Bundle Trust Board Public 9 January 2025

1 OPENING BUSINESS

1.1 10:00 - Patient Story

1.2 10:20 - Presentation of SOX certificates
December SOX of the month -
December Patient Centred SOX -

1.3 Welcome and Apologies
Apologies received from Cara Charles-Barks and Jon Burwell

1.4 Declaration of Interests, Fit & Proper / Good Character

1.5 10:30 - Minutes of the previous meeting
Minutes attached from previous meeting held on 5th December 2024
For approval
1.5 Draft Public Board mins 5 December 2024

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

1.7 10:40 - Chair's Business
Presented by Ian Green
For information

1.8 10:45 - Chief Executive/Managing Director Report
Presented by Lisa Thomas
For infomation
1.8 Chief Executive Report January 2025

2 ASSURANCE AND REPORTS OF COMMITTEES

2.1 10:55 - Integrated Performance Report to include excption reports
Presented by Duncan Murray
For assurance
2.1a IPR Cover Sheet - Trust Board 2025-01
2.1b Integrated Performance Report - January 2024 V3

2.2 11:25 - Audit Committee 12th December 2024
Presented by Richard Holmes
For assurance
2.2 Audit Committee Escalation Report

2.3 11:30 - Finance and Performance Committee 17th December 2024
Presented by Debbie Beaven
For assurance
2.3 Finance and Performance Escalation Report Dec 2024

2.4 11:35 - Clinical Governance Committee 17th December 2024
Presented by Anne Stebbing
For assurance
2.4 CGC escalation 17 Dec 2024

2.5 11:40 - Trust Management Committee 18th December 2024
Presented by Lisa Thomas
For assurance
2.5 TMC escalation report Jan Board

3 STRATEGY AND DEVELOPMENT

3.1 11:45 - External Well Led Review, 6 monthly update on progress - deferred from December
Presented by Fiona McNeight
For assurance
3.1 Well Led Progress Report December 2024

3.2 11:55 - Quarterly Strategy Update
Presented by Lisa Thomas
For assurance
3.2a 2025-01-09 Quarterly-Strategy-Report Cover-Sheet

3.2b 2025-01-09_Quarterly-Strategy-Report v3

3.3 12:05 - Improving Together Update Report
Presented by Alex Talbott
For assurance

3.3a Cover sheet_Improving Together Quarterly Trust Board Report_Jan 2025
3.3b Improving Together Quarterly Trust Board Report_Jan 2025_vF

3.4 12:15 - BREAK

4 PEOPLE AND CULTURE

4.1 12:45 - Health and Safety Quarterly Report
Presented by Melanie Whitfield
For assurance

4.1a HS report cover sheet - Jan Trust Board
4.1b HS Report Q2 FY25 for Board

5 QUALITY AND RISK

5.1 12:55 - Board Assurance Framework and Corporate Risk Register (aligned with Corporate Priorities)
Presented by Fiona McNeight
For assurance

5.1a Trust Board BAF Report January 2025
5.1b Board Assurance Framework December 2024 V1
5.1c CRR tracker v1_December Board Committees 2024
5.1d Corporate Risk Register December 2024
5.1e Risk Appetite Definitions October 2024 FINAL

5.2 13:05 - Quarter 2 Learning from Deaths Report
Presented by Duncan Murray
For assurance

5.2a Cover Sheet - Dec 24 LfD
5.2b 202411 Q2 LFD Report 2024-25v1.2b

5.3 13:15 - Director of Infection Prevention Control Report
Presented by Judy Dyos
For assurance
Links in document available on request

5.3a Report Cover Sheet Dec 2024 - IPC BBAF Q2
5.3b DIPC Report 6 Monthly Update 2024-25 (Final draft v.1)
5.3c SFT IPC BAF Q2 of 2024-25 (v.4 August 2024) Final

5.4 13:25 - Incident Reporting and Risk Report - deferred from December
Presented by Judy Dyos
For assurance

5.4a Q 2_Risk management Report for Trust Board
5.4b Q2 Risk Management Report FINAL

5.5 13:35 - Perinatal Quality and Surveillance Report December (November Data)
Presented by Judy Dyos/Vicki Marston
For assurance
Paper has been presented at Maternity Governance and will be presented at CGC in January

5.5a Front sheet Perinatal Quality Surveillance Report - DECEMBER (November data)
5.5b Perinatal Quality Surveillance Dec 2024 Slides (Nov data)

5.6 13:40 - Maternity Incentive Scheme - Safety Action 4
Presented by Judy Dyos/Vicki Marston
For assurance
Paper has been presented at Maternity Governance will be presented at CGC in January

5.6a Front sheet CNST_Safety Action 4 Board report
5.6b SFT CNST MIS Safety Action 4 Assurance and Compliance report

5.7 13:45 - Maternity Incentive Scheme - Safety Action 10
Presented by Judy Dyos/Vicki Marston
For assurance
Paper has been presented at Maternity Governance will be presented at CGC in January

5.7a Front sheet CNST Safety Action 10 Board report
5.7b CNST Sasfety Action 10 Board Report Dec 24

5.8 13:50 - CQC Maternity Report (if published tbc)
Presented by Judy Dyos/Vicki Marston
For assurance

6 GOVERNANCE

6.1 13:55 - Emergency Preparedness, Resilience and Response Annual Assurance Statement and Compliance
Presented by Niall Prosser
For assurance

6.2 14:05 - Register of Seals
Presented by Fiona McNeight
For assurance

6.2 Register of Seals

7 FINANCIAL AND OPERATIONAL PERFORMANCE

7.1 14:10 - Estates Technical Service Update
Presented by Mark Ellis
For assurance

7.1 Estates Report KPI 2024

8 CLOSING BUSINESS

8.1 14:20 - Agreement of Principal Actions and Items for Escalation

8.2 14:25 - Any Other Business

8.3 14:30 - Public Questions

8.4 Date next Public meeting:6 March 2025

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

Salisbury NHS Foundation Trust

Draft

Minutes of the Public Trust Board meeting held at 10am on Thursday 5th December 2024, Boardroom/MS Teams Salisbury NHS Foundation Trust Boardroom

Board Members:

Ian Green (IG)	Chair
Eiri Jones (EJ)	Non-Executive Director
Debbie Beaven (DB)	Non-Executive Director
Richard Holmes (RH)	Non-Executive Director
Rakhee Aggarwal (RA)	Non-Executive Director
Judy Dyos (JDy)	Chief Nursing Officer
Mark Ellis (ME)	Interim Chief Finance Officer
Duncan Murray (DM)	Chief Medical Officer
Lisa Thomas (LT)	Interim Managing Director
Niall Prosser (NP)	Interim Chief Operating Officer
Melanie Whitfield (MW)	Chief People Officer
Anne Stebbing (AS)	Non-Executive Director
Paul Cain (PS)	Non-Executive Director
Kirsty Matthews (KM)	Non-Executive Director (via Teams)
Cara Charles Barks (CCB)	Chief Executive

In Attendance:

Alex Talbott (AT)	Director of Improvement
Jon Burwell (JB)	Chief Information Officer
Sasha Godfrey (SG)	Board Support Officer (minutes)
Vicki Marston (VM)	Director of Midwifery (for agenda items 5.4, 5.5, 5.6 and 5.7)
Thalina Wijetung (TW)	Visiting fellow
Jayne Sheppard (JS)	Lead Governor (observer)
Jane Podkolinski (JP)	Governor (observer)
France Owen (FO)	Governor (observer via Teams)
Peter Russell (PR)	Governor (observer)
Inez Szczepanska (IS)	Videographer (for agenda item 1.1)
Peter Kosminsky (PK)	Governor (observer via Teams)
Dee Carson (DC)	Practice Education Facilitator (for agenda item 1.1)
Lucy Blinko (LB)	People Promise Manager (for agenda item 1.1)
Besh Nijhar Brown (BNB)	Business Partner, Great Western Hospital (for agenda item 1.1)
Becky Stark (BS)	Practice Educator (for agenda item 1.1)
John Stubs (JS)	Organisational Development Lead (for agenda item 1.1)
Jason Goodchild (JG)	Governor (observer)

ACTION

TB1 5/12/1 **OPENING BUSINESS**

TB1 5/12/1.1 **Staff Story**

MW referred to a video and pod cast that had been circulated previously to all Board members, the video had been developed by staff to support and encourage colleagues applying for jobs. MW introduced Inez Szczepanska (IS), Dee Carson (DC), Becky Stark (BS), John Stubbs (JS), Lucy Blinko (LB) and Besh Nijhar-Brown BNB) and asked them to share their experiences.

BNB referred to her previous role as a retention lead in the BSW and noted a lack of career development had been identified in BAME staff groups, funding was obtained, and a video and pod cast developed with staff at SFT, SFT being the People Promise exemplar site for BSW.

LB introduced an extract from the training video and noted it focused on two candidates, one who had a good experience and one with a bad experience.

DC referred to her role in the video and noted it had been completely out of her comfort zone but explained it had been fun to work with the team and noted the positive feedback that had already been received from colleagues using the training video. DC hoped the video would help candidates prepare for interviews.

IS explained her role was to make people comfortable in front of the camera and added the video was twenty three minutes long and planned to split it into 90 second chunks to make it more accessible to busy clinical staff.

LB shared a slide showing the good feedback that had been received after the training and noted the number of black and minority ethnic staff had increased in the SFT workforce in the last year, and added figures showed staff were promoted to band 6 quite easily but did not progress further. LB noted although the project impetus had been to support BAME staff the training was accessible to everybody. Three sessions had been successfully delivered with more planned in 2025, the same training to be offered in GWH.

BS introduced herself and referred to comments regarding opportunities to progress up the career ladder. BS noted SFT had a diverse workforce and there needed to be a culture to match that. BS added apprenticeships would encourage people to progress and the lack of training, educational resources and facilities needed to be addressed.

LB added there was a workstream within the people promise to look at the progression of internationally educated nurses and their progression over the next two years.

JS noted it had been his first week in the Trust when he was asked to take part in the video and added he had enjoyed the experience and it had been great to work on the video collaboratively.

Discussion:

RA referred to the impact the video would have and considered there was an opportunity to undertake interviews differently, to use more diverse interview panels and be more accepting of differences.

JDy referred to the Surgery Divisional Head of Nursing who was from Sri Lanka, JDy noted they had set up regular sessions to meet with overseas nurses in a relaxed setting which had been popular at first but had recently waned. A survey monkey had been developed to try to find out what the nurses wanted and what their development needs were. JDy noted the interview was the start of the process, staff needed to develop confidence and sometimes needed help to navigate through the process and systems.

DB reflected that candidates could still have a difficult interview experience despite adapting the processes and added post interview coaching would help to build confidence back.

LB referred to the video and noted the content was not necessarily taught to people, the video had been designed to be user friendly, easy to follow, was jam packed with tips and tricks and there were examples of good and bad interviews in the pod cast.

BNB noted the training was designed to demonstrate to applicants that they need to put the work into their applications, to cover the cultural differences based on her personal experience and then to support staff with their career development.

IG congratulated them on their thorough work and thanked them all for attending.

TB1 5/12/1.2 **Presentation of SOX Certificates**

IG presented the SOX nominations:

September SOX of the month – Orthotics Team
September Patient Centred SOX – George Cherian and the Day Assessment and Beatrice Maternity Wards
October SOX of the month – Gilly Ansell, Radiology
October Patient Centred SOX – Bethan Warner, Medical Engineering
November SOX of the month – Sarah Singleton, ENT Secretary
November Patient Centred SOX – Donna Roberts, Manjula Atapattu, Yetunde Oluwasola, Fatma Kay-Cifci and Karen Cordia and the SAL, Theatres and Recovery Teams

IG reflected it was a privilege to hear the positive feedback that had been received both internally and externally and added it was important to meet staff to present the awards and to recognise them publicly.

TB1 5/12/1.3 **Welcome and Apologies**

IG reminded the Board that it was important to operate within the Trust's values and in accordance with the Improving Together approaches around curiosity when seeking assurance. IG asked members and attendees to be engaged and highlight if they needed to step out during the meeting. IG asked the Board to focus on the papers and presenters to assume that papers had been read and to focus on key issues.

IG welcomed Cara Charles Barks (CCB) to her first Trust Board meeting as Chief Executive and noted that apologies had been received from Fiona McNeight, Director of Integrated Governance.

TB1 5/12/1.4 **Declarations of Conflicts of Interest, Fit and Proper/Good Character**

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

TB1 5/12/1.5 **Minutes of the Part 1 (Public) Trust Board meeting held on 3rd October 2024**

IG presented the public minutes from 3rd October 2024 and the following changes were noted:

- EJ noted she was recorded as leaving the meeting but was also noted in the discussion.
- EJ referred to an amendment on page 16.

Decision:

Subject to these two minor amendments the minutes were approved as an accurate reflection of the meeting.

TB1 5/12/1.6 **Matters Arising and Action Log**

IG presented the action log, the following points were noted:

- TB1 4/7/2.6 CGC - infected blood enquiry on the agenda, subject to discussion in the meeting can be closed.
- TB 1 5/9/3 SIRO Annual Data Security and Protection Assurance Report - Cyber Security Report on the agenda and subject to discussion in the meeting can be closed.
- TB1 5/9/6.2 NED MLE – Completed
- TB1 3/10/2.1 IPR – Discussed at Finance and Performance Committee, completed.
- TB1 3/10/7.1 Research Annual Report - DM confirmed all studies carried out at SFT are registered at either a US or UK registry and are easy to access by the national and international scientific community. Internally, the Research Department publish a quarterly newsletter which provides updates on key trials, the SFT library issued a quarterly update including links to studies and a list of the SFT staff involved. Locally thank you letters are sent to participants including the results. The Research Department are working with the Communications Department to use the public facing website to provide further information for current and prospective participants. The Board agreed the action could be closed. DM noted communications and learning would be included in future reports.

It was noted the other two actions were not due until January 2025.

TB1 5/12/1.7 **Register of attendance**

IG presented the register of attendance which was noted.

TB1 5/12/1.8 **Chair's Business**

IG noted the following key points:

- Consultation currently taking place regarding the NHS Ten Year Plan, an event was taking place today with colleagues attending from the other two trusts in the group to provide feedback.
- Memorandum of understanding developed between the three Chairs in the group with an agreement almost in place to operate collectively with one Chief Executive whilst maintaining three independent Chairs.

- Health Care Resourcing Group (HCRG) in process of taking over the delivery and accountability for Community Services which will have an impact on SFT for the Hospice. This will be discussed later in the Private Board.
- The Council of Governors did not approve the changes that the Board had approved to the constitution. IG noted his concern that the constitution was not fit for purpose in the group model and the Board's ability to effectively govern the organisation could be diminished. IG suggested this needed to be reflected upon and rectified.

The update was noted.

TB1 5/12/1.9 **Chief Executive/Managing Director Report**

CCB took her report as read and noted the report provided a summary and context to a number of national projects that the executive teams were contributing to, particularly regarding the regulation of managers in the NHS. CCB assured the Board that the competencies in the leadership and development programme were values driven and complimented the leadership behaviours in the Improving Together Programme.

CCB noted the following points:

- Consistency in regional, local and government priorities regarding H2, working towards a year-end financial deficit of £9.4 million.
- Critical focus on 5 week waits, Salisbury was performing well.
- Focus on Urgent and Emergency Care with new initiatives for managing ambulance handovers.
- Spending time in each organisation and building relationships with the new managing directors.

Discussion:

DB asked if the leadership programme covered primary and social care, CCB confirmed that it did.

EJ referred to the Assisted Dying Bill and noted it was important to get end of life care right, IG suggested the systems end of life strategy was discussed further in Private Trust Board.

AT referred to the Leadership Competencies Regulations and noted members of the Board had a responsibility to describe their work in a way that shows pride and defends their profession. IG noted the Board had the ability and responsibility to provide and shape the leadership required in healthcare to support the local population.

AS referred to the Secretary of State's speech regarding better outcomes for taxpayers and asked if more details could be provided on which outcomes demonstrated better value. CCB noted the government's focus was on urgent emergency care, access to emergency departments, ambulance waiting times and reducing waiting lists. CCB referred to the operating plan which was expected and noted from an acute perspective there would be a critical response to budget allocation, savings and service delivery targets. AS reflected she had hoped for genuine outcomes rather than responsiveness to

performance. CCB noted the Board had an opportunity to create opportunities in BSW by working together and sharing innovation.

DB referred to the tension regarding finances and added not closing beds would have a financial impact but closing them would not be the best outcome for patients. CCB referred to the duty of care and noted finding the right balance between targets and patient care was a concern.

EJ referred to functioning as a unitary organisation and noted it had been agreed that safety was the hospitals priority which would lead to some tough decisions, EJ reflected how the Non-Executive Directors could support the executives whilst still challenging them. IG noted there would be pressure from the system and wider in relation to financial targets and Non-Executive Directors would bring independent objectivity whilst still working together to find opportunities to drive productivity.

LT referred to the focus on performance management as a system and regionally and noted the Board needed to be mindful of the challenge for senior managers trying to respond to priorities agreed by the Board.

IG reflected on the Managing Director's report and noted the Trust was under significant additional pressure at present. LT noted the hospital was currently operating at OPEL 4 and the ambulance trust was in its highest level of escalation, the Trust had taken steps to make sure ambulances were back on the road as soon as possible but there was more to be done on the patient experience.

The Board noted the report.

TB1 5/12/2 **ASSURANCE AND REPORTS OF COMMITTEES**

TB1 5/12/2.1 **Integrated Performance Report (IPR) (M7 October)**

ME presented the Integrated Performance Report which provided a summary of Month 7 (October 2024). ME noted doing the right things for the right reasons should lead to a financially efficient organisation and highlighted the following key points:

- Improvements to the Time to First Outpatient Break Through Objective, and noted waiting leads to further deterioration and higher intervention.
- Significant improvement in staff turnover.
- Productivity challenge for the Trust to try to do more with the resources we have from the Board down to the teams on the ground.
- Good processes for handling ambulances but patients are still in the ED, performance is related to demand and when that demand drops slightly performance improves.
- Significant number of No Criteria To Reside (NCTR) patients, the number of patients that need to be treated in the hospital has an impact on the financial targets.

Discussion:

IG asked what the trajectory in the financial plan was for NCTR patients. ME confirmed it was 34 with 108 reported this month, Breamore Ward had been specifically focused on NCTR and had made good progress.

DB referred to a deep dive at the Finance and Performance Committee in September where the discharge process had been discussed. NP recognised NCTR was a challenge and explained the work that was on going to try to understand the cause of the problem, reduce delays and simplify the process. NP noted the Finance and Performance Committee would be kept updated with progress. NP referred to the data in the report which was from October and noted there had already been improvements in the last few weeks.

AS noted NCTR patients were often vulnerable and recognised these patients still received the care they needed and were kept safe, AS added the referral process needed to be clear and effective.

RH asked how HCRG could help with providing community beds. NP described the different pathways that NCTR patients follow and noted planning with HCRG was ongoing ahead of the contract going live in April.

EJ referred to the patient survey which reported dissatisfaction with discharge and asked if there was anything else that could have contributed to patients not being discharged. NP reflected on the positive steps in cancer diagnostics and patients waiting over 65 weeks. NP referred to the growing pressure in urgent care and noted the Emergency Department was built to see 120 patients per day but recently had seen 200, teams were currently engaged in tackling overcrowding, staff capability and discharge processes. NP referred to Emergency Department attendance numbers and added the Trust was admitting 10% more patients than last year which so far had been absorbed through SDEC improvement work with more actions in place to drive improvement in the second part of the year.

LT referred to the increased figures in incident reporting and noted the daily safety huddles had led to staff being more vigilant in recognising and reporting incidents.

ME noted significant improvements in length of stay and the amount of planned activity and added it was important to the consider challenges in the context of an overall improvement journey.

IG referred to the challenge and assurance required and asked when the Board would receive more feedback on progress. DB noted deep dives had been planned for future Finance and Performance Committees and noted progress would be reported at Finance and Performance Committee, IG asked for any issues to be escalated to Board.

JDy referred to the patient safety huddles that took place on a daily basis at 8.30 am and noted staff were now more vigilant and diligent about reviewing patients and a number of Standard Operating Procedures had been put into place. JDy referred to national changes to the way tissue viability is reported and also changes in reporting C. Difficile that could affect future reporting.

AS acknowledged the safety huddles had raised awareness in the organisation and noted incidents of moderate harm should decrease over time due to better reporting and learning from incidents. JDy noted this would be picked up in the next Risk Report and added some individuals could cause multiple reports.

IG reflected on the significant challenge in urgent care and noted the assurance provided on work taking place.

The Board noted the report.

TB1 5/12/2.2 **Finance and Performance Committee - 26th November**

DB presented the report from the November Finance and Performance Committee, noting the following key points:

- Significant adverse variance.
- The end of year trajectory is not where the system wanted it to be.
- Interventions have a significant risk attached.
- Committee had received assurance that all the right things are being done.
- NCTR was the biggest challenge from quality and financial perspective
- Improvements in theatre utilisation.

Discussion:

DB reflected on the pace and focus of NCTR work. ME noted the Medicine Division had focused on expenditures in their payroll and that had significant success but meant that management capacity was focused and limited at the time. IG added Non-Executives can encourage these conversations to take place.

The Board noted the report.

TB1 5/12/2.3 **Clinical Governance Committee - 26th November**

AS presented the report which provided a summary of escalation points from the meeting held on 26th November. AS reflected the Committee had received Quarter Two reports which meant there was a disconnect between the report and seeking assurance. AS took the report as read.

The Board noted the report.

TB1 5/12/2.4 **Trust Management Committee – 23rd October and 26th November**

LT presented the report which provided a summary of escalation points from the meeting held on 23rd October and 26th November. The report was taken as read. LT highlighted the following points:

- A new recruitment process that required sign off from the ICB.
- Process improvement opportunities identified in corporate policies.
- Pilot on right to work process.
- Good assurance reports received with positive reports from several areas.

Discussion:

EJ asked for assurance that the business safety critical role would not be blocked. LT noted it was early days but provided some reassurance that there was a clear quality impact assessment if posts were not approved. CCB added there was clinical representation on the ICB committee to provide perspective and there was also an escalation process. IG added if there was a compromise on patient safety, he felt assured that conversations would take place. KM reflected it would be interesting to monitor the process and record how many blocks there were to test the process. IG added TMC would feedback any issues to Board. JDy noted there would be a report on the key quality questions of each role for background information. IG added this was a necessary process to manage the workforce.

The Board noted the report.

TB1 5/12/2.5 **People and Culture Committee – 31st October and 28th November**

EJ presented the report which provided a summary of escalation points from the meetings held on 31st October and 28th November. The reports were taken as read and EJ highlighted the following points:

- The Trust was not where it should be in terms of appraisals, but clear work was underway, the Committee would keep a focus on that.
- Work underway to refresh and reform safeguarding training issues.
- Staff completing the care certificate had risen from 25% to 97%.
- Work started on Marthas Rule with the Critical Care Outreach Team.
- New system for managing policies now online.
- Strategic work force plan presented.
- Annual Review of the Committee.
- Positive Medical Education Report.

Discussion:

PC referred to appraisals and asked if not receiving appraisals caused other problems for staff. EJ suggested a future staff story regarding positive and negative appraisal experiences. MW added the appraisal process provided regular reviews on career development and helped with succession planning but sometimes staff did not want an appraisal. MW noted the appraisal form had been redesigned and more training for line managers had been provided. IG reflected appraisals were an opportunity, once and year for the employee and their line manager to look at the future and to plan ahead, it was important for staff to have the capacity and training to have meaningful appraisals.

DM referred to medical appraisals and noted around 85% of doctors have an appraisal for their revalidation on a 5 year cycle, the remaining 15% drift and then catch up.

AS referred to the Strategic Workforce Plan and asked if it incorporated the group. MW noted the Chief People Officers in BSW met and looked at the system as a whole and staff shortages in the system were recognised. LT added the strategy reflected the clinical model but work continued internally as there were different catchment areas and no overlap in staff.

RH referred to the Audit Committee the following week and noted this was the second year with external audit partners and there would be an external audit plan presented.

The Board noted the October and November People and Culture escalation reports.

TB1 5/12/3 **STRATEGY AND DEVELOPMENT**

TB1 5/12/3.1 **Annual Digital Plan Update**

JB presented the report and noted the following points:

- The report set out to achieve the objectives which were aligned to Improving Together.
- The report recognised that some projects had been stopped as there was not enough capacity and to deliver projects with the greatest benefit to the organisation.
- Big improvement in cyber security particularly the risks associated with not having enough resources.
- EPR programme focused on deployment.

Discussion:

IG referred to the digital plan and added it was helpful and provided assurance on work in progress and where timescales had been extended. IG asked if there had been an assessment of risk and prioritising those areas. JB noted projects had been assessed and the risks associated with delays reviewed, the resources and funding had been prioritised accordingly.

DB noted the paper had been received at the Finance and Performance Committee and the committee had been assured that the funding was tracked carefully, there was a slight risk that there would not be enough funding which was a concern.

ME referred to the Strategic Capital Committee and noted ongoing work to identify high risk projects should finance become available.

The report was noted.

TB1 5/12/3.2 **External Well-Led Review – 6 monthly update on progress**

The Board noted the External Well-Led Review 6 monthly update report had been deferred to January Trust Board Meeting.

TB1 5/12/4 **PEOPLE AND CULTURE**

TB1 5/12/4.1 **Nursing Skill Mix Review**

JDy presented the report, noting that it had previously been presented at Clinical Governance Committee and highlighted the following points:

- The report was a mandated paper received at Board twice a year.
- High turnover of staff after the pandemic had led to the Trust being one of the lowest Care Hour Per Patient Trusts in the Country.
- Data now digitalised to make data collection easier.
- Recognised there are still gaps in the number of nurses required.
- Additional staffing requirements needing £1.5m investment.
- Changes to shift patterns to reduce the overlap period could potentially decrease spend by £2m.
- Savings in temporary staffing.

Discussion:

ME noted the Board were asked to support Skill Mix Report it then became part of the business planning process.

CCB noted temporary staffing was an area where investment could have an impact but this needed to be monitored.

EJ felt assured that the process had been followed correctly and the report was fully triangulated. EJ referred to the appendix regarding RN ratio by ward noted the progress but there was a high patient to nurse ratio, EJ asked if the figures included support workers. JDy confirmed the figures related to RNs. EJ asked if the figures could show the ratio of support workers to RNs. JDy explained the ratio was 60:40.

EJ referred to timings and ME explained the timescale was January and noted the overlap in shift hand overs which was a simple roster change and would deliver savings.

DB referred to the financial challenge and advised that the report should separate from CIP and treated as a business case. IG agreed and suggested the Board agree in principle to the proposal subject to the business planning process. ME noted the redistribution of resources.

MW referred to sickness absence and noted sickness absence on wards was higher than the Trust as a whole. MW referred to international recruits and national funding, which was being withdrawn, MW noted her support but added there would be practical challenges.

RA referred to the Workforce Strategy and how it had been reflected in the reports, RA asked if more could be done, MW noted that the nurse skill mix element would be included in future versions of the Workforce Strategy and would be reviewed on an annual basis. CCB referred to links to the clinical strategy and noted wider opportunities in the system with stabilisation in the first twelve months and then transformation over the next ten years.

JDy referred to resourcing and noted a recent three-year programme to train 50000 new nurses in the UK, JDy hoped to be able recruit locally trained nurses.

IG noted some good conversations and asked the Board to approve the Nursing Skills Mix as presented and the Safe Staffing review, and to approve in principal, subject to the business planning process.

The board agreed and noted the report.

TB1 5/12/5 **QUALITY AND RISK**

TB1 5/12/5.1 **Patient Experience Report**

This agenda item was taken after 5.3.

JDy presented the quarter two report, took the paper as read and highlighted the following points:

- 121,000 episodes of care with 77 complaints or concerns received with themes of patient care, communication and values and behaviour.
- Challenge to respond to complaints in time, an improvement with surgery after implementing a different process.
- Increase in response to Friends and Family after implementing a text message service.
- 51% response rate to the Inpatient Survey, positives related to care and feedback on staff.
- Improvement to discharge and continuity of care.
- 5% improvement overall with a score of 8.3.
- Top ten most improved nationally.

Discussion:

IG referred to the improvement since the previous year's staff survey and commended the team on their approach to patient experience.

RH asked what the complaints process was for complaints made against a member of staff. JDy noted if direct complaints regarding staff behaviour were received it would be addressed by education and learning, if the complaint was regarding illegal behaviour the member of staff would follow the HR process.

RH referred to complaints made to the Care Quality Commission (CQC) and asked about the process from a patient perspective. JDy noted the Trust would respond to directly to the CQC, if the complaint is made directly to the Trust, guidance is followed and response would be in 45 days. The reply can be longer if complicated and in agreement with the complainant. JDy referred to the CQC's positive relationship manager who liaised with the Trust and complainants and added the CQC encouraged complaints to be made directly to the Trust.

The Board noted the report.

TB1 5/12/5.2 **Incident Reporting and Risk Report**

The Board noted that the Incident Reporting and Risk Report had been deferred to the January Trust Board meeting.

TB1 5/12/5.3 **Recommendations in the infected blood enquiry report and the impact on the Trust**

This agenda item was taken after item 4.1.

DM presented the report, took the report as read and highlighted the following recommendations from the report:

- Better transfusions practice.
- Review of safety culture and investigation of incidents.
- Approach to candour.

DM asked the Board to consider if the Trust should start work ahead of specific direction from NHS England and if so, are these the right areas to be working on.

Discussion:

IG referred to his previous role at the Terrence Higgins Trust and noted the trauma the incident had caused and referred to problems with receiving compensation. IG noted the importance of looking at the report early and asked if as an organisation the Trust was taking opportunities to explore whether patients should be offered a test for Hepatitis C or HIV as part of a routine clinical assessment. DM noted the test was offered and there was an ethical and legal framework for clinicians to follow. DM added there was more that could be done to make clinicians more aware.

AS noted her support and suggested the scale of the recommendations needed some reflection as there was a need for education and encouragement in the Trust. AS suggested using the Electronic Patient Record as a tool and monitoring progress with an annual update report to the Clinical Governance Committee.

PC noted his support but expressed concern regarding resources and priorities during the winter period.

IG asked the Board to consider endorsing DM's report and to agree to implement the recommendations in the report, acknowledging PC's point regarding resources.

Decision:

The Board agreed further opportunities for testing HIV and blood borne viruses should be explored as part of the clinical assessment process.

DM referred to the Clinical Ethics Committee and suggested they could explore testing opportunities.

The Board noted the report.

DM left the meeting.

TB1 5/12/5.4 **Maternity and Neonatal Quality and Safety Report Quarter two**

This item was taken after agenda item 5.2.

VM joined the meeting.

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

The Board was asked to note:

- Compliance with Labour Ward coordinator being supernumerary and women receiving 1:1 care 100% of the time during quarter two.
- Feedback from ward to board and board to ward evidenced by Safety Champion meetings and attendance by Executive and Non-executive safety champions.
- There had been no still births in Quarter two.
- There were no reportable neonatal deaths in Quarter two.
- Overall trend very positive.
- Good input from Safety Champions, staff clear very clear who the Safety Champions were and where to go with their concerns.
- Steady progress with compliance of Saving Babies Lives, not fully compliant but trajectory shows will be compliant by June 2025.

Discussion:

JDy referred to her role as Safety Champion and noted an escalation regarding not achieving the recommended staffing levels due to the size of the hospital, this would be addressed at a future Executive Directors Meeting.

EJ noted the importance of supporting staff and referred to a wellbeing concern regarding bright digital screens that had been installed in staffrooms which were disrupting staff rest breaks, the screens had now been removed.

EJ referred to work to provide and fund meals for both parents in the Neonatal Unit.

EJ referred to a concern in the Day Assessment Unit regarding length of wait for non-emergency situations and confidentiality issues due to the nature of the building.

CCB asked for more information on the barriers to the Saving Babies Lives compliance but added was assured by the low numbers of still birth rates. VM referred to the digital system and noted it required manual input but there were audits built in. VM noted initially the issue with compliance had not been picked up but there was more focus now. VM added working through the Maternity Safety Programme had also helped and Maternity were now making steady progress.

The Board noted the report.

TB1 5/12/5.5 **Perinatal Culture and Leadership Report**

VM presented the report which referred to a programme commissioned by NHS England to support the Maternity and Neonatal quadrumvirate teams with their cultural and improvement development and noted the following recommendations:

- Following the culture score survey it was recognised Maternity staffing levels were low and staff felt challenged, an action plan was now in place.
- Good programme for making links and networking.
- Safety Action 9 paper presented to Board to make Board aware of work.
- Safety Champions meeting regularly and no requests for extra support required.

Discussion:

IG referred to demands made of the quadrumvirate noted in the report and asked what action was being taken to respond to that. VM noted the division was working on this as a leadership team. IG noted the requirement for the Board to be aware and for the division to support the quadrumvirate, IG asked for further feedback on outcomes and actions taken. **ACTION VM** **VM**

JDy noted a letter had been received from the National Team confirming SFT were exiting from the quality and safety programme. IG reflected on the huge amount of effort and leadership required from the Maternity Division. IG thanked VM and the Maternity Department for their work.

PC referred to the progress made, and hard work required and asked if there was the same programme for other divisions. IG noted the programme was specific to maternity and was part of the Ockendon recommendations. PC asked if there was learning from Maternity that other divisions could use. IG agreed but referred to the intensive support and Executive and Non-Executive time required and noted it would need to be handled in a manageable way.

JDY referred to the heavy investment in Maternity necessary to do this work which was reflected nationally, Maternity was recognised as a significantly challenged area countrywide. PC noted if time permitted other departments may benefit from Maternity's improvement.

CCB reflected on the connection between Maternity Departments across BSW and added learning environment and leadership culture was a critical aspect and made the most difference to a continuous improvement culture. CCB added the Improving Together Programme had given SFT a strong foundation for future improvement and opportunities for excellence.

IG noted the further assurance required for the support to the quadrumvirate. The Board noted the report.

TB1 5/12/5.6 **Perinatal Quality and Surveillance Report October (September data)**

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

This report is prepared to demonstrate assurance to the board on Maternity and Neonatal Quality and Safety issues as required by Maternity Incentive Scheme – year 6 – Safety Action 9.

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

The following key points were noted:

- The Midwife to birth ratio had been 1:30, the recommended ratio is 1:24, this is also reflected in October. September and October had been busy months.
- The unit had not been fully staffed during this period.
- Six incidences reported as moderate.
- Training compliance had been escalated in September and compliance had reached 90%.

The Board noted the report and progress made.

TB1 5/12/5.7 **Perinatal Quality Surveillance Report November (October data)**

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

This report is prepared to demonstrate assurance to the board on Maternity and Neonatal Quality and Safety issues as required by Maternity Incentive Scheme – year 6 – Safety Action 9.

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

- The Midwife to birth ratio remained good.

- One still birth, initial review showed no admissions in care but will go through normal processes.
- Safety Champions feedback had been good throughout the month.

The Board noted the report.

TB1 5/12/7 **CLOSING BUSINESS**

TB1 5/12/7.1 **Any Other Business**

There was no further business to discuss.

TB1 5/12/7.2 **Agreement of Principle Actions and Meeting Reflection**

IG referred to the principal themes from the meeting and noted the following:

- Discussion on NCTR, the need for careful monitoring and the impact on the financial plan.
- Positive patient experience report.

AT referred to the scale of changes SFT was trying to achieve and noted it was possible to get pace from focus but to ask for more pace without focus would put more pressure on staff. IG agreed and noted the Board would need to the hold the tension on external pressure.

IG referred to the conversation regarding papers and reflected some papers had already gone through sub committees and had to then be submitted to Trust Board but the balance needed to be right.

RH acknowledged it was early days for the group model but noted the value of hearing about how initiates across the group are being managed and delivered.

DB suggested there should be time set aside for the Board to think about mid to long term planning.

AT reflected on the SOX awards and staff story at the beginning of the meeting and the need to remember the patient in middle, AT suggested there could be more constructive challenge and curiosity in reports.

TB1 5/12/7.3 **Public Questions**

There were no public questions.

TB1 5/12/7.4 **Date of Next Public Meeting**

The next Public Trust Board meeting will be held on 9th January 2025

TB1 5/12/8 **RESOLUTION**

TB1 5/12/8.1 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

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

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

Committee	Organiser	Reference Number	Deadline	Owner	Action	Current progress made	Completed Status (Y/N)	RAG Rating
Trust Board Public	Sasha Godfrey	TB1 4/7/2.6 Clinical Governance Committee	~~03/10/2024~~ 5/12/2024	Duncan Murray, DM	Report regarding the recommendations in the infected blood enquiry report and the impact on the Trust	**PC Update 26.9.24 report has been completed and will be taken through CGC in October, December Board, on agenda**	Y	3
Trust Board Public	Sasha Godfrey	TB1 5/9/3.1 SIRO Annual Data Security and Protection Assurance Report (includes Toolkit Self-Assessment and Data Protection Annual Report and GDPR)	05/12/2024	Jon Burwell, JB	A deep dive report on cyber security will come to the Board in December.	**On December Board agenda**	Y	3
Trust Board Public	Sasha Godfrey	TB1 3/10/2.1 Integrated Performance Report (IPR) (M5) NCTR	26/11/2024	Lisa Thomas (LT)	project starting with stakeholder mapping to ensure proper focus areas. It was agreed that this will be referred back to F&P for further action. ACTION: LT to follow up with F&P regarding additional NCTR actions.	**Discussed at November's Finance and Performance Committee meeting.**	Y	3
Trust Board Public	Sasha Godfrey	TB1 3/10/5.2 Estates Technical Service Update	09/01/2025	Mark Ellis (ME) John O'Keefe (JoK)	Focus of the report should provide assurance of mitigation of BAF risk. ACTION: ME/JoK to work this through. The F&P committee will receive an updated report and decide what should be escalated to the Board.	**Next report due January 2025**	N	4
Trust Board Public	Sasha Godfrey	TB1 3/10/6.1 Health and Safety Quarter One Report –Tugs	09/01/2025	Melanie Whitfield (MW) Troy Ready (TR)	MW asked what further assurance the Board required re the investigation into tugs. ACTION: MW RH suggested further assurance on timescales, i.e., when is the work implemented to improve tug safety likely to bring about change.	**Next report due January 2025**	N	4
Trust Board Public	Sasha Godfrey	TB1 3/10/7.1 Research Annual Report	05/12/2024	Duncan Murray, DM	DM In light of the report the Board asked for further assurance about how the outcome of research is disseminated more broadly and how do the communications team get involved.	**DM gave a verbal update at 5 December Trust Board. The Board agreed action to be closed.**	Y	3
Trust Board Public	Sasha Godfrey	TB1 5/12/5.5 Perinatal Culture and Leadership Report	TBC	Vicki Marston	Further feedback on actions taken and outcomes on support for the Maternity quadrumviarte		N	4

NHS Salisbury NHS Foundation Trust

Report to:	Trust Board (Public)	Agenda item:	1.8
Date of meeting:	9th January 2025		

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

Recommendation:

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

Executive Summary:

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

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

NHS Salisbury NHS Foundation Trust

Chief Executive Officer's Report

Happy New Year:

I would like to take this opportunity to wish you all a Happy New Year. I am very excited about the year ahead, knowing that we will all embrace and face the challenges ahead together.

Pressure on our services:

The end of 2024 represented an incredibly busy time in the NHS. As we enter 2025, we continue to face significant pressure on our services. This is linked to an increase in the flu and other winter viruses - norovirus and RSV, (Respiratory Syncytial Virus). Our primary focus has been on managing winter escalation and maintaining patient safety. I would like to thank all of our dedicated colleagues for their ongoing commitment to providing outstanding services.

NHS Planning Guidance:

We await the NHS Planning Guidance 2025/26 that has been delayed, with Trusts being informed that it will be released in the New Year.

We expect that the guidance will focus on the 4 key priorities of:

- Reducing waits for elective care (18 weeks)
- Improving A&E and ambulance times
- Improving access to primary care and dental
- Mental Healthcare

Our preparation for the release of the guidance is progressing, with finalised plans required end of March 2025. Plans will have Board to Board sign-off, concentrating on reducing unwarranted variation and strongly focusing on productivity.

Group Development:

With the Christmas period since the last update on Group development, we remain in the early stages. Having said that, on my first day back after the Christmas break, I spent time with colleagues to map key things that we want to achieve over the next 12 months. This covered topics from the core basics through to overarching and guiding strategies. I look forward to updating and sharing with you over the coming months as we embrace the opportunities that working and learning together provides us.

Support to help us move to a new way of working is crucial. As such, we are presently going through a tender process to engage external support to provide additional capacity and resource. Once completed, I will update you on the outcome. Additionally, Browne Jacobson, a law firm with comprehensive experience working with healthcare organisations, are undertaking developmental work with all of our NEDs and Governors across the Group. NEDs and Governors have a crucial role and we want to make sure that we support and enable them to support the ongoing decision making and development of the Group.

Managing Director - Hospital Updates

We ended the calendar year experiencing increase in patients attending ED or being referred from their GP's for respiratory illnesses. Nationally there has been an increase in the number of people who have Flu, and this has been mirrored locally. The expected peak is not until early January and therefore we anticipate a challenging few weeks. It is likely staffing levels will be challenged as an increase in the numbers of patients with flu in the community impact our workforce availability.

Our key metrics for December are outlined in the Integrated Performance Report (IPR) and show overall all a trend for sustained improvement. Whilst the financial position remains challenging in terms of achieving the overall plan, the productivity improvement shows another improvement in month (now showing five months consecutive months of improvement). The board will need to consider the implications of the financial challenges and what additional actions might be required to reduce the overall deficit.

This month we launched the staff engagement exercise on car parking. Demands for car parking on site has reached a point of outstripping capacity which at times has led to frustration from staff and visitors. In March 2024 a working group of interested staff was established to look at what options we might adopt to improve the situation and what alternatives we could develop. There are no perfect solutions recognising the ability to increase car parking on site is not an option for the Trust. Staff are currently in the process of being asked to consider all the different options, recommend any news ones that haven't been considered in the next month so recommendations can be put forward. The final recommendations will come to board in coming months.

The Spinal team were recognised in a three-part feature on BBC South Today television, the crew had been filming with patients and the spinal team for many months, exploring the challenges and successes for patients who are rehabilitating after a spinal cord injury. The programme was a fantastic opportunity to highlight the work the spinal team do every day supporting patients.

Being December, a number of Christmas festivities were arranged during the month. We are enormously grateful to the Stars Appeal for funding the 3,000 free Christmas lunches and breakfasts for staff. The catering team did an outstanding job cooking and serving a two course Christmas lunch, many of the executive and senior management team helped with serving mince pies to staff.

In addition we had Salisbury Cathedral Choir performing traditional carols across the Trust, we also had visits from All Saints Netheravon Primary School Choir, Fordingbridge Choir and Evo Choir to name a few. Characters from the Salisbury Playhouse panto Sleeping Beauty visited Sarum and Imber wards.

We distributed 350 hampers funded by the Stars appeal all across the Trust to staff, as a particular thank you for working over the holiday period. There was a Christmas door competition, there were over 30 doors to judge and after much deliberation Finance won the main prize with runners up in Children's Outpatients for their 'Enter Narnia through the wardrobe' theme and Day Surgery Unit for their 'Take an Elfie' theme.

NHS Salisbury NHS Foundation Trust

Report to:	Trust Board (Public)	Agenda item:	2.1
Date of meeting:	09th January 2025		

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

Recommendation:

The Trust Board are asked to note the Trust's operational performance for Month 8 (November 2024).

Executive Summary:

Breakthrough Objectives

- *Time to First OP Appointment* reduced further from 130 to 129 days and is now at the lowest point since December 2022 continuing below baseline of 139 days since adoption in April 2023.
- *Managing Patient Deterioration* increased from 47.3% to 48.8% and sustained its incremental improvement to total 3.1% since adoption in April 2024 against the target of 60%.
- *Staff Turnover* reduced notably from 18.7% to 17.4% and the lowest point since December 2022 with overall improvement of 3% since adoption in April 2024 against the target of 15%.
- *Productivity* improved for the fifth consecutive month from -15% to -14.9% and is now a total improvement of 3.1% against the adoption baseline of -18% in April 2024.

Deteriorating Performance

- The Emergency Department (ED) continued to be challenged:
  - *Attendances* reduced from 6,879 to 6,772 although remain circa 8% higher than last year.
  - *4-hour Performance* improved slightly from 69.2% to 69.8% but remains under trajectory of 78%.
  - *Ambulance Handover* time remained static at 26 minutes.
  - *Ambulance Handovers >60 minutes* reduced from 102 to 80.
  - *Arrival to Departure >12 hours* increased significantly from 103 to 164.
- *No Criteria to Reside (NCTR)* remained stubbornly high despite reduction from 97 to 94 against the trajectory of 21.

- *Income* is below plan year-to-date driven by underperformance in Elective activity impacting on the ERF income, partially offset by overperformance on Day Cases, Non-Elective and Outpatient activity.

Alerting Metrics

- The Trust formally exited Tiering for Cancer and Diagnostics performance in October.
- Cancer performance improved across all metrics:
  - *28-day Faster Diagnosis Standard (FDS)* increased from 75% to 80.2%.
  - *62-day Standard* increased from 69.8% to 78.7%.
  - Patients waiting *More than 62 days* for Cancer treatment reduced from 78 to 68.
    Note: Cancer performance reports one month behind, October in this IPR.
- Diagnostics *DM01 Standard* improved from 86.3% to 87.9% and continues above the trajectory plan.
- Mixed Sex accommodation breaches increased from 0 to 8.
- *Referral to Treatment (RTT)* waiting list metrics alerted for mixed reasons:
  - Patients waiting *>65 weeks* reduced from 43 to 38 with plans being made to clear although unlikely to meet target: Zero by end of December 2024 (from September).
  - Patients waiting *>52 weeks* increased slightly from 927 to 936 although progress continues to reduce overall cohort number ahead of target: Zero by end of March 2025.
  - Patients waiting *>78 weeks* increased from 0 to 1 as a failure in the referral process didn't allow enough time for treatment, with preventative steps being taken.
  - Total *RTT Waiting List* reduced further from 28,332 to 27,793.

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

NHS
Salisbury
NHS Foundation Trust

Integrated Performance Report

January 2024

(November 2024 data)

Our Strategy 2022-26
IMPROVING together

Summary

Salisbury NHS Foundation Trust

The Trust formally exited from the Tiering process for Cancer and Diagnostic performance in October as positive positions continue in both. The Cancer *28-day FDS* performance improved to 80.2% and the *62-day Standard* also improved to 78.7% with both above national targets. The number of patients waiting *More than 62 days* for Cancer treatment also improved, reducing to 68 patients. *Note: Cancer data is one month behind, reporting October in this IPR.* Diagnostics *Wait Time (DM01)* performance reported 87.9% and the strongest position since February 2024, with the overall number of patients waiting more than 6 weeks reducing to 666 breaches.

The Emergency Department (ED) remained challenged going into winter as *Attendances* remained high at 6,772 total in month and continues to be circa 8% higher than the previous year. The *4-hour performance* demonstrated slight increase at 69.8% for combined performance in November, but below the target of 78%. *Ambulance Handover* performance has decreased marginally to 26 minutes average, although remains a strong performer in the South-West region. Contributing factors to ED performance included challenges to flow as the average number of patients with *No Criteria to Reside (NCTR)* remained static at 94 against a target of 21. For only the second month, data within the IPR includes the *Temporary Use of Escalation Beds and ED Corridor Care*, with static performance in the former at 20 patients and demonstration of an upward trend in the latter since August to 200 total attendances.

Stroke previously measured the percentage of patients admitted from ED to the Stroke unit within 4 hours, however, the most recent changes in the Sentinel Stoke National Audit Programme (SSNAP) scoring, the number of average therapy minutes was identified as the key driver for performance and now reflected within the IPR. Performance for November demonstrated 36 average minutes against the national target of 180 minutes.

The breakthrough objective of *Wait Time to 1st Appointment* reduced to 129 days and its lowest point since December 2022. The number of patients waiting longer than 65 weeks for elective treatment also reduced to 38 ahead of target to have zero waiting by the end of December. The year-to-date *Elective Recovery Fund (ERF)* performance is currently at 115% against plan of 117% (against 100% baseline). Underperformance of Elective activity is the top contributor, mitigated by overperformance in Non-Elective, Day Case and Outpatient activity.

Workforce metrics were generally positive, with the breakthrough objective of *Staff Turnover* reporting 17.4% and the lowest position since December 2022. *Staff Absence* increased to 4% and marginally higher than 2023, whereas *Staff Vacancies* reduced fractionally to 2.2% in October, well below the 5% target and maintaining a consistent improvement for the third month. The breakthrough objective relating to retention measured by *Staff Turnover* also improved, with another small reduction to 18.7% continuing a 6-month trend. Whereas the *Sickness Absence* rate increased to 3.8% at the 15-month average.

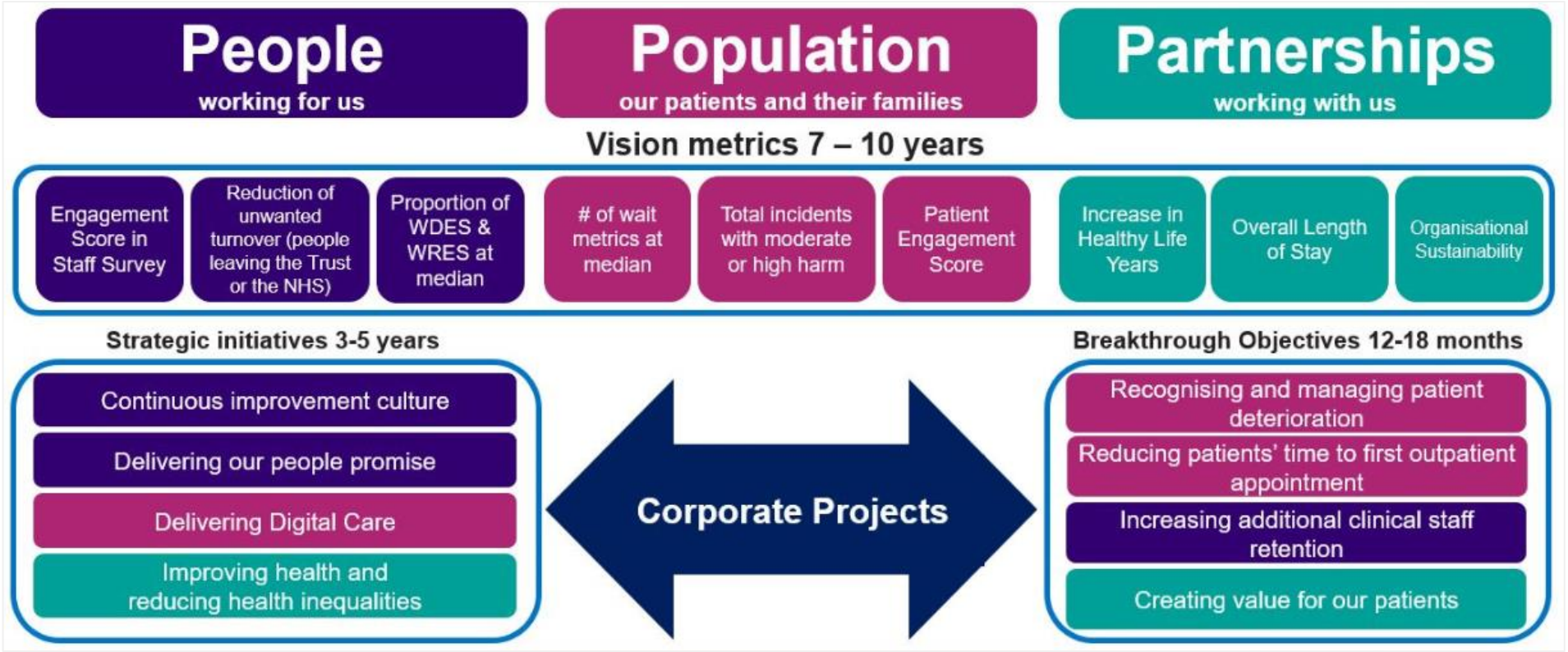
The quality related breakthrough objective of *Managing Patient Deterioration* reported the highest performance since adoption at 48.8% remaining in proximity to the revised target of 60%, whilst *Time to Escalate* also maintained an improved position overall at 297 minutes average. Wider quality metrics were not as strong, with updated practice for *Pressure Ulcers* - in line with recommendations from the National Wound Care Strategy Programme and implemented in October - measuring the total number of Hospital acquired Pressure Ulcers (PUs) increasing to 41 in November. The number of *Incidents* increased to 3.5% against the target of 2.5% and *Care Hours per Patient per Day* remained static at 7.9 hours.

The Finance breakthrough objective of creating value for our patients measured through *Productivity* improved its position for the fifth consecutive month to 14.9%. The Trust recorded an in-month control total deficit of £3.0m against an original deficit target of £0.9m - an adverse variance of £2.1m.

Strategic Priorities

Salisbury NHS Foundation Trust

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



What is an Integrated Performance Report (IPR)

NHS Salisbury NHS Foundation Trust

Our IPR is a summary view of how our Trust is performing against various strategic and operational objectives. It is divided into three sections: Quality of Care, Access and Outcomes, People and Finance and Use of Resources which contain the following within them:

Key Term	Definition
Breakthrough Objective	Trust wide area of focus for the next 12-18 months. We are striving for an improvement of more than 30% in the metrics over this period.
Key Performance Indicator (KPI)	Key metric that is monitored as part of the NHS National Operating Framework and relates to improving patient care and increasing positive outcomes.
Alerting Watch Metric	A metric that has triggered one or more business rules and should be monitored more closely to address worsening performance or celebrate achievement if improving.
Non-Alerting Watch Metric	A metric that we are monitoring but is not a current cause for concern as it is within expected range.

Part 1: Quality of Care, Access and Outcomes

Performance against our Strategic Priorities and Key Lines of Enquiry

Our Priorities

People

Population

Partnerships

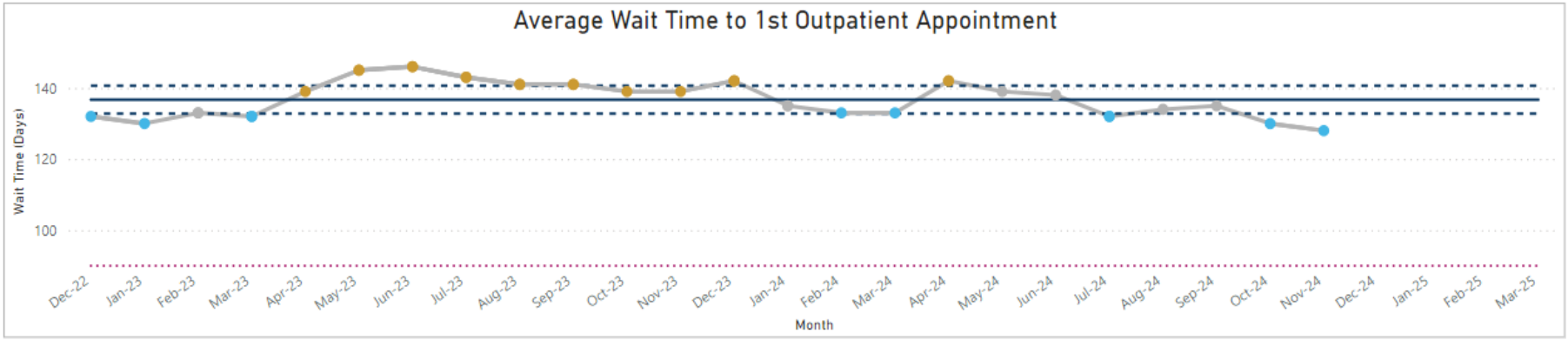
Reducing Patients' Time to First Outpatient Appointment

NHS Salisbury NHS Foundation Trust

Breakthrough Objective

We are driving this measure because… **Baseline: 139 days (April 2023)**	SFT has a growing waiting list with increased numbers of patients waiting longer for their care and has not met the 92% Referral to Treatment (RTT) 18-week elective treatment target since October 21. A small cohort of specialties account for the majority of the Trust's backlog of patients awaiting a 1st Outpatient appointment. An extended wait for a 1st Appointment places achievement of the 18-week RTT target at risk. It is a poor patient experience to wait longer than necessary for treatment and failure against these key performance standards is a clinical, reputational, financial and regulatory risk for the Trust.

Target: ≤90 days Performance: 128 days Position: Special Cause Improvement



Understanding the Performance

Average time to first outpatient reduced slightly to 129 days and continued the improving trend.

In comparison to the previous month the three focus areas:
Colorectal – improved from 122 to 115 days
Urology improved from 150 to 142 days and is the 6th consecutive month of improvement.
Oral Surgery improved from 145 to 120 days

Areas of deterioration:

Dermatology – increased from 251 to 271 days
Ophthalmology - increased from 127 to 138 days

Countermeasure Actions	Due Date
• Dermatology insourcing provision confirmed to commence December for 2 months. Further analysis required to identify longer term requirement.	31st Dec
• Oral Surgery recruitment approved with insourcing provision for outpatient treatments.	Jan 25
• Review of clinic templates alongside job plans and current demand and capacity data to identify mismatches.	Feb 25
• Development of standardised approaches to gap filling and waiting list management	Feb 25

Risks and Mitigations

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

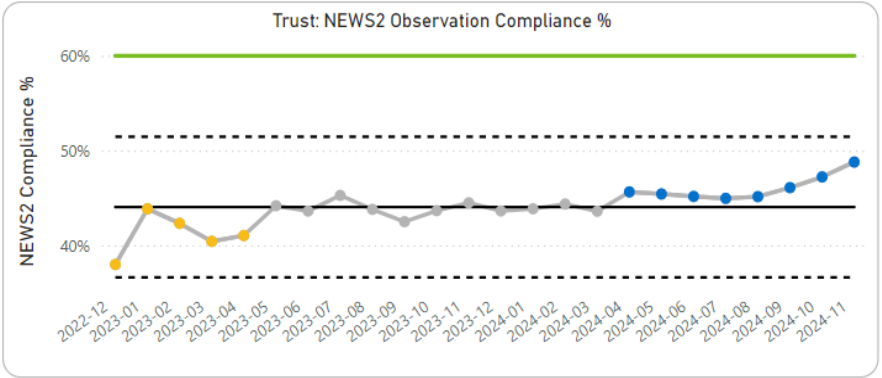
Recognising and Managing Patient Deterioration

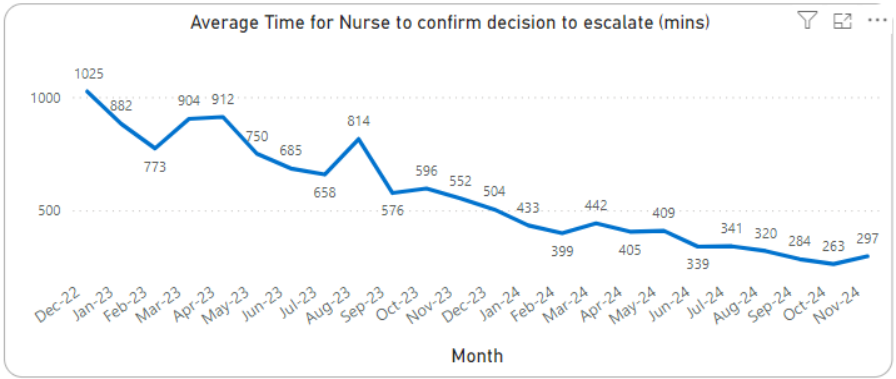
NHS Salisbury NHS Foundation Trust

Breakthrough Objective

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

Target: ≥60% Performance: 48.8% Position: Special Cause Improvement





Understanding the Performance

Observation compliance improved to 48.8% and Time to Escalate maintained improved position overall at 297 minutes average.
Frequency is a nationally set standard which is determined by NEWS2 . The divisional teams continue to undertake work to improve the compliance which currently sits at 49%. Next steps are to better understand which countermeasure is making the biggest impact.
136 staff have completed face to face training. The national NEWS2 e-learning has been added to the learning tree of all clinical staff. Measurement for this element is the average time from observation to documented decision to escalate. There continues to be evidence of improvement.

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

Risks and Mitigations

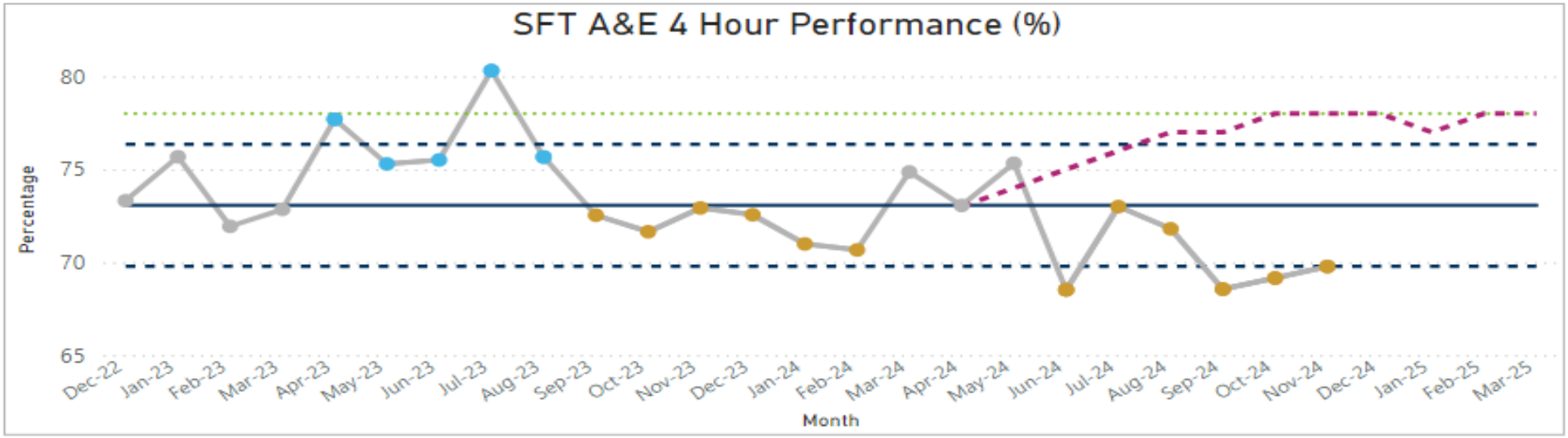
There is still a risk of unrecognised deterioration which may lead to patient harm. However, whilst we continue to learn and improve, other measures allow us to monitor the risk including:

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

Emergency Access 4-hour Standard

Salisbury NHS Foundation Trust

Target: ≥78% Performance: 69.8% Position: Special Cause Concern



Understanding the Performance

Despite attendances remaining circa 10% above plan, 4-hour performance showed some small signs of recovery for the second consecutive month. However, performance continues below the lower control limit and a long way off plan.

The average time for admitted patients within the department occupied 336 hours per day, with an average length of stay of 8hrs 12mins. Non admitted patients occupied 450 hours with an average length of stay of 3hrs 50mins. The combined total of 786 hours per day, evidences the impact on efficiency and ability to process patients through an overcrowded department, which encompasses only 360 hours of assessment and treatment space.

The number of patients placed in the corridor has continued an upward trend since August. Patients are being assessed and treated in inappropriate locations, not only impacting on quality of care, but also leading to longer stays in the ED for all patients.

Countermeasure Actions	Due Date
• ED departmental move – Swapping Minors service and current Rapid Assessment Treatment and Triage (RATT) / Ambulatory spaces will enable an additional 48 hours of assessment and treatment space to counter the current delays seen in admitted and non-admitted delays. Bringing the total to 408hrs of assessment and treatment space.	Dec 24
• Streaming to the Walk in Centre is due to commence in January 2025. With strict criteria for cellulitis as the first pathway to commence.	Ongoing
• A3 working groups have been established and focus remains on Minors and Front Door workstreams.	Dec 24
• Finalise business case to support medical staffing following Demand and Capacity modelling with support from ECIST.	Jan 25

Risks and Mitigations

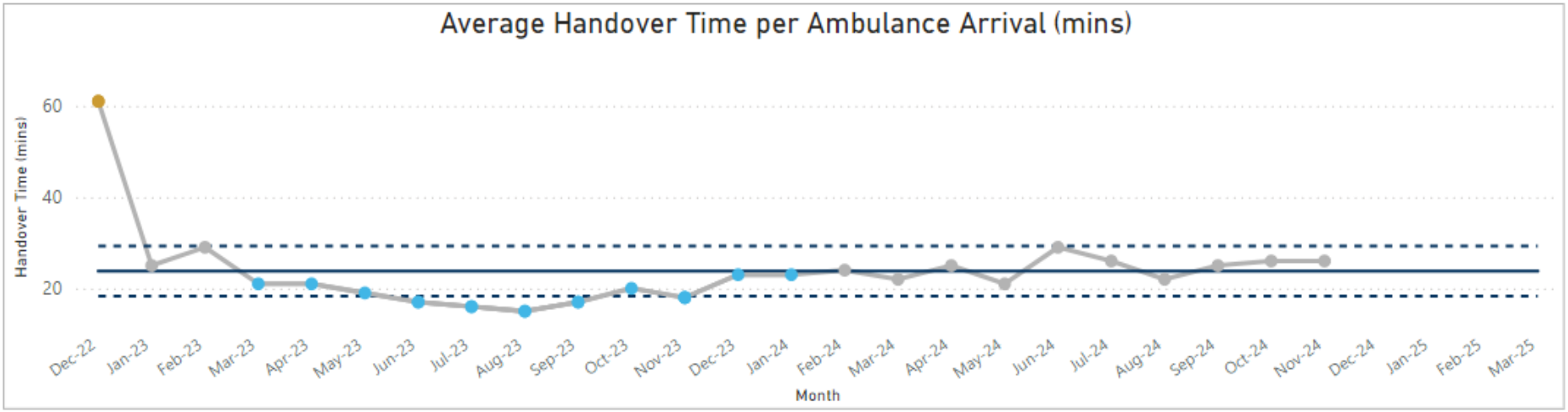
New ambulance handover SOP, W75, implemented by SWAST across whole ICB. This could lead to more patients being looked after in corridors and other non-designated clinical areas. Trust is mitigating with new escalation process and action cards to decompress ED when SOP is triggered.

Demand continues to outstrip capacity due to sustained increase in attendances. Trust mitigating through increasing ambulatory pathways and working with system partners to improve streaming options for ED to manage demand away.

Ambulance Handover Delays

NHS Salisbury NHS Foundation Trust

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



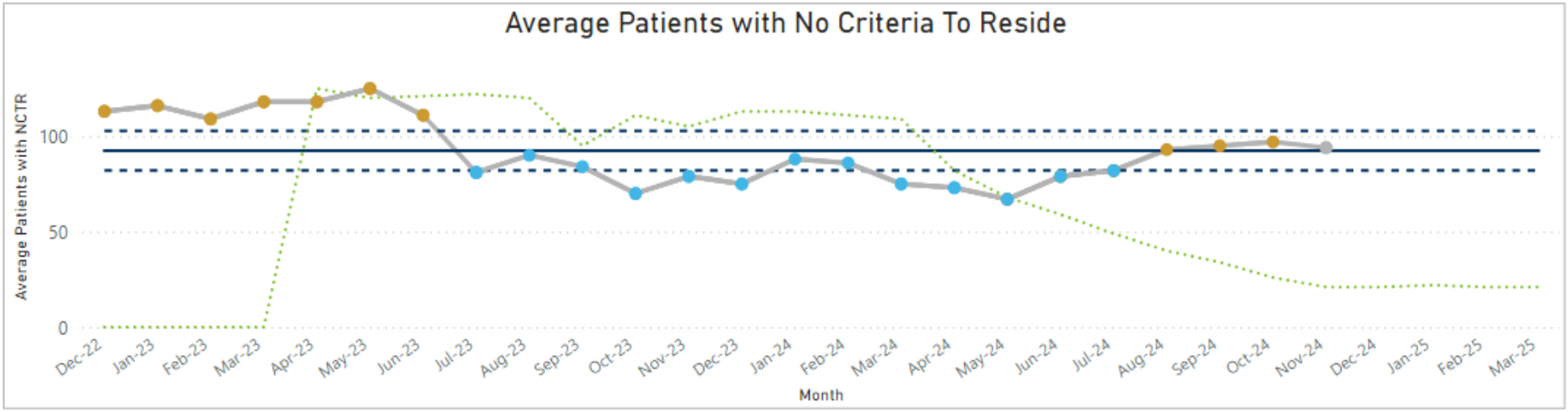
Understanding the Performance
December reflects a third month of consistent performance trend around 26 minutes and the 10th month in standard variation. The good performance re handover times at SFT are sustained by several measures including use of the ambulance corridor to reverse board (patient awaiting inpatient beds) and a 0-tolerance Trust approach to ambulance holds meaning patients are boarded and sat out on wards to facilitate flow from ED 20/11/2024 also saw the introduction of the new rapid handover SOP by SWAST: W75. When certain clinical criteria is met, patients are offloaded at 75mins regardless of formal offload space. SFT have so far avoided this SOP being enacted through the enaction of 'Rapid Ambulance Handover Huddles'.

Countermeasure Actions	Due Date
• Staffing request for an additional Band 6 NIC of RAT, requires approvement at Board. If approved, will allow for streaming of patients from the ambulance handover to either RAT, Minors or pitstop. Reducing the numbers of patients through RAT will decrease the delays current seen for acceptance of ambulance handovers.	31/03/2025
• Review Operational link role action cards to respond to ambulance hold huddles implemented to support delivery of W75.	30/11/2024
• Rapid Ambulance Handover Huddles are being refined and the communication process around this is being improved.	
• Departmental reconfiguration to improve access for ambulances patients and remove current bottleneck of only x2 offload spaces.	12/12/2024

Risks and Mitigations
• RATT whilst remaining a required process, has had an ongoing effect and caused the average handover time to increase due the limitations of 2 offload spaces, which equates to an ability to offload a maximum of 4 ambulances per hour. The departmental move will see RATT expand to 3 spaces delivering the ability to accommodate 6 ambulances per hour.
• Interdepartmental moves will help to mitigate the W75 challenges, with the addition of a RATT bay and 2 further assessment bays. This change is due to be implemented 12th Dec with an immediate anticipated impact seen.

Optimising Beds

Target: ≤25 (5%) Performance: 94 Position: Common Cause



Understanding the Performance
Please note the DQ of this report is currently under review. The average number of patients with No Criteria to Reside (NCTR) has dropped slightly. The internal referral time for patients with NCTR reduced to an average of 1.1 days from 1.6 days in July. The average LoS to patients being NCTR has dropped significantly for the 4th month in a row. Average bed day delays by pathway: P0 – 1 days (1 pts); P1 – 8 days; P2 – 14 days; P3 – no data Note: ED attendances continue to remain high with no decline in conversion rate hence the number of patients being admitted is also higher.

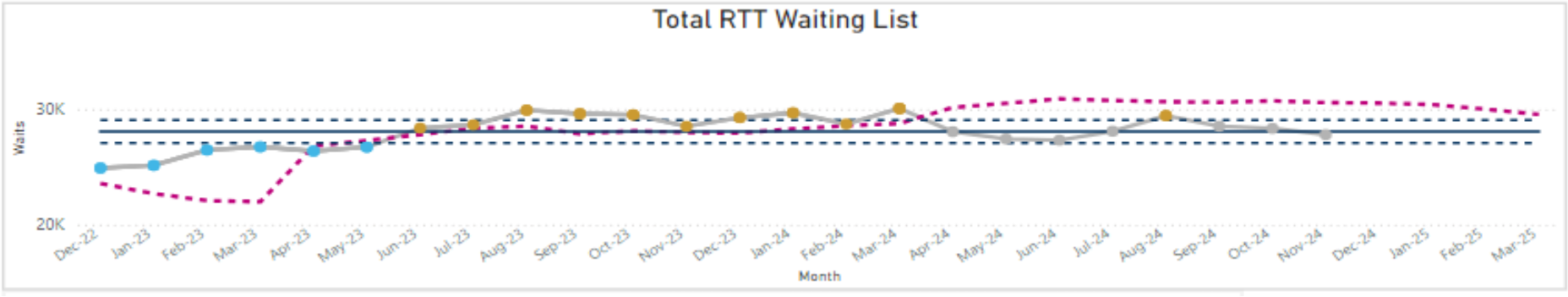
Countermeasure Actions	Due Date
• Ongoing work to reduce time from NCTR to pathway allocation – Sprint Improvement	March 25
• Digitisation of Decision to Admit (D2A) , now delayed due to BSW process, risk to SFT plans	unknown
• Greater use of Hospital at Home (H@H) . Agreement for model of care to be ACP lead with consultant oversight.	Apr 25
• Breamore ward team working to reduce Length of Stay (LoS) and prevent deterioration of patients waiting packages of care.	Complete
• Detailed codes providing details on reasons for delays in discharge.	Complete
• Ward flow work that standardises process to link into NCTR group	April 25
• System working to reduce time for NCTR patients to be allocated beds.	March 25

Risks and Mitigations
• External conflicts such as reduction in capacity in local authority social care teams and financial constraints. • Changes to community model. • Clinical capacity and demand conflicts. • Clinical engagement. Note: it has become apparent that NCTR numbers vary across reporting. This is currently under review.

Total Elective Waiting List (Referral to Treatment)

NHS Salisbury NHS Foundation Trust

Target: ≤30,503 Performance: 27,793 Position: Common Cause



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

Understanding the Performance

The RTT waiting list reduced for the third consecutive month to 27,793 patients and continues below the trajectory. A total 59.2% of patients waited less than 18 weeks for treatment.

Long wait reduction target of zero patients waiting more than 65 weeks by the end of December ended November with 38 patients. One unexpectedly breached 78 weeks as a failure in the referral process didn't allow time to complete treatment, with preventative steps being taken.

Specialties with notable change in month (patients):

- Oral Surgery (-357)
- Trauma and Orthopaedics (-233)
- Urology (-89)
- Cardiology (+72)

Countermeasure Actions

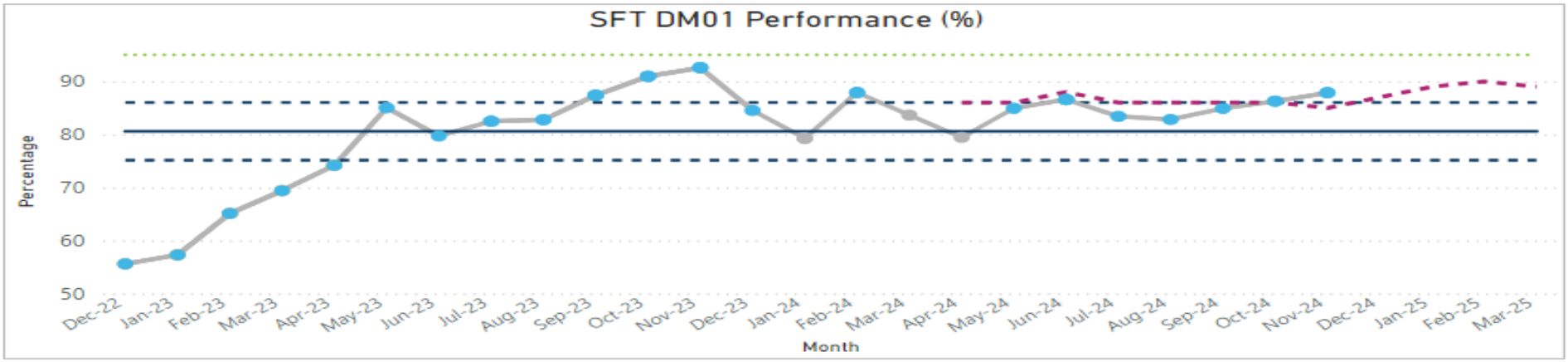
Countermeasure Actions	Due Date
• Quantify the work required to validate all patients currently assigned with non-RTT status in surgical waiting list and explore options to resolve.	31/12/2024
• Continue weekly access meeting to focus on reducing long waits of patients in line with national targets: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

Risks and Mitigations

- Risk of long wait patients having incorrect status (particularly non-RTT) needs full review and action plan to mitigate – Linked to action reference developing Trust CCS software.
- Capacity constraints in some specialties are a risk to reducing overall waiting list and particularly challenging with regards to national reduction targets - being mitigated through additional capacity arrangements where necessary.
- Weekly Access Meeting continuing with aim to reduce risk of long waiters and drive towards national reduction targets.

Diagnostic Waiting Times

Target: ≥95% Performance: 87.9% Position: Special Cause Improvement



	%	Over 6 weeks		%	Over 6 weeks		%	Over 6 weeks		%	Over 6 weeks
MRI	92.5%	66	Dexa	100%	0	Colonoscopy	45.3%	202	Urodynamics	75.0%	21
CT	97.4%	15	Neurophysiology	100%	0	Gastroscopy	79.4%	32	Cystoscopy	100%	0
Ultrasound	99.0%	18	Echo	83.3%	40	Flexi Sigmoid	39.1%	84	Audiology	73.9%	188

Understanding the Performance

DM01 performance further improved in November with a reported performance of 87.87% vs 86.27% in October. There was a small increase in overall waiting list size but the performance does represent an impact in the number of patients impacted (666 patients waiting over 6 weeks in November compared to 717 in October).

There were small decreases in performance in MRI and USS.

Audiology performance decreased from 76 breaches in October to 188 in November but noting that this position now includes all overdue surveillance as well as the traditional diagnostics.

Endoscopy reported a significant improvement, reporting 318 breaches compared to 485 in the previous month.

Countermeasure Actions	Due Date
• Continue outsourcing of cardiac MRI to achieve end of year plan position	Monthly
• Continue with enhanced overtime capacity in USS to maximise capacity	Monthly
• Maximise endoscopy capacity through additional inhouse activity	Monthly
• Business Manager in post for Endoscopy, exploring improvement of booking process and oversight of capacity	M9

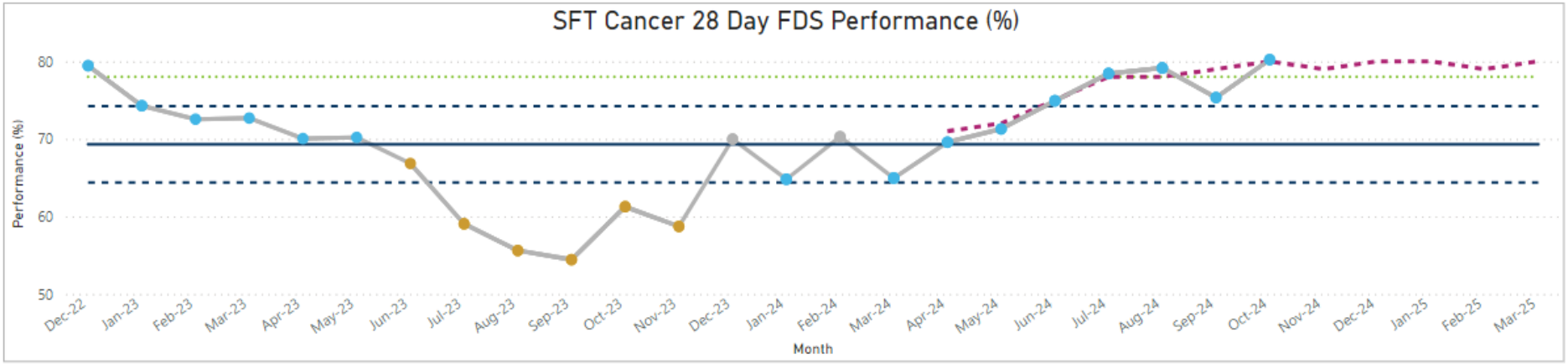
Risks and Mitigations

- There is a predicted reduction in capacity in December in USS which puts at risk the DM01 position in M9. This is due to less available workforce (number of maternity leavers combined with planned absence of senior member of team). Will mitigate as much as possible with overtime and temporary staff allocation and will aim to react/respond to any deficit in the position in M10 to restore DM01 to plan promptly

Cancer 28 Day Faster Diagnosis Standard

NHS Salisbury NHS Foundation Trust

Target: ≥78% Performance: 80.2% Position: H Special Cause Improvement:



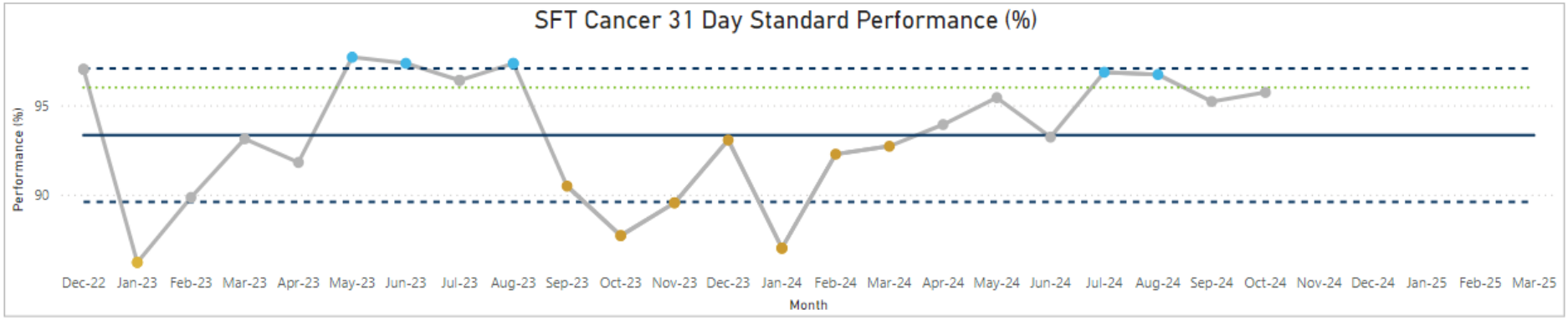
Please note: The performance data is subject to quarterly and six month revisions, this can lead to updates in past reported performance. Changes to shared data at other Trusts can cause variation between the national and internally reported performance.

Understanding the Performance	Countermeasure Actions	Due Date	Risks and Mitigations
28-day performance for October improved (as expected), returning to above plan at 80.2%. Specialties that remain the most challenging at improving above the 77% target are Urology, Lower GI and Haematology with the latter representing a very small cohort of patients (circa 12 per month). Skin and Breast retain 95% performance which is critical to sustain Trust position > 77%. Urology 28-day performance in October was 51.8% vs 58.1% in September. Lower GI 28d performance in October was 57.6% vs 48% in September. Improvement A3s are in place for both Urology and Lower GI. SFT formally exited tiering for 28-day at end of October.	• Urology A3, to include diagnostic pathway improvements, PETCT times, template biopsy booking process etc. • Lower GI A3, to include same day CT to endoscopy pathway, administrative process improvement, booking improvement etc. • Oversight of cancer performance through Cancer Improvement Group to alert to early warning signs of performance concerns and proactive response	M10 M10 Monthly	• Skin pathways remain heavily reliant on insourcing or locum support to achieve correct level of capacity to maintain a < 14 day first seen wait. This is monitored through Cancer Improvement Group and the SWAG Cancer Alliance have confirmed further funding for Q4 insourcing capacity. Future service model of demand vs capacity required.

Cancer 31 Day Standard

Salisbury NHS Foundation Trust

Target: ≥96% Performance: 95.7% Position: Common Cause

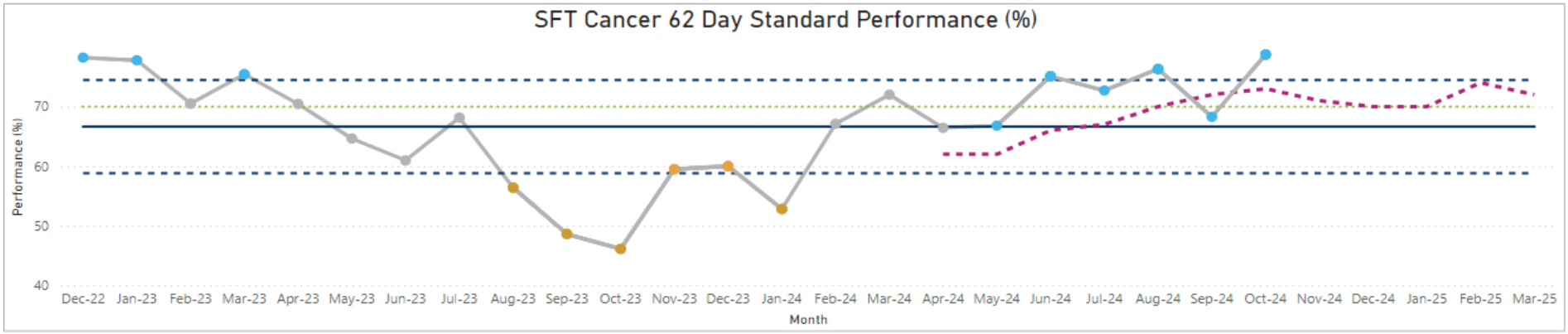


Please note: The performance data is subject to quarterly and six month revisions, this can lead to updates in past reported performance. Changes to shared data at other Trusts can cause variation between the national and internally reported performance.

Understanding the Performance	Countermeasure Actions	Due Date	Risks and Mitigations
Improvement in 31-day performance in October compared with September. 8 patients breached the 31-day standard of 243 treated. 5 of these breaches were in the Skin pathway, 1 in Breast, 1 in Lower GI and 1 in Urology. The main root cause for breaches was due to capacity with the correct treating Consultant being available within 31 days of decision to treat.	• Escalation from MDT Coordinators when patient is booked beyond 31 days. • Escalation at Cancer Improvement Group re identifying any potential future risks to capacity etc. • Booking teams aware of breach dates at point of listed for treated.	Monthly Monthly Monthly	• Skin pathways remain heavily reliant on insourcing or locum support to achieve correct level of capacity. This is monitored through Cancer Improvement Group and the SWAG Cancer Alliance have confirmed further funding for Q4 insourcing capacity. Future service model of demand vs capacity required.

Cancer 62 Day Standard

Target: >70% Performance: 78.7% Position: Special Cause Improvement:



Patients waiting over 62 days for treatment	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24	Apr-24	May-24	Jun-24	Jul-24	Aug-24	Sep-24	Oct-24
	167	119	87	158	145	117	91	73	76	65	61	69	78	68

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

Understanding the Performance

Improvement in 62-day performance at SFT in October, increasing to 78.7% and above trajectory plan position of 73.24%.

25.5 breaches in total:

- 13 x Urology
- 3 x Breast
- 2.5 x Lower GI
- 2.5 x Skin
- 1.5 x Gynaecology
- 1 x Haematology
- 1 x Lung
- 0.5 x Cancer of Unknown Primary
- 0.5 x Upper GI

The main cause for breaches were delays at other healthcare providers and complex diagnostic pathways. SFT formally exited tiering for 62-day at end of October

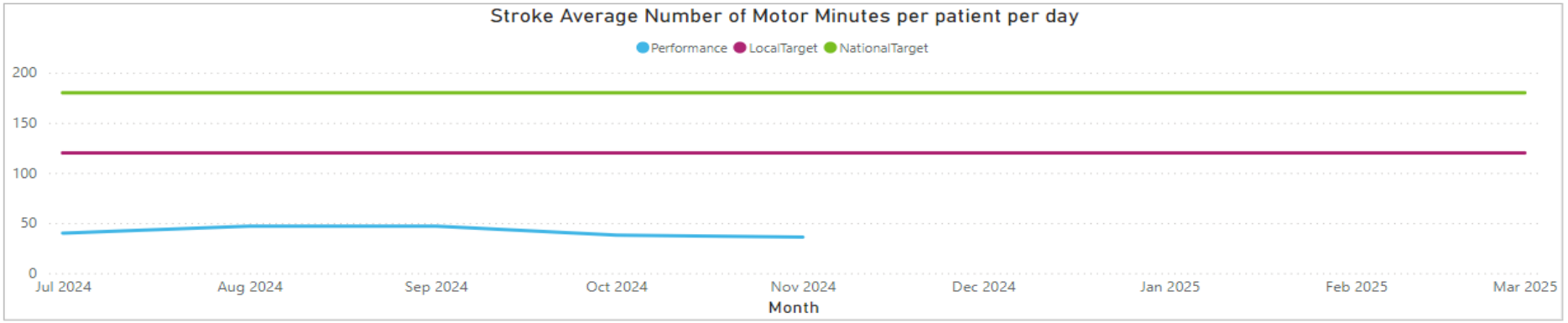
Countermeasure Actions	Due Date
• Sustain robust weekly tracking list meetings, with improved resilience and standardisation across all tumour sites	Weekly
• Backlog trajectories agreed for each tumour site, with stretch target of 6% of overall PTL size >62 days. Aspirational figure provided to each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

Risks and Mitigations

- Whilst there remains focus on reducing 62-day backlog, 62-day compliance will be impacted. Aiming for <6% of PTL size for patients >62 days in their pathway.
- Noted resource within MDT cancer services team remains challenging in terms of capacity.
- Risk associated with Oncology capacity associated with Aseptics and associated outsourcing as well as Consultant Oncologist capacity and vacancies (UHS).
- High volume of patients opting for Surgery for treatment of Prostate cancer, resulting in increased demand and insufficient robot capacity at tertiary centre.
- Skin pathways remain heavily reliant on insourcing. This is monitored through Cancer Improvement Group and the SWAG Cancer Alliance have confirmed further funding for Q4 insourcing capacity.

Stroke Care

Target: ≥180 mins Performance: 36 mins Position:



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

Understanding the Performance

Previously the unit measured the percentage of patients admitted from ED to the Stroke unit within 4 hours. However, the most recent changes in the Sentinel Stoke National Audit Programme (SSNAP) scoring, identify the number of average therapy minutes as the key driver for performance going forward, and a key area of focus for the unit.

Performance for November demonstrated an average 36 minutes. This is a decrease of 2 from previous month and expected based on staffing numbers.

Key Themes from the data:

- Approximately half of all discharges within November were impacted by bed pressures and complex discharges. The complexity of discharges demanding additional staff time and therefore impacting performance.
- Staffing vacancies have been impacted by maternity leave and delays in recruitment, this has impacted the ability of staff to deliver therapy minuets
- Group sessions are a key driver for our therapy minutes. With fewer members of staff and a patient group inappropriate for these sessions, these sessions were reduced.

Countermeasure Actions	Due Date
• **Increased use of Group Therapy Sessions**: Using the Wessex Rehab Centre, as well as volunteers and students, there is a focus on increasing the number of group sessions versus individual sessions, which will increase therapy minutes for all patients.	01/02/25
• **Training for nursing staff on gathering therapy minutes**: As therapy minutes is a MDT metric, an increased focus is on ensuring that motor minutes are being captured by the nursing staff. This is aimed at increasing therapy minutes by better recording work by staff.	01/02/25
• **Ongoing Recruitment:** Recruitment is ongoing for therapist posts, with a view for new staff to be starting in the new year.	01/02/25

Risks and Mitigations

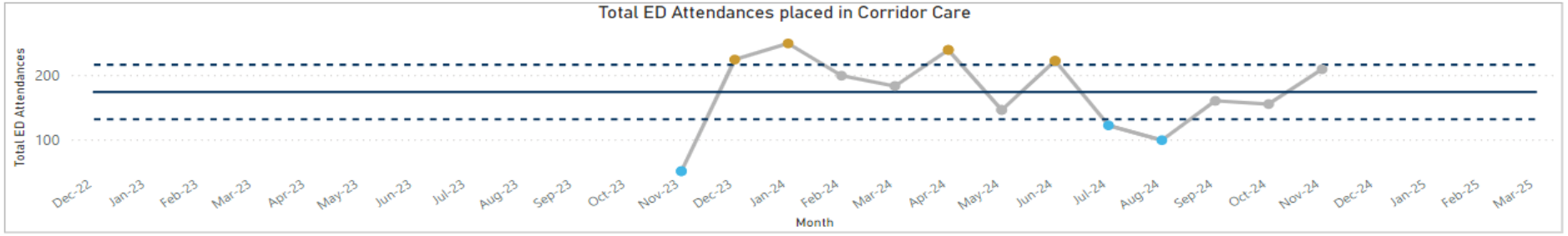
Bed Flow / Length of Stay (LoS): the Stroke Unit LoS impacts on therapy performance. With more complex discharges, therapy minuets are reduced. Driver metrics for the unit are before midday discharges, with a view to improving bed flow. A key driver for performance has been identified as EDS timing. Doctors have been invited to the huddle to identify areas in the process where EDS's have been delayed.

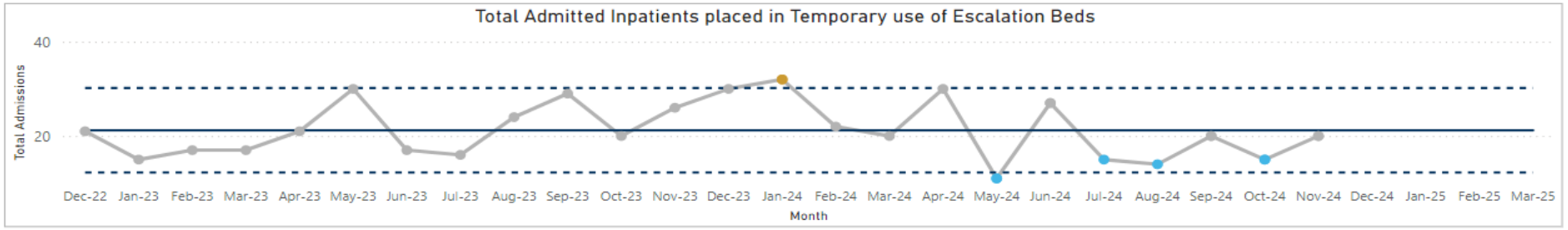
Staffing Numbers: Current staffing numbers for therapy are below recommended levels. Recruitment is ongoing

Temporary use of Escalation Beds & ED Corridor Care

NHS Salisbury NHS Foundation Trust

Target: 0 Performance: Position: Common Cause





Understanding the Performance

For only the second month, data within the IPR includes the use of Temporary Use of Escalation Beds (TUES) and ED corridor care. Demonstration in month shows an upward trend in ED Corridor care since August against a static number of patients placed into Temporary use of Escalation beds. November saw a static number of attendances against an increased average LOS for admitted patients sat at 8h30, leading to significant overcrowding in the department, partially due to the delay in inpatient bed availability.

Temporary use of escalation beds have not increased significantly since June 24, ranging from 15-20 patients per month. Breamore ward reopened this month following a period of closure for refurbishment, which may have mitigated some of the increased need for additional TUES beds.

Countermeasure Actions

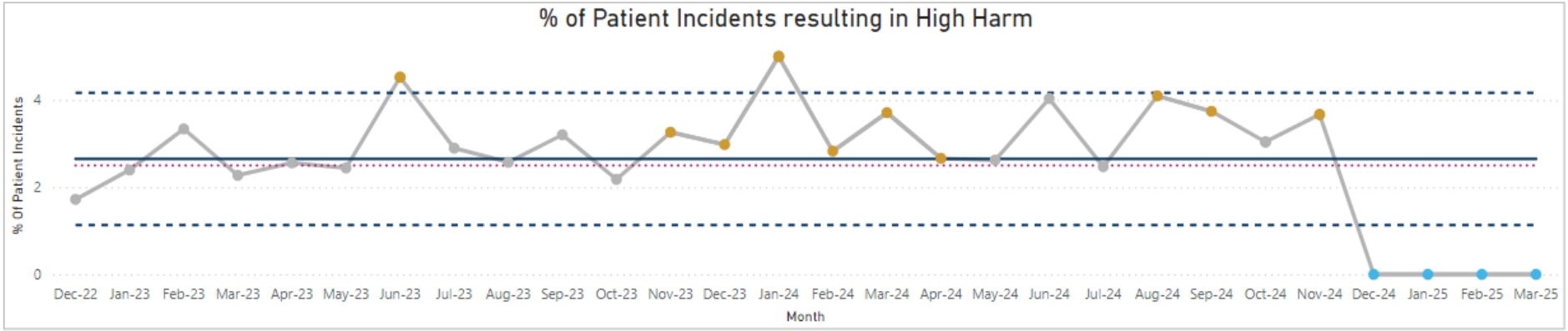
Countermeasure Actions	Due Date
• The Emergency Departmental moves (12th Dec) will increase the assessment and treatment space by 11.77%, the impact of which should reflect in a slight decrease in numbers of patients placed in corridor care (reflected in mid Dec 24 / Jan 25 data at earliest). However, corridor care will continue to allow for efficient movement (in / out) of patients through the department to best utilise the space available. Corridor care remains a reverse queue of patients awaiting inpatient beds. The relocation of RATT allows for the ambulance crews to queue inside the hospital where required. This date remains reflected in ambulance handover delays.	Dec 24

Risks and Mitigations

Temporary Use of Escalation Beds Policy is due to go through CESG on the 8th January and will provide guidance and process regarding the use of these beds. The policy will aim to ensure that patients receive adequate care whilst being cared for within these beds.

Incidents

Target: ≤2.5% Performance: 3.5% Position: Special Cause Concern



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

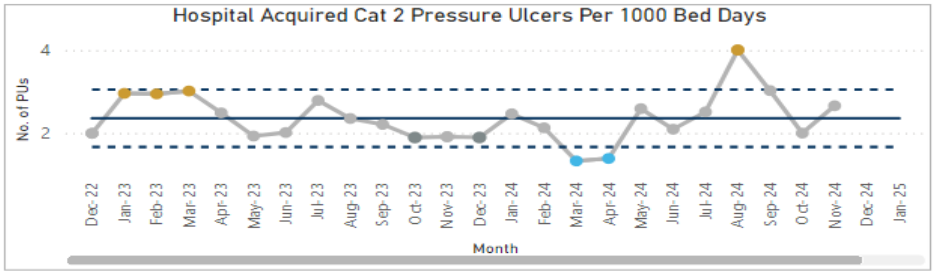
Understanding the Performance	Countermeasure Actions	Due Date
There were 906 total incidents reported in November compared to 954 in October. In November: there were 22 reported moderate incidents, a decrease of 10 incidents from October (32). 1 Major and 1 catastrophic incident reported. The morning incident huddle, where the previous 24h incidents are reviewed and discussed continues to occur with excellent engagement from across the Divisions. (There may be a slight fluctuation in the actual % of reported incidents with harm from previous months, due to data validation and conclusions of reviews which occur retrospectively). A patient safety review (PSR) is undertaken for all patient incidents where moderate harm is reported to have potentially occurred.	• Daily morning huddle across all divisions to discuss previous 24 hours incidents and any immediate actions required • Weekly Patient Safety Summit (PSS) where all moderate, major and catastrophic graded incidents are discussed • Patient Safety Reviews (PSR) are undertaken for all cases where moderate or above harm has occurred to patients • Consider if information from the PSR immediately identifies an unexpected level of risk or emergent issue / trend and a patient safety incident investigation (PSII) is indicated • Learning from incidents forum	Ongoing Weekly Ongoing Ongoing Monthly

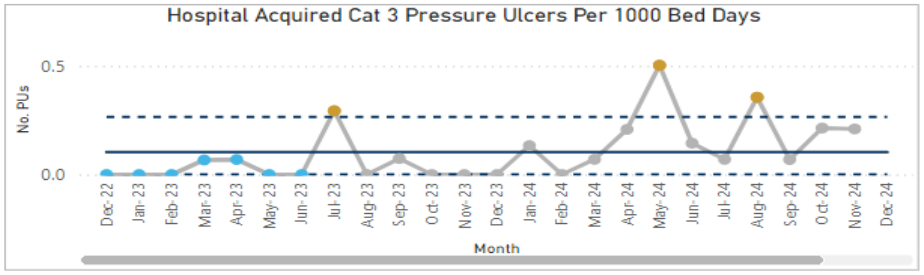
Risks and Mitigations
• No PSII's commenced for November. • Improvements are required for the handling and storing of residual medication (inpatient areas). • The Trust would benefit from a Trust wide discharge policy. • Inconsistent / non standardised approach to discharge checklists and transfer of care forms a risk.

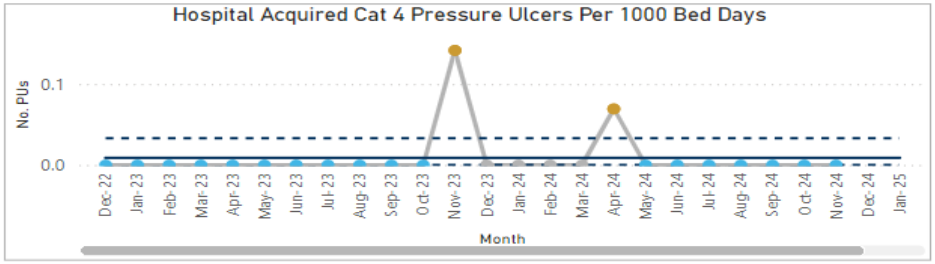
Pressure Ulcers

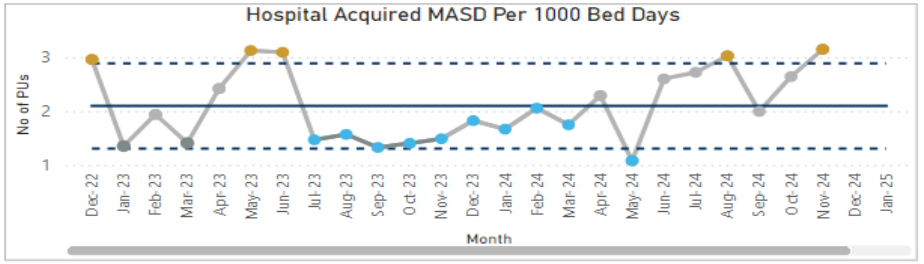
Salisbury NHS Foundation Trust

Target: N/A Performance: 2.7 Position: Common Cause









Understanding the Performance

Trust updated practice in line with national recommendations from the National Wound Care Strategy Programme, and this is only the second month of revised data. This month does show an increase from 33 to 41 Hospital acquired Pressure Ulcers (PUs) in November. 11 of these occurred in patients with a LoS >21 days and other notable findings in month as follows:

- 38 Category 2 PUs – 5 of these were device related. This is an increase in PU2s from October.
- We have seen 8 Deep Tissue Injuries (DTIs) this month.
- 3 Category 3 PUs – 1 of these was device related.
- 0 hospital acquired PU4s.
- Slight increase in patients with hospital acquired Moisture Associated Skin Damage (MASD).

60 Present on admission PUs In November 2024.
38 Present on admission Moisture Associated Skin Damage In November 2024.

Countermeasure Actions

	Due Date
• November featured the national 'STOP the pressure' focus month. Additional study days were held for ward link nurses including external guest speakers with a focus on advance wound management, adult safeguarding, and nutritional input in wound care.	Nov 24
• National 'STOP the pressure' day saw the role out of educational posters and a Tissue viability quiz throughout SFT to raise awareness.	Nov 24
• Two extraordinary Tissue viability group meetings were held, comprising of Tissue viability, Ward Matrons and Heads of Divisions with a view to improving the connection between education and practice on the wards.	Nov 24
• A DTI 14-day pathway was developed to help nurses identify and manage the care of deep tissue injuries and is now available to all staff.	Nov 24

Risks and Mitigations

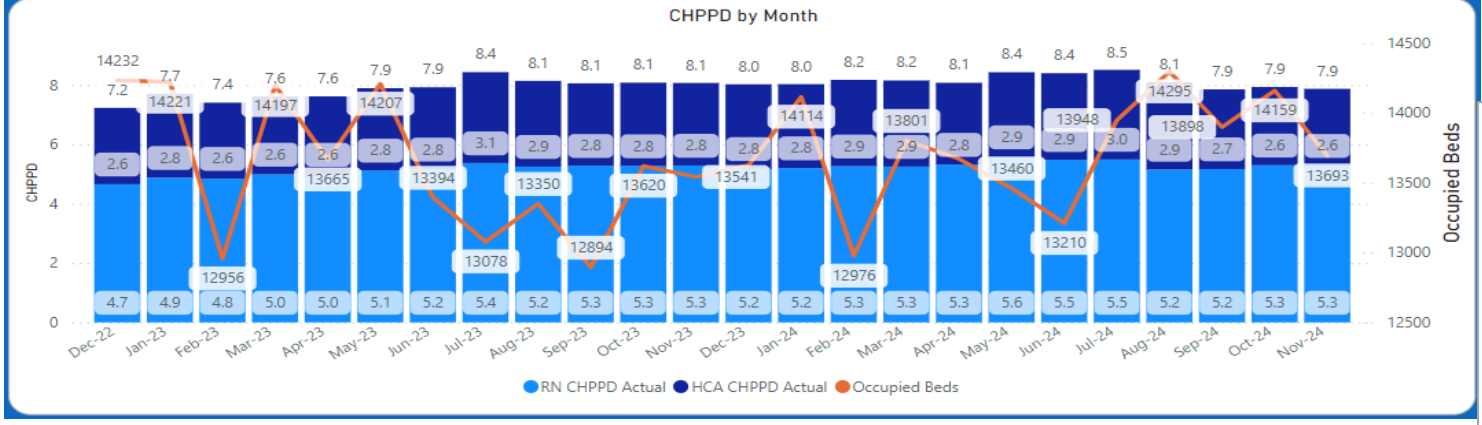
- On going work with the digital education available on MLE to the staff.
- Awaiting approval for MASD pathway.

Care Hours Per Patient Per Day (CHPPD)

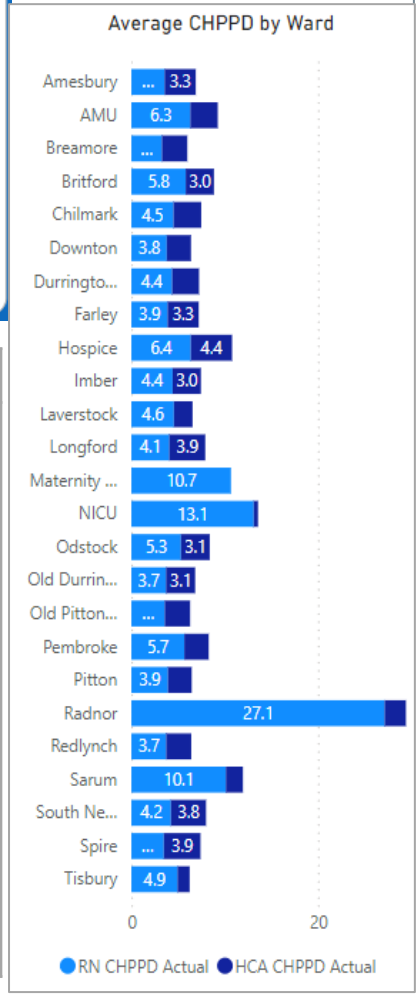
NHS Salisbury NHS Foundation Trust

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

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



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



Understanding the Performance

CHPPD 7.9 in month and 7.3 when excluding critical care and maternity has remained at this level for 3months.
When reviewed on Model Hospital we are in Quartile 2 and benchmark lower that peers within ICS (both in Quartile 3).

Fill rate in month has stayed static except for HCA day shifts – driven by unfilled additional duties for HCAs (above establishment) and ongoing HCA vacancies.

At time of IPR completion temporary staffing costs not available. Has been ongoing high use of RMNs

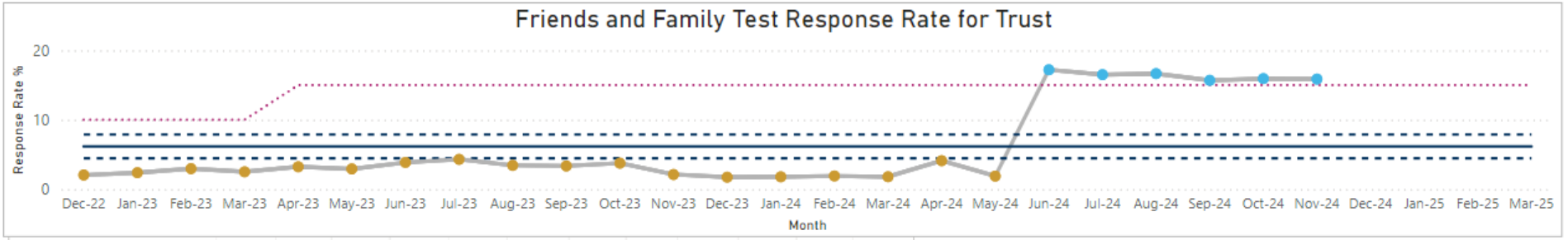
Countermeasure Actions	Due Date
• SNCT data collection completed – data now being reviewed.	End Dec 2024
• Weekly staffing reviews / daily staffing meetings focused on process for approval of additional duties.	On-going
• Annual staffing review being presented at CGC and Trust Board.	Mid Dec 24

Risks and Mitigations

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

Friends and Family Test Response Rate

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



Response Rate by Area	Dec-23	Jan-24	Feb-24	Mar-24	Apr-24	May-24	Jun-24	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24
FFT Response Rate - A&E	0.9%	0.7%	0.5%	0.5%	0.7%	0.6%	20.6%	20.4%	22.0%	20.7%	21.6%	20.6%
FFT Response Rate - Day Case	2.5%	3.1%	3.2%	3.3%	2.1%	2.9%	3.4%	10.8%	11.2%	6.3%	10.3%	8.7%
FFT Response Rate - Inpatient	10.2%	19.1%	19.7%	17.2%	22.3%	18.5%	10.4%	26.3%	31.8%	21.4%	26.0%	24.8%
FFT Response Rate - Maternity	0.5%	3.8%	0.0%	3.0%	0.5%	0.0%	13.7%	9.7%	10.1%	10.3%	9.5%	10.2%
FFT Response Rate - Outpatient	1.1%	0.9%	1.0%	0.8%	1.0%	0.9%	18.3%	16.4%	16.0%	15.8%	15.6%	15.8%

Understanding the Performance

Our response rate in November maintained an improved position since the new digital dashboard and SMS message service went live in June, reporting 15%.

For November, our response rate was 16% with a satisfaction rate of 94% therefore we met our response rate target but slightly fell short of our satisfaction rate target of 95%. We don't have full insight on the dissatisfaction at this stage, but we are looking to provide this with future narratives.

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

Risks and Mitigations

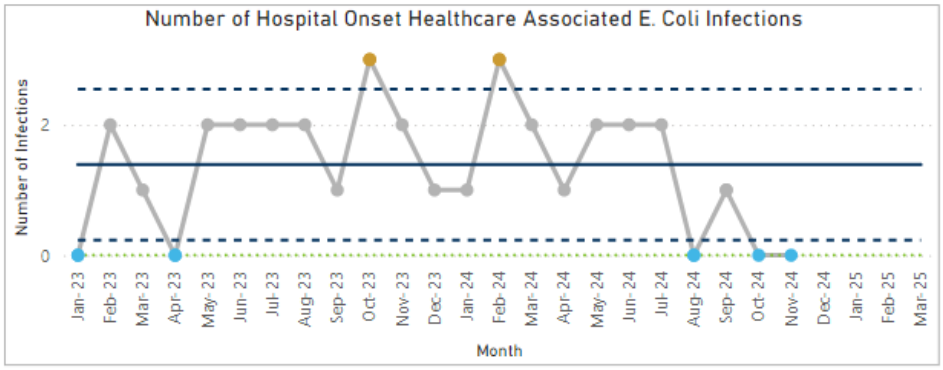
The new dashboard continues to enable better themes and insight analysis of comments. Going forward we will be able to offer more robust analysis and insights from the feedback received. Implementation of the new system has already demonstrated a successful drive towards the Trust's 15% improving together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

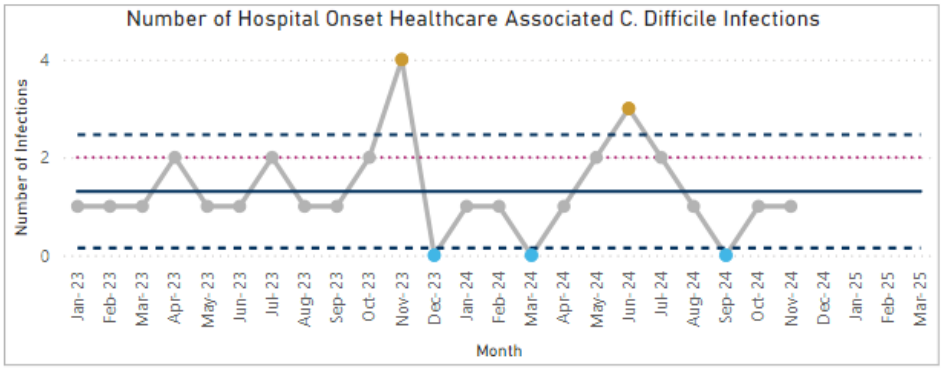
Infection Control

NHS Salisbury NHS Foundation Trust

Position: Special Cause Improvement

Position: Common Cause





Year	2022-2023	2023-2024	2024-2025
MRSA Bacteraemia Infections: Hospital Onset	0	0	0
MSSA Bacteraemia Infections: Hospital Onset	10	10	7

Understanding the Performance

There has been no hospital onset healthcare associated (HOHA) reportable *E.coli* bacteraemia infections, the same as last month.

There have been two HOHA reportable *MSSA* bacteraemia infections, compared with one last month.

For HOHA reportable *C.difficile* cases, there has been one case the same as last month.

An increasing level of diarrhoeal and respiratory activity has been experienced across inpatient areas.

Countermeasure Actions	Due Date
• Completion of required case investigations by clinical areas / teams to identify good practice and any new learning continues with identified timeframes.	Monthly
• From reviews completed for *C.difficile,* lapses in care have been identified which include poor assessment and documentation, and delay in isolation nursing. The divisions continue to monitor those areas that have produced action plans and updates to the Infection Prevention & Control working Group (IPCWG).	Monthly
• The IPC nursing team continue to undertake targeted ward visits and use educational opportunities with staff groups.	Ongoing
• IPC representation at preparedness work internally and at BSW ICB convened meetings, including HCID.	Ongoing

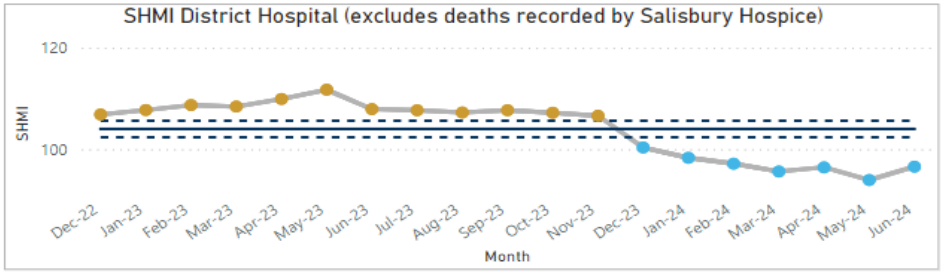
Risks and Mitigations

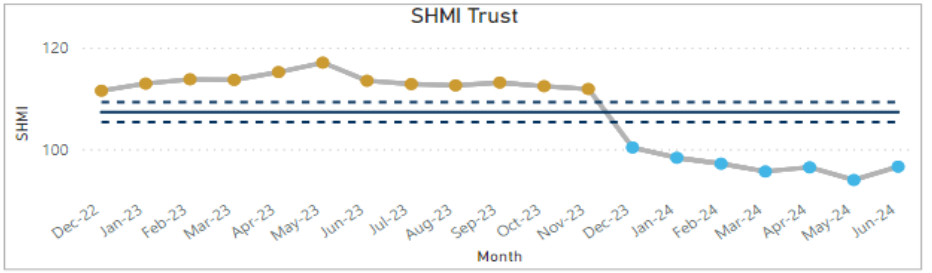
- Policy review work remains ongoing for the IPC team, with good progress achieved against agreed workplan.
- Healthcare associated infections with poor patient outcomes an underlying risk. As of 1st April 2024, the admission date definition for reporting HCAIs has changed, which **may** lead to an increase in cases classified as HOHA.
- NHS Standard Contract 2024/25: minimising *C.difficile* and Gram-negative bloodstream infections received, outlining threshold levels set. For reportable *C.difficile*, the threshold is set at 21 healthcare associated cases. So far, from 1st April to 30th November, there have been 20 cases.
- For one of the reportable *Gram negative bacteraemias,* the Trust has exceeded the threshold level for healthcare associated cases of *Pseudomonas aeruginosa.* The threshold is set at 7 cases, and the Trust has reported 10 cases to date.

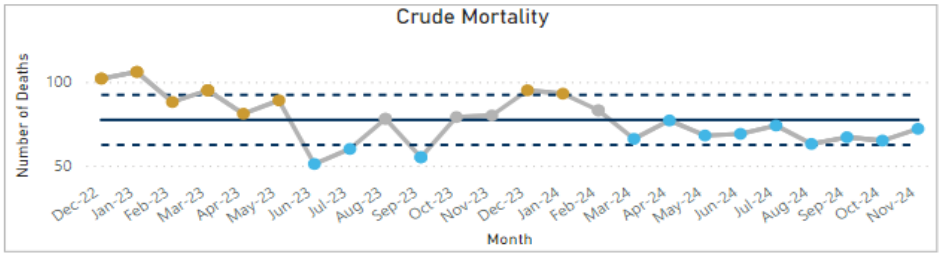
Mortality

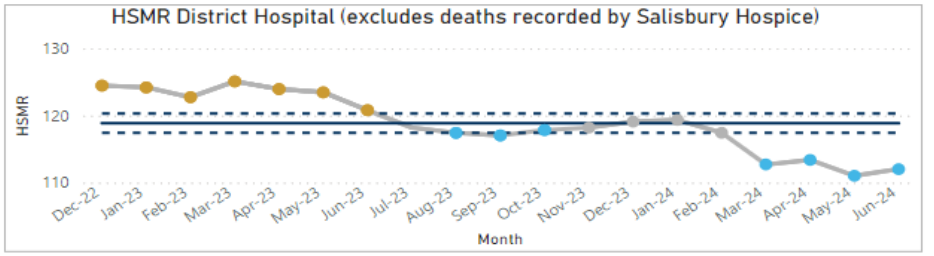
NHS Salisbury NHS Foundation Trust

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









Understanding the Performance

The Summary Hospital-level Mortality Indicator (SHMI) for the 12-month rolling period ending in June 2024 is **0.97** and remains statistically within the expected range.

The Hospital Standardised Mortality Ratio (HSMR) for the 12-month rolling period ending in June 2024 for Salisbury District Hospital is **112** and is higher than expected*

A national revision to the methodology for calculating the SHMI came into effect as per the rolling 12-months of Dec'23 onwards. *This month also sees the introduction of the newly anticipated remodelled HSMR (HSMR+). The Trust has seen an upward shift in the data (also applied to retrospective data) as a result, but the overall trajectory remains a downward one.

Countermeasure Actions	Due Date
• Telstra Health UK (our data intelligence provider) have been asked to provide a detailed summary report to the Trust's upcoming Mortality Surveillance Group (MSG) outlining the changes to the HSMR and the driving factors.	Ongoing / Bi-Monthly
• The number of mortality reviews (SJRs) being undertaken across the Trust continues to increase and the Trust's online mortality system is capturing thematic learning and actions.	Ongoing / Bi-Monthly
• The online mortality system to support learning from deaths was launched in March. Activity has been centred on improving reporting outputs from the mortality reviews and a dashboard is being developed to improve learning. A new training guide for staff and a supporting video have recently been produced.	Ongoing / Bi-Monthly

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 to help us to interpret and analyse our mortality data and identify variations in specific disease groups.
- Where alerts are generated, these are discussed, and a further review of the patient's records may be undertaken.

Watch Metrics: Alerting

NHS Salisbury NHS Foundation Trust

Quality of Care, Access and Outcomes

Metric	Two Months Ago	Last Month	This Month	Improvement Target	National Target	Variation	Variation Detail	Target Met This Month?	Consecutive Months Target Failed
Ambulance Handovers 60+ mins	78	102	80		0		Common Cause Variation	X	48
Complaints Closed within agreed timescale %	28.0%	30.0%	42.0%	85.0%			Common Cause Variation	X	48
ED 12 Hour Breaches (Arrival to Departure)	142	103	164		0		Common Cause Variation	X	48
ED Attendances	6608	6879	6772				Special Cause Concerning - Run Above Mean		
Inpatients Undergoing VTE Risk Assessment within 24hrs %	43.5%	32.8%	35.6%		95%		Special Cause Improving - Run Above Mean	X	48
Mixed Sex Accommodation Breaches	0	0	8	0	0		Common Cause Variation	X	1
Number of High Harm Falls in Hospital	2	4	3	0	0		Common Cause Variation	X	6
Pressure Ulcers Hospital Acquired Cat 2 - Device Related	8	6	5	0				X	8
Pressure Ulcers Hospital Acquired Cat 3 - Device Related	1	2	1	0				X	3
RTT Incomplete Pathways: Total 52 week waits	879	927	936	450	0		Special Cause Concerning - Run Above Mean	X	23
RTT Incomplete Pathways: Total 65 week waits	19	43	38	0	0		Special Cause Improving - Below Lower Control Limit	X	15
RTT Incomplete Pathways: Total 78 week waits	0	0	1	0	0		Special Cause Improving - Below Lower Control Limit	X	1

Watch Metrics: Alerting

Salisbury NHS Foundation Trust

Quality of Care, Access and Outcomes

Understanding the Performance

Pressure on non-elective flows continues to feature in alerting watch metrics – namely in the Emergency Department with the number of ambulance arrivals waiting longer than 60 minutes to be handed over and the number of patients spending longer than 12 hours in the department. ED attendances remain high at 8% year to date above the levels seen in 23/24. With the number of patients no longer meeting the criteria to reside in inpatient beds flow remains the biggest contributor to performance against the 4-hour standard in the Emergency Department.

Progress continues in reducing the longest elective waits, with just 38 patients waiting over 65 weeks at the end of November. The focus now is on eliminating patients waiting over 52 weeks for treatment, the top contributors to this are Plastic Surgery, Dermatology and Oral Surgery with the three specialties accounting for 44% of all patients waiting over 52 weeks.

Falls, Pressure Ulcers and Complaints Closed within agreed timescales all remain in common cause with no significant change to performance.

Countermeasure Actions

- Reconfiguration of the Emergency Department space in M9 will enable an increase the hours of assessment space available from 360 to 408 per day and provide 2 additional off load spaces for Ambulance arrivals.
- Streaming from the Emergency Department to the Walk in Centre will commence in January with the aim of reducing the high levels of demand that the Department is currently consistently seeing. This will begin with specific pathways with the aim of increasing once the process is established.
- Detailed demand and capacity work is being undertaken for Dermatology and Oral Surgery to identify the level of insourcing requirement to compliment capacity to enable elimination of elective waits over 52 weeks. Dermatology provision is already in place, with approval for Oral Surgery. Capacity challenges for Plastic Surgery are slightly different and tied to provision of trauma capacity, ongoing work with Southampton to identify level of capacity and resourcing required to stabilise service.

Risk and Mitigations

- Non elective activity remains high and ability to manage this is limited. Additionally, a high number of patients no longer meeting the criteria to reside in inpatient beds reduces flow in the organisation with congestion in the Emergency Department a consequence.
- Capacity constraints in some specialties are a risk to reducing overall waiting list and particularly challenging with regards to national reduction targets - being mitigated through additional capacity arrangements where necessary.

Watch Metrics: Non-Alerting

NHS Salisbury NHS Foundation Trust

Quality of Care, Access and Outcomes

Metric	Two Months Ago	Last Month	This Month	Improvement Target	National Target	Variation	Variation Detail	Target Met This Month?	Consecutive Months Target Failed
Beds Occupied %	92.6%	91.0%	92.3%	96.0%	92%		Special Cause Improving - Below Lower Control Limit	✓	0
Diagnostics Activity	8200	8871	7826	0			Special Cause Improving - Run Above Mean	✓	0
Patients referred on a suspected cancer pathway and seen within 2 weeks (%)	73.5%	78.7%	81.0%				Special Cause Improving - Above Upper Control Limit		
Pressure Ulcers Hospital Acquired Cat 4 - Device Related	0	0	0	0				✓	0
Proportion of patients spending more than 12 hours in an emergency department	0.7%	0.6%	0.6%				Special Cause Improving - Run Below Mean		
Stroke patients receiving a CT scan within one hour of arrival	79.0%	63.0%	72.0%		50%		Common Cause Variation	✓	0
Total Incidents (All Grading) per 1000 Bed Days	63	66	63				Common Cause Variation		
Total Number of Complaints Received	7	15	19				Common Cause Variation		
Total Number of Compliments Received	78	56	61				Special Cause Improving - Run Above Mean		
Total Patient Falls per 1000 Bed Days	6.82	5.81	6.19	7			Common Cause Variation	✓	0

Part 2: People

Performance against our Strategic Priorities and Key Lines of Enquiry

Our Priorities

People

Population

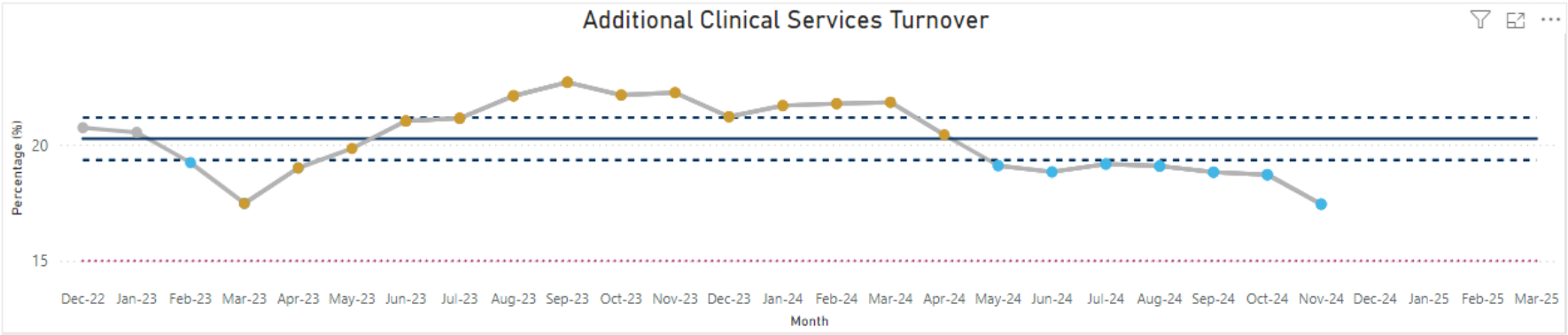
Partnerships

Increasing Additional Clinical Staff Retention

Breakthrough Objective

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

Target: ≤15% Performance: 17.4% Position: Special Cause Improvement



Understanding the Performance

ACS turnover has hit a low of 17.4%, making progress toward the breakthrough target (15%).
This remains the highest turnover staff group but equates to 3.5 WTE leavers in month.
2.2 WTE had less than 2 years' service.
2.9 WTE were under 30 years old.
Leavers reasons:

- 1 WTE to undertake further education/training
- 0.81 WTE work/life balance
- 0.61 WTE Dismissal – SOSR
- 0.6 WTE Other/not known
- 0.5 WTE Child dependents

SFT turnover is down to 12.61%, the lowest recorded level on the BI dashboard.

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

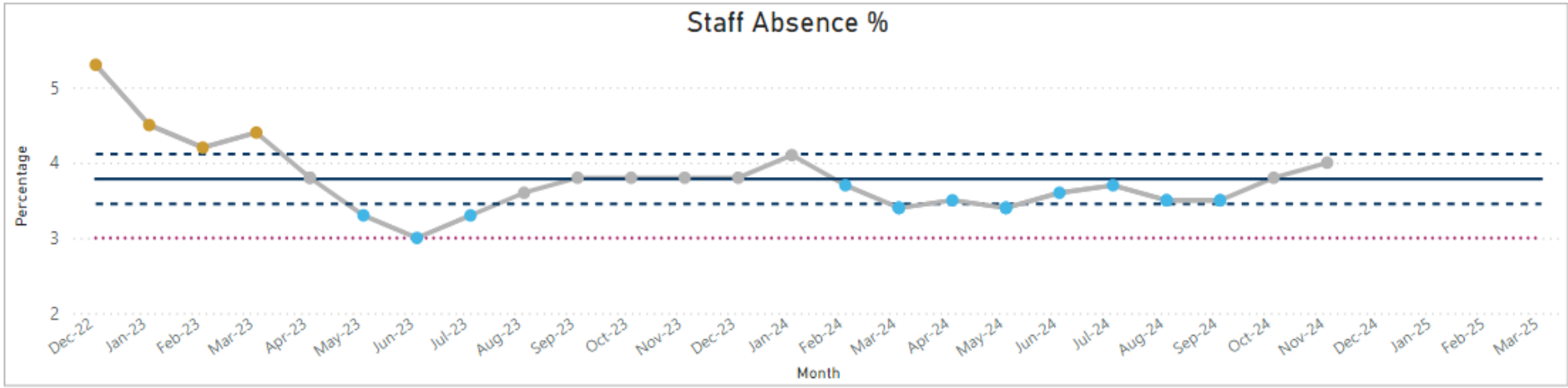
Risks and Mitigations

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

Sickness Absence

Salisbury NHS Foundation Trust

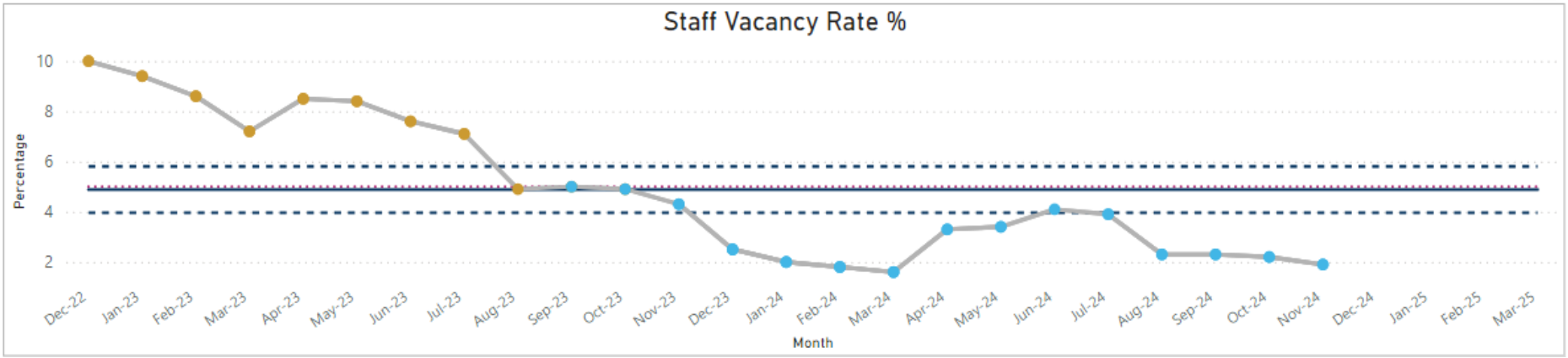
Target: ≤3% Performance: 4% Position: Common Cause



Understanding the Performance	Countermeasure Actions	Due Date	Risks and Mitigations
A small drop in sickness absence rate for November, with the rate at 3.96%, slightly down from 4.04% M7, similar level to last year. Increases of c50% within the cold/cough/flu since M6. Highest absence rate remains Anxiety/Stress/ Depression, accounting for 20% of all absence. W&NB and Surgery remain the highest contributors at 5.8 and 4.4% respectively Additional clinical services remain the highest contributing staff group at 5.9% this month and higher rates of sickness (c8-9%) are noted on some inpatient areas e.g. Pembroke and Chilmark wards Sickness accounted for 4,847FTE days lost to the Trust, with a broad 3/8 long term 5/8 short term split remaining.	• Line Manager (LM) training on Absence Management policy and actions seeking to deliver training opportunities for all LM by year end. sessions programmed through the year, with additional support through breakfast clubs. (Hd ER and Policy). • Reduction of violence and aggression on wards and in ED/AMU, seeking to prevent physical injury and reduce cases of workplace stress and anxiety. 'No excuse for abuse' campaign and training interventions for ward staff planned each month. Excellent feedback so far. • Deep dive of EFM absence causation to generate mitigation actions	Dec 24 Mar 25 Dec 24	• Availability of instructors and advisers to support training interventions and workplace support to LM. Staff are being trained and recruited to fill vacancies in current team. • Availability of LM to attend training. • The ER team has been recruiting to better support the programmed activity but this currently remains a risk until new starters are in post. • Training risks: - Conflict resolution 95.5% - Moving and handling 90.4% - Hand hygiene 74.1% - Infection control 90%

Vacancies

Target: ≤5% Performance: 1.9% Position: Special Cause Improvement



Understanding the Performance	Countermeasure Actions	Due Date	Risks and Mitigations
Trust vacancies stand at 1.93% for M8, well below the 5% target. The highest contributing staff group is infrastructure staff, where there are a total of 120 FTE vacancies. The highest vacancy rates amongst clinical divisions sit within Theatres, Pathology, & GI unit. HR Operations is the highest in corporate. HCA vacancies sit at 78 FTE, adding pressure to the work force in this staff group, which correlates with the high rates of turnover in this group. Work is being undertaken across the divisions to confirm where these are and track against any potential high turnover areas. *NB. M8 figures not availabe at time of writing.* Reporting to ICS, which includes subsidiaries and hosted services show a total of 178 FTE in Month 7, a vacancy ratio of 4.1%.	• Targeted support to the 13 identified hard to recruit roles, seeking to support attraction campaigns to fill these post which generate high agency back fill costs. • Confirmation that vacancies identified as greater than 10% align accurately to team structures in order to ensure that attraction campaigns are focussed on the areas of most need. Further work required to prioritise these areas in line with patient safety/service delivery and to support Trust headcount management. • Development of campaigns to attract ACS and Admin and Clerical staff, both groups subject to high levels of turnover	Jan 25 Jan 25 Dec 24	• DMT and HRBPs working to design and develop attraction packages for hard to recruit roles • Understanding of future resourcing and staff requirements. Workforce trajectory forecasting, seeking to support Divisions and Line Managers with targeted attraction and recruitment campaigns, specifically for hard to fill high value niche posts is a key focus of the recruitment team. • Loss of potential staff through ineffective recruitment and on-boarding processes Implementation of PWC 'overhauling recruitment' programme phase 2 recommendations.

Watch Metrics: Alerting

NHS Salisbury NHS Foundation Trust

People

Metric	Two Months Ago	Last Month	This Month	Improvement Target	National Target	Variation	Variation Detail	Target Met This Month?	Consecutive Months Target Failed
Mandatory Training Rate %	85.1%	85.4%	85.5%	90.0%	85%		Special Cause Concerning - Below Lower Control Limit	X	22
Medical Appraisal Rate %	85.4%	83.7%	85.1%	90.0%			Special Cause Concerning - Below Lower Control Limit	X	4
Non-Medical Appraisal Rate %	74.3%	71.8%	69.8%		90%		Special Cause Concerning - Decreasing Run	X	48

Watch Metrics: Alerting Narrative

NHS Salisbury NHS Foundation Trust

People

Understanding the Performance

Mandatory training remains below target at 85% completion rate across the Trust. The best performing area is facilities with 95% completion. The lowest contributors are Corporate at 82% and medicine at 85%. The 90% target has not been met for since January 2023. The application of significant oversight from management teams remains the most effective action to increase compliance.

Medical appraisals continue to fall month on month and now sit at 83.7%, this is the lowest since October 2023. The number of out of date appraisals has increased from 53 to 62, with the number out of date by >3months increasing from 21 to 30 from the previous month.

Non-medical appraisals rates have fallen back to the same level recorded 12 months ago. This is a worrying trend as the gains made by much effort in Q3 last year have not been consolidated. The main contributors to poor appraisal rates across the Trust are corporate at 57.3% and Medicine at 68.5%. No division is above 76%.

Countermeasure Actions

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

Risk and Mitigations

- Loss of Trust in the accuracy and useability of the MLE system may deter staff from completing mandatory training. Work is ongoing to improve accuracy and design course content which is easy to understand and use.
- Completion of appraisals remains patchy, and susceptible to interpretation from staff and line managers, leading to incomplete appraisals and lack of effective recording. Having delivered a new, more succinct form, which improved the rate from Sep 23, further work is now being planned to improve training and oversight of appraisals for line managers.
- Management time to enable appraisal completion is frequently cited as the main blocker to success.

Part 3: Finance and Use of Resources

Performance against our Strategic Priorities and Key Lines of Enquiry

Our Priorities

People

Population

Partnerships

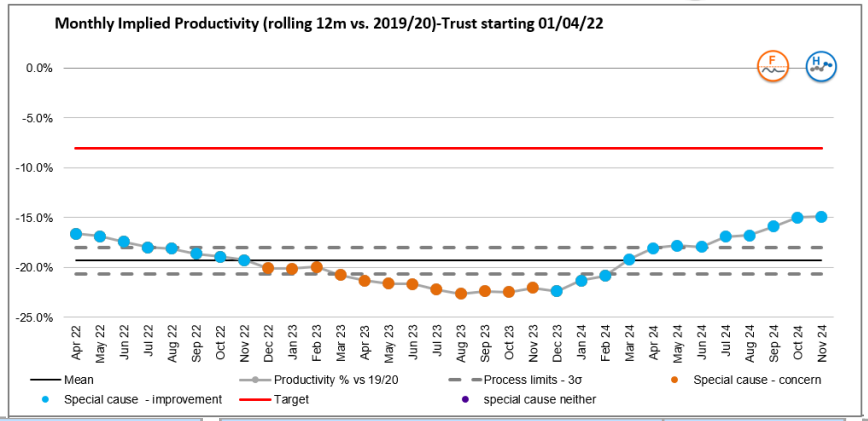
Creating Value for Our Patients

Salisbury NHS Foundation Trust

Breakthrough Objective

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

Target: -8% Performance: -14.9% Position: Special Cause Improvement



Understanding the Performance	Countermeasure Actions	Due Date
In Month 8 pay pressures due to worked WTE above funded levels, sickness cover and agency costs combined with increased drugs, clinical supplies and utilities costs, have been partially mitigated by increased activity, and have driven the 0.1% improvement in productivity delivery. There is an improvement of 4.3% delivery since March and is due to cost increases being mitigated by Non Elective, Day cases and Outpatient activity increases. The calculation is generated by adjusting Pay and Non Pay costs for cumulative inflation since 2019/20 and activity valued at a standard rate to provide a monthly Implied Productivity % as a comparator to 2019/20.	• FRG task and finish group operating on alternate fortnight basis to review headcount above March 23 levels • Modernisation and consistency of admin processes • ERF performance, key metrics and coding opportunities to be shared for review and discussion at next FRG • Temporary staffing controls	Ongoing Ongoing December December

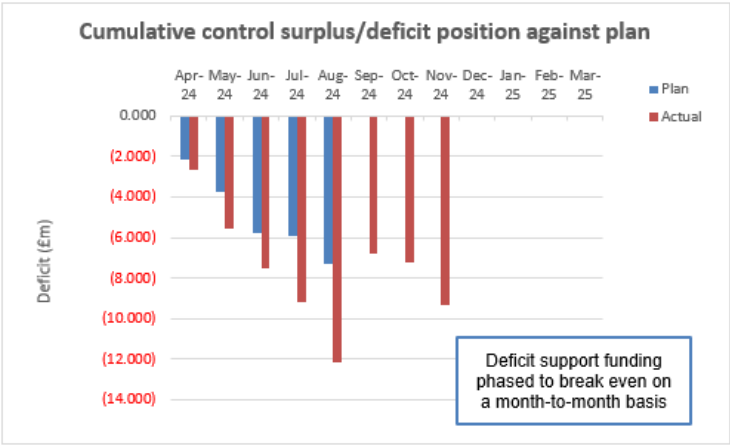
Risks and Mitigations
• The Finance Recovery Group and ERF / Delivery groups support the savings programme and ERF points of delivery.

Income and Expenditure

Salisbury NHS Foundation Trust

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

	November '24 In Month			November '24 YTD			24-25
	Plan £000s	Actual £000s	Variance £000s	Plan £000s	Actual £000s	Variance £000s	Plan £000s
Operating Income							
NHS Clinical income	27,145	26,426	*(719)*	214,653	210,483	*(4,170)*	319,525
Other Clinical Income	27	1,258	*1,231*	7,617	9,192	*1,575*	10,795
Other Income (excl Donations)	3,262	3,174	(87)	26,209	25,721	(488)	39,359
Total income	**30,434**	**30,858**	**424**	**248,479**	**245,395**	**(3,084)**	**369,679**
Operating Expenditure							
Pay	(19,941)	(21,110)	*(1,169)*	(164,728)	(169,172)	*(4,443)*	(246,855)
Non Pay	(9,531)	(11,135)	(1,604)	(78,530)	(81,859)	(3,329)	(117,175)
Total Expenditure	**(29,472)**	**(32,245)**	**(2,773)**	**(243,258)**	**(251,031)**	**(7,773)**	**(364,030)**
EBITDA	**962**	**(1,387)**	**(2,349)**	**5,221**	**(5,636)**	**(10,857)**	**5,649**
Financing Costs (incl Depreciation)	(1,887)	(1,644)	243	(15,099)	(13,550)	1,549	(22,654)
NHSI Control Total	**(925)**	**(3,031)**	**(2,106)**	**(9,878)**	**(19,185)**	**(9,307)**	**(17,005)**
Deficit Support Funding	925	925		9,878	9,878		17,005
Reported Position		**(2,106)**	**(2,106)**	**0**	**(9,307)**	**(9,307)**	



Understanding the Performance

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

The Trust recorded an in-month control total deficit of £3.0m against an original deficit target of £0.9m - an adverse variance of £2.1m. This is adjusted for £0.9m income which is the in-month impact of the £17m.

The deficit position is driven by expenditure pressures driven by non-elective activity volumes and pathways, with underperformance on Elective recovery funding (ERF) points of delivery, Community diagnostics activity, pass through depreciation funding and overperformance on the block BSW contract.

Countermeasure Actions

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

Due Date

Ongoing

Risks and Mitigations

- Pressure on emergency care pathways, particularly in relation to continued levels of patients with no clinical right to reside, as the efficiency plan assumes significant length of stay reductions which will not be realised in full without effective system working.
- Delivery of productivity increases which are contingent on both length of stay reductions, staff availability and recruitment.
- The Trust's £21.1m efficiency savings plan includes more than 40% non recurrent delivery and signals a risk into 25/26.

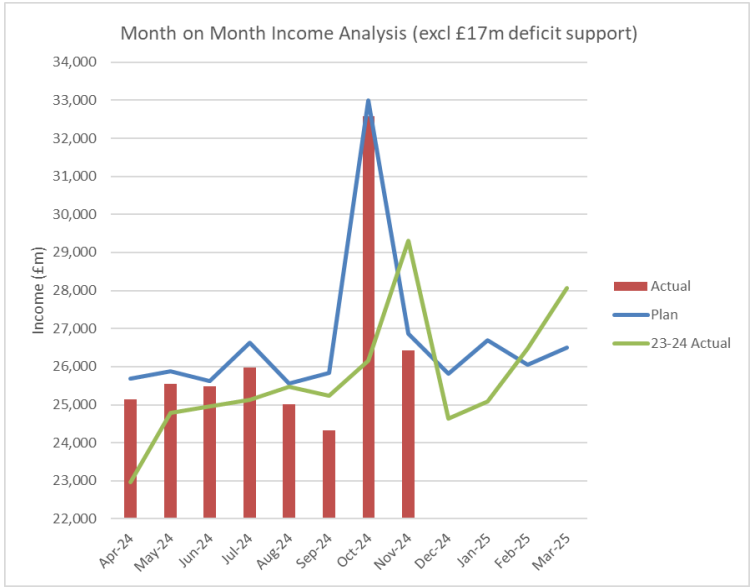
Income and Activity Delivered by Point of Delivery

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

Income by Point of Delivery (PoD) for all commissioners	November '24 YTD		
	Plan (YTD) £000s	Actual (YTD) £000s	Variance (YTD) £000s
A&E	8,215	8,826	611
Day Case	17,963	18,161	198
Elective inpatients	14,757	11,280	(3,477)
Excluded Drugs & Devices (inc Lucentis)	18,571	19,610	1,039
Non Elective inpatients	55,401	56,119	718
Other	68,809	65,798	(3,011)
Outpatients	30,937	30,689	(248)
TOTAL	214,653	210,483	(4,170)

SLA Income Performance of Trusts main NHS commissioners	Contract		
	Plan (YTD) £000s	Actual (YTD) £000s	Variance (YTD) £000s
BSW ICB	127,521	126,041	(1,480)
Dorset ICB	21,216	20,586	(630)
Hampshire, Southampton & IOW ICB	18,939	17,979	(960)
Specialist Services	28,981	30,920	1,939
Other	17,996	14,957	(3,039)
TOTAL	214,653	210,483	(4,170)

	Activity YTD			Activity Last Year Actuals	Variance last year
	Plan	Actuals	Variance		
A&E	49,349	52,787	3,438	49,264	3,523
Day case	19,037	18,462	(575)	16,118	2,344
Elective	3,160	2,446	(714)	2,175	271
Non Elective	19,076	20,654	1,578	18,714	1,940
Outpatients	200,388	200,267	(121)	184,098	16,169



Understanding the Performance

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

The level of uncoded day cases and inpatient spells is 30% in October and 94% in November at the time the activity was taken for reporting purposes. September's activity was fully coded at the SUS submission.

Activity across Day cases and Elective Inpatients was higher in November than in October.

Countermeasure Actions

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

Due Date

December

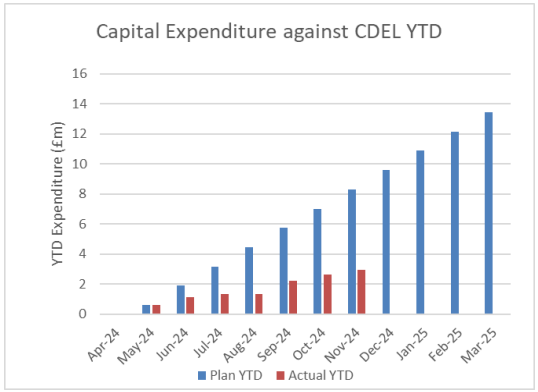
Risks and Mitigations

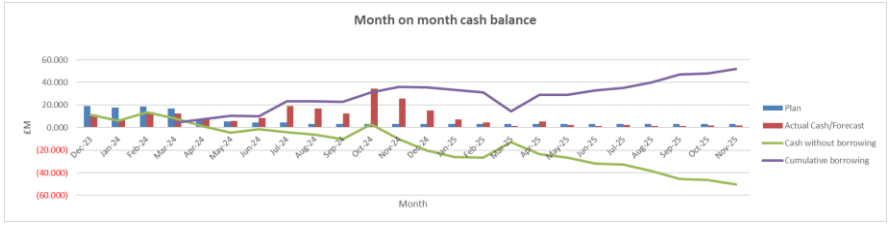
- The NHS England Specialised position for Month 12 23/24 has been published with the full impact of £560k not agreed.
- The Trust is maximising activity recording opportunities, Advice and Guidance and productivity improvements.

Cash Position and Capital Programme

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

	Closing Balance March 2024 £000s	Current Month Balance £000s	Actual In Year Movement £000s
Inventories (Stock)	7,954	8,535	581
Debtors	24,999	28,764	3,765
Cash	28,891	27,568	(1,323)
TOTAL CURRENT ASSETS	**61,844**	**64,867**	**3,023**
Creditors	(58,026)	(43,937)	14,089
Borrowings	(641)	(27,669)	(27,028)
Provisions	(474)	(411)	63
TOTAL CURRENT LIABILITIES	**(59,141)**	**(72,017)**	**(12,876)**
TOTAL WORKING CAPITAL	**2,703**	**(7,150)**	**(9,853)**





Schemes	Annual Plan £000s	November '24 YTD Plan £000s	November '24 YTD Actual £000s	November '24 YTD Variance £000s
CDEL Schemes				
Building schemes CIR	3,609	2,193	909	(1,284)
Building projects	2,682	1,790	1,563	(227)
Fire schemes	500	311	28	(283)
IM&T	6,264	3,779	397	(3,382)
Medical Equipment	393	624	40	(584)
Total CDEL schemes	**13,448**	**8,697**	**2,937**	**(5,760)**
National Funding				
Shared EPR - national element	2,231	1,338	711	(627)
Digital Pathology & LIMS	837	519	156	(363)
Community Diagnostic Centre	1,306	786	502	(284)
CIR Funding	511			
Total National Funding	**4,885**	**2,643**	**1,369**	**-1,274**
IFRS 16 Leases				
Medical Equipment	1,800	600	340	(260)
Vehicles and transport	850	284	456	172
All other leases including property	350	116		(116)
Total IFRS 16 Leases	**3,000**	**1,000**	**796**	**(204)**
GRAND TOTAL	**21,333**	**12,340**	**5,102**	**(7,238)**

Understanding the Performance

Capital expenditure on both CDEL and nationally funded projects totals £5.1m driven by Breamore refurbishments, Imber ward, lifts and CT scanner installation costs.

The cash balance at the end of Month 7 was £27.6m above the planned level of £3.1m. The improvement is due to payments relating to the non-recurrent deficit support, CDC, ERF and Pay award in advance.

Countermeasure Actions

- System revenue support required for February and March

Due Date

Jan/Feb 25

Risks and Mitigations

- The outcome of the Capital cash support application will not be confirmed until February 25
- The aging estate, medical equipment and digital modernisation means that the Trust's capital requirements are in excess of resources.
- The Trust seeks to mitigate the constraint of available system capital by proactively budding for national funds.
- The cash support framework and monitoring draws on finance and procurement resources to ensure that payments are made on a timely basis in line with limited cash balances.

Workforce and Agency Spend

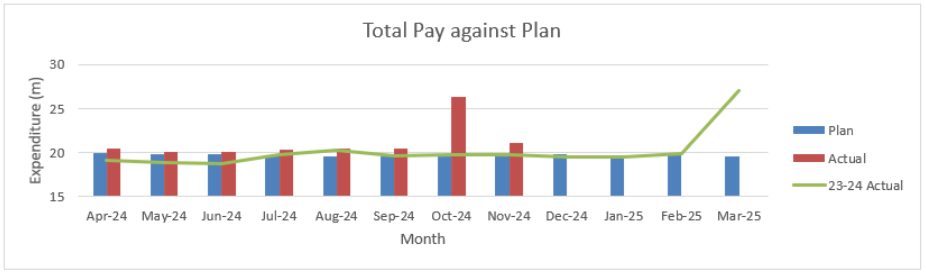
Salisbury NHS Foundation Trust

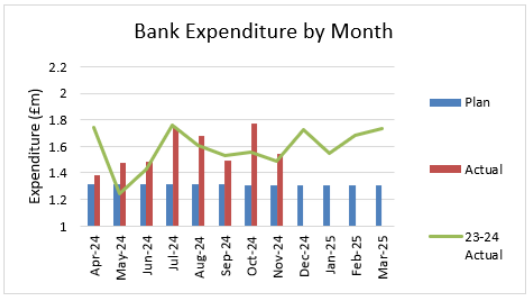
Target: N/A Performance: N/A Position: N/A

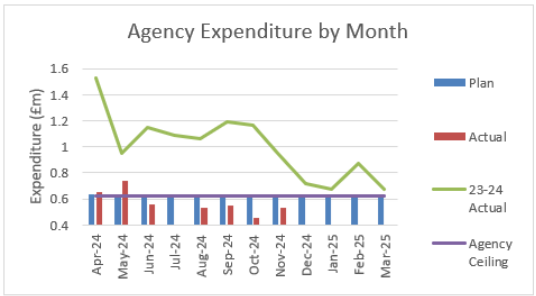
	November '24 YTD		
	Plan £000s	Actual £000s	Variance £000s
Pay - In Post	148,405	151,619	(3,214)
Pay - Bank	10,794	12,561	(1,767)
Pay - Agency	5,048	4,340	708
Other (eg apprenticeship levy)	481	652	(171)
TOTAL	**164,728**	**169,172**	**(4,443)**
Medical Staff	42,316	48,051	(5,735)
Nursing	45,025	44,069	957
Support to Nursing	16,014	13,843	2,171
Other Clinical Staff	22,218	22,334	(116)
Infrastructure staff	38,894	40,222	(1,328)
Other (eg apprenticeship levy)	260	652	(392)
TOTAL	**164,728**	**169,172**	**(4,443)**

Position

	November '24 YTD		
	Plan WTEs	Actual WTEs	Variance WTEs
Medical Staff	535.7	555.24	19.5
Nursing	1,211.1	1,323.94	112.9
Support to Nursing	444.2	572.85	128.6
Other Clinical Staff	825.5	654.86	(170.7)
Infrastructure staff	1,359.6	1,457.84	98.2
TOTAL	**4,376.2**	**4,564.7**	**188.6**







Understanding the Performance

Pay costs in month were £1.2m above plan with the Residents pay awards and A4C Bands 8-9 step points paid in month. The in-month variance is driven by substantive staff above funded levels, with unavailability for sickness and study leave high in month, and agency and nursing agency costs remaining in line with the average monthly run rate for the year to date.

The pay savings target was £8.3m against which achieved pay savings were £5.0m - an adverse variance of £3.3m, with £1.4m recurrent delivery.

There is an over establishment of 188 WTE against the 4,376 WTE Workforce trajectory (4,309 WTE at March 25) with the over establishment across all Pay categories with the exception of Other Clinical Staff.

Countermeasure Actions

- Trust wide and Division workforce control panels in place since November 2023.
- Finance recovery groups to review workforce actions (detailed under Creating Value for our Patients)

Due Date

Ongoing

Ongoing

Risks and Mitigations

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

Appendix

Business rules and Statistical Process Control (SPC) chart guidance

Our Priorities

People

Population

Partnerships

Appendix

Business Rules – Driver Metrics

Salisbury NHS Foundation Trust

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

Appendix

Business Rules – Watch Metrics

Salisbury NHS Foundation Trust

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

Appendix

NHS Salisbury NHS Foundation Trust

Business Rules – Statutory/Mandatory Metrics

These are additional rules only applied to certain metrics that are statutory or mandatory to be monitored at Trust level.
Whether or not a metric has met its target each month will be indicated by a tick or a corss icon in the "Target Met This Month?" column. The number to the right of that indicates how many months in a row the metric has NOT met its target for. Any metric that has met the target in the current reporting month will therefore show a 0 in this column. Different action are suggested depending on hpw many months the target has not been met for.
These metrics are assessed against their improvement target, or their national target where no improvement target exists.

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

Appendix

Reading a Statistical Process Control (SPC) Chart

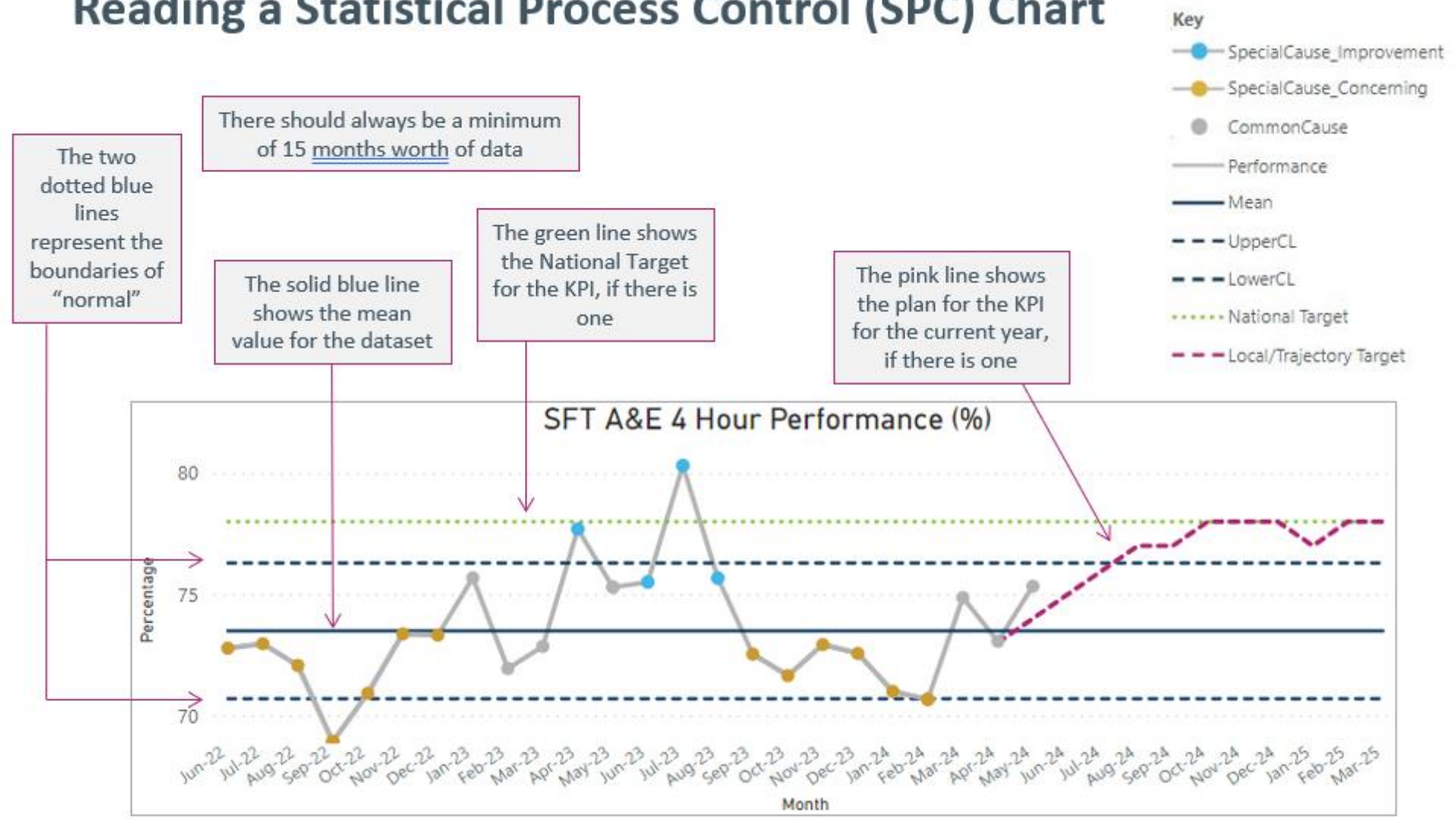
There should always be a minimum of 15 months worth of data

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

The solid blue line shows the mean value for the dataset

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

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



NHS Salisbury NHS Foundation Trust

Report to:	Trust Board (Public)	Agenda item:	2.2
Date of meeting:	9 January 2025		

Report from (Committee Name):	Audit Committee		Committee Meeting Date:	12 December 2024
Status:	Information	Discussion	Assurance	Approval
	X		X	
Prepared by:	Richard Holmes (Audit Committee Chair)			
Non-Executive Presenting:	Richard Holmes			
Appendices (if necessary)	None			

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

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

- The Committee received a deep dive from the Chief Pharmacist regarding the discovery of a significant inconsistency between physical stockholding and accounting stockholding of aseptic stock. Accounting stockholding has been corrected to actual physical stock levels through a £0.5m write off to this year's profit and loss accounts, already reported to F&P. Although significant in value, this error is below the level of financial materiality within the statutory accounts and hence would not have been considered as a 'Material Misstatement' were this to have been previously exposed by audit.

  It is clear that incorrect focus had been given by previous management to the process of reconciliation of actual to accounting stock, reportedly over the past 10+ years. Additional period by period stock reconciliations are now undertaken monthly to prevent this situation recurring. Committee praised the diligence of current management for identifying, exposing and resolving the issue, and requested an update at the next Audit Committee.

- One of the first joint internal audits has been completed covering Group Procurement. Each Trust was audited separately with a resultant overall opinion of 'Partial Assurance with Improvements required', in line with Management expectations. The report identified one High Priority action relating to a finding that "sample testing of contracts awarded with a value greater than £75,000 identified instances where a Conflict of Interest form had not been completed". Management actions have been identified, and the effectiveness of the implementation of these will be monitored by the Head of Internal Audit and reported back to the Audit Committee.

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

- The Committee received a presentation for the Director of Procurement on the roll out of the new 'No Purchase Order, No Payment' policy introduced across the Group which, if effectively implemented by staff across the Trust, will reduce the risk of unauthorised orders and payments. The policy also requires Suppliers ensure that they provide Purchase Numbers on invoices, else they will not receive payment, effectively transferring financial risk to them. The Committee requested clarification on the

'Exempted Items' included in the policy as they seemed unclear and inconsistent.

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

- Internal Audit and Counter Fraud Audit: The Committee received progress reports and audit reports. Progress reports demonstrated satisfactory progress of audits against the audit plans, with nothing exceptional to report. The Counter Fraud team reported that in their view the Trust was 'in a really good place' as regards counter fraud arrangements. Internal Audit reports, other than that for Group Procurement noted above, were received, reviewed, and accepted.

- The Committee was pleased to receive the External Audit Plan and Interim Audit results for the year to end March 2025 from the External Auditors. The Committee thanked and congratulated both them and the SFT Finance Team for providing this information at the December Audit Committee Meeting and in line with best practice timescales for the first time in many years, previous plans having been received after Christmas.

  The External Audit partner confirmed that no issues need to be highlighted to the Audit Committee to date, and anticipated that, based on the plans provided and the work carried out to date, the Audit should progress smoothly.

- The Committee thanked the Director of Integrated Governance for the work to re-present the new-style BAF, noted the intent that other Board committees reviewed risks in detail as appropriate, and noted some potential presentational improvements to be incorporated.

- Throughout the meeting, extra explanations and clarifications were provided regarding matters under discussion to ensure that new Committee Members and Governor Observers were able to understand matters perhaps not previously familiar to them. This will continue as part of their induction into role.

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

- The Committee reviewed the updated Terms of Reference and was pleased that they had now been drafted in line with the recently published best practice NHS Audit Committee Handbook, with a couple of additions to the ToR as a consequence. The ToR were approved as drafted, subject to a final cross check by the Committee Chair and Director of Integrated Governance between the ToR and the Audit Committee handbook in January.

- The usual review of the Register of Losses and Compensation was presented and noted.

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	

NHS Salisbury NHS Foundation Trust

Report to:	Trust Board (Public)	Agenda item:	2.3
	9 January 2025		

Report from (Committee Name):	Finance & Performance Committee		Committee Meeting Date:	16 December 2024
Status:	Information	Discussion	Assurance	Approval
			x	
Prepared by:	Debbie Beaven – Chair of Finance & Performance Committee			
Non-Executive Presenting:	Debbie Beaven			
Appendices (if necessary)	none			

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

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

- **Financial Performance** – We are now £9.3m behind plan, with the current run rate to year end taking us to a £14m deficit. This assumes current delivery of the ERF funding, and acknowledges that we will not deliver the full £21m of CIPS, however there is a relatively high level of confidence that £16.5m of savings will be achieved; the shortfall being £4.4m relating to NCTR (against plan of £5.5m). We have benefited for vacancy savings, which are likely to be non-recurring, although each post is being tested to ensure it is necessary and will add value. There continues to be system pressure for SFT to deliver a best forecast, which is now £10m.
- **NCTR –** Still alerting due to the continuing numbers above plan and the lack of short-term prospects of significant reductions, although there is progress through the "sprint" (now in Week 3). F&P will receive an update at the next meeting when we hope to see evidence of the positive impact of the week A3 meetings and interventions.

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

- **BAF & CRR –** As a result of the new Board approved risk appetites, which are predominately "cautious" we find ourselves with 10 out of 11 strategic risks "out of tolerance" and 15 out of tolerance on the CRR. We agreed there had been a fully engaging process to arrive at the appetites, which reflect where we want to be (and not our expectations) and we felt the current position was reflective of the conversations in the Committees around risk. There will be a review again next year.
- **Coding –** We were advised that there is a paper going to TMC on the prioritisation of coding, with some coding being time critical, income generating, and others with where there is less of a time or income imperative. The objective being to focus on the coding that will have the biggest impact on income and key performance metrics.

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

- **Drug Spend** – deep dive. Costs are ahead of plan with multiple factors affecting price and recoverability through income. We were assured that short term cost avoidance or minimisation is

considered wherever possible, but that patients long term health outcomes were a key consideration in prescribing.

- **Annual Planning –** we received an outline of the planning process and timeline. NHS guidelines are expected before Christmas. F&P will be updated at each meeting ahead of final submission.
- **Procurement look forward –** received a forward look of contracts for renewal.

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

- **Capital** – we received a capital allocation proposal based on a minimum CDEL of £9.5m, the schemes having been through a prioritisation process. The Committee didn't feel it could approve the proposal, given that the capital has not yet been approved, but we agreed to recommend the proposal to Board to enable planning to continue.

NHS Salisbury NHS Foundation Trust

Report to:	Trust Board (Public)	Agenda item:	2.4
Date of meeting:	9 January 2025		

Report from (Committee Name):	Clinical Governance Committee		Committee Meeting Date:	17th December 2024
Status:	Information	Discussion	Assurance	Approval
			X	
Prepared by:	Anne Stebbing, Non-executive Director			
Non-Executive Presenting:				
Appendices (if necessary)				

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

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

- Nothing to escalate

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

- CGC noted continued improvements in both metrics included within IPR for managing deteriorating patients. Noted that aim is to achieve 30 minutes average time for nurse to confirm decision to escalate. (Currently at 297 minutes).
- Noted plans for implementation of Martha's rule in quarter 4 which should further improve recognition and management of deterioration.
- Noted that there are >200 overdue actions from investigations, mainly from prior to PSIRF transition, and the work is being done to ensure these are closed. CGC asked that future patient safety reports include a greater emphasis on the learning identified and how sustainable improvements are to be implemented.
- Several papers scheduled for discussion were not ready and deferred to next meeting. This prompted a discussion around timing of meetings. CGC proposes to hold a meeting next year in October (currently scheduled for no meeting), and to not hold a meeting in December.
- CGC agreed the decision as to which survey the Trust should use for end-of-life care should go to CMB

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

- CGC received verbal assurance on how safe care is maintained when using escalation beds or providing corridor care due to pressures in ED.
- Reviewed the updated BAF and noted 5 new risks on the corporate risk register. CGC discussed the risk appetite approved at Board in October and that a consequence of a more cautious approach is that a large number of BAF and corporate risks are now out of tolerance. CGC agreed that this reflects the current challenges faced by the Trust. CGC questioned how our risk appetite affects what the Trust should focus on.
- CGC asked that the description of BAF risk 6 is made clearer to indicate it refers to executive capacity rather than whole board.

• CGC received update on National Patient Safety Programme and noted progress with fully implementing PSIRF. 2 very active patient safety partners are in post, and further recruitment is underway. • Received the quarterly learning from deaths report and especially noted: a) improved coding of co-morbidity. b) SFT has significantly lower mortality from acute myocardial infarction and following coronary angioplasty than expected. c) 5 diagnoses which have previous triggered mortality alerts are now showing that the Trust is no longer an outlier. • Received the 6 monthly DIPC report and IPC BAF. The IPC BAF demonstrated the Trust is either partially or fully compliant with the standards. CGC stressed the need to ensure we have evidence for all standards to adequately provide assurance.
•

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

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

Report to:	Trust Board (Public)	Agenda item:	2.5
Date of meeting:	9th January 2025		

Report from (Committee Name):	Trust management committee TMC		Committee Meeting Date:	18/12/24
Status:	Information	Discussion	Assurance	Approval
	x			
Prepared by:	Interim Managing Director, Lisa Thomas			
Non-Executive Presenting:	Interim Managing Director, Lisa Thomas			
Appendices (if necessary)	N/A			

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

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

- Elective Recovery Fund (ERF) remains behind plan year to date, improvements were made in November to activity levels and recovery plans are in place to improve performance between now and the year end.
- Updates were given on the number of patients waiting over 65 weeks, the target for end of December was 0 patients waiting, as at the time of the report the number of patients was 38, this reduced by the end of the month but due to some non admitted pathways converting to admitted pathways there were less than 10 patients waiting.

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

- Health and safety update on managing violence and aggression was given at the Committee. For the management of confusion, delirium and dementia the Trust dementia lead has introduced the meet my unmet needs first campaign.
- The new no excuse for abuse campaign went live. There has been a number of incidents which have now resulted in yellow and red cards being issued to patients following the new policy.
- Drugs and Therapeutic Committee is working on developing a revised free of charge/compassionate use policy which will include some advice about how to manage situations where patients receiving treatment under co-payment arrangements are then given access to free of charge/ compassionate use supplies of medication.
- The replacement lift programme for lifts 3 and 4 begins in mid January, the lifts will be replaced one at a time, with one lift always being operational and the main corridor will be unaffected. The programme indicates downtime of 11 weeks.
- The estates strategy will be coming to TMC in January for consideration.

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

- The Committee received an update from Urgent Care Board, where progress was noted in NCTR working group, Surgical SDEC was working to implement a new bed template to increase capacity, the internal wards process group is now established.
- An update from Health and Safety was presented with good progress in reducing lost time to injuries.
- The Committee received the formal exit of cancer tiering with NHS England due to improved performance.
- An update was given on Improving Together, 50% of teams are trained but more work is ongong to ensure teams are actively progressing with huddles.

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

- The process for the Group procurement of Digital software solutions was approved. The process will align software procurement across all three Trusts to align technologies and better economies of scale.
- The Committee reviewed potential rent increases for accommodation in line with district valuer recommendations. The Committee in principle agreed to changes but wanted further work undertaken to limit the potential increases across the different rates.

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

Report to:	Trust Board (Public)	Agenda item:	3.1
Date of meeting:	9 January 2025		

Report title:	Well-Led Areas for Improvement Progress Report			
Status:	Information	Discussion	Assurance	Approval
			x	
Approval Process: (where has this paper been reviewed and approved):	Nil			
Prepared by:	Fiona McNeight, Director of Integrated Governance			
Executive Sponsor: (presenting)	Fiona McNeight, Director of Integrated Governance			

Recommendation:

To note the progress made against the areas for improvement identified as part of the external well-led developmental review in 2023.

Executive Summary:

Following a BSW competitive tender process, AQUA were appointed to deliver an external well-led developmental review. The Trust review took place April – June 2023. As part of the tender process, the 3 Acute Trusts commissioned a shared learning report which is anticipated Autumn 2024 once RUH review has concluded.

Key development themes were identified for each Key Line of Enquiry (KLOE) from the findings of the review and there was Executive agreement to the key development themes and delivery workstreams in November 2023. This was presented to Trust Board in December 2023 and the proposed improvement themes were approved. It was agreed that there would be a bi-annual progress report to Board. A progress update report was presented to the Clinical Governance Committee in June 2024.

There has been further progress made against all identified areas for improvement following the external well-led developmental review and progress report in June 2024, with on-going work being addressed within current programmes of work. The implications of moving to a Group Model will require further consideration in relation to the Well-Led Framework and will be reflected in future reports.

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

NHS Salisbury NHS Foundation Trust

Well-Led Progress Report

Purpose

1.1 The purpose of the report is to provide assurance of progress against the areas for improvement identified through the AQUA External Well-led Review concluded in June 2023.

2 Background

2.1 Following a BSW competitive tender process, AQUA were appointed to deliver an external well-led developmental review. The Trust review took place April – June 2023. As part of the tender process, the 3 Acute Trusts commissioned a shared learning report which is anticipated Autumn 2024 once RUH review has concluded.

Key development themes were identified for each Key Line of Enquiry (KLOE) from the findings of the review and there was Executive agreement to the key development themes and delivery workstreams in November 2023. This was presented to Trust Board in December 2023 and the proposed improvement themes were approved. It was agreed that there would be a bi-annual progress report to Board. A progress update report was presented to the Clinical Governance Committee in June 2024.

Progress against each of the improvement themes is noted below, providing an update to the presented findings from June 2024 (Appendix 1 outlines the review findings).

2.2 With the move to a group model, there is further consideration required of the well-led framework and the implications of working within a revised structure. This will be reflected in future reports as the form, functions and governance arrangements begin to embed. During the transition, this has resulted in a number of interim Executive Director posts which is reflected within the Trust Board Assurance Framework.

3 Improvement theme progress

3.1 <u>KLOE 1: Leadership Capacity and Capability</u>

There were 6 approved areas for improvement:

- NED skillset review and consideration of an Associate NED model – this was completed as part of the recent NED recruitment and 2 NEDs were appointed as Associate NEDs in addition to a substantial NED position.
- Board Committee escalation process and review of escalation templates – this has been completed and the 3A (Alert, Assure and Advise) model has been implemented and utilised well across a number of committees.
- Strengthen Divisional Governance arrangements – the Director of Integrated Governance has worked with the Divisional Management Teams (DMT) and attended Divisional Governance meetings to support standardisation of meeting agendas and content. The Divisional Governance meeting standard agenda template was revised in May 2024. Specialty performance reviews are now being tracked with oversight at the Divisional Performance Reviews (DPR). Deep dives of the Divisional Risk Registers continue with the Chief Medical Officer and Chief Nursing Officer. The Divisional Performance Reviews (DPR) have been reviewed and Leader Standard Work has been implemented for the development of the DPR packs. An Internal Audit of Divisional risk management, completed in May 2024, provided an

overall assessment of 'partial assurance with improvements required'. Areas for improvement related to Divisional oversight of specialty risks registers, consistency of risk reporting at the DPRs, review and updates to risks on Datix and risk management training. Recommendations have been fully implemented.

- Structured Board Development Programme – this work is on-going. Board development days are structured to prioritise key risk discussions. There is current work across the ICS to align Boards functions and plans are underway to introduce joint seminar/development days.
- Board visibility – a revised Go and See Programme has been implemented which have incorporated the Board Safety Walkabouts. There have been Improving Together Board development sessions in April 2023 and June 2024 focussed on Go and See. Executives are undertaking Go and See's regularly and feedback via the Executive 'huddle Board' weekly.
- Talent Management and Succession Planning approach – The Talent Plan is currently drafted and will be presented to TMC in early 2025. The plan outlines a number of initiatives which will be progressed throughout 2025 as this remains a key area of focus. The CPO has met with each Executive Director to discuss succession planning throughout November/December.

3.2 KLOE 2: Vision and Strategy

There were 2 approved areas for improvement:

- Divisional 5-year plans – There is now a structured approach to clinical divisions annual planning. As part of Improving Together each division agrees with the Executive their 4 to 6 key areas for improvement each year in a process known as the scorecard agreement. This process recognises our teams cannot focus on everything and so seeks to give them clarity on their priorities within the scope of the resources available. The scorecard agreement also includes the confirmation of a range of watch metrics (areas of work which continue on a business-as-usual basis) and are therefore not expected to generate significant improvement. The strategy is further cascaded into the organisation via 'specialty' scorecard agreements and the strata of operations below divisional level. Additionally, at this specialty level within Divisions, clinical and operational leaders are engaged in a process of 'responding' to the Trust master strategy with their 3, 5 and 10 year plans. These are complete and are currently subject to clinical validation by the CNO and CMO with support from Clinical Directors. It is anticipated this work will surface to Board by April 2025.
- Health inequalities reporting and awareness – A broad range of activity has continued over the past year to help reduce health inequalities. A few highlights are listed below:

    - Trust staff have been attending a local Farmers Market providing education around skin cancer awareness.
    - New staff have continued to be recruited to roles that will help support our work in reducing health inequalities. For instance, two EDI Cancer Leads have recently been recruited to work with communities to improve early diagnosis and awareness of presenting signs and symptoms of cancer, and secondly to improve staff education around cultural awareness, reasonable adjustments, and the accessible information standard. There will a focus on manual workers and the boating community.
    - The smokefree group are working in close collaboration with Wiltshire Council to provide written resources to our hospital inpatients. There is a visible treating tobacco dependency service with good input from pharmacy ward-based teams and pre-operative assessment teams, with an average of 120 referrals/month.
    - We have continued a virtual diagnostic partnership with NuvoAir for Children and Young People (CYP) with asthma and have established *Asthma Friendly Schools* in collaboration with Wiltshire, BANES and Swindon local authorities. We are also making every contact count with clinic consultations (including using a Smokerlyzer CO monitor on all smoking/vaping parents and giving some very brief advice about cessation). A CYP

asthma business case is in the final stages which will allow even more work to be done enhancing the asthma service particularly for those in the Core 20.

- A series of workshops have been held with key stakeholders across Wiltshire to determine how funds will be spent to address health inequalities in 2025 (see specific priorities below):

Children and Young People

- Poorer mental health in children with adverse childhood experiences
- High number of children from Core20 areas not brought for outpatient appointments.

Adults

- Low uptake of cancer screening and late presentation of symptoms for Core20 populations and routine and manual workers/Gypsy, Roma, Traveller and Boater communities.
- Physical health checks for people with Severe Mental Illness (SMI) in Core20 populations and routine and manual workers/Gypsy, Roma, Traveller and Boater communities.

- A new operations group was established earlier in the year with focus on health inequalities. Our policies have been reviewed, and as result of some process changes, we have seen a significant reduction in the average wait time to first outpatient appointment for people with Learning Disabilities and autism.

- The Wiltshire Health Inequalities Group (WHIG) continue to meet monthly. The Terms of Reference have recently been revised to ensure greater emphasis on the CORE20Plus 5 national priorities.

3.3 KLOE 3: Clear roles and responsibilities and systems of accountability

There were 4 approved areas for improvement:

- Divisional accountability – the Integrated Governance and Accountability Framework was revised in April 2024. The DPR meeting and performance packs have been revised to enhance oversight and accountability. The packs have been replicated for the performance meetings with the specialties (SLT's). There is discussion currently with Senior Leaders regarding the potential change to the divisional structure.
- Quality of Board and Board Committee papers – 2 NHS Provider report writing sessions have been held for Executives, NEDs and Senior Managers. There is Executive approval of Board and Board Committee papers prior to publication. This is an on-going area of focus.
- Review of the Governor observer at Private Board – this is complete. There is no longer a Governor observer at Private Board as agreed with the Lead and Deputy Lead Governor and the Chair.
- Policy compliance – there has been regular reporting to Trust Management Committee of policy compliance. This is improving incrementally but compliance remains a concern. The risk is now recorded on the Corporate Risk Register and the CEO concluded a Policy Summit on 3rd September where all outstanding policy owners were required to attend. The Trust has transitioned to a new system called Eolas Medical. Training sessions ran throughout November. The Trust has been working closely with the provider to maximise the increased system

functionality. There is a backlog of policy updates to now work through and once the system has been fully populated, the compliance reporting will resume. Policy compliance has significantly improved. The focus for the next few months will be on the guidelines.

3.4 KLOE 4: Culture of high quality care

There were 2 approved areas for improvement:

- Freedom To Speak Up Guardian (FTSUG) reporting – The identified increase in FTSU reporting has been investigated and follows the national trajectory for speaking up cases reported nationally (post Lucy Letby). There is focus on the timeliness of responses to concerns raised. This is currently challenged by the lack of resources within the employee relations department to support concerns raised by staff who then use the FTSU route. FTSUG and ambassadors have commenced walkabouts to raise awareness and increase staff engagement, supported by Listening Events held with the FTSUG and CPO out of hours to increase access by all staff. There is a new refreshed policy and strategy. There is continued focus on the triangulation of data from a variety of sources such Employee Relations, Occupational Health and Health and Safety Leads, Risk and PALs, which are discussed regularly to gain further insight into organisational themes although further work is necessary to streamline, analyse and action required on data received. The FTSU Guardian is actively contributing to national work to ensure that Overseas Trained Workers are enabled to raise concerns to enhance worker wellbeing and patient safety. Speaking up data at the Trust shows that a proportional representation of workers that raise concerns are from a BAME background (currently 30%), indicating that there is confidence in the FTSU service for these colleagues. National guidance is being published by the National Guardian's Office to support organisations to tackle detriment to those who raise concerns. FTSUG will bring the recommendations for consideration and action when available.
- Staff survey action planning – Divisions presented their staff survey action plans to TMC in April 2024 and Corporate Services presented in May. The focus for the coming year to strengthen the process will be on follow up on progress of the plans.

3.5 KLOE 5: Appropriate and accurate information being effectively processed, challenged and acted on

There was one approved area for improvement:

- Board cyber and digital awareness – there was a Board development session held in February 2024. A Cyber Security Framework has been developed and presented to Finance and Performance Committee in November to provide a single overview of cyber security for Salisbury NHS Foundation Trust (SFT) which will be updated annually for approval by Trust Board. Any improvement activities identified and assurance on routine cyber controls will continue to be provided through the existing quarterly report to Finance and Performance Committee. The report in November outlined a range of improvements activities that are underway across the different elements of cyber security controls. Noting cyber security continuously evolves and therefore assessment and investment in cyber posture will always be required, the intent is to have a very high standard of cyber posture across the Trust within 18 months, acknowledging the current position remains strong. With the Trust having gone through a range of live events over the last 12 months, the Trust has been able to test in real time their preparedness for resilience. Further testing is still needed however to test and improve the Trust's preparedness for longer term downtime such as those see in recent cyber-attacks and improve resilience of expertise to support the Trust during a cyber event. This includes ICS level desktop exercises as it enables partners to reflect on improvement areas when there is an event that could directly or indirectly impact at a greater scale. The Trust continues to work closely with ICS partners to collectively build capability and have consistent controls in place.

3.6 KLOE 6: Clear effective processes for managing risk, issues and performance

There were 3 approved areas for improvement:

- Alignment of the Board Assurance Framework (BAF) to the ICB BAF – this is now included in the BAF reports to Board and Board Committees on a bi-annual basis.
- Quality Impact Assessment (QIA) Process – the QIA policy has been revised and there is now oversight of the QIAs at Clinical Management Board (CMB) and Finance Recovery Group, where appropriate. This work is ongoing to ensure sustainability of oversight.
- Review of risk appetite – there was a Board development session in April 2024. Risk categories and definitions were developed in conjunction with the subject matter experts together with a proposed risk appetite. The risk appetite was approved by the Board in October 2024. This was a significant process change. This has been applied to each risk within the BAF and CRR. The Trust has moved from an open risk appetite to a more cautious approach to risk which has markedly impacted the status of risks out of tolerance and is reflected within the BAF and CRR dashboards. This was presented for the first time to the Board Committees in December 2024. This will remain a focus for discussion during 2025.

3.7 KLOE 7: Patient, public and external partner engagement

There were 2 approved areas for improvement:

- Structured approach to co-production – the Trust now has two mature patient panels, one in cancer services and another in spinal services. The cancer panel have been heavily involved with developing the Trust's website and implementation of the new Macmillan Hub in the hospital's main entrance, as well as the redesign of the patient areas in Oncology Outpatients. The spinal services panel have been instrumental in improving the toilet facilities in the inpatient area and are currently working with the services on a gait walker trial. The Readership Group continues to review patient literature prior to publication and now has 11 active members. The Trust has 2 Patient Safety Partners (PSPs) involved in the patient safety agenda and they are now active members of our developing learning from incident forums. We hope to recruit a further 2 PSPs in early 2025. Focus groups have been held with patients for stoma, breast care and colostomy services over the past 12 months. The Stoma group have completed a toilet facilities audit across the Trust and are helping us to implement a "stoma friendly" approach to all of our facilities. The Stoma group are also now on route to becoming another established patient panel. There are also plans underway to develop an easy-read readership group and a Carers group in 2025.
- Staff engagement – the Trust now has an Engagement Group leading on staff engagement, contributing to the delivery of the People Promise. Key engagement activities include:
  - 82 work experience students joined the Trust during June, July and August from 21 Schools and Colleges.
  - 28 People have joined the newly launched Ambassador Programme with an aim to visiting at least one school or college a month from September 2024 onwards.
  - 1000+ people attended Open Day of which 60% were staff. 30 Departments took part.
  - The new Staff Council has launched and they have received 37 applications.
  - Over 100 people attended Hearing It, 100 day or 1-year listening events. On average 58% of staff were in clinical roles.
  - The Widening Participation programme plan is in development including consideration of Care Leavers, NHS Reservists, 16-18 year old employment and our role as an anchor institution (with particular regard to the Coventry and Wiltshire College Partnership).
  - Listening report and Our People Magazine published in October.

3.8 KLOE 8: Robust systems and processes for learning, continuous improvement and innovation

There were 3 approved areas for improvement:

- Organisational learning (complaints, incidents & mortality reviews) – There has been a refresh of the Clinical Governance half days as shared learning events. The weekly patient Safety Summit lends itself to shared learning for those incidents graded moderate and above. Shared learning forums have been introduced into the clinical divisions which incorporate a cross divisional forum.
- Growing commercial based research – the Trust is prioritising commercial research studies and is in the process of building this portfolio. There are currently 4 commercial trials open and running. The Trust has been approached to take part in more commercial trials however, the department does not have the capacity to deliver the trials at the moment. Commercial research remains a national priority and the ambition is to deliver to this priority once the infrastructure is in place. The Trust has now transitioned over to the National Institute for Health and Care Research (NIHR) Southwest Central Regional Research Delivery Network (RRDN) and are no longer under the Wessex Clinical Research Network. The funding from the NIHR SWC has been confirmed for 2025/6, a contract for the funding is pending and should be finalised by 31 December 2024.
- Lived experience into Improving Together – staff stories are incorporated into the monthly Improving Together Board. There is a question included in the quarterly staff pulse survey regarding staff Improving Together awareness and confidence. Training roll-out continues with a focus on staff leading improvement through the huddle boards.

4 Summary

4.1 There has been further progress made against all identified areas for improvement following the external well-led developmental review and progress report in June 2024, with on-going work being addressed within current programmes of work. The implications of moving to a Group Model will require further consideration in relation to the Well-Led Framework and will be reflected in future reports.

5 Recommendations

5.1 To note the progress made against the areas for improvement identified as part of the external well-led developmental review in 2023.

Fiona McNeight
Director of Integrated Governance

NHS Salisbury NHS Foundation Trust

Report to:	Trust Board (Public)	Agenda item:	3.2
Date of meeting:	9th January 2025		

Report title:	Quarterly Strategy Update			
Status:	Information	Discussion	Assurance	Approval
	X		X	
Approval Process: (where has this paper been reviewed and approved):	Executive Directors			
Prepared by:	Tony Mears, Associate Director of Strategy			
Executive Sponsor: (presenting)	Lisa Thomas, Managing Director			

Recommendation:

1) The Board is asked to note the report and progress against our Vision Metrics.
2) The Board finds assurance in the process standard work surrounding our strategy deployment.

Executive Summary:

The Trust continues to make positive progress against its 2022-2026 strategy and long-term vision, with improvements observed across most Vision Metrics this quarter. Our strategy is across three key pillars: Population, Partnerships, and People.

- Under the **Population** pillar, diagnostic performance has improved steadily, with the Trust now achieving above 89% against the DM01 target. Cancer performance has notably strengthened, with the Trust exiting national monitoring. The Trust's 18-week RTT performance remains static at approximately 59%, with specific challenges in plastics, dermatology, and oral surgery. Patient engagement has seen significant improvement following the implementation of digital Friends and Family Test solutions, with response rates increasing from 3% to over 15%.
- In the **Partnerships** domain, the BSW Hospitals Group model continues to mature, focusing on three immediate priorities: joint Electronic Patient Record development, left shift, and productivity. SFT remains involved in across ten key system areas. Our long term length of stay ambition is showing improvement (by one day across the Trust over the past 18 months), though No Criteria to Reside (NCTR) numbers remain higher than target at approximately 90 patients.
- The **People** pillar shows sustained improvement in staff engagement (quarterly pulse surveys). Staff turnover has significantly improved thanks to focused work by the OD&P team in addressing root causes. The Trust has also published a new EDI Long Term Plan, though updated WDES and WRES data won't be available until April 2025.

Financial sustainability remains a significant challenge, with the Trust working to reduce its underlying deficit. However, environmental sustainability shows positive progress, with solar power generation increasing from 4% to 14% of total usage, and promising feasibility studies for geothermal energy.

Strategic Initiatives continue to advance, with notable progress in:

- Continuous Improvement Culture: 442 additional staff completed leadership programs
- Sustainable Workforce: First draft of workforce strategy produced
- Delivering Digital Care: Shared EPR program acceleration and completion of key infrastructure projects
- Improving Health & Reducing Health Inequalities: Leading role in BSW health inequalities funding process

The Trust has implemented new governance measures to strengthen oversight of Vision Metrics and Strategic Initiatives, including executive leadership confirmation, monthly metric 'clinics', and clearer assurance routes. These improvements aim to ensure more consistent and effective strategy deployment across the organisation.

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

Report to:	Board of Directors (Public)	Agenda item:	7.1
Date of meeting:	9th January 2025		

Report title:	Quarterly Strategy Update			
Status:	Information	Discussion	Assurance	Approval
	X		X	
Approval Process: (where has this paper been reviewed and approved):	Executive Directors			
Prepared by:	Tony Mears, Associate Director of Strategy			
Executive Sponsor: (presenting)	Lisa Thomas, Managing Director			
Appendices	N/A			

Recommendations:

1) The Board is asked to note the report and progress against our Vision Metrics.
2) The Board finds assurance in the process standard work surrounding our strategy deployment.

Executive Summary:

This paper is an update on the actions progressed to deliver the Trust strategy under the 3 Pillars- Population, People and Partnership. The Trust uses a strategic Planning Framework (SPF) to oversee the delivery of our strategy. To ensure the strategy is progressing the SPF identifies nine metrics to monitor to oversee delivery, these are the Vision Metrics.

- The paper shows progress in most of the vision metrics, there are a number where metrics and monitoring is still maturing, however progress in terms of input actions are outlined for the Board to consider.
- The paper sets out the process and support in place to ensure progress is made against the Vision Metrics and Strategic Initiatives.

The most significant risk to delivery of the five-year strategy remains the financial sustainability of the organisation and the need to work with system partners to develop a financial plan that ensures services can be delivered sustainably.

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

Contents

Introduction & Purpose

The purpose of this paper is to provide assurance to board across the suite of activity deploying our strategy. This includes what our strategy has set out, principally articulated through the strategic planning framework; what we have done; what we are going to do; and the means by which we will deliver. We are already experiencing the impact of our growing and ageing population, have formed our Hospitals Group, seen a change in government, are delivering a significant change programme in the EPR, and seen wholesale change to how community services will be delivered across our system. It is couched in this context that our strategic planning framework and Improving Together strategy delivery methodology keeps us on course. Strong progress has been made this quarter, with improvements, or the sustaining of previous improvements, across almost all Vision Metrics.

Since the last updated to board, Lord Darzi's Independent investigation of the NHS in England was published in September 2024[1] and is clear that a long-term plan is necessary to address the challenges of delivering fit for purpose care. The report set out several key findings that require attention in the upcoming 10-year plan, and that align to the long-term strategy of SFT.

The state of the NHS is not due entirely to what has happened within the health service. The health of the nation has deteriorated and that impacts its performance.

The report identifies the decreasing proportion of our lives spent in good health, backed by recent Office of National Statistics data[2]. This aligns to our health life years Vision Metric.

How long people wait, and the quality of treatment, are at the heart of the social contract between the NHS and the people.

Acute specific waits such as A&E targets, and the elective backlog, are specifically checked in the report. This includes an assessment that as many as 14,000 deaths a year may be attributable to long waits in A&E departments, more than all British armed forces combat deaths since the NHS was founded in 1948. Our Vision Metric targeting how many of our wait metrics are at median specifically focusses our long term work on recovering a position in which timely access to every aspect of our care is possible for our population.

The NHS budget is not being spent where it should be - too great a share is being spent in hospitals, too little in the community, and productivity is too low.

The need to 'left shift' services, long an ambition in think tank discourse, and even policy shifts from the last government toward integrated neighbourhood teams, seems to be here. The financial incentives are likely to change with greater ambition to meet deteriorating health in the community, and prevent acute admissions as well as the complexity of admission. Our partnership work on overall length of stay includes work with our system partners in this regard, as does our increase in healthy life years work. Our Organisational Sustainability vision metric includes our productivity and fiscal health improvement work, targeting the report's assessment that productivity is too low.

Further areas mentioned in the report that align to our Vision Metric work include patient engagement and staff engagement.

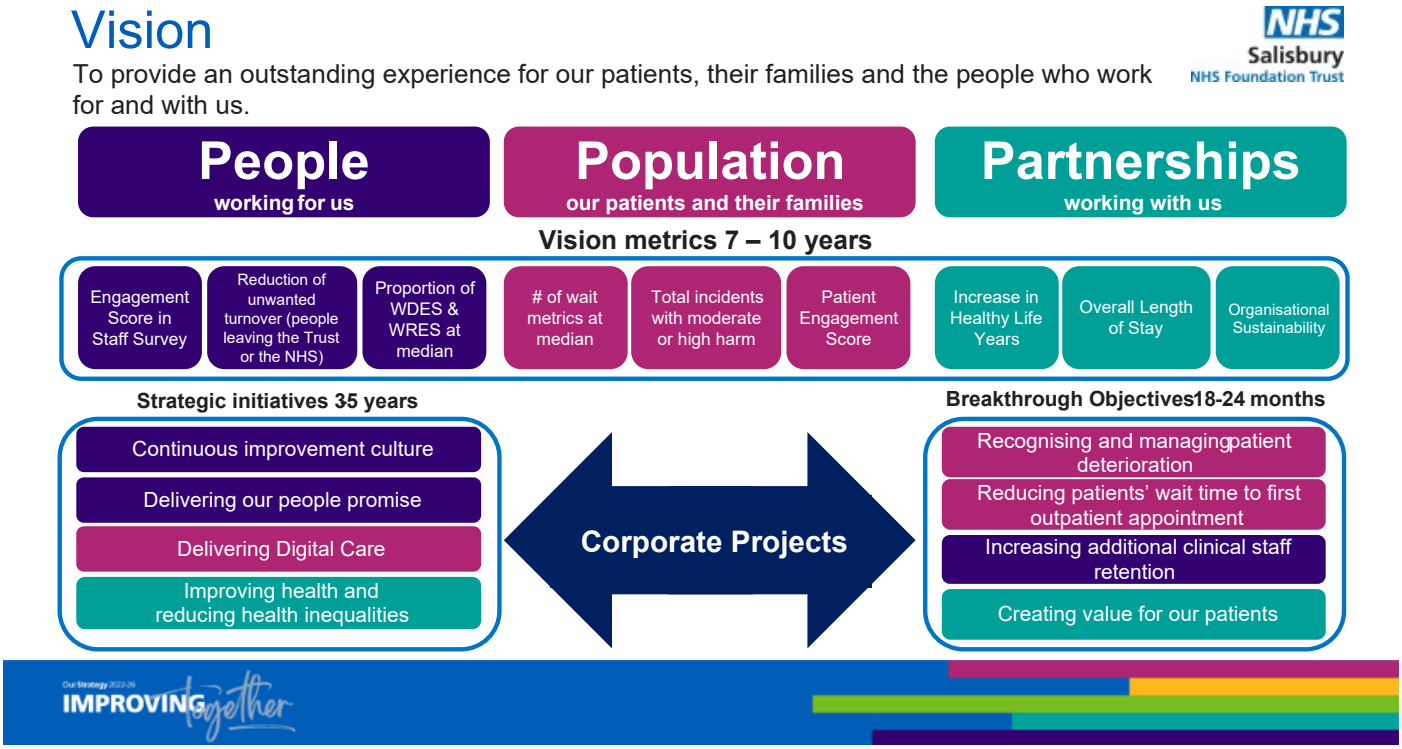
Overall, our Vision Metrics chart a similar course to that set out by Lord Darzi, on which the Department of Health and Social Care and NHS England's 10-year plan will set sail from 2025/26.

Our Strategy

The organisation's strategy is overseen through the Strategic Planning Framework (SPF), the three areas of focus People, Population and Partnerships all have assigned vision metrics which allow the organisation to track progress over a 7-10 year timeframe. Flowing from these are our:

[1] Independent investigation of the NHS in England - GOV.UK
[2] Trends in life expectancy and healthy life expectancy | The Health Foundation

- Strategic Initiatives, which are programmes of work we consider 'must do, can't fail' for our vision to be achieved; these deliver over a 3 –5 year timeframe and flow from multiple Vision Metrics.
- Breakthrough Objectives, which are programmes of work taking place over 18-24 months driving at key areas of improvement. Each Breakthrough Objective is the top (trust wide) contributor to a Vision Metric. I.e., the most significant cause of moderate or high harm is inadequately managing patient deterioration.



This paper is an outline of progress against our Vision Metrics and Strategic Initiatives as the principal means by which we track the delivery of our vision over the medium and long-term.

1) Population

The focus of the population pillar is to improve the health and wellbeing of the local population. This underpins a focus on good quality patient care and improving on how services are shaped and developed through public engagement.

Progress is measured through three Vision Metrics:

- A combined metric looking at Emergency Department 4 hour performance, Cancer performance, Diagnostic standard DM01 and 18-week RTT performance ("number of wait metrics at median")
- Reducing patient harm
- Patient engagement score.

Number of wait metrics at median

The combined performance metric is a way to measure whether patients are receiving timely access to care covering both planned and emergency care. The immediate challenges to recover waiting times even four years on from the Covid Pandemic remains a central focus for the Trust.

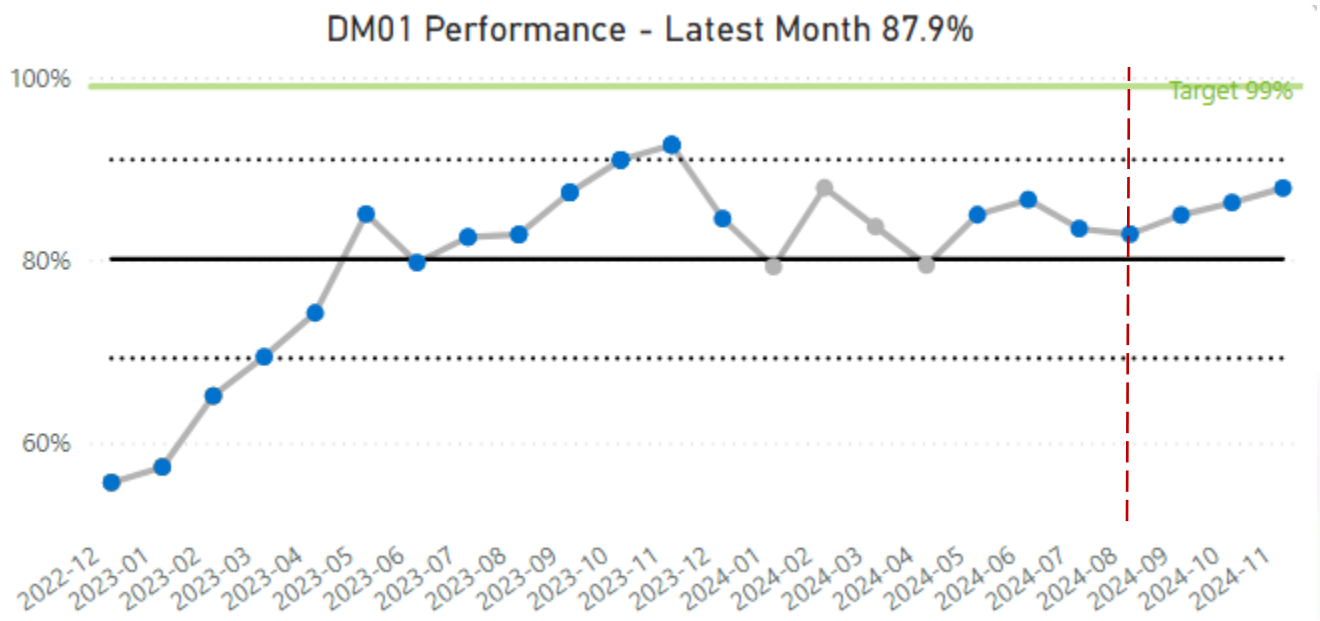
The longer-term strategic aim of replacing the day surgery unit is not only about addressing infrastructure risks,

but also creating an environment which will maximise efficiency and opportunities to reduce waiting times. The ability to attract national capital funding remains a significant challenge. The Campus redevelopment programme, of which a new DSU is a significant part, remains a focus and work is ongoing with regular updates to Board. The age and environment of the estate remain a significant risk and is reflected in the BAF.

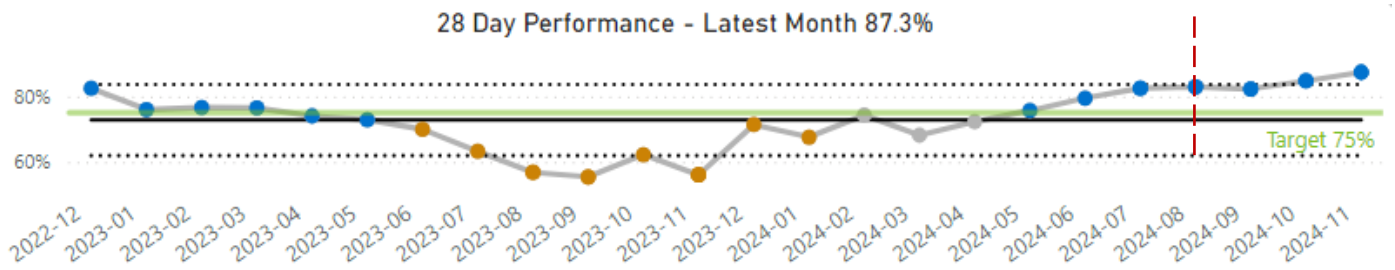
Analysis suggests our population is ageing, with an 87% increase in over 85s projected by 2040, a demographic shift that will put enormous pressure on public services across our system, and our own acute services. As a result, the models of care will need to change to meet a frail elderly population with ever more complex co-morbidities.

Diagnostics (DM01) has improved steadily over the past 24 months and continues to perform against plan for 24/25, aiming to achieve above 89% by March 2025 as per the Trust Performance Trajectory submission for this year. Planning guidance for 26/27 is awaited and we can expect a minimum of 95% target for next year but a possible stretch target to 99% could be required. The same modalities as this year will form part of our continued planning and it can be expected that oversight of histopathology turnaround times will be required as well (expected in 25/26 but not yet formalised). Waiting times have reduced this year due to improvements across Ultrasound in the early part of the year, increasing workforce capacity through incentivised overtime (now adopted by system partners) insourcing during Q1 and some positive increases in substantive recruitment. Endoscopy have also achieved increased capacity during Q3 as a result of fourth room being staffed and available for booking as well as some insourcing that the Cancer Alliance have supported with funding. Of note, the Trust DM01 position now includes patients with an overdue surveillance date across all modalities which is a positive step forward in terms of ensuring that there is an equity of access for all patient groups. Performance and improvement priorities are discussed via weekly department waiting time access group meetings or huddles, as well as the weekly Trust Delivery Group.

The Trust is part of the Community Diagnostics Centre (CDC), where an increase in diagnostics capacity in the community will improve cancer diagnostic rates in the local population. The Trust is an integral part of providing the service and working with primary care to ensure timely access. SFT CDC currently offers patients access to CT, MRI, Ultrasounds and Cardiology Echocardiography with the latter two ‘going live’ from late November and CT and MRI available from March 2024. There have been design and infrastructure challenges in year which caused some delay to the start date of Ultrasound and Cardiac Echocardiography (originally start date was early Q2). Activity delivery is monitored weekly via Trust Delivery Group and there is a monthly SFT CDC Delivery Group led by the Divisional Director for CSFS which reviews performance delivery as well as looking forward to improvements and expansion of the SFT CDC. A system business case is in development for expansion of CDC into 25/26 and 26/27 and for SFT this includes capital bids for fixed CT and MRI scanners (currently delivered via InHealth mobiles), additional Ultrasound room and equipment, audiology suite, fibroscanning (gastroenterology) and phlebotomy. The associated activity and workforce plans for the capital bids form part of the business case development and this is being coordinated by the BSW Programme Director for CDC.



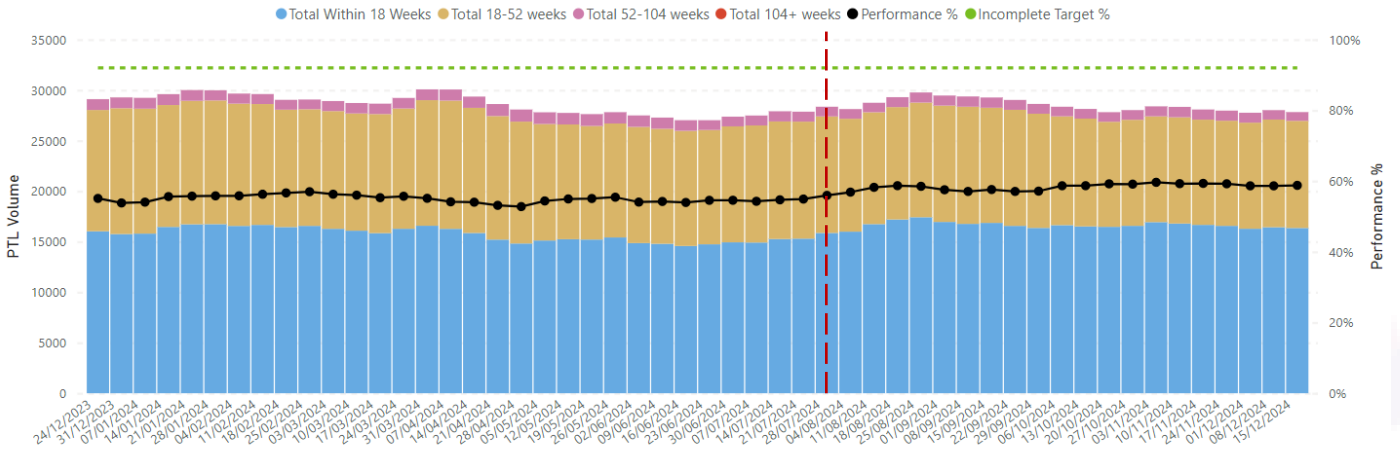
SFT has now exited national monitoring for cancer performance, exiting alongside GWH having both achieved the criteria necessary to provide assurance to region regarding the improvements made. 28-day Faster Diagnosis Standard (FDS) performance improved to 80.2% and back above the target of 78%. 62-day improved to 78.7% and back above the target of 70%. Both beyond trajectory and meeting operational plan standards.



A weekly Cancer Improvement Group meeting monitors early warning signs of deteriorating performance, keeping particular focus on first seen waits (previously nationally monitored two week wait standard) to ensure that low waits at first seen are sustained. This supports compliance against the 28d performance. For the Trust to continue to maintain its strong performance in 28d, the first seen waits in the Breast and Skin pathways need to remain within two weeks. This is because these specialties are high volume and if they become non-compliant against 28d then the whole Trust position will be at risk.

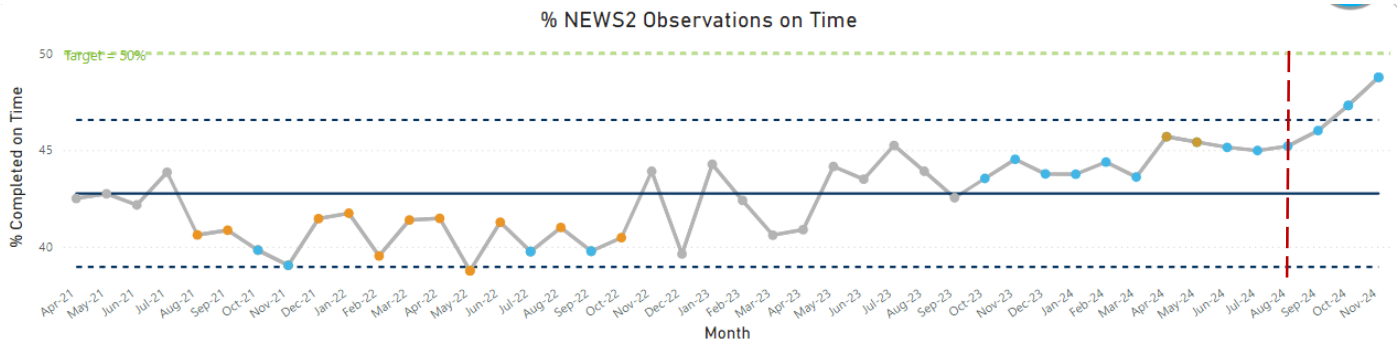
In the medium term the focus on diagnostics and improved networked pathways will improve outcomes, with particular focus on best practice timed pathway improvements within Urology and Colorectal. Both Urology and Colorectal have been slower to improve against the 28d performance standard in year although due to improving endoscopy capacity the SFT position is nearing 70% for the first time in two years. Once a month at Cancer improvement Group the operational teams present their A3 and countermeasure updates to ensure continuous improvement is sustained.

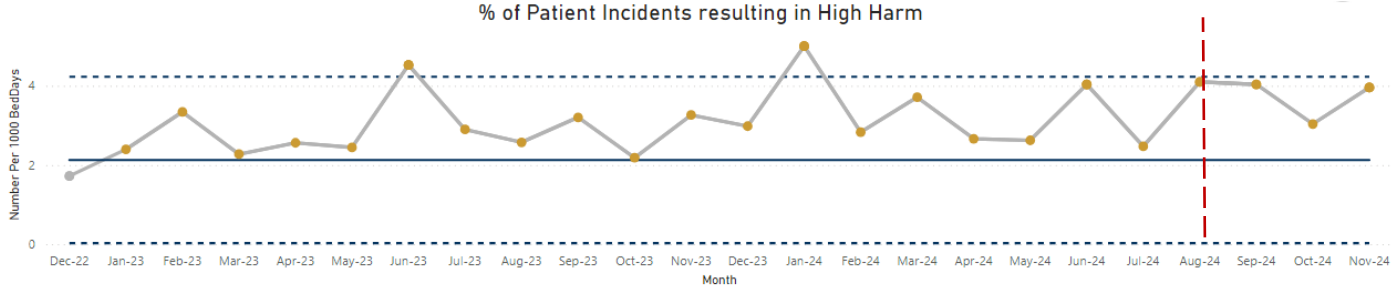
Our 18 week waits for referral to treatment (RTT) has been static at ~59% in 2024/25, against the national target of 92% that has recently formed part of political interventions from the government. The expectation is that 92% performance is recovered by the end of the Parliament (2029), as such the improvement to 92% is unlikely to be required in 2025/26 but rather a milestone on route to that. Our performance is heavily impacted by a small group of services (plastics, dermatology, and oral surgery) making up over half of the cohort waiting over 52 weeks. Shorter term work including the redesign of central booking, and the standing up of Planned Care Board, are tactical responses to help deliver our longer-term strategic position on waits.



Patient harm

The focus on quality improvement is outlined in the quality accounts which illustrate the range of improvements for the last year. The metric used to monitor the vision metric is 'patient incidents resulting in high harm'. The in-year breakthrough objective is to reduce patient deterioration through improving our percentage of 'NEWS2' subsequent observations completed on time. This has seen strong improvement over the past quarter.

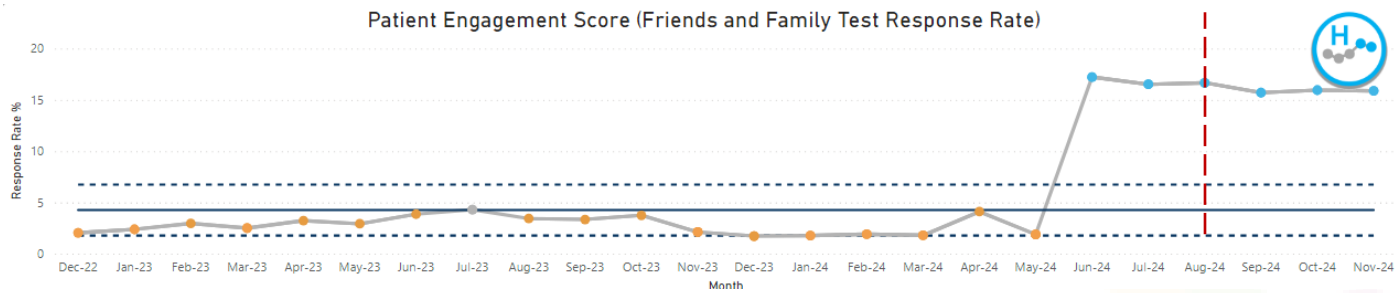




Patient Engagement Score

The Trust had identified a need to improve patient engagement to develop services that are responsive to the population's needs. The most objective way to measure engagement has been through the Friends and Family Test (FFT). Due to the FFT, historically, being paper based we implemented a digital solution in June 2024. This has dramatically increased response rates from ~3% to upward of 15%. This improvement has now been sustained and provides us with richer commentary we can use in our improvement work.

PALs have now established a quarterly meeting drumbeat (commenced from October 2024) and are trialling peer benchmarking / review methods.



2) Partnerships

Our partnership work has centred on our maturing Group model. Now all three hospitals are further on in their development with improving together, we are working toward a Group SPF. In the medium term we will align any Group strategy to the overall ICS strategy published in 2023. There are three immediate priorities we have focused on as the BSW Hospitals Group, they are:

- The development of the joint Electronic Record (EPR)

- The development of our approach to deeper working with community and primary care in pursuit of a true 'left shift' of services, and
- Maximising productivity opportunities across our organisations.

The Trust continues to work in partnership at Place. The ICB completed their change programme, reducing staffing levels by 30%, in September 2024 and working relationships have now been reestablished with the new team structures. The reduced ICB capacity to invest in joint working at Place is both a risk and an opportunity for the Trust as we develop place-based delivery partnerships to ensure the shared aim of integration moves forward. In the medium term our agreed partnership working strands across the ICS, and monitored at system by 'Planning and Delivery Executive Group' (PDEG) are:

- Urgent Care
- Planned Care
- Acute services sustainability review
- Community & Primary Care
- Mental Health
- Workforce
- Medicines management
- Procurement
- Consolidation of corporate services
- Estates and facilities rationalisation

The importance of our tertiary networks with University Hospitals Southampton remains central to delivering high quality services. Our work continues to establish a partnership board with CMO and COO representation. There are obvious operational benefits of continuing to improve services and access for our patients (oncology, plastics, and cancer pathways in particular urology and respiratory) but in addition there are opportunities to improve SFT's scale of planned care services.

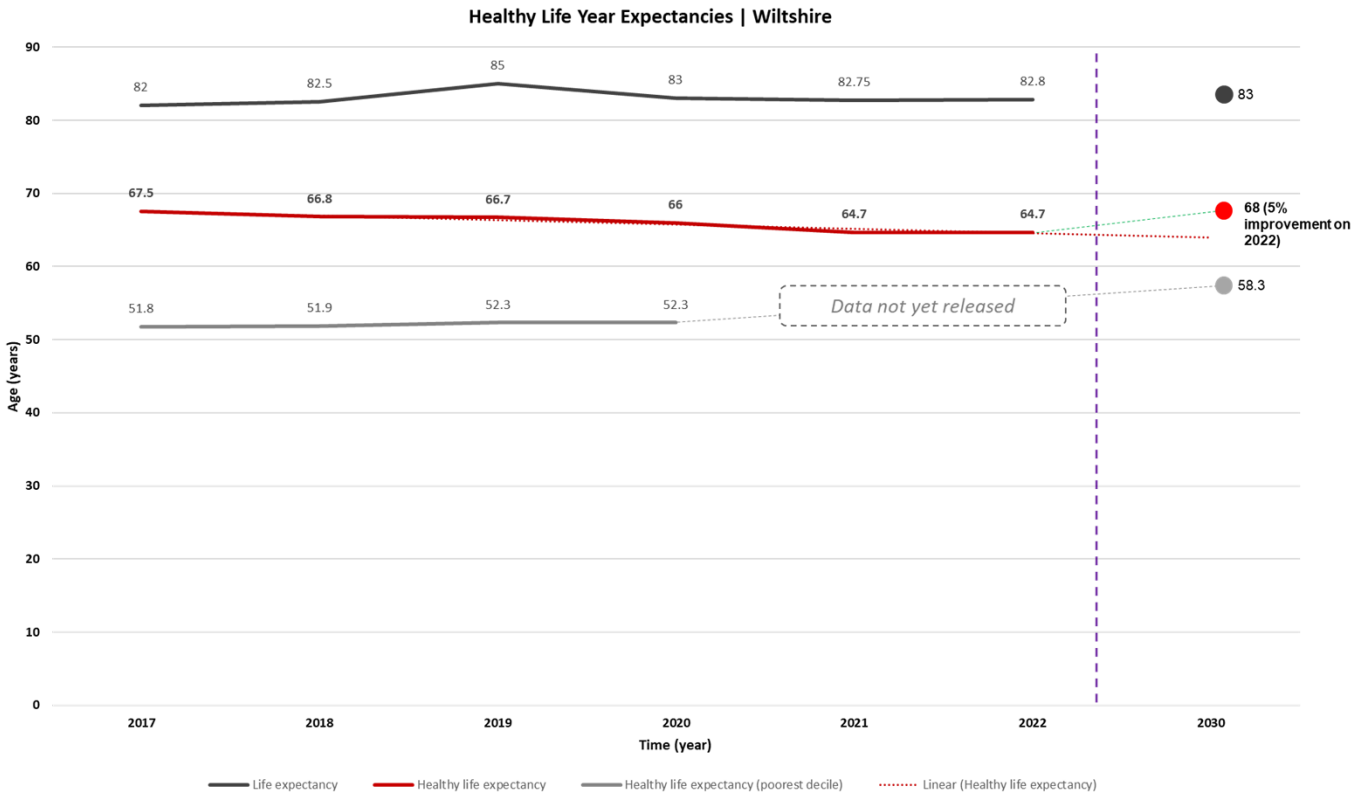
The metrics monitored for progress against our Partnership pillar are:

- Increase in healthy life years.
- Overall length of stay.
- Organisational sustainability.

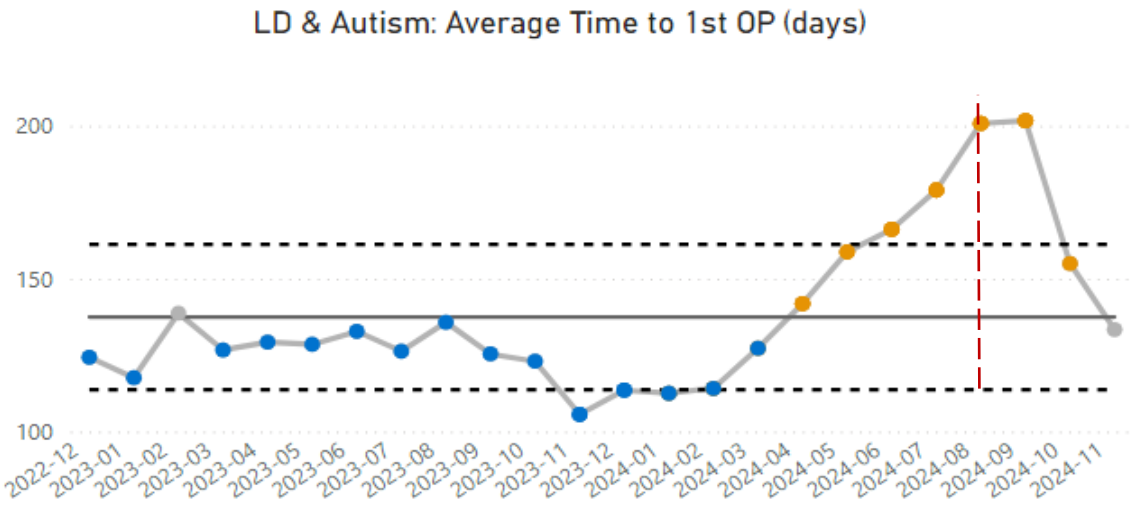
Increase in healthy life years

The A3 thinking behind this Vision Metric is currently being refreshed after 12 months with little iteration and now with the involvement of a broader group of internal SFT colleagues stood up to support the development of the Vision Metric. The information which underpins this metric currently sits within the system population health architecture and national data is only available every 2-3 years. As such we are developing proxy metrics that have historically tracked the headline healthy life expectancy measure and could be relied upon to do so in future at a quarterly cadence. There are several system working groups (from the BSW population health board and it's sub groups, to the local authority inequality programmes) underpinning the programme to influence the wider determinants of health. Our Strategic Initiative 'Improving health and reducing health inequalities' is derived in part from this vision metric.

The national position regarding healthy life expectancy is falling as the impact of the pandemic and growing socio-economic inequity continue to be felt within the health of the population. The below graph sets out the trajectory for healthy life years based in Wiltshire, and the impact of a 5% improvement.



Over the past quarter we have been progressing smaller packages of work internally to ensure that improvement is made in areas we do have control. The below chart shows the progress made to tackle long waits for those with learning disabilities and autism following focused improvement work with operational colleagues. There is evidence that people with learning disabilities have poorer health and experience greater and persistent healthcare inequalities. This is highlighted in the Learning from Lives and Deaths report in 2021[3], which shows disparities in avoidable medical causes of deaths between those with a learning disability and the general population.



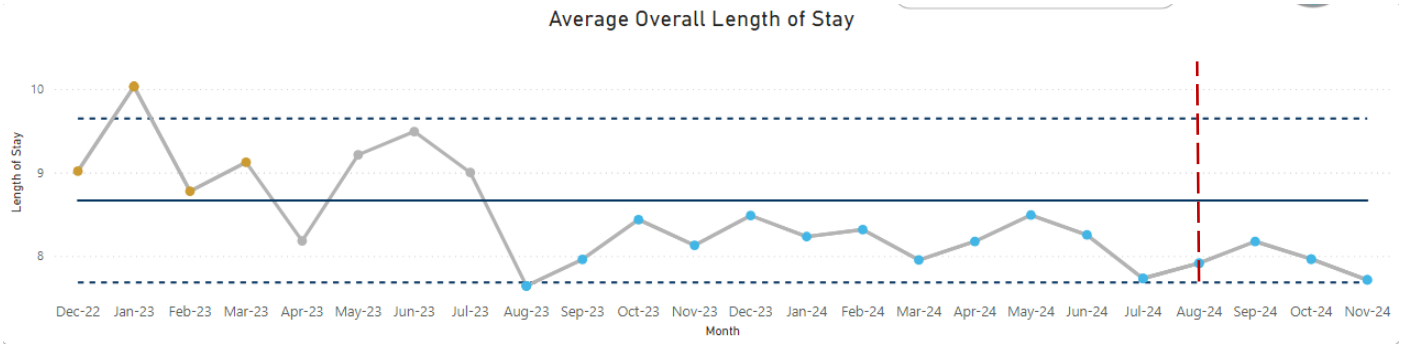
[3] LeDeR-bristol-annual-report-2020.pdf

Overall Length of stay

The focus on length of stay recognises there has been an increase in length of stay over the last four years with patients not achieving optimum pathways from both a patient experience and outcome basis. With patients waiting for onward care (no criteria to reside (NCTR)) increasing from c40 in 2019/20 to over 125 in January 2023. To improve integrated care and help patients return to their usual place of residence the Trust has been working closely with partners to improve pathways.

In the last 18 months this has meant the length of stay has reduced by 1 day across the whole Trust. This has been driven through Trust wide initiatives such as Same Day Emergency Care (SDEC) and Acute Frailty Unit.

The system work has focused on increasing capacity to support patients in their own homes with a move away from bedded capacity (move to increase pathway 1 and reduce pathway 2). This has enabled a reduction in NCTR closer to 90 on average, albeit with recent peaks at ~100. The NCTR Vision Metric is now owned by the Urgent and Emergency Care Board and will be iterated in line with their understanding of the root cause analysis. The plans for 2024/25 continue to focus on this metric with an aim of reducing NCTR to being maximum of 14% of occupied beds with a stretch target of 5%. *(The below data excludes the Spinal Unit.)*

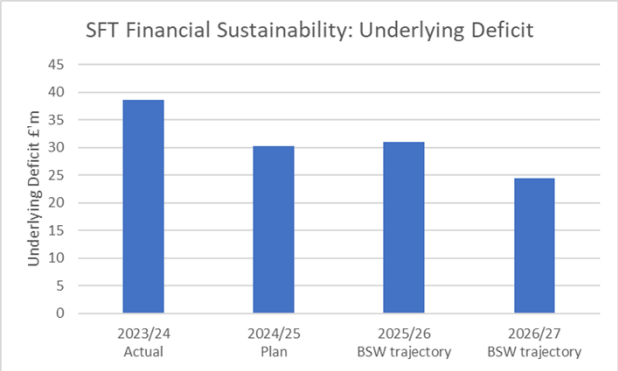


Organisational Sustainability

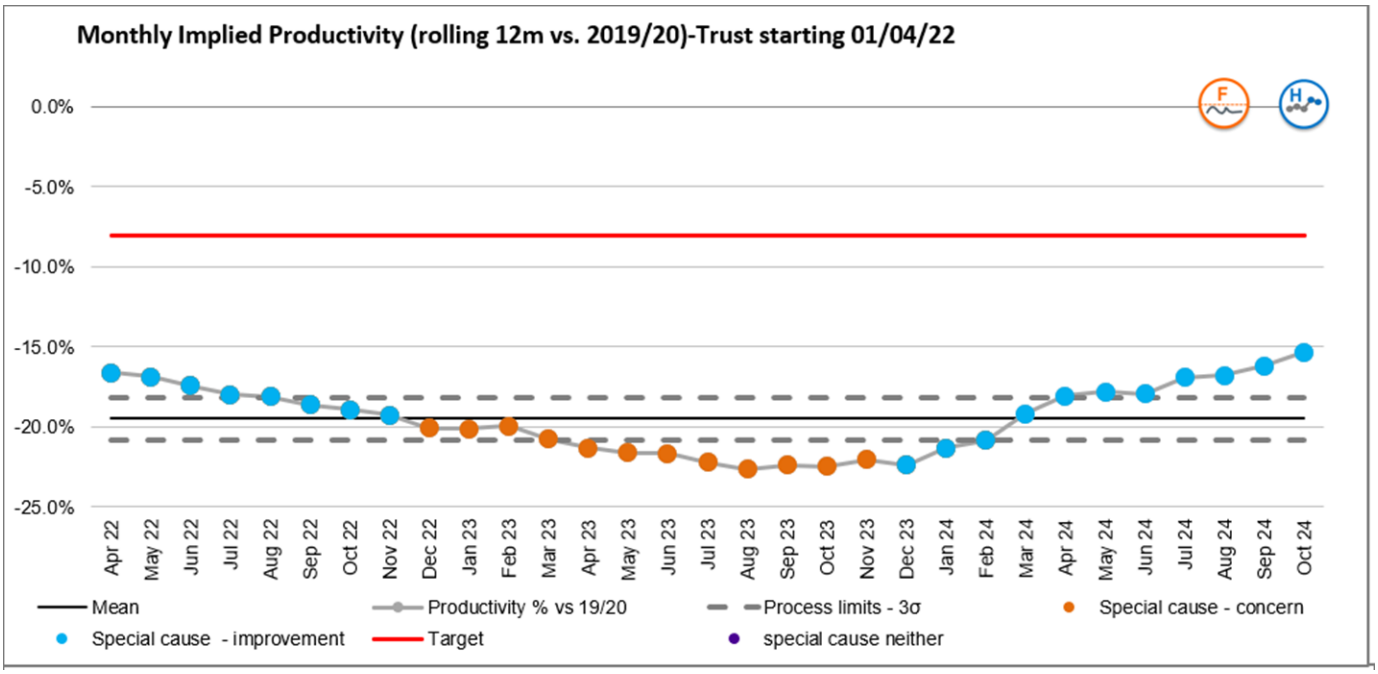
The key elements which underpin this priority include: financial sustainability, having an infrastructure that reflects the needs of a modern hospital (including environmental sustainability), and our role as an anchor institution. The metric used to measure our progress is our deficit as a percentage of turnover, validation of this metric is currently underway. The underpinning assumptions, at a system level, is to address the expected future demand me must move resources from secondary care to prevention and out of hospital provision.

Finance and strategy colleagues continue to engage with BSW to iterative the medium term financial plan ‘MTFP’ across our ICS and this will help to deliver on underlying drivers of financial challenge we must work on together as a system – such as length of stay and prevention. Shorter term, and SFT focussed, work continues to focus on productivity and delivering value for the patient.

At this point, the most material contributor on the A3 for Organisational sustainability is the underlying deficit of the organisation, this is therefore taken as the proxy measure in advance of the full development of the hybrid measure set out above. As the Trust exited 2023/24 this stood at a £39m deficit, with a 2024/25 operational plan driving at reducing this down to £30m, inclusive of a £21m cost improvement programme.

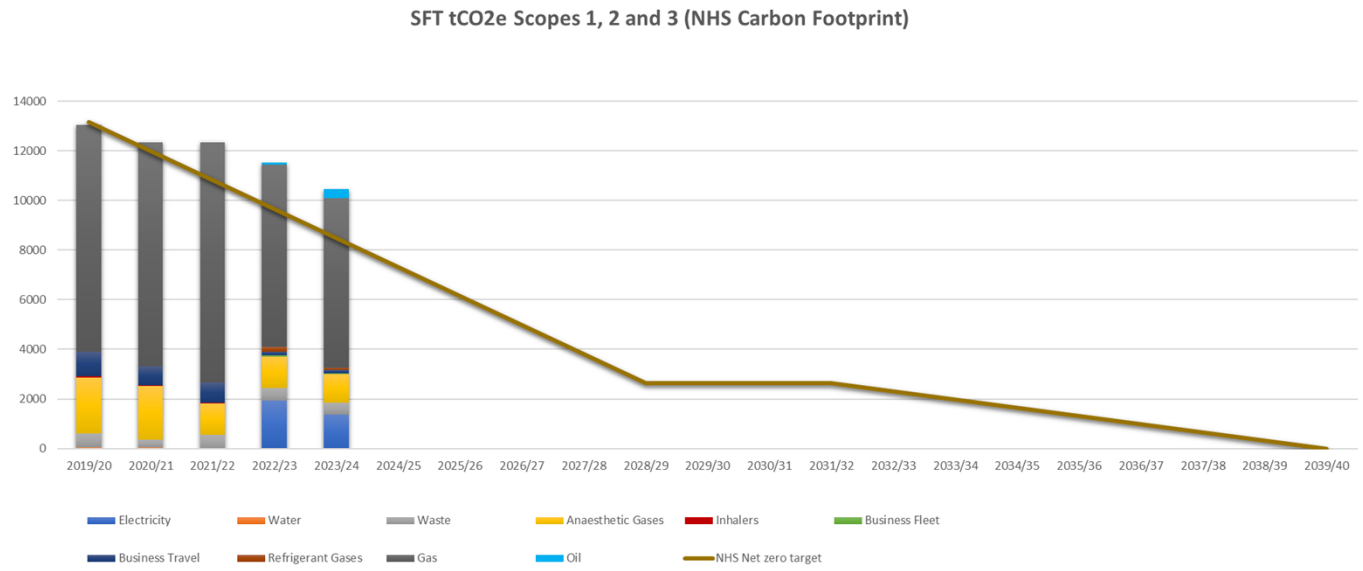


The primary mechanism for delivery against the Organisational Sustainability vision metric is the 'Creating Value for our Patients' breakthrough objective, measured through calculating the movement in the ratio of activity output to cost base and comparing to a baseline of 2019/20, this metric is known as 'Implied Productivity'.



Our sustainability and green plan work continues under the structure of the sustainability committee and with dedicated resourcing through our sustainability lead. More solar power is generated than ever before (14% of our total usage, up from 4%) and progress to extract geothermal energy from the site continues with feasibility studies concluding we can extract 100% of our total energy requirement from this source. The carbon footprint graph below shows our declining emissions against the (line) NHS net zero target.

While a focus on financial and organisational health is crucial for our immediate success, it is important that we also recognise the long-term value of environmental sustainability. Our environmental sustainability is not just a regulatory requirement or a trend; it is a pathway to innovation and differentiation. The alignment of environmental initiatives alongside financial goals will not only enhance our reputation but also attract stakeholders who are increasingly prioritising sustainability and ensure we can offer care to our population while fulfilling our climate and energy obligations.



3) People

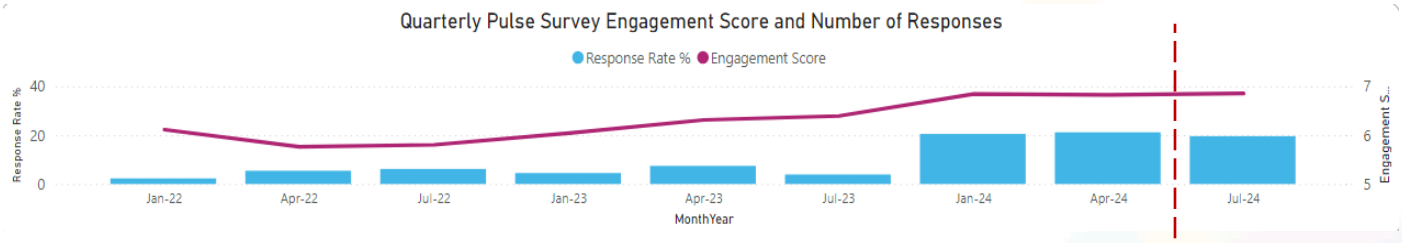
Recognising the workforce of SFT is paramount to delivering safe and effective care. The national people plan was published in 2020 which outlined the expectations of NHS organisations to ensure the NHS has a compassionate, inclusive, and positive culture for staff. The SFT strategy reflects the national ambition with focus on specific improvements for the SFT workforce. The People and Culture Committee oversee delivery of the People strategy with regular updates to Board. To measure progress 3 vision metrics are being monitored:

- Engagement score in the staff survey
- Reduction in turnover
- Proportion of WDES and WRES at median

Engagement score in the staff survey

Engaged staff are critical to delivering our vision. NHS England run the annual staff survey and the previous report showed significant improvement for among SFT staff regarding both response rate and the positivity of those responses.

In addition to the national staff survey, which has not updated since the last report, we also run our own quarterly ‘pulse’ survey, and the below data demonstrates a sustaining improvement of engagement among staff thanks to our active soliciting approach including direct email and rewards such as the free lunch.

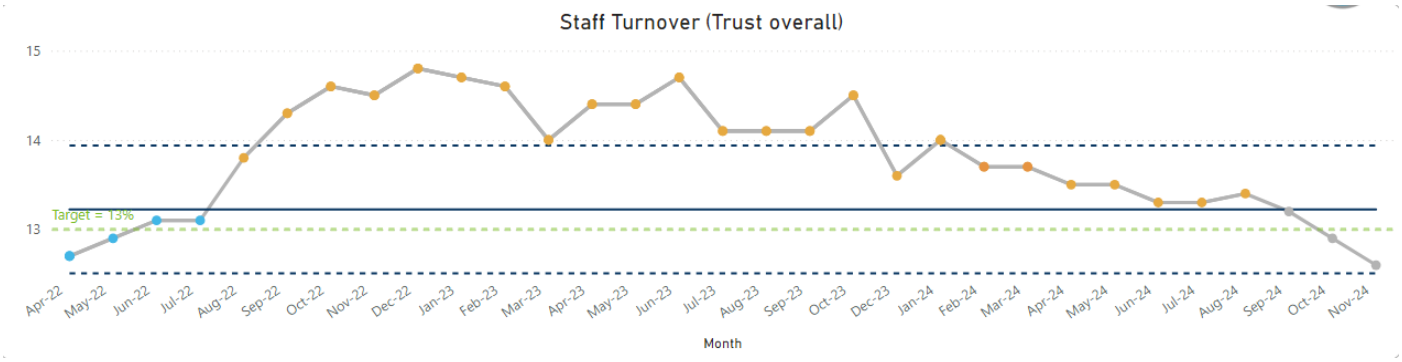


Reducing unwanted turnover

Our ‘increasing staff retention’ short term breakthrough objective is derived from this vision metric to reduce unwanted turnover.

The metric for turnover showed improvement throughout 2023 and the data suggests this improvement has embedded throughout 2024 and has now improved significantly since the last report thanks to a focus by the

OD&P team in understanding root causes such as colleagues moving on after their funded accommodation period due to the cost of housing in Salisbury, or applicants understanding what certain role types really entail to reduce early resignation. In the shorter term there is a focus on HCA roles, this may shift to admin and clerical groups as improvement in the HCA position is embedded.

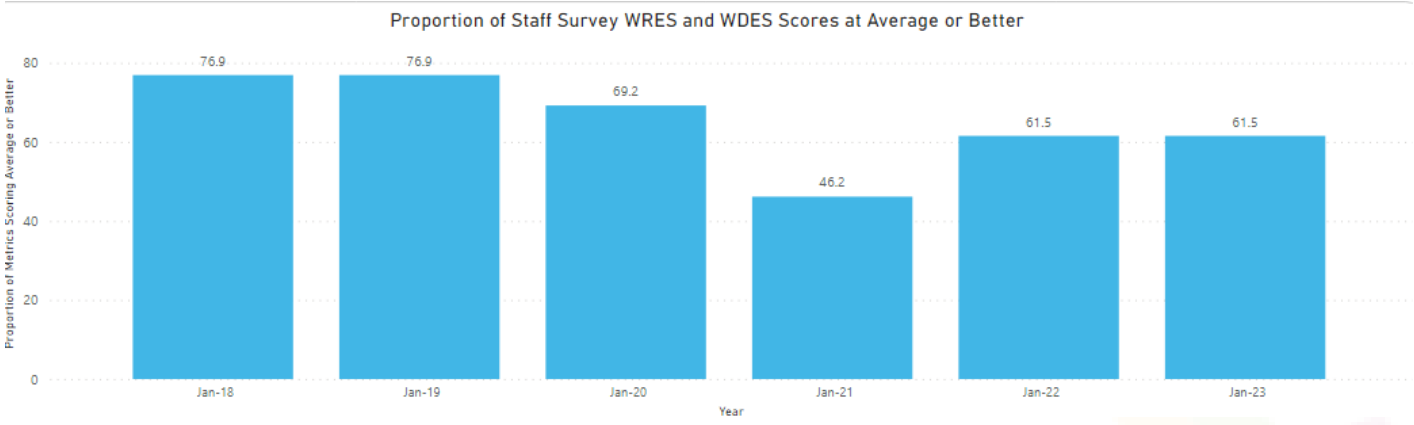


Proportion of staff survey scores at median for - Workforce Disability workforce standard (WDES) and Race Equality workforce standard (WRES)

Throughout 2024 our EDI Long Term Plan has been re-written and published, this encompasses the SW Leading for inclusion work, implements the NHSE six high impact actions and sets the long-term operational milestones to move the culture of the Trust in a positive direction and enable a sense of belonging for all.

Due to it's link to the national datasets, this metric has not updated since the last report. We expect new data to be available by April 2025.

Staff survey results have demonstrated a number of areas where our people are less positive, including Black African Staff, Disabled staff, those who identify as bisexual or are unwilling to state their identity in the survey and our youngest staff members. Immediate actions include improving the culture through training interventions to educate staff and provide support tool for managers, creating EDI objectives in our senior managers, and improved interventions to ensure appointment panels are diverse, inclusive and fair for all staff. Finally, work has taken place to support international staff with training for CV writing, interviews and professional development bids.



Vision Metric Conclusion

Overall, the Trust is making progress in implementing its 2022-2026 strategy, and long-term vision for 2032. Most Vision Metrics have shown positive progress in the last quarter. Oversight of progress by the executive team is through the engine room and regular updates will continue to be provided to Board. The next steps include:

- Finalising monitoring and data collection for all nine-vision metrics for oversight in the Engine room.

Including watch and balance metrics where appropriate.

- Continue refining alignment of the progress against the vision metrics with the BAF to ensure risks to delivery are well articulated and understood.
- Finalise the system medium term financial plan to ensure organisational sustainability through the medium term.

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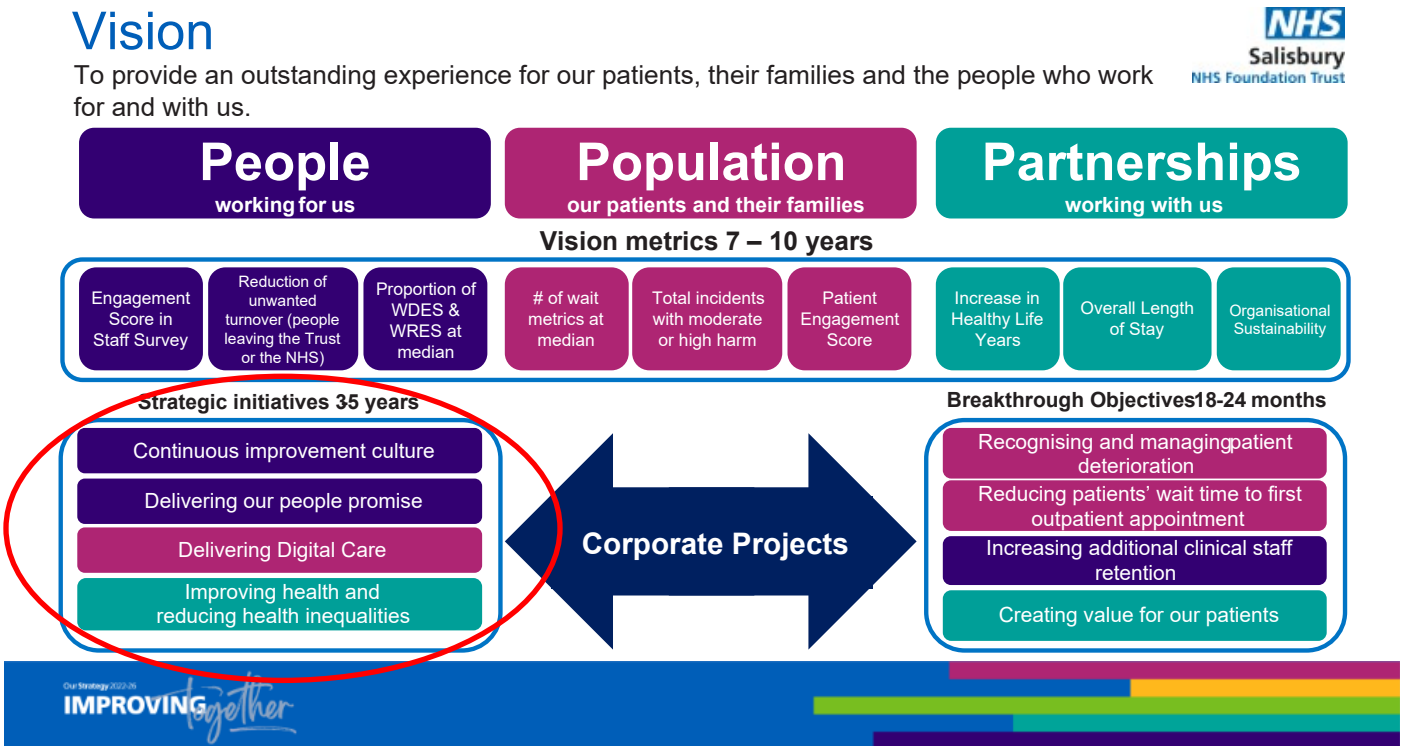
Strategic Initiatives

Strategic Initiatives are must-do, can't fail, packages of work over a 3-5 year time horizon supporting achievement of our Vision. They are corporately led and should positively impact multiple Vision Metrics.

Each Strategic Initiative has an executive lead and is then owned and driven by a named individual and forum within the organisation. The below sections summarise our Strategic Initiatives and progress against them over the last quarter.



Continuous Improvement Culture

Executive lead(s)
Judy Dyos & Alex Talbott

Owning forum(s)
The monthly Improving Together Board oversees the programme of work underpinning this Strategic Initiative. A bespoke team consisting of representation from our leadership development, coach house, transformation, and strategy teams meet monthly to iterate this Strategic Initiative.

Description
Salisbury NHS Foundation Trust faces challenges in achieving Operational Excellence and embedding a culture of continuous improvement, aligned to the Shingo principle of align, enable, and improve. We have not yet fully realised our potential regarding the adoption of improvement tools and methodology. This includes enabling all staff and teams to realise and recognise improvement opportunities, as well as sharing and celebrating the improvements they are making throughout the Trust. We have not yet fully embedded our leadership behaviours and shifted our culture to make improvements part of day-to-day activities and adopt the 'inch wide, mile deep' mindset.

Golden thread
This Strategic Initiative flows from three of our Vision Metrics – Organisational Sustainability, Engagement score in staff survey, and reduction in unwanted turnover. It is also unique in that the successful realisation of this

strategic initiative is the embedding and deployment of our entire operational management system methodology, and therefore the entire strategic planning framework.

Governance and assurance
The progress of this work is reported via Improving Together Board, which escalates through Trust Management Committee, and on to Trust Board.

Progress
In the last quarter 442 more members of staff have completed a leadership programme, Improving Together has its own dedicated online resource for staff, and our work across BSW Hospitals Group has been nominated for an HSJ Partnership award. The Trust also hosted the Catalysis CEO Forum for operational excellence organisations and is beginning to act as a thought leader to our peers with visits from our BSW Hospitals Group colleagues into the executive Engine Room (Strategy Deployment Room) and multiple visits planned for NHS organisations from across England.

Work continues on organisational wide leadership behaviours and their criticality in delivering the methodology. Our internal training programmes for Transformational leaders, Aspiring leaders and Improving Together continue to develop their alignment and integration to create the most value form our collective team resources.

A Sustainable Workforce

Executive lead(S)
Melanie Whitfield

Owning forum(s)
The monthly OD&P directorate management board has ownership and oversight of the Sustainable Workforce Strategic Initiative, this has broad representation from across the People function.

Description
To meet healthcare development challenges, and changes to population demographics, SFT will require the development of new ways of working and a workforce adapted to meet these needs. Our capabilities and capacity to meet service demands depends upon our ability to identify and sustain future workforce needs. SFT employs over 4,400 WTE substantive staff, supplemented by bank workers and agency when required. The Trust strategy and NHS long term workforce plan have identified the need to grow the workforce to meet future demand – this activity requires clear clinical strategy matched to strategic workforce plans and alignment of training to deliver new roles and skill sets. The population of Salisbury and the reasonable commute radii is insufficient to meet this demand for specialist staff, particularly medical staff. Widening participation is needed to open new careers to previously excluded groups.

Golden thread
This Strategic Initiative flows from four of our Vision Metrics – Organisational Sustainability, Engagement score in staff survey, reduction in unwanted turnover, and the proportion of our WDES and WRES scores at median. This Strategic Initiative also connects to our Breakthrough Objective to increase staff retention among our additional clinical staff workforce (HCAs, MCAs, RCAs).

Governance and assurance
The progress of this work is reported to OD&P Management Board, which escalates through Trust Management Committee and People and Culture Committee, then on to Trust Board.

Progress
In the last quarter the first draft of a workforce strategy has been produced and is currently being refined. This has coincided with briefings from system colleagues that a WTE reduction is likely necessary in the next financial year, complicating further our need to grow and shape our workforce to meet increasing, and ever more complex, demand on our services.

Analysis continues of the top contributors to a sustainable workforce and the level of detail beneath. For example, the poor sense of staff belonging and the link to career pathways. Or the refinement of turnover underlying causes, be that by professional group or demographic factors like age.

Delivering Digital Care

Executive lead(S)
Mark Ellis, Jon Burwell

Owning forum(s)
The monthly Digital Steering Group have regular sight of the Strategic Initiative A3, however there is significant individual leadership applied to this package of work which is maturing into a more group / forum based approach.

Description
Digital maturity considers whether organisations have the infrastructure, culture and capabilities in place to maximise the use of digital to enable improved patient care and population interaction within a secure environment. The Trust has a low digital maturity, meaning that the Trust is not able to deliver on patient expectations and there will be missed opportunities in delivery improved/effective care through the lack of joined up systems, electronic processes and comprehensive???. The key causes of these challenges are our EPR (Lorenzo), staff digital literacy, the maturing but not yet mature PowerBI capability, and the digital maturity in health organisations compared to society writ large. The principal countermeasure, and the source of significant organisational focus, is our shared EPR programme with BSW Hospital Group partners and Oracle Cerner.

Golden thread
This Strategic Initiative flows from three of our Vision Metrics – number of wait metrics at median, total incidents with moderate or high harm, and overall length of stay. Similar to our culture of continuous improvement Strategic Initiative this package of work touches everything we do in the organisation and as such is a critical enabler to our entire offering to our population.

Governance and assurance
The progress of this work is reported to Digital Steering Group, which escalates through Trust Management Committee, and on to Trust Board.

Progress
In the last quarter shared EPR programme work has ramped up, with focus on pathway alignment and optimisation across the Group. The has been further development of a digital skills framework to underpin assessment of training needs, in line with the national programme. A connectivity upgrade pilot programme with Longford ward, the upgrading of Pathology systems, and full Imber connectivity are all now complete. Work has continued across the ICS to develop a clear roadmap and improvement programme for the use of Population Health analytics.

Improving Health & Reducing Health Inequalities

Executive lead(S)
Duncan Murray

Owning forum(s)
A hybrid internal / external forum, the monthly ‘Wiltshire Health Inequalities Group’ (WHIG) has partly owned the iteration of the A3 over the past 18 months as much of the work is dependent on partnership working and influencing. This is co-chaired by a public health consultant at Wiltshire Council, the SFT Associate Director of Strategy, and the SFT Associate Medical Director for Inequalities.

Additionally, since August 2024, a monthly internal operations group consisting of the Deputy Chief Operating Officer, Associate Director of Strategy, Head of Business Intelligence, Head of Performance, Surgery Divisional Manager and Associate Medical Director for Inequalities has been meeting monthly to address internal only actions and countermeasures.

Our approach to aligning these forums and actions is maturing.

Description
Those experiencing the most significant socio-economic deprivation in our community are also experiencing the poorest health outcomes. The Wiltshire joint strategic needs assessment (JSNA) has produced evidence of the

causes for health inequality within our 'place' (Wiltshire). The biggest drivers/categories are:

- Population & Deprivation
- Education & Employment
- Alcohol, drugs, smoking, weight, and physical activity
- Housing, crime, and the environment
- Disease and ill health
- Life expectancy and causes of death

These are compounded by environmental drivers such as rurality which affects access, digital inclusion, social isolation, fuel poverty, and reduced access to employment.

While partnerships are forming to tackle these, it is reasonable to expect an acute provider to be able to target a few of these. Trust action has been twofold. Firstly, influence external partners to take action with their resources in line with our analysis of the problems – for example our leadership role in how the local authority and ICB allocated £0.8m of funding for health inequality projects. Secondly, our internal actions to reduce inequity in the aspects of care within our control – for example the LDAN work mentioned in the healthy life years vision metric update above.

Golden thread
This Strategic Initiative flows from three of our Vision Metrics – number of wait metrics at median, patient engagement score, and increase in healthy life years.

Governance and assurance
The progress of this work is reported externally from the WHIG to BSW Population Health Board and on to the Integrated Care Board, and internally through Clinical Management Board, and on to TMC and Board.

Progress
In the last quarter the next iteration of the BSW health inequalities funding process (2025/26) has been finalised with SFT playing a leading role in pushing the targeting of that funding at CORE20PLUS5[4] priorities. Our internal alignment of inequality activity has matured further with smoking cessation and child Asthma workstreams reporting into the WHIG. Our internal work has also produced results with waits reducing for our learning disability patients waiting for CVD related care; further work is not underway at the sub-Strategic Initiative A3 level to understand which cohorts of patients to prioritise next for improvement.

Governance

As an organisation SFT has focused on maturing our understanding of Breakthrough Objectives, ward level improvement (and huddles), executive deployment leadership, and the scorecard agreement cascades. We have learnt from colleagues across the Catalysis CEO Forum that this is a typical first cycle of a maturing continuous improvement OMS. That has meant our Strategic Initiative and Vision Metric g process standard works have remained immature. Over the last quarter this has begun to shift. The new suite of processes around these critical parts of our strategic planning framework are detailed below. We continue to learn and iterate as we do so but are already feeling the benefits of alignment within the organisation.

Vision Metric Governance

Each Vision Metric should have an executive lead and a nominated working level lead with associated forum to iterate the A3 and ensure that Vision Metric identified countermeasures are reflected in the broader work of the organisation. In reflecting on our learning to date we now understand this has not consistently been the case and as such have stood up a number of new measures to improve the quality and consistency of Vision Metric work within the OMS and provide clearer visibility to executive and Board colleagues:

[4] NHS England » Core20PLUS5 (adults) – an approach to reducing healthcare inequalities

- Vision Metrics have had executive leadership confirmed and named owners at the deputy layer of the organisation tasked with updating current thinking and pulling together appropriate groups to support the work. In 4/9cases, these are existing forums.
- Vision Metric 'clinics' have been diarised monthly by the Coach House and Associate Director of Strategy to support Vision Metric owners and associated forums to iterate their A3 thinking and keep the work live as well as updated for Engine Room discussions and to improve the quality of these reports to Board.
- Assurance routes are being clarified to ensure that each Vision Metric is reporting to the relevant parts of the organisation and up to Board.

We are iterating and learning as we improve our routine governance processes, until such time as we reach maturity this report will feature an update on our progress.

Strategic Initiative Governance
Similarly, each Strategic Initiative should have an executive lead and nominated working level owner and forum. This is in place for all of our Strategic Initiatives, but to varying degrees of efficacy and maturity. There has also been a mixed cadence and quality of Strategic Initiative updates to the Engine Room. To improve this we have stood up new process standard work for Strategic Initiatives and are cascading this through the organisation.

Strategic Initiative leaders will also have access to support clinics from the Coach House and Associate Director of Strategy.

The assurance route for the work of Strategic Initiatives is currently subject to executive discussion with options including divisional performance reviews incorporating Strategic Initiative checkpoints. How our Strategic Initiatives are communicated across the divisions and organisation is also under review. The next version of this report will include an update of our Strategic Initiative governance.

------ Report Ends ------

NHS Salisbury NHS Foundation Trust

Report to:	Trust Board (Public)	Agenda item:	3.3
Date of meeting:	9th January 2025		

Report title:	Improving Together Quarterly Report (Q3 2024/25)			
Status:	Information	Discussion	Assurance	Approval
			✓	
Prepared by:	Emma Cox, Head of Continuous Improvement and Coach House Alex Talbott, Director of Improvement			
Executive Presenting:	Alex Talbott, Director of Improvement			
Appendices (if necessary)				

Executive Summary:

Over the latest quarter (Q3 24/25) Improving Together has continued to embed across SFT. The last three months has seen further good work by clinical divisions to introduce and routinely run improvement-led performance review meetings with their speciality teams. This continues to deepen the Operational Management System to enable an effective cascade from 'board to ward' of priorities and, importantly, build a system through which teams can escalate key barriers, risks and issues to improvement through the management system.

To support corporate teams and departments to build up their use of the OMS, work is now underway to introduce an approach to a corporate Division Performance Review (DPR). This work will be reported on in the next quarterly report (1st May 2025).

The leadership behaviours that underpin Improving Together are a crucial element to us building and maintaining a culture of continuous improvement. There is growing evidence of the positive impact our leadership behavioural framework is having on teams and leaders and the introduction of the behaviours to appraisals and recruitment processes is a key next step for 25/26.

The demand for Improving Together training continues to grow and the pipeline of teams booked now runs into Q1 of 25/26. Throughout the next quarter the divisional management teams (DMTs), the Coach House and OD&L teams will be prioritising and scheduling clinical and non-clinical teams for training and support in 2025/26.

As a result of our work we continue to increase SFT's reputation as an organisation which is using a continuous improvement operational management system well. Four visits to SFT from NHS Trusts across England have already been supported and more are lined up for Q4 and into 2025/26. Alongside this our work at SFT is helping to add momentum and direction to the use of Improving Together across the BSW Hospitals Group, which will help us all get the most from our collective Operational Management System.

A review of the next steps listed in October 2024's quarterly update shows:

1. Increase our sharing of successes and improvements across the organisation (including the pink ticket process) Pink ticket process (Executive-led celebration of improvements) now embedded. Monthly spotlight on where Improving Together is working well at SFT starts in January 2025.
2. Host a successful CEO Summit on behalf of the Group and reflect on our learning as a result. Completed with very positive feedback from our visitors and our learning is now influencing

improvement of our processes and routines, especially re strategy deployment and process mapping.

3. Continue to improve the maturity of our OMS by increasing the number of PRMs and improvement huddles that are sustained over time. Since October: 4 further speciality scorecard agreements completed, 2 further speciality PRMs started and 6 team PRMs running.
4. Identify opportunities for collaboration across the Group within our Coach House teams and as part of the Group SPF being developed. This work continues with routine touchpoints and comparisons between the teams part of their standard work. At Group the Improving Together Leads are helping to inform the method and style of reporting for the Group to ensure it maintains the principles of Improving Together.
5. Continue to align Improvement and Leadership training programmes. November pilot of Improver Leader nested within the Transformational Leader programme completed with positive feedback from delegates. Improver Leader will run as part of the Transformational Leader programme for the next Cohort starting in April 2025. Stand alone Improver Leader courses will continue until then to support teams starting their Improving Together work.
6. Plan and implement the review of the SPF and our breakthrough objectives in line with business planning and the formation of the Group SPF. This is underway at the moment. We are re-iterating we should only change Breakthrough Objectives once we have achieved a sustained improvement.

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

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

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

- None escalated from Improving Together Board.

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

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

- The Communications Manager with responsibility for Improving Together communications and marketing has now left SFT. The communications team continue to support Improving Together and work is underway to ensure communications surrounding Improving Together is a core part of the wider team's work.

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

- Clinical division's self-assessments of their maturity in using Improving Together show improving confidence and capability in the approach. This includes the increased use of divisional driver

meetings and improvement huddle boards to maintain constancy of purpose and focus on agreed improvement priorities.

- Utilisation of the Improver Standard training remains high, with a strong pipeline of bookings into 2025 and consistently positive feedback on the training.
- Improver Leader: 100% of speciality triumvirates will be trained by the end of Jan 2025.
- Evidence of the positive impact of our leadership behaviours framework and line manager training is deepening with reductions in line manager turnover and freedom to speak up cases about line managers.

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

Improving Together Quarterly Roadmap Progress Report – January 2025

1. Training update

1.1. Current situation

Introducing It: This brief 90-minute masterclass on the why, the how and the what of Improving Together continues to be well attended. Figures now stand at 906 staff since it was first launched in 2024, throughout Q1-Q2 756 staff attended this stand-alone masterclass. Weekly sessions are scheduled for those due to commence Improving together training, for teams who are working to sustain the approach in their teams as well as for all new starters to the organisation. In addition, this is often a masterclass that is delivered locally and outside of planned sessions to teams upon request.

Improver Standard: The number of teams trained in Improver Standard continues to increase, with 90 teams now having accessed training. In light of the lessons learnt from our current cohort of rotational roles, achievement of our training trajectory of 100% of teams trained in Improver Standard by March 2026 is being reviewed. We now expect to achieve our Improver Standard trajectory by Q2 of 2026/27. This four month delay will give our next cohort of rotational role colleagues to gain enough knowledge and confidence before they begin delivering training.

Improver Leader: The integration of Improver Leader and Transformational Leaders training programmes was piloted in November. Initial findings confirm the benefit of this joined up approach to leadership development and continuous improvement with delegates making the connection between topics and using their learning across the programme. Stand-alone Improver Leader training will still be required throughout the year to ensure teams who are due to commence their Improving Together journey are supported by their line managers in a empowering and productive way. Speciality layer training and the engagement and booking of Clinical Leads remains

challenging. However, bespoke arrangements, are being identified to ensure achievement of 100% by January 2025 for all speciality triumvirates.

Across the courses training participant feedback, utilisation rates and the pipeline of bookings all remain strong.

Masterclasses: We have seen a growth of utilisation in the planned masterclasses (70 staff accessed to date from launch) as awareness of the new approach and dates grows across teams. We have also seen an increase in the number of bespoke/adhoc requests for masterclasses (136 staff accessed since April 2024) across the whole Trust, with requests specifically for facilitated help on A3's, process standard work, and preparing specialities and teams for their scorecard agreement and performance review meetings.

The responsive nature of the Coach House team in providing support to teams has resulted in 123 hours being spent through Q2 in improvement coaching and support to teams directly. This dedicated and personal support to teams is seeing positive outcomes through sustained improvement huddles and maturity of the performance review meeting function, a critical part of the Operational Management System.

1.2. Next steps

Improver Standard: Continue to meet with divisional management teams and OD&L to prioritise the training pipeline. Review the training trajectory and material across OD&L and Coach House areas of expertise.

Improver Leader: Review the November pilot of Improver Leader becoming part of the Transformational Leadership programme and agree approach moving forward across both Coach House and OD&L for this cohort of learners.

Improver Advanced (PRM): Continue to support specialities and teams, through training, process development, pack preparation and practice sessions to increase confidence and the number of PRM's actively/routinely scheduled.

Masterclasses: Improving attendances at planned masterclass remains a priority for the Coach House Team. A communications focus throughout December to further encourage attendance, is being undertaken. In addition, the Coach House team are actively using A3 thinking and testing improvement ideas, through their own improvement huddle to improve the number of attendees on these masterclasses whilst also taking into account the needs of the organisation, recognising the balance between routine vs bespoke/adhoc sessions.

2. Improving Together Maturity

2.1 Maturity Assessment

The maturity self-assessment provides a structured reflection on a team's strengths and identifies areas to focus. The self-assessment aligns the tools to the Shingo principles of ***align, enable and improve*** and is now being routinely reviewed through divisions, specialities and teams.

Further developments are in progress regarding the scoring definitions and in increasing response rates from teams and specialities. See Appendix 1 for the current maturity assessment overview. In

addition, peer review and coaching on the self-assessment should be considered and an approach/process to manage this across division, speciality and team explored in order to ensure the maturity assessment is accurate and reflective of the division, speciality and team position.

Key areas to note from the divisions' self-assessments (Q2 -Q3):

Q2 has seen progress linked to:

- New improvement huddles started, Scorecard Agreements and agreed driver metrics, Performance Review Meetings, Driver meeting maturity and process standard work, increasing DMT confidence. Structured conversations are becoming embedded, A3 thinking is now a standard practise within the divisions and the routine use of Go and See and follow up has improved.

Next areas of focus:

- Sustained efforts on leadership coaching and the golden thread will ensure continued momentum particularly for strategic alignment of teams' work
- Team PRMs moving forward in some specialities within the divisions, supporting the golden thread.
- Continue to prioritise speciality scorecard agreements
- Continue to embed structured conversation and process standard work within the divisions
- Continue to strengthen and improve the frequency of driver meetings to support maturity of the OMS

3. *Celebrating and Cascading Continuous Improvement*

(An objective outlined in the previous report)

3.1 Current Situation

There have been a number of ways in which the organisation has continued to disseminate information about Improving Together, the improvement ideas being made and the thoughts/experiences of staff.

The 'pink ticket' process, currently in use by Executives, has been launched and celebrates the achievements identified across their portfolios. There are a number of ways in which these celebrations are cascaded through the organisation (MD/CEO briefing, the staff bulletin, and line managers email). Medicine divisional colleagues are also now starting to consider adopting this as part of their weekly huddle.

The number of case studies that share successes and improvements continues to grow, with material being updated monthly by the Head of Continuous Improvement and Coach House and disseminated through the bulletin and in training courses (including introducing it). The communications team continue to support the development of videos capturing our best successes and learning from Improving Together. A monthly spotlight is now also being established with a focus theme for each month being communicated.

Trust wide posters have been launched, sharing information not only with staff but our public on the work we are undertaking linked to our breakthrough objectives and celebrating the achievements of the previous breakthrough objectives.

3.2 Next Steps:
Continue to celebrate the improvements achieved and share them across the organisation, recognising the value of sharing to establish greater impact, sustainability and improved performance. Developing our approach and responding to the needs of the organisation in our ways of sharing information will be a continuous process of improvement. At the end of November, the dedicated Improving Together Communications Manager left SFT. The impact of this resourcing gap requires review, as the need for continued and consistent communication support for Improving together and Strategy remains a key part of our overall work programme.

4. Operational Management System (OMS) update

The Operational Management System is how the strategic focus of the organisation cascades up and down from Board to division, speciality and team, and back again.

4.1 Current situation

Improvement Huddles: We have 45 active improvement huddles across the Trust, an increase of 7 from our reporting position in October 2024, an additional 14 are in the planning stage of deployment. The Coach House continue to work to understand the problems and barriers teams face to start and maintain improvement huddles. Some of the reasons being shared are; clinical acuity, staffing levels and priority. Collaborating with the divisional leaders and with the identified areas to work together to help ensure sustained delivery of huddles will be undertaken, recognising that there will not be a one size fits all approach to improve existing performance.

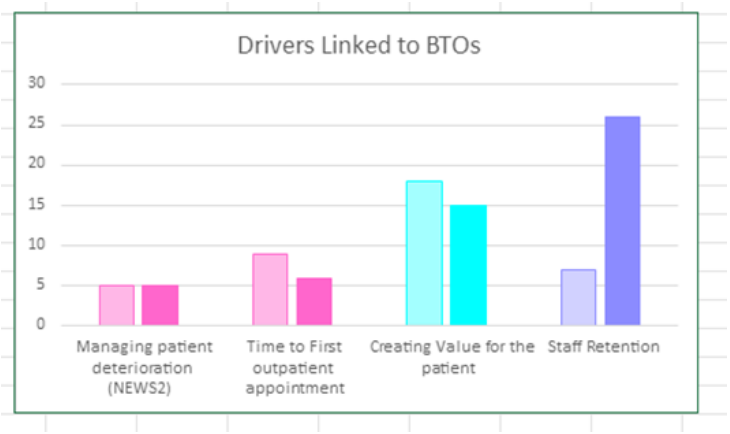
Scorecard agreements and Performance Review Meetings (PRMs):

	CSFS	W&NB	Medicine	Surgery	Corporate	Total
Scorecard	7	3	8	7	2	27 ↑
Speciality Level PRMs	6	3	8	2	2	21 ↑
Team Level PRM's	0	0	1	3	2	6

Alignment of drivers: The organisation continues to see an increase in the number of drivers being chosen at team and speciality layer that directly align and link to the strategic planning framework There are 96 drivers across division, speciality and team level that are directly aligned to the Trust Breakthrough Objectives. The Coach House actively support teams, through the training to identify drivers they can operationally affect change within. The most popular breakthrough objective chosen by our teams is creating value for our patients. The most popular breakthrough objective chosen by our specialities is staff retention.

Project delivery and Corporate Project Prioritisation Group (CPPG): Alignment of our corporate resources to the strategy is a key part of the operational management system. Corporate resource

and its continued allocation is actively discussed at CPPG and during the monthly Engine Room. Examples of the benefits delivered via our projects and programme are shown in Appendix 2.



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

4.2 Next steps

Improvement Huddles: Continuing to understand the reasons for teams not huddling is a key focus for the Coach House and actions are underway within this team to improve the performance moving forward. Identifying and allocating resource to teams who are currently being supported as our rotational role colleagues rotate out will be a key priority to minimise any impact on those teams.

Scorecard agreements and performance review meetings: Continue to support divisional, speciality and team colleagues as requested in the preparation for scorecards and performance review meetings. Reviewing the approach and aligning the PRM function alongside the existing ward performance review structure is an important action that still requires further work, and which the Coach House is working with identified Divisional Heads of Nursing to explore further. It is anticipated that progress will be made during Q4 on this, recognising that we have a number of ward areas ready to implement Performance Review Meetings aligned to their driver metrics.

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

5. Leadership behaviours

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

4.1 Qualitative impact data

The OD and Leadership team continue to see signs of behavioural change and impact.

According to the Freedom to Speak Up data we have seen a huge reduction in cases related to poor management behaviours, currently sat at 21 for the year starting 1st April 2024, this number sat at 76 at this point last year. There has also been a reduction in management turnover with 15-line manager leaving, none of which were in their first year. This time last year this number sat at 51 with 17 being in their first year.

All of our internal leadership programmes are now complete seeing 442 attendees successfully finish with a deeper understanding of our Leadership Behaviours Framework and how it influences and drives the cultures that we want to see. Twenty seven teams across all divisions have received team development which has included elements of behavioural improvements aligned with our framework.

The OD&L team will continue to deliver and add the Leadership Behaviours Framework to its widening portfolio of work to ensure it is embedded and lived throughout our Trust. This will include the addition to recruitment interviews and the annual appraisal in 2025.

6. Wider System working

6.1 Coach House Team Collaboration

(An objective outlined in the previous report)

Coach House Leads at SFT, RUH and GWH have undertaken a compare and contrast review of Improving Together across the AHA. This review has identified areas of further improvement and collaboration notably; simplifying the language, sharing of training across the AHA, sharing of case studies/learning and increasing consistency/commonality of the material and collateral used. In addition, a monthly meeting between the Heads of the Coach Houses is now scheduled alongside quarterly time for the wider teams to come together.

6.2 Group level Strategic Planning Framework (SPF*)*

(An objective outlined in the previous report)

A draft Strategic Planning Framework (SPF) for the BSW Hospitals Group has been developed with the three Trusts Executives. The SPF will guide the Group's focus on the key areas of improvement for our population, people and partnerships. How these cascade into the three trusts will be tested throughout 25/26 and the connection made in the Trust and divisional scorecards in 26/27.

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

6.3 Catalysis CEO Summit

(An objective outlined in the previous report)

A key objective during Q2 was the hosting of the Catalysis CEO Summit. On the 9th and 10th of October 2024, SFT hosted the Catalysis CEO Summit, a total of 24 CEO and Improvement Senior Responsible Officers from across Northern Europe and the UK visited SFT. During the summit, visitors undertook go and see visits to nine teams actively using improving together

methodology (Recruitment, Risk Team, Coach House, Endoscopy, Chilmark, Amesbury, Imber, Cardiology and Pharmacy).

On the 10 October, the group visited local industry partner; Chemring Countermeasures who actively use lean methodology in their production and management systems. The purpose of the visit was to offer the opportunity for colleagues to see lean being practised in another industry and take learning back into their respective organisations. A particular observation was the power of process mapping and running small, quick PDSA cycles on known processes. Work is now underway to strengthen our offer of process mapping training and use across SFT. As a result of this successful industry partner visit, options to establish and forge partnership links with Chemring are being explored, overseen by the Director of Improvement and the Head of Continuous Improvement and Coach House. A proposal for Exec discussion during Q4 is being worked through.

A review the visit can be watched here: https://youtu.be/rZ8uz579MYM

7. Next steps

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

1. Successful recruitment of the second round of rotational roles to the Coach House.
2. Proposal for external partnership working to be developed in preparation for presenting to Execs during Q4.
3. Continue to routinely share stories of improvement being realised across the organisation by our teams.
4. Increase collaborative working across the Senior Leadership Teams of Coach House, OD&L and Transformation Colleagues as part of the Centre of Excellence/Change Forum concept.
5. Further review training material of Improver Standard with OD&L colleagues to improve the training experience and ensure up to date material available for all attendees.
6. Continue to improve the maturity of our OMS by increasing the number of PRMs and improvement huddles that are introduced and sustained over time.
7. Review and further align the maturity assessment scoring, with a focus on leadership behaviours, increasing the number of responses received and introducing peer-to-peer constructure challenge.
8. Continue to plan and implement the review of the SPF and our breakthrough objectives in line with business planning and the formation of the Group SPF.
9. Develop and identify an improved process mapping offer which can be rolled-out across the whole organisation.
10. Develop our first iteration of a Corporate Division Performance Review (DPR)

Salisbury NHS Foundation Trust

Appendix 1:

Maturity Assessment Trust wider Overview

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

Framework	Tool	Behaviour	Quarter 2 position			
			Execs	Divisions	Speciality	Frontline
Align	Scorecard	Focus	3	4	2	2
	Golden Thread		3	4	2	
Enable	Monthly routines (Performance/Executive Review Meeting + A3 summary)	Humility Curiosity A3 thinking Go and See Listen Learn Respect	3	3	2	2
	Weekly Routines (Go and see)		2	3	1	
	Driver Meetings		2	3		
	Weekly Routines (OMS Exec routines, Weekly Exec Huddles)		2			
	Daily Routines (Improvement Huddles, Performance and Improvement Boards)					2
	Process and Leader Standard Work		2	3	2	2
	Process Confirmation		2	3	1	1
	Structured Conversations		1	3	1	2
	DPR		3	4		
	SLT			3	2	
	PRM				1	2
Improve	A3	A3 thinking	2	4	2	2
	Leadership Behaviour		2	4	2	

NHS Salisbury NHS Foundation Trust

Appendix 2

Some of the benefits delivered through the project delivery system;

Urgent Emergency Care projects: Links to Creating value for the patient breakthrough objective

SDEC Bed Day Cost avoidance since go live in March 2023 – March 2024 = £760,000. From March 2024 to November 2024 Year on year savings £52,000 in bed day cost avoidance. Total £812,000

Zero-day length of stay for medical admission Pre SDEC 20.3% now running at 30.0% - **50% improvement** maintained. - SDEC zero-day LoS 45%

AFU Bed Day Cost avoidance August 2023 - July 2024 - £2,803,437. From August 2024 to October 2024 Year on year savings £117,612 in bed day cost avoidance. Total £2,921,049. Average length of stay reduction maintained at 4 days.

Total Bed Day Saving across AMU and AFU - £3,733,049.

Since deployment, 6,174 digital assessment forms have been assigned to 4,778 patients. **Overall completion rate is currently at 71.2% - some individual outpatient services are seeing completion rates of up to 84.3%.**

Current responses show that **2.8% of patients are requesting to be removed from the waiting list**, which aligns with validation rates seen at other Trusts (~3%).

26 of 34 specialities (76% within scope. Aim to increase this to 30 (88% adoption). **Templates in use have reduced from 100+ to just 2**, which will not only optimise this current project but also support the shared EPR project that requires reduced templates.

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

Dr Doctor digital assessments –

Enabled 6 outpatient services to make efficiency improvements in patients triaging processes through waiting lists and use of clinic time.

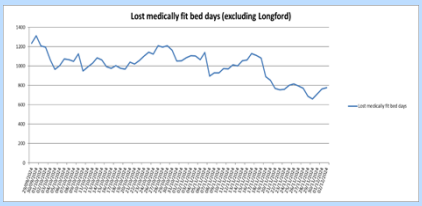
The 2nd phase of the Pre-Op Digital Assessment means patients are automatically contacted every 12 weeks validating whether they want to remain on the wait list/have had any significant health or medication changes. This is helping the Pre-Op team meet NHSE requirements around earlier pre-screening and validation.

Digitalisation of clinic letters

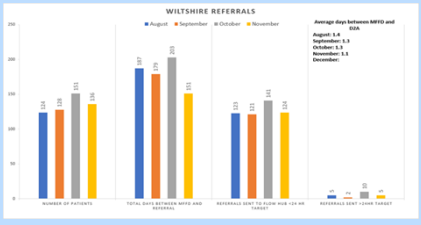
This project is fully transitioning the outpatient clinic letters sent to patients from postal services to a digital system.

Non Criteria to Reside (NCTR): Links to Creating value for the patient breakthrough objective

Decrease in the number of lost days to NCTR



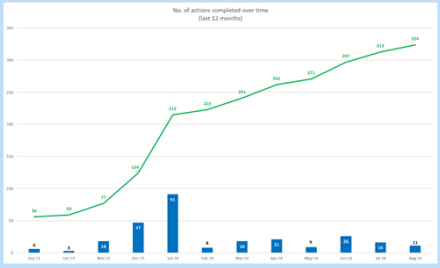
The data below demonstrates a reduction in the LoS between NCTR referral decision and referral from 1.4 days to 1.1.



This is being driven by the collaborative work currently taking place between SFT and our locality system partners, to review and deliver Improvements to our Internal systems and processes.

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

Compliance with national requirements continues to improve. Three Year Delivery Plan now being managed under the Maternity Improvement Plan. **Handover from project to BAU completed on time in October 2024**

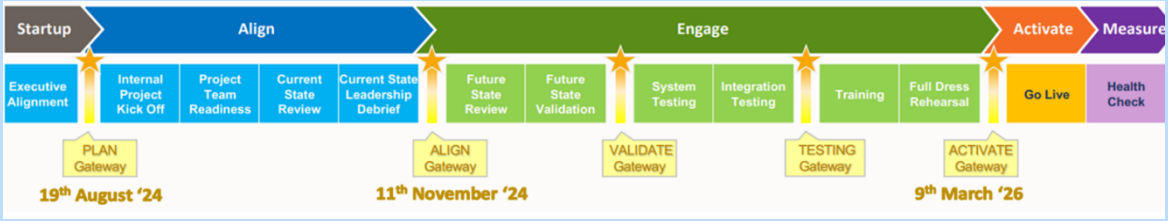


Salisbury NHS Foundation Trust

Strategic Initiative: Digital Care

Shared EPR has successfully signed off the "Align" gateway and moved into the "Engage" Phase

Oracle future state review of model has taken place and future state sessions begin mid-December until March 2025. Go live planned for October 2026



Server Refresh programme has fully **decommissioned 439** of our support servers. Each server decommissioned increases our cyber-security and patient safety, whilst enhancing the user experience through increased performance and resilience.

Integrated Care Record – Digital ReSPECT: Soft launch in November of Digital ReSPECT plans to be viewed and created in the Intregrated Care System (ICR). All plans to be created digitally from February 2025.

Digital clinical upgrades delivered which enhance patient safety, department efficiency and ensure cyber security is maintained: Somerset Cancer Record; Lille Sexual Health system; Teletracking Portering system. Digitally enabled changes on target for delivery in early 2025 include Badgernet Maternity EPR,; Theatreman Aqua upgrade and TPP upgrade from Out of Hours SystmOne Unit to the new Acute Hospital Unit.

NHS Salisbury NHS Foundation Trust

Report to:	Trust Board Meeting (Public)	Agenda item:	4.1
Date of meeting:	9 January 2025		

Report tile:	Health and Safety Report – Q2			
Status:	Information	Discussion	Assurance	Approval
			X	
Approval Process: (where has this paper been reviewed and approved):	H&S Committee and Trust Management Committee			
Prepared by:	Troy Ready – Health and Safety Manager			
Executive Sponsor: (presenting)	Melanie Whitfield – Chief People Officer			

Recommendation:

The Trust Board is asked to note the continued work on the reduction of risks to the H&S of staff and visitors. Specifically violence and aggression and the movement of tugs.

Executive Summary:

Whilst lost time and lost time injuries were up in Q2, the overall trend continues to fall on previous years and there are no obvious trends within these 2 metrics that require specific attention. Violence and aggression, as reported in each period is the highest reported incident and the activity within H&S reflects this risk.

Specific actions to note in the management of violence and aggression include:

1. The No Excuse for Abuse Campaign being finalised, images published and on display,
2. Violence Prevention and Reduction Policy has been finalised with additional changes already made to tweak ongoing improvements,
3. Daily Huddles to coordinate response to staff,
4. Red and yellow cards have commenced being issued to patients and relatives,
5. Updated Datix fields to record and measure red and yellow cards,
6. Commencement of a Violence Prevention and Reduction Portal on SALI to provide more information to staff,
7. Engagement with Local Wiltshire Police to identify and overcome challenges with police responses to hospital calls.

At section 4 on page 8, the report makes reference to the actions taken to manage risks from the internal movement of tugs with a proposed implementation period scheduled between January and March. Key changes will be the reduction of tugs on Maternity Hill and the introduction of a one way traffic flow (up, not down) with a small number of exceptions. The immediate benefit will be the obvious reduction in tugs seen in, and heard on, Maternity Hill. Changes will not be immediate as work is required to ensure tugs can pass clearly in thoroughfares used to access the hospital and ongoing engagement with teams to smooth out tug driver reservations about the change in process.

Whilst Section 9 on page 9 makes reference to a number of risks and actions taken to manage these risks. Specific reference is made towards the following risks:

Risk ID 7931 - Risk Score 16

Theatres electrical power is reliant upon extension leads that are not supported by UPS and compromises the reliability and safety of critical healthcare infrastructure.

Actions: A fortnightly inspection is carried out by the Estates Team, medical devices and theatres team of all theatres. Estates are looking to commence a project to increase the number of sockets with UPS/IPS protected systems.

Risk ID 7932 - Risk Score 16

Wyle house electrical earth failure poses a risk to staff in accommodation due to the breakdown of electrical wiring.

Actions: A Project Manager has been nominated to manage a replacement project and c metal items such as faceplates and light fixtures have been replace with plastic ones to eliminate conductive risks.

Risk ID 7917 - Risk Score 15

A fire risk in main theatres due to the volume of goods stored in theatre corridors.

Actions: Simple but effective actions and frequent fire training and testing have been completed but the volume of equipment continues to expand and theatre trays wrapped in paper offer an ongoing source of fuel.

Actions: A project team has been created to look at storage on and off the theatre footprint after a number of Exec team walkarounds.

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

HEALTH AND SAFETY PERFORMANCE REPORT
FY25 - QUARTER 2

Salisbury NHS Foundation Trust

1. Performance Measures

The ongoing downward trend of lost time injuries and the volume of time lost continues. A number of injuries reported did not result in time lost as staff where not rostered to work the following days and returned to work as rostered. Of the 4 lost time injuries reported in Q1, 2 were reportable (RIDDOR) to the Health and Safety Executive (HSE). At the time of reporting, there has been no formal follow up, request for further information, or notice of intention to inspect the site. This is not surprising given the nature of the injuries reported, and the actions taken by the Trust, before and after the injury, to reduce the risk of harm.

Injury and Frequency Rates by Division

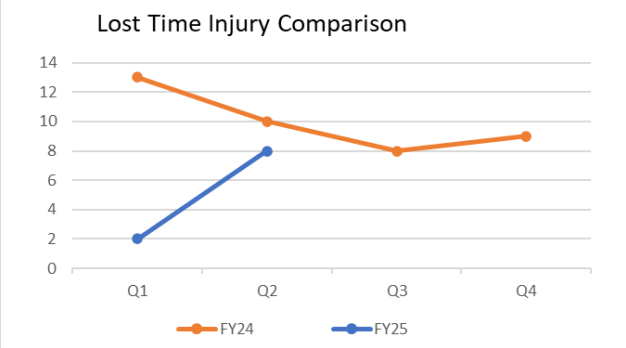
	Days Lost	YTD	LTI	YTD	LTIFR	YTD	LTFR	YTD	RIDDOR	YTD
Estates & Facilities	73	94	-	1	0	2.6	28	18	-	1
Surgery	28	35	3	4	3.9	2.7	2.7	1.8	1	2
Medicine	1	5	1	3	1.7	2.5	0.2	0.3	-	-
W&N	-	-	-	-	-	-	-	-	-	-
CSFS	13	13	4	4	6.6	3.3	1.6	0.8	2	2
Corporate	-	-	-	-	-	-	-	-	-	-
Total	**115**	**147**	**8**	**12**	**2.9**	**2.2**	**3.1**	**2.1**	**3**	**5**

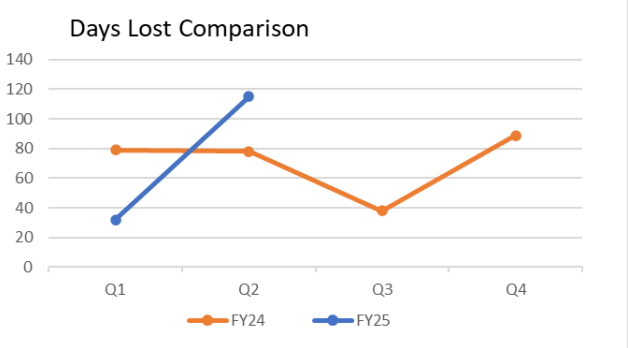
Definitions:
Days lost are the accumulated total of days lost because staff are unfit to work due to work related injury reported in that quarter.
Lost Time Injury Frequency Rate (LTIFR) measures work related hours lost per 1,000,000 hours.
Lost Time Frequency Rate (LTFR) measures work related hours lost per 10,000 hours.
RIDDOR is an incident that must be reported to the Health and Safety Executive
Near Miss is an incident that did not result in harm to staff.

Whilst there has been an increase in the number of lost time injuries, they are still only a small number. The number of incidents reported continue to show an increase in minor or no harm incidents. The exception to this is Estates and Facilities and Women and Newborn where there are only a small number of incidents reported. It should be noted the lost time from Estates and Facilities related to an injury reported in Q1, and who is on a graduated return to work program managed with the Occupational Health Team, and of the 4 lost time injuries within CSFS, 3 were the result of slipping from a chair.

The table below shows the number of H&S related datix reports by severity for each division in Q2.

Division	Incidents reported	No Harm	Minor Harm	Moderate Harm	Serious Harm
Corporate	1	1	-	-	-
CSFS	32	14	12	6	-
Estates and Facilities	7	5	2	-	-
Medicine	54	27	25	2	-
Surgery	43	30	10	3	-
W&N	4	3	1	-	-



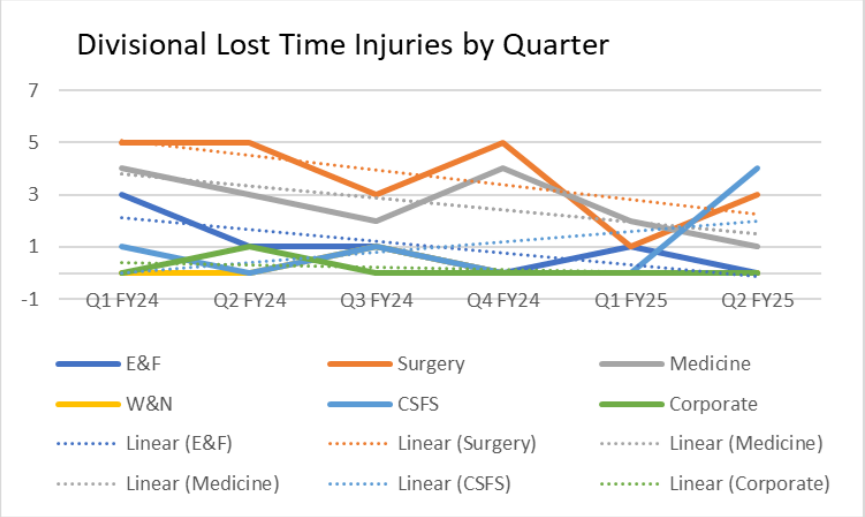


As seen above, days lost across the Trust increased from 33 to 115 and the number of lost time injuries reported rose from 4 to 8. As noted in the Injury and Frequency Rates by Division Table above, Facilities reported the highest amount of time lost. All of which was due to an aggravation of an underlying reported in Q1. That staff member returned to a graduated return to work following surgery in Q2.

CSFS saw an increase in lost time injuries, 3 of which were the result of staff slipping from chairs and sustaining injuries that resulted in time lost and RIDDOR reports to the HSE. Each injury was reported by unrelated departments.

As a year on year comparison, despite the increase in time lost in Q2, performance is tracking just under 10% better than this time last year and trend lines show a consistent reduction over the past 6 quarters.

It was noted in the Annual Health and Safety Report FY24 how the coming quarters will act as an indicator of whether sustained reductions in injuries across the Trust are being achieved, or if there are fluctuations in performance that suggest there is work still to be done. Investigations conducted by the H&S team, do not identify systemic gaps in the management of H&S that would result in injuries. Whilst the graph below, suggests these downward trends towards sustained improvement. As always, the small number of injuries and time lost has the potential to skew results and as seen with time lost in Estates and Facilities and the spike in lost time injuries within CSFS.

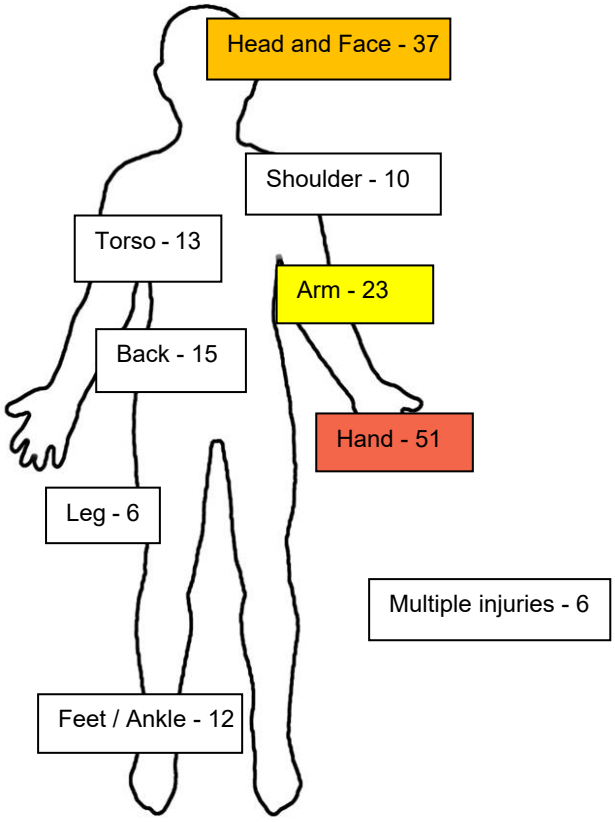


2. Injury Statistics

As noted in the table below, violence and aggression remains the most reported incident and injury type, and whilst the number of incidents reported is significantly higher than this time last year, performance in Q1 this year is more consistent with the overall quarterly pattern in FY24.

Datix Reports by Type	Q2		YTD	
	FY24	FY25	FY24	FY25
Violence and aggression	21	53	46	86
• Antisocial behaviour		18	-	29
• Violence and Aggression – mental health		11	-	27
• Violence and Aggression – confusion and delirium		24	-	30
Manual handling	11	9	14	20
Struck an object	2	4	4	7
Near miss	11	23	11	46
Damage, broken equipment and Infrastructure failure		7		17
Slip and trips and falls	7	18	13	32
Struck by a moving object	3	4	11	15
Other	1	2	1	10
Exposure to sharps	6	18	9	29
Biological exposure		3		7
Radiation exposure		1		2
Electrical exposure		1		1
Chemical exposure	1	2	4	2
Lacerations		-		8
Total	**63**	**145**	**113**	**272**

2.1 Injuries by Body Location



3. Managing Violence and Aggression

The management of violence and aggression continues with further and ongoing action being taken to prevent escalating behaviour and responding to staff exposed to such actions.

3.1 Prevention of Escalating Behaviour

Meet My Unmet Needs First

For the management of confusion, delirium and dementia the Trust Dementia Lead has introduced the Meet My Unmet Needs First Campaign as seen in the image below.

Some common themes identified when investigating violence and aggression from patients with dementia, delirium and confusion is where basic care needs are not being met and patients become agitated and lash out. Reinforcing the basic needs of patients and having staff consider whether these are being met or not before calling security or labelling patients aggressive is another initiative that is expected to reduce the risk of violence and aggression.

Reducing Violence and Aggression in A&E Through a Better Experience Scheme

Q1 saw the installation of the Design Council's Reducing Violence and Aggression in A&E Through a Better Experience Scheme. The basis of the Design Councils approach is to improve the arrival, and waiting experience, for patients and carers through the provision of information about the ED journey. The majority of patients who attend ED do not know what to expect, what the steps of being seen in ED are and what each step in the ED process means.

By communicating what to expect at each step of the ED journey, the Design Council found user anxiety fell and the escalation of anxiety and stress towards acts violence and anti social behaviour also fell. It should be noted, this scheme is not a panacea for all acts of violence and aggression but is instead part of the overall Trust strategy to reduce violence and aggression towards staff. Nor is it effective with patients presenting with confusion, delirium, mental health or intentional actions.

No Excuse for Abuse Campaign

The No Excuse for Abuse Campaign was finalised in Q2 and is expected to be visible across the Trust from the beginning of Q3. There were a number of significant incidents in the first weeks of Q3 that resulted in yellow and red cards being issued to patients. More detail will be provided in the Q3 report.

Assessing the Risk to Staff

There are risk assessments available to demonstrate actions the Trust have taken to reduce the risk of harm from violence and aggression, but the management of patient specific risks are not always evident. It was noted during department audits how there are significant assessments of

risks to patient, and actions to prevent patient harm, but less so for the management of risks to the H&S of staff.

Risk assessments that manage the risk to the harm of staff should be incorporated into patient risk assessments where there is a risk of harm to the patient and to the staff looking after a patient with a risk of violence and aggression.

Violence Prevention and Reduction Training
Internal and externally facilitated training is provided to staff across the Trust. Conflict resolution, advanced communication skills and the violence prevention and breakaway training are all available, regularly scheduled and attended by staff.

3.2 Response to Violence and Aggression
Debrief
Conducting a ward debriefing, where staff are exposed to violence and aggression during or towards the end of a shift has received positive feedback but depends entirely on where violence and aggression is reported with some wards performing this well and others less so. A debriefing huddle should be a standard response at the time of an act of violence and aggression. The Violence Prevention and Reduction Policy is clear on the need to debrief, guidance notes and information is available for staff but discussions at the Violence Prevention and Reduction Working Group suggests a debriefing huddle will depend on how busy a ward is, and the availability to staff to lead it.

Action
Huddle and Debrief Cheat Sheet The H&S Manager is consulting with wards who routinely conduct a debrief and undertake an effective huddle at the end of a shift to ensure staff are OK. The outcome will be a cheat sheet with instructions on how and when to conduct a debrief huddle. There is however a need for divisions to ensure ward leads prioritise the conduct of a huddle rather than prioritise the 'busyness' of a ward.

Daily Huddle
The daily huddle facilitated by the Deputy Chief Nursing Officer and attended by clinical teams and the H&S offer an opportunity to identify and discuss violence and aggression overnight or the previous day. Huddles identify who was involved and allow for a follow up of staff involved. It is taken for granted ward managers would follow up staff who are exposed to violence and aggression or injured and off work. However, the actions of the H&S team in responding to Datix reports, and the follow up of staff, means line managers will not always follow up with staff, because the H&S team has.

Action
Incident Review and Investigation The daily huddle will be used to identify clinical staff who will collaborate with the H&S team to facilitate a more formal investigation of those serious incidents. Outcomes from investigations will then be presented to the huddle and learning cascaded to ward leaders as relevant. This also provides an opportunity for ward managers to be involved in the follow up of staff, in addition to the H&S team.

Follow up by Divisional Management and Executive
The Violence Prevention and Reduction Policy has been further updated and approved by the Violence Prevention and Reduction Working Group to provide further guidance on the follow up of incidents, by the Divisional Management and Executive teams, for more significant or serious incidents. New guidance states the:

- H&S Manager will provide a list of serious incidents and ward / staff involved to the Executive team each week who can determine if there is a need for executive support and who such support will come from.

- Ward leads and the H&S Team will update Divisional Managers after each hdaily huddle chaired by the Deputy Head of Nursing who will also determine if there is a need for further support.

Signposting to Support Services

Staff are routinely signposted to a variety of services to support the aftermath of violence and aggression. Counselling services, TRiM, pastoral services though it is not uncommon to be told that support is usually available from immediate family and friends. The H&S team will reach out to individuals to ensure supports are available and signpoint to services.

Yellow / Red Cards

There has been a number of yellow and red cards issued to patients since the Violence Prevention and Reduction Policy was updated. Warning letters (yellow cards) continue to be issued to patients and relatives and have proven effective at modifying behaviour of some patients. But this approach is only effective if patients acknowledge behaviour and is not used for patients with dementia, delirium or confusion.

Warnings and Exclusion letters are time limited (6 and 12 months respectively) and need to be rescinded after a review once this timeframe expires. To manage this the Risk Team has included a section under the reporting of security incidents on Datix to capture the following information:

- If a yellow or red card has been issued,
- Who the letters were issued by,
- Date of issue and
- Expiry date.

A screenshot of the process is seen below.

This information can be extracted from Datix as also seen below. Yellow / Red cards issued, and due for review, can be included as a standing agenda item at the Violence Prevention and Reduction Working Group to provide oversight of those letters issued and to be rescinded.

ID	Incident date	Stage of care	Detail	Adverse event	Has a Red or Yellow Card been issued?	Who issued the Card?	Date card issued	Date card expired
170547	09/12/2024	Abusive, violent, disruptive or self-harming behaviour	Physical Abuse	Abuse towards patient	Yellow Card	Joe Blogs	09/12/2024	09/12/2025

Template letters developed as part of the Violence Prevention and Reduction Working Group are available for the patient, GP, Lorenzo and Medical Records and will be loaded onto an

updated onto the H&S page of SALI with guidance on the issuing of yellow and red cards and the response to both patients and staff.

Violence Prevention and Reduction Portal on SALI

There is currently no information on the management of violence and aggression immediately available on SALI. The H&S Manager is working on a violence prevention and reduction portal under the H&S page.

The webpage will have three clear information zones.

A. No Excuse for Abuse Campaign
B. Responding to Patients and Relatives who are aggressive:
    a. Violence Prevention and Reduction Policy.
    b. Template Letters.
    c. Diagram as a ready reckoner to manage process.
    d. Information on managing dementia, delirium and confusion.
C. Responding to Staff exposed to violence and aggression:
    a. Diagram as a ready reckoner to manage process with clear focus on immediate manager responsibilities and escalation processes

3.3 Engagement with Wiltshire Police

The H&S Manager has engaged with Wiltshire Police. The Trust has a local officer tasked with liaising with the Trust. An invite has been extended for this Officer to attend the Violence Prevention Working Group.

It was noted by Wiltshire Police, when responding to reports of violence and aggression that 3 common issues arise:

1. Staff reporting an assault will not leave their name, direct number or ward therefore leaving the police with no way to respond effectively.
2. On calling back, hospital staff have advised the police they cannot provide any information to them as this is a breach of confidentiality and police are advised to submit an information request form.
3. Staff are not clear about the level of threat to staff and threats are deprioritised.

Action
Reporting Violence and Aggression to the Policy There is a need to develop a script and list of key actions to ensure are followed when calling the police that can be published, laminated and placed in high risk areas for staff to follow. The H&S Manager is meeting with the Reception Team in the new year to address this action.

3.4 Sexual Safety Charter

NHS England released the Sexual Safety in Healthcare Organisational Charter in September 2023 and the Trust is listed on the NHS England website as a signatory to this Charter. The Charter notes 10 commitments that must be met and the assurance framework has been released by NHS England in October 2024.

The responsibility for overseeing the implementation of these commitments lies with the Trust CPO, with oversight from the Violence Prevention and Reduction Working Group. A Project Lead is being identified and there is need for a working group to develop the Trust response to these commitments against the assurance framework.

4. Reducing the Internal Movement of Tugs

As noted in the previous H&S report, the H&S Manager was undertaking a review of traffic movements, including the operation of tugs within internal corridors. This review is now

completed, after consultation with tug users and identified considerable scope to reduce both the:

- groups of users who operate tugs, and
- volume of tugs that travel up and down Maternity Hill.

A detailed paper outlining use, users, approved routes of travel and directions of travel has been presented to the H&S Committee. Key recommendations are:

- Eliminate the use of theatre department tugs and adopt the modified bed mover attachments to transfer patients between main theatres and day surgery (the freed up tug can be distributed to the grounds and waste team).
- Reduce the use of tugs within the porter department, with the exception of picking up and delivering medical records between 06.00 and 07.30 am and to consider the use of flat bed battery powered trolleys to move boxes of IV fluids from pharmacy to wards.

- Modify the route of travel to eliminate travel down Maternity Hill. Tugs can, and already do, utilise external roads and can access the carousel entrance on Level 2 without introducing further risks. This would reduce the volume of tugs going up and down Maternity Hill. Noting 2 exceptions to this rule:

    - Kitchen trolleys returning from wards with food service trolleys, and
    - Waste teams collecting waste from Maternity Hill but maintain a one way movement of traffic.

Action
After a consultation period and in agreement with the H&S Committee it is proposed that changes above are implemented during an implementation phase between January and March to address any concerns identified, with a view to making this change permanent from April 2025. Departments will explore the purchase of alternative equipment to move equipment as a substitute to tugs.

5. Auditing, Ward Inspections and Risk Assessments
During Q2 the H&S team audited Amesbury and the Medical Engineering Department.

A frequent action identified during audits is the lack of specific risk assessments. In response to this the H&S team has created a weekly risk assessment session where ward sisters are invited to complete assessments of specific risks and document the actions taken to reduce the risk to staff.

Since Q1 18 areas have completed department specific risk assessments with 6 completed in Q2 and more are scheduled for Q3 with the H&S team. Departments who have completed risk assessments include areas such as Dermatology, Tisbury and Cardiac Suite where a number of specific risks exist, that are not present in other areas. 8 inspections were completed during Q2. This is a reduction on Q1 and is the result of leave during the summer period. Q3 will see an increase in the scheduled inspections completed.

Inspections and risk assessments continue to be completed on a scheduled basis each quarter.

6. Lone Working Policy
There are a number of departments that have staff working remotely either in a patient home, in a satellite space or in isolation. Some departments have local procedures to manage the risk of lone working but there is no trust policy on the management of risks to the H&S of staff in this situation.

A DRAFT Lone Working Policy has been developed will be presented to the H&S Committee for discussion and approval in the new year. Key inclusions are:

- Lone working devices where working remotely and in isolation. For example, community (midwives and nursing) and satellite staff (community diagnostic service),
- Escalation procedures,
- Pre community visit risk assessments, and
- How to check patient alerts on community medical records.

7. Fit Testing
The supplier of a respirator mask ceased the supply of a specific mask used by the majority of staff across the Trust. The supplier provided a similar mask, with assurances the pass rates would be similar to the previous mask. Trust results showed this was not the case and staff need to be fitted to an alternative mask. A new smaller mask with 100% pass rates was sourced, trialled and looks to be an effective replacement.

Sone staff have a supply of previously fit tested masks that are no longer available, but will need to be fit tested again to a new mask. As a result of this change compliance has dropped from a Trust wide average of 65% to 30%.

The Fit Test Team has increased testing numbers from an average of 140 to 200 fit tests a month and is testing staff to 1 mask whilst this backlog of non compliant individuals are fit tested. When further capacity for subsequent testing is available, second masks will be fitted and follow up tests for expired masks will continue. Compliance by wards is being reviewed by the H&S team, wards and Deputy Chief Nurse to ensure staff are fit tested.

8. Escalations from the December H&S Committee
There are no escalations to the Board from TMC or the H&S Committee for Q2.

9. Trust Risk Register
There are 43 further risks documented on the Trust Risk Register with a risk score of 8 or above with an element of H&S.

- 7 risks relate to the risk of violence from mental health, or the wider availability of mental health beds and the risk to the H&S of staff from long term admissions of mental health and CAMHS patients. The report has identified many of the actions taken by the Trust to manage this risk, and
- 30 relate to the quality of the buildings, areas in need of repair, outstanding maintenance work or the insufficient funding to conduct maintenance activities or lack of desk / office space. These risks have a H&S element but are reported through to the F&P Committee and to the Board to discuss the resources required to manage these risks. The H&S Manager has a scheduled meeting with the Head, and Deputy Head, of Estates to review high or long standing risks on the Trust Risk Register.

Risks of particular note are outlined below.

HEALTH AND SAFETY PERFORMANCE REPORT

FY25 - QUARTER 2

Salisbury NHS Foundation Trust

Risk ID	Rating	Description	Action
7931	16	Theatres electrical power is reliant upon extension leads that are not supported by UPS	Extension leads are being used for surgical equipment due to insufficient sockets and are not protected by IPS/UPS sockets. This compromises the reliability and safety of critical healthcare infrastructure. A fortnightly inspection is carried out by the Estates Team, medical devices and theatres team of all theatres. Estates are looking to commence a project to increase the number of sockets with UPS/IPS protected systems.
7932	16	Wyle house electrical earth failure poses a risk to staff in accommodation should worn and frayed electrical equipment be used.	The cabling installed during construction is breaking down. A Project Manager has been nominated to manage a replacement project and current mitigation has been to replace metal items such as faceplates and light fixtures with plastic ones to eliminate conductive risks.
7917	15	Fire risk in main theatres due to the volume of goods stored in theatre corridors	Simple but effective actions (practice evacuations, clearer evacuation plans and practice evacuations in and removal of racking adjacent to isolation valves), but the volume of equipment continues to expand and theatre trays wrapped in paper offer an ongoing source of fuel should a fire start. The local fire service noted the improvements made but specify the risk is still an extreme risk that needs further action. Structural changes to the theatre layout are needed to reduce the volume of equipment stored in corridors.
3184	12	Insufficient staff and funding of the ETS program to conduct planned and scheduled maintenance	Paper to H&S Committee
7582	12	Theatre main door remains ajar due to air pressures between theatre and main corridor	Maglock timers to be adjusted
8030	12	Poor working environment in Dietetics office	Go and See arranged with H&S Manager and Head of Estates
8127	10	ED window restrictors are insufficient to stop windows being opened.	Work in progress to resolve

Report written by
Troy Ready
Health and Safety Manager
November 2024

NHS Salisbury NHS Foundation Trust

Report to:	Trust Board (Public)	Agenda item:	5.1
Date of meeting:	9 January 2025		

Report title:	Board Assurance Framework (BAF) and Corporate Risk Register (CRR) Report			
Status:	Information	Discussion	Assurance	Approval
		Yes	Yes	
Approval Process: (where has this paper been reviewed and approved):	Reviewed and discussed at Clinical Governance Committee (CGC) and Finance and Performance (F&P) Committee December 2024			
Prepared by:	Fiona McNeight, Director of Integrated Governance			
Executive Sponsor: (presenting)	Fiona McNeight, Director of Integrated Governance			
Appendices:	Board Assurance Framework December 2024 Summary CRR Tracker v1 December 2024 Corporate Risk Register December 2024 Risk Appetite definitions October 2024			

Recommendation:

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

- Board Assurance Framework (BAF)
- Corporate Risk Register
- Risk Appetite

Specifically, the Board is required to:

- Review the overall risk profile for each strategic priority and agree this reflects all current and future risks.
- Review the risks out of tolerance and request any further assurance required in respect of risk mitigation.
- Review the principle strategic risks (BAF) and any associated gaps in control or assurance.
- Review the risk type assigned to each risk and agree this is accurate.
- Agree escalation points for the Trust Board, to include any emerging risk/s or control concerns.

Executive Summary:

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

The BAF was updated to reflect the suggested changes following the deep dive of all BAF risks at the Board development day in August 2024.

The risk appetite was approved by the Board in October 2024. This was a significant process change which included adoption of new risk types, risk definitions and risk appetite. This has been applied to each risk within the BAF and CRR. The Trust has moved from an open risk appetite to a more cautious approach to risk which has markedly impacted the status of risks out of tolerance and is reflected within the BAF and CRR dashboards.

There are 5 new risks on the CRR. This may be a reflection that the deep dives of the Divisional Risk Registers, escalation of risk through the Divisional Performance Reviews and the review of risks with each Executive Director have had a positive impact on the oversight and escalation of risks.

There are currently 11 strategic risks, with no changes to those previously reported on the BAF. BAF risks 2 (sustainability of services) and 6 (Board capacity) have both had reduction in scores.

Application of the new risk appetite has resulted in 10 of the 11 BAF risks now out of tolerance (previously 4). Whilst not unexpected with a move to a much more cautious risk appetite, this is worth consideration of the Board and Board Committees.

There are 20 risks on the CRR compared to 17 reported in September 2024. There are 5 new risks and 2 risks which have been removed.

With the application of the new risk appetite, there are now 15 risks on the CRR which are out of tolerance compared to 5 at the last report.

The changes noted to the BAF and CRR demonstrate that this is a dynamic process and one of continuous improvement. The application of the new risk appetite approved by the Board in October 2024 has resulted in 25 risks now out of tolerance across the BAF and CRR compared with 9 reported previously. This requires further consideration by the Board and Board Committees. The current risk profile reflects the operational, financial and workforce challenges which ultimately have potential to impact the quality of care provision.

Board Committee feedback

The BAF and CRR were reviewed by both CGC and F&P Committees in December 2024. The shift in the risk appetite profile was acknowledged by both Committees. There were no significant concerns raised and it was acknowledged that the committees will continue to review the risks and risk appetite over the coming months and would also consider the impact of the planning guidance on the Board risk appetite, once published. The Committees were assured that their focus has, and continues to be on the Trust key risks including the financial position, operational challenges and the estate. Improvement in the risk profile in relation to the workforce was noted. The governance processes in relation to risk escalation have resulted in changes to the corporate risk profile and provided assurance that these are effective in the main.

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

Salisbury NHS Foundation Trust

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

Purpose

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

2 Background

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

3 Summary Strategic Risk Profile

3.1 Overall summary

The BAF was updated to reflect the suggested changes following the deep dive of all BAF risks at the Board development day in August 2024. Risk descriptions, controls, assurance and mitigating actions have changed accordingly.

The risk appetite was approved by the Board in October 2024. This was a significant process change which included adoption of new risk types, risk definitions and risk appetite. This has been applied to each risk within the BAF and CRR. The Trust has moved from an open risk appetite to a more cautious approach to risk which has markedly impacted the status of risks out of tolerance and is reflected within the BAF and CRR dashboards.

There are 5 new risks on the CRR. This may be a reflection that the deep dives of the Divisional Risk Registers, escalation of risk through the Divisional Performance Reviews and the review of risks with each Executive Director have had a positive impact on the oversight and escalation of risks.

3.2 BAF summary

There are currently 11 strategic risks, with no changes to those previously reported. BAF risks 2 (sustainability of services) and 6 (Board capacity) have both had reduction in scores.

3.3 BAF Risks Out with Tolerance

Application of the new risk appetite has resulted in 10 of the 11 BAF risks now out of tolerance (previously 4). Whilst not unexpected with a move to a much more cautious risk appetite, this is worth consideration of the Board and Board Committees.

3.4 CRR summary

There are 20 risks on the CRR compared to 17 reported in September 2024. There are 5 new risks and 2 risks which have been removed.

With the application of the new risk appetite, there are now 15 risks out of tolerance compared to 5 at the last report and this is worth consideration of the Board and Board Committees.

New risks since September 2024

There are 5 new risks:

- Risk 8102 (Population): Current vacancy rate in Central Booking 9.5wte. Current theatre utilisation is not meeting Trust KPIs (approximately 70-90 theatre slots not booked per week). Risk of patient harm due to significant backlog of referrals which are triaged but not transferred to Lorenzo. Risk to delay of patient follow up due to backlog of e-outcome forms. Score 20.
- Risk 8250 (Population): Lack of 24/7 access to CT perfusion and CT angiography for patients with acute ischaemic stroke there is a risk that patients will not be able to receive life changing treatment as per national guidance. Score 20.
- Risk 8624 (Population): There is a risk that the incorrect management of patients with reduced mental capacity will occur. This is due to a lack of Staff understanding of the Mental Capacity Assessment (MCA) framework and reducing compliance with safeguarding training. This has been impacted by large scale recruitment drive to nursing role to close vacancy but impacted skills mix. Additionally, staff releasing for the MCA and safeguarding training is a challenge for clinical staff. Score 15.
- Risk 8260 (Population): The planning guidance stipulated that for 24/25 all acute Trusts should seek to ensure patients are seen more quickly in emergency departments: with the ambition to improve to 76% of patients being admitted, transferred or discharged within four hours by March 2024, with further improvement in 2024/25. SFT signed up to 78%. Due to increased demand and activity within the UEC pathway in Wiltshire and a higher than anticipated number of patients with a No Criteria to Reside, the Trust has been unable to meet the nationally agreed targets. Score 15.
- Risk 7090 (Population): Overall colonoscopy capacity provided by the sites is lower than was planned/required in the current year. SDH is delivering the requirement RUH and GWH are not. The service is not delivering the standard of 2 weeks of appointment to first offered diagnostic test and surveillance patients are not being seen. Score 16.

Risks removed:

- Risk 7574 (Population): The continued pressure from urgent care flow alongside the increases in length of stay, compromises the ability for the Trust to undertake planned care. This has been replaced with new risks 8250 and 8260.
- Risk 7239 (Partnerships): Ad hoc issues within the supply chain resulting in products being out of stock, having longer lead times or with delays in delivery. The challenges come from a number of factors including the impact from the Covid-19 pandemic and EU exit and economic and global disruptions which are all out of the control of our local procurement team and who are often only made aware that a product will be delayed at the last minute. Regular meetings with Supply Chain and changes in the current economic climate has resulted in greater contingency and resilience within the supply chain.

Risks with an increased score:

- Risk 5751 (Population): Risk of patient harm caused by a delayed discharge from hospital. Score 15 to 20.
- Risk 7472 (People): As a result of recruitment freeze, staff absences, lack of staff skills development, higher than benchmark turnover (in the southwest)of existing staff and hard to recruit to posts (particularly medical), there is a risk that SFT is unable to manage service provision and operate a safe hospital. Score 9 to 12.

Risks with a decreased score:

- Risk 5704 (Population): Inability to provide a full gastroenterology service due to a lack of medical and nursing workforce. Score 16 to 12.

4 Summary

The changes noted to the BAF and CRR demonstrate that this is a dynamic process and one of continuous improvement. The application of the new risk appetite approved by the Board in October 2024 has resulted in 25 risks now out of tolerance across the BAF and CRR compared with 9 reported previously. This requires further consideration by the Board and Board Committees. The current risk profile reflects the operational, financial and workforce challenges which ultimately have potential to impact the quality of care provision.

5 Recommendations

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

- Board Assurance Framework
- Corporate Risk Register
- The risk appetite

Specifically, the Board is required to:

- Review the overall risk profile for each strategic priority and agree this reflects all current and future risks.
- Review the risks out of tolerance and request any further assurance required in respect of risk mitigation.
- Review the principle strategic risks (BAF) and any associated gaps in control or assurance.
- Review the risk type assigned to each risk and agree this is accurate.
- Agree escalation points for the Trust Board, to include any emerging risk/s or control concerns.

Fiona McNeight
Director of Integrated Governance

Salisbury NHS Foundation Trust

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

Board Assurance Framework
December 2024

Fiona McNeight

Director of Integrated Governance

Board Assurance Framework

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

Trust Values

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

Strategic Priorities

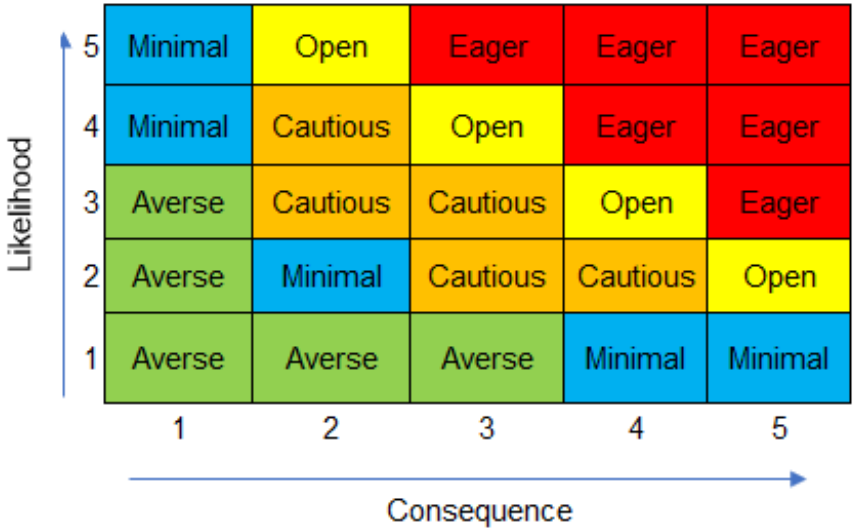
Risk Matrix

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

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

Risk Tolerance	
within tolerance	
outwith tolerance	

Risk Appetite



Averse — Avoidance of risk and uncertainty is key objective

Minimal — Preference for safe options leading to only minimum risk exposure: low likelihood of occurrence of the risk after application of controls

Cautious — Preference for safe options though accept there will be some risk exposure: medium likelihood of occurrence of the risk after application of controls

Open — Willing to consider all options and choose one that is most likely to result in successful delivery; recognise that there could be a high-risk exposure

Eager — Willing to be innovative and take on a very high level of risk but only in the right circumstances

Board Assurance Framework Dashboard

Strategic Risk	Risk Title	Exec Lead	Initial Score	Oct-22	Jan-23	Jun-23	Sep-23	Jan-24	Jun-24	Sep-24	Dec-24	Target	Risk Type	Risk Appetite /Tolerance	Previous risk appetite /tolerance
Risk Detail			Score Trend												
POPULATION - Improving the health and wellbeing of the population we serve															
BAF 1	Delayed or suboptimal deployment of the joint Electronic Record will impact on strategic improvement and impact on the assumed financial benefits to the Trusts operating model	Chief Finance Officer	12						12	12	12	6	Operational	Cautious	Open
BAF 2	Due to the size of our catchment population there is a risk that some services are not sustainable	Chief Medical Officer	15	10	10	10	10	12	12	12	8	8	Clinical	Minimal	Open
BAF 3	Non delivery of programmes within the Digital Plan could result in poor quality services, reputational damage and inability to attract and retain high quality staff	Chief Digital Officer	16	12	12	12	12	12	12	12	12	9	Operational	Cautious	Open
BAF 4	Risks associated with critical plant and building infrastructure that may result in utility or system failure impacting on service delivery.	Chief Finance Officer / Director of estates	12	16	16	16	16	16	16	16	16	12	Operational	Cautious	Open
BAF 5	There is a risk of a shutdown of the IT network due to a cyber attack or system failure which could lead to IT systems access or data loss. This could have a wide range of detrimental impact such as on the delivery of patient care, the security of data and Trust reputation.	Chief Digital Officer	20							20	20	15	Operational	Cautious	Open
BAF 8	Demand for services that outweighs capacity, resulting in an increased risk to patient safety, quality, and effectiveness of patient care.	Chief Operating Officer	20	20	20	16	16	16	12	12	12	9	Clinical	Minimal	Open
People - Supporting our people to make Salisbury NHS Foundation Trust the best place to work															
BAF 6	There is a risk that the Board has limited capacity in terms of time, skills and capacity to effectively oversee the organisation and the delivery of key strategic priorities in 2024/25.	Managing Director	16						16	16	12	8	Workforce	Cautious	Open
BAF 7	Inability to effectively plan for, recruit and retain staff with the right skills which will impact staff experience, morale and well-being which can result in an adverse impact on patient care.	Chief People Officer	20	20	20	16	16	12	12	12	12	9	Workforce	Cautious	Open

Risk Score Key

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

Board Assurance Framework Dashboard

Strategic Risk	Risk Title	Exec Lead	Initial Score	Oct-22	Jan-23	Jun-23	Sep-23	Jan-24	Jun-24	Sep-24	Dec-24	Target	Risk Type	Risk Appetite /Tolerance	Previous risk appetite /tolerance
PARTNERSHIPS - Working through partnerships to transform and integrate our services															
BAF 9	An irreversible inability to reduce the scale of financial deficit	Chief Finance Officer	12	16	16	16	16	16	16	20	20	9	Financial	Cautious	Open
BAF 10	Failure to establish and maintain effective partnerships to support the Integrated Care System with the potential to impact the Trust at PLACE level.	Managing Director/ Chief Operating Officer	9	9	9	9	9	9	9	9	9	6	External	Cautious	Open
BAF 12	Risk of sustained deterioration across key performance metrics (new risk)	Chief Operating Officer	16	16	16	12	12	12	12	12	12	9	Clinical	Minimal	Open

Risk Score Key

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

BAF Risk 1	Delayed or suboptimal deployment of the joint Electronic Patient Record would result in clinical, strategic and financial benefits not being realised including and impact the delivery of the Trust future operating model.		
Strategic Priority	People, Population, Partnership		
Linked Corporate Risks			
Executive Lead	Chief Financial Officer		
Lead Committee	Finance and Performance		
Risk Type	Operational	**Risk Appetite / tolerance**	**Cautious**

Risk Score 2024/25

Initial Score	Jun 23	Sept 23	Jan 24	Jun 24	Sept 24	Dec 24			Target Score
12				12	12 3Lx4C	12 3Lx4C			6 2Lx3C

Context

Becoming a digitally mature organisation with a fit for purpose, integrated Electronic Patient Record (EPR) is a key enabler of the Trust's strategy. The EPR business case articulates the range of anticipated clinical, strategic and financial benefits expected to be achieved through transformation in part driven by the implementation of the EPR. This includes the reduction of duplication and waste as well as the ability to improve access and reduce variability in outcomes across the BSW Acute Hospital Alliance.

Deployment of a common EPR across three acute Trusts is a complex technical and change management process, requiring significant acquisition of skills within our existing workforce and through new recruitment. The level of change both in pathways and culture to maximise the potential of the Shared EPR. Given the multifaceted nature of the programme and the wide range of strategic plans the EPR will enable, the risk that delay or ineffective delivery is substantial.

Controls

- BSW shared EPR programme board in place.
- Joint Committee established to oversee EPR programme at AHA level. Both meet monthly.
- Monthly EPR Delivery Group (CDO/CCIO led) established, with EPR Oversight Group (CEO led) to oversee delivery of local actions, any emerging risks/mitigations and impact of wider change.
- SFT board level engagement in all key aspects of EPR delivery.
- Delivery partnership with Oracle Health.
- Weekly EPR Programme Team meeting with workstream leads
- Delivery partners in areas such as Data Migration in place

Assurance

- Joint committee governance reporting to three boards within AHA
- Phased deployment plan with project milestones overseen by programme board, escalating to joint committee
- NHSE oversight of EPR programme progress and gateways with assurance reviews
- Berkeley independent assurance
- Internal Audits for local Audit Committee assurance

Progress

What is going well/ Future Opportunities?

Implementation oversight governance agreed including NED led Joint Committee meeting bi-monthly.
Shared EPR FBC approved by NHSE in March 2024.
EPR central programme team recruited and majority of resources required at this stage identified (improved from last report)
First "align" gateway passed in November 2024 with a few areas work in progress (mainly developed strategies needing final sign off in December.

What are the current challenges including future risks?

1. Digital transformation has a legacy reputational issue within SFT
2. Significant change programme delivery already occurring with SFT and the Hospitals Group
3. Current financial and operating context could jeopardise acquisition of key skills or individuals
4. Release and backfill of key clinical staff
5. Delivery of programme on time and budget.
6. Lorenzo end of life with limited supplier development to resolve issues identified and comply with Information Standard Notices.

How are these challenges being managed?

1. Strong executive oversight at all levels of digital governance, increased leadership briefings from Dec 24
2. Strengthened digital clinical leadership capacity, EPR programme integrated with Improving Together continuous improvement methodology at Hospitals Group and organisational level, oversight of quantum of change through CEO led group.
3. Recruitment report reviewed weekly at workforce control panel and action to improve onboarding approach across Hospitals Group
4. Targeted engagement on recruitment with Divisions, approach for monitoring backfill impact to be agreed between CFOs and CPOs
5. EPR Programme Director in post, EPR governance manages risk portfolio
6. National escalation on any severe incidents/requirements, monthly supplier engagement to influence development priorities

BAF Risk 2	Due to the size of our catchment population there is a risk that some services are not sustainable		
Strategic Priority	Population		
Linked Corporate Risks	8188, 5704, 7090		
Executive Lead	Chief Medical Officer		
Lead Committee	Finance and Performance		
Risk Type	Clinical	**Risk Appetite / tolerance**	**Minimal**

Risk Score 2024/25

Initial Score	Jun 23	Sept 23	Jan 24	Jun 24	Sept 24	Dec 24				Target Score
15	10	10	12	12	12 3Lx4C	8 2Lx4C				8 2x4

Context

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

Sustainable services is a clear priority for BSW ICB and the Trust strategy.

The Group model provides opportunities for strengthening fragile services that are critical to the sustainability of the Trust to be identified through the development of the Group Strategic Planning Framework (SPF)

Current fragile services prioritised for transformation work are gastro and dermatology.

This risk links with BAF risk 7 given the challenges to recruitment and retention of staff in these fragile services.

Controls

Evolving structures within the Group to provide strategic oversight to the collaborative transformation work.
Regular meetings of the 3 Trust Executive Directors
Gastro waiting list validation and pathway configuration work

Assurance

Agreement of the Group SPF

Progress

What is going well/ Future Opportunities?	What are the current challenges including future risks?	How are these challenges being managed?
The requirement of health and Care legislation to actively collaborate affords an opportunity to redesign services to ensure delivery for the population of BSW as a whole which may be impacted by the formation of a Group Model.	1. Pace of change required for large scale reconfiguration. 2. Cultural change required to deliver service benefit through collaborative transformation.	1. Moved to a Group Model. 2. Formed Group with single CEO to provide strategic direction

BAF Risk 3	Non delivery of programmes within the Digital Plan could result in poor quality services, reputational damage and inability to attract and retain high quality staff		
Strategic Priority	People, Population, Partnership		
Linked Corporate Risks			
Executive Lead	Chief Financial Officer		
Lead Committee	Finance and Performance		
Risk Type	Operational	Risk Appetite / tolerance	Cautious

Risk Score 2024/25										
Initial Score	Jan 23	Jun 23	Sept 23	Jan 24	Jun 24	Sept 24	Dec 24			Target Score
16	12	12	12	12	12	12 3Lx4C	12 3Lx4C			9 3Lx3C

Context

The Trust is digitally immature when benchmarked nationally. The Trust's digital plan sets out a significant agenda to improve integration of systems, maximise the existing Electronic Patient Record (EPR) whilst working towards a more sustainable longer term joint approach across the ICS, expanding the use of data and ensuring we have infrastructure that enables us to effective use technology and stay safe.
As technology touches on most transformation programmes, there is insufficient capacity and funding to deliver all that is asked with our appropriate prioritisation. This constraint risks a slower response to identified clinical or operational risks and requirements, meaning the Trust will be accepting a higher level of associated risk until programmes can be completed/systems introduced. The Trust also may not be able to maintain all desired level of improvements alongside participating in all local and regional initiatives with peers. Current score remains at 12, recognising Trust financial position increases risk associated with sufficient funding to deliver wider elements of the Digital Plan.

Controls

- Monthly Digital Steering Group in place with robust digital governance below this, including programme governance.
- Comprehensive clinical digital leadership in place.
- Digital Innovation Network launched to increase digital profile including digital champions and digital superusers to support change and ownership.
- Cyber security team set up within IT Operational to manage cyber risk mitigation activities.
- Joint CDO, CIO & Deputy CIO across SFT & GWH.

Assurance

- Monthly Digital Steering Group minutes. Prioritised digital plan for the year agreed
- Regular Digital Plan updates to Board committees.
- Annual board update
- Regular minutes from BSW shared EPR programme board with updated governance being set up.
- Rolling cyber desktop exercises results
- Fortnightly risk review meetings in place

Progress

What is going well/ Future Opportunities?

Refreshed Digital Plan approved at Trust Board in November 2022.
Opportunity to build resilience across Hospitals Group across the Digital structures, building on Corporate Services Review work in Nov 23, seeking to progress this in Q4 2024/25.

What are the current challenges including future risks?

1. There remains a large agenda of projects with a digital component which are not resourced, funded or prioritised.
2. Some digital programmes are behind original plans.
3. Lack of funding to deliver full Digital Plan including removing all unsupported technologies.
4. Clinical engagement is limited due to operational pressures.
5. Recruitment and retention of Coding and Business Intelligence skills
6. Clinical Safety Officer role currently vacant

How are these challenges being managed?

1. Prioritisation of programmes through Corporate Projects Prioritisation Group to ensure the change agenda is realistic and QIAs completed for those unfunded or de-prioritised programmes.
2. Programmes are rebased as part of existing programme governance & strong PMB challenge on delivering against this rebased targets in place. Risk mitigations put in place where appropriate.
3. Seeking opportunities for national funding to support programmes.
4. Shared EPR leads identified to champion and engage with wider peers, leadership comms pack for EPR being rolled out in Dec 24. Implementing new communication software to support different digital communication methods.
5. Implementing plan to build resilience with GWH, external coding support agreed with wider business case developed, digital services review.
6. CCIO holding CSO responsibilities whilst ICS CSO proposal is finalised.

BAF Risk 4	Risks associated with critical plant and building infrastructure that may result in utility or system failure impacting on service delivery.		
Strategic Priority	Population		
Linked Corporate Risks	7734, 6229		
Executive Lead	Chief Finance Officer		
Lead Committee	Finance and Performance		
Risk Type	Operational	**Risk Appetite/Tolerance**	**Cautious**

Risk Score 2024/25

Initial Score	Jun 23	Sept 23	Jan 24	May 24	Sept 24	Dec 24			Target Score
12	16	16	16	16	16 4Lx4C	16 4Lx4C			12 3Lx4C

Context

SFT has a substantial estates backlog (£78m – 2024) which impacts service delivery, quality of estate and public/patient experience. Limitations via CDEL and lack of investment capital impact the Trust ability to reduce the estates backlog and creates a corresponding increase in Trust risks; costs to operate and maintain the existing estate, likelihood of future infrastructure and estate failures, compromised service delivery and patient care. Equally environmental sustainability investment is limited reducing the Trust ability to achieve net carbon zero.
Whilst National and/or targeted funding may become available, careful planning and prioritisation of requirements is essential yet remains consistently insufficient to make any marked progress in the reduction of long term risks or exceed the inflationary rate of change to the backlog value. The clinical strategy and the estates strategy are key long-term plans for the Trust evolution and delivery of effective and reliable services over the next 10 years (and beyond) but require significant investment to achieve.

Controls

6 Facet survey of the whole site completed in 2022, providing an up to date and independent assessment of the campus in accordance with National guidance (NHS Estate Code).
The 6-facet data reviewed annually and adjusted to reflect capital investment made in year and increases due to inflation. Last annual update May 2024
Quarterly estates reporting to Trust Board. Annual capital plan reviewed via Strategic Capital committee.
Internal audit on management of backlog maintenance completed in 2023 and recommendations completed.
Internal audit on compliance reporting completed in 2024 and recommendations currently being followed through.

Assurance

Significant improvements in estates governance and risk management introduced including the 10 year capital programme compiled, with investment forecasts for estates backlog and a 5 year plan for year on year spend.
Estates compliance status clearly recorded. Majority of targets achieved. One extreme risk outstanding, most highs reduced. Continued progress to mitigate and conclude compliance actions August 2024 before moving to business as usual.

Progress

What is going well /Future Opportunities?

- 10 year capital programme compiled, includes investment forecast for estates backlog. Program subject to annual prioritisation process
- Additional elective ward completed (replaces poor condition estate)
- Estates strategy renewal, mobilised with target completion Dec 2024.
- Estates strategy update will incorporate Campus project for long term development
- Successful bid for national investment to begin decarbonisation of energy infrastructure, £10m for 2023/24, further bids to be submitted for future years.

What are the current challenges including future risks?

1. Insufficient capital. Inflation pressures alone continue to significantly increase backlog value year-on-year
2. Competing demands for Trust capital each year.
3. Reduction in revenue funding will impact on ability to maintain and repair existing infrastructure.
4. Estates backlog value (£78m) is not actual cost to deliver Likely value £124m
5. Limited electrical infrastructure on campus impacting future redevelopment opportunities
6. Current decarbonisation (Salix) investment does not encompass whole site. Further investment required to realise decarbonisation. Decarbonisation strategy reduces fossil fuel use but increases electrical demand which is a higher cost, Trust utility costs will rise as we become more environmentally sustainable.
7. Lack of adequate investment means infrastructure continues to degrade – level of backlog maintenance increases. Cost to maintain Trust estates and infrastructure increases. Infrastructure failure risk increases
8. Day surgery unit remains Trust highest priority, with no funding source available.
9. Aged areas of the Estate are not fit for purpose or occupation (SFT South and central) but require investment for continued use and are at higher risk of failure.
10. Trust 'space' is in high demand and appetite to remove poor quality buildings challenged with space use.
11. Clinical strategy limitations inhibit the estates strategy.
12. National targeted resources do not address key resilience issues
13. Patient environment quality being compromised e.g., spinal unit
14. Quality of on-site residential accommodation poor with little investment

How are these challenges being managed?

1,2 - Categorisation & prioritisation of Trust capital. Review and prioritisation within Trust framework alongside digital, medical equipment
1,8- Continued lobbying for major service developments – DSU
3- The frequency of maintenance is adjusted where possible, trying to ensure statutory requirements and best practice are maintained, this can result in increased issues at a later date and increased cost pressures.
6 - Funding applications made for environmental sustainability and energy decarbonisation (e.g. Salix)
9 - Investigations into strategic partnership models to allow development and investment of the estate.
7,9,10 - Continued review of poor-quality accommodation use, identifying opportunities to vacate (e.g remove and dispose archive material) with potential to demolish and remove risk
10 - Increased scrutiny of estate requests via space allocation committee. Management of space utilisation 'creep'.
11, 13 - Estate's strategy mobilised
12 - Monthly meetings with regional NHSEI colleagues to highlight priorities and risks
14 - Board paper planned to present options for on-site residential accommodation

BAF Risk 5	There is a risk of a shutdown of the IT network due to a cyber attack or system failure which could lead to IT systems access or data loss. This could have a wide range of detrimental impact such as on the delivery of patient care, the security of data and Trust reputation.		
Strategic Priority	People, Population, Partnership		
Linked Corporate Risks			
Executive Lead	Chief Financial Officer		
Lead Committee	Finance and Performance		
Risk Type	Operational	**Risk Appetite / tolerance**	**Cautious**

Risk Score 2024/25

Initial Score	Jun 23	Sept 23	Jan 24	Jun 24	Sep 24	Dec 24			Target Score
20					20 4Lx5C	20 4Lx5C			15 3Lx5C

Context

The Global cyber position is a continuous evolving picture with new threats on a daily basis, therefore the inherent risk to the NHS remains high. The impact of a cyber attack is wide reaching, disrupting clinical care and operational delivery, increasing the risk of reputational damage and legal challenge due to the risk of data availability and loss. A cyber attack will impact whether it is directly against the Trust or indirectly against a partner or third-party supplier.
The Trust has a range of controls and processes in place, engaging with national, regional and local peers to provide a networked approach to cyber security. However, a cyber attack can commence very easily, and it is impossible to have complete cover. Recent cyber events highlight that the healthcare supply chain is an increasingly targeted area.
The NHS has released a new cyber strategy for healthcare to help ensure organisations maintain good cyber posture, protect as one and focus on staff awareness and development as this is often an attack vector.
Given this is an inherent risk, the expectation is that this risk will always be out of tolerance.

Controls

- Local cyber security team in place
- Digital Steering Group oversight of cyber plans
- Modern and secure cyber security technologies including VPN, antivirus, bitsight, endpoint protection, medical equipment, IoT, modern firewalls, etc
- Security patching controls
- Multifactor authentication on NHS Mail
- Cyber awareness programme and phishing feedback/retraining
- Member of ICB TDA Cyber Group and National forums including Cyber Associates Network and Executives Forum
- Close engagement with NHSE regional cyber lead

Assurance

- Weekly tech group minutes,
- Replacement programme – unsupported servers
- Monitoring of Infrastructure downtime
- IT Health Assurance Dashboard oversight
- Quarterly cyber report to FIDC
- Annual Data Security and Protection Toolkit (DSPT) internal audit and penetration testing
- Data, Security and Protection Toolkit submission with annual internal audit assessment as part of this
- Cyber awareness plan
- Phishing testing

Progress

What is going well/ Future Opportunities?

Trust met DSPT standards for 2023/24.
Good coverage of cyber toolsets to monitor the Trust and respond to cyber events.
The Trust has a high Bitsight score showing good internet facing cyber posture.
Opportunity for closer ICS working and national funding through ICS wide procurements.
Approval of ICS wide cyber lead agreed by ICB.

What are the current challenges including future risks?

1. Improvement required in Cyber Security Preparedness, in particular stronger planning for business continuity for longer term cyber attack.
2. Board visibility of cyber controls and improvement plans needs improving.
3. Trust is required to expand Multi-Factor Authentication (MFA) in line with national policy.
4. Alignment of cyber security controls and policies across ICS will enable improved support in the event of a cyber attack.
5. Supplier controls and oversight requires enhancement given recent cyber attacks

How are these challenges being managed?

1. Review of existing and planned system business continuity for extended outages and for systems which are shared across the region/clinical networks to ensure business continuity plans are fit for purpose. Starting with new Pathology LIMS.
2. Development of cyber security framework for annual Board assurance, approval in Dec 24.
3. MFA improvement plan in development to provide assurance of application MFA compliance ahead of June 2024 CAF (new DSPT) deadline.
4. Completion of Softcat cyber gap analysis for all ICS partners.
5. Engaging with existing suppliers to clarify the current position on sub-contractors/dependant suppliers, assurance of supplier penetration testing and preparedness with support from ICS procurement team.

BAF Risk 6	There is a risk that the Board has limited capacity in terms of time, skills and capacity to effectively oversee the organisation and the delivery of key strategic priorities in 2024/25.		
Strategic Priority	People		
Linked Corporate Risks			
Executive Lead	Managing Director		
Lead Committee	Board of Directors		
Risk Type	Workforce	**Risk Appetite / tolerance**	**Cautious**

Risk Score 2024/25									
Initial Score	June 24	Sept 24	Dec 24						Target score
16	16	16 4Lx4C	12 3Lx 4C						8 2Lx4C

Context	Controls	Assurance
The Executive team will have three interim roles (MD, COO, CFO) which can limit stability of leadership in year. There is a delay to substantive recruitment due to uncertainty on future governance arrangements in the group, the uncertainty could also lead to further attrition of key roles. There are a number of strategic objectives which will render significant leadership capacity including replacement EPR and financial recovery which dilutes capacity on BAU improvements. Changes in executive team can mean loss of organisational knowledge and experience which in the short term can slow progress or risk delivery which impacts on the reputation of the organisation.	Board oversight of key metrics through IPR AHA Joint Committee on EPR to ensure oversight and shared delivery. Interim mitigation plans enacted for all roles Remuneration committee for oversight of performance. Succession planning in place	- Engine room oversight of breakthrough metrics/strategic initiatives and vision metrics to focus on delivery and risks.

Progress

What is going well/ Future Opportunities?	What are the current challenges including future risks?	How are these challenges being managed?
Interim roles predominately held by SFT substantive employees maintaining organisational knowledge. Recruitment plans underway to commence MD Q4 2024. CMO role now substantive recruited	• Uncertainty about group governance structures leading to further attrition in key roles. • Attracting high calibre candidates in context of uncertainty as group governance develops.	- Regular executive team development . - Recruitment process planning underway - Board oversight of risks and strategic programme

BAF Risk 7	Inability to effectively plan for, recruit and retain staff with the right skills which will impact staff experience, morale and well-being which can result in an adverse impact on patient care.											
Strategic Priority	**People**			**Risk Score 2024/25**								
Linked Corporate Risks	7472, 8102			Initial Score	Jun 23	Sept 23	Jan 24	Jun 24	Sept 24	Dec 24				Target Score
Executive Lead	Chief People Officer													
Lead Committee	People and Culture Committee			20	16	16	12	12	12 3Lx4C	12 3Lx4C				12 3Lx4C
Risk Type	Workforce	**Risk Appetite / tolerance**	**Cautious**											

Context	Controls	Assurance
Quarterly pulse survey is indicating a maintained position against all elements of the People Promise. Currently showing an above average return on the National Staff Survey. There is a National shortage of workforce across a range of professions and BSW mirror the National picture. Attraction to geographical area through recruitment and retention premia, Golden Handshake welcome payment, offer of relocation payment and re-launched 'Refer a friend scheme' has been successful. These initiatives are now subject to authorisation by the ICB further to increased financial and workforce controls. Financial target includes a WTE reduction of 220wte which at month 7 is off track. This year's breakthrough objective is to increase staff retention/reduce turnover of HCAs from 20% to 15% (current position at month 7 is 18%). Alongside a revised Trust all staff turnover of 13%. On-going challenge to attract Consultant medical workforce in specific specialties (links to BAF risk 2). Recognition of the need to improve transparency of career pathways and access to continuous professional development (CPD). Focus of the newly appointed Associate Director.	Weekly workforce Control Panel overseeing vacancies Financial recovery programme –group now meet fortnightly International RN and Midwife recruitment HCA recruitment and retention facilitator in post Staff retention now a breakthrough objective with clear focus Active update and review of all people policies which are being written and implemented in support of a just and restorative culture. Workstreams for all 7 elements of the People Promise benchmarked against staff survey. Monthly and quarterly governance schedule established. Established leadership development programme plus launch of the people management skills modular programme Overhauled recruitment process; emphasis on high impact actions People Promise Manager retained with an extended portfolio to include widening participation IPR metrics monthly reporting	Improved vacancy position as a result of attraction incentives; c2,3% Completion rate of the National Staff Survey is 50.4% (National average is 41.6%) Maximum take up on the leadership development, wellbeing and appraisal training courses Time to hire recruitment process – significant reduction in days. Sickness absence 3.8% (October) Turnover 12.88% (October)

Progress

What is going well/ Future Opportunities?	What are the current challenges/future risks?	How are these challenges being managed?
Leadership including clinical leads first introduced this year with good uptake. Leadership engagement – practical support including investment and participation Head of Education leading improvement projects e.g. increasing apprenticeships/Safe Learning Environment Charter Development of a strategic workforce plan. NHS Ambassadors and take up of work experience in the Trust	1. Increasing retention and reducing turnover 2. Line managers capacity & capability to manage exit interviews and complete appraisals 3. Non-Medical Appraisal compliance – slow improvement 4. Manager's capacity to manage staff wellbeing and career development due to operational pressures. 5. Lack of Strategic workforce planner 6. HCA retention 7. Increasing ward-based absence	1. A comprehensive improvement programme against all 7 elements of the People Promise and focus on breakthrough objective (turnover). 2. Approach to appraisal & career conversation part of talent and succession planning launch. Soft launch of c18 modules for Line managers, formal launch of required core modules April 25 (Licence to Manage). 3. Improving line manager training. 4. As per 2. 5. Outstanding – post to be considered at WCP 6. Breakthrough objective for 24/25 7. Detailed breakdown of absence data to be shared with ward leads

BAF Risk 8	Demand for services that outweighs capacity, resulting in an increased risk to patient safety, quality, and effectiveness of patient care.		
Strategic Priority	Population		
Linked Corporate Risks	7573, 8260, 5751		
Executive Lead	Chief Operating Officer		
Lead Committee	Finance and Performance		
Risk Type	Clinical	**Risk Appetite / tolerance**	Minimal

Risk Score 2024/25

Initial Score	Jun 23	Sept 23	Jan 24	Jun 24	Sept 24	Dec 24				Target score
20	16	16	16	12	12 3Lx4 C	12 3Lx4C				9 3Lx3C

Context

Our operational context remains challenging with demand for Urgent and Emergency services currently outstripping our capacity and this is consistently meaning patients are waiting for treatment longer than the national constitutional standard, which can also lead to substandard care.

Demand within urgent care continues to grow at 10% year on year which is leading to the continued use of escalation capacity and putting undesired pressure on clinical services which is compromising efficiency and effectiveness of the operational flow and compromises patient care.

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

Controls

BSW system support to identify / enhance out of hospital offering and capacity such as virtual ward and care co-ordination centre in place.
Further productivity improvements in SFT, Urgent Care, introduced new ways of working within SDEC / frailty model / ED etc

Increasing SFT capacity through opening of Imber ward.

Utilisation of escalation capacity and outsourcing when required.

Assurance

BSW Virtual ward and care co-ordination centre in place reducing demand on SFT beds and admissions
SDEC model reducing bed occupancy requirements for SFT
Acute Frailty model started August 23 – decreased LOS
Overall bed escalation and bed occupancy has decreased since Q4 2022/23.

Progress

What is going well/ Future Opportunities?	What are the current challenges including future risks?	How are these challenges being managed?
Improvement plan developed and range of system/ sft groups to help reduce NC2R to 5% of bed base. The Trust opened Imber ward in June 24 which will support increasing bed capacity, enabling further improvements to elective and non-elective flow. Urgent care and flow board identifying further improvements that can support flow e.g. weekend working	1. Relatively high NCTR bed occupancy limiting available bed capacity. 2. Continued escalation into DSU compromising surgery rates and recovery of 2019/20 activity levels. 3. On going workforce challenges within a number of specialities. Eg frailty team. 4. Continued growth in NEL demand that is higher than forecast/planned. 5. Ageing estate is limiting productivity opportunities.	1. BSW and SFT specific work programme on reducing NC2R as percentage of bed base. Aiming for 14% during 24/25. 2. Urgent care Board to oversee transformation programme. Rebasing of the hospital capacity to enable and support improved functionality of key flow components ie reintroducing a discharge lounge. 3. Dedicated work within people committee to support recruitment into hard to recruit posts.

BAF Risk 9	SFT is unable to reduce its expenditure sufficiently to deliver financial sustainability		
Strategic Priority	Partnership		
Linked Corporate Risks	5955, 6857, 7308		
Executive Lead	Chief Finance Officer		
Lead Committee	Finance and Performance		
Risk Type	Financial	**Risk Appetite / tolerance**	Cautious

Risk Score 2024/25

Initial Score	Jun 23	Sept 23	Jan 24	Jun 24	Sept 24	Dec 24				Target Score
12	16	16	16	16	20 5Lx4C	20 5Lx4C				9 3Lx3C

Context

The Trust has had an underlying deficit greater than 5% of turnover for a number of years. This has led to a reducing cash balance, in turn constraining its ability to invest in capital programmes.

Continued pressure on urgent case pathways and agency pressures driven by hard to recruit posts have led to this position deteriorating leading to a requirement for cash support, and due to the financial pressure across the NHS the availability of cash support is increasingly uncertain. The Trust is not alone with BSW ICS reporting an underlying deficit relative to allocation funding.

The inability to deliver a breakeven position required to maintain a sufficient cash balance risks the ability to deliver safe and effective care and/or regulatory action associated with breach of license conditions.

Controls

ICB engaged in supporting SFT cash position through phasing of contractual payments.
Finance & Performance Committee oversight of cash position with escalation to Board.
Agreement of annual financial plan including cash requirements.
Escalation to ICB and engagement in NHSE revenue support process.
The BSW-wide procurement workplan levies the ICS spending power to mitigate the impact of inflation.
Breakthrough objective initiatives focus on maximising the clinical outputs of the Trust while maximising the input resource required.
Enhanced BSW recruitment and investment controls

Assurance

External audit value for money assessment.

Monthly reporting on performance and forecast through Financial Recovery Group, escalated to Finance and Performance Committee.

Cash flow forecasting included in Finance and Performance Committee reporting.

Reporting of improved productivity as demonstrated by Creating value for the patient: Improving productivity breakthrough objective measurement

Third party assessment on financial plans and efficiency programme undertaken with BSW

Progress

What is going well/ Future Opportunities?	What are the current challenges including future risks?	How are these challenges being managed?
Focus on increase in productivity to mitigate further decline in financial position and maximise opportunities for ERF. Acute Alliance programme of benchmarking to identify opportunities. LOS reductions having favourable impact on bed base. Work on longer stays on-going.	1. Delivering CIP plans against identified opportunity in context of significant operational challenges. 2. Increasing proportion of savings programme will have to be delivered through clinical service transformation. 3. Adequate cash reserves to service capital programme 4. Medium term financial outlook is uncertain 5. Long term capital programme needs to be assessed against available CDEL and additional funding sources. 6. BSW transformation programme immature and not fully developed.	1. Improving together programme improving a structured approach to change. 2. Working with ICS to develop BSW sustainability programme. 3. Engagement in capital cash support programme 4. BSW mid-term plan under development 5. Trust and BSW strategic capital groups developing prioritisation. 6. BSW-wide oversight through System Recovery Group, chaired by BSW ICB CEO. 10 programmes of work established

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

Risk Score 2024/25									
Initial Score	Jun 23	Sept 23	Jan 24	Jun 24	Sept 24	Dec 24			Target Score
9	9	9	9	9	9 3Lx3C	9 3Lx3C			6 2Lx3C

Context

The Integrated Care Board continues to develop and respond to changing national guidance on role and functions. In turn this places risk to how quickly trusted successful partnership working can enable service integration and delivery. As the ICB develops further, there remains a need to focus on place.

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

The community services contract has now gone live which offers both an opportunity and presents a challenge to the integration of services for SFT.

Controls

ICB and Wiltshire PLACE with SFT representation
Established AHA with SFT representation
SFT executive representation within ICS workstreams

Assurance

Community services delivery plan published

Progress

What is going well/ Future Opportunities?	What are the current challenges including future risks?	How are these challenges being managed?
Work with the Acute Hospital Alliance continues to develop and gather momentum. Acute Alliance Clinical strategy in place. Elective and Urgent care well established forums New Community services tender creates an opportunity for a reset. Wiltshire Council have relaunched the aging well board.	1. Place based working still in infancy, further work to progress placed based strategy for integrated care. 2. Challenge to develop relationships across multiple partners at place, including the capacity to influence and support the wide range of groups. 3. BSW completing tender for community services. 4. ICB is currently undergoing a mandated organisational review of form and function. The outcome of this is not yet fully known and this may place additional responsibility on other partners. ICB programme may also shift the balance between system and place. 5. New partner for SFT with HCRG winning community tender	1. The Trust is represented at appropriate meetings at PLACE, Acute Providers and the ICS. 2. Exec team members developing relationships with professional colleagues, attending stakeholder events. 3. Community service programme board being established.

BAF Risk 12	Risk of sustained deterioration across key performance metrics		
Strategic Priority	Population		
Linked Corporate Risks	7078, 7573, 5751, 8250, 8260, 8102		
Executive Lead	Chief Operating Officer		
Lead Committee	Finance and Performance		
Risk Type	Clinical	Risk Appetite / tolerance	Minimal

Risk Score 2024/25

Initial Score	Jun 23	Sept 23	Jan 24	Jun 24	Sept 24	Dec 24			Target score
16	12	12	12	12	12 3Lx4C	12 3Lx4C			9 3Lx3C

Context

There is a risk that all performance targets (Cancer, Planned Care, Diagnostic targets, Urgent Care standards) are not improving due to significant gaps in workforce and ongoing industrial action.

Due to significant gaps in workforce across a number of functions (e.g Theatres, Diagnostics, central booking) alongside demand being greater than capacity, key performance and quality metrics are showing sustained deterioration. There remains risk of regulatory action if the Trusts fails to meet agreed access targets.

The ongoing likelihood of industrial action has reduced although the potential impact remains significant on the Trusts ability to meet performance targets due to the level of cancellations.

Controls

Planned care and urgent Care boards for transformation
BSW Planned Care Board and Elective Recovery group
Delivery group monitors performance weekly
Cancer improvement group

Assurance

Trust reports performance against agreed trajectories within the IPR.

52/65 week performance is on trajectory although delivery will be tight in certain specialities.

Outsourcing arrangement for additional capacity in Radiology which has improved DMO1 performance significantly in Ultrasound, MRI and CT.

Annual planning includes demand and capacity planning

Progress

What is going well/ Future Opportunities?	What are the current challenges including future risks?	How are these challenges being managed?
DM01 improved during Q2& Q3 with additional capacity and focused recovery. Some recovery of long waits for Breast Reconstruction activity reducing the number waiting over 78 weeks. Cancer backlog for skin has reduced with focused funding from Cancer alliance and increased outsourcing.	1. Number of Patients waiting for planned treatment is increasing; industrial action impacting. 2. Significant issue with Plastic breast reconstruction services due to Consultant capacity. 3. Outpatient waits not reducing in line with expectations – further improvement work targeted to reduce follow up's increase PIFU and improve pathways for patients.	1. Improved governance processes for oversight of performance (delivery group. Cancer improvement group). New process standard work in place from January 2024. 2. Planned Care and Urgent Care SFT Boards in place to support transformation – focus on outpatient in Q4. 3. BSW Urgent care and Planned care boards well established to help support delivery.

Corporate Risk Register Summary - December 2024 v1

Risk (Datix) ID	Risk Title	Exec Lead	Date Risk Added	Initial Score	Jan-23	Jun-23	Sep-23	Jan-24	Jun-24	Sep-24	Dec-24	Target
Risk Detail				Score Trend								
POPULATION - Improving the health and wellbeing of the population we serve												
5704	Inability to provide a full gastroenterology service due to a lack of medical and nursing workforce	Chief Medical Officer	31-Jan-19	16	9	15	15	15	12	16	12	8
5751	Risk of patient harm caused by a delayed discharge from hospital.	Chief Operating Officer	11-Mar-19	16	20	20	15	15	15	15	20	12
5955	Insufficient organisation wide robust management control procedures. **Risk tolerated**	Chief Finance Officer	13-Aug-19	15	9	9	9	9	6	6	6	6
7946	As a result of competing priorities, shifting resource plans and sub-optimal scoping of projects there is a risk that transformation programmes and projects will not be delivered to time which may result in the Trust not realising the benefits of the work.	Chief Medical Officer/Director of Transformation	02-Jan-24	12				12	12	12	12	9

6229	The DSU building is 'end of life' and has been identified as priority for replacement. The fabric of the building is problematic and leads to numerous rook leaks and delayed / cancelled procedures. Failure of the air handling unit is becoming a regular occurrence, this in turn affects the overall environment, prevents activity from taking place owing to infection control policies and results in cancellations of elective procedures. Incidents relating to the building condition are increasing and impacting on patient safety, care and experience	Chief Operating Officer	02-Jan-23	12	20	20	20	20	20	20	20	4
7573	The risk of sustained use of escalation bed capacity (e.g. DSU, Discharge lounge, intervention radiology) has an impact on patient safety due to not enough substantive staff for increased bed capacity, patients not always placed initially in most appropriate ward. The more beds the Trust has open the impact on operational effectiveness, e.g. ward rounds, clinical support services.	Chief Operating Officer	16-Jan-23	20	20	20	15	12	9	9	9	9
7807	As a result of a lack of mental health provision there is a risk that patients with specialist mental health needs are being managed in the acute setting. This may result in sub-optimal care with less therapeutic value than if undertaken in the right setting with appropriately trained staff.	Chief Medical Officer	16-Aug-23	20			20	15	15	12	12	9

8102	Current vacancy rate in Central Booking 9.5wte. Current theatre utilisation is not meeting Trust KPIs (approx 70-90 theatre slots not booked per week). Risk of patient harm due to significant backlog of referrals which are triaged but not transferred to Lorenzo. Risk to delay of patient follow up due to backlog of e-outcome forms. **New risk**	Chief Operating Officer	01-Nov-24	20							20	12
8250	Lack of 24/7 access to CT perfusion and CT angiography for patients with acute ischaemic stroke there is a risk that patients will not be able to receive life changing treatment as per national guidance. **New risk**	Chief Operating Officer	03-Dec-24	20							20	6
8264	There is a risk that the incorrect management of patients with reduced mental capacity will occur. This is due to a lack of Staff understanding of the Mental Capacity Assessment(MCA) framework and reducing compliance with safeguarding training. This has been impacted by large scale recruitment drive to nursing role to close vacancy but impacted skills mix. Additionally staff releasing for the MCA and safeguarding training is a challenge for clinical staff. **New risk**	Chief Nursing Officer	10-Dec-24	15							15	9

8260	The planning guidance stipulated that for 24/25 all acute Trusts should seek to ensure patients are seen more quickly in emergency departments: with the ambition to improve to 76% of patients being admitted, transferred or discharged within four hours by March 2024, with further improvement in 2024/25. SFT signed up to 78%. Due to increased demand and activity within the UEC pathway in Wiltshire and a higher than anticipated number of patients with a No Criteria to Reside, the Trust has been unable to meet the nationally agreed targets. **New risk**	Chief Operating Officer	06-Dec-24	15							15	8
7090	Overall colonoscopy capacity provided by the sites is lower than was planned/required in the current year. SDH is delivering the requirement RUH and GWH are not. The service is not delivering the standard of 2 weeks of appointment to first offered diagnostic test and surveillance patients are not being seen. **New risk**	Chief Operating Officer	01-Nov-24	12							16	8

8188	ERCP is highly technical and intrinsically high risk procedure with exacting training and regulatory requirements. In a challenging market SFT has been unable to recruit substantive ERCP practitioners for several years. ERCP is therefore currently delivered by an outsourcing company providing one session for ERCP per week, with no cover for annual leave. On its own this arrangement provides no ability to flex capacity to meet peaks in demand, or to always accommodate patients with severe illness who need intervention before the next available list. Therefore some patients will not get timely intervention, with acute inpatients suffering deterioration in their condition possibly resulting in worsening organ failure, and outpatients waiting longer, resulting in a poor experience and possibly developing complications while waiting.	Chief Medical Officer	08-Aug-24	12						12	12	9
8174	A National review of paediatric audiology assessments has identified variation in practice/quality that may have underdiagnosed hearing loss in young children. A Regional assessment of SFT services has identified a high risk of potential harm and mandated a review of c200 cases from 2017 to date. There is a risk that the review could discover significant harm to children and this could result in reputational and litigation risk in the future.	Chief Medical Officer	30-Jul-24	10						10	10	5

8054	As a result of out of date policies there is a risk that mandated processes and procedures may not be followed correctly which may result in compromised quality of care for patients and negatively impact workforce practices. This may result in regulatory action.	Director of Integrated Governance	09-Apr-24	9					9	9	9	6
People - Supporting our people to make Salisbury NHS Foundation Trust the best place to work													
7472	As a result of recruitment freeze, staff absences, lack of staff skills development, higher than benchmark turnover (in the southwest)of existing staff and hard to recruit to posts (particularly medical), there is a risk that SFT is unable to manage service provision and operate a safe hospital.	Chief People Officer	12-Oct-22	16	16	16	16	12	12	9	12	9
7078	As a result of competing priorities and deliverables there is a risk of slippage of the Improving Together Programme deadlines	Director of Improvement	13-Oct-21	12	9	6	9	9	9	6	6	6
PARTNERSHIPS - Working through partnerships to transform and integrate our services													
6857	There is a risk that weaknesses in controls give rise to an opportunity for fraud, in turn resulting in the Trust incurring financial losses **Risk tolerated**	Chief Finance Officer	12-Mar-21	6	8	8	8	8	8	8	8	8
7734	Shortfall in funding available (locally and nationally) for capital programme, leading to a potential risk to the safety and availability of buildings and equipment to deliver services.	Chief Finance Officer	16-Jun-23	15		15	15	15	15	15	15	8

7308	The financial plan for 2022/23 is a deficit plan with assumed 2.2% savings. There is a material risk that the deficit will be larger than planned due to the operational constraints, inability to achieve financial savings and ongoing pressures related to patients with no criteria to reside. Therefore there is a risk that cash flow is challenged during the year resulting in the Trust having to take emergency cash measures.	Chief Finance Officer	12-Mar-21	15	16	20	20	20	20	20	20	9

Risk Score Key

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

Risk Appetite

ID	Directorate	Location (exact)	Opened	Source of Risk	Rating (initial)	Description	Likelihood (current)	Consequence (current)	Rating (current)	Actions	Action Due Date	Action Done Date	Action Lead	Source of Review	Review Date	Rating (target)	Assurance Framework link (AF Risk Ref)	Assurance Committee	Executive Lead	Risk Owner	Date Escalated to Corporate Risk	Controls in Place	Gaps in Control	Assurance on Controls	Gaps in Assurance
5955	Finance and Procurement	Trustwide	13/08/2019	Trustwide risk assessment	15	Insufficiently robust management control procedures across the organisation which pose a financial, reputational, legal and operational/clinical risk.	Do not expect it to happen again but it is possible	Moderate	6	Reviewing Trust wide risk training, aiming to roll out programme to all middle managers	31/03/2020	17/06/2020	Thomas, Lisa	Trust Board	31/03/2025	6	Population	Trust Board (Corporate Risk Register)	Director of Finance	Ellis, Mark	13/08/2019	SFI's standard operating procedures corporate policies (e.g. HR) Governance assurance map risk register Leadership development programme in place Regular finance training provided for budget holders	-Education and training on management of risk across the organisation.	-Low levels of reported Fraud -low volume of litigation -head of internal audit opinion -Infrequent high risk audit findings -Internal audit reports highlighting weaknesses in controls and processes. (Auditors are assured by responsiveness of recomendations)	N/A
										Process mapping underway for business critical controls	31/12/2019	16/12/2019	Thomas, Lisa											
										Trust identifying additional procurement training for those areas of non compliance across the organisation. New process targeting individuals starts in November 2019.	29/03/2020	17/06/2020	Willoughby, Kelly											
										Trust developed draft risk training specification for additional support for directorates- view to tender and award before December 2019.	31/12/2020	07/01/2021	Thomas, Lisa											
										Introduce a monthly informatics department management committee that feeds into monthly executive performance reviews	31/10/2019	18/10/2019	Burwell, Jonathan											
										Approval of IT General Controls plan at Informatics DMC and ratify at exec performance review	31/01/2020	02/03/2020	Scott, Andy											
										Approach to testing of backups agreed	20/03/2020	02/03/2020	Cowling, Andrew											
										All IT system contracts reviewed with IAA and IAO confirmed and delivery of duties being monitored	31/12/2020	15/12/2020	Burwell, Jonathan											
										Full review of informatics standard operating procedures including putting in place monitoring processes	30/06/2022	06/01/2023	Scott, Andy											
										Full implementation of IT general controls framework	31/12/2021	12/03/2021	Scott, Andy											
										Complete a stocktake of all IT operational infrastructure	31/01/2020	02/03/2020	Burwell, Jonathan											
										Implement a robust asset management system	30/10/2020	01/07/2020	Burwell, Jonathan											
										Implement a centralised rolling replacement programme for computers, laptops and iPads	01/04/2020	28/04/2020	Burwell, Jonathan											
										Complete review of IT security policies	30/10/2021	09/12/2021	Burwell, Jonathan											
										Review of existing storage locations of Informatics SOPs to centralise and improve searchability though using modern software such as CITO or Sharepoint	31/08/2021	16/08/2021	Burwell, Jonathan											
										Embed improving together methodology in performance review reporting structure.	31/01/2023	04/05/2023	Ellis, Mark											
										Development of a standard budgetary management and control training pack for leaders and managers	29/12/2023	29/12/2023	Ellis, Mark											
										Financial management responsibilities reflected in managers 'appraisal process	30/06/2024	05/06/2024	Ellis, Mark											
7078	Transformation & IM&T	Trust Offices	12/10/2021	Trusts Objectives	12	As a result of competing priorities and deliverables there is a risk of slippage of the Improving Together work programme deadlines. The impact of this would be a delay in the pace and scale of the rollout of our shared continuous improvement approach across the Trust and within the AHA. This could result in the Trust not being able to improve performance (quality, people, operational & financial) as far as it could have if the programme had stayed on track.	Do not expect it to happen again but it is possible	Moderate	6	Use of existing PMB groups to address issues on A3 content	22/11/2021	14/01/2022	Cox, Emma	Executive Director Meeting	31/03/2025	6	People	Trust Board (Corporate Risk Register)	Director of Transformation	Talbott, Alex	13/10/2021	Responsibility for delivery sitting with Director of Improvement. Executive oversight of delivery through the monthly Improving Together Board chaired by CEO. Reporting will include progress against the October 2024 to March 2026 roadmap and case studies from across the organisation on the benefit and impact of Improving Together. The Trust Board receive a quarterly board report from the programme board. In preparation for the monthly programme board report and quarterly Trust Board report each of the nine workstreams are reviewed and update by each of the workstream leads (Exec and manager leads). Risks relating to the programme are reviewed on a monthly basis by the Director of Improvement and the Head of the Coach House. This generates new and refresh mitigations as the risk and resultant issues develop month-by-month. E.g. Coach House staffing changes. 03/09/24: Coach House beginning to track if improvement huddles are active and supporting teams to set up their performance review meetings.	05/06/24: Process confirmation of the routine use of Improving Together tools such as the improvement huddle boards and divisional weekly driver meetings. This is beginning to be picked up in Divisional Performance Review meetings and the Executive huddle. 03/09/24: No systematic process to review the active use of improvement huddle driver meetings and performance review meetings.	- Monthly reviews in preparation for the Improving Together Programme Board between the Director of Improvement and the Head of the Coach House. - Reviews of the workstreams against the overall roadmap at the monthly Improving Together Programme Board and the programme board minutes. 05/06/24: Any off-track workstreams have known and owned actions in place to bring them back on-track. - Quarterly reports to Trust Board. - Monthly Engine Room reviews led by the Executives, including quarterly Engine Rooms taking in progress across the four boards: vision metrics, strategic initiatives, breakthrough objectives and corporate projects. -Training continues to be on-trajectory with the Coach House team prioritising training delivery while staffing capacity is constrained. 05/06/24: - Review and monitoring of training place utilisation on a weekly and monthly basis by the Coach House team. - Quarterly maturity self-assessment by the divisional management teams 03/09/24: Starting to be able to describe how many active huddles and PRMs we have.	Behind trajectory of Improver Advanced training - 05/06/24: new training approach using masterclasses now in place to mitigate this - 03/09/24: It has been difficult to bring staff to this new set of classes. Attendance remains below optimal utilisation. 05/06/24: Process confirmation of the quarterly maturity self-assessment by the divisional management teams - who and how do we review the rationale and accuracy of the self-assessment.
										Recruitment to coach house to cover maternity leave (B6 improvement practitioner) for 6 months	29/09/2023	06/10/2023	Cox, Emma											
										Recruitment of the three B7 rotational Senior Improvement Practitioner roles into the Coach House. Await final approval of the business case at F&P on 26th September 2023.	31/10/2023	02/01/2024	Cox, Emma											
										Review of training delivery approach and programme in order to bring the Trust back on trajectory. This includes learning from the past year of training delivery within current structure	29/02/2024	05/06/2024	Cox, Emma											
										Develop and deliver the next Improving Together sustainability roadmap session on 15th July 2024 to map out the next 18 months of the programme (October 2024 to March 2026).	16/07/2024	03/09/2024	Talbott, Alex											
										Socialise and develop the October 2024 to March 2026 roadmap with the deputies, divisions and corporate leads. Develop the workstreams in more detail with the leads and their respective executive sponsors so that come October we can manage against each workstream via the Improving Together Board.	30/09/2024	02/12/2024	Talbott, Alex											
6857	Finance and Procurement	Trustwide	12/03/2021	Financial management	6	There is a risk that weaknesses in controls give rise to an opportunity for fraud, in turn meaning the Trust incurs financial losses.	Will probably recur, but is not a persistent issue.	Minor	8	continue programme of fraud awareness and prevention with Counter Fraud team	31/03/2022	13/04/2022	Thomas, Lisa	Departmental Team meeting	30/06/2025	8	Partnerships	Trust Board (Corporate Risk Register)	Director of Finance	Ellis, Mark	12/03/2021	budgetary controls internal control procedures in built into financial systems between purchasing and paying training to all staff on induction	Standard operating procedures across the Whole Trust inconsistently applied	Counter Fraud reports budget monitoring reports fraud investigations low level reporting	investigative fraud allegations show sporadic gaps in procedures.
										Address the drivers of fraud- financial wellbeing of staff	30/06/2022	21/06/2022	Thomas, Lisa											
8054	Chief Executive	Trustwide	09/04/2024	Clinical Governance	9	As a result of out of date policies in Microguide, there is a risk that mandated processes and procedures may not be followed correctly which may result in compromised quality of care for patients and negatively impact workforce practices. This may result in regulatory action.	May recur occasionally	Moderate	9	Meeting with all Divisional Management Teams to agree policy management framework	28/06/2024	10/12/2024	Nye, Kylie	Trust Management Committee	28/02/2025	6		Trust Board (Corporate Risk Register)	Director of Integrated Governance	McNeight, Fiona	09/04/2024	Microguide system to access all policies and guidelines. Oversight of policy compliance reported to Trust management Committee. Dedicated resource in some divisions (W&NB specifically) providing oversight of compliance Named authors for each policy. Policy compliance report from Microguide.	Consistent ownership and oversight of policy management across all divisions. Capacity of policy owners to review and update the policy and system	Improving picture of compliance with out of date policies No reported incidents relating to out of date policies	Guideline compliance requires further oversight
										Draft a new policy management framework	28/06/2024	10/12/2024	Nye, Kylie											
										Policy Summit to be held 3rd September	30/09/2024	10/12/2024	McNeight, Fiona											
										Compliance report to be presented to TMC now Microguide transitioned to Eolas	28/02/2025		McNeight, Fiona											
7573	Operations Directorate	Trustwide	16/01/2023	Bed meeting	15	The risk of sustained use of escalation bed capacity (e.g. DSU, Discharge lounge, intervention radiology & boarded beds) has an impact on patient safety and experience due to not enough substantive staff for increased bed capacity, patients not always placed initially in most appropriate ward. The more beds the Trust has open the impact on operational effectiveness, e.g. ward rounds, clinical support services.	May recur occasionally	Moderate	9	Urgent and Emergency Care Board established to hold transformation programmes to reduce bed occupancy	29/09/2023	07/09/2023	Thomas, Lisa	Trust Board	31/03/2025	9	Population	Trust Board (Corporate Risk Register)	Chief Operating Officer	Prosser, Niall	16/01/2023	site report, clinical safety huddle patient safety meeting nurse staffing meetings x2 daily urgent care board	system plans for reduction in NCTR including use of additional bedded capacity	Bed occupancy has started to reduce whiteparish ward closed to enable refurbishment Number of patients in ED waiting for bed overnight reducing	Number of beds open still higher than core bed footprint NCTR remains higher than expected Turnover of staff increasing
										expansion of SDEC to surgery and Gynae specialities to further prevent admissions and need for beds	29/12/2023	15/01/2024	Thomas, Lisa											
										work with BSW on NCTR reduction plan - particularly those waiting for care Act assessment in beds	29/12/2023	15/01/2024	Thomas, Lisa											
										finalise winter plan to optimise flow, including OPEL levels, escalation protocols	31/10/2023	15/01/2024	Thomas, Lisa											
8174	Surgery	Audiology	30/07/2024	NHS England	10	A national review of paediatric audiology assessments has identified variation in practice/quality that may have underdiagnoses hearing loss in young children. A regional assessment of SFT services has identified a high risk of potential harm and mandated a detailed review of @200 cases from 2017 to the present. There is a risk that the assessment could discover significant harm to children inadequately assessed historically and this could result in reputational and litigation risk in the future.	Do not expect it to happen again but it is possible	Catastrophic	10	Service doing retrospective harm review, consistent with NHSE incident requirements.	31/03/2025		Smith, Rory	Clinical Governance Committee	31/01/2025	5	Population	Trust Board (Corporate Risk Register)	Chief Medical Officer	Murray, Dr Duncan	30/07/2024	National agreed process for review is being coordinated by NHS England and BSW ICS well engaged leadership team in audiology have been recognized by the initial review visit and the service is felt to be safe to continue with extra measures (external double reporting) agreed action plan for remediation including national accreditation scheme	Department have identified that it will take time and resources to attain national accreditation Extra resource may be required to complete historic reviews in a timely fashion (this is being supported by NHSE)	Initial review identified a good culture of improving and ownership of the issues within the department Clinical Governance Committee is sighted on the risk and has requested regular updates Process of historic review has been agreed with department and ICB and region.	until the retrospective review is complete the extent of any harm will not be known
7472	Organisational Development and People	Organisational Development & People Department	12/10/2022	Trustwide risk assessment	16	As a result of recruitment freeze, staff absences, lack of staff skills development, higher than benchmark turnover (in the southwest)of existing staff and hard to recruit to posts (particularly medical), there is a risk that SFT is unable to manage service provision and operate a safe hospital. Updated 22/08 and 20/11/24	Will probably recur, but is not a persistent issue	Moderate	12	Staff resource plans identified and agreed with Divisional Management Teams.	31/03/2024	12/06/2024	Crowley, Ian	Trust Board	31/01/2025	9	People	Trust Board (Corporate Risk Register)	Director of Organisational Development and People	Whitfield, Melanie	12/10/2022	Monthly analysis of Workforce Data against Staffing Availability levels Breakthrough objective - turnover - people promise improvement projects Targeted attraction and recruitment campaigns against identified priority vacancies. Line management training to support delivery of Career and well being conversations. Weekly divisional and trust workforce control panels -recent addition of weekly ICB vacancy control panel Monthly financial recovery - workforce - include oversight vacancies and bank and agency. First 90 day and 1 year anniversary feedback events. Hearing it campaign. We have a specialist interim involved in resource planning and strategic workforce management. BSW Hospitals Group emerging clinical strategy to meet long term NHS workforce plan targets Quarterly nursing safe staffing meetings.	Limited resources to deliver the NHS Widening participation agenda. Line management confidence to manage absence and grievance procedures. Insufficient wellbeing and career conversations. Further review of exit process and appraisals are required Reviewed 20/11	Improving KPIs for vacancy rate, time to hire, and sickness absence control - slowly improving staff retention. 22/08: Lowest vacancy rate and time to hire than we have ever had. Positive trend on quarterly pulse survey. 20/11 - no changes	Number of days absence/time lost due to short intermittent periods of absence being effectively managed within wards. Improving control and effective management of temporary staffing numbers - documentation gaps in medical and nursing workforce. 22/08: Limited meaningful data from exit interviews Updated 20/11
										Mechanism to manage career pathways and career conversations delivered.	14/01/2023	07/06/2023	Crowley, Ian											
										Delivery of the widening participation initiative.	31/07/2024	22/08/2024	Crowley, Ian											
										Recruitment processes optimised (pwc recommendations implemented).	30/04/2023	07/06/2023	Crowley, Ian											
										Movers and leavers project delivered.	31/12/2024		Crowley, Ian											
										People Promise actions for this year to be delivered.	31/03/2024	12/06/2024	Crowley, Ian											
										Health and Well-being plan delivered.	30/09/2023	17/09/2023	Crowley, Ian											
										Exit and appraisal policy review and application.	31/03/2024	12/06/2024	Whitfield, Melanie											
										12/06: Ongoing delivery of all elements of the People Promise.	31/01/2025		Whitfield, Melanie											

		Org					W			12/06: Conclude the line management skills build pilot in July and launch trustwide.	30/09/2024	22/08/2024	Crowley, Ian						Dire			Nursing skills mix bi-annual reviews. Monthly Organisation Development, Culture and Learning working Group providing oversight of training - MDT approach Absence data oversight in DPRs plus IPR			
										Disaggregate turnover and absence data in IPR to highlight hotspots and tailor appropriate actions	31/12/2024		Crowley, Ian											
8188	Surgery	Endoscopy	08/08/2024	Complaints, Directorate risk assessment, Incident reports	12	ERCP is highly technical and intrinsically high risk procedure with exacting training and regulatory requirements. In a challenging market SFT has been unable to recruit substantive ERCP practitioners for several years. ERCP is therefore currently delivered by an outsourcing company providing one session for ERCP per week, with no cover for annual leave. On its own this arrangement provides no ability to flex capacity to meet peaks in demand, or to always accommodate patients with severe illness who need intervention before the next available list. Therefore some patients will not get timely intervention, with acute inpatients suffering deterioration in their condition possibly resulting in worsening organ failure, and outpatients waiting longer, resulting in a poor experience and possibly developing complications while waiting.	May recur occasionally	Major	12	Intensive support for GI services	31/12/2024		Dyos, Judy	Directorate Management Team Meeting	31/01/2025	9	Population	Trust Board (Corporate Risk Register)	Chief Medical Officer	Murray, Dr Duncan	09/08/2024	1. Clinicians in Southampton offer ad hoc support for complex cases that should be performed in tertiary units, and more clinically urgent cases that cannot wait to the next scheduled SFT session 2. There is some limited ability for the outsourcing company to deliver additional sessions to cover peaks in demand 3. An ERCP patient tracker has been introduced to have oversight of demand and waiting times, and to support most appropriate booking priority within the constraints nof available capacity. Introduction of tracker improves anticipation of capacity and access challenges to allow earlier escalation	1. The arrangement with UHS is ad hoc, reliant on good will and not supported by an SLA 2. Attempts at substantive recruitment to SFT posts have failed, and multiple options to provide more resilient and sustainable support from local partners in UHS and UHD have failed 3. An option to redeploy surplus capacity from a BSW AHA partner is being explored at executive and service level	1. Outcomes from the procedures that are performed at SFT (approx 115 per year) are satisfactory compared to regulatory standards	1. Recent complaint and related incident report 2. Informal concerns raised by service users (referring gastroenterologists) 3. Discussions with respected external expert opinions criticising service structure and model of provision
										Surgery DMT to conclude discussions with GWH around mutual aid, requesting executive support as required.	31/12/2024		Insull, Victoria											
7807		Trustwide	16/08/2023	Incident reports, Trustwide risk assessment, Violence and Aggression	20	As a result of a lack of community and acute mental health provision there is a risk that patients with specialist mental health needs are being managed in the acute setting. This may result in sub-optimal care with less therapeutic value than if undertaken in the right setting with appropriately trained staff. This also impacts on staff morale and staff retention.	Will probably recur, but is not a persistent issue	Moderate	12	Agree an approval algorithm for mental health 1 to 1 support with AWP.	28/02/2024		Osman, Laura	Trust Board	31/01/2025	9	Population	Trust Board (Corporate Risk Register)	Chief Medical Officer	Murray, Dr Duncan	16/08/2023	Daily review of mental health needs across the organisation and identify staffing requirements. Use of agency RMNs. As required Meetings with key agency to discuss current patients and plans to mitigate risk. Risk Assessments and care planning in conjunction with AWP	Availability of adult mental health beds and tier 4 CAMHS beds. Inconsistent standards of agency RMN skills and knowledge. 02/09/24: Out of hours cover provision is at arm's length. Recent changes to this service not fully embedded and impact of changes not yet understood.	Recent audit 28/05/24 demonstrated improved compliance with Mental Health Act. 02/09/24: Operational KPIs of MHLS consistently good.	Long length of stay for mental health patients requiring community or MH inpatient facilities. Increase number of incidents reported in relation to mental health patients (alongside increase in patient load and acuity). 28/05/24: Recent audit identified variability in meeting the requirements as set out in the Mental Health Act regarding
										Ongoing collaboration with partners at ICS and regional level related to Mental Health Provision.	31/03/2024	21/11/2024	Murray, Dr Duncan											
										Meeting to improve governance structures and assurance processes regarding Mental Health groups	31/12/2024		Murray, Dr Duncan											
7946	Transformation & IM&T	Trustwide	02/01/2024	Departmental risk assessment	12	As a result of competing priorities, shifting resource plans and sub-optimal scoping of projects there is a risk that transformation programmes and projects will not be delivered to time which may result in the Trust not realising the benefits of the work and delaying the start of new work.	Will probably recur, but is not a persistent issue	Moderate	12	Training refresher on project documentation in the transformation team	29/03/2024	05/06/2024	Arnett, Louise	Directorate Management Team Meeting	31/01/2025	9	Population	Trust Board (Corporate Risk Register)	Director of Transformation	Talbott, Alex	02/01/2024	05/05/24: Transformation programme Boards, including Digital Steering Group (DSG) Resource scheduling bi-weekly meeting Urgent and Emergency Care and Planned Care Boards Small projects Board Corporate Projects Prioritisation Group feeding into the Engine Room Project documentation to support delivery 03/09/24: Annual review of transformation workplan and resource alignment in conjunction with business planning round started in Sept/Oct 2024. Corporate Deep Dive 25/11/24: Align and connect resource planning with business planning for 2025/26	Capacity and capability to deliver to time 03/09/24: A routinely used standardised approach to scoping and scheduling projects with robust SRO engagement with the timeline (i.e. we have the standard, but do we use it routinely?) Corporate Deep Dive 25/11/24: Capacity to demand mismatch for resource allocation to top contributing projects for achieving the organisation's plan.	Good knowledge of transformation programmes and projects underway 05/05/24: Monthly review of on/off-track to project/programme plan at Transformation team Performance Review Meeting. 03/09/24: Increasing use of standard scoping and project documentation across the Transformation team is increasing accuracy of timelines and what's needed to achieve them. Corporate Deep Dive 25/11/24: Seeing a longer-term view (6-12 months) of which projects are coming down the pipeline than before.	Programme slippage remains in some projects started before the introduction of the new standards. Sub-standard documentation.
										Track project delivery via transformation senior leadership team meeting	29/03/2024	05/06/2024	Talbott, Alex											
										Continue to strengthen the role of Corporate Project Prioritisation Group (CPPG) by ensuring it runs monthly and routing resource requests and major resourcing changes via CPPG.	30/09/2024	25/10/2024	Talbott, Alex											
										05/06/24: Implementation of standardised project documentation - including scoping, scheduling and project plan sign off by the SRO.	30/06/2024	31/07/2024	Arnett, Louise											
										Support provided to the Project Managers to practise and develop their knowledge of the Programme Management Industry Standard (PMIS) as all new projects and programmes are stood up. Peer review to be used to highlight best practise and share learning.	31/10/2024	25/10/2024	Lewis, Neil											
										Action agreed at CPPG November 2024 : Review through future CPPG agenda item where project work has started prior to formal prioritisation and filtering / or emerged outside of annual business planning to ascertain whether we could have been more effective in our approach. This learning will help understand any change needed to CPPGs role and remit - or whether a change in organisational practice is needed	31/01/2025		Arnett, Louise											
										Action agreed at CPPG November 2024: To sense check that projects prioritised under an SI or BTO can show the link back as a countermeasure in the relevant A3 and CPPG to take a harder line in wanting to see that evidence and linkage when reviewing new work	31/01/2025		Ellis, Mark											
										Transformation Team to explore "resourcing" which is emerging as the top contributor to projects currently being off track. This requires a deeper understanding of the root causes and identification of countermeasures to address potential improvements	28/02/2025		Arnett, Louise											
5704	Surgery	Trustwide	31/01/2019	Directorate risk assessment	16	A risk that the current lack of substantive Gastroenterology medical and nursing workforce will impact on the ability of the service to deliver sustainable comprehensive safe and effective care to patients.	May recur occasionally	Major	12	Ongoing recruitment drive.	30/09/2019	25/04/2019	Clarke, Lisa	Intensive Support Meeting	31/01/2025	8	Population	Trust Board (Corporate Risk Register)	Chief Medical Officer	Murray, Dr Duncan	31/01/2019	Sustainable provision of service through use of long-term locums provided by ID Medical. Ongoing recruitment efforts for specialist nursing and unfilled medical posts. May 2023 - New Fixed term gastroenterologist starting end of May 23 August 23 - Deputy CMO commissioned to provide oversight of the service and to describe road map to sustainability through partnership with neighbouring acute Trusts. External support from senior gastroenterologist providing elements of IBD service October 23 - continued support from executive team for improvements with fortnightly assurance meetings. Partnerships with local GP in place and due to commence Nov 23 supporting with specific clinical pathways. 02/09/24: Further recruitment of fixed-term consultant gastroenterologists; currently only one ID Medical employed at SFT.	Unsuccessful recruitment to specialist Nurse roles, which has a particular impact on Hepatology and IBD service provision. Until substantive recruitment is complete, off site provision of GI Bleed on-call service will continue. May 2023 - Substantive consultant has handed in notice - leaving end of July 2023. Fixed term consultant going on Mat leave in mid June 2023. Clinical leadership of GI Unit changing hands. June 23 - Resignation of substantive consultant. August 23 - long term capacity and demand planning remains challenging due to non substantive medical workforce October 23 - business case in progress with Southampton hospital to increase support for ERCP / IBD services June 23 - Risk to service provision around ERCP, inflammatory bowel disease, and nutrition. 02/09/24: Resignation of fixed-term gastroenterologist and subsequent threatened resignation of single substantive gastroenterologist (current clinical lead).	Regular contract monitoring meetings with ID Medical. Monitoring of Key Quality Indicators demonstrating a safe service. 3 new substantive GI Consultants in post and providing oversight and assessment of current service performance. Additional service development time has been job planned for the new consultants to support development of the service and increased governance May 2023 - Reduction in Endoscopy long waiters. August 23 - endoscopy performance remains above peer average in BSW. external quality data does not suggest the Trust is an outlier. October 23 - Reduction in long waiters for both gastro and endoscopy through focussed attention on waiting lists 30/05:Current substantive Gastroenterologist as clinical lead for service. 02/09/24: Access times for first outpatient appointments in several sub-specialties have improved significantly. No increase in complaints for service. Regular audit of ERCP outcomes compliant with national benchmarking.	Service is not meeting all required performance standards but this is understood and related to post-Covid elective recovery challenges. No service specific concerns identified currently. New consultants are uncovering new risks as they explore the service but action plans are being developed and will be raised as new specific risks. May 2023 - With fluctuation in staffing levels in endoscopy and gastro over the last 6 months there has been an impact on waiting list levels. Mitigations are in place to regain control August 23 - as June update. All subject to ongoing work overseen by Deputy CMO 02/09/24: Internal concerns being voiced by team members around quality, capacity and cultural issues within the team.
										Continual clinical prioritisation to ensure that high risk areas are covered.	01/04/2019	17/04/2019	Clarke, Lisa											
										Continuing insourcing of private provider to endoscopy.	30/06/2019	25/04/2019	Vandyken, Mrs Ali											
										Quantification and mitigation of the risk to bowel scope.	01/04/2019	17/04/2019	Vandyken, Mrs Ali											
										Tender for elements of the Gastroenterology service.	01/04/2019	17/04/2019	Stagg, Andrew											
										Monthly update to F&P Committee and CGC.	10/05/2019	25/04/2019	Hyett, Andy											
										Presentation of gastro strategy to Finance and Performance Committee.	31/05/2019	12/06/2019	Hyett, Andy											
										Put together a workshop with CDs and Clinical Leads to discuss options for service provision.	01/10/2019	22/10/2019	Hyett, Andy											
										Continue conversations and meetings with alternative NHS providers for likely future joint partnership for delivery of service	30/09/2019	29/08/2019	Henderson, Dr Stuart											
										Medical Director to link with other STP partners around system wide solution.	31/12/2019	21/02/2020	Blanshard, Dr Christine											
										Case for change to develop a GI unit to be completed	31/12/2019	04/03/2020	Hyett, Andy											
										New GI unit to be launched on 1st April	01/04/2020	07/05/2020	Hyett, Andy											
										To recruit medical and nursing staff for the GI Unit	28/06/2024		Insull, Victoria											
										Confirm Southampton will be able to take over full responsibility for the GI Bleed out of hours service.	23/04/2021	23/04/2021	Branagan, Mr Graham											
										Secure support for existing junior doctors	30/07/2021	31/08/2021	Branagan, Mr Graham											
										Ongoing regular review of workforce strategy in GI unit	01/12/2021	20/12/2021	East, Rachael											
										Recruitment to Nutrition Service Vacancy required.	31/01/2022	28/03/2022	East, Rachael											
										Develop joint governance meeting between medicine and surgery	31/08/2023	20/11/2023	East, Rachael											
										Recruitment of new clinical lead for GI Unit	31/05/2023	22/06/2023	Stephens, Mr Paul											
										CMO to report outcome of GI services review once complete.	30/09/2024	02/09/2024	Murray, Dr Duncan											
										Surgical division to provide assurance report on oversight of operational delivery and any impacts to quality to CGC on 27th June 2023.	27/06/2023	13/07/2023	East, Rachael											
										Intensive support meetings to commence fortnightly	24/07/2023	17/08/2023	East,											
										GI Unit enhanced support programme ongoing to identify strategic aims for 24/25 to address stats and service	28/06/2024		Insull, Victoria											
										02/09/24: GI services to be put into intensive support	06/09/2024	21/11/2024	Murray, Dr Duncan											
7734	Finance and Procurement	Finance Department	16/06/2023	Financial management	15	Shortfall in funding available (locally and nationally) for capital programme, leading to a potential risk to the safety and availability of buildings and equipment to deliver services.	Will undoubtedly recur, possibly frequently	Moderate	15	2024/25 medical equipment brought into 2023/24 as backfill against estates program slippage.	31/03/2024	05/06/2024	Ellis, Mark	Finance and Performance Committee	31/03/2025	8	Resources	Finance Committee, Trust Board (Corporate Risk Register)	Director of Finance	Ellis, Mark	21/09/2023	- capital control group prioritises capital programme - monitor Datix incident reporting related to infrastructure and equipment.	- financial constraints on ability to address whole scale estate risk. - unclear regional/national process for emergency capital bids 21/11/24: High cost and high priority EPR programme underway - arising pressures may impact other programmes.	- incident reporting highlighting areas of concern - sub groups maintain 5 year capital plans providing visibility of programme deliverables and gaps	21/11/24:Availability of cash to service capital programme. - increasing level of maintenance required - increasing number of incidents of operational disruption particularly in day surgery 21/11/24: Uncertainty of reporting in latter years of EPR programme.
										24/25 Capital monitoring in place. Ongoing processes. Board reporting continues, including specific updates on digital & estates.	31/12/2024	21/11/2024	Ellis, Mark											
										25/26 Capital prioritisation and planning underway	31/03/2025		Ellis, Mark											
										Capital cash support request submitted to NHSE	31/03/2025		Ellis, Mark											
		partment				The planning guidance stipulated that for 24/25 all acute Trusts should seek to ensure patients are seen more quickly in emergency departments: with the ambition to improve to 76% of patients being admitted, transferred or discharged within four hours by March 2024, with further improvement in 2024/25. SFT signed up to 78%	possibly frequently	te		Medical SDEC expansion & GP Assessment area development	01/12/2025		Bagg, Danielle	t Committee				e Risk Register)	g Officer	Vall		OPEL Card and escalation plans in place Daily capacity meetings x 4 Silver bleep holders and Matron of the day in place for the Divisions Wait 75 actions implemented to support flow when at risk of ambulance holds over 75 minutes EDEL levels within ED Escalation plans in place to flex ED and Wards when needed	Further redirection in ED to external partners ie No alternatives in working hours	Reductions in LOS for medicine	Performance is below target
										Surgical SDEC on Downton Ward	01/04/2025		Byelong, Collette											
										Development of Frailty SDEC	01/12/2025		Lee, James											
										Implementation of Virtual Wards	01/12/2025		Lee, James											
										Breamore ward for NCTR patients	20/11/2024	20/11/2024	Needle, Sarah											

8260	Medicine	Emergency Dep	06/12/2024	Access targets	15	2024/25. SFT signed up to 78%. Ambulances getting to patients quicker: with improved ambulance response times for Category 2 incidents to 30 minutes on average over 2023/24, with further improvement in 2024/25 towards pre-pandemic levels. Due to increased demand and activity within the UEC pathway in Wiltshire and a higher than anticipated number of patients with a No Criteria to Reside, the Trust has been unable to meet the nationally agreed targets.	Will undoubtedly recur, p	Moderat	15	Discharge initiative across Medicine	31/12/2024	10/12/2024	Needle, Sarah	Trust Management	06/01/2025	8		Trust Board (Corporate	Chief Operating	Prosser, N	06/12/2024	to support flow UEC Board in place to support improvements in UEC pathway Medical SDEC in place with plans to expand over next 12 months Surgical SDEC plan in place for January Frailty SDEC commenced and more support at Front door from Frailty team Implementation of Virtual wards NCTR working group in place - Breamore ward in place for patients with NCTR patients	Out of hours- significant gaps in community pharmacy GP collective action Inability to control demand Medical staffing to meet demand in ED	Increase in 0 Day LOS Data that supports increased demand Shortages in professional groups	Performance is below target Higher numbers of patients with NCTR than anticipated
												NCTR working group as part of UEC Board	01/05/2025		Cavill, Emma										
												Ward Processes working group as part of UEC board	02/06/2025		Bagg, Danielle										
												Streaming in ED	02/06/2025		Garrett, Neil										
												Reconfiguration of ED to support more RATT space and in/out assessment space	12/12/2024		Garrett, Neil										
8264		Trustwide	10/12/2024	Clinical Governance	15	There is a risk that the incorrect management of patients with reduced mental capacity will occur. This is due to a lack of Staff understanding of the Mental Capacity Assessment(MCA) framework and reducing compliance with safeguarding training. This has been impacted by large scale recruitment drive to nursing role to close vacancy but impacted skills mix. Additionally staff releasing for the MCA and safeguarding training is a challenge for clinical staff.	Will undoubtedly recur, possibly frequently	Moderate	15					Quality Directorate Leads meeting	10/03/2025	9	Population	Clinical Governance Committee, Trust Board (Corporate Risk Register)	Director of Nursing	Dyos, Judy		MCA and safeguarding training in place Safeguarding lead monitors training levels and reports to CGC Week day oversight of all incidents in previous 24 hrs. with safeguarding input. Audits regarding mental capacity assessments. Weekly patients safety meeting reviewing all moderates and above Safeguarding supervision	Training numbers is lower than we want it to be . Documentation poor Reports from dementia lead that staff not practicing least restrictive options	Reporting of data regarding mental capacity and safeguarding to ISC, CMB and onwards CGC Safeguarding leads monitoring on weekly basis Weekly patients safety look's at all moderates and above. Risk team monitor for high volume low harm themes for low harm, no harm	Training data , numbers failing Incident review data
7090	Surgery	Bowel Screening Service	27/10/2021	Service Delivery Plan	12	Overall colonoscopy capacity provided by the sites is lower than was planned/required in the current year. SDH is delivering the requirement RUH and GWH are not. This means the service is not delivering the service standard of 2 weeks from SSP appointment to first offered diagnostic test and surveillance patients are not being seen.	Will probably recur, but is not a persistent issue	Major	16	Service development plan underway with NHSE review	31/10/2022		Dawson, Anne	Departmental Team meeting	01/01/2025	8		Trust Board (Corporate Risk Register)	Chief Operating Officer	Harris, Becky		Continue to request additional lists at RUH and GWH. Support provision of additional colonoscopists at all sites. Share capacity between sites to best achieve first offered in 14 days	GWH continually provide insufficient capacity to cover FIT positive patients a diagnostic test within 2 weeks. Patients are offered a colonoscopy at RUH and SDH but choose not to travel and would rather wait for an appointment at GWH. The lack of capacity effects patients awaiting repeat and surveillance procedures.	We do try and backfill any cancelled lists with a reserve list of patients that have been assessed and sent bowel prep, although this proves difficulty for cancellations at short notice as the patient has a 3 day diet to follow.	Any surges in activity due to health promotion have a negative effect on our ability to achieve this target. With the industrial action and shortfall of lists provided by GWH and RUH, we continue to breach this standard (2 weeks from SSP appointment to first offered diagnostic test)
										GWH Endoscopy issues causing insufficient BCSP capacity: 1)Faulty boiler that needs replacing -awaiting capital funding 2)Recurring water contamination issues 3) 2 rooms require ventilation works which will result in shutdown for 1 week per room 4) Service waits	01/01/2025		Harris, Becky										
7308	Finance and Procurement	Trustwide	19/04/2022	Trusts Objectives, Trustwide risk assessment	15	The financial plan for 2024/25 is for an underlying deficit plan with assumed 6% savings. There is a material risk that the deficit will be larger than planned due to the operational constraints, inability to achieve financial savings and ongoing pressures related to patients with no criteria to reside. Cash balances have depleted and the Trust is engaged in NHSE cash support process. 02/09/2024: Increasing risk that improvement work around patient flow is offset by higher growth than what was planned.	Will undoubtedly recur, possibly frequently	Major	20	Grip and Control processes reviewed in all Divisions to ensure robust financial governance	29/07/2022	11/10/2022	Thomas, Lisa	Finance and Performance Committee	31/03/2025	9	Partnerships	Finance Committee, Trust Board (Corporate Risk Register)	Director of Finance	Ellis, Mark	19/04/2022	Cash flow forecasting – monitoring reports to F&P - SFI's ensuring strong financial governance - budget signed off for April 2024/25 based on internal assumptions - ICB transitional funding agreed. - Weekly agency usage monitoring - Fortnightly financial recovery group chaired by CEO - Enhanced vacancy control and temporary staffing process - System investment triple lock 02/09/2024: Medical rate card went live in August 2024.	- Delivery of 6% CIP dependent on external action - Uncertain impact of winter pressures, staffing gaps, and effects of industrial action	2023/24 efficiency plan delivered in full (5%) Improving Together methodology being used to underpin 24/25 programme. Continued upward trajectory in Trust productivity calculation. 16 theatres fully operational. 02/09/2024: Downward trend in nursing bank and agency - continued reduction in UEC length of stay.	Ongoing agency bookings - particularly hard to recruit to medical posts. Pay overspend Low theatre utilisation. Forecasted £17 million deficit.
										Deployment of winter plans.	30/11/2022	15/12/2022	Ellis, Mark										
										Seeking support for unfunded pressures from the ICB and SpecCom.	31/01/2023	31/03/2023	Ellis, Mark										
										Review of agency booking process.	31/01/2023	31/03/2023	Whitfield, Melanie										
										3-year forecast being undertaken in Q1, including risks and impact on cash flow.	29/09/2023	29/12/2023	Ellis, Mark										
										Identification of additional savings opportunities managed through Divisions with oversight from FRG.	31/12/2024		Ellis, Mark										
										Organisation wide communications strategy for financial recovery	30/09/2024	21/11/2024	Ellis, Mark										
6229	Surgery	Day Surgery Unit	04/03/2020	Access targets, Complaints, Departmental risk assessment, External audit reports, Incident reports, Other assurance not listed, Service Delivery Plan, Waiting times	12	[07/07/2023 12:00:42 Laurence Arnold] The DSU building is 'end of life' and has been identified as priority for replacement. The fabric of the building is problematic and leads to numerous roof leaks and delayed/cancelled procedures. Incidents relating to the building's condition are increasing and impacting on patient safety, care and experience.	Will undoubtedly recur, possibly frequently	Major	20	DSU risk escalated to wider stakeholders to ensure remains priority scheme for BSW and South West Region	13/06/2023	13/06/2023	Arnold, Laurence	Trust Board	31/03/2025	4	Population	Trust Board (Corporate Risk Register)	Chief Operating Officer	O'Keeffe, John	13/01/2023	[07/07/2023 12:00:42 Laurence Arnold] None ad hoc nature of issues results in limitations around mitigations. Staff manage individual cases and issues None ad hoc nature of issues results in limitations around mitigations.	[07/07/2023 12:00:42 Laurence Arnold] Substantial capital investment is required - the whole facility needs to replacing, necessitating national capital funding. Funding for new DSU. Poor environment for staff - lack of wellbeing facilities.	None Constant lobbying being undertaken to attempt to secure funding.	[07/07/2023 12:00:42 Laurence Arnold] Problems persist - Roof leaks, heating failures and significant investment identified in the critical plant survey (2020). Regular failure in AHU's resulting in patient cancellations Roof leaks, heating failures and significant investment identified in the critical plant survey (2020). Failure of the air handling unit is becoming a regular occurrence, this in turn affects the overall environment, prevents activity from taking place owing to infection control policies and results in cancellations of elective procedures. Regular failure in AHU's resulting in patient cancellations Regular problems with maintaining temperatures safely - theatre F particularly difficult. Air handling plant is sub-optimal for the needs of the facilities. Results in inconvenience for patients - cancellations, and being moved to main theatres. The DSU building is 'end of life' and has been identified as priority for replacement. The fabric of the building is problematic and leads to numerous rook leaks and delayed / cancelled procedures. Failure of the air handling unit is becoming a regular
5751	Operations Directorate	Discharge Team	11/03/2019	Directorate risk assessment	15	Risk of patient harm caused by patients remaining in hospital when their clinical need does not require this (no right to reside). This risk is caused by capacity/resource constraints in out of hospital care. 02/09/24: Failure to reduce NC2R is leading to increased bed occupancy and delaying continued financial recovery.	Will undoubtedly recur, possibly frequently	Major	20	Winter director managing Trustwide ECIST actions.	01/05/2019	12/06/2019	Hyett, Andy	Trust Board	31/03/2025	12	Population	Trust Board (Corporate Risk Register)	Chief Operating Officer	Prosser, Niall	11/03/2019	Site and Flow meetings 3x a day. Specific medicine ward level discharge meeting Daily reporting and monitoring. System escalation plan revised and approved. Patient flow score card monitoring delivery of KPIs. Expert panel which reviews all patients with LoS over 7 days with CTR. Monthly urgent care board which the COO attends. Deputy Chief Operating Officer role in place. No right to reside is an approved breakthrough objective as part of the Improving Together Programme Improved data quality Improved use of e-Whiteboards on wards. 02/09/24: Working groups with BSW system to improve discharge process and capacity. Experienced subject matter experts - focussed on work to resolve current issues.	Reporting of timelines in patients journeys challenging with current IT systems. - capacity gap in Council for domiciliary care which means significant shortage of available care hours. 02/09/24: Complexity in pathway management is leading to delays in discharge.	02/09/24: Monthly reporting of number of patients waiting for discharge & pathways is well understood.	Understanding of discharge process at ward level (nursing and medical) is inconsistent. Use of e-whiteboards although improved is still inconsistent with no training delivered to new starters. 02/09/24: Understanding headline number in place but further work required to truly understand reasons for delays.
										Winter Director coordinating trajectory for delivery of DTOC target.	01/05/2019	12/06/2019	Hyett, Andy										
										Trust actions being led by COO and Medicine CD and managed through weekly delivery meeting and monthly PMB.	01/05/2019	12/06/2019	Hyett, Andy										
										Weekly expert panel meeting to challenge discharge pathways chaired by CCG director of quality.	01/05/2019	12/06/2019	Hyett, Andy										
										Trust implementing discharge PTL	01/07/2019	04/09/2019	Hyett, Andy										
										Escalation to EDLDB non delivery of trajectory	01/07/2019	04/09/2019	Hyett, Andy										
										Mitigation actions being prepared to mitigate lack of capacity in the community.	01/08/2019	04/09/2019	Hyett, Andy										
										All providers required to present their winter plans to EDLDB in September.	30/09/2019	22/10/2019	Hyett, Andy										
										Business case to expand ESD service going to TMC in September and COO and DoF meeting Wiltshire Health and Care to align services	30/11/2019	10/12/2019	Hyett, Andy										
										CEO DOF and COO representing SFT at system wide winter summit on 25th October 2019.	31/10/2019	10/12/2019	Hyett, Andy										
										COO representing Trust at Regional Workshop w/b 9th December	14/12/2019	04/03/2020	Hyett, Andy										
										System wide actions to be monitored through the ED local delivery board.	01/04/2020	28/04/2020	Hyett, Andy										
										COO escalating the need for an ED LDB risk log reflecting the risks carried by each provider organisation.	19/12/2019	04/03/2020	Hyett, Andy										
										Risk to be captured on newly developed ED Local Delivery Board Risk Register.	31/03/2020	28/04/2020	Hyett, Andy										
										Action plan to be developed for 2021 by Urgent Care Board.	31/03/2021	04/05/2021	Hyett, Andy										
										Reinstate the challenge of stranded patients by the Medical Director by the end of October.	01/11/2020	20/10/2020	Hyett, Andy										
										Development of Transformation Programme for improved Discharge processes.	31/05/2021	28/06/2021	Hyett, Andy										
										Agreement of system escalation triggers.	31/05/2021	28/06/2021	Hyett, Andy										
										Review of bed modelling in light of increased urgent and elective activity.	31/05/2021	30/06/2021	Humphrey, Kieran										
										Agreement of Improvement Trajectory with system partners.	30/07/2021	08/10/2021	Hyett, Andy										
										Delivery of the Transformation Improvement Plan.	30/11/2021	30/12/2021	Wood, Paul										
										Delivery of the BSW Urgent Care Board discharge improvement plan which the Trust is contributing to	31/10/2022	11/10/2022	Thomas, Lisa										
										Trust working with BSW on delivery of 57 additional community beds at South newton from November.	30/11/2022	28/12/2022	Thomas, Lisa										
										Trust developing winter plan for implementation focusing on pathway 0 patients to maximise available bed capacity	31/10/2022	28/12/2022	Thomas, Lisa										
										Discharge Hub being established at SFT to support efficient and effective discharge process and improve partner working	29/09/2023	14/08/2023	Cavill, Emma										
										SFT to complete bed modelling and potential pathway improvements with Wiltshire Place colleagues	30/11/2023	15/01/2024	Thomas, Lisa										

										Further engagement with system partners to understand their actions	25/09/2024	19/11/2024	Cavill, Emma												
										02/09/24: Established A3 approach - Support delivery of NC2R challenges & joint system working group implementation.	31/12/2024		Prosser, Niall												
										Launching multi-agency dedicated team for 12 weeks to undertake further A3 thinking within pathway 1 and interface delay challenges.	31/03/2025		Prosser, Niall												
8250	Medicine	Fairfax Stroke Unit	26/11/2024	National guidance	20	Current national guidance requires acute stroke units to have access to enhanced neuro-imaging assessments for patients with acute ischaemic stroke 24/7. Patients are required to have an available slot for imaging within an hour from arrival at hospital. This includes provision of CT angiography and CT profusion 24 hours per day. Current provision in SFT is Non-Contrast CT head Scans 24 hours per day, and CT angiography between 08:00 - 20:00 and no access to CT profusion. Without 24/7 access to CT profusion and CT angiography, a cohort of patients would be missed who may have been eligible for reperfusion therapies, thrombolysis and mechanical thrombectomy. There is therefore a risk to patients, in that they are not able to receive life-changing treatment as dictated by stroke national guidance. There is also a risk to the organisation, as there is a case for potential litigation if patients suffered as a result of lack of access to the above.	Will undoubtedly recur, possibly frequently	Major	20	Business case submitted to TMC and escalated to ICB. ICB investment committee rejected request but now escalated back to MDs meeting for further guidance on next steps.	23/12/2024		Needle, Sarah	Directorate Management Team Meeting	31/12/2024	6	Trust Board (Corporate Risk Register)	Chief Operating Officer	Barrett, Mrs Jessica	03/12/2024	The Trust current sends patients to Southampton for mechanical thrombectomy.	There is currently a business case in development which would include recruitment and training which would ensure provision of CT angiography and CT profusion to the required national standard.	There are currently no incident or complaint forms linked to this issue.	Audits: a Recent audit of data relating to advanced imaging indicated that there would be likely 69 patients per year who would be eligible for reperfusion treatments if national guidance was met.
8102	Surgery	Central Booking Office	23/05/2024	Access targets, Complaints, Data quality, Trusts Objectives, Waiting times	20	Current vacancy in rate in Central Booking 9.5WTE with a further 2.5WTE due to leave the department in the next four weeks. Current theatre utilisation is not meeting Trust KPI's with approximately 70 - 90 theatre slots not booked each week, this will increase due to pending resignations. There is a risk of patient harm due to a significant backlog of referral which have triaged but have not been transferred from eRS to Lorenzo. There is also a delay to patient follow up due to a further significant backlog of e-outcome forms meaning patients are not being added to follow up access plans in a timely manner. The staff are taking between 50 - 150 calls a day (depending on role) which adds an additional pressure and is blocking them from booking and processing urgent referrals. This may result in a loss of confidence from our clinical teams and patients.	Will undoubtedly recur, possibly frequently	Major	20	Review and revision of current operational structure, to ensure fit for future state, including career progression opportunities, to support recruitment and retention. Support provided by OD&P specialist	30/09/2024	16/10/2024	Critchley, Jennifer	Trust Board	31/01/2025	12	Trust Board (Corporate Risk Register)	Chief Operating Officer	Critchley, Jennifer		2 bank staff have been approved by WCP to help with eRS transfers. Secretariat team are supporting with booking forms and e-outcome forms wherever possible but this is not keeping on top of the backlog as minimal hours across the week. DMT initiative has taken place whereby senior managers were present in Central Booking W/C 13/05/24. Processes have been updated where clinical buy in supports - for example moving over to electronic triage.	Further bank staff required to increase establishment until successful recruitment has taken place. Band matching exercise needs to be finalised to boost staff morale and reinstate faith and confidence in management team.	Proposal to revise current structure, including roles and responsibilities supported by Exec 2/7. Working with OD&P specialist to redefine JD's and career progression structure. Recruitment Team to support with appropriate advertising campaign in recognition of the criticality of these roles. Recruitment Team to support with identifying external agency solution to support in short term	Approx 70 - 90 theatre slots unbooked each week. Approx 7000 follow up access plans to be added to Lorenzo, currently on e-outcome form report, this is across all specialties / divisions with some particular areas of concern requiring a focused tie period to catch up, this will be achievable with the support of bank staff. Approx 1500 routine referrals to be transferred from eRS to Lorenzo access plans
										Short term mitigation to be agreed for either bank or external agency support. Recruitment team to approach external agencies to scope options to coincide with conclusion of bank support post college/university summer holidays.	31/01/2025		Critchley, Jennifer												

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Virtual Meeting Etiquette:

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

Risk Appetite Definitions
September 2024

Fiona McNeight

Director of Integrated Governance

Contents

Salisbury NHS Foundation Trust

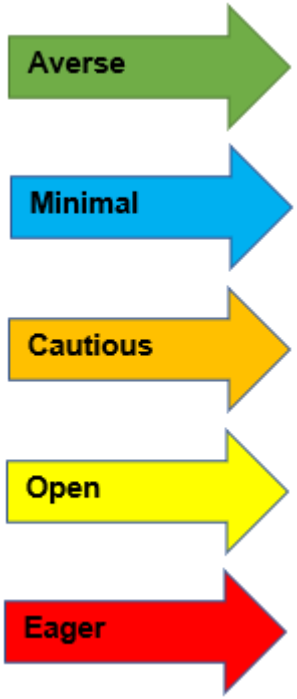
Background

- Board development session in February 2024.
- Agreement to develop definitions for each risk category and risk appetite scale and present to Trust Board for approval in a phased approach with final approval in October 2024.

Risk Appetite scales

Salisbury NHS Foundation Trust

Based on risk appetite guidance provided within the ‘Orange Book’.



Avoidance of risk and uncertainty is key objective

Preference for safe options leading to only minimum risk exposure: low likelihood of occurrence of the risk after application of controls

Preference for safe options though accept there will be some risk exposure: medium likelihood of occurrence of the risk after application of controls

Willing to consider all options and choose one that is most likely to result in successful delivery; recognise that there could be a high-risk exposure

Willing to be innovative and take on a very high level of risk but only in the right circumstances

Risk Appetite scales

Salisbury NHS Foundation Trust

Consequence	1	2	3	4	5
5	Minimal	Open	Eager	Eager	Eager
4	Minimal	Cautious	Open	Eager	Eager
3	Averse	Cautious	Cautious	Open	Eager
2	Averse	Minimal	Cautious	Cautious	Open
1	Averse	Averse	Averse	Minimal	Minimal

Likelihood

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

Approved Risk Categories

Salisbury NHS Foundation Trust

Defined 5 risk types (known as Level 1 Risk Types) – principal risks which arise from the nature of the Trust's operating environment

Defined 24 Risk Categories (known as Level 2 Risk Categories) – each aligned to one of the 5 Risk Types. These have been determined through aligning the Corporate Risk Register risks to a broader, industry-recognised Risk Category.

Definitions

Salisbury NHS Foundation Trust

Definitions have been drafted by the subject matter experts for each risk type and risk appetite scale with a proposed risk appetite (outlined in red on each scale)

Risk Types & Risk Categories

Based on Government's 'Orange Book'

Salisbury NHS Foundation Trust

Risk Appetite Levels:

Averse | Minimal | Cautious | Open | Eager

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Workforce Risks

Workforce Supply

NHS Salisbury NHS Foundation Trust

Definition

The Trust has sufficient staff numbers, with the right skills mix, in the right locations to deliver an effective and safe service to patients

Adverse	Minimal	Cautious	Open	Eager
We prioritise patient safety and quality of care, thus we have a low tolerance for understaffing and will invest in recruiting additional staff even if it means higher short-term costs.	We have a low tolerance for gaps in specialist care and will ensure we have a sufficient number of specialist staff in each department to provide high-quality, expert care	We aim to maintain optimal staffing levels and are willing to accept some temporary understaffing during peak periods if it is balanced by efficient use of current resources and temporary staff	We will maintain a balanced mix of specialist and generalist staff, accepting that some departments may need to rely on generalists during peak times	We are prepared to operate with minimal staffing levels to reduce costs, accepting the potential for increased workload on existing staff and a possible impact on service delivery

Workforce Deployment

NHS Salisbury NHS Foundation Trust

Definition

The Trust is able to flexibly deploy the right staff to the right areas, enabling SFT to generate efficiencies and innovation.

Adverse	Minimal	Cautious	Open	Eager
We have a low tolerance for rigid role definitions and will invest heavily in cross-training programs to ensure staff can be deployed flexibly across different functions and departments as needed	We will use temporary and agency staff to supplement our workforce during peak periods, balancing the need for flexibility with the importance of continuity in patient care	We will support some level of cross-training to allow staff to cover critical roles, accepting that not all staff will be interchangeable across all functions	We will adopt flexible staffing practices to a reasonable extent, accepting occasional shortfalls or overstaffing during non-peak periods to manage costs and efficiency	We will limit cross-training initiatives, accepting the risk that staff may not be able to easily switch roles or departments in response to changing needs

Workforce Performance

NHS Salisbury NHS Foundation Trust

Definition

Staff are sufficiently trained to deliver in their role, and that they are performing and delivering to required standards

Adverse	Minimal	Cautious	Open	Eager
We have no tolerance for skill gaps among staff and will invest heavily in ongoing training and development programs to ensure all staff are highly skilled and up-to-date with the latest medical practices and procedures	We are willing to tolerate some skill gaps among staff, for short periods of time, but seek to provide opportunities for training and education at the earliest opportunity	We support regular training and development but are willing to prioritize certain key areas over others based on strategic importance and available budget	We are willing to accept limited skill gaps in non-mandated areas, where cover can be provided by external agencies and temporary staff solutions	We will limit investment in training and development to essential compliance and regulatory requirements, accepting that some skill gaps may persist among staff

Workforce Retention

NHS Salisbury NHS Foundation Trust

Definition

The Trust does all it can to retain staff by seeking to improve the staff experience, which in turn enables high quality patient care. As such the Trust does all it can to reduce turnover across the Trust.

Adverse	Minimal	Cautious	Open	Eager
We have no tolerance for high staff turnover and burnout, and will implement robust well-being programs and deliver competitive benefits to retain staff and maintain high morale	High levels of turnover will not be tolerated, and staff burnout will be contained through the implementation of effective well-being programs and focussed interventions on staff areas which have moderate to high levels of turnover	We will implement well-being measures and deliver benefits, accepting some level of turnover as inevitable, but ensuring critical roles are retained through a keen focus on areas of concern and high and increasing turnover turnover	We will implement well-being measures and deliver benefits, accepting some level of turnover as inevitable, but ensuring critical roles are retained through a keen focus on areas of concern and high and increasing turnover	We will focus on cost containment, accepting higher turnover and some level of staff dissatisfaction, with a focus on filling critical roles as needed.

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Operational Risks

Business Continuity Risk

Salisbury NHS Foundation Trust

Definition

To ensure the Trust has effective processes (Business Continuity Plans or BCP) in place for maintaining continuity of key services in the face of disruption from identified local risks, these are in line with the Civil Contingencies Act 2004 and Health and Care Act 2022. This will range from extreme shortages in staff groups to Major Mass Casualty planning.

Adverse	Minimal	Cautious	Open	Eager
The Trust invests in the ability to understand its BCP in detail and is unwilling to accept any risks in relation to gaps in plans. The financial implications of securing full BCP that are all tested to cover all situations at all times are accepted.	The Trust seeks to provide adequate BCP to ensure patient safety and constitutional standards are met at a Trust level where possible, with minimal areas of risk gaps in plans and audit of plans.	The Trust will ensure that BCP and testing is focused on areas most at risk from the impact of any incident and areas that are most likely to be impacted. Accepting the risk that some areas not tested will not be compliant.	The Trust is willing to tolerate reduce levels of compliance with BCP and testing, accepting the risk that significant numbers of areas may not be fully compliant with BCP.	The Trust does not prioritise regular reviews of BCP plans does not seek assurance by way of testing and responds reactively to incidents in a manner that it deems appropriate.

Health and Safety Risk

Salisbury NHS Foundation Trust

Definition

To ensure the Trust has a structured health and safety management system that enables the Trust, and accountable officers, to demonstrate actions that eliminate or reduce the risk to the health and safety of staff, visitors and contractors as far as is reasonably practicable.

Adverse	Minimal	Cautious	Open	Eager
Any risk to the H&S of staff, or others, that is catastrophic (score >15) will result in tasks being ceased, an action plan developed and immediate steps taken to ensure the safety of staff, and others, before a task recommences.	Where there is a risk to the H&S of staff or others > 8 but < 15, the Trust will accept an impact to the service or finances where necessary and will develop an action plan to reduce the consequence and likelihood of harm. Where there is a clear and agreed plan of action, the risk activity does not need to cease.	The Trust accepts other priorities may take precedence over moderate risks (4-6) to the H&S of staff and others and resources may be allocated according to other non H&S related risks.	The Trust will monitor low (1-3) or moderate (4 -6) risks, where cost effective and practical solutions are available, until greater priorities are managed and resources are freed to reduce the risk to the health and safety of staff, or the risk score changes.	The Trust will accept risks to the H&S of staff, and others, where the consequence of harm is low (risk score of 1-3) or moderate (4 -6) and where there are no practical or cost-effective solutions available to reduce the risk.

Information Governance (IG) Risk

Salisbury NHS Foundation Trust

Definition

To ensure that the Trust has the right processes and systems for collecting, storing, managing and maintaining information (including archiving and deleting) in all its forms in order to support business needs and comply with regulations.

Adverse	Minimal	Cautious	Open	Eager
The Trust will adhere to national IG best practice guidance to the letter, regardless of any operational or clinical benefit. IG and data protection (DP) risks identified will need to be fully mitigated before any data is shared and/or contracts are signed. Staff cannot work unless they are IG training compliant.	Wherever possible, the Trust will adhere to national IG/DP best practice. IG risks in contracts and data sharing agreements must be minimal for it to be acceptable to the Trust. Wherever possible all data stored adheres to the data retention policy.	The Trust will ensure IG training is prioritised and mandated for all. Mitigations to risks identified in IG and DP reviews will be carefully considered and an informed judgement will be taken on a case by case basis. Invariably the risk the Trust will accept is low.	Whilst IG training is mandated, the Trust will willing to accept lower compliance. IG and DP risks are identified, reviewed on a case by case basis but IG is prioritised lower that operational/clinical risk mitigation. Data stored adheres to the data retention policy only in high risk areas.	The Trust will predominantly prioritise data sharing for clinical and operational benefits above IG legislation, accepting the risk of potential legal/regulatory action. IG Training and effective data management is not a Trust priority and not mandated.

Information Security Risk

NHS Salisbury NHS Foundation Trust

Definition

To ensure that the management of information security is designed to protect confidential, private and sensitive information or data from unauthorised access, use, misuse, disclosure, destruction, modification or disruption.

Adverse	Minimal	Cautious	Open	Eager
Cyber is a high priority for Trust to invest in risk mitigations, accepting the increase in financial risk at all times. The Trust will prioritise patching and the application of restrictions to support cyber security, even when it may impact operational or clinical practice.	Cyber is a high priority for Trust to invest in risk mitigations, invariably accepting the increase in financial risk. Applying patching and restrictions will be a priority to support cyber security, where it does not significantly impact operational or clinical practice, unless the threat is significant.	The Trust will invest to reduce the risk of cyber attack where it is practical to do so. The trust will balance the need for cyber restrictions With the wider risk of the organisation, adhering to cyber policy and practices, wherever practically possible, unless the cyber threat is significant	The Trust is willing to reduce restrictions supporting cyber security for the wider benefit of the organisation. Adherence to cyber related policies and practices remains important but not essential.	The Trust will seek to only invest in cyber security when there is funding available, accepting the risk otherwise of not doing so. Adherence to cyber policy and practices are encouraged but not treated as a priority. The Trust accepts the risk of regulatory action.

Information Technology Risk

Salisbury NHS Foundation Trust

Definition

To ensure the Trust has appropriate processes in place to manage the use, ownership operation, involvement, development and adoption of IT to prevent unplanned business disruption.

Adverse	Minimal	Cautious	Open	Eager
Investing in technology is a high priority, regardless of whether there is financial return on investment (RoI) or not. There is eagerness to be lead technological innovation piloting, accepting the associated risks. The replacement of aging software and hardware is prioritised ahead of almost anything else.	The Trust will prioritise operational/clinical benefits over financial RoI when investing in technology. There is interest in exploring technological innovation, at times being at the forefront of this. The Trust will, accept small pockets of aging technology, however will adhere to national expectations on digital maturity.	The Trust will consider business cases that balances the financial risks of technology investment with the operational/clinical benefits. Technological innovation will be on a fast follower basis only. The Trust will have a higher level of aging technology, accepting the risks/disbenefits to the organisation.	Investment in technology, without a clear financial RoI is rare. The Trust will support Technological innovation trials where there is high risk needing mitigation. The Trust will ensure there is no regulatory action but will otherwise accept the risks associated with increasingly aging technology.	The Trust will invest in technology only where it is essential to do so, and only when there is a deliverable financial RoI. The default will be to not participate in Technological innovation pilots. The Trust accepts the risks associated with having extensive aging technology, including regulatory action.

Estates/Physical Assets Risk

Salisbury NHS Foundation Trust

Definition

It is essential that the condition of the SFT estate and physical assets are accurately assessed, built, specified, managed and maintained by competent in-house staff supported by professional external expertise where required in line with the relevant legislation & guidance, to ensure they are fit for purpose and safe for patients, staff and visitors. The correct processes and systems for collecting, storing, managing and maintaining Estates information in all its forms in order to support business needs and comply with regulations should be in place and fit for purpose.

Adverse	Minimal	Cautious	Open	Eager
SFT will adhere to national guidance (NG), regardless of any benefit. No value engineering (VE) will be implemented. A full backlog maintenance survey (BM) will be carried out annually. All approved and competent engineers will work in one discipline. Estates software will be replaced regardless of costs	Wherever possible, SFT will adhere to NG. VE will be considered if appropriate. A 50% BM site survey will be carried out annually. All approved and competent engineers will work across two disciplines. Estates software will be kept up to date while exploring areas to enhance its capabilities.	Wherever possible, SFT will adhere to NG. VE will be considered if appropriate. A 20% BM site survey will be carried out annually. All approved and competent engineers will work across two + disciplines. Estates software will be kept up to date while exploring areas to enhance its capabilities.	Wherever possible, SFT will adhere to NG. VE will be considered if appropriate. A 100% paper-based BM review will be carried out annually . All approved and competent engineers will work across three+ disciplines. Estates software will be maintained at current levels while exploring areas to enhance its capabilities.	SFT will not adhere to NG. VE will be encouraged. No BM reviews will take place, and an estimate will be submitted as part of our national return obligation. All approved and competent engineers will work across many disciplines. Estates software will be maintained at minimum levels with no view to enhance.

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Clinical Risks

Infection Prevention and Control Risk

Salisbury NHS Foundation Trust

Definition

To ensure the Trust has appropriate processes in place to avoid healthcare associated infections and preventable harm.

Recommended status – minimal or averse

Averse	Minimal	Cautious	Open	Eager
The Trust will adhere to all national IPC guidance regardless of any cost. A full complement of IPC team members will be employed, supported by link professionals across the divisions. IPC team members will have completed all required training. Link professionals attend 100% training sessions	Wherever possible, the Trust will adhere to national IPC guidance. A full complement of IPC team members will be employed, supported by link professionals. IPC team members will have completed all required training. Link professionals attend 80% training sessions External support may be required from UKHSA, or system partners	Wherever possible, the Trust will adhere to national IPC guidance. A full complement of IPC team members will be employed, supported by link professionals. IPC team members will have completed 75% required training/have experience in IPC. Link professionals attend 60% training sessions. External support is required from UKHSA, or system partners	The Trust will aim to meet national IPC guidance. A full complement of IPC team members maybe employed, supported by link professionals. IPC team members will have completed 50% required training/have some experience in IPC. Link professionals attend 40% training sessions. External support will be required from UKHSA, or system partners	The Trust will aim to meet minimum national IPC guidance. A full complement of IPC team members maybe employed, supported by link professionals. IPC team members will have completed 0-50% required training/have some/no experience in IPC. Link professionals attend 20% training sessions. External support will be required from UKHSA, or system partners

Patient Experience

NHS Salisbury NHS Foundation Trust

Definition

To ensure that the Trust has accessible, diverse and equitable means by which our service users, their carers and visitors can share their experiences openly and honestly, with assurances that these are embraced and seen as opportunities for improvement.
The Trust accepts that despite the priority of a person-centred patient experience, this may at times be compromised in favour of delivering safe and effective care.

Averse	Minimal	Cautious	Open	Eager
The Trust will strictly adhere to national patient experience targets (complaints standards, national surveys and Friends and Family Feedback) and will ensure we comply with or exceed minimum targets. The Patient Experience team will be at full complement to deliver on these targets. Patient experience may only be compromised in favour of delivering safe and effective care, when any mitigations will be established.	The Trust will adhere to national patient experience targets, (complaints standards, national surveys and Friends and Family Feedback). The Patient Experience team will be at full complement to deliver on these targets The Trust accepts patient experience may be compromised in favour of delivering safe and effective care, but anything fundamentally detrimental to patient experience will be mitigated.	The Trust will aim to exceed minimum national patient experience targets and aim to prioritise a person-centred patient experience. Local improvements made as a result of complaints and triangulation of data established through trusted patient engagement forums, (including Friends and Family Testing and National Surveys) is prioritised. Improvements are driven in balance with delivering safe and effective care,.	The Trust will aim to exceed national patient experience targets and will prioritise a person-centred patient experience. This will include some risk exposure through organised, trusted patient engagement opportunities such as patient panels, Patient Safety Partners and Patient Stories. Using these forums to openly expose inefficiencies and drive improvement (where possible) with the same priority as delivering safe and effective care.	The Trust will exceed national patient experience targets and strictly adhere to a person-centred patient experience. Exposing itself to pro-active patient engagement and involvement across a diverse range of communities and our local community. This may include proactive duty of candour where necessary. Improvements are driven with the same priority as delivering safe and effective care.

Patient Safety and Outcomes

NHS Salisbury NHS Foundation Trust

Definition

To ensure that the Trust has systems and processes in place to deliver safe, timely and effective care to our patients.

Averse	Minimal	Cautious	Open	Eager
The Trust will strictly adhere to all evidence based processes, policies and procedures to deliver the highest possible standards of care at all times. Workforce standards will meet minimum requirements to deliver the care. Mitigations will be robust to ensure care is optimal at each point of contact. Patient safety will take priority over financial and patient experience targets.	The Trust will adhere to evidence based processes, policies and procedures as far as possible. Workforce standards may not always meet optimal levels but any gaps will be mitigated to ensure patient safety is prioritised. Preferred care options may not be possible due to financial constraints. Care outside the accepted footprint will be minimised and mitigated.	The Trust supports evidence based best practice but balances this with financial stability. Patient safety and effective outcomes are prioritised with a balance achieved between these, patient experience and financial responsibility. Patients will be cared for within the budgeted footprint of the Trust where possible.	The Trust supports evidence based best practice but balances this with financial stability and an appetite for cautious research projects. Patient safety and effective outcomes are prioritised with a balance achieved between these, patient experience, research objectives and financial responsibility. Patients may need to be cared for in corridors or other escalation areas to meet targets.	The Trust supports evidence based best practice but balances this with financial stability and an appetite for ambitious research projects. Patient safety and effective outcomes are prioritised with a balance achieved between these, patient experience, research objectives and financial responsibility. Patients may need to be cared for in corridors or other escalation areas to meet targets.

Research

NHS Salisbury NHS Foundation Trust

Definition

To ensure that the Trust deliver Research safely to patients, providing adequate oversight and complies with Regulations. To provide legal ownership of Trust generated research and in improve the health of the community.

Adverse	Minimal	Cautious	Open	Eager
Research studies delivered to patients or using patients' data require appropriate National Regulatory Approvals. Regulatory non compliance is a legal and reputational risk to the Trust. The Trust ensures that appropriate governance and oversight frameworks are in place to ensure that all research delivered to its patients have the appropriate ethical , legal , regulatory complaint.	The Trust Research department conducts comprehensive feasibility and risk assessment during the planning and set up stage of all sponsored research projects as well as robust local multi disciplinary feasibility assessments to all hosted research projects to identify risks and develop mitigating strategies. Relevant central and specialised Trusts departments such as Pharmacy, Radiology or Information Governance work closely with the Trust Research department to identify and mitigate risks	The research department workforce is monitored on an ongoing basis to ensure that all the Trust and Healthcare worker Statutory training and certification is up to date. In additional all Research staff hold a Good Clinical Practice (GCP) certificate and have bi-yearly training to ensure that these are up to date. Research staff attend National Institute for Health Research (NIHR) training as well as research study specific training prior to delivering any Research study in the Trust.	The Trust holds the research department to account in ensuring that all Trusts generated research have the appropriate sponsor oversight and monitoring during the life span of the study. The research department is continuously developing and maintaining SOPs , assurance systems and ensure that the research processes adhere to protocols and ICH GCP standards.	The Trusts Research Department collaborates with other NHS R&D departments, Education Partners , Industry Partners and other regional and national organisation to share best practices and resources . The Trusts Research department seeks support from research networks and consortia to enhance research quality , mitigate risks, identify training needs and collaborate on providing best care and making research safe and accessible to the community.

Capacity Planning Risk

Salisbury NHS Foundation Trust

Definition

To ensure the Trust has effective processes in place for planning and providing capacity to treat elective, non-elective, and clinically urgent patients to maintain patient safety and meet constitutional standards.

Adverse	Minimal	Cautious	Open	Eager
The Trust invests in the ability to understand its capacity in detail and is unwilling to accept any risks in relation to capacity. The financial implications of securing adequate capacity to meet all constitutional standards and maintain patient safety at all times are accepted.	The Trust seeks to provide adequate capacity to ensure patient safety and constitutional standards are met at a Trust level where possible, with minimal areas of risk or capacity gaps.	The Trust will ensure that capacity is planned to meet the demand for elective and non-elective (acute) admissions to our hospitals, managing this risk to provide safe treatment and care to our patients.	The Trust is willing to tolerate reduce levels of performance against some constitutional standards in order to prioritise clinically urgent patients.	The Trust does not prioritise regular reviews of demand versus capacity and responds reactively to peaks in demand. The Trust is willing to accept low compliance to constitutional standards, prioritising clinically urgent patients.

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Financial Risks

Counter Fraud Risk

NHS Salisbury NHS Foundation Trust

Definition

To ensure that the Trust has systems and processes in place to create an effective control environment to protect the organisation from internal and external fraud.

Averse	Minimal	Cautious	Open	Eager
The Trust prioritises fraud prevention through strong governance and reporting structures with clearly defined roles and responsibilities around fraud risk. Processes and systems that actively look for fraud in key risk areas supported by comprehensive risk assessments and key controls. Rapid and effective investigations into fraud cases. Avoidance of financial loss is a key objective.	The Trust aims to balance fraud prevention with potential rewards but are still focused on minimising risk through effective governance and controls supported by comprehensive risk assessment and effective, prompt investigation.	The Trust seeks a balanced response to fraud risks and are willing to accept a level of risk with possibility of some limited financial loss. Resources generally restricted to existing commitments.	The Trust are open to taking moderate risks. High levels of devolved authority. The Trust is prepared to invest for return and minimise the possibility of financial loss by managing the risks to a tolerable level. Resources allocated in order to capitalise on opportunities.	The Trust has a very high tolerance for fraud risk and is willing to take considerable risks to achieve their strategic objectives. Management by trust rather than tight control.

Supply Chain Risk

NHS Salisbury NHS Foundation Trust

Definition

To ensure that the Trust has systems and processes in place to deliver an effective supply chain service to our clinical teams, supporting patient care through ensuring the right product is in the right place, at the right time.

Averse	Minimal	Cautious	Open	Eager
The Trust prioritises stability and predictability in our supply chain operations characterised by stringent controls, rigorous supplier assessments, and extensive contingency plans. Avoiding transformative process, change, suppliers or markets where there maybe value but that could introduce significant variability or uncertainty into the supply chain.	The Trust aims to balance risk with potential rewards but are still focused on minimising disruptions. thorough risk assessments and have moderate contingency plans in place for supply Disruption. We may engage in some riskier supply chain strategies around alternative products and processes but with careful monitoring and control mechanisms in place.	The Trust seeks a balanced risk appetite and are willing to accept a moderate level of risk in their supply chain in exchange for potential benefits. Through using a mix of traditional and innovative supply chain practices, they actively manage risks but are open to exploring new suppliers, markets, and technologies that could offer competitive advantages to our clinical teams based on a value-based procurement methodology approach	The Trust are open to taking significant risks to achieve substantial financial rewards and competitive advantage. The Trust is happy to purse strategies of entering emerging markets or supplies from high-risk supply change routes adopting cutting-edge technologies. We are agile and capable of responding quickly to disruptions on large scale due to the level of standardisation and consistent processes	The Trust has a very high tolerance for risk and is willing to take considerable risks to achieve their strategic objectives. The Trust prioritises innovation and rapid growth over stability and supply disruption. Investing in new high-risk ventures and have minimal risk mitigation strategies on this change. Our focus is on seizing opportunities and adapting quickly to changes in the supply chain environment. In a flexible way through minimised process control

Financial reporting risk

Salisbury NHS Foundation Trust

Definition

To ensure that reported financial information reported is correct, true and fair and does not contain material misstatement.

Averse	Minimal	Cautious	Open	Eager
The Trust prioritises robust financial management and reporting, characterised by stringent grip and controls to avoid uncertainty.	The Trust delivers sound financial management and reporting, with no material misstatements or variances to forecast.	The Trust aims to balance sound financial management and reporting against earlier reporting timescales with careful monitoring and review of post reporting period transactions.	The Trust is willing to accept a moderate level of risk in the reported financial position in exchange for reduced reporting timescales.	The Trust is willing to accept a high level of risk in the reported financial position through reduced process controls. This will minimise reporting timescales and provide focus and opportunities to improving the reported position.

Financial Management & Waste Reduction risk

Salisbury NHS Foundation Trust

Definition

The risk of direct or indirect loss resulting from inadequate systems and processes to the Trust's management of its Finances.

Adverse	Minimal	Cautious	Open	Eager
No appetite for decisions or actions which may result in financial loss	Only prepared to accept minimal possibility of material financial impacts or losses or reporting misstatements if essential to safe and effective patient care and outcomes	Limited financial impacts or losses are accepted if they yield upside opportunities elsewhere within the Trust. Value for money is a key focus	Prepared to invest and/or accept financial impacts or losses for the benefit of improved patient care and outcomes if appropriate controls are in place and value for money is delivered	Proactively invest and/or accept financial impacts or losses for the benefit of patient care and outcomes, recognising that the potential for substantial gain outweighs inherent risks

Revenue Funding & Cash Management Risk

Salisbury NHS Foundation Trust

Definition

To ensure that the Trust's funding sources and cash are adequately managed with funds available as the business requires.

Averse	Minimal	Cautious	Open	Eager
We will retain a minimum cash balance of £9.911m All income contracts will be signed in line with national guidance and SFIs	We will retain a minimum cash balance of £4.956m All income contracts will be signed in line with national guidance and SFIs	We will retain a minimum balance of £1.129m in line with NHSE guidance ICB and NHSE commissioning contracts will be signed in line with national guidance and material NHS service contracts in line with SFIs	We will retain a minimum balance of £1.129m in line with NHSE guidance ICBs and NHSE commissioning contracts will be signed in line with national guidance	We will retain a minimum balance of £1.129m in line with NHSE guidance ICBs and NHSE commissioning contracts will be signed in line with national guidance

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External Risks

Legal and Governance Risk

Salisbury NHS Foundation Trust

Definition

To ensure that the Trust has systems and processes in place to operate in accordance within legal and regulatory frameworks and the UK Corporate Governance Code, where applicable.

Averse	Minimal	Cautious	Open	Eager
The Trust has no appetite for decisions that may compromise compliance with statutory, regulatory or policy requirements or decisions that could lead to additional scrutiny or attention on the organisation.	The Trust will avoid any decisions that may result in heightened regulatory challenge unless absolutely essential. The Trust appetite for risk taking is limited to those events where there is no chance of significant repercussions.	The Trust is prepared to accept the possibility of limited regulatory challenge and would seek to understand where similar actions had been successful elsewhere before taking any decision.	The Trust is prepared to accept the possibility of some regulatory challenge as long as there is reasonable confidence we would be able to challenge this successfully.	The Trust is willing to take decisions that will likely result in regulatory intervention if there is justification and where the potential benefits outweigh the risks. Willing to take decisions that are likely to bring scrutiny of the organisation.

Partnership working risk

NHS Salisbury NHS Foundation Trust

BAF 10 link

Definition

To establish and maintain effective partnerships to support the ICS, our work at 'place', and the delivery of our externally dependent strategic initiatives (and aspects of our vision) – i.e. increase in healthy life years or reductions in length of stay beyond NCTR.

Averse	Minimal	Cautious	Open	Eager
The Trust has nominated leadership for all relevant partnership forums and actively leads system and place wide working to resolve our externally driven challenges. Senior leadership time within the Trust is prioritised for system working even at the expense of operational focus. The Trust maintains excellent relationships with external partners, with significant influence over external decision making through the integration of services and role sharing.	The Trust is engaged in most partnership working forums and seeks leadership roles where appropriate. Capacity is dedicated to shared priorities across the system/place and the AHA. The Trust maintains good relationships with most external partners and has some influence over external decision making through seeking to integrate services and role sharing.	The Trust is engaged in some partnership working forums but not in a leading capacity. Some resource is dedicated to working on shared priorities, and the Trust is prepared to tolerate influence by external parties. The Trust maintains cordial relationships with key partners and is prepared to tolerate poor relationships with wider partners to achieve SFT focussed goals at the expense of partnrs.	The Trust is engaged in mixed partnership working, seeking non-traditional partnerships that may or may not advance our vision. The Trust is prepared to tolerate negative impacts from partners due to an SFT focussed approach.	The Trust invests time in non-traditional partnerships at the expense of traditional health ecosystem partners. As such the Trust is prepared to tolerate hostile relationships with relevant external organisations and focus solely on advancing SFTs aims that may yield advantage i.e. incubating health technology start-ups.

Reputational Risk

Salisbury NHS Foundation Trust

Definition

Potential for negative publicity, public perception or uncontrollable events which could have an adverse impact on the Trust's reputation.

Averse	Minimal	Cautious	Open	Eager
The Trust has no appetite for decisions that could lead to additional scrutiny or attention on the organisation.	The Trust appetite for risk taking is limited to those events where there is no chance of significant repercussions.	The Trust is prepared to accept the possibility of limited reputational risk if appropriate controls are in place to limit any fallout.	The Trust is prepared to accept the possibility of some reputational risk as long as there is the potential for improved outcomes for our stakeholders.	The Trust is willing to take decisions that are likely to bring scrutiny of the organisation. The Trust outwardly promotes new ideas and innovations where potential benefits outweigh the risks.

Strategic planning risk

Salisbury NHS Foundation Trust

BAF 6 link

Definition

Strategic planning faces significant uncertainty due to the challenge of providing DGH services to ageing rural populations; the lack of integrated care; organisational scale; and constancy of purpose regarding the operational management system.

Averse	Minimal	Cautious	Open	Eager
The Trust fully deploys the I/T OMS and uses it to prioritise all activity. The Trust has clear plans to provide sustainable services to our population and plans with all partners in the system to do so in a coherent manner. The Trust integrates care wherever possible.	I/T is integrated with the planning cycle and is fully embedded for the cascade of organisational strategy. The Trust is able to meet the needs or our population and is in the process of integrated some aspects of care. The Trust considers growing its base of core services to provide scale and leverage regional services, and other value adding activity, to provide sustainable scale to the organisation so it may serve the population in perpetuity.	I/T is adopted across 30-50% of the organisation with most senior leaders fully engaged. It is maturing within the planning cycle and is able to cascade the strategy across most aspects of the SPF. The Trust is meeting the needs of the population but is prepared to tolerate some risk that may not always be the case. The Trust is attempting to integrate some services. The Trust is prepared to tolerate the risk only growing some core and regional services.	I/T is failing to embed fully and the Trust is prepared to tolerate this risk. The Trust accepts the risk that it may not be able to provide all current services to our population beyond 2030. The Trust is therefore seeking to grow its base of core services to provide scale and leverage regional services, and other value adding activity such as the domiciliary care market, to provide scale to the organisation..	The Trust is prepared to tolerate I/T gradually diminishing as the OMS if it means significantly growing the business. The Trust seeks to grow its core business and subsidiary activities to drive income and organisational scale, potentially destabilising core commissioned services.

NHS Salisbury NHS Foundation Trust

Report to:	Trust Board (Public)	Agenda item:	5.2
Date of meeting:	9 January 2025		

Report tile:	Q2 Learning from Deaths Report 2024-25			
Status:	Information	Discussion	Assurance	Approval
	Yes	Yes	Yes	
Approval Process: (where has this paper been reviewed and approved):	Mortality Surveillance Group Clinical Governance Committee			
Prepared by:	Mr Charles Ranaboldo, Trust Mortality Lead Dr Ben Browne, Associate Medical Director			
Executive Sponsor: (presenting)	Mr Duncan Murray, Chief Medical Officer			

Recommendation:

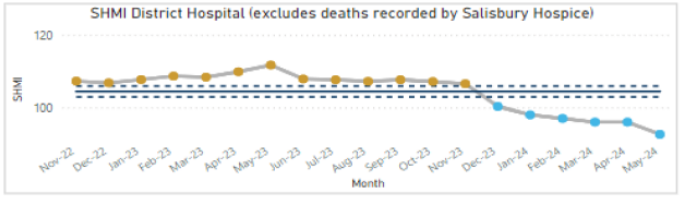
The paper is to provide assurance to the committee that the Trust is learning from deaths and making improvements.

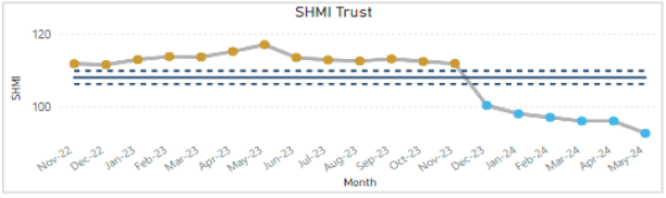
Executive Summary:

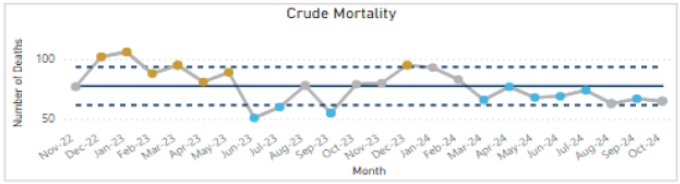
Summary:

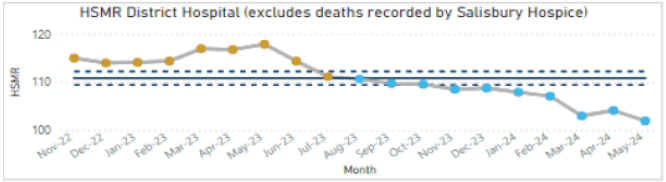
- The latest SHMI figure for the Trust is now 0.94 (12-month period ending in May 2024). This is the lowest recorded figure for some time (980 observed deaths versus 1045 expected). According to NHSE this figure remains statistically within the expected range for the Trust.
- Significant progress has been made in relation to coding and the percentage of patients with a ‘zero’ co-morbidity score has decreased. This is now closer to the national average.
- The HSMR is currently being remodelled and changes to the methodology will be reflected in subsequent learning from deaths reports.
- The MaMR (online mortality review process which documents, extracts lessons learned and helps with analysis of all deaths in the Trust), has been revised in the light of early experience. A new guide to its use and supporting video has been produced.
- The IT issue of patients being assigned to ‘General Medicine’ and not assigned in MaMR to their appropriate consultant and subspecialty is being tackled. The primary problem resides with the Electronic Patient Record (EPR) system which cannot be resolved, however, a change to the data feed should now allow the correct specialty to be assigned. Patient reviews can now be passed very easily from one team to another, without the originator needing to complete the whole record for a patient that they have been allocated but with whom they are relatively unfamiliar.
- It is now agreed that a new MaMR record can be created before the data is fed from the EPR. We are hoping that very few duplicate records will be generated, and that this will enable teams to complete their reviews contemporaneously.
- A new Excel dashboard has been developed to help track mortality reviews. This has been passed to the AMaT team (contractual supplier of the MaMR module) as a template for future development.

- Transfers (internal/external): Patient flow issues may be an emerging theme in learning from mortality reviews. This has been discussed at the Trust's Mortality Surveillance Group (MSG) and is being closely monitored.









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

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QUARTER 2 2024/25 LEARNING FROM DEATHS REPORT

November 2024

A summary document outlining the learning from deaths at Salisbury NHS Foundation Trust during the first financial quarter of 2024/25. Data correct as of 29.10.2024 [unless otherwise stated in the report]

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GLOSSARY OF TERMS

CHARLSON COMORBIDITY INDEX (CCI) SCORE
The Charlson Comorbidity Score is a method of measuring comorbidity. It is a weighted index that predicts the risk of death based on the number and severity of 19 comorbid conditions.

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

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

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

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

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

PSIRF
Patient Safety Incident Response Framework

RESPECT
The Recommended Summary Plan for Emergency Care and Treatment (ReSPECT) provides a personalised recommendation for an individual's clinical care in emergency situations whether they are not able to make decisions or express their wishes.

SFT
Salisbury NHS Foundation Trust.

SHMI
The SHMI is the ratio between the actual number of patients who die following hospitalisation at the trust and the number that would be expected to die based on average England figures, given the characteristics of the patients treated there. It covers in-hospital deaths and deaths that occur up to 30 days post discharge for all diagnoses excluding still births. The SHMI is an indicator which reports on mortality at trust level across the NHS in England and it is produced and published as an official statistic by NHS Digital.

SII
Serious Incident requiring Investigation.

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

SMR

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

SOX

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

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Learning from Deaths Report – Quarter 2

Purpose and Background

To comply with the national requirements of the Learning from Deaths framework, Trust Boards must publish information on deaths, reviews, and investigations via a quarterly report to a public board meeting. The Learning from Deaths initiative aims to promote learning and improve how Trusts support and engage bereaved families and carers of those who die in our care.

Executive Summary

- **The** latest SHMI figure for the Trust is now 0.94 (12-month period ending in May 2024). This is the lowest recorded figure for some time (980 observed deaths versus 1045 expected). According to NHSE this figure remains statistically within the expected range for the Trust.
- Significant progress has been made in relation to coding and the percentage of patients with a 'zero' co-morbidity score has decreased. This is now closer to the national average.
- The HSMR is currently being remodelled and changes to the methodology will be reflected in subsequent learning from deaths reports.
- The MaMR (online mortality review process which documents, extracts lessons learned and helps with analysis of all deaths in the Trust), has been revised in the light of early experience. A new guide to its use and supporting video has been produced.
- The IT issue of patients being assigned to 'General Medicine' and not assigned in MaMR to their appropriate consultant and subspecialty is being tackled. The primary problem resides with the Electronic Patient Record (EPR) system which cannot be resolved, however, a change to the data feed should now allow the correct specialty to be assigned. Patient reviews can now also be passed very easily from one team to another, without the originator needing to complete the whole record for a patient that they have been allocated but with whom they are relatively unfamiliar.
- It is now agreed that a new MaMR record can be created before the data is fed from the EPR. We are hoping that very few duplicate records will be generated, and that this will enable teams to complete their reviews contemporaneously.
- A new Excel dashboard has been developed to help track mortality reviews. This has been passed to the AMaT team (contractual supplier of the MaMR module) as a template for future development.
- Transfers (internal/external): Patient flow issues may be an emerging theme in learning from mortality reviews. This has been discussed at the Trust's Mortality Surveillance Group (MSG) and is being closely monitored.

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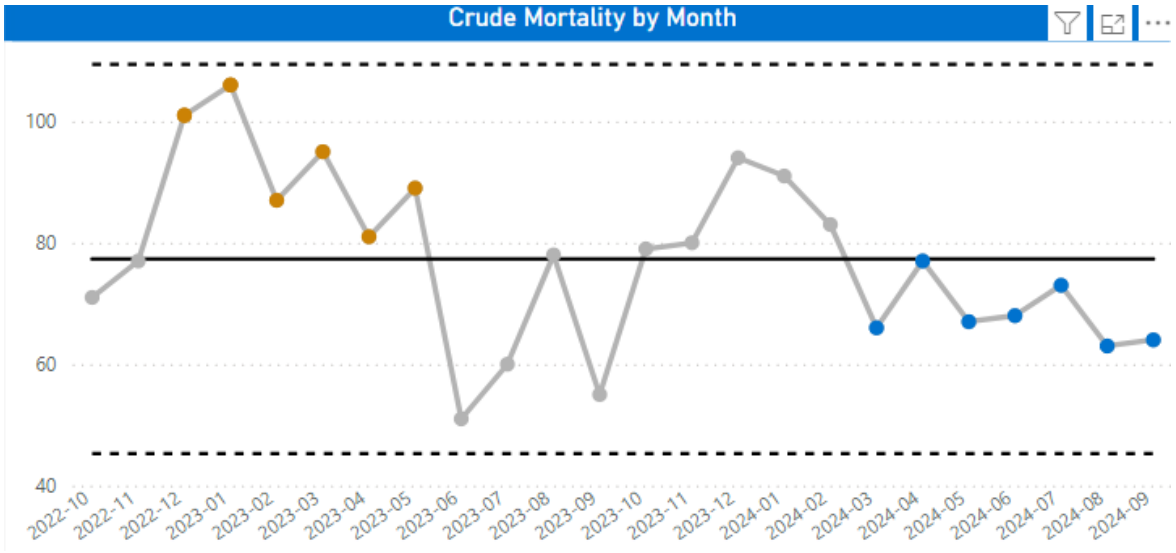
NHS Salisbury NHS Foundation Trust

Learning from Deaths in Q2

The hospital mortality group (MSG) met on 17th September 2024 during Q2, where learning, improvement themes and actions arising from mortality diagnosis group alerts and individual case reviews were discussed. The learning outlined in this report reflects a summary of the key highlights, and the information reviewed and discussed at the MSG.

1. Data Overview



1.1. The graph above has been obtained from the Trust Power-Bi data dashboard. It shows the number of deaths occurring in SFT, as reported monthly, with below average numbers continuing to be observed during each month from March 2024 onwards. The graph and table on the next page provide a more detailed breakdown of these figures.

NHS Salisbury NHS Foundation Trust

Mortality Overview

NHS Salisbury NHS Foundation Trust

Total Deaths as Reported by the Medical Examiner: Oct-22 - Sep-24

Mortality Overview: Oct-22 - Sep-24

Year-Month	Total Deaths as Reported by the ME	Deaths Reviewed by the ME	SJRs Requested by the ME	ED Deaths	Hospice Deaths	Covid19 as Primary Cause of Death (1a)	Total Stillbirth Deaths	Late Miscarriage 22 - 23+6 Weeks	Stillbirths >24+0 - 36+6	Stillbirths >37+0	Total Neonatal Deaths	Total Maternal Deaths	Total Learning Disability Deaths	Total Serious Mental Illness Deaths
2024-09	67	66	3	2	18	2	0	0	0	0	0	0	0	0
2024-08	63	62	4	2	14	2	0	0	0	0	0	0	2	0
2024-07	74	72	5	5	17	1	0	0	0	0	0	0	2	0
2024-06	69	67	5	3	12	4	0	0	0	0	0	0	0	2
2024-05	68	67	5	2	14	0	0	0	0	0	0	0	1	1
2024-04	77	76	7	5	6	0	0	0	0	0	0	0	1	1
2024-03	66	66	4	2	9	1	0	0	0	0	0	0	0	0
2024-02	83	82	4	6	15	0	1	0	1	0	1	0	2	0
2024-01	93	93	2	6	11	3	0	0	0	0	2	0	1	0
2023-12	95	92	4	7	16	0	1	0	1	0	0	0	0	0
2023-11	80	78	10	4	10	4	2	0	2	0	0	0	1	1
2023-10	79	78	6	3	12	3	0	0	0	0	0	0	1	3

Person Centred & Safe | Professional | Responsive | Friendly | Progressive

2. Summary of Learning and Actions Taken in Q2

2.1. Total deaths:203

Total reviewed (ME):198 (98%)

Number of primary reviews requested by ME:12

Primary reviews:43 (21%)

Number of further reviews requested by specialities:4

Number of secondary reviews requested by specialities:0

2.2. Twenty-five learning points have been entered and are summarised in the table below. Only 6 are negative but patient flow seems to be an emerging theme

	Negative	Positive	Total
Assessment, investigation or diagnosis		5	5
Clinical monitoring		2	2
Communication - with relatives/carers		3	3
Communication with clinical colleagues		1	1
Communication with patients		2	2
Documentation		1	1
Documentation	1		1
EoLC support or delivery		3	3
Medical Device or Equipment Management	1		1
Service Provision/Staffing		1	1
Service Provision/Staffing	1		1
Transfers (internal/external); Patient flow	3		3
Treatment and management plan		1	1
Total	6	19	25

2.3. Taken from MaMR there were no quality-of-care scores categorised as ‘very poor’ or ‘poor care’ in Q2

Quality of care score – Q2

Score	Definition	ME reviews	Primary reviews					Further primary reviews					Secondary reviews
			admission & initial	ongoing	during procedure	perioperative	overall	admission & initial	ongoing	during procedure	perioperative	overall	
1	Very poor care	0	0	0	0	0	0	0	0	0	0	0	0
2	Poor care	0	0	0	0	0	0	0	0	0	0	0	0
3	Adequate care	0	0	2 (5%)	0	1 (2%)	2 (5%)	0	0	0	0	0	0
4	Good care	0	8 (19%)	2 (5%)	2 (5%)	2 (5%)	6 (14%)	0	0	0	0	0	0
5	Excellent care	0	3 (7%)	2 (5%)	1 (2%)	0	3 (7%)	0	0	0	0	0	0
Total number of responses		**198 (98%)**					**43 (21%)**					**0**	**0**

3. Review of Intelligence data

3.1. Following the introduction of the Medical Examiner (ME) system, much of the emphasis in mortality reviewing has been on cases where independent opinion has identified areas of potential concern, either based on complaints or concerns expressed by relatives, or issues picked up by the ME directly; these are in addition to statutory reviews of cases such as Learning disability and Autism.

There is little focus on what has been done well, and for that reason the new online Mortality review platform has been configured to include sections for learning and sharing of aspects of care that have gone particularly well and, for example, where actions might be taken which apply outside the speciality doing the review.

The funnel plots at the end of this report (Figs 3 and 4 in the appendix) illustrate two Diagnosis groups where practice has been better than expected.

These data should be shared widely with the Trust employees as examples of the great care that is being delivered by the organisation.

3.2. Progress has been made in relation to improving coding and the percentage of patients with a 'zero' co-morbidity score has significantly decreased (those with no recorded comorbidity). SFT is now closer to the national average (as indicated by the blue line on the graph in section 7.3. of the Appendices)

3.3. The Trust's position for inpatient mortality associated with Acute myocardial infarction (AMI) between the 95% (dashed blue line) and 99.8% (continuous blue line) Control limits (CLs) suggests that the figures are better than expected for care of this Diagnosis group compared to national results. The figures for the year to July 2024 included 307 AMI cases with approximately half the number of deaths observed compared to the number expected: 11 deaths compared to an expected number of 19.9 deaths. Appendix Figure 3.

3.4. The Trust's position for Coronary angioplasty outside both the 95% (dashed blue line) and 99.8% (continuous blue line) Control limits (CLs) suggests that the figures are statistically significantly better than expected for care of this Diagnosis group compared to national results. The figures for the year to July 2024 included 429 cases with only a single death observed, compared to an expected number of 8.4 deaths. Appendix Figure 4.

3.5. The mortality linked to five Diagnostic Groups which have triggered alerts have also received attention in the past two years: Pneumonia, Acute Renal Failure, Aspiration Pneumonia, Cancer of the Colon and Septicaemia. We have reviewed each of these using similar methodology. In each case the Trust is no longer an outlier in terms of relative risk control limits, with mortality now approximating to the national mean. Appendix last 5 charts.

3.6. Improvements in mortality figures have been confirmed for these Diagnosis groups. The Mortality Steering Group and associated teams will continue to respond to Alerts from Telstra UK and SHMI in a thorough way, focussing on learning and actions which can be taken to reduce risk to and improve outcomes for patients in all Diagnosis groups.

With the new online Mortality review platform in place, it is anticipated that any future Alerts can be dealt with by interrogating the data already in the system on any particular group of cases.

It is therefore essential that clinical teams continue to use the online platform (MaMR) to enter clinical data and assessments of quality of care for all mortality cases admitted under their care

or where they have taken over care of that case for the significant or most relevant part of the inpatient stay.

4. End of Life care

4.1. From 1st April 2024 the NACEL survey replaced the Trust's Your Views Matter (YVM) survey for 9-months to allow for national benchmarking to take place for this period.

4.2. The National Audit of Care at the End of Life (NACEL) is a national comparative audit of the quality and outcomes of care experienced by the dying person and those important to them during the last admission leading to death in acute hospitals, community hospitals and mental health inpatient providers in England, Wales, and Jersey. NHS Benchmarking Network is commissioned by Health Quality Improvement Partnership (HQIP) on behalf of NHS England and the Welsh Government. NACEL is featured on NHS England's Quality Accounts list for 2024/25.

NACEL collects data from four sources:

Quality Survey: This is an online survey completed by relatives, carers and those important to the person who died in hospital, to report their experiences of the care and support received at the end of life.

Case Note Review: This is data collected from patient notes about the care they received during their final admission to hospital. It focusses on 10 indicators of care, including recognition of dying, timely review of the dying and deceased patient, etc.

Hospital/ Site Overview: questions focus on the specialist palliative care workforce, staff training, anticipatory prescribing and quality and outcomes within the hospital/site.

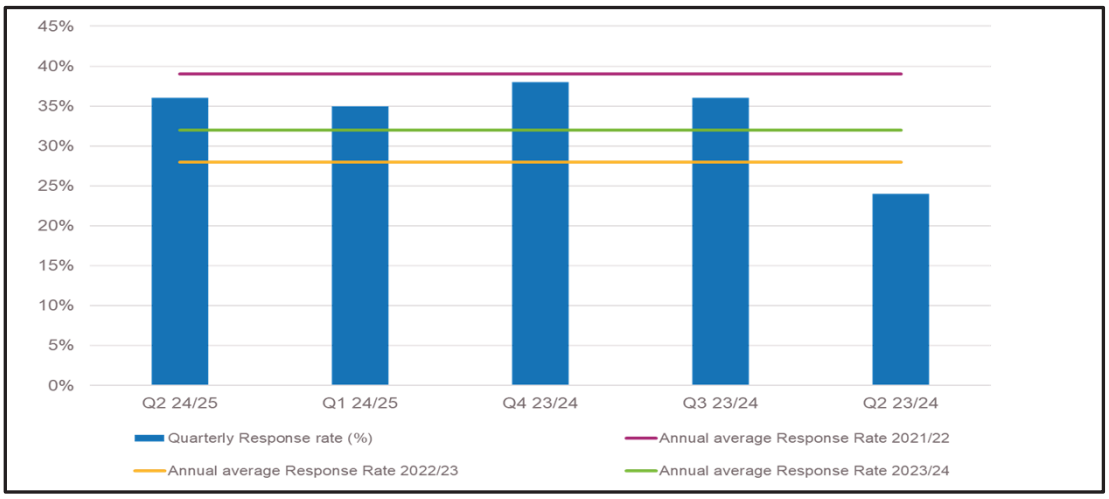
Staff Reported Measure: this survey is completed by staff who are most likely to come into contact with dying patients and their loved ones. The survey asks questions about staff confidence and experience in delivering care at the end of life, the support they receive and the culture of their workplace. This is not a staff satisfaction survey such as the NHS staff survey. About NACEL — National Audit of Care at the End of Life

The NACEL bereavement survey focuses on the insights taken from the Quality Survey.

4.3. In total, during Q2 2024/25 there were 204 deaths, 10 less than during Q1. There were 123 surveys sent during this period. We were able to achieve an average sampling of 60% of

bereaved families. This is an increase on the percentage of surveys sent in Q1 (54%) and exceeds the average sampling for 2023/2024 (54%).

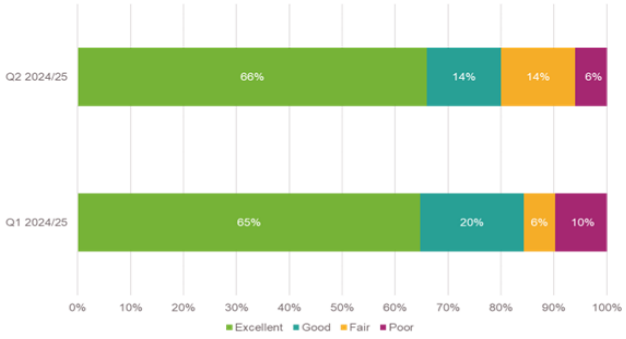
4.4. The average response rate achieved for Q2 was 36%. This is slightly higher than last quarter (35%) and the average for 2023/24 (32%).



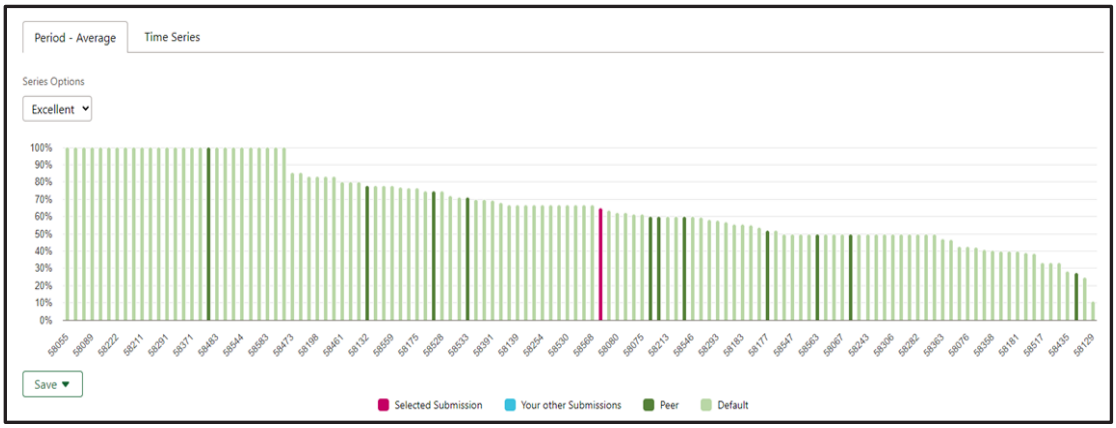
1NACEL Survey Quarterly Response Rates for SFT (Compared to National Average)

4.5. During Q2 66% of those surveyed rated their overall experiences with the Trust's end of life care as excellent. 6% rated the overall experience as poor. However, there is an overall decline in good/excellent rating for the Trust where comparing the results of Q1 to Q2.

4.6. The data shows that just under 65% of SFT's respondents described their overall rating of care and support given by the hospital to the dying person as "excellent" (highlighted in pink in the graph in 1.3.8.). The graph also shows how SFT ranks in comparison to peers across the South West (SW) (shown in dark green). Overall, the Trust's rating has marginally increased in comparison to other Trusts in response to this question.



4.7. The Trust's comparative performance with our South West peers has improved from 6th to 5th position overall.

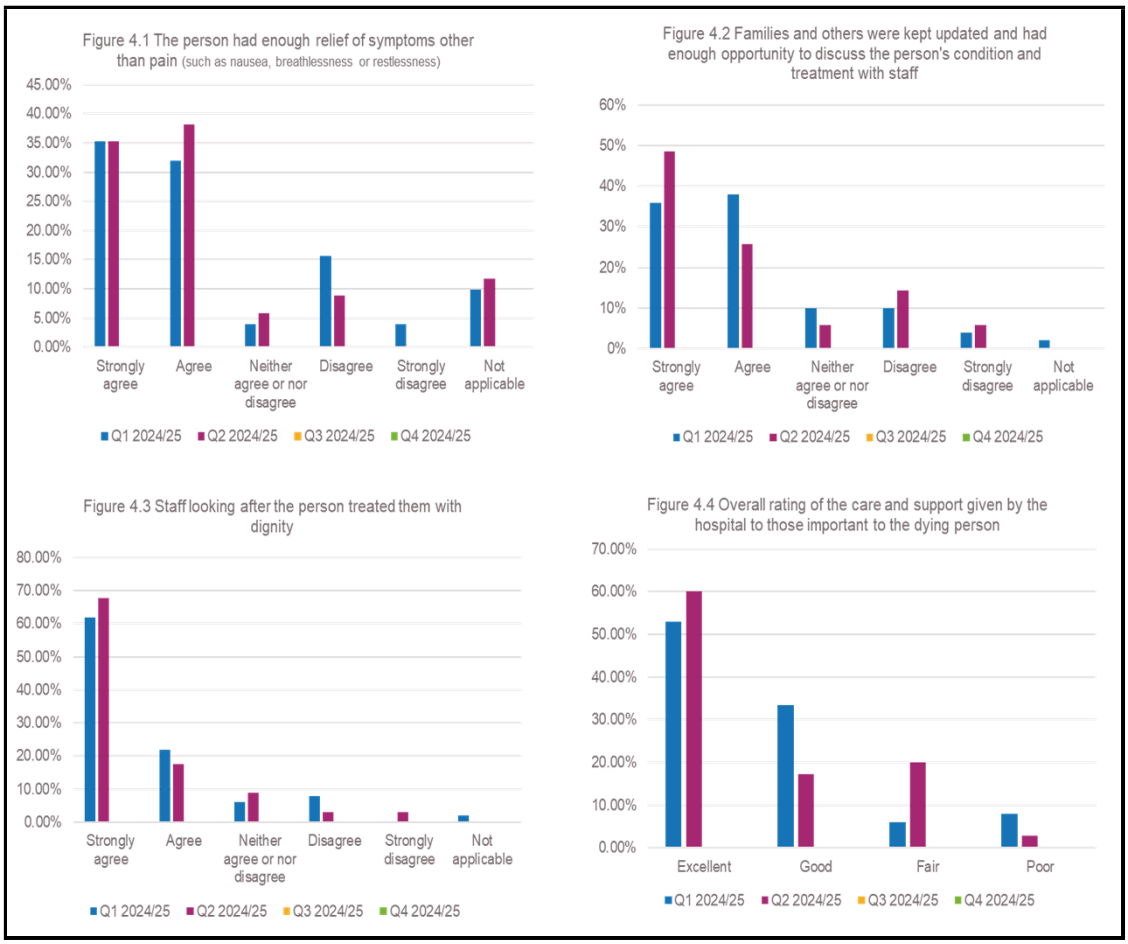


4.8. 18 survey participants requested a call-back from PALS, one of these resulted in a formal complaint being raised.

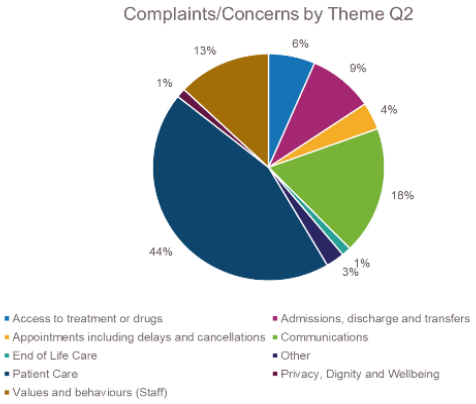
Figures 4.1 to 4.4 show the overall ratings in the key areas of patient experience.

4.9. SFT was noted to have outperformed both nationally and against our South West peers in relation to the question in figure 4.2. below. Performing comparatively with the questions outlined in figures 4.3 and 4.3. However, the Trust remains an outlier in relation to pain relief (both nationally and when compared against our SW peers).

Salisbury NHS Foundation Trust



EOL Care – Correlation with Complaints



4.10. The chart adjacent shows the themes for complaints during Q2.

4.11. There was a total of 77 complaints/ concerns logged during this period, of which 1% were related to end-of-life care.

4.12. There was only one complaint noted in relation to End of Life Care.

4.13. The NACEL survey is unable to be used to reliably correlate complaint themes by location with this quarter. PALS worked with the Medical Examiners to look at how we may be able to supplement this data following the last quarterly report. A relocation of the covering form was implemented towards the end of Q2.

5. Medical Examiners (MEs)

Please refer to the mortality overview table in section 1 for the full breakdown of data

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

5.2. 12 Structured Judgement Reviews were requested by the Medical Examiners during Q2 out of a total of 200 patient cases reviewed.

5.3. Overall, 98% of all patients who died whilst under the care of SFT were subject to a Medical Examiner review during Q2 (similar figures were observed during Q1).

5.4. There were no maternal deaths or deaths in patients with a serious mental illness reports during Q2. There were 4 reviews requested for patients with a learning disability/autism. These cases will be subjected to a mortality review (using the validated SJR method) and a review by our learning disability/autism nurse for a specialist input of potential learning. The learning disability /autism cases are also submitted to the national LeDer programme to support further learning (NHS England » Learning from lives and deaths – People with a learning disability and autistic people (LeDeR) .

6. Litigation

New Enquiries from the Coroner During Q2

6.1. During this reporting period, there were five new enquiries from the coroner concerning the deaths of patients known to SFT.

6.2. Statements have been requested in 4 of those cases, and the final case was a request for the complaint investigation or review only at this stage.

Inquests Concluded in Q2 from Previous Reporting Periods

6.3. Four inquests were concluded in this quarter.

6.4. Statements were provided by SFT in all four cases - one case was dealt with as read only (no witnesses called) and witnesses from SFT were called in the other three. SFT was an interested party in three of the four cases.

6.5. There were no jury cases.

6.6. In one inquest the coroner advised that the use of a non falls handling trained security guard to provide care was insufficient to meet the patient's needs (patient high risk of falls) combined

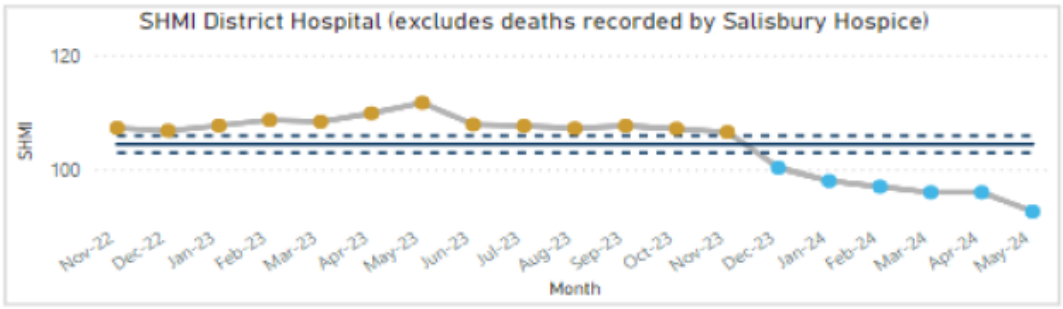
with the repeated lack of sufficient requests for enhanced nursing support. A Clinical Review was undertaken in relation to this, and an improvement plan formulated. Since the time of the case being first raised, the Trust has made significant improvements in reducing inpatient falls through focus on this as one of the Trust's breakthrough objectives (organisational highest priority) in 2023/24.

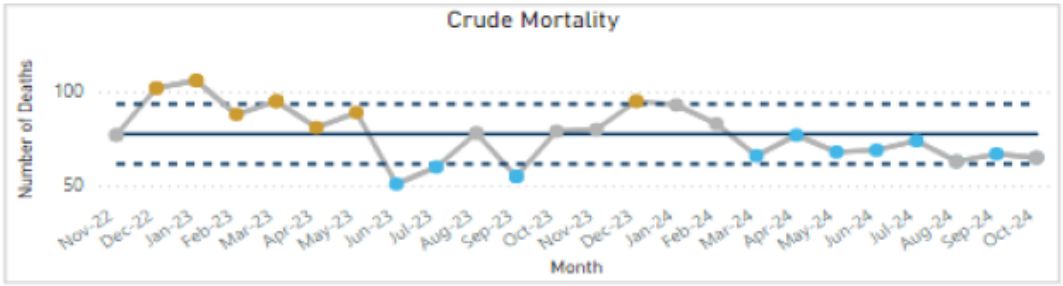
6.7. In another inquest the patient had an unwitnessed fall in which the CT scan revealed a traumatic intracerebral haemorrhage which had contributed to their death. The coroner concluded that the death was an accident. However, a local investigation was also completed in relation to this (SWARM report) and three recommendations were taken forward by the Trust (improving recording of lying/standing BP, improving the identification of patients at high risk of falls, and improved training of manual handling for patients who have had a fall).

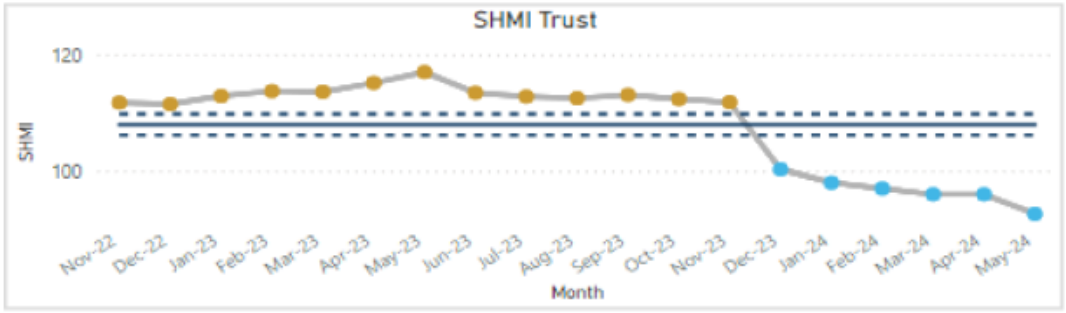
APPENDICES – Supplementary Data

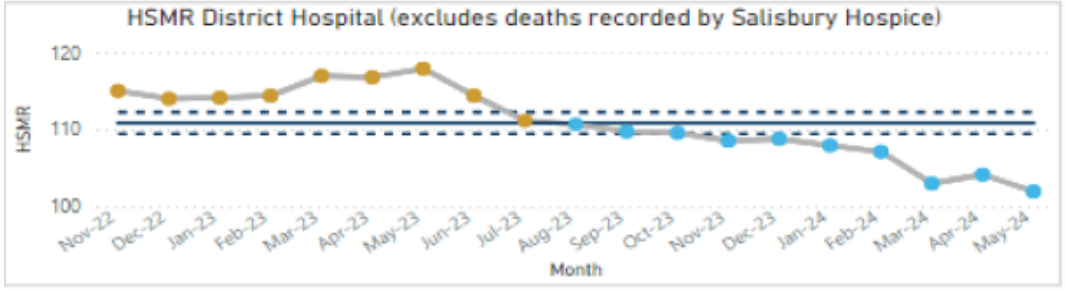
7. HSMR and SHMI Rolling 12-month Trends

7.1. A two-month time lag has been applied to the HSMR data to improve the accuracy of data for the 12-month period. This is due to a potential coding backlog for the two most recent months of discharge data. Therefore, the latest published HSMR is for the 12-month rolling period ending in May 2024. Both the HSMR and SHMI have continued to see a decline in recent months. A national revision to the modelling of the SHMI came into effect from the 12-month rolling period ending in December 2023 onwards, resulting in no distinction between the Trust and District SHMI figures beyond this time.

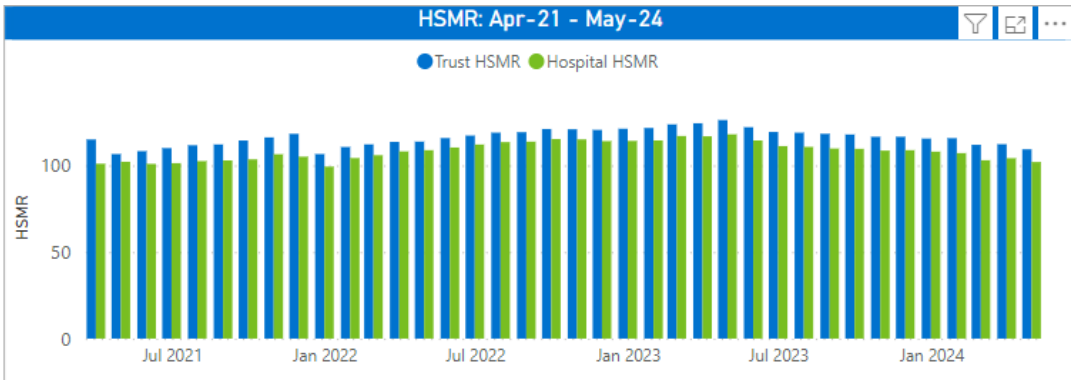


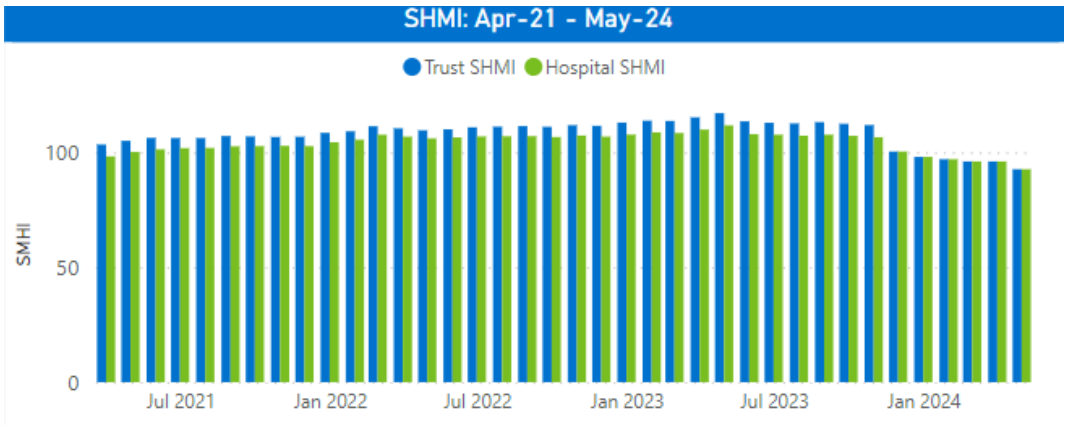






7.2. HSMR and SHMI Reported as Bar Charts

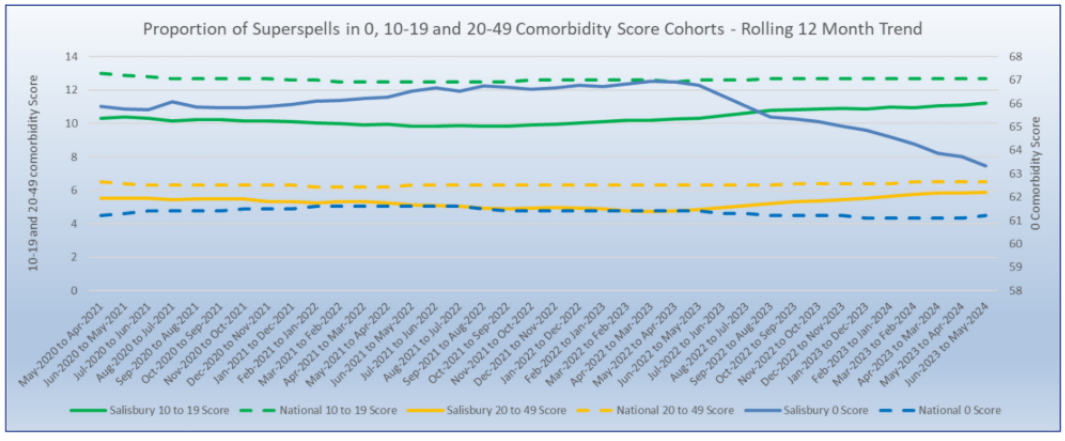




7.3. Comorbidity Score Comparison

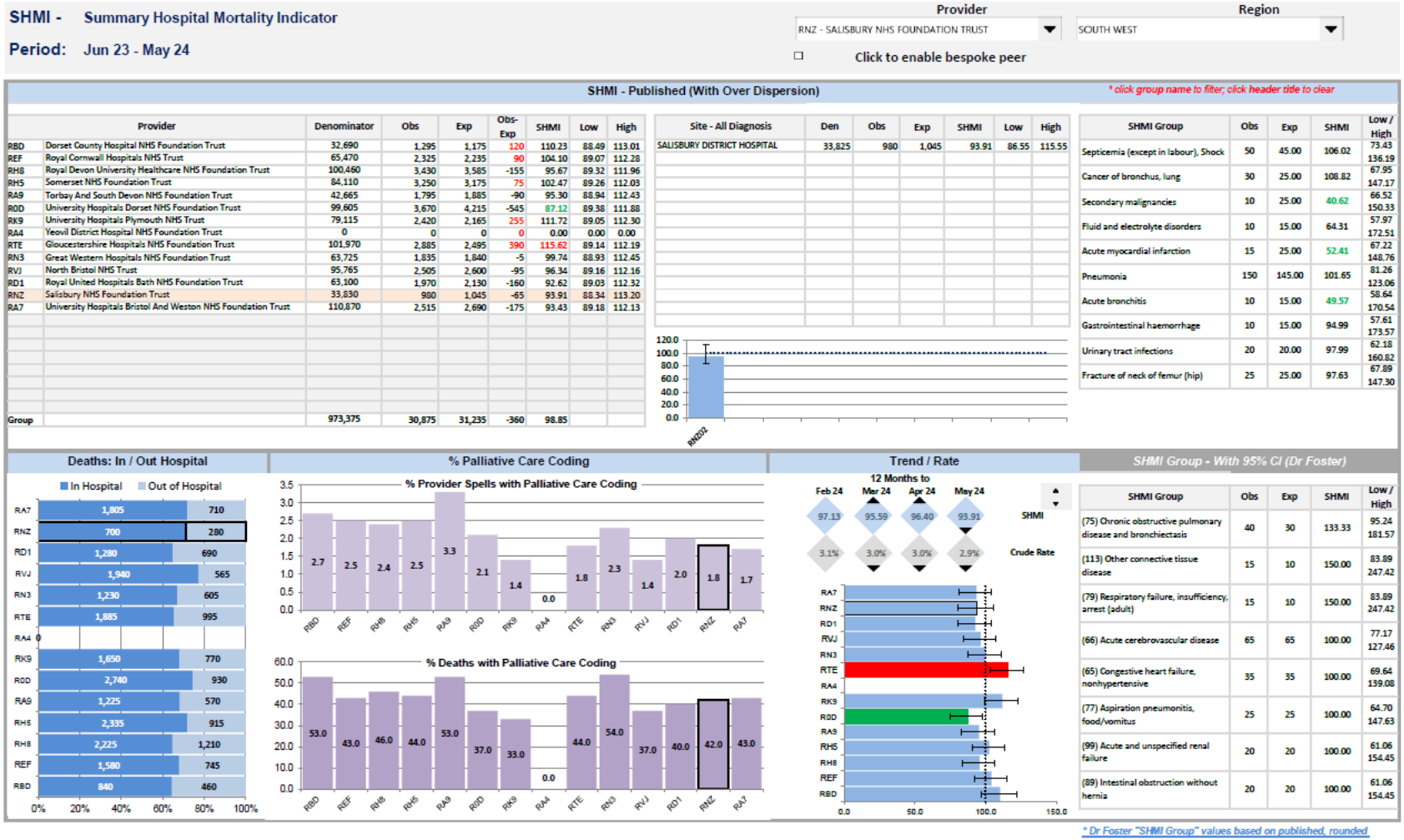
Comorbidity Score Comparison vs National

The Trust has seen a fall in the proportion of superspells within the zero comorbidity score cohort in latter periods and a corresponding increase in the 10-19 and 20-49 cohorts.



Salisbury NHS Foundation Trust

7.3 Latest SHMI data supplied by Telstra U.K. (Dr Foster) - 12 Month Period Ending in May 2024



SHMI - Summary Hospital Mortality Indicator

Period: Jun 23 - May 24

Provider: RNZ - SALISBURY NHS FOUNDATION TRUST

Region: SOUTH WEST

Click to enable bespoke peer

SHMI - Published (With Over Dispersion)

** click group name to filter; click header title to clear*

	Provider	Denominator	Obs	Exp	Obs-Exp	SHMI	Low	High
RBD	Dorset County Hospital NHS Foundation Trust	32,690	1,295	1,175	120	110.23	88.49	113.01
REF	Royal Cornwall Hospitals NHS Trust	65,470	2,325	2,235	90	104.10	89.07	112.28
RH8	Royal Devon University Healthcare NHS Foundation Trust	100,460	3,430	3,585	-155	95.67	89.32	111.96
RH5	Somerset NHS Foundation Trust	84,110	3,250	3,175	75	102.47	89.26	112.03
RA9	Torbay And South Devon NHS Foundation Trust	42,665	1,795	1,885	-90	95.30	88.94	112.43
R0D	University Hospitals Dorset NHS Foundation Trust	99,605	3,670	4,215	-545	87.12	89.38	111.88
RK9	University Hospitals Plymouth NHS Trust	79,115	2,420	2,165	255	111.72	89.05	112.30
RA4	Yeovil District Hospital NHS Foundation Trust	0	0	0	0	0.00	0.00	0.00
RTE	Gloucestershire Hospitals NHS Foundation Trust	101,970	2,885	2,495	390	115.62	89.14	112.19
RN3	Great Western Hospitals NHS Foundation Trust	63,725	1,835	1,840	-5	99.74	88.93	112.45
RVJ	North Bristol NHS Trust	95,765	2,505	2,600	-95	96.34	89.16	112.16
RD1	Royal United Hospitals Bath NHS Foundation Trust	63,100	1,970	2,130	-160	92.62	89.03	112.32
RNZ	Salisbury NHS Foundation Trust	33,830	980	1,045	-65	93.91	88.34	113.20
RA7	University Hospitals Bristol And Weston NHS Foundation Trust	110,870	2,515	2,690	-175	93.43	89.18	113.13
Group		973,375	30,875	31,235	-360	98.85		

Site - All Diagnosis	Den	Obs	Exp	SHMI	Low	High
SALISBURY DISTRICT HOSPITAL	33,825	980	1,045	93.91	86.55	115.55

SHMI Group	Obs	Exp	SHMI	Low / High
Septicemia (except in labour), Shock	50	45.00	106.02	73.43 136.19
Cancer of bronchus, lung	30	25.00	108.82	67.95 147.17
Secondary malignancies	10	25.00	40.62	66.52 150.33
Fluid and electrolyte disorders	10	15.00	64.31	57.97 172.51
Acute myocardial infarction	15	25.00	52.41	67.22 148.76
Pneumonia	150	145.00	101.65	81.26 123.06
Acute bronchitis	10	15.00	49.57	58.64 170.54
Gastrointestinal haemorrhage	10	15.00	94.99	57.61 173.57
Urinary tract infections	20	20.00	97.99	62.18 160.82
Fracture of neck of femur (hip)	25	25.00	97.63	67.89 147.30

Deaths: In / Out Hospital

In Hospital / Out of Hospital

	In Hospital	Out of Hospital
RA7	1,805	710
RNZ	700	280
RD1	1,280	690
RVJ	1,940	565
RN3	1,230	605
RTE	1,885	995
RA4	0	
RK9	1,650	770
R0D	2,740	930
RA9	1,225	570
RH5	2,335	915
RH8	2,225	1,210
REF	1,580	745
RBD	840	460

% Palliative Care Coding

% Provider Spells with Palliative Care Coding

RBD	REF	RH8	RH5	RA9	R0D	RK9	RA4	RTE	RN3	RVJ	RD1	RNZ	RA7
2.7	2.5	2.4	2.5	3.3	2.1	1.4	0.0	1.8	2.3	1.4	2.0	1.8	1.7

% Deaths with Palliative Care Coding

RBD	REF	RH8	RH5	RA9	R0D	RK9	RA4	RTE	RN3	RVJ	RD1	RNZ	RA7
53.0	43.0	46.0	44.0	53.0	37.0	33.0	0.0	44.0	54.0	37.0	40.0	42.0	43.0

Trend / Rate

12 Months to

	Feb 24	Mar 24	Apr 24	May 24
SHMI	97.13	95.59	96.40	93.91
Crude Rate	3.1%	3.0%	3.0%	2.9%

SHMI Group - With 95% CI (Dr Foster)

SHMI Group	Obs	Exp	SHMI	Low / High
(75) Chronic obstructive pulmonary disease and bronchiectasis	40	30	133.33	95.24 181.57
(113) Other connective tissue disease	15	10	150.00	83.89 247.42
(79) Respiratory failure, insufficiency, arrest (adult)	15	10	150.00	83.89 247.42
(66) Acute cerebrovascular disease	65	65	100.00	77.17 127.46
(65) Congestive heart failure, nonhypertensive	35	35	100.00	69.64 139.08
(77) Aspiration pneumonitis, food/vomitus	25	25	100.00	64.70 147.63
(99) Acute and unspecified renal failure	20	20	100.00	61.06 154.45
(89) Intestinal obstruction without hernia	20	20	100.00	61.06 154.45

** Dr Foster "SHMI Group" values based on published, rounded values with 95% CIs*

HMI_Jun23_May24

HEALTH | dr foster

Salisbury NHS Foundation Trust

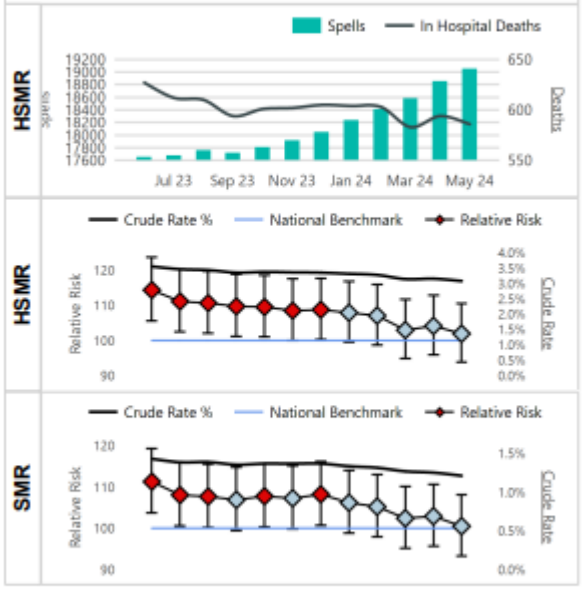
HSMR for the 12 Month Period Ending in May 2024 for Salisbury District Hospital [Excludes Hospice Data]

HEALTH | dr foster. HEALTHCARE INTELLIGENCE PORTAL

Mortality Summary for 12 months to May-2024 as at 29/10/2024

SALISBURY NHS FOUNDATION TRUST - SALISBURY DISTRICT HOSPITAL (RNZ02)

Rolling 12 month trends



Diagnosis Groups

Relative Risk Alerts (Top 10)	CUSUM	Obs	Exp	RR	LCI	Trend
Systemic lupus erythematosus and connective tissue disorders	0	2	0.2	1216.4	136.6	
Other hereditary and degenerative nervous system conditions	1	5	1.4	368.9	118.9	
Cancer of kidney and renal pelvis	1	4	1.0	412.3	110.9	

CUSUM 99% Threshold (Top 6)	CUSUM	Obs	Exp	RR	LCI	Trend
Other hereditary and degenerative nervous system conditions	1	5	1.4	368.9	118.9	
Cancer of kidney and renal pelvis	1	4	1.0	412.3	110.9	
Chronic obstructive pulmonary disease and bronchiectasis	1	27	19.9	135.9	89.5	
Phlebitis, thrombophlebitis and thromboembolism	1	1	0.2	617.2	8.1	

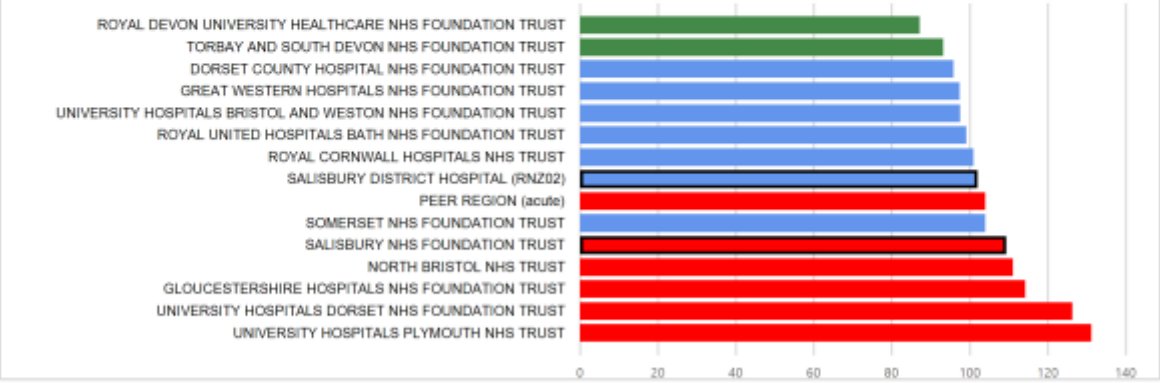
CUSUM 99.9% Threshold (Top 6)	CUSUM	Obs	Exp	RR	LCI	Trend
Septicemia (except in labour)	1	42	35.3	119.0	85.7	

Patient Safety Indicators	Obs	Exp	RR	LCI	Trend

Mortality Influencers

Performance	Site	Trust	Peer	National
HSMR	101.9	109.3	104.1	99.5
SMR	100.5	108.4	104.2	99.4
Non-elective (HSMR)	102.4	109.2	104.2	99.1
Weekday, emergency (HSMR)	101.7	108.9	102.6	97.9
Weekend, emergency (HSMR)	104.6	109.9	109.1	102.7
Saturday, emergency (HSMR)	99.7	99.1	108.8	102.9
Sunday, emergency (HSMR)	110.0	122.2	109.8	102.5
Coding/Casemix	**Site**	**Trust**	**Peer**	**National**
% Non-elective deaths with palliative care (HSMR)	47.4%	55.4%	45.7%	45.2%
% Non-elective spells with palliative care (HSMR)	4.2%	5.4%	4.7%	5.0%
% Spells in Symptoms & Signs chapter	6.6%	6.6%	7.6%	6.5%
% Non-elective spells with Charlson comorbidity score = 0 (HSMR)	46.9%	46.4%	44.0%	41.8%
% Non-elective spells with Charlson comorbidity score = 20+ (HSMR)	13.3%	13.6%	14.7%	16.2%
% Non-elective spells in Risk Band (0-10%) (HSMR)	88.4%	87.2%	87.6%	86.5%

HSMR Peer Comparison



Salisbury NHS Foundation Trust

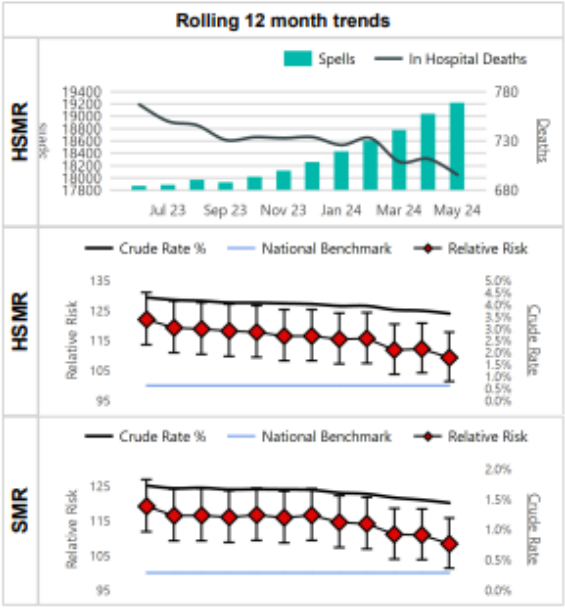
HSMR for the 12 Month Period Ending in May 2024 for SFT [Includes Hospice Data]

HEALTH | dr foster. HEALTHCARE INTELLIGENCE PORTAL

Mortality Summary for 12 months to May-2024 as at 29/10/2024

SALISBURY NHS FOUNDATION TRUST - All Sites

Rolling 12 month trends



Diagnosis Groups

Relative Risk Alerts (Top 10)	CUSUM	Obs	Exp	RR	LCI	Trend
Systemic lupus erythematosus and connective tissue disorders	0	2	0.2	1216.4	136.6	
Other lower respiratory disease	1	15	8.2	182.7	102.2	
Cancer of pancreas	0	18	10.7	168.9	100.0	

CUSUM 99% Threshold (Top 6)	CUSUM	Obs	Exp	RR	LCI	Trend
Other lower respiratory disease	1	15	8.2	182.7	102.2	
Cancer of brain and nervous system	1	4	1.1	350.8	94.4	
Chronic obstructive pulmonary disease and bronchiectasis	1	28	20.6	136.2	90.5	
Other hereditary and degenerative nervous system conditions	1	5	1.8	279.3	90.0	
Cancer of kidney and renal pelvis	1	4	1.5	261.2	70.3	
Cancer of colon	1	9	7.2	124.3	56.7	

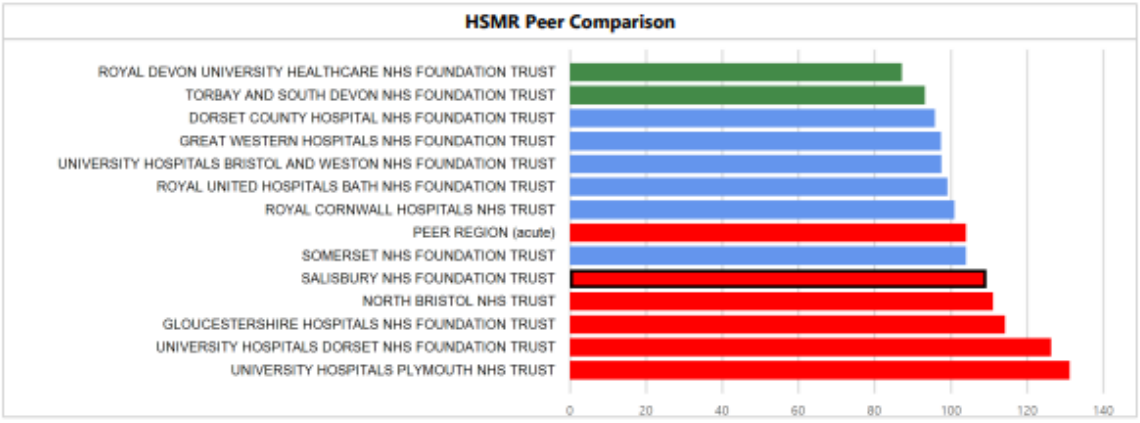
CUSUM 99.9% Threshold (Top 6)	CUSUM	Obs	Exp	RR	LCI	Trend
Cancer of bronchus, lung	1	29	21.3	136.4	91.4	
Septicemia (except in labour)	1	43	35.7	120.4	87.1	
Other connective tissue disease	1	9	6.2	145.1	66.2	

Patient Safety Indicators	Obs	Exp	RR	LCI	Trend

Mortality Influencers

Performance	Site	Trust	Peer	National
HSMR		109.3	104.1	99.5
SMR		108.4	104.2	99.4
Non-elective (HSMR)		109.2	104.2	99.1
Weekday, emergency (HSMR)		108.9	102.6	97.9
Weekend, emergency (HSMR)		109.9	109.1	102.7
Saturday, emergency (HSMR)		99.1	108.8	102.9
Sunday, emergency (HSMR)		122.2	109.8	102.5
Coding/Casemix	Site	Trust	Peer	National
% Non-elective deaths with palliative care (HSMR)		55.4%	45.7%	45.2%
% Non-elective spells with palliative care (HSMR)		5.4%	4.7%	5.0%
% Spells in Symptoms & Signs chapter		6.6%	7.6%	6.5%
% Non-elective spells with Charlson comorbidity score = 0 (HSMR)		46.4%	44.0%	41.8%
% Non-elective spells with Charlson comorbidity score = 20+ (HSMR)		13.6%	14.7%	16.2%
% Non-elective spells in Risk Band (0-10%) (HSMR)		87.2%	87.6%	86.5%

HSMR Peer Comparison



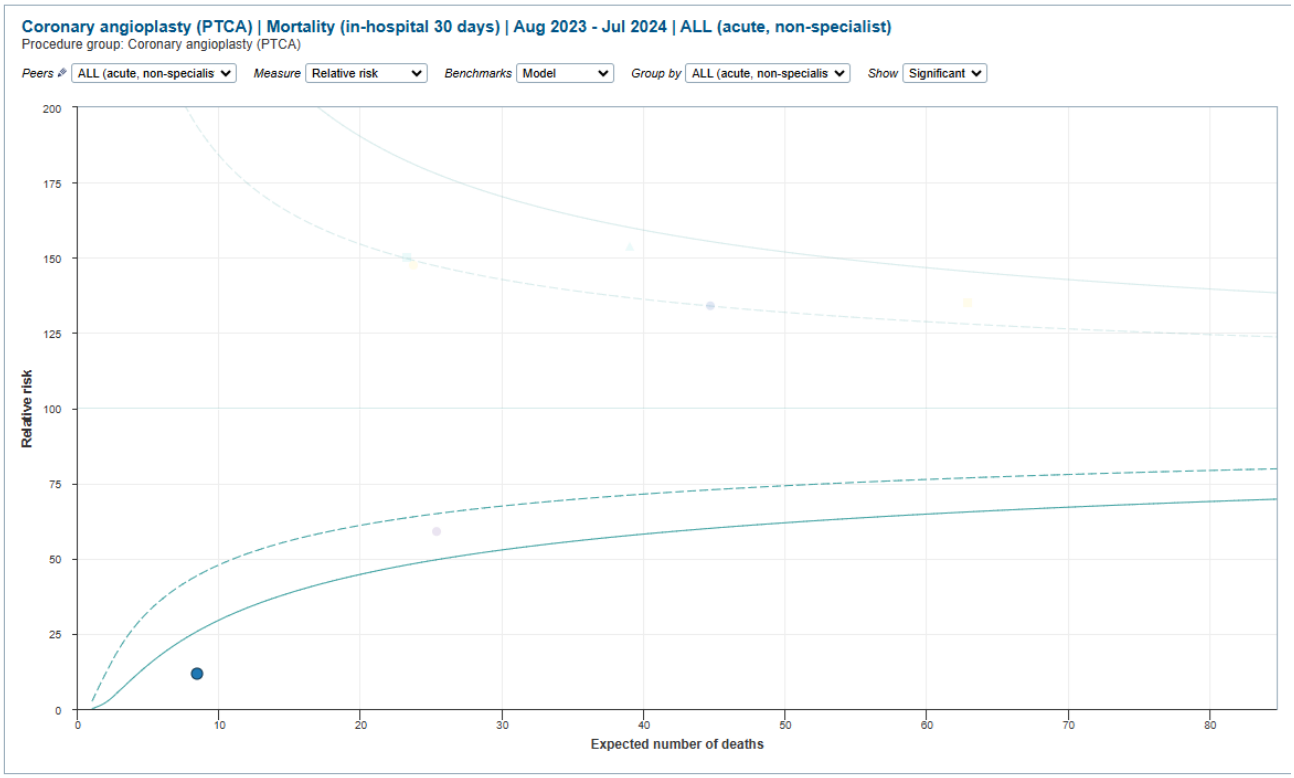


Figure 2 *Funnel plot showing the relative risk for Coronary angioplasty for the 12 months up to July 2024 (the latest figures available) and the equivalent positions of comparable Trusts*

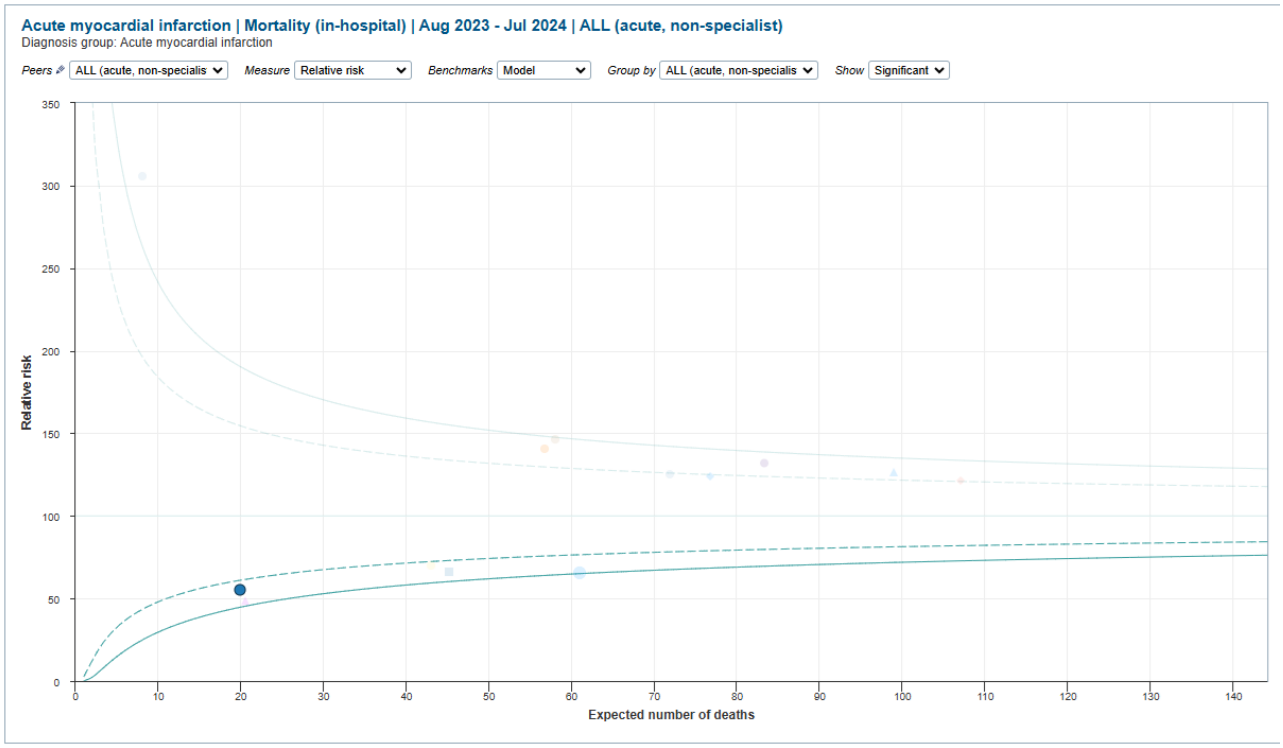
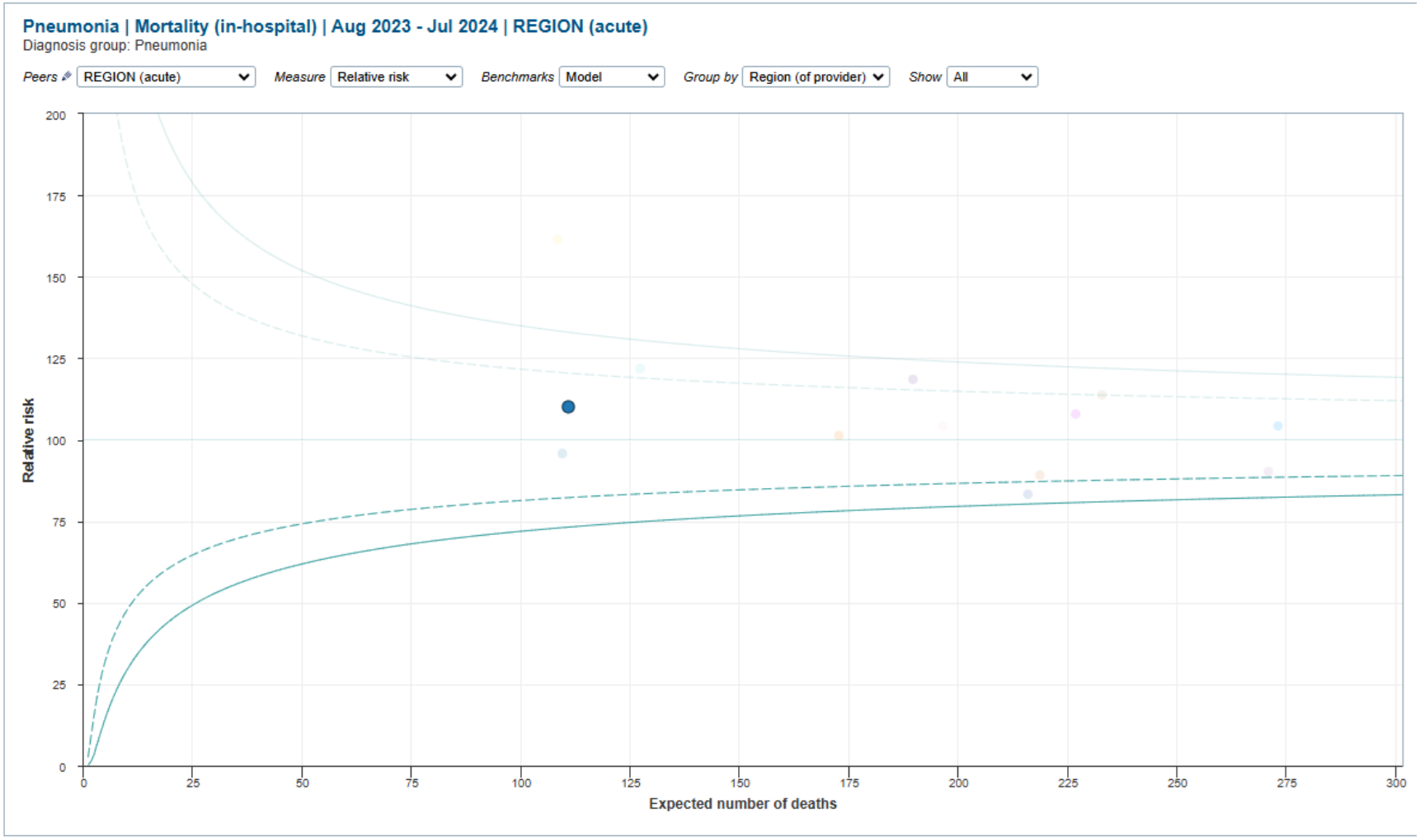
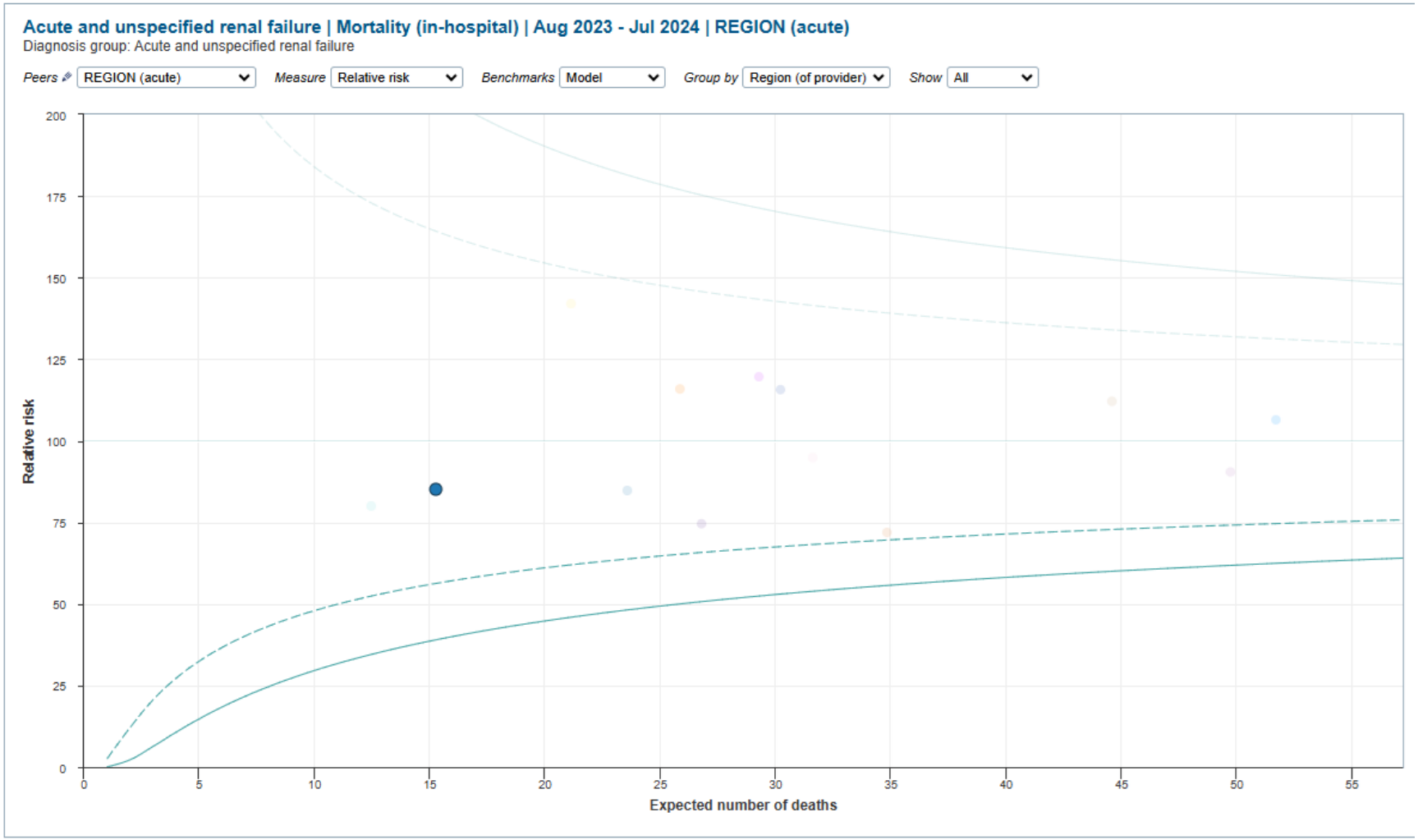


Figure 3 *Funnel plot showing the relative risk for Acute myocardial infarction for the 12 months up to July 2024 (the latest figures available) and the equivalent positions of comparable Trusts*

Salisbury NHS Foundation Trust



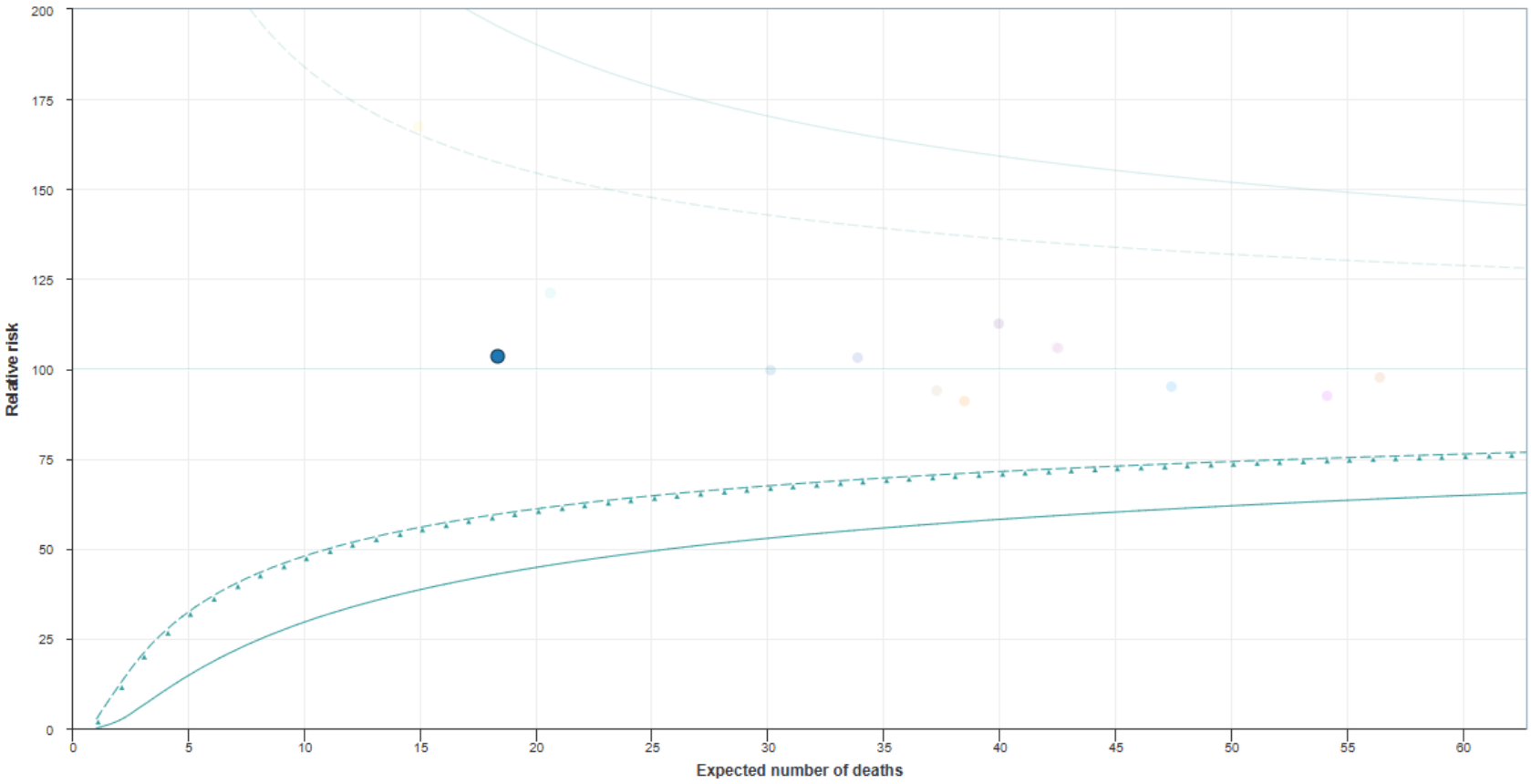

Acute and unspecified renal failure | Mortality (in-hospital) | Aug 2023 - Jul 2024 | REGION (acute)
Diagnosis group: Acute and unspecified renal failure
Peers REGION (acute)
Measure Relative risk
Benchmarks Model
Group by Region (of provider)
Show All
Relative risk
200
175
150
125
100
75
50
25
0
0
5
10
15
20
25
30
35
40
45
50
55
Expected number of deaths

NHS
Salisbury
NHS Foundation Trust

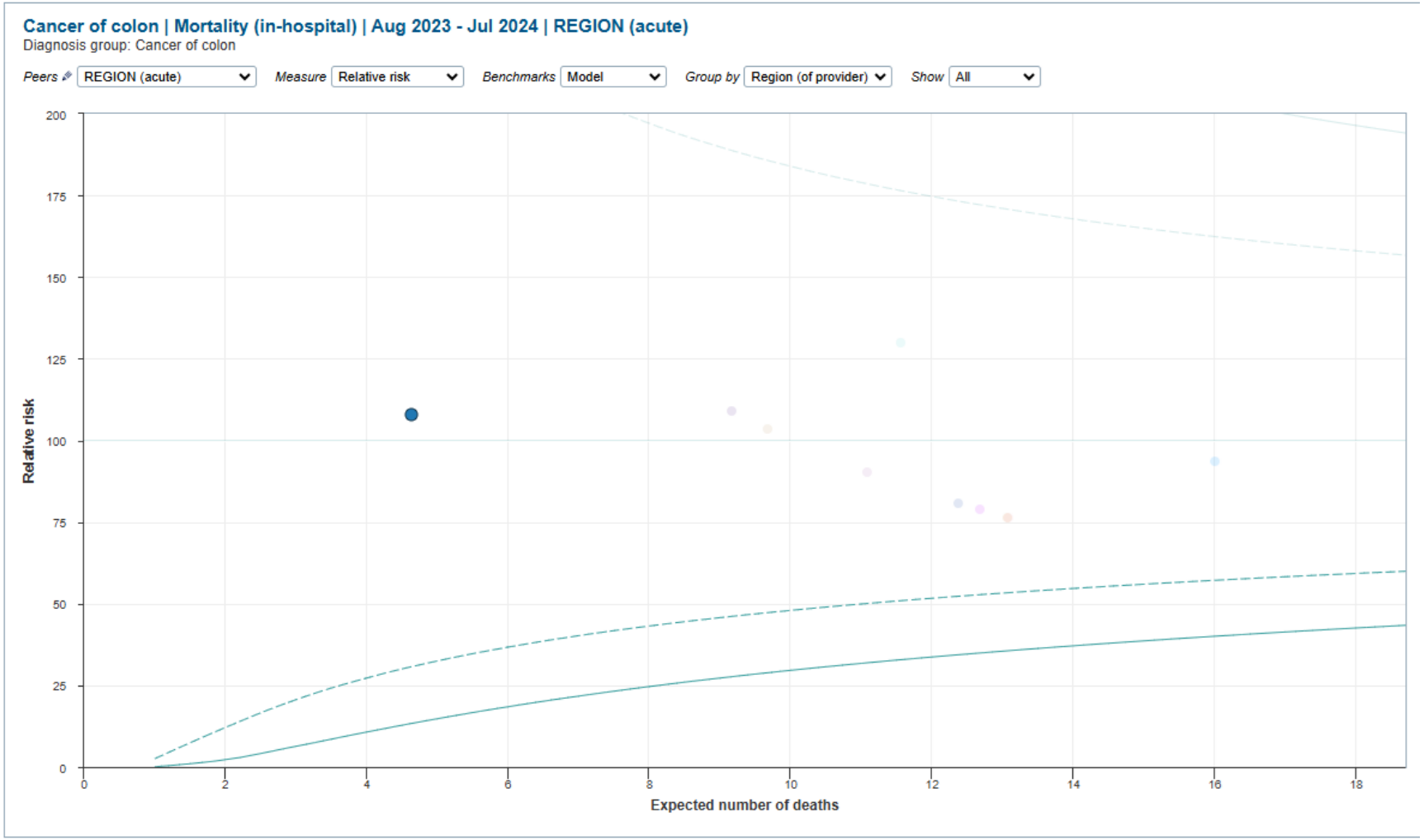
Aspiration pneumonitis, food/vomitus | Mortality (in-hospital) | Aug 2023 - Jul 2024 | REGION (acute)

Diagnosis group: Aspiration pneumonitis, food/vomitus

Peers REGION (acute) *Measure* Relative risk *Benchmarks* Model *Group by* Region (of provider) *Show* All



Salisbury NHS Foundation Trust

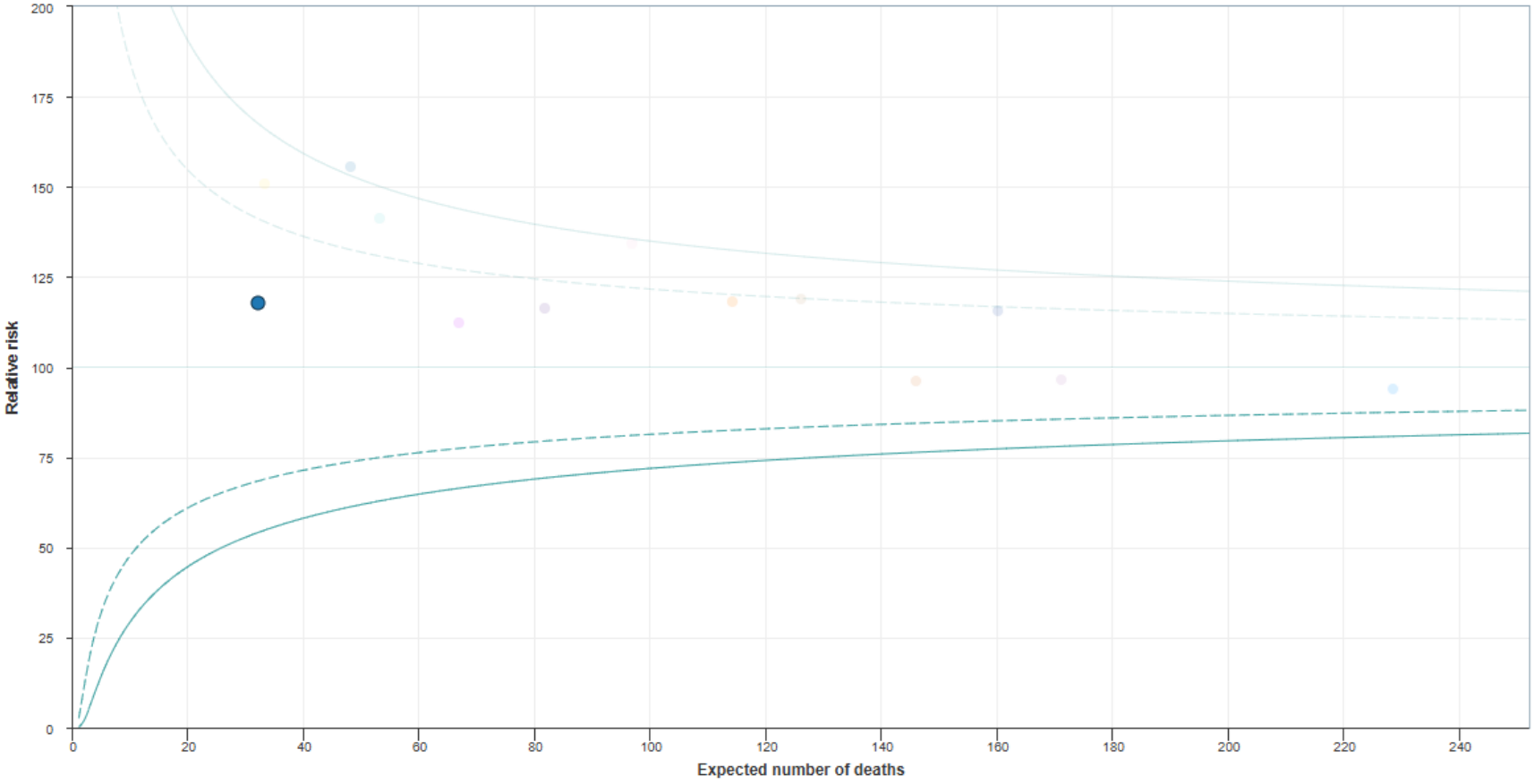


NHS
Salisbury
NHS Foundation Trust

Septicemia (except in labour) | Mortality (in-hospital) | Aug 2023 - Jul 2024 | REGION (acute)

Diagnosis group: Septicemia (except in labour)

Peers: REGION (acute) | Measure: Relative risk | Benchmarks: Model | Group by: Region (of provider) | Show: All



NHS Salisbury NHS Foundation Trust

Report to:	Trust Board (Public)	Agenda item:	5.3
Date of meeting:	9 January 2025		

Report title:	Director of Infection Prevention Control Report			
Status:	Information	Discussion	Assurance	Approval
	Yes		Yes	
Approval Process: (where has this paper been reviewed and approved):	Clinical Governance Committee			
Prepared by:	Fiona McCarthy – Lead Nurse Infection Prevention and Control Team Fiona Hyett – Dep CNO			
Executive Sponsor: (presenting)	Judy Dyos – Chief Nurse and DIPC			

Recommendation:

Trust Board are asked to note the delivery against the National Infection Prevention and Control Board Assurance Framework (v4) for quarter 2.

Executive Summary:

The National Infection Prevention and Control board assurance framework is issued by NHS England for use by organisations to enable the to provide assurance using an evidence-based approach to maintain the safety of patients, service users, staff and others. Whilst use of the framework is not compulsory it provides organisations with an approach to ensure compliance with infection prevention and control (IPC) standards.

It provides an assurance structure for boards against which the system can effectively self-assess compliance with the measures set out n the National Infection Prevention and Control Manual (NIPCM), the Health and Social Care Act 2008:code of practices on the prevention and control of infections, and other related disease-specific infection prevention and control guidance issued by UK Health Security Agency (UKHSA).

Attached is the most recent IPC Board Assurance Report for quarter 2. There are 10 focused domains outlined below which also shows level of compliance for each domain. In total there are 54 key lines of enquiry and we are fully compliant with 45:

Domain	Topic	No of KLOE	Compliance
1	Systems to manage and monitor the prevention and control of infection	8	7 – fully 1 - partial

2	Provide and maintain a clean and appropriate environment in managed premises that facilitates the prevention and control of infections	9	6 – fully 3 - partial
3	Ensure appropriate antimicrobial stewardship to optimise service user outcomes and reduce the risk of adverse events and antimicrobial resistance	6	6 - fully
4	Provide suitable accurate information on infections to patients/service users, visitors/carers and any person concerned with providing further support, care or treatment nursing / medical in a timely fashion	5	4 – fully 1 - partial
5	Ensure early identification of individuals wo have or are at risk of developing an infection so they receive timely and appropriate treatment to reduce the risk of transmitting infection to others	5	5 - fully
6	Systems in place to ensure all care workers are aware of and discharge their responsibilities in the process of preventing and controlling infection	6	4 – fully 2 - partial
7	Provide adequate isolation precautions and facilities	4	4 - fully
8	Provide adequate access to laboratory /diagnostic support as appropriate	7	5 – fully 2 - partial
9	Have and adhere to policies designed for individuals care and provider organisations that will help to prevent and control infections	1	1 – fully
10	Have a system in place to manage the occupational health needs and obligations of staff in relation to infection.	3	3 - fully

Work will continue within the Infection Control Working Group to progress to full compliance with the 9 that are partially met, there are zero KLOE in which we are fully non-compliant.

Board Assurance Framework – Strategic Priorities	Select as applicable:
Population: Improving the health and well-being of the population we serve	Yes
Partnerships: Working through partnerships to transform and integrate our services	No
People: Supporting our People to make Salisbury NHS Foundation Trust the Best Place to work	Yes
Other (please describe):	N/a

DIRECTOR OF INFECTION PREVENTION AND CONTROL

6 Monthly Update Report

April 2024 – September 2024

JUDY DYOS
Director of Infection Prevention and Control (DIPC)

November/December 2024 (Final draft v.1)

CONTENTS

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 (IPC) is delegated to the Director of Infection Prevention & Control (DIPC) who is the Chief Nursing Officer (CNO).

The DIPC Reports together with the IPC Board Assurance Framework (BAF) and monthly Integrated Performance Reports (IPR), 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 update 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 2024/25 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 December 2022),* 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, which has involved:

- One Human Metapneumovirus (HMPV) outbreak and one *Bordetella pertussis* period of increased incidence (PII) in medicine
- Three *Clostridioides difficile (C.difficile)* PIIs in medicine
- Significant amounts of work have been completed and remain ongoing for antibiotic stewardship, decontamination, cleaning services, water, and ventilation safety.

2. GOVERNANCE ARRANGEMENTS

The work towards achieving the objectives of the Annual Action Plan 2024/25 is monitored via the Infection Prevention and Control Working Group (IPCWG), which reports to the Infection Prevention and Control Committee (IPCC) chaired by the Director of Infection Prevention/Chief Nursing Officer. Finally 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 Infection Prevention and Control (IPC) team 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 IPC team currently comprises an Infection Control Doctor (ICD)/Consultant Microbiologist, and 3.0 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 Deputy ICD and one of whom is the Trust Antimicrobial Stewardship Lead.

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)
- 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. 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 Integrated Care System (ICS) and other regulatory bodies, e.g., NHS England (NHSE).

The Trust is also required to record these incidents in line with 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.

In January 2024, the Trust implemented the *Patient Safety Incident Response Framework (PSIRF) (NHSE, 2022),* which replaces the *Serious Incident Framework: Supporting learning to prevent recurrence (NHSE, 2015)* and makes no distinction between 'patient safety incidents' and Serious Incidents'.

During quarters 1 and 2 of 2024/25, the Trust has had **no** declared internal outbreaks of:

- Viral gastroenteritis (Norovirus)
- *Staphylococcus aureus*, including Methicillin Resistant *Staphylococcus aureus* (MRSA)
- Methicillin Sensitive *Staphylococcus aureus* (MSSA)
- Invasive Group A Streptococcus (iGAS)
- Multi-drug resistant *Acinetobacter baumannii* (MDRAB)
- Carbapenemase Producing Enterbacterales (CPE)
- Chickenpox (Varicella zoster)
- Extended Spectrum Beta Lactamase (ESBL) producers, including *Klebsiella Pneumoniae*
- SARS-CoV (COVID-19)
- *Bordetella pertussis* (Whooping cough)
- Respiratory Syncytial Virus (RSV)
- Influenza ('flu)
- Vancomycin Resistant Enterococcus (VRE)
- Tuberculosis (TB).

Additional information regarding alert organisms can be accessed from the UKHSA website:
UK Health Security Agency - GOV.UK (www.gov.uk)

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 Respiratory Illnesses

5.1.1 SARS-CoV (COVID-19)

During quarters 1 and 2 of 2024/25, the Trust continued to experience COVID-19 activity, 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 continued to be discussed at the Virtual Board Round (VBR) meetings which were held until mid-August, then disbanded. It was agreed that the VBR group members would continue to have oversight of the positive lists circulated by Informatics, with responsibilities to escalate any exceptions or concerns via the IPCWG and Operational Working Group (OWG) accordingly. Where clusters of any respiratory illness cases were identified, the divisions are required to implement additional monitoring measures; increased auditing of practices and environmental cleaning. It was also identified that if required, the VBR meetings would be reconvened.

No new COVID-19 outbreaks were declared for the Trust during quarters 1 and 2 of 2024/25 across inpatient areas. COVID-19 positive cohort bays have been created at different times on Breamore, Imber and Spire Wards (medical division).

5.1.2 Influenza and Respiratory Syncytial Virus (RSV)

During quarters 1 and 2 of 2024/25, there have been cases of Influenza A and B and Respiratory Syncytial Virus (RSV) identified for both adults and children admitted to the Trust. The patients were nursed under isolation precautions, with no onward transmission or links identified.

The IPCWG have reviewed the Seasonal Illness Plan to ensure that this reflects the updated management agreed for the various aspects covered by the document. Following final approval by the IPCC, the Seasonal Illness Plan was cascaded and made available centrally for all staff to access.

5.1.3 Human Metapneumovirus (HMPV) and *Bordetella pertussis* (Whooping cough)

During quarter 1 of 2024/25, the Trust declared a period of increased incidence (PII) of *pertussis* (a total of two cases, both patients were also identified to have HMPV), coupled with a simultaneous outbreak of HMPV (total of five cases) on Farley Ward (medical division). Review meetings were held and attended by the relevant personnel, to ensure that the required actions were identified and implemented. The positive patients were appropriately isolated, with monitoring of the identified contact patients and staff.

A number of control measures were instigated, including essential visiting only; mask wearing (Fluid resistant surgical mask) for all needing to enter the ward; ensuring the required follow up of contact patients already discharged; consideration of vaccination requirements and implementation; additional environmental cleaning; increased practice assurance checks, and wider communications as needed. Farley Ward remained open to admissions throughout, with no impact on the service delivery for acute stroke management and care. The Integrated Care Bureau (ICB) and local UKHSA were notified and updated of the situation.

Throughout quarter 1, when notified of new HMPV and/or pertussis cases, the ICD/Consultant Microbiologists and ICNs reviewed all available information including recent care episodes at the Trust to ensure the completion of any required follow up actions.

5.1.4 Pulmonary Tuberculosis (TB)

When informed of a patient with a suspected diagnosis of Pulmonary TB, management advice for isolation precautions and the wearing of personal protective equipment (PPE) has been provided by the ICNs. During quarters 1 and 2 of 2024/25, when patients were admitted with a new or known diagnosis of pulmonary TB, additional support was provided to the relevant teams (all were unrelated cases). This included instructions provided by the ICD to the Respiratory Team, with follow up undertaken by the ICNs and input from the Trust Fit Testing Team.

5.2 Carbapenemase Producing Enterbacterales (CPE)
When notified of new CPE/CPO cases, the Consultant Microbiologist and ICNs review all available information including recent care episodes at the Trust to ensure the completion of any required actions. The ICD and ICNs have provided ongoing advice and support to the medical and surgical divisions, around risk assessment, the management of specific patients, the wearing of PPE and environmental decontamination requirements. There have been no outbreaks of CPE declared for the Trust during quarters 1 and 2 of 2024/25.

5.3 *Clostridioides difficile (C.difficile)* periods of increased incidence (PII)
During quarters 1 and 2 of 2024/25, three unrelated PIIs of *C.difficile* were declared for the Trust for the clinical support and family services, and medical divisions *(see section 6.4 for details).*

5.4 Norovirus (viral gastroenteritis)
During quarters 1 and 2 of 2024/25, the Trust has experienced a continued 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. It was necessary to close bays at different times within the medical and surgical divisions.

During June 2024, three medical wards (Durrington Acute Frailty Unit (AFU); Pitton and Breamore Wards) were closed with symptoms of diarrhoea and/or vomiting reported for patients, staff members and visitors. Separate review meetings were held with the DIPC and Deputy DIPC, divisional and ward team representatives to review and progress resolution. This aided discussions for overall management decisions and monitoring and consideration of service provision.

5.5 Varicella Zoster (Chickenpox)
During quarter 1 of 2024/25, a staff member was admitted as an inpatient and isolated within a sideroom facility on a medical ward prior to confirmation of the positive Varicella Zoster result. A review meeting was held to assess the staff member's working pattern and management as a patient from admission. Actions were identified following contact tracing of patients and staff, with additional learning for the ward team relating to the wearing of PPE. Completion of the actions involved the Occupational Health and medical division teams.

5.6 Measles
In response to national UKHSA alerts and NHSE guidance released during quarter 4 of 2023/24, the Trust formed a Measles Preparedness Group with the membership of key personnel. Response action cards were developed to ensure the appropriate measures implemented for a suspected or confirmed case attending SFT. Internal messaging continues to raise awareness for staff. There have been no inpatient cases identified during quarters 1 and 2 of 2024/25.

5.7 Additional patient screening requirements
During quarter 2 of 2024/25, following information notified to the Consultant Microbiologists, the Trust instigated additional screening for identified patients:

- Screening for *Candida auris* of all patient transfers to SFT from identified units within University Hospitals Southampton NHS Foundation Trust.
- Screening for CPE of all patient transfers to SFT from Dorset County Hospital NHS Foundation Trust.

The Consultant Microbiologists were made aware of outbreak management information by both Trusts, and the implications for SFT were reviewed. The resulting screening requirements were communicated to key staff groups and operational teams, with detailed advice for the screening and management of relevant patients provided.

5.8 High Consequence Infectious Diseases (HCID) Preparedness
During quarter 2 of 2024/25, in response to national UKHSA alerts and updated NHSE guidance relating to Monkeypox (Mpox), the Trust formed an Mpox Touchpoint Group with the membership of key personnel. Action cards were reviewed to ensure the appropriate measures are implemented for a suspected or

confirmed case. Part of this work has included review of updated HCID guidance. A decision has been made to include all HCIDs within one policy document which the ICD has written. This document will be approved via the EPRR route.

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 4.4) updated December 2021).*

(Of note: No final comparative MRSA, MSSA, E.coli, Klebsiella spp. and Pseudomonas spp. BSI incidence by Acute Trust data for 2023/24 has been available to access, but this information will be included when available).

6.1 Methicillin Resistant *Staphylococcus aureus* (MRSA) bacteraemias

During quarter 1 of 2024/25, there have been two unrelated community onset MRSA bacteraemia cases reported from inpatient blood culture samples by the Trust (in May and June 2024). The Trust's MRSA hospital onset case target for 2024/25 is zero. *(Of note: one of these cases was classified as community onset; healthcare associated (COHA)).*

Post Infection Review (PIR) meetings were held to discuss the cases and support the completion of the required documentation. Action plans were developed by the medical and surgical divisions capture the identified learning within the Trust with improving compliance with established policies for MRSA screening and commencing treatment, care of vascular devices and appropriate escalation (when needed). Progress with these actions and identified learning were monitored by the IPCWG.

6.2 Methicillin Sensitive *Staphylococcus aureus* (MSSA) bacteraemias

During quarters 1 and 2 of 2024/25, there have been 4 unrelated healthcare associated MSSA bacteraemia cases, of which all 4 cases were hospital onset and no cases were community onset. For these hospital onset cases, the sources of infection were identified as:

- Unknown/unclear source (1 case)
- Surgical site infection (1 case)
- PVC related (1 case)
- No underlying focus of infection (1 case), with associated clinical infection gastroenterology related.

Post infection reviews were requested to be completed by the ward teams. For those reviews completed, key learning identified the requirement for continued monitoring of all invasive devices by staff, adherence to the relevant Trust policies relating to the taking of blood cultures and skin disinfection/decontamination and maintaining the required care documentation. *(Of note: the Trust Medical Devices Safety Officer (MDSO) is coordinating training related to care of peripheral vascular devices (PVD) to have 'line leaders' in areas. This will be a key person within each clincial team to ensure a best practice approach).*

(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 function 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).

6.3 Gram-negative organism bloodstream infections (GNBSIs)

The increase in gram negative organism bacteraemia infections remains 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.

The UK Government has developed a new 5-year action plan for antimicrobial resistance – 'Confronting antimicrobial resistance 2024 to 2029', which builds on the achievements and lessons from the first national action plan *'Tackling antimicrobial resistance 2019 – 2024' (published January 2019).* The overall aims are to optimise the use of antimicrobials; reduce the need for, and unintentional exposure to, antibiotics, and support the development of new antimicrobials.

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 2024/25, there have been 14 unrelated healthcare associated *E.coli* bacteraemia cases, of which 6 cases were community onset, and 8 cases were hospital onset. Of the 8 hospital onset cases identified, an unknown or no underlying focus of infection was identified for four cases, and the remaining 4 cases had a source of infection identified. Of these unrelated 4 cases, the sources of infection were:

- Lower urinary tract (2 cases)
- Gastrointestinal or intraabdominal collection (2 cases).

The Trust will continue to collaborate 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, 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 2024/25 is no more than 39 healthcare associated cases (*as detailed in the Official NHS Standard Contract 2024/25: Minimising Clostridioides difficile and Gram-negative bloodstream infections document (version 2) updated June 2024).*
NHS Standard Contract 2024/25: Minimising Clostridioides difficile and Gram-negative bloodstream infections

6.3.2 *Klebsiella spp*. and *Pseudomonas aeruginosa*
During quarters 1 and 2 of 2024/25, there have been 5 unrelated healthcare associated *Klebsiella spp.* bacteraemia cases, of which one case was community onset and 4 cases were hospital onset. There have been 8 unrelated healthcare associated *Pseudomonas aeruginosa* bacteraemia cases, of which one case was community onset and 7 cases were hospital onset. To note, the Trust has exceeded the threshold for *Pseudomonas aeruginosa* bacteraemia cases.

The Trust's *Klebsiella spp.* case threshold for 2024/25 is no more than 13 healthcare associated cases and for *Pseudomonas aeruginosa,* no more than 7 healthcare associated cases (*as detailed in the Official NHS Standard Contract 2024/25: Minimising Clostridioides difficile and Gram-negative bloodstream infections document (version 2) updated June 2024).*
NHS Standard Contract 2024/25: Minimising Clostridioides difficile and Gram-negative bloodstream infections

Further information relating to official statistics and benchmarking of performance can be found at:
Statistics at UKHSA - UK Health Security Agency - GOV.UK (www.gov.uk)

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 2024/25, the *C.difficile* case threshold objective set for the Trust by NHSE is no more than 21 healthcare associated reportable cases. 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 2024/25, the Trust has reported 17 healthcare associated *C.difficile* cases to UKHSA, of which 8 cases were community onset and 9 cases were hospital onset. Incident investigations are conducted 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).

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: From an ICB perspective, the appeals process is not in place anymore and the fines associated are no longer in existence and third-party arbitration not in place. Apportion categories are being reviewed nationally and may change or disappear next year 2024/25).*

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.

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

During quarters 1 and 2 of 2024/25, there were three PIIs of *C.difficile* declared for the Trust for the clinical support and family services, and medical divisions (detailed in Table 1 below).

Date PII declared	**Area** *(number of positive cases in brackets)*	**Ribotyping results**	**Final outcome**
01.05.24	Sarum Ward (3 cases)	1 case = 014 1 case = 015 1 case = sample not available to send to Reference Laboratory for ribotyping	Remained a PII
03.06.24	Pitton Ward (3 cases)	1 case = 002 1 case = 015 1 case = 054	Remained a PII
23.07.24	Durrington AFU (3 initial cases) (*further 2 cases where patients had received a period of care on AFU)*	1 case = 014 1 case = 005 1 case = C.difficile not able to be grown from sample sent to Reference Laboratory *1 case = 002* *1 case = 023*	Remained a PII

(Table 1)

In response to each of the declarations, measures were instigated, and included increased monitoring of practices and checks; completion of an antibiotic stewardship audit; ribotyping of identified positive stool samples (completed at the External Reference Laboratory); and additional daily enhanced environmental cleaning of the areas by Housekeeping. A DATIX report was generated for each PII to ensure escalation to the Patient Safety Summit Group (PSSG). Each PII of *C.difficile* was monitored by the IPCWG, with the divisions required to feedback and provide updates to this group.

Please see Appendix B for the Infection Prevention & Control 'Dashboard' for quarters 1 and 2 of 2024/25 for further detail of HCAI data.

6.5 BSW Collaboratives

During quarters 1 and 2 of 2024/25, representatives from the Trust have attended a newly formed BSW ICS HCAI and Infection Prevention Management (IPM) collaborative. These partnership meetings are held quarterly and enable a system wide approach to monitor and improve IPC for the populations of BSW. The meetings provide an opportunity for thematic reviews of HCAI data and shared learning from communicable disease incidents, with outcomes fedback to the IPCWG.

6.6 NHS Standard Contract 2024/25

Table 3 below summarises 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 2024/25 (*as detailed in the Official NHS Standard Contract 2024/25 document; Minimising Clostridioides difficile and Gram-negative bloodstream infections (version 2) updated June 2024).*

Organisation code	Name	Case thresholds for 2024/25			
		C.difficile	*E.coli*	*P.aeruginosa*	*Klebsiella spp.*
RNZ	Salisbury NHS Foundation Trust	21 ↓	39 ↑	7 ↓	13 ↑

(Table 2)

6.7 Surgical Site Infection Surveillance (SSIS)

The ICNs and IPC team secretary 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 neck of femur (NOF) surgery has continued during quarters 1 and 2 of 2024/25.

- Final data collection for quarter 4 of 2023/24 was reconciled within the required timeframe set by UKHSA. A total of 74* cases were entered onto the national database, with no infections identified.
- Final data collection for quarter 1 of 2024/25 was reconciled within the required timeframe. A total of 44 cases were entered onto the national database, with no infections identified. (*Following reconciliation of data for quarter 1 of 2024/25, four additional patients (two from April and two from May 2024) were identified for inclusion within the quarter 4 of 2023/24 dataset. These patients were not identified within the specified timeframes and therefore not recorded, within the active surveillance period. The Trust notified UKHSA and these patients were added to the original cohort group, with a final total of 78 cases with no identified infections).*
- Data collection has continued in quarter 2 of 2024/25, with final records to be entered onto the national database and submitted for reconciliation by the end of quarter 3 of 2024/25 (31st December 2024).

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

(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).

6.8 PreciSSIon

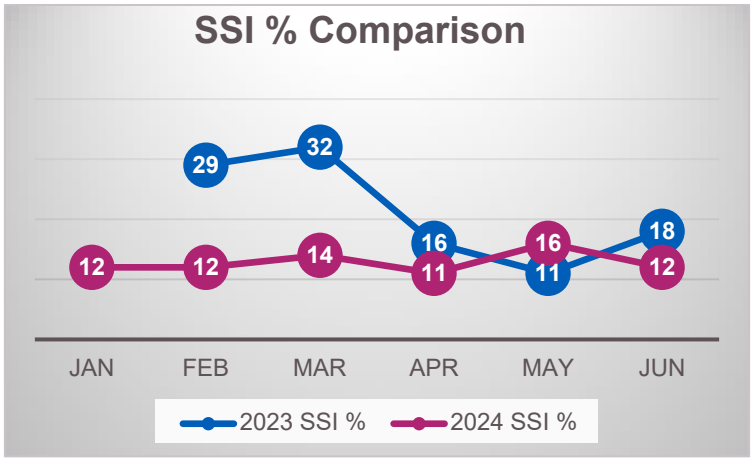
A new national PreciSSIon project, focussed on reducing the incidence of SSI after caesarean birth launched in October 2022. A care bundle was developed by reviewing literature for interventions that showed reduction by up to 50% of SSI in colorectal surgery and consists of:

- 2% chlorhexidine skin preparation for all cases
- Use of dual ring wound protector
- Repeat antibiotic therapy after 4 hours operating time
- Antibacterial suture for mass closure and skin.

This has been adapted for maternity patients to see if the results can be replicated for caesarean sections:

- 2% chlorhexidine skin preparation for all cases
- 2 minutes drying time
- Repeat dose of antibiotic therapy after >1.5 L blood loss
- Wound protector used if booking BMI >40
- Antimicrobial sutures for sheath and skin
- Surgical glove change after delivery of placenta.

Following the implementation of the PreciSSIon bundle in July 2023, there is clear evidence of a reduction in surgical site infection rates within the Maternity Unit following birth by caesarean section. Ongoing compliance for the bundle is currently at 98% with individual cases being reviewed to understand further why the bundle was unable to be used. The ongoing theme at present is omission of 2nd dose of IV antibiotics after identification of blood loss above 1500mls. This is addressed on a case-by-case basis.



(Table 3)

The graph above (Table 3) in blue shows the baseline data for 2023 which showed an approximate SSI rate of 16.9%. The red line represents the 2024 baseline data following the implementation of PreciSSIon which has shown a reduction to 13.2%.

There are ongoing reviews with the PreciSSIon elements and looking more closely at SSI rates within women with raised BMI, smoking and diabetes to identify potential improvement in outcome and patient satisfaction. One element being considered is the introduction of negative pressure dressings and PreciSSIon have decided to proceed with PiCO dressings in the raised BMI category. This is currently in early stages at SFT, a business case has been submitted to the DMT and was not initially successful and more data has been requested and resubmission highlighting stating the clinical benefit and financial impact.

6.9 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 quality performance indicator. The IPC team secretary undertakes 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 2024/25, the Trust compliance rates for MRSA emergency screening ranged from 87.31% - 96.58%. For MRSA elective screening, the Trust compliance rates were 67.5% in April and 69.64% in July.

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.

6.10 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). The Unit Leads/Matrons are responsible for completing data submission onto the national database within the required timeframes. From the data submitted so far, report updates have been provided by UKHSA and cascaded to the area leads. A national report for these statistics is expected to be published during quarter 3 of 2024/25 and will be shared with the relevant personnel and reviewed by the IPCWG.

6.11 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 IPC team secretary 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 IPC team for review, there have been no externally reportable infection alert organisms identified for this patient group during quarters 1 and 2 of 2024/25.

7. HAND HYGIENE

Fifty-eight 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. The clinical divisions have been undertaking some peer cross auditing within their areas and specialities to further validate audit processes.

For the internal hand hygiene audits completed, the overall average compliance rate for quarters 1 and 2 of 2024/25 ranges from 60% - 100%. It should be noted that completion of these audits remains variable across all divisions, which the divisions have reported as being due to reduced staffing levels and/or 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 has been revised, and the impact of these measures being monitored by the IPCWG, DMTs and Patient Led Assessment in the Clinical Environment (PLACE) Steering Group. *(Of note: during quarters 1 and 2 of 2024/25, there have been five PLACE Steering Group meetings held (April, May, July, August and September).*

7.1 Provision of hand hygiene products
During quarter 1 of 2024/25, the ICNs have been actively involved with other teams including the Emergency, Planning, Resilience and Response (EPRR) Team, Procurement and Housekeeping Department, in accessing an alternative supplier for GOJO Industries hand hygiene products following the company ceasing trading/production from April 2024. Part of this work has involved review of alternative products and identifying key critical areas for phase 1 of the product change over. This work continued into quarter 2 of 2024/25 with further rollout phases identified across the Trust site. This has created an opportunity for the IPC team to review the number/location and placement of wall mounted alcohol hand rub (AHR) gel dispensers in all areas.

During quarter 2 of 2024/25, the IPC team has been working closely with other departments to ensure the installation of new hand wash soap and gel dispensers throughout the hospital. This collaboration aims to enhance hand hygiene standards and contribute to the overall well-being of the patient, staff and visitors. This work will continue into quarter 3 of 2024/25 with further rollout across the Trust site with replacement of hand moisturisers dispensers and end of bed AHR gel holders (point of care).

8. ANTIBIOTIC STEWARDSHIP

8.1 Key successes

Antimicrobial stewardship (AMS) ward rounds

AMS ward rounds with a Consultant Microbiologist, antimicrobial pharmacist and antimicrobial technician are taking place twice weekly. The regularity and frequency of visits has, created its own demand for the service. Furthermore, non-medical/independent prescribers and Biomedical Scientists (BMS) are also attending AMS ward rounds as part of their own training and development.
Subjectively, most interventions made, involved stopping Intravenous (IV) antibiotics, prompt IV-to-Oral (PO) antibiotic switches, and reviewing antibiotics due to treatment efficacy.

Commissioning for Quality and Innovations (CQUIN)

The successful completion of 2023/2024 IVOS CQUIN led to further encouragement within the AMS community to continue this data gathering as a non-mandatory CQUIN for the 2024/2025 year. The Trust has achieved the following compliance:

Quarter	No. of cases audited	No. of patients still receiving IV antibiotics past the point at which they meet switching criteria	Percentage of patients still receiving IV antibiotics past the point at which they meet switching criteria
Q1	78	12	15.38%
Q2	100	16	16.00%

(Table 4)

From the results shown above (Table 4), the Trust is achieving the CQUIN aims and objectives.

8.2 Guidance Development

A full review of all policies in the antimicrobial section of Microguide (now Eolas Medical) has now been completed and segregated into body systems since quarter 4 of 2023/24. Furthermore, all guidance now contains review and expiry dates to aid with future updating. Outstanding guidance that still requires review and expiry dates are the Keratitis and Neutropenic Sepsis guidelines. The Antibiotic Reference Group (ARG) have been informed that there are larger pieces of work ongoing within Haematology/Oncology and that in time this will be part of a larger update.

8.3 Risk Management

From April 2024, there have been 65 DATIX reports directly relating to antibiotics with one DATIX listed as minor harm and two DATIXs listed as moderate harm. A review of the DATIXs, indicated issues with delayed/dose omissions (23), incorrect dosing (7), prescribing of antimicrobials listed as an allergy (5), interactions with regular medication (2) and excessive antimicrobial duration (2). Other themes include, information governance issues, incorrect administration of antimicrobial doses, incorrect route of administration used, incorrect prescribing and incorrect formulation issues.

8.4 Staff resources

A new Lead Pharmacist for Antimicrobials & HIV has accepted the post. This staff member will commence their new role on 18th November 2024, working 3 days a week (Monday, Tuesday & Thursday) which may limit staffing resources in the foreseeable future. Additionally, our Antimicrobial Consultant Microbiologist will

be retiring in January 2025. Their involvement on AMS rounds and at ARG will be greatly missed and we will be looking forward to hearing from Microbiology as to how this position will be filled/replaced.

8.5 Antibiotic Reference Group (ARG) Action plan for 2024

- ARG to review total antibiotic consumption and to create a stepwise plan for its reduction. AMS team to review data collection on treatment information and undertake an audit of total antibiotic consumption within SDH.
- The Microguide application is currently switching publishers to a company called Eolas Medical and at present no updates are possible during this switch. Once this is completed, the AMS team will update and publish some approved Drugs and Therapeutics Committee (DTC) guidance.
- Resolution and management of several current and future stock supply issues

8.6 Challenges

- There have been several antibiotic stock supply issues that have made an impact on current clinical practice. Furthermore, this situation remains fluid as further supply issues might impact the Trust in the future.
- There has been increased rogue prescribing of antimicrobials especially in quarter 1 of 2024/25. This has reduced in quarter 2 of 2024/25. The AMS team will be monitoring specific wards and prescribers to provide targeted education especially with the introduction of new junior doctors.
- The AMS service will be facing significant staff changes in the coming months and a reduction of staff hours dedicated to antimicrobial stewardship.

8.7 Summary

As outlined in the sections above, this is the current work undertaken by the ARG in relation to AMS and issues affecting this, guidance creation, development and reviews and supporting national improvement frameworks.

8.8 Recommendations

Continuation of action plan above and resolution/mitigation of ongoing challenges. Additionally, to continue advising the IPCC of work being undertaken by the ARG.

9. AUDIT

The ICNs have not undertaken any formal policy audit due to ongoing clinical workload but have been involved in supporting identified clinical areas to complete the Tendable inspections 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 clinical visits to ward areas*).

When required, the HoNs and Matrons have completed additional Tendable IPC inspections within identified clinical areas. The ICNs have continued to support the areas and staff with addressing any concerns arising from these inspections. For quarters 1 and 2 of 2024/25, the overall average IPC compliance scores reported have ranged from 87.98% - 93.69% for those audits completed.

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 IPC team. Mean compliance scores for quarters 1 and 2 of 2024/25 were 77% for staff completion of hand hygiene assessments and 91% for staff completion for IPC computer-based learning (CBL) package *(LEARN data accessed 01.10.24).*

The low hand hygiene assessment compliance is an ongoing concern. 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 continue to work with the Education Department to improve compliance for staff completing these mandatory training modules.

As requested by the DIPC, the hand hygiene assessment trial (previously discussed in 2022/23), has been slowly progressed by the divisions within inpatient areas. This is an alternative to using the UV light box to assess hand hygiene technique, where the clinical leader (Band 7) assesses staff members washing their hands using soap and water. Progress with this work has been reported to the IPCWG, by the medical and surgical divisions.

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 clinical visits undertaken by the ICNs.

Formal 'virtual' meetings with the Infection Control Link Professionals (ICLPs) group have been held during quarters 1 and 2 of 2024/25. 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 2024/25

The Creutzfeldt-Jacob Disease (CJD) policy re-write was led by the Deputy ICD/Consultant Microbiologist, with the support of the Decontamination Lead. Flow-chart style appendices have been added to improve ease of use for clinical staff. The final policy was approved at the IPCC prior to ratification at CMB on 18th September 2024. It is currently awaiting uploading onto Eolas Medical, following the transfer of Microguide to Eolas Medical.

The Decontamination Policy has been re-written and will be presented to IPCC in October 2024 for approval, prior to ratification at CMB during quarter 3 of 2024/25. The policy has been split into two sections; one section covering the regulatory and governance requirements and a separate section for clinical aspects. Having a separate clinical section will offer more user-friendly information for staff to refer to.

11.2 Progress on actions during quarters 1 and 2 of 2024/25

New Laboratory autoclaves, installed in quarter 4 of 2022/23, continue to be unreliable and ongoing work to resolve the situation has so far been unsuccessful. The working group are now being supported by the Deputy Director of Procurement, who is keen to make the discussions with the manufacturer more formalised, with specific references to the contract, to facilitate resolution.

Ongoing refurbishment of Sterile Services Limited (SSL) continues to be a challenge. Quarters 1 and 2 has been a critical phase where operational capacity was reduced whilst work focused on the instrument washers, clean room (where instrument trays are laid out and wrapped) and autoclaves. Mitigations to keep the impact on production to a minimum were put in place, and no significant events occurred. The final phase of the refurbishment is due to be completed in quarter 3 of 2024/25 and will be associated with handover of decontamination equipment. Clarity between SFT and SSL relating to future responsibility for services and maintenance of decontamination equipment is still required.

11.3 Key challenges for quarters 3 and 4 of 2024/25

Continue the work to improve accessibility of information for staff by introducing a new section on Eolas Medical (Microguide replacement) specifically covering decontamination. The policy, any quick reference guides/posters for display and any generic SOPs will be housed here. This will facilitate access for staff and direct them towards agreed practice. Once the information is more accessible, auditing will capture any gaps in knowledge or practice and enable focussed education to support staff. Opportunities to undertake audits via Tendable Inspections are being explored.

Flexible endoscope use and storage options will need reassessing during quarters 3 and 4 of 2024/25. Reconfiguring the scope storage in the Endoscopy Unit as a result of Joint Advisory Group (JAG) on GI Endoscopy actions, gives opportunity to use a scope storage cabinet in another location which has environmental and operational benefits for both the clinical and SSL teams. Ensuring the new location is appropriate will need consideration and risk assessing, as well as agreement with the Authorised Engineer for Decontamination (AED). In addition, work continues to install an additional scope storage cabinet in Urology but is making slow progress.

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 Division.

12.1 Patient led assessment of the care environment (PLACE) internal audits

The Trust has undertaken a programme of internal PLACE audits which commenced in February 2024. A total of 25 audits have been completed, with a further 21 planned 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.

The National PLACE inspection is due to be undertaken on the 7th November 2024 with the results being available from February 2025.

12.2 Deep clean programme/rapid response team

The deep clean programme commenced in April 2024 and is currently ahead of schedule by approximately 3 weeks.

12.3 Improvement Work Over the past 6 months

Recruitment drives of group interviews, working alongside Human Resources (HR) to attract new Cleaning Assistants.

Please find below cleaning data for the last 18 months:

2024/25 MONTH	APR	MAY	JUN	JUL	AUG	SEP	OCT	NOV	DEC	JAN	FEB	MAR	TOTALS
POST INFECTIONS	766	1007	1201	1079	994	902							
ENHANCED HRS	87.25	51.75	73.5	80	55	55.75							
DOUBLE CLEANS HRS	73.75	77	92.75	74	85.75	37.5							
BIOQUELL	52	74	92	91	50	43*							

(Table 5)

2023/24 MONTH	APR	MAY	JUN	JUL	AUG	SEP	OCT	NOV	DEC	JAN	FEB	MAR	TOTALS
POST INFECTIONS	882	850	735	656	666	810	934	884	1055	995	988	785	**10240**
ENHANCED HRS	95.50	104	53.5	57.75	64	83.25	69	81.25	117.75	108.75	108.75	83.5	**1027**

DOUBLE CLEANS HRS	10	33	61.5	70.25	49.25	59.25	54	67.75	56.25	98	72	103	**735.25**
BIOQUELL	0	31	37	54	59	45	56	74	62	59	113	66	**656**

(Table 6)

12.4 Successes from the past 6 months

- Reached 99% or above each month for our KPIs linked to the operational response times in starting an environmental clean within 3 hours.
- Successfully recruited 12 new Cleaning Assistants (vacancies and new standards).

12.5 Challenges for the coming 6 months

Housekeeping Department are working towards the new National Cleaning Standards including key elements, task lists, risk categories, audit requirements over a phased implementation period.

13. WATER SAFETY MANAGEMENT

This section summarises the water safety management precautions that the Trust has taken over quarters 1 and 2 of 2024/25. The Trust manages the safety of water systems in line with the Health Technical Memorandum (HTM) 04-01 (Pt 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 deputy RP (dRP) water) from Estates Technical Services (ETS) 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 7 below – *Legionella,* listing counts reported >1000 cfu/l) 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 sampling results for Quarters 1 and 2 of 2024/25						
	Ward/ Department	LG Ref	Location	Action plan	Test result as of 25/09/2024	
					Pre	Post
1	Chilmark Suite	PFI	4.10.08	1st clear sample, further samples required	ND	ND
2	Chilmark Suite	PFI	4.10.105	1st clear sample, further samples required	ND	ND
3	Dermatology	PFI	2.11.33	1st clear sample, further samples required	ND	ND
4	Dermatology	PFI	2.11.45	1st clear sample, further samples required	ND	ND
5	Dermatology	PFI	2.11.40	1st clear sample, further samples required	ND	ND
6	Amesbury Suite	PFI	4.10.236	1st clear sample, further samples required	ND	ND
7	Plastics	PFI	3.10.09			
8	ENT	416102	3.04.24	POU fitted, investigate temperature/circulation issues	4200	
9	Pembroke Ward	416117	3.04.50	POU fitted, investigate temperature and circulation issues	600	
10	Sarum Ward	416064	4.05.17	Clean, disinfect outlet and resample	380	

(Table 7)

13.2 *Pseudomonas*
Six monthly sampling has been completed, with some live counts identified, and remedial works and resampling completed. No live counts are being managed currently and the next round of sampling is due to commence in November 2024.

13.3 Pool Water Quality
One failure recorded in this period, a test completed on the learner pool at the Leisure Centre failed a test in May 2024 and the pool was out of use on the 14th May. The pool was backwashed and resampled, and a clear result was obtained on the 15th May.

13.4 Achievements for quarters 1 and 2 of 2024/25

- Managed service for water sampling has been introduced, this is more cost effective and releases the inhouse team from this task to enable them to focus on the maintenance of the hot and cold-water systems.
- Completion of six-monthly *Pseudomonas* testing, some high counts were identified, remedial woks have been completed and these have been sampled and are now all clear.
- Delivery of actions from the site water risk assessment (RA), these include valve replacement to enable tank cleaning and replacement of old worn taps, etc that present a water safety risk.
- Regular meetings of the Water Safety Operations group. This group focus on the delivery of PPMs, actions related to any 'live' counts and tasks for the sites water RA. This group reports to the WSG and has agreed KPIs to report against quarterly.
- Flushing compliance is 90%.

13.5 Key focus for quarters 3 and 4 of 2024/25

- Completion of actions from the sites water RA, 40% of actions have currently been completed, target 60% of actions completed by the end of quarter 4 of 2024/25.
- Regular meetings of the Water Safety Operations Group.
- Improvements in key areas of maintenance e.g. six-monthly TMV maintenance, currently at 20% of PPM with target of 50% by the end of quarter 4 of 2024/25.

- Introduction of a new process for the flushing of clinical areas, with the support of the WSG. This new process will save water, energy and in turn release some additional resource for the ETS team to focus on the delivery of water safety PPM.
- With the support of the ICNs, completion of *Pseudomonas* risk assessments of the augmented care areas/wards. These RAs will be approved by the WSG, and any actions generated from these will be completed by ETS, WSG and the clinical teams.

14. SPECIALIST VENTILATION SYSTEMS MANAGEMENT

This section summarises the actions/precautions that the Trust has taken over quarters 1 and 2 of 2024/25 in relation to the critical ventilation systems. The Trust manages the safety of ventilation systems in line with the Health Technical Memorandum (HTM) 03-01 and operates a permit to work system to ensure that approval has been sought by the key stakeholders (e.g. Theatres, Pharmacy and Laboratories) of the system prior to its isolation.

14.1 Achievements for quarters 1 and 2 of 2024/25

- Annual PPM completed in Main Theatres and Day Surgery Unit (DSU) Theatres.
- Annual PPM completed on Pathology Laboratories, Cardiac Outpatients, Radnor Ward, Longford Ward, Britford and Downton Wards.
- Annual Local Extract Ventilation (LEV) testing completed on systems located in Medical Engineering, Orthotics, Estates and Wessex Rehabilitation.
- Ventilation duct cleaning completed on Laverstock Ward; cleaning has been completed prior to the ventilation being re-commissioned.
- Ventilation Safety Group (VSG) meeting regularly. This is now also supported by an operational group which focuses on the delivery of KPIs related the management and maintenance of critical ventilation systems.

14.2 Key focus for quarters 3 and 4 of 2024/25

- Completion of PPMs to include 40-point check for critical systems as per the guidance in HTM 03-01.
- Delivery of all remedial works post the fire damper testing process.
- Plan and deliver the replacement of the faulty pressure stabilisers in DSU.
- Plan and deliver a ventilation duct cleaning programme. It is evident from the survey completed for the fire dampers this is urgently required especially for critical systems e.g. Main Theatres.
- Training of two of the ETS staff on the maintenance of critical ventilation systems with a view to a formal appointment at Competent Persons (CPs) in line with the roles and responsibilities within the HTM 03-01.

15. CONCLUSION

This six-monthly update 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 2024/25 in reducing HCAI rates for the Trust.

For quarters 3 and 4 of 2024/25, the key ambitions for the Trust will include:

- 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

The author would like to acknowledge the assistance of the following people in the compilation of this report:

- Fiona McCarthy, Lead Nurse, Infection Prevention and Control Team (Sections 1, 2, 3, 4, 5, 6, 7, 9, 10, 15 and 16; Appendices A, B and C)
- Rebecca Roberts, Matron for Maternity Services (Section 6.8)
- Vinesh Perumal, Lead Pharmacist – Antimicrobials and HIV (Section 8)
- Clare Goodyear, Trust Decontamination Lead and Medical Device Safety Officer (Section 11)
- Michelle Sadler, General Manager, Facilities and Amanda Urch, Head of Housekeeping and Portering (Section 12)
- Terry Cropp, Technical Services Manager, Estates Department (Sections 13 and 14).

APPENDIX A

Infection Prevention & Control – Annual Action Plan 2024/25

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 Bed 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	IPC team	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 UK Health Security Agency (UKHSA) 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 PLACE Steering Group meetings.	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 Bed 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/ IPC team	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:		
Standard infection control precautions (incorporated within National IPC Manual (NIPCM))	ICNs	In place
Outbreak Management	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)	IPC team	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*	ICD/IPC team	In place
Additional policies:		In place
CJD & Transmissible Spongiform Encephalitis (TSE)	Deputy 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 IPC	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 (incorporated within NIPCM)	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	IPC team	Continuous
Continue the provision of ongoing infection prevention and control education for existing staff	IPC team	Continuous
Continue recording and maintaining training records for all staff via the LEARN (previously 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 Continuous
Enhance and monitor the role of the Infection Control Link Professionals.	HoN/Matrons/ICNs	

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 %)	
				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			
Clinical Support Family Services	Sarum Ward (inc. Children DAU)	1 + 1*	1 + 1																Q1 C.difficile	99.02%	
	Hospice Unit																			100%	
	Longford Ward									1										81.08%	
	CS&FS Totals:	**1 + 1***	**1 + 1**							**1**											
Women & Newborn	Labour Ward		1 + 1																	96.47%	
	Neonatal Unit																			95.95%	
	Post-natal Ward											1								93.61%	
	W&N Totals:		**1 + 1**									**1**									
Medicine	AMU (inc. SDEC)	2	1			1			1		1	4						1		91.03%	
	Breamore Ward																			90.39%	
	Durrington AFU	1	1						2	1		1							Q2 C.difficile	87.86%	
	ED (inc. SSEU)				1				11		5	36		1	2		1	9			81.24%
	Farley Ward						1												Q1 HMPV	Q1 Pertussis	90.19%
	Imber Ward	2 + 2																		80.24%	
	Laverstock Ward	1																		82.43%	
	Pembroke Ward									1						1				95.83%	
	Pembroke Suite																			99.17%	
	Pitton Ward	2 + 4																	Q1 C.difficile	78.52%	
	Redlynch Ward						1						3			1				88.66%	
	Spire Ward	1 + 1	1																	74.56%	
	Tisbury CCU	1							1	1										86.48%	
	Whiteparish Ward	1					1													93.59%	
	Nunton Unit																			100%	
	Medicine Totals:	**6 + 12**	**2 + 1**		**1**	**1**	**3**		**15**	**3**	**6**	**41**	**3**	**1**	**2**	**2**	**1**	**10**			

Surgery	Amesbury Suite									2			1								87.18%	
	Britford Ward (inc. SAU)	1							1				1								83.36%	
	Chilmark Suite	1																			76.74%	
	Day Surgery Unit																				85.71%	
	Downton Ward	1								1											67.12%	
	Odstock Ward	1																			76.04%	
	Radnor Ward		1				1			1			2			2					98.50%	
	Surgery Totals:	**2 + 2**	**1**				**1**		**1**	**4**			**4**			**2**						
Additional info: Other *C.difficile* samples, e.g. GP, other Emergency Assessment, OPD, Mortuary, Private or Community Hospitals			**3**																			

***C.difficile*: 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**

*There was an additional paediatric case (not reportable) tested in the Laboratory where the child was under 2 years of age, which was followed up at the time by the Consultant Microbiologist

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

Hand hygiene scoring:

	Score 85% and above
	Score 61% - 84%
	Score 60% and below

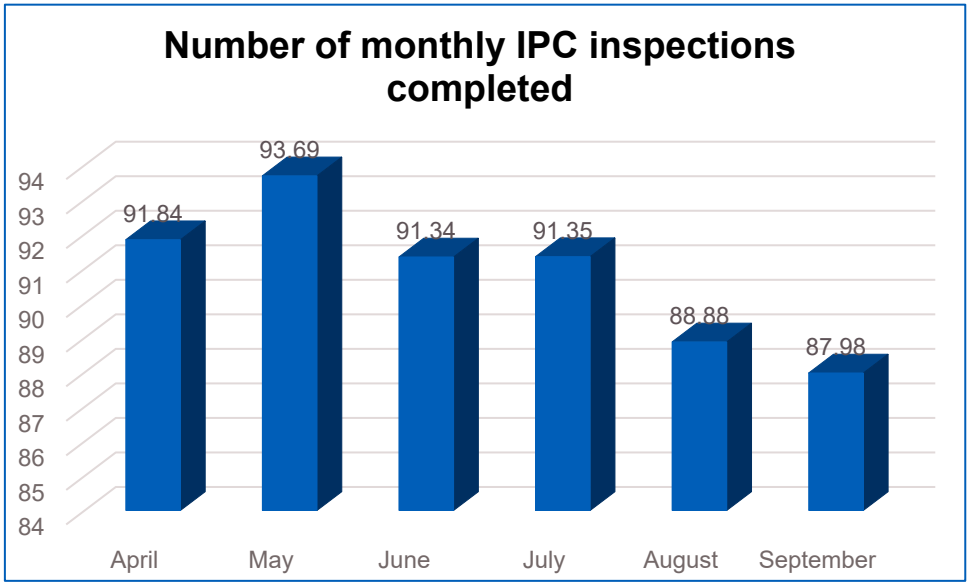
(Where more than 1 audit has been completed during a month, colour rate according to the lowest compliance score achieved)

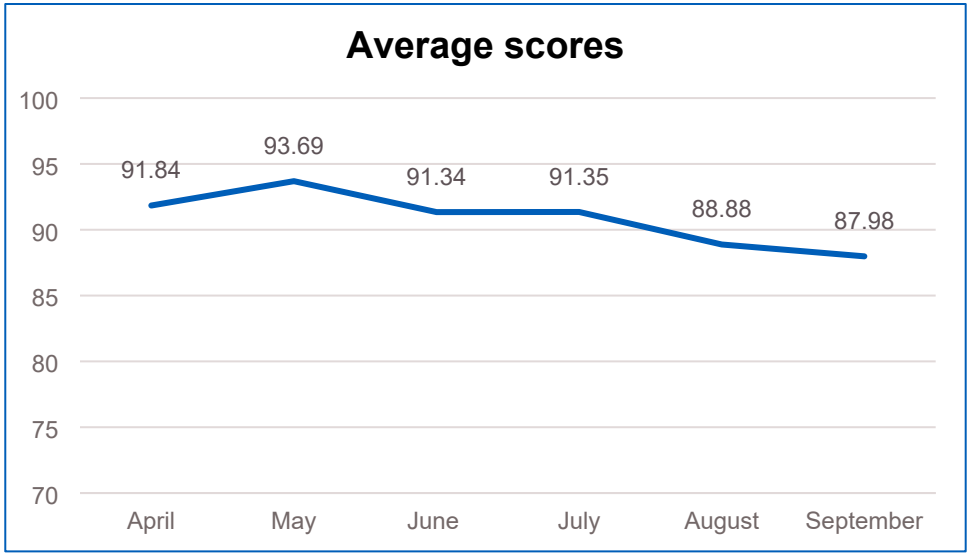
Salisbury NHS Foundation Trust

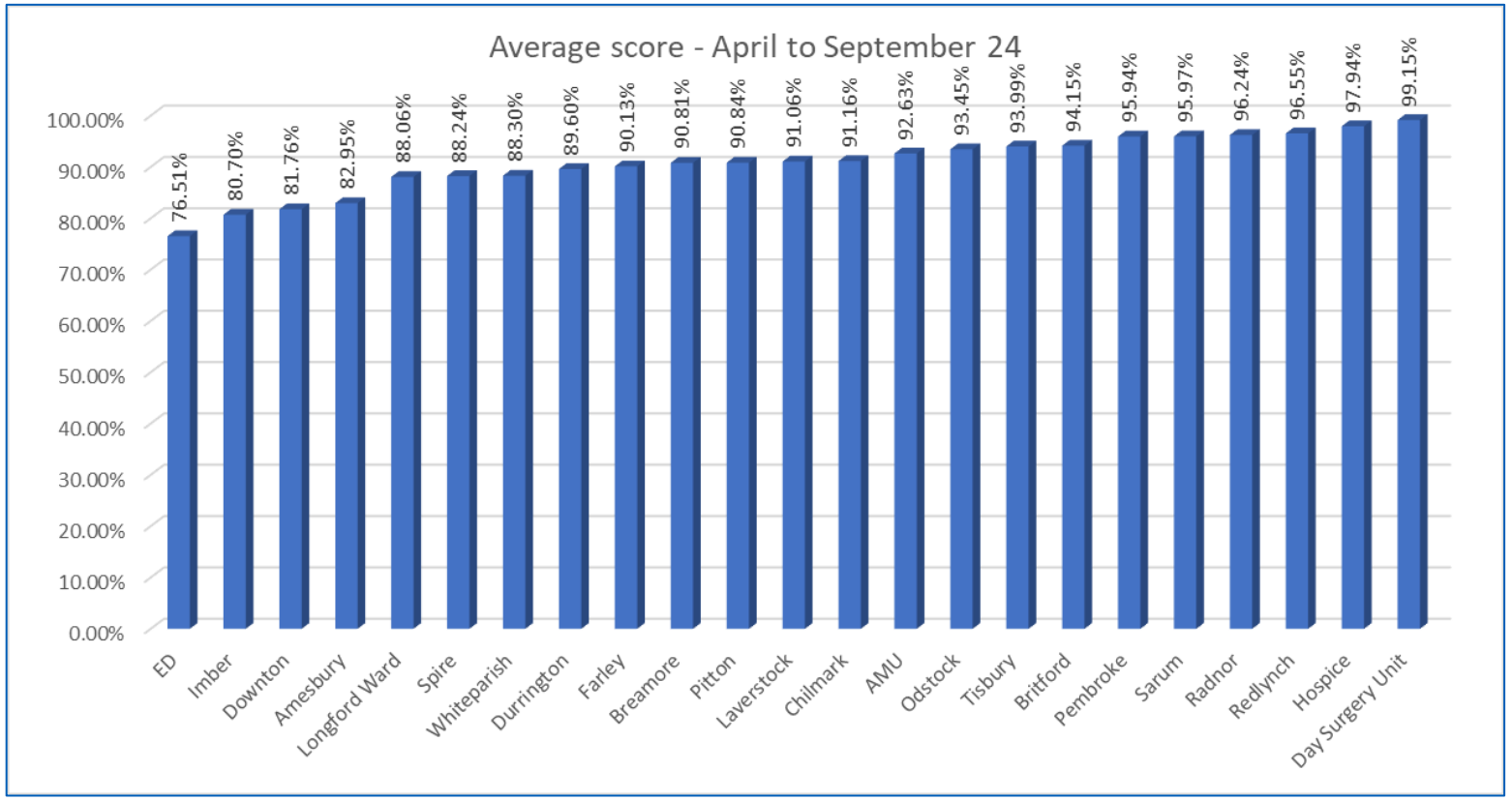
APPENDIX C

Tendable Infection Prevention & Control (IPC) Audit Inspection Summary for April 2024 – September 2024

Overall







(Information provided by Tendable review Team at SFT)

National Infection Prevention and Control Board Assurance Framework

Version 4.0 August 2024

Publication approval reference:

Introduction

The National Infection Prevention and Control board assurance framework ('the framework') is issued by NHS England for use by organisations to enable them to respond using an evidence-based approach to maintain the safety of patients, services users, staff and others. The framework is for use by all those involved in care provision in England and can be used to provide assurance in NHS settings or settings where NHS services are delivered. This framework is not compulsory but should be used by organisations to ensure compliance with infection prevention and control (IPC) standards (unless alternative internal assurance mechanisms are in place).

The purpose of the framework is to provide an assurance structure for boards against which the system can effectively self-assess compliance with the measures set out in the National Infection Prevention and Control Manual (NIPCM), the Health and Social Care Act 2008: code of practice on the prevention and control of infections, and other related disease-specific infection prevention and control guidance issued by UK Health Security Agency (UKHSA).

The aim of this document is to identify risks associated with infectious agents and outline a corresponding systematic framework of mitigation measures.

The framework should be used to assure the executive board or equivalent, directors of infection prevention and control, medical directors, and directors of nursing of the assessment of the measures taken in line with the evidence based recommendations of the NIPCM (or whilst the NIPCM is being implemented) including the relevant criterion outlined in the Health and Social Care Act 2008: code of practice on the prevention and control of infections. The outcomes can be used to provide evidence to support improvement and patient safety. The adoption and implementation of this framework remains the responsibility of the **organisation and all registered care providers** must demonstrate compliance with the Health and Social Care Act 2008. This requires demonstration of compliance with the ten criteria outlined.

If the criterion is not applicable within an organisation or setting for example, ambulance services then select not applicable option.

Links

NHS England » National infection prevention and control manual (NIPCM) for England

Health and Social Care Act 2008: code of practice on the prevention and control of infections - GOV.UK (www.gov.uk)

Legislative framework

The legislative framework required to protect patients, service users, staff and others from avoidable harm in a healthcare s etting is detailed in the Health and Social Care Act 2008: code of practice on the prevention and control of infections, the duty of care and responsibilities are set out in the Health and Safety at Work Act 1974, and associated regulations for employers and employees.

Local risk assessment processes are central to protecting the health, safety and welfare of patients, service users, staff an d others under relevant legislation. This risk assessment process (primary care, community care and outpatient settings, acute inpatient areas, and primary and community care dental settings) has been designed to support services in identifying hazards and risks, and includes guidance on measures that should be maintained to improve and provide safer ways of working by balancing risks appropriately. Where it is not possible to eliminate risk, organisations must assess and mitigate risk and provide safe systems of work using the risk assessment process and the organisation's governance processes.

Links

Health and Social Care Act 2008: code of practice on the prevention

Health and Safety at Work etc. Act 1974

Primary care, community care and outpatient settings

Acute Inpatient areas

Primary and community care dental settings

Instructions for use

The adoption and implementation of the National Infection Prevention and Control Board Assurance Framework remains **the responsibility of the organisation and all registered care providers** must demonstrate compliance with the Health and Social Care Act 2008. This requires demonstration of compliance with the ten criteria outlined in the Act.

The Board Assurance Framework worksheet is ordered by the ten criteria of the Act and allows for evidence of compliance, gaps in compliance, mitigations, and comments to be recorded in a text format.

The compliance rating column allows for the selection of a RAG rating for each criteria using a drop down list. Specifically: not applicable, non-compliant, partially compliant, compliant.

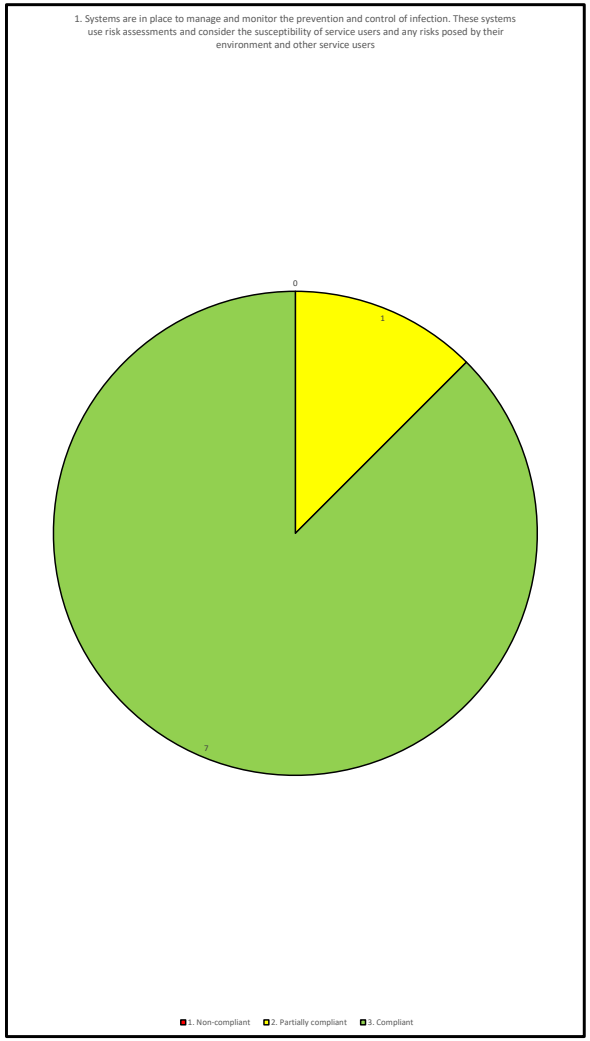
Once options have been selected a summary plot for each criteria is generated automatically, which are displayed in the corresponding worksheet. The overall RAG status for an organisation/provider across all ten criteria is shown in plots under the summary worksheet.

N.B. Use of the framework **is not compulsory** but should be used by organisations to ensure compliance with infection prevention and control (IPC) standards (unless alternative internal assurance mechanisms are in place). In addition, not all of the criteria outlined in the framework will be relevant or applicable to all organisations or settings.

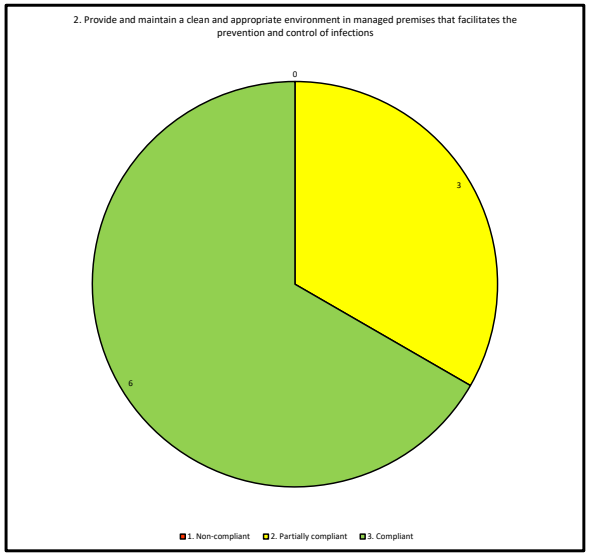
Please note: Specific URL's referred to in the document can be accessed via the ' Hyperlinks included in the BAF' tab. Or alternatively, can be accessed by clicking here.

Infection Prevention and Control board assurance framework v4.0

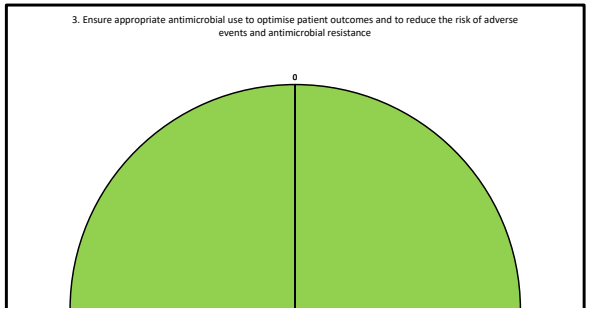
	Key Lines of Enquiry	Evidence	Gaps in Assurance	Mitigating Actions	Comments	Compliance rating
1. Systems to manage and monitor the prevention and control of infection. These systems use risk assessments and consider the susceptibility of service users and any risks their environment and other users may pose to them						
Organisational or board systems and process should be in place to ensure that:						
1.1	There is a governance structure, which as a minimum should include an IPC committee or equivalent, including a Director of Infection Prevention and Control (DIPC) and an IPC lead, ensuring roles and responsibilities are clearly defined with clear lines of accountability to the IPC team.	Infection Prevention & Control Committee (IPCC) meetings held quarterly, with DIPC reports to Trust Board six monthly. Divisional Heads of Nursing (DHoN) attendance at IPCC meetings to provide assurance reports to DIPC. IPC related moderate harm incidents discussed at Patient Safety Summit (PSS) weekly then disseminated through Divisional Governance meetings.				3. Compliant
1.2	There is monitoring and reporting of infections with appropriate governance structures to mitigate the risk of infection transmission.	Reporting and monitoring via IPCWG and IPCC meetings. Membership includes representation from all clinical divisions and support services e.g. Facilities/ Housekeeping. IPC related moderate harm and above incidents discussed at Patient Safety Summit weekly.				3. Compliant
1.3	That there is a culture that promotes incident reporting, including near misses, while focusing on improving systemic failures and encouraging safe working practices, that is, that any workplace risk(s) are mitigated maximally for everyone.	Risk assessments in place. Approved through Trust governance processes/ policies. Risk assessments completed on DATIX system. Any new risks identified are escalated via the normal Trust governance processes. Continued microbiologists and IPC Nursing Team advice on infectious agents.	Potential for risk assessments becoming out of date.	Discussions and monitoring via existing Trust processes (including IPCWG to IPCC). Incident investigation/SWARM processes, learning and actions shared with teams.	wihtin the divisions, incidents are reviewed and discussed when occur and operationally as required.	3. Compliant
1.4	They implement, monitor, and report adherence to the NIPCM.	Existing IPC Trust policies and National IPC Manual (NIPCM) are available to all staff via Eolas Medical (previously Microguide). Tendable inspections in place as per standard operating procedure (SOP). Ward area reviews for policy practice compliance including ad.hoc 'spot checks' by Divisional and Speciality Matrons and IPC Nursing Team. Additional monitoring of practice compliance when periods of increased incidence (PIIs) identified. IPC Board Assurance Framework (BAF) document submitted quarterly to Trust Board and IPCC, following completion by participants of the IPCWG.	Requirement for Tendable inspections to be reviewed in line with NIPCM. Tendable inspections not undertaken in outpatient areas or Theatres. Outpatients undertake audits without Tendable including BBE, environmental, hand hygiene and they also complete a templated cleaning task list. Review of IPC policies ongoing but existing policies accessible on Eolas Medical (transferred from Microguide).			3. Compliant
1.5	They undertake surveillance (mandatory infectious agents as a minimum) to ensure identification, monitoring, and reporting of incidents/outbreaks with an associated action plan agreed at or with oversight at board level.	Mandatory surveillance and reporting of alert organisms completed via Trust policy existing/established processes. Completion of investigations (post infection reviews (PIRs) and SWARMs) and divisional reporting slides to IPCC. Formal Virtual Board Rounds (VBR) dicontinued in August 2024. However, COVID-19 and respiratory illnesses monitoring continues by members of the VBR group (including divisions). Outbreak Management Review meetings as required (with appropriate/key representation) and required external reporting completed. Tendable/practice inspections increased if an area has a declared outbreak or experiencing a period of increased incidence (PII) of infection. DIPC reports to Trust Board six monthly. MRSA elective and emergency screening auditing undertaken. Divisional feedback requirements on identified actions for non-compliance with policy. Mandatory surgical site infection surveillance (SSIS) for orthopaedic surgery currently undertaken for repair of neck of femur category.	Divisional action trackers to be established for areas of increased incidents and Matrons to monitor completion and report via IPCWG.			3. Compliant
1.6	Systems and resources are available to implement and monitor compliance with infection prevention and control as outlined in the responsibilities section of the NIPCM.	Tendable IPC inspections in place as per existing SOP and other infection control reviews e.g. hand hygiene, Bare below the elbow (BBE) and environmental audits completed at least monthly with Divisional Matrons oversight if action plans required.		Existing IPC Trust policies.	Monthly audits reviewed and discussed within divisional meetings re: compliance and associated actions.	3. Compliant



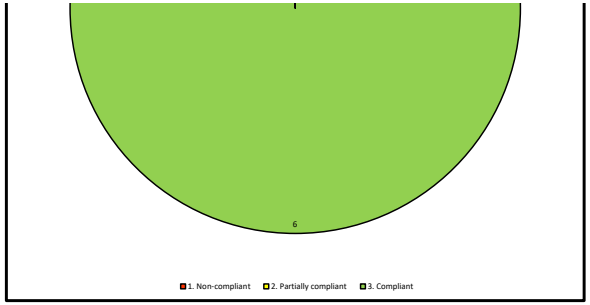
1.7	All staff receive the required training commensurate with their duties to minimise the risks of infection transmission.	Mandatory training module e-learning (LEARN) available. IPC policies in place. Tendable IPC inspections and hand hygiene practice compliance audits. Initial training at induction wihtin divisions with mandatory annual updates. Focused training following any outbreaks or incidents.	Hand hygiene assessment compliance across Trust tracking below 85% target.	Compliance with hand hygien practice monitored through Tendable from M5 - giving better oversight of compliance. Average compliance across wards for M5 87% and M6 85%. Oversight of outcomes monitored through IPCWG Implementation of alternative approch to assess hand hygiene in practices rolled out across wards to improve compliance. Matrons and ward leads focusing on ward based hand hygiene assessments and protection of ICLP meeting time. Staff educational IPC related and hand hygiene video created and uploaded within the LEARN.	No significant improvement in compliance noted.	2. Partially compliant
1.8	There is support in clinical areas to undertake a local dynamic risk assessment based on the hierarchy of controls to prevent/reduce or control infection transmission and provide mitigations. (primary care, community care and outpatient settings, acute inpatient areas, and primary and community care dental settings)	Risk assessments in place. Approved through Trust governance processes/policies. Risk assessments completed on DATIX system. Any new risks identified are escalated via the normal Trust governance processes.	Knowledge limitations of ward leads and nurse in charge cohorts, further training on both risk assessment and mitigation required.		Post infection reviews (PIRs)/incident investigations completed with support of division/s and IPC team as a result of infection on ward.	3. Compliant
2. Provide and maintain a clean and appropriate environment in managed premises that facilitates the prevention and control of infections						
System and process are in place to ensure that:						
2.1	There is evidence of compliance with National cleanliness standards including monitoring and mitigations (**excludes some settings e.g. ambulance, primary care/dental unless part of the NHS standard contract** these setting will have locally agreed processes in place).	Housekeeping Department monitor standards of environmental cleanliness. Currently working towards the new 2021 National Cleaning Standards and currently evidence the 2008 standards. Business case approved by Trust Board for additional cleaning hours.	Funding has been secured over a 3 year implementation period for the new standards. Oversight through implementation group chaired by DCNO.	Derogation against the new cleaning standards was in place until 31st March 2024, a request to extend derogation was refused. The Trusts Management Committee received an investment paper in April 2024 and approved a revised date for compliance of 31.01.2027. Continue with current cleaning schedules and frequencies. Prioritise with support of the IPC Nursing Team. Approval at IPCC.		2. Partially compliant
2.2	There is an annual programme of Patient-Led Assessments of the Care Environment (PLACE) visits and completion of action plans monitored by the board.	Annual national PLACE inspection completed 7/11/24, with patient assessors and volunteers. These are communicated within the quarterly cleanliness report to Trust Board (via DIPC), with an action plan. The Trust also undertakes a year long PLACE 'Lite' programme, with findings discussed at the monthly PLACE Steering Group.				3. Compliant
2.3	There are clear guidelines to identify roles and responsibilities for maintaining a clean environment (including patient care equipment) in line with the national cleanliness standards.	Clear guidelines with two cleaning task lists (CTLs); one for Housekeeping Staff and one for ward teams/staff to complete on a daily basis. The Housekeeping CTLs are reviewed and signed off weekly by the Housekeeping Management Team. Decontamination Policy				3. Compliant
2.4	There is monitoring and reporting of water and ventilation safety, this must include a water and ventilation safety group and plan. **2.4.1** Ventilation systems are appropriate and evidence of regular ventilation assessments in compliance with the regulations set out in HTM:03-01. **2.4.2** Water safety plans are in place for addressing all actions highlighted from water safety risk assessments in compliance with the regulations set out in HTM:04-01.	There are Water Safety and Ventilation Working Groups set up and well attended. There are policies and a Water Safety Plan. Ventilation systems are maintained and verified in accordance to HTM and an annual audit is conducted by the Authorised Engineer (AE). There is a current water safety risk assessment in place and actions being worked through.			Risk assessments for Pseudomonas being undertaken within identified augmented areas.	3. Compliant
2.5	There is evidence of a programme of planned preventative maintenance for buildings and care environments and IPC involvement in the development new builds or refurbishments to ensure the estate is fit for purpose in compliance with the recommendations set out in HBN:00-09	Planned Preventative Maintenance (PPMs) are in place for building maintenance and IPC Team are included for new builds and refurbishments.	Funding and staff resources restricts PPM coverage.	Contractors used when possible.		3. Compliant

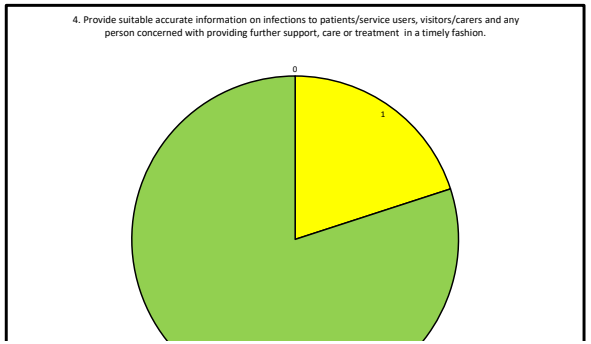


2.6	The storage, supply and provision of linen and laundry are appropriate for the level and type of care delivered and compliant with the recommendations set out in HTM:01-04 and the NIPCM.	Linen and laundry is kept in a dedicated linen cupboard/covered trolley and is topped up by our Contractors twice per day. Linen usage is also reviewed at the monthly PLACE Steering Group and within the internal PLACE 'Lite' inspections. Key performance indicators (KPIs) are also reviewed every month. Linen Policy in place for users.				3. Compliant
2.7	The classification, segregation, storage etc of healthcare waste is consistent with HTM:07:01 which contains the regulatory waste management guidance for all health and care settings (NHS and non-NHS) in England and Wales including waste classification, segregation, storage, packaging, transport, treatment, and disposal.	Policy in place. Practices monitored via auditing processes, with reporting at Waste Management Group. A Tiger waste stream has been fully implemented and an action plan to deliver the NHSE Clinical Waste Strategy is in place.				3. Compliant
2.8	There is evidence of compliance and monitoring of decontamination processes for reusable devices/surgical instruments as set out in HTM:01-01, HTM:01-05, and HTM:01-06.	Instrument (HTM 01-01) and endoscopic (HTM 01-06) reprocessing undertaken centrally in SSL who are audited by BSI (last audit November 2024 - compliant with three minor comments). Automated HLD of Invasive ultrasound probes in place in many areas with manual wipe system in place where unavailable (due to device incompatibility or low usage making automated system inappropriate). Local auditing of specific themes is undertaken e.g IHEEM (flexible endoscopes), Ultrasound Infection Prevention Toolkit (ultrasound probes), Tristel (manual high level disinfection). SOPs are in place where specific procedures are carried out in local departments.	More regular auditing of specific processes would be preferred and offer increased assurance. No formal auditing process for general re-usable medical devices (such as obs machines or infusion pumps) to enable evidence of compliance. Some departmental SOPs are due for review and departments reporting compliance with their SOPs at Decontamination working Group (DWG)could be improved.	Development of an inspection audit within the Tendable system will improve capture of evidence - expectation that this will progress during Q4 of 2024-25. Any concerns or issues around decontamination, contaminated equipment, and/or central re-processing reported via DATIX or SSL Synergy Trak. Trends reported, monitored and discussed at DWG.	HTM 01-05 (Primary Care Dental) not applicable at SFT.	2. Partially compliant
2.9	Food hygiene training is commensurate with the duties of staff **as per food hygiene regulations**. If food is brought into the care setting by a patient/service user, family/carer or staff this must be stored in line with food hygiene regulations.	Training records for Catering staff and training recorded on the MLE for ward based clinical staff.	There is a nominated Antibiotic Pharmacist supported by Consultant Microbiologist and Pharmacy Technician which as a team undertake weekly antibiotic stewardship (AMS) ward rounds. Furthermore, weekly MDT Diabetic Foot ward rounds are undertaken. Additionally, the AMS team also attend a monthly C.difficile ward round. AMS currently undertaking IVOST CQUIN.	Each inpatient ward has at least one member of staff who has been trained. Ward based catering facilities (kitchen/food storage areas) are routinely inspected by the Catering Manager. Facilities are provided to store food in line with Food Hygiene Regulations, for a maximum of 30 minutes, in line with Trust policy.	The Catering Team, working with the Trusts Education Team, will be launching a new e-learning module for ward based staff. To note - storing food (brought into hospital) in line with Food Hygiene Regulations, does not make it safe and could present a cross contamination risk to the food supplied by the Trust.	2. Partially compliant
3. Ensure appropriate antimicrobial stewardship to optimise service user outcomes and to reduce the risk of adverse events and antimicrobial resistance						
Systems and process are in place to ensure that:						
3.1	If antimicrobial prescribing is indicated, arrangements for antimicrobial stewardship (AMS) are maintained and where appropriate a formal lead for AMS is nominated.	There is a nominated Antibiotic Pharmacist supported by Consultant Microbiologist and Pharmacy Technician which as a team undertake weekly antibiotic stewardship (AMS) ward rounds. Furthermore, weekly MDT Diabetic Foot ward rounds are undertaken. Additionally, the AMS team also attend a monthly C.difficile ward round. AMS currently undertaking IVOST CQUIN.	The AMS ward round cannot cover all areas/ward of the hospital due to time restraints. The whole AMS team cannot commit to every ward round involved with the AMS service but to mitigate this a member of the team will try to make an attendance.	Using electronic prescribing and drug charts to provide a targeted approach to AMS ward rounds. The implementation of a antibiotic filter programme is being created to facilitate identification of patients on IV antibiotics but requires data quality reviews and upgrades to the report.	AMS pharmacist leaving -plans in place for replacement.	3. Compliant
3.2	The board receives a formal report on antimicrobial stewardship activities annually which includes the organisation's progress with achieving the UK AMR National Action Plan goals.	The IPCC receives a quarterly and bi-annual report on the activities and work performed by the Antimicrobial Reference Group (ARG). Additionally, an antimicrobial report is also created for Medicine Assurance for the Clinical Governance Group.	Reports only cover activities within the last quarter or last 6 months.	Key issues on AMS activities are discussed every 6-8 weeks at ARG.		3. Compliant
3.3	There is an executive on the board with responsibility for antimicrobial stewardship (AMS), as set out in the UK AMR National Action Plan.	The board executive responsible for AMS as set out in the UK AMR Action Plan is the DIPC.	Nil	The DIPC has oversight over antimicrobial stewardship, via ARG feeding into the Infection Prevention & Control Committee (IPCC).		3. Compliant

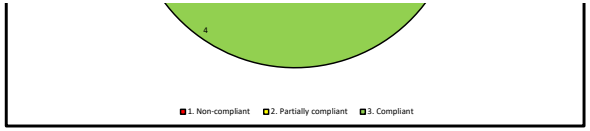


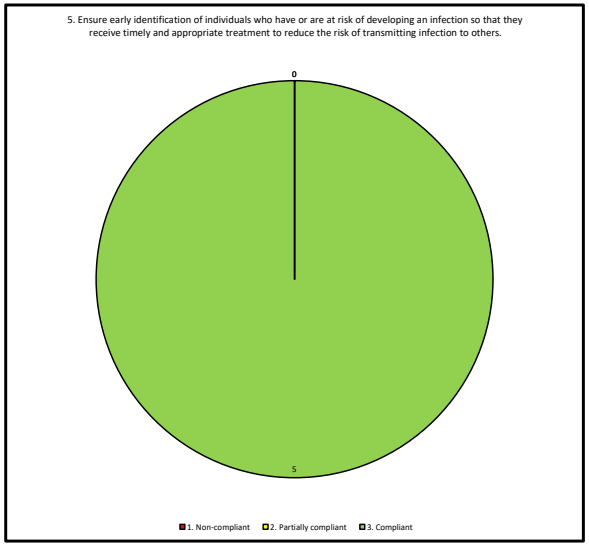
3.4	NICE Guideline NG15 'Antimicrobial Stewardship: systems and processes for effective antimicrobial medicine use' or Treat Antibiotics Responsibly, Guidance, Education, Tools [TARGET] are implemented and adherence to the use of antimicrobials is managed and monitored: •To optimise patient outcomes. •To minimise inappropriate prescribing. •To ensure the principles of Start Smart, Then Focus are followed.	Targeted C.difficile round. Daily ICU ward round. Within critical care, drug charts are embedded with AMS principles. IPCC report (quarterly) and DIPC report (bi-annual) completed by the Antimicrobial Pharmacist to provide assurance to the board regarding total antimicrobial prescribing, and use of broad- spectrum antibiotics. Antimicrobial Review Group (ARG) reviews antibiotic policies in light of national and international guideline changes or emergence of new evidence. Also reviews drug safety incidences where antibiotics are involved. Microguide provides antimicrobial guidance (regularly reviewed by ARG). Antibiotic stewardship included in the	Time and staffing constraints in conducting C.difficile round especially within Pharmacy at present due to limited clinical staff. C.difficile cases reviews not completed in a timely manner due to staff and time constraints. No formal education of medical staff beyond FY2. Limited access to nursing teaching program.	Continuation of AMS round twice weekly. Monitoring C.difficile incidence occurs regularly and the AMS team conduct ad hoc rounds where feasible.		3. Compliant
3.5	Contractual reporting requirements are adhered to, progress with incentive and performance improvement schemes relating to AMR are reported to the board where relevant, and boards continue to maintain oversight of key performance indicators for prescribing, including: •Total antimicrobial prescribing. •Broad-spectrum prescribing. •Intravenous route prescribing. •Treatment course length.	IPCC (quarterly), DIPC (bi-annual) and Medicines Assurance reports completed by the Antimicrobial Pharmacist to provide assurance to the board regarding antimicrobial prescribing. Antimicrobial Review Group (ARG) reviews antibiotic policies in light of national and international guideline changes or emergence of new evidence. Also reviews drug safety incidences where antibiotics are involved.	Reporting created retrospectively and does not cover all wards within SDH.			3. Compliant
3.6	Resources are in place to support and measure adherence to good practice and quality improvement in AMS. This must include all care areas and staff (permanent, flexible, agency, and external contractors)	Microguide section on antibiotics now updated by Microbiology Consultant and Pharmacy. Antimicrobial guidance is being renewed and created to aid and support adherence to AMS principles. The AMS team is contactable and offers support on a daily basis in working hours.	Microguide updating has progressed significantly but also at the pace that staffing, workload and time pressures allow. The AMS are monitoring user feedback. There is a suitable time gap between guidance creation and implementation into practice. Support from AMS team only available when staff are available.	Continuation of AMS round twice weekly. Monitoring C.difficile incidence occurs regularly and the AMS team conduct ad hoc rounds where feasible. Microbiology and Pharmacy advice and support on AMS available in working hours. Additionally, SDH has a live version of micro/infection guidance.		3. Compliant
4. Provide suitable accurate information on infections to patients/service users, visitors/carers and any person concerned with providing further support, care or treatment nursing/medical in a timely fashion						
Systems and processes are in place to ensure that:						
4.1	Information is developed with local service-user representative organisations, which should recognise and reflect local population demographics, diversity, inclusion, and health and care needs.	Information available on Trust website, including visiting information and potential restrictions. Patient information leaflets available.			Further work to do related to under-represented groups	3. Compliant
4.2	Information is appropriate to the target audience, remains accurate and up to date, is provided in a timely manner and is easily accessible in a range of formats (eg digital and paper) and platforms, taking account of the communication needs of the patient/service user/care giver/visitor/advocate.	Regular review of information available and accessible formats e.g. website, leaflets undertaken within the Trust.				3. Compliant
4.3	The provision of information includes and supports general principles on the prevention and control of infection and antimicrobial resistance, setting out expectations and key aspects of the registered provider's policies on IPC and AMR.	In place. Regular review of information and any changes in practice undertaken by the Antibiotic Reference Group (ARG) and IPCWG.				3. Compliant



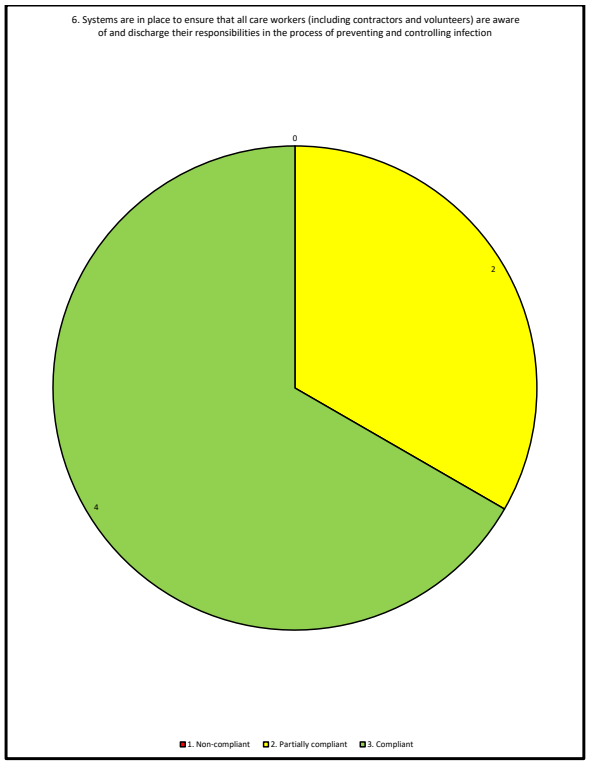


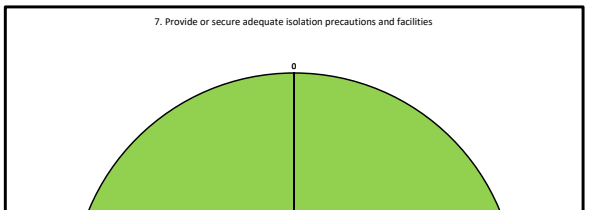
4.4	Roles and responsibilities of specific individuals, carers, visitors, and advocates when attending with or visiting patients/service users in care settings, are clearly outlined to support good standards of IPC and AMR and include: • Hand hygiene, respiratory hygiene, PPE (mask use if applicable) • Supporting patients/service users' awareness and involvement in the safe provision of care in relation to IPC (eg cleanliness) • Explanations of infections such as incident/outbreak management and action taken to prevent recurrence. • Provide published materials from national/local public health campaigns (eg AMR awareness/vaccination programmes/seasonal and respiratory infections) should be utilised to inform and improve the knowledge of patients/service users, care givers, visitors and advocates to minimise the risk of transmission of infections.	Existing IPC Trust policies in place. Posters and patient information resources available. Adherence to national and local public health campaigns e.g. Antibiotic Awareness week and Global Hand Hygiene Day.				3. Compliant
4.5	Relevant information, including infectious status, invasive device passports/care plans, is provided across organisation boundaries to support safe and appropriate management of patients/service users.	*Divisional feedback - Surgery: Cannulation pathways and VIP scores; documentation audits, and other Tendable inspections.*	*Divisional feedback: Challenges generated following implementation of E-Document.*		*Medicine division: Information no longer available at point of care. (Of note: during quarter 1 of 2024/25 VIP pathways returned to point of care). All other documents remain on EPMA which is readily*	2. Partially compliant
5.	**Ensure early identification of individuals who have or are at risk of developing an infection so that they receive timely and appropriate treatment to reduce the risk of transmitting infection to others.**					
Systems and processes are in place to ensure that patient placement decisions are in line with the NIPCM:						
5.1	All patients/individuals are promptly assessed for infection and/or colonisation risk on arrival/transfer at the care area. Those who have, or are at risk of developing, an infection receive timely and appropriate treatment to reduce the risk of infection transmission.	Admission screening for MRSA (elective and emergency), timely stool sampling, etc. Review of microbiology/infection alerts on Lorenzo system. CPE screening for identified/appropriate patients.	Missed screens identified via monthly MRSA compliance audit.	Matrons identify reasons for gaps with area leads with associated actions.	Divisional tracker to monitor missed screens and associated actions.	3. Compliant
5.2	Patients' infectious status should be continuously reviewed throughout their **stay/period of care**. This assessment should influence placement decisions in accordance with clinical/care need(s). If required, the patient is placed /isolated or cohorted accordingly whilst awaiting test results and documented in the patient's notes.	Use of Isolation Risk Assessment Tool (IRAT). Daily monitoring of sideroom usage and occupancy by Matrons. Coordination with Clinical Site Team for potential cohort nursing of identified patients. Discussed at ward rounds with escalation to IPC Team for advice.			Daily discussions (as appropriate) with IPC Team and ward team. Included within the ward safety brief. Trust Isolation Policy and appendices relating to patient assessment in place. Practice monitored through incident reporting and case reviews such as c-diff.	3. Compliant
5.3	The infection status of the patient is communicated prior to transfer to the receiving organisation, department, or transferring services ensuring correct management/placement.	Transfer of care forms completed on discharge to other care facilities and SBAR handovers between wards. Alerts on Lorenzo electronic system. Clinical Site Team handover for inter-hospital transfers.	Potential for missed infections through documentation and communication gaps in transfer of care information and handovers.			3. Compliant
5.4	Signage is displayed prior to and on entry to all health and care settings instructing patients with respiratory symptoms to inform receiving reception staff, immediately on their arrival.	Agreed messaging/posters in place.	Inappropriate removal of IPC signage by staff to display other key messages. Variation from Trust standardised signage leading to inconsistency in clinical areas.	Tendable inspections and daily sideroom checks including signage.		3. Compliant
5.5	Two or more infection cases (or a single case of serious infection) linked by time, place, and person triggers an incident/outbreak investigation and this must be reported via governance reporting structures.	Completion of investigations (PIRs and SWARMs) and divisional reporting assurance slides; completion of clinical reviews (as appropriate), and PII monitoring. Report via Patient Safety Summit and divisional governance structure. PII investigations meetings and Outbreak Management Review meetings as required; external reporting completed. IPCC meeting quarterly and DIPC reports to Trust Board.	Potential delays in completion of PIRs and SWARMs and identified learning.	Divisional trackers in place to monitor.		3. Compliant
6.	**Systems are in place to ensure that all care workers (including contractors and volunteers) are aware of and discharge their responsibilities in the process of preventing and controlling infection**					
Systems and processes are in place to ensure:						



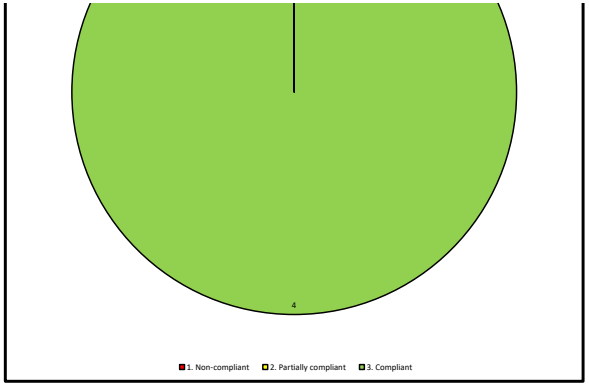


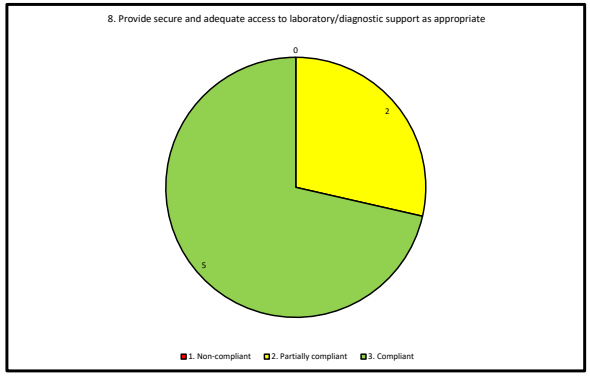
6.1	Induction and mandatory training on IPC includes the key criteria (SICPs/TBPs) for preventing and controlling infection within the context of the care setting.	Mandatory training module e-learning (LEARN) available. New starter checklists for IPC available for both clinical and non-clinical staff groups.	Less than 100% compliance with LEARN completion and failure to utilise checklists in all areas.		Ongoing review by divisions with DHoN oversight and regular monitoring.	3. Compliant
6.2	The workforce is competent in IPC commensurate with roles and responsibilities.	Compliance with IPC practice audit results e.g. hand hygiene, use of personal protective equipment (PPE). Training data compliance		Peer/cross auditing within the clinical divisions of compliancew with practice and increased frequency of auditing when non-compliance evident. Tendable audit shows average compliance with IPC audits of M5 90%, M6 88%	New LEARN package being implemented with education service which will be mapped across staff groups.	2. Partially compliant
6.3	Monitoring compliance and update IPC training programs as required.	Area leads monitor compliance with e-learning via LEARN (MLE reports).	Area leads need to tailor checklists to their specialist areas to ensure they meet the requirements of each speciality. **Fit testing** - training information added manually once employee is seen in the department. LEARN/MLE will not record/account for change in staff members facial features, teeth removal and weight loss, so the recall is 2 yearly regardless.	Reminders automatically for fit testing are generated until compliance is added. Ward leads to check compliance of all staff monthly.		3. Compliant
6.4	All identified staff are trained in the selection and use of personal protective equipment / respiratory protective equipment (PPE/RPE) appropriate for their place of work including how to safely put on and remove (donning and doffing) PPE and RPE.	All patient facing staff are captured at Induction and a Fit Testing appointment made. RPE training and advice given at Fit Test appointment. (Of note: PPE training not given by Fit Testing Team. Instructions for PPE donning and doffing within existing Trust policy/action card).	If appointment not attended, no RPE training will take place within the Fit Testing Department.	Ward/area leads to ensure/push fit mask refresher training and monitor compliance. Use of personal risk assessments. IPC induction checklist not to be signed off until fit mask training undertaken.	Trust compliant with NHS England guidance for staff to be fit tested for two RPE face masks. Divisions to monitor compliance and push training.	2. Partially compliant
6.5	That all identified staff are fit-tested as per Health and Safety Executive requirements and that a record is kept.	An 8.00hrs - 16.00hrs, Monday to Friday Fit Testing service is available for staff to access, plus nights and weekends if wards or departments need these times. All patient facing staff are invited for their Fit Test and the department follows the Trust policy of x2 fitted masks for each employee. All records are given to the employee. All records are held on ESR, LEARN/MLE and a database is held for those that are not contracted.	Cannot always identify staff if names are not on induction list or contracted staff do not contact Fit Testing Team. Messaging clear in Trust internal communications e.g. Bulletin.		Fit Testing Team available for advice.	3. Compliant
6.6	If clinical staff undertake procedures that require additional clinical skills, for example, medical device insertion, there is evidence staff are trained to an agreed standard and the staff member has completed a competency assessment which is recorded in their records before being allowed to undertake the procedures independently.	Competency sign off for clinical procedures following training completion. Specific competency and Expanded Practice process as required.	Lack of evidence of competency sign off i.e. catheter, central lines, cannulation and venepuncture.	Ward/Clinical Leads to monitor competence of their staff and ensure compliance and acceptable percentages of competence within team.	Training provided as required relating to procedure and assessment document completed. Depending on procedure may be agreed by Expanded Practice Validation Group.	3. Compliant
7. Provide or secure adequate isolation precautions and facilities						
Systems and processes are in place in line with the NIPCM to ensure that:						
7.1	Patients that are known or suspected to be infectious as per criterion 5 are individually clinically risk assessed for infectious status when entering a care facility. The result of individual clinical assessments should determine patient placement decisions and the required IPC precautions. Clinical care should not be delayed based on infectious status.	Existing IPC policies in place including Isolation Risk Assessment Tool to aid patient assessment and requirement for isolation facility/sideroom. Daily sideroom reviews undertaken by the divisional Matrons with support from the IPC Nursing Team (as required). Completion of admission screens for alert organisms as per established policies (e.g. MRSA, CPE, etc). Risk assessment completed on admission or in Emergency Department or Pre-Operative Assessment unit (POAU). Clinical Site Team aware when transfer into hospital.	Availability of isolation facilities/siderooms due to capacity challenges and patient compliance. Requirement for sideroom escalated to Clinical Site Team but limited resource or gaps in clinical decision making to de-isolate patients where possible.	Unable to enforce isolation nursing with patients - appropriate information/advice given. All entry points to identify patients infection risk on admission. Utilisation of SBAR handover to ensure IPC status captured. Divisional Matrons to check sideroom status daily and ensure updates provided to Clinical Site Team. Clinical Site Team to update sideroom tracker daily.		3. Compliant

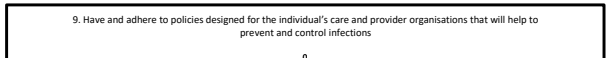




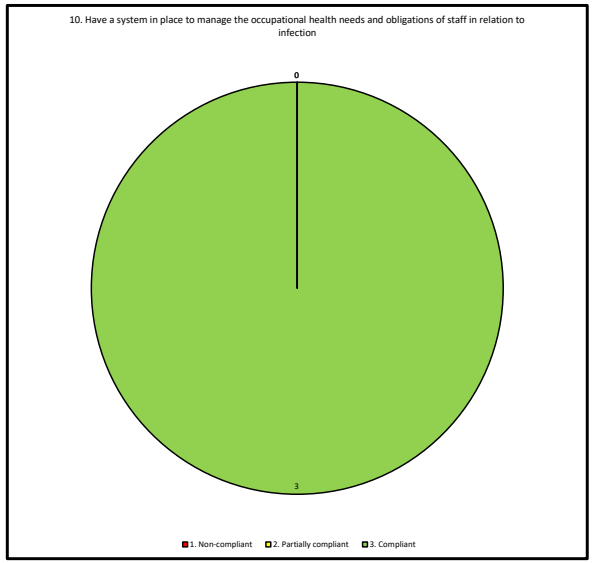
7.2	Isolation facilities are prioritised, depending on the known or suspected infectious agent and all decisions made are clearly documented in the patient's notes. Patients can be cohorted together if: • Single rooms are in short supply and if there are two or more patients with the same confirmed infection. • There are situations of service pressure, for example, winter, and patients may have different or multiple infections. In these situations, a preparedness plan must be in place ensuring that organisation/board level assurance on IPC systems and processes are in place to mitigate risk.	Existing IPC policies in place and established sideroom priority list available (within the Trust Bed Management Policy and Respiratory Illness Guide (access via SALi and Eolas Medical). Escalation of isolation requirements for cohort nursing agreed in Trust preparedness plan e.g. winter plan. Additional advice and support available from the Microbiologist and IPC Nursing Team.	No gaps identified.			3. Compliant
7.3	Transmission based precautions (TBPs) in conjunction with SICPs are applied and monitored and there is clear signage where isolation is in progress, outlining the precautions required.	Isolation policy in place, with established signage for source isolation nursing available.	Staff compliance and knowledge.	Divisional Matron checks during ward visits.	Review of isolation signage underway, following discussion at IPCWG meeting to include revised PPE and waste management information.	3. Compliant
7.4	Infectious patients should only be transferred if clinically necessary. The receiving area (ward, hospital, care home etc.) must be made aware of the required precautions.	Policy in place and transfer of care letter. Use of SBAR handover to ensure cascade of management requirements. Discussion at daily Capacity meetings and plan to move patient if clinically required.			Discussed with Divisional Teams and Clinical Site Team at daily Bed Capacity Meetings if clinical transfer required.	3. Compliant
8. Provide secure and adequate access to laboratory/diagnostic support as appropriate						
Systems and processes to ensure that pathogen-specific guidance and testing in line with UKHSA are in place:						
8.1	Patient/service user testing for infectious agents is undertaken by competent and trained individuals and meet the standards required within a nationally recognised accreditation system.	Training and competency records for BMS and MLA staff are in place.	Awaiting visit from UKAS.		We have approached UKAS to come to visit but have not received a date from them yet.	3. Compliant
8.2	Early identification and reporting of the infectious agent using the relevant test is required with reporting structures in place to escalate the result if necessary.	Process in place.				3. Compliant
8.3	Protocols/service contracts for testing and reporting laboratory/pathology results, including turnaround times, should be in place. These should be agreed and monitored with relevant service users as part of contract monitoring and laboratory accreditation systems.	Antenatal and General Laboratory are monitored on a monthly basis. These are available in the user handbook and are in line with the IDPS.				3. Compliant
8.4	Patient/service user testing on admission, transfer, and discharge should be in line with national guidance, local protocols and results should be communicated to the relevant organisation.	Policies in place.			The Laboratory will test what samples sent but do not make the decision on what tests are requested.	3. Compliant
8.5	Patients/service users who develops symptom of infection are tested / retested at the point symptoms arise and in line with national guidance and local protocols.	Policies in place.				3. Compliant
8.6	There should be protocols agreed between laboratory services and the service user organisations for laboratory support during outbreak investigation and management of known/ emerging/novel and high-risk pathogens.	We would support with outbreak investigation and transport of specimens depending on the pathogen, risk assessments and available information. These protocols would be agreed when put in place.	No written protocol in place.			2. Partially compliant
8.7	There should be protocols agreed between laboratory services and service user organisations for the transportation of specimens including routine/ novel/ emerging/high risk pathogens. This protocol should be regularly tested to ensure compliance.	We would support with outbreak investigation and transport of specimens depending on the pathogen, risk assessments and available information. These protocols would be agreed when put in place.	No written protocol in place.			2. Partially compliant
9. Have and adhere to policies designed for the individual's care and provider organisations that will help to prevent and control infections						



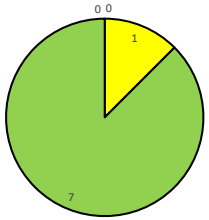




9.1	Systems and processes are in place to ensure that guidance for the management of specific infectious agents is followed (as per UKHSA and the NIPCM) (UKHSA and NHSE A to Z pathogens list to be added once published). Policies and procedures are in place for the identification of and management of outbreaks/incidence of infection. This includes monitoring, recording, escalation and reporting of an outbreak/incident by the registered provider.	Existing IPC Trust policies and National IPC Manual are available to all staff via Eolas Medical. Policy reviews plan in place (as agreed by the IPCWG). Additional monitoring of practice compliance when PIIs and outbreaks identified. Outbreak Management Review meetings as required; external reporting completed.			IPC policies review programme monitored via the IPCWG and IPCC.	3. Compliant
10. Have a system in place to manage the occupational health needs and obligations of staff in relation to infection						
Systems and processes are in place to ensure that any workplace risk(s) are mitigated maximally for everyone. This includes access to an occupational health or an equivalent service to ensure:						
10.1	Staff who may be at high risk of complications from infection (including pregnancy) have an individual risk assessment.	Trust pregnancy risk assessment is completed by managers and sent to OH as per policy. All other illnesses which would be increased risk - OH would be involved via management referral route.			The risk is managers not referring on.	3. Compliant
10.2	Staff who have had an occupational exposure are referred promptly to the relevant agency, for example, GP, occupational health, or accident and emergency, and understand immediate actions, for example, first aid, following an occupational exposure including process for reporting.	Contamination policy, which advices OH or Emergency Department for out of hours. Reporting is via DATIX and then followed up by OH or Health & Safety.				3. Compliant
10.3	Staff have had the required health checks, immunisations and clearance undertaken by a competent advisor (including those undertaking exposure prone procedures (EPPs).	All staff complete a PPQ and we assess their vaccine requirements. If vaccines are required we invite them for an OH appointment. If they DNA 3 times we inform their recruitment they haven't attended OH. For EPP staff – we require evidence of Hepatitis B, Hepatitis C and HIV 1 & 2 identified validated samples before health clearance is provided. Once we have this evidence, we will clear them.				3. Compliant

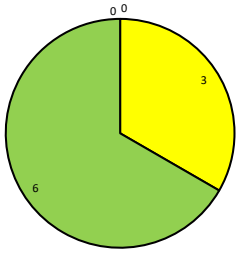


1. Systems are in place to manage and monitor the prevention and control of infection. These systems use risk assessments and consider the susceptibility of service users and any risks posed by their environment and other service users



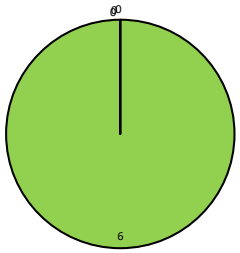
1. Non-compliant 2. Partially compliant 3. Compliant

2. Provide and maintain a clean and appropriate environment in managed premises that facilitates the prevention and control of infections



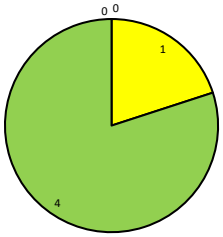
1. Non-compliant 2. Partially compliant 3. Compliant

3. Ensure appropriate antimicrobial use to optimise patient outcomes and to reduce the risk of adverse events and antimicrobial resistance



1. Non-compliant 2. Partially compliant 3. Compliant

4. Provide suitable accurate information on infections to patients/service users, visitors/carers and any person concerned with providing further support, care or treatment in a timely fashion.



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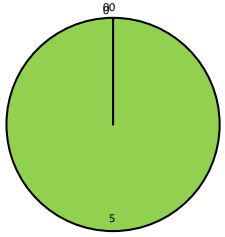
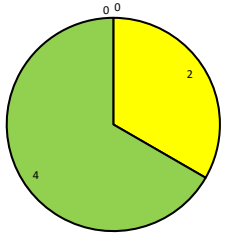
5. Ensure early identification of individuals who have or are at risk of developing an infection so that they receive timely and appropriate treatment to reduce the risk of transmitting infection to others.



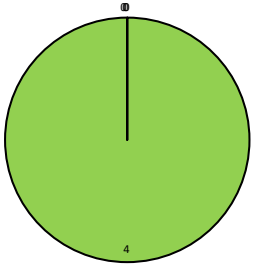
1. Non-compliant 2. Partially compliant 3. Compliant

6. Systems are in place to ensure that all care workers (including contractors and volunteers) are aware of and discharge their responsibilities in the process of preventing and controlling infection



1. Non-compliant 2. Partially compliant 3. Compliant

7. Provide or secure adequate isolation precautions and facilities



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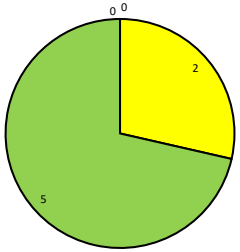
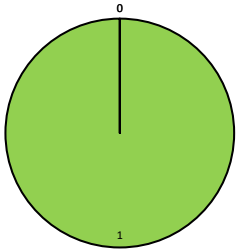
8. Provide secure and adequate access to laboratory/diagnostic support as appropriate



1. Non-compliant 2. Partially compliant 3. Compliant

9. Have and adhere to policies designed for the individual's care and provider organisations that will help to prevent and control infections



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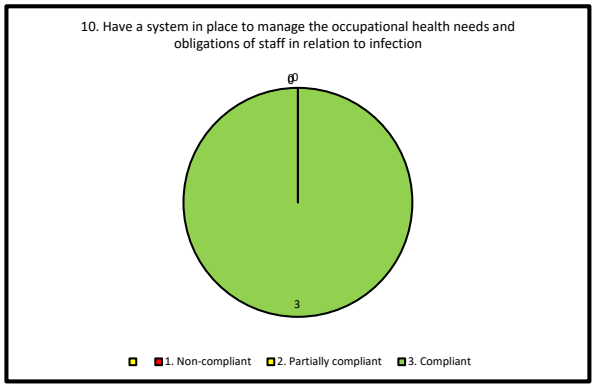
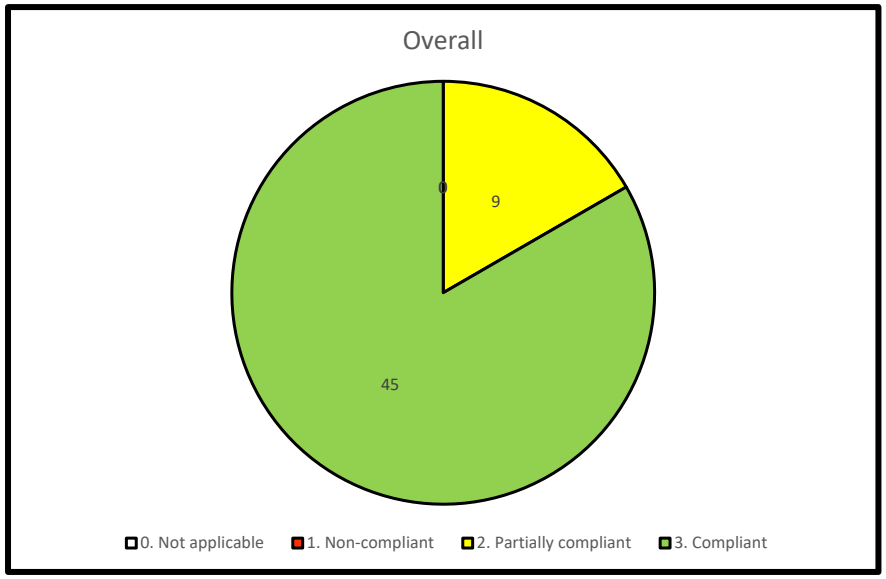
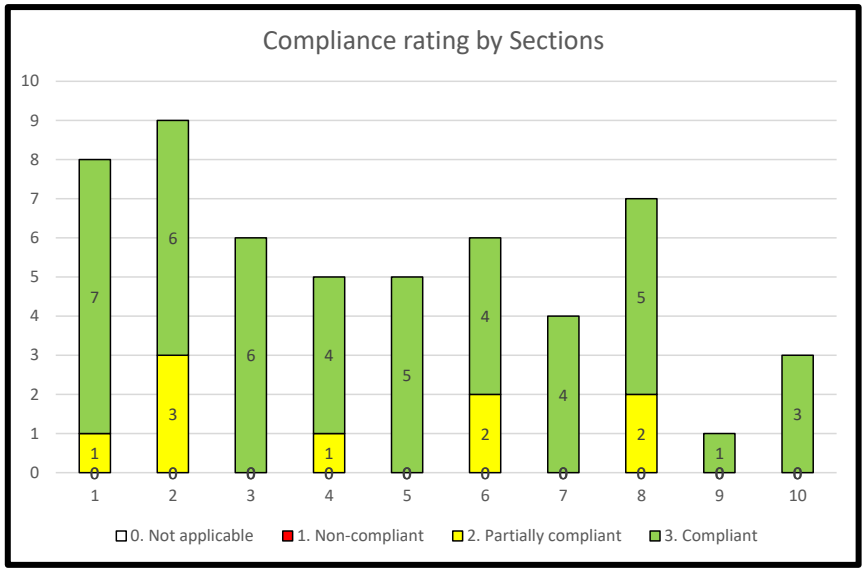

10. Have a system in place to manage the occupational health needs and obligations of staff in relation to infection
0
3
1. Non-compliant
2. Partially compliant
3. Compliant


Overall
0
9
45
0. Not applicable
1. Non-compliant
2. Partially compliant
3. Compliant


Compliance rating by Sections
10
9
8
7
6
5
4
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2
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0
1
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7
8
9
10
0. Not applicable
1. Non-compliant
2. Partially compliant
3. Compliant

NHS Salisbury NHS Foundation Trust

Report to:	Trust Board (Public)	Agenda item:	5.4
Date of meeting:	9th January 2025		

Report tile:	Q2 Risk Management Report			
Status:	Information	Discussion	Assurance	Approval
	Yes	Yes	Yes	Yes
Approval Process: (where has this paper been reviewed and approved):	Clinical Management Board (November) Clinical Governance Committee (December)			
Prepared by:	Louise Jones- Head of Risk Management			
Appendices (if necessary)				

Recommendation:

The report aims to provide an overview of risk management activity in Quarter 2.

Executive Summary:

Reporting of incidents has remained consistent throughout quarter 2. The overall average number of moderate harm incidents have gradually increased Of the 2776 incidents reported in Q2, 90 of these were moderate or above harm which is an average 3.24% of incidents compared with 3.08% of incidents in Q1 and 3.46% in Q4. This may be due to the daily morning incident huddle (implemented in Q2) which is closely monitoring the level of harm apportioned to an incident.

All patient safety incidents, where harm has occurred, continue to be reviewed through the weekly patient safety summit. In several cases, once a patient safety review is completed the incident is reclassified but this can take a number of weeks for this to be undertaken, meanwhile the incident remains recorded that harm has occurred which will affect the reported data of harm.

Duty of Candour compliance has reduced in quarter 2 despite the continued drive of education & awareness. In person support is being provided to areas to support with DoC going forward. In quarter 3 the Patient Safety Oversight Group (PSOG) will be commencing which will provide an opportunity to strengthen the quality of the patient safety reports with the aim that they will be shared sooner. There is also additional education being cascaded to support with the completion of PSRs by the Patient Safety Team. Trust Duty of Candour leaflet is being ratified

The team has been working on Datix system configuration to capture PSR 1 & 2 data –At current, this is a manual data analysis process to capture compliance against the KPIs.

The issues that the Trust experienced in Q1 relating to the Trusts organisational (ODN) codes, resulting in incidents not reaching the national Learning from Patient Safety Events (LFPSE) platform has occurred again nationally on 30th October resulting in all incidents reported during that time period requiring to be manually re-exported.

Team vacancy has impacted our processing of external incidents which has caused a backlog. This is currently being rectified.

RLDatix have retracted their service in assisting with upgrades – we have been working with I.T to ensure these are covered locally. Our next upgrade we are working towards with IT is due in December.

Matron Deep Dives has been implemented in Q2 to review all ward/ department level risks in Surgery and Medicine Divisions. This is facilitating standardisation across the Divisions in reviewing their ward/department risks. CSFS will be the focus for Q3. The Matron Deep Dives are providing an opportunity to enhance learning & education around risk registers.

Surgery pre mini deep dive		**Post mini deep dive**	
Number of open risks	161	Number of open risks	146
Open and mitigated with actions	43	Open and mitigated with actions	45
Open and mitigated without actions	45	Open and mitigated without actions	37
Tolerated	73	Tolerated	64
Closed in the last 3 months	13	Closed in the last 3 months	38
Escalated to Divisional Risk Register	2	Escalated to Divisional Risk Register	5

Medicine pre mini deep dive		**Medicine mini deep dive**	
Number of open risks	80	Number of open risks	81
Open and mitigated with actions	38	Open and mitigated with actions	44
Open and mitigated without actions	25	Open and mitigated without actions	20
Tolerated	17	Tolerated	17
Closed in the last 3 months	18	Closed in the last 3 months	15
Escalated to Divisional Risk Register	2	Escalated to Divisional Risk Register	0

As a consequence of a Datix system outage, the 6 monthly divisional deep dives have not been completed in Q2 but are being rescheduled.

Engagement in the Learning from Incidents forums is improving with multidisciplinary attendance being encouraged.

We have worked alongside Psychology to implement the means for capturing staff psychological harm in Datix incidents.

Work continues towards closing all the ongoing SII/CRs over the coming months. The current status of is as follows:

6 reports currently in progress 3 SIIs & 3 CR's (24 in Q1)

1 (CR 613) at CRG readership group (Maternity)
2 (SII 603 & CR 607) pending exit dates (Surgery and Medicine)

2 (SII 586 & CR 572) pending post exit changes (Maternity & Medicine)
1 (SII 574) report pending CEO sign off (Maternity)

Board Assurance Framework – Strategic Priorities	Select as applicable:
Population: Improving the health and well-being of the population we serve	Yes
Partnerships: Working through partnerships to transform and integrate our services	Yes
People: Supporting our People to make Salisbury NHS Foundation Trust the Best Place to work	No
Other (please describe):	N/a

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Risk Management Report

Salisbury NHS Foundation Trust

Quarter Two (July, August & September 2024)

Louise Jones

Overview

Salisbury NHS Foundation Trust

This report has been written by the Risk Management team for SFT to detail the current trust position in relation to the following:

Q2 Data

- Total Reported Incidents in Q2
- Total Q2 Incidents by Category
- Breakdown of Moderate incidents in Q2
- Outstanding Serious Incident Investigations (SII) and Clinical reviews (CR) in Q2
- Never Events
- SII/CR Action Compliance and Deep Dives
- Risk Registers
- Duty of Candour (DoC)

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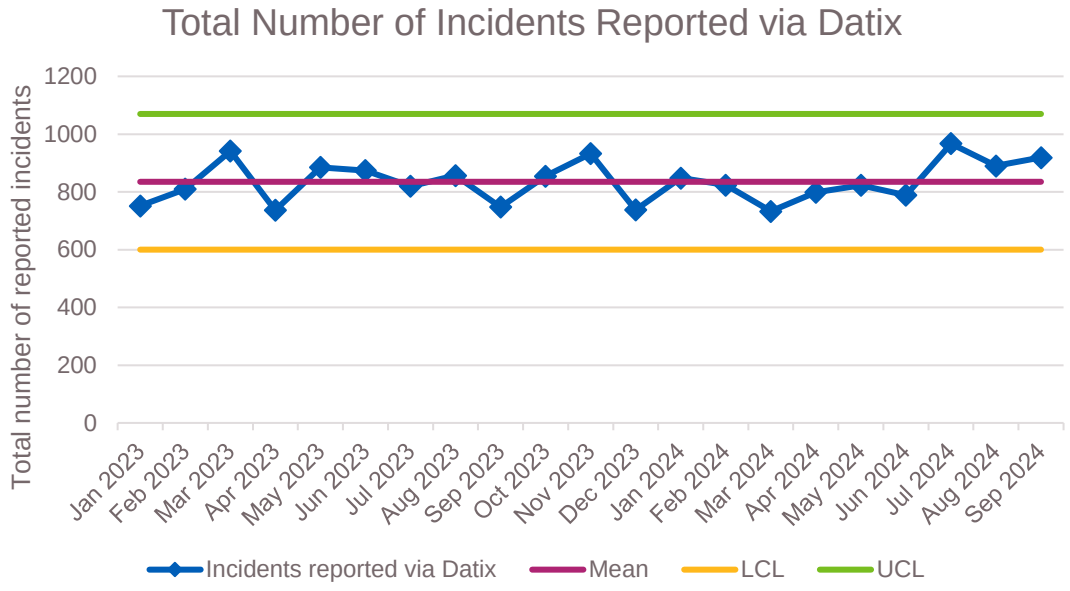
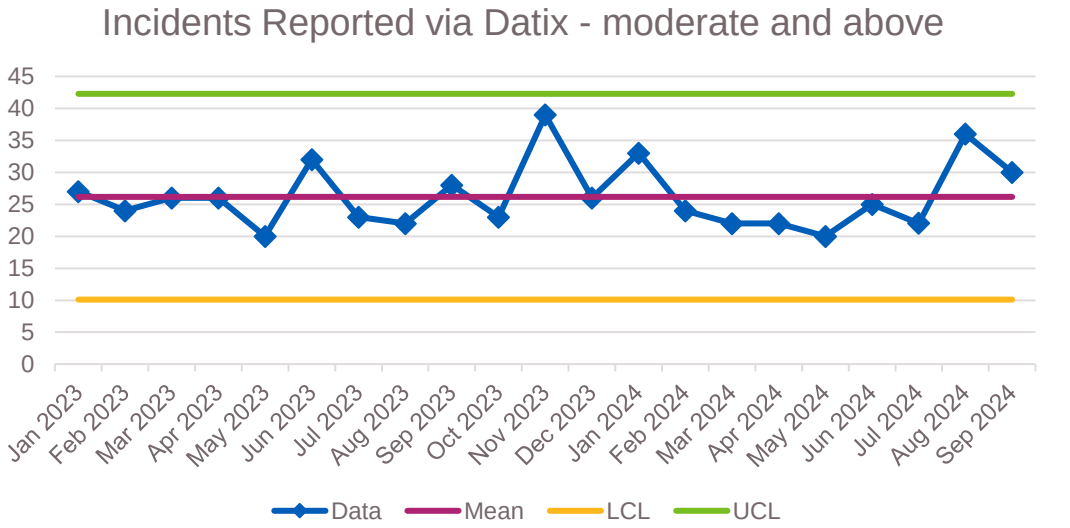
Annual Review of Incidents 2023 - 2024

Incident Reporting Overall Profile





Salisbury NHS Foundation Trust

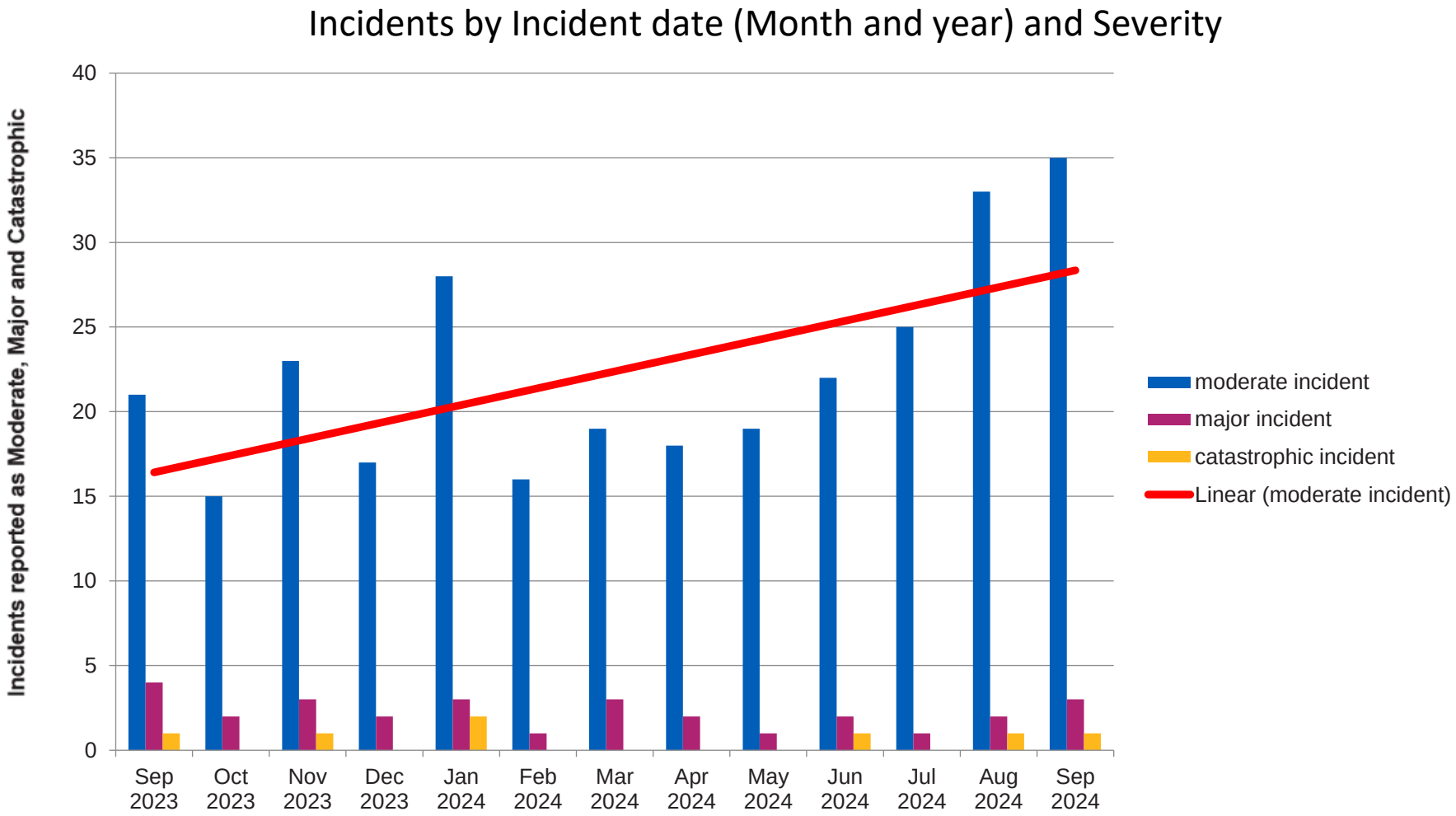
The SPC charts show that our reporting culture has remained consistent throughout the last financial year. The number of moderate incidents has increased over the last quarter which may be down to the additional vigilance at the morning incident huddle where the previous 24-hour incidents are reviewed and discussed. There has been an increase of incidents noted in Maternity, ED and in addition issues relating to discharge processes across some medical wards. These are being reviewed through Patient Safety Reviews and Thematic Analysis where themes have been identified. There were no other themes noted otherwise.

The issues that the Trust experienced in Q1 relating to the Trusts organisational (ODN) codes was rectified. There was a repeated (national) issue in Q2 with incidents not reaching the national Learning from Patient Safety Events (LFPSE) platform resulting in all incidents reported during that time period requiring to be manually re-exported.

There has been a rise in reporting across the organisation which continues to reflect a good reporting culture.

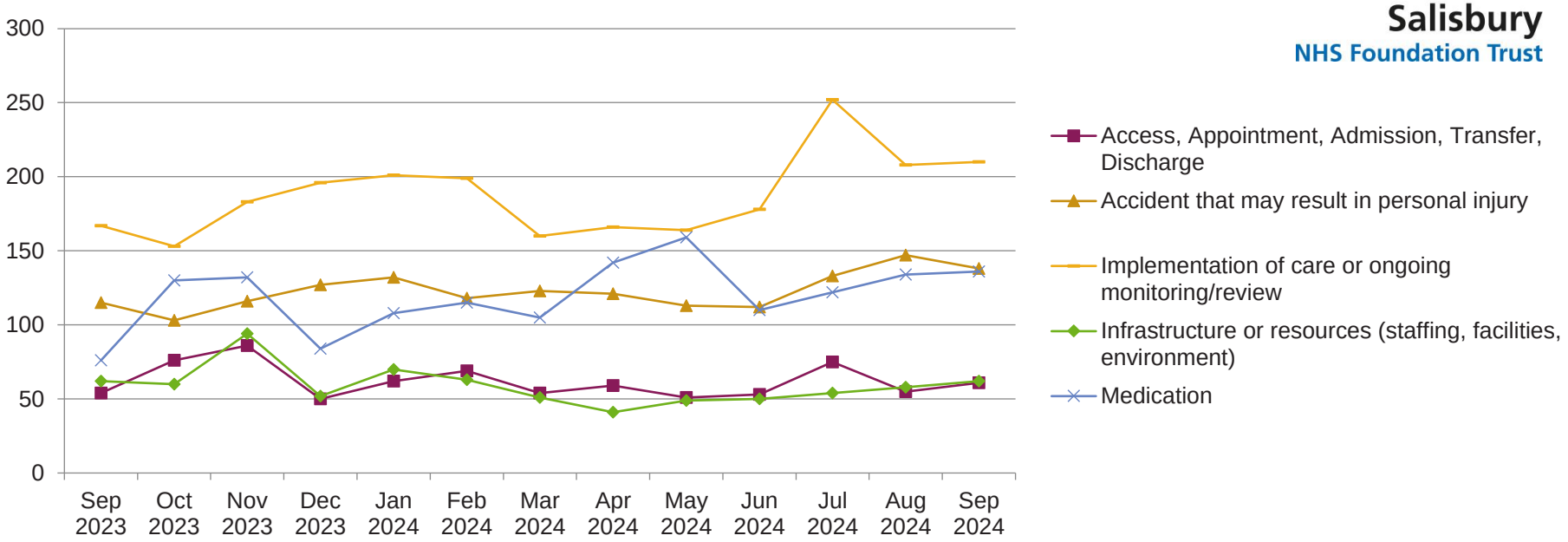
Total Annual moderate/Severe Incidents

Each moderate and above case is scrutinised through the weekly patient summit with executive oversight and agreement of further review, if necessary, in line with our PSIRF Policy and Plan. The overall average of moderate harm has increased over the last 12 months.



Total Annual Incidents by Category

Incidents by Reported (Month and year) and Stage of care



The above run chart demonstrates 13 months of reported incidents and will be further broken down to look at Q2 later in the report.

The highest reported incident type is ‘implementation of care or ongoing monitoring/review’, this includes all reported pressure ulcers.

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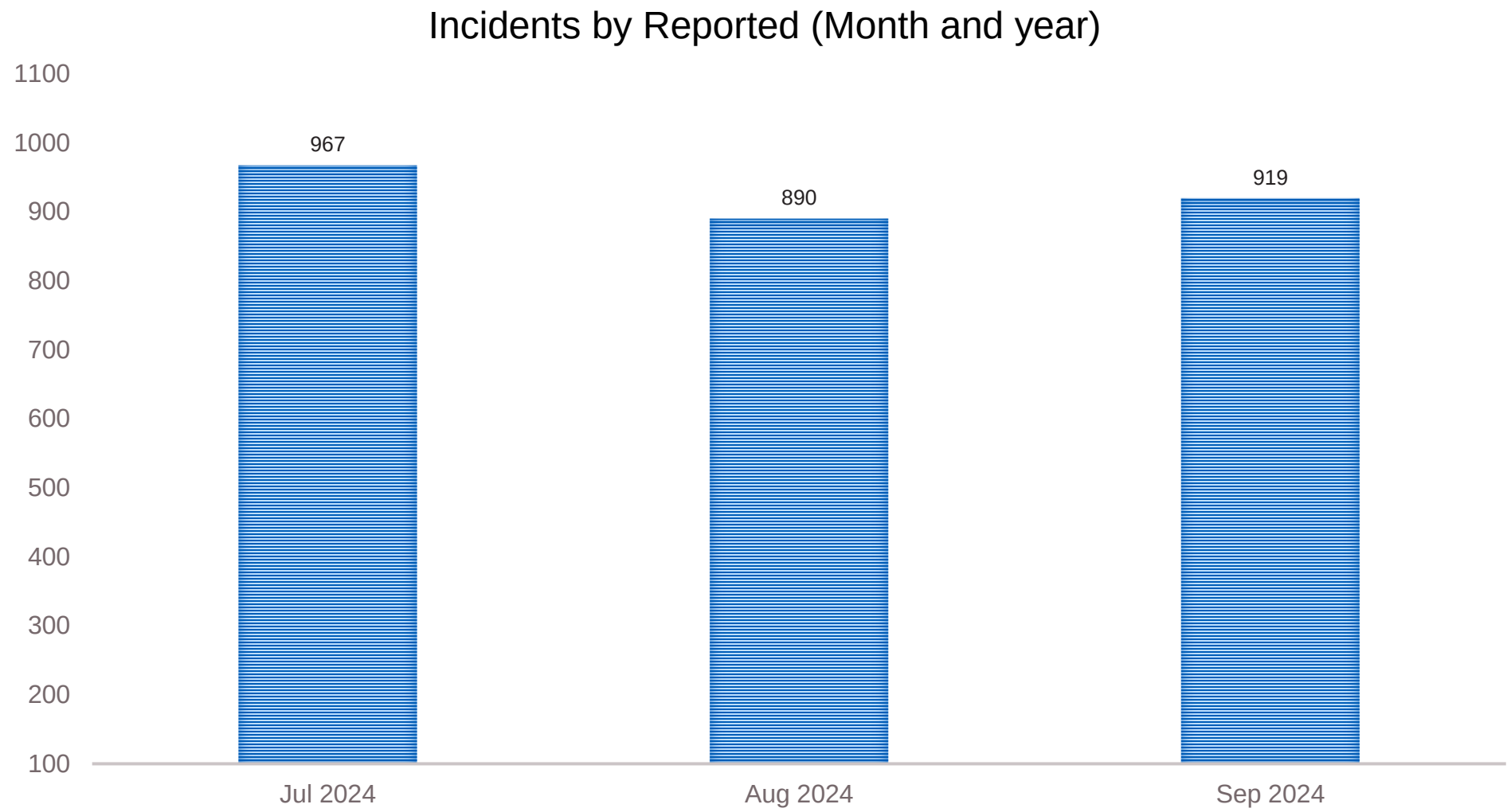
Quarter 2 Incidents (July, Aug, Sept 2024)

Total Reported Incidents in Q2

In Q2 there were a total of 2776 incidents reported, an increase of 346 incidents in comparison to Q1 where 2430 were reported, the below table breaks this down by month.

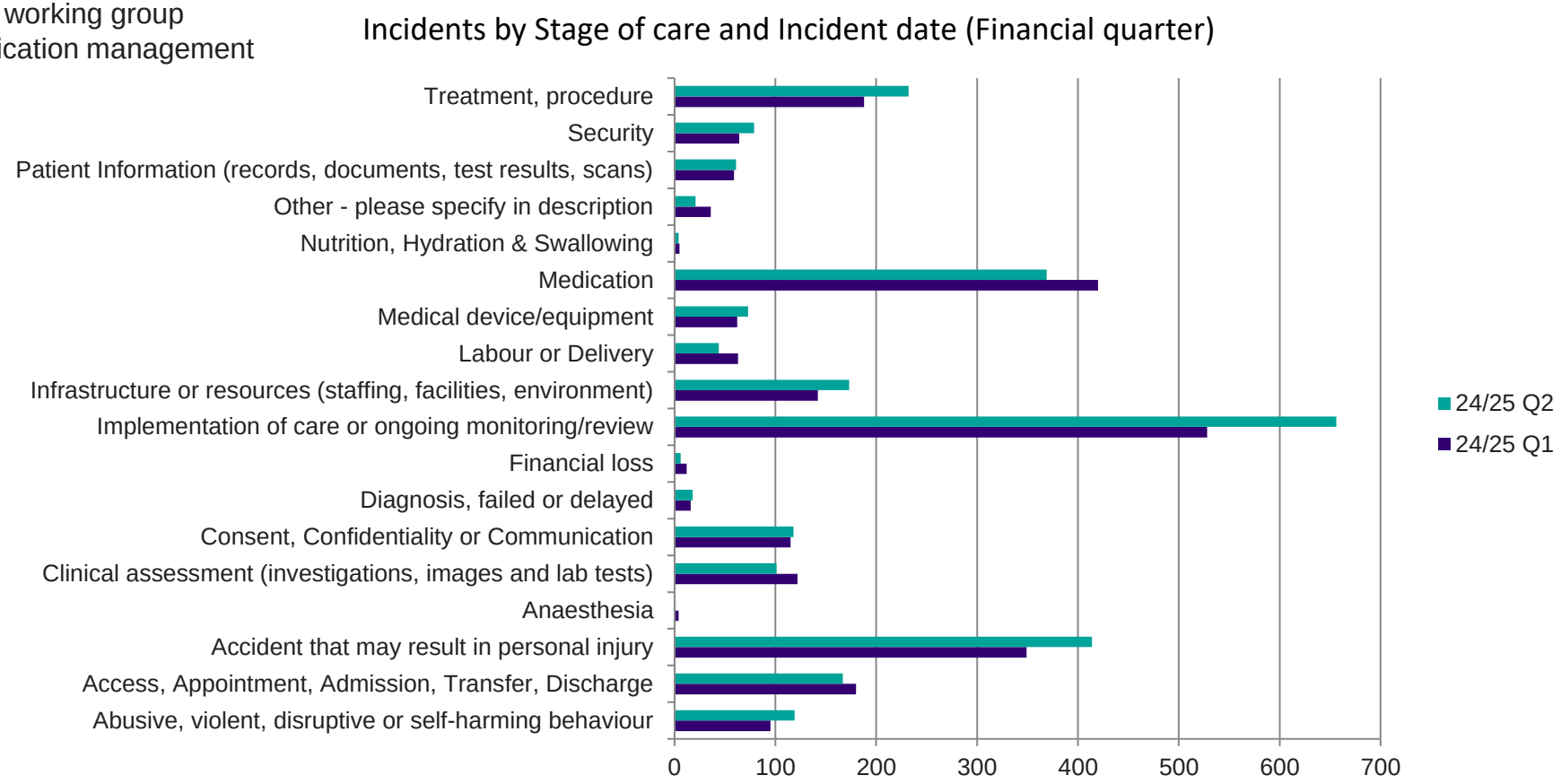


Total Q2 Incidents by Category

Similarly to the Annual picture, the highest reported incident type in Q2 is implementation of care or ongoing monitoring/review

There are several ongoing workstreams and breakthrough objectives that are in place to focus on the areas identified in the data, these include:

- Recognising the deteriorating patient (Breakthrough objective 24/25)
- Pressure damage reduction
- IPC working group
- Falls Working group
- VTE working group
- Medication management

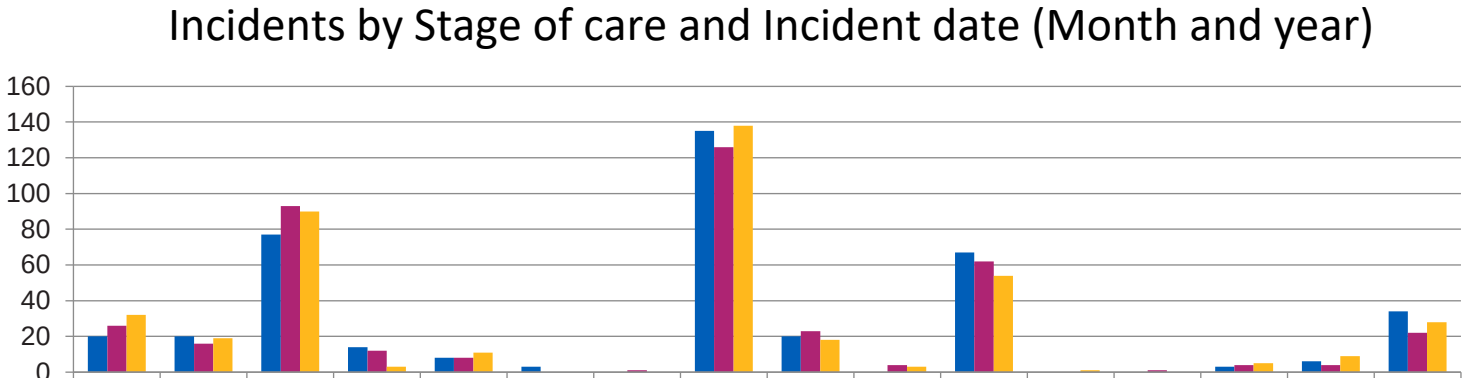


Breakdown of Q2 (July 24 – September 24)

Medicine Divisional Stage of Care

Salisbury NHS Foundation Trust

This chart shows incidents in the medicine division for Quarter 2.
In total 1220 incidents occurred in medicine during Q2.



	Abusive, violent, disruptive or self-harming behaviour	Access, Appointment, Admission, Transfer, Discharge	Accident that may result in personal injury	Clinical assessment (investigations, images and lab tests)	Consent, Confidentiality or Communication	Diagnosis, failed or delayed	Financial loss	Implementation of care or ongoing monitoring/review	Infrastructure or resources (staffing, facilities, environme…	Medical device/equipment	Medication	Nutrition, Hydration & Swallowing	Other - please specify in description	Patient Information (records, documents, test results,…	Security	Treatment, procedure
Jul 2024	20	20	77	14	8	3	0	135	20	0	67	0	0	3	6	34
Aug 2024	26	16	93	12	8	0	1	126	23	4	62	0	1	4	4	22
Sep 2024	32	19	90	3	11	0	0	138	18	3	54	1	0	5	9	28

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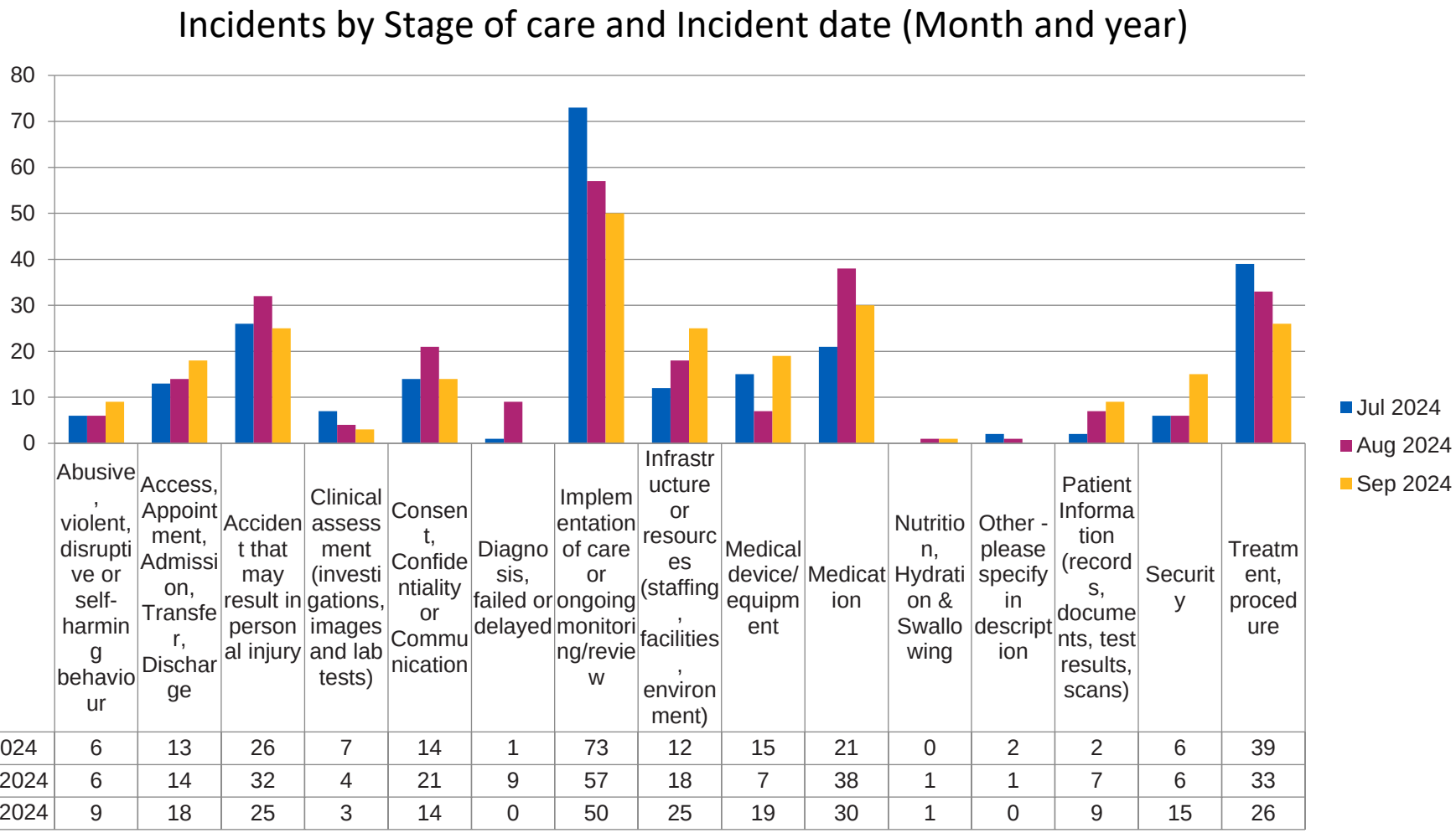
Breakdown of Q2 (July 24 – September 24)

Surgery Divisional Stage of care

This chart shows incidents in Surgery Division for Quarter 2.
In total 735 incidents occurred in Surgery during Q2.



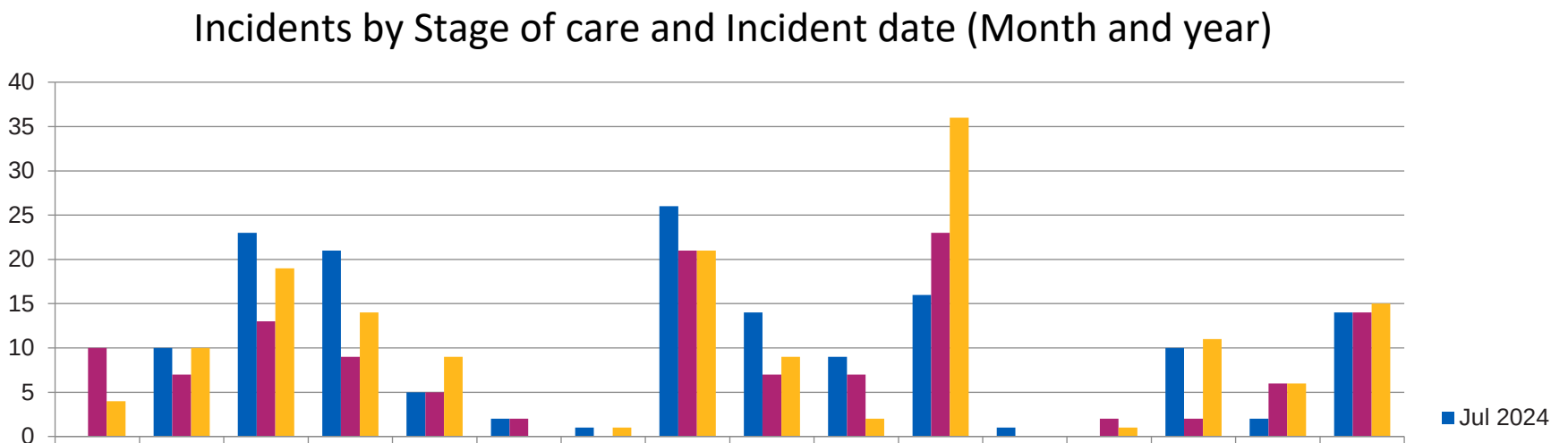
	Abusive, violent, disruptive or self-harming behaviour	Access, Appointment, Admission, Transfer, Discharge	Accident that may result in personal injury	Clinical assessment (investigations, images and lab tests)	Consent, Confidentiality or Communication	Diagnosis, failed or delayed	Implementation of care or ongoing monitoring/review	Infrastructure or resources (staffing, facilities, environment)	Medical device/ equipment	Medication	Nutrition, Hydration & Swallowing	Other - please specify in description	Patient Information (records, documents, test results, scans)	Security	Treatment, procedure
Jul 2024	6	13	26	7	14	1	73	12	15	21	0	2	2	6	39
Aug 2024	6	14	32	4	21	9	57	18	7	38	1	1	7	6	33
Sep 2024	9	18	25	3	14	0	50	25	19	30	1	0	9	15	26

Breakdown of Q2 (July 24 – September 24)

CSFS Divisional Stage of care

NHS Salisbury NHS Foundation Trust

This chart shows incidents in the CSFS division for Quarter 2.
In total 440 incidents occurred in CSFS during Q2.

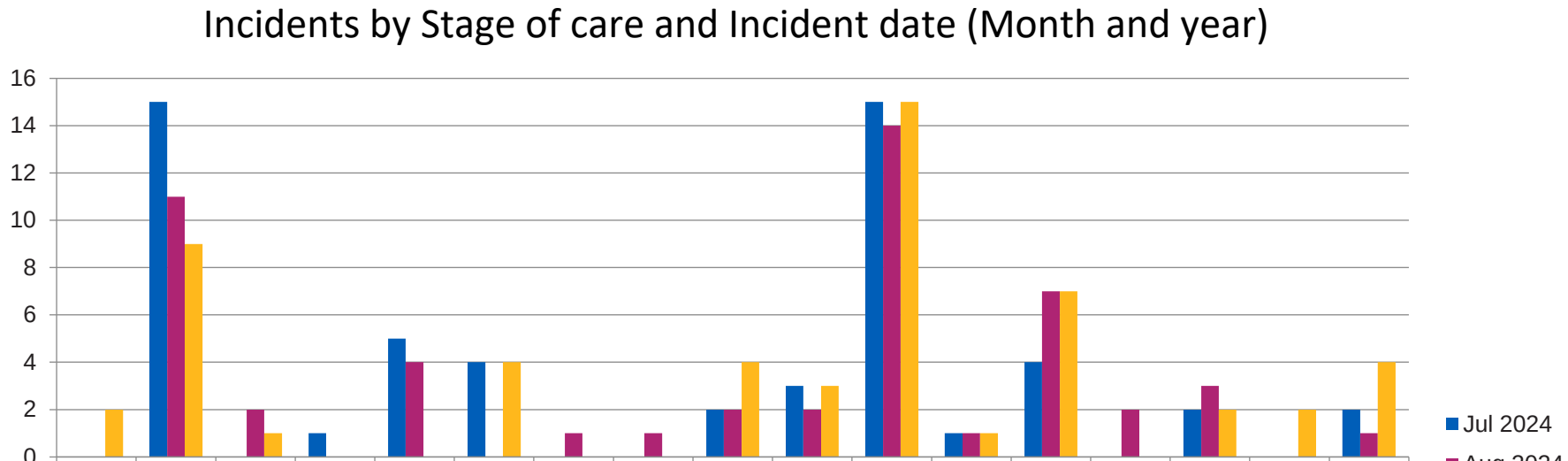


	Abusive, violent, disruptive or self-harming behaviour	Access, Appointment, Admission, Transfer, Discharge	Accident that may result in personal injury	Clinical assessment (investigations, images and lab tests)	Consent, Confidentiality or Communication	Diagnosis, failed or delayed	Financial loss	Implementation of care or ongoing monitoring/review	Infrastructure or resources (staffing, facilities, environment)	Medical device/ equipment	Medication	Nutrition, Hydration & Swallowing	Other - please specify in description	Patient Information (records, documents, test results, scans)	Security	Treatment, procedure
Jul 2024	0	10	23	21	5	2	1	26	14	9	16	1	0	10	2	14
Aug 2024	10	7	13	9	5	2	0	21	7	7	23	0	2	2	6	14
Sep 2024	4	10	19	14	9	0	1	21	9	2	36	0	1	11	6	15

Breakdown of Q2 (July 24 – September 24)

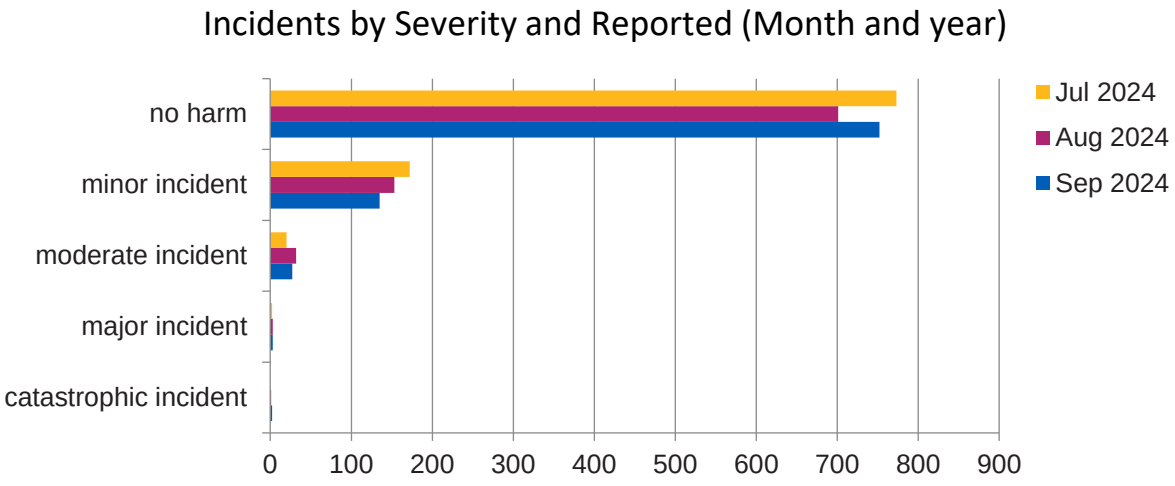
WNB Divisional Stage of care

This chart shows incidents in the women and new-born division for Quarter 2. In total 159 incidents occurred in CSFS during Q2.

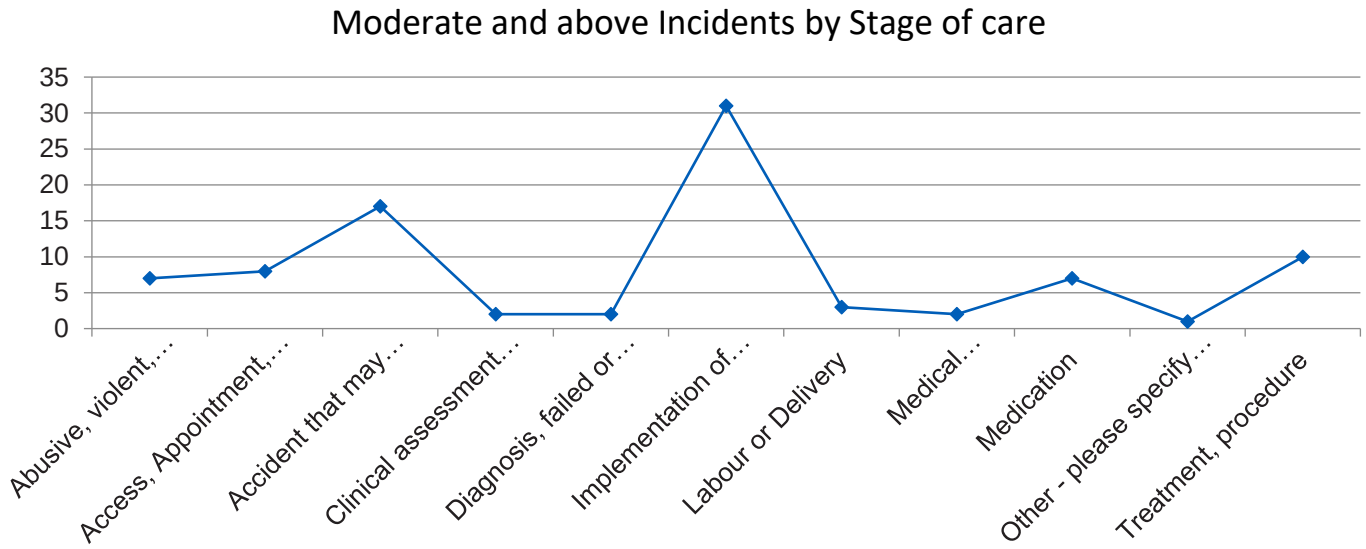


	Abusive, violent, disruptive or self-harming behaviour	Access, Appointment, Admission, Transfer, Discharge	Accident that may result in personal injury	Anaesthesia	Clinical assessment (investigations, images and lab tests)	Consent, Confidentiality or Communication	Diagnosis, failed or delayed	Financial loss	Implementation of care or ongoing monitoring/review	Infrastructure or resources (staffing, facilities, environment)	Labour or Delivery	Medical device/ equipment	Medication	Other - please specify in description	Patient Information (records, documents, test results, scans)	Security	Treatment, procedure
Jul 2024	0	15	0	1	5	4	0	0	2	3	15	1	4	0	2	0	2
Aug 2024	0	11	2	0	4	0	1	1	2	2	14	1	7	2	3	0	1
Sep 2024	2	9	1	0	0	4	0	0	4	3	15	1	7	0	2	2	4

Breakdown of Moderate and above incidents in Q2



Of the 2776 incidents reported in Q2, 90 of these were moderate or above harm which is an average 3.24% of incidents compared with 3.08% of incidents in Q1 and 3.46% in Q4. This will look slightly different to the IPR data as these figures include all reported incidents on Datix not just patient safety incidents.



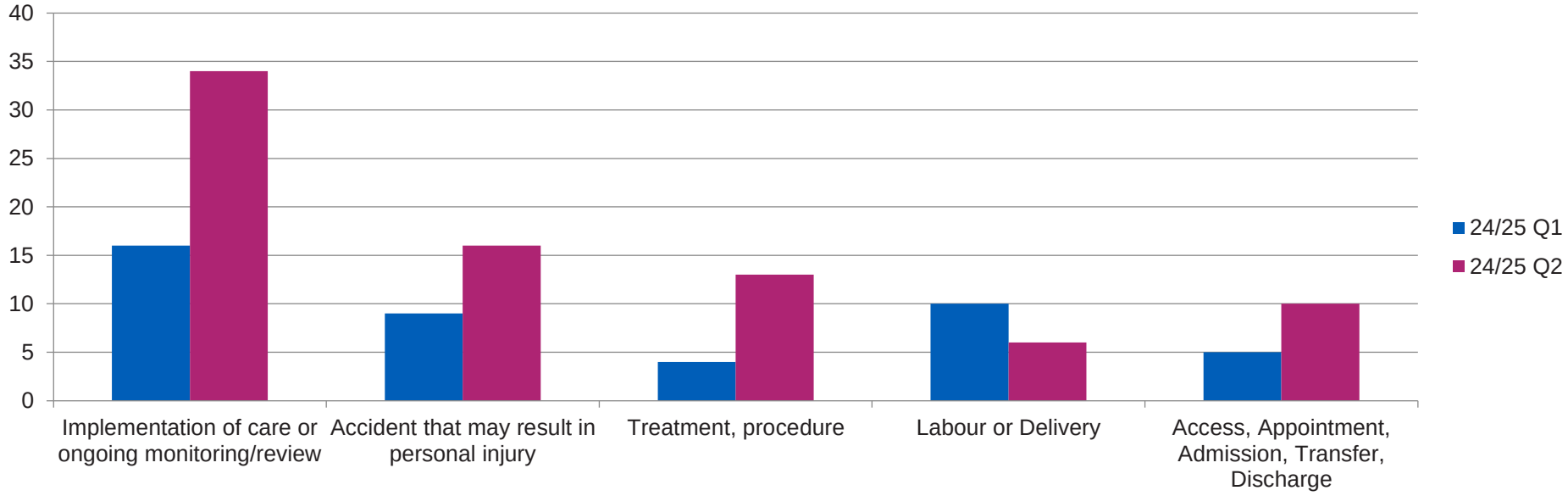
This separates the moderate and above incidents into categories, the next slide will break this down further.

Continued Breakdown of Moderate incidents in Q2

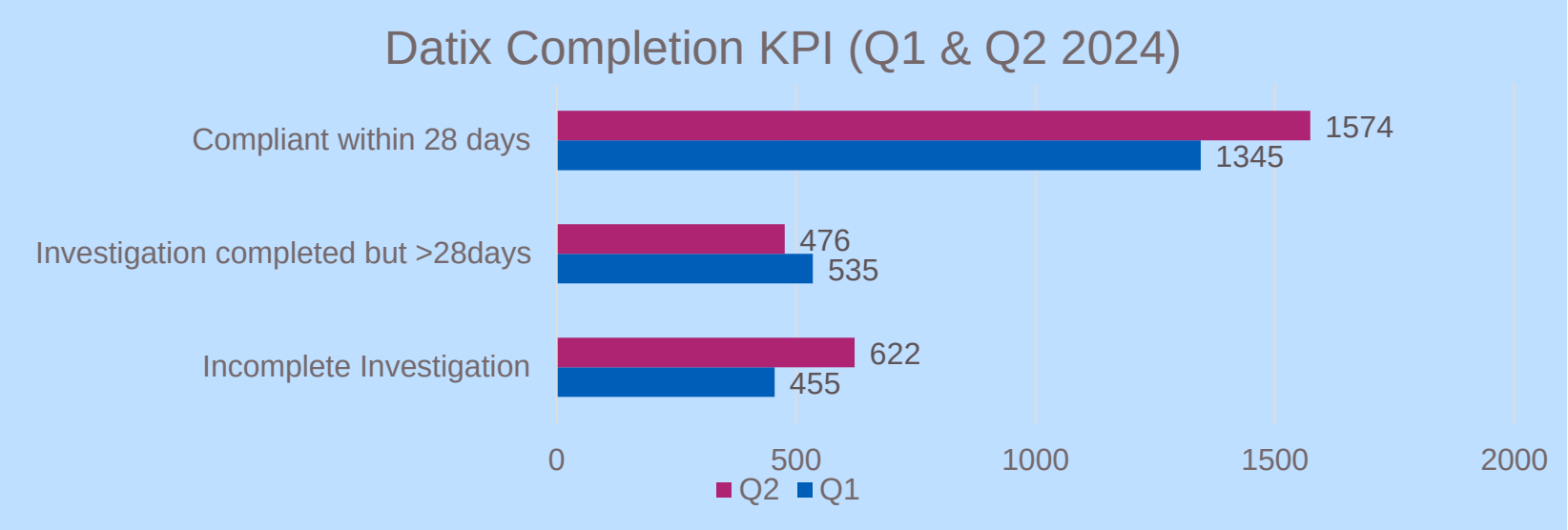
The highest reported moderate incident category is Implementation of care or ongoing monitoring, the graph below breaks this down into subtypes of the incident.

As previously reported in quarter 1 ‘Delay or failure to monitor’ is an area of focus for the Trust currently and is one of our breakthrough objectives.

Pressure ulcers continue to be a focus for the Trust (There are plans to change the categorisation of deep tissue injuries and ungradable pressure ulcers in quarter 3). As previously reported, it is important to note that these figures represent datix reporting and so if a patient moves around to different wards, each ward area would be expected to report any pressure ulcers during assessment so there may be multiple incidents in relation to the same pressure ulcer). TVN team keep a log of the reconciled data. Other themes in Medicine have been an increase in the number of mental health patients self-harming in ED , inconsistency in completion of mental health assessment in ED and delay in administering time critical medications in ED. Work is in place to address these themes.



Datix Completion KPI (Q2)



There were 2672 no/low harm incidents reported in Q2 compared to 2335 in Q1 - of these incidents 77% have had a completed Datix review (as opposed to the 81% in Q1) although the percentage is less, due to the increase in overall reported incidents in quarter 2 we have processed an additional 170 incidents in Q2 than Q1.

59% of the 2672 total low/no harm incidents were completed within the 28-day KPI (58% in Q1).

23% of the total incidents still require a Datix review, these are all currently classified as low/ no harm.

Serious Incident Investigations (SII) and Clinical reviews (CR) updates

Salisbury NHS Foundation Trust

In Q2- 3 PSIIs have commenced:

July PSII 7 – Wrong route medication (Never Event)
July PSII 8 – Discharge process (Local priority)
Sept PSII 9- Unexpected death (National priority)

Work continues towards closing all the ongoing SII/CRs over the coming months. The current status of is as follows:

6 reports currently in progress 3 SIIs & 3 CR's (24 in Q1)

- 1 **(CR 613)** at CRG readership group (Maternity)
- 2 **(SII 603 & CR 607)** pending exit dates (Surgery and Medicine)
- 2 **(SII 586 & CR 572)** pending post exit changes (Maternity & Medicine)
- 1 **(SII 574)** report pending CEO sign off (Maternity)

SII/CR Action Compliance and Deep Dives

As this table shows, there are currently 211 outstanding actions across the 4 clinical divisions.

Directorate	Open actions
CSFS	24
Medicine	97
Surgery	52
Women and Newborn	38

Whilst we continue to work towards closing the current SII/CRs, new actions are still being added as reports are approved and signed off. A piece of work is currently being undertaken to group actions together and where able, feed into existing workstreams to oversee, progress and align with the Trusts improvement work.

We are currently holding divisional deep dives which occur every 6 months,
the Divisional Management Teams, Executives and Risk Management attend to review their Risk Registers and compliance report with open and overdue actions.

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Risk Registers and Duty of Candour

Divisional and Service Level Risk Registers

NHS Salisbury NHS Foundation Trust

During Q2 The Risk Management team have implemented Matron Mini Deep dives for service /departmental level risks across the Trust. These are planned to run quarterly going forward. The aim is to standardise these meetings across the divisions so there is better awareness of new risks, risks that are increasing in score and risks that require closure.

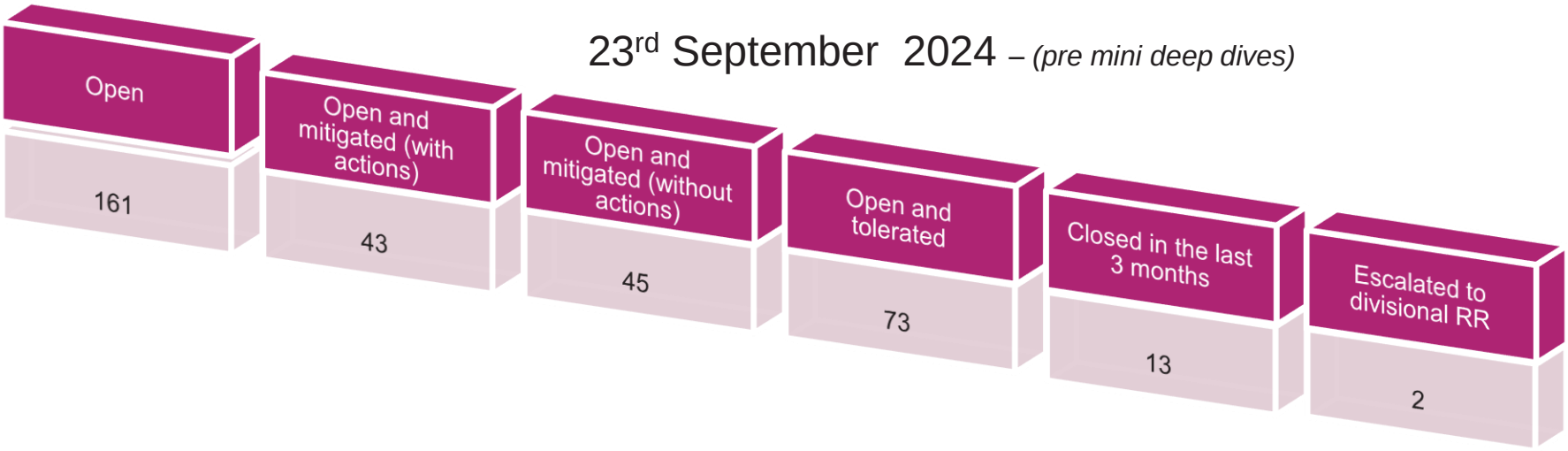
The following two slides show the improvement in the risk registers in the two divisions following the implementation of the mini deep dives in Medicine and Surgery to date.

There is work planned to focus on Clinical Support and Family Services next.

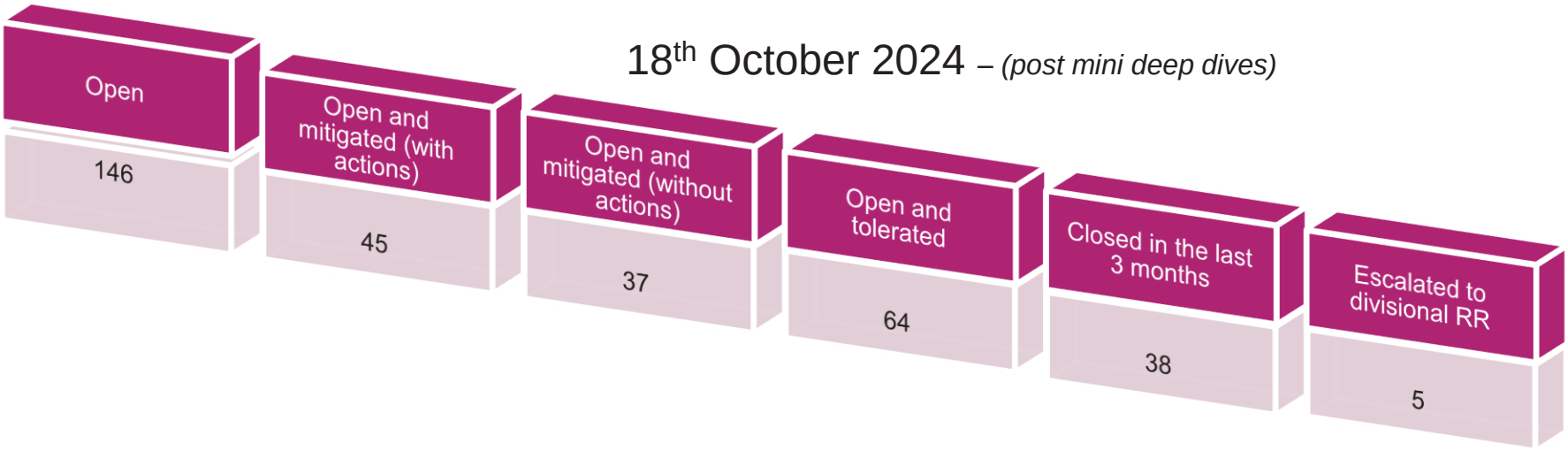
Surgery Local Risks

NHS Salisbury NHS Foundation Trust

23rd September 2024 – *(pre mini deep dives)*



18th October 2024 – *(post mini deep dives)*



Medicine Local Risks

NHS Salisbury NHS Foundation Trust

23rd September 2024 – *(pre mini deep dives)*

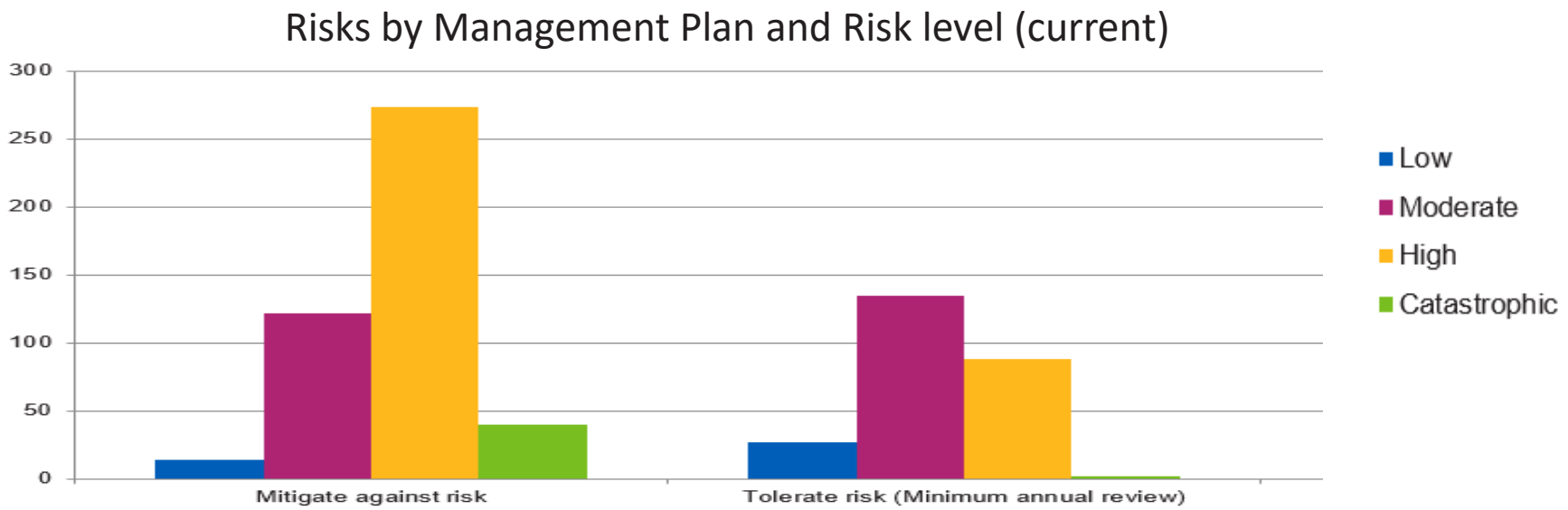
18th October 2024 – *(post mini deep dives)*

Trust wide Risk Registers

As of 18th October 2024, there are 704 open risks throughout the Trust compared with 767 in Q1, of these 250 (284 in Q1) are being tolerated while 447 (476 in Q1) are being mitigated.

Of the 447 mitigated risks, 132 of these still do not have actions, work continues to address this with the risk owners.

	Q1	Q2
New Risks	-	11
Closed Risks (Service Level)	86	96
Closed Risks (Divisional Level)	4	17



Duty of Candour (DoC) Part 1

Salisbury NHS Foundation Trust

Duty of candour is a three-stage process that requires an apology for any incident reported as moderate or above. This is broken down into the following stages:

Stage 1 – verbal apology

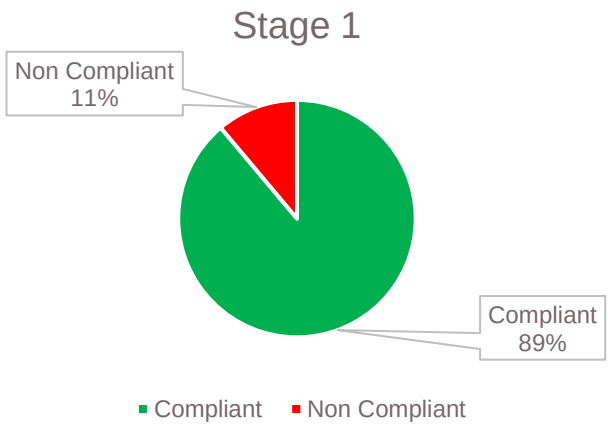
Stage 2 -following the verbal apology with a letter outlining what was said in the apology.

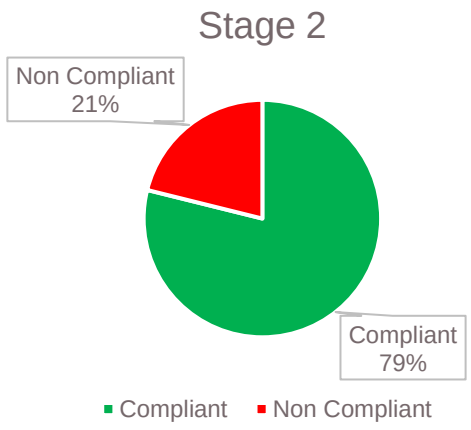
Stage 3- an opportunity to share the findings of the incident/review.

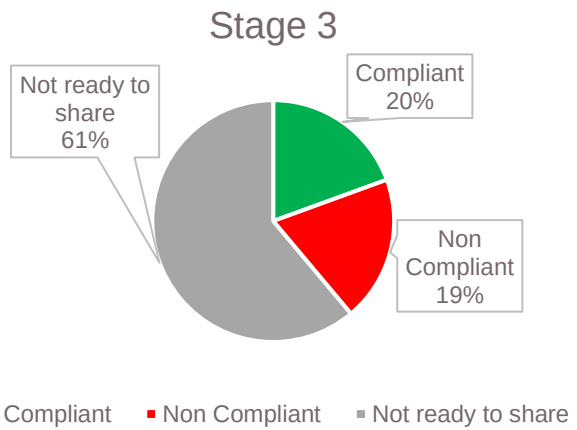
It is a requirement that the above is captured on our Datix system to evidence that stage 1, 2 and 3 has occurred as currently this is how the Trust compliance is reported.

All DoC is discussed at the weekly Patient Safety Summit to keep track of compliance. The charts below reflect compliance in all 3 of Duty of Candour stages.

Compliance has reduced in quarter 2 despite the continued drive of education & awareness. In quarter 3 the Patient Safety Oversight Group (PSOG) will be commencing which will provide an opportunity to strengthen the quality of the reports so they can be shared sooner. There is also additional education being cascaded to support with the completion of PSRs by the Patient Safety Team.







Duty of Candour (DoC) Part 2

Salisbury NHS Foundation Trust

Q1 (Apr-Jun 2024)		
	Compliance Percentage as of Q1 Report	Compliance Percentage Q1 as of Present
Stage 1 Compliance	95%	98%
Stage 2 Compliance	83%	94%
Stage 3 Compliance	79%	93%

Q2 (Jul-Sept 2024)		
	Compliance per cases	Compliance Percentage Q2 as of Present
Stage 1 Compliance	64/72	89%
Stage 2 Compliance	56/71	79%
Stage 3 Compliance	14/28 (64 not ready to share)	50%

In Conclusion…

Salisbury NHS Foundation Trust

- The team has been working on Datix system configuration to capture PSR 1 & 2 data –At current, this is a manual data analysis process to capture compliance against the KPIs.
- Team vacancy has impacted our processing of external incidents which has caused a backlog. This is currently being rectified.
- The daily incident huddle was implemented in Q2, there is excellent engagement with this. The scrutiny within this meeting means incident grading is being altered to reflect better understanding of the significance of actual harm to the patients.
- We have commenced ward follow ups to support with DoC.
- RLDatix have retracted their service in assisting with upgrades – we have been working with I.T to ensure these are covered locally. We are looking to upgrade in December.
- Of the 2776 incidents reported in Q2, 90 of these were moderate or above harm which is an average 3.24% of incidents compared with 3.08% of incidents in Q1 and 3.46% in Q4.
- Matron Deep Dives has been implemented to review all ward/ department level risks in Surgery and Medicine Divisions. This is facilitating standardisation across the Divisions in reviewing their ward/department risks. CSFS will be the focus for Q3. The Matron Deep Dives are providing an opportunity to enhance learning & education around risk registers.
- As a consequence of a Datix system outage, the 6 monthly divisional deep dives have not been completed in q2 but are being rescheduled.
- Engagement in the Learning from Incidents forums is improving with multidisciplinary attendance being encouraged.
- Themes and trends continue to be analysed and fed into the monthly divisional Learning From Incidents forum.
- We have worked alongside Psychology to implement the means for capturing staff psychological harm in Datix incidents.
- Trust Duty of Candour leaflet is being ratified.

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Appendices

Medicine Highest Rated Risks October 2024

The highest rated risks in the Medicine Division at 21/10/2024 are:

NHS Salisbury NHS Foundation Trust

ID	Title	Location (exact)	Rating (current)	Escalation status
7191	Risk of Lab closure/loss of activity due to a lack of Cath Lab trained Nurses.	Cardiac Suite	16	Local Management
7852	Ongoing risk of patient disease relapse whilst awaiting admission to UHS for transplant	Pembroke Ward	16	Local Management
5577	Ability of the Emergency Department to accommodate demand 24/7	Emergency Department	15	Divisional Governance Committee Risk Register
5875	Increased incidence of violence and aggression towards staff and patients leading to harm and detrimental impact on wellbeing	Medicine Directorate Management offices	15	Divisional Governance Committee Risk Register
6210	Failure to manage with financial budget	Directorate Wide	15	Divisional Governance Committee Risk Register
6211	Difficulty in providing adequate inpatient bed capacity due to GP/ED attendances and discharge delays	Directorate Wide	15	Divisional Governance Committee Risk Register
7935	Non escalation of NEWS 2 leading to increased numbers of deteriorating patients and harm	Medicine Directorate Management offices	15	Divisional Governance Committee Risk Register
7936	Patient experience and care delivery impacted for patients nursed in the ED corridor.	Emergency Department	15	Divisional Governance Committee Risk Register

Surgery Highest Rated Risks October 2024

The highest rated risk in the Surgery Division at 21/10/2024 is:

NHS Salisbury NHS Foundation Trust

ID	Title	Location (exact)	Rating (current)	Escalation status
5704	Gastroenterology Service Provision	Trustwide	20	Divisional Governance Committee Risk Register
6229	Risk of DSU - Estate Infrastructure failure	Day Surgery Unit	20	Divisional Governance Committee Risk Register
8102	Central Booking under recruited resulting in risk of patient harm and impact on theatre / clinic utilisation	Central Booking Office	20	Divisional Governance Committee Risk Register
7931	Lack of appropriate electrical power infrastructure in the theatres.	Main Theatres	16	Divisional Governance Committee Risk Register
7090	Insufficent diagnostic test/colonoscopy capacity across all 3 sites resulting in delay in seeing patients	Bowel Screening Service	16	Escalate to.....
6734	Overdue Opthalmology Follow Ups	Ophthalmology Outpatients	15	Divisional Governance Committee Risk Register
7096	Gastroenterology - Lack of resilience in the ERCP service.	GI Unit	15	Divisional Governance Committee Risk Register
7917	Fire risk in Main Theatres corridors	Main Theatres	15	Divisional Governance Committee Risk Register
8007	Spinal urology patients on routine elective waiting lists	Urology	15	Divisional Governance Committee Risk Register
8095	Post-nephrostomy insertion aftercare	Urology	15	Divisional Governance Committee Risk Register

CSFS Highest Rated Risks October 2024

The highest rated risks in CSFS Division at 21/10/2024 are:

NHS Salisbury NHS Foundation Trust

ID	Title	Location (exact)	Rating (current)	Escalation status
7893	Lloyds returning their outpatient contract	Pharmacy	16	Divisional Governance Committee Risk Register
8100	Reduced MLA staffing in Laboratory Medicine impacting on service delivery and staff wellbeing.	Laboratory Medicine	15	Divisional Governance Committee Risk Register
8169	Lack of pharmacy clinical service - impact on discharges, medicines reconciliation and emergency duty cover service	Pharmacy	15	Divisional Governance Committee Risk Register
8170	Lack of clinical pharmacy service at weekends	Pharmacy	15	Divisional Governance Committee Risk Register
8192	Delays in reporting referral laboratory results in Laboratory Medicine	Laboratory Medicine	15	Divisional Governance Committee Risk Register
7873	Risk that therapies budget is under WTE working and reduction will impact service provision.	All clinical areas	15	Divisional Governance Committee Risk Register
7879	Reduction in trained and experienced staff in Haematology and Blood Transfusion	Laboratory Medicine	15	Divisional Governance Committee Risk Register

W&NB Highest Rated Risks October 2024

The highest rated risks in Women and Newborn Division at 21/10/2024 are:

NHS Salisbury NHS Foundation Trust

ID	Title	Location (exact)	Rating (current)	Escalation status
7995	Embryology Staffing number	Fertility Centre	12	Local Management
7694	Lack of space in the Fertility Centre	Fertility Centre	12	Local Management
7357	Unable to meet 28 day faster cancer diagnosis	Gynaecology Outpatients	10	Local Management
7659	Poor uterine vision during a hysteroscopy due to aged flexiscopes	Gynaecology Outpatients	10	Local Management
7923	Neonatal unit heating	Neonatal Unit	10	Local Management

DOC guide (Lifted from DOC policy)

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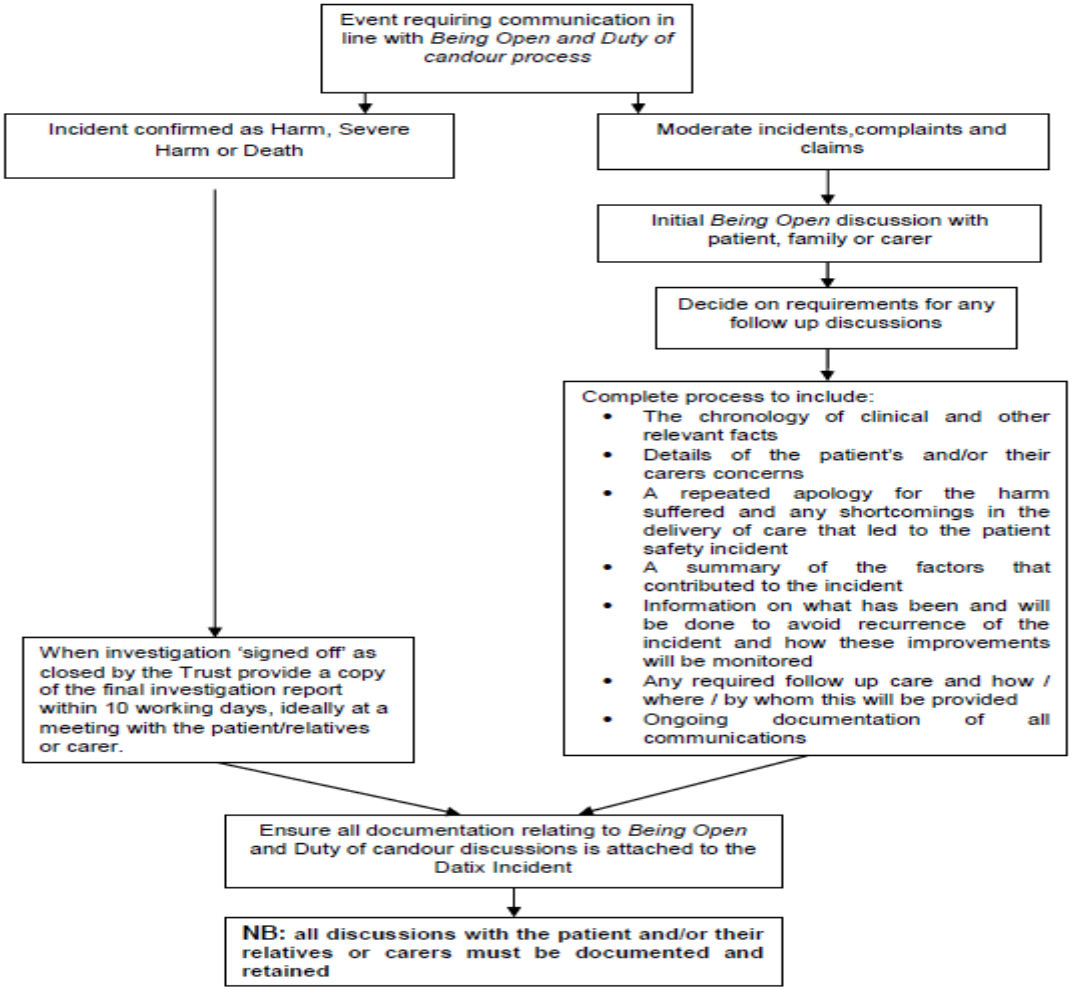

Report to:	Trust Board (Public)	Agenda item:	5.5
Date of meeting:	9th January 2025		

Report tile:	Perinatal Quality Surveillance - Salisbury NHSFT Maternity & Neonatal services –**November data 2024**			
Status:	Information	Discussion	Assurance	Approval
	x	x	x	
Approval Process: (where has this paper been reviewed and approved):	Divisional Governance 20.12.24			
Prepared by:	Vicki Marston –Director of Midwifery and Neonatal Services			
Executive Sponsor: (presenting)	Judy Dyos - Chief Nursing Officer			

Recommendation:

The Trust Board are asked to note the contents of the monthly Perinatal Quality Surveillance Report. This report is prepared to demonstrate assurance to the board on Maternity and Neonatal Quality and Safety issues as required by Maternity Incentive Scheme – year 6 – Safety Action 9.

As per CNST Maternity Incentive Scheme requirements this will be a monthly report to Trust Board and will require noting in minutes.

Executive Summary:

The Maternity Incentive Scheme (safety action 9) states an expectation that discussions regarding safety intelligence, including the number of incidents reported as serious harm, themes identified, and actions being taken to address any issues; staff and service user feedback; minimum staffing in maternity services and training compliance take place at Board level monthly. The perinatal Quality Surveillance Models sets out a model to report this and the information required is shared in the Perinatal Quality Surveillance report for SFT for November 2024.

The report comprises of a slide pack which has been designed collaboratively across the LMNS, ensuring that Trust Board at SFT, RUH and GWH are receiving the same metrics for review in each provider across BSW

Summary:

Staffing:

- Midwife to birth ratio improved 1:27–, however SFT recommended ratio 1:24
- 1:1 care in labour achieved 100% in November
- Supernumerary status of labour ward maintained 100% time.

- Fill rates across Midwifery, MCA and Neonatal nursing between 85- 99.7%

Incidences reported as moderate.

- 6 Incidences reported as moderate.
  - 3 x Term admission to Neonatal Unit. All in process of review at present.
  - 2 x Massive Obstetric Haemorrhage
  - 1x Readmission

PMRT

- No cases for review in October

Training

- Compliance for PROMPT, CTG and NLS training 90% for November 30th, 2024.

Service user and staff feedback

- Feedback received from varying sources including MNVP, safety champions, friends, and family survey and PALS
- Safety Champions meeting well attended and escalation taken for action by Exec and Non-exec safety champions, You said/We did boards updated monthly on wards.

National Guidance

- CNST compliance 9 out of 10 for 2023. MIS year 6 published in April 2024.
  - Submission to LMNS of progress with Saving Babies Lives Nov 24. Awaiting percentage compliance to be received in response.
- Ockenden
  - Total - 71 closed actions.
  - Current position O red, 17 amber (in progress)

Health Inequalities

- Listening Event for hard-to-reach communities, with support from MNVP and family nurse partnership this was held in November.
- Translation Services- Currently purchasing 10 ‘pocket talk devices’ to aid point of contact translation.

-

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

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Perinatal Quality Surveillance
December 2024 *(November Data)*

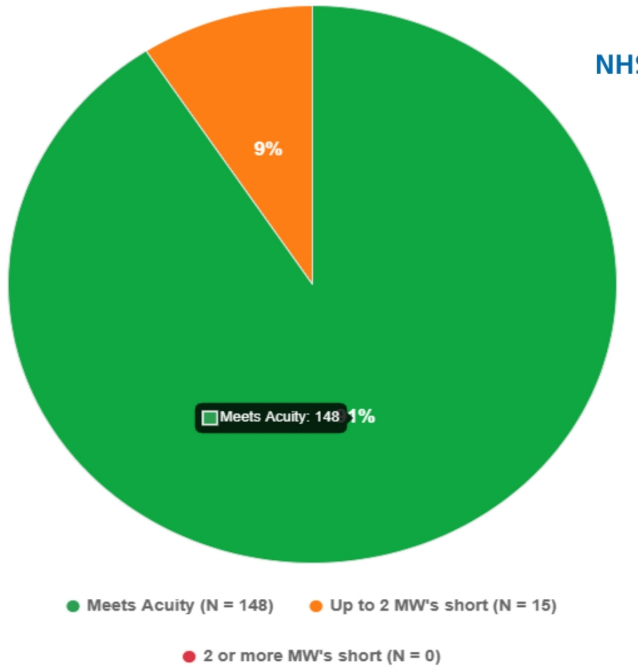
Maternity and Neonatal Unit

Salisbury Foundation Hospital

Safe: Maternity & Neonatal Workforce

	Target	Threshold		Aug '24	Sept '24	Oct '24	Nov '24	Comment
		Green	Red					
Midwife to birth ratio	1:24	1:24	>1:24	1:25	1.30	1:30	1:27	Ratio decreased this month due to decrease in expected births and acuity.
Compliance with supernumerary Status of LW Coordinator %	0	0	>1	100%	100%	100%	100%	
1:1 care not provided	0	0	>1	0	0	0	0	
Confidence factor in Birthrate+ recording	60%	>60%	<50%	84.97 %	83.3%	83.87 %	85.56 %	Percentage of possible episodes for which data was recorded.
Consultant presence on LW (hours/week)	40	40		40	40	40	40	
Neonatal shifts staffed to BAPM standards	100%	>90	<90	-	-	-	80%	Recruitment plan in place to support BAPM standards compliance
Daily multidisciplinary team ward round	90%	>90%	<80%	100%	100%	100%	100%	
Consultant non-attendance when clinically indicated (in line with RCOG guidance)	0	0	>1	0	0	0	0	

Acuity by RAG vs staffing data



NHS Salisbury NHS Foundation Trust

Is the standard of care being delivered?

- Supernumerary Labour Ward coordinator status achieved 100% time
- 1:1 care in labour achieved 100% of time

What are the top contributors for under/over-achievement?

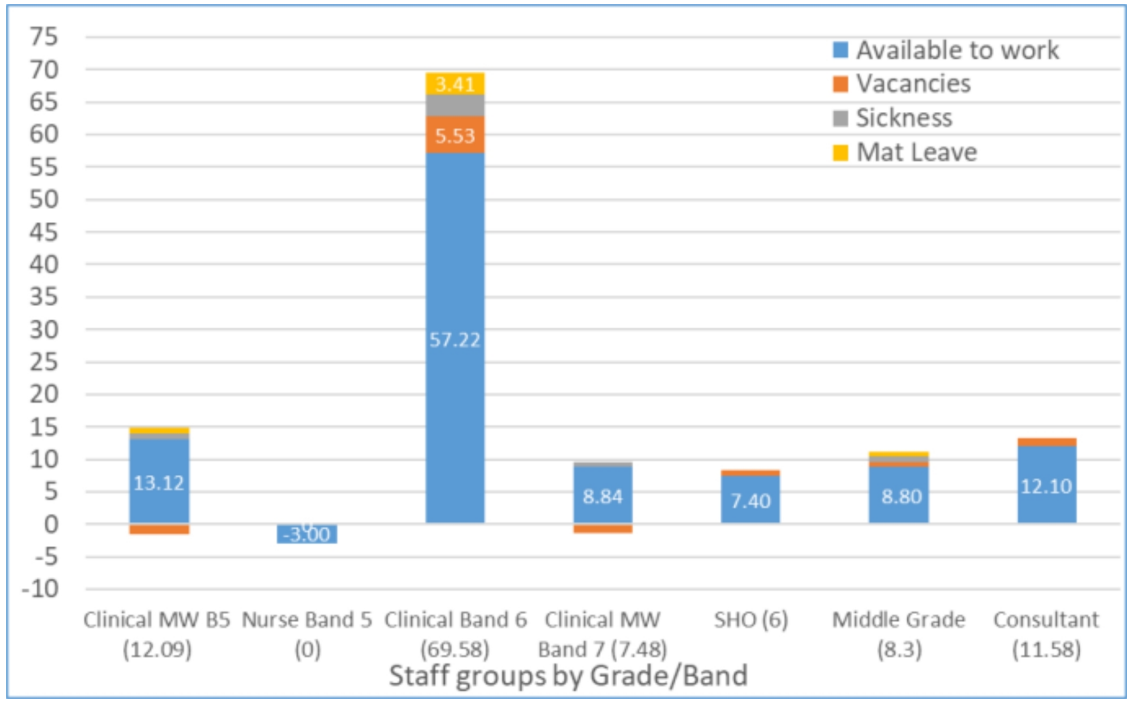
- The Midwife to Birth ratio decreased this month due to a decrease in expected births and acuity.
- A recruitment plan is in place to support an increase in NNU workforce to support BAPM standards.

Countermeasures / Action (completed last month)	Owner
NNU Nurse Band 6 recruitment	NNU Matron

Countermeasures / Action (planned this month)	Owner
NNU Nurse Band 5 recruitment	NNU Matron

Safe: Maternity & Neonatal Workforce (cont)

Table 1. Total WTE vacancy and availability to work - by role



Is the standard of care being delivered?

• Our staffing vs acuity ratio was very positive this month showing 91% of the time there were required staffing numbers for acuity

What are the top contributors for under/over-achievement?

• Available workforce numbers this month show a decrease due to significant numbers of both long and short term sickness.

• MCA fill rates have been affected by vacancy rate – successful recruitment undertaken in month to improve this..

Table 2. Average midwife/MCA/Neonatal nurse shift fill rates

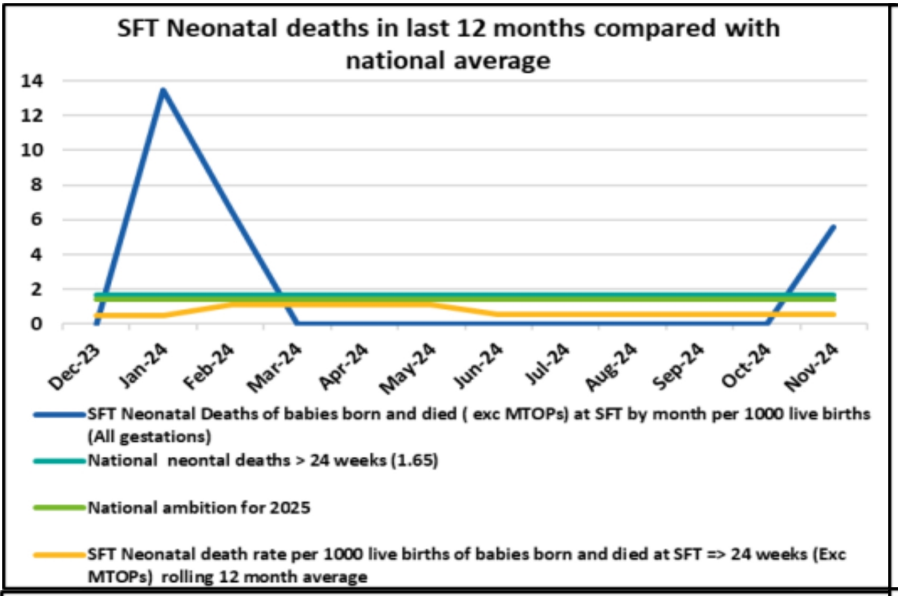
		Aug '24	Sept '24	Oct '24	Nov '24
Midwives	Day	97.3%	97.6%	93.95%	99.42%
	Night	99.5%	96.8%	96.50%	96.77%
MCA/MSWs	Day	94.6%	92.8%	92.61%	85.37%
	Night	92.5%	88.7%	91.84%	93%
NNU Nurses	Day	-	-	-	97.04%
NNU Nurses	Night	-	-	-	99.75%

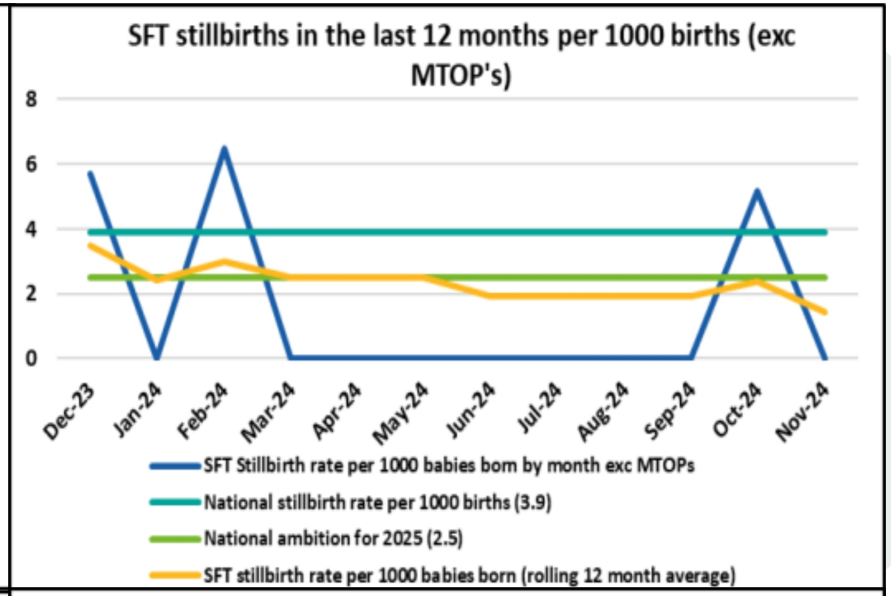
Countermeasures / Action (completed last month)	Owner
MCA recruitment	Workforce lead/HOM
NNU Band 6 recruitment	NNU Matron

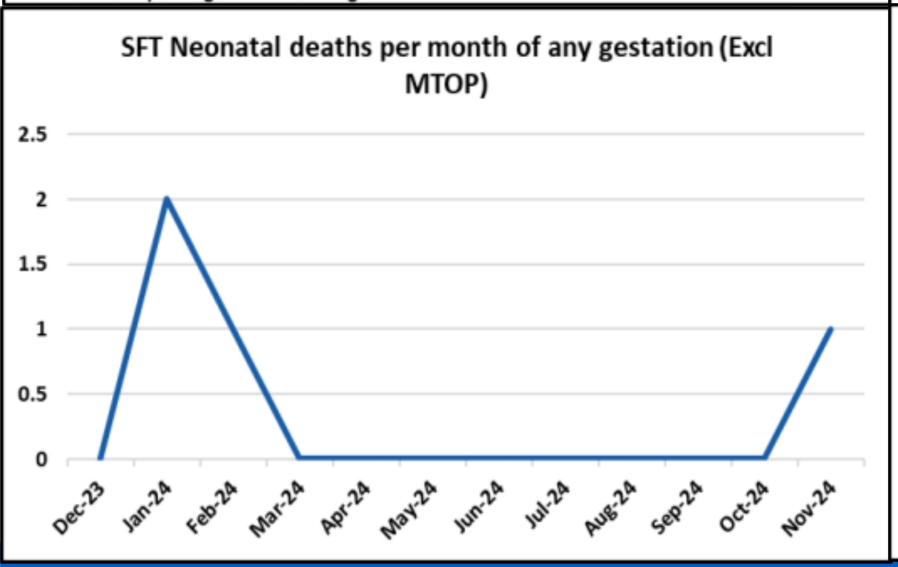
Countermeasures / Action (planned this month)	Owner
Further MCA recruitment	Workforce lead/HOM

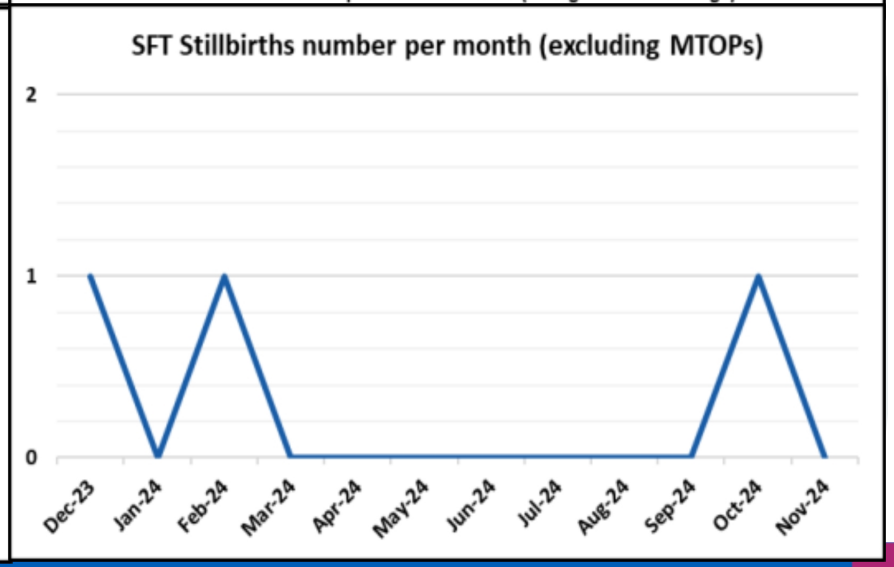
Safe: Perinatal Mortality Review Tool (PMRT)

Salisbury NHS Foundation Trust









- All perinatal deaths have been reported using the Perinatal Mortality Review Tool (PMRT). PMRT reporting is mandated by MIS Safety Action 1 for year 6. A quarterly update paper is shared with the board.
- Neonatal deaths of any gestation are a registerable birth and have been included in these numbers.
- Stillbirth rate is presented per 1000 births for national benchmarking, therefore the number presented on the graphs will not automatically correlate to direct numbers per month.
- There were 5 perinatal losses in November > 12 weeks-
- 3 MTOP <22 weeks for medical reasons
- 1 miscarriage < 22 weeks
- 1 Neonatal death at 21+6 weeks

PMRT Action Plans for Salisbury Foundation Trust – November 2024 review

PMRT case ID	Issue text		Action plan text	Person responsible	Target date
	There were no cases to review under PMRT in November.				

PMRT grading of care – Key

Salisbury NHS Foundation Trust

A - The review group concluded that there were no issues with care identified up the point that the baby was confirmed as having died
B - The review group identified care issues which they considered would have made no difference to the outcome for the baby
C - The review group identified care issues which they considered may have made a difference to the outcome for the baby
D - The review group identified care issues which they considered were likely to have made a difference to the outcome for the baby

A- The review group concluded that there were no issues with care identified for the mother following confirmation of the death of her baby
B - The review group identified care issues which they considered would have made no difference to the outcome for the mother
C - The review group identified care issues which they considered may have made a difference to the outcome for the mother
D - The review group identified care issues which they considered were likely to have made a difference to the outcome for the mother

Case Ref	Date	Category	Incident	Outcome/Learning/Actions	HSIB Reference	SI? Reference
				The were no cases ready for PMRT review in November		

INCIDENTS: Moderate Incidents and PSRs

NHS Salisbury NHS Foundation Trust

DATIX Incidents classified as moderate harm and above at month end

Case Ref (DATIX no)	Date of incident	Category	Incident Summary	Comments	Commissioned Y / N	MNSI ref no.?	PSII ref no.?
171036	10/11/24	Moderate	Unexpected Term Admission to NNU	Case currently being reviewed with potential for reclassification	**N**		
171165	14/11/24	Moderate	1.5L PPH	Case currently being reviewed with potential for reclassification	**N**		
171233	16/11/24	Moderate	Readmission	Case currently awaiting notes and review with potential reclassification	**N**		
171321	19/11/24	Moderate	Unexpected Term Admission to NNU	Case currently awaiting notes and review with potential reclassification and addition to rolling audit	**N**		
171656	29/11/24	Moderate	Unexpected Term Admission to NNU	Case currently awaiting notes and review with potential reclassification and addition to rolling audit	**N**		
171661	30/11/24	Moderate	1.5L PPH	Case currently awaiting notes and review with potential reclassification and addition to rolling audit	**N**		

INCIDENTS: Investigation update

NHS Salisbury NHS Foundation Trust

Ongoing Maternity & Neonatal Reviews

Case Ref (DATIX)	Date	Category	Incident	Outcome/Learning/Actions
CCR 613	19/11/2023	Moderate	Eclampsia	Amendments received from readership group. **Next steps**: Finalise report and draft action plan before sending to DMT, CRG and Exit (for approval).
PSII 162915	29/01/2024	Moderate	Preterm baby transferred to tertiary unit for cooling	Draft report received and awaiting final.
MNSI 163944	04/03/2024	Moderate	Baby transferred to tertiary unit for cooling	Final report received and awaiting a date for tripartite meeting. **Next steps:** Action plan to be drafted and sent to DMT, CRG readership panel and exit (for approval).

Responsive

NHS Salisbury NHS Foundation Trust

MNVP Service User feedback (November 2024)

Key achievements and feedback:

Positive Themes:
Great communication & support on NICU
Midwives were supportive, knowledgeable & Kind
Good community care from midwives, especially when they saw the same person
Great support in birth centre, facilitating a mothers 'dream birth'

Areas for Improvement:
No antenatal education offered.
Lack of compassion when something is 'wrong' during scans.
Communication around infant feeding support availability on PN ward

Suggested Next Steps:
Continue to explore options for in person antenatal classes.
More awareness for staff when infant feeding team are/aren't available to ensure correct information given to parents.

Safety Champions/ Staff Feedback

Items for escalation:

- Safety issue raised in respect to the episiotomy scissors. It has been reported that they are blunt and in need of sharpening. Additional meeting is to be scheduled to discuss this issue further.
- Staff report that Obstetric ward rounds are not always conducted on Beatrice Maternity Wards. Audit to be undertaken to establish if these are occurring regularly.
- During the open forum with community midwifery teams, concerns raised about mileage payments but no safety issues. Through discussion there was a clear variation in the amount of home visits being provided. Action: the team will be receiving improving together training in January and this provides an opportunity to drive out the variation that has developed in different areas of the patch.

Compliments and Complaints

1 complaint and no concerns logged in November 2024
19 compliments logged
6 SOX:
"Jess was my midwife for my labour. It was my first baby and I was very nervous. Jess was fantastic throughout the whole process. She was friendly and supportive and took the time to clearly explain what was happening at each stage and what my options were, along with the pros and cons of each. I felt she took the time to listen to me and addressed my specific concerns and queries. She advocated for me with other members of staff and was encouraging throughout, helping me to get through it and offering practical advice. My labour didn't go to plan, but despite this Jess made it a really positive experience. She is an absolute asset to the department, and I would like her to receive some recognition"

Friends and Family Test

Nov 2024 FFT

Our response rate remains consistent with the previous months results. However, we have seen an increase In the percentage of positive comments (4%).

Health Inequalities Priorities

NHS Salisbury NHS Foundation Trust

Listening events: One of our priorities is to hear the voices from hard-to-reach communities. Working in collaboration with the Family Nurse Practitioner (FNP) and the local MNVP, a listening event was held in November. Work is ongoing to explore the data.

Ongoing Projects: A working party has been appointed to explore the possibility of offering women face to face parent education classes. Work is ongoing to establish a pathway to enable all Hubs to offer in person education classes.

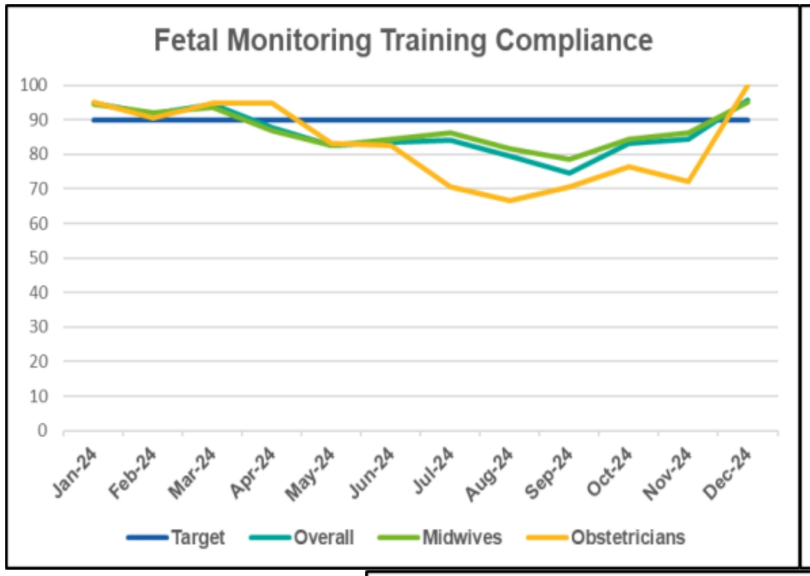
Equality Data: To maintain a standardised approach to data reporting across the BSW work continues to establish a health inequality dashboard. However, more locally we are starting to look at our local data around birth outcomes for women from the global majority groups, and ethnicity data from maternity services such as Bereavement, mental health, PSR/ PSIR, and pelvic health.

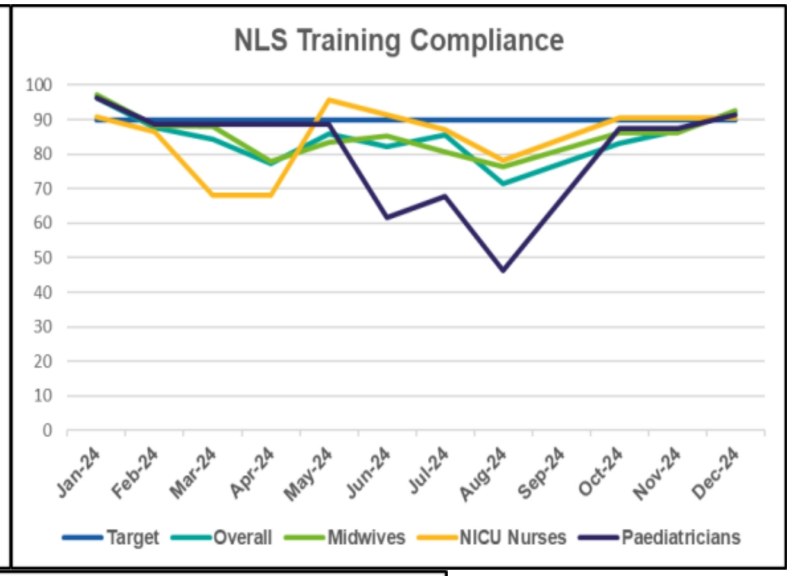
Translation service: As a Trust we are working towards the implementation of a translation tool bar to the Trust's website.

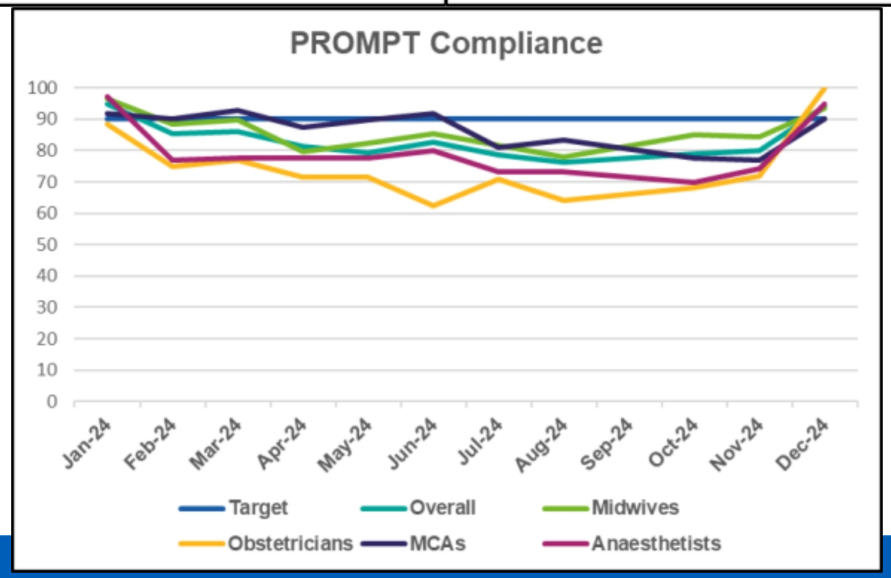
We continue to explore 'at the point of contact' translation services. We hope to purchase 10 'Pocketalk' translation devices (following positive feedback from trials undertaken in Nottingham and Southampton primary care).

Well-led Training

Salisbury NHS Foundation Trust







Training

Updated training plan commenced for 2024 to meet new Core Competency Framework Version 2 requirements, including training requirements for Saving Babies' Lives Care Bundle version 3.

Countermeasures/action:

- 90% training compliance requirements for CNST met for all 3 training elements in all staff groups (30/11/23 - 30/11/24).

Risks:

- Plan being created with MDT for 2025 to try and maintain compliance.

Compliance to National Guidance

Table 1. Ockenden 2022

OCKENDEN 2022		Immediate and Essential Action	Number of actions under each heading rated			
			RED	AMBER	AWAITING CLOSURE	GREEN
Nov-24	1	Workforce Planning and Sustainability	0	2	0	5
	2	Safe Staffing	0	0	0	10
	3	Escalation and Accountability	0	0	0	5
	4	Clinical Governance - Leadership	0	1	0	7
	5	Clinical Governance - Incident Investigation and Complaints	0	0	0	7
	6	Learning from Maternal Deaths	0	0	0	2
	7	Multidisciplinary Learning	0	0	0	7
	8	Complex Antenatal Care	0	3	0	2
	9	Preterm Birth	0	2	0	2
	10	Labour and Birth	0	1	0	5
	11	Obstetric Anaesthesia	0	1	0	6
	12	Postnatal Care	0	1	0	3
	13	Bereavement Care	0	2	0	2
	14	Neonatal Care	0	1	0	5
	15	Supporting Families	0	0	0	3
			0	14	0	71

Ockenden 2022

Key Achievements:

- 1 action closed in November.

Next steps for progression:

- Work progressing well, the remaining actions are more complex so it is taking longer to see formal closure.

Table 2. CNST Maternity Incentive Scheme – Year 6

NHSR Maternity Incentive Scheme- Year 6 - Position November 2024				
	Description	YR 6 Submission	Comment	Current Assessment
1	Perinatal Mortality Review Tool	Compliant	Compliant at present	
2	Maternity Services Data Set	Compliant	Compliant at present	
3	Transitional Care Services	Compliant	Compliant at present	
4	Workforce	Non-Compliant	Progressing	
5	Midwifery Workforce	Compliant	Compliant at present	
6	Saving Babies Lives Bundle Version 3	Non-Compliant	On track	
7	Patient Experience	Compliant	Compliant at present	
8	Training	compliant	Progressing	
9	Quality and Risk	Compliant	Compliant at present	
10	MNSI and EN	Compliant	Compliant at present	

NHS Salisbury NHS Foundation Trust

Maternity Incentive Scheme (CNST)

Key Achievements:

- Progress has continued in all areas with any challenges escalated swiftly for support at CNST meetings.
- Additional training dates have been added throughout October and November to increase compliance (SA8)
- It is anticipated that workforce trajectories will support full compliance (SA4)
- SBL is making good progress (SA6)

Next Steps :

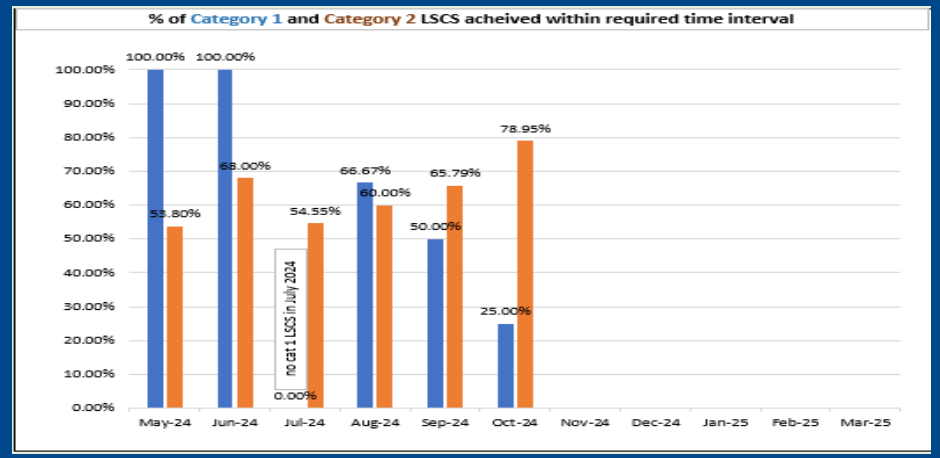
- Evidence to be submitted 30th November.

Themes
PSIRF ‘continuous audits’ & DATIX

Salisbury NHS Foundation Trust

Cat 2 caesarean section times

Results:

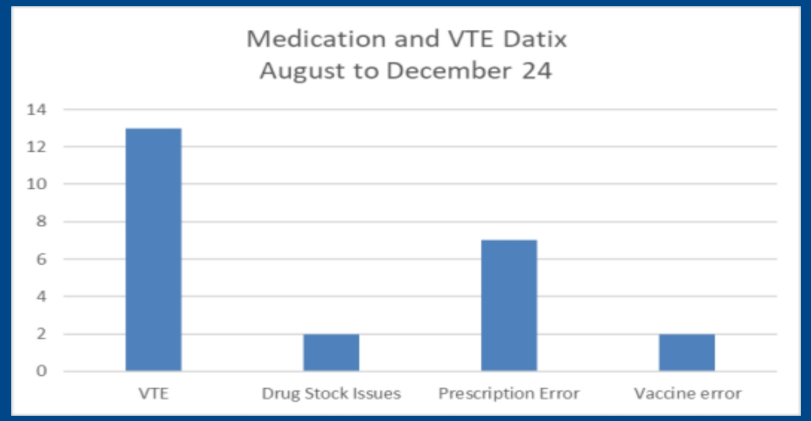


Learning and Actions:

- October 2024 – introduced group call bleep for Cat 2 LSCS replacing cascade bleeping.
- Continuing to audit monthly.
- Encourage midwifery, obstetric, anesthetic & theatre teams to provide detailed narrative of any delays which occur with timings.

Medication errors and VTE

Results:



Learning and Actions:

- Of the VTE assessments, 7 cases involved an incorrect risk assessment and prescription dose and / or duration.
- There is a focus group being organised to discuss how improvements can be made to VTE assessments.

Perinatal Culture & Leadership Programme

NHS Salisbury NHS Foundation Trust

Aims of the programme:

- To support Perinatal leadership teams to develop the conditions for a positive culture of safety and continuous improvement.
- To drive change with a better understanding of the relationship between leadership, safety improvement and safety culture.

Current position:

Following the initial support from a culture coach to the Quad in 2023, and several cultural conversations with staff took place in the early part of 2024. Since the quad have been working on:

- Completion of an action plan, using the themes and data from both the SCORE survey and follow-up cultural conversations
- A more recent staff questionnaire developed by the Quad around Culture & Leadership circulated and completed across September and October 2024
- Review of results and prioritisation of actions following on from survey has been developed and progress commenced.

Report to:	Trust Board (Public)	Agenda item:	5.6
Date of meeting:	9th January 2025		

Report tile:	Maternity Incentive Scheme (Year 6) - Safety Action 4 Trust Board Report			
Status:	Information	Discussion	Assurance	Approval
	x	x	x	
Approval Process: (where has this paper been reviewed and approved):	Women and Newborn Divisional Governance 20.12.2024			
Prepared by:	Hannah Boyd Divisional Director of Operations Women and Newborn Division			
Executive Sponsor: (presenting)	Judy Dyos Chief Nursing Officer			

Recommendation:

The Trust Board are asked to note the contents of the report which provides evidence and assurance that Salisbury NHS Foundation Trust are compliant with the NHS Resolution's Maternity Incentive Scheme (MIS), Clinical negligence Scheme for Trusts (CNST) Safety Action 4 – Workforce Planning.

It is recommended for the Board to formally record to the Trust Board minutes compliance with the following:

- Compliance to short term locum usage.
- Compliance to Long term locum guidance (RCOG).
- Compliance of consultant attendance for the clinical situations listed in the RCOG workforce document.
- Availability of Obstetric anaesthetic cover in line with ACSA standard 1.7.2.1
- Action plan to address lack of compliance to BAPM standards for Neonatal Medical workforce.
- Action plan to address lack of compliance to BAPM standards for Neonatal Nursing workforce.

Executive Summary:

Now in its sixth year of operation, the MIS continues to support safer maternity and perinatal care by driving compliance with ten Safety Actions, which support the national maternity ambition to reduce the number of stillbirths, neonatal and maternal deaths, and brain injuries from the 2010 rate by 50% before the end of 2025.

Safety Action 4 is demonstrating an effective system of clinical workforce planning to the required standard involving the following workforce groups:

- Obstetric medical workforce
- Anaesthetic medical workforce
- Neonatal Medical workforce
- Neonatal Nursing Workforce.

This report gives a summary of all measures in place to demonstrate an effective system of clinical workforce planning to the required standard and to provide evidence for the MIS Year 6 in line with the technical guidance.

Salisbury NHS Foundation Trust is compliant with the following standards:

- Short Term medical locum usage
- Long term medical locum usage
- Consultant attendance at RCOG specific clinical situations
- Obstetric anaesthetic cover in line with ACSA standard 1.7.2.1

Salisbury Foundation Trust is **not compliant** with the British Association of Perinatal Medicine (BAPM) standards for Medical or Nursing workforce. An action plan has been produced in line with the CNST technical guidance, in order to demonstrate ongoing work to address this non-compliance.

Business cases have been written and are under divisional review to address the gaps in neonatal medical and nursing workforce. In order to meet the BAPM standards, the neonatal service would require investment to support an additional 6.8wte Advanced Neonatal Nurse Practitioners (ANNP) and 0.4wte Band 5 Nurses. Although not compliant to the BAPM standards, Salisbury NHS Foundation Trust is able to declare compliance to the CNST MIS Safety Action 4 standard as action plans are in place (Page 10 of the report).

Safety action No. 4		
Can you demonstrate an effective system of clinical workforce planning to the required standard?		
From 2 April 2024 until 30 November 2024		
Requirements number	**Safety action requirements**	**Requirement met? (Yes/ No /Not applicable)**
a) Obstetric medical workforce		
1	Has the Trust ensured that the following criteria are met for employing short-term (2 weeks or less) locum doctors in Obstetrics and Gynaecology on tier 2 or 3 (middle grade) rotas following an audit of 6 months activity: Locum currently works in their unit on the tier 2 or 3 rota OR They have worked in their unit within the last 5 years on the tier 2 or 3 (middle grade) rota as a postgraduate doctor in training and remain in the training programme with satisfactory Annual review of Competency Progrssion (ARCP)? OR They hold a Royal College of Obstetrics and Gynaecology (RCOG) certificate of eligibility to undertake short-term locums?	Yes
2	Has the Trust implemented the RCOG guidance on engagement of long-term locums and provided assurance that they have evidence of compliance	Yes
3	Has the Trust monitored their compliance of consultant attendance for the clinical situations listed in the RCOG workforce document: 'Roles and responsibilities of the 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/ when a consultant is required to attend in person.	Yes
4	Were the episodes when attendance has not been possible reviewed at unit level as an opportunity for departmental learning with agreed strategies and action plans implemented to prevent further non-attendance.	Yes
Do you have evidence that the Trust position regarding question 3 & 4 has been shared:		
5	At Trust Board?	Yes
6	With Board level safety champions?	Yes
7	At LMNS meetings?	Yes
b) Anaesthetic medical workforce		
8	Is there evidence that the duty anaesthetist is immediately available for the obstetric unit 24 hours a day and they have clear lines of communication to the supervising anaesthetic consultant at all times? In order to declare compliance, 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. (Anaesthesia Clinical Services Accreditation (ACSA) standard 1.7.2.1) - Representative month rota acceptable.	Yes
c) Neonatal medical workforce		
9	Does the neonatal unit meet the British Association of Perinatal Medicine (BAPM) national standards of medical staffing? And is this formally recorded in Trust Board minutes?	No
10	If the requirements are not met, Trust Board should agree a workforce action plan and evidence progress against any workforce action plan developed previously to address deficiencies.	Yes
11	Was the above workforce action plan shared with the LMNS?	Yes
12	Was the above workforce action plan shared with the ODN?	Yes
d) Neonatal nursing workforce		
13	Does the neonatal unit meet the British Association of Perinatal Medicine (BAPM) national standards of nursing	No
14	If the requirements are not met, Trust Board should agree a workforce action plan and evidence progress against any workforce action plan developed previously to address deficiencies.	Yes
15	Was the above workforce action plan shared with the LMNS?	Yes
16	Was the above workforce action plan shared with the ODN?	Yes

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

Salisbury
NHS Foundation Trust

Maternity Incentive Scheme Clinical Negligence Scheme for Trusts (CNST) Year 6

Safety Action 4 Workforce Planning - Can you demonstrate an effective system of clinical workforce planning to the required standard?

1. Purpose

Now in its sixth year of operation, NHS Resolution's Maternity Incentive Scheme (MIS) continues to support safer maternity and perinatal care by driving compliance with ten Safety Actions, which support the national maternity ambition to reduce the number of stillbirths, neonatal and maternal deaths, and brain injuries from the 2010 rate by 50% before the end of 2025.

Safety Action 4 is demonstrating an effective system of clinical workforce planning to the required standard involving the following workforce groups:

- Obstetric medical workforce
- Anaesthetic medical workforce
- Neonatal Medical workforce
- Neonatal Nursing Workforce.

This report gives a summary of all measures in place to demonstrate an effective system of clinical workforce planning to the required standard and to provide evidence for the Maternity Incentive Scheme Year 6.

Required standard	**a) Obstetric medical workforce** 1) NHS Trusts/organisations should ensure that the following criteria are met for employing short-term (2 weeks or less) locum doctors in Obstetrics and Gynaecology on tier 2 or 3 (middle grade) rotas: a. currently work in their unit on the tier 2 or 3 rota or b. have worked in their unit within the last 5 years on the tier 2 or 3 (middle grade) rota as a postgraduate doctor in training and remain in the training programme with satisfactory Annual Review of Competency Progressions (ARCP) or c. hold a certificate of eligibility (CEL) to undertake short-term locums. 2) Trusts/organisations should implement the RCOG guidance on engagement of long-term locums and provide assurance that they have evidence of compliance to the Trust Board, Trust Board level safety champions and LMNS meetings. rcog-guidance-on-the-engagement-of-long-term-locums-in-mate.pdf

	3) Trusts/organisations should be working towards implementation of the RCOG guidance on compensatory rest where consultants and senior Speciality, Associate Specialist and Specialist (SAS) doctors are working as non-resident on-call out of hours and do not have sufficient rest to undertake their normal working duties the following day. While this will not be measured in Safety Action 4 this year, it remains important for services to develop action plans to address this guidance. rcog-guidance-on-compensatory-rest.pdf 4) Trusts/organisations should monitor their compliance of consultant attendance for the clinical situations listed in the RCOG workforce document: 'Roles and responsibilities of the consultant providing acute care in obstetrics and gynaecology' into their service roles-responsibilities-consultant-report.pdf 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 nonattendance.
	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. (Anaesthesia Clinical Services Accreditation (ACSA) standard 1.7.2.1)
	c) Neonatal medical workforce The neonatal unit meets the relevant BAPM national standards of medical staffing. or the standards are not met, but there is an action plan with progress against any previously developed action plans. Any action plans should be shared with the LMNS and Neonatal Operational Delivery Network (ODN).
	d) Neonatal nursing workforce The neonatal unit meets the BAPM neonatal nursing standards. or The standards are not met, but there is an action plan with progress against any previously developed action plans. Any action plans should be shared with the LMNS and Neonatal ODN.
Minimum evidential requirement for trust Board	**Obstetric medical workforce** 1) Trusts/organisations should audit their compliance via Medical Human Resources. Information on the CEL for short term locums is available here: www.rcog.org.uk/cel This page contains all the information about the CEL including a link to the guidance document: Guidance on the engagement of short-term locums in maternity care (rcog.org.uk) A publicly available list of those doctors who hold a certificate of eligibility of available at https://cel.rcog.org.uk 2) Trusts/organisations should use the monitoring/effectiveness tool contained within the guidance (p8) to audit their compliance. 3) Trusts/organisations should be working towards developing standard operating procedures, to assure Boards that consultants/senior SAS

	15 doctors working as non-resident on-call out of hours are not undertaking clinical duties following busy night on-calls disrupting sleep, without adequate rest. This is to ensure patient safety as fatigue and tiredness following a busy night on-call can affect performance and decision-making. Evidence of compliance could also be demonstrated by obtaining feedback from consultants and senior SAS doctors about their ability to take appropriate compensatory rest in such situations. NB. All 3 of the documents referenced are all hosted on the RCOG Safe Staffing Hub Safe staffing | RCOG 4) Trusts' positions with the requirement should be shared with the Trust Board, the Board-level safety champions as well as LMNS.
	Anaesthetic medical workforce The rota should be used to evidence compliance with ACSA standard 1.7.2.1. This can be a representative month of the rota.
	Neonatal medical workforce The Trust is required to formally record in Trust Board minutes whether it meets the relevant BAPM recommendations of the neonatal medical workforce. If the requirements are not met, Trust Board should agree an action plan and evidence progress against any action plan developed previously to address deficiencies. A copy of the action plan, outlining progress against each of the actions, should be submitted to the LMNS and Neonatal Operational Delivery Network (ODN).
	Neonatal nursing workforce The Trust is required to formally record to the Trust Board minutes compliance to BAPM Nurse staffing standards annually using the Neonatal Nursing Workforce Calculator (2020). For units that do not meet the standard, the Trust Board should agree an action plan and evidence progress against any action plan previously developed to address deficiencies. A copy of the action plan, outlining progress against each of the actions, should be submitted to the LMNS and Neonatal ODN.
What is the relevant time period?	From 2 April 2024 to 30 November 2024

A) Obstetric Medical Workforce

Short Term Locum usage

An audit of compliance was completed for the time period 1st February 2024 - 31st August 2024, in line with the technical guidance. The audit (found in appendix 1) demonstrated that during this period 74 short term locum shifts were required.
In total 7 Doctors completed these shifts, 4 of these Doctors were Salisbury NHS Foundation Trust employed Doctors and 3 of these not employed at Salisbury NHS Foundation Trust at the time of undertaking the shifts but were all working in their local unit (within the Wessex area) on their Tier 2 or 3 rota.

Salisbury NHS Foundation Trust is 100% compliant with the criteria described above.

The audit has been shared with Trust Board level safety champions and the LMNS.

Long term locum usage

During the time period 1st April 2024 – 30th September 2024 (Q1 and Q2) the trust utilised 4 long term middle grade locum doctors, the audit can be found in Appendix 2.

For all standards the trust is 100% compliant to RCOG guidance on engagement of long-term locums.

The audit has been shared with Trust Board level safety champions and the LMNS.

Compensatory Rest

Trusts/organisations should be working towards developing standard operating procedures, to assure Boards that consultants/senior SAS doctors working as non-resident on-call out of hours are not undertaking clinical duties following busy night on-calls disrupting sleep, without adequate rest.

This is to ensure patient safety, as fatigue and tiredness following a busy night on-call, can affect performance and decision-making. Evidence of compliance could also be demonstrated by obtaining feedback from consultants and senior SAS doctors about their ability to take appropriate compensatory rest in such situations.

The obstetric department has a Standard Operating Procedure (SOP) that was implemented as part of MIS Year 5 re compensatory rest and the team continues to discuss and review feedback from the medical teams on their ability to take the rest.

Compensatory rest is not being measured formally as part of MIS Year 6, but the service continues to work towards the guidance.

Roles and responsibilities of the consultant providing acute care in obstetrics and gynaecology.

The obstetric consultant team and maternity senior management team should acknowledge and commit to incorporating the principles outlined in the RCOG workforce document: *'Roles and responsibilities of the consultant providing acute care in obstetrics and gynaecology'* into their service.

Trusts should monitor their compliance of consultant attendance for the clinical situations listed in the RCOG document when a consultant is required to attend in person:

- In the event of high levels of activity e.g., a second theatre being opened, unit closure due to high levels of activity requiring obstetrician input.
- Any return to theatre for obstetrics or gynaecology
- Team debrief requested
- If requested to do so.
- Early warning score protocol or sepsis screening tool that suggests critical deterioration where HDU / ITU care is likely to become necessary.
- Caesarean birth for major placenta praevia / abnormally invasive placenta

- Caesarean birth for women with a BMI >50
- Caesarean birth <28/40
- Premature twins <30/40
- 4th Degree perineal tear repair
- Unexpected intrapartum stillbirth
- Eclampsia
- Maternal Collapse e.g., septic shock, massive abruption
- PPH 2L where the haemorrhage is continuing, and Massive Obstetric Haemorrhage protocol has been instigated.

For the period 1st April 2024 – 30th July 2024 there were 11 cases meeting the criteria above.

The audit (Appendix 3) demonstrates 90% compliance to the standard.

There was 1 case where the Consultant was not in attendance, however the case was discussed with the Consultant on-call at the time. The case was reviewed using the 72-hour review process and it was concluded that the non-attendance did not have any impact on the clinical case and it was managed appropriately from a clinical perspective. The medical teams are aware of the expectation of consultant attendance for future cases.

Continued audits for this element of Safety Action 4 continue monthly within the maternity and obstetric service.

The RCOG document also defines clinical situations in which the consultant must ATTEND, **unless** the most senior doctor present has documented evidence as being signed off as competent:

- Trial of instrumental birth
- EBL >1.5litres and ongoing bleeding
- Vaginal twin birth
- Caesarean birth for women with a BMI >40
- Caesarean birth for transverse lie
- Caesarean birth at full dilatation
- Caesarean birth at <32/40
- 3rd degree perineal tear repair
- Vaginal breech birth

In these situations, the senior doctor and the consultant should decide in advance if the consultant should be INFORMED prior to the senior doctor undertaking the procedure. Informing the Consultant of the clinical situations described above in all cases is trust guidance regardless of competency.

B) Anaesthetic staffing

For safety action 4 of the maternity incentive scheme, evidence must be provided to demonstrate that a duty anaesthetist is immediately available for the obstetric unit 24 hours a day. Where the duty anaesthetist has other responsibilities, they should be able to delegate care of their non-obstetric patients to be able to attend immediately to obstetric patients. (ACSA standard 1.7.2.1).

The Salisbury NHS Foundation Trust Anaesthetic department handbook states that:

Labour ward cover:
A dedicated consultant obstetric anaesthetist is available on bleep 1805 from 08.00 to around 18.00 from Monday to Friday.
Out of hours (from 18.00 - 08.00 and at all times over weekends) cover is by the second on-call SpR or by the first on call SHO, if the latter is sufficiently experienced. The anaesthetist covering obstetrics should carry bleep 1805 at all times. It is expected that the anaesthetist covering obstetrics should be able to delegate their non-obstetric workload, in order to attend labour ward promptly. If this is an issue this should be escalated to the general consultant on-call.

The following demonstrates 100% compliance with this standard by month and the rota can be found in Appendix 4 as required evidence.

Month	April 2024	May 2024	June 2024	July 2024	Aug 2024	Sept 2024	Oct 2024	Nov 2024
% compliance	100	100	100	100	100	100	100	100

C) Neonatal medical staffing

The British Association of Perinatal Medicine (BAPM) have listed requirements for the national standards of medical staffing in section 6.4 of BAPM Quality Service Standards. Salisbury is a Local Neonatal Unit (LNU) and therefore the standards for this type of unit are as described below:

6.4 Requirements for a Local Neonatal Unit (LNU) It is anticipated that teams at each tier will be made up from the following groups:

• Tier 1: Rotas should be EWTD compliant and have a minimum of 8 WTE staff who do not cover general paediatrics in addition.

• Tier 2: Shared rota with paediatrics as determined by a Trust or Health Board's annual NNU activity, comprising a minimum of 8 WTE staff.

• Tier 3: Consultants should have a CCT in paediatrics or CESR in paediatrics or an equivalent overseas neonatal or paediatric qualification and substantial exposure to tertiary neonatal practice at least the equivalent of neonatal SPIN. At least one LNU Tier 3 consultant should have either a CCT in neonatal medicine or neonatal SPIN module (if this was available during training). All consultants covering the service must demonstrate expertise in neonatal care (based on training, experience, CPD and on-going appraisal).

Salisbury Neonatal Medical Workforce

The Salisbury LNU does not meet the BAPM national standards of medical staffing.

The area of staffing for which Salisbury is **not compliant** is in the Tier 1 cover, which BAPM dictates should have a Tier 1 cover 24 hours a day, 7 days per week, *that does not cover both general paediatrics and the neonatal unit*. In Salisbury the Tier 1 medic is exclusively available 09.00-17.00hrs for the neonatal unit. After 17.00hrs the tier 1 medic covers both neonatal and general paediatrics.

The Salisbury paediatric staffing model is outlined below in Table 1.

Table 1.

Salisbury paediatric staffing model October 2024	
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)*
Tier 3	*Consultant cover*
Monday – Fri 09.00- 17.00	
Tier 1	*1 doctor on rota for NICU / Postnatal ward and Births*
Tier 2	*Joint cover for NICU / maternity and general paediatrics (minimum 1 doctor)*
Tier 3	*Resident Consultant*
Monday - Friday 17.00-21.00	
Tier 1	*1 doctor joint cover NICU and general paediatrics.*
Tier 2	*Joint cover for NICU / maternity and general paediatrics (minimum 1 doctor)*
Tier 3	*Resident Consultant*
Monday - Friday 21.00-09.00 and weekends 24 /7	
Tier 1	*1 doctor covering NICU and general paediatrics.*
Tier 2	*resident on call consultant or registrar shared with Paediatrics*
Tier 3	*Consultant on call*

Based on mitigating factors, the Trust Board has previously accepted that the neonatal unit is staffed safely with our current staffing structure described above.

To meet the current standard, the neonatal unit would require a minimum of 8 WTE staff who are exclusively working in the neonatal unit 24 hours a day.

<u>Current Mitigating Factors</u>

To date, the mitigating factors for non-compliance with BAPM standard for medical staffing have been:

1. There have been no clinical incidences, datix events or concerns regarding non-availability of a Tier 1 doctor for the neonatal unit, due to them covering neonates and paediatrics at the same time.
2. If there is a clinical concern with a baby, then the most useful and safest clinical approach is to have early on-site consultant involvement in the baby's care. Due to the working rota of the paediatric consultants (including resident nights at middle grade level), there is a resident paediatric consultant immediately available within the hospital

for approximately 80% of the total 168 hours of the week. This is a greater proportion of resident consultant availability throughout the entirety of the week (including nights and weekends) than any regional NICU has within their rota'd hours.
3. There is a unit culture of early escalation to middle grade/ consultant for neonatal issues aligned to the size of our LNU and paediatric unit.
4. General Paediatric /NICU / maternity areas are in close geographical proximity.
5. NICU nurses undertake some extended roles including attending preterm or complex births with the medical team, taking bloods and siting IV cannulas.

An action plan in Year 5 of the MIS was created, with the action to write a Business Case to increase the medical cover to the Neonatal Unit to reach BAPM standards. The Business case has been written and is currently under divisional review, following which it will progress to Trust board for consideration and approval. The request is to increase the medical workforce by 6.8wte Advanced Neonatal Practitioners. The Action plan for MIS Year 6 can be found on 10.

This report and action plan has been shared with the LMNS and the Neonatal Operational Delivery Network (ODN).

D) Neonatal nursing staffing

To meet safety action 4 of the maternity incentive scheme the neonatal unit needs to demonstrate that it meets the Neonatal nurse staffing standards set out in the BAPM Service and Quality Standards (2022).

The Neonatal Nursing Workforce Calculator (2020) is used on a quarterly basis to calculate compliance to the standards. The results for Q2 can be found in Appendix 5. **The Neonatal unit is not compliant with BAPM standards and this is consistent on a quarterly basis**. The tool calculates workforce based on a number of activity and acuity and consistently the requirement to meet the BAPM standards would need to include:

- Increase in registered nursing hours by 0.2wte - 0.4 wte.
- Increase in non-registered nursing hours by 2 wte.

Q2 SFT LNU WORKFORCE DEMAND	FUNDED	IN POST	Calculated requirement (from tool)	Adverse Variance Funded vs required
Total direct care nurses	22.19	20.07	24.55	2.36
Total registered nurses (band 5 and above)	21.39	18.05	21.66	0.27
of which QIS	14.99	13.19	15.16	0.17
Total Non QIS	6.40	4.86	6.50	0.1
Total Non Reg	0.80	2.02	2.89	2.09
% REGISTERED NURSES QIS QUALIFIED		73.1%	70.0%	

An action plan in Year 5 of the MIS was created, with the action to write a business case to increase the registered and non-registered nursing establishment. The Business case has been written and is currently under Divisional Review, following which it will progress to Trust

board for consideration and approval. The Action plan for MIS Year 6 is to submit the case to board to seek approval and this can be found on page 10.

This report and action plan has been shared with the LMNS and the Neonatal Operational Delivery Network (ODN).

E) Recommendations

It is recommended for the Board to note the contents of the report and formally record to the Trust Board minutes compliance with the following:

- Compliance to short term locum usage.
- Compliance to Long term locum guidance (ROCG).
- Compliance of consultant attendance for the clinical situations listed in the RCOG workforce document.
- Availability of Obstetric anaesthetic cover in line with ACSA standard 1.7.2.1
- Action plan to address lack of compliance to BAPM standards for Neonatal Medical workforce.
- Action plan to address lack of compliance to BAPM standards for Neonatal Nursing workforce.

Using the CNST NHSR Safety Action Board Notification template, Salisbury NHS Trust can demonstrate compliance to Safety Action 4 as per Appendix 6.

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

	Area	Action	Owner	Complete Y/N	Current progress made
MIS YEAR 5	**Neonatal Medical workforce** **NON-COMPLIANCE to BAPM standards**	**Business Case to be written to support increase in Neonatal medical workforce to ensure compliance to BAPM standards**	Mary Pedley Neonatal Clinical Lead		In Draft with the divisional team for review
	Neonatal Nursing workforce **NON-COMPLIANCE to BAPM standards**	**Business Case to be written to support increase in Neonatal nursing workforce to ensure compliance to BAPM standards**	Geoff Dunning Neonatal Unit Matron		In Draft with the divisional team for review
MIS YEAR 6	**Neonatal Medical workforce** **NON-COMPLIANCE to BAPM standards**	**Business Case to be reviewed by divisional team and submitted through business case approval process to board for consideration and review.**	Mary Pedley Neonatal Clinical Lead Women and Newborn Divisional Triumvirate	In progress	Divisional sign off by: 31/01/2025 Trust Investment Group by: 28/02/2025 Trust Management Committee by: 31/03/2025 Trust Board by: 31/05/2025
	Neonatal Nursing workforce **NON-COMPLIANCE to BAPM standards**	**Business Case to be reviewed by divisional team and submitted through business case approval process to board for consideration and review.**	Geoff Dunning Neonatal Unit Matron Women and Newborn Divisional Triumvirate	In progress	Divisional sign off by: 31/01/2025 Trust Investment Group by: 28/02/2025 Trust Management Committee by: 31/03/2025 Trust Board by: 31/05/2025

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APPENDIX 1

Audit Standard – Short Term Locum Usage

Trusts should ensure that the following criteria are met for employing short-term (2 weeks or less) locum doctors in Obstetrics and Gynaecology on tier 2 or 3 (middle grade) rotas:

a) currently work in their unit on the tier 2 or 3 rota
or
b) have worked in their unit within the last 5 years on the tier 2 or 3 (middle grade) rota as a postgraduate doctor in training and remain in the training programme with satisfactory Annual Review of Competency Progressions (ARCP)
or
c) hold a certificate of eligibility (CEL) to undertake short-term locums.

Time period:

An audit of compliance with our Medical HR colleagues was completed for the time period 1st February 2024 - 31st August 2024

Method:

The audit was completed using the RCOG guidance as above, with links to the following guidance https://www.rcog.org.uk/media/tyrb4dfr/rcog-guidance-on-engagement-of-short-term-locums-in-maternity-care-august-2022.pdf

Results:

The audit demonstrated that during this period, 74 (short term) middle grade locum shifts were required, 7 Doctors completed these shifts, 4 of these Doctors were Salisbury NHS Foundation Trust employed Doctors and 3 of these not employed at Salisbury NHS Foundation Trust at the time of undertaking the shifts.
The 3 Doctors not employed at Salisbury NHS Foundation Trust, were all however working in their local unit (within the Wessex area) on their Tier 2 or 3 rota and therefore Salisbury NHS Foundation Trust is 100% compliant with the RCOG guidance.

APPENDIX 2

Audit Standard – Long Term Locum Usage

Trusts/organisations should implement the RCOG guidance https://rcog-guidance-on-the-engagement-of-long-term-locums-in-mate.pdf on engagement of long-term locums and provide assurance that they have evidence of compliance to the Trust Board, Trust Board level safety champions and LMNS meetings.

Time period:

Audit on Long Term Locum usage 1st April 2024 – 30th September 2024

Method:

The audit was completed using the RCOG Monitoring of compliance/effectiveness tool within the RCOG guidance https://rcog.org.uk/media/uuzcbzg2/rcog-guidance-on-the-engagement-of-long-term-locums-in-mate.pdf

Results:

Quarter 1 (Q1) compliance

Locum 1 commenced employment as a long-term locum prior to Q1 and therefore standards 1-6 are not applicable during this time period, standards 7 and 8 were 100% compliant. Locum 2 commenced employment in Q1 therefore standards 6 and 7 were not compliant as the employment remained ongoing. The trust was 100% compliant with standards 1-6.

The results can be seen in Table 1.

Table 1. Q1 Compliance

Standard	Locum 1 compliance % (commenced prior to Q1)	Locum 2 compliance % (commenced in Q1)
Standard 1 Locum doctor CV reviewed by consultant lead prior to appointment	**n/a**	**100%**
Standard 2 Discussion with locum doctor re clinical capabilities by consultant lead prior to starting or on appointment	**n/a**	**100%**
Standard 3 Departmental induction by consultant on commencement date	**n/a**	**100%**

Standard 4 Access to all IT systems and guidelines and training completed on commencement date	**n/a**	**100%**
Standard 5 Named consultant supervisor to support locum	**n/a**	**100%**
Standard 6 Supernumerary clinical duties undertaken with appropriate direct supervision	**n/a**	**100%**
Standard 7 Review of suitability for post and OOH working based on MDT feedback	**100%**	**n/a**
Standard 8 Feedback to locum doctor and agency on performance	**100%**	**n/a**

Quarter 2 (Q2) compliance

During the time period 1st July 2024 – 30th September 2024 (Q2) the trust utilised 3 long term middle grade locum doctors.

Locum 1 commenced employment as a long term locum in Q2 demonstrating 100% compliant to all standards.
Locum 2 and Locum 3 were both in post prior to Q2 and therefore standards 1-6 were not applicable during this time period, standards 7 and 8 were 100% compliant.

The results can be seen in Table 2.

Table 2. Q2 Compliance

Standard	Locum 1 compliance % (commenced in Q2)	Locum 2 compliance % (commenced prior to Q2)	Locum 3 compliance % (commenced prior to Q2)
Standard 1 Locum doctor CV reviewed by consultant lead prior to appointment	**100%**	**n/a**	**n/a**
Standard 2 Discussion with locum doctor re clinical capabilities by consultant lead prior to starting or on appointment	**100%**	**n/a**	**n/a**

Standard 3 Departmental induction by consultant on commencement date	**100%**	**n/a**	**n/a**
Standard 4 Access to all IT systems and guidelines and training completed on commencement date	**100%**	**n/a**	**n/a**
Standard 5 Named consultant supervisor to support locum	**100%**	**n/a**	**n/a**
Standard 6 Supernumerary clinical duties undertaken with appropriate direct supervision	**100%**	**n/a**	**n/a**
Standard 7 Review of suitability for post and OOH working based on MDT feedback	**100%**	**100%**	**100%**
Standard 8 Feedback to locum doctor and agency on performance	**100%**	**100%**	**n/a**

Overall the trust can demonstrate 100% compliance to the standards on long term locum usage.

APPENDIX 3

Audit Standard – Roles and responsibilities of the consultant providing acute care in obstetrics and gynaecology.

Trusts should monitor their compliance of consultant attendance for the clinical situations listed in the RCOG document when a consultant is required to attend in person:

- In the event of high levels of activity e.g., a second theatre being opened, unit closure due to high levels of activity requiring obstetrician input.
- Any return to theatre for obstetrics or gynaecology
- Team debriefs requested if requested to do so.
- Early warning score protocol or sepsis screening tool that suggests critical deterioration where HDU / ITU care is likely to become necessary.
- Caesarean birth for major placenta praevia / abnormally invasive placenta
- Caesarean birth for women with a BMI >50
- Caesarean birth <28/40
- Premature twins <30/40
- 4th Degree perineal tear repair
- Unexpected intrapartum stillbirth
- Eclampsia
- Maternal Collapse e.g., septic shock, massive abruption
- PPH 2L where the haemorrhage is continuing, and Massive Obstetric Haemorrhage protocol has been instigated.

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.

Time period:

An audit of compliance was completed for the time period 1st April 2024 – 31st July 2024.

Method:

The Maternity Information System and the Datix System were interrogated to identify the cases meeting the above criteria.

Results:

There were 11 cases meeting the criteria above, displayed on page 16. The audit demonstrates 90% compliance to the standard. There was 1 case where the Consultant was not in attendance, however the case was discussed with the Consultant on-call. Using the 72-hour review process non-attendance was reviewed and discussed, the case was managed appropriately from a clinical perspective. The medical teams are aware of the expectation of consultant attendance for future cases.
Continued audits for this Safety Action will be completed monthly by the Quality and Safety Team.

Date	Clinical Situation(s)	Comments
22/04/24	**PPH 2L where the haemorrhage is continuing, and Massive Obstetric Haemorrhage has been instigated.**	Consultant present.
23/04/24	**PPH 2L where the haemorrhage is continuing, and Massive Obstetric Haemorrhage has been instigated.**	Consultant present.
02/05/24	**PPH 2L where the haemorrhage is continuing, and Massive Obstetric Haemorrhage has been instigated.**	Consultant present.
01/06/24	**PPH 2L where the haemorrhage is continuing, and Massive Obstetric Haemorrhage has been instigated.**	Consultant not present. Consultant aware when MOH call put out, not requested to attend. Total amount 2L.
03/06/24	**Caesarean birth for women with BMI >50**	Consultant present.
09/06/24	**Maternal collapse and Early warning score protocol that suggests critical deterioration where HDU / ITU care is likely to become necessary.**	Consultant present.
19/06/24	**Caesarean birth for major placenta praevia / abnormally invasive placenta**	Consultant present.
27/06/24	**PPH 2L where the haemorrhage is continuing, and Massive Obstetric Haemorrhage has been instigated.**	Consultant present.
04/07/24	**Caesarean birth for women with BMI >50**	Consultant present.
11/07/24	**PPH 2L where the haemorrhage is continuing, and Massive Obstetric Haemorrhage has been instigated.**	Consultant present.
28/07/24	**Early warning score protocol that suggests critical deterioration where HDU / ITU care is likely to become necessary.**	Consultant not present.

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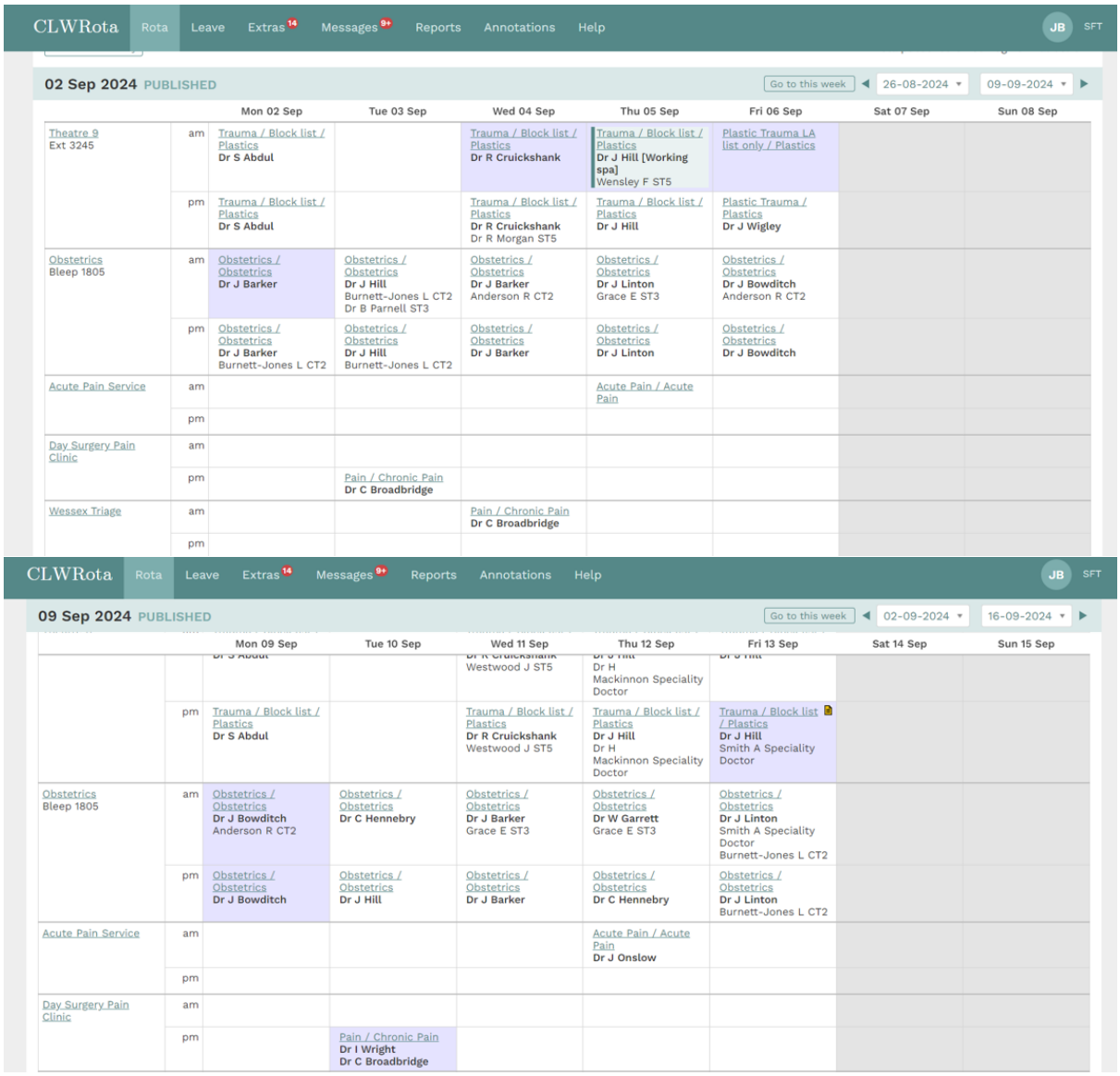
Appendix 4 - Anaesthetic Rota January – September 2024



CLWRota | Rota | Leave | Extras 14 | Messages 9+ | Reports | Annotations | Help | JB SFT

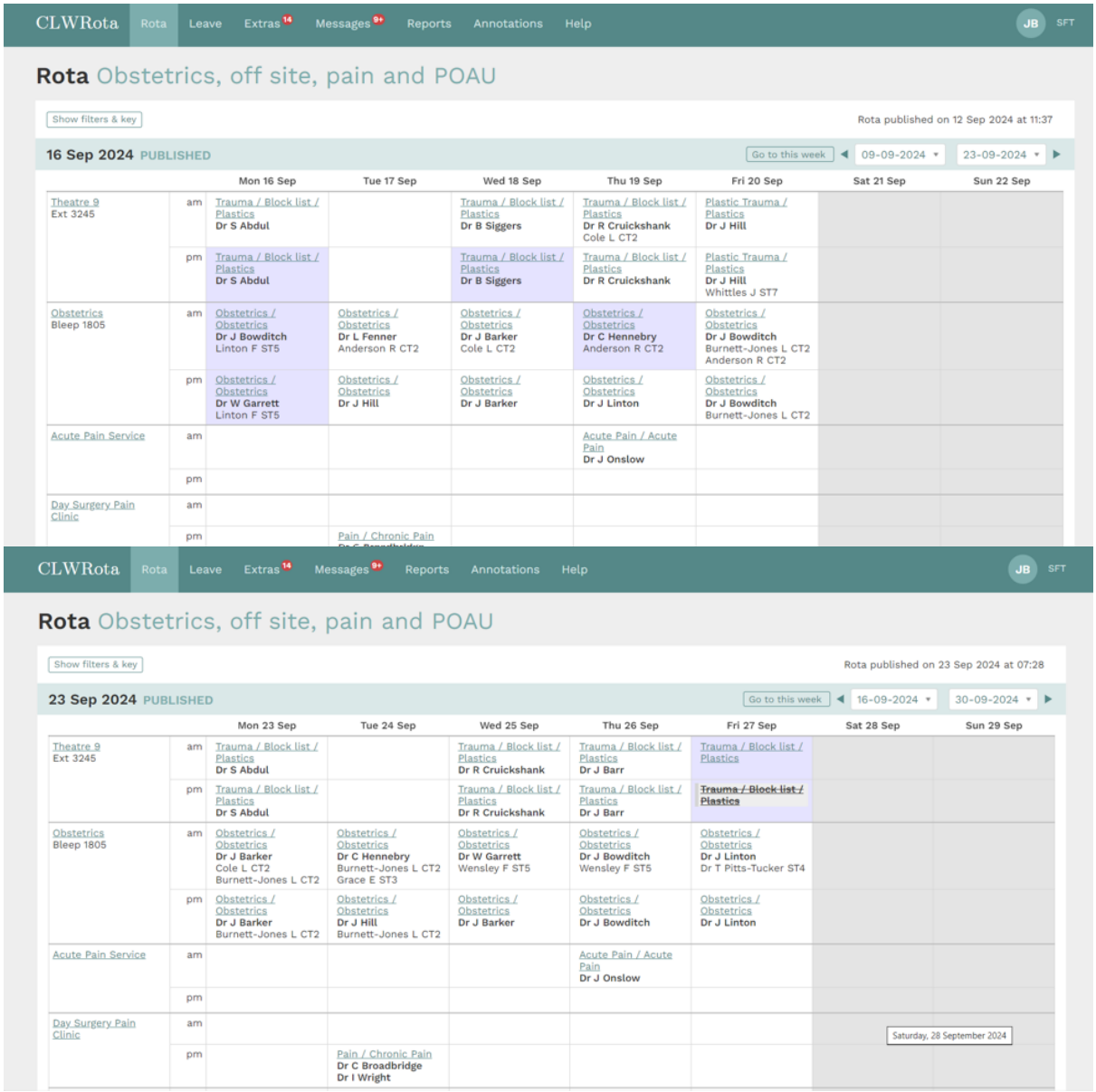
02 Sep 2024 PUBLISHED — Go to this week | 26-08-2024 | 09-09-2024

		Mon 02 Sep	Tue 03 Sep	Wed 04 Sep	Thu 05 Sep	Fri 06 Sep	Sat 07 Sep	Sun 08 Sep
Theatre 9 Ext 3245	am	Trauma / Block list / Plastics **Dr S Abdul**		Trauma / Block list / Plastics **Dr R Cruickshank**	Trauma / Block list / Plastics **Dr J Hill [Working spa]** Wensley F ST5	Plastic Trauma LA list only / Plastics		
	pm	Trauma / Block list / Plastics **Dr S Abdul**		Trauma / Block list / Plastics **Dr R Cruickshank** Dr R Morgan ST5	Trauma / Block list / Plastics **Dr J Hill**	Plastic Trauma / Plastics **Dr J Wigley**		
Obstetrics Bleep 1805	am	Obstetrics / Obstetrics **Dr J Barker**	Obstetrics / Obstetrics **Dr J Hill** Burnett-Jones L CT2 Dr B Parnell ST3	Obstetrics / Obstetrics **Dr J Barker** Anderson R CT2	Obstetrics / Obstetrics **Dr J Linton** Grace E ST3	Obstetrics / Obstetrics **Dr J Bowditch** Anderson R CT2		
	pm	Obstetrics / Obstetrics **Dr J Barker** Burnett-Jones L CT2	Obstetrics / Obstetrics **Dr J Hill** Burnett-Jones L CT2	Obstetrics / Obstetrics **Dr J Barker**	Obstetrics / Obstetrics **Dr J Linton**	Obstetrics / Obstetrics **Dr J Bowditch**		
Acute Pain Service	am				Acute Pain / Acute Pain			
	pm							
Day Surgery Pain Clinic	am							
	pm		Pain / Chronic Pain **Dr C Broadbridge**					
Wessex Triage	am			Pain / Chronic Pain **Dr C Broadbridge**				
	pm							

CLWRota | Rota | Leave | Extras 14 | Messages 9+ | Reports | Annotations | Help | JB SFT

09 Sep 2024 PUBLISHED — Go to this week | 02-09-2024 | 16-09-2024

		Mon 09 Sep	Tue 10 Sep	Wed 11 Sep	Thu 12 Sep	Fri 13 Sep	Sat 14 Sep	Sun 15 Sep
				Westwood J ST5	Dr H Mackinnon Speciality Doctor			
	pm	Trauma / Block list / Plastics **Dr S Abdul**		Trauma / Block list / Plastics **Dr R Cruickshank** Westwood J ST5	Trauma / Block list / Plastics **Dr J Hill** Dr H Mackinnon Speciality Doctor	Trauma / Block list / Plastics **Dr J Hill** Smith A Speciality Doctor		
Obstetrics Bleep 1805	am	Obstetrics / Obstetrics **Dr J Bowditch** Anderson R CT2	Obstetrics / Obstetrics **Dr C Hennebry**	Obstetrics / Obstetrics **Dr J Barker** Grace E ST3	Obstetrics / Obstetrics **Dr W Garrett** Grace E ST3	Obstetrics / Obstetrics **Dr J Linton** Smith A Speciality Doctor Burnett-Jones L CT2		
	pm	Obstetrics / Obstetrics **Dr J Bowditch**	Obstetrics / Obstetrics **Dr J Hill**	Obstetrics / Obstetrics **Dr J Barker**	Obstetrics / Obstetrics **Dr C Hennebry**	Obstetrics / Obstetrics **Dr J Linton** Burnett-Jones L CT2		
Acute Pain Service	am				Acute Pain / Acute Pain **Dr J Onslow**			
	pm							
Day Surgery Pain Clinic	am							
	pm		Pain / Chronic Pain **Dr I Wright** **Dr C Broadbridge**					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Rota
Leave
Extras 14
Messages 9+
Reports
Annotations
Help
JB
SFT
Rota Obstetrics, off site, pain and POAU
Show filters & key
Rota published on 12 Sep 2024 at 11:37
16 Sep 2024 PUBLISHED
Go to this week
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Rota Obstetrics, off site, pain and POAU
Show filters & key
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23 Sep 2024 PUBLISHED
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Dr J Linton
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Dr J Barker
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Dr J Hill
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Acute Pain Service
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Acute Pain / Acute Pain
Dr J Onslow
pm
Day Surgery Pain Clinic
am
Saturday, 28 September 2024
pm
Pain / Chronic Pain
Dr C Broadbridge
Dr I Wright

Neonatal Unit Nursing Workforce Calculator APPENDIX 5

TRUST	Salisbury
UNIT	Salisbury
DESIGNATION	LNU
COMPLETED BY	Geoffrey Dunning
DATE COMPLETED	03/10/2024

COLOUR CODING

Unit to complete
Unit to check and correct if necessary
Summed from inputs
Calculated requirement from tool

This is the return for Q4. Please input workforce data as of 31st March 2024

Data from q3 has been rolled over but needs checking and updating

CURRENT NURSE STAFFING: EXCLUDING DIRECT CARE As of end March 2024

	WTE FUNDED	WTE IN POST	Headcount	Comments. Please give banding, plus any plans for change
Consultant Nurse				
Matron	0.80	0.80	1	Band 8a
Ward manager				
Practice educators /PDN	1.00	1.00	2	0.8 Band 7 & 0.2 Band 6
Research				
Family integrated care				
Outreach				
Feeding	1.00	1.00	2	1.0 Band 7
Bereavement	0.10	0.10		Band 7 for all of manternity 0.1WTE is NICU contribution to role
Transport team (Nurse staffing only)				
Risk / Governance nurse	0.40	0.40	1	Band 7
Other (please state)	0.25	0.25	1	Band 7 Psychotherapist 0.2WTE & PNA 0.05WTE

Note: These nurses should **NOT** be included in the direct care figures below.

Please record ANNP nurses further down this page

CURRENT NURSE STAFFING: DIRECT CARE ONLY As of end March 2024

	WTE FUNDED	WTE IN POST	Head count	Comments. Eg Planned joiners, leavers, retirements
BAND 7				
BAND 6	8.20	6.40	10	1.0WTE Band 6 going to advert + 0.4WTE band 6 Infant feeding (direct care role)
BAND 5	13.19	11.65	12	1.0 WTE band 5 going to advert
Band 5 QIS in post		6.79	7	0.78WTE completed course; 0.92WTE completed but needs to complete placment after ML
Band 5 Non QIS in post		4.86	5	1.0WTE Starts course this year
BAND 4 - Nursing Associate		0.00	0	0.61WTE starts course March 2025
BAND 4 - Nursery nurse	0.00	1.22	2	
BAND 2/3	0.80	0.80	1	
Total	22.19	20.07	37	
% vacancies (in post cf funded)		9.6%		

Numbers should be for nurses providing direct patient care on neonatal unit only.
Please **exclude**
- transitional care staffing
- additional roles e.g. management, outreach, education as listed in table above.
- ANNPs on tier 1 and 2 rotas

The requirement is the output from the tool based on activity and BAPM ratios

	FUNDED	IN POST	Calculated requirement (from tool)
Total direct care nurses	22.19	20.07	24.55
Total registered nurses (band 5 and abov	21.39	18.05	21.66
of which QIS	14.99	13.19	15.16
Total Non QIS	6.40	4.86	6.50
Total Non Reg	0.80	2.02	2.89
% REGISTERED NURSES QIS QUALIFIED		73.1%	70.0%

ADDITIONAL DATA	From	To	WTE	Head Count	Comments (if needed)
New Starters (WTE)	1/1/24	31/3/24			
Leavers (WTE)	1/1/24	31/3/24	0.8	2	0.4WTE Band 6; 0.4WTE Band 5
Net Gain / Loss	1/1/24	31/3/24	**-0.8**	**-2**	
Turnover	1/1/24	31/3/24	**0%**	**0%**	
Vacancy Rate (direct care)	1/1/24	31/3/24	**9.6%**		
Sickness rate (%) in quarter	1/1/24	31/3/24	**3.47%**		
Maternity Leave (WTE at end quarter)	1/1/24	31/3/24	**2**	1.92 on ML	1WTE returned from ML
			WTE	**Cost in £'s**	
Bank Usage (hours) in quarter	1/1/24	31/3/24		**£15,236**	
Agency Usage (WTE) in quarter	1/1/24	31/3/24	**0**		

This is required by the national team

ADVANCED NEONATAL NURSE PRACTITIONERS As of end March 2024

	Band	WTE Funded	WTE In post	Head Count	Source of funding
Trainee ANNP	7	1	0	1	Other
ANNP					Please Select
Senior ANNP					Please Select

For source of funding please say whether funded from Medical or Nursing Budget. If other please note where from in comments box

DECLARED COTS	**DECLARED**	Calculated requirement (from tool)
NICU	1	1
HDU	2	2
SCBU	7	6
TOTAL	10	9

These are ODN figures for your declared (commissioned) cots. If they are wrong please correct.
The requirement is the output from the tool based on care days at 80% occupancy

ANNUAL CARE LEVEL DAYS.

HRG 2016	CARE DAYS 2022/23		summed
HRG 1	98	IC (HRG 1)	98
HRG 2	656	HD (HRG 2)	656
HRG 3	1358	SC (HRG 3-5)	1852
HRG 4	19		
HRG 5	475		
Uncoded			
Total	2606		2606

These are care days by HRG16 for 2022/23 from badgernet where the ward location was coded as NNU.
Transitional care and care given on postnatal ward are excluded.
For purposes of this tool we are assuming that all days not coded as HRG16 1 or 2 are special care.
If you believe figures are significantly incorrect please contact j.bobby@nhs.net

Comments

Business case has been submitted to the Divisional team for review. Following this it will go to the TRust Board for conisderation and approval.
ANNP trainee has been recruited awaiting invoice from university so placment can be started and nurse uplifted with NCCR funds to band 7 for 3 years training then band 8a when course complete. This funding requires finance to assign to LNU budget.

APPENIDX 6 – Compliance to CNST Year 6 Board Declaration

Safety action No. 4		
Can you demonstrate an effective system of clinical workforce planning to the required standard?		
From 2 April 2024 until 30 November 2024		
Requirements number	**Safety action requirements**	**Requirement met? (Yes/ No /Not applicable)**
a) Obstetric medical workforce		
1	Has the Trust ensured that the following criteria are met for employing short-term (2 weeks or less) locum doctors in Obstetrics and Gynaecology on tier 2 or 3 (middle grade) rotas following an audit of 6 months activity: Locum currently works in their unit on the tier 2 or 3 rota OR They have worked in their unit within the last 5 years on the tier 2 or 3 (middle grade) rota as a postgraduate doctor in training and remain in the training programme with satisfactory Annual review of Competency Progrssion (ARCP)? OR They hold a Royal College of Obstetrics and Gynaecology (RCOG) certificate of eligibility to undertake short-term locums?	Yes
2	Has the Trust implemented the RCOG guidance on engagement of long-term locums and provided assurance that they have evidence of compliance	Yes
3	Has the Trust monitored their compliance of consultant attendance for the clinical situations listed in the RCOG workforce document: 'Roles and responsibilities of the 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/ when a consultant is required to attend in person.	Yes
4	Were the episodes when attendance has not been possible reviewed at unit level as an opportunity for departmental learning with agreed strategies and action plans implemented to prevent further non-attendance.	Yes
Do you have evidence that the Trust position regarding question 3 & 4 has been shared:		
5	At Trust Board?	Yes
6	With Board level safety champions?	Yes
7	At LMNS meetings?	Yes
b) Anaesthetic medical workforce		
8	Is there evidence that the duty anaesthetist is immediately available for the obstetric unit 24 hours a day and they have clear lines of communication to the supervising anaesthetic consultant at all times? In order to declare compliance, 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. (Anaesthesia Clinical Services Accreditation (ACSA) standard 1.7.2.1) - Representative month rota acceptable.	Yes
c) Neonatal medical workforce		
9	Does the neonatal unit meet the British Association of Perinatal Medicine (BAPM) national standards of medical staffing? And is this formally recorded in Trust Board minutes?	No
10	If the requirements are not met, Trust Board should agree a workforce action plan and evidence progress against any workforce action plan developed previously to address deficiencies.	Yes
11	Was the above workforce action plan shared with the LMNS?	Yes
12	Was the above workforce action plan shared with the ODN?	Yes
d) Neonatal nursing workforce		
13	Does the neonatal unit meet the British Association of Perinatal Medicine (BAPM) national standards of nursing	No
14	If the requirements are not met, Trust Board should agree a workforce action plan and evidence progress against any workforce action plan developed previously to address deficiencies.	Yes
15	Was the above workforce action plan shared with the LMNS?	Yes
16	Was the above workforce action plan shared with the ODN?	Yes

NHS Salisbury NHS Foundation Trust

Report to:	Trust Board (Public)	Agenda item:	5.7
Date of meeting:	9th January 2025		

Report tile:	Maternity Incentive Scheme (Year 6) - Safety Action 10 Trust Board Report			
Status:	Information	Discussion	Assurance	Approval
	x	x	x	
Approval Process: (where has this paper been reviewed and approved):	Divisional Governance 20.12.2024			
Prepared by:	Vicki Marston –Director of Midwifery and Neonatal Services			
Executive Sponsor: (presenting)	Judy Dyos - Chief Nursing Officer			

Recommendation:

The Trust Board are asked to note the contents of the report which provides assurance that Salisbury NHS Foundation Trust Maternity services have reported 100% of qualifying cases to Maternity and Newborn Safety Investigations (MNSI) programme and to NHS Resolution's Early Notification (EN) Scheme from 8 December 2023 to 30 November 2024 as per CNST Maternity Incentive scheme Safety Action 10.

Executive Summary:

The Maternity and Newborn Safety Investigations (MNSI) programme is part of a national strategy to improve maternity safety across the NHS in England. All NHS trusts are required to notify MNSI about certain patient safety incidents that happen in maternity care so that an independent investigation can be conducted if it meets criteria. MNSI criteria includes certain cases of early neonatal deaths, intrapartum stillbirths and severe brain injury born at term following labour. The MNSI investigation replaces NHS Trusts internal investigations and, where relevant, makes safety recommendations to improve services locally and nationally.

NHS Resolutions Early Notification (EN) Scheme is an initiative that provides early and rapid response to families in cases of severe harm. The scheme investigates potential medical negligence claims related to serious brain injuries sustained by babies at birth and provides compensation where negligence is identified. For all MNSI qualifying cases, it is the responsibility of individual Trust's to notify both MNSI and EN Scheme.

During the specified time frame the one family to whom this applies received information on the role of MNSI and EN by letter which was signed for. Salisbury NHS Foundation Trust Maternity services can also confirm compliance with statutory Duty of Candour for this case.

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

Maternity Incentive Scheme (Year 6) - Safety Action 10

Trust Board Report

Purpose of the Report

This report is to provide assurance to Trust Board that Salisbury have reported 100% of qualifying cases to Maternity and Newborn Safety Investigations (MNSI) programme and to NHS Resolution's Early Notification (EN) Scheme from 8 December 2023 to 30 November 2024 as part of the requirements of NHS Resolution's Maternity Incentive Scheme for the Clinical Negligence Scheme for Trusts (CNST) Safety Action 10.

The required standard and evidence for Safety Action 10 is outlined below.

Required Standard
For all qualifying cases which have occurred during the period 8 December 2023 to 30 November 2024, the Trust Board are assured that: 1. the family have received information on the role of MNSI 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 Evidence Requirement for Trust Board
Trust Board sight of Trust legal services and maternity clinical governance records of qualifying MNSI/ EN incidents and numbers reported to MNSI and NHS Resolution. **Trust Board** sight of evidence that the families have received information on the role of MNSI and NHS Resolution's EN scheme. **Trust Board** sight of evidence of compliance with the statutory duty of candour.

Background

The Maternity and Newborn Safety Investigations (MNSI) programme is part of a national strategy to improve maternity safety across the NHS in England. All NHS trusts are required to notify MNSI about certain patient safety incidents that happen in maternity care so that an independent investigation can be conducted if it meets criteria. MNSI criteria includes certain cases of early neonatal deaths, intrapartum stillbirths and severe brain injury born at term following labour. The MNSI investigation replaces NHS Trusts internal investigations and, where relevant, makes safety recommendations to improve services locally and nationally.

NHS Resolutions Early Notification (EN) Scheme is an initiative that provides early and rapid response to families in cases of severe harm. The scheme investigates potential medical negligence claims related to serious brain injuries sustained by babies at birth and provides compensation where negligence is identified. For all MNSI qualifying cases,

it is the responsibility of individual Trust's to notify both MNSI and EN Scheme.

Trusts are also required to complete statutory duty of candour requirements and ensure families receive information on MNSI and ENS.

Current position

During the reporting period there have been two term babies born with HIE. One baby qualified for MNSI investigation and Early Notification (grade 2 HIE). The other case involved a baby with mild HIE which was rejected as it did not qualify. The one qualifying case was referred to MNSI and has been investigated. It was also referred to the Early Notification scheme.

There have been no term stillbirths or neonatal deaths that have met MNSI criteria during the reporting timeframe.

Safety action requirement		Local compliance
10.6	Has Trust Board had sight of evidence that the families have received information on the role of MNSI and NHS Resolution's EN scheme?	YES - One qualifying case during the reporting period . This was referred to MNSI and EN Scheme. The family received a letter (DoC 2) with information about MNSI and EN scheme. This is now noted within the Quarterly Quality & Safety Report to Trust Board.
10.7	Has Trust Board had sight of evidence of compliance with the statutory duty of candour?	YES - Compliance with DoC stage 1 & 2. DoC stage 3 will be completed following the tripartite meeting with parents on 18th Dec in line with DoC requirements. .

Recommendation and next steps

The Trust Board is required to acknowledge and note compliance with safety action 10 Year 6 (subsections 10.6 and 10.7) for the purposes of the Maternity Incentive Scheme Year 6 requirements.

NHS Salisbury NHS Foundation Trust

Report to:	Trust Board (Public)	Agenda item:	6.2
Date of meeting:	9 January 2025		

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

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

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

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

No.	Date signed in Register	Approval Details	Held on file with:	Signature one:	Signature Two:
378	8 October 2024	Transfer of registered title 24 Ravenscroft, Salisbury SP2 8DL	Laurence Arnold	Mark Ellis	Lisa Thomas
379	8 October 2024	Transfer of registered title 26 Ravenscroft, Salisbury SP2 8DL	Laurence Arnold	Mark Ellis	Lisa Thomas

380	10 October 2024	Memorandum of terms of occupation car park 8, 9 and 10 between SFT Charitable Fund and SFT	Laurence Arnold	Mark Ellis	Ian Green
381	18 October 2024	Contract and transfer 21 Ayleswade Road, Salisbury	Laurence Arnold	Lisa Thomas	Mark Ellis
382	1 November 2024	Contract and transfer 14 Owlswood, Salisbury	Laurence Arnold	Mark Ellis	Lisa Thomas
383	11 December 2024	HM Land Registry South Newton	Laurence Arnold	Mark Ellis	Lisa Thomas

NHS Salisbury NHS Foundation Trust

Report to:	Trust Board (Public)	Agenda item:	7.1
Date of meeting:	9 January 2024		

Report title:	Estates Technical Service Update			
Status:	Information	Discussion	Assurance	Approval
	x		x	
Approval Process: (where has this paper been reviewed and approved):	Finance & Performance Committee			
Prepared by:	John O'Keeffe – Head of Estates			
Executive Sponsor: (presenting)	Mark Ellis – Chief Financial Officer			
Appendices	Appendix A – Estates Safety Group KPI Report			

Recommendation:
The Board is asked to note the content of the paper summarising the key performance indicators relating to the Estates safety groups as recommended by internal audit.

Executive Summary:
Internal audit reported that Estates compliance metrics for health and safety regulatory requirements were not clearly reported through governance structures and one of the recommendations was that we should report core KPIs to Board and F&PC within the quarterly reports. This paper covers off the recommendation and shows a summary position from the last quarterly Estates safety groups. These are still being developed and may change over time as the safety groups challenge the tasks and compliance standards. Any areas that are amber and red are actively worked on while green are monitored. What can be seen is that in the areas that require action it appears the primary cause is staff carrying out reactive requests as opposed to planned, we are working to understand and reverse this trend. Going forwards this will be an appendix to the normal quarterly report.

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

Appendix A – Estates Safety Group KPI Report – November 2024

1.0 Introduction

This is a quarterly update to Finance and Performance committee summarising the key performance indicators relating to the Estates safety groups as recommended by internal audit.

2.0 Asbestos Safety Group

The Asbestos Safety Group (ASG) is established to provide the Health & Safety Committee & subsequently the Trust Board of Directors with assurance that they have suitable governance, competence and accountability arrangements in place to manage asbestos on site.

Asbestos KPI's are not ready for this report, we have only recently appointed an approved person (AP) to this role, and they are actively working on these.

3.0 Electrical Safety Group

The Electrical Safety Group (ESG) is established to provide the Health & Safety Committee & subsequently the Trust Board of Directors with assurance that they have suitable governance, competence and accountability arrangements in place to provide safe electrical systems at Salisbury NHS Foundation Trust.

Task	Sept 2024
EICR	**Amber** 50 – 75%
Portable Appliance Testing	**Red** < 50%
Emergency Lighting Monthly	**Green** 75 – 100%
Emergency Lighting Annual	**Green** 75 – 100%
Generator weekly test	**Green** 75 – 100%
CP Training	**Green** 75 – 100%
Lightning Protection test	**Green** 75 – 100%
IPS/UPS 6 monthly test	**Green** 75 – 100%

EICR – Electrical installation condition report – This is a 5-year rolling programme that is in its 4th year, we expect to be in a green position by March 2025

Portable Appliance Testing, this is an annual contract, and the start date was delayed by a month, we are now in a green position.

4.0 Fire Safety Group

To provide the Health & Safety Committee & subsequently the Trust Board of Directors with assurance that they have suitable governance, competence and accountability arrangements in place to manage all fire related systems, processes and procedures.

Task	Aug 2024
Staff Trust wide compliant with fire face-to-face training.	Red – 15% 0-80%
Fire doors surveyed within the last 12 months.	Red – 10% 0-80%
Extinguishers serviced and in date.	Amber – 85% 81-90%
Fire detection serviced within the last 12 months	Green – 98% 91 – 100%
Fire Risk Assessments complete	Green – 100% 91 – 100%
Fire Risk Assessments in date	Amber – 87% 81-90%
Policy in date	Green Yes/No

Face to face training - This is the New mandatory training that was instigated on MLE in January, after a slow uptake we are progressing in the right direction and expect to see a month-on-month increase.

Fire door surveys – this was scheduled to be carried out in house but a shortage of staff and more resources being spent on reactive works meant that planned works slipped. The teams have been reminded of the need to carry out planned maintenance and if critical contract support will be used. Contractors are being brought in to carry this out and the % will increase.

Extinguisher service. A delay in the start of the contract meant the contractor was slightly behind schedule at the time of the report, we are currently at 90%+ and will be at 100% within the month.

Fire risk assessments in date. This has been brough back in house and the % is increasing with an expectation we will be green by the next report.

5.0 Safer Environment Group (Confined Spaces, Lifts, Pressure systems, Working at Height)

The Safer Environment Group (SEG) is established to provide the Health & Safety Committee & subsequently the Trust Board of Directors with assurance that they have suitable governance, competence and accountability arrangements in place to manage Pressure Systems, Lifts, Working at Height and Confined Spaces on site.

Pressure Systems		**Lifts**	
Task	July 2024	Task	July 2024

Completion of visual inspections	Amber 50-75%	Annual Insurance Inspections	Green 75 – 100%
Completion of working inspections	Amber 50-75%	Monthly PPM (Contractor)	Amber 50-75%
Pressure Systems		**Lifts**	
Completion of thorough inspections	Amber 50-75%	Weekly PPM (Estates)	Green 75 – 100%
Training (AP)	Green Yes/No	Training (AP)	Green 75 – 100%
Training (CP)	Red Yes/No	Training – Lift Wardens	Green 75 – 100%
Policy in date	Green Yes/No	Policy in date	Green 75 – 100%
Confined Spaces		**Working at Height**	
Task	July 2024	Task	July 2024
Annual Maintenance of Monitoring Equipment	Red Yes/No	Annual checks of fixed and portable ladders	Green 75 – 100%
6M AP Audit of signage / control measures	Red Yes/No	Management of W@H with PTW	Green Yes/No
Training (AP)	Red Yes/No	Training (AP)	Green Yes/No
Permits issued for entry	Green Yes/No	Training (CP)	Red Yes/No
Policy in date	Green Yes/No	Policy in date	Green Yes/No

Completion of visual, working, and thorough inspections. Recently appointed a member of staff to work solely on pressure systems in conjunction with the external inspector to increase the number of inspections completed, this is progressing well.

Training (CP) pressure – we currently do not have the expertise in house to carry out this role, we use external contractors when required which is not frequent.

Monthly PPM (Contractor) lifts – Contractor had fallen behind schedule this is being monitored

Annual Maintenance of Monitoring Equipment – Currently in progress will be green shortly (Nov)

6M AP Audit of signage / control measures – AP recently appointed will be green shortly (Nov)

Training (AP) – now completed.

Training (CP) working at height – training completed appointment imminent.

6.0 Ventilation Safety Group

The Ventilation Safety Group (VSG) is established to provide both the Infection Prevention & Control Committee and Health & Safety Committee and subsequently the Trust Board of Directors with assurance that they have suitable governance, competence and accountability arrangements in place to minimise the risk of harm and infection from ventilation systems.

Task	Aug 2024
Critical ventilation Annual maintenance	**Green** 75 – 100%
Theatre ventilation Annual verification	**Green** 75 – 100%
Critical ventilation Quarterly maintenance	**Red** < 50%
UCV Theatre Biannual maintenance	**Green** 75 – 100%
LEV inspection and Tests	**Green** 75 – 100%
General ventilation maintenance	**Amber** 50-75%
General ventilation Biannual maintenance	**Red** < 50%
Training (AP)	**Green** 75 – 100%
Training (CP)	**Red** < 70%
Policy in date	**Green** Yes/No

Critical ventilation Quarterly maintenance, General ventilation maintenance & General ventilation Biannual maintenance – A shortage of staff and more resources being spent on reactive works meant that planned works slipped. The teams have been reminded of the need to carry out planned maintenance and if critical contract support will be used. The new CAFM system should prevent this happening again with its reporting feature. We expect these to be green by the next report.

Training (CP) one staff member trained , others identified and training booked, expect to be green mid-2025, contractor support brought in if required.

7.0 Water Safety Group

The Water Safety Group (WSG) is established to provide both the Infection Prevention & Control Committee and Health & Safety Committee and subsequently the Trust Board of Directors with assurance that they have suitable governance, competence and accountability arrangements in place to minimise the

risk of harm and infection from water used by patients, staff and visitors associated with waterborne pathogens.

Task	July 2024
Annual Tank Inspection	**Green** 75 – 100%
Shower Head / Hose (Quarterly)	**Green** 75 – 100%
Monthly temperature checks	**Amber** 50 – 75%
TMV Maintenance	**Red** < 50%
Legionella Sampling	Annual sampling due to commence in July.
Pseudomonas Sampling (6 monthly)	**Green** 75 – 100%
Flushing of low use outlets (LUO)	**Green** 75 – 100%

Monthly temperature checks, A shortage of staff and more resources being spent on reactive works meant that planned works have slipped. The teams have been reminded of the need to carry out planned maintenance.

TMV Maintenance, A shortage of staff and more resources being spent on reactive works meant that planned works have slipped. The teams have been reminded of the need to carry out planned maintenance and if critical contract support will be used. We are bringing in contract support to bring this and the new CAFM system should prevent this happening again with its reporting feature.

8.0 Summary

While the majority of the safety group KPI's show that the specialist areas are being maintained and monitored within limits , there are areas that are not performing as well as they could and while this appears to be caused by staff carrying out reactive requests as opposed to planned, we will be investigating further using both root cause analysis and A3 thinking to determine the best way to proceed. As an interim measure resource will be diverted and additional labour brought in for critical works.