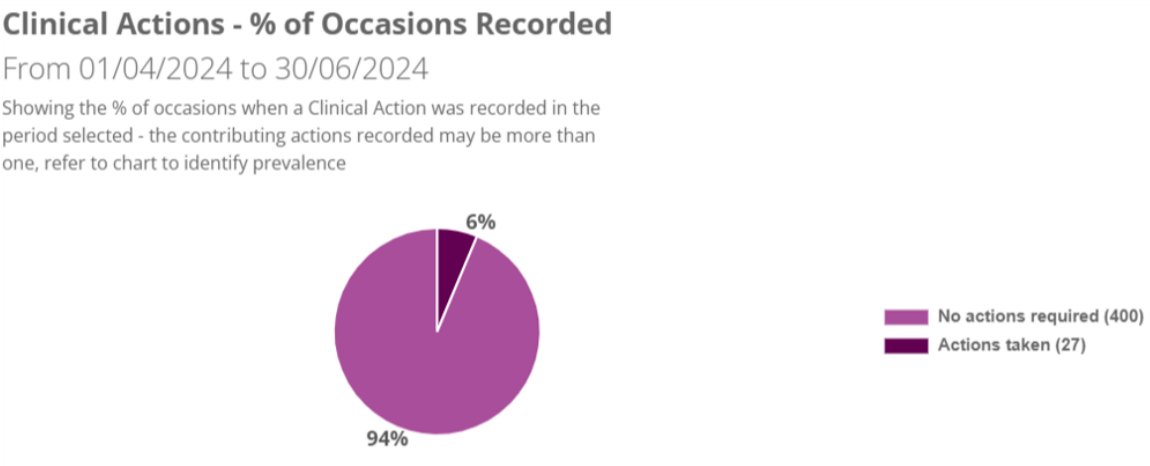


Figure 4. Number and percentage of clinical actions taken

Number & % of Clinical Actions Taken

From 01/04/2024 to 30/06/2024

CA1	Delay commencing IOL	18	47%
CA2	Delay on-going IOL	18	47%
CA3	Delay/cancel Elective LSCS	2	5%
	Total	38	

Figure 5. Graph showing percentage of occasions when a management action was recorded

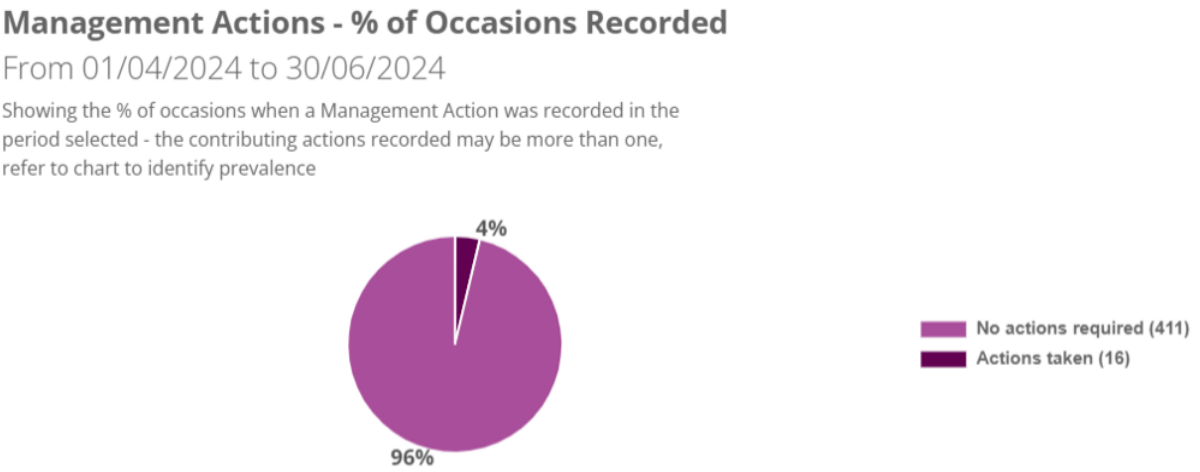


Figure 6. Number and percentage of management actions taken

Number & % of Management Actions Taken

From 01/04/2024 to 30/06/2024

MA1	Redeploy staff from ward	2	11%
MA2	Redeploy staff from community	1	5%
MA3	Staff unable to take breaks	6	32%
MA4	Staff working beyond rostered hours	0	0%
MA5	Staff sourced from Midwifery Bank	1	5%
MA6	Matron/Midwifery Managers working clinically	0	0%
MA7	Specialist Midwives to work clinically	2	11%
MA8	Initiate the escalation policy	2	11%
MA9	Contact on-call duty Manager	5	26%
	Total	19	

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 unit 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. We have ensured that our 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
April	31	62	100%
May	31	62	100%
June	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

	April	May	June
Birth Centre	100%	100%	100%
Labour Ward site 1	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 April 2024 to 30th June 2024. Out of 546 data admissions (confidence factor of 78% recorded) there were 2 red flags entered onto the system with the reasons detailed below:

Figure 9. Number and percentage of red flags recorded during Q1

Number & % of Red Flags Recorded

From 01/04/2024 to 30/06/2024

RF1	Delayed or cancelled time critical activity e.g. Delay Elective LSCS >4 hours	2	100%
RF2	Missed or delayed care (for example, delay of 60 minutes or more in washing and suturing) e.g. Waiting for suturing >60 mins	0	0%
RF3	Missed medication during an admission to hospital or midwifery-led unit (for example, diabetes medication)	0	0%
RF4	Delay of more than 30 minutes in providing pain relief	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	2	

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 haemorrhage is continuing, and Massive Obstetric Haemorrhage protocol has been instigated.

For Quarter 1 (1st April 2024 – 30th June 2024) there were 8 cases meeting the criteria above. The audit demonstrates 100% compliance to the standard. The case where the Consultant was informed but not present was deemed acceptable, as the haemorrhage did not continue over 2L. Table 1 lists the clinical scenario's

Figure 10. Table showing the 8 cases meeting the above criteria and 100% compliance achieved

Date	Clinical Situation(s)	Comments
2/04/24	**PPH 2L where the haemorrhage is continuing, and Massive Obstetric Haemorrhage has been instigated.**	Consultant present.
3/04/24	**PPH 2L where the haemorrhage is continuing, and Massive Obstetric Haemorrhage has been instigated.**	Consultant present.
2/05/24	**PPH 2L where the haemorrhage is continuing, and Massive Obstetric Haemorrhage has been instigated.**	Consultant present.
1/06/24	**PPH 2L where the haemorrhage is continuing, and Massive Obstetric Haemorrhage has been instigated.**	Consultant not present. Consultant aware when MOH call put out, not requested to attend. Total amount 2L.
3/06/24	**Caesarean birth for women with BMI >50**	Consultant present.
3/06/24	**Maternal collapse and Early warning score protocol that suggests critical deterioration where HDU / ITU care is likely to become necessary.**	Consultant present.
3/06/24	**Caesarean birth for major placenta praevia / abnormally invasive placenta**	Consultant present.
7/06/24	**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 our Medical HR colleagues was completed for the time period 1st April 2024 – 30th June 2024. The audit demonstrated that during this period, 38 (short term) middle grade locum shifts were required, 6 Doctors completed these shifts, 4 of these Doctors were Salisbury NHS Foundation Trust employed Doctors and 2 of these Doctors were a locum, not employed at Salisbury NHS Foundation Trust at the time of undertaking the shifts. One Doctor was however working in their local unit (within the Wessex area) on their Tier 2 or 3 rota and the other Doctor evidenced a Certificate of Eligibility, therefore 100% compliant with the criteria described above.

10.3 Long term locum usage

During the time period 1st April 2024 – 30th June 2024 the trust has utilised 2 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. The other doctor commenced employment as a long term locum in the last week of Q1, and therefore Standards 6 and 7 were not applicable as of 30th June 2024.

For all standards that were applicable the trust was 100% compliant (see below).

Figure 11. Table shows 100% compliance with locum standards being met

Standard	Compliance % for Locum 1 (Commenced in Q1)	Compliance % for Locum 2 (in post prior to Q1)
Standard 1 Locum doctor CV reviewed by consultant lead prior to appointment	100%	N/A
Standard 2 Discussion with locum doctor re clinical capabilities by consultant lead prior to starting or on appointment	100%	N/A
Standard 3 Departmental induction by consultant on commencement date	100%	N/A
Standard 4 Access to all IT systems and guidelines and training completed on commencement date	IT / microguide 100%	N/A
Standard 5 Named consultant supervisor to support locum	100%	N/A
Standard 6 Supernumerary clinical duties undertaken with appropriate direct supervision	100%	N/A
Standard 7 Review of suitability for post and OOH working based on MDT feedback	N/A	100%
Standard 8 Feedback to locum doctor and agency on performance	N/A	100%

11.0 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 demonstrates compliance with this standard by month.

Figure 12. Compliance demonstrating dedicated obstetric anaesthetist 24 hour cover

Month	April 2024	May 2024	June 2024
% compliance	100	100	100

12.0 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 both year 3 and year 4 of MIS, Trust Board should evidence progress against the action plan developed in year 3 of MIS as well include new relevant actions to address deficiencies.

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. The following action plan is in place.

Figure 13. Action plan for medical staffing against BAPM criteria

Action	Owner	Deadline	Rating
Utilise Ockenden funding for medical staffing to provide neonatal MDT round led by Paediatric consultants with interest in Neonates (not specifically BAPM standard but allows for definite neonatal consultant ward round if Paediatric side busy)	Mary Pedley-Duncalfe Heba Hassan	July 2024	
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	
Appoint trainee ANNP to start training September 2025 Funding obtained from ODN Start of process to improve medical staffing	Mary Pedley-Duncalfe, Sarah Cadey-Osment, Katherine Barrio	Interview date set 30th August 2024	
Write a business case to outline what full BAPM compliance would entail to	Mary Pedley-Duncalfe	September 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.

13.0 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 June 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 in training currently. 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.

Figure 14. Compliance with BAPM standards for Neonatal Nurses with respect to QIS training

	Funded June 24	In post June 24	Calculated requirement (from tool)	Variance
Total direct care nurses	24.08	22.15	24.55	0.47
Total registered nurses (band 5 and above)	23.28	21.35	21.66	-1.62
of which QIS	13.64	14.43	15.16	1.52

Total Non-QIS	9.64	6.92	6.50	-3.14
Total Non Reg	0.80	2.02	2.89	2.09
% Registered Nurses QIS Qualified		68%	70.0%	

14.0 Recommendations

It is recommended for the Board to note the contents of the report and formally record to the Trust Board minutes compliance with BAPM standards for both neonatal nurse staffing and neonatal medical workforce if compliance is met, or agree to the action plan if not met.

Report Author(s)

Name(s): Katherine Barrio & Hannah Boyd

Title(s): Head of Maternity & Neonatal Services and Divisional Director of Operations for Women & Newborn

Date: 13/09/2024

Avoidable Term Admissions to the Neonatal Unit (ATAIN) and Transitional Care Report

(Quarter 1 2024-25)

1.0 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 3.7%, 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.

2.0 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

We have also introduced 'Think 45' project. This project has been running across the TV&W ODN and we have adopted it is Salisbury to reduce the amount of term respiratory admissions we admit to the unit. Please see below pdf outlining the purpose of the project:

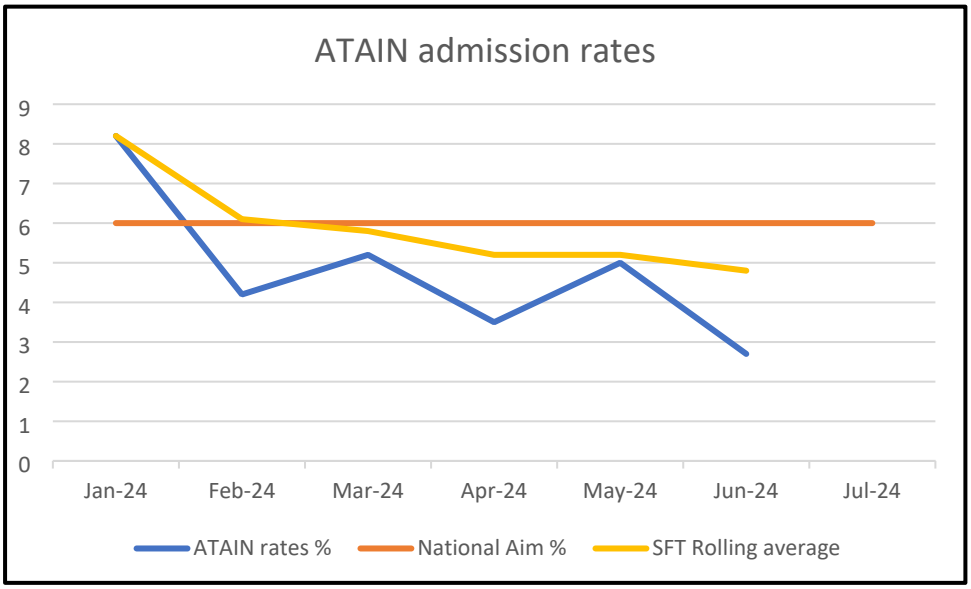
Think 45 minutes!! presentation.pdf

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.

3.0 Trust ATAIN rates

The following graph outlines the 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)

	April 2024	May 2024	June 2024
Total number of admissions in month	**6**	**7**	**4**
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.	**1**	**0 @ present, dept. behind with ATAIN**	**0 @ present, dept. behind with ATAIN reviews 2 outstanding**
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.	**1 – This was a bilious vomiting infant**	**0 @ present**	**0 @ present**
	April 2024	**May 2024**	**June 2024**
Total number of case reviews undertaken in month	**6**	**7**	**2**
Total number of case reviews with both maternity and neonatal staff present	**6**	**4 – 3 remain outstanding**	**2 – 2 remain outstanding**

4.0 Findings and learning from the ATAIN review meetings

4.1 Neonatal

Over the past quarter we have found discrepancies in the amount of time that PEEP has been delivered to the 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, so we are asking for the PEEP to be delivered for between 30-45mins. We will then 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. The labour lead 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 Q1 (in addition to the above themes) we have referred the following learning:

- 3 CTG's have been escalated to the maternity CTG meeting.

- 1 Bilious vomit infant has gone through the PSR process (normal process for infants transferred off site for investigations).
- 3 patients have been escalated to be discussed at maternity governance meeting.

5.0 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.

6.0 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 Q1

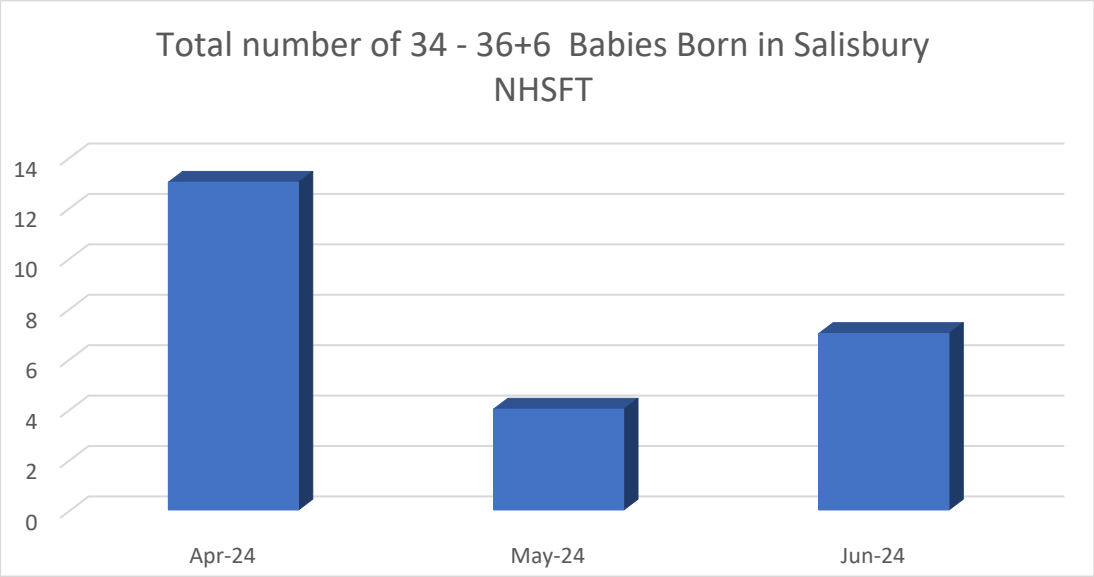
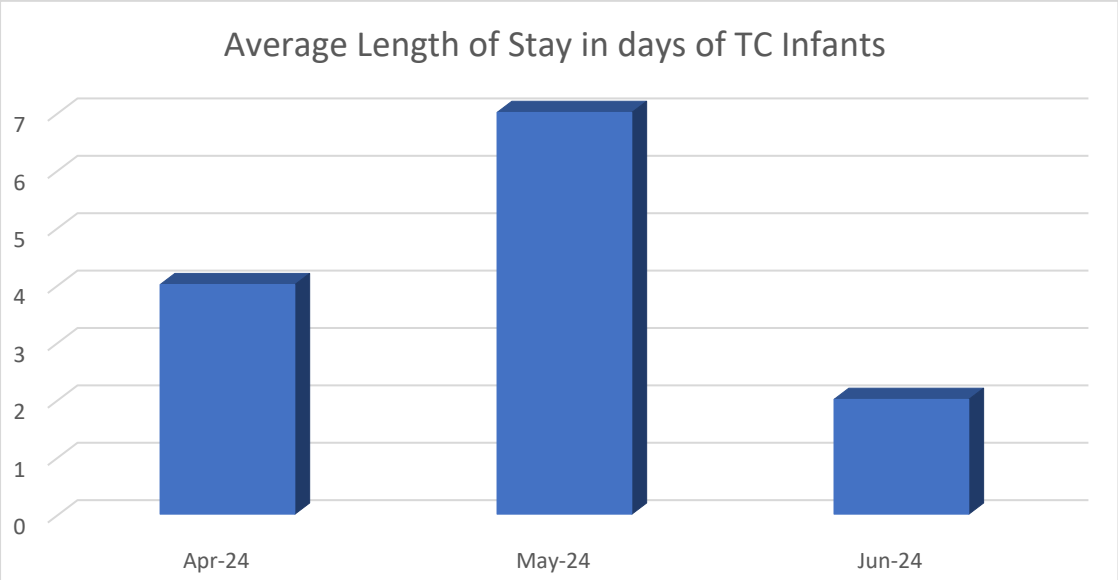


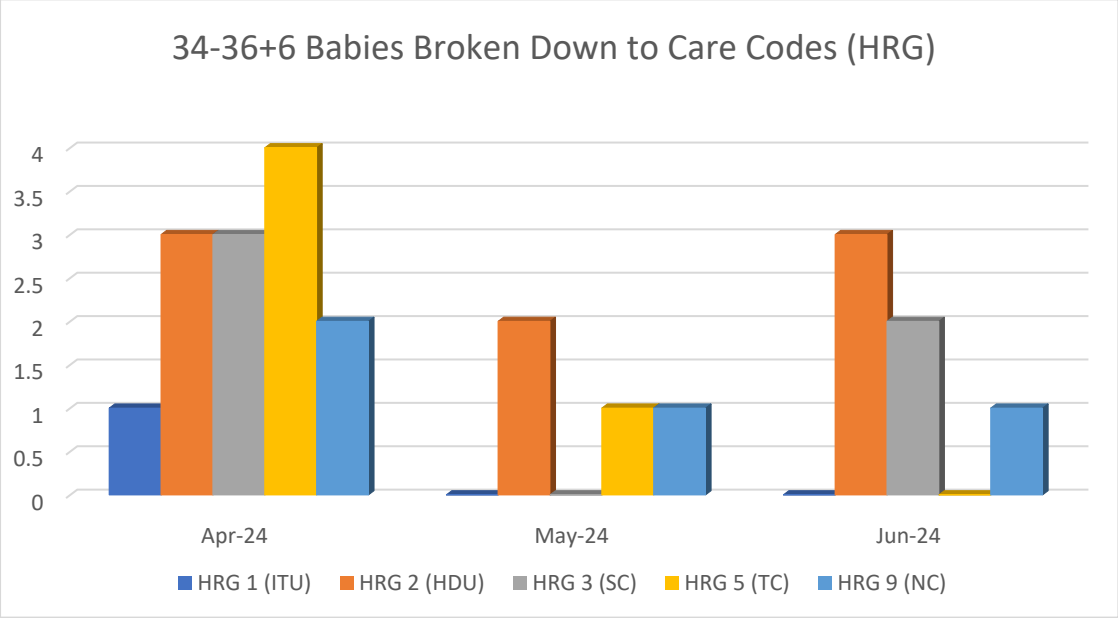
Figure 4. Average length of stay in days for TC infants



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 since Q1

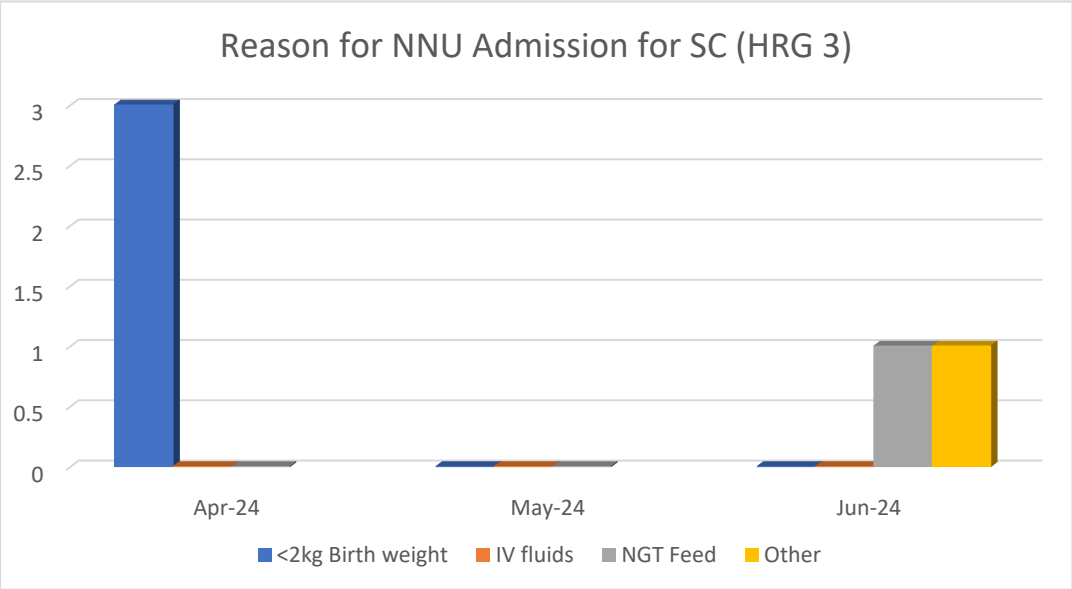


It is then possible to drill down further on special care infants (HRG 3) to ascertain if these infants could in-fact be coded as TC infants.

This graph below shows that from April 2024 there have been 2 infants that could have been TC infants that have been admitted to the neonatal unit as a SC care infant and have therefore been separated from their mothers.

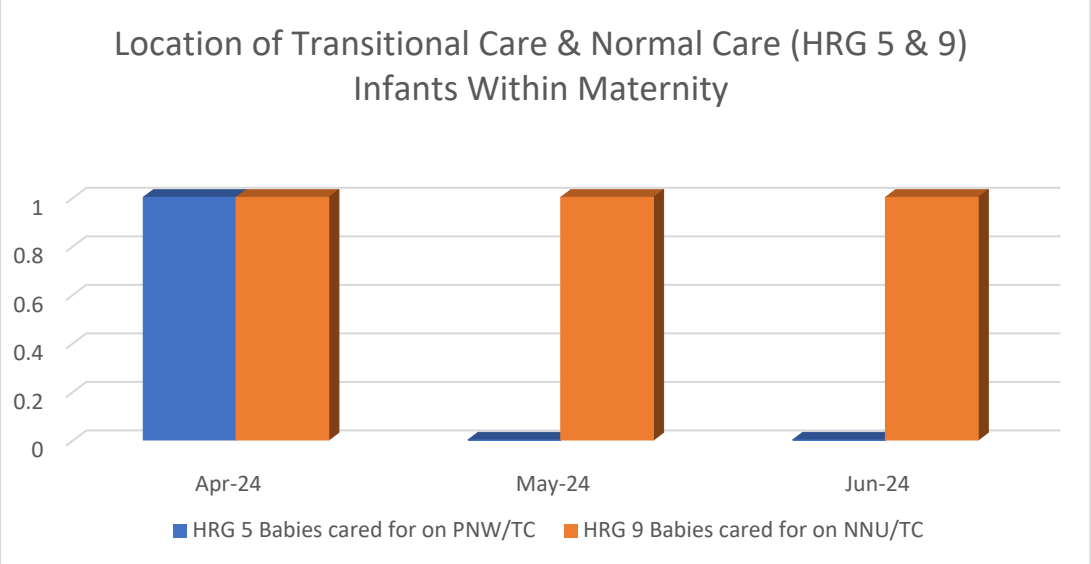
The two infants were again a twin whose sibling required high flow respiratory support. This has been shown over time to be a theme, suggestion to discuss in ATAIN splitting up of twins in these situations.

Figure 6. Reason for NNU admission



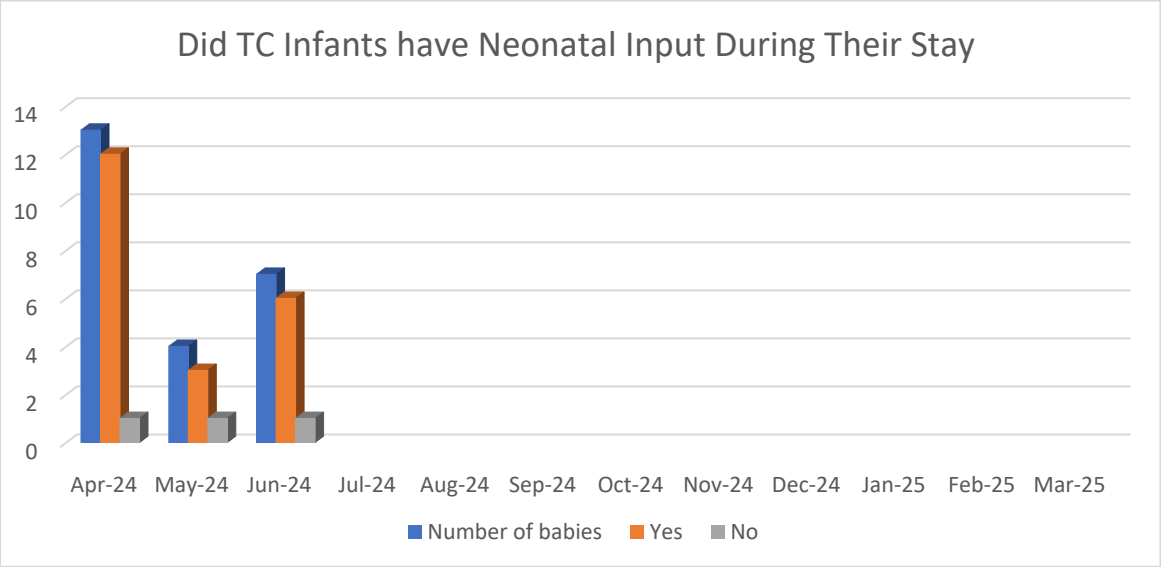
The graph below shows that SFT have cared for the babies in the correct setting (PNW/LNU TC) but during most months have one normal care (HRG 9) infant on the neonatal unit. This has not been reviewed as a deep dive yet as there are very low numbers but this can be anything from 'place of safety' infants, a twin that requires less than their sibling, lack of space on PNW/TC etc.

Figure 7. Location of care setting



6.3 Did all TC infants have Neonatal involvement?

Figure 8. Babies receiving neonatal input during their stay



7.0 Pre-term babies (34 – 36+6 weeks gestation)

Figure 9. Table showing number of admissions each month during Q1

	April 2024	May 2024	June 2024
Total number of admissions	13	4	7

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.

8.0 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	GD/SC-O/BR & SL	30/11/24	On going midwifery education continues and is now in a sustaining phase. Maternity	

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.			nurses have completed a period of supernumerary. Ongoing discussion with DMT regarding staffing model	
Ongoing neonatal out reach to BPN TC to support staff. Neonatal TC link nurse (Band 6) allocated. TC resource files completed and located on LW & BPN. Neonatal practice development lead to work with maternity education team to increase learning opportunities for MW's working with TC infants	GD/TH/SC-O & SL		Fully embedded	
CNST TC audits collected and reported quarterly to board LMNS & ODN	GD/BR		Fully embedded	
Actions from ATAIN reviews for babies >37 weeks				
Action	**Responsible person**	**Deadline**	**Progress made**	**Rag rating**
CAT 2 C-section timing audit	SM-G/DF		Update required	
Update ATAIN meeting TOR as >3yeas old	ATAIN group		Septembers ATAIN meeting	
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		To be discussed in September TC meeting	

9.0 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: 09/09/2024

NHS Salisbury NHS Foundation Trust

Report to:	Trust Board (Public)	Agenda item:	7.6
Date of meeting:	3rd October 2024		

Report tile:	Maternity and Neonatal bi-annual Staffing report – September 2024			
Status:	Information	Discussion	Assurance	Approval
	Yes		Yes	
Approval Process: (where has this paper been reviewed and approved):	Approved by Women and Newborn Divisional Management Team 19.09.24. Divisional Governance 20.09.2024 CGC 24.9.2024			
Prepared by:	Vicki Marston - Director of Maternity and Neonatal Services			
Executive Sponsor: (presenting)	Judy Dyos - Chief Nursing officer			

Recommendation:

The Trust Board are asked to note the contents of this report which has been provided for information and assurance processes.

In order to demonstrate compliance with the 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.

Executive Summary:

This report provides a bi-annual Midwifery and Neonatal staffing report as per Maternity Incentive Scheme (Year 6) – Safety Action 5 recommendation and requirement.

The Committee are asked to note and minute the following required standards as set out in the report to provide evidence for NHS Resolutions Maternity CNST Incentive Scheme.

The required standards are as below:

a) A systematic, evidence-based process to calculate midwifery staffing establishment is completed.

b) Trust Board to evidence midwifery staffing budget reflects establishment as calculated in a) above.

c) The midwifery coordinator in charge of labour ward must have supernumerary status; (defined as having 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.

d) All women in active labour should receive one-to-one midwifery care.

e) Submit a midwifery staffing oversight report that covers staffing/safety issues to the Board every 6 months, during the maternity incentive scheme year six reporting period.

To note vacancy levels and recruitment challenges and plans in place to mitigate against this by use of escalation policy.

To note the agreement from Trust Board and ICB for the recommended uplift of 3.27 WTE Midwives.

To note that an action plan to review neonatal staffing was shared at Trust Board March 2024, and a business case is being written to support an increase of non-registered staff. Whilst 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, we have a current shortfall in Neonatal staffing against current activity.

In addition to note the challenges and mitigations in Midwifery staffing over the 6-month period this covers, and to acknowledge that the required standards as set out above have been met and are evidenced in the report

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

BI-ANNUAL MIDWIFERY, MATERNITY AND NEONATAL STAFFING REPORT September 2024

1. Purpose

The aim of this report is to provide assurance to the Trust Board that there was an effective system of midwifery workforce planning and monitoring of safe staffing levels from April 2024 to September 2024. This is a requirement of the NHSLA Maternity Incentive Scheme and relates to Safety Action 5.

2. Background

It is a requirement, that as NHS providers. we continue to have the right people with the right skills in the right place at the right time to achieve safer nursing and midwifery staffing in line with the National Quality Board (NQB) requirements.

Organisational requirements for safe midwifery staffing for maternity settings (NICE 2017) states that midwifery staffing establishments develop procedures to ensure that a systematic process is used to set the midwifery staffing establishment, to maintain continuity of maternity services and to always provide safe care to women and babies in all settings.

In addition, the Maternity Incentive Scheme, (MIS Clinical Negligence Scheme for Trusts), Year 6, sets out clear expectations in relation to demonstrating an effective system of midwifery workforce planning.

To provide evidence for NHS Resolutions Maternity CNST Incentive Scheme, this paper provides staffing data on Midwifery and Neonatal Nursing Staffing. The required standards are as below:

a) A systematic, evidence-based process to calculate midwifery staffing establishment is completed.

b) Trust Board to evidence midwifery staffing budget reflects establishment as calculated in a) above.

c) The midwifery coordinator in charge of labour ward must have supernumerary status; (defined as having 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.

d) All women in active labour should receive one-to-one midwifery care.

e) Submit a midwifery staffing oversight report that covers staffing/safety issues to the Board every 6 months, during the maternity incentive scheme year six reporting period.

3.Executive Summary

This report gives a summary of all measures in place to ensure safe midwifery staffing; including workforce planning, planned versus actual midwifery staffing levels, the midwife to birth ratio, specialist hours, compliance with supernumerary labour ward coordinator, one to one care in labour and red flag incidents.

4. Birthrate Plus Workforce Planning and staffing levels.

A formal **Birthrate Plus®** assessment was carried out through October to December 2023, as per NICE (2017) national recommendation for repeat assessment timeframes, which reviewed the acuity of women who used maternity services. It was formally reported in February 2024; suggested changes to Midwifery establishment were presented to, and accepted by Trust boardon 2nd May 2024. It included an uplift of the midwifery establishment by 3.27WTE Band 6 Midwives.

The current midwifery establishment at SFT is calculated using a midwife/birth ratio of 1:24 as recommended by the SFT Birthrate Plus® report in February 2024. Birthrate Plus® is the national workforce tool recommended by NICE (2014). Current funded establishment is based upon a projected total of 2200 births per annum. To monitor the safety of this approach we also use the Birthrate Plus® acuity tool, inputting precise data

detailing risk and acuity of inpatients on Labour Ward 4 hourly, and Postnatal 6 hourly. This gives us up to date feedback on the level of safe staffing against the acuity and activity of the day. The tool also measures, by exception, where 1:1 care is not possible for labouring women, and when the labour ward coordinator is not able to maintain supernumerary status.

Birthrate Plus® is the only recognised national tool for calculating midwifery staffing levels and provides a robust and proven methodology for determining midwifery staffing establishments. Table 1 shows the recommendations from Birthrate Plus® February 2024.

Birthrate Plus® recommended WTEs - February 2024

Total Births	**2200**
Core Hospital Services	
Delivery Suite	31.86
Antenatal/postnatal Ward	24.52
Outpatient Services	2.79
Maternity DAU	6.48
Community Inc. Homebirth provision	27.63
Total Clinical wte Band 3-7	**93.28**

Our substantive funded establishment at the time of writing has been agreed to be uplifted by 3.27 WTE by Trust Board and ICB to meet the birthrate plus recommendation for staffing levels. Historically recruiting to our funded establishment has been challenging, however there has been improved recruitment over recent months which has ensured more consistent staffing levels. There are still a number of midwifery vacancies (at the time of writing this is at 8.47 WTE + the 3.27TWE to be added to budget) which fluctuate from month to month, but by the end of October 2024 we expect to be fully recruited to

establishment.

We continue to recognise that there is a need to balance the junior workforce with experienced staff and in particular the recruitment into senior Band 6 positions is a challenge for Salisbury. We have however externally recruited into four senior Band 6 positions in the period of this report. Although challenges in recruitment are not just isolated to Salisbury, the military population, lack of city lifestyle and size of the maternity service are all contributory factors to recruitment challenges.

The concept of flexible working across the maternity pathway, rather than having fixed areas of working, as an alternative approach to providing maternity care, is being piloted to aid recruitment. We have adapted to look at several varying processes to attract staff, including supporting return to practice midwives, financial incentives, and varying contracts. From a flexible working perspective, we have trialed an increase in requesting for staff, stepping out of the policy dictating numbers of requests and doubling them to allow staff more opportunity to balance work and home life. This has been well-received by staff and supports our work around retention.

Our collaborative work with Gloucester and GWH to recruit international midwives has been successful, we have 7 international midwives working within the service now. We also have 2 Maternity care assistants who have started a Midwifery apprenticeship and one nurse who has commence a nurse to midwife conversion course. Exploring all options for recruitment is enabling us to draw form a variety of sources, as well as supporting recruitment of individuals with valuable experience in other areas of the NHS.

1. Planned Versus Actual Midwifery Staffing Levels

The following table outlines percentage fill rates for the inpatient ward areas by month.

	Day qualified % Fill rates.	Night qualified % Fill rates
March 2024	94.2%	97.9%
April 2024	97.2%	99.3%
May 2024	97.1%	98.6%
June 2024	97.3%	98.9%
July 2024	97.9%	98.5%
August 2024	97.3%	99.5%

Maternity leave has been consistently high amongst midwives. In March 2024 we had 7.65WTE midwives on maternity leave, dropping to 4.42WTE in September 2024 - this does put further pressure on fill rates.

When staffing is less than optimum, the following measures are taken in line with the Maternity Department escalation policy:

- Utilisation of Bank Midwives.
- Community staff working flexibly in the unit as and when required.
- Non-clinical midwives working clinically to support acuity.
- 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 and Neonatal services, to ensure a team approach to day to day working also contributes to ensuring staff are assigned to clinical areas according to fluctuating activity levels.
- Recruitment of nurses to the maternity services.

All the above actions are designed to maximise staffing into critical functions to maintain safe care for the women and their babies.

It is important to recognise staff wellbeing is impacted with the shortfall of staff within the service and staff are feeling the pressure of vacancies. It is recognised that although staff have undertaken bank work to close day to day gaps this is not a sustainable long-term solution.

5. Midwife to Birth Ratio

Birthrate Plus® has calculated an individualised midwife to birth ratio for Salisbury, recommending a rate of 1:24. The recommended ratio takes into account anticipated levels of risk and safeguarding which both affect the amount of time and care required for women and their families. This rate is reached via calculations between monthly birth numbers and available numbers of midwives. The ratios are analysed monthly and are affected by fluctuating birth numbers and variations in establishment month to month.

The table below outlines the real time monthly birth to midwife ratio for the past 6 months.

Month	March 23	April 24	May 24	June 24	July 24	August 24
Midwife to birth ratio	1:30	1:32	1:28	1:25	1:25	1:25

6. Specialist Midwives

Birthrate Plus® recommends a percentage of the total midwifery establishment is not included in the clinical numbers. This percentage is tailored to units considering size, acuity and whether units are multi-centered. These roles include management positions and specialist midwives. Some roles deemed out of scope are the Named Midwife for Safeguarding Children, Antenatal and Postnatal Screening Leads, Perinatal Mental Health Lead Midwife, Practice Educator, Fetal Surveillance Lead and Midwifery Matrons amongst others.

Birthrate Plus® has a standard percentage of roles deemed out of scope and adapts it depending on unit size, recognising that the national ask of each maternity unit is the same despite the number of births, and therefore smaller units may require a higher percentage of non-clinical staff. This was reflected in our most recent Birthrate Plus® assessment outcome where the suggested numbers of specialist midwife roles increase by 1.59WTE.

7. Birthrate Plus® Live Acuity Tool

The Birthrate Plus® Live Acuity Tool is used in the intrapartum and the other maternity inpatient areas. It is a tool for midwives to assess their 'real time' workload determined bythe number of women needing care, and their condition during admission, 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 Birthrate Plus®.

The Birthrate Plus® classification system is a predictive/prospective tool rather than the retrospective assessment of process and outcome of labour used previously. The tool is completed four hourly by the labour ward coordinator. An assessment is produced on the

number of midwives needed in each area to meet the needs of the women including the requirement of achieving the one-to-one care in labour standard for all women and increased ratios of midwifery time for women in the higher need categories. This provides an assessment on admission, of where a woman fits within the identified Birthrate Plus® categories and alerts midwives when events during labour move her into a higher category and increased need of midwifery support.

This safe staffing tool kit supports most of the components in the NICE Guidance (and is endorsed by NICE) on '*Safe Midwifery Staffing for Maternity Settings'* necessary for the determination of maternity staffing requirements for establishment settings. It provides evidence of what actions are taken at times of higher acuity and use of the escalation policy when required.

8. Supernumerary Labour Ward Coordinator

One of the safety standards mandated by CNST is the need to have a supernumerary Labour Ward Coordinator leading on every Labour Ward 24-hours a day;we have ensured that our rostering reflects this requirement. The Birthrate Plus® acuity tool monitors this every 4 hours. It also takes into account risk factors, acuity and dependency of women, environmental factors and skill mix, enabling the co-ordinator to flex staffing to the need of the service within a shift, by redirecting staff and prioritising care. A detailed escalation policy also ensures the coordinator retains this supernumerary status enabling oversight of activity. Supernumerary status of the coordinator was maintained 100% of the measured occasions in the 6 months this report relates to.

The following table outlines the compliance against this action by month:

	Number of days per month	Number of shifts per month	Compliance
March 24	31	62	100%
April 24	30	60	100%
May 24	31	62	100%
June 24	30	60	100%
July 24	31	62	100%
August 24	31	62	100%

9. One to One care in Established Labour

Women in established labour are required to have one to one care and support from an assigned midwife. Care will not necessarily be given by the same midwife for the whole labour, but it is expected that the midwife caring for a woman in established labour will not have any other cases allocated to her.

If there is an occasion where one to one care cannot be achieved, then this will prompt the labour ward coordinator to follow the course of actions within the acuity tool and the escalation policy depending on the situation.

The following table outlines compliance with provision of 1:1 care by Month.

	March 24	April 24	May 24	June 24	July 24	August 24
Birth Centre	100%	100%	100%	100%	100%	100%
Labour Ward	100%	100%	100%	100%	100%	100%

10. Red Flag Incidents

A midwifery red flag event is a warning sign that something may be wrong with midwifery staffing (NICE 2015). If a midwifery red flag event occurs, the midwife in charge of the service is notified. The midwife in charge will then determine whether midwifery staffing is the cause and the action that is needed. Red flags are collected through the live Birthrate Plus® acuity tool.

The following tables demonstrate red flag events for the 6-month period from 1st March 2024 to 31st August 2024. Out of 894 data admissions (confidence factor of 81% recorded) there were 6 red flags entered onto the system with the reasons detailed below:

Number & % of Red Flags Recorded

From 01/03/2024 to 31/08/2024

RF1	Delayed or cancelled time critical activity e.g. Delay Elective LSCS >4 hours	5	83%
RF2	Missed or delayed care (for example, delay of 60 minutes or more in washing and suturing) e.g. Waiting for suturing >60 mins	1	17%
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	6	

Each red flag is recorded on the acuity tool and reported via datix, this ensures timely review and action planning to reduce repeat incidents and maintain safety.

11. Safety and Overview

For the service to demonstrate safe staffing on a daily basis, the Maternity Duty Manager plays a fundamental role in responding to the constant changing clinical situations within maternity services, both in the building and in the community environment. The Duty Manager is available to provide 24/7 support to the Maternity and Neonatal Service, providing a helicopter view across all areas and maintaining safety at every level. The Maternity Duty Manager rota is covered by Band 7 and Band 8 midwifery leaders and provides visible responsive leadership to Maternity and Neonatal Services.

Maternity Services continue to report missed breaks via Datix and when the coordinator is unable to maintain their supernumerary status. At such a time the involvement of the Duty Manager and use of the Maternity Escalation Policy ensures oversight and transparency when staffing and incidents occur. Additionally, Red Flag reporting is discussed monthly at the Maternity Risk and Governance meeting, with any themes reported to the Trust Clinical Risk Group via the perinatal

quality slides.

Staffing is discussed at the monthly Maternity Risk and Governance meeting, forms part of the Executive Performance Review monthly meetings (as an Improving together divisional driver) and is discussed with the Board level Safety Champions monthly. In addition, it is reported to Trust Board and LMNS Board via its inclusion in the perinatal quality slide set, which is presented to both boards monthly. The reporting mechanisms ensure clear escalation and visibility of staffing challenges.

12. Risks

Delivery of Continuity of Carer Model

In February 2016 the report *'Better Births'*, set out the Five Year Forward View for NHS Maternity Services in England to become safer and more personal. At the heart of its vision is a recommendation that there should be midwifery Continuity of Carer teams in place, to ensure safe care based on a relationship of mutual trust and respect, in line with the woman's decisions. In 2022 there was clear guidance published to NHS Trusts advising that if adequate staffing levels were not in place, then continuity of carer teams should be immediately paused until full establishment of staff was reached. With our vacancy rates and predicted junior workforce we have followed this advice and paused our rollout of continuity of carer at present.

13.0 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. The Trust is required to formally record in 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 August 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 underfunded 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 in training currently. An action plan to review neonatal

staffing was shared at Trust Board March 2024, and a business case has now been written to support an increase of non-registered staff. 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.

	FUNDED August 24	IN POST August 24	Calculated requirement (from tool)	Variance
Total direct care nurses	**24.09**	**21.03**	**24.55**	**0.46**
Total registered nurses (band 5 and above)	**23.29**	**20.23**	**21.66**	**-1.63**
of which QIS	**13.65**	**13.95**	**15.16**	**1.51**
Total Non QIS	**9.64**	**6.23**	**6.50**	**-3.14**
Total Non Reg	**0.80**	**0.80**	**2.89**	**2.09**
% REGISTERED NURSES QIS QUALIFIED		**69%**	**70%**	

13. Conclusion and Next Steps

The paper demonstrates the current staffing establishment in the maternity service, challenges, risks, and mitigations in place. The ongoing work to recruit and retain is key to the long-term staffing within the service.

Next steps are detailed:

- Continue to recruit to turnover and focus on retaining staff utilising all options available to the Trust for recruitment and retention
- Utilise Bank and Agency staff when required.
- Review working patterns and flexibility models within the current service.
- Monitor staffing monthly through staffing dashboard and escalate concerns accordingly.
- Where opportunities to over recruit become an option ensure this is available to the team.
- Review the Maternity Care Assistant competency framework with the LMNS to ensure their role is included in workforce planning and skill mix – ultimately reducing midwifery staffing in the postnatal ward environment.
- Continue with retention work and input from the PMA team to support staff.

- Continued consideration of any exit interview themes and actions associated with them.

14. Recommendations

It is recommended that the Board note the contents of the report and formally record in the Trust Board minutes the compliance to those metrics requiring noting as evidence for CNST compliance.

NHS Salisbury NHS Foundation Trust

Report to:	Trust Board (Public)	Agenda item:	7.7
Date of meeting:	3 October 2024		

Report title:	Board Assurance Framework (BAF) and Corporate Risk Register (CRR) Report			
Status:	Information	Discussion	Assurance	Approval
		Yes	Yes	
Approval Process: (where has this paper been reviewed and approved):	N/A			
Prepared by:	Fiona McNeight, Director of Integrated Governance			
Executive Sponsor: (presenting)	Fiona McNeight, Director of Integrated Governance			
Appendices:	Board Assurance Framework September 2024 Summary CRR Tracker v1 September 2024 Corporate Risk Register September 2024			

Recommendation:

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

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

Specifically, the Committee is required to:

- Review the overall risk profile for each strategic priority and agree this reflects all current and future risks.
- Review the risks out with tolerance and request any further assurance required in respect of risk mitigation.
- Review the principle strategic risks (BAF) and any associated gaps in control or assurance.
- Agree escalation points for the Trust Board, to include any emerging risk/s or control concerns.

Executive Summary:

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

The BAF has been updated to reflect the suggested changes following the deep dive of all BAF risks at the Board development day in August 2024. Risk descriptions, controls, assurance and mitigating actions have changed accordingly. There are currently 11 strategic risks. BAF risk 5 is a new strategic risk regarding the

potential for a cyber-attack which has replaced the strategic risk in relation to the nursing workforce which has been removed.

There are 18 risks on the CRR compared to 21 reported in June 2024. There are 2 new risks, 2 risks which have moved within tolerance, 1 risk has moved out of tolerance in addition to improvement in risk score for 2 risks. Overall, there has been a positive shift in the CRR risk profile.

There are 5 risks out of tolerance compared to 7 at the last report. Risks 7807 and 7955 have moved within tolerance. Risk 5704 has moved out of tolerance again.

There has been an ongoing positive shift in the overall risk profile since June 2024. The 3 on-going strategic challenges that the Trust faces and is reflected in the risks out of tolerance remain consistent and relate to the financial position, the estate and the significant change programmes the Trust is facing. Over the last 12 months there has been steady improvement across the risks relating to operational performance and workforce. Overall, there has been a positive shift in the CRR risk profile. There are 5 CRR risks out with tolerance. Two corporate risk themes reflect the strategic challenges regarding the financial position and the estate.

Feedback from Board Committees

The BAF and CRR has been considered at Clinical Governance Committee, Finance and Performance Committee and People and Culture Committee with the following feedback:

- BAF Risk 4 - The score of 16 on critical plant and building infrastructure was discussed as it had been noted this score had remained static for 8 months.
- BAF Risk 5 – A cyber security deep dive is expected at November's F&P Committee and the scoring and controls will be picked up as part of that discussion with the Interim Chief Digital Officer.
- BAF Risk 9 financial deficit – It was noted that this was going to be changed to match the ICB score of 20. This has now been updated in the spreadsheet and in the slides.
- BAF Risk 10 – This risk will be reviewed in the wider partnership context as it is currently focused on PLACE and community.
- BAF Risk 12 - Sustained deterioration of performance metrics – F&P discussed if this metric should be improving as it had been a score of 12 for 5 months and improvements had been seen across performance metrics in the IPR.

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

Salisbury NHS Foundation Trust

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

Purpose

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

2 Background

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

3 Summary Strategic Risk Profile

3.1 BAF summary

The BAF has been updated to reflect the suggested changes following the deep dive of all BAF risks at the Board development day in August 2024. Risk descriptions, controls, assurance and mitigating actions have changed accordingly. There are currently 11 strategic risks. BAF risk 5 is a new strategic risk regarding the potential for a cyber-attack which has replaced the strategic risk in relation to the nursing workforce which has been removed. The 3 on-going challenges that the Trust faces and is reflected in the risks out of tolerance remain consistent and relate to the financial position, the estate and the significant change programmes the Trust is facing. Over the last 12 months there has been steady improvement across the risks relating to operational performance and workforce.

3.2 BAF Risks Out with Tolerance

There are 4 strategic risks out with tolerance; an increase of one risk since June 2024:

- BAF 4 - Risks associated with critical plant and building infrastructure that may result in utility or system failure impacting on service delivery. Score unchanged at 16.
- BAF 5 - There is a risk of a shutdown of the IT network due to a cyber-attack or system failure which could lead to IT systems access or data loss. This could have a wide range of detrimental impact such as on the delivery of patient care, the security of data and Trust reputation. Score 20. New risk escalated from the CRR.
- BAF 6 - There is a risk that the Board has limited capacity in terms of time, skills and capacity to effectively oversee the organisation and the delivery of key strategic priorities in 2024/25. Score unchanged at 16. This risk is under review and will be revised to reflect the major change projects that the Trust will face.
- BAF 9 - An irreversible inability to reduce the scale of financial deficit. Score unchanged at 16.

All of the above risks have a score greater than 15. These all fall within an open risk appetite and therefore any score over 12 is out of tolerance. The risk tolerance has not identified any unexpected risks out with tolerance and reflect the challenges discussed at Board and Board Committees and evidenced through the Integrated Performance Report metrics and individual reports.

3.3 **CRR summary**

There are 18 risks on the CRR compared to 21 reported in June 2024. There are 2 new risks, 2 risks which have moved within tolerance, 1 risk has moved out of tolerance in addition to improvement in risk score for 2 risks. Overall, there has been a positive shift in the CRR risk profile.

There are 5 risks out of tolerance compared to 7 at the last report. Risks 7807 and 7955 have moved within tolerance. Risk 5704 has moved out of tolerance again.

Risks out of tolerance:

- Risk 5704 (Population): Inability to provide a full gastroenterology service due to a lack of medical and nursing workforce. Score 16 from 12. The shift is as a result of concerns being raised internally regarding the quality of care together with the resignation of a fixed term gastroenterologist and subsequent threat of resignation by the clinical lead (single substantive gastroenterologist).
- Risk 5751: Risk of patient harm caused by a delayed discharge from hospital. Score unchanged at 15.
- Risk 7308 (Partnership): The financial plan for 2022/23 is a deficit plan with assumed 2.2% savings. There is a material risk that the deficit will be larger than planned due to the operational constraints, inability to achieve financial savings and ongoing pressures related to patients with no criteria to reside. Therefore, there is a risk that cash flow is challenged during the year resulting in the Trust having to take emergency cash measures. Score unchanged at 20.
- Risk 7734 (Partnership): Shortfall in funding available (locally and nationally) for capital programme, leading to a potential risk to the safety and availability of buildings and equipment to deliver services. Score unchanged at 15.
- Risk 6229 (Population) - The DSU building is 'end of life' and has been identified as priority for replacement. Score is unchanged at 20.

New risks since June 2024

There are 2 new risks:

- Risk 8188 (Population): In a challenging market the Trust is unable to recruit substantive ERCP practitioners. ERCP is therefore currently delivered by an outsourcing company providing one session per week with no cover for annual leave. This arrangement provides no ability to flex capacity to meet peaks in demand, or to always accommodate patients with severe illness who need intervention. Score 12.
- Risk 8174 (Population): A National review of paediatric audiology assessments has identified variation in practice/quality that may have underdiagnosed hearing loss in young children. A Regional assessment of SFT services has identified a high risk of potential harm and mandated a review of c200 cases from 2017 to date. There is a risk that the review could discover significant harm to children and this could result in reputational and litigation risk in the future. Score 10.

Risks removed:

- Risk 7039 (Population) - The Trust is currently experiencing increased demand and patient acuity across all in-patient areas, at a time of increased nursing sickness, maternity leave, leavers and retirement and reduced recruitment. This causes a shortfall in Care Hours per Patient day (CHPPD), increases risk of burnout for remaining staff, causes delay to flow and discharges and inability to provide required care for all patients. This risk was closed given the positive response to recruitment and turnover reduction coupled with sustained improvement in CHPPD.
- Risk 5360 (Population) - Risk of a cyber or ransomeware attack resulting in the potential loss of IT systems, compromised patient care and financial loss. This risk has been escalated to the BAF and therefore closed.

- Risk 7809 (Population) - There is a risk that the Trust has an unidentified gap in effective clinical care may be the cause of the sustained deterioration in HSMR and SMR. There is a current failure to provide adequate assurance that the change in statistics is not a result of avoidable harm. This risk was closed as mortality benchmarking figures have significantly improved.
- Risk 6858 (Partnerships) - There is a risk as new guidance and models of working emerge, the immaturity of partnerships between the Trust and wider BSW organisations will impact on progress to achieve key objectives. This risk is reflected on the BAF as a strategic risk and therefore closed.

Risks with an increased score:

- Risk 5704 (Population): Inability to provide a full gastroenterology service due to a lack of medical and nursing workforce. Score 16 from 12. The shift is as a result of concerns being raised internally regarding the quality of care together with the resignation of a fixed term gastroenterologist and subsequent threat of resignation by the clinical lead (single substantive gastroenterologist).

Risks with a decreased score:

- Risk 7807 (Population): As a result of a lack of mental health provision there is a risk that patients with specialist mental health needs are being managed in the acute setting. This may result in sub-optimal care with less therapeutic value than if undertaken in the right setting with appropriately trained staff. Score 15 to 12. Now within tolerance.
- Risk 7955 (Population): There is a risk that ongoing industrial action compromises the quality and timeliness of patient care, compromises operational effectiveness and impacts on the workforce morale. Score 16 to 8. Now within tolerance.
- Risk 7472 (People): As a result of staff absences, higher than benchmark turnover (in the Southwest) of existing staff and hard to recruit to posts (particularly medical), there is a risk that SFT is unable to manage service provision and operate a safe hospital. Score 12 to 9.
- Risk 7078 (People): As a result of competing priorities and deliverables there is a risk of slippage of the Improving Together Programme deadlines. Score 9 to 6 (Target score).

4 Summary

There has been an ongoing positive shift in the overall risk profile since June 2024. The 3 on-going strategic challenges that the Trust faces and is reflected in the risks out of tolerance remain consistent and relate to the financial position, the estate and the significant change programmes the Trust is facing. Over the last 12 months there has been steady improvement across the risks relating to operational performance and workforce. Overall, there has been a positive shift in the CRR risk profile. There are 5 CRR risks out with tolerance. Two corporate risk themes reflect the strategic challenges regarding the financial position and the estate.

The changes noted to the BAF and CRR demonstrate that this is a dynamic process and one of continuous improvement.

5 Recommendations

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

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

Specifically, the Committee is required to:

- Review the overall risk profile for each strategic priority and agree this reflects all current and future risks.
- Review the risks out with tolerance and request any further assurance required in respect of risk mitigation.
- Review the principle strategic risks (BAF) and any associated gaps in control or assurance.
- Agree escalation points for the Trust Board, to include any emerging risk/s or control concerns.

Fiona McNeight
Director of Integrated Governance

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.

Board Assurance Framework
September 2024

Fiona McNeight

Director of Integrated Governance

Board Assurance Framework

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

Trust Values

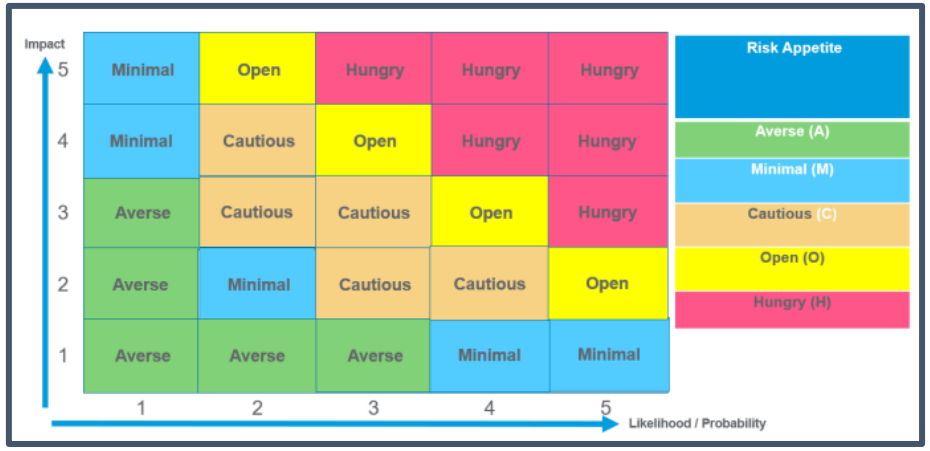
The core values and behaviours to support the achievement of the Trust vision:

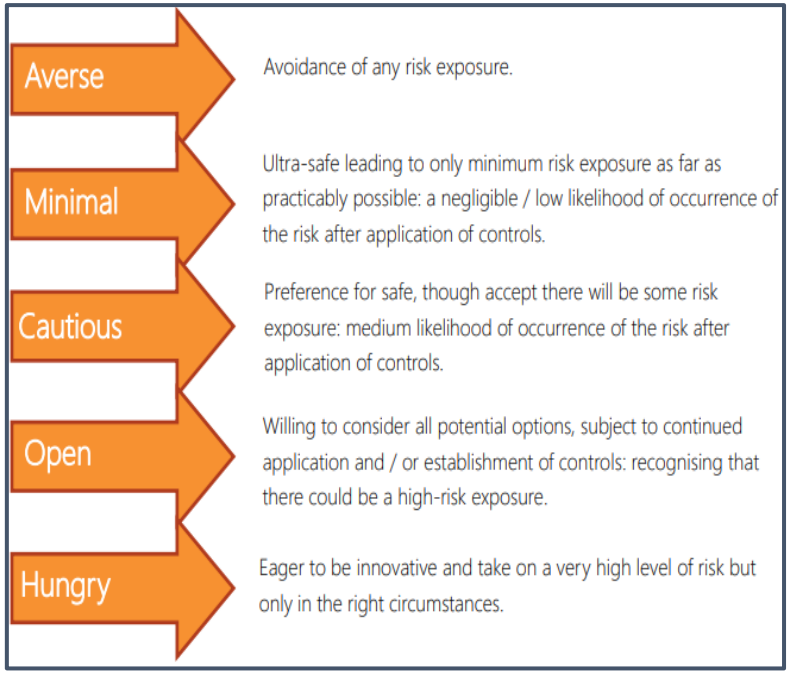
Strategic Priorities

Risk Matrix

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

Risk Appetite





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

Risk Tolerance	
within tolerance	
outwith tolerance	

Board Assurance Framework Dashboard

Strategic Risk	Risk Title	Exec Lead	Initial Score	Oct-22	Jan-23	Jun-23	Sep-23	Jan-24	Jun-24	Sep-24	Target
Risk Detail			Score Trend								
POPULATION - Improving the health and wellbeing of the population we serve											
BAF 1	Delayed or suboptimal deployment of the joint Electronic Record will impact on strategic improvement and impact on the assumed financial benefits to the Trusts operating model	Chief Finance Officer	12						12	12	6
BAF 2	Due to the size of our catchment population, there is a risk that some services are not sustainable	Chief Medical Officer	15	10	10	10	10	12	12	12	8
BAF 3	Non delivery of programmes within the Digital Plan could result in poor quality services, reputational damage and inability to attract and retain high quality staff	Chief Digital Officer	16	12	12	12	12	12	12	12	9
BAF 4	Risks associated with critical plant and building infrastructure that may result in utility or system failure impacting on service delivery.	Chief Executive Officer / Director of estates	12	16	16	16	16	16	16	16	8
BAF 5	There is a risk of a shutdown of the IT network due to a cyber-attack or system failure which could lead to IT systems access or data loss. This could have a wide range of detrimental impact such as on the delivery of patient care, the security of data and Trust reputation.	Chief Digital Officer	20							20	15
BAF 8	Demand for services that outweighs capacity, resulting in an increased risk to patient safety, quality, and effectiveness of patient care.	Chief Operating Officer	20	20	20	16	16	16	12	12	9
People - Supporting our people to make Salisbury NHS Foundation Trust the best place to work											
BAF 6	There is a risk that the Board has limited capacity in terms of time, skills and capacity to effectively oversee the organisation and the delivery of key strategic priorities in 2024/25.	Chief Executive Officer	16						16	16	8
BAF 7	Inability to effectively plan for, recruit and retain staff with the right skills which will impact staff experience, morale and well-being which can result in an adverse impact on patient care.	Chief People Officer	20	20	20	16	16	12	12	12	9

Risk Score Key

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

Board Assurance Framework Dashboard

PARTNERSHIPS - Working through partnerships to transform and integrate our services										
BAF 9	An irreversible inability to reduce the scale of financial deficit	Chief Finance Officer	12	16	16	16	16	16	16	20	9
BAF 10	Failure to establish and maintain effective partnerships to support the Integrated Care System with the potential to impact the Trust at PLACE level.	Chief executive Officer/ Chief Operating Officer	9	9	9	9	9	9	9	9	6
BAF 12	Risk of sustained deterioration across key performance metrics (new risk)	Chief Operating Officer	16	16	16	12	12	12	12	12	9

Risk Score Key

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

BAF Risk 1	Delayed or suboptimal deployment of the joint Electronic Patient Record would result in clinical, strategic and financial benefits not being realised including and impact the delivery of the Trust future operating model.
Strategic Priority	People, Population, Partnership
Linked Corporate Risks	
Executive Lead	Chief Financial Officer
Lead Committee	Finance and Performance
Risk Type	Capacity — Risk Appetite / tolerance: Open

Risk Score 2024/25

Initial Score	Apr 22	Jul 22	Oct 22	Jan 23	Jun 23	Sep 23	Jan 24	Jun 24	Sep 24	Target Score
12								12	12	6

Context

Becoming a digitally mature organisation with a fit for purpose, integrated Electronic Patient Record (EPR) is a key enabler of the Trust's strategy. The EPR business case articulates the range of anticipated clinical, strategic and financial benefits expected to be achieved through transformation in part driven by the implementation of the EPR. This includes the reduction of duplication and waste as well as the ability to improve access and reduce variability in outcomes across the BSW Acute Hospital Alliance.

Deployment of a common EPR across three acute Trusts is a complex technical and change management process, requiring significant acquisition of skills within our existing workforce and through new recruitment. The level of change both in pathways and culture to maximise the potential of the Shared EPR. Given the multifaceted nature of the programme and the wide range of strategic plans the EPR will enable, the risk that delay or ineffective delivery is substantial.

Controls

BSW shared EPR programme board in place.
Joint Committee established to oversee EPR programme at AHA level. Both meet monthly.
Monthly EPR Delivery Group (CDO/CCIO led) established, with EPR Oversight Group (CEO led) to oversee delivery of local actions and any emerging risks/mitigations.
SFT board level engagement in all key aspects of EPR delivery.
Delivery partnership with Oracle Health.
Weekly EPR Programme Team meeting with workstream leads

Assurance

Joint committee governance reporting to three boards within AHA
Phased deployment plan with project milestones overseen by programme board, escalating to joint committee
NHSE oversight of EPR programme progress and gateways.
Berkeley to provide independent assurance of initial set up.

Progress

What is going well/ Future Opportunities?

New implementation oversight governance agreed with first Joint Committee taking place in June 24
Shared EPR FBC approved by NHSE in March 2024, with new governance set up and central programme team recruited.
Programme board reporting on plan in September 24 (plan baselined by external partners), noting risks associated with recruitment.

What are the current challenges including future risks?

1. Digital transformation has a legacy reputational issue within SFT
2. Significant change programme delivery already occurring with SFT and the AHA
3. Current financial and operating context could jeopardise acquisition of key skills or individuals
4. Release and backfill of key clinical staff
5. Recruitment into shared EPR roles and delivery of programme on time and budget.
6. Lorenzo end of life with limited supplier development to resolve issues identified and comply with Information Standard Notices.

How are these challenges being managed?

1. Strong executive oversight at all levels of digital governance
2. Strengthened digital clinal leadership capacity, EPR programme integrated with Improving Together continuous improvement system at AHA and organisational level
3. Recruitment report reviewed weekly at workforce control panel and action to improve onboarding approach across AHA
4. Targeted engagement on recruitment with Divisions, backfill plans to be captured within workforce workstream.
5. National escalation on any severe incidents/requirements, monthly supplier engagement to influence development priorities.

BAF Risk 2	Due to the size of our catchment population there is a risk that some services are not sustainable		
Strategic Priority	Population		
Linked Corporate Risks	5704, 8188		
Executive Lead	Chief Medical Officer		
Lead Committee	Finance and Performance		
Risk Type	Innovation	Risk Appetite / tolerance	Open

Risk Score 2024/25

Initial Score	April 22	July 22	Oct 22	Jan 23	June 23	Sept 23	Jan 24	June 24	Sept 24	Target Score
15	10	10	10	10	10	10	12	12	12	8

Context

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

Sustainable services is a clear priority for BSW ICB, the AHA and the Trust strategy.

The governance mechanism in the AHA for prioritising fragile services for review and transformation and work to ensure there is clear alignment of strategy and delivery at organisation and system level has paused in light of consideration of change to the system structure.

Current fragile services prioritised for transformation work are gastro and dermatology.

This risk links with BAF risk 7 given the challenges to recruitment and retention of staff in these fragile services.

Controls

Dermatology mutual aid agreement with RUH.
GI bleed service, ERCP and IBD being managed in partnership with Southampton (UHS).
Gastro waiting list validation and pathway configuration work

Assurance

Reduction in time to first outpatient appointment.

Progress

What is going well/ Future Opportunities?

The requirement of health and Care legislation to actively collaborate affords an opportunity to redesign services to ensure delivery for the population of BSW as a whole which may be impacted by the formation of a Group Model.

Re-start work to reset priorities and resourcing of AHA clinical transformation projects to ensure faster pace of delivery.

What are the current challenges including future risks?

1. Pace of change required for large scale reconfiguration.
2. Current fragile services could be at risk of regulatory enforcement action.

How are these challenges being managed?

1. Changes to the BSW system structure. Move to a Group Model.
2. Gastro service – current CEO to CEO discussions re: service model.

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

Risk Score 2024/25

Initial Score	Apr 22	Jul 22	Oct 22	Jan 23	Jun 23	Sep 23	Jan 24	Jun 24	Sep 24	Target Score
16	12	12	12	12	12	12	12	12	12	9

Context

The Trust is digitally immature when benchmarked nationally. The Trust's digital plan sets out a significant agenda to improve integration of systems, maximise the existing Electronic Patient Record (EPR) whilst working towards a more sustainable longer term joint approach across the ICS, expanding the use of data and ensuring we have infrastructure that enables us to effective use technology and stay safe.
As technology touches on most transformation programmes, there is insufficient capacity and funding to deliver all that is asked with our appropriate prioritisation. This constraint risks a slower response to identified clinical or operational risks and requirements, meaning the Trust will be accepting a higher level of associated risk until programmes can be completed/systems introduced. The Trust also may not be able to maintain all desired level of improvements alongside participating in all local and regional initiatives with peers. Current score remains at 12, recognising Trust financial position increases risk associated with sufficient funding to deliver wider elements of the Digital Plan.

Controls

Monthly Digital Steering Group in place with robust digital governance below this, including programme governance.
Comprehensive clinical digital leadership in place.
Digital Innovation Network launched to increase digital profile including digital champions and digital superusers to support change and ownership.
Cyber security team set up within IT Operational to manage cyber risk mitigation activities.
Joint CDO, CIO & Deputy CIO across SFT & GWH.

Assurance

Monthly Digital Steering Group minutes.
Prioritised digital plan for the year agreed
Regular Digital Plan updates to Board committees.
Regular minutes from BSW shared EPR programme board with updated governance being set up.
Rolling cyber desktop exercises results
Fortnightly risk review meetings in place

Progress

What is going well/ Future Opportunities?

Refreshed Digital Plan approved at Trust Board in November 2022.
Fortnightly working group established to build on AHA digital services review, bring ICB into scope. Joint CDO decision remains with CEOs.

What are the current challenges including future risks?

1. There remains a large agenda of projects with a digital component which are not resourced, funded or prioritised.
2. Some digital programmes are behind original plans.
3. Lack of funding to deliver full Digital Plan including removing all unsupported technologies.
4. Clinical engagement is limited due to operational pressures.
5. Recruitment and retention of Business Intelligence skills

How are these challenges being managed?

1. Prioritisation of programmes through Corporate Projects Prioritisation Group to ensure the change agenda is realistic and QIAs completed for those unfunded or de-prioritised programmes.
2. Programmes are rebased as part of existing programme governance & strong PMB challenge on delivering against this rebased targets in place. Risk mitigations put in place where appropriate.
3. Seeking opportunities for national funding to support programmes.
4. Clinical leads supporting identifying champions for key activities (Shared EPR, implementation activities). Implementing new communication software to support different digital communication methods.
5. Implementing plan to build resilience with GWH, digital services review.

BAF Risk 4	Risks associated with critical plant and building infrastructure that may result in utility or system failure impacting on service delivery.
Strategic Priority	Population
Linked Corporate Risks	6229, 7734
Executive Lead	Chief Finance Officer
Lead Committee	Finance and Performance
Risk Type	Infrastructure — Risk Appetite/Tolerance: Open

Risk Score 2024/25

Initial Score	July 22	Oct 22	Jan 23	June 23	Sept 23	Jan 24	May 24	Sept 24	Target Score
12	16	16	16	16	16	16	16	16	8

Context

SFT has a substantial estates backlog (£78m – 2024) which impacts service delivery, quality of estate and public/patient experience. Limitations via CDEL and lack of investment capital impact the Trust ability to reduce the estates backlog and creates a corresponding increase in Trust risks; costs to operate and maintain the existing estate, likelihood of future infrastructure and estate failures, compromised service delivery and patient care. Equally environmental sustainability investment is limited reducing the Trust ability to achieve net carbon zero. Whilst National and/or targeted funding may become available, careful planning and prioritisation of requirements is essential yet remains consistently insufficient to make any marked progress in the reduction of long term risks, or exceed the inflationary rate of change to the backlog value. The clinical strategy and the estates strategy are key long term plans for the Trust evolution and delivery of effective and reliable services over the next 10 years (and beyond), but require significant investment to achieve.

Controls

6 Facet survey of the whole site completed in 2022, providing an up to date and independent assessment of the campus in accordance with National guidance (NHS Estate Code).
The 6-facet data reviewed annually and adjusted to reflect capital investment made in year and increases due to inflation. Last annual update May 2024 Quarterly estates reporting to Trust Board. Annual capital plan reviewed via Strategic Capital committee.
Internal audit on management of backlog maintenance completed in 2023 and recommendations completed.
Internal audit on compliance reporting completed in 2024 and recommendations currently being followed through.

Assurance

Significant improvements in estates governance and risk management introduced including the 10 year capital programme compiled, with investment forecasts for estates backlog and a 5 year plan for year on year spend.
Estates compliance status clearly recorded. Majority of targets achieved. One extreme risk outstanding, most highs reduced.
Continued progress to mitigate and conclude compliance actions August 2024 before moving to business as usual.

Progress

What is going well /Future Opportunities?

- 10 year capital programme compiled, includes investment forecast for estates backlog. Program subject to annual prioritisation process
- Additional elective ward completed (replaces poor condition estate)
- Estates strategy renewal, mobilised with target completion Dec 2024.
- Estates strategy update will incorporate Campus project for long term development
- Successful bid for national investment to begin decarbonisation of energy infrastructure, £10m for 2023/24, further bids to be submitted for future years.

What are the current challenges including future risks?

1. Insufficient capital. Inflation pressures alone continue to significantly increase backlog value year-on-year
2. Competing demands for Trust capital each year.
3. Reduction in revenue funding will impact on ability to maintain and repair existing infrastructure.
4. Estates backlog value (£78m) is not actual cost to deliver Likely value £124m
5. Limited electrical infrastructure on campus impacting future redevelopment opportunities
6. Current decarbonisation (Salix) investment does not encompass whole site. Further investment required to realise decarbonisation. Decarbonisation strategy reduces fossil fuel use but increases electrical demand which is a higher cost, Trust utility costs will rise as we become more environmentally sustainable.
7. Lack of adequate investment means infrastructure continues to degrade – level of backlog maintenance increases. Cost to maintain Trust estates and infrastructure increases. Infrastructure failure risk increases
8. Day surgery unit remains Trust highest priority, with no funding source available.
9. Aged areas of the Estate are not fit for purpose or occupation (SFT South and central) but require investment for continued use and are at higher risk of failure.
10. Trust 'space' is in high demand and appetite to remove poor quality buildings challenged with space use.
11. Clinical strategy limitations inhibit the estates strategy.
12. National targeted resources do not address key resilience issues
13. Patient environment quality being compromised e.g., spinal unit
14. Quality of on-site residential accommodation poor with little investment

How are these challenges being managed?

1,2 - Categorisation & prioritisation of Trust capital. Review and prioritisation within Trust framework alongside digital, medical equipment
1,8- Continued lobbying for major service developments – DSU
3- The frequency of maintenance is adjusted where possible, trying to ensure statutory requirements and best practice are maintained, this can result in increased issues at a later date and increased cost pressures.
6 - Funding applications made for environmental sustainability and energy decarbonisation (e.g. Salix)
9 - Investigations into strategic partnership models to allow development and investment of the estate.
7,9,10 - Continued review of poor-quality accommodation use, identifying opportunities to vacate (e.g remove and dispose archive material) with potential to demolish and remove risk
10 - Increased scrutiny of estate requests via space allocation committee. Management of space utilisation 'creep'.
11, 13 - Estate's strategy mobilised
12 - Monthly meetings with regional NHSEI colleagues to highlight priorities and risks
14 - Board paper planned to present options for on-site residential accommodation

BAF Risk 5	There is a risk of a shutdown of the IT network due to a cyber attack or system failure which could lead to IT systems access or data loss. This could have a wide range of detrimental impact such as on the delivery of patient care, the security of data and Trust reputation.		
Strategic Priority	People, Population, Partnership		
Linked Corporate Risks	5360 (Cyber)		
Executive Lead	Chief Financial Officer		
Lead Committee	Finance and Performance		
Risk Type	Infrastructure	**Risk Appetite / tolerance**	**Open**

Risk Score 2024/25

Initial Score	Apr 22	Jul 22	Oct 22	Jan 23	Jun 23	Sep 23	Jan 24	Jun 24	Sep 24	Target Score
20									20	15

Context

The Global cyber position is a continuous evolving picture with new threats on a daily basis, therefore the inherent risk to the NHS remains high. The impact of a cyber attack is wide reaching, disrupting clinical care and operational delivery, increasing the risk of reputational damage and legal challenge due to the risk of data availability and loss. A cyber attack will impact whether it is directly against the Trust or indirectly against a partner or third-party supplier.
The Trust has a range of controls and processes in place, engaging with national, regional and local peers to provide a networked approach to cyber security. However, a cyber attack can commence very easily, and it is impossible to have complete cover. Recent cyber events highlight that the healthcare supply chain is an increasingly targeted area.
The NHS has released a new cyber strategy for healthcare to help ensure organisations maintain good cyber posture, protect as one and focus on staff awareness and development as this is often an attack vector.

Controls

Local cyber security team in place
Digital Steering Group oversight of cyber plans
Modern and secure cyber security technologies including VPN, antivirus, bitsight, endpoint protection, medical equipment, IoT, modern firewalls, etc
Security patching controls
Multifactor authentication on NHS Mail
Cyber awareness programme and phishing feedback/retraining
Member of ICB TDA Cyber Group and National forums including Cyber Associates Network and Executives Forum
Close engagement with NHSE regional cyber lead

Assurance

Weekly tech group minutes,
Unsupported server replacement programme
Monitoring of Infrastructure downtime
IT Health Assurance Dashboard oversight
Quarterly cyber report to FIDC
Annual Data Security and Protection Toolkit (DSPT) internal audit and penetration testing
Data, Security and Protection Toolkit
Cyber awareness plan
Phishing testing

Progress

What is going well/ Future Opportunities?

Trust met DSPT standards for 2023/24.
Good coverage of cyber toolsets to monitor the Trust and respond to cyber events.
The Trust has a high Bitsight score showing good internet facing cyber posture.
Opportunity for closer ICS working and national funding through ICS wide procurements.

What are the current challenges including future risks?

1. Improvement required in Cyber Security Preparedness, in particular stronger planning for business continuity for longer term cyber attack.
2. Board visibility of cyber controls and improvement plans needs improving.
3. Trust is required to expand Multi-Factor Authentication (MFA) in line with national policy.
4. Alignment of cyber security controls and policies across ICS will enable improved support in the event of a cyber attack.
5. Supplier controls and oversight requires enhancement given recent cyber attacks

How are these challenges being managed?

1. Review of existing and planned system business continuity for extended outages and for systems which are shared across the region/clinical networks to ensure business continuity plans are fit for purpose. Starting with new Pathology LIMS.
2. Development of cyber security framework for annual Board assurance.
3. MFA improvement plan expected to be developed by November 2024.
4. Completion of Softcat cyber gap analysis for all ICS partners.
5. Engage with existing suppliers to clarify the current position on sub-contractors/dependant suppliers, assurance of supplier penetration testing and preparedness with support from ICS procurement team.

BAF Risk 6	There is a risk that the Board has limited capacity in terms of time, skills and capacity to effectively oversee the organisation and the delivery of key strategic priorities in 2024/25.		
Strategic Priority	People		
Linked Corporate Risks			
Executive Lead	Chief Executive Officer		
Lead Committee	Board of Directors		
Risk Type	Capability and Skills	**Risk Appetite / tolerance**	**Open**

Risk Score 2024/25										
Initial Score	June 24	Sept 24								Target score
16	16	16								8

Context	Controls	Assurance
The Executive team will have four interim roles (CEO, COO, CFO and CMO) which can limit stability of leadership in year. There is a delay to substantive recruitment due to uncertainty on future governance arrangements in the AHA, the uncertainty could also lead to further attrition of key roles. There are a number of strategic objectives which will render significant leadership capacity including replacement EPR, Community Services tender and financial recovery which dilutes capacity on BAU improvements. Changes in executive team can mean loss of organisational knowledge and experience which in the short term can slow progress or risk delivery which impacts on the reputation of the organisation.	Board oversight of key metrics through IPR AHA Joint Committee on EPR to ensure oversight and shared delivery. Interim mitigation plans enacted for all roles Remuneration committee for oversight of performance. Succession planning in place	- Engine room oversight of breakthrough metrics/strategic initiatives and vision metrics to focus on delivery and risks.

Progress

What is going well/ Future Opportunities?	What are the current challenges including future risks?	How are these challenges being managed?
Interim roles predominately held by SFT substantive employees maintaining organisational knowledge. Recruitment plans underway to commence CMO in September 2024.	• Uncertainty about AHA governance structures leading to further attrition in key roles. • Attracting high calibre candidates in context of uncertainty	- Regular executive team development . - Recruitment process planning underway - Board oversight of risks and strategic programme

BAF Risk 7	Inability to effectively plan for, recruit and retain staff with the right skills which will impact staff experience, morale and well-being which can result in an adverse impact on patient care.		
Strategic Priority	**People**	**Risk Score 2024/25**	
Linked Corporate Risks	5704, 8188, 7472, 7573		
Executive Lead	Chief People Officer		
Lead Committee	People and Culture Committee		
Risk Type	Capability and Skills	**Risk Appetite / tolerance**	**Open**

Initial Score	July 22	Oct 22	Jan 23	June 23	Sept 23	Jan 24	June 24	Sept 24		Target Score
20	20	20	20	16	16	12	12	12		12

Context	Controls	Assurance
BMA and RCN are currently considering a national pay offer. Quarterly pulse survey is indicating a maintained position against all elements of the People Promise. There is a National shortage of workforce across a range of professions and BSW mirror the National picture. Attraction to geographical area through recruitment and retention premia, Golden Handshake welcome payment, offer of relocation payment and re-launched 'Refer a friend scheme' has been successful. Financial target includes a WTE reduction of 220wte which at month 4 is off track. Tender process for provision of community services would result in TUPE of approx. 1000 staff. This year's breakthrough objective is to increase staff retention with a revised Trust turnover of 15%. Particular focus on reducing HCA turnover from 20% to 15%. On-going challenge to attract Consultant medical workforce in specific specialties (links to BAF risk 2)	Workforce Control Panel overseeing vacancies Financial recovery programme –group now meet fortnightly International RN and Midwife recruitment HCA recruitment and retention facilitator in post Staff retention now a breakthrough objective with clear focus Active update and review of all people policies which are being written and implemented in support of a just and restorative culture. Workstreams for all 7 elements of the People Promise benchmarked against staff survey Established leadership development programme plus launch of the people management skills modular programme Overhauled recruitment process; emphasis on high impact actions People Promise Manager retained with an extended portfolio to include widening participation	Improved vacancy position as a result of attraction incentives; c3.3% Pulse survey showing increasing staff engagement from 6.82 to 6.85 (above Picker average) Maximum take up on the leadership development, wellbeing and appraisal training courses Time to hire recruitment process – significant reduction in days. Sickness absence 3.4% (below 12-month average) Turnover 13.49% (July)

Progress

What is going well/ Future Opportunities?	What are the current challenges/future risks?	How are these challenges being managed?
Leadership including clinical leads first introduced this year with good uptake. Leadership engagement – practical support including investment and participation e.g. Tent Talks. Head of Education leading improvement projects e.g. increasing apprenticeships. Development of a strategic workforce plan. Permanent appointment to Associate Director for culture, leadership & learning.	1. Increasing retention and reducing turnover 2. Line managers capacity & capability to manage exit interviews and complete appraisals 3. Non-Medical Appraisal compliance – slow improvement 4. Manager's capacity to manage staff wellbeing and career development due to operational pressures. 5. Lack of Strategic workforce planner 6. HCA retention	1. A comprehensive improvement programme against all 7 elements of the People Promise and focus on breakthrough objective (turnover). 2. Approach to appraisal & career conversation part of talent and succession planning launch. Line managers training course to be launched Autumn 2024 (Licence to Manage). 3. Improving line manager training. 4. As per 2. 5. Interim in post – active monitoring of KPIs at DPR's 6. Breakthrough objective for 24/25

BAF Risk 8	Demand for services that outweighs capacity, resulting in an increased risk to patient safety, quality, and effectiveness of patient care.		
Strategic Priority	Population		
Linked Corporate Risks	5751, 7573, 7574		
Executive Lead	Chief Operating Officer		
Lead Committee	Finance and Performance		
Risk Type	Capacity	**Risk Appetite / tolerance**	Open

Risk Score 2024/25

Initial Score	July 22	Oct 22	Jan 23	June 23	Sept 23	Jan 24	June 24	Sept 24		Target score
20	20	20	20	16	16	16	12	12		9

Context

Our operational context remains challenging with demand for Urgent and Emergency services currently outstripping our capacity and this is consistently meaning patients are waiting for treatment longer than the national constitutional standard, which can also lead to substandard care.

Demand within urgent care continues to grow at 10% year on year which is leading to the continued use of escalation capacity and putting undesired pressure on clinical services which is compromising efficiency and effectiveness of the operational flow and compromises patient care.

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

Controls

BSW system support to identify / enhance out of hospital offering and capacity such as virtual ward and care co-ordination centre in place.
Further productivity improvements in SFT, Urgent Care, introduced new ways of working within SDEC / frailty model / ED etc

Increasing SFT capacity through opening of Imber ward.

Utilisation of escalation capacity and outsourcing when required.

Assurance

BSW Virtual ward and care co-ordination centre in place reducing demand on SFT beds and admissions
SDEC model reducing bed occupancy requirements for SFT
Acute Frailty model started August 23 – decreased LOS
Overall bed escalation and bed occupancy has decreased since Q4 2022/23.

Progress

What is going well/ Future Opportunities?	What are the current challenges including future risks?	How are these challenges being managed?
Improvement plan developed and range of system/ sft groups to help reduce NC2R to 5% of bed base. The Trust opened Imber ward in June 24 which will support increasing bed capacity, enabling further improvements to elective and non elective flow. Urgent care and flow board identifying further improvements that can support flow eg weekend working	1. Relatively high NCTR bed occupancy limiting available bed capacity. 2. Continued escalation into DSU compromising surgery rates and recovery of 2019/20 activity levels. 3. On going workforce challenges within a number of specialities. Eg frailty team. 4. Continued growth in NEL demand that is higher than forecast/planned. 5. Ageing estate is limiting productivity opportunities.	1. BSW and SFT specific work programme on reducing NC2R as percentage of bed base. 2. Urgent care Board to oversee transformation programme. Rebasing of the hospital capacity to enable and support improved functionality of key flow components ie reintroducing a discharge lounge. 3. Dedicated work within people committee to support recruitment into hard to recruit posts.

BAF Risk 9	SFT is unable to reduce its expenditure sufficiently to deliver financial sustainability		
Strategic Priority	Partnership		
Linked Corporate Risks	6857, 7308,7734		
Executive Lead	Chief Finance Officer		
Lead Committee	Finance and Performance		
Risk Type	Finance	Risk Appetite / tolerance	Open

Risk Score 2024/25

Initial Score	July 22	Oct 22	Jan 23	June 23	Sept 23	Jan 24	June 24	Sept 24		Target Score
12	12	16	16	16	16	16	16	20		9

Context

The Trust has had an underlying deficit greater than 5% of turnover for a number of years. This has led to a reducing cash balance, in turn constraining its ability to invest in capital programmes.

Continued pressure on urgent case pathways and agency pressures driven by hard to recruit posts have led to this position deteriorating leading to a requirement for cash support, and due to the financial pressure across the NHS the availability of cash support is increasingly uncertain. The Trust is not alone with BSW ICS reporting an underlying deficit relative to allocation funding.

The inability to deliver a breakeven position required to maintain a sufficient cash balance risks the ability to deliver safe and effective care and/or regulatory action associated with breach of license conditions.

Controls

ICB engaged in supporting SFT cash position through phasing of contractual payments.
Finance & Performance Committee oversight of cash position with escalation to Board.
Agreement of annual financial plan including cash requirements.
Escalation to ICB and engagement in NHSE revenue support process.
The BSW-wide procurement workplan levies the ICS spending power to mitigate the impact of inflation.
Breakthrough objective initiatives focus on maximising the clinical outputs of the Trust while maximising the input resource required.

Assurance

External audit value for money assessment.

Monthly reporting on performance and forecast through Financial Recovery Group, escalated to Finance and Performance Committee.

Cash flow forecasting included in Finance and Performance Committee reporting.

Reporting of improved productivity as demonstrated by Creating value for the patient: Improving productivity breakthrough objective measurement

Progress

What is going well/ Future Opportunities?	What are the current challenges including future risks?	How are these challenges being managed?
Focus on increase in productivity to mitigate further decline in financial position and maximise opportunities for ERF. Acute Alliance programme of benchmarking to identify opportunities. LOS reductions having favourable impact on bed base. Work on longer stays on-going.	1. Delivering CIP plans against identified opportunity in context of significant operational challenges. 2. Increasing proportion of savings programme will have to be delivered through clinical service transformation. 3. Adequate cash reserves to service capital programme 4. Medium term financial outlook is uncertain 5. Long term capital programme needs to be assessed against available CDEL and additional funding sources. 6. BSW transformation programme immature and not fully developed.	1. Improving together programme improving a structured approach to change. 2. Working with ICS to develop BSW sustainability programme. 3. Engagement in capital cash support programme 4. BSW mid-term plan under development 5. Trust and BSW strategic capital groups developing prioritisation. 6. BSW-wide oversight through System Recovery Group, chaired by BSW ICB CEO.

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

Risk Score 2024/25

Initial Score	July 22	Oct 22	Jan 23	June 23	Sept 23	Jan 24	June 24	Sept 24		Target Score
9	9	9	9	9	9	9	9	9		6

Context

The Integrated Care Board continues to develop and respond to changing national guidance on role and functions. In turn this places risk to how quickly trusted successful partnership working can enable service integration and delivery. As the ICB develops further, there remains a need to focus on place.

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

The community services contract has now gone live which offers both an opportunity and presents a challenge to the integration of services for SFT.

Controls

ICB and Wiltshire PLACE with SFT representation
Established AHA with SFT representation
SFT executive representation within ICS workstreams

Assurance

Community services delivery plan published

Progress

What is going well/ Future Opportunities?	What are the current challenges including future risks?	How are these challenges being managed?
Work with the Acute Hospital Alliance continues to develop and gather momentum. Acute Alliance Clinical strategy in place. Elective and Urgent care well established forums New Community services tender creates an opportunity for a reset. Wiltshire Council have relaunched the aging well board.	1. Place based working still in infancy, further work to progress placed based strategy for integrated care. 2. Challenge to develop relationships across multiple partners at place, including the capacity to influence and support the wide range of groups. 3. BSW completing tender for community services. 4. ICB is currently undergoing a mandated organisational review of form and function. The outcome of this is not yet fully known and this may place additional responsibility on other partners. ICB programme may also shift the balance between system and place.	1. The Trust is represented at appropriate meetings at PLACE, Acute Providers and the ICS. 2. Exec team members developing relationships with professional colleagues, attending stakeholder events.

BAF Risk 12	Risk of sustained deterioration across key performance metrics		
Strategic Priority	Population		
Linked Corporate Risks	5751, 7573, 7574, 7039, 7807,7955		
Executive Lead	Chief operating Officer		
Lead Committee	Finance and Performance		
Risk Type	Covid Recovery	Risk Appetite / tolerance	Open

Risk Score 2024/25

Initial Score	Oct 22	Jan 23	June 23	Sept 23	Jan 24	June 24	Sept 24			Target score
16	16	16	12	12	12	12	12			9

Context

There is a risk that all performance targets (Cancer, Planned Care, Diagnostic targets, Urgent Care standards) are not improving due to significant gaps in workforce and ongoing industrial action.

Due to significant gaps in workforce across a number of functions (e.g Theatres, Diagnostics, central booking) alongside demand being greater than capacity, key performance and quality metrics are showing sustained deterioration. There remains risk of regulatory action if the Trusts fails to meet agreed access targets.

The ongoing impact of industrial action is a significant risk to meeting performance targets due to the level of cancellations.

Controls

Planned care and urgent Care boards for transformation
BSW Planned Care Board and Elective Recovery group
Delivery group monitors performance weekly
Cancer improvement group

Assurance

Trust reports performance against agreed trajectories within the IPR.

52/65 week performance is on trajectory although delivery will be tight in certain specialities.

Outsourcing arrangement for additional capacity in Radiology which has improved DMO1 performance significantly in Ultrasound, MRI and CT.

Annual planning includes demand and capacity planning

Progress

What is going well/ Future Opportunities?	What are the current challenges including future risks?	How are these challenges being managed?
DM01 improved during Q2& Q3 with additional capacity and focused recovery. Some recovery of long waits for Breast Reconstruction activity reducing the number waiting over 78 weeks. Cancer backlog for skin has reduced with focused funding from Cancer alliance and increased outsourcing.	1. Number of Patients waiting for planned treatment is increasing; industrial action impacting. 2. Significant issue with Plastic breast reconstruction services due to Consultant capacity. 3. Outpatient waits not reducing in line with expectations – further improvement work targeted to reduce follow up's increase PIFU and improve pathways for patients.	1. Improved governance processes for oversight of performance (delivery group. Cancer improvement group). New process standard work in place from January 2024. 2. Planned Care and Urgent Care SFT Boards in place to support transformation – focus on outpatient in Q4. 3. BSW Urgent care and Planned care boards well established to help support delivery.

ID	Directorate	Location (exact)	Opened	Source of Risk	Rating (initial)	Description	Likelihood (current)	Consequence (current)	Rating (current)	Actions	Action Due Date	Action Done Date	Action Lead	Source of Review	Review Date	Rating (target)	Assurance Framework Link (AF Risk Ref)	Assurance Committee	Executive Lead	Risk Owner	Date Escalated to Corporate Risk	Controls in Place	Gaps in Control	Assurance on Controls	Gaps in Assurance
5955	Finance and Procurement	Trustwide	13/08/2019	Trustwide risk assessment	15	Insufficiently robust management control procedures across the organisation which pose a financial, reputational, legal and operational/clinical risk.	Do not expect it to happen again but it is possible	Moderate	6	Reviewing Trust wide risk training, aiming to roll out programme to all middle managers	31/03/2020	17/06/2020	Thomas, Lisa	Trust Board	31/12/2024	6	Population	Trust Board (Corporate Risk Register)	Director of Finance	Ellis, Mark	13/08/2019	SFI's standard operating procedures corporate policies (e.g. HR) Governance assurance map risk register Leadership development programme in place Regular finance training provided for budget holders	-Education and training on management of risk across the organisation.	-Low levels of reported Fraud -low volume of litigation -head of internal audit opinion -Infrequent high risk audit findings -Internal audit reports highlighting weaknesses in controls and processes. (Auditors are assured by responsiveness of recomendations)	N/A
										Process mapping underway for business critical controls	31/12/2019	16/12/2019	Thomas, Lisa											
										Trust identifying additional procurement training for those areas of non compliance across the organisation. New process targeting individuals starts in November 2019.	29/03/2020	17/06/2020	Willoughby, Kelly											
										Trust developed draft risk training specification for additional support for directorates- view to tender and award before December 2019.	31/12/2020	07/01/2021	Thomas, Lisa											
										Introduce a monthly informatics department management committee that feeds into monthly executive performance reviews	31/10/2019	18/10/2019	Burwell, Jonathan											
										Approval of IT General Controls plan at Informatics DMC and ratify at exec performance review	31/01/2020	02/03/2020	Scott, Andy											
										Approach to testing of backups agreed	20/03/2020	02/03/2020	Cowling, Andrew											
										All IT system contracts reviewed with IAA and IAO confirmed and delivery of duties being monitored	31/12/2020	15/12/2020	Burwell, Jonathan											
										Full review of informatics standard operating procedures including putting in place monitoring processes	30/06/2022	06/01/2023	Scott, Andy											
										Full implementation of IT general controls framework	31/12/2021	12/03/2021	Scott, Andy											
										Complete a stocktake of all IT operational infrastructure	31/01/2020	02/03/2020	Burwell, Jonathan											
										Implement a robust asset management system	30/10/2020	01/07/2020	Burwell, Jonathan											
										Implement a centralised rolling replacement programme for computers, laptops and iPads	01/04/2020	28/04/2020	Burwell, Jonathan											
										Complete review of IT security policies	30/10/2021	09/12/2021	Burwell, Jonathan											
										Review of existing storage locations of Informatics SOPs to centralise and improve searchability though using modern software such as CITO or Sharepoint	31/08/2021	16/08/2021	Burwell, Jonathan											
										Embed improving together methodology in performance review reporting structure.	31/01/2023	04/05/2023	Ellis, Mark											
										Development of a standard budgetary management and control training pack for leaders and managers	29/12/2023	29/12/2023	Ellis, Mark											
										Financial management responsibilities reflected in managers ' appraisal process	30/06/2024	05/06/2024	Ellis, Mark											
7078	Transformation & IM&T	Trust Offices	12/10/2021	Trusts Objectives	12	As a result of competing priorities and deliverables there is a risk of slippage of the Improving Together work programme deadlines. The impact of this would be a delay in the pace and scale of the rollout of our shared continuous improvement approach across the Trust and within the AHA.	o happen again but it is possible	Moderate	6	Use of existing PMB groups to address issues on A3 content	22/11/2021	14/01/2022	Cox, Emma	ive Director Meeting	31/12/2024	6	People	(Corporate Risk Register)	of Medical Officer	Talbott, Alex	13/10/2021	Responsibility for delivery sitting with Director of Improvement. Executive oversight of delivery through the monthly Improving Together Board chaired by CEO. Reporting will include progress against the October 2024 to March 2026 roadmap and case studies from across the organisation on the benefit and impact of Improving Together. The Trust Board receive a quarterly board report from the programme board. In preparation for the monthly programme board report and quarterly Trust Board report each of the nine workstreams are reviewed and update by each of the workstream leads (Exec and manager leads)	05/06/24: Process confirmation of the routine use of Improving Together tools such as the improvement huddle boards and divisional weekly driver meetings. This is beginning to be picked up in Divisional Performance Review meetings and the Executive huddle.	- Monthly reviews in preparation for the Improving Together Programme Board between the Director of Improvement and the Head of the Coach House. - Reviews of the workstreams against the overall roadmap at the monthly Improving Together Programme Board and the programme board minutes. 05/06/24: Any off-track workstreams have known and owned actions in place to bring them back on-track. - Quarterly reports to Trust Board. - Monthly Engine Room reviews led by the Executives, including quarterly Engine Rooms taking in progress across the four boards: vision metrics, strategic initiatives, breakthrough objectives and corporate projects.	Behind trajectory of Improver Advanced training - 05/06/24: new training approach using masterclasses now in place to mitigate this - 03/09/24: It has been difficult to bring staff to this new set of classes. Attendance remains below optimal utilisation.
										SRO leads to prioritise the work and engage with specific task and finish groups	30/11/2021	14/01/2022	Cox, Emma											
										Executive to agree new road map by end of July.	31/07/2022	31/10/2022	Provins, Esther											
										Commence recruitment for Programme Director.	30/08/2022	29/12/2022	Collins, Peter											
										Sustainability workshop completed with Execs and KPMG. Produced roadmap and key area of priorities and assumption in the next 18 months. Detailed roadmaps and requirements to be presented to the Improving Together Programme Board in March 2023.	20/03/2023	09/06/2023	Cox, Emma											
										Recruitment to coach house to cover maternity leave (B6 improvement practitioner) for 6 months	29/09/2023	06/10/2023	Cox, Emma											
										Recruitment of the three B7 rotational Senior Improvement Practitioner roles into the Coach House. Await final approval of the business case at F&P on 26th September 2023.	31/10/2023	02/01/2024	Cox, Emma											

						This could result in the Trust not being able to improve performance (quality, people, operational & financial) as far as it could have if the programme had stayed on track.	Do not expect it to			Review of training delivery approach and programme in order to bring the Trust back on trajectory. This includes learning from the past year of training delivery within current structure	29/02/2024	05/06/2024	Cox, Emma	Executi			Trust Board	Chi			workstream leads (Exec and manager leads). Risks relating to the programme are reviewed on a monthly basis by the Director of Improvement and the Head of the Coach House. This generates new and refresh mitigations as the risk and resultant issues develop month-by-month. E.g. Coach House staffing changes. 03/09/24: Coach House beginning to track if improvement huddles are active and supporting teams to set up their performance review meetings.	03/09/24: No systematic process to review the active use of improvement huddle driver meetings and performance review meetings.	-Training continues to be on-trajectory with the Coach House team prioritising training delivery while staffing capacity is constrained. 05/06/24: - Review and monitoring of training place utilisation on a weekly and monthly basis by the Coach House team. - Quarterly maturity self-assessment by the divisional management teams 03/09/24: Starting to be able to describe how many active huddles and PRMs we have.	05/06/24: Process confirmation of the quarterly maturity self-assessment by the divisional management teams - who and how do we review the rationale and accuracy of the self-assessment.
										Develop and deliver the next Improving Together sustainability roadmap session on 15th July 2024 to map out the next 18 months of the programme (October 2024 to March 2026).	16/07/2024	03/09/2024	Talbott, Alex											
										Socialise and develop the October 2024 to March 2026 roadmap with the deputies, divisions and corporate leads. Develop the workstreams in more detail with the leads and their respective executive sponsors so that come October we can manage against each workstream via the Improving Together Board.	30/09/2024		Talbott, Alex											
6857	Finance and Procurement	Trustwide	12/03/2021	Financial management	6	There is a risk that weaknesses in controls give rise to an opportunity for fraud, in turn meaning the Trust incurs financial losses.	recur, but is not a	Minor	8	continue programme of fraud awareness and prevention with Counter Fraud team	31/03/2022	13/04/2022	Thomas, Lisa	Departmental Team meeting	30/06/2025	8	Partnerships	Trust Board (Corporate Risk Register)	Director of Finance	Ellis, Mark	12/03/2021	budgetary controls internal control procedures in built into financial systems between purchasing and paying training to all staff on induction	Standard operating procedures across the Whole Trust inconsistently applied	Counter Fraud reports budget monitoring reports fraud investigations low level reporting Risk assessment	investigative fraud allegations show sporadic gaps in
										Address the drivers of fraud- financial wellbeing of staff	30/06/2022	21/06/2022	Thomas, Lisa											
7955		Trustwide	01/01/2024	Waiting times	16	There is a risk that ongoing industrial action compromises the quality and timeliness of patient care, compromises operational effectiveness and impacts on the workforce morale.	Do not expect it to happen again but it is possible	Major	8	industrial action planning group - focusing on ensuring the hospital remains safe during industrial action and tries to minimise the disruption caused on elective programme.	12/07/2024	02/09/2024	Dickinson, Jane	Trust Board	30/09/2025	8		JBD, Trust Board (Corporate Risk Register)	Chief Operating Officer	Prosser, Niall	15/01/2024	EPRR infrastructure IA planning CGC oversight People and Culture committee TMC Pulse survey	Not able to look at longitudinal impact of patients receiving care during strike periods where staffing levels may be different. Minimum staffing levels means cancelling planned patient care due to availability.	Harm related incident reporting low during strike periods sickness levels static and not deteriorating	Patient waiting times increasing in planned care cancelled procedures during strike period cancer performance compromised
										post industrial action review of the impact on elective waiting lists and any potential harm that has been caused	12/07/2024	02/09/2024	Dickinson, Jane											
8054	Chief Executive	Trustwide	09/04/2024	Clinical Governance	9	As a result of out of date policies in Microguide, there is a risk that mandated processes and procedures may not be followed correctly which may result in compromised quality of care for patients and negatively impact workforce practices. This may result in regulatory action.	May recur occasionally	Moderate	9	Meeting with all Divisional Management Teams to agree policy management framework	28/06/2024		Nye, Kylie	Trust Management Committee	27/09/2024	6		Trust Board (Corporate Risk Register)	Director of Integrated	Nye, Kylie	09/04/2024	Microguide system to access all policies and guidelines. Oversight of policy compliance reported to Trust management Committee. Dedicated resource in some divisions (W&NB specifically) providing oversight of compliance	Microguide system functionality is limited - resource intensive to manage. Consistent ownership and oversight of policy management across all divisions. Capacity of policy owners to review	Improving picture of compliance with out of date policies No reported incidents relating to out of date policies	Approx 70-100 out of date policies
										Draft a new policy management framework	28/06/2024		Nye, Kylie											
										Policy Summit to be held 3rd September	30/09/2024		McNeight, Fiona											
7472	Organisational Development and People	Organisational Development & People Department	12/10/2022	Trustwide risk assessment	16	As a result of staff absences, higher than benchmark turnover (in the southwest)of existing staff and hard to recruit to posts (particularly medical), there is a risk that SFT is unable to manage service provision and operate a safe hospital. Updated 22/08	May recur occasionally	Moderate	9	Staff resource plans identified and agreed with Divisional Management Teams.	31/03/2024	12/06/2024	Crowley, Ian	Trust Board	31/12/2024	9	People	Trust Board (Corporate Risk Register)	Director of Organisational Development and People	Whitfield, Melanie	12/10/2022	Monthly analysis of Workforce Data against Staffing Availability levels Breakthrough objective - turnover - people promise improvement projects Targeted attraction and recruitment campaigns against identified priority vacancies. Line management training to support delivery of Career and well being conversations. Weekly divisional and trust workforce control panels. Monthly financial recovery - workforce - include oversight vacancies and bank and agency. First 90 day and 1 year anniversary feedback events. Hearing it campaign. We have a specialist interim involved in resource planning and strategic workforce management. AHA clinical strategy to meet long term NHS workforce plan targets Quarterly nursing safe staffing meetings. Nursing skills mix bi-annual reviews. Updated 22/08	Limited resources to deliver the NHS Widening participation agenda. Line management confidence to manage absence and grievance procedures. Insufficient wellbeing and career conversations. Further review of exit process and appraisals are required Updated 22/08	Improving KPIs for vacancy rate, time to hire, and sickness absence control - slowly improving staff retention. 22/08: Lowest vacancy rate and time to hire than we have ever had. Positive trend on quarterly pulse survey. 22/08	Number of days absence/time lost due to short intermittent periods of absence being effectively managed. Improving control and effective management of temporary staffing numbers. 22/08: Limited meaningful data from exit interviews Updated 22/08
										Mechanism to manage career pathways and career conversations delivered.	14/01/2023	07/06/2023	Crowley, Ian											
										Delivery of the widening participation initiative.	31/07/2024	22/08/2024	Crowley, Ian											
										Recruitment processes optimised (pwc recommendations implemented).	30/04/2023	07/06/2023	Crowley, Ian											
										Movers and leavers project delivered.	31/12/2024		Crowley, Ian											
										People Promise actions for this year to be delivered.	31/03/2024	12/06/2024	Crowley, Ian											
										Health and Well-being plan delivered.	30/09/2023	17/09/2023	Crowley, Ian											
										Exit and appraisal policy review and application.	31/03/2024	12/06/2024	Whitfield, Melanie											
										12/06: Ongoing delivery of all elements of the People Promise.	31/10/2024		Whitfield, Melanie											
										12/06: Conclude the line management skills build pilot in July and launch trustwide.	30/09/2024	22/08/2024	Crowley, Ian											
7573	Operations Directorate	Trustwide	16/01/2023	Bed meeting	15	The risk of sustained use of escalation bed capacity (e.g. DSU, Discharge lounge, intervention radiology & boarded beds) has an impact on patient safety and experience due to not enough substantive staff for increased bed capacity, patients not always placed initially in most appropriate ward. The more beds the Trust has open the impact on operational effectiveness, e.g. ward rounds, clinical support services.	May recur occasionally	Moderate	9	Urgent and Emergency Care Board established to hold transformation programmes to reduce bed occupancy	29/09/2023	07/09/2023	Thomas, Lisa	Trust Board	31/12/2024	9	Population	Trust Board (Corporate Risk Register)	Chief Operating Officer	Prosser, Niall	16/01/2023	site report, clinical safety huddle patient safety meeting nurse staffing meetings x2 daily urgent care board	system plans for reduction in NCTR including use of additional bedded capacity	Bed occupancy has started to reduce whiteparish ward closed to enable refurbishment Number of patients in ED waiting for bed overnight reducing	Number of beds open still higher than core bed footprint NCTR remains higher than expected Turnover of staff increasing
										expansion of SDEC to surgery and Gynae specialities to further prevent admissions and need for beds	29/12/2023	15/01/2024	Thomas, Lisa											
										work with BSW on NCTR reduction plan - particularly those waiting for care Act assessment in beds	29/12/2023	15/01/2024	Thomas, Lisa											
										finalise winter plan to optimise flow, including OPEL levels, escalation protocols	31/10/2023	15/01/2024	Thomas, Lisa											

7239	Finance and Procurement	Procurement	10/03/2022	Other assurance not listed	12	All Trusts across the region are experiencing ad hoc issues within the supply chain resulting in products being out of stock, having longer lead times or with delays in delivery. This means the Supply Chain team within Procurement are needing to be reactive to the situation and challenges as they unfold to mitigate these risks which creates additional pressure on the team and, on occasion, can impact operational activity across the Trusts. The challenges come from a number of factors including the impact from the Covid-19 pandemic and EU exit and economic and global disruptions which are all out of the control of our local procurement team and who are often only made aware that a product will be delayed at the last minute.	May recur occasionally	Moderate	9	Dedicated time is allocated on a weekly basis to highlight and review any risks on stock issues across the ICS and the Supply Chain teams are implementing a daily huddle to highlight risks and increase communication. Actions are also underway to understand how we can use the data we have available to help us manage supply chain disruption issues.	27/09/2024		Christoforidis, Stefanos	Departmental Team meeting	27/09/2024	6		Trust Board (Corporate Risk Register)	Director of Finance	Webb, Rob	05/06/2024	As this is a national challenge NHS Supply Chain are continuously reviewing the situation to source alternative products and have invested in more storage space to be able to hold more stock to support local NHS Trusts, therefore reducing the risk of out of stock items and delayed deliveries. Procurement also sit on the Southern Customer Board and have regular routine engagement with NHS Supply Chain so we can keep up to date with challenges as they unfold. To further mitigate the risks and reduce the impact at a local level our supply chains continue to improve their ways of working across the region and have regular routines and communications each week to share information and when needed products to avoid any Trust going out of stock of an item. Procurement have a standard approach across the ICS to finding an alternative product meaning that work isn't duplicated and information can be cascaded quickly and efficiently across the 3 Trusts	With so many orders released and deliveries expected daily we do not have the resource to make sure we are checking that all expected orders have arrived on time or engage with the suppliers to confirm lead-times in order to mitigate this risk further. It is only recently that the volume and frequency of these challenges are having such and impact and so our team are not resourced to be able to support micro management of orders. A robust and formal process to contract manage critical contracts across the ICS is anticipated to reduce the risk of issues in our supply chain. A formal review process is being implemented at SFT shortly with a view that if successful this would be rolled out across GWH & RUH.	Assurance that the current controls are working can be taken from the number of items that do result in being out of stock against the number of stock issues the procurement department are managing on weekly basis. Services are not being disrupted because the Procurement team are working with stakeholders to identify alternative products. Further the Trusts across BSW have greater resilience than if they were working alone as it is easier to see stock available at other locations and share this when needed.	*
8174	Surgery	Audiology	30/07/2024	NHS England	10	A national review of paediatric audiology assessments has identified variation in practice/quality that may have underdiagnoses hearing loss in young children. A reginal assessment of SFT services has identified a high risk of potential harm and mandated a detailed review of @200 cases from 2017 to the present. There is a risk that the assessment could discover significant harm to children and this	Do not expect it to happen again but it is possible	Catastrophic	10	Service doing retrospective harm review, consistent with NHSE incident requirements.	31/03/2025		Smith, Rory	Clinical Governance Committee	31/12/2024	5	Population	Trust Board (Corporate Risk Register)	Chief Medical Officer	Murray, Dr Duncan	30/07/2024	National agreed process for review is being coordinated by NHS England and BSW ICS well engaged leadership team in audiology have been recognized by the initial review visit and the service is felt to be safe to continue with extra measures (external double reporting) agreed action plan for remediation including national accreditation scheme	Department have identified that it will take time and resources to attain national accreditation Extra resource may be required to complete historic reviews in a timely fashion (this is being supported by NHSE)	Initial review identified a good culture of improving and ownership of the issues within the department Clinical Governance Committee is sighted on the risk and has requested regular updates Process of historic review has been agreed with department and ICB and region.	until the retrospective review is complete the extent of any harm will not be known
8188	Surgery	Endoscopy	08/08/2024	Complaints, Directorate risk assessment, Incident reports	12	ERCP is highly technical and intrinsically high risk procedure with exacting training and regulatory requirements. In a challenging market SFT has been unable to recruit substantive ERCP practitioners for several years. ERCP is therefore currently delivered by an outsourcing company providing one session for ERCP per week, with no cover for annual leave. On its own this arrangement provides no ability to flex capacity to meet peaks in demand, or to always accommodate patients with severe illness who need intervention before the next available list. Therefore some patients will not get timely intervention, with acute inpatients suffering deterioration in their condition possibly resulting in worsening organ failure, and outpatients waiting longer, resulting in a poor experience and possibly developing complications while waiting.	May recur occasionally	Major	12	Intensive support for GI services	31/12/2024		Murray, Dr Duncan	Directorate Management Team Meeting	08/10/2024	9	Population	Trust Board (Corporate Risk Register)	Chief Medical Officer	Murray, Dr Duncan	09/08/2024	1. Clinicians in Southampton offer ad hoc support for complex cases that should be performed in tertiary units, and more clinically urgent cases that cannot wait to the next scheduled SFT session 2. There is some limited ability for the outsourcing company to deliver additional sessions to cover peaks in demand 3. An ERCP patient tracker has been introduced to have oversight of demand and waiting times, and to support most appropriate booking priority within the constraints nof available capacity. Introduction of tracker improves anticipation of capacity and access challenges to allow earlier escalation	1. The arrangement with UHS is ad hoc, reliant on good will and not supported by an SLA 2. Attempts at substantive recruitment to SFT posts have failed, and multiple options to provide more resilient and sustainable support from local partners in UHS and UHD have failed 3. An option to redeploy surplus capacity from a BSW AHA partner is being explored at executive and service level	1. Outcomes from the procedures that are performed at SFT (approx 115 per year) are satisfactory compared to regulatory standards	1. Recent complaint and related incident report 2. Informal concerns raised by service users (referring gastroenterologists) 3. Discussions with respected external expert opinions criticising service structure and model of provision
7574	Operations Directorate	Trustwide	16/01/2023	Service Delivery Plan	15	The continued pressure from urgent care flow alongside the increases in length of stay, compromises the ability for the Trust to undertake planned care.	Will probably recur, but is not a persistent issue	Moderate	12	Outpatient transformation programme request for additional support - to ensure progress in reducing patients waiting, reduction in follow ups and increased in PIFU	29/09/2023	07/09/2023	Thomas, Lisa	Weekly Delivery Group	30/08/2024	9	Population	Trust Board (Corporate Risk Register)	Chief Operating Officer	Prosser, Niall		delivery Group IPR EPR meetings with Divisions Planned care board Theatre productivity programme BSW Elective Care Board N	Impact of NCTR patients on available bed capacity no real reduction in time to first outpatient appointment risking 78 WW	Longer waits over 78 weeks 104 week waits on trajectory growth in waiting list fairly stable	some specialities under pressure for 52 benchmark lower for productivity that comparable Trusts can't achieve 2019/20 levels of activity due to bed capacity
										Work with Wiltshire Alliance to reduce NCTR impacting on elective beds through the development of virtual wards, discharge hub and pathway changes for non bedded capacity.	29/09/2023	07/09/2023	Thomas, Lisa										
										planned care board to focus on outpatients for the next three months in line with NHS letter 2/8	30/12/2023	15/01/2024	Thomas, Lisa										
										winter plan includes expansion within DSU for chairs to mitigate against winter escalation	29/12/2023	15/01/2024	Thomas, Lisa										
										New ward opens with new timetable for April/May 2024 to increase planned care capacity	30/04/2024		Thomas, Lisa										
7807		Trustwide	16/08/2023	Incident reports, Trustwide risk assessment, Violence and Aggression	20	As a result of a lack of community and acute mental health provision there is a risk that patients with specialist mental health needs are being managed in the acute setting. This may result in sub-optimal care with less therapeutic value than if undertaken in the right setting with appropriately trained staff.	but is not a persistent issue	Moderate	12	Agree an approval algorithm for mental health 1 to 1 support with AWP.	28/02/2024		Osman, Laura	Trust Board	31/12/2024	9	Population	Trust Board (Corporate Risk Register)	Director of Nursing	Murray, Dr Duncan	16/08/2023	Daily review of mental health needs across the organisation and identify staffing requirements. Use of agency RMNs. As required Meetings with key agency to discuss current patients and plans to	Availability of adult mental health beds and tier 4 CAMHS beds. Inconsistent standards of agency RMN skills and knowledge. 02/09/24: Out of hours cover provision is at arm's length. Recent	~~Recent audit 28/03/24 demonstrated~~ improved compliance with Mental Health Act. 02/09/24: Operational KPIs of MHLS consistently good.	Long length of stay for mental health patients requiring community or MH inpatient facilities.
										Ongoing collaboration with partners at ICS and regional level related to Mental Health Provision.	31/03/2024		Murray, Dr Duncan										
						As a result of competing priorities, shifting resource plans and sub-optimal scoping of projects there is a risk that transformation	not a persistent issue	te		Training refresher on project documentation in the transformation team	29/03/2024	05/06/2024	Arnett, Louise	nt Team Meeting	24		on	e Risk Register)	formation	Alex		05/05/24: Transformation programme Boards, including Digital Steering Group (DSG) Resource scheduling bi-weekly meeting Urgent and Emergency Care and Planned Care Boards Small projects Board	Capacity and capability to deliver to time 03/09/24: A routinely used	Good knowledge of transformation programmes and projects underway 05/05/24: Monthly review of on/off-track to project/programme plan at Transformation team Performance	Programme slippage remains in some projects started
										Track project delivery via transformation senior leadership team meeting	29/03/2024	05/06/2024	Talbott, Alex										
										Continue to strengthen the role of Corporate Project Prioritisation Group (CPPG) by ensuring it runs monthly and routing resource requests and major resourcing changes via CPPG.	30/09/2024		Talbott, Alex										

7946	Transformation & IM&T	Trustwi	02/01/2024	Departmental risk assessment	12	projects there is a risk that transformation programmes and projects will not be delivered to time which may result in the Trust not realising the benefits of the work and delaying the start of new work.	Will probably recur, but is	Modera	12	05/06/24: Implementation of standardised project documentation - including scoping, scheduling and project plan sign off by the SO.	30/06/2024	31/07/2024	Arnett, Louise	Directorate Manageme	30/09/2(	9	Populati	Trust Board (Corporat	Director of Trans	Talbott, A	02/01/2024	Small projects Board Corporate Projects Prioritisation Group feeding into the Engine Room Project documentation to support delivery 03/09/24: Annual review of transformation workplan and resource alignment in conjunction with business planning round started in Sept/Oct 2024.	03/09/24: A routinely used standardised approach to scoping and scheduling projects with robust SRO engagement with the timeline (i.e. we have the standard, but do we use it routinely?)	Transformation Team Performance Review Meeting. 03/09/24: Increasing use of standard scoping and project documentation across the Transformation team is increasing accuracy of timelines and what's needed to achieve them.	before the introduction of the new standards. Sub-standard documentation.
										Support provided to the Project Managers to practise and develop their knowledge of the Programme Management Industry Standard (PMIS) as all new projects and programmes are stood up. Peer review to be used to highlight best practise and share learning.	31/10/2024		Lewis, Neil											
7734	Finance and Procurement	Finance Department	16/06/2023	Financial management	15	Shortfall in funding available (locally and nationally) for capital programme, leading to a potential risk to the safety and availability of buildings and equipment to deliver services.	Will undoubtedly recur, possibly frequently	Moderate	15	2024/25 medical equipment brought into 2023/24 as backfill against estates program slippage.	31/03/2024	05/06/2024	Ellis, Mark	Finance and Performance Committee	31/12/2024	8	Resources	Finance Committee, Trust Board (Corporate Risk Register)	Director of Finance	Ellis, Mark	21/09/2023	- capital control group priorities capital programme - monitor Datix incident reporting related to infrastructure and equipment.	- financial constraints on ability to address whole scale estate risk. - unclear regional/national process for emergency capital bids	- incident reporting highlighting areas of concern - sub groups maintain 5 year capital plans providing visibility of programme deliverables and gaps	- increasing level of maintenance required - increasing number of incidents of operational disruption
										24/25 Capital monitoring in place. Ongoing processes. Board reporting continues, including specific updates on digital & estates.	31/12/2024		Ellis, Mark											
5751	Operations Directorate	Discharge Team	11/03/2019	Directorate risk assessment	15	Risk of patient harm caused by patients remaining in hospital when their clinical need does not require this (no right to reside). This risk is caused by capacity/resource constraints in out of hospital care. 02/09/24: Failure to reduce NC2R is leading to increased bed occupancy and delaying continued financial recovery.	Will undoubtedly recur, possibly frequently	Moderate	15	Winter director managing Trustwide ECIST actions.	01/05/2019	12/06/2019	Hyett, Andy	Trust Board	31/12/2024	12	Population	Trust Board (Corporate Risk Register)	Chief Operating Officer	Prosser, Niall	11/03/2019	Site and Flow meetings 3x a day. Specific medicine ward level discharge meeting Daily reporting and monitoring. System escalation plan revised and approved. Patient flow score card monitoring delivery of KPIs. Expert panel which reviews all patients with LoS over 7 days with CTR. Monthly urgent care board which the COO attends. Deputy Chief Operating Officer role in place. No right to reside is an approved breakthrough objective as part of the Improving Together Programme Improved data quality Improved use of e-Whiteboards on wards. 02/09/24: Working groups with BSW system to improve discharge process and capacity. Experienced subject matter experts - focussed on work to resolve current issues.	Reporting of timelines in patients journeys challenging with current IT systems. - capacity gap in Council for domiciliary care which means significant shortage of available care hours. 02/09/24: Complexity in pathway management is leading to delays in discharge.	02/09/24: Monthly reporting of number of patients waiting for discharge & pathways is well understood.	Understanding of discharge process at ward level (nursing and medical) is inconsistent. Use of e-whiteboards although improved is still inconsistent with no training delivered to new starters. 02/09/24: Understanding headline number in place but further work required to truly understand reasons for delays.
										Winter Director coordinating trajectory for delivery of DTOC target.	01/05/2019	12/06/2019	Hyett, Andy											
										Trust actions being led by COO and Medicine CD and managed through weekly delivery meeting and monthly PMB.	01/05/2019	12/06/2019	Hyett, Andy											
										Weekly expert panel meeting to challenge discharge pathways chaired by CCG director of quality.	01/05/2019	12/06/2019	Hyett, Andy											
										Trust implementing discharge PTL	01/07/2019	04/09/2019	Hyett, Andy											
										Escalation to EDLDB non delivery of trajectory	01/07/2019	04/09/2019	Hyett, Andy											
										Mitigation actions being prepared to mitigate lack of capacity in the community.	01/08/2019	04/09/2019	Hyett, Andy											
										All providers required to present their winter plans to EDLDB in September.	30/09/2019	22/10/2019	Hyett, Andy											
										Business case to expand ESD service going to TMC in September and COO and DoF meeting Wiltshire Health and Care to align services	30/11/2019	10/12/2019	Hyett, Andy											
										CEO DOF and COO representing SFT at system wide winter summit on 25th October 2019.	31/10/2019	10/12/2019	Hyett, Andy											
										COO representing Trust at Regional Workshop w/b 9th December	14/12/2019	04/03/2020	Hyett, Andy											
										System wide actions to be monitored through the ED local delivery board.	01/04/2020	28/04/2020	Hyett, Andy											
										COO escalating the need for an ED LDB risk log reflecting the risks carried by each provider organisation.	19/12/2019	04/03/2020	Hyett, Andy											
										Risk to be captured on newly developed ED Local Delivery Board Risk Register.	31/03/2020	28/04/2020	Hyett, Andy											
										Action plan to be developed for 2021 by Urgent Care Board.	31/03/2021	04/05/2021	Hyett, Andy											
										Reinstate the challenge of stranded patients by the Medical Director by the end of October.	01/11/2020	20/10/2020	Hyett, Andy											
										Development of Transformation Programme for improved Discharge processes.	31/05/2021	28/06/2021	Hyett, Andy											
										Agreement of system escalation triggers.	31/05/2021	28/06/2021	Hyett, Andy											
										Review of bed modelling in light of increased urgent and elective activity.	31/05/2021	30/06/2021	Humphrey, Kieran											
										Agreement of Improvement Trajectory with system partners.	30/07/2021	08/10/2021	Hyett, Andy											
										Delivery of the Transformation Improvement Plan.	30/11/2021	30/12/2021	Wood, Paul											
										Delivery of the BSW Urgent Care Board discharge improvement plan which the Trust is contributing to	31/10/2022	11/10/2022	Thomas, Lisa											
										Trust working with BSW on delivery of 57 additional community beds at South newton from November.	30/11/2022	28/12/2022	Thomas, Lisa											
										Trust developing winter plan for implementation focusing on pathway 0 patients to maximise available bed capacity	31/10/2022	28/12/2022	Thomas, Lisa											

										Discharge Hub being established at SFT to support efficient and effective discharge process and improve partner working	29/09/2023	14/08/2023	Cavill, Emma																			
										SFT to complete bed modelling and potential pathway improvements with Wiltshire Place colleagues	30/11/2023	15/01/2024	Thomas, Lisa																			
										Further engagement with system partners to understand their actions	25/09/2024		Cavill, Emma																			
										02/09/24: Established A3 approach - Support delivery of NC2R challenges & joint system working group implementation.	31/12/2024		Prosser, Niall																			
5360	Transformation & IM&T	Information Technology	28/02/2018	Data Protection	15	Risk of a cyber or ransomware attack, resulting in the potential loss of IT systems, compromised patient care and financial loss.	May recur occasionally	Catastrophic	15	02/10/18 IT Technical group on 8/10/18 to discuss what Anti virus software should be purchased	10/10/2018	14/12/2018	Noble, Bob	Digital Steering Group	30/10/2024	8	Population	Trust Board (Corporate Risk Register)	Director of Finance	Burwell, Jonathan	11/02/2020	- Information Security Team in place to proactively manage CareCERT compliance, Team trained on software being used in cyber protection - IG/Data protection walkaround to test understanding - Digital Steering Group oversight of cyber plans - Security patching controls - Multifactor authentication on NHS Mail - Core Infrastructure replacement including best practice firewalls configuration - Medical equipment and IoT monitoring - Modern and secure cyber security technologies including VPN, antivirus, bitsight, endpoint protection, vulnerability scanning, PAM, SIEM, password monitoring, etc - Cyber awareness programme and phishing feedback/retraining - Member of ICB TDA Cyber Group - Members of National forums including Cyber Associates Network and Cyber Executives Forum - Close engagement with NHSE regional cyber lead - Microsoft Defender on all client devices and servers	- A number of outstanding devices for Critical CareCERT. Log4j critical careCERT is a significant wide ranging risk that is considered. - A number of MDE alerts in last 12 months related to staff clicking on phishing emails.	Informatics Tech Group oversees progress in CareCERT/High Security Alert compliance, patching monitored and wider cyber activities. IT Health dashboard monitoring including High Security Alert dashboard. Quarterly digital update to F&P Annual penetration test results Board agreed moderate risk appetite for cyber security risk in 2024 IG, DP and Cyber related Policies in place and up to date. Rolling progress of desktop exercises to test business continuity plans and preparedness Trust compliant with DSPT assessment and DSPT Internal Audit Report and Phishing testing Microsoft Deference Endpoint reports All devices on supported version of Windows (Windows 10 version 21H2) Unsupported service replacement programme	Poor recent phishing exercise results. Improvements in cyber security preparedness. A requirement to extend multifactor authentication. Additional supplier assurance required given recent cyber attacks on supply chain.
										Completion of KPI report for Cyber	17/09/2021	12/10/2021	Badham, Gareth																			
										Completion Log4j Critical CareCERT mitigations that are currently available.	30/03/2023	22/05/2023	Gibson, Richard																			
										Implement Privileged Access Management solution	30/03/2024	09/05/2024	Gibson, Richard																			
										Rollout of SpecOps	16/12/2022	16/12/2022	Gibson, Richard																			
										Procure a solution to monitor networked medical devices	31/03/2023	22/05/2023	Gibson, Richard																			
										Undertaken awareness of Metacompliance training, focusing on Phishing	30/10/2023	30/10/2023	Gibson, Richard																			
										Review of additional actions required to increase cyber preparedness	30/10/2024		Burwell, Jonathan																			
										Action plan to improve awareness of phishing attacks and retraining of those who failed recent test MLE new content - Liam T Face to Face delivery - Liam T report to DSG - SL rerun specific exercise - JB (Jignesh)	30/09/2024		Gibson, Richard																			
										Deliver implementation plan for multi-factor authentication across suppliers.	31/12/2024		Gibson, Richard																			
										Undertake additional assurance exercise with key suppliers (both digital and non-digital)	31/12/2024		Burwell, Jonathan																			
										Ongoing recruitment drive.	30/09/2019	25/04/2019	Clarke, Lisa																			
										Continual clinical prioritisation to ensure that high risk areas are covered.	01/04/2019	17/04/2019	Clarke, Lisa																			
										Continuing insourcing of private provider to endoscopy.	30/06/2019	25/04/2019	Vandyken, Mrs Ali																			
										Quantification and mitigation of the risk to bowel scope.	01/04/2019	17/04/2019	Vandyken, Mrs Ali																			
										Tender for elements of the Gastroenterology service.	01/04/2019	17/04/2019	Stagg, Andrew																			

5704	Surgery	Trustwide	31/01/2019	Directorate risk assessment	16	A risk that the current lack of substantive Gastroenterology medical and nursing workforce will impact on the ability of the service to deliver sustainable comprehensive safe and effective care to patients.	Will probably recur, but is not a persistent issue	Major	16	Monthly update to F&P Committee and CGC.	10/05/2019	25/04/2019	Hyett, Andy	Intensive Support Meeting	31/12/2024	8	Population	Trust Board (Corporate Risk Register)	Chief Medical Officer	Murray, Dr Duncan	31/01/2019	Sustainable provision of service through use of long-term locums provided by ID Medical. Ongoing recruitment efforts for specialist nursing and unfilled medical posts. May 2023 - New Fixed term gastroenterologist starting end of May 23 August 23 - Deputy CMO commissioned to provide oversight of the service and to describe road map to sustainability through partnership with neighbouring acute Trusts. External support from senior gastroenterologist providing elements of IBD service October 23 - continued support from executive team for improvements with fortnightly assurance meetings. Partnerships with local GP in place and due to commence Nov 23 supporting with specific clinical pathways. 02/09/24: Further recruitment of fixed-term consultant gastroenterologists; currently only one ID Medical employed at SFT.	Unsuccessful recruitment to specialist Nurse roles, which has a particular impact on Hepatology and IBD service provision. Until substantive recruitment is complete, off site provision of GI Bleed on-call service will continue. May 2023 - Substantive consultant has handed in notice - leaving end of July 2023. Fixed term consultant going on Mat leave in mid June 2023. Clinical leadership of GI Unit changing hands. June 23 - Resignation of substantive consultant. August 23 - long term capacity and demand planning remains challenging due to non substantive medical workforce October 23 - business case in progress with Southampton hospital to increase support for ERCP / IBD services June 23 - Risk to service provision around ERCP, inflammatory bowel disease, and nutrition. 02/09/24: Resignation of fixed-term gastroenterologist and subsequent threatened resignation of single substantive gastroenterologist (current clinical lead).	Regular contract monitoring meetings with ID Medical. Monitoring of Key Quality Indicators demonstrating a safe service. 3 new substantive GI Consultants in post and providing oversight and assessment of current service performance. Additional service development time has been job planned for the new consultants to support development of the service and increased governance May 2023 - Reduction in Endoscopy long waiters. August 23 - endoscopy performance remains above peer average in BSW. external quality data does not suggest the Trust is an outlier. October 23 - Reduction in long waiters for both gastro and endoscopy through focussed attention on waiting lists 30/05:Current substantive Gastroenterologist as clinical lead for service. 02/09/24: Access times for first outpatient appointments in several sub-specialties have improved significantly. No increase in complaints for service. Regular audit of ERCP outcomes compliant with national benchmarking.	challenges. No service specific concerns identified currently. New consultants are uncovering new risks as they explore the service but action plans are being developed and will be raised as new specific risks. May 2023 - With fluctuation in staffing levels in endoscopy and gastro over the last 6 months there has been an impact on waiting list levels. Mitigations are in place to regain control August 23 - as June update. All subject to ongoing work overseen by Deputy CMO 02/09/24: Internal concerns being voiced by team members around quality, capacity and cultural issues within the team.
										Presentation of gastro strategy to Finance and Performance Committee.	31/05/2019	12/06/2019	Hyett, Andy																		
										Put together a workshop with CDs and Clinical Leads to discuss options for service provision.	01/10/2019	22/10/2019	Hyett, Andy																		
										Continue conversations and meetings with alternative NHS providers for likely future joint partnership for delivery of service	30/09/2019	29/08/2019	Henderson, Dr Stuart																		
										Medical Director to link with other STP partners around system wide solution.	31/12/2019	21/02/2020	Blanshard, Dr Christine																		
										Case for change to develop a GI unit to be completed	31/12/2019	04/03/2020	Hyett, Andy																		
										New GI unit to be launched on 1st April	01/04/2020	07/05/2020	Hyett, Andy																		
										To recruit medical and nursing staff for the GI Unit	28/06/2024		Insull, Victoria																		
										Confirm Southampton will be able to take over full responsibility for the GI Bleed out of hours service.	23/04/2021	23/04/2021	Branagan, Mr Graham																		
										Secure support for existing junior doctors	30/07/2021	31/08/2021	Branagan, Mr Graham																		
										Ongoing regular review of workforce strategy in GI unit	01/12/2021	20/12/2021	East, Rachael																		
										Recruitment to Nutrition Service Vacancy required.	31/01/2022	28/03/2022	East, Rachael																		
										Develop joint governance meeting between medicine and surgery	31/08/2023	20/11/2023	East, Rachael																		
										Recruitment of new clinical lead for GI Unit	31/05/2023	22/06/2023	Stephens, Mr Paul																		
										CMO to report outcome of GI services review once complete.	30/09/2024	02/09/2024	Murray, Dr Duncan																		
										Surgical division to provide assurance report on oversight of operational delivery and any impacts to quality to CGC on 27th June 2023.	27/06/2023	13/07/2023	East, Rachael																		
										Intensive support meetings to commence fortnightly from 24th July.	24/07/2023	17/08/2023	East, Rachael																		
										GI Unit enhanced support programme ongoing to identify strategic aims for 24/25 to address stats and service	28/06/2024		Insull, Victoria																		
										02/09/24: GI services to be put into intensive support	06/09/2024		Murray, Dr Duncan																		
6229	Surgery	Day Surgery Unit	04/03/2020	Access targets, Complaints, Departmental risk assessment, External audit reports, Incident reports, Other assurance not listed, Service Delivery Plan, Waiting times	12	[07/07/2023 12:00:42 Laurence Arnold] The DSU building is 'end of life' and has been identified as priority for replacement. The fabric of the building is problematic and leads to numerous roof leaks and delayed/cancelled procedures. Incidents relating to the building's condition are increasing and impacting on patient safety, care and experience.	Will undoubtedly recur, possibly frequently	Major	20	DSU risk escalated to wider stakeholders to ensure remains priority scheme for BSW and South West Region	13/06/2023	13/06/2023	Arnold, Laurence	Trust Board	31/12/2024	4	Population	Trust Board (Corporate Risk Register)	Chief Operating Officer	O'Keeffe, John	13/01/2023	[07/07/2023 12:00:42 Laurence Arnold] None ad hoc nature of issues results in limitations around mitigations. Staff manage individual cases and issues None ad hoc nature of issues results in limitations around mitigations.	[07/07/2023 12:00:42 Laurence Arnold] Substantial capital investment is required - the whole facility needs to replacing, necessitating national capital funding. Funding for new DSU. Poor environment for staff - lack of wellbeing facilities.	None Constant lobbying being undertaken to attempt to secure funding.	[07/07/2023 12:00:42 Laurence Arnold] Problems persist - Roof leaks, heating failures and significant investment identified in the critical plant survey (2020). Regular failure in AHU's resulting in patient cancellations Roof leaks, heating failures and significant investment identified in the critical plant survey (2020).
7308	Finance and Procurement	Trustwide	19/04/2022	Trusts Objectives, Trustwide risk assessment	15	The financial plan for 2024/25 is for an underlying deficit plan with assumed 6% savings. There is a material risk that the deficit will be larger than planned due to the operational constraints, inability to achieve financial savings and ongoing pressures related to patients with no criteria to reside. Cash balances have depleted and the Trust is engaged in NHSE cash support process. 02/09/2024: Increasing risk that improvement	ndoubtedly recur, possibly frequently	Major	20	Grip and Control processes reviewed in all Divisions to ensure robust financial governance	29/07/2022	11/10/2022	Thomas, Lisa	nance and Performance Committee	31/12/2024	9	Partnerships	nittee, Trust Board (Corporate Risk Register)	Director of Finance	Ellis, Mark	19/04/2022	Cash flow forecasting -- monitoring reports to F&P - SFI's ensuring strong financial governance - budget signed off for April 2024/25 based on internal assumptions - ICB transitional funding agreed. - Weekly agency usage monitoring - Fortnightly financial recovery group chaired by CEO - Enhanced vacancy control and temporary staffing process - System investment triple lock	- Delivery of 6% CIP dependent on external action - Uncertain impact of winter pressures, staffing gaps, and effects of industrial action	2023/24 efficiency plan delivered in full (5%) Improving Together methodology being used to underpin 24/25 programme. Continued upward trajectory in Trust productivity calculation. 16 theatres fully operational. 02/09/2024: Downward trend in nursing bank and agency - continued	Ongoing agency bookings - particularly hard to recruit to medical posts. Pay overspend Low theatre utilisation. Forecasted £17
										Divisions asked to identify full CIP and or productivity plans to ensure they manage within Budget for 2022/23	29/07/2022	11/10/2022	Thomas, Lisa																		
										Deployment of winter plans.	30/11/2022	15/12/2022	Ellis, Mark																		
										Seeking support for unfunded pressures from the ICB and SpecCom.	31/01/2023	31/03/2023	Ellis, Mark																		
										Review of agency booking process.	31/01/2023	31/03/2023	Whitfield, Melanie																		
										3-year forecast being undertaken in Q1, including risks and impact on cash flow.	29/09/2023	29/12/2023	Ellis, Mark																		

						02/09/2024: Increasing risk that improvement work around patient flow is offset by higher growth than what was planned.		Will un		Identification of additional savings opportunities managed through Divisions with oversight from FRG.	31/12/2024		Ellis, Mark		Fina			Finance Comm			02/09/2024: Medical rate card went live in August 2024.		reduction in UEC length of stay.	million deficit.
										Organisation wide communications strategy for financial recovery	30/09/2024		Ellis, Mark												

Corporate Risk Register Summary - September 2024 v1

Risk (Datix) ID	Risk Title	Exec Lead	Date Risk Added	Initial Score	Jan-23	Jun-23	Sep-23	Jan-24	Jun-24	Sep-24	Target
Risk Detail				Score Trend							
POPULATION - Improving the health and wellbeing of the population we serve											
5704	Inability to provide a full gastroenterology service due to a lack of medical and nursing workforce	Chief Medical Officer	31-Jan-19	16	9	15	15	15	12	16	6
5751	Risk of patient harm caused by a delayed discharge from hospital.	Chief Operating Officer	11-Mar-19	16	20	20	15	15	15	15	12
5955	Insufficient organisation wide robust management control procedures. **Risk tolerated**	Chief Finance Officer	13-Aug-19	15	9	9	9	9	6	6	6
7946	As a result of competing priorities, shifting resource plans and sub-optimal scoping of projects there is a risk that transformation programmes and projects will not be delivered to time which may result in the Trust not realising the benefits of the work.	Chief Medical Officer/Director of Transformation	02-Jan-24	12				12	12	12	9
6229	The DSU building is 'end of life' and has been identified as priority for replacement. The fabric of the building is problematic and leads to numerous rook leaks and delayed / cancelled procedures. Failure of the air handling unit is becoming a regular occurrence, this in turn affects the overall environment, prevents activity from taking place owing to infection control policies and results in cancellations of elective procedures. Incidents relating to the building condition are increasing and impacting on patient safety, care and experience	Chief Operating Officer	02-Jan-23	12	20	20	20	20	20	20	4

7573	The risk of sustained use of escalation bed capacity (e.g. DSU, Discharge lounge, intervention radiology) has an impact on patient safety due to not enough substantive staff for increased bed capacity, patients not always placed initially in most appropriate ward. The more beds the Trust has open the impact on operational effectiveness, e.g. ward rounds, clinical support services.	Chief Operating Officer	16-Jan-23	20	20	20	15	12	9	9	9
7574	The continued pressure from urgent care flow alongside the increases in length of stay, compromises the ability for the Trust to undertake planned care.	Chief Operating Officer	16-Jan-23	15	15	15	15	15	12	12	9
7807	As a result of a lack of mental health provision there is a risk that patients with specialist mental health needs are being managed in the acute setting. This may result in sub-optimal care with less therapeutic value than if undertaken in the right setting with appropriately trained staff.	Chief Medical Officer	16-Aug-23	20			20	15	15	12	9
7955	There is a risk that ongoing industrial action compromises the quality and timeliness of patient care, compromises operational effectiveness and impacts on the workforce morale.	Chief Operating Officer	01-Jan-24	16				16	16	8	8
8188	In a challenging market the Trust is unable to recruit substantive ERCP practitioners. ERCP is therefore currently delivered by an outsourcing company providing one session per week with no cover for annual leave. This arrangement provides no ability to flex capacity to meet peaks in demand, or to always accommodate patients with severe illness who need intervention. **New risk**	Chief Medical Officer	08-Aug-24	12						12	9

8174	A National review of paediatric audiology assessments has identified variation in practice/quality that may have underdiagnosed hearing loss in young children. A Regional assessment of SFT services has identified a high risk of potential harm and mandated a review of c200 cases from 2017 to date. There is a risk that the review could discover significant harm to children and this could result in reputational and litigation risk in the future. **New risk**	Chief Medical Officer	30-Jul-24	10						10	5
8054	As a result of out of date policies there is a risk that mandated processes and procedures may not be followed correctly which may result in compromised quality of care for patients and negatively impact workforce practices. This may result in regulatory action.	Director of Integrated Governance	09-Apr-24	9					9	9	6
People - Supporting our people to make Salisbury NHS Foundation Trust the best place to work											
7472	As a result of staff absences, higher than benchmark turnover (in the Southwest) of existing staff and hard to recruit to posts (particularly medical), there is a risk that SFT is unable to manage service provision and operate a safe hospital	Chief People Officer	12-Oct-22	16	16	16	16	12	12	9	9
7078	As a result of competing priorities and deliverables there is a risk of slippage of the Improving Together Programme deadlines	Director of Improvement	13-Oct-21	12	9	6	9	9	9	6	6
PARTNERSHIPS - Working through partnerships to transform and integrate our services											
6857	There is a risk that weaknesses in controls give rise to an opportunity for fraud, in turn resulting in the Trust incurring financial losses **Risk tolerated**	Chief Finance Officer	12-Mar-21	6	8	8	8	8	8	8	8

7239	Ad hoc issues within the supply chain resulting in products being out of stock, having longer lead times or with delays in delivery. The challenges come from a number of factors including the impact from the Covid-19 pandemic and EU exit and economic and global disruptions which are all out of the control of our local procurement team and who are often only made aware that a product will be delayed at the last minute **De-escalated from BAF June 24**	Chief Finance Officer	10-Jun-24	12					9	9	6
7734	Shortfall in funding available (locally and nationally) for capital programme, leading to a potential risk to the safety and availability of buildings and equipment to deliver services.	Chief Finance Officer	16-Jun-23	15		15	15	15	15	15	8
7308	The financial plan for 2022/23 is a deficit plan with assumed 2.2% savings. There is a material risk that the deficit will be larger than planned due to the operational constraints, inability to achieve financial savings and ongoing pressures related to patients with no criteria to reside. Therefore there is a risk that cash flow is challenged during the year resulting in the Trust having to take emergency cash measures.	Chief Finance Officer	12-Mar-21	15	16	20	20	20	20	20	9

Risk Score Key

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

Risk Appetite

NHS Salisbury NHS Foundation Trust

Report to:	Trust Board (Public)	Agenda item:	7.8
Date of meeting:	3rd October 2024		

Report title:	Risk Appetite			
Status:	Information	Discussion	Assurance	Approval
		x		x
Approval Process: (where has this paper been reviewed and approved):	Definitions developed by subject matter experts. Risk appetite proposal presented to Trust Board Development Day in February 2024 and further presentation at Public Trust Board in July 2024. Each Committee has received and reviewed their risk types and categories in September 2024			
Prepared by:	Fiona McNeight, Director of Integrated Governance			
Executive Sponsor: (presenting)	Fiona McNeight, Director of Integrated Governance			
Appendices	N/A			

Recommendation:

The Trust Board is asked to:

- Approve the risk category definitions.
- Approve the risk appetite level descriptors for each risk category.
- Approve the risk tolerance level proposed for each risk category (outlined in red).
- Approve the overall risk type tolerance level (based on the risk category tolerance levels within the risk type).

Executive Summary:

The risk appetite approach was first proposed at the Board Development Day in February 2024. It was agreed that there would be a phased approach to support development of risk definitions and risk appetite level descriptors for approval by Trust Board.

Subject matter experts developed these for the workforce risks, operational risks and clinical risks and these were presented at Trust Board in July 2024. The Board proposed that the definitions and descriptors for the remaining 2 risk types (financial and external risks) should be developed and the Board committees to review the relevant risk types in September prior to final approval at Trust Board in October 2024.

The Board Committees have reviewed the following:

- Clinical Governance Committee – clinical risk
- People and Culture – workforce risk

- Finance and Performance – operational risk and financial risk
- Executive – external risk

Risk definitions and risk appetite level descriptors have now been developed for each of the 24 risk categories. The Board Committees have reviewed the risk definitions, the risk appetite level descriptors and the proposed risk tolerance level for each risk category and the overall risk tolerance level for each of the 5 risk types have been determined based on this.

Following feedback at Finance and Performance Committee the following changes were made to the risk appetite:

- Counter Fraud Risk was updated to a 'Averse' risk appetite level (green)
- Financial Reporting Risk was updated to a 'Minimal' risk appetite level (blue)

This did not impact the overall risk type tolerance level for financial risk, which remains at 'cautious'.

Following feedback at Clinical Governance Committee the following changes were made to the risk appetite:

- Infection, Prevention and Control was updated to a 'Minimal' risk appetite (blue).

This has impacted the overall risk type tolerance level, changing from a 'cautious' risk appetite to a 'minimal risk appetite for clinical risk.

The People and Culture Committee confirmed the definitions, categories, and overall risk type tolerance level as 'cautious' with no suggested changes.

The overall suggestion from the committees is to evaluate the appropriateness and effectiveness over the next 6 months.

A risk appetite statement and risk appetite framework will be developed to be approved by the Board based on approval of the risk definitions, risk appetite descriptors and risk appetite levels.

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):	

Salisbury NHS Foundation Trust

Virtual Meeting Etiquette:

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

Risk Appetite Definitions
September 2024

Fiona McNeight

Director of Integrated Governance

Contents

Salisbury NHS Foundation Trust

Background

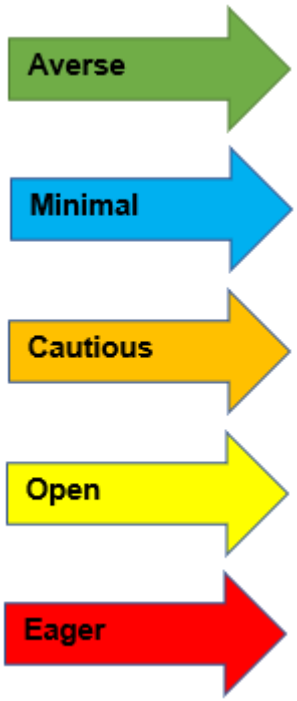
Salisbury NHS Foundation Trust

- Board development session in February 2024.
- Agreement to develop definitions for each risk category and risk appetite scale and present to Trust Board for approval in a phased approach with final approval in October 2024.

Risk Appetite scales

Salisbury NHS Foundation Trust

Based on risk appetite guidance provided within the ‘Orange Book’.



Avoidance of risk and uncertainty is key objective

Preference for safe options leading to only minimum risk exposure: low likelihood of occurrence of the risk after application of controls

Preference for safe options though accept there will be some risk exposure: medium likelihood of occurrence of the risk after application of controls

Willing to consider all options and choose one that is most likely to result in successful delivery; recognise that there could be a high-risk exposure

Willing to be innovative and take on a very high level of risk but only in the right circumstances

Risk Appetite scales

Salisbury NHS Foundation Trust

Consequence	1	2	3	4	5
5	Minimal	Open	Eager	Eager	Eager
4	Minimal	Cautious	Open	Eager	Eager
3	Averse	Cautious	Cautious	Open	Eager
2	Averse	Minimal	Cautious	Cautious	Open
1	Averse	Averse	Averse	Minimal	Minimal

Likelihood

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

Approved Risk Categories

Salisbury NHS Foundation Trust

Defined 5 risk types (known as Level 1 Risk Types) – principal risks which arise from the nature of the Trust's operating environment

Defined 24 Risk Categories (known as Level 2 Risk Categories) – each aligned to one of the 5 Risk Types. These have been determined through aligning the Corporate Risk Register risks to a broader, industry-recognised Risk Category.

Definitions

Salisbury NHS Foundation Trust

Definitions have been drafted by the subject matter experts for each risk type and risk appetite scale with a proposed risk appetite (outlined in red on each scale)

Risk Types & Risk Categories

Based on Government's 'Orange Book'

Salisbury NHS Foundation Trust

Risk Appetite Levels:

Averse | Minimal | Cautious | Open | Eager

NHS
Salisbury
NHS Foundation Trust

Workforce Risks

Workforce Supply

NHS Salisbury NHS Foundation Trust

Definition

The Trust has sufficient staff numbers, with the right skills mix, in the right locations to deliver an effective and safe service to patients

Adverse	Minimal	Cautious	Open	Eager
We prioritise patient safety and quality of care, thus we have a low tolerance for understaffing and will invest in recruiting additional staff even if it means higher short-term costs.	We have a low tolerance for gaps in specialist care and will ensure we have a sufficient number of specialist staff in each department to provide high-quality, expert care	We aim to maintain optimal staffing levels and are willing to accept some temporary understaffing during peak periods if it is balanced by efficient use of current resources and temporary staff	We will maintain a balanced mix of specialist and generalist staff, accepting that some departments may need to rely on generalists during peak times	We are prepared to operate with minimal staffing levels to reduce costs, accepting the potential for increased workload on existing staff and a possible impact on service delivery

Workforce Deployment

Salisbury NHS Foundation Trust

Definition

The Trust is able to flexibly deploy the right staff to the right areas, enabling SFT to generate efficiencies and innovation.

Adverse	Minimal	Cautious	Open	Eager
We have a low tolerance for rigid role definitions and will invest heavily in cross-training programs to ensure staff can be deployed flexibly across different functions and departments as needed	We will use temporary and agency staff to supplement our workforce during peak periods, balancing the need for flexibility with the importance of continuity in patient care	We will support some level of cross-training to allow staff to cover critical roles, accepting that not all staff will be interchangeable across all functions	We will adopt flexible staffing practices to a reasonable extent, accepting occasional shortfalls or overstaffing during non-peak periods to manage costs and efficiency	We will limit cross-training initiatives, accepting the risk that staff may not be able to easily switch roles or departments in response to changing needs

Workforce Performance

Salisbury NHS Foundation Trust

Definition

Staff are sufficiently trained to deliver in their role, and that they are performing and delivering to required standards

Adverse	Minimal	Cautious	Open	Eager
We have no tolerance for skill gaps among staff and will invest heavily in ongoing training and development programs to ensure all staff are highly skilled and up-to-date with the latest medical practices and procedures	We are willing to tolerate some skill gaps among staff, for short periods of time, but seek to provide opportunities for training and education at the earliest opportunity	We support regular training and development but are willing to prioritize certain key areas over others based on strategic importance and available budget	We are willing to accept limited skill gaps in non-mandated areas, where cover can be provided by external agencies and temporary staff solutions	We will limit investment in training and development to essential compliance and regulatory requirements, accepting that some skill gaps may persist among staff

Workforce Retention

Salisbury NHS Foundation Trust

Definition

The Trust does all it can to retain staff by seeking to improve the staff experience, which in turn enables high quality patient care. As such the Trust does all it can to reduce turnover across the Trust.

Adverse	Minimal	Cautious	Open	Eager
We have no tolerance for high staff turnover and burnout, and will implement robust well-being programs and deliver competitive benefits to retain staff and maintain high morale	High levels of turnover will not be tolerated, and staff burnout will be contained through the implementation of effective well-being programs and focussed interventions on staff areas which have moderate to high levels of turnover	We will implement well-being measures and deliver benefits, accepting some level of turnover as inevitable, but ensuring critical roles are retained through a keen focus on areas of concern and high and increasing turnover turnover	We will implement well-being measures and deliver benefits, accepting some level of turnover as inevitable, but ensuring critical roles are retained through a keen focus on areas of concern and high and increasing turnover	We will focus on cost containment, accepting higher turnover and some level of staff dissatisfaction, with a focus on filling critical roles as needed.

NHS
Salisbury
NHS Foundation Trust

Operational Risks

Business Continuity Risk

Salisbury NHS Foundation Trust

Definition

To ensure the Trust has effective processes (Business Continuity Plans or BCP) in place for maintaining continuity of key services in the face of disruption from identified local risks, these are in line with the Civil Contingencies Act 2004 and Health and Care Act 2022. This will range from extreme shortages in staff groups to Major Mass Casualty planning.

Adverse	Minimal	Cautious	Open	Eager
The Trust invests in the ability to understand its BCP in detail and is unwilling to accept any risks in relation to gaps in plans. The financial implications of securing full BCP that are all tested to cover all situations at all times are accepted.	The Trust seeks to provide adequate BCP to ensure patient safety and constitutional standards are met at a Trust level where possible, with minimal areas of risk gaps in plans and audit of plans.	The Trust will ensure that BCP and testing is focused on areas most at risk from the impact of any incident and areas that are most likely to be impacted. Accepting the risk that some areas not tested will not be compliant.	The Trust is willing to tolerate reduce levels of compliance with BCP and testing, accepting the risk that significant numbers of areas may not be fully compliant with BCP.	The Trust does not prioritise regular reviews of BCP plans does not seek assurance by way of testing and responds reactively to incidents in a manner that it deems appropriate.

Health and Safety Risk

Salisbury NHS Foundation Trust

Definition

To ensure the Trust has a structured health and safety management system that enables the Trust, and accountable officers, to demonstrate actions that eliminate or reduce the risk to the health and safety of staff, visitors and contractors as far as is reasonably practicable.

Adverse	Minimal	Cautious	Open	Eager
Any risk to the H&S of staff, or others, that is catastrophic (score >15) will result in tasks being ceased, an action plan developed and immediate steps taken to ensure the safety of staff, and others, before a task recommences.	Where there is a risk to the H&S of staff or others > 8 but < 15, the Trust will accept an impact to the service or finances where necessary and will develop an action plan to reduce the consequence and likelihood of harm. Where there is a clear and agreed plan of action, the risk activity does not need to cease.	The Trust accepts other priorities may take precedence over moderate risks (4-6) to the H&S of staff and others and resources may be allocated according to other non H&S related risks.	The Trust will monitor low (1-3) or moderate (4 -6) risks, where cost effective and practical solutions are available, until greater priorities are managed and resources are freed to reduce the risk to the health and safety of staff, or the risk score changes.	The Trust will accept risks to the H&S of staff, and others, where the consequence of harm is low (risk score of 1-3) or moderate (4 -6) and where there are no practical or cost-effective solutions available to reduce the risk.

Information Governance (IG) Risk

Salisbury NHS Foundation Trust

Definition

To ensure that the Trust has the right processes and systems for collecting, storing, managing and maintaining information (including archiving and deleting) in all its forms in order to support business needs and comply with regulations.

Adverse	Minimal	Cautious	Open	Eager
The Trust will adhere to national IG best practice guidance to the letter, regardless of any operational or clinical benefit. IG and data protection (DP) risks identified will need to be fully mitigated before any data is shared and/or contracts are signed. Staff cannot work unless they are IG training compliant.	Wherever possible, the Trust will adhere to national IG/DP best practice. IG risks in contracts and data sharing agreements must be minimal for it to be acceptable to the Trust. Wherever possible all data stored adheres to the data retention policy.	The Trust will ensure IG training is prioritised and mandated for all. Mitigations to risks identified in IG and DP reviews will be carefully considered and an informed judgement will be taken on a case by case basis. Invariably the risk the Trust will accept is low.	Whilst IG training is mandated, the Trust will willing to accept lower compliance. IG and DP risks are identified, reviewed on a case by case basis but IG is prioritised lower that operational/clinical risk mitigation. Data stored adheres to the data retention policy only in high risk areas.	The Trust will predominantly prioritise data sharing for clinical and operational benefits above IG legislation, accepting the risk of potential legal/regulatory action. IG Training and effective data management is not a Trust priority and not mandated.

Information Security Risk

Salisbury NHS Foundation Trust

Definition

To ensure that the management of information security is designed to protect confidential, private and sensitive information or data from unauthorised access, use, misuse, disclosure, destruction, modification or disruption.

Adverse	Minimal	Cautious	Open	Eager
Cyber is a high priority for Trust to invest in risk mitigations, accepting the increase in financial risk at all times. The Trust will prioritise patching and the application of restrictions to support cyber security, even when it may impact operational or clinical practice.	Cyber is a high priority for Trust to invest in risk mitigations, invariably accepting the increase in financial risk. Applying patching and restrictions will be a priority to support cyber security, where it does not significantly impact operational or clinical practice, unless the threat is significant.	The Trust will invest to reduce the risk of cyber attack where it is practical to do so. The trust will balance the need for cyber restrictions With the wider risk of the organisation, adhering to cyber policy and practices, wherever practically possible, unless the cyber threat is significant	The Trust is willing to reduce restrictions supporting cyber security for the wider benefit of the organisation. Adherence to cyber related policies and practices remains important but not essential.	The Trust will seek to only invest in cyber security when there is funding available, accepting the risk otherwise of not doing so. Adherence to cyber policy and practices are encouraged but not treated as a priority. The Trust accepts the risk of regulatory action.

Information Technology Risk

Salisbury NHS Foundation Trust

Definition

To ensure the Trust has appropriate processes in place to manage the use, ownership operation, involvement, development and adoption of IT to prevent unplanned business disruption.

Adverse	Minimal	Cautious	Open	Eager
Investing in technology is a high priority, regardless of whether there is financial return on investment (RoI) or not. There is eagerness to be lead technological innovation piloting, accepting the associated risks. The replacement of aging software and hardware is prioritised ahead of almost anything else.	The Trust will prioritise operational/clinical benefits over financial RoI when investing in technology. There is interest in exploring technological innovation, at times being at the forefront of this. The Trust will, accept small pockets of aging technology, however will adhere to national expectations on digital maturity.	The Trust will consider business cases that balances the financial risks of technology investment with the operational/clinical benefits. Technological innovation will be on a fast follower basis only. The Trust will have a higher level of aging technology, accepting the risks/disbenefits to the organisation.	Investment in technology, without a clear financial RoI is rare. The Trust will support Technological innovation trials where there is high risk needing mitigation. The Trust will ensure there is no regulatory action but will otherwise accept the risks associated with increasingly aging technology.	The Trust will invest in technology only where it is essential to do so, and only when there is a deliverable financial RoI. The default will be to not participate in Technological innovation pilots. The Trust accepts the risks associated with having extensive aging technology, including regulatory action.

Estates/Physical Assets Risk

NHS Salisbury NHS Foundation Trust

Definition

It is essential that the condition of the SFT estate and physical assets are accurately assessed, built, specified, managed and maintained by competent in-house staff supported by professional external expertise where required in line with the relevant legislation & guidance, to ensure they are fit for purpose and safe for patients, staff and visitors. The correct processes and systems for collecting, storing, managing and maintaining Estates information in all its forms in order to support business needs and comply with regulations should be in place and fit for purpose.

Adverse	Minimal	Cautious	Open	Eager
SFT will adhere to national guidance (NG), regardless of any benefit. No value engineering (VE) will be implemented. A full backlog maintenance survey (BM) will be carried out annually. All approved and competent engineers will work in one discipline. Estates software will be replaced regardless of costs	Wherever possible, SFT will adhere to NG. VE will be considered if appropriate. A 50% BM site survey will be carried out annually. All approved and competent engineers will work across two disciplines. Estates software will be kept up to date while exploring areas to enhance its capabilities.	Wherever possible, SFT will adhere to NG. VE will be considered if appropriate. A 20% BM site survey will be carried out annually. All approved and competent engineers will work across two + disciplines. Estates software will be kept up to date while exploring areas to enhance its capabilities.	Wherever possible, SFT will adhere to NG. VE will be considered if appropriate. A 100% paper-based BM review will be carried out annually . All approved and competent engineers will work across three+ disciplines. Estates software will be maintained at current levels while exploring areas to enhance its capabilities.	SFT will not adhere to NG. VE will be encouraged. No BM reviews will take place, and an estimate will be submitted as part of our national return obligation. All approved and competent engineers will work across many disciplines. Estates software will be maintained at minimum levels with no view to enhance.

NHS
Salisbury
NHS Foundation Trust

Clinical Risks

Infection Prevention and Control Risk

Salisbury NHS Foundation Trust

Definition

To ensure the Trust has appropriate processes in place to avoid healthcare associated infections and preventable harm.

Recommended status – minimal or averse

Averse	Minimal	Cautious	Open	Eager
The Trust will adhere to all national IPC guidance regardless of any cost. A full complement of IPC team members will be employed, supported by link professionals across the divisions. IPC team members will have completed all required training. Link professionals attend 100% training sessions	Wherever possible, the Trust will adhere to national IPC guidance. A full complement of IPC team members will be employed, supported by link professionals. IPC team members will have completed all required training. Link professionals attend 80% training sessions External support may be required from UKHSA, or system partners	Wherever possible, the Trust will adhere to national IPC guidance. A full complement of IPC team members will be employed, supported by link professionals. IPC team members will have completed 75% required training/have experience in IPC. Link professionals attend 60% training sessions. External support is required from UKHSA, or system partners	The Trust will aim to meet national IPC guidance. A full complement of IPC team members maybe be employed, supported by link professionals. IPC team members will have completed 50% required training/have some experience in IPC. Link professionals attend 40% training sessions. External support will be required from UKHSA, or system partners	The Trust will aim to meet minimum national IPC guidance. A full complement of IPC team members maybe employed, supported by link professionals. IPC team members will have completed 0-50% required training/have some/no experience in IPC. Link professionals attend 20% training sessions. External support will be required from UKHSA, or system partners

Patient Experience

NHS Salisbury NHS Foundation Trust

Definition

To ensure that the Trust has accessible, diverse and equitable means by which our service users, their carers and visitors can share their experiences openly and honestly, with assurances that these are embraced and seen as opportunities for improvement.
The Trust accepts that despite the priority of a person-centred patient experience, this may at times be compromised in favour of delivering safe and effective care.

Averse	Minimal	Cautious	Open	Eager
The Trust will strictly adhere to national patient experience targets (complaints standards, national surveys and Friends and Family Feedback) and will ensure we comply with or exceed minimum targets. The Patient Experience team will be at full complement to deliver on these targets. Patient experience may only be compromised in favour of delivering safe and effective care, when any mitigations will be established.	The Trust will adhere to national patient experience targets, (complaints standards, national surveys and Friends and Family Feedback). The Patient Experience team will be at full complement to deliver on these targets The Trust accepts patient experience may be compromised in favour of delivering safe and effective care, but anything fundamentally detrimental to patient experience will be mitigated.	The Trust will aim to exceed minimum national patient experience targets and aim to prioritise a person-centred patient experience. Local improvements made as a result of complaints and triangulation of data established through trusted patient engagement forums, (including Friends and Family Testing and National Surveys) is prioritised. Improvements are driven in balance with delivering safe and effective care,.	The Trust will aim to exceed national patient experience targets and will prioritise a person-centred patient experience. This will include some risk exposure through organised, trusted patient engagement opportunities such as patient panels, Patient Safety Partners and Patient Stories. Using these forums to openly expose inefficiencies and drive improvement (where possible) with the same priority as delivering safe and effective care.	The Trust will exceed national patient experience targets and strictly adhere to a person-centred patient experience. Exposing itself to pro-active patient engagement and involvement across a diverse range of communities and our local community. This may include proactive duty of candour where necessary. Improvements are driven with the same priority as delivering safe and effective care.

Patient Safety and Outcomes

Salisbury NHS Foundation Trust

Definition

To ensure that the Trust has systems and processes in place to deliver safe, timely and effective care to our patients.

Averse	Minimal	Cautious	Open	Eager
The Trust will strictly adhere to all evidence based processes, policies and procedures to deliver the highest possible standards of care at all times. Workforce standards will meet minimum requirements to deliver the care. Mitigations will be robust to ensure care is optimal at each point of contact. Patient safety will take priority over financial and patient experience targets.	The Trust will adhere to evidence based processes, policies and procedures as far as possible. Workforce standards may not always meet optimal levels but any gaps will be mitigated to ensure patient safety is prioritised. Preferred care options may not be possible due to financial constraints. Care outside the accepted footprint will be minimised and mitigated.	The Trust supports evidence based best practice but balances this with financial stability. Patient safety and effective outcomes are prioritised with a balance achieved between these, patient experience and financial responsibility. Patients will be cared for within the budgeted footprint of the Trust where possible.	The Trust supports evidence based best practice but balances this with financial stability and an appetite for cautious research projects. Patient safety and effective outcomes are prioritised with a balance achieved between these, patient experience, research objectives and financial responsibility. Patients may need to be cared for in corridors or other escalation areas to meet targets.	The Trust supports evidence based best practice but balances this with financial stability and an appetite for ambitious research projects. Patient safety and effective outcomes are prioritised with a balance achieved between these, patient experience, research objectives and financial responsibility. Patients may need to be cared for in corridors or other escalation areas to meet targets.

Research

NHS Salisbury NHS Foundation Trust

Definition

To ensure that the Trust deliver Research safely to patients, providing adequate oversight and complies with Regulations. To provide legal ownership of Trust generated research and in improve the health of the community.

Adverse	Minimal	Cautious	Open	Eager
Research studies delivered to patients or using patients' data require appropriate National Regulatory Approvals. Regulatory non compliance is a legal and reputational risk to the Trust. The Trust ensures that appropriate governance and oversight frameworks arein place to ensure that all research delivered to its patients have the appropriate ethical , legal , regulatory complaint.	The Trust Research department conducts comprehensive feasibility and risk assessment during the planning and set up stage of all sponsored research projects as well as robust local multi disciplinary feasibility assessments to all hosted research projects to identify risks and develop mitigating strategies. Relevant central and specialised Trusts departments such as Pharmacy, Radiology or Information Governance work closely with the Trust Research department to identify and mitigate risks	The research department workforce is monitored on an ongoing basis to ensure that all the Trust and Healthcare worker Statutory training and certification is up to date. In additional all Research staff hold a Good Clinical Practice (GCP) certificate and have bi-yearly training to ensure that these are up to date. Research staff attend National Institute for Health Research (NIHR) training as well as research study specific training prior to delivering any Research study in the Trust.	The Trust holds the research department to account in ensuring that all Trusts generated research have the appropriate sponsor oversight and monitoring during the life span of the study. The research department is continuously developing and maintaining SOPs , assurance systems and ensure that the research processes adhere to protocols and ICH GCP standards.	The Trusts Research Department collaborates with other NHS R&D departments, Education Partners , Industry Partners and other regional and national organisation to share best practices and resources . The Trusts Research department seeks support from research networks and consortia to enhance research quality , mitigate risks, identify training needs and collaborate on providing best care and making research safe and accessible to the community.

Capacity Planning Risk

Salisbury NHS Foundation Trust

Definition

To ensure the Trust has effective processes in place for planning and providing capacity to treat elective, non-elective, and clinically urgent patients to maintain patient safety and meet constitutional standards.

Adverse	Minimal	Cautious	Open	Eager
The Trust invests in the ability to understand its capacity in detail and is unwilling to accept any risks in relation to capacity. The financial implications of securing adequate capacity to meet all constitutional standards and maintain patient safety at all times are accepted.	The Trust seeks to provide adequate capacity to ensure patient safety and constitutional standards are met at a Trust level where possible, with minimal areas of risk or capacity gaps.	The Trust will ensure that capacity is planned to meet the demand for elective and non-elective (acute) admissions to our hospitals, managing this risk to provide safe treatment and care to our patients.	The Trust is willing to tolerate reduce levels of performance against some constitutional standards in order to prioritise clinically urgent patients.	The Trust does not prioritise regular reviews of demand versus capacity and responds reactively to peaks in demand. The Trust is willing to accept low compliance to constitutional standards, prioritising clinically urgent patients.

NHS
Salisbury
NHS Foundation Trust

Financial Risks

Counter Fraud Risk

NHS Salisbury NHS Foundation Trust

Definition

To ensure that the Trust has systems and processes in place to create an effective control environment to protect the organisation from internal and external fraud.

Averse	Minimal	Cautious	Open	Eager
The Trust prioritises fraud prevention through strong governance and reporting structures with clearly defined roles and responsibilities around fraud risk. Processes and systems that actively look for fraud in key risk areas supported by comprehensive risk assessments and key controls. Rapid and effective investigations into fraud cases. Avoidance of financial loss is a key objective.	The Trust aims to balance fraud prevention with potential rewards but are still focused on minimising risk through effective governance and controls supported by comprehensive risk assessment and effective, prompt investigation.	The Trust seeks a balanced response to fraud risks and are willing to accept a level of risk with possibility of some limited financial loss. Resources generally restricted to existing commitments.	The Trust are open to taking moderate risks. High levels of devolved authority. The Trust is prepared to invest for return and minimise the possibility of financial loss by managing the risks to a tolerable level. Resources allocated in order to capitalise on opportunities.	The Trust has a very high tolerance for fraud risk and is willing to take considerable risks to achieve their strategic objectives. Management by trust rather than tight control.

Supply Chain Risk

NHS Salisbury NHS Foundation Trust

Definition

To ensure that the Trust has systems and processes in place to deliver an effective supply chain service to our clinical teams, supporting patient care through ensuring the right product is in the right place, at the right time

Averse	Minimal	Cautious	Open	Eager
The Trust prioritises stability and predictability in our supply chain operations characterised by stringent controls, rigorous supplier assessments, and extensive contingency plans. Avoiding transformative process, change, suppliers or markets where there maybe value but that could introduce significant variability or uncertainty into the supply chain.	The Trust aims to balance risk with potential rewards but are still focused on minimising disruptions. thorough risk assessments and have moderate contingency plans in place for supply Disruption. We may engage in some riskier supply chain strategies around alternative products and processes but with careful monitoring and control mechanisms in place.	The Trust seeks a balanced risk appetite and are willing to accept a moderate level of risk in their supply chain in exchange for potential benefits. Through using a mix of traditional and innovative supply chain practices, they actively manage risks but are open to exploring new suppliers, markets, and technologies that could offer competitive advantages to our clinical teams based on a value-based procurement methodology approach	The Trust are open to taking significant risks to achieve substantial financial rewards and competitive advantage. The Trust is happy to purse strategies of entering emerging markets or supplies from high-risk supply change routes adopting cutting-edge technologies. We are agile and capable of responding quickly to disruptions on large scale due to the level of standardisation and consistent processes	The Trust has a very high tolerance for risk and is willing to take considerable risks to achieve their strategic objectives. The Trust prioritises innovation and rapid growth over stability and supply disruption. Investing in new high-risk ventures and have minimal risk mitigation strategies on this change. Our focus is on seizing opportunities and adapting quickly to changes in the supply chain environment. In a flexible way through minimised process control

Financial reporting risk

Salisbury NHS Foundation Trust

Definition

To ensure that reported financial information reported is correct, true and fair and does not contain material misstatement.

Averse	Minimal	Cautious	Open	Eager
The Trust prioritises robust financial management and reporting, characterised by stringent grip and controls to avoid uncertainty.	The Trust delivers sound financial management and reporting, with no material misstatements or variances to forecast.	The Trust aims to balance sound financial management and reporting against earlier reporting timescales with careful monitoring and review of post reporting period transactions.	The Trust is willing to accept a moderate level of risk in the reported financial position in exchange for reduced reporting timescales.	The Trust is willing to accept a high level of risk in the reported financial position through reduced process controls. This will minimise reporting timescales and provide focus and opportunities to improving the reported position.

Financial Management & Waste Reduction risk

Salisbury NHS Foundation Trust

Definition

The risk of direct or indirect loss resulting from inadequate systems and processes to the Trust's management of its Finances.

Adverse	Minimal	Cautious	Open	Eager
No appetite for decisions or actions which may result in financial loss	Only prepared to accept minimal possibility of material financial impacts or losses or reporting misstatements if essential to safe and effective patient care and outcomes	Limited financial impacts or losses are accepted if they yield upside opportunities elsewhere within the Trust. Value for money is a key focus	Prepared to invest and/or accept financial impacts or losses for the benefit of improved patient care and outcomes if appropriate controls are in place and value for money is delivered	Proactively invest and/or accept financial impacts or losses for the benefit of patient care and outcomes, recognising that the potential for substantial gain outweighs inherent risks

Revenue Funding & Cash Management Risk

Salisbury NHS Foundation Trust

Definition

To ensure that the Trust's funding sources and cash are adequately managed with funds available as the business requires.

Averse	Minimal	Cautious	Open	Eager
We will retain a minimum cash balance of £9.911m All income contracts will be signed in line with national guidance and SFIs	We will retain a minimum cash balance of £4.956m All income contracts will be signed in line with national guidance and SFIs	We will retain a minimum balance of £1.129m in line with NHSE guidance ICB and NHSE commissioning contracts will be signed in line with national guidance and material NHS service contracts in line with SFIs	We will retain a minimum balance of £1.129m in line with NHSE guidance ICBs and NHSE commissioning contracts will be signed in line with national guidance	We will retain a minimum balance of £1.129m in line with NHSE guidance ICBs and NHSE commissioning contracts will be signed in line with national guidance

NHS
Salisbury
NHS Foundation Trust

External Risks

Legal and Governance Risk

Salisbury NHS Foundation Trust

Definition

To ensure that the Trust has systems and processes in place to operate in accordance within legal and regulatory frameworks and the UK Corporate Governance Code, where applicable.

Averse	Minimal	Cautious	Open	Eager
The Trust has no appetite for decisions that may compromise compliance with statutory, regulatory or policy requirements or decisions that could lead to additional scrutiny or attention on the organisation.	The Trust will avoid any decisions that may result in heightened regulatory challenge unless absolutely essential. The Trust appetite for risk taking is limited to those events where there is no chance of significant repercussions.	The Trust is prepared to accept the possibility of limited regulatory challenge and would seek to understand where similar actions had been successful elsewhere before taking any decision.	The Trust is prepared to accept the possibility of some regulatory challenge as long as there is reasonable confidence we would be able to challenge this successfully.	The Trust is willing to take decisions that will likely result in regulatory intervention if there is justification and where the potential benefits outweigh the risks. Willing to take decisions that are likely to bring scrutiny of the organisation.

Partnership working risk

NHS Salisbury NHS Foundation Trust

BAF 10 link

Definition

Failure to establish and maintain effective partnerships to support the ICS, our work at 'place', and the delivery of our externally dependent strategic initiatives (and aspects of our vision) – i.e. increase in healthy life years or reductions in length of stay beyond NCTR.

Averse	Minimal	Cautious	Open	Eager
The Trust has nominated leadership for all relevant partnership forums and actively leads system and place wide working to resolve our externally driven challenges. Senior leadership time within the Trust is prioritised for system working even at the expense of operational focus. The Trust maintains excellent relationships with external partners, with significant influence over external decision making through the integration of services and role sharing.	The Trust is engaged in most partnership working forums and seeks leadership roles where appropriate. Capacity is dedicated to shared priorities across the system/place and the AHA. The Trust maintains good relationships with most external partners and has some influence over external decision making through seeking to integrate services and role sharing.	The Trust is engaged in some partnership working forums but not in a leading capacity. Some resource is dedicated to working on shared priorities, and the Trust is prepared to tolerate influence by external parties. The Trust maintains cordial relationships with key partners and is prepared to tolerate poor relationships with wider partners to achieve SFT focussed goals at the expense of partnrs.	The Trust is engaged in mixed partnership working, seeking non-traditional partnerships that may or may not advance our vision. The Trust is prepared to tolerate negative impacts from partners due to an SFT focussed approach.	The Trust invests time in non-traditional partnerships at the expense of traditional health ecosystem partners. As such the Trust is prepared to tolerate hostile relationships with relevant external organisations and focus solely on advancing SFTs aims that may yield advantage i.e. incubating health technology start-ups.

Reputational Risk

Salisbury NHS Foundation Trust

Definition

Potential for negative publicity, public perception or uncontrollable events which could have an adverse impact on the Trust's reputation.

Averse	Minimal	Cautious	Open	Eager
The Trust has no appetite for decisions that could lead to additional scrutiny or attention on the organisation.	The Trust appetite for risk taking is limited to those events where there is no chance of significant repercussions.	The Trust is prepared to accept the possibility of limited reputational risk if appropriate controls are in place to limit any fallout.	The Trust is prepared to accept the possibility of some reputational risk as long as there is the potential for improved outcomes for our stakeholders.	The Trust is willing to take decisions that are likely to bring scrutiny of the organisation. The Trust outwardly promotes new ideas and innovations where potential benefits outweigh the risks.

Strategic planning risk

Salisbury NHS Foundation Trust

BAF 6 link

Definition

Strategic planning faces significant uncertainty due to the challenge of providing DGH services to ageing rural populations; the lack of integrated care; organisational scale; and constancy of purpose regarding the operational management system.

Averse	Minimal	Cautious	Open	Eager
The Trust fully deploys the I/T OMS and uses it to prioritise all activity. The Trust has clear plans to provide sustainable services to our population and plans with all partners in the system to do so in a coherent manner. The Trust integrates care wherever possible.	I/T is integrated with the planning cycle and is fully embedded for the cascade of organisational strategy. The Trust is able to meet the needs or our population and is in the process of integrated some aspects of care. The Trust considers growing its base of core services to provide scale and leverage regional services, and other value adding activity, to provide sustainable scale to the organisation so it may serve the population in perpetuity.	I/T is adopted across 30-50% of the organisation with most senior leaders fully engaged. It is maturing within the planning cycle and is able to cascade the strategy across most aspects of the SPF. The Trust is meeting the needs of the population but is prepared to tolerate some risk that may not always be the case. The Trust is attempting to integrate some services. The Trust is prepared to tolerate the risk only growing some core and regional services.	I/T is failing to embed fully and the Trust is prepared to tolerate this risk. The Trust accepts the risk that it may not be able to provide all current services to our population beyond 2030. The Trust is therefore seeking to grow its base of core services to provide scale and leverage regional services, and other value adding activity such as the domiciliary care market, to provide scale to the organisation..	The Trust is prepared to tolerate I/T gradually diminishing as the OMS if it means significantly growing the business. The Trust seeks to grow its core business and subsidiary activities to drive income and organisational scale, potentially destabilising core commissioned services.

Report to:	Trust Board (Public)	Agenda item:	7.9
Date of meeting:	03 October 2024		

Report tile:	Patient Feedback Report – Q1 2024/25			
Status:	Information	Discussion	Assurance	Approval
	Yes	Yes	Yes	Yes
Approval Process: (where has this paper been reviewed and approved):	Clinical Governance Committee – 24th September 2024 Patient Experience Steering Group – 25th September 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 Committee.

Executive Summary:

This report provides summary and insights drawn from the various methods by which our patients feedback on our services. This includes analysis of complaints, concerns, compliments, Friends and Family Testing and any National surveys reported during Q1 of 2024/25.

To summarise the contents of this paper:

Complaints/concerns/compliments and enquiries:

Patient activity across the Trust has increased again this quarter, however, in comparison the total number of complaints and concerns is not considered to have increased at a proportionate rate.

A total of 490 comments/enquiries were logged by the PALS team in Q1, this is the same as the previous quarter, this volume is a pressure within the current team resourcing. Of these 114 were not related to any of the clinical divisions and 67% were related to charges for car parking.

A total of 165 compliments were recorded on Datix this quarter across the Trust (less than last quarter), there is a noted backlog of approximately 220 still awaiting logging with PALS. PALS capacity has been flagged on the Quality Risk register.

For Q1 the top three most prevalent high-level themes for complaints across the Trust were the same as those seen in both Q4. These were in relation to **Patient Care** (48%) and **Communication** (20%). Access to treatment or drugs is a new theme this quarter (11%) – see Table 1.2.

Within these themes **unsatisfactory treatment, lack of** or **insensitive communication** and **delays with receiving treatment** 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, however the overall Trust average is noted to be on a positive trajectory, edging close to this target (see Figure 1.4). Surgery are noted to have significantly improved their response within timescale this quarter, in comparison to their previous quarterly performances.

The number of **reopened complaints/concerns** this quarter is currently estimated to be around 5%. 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.

Friends and Family Test (FFT) Trust wide average response rate for Q1 has seen a peak with the introduction of the new digital solution. In total for Q1 there was a total of 7,578, this is 5,536 more than Q4. This equates to an average response rate of 9.6% (of eligible population). FFT experience ratings have decreased slightly to 96%. The project to launch a digital provider went live on the 1st June 2024, this is credited to the increase in response rates seen this quarter.

New sections of this report for the committee to note:

This report contains new sections in an attempt to draw together wider themes. This includes a summary of cases open with the CQC and PHSO, internal triangulation with risk, safety and freedom to speak up and comparisons with the two acute trusts within the ICB.

There are no themes to report this month.

Local Surveys:

Real-time feedback (RTF) remains a standing item for discussion at the PESG. Overall good satisfaction rates, though some issues still noted around noise at night. High levels of satisfaction related to cleanliness of the ward areas and receiving enough to eat and drink. A total of 73 surveys were completed during this quarter and an average overall satisfaction rating of 81.0% was achieved.

Your Views Matter Annual Report has been replaced with the National Audit for End of Life Care (NACEL) Survey. It should be noted that there is limited ability for comparison with the Trust's YVM survey results for 2023/24 as a result of this change. However, the NACEL survey does present an opportunity to compare the Trust's performance within these measures with our BSW acute Trust counterparts.

65% of SFT's respondents described their overall rating of care and support given by the hospital to the dying person as "excellent", compared with 10% who described this as "Poor".

The NACEL survey is unable to be used to correlate complaint themes by location with this data as this is not collected as part of the audit. PALS are working with Medical Examiners to look at how they may be able to supplement this data going forward.

7 survey participants requested a call-back from PALS, none of these resulted in a formal complaint or concern being raised.

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

Patient Experience - Patient Feedback
Q1 Report 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

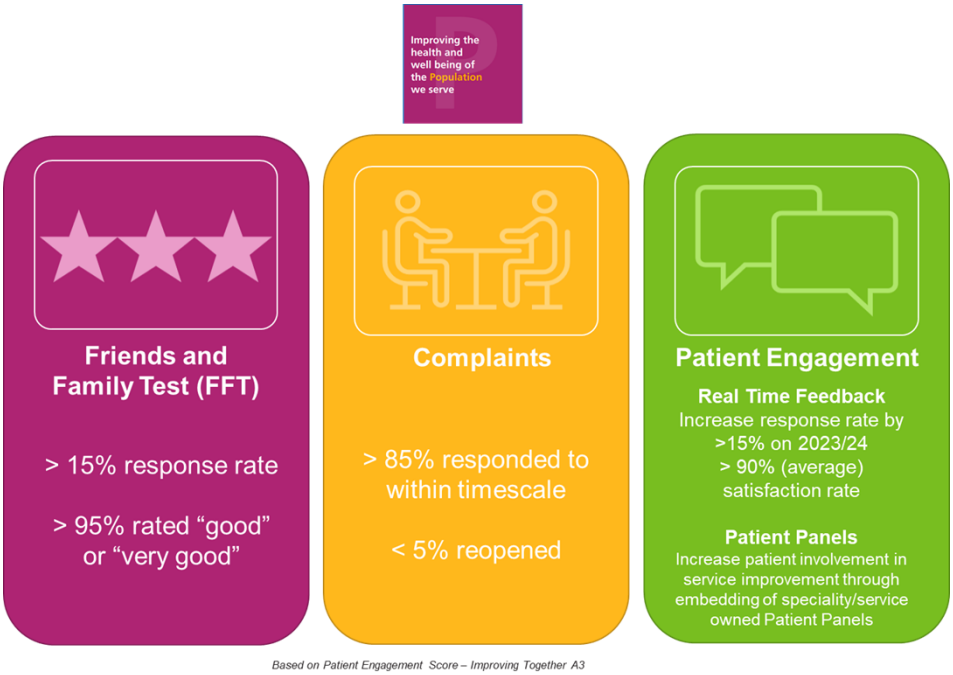
Patient experience is defined as “the sum of all interactions, shaped by an organisation’s culture that influence patient perceptions across the continuum of care”. Nationally, the scrutiny in relation to compassionate healthcare, as well as in engaging with the public, is to understand their voice and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



Based on Patient Engagement Score – Improving Together A3

Contents

1. Complaints, Concerns and Compliments - Trust Overview

There were a total of 3 items of feedback posted on the NHS Website* in Q1.

Average rating on responses: ★★★★★

	Positive	Neutral	Negative	Average star rating
Q1 24/25	3	0	0	★★★★★
Q4 23/24	2	1	0	★★★★★
Q3 23/24	6	1	0	★★★★★
Q2 23/24	2	0	2	★★★
Total / Average	14	2	2	★★★★½

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 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
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
Q1 2023 - 24	35,540	34, 554	40, 495	4, 206	114, 795

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.

Further analysis of compliments is included within the individual Division's reports.

Complaints and Concerns

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

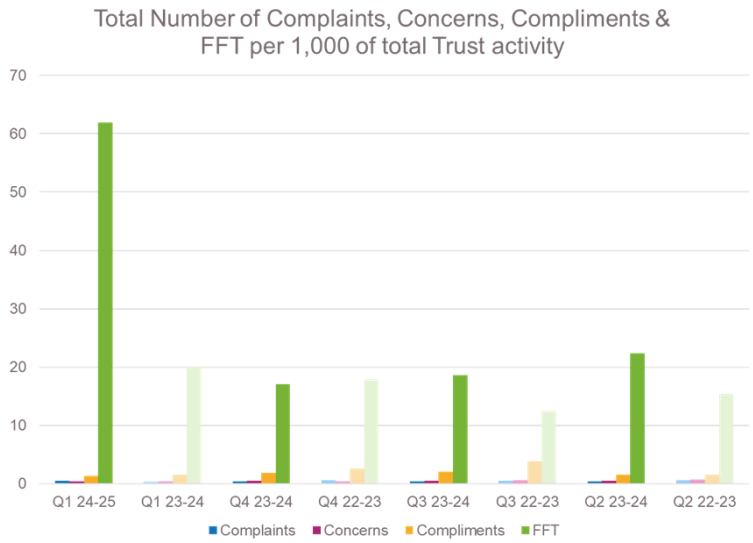


Figure 1.1 shows a slight increase in the total number of both complaints and concerns received for Q1, in comparison with Q4. These numbers continue to remain overall lower when comparing the same period last year *(opaque graphs show 2022/23 reporting)*.

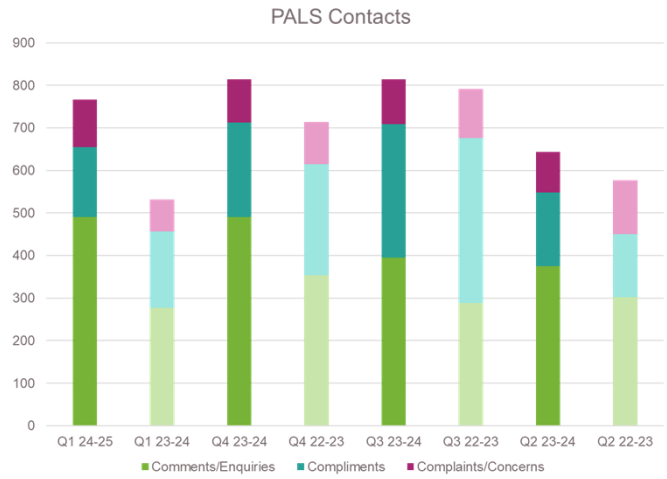
FFT feedback has significantly increased this quarter, owed to the transition of the FFT process to a digital solution. This launched on the 1 June 2024. Further details are contained in the Friends and Family (FFT) section of this report.

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 165 compliments recorded on Datix. However, there are an estimated 220 still outstanding for logging. There are mitigation plans in place for additional PALS resourcing to tackle this backlog and these will be included in the Q2 report.

In Q4 the PALS department logged 490 comments/enquiries. The same number as Q4.

This equates to an average of 4.0 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



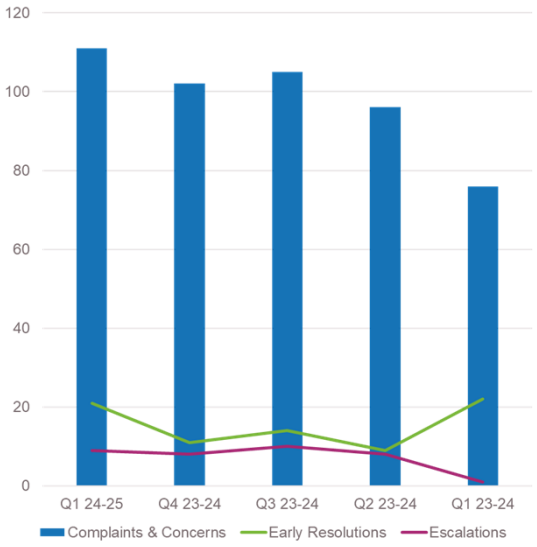
During Q1 there were a total of 111 complaints and concerns logged (102 in Q4).

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

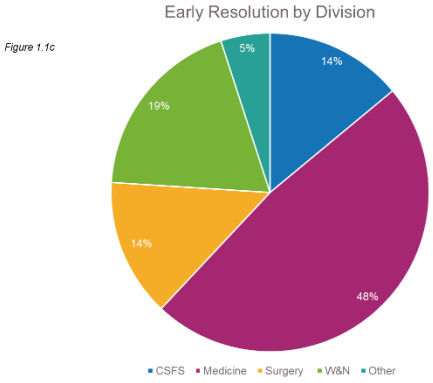


21 of the 111 were considered to achieve an earlier resolution than anticipated in Q1.

9 of the 111, 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 21.

Table 1.2 below shows the themes for complaints and concerns received in Q1 (trust wide).

Highlighted are the top three most prevalent themes. **Patient Care** and **Communication** are consistent themes with the previous quarter, however **Access to treatment or drugs** 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 Q1 Complaints/concerns

	CSFS	Medicine	Surgery	Women & Newborn	Non-clinical	Total by theme	% of total by theme
Access to treatment or drugs		3	8	1		12	11%
Admissions, discharge and transfers	1	2				3	3%
Appointments including delays and cancellations			5	2		7	6%
Clinical Treatment							
Commissioning Services							
Communications	1	11	6	4		22	20%
End of Life Care	1	5				6	5%
Facilities Services							
Other							
Patient Care	6	24	20	3		53	48%
Prescribing errors	1					1	1%
Privacy, dignity & wellbeing							
Values and behaviours (Staff)	1	1	4	1		7	6%
Total by Division	**11**	**46**	**43**	**11**	**0**		
Divisions Total	111						

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 Q4.

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

Access to treatment or drugs is a new theme for Q1. With **Delay in receiving treatment** featuring as the highest causes under this category (see Table 1.2c).

Table 1.2a

Patient Care	53	48%
Assistance not given	1	2%
Correct diagnosis not made	4	8%
Delay in making diagnosis	1	2%
Further complications	2	4%
Harm	2	4%
Inappropriate treatment	8	15%
Infection risk	2	4%
Neglect	2	4%

Nursing Care	4	8%
Unsatisfactory treatment	**27**	**51%**

Table 1.2b

Communications	22	20%
Insensitive communication	**11**	**50%**
Lack of communication	9	41%
Wrong information	2	9%

Table 1.2c

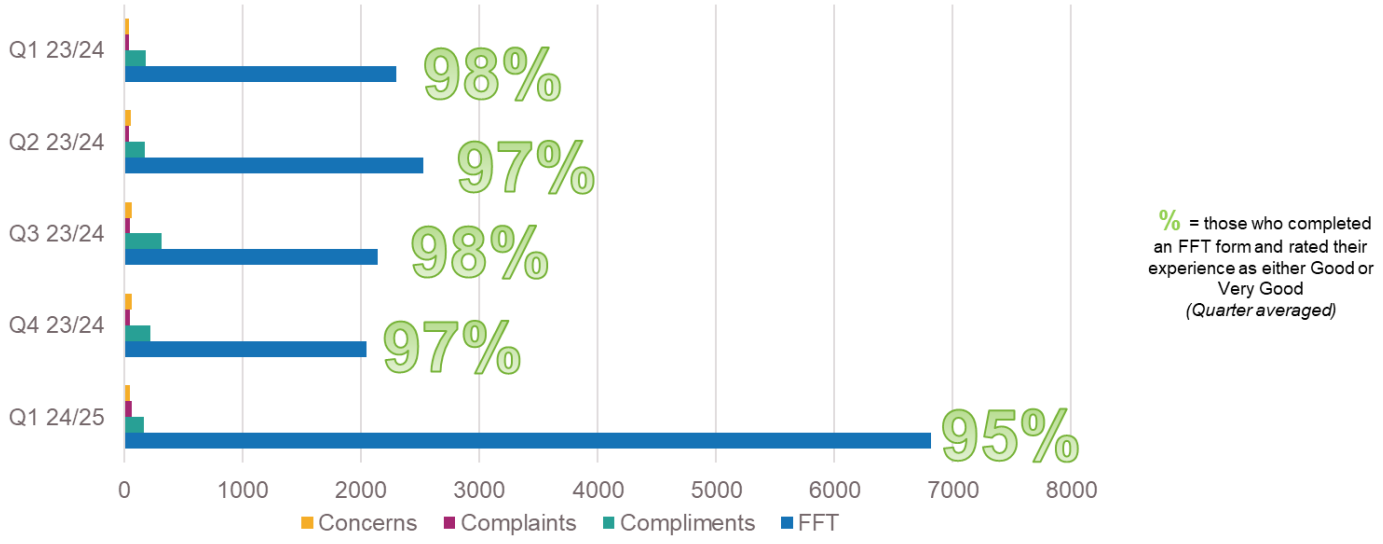
Access to treatment or drugs	12	11%
Delay in receiving treatment	**6**	**50%**
Funding problems	1	8%
Operation cancelled	2	17%
Operation cancelled following admission	1	8%
Operation delayed	1	8%
Treatment unavailable	1	8%

Further analysis of these themes is reported within the Divisional reports.

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 seen a slight decrease in satisfaction this quarter, the first time this this has dropped below 97%. 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.

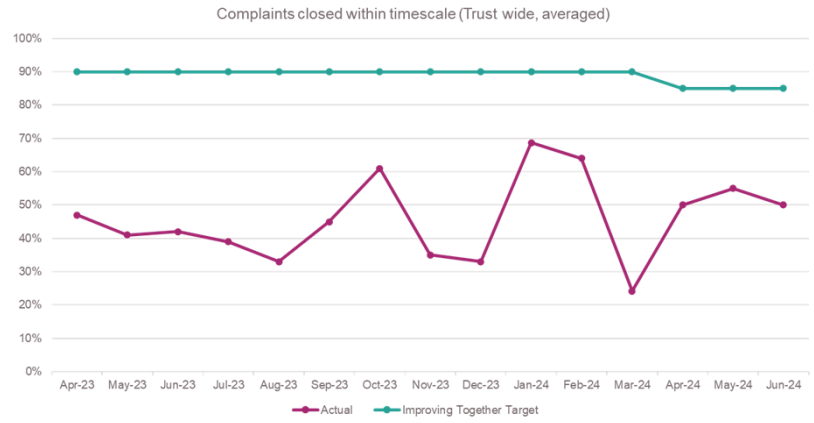


Overdue Complaints

The Trusts Improving Together Target for response to complaints within their agreed timescale has been adjusted for 2024/25, reducing to 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)



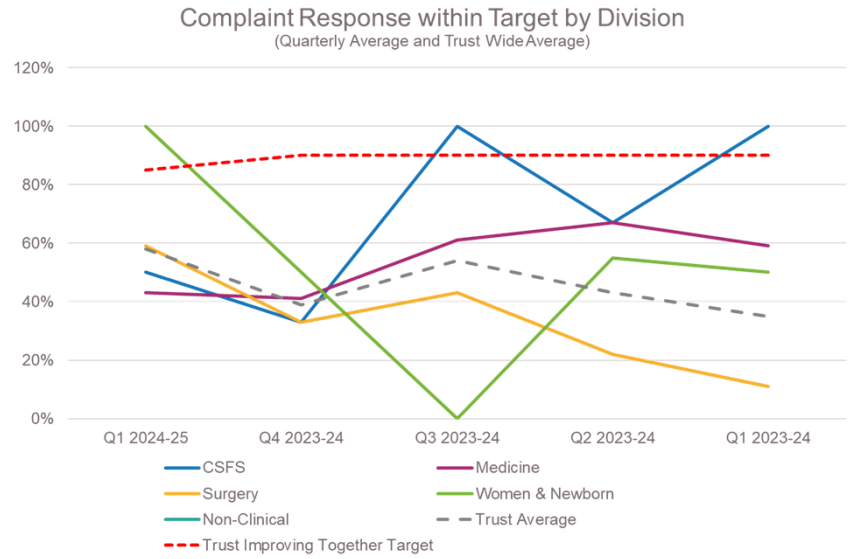
There are various factors that can influence the inability to achieve the timescale for response.

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

This target continues to be monitored via the Integrated Performance Report (IPR) as a watch metric.

At Division level, we are seeing varied compliance to this target. This is largely impacted by operational pressures, along with complexity and the number of complaints requiring response within similar timeframes. There is still some work to be done with some staffing groups and speciality areas to demonstrate the benefits of early resolution, particularly when operational pressures can make these harder to prioritise.

Figure 1.4 – Complaints closed within Target (by Division and Trust Total)



Surgery are noted to have significantly improved their response rate this quarter. This is credited to a review of their complaints process, which has now been streamlined and firmer accountability and ownership of individual complaints has been in place since June 2024.

Women and Newborn were able to achieve 100% compliance with this target this quarter.

(see Section 3 Division Summaries – Complaints, Concerns and Compliments) for more detailed breakdowns for each Division.

Reopened Complaints

Figure 1.5 – Number of re-opened complaints or concerns

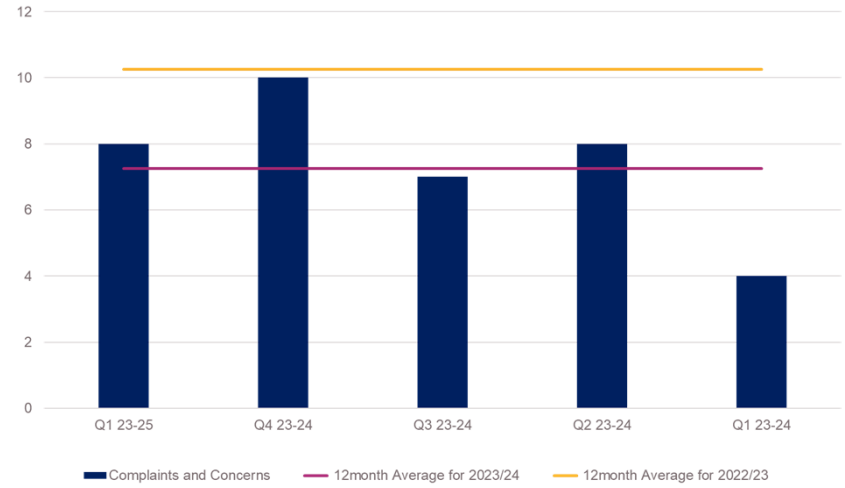


Figure 1.5 shows the number of reopened complaints and concerns (in total), compared with previous quarters.

The yellow lines shows the average for 2022/23.

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

The number of reopened complaints and concerns has decreased this quarter. However, it is marginally higher than the 2023/24 average.

For those which have reopened the reasons were varied with no clear themes. The PALS team and the Division Leads continue to work hard to realise the benefits of concluding investigations with complaint meetings. Where written responses are required ensuring these address all the points raised, contain empathetic apologies, are factually accurate and demonstrate lessons learnt are continually emphasised as the key principles.

Reopened complaints have been incorporated into the Patient Experience Quality Priorities for 2024/25 as an additional quality measure for the complaints process. This Trust aims to have less than <5% of total complaints/concerns reopened, performance against this target will be reflected upon annually, as part of the Patient Experience Q4 report.

2. Learning from Patient Experience

Patient Stories

For April's Patient Experience Steering Group (PESG) the committee heard Helen's story. This story was a recount of her experiences as a British Sign Language user, during her 12week inpatient stay.

The following learning was taking from Helen's story:

✓ Better methods of communicating what is available and empowering patients to tell us what they need

✓ Diversifying the ways we can communicate

✓ More education for staff on the rights to BSL interpreters under the Equality Act and how to access these

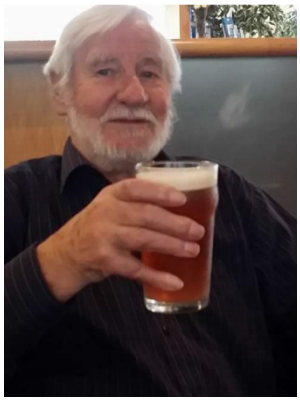
✓ Better support for our staff on the importance of the right methods of communication, especially for key points in the patient's journey

This tiggered the **Hard of Hearing Project** which launched during Deaf Awareness Week (May 2024).

During that week the PALS team with support from colleagues from Speech and Language undertook a Trolley Dash, which visited 17 different locations and spoken to over 60 members of staff. The aim of the trolley dash was to:

- ✓ Launch of refreshed SaLi resources and website pages
- ✓ Showcasing the HoH Resource Boxes
- ✓ Practical demonstration of the challenges of hearing loss using noise cancelling headphones
- ✓ Simple techniques and guidance for communicating with those who are Deaf or hard of hearing
- ✓ Launch the new on demand BSL services provider - SignLive

Full details of this project are contained in the Patient Engagement Annual Report.



In June, the committee heard an in-person patient story from Louise, daughter of Harry who passed away from rectal cancer (*pictured*). Her story had also been shared with the Medicine's Division at their Learning from Incidents forum.

Themes from the patient story included, poor communication, patient and family not being listened to and the distress causes by the Clinical Review process. Medicine as a Division were able to reflect and learn from this experience and this also gave the Trust an opportunity to update Louise on the new PSIRF processes and how the Clinical Review process has subsequently changed to put the patient/families at the centre of these investigations.

Patient Experience Division Presentations

We continue to develop the agenda of the Patient Experience Steering Group to ensure there are equal opportunities for sharing patient experiences seen through DMT's and Clinical Governance Sessions. Throughout Q1, complaints and FFT data from Q4 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 – Q4 Patient Experience data presented to Divisions during Q1:

Division	Data presented to Division	Division update to PESG
Surgery	17th July 2024	*Deferred to July 2024
CSFS	27th June 2024	26th June 2024
Medicine	28th May 2024	26th June 2024
Women & Newborn	17th May 2024	24th April 2024
Facilities (Food & Nutrition /PLACE)	4th June 2024	24th April 2024

Facilities Update to PESG (24th April 2024):

Summary of services and noted 11 SOX's since January. 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. Staff Park and Ride service was highlighted as particularly successful, acknowledging 47 regular staff users, allowing flexibility staff parking spaces to be moved over to patient parking. Challenges were recognised around the registering of blue badges and the delays with applying for the permit resulting in patients receiving PCNs. This was a noted theme for enquiries to the PALS office this quarter as a result.

Women and Newborn Update to PESG (24th April 2024):

Shared the National Maternity Patient Experience Survey 2023 – overall positive summary.

Feed back about the new booklet being offered to women. Considerations currently around offering this in different languages and in a digital format.

There is move towards digital maternity notes and this will be included in the booklet.

There was noted to be a positive response to the changes to visiting rules (particularly around partners staying on the ward).

Medicine Division Update to PESG (26th June 2024)

Emphasis on positive feedback, covering various SOX awards. The division is working closely with PALS to share achievements and continually looking at ways to improve patient experiences, using the Improving Together methodology. The continued development of the Divisions Learning from Incidents Forum was showcased, assurance was taken on the level of staff engagement.
Noted that AFU were finalists for Health Service Journal award – SDEC (Same Day Emergency Care service)

The division reflected their challenges with: Communication, Admission/Discharge processes, Patient Care and Staff Attitude/Behaviour as currently themes from complaints.

Shared the learning from complaints – actions taken include promotion of more early resolution meetings and patient stories being shared through the incident forums. Staff encouraged to attend the Trust's communication workshops, work being done to improve admission and discharge paperwork.

Assurance was taken that if CQC were to visit, that staff able to articulate these improvements and share this learning if questioned.

CSFS Division Update to PESG (26th June 2024)

Shared positive feedback from patients mostly outpatient feedback, various SOX have been submitted.

Complaint themes for Q4, feature patient care quite highly but noted that compliments still far exceed the number of complaints on a per 1,000 basis. Review of location of complaints, concerns and compliments, no emerging themes of note.

FFT response rates for Q4, noted a dip in response rate, but recognise that the introduction of the new SMS solution will significantly impact the Divisions overall response rate going forward.

Shared divisional challenges including replacing CT scanner which is delayed and causing extended wait times, and the delivery of ultrasound machines to the hospice to reduce patients being transferred to other departments.

Assurance was taken that if CQC were to visit, that staff able to articulate these improvements and share this learning if questioned.

Patient Safety Partners to be invited to the CSFS's Learning from Incidents Forums (LFIF) once these go live.

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 May 2024 Bands 6 and 7 staff as part of the new Imber Ward launch in the late Spring.

4. CQC & PHSO Complaints Summary *(new)

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 1 the Trust received 4 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 Q1

Concern (listed chronologically)	Location / Area related	Request from CQC	Outcome
Concern 1	AMU	Information on staff training on AMU in relation to : - peripheral intravenous access devices - deep vein thrombosis - in addition, any complaints or concerns raised about staff by patients in the last 3 months	Information shared, no further follow-up from CQC
Concern 2	Odstock/Laverstock	Assurance around general care received	Information shared, case was closed by the CQC
Concern 3	Redlynch	Assurance that staff on Redlynch ward have received stoma care training and assurance on how the senior leadership team have assurances patients with stomas are cared for appropriately (there was also an additional request for the investigation details of this concern to be shared)	Information shared, no further follow-up from CQC.
Concern 4	ED	Request for specific update related to follow-up of a complainant via the PALS complaints process.	Information shared, no further follow-up from CQC

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

	Q1 24-25			
Across all Directorates	4			

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 1 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 Q1

Concern	Location/Area related	Request from PHSO	Outcome
None.			

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

	Q1 24-25			
Across all Directorates	0			

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

This quarter, leads from Risk, Patient Safety, Experience and Freedom to Speak Up have attempted to re-group the previously held data triangulation meetings. The group was expanded last year to include H&S, Occupational Health, and OD&P. However this expansion was unsuccessful given the complexity of the data being compared, and the different formats and systems being used.

The first meeting reviewed data from Q1 and Table 5.1 below is a summary of these discussions:

Table 5.1 Triangulating Data – Leads Meeting Summary – Q1 24/25

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.
• Nil to alert this quarter.
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.
• Nil to advise this quarter.
ASSURE: Inform the board where positive assurance has been achieved, share any practice, innovation or action that the Committee considers to be outstanding.
• Sub-themes from complaints were reflected to have some links with elements of the Fundamentals of Care – task group has already been established to look at this in September. • Risk will be reconsidering their theme data to look at themes that are increasing but may not be the highest prevalence. Recognised there are robust reporting processes in place for reporting pressure ulcers and falls, which may dictate prevalence. • This group will continue to meet quarterly to review and compare data. This summary will be shared with the "We are Safe and Health Group" and also in the quarterly Patient Experience Report for Q1.

6. Triangulation of data – ICB Acute Trusts *(new)

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 data, however more work is needed to ensure that the data is compared relatively, particularly given the difference 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

Nil to update this quarter.

8. Division Summaries – Complaints, Concerns and Compliments

Non-Clinical Divisions (Facilities, Quality, Trust Offices, Corporate etc.)

0 complaints/concerns were recorded for **non-clinical** divisions in Q1.

There were a total of 114 comments/enquiries logged for the non-clinical divisions in Q1 (76 more than in Q4). **67%** of these were related to **charges for car parking**.

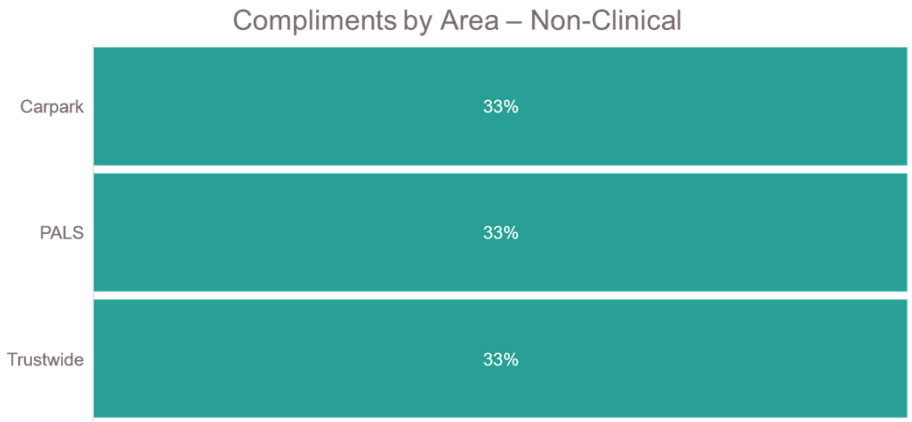
PALS are currently working with the Car Parking team to understand the causes for the themes around incorrectly issued parking charges, which make up a vast majority of these.

Compliments – Non-Clinical Divisions (Facilities, Trust Offices, Corporate etc.)

There were 3 compliments recorded on Datix for non-clinical divisions across Q1.

Figure 8.0 shows the proportion of these complaints by location for this period:

Figure 8.0 – Proportion of compliments by area



Clinical Support and Family Services (CSFS)

- There were a total of 11 complaints and concerns received during Q1 (4 more than Q4)
- The division achieved a 50% response rate for response to complaints and concerns during this period (33% achieved in Q4)
- 0 complaints/concerns were reopened
- 19 compliments were formally logged on Datix (13 in Q4), at time of reporting there were no outstanding compliments for logging with PALS.

Table 8.1 Summary of number of received, reopened and response within timeframe, also includes quarterly average for 23/24 as a comparator.

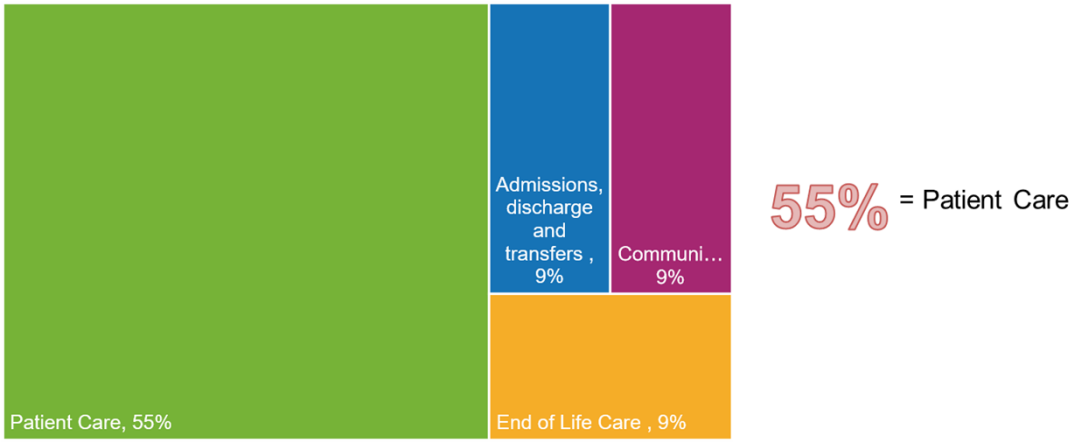
- Positive downward trajectory on previous quarter
- Negative downward trajectory on previous quarter
- No change on previous quarter
- Positive upward trajectory on previous quarter
- Negative upward trajectory on previous quarter

	Q2 23-24	Q3 23-24	Q4 23-24	Q1 24-25	Quarterly average for 23/24
Complaints	▸ 2	▲ 5	▼ 3	▲ 6	3
Concerns	▲ 5	▼ 2	▲ 4	▲ 5	3
Compliments	▼ 5	▲ 19	▼ 13	▲ 19	11.25
FFT Responses	▼ 315	▼ 241	▼ 176	▲ 1,847	283.75
Re-opened complaints/concerns	▸ 0	▸ 0	▸ 0	▸ 0	0
% closed complaints responded to within agreed timescale	▼ 67%	▲ 100%	▼ 33%	▲ 50%	75%
Complaints closed in this quarter	3	3	3	6	3
Complaints by Division activity (per 1,000)	▸ 0.06 (33,871)	▲ 0.15 (33,495)	▼ 0.08 (36,547)	▲ 0.16 (36,630)	Average quarterly activity for the Division
Concerns by Division activity (per 1,000)	▸ 0.15 (33,871)	▼ 0.06 (33,495)	▲ 0.11 (36,547)	▲ 0.14 (36,630)	34,863
Compliments by Division activity (per 1,000)	▼ 0.15 (33,871)	▲ 0.57 (33,495)	▼ 0.36 (36,547)	▲ 0.52 (36,630)	

Figure 8.1 demonstrates the most prevalent high-level themes for opened complaints during Q1.

Figure 8.1 – Summary of themes for CSFS Complaints and Concerns – Q1 2024/25

This quarter **patient care** remains a consistent, dominant theme from Q4. **Admissions, discharge and transfer** and **end of life care** are new themes this quarter.



Within these themes the following tables shows a sub-category breakdown for further context of these complaints:

Table 8.1a

Patient Care	**6**	**55%**
Assistance not given	1	17%
Inappropriate treatment	1	17%
Infection risk	1	17%
Nursing Care	1	17%
Unsatisfactory treatment	**2**	**33%**

Compliments – Clinical Support and Family Services

Figure 8.2 – CSFS Compliments breakdown

There were a total of 19 compliments for CSFS across Q1. This is an increase on previous quarters and all have been logged on Datix. Figure 8.2 shows a breakdown of where the compliments were received: Sarum, Spinal Unit and Radiology were noted to have the highest proportion of these compliments.

Figure 8.2a is a word cloud summarising key themes from this compliments.

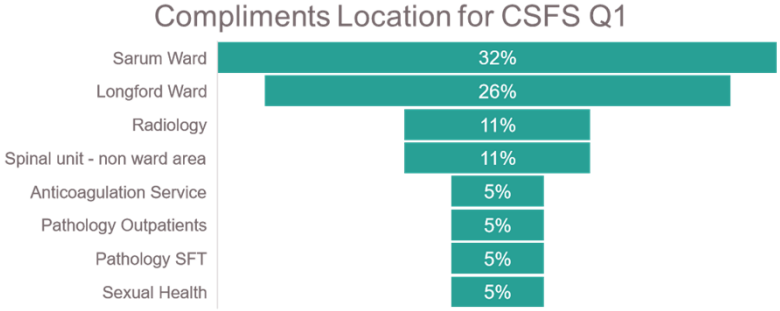


Figure 8.3 shows correlation of number of complaints, concerns and compliments by patient activity for Clinical Support & Family Services**.**

Figure 8.4 shows the location of complaints, concerns and compliments by area:

Figure 8.3 – CSFS patient activity correlation with feedback

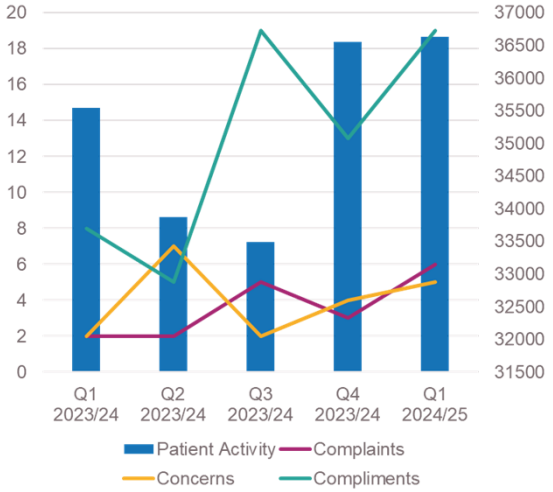
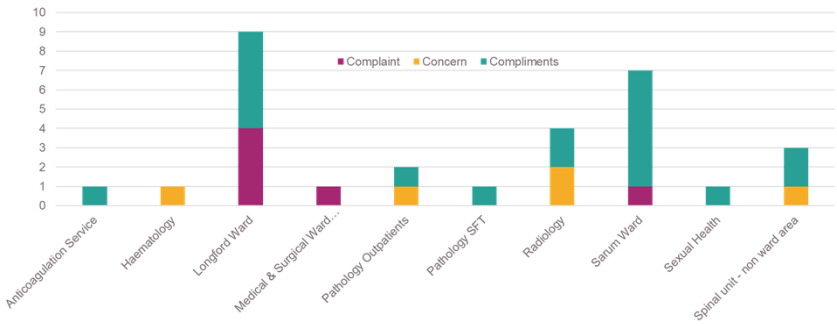


Figure 8.4 – Location of complaints, concerns and compliments by area



The Division has seen a slight increase in the total number of logged complaints and concerns over the past two quarters, patient activity remains similar.

Women and Newborn

- There were a total of 11 complaints and concerns for Q1 – same as Q4.
- 3 complaints were closed in Q1; 100% of these were within the agreed timescale. This is a significant increase on the 50% achieved in the previous quarter.
- 0 complaints were reopened.
- 19 compliments were formally logged on Datix, however 37 remain unreported due to a backlog with reporting within PALS, total indicated below in (brackets).

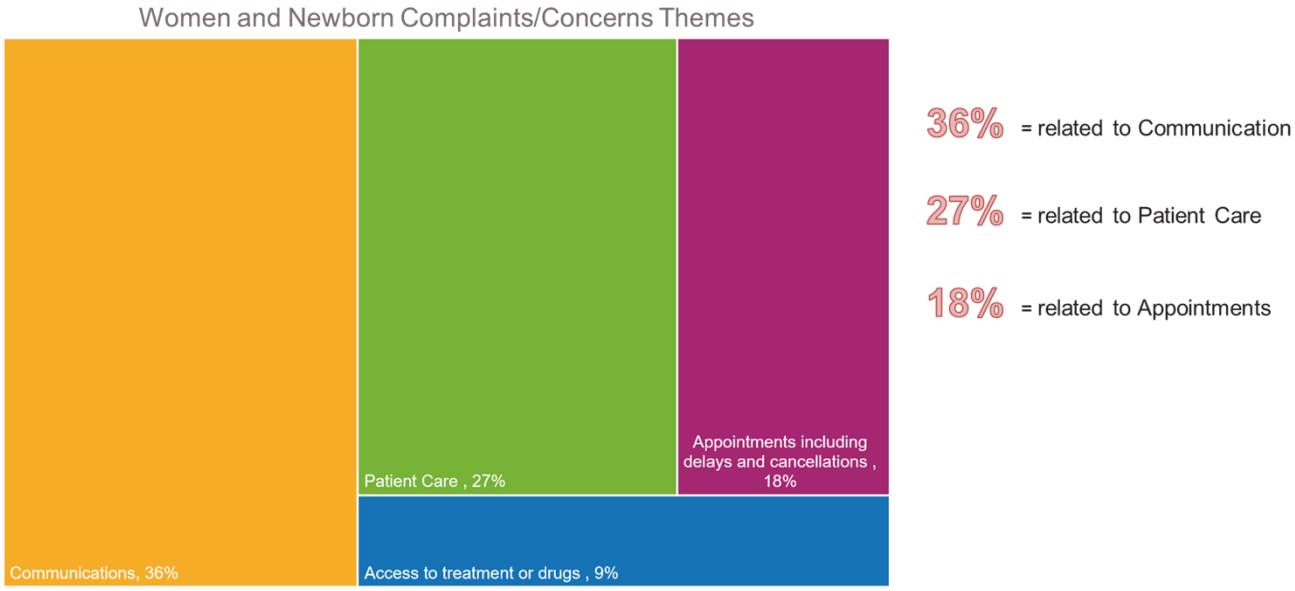
Table 8.2 Summary of number of received, reopened and response within timeframe, also includes quarterly average for 23/24 as a comparator.

- Positive downward trajectory on previous quarter
- Negative downward trajectory on previous quarter
- No change on previous quarter
- Positive upward trajectory on previous quarter
- Negative upward trajectory on previous quarter

	Q2 23-24	Q3 23-24	Q4 23-24	Q1 24-25	Quarterly average for 23/24
Complaints	▲ 4	▲ 6	▼ 4	▲ 8	4.25
Concerns	▲ 8	▼ 6	▲ 7	▼ 3	6
Compliments	▼ 16	▼ 4	▲ 36	▼ 19 (56)	28.5
FFT Responses	▼ 18	▲ 38	▼ 28	▲ 319	33
Re-opened complaints/concerns	▲ 1	▲ 2	▼ 1	▼ 0	0.5
% closed complaints responded to within agreed timescale	▼ 55%	▼ 0%	▲ 50%	▲ 100%	39%
Complaints closed in this quarter	11	2	8	3	6
Complaints by Division activity (per 1,000)	▲ 0.92 (4, 330)	▲ 1.34 (4, 471)	▼ 0.87 (4, 576)	▲ 1.51 (5, 291)	Average quarterly activity for the Division
Concerns by Division activity (per 1,000)	▲ 1.85 (4, 330)	▼ 1.34 (4, 471)	▲ 1.53 (4, 576)	▼ 0.57 (5, 291)	4,396
Compliments by Division activity (per 1,000)	▼ 3.70 (4, 330)	▼ 0.89 (4, 471)	▲ 7.87 (4, 576)	▼ 3.59 (5, 291)	

Figure 8.5 – Summary of themes for W&N Complaints and Concerns – Q1 2024/25

Communication remains the highest theme for complaints this quarter, and consistent with Q4. **Patient care** is a theme again this quarter, and in higher proportion. **Appointments, including delays and cancellations** are a new theme this quarter.



Within these themes, **lack of communication** made up 75% of those categorised under **communication**.

Tables 8.2a to 8.2c, shows the sub-category breakdown for further context of these themes.

Table 8.2a

Communications	**4**	**36%**
Insensitive communication	1	25%
Lack of communication	3	75%

Table 8.2b

Patient Care	**3**	**27%**
Further complications	1	33%
Inappropriate treatment	1	33%
Unsatisfactory treatment	1	33%

Table 8.2c

Appointments	**2**	**18%**
Appointment postponed	1	50%
Unsatisfactory outcome	1	50%

Compliments – Women & Newborn

There was a total of 19 recorded compliments for W&N across Q1, that were all formally recorded on Datix. There is currently 37 which remain unlogged by PALS for this period.

Figure 8.6 shows a breakdown of where the compliments recorded on Datix were received.

Figure 8.6a is a word cloud to summarise these compliments

Figure 8.6 – W&NB compliments location

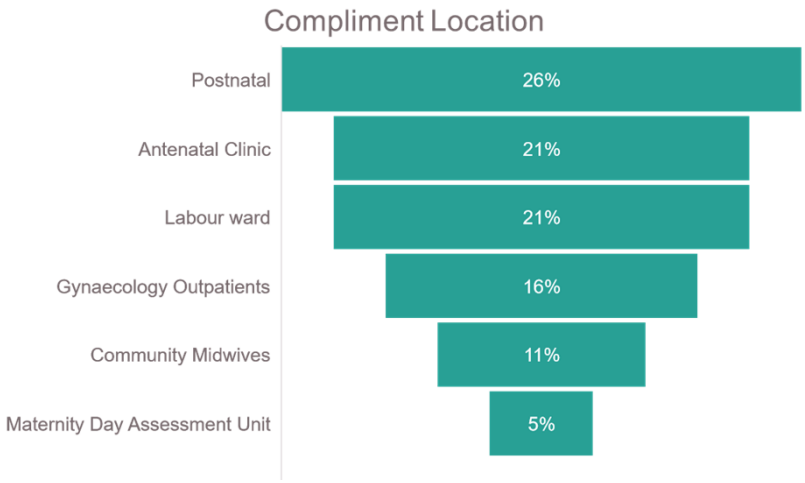


Figure 8.6a – W&NB compliments word cloud

Figure 8.7 shows correlation of number of complaints, concerns and compliments by patient activity for Women and Newborn

Figure 8.8 shows the location of complaints, concerns and compliments by area.

Figure 8.7 - WNB patient activity correlation with feedback

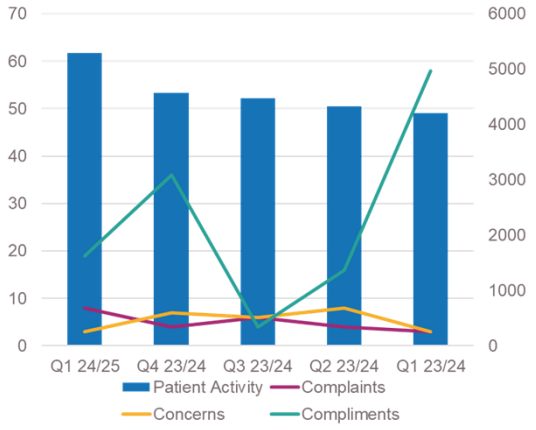
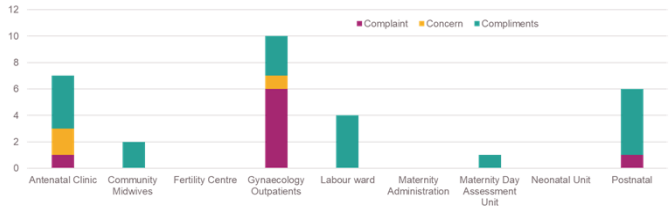


Figure 8.8 – Location of complaints, concerns and compliments by area



The Division seen a increase in patient activity this quarter, this has grown steadily over the past 12months. Total complaints and concerns received in this period remained static despite this.

Medicine

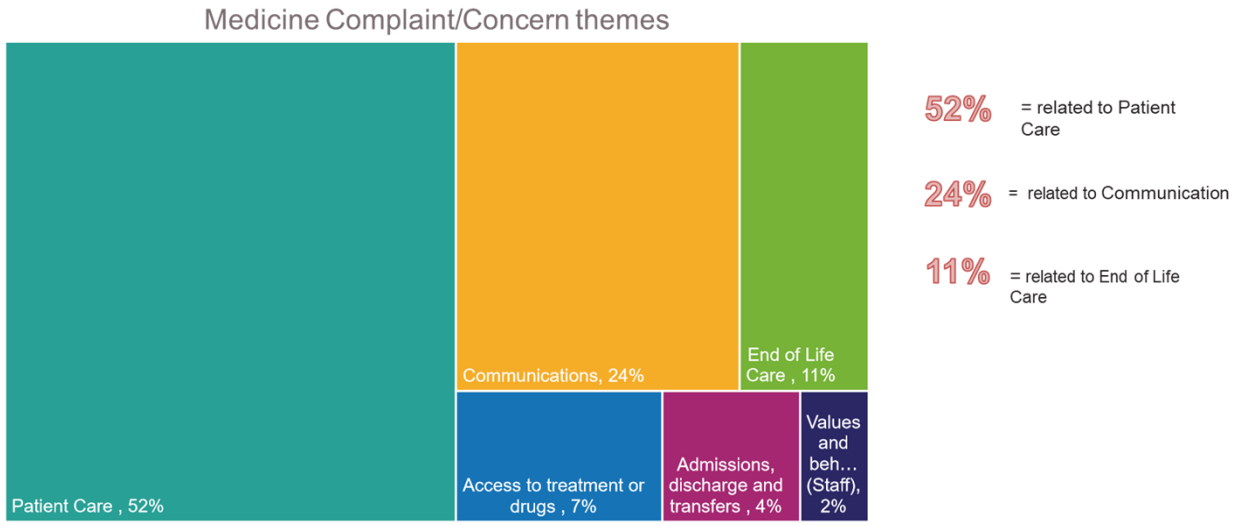
- There were a total of 46 complaints and concerns for Q1, this is an increase on the total number seen for Q4 (n~34).
- 90 compliments were formally logged on Datix. This is more than Q4, however 139 remain unreported due to a backlog with reporting within PALS, total indicated below in (brackets).
- 7 complaints were closed in Q1; with 43% being responded to within the agreed timescale. This is a slight improvement on Q4.
- 2 complaints/concerns reopened this quarter, 2 less than Q4.

- Positive downward trajectory on previous quarter
- Negative downward trajectory on previous quarter
- No change on previous quarter
- Positive upward trajectory on previous quarter
- Negative upward trajectory on previous quarter

Table 8.3 Summary of number of received, reopened and response within timeframe, also includes quarterly average for 23/24 as a comparator.

	Q2 23-24	Q3 23-24	Q4 23-24	Q1 24-25	Quarterly average for 23/24
Complaints	▲ 18	▼ 15	▶ 15	▲ 29	15
Concerns	▲ 20	▲ 21	▼ 19	▼ 17	19
Compliments	▲ 101	▲ 169	▼ 79	▼ 90 (229)	100
FFT Responses	▲ 935	▼ 799	▲ 864	▲ 1,730	792.75
Re-opened complaints/concerns	▶ 2	▼ 1	▲ 4	▼ 2	2.25
% closed complaints responded to within agreed timescale	▲ 67%	▼ 61%	▼ 41%	▲ 43%	57%
Complaints closed in this quarter	15	18	17	7	18
Complaints by Division activity (per 1,000)	▲ 0.52 (34, 921)	▼ 0.43 (35, 002)	▼ 0.40 (37, 402)	▲ 0.76 (38, 139)	Average quarterly activity for the Division
Concerns by Division activity (per 1,000)	▲ 0.57 (34, 921)	▲ 0.60 (35, 002)	▼ 0.51 (37, 402)	▼ 0.45 (38, 139)	35,470
Compliments by Division activity (per 1,000)	▲ 2.89 (34, 921)	▲ 4.83 (35, 002)	▼ 2.11 (37, 402)	▲ 2.36 (38, 139)	

Figure 8.9 – Summary of themes for Medicine Complaints and Concerns – Q1 2024/25



For comparison, two of the top themes noted for Q4 remained consistent again this quarter. **Patient Care** has however replaced **Communication** as the most prevalent theme. New emerging theme related to **end of life care** this quarter.

Tables 8.3a to 8.3c show a breakdown of all the sub-categories for further context of the themes from these complaints:

Table 8.3a

Patient Care	**24**	**52%**
Correct diagnosis not made	1	4%
Inappropriate treatment	2	8%
Neglect	2	8%
Nursing Care	1	4%
Unsatisfactory treatment	18	75%

Table 8.3b

Communications	**11**	**24%**
Insensitive communication	5	45%
Lack of communication	5	45%
Wrong information	1	9%

Table 8.3c

End of life care	**5**	**11%**
Dignity in End of Life Care	2	40%
Lack of Care	2	40%
Poor communication	1	20%

Compliments - Medicine

There was a total of 90 compliments logged for Medicine on Datix for Q1, this was noted to be higher than the previous quarter and it should be noted the significant number of compliments that remain unrecorded due to PALS capacity this quarter.

Figure 8.10 shows a breakdown of where the compliments were received:

Figure 8.10a is a word cloud to summarise these compliments

Figure 8.10 – Medicine Compliments breakdown

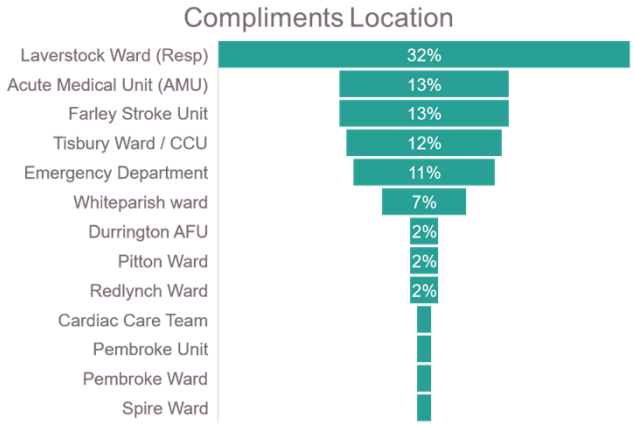


Figure 8.10a – Word cloud

Figure 8.11 shows correlation of number of complaints, concerns and compliments by patient activity for Medicine.

Figure 8.12 shows the location of complaints, concerns and compliments by area:

Figure 8.11 – Complaints, concerns and compliments correlation with patient activity

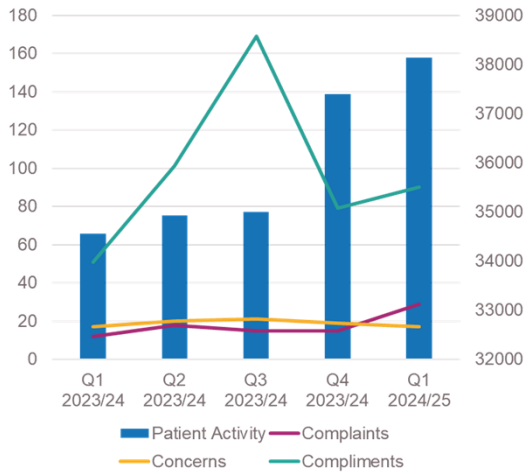


Figure 8.12 – Location of complaints, concerns and compliments by area

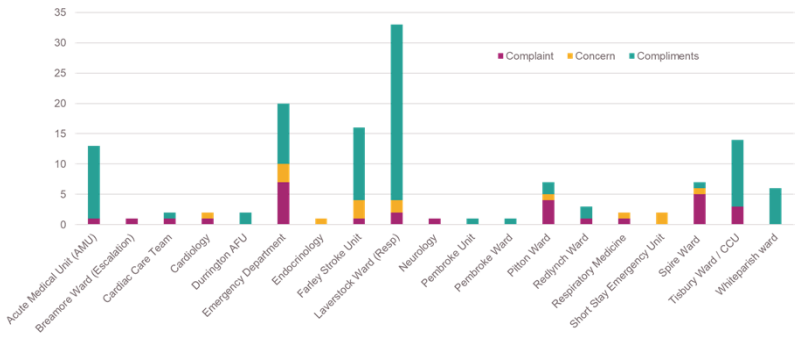


Figure 8.11 is demonstrating a relatively static number of concerns and complaints compared with the continued increase in patient activity.

Surgery

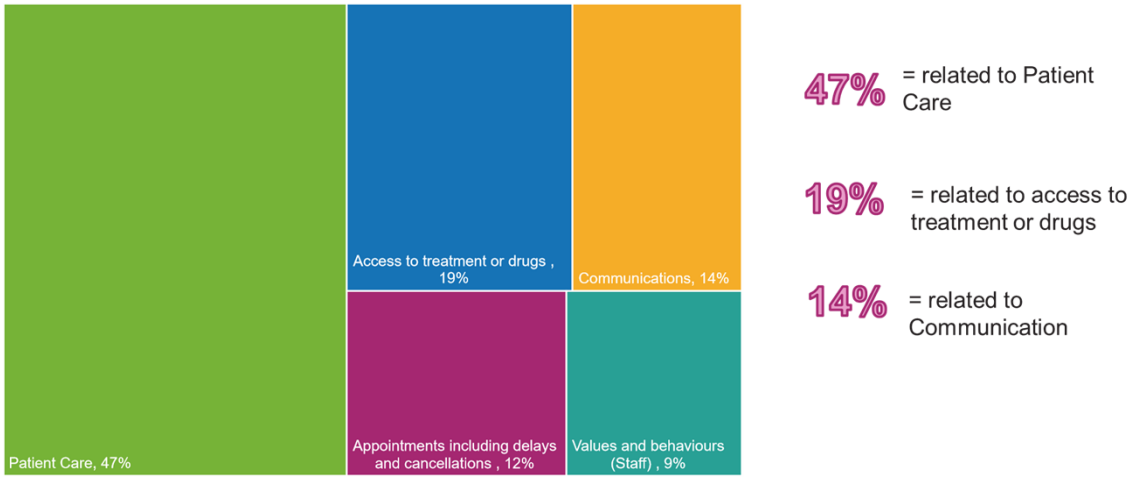
- There were a total of 43 complaints and concerns for Q1, an decrease of 4 from Q4.
- 17 complaints were closed in Q1, 1 less than Q4. 59% of these were on target compared with 33% in Q4.
- 4 were reopened this quarter, a decrease of 1 from the previous quarter.
- 37 compliments were logged this quarter. A slight decrease on Q4. However, 44 remain unreported due to a backlog with reporting within PALS, total indicated below in (brackets).

Table 8.4 Summary of number of received, reopened and response within timeframe, also includes quarterly average for 23/24 as a comparator.

- Positive downward trajectory on previous quarter
- Negative downward trajectory on previous quarter
- No change on previous quarter
- Positive upward trajectory on previous quarter
- Negative upward trajectory on previous quarter

	Q2 23-24	Q3 23-24	Q4 23-24	Q1 24-25	Quarterly average for 23/24
Complaints	▼ 16	▲ 17	▲ 22	▼ 20	18.25
Concerns	▲ 23	▲ 29	▼ 25	▼ 23	24
Compliments	▼ 51	▲ 111	▼ 92	▼ 37 (81)	79
FFT Responses	▼ 1,261	▼ 1,057	▼ 968	▼ 2, 769	1140.25
Re-opened complaints/concerns	▲ 5	▼ 4	▲ 5	▼ 4	4
% closed complaints responded to within agreed timescale	▲ 22%	▲ 43%	▼ 33%	▲ 59%	27%
Complaints closed in this quarter	27	14	18	17	22
Complaints by Division activity (per 1,000)	▼ 0.40 (39,997)	▲ 0.41 (41,789)	▲ 0.53 (41,456)	▼ 0.47 (42,344)	**Average quarterly activity for the Division**
Concerns by Division activity (per 1,000)	▲ 0.58 (39,997)	▲ 0.69 (41,789)	▼ 0.60 (41,456)	▼ 0.54 (42,344)	40, 934
Compliments by Division activity (per 1,000)	▼ 1.28 (39,997)	▲ 2.66 (41,789)	▼ 2.22 (41,456)	▼ 0.87 (42,344)	

Figure **8.13 –** Summary of themes for Surgery Complaints and Concerns – Q1 2024/25



For comparison, two of the top themes common for Q4 remained consistent again this quarter. **Patient care** and **communication**. There is a new emerging theme this quarter, related to **access to treatment or drugs**.

Within these three most prevalent theme(s), tables 8.4a - 8.4c show the full sub-category breakdown for further context of the themes of these complaints:

Table 8.4a

Patient Care	**24**	**47%**
Correct diagnosis not made	5	21%
Delay in making diagnosis	2	8%
Further complications	6	25%
Harm	1	4%
Nursing Care	3	13%
Pain management	1	4%
Unsatisfactory treatment	6	25%

Table 8.4b

Access to treatment or drugs	**4**	**19%**
Delay in receiving treatment	3	75%
Treatment unavailable	1	25%

Table 8.4c

Communications	**5**	**14%**
Delay in receiving/sending information	1	20%
Insensitive communication	2	40%
Lack of communication	1	20%
Wrong information	1	20%

Compliments – Surgery

There was a total of 37 compliments logged on Datix for Q1, this was noted to be lower than the previous quarter, however it should be noted the significant number of compliments that remain unrecorded due to PALS capacity this quarter (44).

Figure 8.14 shows a breakdown of where the compliments were received. Radnor ward received the highest proportion of these compliments.

Figure 8.14a is a word cloud to summarise these compliments

Figure 8.14 – Surgery Compliments breakdown

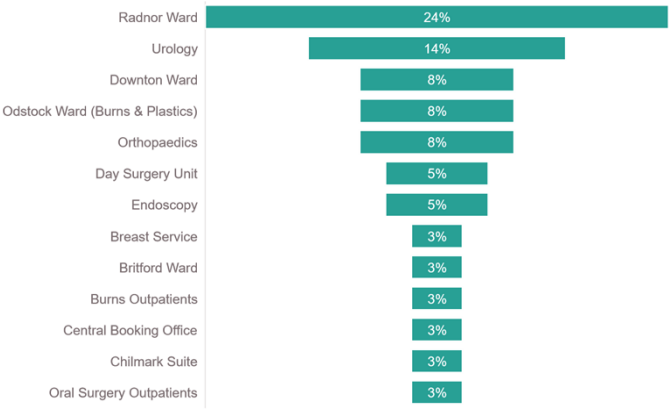


Figure 8.14a compliments word cloud

Figure 8.15 shows correlation of number of complaints, concerns and compliments by patient activity for Surgery.

Figure 8.16 shows the location of complaints, concerns and compliments by area:

Fig 8.15 Activity compared with Complaints, Concerns and compliments

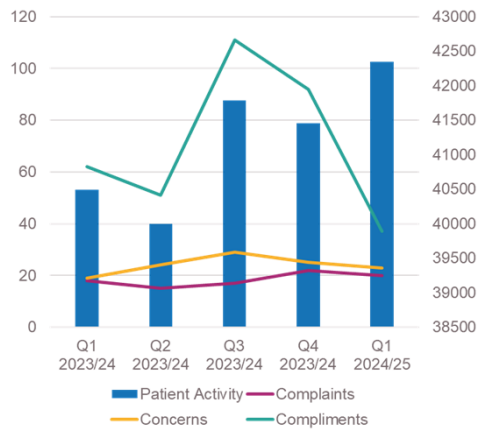


Figure 8.16 – Location of complaints, concerns and compliments by area

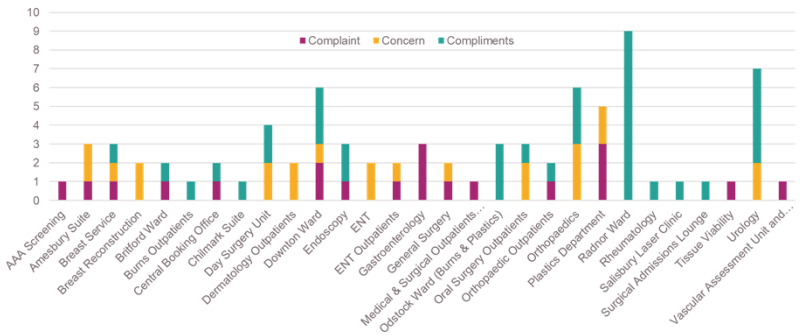
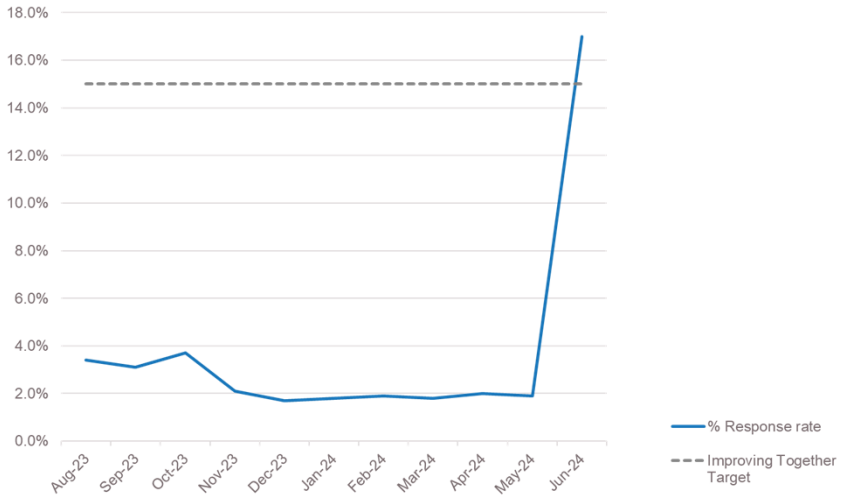


Figure 8.15 is demonstrating a slight decline in the number of recorded complaints and concerns. This is also against a backdrop of increased patient activity.

9. 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 **7,578** patients provided feedback through the paper form for the Friends and Family Test (FFT) in Q1. This is 5,536 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 is still below the target, despite the launch of the digital solution. However assurance is felt that this is expected to meet and even exceed this in Q2, as the system would be fully live throughout that reporting period.

96% Of those surveyed rated their experience of our hospital as Good or Very Good (average for Q1 2024-25)

9.64%* Response rate (*of eligible population and averaged for Q1 2024-25)

The following key words and themes for June (only) are demonstrated here:

Top 10 Words

+ Positive		− Negative	
1. Good	939	1. Appointment	75
2. Staff	854	2. Time	60
3. Friendly	545	3. Waiting	52
4. Time	511	4. Hours	47
5. Excellent	433	5. Staff	42
6. Service	427	6. Wait	38
7. Helpful	406	7. Consultant	35
8. Appointment	375	8. Seen	30
9. Efficient	328	9. Scan	28
10. Professional	314	10. Still	24

Top 10 Themes

+ Positive		− Negative	
1. Staff attitude	2501	1. Staff attitude	165
2. Implementation of care	1331	2. Environment	126
3. Environment	1078	3. Waiting time	117
4. Communication	793	4. Communication	112
5. Patient Mood/Feeling	725	5. Implementation of care	109
6. Waiting time	684	6. Clinical Treatment	95
7. Clinical Treatment	646	7. Patient Mood/Feeling	92
8. Admission	527	8. Admission	76
9. Staffing levels	136	9. Staffing levels	24
10. Catering	46	10. Catering	12

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 97% 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 23-24	Q3 23-24	Q4 23-24	Q1 24-25
Across all Directorates	▲ 22.36 (113, 119)	▼ 18.66 (114, 757)	▼ 17.00 (119, 981)	▲ 61.91 (122, 404)

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

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

Friends and Family Test – Digital Go Live

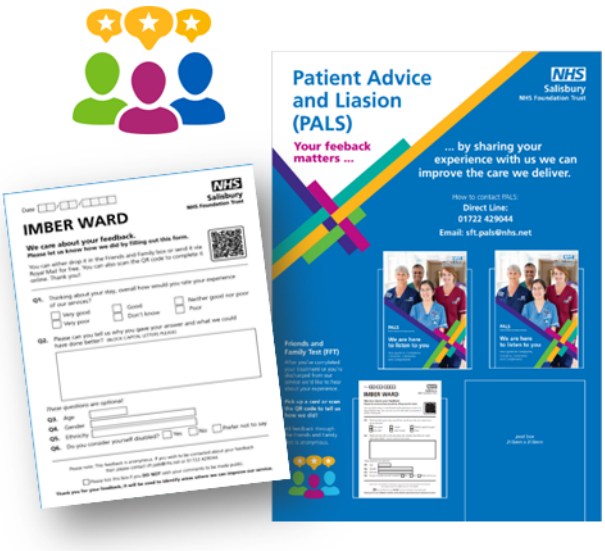
The digital FFT launch on the 1st June 2024. This transition has already demonstrated the following benefits:

- ✓ 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 also 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 are also being considered for outpatient areas as part of a second phase roll-out.

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



Challenges to note:

The loss of clinic level feedback was an anticipated drawback of the implementation of the new system. However, this was necessary in order to improve response rate and the accuracy of reporting.

This does pose an opportunity for individual services and clinics to consider alternative, more bespoke and appropriate ways to measure their service's performance and to develop local

service improvement action plans. These services are currently in conversation with the Patient Experience teams on how they might achieve this.

We continue to regularly promote positive feedback received via FFT through weekly social media plugs under "*#ThankyouThursday*" and "*#FeedbackFriday*" hashtags. Examples take from Quarter 1 24/25:

10. 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.

Real-time feedback (RTF) has reduced in Q1, due to availability of volunteers, governors and work experience students. In Q4 a total of 102 surveys were completed – achieving an overall average satisfaction rating of 81.6%. This quarter has seen a reduction of number of surveys (n~73), and marginal reduction in overall satisfaction score (81.0%). See Table 10.1 for in month breakdown.

RTF is now regularly presented to the Patient Experience Steering Group, reflecting on the data from the previous month. Summary of analysis to date:

Table 10.1 Number of inspections and locations visited

Month	Total number of surveys	Number of inpatient areas visited	Wards surveyed	Average Score
April	**44**	**8**	Spire, Britford, Braemore, Pembroke, Downton, AMU, Whiteparish, Tisbury	78.4%
May	**16**	**5**	Longford, Braemore, Durrington, Laverstock, AMU	87.0%
June	**13**	**4**	Pembroke, Amesbury, Farley, Durrington	82.5%
Total	**73**	**17**	81.0%	

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

Area	Number of inspections	Average score
Spire	5	68.26%
Britford	5	70.70%
Breamore	4	71.04%
Pembroke	1	78%
Downton	7	79.11%
AMU	3	81.45%
Whiteparish	8	83.38%
Tisbury	11	84.38%

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

Area	Number of inspections	Average score
Longford Ward	4	80.65%
Breamore	4	87.16%
Durrington	1	89%
Laverstock	5	90.28%
AMU	2	90.64%

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

Area	Number of inspections	Average score
Pembroke	2	79.82%
Amesbury	5	80.08%
Farley	3	83.50%
Durrington	3	87.48%

Tables 10.2 and10.3 shows the breakdown of average response to specific questions.

There is a notable consistency with last quarter in relation to negative themes around noise at night, however the prevalence this quarter has been attributable to noise at night from staff.

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

Table 10.2 highest scoring questions:

Question Text	Answer score (%)	Responded Answers
Are you receiving enough to drink?	100	43
Are you receiving enough to eat?	97.6	43
Do you feel safe?	95.4	44
How would you rate the cleanliness of the ward you are in?	93.1	44
Do you feel comfortable?	93.1	44
How would you describe the trust and confidence you have in those involved in your care?	91.5	44

Table 10.3 lowest scoring questions:

Question Text	Answer score (%)	Responded Answers
Is there noise at night from staff?	36.3	44
Do you feel Nervous?	39.3	33
Is there noise at night from Equipment or machines?	41.8	43
Do you feel Anxious?	45.4	33
How would you describe the quality of written information provided about your operation or procedure?	50	5
Is there noise at night from other patients?	56.8	44
Do you feel Bored?	60.6	33
How would you describe the noise level on the ward at night?	66.1	44

The RTF annual report is scheduled for presentation at PESG in September. This includes a deep dive around themes related to discharge planning, correlating this with a complaint theme also seen around this same relative time period. This covers the period July 2023 to July 2024. More detailed on the interpretation of this data can found in that annual report.

National Audit for End of Life Care (NACEL) Survey – Q1 Report 2024/25

From 1st April 2024 the NACEL survey replaced the Trust's Your Views Matter (YVM) survey for 9months to allow for national benchmarking to take place for this period. YVM is anticipated to resume for the final quarter of 2024/25.

It should be noted that there is limited ability for comparison with the Trust's YVM survey results for 2023/24 as a result of this change. However, the NACEL survey does present an opportunity to compare the Trust's performance within these measures with our BSW acute Trust counterparts.

This report contains no comparisons to previous quarter's performance, with the exception of response rates. These were noted to have decreased slightly on Q4 (going down from 38% to 35% this quarter). However, this is slightly higher than the average seen for 2023/24 (32%).

This is also against a decreased survey rate, of 54% of bereaved families agreeing to receiving this survey, compared with 69% in Q4.

65% of SFT's respondents described their overall rating of care and support given by the hospital to the dying person as "excellent", compared with 10% who described this as "Poor". Comparisons for previous quarters cannot be made, as the rating scales are different this quarter.

In summary, the Trust has performed well in the vast majority of the quality survey focuses when compared with both the national data set and our South West peers. Response rates have been largely maintained when compared with previous quarters despite the change in process and survey.

The Trust outperformed both nationally and our South West peers in relation to three out of the four areas that the SFT focuses (dignity for the dying person, communication, and support for family/others of the dying person). However, relief of symptoms is an area to highlight, as an area of comparative underperformance. Support for families in terms of provision of appropriate interpreters for family/others the Trust also underperformed by comparison.

The NACEL survey is unable to be used to correlate complaint themes by location with this data as this is not collected as part of the audit. PALS are working with Medical Examiners to look at how they may be able to supplement this data.

7 survey participants requested a call-back from PALS, none of these resulted in a formal complaint or concern being raised.

Full report is scheduled for presentation to the End of Life Care Steering Group and Patient Experience Steering Group in September 2024.

11. Patient and Public Feedback – National Surveys

The National Inpatient Survey Report 2023 is anticipated for publication on the 21st August 2024. The findings will be included in the Q2 report.

Scheduled Reporting of Surveys

National Inpatient Survey 2023 – will be reported in (Q2) 24/25

Children and Young People Survey 2023 – will be reported in (TBC) 24/25

NHS Salisbury NHS Foundation Trust

Report to:	Trust Board (Public)	Agenda item:	7.10
Date of meeting:	3 October 2024		

Report tile:	Q1 Risk Management Report			
Status:	Information	Discussion	Assurance	Approval
	Yes	Yes	Yes	Yes
Approval Process: (where has this paper been reviewed and approved):	Clinical Management Board (August) Clinical Governance Committee (September)			
Prepared by:	Louise Jones- Head of Risk Management			
Appendices (if necessary)				

Recommendation:

The report aims to provide an overview of risk management activity in Quarter 1.

Executive Summary:

Reporting of incidents has remained consistent throughout the last year. The overall average of moderate harms has gradually decreased.

All Datix incidents undergo a robust quality check to ensure accuracy of reporting and reduce unwarranted variation.

The backlog of quality checks has been reduced and all incidents are now quality checked contemporaneously.

Trust wide daily incident huddle is undertaken each morning to review all incidents reported the previous 24 hours.

Datix Incident workflow has been updated to simplify incident journey for users and enables full transparency of data for accurate reporting. 81% of all no harm/low harms incidents reported in Q1 have been reviewed and closed. 58% were closed within the 28-day timeframe.

Backlog of externally reported incidents are now completed and contemporaneous.

Duty of Candour compliance has improved (stage 1 95% +16% Q4, stage 2 83% +13% Q4 and stage 3 78% +24% Q4). Ward follow ups from the team have been implemented to support with DoC following morning Datix Incident huddle, to support compliance.

100% of patient safety incidents have now been automatically forwarded to the LFPSE platform with the correct ODS code since the transition in December.

2480 incidents were reported in Q1 throughout the Trust, 3.08% of these were moderate or above harm. These incidents continue to be scrutinised through the weekly patient summit with executive oversight.

Progress has been made with each division to start their Learning from Incidents. Forums are running in 3 of the 4 divisions now.

Themes and trends continue to be analysed and fed into the monthly Divisional Learning From Incidents Forum.

Salisbury NHS Foundation Trust

Matron Risk Register Deep Dive has been implemented to review all ward/ department level risks as a pilot in Medicine Division.

Work in progress across all divisions following the KPMG audit to standardise and have clear audit trail of escalation for risks of concern.

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	No
Other (please describe):	N/a

NHS
Salisbury
NHS Foundation Trust

Risk Management Report

Salisbury NHS Foundation Trust

Quarter One (April, May and June 2024)

Louise Jones

Overview

Salisbury NHS Foundation Trust

This report has been written by the Risk Management team for SFT to detail the current trust position in relation to the following:

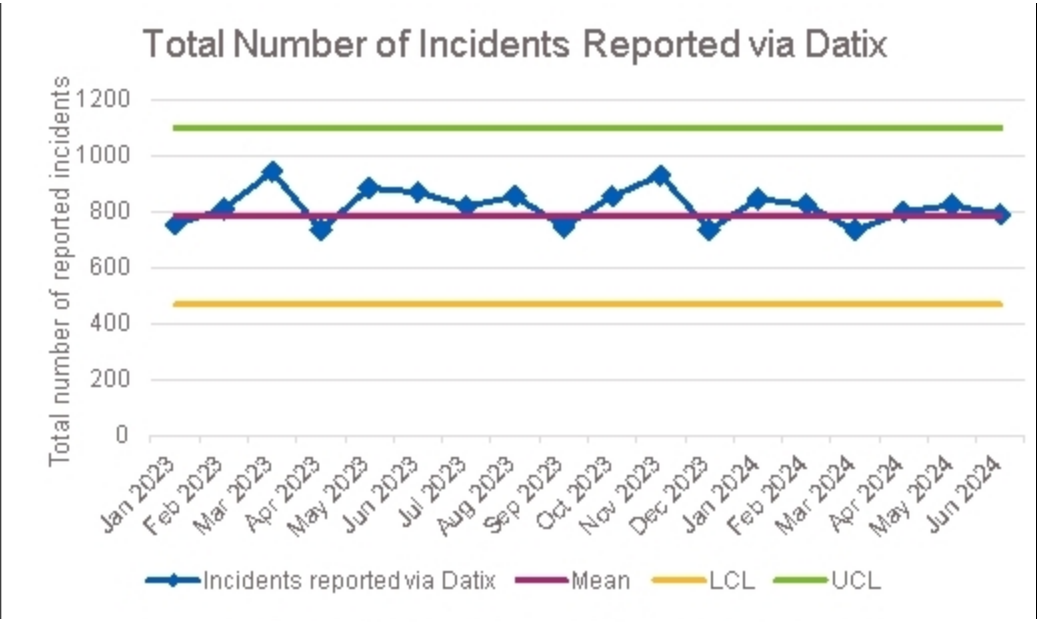
Q1 Data

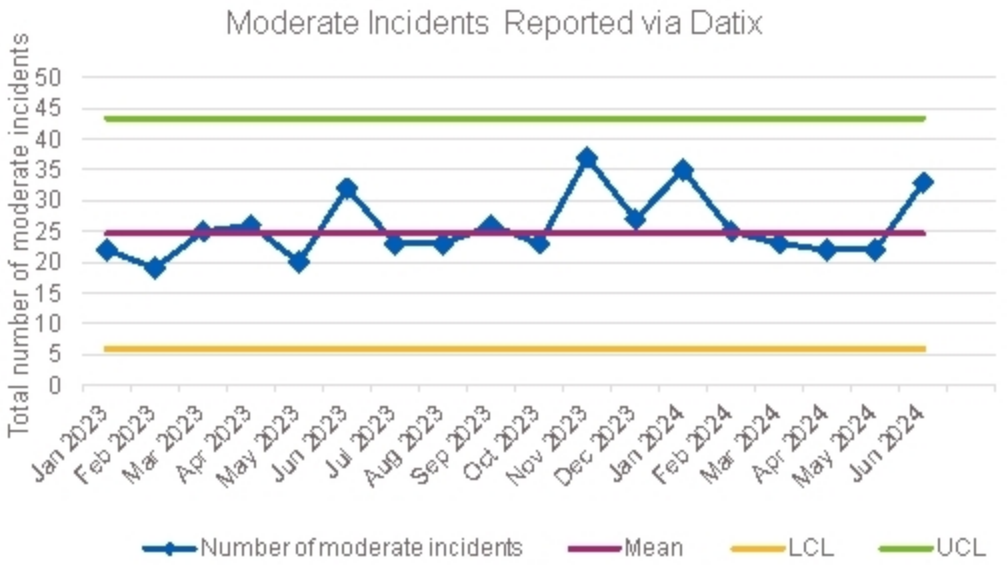
- Total Reported Incidents in Q1
- Total Q1 Incidents by Category
- Breakdown of Moderate incidents in Q1
- Outstanding Serious Incident Investigations (SII) and Clinical reviews (CR) in Q1
- Never Events
- SII/CR Action Compliance and Deep Dives
- Risk Registers
- Duty of Candour (DoC)

NHS
Salisbury
NHS Foundation Trust

Annual Review of Incidents 2023 - 2024

Incident Reporting Overall Profile





NHS
Salisbury
NHS Foundation Trust

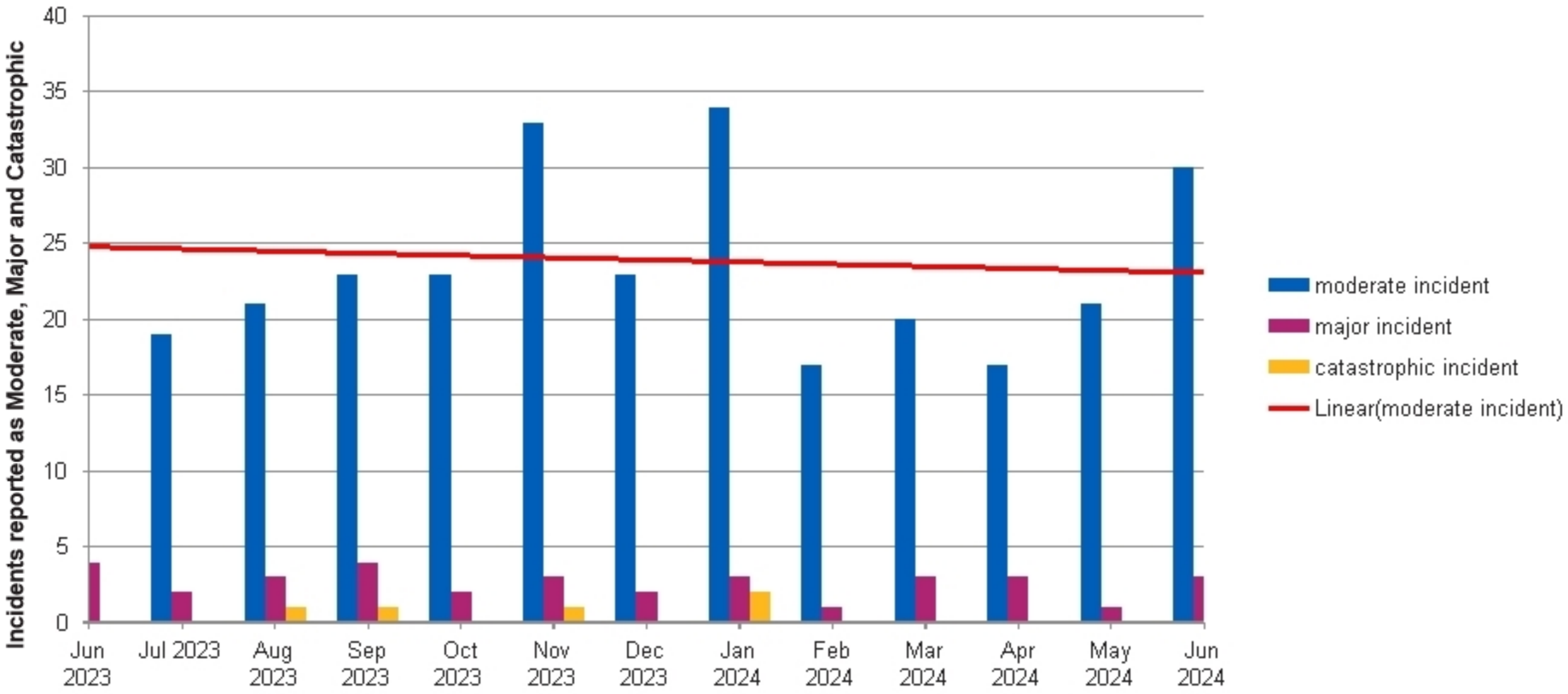
The SPC charts show that our reporting culture has remained consistent throughout the last financial year.
In December 2023, the trust switched to the Learning From Patient Safety Events (LFPSE) system for reporting our patient safety incidents to the national platform, this has replaced the National Reporting Learning System (NRLS).

In Q1 there were issues with 1000+ incidents not automatically reaching the national LFPSE platform. Our Trusts organisational (ODN) code had disappeared somewhere in the automatic export. SFT were not alone with this issue. Each incident was then required to be manually uploaded. Although we don't know what caused the issue, 100% of SFTs incidents are now uploaded and a daily check is in place to ensure this continues.

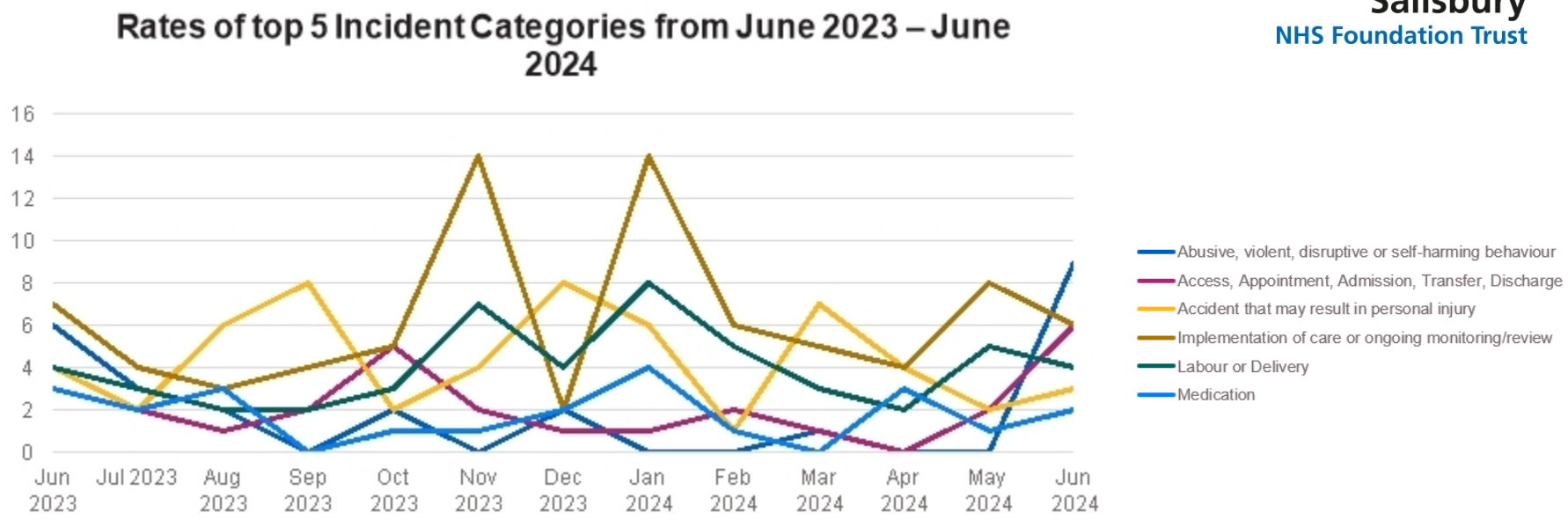
There was an increase of 8 moderate incidents reported in June compared to May, these were noted to be in ED and Maternity.

Total Annual moderate/Severe Incidents

Each moderate and above case is scrutinised through the weekly patient summit with executive oversight and agreement of further review if necessary, in line with our PSIRF Policy and Plan. The overall average of moderate harm is gradually decreasing within the overall incidents.



Total Annual Incidents by Category



The above run chart demonstrates 13 months of reported incidents and will be further broken down to look at Q1 later in the report.

The highest reported incident type is implementation of care or ongoing monitoring/review, this includes all reported pressure damage . New nationally set assessment and management processes were implemented for pressure damage this year and education and training is ongoing in how to apply the new principles and assessment tools. This data includes pressure damage that has been observed on admission to the hospital, hospital acquired pressure damage data can be found in the IPR report

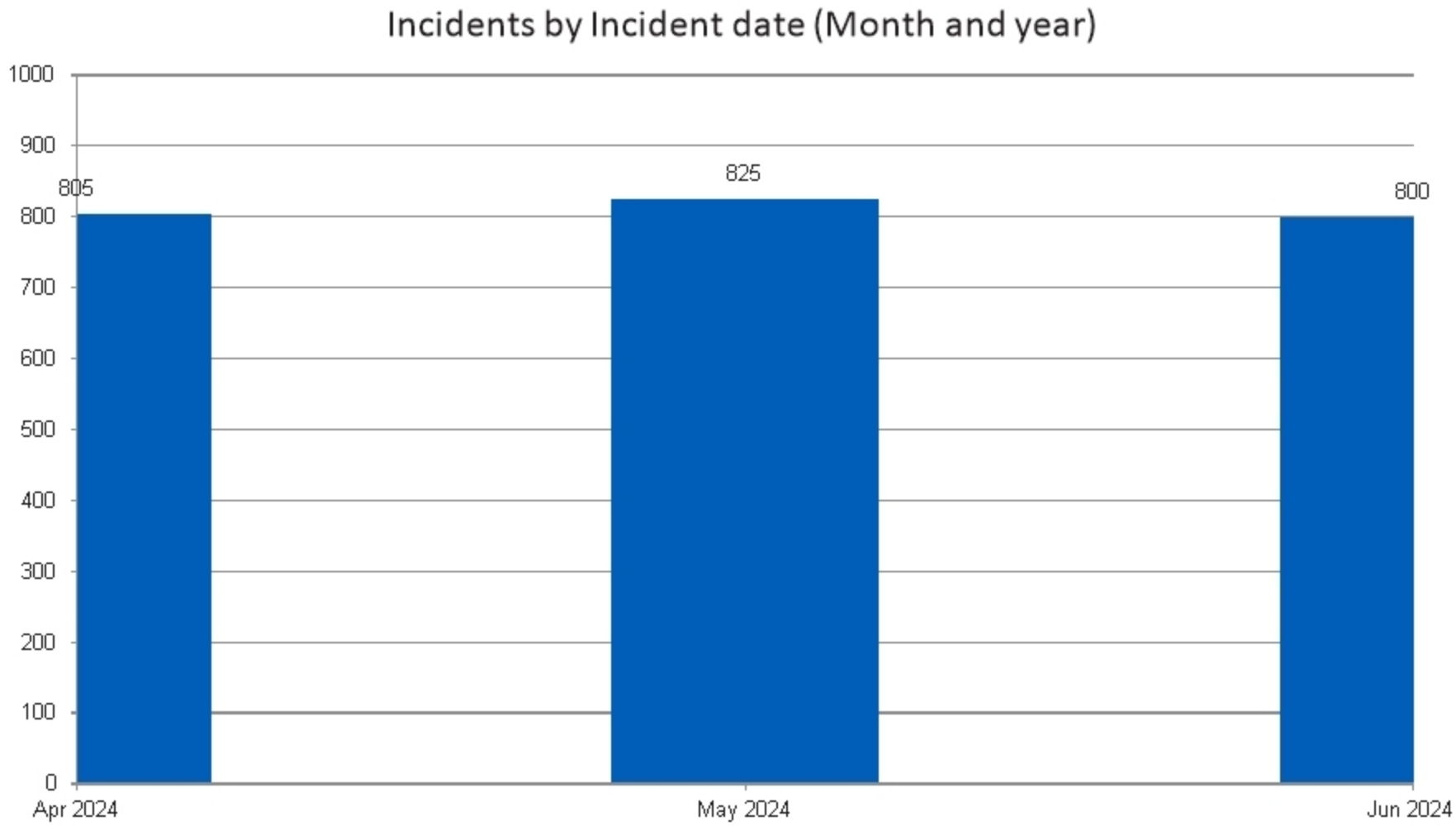
There has been an increase in the number of incidents reported in relation to violence and aggression within the emergency department in June. Support has been provided to staff affected by any violence and aggression and a member of the health and safety team contact individuals to ensure staff wellbeing.

NHS
Salisbury
NHS Foundation Trust

Quarter 1 Incidents (April, May, June 2024)

Total Reported Incidents in Q1

In Q1 there were a total of 2430 incidents reported, an increase in comparison to Q4 where 2367 were reported, the below table breaks this down by month.

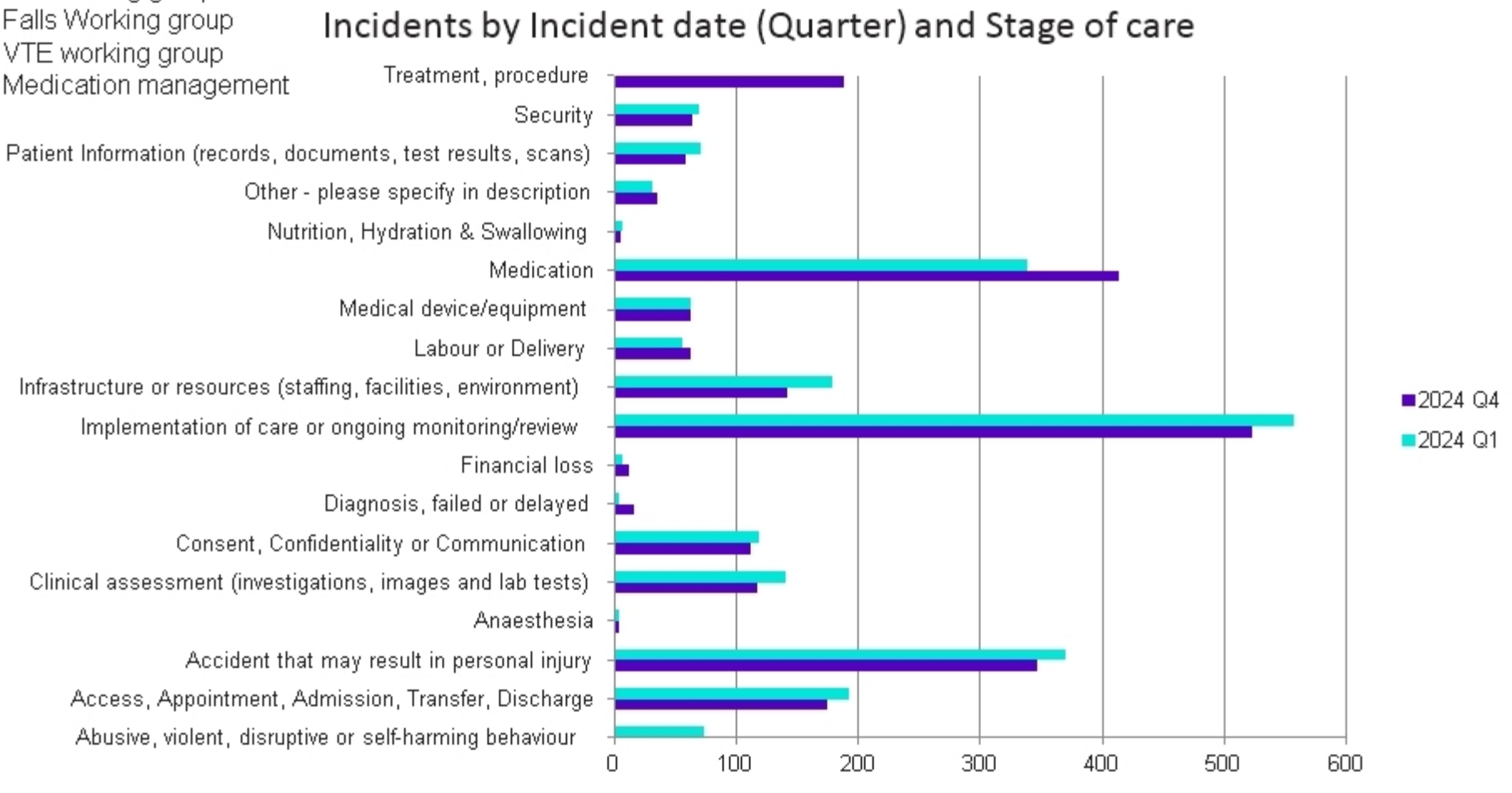


Total Q1 Incidents by Category

Similarly to the Annual picture, the highest reported incident type in Q1 is implementation of care or ongoing monitoring/review

There are several ongoing workstreams and breakthrough objectives that are in place to focus on the areas identified in the data, these include:

- Recognising the deteriorating patient (Breakthrough objective 24/25)
- Pressure damage reduction
- IPC working group
- Falls Working group
- VTE working group
- Medication management

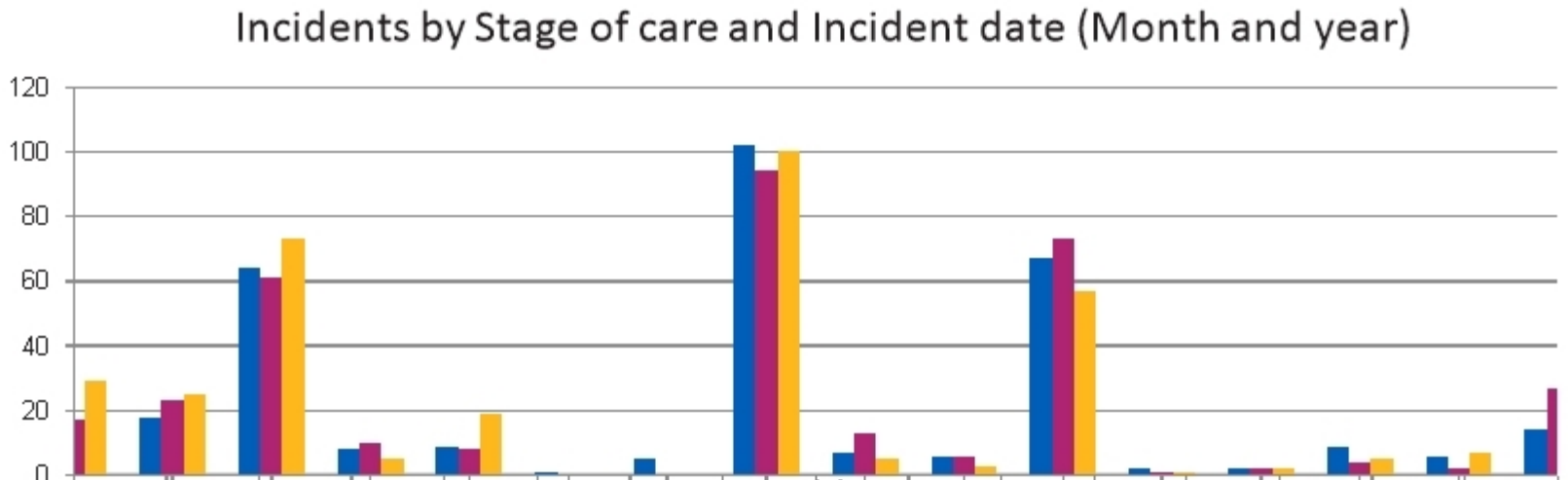


Breakdown of Q1 (April 24 – June 24)

Medicine Divisional Stage of Care

NHS Salisbury NHS Foundation Trust

This chart shows incidents in the medicine division for Quarter 1.

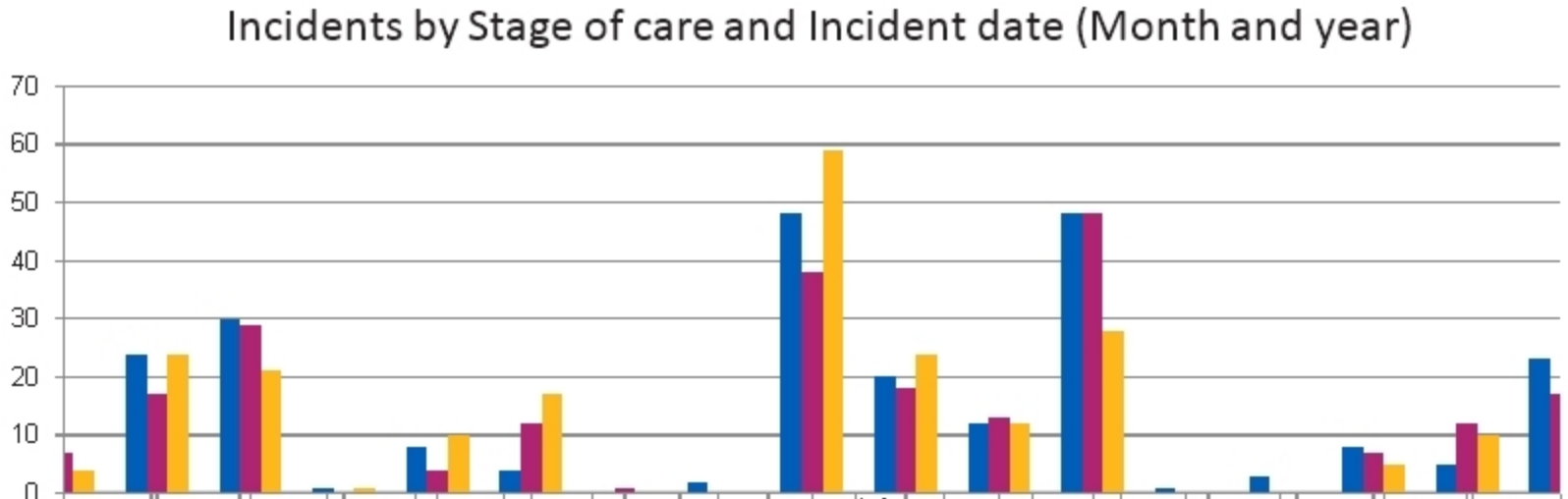


	Abusive, violent, disruptive or self-harming behaviour	Access, Appointment, Admission, Transfer, Discharge	Accident that may result in personal injury	Clinical assessment (investigations, images and lab tests)	Consent, Confidentiality or Communication	Diagnosis, failed or delayed	Financial loss	Implementation of care or ongoing monitoring/review	Infrastructure or resources (staffing, facilities, environment)	Medical device/ equipment	Medication	Nutrition, Hydration & Swallowing	Other - please specify in description	Patient Information (records, documents, test results, scans)	Security	Treatment, procedure
Apr 2024	20	18	64	8	9	1	5	102	7	6	67	2	2	9	6	14
May 2024	17	23	61	10	8	0	0	94	13	6	73	1	2	4	2	27
Jun 2024	29	25	73	5	19	0	0	100	5	3	57	1	2	5	7	29

Breakdown of Q1 (April 24 – June 24)

Surgery Divisional Stage of care

This chart shows incidents in the surgery division for Quarter 1.

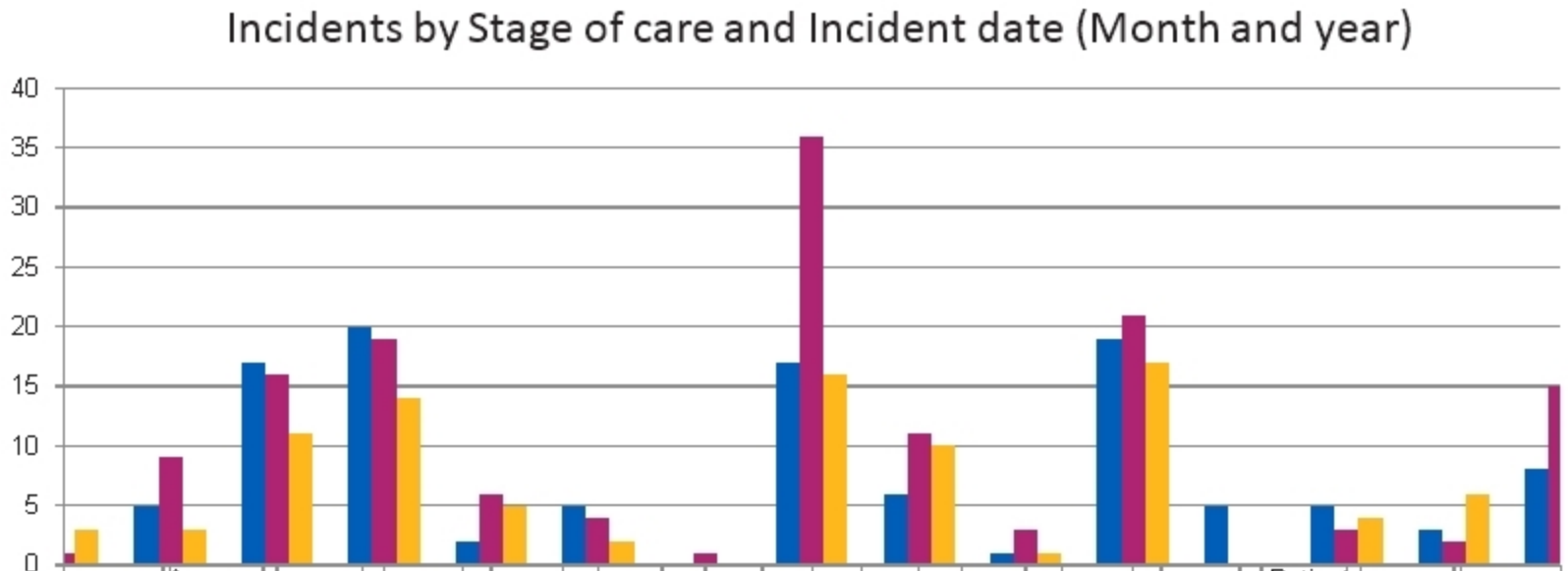


	Abusive, violent, disruptive or self-harming behaviour	Access, Appointment, Admission, Transfer, Discharge	Accident that may result in personal injury	Anaesthesia	Clinical assessment (investigations, images and lab tests)	Consent, Confidentiality or Communication	Diagnosis, failed or delayed	Financial loss	Implementation of care or ongoing monitoring/review	Infrastructure or resources (staffing, facilities, environment)	Medical device/ equipment	Medication	Nutrition, Hydration & Swallowing	Other - please specify in description	Patient information (records, documents, test results, scans)	Security	Treatment, procedure
Apr 2024	9	24	30	1	8	4	0	2	48	20	12	48	1	3	8	5	23
May 2024	7	17	29	0	4	12	1	0	38	18	13	48	0	0	7	12	17
Jun 2024	4	24	21	1	10	17	0	0	59	24	12	28	0	0	5	10	29

Breakdown of Q1 (April 24 – June 24)

CSFS Divisional Stage of care

This chart shows incidents in the CSFS division for Quarter 1.



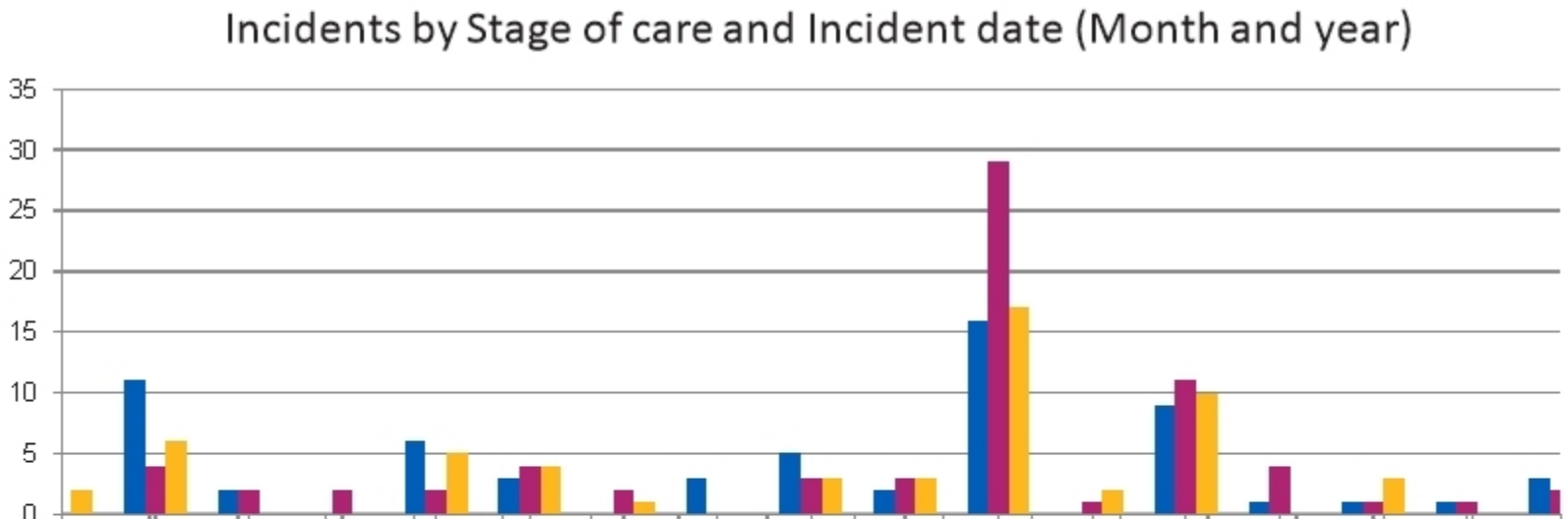
	Abusive, violent, disruptive or self-harming behaviour	Access, Appointment, Admission, Transfer, Discharge	Accident that may result in personal injury	Clinical assessment (investigations, images and lab tests)	Consent, Confidentiality or Communication	Diagnosis, failed or delayed	Financial loss	Implementation of care or ongoing monitoring/review	Infrastructure or resources (staffing, facilities, environment)	Medical device/equipment	Medication	Other - please specify in description	Patient Information (records, documents, test results, scans)	Security	Treatment, procedure
Apr 2024	1	5	17	20	2	5	0	17	6	1	19	5	5	3	8
May 2024	1	9	16	19	6	4	1	36	11	3	21	0	3	2	15
Jun 2024	3	3	11	14	5	2	0	16	10	1	17	0	4	6	18

Breakdown of Q1 (April 24 – June 24)

WNB Divisional Stage of care

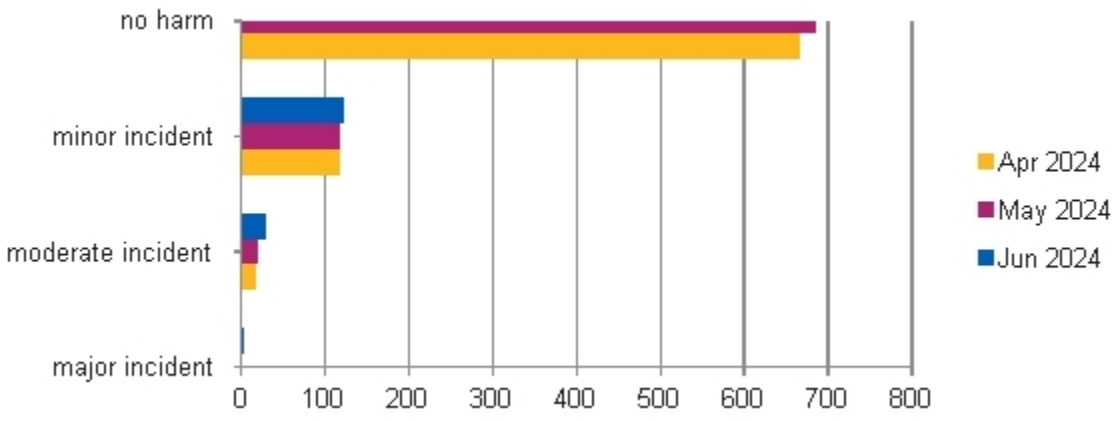
Salisbury NHS Foundation Trust

This chart shows incidents in the women and new-born division for Quarter 1.



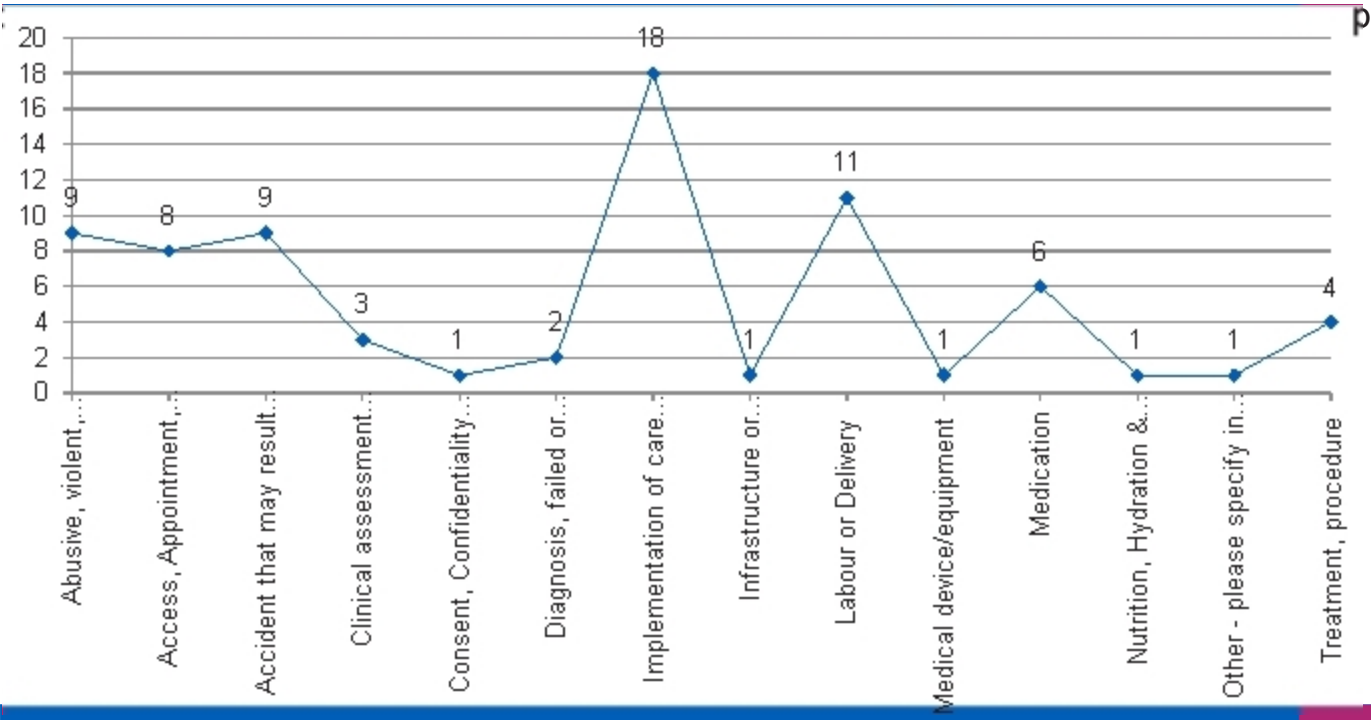
	Abusive, violent, disruptive or self-harming behaviour	Access, Appointment, Admission, Transfer, Discharge	Accident that may result in personal injury	Anaesthesia	Clinical assessment (investigations, images and lab tests)	Consent, Confidentiality or Communication	Diagnosis, failed or delayed	Financial loss	Implementation of care or ongoing monitoring/review	Infrastructure or resources (staffing, facilities, environment)	Labour or Delivery	Medical device/ equipment	Medication	Other - please specify in description	Patient Information (records, documents, test results, scans)	Security	Treatment, procedure
Apr 2024	0	11	2	0	6	3	0	3	5	2	16	0	9	1	1	1	3
May 2024	0	4	2	2	2	4	2	0	3	3	29	1	11	4	1	1	2
Jun 2024	2	6	0	0	5	4	1	0	3	3	17	2	10	0	3	0	2

Breakdown of Moderate incidents in Q1



Salisbury NHS Foundation Trust

Of the 2430 incidents reported, 75 of these were moderate or above harm which is on average 3.08% of incidents compared with 3.46% of incidents in Q4 and 3.6% in Q3. This will look slightly different to the IPR data as these figures include all reported incidents on Datix not just patient safety incidents.



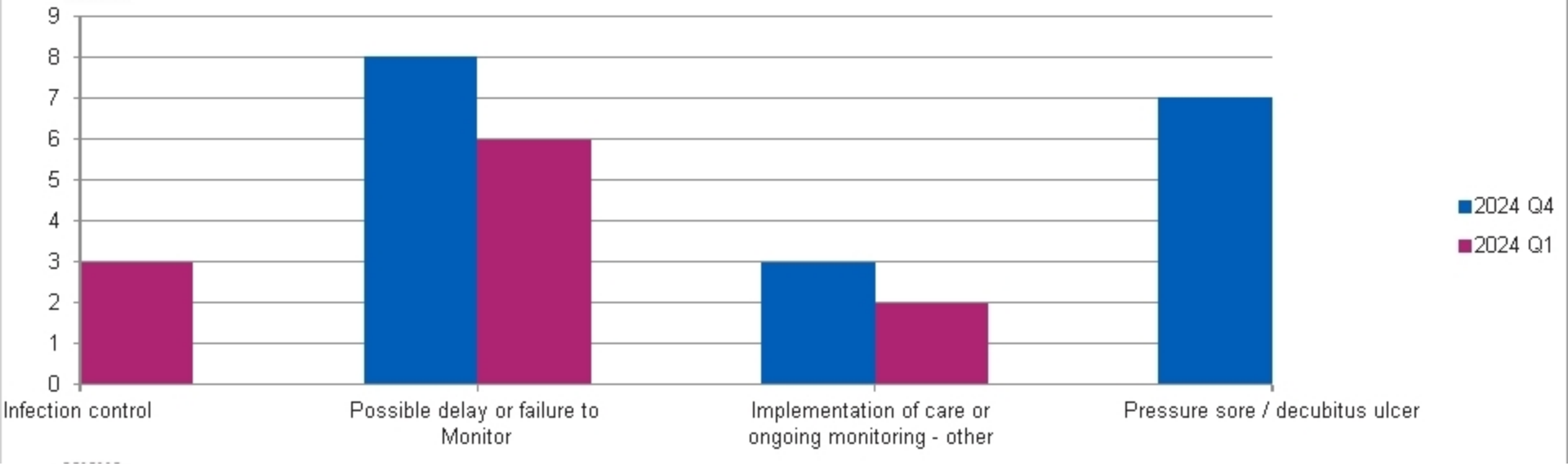
This separates the moderate and above incidents into categories, the next slide will break this down further.

Continued Breakdown of Moderate incidents in Q1

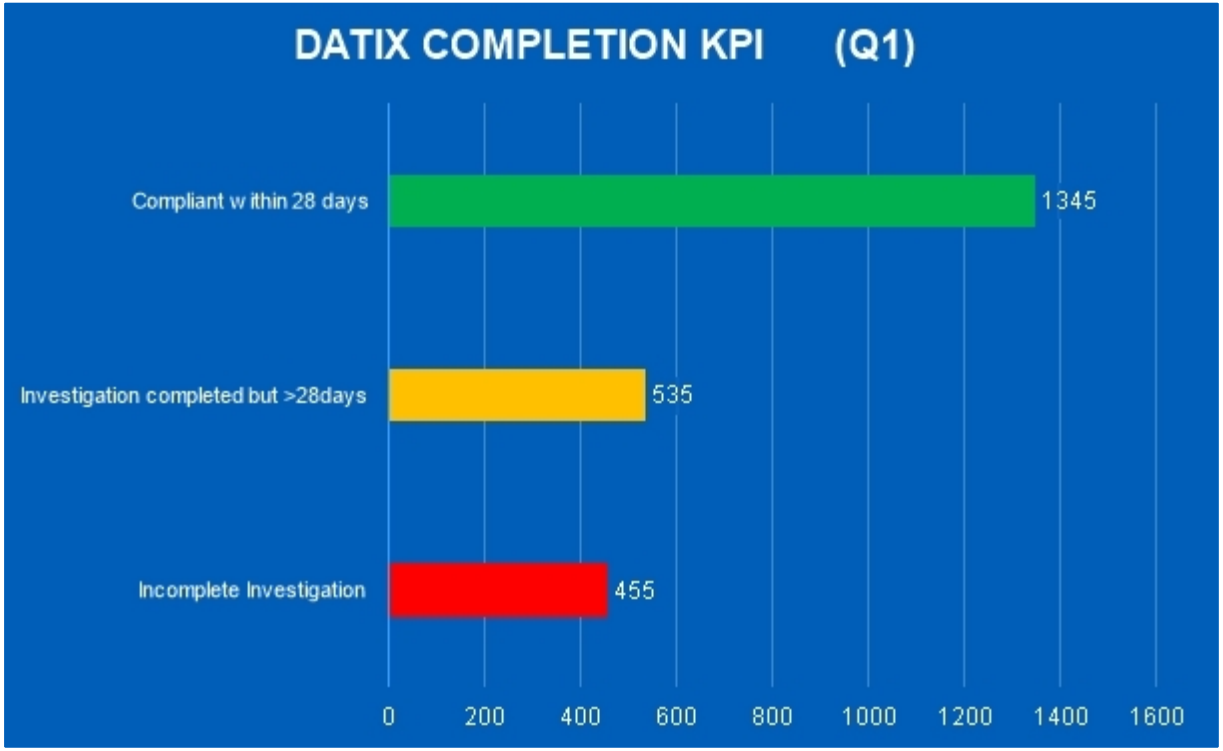
The highest reported moderate incident category is Implementation of care or ongoing monitoring, the graph below breaks this down into subtypes of the incident.

Delay or failure to monitor is an area of focus for the Trust currently and is one of our breakthrough objectives.

Pressure sores have been a focus of ours for some time, ongoing work includes; TVN has introduced the new aSSKINg bundle for the assessment of patient skin and there are new body maps being introduced throughout the trust. (It is important to note that these figures represent datix reporting and so if a patient moves around to different wards, each ward area would be expected to report any pressure ulcers during assessment so there may be multiple incidents in relation to the same pressure ulcer). TVN team keep the reconciled data.



Datix Completion KPI (Q1)



There were 2335 no/low harm incidents reported in Q1- of these incidents 81% have had a completed Datix review.

58% of the 2335 total low/no harm incidents were completed within the 28-day KPI.

20% of the total incidents still require a Datix review.

Serious Incident Investigations (SII) and Clinical reviews (CR) updates

We have commissioned 8 PSIIs in total- 3 are never events, and 3 are linked to local PSIRF priorities.

Feb PSII 1 – Risk Assessment- Maternity (local priority)
Feb PSII 2 – Wrong site surgery (Never Event)
Feb PSII 3 – Emerging theme/high risk- Ophthalmology (Local priority)
March PSII 4 – Wrong biopsy site (Never Event)
April PSII 5 – Bowel obstruction (National priority)
May PSII 6 – Referral process- incorrect patient listed for surgery (Local priority)
July PSII 7 – Wrong route medication (Never Event)
July PSII 8 – Discharge process (Local priority)

To Note- from April 2023- June 2024 the Trust has had 5 never event

- Retained swab at LSCS (Moderate harm)
- Retained mouth prop (Child dental extraction- no harm)
- Wrong site surgery (Wrong mole removal-moderate harm)
- Wrong biopsy site (Minor harm)
- Wrong route medication (No harm)

We will continue to work towards closing all the ongoing SII/CRs over the coming months. The current status of reports is as follows:

- 1 report that is currently in writing
- 3 reports awaiting CRG review
- 7 reports awaiting changes post CRG

SII/CR Action Compliance and Deep Dives

As this table shows, there are currently 78 outstanding actions across the 4 clinical divisions.

Directorate	Open actions
CSFS	6
Medicine	47
Surgery	15
Women and Newborn	10

The Risk Management Team continue to work collaboratively with the divisional teams to ensure timely completion of the actions. Whilst we continue to work towards closing the current SII/CRs, new actions are still being added, however consideration is now given to establish whether the actions can be fed into existing workstreams.

Traditionally we aim to hold a deep dive meeting for each clinical division every 3 months. The Divisional Management Teams, Executives and Risk Management attend to go through their Risk Registers and compliance with open actions. Dates are scheduled for the next divisional MDT deep dive meeting.

The risk management team are implementing Matron Mini Deep dives for service level risks across the trust, these will happen quarterly.

NHS
Salisbury
NHS Foundation Trust

Risk Registers

Divisional and Service Level Risk Registers

NHS Salisbury NHS Foundation Trust

KPMG carried out an internal audit of the divisional risk management processes in Q1 and provided an overall assessment of ‘partial assurance with improvements required’. Our rating is driven by the need to ensure divisional risks are consistently reported at Executive level, and to ensure there is appropriate management of service level risks across divisions”.

In Q1 a pilot exercise was carried out in Medicine to run a deep dive with the Matrons to look at service/department level risks. The plan is to standardise this and to roll out across the other divisions so there is better awareness of new risks, risks that are increasing in score and risks that require closure.

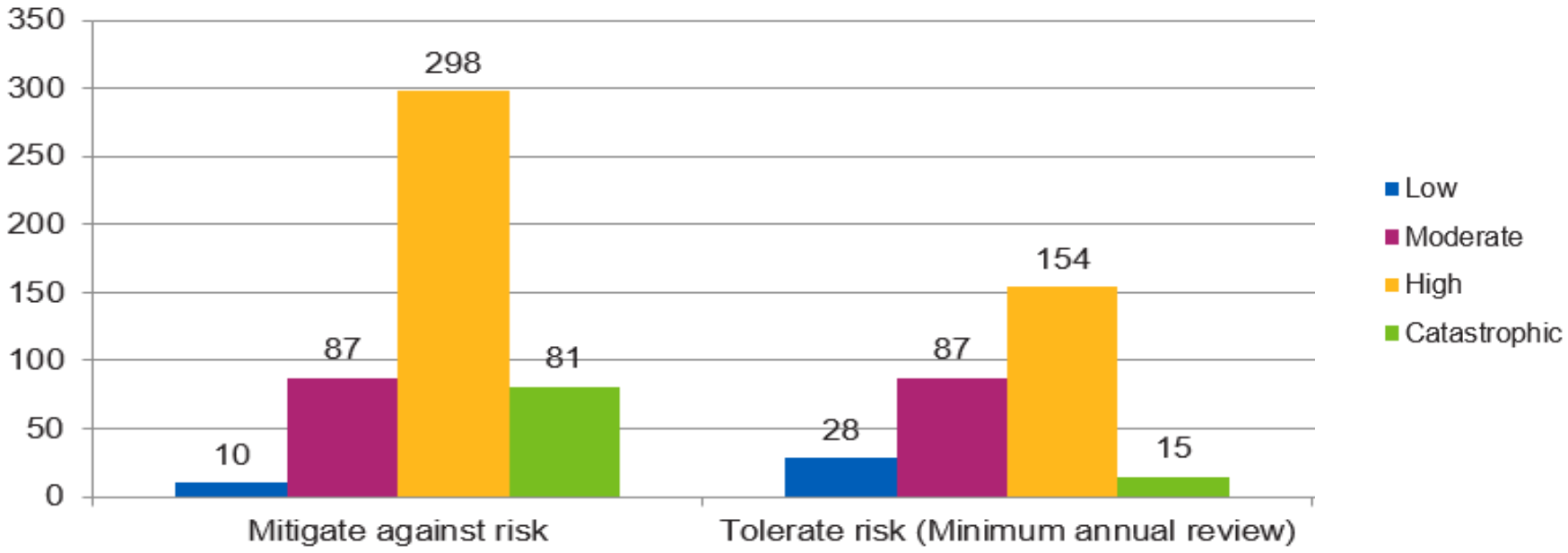
Trust wide Risk Registers

As of 30th July 2024, there are 767 open risks throughout the trust, of these 284 are being tolerated while 476 are being mitigated.

Of the 476 mitigated risks, 163 of these do not have actions, work is in progress to address this with risk owners.

During Q1:

- 11 New risks opened at service level
- 86 Risks were closed at service level
- 4 Risks were closed at divisional level



Duty of Candour (DoC) Part 1

Salisbury NHS Foundation Trust

Duty of candour is a three-stage process that requires an apology for any incident reported as moderate or above. This is broken down into the following stages:

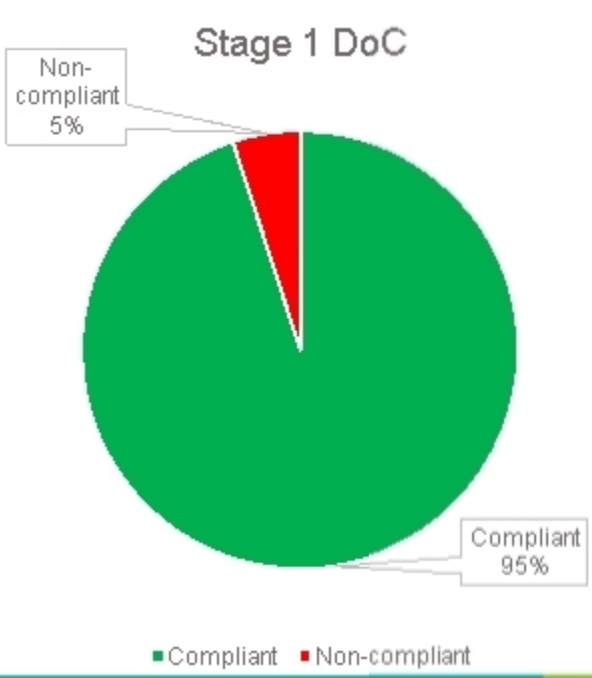
Stage 1 – verbal apology

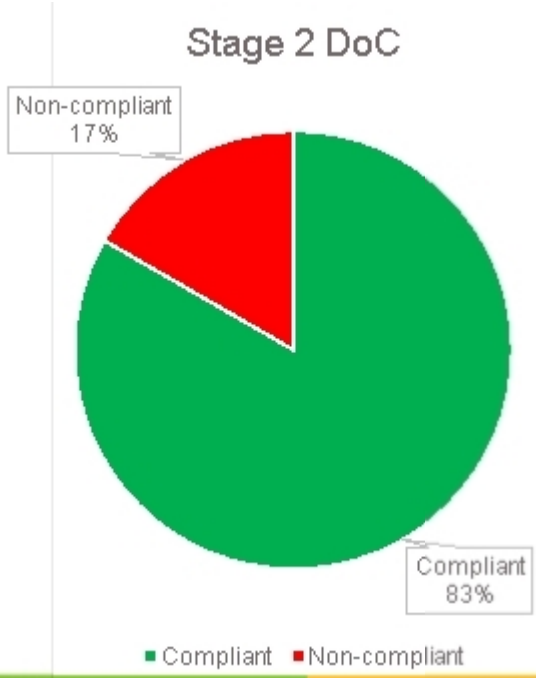
Stage 2 -following the verbal apology with a letter outlining what was said in the apology.

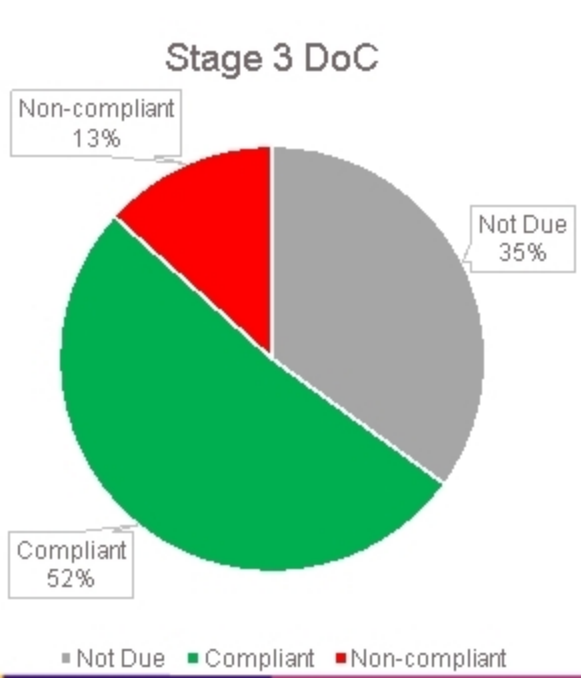
Stage 3- an opportunity to share the findings of the incident/review.

It is a requirement that the above is captured on our Datix system to evidence that stage 1, 2 and 3 has occurred as currently this is how the Trust compliance is reported.

All DoC are discussed at the weekly Patient Safety Summit to keep track of compliance. An increase in compliance has been noted in Q1.The charts below reflect compliance in all 3 of Duty of Candour.







Duty of Candour (DoC) Part 2

NHS Salisbury NHS Foundation Trust

Q1 (Apr-Jun 2024)		
	Compliance against total cases	Compliance Percentage (Q4 23-24 Comparison)
Stage 1 Compliance	57/60	95% (+16%)
Stage 2 Compliance	50/60	83% (+13%)
Stage 3 Compliance	31/39 (21 not due)	79% (+24%)

In Conclusion…

NHS Salisbury NHS Foundation Trust

- All Datix incidents undergo a robust quality check to ensure accuracy of reporting and reduce unwarranted variation. The backlog of quality checks has been reduced and all incidents are now quality checked contemporaneously.
- Datix Incident workflow updated, to simplify incident journey for users and enables full transparency of data for accurate reporting.
- Backlog of externally reported incidents are now completed and contemporaneous.
- Daily incident huddle for 15 minutes to review all incidents reported the previous 24 hours.
- Ward follow ups to support with DoC following morning datix Incident huddle, to support compliance.
- A KPI of 28 days to complete a low harm Datix investigation has been set and is being monitored quarterly.
- All incidents where moderate or above harm is reported are discussed through the weekly PSS within 7-14 days. Compliance to follow in Q2.
- All patient safety reviews are expected to be completed within 28 working days. Compliance to follow in Q2.
- 100% of patient safety incidents have now been automatically forwarded to the LFPSE platform with the correct ODS code since the transition in December.
- 2480 incidents were reported in Q1 throughout the trust, 3.08% of these were moderate or above harm. These incidents continue to be scrutinised through the weekly patient summit with executive oversight.
- Progress has been made with each division to start their Learning from Incidents. Forums are running in 3 of the 4 divisions now.
- Themes and trends continue to be analysed and fed into the monthly divisional Learning From Incidents forum.
- Matron Deep Dive has been implemented to review all ward/ department level risks as a pilot in Medicine Division.
- Work in progress across all divisions following the KPMG audit to standardise and have clear audit trail of escalation for risks of concern.

NHS
Salisbury
NHS Foundation Trust

Appendices

DOC guide (From DOC policy)

Salisbury NHS Foundation Trust