Bundle Trust Board Public 12 January 2023

1 OPENING BUSINESS

1.1 10:00 - Presentation of SOX Certificates

Presentation of SOX certificates
November SOX of the month – Jinu John, Tracey Quinney, Suzie Crane and James Wigley
November Patient Centred SOX – Heather Spicer and the Clinical Biochemistry Team
December SOX of the month – Catering Team
December Patient Centred SOX - Spinal Team

1.2 10:10 - Staff Story

Introduced by Melanie Whitfield
Amila Maduragoda

1.3 Welcome and Apologies

Apologies received from Paul Kemp and Debbie Beaven, Rakhee Aggarwal

1.4 Declaration of Interests, Fit and Proper/Good Character

1.5 10:30 - Minutes of the previous meeting

Minutes attached from meeting held on 3 November 2022
For approval

1.5 V2 Draft Public Board mins 3 November 2022.docx

1.6 10:35 - Matters Arising and Action Log

1.6 Public Action Log January 2023.pdf

1.7 10:40 - Chairman's Business

Presented by Tania Baker
For information

1.8 10:45 - Chief Executive Report

Presented by Stacey Hunter
For information

1.8 CEO Board Report Jan 2023.docx

2 ASSURANCE AND REPORTS OF COMMITTEES

2.1 10:55 - Clinical Governance Committee - 20 December

Presented by Eiri Jones
For assurance

2.1 Escalation report - from December 2022 CGC to January Board 2023.docx

2.2 11:00 - Audit Committee - 15 December

To note

2.2 Escalation report from Committee to Board - Audit Committee 15th December 2022.docx

2.3 Trust Management Committee - 21 December - meeting cancelled

2.4 11:05 - Integrated Performance Report to include exception reports

Presented by Lisa Thomas
For assurance

2.4a IPR cover sheet - Trust Board, January '23.doc

2.4b Integrated Performance Report Jan_23 FINAL v2.pdf

3 QUALITY AND RISK

3.1 11:35 - CNST/Maternity Incentive Scheme

Presented by Joanne Cowan, Director of Maternity and Neonatal Services, Hannah Boyd, Divisional Director of Operations for Women and Abigail Kingston, Clinical Director for Women and Newborn Division
For assurance

3.1b CNST MIS Board self certification report 2022 for Board JH AK HB Jan 22 AJK.docx

3.1c Gap analysis safety action 1-3 JH year 4 22 23.pdf

3.1d Gap Analysis action 4-6 JH year 4 22 23.pdf

3.1e Copy of Gap analysis action 7-10 year 4 JH 22 23 additions.pdf

3.1f MIS_Year4_Board_-Declaration_-Form AK JH 231222.pdf

3.1a Cover sheet for paper to Board Maternity Incentive Scheme Jan 23 JH AK.docx

3.2 Patient Experience Q1 (deferred from November) and Q2 - deferred to March

3.3 11:45 - Learning from Death Report Q2

Presented by Peter Collins
For assurance

3.3 Learning from Deaths Cover Sheet Q2 LFD Report 2022-23.docx

3.4 11:55 - Director of Infection Prevention and Control 6 monthly Report

Presented by Judy Dyos
For assurance

3.4a Front sheet DIPC 6 monthly.docx

3.4b DIPC Report 6 monthly Update 2022-23 (Draft v.1).doc

3.4c Q2 IPC HCAI report 22_23_ V1.pptx

3.5 12:05 - BREAK 20 MINUTES

4 PEOPLE AND CULTURE

4.1 12:25 - People Plan

Presented by Melanie Whitfield
For information

4.1a Trust Board People Plan cover sheet January 2023.docx

4.1b Appendix 1. The People Plan at SFT 2022-26 v4. Board. MW.docx

4.1c Appendix 2 - Compassionate Inclusive - EDI Strategy.docx

4.1d Appendix 3 - Safe & Healthy - Health and Wellbeing plan 2022-26.docx

4.1e Appendix 3a - Safe & Healthy - Health and Safety Plan 2022 - 2024.pptx

4.1f Appendix 4 - Always Learning - Organisational Development plan 2022-26.docx

4.1g Appendix 5 - We are a team - Team plan (to follow).docx

4.1h Appendix 6 - OD&P 5 year ambition slide deck (as at Oct 2022).pptx

4.1i Appendix 7 - Identifying Trends in healthcare and work.docx

4.1j Appendix 8 - OD&P 5 year ambition slide deck (Board) v4.pptx

4.2 12:35 - Health and Safety Quarter 3 Report

Presented by Melanie Whitfield
For assurance

4.2 HS Report Board Report Q3 (003).docx

4.3 12:45 - Annual Medical Education Performance Report

Presented by Peter Collins
For assurance

4.3a ODPMB cover sheet for annual report - November 2022.docx

4.3b Annual Medical Education Report 2021-2022 final.docx

5 GOVERNANCE

5.1 12:55 - Emergency Preparedness, Resilience and Response Annual Assurance Statement and Compliance

Presented by Lisa Thomas
For information

5.1a Trust Board EPRR Assurance Statement 12th January 2023 (1).docx

5.1b Appendix to Report Section 5.2 A SFT EPRR Annual Assurance Summary 2022 V1.pdf

5.1c Appendix to Report Section 5.2 B SFT EPRR Assurance outcome 2022 FINAL.pdf

5.2 Register of Seals - no new seals added since last report

5.3 Annual Review of Constitution - deferred to March

6 CLOSING BUSINESS

6.1 13:05 - Agreement of Principle Actions and Items for Escalation

6.2 13:10 - Any Other Business

6.2.1 Short Term Changes to SFIs

Presented by Mark Ellis
For approval

6.2.1 AOB SFI alteration.docx

6.3 13:15 - Public Questions

6.4 Date next meeting

9 March 2023

7 Resolution

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

Salisbury NHS Foundation Trust

Draft
Minutes of the Public Trust Board meeting held at 10:00am on Thursday 3rd November 2022, MS Teams
Salisbury NHS Foundation Trust
Boardroom

Board Members:

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

In Attendance:

Naginder Dhanoa (ND)	Chief Digital Officer
Kylie Nye (KN)	Head of Corporate Governance (minutes)
Fiona McNeight (FMc)	Director of Integrated Governance
Lucinda Herklots (LH)	Lead Governor (observer)
Jane Podkolinski (JP)	Governor (observer)
Venetia Field (VF)	Associate Director of OD & Education (Observer)
Helen Rynne (HR)	Patient Experience Lead (TB1 3/11/1.2)
Matt Long (ML)	Armed Forces Serving & Veteran Welfare Officer (TB1 3/11/1.2)
Jon Burwell (JB)	Chief Information Officer (TB1 3/11/3.1)
Joanne Hayward (JH)	Director of Midwifery (TB1 3/11/3.1)

ACTION

TB1 3/11/1 OPENING BUSINESS

TB1 3/11/1.1 Presentation of SOX (Sharing Outstanding Excellence) Certificates

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

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

NM noted the wide variety of nominations that are put forward each month and the great work underway during extremely challenging times. NM and the Board congratulated the members of staff who had received a SOX award.

The Board discussed the SOX nominations coming to Board and SH noted that it had been agreed that the executives would be visiting staff due the challenges on the wards. The Board noted that the SOX nominations highlighted this month reiterated the importance of end-of-life care and the great care being delivered despite the current challenges.

TB1 3/11/1.2 **Patient Story**

HR introduced Matt Long to the meeting who read out a story from veteran who had been treated at Salisbury NHS Foundation Trust.

The patient reiterated that they were treated with dignity and respect at Salisbury and they felt supported and safe in the hospital environment. The patient particularly mentioned the great care he had received on Odstock ward. ML noted that the patient felt this was his first experience of a hospital delivering on the pledges and promises they have made regarding veteran care.

Discussion:
NM thanked ML for attending to read the story and noted that it was positive to hear from a patient who is extremely happy with the experience they have had in the Trust.

PC thanked ML for sharing the story and highlighted that ML is one of the people who is instrumental in ensuring the care provided to veterans is outstanding and specific to individual's needs.

SH noted that ML had been a recipient of a 2022 Staff Award and noted that it was a good opportunity for the Board to express their thanks for his contribution.

EJ noted that ML's worked aligned to the Getting it Right First Time (GIRFT) programme. EJ acknowledged the importance of hospital care for veterans in supporting individuals to integrate themselves back into society. EJ further referenced those families who might be repatriated back to Wiltshire and noted the impact of healthcare provision and the workforce opportunities that could arise.

LT asked ML if there was one thing the Trust could do differently in terms of veteran care. ML explained that a single point of contact would be useful for those patients who use the Trust services regularly. This would provide consistency and immediate response should the patient have any concerns. Additionally, ML suggested a military policy to set criteria around care for those who might have to exit the service as a result of their injury or illness. ML highlighted the increasing challenges of people losing their job due to the wait for procedures. A dedicated single point of contact for those where there might be justification to expedite their case would enable dedicated coordination.

The Board extended their thanks to the patient who had shared their story and to ML for the progress made in his role as welfare officer.

TB1 3/11/1.3 **Welcome and Apologies**

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

- Michael von Bertele, Non-Executive Director

TB1 3/11/1.4 **Declarations of Conflicts of Interest**

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

TB1 3/11/1.5 **Minutes of the Part 1 (Public) Trust Board meeting held on 8th September 2022.**

NM presented the public minutes from 8th September 2022.

The board approved the minutes as a correct record of the meeting.

TB1 3/11/1.6 **Matters Arising and Action Log**

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

TB1 Public 08/09/2022 - Health and Safety Annual Report – The Board noted the reporting structure for the Health and Safety Report had been resolved. Item closed.

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

TB1 3/11/1.7 **Chairman's Business**

NM referenced the current external challenges that are causing concern and worry for the healthcare sector and for people on an individual level. Currently, from a financial perspective there are a lot of unknowns in how organisations and systems will be expected to move forward. What is clear is that regardless of financial challenges, the government is hoping for NHS organisations to implement rapid changes to improve the patient experience and care they are receiving.

It is recognised that where there are methods of improvement and the capability to improve patient experience and care, the Trust should be implementing those changes. However, it is recognised that in some instances this will not be possible.

NM noted that as part of the Board this month there is a requirement to understand how the organisation is functioning currently as there have been several critical incidents during the month. There are also other strands of work ongoing, particularly around the recruitment and retention of staff which the Board need assurance on.

TB1 3/11/1.8 **Chief Executive's Report**

SH presented her report and highlighted the following key points:

- The Trust's services and teams remain under considerable pressure with the Trust reporting the highest levels of escalation OPEL 4 on 42 occasions and responding to 4 critical incidents

since the last public Board. This highlights the reality of what is happening in the Trust and the systemic issues which are and will continue to be difficult to resolve in the Trust and in the system.

- There are concerns around levels of risk in the Emergency Department and due to everyone's hard work the Trust has managed some of the pressure but not in a way that is sustainable. The Executive Team is working hard to allow divisions and teams to work in a space that is consistent with the culture the Trust is trying to embed as part of Improving Together.
- There is a group of people leading a piece of work on recruitment and retention. As a result of this there are some proposals that have been discussed at Board Committees and will be picked up as part of the Winter Plan in the Private Board.
- The Trust is continuing to encourage everyone to get their Flu and COVID Vaccination.
- In terms of financial sustainability, the Trust is starting to feel more stretched and this position will be further challenge by the proposals in the Winter Plan.
- Despite the challenges facing the organisation, there is also lots of good work happening in the Trust. There have been parts of the organisation who have been recipients of external awards in the past few months. Additionally, there has been good partnership work across the Acute Hospital Alliance (AHA), although it is recognised that the paper appended to the CEO report requires some work to be fit for purpose.
- SH informed the Board that there is currently a level of tension in the organisation, given the sustained level of pressure and this was being felt by leadership team, which is inevitable but challenging in the context the Trust is currently in.

Discussion:
EJ noted that the work around recruitment and retention is critical and noted the importance of learning from those who are leaving the organisation. MW recognised that the Trust can improve upon the communication with staff when they decide to leave. The Trust do performance exit interviews and there are themes in relation to retirement and flexible working. Flexible working is a component of the People Plan, however, it must be acknowledged that for line managers, it can be a complex process.

PK noted that to enable flexible working an organisation requires robust infrastructure. MW agreed but explained that team-based rostering which has been implemented into the Trust for a few years, does work well. There are also further rostering tools available which the team are looking to roll out. The Board noted that it would be useful for the OD & People team to get feedback from team leaders and line managers about their experience of flexible working in their teams.

JD noted that two pilots of team-based rostering on different wards had worked effectively in that people had more freedom to make their own choice. The key issue is that some staff were less flexible and this can make team rostering problematic. JD noted that Fiona Hyett would be returning to her role as Deputy Chief Nursing Officer in the new year and explained she has been using flexible hours for staff working for the

vaccination programme, so it is expected she will bring some shared learning and experience. JD noted that essentially, whilst the Trust will go to every effort to be able to offer flexible working, the need to cover a 24/7 service is paramount.

JD referred to other themes in terms of retention and noted that the HCA support provision for new members of staff had been effective and there are plans to bolster this service with a further role to support.

SH noted that flexible working needs to be supported culturally, as well being supported with the correct tools and there is some work to do to rationalise this across the Trust.

TB1 3/11/1.9 **Feedback from Shadow Board**

RA provided an update on the Shadow Board feedback. The Board noted that NM had attended to speak to the group about his career.

- RA noted that it had been a productive meeting and interesting to observe how people fit into roles in terms of presenting papers that were not their own. As the members are not subject experts, they critique the papers in different ways which is a good learning experience.
- The groups spoke about objective and action setting in the reports, noting and taking ownership of the fact that a number were not Specific, Measurable, Achievable, Relevant or Time-bound (SMART) objectives.
- Upon triangulating the papers, the Shadow Board felt that staffing is currently the ultimate priority to focus on and reviewing how recruitment and retention efforts feed into workforce analysis and skill mix.
- The Shadow Board noted the ambitions of the digital plan, highlighting the focus is on how the Trust shifts people's thinking about digital. There was also further thought on how the digital teams take the organisation along with them in terms of development and learning.
- The key area of feedback around the Learning from Deaths Report was that the specific learning is unclear in the report.
- The sequencing of the Trust Board agenda was also discussed and they agreed that all of the reports should be triangulated and the Board Assurance Framework (BAF) discussion should happen at the end of the meeting.

Discussion:
SH noted that she would like Shadow Board members to present the feedback going forward. RA supported this and MW noted she would take this back to the group. **ACTION:MW** **MW**

VF noted that she attended the Shadow Board and the learning from each meeting had been positive.

EJ and RA noted they had already seen growth in individuals around the table, noting it was not just around an increase in confidence but it is about developing an understanding of what it is like to be a Board

member. EJ noted the importance of reverse mentoring and highlighted that the Trust Board could learn a lot from the reflections at the meeting.

PC reflected on the comments regarding the learning from deaths report, noting the suggestions around the learning being clearer in the report. PC noted that it might be helpful if the Shadow Board had further guidance on what assurance is and an understanding of how risk management works in an organisation of this size. The Board discussed and agreed that it would be useful for the Shadow Board members to attend Board seminars to learn alongside the Board. **ACTION: KN/SH to invite shadow board members to seminars.** **KN**

TB1 3/11/1.10 **Register of Attendance**

The register of attendance was noted.

TB1 3/11/2 **ASSURANCE AND REPORTS OF COMMITTEES**

TB1 3/11/2.1 **Clinical Governance Committee (CGC) 25th October 2022**

EJ presented the report, providing a summary of escalation points from the meeting held on 25th October. EJ asked for the report to be taken as read highlighting the key points as detailed in the report.

The report was noted.

TB1 3/11/2.2 **Finance and Performance Committee (F&P) 25th October 2022**

EJ provided a summary of escalation points from the Finance and Performance Committee held on 25th October. EJ asked for the report to be taken as read highlighting the key points as detailed in the report.

Discussion:
PK noted that, in reference to the procurement report on the minor injuries' unit, the paper had been updated since the Committee meeting. PK noted that the Committee had received a less detailed paper on the procurement process and it had been presented as a retrospective approval. ME highlighted that the procurement team had not been involved in this commercial contract beforehand and noted that this is an example of the team finding the anomalies in some contracts and ensuring due diligence around process and contract management.

SH noted that the work Rob Webb, the Director of Procurement, leads on the Trust and wider system's behalf is outstanding. The Board agreed that RW is an outstanding Director of procurement and the Trust is fortunate for his consistent performance.

The report was noted.

TB1 3/11/2.3 **Trust Management Committee (TMC) 26th October 2022**

SH presented the escalation report from TMC held on 26th October. SH asked for the report to be taken as read and noted the key points detailed in the report, including the business cases which were considered.

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

- The committee received the Board Assurance Framework (BAF) and heard that following the Risk Appetite session at the Trust Board Development Day in May 2022, the Board Assurance Framework has been completely revised to apply the risk appetite. It was noted that the BAF is a dynamic tool and supports conversation at Board and Committee level and helps to support a focus on the risks outside of tolerance.

The report was noted.

TB1 3/11/2.4 **People and Culture Committee 27th October 2022**

RA presented the escalation report from the Committee held on 27th October. RA asked for the report to be taken as read and noted the key points detailed within.

Discussion:
TB queried if the Trust has any plans to support talent management and asked if this can be considered, given the other challenges with staffing. MW explained that there is recognition that the development of managers is important. However, the plans to work on talent management are in the early stages and require having an overview of the requirement of different roles, understanding where there might be gaps across the organisation and then providing a solution or intervention. SH noted that there are pockets of talent management across the Trust but it is inconsistent. This inconsistency provides a different problem and is reflected in staff survey when discussing inequity of roles. TB noted that without proper talent management these people are likely to move on and it would be useful to take this to a TMC leadership discussion with the senior leadership team to get their thoughts.

RA referenced the low number of people who had responded to the Staff Survey. MW considered that this could be survey fatigue, especially as the Trust is extremely busy. The National Staff Survey response is down for all Trusts but it is noted that SFT is trending below the average. The team are looking at incentives to complete the survey and the reminders to complete it have gone to staff mailboxes rather than the junk inbox where the original email landed. SH noted that the message should be communicated that change can only happen when productive and useful feedback is provided.

The report was noted.

TB1 3/11/2.5 **Integrated Performance Report (IPR) (M6)**

PC presented the Integrated Performance Report which provided a summary of October 2022 performance metrics. PC highlighted some key points from the report:

- There is a focus on improvement and there is evidence that there are pockets of improvement starting to take place. There has been an improvement in falls and management of the elective backlog. The IPR highlights the areas of performance where there has been deterioration but it is also important to focus on the areas of improvement.
- There are ongoing pressures around bed occupancy and noted the consequences including, less efficiency and less flow through hospital.
- PC also highlighted poor performance around the DM01 diagnostic standard. The Board noted that workforce availability underpins a lot of the challenges around performance.

Discussion:
PK raised concerns around the IPR and noted that, as mentioned in previous Board meetings, the report is not providing assurance. PK commented that the report tells a story about what has happened and does not provide any assurance around the actions being taken. The Board acknowledged that these comments had been made previously and that progress would be slow with SH suggesting that it will be difficult to vastly improve on the IPR in the next 6 months. The reason for this is that the executive team are being patient with divisional colleagues in relation to the learning they must do in developing SMART actions and reflecting that in a meaningful and useful report. SH further noted that in such a challenging context, mitigating actions are sometimes unknown.

It was acknowledged that the IPR is meant to provide assurance to the Board and it is not currently achieving that. The Board discussed developing achievable actions and PC agreed that the IPR needs to provide better assurance from a performance and continuous improvement lens but that this is difficult to do in a quick way.

DB acknowledged that whilst it is a challenging context this is occurring across the NHS and these pressures will be with the NHS for years.

TB reflected that the report has changed a lot and it is now in a better shape with clear alignment to the strategic priorities. TB noted that the Board should recognise that it is work in progress and is not where anyone would want it to be and noted that progress will be gradual. SH agreed that improvement will be gradual. SH explained that there is a level of learned helplessness in the Trust and it is up to the executive team to provide people with time to make improvements to the services they are accountable for.

EJ commented that this is the right conversation to be having as a Board and agreed with TB's comments in relation to the IPR. EJ suggested that if there are areas where SMART actions cannot be confirmed the report needs to be explicit about this and the Board should have these honest conversations when assurance is not provided.

The Board discussed that there are escalation areas open without substantive staff and that can be unsafe. In the current context staff are unable to demonstrate best practice 24/7 due to the lack of staffing.

LT explained that the Winter Plan does have actions to combat some of the challenges described in the IPR. LT explained that the learning from her new role so far is that in finance there is an expectation to submit forecasts to year-end and yet the rest of the organisation does not have to. The operational teams have improved in terms of data. However, the analysis requires improvement but there are plans to mitigate this. There is a big gap in terms of looking ahead and this will be worked on. LT explained the incremental changes that she would hope to see and noted that from this month, the performance team will be sense checking this report and providing feedback.

MW referenced the quick turnaround of the large amount of data executive colleagues are meant to interpret each month. MW noted that time is required to coach the senior leadership team to interpret this data so they can provide meaningful solutions and therefore provide assurance.

NM noted that there will be instances that the Board would not receive sufficient assurance. The workforce challenges are difficult and if anyone came to Board with a set of actions that were not realistic, they will be rejected. NM noted that there is a good template but agreed that it does require further work. JD suggested that the IPR could be linked to the A3 outcomes and there are opportunities to do this.

TB1 3/11/3 FINANCE AND PERFORMANCE

TB1 3/11/3.1 Digital Plan 2022-26

NG and JB presented the 2022/26 Digital Plan. JB noted that the Board is asked to approve the Digital Plan, noting the intent for the level of programmes to be vastly reduced by October 2023 to focus all efforts on the shared EPR implementation. The oversight for delivery on this plan will be overseen by the Digital Steering Group.

JB provided an overview of the Digital Plan and the activities expected over the next few years. The Board noted that the Digital Plan is designed to provide a realistic programme of activities and there is now mature governance processes for the digital agenda.

In terms of risks there are two key areas. The first relates to the shared EPR programme which will require £8m of capital across the next two years. To secure this there needs to be an agreed tactical approach as agreed at the Strategic Capital Group.

The second risk is around ownership of programmes of work as historically this has not been done well in the past. There are key areas where improvements are required and there needs to be some consistency guidance, messaging to staff and communications support.

Discussion:
LT thanked JB for the plan, noting that it was a useful report mapping key areas of work over the next few years. LT noted that from her perspective the strategic risk missing is around capacity, as the reality is there are significant capacity constraints. The projects described require big process changes and will require the resource to deliver. The Board discussed that the capacity for releasing people for training is going to be incredibly difficult. PK agreed with LT, noting the scale of the challenge.

PK queried if the current supplier has a hard stop based on when the Great Western Hospitals NHS Foundation Trust's license runs out. JB explained that SFT's runs out first. The programme goes live in March 2025 at the end of the first year of two-year extension.

NG referenced the capacity concerns, noting that the teams had so far received great input from clinical colleagues.

The Board discussed recruitment and reflected on the challenge for clinical staff to be available for training when they are so stretched. NG explained that training around the new EPR system will have to be available 24/7 for the first 18 months to support staff across all groups.

SH noted that the Digital Plan had been supported by TMC.

Decision:
The Board approved the Digital Plan.

TB1 3/11/3.2 **Improving Together Highlight Report**

PC presented the report, which provided the Board with a monthly progress update of the Improving Together Programme. PC took the report as read noting that in line with feedback from September's meeting, mitigations are now included for workstreams off track.

Discussion:
TB queried if there is the resource and capacity in the organisation to take this work on.

The Board discussed that this work is essential to support continuous improvement and embed cultural change but acknowledged that if there is no capacity to learn, the objectives would not be achieved.

PC noted that there needs to be a balance between delivering training and allowing work to be delivered and wards to continue functioning. The Coach House have tailored their training approach to ensure training is delivered when teams are available and motivated. PC explained that when trying to implement new ways of working, there is a degree of processes running alongside each other. SH noted that patience is key and any cultural change programme takes around 7-8 years to properly embed. The Trust has seen delays in progress and noted that there

would still be challenges in delivery without the additional operational pressure staff have been experiencing.

SH noted that some of the frontline staff who have been practising these new ways of working are going to take over as All Staff Briefing to encourage other staff and answer any questions.

The Board discussed being patient with expectations and TB noted that no other organisation has tried to embed this work under the current circumstances. TB therefore asked if expectations in relation to inputs and outputs had been managed. ME noted that when speaking with staff there is an element of thinking that Improving Together is just another piece of work to do rather than an updated approach to doing things.

JD explained that she had joined front line teams in training and it had been a positive experience. The clear challenge currently is that the matrons have not been trained but there are plans to manage these gaps. MW referenced the challenges of people releasing some time to do training, noting that a full 3-day programme was shortened to 3 half days and people were still unable to attend training.

PC noted that the Trust is at the stage where it is the appropriate time to re-review and ensure everyone understands the vision, how this is measured and the programmes of work aligned to this. PC discussed that 12-18 months into the project is normally the correct time to do this and the outcomes of this work will be fed back to the Board.

FMc noted that as part of the external Well-Led review which is due to take place next year, part of that work will be looking at benefits across the three acute Trusts in the BSW ICS.

TB1 3/11/4 QUALITY AND RISK

TB1 3/11/4.1 Board Assurance Framework (BAF) and Corporate Risk Register (CRR)

FMc presented the report which asked the Board to review the overall risk profile for each strategic priority and agree that this reflects the current and future risks. It was noted that the risk theme, appetite, and tolerance level has been applied to each risk. FMc noted that the BAF had been discussed in detail at the Board Committees and highlighted the following key points:

- FMc referenced a small error in the paper which would be amended.
- The Committees have focus on risks out with tolerance and it was agreed that these risks are reflective of the current context.
- There has been good discussion at the Board Committees and feedback indicated that people are finding it easier to navigate.

The report was noted.

TB1 3/11/4.2 Patient Experience Report Q1 – deferred to January

TB1 3/11/4.3 **Learning from Deaths Report Q1**

PC presented the report which provided the Board with assurance that the Trust is learning from deaths and making improvements. PC took the report as read but highlighted the following key points:

- The feedback from the Shadow Board in relation to the report and how the team demonstrates learning is helpful and will be taken into consideration for future reporting.
- It is recognised that there is an issue around coding and measures are being taken to try and improve this position.
- HSMR for the 12-month period end May 2022 is statistically higher than expected. PC noted that HSMR will be recalculated and it is expected that the figure will come down when the hospice numbers are reported separately. PC noted that whilst there is an concerning upward trend, the data, when recalculated to allow for the hospice, indicates that the Trust's mortality rates are within the expected range.

Discussion:
SH noted her concerns with this position and asked if there was anything different the Trust could be doing to provide additional assurance. PC noted that the data is provided by an external organisation who do provide a good level of challenge and engagement with had improved. However, it was discussed that more can be done collectively within the BSW to look at how mortality numbers vary across the three acute Trusts.

TB challenged that although SHMI is within the expected range it has been variable and is nearer to the top of the expected range. This is concerning when considering the context of the challenges currently faced. TB noted that a lot of work that has been done and there is a good level of transparency on this issue but it does remain a concern to which the Board has not received an adequate answer. The Trust has never had to exclude the hospice figures historically.

PC explained that mortality modelling is based on pre-COVID expectations. However, this is not just about COVID, there has been changes to the population's lifestyle choices and a reduction in attendance to regular health care checks. There was a suggestion about how long the Trust should wait to review the position, which was three months.

EJ noted that the data can be confusing as there is not an outlying service causing this, which would indicate coding could be an issue. PC suggested that the team could provide assurance by sharing an understanding of how the data is managed. PC suggested that there is a need to understand the data in a granular way and work is underway to improve this. TB noted that she was encouraged by the discussion and transparency of the issues.

TB1 3/11/4.4 **East Kent Maternity Report**

This was taken after item TB1 3/11/4.1.

JD and JH presented the report which asked the Board to note the information provided on the outcomes of the East Kent maternity review by Dr Kirkup. JD highlighted the following key points:

- The review looked at 202 cases including 65 baby deaths from 2009-2020 at East Kent NHS Foundation Trust. The Kirkup panel found that in 95 of the 202 cases outcomes could have been different. Furthermore, the outcome could have been different in 45 of the 65 baby deaths if recognised standards of care had been met. The findings are broken down into 5 key themes which are detailed in the report.
- Recommendations from the report are included and strongly link with recommendations from previous national reports into failing maternity services.
- A "true to us" assessment for Salisbury NHS Foundation Trust will be undertaken once the Maternity team have had the time to work through the findings in full.

Discussion:
The Board had a detailed discussion and JD provided assurance that the is already work underway to prevent some of these risks highlighted in this report. As part of the extensive work into SFT's maternity service, a cultural review was undertaken as it was felt this was one of the department's most significant risks.

JD noted that there are meetings planned on 18th-19th November with the Maternity Improvement Advisor and Regional Chief Midwife to review how, from an NHS wide process perspective, this report will be put into action.

SH referred to the language around this report and specifically 'reading the signals', noting that this could relate to any service in the NHS. SH noted that the Trust should consider what it might be able to do around the 'true to us' piece and looking at this on a wider scale. JD explained that there will possibly be changes to how CQC assessments are approached.

ME noted that he had attended a Board Safety Walk with MvB around maternity. The staff they spoke to, although mostly senior, were positive when talking about improvements and leaderships. The required improvements to the estate were raised as point of concern but overall, there was a good team ethos.

RA referred to continuity of care and asked how the Trust is taking forward the MBRRACE (Mothers and Babies: Reducing Risk through Audits and Confidential Enquires) work. RA referenced the social inequalities part of the MBRRACE which is linked to culture. JH explained that the work in relation to the CQC report and the Ockenden recommendations has been a key focus in recent months and the work on this has been paused. However, the Trust is still engaged in the national meetings. RA noted the importance of the continuity of carer in identifying pockets of deprivation and ensuring the correct level of care is implemented. SH noted hers and the wider executive team concerns that

the constant operational demand means that tackling wider systemic issues regarding health inequalities is challenging. RA noted that whilst this is not easy to focus on alongside other challenges, this is intrinsically linked to population health and child well-being.

EJ noted that as the NED Maternity Champion she regularly visits the ward and speaks to all staff and women who are using the service.

TB noted the enhanced spotlight that maternity services has been under for the past few years and asked if the Trust provides an opportunity for staff to discuss the report from a professional and mental perspective. JH explained that there have been several listening and talking events with staff. They receive a lot of communications about the reports that have been released and open forums have been held. What is clear is that only positive outcomes can come as a result of these reports.

RA noted that from an education perspective there has been a reported 70% drop off from Midwifery courses which indicates potential future staff are stepping back from the profession.

NM thanked JH and the maternity for their continued efforts in service improvement.

TB1 3/11/5 **PEOPLE AND CULTURE**

Tb1 3/11/5.1 **Nursing Skill Mix Review**

JD presented the report, which provided detail of the bi-annual nursing skill mix review and safe staffing report. JD noted that the report had been discussed at length in F&P Committee and CCG. It was noted that whilst valuable discussion and oversight had occurred at F&P, no definitive funding approval had been reached, deferring to anticipated Board discussions with concurrent winter staffing plans.

Discussion:
The Board had a detailed discussion with SH escalating that the discussion at the Committees did not support a further change in headroom. The headroom was increased from 19% - 24% from April 2021 which the Board is content with.

The Board discussed the difficult conversations at Committee related to the fact that this tool points to additional investment for nurses but there is not an equivalent for other staff groups.

JD and MW noted that they are involved in a large piece of work across the Acute Hospital Alliance (AHA) which provides us local, real-life reflections on where the Trust is with staffing in comparison to others. When benchmarked against the two acutes in the AHA, SFT has the lowest fill rate.

EJ explained that from a CGC perspective, this report assures the Board that the process has been done correctly and that has been delivered. It is about ensuring establishments are correct and the correct process has

been followed. A separate piece of work is needed around different staff groups and outcomes when considering investment.

PK noted that there is a declining efficiency in our workforce and it would be useful for the Trust to have a better understanding of this. SH agreed that whilst the Improving Together work is aimed at ensuring wards and departments are working more efficiently, there needs to be a wider analysis.

The Board noted that the recommendations as a result of this process will be considered as part of the normal business planning process.

TB1 3/11/5.2 **Education and Development Annual Report - deferred**

TB1 3/11/6 **GOVERNANCE**

TB1 3/11/6.1 **Register of Seals Q2**

FMc presented the report which asked the Board to note the entries to the Trust's Register of Seals.

There was one entry which had been signed in the reporting period.

The Board noted the report.

TB1 3/11/7 **CLOSING BUSINESS**

TB1 3/11/7.1 **Agreement of Principle Actions and Items for Escalation**

NM noted the key points from the meeting as follows:

- The IPR requires further work to provide the level of assurance the Non-Executive Directors are looking for. This will require some patience as the report is improved and developed over several months.

The key areas of escalation were noted.

TB1 3/11/7.2 **Any Other Business**

SH noted that this would be NM's last public Trust Board meeting. SH noted the opportunities to recognise NM's contribution to SFT over the coming months but thanked NM for his support to her and noted that NM's 9 years as Chair had been a significant and impactful era, which has helped shape the organisation.

NM thanked his Board colleagues and wished the Board and Trust every success going forward.

SH noted that this was also PK's last public Trust Board meeting. SH noted that PK's contribution to the Trust had helped to lead the way for continuous improvement and striving for exceptional governance practices. SH commended PK's role as Audit Committee chair and the

level and quality of challenge which has helped the organisation to reflect, stay safe and improve.

There was no further business.

TB1 3/11/7.3 **Public Questions**

There were no public questions.

TB1 3/11/7.4 **Date of Next Public Meeting**

Thursday 12th January 2023, Board Room, Salisbury NHS Foundation Trust

TB1 3/11/8 **RESOLUTION**

TB1 3/11/8.1 Resolution to exclude representatives of the media and members of the public from the remainder of the meeting (due to the confidential nature of the business to be transacted).

Master Action Log
Open Actions

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

1	Deadline passed, Update required
2	Progress made, update required at next meeting
3	Completed
4	No progress made/ Deadline in future

Committee	Organiser	Reference Number	Deadline	Owner	Action	Current progress made	Completed Status (Y/N)	RAG Rating
Trust Board Public	Sasha Grandfield	TB1 3/11/1.9 Feedback from Shadow Board	12/01/2023	Melanie Whitfield, MW	SH noted that she would like Shadow Board members to present the feedback going forward. RA supported this and MW noted she would take this back to the group.	Eiri to discuss with Shadow Board members at their meeting on 29th Nov.	N	2

Salisbury NHS Foundation Trust

Report to:	Trust Board (Public)	**Agenda item:**	1.8
Date of Meeting:	12 January 2023		

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

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

Executive Summary:
The purpose of the Chief Executive's report is to highlight developments that are of strategic and significant relevance to the Trust and which the Board of Directors needs to be aware of. This report covers the period since the last public board meeting in Nov 22. The report highlights: • Key national communications for Board awareness and information. • Level of sustained pressure resulting in continued highest levels of escalation (OPEL 4) over the period. • The position in relation to seasonal infections and COVID and the impact on services and patient experience including the latest position for Flu and COVID vaccination for staff. • Impact of continued operational pressures and utilities costs on our financial plan. • Preparation Industrial action. • BSW Integrated Care Systems escalation and information.

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

1. Our Population

1.1 Operational Context

There has been increased and sustained pressure on our services and teams during November and December with the Trust reporting consistently our highest levels of escalation OPEL 4. We have had two further critical incidents related to a lack of capacity in our Emergency Department and ward beds. Our ED and EPRR teams also supported the Industrial Action in the ambulance service on the 21st of December to ensure that patients arriving to the hospital were responded to in a timely manner. Our teams planning and preparation for this worked exceptionally well on the day as did the operational oversight.

The Board have been well sighted on the factors driving the OPEL levels throughout the year. In addition to continuing to support a material number of patients (circa 110) whose discharge is delayed whilst they wait for ongoing care outside of hospital, this last period has seen an increase in the numbers of people needing hospital care with respiratory infections COVID, Flu, Respiratory Syncytial Virus (RSV). This is detrimental to timely flow within the hospital and gives rise to patients having longer waits in our Emergency Department to access an appropriate bed. The clinical and operational teams must observe the relevant Infection Prevention and Control advice re which clinical areas these specific types of patients with different respiratory infections can be safely cared for. Given overall bed occupancy is extremely high, teams are often having to move several patients to create a bed for someone with respiratory infection in the right ward. This is complex and inevitably takes times which is what creates prolonged waiting times in the Emergency Department. The Chief Operating Officer will share some further details and specifics that quantify this with Board colleagues in our session today.

The most recent data (Dec 22) shows SFT supported 100 patients admitted with respiratory infections patients 50% of which are COVID infections. This places significant additional in respect of our overall bed base and has resulted in additional escalation areas having to be supported. The impact of the increased respiratory admissions has also impacted on our critical care capacity with increased numbers of level 3 (intensive care) patients last week breaching our core critical care capacity. Staff also had to working outside of Guidance for the Provision of Intensive Care (GPIC ratios for 1:1 staffing for level 3 patients. Colleagues did activate the relevant processes for mutual aid and clinical transfers, but this wasn't available as in reality all ICU were facing the same pressures on services.

Infection management has led to mixed sex breaches and a Duty of Candour letter is provided to patients in the Emergency Department if being admitted detailing the prioritisation of infection management over gender specific accommodation.

The Chief Nurse, Chief Medical Officer and the Chief Operating Officer are providing executive oversight of the complex challenges this surge of respiratory infections is having.

Our leadership teams are implementing the additional actions that the Board agreed for our Winter plan when we met in November, and I know the Board will want to join me in paying tribute to our teams. Our teams across our urgent and emergency pathways are working in an exceptionally challenging context and understandably finding it difficult. Despite this there are many examples supported by ongoing feedback from those who use our services of staff doing providing great care and excellent patient experiences. To continue to achieve this in the face of significant pressure is remarkable and testament to our team's passion and commitment for our local communities.

I acknowledge that for some patients the longer waiting times and pressurised context will have had an adverse impact of their experience and I would like to both apologise for this and reassure our local communities that our teams are doing their very best to respond.

The Board will recall that part of our local system Wiltshire plan for additional Winter capacity was for additional beds (circa 57) at the South Newton site that the local care provider would deliver. This hasn't happened to date due to challenges around the regulatory frameworks which I will brief the Board on in our private session. This presents a material gap in the Wiltshire plans and creates an additional concern for us over the coming weeks.

It is a very challenging context, and the Board will note this is giving rise to increased risks detailed in the Board Assurance Framework and on the Corporate Risk Register and continued pressure in some of our performance and quality metrics captured in our Integrated Performance Report.

1.2 Vaccination

Our vaccination team are supporting both the COVID booster programme and the annual Flu vaccination. On a positive note, we have the highest vaccination levels for covid in the southwest at 69.9% and 2nd highest for Flu at 64.5% which may contribute to reduced staff sickness as we move through the next 4-8 weeks. I would like to thank our teams who are delivering this on our behalf for all their hard and persistence in delivering this.

1.3 Financial sustainability

We have as a Trust has been forecasting that we would meet our financial plan in 2022-23, albeit noting some material risks, in particular the inflationary pressure on utilities and the impact of a challenging winter on the bed base and the workforce. As the Autumn progressed it has become clear that these risks are manifesting, and as such we are reviewing what the consequences are for our financial forecast, along with what options are available to us to offset these pressures.

2.0 Our People

2.1 Staffing

Our staffing situation remains a concern. Turnover remains consistently above the target of 10% and staff sickness as would anticipate has increased during December which is impacting on the staffing availability on a day-to-day basis.
We continue to prioritise recruitment and continuous improvement work to our recruitment processes is ongoing with a significant project group working on this over the coming months. A new recruitment campaign has been launched. The focus of this campaign is Healthcare Assistants, facilities staff and admin and clerical. The campaign has involved posters on buses, new web pages and a doorstep leaflet drop. Early signs are encouraging with the recruitment team reporting an increased number of calls asking about roles – but we have a long way to go.
The new pages can be viewed here https://www.salisbury.nhs.uk/working-for-team-salisbury/

We will monitor and measure the impact of the Board decisions re Band 2 pay and supporting the progression of clinical Band 2 into Band 3 roles where the criteria is reached on both recruitment and turnover in these groups. It is too early to evaluate the impact at this stage.

2.2 Retention of staff

The People directorate are developing ways to best capture how colleagues are experiencing work life in the Trust. The Trust launched our hub for staff during this last period which is a scheme whereby staff can both donate and or have access to support with basic provisions given the impact of the cost-of-living crisis. Whilst the scheme is still in its infancy it has already supported over 30 members of staff which is excellent. Our facilities department and volunteers have been instrumental in making this happen and I know they have been overwhelmed by the generosity of our staff who are donating.

The Trust has received some of the results back from the recent NHS Staff survey which completed in November. This is embargoed currently and gives opportunity for the Chief People Officer and her team to analyse and understand what this important feedback is telling us. We will share this with the Board in due course and ensure that this is aligned with our operational planning and priorities in relation to our people over this next 2 years.

2.3 Staff Wellbeing

In the run up to Christmas 200 hampers were distributed to all teams, departments and wards. These were from the Executive and were supported by the Stars Appeal as a thank you to everyone. Stars once again supported Christmas trees and lights across the site plus - in collaboration with Art care - a fantastic 9 days of public and staff music events with 14 different acts including choirs, a DJ, saxophone and harp recitals and online performances – in total there were 39 sessions including one hosted by Father Christmas.
And Christmas wouldn't be quite right without food. This year a free Christmas lunch or breakfast was provided to all staff that wanted one – and the incredible catering team managed numerous sittings feeding close to 2000 staff. My personal thanks to the catering team who provided not only a lovely meal but also ensured the service was slick and festive.

We have recently agreed some investment from the Hospital League of Friends to enable our wards and departments to improve their coffee/rest areas. This work has been led by Kate Jenkins, Clinical Psychologist and is an alternative to a separate staff wellbeing area on the back of feedback from our teams that they would prefer this. It is fantastic to have this opportunity and the team will now progress the plan over the coming weeks.

2.4 Industrial Action

Following action at GWH and RUH in December, the RCN have notified me that Salisbury will be one of the Trust's included in Strike Action over the period 18/19th Jan. Recognising that staff have a right to demonstrate their strength of feeling by taking lawful industrial action, we will be respectful of our colleagues wanting to act at this time. However, our primary focus must remain the delivery of safe, timely and consistent care to our patients, and we will be negotiating with the RCN Strike Committee to understand the mechanisms we will need to put in place to manage patient safety. The RCN have indicated that formal negotiations will commence on 9th Jan. The Trust's position will be represented by Chief Nurse, Judy Dyos and Chief People Officer, Melanie Whitfield who have drawn from the negotiating experience of other Trusts in December to ensure that we are in the best place to seek practical and timely derogations to aid planning for strike days.

With action planned for the 28th of December postponed, we now anticipate that the South West Ambulance Service Trust (SWAST) will be affected by industrial action on 11th and 23rd Jan, our planning will reflect the lessons from the strike on 21st Dec. The actions of the site and ED teams in managing the impact of this action is very much appreciated. The Royal College of Midwives concluded their statutory ballot in December but did not receive a mandate for action in their national vote. The Chartered Society of Physiotherapists balloted locally in December, and received a mandate for action in Salisbury, however, we are yet to

receive notification of any action from the Union. Looking forward, the statutory ballots of the British Medical Association (Junior Doctors) and HCSA (hospital doctors union) are expected later this month.

3.0 Our Partnerships

3.1 National Communications

NHSE/I distributed the operational planning guidance and detailed appendices on the 23rd of December 2023. The Executive and senior leadership teams are working through our assumptions and approach to this at an organisation, Acute Hospital Alliance and BSW system level. We will share further details of this with the Board in February – some of the specific changes include a return to Payment by Results for elective activity (follow up outpatients are excluded), plan for 92 bed occupancy for acute trusts, recovery of the 4-hour emergency care standard to a minimum of 76% and ambulance category response times back to a maximum of 30mins.

3.2 BSW Integrated Care System

There is nothing to escalate to the Board from BSW ICB with much of the focus being on delivery of the winter plan and the year end position from a finance and performance perspective. The Wiltshire Integrated Care Alliance continues to over-see and drive delivery of the priorities of the place-based plan for winter which are focused on delivering increased capacity to support discharges from hospitals.

The BSW Urgent Care Board has Care Co-ordination as one of its 3 transformation programmes and is in the process (3 weeks) of a practical test of change focused on making multi-sector, multi-disciplinary clinical support available to ambulance crews either prior to the dispatch of an ambulance and or to crews on scene. The early results are very encouraging and demonstrate a reduction in the number of ambulance conveyances to ED across BSW as well as yielding positive feedback from the ambulance crews re the level of support and options this is providing them with. The test of change will continue over the next few weeks to inform a business case for substantive change. Once the outcomes are available from the test of change, we will share them with the Board. This work is attracting regional and national attention as it has the potential to be genuinely transformation for our communities and staff.

We are supporting BSW ICB colleagues assessing the opportunities and feasibility of the NHS using the South Newton site on a long-term basis. I will provide a further verbal update to the Board in our private session.

3.3 Other partnerships

And finally, the SFT podcast series *The Cake* has been picked up by the BBC and edited versions will be broadcast on BBC Wiltshire starting later this month and then hosted nationally on BBC Sounds.

NHS Salisbury NHS Foundation Trust

Report to:	Trust Board (Public)	**Agenda item:**	2.1
Date of Meeting:	12th January 2023		

Report from: (Committee Name)	Clinical Governance Committee		**Committee Meeting Date:**	20th December 2022
Status:	**Information**	**Discussion**	**Assurance**	**Approval**
	X	X	X	
Prepared by:	Miss Eiri Jones, Chair CGC			
Board Sponsor (presenting):	Miss Eiri Jones, Chair CGC			

Recommendation
Trust Board members are asked to note and where relevant, discuss the items escalated from the Clinical Governance Committee (CGC) meeting held on the 20th December 2022. The report both provides assurance and identifies areas where further assurance has been sought and is required.

Key Items for Escalation

- Key information / issues / risks / positive care to escalate to the Board are as follows:
  - This month's meeting had a limited agenda due to the expected nursing industrial action and ongoing service pressures. Items deferred will be followed up in forthcoming meetings.
  - During the discussion on the action log, it was noted that a backlog of discharge summaries had been confirmed. The committee have asked for an update from the Chief Medical Officer in relation to any risk involved and the plan to address.
  - The discussion about the Integrated Performance Report section relating to quality impact identified an increase in grade 2 pressure ulcers and E Coli though noting that the Trust is still in a good position in relation to infection prevention performance. A request for further assurance in relation to impact of ambulance offloading delays and the forthcoming industrial action was raised. Ongoing concern in relation to DM01 was noted, however cancer diagnostic performance had a continued focus from the relevant teams.
  - Several reports were presented in relation to clinical audit. The corporate team are supporting divisional teams to move to an outcome focussed approach using real time data in relation to these audits. Divisional teams will be supported with this work. The committee asked for an update on progress at the next report as per the committee cycle of business.
  - The Learning from Deaths report was presented and noted. It was flagged that this will be discussed further at the January Board meeting.

- The Chief Executive flagged that the Emergency Department continued to be under intense pressure and that the teams involved were doing everything they could to deliver safe care to patients. The Executive team were noted to be providing ongoing support to the department.
- The committee and the Governor observer asked for thanks to be given to all Trust staff during this challenging time.

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

Salisbury NHS Foundation Trust

Report to:	Trust Board (Public)	**Agenda item:**	2.2
Date of Meeting:	12th January 2023		

Report from: (Committee Name)	Audit Committee		**Committee Meeting Date:**	15th December 2022
Status:	**Information**	**Discussion**	**Assurance**	**Approval**
	X		X	
Prepared by:	Paul Kemp (Audit Committee Chair)			
Board Sponsor (presenting):	Paul Kemp			

Recommendation
The Trust Board is asked to note the matters below.

Key Items for Escalation

Matters Arising and Deep Dive

The principal matter discussed at the Committee were as follows

- The committee received a report on the contractual status of provider-to-provider commercial arrangements, following up on the earlier request to the Board for retrospective approval of a contract for the Walk-In Centre provision. The review highlighted three arrangements which lacked a formal contractual arrangement, all of which were in work to catch up. The Committee will continue to monitor progress in this area.
- Three Internal Audit reports were presented to the committee, two of which were not risk rated and had no management action plan or timetable attached. These were reviews on the scoring of the Maternity Incentive Scheme and the Financial Sustainability Return. The third report was a more normal review of payroll processes. The report was rated as medium risk overall with three medium risk findings and one low risk finding. Management plans are to complete the changes needed to address these risks by the end of February 2023
- In addition, there was a counter fraud proactive investigation of sickness reporting, which contained some troubling findings indicating that management processes were deficient in this area. For example, out of a sample of 25, 10 reports were filed late and many updates were made retrospectively. Return to Work reports were found to be in a variety of formats and were not being completed by some departments. HR have committed to a number of actions to update and reinforce policy in this area,

but there were no actions shown to monitor or ensure future compliance. The Committee recommended a re-audit in 6 – 9 month time.

- The committee received a deep dive presentation on the status of the outsourcing contract with SBS for financial transaction reporting. The contract is clearly actively and effectively managed and there were only a small number of ongoing actions that were in work at the time of the report

Regular Progress Reports

The Committee received regular reports from Internal Audit, External Audit and Counter Fraud as to activities undertaken since the last meeting. The Committee Terms of Reference and annual work plan were reviewed and approved.

As noted from the previous meeting, the internal audit programme is running a little behind schedule – understandably under the current circumstances. It is likely that at least one scheduled investigation will run over into 2022/23.

Salisbury NHS Foundation Trust

Report to:	Trust Board (Public)	**Agenda item:**	2.4
Date of Meeting:	12th January 2023		

Report Title:	Integrated Performance Report			
Status:	**Information**	**Discussion**	**Assurance**	**Approval**
			X	
Approval Process (where has this paper been reviewed and approved)	Sections approved by responsible committee: • Operational performance & resources: Finance & Performance Committee • Quality & care: Clinical Governance Committee • Workforce: People & Culture Committee			
Prepared by:	Louise Drayton, Head of Performance Emilia Scutt, Performance and Capacity Manager			
Executive Sponsor (presenting):	Peter Collins, Chief Medical Officer			
Appendices (list if applicable):	Not applicable			

Recommendation:
The Trust Board are asked to note the Trust's performance for Month 8 (November 2022)

Executive Summary:
The average wait to first appointment has increased for the third consecutive month, with month end average of 118 days. The Trust continues to have zero patients waiting over 104 weeks, is on target to deliver the trajectory of zero patients waiting 78 weeks by the end of the financial year (a total of 6 against a trajectory of 20 patients) and is ahead of trajectory in terms of the reducing of patients waiting over 52 weeks with a total of 414 patients at month end. In terms of overall waiting list size, the Trust's position remains 1413 behind plan, however improved in month by 779 to 24,829 patients, a circa 35% reduction in variance between actual vs plan from October (25,605 in M7). The number of excess bed days related to internal reasons after a decision that a patient no longer meets the criteria to reside has reduced in M8 to 424; this is a significant improvement from M7 (620) and is the lowest seen since August '22. The availability of workforce to deliver the operational priorities of the organisation remains extremely challenging. Turnover of staff has increased consistently since April '21, with a M8 position of 14.5% (9.9% in Apr 21) and vacancy levels of 12.6%. The vacancy rate has reduced significantly in month, dropping from 12.6% to 9.25%. Improving understanding of turnover data is a key focus of

the Movers and Leavers project in order to generate retention positive actions.

Work to reduce the number of patient falls continues as a key focus of the “Improving Together” programme, with a M7 position of 7.48 falls per 1000 bed days against a target of 6.6 which was an improvement in comparison to 8.58 in M7. Work continues in relation to the roll out of “Bay watch”, though further focus is required in terms of staff availability to attend formal training.

There has been an improvement against the 4 hour standard performance target for the 2nd month running in M8 of 73.4% compared with 70.9% in M7. Despite the improvements, flow out of the department remains significantly challenged and the Trust continues to experience high occupancy levels, which in turn adversely impacts ED performance. This is evidenced by a further deterioration to 50% of patients staying in ED for over 4 hours after a decision to admit (DTA) has been made. The total number of hours lost to these delays equates to 6.3 ED spaces/37% of ED capacity per day which is unable to be used due to being blocked with patients awaiting admission. The proportion of ambulance arrivals that waited over 30 minutes for handover decreased in comparison to M7, however the general trend is an increased level that is outside of tolerance since March 22.

Improvement in performance noted against Stroke standards, with 33% of patients arriving on the stroke unit within 4 hours (26% in M7) against a national target of 90%, with main challenges associated with Trust-wide operational pressures and associated impact on staffing.

Despite the significant pressure on flow around the hospital the number of patients experiencing more than one bed move decreased in November from 2.16 to 1.65; this is lower than the reported percentage for the same month last year. This improvement is felt to be as a result of the implementation of the discharge lounge to release beds to non-elective admissions earlier in the day alongside ongoing improvement work associated with the use of e-whiteboards.

Static performance noted in relation to delivery of the 6-week diagnostic standard in comparison with M7, with performance of 64.67%. There has been an overall decline in total waiting list size by 721 patients, resulting in a total waiting list size of 2363 compared with 2496 in M7. Improvement noted within Audiology and Echocardiography, though performance in MRI and USS remains stable, with ongoing challenges across all services related to workforce capacity and availability.

The proportion of patients referred on a suspected cancer pathway that were seen within 14 days improved to 89% (standard 92%), with ongoing capacity constraints most evident within skin and Lower GI due to an increase in referrals as well as staffing and recruitment challenges. The 28 day faster diagnosis standard was achieved, with challenges associated with diagnostic capacity. Opportunities for further improvement identified within the prostate cancer pathway, with progress monitored via Cancer Improvement Group. Deterioration in performance against the 62-day standard noted in November (73.7%). Breaches associated with patient choice, insufficient capacity within oncology re the delivery of chemotherapy and diagnostic capacity.

The Trust reported further increase in reported category 2 pressure ulcers per 1000 bed days in November (2.56) alongside an increase in the number of reported serious incident investigations from 1 in M7 to 3. It is important to note that the volume of reported pressure ulcers and incidents may be detrimentally affected by operational pressures and staff ability to report. This will remain under close monitoring to identify any trends.

In Month 8, the Trust recorded a control total deficit of £2.9m against a target of £1.3m; an adverse variance of £1.6m. Agency costs increased by £0.5m in month, offsetting reductions in substantive and bank pay of £0.3m. Non-pay costs increased materially with increases in electricity prices and elective Orthopaedics work in month. ‘Pass through’ non pay costs continue to run in excess of those planned for, now accounting for 70% of costs above plan.

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

Integrated Performance Report

NHS
Salisbury
NHS Foundation Trust

November 2022

Summary

November 2022

Salisbury NHS Foundation Trust

The average wait to first appointment has increased for the third consecutive month, with month end average of 118 days. The Trust continues to have zero patients waiting over 104 weeks, is on target to deliver the trajectory of zero patients waiting 78 weeks by the end of the financial year (a total of 6 against a trajectory of 20 patients) and is ahead of trajectory in terms of the reducing of patients waiting over 52 weeks with a total of 414 patients at month end.
In terms of overall waiting list size, the Trust's position remains 1413 behind plan, however improved in month by 779 to 24,829 patients, a circa 35% reduction in variance between actual vs plan from October (25,605 in M7).
The number of excess bed days related to internal reasons after a decision that a patient no longer meets the criteria to reside has reduced in M8 to 424; this is a significant improvement from M7 (620) and is the lowest seen since August '22. The availability of workforce to deliver the operational priorities of the organisation remains extremely challenging. Turnover of staff has increased consistently since April '21, with a M8 position of 14.5% (9.9% in Apr 21) and vacancy levels of 12.6%. The vacancy rate has reduced significantly in month, dropping from 12.6% to 9.25%. Improving understanding of turnover data is a key focus of the Movers and Leavers project in order to generate retention positive actions.
Work to reduce the number of patient falls continues as a key focus of the "Improving Together" programme, with a M7 position of 7.48 falls per 1000 bed days against a target of 6.6 which was an improvement in comparison to 8.58 in M7. Work continues in relation to the roll out of "Bay watch", though further focus is required in terms of staff availability to attend formal training
There has been an improvement against the 4 hour standard performance target for the 2nd month running in M8 of 73.4% compared with 70.9% in M7. Despite the improvements, flow out of the department remains significantly challenged and the Trust continues to experience high occupancy levels, which in turn adversely impacts ED performance. This is evidenced by a further deterioration to 50% of patients staying in ED for over 4 hours after a decision to admit (DTA) has been made. The total number of hours lost to these delays equates to 6.3 ED spaces/37% of ED capacity per day which is unable to be used due to being blocked with patients awaiting admission. The proportion of ambulance arrivals that waited over 30 minutes for handover decreased in comparison to M7, however the general trend is an increased level that is outside of tolerance since March 22.
Improvement in performance noted against Stroke standards, with 33% of patients arriving on the stroke unit within 4 hours (26% in M7) against a national target of 90%, with main challenges associated with Trust-wide operational pressures and associated impact on staffing.
Despite the significant pressure on flow around the hospital the number of patients experiencing more than one bed move decreased in November from 2.16 to 1.65; this is lower than the reported percentage for the same month last year. This improvement is felt to be as a result of the implementation of the discharge lounge to release beds to non-elective admissions earlier in the day alongside ongoing improvement work associated with the use of e-whiteboards.
Static performance noted in relation to delivery of the 6-week diagnostic standard in comparison with M7, with performance of 64.67%. There has been an overall decline in total waiting list size by 721 patients, resulting in a total waiting list size of 2363 compared with 2496 in M7. Improvement noted within Audiology and Echocardiography, though performance in MRI and USS remains stable, with ongoing challenges across all services related to workforce capacity and availability.
The proportion of patients referred on a suspected cancer pathway that were seen within 14 days improved to 89% (standard 92%), with ongoing capacity constraints most evident within skin and Lower GI due to an increase in referrals as well as staffing and recruitment challenges. The 28 day faster diagnosis standard was achieved, with challenges associated with diagnostic capacity. Opportunities for further improvement identified within the prostate cancer pathway, with progress monitored via Cancer Improvement Group. Deterioration in performance against the 62-day standard noted in November (73.7%). Breaches associated with patient choice, insufficient capacity within oncology re the delivery of chemotherapy and diagnostic capacity.
The Trust reported further increase in reported category 2 pressure ulcers per 1000 bed days in November (2.56) alongside an increase in the number of reported serious incident investigations from 1 in M7 to 3. It is important to note that the volume of reported pressure ulcers and incidents may be detrimentally affected by operational pressures and staff ability to report. This will remain under close monitoring to identify any trends.
In Month 8, the Trust recorded a control total deficit of £2.9m against a target of £1.3m; an adverse variance of £1.6m. Agency costs increased by £0.5m in month, offsetting reductions in substantive and bank pay of £0.3m. Non-pay costs increased materially with increases in electricity prices and elective Orthopaedics work in month. 'Pass through' non pay costs continue to run in excess of those planned for, now accounting for 70% of costs above plan.

What we are measuring – our Strategic Priorities

Improving the health and well being of the Population we serve

Working through Partnerships to transform and integrate our services

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

Our focus – Breakthrough Objectives and Strategic Initiatives

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

What is an Integrated Performance Report (IPR)?

NHS Salisbury NHS Foundation Trust

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

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

Business Rules - Driver Metrics

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

Business Rules - Watch Metrics

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

Business Rules - Statutory/Mandatory Metrics

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

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

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

NHS
Salisbury
NHS Foundation Trust

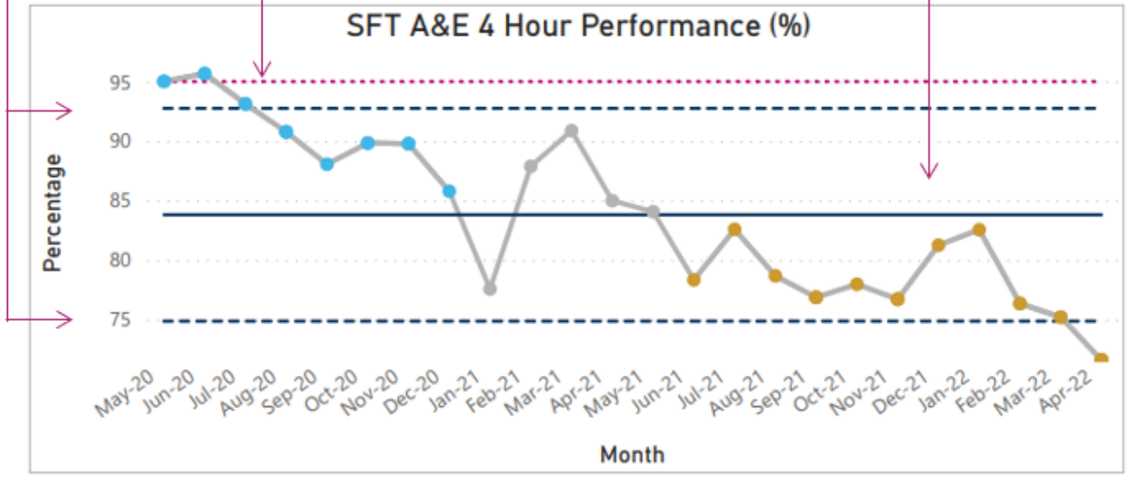
Reading a Statistical Process Control (SPC) Chart

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

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

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

The solid grey line shows the mean value for the dataset



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

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

Grey markers show normal behaviour with no significant cause for variation

Part 1: Quality of Care, Access and Outcomes

Performance against our Strategic Priorities and Key Lines of Enquiry

Salisbury NHS Foundation Trust

Our Priorities

Population

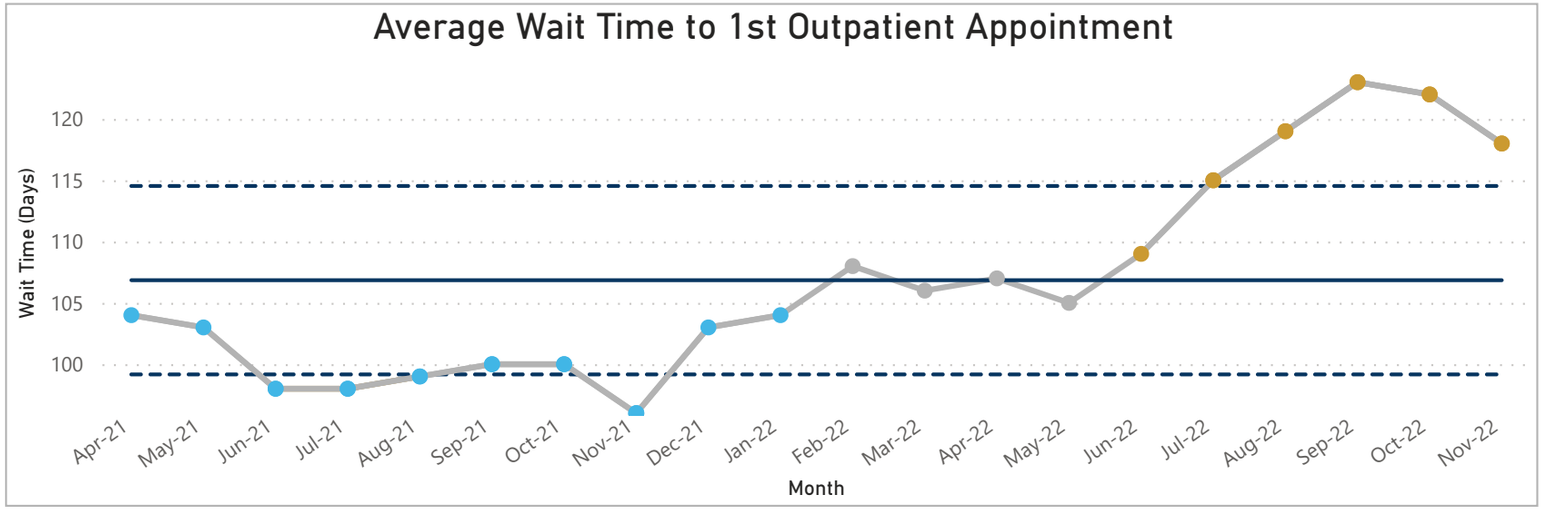
Partnerships

People

Reducing Patient Waiting Times

Target 87 days

Breakthrough Objective



We are driving this measure because…

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

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

Understanding the performance:

The performance data shows an improvement over the last two months for the average time patients have waited for their first appointment, as measured against the total average waits of the entire waiting list as opposed to the average of those actually attending for appointments, which previously showed a continued deterioration owing to the need to respond to national expectations to focus on eliminating all non-admitted waits for first appointment over 52 weeks.
The Trust continues to focus on seeing patients in line with clinical need, referral type, e.g. Cancer 2 week wait and Urgent referrals, and by longest wait, in line with NHS England requirements.
SFT continues to have success in ensuring there are no >104week waits, and at November month end was well ahead of its trajectory of 20 >78week waits, with a total of 6. Over 52 week waits also continue to reduce and at month end to 414, with 216 non-admitted pathways, 41 of which awaiting a date for first appointment.

Actions (SMART):

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

- Patients to continue to be booked in line with NHS England recommendations, with weekly validation of long waiting patients.

- Support given to Divisions to better understand and map demand and capacity in preparation for 2023/24 planning round.

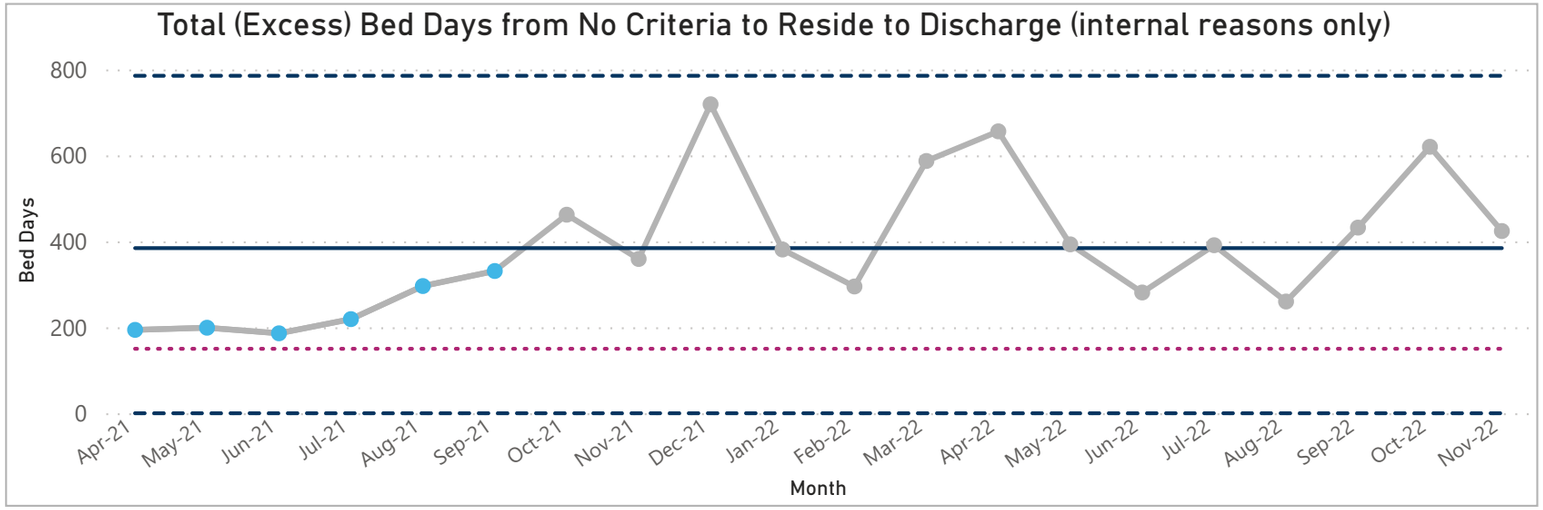
Risks and mitigations:

Limitations continue in relation to the Trust's ability to comprehensively map demand and capacity at a subspeciality/pathway level, however support is planned and capacity in place, with the commencement in post of the new Head of Performance, to assist in improved modelling to better understand this in readiness for the 2023/24 planning round. Resource limitations at both DMT and Speciality level have been raised and a paper proposing enhanced Divisional structures has been drafted.

Optimising Beds

Target 150 days

Breakthrough Objective



We are driving this measure because…

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

Understanding the performance:

The excess bed days after a decision that a patient no longer meets the criteria to reside has reduced in November to 424. This is the lowest number seen for the past 3 months but remains higher in comparison with the same time last year (359).

Actions (SMART):

• There have been concentrated effort from teams to address the delays for this group. Therapy teams review the reporting daily to support focussed actions to promote progress and prioritise these at the start of the day. Also the use of e-whiteboards which is where the delay information is recorded is an area that remains critical to the accuracy of the reported data.
• The e-whiteboard group meets regularly and is currently collating requests for education and developments for the supplier to review in December '22.
• There has been some process mapping work to support this and the group membership is widening to include more interested members of the Multi-disciplinary Team (MDT). It is anticipated that there will be an outcome to this work agreed by January and will reflect better the work done to improve in the area of bed days lost to internal reasons.

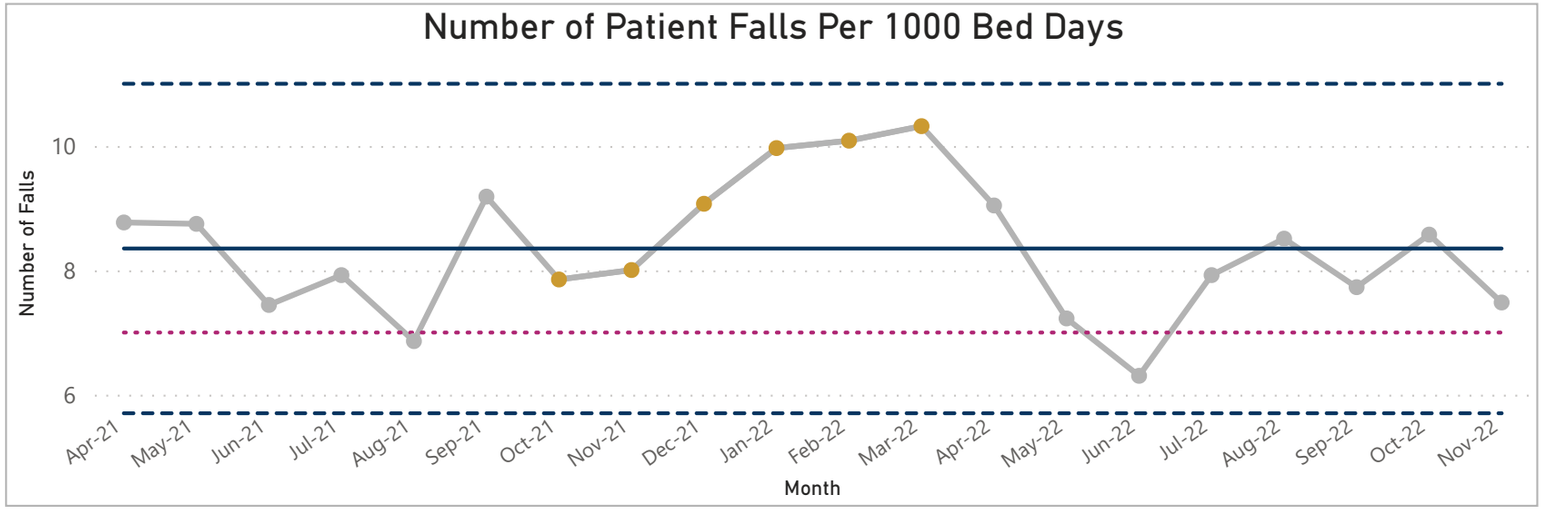
Risks and mitigations:

The risks to this work include:
- Staffing and availability to facilitate the background work
- A reduced level in staffing for therapies to directly address delays relating to their service and widespread winter pressures
- Any escalation of beds will mean that teams doing the discharge assessment work will be spread more thinly, increasing response times and Length of Stay (LOS)

Reducing Patient Harm

Target 7

Breakthrough Objective



We are driving this measure because...

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

Understanding the performance:

Overall falls fell from 134 in October to 111 in November. 8.2 per 1000 bed days (national standard aim 6.6).
There were 5 falls with harm: 4 moderate and 1 major.
Training is being delivered at ward level, the falls lead endeavours to review every patient who falls and also delivers training on a rotational level for all ward teams.
A National eLearning module is available on Kalidus but with low up-take. This is not mandatory and its worth will be reviewed in collaboration with colleagues in BSW in January 2023.
Improving Together falls reduction breakthroughs for Pitton and Farley Wards.
Lye and Stand Bp compliance for Orthopaedic Wards.
Revision of bed rails and falls risk assessment recognised as necessary due to continued non compliance and ambiguity questioning.
Equipment for ultra low beds and falls sensor alarms is complete. MDMS are leading on sourcing crash mats which should be trialled in January 2023.
Bay Watch has commenced on Farley, Pitton and Whiteparish Wards with varying success. Farley ward had no falls in their bay watch bay for November, and only 1 fall overall in November. Pitton ward needs more support and education-this will continue in January 2023.

Actions (SMART):

•Training at induction for Healthcare Assistants (HCAs) has been completed and will continue. Interactive training session is being designed to commence in April 2023. 295 members of staff have been formally trained.
• "Bay watch": - Commenced within Farley, Whiteparish and Pitton wards; more support and education required
- Amesbury and Durrington wards to commence in January '23
• Post falls MDT huddles commence on Farley and Pitton wards 12/12/2022. This reviews patients in real time for learning and reducing the risk of further falls.
• The redesign of the bed rails and falls risk will be rolled out after electronic records has been completed on all wards-summer 2023.
• 20 ultralow beds and 17 falls sensors have been purchased and are all in use. Crash mats will be trialled in January 23 and support request for STARs appeal for purchasing.
• 36 new monitoring equipment is being rolled out to wards that measures and times lying and standing BP which should improve compliance-monitored on monthly audits which have improved month on month.
• Slippers for patients is an improvement project supported by the Stars appeal and commenced on Durrington Ward; to be audited monthly.

Risks and mitigations:

There has been an influx of new staff to wards and the Falls Lead although teaching HCAs at Induction, needs to continue training for qualified staff at ward level. Wards with high rates take priority with intensive training.

Good communication with colleagues in BSW-reviewing validity of National eLearning programme. Not mandatory in Salisbury. Vacancies, sickness and capacity have all had an effect on training on the wards but reviewing patients at ward level had been beneficial for ward teams.

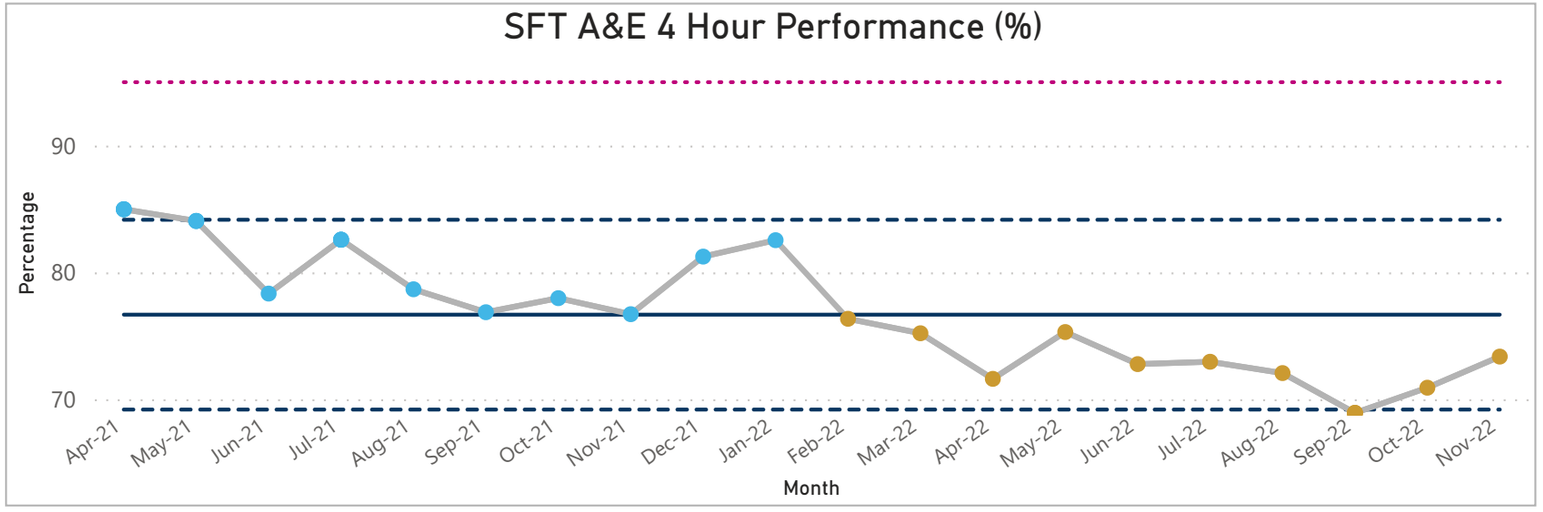
Bay watch needs further buy in from therapy staff and some senior doctors. The success for Farley ward will be championing this as well as continued training. Aim to have all wards using this by June 2023.

Monthly data collection continues.

Emergency Access (4hr) Standard

Target 95%

National Key Performance Indicators



Performance Latest Month: 73.4%

Attendances: 6131

>12 hrs in ED Breaches: 72

Understanding the performance:

There has been a sustained improvement against the 4 hour standard performance target for the 2nd month running in M8 of 73.4% compared with 70.9% in M7 and 68.9% in M6. There has been a slight decrease in attendances in M8 of 205 compared which equates to c.7 per day. The protection of at least 2 Ambulatory trolleys within the AMU footprint has continued to pay dividends and has supported both the increased 4hr performance and also the reduction in attendances with patients going direct to AMU rather than being diverted to ED.
Despite the improvements, flow out of the department remains significantly challenged and the Trust continues to experience high occupancy levels, which in turn adversely impacts ED performance. This is evidenced by a further deterioration to 50% of patients staying in ED for over 4 hours after a decision to admit (DTA) has been made. The total number of hours lost to these delays equates to 6.3 ED spaces/37% of ED Capacity per day which is unable to be used due to being blocked with patients awaiting admission. However, despite the overall increase in patients waiting over 4hrs there was a decrease in the 12hrs DTA to admission breaches from 163 in M7 to 72 in M8.

Actions (SMART):

-Ongoing scoping/development of an SDEC model/area with enhanced support now provided through CPPG. Area identified and project group established with. Full time project manager to work through staffing, policies, models and space requirements. A joint national bid for £1.1M submitted with GWH to help facilitate delivery of the project.

-The new ED Tracker roles have been recruited to in M8. This role will be vital in assisting the department maintain its flow by keeping accurate records of patients journeys, liaising with teams involved in the patients care and chasing outstanding investigations and bed requests.

-ED/AMU Matron has pushed forward with the working group to support streaming of patients at the Front Door, engaging with minors lead, Consultants and wider nursing team. The timeline for the training, pathways and standard operating procedures to be in place is currently M10 (Jan 2023). This will be supported by the new practice educator who commences in post in M9.
-Time between DTA and Admission added as driver metric for the medical division using the improving together methodology to help work through the root causes and establish countermeasures and improvement trajectories.

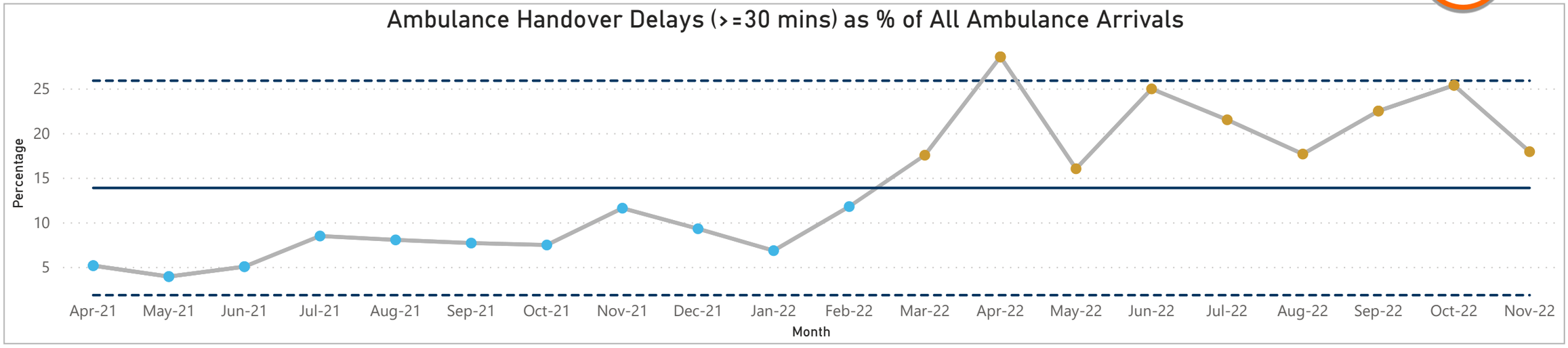
Risks and mitigations:

-Flow out of the department remains challenging with high occupancy levels continuing across the Trust, resulting in capacity issues within the department. The ED team continue to attempt to mitigate the reduction in capacity by looking at opening additional areas to enable them to see and treat patients and utilising more streamlined processes in an attempt to reduce risk.

-New Emergency Department escalation levels (EDEL) have been agreed by the division and executive team to support ED in times of pressure and mirror the OPEL format with triggers for each level. These will be reviewed and agreed at the ED senior checkpoint meetings throughout the day and communicated at the trust wide capacity meetings. The plan is for these to come into action in M9.
-Gaps in all areas of workforce remain. Recruitment to vacancies continues; overseas medical recruitment has proved successful with 3 SHO's and 2 Staff Grade doctors starting across M9/10. Current mitigation for medical vacancies is consultant acting down out of hours, however this is not sustainable and other options are being explored. Nursing gaps are reviewed daily and robustly supporting by the senior nursing team across the divisions to ensure safety is maintained.

Ambulance Handover Delays

National Key Performance Indicators



Understanding the performance:

The proportion of ambulance arrivals that waited over 30 minutes for handover decreased in comparison to M7, however the general trend is an increased level that is outside of tolerance since March 22.

There were 131 patients that waited longer than 60 minutes to be handed over. The average numbers of hours lost per day to handover delays was 14 in M8, lower than the previous two months.

Actions (SMART):

Unable to achieve protecting an increase to 4 Ambulatory trollies to support flow early at the Front Door and assist in delivering Same Day Emergency Care (SDEC) in M8, plan to increase this in M9.

Ongoing scoping/development of an SDEC model/area with enhanced support now provided through CPPG. Area identified and project group established with Full time project manager to work through staffing, policies, models and space requirements.

A joint national bid for £1.1M submitted with GWH to help facilitate delivery of the project. This will help to generate flow out of ED and also facilitate patients going direct to specialty without the need for ED involvement.

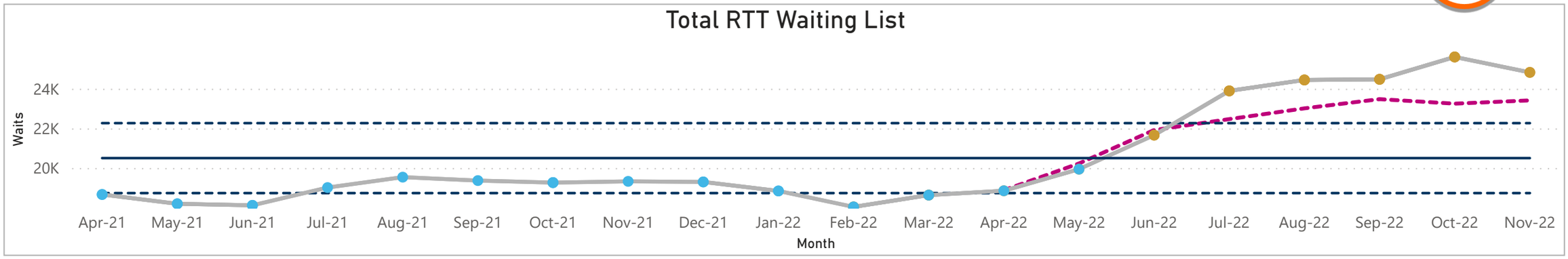
Risks and mitigations:

High bed occupancy and staffing challenges evident across the Trust, resulting in poor flow out of the Emergency Department remains the biggest challenge in being able to off load ambulances in a timely manner. The estates works on Breamore has now completed and the reopening of wards sees the introduction of a discharge lounge along with a further 12 beds for patients with no criteria to reside.

Expected increase of respiratory conditions (Flu & Covid) presenting in the Winter, may result in delays off loading where lateral flow tests are required, to ensure isolation processes are followed. No further actions identified currently as service is limited to the number of cubicles with doors for isolation purposes.

Total Elective Waiting List (Referral to Treatment)

National Key Performance Indicators



Month	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22
Longest Waiting Patient (Weeks)	107	111	116	116	120	99	99	95	98	94	95	87

Understanding the performance:

The total referral to treatment (RTT) waiting list size position remains 1413 behind plan, however, improved in month by 779, a circa 35% reduction in variance between actual and plan from October.

This has been driven by improved clock stops with admitted stops increasing circa 15% and non-admitted 10%, resulting in an overall number of stops 11% higher than in October, whilst clock starts rose by a lesser extent (6%).

However, overall activity year to date stands at 96% of both Plan and the 104% recovery target.

Actions (SMART):

• Despite in the in-month improvement, SFT remains behind plan. Admitted stops improved across the board from October apart from small decreases in Respiratory Medicine and Plastic Surgery (which reflects the reduced escalation into Day Surgery Unit (DSU, across Nov when compared to Oct).

• The largest proportion of the waiting lists sits within the non-admitted pathways. Despite the increased number of non-admitted clock stops there remains a number of specialities that have remained below their current year to date average. These will form the basis of analysis of activity vs plans by specialty to understand any ongoing reduced levels of activity.

• A plan submitted by the Surgery Division to mitigate the effects of likely high levels of escalation into DSU in January, whilst ensuring patients safety remains paramount at all times, has been partially approved, with those specialities affected asked to undertake additional outpatient work in place on any lost theatre sessions.

Risks and mitigations:

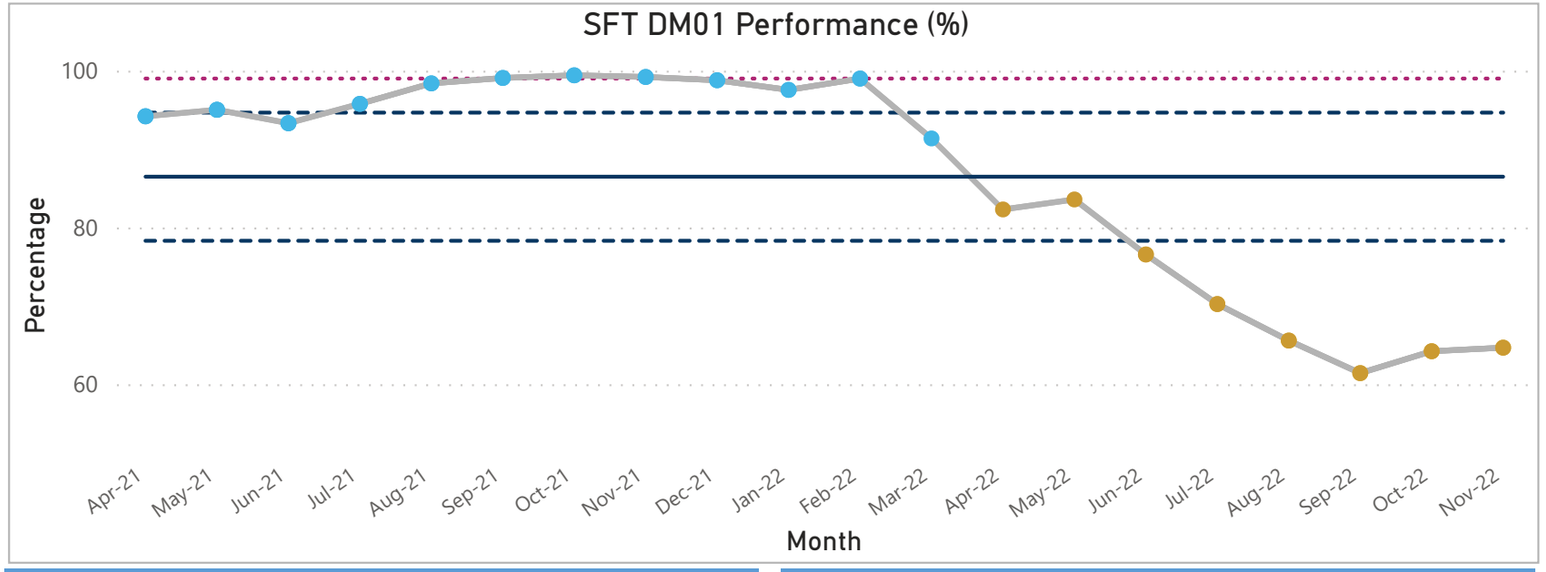
Non-elective flow continues to place significant pressure on the elective programme. Whilst the use of upstairs in DSU throughout November was reduced from October, the risk remains with regard to increase demand from non-elective pathways and admissions. The impact upon the elective care programme and staffing morale should not be underestimated. The Divisions of Surgery and Women and Newborn both have specialities in the top three in terms of pressures for the March 2023 78-week wait target. Clearly there remains on ongoing elevated risk as we progress further into winter with bed modelling suggesting a non-elective demand on beds peaking throughout January.

New ways of working across the two theatre footprints have been developed and signed off to maximise outputs through different ways of utilising the estate, with new Standard Operating Procedures (SOPs) providing greater planning and transparency in planning and delivering lists during ongoing periods of escalation.

Diagnostic Wait Times Performance (DM01)

Target 99%

National Key Performance Indicators



Performance Latest Month: 64.7%

Waiting List Volume: 3283

MRI	58.6%	CT	99.8%
US	52.1%	DEXA	100.0%
Audio	71.5%	Cardio	92.2%
Neuro	100.0%	Colon	75.4%
Flexi Sig	70.3%	Gastro	94.3%

Understanding the performance:

Overall DM01 performance has remained relatively static in M8 compared to M7 (from 64.22% to 64.67%) but there has also been an overall decline in total waiting list size (decline of 721 patients) and decline of total breaches by 133 patients to total number of patients impacted at 2,363 in M8 compared to 2,496 in M7.

Areas that have had the most significant improvement in number of patients breaching are Audiology (improvement from 156 to 55 breaches) and Echocardiography (improvement from 126 to 25 breaches). Performance in MRI and USS remain relatively stable with minor deteriorations in breach numbers (increase of 8 breaches for MRI and 25 breaches for USS).
There is an increase of the number of patients breaching in endoscopy (increase of 36 breaches). The largest constraint impacting DM01 performance remains as workforce capacity.

Actions (SMART):

- MRI mobile scanner remaining on site until 31/12/22 and scanned alongside fixed scanners to clear some of backlog
- Mobilisation meeting with USS insource supplier w/c 5/12/22 re details of deployment of resource from January 2023
- Audiology B6 new starter in post from December to support stabilisation of capacity
- New Hall capacity for MRI available weekly through M9 (full day list)
- RRP for Sonography staff approved and to be actioned from December 22

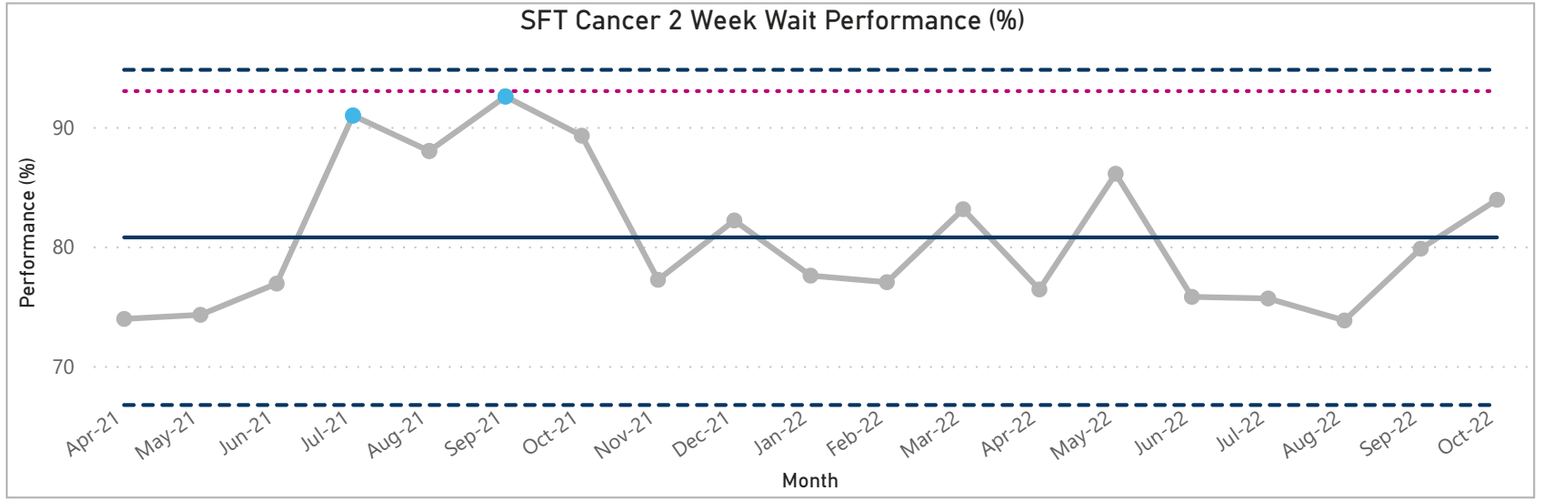
Risks and mitigations:

- MRI1 scanner downtime (quench fault) early M9 reduced capacity when it was planned to staff three scanners to clear proportion of backlog and long waiters. Scanner operational again at time of report but cold weather will cause risk to scanner running. Working with Siemens and Estates to mitigate risk.
- Echocardiography, Radiography and Sonography remain dependent on high volume of agency/locum/overtime staffing to maintain capacity. Recruitment ongoing.
- Mobile MRI scanner to be removed from site 31/12/22 (currently unable to staff to represent good value for money). Whilst unable to staff, if our staffing capacity were to change it will remove the option to enable three scanners of capacity. Will look to staff fixed assets 7 days per week in place of scanner capacity.
- Nurse Endoscopist workforce has constrained capacity and impacted breaches; expected return date of staff from New Year.
- Admin teams within Radiology and Endoscopy experiencing some resourcing issues which is challenging for booking and associated efficiency (further constrained by postal strikes etc.) Recruitment plans in place.

Cancer 2 Week Wait Performance

Target 93%

National Key Performance Indicators



	Performance	Num	Den	Breaches
Two Week Wait Standard:	83.9%	876	1044	168
Two Week Wait Breast Symptomatic Standard:	96.7%	29	30	1

Understanding the performance:

The Trust has seen further improvement in 2 week wait performance, with month end performance of 89%; improvement in comparison to Month 7 position of 83%. Capacity constraints most evident within Skin and Lower GI pathways as a result of increase in referrals, staffing and associated recruitment challenges.

• **Colorectal:** 49 breaches, 29 of which were related to endoscopy capacity as a result of staff sickness. The average wait to first appointment was 19 days. A further 15 breaches reported as a result of administrative delays associated with receipt of incomplete GP referrals (including lack of qFIT, up to date bloods and any prerequisite tests to ensure effective triage).

• **Skin:** 32 breaches, 13 of which as a result of insufficient outpatient capacity. The average wait for first appointment was 13 days. Further challenges anticipated over December due to unsuccessful recruitment drive.

Actions (SMART):

Colorectal 2 week wait Capacity:
• Division to review demand and capacity within GI alongside performance team by Q4 2022/23 to support identification of further actions.
•Cancer Services are working alongside SFT GP Liaison manager to facilitate further communications to primary care around process and requirements within secondary care for patients without qFIT. Endoscopy service is currently facilitating additional weekend lists to mitigate against lost capacity.

Skin 2 week wait Capacity:
• Division to review demand and capacity within Skin services alongside performance team by Q4 2022/23 to support identification of further actions.

Risks and mitigations:

Pathway Improvement: Weekly Cancer Improvement Group (CIG) established to enable oversight of potential risks/challenges within services, as well as engagement from DMT. Work streams feeding in from Cancer PTL Meeting and onto Cancer Board. Delivery against optimum timed best practice pathway milestones monitored against CQUIN achievement data to measure the success of the current pathways.

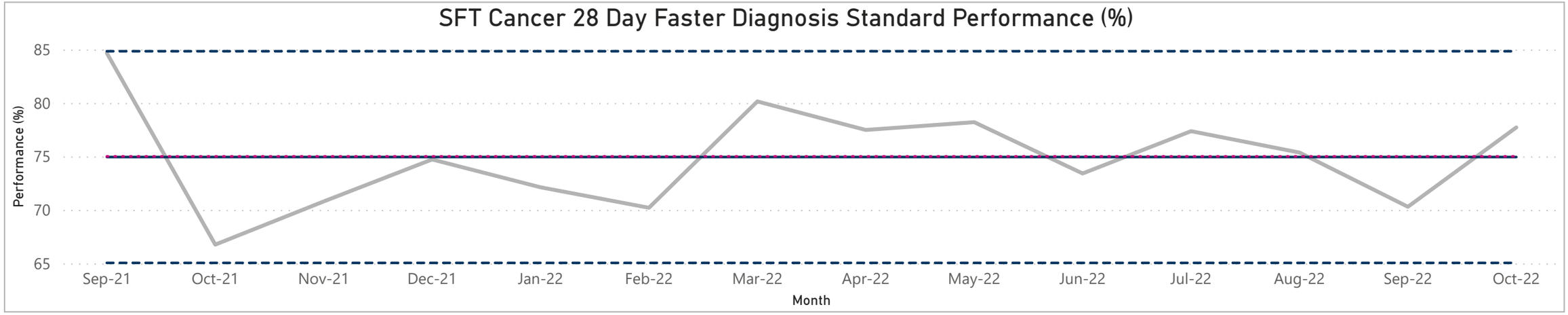
Winter pressures and impact of CV19: Winter pressures including the impact of CV19 on staffing and patient fitness/cancellations as well as bed capacity may detrimentally impact on our ability to deliver the 2ww standard. Assurance and escalation to be provided from divisions through CIG and Delivery Group in terms of specific actions required to mitigate.

Trajectory against performance standards: As part of the CIG each speciality has been asked to complete a trajectory against Cancer Waiting Times (CWT) standards, with the support of the performance team. This is expected by January 2023.

Cancer 28 Day Faster Diagnosis Standard Performance

Target 75%

National Key Performance Indicators



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

Understanding the performance:

28 day faster diagnosis standard achieved for November '22, with month end validated performance of 80.3%. On average, patients were informed of their diagnosis (either benign or malignant) by day 20 of their pathway, with high performance noted within Skin, Breast and Colorectal pathways. The prostate pathway remains particularly challenged, with patients on average being informed of their diagnosis by day 54 ; this therefore impacts on service's ability to deliver the 62 day standard.

Breaches reported as a result of the following, with main challenges associated with the prostate cancer pathway:

- Insufficient diagnostic capacity, particularly in relation to template biopsies, histopathology reporting capacity and PET-CT capacity

Actions (SMART):

Urology:

- **Prostate pathway diagnostic capacity:** Demand and capacity modelling currently being undertaken in relation to mpMRI and template biopsies to further understand gap and associated need. Due for completion by Q4 2022/23.
- **Revisions to existing triage process:** Triage SOP amended to involve CNS led telephone triage and same day mpMRI request from November '22 and should result in a reduction of days waited from triage to MRI; cancer services to audit once data available (approximately Q4 2022/23) and Urology service to finalise written SOP. Navigator-led booking for template biopsy to be implemented from Q4 2022/23 to ensure patients are prepared appropriately and booked within relevant timeframes.
- **Nurse training in template biopsies:** Additional training to be provided to urology nursing staff. There is no confirmed date for this as of yet.

Radiology gap analysis: GAP Analysis work is being undertaken by Cancer Services to audit expected wait for diagnostic imaging vs current waits. For discussion with radiology/Clinical Support and Family Services (CSFS) Division in early December '22 to identify opportunitites for alignment with national best practice timed pathway KPIs.

Risks and mitigations:

Histopathology reporting capacity: Histopathology reporting timeframes stretched as a result of consultant capacity. Cancer cases already outsourced to support capacity, though there have been restraints nationally. CSFS are currently auditing outsourcing pathology labs with the intention to resource a safe and reliable pathology lab. Challenges due to procurement understaffing and inability to agree SLA's which meet the KPI's required for success against the Cancer Pathway.

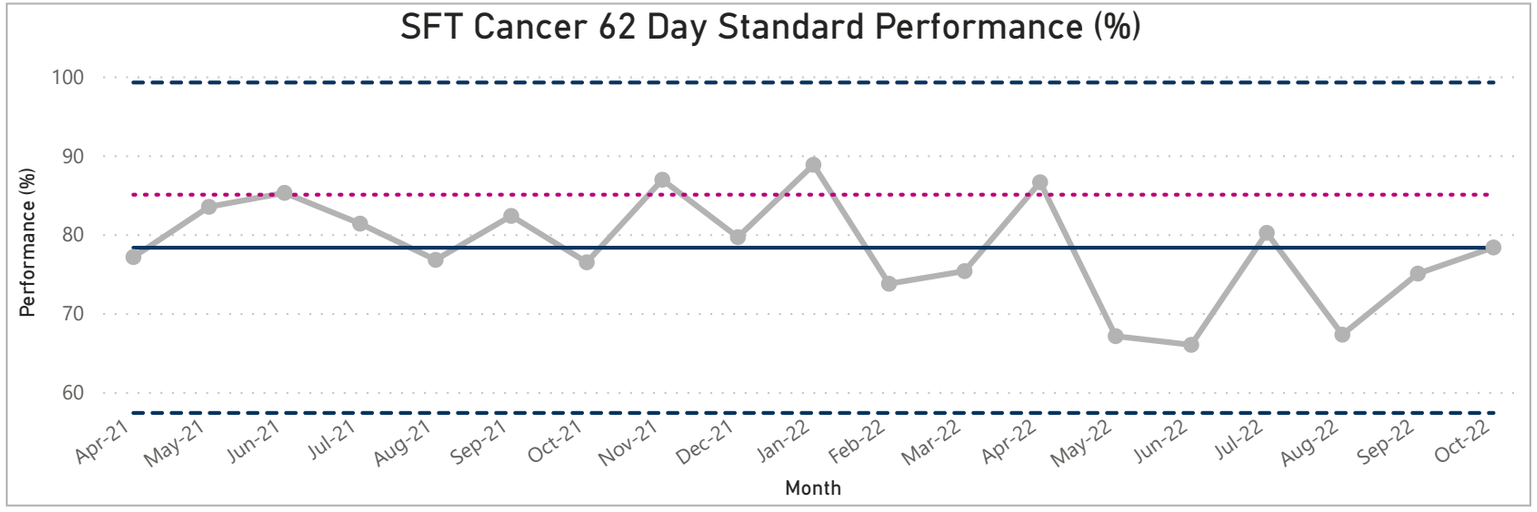
Pathway Improvement: Weekly Cancer Improvement Group established to enable oversight of potential risks/challenges within services. Delivery against optimum timed best practice pathway milestones monitored against CQUIN achievement data to measure the success of the current pathways in conjunction with Divisional Management. Work streams feeding in from Cancer PTL Meeting and onto Cancer Board.

PET-CT capacity constraints across all tumour sites: Mobile scanner in the process of being implemented at SFT to reduce waiting times and improve patient experience; 15 additional slots per weeks available though not solely for use by SFT patients. To note, PET-CT capacity is managed by Alliance Medical.

Cancer 62 Day Standard Performance

Target 85%

National Key Performance Indicators



	Performance	Num	Den
62 Day Standard:	78.3%	65	83
62 Day Screening:	84.6%	6	7

Understanding the performance:

62 day performance standard not achieved, with month end performance 73.7%. Breakdown of breaches includes: Colorectal (6), Urology (6), Lung (1.5), Haematology (1), Skin (1), Breast (1), Upper GI (1).

Breach reasons predominantly associated with complex and many diagnostic tests needed to obtain diagnosis (over and beyond normal expectations), capacity issues with diagnostic or treatment planning and patient initiated delays.

Significant constraints remain ongoing in relation to chemotherapy delivery due to staffing capacity within pharmacy and nursing on the Pembroke suite, which is impacting ability to provide treatment within 31 days of decision to treat.

Actions (SMART):

Oncology capacity:

• Outsourcing of chemotherapy will continue until Q4 2022/23 to allow the newly appointed accountable pharmacist to commence in post and review the needs of the service. Clinical Support and Family Services Division are currently reviewing processes and considering a mixture of batch purchasing and patient specific purchasing of Chemotherapy going forward. All issues with Chemo screening have been resolved, with interim support from University Hospitals Southampton NHS Foundation Trust.

• Pre-assessment for Chemotherapy is currently at 3 weeks on average. Cancer services has implemented a more robust process to ensure patients on a 62 day pathway are flagged to oncology and therefore prioritised for pre-assessment, with adequate escalation as required. Oncology Navigator attends PTL to be sighted on upcoming oncology patients coming through system to have oversight.

Risks and mitigations:

PET-CT capacity: Detailed outlined as per 28 day FDS slide

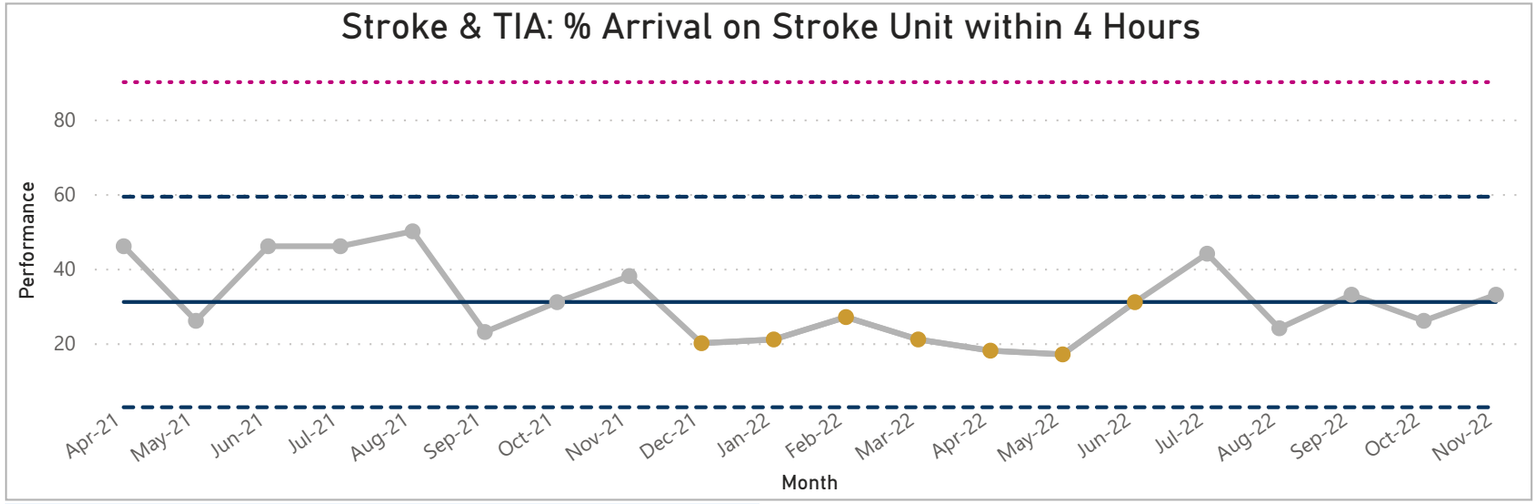
PTL management processes: PTL meeting process amended from November '22 to focus on all confirmed cancers, backlog patients and potential risk patients. Measures of success to be monitored include reduction in volume of patients waiting over 62 days for treatment, stratified risk of confirmed cancers and streamlined escalation to support services.

Winter pressures and impact of CV19: Winter pressures including the impact of CV19 on staffing and patient fitness/cancellations as well as bed capacity may detrimentally impact on our ability to deliver the 62 day standard. Assurance and escalation to be provided from divisions through CIG and Delivery Group in terms of specific actions required to mitigate.

Trajectory against performance standards and backlog reduction: As part of the CIG each speciality has been asked to complete a trajectory against CWT standards and backlog reduction, with the support of the performance team. This is expected by January 2023

Stroke Care

National Key Performance Indicators



SSNAP Case Ascertainment Grade

Highest Level = Grade A
Lowest Level = Grade E

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

Understanding the performance:

The national target for arrival on stroke unit within 4 hours is 90%; November performance of 33%.

Ongoing challenges due to Trust-wise bed pressures, with general medicine patients outlying in to stroke beds as well as ongoing staffing pressures associated with stroke nursing staff being required to provide cover for other wards. This is resulting in Farley ward often being unable to maintain appropriate staffing levels (expectation of at least 5 nurses at any one time due to acuity levels) and in turn prevents the service from being able to accept patients in a timely manner due to the inability to provide 1:1 input for patients such as those that are thrombolysed.

Actions (SMART):

- In order to increase understanding and staff availability to recognise stroke symptoms and in turn ensure timely transfer of priority patients from ED to Farley ward, simulation training is being scheduled for ED staff; date to be confirmed.

- Ongoing action associated with prioritisation of bed moves out of Farley to facilitate stroke patients transferring in. This action includes ongoing identification of patients which are suitable to move off the ward daily, such as medical non-stroke patients or patients no longer requiring therapy input

Risks and mitigations:

- Hyperacute stroke patients at risk of worsening outcomes without access to specialist case within appropriate timeframes, in turn increasing LOS. Ongoing meetings with Medicine Matrons and bed managers to highlight importance of prioritisation of stroke patients and staffing issues.
- Weekly updates with site team to discuss arising issues of admitting and transferring patients from the wards; this has enabled prompt facilitation of bed moves when a potential stroke patient is identified in ED when capacity allows.
- Risk of staffing shortages during periods of operational pressure when stroke nurses are moved to support other clinical areas; direct impact on service's ability to receive patients from the Emergency Department (ED), especially those who are thrombolysed and require 1:1 input.
- Significant risk associated with bed allocation; service looking to ensure adequate allocation of stroke beds to improve transfer times from ED and ensure stroke patients are prioritised going forward, though this isn't achievable at present.

Maternity

Are We Safe?

	Metrics	Target for RAG	Which Direction is Good	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22
Perinatal Morbidity and Mortality (M&M)	Number of late fetal losses (22+0 to 23+6 weeks excl TOP)	1	Down	0	0	0	0	0	0	0	0
	Number of stillbirths (>+ 24 weeks excl TOP)	1	Down	0	0	0	1	0	0	0	0
	Number of neonatal deaths : 0-28 days	1	Down	0	1	0	0	0	0	0	0
	Medical termination over 24 +0 registered	NA	Down	0	0	1	0	0	0	0	0
Maternal M&M	Number of Maternal Deaths	9.1	Down	0	0	0	0	0	0	0	0
	Number of women requiring admission to ITU	0	Down	0	0	2	0	0	0	0	0
Insight	Number or Datix incidents - moderate or above	1	Down	1	2	3	1	4	2	1	1
	Datix incidents moderate harm (not SII)	2	Down	0	1	3	3	4	1	1	1
	Datix incidence SII	0	Down	0	1	0	3	0	0	0	0
	HSIB referrals	NA	Down	0	0	0	0	0	1	0	0
	HSIB/NHSR/CQC or other organisation with a concern or request	0	Down	0	0	0	0	0	0	0	0
	Coroner Reg 28 made directly to trust	0	Down	0	0	0	0	0	0	0	0
Workforce	Minimum safe staffing in maternity services :Obstetric cover - hours	40	NA	40	40	40	40	40	40	40	40
	Midwife to Birth ratio	1.28	NA	1.31	1.32	1.32	1.32	1.33	1.35	1.33	1.29
	Midwifery vacancy rate (black= over establishment; red =under establishment	0 WTE	Down	17.2	17.4	18.8	20	19.64	19.65	18.84	18.84
	Provision of 1 to 1 care in established labour (%)	100%	Up	100	100	100	100	100	100	100	100
	Datix relating to workforce	0	Down	3	1	0	2	1	1	1	0
	Compliance with supernumery status of the LW coordinator - %	100%	Up	100	100	100	100	100	100	100	100
	Numbers of times maternity unit on divert	0	Down	0	0	0	0	0	0	0	0
Involvement	Service user feedback : Number of Compliments	NA	Up	27	27	31	31	21	31	10	26
	Service user feedback : Number of Complaints	1	Down	2	0	1	1	4	2	1	2
	Number of SOX	NA	Up	8	7	6	5	2	7	4	7
Assurance	Progress in achievement of 10 safety actions(CNST)	10	Up	5	5	5	5	5	5	6	7
	Training compliance - MDT PROMPT %	0.9	Up	72.3	83.6	86.5	86.2	77.0	77.0	82.1	93.0
	Term babies admitted to NNU unexpectedly %	<5.8%	Down	1.8%	4.7%	2.3%	4.6%	6.1%	5.8%	4.7%	2.9%
	Term babies admitted to NNU unexpectedly	-	Down	3	8	4	8	10	11	8	5

Understanding the performance:

Reduction in term admissions to NICU.

Midwifery vacancies remain high impacting midwife to birth ratio.

Increase in compliance with Prompt from 82.1% to 93% . This meets the required compliance for our reporting deadline of 5th December.

Increase in progress of CNST safety actions to 7 out of 10 as we have achieved training element of the actions required.

Actions (SMART):

Midwifery staffing vacancies- Staffing remains a Driver for improving together which ensures action and oversight. International recruitment continues, with a further 2 arrivals of international midwives.

Extra CTG training session enabled us to meet this requirement in line with CNST.

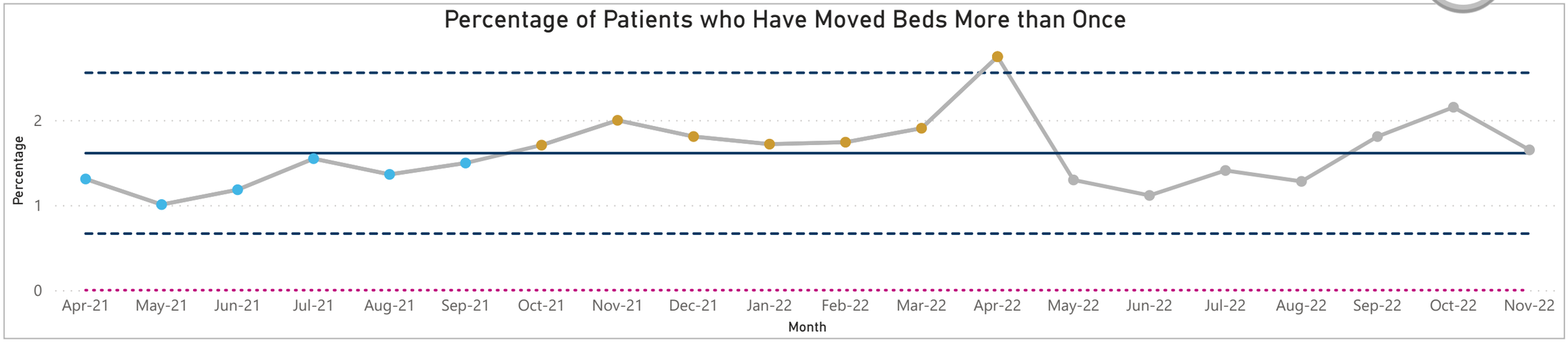
Admissions to NICU have been reviewed via multidisciplinary ATAIN meetings for themes. Thematic review of August, September and October in December. Reduction in admissions noted this month.

Risks and Mitigations:

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

Patients Who Have Moved Beds More Than Once

Are We Safe?



Understanding the performance:

The percentage of patients moved more than once has dropped to 1.65 in November '22 in comparison to Month 7 (2.15) and is in fact lower than the reported percentage for the same month last year (1.61).

Actions (SMART):

- The Trust escalation status and use of escalation beds is related to the number of bed moves a patient may experience in order to accommodate patient needs in clinical specialty when the hospital is full requires prioritisation and movement. November saw the Trust escalated with flow into the community a particular challenge.

- The implementation of the discharge lounge is hoped that the earlier release of beds to non-elective admissions in the day will support the reduction in moving patients at the end of their journey to beds to accommodate new patients in specialist areas. This service is developing and is reviewed through the Medicine division.

- E-whiteboard improvement work is hoped to be able to highlight at a glance those people who have already moved so as to support the decision making at times of escalation. Outcome anticipated January '23

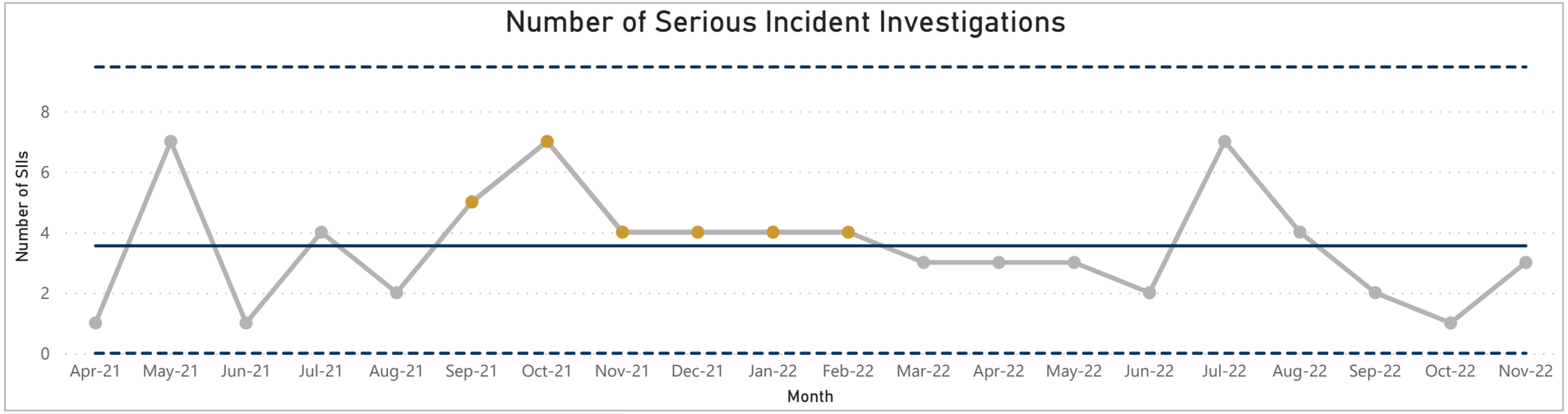
Risks and mitigations:

Risks to this work include:

- Increased levels of demand and use of escalation capacity
- Challenged staffing across all Multi-disciplinary Teams (MDT), site, and administration affecting the patient journey, including the availability of the lounge
- Limitations of e-whiteboard being raised by the provider

Incidents

Are We Safe?



Year	2021-2022	2022-2023
Never Events	3	0

Understanding the performance:

There were 5 Serious Incident Investigations (SIIs) commissioned for review in November 2022:

- SII 528- Delay in diagnosis and treatment- Child
- SII 530- delay in diagnosis (cancer)
- SII 532- Missed to follow up (incident occurred in February)
- SII 533- fall with injury
- SII 534 – Failure to act on code red result (incident occurred in 2015).

The chart above shows the number of SII occurrences by month hence why the number of SII occurrences, and those commissioned for review does not always align.

Actions (SMART):

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

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

Risks and mitigations:

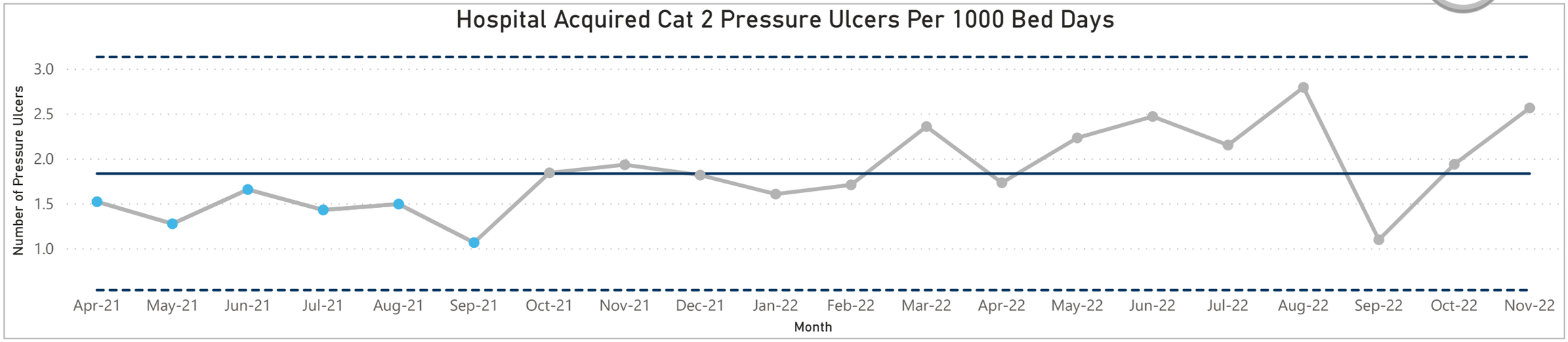
- Once an incident has been identified and a 72 hour report completed, it will be established as to whether there are immediate safety actions that need to be implemented or escalated immediately.

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

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

Pressure Ulcers

Are We Safe?



Understanding the performance:

42 Hospital acquired Pressure ulcers (PUs) in November. This is a further increase from Month 7, likely as a result of ongoing staffing concerns and operational pressures:

- 38 Category (Cat) 2 PUs; this is an increase from October (30).
- 4 Device related PUs, 3 of these are from one patient caused by POP. No failure of device identified, SWARM completed and no new learning identified as per previous SWARM reports for POP related PUs. All appropriate actions were taken relating to POP use and care.
- 2 DTIs; this is a decrease from October (6). SWARMs have been completed for both areas and actions and learning will be shared at the monthly Share and Learn meeting. Poor documentation was found in one case- this wound may have been Present on admission but due to poor/no documentation there is no evidence of this.
- 2 Unstageable PUs. 1 of these is unfortunately minimum Cat 3 PU- 72 hour report has been completed and presented at Patient Safety Summit where it was decided that this would be for local review.
- No Hospital acquired Cat 4 PUs identified
- 44 Present on admission PUs

Actions (SMART):

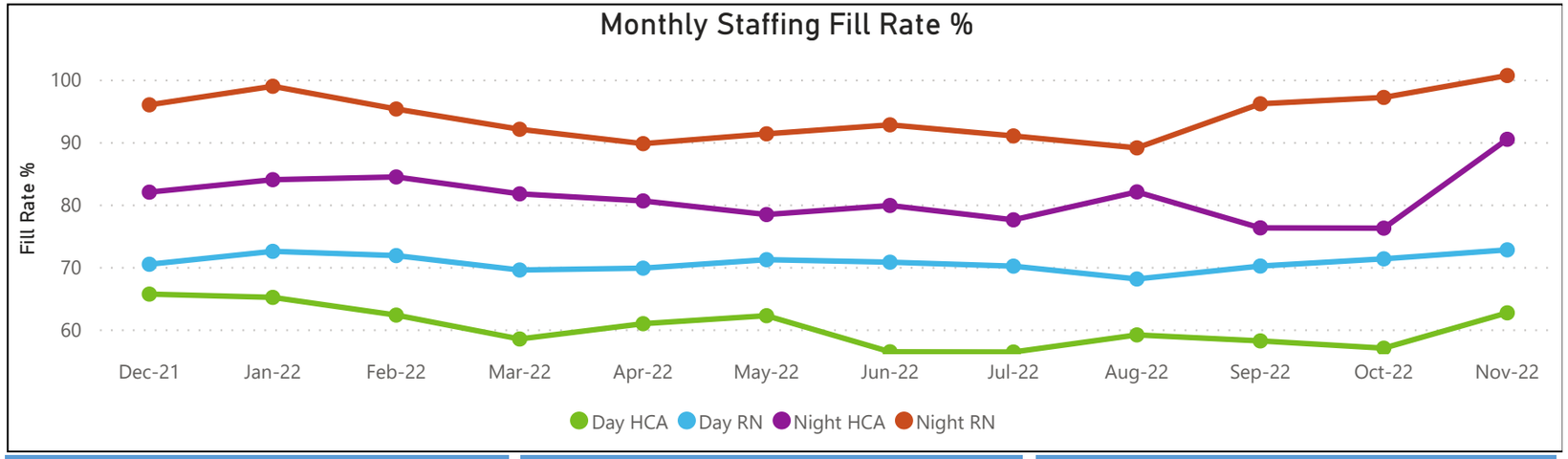
- EPMA work commenced for wound assessment form on Lorenzo to ensure accurate and provides appropriate information for assessment.
- New Hospital acquired PU investigation process being implemented; there has been good engagement from ward leads with the SWARM investigations and actions. Learning has been identified and actions undertaken for teaching on wards with areas of concern. The December Share and Learn will implement the sharing of these SWARMS where further feedback and insight will be gained.
- Safety Thermometer data collation issues have now been resolved with IT since implementation in October '22.
- Electronic datix validation on Lorenzo has completed testing and is now live. All validation for patients in December will be completed in duplicate on Lorenzo and on excel spreadsheet to ensure the data collected for monthly PU figures is accurate.

Risks and mitigations:

- Duplicate input of validation data on Lorenzo and excel spreadsheet will increase the workload during a period of increased operational pressure for the Tissue Viability (TV) team but must be completed to ensure data accuracy.
- TV team have appointed new staff into outstanding vacancies, however, start dates have not yet been confirmed and the TV team will only have one clinical member from January. This is a concern due to current increased service demand both clinically and non-clinically.

Nurse Staff Fill Rate

Are We Safe?



Ward	Day RN	Night RN	Day HCA	Night HCA
Amesbury	96%	100%	67%	124%
Britford	88%	101%	83%	97%
Chilmark	79%	97%	69%	88%
Downton	125%	152%	74%	135%
Farley	83%	92%	56%	109%
Hospice	83%	101%	82%	101%
Longford	81%	116%	77%	97%
Maternity	86%	92%		
NICU	104%	99%	85%	
Odstock	104%	93%	79%	97%
Pembroke	101%	101%	62%	97%
Pitton	83%	104%	75%	117%
Radnor	83%	90%	37%	56%
Sarum	95%	113%	70%	
Spire	111%	132%	75%	113%
Tisbury	72%	93%	61%	93%
Whiteparish	124%	128%	74%	128%

Understanding the performance:

There was an encouraging rise in all four markers of fill rate for the month of month of November, most notably night time Healthcare Assistants (HCAs) increasing from 76% to 90% fill rate.

Night shift coverage remains the highest fill rate, likely as a result of unsocial hours payment and popularity amongst available bank and agency staff. Whilst day time coverage also saw improvements, HCAs coverage remains below 70% with this being reflected in the proposed winter incentive to invite day time coverage for same rates of payment.

Increased coverage saw welcome increase in care hours per patient day (CHPPD) up to 7.4 from 7.0 for month of November.

Actions (SMART):

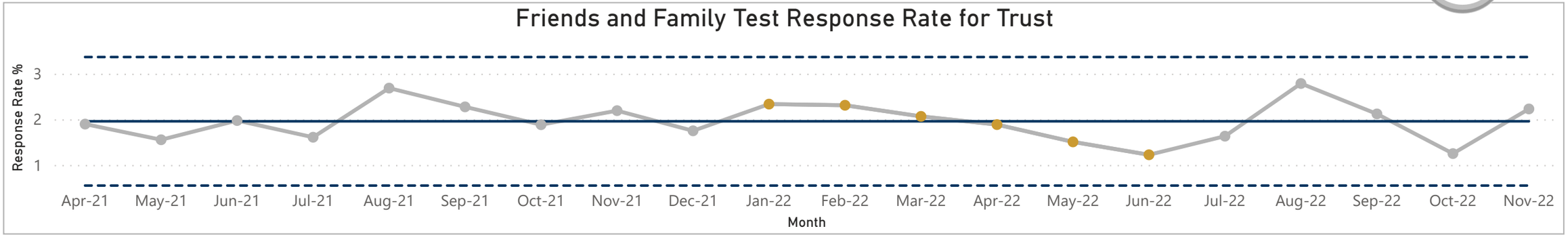
- Increase hourly rate of pay for Band 2 staff to top of scale (from 01/12/22)
- Review of all Band 2/Band 3 job descriptions with view of regarding Band 2 to Band 3 with effect from New Year (costing with execs for approval 12/12/22)
- Development of non clinical support role underway, timescales to be confirmed (plan to appoint x18 full-time Band 2 posts)
- Bank incentive scheme (current allocation on arrival incentive for Registered Nurses and HCA) for Winter approved by execs and due to start 30/12/22
- Long line agency requests now being filled (16/22 confirmed)
- All actions being monitored as part of executive-led weekly winter planning meets.

Risks and mitigations:

Risks to this work include:
- Ongoing high turnover rate for RN and HCAs
- National and international recruitments
- Twice monthly HCA inductions
- Ongoing support and intervention of NHS England re HCA gap

Friends and Family Test Response Rate

Our Care



Response Rate by Area	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22
FFT Response Rate - A&E	0.0%	0.1%	0.1%	0.0%	0.2%	0.0%	0.2%	0.1%	0.3%	0.4%	0.3%	1.1%
FFT Response Rate - Day Case	6.9%	10.1%	5.3%	5.0%	4.8%	4.6%	3.3%	4.6%	8.9%	6.8%	3.1%	2.5%
FFT Response Rate - Inpatient	6.9%	13.4%	9.5%	7.1%	5.7%	7.1%	6.8%	7.5%	10.9%	11.5%	5.2%	10.5%
FFT Response Rate - Maternity	10.8%	0.9%	2.5%	5.9%	11.5%	0.9%	0.4%	1.6%	7.8%	1.1%	1.2%	0.0%
FFT Response Rate - Outpatient	0.8%	0.9%	1.6%	1.6%	1.3%	0.8%	0.6%	0.9%	1.5%	0.9%	0.9%	1.6%

Understanding the performance:

The NHS Friends and Family Test (FFT) was created to help service providers and commissioners understand whether patients are happy with the service provided, or where improvements are needed. It's a quick and anonymous way to give views after receiving NHS care or treatment Areas are encouraged to offer feedback forms to patients at discharge or during their stay. Weekly emails are sent to leads showing feedback received in the previous week, allowing them to pick up any immediate causes for concern and mitigate these where possible. Negative feedback is review by the ward and PALS, twice a year.

FFT responses have almost doubled in the last month. Staff are still being encouraged and reminded to offer FFT through the PALS outreach services although we appreciate that this sole method of obtaining response will inevitably mean fluctuations in activity consequent to pressures.

It is noted that in the last few months the average responses of patients who are satisfied with the service they received, have dropped from 99% to 96%

Actions (SMART):

Long-term action: Securing a provider to gather patient feedback vis SMS will be key to moving towards achievement of our objectives under the Improving Together Programme over the next 6-12months:

Aims:

- Increase overall response rates to FFT
- Diverse methods for completion (including, online, SMS, over the phone)
- Increased accessibility and options for inclusivity (sight impairments, languages and additional demographic options)
- Robust analysis of data for insight and meaningful comparison/benchmarking via a real-time dashboard
- Opportunity to align our processes in FFT across the ICS

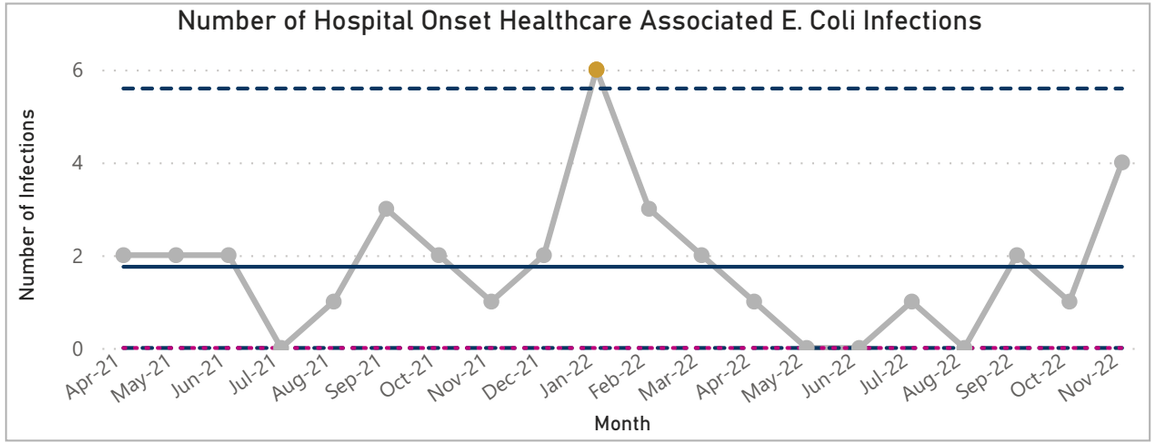
Risks and mitigations:

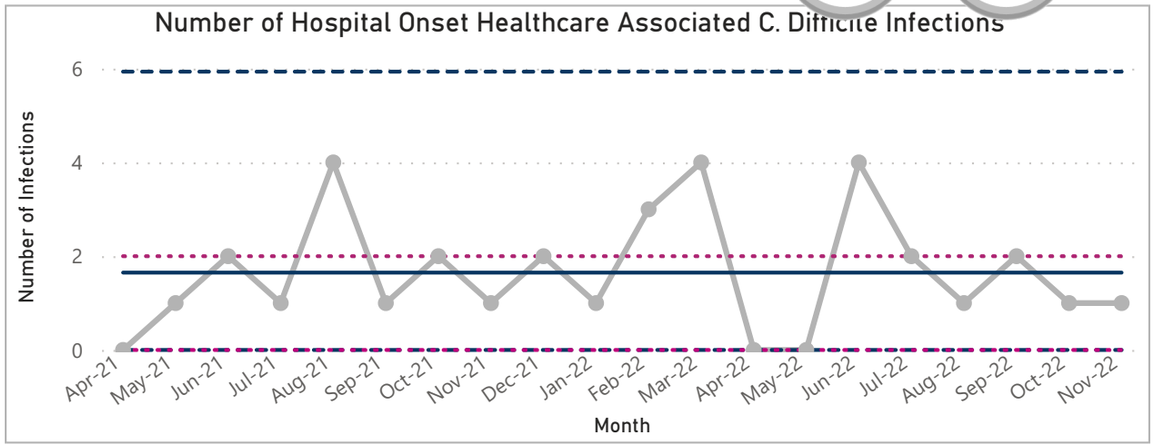
- Continued low response rate, due to limited methods for accessibility and the reliance on staff to promote completion of a physical card, this is directly impacted when there are staff shortages and operational pressures. The current method requires manual input and theming, which there is limited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

- Implementation of the new IT solution to increase response rates and improve analysis is now likely to be delayed from Autumn 2022 to early in the New Year of 2023. A revised implementation timescale is currently being worked through with CPPG and the related Work Package Groups.

Infection Control

Are We Safe?





Understanding the performance:

There have been four hospital onset healthcare associated reportable E.coli bacteraemia infections and one hospital onset healthcare associated reportable C.difficile case reported for November '22. The Trust is not exceeding set trajectories for 2022/23 for these specific reportable cases.

The Infection Control Nurses (ICNs) continue to undertake targeted ward visits and utilise educational opportunities with different staff groups.

Small practice improvements with infection prevention and control compliance noted from individual staff interactions undertaken, with the aim of sharing information with their colleagues.

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

Actions (SMART):

• Completed trial of alternative approach for staff in ward areas to complete hand hygiene education and assessments; evaluation required at Divisional level to enable roll out. ICNs are under pressure to facilitate this roll out , which was due for completion by Q1 2022/23, though success is dependent on engagement from the Medicine Division and has not been feasible to date due to operational pressures.

• Ongoing action associated with the completion of required case investigations by clinical areas to identify good practice and learning. The Infection Prevention & Control (IPC) team facilitate this process so that areas can take ownership and progress any actions or identified learning.

• Ongoing feedback required from clinical areas at monthly 'Share & Learn' meeting to identify actions moving forward from any themes/trends arising from all cases (ICNs in attendance). Attendance and engagement has been variable, with escalation by the chair/s to the relevant reporting group.

• Involvement with BSW IPC and Gram-Negative Bloodstream Infections (GNBSIs) collaborative workstreams. Feedback from sessions is shared routinely via the SFT IPC Working Group

Risks and mitigations:

• Continued increased clinical workload for IPC nursing team including managing COVID-19 outbreaks, impacting on ability to focus on other HCAI prevention work.

• Ongoing nursing vacancy within the IPC team which has delayed the ability for the service to undertake additional educational activities and policy practice reviews. Secondment plan for position has been initiated to commence January 2023.

• An underlying risk continues to be a potential increase in incidence of reportable healthcare associated infections with poor patient outcomes and Trust exceeds agreed trajectories.

• Variable staffing levels continually reported by clinical areas affecting ability to facilitate learning in ward environment.

Poor return of completed case investigation documentation by r• elevant clinical areas, therefore unable to identify evidence of learning.

• Limited evidence of IPC practice assurance provided by the clinical divisions due to ongoing operational challenges and workload pressures for teams.

• No progress on IPC collaboratives with BSW colleagues.

Mortality

Are We Safe?

Metric Name	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22
Crude Mortality	63	76	62	68	69	65	64	79	94	86	84	84	88	84	77	88	82	73	75	77
HSMR District Hospital (excludes deaths recorded by Salisbury Hospice)	100	102	100	101	102	102	103	106	105	101	104	107	109	109	111					
HSMR Trust	111	108	109	108	108	109	110	110	113	113	109	111	116	115	117					
SHMI District Hospital (excludes deaths recorded by Salisbury Hospice)	98	100	101	101	101	102	102	102	102	104	105	107	106	106	106					
SHMI Trust	103	105	106	106	106	107	107	107	107	108	109	111	110	110	110					

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

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

Understanding the performance:

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

The Summary Hospital-Level Indicator (SHMI) for the 12-month rolling period of July 2021 to June 2022 for Salisbury District Hospital is 106.48.

The Hospital Standardised Mortality Ratio (HSMR) for the 12-month rolling period of July 2021 to June 2022 for Salisbury District Hospital is 111.5.

Actions (SMART):

N/A

Risks and mitigations:

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

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

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

Watch Metrics: Alerting

Quality of Care, Access and Outcomes

Metric	Two Months Ago	Last Month	This Month	Improvement Target	National Target	Variation	Variation Detail	Target Met This Month?	Consecutive Months Target Failed
% of Total Incidents Resulting in High Harm (Mod/Maj/Cat)	31.0%	27.0%	35.0%			H	Special Cause Concerning - Two Out of Three High		
Ambulance Handovers 30-<60 mins	157	180	164			H	Special Cause Concerning - Two Out of Three High		
Total Number of Compliments Received	4	26	47			L	Special Cause Concerning - Run Below Mean		
Trust Performance RTT %	62.2%	63.7%	65.2%		92%	L	Special Cause Concerning - Run Below Mean	X	20
Average hours lost to Ambulance Handover delays per day	20	22	14		0	H	Special Cause Concerning - Run Above Mean	X	20
ED 12 Hour Breaches (Arrival to Departure)	116	163	72		0	H	Special Cause Concerning - Run Above Mean	X	20
ED Attendances	6191	6336	6131			H	Special Cause Concerning - Run Above Mean		
Proportion of patients spending more than 12 hours in an emergency department	2.7%	3.8%	1.7%			H	Special Cause Concerning - Run Above Mean		
% Beds Occupied	96.2%	97.4%	97.7%		95%	H	Special Cause Concerning - Above Upper Control Limit	X	10
Average Patients with No Criteria to Reside	126	140	146	35		H	Special Cause Concerning - Above Upper Control Limit	X	20
DM01 Waiting List Volume	6558	6975	6688			H	Special Cause Concerning - Above Upper Control Limit		
Ambulance Handovers 60+ mins	187	258	131		0		Common Cause Variation	X	20
Cancer 62 Day Screening Performance	100.0%	80.0%	84.6%		90%		Common Cause Variation	X	2
Mixed Sex Accommodation Breaches	89	26	14	0	0		Common Cause Variation	X	3
Total Number of Complaints Received	26	27	19		0		Common Cause Variation	X	6

Watch Metrics: Alerting Narrative

Quality of Care, Access and Outcomes

Understanding the performance:

The continued pressure on the urgent and emergency pathways across the Trust dominates the alerting quality metrics. With average bed occupancy levels being at 97.4% across the Trust, has consequently meant there is no improvement in the number of hours lost to ambulance handovers (average of 20 hours per day), an increase in the proportion of patients spending longer than 12 hours in the Emergency Department (3.8% versus 2.7% in M6), and an increase in both complaints and the percentage of incidents resulting in high harm.

Driving some of the operational pressures is the number of patients in the hospital that do not meet the criteria to reside (NCTR), which rose to 140 in M7 from 126 in M6. This represents about 30% of the bed base, significantly reducing the number of available beds for admissions on both the elective (and thereby reducing elective waiting list lengths) and the non-elective pathway.

Actions (SMART):

The Winter plan is focused around 3 areas – protecting assessment capacity, discharge and recruitment of staff. There are specific actions around creating a new Same Day Emergency Care (SDEC) area with protected capacity, with the aim of seeing urgent and emergency patients more quickly and being treated as an ambulatory patient not requiring admission. The effect of this should be that the length of stay is reduced, reducing the bed requirement. A new SDEC area is planned to open in M8, led by the medical division.

Actions in relation to Referral to Treatment and Diagnostic backlog are detailed on the relevant earlier page in the pack.

Risks and Mitigations:

Staffing risks remain high in terms of availability and vacancy. Additional measures have been agreed to uplift the pay of band 2 Health Care assistants, and significant work is being undertaken to recruit and retain these staff with the aim of improving the number of care hours per patient per day.

The ability to reduce the number of patients not meeting the criteria to reside is a significant risk for Winter. Work continues in partnership with the system with the intention to open additional bed capacity in South Wiltshire that all three acute Trusts can access. There are currently delays to this project as the system works with CQC to progress.

Watch Metrics: Non-Alerting

Quality of Care, Access and Outcomes

Metric	Two Months Ago	Last Month	This Month	Improvement Target	National Target	Variation	Variation Detail	Target Met This Month?	Consecutive Months Target Failed
% of Inpatients Undergoing VTE Risk Assessment	99.3%	98.4%	98.7%		95%		Common Cause Variation	✓	0
Ambulance Arrivals	1099	1187	1144			L	Special Cause Improving - Run Below Mean		
Ambulance Handovers 15-<30 mins	281	259	328				Common Cause Variation		
Cancer 2 Week Wait Breast Performance	94.4%	96.0%	96.7%		90%	H	Special Cause Improving - Two Out of Three High	✓	0
Cancer 31 Day Performance Overall	93.4%	98.4%	98.6%		96%		Common Cause Variation	✓	0
Neonatal Deaths Per 1000 Live Births	0	0	0		0	L	Special Cause Improving - Run Below Mean	✓	0
Number of High Harm Falls in Hospital	0	0	0	0	0	L	Special Cause Improving - Run Below Mean	✓	0
Pressure Ulcers Hospital Acquired Cat 2	16	30	38				Common Cause Variation		
Pressure Ulcers Hospital Acquired Cat 3	0	0	0			L	Special Cause Improving - Run Below Mean		
Pressure Ulcers Hospital Acquired Cat 4	0	0	0			L	Special Cause Improving - Run Below Mean		
RTT Incomplete Pathways: Total 104 week waits	0	0	0	0	0	L	Special Cause Improving - Run Below Mean	✓	0
RTT Incomplete Pathways: Total 52 week waits	433	485	448	565	0	L	Special Cause Improving - Below Lower Control Limit	✓	0
RTT Incomplete Pathways: Total 78 week waits	46	28	6	20	0	L	Special Cause Improving - Below Lower Control Limit	✓	0
Serious Incident Investigations	2	1	3				Common Cause Variation		
Stillbirths Per 1000 Total Births	0	0	0				Common Cause Variation		
Stroke & TIA: % CT'd within 1 hour	44.0%	42.0%	50.0%		50%		Common Cause Variation	✓	0
Total Incidents (All Grading) per 1000 Bed Days	51	52	58				Common Cause Variation		

Part 3: People

Performance against our Strategic Priorities and Key Lines of Enquiry

Salisbury NHS Foundation Trust

Our Priorities

Population

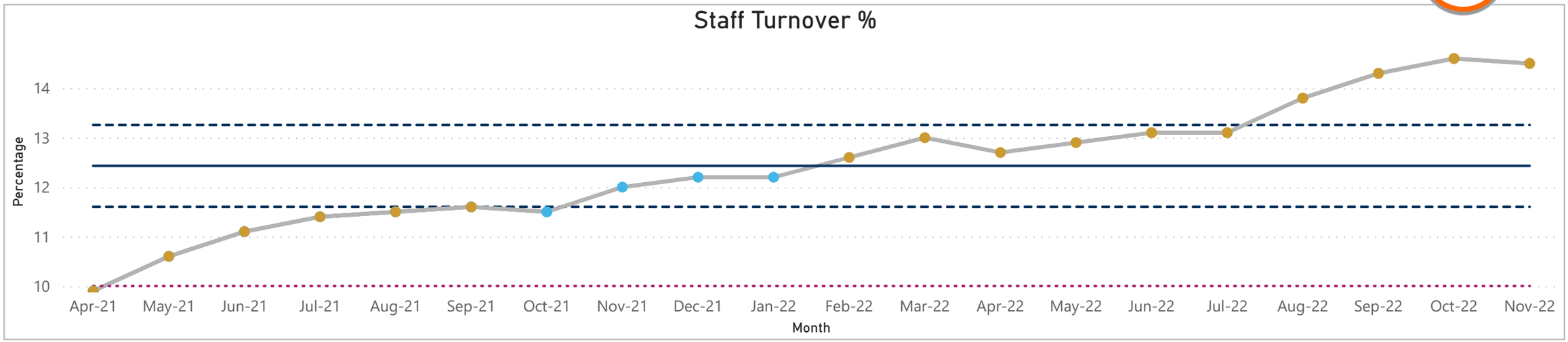
Partnerships

People

Workforce - Turnover

Target 10%

People



Understanding the performance:

As reported last month, the Turnover graph continues to flatten against the previous upward curve, dropping 0.13% against last months data. In November, 39.07 (full time equivalent, FTE) started with the Trust compared with 37.30 (FTE) leavers.

All Divisions remain 'red' against the Trust 10% target.

Understanding Turnover data, to generate retention positive actions remains challenging. In the year to November '22, 55% of leavers did not disclose exit information, although 19% of staff indicated that they were remaining within the NHS, with a third of that number remaining with SFT (9% of the total leavers). Improving understanding of this data is a key part of the Movers and Leavers project.

Underlying themes for leaving remain retirement, a lack of opportunity for flexible working and promotion.

Actions (SMART):

In order to better inform retention initiatives, a 'Movers and Leavers' project has been initiated to examine improvements to re-deployment and exit processes within the Trust. In addition to process improvements, project benefits will also include improved uptake and data definition from Exit interviews, which will support improved retention initiatives. The project timeline will be scoped by the end of January '23.

Outline staff survey results are expected from 9 Dec, these will be used to inform Divisional Teams and help to identify areas of concern within their divisions. A program of listening events to support actions from the Staff Survey will be conducted, with the aim of every member of staff having attended one such event before 31 March '23.

HR Business Partners will continue to support Divisional Line managers deliver appraisals and career conversations. All those RN in the 45-55 age group will have had a career conversation before 31 March '23.

Risks and mitigations:

Corporate Risk – Sustainable Workforce. Action plans include: Wellbeing website delivered, additional financial planning sessions programmed, wellbeing ambassador training started.

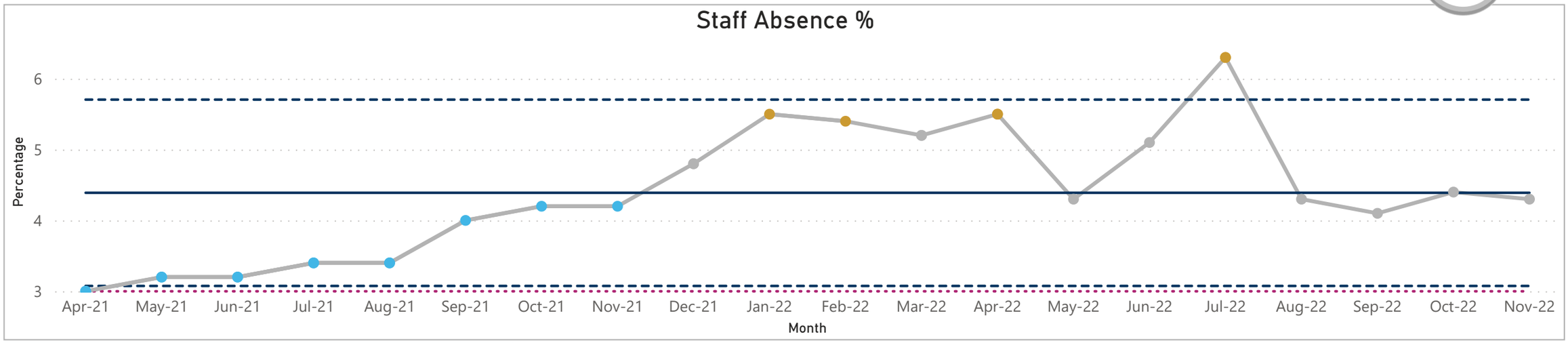
Driver metrics to support Workforce availability as a breakthrough objective will be developed for implementation in January '23.

The Safety Specialist and Mental Health First Aider have agreed to conduct exit interviews for all Theatres leavers to capture reasons for leaving more comprehensively. Themes and trends will be discussed at future governance meetings and with the BP, with a view to identifying actions to include in the wider Theatres OD programme.

Workforce - Sickness

Target 3%

People



Understanding the performance:

Sickness absence remains above the target level of 3%, demonstrating a modest decline to 4.25% this month. As the Trust approaches the winter period, with increasing seasonal infection increases this represents an encouraging position. COVID-19 and flu numbers have slightly increased, but overall absence is down. Data shows that the best performing areas are Women and Newborn and Corporate divisions, both of which are graded 'amber'; below the 4% threshold at 3.98% and 3.44% respectively.

Mental Health illness remains the highest contributor to short term frequent absences.

Actions (SMART):

A business case has been written to provide a short term increase in staff to support Divisions in the management of absence procedures and well-being conversations. The intent is to improve visibility and management of long term absence cases and, in conjunction with the 26 Wellbeing Ambassadors, deliver well-being conversations to all staff by 31 March '23.

Occupational Health (OH) capacity has now increased with the recruitment of 2 x Agency OH advisers and an increase to full time hours of our Physio in December '22. This has generated increased capacity which should see management referral Key Performance Indicators (KPIs; appt booking not to exceed 5 working days) and pre-employment checks (90% delivered in 5 working days) delivered to KPI.

Risks and mitigations:

Corporate Risk – Delivery of OH service
Occupational Health remains short staffed. New KPIs have been identified to prioritise support to new starters followed by The OH team have developed a new set of KPIs, prioritising support to enable new starters and improve the speed of appointments for management referrals of staff.

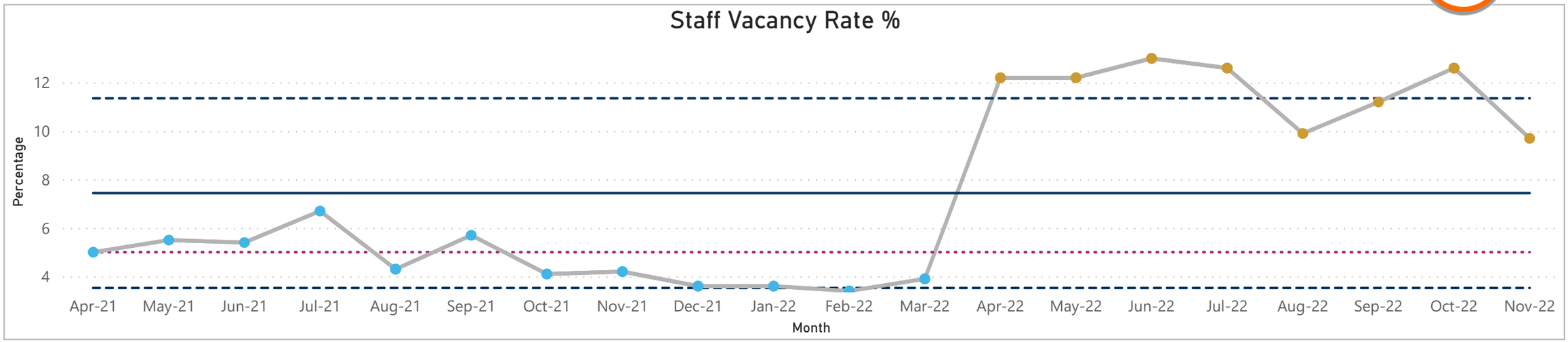
Corporate Risk – Sustainable Workforce
Absence management actions are not effective. Weekly workforce cell will review data on short term and long-term absences, target systemic absence management practices and reinforce staff alerts surrounding absence.

Targeted absence management support with Theatre Operating Department Practitioners (ODPs) and Clinical Endoscopists requested from ER Team by Business Partners (BPs) to assist delivery of elective activity and DM01 targets.

Workforce - Vacancies

Target 5%

People



Understanding the performance:

The vacancy rate has reduced significantly this month, dropping from 12.6% to 9.25%.

The effect of the concerted recruitment programme reported over the last 3 months has started to reduce vacancies as notice periods have elapsed and staff started work.

Actions (SMART):

The winter period is challenging for recruitment, but the resourcing team have launched a local advertising campaign within a 30 min travel to work radius, using leaflet, back of bus advertising and local radio.

The theatres campaign has offered 21 nurse and 13 Healthcare Assistant (HCA) positions.

Therapy services will set up a recruitment campaign, with an Open Day in mid-January '23, seeking to reduce vacancy numbers to zero. In the Medicine Division, 2 substantive Head of Nursing positions have been filled, providing much needed managerial capacity to support recruitment activity.

The 'starters' project, highlighted by a PwC audit has begun. This seeks to improve onboarding processes, with delivery against medium term project plan benefits complete by June '23.

Risks and mitigations:

Corporate Risk – Sustainable Workforce

- Resourcing Plans delivered
- Implementation of PWC 'overhauling recruitment' recommendations to generate more efficient processes.
- Recruitment campaigns are being refreshed.
- Communication of single version of recruiting picture across the Trust.
- Creation of career pathways and improved career structures to better advertise roles and opportunities.

Since July '22, time from authorisation of a vacancy to employment checks completed has reduced from 58 to 49 days.

Watch Metrics: Alerting

People

Metric	Two Months Ago	Last Month	This Month	Improvement Target	National Target	Variation	Variation Detail	Target Met This Month?	Consecutive Months Target Failed
Medical Appraisal Rate %	82.0%	85.8%	86.6%	90.0%			Common Cause Variation	X	20
Non-Medical Appraisal Rate %	63.2%	64.7%	65.5%	86.0%			Special Cause Concerning - Run Below Mean	X	20

Watch Metrics: Alerting Narrative

People

Understanding the performance:

Non-Medical Appraisal Rate

Non-Medical appraisals remain red against the target of 85%, but for the first time in 4 months show a modest upward trajectory to 64.7% completio.

There has been an improvement in the lowest level of completion, but three areas remain below a 10% completion rate. Ineffective management of appraisals remains an area of concern in Staff Survey and Pulse survey data, leading to low morale among staff.

Actions (SMART):

A simplified process for appraisals has been agreed and once rolled out in January, will be measured over a four month period to assess the impact on completion rates.

Line Managers breakfast sessions have been re-instigated to support those line mangers who need help and guidance on delivery of appraisals to staff, pointing out training courses where required.

Risks and Mitigations:

Corporate Risk - Sustainable Workforce.

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

Watch Metrics: Non-Alerting

People

Metric	Two Months Ago	Last Month	This Month	Improvement Target	National Target	Variation	Variation Detail	Target Met This Month?	Consecutive Months Target Failed
Mandatory Training Rate %	91.3%	91.0%	90.8%	90.0%	85%	H	Special Cause Improving - Two Out of Three High	✓	0

Part 4: Finance and Use of Resources

Performance against our Strategic Priorities and Key Lines of Enquiry

Salisbury NHS Foundation Trust

Our Priorities

Population

Partnerships

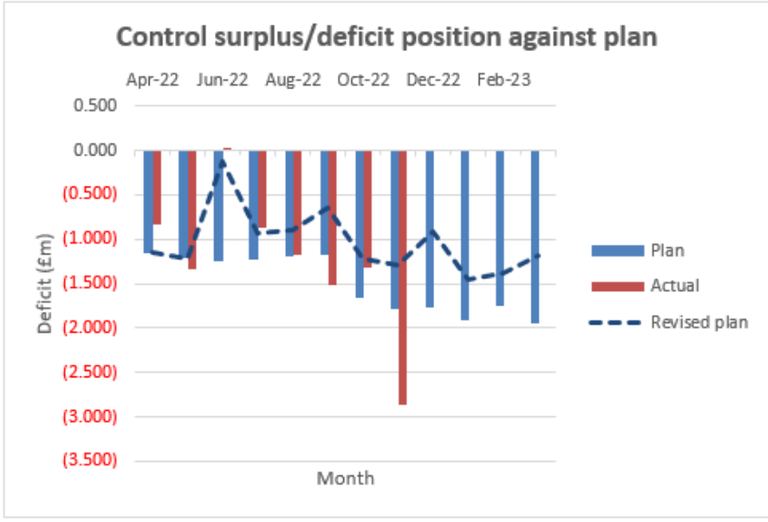
People

Income and Expenditure

Income & Expenditure:

Finance and Use of Resources

	Nov '22 In Month			Nov '22 YTD			22-23 Plan
	Plan £000s	Actual £000s	Variance £000s	Plan £000s	Actual £000s	Variance £000s	Plan £000s
Operating Income							
NHS Clinical income	21,946	21,737	(209)	176,223	177,926	1,703	260,775
Other Clinical Income	714	1,192	478	5,715	7,287	1,572	8,573
Other Income (excl Donations)	2,797	3,609	812	23,164	26,727	3,563	34,540
Total income	**25,457**	**26,537**	**1,081**	**205,102**	**211,940**	**6,838**	**303,888**
Operating Expenditure							
Pay	(16,899)	(18,067)	(1,168)	(134,858)	(138,849)	(3,991)	(199,429)
Non Pay	(8,170)	(9,726)	(1,556)	(64,358)	(69,836)	(5,478)	(96,646)
Total Expenditure	**(25,069)**	**(27,792)**	**(2,724)**	**(199,216)**	**(208,684)**	**(9,468)**	**(296,075)**
EBITDA	**388**	**(1,255)**	**(1,643)**	**5,886**	**3,256**	**(2,630)**	**7,813**
Financing Costs (incl Depreciation)	(1,686)	(1,615)	71	(13,360)	(13,164)	196	(20,213)
NHSI Control Total	**(1,298)**	**(2,870)**	**(1,572)**	**(7,474)**	**(9,908)**	**(2,434)**	**(12,400)**
Add: impact of donated assets	(68)	(58)	*10*	(544)	(235)	*309*	(816)
Surplus/(Deficit)	***(1,366)***	***(2,927)***	***(1,561)***	***(8,018)***	***(10,143)***	***(2,125)***	***(13,216)***
NHSI Control Total including BSW ICB support	**(265)**	**(1,836)**	**(1,572)**	**793**	**(1,641)**	**(2,434)**	**0**



Understanding the performance:

In month 7 the Trust recorded a control total deficit of £2.9m against a target of £1.3m - an adverse variance of £1.6m.

Agency pay costs increased by £0.5m in month offsetting reductions in substantive and bank pay of £0.3m. Non pay costs increased materially with increases in Electricity prices and elective Orthopaedics work in month. 'Pass through' non pay costs continue to run in excess of those planned for, now accounting for 70% of costs above plan.

Actions (SMART):

Agreement was reached on the distribution of the Bath, Swindon & Wiltshire (BSW) Integrated Care Board (ICB) planned surplus and £12.4m was paid to SFT in October.

People workstreams are focusing on retention of staff, with the uplift of all Band 2s to the top of scale with effect from 1 December. A review of the HCA roles that have fulfilled clinical competencies and can be regraded to Band 3 is under way with the expectation that this is effective from January 2023.

The BSW-wide procurement 2022/23 workplan levers the Integrated Care System (ICS) spending power to mitigate the impact of inflation.

Risks and mitigations:

Pressure on emergency care pathways which results in increased costs associated with the Trust's bed base, reductions of elective inpatient care and premium costs of bank and agency to cover vacancies and unavailability.

An ongoing requirement for the provision of additional beds at South Newton would represent a financial risk to the Trust if unfunded.

The Trust has a forecast delivery of £9.7m efficiency savings split 50:50 between recurrent and non-recurrent schemes. This signals a significant risk if further recurrent efficiencies are not identified.

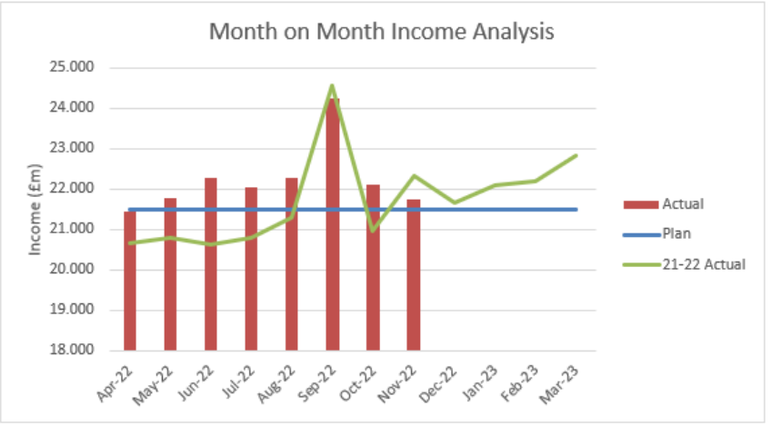
Income & Activity Delivered by Point of Delivery

Clinical Income:

Finance and Use of Resources

Income by Point of Delivery (PoD) for all commissioners	November '22 YTD Plan (YTD) £000s	Actual (YTD) £000s	Variance (YTD) £000s
A&E	7,190	6,899	(291)
Day Case	13,653	13,126	(527)
Elective inpatients	9,207	9,336	129
Excluded Drugs & Devices (inc Lucentis)	14,777	15,986	1,209
Non Elective inpatients	46,876	48,010	1,134
Other	59,809	61,022	1,213
Outpatients	24,711	23,547	(1,164)
TOTAL	**176,223**	**177,926**	**1,703**

SLA Income Performance of Trusts main NHS commissioners	Contract Plan (YTD) £000s	Actual (YTD) £000s	Variance (YTD) £000s
BSW ICB	104,513	105,532	1,019
Dorset ICB	17,519	17,414	(105)
Hampshire, Southampton & IOW ICB inc Portsmouth	14,285	14,285	-
Specialist Services	27,610	27,542	(68)
Other	12,296	13,153	857
TOTAL	**176,223**	**177,926**	**1,703**



	Activity YTD Plan	Activity YTD Actuals	Activity YTD Variance	Activity Last Year Actuals	Variance last year
A&E	47,173	48,841	1,668	46,551	2,290
Day case	15,630	15,142	(488)	13,887	1,255
Elective	2,294	2,273	(21)	1,895	378
Non Elective	19,278	17,685	(1,593)	18,995	(1,310)
Outpatients	171,637	169,230	(2,407)	181,826	(12,596)

Understanding the performance:

The Trust is ahead of the Clinical income plan year to date due to BSW ICB Elective Recovery Fund (ERF) and pay award funding, overperformance on Channel Islands spinal patients and additional Cystic Fibrosis patients and drugs. NHS England Specialised services continues to overperform on cost and volume high cost drugs and devices which is being offset by the transfer of the Genetics service with an income reduction of £0.6m per month. The Dorset ICB position reflects the agreement on the Sleep service.

A&E activity has been lower in November than October with less attendances at the A&E department and the Walk in centre in month. Day case activity in November was 127 more cases than in October with 58 additional cases undertaken in Urology. Activity in elective inpatients fell below plan in month by 62 cases with the majority of specialties reporting more activity than in October. Non Elective activity was higher than in October mainly within medical specialties and Outpatient activity was higher than in October with more activity within General surgery, Urology and Plastic Surgery.

Actions (SMART):

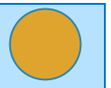
The BSW ICB contract has been signed by both parties.
The NHS England contracts require updating for the inclusion of agreed quality schedules, final agreement on the finance and information schedules and the removal of public health aspects within the HIV contract which were not part of the contract tender.
A new tariff has been published to reflect the National Insurance changes effective from 6 November.

Risks and mitigations:

Pay award funding has been allocated to ICB systems on a fair shares basis and additional funding of 1.66% including pay arrears was paid in September. There has been a shortfall in the pay award allocation compared with expected costs and an additional £700k above the 1.66% funding is being paid by BSW ICB.
The BSW ERF funding has now been confirmed at £2,150k and is higher than originally planned.
£900k funding has been agreed for the 14 South Newton beds.

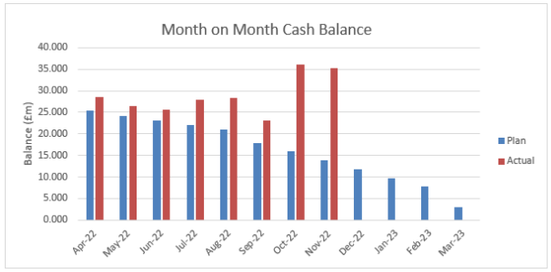
Cash Position & Capital Programme

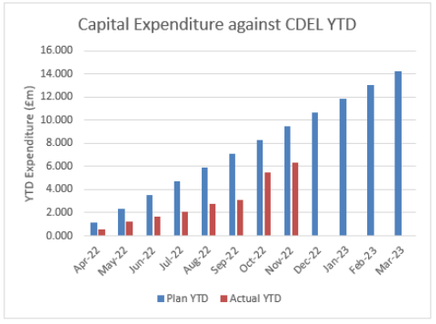
Capital Spend: 

Cash & Working: 

Finance and Use of Resources

	Closing Balance March 2022 £000s	Current Month Balance £000s	Actual In Year Movement £000s	
Inventories (Stock)	7,939	8,470	531	
Debtors	14,296	17,296	3,000	
Cash	33,447	35,351	1,904	
TOTAL CURRENT ASSETS	**55,682**	**61,117**	**5,435**	
Creditors	(46,637)	(51,736)	(5,099)	
Borrowings	(1,102)	(1,255)	(153)	
Provisions	(1,235)	(1,041)	194	
TOTAL CURRENT LIABILITIES	**(48,974)**	**(54,032)**	**(5,058)**	
TOTAL WORKING CAPITAL	**6,708**	**7,085**	**377**	





Payables age profile	Total Payables £'000	0-30 days £'000	31-60 days £'000	61-90 days £'000	90+ days £'000
Nov-22	**7,152**	4,929	781	291	1,151
Oct-22	**6,373**	4,638	365	47	1,323
Sep-22	**5,766**	4,304	101	282	1,079
Movement vs prev mth	*779*	*291*	*416*	*244*	*(172)*

Schemes	Annual Plan £000s	November '22 YTD Plan £000s	November '22 YTD Actual £000s	November '22 YTD Variance £000s
CDEL Schemes				
Building schemes CIR	3,758	2,456	934	1,522
Building projects	3,154	2,032	1,945	87
IM&T	4,166	2,552	2,152	400
Medical Equipment	2,528	2,168	807	1,361
Other	1,414	283	243	40
Total CDEL schemes	***15,020***	***9,491***	***6,081***	***3,410***
National Funding				
TIF - New ward	*2,048*	*144*	*144*	0
Pathology LIMS	*712*	*75*	*75*	0
Total National Funding	***2,760***	***219***	***219***	0
GRAND TOTAL	**17,780**	**9,710**	**6,300**	**3,410**

Understanding the performance:

Capital expenditure is significantly behind plan, -c35% year to date, particularly within Medical Equipment and Building schemes. A revised forecast has been agreed at Trust Board which fully utilises the capital funding by year end. The forecast now includes the refurbishment of the Douglas Arter Centre as part of the decant for the additional ward scheme together with further agreed investment in medical equipment and building schemes. A further £300k BSW Capital Departments Expenditure Limit (CDEL) allocation has now been confirmed and plans are being developed to spend this.

The improvement in the cash position, following the receipt of the BSW ICB funding, mitigates any risk to the cash balance for the remainder of the financial year.

Actions (SMART):

The capital plan has been reviewed in the context of known supply chain restraints. Alternative projects initially planned for 2023/24 which can be brought forward to 2022/23 have been identified to mitigate the risk of further slippage.

The unallocated BSW capital allocation has now been released, with Trust Board agreeing to an increase in the SFT 2022/23 capital plan of £795k in October, and a prioritised list of requests has now received final approval. A further £300k funding has now been confirmed.

The additional ward project was given final approval on 3rd November 2022.

Risks and mitigations:

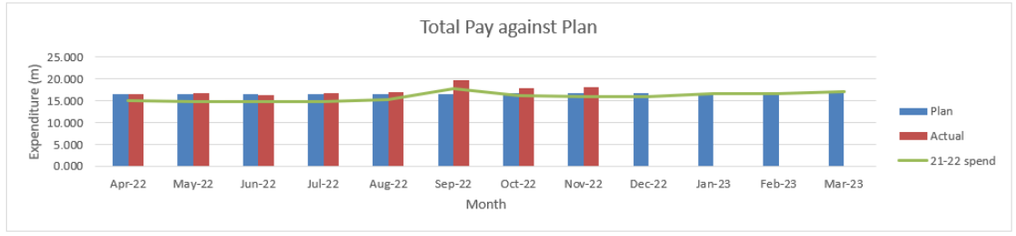
Supply chain disruption and inflationary pressures remain a significant draw of time on the procurement team. This gives rise to a risk in both lead times and overall procurement capacity.

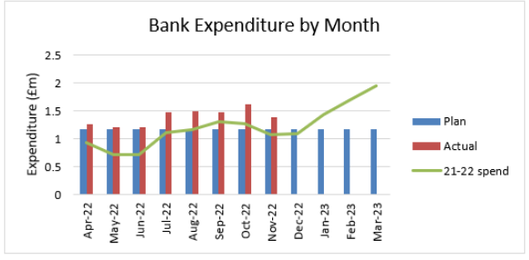
The constraint of both available cash and system capital expenditure limits gives rise to both a mid and long term risk to the Trust. The context of digital modernisation programmes, along with an aging estate and medical equipment means the Trust's five year capital requirement is well in excess of available resources. The Trust seeks to in part mitigate this risk through the proactive bidding for national funds where available. A CT scanner bid is currently under development to secure national funding of £1.7m in 2022/23.

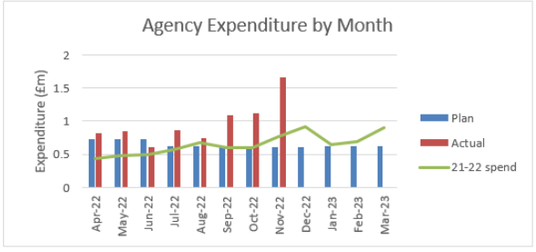
Workforce and Agency Spend

Pay:

Finance and Use of Resources







	November '22 YTD		
	Plan £000s	Actual £000s	Variance £000s
Pay - In Post	119,256	119,460	(203)
Pay - Bank	9,534	11,101	(1,567)
Pay - Agency	5,276	7,769	(2,493)
Other (eg. Apprenticeship Levy)	792	519	273
TOTAL	**134,858**	**138,849**	**(3,991)**
Medical Staff	35,597	35,953	(357)
Nursing	31,993	35,766	(3,774)
Support to Nursing	9,754	10,923	(1,170)
Other Clinical Staff	22,038	20,528	1,510
Infrastructure staff	34,684	35,159	(474)
Other (eg. Apprenticeship Levy)	792	519	273
TOTAL	**134,858**	**138,849**	**(3,991)**

	November '22		
	Plan WTEs	Actual WTEs	Variance WTEs
Medical Staff	490.6	472.29	18.3
Nursing	1,103.6	1,126.10	- 22.5
Support to Nursing	515.1	556.16	- 41.1
Other Clinical Staff	689.8	600.71	89.1
Infrastructure staff	1,461.1	1,443.92	17.1
TOTAL	**4,260.2**	**4,199.2**	**61.0**

Understanding the performance:

Pay expenditure increased by £220k in month and was £1,105k above the average monthly run rate, adjusted for the Genetics service, for the year to date.

The increase in Registered Nursing agency costs accounts for £309k of the total increase in agency spend (59%) with support to nursing a further £52k. £80k of the registered agency nursing related to a ventilated patient within the Spinal unit who requires 1:1 care 24 hours per day and is expected to require continued support for a minimum of two months. There was an increase in Registered Nursing agency spend across all clinical divisions, mainly due to vacancies and increased sickness in month, but highest in Medicine, where Whiteparish ward and the Emergency department showed the highest increases.
The levels of substantive vacancies have reduced from 13% to 11% with the number of substantive WTEs increased by 41 WTE in month. Within this the biggest increases have been in Infrastructure staff 27 WTE, mainly across Admin and Estates teams, and Support to nursing 24 WTE. Substantive nursing and medical WTE reduced n month by 7 WTEs.

Actions (SMART):

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

Risks and mitigations:

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

Unions have balloted on industrial action with a number of positions now confirmed. It is anticipated that there will be disruption to patient pathways and additional costs to mitigate.

Data Sources: Narrative and Breakthrough Objectives

Understand the Data

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

Data Sources: Watch Metrics (1)

Understand the Data

Metric Type	Metric Name	Data Source	Executive Lead	Data Quality Rating
Watch	% of Inpatients Undergoing VTE Risk Assessment	Quality Team	Peter Collins	High
Watch	% of Total Incidents Resulting in High Harm (Mod/Maj/Cat)	DATIX Team	Judy Dyos	Medium
Watch	Mandatory Training Rate %	MLE	Melanie Whitfield	High
Watch	Medical Appraisal Rate %	ESR	Melanie Whitfield	High
Watch	Mixed Sex Accommodation Breaches	Site Team	Judy Dyos	Low
Watch	MSSA Bacteraemia Infections: Hospital Onset	Infection Control Team	Judy Dyos	High
Watch	Neonatal Deaths Per 1000 Live Births	E3 Maternity System	Peter Collins	High
Watch	Non-Medical Appraisal Rate %	ESR	Melanie Whitfield	High
Watch	Number of High Harm Falls in Hospital	DATIX Team	Judy Dyos	Medium
Watch	Pressure Ulcers Hospital Acquired Cat 2	DATIX Team	Judy Dyos	High
Watch	Pressure Ulcers Hospital Acquired Cat 3	DATIX Team	Judy Dyos	High
Watch	Pressure Ulcers Hospital Acquired Cat 4	DATIX Team	Judy Dyos	High
Watch	Serious Incident Investigations	DATIX Team	Judy Dyos	Medium
Watch	Stillbirths Per 1000 Total Births	E3 Maternity System	Peter Collins	High
Watch	Stroke & TIA: % Bedside Swallow Assessment within 4 hours	Trust Data Warehouse	Peter Collins	High
Watch	Stroke & TIA: % CT'd within 1 hour	Trust Data Warehouse	Peter Collins	High
Watch	Total Incidents (All Grading) per 1000 Bed Days	DATIX Team	Judy Dyos	High
Watch	Total Number of Complaints Received	PALS Team	Judy Dyos	High
Watch	Total Number of Compliments Received	PALS Team	Judy Dyos	High

Data Sources: Watch Metrics (2)

Understand the Data

Metric Type	Metric Name	Data Source	Executive Lead	Data Quality Rating
Watch	DM01 Waiting List Volume	Trust Data Warehouse	Lisa Thomas	High
Watch	Ambulance Handovers 15-<30 mins	SWAST AR119 report	Lisa Thomas	High
Watch	Ambulance Handovers 30-<60 mins	SWAST AR119 report	Lisa Thomas	High
Watch	Ambulance Handovers 60+ mins	SWAST AR119 report	Lisa Thomas	High
Watch	% Beds Occupied	Lorenzo via Trust Data Warehouse	Lisa Thomas	Medium
Watch	Ambulance Arrivals	Lorenzo via Trust Data Warehouse	Lisa Thomas	High
Watch	Average hours lost to Ambulance Handover delays per day	Lorenzo via Trust Data Warehouse	Lisa Thomas	High
Watch	ED 12 Hour Breaches (Arrival to Departure)	Lorenzo via Trust Data Warehouse	Lisa Thomas	Medium
Watch	ED Attendances	Lorenzo via Trust Data Warehouse	Lisa Thomas	High
Watch	Proportion of patients spending more than 12 hours in an emergency department	Lorenzo via Trust Data Warehouse	Lisa Thomas	High
Watch	RTT Incomplete Pathways: Total 104 week waits	Lorenzo via Trust Data Warehouse	Lisa Thomas	High
Watch	RTT Incomplete Pathways: Total 52 week waits	Lorenzo via Trust Data Warehouse	Lisa Thomas	High
Watch	RTT Incomplete Pathways: Total 78 week waits	Lorenzo via Trust Data Warehouse	Lisa Thomas	High
Watch	Trust Performance RTT %	Lorenzo via Trust Data Warehouse	Lisa Thomas	High
Watch	Average Patients with No Criteria to Reside	e-whiteboards via Trust Data Warehouse	Lisa Thomas	Medium
Watch	Cancer 2 Week Wait Breast Breaches	Cancer Services	Lisa Thomas	High
Watch	Cancer 2 Week Wait Breast Den	Cancer Services	Lisa Thomas	High
Watch	Cancer 2 Week Wait Breast Num	Cancer Services	Lisa Thomas	High
Watch	Cancer 2 Week Wait Breast Performance	Cancer Services	Lisa Thomas	High
Watch	Cancer 31 Day Performance Overall	Cancer Services	Lisa Thomas	High
Watch	Cancer 62 Day Screening Den	Cancer Services	Lisa Thomas	High
Watch	Cancer 62 Day Screening Num	Cancer Services	Lisa Thomas	High
Watch	Cancer 62 Day Screening Performance	Cancer Services	Lisa Thomas	High
Watch	Cancer 62 Days Standard Den	Cancer Services	Lisa Thomas	High
Watch	Cancer 62 Days Standard Num	Cancer Services	Lisa Thomas	High

Data Sources: Other Metrics (1)

Understand the Data

Metric Type	Metric Name	Data Source	Executive Lead	Data Quality Rating
Other	Cancer 2 Week Wait Breaches	Cancer Services	Lisa Thomas	High
Other	Cancer 2 Week Wait Den	Cancer Services	Lisa Thomas	High
Other	Cancer 2 Week Wait Num	Cancer Services	Lisa Thomas	High
Other	DM01 Performance: Audio	Trust Data Warehouse	Lisa Thomas	Medium
Other	DM01 Performance: Cardio	Trust Data Warehouse	Lisa Thomas	Medium
Other	DM01 Performance: Colon	Trust Data Warehouse	Lisa Thomas	Medium
Other	DM01 Performance: CT	Trust Data Warehouse	Lisa Thomas	Medium
Other	DM01 Performance: DEXA	Trust Data Warehouse	Lisa Thomas	Medium
Other	DM01 Performance: Flexi Sig	Trust Data Warehouse	Lisa Thomas	Medium
Other	DM01 Performance: Gastro	Trust Data Warehouse	Lisa Thomas	Medium
Other	DM01 Performance: MRI	Trust Data Warehouse	Lisa Thomas	Medium
Other	DM01 Performance: Neuro	Trust Data Warehouse	Lisa Thomas	Medium
Other	DM01 Performance: US	Trust Data Warehouse	Lisa Thomas	Medium
Other	Longest Waiting Patient (Weeks)	Lorenzo via Trust Data Warehouse	Lisa Thomas	High
Other	Day HCA	Health Roster	Melanie Whitfield	High
Other	Day RN	Health Roster	Melanie Whitfield	High
Other	Night HCA	Health Roster	Melanie Whitfield	High
Other	Night RN	Health Roster	Melanie Whitfield	High

Data Sources: Other Metrics (2)

Understand the Data

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

Data Sources: Other Metrics (3)

Understand the Data

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

Data Sources: Other Metrics (4)

Understand the Data

Metric Type	Metric Name	Data Source	Executive Lead	Data Quality Rating
Other	Add: impact of donated assets	Finance Division	Mark Ellis	High
Other	Financing Costs	Finance Division	Mark Ellis	High
Other	Income by PoD: A&E Actual	Finance Division	Mark Ellis	High
Other	Income by PoD: A&E Plan	Finance Division	Mark Ellis	High
Other	Income by PoD: Daycase Actual	Finance Division	Mark Ellis	High
Other	Income by PoD: Daycase Plan	Finance Division	Mark Ellis	High
Other	Income by PoD: Elective IP Actual	Finance Division	Mark Ellis	High
Other	Income by PoD: Elective IP Plan	Finance Division	Mark Ellis	High
Other	Income by PoD: Excluded Drugs & Devices Actual	Finance Division	Mark Ellis	High
Other	Income by PoD: Excluded Drugs & Devices IP Plan	Finance Division	Mark Ellis	High
Other	Income by PoD: Non Elective IP Actual	Finance Division	Mark Ellis	High
Other	Income by PoD: Non Elective IP Plan	Finance Division	Mark Ellis	High
Other	Month on month I&E Surplus/(Deficit) Actual	Finance Division	Mark Ellis	High
Other	Month on month I&E Surplus/(Deficit) Plan	Finance Division	Mark Ellis	High
Other	NHS Clinical income	Finance Division	Mark Ellis	High
Other	NHS Clinical income Plan	Finance Division	Mark Ellis	High
Other	Non Pay	Finance Division	Mark Ellis	High
Other	Other Clinical income	Finance Division	Mark Ellis	High
Other	Other Clinical income Plan	Finance Division	Mark Ellis	High
Other	Other income (excl donations)	Finance Division	Mark Ellis	High
Other	Other income (excl donations) Plan	Finance Division	Mark Ellis	High
Other	Pay	Finance Division	Mark Ellis	High
Other	Share of Gains on Joint Ventures	Finance Division	Mark Ellis	High
Other	Surplus/(Deficit)	Finance Division	Mark Ellis	High

Data Sources: Other Metrics (5)

Understand the Data

Metric Type	Metric Name	Data Source	Executive Lead	Data Quality Rating
Other	Activity by PoD: A&E	Finance Division	Mark Ellis	High
Other	Activity by PoD: Day case	Finance Division	Mark Ellis	High
Other	Activity by PoD: Elective	Finance Division	Mark Ellis	High
Other	Activity by PoD: Non Elective	Finance Division	Mark Ellis	High
Other	Activity by PoD: Outpatients	Finance Division	Mark Ellis	High
Other	Capital Expenditure: Building Projects Actual	Finance Division	Mark Ellis	High
Other	Capital Expenditure: Building Projects Plan	Finance Division	Mark Ellis	High
Other	Capital Expenditure: Building Schemes Actual	Finance Division	Mark Ellis	High
Other	Capital Expenditure: Building Schemes Plan	Finance Division	Mark Ellis	High
Other	Capital Expenditure: IM&T Actual	Finance Division	Mark Ellis	High
Other	Capital Expenditure: IM&T Plan	Finance Division	Mark Ellis	High
Other	Capital Expenditure: Medical Equipment Plan	Finance Division	Mark Ellis	High
Other	Income by PoD: Other Actual	Finance Division	Mark Ellis	High
Other	Income by PoD: Other Plan	Finance Division	Mark Ellis	High
Other	Income by PoD: Outpatients Actual	Finance Division	Mark Ellis	High
Other	Income by PoD: Outpatients Plan	Finance Division	Mark Ellis	High
Other	Month on month cash balance	Finance Division	Mark Ellis	High
Other	Month on month Income Analysis Actual	Finance Division	Mark Ellis	High
Other	Month on month Income Analysis Plan	Finance Division	Mark Ellis	High
Other	SLA Income: BSW CCG	Finance Division	Mark Ellis	High
Other	SLA Income: Dorset CCG	Finance Division	Mark Ellis	High
Other	SLA Income: Hampshire, Southampton and IoW CCG	Finance Division	Mark Ellis	High
Other	SLA Income: Other	Finance Division	Mark Ellis	High
Other	SLA Income: Specialist Services	Finance Division	Mark Ellis	High

Data Sources: Other Metrics (6)

Understand the Data

Metric Type	Metric Name	Data Source	Executive Lead	Data Quality Rating
Other	Agency total Actual	Finance Division	Mark Ellis	High
Other	Agency Total Plan	Finance Division	Mark Ellis	High
Other	Bank total Actual	Finance Division	Mark Ellis	High
Other	Bank total Plan	Finance Division	Mark Ellis	High
Other	Capital Expenditure: Additional funds approved in year Actual	Finance Division	Mark Ellis	High
Other	Capital Expenditure: Additional funds approved in year Plan	Finance Division	Mark Ellis	High
Other	Capital Expenditure: Medical Equipment Actual	Finance Division	Mark Ellis	High
Other	Capital Expenditure: Other Actual	Finance Division	Mark Ellis	High
Other	Capital Expenditure: Other Plan	Finance Division	Mark Ellis	High
Other	Month on Month CAPEX Actual	Finance Division	Mark Ellis	High
Other	Month on Month CAPEX Plan	Finance Division	Mark Ellis	High
Other	Month on Month total pay Actual	Finance Division	Mark Ellis	High
Other	Month on Month total pay Plan	Finance Division	Mark Ellis	High

Salisbury NHS Foundation Trust Maternity Self Certification
Maternity Incentive Scheme NHS Resolution,
Board Assurance Report
January 2023

1. Introduction

Governance - This report has been reviewed and ratified by the Women and Newborns (WNB) divisional management team, with independent review by the national maternity improvement advisor assigned to SFT as part of the maternity safety support programme. The report has furthermore been reviewed by the board maternity safety champion. None of the declared compliance in this reports contradicts any external report for the maternity service, including CQC reports.

NHS Resolution is operating year four of the Clinical Negligence Scheme for Trusts (CNST) maternity incentive scheme to continue to support the delivery of safer maternity care.

The maternity incentive scheme applies to all acute Trusts that deliver maternity services and are members of the CNST. As in previous years, members will contribute an additional 10% of the CNST maternity premium to the scheme creating the CNST maternity incentive fund.

The scheme incentivises ten maternity safety actions as referenced in previous years' schemes. Trusts that can demonstrate they have achieved all of the ten safety actions will recover the element of their contribution relating to the CNST maternity incentive fund and will also receive a share of any unallocated funds.

Trusts that do not meet the ten-out-of-ten threshold will not recover their contribution to the CNST maternity incentive fund but may be eligible for a small discretionary payment from the scheme to help to make progress against actions they have not achieved. Such a payment would be at a much lower level than the 10% contribution to the incentive fund.

In 2021 the Maternity service at Salisbury NHS Foundation Trust (SFT) was successful in achieving compliance in 4 of the 10 criteria for NHS Resolution (NHSR), Clinical Negligence Scheme for Trusts (CNST).

1.1 Maternity incentive scheme year Four: Conditions

In order to be eligible for payment under the scheme, Trusts must submit their completed Board declaration form to NHS Resolution (nhsr.mis@nhs.net) by **12 noon on Thursday 2 February 2023** and must comply with the following conditions:

a) Trusts must achieve all ten maternity safety actions
b) The declaration form is submitted to Trust Board with an accompanying joint presentation detailing position and progress with maternity safety actions by the Director of Midwifery/Head of Midwifery and Clinical Director for Maternity Services
c) The 'Board Declaration Form' must be signed and dated by the Trust Chief Executive to confirm the following:

- The Trust Board are satisfied that the evidence provided to demonstrate achievement of the ten maternity safety actions meets the required safety actions' sub-requirements as set out in the safety actions and technical guidance document included in this document.

- There are no reports covering either year 2021/22 or 2022/23 that relate to the provision of maternity services that may subsequently provide conflicting information to your declaration (e.g. Care Quality

Commission (CQC) inspection report, Healthcare Safety Investigation Branch (HSIB) investigation reports etc.). All such reports should be brought to the MIS team's attention before Thursday 2 February 2023.

Whilst SFT received their CQC report in July 2021 there are no recommendations highlighted in that report that are similar to the standards in the year 4 MIS.

d) The Board must give their permission to the Chief Executive to sign the 'Board Declaration Form' prior to submission to NHSR. Trust Board declaration form must be signed by the Trusts Chief Executive. If the form is signed by another Trust member this will not be considered**.**
e) In addition, the CEO of the Trust will ensure that the Accountable Officer (AO) for their Integrated Care System (ICB) is apprised of the MIS safety actions' evidence and declaration form. The CEO and AO must both sign the Board declaration form as evidence that they are both fully assured and in agreement with the compliance submission to NHS Resolution Note: CCG functions will be subsumed into integrated care systems, with CCGs ceasing to exist as statutory organisations by July 2022.
f) Trust submissions will be subject to a range of external validation points, these include cross checking with: MBRRACE-UK data (safety action 1 standard a, b and c), NHS England & Improvement regarding submission to the Maternity Services Data Set (safety action 2, criteria 2 to 7 inclusive), and against the National Neonatal Research Database (NNRD) and HSIB for the number of qualifying incidents reportable (safety action 10, standard a)). Trust submissions will also be sense checked with the CQC, and for any CQC visits undertaken within the time period, the CQC will cross-reference to the maternity incentive scheme via the key lines of enquiry.
g) ·The Regional Chief Midwives will provide support and oversight to Trusts when receiving Trusts' update at Local Maternity and Neonatal System (LMNS) and regional meetings, focusing on themes highlighted when Trusts have incorrectly declared MIS compliance in previous years of MIS.
h) · NHS Resolution will continue to investigate any concerns raised about a Trust's performance either during or after the confirmation of the maternity incentive scheme results. Trusts will be asked to consider their previous MIS submission and reconfirm if they deem themselves to be compliant. If a Trust re-confirm compliance with all of the ten safety actions then the evidence submitted to Trust Board will be requested by NHS Resolution for review. If the Trust is found to be non-compliant (self-declared non-compliant or declared non-compliant by NHS Resolution), it will be required to repay any funding received and asked to review previous years' MIS submissions.
i) · NHS Resolution will publish the outcomes of the maternity incentive scheme verification process, Trust by Trust, for each year of the scheme (updated on the NHS Resolution Website).

1.2 Evidence for submission

- The Board declaration form must not include any narrative, commentary, or supporting documents. Evidence should be provided to the Trust Board only, and will not be reviewed by NHS Resolution, unless requested as explained above.
- Trusts must declare YES/NO or N/A (where appropriate) against each of the elements within each safety action sub-requirements.
- The Trust must also declare on the Board declaration form whether there are any external reports which may contradict their maternity incentive scheme submission and that the MIS evidence has been discussed with commissioners.
- Trusts will need to report compliance with MIS by Thursday 2 February 2023 at 12 noon using the Board declaration form, which will be published on the NHS Resolution website in the forthcoming months.
- The Trust declaration form must be signed by the Trust's CEO, on behalf of the Trust Board and by Accountable Officer (AO) of Clinical Commissioning Group/Integrated Care System.
- Only for a set amount of safety action requirements, Trusts will be able to declare N/A (not applicable) against some of the sub requirements.

· The declaration form will be available on the MIS webpage at a later date.

1.3 Timescales and appeals

Any queries relating to the ten safety actions must be sent in writing by e-mail to NHS Resolution (nhsr.mis@nhs.net) prior to the submission date. · The Board declaration form must be sent to NHS Resolution (nhsr.mis@nhs.net) between Thursday 26 January 2023 and Thursday 2 February 2023 at 12 noon. An electronic acknowledgement of Trust submissions will be provided within ten working days from submission date.

· Submissions and any comments/corrections received after 12 noon on Thursday 2 February 2023 will not be considered.

· Further detail on the results publication, appeals and payments process will be communicated at a later date

1.4 . **For Trusts who have not met all ten safety actions**

Trusts that have not achieved all ten safety actions may be eligible for a small amount of funding to support progress. In order to apply for funding, such Trusts must submit an action plan together with the Board declaration form by 12 noon on 2 February 2023 to NHS Resolution (nhsr.mis@nhs.net). The action plan must be specific to the action(s) not achieved by the Trust and must take the format of the action plan template which will be provided within the Board declaration form. Action plans should not be submitted for achieved safety actions

2. MIS Year 4 Criteria Safety Actions

Table 1 below describes the ten safety actions and provides overall current compliance.

Table 1.

Criteria for Maternity CNST		RAG SCORING
1	Are you using the National Perinatal Mortality Review Tool to review perinatal deaths to the required standard?	
2	Are you submitting data to the Maternity Services Data Set (MSDS) to the required standard?	
3	Can you demonstrate that you have transitional care services in place to minimise separation of mothers and their babies and to support the recommendations made in the Avoiding Term Admissions into Neonatal units Programme?	
4	Can you demonstrate an effective system of clinical workforce planning to the required standard?	
5	Can you demonstrate an effective system of midwifery workforce planning to the required standard?	
6	Can you demonstrate compliance with all five elements of the Saving Babies' Lives care bundle version 2?	
7	Can you demonstrate that you have a mechanism for gathering service user feedback and that you work with service users through you maternity voices partnership (MVP) to co-produce local maternity services?.	

8	Can you evidence that a local training plan is in place to ensure that all six core modules of the Core Competency Framework will be included in your unit training programme over the next 3 years, starting from the launch of MIS year 4? In addition, can you evidence that at least 90% of each relevant maternity unit staff group has attended an 'in house', one-day, multi-professional training day which includes a selection of maternity emergencies, antenatal and intrapartum fetal surveillance and newborn life support, starting from the launch of MIS year 4?	
9	Can you demonstrate that there are robust processes in place to provide assurance to the Board on maternity and neonatal safety and quality issues?	
10	Have you reported 100% of qualifying cases to Healthcare Safety Investigation Branch (HSIB) and to NHS Resolution's Early Notification (EN) Scheme from 1 April 2021 to 5 December 2022?	

3. Analysis

3.1 Safety action 1:

Are you using the National Perinatal Mortality Review Tool to review perinatal deaths to the required standard?

Mothers and Babies Reducing Risk through Audits and Confidential Enquires (MBRRACE) has developed and establish a National standardised Perinatal Mortality Review Tool (PMRT). The PMRT has been designed with user and parent involvement to support high quality standardised perinatal reviews on the principle of 'review once, review well'. The aim of the PMRT programme is to introduce the PMRT to support standardised perinatal mortality reviews across maternity and neonatal units.

The PMRT has been designed to support the review of the care of the following babies:

- All late fetal losses 22+0 to 23+6
- All antepartum and intrapartum stillbirths
- All neonatal deaths from birth at 22+0 to 28 days after birth
- All post-neonatal deaths where the baby is born alive from 22+0 but dies after 28 following care in a neonatal unit; the baby may be receiving planned palliative care elsewhere (including at home) when they die.

Required standard	a) i. All perinatal deaths eligible to be notified to MBRRACE-UK from 6 May 2022 onwards must be notified to MBRRACE-UK within seven working days and the surveillance information where required must be completed within one month of the death. Deaths where the surveillance form needs to be assigned to another Trust for additional information are excluded from the latter. ii. A review using the Perinatal Mortality Review Tool (PMRT) of 95% of all deaths of babies, suitable for review using the PMRT, from 6 May 2022 will have been started within two months of each death. This includes deaths after home births where care was provided by your Trust.
	b) At least 50% of all deaths of babies (suitable for review using the PMRT) who were born and died in your Trust, including home births, from 6 May 2022 will have been reviewed using the PMRT, by a multidisciplinary review team. Each of these reviews will have been completed to the point that at least a PMRT draft report has been

	generated by the tool within four months of each death and the report published within six months of each death.
	c) For at least 95% of all deaths of babies who died in your Trust from 6 May 2022, the parents will have been told that a review of their baby's death will take place, and that the parents' perspectives and any questions and/or concerns they have about their care and that of their baby have been sought. This includes any home births where care was provided by your Trust staff and the baby died either at home or in your Trust. If delays in completing reviews are anticipated parents should be advised that this is the case and be given a timetable for likely completion. Trusts should ensure that contact with the families continues during any delay and make an early assessment of whether any questions they have can be addressed before a full review has been completed; this is especially important if there are any factors which may have a bearing on a future pregnancy. In the absence of a bereavement lead ensure that someone takes responsibility for maintaining contact and for taking actions as required.
	d) Quarterly reports will have been submitted to the Trust Board from 6 May 2022 onwards that include details of all deaths Technical guidance for safety action 1 reviewed and consequent action plans. The quarterly reports should be discussed with the Trust maternity safety and Board level safety champions.
Minimum evidential requirement for trust Board	Notifications must be made and surveillance forms completed using the MBRRACE-UK reporting website. The perinatal mortality review tool must be used to review the care and reports should be generated via the PMRT. A report has been received by the Trust Board each quarter from 6 May 2022 onwards that includes details of the deaths reviewed 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) and c) have been met. For standard c) for any parents who have not been informed about the review taking place, reasons for this should be documented within the PMRT review.

The maternity service can confirm that the PMRT is used in review processes.

a) i) It should be noted that from the 6 May 2022 there were 3 eligible cases requiring notification to MBRRACE. These were reported within 7 working days and the surveillance information completed within one month of the death.
ii) 100% of all deaths of babies suitable for review using PMRT (one baby) were done and commenced within two months of the death.

b) 100% of cases of all deaths of babies suitable for review using PMRT (one baby), who were born and died in the Trust from 6th May 2022 to 5th December 2022, have been reviewed using the PMRT by an MDT, the draft report generated within 4 months and published within 6 months.

Date of delivery	Date of diagnosis	Gestation at diagnosis	Gestation at delivery	Type of loss	HSIB / SI	Parents given MBRRACE/ PMRT information and Duty of Candour	MBRRACE ID	CNST Safety action 1ai) MBRACCE notification within 7 working days Surveillance completed within 1 month	CNST Safety action 1c) Parental engament sought	CNST Safety action 1aii) PMRT commenced within 2 months	External reviewer	CNST Safety action 1b) PMRT review meeting within 4 months	CNST Safety action 1b) PMRT draft report within 4 months.	CNST Safety action 1b) PMRT report published within 6 months	Report sent to Consultant	Debrief appointment	Reopen Surveillance and add cause of death	Report added to datix/ datix updated
11/05/2022	11/05/2022	21+5	21+5	NND	No	MBRRACE ye	81562	Yes Notification + Surveillance 12/05/2022	NA	NA	NA	NA	NA	NA	NA	15/07/2022		NA< 22 wks
28/06/2022	Fetocide	24	24+1	MTOP/ Stillbirth	No	MBRRACE ye	82320	Yes 04/07/2022	NA	NA	NA	NA	NA	NA	NA	22/08/2022	NA	NA- MTOP
26/07/2022	24/07/2022	38+1	38+3	Stillbirth	No	Yes	82745	Yes Notification 27/9/2022 Surveillance 1/8/2022	05/08/2022	12/08/2022	GWH	Yes	29/09/2022	24/10/2022	Yes	Awaiting Joint debrief with patient experience M		

c) Within the same time frame, of the required 95% standard, the parents were told that a review of their baby's

death would take place and that the parent's perspectives or any concerns they had regarding their care would be included in the review.

d) Quality and safety reports went to board for Q1 on 8th September and Q2 went to board on 8th December. Both reports contain the PMRT board reports with all deaths reviewed by PMRT, actions and that standards a,b and c above were met.

Salisbury NHS Foundation Trust are declaring full compliance with safety action 1.

3.2 Safety action 2:

Are you submitting data to the Maternity Services Data Set (MSDS) to the required standard?

Required standard	This relates to the quality, completeness of the submission to the Maternity Services Data Set (MSDS) and ongoing plans to make improvements.
	1. By 31st October 2022, Trusts have an up to date digital strategy for their maternity services which aligns with the wider Trust Digital Strategy and reflects the 7 success measures within the What Good Looks Like Framework. The strategy must be shared with Local Maternity Systems and be signed off by the Integrated Care Board. As part of this, dedicated Digital Leadership should be in place in the Trust and have engaged with the NHSEI Digital Child Health and Maternity Programme. 2. Trust Boards to assure themselves that at least 9 out of 11 Clinical Quality Improvement Metrics (CQIMs) have passed the associated data quality criteria in the "CNST Maternity Incentive Scheme Year 4 Specific Data Quality Criteria" data file in the Maternity Services Monthly Statistics publication series for data submissions relating to activity in July 2022. The data for July 2022 will be published during October 2022. 3. July 2022 data contained height and weight data, or a calculated Body Mass Index (BMI), recorded by 15+0 weeks gestation for 90% of women reaching 15+0 weeks gestation in the month. 4. July 2022 data contained Complex Social Factor Indicator (at antenatal booking) data for 95% of women booked in the month. 5. July 2022 data contained antenatal personalised care plan fields completed for 95% of women booked in the month. (MSD101/2) 6. July 2022 data contained valid ethnic category (Mother) for at least 90% of women booked in the month. Not stated, missing and not known are not included as valid records for this assessment as they are only expected to be used in exceptional circumstances. (MSD001) 7. Trust Boards to confirm to NHS Resolution that they have passed the associated data quality criteria in the "CNST Maternity Incentive Scheme Year 4 Specific Data Quality Criteria" data file in the Maternity Services Monthly Statistics publication series for data submissions relating to activity in July 2022 for the following metrics: Midwifery Continuity of carer (MCoC) i. Over 5% of women who have an Antenatal Care Plan recorded by 29 weeks and also have the CoC pathway indicator completed. ii. Over 5% of women recorded as being placed on a CoC pathway where both Care Professional ID and Team ID have also been provided. iii. At least 70% of MSD202 Care Activity (Pregnancy) and MSD302 Care Activity (Labour and Delivery) records submitted in the reporting period have a valid Care Professional Local Identifier recorded. Providers submitting zero Care Activity records will fail this criterion.

	Criteria i and ii are the data quality metrics used to determine whether women have been placed on a midwifery continuity of carer pathway by the 28 weeks antenatal appointment, as measured at 29 weeks gestation. Criteria iii are fundamental building blocks and a necessary step towards measuring whether or not women have received midwifery continuity of carer (though it is not the complete measurement). The data for July 2022 will be published in October 2022. If the data quality for criteria 7 are not met, trusts can still pass safety action 2 by evidencing sustained engagement with NHS Digital which at a minimum, includes monthly use of the Data Quality Submission Summary Tool supplied by NHS Digital (see technical guidance for further information)
Minimum evidential requirement for trust Board	1) Criteria 1 will be reported to NHS Resolution as part of trusts' self-declaration using the Board declaration form. 2) For criteria 2 to 7, the "CNST Maternity Incentive Scheme Year 4 Specific Data Quality Criteria" data file in the Maternity Services Monthly Statistics publication series displays whether trusts have passed the requisite data quality thresholds.

1. SFT has an up to date digital strategy presented to the Trust digital strategy group on 20.09.22. This was agreed by the ICB and reviewed by the LMNS.

2-7. SFT scorecard for MSDS submission shows 11 out of 11 CQIMs passed.

Salisbury NHS Foundation Trust are declaring full compliance with safety action 2.

3.3 Safety action 3:

Can you demonstrate that you have transitional care services in place to minimise separation of mothers and their babies and to support the recommendations made in the Avoiding Term Admissions into Neonatal units Programme?

Required standard	a) Pathways of care into transitional care have been jointly approved by maternity and neonatal teams with a focus on minimising separation of mothers and babies. Neonatal teams are involved in decision making and planning care for all babies in transitional care. b) The pathway of care into transitional care has been fully implemented and is audited quarterly. Audit findings are shared with the neonatal safety champion, LMNS, commissioner and Integrated Care System (ICS) quality surveillance meeting each quarter. c)A data recording process (electronic and/or paper based for capturing all term babies transferred to the neonatal unit, regardless of the length of stay, is in place. d) A data recording process for capturing existing transitional care activity, (regardless of place - which could be a Transitional Care (TC), postnatal ward, virtual outreach pathway etc.) has been embedded. If not already in place, a secondary data recording process is set up to inform future capacity management for late preterm babies who could be cared for in a TC setting. The data should capture babies between 34+0-36+6 weeks gestation at birth, who neither had surgery nor were transferred during any admission, to monitor the number of special care or normal care days where supplemental oxygen was not delivered. e) Commissioner returns for Healthcare Resource Groups (HRG) 4/XA04 activity as per Neonatal Critical Care Minimum Data set (NCCMDS) version 2 are available to be shared on request with the operational delivery network (ODN), LMNS and commissioners to inform capacity planning as part

	of the family integrated care component of the Neonatal Critical Care Transformation Review and to inform future development of transitional care to minimise separation of mothers and babies. f) Reviews of babies admitted to the neonatal unit continue on a quarterly basis and findings are shared quarterly with the Board Level Safety Champion. Reviews should now include all neonatal unit transfers or admissions regardless of their length of stay and/or admission to BadgerNet. In addition, reviews should report on the number of transfers to the neonatal unit that would have met current TC admissions criteria but were transferred or admitted to the neonatal unit due to capacity or staffing issues. The review should also record the number of babies that were transferred or admitted or remained on Neonatal Units because of their need for nasogastric tube feeding, but could have been cared for on a TC if nasogastric feeding was supported there. Findings of the review have been shared with the maternity, neonatal and Board level safety champions, LMNS and ICS quality surveillance meeting on a quarterly basis. g) An action plan to address local findings from the audit of the pathway (point b) and Avoiding Term Admissions Into Neonatal units (ATAIN) reviews (point f) has been agreed with the maternity and neonatal safety champions and Board level champion. h) Progress with the revised ATAIN action plan has been shared with the maternity, neonatal and Board level safety champions, LMNS and ICS quality surveillance meeting.
Minimum evidential requirement for trust Board	Board Local policy/pathway available which is based on principles of British Association of Perinatal Medicine (BAPM) transitional care where: Evidence for standard a) to include: · There is evidence of neonatal involvement in care planning · Admission criteria meets a minimum of at least one element of HRG XA04 but could extend beyond to BAPM transitional care framework for practice · There is an explicit staffing model · The policy is signed by maternity/neonatal clinical leads and should have auditable standards. · The policy has been fully implemented and quarterly audits of compliance with the policy are conducted. Evidence for standard b) to include: · An audit trail is available which provides evidence that ongoing audits from year 3 of the maternity incentive scheme of the pathway of care into transitional care are being completed as a minimum of quarterly. If for any reason, reviews have been paused, they should be recommenced using data from quarter 1 of 2022/23 financial year. · Audit findings are shared with the neonatal safety champion on a quarterly basis. Where barriers to achieving full implementation of the policy are encountered, an action plan should be agreed and progress overseen by both the board and neonatal safety champions. Evidence for standard c) to include: · Data is available (electronic and/or paper based) on all term babies transferred or admitted to the neonatal unit. This will include admission data captured via Badgernet as well as transfer data which may be captured on a separate paper or electronic system. · If a data recording process is not already in place to capture all babies transferred or admitted to the NNU this should be in place no later than Monday 18 July 2022. Evidence for standard d) to include: · Data is available (electronic or paper based) on transitional care activity (regardless of place - which could be a TC, postnatal ward, virtual outreach pathway etc.). · Secondary data is available (electronic or paper based) on babies born between 34+0-36+6 weeks gestation at birth, who did not have surgery nor were transferred during any admission, to monitor the number of special care or normal care days where supplemental oxygen was not delivered to inform future capacity management for late preterm babies who could be cared for in a TC setting. Evidence for standard e) to include: · Commissioner returns for Healthcare Resource Groups (HRG) 4/XA04 activity as per Neonatal Critical Care Minimum Data Set (NCCMDS) version 2 are available to share on request, for example to support service development and capacity planning, with the LMNS, ODN and/or commissioner. Evidence for standard f) to include: · An audit trail is available which provides evidence that ongoing reviews from year 3 of the maternity incentive scheme of term admissions are being completed as a minimum of quarterly. If for any reason, reviews have been paused, they should be recommenced using data from quarter 1 of 2022/23 financial year. · If not already in place, an audit trail is available

	which provides evidence that reviews from Monday 18 July 2022, now include all term babies transferred or admitted to the NNU, irrespective of their length of stay, are being completed as a minimum of quarterly. If your reviews already included all babies transferred or admitted to the NNU then this should continue using data from quarter 1 of 2022/23 financial year. · Evidence that the review includes: the number of transfers or admissions to the neonatal unit that would have met current TC admission criteria but were transferred or admitted to the neonatal unit due to capacity or staffing issues and the number of babies that were transferred or admitted to, or remained on NNU because of their need for nasogastric tube feeding, but could have been cared for on a TC if nasogastric feeding was supported there. · Evidence that findings of all reviews of term babies transferred or admitted to a neonatal unit are reviewed quarterly and the findings have been shared quarterly with the maternity and neonatal safety champions and Board level champion, the LMNS and ICS quality surveillance meeting. Evidence for standard g) and h): · An audit trail is available which provides evidence and rationale for developing the agreed action plan to address local findings from the pathway audit (point b) and the ATAIN reviews (point f).Evidence that progress with the action plan has been shared with the neonatal, maternity safety champion, and Board level champion, LMNS and ICS quality surveillance meeting each quarter. · Self-certification by the Trust Board and submitted to NHS Resolution using the Board declaration form

What is the relevant time period?

a) The expectation is that the pathway has been in place since year 2 of the scheme and should now be business as usual. If for any reason this is not in place it should be by Thursday 16 June 2022 at the very latest.

b) The expectation is that the audits have been in place since year 3 of the scheme and should now be business as usual. If for any reason, audits have been paused, they should be recommenced, using data from quarter 1 of 2022/23 financial year and be completed on a quarterly basis. There should be evidence that audit findings are shared with the neonatal safety champion each quarter.

c) Reviews of babies transferred to the neonatal unit, including those not captured on BadgerNet and regardless of length of stay should be in place from no later than Monday 18 July 2022.

d) Data collection process should have been met and in place in year 3 of the scheme. If for any reason it was not, this should be achieved by no later than 16 June 2022. Secondary data collection process for late pre-terms in place by no later than 16 June 2022.

e) Commissioner returns on request – as per ODN request

f) The expectation is that the reviews have been in place since year 3 of the scheme and should now be business as usual. If for any reason, reviews have been paused, they should be recommenced using data from quarter 1 of 2022/23 financial year and be completed on a quarterly basis. Reviews of babies transferred to the neonatal unit, including those not captured on BadgerNet and regardless of length of stay, should be included from Monday 18 July 2022. If your reviews already included all babies transferred or admitted to the NNU then this should continue using data from quarter 1 of 2022/23 financial year. There should be evidence that review findings have been shared quarterly with the maternity and neonatal safety champions and Board level champion, the LMNS and ICS quality surveillance meeting.

g) Evidence of an action plan (to address points b, and f) being agreed with the maternity and neonatal safety champions and Board level champion and signed off by the Board no later than 29 July 2022. h) Evidence of progress with the action plan being shared with the neonatal, maternity safety champion, Board level champion and LMNS and ICS quality surveillance meeting each quarter following sign off at the Board.

Discussion & Evidence:

a) We have a transitional care (TC) pathway embedded and the pathway meets all the standards required, with a focus on minimising separation of mothers and babies. This has been agreed and signed off by clinical leads.

b) Combined audits of TC and ATAIN (avoiding term admission to NICU) have been completed and presented quarterly to our safety champions*. Quarter 1 audit has been presented to the LMNS in May 2022 with ICS oversight, however quarter 2 has not been presented to the LMNS.*

c) The Badgernet database is used by the Trust for all admissions to transitional care and to the neonatal unit.
d) We are using badgernet to code existing transitional care babies, however the process currently includes babies who are coded as being admitted to the NNU for the first 24 hours in many cases. We do not regularly review this data in order to inform future capacity management of transitional care and we plan to develop an action plan to address this in year 5 and decrease the number of babies admitted to the NNU and therefore separated from their carer.
e) All data containing HRG codes available to ODN upon request using this database.
f) Reviews of babies admitted to the neonatal unit have not included those babies who would have been admitted to a transitional care area had we had the capacity in staffing or infrastructure to accommodate this. We have an unequitable system where those women who require more intensive postnatal care may still be separated from their babies and we are not regularly reviewing this as part of our audit.
g) The current action plan from the regular audit of term admissions to the NNU is not robust. It does not reflect timeframes for actions or owners of actions.
h) Quarter 1 audit for ATAIN has been shared with safety champions, LMNS and ICS, however quarter 2 has not been presented outside of the Trust.

Salisbury NHS Foundation Trust are NOT declaring full compliance with safety action 3.

3.4 Safety action 4:

Can you demonstrate an effective system of clinical workforce planning to the required standard?

Required standard	a) Obstetric medical workforce 1. 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 https://www.e-lfh.org.uk/programmes/avoiding-term-admissions-into-neonatal-units/ https://www.england.nhs.uk/coronavirus/wp-content/uploads/sites/52/2020/04/Illness-in-newborn-babies-leaflet-FINAL-070420.pdf Implementing-the-Recommendations-of-the-Neonatal-Critical-Care-Transformation-Review-FINAL.pdf (england.nhs.uk) consultant providing acute care in obstetrics and gynaecology' into their service: https://www.rcog.org.uk/en/careers-training/workplace-workforce-issues/roles-responsibilities-consultant-report/ 2. Units should monitor their compliance of consultant attendance for the clinical situations listed in this 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 LMNS. b) Anaesthetic medical workforce 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) c) Neonatal medical workforce The neonatal unit 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. If the requirements had been met in year 3 without the need of developing an action plan to address deficiencies, however they

	are not met in year 4, Trust Board should develop an action plan in year 4 of MIS to address deficiencies. d) Neonatal nursing workforce The neonatal unit meets the service specification for neonatal nursing standards. 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. If the requirements had been met in year 3 without the need of developing an action plan to address deficiencies, however they are not met in year 4, Trust Board should develop an action plan in year 4 of MIS to address deficiencies and share this with the Royal College of Nursing, LMNS and Neonatal Operational Delivery Network (ODN) Lead.
Minimum evidential requirement for trust Board	Obstetric medical workforce Sign off at Trust Board level acknowledging engagement with the RCOG document along with an action plan to review any non-attendance to the clinical situations listed in the document. Trusts should evidence their position with the Trust Board, Trust Board level safety champions and meetings at least once from the relaunch of MIS year 4 in May 2022. LMNS Anaesthetic medical workforce The rota should be used to evidence compliance with ACSA standard 1.7.2.1. Neonatal medical workforce The Trust is required to formally record in Trust Board minutes whether it meets the recommendations of the neonatal medical workforce. If the requirements are not met, Trust Board should evidence progress against the action plan developed in year 3 of MIS to address deficiencies. Neonatal nursing workforce The Trust is required to formally record to the Trust Board minutes the compliance to the service specification standards annually using the neonatal clinical reference group nursing workforce calculator. For units that do not meet the standard, the Trust Board should evidence progress against the action plan developed in year 3 of MIS to address deficiencies. A copy of the action plan, outlining progress against each of the actions, should be submitted to the Royal College of Nursing (cypadmin@rcn.org.uk), LMNS and Neonatal Operational Delivery Network (ODN) Lead.

Obstetric workforce

The maternity team and obstetricians acknowledge and incorporate the principles of the RCOG document. The policy for the Trust was approved by maternity governance and published in July 2021 and updated in October 2022.
This SOP can be accessed by following this link
SOP of Responsibilities of the On Call Consultant (microguide.global)
An audit has been completed monthly and included in the gap analysis for this action. This audit and SOP have also been shared with the safety champions.
The RCOG document can be accessed here
https://www.rcog.org.uk/en/careers-training/workplace-workforce-issues/roles-responsibilities-consultant-report/ 2.

Aneasthetic workforce

The anaesthetic rota is compliant with ACSA 1.7.2.1. A six month rota is included as evidence.

Neonatal Medical Workforce

The neonatal unit does not meet the British Association of Perinatal Medicine (BAPM) national standards of junior medical staffing. The Trust has accepted that our small unit is staffed safely with our current staffing structure described below and furthermore is aware of the likely future redesignation of the neonatal unit to a level 3 unit.
To meet the current standard we would require a tier 1 doctor to cover the neonatal unit exclusively rather than our current model of having them split across paediatrics. This has been reviewed through the quarterly Q&S report with the maternity safety champions at the May 2022 meeting and through Trust Board at the September 2022 meeting.

Descriptions of paediatric medical roles in SFT
Tier 1 - GPVTS ST1/2 or F2 or trust grade SHO

Tier 2 - paediatric ST3-8 or consultant out of hours (shared with general paediatric service)

Monday – Fri 09.00- 17.00
Tier 1 - 1 doctor on rota for NICU / PNW / Deliveries
Tier 2 - joint cover for NICU / maternity and general paediatrics (minimum 1 doctor)
Tier 3 – consultant cover

Monday - Friday 17.00-21.00

Tier 1 - 1 doctor joint NICU and general paediatrics
Tier 2 - 1 doctor joint cover NICU and general paediatrics (usually ST3-8)
Tier 3 – consultant on call cover

Monday - Friday 21.00-09.00 and weekends 24 /7

Tier 1 - 1 doctor covering NICU and general paediatrics
Tier 2 - 1 doctor covering NICU and general paediatrics. At night this is most likely to be covered by a consultant but there are some registrar night shifts and some consultant long day shifts at the weekend
Tier 3 – consultant on call cover for both areas

To date the mitigating factors have been:

1. Overnight it is usually a resident consultant on site with a second consultant available from home in case of twins etc., though this is the majority of nights (approx. 80%) it does not apply every night.

2. We are a relatively small DGH in terms of both NICU cots and paediatric unit.

3. General Paediatric /NICU / maternity areas are in close proximity.

4. NICU nurses undertake some extended roles including attending preterm or difficult deliveries with the medical team, bloods and IV cannulas

Neonatal nursing workforce

The Trust has submitted a neonatal workforce paper to the Trust board outlining an action plan to increase the percentage of shifts covered by nurses with QIS (qualified in specialty). The calculation tool recommended for the workforce review was used in September 2022 and shows a QIS percentage of 63% when the standard is 70%. A full action plan will be submitted to the RCN, LMNS and ODN lead as required.

Salisbury NHS Foundation Trust are declaring full compliance with safety action 4.

3.5 Safety action 5:

Can you demonstrate an effective system of midwifery workforce planning to the required standard?

Required standard	a) A systematic, evidence-based process to calculate midwifery staffing establishment is completed. b) Trust Board to evidence midwifery staffing budget reflects establishment as calculated in a) above. c) The midwifery coordinator in charge of labour ward must have supernumerary status; (defined as having no caseload of their own during their shift) to ensure there is an oversight of all birth activity within the service d) All women in active labour receive one-to-one midwifery care e) Submit a midwifery staffing oversight report that covers staffing/safety issues to the Board every 6 months, during the maternity incentive scheme year four reporting period.
Minimum evidential requirement for trust Board	The report submitted will comprise evidence to support a, b and c progress or achievement. It should include: · · A clear breakdown of BirthRate+ or equivalent calculations to demonstrate how the required establishment has been calculated · · In line with midwifery staffing recommendations from Ockenden, Trust Boards must provide evidence (documented in Board minutes) of funded establishment being compliant with outcomes of BirthRate+ or equivalent calculations. · · Where Trusts are not compliant with a funded establishment based on BirthRate+ or equivalent calculations, Trust Board minutes must show the agreed plan, including timescale for achieving the appropriate uplift in funded establishment. The plan must include mitigation to cover any shortfalls. · · The plan to address the findings from the full audit or table-top exercise of BirthRate+ or equivalent undertaken, where deficits in staffing levels have been identified must be shared with the local commissioners. · · Details of planned versus actual midwifery staffing levels to include evidence of mitigation/escalation for managing a shortfall in staffing. · -The midwife to birth ratio · -The percentage of specialist midwives employed and mitigation to cover any inconsistencies. BirthRate+ accounts for 8-10% of the establishment, which are not included in clinical numbers. This includes those in management positions and specialist midwives. · · Evidence from an acuity tool (may be locally developed), local audit, and/or local dashboard figures demonstrating 100% compliance with supernumerary labour ward co-ordinator status and the provision of one-to-one care in active labour. Must include plan for mitigation/escalation to cover any shortfalls.
What is the relevant time period?	From 6 May 2022 until 5 December 2022

a) Birth rate plus was last calculated in December 2019 and will be re-calculated in 2023.
b) Six monthly staffing reports to CGC and up to Trust board submitted with evidence of birthrate+ calculation. Trust board have previously agreed to fund establishment in line with this calculation and this is reflected in our budget. No further documented discussion of this agreement, however, has been shown in board minutes as requested by CNST – see conclusion for action to minute agreement.
c) The midwife on the labour ward is supernumerary and this is audited in real time using the acuity tool every 4 hours. Each occasion when this has been breached is reviewed, reported via datix and it has been only sporadic and not a recurrent event.
d) All women in labour within our Trust receive 1:1 midwifery care.
e) The supernumerary status of the labour ward co-ordinator and midwife to birth ratio are included in each six monthly maternity staffing report. All reports are discussed thoroughly at CGC and noted in escalation to board.

Salisbury NHS Foundation Trust are declaring full compliance with safety action 5.

3.6 Safety action 6:

Can you demonstrate compliance with all five elements of the Saving Babies' Lives care bundle version two?

Required standard	1. Trust Board level consideration of how its organisation is complying with the Saving Babies' Lives care bundle version two (SBLCBv2), published in April 2019. Note: Full implementation of the SBLCBv2 is included in the 2020/21 standard contract. 2. Each element of the SBLCBv2 should have been implemented. Trusts can implement an alternative intervention to deliver an element of the care bundle if it has been agreed with their commissioner (CCG). It is important that specific variations from the pathways described within SBLCBv2 are also agreed as acceptable clinical practice by their Clinical Network 3. The quarterly care bundle survey should be completed until the provider trust has fully implemented the SBLCBv2 including the data submission requirements. The survey will be distributed by the Clinical Networks and should be completed and returned to the Clinical Network or directly to England.maternitytransformation@nhs.net from May 2022 onwards. Evidence of the completed quarterly care bundle surveys should be submitted to the Trust board.
Minimum evidential requirement for trust Board	Element one Process indicators: A. Percentage of women where Carbon Monoxide (CO) measurement at booking is recorded. B. Percentage of women where CO measurement at 36 weeks is recorded. Note: The relevant data items for these process indicators should be recorded on the provider's Maternity Information System (MIS) and included in the MSDS submissions to NHS Digital in an MSDSv2 Information Standard Notice compatible format, including SNOMED-CT coding. The Trust board should receive data from the organisation's MIS evidencing an average of 80% compliance over a four month period (i.e. four consecutive months in during the MIS year 4 reporting timeframe). If there is a delay in the provider Trust's ability to submit these data to MSDS then compliance can be determined using their interim data recording method. The denominator should still be the total number of women at booking or 36 weeks gestation, as appropriate for each process indicator. If the provider Trust is unable to record these data on their maternity information system an audit of 60 consecutive cases would be acceptable evidence to demonstrate >80% of women

	having a CO measurement recorded at 36 weeks. The denominator for the audit should be 60 consecutive women at 36 weeks gestation, whereas the denominator for the electronic audit would be the total number of women at 36 weeks gestation. In addition to this, the audit should be accompanied by a brief description of the stop smoking strategy within the Trust and any plans for improvement. **A Trust will fail Safety Action 6 if the process indicator metric compliance is less than 80%. If the process indicator scores are less than 95% Trusts must also have an action plan for achieving >95%.** In addition, the Trust board should specifically confirm that within their organisation they: 1) Pass the data quality rating on the National Maternity Dashboard for the 'women who currently smoke at booking appointment' Clinical Quality Improvement Metric. 2) Have a referral pathway to smoking cessation services (in house or external). 3) Audit of 20 consecutive cases of women with a CO measurement ≥4ppm at booking, to determine the proportion of women who were referred to a smoking cessation service. 4) Have generated and reviewed the following outcome indicators within the Trust for four consecutive months within the MIS year 4 reporting period: · Percentage of women with a CO measurement ≥4ppm at booking. · Percentage of women with a CO measurement ≥4ppm at 36 weeks. · Percentage of women who have a CO level ≥4ppm at booking who subsequently have a CO level <4ppm at the 36 week appointment. <u>Additional information</u> If your Trust is planning on using the maternity dashboard to evidence an average of 80% compliance over four months, please be advised that there is a three month delay with MSDSv2 data, for example data submitted at the end of August 2022 will be published on the dashboard at the end of November 2022. If your Trust does not have an in house stop smoking service or a pathway to an external service, please contact your local authority stop smoking service or escalate to your local maternity system to enable the Trust to ensure provision is in place. **Percentage of women where Carbon Monoxide (CO) measurement at booking is recorded.** **Women declining CO testing at booking / 36 weeks appointment** Standard A and B of element 1 require Trusts to demonstrate that 80% of women had CO testing at booking and at 36 weeks respectively and that this is recorded in the Trusts' information system. In the event of a high number of women declining CO testing a Trust would be at risk of failing standard A and B by not reaching the 80% testing rate. We suggest Trusts proactively monitor their testing rate and consider interventions to maintain adequate compliance. Element two Process indicator: 1) Percentage of pregnancies where a risk status for fetal growth restriction (FGR) is identified and recorded using a risk assessment pathway at booking and at the 20 week scan (e.g. Appendix D).

	Note: The relevant data items for these indicators should be recorded on the provider's Maternity Information System and included in the MSDS submissions to NHS Digital in an MSDSv2 Information Standard Notice compatible format, including SNOMED-CT coding. The Trust board should receive data from the organisation's MIS evidencing 80% compliance. If there is a delay in the provider Trust Maternity Information System's ability to record these data at the time of submission an in house audit of 40 consecutive cases of women at 20 weeks scan using locally available data or case records should have been undertaken to assess compliance with this indicator. **A Trust will fail Safety Action 6 if the process indicator metric compliance is less than 80%. If the process indicator scores are less than 95% Trusts must also have an action plan for achieving >95%.** In addition the Trust board should specifically confirm that within their organisation: 2) Women with a BMI>35 kg/m2 are offered ultrasound assessment of growth from 32 weeks' gestation onwards 3) In pregnancies identified as high risk at booking uterine artery Doppler flow velocimetry is performed by 24 completed weeks gestation 4) There is a quarterly audit of the percentage of babies born <3rd centile >37+6 weeks' gestation. 5) They have generated and reviewed the percentage of perinatal mortality cases for 2021 where the identification and management of FGR was a relevant issue (using the PMRT). 6) Their risk assessment and management of growth disorders in multiple pregnancy complies with NICE guidance or a variant has been agreed with local commissioners (CCGs) following advice from the Clinical Network. 7) They undertake a quarterly review of a minimum of 10 cases of babies that were born <3rd centile >37+6 weeks' gestation. The review should seek to identify themes that can contribute to FGR not being detected (e.g. components of element 2 pathway and/or scanning related issues). The Trust board should be provided with evidence of quality improvement initiatives to address any identified problems. Trusts can omit the above mentioned quarterly review of a minimum of 10 cases of babies that were born <3rd centile >37+6 weeks' gestation for quarter 3 of this financial year (2021/22) if staffing is critical and this directly frees up staff for the provision of clinical care. Element three Process indicators: A. Percentage of women booked for antenatal care who had received reduced fetal movements leaflet/information by 28+0 weeks of pregnancy. B. Percentage of women who attend with RFM who have a com B. puterised CTG (a computerised system that as a minimum provides assessment of short term variation). Note: The SNOMED CT code is still under development for RFM and therefore an in-house audit of two weeks' worth of cases or 20 cases of women attending with RFM whichever is the smaller to assess compliance with the element three process indicators. **A Trust will fail Safety Action 6 if the process indicator metric compliance is less than 80%. If the process**

	indicator scores are less than 95% Trusts must also have an action plan for achieving >95% Element four There should be Trust board sign off that staff training on using their local CTG machines, as well as fetal monitoring in labour are conducted annually. The fetal monitoring sessions should be consistent with the Ockenden Report recommendations, and include: intermittent auscultation, electronic fetal monitoring with system level issues e.g. human factors, escalation and situational awareness. The Trust board should specifically confirm that within their organization 90% of eligible staff (see Safety Action 8) have attended local multi-professional fetal monitoring training annually as above. Please refer to safety action 8 for more information re training. Element five Process indicators: A. Percentage of singleton live births (less than 34+0 weeks) receiving a full course of antenatal corticosteroids, within seven days of birth. B. Percentage of singleton live births occurring more than seven days after completion of their first course of antenatal corticosteroids. C. Percentage of singleton live births (less than 30+0 weeks) receiving magnesium sulphate within 24 hours prior birth. D. Percentage of women who give birth in an appropriate care setting for gestation (in accordance with local ODN guidance). Note: The relevant data items for these process indicators should be recorded on the provider's Maternity Information System and included in the MSDS submissions to NHS Digital in an MSDSv2 Information Standard Notice compatible format, including SNOMED-CT coding. If there is a delay in the provider Trust MIS's ability to record these data then an audit of 40 cases consisting of 20 consecutive cases of women presenting with threatened preterm labour before 34 weeks and 20 consecutive cases of women who have given birth before 34 weeks using locally available data or case records should have been undertaken to assess compliance with each of the process indicators. The Trust board should receive data from the organisation's Maternity Information System evidencing 80% compliance with process indicators A, C and D. The percentage for process indicator B should be as low as possible and can be reported as the proportion. **A Trust will not fail Safety Action 6 if the process indicator scores are less than 80%. However, Trusts must have an action plan for achieving >80%.** In addition, the Trust board should specifically confirm that within their organisation: · They have a dedicated Lead Consultant Obstetrician with demonstrated experience to focus on and champion best practice in preterm birth prevention. (Best practice would be to also appoint a dedicated Lead Midwife. Further guidance/information on preterm birth clinics can be found on

	https://www.tommys.org/sites/default/files/2021-03/reducing%20preterm%20birth%20guidance%2019.pdf · - Women at high risk of preterm birth have access to a specialist preterm birth clinic where transvaginal ultrasound to assess cervical length is provided. If this is not the case the board should describe the alternative intervention that has been agreed with their commissioner (CCG) and that their Clinical Network has agreed is acceptable clinical practice. · An audit of 40 consecutive cases of women booking for antenatal care has been completed to measure the percentage of women that are assessed at booking for the risk of preterm birth and stratified to low, intermediate and high risk pathways, and the percentage of those assessed to be at increased risk that are referred to the appropriate preterm birth clinic and pathway. The assessment should use the criteria in Appendix F of SBLCBv2 or an alternative which has been agreed with local CCGs following advice from the Clinical Network. · Their risk assessment and management in multiple pregnancy complies with NICE guidance or a variant that has been agreed with local commissioners (CCGs) following advice from the provider's clinical network.

The bundle is designed to tackle stillbirth and early neonatal death. It brings together five Elements of care:

1. Smoking
2. Fetal Growth Restriction
3. Reduced Fetal Movements
4. Fetal Monitoring
5. Preterm Birth

1. *Trust Board level consideration of how its organisation is complying with the Saving Babies' Lives care bundle version two (SBLCBv2), published in April 2019*. The Trust board receives a quarterly quality & safety report reviewing progress on the saving babies' lives care bundle and this is also discussed through the maternity safety champion meetings.

2. The Trust has not yet fully implemented every element of the saving babies lives care bundle. The table below shows the current compliance and progress on compliance.

3. The quarterly care bundle survey is being completed by the Trust.

Table 2.- Compliance with the 5 elements

Element one	RAG scoring	Narrative
A. Percentage of women where Carbon Monoxide (CO) measurement at booking is recorded		Regular audits show compliance of over 70% on consecutive audit but action plans have not been robust.
B. Percentage of women where CO measurement at 36 weeks is recorded		Percentage over 90% on consecutive cases audit.
In addition, the Trust board should specifically confirm that within their organisation they: 1) Pass the data quality rating on the National Maternity Dashboard for the 'women who currently smoke at booking appointment' Clinical Quality Improvement Metric. 2) Have a referral pathway to smoking cessation services (in house or external). 3) Audit of 20 consecutive cases of women with a CO measurement ≥4ppm at booking, to determine the proportion of women who were referred to a smoking cessation service. 4) Have generated and reviewed the following outcome indicators within the Trust for four consecutive months within the MIS year 4 reporting period: · Percentage of women with a CO measurement ≥4ppm at booking. · Percentage of women with a CO measurement ≥4ppm at 36 weeks. · Percentage of women who have a CO level ≥4ppm at booking who subsequently have a CO level <4ppm at the 36 week appointment.		1) Passed 2) Pathway in place 3) regular audits quarterly **but not including referrals and so we are unable to evidence this.** 4) quarterly audits include all three measures

Element two:	RAG scoring	Narrative
A. Percentage of pregnancies where a risk status for fetal growth restriction (FGR) is identified and recorded at booking and at 20 weeks. In addition the Trust board should specifically confirm that within their organisation: 1) Women with a BMI>35 kg/m2 are offered ultrasound assessment of growth from 32 weeks' gestation onwards. 2) in pregnancies identified as high risk at booking uterine artery Doppler flow velocimetry is performed by 24 completed weeks gestation. 3) There is a quarterly audit of the percentage of babies born <3rd centile >37+6 weeks' gestation. 4) They have generated and reviewed the percentage of perinatal mortality cases for 2021 where the identification and management of FGR was a relevant issue (using the PMRT). 5) Their risk assessment and management of growth disorders in multiple pregnancy complies with NICE guidance or a variant has been agreed with local commissioners (CCGs) following advice from the Clinical Network. 6) They undertake a quarterly review of a minimum of 10 cases of babies that were born <3rd centile >37+6 weeks' gestation. The review should seek to identify themes that can contribute to FGR not being detected (e.g. components of element 2 pathway and/or scanning related issues).		Risk assessment not done at 20 weeks as this is not a time for routine review along the patient pathway. Benchmarking with other Trusts reveals that alternative pathways agreed with other CCGs within clinical network. Action plan to be produced to address this. 1.offered from 28 weeks 2.UAD not offered, alternative pathway for assessment discussed with CCG. 3.quaterly audits completed 4. There has been auditing of PMRT cases where FGR was a relevant issue but the governance process ensuring that the review is discussed and a relevant action plan generated is not robust 5.Guideline on microguide complies with NICE guidance. 6.regular audit of cases of babies born at term who are FGR takes place but once again governance processes are not robust. The next steps are to ensure discussion at appropriate governance meetings of themes and action plans.

The Trust board should be provided with evidence of quality improvement initiatives to address any identified problems.		
Element three	**RAG scoring**	**Narrative**
A. Percentage of women booked for antenatal care who had received leaflet/information by 28+0 weeks of pregnancy		100% compliance on regular audits
B. Percentage of women who attend with RFM who have a computerised CTG.		100% compliance on regular audits
Element four	**RAG scoring**	**Narrative**
A. Percentage of staff who have received training on intrapartum fetal monitoring in line with the requirements of Safety Action eight, including: intermittent auscultation, electronic fetal monitoring, human factors and situational awareness. annual competency assessment		See SA 8
B. Percentage of staff who have successfully completed mandatory annual competency assessment		See SA 8
Element 5	**RAG scoring**	**Narrative**
A. Percentage of singleton live births (less than 34+0 weeks) receiving a full course of antenatal corticosteroids, within seven days of birth.		Most recent audit shows 55% of women receive full course of steroids, action plan needed to achieve >80% which will then confirm compliance.
B. Percentage of singleton live births (less than 30+0 weeks) receiving magnesium sulphate within 24 hours prior birth.		
C. Percentage of women who give birth in an appropriate care setting for gestation (in accordance with local ODN guidance).		

Additional requirements have been met. Preterm lead clinicians are identified, and two specialist clinics are embedded to review all women at risk and include transvaginal scanning. A recent audit of notes shows that 87.5% of women are risk assessed at booking into low, intermediate and high-risk groups, however the cases were not consecutive and so repeated audit will be undertaken.

Salisbury NHS Foundation Trust are NOT declaring full compliance with safety action 6.

3.7 Safety action 7:

Can you demonstrate that you have a mechanism for gathering service user feedback, and that you work with service users through your Maternity Voices Partnership (MVP) to coproduce local maternity services?

Required standard	Can you demonstrate that you have a mechanism for gathering service user feedback, and that you work with service users through your Maternity Voices Partnership (MVP) to coproduce local maternity services?
Minimum evidential requirement for trust Board	Evidence should include: · Terms of Reference for your MVP. They reflect the core principles for Terms of Reference for a MVP as outlined in annex B of Implementing Better Births: A resource pack for Local Maternity Systems · Minutes of MVP meetings demonstrating how service users are listened to and how regular feedback is obtained, that actions are in place to demonstrate that listening has taken place and evidence of service developments resulting from coproduction between service users and staff. · Written confirmation from the service user chair that they are being remunerated as agreed and that this remuneration reflects the time commitment and requirements of the role given the agreed work programme. Remuneration should take place in line with agreed Trust processes. · The MVP's work programme, minutes of the MVP meeting which agreed it and minutes of the LMNS board that ratified it · Written confirmation from the service user chair that they and other service user members of the MVP committee are able to claim out of pocket expenses, including travel, parking and childcare costs in a timely way. · Evidence that the MVP is prioritising hearing the voices of women from Black, Asian and Minority Ethnic backgrounds and women living in areas with high levels of deprivation, given the findings in the MBRRACE-UK reports about maternal death and morbidity and perinatal mortality. · Evidence that the MVP Chair is invited to attend maternity governance meetings and that actions from maternity governance meetings, including complaints' response processes, trends and themes, are shared with the MVP
What is the relevant time period?	From 6 May 2022 until 5 December 2022

Our mechanisms for service user feedback is through the family experience midwife and includes……

A Maternity Voices Partnership plus (MVPP) group is a multidisciplinary NHS working group for review and coproduction of local maternity services. The MVP is a conduit between service users and maternity and neonatal services and works collaboratively within the LMNS.

The MVPP meets with services within the LMNS and the MVPP Chair is represented on the operational and board LMNS meetings which are monthly and attended by SFT representatives from the maternity unit. The MVPP reflects the experiences of the local community but remains independent and accessible to all sections of the community. Within the maternity incentive scheme period the MVPP have worked collaboratively with SFT to co-produce the local maternity service and the local MVPP representative meets monthly with the Family Experience Midwife to facilitate this. Examples of this work are:

- Increasing women's choice of place of birth- opening in October 2022 the alongside midwifery unit.
- Involvement of MVPP on BAME working safety summit held in April 2022.
- Attendance at local governance meetings
- Involvement of reviewing policies – infant feeding
- Working with the Family Experience Midwife around complaints and compliments from users.
- Using social media
- Feedback to SFT from users
- Allowing birth partners on postnatal ward overnight

The LMNS has signed off the MVP work programme which also includes prioritisation of minority groups.

Salisbury NHS Foundation Trust are declaring full compliance with safety action 7.

3.8 Safety action 8:

Can you evidence that a local training plan is in place to ensure that all six core modules of the Core Competency Framework will be included in your unit training programme over the next 3 years, starting from the launch of MIS year 4?

In addition, can you evidence that at least 90% of each relevant maternity unit staff group has attended an 'in house', one-day, multi-professional training day which includes a selection of maternity emergencies, antenatal and intrapartum fetal surveillance and newborn life support, starting from the launch of MIS year 4?

Required standard and Minimum evidential requirement	Can you evidence that: a) A local training plan is in place to ensure that all six core modules of the Core Competency Framework, will be included in your unit training programme over 3 years, starting from the launch of MIS year 4 in August 2021. b) 90% of each relevant maternity unit staff group have attended an 'in house' one day multi-professional training day, that includes maternity emergencies starting from the launch of MIS year four in August 2021? c) 90% of each relevant maternity unit staff group have attended an 'in-house' one day multi-professional training day that includes antenatal and intrapartum fetal monitoring, starting from the launch of MIS year four in August 2021.

	d) Can you evidence that 90% of the team required to be involved in immediate resuscitation of the newborn and management of the deteriorating newborn infant have attended in-house neonatal life support training or a Newborn Life Support (NLS) course starting from the launch of MIS year four in August 2021..
What is the relevant time period?	Any 12 consecutive months within the period: 1st August 2021 until 5th December 2022

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a) A local training plan detailing the introduction of the six core modules has been commenced, with all training being delivered to staff by August 2024.
b) Compliance with PROMPT for 12 consecutive months ending on December 5th 202, is shown in table 3. 90% or more of each relevant maternity unit staff group have attended an 'in house' one day multi-professional training day, that includes maternity emergencies

Table 3.

MDT PROMPT TRAINNG	
Staff group	Compliance
Midwives	96.64%
MCA's	90.70%
Obstetricians – consultants	90.9%
Obstetricians – other grades	92.3%
Anaesthetists consultants	96.88%
Anaesthetists – other	not applicable 0%

c) Compliance with fetal monitoring as of December 5th, 2022, is shown in table 4. We have not achieved compliance with non-consultant doctors.

Table 4.

Fetal monitoring	
Staff group	Compliance
Midwives	93.69%
Obstetricians - consultants	100%
Obstetricians – other grades	84.6% (11 out of 13)

d) Compliance with newborn life support training as of December 5th 2022, is shown in table 5. We have not achieved compliance with the non-consultant grades of paediatricians as we only have 9 doctors and 8 are trained.

Table 5

Newborn Life support	
Staff group	Compliance
Midwives	92.79%
Neonatal nurses	100%
Paediatricians - consultants	90.9%
Paediatricians – other grades	88.8% (8 out of 9)

Salisbury NHS Foundation Trust are NOT declaring full compliance with safety action 8.

3.9 Safety action 9:

Can you demonstrate that there are robust processes in place to provide assurance to the Board on maternity and neonatal safety and quality issues?

Required standard	a)The pathway developed in year 3, that describes how safety intelligence is shared from floor to Board, through local maternity and neonatal systems (LMNS), and the Regional Chief Midwife has been reviewed in line with the implementing-a-revised-perinatal-quality-surveillance-model.pdf (england.nhs.uk) The revised pathway should formalise how Trust-level intelligence will be shared with new LMNS/ICS and regional quality groups to ensure early action and support is provided for areas of concern or need. b) Board level safety champions present a locally agreed dashboard to the Board quarterly, including; the number of incidents reported as serious harm, themes identified and actions being taken to address any issues; staff feedback from frontline champions and walk-abouts; minimum staffing in maternity services and training compliance are taking place at Board level no later than 16 June 2022. NB, The training update should include any modifications made as a result of the pandemic / current challenges and a rough timeline of how training will be rescheduled later this year if required. This additional level of training detail will be expected by 16 June 2022. c) Trust Boards have reviewed current staffing in the context of the letters to systems on 1 April 2022 and 21 September 2022 regarding the roll out of Midwifery Continuity of Carer as the default model of care. A decision has been made by the Board as to whether staffing meets safe minimum requirements to continue rollout of current or planned MCoC teams, or whether rollout should be suspended d) Board level and maternity safety champions are actively supporting capacity and capability building for staff to be involved in the Maternity and Neonatal Safety Improvement Programme (MatNeoSIP)
Minimum evidential requirement for trust Board	· Evidence of a revised pathway which describes how frontline midwifery, neonatal, obstetric and Board safety champions share safety intelligence between a) each other, b) the Board, c) new LMNS/ICS quality group and d) regional quality groups involving the Regional Chief Midwife and Lead Obstetrician to ensure early action and support is provided for areas of concern or need in line with the perinatal quality surveillance model. · · Evidence that a clear description of the pathway and names of safety champions are visible to maternity and neonatal staff. · · Evidence 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 feedback from frontline champions and engagement sessions; minimum staffing in maternity services and training compliance are taking place at Board level no later than 16 June 2022. NB- The training update should include any modifications made as a result of the pandemic / current challenges and a rough timeline of how training will be rescheduled later this year if required. This additional level of training detail will be expected by 16 June 2022.

	· · Evidence of the engagement sessions (e.g. staff feedback meeting, staff walkaround sessions etc.) being undertaken by a member of the Board. · · Evidence of progress with actioning named concerns from staff workarounds are visible to both maternity and neonatal staff and reflects action and progress made on identified concerns raised by staff and service users. · · Evidence that the Trust's claims scorecard is reviewed alongside incident and complaint data and discussed by the maternity, neonatal and Trust Board level safety champions to help target interventions aimed at improving patient safety at least twice in the MIS reporting period at a Trust level quality meeting. This can be a board or directorate level meeting. · Evidence for point c): This is to be evidenced by a minuted Board level discussion and decision since 1 April 2022 on how a Trust's current workforce position should determine current and future rollout of MCoC. Where more than one discussion has taken place, the most recent evidence should be submitted. · Evidence for point d): Evidence of how the Board and Safety Champions have supported staff involved in part d) of the required standard and specifically in relation to: · active participation by staff in contributing to the delivery of the collective aims of the MatNeo Patient Safety Networks, and undertaking of specific improvement work aligned to the MatNeoSIP national driver diagram and key enabling activities · engagement in relevant improvement/capability building initiatives nationally, regionally or via the MatNeo Patient Safety Networks, of which the Trust is a member · support for clinicians identified as MatNeoSIP Improvement Leaders to facilitate and lead work through the MatNeo Patient Safety Networks and the National MatNeoSIP network · utilise insights from culture surveys undertaken to inform local quality improvement plans · maintain oversight of improvement outcomes and learning, and ensure intelligence is actively shared with key system stakeholders for the purpose of improvement
What is the relevant time period?	Time period for points a and b) · Evidence of a revised written pathway, in line with the perinatal quality surveillance model, that is visible to staff and meets the requirements detailed in part a) and b) of the action is in place no later than 16 June 2022. The expectation is that work has already commenced on this in line with the Ockenden response (Ockenden, 2021). · Evidence 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 feedback from frontline champions and walk-abouts; minimum staffing in maternity services and training compliance are taking place at Board level no later than 16 June 2022. NB, The training update should include any modifications made as a result of the pandemic / current challenges and a rough timeline of how training will be rescheduled later this year if required. This additional level of training detail will be expected by 16 June 2022. · The expectation is that quarterly engagement sessions have continued from year 3 of the scheme. If for any reason these have been paused, they should be recommenced no later than 16 June 2022. The reason for pausing feedback sessions should be captured in the minutes of the Board meeting, detailing mitigating actions to prevent future disruption to these sessions. · Progress with actioning named concerns from staff engagement sessions are visible to both maternity and neonatal staff and reflects action and progress made on identified concerns raised by staff and service users from no later than 16 June 2022. · Evidence that the Trust's claims scorecard is reviewed alongside incident and complaint data and discussed by the maternity, neonatal and Trust Board level safety champions at a Trust level (board or directorate) quality meeting each quarter, beginning no later than quarter 2 of 2022/23 (July 2022). Time period for points c) · Board level discussion and decision since 1st April 2022 on how a trust's current workforce position should determine current and future rollout of MCoC. Where more than one discussion has taken place, the most recent evidence should be submitted. Time period for points d) · Attendance or representation at a minimum of two engagement events such as Patient Safety Network meetings, MatNeoSIP webinars and/or the annual national learning event by 5th December 2022.

	· Evidence that insights from culture surveys undertaken have been used to inform local quality improvement plans by 5th December 2022.

a) The revised pathway for maternity safety champions formalises how Trust-level intelligence will be shared with new LMNS/ICS and regional quality groups to ensure early action and support is provided for areas of concern or need and is visible in all clinical areas for staff.
b) The quarterly quality & safety reports to Trust board and the monthly IPR report on all of the agreed metrics in this action. Board safety champions undertake a walk round of the department bimonthly to hear any concerns raised by staff relating to safety issues. Progress on actions from walk abouts and staff feedback is collated and reviewed and has been made available to staff in 'you said, we did' format on the NNU. Replication of this for any issues raised in maternity is planned. The Trust has **not** reviewed it's claims scorecard alongside incident and complaint data and discussed by the maternity, neonatal and Trust Board level safety champions to help target interventions aimed at improving patient safety at least twice in the MIS reporting period at a Trust level quality meeting and therefore cannot claim compliance with this action.
c) The Trust has reviewed it's ability to move ahead with the continuity of carer model based on current workforce regularly within 2021/22. The current workforce position has determined that we suspend CoC rollout at SFT.
d) Safety champions have supported attendance at MatNeoSIP learning events in 2022 – the Q&S matron and DOM have both been enabled to attend learning event webinars. We have also been actively engaged in the PeriPREM programme which is being embedded as a new quality improvement project. Learning from our culture score survey has lead to a unit-wide project with an external coaching company called the 'changemaker group' and the progress with this has been shared with the Trust board. A new behaviour charter is in draft form on the back of this work.

Salisbury NHS Foundation Trust are NOT declaring full compliance with safety action 9.

3.10 Safety action 10:

Have you reported 100% of qualifying cases to Healthcare Safety Investigation Branch (HSIB) and to NHS Resolution's Early Notification (EN) Scheme from 1 April 2021 to 5 December 2022?

Required standard	A) Reporting of all qualifying cases to HSIB from 1 April 2021 to 5 December 2022 2. B) Reporting of all qualifying EN cases to NHS Resolution's Early Notification (EN) Scheme from 1 April 2022 until 5 December 2022 3. C) For all qualifying cases which have occurred during the period 1 April 2021 to 5 December 2022, the Trust Board are assured that: 1. the family have received information on the role of HSIB and NHS Resolution's EN scheme; and 2. there has been compliance, where required, with Regulation 20 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 in respect of the duty of candour.
Minimum evidential requirement for trust Board	Trust Board sight of Trust legal services and maternity clinical governance records of qualifying HSIB/EN incidents and numbers reported to HSIB and NHS Resolution. Trust Board sight of evidence that the families have received information on the role of HSIB and EN scheme.

	Trust Board sight of evidence of compliance with the statutory duty of candour.
What is the relevant time period?	Reporting to HSIB – from Wednesday 1 April 2021 to 5 December 2022 Reporting period to HSIB and to NHS Resolution - from 1 April 2022 to 5 December 2022

A. All qualifying cases for the qualifying time period were reported to the health care safety investigation branch (HSIB).There were 4 cases in this time frame, three have been taken by HSIB and one rejected when clinical information reviewed.
B. Two cases requiring reporting to ENS have not been notified. Both cases are under investigation by HSIB. The most recent case was 24 hours before the end of the period on 4th December and should have been reported to ENS by 5th January. The ENS reporting has a single point of failure currently as done by legal services.
C.
    i. Both families received written information regarding HSIB. The first family did not receive information on ENS due to the scheme being paused (*During this period, trust reporting to NHS Resolution was paused in order to support trusts during the pandemic. Trusts continued to report all eligible EN cases meeting the above criteria to HSIB for learning investigations to take place. HSIB then reported potential eligible EN cases to NHS Resolution for further consideration from a legal perspective).* *The reporting wizard for ENS is completed by the head of litigation and we have been unable to corroborate that the field of family notification has been checked in order to guarantee compliance.
    ii. Duty of candour compliance is confirmed.

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Salisbury NHS Foundation Trust are NOT declaring full compliance with safety action 10

4. Conclusion

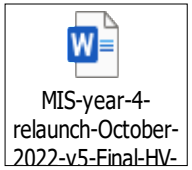
In order for the maternity service to declare compliance with 8 safety actions the following points must be noted and accepted by the Board. This discussion must be minuted to show agreed compliance with the proposed self declaration.

Safety Action four – medical workforce
a)Obstetric workforce- The Board acknowledge the maternity service engagement with and commitment to the RCOG document on the roles and responsibilities of the consultant.
c) The board acknowledge that the Neonatal medical and nursing workforce are not compliant with BAPM standards. The board recognize that redesignation is likely to change our staffing requirements and that mitigation needs regular review but that it is unlikely that we will change the medical staffing. The board acknowledge that the nursing workforce will be subject to an action plan for review to achieve compliance.
Safety Action 5- midwifery workforce
b) Board to acknowledge and minute that staffing establishment reflects current birth rate + calculation, evidence in file.
Safety action 9 board assurance
c) The board need to acknowledge that the decision regarding the Midwifery Continuity of Care (MCoC) model is to suspend implementation due to current inability to meet minimum staffing requirements as presented in September 2022 maternity staffing paper through CGC.

Moving forward into year 5, the 2 non compliant safety action, have been action planned and work is ongoing to achieve compliance by year 5. It must be noted that year 4 was challenging to comply with as there were several re iterations of the standards and evidence requirements. This reflected the national strain on maternity services since the covid pandemic. Year 5 is yet to be published. The Board declaration form will be accompanied by the action plans detailing work required to demonstrate full compliance when the Trust submit this to NHSR by noon on 2 nd February 2023.

Maternity Incentive Scheme Gap Analysis - Year three 2021

Safety Action		Initials	Name	Role
1	National Perinatal Mortality Review Tool	ST	Stephanie Thompson	Bereavment Lead Midwife
		SMG	Sophie Moloney-geaney	Consultant Obstetrician and Gynaecologist
2	Maternity Services Data Set	Informatics	Carmel Payne	Senior Information Analyst & Reporting Lead
3	ATAIN	MP	Mary Pedley	Neonatal Consultant
		SH	Sam Hayward	Consultant
		GD	Geoff Dunning	NNU manager
	Medical Workforce Planning	AJK	Abi Kingston	Consultant
		JB	Julia Bowditch	Consultant Anaesthetist
		CA	Chris Anderson	Paediatirc Consultant
		GD	Geoff Dunning	NNU manager
5	Midwifery Workforce Planning	JH	Joanne Hayward	Director of Maternity and Neonatal Services
		VM	Vicki Marston	Deputy Head of Midwifery
6	Saving Babies Lives	VH	Tori Harper	Fetal Surveillance Lead Midwife
		SMV	Stuart Verdin	Consultant
7	Patient Feedback	AL	Alison Lambert	Family Experience Midwife
8	Maternity Training	SS/SL	Sally Smith/Scarlett Leahy	Practice Development Midwives
9	Safety Champions	JH	Joanne Hayward	Director of Maternity and Neonatal Services
		AJK	Abi Kingston	Consultant
		GD	Geoff Dunning	NNU manager
		JD	Judy Dyos	Chief Nurse
		EJ	Eiri Jones	NED
10	Early Notification Scheme	RC	Rachel Coleman	Quality and Safety Matron
		JL	Judith Leach	Trust Legal Team



Safety action 1: Are you using the National Perinatal Mortality Review Tool to review perinatal deaths to the required standard?

Action fully completed
Ongoing actions required to achieve completion (i.e. action near completion and specific completion date identified on plan)
Outstanding actions required to achieve completion (i.e. action complete within the next 6 months)

Item number	Recommendation - Please see Technical Guidance	Evidence required	Lead	Actions	RAG	Evidence
a)	i. All perinatal deaths eligible to be notified to MBRRACE-UK from 6 May 2022 onwards must be notified to MBRRACE-UK within seven working days and the surveillance information where required must be completed within one month of the death. Deaths where the surveillance form needs to be assigned to another Trust for additional information are excluded from the latter. ii. A review using the Perinatal Mortality Review Tool (PMRT) of 95% of all deaths of babies, suitable for review using the PMRT, from 6 May 2022 will have been started within two months of each death. This includes deaths after home births where care was provided by your Trust.	i.Notifications must be made and surveillance forms completed using the MBRRACE-UK reporting website. ii.The perinatal mortality review toolkit must be used to review care and darft reports should be generated via the PMRT	ST	Compliant		MBRRACE and PMRT database.xlsx
b)	At least 50% of all deaths of babies (suitable for review using the PMRT) who were born and died in your Trust, including home births, from 6 May 2022 will have been reviewed using the PMRT, by a multidisciplinary review team. Each of these reviews will have been completed to the point that at least a PMRT draft report has been generated by the tool within four months of each death and the report published within six months of each death.	All reviews need to be MDT review	ST	Compliant		MBRRACE and PMRT database.xlsx
c)	For at least 95% of all deaths of babies who died in your Trust from 6 May 2022, the parents will have been told that a review of their baby's death will take place, and that the parents' perspectives and any questions and/or concerns they have about their care and that of their baby have been sought. This includes any home births where care was provided by your Trust staff and the baby died either at home or in your Trust. If delays in completing reviews are anticipated parents should be advised that this is the case and be given a timetable for likely completion. Trusts should ensure that contact with the families continues during any delay and make an early assessment of whether any questions they have can be addressed before a full review has been completed; this is especially important if there are any factors which may have a bearing on a future pregnancy. In the absence of a bereavement lead ensure that someone takes responsibility for maintaining contact and for taking actions as required.		ST	Compliant		
d)	Quarterly reports will have been submitted to the Trust Board from 6 May 2022 onwards that include details of all deaths	Q1, Q2, Quality and Safety reports including PMRT quareterly teports at Clinical Governence Committee	ST	Compliant		Quality_Safety Report for Q1 22 23 IH for Quality_Safety Report for Q2 22 23 IH_USE 4-december-2022 blic-papers-bundle

Safety action 2: Are you submitting data to the Maternity Services Data Set (MSDS) to the required standard?

Action fully completed
Ongoing actions required to achieve completion (i.e. action near completion and specific completion date identified on plan)
Outstanding actions required to achieve completion (i.e. action complete within the next 6 months)

Item number	Recommendation - Please see Technical Guidance	Evidence required	Lead	Actions	Evidence	RAG
a)	This relates to the quality, completeness of the submission to the Maternity Services Data Set (MSDS) and ongoing plans to make improvements.	1. By 31st October 2022, Trusts have an up to date digital strategy for their maternity services which aligns with the wider Trust Digital Strategy and reflects the 7 success measures within the What Good Looks Like Framework. The strategy must be shared with Local Maternity Systems and be signed off by the Integrated Care Board. As part of this, dedicated Digital Leadership should be in place in the Trust and have engaged with the NHSEI Digital Child Health and Maternity Programme.	Informatics	Compliant	confirmaiton of digital strategy at ICS and LMNS Dec	
		2. Trust Boards to assure themselves that at least 9 out of 11 Clinical Quality Improvement Metrics (CQIMs) have passed the associated data quality criteria in the "CNST Maternity Incentive Scheme Year 4 Specific Data Quality Criteria" data file in the Maternity Services Monthly Statistics publication series for data submissions relating to activity in July 2022. The data for July 2022 will be published during October 2022.			CNST-July-2022-scorecard.xlsx F3A38449.msg	
		3. July 2022 data contained height and weight data, or a calculated Body Mass Index (BMI), recorded by 15+0 weeks gestation for 90% of women reaching 15+0 weeks gestation in the month.				
		4. July 2022 data contained Complex Social Factor Indicator (at antenatal booking) data for 95% of women booked in the month.				
		5. July 2022 data contained antenatal personalised care plan fields completed for 95% of women booked in the month. (MSD101/2)				
		6. July 2022 data contained valid ethnic category (Mother) for at least 90% of women booked in the month. Not stated, missing and not known are not included as valid records for this assessment as they are only expected to be used in exceptional circumstances. (MSD001)				
		7. Trust Boards to confirm to NHS Resolution that they have passed the associated data quality criteria in the "CNST Maternity Incentive Scheme Year 4 Specific Data Quality Criteria" data file in the Maternity Services Monthly Statistics publication series for data submissions relating to activity in July 2022 for the following metrics:				

Safety action 3: Can you demonstrate that you have transitional care services in palce to mnimise seperation of mothers and their babies and to support the reccommedations made in the Avoiding Term Admission into the Neonatal Units Programme ?

Action fully completed
Ongoing actions required to achieve completion (i.e. action near completion and specific completion date identified on plan)
Outstanding actions required to achieve completion (i.e. action complete within the next 6 months)

Item number	Recommendation - Please see Technical Guidance	Evidence required	Lead	Actions	Evidence	RAG
a	Pathways of care into transitional care have been jointly approved by maternity and neonatal teams with a focus on minimising separation of mothers and babies. Neonatal teams are involved in decision making and planning care for all babies in transitional care.		GD	Compliant	Salisbury TC policy 1.5 (2022).doc	
b	The pathway of care into transitional care has been fully implemented and is audited quarterly. Audit findings are shared with the neonatal safety champion, LMNS, commissioner and Integrated Care System (ICS) quality surveillance meeting each quarter.		GD	Non Compliant	Presentation	
c	A data recording process (electronic and/or paper based for capturing all term babies transferred to the neonatal unit, regardless of the length of stay, is in place.		GD	Compliant	NICU & Maternity ATAIN Spreadsheet	
d	A data recording process for capturing existing transitional care activity, (regardless of place - which could be a Transitional Care (TC), postnatal ward, virtual outreach pathway etc.) has been embedded. If not already in place, a secondary data recording process is set up to inform future capacity management for late preterm babies who could be cared for in a TC setting. The data should capture babies between 34+0-36+6 weeks gestation at birth, who neither had surgery nor were transferred during any admission, to monitor the number of special care or normal care days where supplemental oxygen was not delivered.		GD	Non Compliant		
e	Commissioner returns for Healthcare Resource Groups (HRG) 4/XA04 activity as per Neonatal Critical Care Minimum Data set (NCCMDS) version 2 are available to be shared on request with the operational delivery network (ODN), LMNS and commissioners to inform capacity planning as part of the family integrated care component of the Neonatal Critical Care Transformation Review and to inform future development of transitional care to minimise separation of mothers and babies.		GD	Compliant	none requested	
f	Reviews of babies admitted to the neonatal unit continue on a quarterly basis and findings are shared quarterly with the Board Level Safety Champion. Reviews should now include all neonatal unit transfers or admissions regardless of their length of stay and/or admission to BadgerNet. In addition, reviews should report on the number of transfers to the neonatal unit that would have met current TC admissions criteria but were transferred or admitted to the neonatal unit due to capacity or staffing issues. The review should also record the number of babies that were transferred or admitted or remained on Neonatal Units because of their need for nasogastric tube feeding, but could have been cared for on a TC if nasogastric feeding was supported there.Findings of the review have been shared with the maternity, neonatal and Board level safety champions, LMNS and ICS quality surveillance meeting on a quarterly basis.		GD	Non Compliant	Safety Champion minutes November 22.docx; MIS standard 3 2022-2023 Q1&2.pptx	
g	An action plan to address local findings from the audit of the pathway (point b) and Avoiding Term Admissions Into Neonatal units (ATAIN) reviews (point f) has been agreed with the maternity and neonatal safety champions and Board level champion.		GD	Non Compliant		
h	Progress with the revised ATAIN action plan has been shared with the maternity, neonatal and Board level safety champions, LMNS and ICS quality surveillance meeting.		GD	Non Compliant		

Action fully completed
Ongoing actions required to achieve completion (i.e. action near completion and specific completion date identified on plan)
Outstanding actions required to achieve completion (i.e. action complete within the next 6 months)

Safety action 4: Can you demonstrate an effective system of clinical* workforce planning to the required standard?

Item number	Recommendation - Please see Technical Guidance	Evidence required	Lead	Related Risks	Actions	Evidence	RAG
a	Obstetric medical workforce 1. 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	Sign off at Trust Board level acknowledging engagement with the RCOG document along with an action plan to review any non-attendance to the clinical situations listed in the document. Trusts should evidence their position with the Trust Board, Trust Board level safety champions and LMNS meetings at least once from the relaunch of MIS year 4 in May 2022.	AK		Miutes from bord meeting where sign off accepted	CONSULTANT ON CALL AUDIT.docx; 57160306.mhtml; roles-and-responsibilities-of-the-consu; Safety Champion minutes November 22.docx	
b	b) Anaesthetic medical workforce 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 rota should be used to evidence complince with ACSA standard 1.7.2.1	JB			obs anaesthetic rota Jan - July 2022.xlsx	
c	) Neonatal medical workforce The neonatal unit 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. If the requirements had been met in year 3 without the need of developing an action plan to address deficiencies, however they are not met in year 4, Trust Board should develop an action plan in year 4 of MIS to address deficiencies.	The Trust is to formally record in Trust Board minutes whether it meets the reccomendations of the neontal medical workforce.If the requirements are not met , Trust Board should eveidence progress against the action plan developed in Year 3 of MIS to address deficiences	MP		Minutes from board neeting where non complince and associated action plan accepted	Safety Action 4.xlsx	
d	Neonatal nursing workforce The neonatal unit meets the service specification for neonatal nursing standards. 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. If the requirements had been met in year 3 without the need of developing an action plan to address deficiencies, however they are not met in year 4, Trust Board should develop an action plan in year 4 of MIS to address deficiencies and share this with the Royal College of Nursing, LMNS and Neonatal Operational Delivery Network (ODN) Lead.	The Trust is required to formally record to the Trust Board minutes the compliance to the service specification standards annually using the neonatal clinical reference group nursing workforce calculator. For units that do not meet the standard, the Trust Board should evidence progress against the action plan developed in year 3 of MIS to address deficiencies.	GD		**Non compliant**	Salisbury Neonatal Workforce Tool (September)	

Action fully completed
Ongoing actions required to achieve completion (i.e. action near completion and specific completion date identified on plan)
Outstanding actions required to achieve completion (i.e. action complete within the next 6 months)

Safety action 5: Can you demonstrate an effective system of midwifery workforce planning to the required standard?

Item number	Recommendation - Please see Technical Guidance	Evidence required	Lead	Actions	Evidence	RAG
a	A systematic, evidence-based process to calculate midwifery staffing establishment is completed.	Birthrate+ report Dec 2019	VM/JH	Completed December 2019	SFT Final BR+ report December 2019.docx	
b	Trust Board to evidence midwifery staffing budget reflects establishment as calculated in a) above.				establishment.docx	
c	The midwifery coordinator in charge of labour ward must have supernumerary status; (defined as having no caseload of their own during their shift) to ensure there is an oversight of all birth activity within the service	acuity BR plus tool			as in e)	
d	All women in active labour receive one-to-one midwifery care	audit monthly			Midwifery Staffing Report March 2022.docx as in e)	
e	Submit a midwifery staffing oversight report that covers staffing/safety issues to the Board every 6 months, during the maternity incentive scheme year four reporting period.	staffing report -			5.1 - Maternity & Neonatal Staffing Report September	

Action fully completed
Ongoing actions required to achieve completion (i.e. action near completion and specific completion date identified on plan)
Outstanding actions required to achieve completion (i.e. action complete within the next 6 months)

Safety action 6: Can you demonstrate compliance with all five elements of the Saving Babies' Lives care bundle Version 2?

Item number	Recommendation	Elements	Evidence required	Lead	Actions	Evidence	RAG
1	Copy of South West RNZ v2 Survey 7 Oct South West RNZ v2 Survey 6.xlsm 1. Trust Board level consideration of how its organisation is complying with the Saving Babies' Lives care bundle version two (SBLCBv2), published in April 2019. Note: Full implementation of the SBLCBv2 is included in the 2020/21 standard contract.	Element one Process indicators : A. Percentage of women where Carbon Monoxide (CO) measurement at booking is recorded. B. Percentage of women where CO measurement at 36 weeks is recorded.	Standard A and B of element 1 require Trusts to demonstrate that 80% of women had CO testing at booking and at 36 weeks respectively and that this is recorded in the Trusts' information system. In the event of a high number of women declining CO testing a Trust would be at risk of failing standard A and B by not reaching the 80% testing rate. We suggest Trusts proactively monitor their testing rate and consider interventions to maintain adequate compliance. In addition, the Trust board should specifically confirm that within their organisation they: 1) Pass the data quality rating on the National Maternity Dashboard for the 'women who currently smoke at booking appointment' Clinical Quality Improvement Metric. 2) Have a referral pathway to smoking cessation services (in house or external). 3) Audit of 20 consecutive cases of women with a CO measurement ≥4ppm at booking, to determine the proportion of women who were referred to a smoking cessation service. 4) Have generated and reviewed the following outcome indicators within the Trust for four consecutive months within the MIS year 4 reporting period: · Percentage of women with a CO measurement ≥4ppm at booking. · Percentage of women with a CO measurement ≥4ppm at 36 weeks. · Percentage of women who have a CO level ≥4ppm at booking who subsequently have a CO level <4ppm at the 36 week appointment.	TH/SV	Non compliant with A - needs action plan Compliant with B 1) Pass 2)Pathway in place - Pass 3) Regular audits quarterly but not including referrrals so unable to evidence - Fail 4)Quarterly audtis including all three elements - Pass	SBL Element 1 Dashboard.xlsx	
		Element 2 A. Percentage of pregnancies where a risk status for fetal growth restriction (FGR) is identified and recorded at booking and at 20 weeks.	In addition the Trust board should specifically confirm that within their organisation:		Non compliant - needs action plan		
			1) Women with a BMI>35 kg/m2 are offered ultrasound assessment of growth from 32 weeks' gestation onwards		1)Pass	Policy - BMI – Care of pregnant women with a body mass index over 30kg/m2 accessed here :https://viewer.microguide.global/guide/100000303#content,60bf23a8-3200-4635-85bd-817f162dd3f3	
			2) In pregnancies identified as high risk at booking uterine artery Doppler flow velocimetry is performed by 24 completed weeks gestation		2) UAD not offerred - alternative pathway in place - disussed with commisioners - Pass	2021 - Antenatal - Guideline - Fetal growth	
			3)) There is a quarterly audit of the percentage of babies born <3rd centile >37+6 weeks' gestation.		3) Pass	Q1 AUDIT Report SGA Data 2022-2023.docx Q2 AUDIT Report SGA Data 2022-2023.docx	
			4)) They have generated and reviewed the percentage of perinatal mortality cases for 2021 where the identification and management of FGR was a relevant issue (using the PMRT).		4)Non compliant as action plan not robust enough		
			5) Their risk assessment and management of growth disorders in multiple pregnancy complies with NICE guidance or a variant has been agreed with local commissioners (CCGs) following advice from the Clinical Network.		5) Pass- guideline on microguide	2020 Multiple pregnancy.doc	
			6) They undertake a quarterly review of a minimum of 10 cases of babies that were born <3rd centile >37+6 weeks' gestation. The review should seek to identify themes that can contribute to FGR not being detected (e.g. components of element 2 pathway and/or scanning related issues). The Trust board should be provided with evidence of quality improvement initiatives to address any identified problems. Trusts can omit the above mentioned quarterly review of a minimum of 10 cases of babies that were born <3rd centile >37+6 weeks' gestation for quarter 3 of this financial year (2021/22) if staffing is critical and this directly frees up staff for the provision of clinical care.		6)non compliant - audits completed but no evidence of robust governence process fro discussion ro sharing		
		Element 4 A. Percentage of women booked for antenatal care who had received reduced fetal movements leaflet/information by 28+0 weeks of pregnancy. B. Percentage of women who attend with RFM who have a computerised CTG (a computerised system that as a minimum provides assessment of short term variation). Note: The SNOMED CT code is still under development for RFM and therefore an in-house audit of two weeks' worth of cases or 20 cases of women attending with RFM whichever is the smaller to assess compliance with the element three process indicators.	There should be Trust board sign off that staff training on using their local CTG machines, as well as fetal monitoring in labour are conducted annually. The fetal monitoring sessions should be consistent with the Ockenden Report recommendations, and include: intermittent auscultation, electronic fetal monitoring with system level issues e.g. human factors, escalation and situational awareness. The Trust board should specifically confirm that within their organization 90% of eligible staff (see Safety Action 8) have attended local multi-professional fetal monitoring training annually as above. Please refer to safety action 8 for more information re training.		Compliant	CTG TRAINING.docx CTG Training Day Plan .docx December CTG compliance.xlsx	
		Element five Process indicators: A. Percentage of singleton live births (less than 34+0 weeks) receiving a full course of antenatal corticosteroids, within seven days of birth. B. Percentage of singleton live births occurring more than seven days after completion of their first course of antenatal corticosteroids. C. Percentage of singleton live births (less than 30+0 weeks) receiving magnesium sulphate within 24 hours prior birth. D. Percentage of women who give birth in an appropriate care setting for gestation (in accordance with local ODN guidance). Note: The relevant data items for these process indicators should be recorded on the provider's Maternity Information System and included in the MSDS submissions to NHS Digital in an MSDSv2 Information Standard Notice compatible format, including SNOMED-CT coding. If there is a delay in the provider Trust MIS's ability to record these data then an audit of 40 cases consisting of 20 consecutive cases of women presenting with threatened preterm labour before 34 weeks and 20 consecutive cases of women who have given birth before 34 weeks using locally available data or case records should have been undertaken to assess compliance with each of the process indicators.	In addition, the Trust board should specifically confirm that within their organisation: They have a dedicated Lead Consultant Obstetrician with demonstrated experience to focus on and champion best practice in preterm birth prevention. (Best practice would be to also appoint a dedicated Lead Midwife. Further guidance/information on preterm birth clinics can be found on https://www.tommys.org/sites/default/files/2021-03/reducing%20preterm%20birth%20guidance%2019.pdf · Women at high risk of preterm birth have access to a specialist preterm birth clinic where transvaginal ultrasound to assess cervical length is provided. If this is not the case the board should describe the alternative intervention that has been agreed with their commissioner (CCG) and that their Clinical Network has agreed is acceptable clinical practice. An audit of 40 consecutive cases of women booking for antenatal care has been completed to measure the percentage of women that are assessed at booking for the risk of preterm birth and stratified to low, intermediate and high risk pathways, and the percentage of those assessed to be at increased risk that are referred to the appropriate preterm birth clinic and pathway. The assessment should use the criteria in Appendix F of SBLCBv2 or an alternative which has been agreed with local CCGs following advice from the Clinical Network. Their risk assessment and management in multiple pregnancy complies with NICE guidance or a variant that has been agreed with local commissioners (CCGs) following advice from the provider's clinical network.		Compliant	NNAP_QUARTERLY_REPORT_Q1+ 2122_Sa Q2 2022.23 Element 5 audit discussion	

Action fully completed
Ongoing actions required to achieve completion (i.e. action near completion and specific completion date identified on plan)
Outstanding actions required to achieve completion (i.e. action complete within the next 6 months)

Safety action 7: Can you demonstrate that you have a mechanism for gathering service user feedback, and that you work with service users through your Maternity Voices Partnership to coproduce local maternity services?

Item number	ommendation - Please see Technical Guida	Evidence required	Lead	Related Risks	Actions	Complete	Evidence	RAG
a)	Can you demonstrate that you have a mechanism for gathering service user feedback, and that you work with service users through your Maternity Voices Partnership (MVP) to coproduce local maternity services?	Terms of Reference for your MVP. They reflect the core principles for Terms of Reference for a MVP as outlined in annex B of Implementing Better Births: A resource pack for Local Maternity Systems	AL	No	Compliant		MVPP_TermsOfRe erenceSept2021.pd	
		Minutes of MVP meetings demonstrating how service users are listened to and how regular feedback is obtained, that actions are in place to demonstrate that listening has taken place and evidence of service developments resulting from coproduction between service users and staff.			Compliant		MVP Friends and Family 11.10.22; 09.05.2022. Infant feeding .docx; MVP+ Meeting Minutes - 171122 NG.docx	
		Written confirmation from the service user chair that they are being remunerated as agreed and that this remuneration reflects the time commitment and requirements of the role given the agreed work programme. Remuneration should take place in line with agreed Trust processes.			Compliant		letter from MVP irming remuneratio	
		The MVP's work programme, minutes of the MVP meeting which agreed it and minutes of the LMNS board that ratified it · Written confirmation from the service user chair that they and other service user members of the MVP committee are able to claim out of pocket expenses, including travel, parking and childcare costs in a timely way.			Compliant		MVP Workplan 011222.xlsx	
		Evidence that the MVP is prioritising hearing the voices of women from Black, Asian and Minority Ethnic backgrounds and women living in areas with high levels of deprivation, given the findings in the MBRRACE-UK reports about maternal death and morbidity and perinatal mortality.			Compliant		MVP Workplan 011222.xlsx	
		Evidence that the MVP Chair is invited to attend maternity governance meetings and that actions from maternity governance meetings, including complaints' response processes, trends and themes, are shared with the MVP			Compliant		Maternity Governance Minutes September	

Can you evidence that a local training plan is in place to ensure that all six core modules of the Core Competency Framework will be included in your unit training programme over the next 3 years, starting from the launch of MIS year 4?
In addition, can you evidence that at least 90% of each relevant maternity unit staff group has attended an 'in house', one-day, multi-professional training day which includes a selection of maternity emergencies, antenatal and intrapartum fetal surveillance and newborn life support, starting from the launch of MIS year 4?

Action fully completed
Ongoing actions required to achieve completion (i.e. action near completion and specific completion date identified on plan)
Outstanding actions required to achieve completion (i.e. action complete within the next 6 months)

Item number	Recommendation - Please see Technical Guidance	Evidence required	Lead	Related Risks	Actions	Complete	Evidence	RAG
a	A local training plan is in place to ensure that all six core modules of the Core Competency Framework, will be included in your unit training programme over 3 years, starting from the launch of MIS year 4 in August 2021.	core competency framework plan	Practice Education Team		Compliant		Core Competency Framework Timetable.docx	
b	90% of each relevant maternity unit staff group have attended an 'in house' one day multi-professional training day, that includes maternity emergencies starting from the launch of MIS year four in August 2021?	dashboard			Compliant		December 22 Prompt compliance.xlsx	
c	90% of each relevant maternity unit staff group have attended an 'in-house' one day multi-professional training day that includes antenatal and intrapartum fetal monitoring, starting from the launch of MIS year four in August 2021.	dashboard			Compliant		December CTG compliance.xlsx	
d	involved in immediate resuscitation of the newborn and management of the deteriorating newborn infant have attended in-house neonatal life support training or a Newborn Life Support (NLS) course starting from the launch of MIS year four in August 2021..	dashboard			Compliant		BNLS Dec 2022.xlsx	

Action fully completed
Ongoing actions required to achieve completion (i.e. action near completion and specific completion date identified on plan)
Outstanding actions required to achieve completion (i.e. action complete within the next 6 months)

Can you demonstarte that there is are robust processes in place to provide assurance to the Board on maternity and neonatal safety and quality issues ?

Item number	Recommendation - Please see Technical Guidance	Evidence required	Lead	Related Risks	Actions	Complete	Evidence	RAG
a	The pathway developed in year 3, that describes how safety intelligence is shared from floor to Board, through local maternity and neonatal systems (LMNS), and the Regional Chief Midwife has been reviewed in line with the implementing-a-revised-perinatal-quality-surveillance-model.pdf (england.nhs.uk) The revised pathway should formalise how Trust-level intelligence will be shared with new LMNS/ICS and regional quality groups to ensure early action and support is provided for areas of concern or need.	Evidence of a revised pathway which describes how frontline midwifery, neonatal, obstetric and Board safety champions share safety intelligence between a) each other, b) the Board, c) new LMNS/ICS quality group and d) regional quality groups involving the Regional Chief Midwife and Lead Obstetrician to ensure early action and support is provided for areas of concern or need in line with the perinatal quality surveillance model.	JH		Compliant		SOP Maternity Safety ChampionsV4.doc	
		Evidence that a clear description of the pathway and names of safety champions are visible to maternity and neonatal staff.	JH		Compliant		as above visible in ward areas	
b	Board level safety champions present a locally agreed dashboard to the Board quarterly, including; the number of incidents reported as serious harm, themes identified and actions being taken to address any issues; staff feedback from frontline champions and walk-abouts; minimum staffing in maternity services and training compliance are taking place at Board level no later than 16 June 2022. NB, The training update should include any modifications made as a result of the pandemic / current challenges and a rough timeline of how training will be rescheduled later this year if required. This additional level of training detail will be expected by 16 June 2022.	Evidence 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 feedback from frontline champions and engagement sessions; minimum staffing in maternity services and training compliance are taking place at Board level no later than 16 June 2022. NB- The training update should include any modifications made as a result of the pandemic / current challenges and a rough timeline of how training will be rescheduled later this year if required. This additional level of training detail will be expected by 16 June 2022.	JH/JD		Compliant		June 22 May data JH final v 2.pptx; Safety Champion minutes May 22.docx; [redacted].pdf; neonatal champion walkabout you said we did - may; 2022 maternity safety champions walkabout.xlsx	
		Evidence of the engagement sessions (e.g. staff feedback meeting, staff walkaround sessions etc.) being undertaken by a member of the Board	JD/EJ				2022 maternity safety champions walkabout.xlsx	
		Evidence of progress with actioning named concerns from staff workarounds are visible to both maternity and neonatal staff and reflects action and progress made on identified concerns raised by staff and service users.	ALL		Compliant		as above	
		Evidence that the Trust's claims scorecard is reviewed alongside incident and complaint data and discussed by the maternity, neonatal and Trust Board level safety champions to help target interventions aimed at improving patient safety at least twice in the MIS reporting period at a Trust level quality meeting. This can be a board or directorate level meeting.	JD/EJ		action plan included in decleration		no eidence habe emailed J Leathch - JD unsre	
c	Trust Boards have reviewed current staffing in the context of the letters to systems on 1 April 2022 and 21 September 2022 regarding the roll out of Midwifery Continuity of Carer as the default model of care. A decision has been made by the Board as to whether staffing meets safe minimum requirements to continue rollout of current or planned MCoC teams, or whether rollout should be suspended	minuted Board level discussion and decision since 1 April 2022 on how a Trust's current workforce position should determine current and future rollout of MCoC. Where more than one discussion has taken place, the most recent evidence should be submitted.	JD/EJ				Minuted at Board meeting 12th Jan	
d	Board level and maternity safety champions are actively supporting capacity and capability building for staff to be involved in the Maternity and Neonatal Safety Improvement Programme (MatNeoSIP)	active participation by staff in contributing to the delivery of the collective aims of the MatNeo Patient Safety Networks, and undertaking of specific improvement work aligned to the MatNeoSIP national driver diagram and key enabling activities engagement in relevant improvement/capability building initiatives nationally, regionally or via the MatNeo Patient Safety Networks, of which the Trust is a member	ALL		Compliant		Changemake Groups in response to culture; J HAYWARD ATTENDENCE AT MAT NEO - ; Escalation and speak up posters.docx; 93CC1F9A.msg; Rachel Coleman MatNeo Attendance.docx; Parents speak up Sarum, DAU, PNW LW, NICU; Staff escalation PNW LW.pptx	

Action fully completed
Ongoing actions required to achieve completion (i.e. action near completion and specific completion date identified on plan)
Outstanding actions required to achieve completion (i.e. action complete within the next 6 months)

Have you reported 100%of qualifying cases to Healthcare Safety Investigation Branch (HSIB) and to NHS Resolutions Early Notifiaction (EN) Scheme from 1 April 2021 to 5th December 2022

Item number	Recommendation - Please see Technical Guidance	Evidence required	Lead	Related Risks	Actions	Complete	Evidence	RAG
a	Reporting of all qualifying cases to HSIB from 1 April 2021 to 5 December 2022 2. B) Reporting of all qualifying EN cases to NHS Resolution's Early Notification (EN) Scheme from 1 April 2022 until 5 December 2022 3.	Trust Board sight of Trust legal services and maternity clinical governance records of qualifying HSIB/EN incidents and numbers reported to HSIB and NHS Resolution.	RC/JL	No				
b	For all qualifying cases which have occurred during the period 1 April 2021 to 5 December 2022, the Trust Board are assured that: 1. the family have received information on the role of HSIB and NHS Resolution's EN scheme; and 2. there has been compliance, where required, with Regulation 20 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 in respect of the duty of candour.	Trust Board sight of evidence that the families have received information on the role of HSIB and EN scheme.			Compliant		DOC MI-004228.docx DOC MI-011606.doc Stage 2 DOC.doc Stage 2 DOC.doc	
		Trust Board sight of evidence of compliance with the statutory duty of candour.			Compliant		as above	

NHS Resolution

#N/A

Action No.	Maternity safety action	Action met? (Y/N)
1	Are you using the National Perinatal Mortality Review Tool to review and report perinatal deaths to the required standard?	Yes
2	Are you submitting data to the Maternity Services Data Set to the required standard?	Yes
3	Can you demonstrate that you have transitional care services in place to minimise separation of mothers and their babies and to support the recommendations made in the Avoiding Term Admissions into Neonatal units Programme?	No
4	Can you demonstrate an effective system of clinical workforce planning to the required standard?	Yes
5	Can you demonstrate an effective system of midwifery workforce planning to the required standard?	Yes
6	Can you demonstrate compliance with all five elements of the Saving Babies' Lives care bundle V2?	No
7	Can you demonstrate that you have a mechanism for gathering service user feedback, and that you work with service users through your Maternity Voices Partnership (MVP) to coproduce local maternity services?	Yes
8	Can you evidence that a local training plan is in place to ensure that all six core modules of the Core Competency Framework will be included in your unit training programme over the next 3 years, starting from the launch of MIS year 4? In addition, can you evidence that at least 90% of each relevant maternity unit staff group has attended an 'in house', one-day, multi-professional training day which includes a selection of maternity emergencies, antenatal and intrapartum fetal surveillance and newborn life support, starting from the launch of MIS year 4?	No
9	Can you demonstrate that there are robust processes in place to provide assurance to the Board on maternity and neonatal safety and quality issues?	No
10	Have you reported 100% of qualifying cases to Healthcare Safety Investigation Branch (HSIB) and to NHS Resolution's Early Notification (EN) Scheme from 1 April 2021 to 5 December 2022?	No

NHS Resolution

#N/A

An action plan should be completed for each safety action that has not been met

Action plan 1

Safety action	Q3 Transitional care	**To be met by**	Q4 = 2023/24
Work to meet action	*To clarify process defined to ensure the quarterly reports are shared routinely with divisional governence, safety champions, LMNS and ICS; ATAIN action pan needs to be more robust ensuring that ownersare identified for actions and timeframe for completion detailed alongside developing an action tracker to show progress - to be shared and discussed at forums cited previously. Review of transitional care model delivery*		
Does this action plan have executive level sign off	Yes	**Action plan agreed by head of midwifery/clinical director?**	Yes
Action plan owner	*Mary Pedley Consultant Paedidatrician /Geoff Dunning Neonatal Matron*		
Lead executive director	*Judy Dyos:Chief Nurse*		
Amount requested from the incentive fund, if required			*£40,735.00*
Reason for not meeting action	*quarterly audits not shared rountinely with LMNS and ICS ; ATAIN action plan not robust enough and not signed off by Board*		
Rationale	*needs more detailed monitotirng and oversight and key forums to ensure delivering against standards of CNST.*		
Benefits	*In Q1 23/24 a workplan will be developed to enure consistency with reporting at key forums ensuring data and themes identified and shared with system for learning; In Q1 and ATAIN action plan will be more detailed identifying owners of actions and clear time frames , this will be approved through the divisional governence process*		
Risk assessment	*Non complince with safety action resulting in potentially separating mum and babies uneccessarily; not ideintifying key learning to improve quality and clinical outcomes which may effect womens experience*		

	How?	**Who?**	**When?**
Monitoring	quarterly reports to be presented at monthly audit meeting, neonatal governence and monitored thorugh	J Hayward - DOM	Quarterly through safety champions and presented for apporval to board via quality and safety report reported

Action plan 2

Safety action	Q8 In-house training	**To be met by**	Q4 = 2023/24

Work to meet action	*to ensure clinicans are rostered to attend and monthly monitoring of compliance through matenrity governence using staff groups rather than overall percentage , escalating to divisonal governence if slippage noted ;recruit a band 2 administrative support to support training programme within the education team ; NOTE: band 6 midwife funding requested in safety action 3 action plan*

Does this action plan have executive level sign off	Yes	**Action plan agreed by head of midwifery/clinical director?**	Yes

Action plan owner	*Rachel Coleman Quality and Safety Matron*
Lead executive director	*Judy Dyos Chief Nurse*
Amount requested from the incentive fund, if required	*£25,700.00*
Reason for not meeting action	*non attendence of clinicians*
Rationale	*more robust planning and monitoring thorughout the year will ensure that any slippage will be identified and escalated more timely*
Benefits	*Attendance montiored monthly thorugh governence meetings commencing Q1 23/24 ; ensure yearly training planned and clinicians from all staff group allocated training throughout the year by end of Q1 23/24; define a process fro non attendence to inlcude escalation to leads fro each staff group by Q1 23/24 ; to recruit an administrative role within the maternity education team to assist with monitoring and implementation - band 2-*
Risk assessment	*No compliance with safety action , safety effective by clinicians not being updated and trained in key obstetric and neonatal emrgencies / training*

	How?	**Who?**	**When?**
Monitoring	Monthly thorugh goverence meetings and bi monhtly thorugh safety champions	Rachel Coleman Quality and Safety Matron	Commencing Q1 23/24

Action plan 3

Safety action	Q6 SBL care bundle	**To be met by**	Q4 = 2023/24

Work to meet action	*Training/ updating of midwives to ensure compliance wiith monitoring CO at booking ; training of audit owners to ensure audits completed are in accordance with techinical guidence according to MIS ; to recruit a band 6 midwife 1.0 WTE as a pre term birth midwife to ensure clincial pathways and policies reflect current guidence, audits are robust and learning identified and shared within the service; liaising with*

Does this action plan have executive level sign off	Yes	**Action plan agreed by head of midwifery/clinical director?**	Yes

Action plan owner	*Stuart Verdin Consultant Obstetricican / Rachel Coleman Quality and Safety Matron*
Lead executive director	*Judy Dyos Chief Nurse*
Amount requested from the incentive fund, if required	*£50,641.00*
Reason for not meeting action	*Poor understanding of technical guidence for audits and midwives not evidenceing CO monitoring of > 80 % of women at booking*
Rationale	*more clarity on guidence for audit and midwvies will be trained/updated to comply with CO montioring*
Benefits	*Audit owners will review audits and quarterly audits will be reviewed t the monthly audit meetin and safety champions to enure complince with standard by Q2 22/23; training update to beome more robust on manadatory yearly midwfery study day , Q1 to commence face to face teaching seesions with community midwives , quarterly data to be shared as above and with CMW to aid understanding*
Risk assessment	*non complince with safety action ; risk to womens health and risk of increased fetal growth restriction nd associated co moribidities*

	How?	**Who?**	**When?**
Monitoring	Through audit , safety champions and governence	Audit owners	Quarterly commenecing Q1 23/24

Action plan 4

Safety action	Q9 Safety Champions	**To be met by**	Q4 = 2023/24

Work to meet action	*to enusre the Trust claims scorecard is discussed quarterly at divisonal governence and subsequent reports shared thorught the quarterley quality and safety report seen at Board ; with safety champions, LMNS and ICS and any identified learning to be shared through learning events and departmental governence forums.*

Does this action plan have executive level sign off	Yes	**Action plan agreed by head of midwifery/clinical director?**	Yes

Action plan owner	*Joanne Hayward Director of Maternity and Neonatal services*
Lead executive director	*Judy Dyos Chief Nurse*
Amount requested from the incentive fund, if required	*£0.00*
Reason for not meeting action	*Trust score card not reviewed at correct forums and no learning shared*
Rationale	*More robust planning of reporting within governence processes will meet the required standard*
Benefits	*planned into governence workplan by Q1 23/24 to ensure compliance*
Risk assessment	*Non compliance with safety action*

	How?	**Who?**	**When?**
Monitoring	Through govenence process quarterly	Joanne Hayward , DOM	every quarter through 23/24

Action plan 5

Safety action	Q10 EN scheme	**To be met by**	Q2 = 2023/24

Work to meet action

Does this action plan have executive level sign off	Yes	**Action plan agreed by head of midwifery/clinical director?**	Yes

Action plan owner	*Rachel Coleman, Quality and Safety Matron*
Lead executive director	*Judy Dyos Chief Nurse*
Amount requested from the incentive fund, if required	*£0.00*
Reason for not meeting action	*did not refer in accordance with guidence for HSIB/ENS- no clearly defined process and 'single point of failure' regarding reporting within the Trust*
Rationale	*more robust process to ennsure compliance in place by Q1 23/24 with attention to single point of failure for completion of notification*
Benefits	timely referral fro babies and familes
Risk assessment	*imrpoved process and patient experience*

	How?	**Who?**	**When?**
Monitoring	review process and single point of failure	Rachel Coleman Quality and Safety Matron	Monitored through maternity goverennce meetings

Action plan 6

Safety action		**To be met by**	
Work to meet action	*Brief description of the work planned to meet the required progress.*		
Does this action plan have executive level sign off		**Action plan agreed by head of midwifery/clinical director?**	
Action plan owner	*Who is responsible for delivering the action plan?*		
Lead executive director	*Does the action plan have executive sponsorship?*		
Amount requested from the incentive fund, if required			
Reason for not meeting action	*Please explain why the trust did not meet this safety action*		
Rationale	*Please explain why this action plan will ensure the trust meets the safety action.*		
Benefits	*Please summarise the key benefits that will be delivered by this action plan and how these will deliver the required progress against the safety action. Please ensure these are SMART.*		
Risk assessment	*What are the risks of not meeting the safety action?*		

	How?	**Who?**	**When?**
Monitoring			

Action plan 7

Safety action		**To be met by**	
Work to meet action	*Brief description of the work planned to meet the required progress.*		
Does this action plan have executive level sign off		**Action plan agreed by head of midwifery/clinical director?**	
Action plan owner	*Who is responsible for delivering the action plan?*		
Lead executive director	*Does the action plan have executive sponsorship?*		
Amount requested from the incentive fund, if required			
Reason for not meeting action	*Please explain why the trust did not meet this safety action*		
Rationale	*Please explain why this action plan will ensure the trust meets the safety action.*		
Benefits	*Please summarise the key benefits that will be delivered by this action plan and how these will deliver the required progress against the safety action. Please ensure these are SMART.*		
Risk assessment	*What are the risks of not meeting the safety action?*		

	How?	**Who?**	**When?**
Monitoring			

Action plan 8

Safety action		**To be met by**	
Work to meet action	*Brief description of the work planned to meet the required progress.*		
Does this action plan have executive level sign off		**Action plan agreed by head of midwifery/clinical director?**	
Action plan owner	*Who is responsible for delivering the action plan?*		
Lead executive director	*Does the action plan have executive sponsorship?*		
Amount requested from the incentive fund, if required			
Reason for not meeting action	*Please explain why the trust did not meet this safety action*		
Rationale	*Please explain why this action plan will ensure the trust meets the safety action.*		
Benefits	*Please summarise the key benefits that will be delivered by this action plan and how these will deliver the required progress against the safety action. Please ensure these are SMART.*		
Risk assessment	*What are the risks of not meeting the safety action?*		

	How?	**Who?**	**When?**
Monitoring			

Action plan 9

Safety action		**To be met by**	
Work to meet action	*Brief description of the work planned to meet the required progress.*		
Does this action plan have executive level sign off		**Action plan agreed by head of midwifery/clinical director?**	
Action plan owner	*Who is responsible for delivering the action plan?*		
Lead executive director	*Does the action plan have executive sponsorship?*		
Amount requested from the incentive fund, if required			
Reason for not meeting action	*Please explain why the trust did not meet this safety action*		
Rationale	*Please explain why this action plan will ensure the trust meets the safety action.*		
Benefits	*Please summarise the key benefits that will be delivered by this action plan and how these will deliver the required progress against the safety action. Please ensure these are SMART.*		
Risk assessment	*What are the risks of not meeting the safety action?*		

	How?	**Who?**	**When?**
Monitoring			

Action plan 10

Safety action		**To be met by**	
Work to meet action	*Brief description of the work planned to meet the required progress.*		
Does this action plan have executive level sign off		**Action plan agreed by head of midwifery/clinical director?**	
Action plan owner	*Who is responsible for delivering the action plan?*		
Lead executive director	*Does the action plan have executive sponsorship?*		
Amount requested from the incentive fund, if required			
Reason for not meeting action	*Please explain why the trust did not meet this safety action*		
Rationale	*Please explain why this action plan will ensure the trust meets the safety action.*		
Benefits	*Please summarise the key benefits that will be delivered by this action plan and how these will deliver the required progress against the safety action. Please ensure these are SMART.*		
Risk assessment	*What are the risks of not meeting the safety action?*		

	How?	**Who?**	**When?**
Monitoring			

NHS Resolution

Maternity incentive scheme - Board declaration Form

Trust name Salisbury Hospital NHS Foundation Trust
Trust code #N/A

All electronic signatures must also be uploaded. Documents which have not been signed will not be accepted.

	Safety actions	Action plan	Funds requested	Validations
Q1 NPMRT	Yes		-	
Q2 MSDS	Yes		-	
Q3 Transitional care	No	Yes	40,735	
Q4 Clinical workforce planning	Yes		-	
Q5 Midwifery workforce planning	Yes		-	
Q6 SBL care bundle	No	Yes	50,641	
Q7 Patient feedback	Yes		-	
Q8 In-house training	No	Yes	25,700	
Q9 Safety Champions	No	Yes	-	
Q10 EN scheme	No	Yes	-	
Total safety actions	**5**	**5**		
Total sum requested			**117,076**	

Sign-off process:

Electronic signature

For and on behalf of the board of Salisbury Hospital NHS Foundation Trust

Electronic signature

For and on behalf of the board of Salisbury Hospital NHS Foundation Trust

Confirming that:
The Board are satisfied that the evidence provided to demonstrate compliance with/achievement of the maternity safety actions meets standards as set out in the safety actions and technical guidance document and that the self-certification is accurate.

Electronic signature

For and on behalf of the board of Salisbury Hospital NHS Foundation Trust

Electronic signature

For and on behalf of the board of Salisbury Hospital NHS Foundation Trust

Confirming that:
The content of this form has been discussed with the commissioner(s) of the trust's maternity services

Electronic signature

For and on behalf of the board of Salisbury Hospital NHS Foundation Trust

Electronic signature

For and on behalf of the board of Salisbury Hospital NHS Foundation Trust

Confirming that:
There are no reports covering either **this year (2020/21) or the previous financial year (2019/20)** that relate to the provision of maternity services that may subsequently provide conflicting information to your declaration. Any such reports should be brought to the MIS team's attention.

Electronic signature

For and on behalf of the board of Salisbury Hospital NHS Foundation Trust

Electronic signature

For and on behalf of the board of Salisbury Hospital NHS Foundation Trust

Confirming that:
If applicable, the Board agrees that any reimbursement of maternity incentive scheme funds will be used to deliver the action(s) referred to in Section B (Action plan entry sheet)
We expect trust Boards to self-certify the trust's declarations following consideration of the evidence provided. Where subsequent verification checks demonstrate an incorrect declaration has been made, this may indicate a failure of board governance which the Steering

Name:
Position:
Date:

Salisbury NHS Foundation Trust

Report to:	Trust Board (Public)	**Agenda item:**	3.1
Date of Meeting:	12 January 2023		

Report Title:	Maternity Incentive Scheme NHS Resolution, Board Assurance Report, January 2023			
Status:	**Information**	**Discussion**	**Assurance**	**Approval**
		x	x	x
Approval Process (where has this paper been reviewed and approved)	Divisional governance; noting at maternity governance			
Prepared by:	Joanne Hayward, Director of Maternity and Neonatal Services; Abi Kingston Clinical Director for Womens and Newborn Division Hannah Boyd Director of Operations for Womens and Newborn Division			
Executive Sponsor (presenting):	Judy Dyos, Chief Nurse			
Appendices (list if applicable):	Gap Analysis- safety action 1-3 Gap Analysis – safety action 4-6 Gap analysis – safety action 7-10 NHS Resolution deceleration for submission			

Recommendation:
For the Board to approve compliance following discussion and review of submitted evidence.

Executive Summary:
NHS Resolution is operating year four of the Clinical Negligence Scheme for Trusts (CNST) maternity incentive scheme to continue to support the delivery of safer maternity care. The scheme incentivises ten maternity safety actions as referenced in previous years' schemes. Trusts that can demonstrate they have achieved all of the ten safety actions will recover the element of their contribution relating to the CNST maternity incentive fund and will also receive a share of any unallocated funds. In 2021 the Maternity service at Salisbury NHS Foundation Trust (SFT) was successful in achieving compliance in 4 of the 10 criteria for NHS Resolution (NHSR), Clinical Negligence Scheme for Trusts (CNST/ year 3). It should be noted that the year 4 scheme has had several reiterations of the safety actions following the pandemic and extension of submission dates to assist Trust to achieve the safety actions by the submission date of 12 noon 2nd February 2023. **The Maternity service at SFT for year 4 is declaring compliance with 5 out of the 10 safety actions**. The remaining 5 will have action plans submitted to NHS Resolution with financial costings for approval.

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

NHS Salisbury NHS Foundation Trust

Report to:	Trust Board (Public)	**Agenda item:**	3.3
Date of Meeting:	12 January 2023		

Report Title:	Q2 Learning from Deaths Report 2022 - 2023			
Status:	**Information**	**Discussion**	**Assurance**	**Approval**
			x	
Approval Process (where has this paper been reviewed and approved)	Mortality Surveillance Group/ Clinical Effectiveness Steering Group and Clinical Governance Committee			
Prepared by:	Dr Ben Browne, Head of Clinical Effectiveness			
Executive Sponsor (presenting):	Dr Peter Collins, Chief Medical Officer			
Appendices (list if applicable):				

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

Executive Summary:

Summary:
There were 243 inpatient deaths in Q2. This figure is inclusive of patients who died in either the Emergency Department or the Hospice.

During Q2:

- There were 7 deaths where COVID-19 was identified as the primary cause of death (most occurring in July 2022).
- There was 1 stillbirth and 0 neonatal deaths in Q2.
- There were 0 maternal deaths in Q2.
- There were 2 deaths reported in patients with a learning disability in Q2.
- There were no deaths identified in patients with a serious mental illness in Q2.

- There has been a positive reduction in the number of concerns being identified by the Medical Examiners in Q2 through their screening processes. This may be due to the reduction in falls being seen, however, these findings will be closely monitored and continue to be discussed at the Trust's Mortality Surveillance Group.

- 107 families gave consent for the Trust's Your Views Matter bereavement survey to be posted and 27 completed surveys were returned.
    - 67% of respondents rated the overall end of life care as good or very good.
    - There appears to have been a lower overall rate of satisfaction observed in the month of September.
    - Areas such as compassion and dignity satisfaction rates continue to be largely positive. However, symptom management and communications has seen some decline.

National Benchmarks

It was agreed at the Mortality Surveillance Group that a two-month time lag will now be applied to the HSMR data to improve the accuracy of data for the 12-month period. This is due to a potential coding backlog for the two most recent months of discharge data. Therefore, the latest HSMR is for the 12-month rolling period ending in May 2022.

- The HSMR (relative risk) for the Trust (includes hospice data) for the twelve-month period ending in May 2022 is 115.1 and is statistically higher than expected (106.8 – 124.0, 95% confidence limits).
- The HSMR (relative risk) for Salisbury District Hospital (excludes hospice data) for the twelve-month period ending in May 2022 is 109.8 and is statistically higher than expected (101.3 – 118.9).
- Weekday HSMR is 113.1 and weekend HSMR is 125.6. Both are statistically higher than expected.

- The SHMI for Salisbury District Hospital for the twelve-month period ending in May 2022 is 1.0605 and for Salisbury Trust is 1.0956. Both are within the expected ranges, as reported by NHS Digital.

Board Assurance Framework – Strategic Priorities	Select as applicable
Local Services - We will meet the needs of the local population by developing new ways of working which always put patients at the centre of all that we do	☐
Specialist Services - We will provide innovative, high quality specialist care delivering outstanding outcomes for a wider population	☐
Innovation - We will promote new and better ways of working, always looking to achieve excellence and sustainability in how our services are delivered	☐
Care - We will treat our patients, and their families, with care, kindness and compassion and keep them safe from avoidable harm	☒
People - We will make SFT a place to work where staff feel valued and are able to develop as individuals and as teams	☐
Resources - We will make best use of our resources to achieve a financially sustainable future, securing the best outcomes within the available resources	☐
Other (please describe) -	☐

NHS Salisbury NHS Foundation Trust

Report to:	Trust Board – Public	**Agenda item:**	3.4
Date of Meeting:	12 January 2023		

Report Title:	**Director of Infection Prevention and Control, 6 monthly Report**			
Status:	**Information**	**Discussion**	**Assurance**	**Approval**
			x	
Approval Process (where has this paper been reviewed and approved)	IPCC			
Prepared by:	Fiona McCarthy Lead Nurse Infection Prevention Judy Dyos Chief Nursing Officer			
Executive Sponsor (presenting):	Judy Dyos, Chief Nursing Officer			
Appendices (list if applicable):	Appendix A Infection Prevention & Control – Annual Action Plan 2022/23 Appendix B Bacteraemia's - all cases are reportable to UK Health Security Agency (UKHSA) Appendix C Tendable Infection Prevention & Control (IPC) Inspection Compliance scores for Quarters 1 & 2 of 2022/23			

Recommendation:
The Trust Board are asked to note the Trust's performance regarding Infection prevention in this 6-monthly report .

Executive Summary:
The purpose of this six monthly DIPC Report is to summarise the work undertaken at Salisbury NHS Foundation Trust (SFT) and inform the Trust Board of the progress made against the 2022/23 Annual Action Plan, to reduce healthcare associated infections (HCAI) and sustain improvements in infection prevention and control practices. The action plan focuses on the Trust achieving the standards identified in *'The Health and Social Care Act 2008: Code of Practice on the prevention and control of infections and related guidance' (revised July 2015),* to ensure that patients are cared for in a clean and safe environment, where the risk of HCAI is kept as low as possible. For the reported period, the Trust has experienced a challenging six months for infection prevention and control, with the ongoing response and recovery from the COVID-19 pandemic. This has involved: • Fourteen COVID-19 outbreaks affecting inpatient areas • Significant amounts of work have been completed and remain ongoing for antibiotic stewardship, decontamination, cleaning services, water, and ventilation safety.

However, it is important to note that the following risks to delivery were identified:

- Challenging hand hygiene assessment compliance despite new process being undertaken.
- Delay in the Trust implementation of the national programme *'Every Action Counts'* due to the Infection Prevention and Control Team (IPCT) nursing vacancy and the ongoing COVID-19 workload impacting roll out.

Included in the report for the first time are graphs demonstrating how Salisbury's NHS Foundation Trust benchmark against other local and regional trusts in relation to key Health Care Associated Infections.

- C. Difficile – In line with others in region and regional incidence is lower than national numbers
- MRSA- BSW benchmarks well against national data , trust level not provided
- E Coli – SFT lowest in regional data
- MSSA– below or in line with others in the region
- Klebsiella- SFT lowest in regional data
- Pseudomonas – increased incidence in August / September

In most cases the position is favourable although pseudomonas cases increased in the later months of the reporting period. Monitoring and Point of Usage filters programme is in place and managed via the water safety group . While we are not outliers for C.difficile and BSW benchmark well, we continue to focus on the collaborative work with partners in reducing this further and improving antimicrobial stewardship across our community.

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

INFECTION PREVENTION AND CONTROL

DIRECTOR OF INFECTION PREVENTION AND CONTROL

6 MONTHLY UPDATE REPORT

April 2022 – September 2022

JUDY DYOS
Director of Infection Prevention and Control (DIPC)

October 2022 (Draft v.2)

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APPENDICES

1. INTRODUCTION

The Trust Board recognises their collective responsibility for minimising the risks of infection and has agreed the general means by which it prevents and controls these risks. The responsibility for infection prevention and control is delegated to the Director of Infection Prevention & Control (DIPC) who is the Chief Nursing Officer.

The DIPC Reports together with the monthly Key Quality Performance Indicators (KQPI) Report are the means by which the Trust Board assures itself that prevention and control of infection risks are being managed effectively.

The purpose of this six monthly DIPC Report is to summarise the work undertaken at Salisbury NHS Foundation Trust (SFT) and inform the Trust Board of the progress made against the 2022/23 Annual Action Plan (Appendix A), to reduce healthcare associated infections (HCAI) and sustain improvements in infection prevention and control practices.

The action plan focuses on the Trust achieving the standards identified in *'The Health and Social Care Act 2008: Code of Practice on the prevention and control of infections and related guidance' (revised July 2015),* to ensure that patients are cared for in a clean and safe environment, where the risk of HCAI is kept as low as possible.

For the reported period, the Trust has experienced a challenging six months for infection prevention and control, with the ongoing response and recovery from the COVID-19 pandemic. This has involved:

- Fourteen COVID-19 outbreaks affecting inpatient areas
- Significant amounts of work have been completed and remain ongoing for antibiotic stewardship, decontamination, cleaning services, water, and ventilation safety.

However, it is important to note that the following risks to delivery were identified:

- Continued low hand hygiene assessment compliance despite new process being undertaken.
- Delay in the Trust implementation of the national programme *'Every Action Counts'* due to the Infection Prevention and Control Team (IPCT) nursing vacancy and the ongoing COVID-19 workload impacting roll out.
- Trust involvement with infection prevention and control (IPC) collaboratives with regional colleagues has not progressed.

2. GOVERNANCE ARRANGEMENTS

The work towards achieving the objectives of the Annual Action Plan 2022/23 is monitored via the Infection Prevention and Control Working Group (IPCWG), which reports to the Infection Prevention and Control Committee (IPCC) and onto the Clinical Governance Committee (CGC), which completes the governance arrangements.

3. INFECTION PREVENTION & CONTROL ARRANGEMENTS

A comprehensive infection prevention and control service is provided Trust wide. The IPCT provides a liaison and telephone consultation service for all inpatient and outpatient services, with additional arrangements for seven-day service cover by an Infection Control Nurse (ICN) during declared Norovirus outbreaks and other clinical activity exceptions.

The IPCT currently comprises an Infection Control Doctor (ICD)/Consultant Microbiologist, and 2.0 whole time equivalent (w.t.e) ICNs and secretary (0.6 w.t.e). In addition, there are 3 Consultant Microbiologists, one of whom is the Trust Antimicrobial Lead. (*Of note: For the reported period, there has continued to be a 1.0 w.t.e vacancy for a Band 6 ICN. Following an extensive recruitment exercise, a secondment position has been accepted by an internal staff member to commence in January 2023).*

4. ASSURANCE ACTIVITIES

The IPCC monitors the action plan on behalf of the Trust Board, which is achieved through the following actions:

- Agree an annual infection control programme and monitor its implementation
- Oversee the implementation of infection control policies and procedures
- Monitor and review the incidence of HCAI
- Develop and review information regarding infection prevention and control
- Monitor the activities of the Infection Prevention and Control Team
- Benchmark the Trust's delivery of control of infection standards in various accreditation systems, and against Care Quality Commission (CQC) Regulations
- Monitor the implementation of infection prevention and control education
- Receive regular updates from the Antibiotic Reference Group (ARG)
- Receive regular updates from the IPCWG
- Monitor compliance and formal reporting on Legionellosis and *Pseudomonas* water management, via the Water Safety Group (WSG)
- Receive regular reports from the Decontamination Working Group (DWG)
- Receive regular reports from the Ventilation Safety Group (VSG) *(Of note: creation of Ventilation Safety Group during quarter 4 of 2021/22)*
- Receive regular reports from the Facilities Division regarding cleaning programmes.

5. HEALTHCARE ASSOCIATED INFECTION (HCAI) STATISTICS AND SURVEILLANCE

The Trust is required to report any HCAI outbreaks externally as a serious incident (SI). An outbreak is defined as the occurrence of two or more related cases of the same infection over a defined period. When a HCAI outbreak is declared, the Trust initially reports the outbreak to the relevant Clinical Commissioning Group (CCG) and other regulatory bodies, e.g., NHS Improvement (NHSi), within 2 working days, and must undertake an investigation and submit a formal written report within 45 working days.

The Trust is also required to record these incidents on the strategic executive information system (STEIS) in line with the *Serious Incident Framework: Supporting learning to prevent recurrence (NHS England, March 2015)*, and the *Public Health England (PHE) HCAI: Operational Guidance & Standards for Health Protection Units (HPUs) (July 2012),* PHE now UK Health Security Agency (UKHSA) from 1st October 2021.

During quarters 1 and 2 of 2022/23, the Trust has had **no** declared internal outbreaks of:

- *Clostridioides difficile* (*C.difficile*)
- Viral gastroenteritis (Norovirus)
- *Staphylococcus aureus*, including Methicillin Resistant *Staphylococcus aureus* (MRSA)
- Methicillin Sensitive *Staphylococcus aureus* (MSSA)
- Carbapenemase producing enterobacteriaceae (CPE)
- Invasive Group A Streptococcus (iGAS)
- Multi-drug resistant Acinetobacter baumannii (MDRAB)
- Chickenpox (Varicella zoster)
- Extended Spectrum Beta Lactamase (ESBL) producers, including *Klebsiella Pneumoniae*
- Pertussis
- Respiratory Syncytial Virus (RSV)
- Influenza ('flu)
- Vancomycin Resistant Enterococcus (VRE)
- Tuberculosis (TB).

Additional information regarding alert organisms can be accessed from the PHE website: https://www.gov.uk/government/organisations/public-health-england

The ICNs provide clinical teams with infection control advice, support, and education on a daily basis to all inpatient and outpatient areas. The management of patients admitted with suspected

and known alert organisms is discussed, and risk assessments undertaken. The Isolation Risk Assessment Tool (IRAT), Flowchart for the Management of Inpatients with Diarrhoea, and Diarrhoea Pathway have been developed and implemented to assist staff competency and confidence in the management of cases.

The availability of sideroom facilities across the Trust site to isolate infected patients can be limited at times when demands on bed capacity are high. In such instances, risk-based decisions are necessary. Patients with alert organisms can be safely managed either within cohort bays, or isolation nursed in a bedspace. The ICNs continue to review patients nursed in siderooms to prioritise high risk patients. Information and guidance are communicated to and discussed with, the ward nursing and medical teams, including the Clinical Site Coordinators (as necessary). Additional written documentation is provided to support staff in the ongoing management of these patients.

5.1 SARS-CoV (COVID-19)

The Trust continued to experience COVID-19 activity during quarters 1 and 2 of 2022/23, and the ICNs worked closely with the divisions and Clinical Site Team around COVID-19 management. All newly identified COVID-19 positive cases for inpatients were discussed at the Virtual Board Round (VBR) meetings. This group is chaired by the Deputy DIPC, with core attendance including Consultant Microbiologists, ICNs, and divisional representatives. All cases are reviewed to ensure the correct management and classification of positive cases; the management of any identified patient contacts; and consideration of any potential links between positive cases. Staffing continues to be an agenda item at the VBR meetings, with attendees reporting any identified trends or concerns around COVID-19 related staff sickness for discussion. Any matter deemed to require escalation from the VBR group is taken by the chair to the Incident Management Team (IMT).

IPC guidance has continued to evolve throughout the pandemic, with several key documents being updated or published by the UKHSA. During quarter 1, this has included new COVID-19 pathogen specific advice for health and care professionals and a National Infection Prevention and Control Manual (NIPCM) for England.

The Trust has continued to implement practice changes across testing, the management of identified contact patients, the wearing of Level 1 facemasks and social/physical distancing. As a result, the ICNs provided increased guidance and support to staff, particularly in relation to testing and the management of both positive patients and contact patients.

During quarter 2, review at the Clinical Management Board (CMB) and IMT clarified the Trust's adoption of the Aerosol Generating Procedures (AGPs) as outlined in the NIPCM for England. Consideration was also given to the ongoing requirements for the wearing of Level 1 facemasks across the Trust site. From the end of August, Level 1 facemasks remained a requirement to be worn in clinical areas, however, were no longer required to be worn in the main corridors or non-clinical areas.

The Trust is reflecting the move by all healthcare settings back towards their own pre-pandemic policies. However, it is recognised that there may be a period of transition as the Trust makes changes to policies and SOPs, dependent on local variation in COVID-19 infection levels.

5.2 COVID-19 outbreak prevention and management

During quarters 1 and 2 of 2022/23, updates to the outbreak management and reporting iRespond card were completed. The aim of the card continues to ensure that the Trust implements a rapid and well coordinated response to an outbreak of COVID-19 infection, in line with requirements set out in the Southwest Regional COVID-19 Healthcare Setting Outbreak Framework. The roles and responsibilities of all individuals and departments involved in outbreak management are clearly defined, making efficient use of available resources in order to limit the spread of infection and minimise the disruption of clinical services.

It was necessary for the Trust to implement the planned outbreak response process during quarters 1 and 2 of 2022/23, with the declaration of 14 COVID-19 outbreaks for inpatient areas within the medical and surgical divisions:

- **Farley Ward** (Acute Stroke Services) declared on **6th April 2022**, with positive results for 6 patients and no staff member linked to this outbreak cohort. The outbreak was closed by the Trust on 11th May 2022.
- **Tisbury CCU** (Cardiology) declared on **27th April 2022**, with positive results for 3 patients and no staff members linked to this outbreak cohort. The outbreak was closed by the Trust on 1st June 2022.
- **Amesbury Suite** (Trauma and Orthopaedics) declared on **27th April 2022**, with positive results for 8 patients and no staff members linked to this outbreak cohort. The outbreak was closed by the Trust on 1st June 2022.
- **Whiteparish Ward** (Endocrinology) declared on **27th April 2022**, with positive results for 8 patients and no staff members linked to this outbreak cohort. The outbreak was closed by the Trust on 9th June 2022.
- **Laverstock Ward** (Respiratory) declared on **14th June 2022**, with positive results for 19 patients and no staff members linked to this outbreak cohort. The outbreak was closed by the Trust on 26th August 2022.
- **Tisbury CCU** (Cardiology) – 2nd outbreak declared on **20th June 2022**, with positive results for 11 patients and no staff members linked to this outbreak cohort. The outbreak was closed by the Trust on 15th August 2022.
- **Redlynch Ward** (Gastroenterology) declared on **21st June 2022**, with positive results for 21 patients and no staff members linked to this outbreak cohort. The outbreak was closed by the Trust on 1st September 2022.
- **Pitton Ward** (Acute Frailty) declared on **30th June 2022**, with positive results for 18 patients and no staff members linked to this outbreak cohort. The outbreak was closed by the Trust on 6th October 2022.
- **Britford Ward** (Surgery) declared on **30th June 2022**, with positive results for 10 patients and no staff members linked to this outbreak cohort. The outbreak was closed by the Trust on 15th August 2022.
- **Day Surgery Unit** (Escalation) declared on **6th July 2022**, with positive results for 6 patients and no staff members linked to this outbreak cohort. The outbreak was closed by the Trust on 3rd August 2022.
- **Downton Ward** (Surgery) declared on **6th July 2022**, with positive results for 13 patients and no staff members linked to this outbreak cohort. The outbreak was closed by the Trust on 1st September 2022.
- **Breamore Ward** (Stroke Rehabilitation) declared on **7th July 2022**, with positive results for 11 patients and no staff members were linked to this outbreak cohort. The outbreak was closed by the Trust on 24th August 2022.
- **Whiteparish Ward** (Endocrinology) – 2nd outbreak declared on **12th July 2022,** with positive results for 14 patients and no staff members linked to this outbreak cohort. The outbreak was closed by the Trust on 24th August 2022.
- **Durrington Ward** (Acute medical) declared on **14th July 2022**, with positive results for 13 patients and no staff members linked to this outbreak cohort. The outbreak was closed by the Trust on 2nd September 2022.

There was a requirement to close bays, with the creation of positive cohort bays in identified areas. Laverstock Ward was closed temporarily from 16th to 21st June to aid outbreak management.

For these outbreaks, the Outbreak Management Group (OMG) was formed with review meetings held throughout. The meetings were well attended by all required individuals and departments within the Trust and by representatives from UKHSA and BaNES, Swindon, and Wiltshire (BSW) Integrated Care Board (ICB). The OMG ensured that appropriate arrangements were in place to care for the affected patients and staff, instigating and monitoring the effectiveness of the control measures implemented in containing the spread of infection. The impact on service delivery was constantly reviewed, with communication to all relevant groups, including patients, relatives,

carers, and staff completed as appropriate. The production and distribution of meeting notes and actions was undertaken by the ICNs.

The outbreaks were reported externally to the NHS Outbreak System on the Insights Platform for NHS England & NHS Improvement (NHSE&I) within the expected reporting timeframes (within 24 hours of declaration). Updates were reported on the same system when additional cases were identified and/or following an outbreak management review meeting. A further notification was made on the same system at the ending of an outbreak, defined as when there had been no confirmed cases with onset dates in the 28 days since the last positive result.

During quarter 2, following discussion at the IPCWG and with approval of the DIPC, the internal timeframe for an outbreak was reduced to 14 days since the last positive case related to the outbreak cohort. IPC practice and monitoring measures continued to be in place for the subsequent 14 days until the external reporting criteria of 28 days was met.
COVID-19 outbreak status timeframes reviewed internally and reduced to 14 days by the Trust. This was following regional outbreak management feedback and risk assessment decision.

For the declared COVID-19 outbreaks, application of the national COVID-19 case definitions to these 161 patient cases classifies 87 as hospital onset; definite healthcare associated. The Trust recognises that where any infections are classified as hospital onset healthcare associated then there is clearly scope for learning, and that this is the same for COVID-19 infections.

During this prolonged outbreak period, the ICNs have worked additional hours to provide extra support and oversight of the outbreak areas. This has also been necessary to complete the required outbreak management administration tasks for external reporting on the NHSE&I outbreak portal.

5.4 Influenza
During quarter 2 of 2022/23, there have been cases of Influenza A identified for both adults and children admitted to the Trust. The patients were nursed under isolation precautions, with no onward transmission or links identified. Cases of Respiratory Syncytial Virus (RSV) were also identified, with the majority of cases in children. Subsequently to this reporting period increases in Influenza and RSV have been significant and will be reflected in the CEO report for January 2023 and the next 6 monthly DIPC report .

5.5 Norovirus (viral gastroenteritis)
During quarters 1 and 2 of 2022/23, the Trust has experienced a consistent level of activity associated with patients experiencing diarrhoea and/or vomiting. This included patients admitted with symptoms of diarrhoea and/or vomiting and isolated in a sideroom from admission, and patients who were nursed in a bay environment and developed symptoms during their admission period.

As previously reported, the DIPC commissioned the divisions to undertake a clinical review of the four viral gastroenteritis (Norovirus) outbreaks declared during quarter 4 of 2021/22 from 11th to 24th March 2022. This review was completed during quarter 2 of 2022/23 with a final report detailing recommendations and identified actions, for presentation at the Patient Safety Steering Group (PSSG) during quarter 3 of 2022/23. A total of 4 wards within the medical and surgical divisions were affected with bay closures/ward closures during the declared outbreak period. These closures ensured the safe management of patients and continued service provision. The Trust Norovirus Outbreak Management policy was followed with the appropriate internal and external personnel involved.

5.6 Monkeypox virus
Monkeypox is an infectious viral disease that became a global problem after cases were detected around the world in May 2022. There have been 3,485 cases confirmed as of 26th September 2022 in the UK.

The Trust followed the national guidance as it arose, formed a Monkeypox cell that had regular meetings with key staff and produced a detailed guideline and action cards for staff to follow in terms of when to suspect monkeypox clinically, how to test and how to manage the patient if positive. There were also vaccines given to high-risk patients seen in the Genito-Urinary Medicine (GUM) Department. Trust networks were also used to promote the vaccination programme, this was presented as a deep dive at the October CGC meeting.

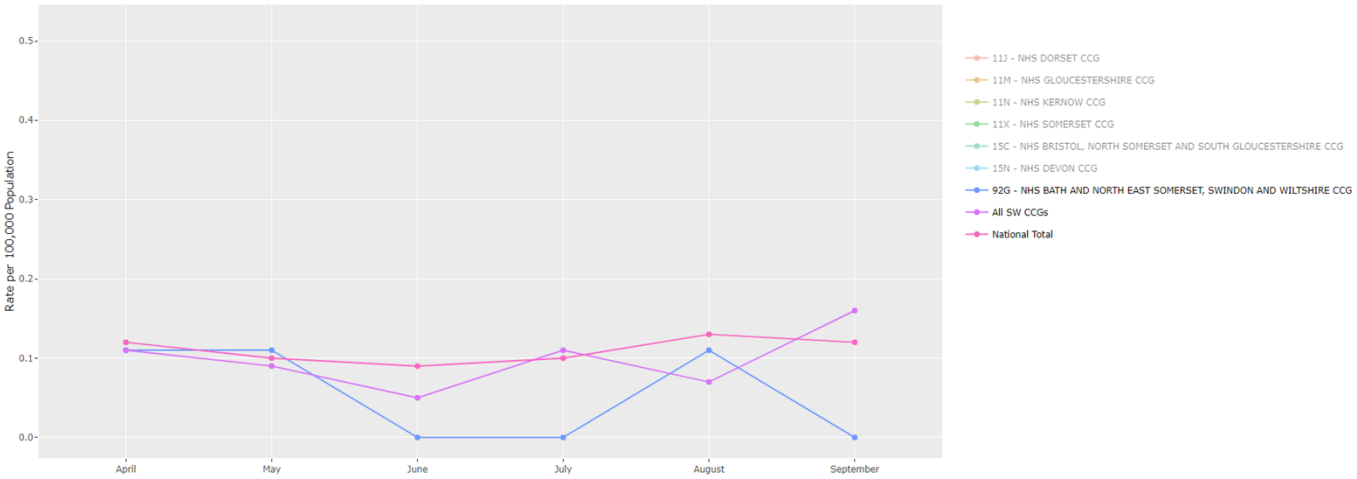
At Salisbury, there were 5 cases diagnosed. All patients with a positive result were managed at home by the GUM Team as per national and local guidance and there were no severe infections requiring hospital admission to SFT. Contacts were followed up and managed by UKHSA.

6. MANDATORY SURVEILLANCE

Alert organism and alert condition surveillance data is collected and used by the Trust to detect outbreaks and monitor trends. It is a mandatory requirement for NHS Acute Trusts to report Methicillin Resistant *Staphylococcus aureus* (MRSA) and Methicillin Sensitive *Staphylococcus aureus* (MSSA) bacteraemias, and *Clostridioides difficile* infections to the Department of Health (DH) via the HCAI Data Capture Site (DCS) system, hosted by UKHSA (*Mandatory enhanced MRSA, MSSA and Gram negative bacteraemia, and Clostridioides difficile infection surveillance Protocol (version 4.3) updated January 2020).*

6.1 Methicillin Resistant *Staphylococcus aureus* (MRSA) bacteraemias

During quarters 1 and 2 of 2022/23, there have been no hospital or community onset MRSA bacteraemia cases reported by the Trust. The Trust's MRSA hospital onset case target for 2022/23 is zero. Table 1 taken from the Bath Swinson and Wiltshire ICS (BSWICS) Health Associated Infection (HCAI) report for Q2 indicates that BSW benchmark well for MRSA rates against national and southwest data .



(Table1 BSW MRSA data)

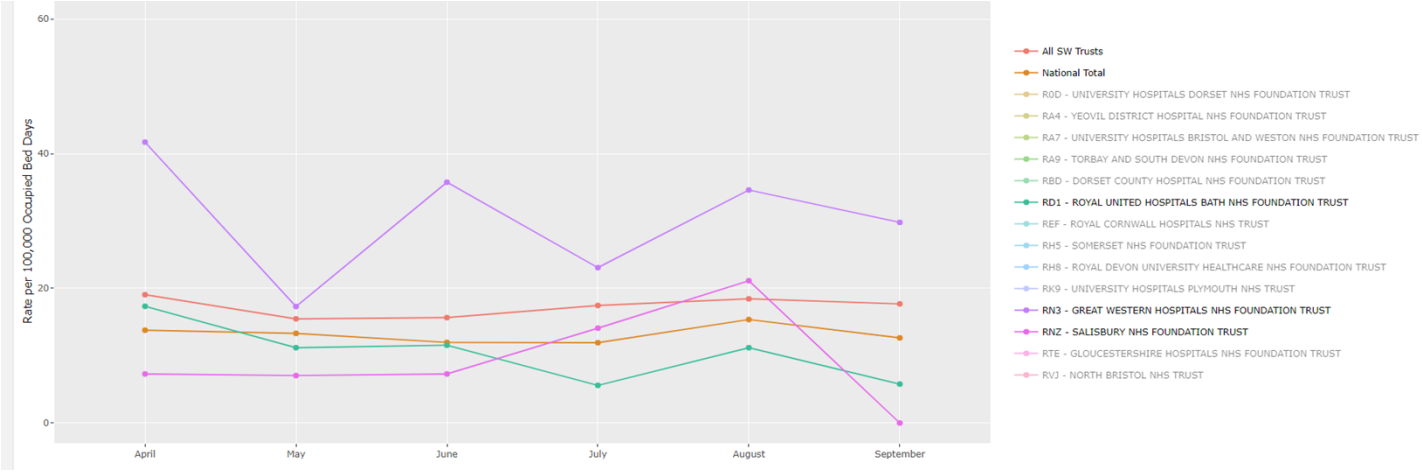
6.2 Methicillin Sensitive *Staphylococcus aureus* (MSSA) bacteraemias

During quarters 1 and 2 of 2022/23, there have been 8 unrelated healthcare associated MSSA bacteraemia cases, of which 3 cases were community onset and 5 cases were hospital onset. For the hospital onset cases the sources of infection were identified as:

- Endocarditis (1 case)
- Unknown/unclear source (4 cases).

Post infection reviews were requested to be completed by the ward teams. Of those reviews completed, none of these infections were associated with a vascular access device.

Of note: Currently, there is no national guidance for data definition of MSSA bacteraemia cases for reduction targets to be set. UKHSA are collating data which may act as a baseline for trajectory setting in the future. Therefore, the Trust has applied the definition criteria used for MRSA bacteraemia cases to the MSSA bacteraemia cases recorded within the Trust. This allows the cases to be classified as either hospital onset or community onset. Table 2 demonstrates that SFT benchmark well against national data in general .



(Table 2 Trust MSSA data)

6.3 Gram-negative organism bloodstream infections (GNBSIs)

The increase in gram negative organism bacteraemia infections is a national concern and mandatory surveillance of *Escherichia coli (E.coli), Klebsiella species (spp.)* and *Pseudomonas aeruginosa* bacteraemias continues. This reporting at the Trust now requires enhanced investigation and data entry onto the UKHSA DCS website. This work is undertaken by the ICNs.

A national action plan 'Tackling antimicrobial resistance 2019 – 2024' (January 2019) advises that work should continue to reduce healthcare associated GNBSIs, adopting a systematic approach to preventing infections and delivering a 25% reduction by 2021/22 with a full 50% reduction by 2023/24.

6.3.1 *Escherichia coli (E.coli)*

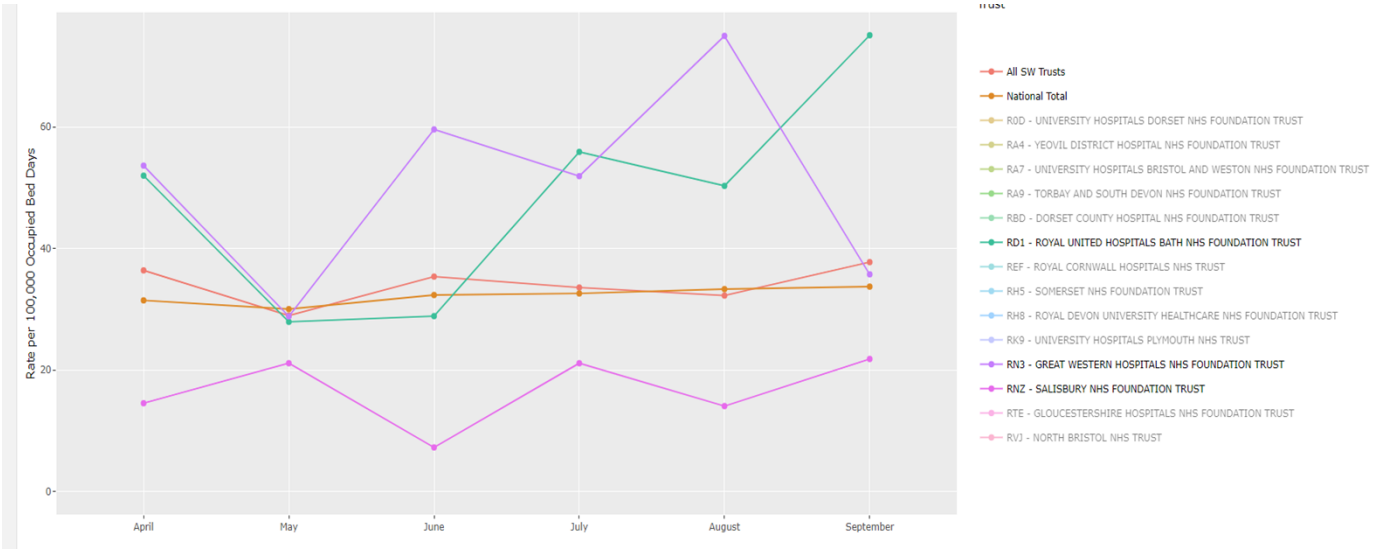
Following the identification of a positive blood culture result for *E.coli,* a Consultant Microbiologist completes a UKHSA mandatory enhanced surveillance form. In consultation with the relevant clinician, key patient factors are considered in order to establish if the case is likely to be healthcare related. However, it may not be possible to determine.

During quarters 1 and 2 of 2022/23, there have been 14 unrelated healthcare associated *E.coli* bacteraemia cases, of which 10 cases were community onset and 4 cases were hospital onset. Of the 4 hospital onset cases identified, an unknown or no underlying focus of infection was identified for one case, and the remaining 3 cases had a source of infection identified. Of these unrelated 3 cases, the sources of infection were:

- Lower urinary tract (1 case)
- Gastrointestinal or intra-abdominal collection (1 case)
- Upper respiratory tract (1 case)

The Trust will continue to work closely with local community and hospital partners to reduce the incidence of *E.coli* bloodstream infections (BSIs) for the whole health economy, with the initial focus on reducing those infections related to urinary tract infection (UTI). In addition, as usual activity levels resume, the ICNs will continue to work collaboratively with the relevant ICBs who are leading on achieving this Quality Premium guidance.

The Trust's *E.coli* case threshold for 2022/23 is no more than 35 healthcare associated cases (*as detailed in the Official NHS Standard Contract 2022/23 document (version 1) published 27th April 2022).* Table 3 demonstrates that SFT benchmark well against national and local case numbers .



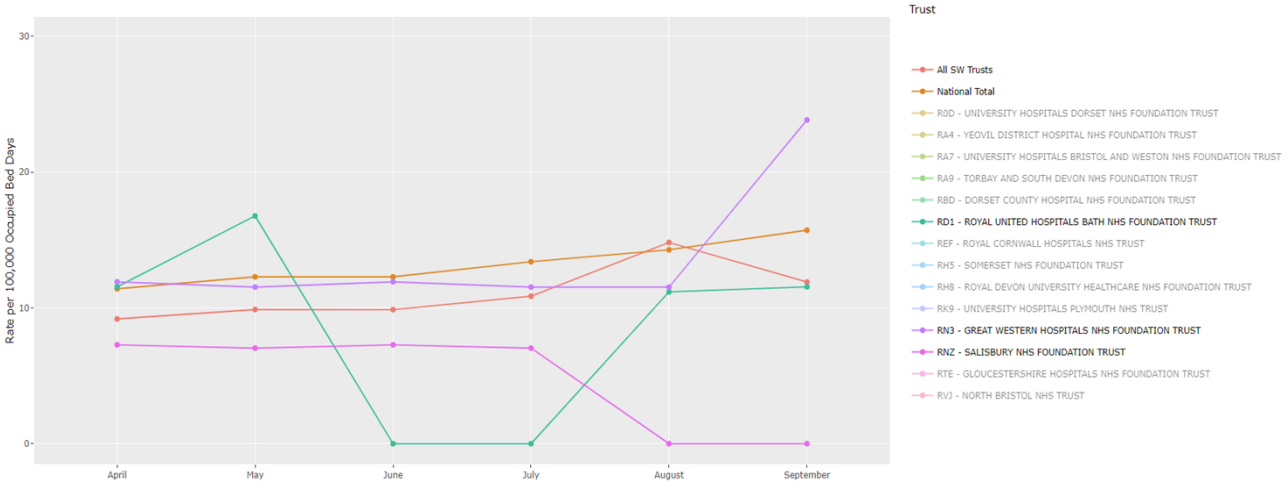
(Table 3 Trust E Coli Data)

6.3.2 *Klebsiella spp.* and *Pseudomonas aeruginosa*

During quarters 1 and 2 of 2022/23, there have been 4 unrelated healthcare associated *Klebsiella spp.* bacteraemia cases, of which 2 cases were community onset and 2 cases were hospital onset. There have been 5 unrelated healthcare associated *Pseudomonas aeruginosa* bacteraemia cases, of which one case was community onset and 4 cases were hospital onset.

The Trust's *Klebsiella spp.* case threshold for 2022/23 is no more than 14 healthcare associated cases and for *Pseudomonas aeruginosa,* no more than 12 healthcare associated cases (*as detailed in the Official NHS Standard Contract 2022/23 document (version 1) published 27th April 2022).*

Further information relating to official statistics and benchmarking of performance can be found at: https://www.gov.uk/government/collections/healthcare-associated-infections-hcai-guidance-data-and-analysis However local data taken from the NHS Bath Swinson and Wiltshire(BSW) Health Associated Infection(HCAI) report for Q2 (Table 4) demonstrates SFT as the trust with the lowest levels and well below national levels of Klebsiella.



(Table 4 Trust Klebsiella data)

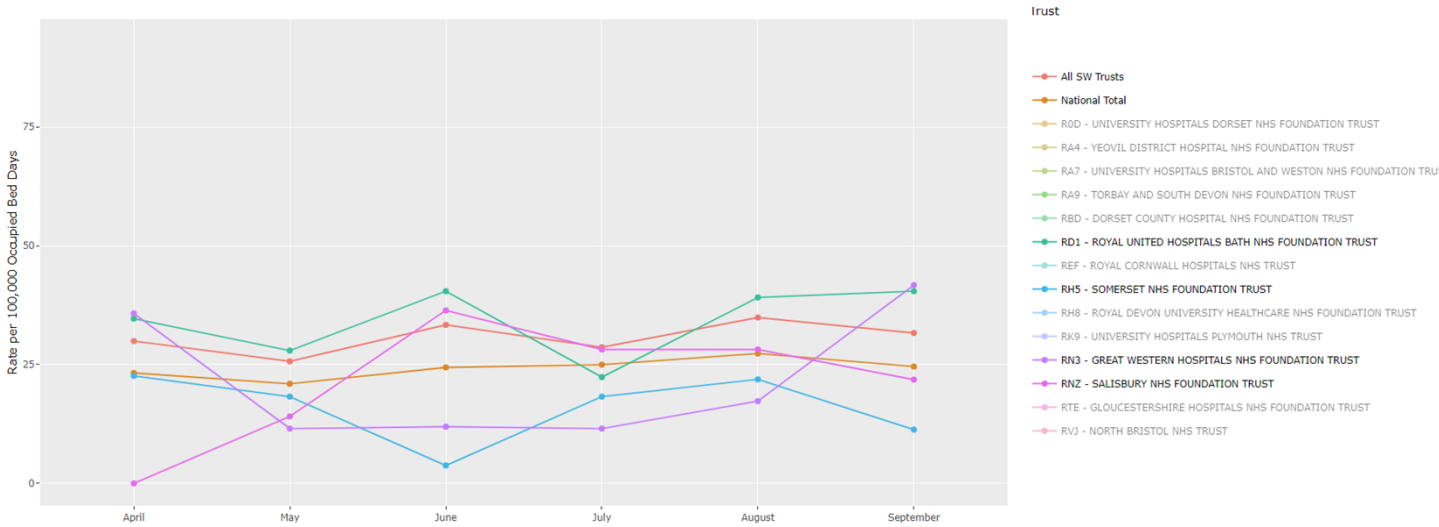
6.4 *Clostridioides difficile (C.difficile) Infection*

The control of this infection is managed by the combination of adherence to the correct infection control practices, environmental cleaning, equipment decontamination and prudent antibiotic stewardship.

The Trust continues to apply Department of Health (DH) guidance for *C.difficile* testing and all *C.difficile* positive stool samples that test toxin positive are reportable to UKHSA. For 2019/20, changes were made to the *C.difficile* reporting algorithm. This included the addition of a prior healthcare exposure element for community onset cases and reducing the number of days to apportion hospital onset healthcare associated cases from three or more (day 4 onwards) to two or more (day 3 onwards) days following admission.

For 2022/23, the *C.difficile* case threshold objective set for the Trust by NHSE&I is no more than 23 healthcare associated reportable cases. All Trust thresholds are derived from a 2019 calendar year baseline, to avoid capturing changes related to the pandemic and include healthcare associated cases only. Guidance for testing and reporting *C.difficile* cases remained unchanged, and the safety and care of patients remains our concern and priority.

During quarters 1 and 2 of 2022/23, the Trust has reported 18 healthcare associated *C.difficile* cases to UKHSA, of which 9 cases were community onset and 9 cases were hospital onset. Incident investigations are carried out for all hospital onset cases using a 'SWARM' approach. This process is facilitated by the ICNs with the relevant Clinical Leader and divisional Matron to assess whether there were any lapses in quality care provided to the patient and whether this contributed to the case. In addition, the ICNs review the community onset cases to establish whether any lapses in care occurred during their previous hospital admission (in the preceding 4 weeks). Table 5 below demonstrates a spike in June 2022 but that overall SFT are in line with other trusts in BSW which benchmarks well overall nationally as seen in table 6.



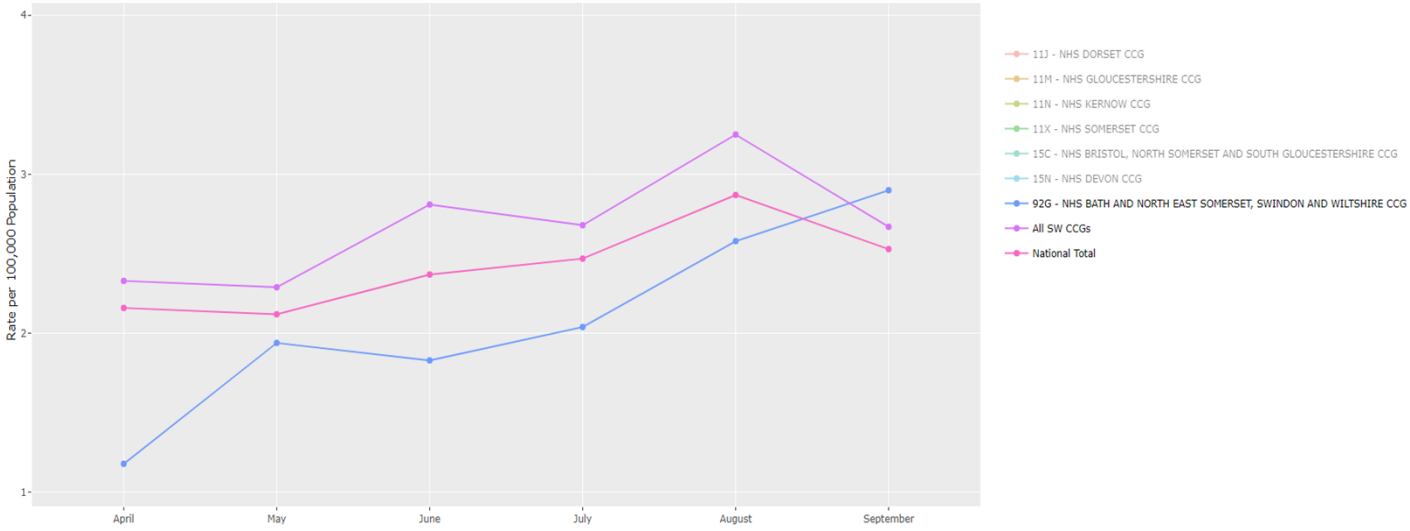
(Table 5 Trust C. Difficile Data)

From the completed incident investigations for the hospital onset cases, lapses in care were identified. Key learning has included improvements required for the use of the Diarrhoea Pathway, instigation of isolation nursing and closure of bays, timeliness of sampling symptomatic patients, and timeliness of clinical reviews for these patients. *Of note: No incident reviews of healthcare associated C.difficile cases have been identified for submission to the relevant ICBs as there have been no Appeals Process Panels held.*

In addition, the ICNs have completed extra investigations for the *C.difficile* cases identified within the community setting, where these patients have previously had a recent inpatient episode of care

at the Trust. This has resulted in the implementation of enhanced environmental cleaning of identified clinical areas.

Representatives from the Trust were involved in the Southwest Regional HCAI *C.difficile* infection improvement collaborative event held during quarter 2 of 2021/22. The aim being to reduce harm to the population of the Southwest Region from *C.difficile* infection and share wider learning, with outcomes fedback to the DIPC and IPCWG. Due. Table 2 shows that the Southwest benchmarks positively against national data for C.difficile infection rates



(Table 6 BSW C. Difficile Data)

6.4.1 Periods of increased incidence (PII) of *C.difficile*

During quarters 1 and 2 of 2022/23, two unrelated PIIs of *C.difficile* were declared within the medical and surgical divisions for two separate wards (Farley and Downton Wards). The required incident investigations were completed for the positive cases with the involvement of relevant personnel. Further measures were also implemented across the areas, including additional environmental cleaning by Housekeeping and extra audits, and monitoring of practices, overseen by the relevant senior staff including the Head of Nursing (HoN) and Matrons.

From the positive samples sent for ribotyping, the ICD noted that the results were all different, with no links identified.

Please see Appendix B for the Infection Prevention & Control 'Dashboard' for quarters 1 and 2 of 2022/23 for further detail of HCAI data.

6.5 NHS Standard Contract 2022/23

Table 7 below summaries the threshold levels for the Trust's count of healthcare associated (i.e., hospital onset healthcare associated (HOHA) and community onset healthcare associated (COHA)) cases for 2022/23 (*as detailed in the Official NHS Standard Contract 2022/23 document; Minimising Clostridioides difficile and Gram-negative bloodstream infections (version 1) published 27th April 2022).*

Organisation code	Name	Case thresholds for 2022/23			
		C.difficile	*E.coli*	*P.aeruginosa*	*Klebsiella spp.*
RNZ	Salisbury NHS Foundation Trust	23	35	12	14

(Table 7)

6.6 Surgical Site Infection Surveillance (SSIS)
The ICNs coordinate data collections for the national SSIS programme of various surgical procedures, which are applicable to the Trust. For the mandatory surveillance of SSI following orthopaedic surgery, Trusts must participate in a minimum of one surveillance period in at least one category of orthopaedic procedures during a financial year. The Trust complies with this annual requirement to undertake SSIS.

Active data collection for the category of repair of fractured neck of femur (NOF) surgery has continued from quarter 4 of 2021/22 into quarters 1 and 2 of 2022/23, to ensure than an extended cohort number of cases is attained.

Final data collection for quarter 4 of 2021/22 was reconciled within the required timeframe set by UKHSA. There were a total of 50 cases entered onto the national database, with one deep incisional SSI identified. This was followed up by the Consultant for the patient, who reviewed the case identifying nothing unexpected and with no clear trends. The case was also discussed at departmental meetings by the speciality surgical team. The ICNs have provided information to UKHSA as requested.

From the data collected during quarter 1 of 2022/23, a total of 60 cases were identified, with a final total of 48 cases entered onto the national database and reconciled within the required time frame set by UKHSA. There were no infections identified. *Of note: It has been noted that on reconciliation of data, the number of patients included within the reporting periods, have reduced from those first identified. This is a result of the clinical code allocated to the operation, being different from those being included within this category of surveillance, as set out by UKHSA.*

Data collection continued in quarter 2 of 2022/23, with final records to be entered onto the national database and submitted for reconciliation by the end of quarter 3 of 2022/23.

Formal reports outlining progress with SSIS have been presented at the IPCC meetings and disseminated to relevant Trust personnel.

The IPCT requested that the orthopaedic team complete a review of the NICE guideline (NG125) for surgical site infections during quarters 1 and 2 of 2022/23 to provide additional assurances around pre-operative, intra-operative and post-operative practices in reducing the incidence of SSI. The outcome will be fedback via the IPCWG during quarter 3 of 2022/23.

6.7 MRSA screening
The Trust has continued to report MRSA screening rates for all elective and emergency admissions to ensure continued improvement in reducing infections. These screening compliance rates are monitored by the Divisional Management Teams (DMTs) and reported as a KQPI. The ICNs undertake a monthly emergency admission MRSA screening audit, and a quarterly elective admission MRSA screening audit.

Feedback is provided to DMTs about compliance rates and any identified missed screens for follow up actions. For quarters 1 and 2 of 2022/23, the Trust compliance rates for MRSA emergency screening ranged from 86.18% - 93.23%. For MRSA elective screening, the Trust compliance rates ranged from 68.57% (April) – 79.55% (July). However, it must be acknowledged that the number of elective patients within both elective screening cohorts remains exceptionally small.

Outcomes of any follow up of actions undertaken by the clinical divisions are included within their current reporting processes and to include any shared learning. The current Trust screening policy exceeds the requirements outlined within the Department of Health guidance published in 2015 and continues following further review by the Trust.

6.8 Infection in Critical Care Quality Improvement Programme (ICCQIP)
From April 2017, the Trust has participated in the surveillance of bloodstream infections in patients attending the Intensive Care Unit (ICU) and Neonatal Unit (NNU). From the data submitted so far, report updates have been provided by PHE and cascaded to the area leads. A query was raised by UKHSA for ICU data submitted for quarter 1 (April – June 2022), which was fully investigated by the ICU Team. The dataset records were correct and confirmed to UKHSA.

6.9 Private Healthcare Information Network (PHIN)
The Trust continues to complete mandatory reporting externally regarding private patients via PHIN. In relation to infection prevention and control, this involves the ICNs undertaking monthly cross checking of a dedicated SharePoint database of private patients. If it is identified that a patient has a HCAI that is externally reportable (as per national mandatory reporting definitions), then this is added to the SharePoint database for the relevant patient, for submission to PHIN by the Trust.

From the data provided to the ICNs for review, there have been no externally reportable infection alert organisms identified for this patient group during quarters 1 and 2 of 2022/23.

7. HAND HYGIENE
Fifty-three areas (including wards and departments) across the four clinical divisions carry out a monthly audit of hand hygiene compliance in their area against the World Health Organisation's (WHO) '5 moments for Hand Hygiene'.

The Trust target for hand hygiene compliance rates is >85%, with formal reporting by the divisions of measures implemented to improve non-compliance. When compliance is poor, the ICNs support individual clinical areas and staff groups promoting patient safety and hand decontamination. The audit results continue to be disseminated according to staff groups for each area. This action has provided evidence to strengthen the feedback process for the divisions to take the necessary action.

Due to the ongoing COVID-19 pandemic, there have been no audits completed by the external auditor during quarters 1 and 2 of 2022/23. However, arrangements have been made to recommence this work during quarter 4 of 2022/23. The clinical divisions have been undertaking some peer cross auditing within their areas and specialities to further validate the audit process.

Detailed analysis was undertaken to identify the key areas of non-compliance, which were predominantly staff missing moment number 5, handwashing after contact with patient surroundings and following removal of gloves. The results were reported via the DIPC, and the IPCC and feedback was provided to the clinical leaders and DMTs to address the shortfall in practice. Additional education and support have been provided by the ICNs to staff groups focusing on these audit findings.

For the internal hand hygiene audits completed, the overall average compliance rate for quarters 1 and 2 of 2022/23 ranges from 74.52% - 100%. It should be noted that completion of these audits has been variable across all divisions, which the divisions have reported as being due to reduced staffing levels and ongoing operational/bed capacity challenges.

The 'Red, Amber and Green' (RAG) rating for the hand hygiene compliance audits continues and includes actions to be identified for areas that do not achieve the 'pass threshold' of 85% or show improvements. This RAG rating was further revised, and the impact of these measures being monitored by the IPCWG, DMTs and Patient Led Assessment in the Clinical Environment (PLACE) Steering Group.

8. ANTIBIOTIC STEWARDSHIP

The Antimicrobial Reference Group (ARG) currently has a new chair which is the Lead Antimicrobial Pharmacist who started in late June 2022. Antimicrobial stewardship (AMS) ward rounds have been continuing weekly with a Consultant Microbiologist, Antimicrobial Pharmacist and Antimicrobial Pharmacy Technician.

A review of AMS ward round data indicates, the AMS team has seen 281 patients and made 107 interventions in the last quarter. The majority of interventions made, involved inappropriate duration of antibiotics, and differing antibiotic prescribing compared to Trust guidance.

8.1 Commissioning for Quality and Innovations (CQUINs) for 2021/22

CQUINs restarted in April 2022, with SFT being assigned the urinary tract infection (UTI) CQUIN: "CCG2: Appropriate antibiotic prescribing for UTI in adults aged 16" (extended from previous UTI CQUIN). The current UTI CQUIN will involve patients aged 16 or over, including patients with catheter associated UTI (CAUTI), looking to achieve a targeted compliance of 40-60%. Quarter 1 and quarter 2 figures indicate 80% and 79% compliance respectively.

8.2 Total antibiotic consumption

Reducing total antimicrobial usage has now become part of the NHS contract. Our target is to reduce antimicrobial use by 2% every year. In a rolling 12-month period, there is a 0.54% reduction in total consumption of antibiotics, indicating that SFT is not currently compliant with the NHS contract. Extrapolation of data indicates that Britford Ward, Acute Medical Unit (AMU), Emergency Department (ED) Majors, Laverstock and Downton Wards have high daily defined dosages (DDDs) in comparison with other hospital wards.

SFT does have a higher consumption of antibiotics from the WHO AWaRe 'Watch' category compared to the WHO AWaRe 'Access' category with highest usage of antibiotics: Co-Amoxiclav, Cefuroxime and Ciprofloxacin. It must be noted that the above antibiotics are prominent in current antimicrobial policies, however this will be reviewed in the future.

8.3 Action plan for 2022/2023

1. Review of COVID-19 guidance as current positive patients have seen a four-fold increase within the southwest region
2. Review of Oseltamivir and Influenza vaccine guidance as flu season has started early
3. Review and updating of Microguide
4. ARG to discuss antibiotic input/protocols within Electronic Prescribing and Medicines Administration (EPMA) system
5. Review of antibiotic related patient group directives (PGDs)

8.4 Ongoing challenges

AMS ward rounds occur weekly; however, a second truncated ward round has been undertaken pending staff availability. The Lead Antimicrobial Pharmacist is in the process of implementing a ward round rota to determine if this can continue moving forward.

The referrals to the AMS Team are reliant on the wider clinical pharmacy staff. In the future, with the role out of EPMA, the ARG hope a programme can be made to quantify all antibiotics used within SFT in real time, thus eliminating the reliance and need for referral streams.

Data from infection prevention and control is currently being reviewed by the Lead Antimicrobial Pharmacist to ascertain an accurate picture of *C.difficile* rates within the hospital with an aspiration of a *C.difficile* ward round occurring monthly.

Continuation of the UTI CQUIN is producing a high rate of compliance above the stated target, with the expectation of passing the CQUIN. A possible new CQUIN regarding intravenous (IV) to oral switch might be released in the near future.

9. AUDIT

The ICNs have not undertaken any formal policy audit during quarters 1 and 2 of 2022/23 but have been involved in supporting identified clinical areas to complete the Tendable inspections *(formerly Perfect Ward Application)* for infection prevention and control. This process ensures that audit is clinically focused and targeted at improving infection prevention and control practices for all disciplines across the Trust. *Of note: these inspections include policy practice standards as part of audit criteria.*

Any observations/findings are fedback verbally to the clinical leader/nurse in charge at the time with instruction to access the results report to identify any required actions. The results are also available for the HoN and Matrons to access (via the application), with formal reports fedback via the PLACE Steering Group. (*Completion of these audits has been in addition to the 'spot checks' and observational practice audits undertaken by the ICNs during daily clinical visits to ward areas*).

The HoN, Matrons and clinical leaders also complete the additional Tendable quick COVID-19 assessment inspections within identified clinical areas. These focus on monitoring and assurance around several measures, including signage, provision of hand hygiene opportunities, provision of PPE and observations of PPE practices, and adherence with the relevant COVID-19 pathway in the area. It also includes the questioning of staff around COVID-19 symptoms for patients and staff and the resulting actions indicated, isolation and decontamination practices, and demonstrating awareness of visiting guidance and how to escalate any staffing concerns. When required, the ICNs have continued to support the areas and staff with addressing any concerns arising from these inspections. For quarters 1 and 2 of 2022/23, the overall average IPC compliance scores reported have ranged from 81.97% - 98.79%.

Please see Appendix C for further details, the results continue to provide transparency across a number of IPC indicators at practice level.

10. EDUCATION AND TRAINING ACTIVITIES

Education and training continues to be an important part of the work of the IPCT. Mean compliance scores for quarters 1 and 2 of 2022/23 were 79% for staff completion of hand hygiene assessments and 91% for staff completion for IPC computer-based learning (CBL) package *(LEARN data accessed 01.10.2022).*

The low hand hygiene assessment compliance is an ongoing concern and may be attributed to the access opportunities for staff due to the COVID-19 pandemic. In response, the ICNs have continued to focus on the promotion of different working opportunities for staff to complete their hand hygiene assessment. This has included arranging extra sessions within specific work areas and enabling identified staff to be trained to undertake hand hygiene assessments. Furthermore, the clinical divisions facilitated the completion of hand hygiene assessments for staff by utilising an ultra-violet (UV) light box for rotation through their divisional areas and departments. In addition, the ICNs are working with the Education Department to improve compliance for staff completing these mandatory training modules.

During March 2022, the DIPC requested a review of the method currently used for assessing hand hygiene technique to simplify the process and improve compliance. It was agreed to trial an alternative process with one of the clinical wards reporting a low compliance, with the support of the Practice Education Team. The hand hygiene assessment trial commenced on Pitton Ward, with the ward leader assessing the hand hygiene technique of staff members by observing hand washing in the ward environment. This was supported by the ICNs to ensure a clear and systematic process was followed for the assessments. However, it has since been identified that the LEARN reports are not reflecting full compliance for the ward team, which has been followed up. Another ward area was nominated for the extension of this work; however this has not progressed, and the division have been asked to identify another area. This work will be progressed during quarters 3 and 4 of 2022/23 with outcomes reported via the IPCWG.

The ICNs have contributed to formal and informal teaching sessions within clinical areas and other Trust departments. Several of the core infection prevention and control sessions have been delivered for different staff groups, in addition to specific topic requests. The ICNs have also met with small groups and teams or on a one-to-one basis, to provide guidance and aid improved understanding of policies and practices. There has been a continued focus on promoting learning through the daily clinical visits undertaken by the ICNs.

There has been a delay in the Trust implementation of the national programme *'Every Action Counts'* due to the IPCT nursing vacancy and the ongoing COVID-19 workload impacting roll out.

Formal 'virtual' meetings with the Infection Control Link Professionals (ICLPs) group have been held during quarters 1 and 2 of 2022/23. Communications via e-mail and through discussions with various ICLPs as part of both routine and additional visits undertaken by the ICNs to clinical and non-clinical areas have continued. Details of education opportunities provided are available from the ICNs.

11. DECONTAMINATION

11.1 Key Success stories in quarters 1 and 2 of 2022/23

The Trust successfully undertook a tendering exercise for the post of Authorised Engineer for Decontamination (AE(D)), and the contract commenced in June 2022. This transition is a natural opportunity for a 'Fresh Eyes' approach to decontamination, assessing our existing processes and identifying where improvements can be made. Our new AE(D) also holds the post at RUH, which will facilitate opportunities for shared learning and benchmarking.

ETS have identified Jon Thorne (JT) to take on the role of Authorised Person for Decontamination (AP(D)). JT is already familiar with the SDH site and much of the equipment. Our AE(D) will support and mentor JT as he gains experience in the new role and prior to formal AP(D) training, likely during quarters 3 and 4 of 2022/23. Having an AP(D) in post at SFT after a prolonged vacancy in this role (previously covered by the AE(D) to ensure compliance with HTM requirements), is a very positive step to ensuring processes are managed robustly with a local focus. Going forward, the AE(D) can focus on acting in their capacity as an external expert offering independent auditing and technical advice.

The SSL contract review between SFT and Steris has been completed. The review facilitated discussions to ensure the contract reflects current practice and outlines expectations. The governance arrangements have also been reviewed and regular meetings to discuss contractual and operational issues will commence in quarter 3 of 2022/23.

11.2 Progress on actions during quarters 1 and 2 of 2022/23

Work to transfer the decontamination audits to the Tendable app is progressing, and a test audit has been created. Once confirmed the format will be made 'live' and results monitored via the Decontamination Working Group (DWG). The questions will enable compliance against Trust policies, the IPC Board Assurance Framework (BAF), and relevant National Patient Safety Alerts (NPSA) to be monitored.

A Project Board has been set up to oversee the refurbishment work in Sterile Services Limited (SSL). Tenders have been submitted and a preferred supplier identified. Once awarded, a firm date for commencement of the work and timescale will be known. The Project Board is aware of the potential impact on the department operationally and aim to minimise the disruption to instrumentation reprocessing wherever possible.

Fertility Clinic have trialled a second device to undertake automated decontamination of invasive ultrasound probes, with positive outcome. This is an alternative to our existing fleet of devices so a separate contractual arrangement will need to be arranged.

11.3 Key challenges for quarters 3 and 4 of 2022/23

The Creutzfeldt-Jakob disease (CJD) and Decontamination policies require review to ensure their content remains appropriate. Progress against workplans relating to 'business as usual' activity is slow due to the backdrop of operational pressures which continue to challenge priorities.

12. CLEANING SERVICES

This section summarises the key components of the Trust's cleaning programme, to ensure the provision of a safe and clean environment for patients and their relatives, visitors, and staff. The following areas of work are managed by the Housekeeping Department and Facilities Directorate.

12.1 Patient led assessment of the care environment (PLACE) internal audits

The Trust has undertaken a programme of PLACE audits which commenced in June 2022. We plan to undertake approximately 60 internal PLACE audits over the coming year.

The result of each PLACE assessment is submitted to the Health and Social Care Information Centre using the PLACE 'Lite' tool and discussed with ward leaders at the monthly PLACE Steering Group meetings.

To support social distancing and to minimise footfall within clinical areas the number of participants in PLACE inspections will be limited, with limited Governors or Volunteers present.

12.2 National PLACE

We have been informed by NHS Improvement (NHSi) that this year's National PLACE inspection will be taking place in November 2022.

12.3 Deep clean programme/rapid response team

The deep clean programme commenced in April 2022 with a plan to deep clean every sideroom, bedspace and outer area over the coming year *(a copy of the Deep Clean programme is available from the Housekeeping Department).*

12.4 Improvement Work Over the past 6 months

To support the Trust's COVID-19 response the Housekeeping Team is still providing a 24-hour service with a small cleaning team on site out of hours. We are currently funding this out of existing housekeeping budgets and will continue to review with a desire to scale this back as Hospital activity allows.

Below are **Tables 8, 9** and **10** (overleaf) from the past 3 years indicating the increased activity during the pandemic.

2022/23 MONTH	APR	MAY	JUN	JUL	AUG	SEP	OCT	NOV	DEC	JAN	FEB	MAR	TOTALS
POST INFECTION CLEANS	1305	741	855	1176	717	687							
ENHANCED HRS	66.50	50	73	112.75	102	63.25							
DOUBLE CLEANS HRS	42.25	50.25	64.25	84.75	51.25	50							
BIOQUELL	34	47	32	30	42	33							

(Table 8)

2021/22 MONTH	APR	MAY	JUN	JUL	AUG	SEP	OCT	NOV	DEC	JAN	FEB	MAR	TOTALS
POST INFECTION CLEANS	1076	934	850	1106	1105	1127	1180	1114	1386	1322	1436	1807	**14443**
ENHANCED HRS	67.75	67.50	50	66.5	70.75	70.25	73.50	71	65.50	86.50	124.75	113.75	**927.75**
DOUBLE CLEANS HRS	104	84.75	79.5	88.0	93.25	60.50	44.75	35.75	50.50	91	51	65.75	**846.75**
BIOQUELL	39	40	38	61	56	49	36	35	60	40	38	51	**543**

(Table 9)

2020/21 MONTH	APR	MAY	JUN	JUL	AUG	SEP	OCT	NOV	DEC	JAN	FEB	MAR	TOTALS
POST INFECTION CLEANS	1564	1726	1558	1408	1121	1180	1200	1304	1575	2589	1694	1341	**18260**
ENHANCED HRS	38.5	48.25	47.5	72.25	95	56	53.75	96.5	105.5	102.25	65.25	57	**837.75**
DOUBLE CLEANS HRS	4.5	0	40.25	82.25	60.25	77.5	105	149.5	140.25	0	26.25	27	**712.75**
BIOQUELL	30	29	37	62	36	42	39	30	50	10	58	50	**473**

(Table 10)

12.5 Challenges for the coming 6 months
Housekeeping is working towards the new National Cleaning Standards including key elements, task lists, risk categories, audit requirements over a phased implementation period.

Recruitment remains a challenge due to a reduction in applicants and the incentives associated with clinical posts (for healthcare support workers). Recruitment is required to undertake the new Cleaning Standards and we are working with OD & People/Human Resources and recruitment agencies to support this recruitment drive.

12.6 Successes from the past 6 months
Housekeeping have been successful in securing funding towards the new cleaning standards and there will be a rolling implementation plan.

Housekeeping prepared the allocated South Newton Site wards (Nadder Ward and Pembroke Lodge) in preparation for the relocation of patients from Breamore Ward to enable replacement of the hot and cold-water pipework on the ward.

Housekeeping continues to provide cleaning services for the Vaccination Centre at Salisbury City Hall.

13. WATER SAFETY MANAGEMENT

This section summarises the water safety management precautions that the Trust has taken over quarters 1 and 2 of 2022/23. The Trust manages the safety of water systems in line with the Health Technical Memorandum (HTM) 04-01 (Part B) Safe Water in Healthcare Premises and HTM 04-01 (Pt C) *Pseudomonas* (guidance for augmented care units), together with the technical guidance document HSG274 (Part 2).

To assist the management process in respect of the water systems across the site, regular meetings of teams (Responsible Person (RP) and designated Responsible Person (dRP) water) from Estates Technical Services (ETS) Team and FES Ltd (PFI maintenance contractor) are held monthly, to review progress with planned preventative maintenance (PPMs) and actions in respect of water safety.

13.1 Legionella
The Trust continues to keep the domestic hot water temperature elevated above 65°C as a precaution in the challenge of *Legionella* control. The water systems within hospitals are complex; therefore, the testing and controls we have in place are designed to mitigate the risks to our patients and staff.

Emergency review meetings (see Table 11 overleaf) for *Legionella* (listing counts reported >1000 cfu/l) and high counts for *Pseudomonas* (Table 12) have taken place in the Trust as a result of the sample results). The actions and results of the ongoing checks have been circulated to senior

members of the Trust in a series of e-mails as events occur, and as regular reports to the Water Safety Group (WSG) and IPCC. Actions taken have included the cleaning and disinfection of outlets, with temperature checks and increased flushing where necessary.

Legionella						
	Ward/ Department	LG Ref	Location	Action plan	Test result as of 11/10/2022	
					Pre	Post
1	Breamore Ward	27 + 28	WHB (wash hand basin) far end of ward	Outlet back in use, PALL filter fitted, remedial on systems required.	4600	4800
2	Emergency Department	33	Majors' cubicle 11	Outlet left in use; PALL filter fitted. Additional sample to be taken for Cubicle 9.	400	1200
3	Short Stay Emergency Unit (SSEU)	31	SSEU Nurse Base	Fit PALL filter, clean disinfect and resample.	1800	1200
4	Block 81	53	Room 2	Carry out additional flushing and resample.	57000	200
5	Tisbury CCU	112	Bay 2 WHB	Outlet left in use; PALL filter fitted.	800	1800
6	Tisbury CCU	113	Bay 4 WHB	Outlet left in use, PALL filter fitted, carry out additional flushing and sample shower in Room 4.01.22.	1000	120
7	Pathology Laboratory	93	Blood RM	Fit PALL filter, investigate issues with system (temperature/circulation).	16000	800
8	Block 05	119 (IVF)	Room 6 WHB	Outlet tap replaced; additional samples required.	4000	20
9	Main Switchboard	40	Kitchen	Outlet back in use with PALL filter fitted, works required on system, fed from Sector 04.	22000	1700
10	Main Switchboard	41	Kitchen	Fit PALL filter, clean and disinfect outlet and resample.	8400	4000
11	Ear, Nose & Throat (ENT) Department	13	3.04.14	Fit PALL filter, investigate issues with system (temperature/circulation).	1000	1800
12	ENT Department	15	3.04.24	Fit PALL filter, investigate issues with system (temperature/circulation).	4200	940
13	Level 3 Laboratories	86	3.14.37	Fit PALL filter, investigate issues with system (temperature/ circulation).	30000	20
14	L3 Laboratories	87	3.14.37	Fit PALL filter, investigate issues with system (temperature/circulation).	1000	920
15	L3 Laboratories	88	3.14.17A	Fit PALL filter, investigate issues with system (temperature/circulation).		1000
16	L3 Laboratories	92	3.15.13	Fit PALL filter, investigate issues with system (temperature/ circulation).	3200	120
17	Level 4 Laboratories	103	4.14.27	Fit PALL filter, investigate issues with system (temperature/ circulation).	10000	400
18	L4 Laboratories	104	4.14.12	Fit PALL filter, investigate issues with system (temperature/ circulation).	2600	1000
19	Main Kitchens	257	Chemical cupboard	Outlet disinfected and resampled.	1800	60
20	Amesbury Suite		4.10.207	Outlet disinfected and resampled.	40	>20

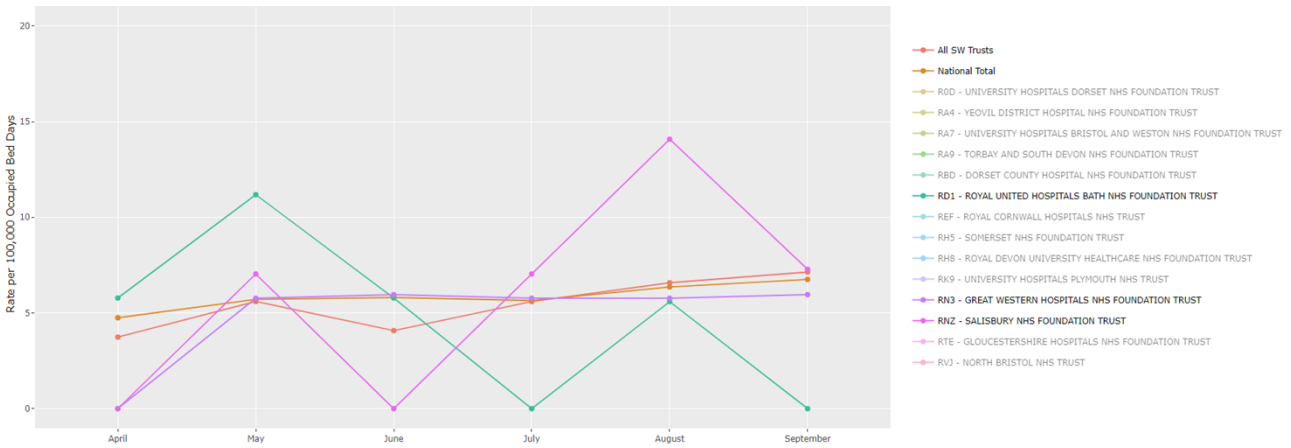
(Table 11)

13.2 *Pseudomonas* Sampling

Live counts of *Pseudomonas* are being managed on Sarum Ward and Odstock Ward, the latest actions and results from resampling as listed on Table 12 below. Positive outlets are being managed using point of use filters (POU); next round of testing (6 monthly) is due week commencing 3rd October 2022. These areas (Sarum and Odstock Wards) that are currently being managed with POU filters take priority with this round of testing followed by NNU, ICU (Radnor Ward) and Pembroke Unit. Table 13 shows a spike in pseudomonas infections in the last three months of this reporting period and close monitoring and point of use filtering is in place.

Pseudomonas						
	Ward/Department	PS Ref	Location	Action plan	Test result as of 11/10/2022	
					Pre	Post
1	Sarum Ward	109	4.06.09	Clean, disinfect and resample.	50	1
2	Sarum Ward	114	4.06.12	Clean, disinfect and resample.	14	1
3	Sarum Ward	108	4.06.08	Clean, disinfect and resample. PALL filter fitted.	>100	>100
4	Odstock Ward	171	S/C 4.11.07	Remedial works required. PALL filter fitted.	>100	
5	Odstock Ward	197	Shower (SHW) 4.11.20	Remedial works required; PALL filter fitted.	>100	
6	Odstock Ward	200	SHW 4.11.21	Remedial works required; PALL filter fitted.	>100	
7	Odstock Ward	209	SHW 4.11.29	Remedial works required; PALL filter fitted.	>100	
8	Odstock Ward	216	SHW 4.11.33	Remedial works required; PALL filter fitted.	>100	
9	Odstock Ward	228	SHW 4.11.43	Remedial works required; PALL filter fitted.	>100	
10	Odstock Ward	231	SHW 4.11.41	Remedial works required; PALL filter fitted.	>100	
11	Odstock Ward	235	SHW 4.11.43	Remedial works required; PALL filter fitted.	>100	
12	Odstock Ward	241	SHW 4.11.51	Resample pre + post.	1	Not detected (ND)

(Table 12)



(Table 13 Trust Pseudomonas data)

13.3 Pool Water Quality

Following a positive sample from microbiological testing completed on 26th September 2022, the Spinal Unit Pool was shut at 11am on 28th September 2022. Remedial works were completed by the ETS Team, and the pool was resampled on 29th September. Following a clear sample, the pool was reopened on 4th October 2022.

13.4 Achievements for quarters 1 and 2 of 2022/23

- Full site wide risk assessment completed by the Water Hygiene Centre, the risk assessment covers all generation and storage of hot and cold-water systems. This includes identifying risks associated with the design, installation, and maintenance of these systems.
- Audit completed on water safety; the audit is completed in line with the Premises Assurance Model (PAM). The water Authorised Engineer (AE) has noted that there has been an improvement in elements of water, however, noting that further work is required.
- Trial of an electronic system for the PPM of shower head/hose quarterlies and PALL POU filter replacements.
- Completion of routine *Legionella* and *Pseudomonas* testing and development of subsequent action plans.
- Maintenance and monitoring of the temperature of the main circulated hot and cold-water systems across the SFT Estate.
- Capital funded works commenced in October 2022 on the replacement of the hot and cold-water pipework on Breamore Ward. The works is being completed as part of an action plan as a result of high counts of *Legionella* on the ward.
- Improvements in flushing compliance for Priority 1 areas at 78%.

13.5 Key Focus for quarters 3 and 4 of 2022/23

- Maintaining the level of flushing compliance for Priority 1 and 2 areas to circa 75%.
- Develop an action plan related to the actions identified from the site water risk assessment.
- Engagement of key members (DIPC, Consultant Microbiologist, ICNs) of the WSG in supporting action plans and quarterly meetings of the WSG.
- Ensuring that the Water Safety plan is approved/adopted by the WSG.
- Completion of *Pseudomonas* testing (6 monthly) for the augmented wards (ICU (Radnor Ward), NNU, Pembroke Unit, Sarum and Odstock Wards).
- Completion of tasks highlighted by the AE Water from the water safety audit completed on 16th September 2022.

14. SPECIALIST VENTILATION

This section summarises the management and actions on the Trust Specialist Ventilation systems that the Trust has taken over quarters 1 and 2 of 2022/23.

The annual PPM has been completed on the air handling units (AHUs) that supply Main Theatres Department (MTD), Sterile Services Limited (SSL), Pharmacy Aseptic Unit, Radiology Xray, Sarum Ward, SSL Clean Room, MRI 2, Eye Clinic, Emergency Department (ED, Tisbury CCU and Catheterisation Laboratories. The next areas scheduled to be completed include the AHUs that supply the main laboratories (Genetics, Pathology & Microbiology).

Air change rate (AC) survey works have now been completed in wards areas. This has highlighted some spaces that have AC rates below 6 air changes per hour. The ETS Team are investigating these areas, and to date a fault has been identified with the ventilation system supplying Downton Ward which will rectified as soon as possible and Sarum Ward, which has been rectified.

A full PPM including the replacement of the supply fans, inverters and unit filters was completed on the 9th July 2022 on the Pharmacy Aseptic Unit. As part of these works, the alignment of the motor and fan pulley has been checked and adjusted, and this has resulted in significant improvements to its performance.

The annual clean and de-grease of the main extract system for the kitchens was completed on the 9th June 2022.

An overhaul including the replacement of the supply motors and unit filters was completed on 27th August 2022 on the SSL Clean Room AHU. As part of the works, both the motors have been replaced along with new bearings for the fan and this has resulted in significant improvements to its performance.

Authorised Persons (APs) were appointed formally for the Trusts specialist ventilation systems by the designated Person (dP) on the recommendations of the Authorised Engineer (AE) on 28th August 2022. The annual Theatres and Laboratories verifications were completed in September 2022 (September 20th and 22nd).

14.1 Achievements for quarters 1 and 2 of 2022/23

- The formation of a Ventilation Safety Group (VSG) as recommended by HTM 03, this group met in July and October 2022 and has representation from the IPC Nursing Team, Microbiological Consultants, the Surgical Division and Pharmacy. This steering group is chaired by the Head of Estates and is scheduled to meet quarterly.
- The formal appointment of the Head of Estates and Estates Officer Mechanical as ventilation Authorised Persons (APs), these appointments were made in line with the HTM 03 by the Director of Estates as the designated Person (DP).
- Introduction of a Permit to Work process to ensure critical ventilation systems are only removed from service following approval from the area/department that the system serves.
- Completion of a survey of AC rates for ward areas (these areas are not subject to annual verifications e.g., Theatres). This information has identified some remedial work, to date remedial works have been completed on Sarum and Downton Wards.

14.2 Key Focus for quarters 3 and 4 of 2022/23

- Completion of annual verifications on critical plant to include the Maternity Theatre, Pharmacy Aseptic Unit and the Mortuary.
- Remedial works on wards ventilation systems as highlighted by the A/C survey.
- Completion of actions identified by the Trusts Ventilation Authorising Engineer (AE) following the audit completed February 2022.
- Ensuring PPMs are completed on Specialist Ventilation Systems as per the guidance in HTM 03.
- Formal training and appointment of the Estates Engineers as Competent Persons (CPs), these appointments will be made by the Trusts APs.

15. CONCLUSION

This six monthly DIPC Report has provided the Trust Board with evidence of the measures in place that have made a significant contribution to improving infection prevention and control practices across the Trust. The report has detailed the progress against the Action Plan for 2022/23 in reducing HCAI rates for the Trust.

For quarters 3 and 4 of 2022/23, the key ambitions for the Trust will include:

- Continued response to the impact of COVID-19 and recovery period as the Trust reverts to business as usual (dependent on local variation in COVID-19 infection levels)
- Ongoing focus on the reduction of all reportable HCAIs and ensure preventable infections are avoided
- Continued reinforcement to improve compliance with hand hygiene practices and behaviours
- Maintaining achievements with antimicrobial stewardship
- Sustain progress with contingency planning and improvement plans for decontamination services
- Maintaining progress with education, training and audit relating to infection control practices and policies
- Monitor and manage water and ventilation safety
- Maintaining a clean and safe environment for patients and staff through the Trust Housekeeping service.

16. ACKNOWLEDGEMENTS

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- Vinesh Perumal, Lead Pharmacist – Antimicrobials and HIV (Section 8)
- Clare Goodyear, Trust Decontamination Lead and Medical Device Safety Officer (Section 11)
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- Terry Cropp, Technical Services Manager, Estates Department (Sections 13 and 14).
- Connie Timmins – BSW ICS Benchmarking data

C. Difficile Data)

APPENDIX A

Infection Prevention & Control – Annual Action Plan 2022/23

Please note: The numbering **does not** depict the order of priority for the Trust but reflects the numbered duties within the Hygiene Code.

Domain and Key Actions	Who By	Status
1 Management, Organisation and the Environment **1.1 General duty to protect patients, staff and others from HCAIs** **1.2 Duty to have in place appropriate management systems for Infection Prevention and Control**		
Continue to promote the role of the DIPC in the prevention & control of HCAI	CEO	Continuous
DIPC as Chair of the Infection Prevention & Control Committee (IPCC)	CEO	In place
Lead infection prevention & control in the Trust and provide a six-monthly public report to the Trust Board	DIPC	In place
Monitor and report uptake of mandatory training programme	IPCT	In place
Continue contribution to implementation of the Capacity Management policy	DIPC	In place
Ensure a programme of audit (incorporating Saving Lives High Impact Interventions) is in place to systematically monitor & review policies, guidelines and practice relating to infection prevention & control	IPCWG/IPCC	Monthly
Continue to review staffing levels via Workforce Planning	Deputy CNO	Continuous
Complete bedpan washer replacement and dirty utility room upgrade programme within the Trust (for inpatient clinical areas), including the Spinal Unit.	DIPC	Complete
1.3 Duty to assess risks of acquiring HCAIs and to take action to reduce or control such risks		
Maintain the role of DIPC as an integral member of the Trust's Clinical Governance & risk structures (including Assurance Framework)	CEO	Continuous
Ensure active maintenance of principle risks relating to infection prevention and control, and that the system of Root Cause Analysis (RCA) is used to review risks relating to these	DIPC/ICD/ICNs	In place
Active Surveillance & Investigation:		
Continue implementation of mandatory Surveillance Plan for HCAI & produce quarterly reports for IPCC	IPCT	In place
Review implementation of 'alert organism' & 'alert condition' system	ICD/Microbiologists	Continuous
Use comparative data on HCAI & microbial resistance to reduce incidence & prevalence	ICD/Microbiologists	In place
Promote liaison with Public Health England (PHE) for effective management & control of HCAI.	DIPC/ICD/ICNs	Continuous

Domain and Key Actions	Who By	Status
1.4 Duty to provide and maintain a clean and appropriate environment for health care		
Ensure maintenance and monitoring of high standards of cleanliness via policy management and audit, and environmental audits	DIPC/Housekeeping Manager	Monthly
Review schedule of cleaning frequency and standards of cleanliness, making them publicly available	DIPC/Housekeeping Manager/Matrons	Monthly
Ensure adequate provision of suitable hand washing facilities, hand products/alcohol gel and continued implementation of 'WHO - Five Moments' and use of 'CleanYourHands' resources	ICNs	Continuous
Continue IP&C involvement in overseeing all plans for construction & renovation	Head of Estates	Continuous
Ensure effective arrangements are in place for appropriate decontamination of instruments and other medical devices/equipment	DIPC/Decon. Lead	Continuous
Ensure the supply and provision of linen and laundry adheres to health service guidance	Head of Facilities	Continuous
Ensure adherence to the uniform and Bare below the elbow (BBE) policies and workwear guidance through audit and formal reporting via the monthly Matrons Monitoring Group meetings (renamed PLACE Steering Group from quarter 2 of 2020/21).	DIPC/HoNs/Matrons	Continuous
1.5 Duty to provide information on HCAIs to patients and the public **1.6 Duty to provide information when a patient moves from one health care body to another** **1.7 Duty to ensure co-operation**		
Ensure publication of DIPC report via the Trust website	DIPC	6 monthly
Review Capacity Management policy & documentation to ensure communication regarding an individual's risk, nature and treatment of HCAI is explicit	DIPC	Completed
Include obligations under the Code to appropriate policy documents.	DIPC	Ongoing
1.8. Duty to provide adequate isolation facilities		
Continue implementation and monitoring of the Isolation policy and monitoring of practice via audit.	HoNs/Matrons/ IPCT	Ongoing
1.9. Duty to ensure adequate laboratory support		
Ensure the microbiology laboratory maintains appropriate protocols and operations according to standards acquired for Clinical Pathology Accreditation.	ICD/Microbiologists/ Laboratory Manager	Continuous

Domain and Key Actions	Who By	Status
1.10 Duty to adhere to policies and protocols applicable to infection prevention and control		
Core policies are:		
Standard infection control precautions	ICNs	In place
Aseptic technique	ICNs	In place
Major outbreaks of communicable infection (Outbreak policy)	ICNs	In place
Isolation of patients	ICD	In place
Safe handling and disposal of sharps	H&S Lead	In place
Prevention of occupational exposure to blood-borne viruses (BBVs), including prevention of sharps injuries	ICNs	In place
Management of occupational exposure to BBVs and post exposure prophylaxis.	H&S & OH Lead	In place
Closure of wards, departments and premises to new admissions (Outbreak & Capacity Management)	IPCT	In place
Disinfection policy	Facilities GM	In place
Antimicrobial prescribing	ICD/Lead Pharmacist	In place
Mandatory reporting HCAIs to Public health England (PHE)	ICD	In place
Control of infections with specific alert organisms; MRSA and *C.difficile*	IPCT	In place
Additional policies:		
Transmissible Spongiform Encephalitis (TSE)	ICD/Decon. Lead	In place
Glycopeptide Resistant Enterococcus (GRE)	ICD	Included in
Acinetobacter species	ICD	Isolation
Viral Haemorrhagic fever (VHF)	ICD	Policy
Prevention of spread of Carbapenem resistant organisms	ICD	In place
Diarrhoeal infections	ICD	In place
Surveillance	ICNs	In place
Respiratory viruses (RSV)	NNU Lead	In place
Infection control measures for ventilated patients	ITU Lead/Matrons	In place
Tuberculosis	ICD	In place
Legionellosis risk management policy and procedures, including pseudomonas	Head of Estates	In place
Strategic Cleaning Plan & Operational Policy	Facilities GM	In place
Building & Renovation – Inclusion of Infection Control within Building Change, Development & Maintenance	Head of Estates	In place
Waste Management Policy	Waste Manager	In place
Linen Management Policy	ICNs	In place
Decontamination of medical devices, patient equipment & endoscopes	Decon. Lead	In place

Domain and Key Actions	Who By	Status
1.11 Duty to ensure, so far as is reasonably practicable, that healthcare workers are free of and are protected from exposure to communicable infections during the course of their work, and that all staff are suitably educated in the prevention and control of HCAIs		
Ensure all staff can access relevant Occupational Health & Safety Services (OHSS)	Head of OD&P & OH Lead	Continuous
Ensure occupational health policies on the prevention and management of communicable infections in healthcare workers, including immunisations, are in place	OH Lead	Continuous
Continue the provision of infection prevention and control education at induction	IPCT	Continuous
Continue the provision of ongoing infection prevention and control education for existing staff	IPCT	Continuous
Continue recording and maintaining training records for all staff via the MLE	Education Dept.	Continuous
Ensure infection prevention and control responsibilities are reflected in job descriptions, appraisal and objectives of all staff	DIPC/DMTs	In place
Enhance and monitor the role of the Infection Control Link Professionals.	HoN/Matrons/ICNs	Continuous

APPENDIX B (April 2022 – September 2022)

Clinical Divisions	Inpatient areas/wards	*Clostridioides difficile* - all cases (reportable and not reportable)		Bacteraemias - all cases are reportable to UK Health Security Agency (UKHSA)															Outbreak declared	PII declared	Hand Hygiene (mean %)	IPC PWA (mean %)
		Sample taken		*MRSA*			*MSSA*			*E.coli*			*Pseudomonas aeruginosa*			*Klebsiella sp.*						
		Hospital onset healthcare associated	Community onset healthcare associated	Hospital onset HA	Community onset HA	Community onset CA	Hospital onset HA	Community onset HA	Community onset CA	Hospital onset HA	Community onset HA	Community onset CA	Hospital onset HA	Community onset HA	Community onset CA	Hospital onset HA	Community onset HA	Community onset CA	See main repot for details	PII of C.difficile		
Clinical Support & Family Services	Sarum Ward (inc. Children DAU)		2					1	1												100%	98.79%
	Hospice Unit																				93.66%	95.46%
	Longford Ward	1					1														98.13%	92.14%
	CS&FS Totals:	1	2				**1**	**1**	**1**													
Women & Newborn	Labour Ward	1																			97.42%	Maternity 91.8%
	Neonatal Unit																				100%	
	Post-natal Ward																				100%	
	W&N Totals:	1																				
Medicine	AMU	2	2 + 1						2												96.17%	87.62%
	Breamore Ward	2								1									C19		100%	91.69%
	Durrington Ward	1					1			1									C19		91.34%	91.66%
	ED (inc. SSEU)		2					2	5		6	35		1			1	6			100%	92.13%
	Farley Ward	1	2									2							C19	09.06.22	92.28%	96.47%
	Laverstock Ward											1							C19		98.44%	89.55%
	Pembroke Ward	1	1																		100%	93.08%
	Pembroke Suite										1										98.89%	N/A
	Pitton Ward	1																	C19		100%	90.83%
	Redlynch Ward	2					1												C19		97.3%	92.57%
	Spire Ward	1											1								84.03%	95.02%
	Tisbury CCU	2																	C19 x2		91.87%	95.53%
	Whiteparish Ward												1						C19 x2		98.28%	92.06%
	Nunton Unit																				100%	N/A
	Medicine Totals:	6 + 7	5 + 3				**2**	**2**	**7**	**2**	**7**	**38**	**2**	**1**			**1**	**6**				
Surgery	Amesbury Suite																		C19		74.52%	84.31%
	Britford Ward including SAU		1							1	2	1				1	1		C19		86.02%	91.65%
	Chilmark Suite																				82.53%	87.44%
	Day Surgery Unit																		C19		84.03%	81.97%
	Downton Ward	1 + 3					2												C19	10.08.22	78.58%	91.21%
	Odstock Ward	1																			86.70%	93.87%
	Radnor Ward									1			2		1	1					95.47%	94.75%
	Surgery Totals:						**2**			**2**	**2**	**1**	**2**		**1**	**2**	**1**					
Additional info: Other *C.difficile* samples, e.g. GP, Emergency Assessment, SAU, OPD, Mortuary, Private Hospital			3 + 3																			

All SFT samples including inpatient and outpatient areas, GP and other e.g., Emergency Assessment *C.difficile* **reportable** cases = **red** *C.difficile* **not** reportable cases = **blue**

Bacteraemia classification codes:

- Hospital onset healthcare associated, is shown as Hospital onset HA
- Community onset healthcare associated, is shown as Community onset HA
- Community onset community associated, is shown as Community onset CA

Outbreak codes: C19 is COVID-19 outbreak declared

Tendable (previously Perfect Ward) scoring:

	More than 90%
	70% - 90%
	Less than 70%
	No inspection completed

(Where more than 1 audit has been completed during a month, colour rate according to the lowest compliance score achieved)

Hand hygiene scoring:

	Score above 85%
	Score 61% - 84%
	Score below 60%

(Where more than 1 audit has been completed during a month, colour rate according to the lowest compliance score achieved)

APPENDIX C

Tendable Infection Prevention & Control (IPC) Inspection Compliance scores for Quarters 1 & 2 of 2022/23

Ward/ Dept	Division	April 2022	May 2022	June 2022	July 2022	August 2022	September 2022
Sarum Ward	CSFS	11.04.2022 (98%) 28.04.2022 (97.8%)	23.05.2022 (95.7%)	19.06.2022 (100%)	22.07.2022 (100%)	18.08.2022 (100%)	18.09.2022 (100%)
Hospice Unit	Initially Medicine, then moved to CSFS	19.04.2022 (96.1%)	13.05.2022 (96.2%)	06.06.2022 (95.5%)	05.07.2022 (92.3%)	12.08.2022 (93.9%) 23.08.2022 (96.2%)	28.09.2022 (98%)
Longford Ward	Initially Medicine, then moved to CSFS	06.04.2022 (94.3%)	11.05.2022 (90.2%)	07.06.2022 (94.3%) 20.06.2022 (90.6%)	07.07.2022 (88.7%) 28.07.2022 (92.3%)	03.08.2022 (98.1%) 09.08.2022 (88.5%)	15.09.2022 (92.3%)
Acute Medical Unit	Medicine	06.04.2022 (88.5%)	02.05.2022 (90.4%)	05.06.2022 (86.3%)	30.07.2022 (90.2%)		05.09.2022 (82.7%)
Breamore Ward	Medicine	18.04.2022 (98.1%)	25.05.2022 (98.1%)		11.07.2022 (74.5%) 18.07.2022 (90.2%) 29.07.2022 (92%)	05.08.2022 (93.8%) 15.08.2022 (92.5%)	14.09.2022 (94.3%)
Durrington Ward	Medicine	26.04.2022 (88%)	25.05.2022 (79.2%)	10.06.2022 (94.3%) 27.06.2022 (94.3%)	15.07.2022 (88.5%) 27.07.2022 (88.5%)	08.08.2022 (100%) 15.08.2022 (86.8%) 19.08.2022 (92.5%)	02.09.2022 (98.1%) 28.09.2022 (98.1%)
Emergency Department	Medicine	21.04.2022 (89.6%)	21.05.2022 (95.8%)	09.06.2022 (93.5%)			01.09.2022 (89.6%)
Farley Ward	Medicine	17.04.2022 (96.2%)	19.05.2022 (94.1%)	13.06.2022 (98.1%)	24.07.2022 (100%)	15.08.2022 (98.1%)	19.09.2022 (92.3%)
Laverstock Ward	Medicine	05.04.2022 (96.2%)	12.05.2022 (92.3%)	09.06.2022 (100%) 15.06.2022 (80%) 21.06.2022 (86%) 28.06.2022 (88%)	04.07.2022 (96.2%) 11.07.2022 (96.2%) 19.07.2022 (84.9%) 25.07.2022 (94.3%)	01.08.2022 (84.6%) 08.08.2022 (83%) 16.08.2022 (84.3%) 24.08.2022 (81.1%)	13.09.2022 (96.2%)
Pembroke Ward	Medicine	01.04.2022 (86.5%)	16.05.2022 (96.1%)	21.06.2022 (96.2%)	11.07.2022 (94.3%)		26.09.2022 (92.3%)
Pitton Ward	Medicine	20.04.2022 (100%)	11.05.2022 (94.2%) 25.05.2022 (82%)	20.06.2022 (86.5%) 30.06.2022 (88.2%)	08.07.2022 (84.6%) 22.07.2022 (96.2%)	01.08.2022 (92.5%) 18.08.2022 (94.2%)	02.09.2022 (84.9%) 15.09.2022 (90.4%) 20.09.2022 (96.2%)
Redlynch Ward	Medicine	09.04.2022 (88.7%) 11.04.2022 (96.1%) 17.04.2022 (88.7%)		22.06.2022 (98.1%) 23.06.2022 (94.1%) 24.06.2022 (98.1%) 26.06.2022 (94.2%) 27.06.2022 (92.5%)	08.07.2022 (80.8%) 12.07.2022 (84%) 25.07.2022 (90.2%) 29.07.2022 (96.1%)	05.08.2022 (94.2%) 22.08.2022 (90.2%) 24.08.2022 (92.2%)	07.09.2022 (90.4%) 13.09.2022 (96.2%) 18.09.2022 (94.2%) 20.09.2022 (96.2%) 25.09.2022 (96.2%)
Spire Ward	Medicine	15.04.2022 (94.2%)		12.06.2022 (96.2%)	19.07.2022 (94.2%)	16.08.2022 (96.2%)	18.09.2022 (94.3%)
Tisbury CCU	Medicine	03.04.2022 (98.1%)	02.05.2022 (98.1%) 07.05.2022 (98.1%) 16.05.2022 (88.5%) 22.05.2022 (96.2%) 28.05.2022 (92.5%)	04.06.2022 (92.5%) 22.06.2022 (94.1%) 29.06.2022 (100%)	06.07.2022 (96.2%) 13.07.2022 (97.8%) 20.07.2022 (94.3%) 26.07.2022 (94.3%) 31.07.2022 (96.1%)	07.08.2022 (98.1%) 14.08.2022 (98.1%)	01.09.2022 (92.3%) 09.09.2022 (94.3%)
Whiteparish Ward	Medicine	05.04.2022 (96.2%)	10.05.2022 (94.3%) 21.05.2022 (86.8%) 29.05.2022 (86.5%)	02.06.2022 (90.6%)	07.07.2022 (90.2%) 15.07.2022 (86.8%) 18.07.2022 (94.2%) 26.07.2022 (96.2%) 31.07.2022 (94.2%)	06.08.2022 (92.5%) 13.08.2022 (96.2%) 19.08.2022 (92.3%)	27.09.2022 (91.8%)

Ward/ Dept	Division	April 2022	May 2022	June 2022	July 2022	August 2022	September 2022
Amesbury Suite	Surgery	23.04.2022 (81.3%)	07.05.2022 (76.5%) 12.05.2022 (81.1%) 19.05.2022 (88.5%)	02.06.2022(88%) 16.06.2022 (90.2%)	02.07.2022 (90.4%)	18.08.2022 (82.4%)	29.09.2022 (80.4%)
Britford Ward	Surgery	22.04.2022 (93.9%)	04.05.2022 (97.8%) 18.05.2022 (64.7%)	02.06.2022 (88.2%) 30.06.2022 (94.1%)	05.07.2022 (92.5%) 14.07.2022 (92.3%) 25.07.2022 (90.4%)	09.08.2022 (98.1%) 16.08.2022 (96.2%)	01.09.2022 (100%)
Chilmark Suite	Surgery		26.05.2022 (78.7%)	30.06.2022 (82.4%)	31.07.2022 (97.7%)	22.08.2022 (98%)	30.09.2022 (80.4%)
Day Surgery Unit	Surgery	25.04.2022 (92.9%)	27.05.2022 (97.6%)	08.06.2022 (56.5%) 27.06.2022 (91.1%)	05.07.2022 (57.8%) 06.07.2022 (65.3%) 13.07.2022 (62.2%) 18.07.2022 (78.4%) 25.07.2022 (95.6%)	01.08.2022 (86%) 08.08.2022 (91.1%) 15.08.2022 (88.9%) 23.08.2022 (90.9%)	16.09.2022 (93.3%)
Downton Ward	Surgery		06.05.2022 (98.1%)	13.06.2022 (100%)	05.07.2022 (78.8%) 14.07.2022 (90.4%) 14.07.2022 (86.8%) 18.07.2022 (96.2%) 26.07.2022 (84.9%) 27.07.2022 (88.5%) *2 inspections recorded 14.07.2022*	01.08.2022 (98.1%) 10.08.2022 (96.2%) 18.08.2022 (86.5%) 25.08.2022 (90.6%)	07.09.2022 (90.6%)
Odstock Ward	Surgery	15.04.2022 (90.2%)	07.05.2022 (92.5%) 18.05.2022 (92%)	19.06.2022 (94.2%)	12.07.2022 (94.1%)	22.08.2022 (96.1%)	26.09.2022 (98%)
Radnor Ward	Surgery	04.04.2022 (86.3%)	16.05.2022 (92.3%)	24.06.2022 (98%)	16.07.2022 (100%)	15.08.2022 (97.8%)	21.09.2022 (94.1%)
Maternity	Women & Newborn		10.05.2022 (90.9%) 10.05.2022 (92.7%) *2 inspections recorded 14.07.2022*				

Tendable (previously Perfect Ward) scoring:

	More than 90%
	70% - 90%
	Less than 70%
	No inspection completed

(Where more than 1 audit has been completed during a month, colour rate according to the lowest compliance score achieved

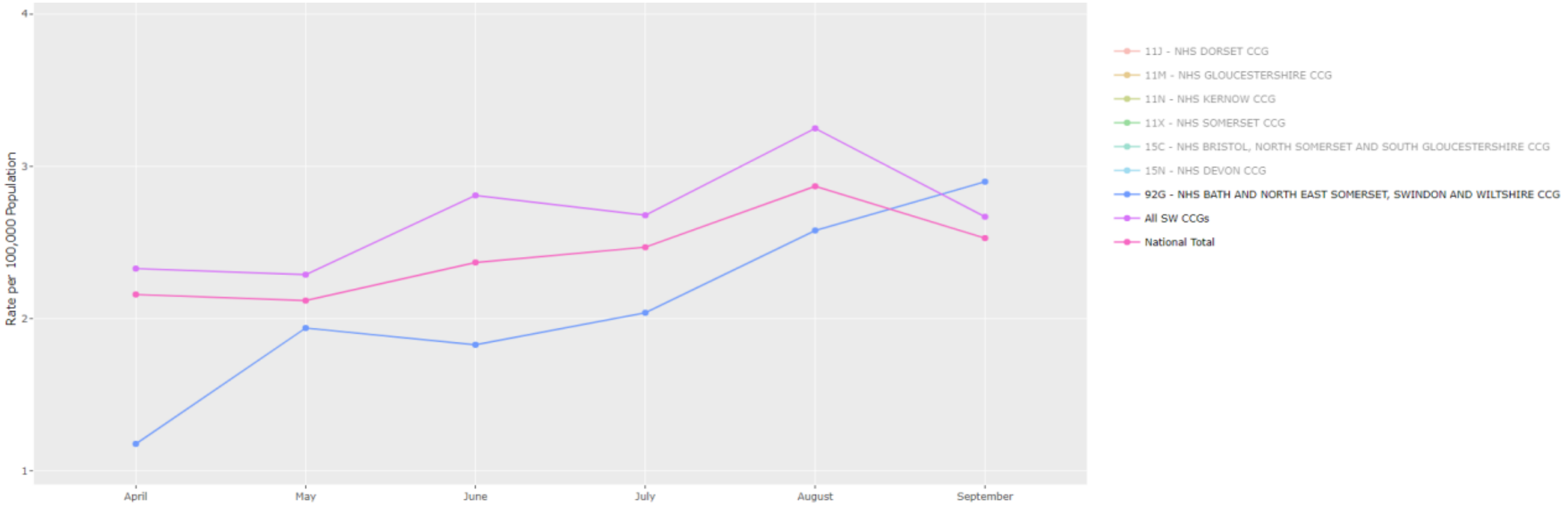
NHS
Bath and North East Somerset, Swindon and Wiltshire
Integrated Care Board

NHS BSW ICB- Health Care Associated infections Q2

Connie Timmins, Lead Nurse for Infection Prevention and Control

Health Care Associated Infections (HCAI)- Clostridium *difficlie* (CDI)

Bath and North East Somerset, Swindon and Wiltshire
Integrated Care Board



BSW CDI counts of infections

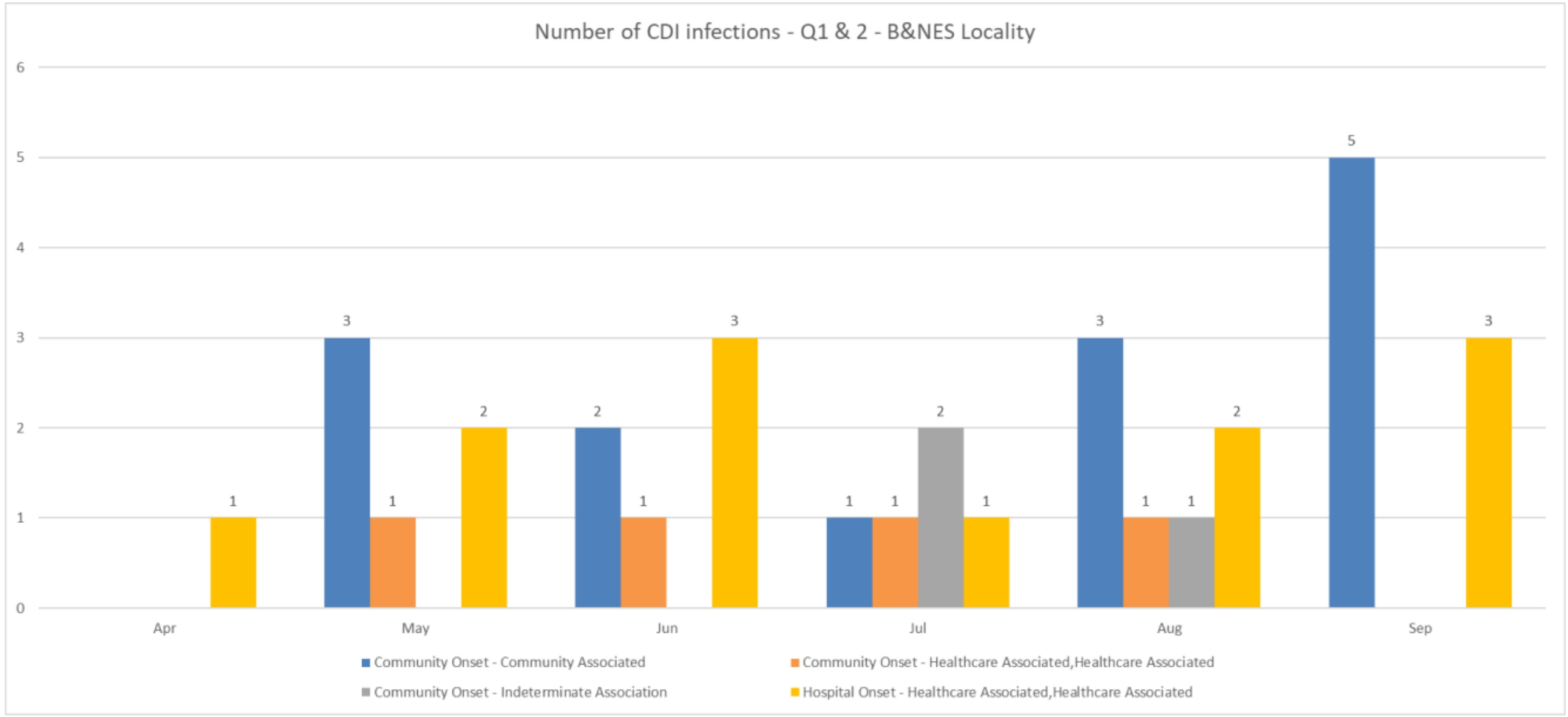
NHS
Bath and North East Somerset, Swindon and Wiltshire
Integrated Care Board

CDI Counts	Hospital Onset-Healthcare Associated (HOHA)	Community Onset, indeterminate association (COIA)	Community Onset, Healthcare Associated (COHA)	Community onset, community Associated (COCA)
April	5	1	4	1
May	5	1	5	7
June	8	2	3	3
July	3	2	6	8
August	4	3	8	9
September	9	1	4	12
Total YTD 22/23	34	10	30	40

Total BSW CDI	Threshold set by NHSE/I	Same time period 21/22	Difference
114	217	116	-2 ↓

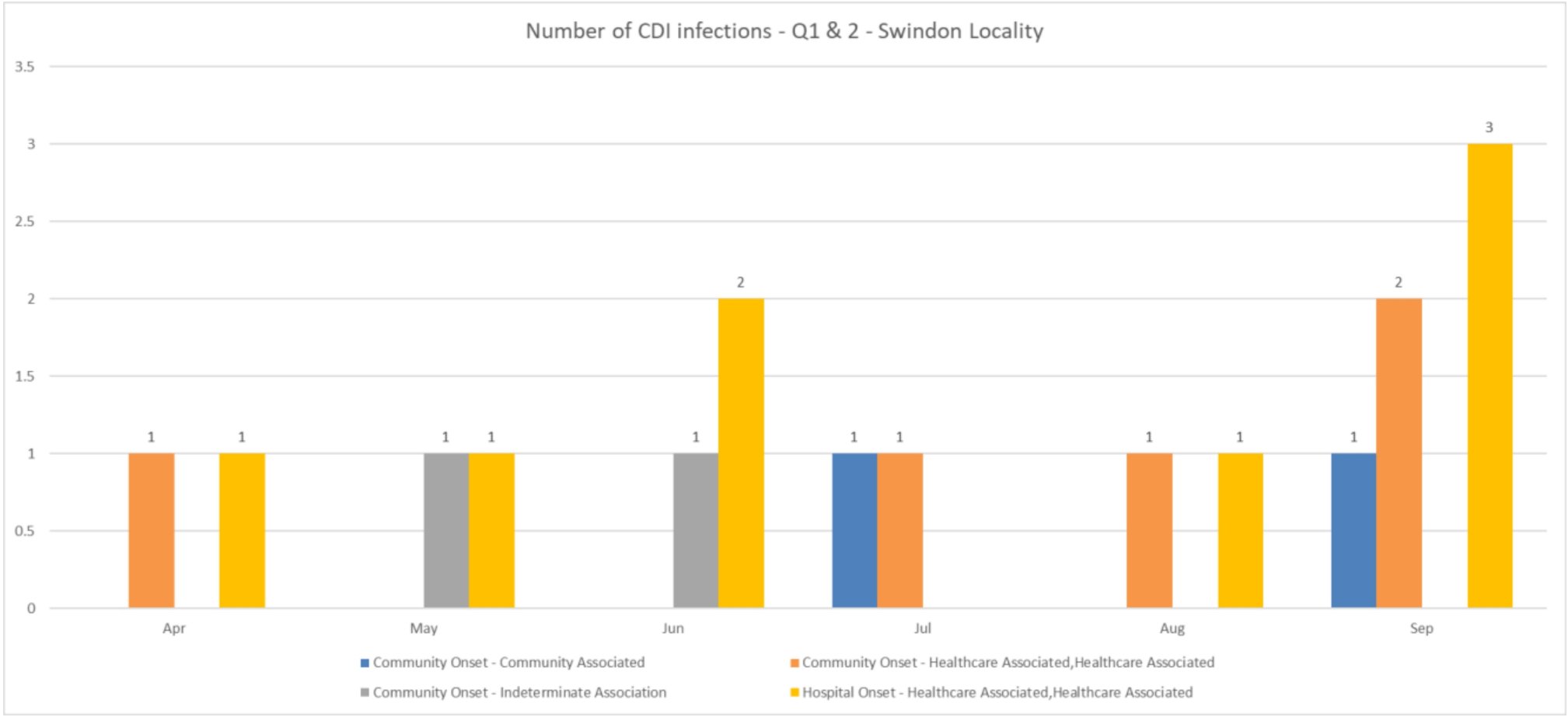
B&NES ICA CDI counts of infection

Bath and North East Somerset, Swindon and Wiltshire
Integrated Care Board



Swindon ICA CDI counts of infection

NHS
Bath and North East Somerset, Swindon and Wiltshire
Integrated Care Board

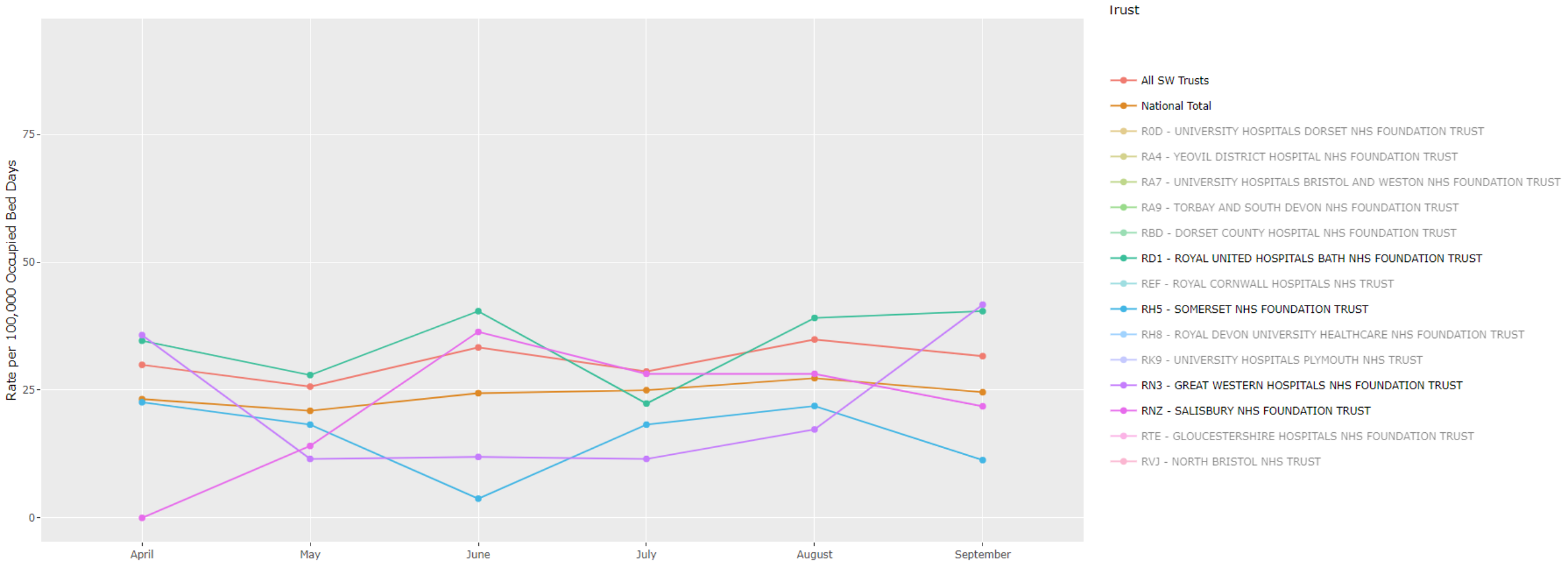


Wiltshire ICA CDI counts of infections

NHS
Bath and North East Somerset, Swindon and Wiltshire
Integrated Care Board

Trust CDI data

Bath and North East Somerset, Swindon and Wiltshire
Integrated Care Board



Trust CDI counts

NHS
Bath and North East Somerset, Swindon and Wiltshire
Integrated Care Board

GWH	Hospital Onset-Healthcare Associated (HOHA)	Community Onset, indeterminate association (COIA)	Community Onset, Healthcare Associated (COHA)	Community onset, community Associated (COCA)
April	3	0	3	0
May	1	1	1	0
June	2	1	0	1
July	0	0	2	1
August	2	0	1	1
September	4	0	3	3
Total YTD	12	2	10	6

Total GWH CDI (COHA and COCA)	Threshold set by NHSE/I	Same time period 21/22	Difference
22	48	24	-2 ↓

Trust CDI counts

NHS
Bath and North East Somerset, Swindon and Wiltshire
Integrated Care Board

RUH	Hospital Onset-Healthcare Associated (HOHA)	Community Onset, indeterminate association (COIA)	Community Onset, Healthcare Associated (COHA)	Community onset, community Associated (COCA)
April	5	0	1	3
May	4	0	1	7
June	5	0	2	3
July	2	2	2	5
August	3	3	4	9
September	5	1	2	7
Total YTD	24	6	12	33

Total RUH CDI (COHA & HOHA)	Threshold set by NHSE/I	Same time period 21/22	Difference
36	42	22	+12 ↑

Trust CDI counts

NHS
Bath and North East Somerset, Swindon and Wiltshire
Integrated Care Board

SFT	Hospital Onset-Healthcare Associated (HOHA)	Community Onset, indeterminate association (COIA)	Community Onset, Healthcare Associated (COHA)	Community onset, community Associated (COCA)
April	0	0	0	1
May	0	0	2	0
June	4	1	1	0
July	2	0	2	2
August	1	0	3	1
September	2	0	1	3
Total YTD	9	1	9	7

Total SFT CDI	Threshold set by NHSE/I	Same time period 21/22	Difference
18	23	15	+3 ↑

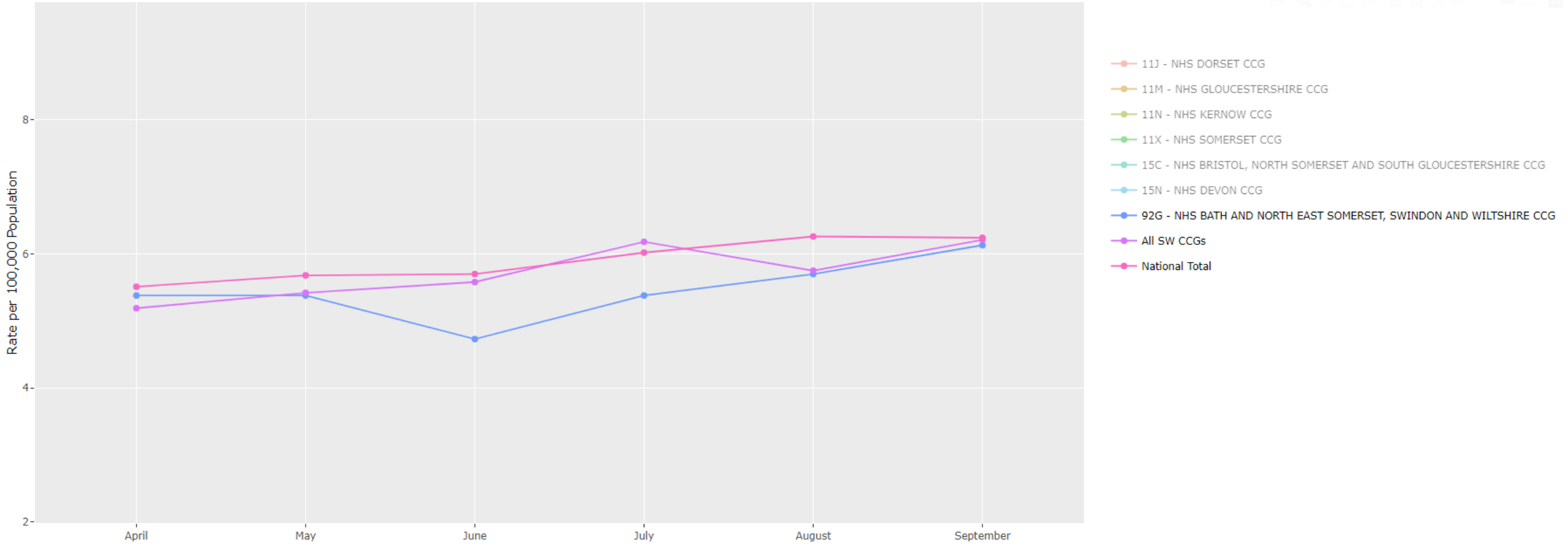
Clostridium Difficile (CDI)

NHS
Bath and North East Somerset, Swindon and Wiltshire
Integrated Care Board

- CDI cases have experienced a recent uptick at the end of Q2, this is within the Hospital Onset, Hospital Acquired (HOHA) and the Community Onset Community Acquired (COCA) apportionment groups .
- The cause is been investigated by the ICB and acute trust colleagues who are undertaking thematic reviews
- BSW remain under threshold at present but there is the potential for breach if the current trajectory continues.
- UKHSA Field Epidemiology Services (FES) have produced some insights into the national, regional and local BSW data which will be utilised within the improvement collaborative.
- The BSW system attends regional CDI collaborative meetings and is now moving from the data collection phase into the reduction workstream phase, BSW will work collaboratively with both system and regional partners to look at reducing inappropriate antibiotic use in the population, ensure that patients receive a correct and timely diagnosis of CDI, ensure that we Get it Right First Time (GIRFT) with treatment and review, update and roll out effective CDI bundles across health and social care.
- Antimicrobial prescribing within primary care is a key area of focus, in particular prescribing around skin and soft tissue infections , Urinary Tract Infections (UTI) and pneumonias.
- Work has also commenced looking at our bed occupancy and turnover to understand if there is a correlation between higher rates of infection and high demand.

Health Care Associated Infections (HCAI)- E-Coli

NHS
Bath and North East Somerset, Swindon and Wiltshire
Integrated Care Board



BSW E-Coli counts of infections

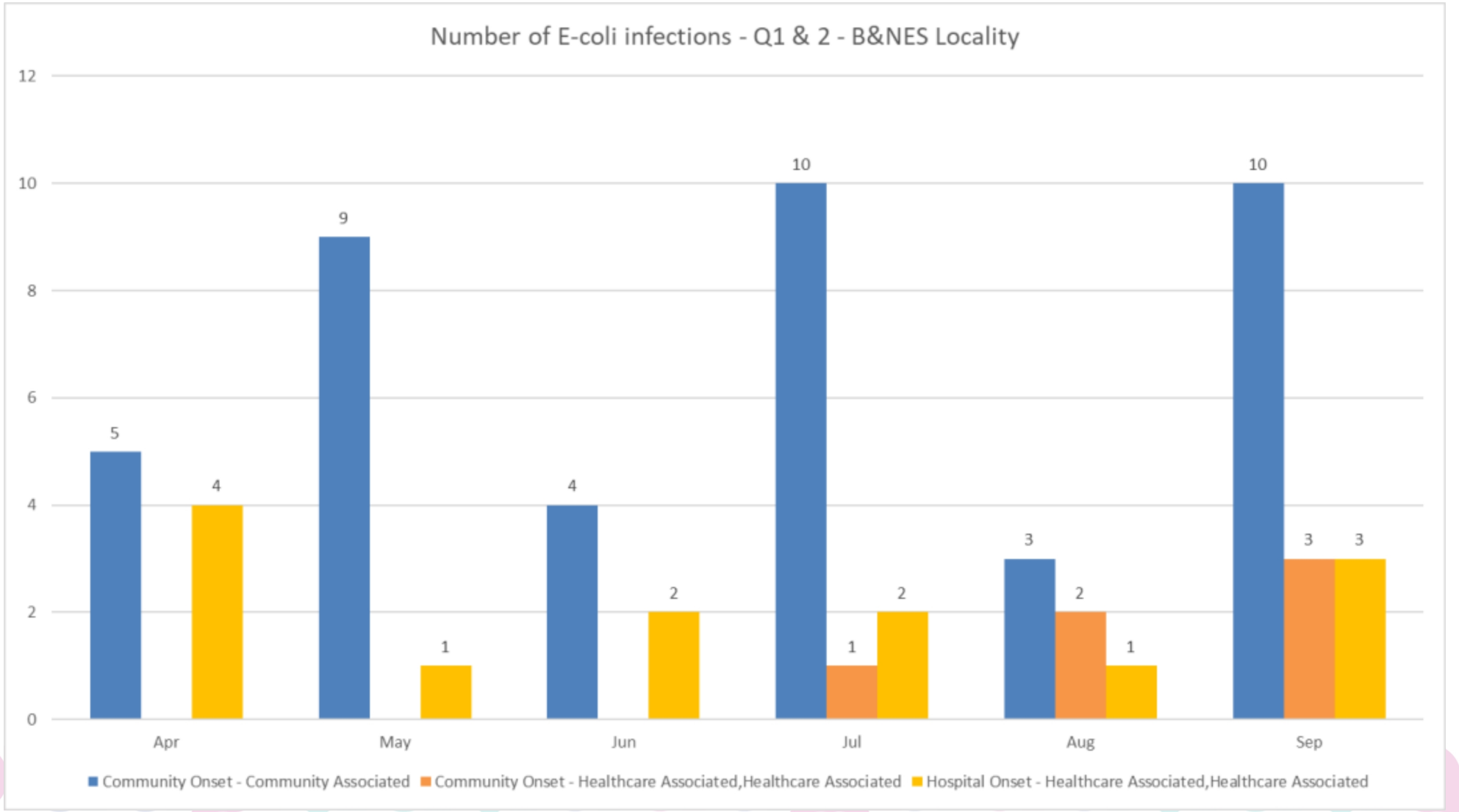
NHS
Bath and North East Somerset, Swindon and Wiltshire
Integrated Care Board

E-coli Counts	Hospital Onset-Healthcare Associated (HOHA)	Community Onset, Healthcare Associated (COHA)	Community onset, community Associated (COCA)
April	10	10	30
May	6	8	36
June	7	8	29
July	10	10	30
August	16	8	29
September	9	11	37
Total YTD	58	55	191

Total BSW E-coli	Threshold set by NHSE/I	Same time period 21/22	Difference
304	516	254	+50 ↑

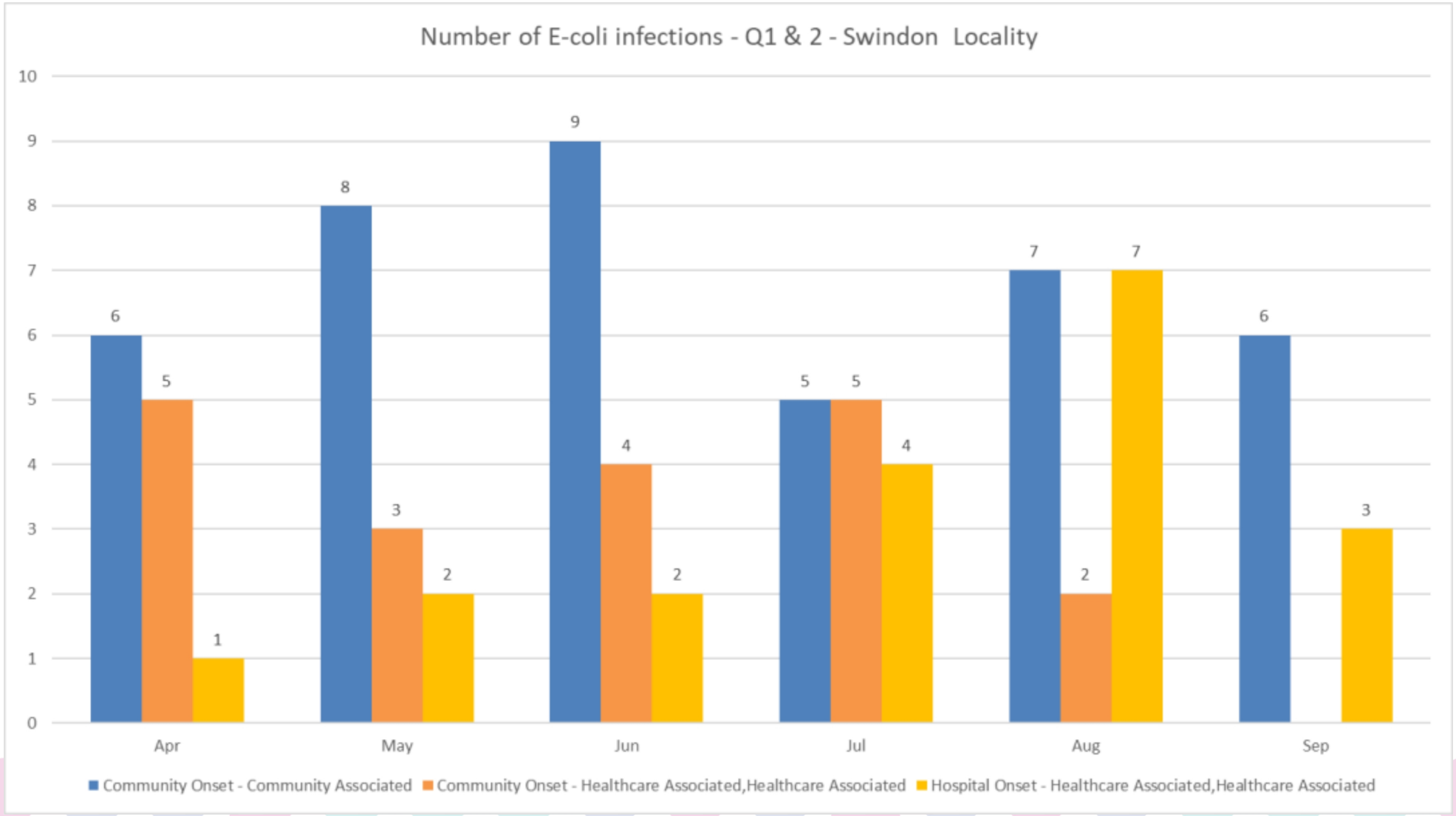
B&NES ICA E-Coli counts of infection

Bath and North East Somerset, Swindon and Wiltshire
Integrated Care Board



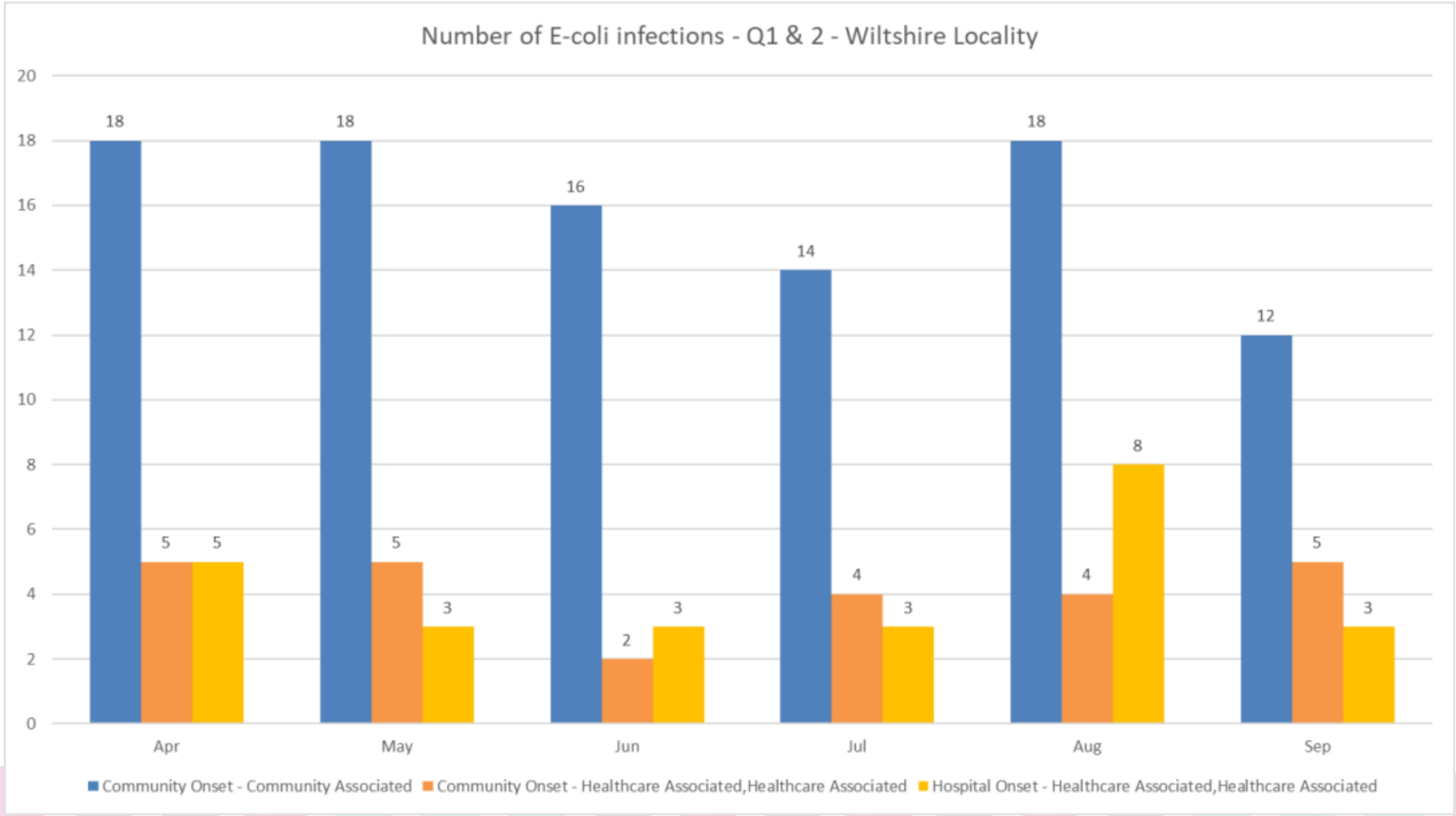
Swindon ICA E-coli counts of infection

NHS
Bath and North East Somerset, Swindon and Wiltshire
Integrated Care Board



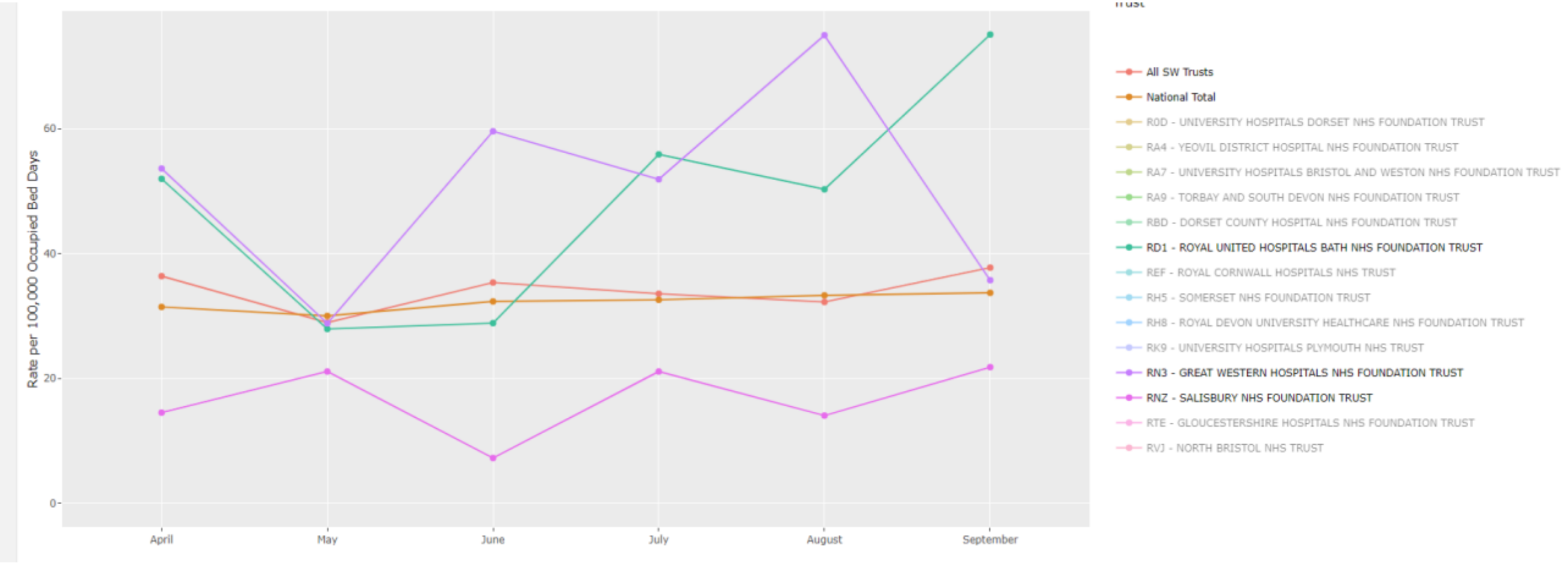
Wiltshire ICA E-coli counts of infection

NHS
Bath and North East Somerset, Swindon and Wiltshire
Integrated Care Board



Trust E-coli data

Bath and North East Somerset, Swindon and Wiltshire
Integrated Care Board



Trust E-Coli counts

NHS
Bath and North East Somerset, Swindon and Wiltshire
Integrated Care Board

GWH	Hospital Onset-Healthcare Associated (HOHA)	Community Onset, Healthcare Associated (COHA)	Community onset, community Associated (COCA)
April	2	7	17
May	1	4	13
June	3	7	14
July	4	5	10
August	9	4	13
September	3	3	15
Total YTD	22	30	82

Total GWH E-coli (COHA & HOHA)	Threshold set by NHSE/I	Same time period 21/22	Difference
52	69	46	+6 ↑

Trust E-Coli counts

NHS
Bath and North East Somerset, Swindon and Wiltshire
Integrated Care Board

RUH	Hospital Onset- Healthcare Associated (HOHA)	Community Onset, Healthcare Associated (COHA)	Community onset, community Associated (COCA)
April	7	2	13
May	3	2	25
June	4	1	11
July	6	4	19
August	5	4	14
September	6	7	23
Total YTD	31	24	118

Total RUH E-coli (COHA & HOHA)	Threshold set by NHSE/I	Same time period 21/22	Difference
56	76	43	+12 ↑

Trust E-Coli counts

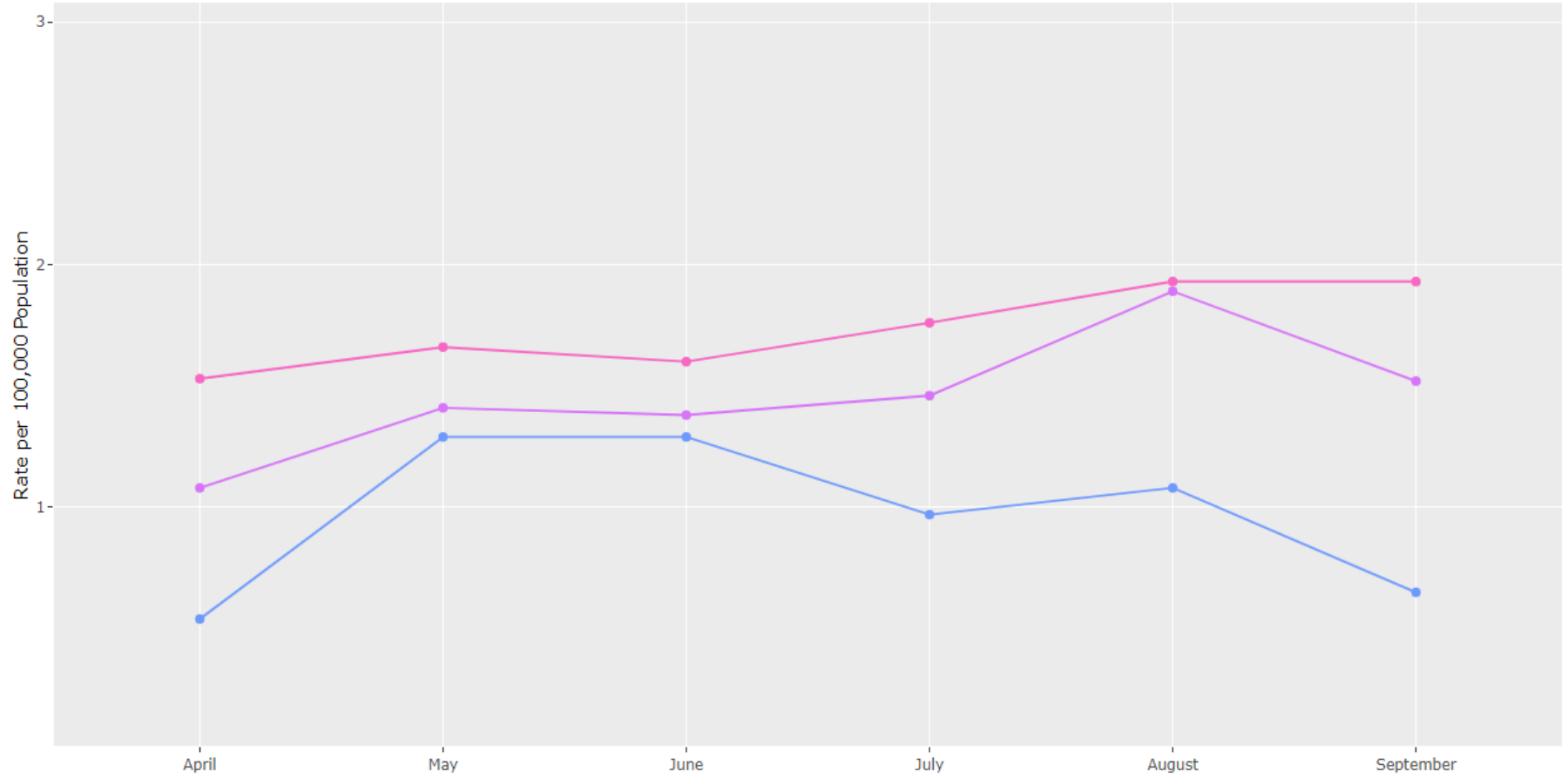
NHS
Bath and North East Somerset, Swindon and Wiltshire
Integrated Care Board

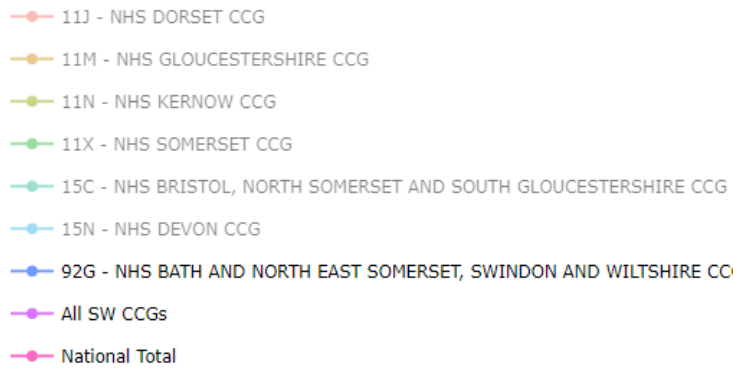
SFT	Hospital Onset- Healthcare Associated (HOHA)	Community Onset, Healthcare Associated (COHA)	Community onset, community Associated (COCA)
April	1	1	6
May	0	3	6
June	0	1	9
July	1	2	7
August	0	2	5
September	2	1	6
Total YTD	4	10	39

Total SFT E-coli (COHA & HOHA)	Threshold set by NHSE/I	Same time period 21/22	Difference
52	69	46	+6 ↑

Health care Associated Infections (HCAI)- Klebsiella

NHS
Bath and North East Somerset, Swindon and Wiltshire
Integrated Care Board





BSW ICB count of infections – Klebsiella

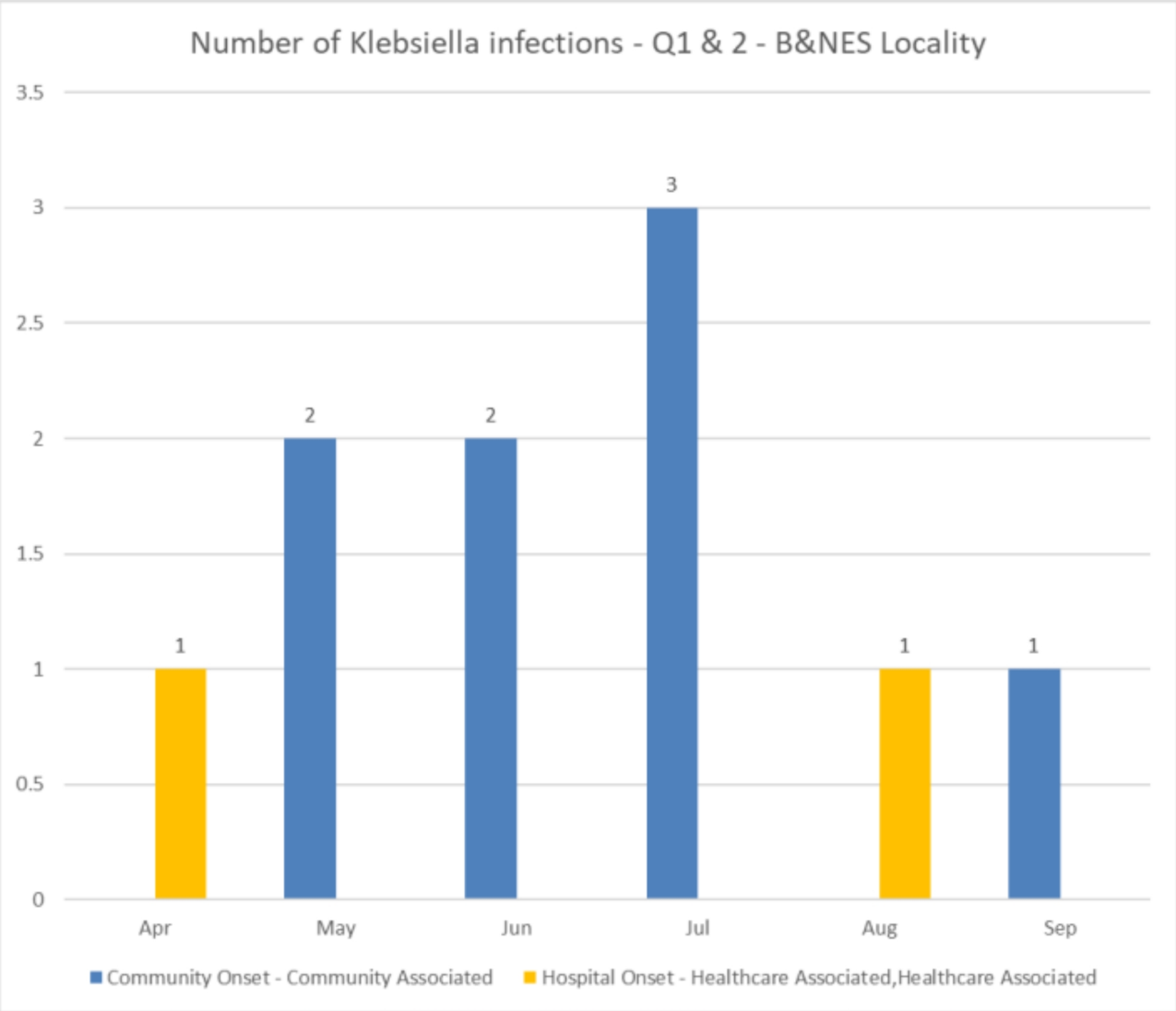
Bath and North East Somerset, Swindon and Wiltshire Integrated Care Board

Klebsiella Counts	Hospital Onset-Healthcare Associated (HOHA)	Community Onset, Healthcare Associated (COHA)	Community onset, community Associated (COCA)
April	2	0	0
May	1	1	4
June	2	0	3
July	2	0	1
August	2	0	2
September	2	2	2
Total YTD	11	3	12

Total BSW Klebsiella	Threshold set by NHSE/I	Same time period 21/22	Difference
26	137	70	-44 ↓

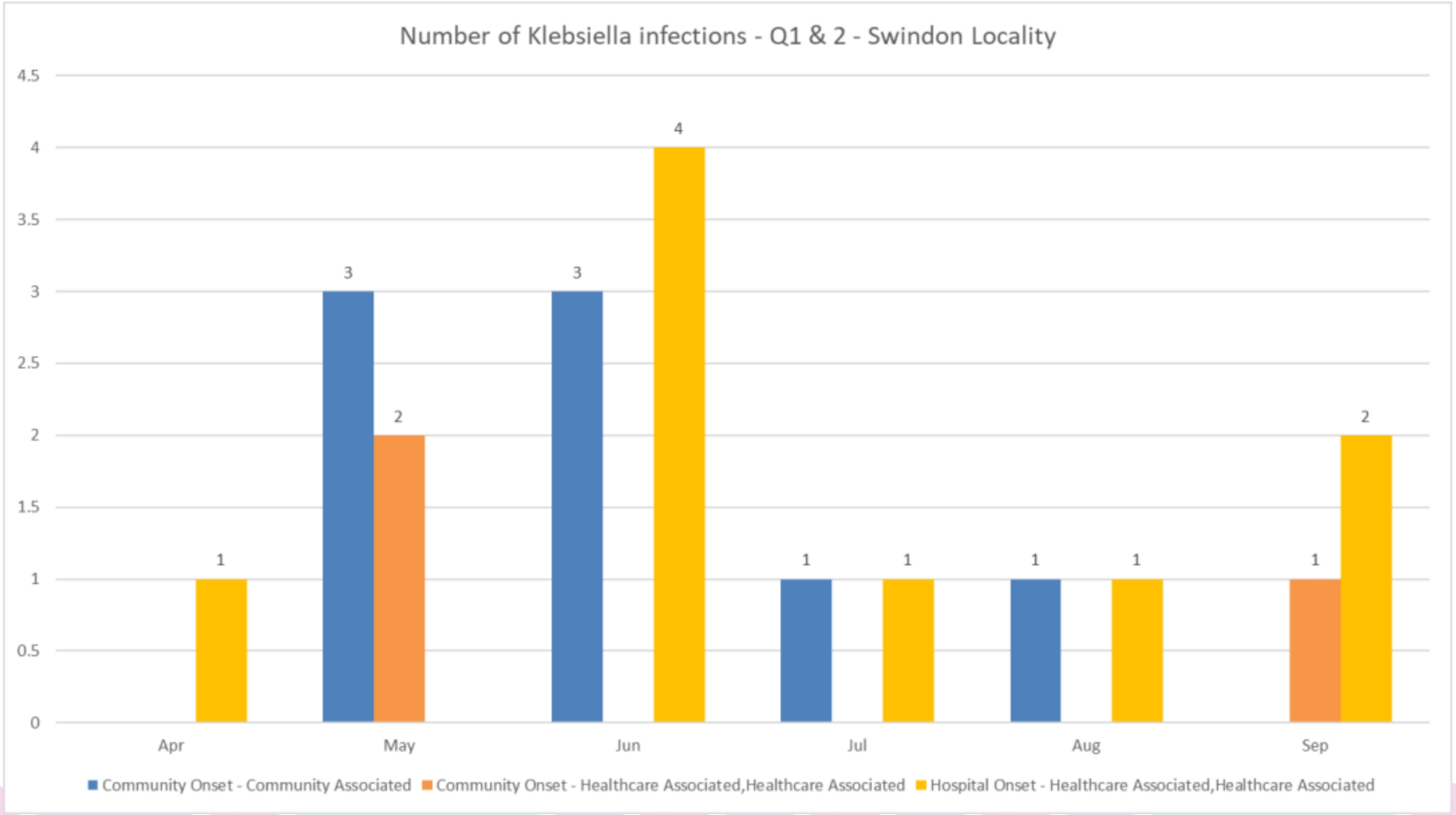
B&NES ICA Klebsiella counts of infection

Bath and North East Somerset, Swindon and Wiltshire
Integrated Care Board



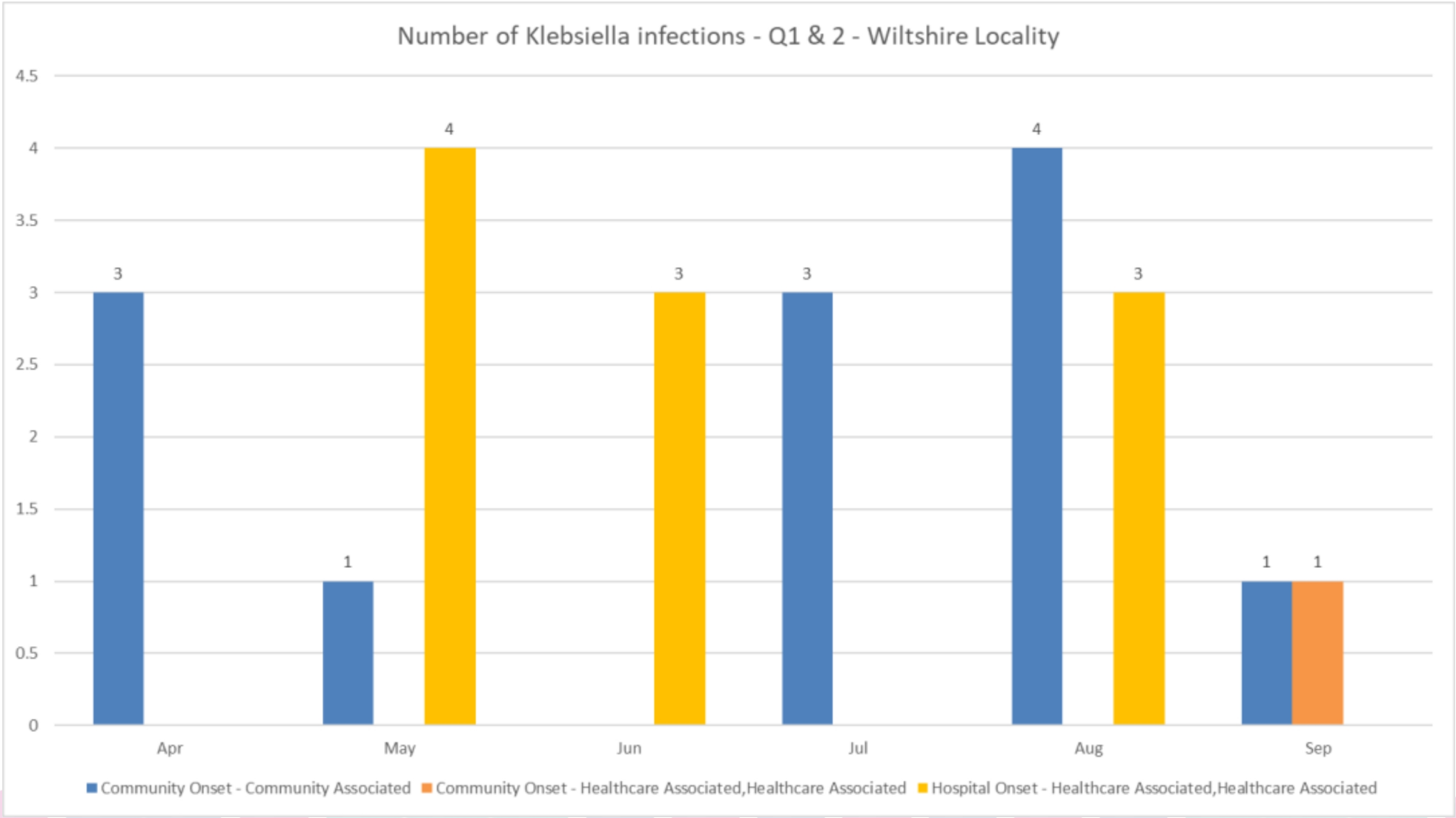
Swindon ICA Klebsiella counts of infection

NHS
Bath and North East Somerset, Swindon and Wiltshire
Integrated Care Board



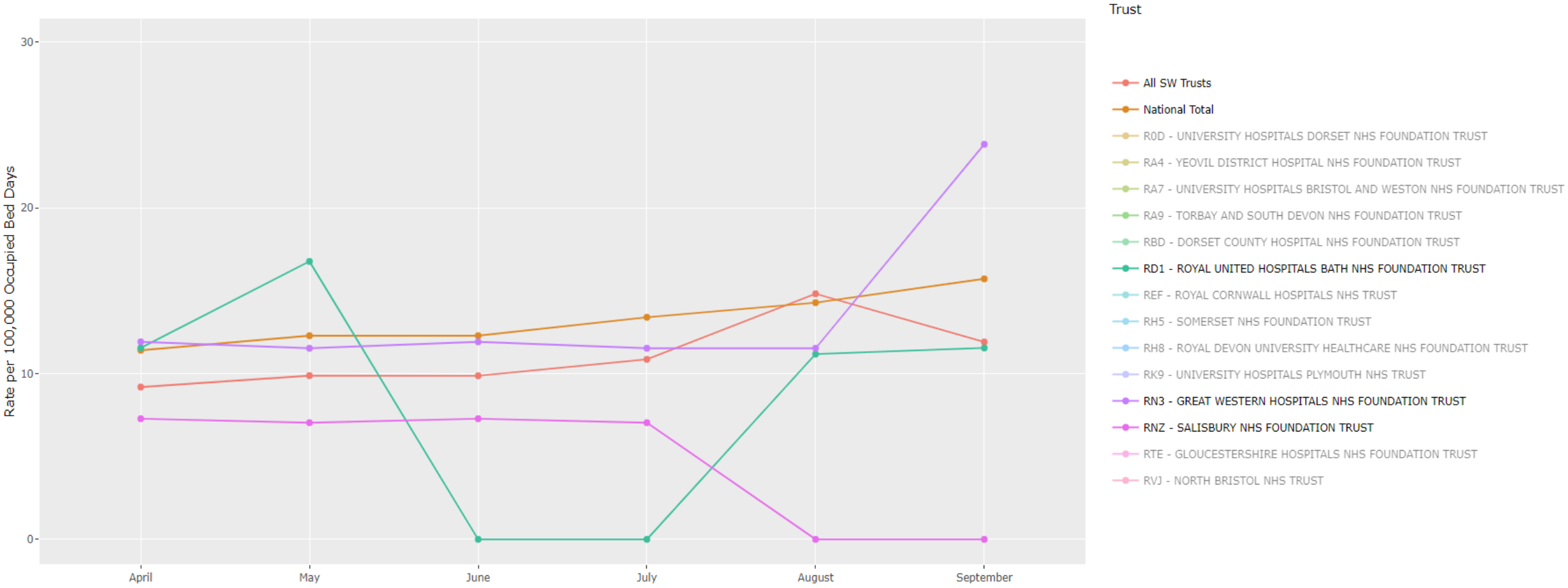
Wiltshire ICA Klebsiella counts of infection

NHS
Bath and North East Somerset, Swindon and Wiltshire
Integrated Care Board



Trust Klebsiella data

NHS
Bath and North East Somerset, Swindon and Wiltshire
Integrated Care Board



Trust Klebsiella counts of infection

Bath and North East Somerset, Swindon and Wiltshire
Integrated Care Board

GWH	Hospital Onset-Healthcare Associated (HOHA)	Community Onset, Healthcare Associated (COHA)	Community onset, community Associated (COCA)
April	2	0	0
May	1	1	4
June	2	0	3
July	2	0	1
August	2	0	2
September	2	2	0
Total YTD	11	3	10

Total GWH Klebsiella (COHA & HOHA)	Threshold set by NHSE/I	Same time period 21/22	Difference
14	23	9	+5 ↑

Trust Klebsiella counts of infection

Bath and North East Somerset, Swindon and Wiltshire Integrated Care Board

RUH	Hospital Onset- Healthcare Associated (HOHA)	Community Onset, Healthcare Associated (COHA)	Community onset, community Associated (COCA)
April	2	0	2
May	2	1	3
June	0	0	3
July	0	0	7
August	1	1	1
September	1	1	1
Total YTD	6	3	17

Total RUH Klebsiella (COHA & HOHA)	Threshold set by NHSE/I	Same time period 21/22	Difference
9	26	11	-2 ↓

Trust Klebsiella counts of infection

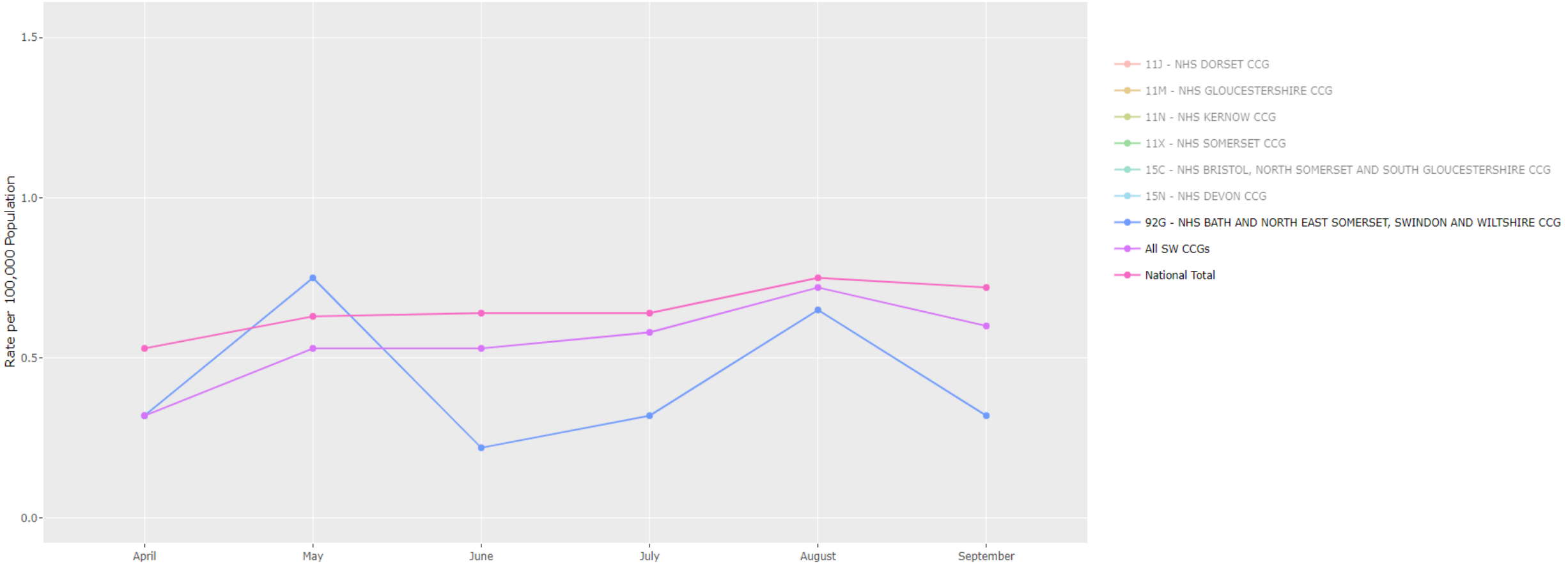
Bath and North East Somerset, Swindon and Wiltshire Integrated Care Board

SFT	Hospital Onset-Healthcare Associated (HOHA)	Community Onset, Healthcare Associated (COHA)	Community onset, community Associated (COCA)
April	0	1	1
May	0	1	2
June	1	0	0
July	1	0	1
August	0	0	1
September	0	0	1
Total YTD	2	2	6

Total SFT Klebsiella (COHA & HOHA)	Threshold set by NHSE/I	Same time period 21/22	Difference
4	14	8	-4 ↓

Health Care Associated Infections (HCAI)- Pseudomonas

NHS
Bath and North East Somerset, Swindon and Wiltshire
Integrated Care Board



BSW ICB counts of infection Pseudomonas

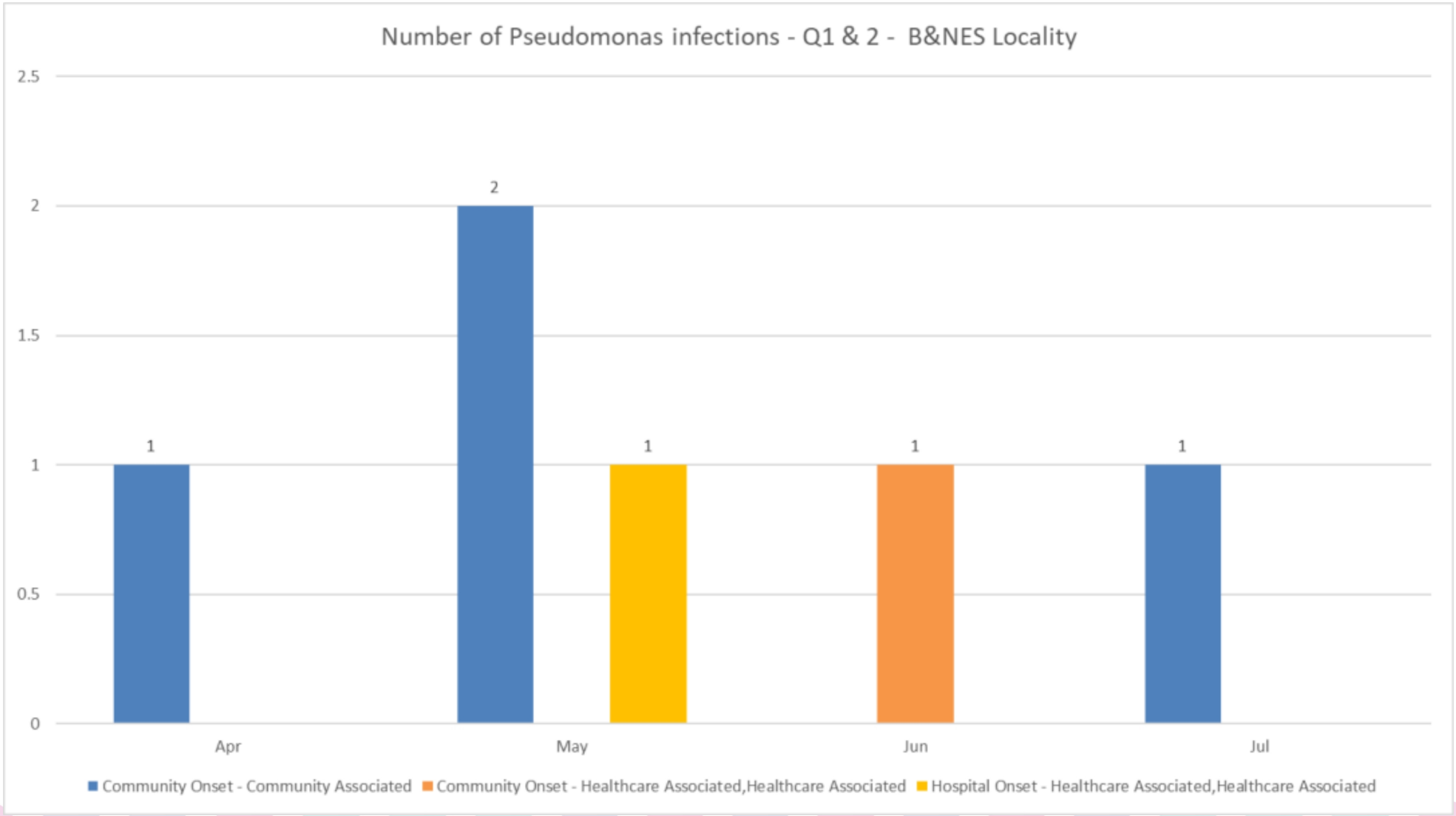
NHS
Bath and North East Somerset, Swindon and Wiltshire
Integrated Care Board

Pseudomonas Counts	Hospital Onset-Healthcare Associated (HOHA)	Community Onset, Healthcare Associated (COHA)	Community onset, community Associated (COCA)
April	1	0	2
May	3	0	4
June	1	1	0
July	1	0	2
August	4	1	1
September	3	0	0
Total YTD	13	2	9

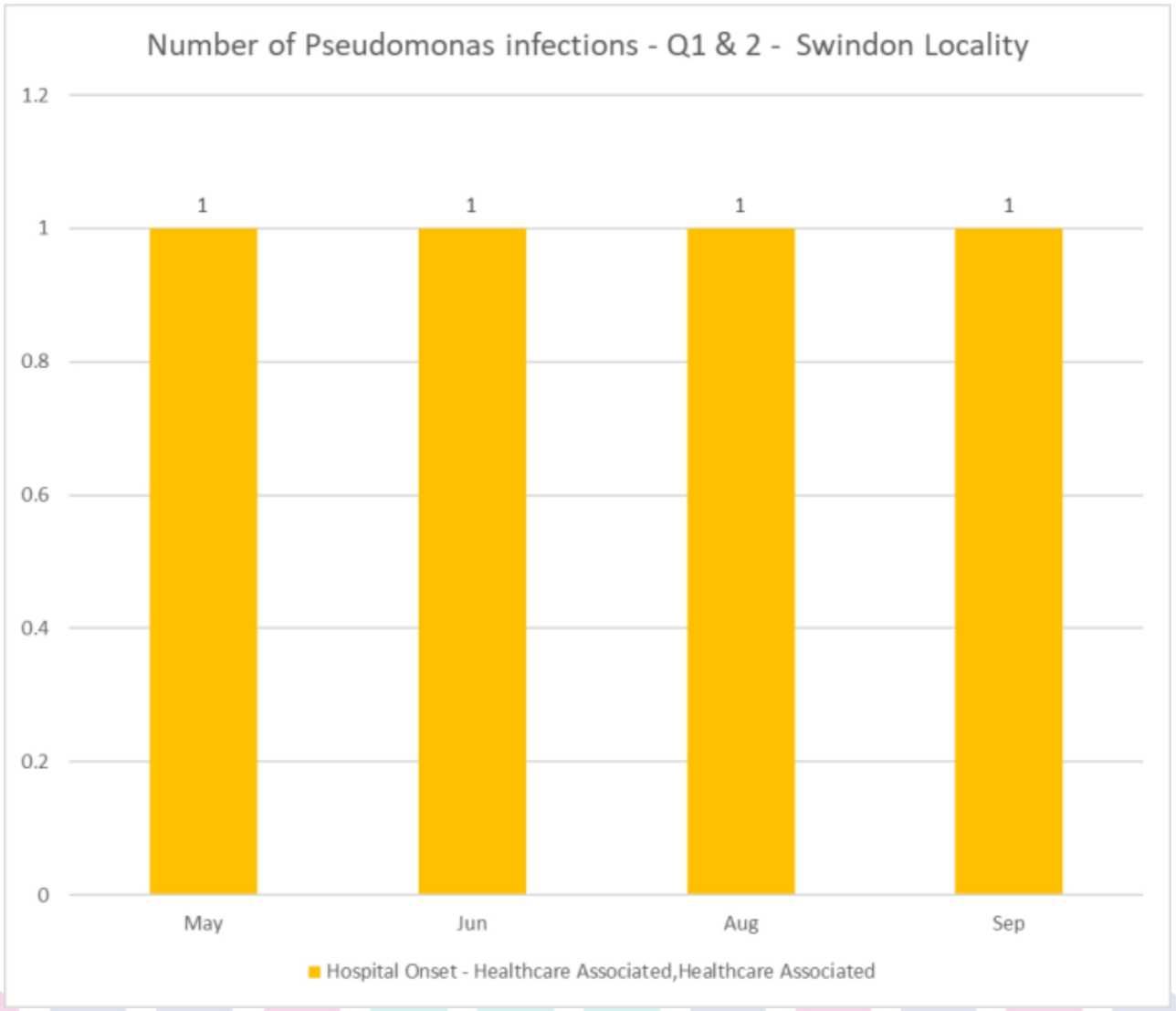
Total BSW pseudomonas	Threshold set by NHSE/I	Same time period 21/22	Difference
24	84	43	-19 ↓

B&NES ICA Pseudomonas counts of infection

Bath and North East Somerset, Swindon and Wiltshire Integrated Care Board



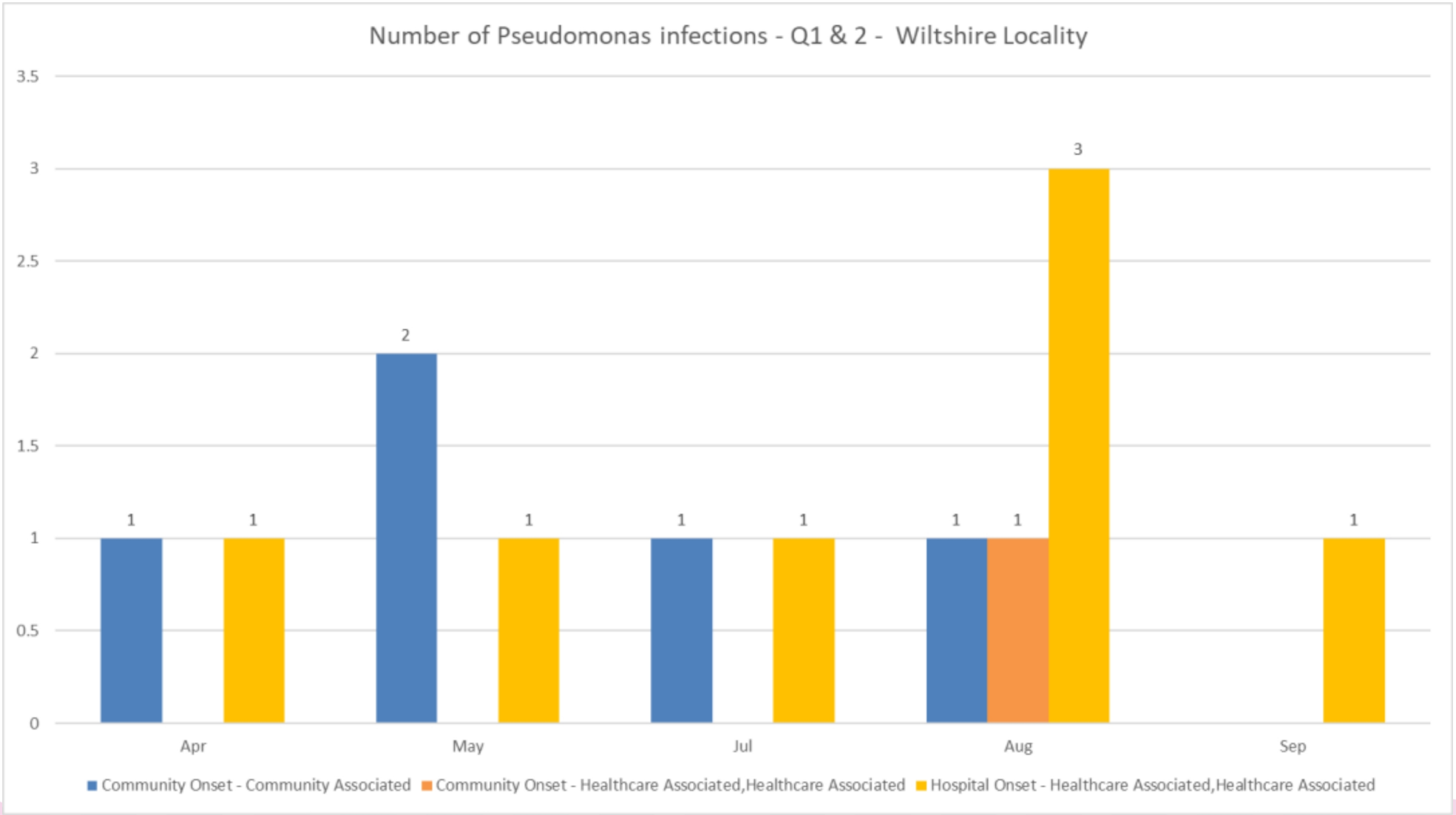
Swindon ICA pseudomonas counts of infection



NHS
Bath and North East Somerset, Swindon and Wiltshire
Integrated Care Board

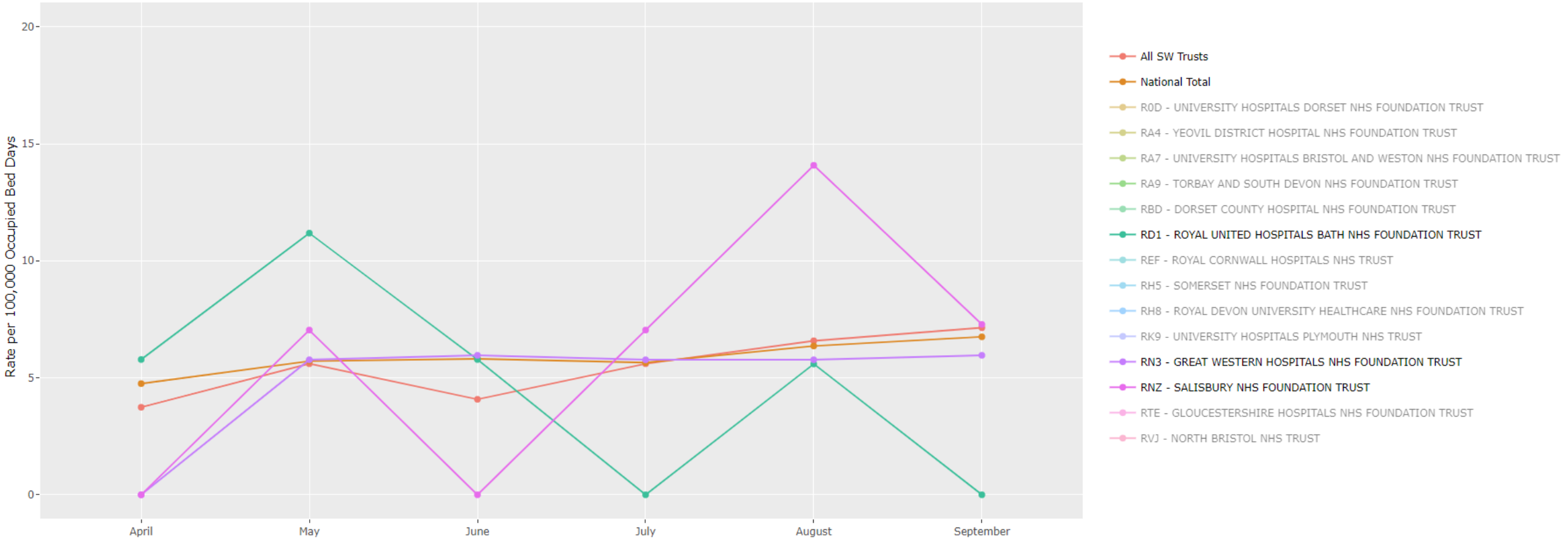
Wiltshire ICA pseudomonas counts of infection

NHS
Bath and North East Somerset, Swindon and Wiltshire
Integrated Care Board



Trust Pseudomonas data

NHS
Bath and North East Somerset, Swindon and Wiltshire
Integrated Care Board



Trust counts if infection- pseudomonas

Bath and North East Somerset, Swindon and Wiltshire Integrated Care Board

GWH	Hospital Onset- Healthcare Associated (HOHA)	Community Onset, Healthcare Associated (COHA)	Community onset, community Associated (COCA)
April	0	0	0
May	1	0	1
June	1	0	1
July	1	0	1
August	1	0	1
September	1	0	0
Total YTD	5	0	4

Total GWH pseudomonas (COHA & HOHA)	Threshold set by NHSE/I	Same time period 21/22	Difference
5	19	8	-3 ↓

Trust counts of infection – pseudomonas

Bath and North East Somerset, Swindon and Wiltshire Integrated Care Board

RUH	Hospital Onset-Healthcare Associated (HOHA)	Community Onset, Healthcare Associated (COHA)	Community onset, community Associated (COCA)
April	1	0	2
May	2	0	4
June	0	1	2
July	0	0	0
August	1	0	2
September	0	0	0
Total YTD	4	1	10

Total RUH pseudomonas (COHA & HOHA)	Threshold set by NHSE/I	Same time period 21/22	Difference
5	17	11	-6 ↓

Trust counts of infection – pseudomonas

Bath and North East Somerset, Swindon and Wiltshire Integrated Care Board

SFT	Hospital Onset-Healthcare Associated (HOHA)	Community Onset, Healthcare Associated (COHA)	Community onset, community Associated (COCA)
April	0	0	0
May	1	0	0
June	0	0	0
July	1	0	1
August	1	1	0
September	1	0	0
Total YTD	4	1	1

Total SFT pseudomonas (COHA & HOHA)	Threshold set by NHSE/I	Same time period 21/22	Difference
5	12	87	-3 ↓

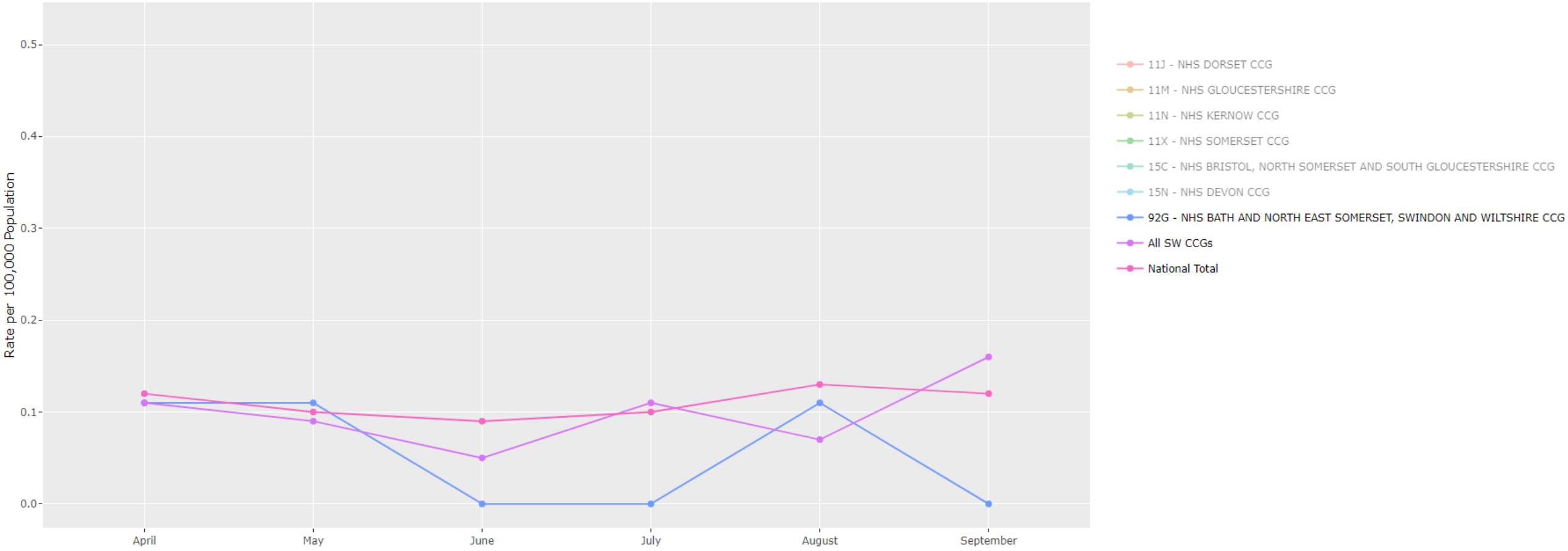
Gram Negative Blood stream infections – E-coli, Klebsiella and Pseudomonas

NHS
Bath and North East Somerset, Swindon and Wiltshire
Integrated Care Board

- Whilst BSW system remain under threshold for GNBSI cases, inducing E-Coli, Klebsiella and Pseudomonas
- The data collected following the audits undertaken within primary care against the BSW system management of UTI's is currently being reviewed and analysed, early review has indicated that compliance with NICE guidance is not optimal and work is required to be undertaken to improve this, it has also indicated that prescribing for UTI's does not always follow guidance and further deep dive into this needs to be undertaken to understand barriers, concerns and clinician feedback on why this may be, this may also link into some of the CDI work streams related to inappropriate antibiotic prescribing.
- Hydration remains a key workstream in the gram negative blood stream infection reduction and linking in with the regional project where we are awaiting further details
- Another area of exploration related to this workstream is to understand if there is any link between waiting lists and infections and also between cost of living and impact that may have on cases.

Health Care Associated Infections (HCAI)- MRSA

Bath and North East Somerset, Swindon and Wiltshire
Integrated Care Board



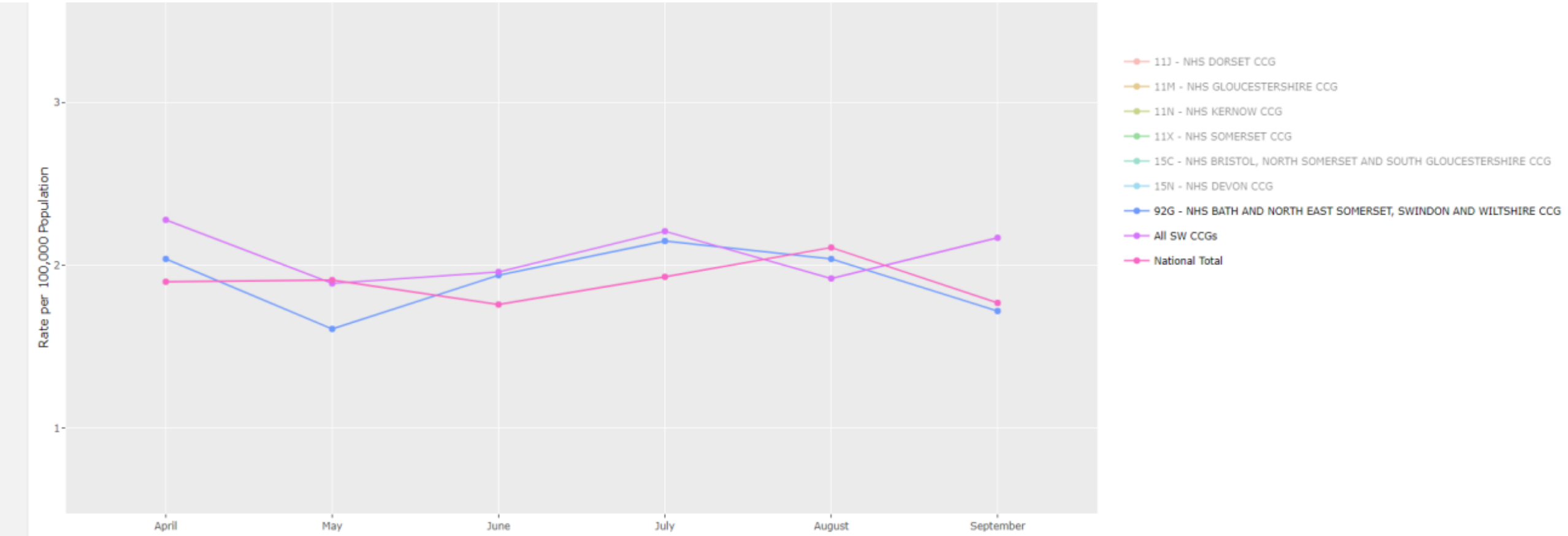
MRSA

NHS
Bath and North East Somerset, Swindon and Wiltshire
Integrated Care Board

- 1 case of MRSA bacteraemia during Q2, this is a total of 3 MRSA cases
- All cases are B&NES cases.
- Primary source for all three cases is skin and soft tissue this is in line with other themes and trends from previous MRSA cases
- MRSA cases remain low year to date, with no hospital onset cases reported for Q1 & Q2.

Health Care Associated Infections (HCAI) – MSSA

NHS
Bath and North East Somerset, Swindon and Wiltshire
Integrated Care Board



BSW ICB counts of infection- MSSA

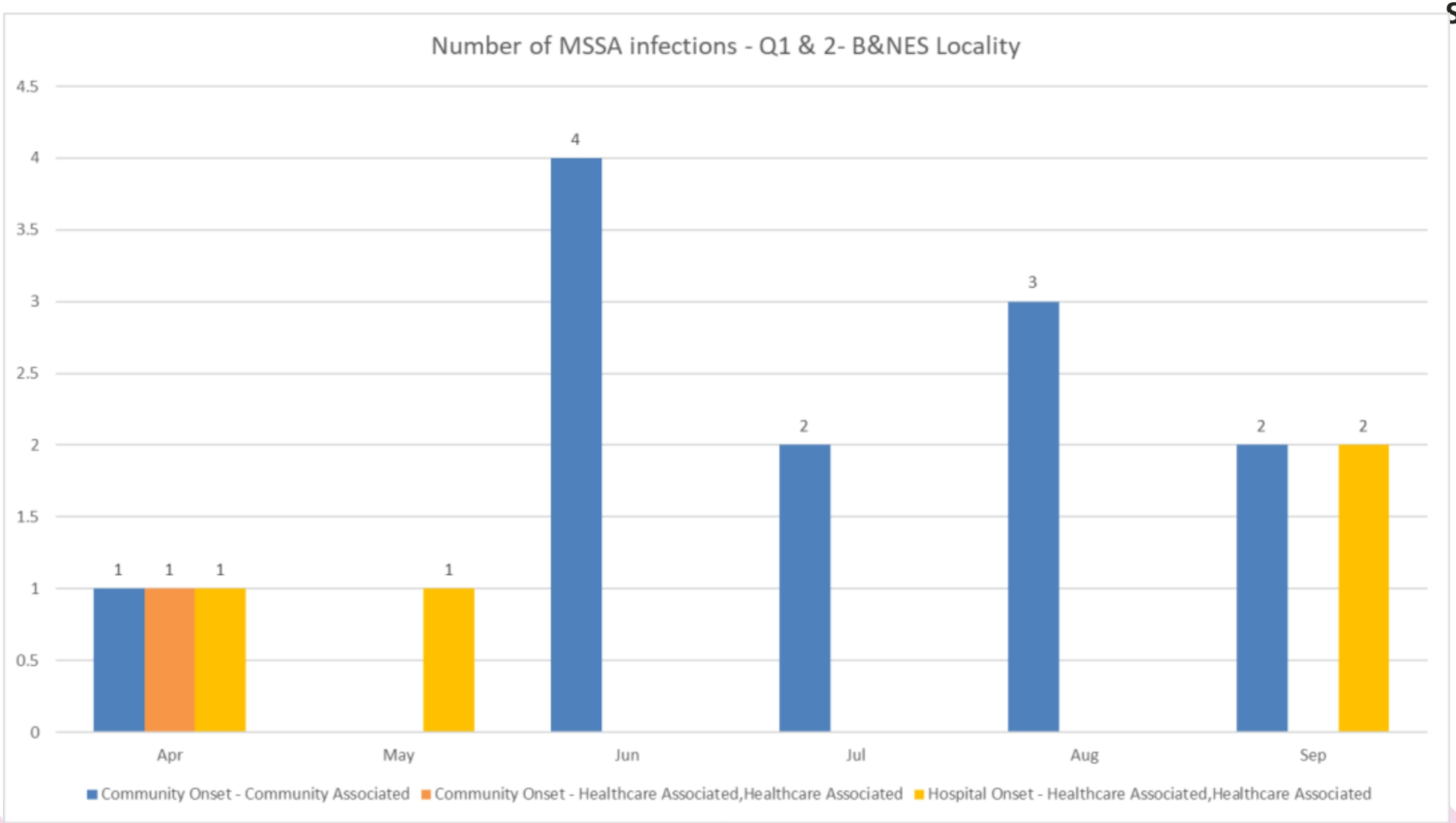
Bath and North East Somerset, Swindon and Wiltshire Integrated Care Board

MSSA	Hospital Onset-Healthcare Associated (HOHA)	Community Onset, Healthcare Associated (COHA)	Community onset, community Associated (COCA)
April	6	3	10
May	6	2	7
June	7	1	10
July	3	2	15
August	7	1	10
September	4	1	11
Total YTD	34	10	63

Total BSW MSSA	Threshold set by NHSE/I	Same time period 21/22	Difference
107	N/A	114	-7 ↓

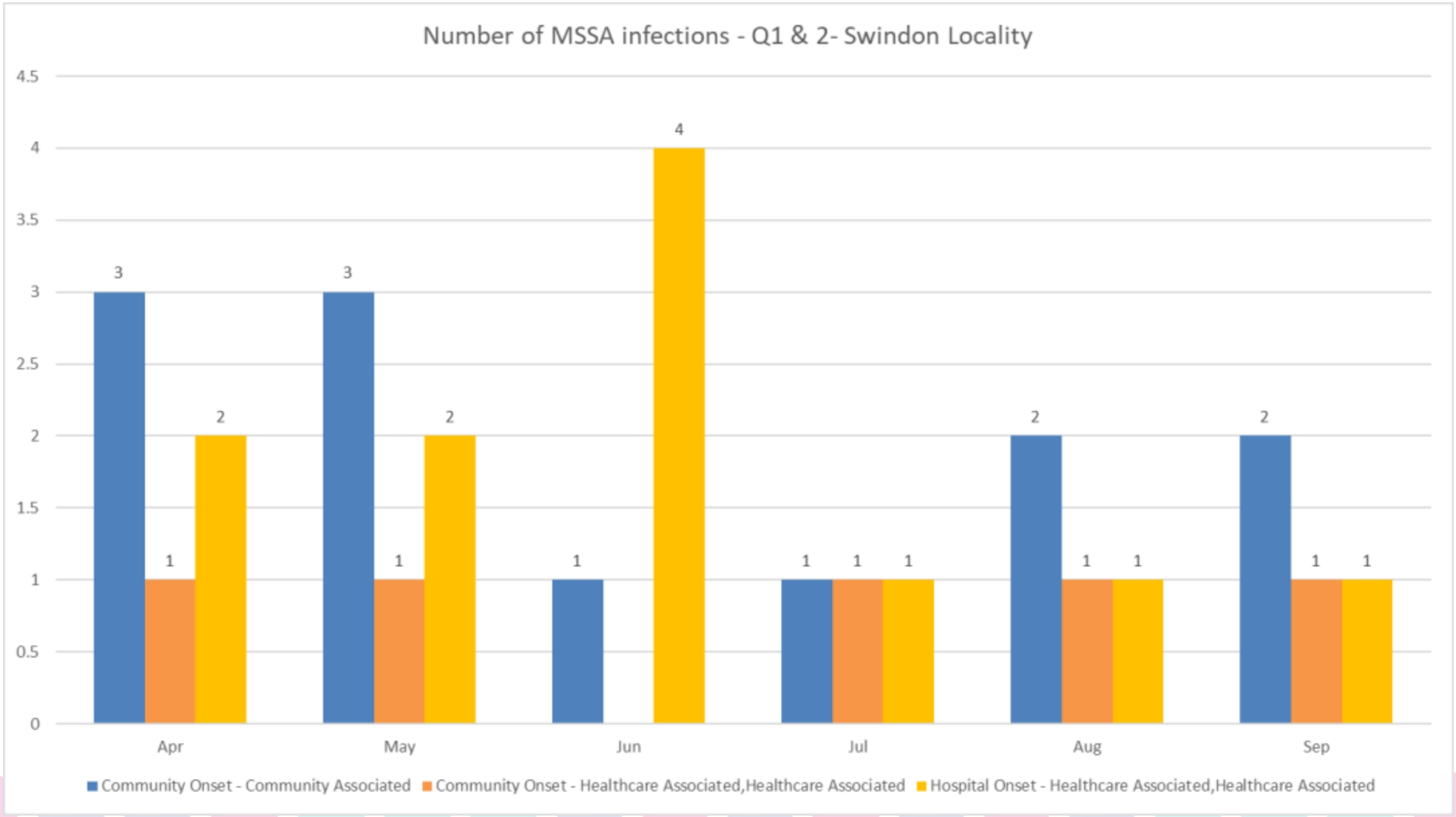
B&NES ICA counts of infection - MSSA

Bath and North East Somerset, Swindon and Wiltshire
Integrated Care Board



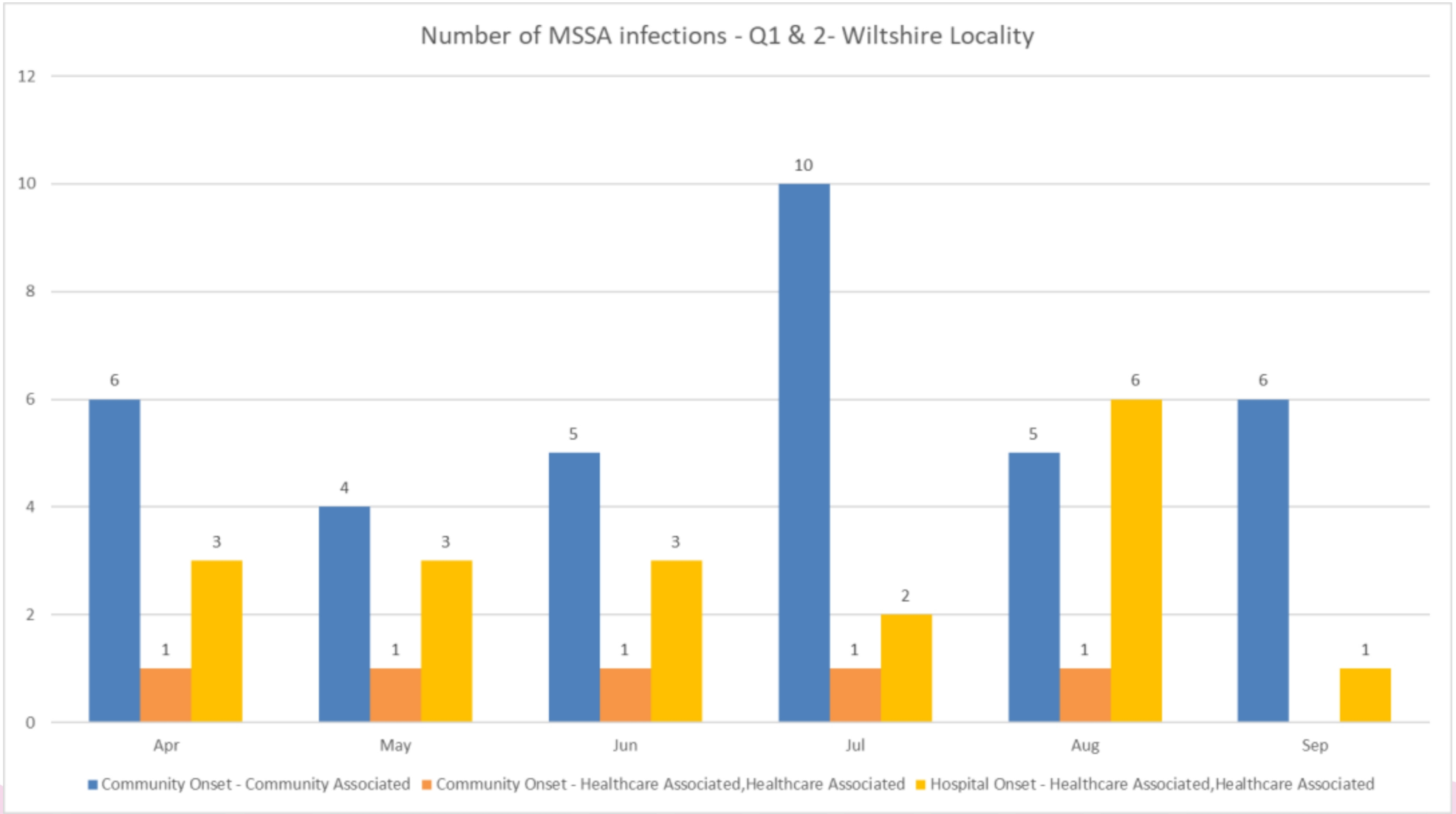
Swindon ICA counts of infection – MSSA

Bath and North East Somerset, Swindon and Wiltshire
Integrated Care Board



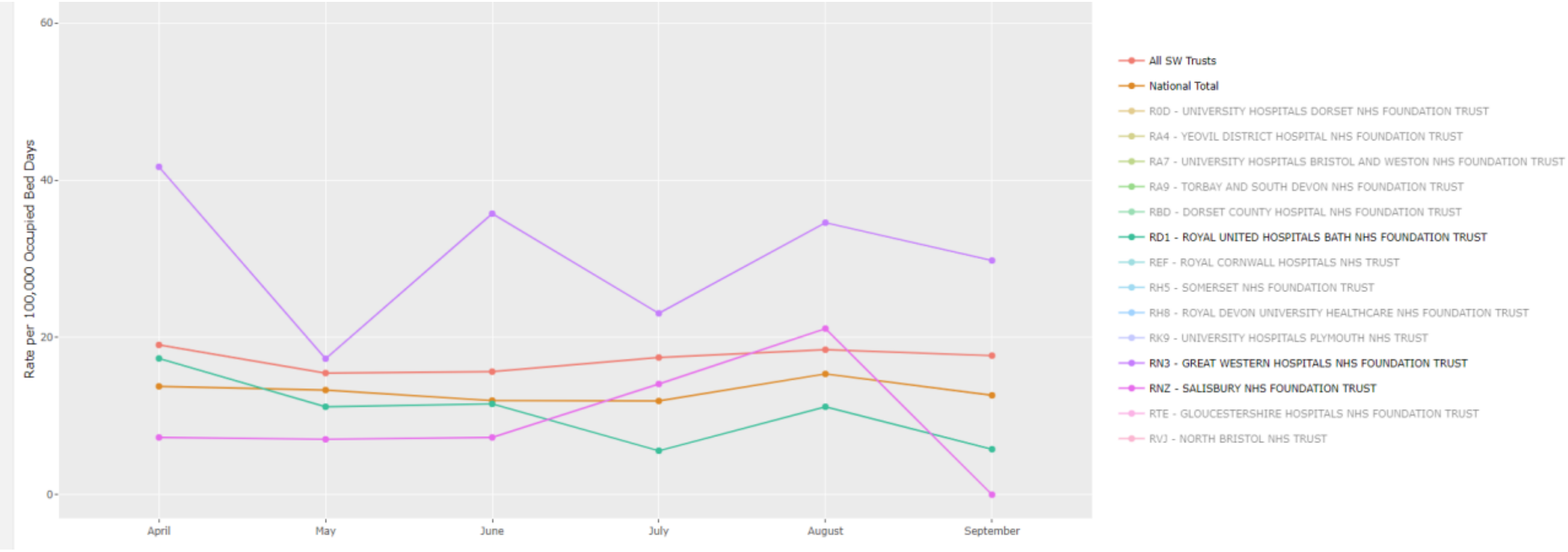
Wiltshire ICA counts of infections- MSSA

Bath and North East Somerset, Swindon and Wiltshire
Integrated Care Board



Trust counts of infection- MSSA

NHS
Bath and North East Somerset, Swindon and Wiltshire
Integrated Care Board



Trust MSSA data

NHS
Bath and North East Somerset, Swindon and Wiltshire
Integrated Care Board

GWH	Hospital Onset-Healthcare Associated (HOHA)	Community Onset, Healthcare Associated (COHA)	Community onset, community Associated (COCA)
April	5	2	6
May	2	1	5
June	5	1	2
July	1	3	4
August	4	2	2
September	3	2	7
Total YTD	20	11	26

Total GWH MSSA (COHA & HOHA)	Same time period 21/22	Difference
31	21	+10 ↑

Trust counts of infection – MSSA

Bath and North East Somerset, Swindon and Wiltshire Integrated Care Board

RUH	Hospital Onset-Healthcare Associated (HOHA)	Community Onset, Healthcare Associated (COHA)	Community onset, community Associated (COCA)
April	2	1	4
May	2	0	1
June	2	0	8
July	1	0	6
August	2	0	7
September	1	0	6
Total YTD	10	1	32

Total RUH MSSA (COHA & HOHA)	Same time period 21/22	Difference
11	16	-5 ↓

Trust counts of infection – MSSA

Bath and North East Somerset, Swindon and Wiltshire Integrated Care Board

SFT	Hospital Onset-Healthcare Associated (HOHA)	Community Onset, Healthcare Associated (COHA)	Community onset, community Associated (COCA)
April	0	1	0
May	0	1	0
June	1	0	2
July	1	1	4
August	3	0	2
September	0	0	0
Total YTD	5	3	8

Total SFT MSSA (COHA & HOHA)	Same time period 21/22	Difference
8	10	-2 ↓

MSSA

Bath and North East Somerset, Swindon and Wiltshire Integrated Care Board

- There is a rising trend in MSSA cases, this is a local, regional and national.
- All acute trusts are monitoring their cases and have assigned reduction targets within their organisations as there are currently no nationally set thresholds for MSSA.
- Reviews of cases have identified that invasive line management, and standard precautions may be a contributory factor associated with these cases.
- Further work needs to be undertaken to review our community cases to understand root causes and contributory factors associated with these factors.

Salisbury NHS Foundation Trust

Report to:	Trust Board (Public)	**Agenda item:**	4.1
Date of Meeting:	12 January 2023		

Report Title:	People Plan			
Status:	**Information**	**Discussion**	**Assurance**	**Approval**
				*
Approval Process (where has this paper been reviewed and approved)	People and Culture Committee. 24 November 2022			
Prepared by:	Melanie Whitfield Chief People Officer			
Executive Sponsor (presenting):	Melanie Whitfield Chief People Officer			
Appendices (list if applicable):	Appendix 1. The People Plan at SFT. Appendix 2. Compassionate Inclusive – EDI strategy. Appendix 3. Safe & Healthy – Health & Wellbeing plan. Appendix 3a. Safe & Healthy – Health & Safety Plan 2022-2024. Appendix 4. Always Learning – Organisation Development plan 2022-26. Appendix 5. We are a Team – Team plan. Appendix 6. OD&P 5 year ambition slide deck. Appendix 7. Identifying Trends in healthcare and work. Appendix 8. OD&P 5 year ambition slide deck.			

Recommendation:
The Board are asked to note and approve the long-term people plan for SFT.

Executive Summary:
Salisbury NHS Foundation Trust's 'Our Strategy 2022 to 2026' is a key step for the trust as we set our future and priorities, which include important commitments to our community over the next five years.

Our Vision:

Strategy and Priorities
'Our Strategy' confirms our new Trust priorities which are:

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

The Long-Term People Plan at Salisbury NHS Foundation Trust contains the actions which will support the delivery of the four pillars of The NHS People Plan for 20/21 action for us all. Beginning with embedding the seven elements of Our People Promise and the People Plan, we will work towards improving our people retention and increasing their availability and capability. The future of human resources and organisational development report outlines eight themes and a vision for what human resources and organisational development will look like in 2030 and to which we aspire.

Driver Metrics
From 'Our Vision' and 'Our Strategy', we have identified and agreed the People Promise is a Strategic Objective under our Improving Together programme. The driver metrics are:

An outstanding experience for our people

	What does good look like for us?	*What will we measure (to help us know we are moving in the right direction)*	*What is our indicator of success?*
1	More people would recommend SFT as a place to work, feeling motivated and supported to make improvements to their work (and the standard of care we give)	Improvement in staff engagement score within staff survey	We will achieve the upper quartile for acute providers
2	More people stay within our workforce and take up opportunity's of promotion or changes of role	Reduction of unwanted turnover (people leaving the Trust or the NHS)	Turnover in line with Trust target of 10% and an increasing stability index
3	Our people recognise and experience SFT as an inclusive employer	Positive trend against the 7 WDES and 4 WRES indicators in the NHS staff survey	Achieving the median for our benchmark group across the workforce equality standards at SFT

Our outcomes against each pillar are as follows:

Pillar 1 – Looking after our people
People feel safe and supported with their physical health, mental health and wellbeing and therefore,are better able to provide high-quality, compassionate care to our patients. Salisbury NHS Foundation Trust is a great place to live and work in.

Pillar 2 – Improve belonging in the NHS
People develop and thrive in a compassionate and inclusive environment where they can see that inequalities are being addressed.
Leaders are clear on how they need to behave to perform effectively and deliver the NHS People Promise.
A single framework for leadership competence and behaviours which underpins recruitment, conduct, performance and personal or professional development.
A common curriculum provides open access to learning and career pathways.

Pillar 3 – New Ways of Working and Delivering Care
New ways of working and delivering care that optimises the skills of our people, makes better use of technology and encourages wider innovation to meet population health needs.
To continue to drive for operational excellence, quality of care and value for money.

Pillar 4 – Growing for the Future
An integrated and dynamic workforce. Activity and financial planning to meet current and future population, service and workforce needs. Workforce planning responsibilities and outputs at organisational, system, regional and national levels are clear.
The system is retaining, recruiting and, where required, growing its workforce to meet future need. The 'one workforce' across the Integrated Care System is representative of the local communities served.
Education and training opportunities are fit for the needs of current and future people, workforce requirements and our services.

Pillar 5 – The Vision for the Future of the People Profession
An outstanding people profession team at Salisbury NHS Foundation Trust providing modern employment practices

Governance
Delivery of the Salisbury NHS Foundation Trust People Plan will be overseen and governed by the People and Culture Committee, part of the assurance committees to Board. We will measure our progress against these aspirations by agreeing annual goals that are, purposeful, actionable, continuous, and trackable. These will be made available through a story board of Purpose, Priority and Impact slides each year.

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) -	☐

The Long-Term People Plan at Salisbury NHS Foundation Trust

(2022-2027)

A response to the Salisbury Foundation NHS Trust Strategy outlining our approach to delivering the People Plan, the People Promise, the priorities and operational planning guidance and the future of NHS Human Resources and Organisational Development Report

October 2022

1 Contents

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2 Executive Summary

Salisbury NHS Foundation Trust's 'Our Strategy 2022 to 2026' is a key step for the trust as we set our future plans and priorities, which include important commitments to our community over the next five years. Our Vision:

2.1 Strategy and Priorities

'Our Strategy' confirms our new Trust priorities which are:

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

This document outlines Long Term People Plan at Salisbury NHS Foundation Trust. It contains the actions which will support the delivery of the four pillars of The NHS People Plan for 20/21 action for us all. Beginning with embedding the seven elements of Our People Promise and the People Plan, we will work towards improving our people retention and increasing their availability and capability. The future of human resources and organisational development report outlines eight themes and a vision for what human resources and organisational development will look like in 2030 and to which we aspire.

2.2 Driver Metrics

From 'Our Vision' and 'Our Strategy', we have identified and agreed the People Promise is a Strategic Objective under our Improving Together programme. The driver metrics are:

An outstanding experience for our people

	What does good look like for us?	*What will we measure (to help us know we are moving in the right direction)*	*What is our indicator of success?*
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2.3 Our outcomes against each pillar are as follows:

2.3.1 Pillar 1 – Looking after our people

- People feel safe and supported with their physical and mental health and wellbeing and are, therefore, better able to provide high-quality, compassionate care to our patients. Salisbury NHS Foundation Trust is a great place to live and work in.

2.3.2 Pillar 2 – Improve belonging in the NHS

- People develop and thrive in a compassionate and inclusive environment where they can see that inequalities are being addressed.
- Leaders are clear on how they need to behave to perform effectively and deliver the NHS People Promise.
- A single framework for leadership competence and behaviour underpins recruitment, conduct, performance and personal or professional development.
- A common curriculum provides open access to learning and career pathways.

2.3.3 Pillar 3 – New Ways of Working and Delivering Care

- New ways of working and delivering care that optimises the skills of our people, makes better use of technology, and encourages wider innovation to meet population health needs.
- To continue to drive for operational excellence, quality of care and value for money.

2.3.4 Pillar 4 – Growing for the Future

- An integrated and dynamic workforce. Activity and financial planning meets current and future population, service and workforce needs. Workforce planning responsibilities and outputs at organisational, system, regional and national levels are clear.
- The system is retaining, recruiting and, where required, growing its workforce to meet future need. The 'one workforce' across the Integrated Care System is representative of the local communities served.
- Education and training opportunities are fit for the needs of current and future people, workforce requirements and our services.

2.3.5 Pillar 5 – The Vision for the Future of the People Profession

- An outstanding people profession team at Salisbury NHS Foundation Trust providing modern employment practices

2.4 Governance

Delivery of the Salisbury NHS Foundation Trust People Plan will be overseen and governed by the People and Culture Committee, part of the assurance committees to Board. We will measure our progress against these aspirations by agreeing annual goals that are, purposeful, actionable, continuous, and trackable. These will be made available through a story board of Purpose, Priority and Impact slides each year.

3 National Picture

A series of key national documents and initiatives have been designed to help NHS organisations improve their processes and practices in relation to the people working in the NHS. An overview of each of these follows. They form the basis for the work that we will be carrying out across our 5-year Long-Term People Plan.

3.1 NHS People Plan Pillars

The NHS People plan pillars are:

Building on the 2019 Interim People Plan, these four pillars underpin everything we will do in the Organisational Development and People directorate (hereafter referred to as OD&P). They are a simple but meaningful way of grouping the activities we undertake.

3.2 The People Promise

The NHS People Promise is a promise we make to ourselves and each other as part of the NHS workforce to improve the experience of working for the NHS.

The elements of the promise are:

At Salisbury NHS Foundation Trust we are fortunate to be one of 23 Exemplar Sites charged by NHS England with implementing all areas of the promise over 12 months and measuring our success.

Please see Appendices for the supporting long term plans OD&P will be championing against each of the seven People Promise elements this year:

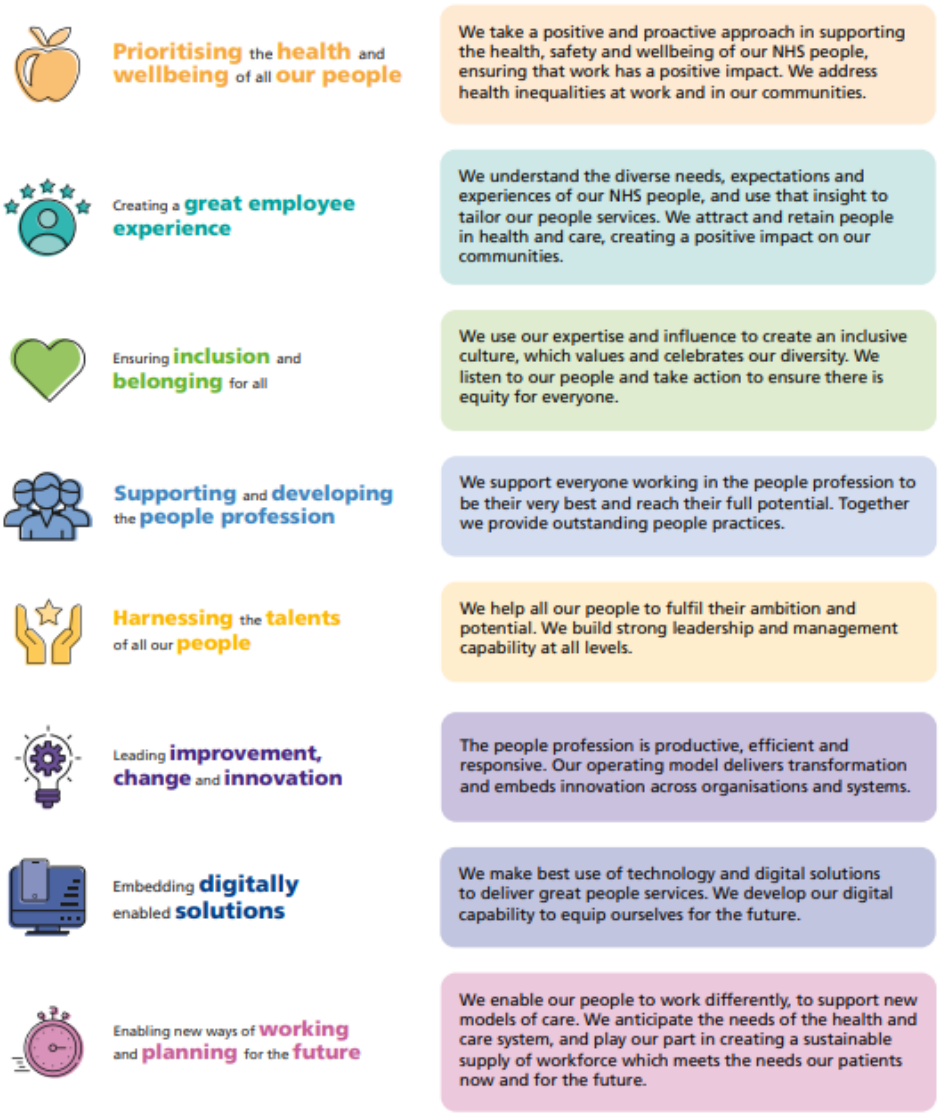
- Appendix 1 - 'We are compassionate and inclusive'
  - 1a Equality, Diversity and Inclusion Strategy
  - 1b Compassionate Leadership
- Appendix 2 - 'We are recognised and rewarded'
  - 2 Recognition and Reward Plan (in development)
- Appendix 3 - 'We each have a voice that counts'
  - 3 Freedom to Speak Up and Just and Learning Culture Plan (to follow)
- Appendix 4 - 'We are safe and healthy'
  - 4a Health and Wellbeing Plan

- 4b Health and Safety Management Plan
- Appendix 5 - 'We are always learning'
  - 5a Organisational Development Plan
- Appendix 6 - 'We work flexibly'
  - 6 Flexible Working Plan (in development)
- Appendix 7 – 'We are a team'
  - 7 Team Plan (OD plan with further additions to follow)

3.3 The future of NHS human resources and organisational development report

This NHS England report was published in November 2021 and holds a vision for 2030. Co-created by members of the profession, people working in the NHS and leaders, this vision sets out how the profession and the services we provide need to evolve in order to challenge, develop, enable, partner and deliver the health and care system we need in the future.

The key elements are:



3.4 Looking after our people – retention programme

NHS England are running the Looking After Our People – Retention programme of work to improve retention by working across systems and regions to improve the chances of people staying in the local health arena as they progress their careers**.**

In our area Salisbury NHS Foundation Trust is engaged with the Bath and North East Somerset, Swindon and Wiltshire Partnership Recruitment and Retention Programme. Our Chief People Officer has been appointed as Senior Reporting Officer for this region-wide activity.

Many of the key principles and practical activities outlined in the Improving Staff Retention guide will be included in the interventions used at Salisbury NHS Foundation Trust to encourage people to stay and progress their careers with us.

3.5 Workforce Transformation

Health Education England have a range of tools to support trusts with Workforce Transformation. They encourage the introduction of new and emerging roles which can be accessed via the roles explorer directory.

Whilst at Salisbury NHS Foundation Trust there is a positive aspiration and intention to make the most of the workforce transformation offers available, the implementation of these workforce transformation activities has been limited. Only a handful of new roles have been introduced to date. This may be a result of sustained operational challenges and does mean we are not yet as advanced as other peer NHS organisations in this area.

4 Local Position

4.1 Salisbury NHS Foundation Trust – 'Our Vision' and 'Our Strategy'

Salisbury NHS Foundation Trust has a workforce of 4,897 and enjoys the support of 180 volunteers. The Trust works in partnership with 2 subsidiary companies, Odstock Medical Ltd and Salisbury Trading Ltd and recognises 3,000 Independent contractors. Each of these skilled and compassionate people help us provide health care for a population of 270,000 people in Wiltshire, Dorset and Hampshire.

In launching 'Our Vision' and 'Our Strategy' we have made our pledge to ensure we offer an outstanding experience to the people who use our services. We need to be the Best Place to Work for our teams and our partners.

We have synthesised the priorities for the whole Trust under three themes:

1. **Supporting our People**: our aim to improving the health and wellbeing of the people who work for us. We want to give them the best opportunity to achieve a fulfilling career that makes a real difference to the lives of the people who access our services.
2. **Improving Together – our approach to building a culture of continuous improvement:** Using an approach that will be consistently applied across Bath and North East Somerset, Swindon and Wiltshire Partnership, the Trust will design and deliver an integrated organisational development and continuous improvement methodology. This will provide the training, tools, and operating climate to support everyone to make the improvements to the way we work and care we provide
3. **Encouraging our future leaders** - We want to support our people and our partners with the tools that will enable them to achieve their best careers, across all the roles that make up and support our Integrated Care System and its future leadership.

4.2 OD&P Metrics

From 'Our Vision' and 'Our Strategy', we have identified and agreed the People Promise is a Strategic Objective under our Improving Together programme. The driver metrics are:

An outstanding experience for our people

	What does good look like for us?	*What will we measure (to help us know we are moving in the right direction)*	*What is our indicator of success?*
1	More people would recommend SFT as a place to work, feeling motivated and supported to make improvements to their work (and the standard of care we give)	Improvement in staff engagement score within staff survey	We will achieve the upper quartile for acute providers
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3	Our people recognise and experience SFT as an inclusive employer	Positive trend against the 7 WDES and 4 WRES indicators in the NHS staff survey	Achieving the median for our benchmark group across the workforce equality standards at SFT

Our long-term plan is written in the format of the National People Plan, with all activities targeted at delivering against this strategic objective and measured against these metrics.

4.3 Salisbury NHS Foundation Trust Values

The Trust have restated and refined our values to ensure they remain relevant and drive the way we work towards our strategic priorities as an organisation. In recognising the scale of our current and future challenges, we have added a further value, **Progressive**. This reflects our desire and commitment to tackle future challenges and opportunities with positivity and a continuous improvement ethos.

Person Centred & Safe | **Professional** | **Responsive** | **Friendly** | **Progressive**

We will be:

- **Person Centred & Safe** - Our focus is on delivering high quality, safe and person focussed care through teamwork and continuous improvement.
- **Professional** - We will be open and honest, efficient and act as role models for our teams and our communities.
- **Responsive** - We will be action oriented and respond positively to feedback.
- **Friendly** - We will be welcoming to all, treat people with respect and dignity, and value others as individuals.
- **Progressive** - We will constantly seek to improve and transform the way we work, to ensure that our services respond to the changing needs of our communities.

4.4 Improving Together

Improving together is a trust-wide initiative bringing a single methodology of continuous improvement supported by the development of a coaching culture. Evidence shows that a culture of continuous improvement leads not only to better patient care but also to increased satisfaction at work. Underpinning improving together is the desire to make Salisbury NHS Foundation Trust the 'Best Place to Work.' OD&P directorate will use this approach and methodology in the interventions they use to make improvements to our own practices and to those that impact on people's experience.

4.5 NHS England and CQC

Salisbury NHS Foundation Trust is regulated by the Care Quality Commission (CQC) and NHS England who monitor the performance of the trust. The well-led framework for health providers has a strong focus on financial and resource governance. It provides a single structure to enable the leadership, management, and governance of the organisation to be assessed. As in the rest of the trust, our work within OD&P directorate must align and adhere to these performance measures alongside the NHSE Performance Framework. Our work feeds into both the internal and external governance structures that ensure our organisation and the services we provide are performing safely and appropriately.

4.6 OD&P directorate vision

The NHS Long Term Plan, looking at health care services in 2030, sets out a vision for a fundamentally different way of working than today. At Salisbury NHS Foundation Trust we recognise that, if we are to meet the challenges ahead, our people professionals and managers will need to adapt and evolve our approach to people practices. There is growing evidence of the links between the wellbeing of our people to the quality of care they deliver and to retaining them in the organisation. This is further complemented by increasing competency and adoption of digital technology, automation of tasks and agile working including blending in the potential for on-site and remote working.

The people profession at Salisbury NHS Foundation Trust includes operational human resources (HR), organisational development (OD) education and learning, workforce planning, occupational health, health and safety, internal and external communications. We, alongside managers and trade unions, contribute to and improve our NHS people's working experiences directly. We do this through our own behaviours and the people practices we adopt.

We recognise the HR/ OD must be at the forefront of the NHS Long Term Plan vision and changes. We must be involved in the leadership, inspiration and development in of people, creating new systems and processes to deliver desired health outcomes, all while ensuring our people feel valued and supported.

The drive for change is set against a backdrop of rapid and widespread innovation in the way we approach integrated care, the nature of providing healthcare and the wider societal shifts that affect the nature of work.

4.7 Partnerships

We will continue to build relationships and collaborative working across Bath and North East Somerset, Swindon and Wiltshire Partnership Bath and North East Somerset, Swindon and Wiltshire Partnership and the 101 organisations that make up our local health and care system. Overcoming traditional care and career boundaries, transforming roles to help increase and spread innovative practise and create a consistently compassionate, inclusive and values driven work environment in support of the patients we service.

Salisbury NHS Foundation Trust Chief People Officer (CPO), the Senior Responsible Officer for the Recruitment and Retention collaboration, is leading the collaboration of integration of people services in our acuate health care alliance (AHA). We are one of 23 Trusts in the UK to be a People Promise exemplar site and one of the 10 participating in the Disability Aware Programme.

Curious to explore new career pathways and to share expertise and knowledge across health and care providers, we are keen on increasing our footprint and impact across our local system.

5 Identifying Trends

Underpinning our long-term plan is an acknowledgement that trends in health and care and ways of working form an important context for how our people services need to evolve. Examples of current trends include:

Service related

- Regional demand for health services is rising due to an aging population with increasingly complex healthcare needs
- Workforce growth has not kept up with increasing demand for services
- Shortages and a back log of care such as in children's services and mental health driving the need for greater integration across health and social care

Patient related

- People experience inequalities in life expectancy and access to care in more deprived areas
- People of all ages wanting to take more control of how they manage their physical and mental wellbeing

Workforce related

- Demographics within the workforce are changing with a four generational workforce at the trust
- There is increased competition for the workforce due to a UK labour shortage
- Training and appraisal are likely to identify the need to develop new types of skills and knowledge which in turn may need to new roles or different ways of working
- Technological change is likely to reshape job and skill demands

Lifestyle related

- People's expectations of work are changing and seek roles where they have autonomy, feel their work makes a contribution and feel they are listened to
- People want to balance their work more easily with other areas of their life
- There is an increase in non-linear careers rather than careers for life

Additional information and statistical data in relation to these trends can be found as Appendix 8.

6 Anchor Institutions

The NHS Long Term Plan recognised the potential for the NHS to act as an 'anchor institution.' These are described as large organisations that are unlikely to relocate and have a significant stake in their local area. They have sizeable assets that can be used to support their local community's health and wellbeing and tackle health inequalities.

By changing how we work here at Salisbury NHS Foundation Trust and by working more seamlessly with our care partners, we have the opportunity to genuinely improve the employment experience of our people and the lives of the populations we care for. As an anchor institution and employer of choice, we can reach into our communities, reduce inequalities by improving access to services and using innovative approaches to delivery.

We have seized this opportunity and agreed a partnership with Coventry and Warwick University to build a learning and training campus on site. This will bring a wider breadth of higher education and skills development provision to the population of South Wiltshire.

It is important to us that people recommend Salisbury NHS Foundation Trust as a good employer. In 2016, 72.2% of our people would have recommended the trust as a place to work, which at that time was well above average for our type of organisation. However, recently our score has fallen from 68.2% to 56.9% in the past 12 months. This tells us we must do better across a number of elements of the People Promise to restore our level of recommendations received.

To transform the experience our people, have at work, colleagues from across the people profession and managers at every level will need to change the way we lead and act within our organisation and our locality and region.

7 Our Long-Term People Plan

In this section we set out our ambition for Salisbury NHS Foundation Trust, how OD&P and the community will develop and work differently over the years ahead. Each year our plan aligns to the guidance provided by NHS England in Appendix 9. We aim to create a steady improvement curve to achieve this outcome and will update this document with annual milestones as laid out in Appendix 10 and Appendix 11.

7.1 Pillar 1: Looking after our People:

To achieve outstanding care for our patients we must strive to look after ourselves and each other and to create an outstanding experience for our people. We recognise that the past 2 years has had a significant physical, mental, and psychological impact on us.

7.1.1 The People Promise aspirations include:

- **Creating a great employee experience**: we understand the diverse needs, expectations and experiences of our NHS people and use that insight to tailor our people services
- **Prioritising the health and wellbeing of all our people:** We take a positive and proactive approach in supporting the health, safety and wellbeing of our people ensuring that work has a positive impact. We address health inequalities at work and in our communities.

Here at Salisbury NHS Foundation Trust, we will measure our progress against these aspirations by agreeing annual goals that are, purposeful, actionable, continuous, and trackable.

7.1.2 Our outcome:

- People feel safe and supported with their physical and mental **health and wellbein**g and are, therefore, better able to provide high-quality, compassionate care to our patients. Salisbury NHS Foundation Trust is a **great place to live and work in**.

7.1.3 Our 3 to 5-year aspiration:

Recent survey results have meant that the trust is currently placed within the second quartile for most of the survey response areas. We therefore aspire to see a trend of movement towards and into the third quartile and a longer-term aspiration to move towards and into the upper quartile in the following areas:

1. An increase in engagement with the survey. We aim to see an increase in the number of people completing the survey year on year.
2. Increased recommendations. We aim to see a positive trend of people recommending Salisbury NHS Foundation Trust as a place to work year on year.
3. Better representation. We aim to receive responses to the survey across all staff groups and protected characteristics year on year.
4. Improved engagement at work. We aim to see an increasingly positive trend across the dimensions of motivation, involvement, and advocacy year on year.

5. Reduced negative health and safety measures. We will pay particular attention to indictors of burn out and staff experience. By identifying feelings of stress and anxiety earlier, and ensuring we introduce, adapt, and continually evaluate our interventions to reduce those concerns we aim to see a reduction of negative indicators year on year.
6. Increased flexibility. We will support people to have a greater choice in where when and how they work to help them achieve a better work life balance. We aim to see a positive trend across the flexible working dimensions year on year.

7.2 Pillar 2: Improve belonging in the NHS:

The NHS was established on the principles of social justice and equity. This is captured in our NHS constitution and supported by our local values Patient Centred and Safe; Professional; Responsive; Friendly; and Progressive. However, the NHS Staff Survey results at Salisbury NHS Foundation Trust tells us that the treatment of our colleagues, particularly from minority groups, falls short of these principles in some areas.

Failing to address belonging in the Trust limits our collective potential. We risk preventing ourselves from delivering excellence in healthcare by not identifying and using our best talent, from closing the gap on health inequalities and making service change that meets the needs of our population.

7.2.1 The People Promise aspirations include:

- **Ensuring inclusion and belonging for all.** We use expertise and influence to create an inclusive culture which values and celebrates our diversity.
- **Listening.** We listen to our people and take action to ensure there is equity for everyone.

Here at Salisbury NHS Foundation Trust we will measure our progress against these aspirations by agreeing annual goals that are, purposeful, actionable, continuous, and trackable and include ensuring our people have a voice and, building on the trust's Improving Together ethos, that our leadership is compassionate and inclusive.

7.2.2 Our Outcomes:

- People develop and thrive in a compassionate and inclusive environment where they can see that inequalities are being addressed.
- Leaders are clear on how they need to behave to perform effectively and deliver the NHS People Promise.
- A single framework for leadership competence and behaviour underpins recruitment, conduct, performance and personal or professional development.
- A common curriculum provides open access to learning and career pathways.

7.2.3 Our 3 to 5-year aspiration:

We will:

1. Continue to take regular quarterly pulse checks on the lived experience of our people. We aim to listen to their experience and progressing actions which make a positive difference to their work experience.

2. Design, develop and host diverse network groups and development courses. We aim to provide safe forums for feedback, exploration and personal growth with all staff groups reporting fairer treatment and a sense of equality of opportunity.
3. Require all managers and leaders to attend both skill and behavioural training workshops to build their personal sense of competence and demonstrate their successful application of new skills. We aim to support them to continually improve their results in sense of team, value of appraisals and the embedding of a compassionate culture.

7.3 Pillar 3: New Ways of Working and Delivering Care

We found a new agility through our response the Covid 19 pandemic. We worked more quickly, with less bureaucracy, empowering individuals, and teams to do what they knew was right to ensure we could continue to provide care and look after each other. There are several good practices we would want to keep and some new ways of working we should continue to explore. We aim to help people to continue to work with Trust, giving them flexibility and a sense of opportunity in their own roles to develop in their career. Doing this effectively will impact on the way we design and deliver care across the whole patient pathway.

Working within our Improving Together Programme which provides a strategic commitment to introduce a unified approach to continuous improvement methodology, we will support a culture where this way of working can thrive. We will support and develop the coaching and leadership capabilities of our people across the organisation.

7.3.1 The People Promise aspirations align to our strategic ambitions and include:

- **Team effectiveness.** We see people working and learning together in multi-professional teams that are actively designed around the full range of experience and capabilities of clinical and non-clinical colleagues.
- **Role development.** We explore and plan for the adoption of new roles.
- **Volunteers.** We continue to increase support and develop the longer-term volunteering opportunities, bringing a wider cohort of volunteers, and perhaps even new people into Salisbury NHS Foundation Trust as employees.
- **Training and development.** We ensure we return to the regular training and development commitment to our people by expanding our e-learning and acting with a renewed emphasis on recognising the importance of flexible skills and building capabilities.

7.3.2 Our Outcomes:

- New ways of working and delivering care that optimises the skills of our people, makes better use of technology, and encourages wider innovation to meet population health needs
- To continue to drive for operational excellence, quality of care and value for money

7.3.3 Our 3 to 5-year aspiration:

We will

1. See a positive increase in the NHS Staff Survey engagement and an improving trajectory of results with people reporting:
   - increasing opportunities for development
   - that they can explore and apply for new roles and career pathways
   - that the value of their appraisal is improving
   - that they feel a true sense of team
2. See a reduction in patient complaints and a correlating increase in patient compliments. We will be able to directly see a link between to increased training and learning for our people and experimentation with new roles or patient outcomes as creating this feedback loop.
3. Effectively use and implement e-rostering across the whole Trust. We will roll it out for all clinical staff groups including the medical and non-medical workforce, thereby increasing the visibility and optimal deployment of the available people.
4. Benefit from an increasing number of active volunteers, across all age groups, who both speak well of their experience and attract new applicants to health and social care.

7.4 Pillar 4: Growing for the Future

Nationally we hear a narrative supporting an increase in enquiries and interest in joining the NHS workforce and indeed an unprecedented in increase in training places. Nursing and medical placements at universities are increasing which means that all NHS trusts must manage increasing numbers of trainees at any one time with the associated mentoring and support arrangements that need to be in place.

In these challenging times Salisbury NHS Foundation Trust turnover has increased to 12.2% and we welcome in the region of 40 new starters every month. This is high for us as an organisation. Traditionally we have enjoyed a steady turnover of 10% which compared to peers in our region is relatively low; Royal United Hospitals Bath NHS Foundation Trust and Great Western Hospitals NHS Foundation Trust have trended at around 12 to 13.5% respectively over 3 years. We aim to return to our previous level of c10%.

7.4.1 Our strategic aspirations include:

A focus on recruitment. We could improve on:

- our role descriptions,
- selection methodology
- on boarding
- first year training experience

It remains we must:

- Attract amazing people to join our teams
- Increase our reputation providing rewarding careers for apprenticeships not only for general care but in our specialist units
- Refresh our talent pipelines
- Engage more clinical support workers

- Increase our apprentice offer, driven by our widening participation agenda
- Further develop our international recruitment programme
- Encourage people to return to practice

A focus on retention. We could

- Be bold and radical in our practice, recognising the significant societal shift the pandemic has brought to our working practices
- Offer greater flexibility, varied roles, clear career paths and a more modern employment experience
- Focus on people who are most vulnerable to leaving our employment. Our most recent NHS Staff Survey suggests that people in one of our youngest age groups (21 – 30) are the least satisfied when responding to the engagement questions on motivation, involvement and advocacy.
- Make the most of our skilled and loyal people by:
    - building their access to personal development
    - increasing opportunities to learn together in multi professional teams
    - designing and enabling training and development that allows everyone to thrive.

All of this will increase our ability to support and influence the system we work within and will benefit the patients and the services we provide.

7.4.2 Our Outcomes:

- An integrated and dynamic workforce. Activity and financial planning meets current and future population, service and workforce needs. Workforce planning responsibilities and outputs at organisational, system, regional and national levels are clear.
- The system is retaining, recruiting and, where required, growing its workforce to meet future need. The 'one workforce' across the Integrated Care System is representative of the local communities served
- Education and training opportunities are fit for the needs of current and future people, workforce requirements and our services

7.4.3 Our 3-5 Year Aspiration:

We will

1. Develop and deliver a proactive widening participation agenda. This will support a year-on-year increase in the marketing and uptake of apprenticeship schemes across clinical and non-clinical careers. This will provide a visible pipeline of talent building resilience into our staffing levels across the trust.
2. Grow our international recruitment from strength to strength. We see a developing success rate across a wider staff group, attracting into our hard to recruit spots such a radiology/ specialist consultancy. This will be complemented by a proactive medical assistance programme.
3. Grow our domestic recruitment. We see a gradual increase in enquires from school leavers for clinical placements; more people are actively exploring return

to practice; and there is a well-advertised and high take up offer for those approaching retirement that supports more people to retire and return.

4. Turnover stabilises at around 10% (down from 12%) across all staff groups. We aim to see a positive trend of people choosing to stay after their first year, increasing stability. This trend will be correlated by a reduction in people citing career development as their reason for leaving the organisation.

7.5 Pillar 5: The Vision for the Future of the People Profession

In line with the Future of NHS Human Resources and Organisational Development report, our vision for the people profession at Salisbury NHS Foundation Trust extends to 2030.

The vision for the people profession in the NHS extends over a longer time frame of 8 years to 2030. Co-created by members of the profession, people working in the NHS and leaders the vision sets out how the profession and the service we provide need to evolve to challenge, develop, enable, partner and deliver the health and care system we need in the future.

7.5.1 Our strategic aspirations include:

- **Health and wellbeing.** Developing strategies to develop and prioritise the health and wellbeing offer for our people.
- **Employee experience.** Creating a great experience for our people and building people metrics into performance dashboards so that we consider them with the same scrutiny as operational and financial performance.
- **Inclusion and belonging:** Continue to use our expertise and influence to create an inclusive culture at Salisbury NHS Foundation Trust.
- **Professionalism.** Growing the reputation of our team within and outside of the trust by developing the professional competence of our OD&P team and harnessing career development opportunities.
- **Leadership**. Harnessing the talents of our people and developing a strong leadership and management capability across the trust at all levels.
- **Change and Innovation.** Using the Improving Together methodology to ensure that our own operating model delivers a service that is productive, efficient, and responsive and supports the embedding of innovation and transformation across the system.
- **Digital Solutions.** Use digital solutions to better support and deliver our people services now and in the future.
- **Workforce planning.** Enable our people to work differently to support new models of care and changing needs of the health and care system whilst creating effective and sustainable workforce supply.

7.5.2 Our Outcome:

- An outstanding people profession team at Salisbury NHS Foundation Trust providing modern employment practices.

7.5.3 Our 3-5 Year Aspiration:

We will

1. Continue to grow the OD&P team's ability to support and deliver the trust's 'Our Vision' and 'Our Strategy' and to embed the People Promise.
2. Continue to develop and grow the competence and experience of our team so that they can better support the rest of the organisation who in turn support the patients and deliver services.
3. Continue to implement and deliver world-class leadership, education, and training at Salisbury NHS Trust, empowering our people across the trust to lead and be part of effective teams, providing excellent care.
4. Create and use effective systems, digital technology, and tools to support the delivery of our own services and to empower colleagues in the organisation to do the same.
5. Take a strategic role in promoting and supporting a positive organisational culture that attracts and retains excellent and effective people.
6. Deliver high class workforce planning and tools to enable effective career pathways and the introduction of new and emerging roles.
7. Forge a reputation as visible leaders for the People Profession across the Bath and North East Somerset, Swindon and Wiltshire Partnership whilst also working in partnership with other NHS trusts in our vicinity.

8 Conclusion - making it happen

Delivery of the Salisbury NHS Foundation Trust People Plan will be overseen and governed by the People and Culture Committee, part of the assurance committees to Board. Every year our purpose, priorities and impact slides and associated action plans for the current year will be shared. Progress will be monitored on an ongoing basis by the team and presented as required to committees and boards, normally at least once a month.

This is a living document that will be updated and refreshed as required over the coming 5 years.

Alongside our priorities here at Salisbury NHS Foundation Trust, this work will consider increasing co-operation and collaboration with local partners. This will enable optimisation of shared resource across Bath and North East Somerset, Swindon and Wiltshire Partnership and will also be balanced with national direction.

The job of the People Practice team is not to fix the problems but to ensure managers have the skills needed to respond effectively to our people needs. We aim to ensure that our people have the skills to overcome challenges and deliver the NHS services and the care they aspire to.

9 Links

Statutory requirements for workforce

- Equality Act 2010 - https://www.gov.uk/guidance/equality-act-2010-guidance
- Public Sector Equality Duty - http://www.legislation.gov.uk/ukpga/2010/15/section/149
- Workforce Race Equality Standard (WRES) - https://www.england.nhs.uk/about/equality/equality-hub/equality-standard/
- Workforce Disability Equality Standard (WDES) - https://www.england.nhs.uk/about/equality/equality-hub/wdes/

10 Appendices

- Appendix 1 - 'We are compassionate and inclusive'
    - 1a Equality, Diversity, and Inclusion Strategy
    - 1b Compassionate Leadership
- Appendix 2 - 'We are recognised and rewarded'
    - 2 Recognition and Reward Plan (in development)
- Appendix 3 - 'We each have a voice that counts'
    - 3 Freedom to Speak Up and Just and Learning Culture Plan (to follow)
- Appendix 4 - 'We are safe and healthy'
    - 4a Health and Wellbeing Plan
    - 4b Health and Safety Management Plan
- Appendix 5 - 'We are always learning'
    - 5 Organisational Development Plan
- Appendix 6 - 'We work flexibly'
    - 6 Flexible Working Plan (in development)
- Appendix 7 – 'We are a team'
    - 7 Team Plan (OD plan with additions to follow)
- Appendix 8– Identifying Trends in healthcare and work
- Appendix 9 – NHSE 2022/2023 Priorities and Operational Guidance
- Appendix 10 – OD&P 5-year ambition slide deck (as at Oct 2022)
- Appendix 11 – People Plan and People Promise slide deck

NHS
Salisbury
NHS Foundation Trust

EDI Strategy 2022/25

People Promise

Contents

Welcome

Welcome from the Trust Chair and Chief Executive

Welcome to Salisbury NHS Foundation Trust's Equality, Diversity and Inclusion (EDI) Strategy 2022-2025.

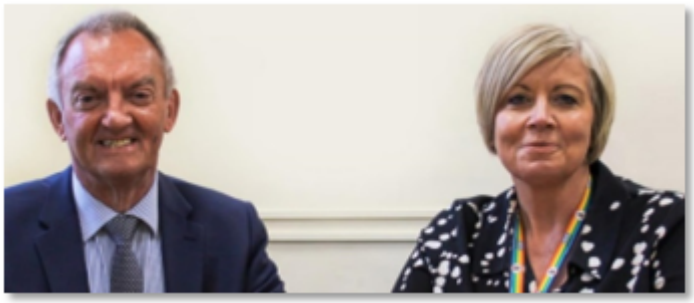
Our people have shown tremendous resilience working through the pandemic and we will demonstrate our duty of care by responding positively to the NHS People Promise. Keeping our people safe and healthy, giving them a voice that counts and inspiring compassionate and inclusive leadership is essential in enhancing a sense of belonging.

We must be diverse, inclusive and equitable in everything we do. We have to reflect the communities and individuals who we serve, otherwise we will not meet their needs. We must also be responsive and effective and a crucial part of this is for us to appreciate the diverse talents of all our people. Furthermore, all our people should feel confident to bring their authentic self to work. It's the individual uniqueness of our colleagues that makes the NHS and our Trust such a vibrant and energetic place to work.

We also need to go further to develop our understanding of our communities and we will do this by working in partnership. Diversity is about everyone and delivering for everyone is key to our core purpose of providing great quality health care. This strategy is an integral part of our vision for the future and we are confident that, as a result, we will be better equipped to deliver our aspirations as a Trust. This strategy is of fundamental importance to us as a Trust and we'll be monitoring our progress regularly to ensure it is delivered.

Our EDI strategy builds upon what we have already achieved and pledges to address inequalities our people, patients and communities experience with real purpose and action. It was developed from listening to our people, patients, partners and members of our local communities, and their valuable feedback provided the basis of our equality aims and objectives.

Salisbury NHS Foundation Trust will respect the diversity of our workforce, celebrate individual difference and strive to be an inclusive workplace where everyone can flourish.



Nic Marsden
Trust Chair

Stacey Hunter
Chief Executive Officer

1. Introduction

This strategy reflects the Trusts commitment to ensuring that our services are fully accessible and that they meet the diverse needs of the people we serve. It also aims to positively promote inclusivity and ensure our treatment pathways are always personalised and meet individual needs.

Additionally, it identifies our workforce aspirations and establishes our priority areas to support and promote diversity and inclusion for all staff. This strategy is built around the four goals stipulated by the Equality Delivery System for the NHS (EDS2), which looks at service user health outcomes, patient experience and access to our services, as well as how representative and supported our leadership and workforce is.

The strategy supports the Trust's requirement to meet its obligations under the Equality Act 2010 and incorporates the mandatory requirements for the Workforce Race Equality Standard (WRES), Workforce Disability Equality Standard (WDES) and the Accessible Information Standards. It provides an overview of our achievements to date and the objectives and targets that we have set for the next 3 years in relation to all of the groups protected within the Equality Act 2010. The implementation of this strategy, and achieving the priorities within it, will ensure that all members of our staff feel enabled and supported in their role which will result in the delivery of high quality person centred care for our patients.

The delivery of this strategy will be overseen by the EDI Committee to ensure that it remains fit for purpose and takes account of any new requirements or changes to legislation, standards (new or revised), government consultation/feedback, health inequality outcomes and data or information.

This strategy will be subject to review and evaluation on a yearly basis. The priority objectives set out in this strategy are fluid and will be prioritised in accordance with SFTs Trust Strategy and People and Organisational Development Strategy. The EDI Committee has ownership of and responsibility for the implementation of this strategy. A detailed action plan, with metrics, indicators and timescales, will be produced and monitored by the EDI Committee on a regular basis.

2. Our EDI Commitments

This is a time of great transition for the NHS nationally and locally in terms of organisational and cultural change and required improvements in quality, safety, operational and financial performance. In order to meet these challenges, delivery of our services in a culture that promotes and values equality, diversity and inclusion with our patients, carers, public, staff and volunteers is important.

There are many national, internal and external levers that give us a clear direction for delivery and compliance including:

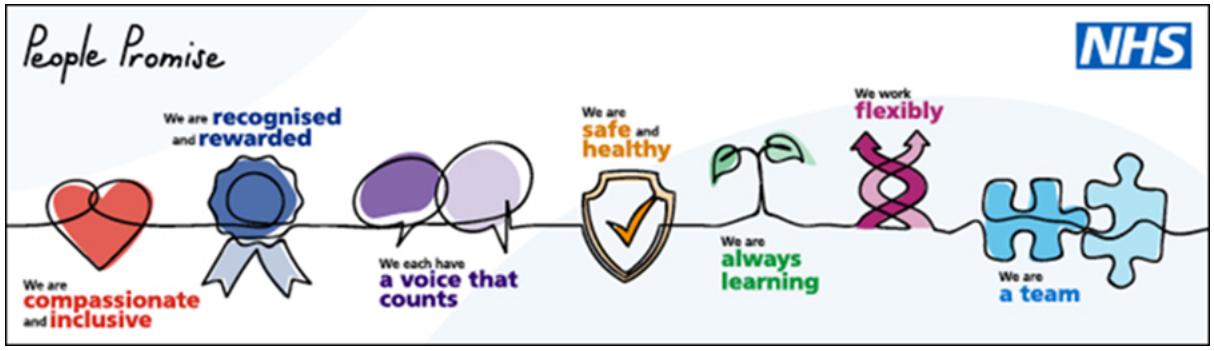
- Equality Act 2010
- The Health and Social Care Act 2012
- The NHS Constitution
- NHS Equality Delivery System
- Workforce Race Equality Standard
- Workforce Disability Equality Standard
- NHS Accessible Information Standard
- NHS Five Year Forward View (2014)
- The NHS People Plan 2020

2.1 NHS People Plan

We are the NHS: People Plan 2020/21 – action for us all, along with Our People Promise, sets out what our NHS people can expect from their leaders and from each other. It focuses on how we must all continue to **look after each other** and foster a **culture of inclusion and belonging**, as well as take action to **grow our workforce, train our people**, and **work together differently** to deliver patient care.

The NHS People Plan includes specific commitments around:

1. **Looking after our people** – with quality health and wellbeing support for everyone
2. **Belonging in the NHS** – with a particular focus on tackling discrimination
3. **New ways of working and delivering care** – making effective use of the full range of our people's skills and experience
4. **Growing for the future** – how we recruit and retain our people



2.2 Equality Act 2010 (Section 149)

Under section 149 of the Equality Act (2010), a public sector equality duty was created, which is a statutory obligation for all public authorities. This is defined in legislation as the general duty and all public authorities are adherent to the following obligations to:

- Eliminate unlawful discrimination, harassment and victimisation and other conduct prohibited by the Act.
- Advance equality of opportunity between people who share a protected characteristic and those who do not.
- Foster good relations between people who share a protected characteristic and those who do not.

The specific duty of the public sector equality duty is to:

- Publish workforce equality demographic data by 31/1/2012 (annually thereafter).

2.3 Workforce Race Equality Standard (WRES)

The WRES is included in the NHS standard contract and the Trust WRES Report 2021 highlighted improvement is required in regard to recruitment and selection and career development and progression.

- Our WRES 2021 report identified that white staff are 2.1 times more likely to be appointed from shortlisting than BAME staff;
- The recently introduced disparity index has identified that white staff are 9.8 times more likely to be promoted from lower to higher pay band than BAME staff.

2.4 Workforce Disability Equality Standard (WDES)

The Workforce Disability Equality Standard (WDES) is a set of ten specific measures (metrics) which enables the Trust to compare the workplace and career experiences of disabled and non-disabled staff.

- The Trust WDES report 2021 highlighted that job applicants that declare 'No' to disability status are 1.14 times more likely to be appointed from interview than disabled applicants.
- We have also identified a disparity between staff disclosing their disability status on HR systems (104) and in the NHS staff survey (358).

3. Our Vision

Our Trust vision is to provide an outstanding experience for our patients, their families and the people who work for and with us. More specifically to equality, diversity and inclusion (EDI) this is to have a workforce that fully reflects the communities we serve and a workplace culture in which everyone feels valued and is treated with fairness and respect, where we collectively work to eliminate unlawful discrimination, promote equal opportunity and foster good relations.

We aim to achieve our EDI vision by…

- Developing ways to manage performance and ensuring that all areas embed EDI best practice
- Ensuring there is visible leadership of EDI, that people are leading by example and that we achieve what we say we will within the deadlines agreed
- Building strong community connections and networks so that our activity is informed by conversations with local people and partners and our values help influence partner organisations
- Embedding a zero-tolerance approach to any form of discrimination, bullying, harassment and victimisation and bringing people together to create a positive movement for change
- Building the EDI capability of our people so that we are all confident to challenge when we witness language or behaviour that doesn't fit with the Trusts' values, using positive action to build a diverse workforce, ensuring access to opportunities for current staff, supporting our Staff Network Groups and ensuring that we support our Disabled colleagues with reasonable adjustments
- Embedding an effective way of measuring and evaluating what we are achieving and what impact we are having across the organisation
- Working in partnership with local, regional and national partners we will promote the health, wellbeing and independence of the people we serve by tackling health inequality through effective use of data; improve patient access and experience through inspiring engagement and involvement; and continually improve the quality and safety of everything we do through the effective use of Quality Improvement methodologies.
- In line with the Trust strategic priorities we are committed to working in partnership with the Inclusion Pillar and EDI Leads across BSW Integrated Care System to identify best practice and participate in joint initiatives to achieve our equality, diversity and inclusion objectives.

4. Our EDI Objectives

We have identified four strategic objectives that will guide and underpin our collective work over the next 3 years; they are the how we will deliver our Trust and EDI Vision. The Strategic objectives and specific projects and area of work are explored in more details as follows:

Strategic Objective 1: Better Health Outcomes

We want to identify if there are health inequalities in our services and have systems in place to tackle these in an open and transparent way. We want to ensure that inequalities are flagged and transformed into service improvement measures, which are evident in business planning and captured by the Trust's equality, diversity and inclusion work streams.

Strategic Objective 1: Better Health Outcomes		
Outcome	**Action**	**Completion date**
1. Services are designed and delivered to meet the health needs of local communities	1A. We will introduce an Equality Standard Framework for our clinical and corporate Business Areas to undertake a baseline mapping of EDS2.	March 2023 (Reviewed annually thereafter)
2. Individual people's health needs are assessed and met in appropriate and effective ways	1B. We will deliver 4 community engagement events to work with under-represented communities and identify barriers to accessing services and with patients who may have been treated inequitably and involve them in discussions on how we can improve.	March 2024 (Quarterly from Q4 2022/23)
3. When people use NHS services their safety is prioritised and they are free from mistakes, mistreatment and abuse	1C. We will routinely monitor feedback from all patient groups and analyse comments and complaints from those who use our services and investigate areas where services can be improved.	March 2025 (Annually from January 2023)
4. Screening, vaccination and other health promotion services reach and benefit all local communities	1D. We will develop greater insight into patient, family and career experience across for all groups protected by the Equality Act 2010 by promoting findings of the Joint Strategic Needs Assessment (JSNA) via a Monthly EDI Spotlight Newsletter.	March 2025 (Monthly from January 2023).

Strategic Objective 2: Improve patient access and experience

We want to ensure that our services are accessible to all service users and carers who require care and treatment. We want to ensure the information we provide can be adapted to meet individual needs.

Strategic Objective 2: Improve patient access and experience		
Outcome	**Action**	**Completion date**
People, carers and communities can readily access hospital, community health or primary care services and should not be denied access on unreasonable grounds	1A. We will identify and develop recording and monitoring systems to gather and analyse patient diversity data and ensure an ongoing commitment to the Accessibility Standards and Accessible Information Standard. 1B. We will undertake a rapid assessment of Trust communication platforms to ensure diversity in all Trust images and branding and that these represent the communities we serve. 1C. We will sign up to the British Deaf Association's British Sign Language (BSL) Charter and improve access to interpreters and establish systems to monitor their effectiveness 1D. We will conduct an accessibility audit across all SFT sites	June 2023 (Reviewed annually thereafter) March 2023 September 2023 March 2024
People are informed and supported to be as involved as they wish to be in decisions about their care	1E. We will build strong and effective partnerships with all our stakeholders to address issues of inequality and exclusion, including access to services and employment, across the city.	Ongoing until March 2025
People report positive experiences of the NHS	1F. The EDI team will work in partnership with the Patient Experience Team to identify positive and negative equality impacts in patient experience and engagement and report findings to Divisional Performance Review meetings.	March 2025 (Quarterly from April 2023)
People's complaints about services are handled respectfully and efficiently	1G. We will routinely monitor feedback from all patient groups and analyse comments and complaints from those who use our services and investigate areas where services can be improved.	March 2025 (Annually from January 2023)

Strategic Objective 3: A representative and supported workforce

An inclusive and diverse workforce that is representative of the community with measurable improvement through effective recruitment, selection and promotion in order to positively attract, retain and support the progression of under-represented groups of staff at all levels. An environment that embraces diversity, and promotes inclusion, gender equality and a zero tolerance to all forms of discrimination, bullying, harassment and victimisation and provides a safe and caring environment for staff where they can be themselves at work.

Strategic Objective 3: A representative and supported workforce		
Outcome	**Action**	**Completion date**
Fair NHS recruitment and selection processes lead to a more representative workforce at all levels	1A. We will develop an approach to Representative (Diverse) Recruitment Panels so that our recruitment process is representative in terms of both ethnicity and gender. 1B. We will aim to De-Bias the Recruitment process by delivering the national 'No More Tick Boxes' actions. 1C. We will review and update the Recruitment and Selection training through an EDI lens.	December 2022 March 2024 March 2023
The NHS is committed to equal pay for work of equal value	1D. We will deliver on our commitment to publishing and developing actions plans to reduce the Gender Pay Gap year on year form 2022-2025.	March 2025
Training and development opportunities are taken up and positively evaluated by all staff	1E. We will review our management and leadership development programmes to embed the skills and knowledge required to promote an inclusive workplace and to recognise and value diversity	June 2023
When at work, staff are free from abuse, harassment, bullying and violence from any source	1F. We will actively support our Staff Network Groups and enable virtual networks where required. This will help staff to connect with each other, strengthen their collective voice to influence and inform EDI work across the Trust. 1G. We will embed a just and learning culture.	March 2025 (Bi-monthly from January 2023)
Staff report positive experiences of their membership of the workforce	1G. We will further interrogate workforce diversity data, at a corporate and local level, to develop a better understanding of the profile of the Trust and where targeted and / or positive action needs to be taken 1H. We will report on the WRES and WDES metrics and develop action plans that tackle the main issues of concern	March 2025 (Reviewed annually from March 2023

Strategic Objective 4: Inclusive Leadership

We want our workforce to demonstrate compassionate and inclusive leadership. We will create a culture where staff feel valued and recognised for their important and individual contributions. We will promote an environment where health inequalities can be identified in a safe and transparent way and for the organisation to learn and improve as a result.

Strategic Objective 4: Inclusive Leadership		
Outcome	**Action**	**Completion date**
Boards and senior leaders routinely demonstrate their commitment to promoting equality within and beyond their organisations	1A. We will ensure all leaders (Non-Executive Directors, Governors, Directors and Senior Managers) receive EDI leadership training. 1B. We will continually build a network of Equality Champions that provide active support to, and are advocates for, the EDI agenda. 1C. We will celebrate key EDI events across SFT with a wide range of communications and activities, all supported by the Board and Senior Leadership Team.	March 2024 March 2025 March 2025
Middle managers and other line managers support their staff to work in culturally competent ways within a work environment free from discrimination	1D. We will develop and deliver leadership education, training and awareness that supports the provision of compassionate and inclusive leadership and clearly communicates people's responsibilities in leading the agenda.	March 2025
Positive, measurable culture change by mainstreaming equality, diversity and inclusion	1E. We will successfully meet the requirements for EDS2, become a Disability Confident Leader, ensuring processes and systems are in place to address the bullying and harassment of disabled workforce; promoting the abilities of our disabled workforce and meeting all of the requirements of the accessible Information Standard. 1F. We will develop a Race Equality Charter and programme aimed at reducing violence, aggression and discrimination towards ethnic minority staff, making it easier and safe for people to report incidents. 1G. We will develop an EDI data dashboard to monitor the progress we're making on all aspects of the agenda (A3 Development) 1H. We will develop a Diversity and Inclusion Calendar that highlights significant dates and events. 1I. We will Launch a selection of ten EDI online training and awareness programmes for staff	March 2025 October 2022 March 2023 December 2022 March 2023

Health and Wellbeing Plan 2022-2026

September 2022

1. Table of Contents

Contents

2. Introduction / Executive summary

The purpose of this document is to outline a health and wellbeing plan for Salisbury NHS Foundation Trust (SFT) for 2022-2026.

This has been written in the context of the Trust's locally developed Long Term People Plan 2022-2026, the NHS People Plan and NHS Our People Promise. The key components of the SFT People Plan are included in Appendix 1 for reference.

The trust sets out its clear commitment to health and wellbeing, as part of its strategic people aim within its 2022-2026 strategy as follows:

> *"To ensure we offer an outstanding experience to the people who use our services, we need to be the Best Place to Work for our teams and our partners. We will focus on the health and wellbeing of the people who work for us – giving them the best opportunity to achieve a fulfilling career which makes a real difference to the lives of the people who access our services. Our people will be recognisable through our shared values that they demonstrate in everything they do."*

Looking after the health and wellbeing of our people involves leaders, managers, all those who supervise people and members of staff themselves and is an important consideration in how we go about our working lives every day. We also recognise that a lot of the activities and themes within the SFT people plan and NHS People Plan are intrinsically, and either directly or indirectly linked to health and wellbeing, for example our work on equality diversity and inclusion, flexible working, organisation development and design.

We recognise that stress and anxiety, closely followed by muscular skeletal issues are the most common causes of absence. Coupled with these important indicators which are relevant to health and wellbeing, our staff survey result for 2021 highlighted room for improvement in terms of how well our people feel that we as a Trust are supporting their health and wellbeing. Further information can be found in Section 6.

We are not alone in striving to continually improve our health and wellbeing offer; many other organisations are tackling similar challenges to us. We are part of the Bath, North East Somerset, Swindon and Wiltshire Integrated Care System (BSW), covering Wiltshire, Dorset and Hampshire and we are keen to work in partnership with the local community for mutual benefit and to work collaboratively with BSW colleagues so that all parties benefit from ideas and provision.

The NHS has outlined a health and wellbeing framework which encourages NHS organisations to adopt an approach which takes account of the broader organisational and cultural factors that underpin an individual's ability to bring their best self to work. Our health and wellbeing offer has been being developed in line with the framework, aligning the national framework to our own strategic aims, and we are committed to improving and developing against all of the 7 segments within the framework – more detail can be found in Section 4.

This plan sets out our 2022/23 priorities – see Section 7, which we have developed through an overall overview of the current activity, and inputs from a range of stakeholder groups. We are concentrating on these priorities during 2022/23, planning in more detail our actions and impact measures against each of them. To highlight two key areas; during 2022, given the current economic climate and conscious of impact this has on staff we are putting in place a number of interventions aimed at supporting financial wellbeing. We are also making progress against our commitment to launch wellbeing conversations, using a structured approach, to all areas of the Trust.

The Trust has also been granted time limited funding from NHSE&I to support initiatives aimed at improving the wellbeing of our staff from diverse ethnic groups who make up a significant proportion of our workforce. Included in this document are brief details of what we see as a very important project that we have set up to focus on this, by firstly seeking to better understand wellbeing needs of these groups and use the information we obtain to make improvements. Along with our key priorities for 2022/23, we have a section in our plan about themes for the longer term, which, based on further discussions and diagnostic work, will be translated annually into a detailed implementation plan for each year.

3.1 About Salisbury Foundation Trust

Salisbury Foundation Trust (Sft) has a dedicated workforce of 4,897, enjoys the support of 180 volunteers, works in partnership with 2 subsidiary companies, Odstock Medical Ltd and Salisbury Trading Ltd and recognises 3,000 Independent contractors. All of these are committed to providing healthcare services for the Trust.

The hospital has defined its 2022-26 strategic priorities as follows:

- improving the health and wellbeing of the population we serve
- working in Partnership to transform and integrate our services
- supporting our people to make SFT the best place to work

The staff health and wellbeing plan sits at the heart of and is fundamental to the achievement of these priorities as a Trust.

In a statement published June 2021, the Kings Fund makes the strong point that staff who are psychosocially healthy are better able to meet the needs and preferences of patients. It also highlights the fact that staff in the NHS are its biggest asset and highest cost - without which the NHS would not exist - and that it lags behind other organisations in terms of care for staff, which it says needs to change.

The statement is included in full in Appendix 2

3.2 The Context for our Health and Wellbeing plan

The demands that the Covid 19 pandemic have placed on the Trust are unprecedented. The Trust has faced an immensely challenging period over the past two years, along with its communities and the NHS overall. Whilst a huge amount has been done to tackle and overcome the impact of the pandemic, at the time of writing, the effects are still very evident. We continue to experience fluctuations in Covid infection levels, which affect patient care and staff absence levels. Coupled with this, we are striving to deal with the backlogs in elective care and to manage the discharge of patients for whom home or a community setting has been determined as the best place for them to continue recovery.

In summary, the pandemic continues to affect the hospital, its services and its staff, and this has brought into the spotlight and underlined the importance of the health and wellbeing of our people. In line with many organisations nationally and globally, the pandemic has taken its toll, both physically and mentally, on our workforce, who have worked tirelessly through these extremely difficult and demanding circumstances for our national health service.

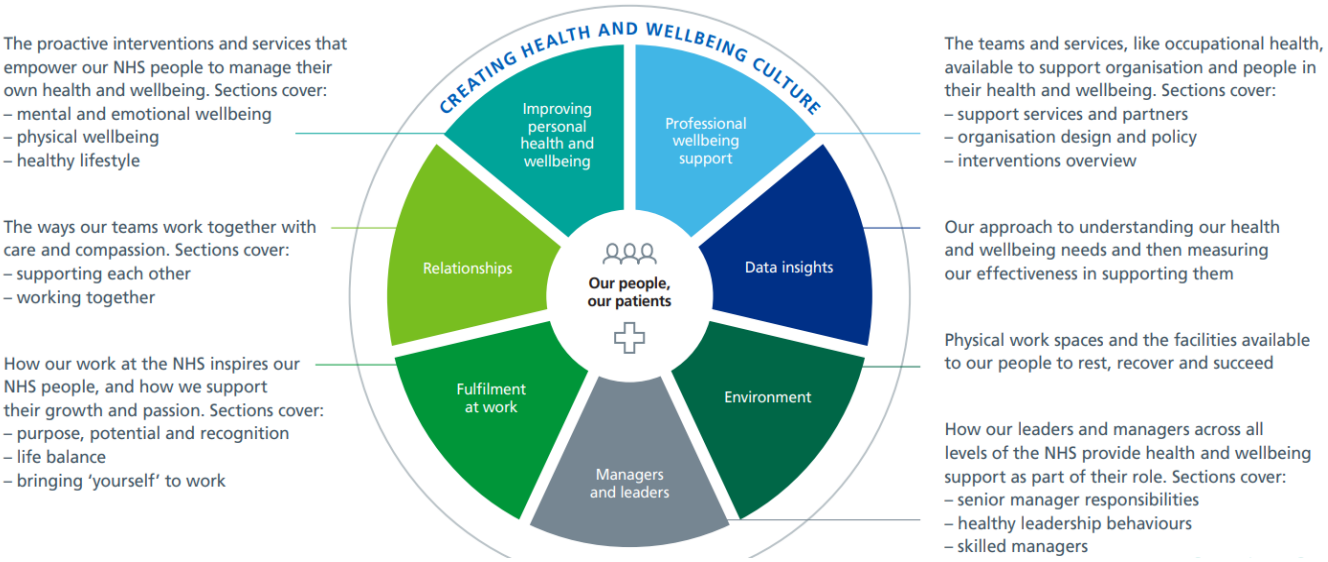
As already mentioned in the executive summary, we are also facing a cost of living crisis, the effect of which is being felt by many of our employees, bringing to the forefront the need to support the financial wellbeing of our people.

4 SFT Health and Wellbeing plan

Our plan aligns to the 7 components for health and wellbeing set out in the NHS Health and Wellbeing Framework, a summary diagram of which is included below. The 7 segments of the framework are referenced in italics against our own strategic aims, listed below:

- **Work together to look after and support the health and wellbeing of our people**
  (Relationships)
- **Integrate health and wellbeing into our ways of managing and working, in everything we do, so it is part of our everyday culture**
  (Managers and leaders)
- **Be aware of the health and wellbeing impacts of our decisions and measure the impact of our plan**
  (Data insights)
- **Provide health and wellbeing services to support good attendance, aid recovery from illness and support emotional, physical and financial wellbeing**
  (Professional wellbeing support)
- **Make the best use of our facilities, to provide comfortable work and rest spaces that aid wellbeing**
  (Environment)
- **Give people the tools and support to help them take responsibility for their health and wellbeing**
  (Improving personal health and wellbeing)
- **Work with our internal networks, health and wellbeing and human resource teams to develop a workforce which embraces diversity and provides everyone with the opportunity to maximise their potential**
  (Fulfilment at work)

4.1 The NHS Health and Wellbeing Framework diagram:



Further details of the framework can be found by accessing this link:
NHS-health-and-wellbeing-framework-strategic-overview.pdf (england.nhs.uk)

5 SFT Key Health and Wellbeing Priorities

People's health and wellbeing is really important for their morale and to enable to give their best at work, providing the very best patient care.

Through our health and wellbeing interventions, we are making it a priority for our people to:

- Enjoy coming to work and feel valued
- Feel that their health and wellbeing is important to us as an employer
- Be supported in accessing sources of help for improving their health and wellbeing, where needed
- Encouraged to maintain a good level of attendance
- Work with us as an employer to continually improve the effectiveness and efficiency in how we work
- Be provided with an environment in which they can thrive, and perform to their best ability

As an organisation, through implementing health and wellbeing interventions to meet these priorities, we expect to see benefits which would include:

- reduced absence levels,
- improved ability to attract and retain staff,
- increased stability within teams,
- improved levels of staff engagement
- an increased capability to provide the required quality of patient care.

5.1 How we will do this: Methodology & Approach to building a Health and Wellbeing Culture

Building in the actions that help us achieve our ambition across all aspects of our people practises as follows:

Health & Wellbeing plan to be delivered via a range of approaches as follows:	What these mean and what we will do:
Preventative Measures	Use data insights, anecdotal and qualitative feedback and listening to prevent the escalation of health and wellbeing issues
Targeted Interventions	Take supportive actions and deploy our support services involving subject matter experts, where health and wellbeing issues are most prevalent
Healthy Leadership	Be clear about what we mean by healthy leadership behaviours, identify and communicate roles and responsibilities for health and wellbeing to our
Processes and Guides	Develop tools and information to support employees, their supervisors and leaders to stay healthy and well and to help us track our improvements
Integrated Planning and Delivery	Provide a dedicated health and wellbeing resource to champion health and wellbeing, who will create and oversee the delivery of an annual plan,
Raising Awareness	Promote health and wellbeing activities and Events, make sure people know where and how to access support activity, monitor the impact of health and wellbeing events and activities
Working in Partnership	Share information, learning with organisations in the community (and nationally) who can help us improve our health and wellbeing offering

5.2 Who we will involve

Everyone in the workforce plays a role in doing what they can to stay healthy and well. In addition, to help SFT to implement our health and wellbeing plan, there will be individuals and groups who have the expertise and specialist knowledge in related fields, who will be key to the successful delivery of the plan. SFT is also an exemplar site for the People Promise which has the health and wellbeing of staff at its heart. This plan supports the 'We are safe and healthy' element of the promise.

5.2.1 Our internal stakeholders are committed groups and individuals within the Trust who run health and wellbeing related activities and/or are involved in networks and groups which have a health and wellbeing element to them. Key groups and roles are as follows:

Mental Health First Aider network	Wellbeing Guardian Tania Baker (non-executive director role)	Occupational Health Service
OD & P Leadership and people partnering Team	Clinical Psychology	Onsite Odstock Health and Fitness Centre
Estates and Facilities Management	Health and Safety	Trade Union partners
Communications team	Equality and Diversity roles and EDI networks	Art Care, League of Friends and Stars Appeal

In addition, we have a number of clinical staff, who have a special interest in health and wellbeing and we are keen to involve them in the successful implementation of our plan.

5.2.2 Our external partners are also important to making our plan successful. We recognise the value of collaborating with organisations who have a wellbeing purpose and/or interest, and in some cases share similar challenges to us, we will continue to build relationships and collaborative working across Bath and North East Somerset, Swindon and Wiltshire Partnership (BSW), with NHSE and the other People Promise exemplar sites, plus the many other organisations that make up our local health and care system.

6 Roles and Responsibilities

We recognise the following roles and responsibilities in relation to health and wellbeing:

- **All individuals** – it is important for everyone to take responsibility for their health and wellbeing, taking action to improve where needed
- **Those who manage and lead people –** as part of the way we work, taking an interest in the health and wellbeing of the people who work for them, and doing what they can to help them
- **Wellbeing experts –** those with dedicated accountability for the various aspects of health and wellbeing, including occupational health, our clinical psychology team, health and safety and other members within the OD & People team, along with other internal stakeholders listed as internal partners in this document
- **Defining what we mean by healthy leadership behaviours** – to ensure that our leaders' behaviours underpin a healthy culture at work are behaving as role models for healthy ways of working that are
- **Documenting wellbeing related processes** such as Wellbeing Conversations, clearly signposting to employees where they can access these and other wellbeing related sources of help and

7 Our story so far and what we have achieved to date

A lot of activity is already being undertaken in the area of health and wellbeing.

7.1 The Activity Table lists some of the activities that are either ongoing or have taken place:

• Development and implementation of a Post Covid Recovery Plan	This is supported by one FTE for 2 years to implement a wide range of psychological interventions, workshops, events, and initiatives to support wellbeing.
• Dedicated oversight of health and wellbeing activity	The trust has made a commitment to appointing roles dedicated to oversight and co-ordination of health and wellbeing activity.
• Embarked on an improvement plan for our occupational health and counselling service, to which provides medical and counselling referrals.	To enable our Occupational Health service to focus on core activity and implement improvements to address the issues that have arisen during the pandemic we have moved accountability for wellbeing to the Head of D&I & Wellbeing Occupational Health is a key stakeholder in the plan and will work in close partnership with the Head of D&I & Wellbeing.
• Provision of physiotherapy services	Services for staff are delivered via our in-house Physiotherapy team.
• Building of a Mental Health First Aider network	We will continue to grow and develop the MHFA network.
• Delivering psychological staff wellbeing training sessions and ongoing support to line managers	Training funded by Stars Appeal.
• Appointed a Freedom to Speak Up Guardian and a Wellbeing Guardian (a non-executive Board director)	There is an ongoing commitment to develop these roles to align with our health and wellbeing plan and to continue to build our Freedom to Speak Up Ambassador resources across the Trust.
• Development of a dedicated website for health and wellbeing	The new site is on the internet to enable our workforce to access a range of health and wellbeing resources both when they are at and outside of work.
• Piloted structured wellbeing conversations	The results of the pilots have been analysed and training has been developed to support managers. Wellbeing conversations are being steadily rolled out across the Trust.

• Made improvements to our physical environment	These have included rest and refreshment areas Springs and Hedgerows, better maintenance of some of our outdoor garden spaces, and ongoing participation in the Cycle to Work Scheme including facilities to repair bicycles on site.
• Begun to regularly scrutinise our metrics and qualitative feedback related to health and wellbeing	Analysing metrics, including absence, turnover, referrals, and the staff survey is helping us to improve our ability to feed information into relevant decision–making groups and to shape our priorities going forwards.
• Listening Events for nurse & HCA groups and in each division, stay conversations, staff survey results feedback groups entitled 'You own it, we enable it'	Events are designed to provide feedback to feed into our health and wellbeing plan, to encourage staff engagement and to demonstrate how their voices are being heard through the actions the trust implements.
• Maintained and cultivated good linkages with League of friends, Stars Appeal Charity, Volunteers and Art Care	A wide range of events is being delivered via a calendar of Social Events for staff to enhance wellbeing, enjoyment and experience of working as part of the SFT team.
• Commenced Race Equality project to improve wellbeing of our staff from diverse ethnic groups	Focus groups have commenced to identify the key themes for improvement to enable detailed planning and delivery.

…. We also know that we have a lot more to do!

Our plan has already highlighted the key people priorities for improving attendance, retention, supporting financial wellbeing and providing an environment where people enjoy their work, can thrive in their careers, and getting the best from them. Our current position is as follows:

7.2 Attendance levels have an impact on patient care and colleagues across the Trust. In the 12 months to March 2022, the Trust's sickness absence rate was 3.92%. This compares to a sickness rate for similar Trusts nationally of 4.59%. In terms of types of absence, 51% of the Trust's sickness was long term (28 days and over). The most common reasons for sickness were anxiety/stress/depression/other psychiatric illnesses, infectious diseases, and other Musculo skeletal problems.

Whilst absence rates may be a common issue across the NHS, and we do not necessarily compare unfavourably to the population as a whole, it is a nonetheless a key indicator for health and wellbeing, and we are committed to improving our attendance levels in the interests of our people and those who we provide healthcare services to.

7.3 Staff turnover has increased from 9.50% to 12.24% over the past 2 years (as highlighted in the SFT People Plan) with 86% of these leaving the sector. Turnover rates can by no means be fully attributable to Health and Wellbeing, but we do need to take action to ensure that we prevent people from leaving for reasons related to health and wellbeing ie where leaver information suggests that we could have avoided this.

7.4 NHS Staff Survey feedback within our 2021 results are telling in relation to health and wellbeing and give us an insight about how people are feeling and how the Trust is approaching this.

Some of the survey feedback is relevant to and illustrates the areas we need to tackle in improving how we support our people's health and wellbeing. These are some examples of what our people have said, including comparisons to previous years and to others NHS organisations, as follows:

51.7% of staff believed the organisation takes positive action on health and wellbeing, compared to 56.4% average.
This question was not included in the 2020 survey.

36.9% of staff said they worked additional paid hours for this organisation, over and above contracted hours, compared to 38.4% on average for other similar organisations.
This is an increase on last year's figure of 34.9%.

In last 12 months, 29.8% have experienced musculoskeletal (MSK) problems as a result of work activities, compared to 30.9% average.
This compares to 24.2% in 2020.

In last 12 months, 45.4% have felt unwell due to work related stress compared to 46.8% on average.
This is an increase on 44.1% in 2020.

In last 12 months, 45.4% have felt unwell due to work related stress, compared to 46.8% on average.
This compares to 44.1% in 2020.

In the 3 months before completing the 2021 survey, 52.0% have come to work when not feeling well enough to perform duties, compared to 54.9% on average.
This is an increase on 44.0% in 2020.

27.9% have felt pressure from their manager to come to work when not feeling well enough, compared to 26.1% on average.
This is an increase on 23.9% in 2020.

42.2% often/always find work emotionally exhausting compared to 37.7% on average
38.4% often/always feel burnt out because of work, compared to 35.2% on average

Additionally, early in 2022, a Pulse survey was also sent out to our workforce. The response rate to this was low, but of the 111 (2.75%) people who did respond, this provided the following feedback in relation to health and wellbeing:

- **53.2%** said that the organisation is proactively supporting their health and wellbeing. This is 1.5% less than the NHS average for similar organisations.
- **64.5%** agreed with the statement "In my team we support each other", which is 10.2% lower than the NHS average.
- **56.6%** of staff agreed they had had a conversation about their health and wellbeing within the last 3 months. This is 3% lower than the NHS average.

We also have sources of data other than via the staff survey, qualitative and anecdotal feedback at our fingertips, but our issue is how we harness this in a better way, to be able to track how we are doing in terms of health and wellbeing and where we need to target greater support. We plan to use information better to help us improve, just a few examples of some of the key areas we would like to use information to answer are:

- ? Occupational Health - finding ways to better assess whether the improvements we are implementing in our OH service is serving to get people back to work more quickly following a referral.
- ? Sickness - we have seen a steady increase in long term sickness cases. Of the number of cases where we are able to provide support through occupational health, either of a psychological nature or to help with physical conditions, how we can increase the numbers of people returning to work and how we can help support them to return more quickly.

In summary, we currently have health and wellbeing activities in place, and a lot of commitment and effort being put in.
This is very encouraging!

7.5 2022 - During the early part of 2022 we have focussed on understanding and pulling together what we are currently doing and considering how we can best support a strong Health & Wellbeing agenda going forward. We need to acknowledge and factor in what our committed workforce has been up against over the past two years in view of the pandemic and make sure that we don't 'run before we can walk', that we give people what they need now, as we gradually ease away from the unplanned challenges that Covid has faced us with for such a long period.

7.6 Observations - the key observations from this work are that going forward into this year, we need to:

- Use the strategic wellbeing framework to align our intervention and provide transparency/ oversight of a holistic approach to help and wellbeing across all aspects of our working life
- Be more joined up to bring together the good work that is happening in individual pockets and groups, so we are harnessing and coalescing both health and wellbeing – the sum is greater than the parts
- Improve our assessment of the impact of our health and wellbeing activities and interventions. This will be about using metrics to track what difference our activities are having, and reprioritising to areas of need, using our resources well based on what our measures tell us.
- Resource for health and wellbeing appropriately, recognising that whilst everyone has a part to play and our success and ability to drive and measure improvement will be complimented by having a dedicated focus for health and wellbeing well directed and prioritised to the issues of greatest need.

Given where we are now, the majority of our priorities for 2022/23 will involve putting in place a solid infrastructure and foundation to deliver our health and wellbeing offer

8. Setting us up for Success – our 2022/23 priorities

Action	Impact/Outcome	Benefit
Recruit dedicated wellbeing resources.	• Focused attention to enable the continual development of the plan and ongoing implementation plans for health and wellbeing	• Deployment of resources where most needed and greatest impact • Positive perception from staff of Trust commitment to wellbeing
Re-establish our Health and Wellbeing Committee, agree terms of reference and sign off the plan	• Provide a forum for all stakeholders to discuss health and wellbeing matters	• Both the plan and its implementation will improve with greater staff involvement • Improved positive impression of the trust's support for health and wellbeing and the impact that it has on staff experience
Agree the detailed health and wellbeing annual action plan for 2022/2023, including individual responsibilities for their delivery and the measures to be used. This will support our high-level priorities and incorporate the Post Covid Recovery Plan and our commitments as a People Promise Exemplar Site	• Clear responsibilities and actions to enable progress against the plan • A coordinated overview of all health and wellbeing activity into a single plan	• Actions can be tracked, and their delivery monitored • Duplication of effort can be reduced • Milestones can be centrally agreed and monitored
Undertake a diagnostic exercise, using some parts of the NHS Health and Wellbeing Framework diagnostic tool to assess our current position against 'what good looks like'	• Provide a baseline from which to develop stretching goals to be set	• Provides a benchmark for SFT against best practice • Will enable priorities for 2023-26 to be explored and mapped out
Develop a wellbeing information dashboard to collate health and wellbeing metrics Our health and wellbeing annual plan will identify what we are going to measure and track to help evaluate all the current activity and enable us to undertake cost benefit analyses on wellbeing related investments	• Create appropriate interventions based on our findings from the accurate, regular, tracking of metrics such as absence, survey feedback, exit interview feedback, OH referrals and other qualitative and anecdotal feedback • Measure the impact of health and wellbeing services and activities and take timely action where necessary	• Improved attendance and shorter periods of absence by matching interventions to the highest reasons for absence • Increased % people returning to work following OH referral and improved timescales between referral and return • Increased % in positive feedback from staff and pulse surveys • Reduced turnover (where reasons can be partly attributed to health and wellbeing issues)

Action	Impact/Outcome	Benefit
Develop a wellbeing policy, to set out the Trust's commitment to health and wellbeing and expand on the roles of those who manage and supervise people and define our healthy leadership behaviours Determine the best way to build the healthy leadership behaviours across all of our L&D activities which have a bearing on management skills, coaching, health and wellbeing	• Greater clarity of what behaviours are expected of leaders • Roles and responsibilities, and what these mean, are clear to all • Outlines what is expected in relation to Wellbeing conversations • Outlines OH services, role & related services	• Consistency in the way that people are treated by their supervisors and leaders • Greater awareness of the Health and Wellbeing offer at SFT
Continue to roll out wellbeing conversations across the Trust	• Regular focus on wellbeing at an individual level	• Enables action to be taken on wellbeing issues and avoid situations worsening, contributes to reducing absence levels, length of absence and staff turnover
Explore the concept of having health and wellbeing champions. Learning from the work that other Trusts have carried out to ensure that we appoint the right people to these roles and support them in executing this responsibility. Develop the role of the Wellbeing Guardian (non-Executive Director) to support our health and wellbeing offer.	• Identified, known individuals who people can access to discuss health and wellbeing issues, who act as a vehicle for raising issues so that action can be taken	• Increased 'intelligence' around health and wellbeing • Increase in staff awareness and positive perceptions of health and wellbeing support
Explore what we can do in the area of financial wellbeing, through looking into the flexibilities that are available to Trusts to help people to manage their income and help them with their pension choices.	• Making available more choices for people to manage their income /pension • Ensuring staff have access to external financial wellbeing support and services	• Reduction in turnover that is attributable to financial concerns • Reduction in absence related to stress • Improved perception of staff of positive action around wellbeing via staff survey results
Engage our estates and facilities colleagues, to contribute to a searching dialogue to identify further improvements to our physical environment, both indoor and outdoor.	• Inclusion of health and wellbeing related property improvements	• Begin to see improvements in the physical working environment to enhance health and wellbeing

Action	Impact/Outcome	Benefit
Continue to deliver our OH improvement plan, including improvements in the management of referrals, integrated metrics and the development of a portal to manage OH referrals Continue to build team capacity including by recruiting a Head of Occupational Health	• A portal will be in place to manage OH referrals and support reporting (EOPAS) • Focused attention at leadership level, on the continual improvement of OH Services for the Trust	• Faster and more efficient access to OH services • Improved ability to monitor trends (numbers and reasons) for referrals, to enable proactive and targeted interventions • Improved ability to align with related agendas and services, for example health and safety, health and wellbeing, clinical psychology and physiotherapy
Ensure that support for Carer responsibilities and flexible working options are well promoted across the Trust	• Increased awareness of support for those with caring Carer responsibilities, including suitable flexible working opportunities if appropriate	• Carer numbers known • Feedback that shows people are aware of the support the trust offers for carers
Occupational Health to work with Health and Safety to jointly explore the scope for a Health Surveillance programme	• Proactive management of absence and the prevention of injuries and accidents	• Decrease in length of absence • Reduced accident/injury rate
Complete Race Equality Project (funding to be spent by June 2023) and ensure that mechanisms are in place to sustain the improvements made	• Ensure wellbeing offer is inclusive to all staff • Increase satisfaction with wellbeing offer	• Improve morale, retention, and attendance of our diverse staff groups

9. The Longer Term agenda - 2023-24 and beyond

Progress against the 2022-23 priorities will be assessed towards the end of the year and fed into a detailed annual plan for 2023-24 to continue implementation and build on achievements and further priorities. We recognise that a health and wellbeing culture that forms part of our 'DNA' will not happen overnight, it will take time to embed.

What we know is that we will need to:

- Continue to embed healthy leadership behaviours, educating and developing our people
- To build the outcomes of the NHS Framework diagnostic tool into a robust 2023-34 health and wellbeing plan, continuing the methodology and systematic approach that we will be adopting in 2022-23.
- Continue to identify and feed wellbeing considerations into improvement works related to our physical working environment, tapping where possible into the Capital programme and working with our charity and volunteer groups.
- Explore the overall scope for how health and wellbeing can feature in the future Operating Model
- Focus more on org design, our job design, our reward and recognition processes that serve to value (add more)
- Ensure that the improvements we make to our wellbeing offer for staff from diverse ethnic backgrounds are sustained









10. Conclusion - making it happen

As outlined above oversight of the delivery and continued evolution of the plan will be via a Health and wellbeing committee, steered and led by the lead role for wellbeing.

This committee will in turn report to OD&P Board and the People Committee.

11. Appendices

11.1 Appendix One: The priorities outlined by the CPO in the SFT People Plan

In launching the Salisbury NHS Foundation Trust 'Our 5-year vision and strategy' we have made our pledge to ensure we offer an outstanding experience to the people who use our services, we need to be the Best Place to Work for our teams and our partners. We have synthesised our priorities under three themes

Supporting our People : The health and wellbeing of the people who work for us – giving them the best opportunity to achieve a fulfilling career which makes a real difference to the lives of the people who access our services

Improving Together – our approach to building a culture of continuous improvement: Using an approach that will be consistently applied across BSW, the Trust will design and deliver an integrated organisational development and continuous improvement methodology, providing the training, tools and operating climate to support everyone to make the improvements to the way we work and care we provide.

Encouraging our future leaders - We want to support our people and our partners with the tools that will enable them to achieve their best careers, across all the roles that make up and support our ICS and its future leadership.

In addition we have restated and refined our values to ensure they remain relevant and drive the way we work towards our strategic priorities as an organisation. In recognising the scale of our current and future challenges, we have added a further value, Progressive. This reflects our desire and commitment to tackle future challenges and opportunities with positivity and a continuous improvement ethos. We will be:

- Person Centred & Safe - Our focus is on delivering high quality, safe and person focussed care through teamwork and continuous improvement.
- Professional - We will be open and honest, efficient and act as role models for our teams and our communities.
- Responsive- We will be action oriented and respond positively to feedback.
- Friendly - We will be welcoming to all, treat people with respect and dignity and value others as individuals.
- Progressive - We will constantly seek to improve and transform the way we work, to ensure that our services respond to the changing needs of our communities.

11.2 Appendix Two: The statement made by the Kings Fund – 9 June 2021

"Staff across health and care are working under intense pressure and for many, it is taking a toll on their wellbeing. In response, a broad coalition of health and care organisations have come together to speak with one voice about the need to prioritise the emotional and physical wellbeing of health and care staff.

One of the most important things that the Covid-19 pandemic has highlighted over the past year has been that the physical and emotional wellbeing of health and care staff, must be of equal priority to that of patients. This has not always been the case in the past for a number of reasons, including a narrow focus on performance and, sometimes, putting patients' needs ahead of those of staff. Staff who are psychosocially healthy are better able to meet the needs and preferences of patients. So, it is essential to respond to needs of staff now as we emerge from the critical stage of the pandemic and the NHS is in its most fragile state ever.

While staff are by far the biggest cost for the NHS, they are also the biggest asset; without dedicated staff and the wide range of skills they bring, the NHS simply would not exist. The safe, effective, efficient, and compassionate care that we all look to the NHS to provide is only possible if staff, both clinical and non-clinical, are physically and emotionally healthy. However, although the NHS is one of the world's largest direct or indirect employers, it lags behind other organisations in terms of care for staff. This **must** change.

Health and care staff need to feel that their wellbeing and psychological health are valued by their employing organisations not solely during the height of extraordinary situations, such as the pandemic, but each and every day. This cannot be achieved by words alone; but must be achieved by **actions**.

We wish to create a culture at work in which staff feel safe and encouraged to speak about their experiences. Wellbeing can be affected by our experiences at work but also the conditions in which we work. We actively acknowledge the importance of our relationships, our peers at work, and the teams in which we work. Leadership and team cohesion are vitally important. Staff receive much support at home and informally from colleagues though some may also benefit from more focused psychosocial responses to our needs of, usually, a non-medical nature that include, for example peer support.

Organisations can do much to promote informal support and to create more formal responses. This means we should take a systemic, preventive approach and not simply focus on treating people's experiences as symptoms of personal stress. It also means actively identifying, and addressing, the wider causes of poor psychosocial wellbeing. That approach requires a focus on psychosocial aspects of work at organisational levels such as emotional labour, workloads, team functioning, valuing diversity, absence of bullying and harassment, civility and respect, the availability and use of supervision, and kindness and compassion for staff and patients. Importantly, these considerations apply in caring for patients but also in recognising the importance of non-clinical staff to achieving safe and superb care, and through practical matters such as adequate hospital parking facilities and flexible working patterns.

We believe that organisations that commission services and employers both have crucial responsibilities to live up to in achieving the vision set out in this statement. Alongside this, we believe that change is the responsibility of everyone within health and social care and that we all have a role to play.

Janet Monkman, Chief Executive, Academy of Healthcare Sciences

Eddie Crouch, Chair, British Dental Association

Dr Chaand Nagpaul CBE, Chair of Council, British Medical Association

Daryl O'Connor, Trustee, British Psychological Society

Hannah Abbott, President, College of Operating Department Practitioners

Jonathan Stewart, National Chairman, Health Estates and Facilities Management Association

Richard Murray, Chief Executive, The King's Fund

Dr Minesh Patel, Chairman, National Association of Primary Care

Katherine Henderson, President, Royal College of Emergency Medicine

Victoria Tzortziou Brown OBE, Joint Honorary Secretary, Royal College of General Practitioners

Stephen W Jones, Professional Lead for Mental Health, Royal College of Nursing

Steve Ford, Chief Executive, Royal College of Occupational Therapists

Adrian James, President, Royal College of Psychiatrists

Prof. Claire Anderson, Chair, English Pharmacy Board, Royal Pharmaceutical Society

Gill Walton, Chief Executive and General Secretary, Royal College of Midwives"

NHS
Salisbury
NHS Foundation Trust

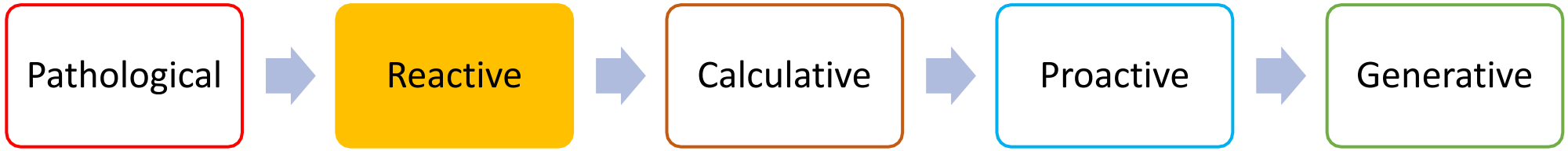
Health and Safety Management Plan 2022 – 2024

This plan supports the ‘We are safe and healthy’ element of the People Promise.

Executive Summary

Salisbury NHS Foundation Trust

The management of health and safety (H&S) at Salisbury Foundation Trust (SFT) is driven by obligations specific to procedural requirements. For example, the Key Lines of Enquiry outlined in CQC inspections. In adopting Professor Hudson's Safety Culture Maturity Model, as seen below, this approach is identified as a reactive culture.



A reactive culture does not allow organisational leaders to demonstrate the individual obligations expected to ensure H&S is planned, coordinated and systematically managed. A calculative culture utilises a formal H&S management system (H&SMS), formal risk profiling, performance measuring and formal assurance program to demonstrate H&S is managed in a planned and coordinated manner. This H&S Plan provides a 2 year plan and 4 key outcomes that will enable SFT to become a calculative culture and enable leaders at SFT to demonstrate individual obligations expected of H&S regulators.

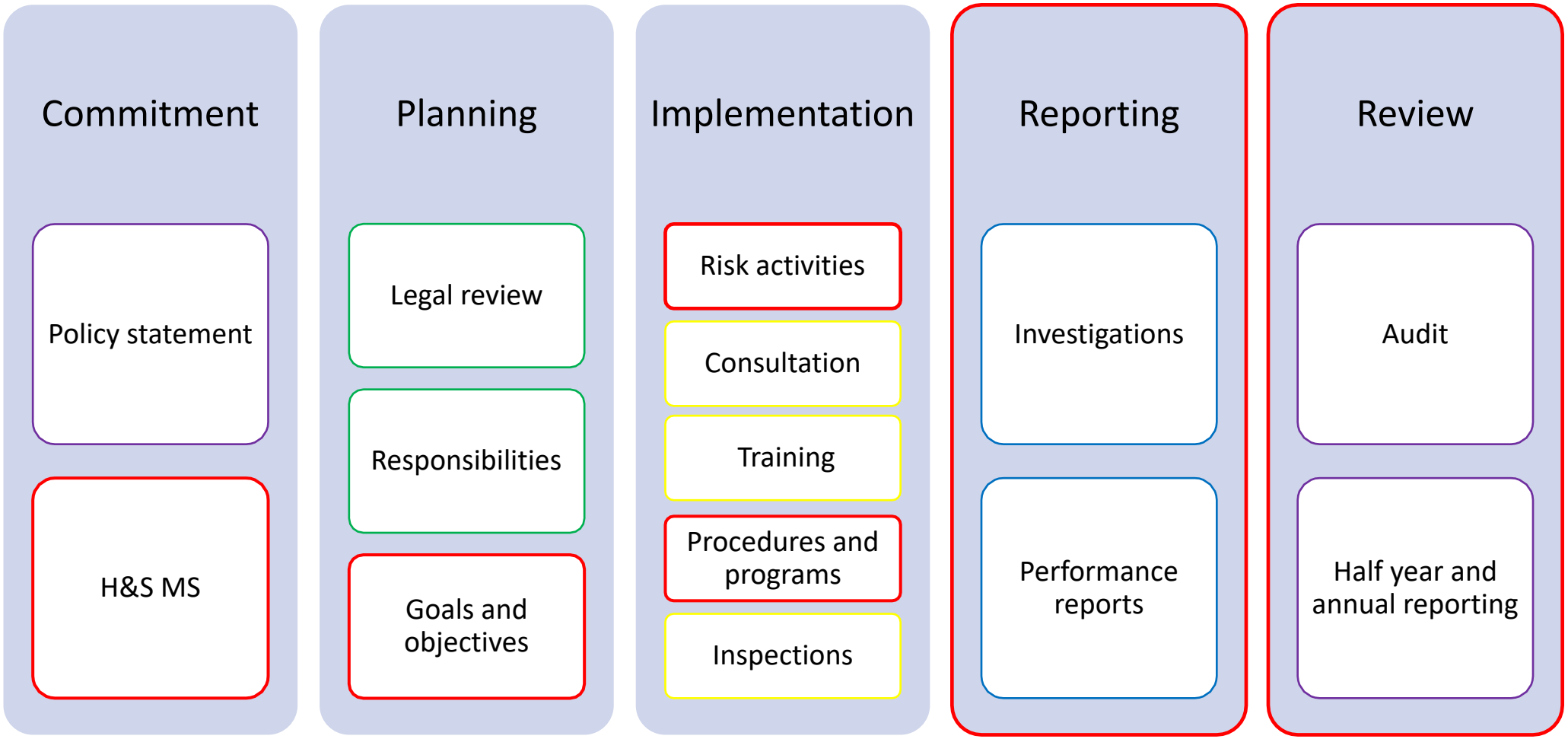
KEY OUTCOME 1

By November 2024, SFT will have an embedded H&SMS with measurable performance objectives, a documented risk profile based on first hand task analysis activity completed by the H&S team and a robust audit program that provides assurance to TMC, and Board of Directors, that H&S is being managed effectively, and identifies and actions gaps in the management of H&S.

A Health and Safety Management System (H&SMS) at SFT

Salisbury NHS Foundation Trust

A calculative H&S culture is one based on the development, and implementation, of a formal H&SMS and whilst there are a number of key requirements to implement an effective H&SMS, the specific actions required for SFT are outlined in red below.



Planning and Performance Reporting

Salisbury NHS Foundation Trust

An effective H&SMS drives continuous improvement in performance and therefore requires a suite of H&S performance measures and frequency reports to measure performance against determined objectives. It is not enough to provide statistics alone, there must be narrative, analysis and recommendations. Effective key performance indicators include targets that measure the consequence and likelihood of harm (negative measures) as well as activities that demonstrate H&S activity to reduce injury frequency and consequence (positive measures). The positive and negative performance indicators to be measured at SFT are listed below.

Objectives
Identify and improve hours lost from work related injuries
Identify and improve LTIFR below per million hours worked
Identify and improve LTFR below x per 1,000 hours worked
Number of task analysis completed by the H&S team
Complete formal root cause investigations for 100% of all lost time injuries

KEY OUTCOME 2

H&S reports will measure performance against objectives:

- Bimonthly reports will focus on granular activity and performance.
- Half year reports will look at areas of improvement to steer direction and resources towards objectives not achieved, and
- An annual review will provide strategic gaps and assurances for the Board to consider.

Procedures – Risk Activity and Matrix

A review of the current risk register shows risks are conflated with issues, risks remain escalated for prolonged periods of time despite corrective actions, or evidence unreasonably due to unusually high consequence rates. An effective risk register is based on formal risk profiling, task review and hazard analysis that consider the effectiveness of actions implemented, and determine if risks to H&S are being managed or not. There is no evidence of formal risk analysis activity and risk management activity is often reactive to events.

Risk profiling provides Officers at SFT with the first hand knowledge of risks to the H&S of staff, the actions taken to manage these risks and gaps in the management of H&S that should be prioritised. This is considered the first step an Officer is required to demonstrate when overseeing H&S.

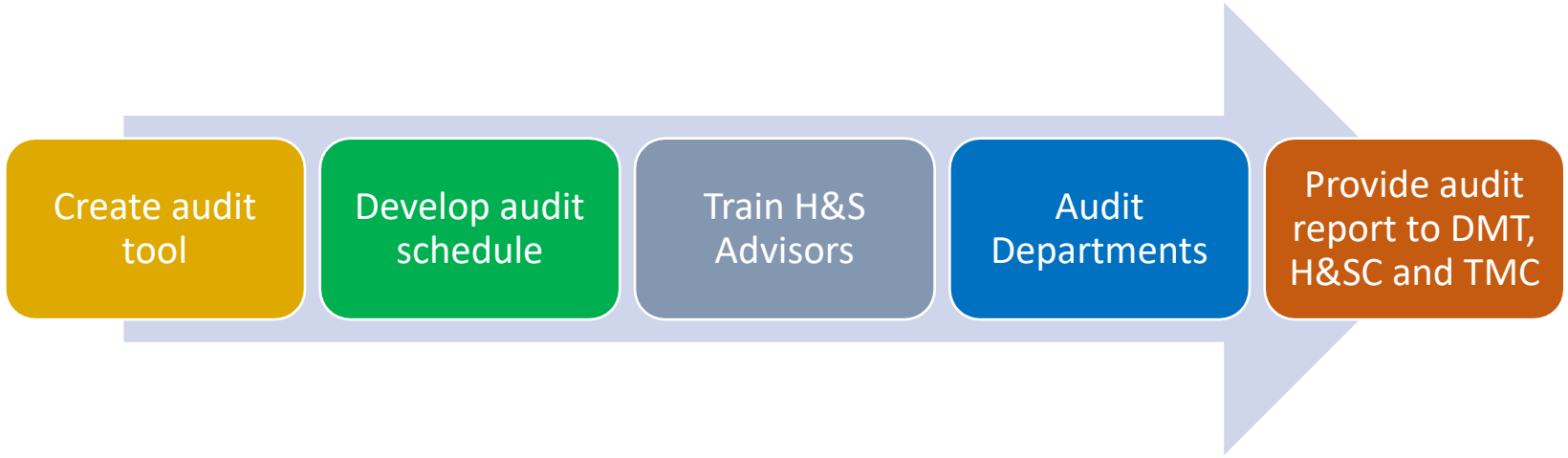
KEY OUTCOME 3

The H&S team will develop a divisional task analysis calendar and complete task analyses to identify hazards, determine the effectiveness of controls and alert the Trust to current risk exposure. The completion of Divisional and Department task analysis will be measured as a positive performance indicator to show preventative H&S initiatives and will prioritise areas of higher lost time injury rates and incident reports.

Audit Program

Salisbury NHS Foundation Trust

The current audit program at SFT is limited to annual inspection of the immediate work areas by managers. In the walk arounds with managers, this is more akin to a workplace inspection and needs to be distinguished from expert and bespoke auditing of divisions to identify gaps in the management of H&S locally. Hand in hand with increased risk analysis activity and H&S reporting is a need to conduct robust, independent gap analysis audits against an objective audit tool. There is no such audit tool at SFT.



KEY OUTCOME 4

Implement a robust audit program to review the effectiveness of H&S management, by Division and Department. Audits are expected to identify gaps in the management of H&S and provide a local action plan. The need for quality auditing is a further obligation leaders at SFT must ensure to demonstrate H&S is effectively managed.

Timeline and Key Actions for 2022

Salisbury NHS Foundation Trust

Timeline	Activity	Action
October to December	Task Analysis	Develop task analysis tool and commence activity against a calendar by division and department
	Reporting	Develop performance metrics and provide draft reports for H&SC, OD&P and TMC
	Audit	Develop an audit tool against standard H&S audit tools and calendar to conduct audits
	Procedure Review	Develop procedures identified as expired or not available
	Investigation tool	Determine if there is a root cause analysis investigation tool to conduct investigations

Calendar of Key Dates and Actions 2023/2024

Salisbury NHS Foundation Trust

Nov 22	Dec	Jan 23	Feb	Mar	Apr	May	June	Jul	Aug	Sept	Oct
		Estates - technical		Medicine				CSFS			Pathology
	Kitchen	Odstock fitness	Pathology	Porters		Theatres	ED & AMU	Surgery wards			ICU, CCU & NICU
	Q3			E of Y Report			Q1			½ year review	

Nov	Dec	Jan 24	Feb	Mar	Apr	May	Jun	Jul	Aug	Sept	Oct
Estates - Ops		Rehab & Spinal		Surgery				Clinical Engineering		Midwifery & Neonates	
Clinical Engineering	Post, Courier & Transport	Education Team		IR, Nuc Med & Cath Lab			Security & Parking	Radiology	MHLT		
	Q3			E of Y Report			Q1			½ year report	

TMC H&S Report

Audit

Task Analysis

Salisbury
NHS Foundation Trust

Organisational Development Plan

2022-2026

Our approach to organisational development, education and leadership

1. Executive Summary

The 2022-2026 Organisational Development Plan is divided into two pillars: Education and Leadership. It has been written to support the Salisbury NHS Foundation Trust's vision of 'providing outstanding experience for our patients, their families and the people who work for and with us'. When implemented, its goal is to provide the education and learning opportunities and a leadership culture which enables us to deliver our strategy of:

'Improving the health and wellbeing of the **population** we serve; working through **partnerships** to transform and integrate our services' and supporting our **people** to make Salisbury NHS Foundation Trust the best place to work'

This will be underpinned by our values, the NHS People Promise and the NHS People Plan.

Our vision: *To embed a culture of organisational learning by providing our staff with the resources and opportunities to continually develop their knowledge, skills and behaviours so they can apply the highest standards of professionalism and care always.*

We will develop and introduce a systematic and sustainable approach to education and leadership that provides staff with access to a range of quality opportunities throughout their career; building a strong foundation that ensures all our staff are supported now, and in the future.

This plan sets out our ambitions for the next 5 years. It will be used as the basis for our Organisational Development plans which will remain a living document. It sets out the route map for the next 3 - 5 years; strengthening the provision of training and education whilst developing and embedding a culture of compassionate leadership. We will focus on developing and maximising our staff's contribution in support of the Trust's vision, through training and education for all staff, enabling us to create a continuous learning culture within SFT.

The plan supports the People Promise elements: 'We are compassionate and inclusive', 'We are a team' and 'We are always learning.'

The plan sets out how SFT will ensure that the workforce has the right skills and knowledge to meet the challenges whilst continuing to deliver high-quality care. The delivery of the plan is divided into two subject areas:

The leadership pillar will provide:

- analysed and designed learning opportunities to develop exceptional leaders and managers who are compassionate and inclusive.
- a structured set of leadership, management and coaching programmes within defined career pathways, in support of providing the highest quality of care for the population we serve.

The education pillar will provide:

- the direction and guidance to lead and support the development of career pathways for all professions.
- the necessary training and education that ensures we have a workforce with the required skills, knowledge and behaviours to deliver safe, efficient and effective high-quality care, to meet the healthcare needs of the population.
- governance to develop quality metrics to drive training and education priorities for all staff, demonstrate it is of high standard and impacts positively on the quality of care.

There are critical success factors which we must achieve if we are to implement our plan and realise our goals. These have been identified as: strong engaged leadership; executive commitment and resourcing; robust policy and processes; good people management practices and the engagement and partnership from our staff.

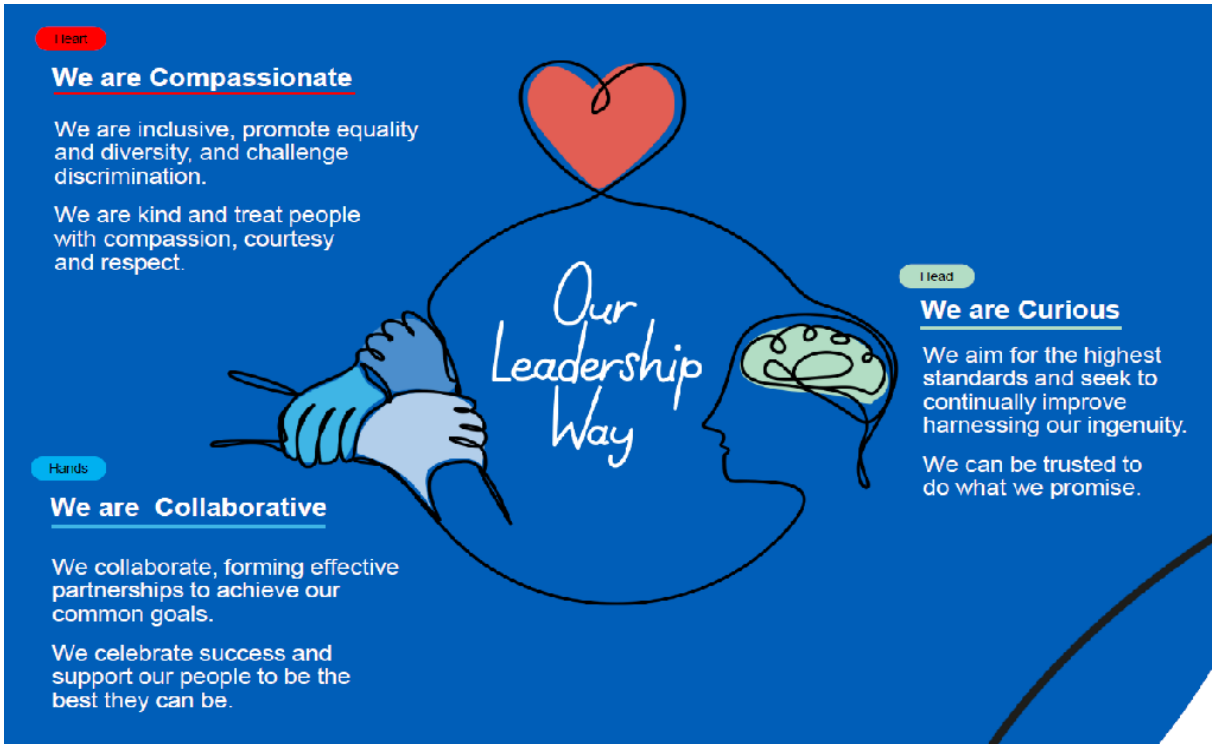
2. Rationale

The Organisational Development plan has been derived from research conducted, the findings of which are in Appendix 2. During our research and in conversation with our staff, capturing our current approach, we face the following challenges.

Current State	Future state
Lack of knowledge as to what is available to whom	Development linked to roles and learning pathways, with planned and integrated activities to progress along pathway Data identifies and drives development areas required, linked to strategic, operational, team and individual plans Development activities advertised and widely communicated enabling people to know what is available and when
Programmes designed specifically for one area	Sharing and communicating of designed programmes (case studies) Tailored development activities available to other areas, mapped to role/learning pathway and area of focus to address
Staff booked on training but unable to attend, or taken out of training/learning activities	Leaders, Managers and OD, Learning and Education work in partnership, so that the importance of development is acknowledged and recognised Only when operational needs are critical, staff are withdrawn Use of ward buddies to enable training to take place
No known standards so variations in training content and delivery	Standards established for all designed programmes to be benchmarked against Consistency in approach, content, delivery and evaluation (variations dependent on specific area needs only and not the norm)
Inconsistent evaluation of learning and development	Evaluation of learning is structured, planned, and linked to measurable organisational outcomes Focus on measuring transference of learning into the workplace, and sharing of knowledge with teams to increase teams learning Data is used to benchmark current, to identify future and to track progress
Where to find information, lack of understanding as to who does what, and what's available	Easily accessible 'go to resource area' Managers and SFT OD, Learning and Education working in partnership OD, Learning, and Education offering widely published, including who does what and who can help etc.

3. Delivery approach:

Co-created with NHS staff, 'Our Leadership Way' sets out the compassionate and inclusive behaviours **all** leaders need to demonstrate. These key components will be the foundation of all OD Learning, Training and Development activities within SFT.



The following principles are to be considered and incorporated into all OD interventions to enable the successful delivery of our goals:

Design of activities

- Evidence based analysis and decision making.
- Adopting the appropriate approach to learning. Apply the 70/20/10 model. Where 70% of learning comes from experiences at work; 20% of learning comes from social or peer to peer learning through mentoring, feedback or colleagues; and 10% comes from formal training in a classroom or virtual environment. The three components of the 70/20/10 model reinforce one another, helping to promote new and sustainable behaviours, leading to improved performance.
- Adopt a continuous improvement and agile approach – respond to the changing requirements of the learner, the requirement and learning delivery methodology advances
- Embed the values and behaviours throughout all learning and development interventions.
- Champion multi-discipline education, training, learning and development as enablers to increasing understanding of different roles, with opportunities to learn from different perspectives

Supporting staff

- Enable access to training, education and learning activities flexibly and at a time that is right for them for example but not limited to providing learning through different mediums (Technology Enabled Learning (TEL); Ted Talks; Mentoring; Coaching; structured programmes; recommended journals, books and video's)
- Create a resource area where staff can access readily and easily to find relevant quick fix information to encourage self-learning and support.
- Provide centralised knowledge centre where staff take responsibility for their own development, utilising self-assessment and knowledge tools
- Maintain Kallidus Learn usage for managing our staffs' education, training, learning and development and determine reporting functionality.
- Review education, training, learning and development policies to reflect current requirements.
- Support leaders and managers to understand the needs, expectations and aspirations of their teams – spot, nurture and develop talent at all levels.
- Develop empowered competent people, who are encouraged to develop their skills, and engage in ongoing personal development

Developing capability:

- Encourage the sharing of knowledge gained from development activities through supporting development sessions/time during team meetings, with staff who have undertaken any form of education, learning, training or development sharing with their team what they have gained from the event and how they will use it.
- Build strong capability at all levels, through proactive development and stretch opportunities consistently, and well in advance of being appointed into new roles
- Central to our plan will be the growing capability and the value placed on coaching individuals and teams; unlocking the potential in our staff to thrive in their roles
- Develop leaders, managers and team capabilities, skills and understanding to create working environments were all our staff prosper, thrive and fulfil their potential

Develop and employ a robust and agile evaluation strategy

- Review how we evaluate all education, training, learning or development activities – linking to measurable outputs and improvements in individual, team and therefore trust performance, the difference it will make and the methodology for sharing learning.
- Develop robust evaluation and evidence-based reporting to measure and demonstrate impact in the workplace
- Monitor the effectiveness and contribution of education, training, learning and development to the Trust's overall performance.

Our plan will develop to ensure we offer a wide range of career enhancing opportunities that enable ongoing career progression and professional development. Career pathways will be developed for all professions to ensure better talent management and opportunities for growth and progression. This will enhance our external and internal reputation as an employer of choice as we develop our offer to the wider population and respond to workforce developments that result in new roles and training. The scope of this work will include but not be limited to:

- Developing viable educational opportunities for clinical and non-clinical staff.
- Developing sustainable career programmes across all professions
- Implementing identified viable and sustainable educational opportunities with demonstrable metrics.
- Reviewing progress against set improvement metrics.
- Supporting career pipelines including:
    - Maximising the support and appropriate use of apprenticeship pathways
    - Growing own programmes
    - Delivering student and learner practice placements
    - Developing student and learner mentoring/supervision programmes
- Supporting cross-professional and multi-discipline training.

4. Our Approach to Strengthen our Performance Capability

Throughout our work delivering the OD Leadership and Education plan, we will consider the following points:

- Continue to align education and training with current and future Trust needs, with the core aim of improving patient care and service delivery, whilst supporting and developing our people
- All education and training activities must be linked to learning and career pathways
- Enable access to high quality education, training and CPD that ensures safe and high-quality services for the future
- Promote a culture that values education, training and continuous improvement, recognising that they are an integral part of individual's working lives and this occurs in a variety of settings, not just in a classroom
- Continuously monitor, evaluate and investigate innovative ways of delivering education and training, to provide content that is engaging, informative and relevant
- Provide appropriate education and training options which recognise the diversity of learner needs and the requirements of individuals and groups within the Trust
- Demonstrate the impact and benefit of education and training on both individual and organisational growth and performance
- Identify and use additional funding sources to complement resources from the Trust's annual allocation
- Integrate education and training policies and activities with broader hospital processes and OD and HR practices

5. Our ambitions are to:

- Develop and invest in a culture of learning together in multi-profession teams that nurture talent, embrace diversity and inspire individuals to reach personal and professional developmental goals
- Deliver education, training, learning and development which directly benefits quality and safety; promotes and supports the personal and career development aspirations of our staff
- Champion emerging technologies driving education, training, teaching, learning and development, fit for a future health service
- Create an environment that supports education, training, teaching, learning and development for all to achieve excellence in patient care
- Ensure that our education provision supports a flexible delivery model to ensure individuals receive the right learning (accredited, where appropriate), at the right time
- Grow the range of engaging and interactive learning opportunities available to support staff development
- Enable access to wide range of quality continuing professional development that provides our staff with opportunities to develop their careers at SFT
- Work with stakeholders to build our leadership and management capability and embed a compassionate and inclusive leadership culture
- Introduce and embed a culture of coaching, a critical enabler to our Improving Together, continuous improvement programme
- Evaluate what we do, so we continually improve the education, training, teaching, learning, and development experience for all our staff, measuring the effectiveness of the training and the impact in the workplace
- Support all staff to invest in their careers, through formal and informal training to reach personal and professional goals, including providing the time, space and funding to do so
- Enable our staff to meet current and future needs by providing the opportunities and resources for them to develop their skills, knowledge and competence
- Develop mutually beneficial partnerships with regional healthcare organisations, schools, patients and learners supporting a community of learning, to facilitate a range of routes into professions
- Support staff to transition into new or enhanced roles such as Advanced Clinical Practitioners, Nursing Associates, Physician Associates, Associate Practitioners, Peer Support Workers, Enhanced Clinical Practitioners etc

6. The focus of the education pillar will be on:

Growing for the future

Harnessing the talents of all our people

Developing our people

Supporting everyone to be their very best

Creating an environment for learning

Learning is part of our daily routine

Career Enhancing Education

Providing opportunities for all to enhance their knowledge & skills

Innovative Education

Embrace & apply innovative educational technologies as we learn together

7. The focus of the leadership pillar will be on:

Compassionate, Inclusive Leadership at every level

Everyone thrives through inclusive & compassionate leadership

Developing our people

Supporting everyone to be their very best

Quality and Patient Safety

***Empowering our people to drive improvements in safety and* quality**

8. Growing for the future - Harnessing the talents of all our staff:

We will develop a talent programme that allows us to identify, train and develop talent within our workforce, to enable us to retain staff at all levels. We need to provide clarity and opportunities for staff to develop and progress within the Trust. Talent development includes training, upskilling and re-skilling employees to move careers forward. Progression is not always about upward moves; sideways opportunities provide valuable experience to develop a more rounded career, and projects or secondments are opportunities to stretch and grow.

Through our plan we will identify and develop clear and accessible structured development routes; clearly mapped out career pathways and access to the provision of accessible high-quality learning and development opportunities. This will enable us to develop future organisational capability whilst our staff develop, enhance and broaden their skills with greater opportunities to achieve their potential. Opportunities to recruit directly into entry-level clinical roles, apprenticeships and non-clinical roles will be sought after as these will be our tomorrow talent.

How we will we do this?	What will success look like?

• Enable our staff to fulfil their ambitions and potential through clearly defined career pathways, regular constructive conversations with managers around aspirations and easy access to development opportunities
• Build strong leadership and management capability at all levels.
  ○ Provide training before or within the first month of appointment
• Design and develop talent management and talent development frameworks clearly articulating our approach to identifying and developing our talent
  ○ Define what we mean by talent, how we identify and develop SFT talent, and the role leaders/managers play in identifying talent
  ○ Provide Line Managers and leaders with access to coaching, easy to use toolkits, action learning sets and development programmes
  ○ Managers and leaders adopt and embed a coaching culture
  ○ Identify, support and prepare aspiring leaders through proactive development and stretch opportunities, such as secondments, placements etc.
• Support individual development conversations with clearly defined career pathways and opportunities for stretch and education
• Grow organisational coaching capability
• Develop and grow our staff to enable us to be responsive to our immediate and future needs
	• Staff feedback through surveys that they feel valued identifiable through year-on-year % increase around People Promise questions ‘we are always learning’
	• Decline in leaver survey numbers citing lack of opportunity
	• Measurable evaluation of development programmes indicate change in behaviour, ways of working or practice
	• Talent framework and activities in place to effectively spot and manage talent
	• Talent and management framework widely understood across SFT
	• Leadership development programmes developed and embedded at all levels
	• Managers self-reporting on individual/group learning activities
	• Increase in coaching and mentoring relationships formed across the Trust
	• Programmes to identify and develop coaches and mentors in place and widely understood and utilised

9. Developing our people - Supporting everyone aspire to reach their potential:

We will invest in staff development to help employees hone strengths and grow skills, which better equip them for their current and future roles. Balancing the needs of patient care and time out for development is a recognised challenge, however with the opportunities presented through the changing learning and development landscape of – such as Technology Enabled Learning, Mobile Learning, coaching etc. there are more opportunities to design 'just in time learning and bite size learning'.

Our education provision must acknowledge differences to ensure the individual has access to supported learning opportunities appropriate to their preferences, profession and experience. A diverse workforce provides opportunities for sharing ideas, approaches and different perspectives which increases and broadens learning. Providing the resources, opportunities and environments to facilitate sharing of best practice among workers, makes for a more innovative and productive workforce.

How we will we do this?	What will success look like?
• Provide accessible opportunities to learn and develop • Provide clear development and training pathways across all professions • Embrace technology enabled learning making it is easy to access 'learning at the point of need' • Develop staff awareness that learning, training and development happens in diverse environments and not just in a training room. Embed 70-20-10 approach to learning. • Develop accessible learning resources for self-development, both online and physical resources • Compassionate behaviours detailed in our behavioural framework appraised during interviews and performance reviews • Embed quality regular discussions on performance, development and aspirations becomes part of DNA • Staff report feeling empowered and enabled to make change and do things differently having experienced Improving Together training, tools and techniques, measured using pulse checks and staff survey • Identify opportunities and encourage all our staff to be working collaboratively across the Integrated Care System (ICS) • Trust in teams enables and encourages through coaching, learning together and sharing	• Staff feedback through surveys that they feel valued and are clear about their role, what they are responsible and accountable for (People Promise questions – 'we each have a voice that counts') • Use of data to inform training/learning requirements and to measure the impact of change following (Kirkpatrick's Model) • Number and quality of appraisals completed will be improved • Open, honest and constructive discussions on how our values are demonstrated take place during the appraisal • Numbers of people through appraiser or appraisee training to introduce new values-based appraisal discussions • Mandatory and statutory training compliance • Appraisal compliance and quality • Participants in and measurable outcomes from all leadership and personal development programmes/activities • Numbers of visitors to learning resources hub; highest and lowest content interest; requests for material/resources to be added to hub • Reduction in the number of reported incidents of poor behaviour through our Freedom to Speak Up Guardian and staff surveys – there will be an initial increase in reported incidents which will indicate the development of a more

	open culture where staff feel safe to raise concerns • Through high quality at least once a year appraisal, all staff are clear about their contribution to our vision, values and strategy and feel that their role makes a difference to our service users • Engaged workforce where staff feel connected to and able to shape the way things get done • Achieved the measures set out in our Staff Survey that mean staff feel supported and valued by their managers and have equal access to and opportunity for development • Fewer staff will intend to leave or leave the Trust due to lack of development or opportunity • Staff will be working collaboratively across the Integrated Care System (ICS) • Staff are and believe others are living our values and behaviours • Staff say they are able to shape decisions and are supported to implement new ideas

10. Compassionate and Inclusive Leadership at every level - Everyone thrives through inclusive & compassionate leadership

Effective leadership is critical to an organisation's culture and plays a key role in shaping the culture. To nurture a culture of compassion in an organisation means shifting from traditional command-and-control towards a way that distributes leadership to wherever expertise, capability and motivation sits within the organisation.

The fundamentals of compassionate, inclusive leadership mean everyone taking responsibility for ensuring high quality, continually improving and compassionate care; shared leadership in teams; continual development of team working; leaders working across boundaries and a consistent approach to leadership across the organisation, characterised by authenticity, openness, curiosity, kindness, appreciation and compassion.

How will we do this?	What will success look like?
• Design an SFT framework for leadership competence and behaviour • Strengthen the ability of people to lead with compassion by developing individual self-compassion and collective compassion in teams • Create an open, transparent and learning culture where we all act consistently with and demonstrate our values • Improve staff understanding of what it means to work in and lead teams • Implement a leadership development framework for all staff across SFT • Embed within our leadership development programmes empathy and effective listening, developing a coaching style and self-awareness through diagnostic tools for self-assessment (e.g., 360 feedback) • Foster learning for development of effective teams, ensuring high quality values-based induction and appraisals • Ensure our leadership programmes include development on 'reflection', reflective listening, practicing empathy, authenticity, openness, curiosity, kindness, appreciation and compassion • Adopt and embed an 'appreciative inquiry' approach • Provide opportunities to learn from experience and incidents, involving input from those who are using our services • Celebrate the learning and success of our staff, offering reward and recognition where appropriate	• Leadership, management and coaching programmes designed and embedded • Delivery of an annual leadership festival, building on a range of activities running throughout the year with inspirational speakers and opportunities for our leaders to work on key issues • A suite of programmes designed and piloted covering Board Leadership, Executive Team, Senior Leaders, Middle Leaders and Team Leaders • An Understanding Self module designed that **all** leaders attend, incorporating 360 feedback, coaching and reflection • Developed and launched our Leadership Toolkit covering Team development, 121 support, 360 feedback, Emotional Intelligence tool, coaching, mentoring • All new leaders attend New to Leading programme within the first month of taking up their post, which covers the How and the What of a leader in SFT • Use of SMEs to develop the skills of leaders in Finance management, Business Case writing skills etc. • An effective performance management and personal and professional development is in place and utilised • Our people confidently encourage effective conversations about behaviours, attitudes and performance • Our Leaders are inspirational, inclusive, compassionate and lead the development of outstanding teams

• Host a leadership conference with inspirational speakers for our leaders to learn from and reflect on their experiences and knowledge, starting with a Leadership Festival • Promote visible leadership at all levels • **All** managers and leaders attend both skills and behavioural training workshops building their competence and demonstrating their successful application through continually improving results in sense of team, value of appraisals and embedding of a compassionate culture	• Deliver bite-sized learning interventions underpinned by our values • Our people develop and thrive in a compassionate and inclusive environment that addresses inequalities • Leadership behaviour improvement seen on Trust performance metrics

11. Quality and Patient safety - Empowering our people to drive improvements in safety and quality

Various reports maintain that quality must be at the heart of everything the NHS does and defined the three key domains that underpin quality as Patient Safety (consistently delivering safe, harm-free quality care to all patients); Patient Experience (providing an excellent quality healthcare experience for patients, carers and visitors); and Clinical Effectiveness and Outcomes (providing high quality evidence-based care that is effective to ensure the best possible outcomes).

We commit to embedding and improving quality in everything we do, seeking to ensure that what we do and how we work delivers the best outcomes for our patients, in a safe and caring environment. To achieve this, we must include quality in our learning and education provision.

Failing to deliver the standard of care we aspire to, must be acknowledged and treated as an opportunity to improve and learn from. Learning from clinical incidents, near misses, poor patient experience, and complaints received from service users should be widely shared, discussed and reflected upon.

How will we do this?	What will success look like?
• Continually strive to promote the highest standards for patient safety and quality, with a focus on greater workforce compliance and understanding of the legislative requirements • Provide a comprehensive range of training and education activities specifically aimed at meeting the needs and improving the quality of trust patients by working closely with patient groups and multi-disciplinary staff • Develop a strong research and development culture among Clinical & Non-Clinical groups – how we develop, promote, utilise and share research across the trust amongst clinical and non-clinical groups • Promote and support SHINE (Salisbury Hospital Improving & Networking for Excellence), to highlight clinical effectiveness by spotlighting clinical projects, learning and reports whose aim is to improve the quality of care we deliver to our patients and to engage in professional development to facilitate better patient outcomes, taking place within SFT • The importance of the role of supportive observation and the use of technology to release time to care	• Data/feedback from patient groups is used to inform the contents of our programmes and patient feedback is referenced in the delivery of education programmes • Learning, development and continuous improvement methodologies are used to support and improve the patient's experience • Staff are supported in developing skills to design and deliver high quality programmes relating to health promotion • Action Learning is used to support staff with transferring learning into the workplace by sharing information from incident reviews and learning from others • Communities of Practice are developed where practitioners from across the Trust come together to share their experiences, to learn from each other on key issues, and apply learning back in their areas • Active promotion positively driving a culture of accountability and transparency in all aspects of clinical and Corporate Governance • Increase in multi-professional local training events offered by Divisions / Departments

• Develop our staff (clinical and non-clinical) to work together effectively in multi-professional teams • Establish multi-professional leadership framework within Divisions • Education and training informed by the need to continuously improve quality and safety standards, through learning from SI's, with reports and feedback on patient safety incorporated into education and training programmes and organisational wide learning from incidents and complaints • Align statutory, mandatory and essential training with patient safety and quality domains • Educate staff in clinical risk and quality tools to benefit patient care	• Inter-professional education and continuing professional development programmes that support team working on offer • High quality education opportunities are provided that ensure all staff have the skills and knowledge to deliver safe and outstanding care

12. Creating an environment for learning - *Learning is part of our daily routine*

A learning environment is one where learning is embedded into how things are done at an individual, team and organisational level. At an Individual level learning takes place in a supportive environment that allows employees to apply their learning. At a team level it's a key place where social learning and dialogue can occur, with leaders having an important role to play in ensuring that their employees also have the relevant support for learning. And at the organisational level there needs to be structures and systems in place to support learning, as well as a shared vision for learning and transformation.

Successful organisations know that a skilled and developed workforce is the key to delivering organisation outcomes. Recruiting, developing and retaining the right skills, is an important element of people practice. To remain relevant in a challenging labour market, organisations must think strategically about how they invest in and develop the knowledge, skills and abilities of the workforce. The ability to learn, adapt and continuously improve is vital in the face of challenges that seen over the last two years. Digital tools and innovative processes are vital as organisations navigate a complex landscape.

How will we do this?	What will success look like?
• Increase use of internal knowledge-sharing events, job rotation, secondment and shadowing, action learning sets and collaborative learning • Give Learners greater control of their learning, reflecting the need for agility and flexibility in meeting bespoke individual needs • Support flexible and innovative delivery to enable our people to receive the right evidence-based learning, in the right place, in the right way, at the right time • Foster a culture of reflective practice, encouraging the sharing of learning from the workplace with other professionals through regular inter-team learning discussions • Bring different team members together from across the Trust (and wider system) to learn from and be supportive to each other • Sharing leadership in teams and encouraging others to share in decision making creating the opportunity to learn from each other • Encourage leaders to foster a culture of innovation in their teams and find opportunities for professionals from one division/directorate to help solve a problem in another using Improving Together tools and techniques • Devote dedicated time for our people to engage in training and learning, by	• Participation in action learning sets with feedback of positive outcomes and incorporation of practical solutions to problem/issues, back into the workplace • A programme of once a month 'Lunch & Learns' for sharing learning, with month on month increasing participation and participant requests on who they want to hear from/ what they want to learn about • Increase in staff survey questions scores - 'I have opportunities to improve my knowledge and skills and I am able to access the right learning and development opportunities when I need to' • Evidence seen of Improving Together programme tools and techniques being used as the programme roles out across the trust • Leaders actively stepping back from leading team meetings, providing opportunities for their team members to lead meetings and discussions instead • Pre and post learning discussions take place between learner and their leader as to what the deliverables will be from attending a learning, training or development activities, and how they will measure the transfer back into the workplace of what is learnt, and what will be different

scheduling in and protecting individual and team learning time • Encourage our people to join action learning sets, which build collective wisdom and develop reflective practice • Encourage participation in Cross Sector networking and learning events to learn from others, share best practice and to broaden network • Develop the mind-set and embed the thinking that it is everyone's responsibility to seek out new knowledge, answers, and skills to continuously improve, constantly innovate, rethink, and formulate new ways to be better • Develop the skills to design and deliver technology enabled and mobile learning or recruit for a digital learning creator to develop mobile and technology enabled learning resources that support our programmes. • Embed a formalised diagnostic tool for the design of tailored programmes/initiatives that focuses on how the data supports the need, how learning with be transferred into the workplace and clearly defined benchmarks for measuring impact and ROI. • Organise and promote 'Lunch & Learn' sessions to encourage best practice sharing	• Individuals who have attended learning, training or development activities sharing their learnings with others in the team • Evidence of cross department/divisional working with professionals working across the Trust to help solve a problem in another area using Improving Together tools and techniques • Ever increasing resources being made available on the 'learning hub', with increased uptake and requests for new resources or suggestions of materials • Completion of Improving Together programmes • Embracing and developing digitally enabled learning resources • Data is used to inform the design of learning interventions, enabling us to benchmark, measure and monitor impact • SME's share their experiences and knowledge in informal settings, increasing the knowledge transfer across SFT

APPENDICES

APPENDIX (1)

SFT Education and Training Programmes

SFT benefits from multi-professional, multi-directorate delivered education and professional development. There are specific teams under this umbrella delivering across the divisions and offering mature training programmes some of which are highlighted below.

1. SFT offers a formal graduate scheme where students can specialise in one of six areas:
   - general management
   - finance
   - human resources
   - health informatics
   - policy and strategy
   - health analysis

The SFT Graduate Scheme lasts for 2 years except Finance which lasts for 2.5 years. Graduate students are employed on a fixed-term contract and receive a paid salary. The programme includes:

- intensive foundation training
- structured work placements, training alongside experienced clinicians and managers
- an education programme leading to either a professional or a postgraduate qualification, depending on your specialism
- specialist management development training including support and careers guidance

2. The SFT offers a wide range of apprenticeships, including higher and degree level apprenticeships. Apprenticeships provide essential training and development pathways for existing staff to reach their potential and gain qualifications to aid their progression at SFT. Apprenticeships also provide an educational opportunity for newly recruited staff to gain their first step into employment. Apprenticeships are available from Level 2 to Level 7.

3. The SFT medical education team ensures that junior doctors and dentists are equipped to fulfil their roles and responsibilities for patient care and to enable them to develop into effective clinical leaders within the NHS.

4. The SFT Practice Education Team is a multi-disciplinary clinical team (nurses, midwives, ODP, Health Visitors) responsible for a variety of clinical and non-clinical teaching. The team is involved in medicine management within the Trust, supporting staff to be able to administer medication safely. We also support the student nurses on placement and pastorally, and support staff with NMC training to conduct supervisory activities and assessment of student nurses, ODPs, midwives and nursing associates.

5. The OD Leadership Team delivers formal leadership and management training.

6. The NHS Scientist Training Programme (STP) is a 3-year programme of work based learning supported by a University accredited master's degree. Usually, the first year is spent in a range of settings, with the last two years spent specialising. It is offered to science or engineering graduates. Graduates are employed on a fixed-term contract with a paid salary for the full duration of their training. On completion of the NHS STP graduates are eligible to apply for suitable healthcare science posts as a clinical scientist. The NHS STP is offered in the following areas:
   - clinical bioinformatics (including genomics, physical sciences and health informatics)

- life sciences (including andrology, cancer genomics, clinical biochemistry, clinical immunology, genomics, genomic counselling, haematology/transfusion science, histocompatibility and immunogenetics, histopathology, microbiology and reproductive science)
- physical sciences and biomedical engineering (including clinical engineering (e.g. rehabilitation engineering), clinical pharmaceutical science, medical physics (e.g. nuclear medicine, radiotherapy physics, radiation safety, imaging (ionising), imaging (non-ionising), MRI and ultrasound) and reconstructive science)
- physiological sciences (including audiology, cardiac science, critical care science, gastrointestinal physiology, neurophysiology, ophthalmic and vision science, respiratory and sleep science, urodynamic science and vascular science).

APPENDIX (2)

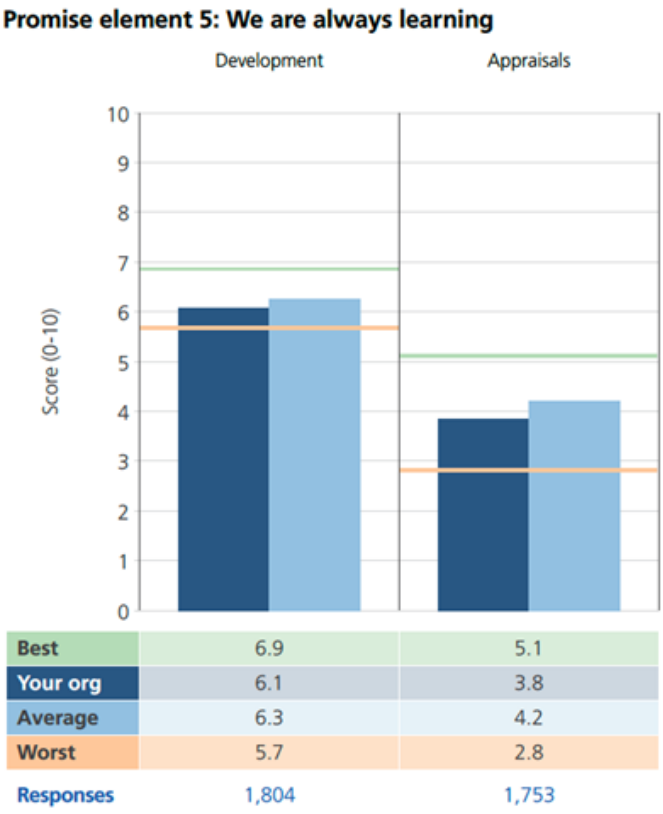
RESEARCH

What staff said – taken from the 2021/22 staff survey:

- 'MLE does not make learning easy, nor does it provide me as a leader with easy access to data for me to help my team develop – it is too clunky, it takes ages to find information, it's not intuitive – in-fact it is very old fashioned and with a tech savvy generation in the organisation it does not inspire them to use it to learn!'
- 'Our offering is very sketchy - over the years we have stripped back due to cost savings and education/training/learning has been the victim!'
- 'We need to rethink how we support our ward staff – the role of Practice Educators based in the wards to nurture, guide, development, appraise, train and be talent spotters – this is not a luxury we need to invest now to stem the flow of staff leaving.'
- 'We don't have the time to spot, develop or even have the conversations with our teams about what and how they could develop'
- 'It's great to offer secondments, the ripple effect this can cause is positive and negative – positive as more people get the opportunity to step up and get experience, negative when they are coming to end of their term, we don't invest in spending time to understand how they got on, what worked well and what didn't etc. and transitioning them back into their old role'.
- 'Occupational Professional Development outside of clinical areas is not seen as a priority to invest in. We need this development to be recognised as necessary for the role – such as life- guard refresher training, and to have specific budget set aside rather than having to find creative ways to get the money to pay for the training'.
- 'There is not enough development of staff, which would increase retention
- 'We simply do not have enough experienced staff to provide training/ educational supervision to an ever-increasing pool of newly qualified, inexperienced staff. There is continuous, natural high staff turnover in these groups. They leave to find better training opportunities and support elsewhere'
- 'There are also virtually no career development opportunities for senior pharmacists with competitor hospitals offering innovative clinical opportunities e.g., ACP and Consultant Pharmacist roles'
- 'We need support from the Trust to grow and restructure our workforce, in a way that provides adequate training capacity, to make our service fit for purpose and fit for the future, for the health of both our patients and our staff'
- 'A long and well recognised record for not encouraging and supporting progression'
- 'Believe the organisation are not interested in investing in people. Yes, saving money is important but also investing in people'
- 'Career progression opportunities should be provided to staff at all levels'
- 'Feel let down with the lack of training for lower bandings, with no opportunities for career development or progression'
- 'I don't think this organisation can give me career growth'
- ' I enjoy working here but would like more training opportunities/development opportunities announced for my skill level'
- 'I feel there is such an emphasis on clinical staff and not admin staff'

Information from the staff survey highlighting our staff experiences and thoughts regarding learning, development, and career progression:

Our lowest results were around the job (motivation, resources) and personal development questions



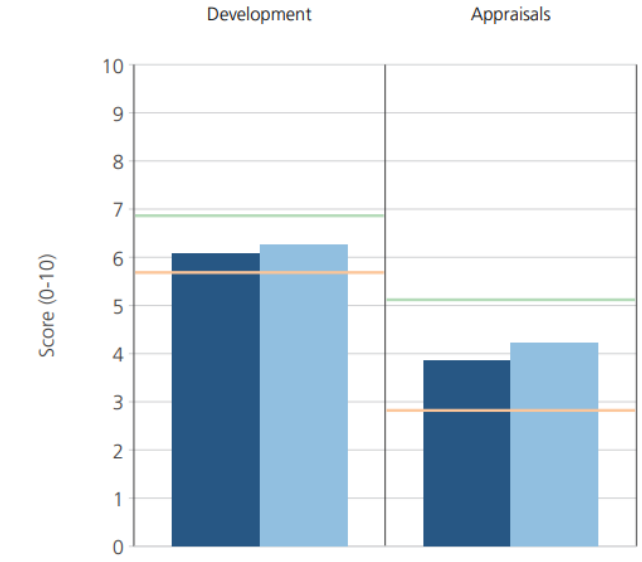
		Comparator Information	Picker Average 2021	Organisation 2020	Organisation 2021			Clinical Support & Family Services	Corporate Directorates	Facilities	Medicine	Surgery	Women and Newborn
Section	Q	Description	n = 227091	n = 2062	n = 1881	SFT Change 2021 vs 2022	SFT vs Picker Average	n = 374	n = 339	n = 144	n = 452	n = 478	n = 94
Development	q20a	Organisation offers me challenging work	68.9%	*	70.0%		1.00	71.0%	75.1%	47.4%	73.4%	69.5%	66.7%
	q20b	There are opportunities for me to develop my career in this organisation	52.9%	*	46.9%		-6.05	52.1%	42.9%	31.3%	48.7%	49.1%	43.3%
	q20c	Have opportunities to improve my knowledge and skills	66.7%	*	63.2%		-3.41	70.5%	59.1%	44.8%	66.0%	62.1%	68.9%
	q20d	Feel supported to develop my potential	52.2%	*	46.5%		-5.73	53.4%	46.0%	39.8%	44.7%	46.1%	41.1%
	q20e	Able to access the right learning and development opportunities when I need to	55.2%	*	48.9%		-6.28	53.6%	47.1%	46.6%	49.4%	46.9%	47.8%
Appraisals	q19a	Received appraisal in the past 12 months	82.3%	*	75.5%		-6.79	80.6%	59.7%	73.8%	82.3%	76.4%	76.1%
	q19b	Appraisal helped me improve how I do my job	21.1%	*	19.4%		-1.67	14.0%	17.4%	37.0%	23.6%	17.2%	13.6%
	q19c	Appraisal helped me agree clear objectives for my work	31.3%	*	28.8%		-2.49	24.9%	26.5%	41.8%	33.0%	26.0%	27.3%
	q19d	Appraisal left me feeling organisation values my work	30.1%	*	30.7%		0.62	31.8%	30.2%	44.0%	28.4%	29.8%	26.9%

Key:
100.0%
> 3 ppt above
< 3 ppt below
In between

Source: RNZ_NSS21_RAG_Report

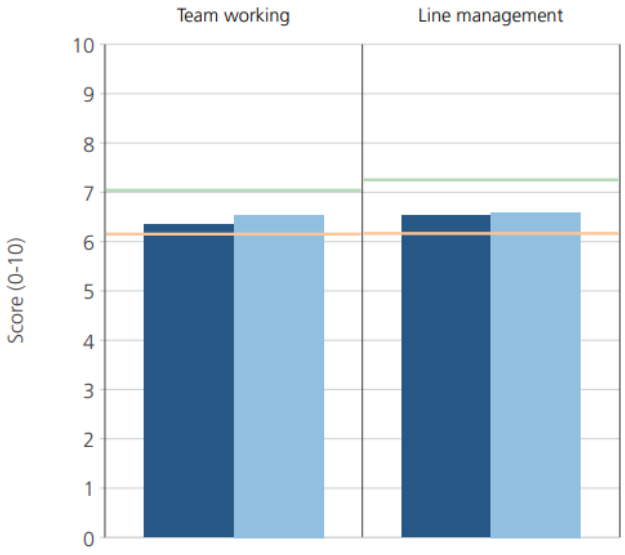
Graphs of specific staff survey questions

Promise element 5: We are always learning



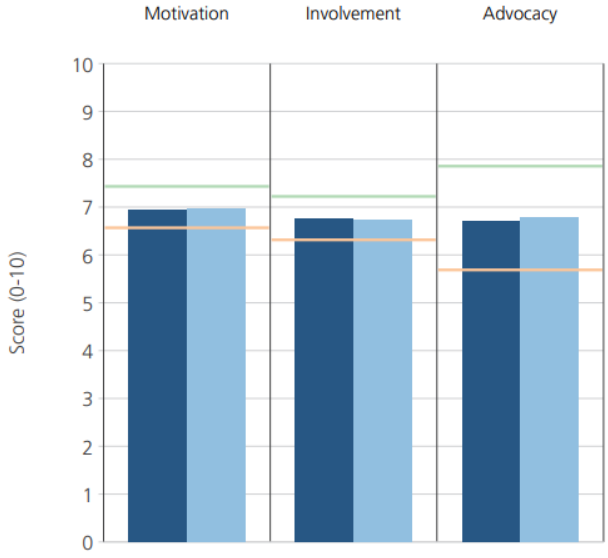
	Development	Appraisals
Best	6.9	5.1
Your org	6.1	3.8
Average	6.3	4.2
Worst	5.7	2.8
Responses	1,804	1,753

Promise element 7: We are a team



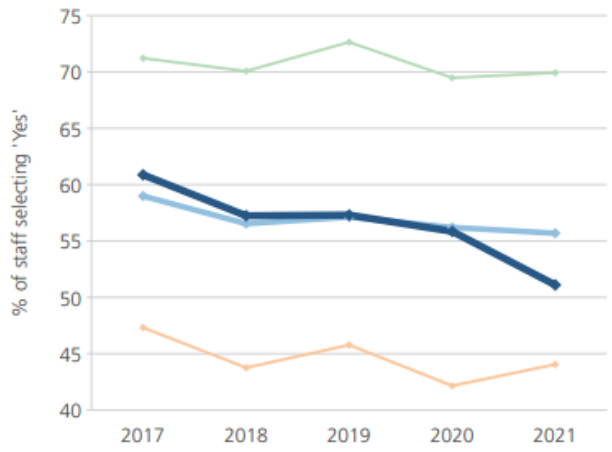
	Team working	Line management
Best	7.0	7.3
Your org	6.3	6.5
Average	6.5	6.6
Worst	6.2	6.2
Responses	1,834	1,823

Staff Engagement



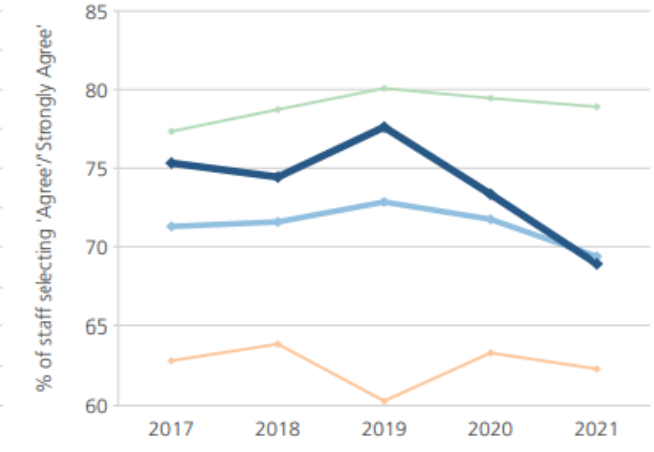
	Motivation	Involvement	Advocacy
Best	7.4	7.2	7.9
Your org	6.9	6.8	6.7
Average	7.0	6.7	6.8
Worst	6.6	6.3	5.7
Responses	1,857	1,857	1,800

Q15
Does your organisation act fairly with regard to career progression / promotion, regardless of ethnic background, gender, religion, sexual orientation, disability or age?



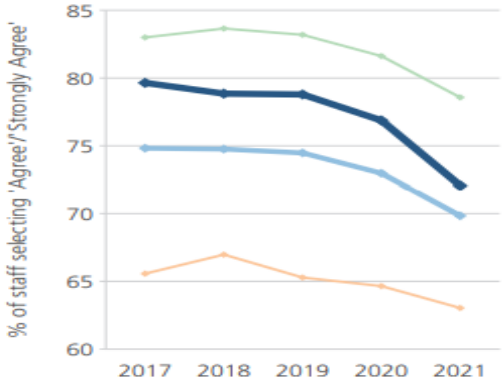
	2017	2018	2019	2020	2021
Best	71.2%	70.1%	72.6%	69.5%	69.9%
Your org	60.9%	57.2%	57.3%	55.9%	51.1%
Average	59.0%	56.5%	57.1%	56.2%	55.7%
Worst	47.3%	43.8%	45.8%	42.2%	44.1%
Responses	1,447	1,288	1,912	2,005	1,805

Q9e
My immediate manager values my work



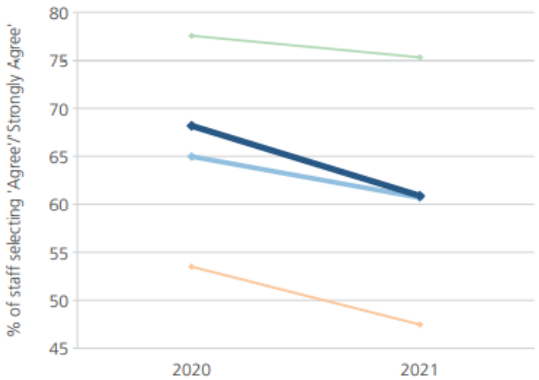
	2017	2018	2019	2020	2021
Best	77.3%	78.7%	80.1%	79.4%	78.9%
Your org	75.3%	74.4%	77.6%	73.3%	68.9%
Average	71.3%	71.6%	72.8%	71.7%	69.4%
Worst	62.8%	63.9%	60.3%	63.3%	62.3%
Responses	1,467	1,308	1,932	2,023	1,816

Q3d
I am able to make suggestions to improve the work of my team / department



	2017	2018	2019	2020	2021
Best	83.0%	83.7%	83.2%	81.6%	78.6%
Your org	79.6%	78.9%	78.8%	76.9%	72.1%
Average	74.8%	74.8%	74.5%	73.0%	69.8%
Worst	65.6%	67.0%	65.3%	64.7%	63.0%
Responses	1,493	1,334	1,948	2,041	1,851

Q21e
I feel safe to speak up about anything that concerns me in this organisation



	2020	2021
Best	77.6%	75.3%
Your org	68.2%	60.9%
Average	65.0%	60.7%
Worst	53.5%	47.5%
Responses	1,999	1,799

Desk top research

In recent years there have been increasing challenges for NHS providers such as undergraduate and post graduate education, future workforce, career and CPD, development pathways, national changes in education, and funding.

Though with these challenges, there are also opportunities. Innovation and new ways of getting our learning, due to technology changing the way education and training can be delivered and received, with eLearning, apps and simulators becoming even more of a key feature of improving the quality and cost of educating the workforce.

The majority of education and training currently provided is in academic or clinical settings, which are time consuming and costly. In a recent survey 92.6% of doctors and 53.2% of nurses found their smartphone to be 'very useful' or 'useful' in helping them to perform their clinical duties, while 89.6% of doctors and 67.1% of nurses owning medical apps were using these as part of their clinical practice. *(OUH – Oxford University Hospital)*

Investing in developing Technology Enabled Learning design capability within the learning and development team, alongside a dedicate person heading up eLearning, has enabled us to develop 'bite-size' education and learning, delivered across different platforms including mobile. Supporting this is a good Learning Management System (LMS) – one that is intuitive, with minimal clicks to reach what you need, so people find it easy to use which increases adoption and usage. *(UHD - University Hospitals Dorset)*

In 2020/21 Health Education England (HEE) stated that it would further develop its eLearning materials, including simulation and that from January 2021 several universities across England will start delivering a pre-registration blended learning nursing degree programme, commissioned by HEE. The programme aims to increase the appeal of a nursing career by widening access and providing a more flexible approach to learning, using current and emerging innovative and immersive technologies. As at today there have been 77+ million eLearning sessions launched on 'the hub' and 31+ thousand eLearning sessions available within 450+ programmes.

Research by the Kings Fund points to multi and interdisciplinary education, training, learning and development activities are proven to strengthen teamwork and communication; enhance understanding and improve patient outcomes. The correlation between effective teamwork and increased patient satisfaction and outcomes, with teams more effective and innovative because they routinely take time out to reflect upon their objectives, working practices, processes and environments, and make changes accordingly. In some areas this might be referred to as developing collaborative practice through which individuals from different disciplines work together to deliver the highest quality of care, which includes the engagement of professionals with any other person who contributes to delivering desired outcomes. This requires the adoption of learning and educational approaches which enable the development of working together with a common purpose, commitment and mutual respect.

Research also suggests that bringing people together to learn is a more effective use of resources, that it helps to remove occupational silo's, promotes a better understanding between individuals undertaking different roles and enhances team working.

In the 'Mind the Gap - Exploring the needs of early career nurses and midwives in the workplace' (2015) report, it highlighted if trusts are to appropriately support staff as they begin their professional careers, the need to consider the generational differences. Seven years on the 4 generational differences within the workforce are only getting broader.

The workplace now consists of four different generations working together - the ‘baby boomers’ (born between 1946 and 1964); ‘generation X’ (born between 1965 and 1979); ‘generation Y’ (born between 1980 and 1994) and ‘generation Z’ (born between 1995 and 2005), with each generational group having differences in values, expectations, perceptions and motivations, all relevant in terms of education and engagement.

Those earlier in their working lives typically have higher expectations for their work/life balance, but nevertheless are career minded. They need to see a clear pathway of progression, to be supported to achieve through personal development and they want a clear career framework, not just for linear promotion but to enable them to diversify within their profession.

In contrast generation Y employees (or ‘millennials’) who have high expectations of employment and are ‘digital natives’. They recognise that education and development are enablers that will help them achieve their ambition, and they expect employers to address these development needs. They attach great importance to employer-supported training, continuing personal and professional development (CPPD), career progression planning, mentorship and preceptorship.

Generation Y (or millennials) also look for real meaning, variation and self-fulfilment in their work, and want greater flexibility in the way in which they provide their services. Should these expectations and needs not be met, early career staff are likely to be more willing than their older colleagues to consider other options

Generation Z employees are highly self-directed digital multi-taskers who value personal freedom, and who will seek progressive and supportive work environments, who are likely to change jobs more than their more senior work colleagues.

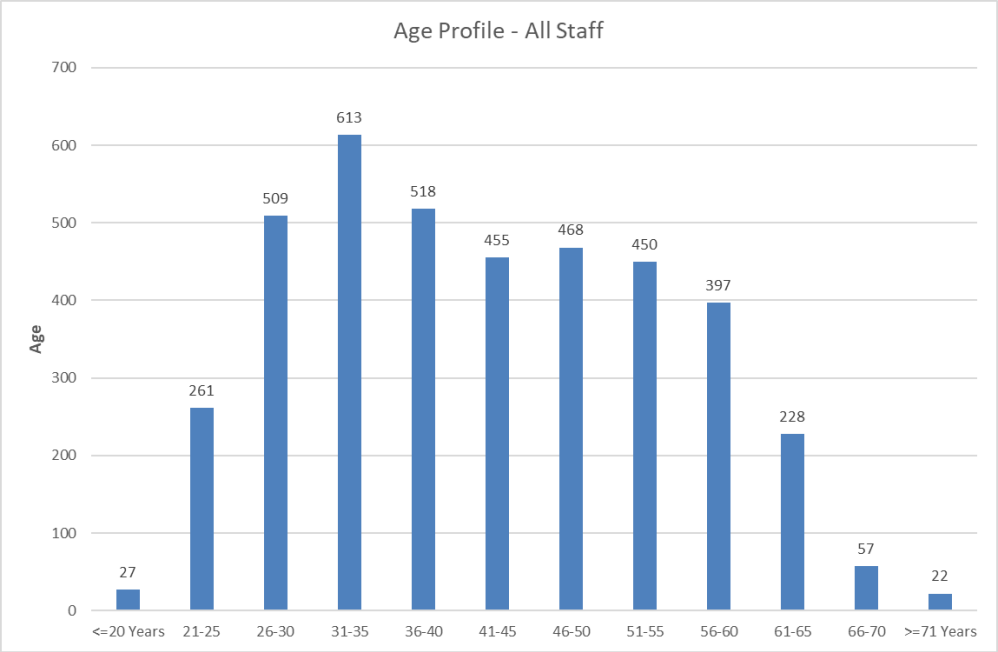
The ‘baby boomers’ of which are workforce is made up of 17.6% are known to be driven towards work; associate their work with their self-worth; loyal to their employers; competitive, goal-centric, and process-oriented and a disciplined as well as focused generation. Baby boomers also consist of one of the most significant learning populations in today’s world, which is because numerous baby boomers are retiring from their jobs and they are looking to learn and develop new skills.

The implications of these generational differences are multifaceted and impact our learning and education provision. We must recognise and respond to this through offering more choice, greater flexibility and better support, such as structured career development if we are to keep these employees engaged.

Employees who are aged 50 and over are the most engaged of any age group, so keeping them in the workforce supports greater productivity. And employers with a 10% higher share of older workers than the average see a 1.1% increase in productivity. By enabling workers to remain in employment longer or tempting them out of retirement there is an opportunity for them to add significant value from their knowledge, experience and approach to innovation.

19% of the workforce within the NHS are 55 and over and have a lot of skills and experience that is in danger of being lost. As part of the 2022/2023 Planning Guidance employers are being encouraged to have career conversations with staff that are mid-career (aged around 40 years) and those approaching retirement (aged 55 and over) to discuss their future, their aspirations, how to help with the transference of their knowledge and any specific things that they want to focus on, including returning from retirement.

SFT's demographics of your workforce are highlighted below, and show that 52%, of our workforce are aged 41 and over. However, we should not lose sight of the fact that 48.14% of our workforce are under the age of 40, who also have requirements from employees.



Since the pandemic there has been renewed interest in career within the NHS – the overall number of page visitors looking for information on training to be a nurse rose by 138% between March and June 2020, with a 103% increase in people seeking information on becoming a paramedic. This provides an opportunity to recruit directly into entry-level clinical roles, apprenticeships and non-clinical roles, refreshing talent pipelines. Between April 2021 and March 2022, the number of nurses, midwives and nursing associates grew by nearly 26,500 – an increase of 3.5%. However, from January 2021 to December 2021 22,500 Nurses and Midwifes left the profession, which is 2.97% of the Nursing and Midwifery population (Nursing & Midwifery Council figures).

There has also been an overwhelming response to the call to recently retired and former staff to join the COVID-19 response which suggests there is more to do to encourage previous members of staff to re-join the NHS. *(NHS England)*

A culture of learning is an essential factor in driving employee engagement - employees will stay at organisations where they feel there is great potential to learn. From a career standpoint and with the rules of work rapidly changing, constant learning leads to continued relevance – a win for both the employee and the business. In fact, companies with strong learning cultures are 92% more likely to innovate. *(Deloitte)*

The best organisations make learning an integral part of the employee lifecycle – that is, they offer a continuous experience starting on day one, with learning the hub at the centre of the employee experience, connecting to activities, such as on-boarding, daily work or career pathways, while also supporting critical compliance.

In today's increasingly digital workplace, the modern learner is self-directed, empowered, and wants to be able to access information customised to fit their needs, whenever they want – and learning should be seamlessly integrated in the journey, facilitated by a technology platform and its tools.

Salisbury
NHS Foundation Trust

Appendix 2 - ‘We are a team’

Team Plan (2022-2026)

(holding document)

Team working is key to embedding the People Promise at Salisbury NHS Foundation Trust. It underpins all of the pillars of our People Plan 2022-2026. It is also supported by our Improving Together Methodology.

Full plan to follow to include:

1. **Rationale**
2. **Approach**
3. **Ambitions**
4. **Activity**
5. **Outcomes**
6. **Metrics**

OD&P

Salisbury NHS Foundation Trust

5 year ambition, our purpose in OD&P and our priorities and their impact for 2022/3

August 2022

Slide deck contents:

- Introduction
- 5 year ambitions
- 2022 – 2023 Priorities, impact, measures and actions
- The People Promise
- 2022 – 2023 Gantt chart
- Appendices
  - ✓ Survey Indicators
  - ✓ Fishbone Diagrams
  - ✓ A3
  - ✓ Driver Diagrams
  - ✓ 2022/3 data
- Planning for 2023 – 2024

Our Purpose in OD&P is to make Salisbury NHS Foundation Trust

NHS Salisbury NHS Foundation Trust

"The best place to work"

This aligns to the Trust vision

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

Supports our Trust values

Person Centred & Safe
Our focus is on delivering high quality, safe and person focussed care through teamwork and continuous improvement.

Professional
We will be open and honest, efficient and act as role models for our teams and our communities.

Responsive
We will be action oriented, and respond positively to feedback.

Friendly
We will be welcoming to all, treat people with respect and dignity and value others as individuals.

Progressive
We will constantly seek to improve and transform the way we work, to ensure that our services respond to the changing needs of our communities.

Is reflected in the NHS People Plan and People Promise

Is underpinned by Our Leadership Way

And enabled by our trust-wide Improving Together methodology

Key Watch metrics

Making Salisbury NHS Foundation Trust "The best place to work"

Salisbury NHS Foundation Trust is an Exemplar Site for the People Promise. From Our Vision and Our Strategy, we have identified and agreed that delivery of the People Promise is a Strategic Objective under our Improving Together programme.

OD&P have three key watch metrics which are to:

1. Increase engagement, in particular recommending Salisbury NHS Foundation Trust as a place to work
2. Reduce turnover (in particular loss from the Trust and from the NHS)
3. Ensure we are an inclusive employer

Our priority and impact slides are written in the format of the National People Plan, with all activities targeted at delivering against these three strategic key watch metrics.

5 year ambitions

Our 5-year view of how we will deliver the People Plan at Salisbury NHS Foundation Trust

OD&P 5 Year ambitions

Making Salisbury NHS Foundation Trust "The best place to work"

Our 5-year ambitions for OD&P are as follows:

1. **Looking after our People:** We strive to actively look after ourselves and each other. Doing so will enable us to deliver outstanding care for our patients and an outstanding experience for our people.

2. **Improve Belonging in the NHS:** We continually listen to our people adapting our efforts to make the culture of our Trust universally understanding, kind and inclusive

3. **New Ways of Working and Delivering Care**: We will develop a culture where continuous improvement thrives and where enhanced people experiences lead to a positive impact on the design and delivery of care

4. **Growing for the Future:** We will have reduced turnover, creating a workplace that supports succession planning and career development opportunities

5-year Ambition 1: Looking after our People

Making Salisbury NHS Foundation Trust "The best place to work"

We strive to actively look after ourselves and each other. Doing so will enable us to deliver outstanding care for our patients and an outstanding experience for our people.

How is this rooted and reflected in the People Plan?

The People Promise describes what we would like to say about working in the NHS by 2024:

- **Creating a great employee experience**: we understand the diverse needs, expectations and experiences of our NHS people and use that insight to tailor our people services
- **Prioritising the health and wellbeing of all our people**: We take a positive and proactive approach in supporting the health, safety and wellbeing of our people ensuring that work has a positive impact.
- **We address health inequalities** at work and in our communities.

What will be different in 5 years' time if we are successful?

- I**ncreased engagement** in the annual NHS Staff Survey with a consistent response rate of over 50%
- **Increased recommendations** so that year on year 70% of people recommend Salisbury NHS Foundation Trust as a place to work
- **Equal opportunity** for all our people to progress within the organisation including those with protected characteristics so that all the pay bands are representative of the workforce.
- **Improved engagement at work**. An increasingly positive trend in the Staff Survey, returning to above average by 6% to 7% for motivation, by 2% to 5% for involvement and by 9-11% for advocacy
- **Reduced negative health and safety measures**. We will pay particular attention to people's experiences and indictors of burn out. We will aim to identify early feelings of stress and anxiety, ensuring we introduce, adapt and continually evaluate our interventions to reduce those concerns.
- **Increased flexibility.** We will support people to have a greater choice in where when and how they work in order to help achieve a better work life balance

What are the gaps we want to close or the shifts we want to make?

- We want to better understand what the **barriers and enablers are to offering more flexible working patterns** building an evidence base for change.
- To establish **the link between the business case** for flexible working and **increased engagement** and crucial skills retention
- We want people to feel they **can make choices to balance their personal life and career** aspirations, without it bringing stigma or negatively impacting their career development or financial decisions about when to retire
- We want people managers to be **empowered to explore conversations about wellbeing** and options around flexible working, and how to make it work.

5-year Ambition 2: Improve belonging in the NHS

Making Salisbury NHS Foundation Trust "The best place to work"

We continually listen to our people adapting our efforts to make the culture of our Trust universally understanding, kind and inclusive

How is this rooted and reflected in the People Plan?

The People Promise describes what we would like to say about working in the NHS by 2024:

- The NHS was established on **principles of social justice and equity**. These are captured in our NHS constitution and supported by our trust values of Patient Centred and Safe / Professional / Responsive / Friendly/ and Progressive . However the NHS Staff Survey results tell us that the treatment of our colleagues from minority groups falls short of these principles in some areas.
- The People Plan recognises a range of positive interventions are required to **increase fairness in people practices**, leadership diversity, increased understanding and acceptance of difference and building confidence to speak up

What will be different in 5 years' time if we are successful?

- People have **pride in their workplace**, their team and their own role
- We use expertise and influence to create an **inclusive culture** which values and celebrates our diversity.
- There is **greater diversity in management** and more senior roles
- **We listen to our people** and take action to ensure there is equity for everyone
- People will feel comfortable and safe **bringing their whole self to work**
- **Representative networks**
- **Social belonging** created by an inclusive and varied activity regular events calendar

What are the gaps we want to close or the shifts we want to make?

We will

- Continue to take **regular quarterly checks** on the lived experience of our people, listening to their experience and progressing actions which make a positive difference to their work experience
- Design, develop and host both **diverse network groups and development courses** which provide safe forums for feedback, exploration and personal growth with all staff groups reporting fairer treatment and a sense of **equality of opportunity**.
- Require all managers and leaders to attend both skill and behavioural training workshops building their personal sense of competence and demonstrating their successful application through continually improving results in **sense of team**, value of appraisals and the **embedding of a compassionate culture**.

5-year Ambition 3: New Ways of Working and Delivering Care

Making Salisbury NHS Foundation Trust "The best place to work"

We will develop a culture where continuous improvement thrives and where enhanced people experiences lead to a positive impact on the design and delivery of care

How is this rooted and reflected in the People Plan?

The People Promise describes what we would like to say about working in the NHS by 2024:

- Building on the new agility developed as our response to the Covid 19 pandemic, we work more quickly, with less bureaucracy, **empowering people and teams to do what they know is right** to ensure we continue to provide excellent care and to look after each other.
- Giving people **flexibility and a sense of opportunity** in their roles and to develop their career so that they continue to work in the trust whilst also having a positive impact on the way care is designed and given.
- Committing to the **Improving Together** methodology and the rigorous development of our coaching capability will create a culture where continuous improvement can thrive.

What will be different in 5 years' time if we are successful?

- See people **working and learning together in multi-disciplinary teams** actively designed around the full range of experience and capabilities of clinical and non-clinical colleagues
- Increased **range of new roles** being explored and used within the trust
- Increase **optimisation and participation of volunteers**, including integration into the workforce
- Ensure we return to the **regular training and development commitment** to our people by expanding our e-learning and acting with a renewed emphasis on recognising the importance of flexible skills and building capabilities
- **Learning is integrated** into every person's career and appraisal process

What are the gaps we want to close or the shifts we want to make?

- See a positive increase in the Staff Survey engagement results with people reporting
  - **increasing opportunities for development** and that they are able to explore new roles and career pathways
  - that the **value of their appraisal is improving**
  - and that there is an ongoing improving trajectory of people feeling **a true sense of team**.
- See a **reduction is patient complaints** alongside a **correlation to increased training**, learning, and experimentation with new roles or patient outcomes by our people.

5-year Ambition 4: Growing for the future

Making Salisbury NHS Foundation Trust "The best place to work"

We will have reduced turnover, creating a workplace that supports succession planning and career development opportunities

How is this rooted and reflected in the People Plan?

The People Promise describes what we would like to say about working in the NHS by 2024:

- We are seeing **an increase in enquiries and renewed interest** to join the NHS workforce
- We have **unprecedented demand for training places**, are expanding our placement capacity and activity to support a wide range of students, trainees and learners
- People are **staying for longer and continually developing** professionally and enjoying flexible and varied roles and career paths
- We attract **amazing new starters every month** who come because of our positive reputation for providing rewarding careers and our specialist services
- We increase our **international recruitment programme**, our **apprenticeship offer** and our support for people to **return to practice**
- We **build loyalty** and skills so that people feel they can **thrive within their teams** for the benefit of patients

What will be different in 5 years' time if we are successful?

- An integrated and dynamic **workforce which meets the needs of a changing population** and workforce needs. Workforce planning responsibilities and outputs at organisational, system, regional and national levels are clear.
- We will have a **reputation for being an employer of choice** that maximises talent and recognises potential
- The system is **retaining, recruiting and, where required, growing** its workforce to meet future need. The 'one workforce' across the Integrated Care System is representative of the local communities served
- **Education and training opportunities** are fit for the needs of current and future people and services

What are the gaps we want to close or the shifts we want to make?

- Develop and deliver a proactive **widening participation agenda** including apprenticeship schemes and a visible pipeline of talent to build resilience into staffing levels.
- **Grow our international recruitment** with expansion across wider staff groups, attracting into our hard to recruit spots such a radiology/ specialist consultant roles, complemented by a proactive medical assistance and trust induction programme.
- **Growing our domestic recruitment**, seeing a gradual increase in enquires from school leavers for clinical placements; more people actively exploring return to practice; and a well-advertised and high take up of the offer to retire and return
- **Turnover stabilises at around 10%.** Over 85% of people choose to stay after their first year, increasing stability. The Staff Survey shows an increase to over 53% of people feeling that there is opportunity to develop their career within the organisation. .

2022 to 2023

Our priorities, impacts, actions and measures to be achieved during 2022 to 2023

Ambition 1 Looking after our People

2022/2023 Priorities

We strive to actively look after ourselves and each other. Doing so will enable us to deliver outstanding care for our patients and an outstanding experience for our people

Priorities and impact 2022/23
1. Looking after our People

NHS Salisbury NHS Foundation Trust

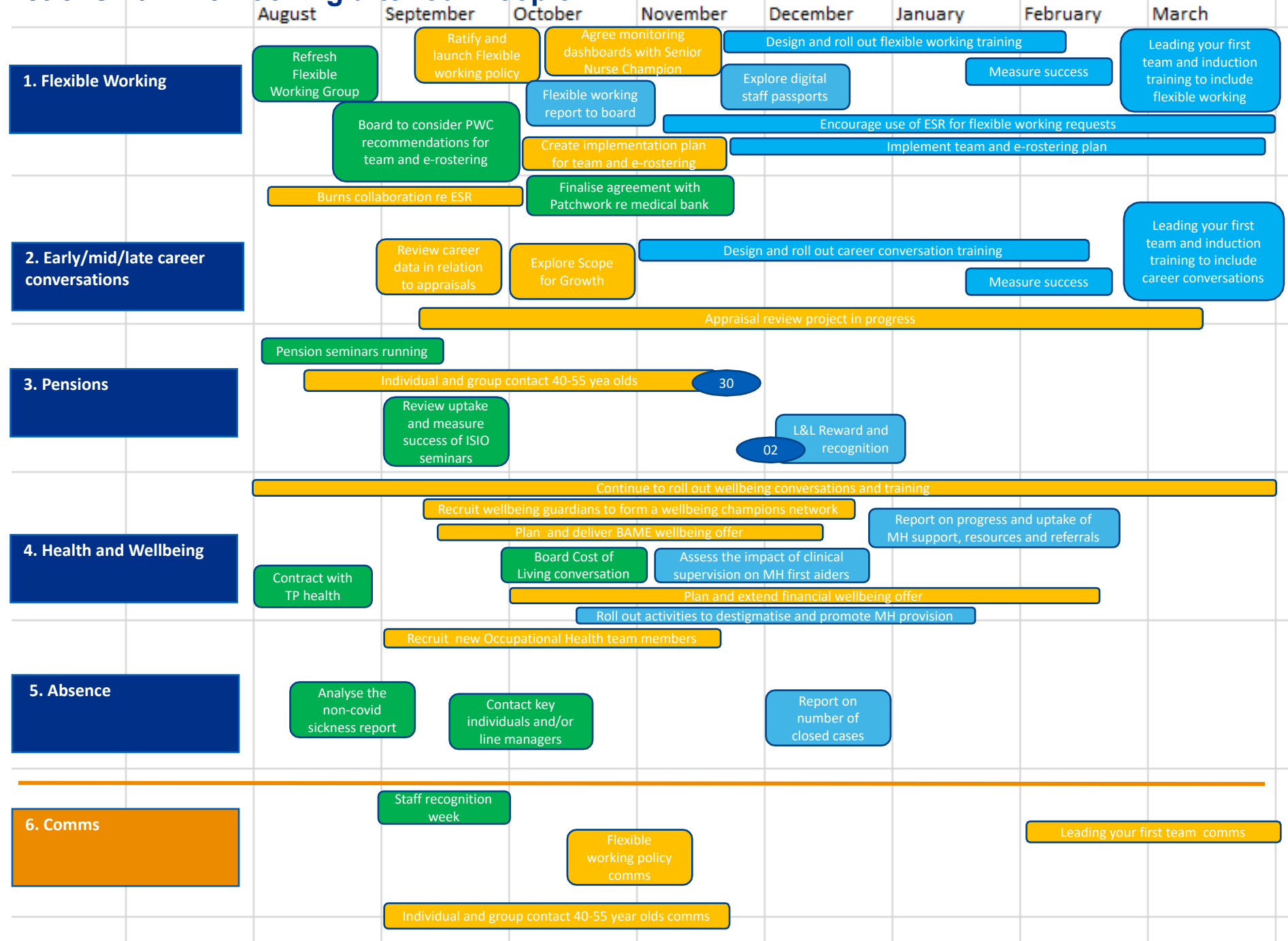
Ambition	Priority	Expected impact. People will feel that….	Actions
We strive to actively look after ourselves and each other. Doing so will enable us to deliver outstanding care for our patients and an outstanding experience for our people	1. **Flexible Working:** Improve retention through a focus on flexible working (Mark)	• They can balance their home and work life more effectively • They can make requests more easily and have them considered appropriately • They want to stay longer	1. Ratification and launch of the policy 2. Repeated communication of trust position on flexible working 3. Train line managers on flexible working as part of Leading your First Team 4. Use ESR to request flexible working 5. Team based rostering
	2. Early/mid/late career conversations Improve retention through a focus on career conversations (Mark & Business Partners)	• They are enabled to develop their career path and identify new or alternative and complimentary career pathways at the trust • They can explain opportunities within the trust to others interested in joining	1. Define policy, process and trigger points 2. Design training for managers and include as integral part of appraisal process 3. Report progress and uptake 4. Measure success and improve process
	3. **Pensions:** Improve retention through a focus on enabling people to understand their pensions (Melanie W)	• They are in better control of their finances • They understand and can tell others about the benefits of the NHS pension • They know the impact of the decisions they make when considering reducing hours or retiring and returning	1. Run a series of pension workshops 2. Report progress and uptake 3. Measure success 4. Embed into organisation's processes
	4**. Health and Wellbeing** Support people through health and wellbeing interventions (Venetia, Melanie W, Kate J)	• Managers are confident in delivering wellbeing conversations and that they recognise how critical they are to the team and patient care • There is less stigma surrounding Mental Health and that they are able to remain healthy at work • They can advocate for the organisation as taking positive action in relation to their financial wellbeing	1. Roll out wellbeing conversations 2. Continue to provide mental health support, resources and referrals 3. Initiate and extend the financial wellbeing offer 4. Launch a dedicated Health and Wellbeing website 5. 200 wellbeing champions to be recruited over next 2 years
	5. Absence: Address the root cause of non-covid related sickness and support return to work (Petrina H)	• Their own and colleagues sickness absences are legitimate • It is recognised that using holiday absence as additional leave is not acceptable	1. Analyse the non-covid related sickness report 2. Identify themes and key individuals 3. Contact individuals and/or line managers 4. Close cases as quickly as possible

Measuring our impact
1. Looking after our People

NHS Salisbury NHS Foundation Trust

Priority	Measures & data	Insights
1. **Flexible Working:**	1. Number of managers trained on flexible working (tba) 2. Number of requests for flexible working through ESR (tba) 3. Number of flexible working requests supported (tba) Survey questions: • Organisation is committed to helping balance work and home life • Achieve a good balance between work and home life • Can approach immediate manager to talk openly about flexible working • Satisfied with opportunities for flexible working patterns	• Leading first team programme to be launched in March so no data available yet • Requests and support for flexible working to be captured via revised ESR appraisal process
2. Early/mid/late career conversations	1. Number of managers trained on enabling career conversations (tba) 2. Number of completed career conversations noted on ESR (tba) 3. Number of people applying for posts following a career conversation (tba) **4. 207 internal promotions** were made (in 12 months – to Aug 2022) Survey questions: • Organisation acts fairly: career progression • There are opportunities for me to develop my career in this organisation • Have opportunities to improve my knowledge and skills • Feel supported to develop my potential	• Training for career conversations, number of career conversations noted and applications received following career conversations to be captured via revised ESR appraisal process
3. **Pensions:**	**1. 927 places** booked on the ISIO **pension workshops** **2. 49 people retired and returned** in 2021/22 (42% of total retirees)	• The number of retire and returners to SFT is high compared to the national average
4. Health and Wellbeing	1. Number of managers trained to deliver wellbeing conversations (tba) **2. 5 wellbeing conversations** recorded on ESR 3. Number of referrals to mental health and psychology service (tba) 4. Number of people taking up financial wellbeing offers (tba) Survey questions: • Organisation takes positive action on health and well-being • Not felt pressure from manager to come to work when not feeling well enough • Not experienced harassment, bullying or abuse from managers • Immediate manager listens to challenges I face	• Significant roll out is planned for Wellbeing Conversations. Currently 40 conversations have been held with only 5 recorded on ESR to date • Financial wellbeing offers yet to begin
5. Absence:	**1. 7,759 absences** recorded in last 12 months 2. Breakdown for the reasons for absence by gender, race, job role, directorate and level (see appendix) **3. 3037 staff were off sick** in 2021/22 and **1917 had two or more episodes** Survey questions: • In last 12 months, have not experienced MSK problems as a result of work activities • In last 3 months, have not come to work when not feeling well enough to perform duties • Never/rarely exhausted by the thought of another day/shift at work	

Actions 2022/23 Looking after our People



Ambition 2 Improve belonging in the NHS

2022/2023 Priorities

We continually listen to our people adapting our efforts to make the culture of our Trust universally understanding, kind and inclusive

Priorities and impact 2022/23

2. Improve belonging in the NHS

NHS Salisbury NHS Foundation Trust

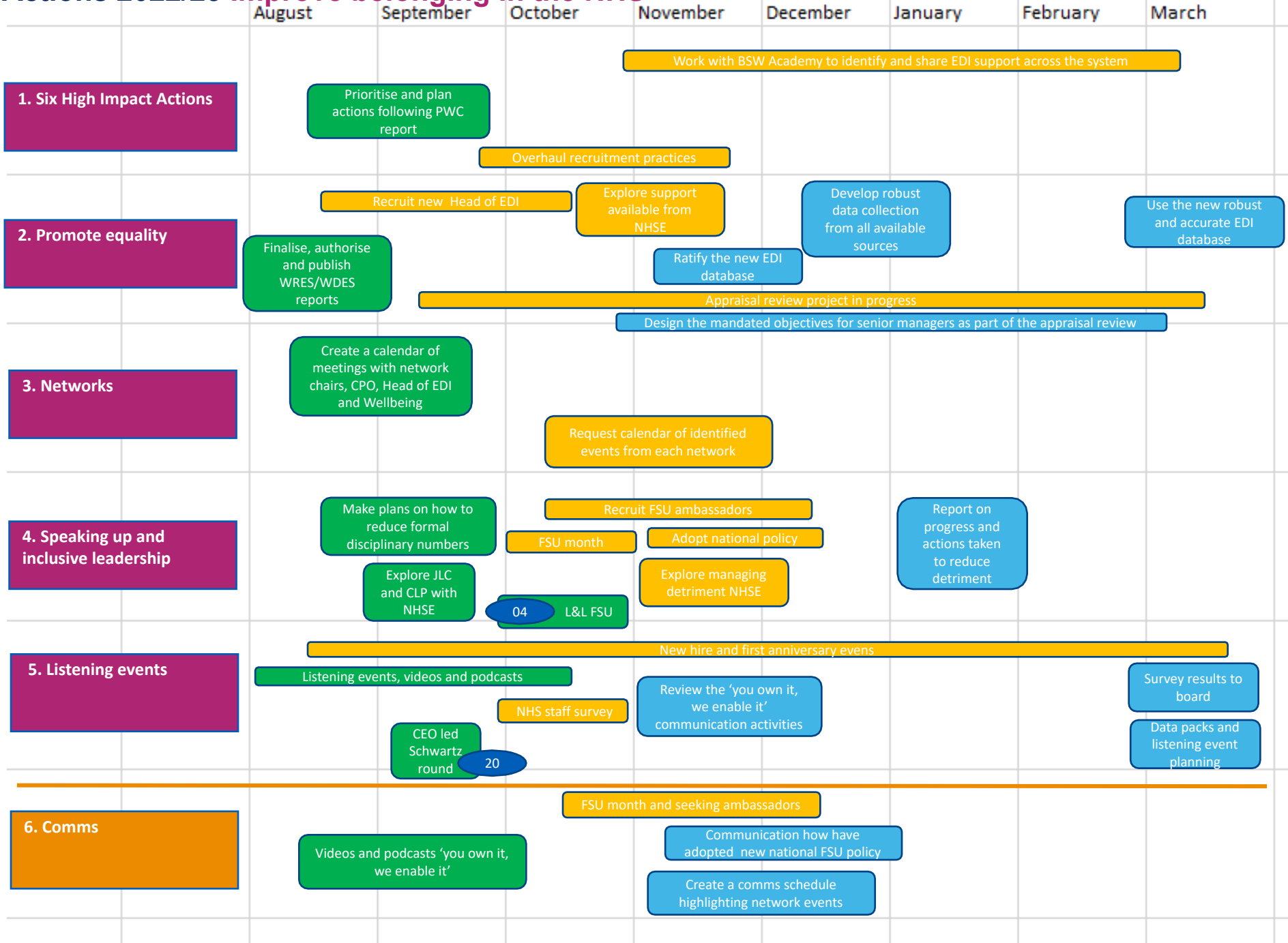
Ambition	Priority	Expected impact. People will feel that….	Actions
We continually listen to our people adapting our efforts to make the culture of our Trust universally understanding, kind and inclusive	1. **Six high impact actions:** Improve the Black Asian and minority ethic disparity ratio and overhauling recruitment and promotion practices including training in how to apply to jobs (tba & Sharon)	• The recruitment process is efficient, fair and inclusive • They have a greater sense of belonging • A diverse workforce will be recruited to the trust • There is a fair and inclusive progression through the pay bands	1. Action PWC recommendations to support delivery against the six-point plan 2. Work with the BSW academy to identify and share EDI support across the system 3. Continue to improve induction and welcome process 4. Design and develop an ESOL friendly training for filling in job applications as part of Leading Your First Team
	2. Promote equality: Implement plans to promote equality across all protected characteristics (tba)	• They are more included meaning they are less likely to leave because of discrimination • They have the same access to promotion across the trust • The leadership of the organisation is reflective of a diverse workforce	1. Ensure that a revised appraisal process includes objectives related to diversity as laid out in the model employer guidance 2. Develop a robust and accurate database for EDI 3. Develop robust data from all available sources 4. Develop a fully representative calendar of events and celebrations
	3. **Networks:** Scope what is needed and reinvigorate the staff networks (tba)	• They are valued and listened to • They can find and join networks that resonate for them if they wish to • They are engaged and energised by the positive action that is taking place across the trust	1. Regular meetings of leads, CPO and Head of Diversity, Inclusion and Wellbeing 2. Leads to identify and create a programme of activity for 2022/3 3. Comms team support and promote the activities programme
	4. Speaking up and inclusive leadership Encourage a culture that is inclusive (Ian / Venetia / Lizzie)	• Able to identify and learn from mistakes more effectively • The organisation culture is one of learning not blame, where their voice counts • They can resolve issues earlier and in a supported way	1. Increase Training for Freedom to Speak up by giving line manager Level 2 training as well as level 1 2. Encourage speaking up instead of fostering a blame culture
	5. Listening events Implement listening events and feedback loops to regularly collect people's views (Melanie and BPs)	• Their voice counts • They can easily identify where feedback has led to improvements	1. New hires and first anniversary 2. Staff Survey workshops for divisions 3. Communication activities to highlight 'you own it, we enable it' 4. Create accessible feedback process and inclusive trust comms

Measuring our impact

2. Improve belonging in the NHS

Priority	Measures	Insights
1. **Six high impact actions**	1. The number of BAME applying to posts (internal and external) **SH** 2. Take up of ESOL friendly training in how to complete job applications **VF** 3. The number of BAME successful applications **SH** 4. WRES and DES and EDI data Survey questions: • There are opportunities for me to develop my career in this organisation • Have opportunities to improve my knowledge and skills • Organisation acts fairly: career progression	207 people were promoted in last 12 months, no data on % of BAME Leading first team programme, including completing applications, to be launched in March so no data available yet
2. Promote equality	1. The WRES and WDES data for the trust **2. 4139 people (92% of staff) undertook diversity and inclusion training** in 2021/22 3. The number of people from a minority group accessing training and development opportunities (tba) 4. Use training tools to assess the accessibility and inclusivity of training interventions Survey questions: • Feel organisation respects individual differences • Not experienced discrimination from manager/team leader or other colleagues • Not experienced harassment, bullying or abuse from managers	Data on minority groups accessing training and development is not currently collected – need to consider best way to do this
3. **Networks**	1. That each network has a chair 2. The number of network members 3. The number of network events a year, leading to a raised profile of the network Survey questions • Colleagues are polite and treat each other with respect • Satisfied with extent organisation values my work • Receive the respect I deserve from my colleagues at work	
4. Speaking up and inclusive leadership	1. The number of people doing the FSU training level 2 2. The Freedom to Speak up board report data 3. Percentages of staff going through leadership and improving together training programmes Survey questions • Feel safe to speak up about anything that concerns me in this organisation • Feel organisation would address any concerns I raised	
5. Listening events	1. The number of listening events held and number of people attending **2. 510 of 658 joiners remained in post** for over a year 3. The number of communication activities highlighting 'you own it, we enabled it' Survey questions • Would feel secure raising concerns about unsafe clinical practice • Would feel confident that organisation would address concerns about unsafe clinical practice • Satisfied with recognition for good work • Satisfied with extent organisation values my work	

Actions 2022/23 Improve belonging in the NHS



Ambition 3 New Ways of Working and Delivering Care

2022/2023 Priorities

We will develop a culture where continuous improvement thrives and where enhanced people experiences lead to a positive impact on the design and delivery of care

Priorities and impact 2022/23:
3. New ways of working and delivering care

NHS Salisbury NHS Foundation Trust

Ambition

We will develop a culture where continuous improvement thrives and where enhanced people experiences lead to a positive impact on the design and delivery of care

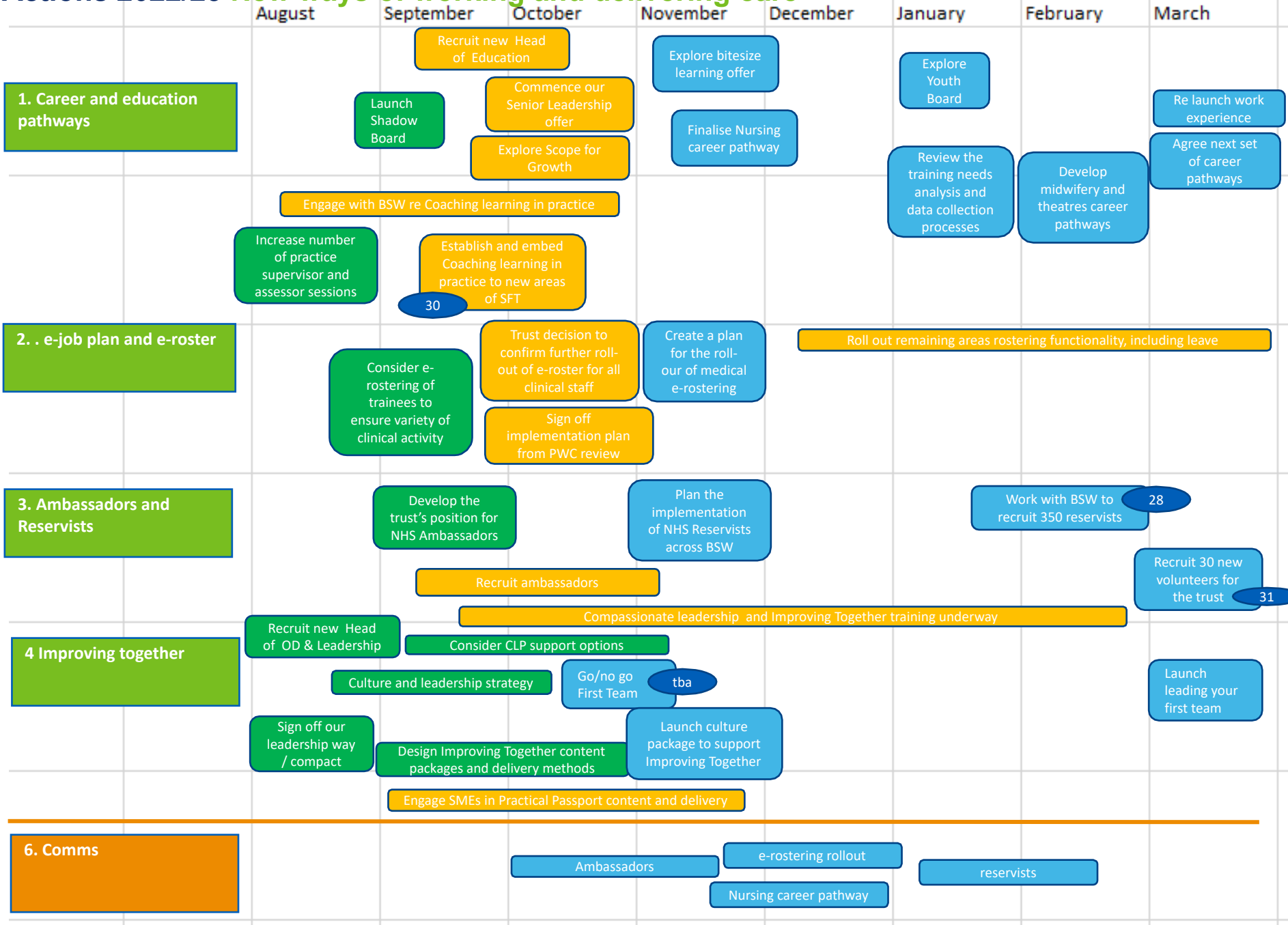
Priority	Expected impact. People will feel that….	Actions
1. **Career and education pathways:** Increase awareness about the potential career pathways in the organisation (Venetia)	• They have varied career progression options leading to better retention as they don't have to seek work elsewhere to access the role they want • Funding is being used more effectively to run services and fill vacancies differently, rather than through agency use	1. Review the training needs analysis and data collection processes 2. Develop and communicate career and education pathways for Nursing, Midwifery and Theatres 3. Plan to expand to other occupations
2. **e-job plan & e-roster:** Ensure highest level of attainment set out by the meaningful use standards to optimise capacity of workforce (Daniel and Clare)	• They have full visibility of their working shifts • They are able to request their annual leave remotely and have full visibility of entitlement and episodes • The system software is used to full potential and enables benchmarking and KPI compliance internally and against other trusts	1. Progress levels of attainment across all workforce groups 2. Create a plan for the roll out of medical e-rostering 3. Roll out remaining areas trust-wide to full rostering – approx. 1250 staff 4. Building on the success of the pilot, roll out team based rostering to further clinical ward areas 5. Rostering KPI compliance reports to be regularly reviewed at Safe Staffing Group
3. Ambassadors and Reservists: Establish NHS ambassadors and Reservists (Venetia and Sharon)	• The NHS and the trust support the local community by offering education and employment opportunities • The trust is proactively working with regional colleagues on a nationally recognised scheme	1. Develop the trust's position and plans for NHS Ambassadors 2. Lead the implementation of NHS Reservists across BSW
4. Improving together: Culture change to support improving together (Venetia)	• They can thrive and be confident in supporting their teams to embed new ways of working • They are supported and encouraged to improve ways of working through continuous improvement and coaching	1. Finalise programme content: improving together, coaching, team dynamics & change 2. Create a plan for further interventions and design delivery that can flex to mee the challenging context of clinical areas

Measuring our impact
3. New ways of working and delivering care

Salisbury NHS Foundation Trust

Priority	Measures & data	Insights
1. **Career and education pathways**	1. The number of professions that have articulated career pathways **2. 2,026 people received appraisals** (69%) 3. The number of people recommended for training and development opportunities in their appraisals 4. The number of training opportunities accessed Survey questions: • Able to access the right learning and development opportunities when I need to • There are opportunities for me to develop my career in this organisation • Have opportunities to improve my knowledge and skills • Feel supported to develop my potential	
2. **e-job plan & e-roster**	1. The number of jobs planned through e-job plan (tba) **2. 2373 people** are fully rostering **3. 1251 people** are only recording leave in e-roster Survey questions: • Enough staff at organisation to do my job properly • Team members understand each other's roles • Not feel pressure from manager to come to work when not feeling well enough	• Team based rostering has been tested successfully in two areas as part of the flex group work. The results were shared nationally and further a roll out is to follow. • The 1251 AfC staff managing annual leave via Healthroster will be on the roll out plan to fully roster • All SFT staff (including medics) manage sickness absence in Healthroster
3. Ambassadors and Reservists	1. The number of NHS ambassadors (tba) 2. The number of organisations in BSW supporting NHS Reservists (tba) 3. The number of NHS reservists in SFT (tba) 4. The number of NHS reservists in BSW (tba) Survey questions: • Would recommend organisation as place to work • I am not planning on leaving this organisation • Feel supported to develop my potential	• Ambassadors work is in early stages so data not yet available • Planning for Reservists not yet completed so data not yet available
4. Improving together	1. The number of Improving Together coaches trained (tba) 2. Number of individuals attending training to support Improving Together (tba) Survey questions: • Able to make suggestions to improve the work of my team/dept • Involved in deciding changes that affect work • Able to make improvements happen in my area of work • Team members often meet to discuss the team's effectiveness	• Roll out of Improving Together is in early stages so number trained is likely to be small. This may also impact on the survey responses in October 2022 but should improve by October 2023 as more people are involved in the programme.

Actions 2022/23 New ways of working and delivering care



Ambition 4 Growing for the future

2022/2023 Priorities

We will have reduced turnover, creating a workplace that supports succession planning and career development opportunities

Priorities and impact 2022/23 :
4. Growing for the future

NHS Salisbury NHS Foundation Trust

Ambition

We will have reduced turnover, creating a workplace that supports succession planning and career development opportunities

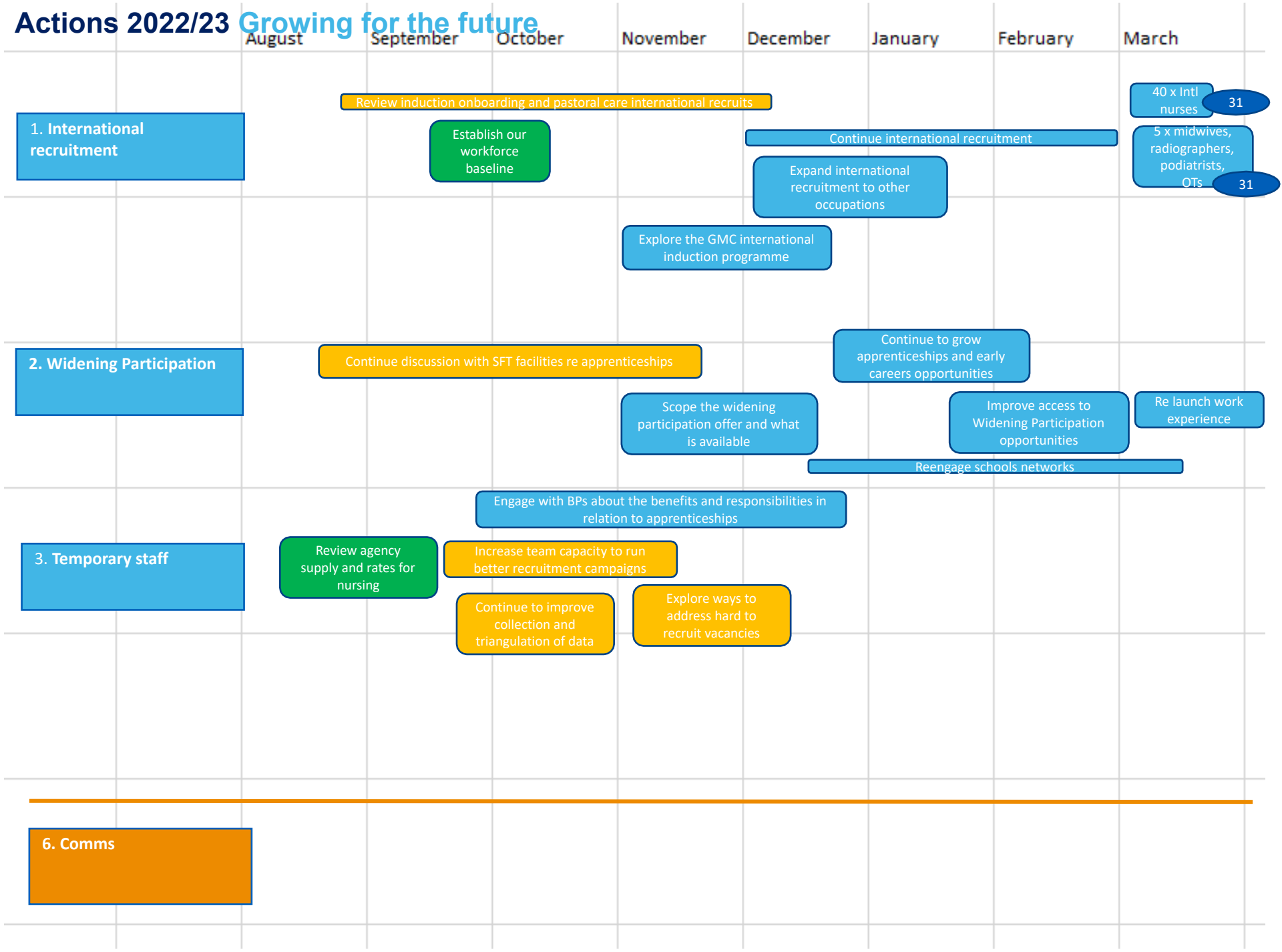
Priority	Expected impact. People will feel that….	Actions
1. **International recruitment:** Expand ethical international recruitment of high quality nurses and midwives (Sharon)	• There is a reduction in spend on temporary staffing • There is more resource in post • They are welcomed and given the best start possible to their career in the UK • They want to stay and make Salisbury home	1. Establish our workforce baseline 2. Continue to recruit international nurses 3. Expand international recruitment to include midwives, radiographers, podiatrist and occupational therapists 4. Improve the on-boarding and pastoral care of international recruits
2. Widening Participation Widen participation and create training and employment opportunities including apprenticeships as a point of entry (Venetia)	• There are opportunities for employment as a result of improved engagement with the community that highlights what is available • Routes into careers for local young and/or disadvantaged people have been improved	1. Scope current offer and what is available 2. Re-engage with schools network 3. Deliver the NHS ambassadors programme 4. Continue to grow apprenticeships and other early careers opportunities
3. **Temporary staff:** Reduce reliance on high cost agency staff and expanding collaborative system banks to make best use of temporary staff (Sharon & Henry)	• There is a sense of improved wellbeing for existing people as they are better supported by bank fill • They can deliver better quality care due to better agency and bank fill • They are reassured that funding is being spent appropriately on agency spend • There is an improvement in the rate from conversions to hire	1. Review agency supply and rates for nursing 2. Continue to improve the collection and triangulation of data and spend through the workforce control panel and full roll out of e-roster 3. Increase team capacity to enable better run recruitment campaigns for all roles

Measuring our impact
4. Growing for the future

NHS Salisbury NHS Foundation Trust

Priority	Measures & data	Insights
1. **International recruitment**	1. Number of new international nurses (tba) 2. Number of new international midwives, radiographers, podiatrist and occupational therapists (tba) **3. 180 international staff have 5+ years service** (as at 31 March 2022) 4. Number of people taking part in induction programme for medical graduates and international-recruits (tba) Survey questions • Organisation acts fairly: career progression • Feel organisation respects individual differences • There are opportunities for me to develop my career in this organisation • Feel supported to develop my potential • Have opportunities to improve my knowledge and skills	
2. Widening Participation	1. Number of schools and colleges engaged with **VF** **2. 32** occupations in the trust are using the apprenticeship scheme with **140** 'live' apprenticeships currently 3. Number people on early career programmes (tba) 4. Currently one new starter has joined the trust as an apprentice Survey questions • Would recommend organisation as a place to work • Able to access the right learning and development opportunities when I need to • There are opportunities to develop my career in this organisation	• Currently apprenticeships are primarily being used for internal career progression rather than for attracting new staff • A handful of apprenticeships are on hold (including the new starter)
3. **Temporary staff**	1. Number of active bank staff (tba) **2. 40% of shifts** requested are **not filled** **3. 50%** of filled shifts use **bank and agency** staff **4. £21,574,502 was our temporary workforce spend** in 2021/22 5. Reduction in vacancy gap (tba) Survey questions • Enough staff at organisation to do my job properly • Teams within organisation work well together to achieve objectives • Satisfied with the extent organisation values my work	

Actions 2022/23 Growing for the future



The People Promise

An overview of our role as an exemplar site

People Promise

This is a promise we must all make to each other – to work together to improve the experience of working in the NHS for everyone.

For many, some parts of the Promise will already match their current experience.

For others, it may still feel out of reach.

We must all pledge to work together to make these ambitions a reality for all of us, within the next four years.

Exemplars

Salisbury NHS Foundation Trust is one of 23 NHS England and NHS Improvement People Promise Exemplar sites in England. We are working together towards this purpose:

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.**

Other Exemplars in our region are: Royal Cornwall Hospitals NHS Trust and Somerset NHS Foundation Trust

Support from NHSEI

- Support us to assess and benchmark our current position
- Help us to identify the steps needed to reach optimum delivery
- Evaluate our outcomes at organisation and system level
- Measure the impacts across all the exemplars
- Give access to resources, data and support from the national and regional teams
- Prepare shared learning to inform potential roll-out to other organisations

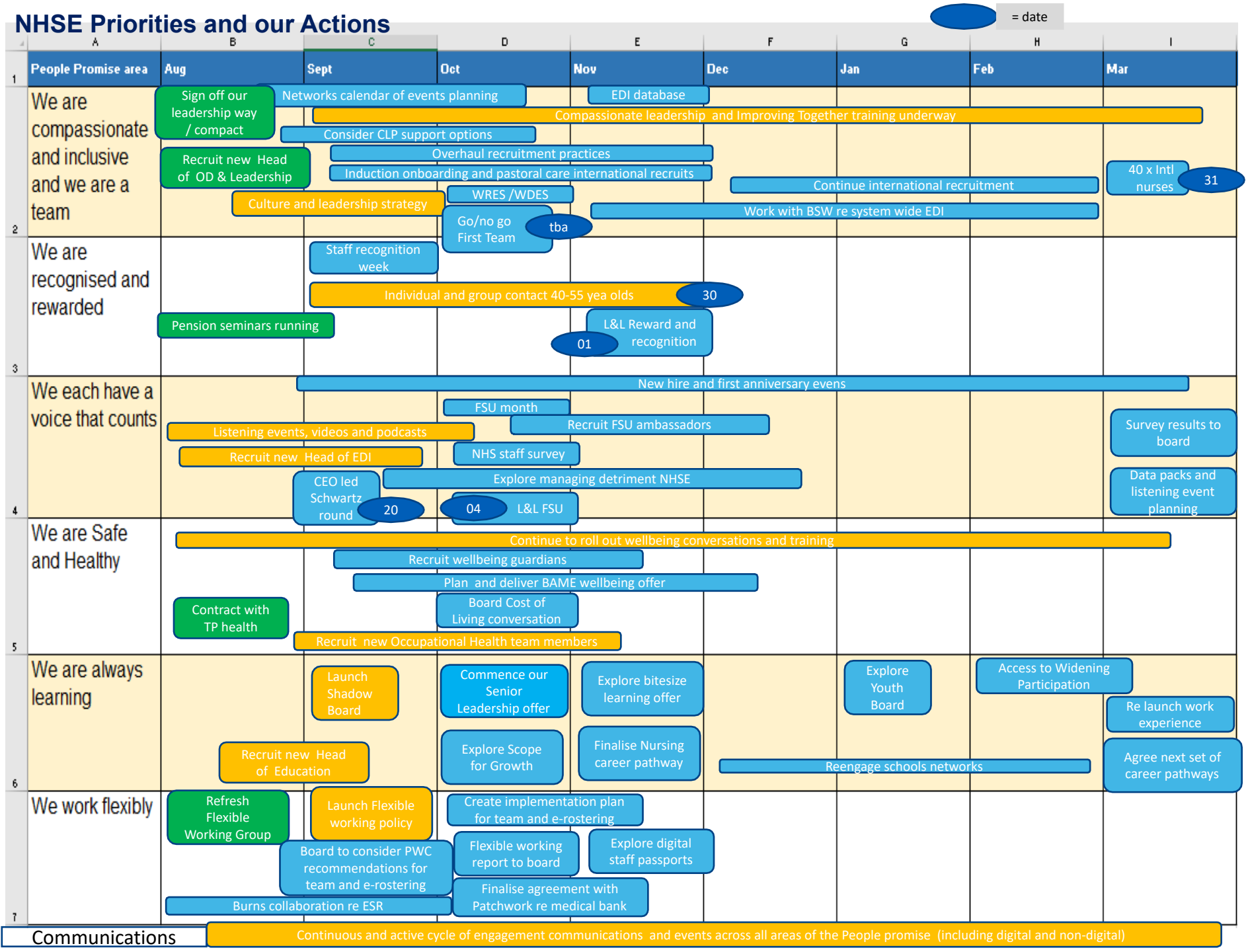
The People Promise – NHSE support offers

NHS Salisbury NHS Foundation Trust

People Promise priority areas for Exemplar sites

	We are compassionate and inclusive		We are recognised and rewarded – Angie Walsh	We each have a voice that counts		We are Safe & healthy – Steve Lee	We are always learning - Caroline Chipperfield / Carolyn May	We work flexibly	
	Culture Transformation - Katy Steward	EDI - Anton Emmanuel		FTSU - Tom Grimes	Employee Engagement – Zoe Evans			Flexible working - Jane Galloway	Enabling Staff movement – Daniel Elkins
1	Implement the Culture Leadership Programme (CLP)	Use of Workforce Race Equality Standard (WRES) and Workforce Disability Equality Standard (WDES) data to set bespoke ambitious targets for improvement, which reflect the specific issues in the organisation that require attention.	Roll-out pensions awareness seminars on the basics and bust myths about how the NHS Pension Scheme works	FTSU Guardian is appointed via an open recruitment process, with sufficient ring fenced time (at least 0.6WTE) to carry out all aspects of their NGO's universal job description and associated activities	Focus on understanding and improving Employee Engagement as a leading indicator of performance, putting it alongside other key measures of performance throughout the organisation to embed the People Promise, using Model Health System data to monitor trends and progress. .	Wellbeing Guardians are appointed and playing an active role as an integral part of the strategic agenda to establish a preventive approach to Health and Wellbeing (HWB) within the organisational culture	Leaders adopt and reflect the behaviours articulated in the NHS Leadership Way	Evidence of communicating and adopting the flexible working policy changes recently introduced in the NHS Terms & Conditions.	Establish workforce sharing agreements as par Enabling Staff Movements toolkit and sign up to the Trusted Frameworks for staff movements.
2	Line managers access a mentoring program so the organisation builds capacity to listen inclusively to diverse voices	Focus on the 6 high impact actions to promote inclusive recruitment and promotion practices to advance BAME representation at every level of the organisation.	Offer 1:1 and group seminars to staff groups affected by pensions tax on pensions and flexible retirement	Adopt the updated national speak up policy and ensure it's openly advertised and promoted to, and by, line managers so that it's accessible to all workers and they know who their Guardian is.	Establish a local listening strategy, maximising national tools, aligned to the different purpose of each tool e.g.: NHS Staff Survey, National Quarterly Pulse Survey and Monthly People Pulse	Ensure HWB conversations take place routinely for all staff, and that line managers and teams have the skills and tools they need to take ownership of health and wellbeing	Leaders access and complete new bitesize learning resources from the NHS Leadership Academy	A minimum of 25% of permanent roles are advertised with clear flexible working options outlined.	Link Occupational Health and Learning Management interfaces with ESR, in preparation for Digital Staff Passports.
3	Develop leadership strategy from the findings on the use of CLP tools that is signed-off by the Board.	Roll-out an induction programme (disseminated via GMC) for international medical graduates and international-recruited staff to increase belonging in the NHS.	Adopt good practice guidance from NHS Employers and other sectors on mitigating the risk of pension tax and flexible working	Review Trust FTSU arrangements against the revised FTSU Guidance and develop / implement an improvement action as appropriate.	Improve team effectiveness as a key lever to improve employee experience and build organisational, team and individual resilience and wellbeing through the TED tool developed by Lancashire Teaching Hospitals.	Strengthen and support Occupational Health to fulfil their role as a clinical service and source of insight and expertise within the wider preventive approach to HWB	Roll out Scope for Growth model for 8C level and above as part of a career conversation for line managers with their direct reports, and agree a development plan	Efficient use of e-rostering with an audit of the level to which team rostering are used to facilitate flexible working. Use of a dashboard or workforce report that enables the board to monitor progress against defined flexible working metrics, with an identified Snr Nurse Champion	Adopt and issue Digital Staff Passports for Doctors in Training and Temporary Staff Movements

NHSE Priorities and our Actions



Appendices

Additional information and resources

Survey Indicators

The responses from the NHS survey provide indicators that can be used to assess our progress towards our 5-year ambitions

Looking after our people - Survey Indicators

Your job

- Organisation is committed to helping balance work and home life
- Achieve a good balance between work and home life
- Can approach immediate manager to talk openly about flexible working
- Satisfied with opportunities for flexible working patterns

Your health, well-being and safety at work

- Don't work any additional paid hours per week for this organisation, over and above contracted hours
- Don't work any additional unpaid hours per week for this organisation, over and above contracted hours
- Organisation takes positive action on health and well-being
- In last 12 months, have not experienced musculoskeletal (MSK) problems as a result of work activities
- In last 3 months, have not come to work when not feeling well enough to perform duties
- Not felt pressure from manager to come to work when not feeling well enough
- Never/rarely find work emotionally exhausting
- Never/rarely exhausted by the thought of another day/shift at work
- Never/rarely worn out at the end of work
- Never/rarely feel every working hour is tiring
- Never/rarely lack energy for family and friends
- Not experienced physical violence from patients/service users, their relatives or other members of the public
- Not experienced physical violence from managers
- Not experienced physical violence from other colleagues
- Last experience of physical violence reported
- Not experienced harassment, bullying or abuse from patients/service users, their relatives or members of the public
- Not experienced harassment, bullying or abuse from managers
- Not experienced harassment, bullying or abuse from other colleagues
- Last experience of harassment/bullying/abuse reported
- Organisation acts fairly: career progression

We strive to actively look after ourselves and each other. Doing so will enable us to deliver outstanding care for our patients and an outstanding experience for our people

Improve belonging - Survey Indicators

Your job
- Satisfied with recognition for good work
- Satisfied with extent organisation values my work

Your team
- Receive the respect I deserve from my colleagues at work
- Team deals with disagreements constructively
- Feel valued by my team

People in your organisation
- Colleagues are polite and treat each other with respect

Your managers
- Immediate manager works with me to understand problems
- Immediate manager listens to challenges I face
- Immediate manager cares about my concerns
- Immediate manager helps me with problems I face

Your health, well-being and safety at work
- Not experienced physical violence from other colleagues
- Not experienced harassment, bullying or abuse from other colleagues
- Not experienced discrimination from manager/team leader or other colleagues
- Would feel secure raising concerns about unsafe clinical practice
- Would feel confident that organisation would address concerns about unsafe clinical practice
- Feel organisation respects individual differences

Your personal development
- There are opportunities for me to develop my career in this organisation
- Have opportunities to improve my knowledge and skills
- Feel supported to develop my potential

Your organisation
- Feel safe to speak up about anything that concerns me in this organisation
- Feel organisation would address any concerns I raised

Background information
- Disability: organisation made adequate adjustment(s) to enable me to carry out work

We continually listen to our people adapting our efforts to make the culture of our Trust universally understanding, kind and inclusive

New Ways of Working and Delivering Care - Survey Indicators

Your job
- Feel trusted to do my job
- Opportunities to show initiative frequently in my role
- Able to make suggestions to improve the work of my team/dept
- Involved in deciding changes that affect work
- Able to make improvements happen in my area of work
- Enough staff at organisation to do my job properly
- Satisfied with recognition for good work
- Satisfied with extent organisation values my work

Your team
- Team members often meet to discuss the team's effectiveness
- Team members understand each other's roles

People in your organisation
- Teams within the organisation work well together to achieve objectives

Your health, well-being and safety at work
- Organisation acts fairly: career progression
- **Your personal development**
- Received appraisal in the past 12 months
- Appraisal helped me improve how I do my job
- Appraisal helped me agree clear objectives for my work
- Appraisal left me feeling organisation values my work
- Organisation offers me challenging work
- There are opportunities for me to develop my career in this organisation
- Have opportunities to improve my knowledge and skills
- Feel supported to develop my potential
- Able to access the right learning and development opportunities when I need to

Your organisation
- Would recommend organisation as place to work
- I don't often think about leaving this organisation
- I am unlikely to look for a job at a new organisation in the next 12 months
- I am not planning on leaving this organisation
- **Background information**
- Disability: organisation made adequate adjustment(s) to enable me to carry out work

We will develop a culture where continuous improvement thrives and where enhanced people experiences lead to a positive impact on the design and delivery of care

Growing for the future - Survey Indicators

Your job
- Always know what work responsibilities are
- Satisfied with recognition for good work
- Satisfied with extent organisation values my work

Your team
- Receive the respect I deserve from my colleagues at work
- Team members understand each other's roles
- Enjoy working with colleagues in team
- Feel valued by my team

People in your organisation
- Teams within the organisation work well together to achieve objectives

Your managers
- Immediate manager works with me to understand problems
- Immediate manager listens to challenges I face
- Immediate manager cares about my concerns
- Immediate manager helps me with problems I face

Your health, well-being and safety at work
- Organisation acts fairly: career progression
- Feel organisation respects individual differences

Your personal development
- There are opportunities for me to develop my career in this organisation
- Have opportunities to improve my knowledge and skills
- Feel supported to develop my potential
- Able to access the right learning and development opportunities when I need to

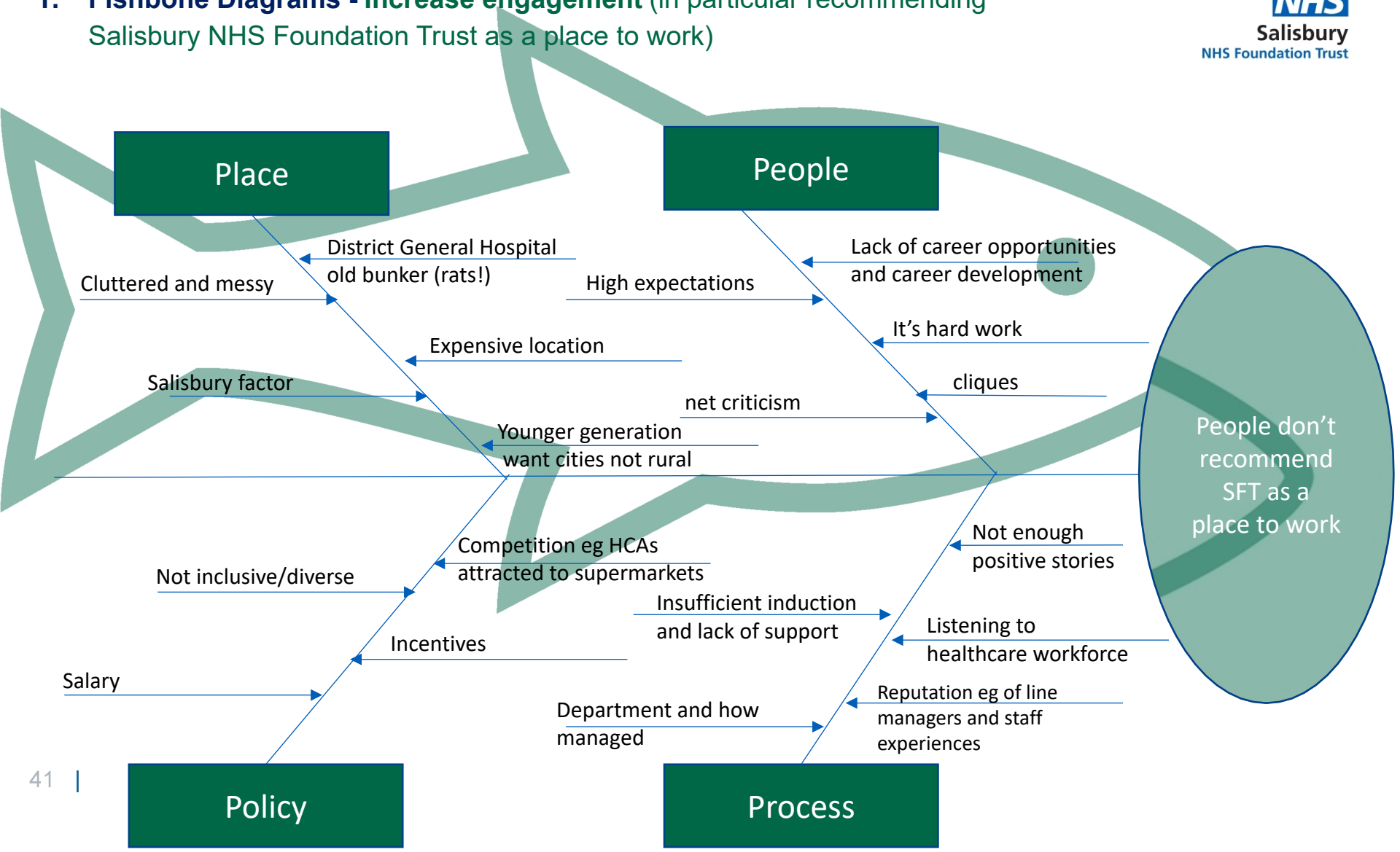
Your organisation
- I don’t often think about leaving this organisation
- I am unlikely to look for a job at a new organisation in the next 12 months
- I am not planning on leaving this organisation

We will have reduced turnover, creating a workplace that supports succession planning and career development opportunities

Fishbone Diagrams

Analysing the problems we face when aiming to meet our Key Watch Metrics. The fishbone diagrams work through cause and effect analysis to determine why the problem is occurring and to enable a shared solution.

1. Fishbone Diagrams - Increase engagement (in particular recommending Salisbury NHS Foundation Trust as a place to work)



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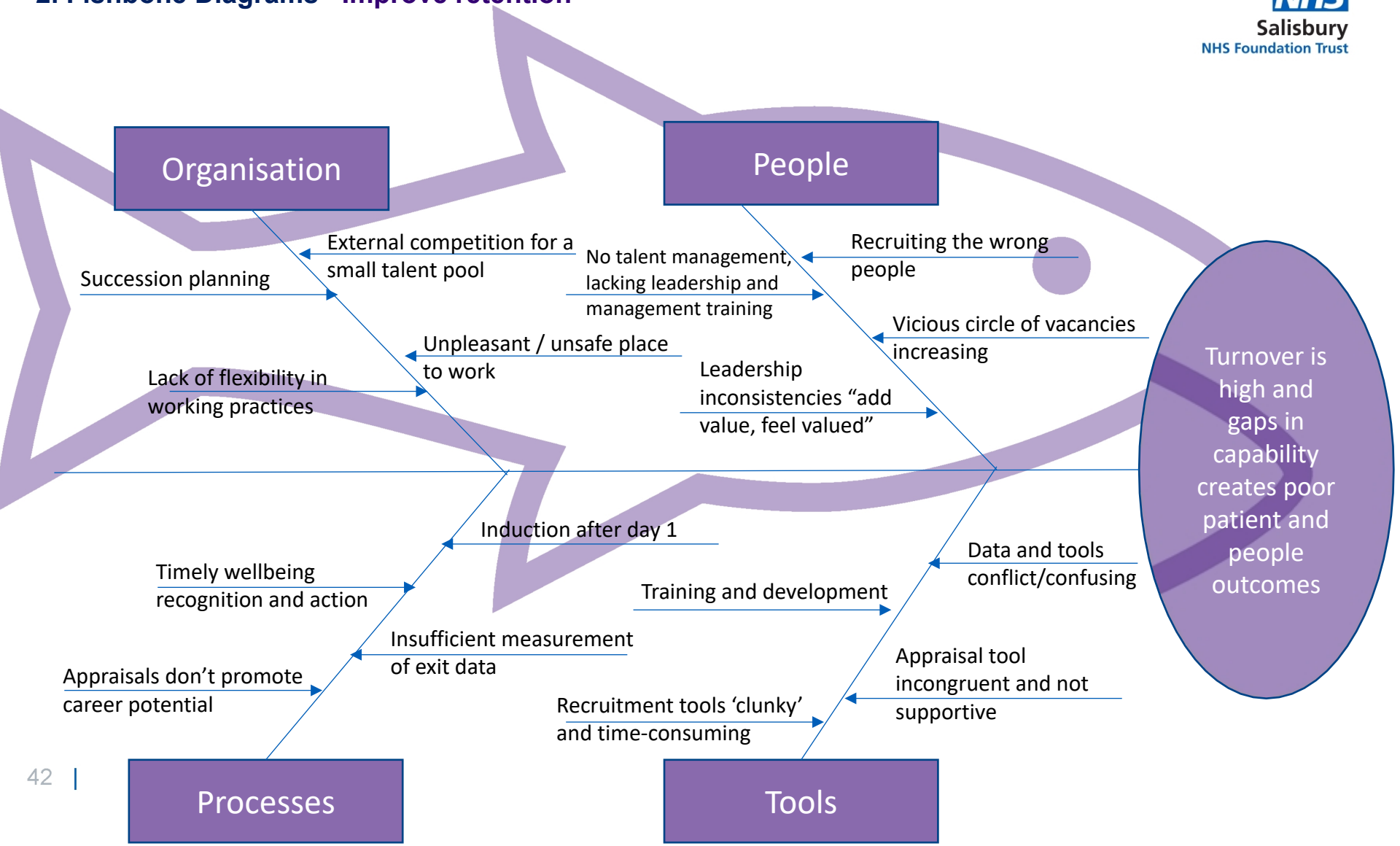
2. Fishbone Diagrams - Improve retention



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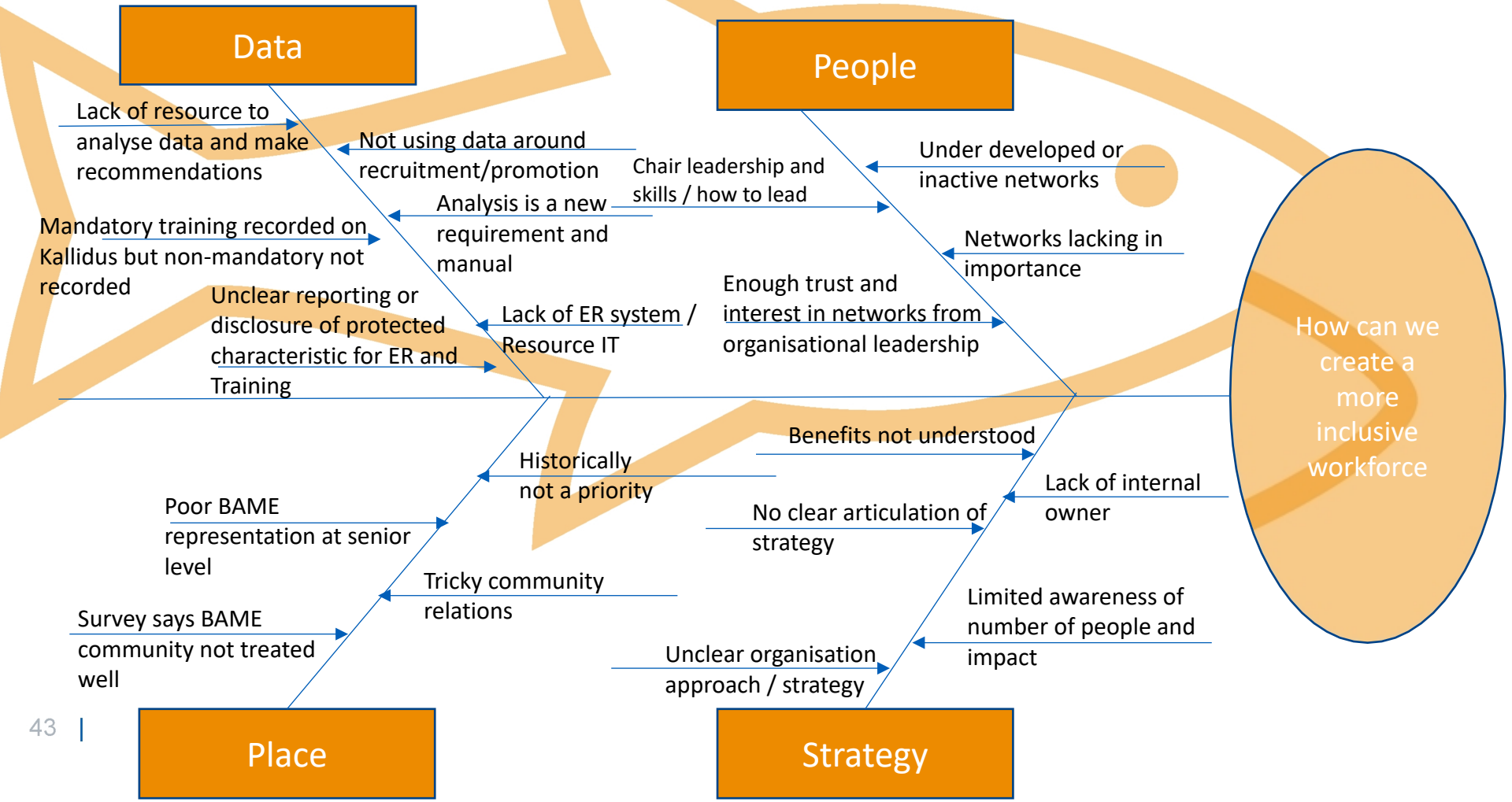
3. Fishbone Diagrams - Ensure we are an inclusive employer



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OD&P A3s

Structured frameworks for thinking through problems.
A visual representation of the whole story on one A3 page.

Our A3 – *Improving Together*

Creating a sustainable workforce

Owner - OD&P

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

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

2. Current Situation

In Month 1 22/23 SFT employed 3,647 WTE substantive staff, supplemented by 256 WTE bank workers and 150 WTE agency workers. Bank and agency numbers fluctuate monthly but our substantive workforce is becoming harder to recruit and retain while we have ambitions ot reduce reliance on temp staff.

While at the same time: 36% staff stated they intend to leave, (staff survey) and fewer are recommending SFT as a great place to work 2020 – Q1 2022 LTO is rising form the target of10% to almost 13% and looks set to continue. Underlying this 40% of those recruited from band 2-4 leave in the first 2 years. Only 1/4 of departments meet their stability target at present. Various reasons for leaving are cited and we need to triangulate with high turnover groups and understand the long term impact of key ares of dissatisfaction in planning our interventions.

3. Vision / Goals

The right skills are deployed, in the right place, at the right time to meet patient needs and deliver the agreed service level.

There is clarity about future workforce/talent needs coupled with a fully resourced plan to hire/train new workforce/talent on time and in full.

SFT is attractive to skilled staff, talent is identified and our people are given opportunities to further their career within SFT, maximising retention rates.

We have a pipeline of talent wanting to work at SFT giving us confidence in our ability to replace all leavers as well as to hire/train to new roles and additional workforce to meet future needs.

Staff are able to take their annual and parental leave safe in the knowledge that their shifts will be covered others. Sickness levels are below national averages and returning to work in a timely manner is a positive experience.

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

Temporary workers are available at affordable prices and deployed to maintain flexibility, through peaks of activity.

Accurate workforce analytics enable us to pinpoint and quickly respond to everchanging service and workforce needs. The workforce is affordable and progressively becoming more productive and agile

SFT will operate above average for all staff survey results and within upper quartile .

1. At least 80% of our people will recommend SFT as a great place to work, signifying a satisfied and supported workforce
2. Staff absences due to stress, anxiety and depression to be reduced to <5000 days per year within 3 years and total absences to be controlled not to be above 24% per month.
3. Staff turnover to be declining to <12.1% (rolling year) within 3 years, incorporating an even spread of turnover across all staff demographics/depts .
4. Meet targeted annual Agency expenditure within 3 years
5. This will result in better outcomes for our patients (ref- Kings fund) with reported patient experience to improve year on year at a rate of X % annual improvement – Measured through steadily declining number of complaints.

4. Root Cause Analysis / Gap Analysis

Why is our vacancy rate increasing?

a. Lack of investment in attraction, recruitment and retention – it should be the collective effort of leaders and managers supported by OD&P to make SFT a place that attracts people to work and stay.

b. Lack of investment/focus in talent management whereby managers understand the skills gaps and aspirations of their staff so that opportunities for them to develop can be made available to them.

c. SFT is operating in a challenging environment where there are a lack of qualified staff that want to work in Salisbury's rural community and SFT is not leveraging potential partnerships to make itself more attractive.

Why do we struggle to fill shifts and have to move staff around the hospital?

a. Poor workforce analytics underpinned by poor processes and data/evidence not being presented in a way that drives proactive actions by leadership and management.

b. Lack of establishment control and workforce forecasting/ planning that accurately defines what staff, roles and skills are needed now and into the future.

c. Limited use of e'rostering leading to lack of early visibility of unfilled shifts such that temporary workers can be identified and procured through a centrally managed process in a timely and affordable fashion.

5. Countermeasures year 1.

Work in Progress

a. Launch attraction campaign, including for hard to fill roles, and revise recruitment practices to maximise the number of skilled people attracted to work at SFT. This includes starters and leavers processes to improve staff experience.

b. Define a new establishment control policy and processes with administrative teams being reorganised to ensure optimal management, helping to underpin accurate workforce information.

c. Roll out and optimise use of erostering as rapidly as possible for all non-medical and medical staff and centralise booking bank and agency workers with new grip and control measures to minimise unnecessary use of agency/ pay escalations.

d. Launch new workforce analytics reports through dashboards for leaders and managers to make better, informed decisions.

Undertake a training need assessment exercise to identify the training needed and consider SFT's approach to talent management

E. Flexible working policy

6. Actions and Risks

Recruitment —Efficiency — process reengineering, staffing the function, better tools and documents. Effectiveness,- develop attraction approaches and ways of working, engage the front line & other client areas, improve consultation skills/approaches

Training —Focus on career path support/enhancement, Leadership stage gates & core competencies, Pride in delivering excellence, Fulfil Stat & Mand,

Planning - Longer planning horizons, regular reviews, more functions involved, greater ownership and responsibility

Deployment —Reservists , E'roster, Temp staffing improvements, Holiday management, absence management

Retention —Improve Occupational health , implement well being strategy, Dept focus, implement a culture of appreciation and inclusion

Risks - include delays to implementation driven by: - effort req'd Vs time available, lack of investment, lack of knowledge/ skill to implement, return of pandemic conditions, leadership and political changes of priority.

7. Costs

Investment in OD&P TBC

Investment in people being released for training

7a. Benefits

As an exemplar of NHS People Promise –strategic capability increases

Happy staff deliver better care

Reduction in £4.5m overspend on agency

Savings from retention & less/ more effective recruitment TBC

8. Insights

We have experienced significant decline against benchmarking group and our year on year measures of employee satisfaction and we are struggling to turn it around.

Systems thinking—Increasing instability drives a lack of staff availability which increases instability.

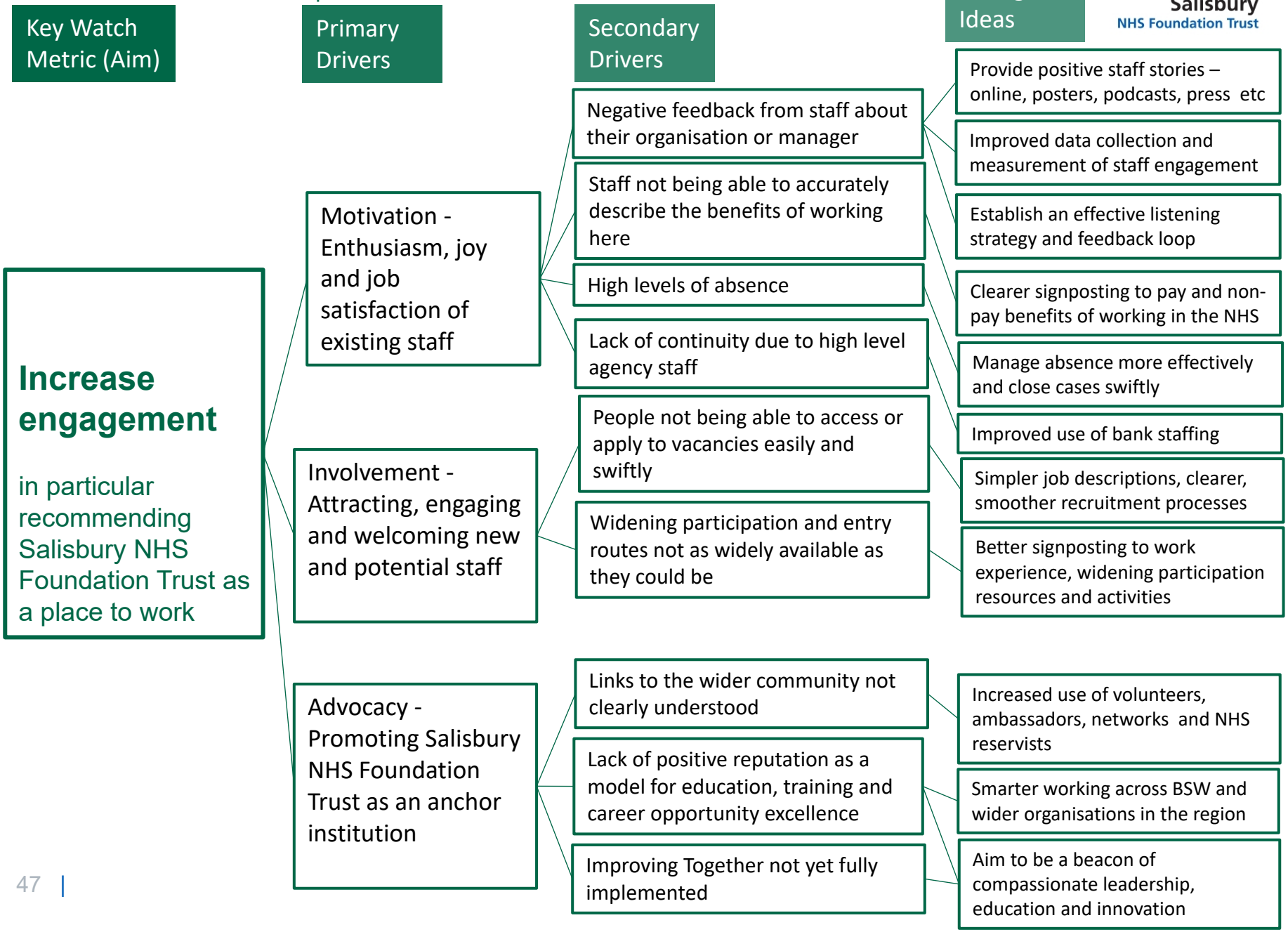
Significant interventions are needed to turn this around. To date we have failed to takle the problem

People management excellence is not the sole province of the OD&P dept, we provide the services and enable the conditions for great people management which delivers a great employee experience and a great place to

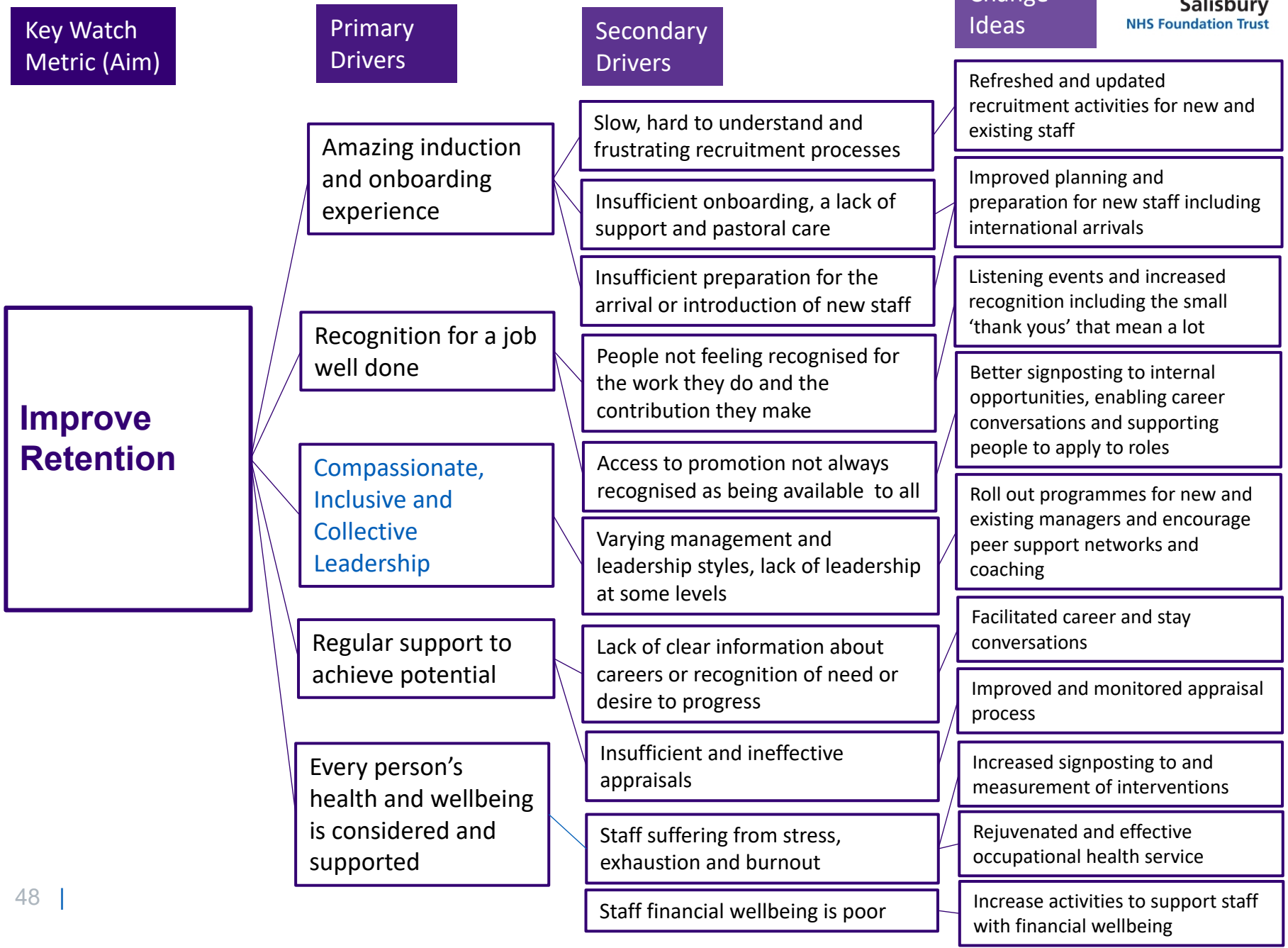
Driver Diagrams

Translating a high level improvement goal or aim into a logical set of high level factors (primary drivers) and identifying our theories of cause and effect about the changes and improvements we are making.

1. Driver Diagram - Increase engagement in particular recommending Salisbury NHS Foundation Trust as a place to work



2. Driver Diagram - Improve retention



3. Driver Diagram - Ensure we are an inclusive employer

Key Watch Metric (Aim)	Primary Drivers	Secondary Drivers	Change Ideas
Ensure we are an inclusive employer	Equality of access to promotion and roles at all levels	Lack of progression beyond a band 5 for BAME people	Consider where glass ceilings are and how to address them
			Give additional support eg how to complete job applications for ESOL
		Clear career frameworks are not in place for all staff groups	Roll out career frameworks and create new for wider staff groups
	An ability to speak up appropriately and without fear of retribution	Some people are afraid to speak up because of detriment	Improve reputation of speaking up to reduce likelihood of detriment
		Line managers not catching issues early enough	Increased roll out of training including managing difficult conversations
		Not all of the networks are fully established	Refresh the membership, role and activities undertaken by networks
		Incomplete EDI database	Clearer collection of data
	Equal access to world class education, training and development	Training needs analysis and identification of training needs is not sufficient	Better signposting and release to attend available training
		Take up of new and existing training not as high as could be	Training for all levels and roles including an increased use of apprenticeships
			Embed a learning culture
	Equal access to working arrangements that suit the person's needs and preferences	Not all disabilities are recorded so reasonable adjustments are not provided	Change language to include living with a condition and provide better support and buddying to access adjustments
		Access to flexible working and e-rostering is not universal	Clarify and simplify flexible working processes and enable e- and team rostering for all
		Not approaching retirement age people aware of pension details and how to return	Deliver pension workshops and encourage retire and return

2022/23 Data

Slides with additional data to further illustrate the measurements included earlier in the pack.

Protected Characteristics – Breakdown as at 31 August 2022

Ethnicity	Non Board	Board Member	Grand Total
Asian	552	1	553
Black	165		165
Mixed	58		58
Not Stated	121	3	124
Other	160		160
White	3829	10	3839
Grand Total	**4885**	**14**	**4899**

Gender	Non Board	Board Member	Grand Total
Female	3723	7	3730
Male	1162	7	1169
Grand Total	**4885**	**14**	**4899**

Sexual Orientatior	Non Board	Board Member	Grand Total
Bisexual	61	1	62
Gay or Lesbian	48		48
Heterosexual or St	4145	6	4151
Not stated (persor	503	6	509
Other sexual orier	9		9
Undecided	2		2
Unspecified	117	1	118
Grand Total	**4885**	**14**	**4899**

Religion	Non Board	Board Member	Grand Total
Atheism	794	3	797
Buddhism	49		49
Christianity	2620	3	2623
Hinduism	137	1	138
I do not wish to disclose my religion/belief	744	6	750
Islam	88		88
Jainism	1		1
Judaism	3		3
Other	327		327
Sikhism	4		4
Unspecified	118	1	119
Grand Total	**4885**	**14**	**4899**

Disability	Non Board	Board Member	Grand Total
No	4497	8	4505
Not Declared	253	6	259
Yes	135		135
Grand Total	**4885**	**14**	**4899**

Status	Non Board	Board Member	Grand Total
Full Time	2447	14	2461
Part Time	2438		2438
Grand Total	**4885**	**14**	**4899**

FTE Sickness – Breakdown for financial year 2021/22

FTE Days Lost - by Ethnicity

Reason	BME	Not Stated	White	Grand Total
S10 Anxiety/stress/depression/other psychiatric illnesses	1137	233	10797	12167
S27 Infectious diseases	2290	377	7518	10185
S12 Other musculoskeletal problems	972	43	3903	4917
S13 Cold, Cough, Flu - Influenza	802	100	2805	3707
S25 Gastrointestinal problems	689	147	2769	3605
S11 Back Problems	486	28	2363	2877
S28 Injury, fracture	282		1628	1910
S30 Pregnancy related disorders	888	36	831	1756
S98 Other known causes - not elsewhere classified	140	5	1572	1717
S21 Ear, nose, throat (ENT)	505	13	1124	1641
S16 Headache / migraine	284	33	1232	1549
S17 Benign and malignant tumours, cancers	189		1318	1507
S26 Genitourinary & gynaecological disorders	353	8	778	1139
S29 Nervous system disorders	8	39	881	929
S15 Chest & respiratory problems	129	1	691	821
S19 Heart, cardiac & circulatory problems	123	1	409	533
S31 Skin disorders	8	1	473	481
S23 Eye problems	21	104	258	383
S24 Endocrine / glandular problems	43		272	315
S22 Dental and oral problems	48	2	182	231
S18 Blood disorders	19		187	206
S14 Asthma	29	13	53	95
S99 Unknown causes / Not specified	1		66	67
S20 Burns, poisoning, frostbite, hypothermia	1		12	13
Grand Total	**9447**	**1184**	**42123**	**52753**

FTE Days Lost - by Gender

Reason	Female	Male	Grand Total
S10 Anxiety/stress/depression/other psychiatric illnesses	10237	1930	12167
S27 Infectious diseases	7943	2242	10185
S12 Other musculoskeletal problems	4096	821	4917
S13 Cold, Cough, Flu - Influenza	2974	733	3707
S25 Gastrointestinal problems	2946	659	3605
S11 Back Problems	2060	817	2877
S28 Injury, fracture	1233	677	1910
S30 Pregnancy related disorders	1756		1756
S98 Other known causes - not elsewhere classified	1298	418	1717
S21 Ear, nose, throat (ENT)	1168	473	1641
S16 Headache / migraine	1363	186	1549
S17 Benign and malignant tumours, cancers	1507		1507
S26 Genitourinary & gynaecological disorders	1095	44	1139
S29 Nervous system disorders	793	136	929
S15 Chest & respiratory problems	536	285	821
S19 Heart, cardiac & circulatory problems	407	126	533
S31 Skin disorders	436	46	481
S23 Eye problems	171	212	383
S24 Endocrine / glandular problems	301	14	315
S22 Dental and oral problems	166	65	231
S18 Blood disorders	179	27	206
S14 Asthma	95		95
S99 Unknown causes / Not specified	56	11	67
S20 Burns, poisoning, frostbite, hypothermia	6	7	13
Grand Total	**42823**	**9930**	**52753**

FTE Sickness – Breakdown for financial year 2021/22

FTE Days Lost - by Role

Reason	Add Prof Scientific and Technic	Additional Clinical Services	Administrative and Clerical	Allied Health Professionals	Estates and Ancillary	Healthcare Scientists	Medical and Dental	Nursing and Midwifery Registered	Grand Total
S10 Anxiety/stress/depression/other psychiatric illnesses	1179	3666	2311	305	648	223	235	3600	12167
S27 Infectious diseases	629	1376	2299	712	672	295	1196	3006	10185
S12 Other musculoskeletal problems	84	1658	737	96	767	44	1	1531	4917
S13 Cold, Cough, Flu - Influenza	189	608	856	227	493	97	64	1173	3707
S25 Gastrointestinal problems	352	847	704	112	316	37	56	1181	3605
S11 Back Problems	56	1260	235	34	151	13	235	894	2877
S28 Injury, fracture	87	440	385	86	553	9	17	333	1910
S30 Pregnancy related disorders	3	394	211	35	21	15	56	1019	1756
S98 Other known causes - not elsewhere classified	124	129	753	5	387	12	31	275	1717
S21 Ear, nose, throat (ENT)	36	177	439	26	96	161	338	370	1641
S16 Headache / migraine	111	504	395	58	46	28	16	390	1549
S17 Benign and malignant tumours, cancers	1		580	5	125		125	670	1507
S26 Genitourinary & gynaecological disorders	96	244	135	6	94	5	2	557	1139
S29 Nervous system disorders		359	18	59	12			481	929
S15 Chest & respiratory problems	216	114	180	17	67	8		219	821
S19 Heart, cardiac & circulatory problems	78	43	151	7	27	7		220	533
S31 Skin disorders	3	327	69	1	3	4		74	481
S23 Eye problems	17	21	122	110	18	10	1	84	383
S24 Endocrine / glandular problems	2	23	34	9	209	1		37	315
S22 Dental and oral problems	3	58	23	7	48	1	2	90	231
S18 Blood disorders	1	3	53	0	23			126	206
S14 Asthma	5	34	23					33	95
S99 Unknown causes / Not specified			47	1			17	1	67
S20 Burns, poisoning, frostbite, hypothermia		3	1		7			2	13
Grand Total	**3273**	**12288**	**10762**	**1919**	**4781**	**970**	**2392**	**16367**	**52753**

FTE Sickness – Breakdown for financial year 2021/22

FTE Days Lost - by division								
Reason	Clinical Support & Family Services	Corporate	Facilities	Medicine	Quality	Surgery	Women and Newborn	Grand Total
S10 Anxiety/stress/depression/other psychiatric illnesses	1927	1158	567	3462	399	3846	808	12167
S27 Infectious diseases	1504	1257	639	3277	173	2432	903	10185
S12 Other musculoskeletal problems	192	341	786	1620	181	1545	252	4917
S13 Cold, Cough, Flu - Influenza	543	439	463	1116	95	827	221	3705
S25 Gastrointestinal problems	492	278	347	1121	46	1153	169	3605
S11 Back Problems	243	121	106	1455	2	848	102	2877
S28 Injury, fracture	197	264	566	494		359	25	1906
S30 Pregnancy related disorders	41	116	21	735		801	42	1756
S98 Other known causes - not elsewhere classified	311	187	442	133	1	490	153	1717
S21 Ear, nose, throat (ENT)	544	280	108	171		428	111	1641
S16 Headache / migraine	296	112	43	437	12	589	59	1547
S17 Benign and malignant tumours, cancers	127	182	125	541		532		1507
S26 Genitourinary & gynaecological disorders	155	15	93	323	6	470	78	1139
S29 Nervous system disorders	1	29		448		449	2	929
S15 Chest & respiratory problems	77	108	14	124	14	392	92	821
S19 Heart, cardiac & circulatory problems	31	101	35	100	86	178	2	533
S31 Skin disorders	19	40	3	158		251	11	481
S23 Eye problems	32	108		168	15	58	3	383
S24 Endocrine / glandular problems	4		205	31	36	39		315
S22 Dental and oral problems	7	51	12	76		83	2	231
S18 Blood disorders	28	108	14	48		4	4	206
S14 Asthma	15	8		11		20	41	95
S99 Unknown causes / Not specified	2	47		17		1		67
S20 Burns, poisoning, frostbite, hypothermia		5	3	1		5		13
Grand Total	**6788**	**5354**	**4590**	**16066**	**1067**	**15800**	**3079**	**52745**

FTE Sickness – Breakdown for financial year 2021/22

FTE Days Lost - by band													
Reason	Band 1	Band 2	Band 3	Band 4	Band 5	Band 6	Band 7	Band 8	Consultant	Non AfC	Specialty Doctor	Trainee Doctor	Grand Total
S10 Anxiety/stress/depression/other psychiatric illnesses		3549	1894	1019	2230	1889	730	620	191		34	10	12167
S27 Infectious diseases	6	1783	1717	586	2217	1809	646	223	489	3	656	50	10185
S12 Other musculoskeletal problems	2	2181	603	199	1315	478	135	3			1		4917
S13 Cold, Cough, Flu - Influenza		1056	524	232	978	551	217	84	17		39	8	3707
S25 Gastrointestinal problems	1	1059	652	201	1101	324	143	68	10		33	13	3605
S11 Back Problems		1267	302	62	418	398	166	28	57		178		2877
S28 Injury, fracture	1	847	305	150	332	130	84	44	3		14		1910
S30 Pregnancy related disorders		416	94	116	905	149	18		9		6	41	1756
S98 Other known causes - not elsewhere classified		809	265	257	55	85	24	190			31		1717
S21 Ear, nose, throat (ENT)		311	107	54	316	475	25	15	333		5		1641
S16 Headache / migraine		662	171	90	346	170	75	18	4	1	13		1549
S17 Benign and malignant tumours, cancers		499	24		410	281	5	163	125				1507
S26 Genitourinary & gynaecological disorders		325	156	28	385	127	111	4			2		1139
S29 Nervous system disorders		58	330	1	89	326	125						929
S15 Chest & respiratory problems		119	141	31	188	119	23	200					821
S19 Heart, cardiac & circulatory problems		97	31	60	146	85	107	6					533
S31 Skin disorders		328	34	2	48	30	16	24					481
S23 Eye problems		16	13	53	67	189	29	15			1		383
S24 Endocrine / glandular problems		227	38	1	28	22							315
S22 Dental and oral problems		53	29	41	59	21	25	2	1		1		231
S18 Blood disorders		42	7	28	45	84		1					206
S14 Asthma		37	18	2	4	34							95
S99 Unknown causes / Not specified		1	6	28		7	3	5	12			5	67
S20 Burns, poisoning, frostbite, hypothermia		10	1			2							13
Grand Total	**10**	**15754**	**7463**	**3241**	**11684**	**7786**	**2709**	**1712**	**1251**	**4**	**1013**	**127**	**52753**

Apprenticeship data as at 31 August 2022

	Level	Live	Paused
Advanced Clinical Practitioner	7	8	1
Associate Project Manager	4	1	1
Business Administrator	3	7	1
Chartered Manager Degree	6	4	
Clinical Coder	3	1	
Coaching Professional	5	4	
Commercial Procurement and Supply	4	3	
Customer Service Practitioner	2	1	
Customer Service Specialist	3	1	
Cyber Security Technologist	4	2	
Diagnostic Radiographer	6	2	
Engineering Technician Maintenance	3	1	
Healthcare Science Practitioner	6	6	
Learning and Skills Teacher	5		1
Nursing Associate	5	15	1
Occupational therapy	6	2	
Operating Department Practitioner	6	3	
Operational/Departmental Manager	5	4	

	Level	Live	Paused
Payroll Administrator	3	2	
Pharmacy Service Assistant	2	2	
Pharmacy Technician	3	5	
Physiotherapy	6	2	
Plumbing and Domestic Heating	3	1	
Production Chef	2	2	
Professional Accountancy	7	1	
Project Manager	6		1
Property Maintenance Operative	2	1	
Registered Nurse Degree	6	4	
Senior Healthcare Support Worker	3	27	
Senior Leader	7	20	1
Senior People Professional	7		1
Team Leader/Supervisor	3	8	1
TOTAL		**140**	**9**
New Recruits		1	1
Funding Transfer		33	

Pension seminar data as at 31 August 2022

Session	Date	Numbers booked	Spaces	Available spaces
Pensions Tax (Annual and Lifetime Allowance)	13/06/2022	14	25	11
	23/06/2022	25	25	0
	29/06/2022	24	25	1
	05/07/2022	25	25	0
	12/07/2022	16	25	9
	20/07/2022	21	25	4
	28/07/2022	11	25	14
	05/08/2022	14	25	11
	09/08/2022	18	25	7
	18/08/2022	24	25	1
Total		192	250	77% uptake

Session	Date	Numbers booked	Spaces	Available spaces
Flexible Working and Pensions	16/06/2022	21	50	29
	21/06/2022	14	50	36
	30/06/2022	39	50	11
	08/07/2022	37	50	13
	13/07/2022	20	50	30
	18/07/2022	29	50	21
	03/08/2022	26	50	24
	08/08/2022	26	50	24
Total		212	400	53% uptake

Session	Date	Numbers booked	Spaces	Available spaces
The McCloud Remedy	14/06/2022	19	50	31
	23/06/2022	27	50	23
	30/06/2022	37	50	13
	04/07/2022	48	50	2
	15/07/2022	49	50	1
Total		180	250	72% uptake

Session	Date	Numbers booked	Spaces	Available spaces
Introduction to NHS Scheme	21/06/2022	50	50	0
	07/07/2022	49	50	1
	13/07/2022	50	50	0
	25/07/2022	40	50	10
	10/08/2022	50	50	0
	24/08/2022	33	50	17
	08/09/2022	49	50	1
	20/09/2022	22	50	28
Total		343	400	86% uptake so far

Appendix 8 - Identifying Trends

Trends in health care and work form an important context for how our people services need to evolve. There are a wide range of factors that may influence our work including the following examples:

Trend 1 – Ageing population

Across Bath and North East Somerset, Swindon and Wiltshire Partnership the demand for health services are rising due to an aging population with increasingly complex healthcare needs – the current population over 75 is 80,000 increasing to 100,000 by 2024, many with multiple, long-term illnesses. We also expect significant population growth in some areas driven by military relocation and some large-scale housing developments planned or underway. Cancer, cardiovascular disease and respiratory disease are the main causes of death in Bath and North East Somerset, Swindon and Wiltshire Partnership area.

Trend 2 - Workforce growth has not kept up with increasing demand

From the latest Bath and North East Somerset, Swindon and Wiltshire Partnership Intelligence Dashboard, we know that NHS supply for December 2021 was 16,304 vs 17,292 demand (using establishment as the demand marker).

Significant inequalities in life expectancy, linked to inequalities in how care is accessed, perpetuates unequal outcomes for our patients. Whilst the area, as a whole, is less deprived than other parts of England, there are pockets of deprivation sitting alongside more wealthy communities. Here people do not live as long and are more likely to have health issues. For example, in some areas of Wiltshire, the gap in life expectancy between the most and least deprived is 11.7 years.

With the severe shortages and a back log of care available in children's services and mental health we need to work in a more joined up and co-ordinated way across health and social care. We aim to break down barriers in career choices and the development of skills leading to the provision of a more integrated offer.

Trend 3 - Ownership

We are experience people of all ages wanting to take more control of how they manage their physical and mental wellbeing, requesting greater self-care and prevention. Helping our workforce and others to develop their confidence in health coaching alongside adoption of technology which is assisting us to communicate better and enable people to access care they need quickly and easily when it suits them. Remote consultations; offering new and flexible ways of working; making use of artificial intelligence (AI) to help us analyse larger quantities of complex information; and increasing innovations such as genomics; is helping us take a proactive and preventative approach to health

At the same time, you would not be surprised to hear that research tells us people's expectations of their employment are also changing.

Trend 4 - Demographics

Demographics within the workforce are changing: By 2030 the number of economically active people aged 65 and over in Bath and North East Somerset, Swindon and Wiltshire Partnership is projected to increase by 4,000 to 24,800[1].

We already have, and will continue to see, a four generational workforce (baby boomers, generation X, millennials and the first-generation Z). It is imperative that we adapt our people practises to ensure all of our people can thrive in their career, no matter which generation or stage of career they are in.

Trend 5 - There is increased competition for the workforce

The UK is facing a labour shortage, linked to the aging population which means more people are leaving it than joining. In the past 12 months 464 have left Salisbury NHS Foundation Trust and 523 people have joined. Through the past 2 years we have seen turnover increase from 9.50% to 12.24% with 86% leaving the sector.

Alongside this, the demand for health and care services is growing, also due to our aging population and so a larger workforce is needed. For example, if the adult social care workforce was to grow proportionally to the number of people aged 75 and over in the Bath and North East Somerset, Swindon and Wiltshire Partnership population, the number of adult social care jobs would need to increase by 25% to around 26,250 jobs in the next 10 years.

Trend 6 People's expectations of work are changing

People increasingly want "good work" (a term used in Taylor's review which refers to meaningful work ie where people have autonomy, feel that their work makes a contribution and that they feel listened to). At Salisbury NHS Foundation Trust three indicative questions in the annual NHS Staff Survey measure our achievement against those elements as follows:

1. There are frequent opportunities for me to show initiative in my role

% of people agreeing or strongly agreeing:

- 2019 Score – 76.6%
- 2020 Score – 74.4%
- 2021 Score – 74.3%

2. I feel that my role makes a difference to patients/service users

% of people agreeing or strongly agreeing:

- 2019 Score – 88.6%
- 2020 Score – 89.9%
- 2021 Score – 87.8%

[1] *According to ONS, 10.9% of the UK population over 65 are economically active. There are 191,000 people in the over 65 age group in Bath and North East Somerset, Swindon and Wiltshire Partnership. According to ONS this is projected to increase by 19% to 228,000 by 2030. If numbers of economically active people in that group increased by a similar percentage, we could see a 4,000 increase in numbers of economically active people from 20,800 in 2022 to 24,800 in 2030.*

3. I am able to make suggestions to improve the work of my department

% of people agreeing or strongly agreeing:

- 2019 Score – 78.8%
- 2020 Score – 76.9%
- 2021 Score – 72.1%

Trend 7 – Work and life balance

We are hearing from our people they want to balance their work more easily with other areas of their life. In the 2021 NHS Staff Survey only 36.8% of our people said that they believe the organisation is committed to helping them balance work and home life. Less than half of our people (46.8%) say they achieve a good balance between work and home life. Whilst 63.2% feel they can approach their immediate line manager to talk openly about flexible working, but only 48.8% say they are satisfied with the opportunities for flexible working patterns. Indications are that being able to work flexibly may become as important as levels of pay and recognition and the potential for career progression. In the last year 66 people left for increased flexible- working and a work/life balance against the 45 who left for better pay or promotion.

Trend 8 – Non-linear careers

There is an increase in non-linear careers rather than careers for life. People are continuing to work later in life and, according to the Office for National Statistics data, 78.1% of people aged 50-64 are economically active. This statistic was published for the first time in 2020, previous comparison data is not available. We may see people making choices about how and where they work, joining new sectors or having portfolio careers. Interestingly, we are not experiencing those societal trends yet at Salisbury NHS Foundation Trust. For example, the number of bank-only staff is currently 660 (down from 798 in 2020), medical locums have increased slightly to 119 (up from 75 in 2020) and one colleague has joined from the armed forces in 2021/22 to date (with six joining in 2020/21).

Over time, expectations may be that we make it easier for people to move in and out of roles. For example: supporting rotations through both health and social care providers; creating more opportunities for different career pathways such as specialist nurse roles, physicians associates or other new and emerging roles; and to enable them to work in health and care for longer through increasing access to flexible and predictable working practices by making use of e-rostering and team-based rosters.

In the 2021 NHS Staff Survey, 46.9% of our people said that there were opportunities for them to develop their career in this organisation, but this varies considerably between our professional groups. Amongst our Estates and Ancillary teams, only 32.2% thought there were opportunities for them to develop their career in the trust, compared with 66.3% of people in medical teams. Overall, 51.1% thought the organisation acts fairly in relation to career progression.

Trend 9 – Technology

Technological change is likely to reshape job and skill demands. Increased use of digital technology and automation may lead to a reduction in routine, repetitive tasks which may allow us to reconfigure roles to become more productive and improve job satisfaction. We must be ready to help our people to feel more confident and skilled in a more modern, digitally enabled work environment. Currently we operate with a range of workforce IT systems which only have limited interoperability between them. This can result in limited up-to-date workforce data, a struggling e rostering programme and, as a consequence, limited effective deployment of people. Many paper-based recruiting, on-boarding, pay roll and time management systems are still in use at the trust which can contribute to inefficiencies or practises with a higher risk of error and fraud.

Trend 10 – New roles and new ways of working

Training and appraisal are likely to identify the need to develop new types of skills and knowledge which in turn may need to new roles or different ways of working. By adopting a continuous and agile approach to the development of training opportunities; providing modular training; increasing the uptake of apprenticeships; widening access to learning opportunities; and developing a coaching culture that enables and recognises innovation; we will undoubtedly create new and improved training initiatives. By identifying new skills, knowledge and approaches we will be able to continue to improve our ways of working in the trust. This will enable us to better recognise the value that can be achieved by facilitating a greater recognition of the diverse views and skills that our people bring.

The 2021 NHS Staff Survey feedback shows us that fewer people at Salisbury NHS Foundation Trust have had an appraisal in the last 12 months (75.5%) when compared with other local trusts. Only 19.4% say that the appraisal has helped them improve how they do their job, with 28.8% saying the appraisal helped them agree clear objectives, and 30.7% saying that the appraisal left them feeling the organisation values their work. Less than half of our people say they are able to access the right learning and development opportunities when they need to (48.9%) or that they feel supported to develop their potential (46.5%). This too varies by professional group with Estates and Ancillary colleagues feeling less positive about these aspects than others such as people working in scientific and technical, allied health professionals or medical roles.

Opportunities

By changing the way we work here at Salisbury NHS Foundation Trust and working more seamlessly with our care partners, we have the opportunity to genuinely improve the employment experience of our people and the lives of the populations we care for. We can reach into our communities, reduce inequalities and act as an “anchor institution” and employer of choice. However our scores which relate to recommending Salisbury NHS Foundation Trust as place to work has fallen from 68.2% to 56.9% in the past 12 months. This tells us we have to do better across a number of elements of the People Promise to restore our level of recommendations received. In 2016, 72.2% of our people would have recommended the trust as a place to work, which at that time was well above average for our type of organisation.

Summary

To transform the experience our people have at work, colleagues from across the people profession and managers at every level will need to change the way we lead and act. We need to continue to recognise the opportunities afforded from these insights and the collective ambition in our region.

OD&P

Salisbury NHS Foundation Trust

5 year ambition, our purpose in OD&P and our priorities and their impact for 2022/3

November 2022

Slide deck contents:

- Introduction
- Driver Metrics
- 5 year ambitions
- 2022 – 2023 Priorities, impact, measures and actions
- The People Promise
- 2022 – 2023 Gantt chart
- Appendices
  - ✓ Survey Indicators
  - ✓ Fishbone Diagrams
  - ✓ A3
  - ✓ Driver Diagrams
  - ✓ 2022/3 data

Our Purpose in OD&P is to make Salisbury NHS Foundation Trust

NHS Salisbury NHS Foundation Trust

"The best place to work"

This aligns to the Trust vision

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

Supports our Trust values

Person Centred & Safe
Our focus is on delivering high quality, safe and person focussed care through teamwork and continuous improvement.

Professional
We will be open and honest, efficient and act as role models for our teams and our communities.

Responsive
We will be action oriented, and respond positively to feedback.

Friendly
We will be welcoming to all, treat people with respect and dignity and value others as individuals.

Progressive
We will constantly seek to improve and transform the way we work, to ensure that our services respond to the changing needs of our communities.

Is reflected in the NHS People Plan and People Promise

Is underpinned by Our Leadership Way

And enabled by our trust-wide Improving Together methodology

Driver Metrics

‘People’ is a strategic objective under Improving Together

‘**People**’ is a strategic objective under Improving Together

Our Strategy 2022-26 IMPROVING Together

NHS Salisbury NHS Foundation Trust

An outstanding experience for our people

Driver Metrics:

	What does good look like for us?	*What will we measure (to help us know we are moving in the right direction)*	*What is our indicator of success?*
D1 Staff motivation and engagement	More people would recommend SFT as a place to work, feeling motivated and supported to make improvements to their work (and the standard of care we give)	Improvement in staff engagement score within staff survey	We will achieve the upper quartile for acute providers
D2 Staff retention	More people stay within our workforce and take up opportunities of promotion or changes of role	Reduction of unwanted turnover (people leaving the Trust or the NHS)	Turnover in line with Trust target of 10% and an increasing stability index
D3 An inclusive employer	Our people recognise and experience SFT as an inclusive employer	Positive trend against the 7 WDES and 4 WRES indicators in the NHS staff survey	Achieving the median for our benchmark group across the workforce equality standards at SFT

5 year ambitions

Our 5-year view of how we will deliver the People Plan at Salisbury NHS Foundation Trust

People Plan pillars

NHS Salisbury NHS Foundation Trust

1

Looking after our People: We strive to actively look after ourselves and each other. Doing so will enable us to deliver outstanding care for our patients and an outstanding experience for our people.

2

Improve Belonging in the NHS: We continually listen to our people adapting our efforts to make the culture of our Trust universally understanding, kind and inclusive

3

New Ways of Working and Delivering Care: We will develop a culture where continuous improvement thrives and where enhanced people experiences lead to a positive impact on the design and delivery of care

4

Growing for the Future: We will have reduced turnover, creating a workplace that supports succession planning and career development opportunities

5

The vision for the future of the People Profession: An outstanding people profession team at Salisbury NHS Foundation Trust providing modern employment practices

Supporting & Developing the People Profession

5-year Ambition 1: Looking after our People

Making Salisbury NHS Foundation Trust "The best place to work"

We strive to actively look after ourselves and each other. Doing so will enable us to deliver outstanding care for our patients and an outstanding experience for our people.

How is this rooted and reflected in the People Plan?

The People Promise describes what we would like to say about working in the NHS by 2024:

- **Creating a great employee experience**: we understand the diverse needs, expectations and experiences of our NHS people and use that insight to tailor our people services
- **Prioritising the health and wellbeing of all our people**: We take a positive and proactive approach in supporting the health, safety and wellbeing of our people ensuring that work has a positive impact.
- **We address health inequalities** at work and in our communities.

What will be different in 5 years' time if we are successful?

- I**ncreased engagement** in the annual NHS Staff Survey with a consistent response rate of over 50%
- **Increased recommendations** so that year on year 70% of people recommend Salisbury NHS Foundation Trust as a place to work
- **Equal opportunity** for all our people to progress within the organisation including those with protected characteristics so that all the pay bands are representative of the workforce.
- **Improved engagement at work**. An increasingly positive trend in the Staff Survey, returning to above average by 6% to 7% for motivation, by 2% to 5% for involvement and by 9-11% for advocacy
- **Reduced negative health and safety measures**. We will pay particular attention to people's experiences and indictors of burn out. We will aim to identify early feelings of stress and anxiety, ensuring we introduce, adapt and continually evaluate our interventions to reduce those concerns.
- **Increased flexibility.** We will support people to have a greater choice in where when and how they work in order to help achieve a better work life balance

What are the gaps we want to close or the shifts we want to make?

- We want to better understand what the **barriers and enablers are to offering more flexible working patterns** building an evidence base for change.
- To establish **the link between the business case** for flexible working and **increased engagement** and crucial skills retention
- We want people to feel they **can make choices to balance their personal life and career** aspirations, without it bringing stigma or negatively impacting their career development or financial decisions about when to retire
- We want people managers to be **empowered to explore conversations about wellbeing** and options around flexible working, and how to make it work.

5-year Ambition 2: Improve belonging in the NHS

Making Salisbury NHS Foundation Trust "The best place to work"

We continually listen to our people adapting our efforts to make the culture of our Trust universally understanding, kind and inclusive

How is this rooted and reflected in the People Plan?

The People Promise describes what we would like to say about working in the NHS by 2024:

- The NHS was established on **principles of social justice and equity**. These are captured in our NHS constitution and supported by our trust values of Patient Centred and Safe / Professional / Responsive / Friendly/ and Progressive . However the NHS Staff Survey results tell us that the treatment of our colleagues from minority groups falls short of these principles in some areas.
- The People Plan recognises a range of positive interventions are required to **increase fairness in people practices**, leadership diversity, increased understanding and acceptance of difference and building confidence to speak up

What will be different in 5 years' time if we are successful?

- People have **pride in their workplace**, their team and their own role
- We use expertise and influence to create an **inclusive culture** which values and celebrates our diversity.
- There is **greater diversity in management** and more senior roles
- **We listen to our people** and take action to ensure there is equity for everyone
- People will feel comfortable and safe **bringing their whole self to work**
- **Representative networks**
- **Social belonging** created by an inclusive and varied activity regular events calendar

What are the gaps we want to close or the shifts we want to make?

We will

- Continue to take **regular quarterly checks** on the lived experience of our people, listening to their experience and progressing actions which make a positive difference to their work experience
- Design, develop and host both **diverse network groups and development courses** which provide safe forums for feedback, exploration and personal growth with all staff groups reporting fairer treatment and a sense of **equality of opportunity**.
- Require all managers and leaders to attend both skill and behavioural training workshops building their personal sense of competence and demonstrating their successful application through continually improving results in **sense of team**, value of appraisals and the **embedding of a compassionate culture**.

5-year Ambition 3: New Ways of Working and Delivering Care

Making Salisbury NHS Foundation Trust "The best place to work"

We will develop a culture where continuous improvement thrives and where enhanced people experiences lead to a positive impact on the design and delivery of care

How is this rooted and reflected in the People Plan?

The People Promise describes what we would like to say about working in the NHS by 2024:

- Building on the new agility developed as our response to the Covid 19 pandemic, we work more quickly, with less bureaucracy, **empowering people and teams to do what they know is right** to ensure we continue to provide excellent care and to look after each other.
- Giving people **flexibility and a sense of opportunity** in their roles and to develop their career so that they continue to work in the trust whilst also having a positive impact on the way care is designed and given.
- Committing to the **Improving Together** methodology and the rigorous development of our coaching capability will create a culture where continuous improvement can thrive.

What will be different in 5 years' time if we are successful?

- See people **working and learning together in multi-disciplinary teams** actively designed around the full range of experience and capabilities of clinical and non-clinical colleagues
- Increased **range of new roles** being explored and used within the trust
- Increase **optimisation and participation of volunteers**, including integration into the workforce
- Ensure we return to the **regular training and development commitment** to our people by expanding our e-learning and acting with a renewed emphasis on recognising the importance of flexible skills and building capabilities
- **Learning is integrated** into every person's career and appraisal process

What are the gaps we want to close or the shifts we want to make?

- See a positive increase in the Staff Survey engagement results with people reporting
  - **increasing opportunities for development** and that they are able to explore new roles and career pathways
  - that the **value of their appraisal is improving**
  - and that there is an ongoing improving trajectory of people feeling **a true sense of team**.
- See a **reduction is patient complaints** alongside a **correlation to increased training**, learning, and experimentation with new roles or patient outcomes by our people.

New ways of working and delivering care

5-year Ambition 4: Growing for the future

Making Salisbury NHS Foundation Trust "The best place to work"

We will have reduced turnover, creating a workplace that supports succession planning and career development opportunities

How is this rooted and reflected in the People Plan?

The People Promise describes what we would like to say about working in the NHS by 2024:

- We are seeing **an increase in enquiries and renewed interest** to join the NHS workforce
- We have **unprecedented demand for training places**, are expanding our placement capacity and activity to support a wide range of students, trainees and learners
- People are **staying for longer and continually developing** professionally and enjoying flexible and varied roles and career paths
- We attract **amazing new starters every month** who come because of our positive reputation for providing rewarding careers and our specialist services
- We increase our **international recruitment programme**, our **apprenticeship offer** and our support for people to **return to practice**
- We **build loyalty** and skills so that people feel they can **thrive within their teams** for the benefit of patients

What will be different in 5 years' time if we are successful?

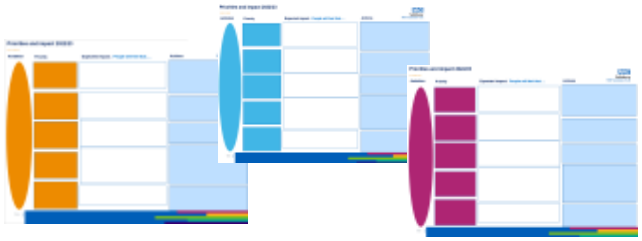
- An integrated and dynamic **workforce which meets the needs of a changing population** and workforce needs. Workforce planning responsibilities and outputs at organisational, system, regional and national levels are clear.
- We will have a **reputation for being an employer of choice** that maximises talent and recognises potential
- The system is **retaining, recruiting and, where required, growing** its workforce to meet future need. The 'one workforce' across the Integrated Care System is representative of the local communities served
- **Education and training opportunities** are fit for the needs of current and future people and services

What are the gaps we want to close or the shifts we want to make?

- Develop and deliver a proactive **widening participation agenda** including apprenticeship schemes and a visible pipeline of talent to build resilience into staffing levels.
- **Grow our international recruitment** with expansion across wider staff groups, attracting into our hard to recruit spots such a radiology/ specialist consultant roles, complemented by a proactive medical assistance and trust induction programme.
- **Growing our domestic recruitment**, seeing a gradual increase in enquires from school leavers for clinical placements; more people actively exploring return to practice; and a well-advertised and high take up of the offer to retire and return
- **Turnover stabilises at around 10%.** Over 85% of people choose to stay after their first year, increasing stability. The Staff Survey shows an increase to over 53% of people feeling that there is opportunity to develop their career within the organisation. .

2022 to 2023

Our priorities, impacts, actions and measures to be achieved during 2022 to 2023



Ambition 1 Looking after our People

2022/2023 Priorities

We strive to actively look after ourselves and each other. Doing so will enable us to deliver outstanding care for our patients and an outstanding experience for our people

Priorities and impact 2022/23
1. Looking after our People

NHS Salisbury NHS Foundation Trust

Ambition	Priority	Expected impact. People will feel that….	Actions
We strive to actively look after ourselves and each other. Doing so will enable us to deliver outstanding care for our patients and an outstanding experience for our people	1. **Flexible Working:** Improve retention through a focus on flexible working (Mark)	• They can balance their home and work life more effectively • They can make requests more easily and have them considered appropriately • They want to stay longer	1. Ratification and launch of the policy 2. Repeated communication of trust position on flexible working 3. Train line managers on flexible working as part of Leading your First Team 4. Use ESR to request flexible working 5. Team based rostering
	2. Early/mid/late career conversations Improve retention through a focus on career conversations (Mark & Business Partners)	• They are enabled to develop their career path and identify new or alternative and complimentary career pathways at the trust • They can explain opportunities within the trust to others interested in joining	1. Define policy, process and trigger points 2. Design training for managers and include as integral part of appraisal process 3. Report progress and uptake 4. Measure success and improve process
	3. **Pensions:** Improve retention through a focus on enabling people to understand their pensions (Melanie W)	• They are in better control of their finances • They understand and can tell others about the benefits of the NHS pension • They know the impact of the decisions they make when considering reducing hours or retiring and returning	1. Run a series of pension workshops 2. Report progress and uptake 3. Measure success 4. Embed into organisation's processes
	4. **Health and Wellbeing** Support people through health and wellbeing interventions (Venetia, Melanie W, Kate J)	• Managers are confident in delivering wellbeing conversations and that they recognise how critical they are to the team and patient care • There is less stigma surrounding Mental Health and that they are able to remain healthy at work • They can advocate for the organisation as taking positive action in relation to their financial wellbeing	1. Roll out wellbeing conversations 2. Continue to provide mental health support, resources and referrals 3. Initiate and extend the financial wellbeing offer 4. Launch a dedicated Health and Wellbeing website 5. 200 wellbeing champions to be recruited over next 2 years
	5. Absence: Address the root cause of non-covid related sickness and support return to work (Petrina H)	• Their own and colleagues sickness absences are legitimate • It is recognised that using holiday absence as additional leave is not acceptable	1. Analyse the non-covid related sickness report 2. Identify themes and key individuals 3. Contact individuals and/or line managers 4. Close cases as quickly as possible

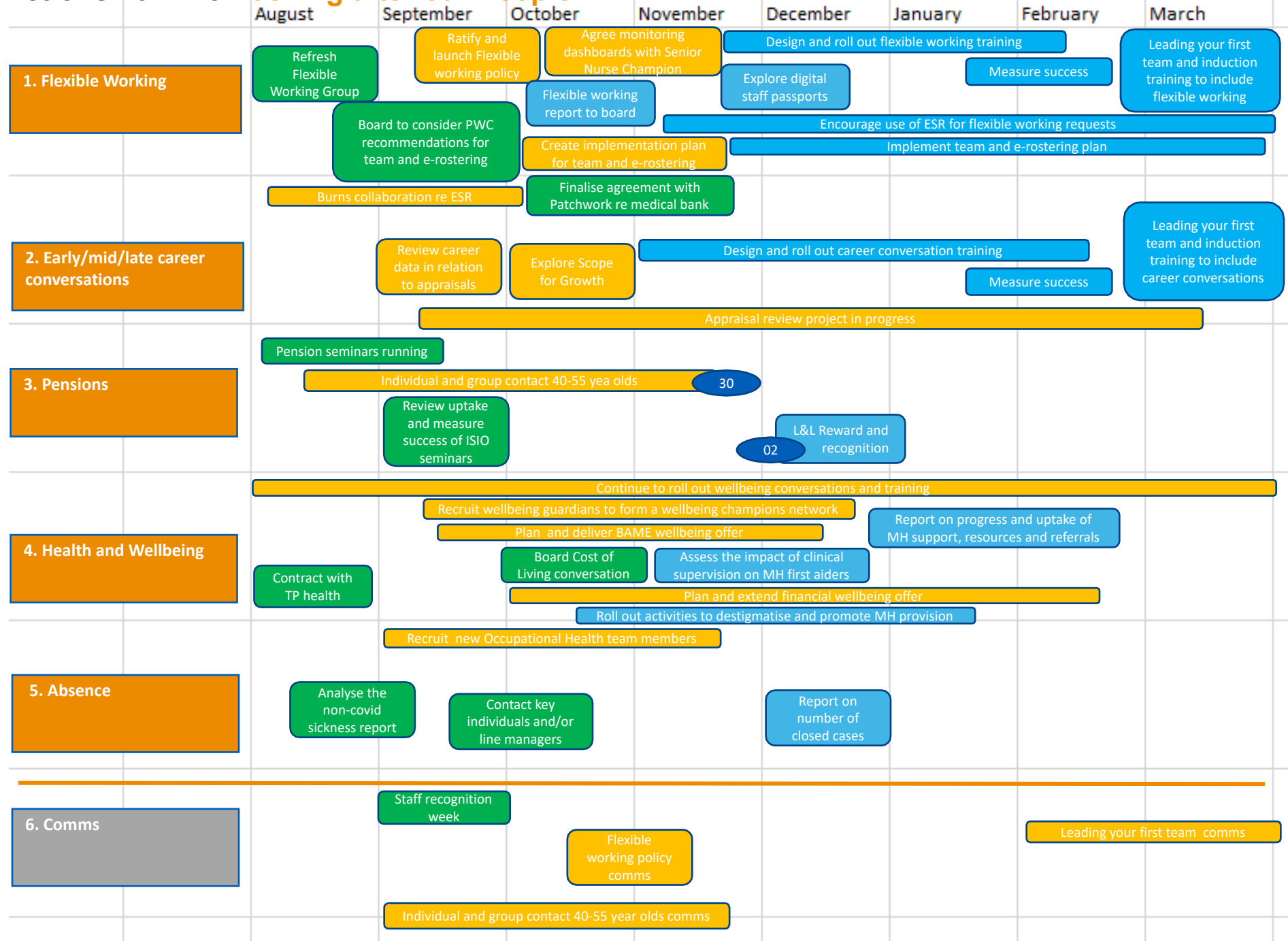
Measuring our impact

1. Looking after our People

NHS Salisbury NHS Foundation Trust

Priority	Measures & data	Insights
1. **Flexible Working:**	1. Number of managers trained on flexible working (tba) 2. Number of requests for flexible working through ESR (tba) 3. Number of flexible working requests supported (tba) Survey questions: • Organisation is committed to helping balance work and home life • Achieve a good balance between work and home life • Can approach immediate manager to talk openly about flexible working • Satisfied with opportunities for flexible working patterns	• Leading first team programme to be launched in March so no data available yet • Requests and support for flexible working to be captured via revised ESR appraisal process
2. Early/mid/late career conversations	1. Number of managers trained on enabling career conversations (tba) 2. Number of completed career conversations noted on ESR (tba) 3. Number of people applying for posts following a career conversation (tba) **4. 207 internal promotions** were made (in 12 months – to Aug 2022) Survey questions: • Organisation acts fairly: career progression • There are opportunities for me to develop my career in this organisation • Have opportunities to improve my knowledge and skills • Feel supported to develop my potential	• Training for career conversations, number of career conversations noted and applications received following career conversations to be captured via revised ESR appraisal process
3. **Pensions:**	**1. 927 places** booked on the ISIO **pension workshops** **2. 49 people retired and returned** in 2021/22 (42% of total retirees)	• The number of retire and returners to SFT is high compared to the national average
4. Health and Wellbeing	1. Number of managers trained to deliver wellbeing conversations (tba) **2. 5 wellbeing conversations** recorded on ESR 3. Number of referrals to mental health and psychology service (tba) 4. Number of people taking up financial wellbeing offers (tba) Survey questions: • Organisation takes positive action on health and well-being • Not felt pressure from manager to come to work when not feeling well enough • Not experienced harassment, bullying or abuse from managers • Immediate manager listens to challenges I face	• Significant roll out is planned for Wellbeing Conversations. Currently 40 conversations have been held with only 5 recorded on ESR to date • Financial wellbeing offers yet to begin
5. Absence:	**1. 7,759 absences** recorded in last 12 months 2. Breakdown for the reasons for absence by gender, race, job role, directorate and level (see appendix) **3. 3037 staff were off sick** in 2021/22 and **1917 had two or more episodes** Survey questions: • In last 12 months, have not experienced MSK problems as a result of work activities • In last 3 months, have not come to work when not feeling well enough to perform duties • Never/rarely exhausted by the thought of another day/shift at work	

Actions 2022/23 Looking after our People



Ambition 2 Improve belonging in the NHS

2022/2023 Priorities

We continually listen to our people adapting our efforts to make the culture of our Trust universally understanding, kind and inclusive

Priorities and impact 2022/23

2. Improve belonging in the NHS

Salisbury NHS Foundation Trust

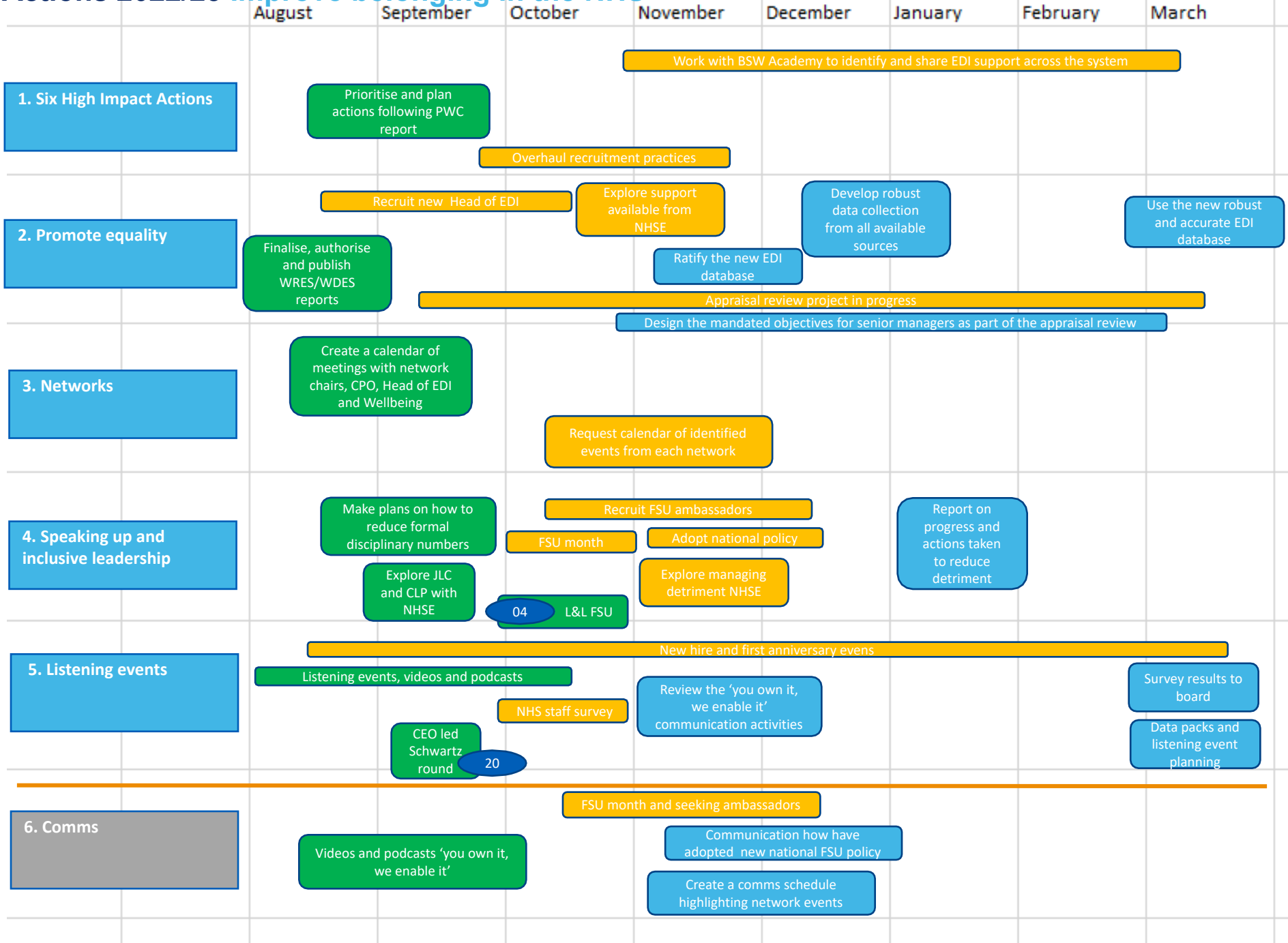
Ambition	Priority	Expected impact. People will feel that….	Actions
We continually listen to our people adapting our efforts to make the culture of our Trust universally understanding, kind and inclusive	1. **Six high impact actions:** Improve the Black Asian and minority ethic disparity ratio and overhauling recruitment and promotion practices including training in how to apply to jobs (tba & Sharon)	• The recruitment process is efficient, fair and inclusive • They have a greater sense of belonging • A diverse workforce will be recruited to the trust • There is a fair and inclusive progression through the pay bands	1. Action PWC recommendations to support delivery against the six-point plan 2. Work with the BSW academy to identify and share EDI support across the system 3. Continue to improve induction and welcome process 4. Design and develop an ESOL friendly training for filling in job applications as part of Leading Your First Team
	2. Promote equality: Implement plans to promote equality across all protected characteristics (tba)	• They are more included meaning they are less likely to leave because of discrimination • They have the same access to promotion across the trust • The leadership of the organisation is reflective of a diverse workforce	1. Ensure that a revised appraisal process includes objectives related to diversity as laid out in the model employer guidance 2. Develop a robust and accurate database for EDI 3. Develop robust data from all available sources 4. Develop a fully representative calendar of events and celebrations
	3. **Networks:** Scope what is needed and reinvigorate the staff networks (tba)	• They are valued and listened to • They can find and join networks that resonate for them if they wish to • They are engaged and energised by the positive action that is taking place across the trust	1. Regular meetings of leads, CPO and Head of Diversity, Inclusion and Wellbeing 2. Leads to identify and create a programme of activity for 2022/3 3. Comms team support and promote the activities programme
	4. Speaking up and inclusive leadership Encourage a culture that is inclusive (Ian / Venetia / Lizzie)	• Able to identify and learn from mistakes more effectively • The organisation culture is one of learning not blame, where their voice counts • They can resolve issues earlier and in a supported way	1. Increase Training for Freedom to Speak up by giving line manager Level 2 training as well as level 1 2. Encourage speaking up instead of fostering a blame culture
	5. Listening events Implement listening events and feedback loops to regularly collect people's views (Melanie and BPs)	• Their voice counts • They can easily identify where feedback has led to improvements	1. New hires and first anniversary 2. Staff Survey workshops for divisions 3. Communication activities to highlight 'you own it, we enable it' 4. Create accessible feedback process and inclusive trust comms

Measuring our impact

2. Improve belonging in the NHS

Priority	Measures	Insights
1. **Six high impact actions**	1. The number of BAME applying to posts (internal and external) **SH** 2. Take up of ESOL friendly training in how to complete job applications **VF** 3. The number of BAME successful applications **SH** 4. WRES and DES and EDI data Survey questions: • There are opportunities for me to develop my career in this organisation • Have opportunities to improve my knowledge and skills • Organisation acts fairly: career progression	207 people were promoted in last 12 months, no data on % of BAME Leading first team programme, including completing applications, to be launched in March so no data available yet
2. Promote equality	1. The WRES and WDES data for the trust **2. 4139 people (92% of staff) undertook diversity and inclusion training** in 2021/22 3. The number of people from a minority group accessing training and development opportunities (tba) 4. Use training tools to assess the accessibility and inclusivity of training interventions Survey questions: • Feel organisation respects individual differences • Not experienced discrimination from manager/team leader or other colleagues • Not experienced harassment, bullying or abuse from managers	Data on minority groups accessing training and development is not currently collected – need to consider best way to do this
3. **Networks**	1. That each network has a chair 2. The number of network members 3. The number of network events a year, leading to a raised profile of the network Survey questions • Colleagues are polite and treat each other with respect • Satisfied with extent organisation values my work • Receive the respect I deserve from my colleagues at work	
4. Speaking up and inclusive leadership	1. The number of people doing the FSU training level 2 2. The Freedom to Speak up board report data 3. Percentages of staff going through leadership and improving together training programmes Survey questions • Feel safe to speak up about anything that concerns me in this organisation • Feel organisation would address any concerns I raised	
5. Listening events	1. The number of listening events held and number of people attending **2. 510 of 658 joiners remained in post** for over a year 3. The number of communication activities highlighting 'you own it, we enabled it' Survey questions • Would feel secure raising concerns about unsafe clinical practice • Would feel confident that organisation would address concerns about unsafe clinical practice • Satisfied with recognition for good work • Satisfied with extent organisation values my work	

Actions 2022/23 Improve belonging in the NHS



Ambition 3 New Ways of Working and Delivering Care

2022/2023 Priorities

We will develop a culture where continuous improvement thrives and where enhanced people experiences lead to a positive impact on the design and delivery of care

New ways of working and delivering care

Priorities and impact 2022/23:
3. New ways of working and delivering care

NHS Salisbury NHS Foundation Trust

Ambition

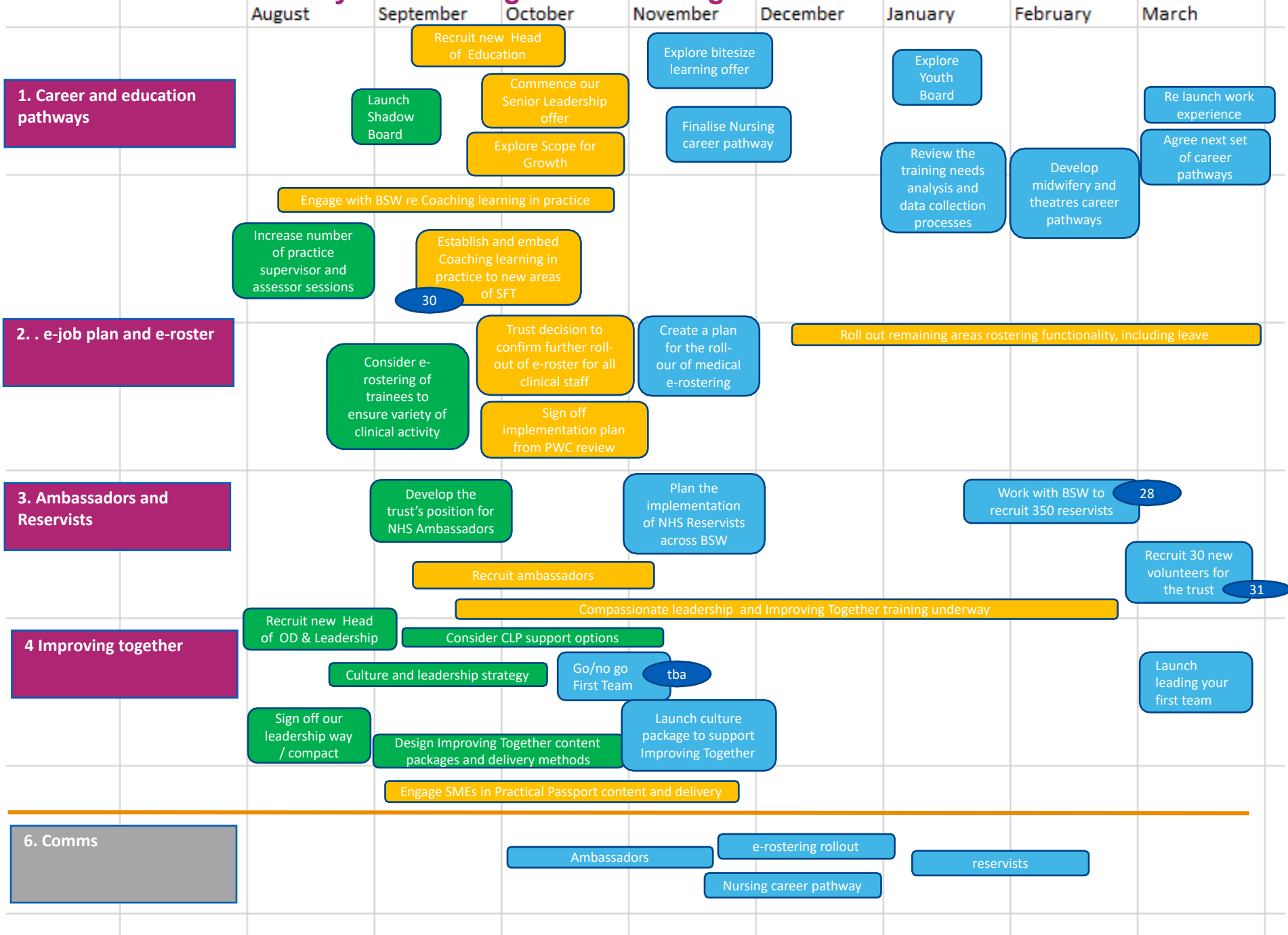
We will develop a culture where continuous improvement thrives and where enhanced people experiences lead to a positive impact on the design and delivery of care

Priority	Expected impact. People will feel that….	Actions
1. **Career and education pathways:** Increase awareness about the potential career pathways in the organisation (Venetia)	• They have varied career progression options leading to better retention as they don't have to seek work elsewhere to access the role they want • Funding is being used more effectively to run services and fill vacancies differently, rather than through agency use	1. Review the training needs analysis and data collection processes 2. Develop and communicate career and education pathways for Nursing, Midwifery and Theatres 3. Plan to expand to other occupations
2. **e-job plan & e-roster:** Ensure highest level of attainment set out by the meaningful use standards to optimise capacity of workforce (Daniel and Clare)	• They have full visibility of their working shifts • They are able to request their annual leave remotely and have full visibility of entitlement and episodes • The system software is used to full potential and enables benchmarking and KPI compliance internally and against other trusts	1. Progress levels of attainment across all workforce groups 2. Create a plan for the roll out of medical e-rostering 3. Roll out remaining areas trust-wide to full rostering – approx. 1250 staff 4. Building on the success of the pilot, roll out team based rostering to further clinical ward areas 5. Rostering KPI compliance reports to be regularly reviewed at Safe Staffing Group
3. Ambassadors and Reservists: Establish NHS ambassadors and Reservists (Venetia and Sharon)	• The NHS and the trust support the local community by offering education and employment opportunities • The trust is proactively working with regional colleagues on a nationally recognised scheme	1. Develop the trust's position and plans for NHS Ambassadors 2. Lead the implementation of NHS Reservists across BSW
4. Improving together: Culture change to support improving together (Venetia)	• They can thrive and be confident in supporting their teams to embed new ways of working • They are supported and encouraged to improve ways of working through continuous improvement and coaching	1. Finalise programme content: improving together, coaching, team dynamics & change 2. Create a plan for further interventions and design delivery that can flex to mee the challenging context of clinical areas

Measuring our impact
3. New ways of working and delivering care

Priority	Measures & data	Insights
1. Career and education pathways	1. The number of professions that have articulated career pathways 2. **2,026 people received appraisals** (69%) 3. The number of people recommended for training and development opportunities in their appraisals 4. The number of training opportunities accessed Survey questions: • Able to access the right learning and development opportunities when I need to • There are opportunities for me to develop my career in this organisation • Have opportunities to improve my knowledge and skills • Feel supported to develop my potential	
2. e-job plan & e-roster	1. The number of jobs planned through e-job plan (tba) 2. **2373 people** are fully rostering 3. **1251 people** are only recording leave in e-roster Survey questions: • Enough staff at organisation to do my job properly • Team members understand each other's roles • Not feel pressure from manager to come to work when not feeling well enough	• Team based rostering has been tested successfully in two areas as part of the flex group work. The results were shared nationally and further a roll out is to follow. • The 1251 AfC staff managing annual leave via Healthroster will be on the roll out plan to fully roster • All SFT staff (including medics) manage sickness absence in Healthroster
3. Ambassadors and Reservists	1. The number of NHS ambassadors (tba) 2. The number of organisations in BSW supporting NHS Reservists (tba) 3. The number of NHS reservists in SFT (tba) 4. The number of NHS reservists in BSW (tba) Survey questions: • Would recommend organisation as place to work • I am not planning on leaving this organisation • Feel supported to develop my potential	• Ambassadors work is in early stages so data not yet available • Planning for Reservists not yet completed so data not yet available
4. Improving together	1. The number of Improving Together coaches trained (tba) 2. Number of individuals attending training to support Improving Together (tba) Survey questions: • Able to make suggestions to improve the work of my team/dept • Involved in deciding changes that affect work • Able to make improvements happen in my area of work • Team members often meet to discuss the team's effectiveness	• Roll out of Improving Together is in early stages so number trained is likely to be small. This may also impact on the survey responses in October 2022 but should improve by October 2023 as more people are involved in the programme.

Actions 2022/23 New ways of working and delivering care



Ambition 4 Growing for the future

2022/2023 Priorities

We will have reduced turnover, creating a workplace that supports succession planning and career development opportunities

Priorities and impact 2022/23 :
4. Growing for the future

NHS Salisbury NHS Foundation Trust

Ambition

We will have reduced turnover, creating a workplace that supports succession planning and career development opportunities

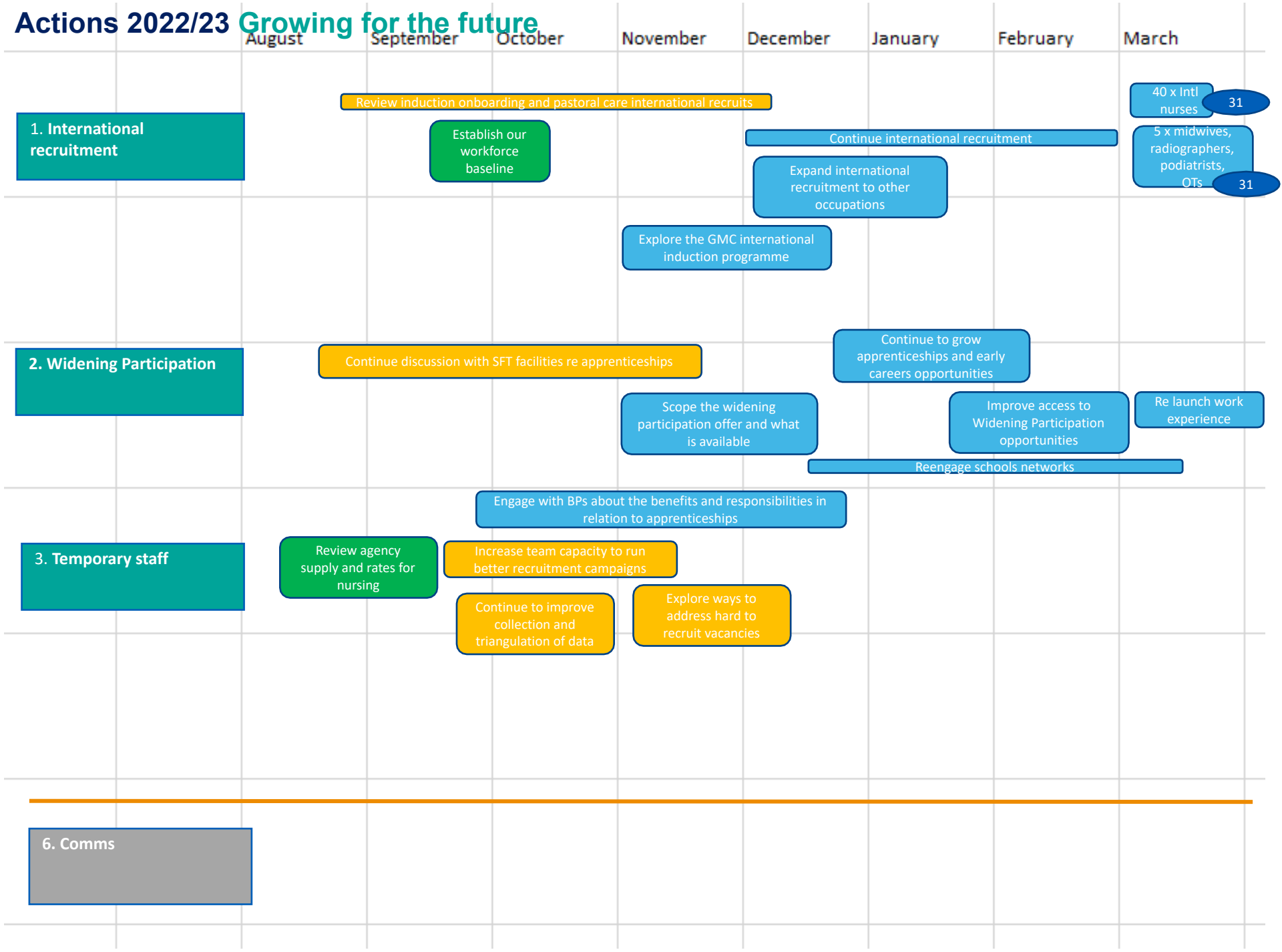
Priority	Expected impact. People will feel that….	Actions
1. **International recruitment:** Expand ethical international recruitment of high quality nurses and midwives (Sharon)	• There is a reduction in spend on temporary staffing • There is more resource in post • They are welcomed and given the best start possible to their career in the UK • They want to stay and make Salisbury home	1. Establish our workforce baseline 2. Continue to recruit international nurses 3. Expand international recruitment to include midwives, radiographers, podiatrist and occupational therapists 4. Improve the on-boarding and pastoral care of international recruits
2. Widening Participation Widen participation and create training and employment opportunities including apprenticeships as a point of entry (Venetia)	• There are opportunities for employment as a result of improved engagement with the community that highlights what is available • Routes into careers for local young and/or disadvantaged people have been improved	1. Scope current offer and what is available 2. Re-engage with schools network 3. Deliver the NHS ambassadors programme 4. Continue to grow apprenticeships and other early careers opportunities
3. **Temporary staff:** Reduce reliance on high cost agency staff and expanding collaborative system banks to make best use of temporary staff (Sharon & Henry)	• There is a sense of improved wellbeing for existing people as they are better supported by bank fill • They can deliver better quality care due to better agency and bank fill • They are reassured that funding is being spent appropriately on agency spend • There is an improvement in the rate from conversions to hire	1. Review agency supply and rates for nursing 2. Continue to improve the collection and triangulation of data and spend through the workforce control panel and full roll out of e-roster 3. Increase team capacity to enable better run recruitment campaigns for all roles

Measuring our impact
4. Growing for the future

NHS Salisbury NHS Foundation Trust

Priority	Measures & data	Insights
1. **International recruitment**	1. Number of new international nurses (tba) 2. Number of new international midwives, radiographers, podiatrist and occupational therapists (tba) **3. 180 international staff have 5+ years service** (as at 31 March 2022) 4. Number of people taking part in induction programme for medical graduates and international-recruits (tba) Survey questions • Organisation acts fairly: career progression • Feel organisation respects individual differences • There are opportunities for me to develop my career in this organisation • Feel supported to develop my potential • Have opportunities to improve my knowledge and skills	
2. Widening Participation	1. Number of schools and colleges engaged with **VF** **2. 32** occupations in the trust are using the apprenticeship scheme with **140** 'live' apprenticeships currently 3. Number people on early career programmes (tba) 4. Currently one new starter has joined the trust as an apprentice Survey questions • Would recommend organisation as a place to work • Able to access the right learning and development opportunities when I need to • There are opportunities to develop my career in this organisation	• Currently apprenticeships are primarily being used for internal career progression rather than for attracting new staff • A handful of apprenticeships are on hold (including the new starter)
3. **Temporary staff**	1. Number of active bank staff (tba) **2. 40% of shifts** requested are **not filled** **3. 50%** of filled shifts use **bank and agency** staff **4. £21,574,502 was our temporary workforce spend** in 2021/22 5. Reduction in vacancy gap (tba) Survey questions • Enough staff at organisation to do my job properly • Teams within organisation work well together to achieve objectives • Satisfied with the extent organisation values my work	

Actions 2022/23 Growing for the future



The People Promise

An overview of our role as an exemplar site

People Promise

This is a promise we must all make to each other – to work together to improve the experience of working in the NHS for everyone.

For many, some parts of the Promise will already match their current experience.

For others, it may still feel out of reach.

We must all pledge to work together to make these ambitions a reality for all of us, within the next four years.

Exemplars

Salisbury NHS Foundation Trust is one of 23 NHS England and NHS Improvement People Promise Exemplar sites in England. We are working together towards this purpose:

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.**

Other Exemplars in our region are: Royal Cornwall Hospitals NHS Trust and Somerset NHS Foundation Trust

Support from NHSEI

- Support us to assess and benchmark our current position
- Help us to identify the steps needed to reach optimum delivery
- Evaluate our outcomes at organisation and system level
- Measure the impacts across all the exemplars
- Give access to resources, data and support from the national and regional teams
- Prepare shared learning to inform potential roll-out to other organisations

The People Promise – NHSE support offers

NHS Salisbury NHS Foundation Trust

People Promise priority areas for Exemplar sites

	We are compassionate and inclusive		We are recognised and rewarded – Angie Walsh	We each have a voice that counts		We are Safe & healthy – Steve Lee	We are always learning - Caroline Chipperfield / Carolyn May	We work flexibly	
	Culture Transformation - Katy Steward	EDI - Anton Emmanuel		FTSU - Tom Grimes	Employee Engagement – Zoe Evans			Flexible working - Jane Galloway	Enabling Staff movement – Daniel Elkins
1	Implement the Culture Leadership Programme (CLP)	Use of Workforce Race Equality Standard (WRES) and Workforce Disability Equality Standard (WDES) data to set bespoke ambitious targets for improvement, which reflect the specific issues in the organisation that require attention.	Roll-out pensions awareness seminars on the basics and bust myths about how the NHS Pension Scheme works	FTSU Guardian is appointed via an open recruitment process, with sufficient ring fenced time (at least 0.6WTE) to carry out all aspects of their NGO's universal job description and associated activities	Focus on understanding and improving Employee Engagement as a leading indicator of performance, putting it alongside other key measures of performance throughout the organisation to embed the People Promise, using Model Health System data to monitor trends and progress. .	Wellbeing Guardians are appointed and playing an active role as an integral part of the strategic agenda to establish a preventive approach to Health and Wellbeing (HWB) within the organisational culture	Leaders adopt and reflect the behaviours articulated in the NHS Leadership Way	Evidence of communicating and adopting the flexible working policy changes recently introduced in the NHS Terms & Conditions.	Establish workforce sharing agreements as par Enabling Staff Movements toolkit and sign up to the Trusted Frameworks for staff movements.
2	Line managers access a mentoring program so the organisation builds capacity to listen inclusively to diverse voices	Focus on the 6 high impact actions to promote inclusive recruitment and promotion practices to advance BAME representation at every level of the organisation.	Offer 1:1 and group seminars to staff groups affected by pensions tax on pensions and flexible retirement	Adopt the updated national speak up policy and ensure it's openly advertised and promoted to, and by, line managers so that it's accessible to all workers and they know who their Guardian is.	Establish a local listening strategy, maximising national tools, aligned to the different purpose of each tool e.g.: NHS Staff Survey, National Quarterly Pulse Survey and Monthly People Pulse	Ensure HWB conversations take place routinely for all staff, and that line managers and teams have the skills and tools they need to take ownership of health and wellbeing	Leaders access and complete new bitesize learning resources from the NHS Leadership Academy	A minimum of 25% of permanent roles are advertised with clear flexible working options outlined.	Link Occupational Health and Learning Management interfaces with ESR, in preparation for Digital Staff Passports.
3	Develop leadership strategy from the findings on the use of CLP tools that is signed-off by the Board.	Roll-out an induction programme (disseminated via GMC) for international medical graduates and international-recruited staff to increase belonging in the NHS.	Adopt good practice guidance from NHS Employers and other sectors on mitigating the risk of pension tax and flexible working	Review Trust FTSU arrangements against the revised FTSU Guidance and develop / implement an improvement action as appropriate.	Improve team effectiveness as a key lever to improve employee experience and build organisational, team and individual resilience and wellbeing through the TED tool developed by Lancashire Teaching Hospitals.	Strengthen and support Occupational Health to fulfil their role as a clinical service and source of insight and expertise within the wider preventive approach to HWB	Roll out Scope for Growth model for 8C level and above as part of a career conversation for line managers with their direct reports, and agree a development plan	Efficient use of e-rostering with an audit of the level to which team rostering are used to facilitate flexible working. Use of a dashboard or workforce report that enables the board to monitor progress against defined flexible working metrics, with an identified Snr Nurse Champion	Adopt and issue Digital Staff Passports for Doctors in Training and Temporary Staff Movements

NHSE Priorities and our Actions

= date

People Promise area	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar
We are compassionate and inclusive and we are a team	Sign off our leadership way / compact; Recruit new Head of OD & Leadership; Culture and leadership strategy	Networks calendar of events planning; Consider CLP support options; Overhaul recruitment practices; Induction onboarding and pastoral care international recruits; WRES /WDES	Go/no go First Team (tba)	EDI database; Compassionate leadership and Improving Together training underway; Work with BSW re system wide EDI	Continue international recruitment			40 x Intl nurses (31)
We are recognised and rewarded	Pension seminars running	Staff recognition week; Individual and group contact 40-55 yea olds (30)				L&L Reward and recognition		
We each have a voice that counts	Listening events, videos and podcasts; Recruit new Head of EDI	New hire and first anniversary evens; FSU month; Recruit FSU ambassadors; NHS staff survey; Explore managing detriment NHSE; CEO led Schwartz round (20); L&L FSU (04)						Survey results to board; Data packs and listening event planning
We are Safe and Healthy	Contract with TP health	Continue to roll out wellbeing conversations and training; Recruit wellbeing guardians; Plan and deliver BAME wellbeing offer; Board Cost of Living conversation; Recruit new Occupational Health team members						
We are always learning	Recruit new Head of Education	Launch Shadow Board	Commence our Senior Leadership offer; Explore Scope for Growth	Explore bitesize learning offer; Finalise Nursing career pathway	Reengage schools networks	Explore Youth Board	Access to Widening Participation	Re launch work experience; Agree next set of career pathways
We work flexibly	Refresh Flexible Working Group	Launch Flexible working policy; Board to consider PWC recommendations for team and e-rostering	Create implementation plan for team and e-rostering; Flexible working report to board		Explore digital staff passports			
Communications	Continuous and active cycle of engagement communications and events across all areas of the People promise (including digital and non-digital)							

Appendices

Additional information and resources

Survey Indicators

The responses from the NHS survey provide indicators that can be used to assess our progress towards our 5-year ambitions

Looking after our people - Survey Indicators

Your job
- Organisation is committed to helping balance work and home life
- Achieve a good balance between work and home life
- Can approach immediate manager to talk openly about flexible working
- Satisfied with opportunities for flexible working patterns

Your health, well-being and safety at work
- Don't work any additional paid hours per week for this organisation, over and above contracted hours
- Don't work any additional unpaid hours per week for this organisation, over and above contracted hours
- Organisation takes positive action on health and well-being
- In last 12 months, have not experienced musculoskeletal (MSK) problems as a result of work activities
- In last 3 months, have not come to work when not feeling well enough to perform duties
- Not felt pressure from manager to come to work when not feeling well enough
- Never/rarely find work emotionally exhausting
- Never/rarely exhausted by the thought of another day/shift at work
- Never/rarely worn out at the end of work
- Never/rarely feel every working hour is tiring
- Never/rarely lack energy for family and friends
- Not experienced physical violence from patients/service users, their relatives or other members of the public
- Not experienced physical violence from managers
- Not experienced physical violence from other colleagues
- Last experience of physical violence reported
- Not experienced harassment, bullying or abuse from patients/service users, their relatives or members of the public
- Not experienced harassment, bullying or abuse from managers
- Not experienced harassment, bullying or abuse from other colleagues
- Last experience of harassment/bullying/abuse reported
- Organisation acts fairly: career progression

We strive to actively look after ourselves and each other. Doing so will enable us to deliver outstanding care for our patients and an outstanding experience for our people

Improve belonging - Survey Indicators

Your job
- Satisfied with recognition for good work
- Satisfied with extent organisation values my work

Your team
- Receive the respect I deserve from my colleagues at work
- Team deals with disagreements constructively
- Feel valued by my team

People in your organisation
- Colleagues are polite and treat each other with respect

Your managers
- Immediate manager works with me to understand problems
- Immediate manager listens to challenges I face
- Immediate manager cares about my concerns
- Immediate manager helps me with problems I face

Your health, well-being and safety at work
- Not experienced physical violence from other colleagues
- Not experienced harassment, bullying or abuse from other colleagues
- Not experienced discrimination from manager/team leader or other colleagues
- Would feel secure raising concerns about unsafe clinical practice
- Would feel confident that organisation would address concerns about unsafe clinical practice
- Feel organisation respects individual differences

Your personal development
- There are opportunities for me to develop my career in this organisation
- Have opportunities to improve my knowledge and skills
- Feel supported to develop my potential

Your organisation
- Feel safe to speak up about anything that concerns me in this organisation
- Feel organisation would address any concerns I raised

Background information
- Disability: organisation made adequate adjustment(s) to enable me to carry out work

We continually listen to our people adapting our efforts to make the culture of our Trust universally understanding, kind and inclusive

New Ways of Working and Delivering Care - Survey Indicators

Your job
- Feel trusted to do my job
- Opportunities to show initiative frequently in my role
- Able to make suggestions to improve the work of my team/dept
- Involved in deciding changes that affect work
- Able to make improvements happen in my area of work
- Enough staff at organisation to do my job properly
- Satisfied with recognition for good work
- Satisfied with extent organisation values my work

Your team
- Team members often meet to discuss the team's effectiveness
- Team members understand each other's roles

People in your organisation
- Teams within the organisation work well together to achieve objectives

Your health, well-being and safety at work
- Organisation acts fairly: career progression
- **Your personal development**
- Received appraisal in the past 12 months
- Appraisal helped me improve how I do my job
- Appraisal helped me agree clear objectives for my work
- Appraisal left me feeling organisation values my work
- Organisation offers me challenging work
- There are opportunities for me to develop my career in this organisation
- Have opportunities to improve my knowledge and skills
- Feel supported to develop my potential
- Able to access the right learning and development opportunities when I need to

Your organisation
- Would recommend organisation as place to work
- I don't often think about leaving this organisation
- I am unlikely to look for a job at a new organisation in the next 12 months
- I am not planning on leaving this organisation
- **Background information**
- Disability: organisation made adequate adjustment(s) to enable me to carry out work

We will develop a culture where continuous improvement thrives and where enhanced people experiences lead to a positive impact on the design and delivery of care

New ways of working and delivering care

Growing for the future - Survey Indicators

Your job
- Always know what work responsibilities are
- Satisfied with recognition for good work
- Satisfied with extent organisation values my work

Your team
- Receive the respect I deserve from my colleagues at work
- Team members understand each other's roles
- Enjoy working with colleagues in team
- Feel valued by my team

People in your organisation
- Teams within the organisation work well together to achieve objectives

Your managers
- Immediate manager works with me to understand problems
- Immediate manager listens to challenges I face
- Immediate manager cares about my concerns
- Immediate manager helps me with problems I face

Your health, well-being and safety at work
- Organisation acts fairly: career progression
- Feel organisation respects individual differences

Your personal development
- There are opportunities for me to develop my career in this organisation
- Have opportunities to improve my knowledge and skills
- Feel supported to develop my potential
- Able to access the right learning and development opportunities when I need to

Your organisation
- I don't often think about leaving this organisation
- I am unlikely to look for a job at a new organisation in the next 12 months
- I am not planning on leaving this organisation

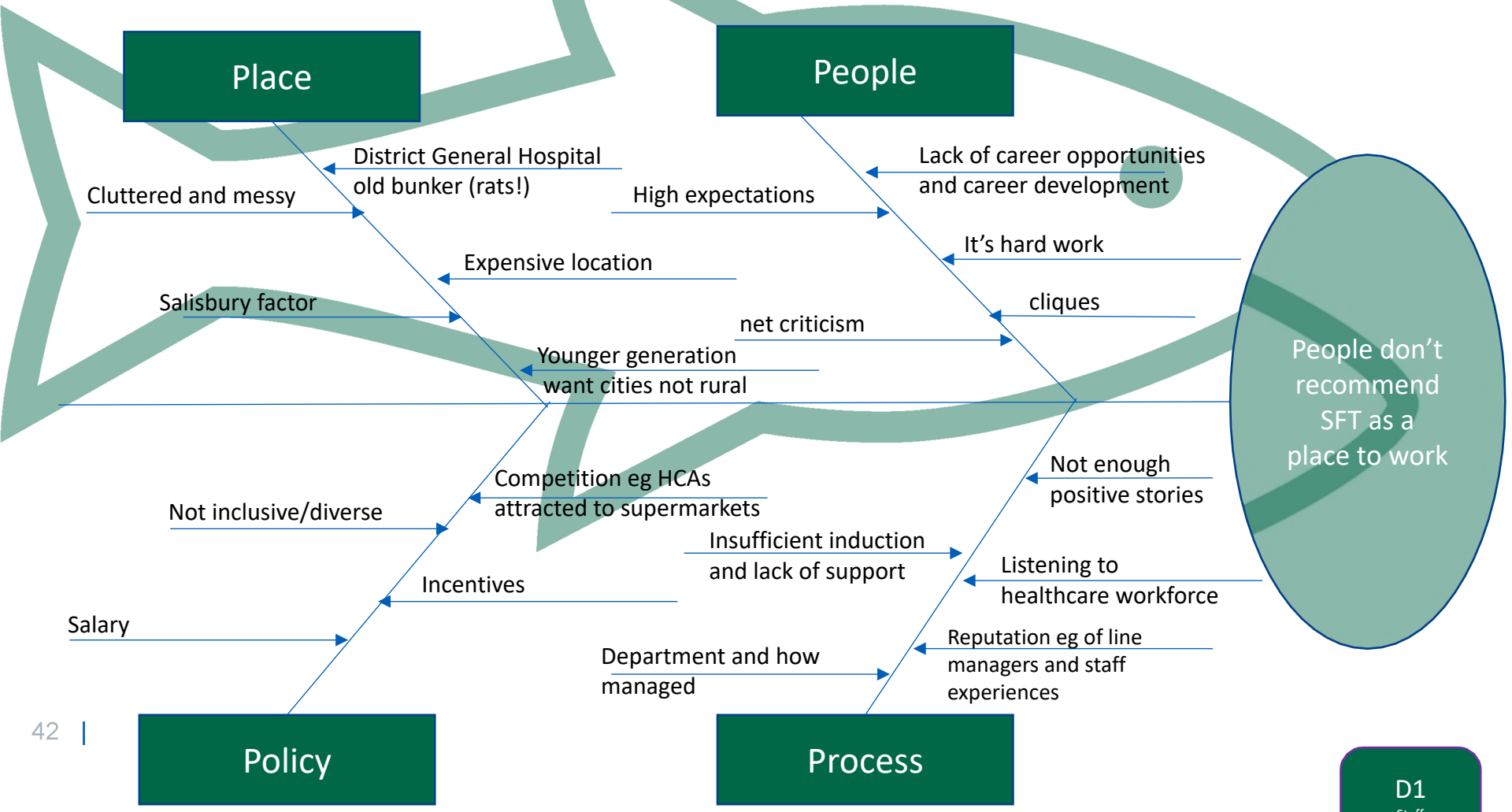
We will have reduced turnover, creating a workplace that supports succession planning and career development opportunities

Fishbone Diagrams

Analysing the problems we face when aiming to meet our Key Watch Metrics. The fishbone diagrams work through cause and effect analysis to determine why the problem is occurring and to enable a shared solution.

Fishbone Diagrams – Driver metric 1: Increase staff engagement and motivation

More People would recommend Salisbury NHS Foundation Trust as a place to work, feeling motivated and supported to make improvements to their work (and the standard of care we give)



D1
Staff motivation and engagement

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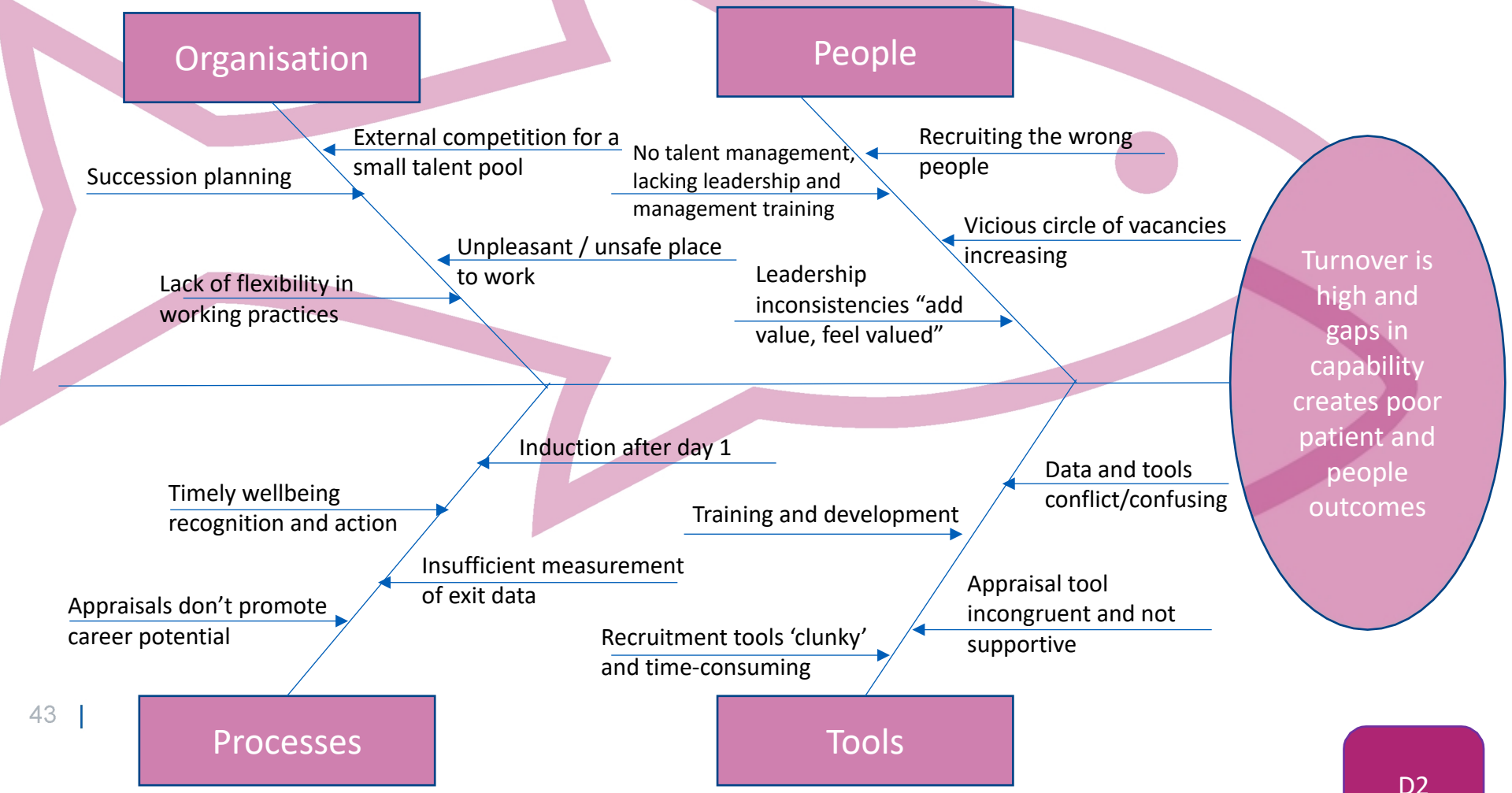
2. Fishbone Diagrams – Driver metric 2: Improve staff retention measured by re

More people stay within our workforce and take up opportunities of promotion or changes

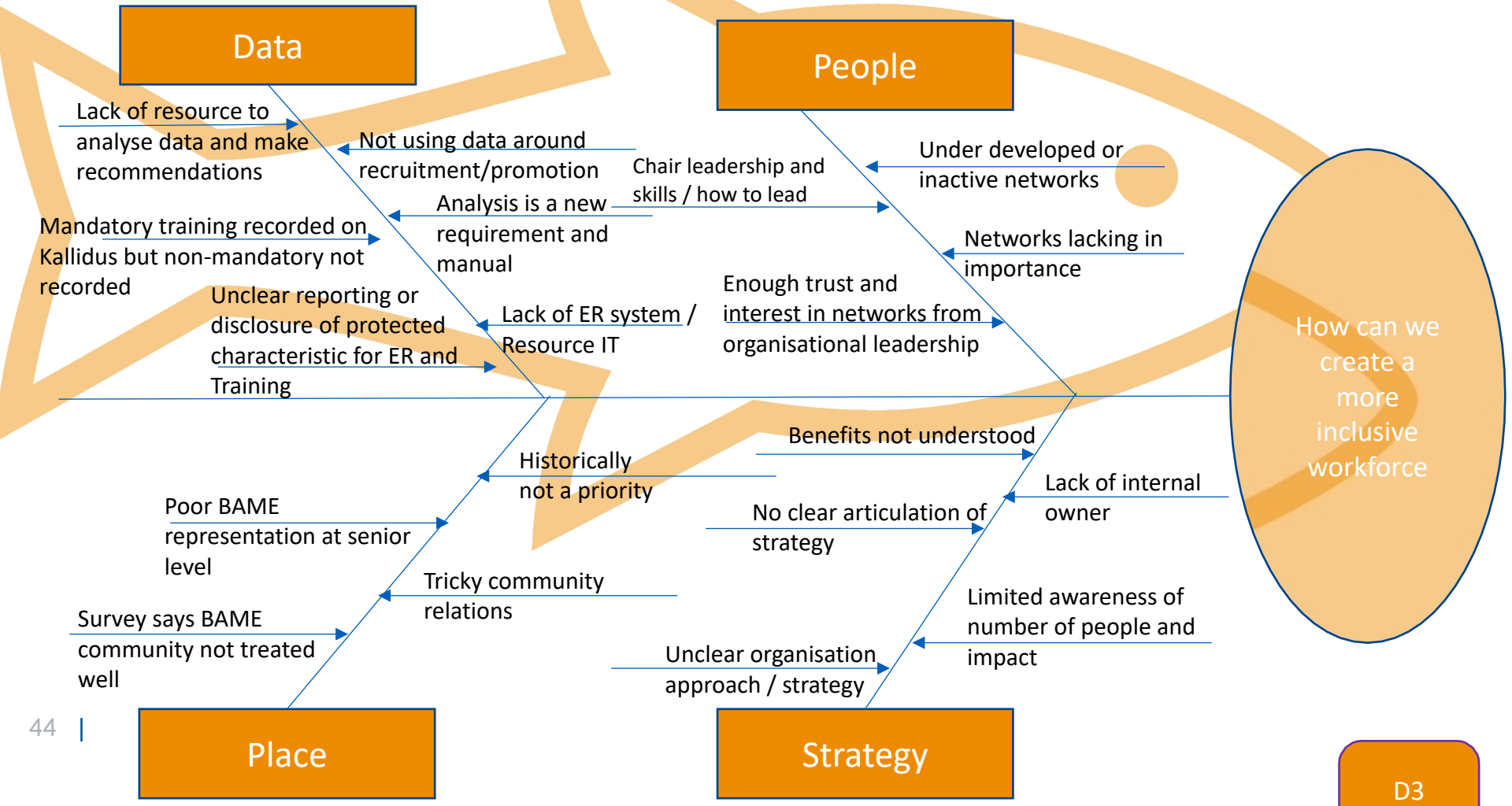


D2
Staff retention

43

3. Fishbone Diagrams – Driver Metric 3: be an inclusive employer

Our people recognise and experience Salisbury NHS Foundation Trust as an inclusive employer



D3
An inclusive employer

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OD&P A3s

Structured frameworks for thinking through problems.
A visual representation of the whole story on one A3 page.

Our A3 – *Improving Together*

Creating a sustainable workforce

Owner - OD&P

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

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

2. Current Situation

In Month 1 22/23 SFT employed 3,647 WTE substantive staff, supplemented by 256 WTE bank workers and 150 WTE agency workers. Bank and agency numbers fluctuate monthly but our substantive workforce is becoming harder to recruit and retain while we have ambitions ot reduce reliance on temp staff.

While at the same time: 36% staff stated they intend to leave, (staff survey) and fewer are recommending SFT as a great place to work 2020 – Q1 2022 LTO is rising form the target of10% to almost 13% and looks set to continue. Underlying this 40% of those recruited from band 2-4 leave in the first 2 years. Only 1/4 of departments meet their stability target at present. Various reasons for leaving are cited and we need to triangulate with high turnover groups and understand the long term impact of key ares of dissatisfaction in planning our interventions.

3. Vision / Goals

The right skills are deployed, in the right place, at the right time to meet patient needs and deliver the agreed service level.

There is clarity about future workforce/talent needs coupled with a fully resourced plan to hire/train new workforce/talent on time and in full.

SFT is attractive to skilled staff, talent is identified and our people are given opportunities to further their career within SFT, maximising retention rates.

We have a pipeline of talent wanting to work at SFT giving us confidence in our ability to replace all leavers as well as to hire/train to new roles and additional workforce to meet future needs.

Staff are able to take their annual and parental leave safe in the knowledge that their shifts will be covered others. Sickness levels are below national averages and returning to work in a timely manner is a positive experience.

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

Temporary workers are available at affordable prices and deployed to maintain flexibility, through peaks of activity.

Accurate workforce analytics enable us to pinpoint and quickly respond to everchanging service and workforce needs. The workforce is affordable and progressively becoming more productive and agile

SFT will operate above average for all staff survey results and within upper quartile .

1. At least 80% of our people will recommend SFT as a great place to work, signifying a satisfied and supported workforce
2. Staff absences due to stress, anxiety and depression to be reduced to <5000 days per year within 3 years and total absences to be controlled not to be above 24% per month.
3. Staff turnover to be declining to <12.1% (rolling year) within 3 years, incorporating an even spread of turnover across all staff demographics/depts .
4. Meet targeted annual Agency expenditure within 3 years
5. This will result in better outcomes for our patients (ref- Kings fund) with reported patient experience to improve year on year at a rate of X % annual improvement – Measured through steadily declining number of complaints.

4. Root Cause Analysis / Gap Analysis

Why is our vacancy rate increasing?

a. Lack of investment in attraction, recruitment and retention – it should be the collective effort of leaders and managers supported by OD&P to make SFT a place that attracts people to work and stay.

b. Lack of investment/focus in talent management whereby managers understand the skills gaps and aspirations of their staff so that opportunities for them to develop can be made available to them.

c. SFT is operating in a challenging environment where there are a lack of qualified staff that want to work in Salisbury's rural community and SFT is not leveraging potential partnerships to make itself more attractive.

Why do we struggle to fill shifts and have to move staff around the hospital?

a. Poor workforce analytics underpinned by poor processes and data/evidence not being presented in a way that drives proactive actions by leadership and management.

b. Lack of establishment control and workforce forecasting/ planning that accurately defines what staff, roles and skills are needed now and into the future.

c. Limited use of e'rostering leading to lack of early visibility of unfilled shifts such that temporary workers can be identified and procured through a centrally managed process in a timely and affordable fashion.

5. Countermeasures year 1.

Work in Progress

a. Launch attraction campaign, including for hard to fill roles, and revise recruitment practices to maximise the number of skilled people attracted to work at SFT. This includes starters and leavers processes to improve staff experience.

b. Define a new establishment control policy and processes with administrative teams being reorganised to ensure optimal management, helping to underpin accurate workforce information.

c. Roll out and optimise use of erostering as rapidly as possible for all non-medical and medical staff and centralise booking bank and agency workers with new grip and control measures to minimise unnecessary use of agency/ pay escalations.

d. Launch new workforce analytics reports through dashboards for leaders and managers to make better, informed decisions.

Undertake a training need assessment exercise to identify the training needed and consider SFT's approach to talent management

E. Flexible working policy

6. Actions and Risks

Recruitment —Efficiency — process reengineering, staffing the function, better tools and documents. Effectiveness,- develop attraction approaches and ways of working, engage the front line & other client areas, improve consultation skills/approaches

Training —Focus on career path support/enhancement, Leadership stage gates & core competencies, Pride in delivering excellence, Fulfil Stat & Mand,

Planning - Longer planning horizons, regular reviews, more functions involved, greater ownership and responsibility

Deployment —Reservists , E'roster, Temp staffing improvements, Holiday management, absence management

Retention —Improve Occupational health , implement well being strategy, Dept focus, implement a culture of appreciation and inclusion

Risks - include delays to implementation driven by: - effort req'd Vs time available, lack of investment, lack of knowledge/ skill to implement, return of pandemic conditions, leadership and political changes of priority.

7. Costs

Investment in OD&P TBC

Investment in people being released for training

7a. Benefits

As an exemplar of NHS People Promise –strategic capability increases

Happy staff deliver better care

Reduction in £4.5m overspend on agency

Savings from retention & less/ more effective recruitment TBC

8. Insights

We have experienced significant decline against benchmarking group and our year on year measures of employee satisfaction and we are struggling to turn it around.

Systems thinking—Increasing instability drives a lack of staff availability which increases instability.

Significant interventions are needed to turn this around. To date we have failed to takle the problem

People management excellence is not the sole province of the OD&P dept, we provide the services and enable the conditions for great people management which delivers a great employee experience and a great place to

Driver Diagrams

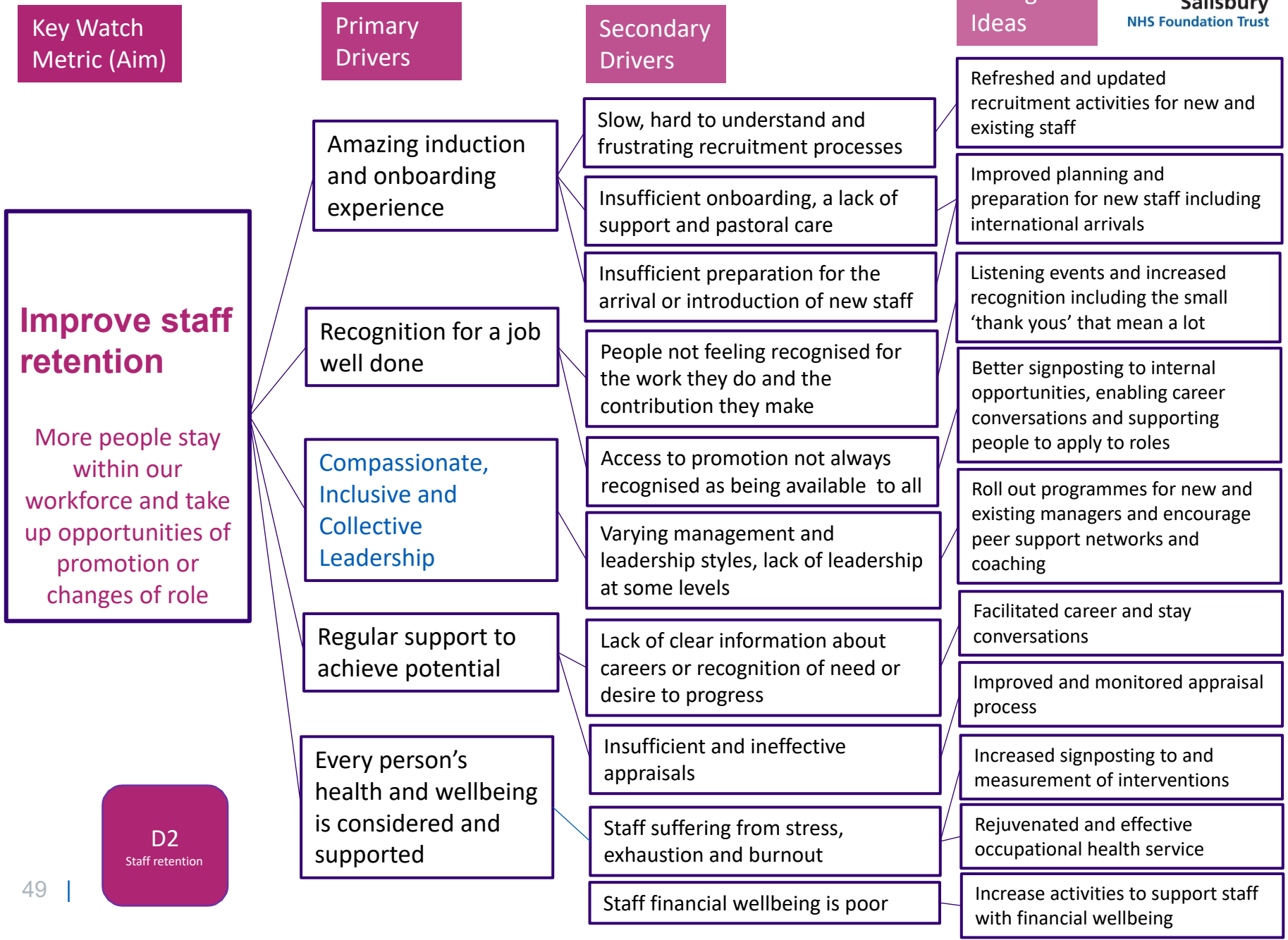
Translating a high level improvement goal or aim into a logical set of high level factors (primary drivers) and identifying our theories of cause and effect about the changes and improvements we are making.

Driver Diagram – Driver Metric 1: Increase Staff engagement

Key Watch Metric (Aim)	Primary Drivers	Secondary Drivers	Change Ideas
Increase staff engagement and motivation More People would recommend Salisbury NHS Foundation Trust as a place to work, feeling motivated and supported to make improvements to their work (and the standard of care we give)	Motivation - Enthusiasm, joy and job satisfaction of existing staff	Negative feedback from staff about their organisation or manager	Provide positive staff stories – online, posters, podcasts, press etc
		Staff not being able to accurately describe the benefits of working here	Improved data collection and measurement of staff engagement
		High levels of absence	Establish an effective listening strategy and feedback loop
		Lack of continuity due to high level agency staff	Clearer signposting to pay and non-pay benefits of working in the NHS
			Manage absence more effectively and close cases swiftly
	Involvement - Attracting, engaging and welcoming new and potential staff	People not being able to access or apply to vacancies easily and swiftly	Improved use of bank staffing
		Widening participation and entry routes not as widely available as they could be	Simpler job descriptions, clearer, smoother recruitment processes
			Better signposting to work experience, widening participation resources and activities
	Advocacy - Promoting Salisbury NHS Foundation Trust as an anchor institution	Links to the wider community not clearly understood	Increased use of volunteers, ambassadors, networks and NHS reservists
		Lack of positive reputation as a model for education, training and career opportunity excellence	Smarter working across BSW and wider organisations in the region
		Improving Together not yet fully implemented	Aim to be a beacon of compassionate leadership, education and innovation

D1
Staff motivation and engagement

Driver Diagram – Driver metric 2: Improve staff retention



D2
Staff retention

Driver Diagram – Driver metric 3: Be an inclusive employer

Key Watch Metric (Aim)	Primary Drivers	Secondary Drivers	Change Ideas
Be an inclusive employer Our people recognise and experience Salisbury NHS Foundation Trust as an inclusive employer	Equality of access to promotion and roles at all levels	Lack of progression beyond a band 5 for BAME people	Consider where glass ceilings are and how to address them
			Give additional support eg how to complete job applications for ESOL
		Clear career frameworks are not in place for all staff groups	Roll out career frameworks and create new for wider staff groups
	An ability to speak up appropriately and without fear of retribution	Some people are afraid to speak up because of detriment	Improve reputation of speaking up to reduce likelihood of detriment
		Line managers not catching issues early enough	Increased roll out of training including managing difficult conversations
		Not all of the networks are fully established	Refresh the membership, role and activities undertaken by networks
		Incomplete EDI database	Clearer collection of data
	Equal access to world class education, training and development	Training needs analysis and identification of training needs is not sufficient	Better signposting and release to attend available training
		Take up of new and existing training not as high as could be	Training for all levels and roles including an increased use of apprenticeships
			Embed a learning culture
	Equal access to working arrangements that suit the person's needs and preferences	Not all disabilities are recorded so reasonable adjustments are not provided	Change language to include living with a condition and provide better support and buddying to access adjustments
		Access to flexible working and e-rostering is not universal	Clarify and simplify flexible working processes and enable e- and team rostering for all
		Not approaching retirement age people aware of pension details and how to return	Deliver pension workshops and encourage retire and return

D3
An inclusive employer

2022/23 Data

Slides with additional data to further illustrate the measurements included earlier in the pack.

Protected Characteristics – Breakdown as at 31 August 2022

Ethnicity	Non Board	Board Member	Grand Total
Asian	552	1	553
Black	165		165
Mixed	58		58
Not Stated	121	3	124
Other	160		160
White	3829	10	3839
Grand Total	**4885**	**14**	**4899**

Gender	Non Board	Board Member	Grand Total
Female	3723	7	3730
Male	1162	7	1169
Grand Total	**4885**	**14**	**4899**

Sexual Orientatior	Non Board	Board Member	Grand Total
Bisexual	61	1	62
Gay or Lesbian	48		48
Heterosexual or St	4145	6	4151
Not stated (persor	503	6	509
Other sexual orier	9		9
Undecided	2		2
Unspecified	117	1	118
Grand Total	**4885**	**14**	**4899**

Religion	Non Board	Board Member	Grand Total
Atheism	794	3	797
Buddhism	49		49
Christianity	2620	3	2623
Hinduism	137	1	138
I do not wish to disclose my religion/belief	744	6	750
Islam	88		88
Jainism	1		1
Judaism	3		3
Other	327		327
Sikhism	4		4
Unspecified	118	1	119
Grand Total	**4885**	**14**	**4899**

Disability	Non Board	Board Member	Grand Total
No	4497	8	4505
Not Declared	253	6	259
Yes	135		135
Grand Total	**4885**	**14**	**4899**

Status	Non Board	Board Member	Grand Total
Full Time	2447	14	2461
Part Time	2438		2438
Grand Total	**4885**	**14**	**4899**

FTE Sickness – Breakdown for financial year 2021/22

FTE Days Lost - by Ethnicity

Reason	BME	Not Stated	White	Grand Total
S10 Anxiety/stress/depression/other psychiatric illnesses	1137	233	10797	12167
S27 Infectious diseases	2290	377	7518	10185
S12 Other musculoskeletal problems	972	43	3903	4917
S13 Cold, Cough, Flu - Influenza	802	100	2805	3707
S25 Gastrointestinal problems	689	147	2769	3605
S11 Back Problems	486	28	2363	2877
S28 Injury, fracture	282		1628	1910
S30 Pregnancy related disorders	888	36	831	1756
S98 Other known causes - not elsewhere classified	140	5	1572	1717
S21 Ear, nose, throat (ENT)	505	13	1124	1641
S16 Headache / migraine	284	33	1232	1549
S17 Benign and malignant tumours, cancers	189		1318	1507
S26 Genitourinary & gynaecological disorders	353	8	778	1139
S29 Nervous system disorders	8	39	881	929
S15 Chest & respiratory problems	129	1	691	821
S19 Heart, cardiac & circulatory problems	123	1	409	533
S31 Skin disorders	8	1	473	481
S23 Eye problems	21	104	258	383
S24 Endocrine / glandular problems	43		272	315
S22 Dental and oral problems	48	2	182	231
S18 Blood disorders	19		187	206
S14 Asthma	29	13	53	95
S99 Unknown causes / Not specified	1		66	67
S20 Burns, poisoning, frostbite, hypothermia	1		12	13
Grand Total	**9447**	**1184**	**42123**	**52753**

FTE Days Lost - by Gender

Reason	Female	Male	Grand Total
S10 Anxiety/stress/depression/other psychiatric illnesses	10237	1930	12167
S27 Infectious diseases	7943	2242	10185
S12 Other musculoskeletal problems	4096	821	4917
S13 Cold, Cough, Flu - Influenza	2974	733	3707
S25 Gastrointestinal problems	2946	659	3605
S11 Back Problems	2060	817	2877
S28 Injury, fracture	1233	677	1910
S30 Pregnancy related disorders	1756		1756
S98 Other known causes - not elsewhere classified	1298	418	1717
S21 Ear, nose, throat (ENT)	1168	473	1641
S16 Headache / migraine	1363	186	1549
S17 Benign and malignant tumours, cancers	1507		1507
S26 Genitourinary & gynaecological disorders	1095	44	1139
S29 Nervous system disorders	793	136	929
S15 Chest & respiratory problems	536	285	821
S19 Heart, cardiac & circulatory problems	407	126	533
S31 Skin disorders	436	46	481
S23 Eye problems	171	212	383
S24 Endocrine / glandular problems	301	14	315
S22 Dental and oral problems	166	65	231
S18 Blood disorders	179	27	206
S14 Asthma	95		95
S99 Unknown causes / Not specified	56	11	67
S20 Burns, poisoning, frostbite, hypothermia	6	7	13
Grand Total	**42823**	**9930**	**52753**

FTE Sickness – Breakdown for financial year 2021/22

FTE Days Lost - by Role

Reason	Add Prof Scientific and Technic	Additional Clinical Services	Administrative and Clerical	Allied Health Professionals	Estates and Ancillary	Healthcare Scientists	Medical and Dental	Nursing and Midwifery Registered	Grand Total
S10 Anxiety/stress/depression/other psychiatric illnesses	1179	3666	2311	305	648	223	235	3600	12167
S27 Infectious diseases	629	1376	2299	712	672	295	1196	3006	10185
S12 Other musculoskeletal problems	84	1658	737	96	767	44	1	1531	4917
S13 Cold, Cough, Flu - Influenza	189	608	856	227	493	97	64	1173	3707
S25 Gastrointestinal problems	352	847	704	112	316	37	56	1181	3605
S11 Back Problems	56	1260	235	34	151	13	235	894	2877
S28 Injury, fracture	87	440	385	86	553	9	17	333	1910
S30 Pregnancy related disorders	3	394	211	35	21	15	56	1019	1756
S98 Other known causes - not elsewhere classified	124	129	753	5	387	12	31	275	1717
S21 Ear, nose, throat (ENT)	36	177	439	26	96	161	338	370	1641
S16 Headache / migraine	111	504	395	58	46	28	16	390	1549
S17 Benign and malignant tumours, cancers	1		580	5	125		125	670	1507
S26 Genitourinary & gynaecological disorders	96	244	135	6	94	5	2	557	1139
S29 Nervous system disorders		359	18	59	12			481	929
S15 Chest & respiratory problems	216	114	180	17	67	8		219	821
S19 Heart, cardiac & circulatory problems	78	43	151	7	27	7		220	533
S31 Skin disorders	3	327	69	1	3	4		74	481
S23 Eye problems	17	21	122	110	18	10	1	84	383
S24 Endocrine / glandular problems	2	23	34	9	209	1		37	315
S22 Dental and oral problems	3	58	23	7	48	1	2	90	231
S18 Blood disorders	1	3	53	0	23			126	206
S14 Asthma	5	34	23					33	95
S99 Unknown causes / Not specified			47	1			17	1	67
S20 Burns, poisoning, frostbite, hypothermia		3	1		7			2	13
Grand Total	**3273**	**12288**	**10762**	**1919**	**4781**	**970**	**2392**	**16367**	**52753**

FTE Sickness – Breakdown for financial year 2021/22

FTE Days Lost - by division								
Reason	Clinical Support & Family Services	Corporate	Facilities	Medicine	Quality	Surgery	Women and Newborn	Grand Total
S10 Anxiety/stress/depression/other psychiatric illnesses	1927	1158	567	3462	399	3846	808	12167
S27 Infectious diseases	1504	1257	639	3277	173	2432	903	10185
S12 Other musculoskeletal problems	192	341	786	1620	181	1545	252	4917
S13 Cold, Cough, Flu - Influenza	543	439	463	1116	95	827	221	3705
S25 Gastrointestinal problems	492	278	347	1121	46	1153	169	3605
S11 Back Problems	243	121	106	1455	2	848	102	2877
S28 Injury, fracture	197	264	566	494		359	25	1906
S30 Pregnancy related disorders	41	116	21	735		801	42	1756
S98 Other known causes - not elsewhere classified	311	187	442	133	1	490	153	1717
S21 Ear, nose, throat (ENT)	544	280	108	171		428	111	1641
S16 Headache / migraine	296	112	43	437	12	589	59	1547
S17 Benign and malignant tumours, cancers	127	182	125	541		532		1507
S26 Genitourinary & gynaecological disorders	155	15	93	323	6	470	78	1139
S29 Nervous system disorders	1	29		448		449	2	929
S15 Chest & respiratory problems	77	108	14	124	14	392	92	821
S19 Heart, cardiac & circulatory problems	31	101	35	100	86	178	2	533
S31 Skin disorders	19	40	3	158		251	11	481
S23 Eye problems	32	108		168	15	58	3	383
S24 Endocrine / glandular problems	4		205	31	36	39		315
S22 Dental and oral problems	7	51	12	76		83	2	231
S18 Blood disorders	28	108	14	48		4	4	206
S14 Asthma	15	8		11		20	41	95
S99 Unknown causes / Not specified	2	47		17		1		67
S20 Burns, poisoning, frostbite, hypothermia		5	3	1		5		13
Grand Total	**6788**	**5354**	**4590**	**16066**	**1067**	**15800**	**3079**	**52745**

FTE Sickness – Breakdown for financial year 2021/22

FTE Days Lost - by band													
Reason	Band 1	Band 2	Band 3	Band 4	Band 5	Band 6	Band 7	Band 8	Consultant	Non AfC	Specialty Doctor	Trainee Doctor	Grand Total
S10 Anxiety/stress/depression/other psychiatric illnesses		3549	1894	1019	2230	1889	730	620	191		34	10	12167
S27 Infectious diseases	6	1783	1717	586	2217	1809	646	223	489	3	656	50	10185
S12 Other musculoskeletal problems	2	2181	603	199	1315	478	135	3			1		4917
S13 Cold, Cough, Flu - Influenza		1056	524	232	978	551	217	84	17		39	8	3707
S25 Gastrointestinal problems	1	1059	652	201	1101	324	143	68	10		33	13	3605
S11 Back Problems		1267	302	62	418	398	166	28	57		178		2877
S28 Injury, fracture	1	847	305	150	332	130	84	44	3		14		1910
S30 Pregnancy related disorders		416	94	116	905	149	18		9		6	41	1756
S98 Other known causes - not elsewhere classified		809	265	257	55	85	24	190			31		1717
S21 Ear, nose, throat (ENT)		311	107	54	316	475	25	15	333		5		1641
S16 Headache / migraine		662	171	90	346	170	75	18	4	1	13		1549
S17 Benign and malignant tumours, cancers		499	24		410	281	5	163	125				1507
S26 Genitourinary & gynaecological disorders		325	156	28	385	127	111	4			2		1139
S29 Nervous system disorders		58	330	1	89	326	125						929
S15 Chest & respiratory problems		119	141	31	188	119	23	200					821
S19 Heart, cardiac & circulatory problems		97	31	60	146	85	107	6					533
S31 Skin disorders		328	34	2	48	30	16	24					481
S23 Eye problems		16	13	53	67	189	29	15			1		383
S24 Endocrine / glandular problems		227	38	1	28	22							315
S22 Dental and oral problems		53	29	41	59	21	25	2	1		1		231
S18 Blood disorders		42	7	28	45	84		1					206
S14 Asthma		37	18	2	4	34							95
S99 Unknown causes / Not specified		1	6	28		7	3	5	12			5	67
S20 Burns, poisoning, frostbite, hypothermia		10	1			2							13
Grand Total	**10**	**15754**	**7463**	**3241**	**11684**	**7786**	**2709**	**1712**	**1251**	**4**	**1013**	**127**	**52753**

Apprenticeship data as at 31 August 2022

	Level	Live	Paused
Advanced Clinical Practitioner	7	8	1
Associate Project Manager	4	1	1
Business Administrator	3	7	1
Chartered Manager Degree	6	4	
Clinical Coder	3	1	
Coaching Professional	5	4	
Commercial Procurement and Supply	4	3	
Customer Service Practitioner	2	1	
Customer Service Specialist	3	1	
Cyber Security Technologist	4	2	
Diagnostic Radiographer	6	2	
Engineering Technician Maintenance	3	1	
Healthcare Science Practitioner	6	6	
Learning and Skills Teacher	5		1
Nursing Associate	5	15	1
Occupational therapy	6	2	
Operating Department Practitioner	6	3	
Operational/Departmental Manager	5	4	

	Level	Live	Paused
Payroll Administrator	3	2	
Pharmacy Service Assistant	2	2	
Pharmacy Technician	3	5	
Physiotherapy	6	2	
Plumbing and Domestic Heating	3	1	
Production Chef	2	2	
Professional Accountancy	7	1	
Project Manager	6		1
Property Maintenance Operative	2	1	
Registered Nurse Degree	6	4	
Senior Healthcare Support Worker	3	27	
Senior Leader	7	20	1
Senior People Professional	7		1
Team Leader/Supervisor	3	8	1
TOTAL		**140**	**9**
New Recruits		1	1
Funding Transfer		33	

Pension seminar data as at 31 August 2022

Session	Date	Numbers booked	Spaces	Available spaces
Pensions Tax (Annual and Lifetime Allowance)	13/06/2022	14	25	11
	23/06/2022	25	25	0
	29/06/2022	24	25	1
	05/07/2022	25	25	0
	12/07/2022	16	25	9
	20/07/2022	21	25	4
	28/07/2022	11	25	14
	05/08/2022	14	25	11
	09/08/2022	18	25	7
	18/08/2022	24	25	1
Total		192	250	77% uptake

Session	Date	Numbers booked	Spaces	Available spaces
Flexible Working and Pensions	16/06/2022	21	50	29
	21/06/2022	14	50	36
	30/06/2022	39	50	11
	08/07/2022	37	50	13
	13/07/2022	20	50	30
	18/07/2022	29	50	21
	03/08/2022	26	50	24
	08/08/2022	26	50	24
Total		212	400	53% uptake

Session	Date	Numbers booked	Spaces	Available spaces
The McCloud Remedy	14/06/2022	19	50	31
	23/06/2022	27	50	23
	30/06/2022	37	50	13
	04/07/2022	48	50	2
	15/07/2022	49	50	1
Total		180	250	72% uptake

Session	Date	Numbers booked	Spaces	Available spaces
Introduction to NHS Scheme	21/06/2022	50	50	0
	07/07/2022	49	50	1
	13/07/2022	50	50	0
	25/07/2022	40	50	10
	10/08/2022	50	50	0
	24/08/2022	33	50	17
	08/09/2022	49	50	1
	20/09/2022	22	50	28
Total		343	400	86% uptake so far

Salisbury NHS Foundation Trust

Report to:	Trust Board (Public)	Agenda item:	4.2
Date of Meeting:	12 January 2023		

Report Title:	Health and Safety Quarterly Report			
Status:	Information	Discussion	Assurance	Approval
			X	
Approval Process	TMC			
Prepared by:	Troy Ready – Health and Safety Manager			
Sponsor (presenting):	Melanie Whitfield – Chief People Officer			
Appendices				

Recommendation

The Board is asked to **note:**

1. The greater assurance H&S is working towards and audit activity scheduled to commence in early 2023.
2. The disparity between Datix injury reports and absences from work that could be work related injuries. The H&S team is undertaking further work to identify and understand the actual impact of work related lost time injuries.
3. The conflation of risks and actions and work being undertaken by the H&S team to obtain a better understanding of the current risk profile across the Trust.
4. Injury rates remain consistent with this time last year.

Executive Summary

This report provides a brief overview of the actions taken to improve the systematic management of H&S across SFT in the past 3 months. Actions include:

- Drafting procedures for improved H&S assurance activity aligned to the requirements of standardised management system ISO 45001.
- Designing a suite of H&S performance measures and reports to provide updates against performance targets.
- Developing a H&S audit calendar and task analysis program.

It is noted that much of the past 3 months have involved the design and planning of H&S activity. The implementation of auditing, task analysis and reviewing risk activity will commence in earnest from January.

The previous health and safety (H&S) report provided to the Board identified the need for a structured H&S management system and the absence of a formal H&S management system was documented as a corporate risk on the OD&P risk register. The following provides an update on the current H&S situation across SFT.

H&S Management System Update

DRAFT procedures have been developed as required by ISO 45001 to provide an assurance structure to the management of H&S at SFT. Specific procedures drafted in the past quarter include:

1. An internal H&S Audit Procedure,
2. An Audit Calendar,
3. H&S Planning Procedure,
4. H&S Management Review Procedure, and
5. A H&S Reporting Procedure

Each of the above draft procedures have been approved by the H&S Committee. Work has also commenced on an internal audit tool and the first internal H&S audit against this audit tool will be conducted in January 2023. In conjunction with internal H&S auditing, task analysis activity has already commenced and will continue according to the calendar below.

Common findings, gaps and actions will be provided within each H&S report to the Board. Each report will communicate where risks to H&S and organisation liability have been identified with clear actions to mitigate exposure.

Calendar of Key Dates and Actions 2023/2024

NHS Salisbury NHS Foundation Trust

Nov 22	Dec	Jan 23	Feb	Mar	Apr	May	June	Jul	Aug	Sept	Oct
		Estates - technical		Medicine – ED and AMU				CSFS			Pathology
	Kitchen	Odstock fitness	Pathology	Porters	Med Eng	Theatres	ED & AMU	Surgery wards			ICU, CCU & NICU
Q3	Q3	Q3	E of Y Report	E of Y Report	E of Y Report	Q1	Q1	Q1	½ year review	½ year review	½ year report

Nov	Dec	Jan 24	Feb	Mar	Apr	May	Jun	Jul	Aug	Sept	Oct
Estates - Ops		Rehab & Spinal		Surgery				Clinical Engineering		Midwifery & Neonates	
Clinical Engineering	Post, Courier & Transport	Education Team		IR, Nuc Med & Cath Lab			Security & Parking	Radiology	MHLT		
Q3	Q3	Q3	E of Y Report	E of Y Report	E of Y Report	Q1	Q1	Q1	½ year report	½ year report	½ year report

TMC H&S Report | Audit | Task Analysis | OD&P H&S Report | Board H&S Report

H&S Goals, Objectives and Reporting

Another key element of the H&SMS being developed is the introduction of key performance measures that can be used to identify H&S performance. H&S reports will include the table below which provides a breakdown of performance measures, injury rates and classifications of injury by division. Performance measures are explained below.

Lost Time Injury Frequency Rate (LTIFR)	LTIFR is a standard H&S performance measure that records the number of lost time injuries reported per 1,000,000 hours worked. A lost time injury is defined as someone who reports a work related injury who cannot return to the following shift.
Lost Time Frequency Rate (LTFR)	LTFR is the total hours lost because of work related injury and absence from work. LTFR is a standard H&S performance measure that records the total hours lost 1,000 hours worked.
RIDDOR	Reportable incident under H&S laws that require the Health and Safety Executive to be notified of injuries that result in greater than 7 days off work
Hours Lost	Accumulated total of hours lost because staff are unfit to work.
Medical Treatment Injury (MTI)	MTI is an injury that requires input from GP or Occupational Health but does not require time off work
Near Miss	An incident that did not result in harm to staff.

H&S reporting will not just provide quantitative figures. Effective reporting requires a qualitative approach to explain the impact of injuries, root cause and corrective actions but also a narrative around concerns staff have that are unlikely to be formally communicated to the H&S Committee, staff side representatives, managers or reported on Datix. There are a number of projects the H&S team has been asked to support and will regularly report on. This includes information from Diversity, Inclusion & Wellbeing Networks, Occupational Health and Safeguarding. It is expected information from each specialism will help provide some of the narrative around health and safety concerns that still protect the privacy and confidentiality of staff raising concerns.

A Draft version of how H&S metrics will be reported is seen in the table below.

Salisbury NHS Foundation Trust

Frequency Rates														
	Hours Lost	YTD	LTFR	YTD	LTIFR	YTD	LTI	YTD	MTI	YTD	Near Miss	YTD	RIDDOR	YTD
Estates														
Facilities														
Surgery														
Medicine														
Newborns														
CSFS														
Corporate														
Total														

Activity	
Incident Investigations	
Return to Work Discussion	
Task Analysis	

Salisbury
NHS Foundation Trust

Distinguishing absence from work and work related injuries

There is still some work required to develop the data available to ensure accurate H&S performance results are provided. Current figures for lost time injuries, wages paid and hours lost do not distinguish injuries that are work related and absences from work that are not work related.

Using September only, 141 staff recorded time lost due to injuries in September (again it is not known how much is work related or not). Removing obvious non work related illness identified 986 FTE work days lost, with anxiety and stress and musculoskeletal injuries the 2 most frequently reported reasons for time off work. Determining what is work related will be the subject of further analysis for future reporting.

FTE Days Lost by Division

Division	FTE Days Lost	No of LTI's
Corporate	30	6
CSFS	364	34
Facilities	111	14
Medicine	146	27
Surgery	290	50
W&N	45	10
Total	**986 days lost**	**141**

Total Hours Worked	106,276
Hours lost per 1000 hours worked	9.3

The current results show performance significantly worse than what would be expected. It would be unrealistic to suggest there were 141 work related lost time injuries reported over the 4 week period of September with a workforce of 4500 staff and demonstrates why work related, and not work related injuries, need to be distinguished. Once accurately reported, further analysis of time lost can occur.

Policy and Procedures

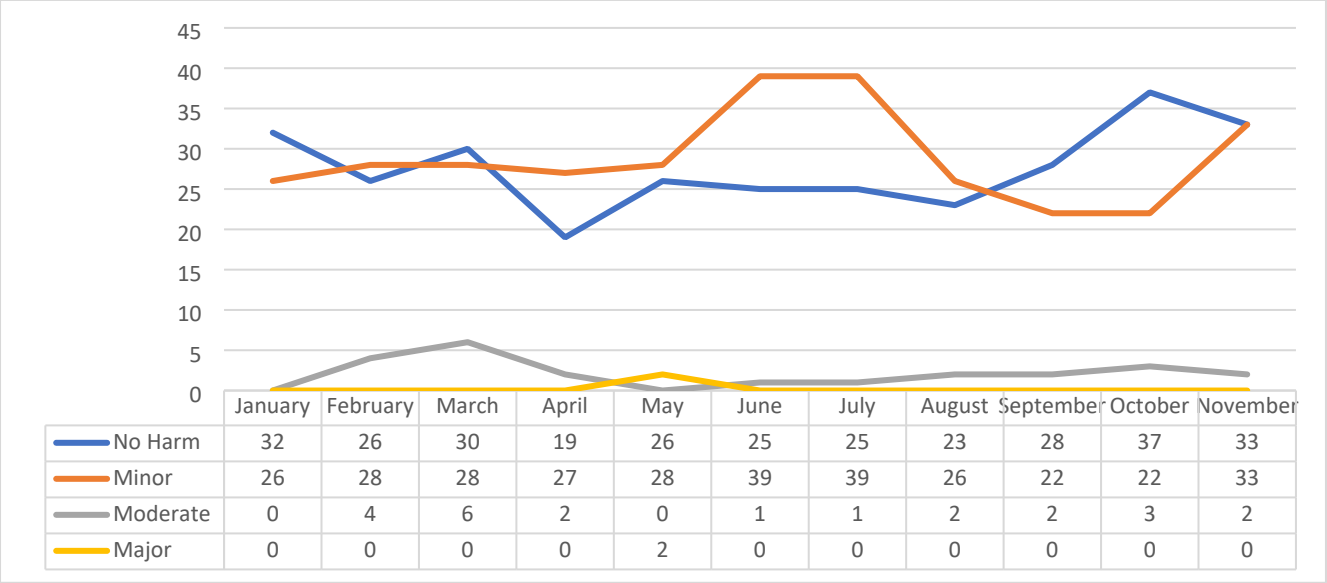
The last H&S report provided an update on the number of procedures and policies that need to be reviewed or developed. A worklist of outstanding H&S policies was provided to the H&S Manager and work continues to identify procedures that need to be developed. A review of this policies identified:

The ongoing review of procedures shows there are now 12 out of date (up from 7), with a further 5 to be reviewed (down from 12). A project plan is currently being drafted to develop timeframes for policies to be reviewed and presented to the H&S Committee and Operational Management Board (OMB).

Injury and Incident Reported on Datix

Injury Rates between September and November saw 2 reportable injuries under the Reporting of Injuries, Diseases and Dangerous Occurrences Regulations (RIDDOR) which suggests much of the time lost that is greater than 7 days was not for work related injuries. Alternatively there may be a gap between Datix and time lost which will be further investigated and understood. Other headline statistics for September show injury rates comparable with this time last year.

Consequence	Number of reports
Low or no harm	175
Moderate harm and time lost from work	7
Major	0



	January	February	March	April	May	June	July	August	September	October	November
No Harm	32	26	30	19	26	25	25	23	28	37	33
Minor	26	28	28	27	28	39	39	26	22	22	33
Moderate	0	4	6	2	0	1	1	2	2	3	2
Major	0	0	0	0	2	0	0	0	0	0	0

RIDDOR 1

A nurse on Durrington Ward was kicked in the leg and physically assaulted by a confused and aggressive patient who was a failed discharge, having assaulted carers at the nursing home the patient had been discharged to the day before.

The patient was not aggressive on presentation to AMU, yet a Band 2 was requested due to the history of aggression but one was not available. Security was not in attendance because the patient was not being aggressive. The patient's behavior escalated quickly, and they attempted to take another patients belongings. In trying to intervene the nurse was held by the patient and kicked in the leg. The staff member finished the shift but did not return and remains off work with anxiety. The Ward Sister and Health and Safety Manager remain in contact with the staff member who continues to receive treatment.

This incident shows the difficulty in sourcing 1:1 supervision and the risk staff are exposed to when staffing resources are not available.

RIDDOR 2

A nurse in ED was performing CPR on a patient. In doing so, a colleague lowered the height of the bed and the nurse performing CPR exacerbated a pre existing back injury. The worker was unfit to work for 10 days, returned to work performing non clinical work and has now returned to clinical duties.

By Incident and Location

60% of the 182 incidents reported during Q3 were attributed to the following 5 categories.

Top 5 Categories of Incident	
Abuse of staff by patient (verbal and or physical)	56
Needlestick injury or other incident connected with sharps	19
Slips, trips, falls and collisions	17
Exposure to electricity, hazards, substance, infection etc	8
Other	7
Total	**107**

Comparing Datix and OD&P data there is the potential for disparity between reporting that needs further analysis in the coming months to determine what is actually work related or not.

Most Reported Incident by Location	**Total**
Theatres	9
Odstock	9
Amesbury Suite	8
Spire	7
ED	7
Whiteparish	7
AMU	7

H&S Risks on Risk Register

Risk	Score	Actions
There are no extreme risks recorded (risk score >15)		
2 risks recorded as high risk		
Non compliance with health and safety law (2022)	12	Progress continues and is expected to be complete by the end of January 2023.
Lack of HSE training for ETS (2016)	9	Funding for training has been allocated and staff are attending external HSE courses
14 risks recorded as medium risk. Some of which are the same risk across divisions		
8 risks recorded as low risk – all of which are previously recorded and duplicated as low risks.		

Commentary on Risk Register

Many of the moderate and low risks do not have actions assigned and are reviewed on an annual basis. Risks therefore remain elevated, or remain on the risk register for prolonged periods of time, despite implementing some corrective actions that reduce the risk to tolerated levels. A wider review of the Trust Risk Register shows many risks are conflated with action plans as a function of normal business operations.

Business as usual activity being recorded as a risk is seen with the current Estates Technical Services (ETS) Risk Register. Many of the 80 extreme risks are action items identified by Authorising Engineers (AE) and there is evidence of an unrealistically conservative approach to assessing the likelihood and consequence of harm has taken place. Doing so does not accurately reflect the risk to SFT. For example, the ETS Risk Register lists a number of extreme risks due to imminent and catastrophic harm. Two such examples include:

• The wording on the interpretation of the Asbestos Register, and

• A spring loaded shower tap in Odstock Fitness Centre not being inspected every 3 months.

Neither risk is likely to cause imminent and catastrophic harm but is indeed an action that needs to be taken. Notwithstanding the confusion between action items and risk, there are still significant risks present within ETS. These can be linked to 2 risks:

1. Computer Aided Facility Management (CAFM) software is used to plan preventative maintenance (PPM). Ensuring all assets are included within the CAFM and subject to PPM 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 extreme risks listed above, but not all assets are currently identified and therefore not subject to PPM, inspection or audit.

Unknown and unallocated assets not documented on the CAFM and not assigned PPM, inspection or audited is a significant risk within ETS.

2. Reactive, and scheduled, maintenance is impacted by the resources available within the Estates team. As above there are currently more than 80 outstanding actions that are prioritised and actioned according to risk, some of which are not completed due to resourcing. The risk remains that actions identified in the CAFM, are not allocated resources sufficient to maintain, inspect and audit plant according to the schedules required by the AE. Understanding what is critical within the 80 outstanding actions and ensuring resources are allocated and timelines for PPM is an ongoing task within ETS.

There is a piece of work to be conducted by the H&S team with the risk owners to understand if there is a risk that needs further action, or if the risk is a business as usual function associated with normal work practices. To better understand those 80 ETS risks, specific risk discussions between H&S and ETS continue to occur on a regular basis. This work is expected to provide the Board with a realistic register of what is actually known to be high risk, where liability actually lies and to provide assurance that risks to H&S are actioned by April 2023.

Salisbury NHS Foundation Trust

Report to:	Trust Board (Public)	**Agenda item:**	4.3
Date of Meeting:	12 January 2023		

Report Title:	Annual Medical Education Performance Report			
Status:	**Information**	**Discussion**	**Assurance**	**Approval**
			x	
Approval Process (where has this paper been reviewed and approved)	Organisational Development and People Management Board - 15 November 2022			
Prepared by:	Dr Emma Halliwell, Director of Medical Education			
Executive Sponsor	Dr Peter Collins, Chief Medical Officer			
Appendices (list if applicable):				

Recommendation:
For assurance and awareness of state of medical education at SFT.

Executive Summary:
When I penned this report 12 months ago, I had hoped that I would be able to report that the situation in the NHS was much improved over two years after the onset of the Covid-19 pandemic and that, as a result, the education and training of our junior doctors had settled back into a 'normal' routine. However, the ongoing and relentless clinical pressures that we are experiencing locally and nationally continue to have a marked impact and it remains a difficult time for all those working in the health and care sectors. The omicron waves of Covid pandemic proved to be a challenge. Thankfully, the number of sick in-patients was markedly reduced compared with previous waves. In contrast, staff sickness was high over this period, and impacted on the staffing levels right across the Trust. This was actively managed to mitigate risk, but our doctors in training were inevitably impacted because of the nature of the resultant working environment. The need for the educational fraternity and employing organisations to work together to prioritise education and training, in light of the sustained clinical pressure, has becoming increasing paramount. It is recognised that the more senior trainees in the craft specialties (e.g. surgery, endoscopy, etc.), who were impacted most by the pandemic, are also going to struggle to gain experience if elective activity has to be sacrificed due to the burden of emergency admissions. The situation also leads to tension with regards to the consistent implementation of 'self-development' time for trainees which has been a requirement for over 12 months now. Both of these will need to be closely monitored. On a more positive note, it was exceedingly pleasing to see the very positive feedback from the GMC survey in departments that have been at the 'coal-face' of all the pressure. The Emergency

Department are to be congratulated; their results for F2 training were outstanding. It proves that we are still able to produce high quality education for our doctors in training despite the challenging circumstances.

Well-being of our junior doctors remains a concern both in the short and long term, but the ability to socialise out of work and the return of face-to-face training has done much to improve morale. Alongside this, the Mess has been fully refurbished and is now a welcoming space that is well used by the junior doctors, medical students and the wider teams. The mess committee are to be praised for all the hard work that has gone into producing an attractive and varied programme of events, which has had a very positive impact.

The medical education team are now well-established in their roles. We were delighted to be joined by Dr. Gail Ng as the lead for our Physician Associate students. She has worked hard to ensure that our increasing PA student cohort have a positive experience whilst they are with us on placement and is doing much to champion their roles at Trust level. It is hoped that the Trust will have a business case in place to look at appointing qualified PAs in the near future.

Nationally, expansion of the Foundation Programme was planned over the next three years to accommodate those graduating following the increase in medical student places. However, there was a large oversubscription to the Foundation Programme this year and so were asked to bring forward this expansion. My thanks go to the Trust Executive Team for agreeing to increase our numbers from a baseline of 21 F1s and 22 F2s, to 33 F1s and 33 F2s, which came into effect in August this year. I would also like to acknowledge the hard work and expertise that Dr. Georgina Morris, Foundation Programme Director, put into designing new rotations which balance the educational requirements of the new doctors in training and the service pressures in the Trust.
Such expansion, whilst welcome, has its own challenges as a reasonable minority of the F1s are new to the NHS, having graduated abroad. This is also the case with those joining GP VTS programmes. As a result, we have advertised for an 'International Medical Graduate Champion' to help oversee the support, education and training of not only these doctors in training but also those that are appointed by the Trust directly.

Ms. Rashi Arora continues to play a vital role as SAS and LED Development Lead. Her CESR mentorship group is gaining traction and it is a privilege to be able to support some of our doctors who wish to take this route onto the specialist register. SAS doctors have been encouraged to take on some wider Trust roles, such as acting as Educational Supervisors for the Foundation Doctors. A lot of work has gone into the development of a process for the appraisal of LEDs; it is envisaged that this will be both robust and educational, as well as not proving too burdensome for all involved.

Our medical education administration team has undergone a transformation in the last year. Our grateful thanks go to Anna Spicer, Foundation Programme Administrator, who has held the fort through all the changes, even though she has only been in post for a short period of time herself. We have been joined by Emma Freeman, Medical Education Manager, and Rebecca Henderson, Medical Education Administrator. This newly formed team are working hard and effectively to support medical education and training at all levels, whilst being willing to challenge the 'status quo', which is refreshing. On our purely practical level, it has meant that myself and my team have been able to handover many administrative tasks which has freed us up to conduct the main aspects of our roles. This stability, optimism and initiative within the team has been lacking in recent years and is a very welcome development.

It remains a privilege to be Director of Medical Education in Salisbury. The wider educational fraternity continue to go 'over and above' what is necessary to support, educate and train our junior doctors whilst shouldering the burden of increasing clinical pressures. I remain grateful for all their expertise and enthusiasm, as well as the support they give me in fulfilling my role.

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

Director of Medical Education
Annual Medical Education Report
August 2021 to August 2022

Produced by: **Dr. Emma Halliwell, Director of Medical Education**

October 2022

Acknowledgements

Ms. Rashi Arora, Specialty and Associate Specialist, and Locally-Employed Doctor Development Lead

Dr. Annabel Harris, Associate Clinical Sub-Dean

Dr. Georgina Morris, Foundation Programme Director

Dr. Ellen Neale, GP Vocational Training Scheme Programme Director

Dr. Gail Ng, Physician Associate Lead

Members of the Medical Education Training Committee

Administrative Staff, Medical Education Department, Education Centre

Distribution List

Ms. Stacey Hunter, Chief Executive, Salisbury NHS Foundation Trust

Dr. Paul Sadler, Post-Graduate Dean, Health Education Wessex

Dr. Peter Collins, Chief Medical Officer, Salisbury NHS Foundation Trust

All members of the Medical Education Training Committee (METC)

All members of People and Culture Committee

Posted on the Medical Education page of the Trust Intranet

Executive Summary

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The omicron waves of Covid pandemic proved to be a challenge. Thankfully, the number of sick in-patients was markedly reduced compared with previous waves. In contrast, staff sickness was high over this period, and impacted on the staffing levels right across the Trust. This was actively managed to mitigate risk, but our doctors in training were inevitably impacted because of the nature of the resultant working environment.

The need for the educational fraternity and employing organisations to work together to prioritise education and training, in light of the sustained clinical pressure, has becoming increasing paramount. It is recognised that the more senior trainees in the craft specialties (e.g. surgery, endoscopy, etc.), who were impacted most by the pandemic, are also going to struggle to gain experience if elective activity has to be sacrificed due to the burden of emergency admissions. The situation also leads to tension with regards to the consistent implementation of 'self-development' time for trainees which has been a requirement for over 12 months now. Both of these will need to be closely monitored.

On a more positive note, it was exceedingly pleasing to see the very positive feedback from the GMC survey in departments that have been at the 'coal-face' of all the pressure. The Emergency Department are to be congratulated; their results for F2 training were outstanding. It proves that we are still able to produce high quality education for our doctors in training despite the challenging circumstances.

Well-being of our junior doctors remains a concern both in the short and long term, but the ability to socialise out of work and the return of face-to-face training has done much to improve morale. Alongside this, the Mess has been fully refurbished and is now a welcoming space that is well used by the junior doctors, medical students and the wider teams. The mess committee are to be praised for all the hard work that has gone into producing an attractive and varied programme of events, which has had a very positive impact.

The medical education team are now well-established in their roles. We were delighted to be joined by Dr. Gail Ng as the lead for our Physician Associate students. She has worked hard to ensure that our increasing PA student cohort have a positive experience whilst they are with us on placement and is doing much to champion their roles at Trust level. It is hoped that the Trust will have a business case in place to look at appointing qualified PAs in the near future.

Nationally, expansion of the Foundation Programme was planned over the next three years to accommodate those graduating following the increase in medical student places. However, there was a large oversubscription to the Foundation Programme this year and so were asked to bring forward this expansion. My thanks go to the Trust Executive Team for agreeing to increase our numbers from a baseline of 21 F1s and 22 F2s, to 33 F1s and 33 F2s, which came into effect in August this year. I would also like to acknowledge the hard work and expertise that Dr. Georgina Morris, Foundation Programme Director, put into designing new rotations which balance the educational requirements of the new doctors in training and the service pressures in the Trust.

Such expansion, whilst welcome, has its own challenges as a reasonable minority of the F1s are new to the NHS, having graduated abroad. This is also the case with those joining GP VTS programmes. As a result, we have advertised for an 'International Medical Graduate Champion' to help oversee the support, education and training of not only these doctors in training but also those that are appointed by the Trust directly.

Ms. Rashi Arora continues to play a vital role as SAS and LED Development Lead. Her CESR mentorship group is gaining traction and it is a privilege to be able to support some of our doctors who wish to take this route onto the specialist register. SAS doctors have been encouraged to take on some wider Trust roles, such as acting as Educational Supervisors for the Foundation Doctors. A lot of work has gone into the development of a process for the appraisal of LEDs; it is envisaged that this will be both robust and educational, as well as not proving too burdensome for all involved.

Our medical education administration team has undergone a transformation in the last year. Our grateful thanks go to Anna Spicer, Foundation Programme Administrator, who has held the fort through all the changes, even though she has only been in post for a short period of time herself. We have been joined by Emma Freeman, Medical Education Manager, and Rebecca Henderson, Medical Education Administrator. This newly formed team are working hard and effectively to support medical education and training at all levels, whilst being willing to challenge the 'status quo', which is refreshing. On our purely practical level, it has meant that myself and my team have been able to handover many administrative tasks which has freed us up to conduct the main aspects of our roles. This stability, optimism and initiative within the team has been lacking in recent years and is a very welcome development.

It remains a privilege to be Director of Medical Education in Salisbury. The wider educational fraternity continue to go 'over and above' what is necessary to support, educate and train our junior doctors whilst shouldering the burden of increasing clinical pressures. I remain grateful for all their expertise and enthusiasm, as well as the support they give me in fulfilling my role.

Dr. Emma Halliwell
Director of Medical Education

1.0 Introduction

This report gives an overview of medical education in Salisbury NHS Foundation Trust (SFT) for the past 12 months from August 2021 until August 2022. These activities are assessed against our strategic objectives which are as follows:

Objectives

1. Maintain accreditation of training
2. Accreditation of medical student placements via university medical schools
3. Maintain a strong educational and training environment for doctors
4. All Educational and Clinical Supervisors to be accredited in line with GMC requirements and trainees only allocated to those supervisors fully recognized
5. Keep the Trust management informed of national policy pertaining to doctors in training and the impact these polices will have on service delivery
6. Feed into the Trust's clinical governance framework to ensure patient safety
7. Provide supportive pastoral care and personal development opportunities, including career guidance information, whilst promoting equality and diversity
8. Medical Education incorporated into Directorate Annual Plans
9. Ensure good quality Trust and Departmental Induction with appropriate evaluation of these.
10. Quality of training maintained in light of the European Working Time Regulations (EWTR) plus changes that result from trainee reductions, The Shape of Training, Broadening the Foundation Programme and the new Junior Doctors' Contract implemented from October 2016 and renegotiated 2019.
11. Ensuring trainees feel valued and are an integral part of the Trust.

All these objectives have proven particularly challenging this year due to the ongoing pressure on service delivery, despite the Covid-19 pandemic stabilising. This has impacted on both training and well-being, and its effects are likely to pertinent for the foreseeable future.

2.0 The Medical Education Department

The Medical Tutors are:

Dr. Emma Halliwell	Director of Medical Education (DME)
Ms. Rashi Arora	SAS and LED Development Lead
Dr. Annabel Harris	Associate Clinical Sub-Dean (ACSD)
Dr. Georgina Morris	Foundation Programme Director (FPD)
Dr. Ellen Neale	GP Vocational Training Scheme (GPVTS) Programme Director

The Education Centre is based on Level 5 of the hospital. The Medical Education Team is as follows:

Mrs. Emma Freeman	Medical Education Manager
Mrs. Rebecca Henderson	Medical Education Administrator and PA to the Associate Clinical Sub Dean
Miss Anna Spicer	Medical Education Administrator, Foundation Programme Co-ordinator, and PA to DME and FPD

3.0 Quality Assurance Methods

The standards and outcomes for postgraduate medical education and training are set by the General Medical Council (GMC).

These standards form the basis for monitoring and implementing education and training of medical staff at Salisbury Foundation NHS Trust. Quality Assurance processes are in place in order to monitor and support the development of medical education both at a local and regional level (Health Education England - Wessex). These processes are usually augmented by the annual GMC trainees and trainers' survey, and triggered visits from the various 'schools' to programmes at the Trust when issues arise.

The Director of Medical Education is required to complete an 'annual return' to HE Wessex as part of the Quality Assurance process.

4.0 Accreditation of Medical Training Posts

4.1 Foundation Programme

Recruitment

Salisbury continues to be a popular hospital for trainees to undertake the Foundation Programme. We continue to be able to recruit a good standard of trainees from medical schools through the national competitive entry process and, as in previous years, have filled all our standard F1 rotational posts (21 in total). For August 2021, we were requested by Wessex Foundation School to create 2 new F1 rotations (2 x 3 x 4 months) in order to take 6 additional F1 doctors due to an expanded national waiting list. In the event, only 4 of these extra posts were recruited to. We therefore had 25 F1s starting with us in August 2021. In addition, we had 2 'out of sync' F1s on extended training post-ARCP.

For August 2022 intake we are anticipating a further significant expansion (approved by Trust Executive team) to take us to 33 F1s (who will remain with us for F2). This expansion was originally planned nationally by UK Foundation Programme to start from 2024 (with increased numbers of UK Medical Graduates finishing their studies over the next 3 years). However, it has been brought forward due to unprecedented numbers of eligible International Medical Graduates applying to the UK Foundation Programme at F1 level (having provisional rather than full GMC registration) and being added to the general recruitment pool.

Regarding F2s, in August 2021 we had 21 in standard rotational posts (having been F1s in Salisbury), 1 extra as a long-standing transfer from Jersey, and 2 out of sync (maternity leave, extended training). In addition, we had 6 F2 'stand-alone' posts (established from August 2020), which have proven popular and successful. In August 2021, 5 out of 6 posts were filled, with one appointee withdrawing late in July 2021. All 5 stand-alone F2s this year were International Medical Graduates and all successfully completed F2 post ARCP.

From August 2022, the 'stand -alone' recruitment programme is being wound-down, but we are maintaining these F2 posts locally in August 2022 as F2 posts for our additional 'waiting-list' F1s and out of sync F2s e.g. those returning from maternity leave. In August 2022, we will have 28 F2s, and anticipate 33 standard F2 posts in the longer term.

Specialised Foundation Post in Medical Education

I am pleased to report that one of our 2-year Foundation Programme rotations now includes a new Foundation Education Fellow post, the first in Wessex, which is an exciting development. The appointee will be part of the highly competitive Specialised Foundation Programme (which has replaced the previous Academic Programme, broadening it from Research-focused placements, to also include Education and Leadership streams). The Salisbury SFP post-holder will receive additional training and experience related to Medical Education, for example involvement in Simulation and placement-based Medical Student and Physician Associate teaching and spend 4 months equivalent time during F2 doing this role alongside training in the Emergency Department.

The Foundation Programme 2021 Curriculum

The Foundation Programme curriculum, which underpins the training and professional development of newly graduated doctors, relaunched for the first time in five years in summer 2021.

The curriculum sets out a holistic approach to care including physical health, mental health and social health and the skills required to manage this in both acute and community settings and for patients with chronic conditions. Foundation doctors must demonstrate that they are competent in initial assessment and management of patients under supervision. Other capabilities are focused on areas such as communication and consultation skills, teamwork, reflective practice, patient safety, quality improvement and teaching. The curriculum provides a framework for educational progression that will help them achieve these skills and supports them through the first two years of professional development after graduation from medical school.

In conjunction with the above, Dr. Annabel Harris, ACSD, and I co-developed and facilitated a series of six workshops for F1s and F2s aimed at developing skills and confidence with teaching and delivering constructive feedback (called the 'Foundations of Teaching' programme). This was inspired by the 'Teaching Tomorrow's Doctors' Course run by Southampton Medical School for clinicians delivering Medical Student teaching. We are indebted to Jacquie Kelly, Faculty Development Lead at Southampton Medical School for her advice and for allowing us to use some of their resources.

The UK Foundation Programme held a 'Sharing best practice day' in Birmingham in May 2022. I presented a poster on the 'Foundations of Teaching' programme alongside 2 of our F2s (Dr Saumitra Mistra and Dr Sabine Coates) who presented a poster on their 'Sport and Talk' well-being-focused project that was conducted as part of the SFT Health-Improvement Project (HIMP) QI programme for Foundation Doctors.

Well-being

We continue to strive to ensure that our Foundation Doctors are supported pastorally as well as clinically to provide the best care for patients. Changes made to rotas because of Covid 19 and the Foundation Programme Expansion have opened up possibilities for working differently and improving workload and supervision during weekend working in Medicine and H@NT surgical cover. A working group has been established through the H@NT Board to develop ideas, act on trainee feedback, and look to implement changes.

The Junior Doctors' kitchen area on Level 5 is now well-utilised, with 24-hour access. The out-going Doctors' Mess Committee (all F2 doctors, led by Dr Nicholas Hicks as Mess President), made astounding progress in re-developing the Mess, which has been transformed from an under-utilised set of rooms in desperate need of refurbishment, into a bright, vibrant space, with a new kitchen and IT suite, and fully redecorated interiors. The programme of Mess Events in 2021/22 was diverse and very well-received. The Mess Formal Event in July 2022 at the Guildhall was a fantastic occasion attended by over 120 people, including Consultants and non-clinicians.

I am greatly indebted to Dr. Emma Halliwell as DME and all the Foundation Training Clinical and Educational supervisors and want to thank them for their ongoing support.

I'd like to formally welcome and thank Anna Spicer who joined us in July 2021 as Foundation Programme Coordinator. Anna joined us at a particularly busy time and has had to get up to speed incredibly quickly. I'm also very pleased to have the support of Emma Freeman, Medical Education Manager, who joined the SFT Medical Education team in Spring 2022 having previously been a Midwife and an experienced member of the Practice Education team.

Dr. Georgina Morris
Foundation Programme Director

4.2 General Practice Training

2021-2022 has been a successful year for GP VTS training in Salisbury District Hospital despite the ongoing coronavirus pandemic and impacts it has had for trainees during that time.

We continue to have some trainees who require additional support for a variety of reasons. We greatly appreciate the positive culture of open communication between ourselves and the Trust which we have in place to enable these trainees to be best supported whilst they undertake their hospital posts.

Ongoing financial cutbacks continue to feature in medical education.

Teaching
The half day monthly ST1&2 teaching schedule was successfully delivered virtually for the past academic year (August 2021 - August 2022) and continues to receive positive feedback from trainees. May I take this opportunity to thank those departments who have contributed to this virtual teaching schedule. The virtual teaching schedule for the next academic year (August 2022 - August 2023) has been established and many speakers have already been contacted.

Recruitment
All GPVTS posts were successfully filled at recruitment for August 2022 commencement onto the new 24:12 GP training programme. All trainees entering the GPVTS training who had graduated from a non-UK Medical school were contacted by myself prior to August 2022 and their past NHS working experience explored. This information was then shared with the Trust. One trainee has since needed to withdraw due to delays with higher level checks.

The challenges of LTFT doctors, as well as the 24:12 training programme regarding hospital posts, remain.

I would like to express my thanks and gratitude to administration team at SDH, for whom there have been some changes over the past year, for their ongoing support and assistance with the mid Wessex GPVTS trainees.

Dr. E Neale
GP & Mid-Wessex TPD (Salisbury ST1&2)

4.3 Medical Posts within Salisbury NHS Foundation Trust

Trainee posts within SFT for 2021/2022 are as follows:

Grade	Number
F1	27
F2	29
Core Trainees	40
GP VTS	16
Specialty trainees	46
Locally-employed doctors	54
Total	**212**

In addition, the Trust also employs 37 SAS doctors.

5.0 Accreditation of Medical Student Placements

This report pertains to medical students present in Salisbury, mostly from Southampton Medical School, and is covering the academic year 2021-2022.

It has been another successful year for Salisbury NHS Foundation Trust and medical student education. This has been due to the ongoing dedication, flexibility and positive attitude of all staff at all levels. This year has not been without its hiccups, but these have been overcome. I remain hugely thankful for all those that have helped and supported myself and the medical students this last year.

The junior doctors' undergraduate education group was a resounding success this year. Junior doctors provided simulation teaching, two Mock OSCEs and evening regional teaching - a collaboration between us and Dorchester. The teaching program, simulation and Mock OSCE went down well with the students and received excellent feedback. In return for their ongoing near-peer teaching of the medical students, Dr. Morris, Foundation Programme Director, and myself designed and delivered our first 'Foundations of Teaching' course. This consisted of 6 evening sessions on 'how to teach' for junior doctors. The feedback for this was excellent and the work we did on this was presented regionally and nationally. This junior doctor supervisory part of the ACSD role was outside of the initial job description and so has been included in this for next year and the role will go from 1 PA to 1.5PA.

Onto medical student numbers. Through our doors we hosted 12 final year medical students for 6 months. Throughout the year we also saw 11x 4th year students in O&G, 8 x 4th years in child health and 30 x 4th year students in acute care modules. We also had 20 students doing their assistantships with us. Due to the covid pandemic the two assistantship blocks were brought forward to before their final exams in order to provide more clinical exposure for the final years. This was hard for the students as they were focussed on their final exams and so difficult to encourage them to look at the 'hidden curriculum' of becoming an F1 which is what the assistantship is about.

We hosted several student selected units and electives in plastics (x4), surgery (x4), emergency medicine (x2), anaesthetics (x1), haematology (x1) and child health (x1). It was great to see people offer to help with this and I know that the students and the university were happy with these placements.

Staff wise we have had a ‘changing of the guard’ year in the undergraduate team. The most notable change was that Sarah Shales (who has been the administrator for the medical students for many years) left at the end of December 2021. She was initially replaced by Janice Seller at the end of January 2022, who stayed a few months before leaving and then finally by Rebecca Henderson who started in June 2022. As you can imagine this has proved a challenge. I would like to thank Anna Spicer who helped hugely during the initial period of transition at the start of the year and Emma Freeman who helped enormously when Janice decided that this was not the right job for her. Emma was instrumental in the recruitment and induction of Mrs. Rebecca Henderson and with her smooth start here at Salisbury.

Other changes to the undergraduate team have been in child health and O&G. Dr. Chris Anderson (child health) and Mr. Greg Pearson(O&G) have both become clinical leads and so stepped away from their medical student role. We would like to thank them both for all they have done for the students.

We have received some lovely feedback over the past year. This one highlights the good work that has been done:
“Lots of staff keen to teach and support, felt very well integrated into the team. One of the best environments for learning I have come across….”

Many thanks to Anna Spicer and Emma Freeman, Dr. Georgina Morris, Dr. Emma Halliwell, Claire Levi and the undergraduate faculty, the teaching block/rotation leads, and everyone involved in providing high quality supervision and teaching to the medical students 2021-2022.

Dr. Annabel Harris
Associate Clinical Sub-Dean

6.0 Strengthen the Education Environment

6.1 SAS and Locally-Employed Doctors

SAS and LEDs are diverse group of Doctors and efforts were made to promote development opportunities linked to service need, their experience and career aspirations.

SAS/LED Education administrative restructuring

Infrastructure has been created to update the database of SAS and LEDs on regular basis. It has been agreed that SAS Fund will also contribute SAS Education administrative support by Education Centre. The current database has 36 SAS and 45 LEDs working at SFT (September 22).

Activities for SAS group

1. *Quarterly Teams meetings with SAS group* until December 2021 – opportunity for the SAS Doctors to meet informally during COVID phase.
2. *Annual SAS Development Day* - 4 February 2022. A locally-designed bespoke Study Day on the theme "Find your niche". A role play was created to give a flavour of career progression opportunities available to the SAS group in a fun environment. A cohort of senior SAS Doctors identified as mentors provided 1:1 support to others. A structured A4 reference guide was created which could be used by appraisers/mentors/educationalists to support SAS appraisals. A regional competition was organised in the afternoon on the topic “Story of my life” where SAS Doctors shared their professional journey and how they overcame barriers to SAS Development. The overall feedback for this session was “Excellent”
3. *SAS mentors and coaches* - SAS Doctors were encouraged to attend a coaching programme, organised by Dr. Clare Hennebry.
4. *HE Wessex promoted courses and educational activities* - SAS Doctors have availed the opportunity to attend HEE funded activities and courses including eCLiPs, PG certificate in career development at Edinburgh Napier University, King’s Fund, Coaching programme etc.

LED group

1. *LED appraisal and revalidation advice sheet* - This advice sheet was developed with the joint efforts of Trust Appraisal Lead and the DME. This advice sheet provides guidance for effective appraisal of our Locally Employed Doctors.

CESR group

1. *CESR trainees’ group* - A group of 16 doctors (SAS &LED) who are going though or preparing for CESR have been identified so tailored support could be provided to this group. A CESR Trainees’ Representative has been nominated.
2. *Medical careers in modern day medicine* - 26 March 2022. This career and wellbeing event organised by the CESR trainees gave the SAS and LEDs an opportunity to network and explore career development opportunities at SFT. Overall feedback was “Excellent”.

On a personal note, I would wish to thank everyone for supporting me in the last year

Ms. Rashi Arora
Trust Training and Development Lead for SAS and LEDs

6.2 Physician Associates

Background

SFT had its first cohort of Physician Associate (PA) students (three from cohort 4) from Bournemouth University in November 2021. I took on the role as Physician Associate Lead in SFT in December 2021.

The three PA students started with their General Medicine block from November 2021 to February 2022 covering Respiratory/ Elderly care/ Stroke/ Cardiology followed by their Acute block from March 2022 – May 2022 covering Acute medicine/ Emergency medicine/ ITU & anaesthetics.

Summary report 2021/2022

I think it is fair to say that the PA students and I have had a challenging but exciting year!

I have learnt a lot about the PA teaching programme from both the University and the students over the past year. I have had great support and advice from Clair Sparks (PA lead at Bournemouth University), who unfortunately has now left, and Carl Heffernan, PA Lead from Poole Hospital. I have also had great support from my fellow Consultant colleagues, who were willing to be supervisors for our PA students. A big thank you to Dr. Tom Jackson, Dr. Russell Mellor, Dr. Toby Black, Dr. Anna Barton, Dr. Danielle Bagg and Dr. Andy Nash for their support.

I have been fortunate that over the last year to have had two very keen Foundation doctors, namely Dr. Grace Wyman and Dr. Maduri Satkunabalan, who have been running weekly teaching sessions for the PA students even when the students were not in the hospital. These sessions were done on TEAMS and they have recently expanded the teaching session to include other PA students from Bournemouth University. Excellent work and well done to the both of them!

Earlier on in the year, I had an opportunity teaching the Year 2 PA students at Bournemouth University. This was useful and it has helped me better understand the role of PAs and their educational needs. I have also had a few PA students assist me with the Wessex Paediatric Competency course that I run on a yearly basis in SFT. Some of whom have expressed an interest in working in SFT.

As of November 2022, we will have another four PA students (cohort 5) joining our PA family. Cohort 4 will start their Obstetrics/ Gynaecology/ Surgery block, as Cohort 5 start their General Medicine block. I am in the process of organising the placements.

The Future

There has been a lot of PA students who are coming to the end of their training who are keen to work in SFT. I am keen that a business case is put forward to create jobs for the excellent PAs who want to work here. I would be happy to set up a preceptorship programme for the first cohort of qualified PAs starting work in SFT and would greatly appreciate the support from the Trust to make this happen.

Dr. Gail Ng
Physician Associate Lead

6.3 Medical Education Training Committee (METC)

This committee includes medical tutors, specialty education leads (College Tutors), and staff from the Education Centre and Medical Personnel. During the past 12 months the Committee met on 5 occasions and, as in previous years, has been proactive in its approach to sharing information and implementing changes to medical education and training. These meetings also provide a forum for the educational faculty to be made aware of concerns and issues in the various departments with regards to training.

These meetings have been particularly helpful this year, as they have ensured that we have a Trust-wide approach to supporting our trainees' well-being and aid their training recovery in the light of the Covid pandemic.

The Medical Education and Training Committee reports to the OD and People Management Board and the minutes of meetings held are therefore submitted here for review and, if necessary, action.

6.4 Quality Assurance Monitoring Data

Local processes to quality assure in addition to the annual GMC survey of trainees include:

1. Local (optional) survey of trainees who started in August 2022 will be undertaken to establish their views of the induction process, educational and clinical supervision and overall support provided by senior members of the Trust.
2. Annual feedback sessions with both the Foundation Year 1 and Foundation Year 2 doctors – summarised and distributed as appropriate by the FPD.
3. Formal feedback from GP VTS trainees at the end of each year - forwarded to the individual departments.
4. Formal evaluation of the main August induction – **Appendix B**
5. Regular informal departmental visits by the DME to meet with trainees and discuss their training experience

6.5 Educational Supervision

All Educational Supervisors in Wessex are required to have undertaken 'The Essentials' course. This is the 2-day course run by HE Wessex that equips Educational Supervisors for their role. Currently this is running as a combination of E-learning and tutorials, most of which are now happening face-to-face again. Once accredited, trainers recognised for these roles are now identified on the GMC register.

The process for maintaining recognition as a trainer is based upon a requirement to undertake 10 hours of educational CPD (8 hours of which has to be face-to-face) within a five-year period. A more robust system is now in place whereby HE Wessex send reminders to supervisors when their recognition is due to expire.

There are many examples of what could be classed as CPD e.g. equality and diversity training, attendance at ARCP panels, career guidance, exam support, supporting trainees through SIIs etc. Several 'Trust Refresher' courses have been facilitated by senior educationalists at SFT, which can form part of the face-to-face element. The two that have been run over the last 12 months had good attendance and received excellent feedback – Appendix **C**

Once all the CPD requirements have been met, an individual's training role is discussed at their appraisal, after which a signed form is sent to HE Wessex to confirm that the trainer has met the requirements for ongoing recognition.

6.6 Medical Education Budgets

The department is supported by the following budgets:

- Medical Education Director (Infrastructure)
- Specialty Doctors' Training

Study Leave (since April 2018 held centrally by HE Wessex and reimbursed to SFT)
Southampton University – Undergraduate Tariff (formerly SIFT)

These budgets have been the responsibility of the DME since July 2013.

The annual 'SIFT' business plan, which outlines how around £550,000 will be spent, is drawn up by the DME and then approved by the Chief Medical Officer. This is used to support medical students with accommodation, travel, administrative support and well-being initiatives. It is also used to develop/train our medical educators. In addition, funds have been allocated for the purchase of the following items of equipment:

- AMU – ultrasound for venous cannulation
- Education – camera and microphone to record training
- Histopathology – text books
- ITU – ultrasound for line insertion/echos/chest scans
- Maxillo-facial – laptop
- Ophthalmology – teaching microscope
- Paediatrics – portable laptop and monitor for simulations
- Resuscitation – defibrillator and disposables
- Simulation – mannequins and clinical skills disposables
- Up-to-Date
- Urology – interactive whiteboards

6.7 Revalidation for Trainees

The GMC revalidation process for secondary care and doctors in training has been in place since 2012, which requires each doctor to revalidate on a 5-yearly cycle. The Postgraduate Dean for HE Wessex (Dr. Paul Sadler) is the Responsible Officer for all doctors in training.

The Trust reports on every trainee involved in an SII or Clinical Review, or named in a Complaint. This information is collated by the DME and returned to the HE Wessex in the requested format known as an exception report (not to be confused with exception reports introduced as part of the new Junior Doctors' Contract). We continue to collate this information every 4 months, with the DME meeting formally with the Head of Risk Management, Patient Safety Facilitator, Clinical Governance Lead for Maternity and the Head of Customer Care to review the information required to generate the required reports.

All trainees about whom an exception report is completed are informed of this and sent a copy of the information submitted. These reports feed into the ARCP process, where information should triangulate with the self-reported incidents on the trainee's Form R.

7.0 Strengthen the Education Environment within the Health Community

The Salisbury Medical Education Department has been limited as to what support it can provide to the wider health community due to the ongoing pandemic. However, it is hope that as we 'learn to live' with Covid, such events can be supported going forward.

The mandatory training sessions required for the trainees have continued to be prioritised. Much to both the trainees' and trainers' relief, most sessions are now taking place face-to-face in the Education Centre. This proves an invaluable opportunity for trainees to meet with their colleagues and to provide peer support.

The benefit of virtual training has been recognised (e.g. accessibility from home if not on shift/post-night etc). To this end the Medical Education team have bought a camera in order to facilitate recording of training sessions, which can then be saved and accessed by trainees at a later date.

8.0 Inform Trust Management of National Policy

The Medical Education and Training Committee (METC) is a cohesive and useful group as it provides a forum for cascading information out to Departments and trainees within SFT via the Educational Leads. The DME reports to the People and Culture Committee in order to continue to highlight the impact of national directives regarding education and training, and recruitment issues on service delivery and safe patient care. Finally the DME meets every other month with the Chief Medical Officer to discuss issues that have arisen at Deanery, Trust and trainee level.

9.0 Clinical Governance Framework

The DME receives clinical review reports involving trainees and has regular communications with the Head of Risk Management. The Trust completes exception reports, which are forwarded to the HE Wessex, on all trainees involved in SIIs and Clinical reviews and named in Complaints (please see section on Revalidation for Trainees). This work has ensured close working with the Risk Departments for both maternity and the overall Trust.

Salisbury's inter-professional Healthcare Improvement Programme (HImP) is a well-established course to help Foundation Doctors learn basic improvement skills by undertaking service improvement projects. The programme is currently led by Dr. Mary Pedley and Louise Arnett, Head of Service Improvement. It continues to be highly regarded both regionally and national, with several Foundation Doctors being invited to present their projects at national quality improvement meetings. The greatest challenge for HImP remains ensuring sustainability of the projects undertaken.

10.0 Careers Advice and Pastoral Care

Career support and pastoral care from the DME, FPD, and College/Specialty/GP and Tutors continues to ensure that trainees receive appropriate and timely assistance and guidance throughout the duration of their time in Salisbury.

Career guidance for Foundation Trainees takes place in both years of the Foundation Programme. There are 2 generic career guidance sessions, with additional specific sessions on interview preparation and applying for GPVTS in Foundation Year 2.

With the Covid pandemic and ongoing clinical pressures, the need for pastoral care and well-being support has been in forefront of everyone's mind.

The DME and FPD continue to provide pastoral care for trainees who require additional support for reasons both within and outside the working environment. As a rule, the FPD mainly supports the Foundation Doctors as issues regarding their welfare are usually escalated in that direction. The DME usually does the same for trainees above Foundation level, but not exclusively so. Both are supported in this regard by an excellent network of departmental educational leads.

Referrals from the Trust to the Wessex PSWU (Professional Support and Well-Being Unit) for the few trainees needing higher level of support, are usually made by educational supervisors, in discussion with the departmental educational leads. However, they are always done with the knowledge and support of the DME.

Unfortunately, the promised rest area (funded via the BMA money from several years' ago) has yet to be a functioning reality. However, concrete steps are being made in this direction now and it is hoped that a permanent solution is just round the corner.

The Mess has been refurbished, with the support of some well-being money. Last year's committee was exceptional in organising events that were inclusive, inviting the wider multidisciplinary teams, and did much to promote a sense of belonging for our junior doctors in Salisbury.

11.0 Trust and Departmental Inductions

This year the UK FPO only offered one week of shadowing for the new Foundation Year 1 doctors. However, this did allow the new doctors to undergo the same level of induction as their more senior colleagues who arrived a week later, whilst addressing areas that were particularly important at the start of their medical careers. They completed an AIM (Acute Illness Management) course and had the opportunity to 'find their feet' on the wards by working alongside the outgoing F1s.

50 new doctors joined the Trust on Wednesday 3rd August 2022, all receiving a mandatory induction followed by their departmental inductions. The Medical Education staff are to be commended for all their hard work in ensuring that everything ran smoothly, especially as none of them were in post last August for the previous induction.

Regular monthly inductions (of up to 20 doctors) follow a similar format but are often held in an alternative venue to the Education Centre.

Formal evaluation of the F1 shadow week and the main August induction was undertaken and as stated in paragraph 6.3 is attached to this document in **Appendix B**

12.0 Challenges for 2022/2023

- Working alongside the Trust and HE Wessex to support training recovery and to address the educational issues that have arisen, and will to continue to arise, as a result of the Covid-19 pandemic and the ongoing clinical pressures in NHS nationally, in order to ensure that our doctors in training continue to progress in their training in a safe and supervised manner.
- Ensuring the emphasis on trainee well-being is maintained and initiatives to improve the lives of doctors in training completed in a timely manner.
- Continuing to ensure that all Named Clinical and Educational Supervisors who are GMC accredited trainers maintain this accreditation and encourage more consultants to take up these supervisory roles.
- Support Named Clinical and Educational Supervisors to ensure they have adequate time in their job plans, that is ring-fenced, to support the doctors in training.
- Continuing to work with the Trust so that, even when vacancies in a rota are at the level that the viability of a rota is jeopardised, the impact on the quality of education provided and the time available by senior doctors to train is minimised.
- Ensuring full implementation of the self-development time for trainees at all levels, as required by the Junior Doctors' contract
- Working with trainees, supervisors, the GoSW and Trust management to ensure that issues raised by doctors in training through exception reports are appropriately addressed and sustainable solutions put in place to resolve recurrent concerns.
- Supporting departments where there have been concerns about training and supervision raised by trainees at their ARCPs or via the GMC survey.
- Support the increasing cohort of Foundation doctors, and their supervisors, to ensure they integrate into teams and become a valuable part of the workforce.
- Looking to continue to develop our SAS and Locally-Employed Doctor cohort and, specifically, how we can support and develop these individuals, including those wanting to join the GMC specialist register via the CESR route.
- Develop our new Physician Associate students programme further and support the trainees whilst they are on placement.
- Develop support mechanisms for International Medical Graduates starting in the Trust in line with GMC guidance.

13.0 References

The following documentary evidence supporting this report is held in the Medical Education Department:

- Medical Education Strategic Plan: 2021-2022
- Evaluation of locally organised teaching
- Nationally analysed formal assessment of feedback from medical students on placement
- Feedback and analysis from the medical students of the local teaching sessions
- Evaluation forms received from shadowing week and induction August 2022
- Study leave database – Accent
- METC agenda and minutes
- Junior Doctors Induction and H@NT course programmes
- Website documentation
- Archives retained according to local policy

Appendix A

GMC Survey 2022

Background

The yearly, national GMC survey has taken place again in 2022 and the results were released in July.

Caveats

Response rate

There was a similar response rate nationally to 2021:

- 76% trainee response (76% 2021)
- 34% trainer response (32% 2021)

However, the trainee response rate was lower regionally and locally:

- 63% Wessex trainee response (63% Salisbury trainees)
- 34% Wessex trainer response (39% Salisbury trainers)

This was despite a high profile and active campaign to ensure as many people as possible completed the survey.

Locally

Results are not reported if there are fewer than three responses to questions, so ability to look at individual departments/training programmes is more limited, especially when looking at the smaller departments. In additional, if only a few trainees in a department/programme respond the results can easily be skewed (positively or negatively) by an outlier.

This means that the results for a hospital like Salisbury can potentially be less representative of the communal experience of all trainees within a particular area and more difficult to interpret.

Results

Results are benchmarked against other Trusts across the country. If the score is significantly negative or positive compared to the national average, the box is highlighted red or green. Where it is negative or positive but shares a confidence interval with the national average, the box is highlighted pink or light green.

The survey also asked questions about patient safety and undermining behaviour, allowing free text comments.

A trainer survey runs alongside the trainee survey.

Benchmarking results for SFT

There were insufficient trainees in a programme, or responses from those that are, for the results to be reported in the following programmes:

- F2 – genito-urinary medicine, general practice, intensive care, obstetrics and gynaecology, pathology, paediatrics, palliative care, psychiatry, surgery
- GP VTS – general medicine, obstetrics and gynaecology, palliative care, surgery

- Also – clinical radiology, endocrinology and diabetes, gastroenterology, haematology/oncology, histopathology, intensive care medicine, ophthalmology, rehabilitation medicine, rheumatology, respiratory medicine, urology

Specialty	***Programme***	***Green flags***	***Red flags***
Anaesthetics	Core	0	0
	Specialty	Local teaching	0
Emergency medicine	F2	Overall satisfaction Clinical supervision Reporting systems Handover Induction Adequate experience Educational governance Feedback	0
	ACCS	0	Local teaching
	GP VTS	0	0
Medicine	F1	0	0
	F2	Teamwork Induction Study leave Rota design	0
	IMT year 1	0	0
Obstetrics and gynaecology	Specialty	0	0
Paediatrics	GP VTS	Clinical supervision out of hours Workload	0
Plastic surgery	Specialty	0	Clinical supervision Supportive environment Educational governance Rota design
Surgery	F1	0	Clinical supervision out of hours Teamwork
	CST	0	Educational supervision
Trauma and orthopaedics	Specialty	0	0
Total		**15**	**8**

The regional teaching domain has been excluded from these results as it is beyond the influence of the Trust.

These results are reported as by programme, rather than by specialty, as the former cover very small cohorts of trainees and therefore are more liable to be skewed.

Other aspects to note:

Palliative medicine: When the results are interrogated by specialty, there were 12 green flags

Surgery: When the results are interrogated by specialty, there were 6 red flags

Patient safety and undermining behaviour

There were two free text comments about the level of staffing on the wards, leading to concerns about patient safety. These mainly referred to reduced nursing staff levels.

There was one free text comments from a paediatric trainee about undermining and bullying behaviour by a post-natal midwife.

Trainer results

These results were only available for a small number of specialties, which is consistent with the last few years.

Specialty	**Green flags**	**Red flags**
Anaesthetics	Overall satisfaction Support and appraisal Professional development	0
Emergency medicine	0	Educational governance
General surgery	Professional development	0
Obstetrics and gynaecology	0	0
Paediatrics	Support and appraisal Professional development Handover and rota design	0
Palliative medicine	Overall satisfaction Professional development	0
Plastic surgery	0	0
Trauma and orthopaedic surgery	0	0
Total	**9**	**1**

Comments

The GMC survey continues to be regarded as the most valuable tool there is for assessing the quality of training of posts nationally. However, when there are only a small number of respondents in a programme it is relatively easy for the results to be affected by the responses of just one trainee. 'Neutral' or 'average' responses can also result in overall results for a department being particularly poor, especially if the particular programme concerned is one of a limited number in the country, due to the manner in which results are analysed and compared. The falling response rate across the country has been a concern for many years and, despite active efforts by the medical education team in Salisbury to promote completion of the survey by trainees and trainers, our response rate has dropped even further this year, although it was slightly higher than HE Wessex as a whole. This continues to threaten the robustness of the data and the ability to draw conclusions from it. There also remains concern at local, regional and national level that some of the questions asked are ambiguous and would be better answered with a 'yes' or 'no' rather than a graded response.

Despite the fact that the GMC survey does not always give us the full picture, it does identify areas where there are significant concerns and also where training is clearly excellent. The results give a guide as to where work needs to be done to improve the quality of the posts and also where there is good practice that should be shared more widely.

I'm pleased to report that our results from the GMC survey this year have shown some improvement on previous years – namely 15 green flags (8 in 2021) v 8 red flags (same as in 2021).

Looking at some specific areas, Emergency Medicine should be highly commended for their excellent results at a time when their clinical environment has been extremely challenging. It is hoped that the ability to finally implement a compliant rota in ED will only serve to improve the trainees' experience here. Similarly, it is reassuring to see the results for F2 in medicine which has been a pressurised area to work in of late.

The IMTs are now in the second year of their revised training structure and the improved results (no red or green flags in 2022 cf 1 red and 8 pink flags in 2021) does, no doubt, partly reflect more stability in their clinical experience, as well as a greater understanding of the expectations of their revised curriculum by both trainees and trainers. However, a lot of work has been undertaken to improve the educational opportunities for this cohort of doctors and our new College Tutor, Dr. Danielle Bagg, has several exciting ideas to build on the progress that has already been made.

The cardiology results (when analysed by post) show improvement on last year with 1 red and 2 pink flags, compared with 6 red flags in 2021. The results of this, and other small departments, are always difficult to assess because of the liability of bias and so can vary widely from one year to the next. However, it is hope that these reflect an improvement in the trainees' experience.

The most disappointing aspect of this year's survey were the results for Plastic Surgery (4 red flags after 2 green flags in 2021). We had thought that real progress had been made in this department and there had been no reports from trainees, via any channel in the Trust, that suggested they were unhappy in any way. Hence, the results were surprising for all of us. I have already met with the Lead Clinician and Educational Lead to analyse the results and discuss possible ways forward. The next step is for me to meet with the trainees directly which is planned within the next month. After that we will be able to put a concrete action plan in place.

Another area that was a surprise was the results for F1 surgery as, historically, these posts always get very good feedback. Looking at the specifics, they are concerned about Clinical Supervision Out of Hours and Teamwork. We suspect that this reflects the burden of reviewing medical patients out of hours, and the pressure the medical SpR is under admitting patients and being the most senior person available on site overnight for medical advice. The Trust is currently undertaking a review of medical staffing levels out of hours and these issues are being fed into that discussion.

The patient safety issue that was reported about the level of staffing on the ward was investigated in May 2022 when it was raised by HE Wessex. This was at the height of the Covid staff absences due to the BA4 and BA5 omicron sub-variants. Trainees were concerned about the lack of nursing staff in individual areas, but they were not aware of the bigger issue of trying to ensure a safe level of staffing across the entire hospital footprint. The Trust acknowledged at this time that there was an increase in patient safety risk due to last minute staff absences and had highlighted it on their corporate risk register. The situation is now much improved and active recruitment is taking place to ensure that an acceptable level of staffing headroom is maintained.

One of the paediatric trainees raised bullying from the midwives as an issue. The trainee was supported by senior members of the paediatric department and the issue was raised with the Head of Midwifery for investigation and action. This investigative process is ongoing and, once concluded, will be fed into the 'Cultural Change' programme that is underway in the obstetric/midwifery departments to ensure action is taken.

These results have been discussed with educational leads for the various departments in order to facilitate further reflection and discussion.

Appendix B

EVALUATION OF F1 SHADOW WEEK

	EXCELLENT	GOOD	OK	POOR	COMMENTS
Medical HR	**11**	**4**	**2**		
Medical Education	**12**	**4**	**1**		
Stacey Hunter **Chief Executive Officer**	**12**	**4**		**1**	
Dr. Emma Halliwell **Director of Medical Education**	**13**	**3**	**1**		
Dr. Grace Whyman **Mess President**	**15**	**2**			
BMA Representative	**12**	**5**			
Lizzie Swift **Speak Up Guardian**	**12**	**5**			
Rex Webb **Equality and Diversity Lead**	**12**	**5**			Nice to hear there is someone to speak with about this.
Dr. Georgina Morris **Foundation Programme Director**	**14**	**2**	**1**		
Smartcards (if applicable)	**9**	**5**			
NHS Mail	**13**	**3**	**1**		
Information Governance	**12**	**4**	**1**		
Bereavement/Coroner's Office	**14**	**3**			
Occupational Health (if applicable)	**7**	**4**	**1**		
Fit Testing (if applicable)	**12**	**3**			
IT training	**10**	**6**		**1**	
Gill Payne **H@N – Hospital at Night**	**11**	**5**	**1**		
Top Tips for F1	**11**	**5**	**1**		
Resuscitation	**15**	**2**			Good refresher course, regarding ALS. Useful resources provided.

EVALUATION OF AUGUST INDUCTION

	EXCELLENT	GOOD	OK	POOR	COMMENTS
INTRODUCTION & WELCOME					
Dr. Emma Halliwell Director of Medical Education	**5**				
Dr. Peter Collins Medical Director	**3**	**2**			
Freedom to Speak Up Guardian Elizabeth Swift	**4**	**1**			
Diversity and Inclusion Rex Webb	**2**	**2**			**N/A**
Dr. Grace Whyman Mess Representative	**3**	**1**	**1**		
BMA Representative	**1**	**1**	**1**		
SESSIONS					
Documentation Judith Leach	**5**				
Resuscitation	**4**	**1**			
IT Training	**4**	**1**			**Quick at trouble shooting, thank you.**
Medical HR	**4**	**1**			
Hand Hygiene	**3**	**2**			
APPOINTMENTS					
Occupational Health (if applicable)	**3**	**1**			**Speedy appointment but had to take annual leave to attend.**
Fit testing	**2**				

Appendix C

EVALUATION TRUST REFRESHER COURSE
10th November 2021

Facilitators : Claire Page, Adam Hughes and Aisling Coy
Attendees: 21

Feedback	Excellent	Good	Satisfactory	Poor
Content	12	9		
Delivery	13	8		

Any topics covered particularly well?

- Exception Reporting
- Trainer Recognition
- Generational Differences
- Handover
- Trainees in difficulty
- Good open, informal, interactive discussion
- Challenges of dealing with different generations
- Trainer Revalidation
- Report writing
- Difficulty of escalating the struggling trainer
- All topics covered in a lively and interactive environment.
- Really inclusive

Any topics that could have been covered better?

- Difficult to see slides
- Giving feedback
- Clinical supervision of specialist nurses + trust grade doctors
- Resilience
- Possible outcome of ARCP
- A very clear list of official do nots
- Changes to surgical curriculum and portfolio
- Education Supervisors appraisal process
- How to deal with concerns raised by trainees

Any topics that you feel should have been covered but weren't?

- Dealing with concerns
- Supervision of PA's, nurse specialists
- Perhaps actual assessments but would be difficult with different levels. HORUS vs ISCP etc.

Was 4 hours for this Refresher: too short / about right (19)/ too long (2)

Any other suggestions or comments?

- Nice to be doing this in person
- Very practical and shared experience was very useful

- Brilliant to have it local and with colleagues in
- Excellent faculty input. Should ideally remain in house.
- Worth running slides
- Excellent refresher- Well done
- Good coffee breaks!
- Enjoyed the start with icebreakers
- Pre-course reading material?

EVALUATION TRUST REFRESHER COURSE
4th May 2022

Facilitators: Emma Halliwell and Claire Page
Attendees = 7

Feedback	Excellent	Good	Satisfactory	Poor
Content	5	2		
Delivery	6	1		

Any topics covered particularly well?
- Trainees in difficulty x3
- Escalation routes pros & cons
- Study leave entitlement & funding
- All topics covered well in my opinion
- Hierarchy of who's who/roles within hospital to support supervisors & trainees.
- All the topics were covered well & it was good to have general update and overview of how somethings have evolved.

Any topics that could have been covered better?
- No comments

Any topics that should have been covered but weren't?
- No comments

Was 4 hours for this Refresher: too short (6)/ about right (1)/ too long (0)

Any other suggestions or comments?
- Small group was helpful to have interactive discussion
- Very informative program
- Great to have face to face training opportunity
- Clear delivery
- Engaging speakers
- Small group worked well
- Thank you!
- Good to have trust update with colleagues
- Nice doing the refresher at SFT so can discuss trust specific issues

Salisbury NHS Foundation Trust

Report to:	Trust Board (Public)	**Agenda item:**	5.1
Date of Meeting:	12 January 2023		

Report Title:	Emergency Preparedness, Resilience and Response Annual Assurance Statement – EPRR Team and ICB Report			
Status:	**Information**	**Discussion**	**Assurance**	**Approval**
			x	
Approval Process (where has this paper been reviewed and approved)	EPRR annual Assurance self-assessment and EPRR Assurance Report Update dated 28th September 2022 approved by Lisa Thomas as Chief Operating Officer (COO) and Accountable Emergency Officer (AEO) ahead of the annual EPRR Confirm and Challenge with the ICB which took place on 14th October 2022			
Prepared by:	Tracey Merrifield – Head of EPRR			
Executive Sponsor (presenting):	Lisa Thomas – COO & AEO			
Appendices (list if applicable):	EPRR Assurance Report Section 5.2 Appendix A ICB Final Outcome letter Section 5.2 Appendix B			

Recommendation:

For the Trust Board to note the process and outcome for the annual EPRR assurance process, documentation attached includes the EPRR Assurance Report submitted as part of the EPRR assurance process and the final letter dated 15th December from the ICB confirming our compliance status as 'Fully compliant'.

Compliance level

Organisation	2020	2021	2022
SFT	Full	Full	Full

Executive Summary:

The final letter summarising the outcome of the annual EPRR assurance process stated:

Good Practice and Innovation

Once again SFT have provided a sound and enviable assurance submission and maintained a prominent level of EPRR activity. We note that you are looking to review your EPRR structures to provide a deputy EPRR lead to enhance resilience.

Next Steps

The outcomes of this assurance review will be included in the annual EPRR System assurance summary letter which is submitted to NHS England South West. The ICB will be required to present a system summary of the assurance process to the LHRP.

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) -	☐

Emergency Preparedness, Resilience & Response – Assurance Update – 28th September 2022

1. Executive Summary

The following paper outlines the continued progress of the EPRR agenda at Salisbury NHS Foundation Trust (SFT) and provides detail as to how we have continued to progress and maintain standards whilst embedding learning from our incident response.

2. Background 2019/20 & 2020/21 Assurance Process

Following the completion of the EPRR Core Standards self-assessment and EPRR Assurance meeting on 23rd August 2019 with Julie-Anne Wales – Head of Corporate Governance and Planning Wiltshire CCG, Louise Cadle - Head of EPRR NHSE South and Andy Ewens - NHSE, SFT were assessed as 'Fully Compliant' against the 64 core standards.

There were no immediate actions required, and it was noted it was encouraging to see SFT develop their work. Although the Core Standards have been developed with a list of requirements to be met, SFT aspires to exceed all of these though the continual development of their EPRR offering.

The 2020 assurance process was light touch and we provided a background assurance paper to update on actions taken and progress made.

3. Looking forward 2022/23

Since the light touch assurance process in August 20202 there have been further developments and key changes at SFT, the detail of which can be seen below:

Staffing

- The Accountable Emergency Officer (AEO) – Andy Hyett, left Salisbury NHS Foundation Trust mid-August
- Lisa Thomas, has taken up the role of AEO and was previously Chief Finance Officer and retains her role as Deputy CEO
- Full Time Substantive EPRR Office Helen Sheppard left SFT May 2022, this substantive role was advertised and successfully recruited to by Sameer Anthony as a substantive EPRR Officer Band 4
- The full-time fixed term contract EPRR Officer for 12 months, for which the position was filled by a secondment Victor Ayaga, came to an end in January 2022, and this post was advertised as a substantive role Band 4 and was successfully filled in April 2022 by Joss Van Nieuwkerk
- Elise Jones , EPRR Officer (Band 4) has increased her hours from 0.6 to 0.8 WTE. Elise is continuing successfully to complete the HEPRR Diploma

- The COVID situational daily reporting and COVID Inquiry work is undertaken by a bank EPRR Officer, Band 3

General

- EPRR Steering Groups continued except for the cancellation of January 2022 due to the operational pressures of COVID and September 2022 due to HM Queen Elizabeth Sate Funeral
- The Mass Casualty Group sits alongside the EPRR Steering group. This group will meet bi-annually as a minimum, the September 2022 meeting was cancelled due to HM Queen Elizabeth Sate Funeral
- Prevent Quarterly compliance audits (continued and completed 8 monthly audits in the 12-month period) Current compliance levels: For Q1 2022 Prevent Levels 1 / 2 – 96%, Prevent Level 3 – 94%, submission for Q2 is due 7th October
- BAU – management of iRespond action cards ensuring accurate compliance and governance updates are being reviewed on a 90-day expiry period
- Head of EPRR / Prevent Lead continues to attendance at the SW Prevent Leads meetings
- Head of EPRR member of SW EPRR Forum, and will jointly support chair Dickie Head (Gloucester Hospital), alongside Libby Beesley (UHB), for the EPRR SW Forum
- SFT attended and represented at the ESAG meetings in relation to the Winter/ Summer Solstice
- EPRR Policy re-written in June 2022 and approved and then revised following publication of new NHS EPRR Framework 8th July 2022
- Mandatory CBRN/PRPS learning package for all ED staff and our Rapid Response team compliance at 85%
- Presentation of Novichok Learning by Head of EPRR SFT o 19th April to EPS Yorkshire and the Humber Branch
- Head of EPRR member of the national task and finish group working on EPRR Core Standards Triannual Review
- Visit to Maidstone & Tunbridge Wells Hospitals to meet and share learning with Executive of Resilience John Weeks, including Air Ambulance visit
- Introduction of an EPRR spreadsheet workplan to linking to other EPRR documentation to give an oversight of workload, developments and progress

Training & Exercising August 2021 – present

- Exercise Florence – Radiology BCP TBX 05/04/2021
- Exercise Iris – MTA with Wiltshire CT – 23/09/2021
- Loggist Refresher & New Training – 06/10/2021, 22/09/2022
- CBRN PRPS – 01/09/2021, 05/10/2021
- Strategic Leadership in a Crisis 14/04/2021
- EPRR Awareness for half day for Discharge team – 27/07/2021

- NPAG Resilience Group – 02/11/2021, 11/02/2022, 04/05/2022, 24/07/2022
- EPRR Mandatory Overview Training On-call – 12/08/2021, 05/12/2021, 21/02/2022, 12/05/2022
- DVI West Mercia Police & LRF - 08/02/2022
- Channel Champion Session -08/03/2022
- Prevent Awareness & referrals Course - 30/03/2022
- Prevent Referrals online course part 2 – Channel - 30/03/2022
- CBRN PRPS SWAST Train the Trainer x 6 09/05/2022
- PREVENT Seminar – 17/05/2022
- LRF Multi Agency Operational Training – x 2 14/06/2022 & 29/09/2022
- BCM Workshop x 6 -24/06/2022 & 09/06/2022
- MOAT – June & September 2022
- Cyber Crime Simulation – 27/09/2022

Training & Exercising Scheduled

- Cyber Crime TBX 11th November 2022
- Industrial Action TBX – October 2022 TBC
- Exercise Mustang – Regional Exercise with SFT participating – 04/10/2022
- EPRR Awareness for half day with Clinical Site Team – 12/10/2022
- Loggist Training – December 2022, March & June 2023
- Loggist Training Refresher – October 2022, January, April, June 2023
- CBRN/PRPS Training – October 2022, January, April July 2023
- Executive on call training – October 2022, February, May August 2023
- Duty Manager on call training – September 2022, January, April & July 2023
- ICC Familiarisation – December 2022, March & June 2023
- Novichok Presentation –NHS Scotland 28th October 2022

In discussion with SWAST to support the new Clinical Training element of PRPS, whereby SFT will be the pilot site, also in discussion with DWFRS and SFT Fire Officer to run a multi-agency exercise on site in 2023.

COVID-19 Response

The EPRR team continue to run the Incident Coordination Centre (ICC) to manage the ongoing Level 3 Regional response to COVID-19, and monitor the SPOC. The incident response demands fluctuate dependent on demand internally and externally and the frequency of meetings and sub-groups expands and retract as required as instructed by the Tactical Commander.

The Daily COVID sitrep requirement is managed by the EPRR team supported by Occupational Health, OD&P and Information Services. This daily sitrep requirement continues seven days per week covered by a bank weekend team, with on-call advice available from the Head of EPRR.

Critical Incident Responses from September 2021 to date

- September 2021 SSL Outage
- 16/02/2022 DSU Water Leak
- 18/03/2022 IT Failure
- 27/04/2022 Capacity Extremis
- 20/05/2022 Power Outage
- 14/07/2022 Patient Flow and reduce workforce
- 09/08/2022 – BSW System response Adestra outage
- 13/09/2022 – SSL Fire
- 16/09/2022 – National Lorenzo Outage

Major Incident Responses from September 2021 to date

- 31/10/2021 Operation Zambezi – Salisbury Train Crash
- 10/03/2022 Suspect Package Southmead – multiagency/partners

Business Continuity Incident Responses from September 2021 to date

- 10/11/2021 – Pest Issue Theatre 7
- 06/05/2022 – Loss of bleeps
- 08/07/2022 – Patient Capacity & Flow
- 06/09/2022 – Sewerage impact Farley
- 08/09/2022 – Instigation of Operation London Bridge
- 21/09/2022 – Patient Flow
- 27/09/2022 – Loss of bleeps (national and local issue)

4. Developments to consider for 2022/23

As the EPRR portfolio continues to expand, we need to consider the longer-term development of the EPRR Team, and how we continue to support the organisation and use their skills to enhance and further embed the EPRR culture across the Trust. The goal for the EPRR Team will always be, to be the best we can and aspire to 'Gold' standards and not to simply achieve the minimum required, this drive is enhance by working with partners and colleagues who are professional and aspire to support the Trust and the wider community.

5. Recommendations

As we continue to manage a Level 3 Response to the COVID situation, and following the light touch assurance of 2020/2021 we believe we have continued to build on our solid EPRR foundations, managed a protracted command and control structure and used this response to continue to reflect and take forward our learning, this has been alongside maintaining training and exercising and a number of business continuity incident and critical incident responses.

Our self -assessment for 2022/23 continues to build on that development and we continue to develop established practices, take learning from incidents responses which have become embedded within our workplan maintaining our statutory obligations, we believe we can demonstrate our compliance status remains unchanged.

Bath and North East Somerset,
Swindon and Wiltshire
Integrated Care Board

Thursday 15 December 2022

Via EMAIL

Dear Lisa,

SFT EPRR Core Standard 2022/23 Assurance Summary

Many thanks for preparing the self-assessment, supporting evidence and your engagement at the EPRR assurance review meeting held on 14th October 2022. This letter summarises the outcomes from the meeting, capturing agreed actions and points from our discussions.

Compliance level

Organisation	2020	2021	2022
SFT	Full	Full	Full

Outcome from the 2022 EPRR Core Standards Deep Dive review

The focus of the deep dive for 2022 was on evacuation and shelter following publication of national guidance last year. The deep dive has highlighted the need for further work in this area particularly around a large-scale incident. This will form part of the LHRP workplan during 2023.

DD4	Evacuation and patient triage
DD6	Patient transportation
DD7	Patient dispersal and tracking
DD8	Patient receiving

Good Practice and Innovation

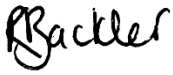
Once again SFT have provided a sound and enviable assurance submission and maintained a prominent level of EPRR activity. We note that you are looking to review your EPRR structures to provide a deputy EPRR lead to enhance resilience.

Next Steps

The outcomes of this assurance review will be included in the annual EPRR System assurance summary letter which is submitted to NHS England South West. The ICB will be required to present a system summary of the assurance process to the LHRP. NHS England will produce and submit a regional report to the NHS England National Team by end of December 2022.

Finally, thanks must go to you and the EPRR team for your hard work over the last year, while managing other concurrent issues and incidents.

Yours sincerely,



Rachael Backler
Executive Director of Planning and Performance (AEO)
NHS Bath and North East Somerset, Swindon and Wiltshire Integrated Care Board

NHS Salisbury NHS Foundation Trust

Report to:	Trust Board (Public)	**Agenda item:**	6.2.1
Date of Meeting:	12 January 2023		

Report Title:	Short term changes to SFI's for Procurement Recommendation Report approvals for capital from 1 January 2023 – 31 March 2023			
Status:	**Information**	**Discussion**	**Assurance**	**Approval**
				x
Approval Process (where has this paper been reviewed and approved)	This is coming direct to F&P following a conversation with the CFO and Director of Procurement Trust Board Jan for approval			
Prepared by:	Rob Webb – Director of Procurement			
Executive Sponsor	Mark Ellis - CFO			
Appendices (list if applicable):				

Recommendation:

Due to the amount of capital projects being managed through the procurement service across the ICS procurement are seeking approval for a short term change to the procurement section of the SFIs from the Finance and Performance committee around:

1. Approving that at the discretion of the Director of Procurement a recommendation report does not need to be written for capital purchases that are placed via the NHS Supply Chain capital and equipment framework up to a value of £350k which is the Director of Procurement current sign off level. Any capital order above this value or outside of an ordering route via NHS Supply Chain will follow the current approval processes. For the avoidance of doubt this is just capital and will not be applicable for revenue contracts during this period
2. All orders placed via this approach in point 1 will be retrospectively captured by a recommendation report in April 2023 that will outline all orders that were placed via this route, during this period and value of orders and detail to give full visibility.
3. That the option, if approved by the CFO, of Chairman's action supported by 2 NEDS can be taken for contract recommendation report approval for capital order values of £750k and above outside of F&P and Trust Board if the timing is such that there is a critical reason (such as lead time) for ensuring approval between committees to place orders. This would then be reported at the next meeting.

Executive Summary:

Procurement is under unprecedented pressure within the capital programme area. With increased lead times and changes on how to spend capital sums before year end the department needs to be as flexible as possible to place orders to meet lead times and complete the expenditure for year end.

The recommendation report process takes time to write and document and is a critical part of the governance process. However, to help deliver some level of flexibility to move the programme forward without creating unnecessary risk procurement would like to ask that some flexibility is offered under the Trust Standing Financial Instructions to the requirement of a recommendation report between January 2023 – March 2023 to enable procurement exercises to move through where lead times are critical.

Under the Trust SFI's procurement will write a recommendation report for anything over £25k. With so many supply chain challenges we need to be as efficient and flexible as possible to ensure orders are placed in good time but effective governance is followed.

To enable this is it is requested that the need for a recommendation report as required under the SFIS currently for capital spend that is placed directly via the NHS Supply Chain framework with a valid quote and Unique Reference Number is not completed for capital orders up to £350,000 for the period Jan – March 2023. This would be used at the discretion of the Director of Procurement and £350,000 is the approval limit for the Director of Procurement. All other contracts placed in this time for revenue would not be subject to this change and would follow normal process and have recommendation reports completed at the time. Any capital orders above £350k will follow normal process and have a recommendation report drafted and signed off prior to order as well as any capital order that is not via the NHS SC route.

To ensure that we capture and document orders placed without a recommendation report in this period for capital, procurement will compile a retrospective report for the end of the year documenting the process and the orders placed via this route and bring this to F&P for oversight.

Furthermore with the potential requirement that some contract recommendation reports over £750k may need approving between either F&P and Trust Board dates due to the lead times of equipment, to ensure money is spent for year end, it is proposed that the CFO where appropriate and at his discretion is able to authorize Chairman's action supported by two Non Executive (NEDS) Directors to approve recommendation reports and report at the next committee so as to ensure the programme can progress. This was the approach utilized for the new ward build.

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) – efficiency and use of resources	☒