Bundle Trust Board Public 6 April 2023

1	OPENING BUSINESS
1.1	10:00 - Presentation of SOX certificates *Presented by Ian Green*
1.2	10:10 - Staff Story *Presented by Melanie Whitfield*
1.3	Welcome and Apologies *Apologies received from Lisa Thomas*
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 9 March 2023* *For approval* 1.5 Draft Public Board mins 9 March 2023.docx
1.6	10:35 - Matters Arising and Action Log 1.6 Public Action Log.pdf
1.7	10:40 - Chairman's Business *Verbal update by Ian Green* *For information*
1.8	10:45 - Chief Executive Report *Verbal update by Stacey Hunter* *For information*
2	PLANNING
2.1	10:50 - 2023/24 Operational Plan *Presented by Mark Ellis* *For assurance* 2.1a 2023-04-06_Board-Item-2.1-ANNUAL OPERATING PLAN - Cover Sheet.docx 2.1b 2023-24_SFT-Internal-Planning-Narrative Final.pdf
3	ASSURANCE AND REPORTS OF COMMITTEES
3.1	11:05 - Clinical Governance Committee - 28 March - to follow *Presented by Eiri Jones* *For assurance* 3.1 Escalation report - from March 2023 CGC to April Board 2023.docx
3.2	11:10 - Finance and Performance Committee - 28 March *Presented by Debbie Beaven* *For assurance* 3.2 March Escalation Report from F and P.docx
3.3	Trust Management Committee - 22 March - Leadership meeting, next full TMC 26 April
3.4	11:15 - People and Culture Committee - 30 March - to follow *Verbal update presented by Tania Baker* *For assurance*
3.5	11:20 - Audit Committee - 22 March *Presented by Richard Holmes* *For assurance* 3.5 March escalation report from Audit Committee.docx
3.6	11:25 - Integrated Performance Report to include exception reports *Presented by Judy Dyos* *For assurance* 3.6a IPR cover sheet - Trust Board Apr '23.docx 3.6b IPR Mar_23 FINAL v7.pdf
4	STRATEGY AND DEVELOPMENT
4.1	Digital Strategy Update - deferred to May
4.2	11:50 - Improving Together Quarterly Update Report Q4

Presented by Peter Collins
For assurance

4.2a Improving Together Quarterly Trust Board Report_April 2023 final version.docx

4.3 12:00 - BREAK

5 FINANCIAL AND OPERATIONAL PERFORMANCE

5.1 12:30 - Review of Standing Financial Instructions

Presented by Mark Ellis
For approval

5.1a cover sheet SFI review Mar23_TB.docx

5.1b DRAFT - Standing Financial Instructions Mar23 v2.docx

6 QUALITY AND RISK

6.1 12:40 - Q3 Learning from Deaths Report

Presented by Peter Collins
For assurance

6.1a Q3 2022-23 Learning from Deaths Cover Sheet.docx

6.1b Learning from deaths report Q3 2022-23.pdf

7 PEOPLE AND CULTURE

7.1 12:50 - Nursing Skill Mix Review

Presented by Judy Dyos
For assurance

7.1a Board cover sheet Safer Staffing april 2023.docx

7.1b Skill mix 6-monthly review - March 23.docx

7.1c Appendix A Front Sheet Maternity & Neonatal Staffing Report March 2023.docx

7.1d Appendix A Maternity and neonatal report March 2023.pdf

7.2 13:00 - National Staff Survey Results 2022

Presented by Melanie Whitfield
For assurance

7.2a Staff Survey Cover_Sheet . Public Board. April. 2023.docx

7.2b Staff Survey April 2023.pptx

8 GOVERNANCE

8.1 13:10 - 2023 Annual Review of Directors Interest/Annual Review of Fit and Proper Persons Test

Presented by Fiona McNeight
For assurance

8.1a Cover sheet Annual Register of Interests 2023.docx

8.1b Trust Directors Register of Interests 2023.pdf

8.1c Register of Interests for all band 8d, equivalent and above staff.pdf

8.2 Integrated Accountability and Governance Framework - deferred to May

8.4 Register of Seals Q4 - no new seals since previous report

9 CLOSING BUSINESS

9.1 13:20 - Agreement of Principle Actions and Items for Escalation

9.2 13:25 - Any Other Business

9.3 13:30 - Public Questions

9.4 Date next meeting

4 May 2023

10 RESOLUTION

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

Salisbury NHS Foundation Trust

Draft
Minutes of the Public Trust Board meeting held at 10:00am on Thursday 9th March 2023, MS Teams
Salisbury NHS Foundation Trust
Boardroom

Board Members:

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

In Attendance:

Fiona McNeight (FMc)	Director of Integrated Governance
Ian Oakley (IC)	Deputy Chief People Officer
Hannah Boyd (HB)	Divisional Director of Operations Maternity
Lucinda Herklots (LH)	Lead Governor (observer)
Jane Podkolinski (JP)	Governor (observer)
Kylie Nye (KN)	Head of Corporate Governance (minutes)
Frank Cunnane (FC)	Public observer (Teams)
Russell Edwards (RE)	Public observer (Teams)
Zoe Gunstone (ZG)	Physiotherapy Student observer
Victoria Aldridge (VA)	Head of Patient Experience

ACTION

TB1 9/3/1 **OPENING BUSINESS**

TB1 9/3/1.1 **Presentation of SOX (Sharing Outstanding Excellence) Certificates**

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

- **January SOX of the month** – Sally Crook, Odstock Health and Fitness and Lisa Hill, Gastro Booking Coordinator
- **January Patient Centred SOX** – Lucy Weston, Midwife and Russell Tyrie, Porter
- **February SOX of the month** – Ben Markham, Housekeeping and Central Booking
- **February Patient Centred SOX** – Sam Edwards, Odstock Ward

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

TB1 9/3/1.2 **Patient Story**

VA joined the meeting and introduced pre-recorded story about a patient who had received treatment for cancer during 2020. The patient had been through several specialities in the Trust before being diagnosed with a rare form of Leukaemia. The patient received chemotherapy as part of his treatment.

The patient's story highlighted that he felt reassured and the staff he had encountered had been measured, courteous and professional. The patient also highlighted how useful it was to have a hotline number he could ring at any point if there were concerns or issues that required medical input.

The patient further highlighted the positive impact Horatio's Garden had whilst they were treated as an inpatient. The patient thanked the Trust for the care he had received, noting his appreciation for all services involved.

Discussion:
JDy noted the good feedback often received by the cancer service which is really positive but noted it would be useful to hear from patients who have been cared by those services struggling in the last few months.

TB queried what engagement the patient experience team receive when they shared the stories across clinical teams. VA explained that the format in which these stories are delivered has been reviewed and going forward they will be filmed so the patient is visible to those viewing. VA further explained that the stories are received at the Patient Experience Steering Group. There is also further work underway to help build relationships within divisions teams. It is acknowledged that divisional governance meetings need to triangulate the patient experience aspect of care.

DBu noted the good feedback about cancer services in the Trust. DBu noted that patient experience can be more difficult with older patients who have multiple health needs. DBu further noted the positive feedback about utilising charitable funding to support those extras for patients that can make the difference, e.g., Horatio's Garden. DBu noted the importance of planning ahead when using charitable funds for ongoing services. LT noted that Horatio's Garden is funded by a separate charity to the Stars Appeal Trust Charity.

SH noted that the story indicated this patient was relatively fit and healthy prior to their diagnosis. However, the story highlighted that there is no dedicated cancer centre at the Trust and the distances between departments that patients have to travel is challenging for those who are less mobile.

RH referenced Horatio's Garden and explained he had spoken to a volunteer who had relayed how valuable and rewarding it had been volunteering in the garden.

ME noted that it was worth being aware how much of the cancer pathway includes waiting when services are challenged.

IG asked VA to pass the Board's thanks to the patient who had shared their story.

TB1 9/3/1.3 Welcome and Apologies

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

- Debbie Beaven, Non-Executive Director
- Melanie Whitfield, Chief People Officer

TB1 9/3/1.4 Declarations of Conflicts of Interest

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

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

- IG advised that he had been appointed to the NHS Safety Commissioners Advisory Board. There were no conflicts of interest with any of the agenda items at the meeting.

TB1 9/3/1.5 Minutes of the Part 1 (Public) Trust Board meeting held on 12th January 2023

IG presented the public minutes from 12th January 2023 and the following key points were noted:

- On pg.7 EJ suggested further clarification on point that state "The maternity incentive scheme applies to all acute Trusts that deliver maternity services and are members of the CNST. Trusts that can demonstrate they have achieved all the ten safety actions will recover the element of their contribution relating to the CNST maternity incentive fund and will also receive a share of any unallocated funds." EJ noted that if you do not meet all ten actions then the Trust receives a proportion back to improve.

- Page 9. EJ asked for it to be confirmed if the SHMI indicator was inside the expected range. PC advised he would check.

Subject to these amendments, the board approved the minutes as a correct record of the meeting.

TB1 9/3/1.6 Matters Arising and Action Log

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

TB1 Closed Health and Safety Quarterly Report Issue.

TB1 12/1/2.5 Integrated Performance Report (IPR) (M8)/ Theatre Activity – LT explained that F&P would be receiving performance deep dives, one of those being focus on theatre activity. This would then feed through to Trust Board via the F&P escalation report. Item closed.

TB1 12/1/2.5 Integrated Performance Report (IPR) (M8)/ Stroke - PC noted that he had sent an email to Stroke to clarify the narrative. PC to feedback at the next meeting.

TB1 12/1/4.2 Health and Safety Quarterly Report Q3 - The new dates for the two reports have been agreed and added to the cycle of business on March's agenda. Item closed

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

TB1 9/3/1.7 Chairman's Business

IG noted he'd had a busy first month and had been pleased to meet so many colleagues across the Trust. IG highlighted that he'd also had the opportunity to chair his first Council of Governors' meeting and had been meeting the governors on an individual basis too.

TB1 9/3/1.8 Chief Executive's Report

SH presented her report and highlighted the following key points:

- In terms of the operational context, challenges continue with a marked increase in pressure towards the end of February/ start of March.
- In terms of successes, there was an ambition to achieve no patients waiting over 78 weeks a month ahead of target. The team have managed to achieve this which, under the circumstances, is a great achievement. SH thanked all staff who helped to achieve this on behalf of the Board.
- SH referred to the recent industrial action and thanked those staff on the Strike Committee who had been working hard to ensure the Trust remains safe. SH referenced the amount of time taken to support industrial action, noting that this has detracted from other areas of work.
- The British Medical Association (BMA) have announced industrial action for 72 consecutive hours, with no derogation in place. This is due to take place w/c 13th March. The assumption is there will be senior staff to cover the gaps. PC provided assurance that emergency care will be safely staffed and work is underway to understand what elective activity might have to be stood down. IC noted his thanks to staff who have been cooperative and have informed the Trust whether they will strike or not. There has been constructive dialogue with the Local Negotiating Committee (LNC) and BMA. Currently the Trust can provide a reasonably good level of assurance that services will continue and but there are concerns around patient flow. IC noted the lessons learnt from previous episodes of industrial action and the command-and-control processes in place to mitigate the risks. The Board noted there might be further pressure in the same week, with teacher strikes also planned.
- The Staff Survey has been published today and SH noted she highlighted the headlines of areas where the Trust has improved and

those where further improvements are required. This will be communicated through the Trust with detailed information packs for divisional colleagues to understand the data and what response might be required. MW will bring plan back around the Staff Survey response in April.

- The Trust are going to be part of a developmental external Well-Led Review. The procurement process was undertaken collectively across the three acute hospitals and SFT is going first. The review will start in April and run for three months.
- There is a lot of work underway at system level and the key focus across the BSW has been about producing a sustainable system operational and financial plan for 2023/24.
- NHS E/I have selected our Acute Hospital Alliance as one of nine successful provider collaboratives to join the new Provider Collaborative Innovator scheme. The ambition of the scheme is to support and accelerate development of the collaboratives so that patients across the country benefit. Further progress on this will be fed back through the Board.

Discussion:
DBu felt assured by the level of response to industrial action. DBu noted that this level of industrial action is not routine and therefore implications for patients are unknown. SH reiterated all industrial action by definition increases the level of risk. JDy reported that the Trust have had one Serious Incident reported as a result of recent industrial action.

SH noted that it should be explicit that the Trust is doing all it can to mitigate the risks that might arise as a result of the strikes. Whilst a decision has not yet been taken about elective work, this will be discussed in the Exec Gold meetings which take place daily. It is inevitable that during a junior doctor strike, more elective activity will be cancelled.

RH referred to the patient impact of the recent strikes and asked if the delayed appointments have all been rebooked. SH explained that these patients will be in a process of being rebooked but this is a dynamic process and can be complex.

TB1 9/3/2 **ASSURANCE AND REPORTS OF COMMITTEES**

TB1 9/3/2.1 **Clinical Governance Committee (CGC) 28th February 2023**

EJ presented the report, providing a summary of escalation points from the meeting held on 28th February 2023. EJ asked for the report to be taken as read highlighting the key points as follows:

- There is evidence that the Committee will seek further assurance and follow through with expected actions when it is required. For example, the Committee has recently asked for further analysis and a related timeline in relation to the backlog of electronic discharge summaries.
- The Committee spent time discussing patient experience, noting that the Trust does perform well from a patient feedback perspective. As part of this the Committee reviewed the Inpatient

Survey and Maternity Survey of which both are on the Board agenda.

- The Committee received and discussed the maternity report which is also required to be discussed at Board. The Committee discussed that safety metrics continue to remain positive. The Improvement Programme is slightly behind but this is largely due to the high level of vacancies within the department.
- The Committee received an update from the Medicine team on divisional governance which indicated an improved picture around quality governance with thin division.

Discussion:
IG referred to safeguarding adults and children and asked if there have been any trends highlighted in these reports. EJ noted that the reports provide a good level of assurance and training has improved significantly. In terms of safeguarding children, it was noted that Child and Adolescent Mental Health Services (CAMHS) cases have increased during the pandemic and the Trust have had to undertake are which is unfamiliar to staff in an acute hospital. JDy provided assurance around the safeguarding teams in both children and adult safeguarding. There are challenges around education in some areas but the teams have reiterated the correct processes to follow in terms of referrals, so the Trust do not lose sight of specific cases.

SH explained that safeguarding demand is monitored at Wiltshire Place and it is clear that demand has increased in all elements of safeguarding. The Trust is structured to support physical health needs and there is not a workforce on substantive basis to respond to the mental health needs of some patients.

MvB queried the content and implications of Oliver McGowan training which will provide all staff with additional training around supporting patients with learning disabilities. JDy noted that there is external support to assist the roll-out of this training. IG reiterated the Board's shared responsibility around safeguarding and the importance of understanding the implications of training. SH referenced the interdependencies between this and reducing health inequalities. SH suggested that the Board need to have a broader conversation about ensuring Health Inequalities is considered in strategic decisions going forward. A Health Inequalities session to be scheduled into the Board Development schedule **ACTION: PC/KN.** **KN/ PC**

TB1 9/3/2.2 **Finance and Performance Committee 28th February 2023**

In DBe's absence, EJ presented the report providing a summary of escalation points from the meeting held on 28th February 2023. EJ asked for the report to be taken as read but noted the following key points:

- The items discussed in the meeting feed into the Board agenda items being discussed today
- The Committee received business cases which will be discussed in the private Board session.

- There was a focused report on diagnostic performance. There is a lot of good work underway which LT is leading on to manage the operational challenges within the Trust's remit to solve.
- Financial and Operational plans were discussed in detail at the meeting and will be further considered in the private Board meeting.

The report was noted.

TB1 9/3/2.3 **Trust Management Committee (TMC) 22nd February 2023**

SH presented the report, providing a summary of escalation points from the meeting held on 22nd February 2023. SH asked for the report to be taken as read highlighting the key points as follows:

- The Committee received and discussed business cases, one of which related to the Surgical Robot business case which was also considered at F&P and is on the private Board agenda for approval.
- The Committee heard from clinical divisions around operational and financial planning and the discussions are summarised in the report.
- There was a paper from Laurence Arnold, the Campus Project Lead, around space allocation and some proposed principles which TMC supported.

The report was noted.

TB1 9/3/2.4 **People and Culture Committee 26th February 2023**

MvB presented the report from the meeting held on 26th February. MvB asked for the report to be taken as read and noted the following key points:

- The Committee reviewed their Terms of Reference and it was agreed that they needed to be updated to reflect and align to the breakthrough objectives, to reflect the Trust's commitment to Equality, Diversity and Inclusion (EDI) and wellbeing. It was also agreed that the ToR would be updated to ensure membership included three NEDs, to ensure quoracy and to align to the other Board Committees.
- An ongoing focus and a breakthrough objective relate to staff availability and the Committee discussed the need to understand why staff leave the organisation, to support the retention effort required.
- The OD&P directorate have made great progress in the last year. The drive for recruitment has been successful with over 1000 staff recruited in the last 12 months. However, this highlights issues with turnover if approx. 25% of the workforce is new. This reiterates the importance of the retention work.

Discussion:

The Board discussed retention efforts with IO explaining that the OD&P team are working through the Improving Together format and utilising the A3 methodology to understand leavers and start to focus on those areas which will have the biggest impact. IG supported this, noting that many of the Trust's challenges will be positively impacted with better staff availability.

The reasons for staff leaving have been widely discussed and RA suggested the next step is about what is going to be done to improve this position. It was acknowledged it is difficult to address the actions to improve retention whilst combatting a tide of people leaving in a short space of time. However, the points highlighted in the Staff Survey and the actions that are developed as a result is a good place to start. The Board acknowledged the importance of People and Culture Committee oversight of the key areas work driven forward by the OD&P team, particularly as staffing is one of the Trust's greatest risks.

IG referred to the Freedom to Speak Up report that was received at the Committee, noting the positive indicator that people are willing to speak up. IG noted it would be useful to consider if the people that speak up feel like the most appropriate action has taken place.

TB1 9/3/2.5 **Integrated Performance Report (IPR) (M9)**

ME presented the Integrated Performance Report which provided a summary of December 2022 performance metrics. ME took the paper as read but highlighted two key issues:

- The first being staff turnover, which had already been discussed earlier in the meeting, as one of the Trust's biggest risks.
- The second key factor affecting performance is the demand for beds which is driving up pressure on capacity and therefore impacts finance, performance, and quality.

Discussion:
MvB asked if the IPR could also display the actual number of patients to indicate how many people have been affected. use of percentages – sometimes small numbers. It was noted that this had been taken as an action at F&P Committee.

DBu queried if there were one or two areas of focus that would impact patients, accepting that some areas of poor performance will not change in the near future. PC explained that the Improving Together approach improving will provide that focus on the areas of improvement that will have the most impact for patients. However, the Board and wider Trust needed to allow the space and time for this improvement as there are no quick solutions. What is going to be more useful is to empower clinical teams to make these improvements within their own departments and over the next 12 months, where training is further embedded in operational systems, the Trust should start to see more of this.

JDy explained that falls are a breakthrough objective and a key focus for all teams to improve. To support delivery of these objectives, the Trust have really focused on recruiting additional nursing staff and more

overseas nurses are being recruited. However, high volumes of new staff also means that training has to be delivered and they also need to understand the expectations and standards required, which takes time. IG noted that an Improving Together session was scheduled for a future Board Development session.

EJ queried when the Board will start to see a shift on performance in relation to the internal actions underway, considering the external factors and No Criteria to Reside (NCTR). SH explained that this will be included as part of the operational and financial plan. SH further noted that if the Trust continues to operate with too many beds open this will have an impact on staff morale, efficiency and productivity and will not result in rapid improvement in the metrics.

SH referred to the Trust's turnover ambition of 10%, noting that there needs to be an incremental breakdown to indicate a timeline of improvement, which is what the plans going forward should achieve.

TB referred to the recently published report from Health Foundation regarding delayed discharges and asked if the teams have had time to reflect on that report. SH explained that the three acutes have been working on the drivers of NCTR for two years and this demonstrates the specifics of what the Trust can influence and what they cannot. It was also noted that the BSW Academy have done a detailed piece of work around domiciliary care which has provided some good data. TB suggested that it would be useful, from a system perspective, to set out some of things that should be reported on and the gaps as it will indicate what we do not do as a system. LT noted that social care does not determine this in the same way as the NHS but ultimately the system will be trying to get into that position.

RA referenced the discussion at People and Culture Committee around person-centre care and person experience. RA noted that this is the missing piece

MvB asked how the Trust were doing in relation to discharges pre-12pm. LT noted that performance on this has been challenged but is linked to improvement opportunities going forward.

TB queried the Maternity dashboard asking why it indicates a safe staffing level with a vacancy rate of 20%. JDy confirmed that the vacancy rate relates to obstetrics, not midwives.

TB1 9/3/3 **STRATEGY AND DEVELOPMENT**

TB1 9/3/3.1 **Digital Strategy Update**

Deferred to April.

TB1 9/3/3.2 **Improving Together Quarterly Update Report Q4**

Deferred to April.

TB1 9/3/4 **FINANCIAL AND OPERATIONAL PERFORMANCE**

TB1 9/3/3.3 **Charitable Funds Strategic Update**

ME presented the report to the Trust Board to provide a summary of the Trust's Stars Appeal Charity and to highlight the charities priorities going forward. ME explained that the charity, as of March 2023, held funds amounting to £16.3m with 58% of that being unrestricted funds.

ME referenced the charity intent which was discussed at the Charitable Fund Committee (CFC) in December and was outlined in the paper. Given the financial constraints of both SFT, and the wider NHS, consideration will also be given to opportunities for the Trust to move faster in its offerings of medical equipment that would otherwise be possible.

Discussion:
IG explained that as part of his induction to the Trust, he had taken the opportunity to speak to those that run the Stars Appeal and it is clear there is a dedicated team. IG reflected that the Board is collectively the Trustee for the charity with responsibilities delegated to the CFC and it is for Trustees to set tone and intent for the charity. What is clear is that there is a significant level of reserve and it is there to be utilised.

SH suggested that the Trustees of the charity should have a separate session to discuss the strategy of the Charity and how this aligns to the Trust's strategy. **ACTION LT/TM** **LT/ TM**

LT highlighted that from a governance viewpoint, this meeting was as the SFT Board. As the charity is a separate legal entity, this needs to be discussed separately and therefore the Trust Board should not be discussing any strategic intent for the charity in this forum. The Board supported this.

(The Board took a 30 min break)

TB1 9/3/5 **QUALITY AND RISK**

TB1 9/3/5.1 **Patient Experience Q3**

JDy presented the report which provided a summary and the insights drawn from the various methods by which our service users feedback on Trust services. JDy took the report as read.

Discussion:
The Board noted that the Patient Experience report was discussed every quarter at CGC. EJ commented that the Head of Patient Experience, Victoria Aldridge, had done an excellent job since commencing in the role, which was supported by an understanding of operational delivery and strategic direction.

The Board discussed the quality and assessment of complaint responses and asked what the process is. SH explained that the divisional teams write the letters with clinical input, the letters are then checked by PALS, then by either KN or FMc, who then forward to SH to sign once content. SH will check and sign so there is a robust process.

The Board noted that the Trust benchmarks well in terms of Ombudsman referrals. However, it is accepted that the Trust needs to improve on complaint response times. The Board heard that response times were agreed with the complainant so it is disappointing that the response times are not where the Board would like to see them. Steps are being taken within divisions on improvement in governance work. Some of the longer waits are due to complaints which span across multiple specialties.

PC suggested some direct work is required to help our public population understand why the Trust collect data. PC noted that there is more the Trust needs to do to recognise groups of people who do not respond to these surveys, e.g., the relatively small percentage of LGBTQ+, as there is a risk that the views of different groups of people is missed. The public need to understand why the Trust ask for certain demographics and that is safe to answer.

The Board recognised that nutrition and hydration was a theme that regularly appeared in complaints and is also in the inpatient survey. JDy referenced a pilot scheme the Trust had undertaken several years ago to introduce a housekeeper role to undertake rounds, ensuring fluids and food were regularly available to staff and the general area around the patient was kept clean. JDy noted that the pilot had been a success and the Trust has been recruiting a team of housekeepers to support this effort across the Trust. EJ noted this importance of this role and the challenges around feeding patients for nurses, particularly when Care Hours Per Patient, Per Day (CHPPD) are stretched.

The Board noted the positive step of reintroducing Real Time Feedback and the value this can add to patient and staff experience.

TB1 9/3/5.2 **National In-patient Survey**

JDy presented the report which provided the Board with a summary of the Trust's Adult National Inpatient Survey 2021 and the action plan progress update. JDy provided a summary of the key headlines, noting that the action plan focuses on timely discharge, safer staffing, facilities and food/ hydration.

Discussion:
SH reflected that ambition around patient experience was missing from the action plan. SH noted that she and the Board needed to see the ambition for patient experience and to quantify the progress made ging forward. JDy and VA to take this forward and reflect for future reports.
ACTION: JDy/ VA.

JDy explained that the Patient Experience Group will take these actions forward and Angie Ansel, Deputy Chief Nursing Officer will be leading this group. JDy noted that the results of the survey have remained considerably stable through an exceptionally challenging time.

TB queried how the actions arising from these surveys land with staff. JDy noted that several of the actions are covered as part of the breakthrough objectives already. Nutrition and hydration, as discussed in the previous report, is a concern and actions are in place via the

Improving Together methodology, alongside the recruitment of additional staff.

TB1 9/3/5.3 **Maternity Quality and Safety Report Q3 22/23**

HB joined the meeting to present the report, alongside JDy as executive lead for Maternity. The report highlights the achievements and demonstrates the current position against local and nationally agreed targets.

HB highlighted the positive work undertaken in Q3, including the birthing unit audit and the data around the professional midwifery advocate. The areas of focus include screening quality assurance action plan, continued Ockenden compliance and progress on the Maternity Safety Programme.

HB noted that the team had recently held an open forum in Maternity and no one escalated any safety issues or concerns. The key theme of concern and challenge was around staffing. There are currently 18 vacant midwife posts and the team is working hard to recruit into those posts. HB noted that a Birth Rate+ review is booked for June 2023.

Discussion:
EJ noted that the report had been updated since CGC as not all of the safety visits were included. (*Post meeting note: the updated report was circulated to Board members).*

EJ summarised her reflections from the several walkabouts in Maternity she had taken part in as part of her Maternity Champion role. What is difficult to ascertain, as all Trust's seemed to report differently, is what is expected to be reported at Board level. EJ noted it would be useful to understand what needs to come here to meet the Maternity Incentive Scheme. SH asked EJ, in her role as Maternity Champion, if she would contact the Chief Midwife to get further clarity on what is expected at Board. **ACTON: EJ** **EJ**

SH referred to Maternity staffing tolls, noting her concerns that the Trust could not meet the requirements set out pre-Ockenden. SH queried what the response will be if the Trust is unable to reach the expected registered midwife number and will it indicate the knowledge, skills and competencies required to run an effective service. SH further queried what HB was most concerned about and key areas of focus.

HB explained that there will be a single maternity plan as so many of the national workstreams contradict and there is a lot of duplication so this will help. Locally, HB explained that the cultural work is ongoing and the momentum needs to continue to ensure the culture in the department continues to improve.

In terms of recruitment, the teams are pursuing other ways in which new overseas staff can be utilised whilst their waiting to practice as registered midwives.

MvB referenced the nitrous oxide statement that had come via the communications team and asked if there were any issues. HB advised

that scavenging is tested regularly and this has not been flagged as a concern.

RA noted that the midwifery pipeline has hugely reduced nationally and there will be a deficit of newly qualified midwives. If the Trust is looking at the different utilisation of nurses and maternity support workers, how can we influence the midwifery conversation nationally and ask consultant midwives to represent and think more broadly about alternative roles. JDy explained that she regularly meets with the southwest Chief Nurses and they have discussed the role of apprenticeships if people are choosing not to go into higher education. Whilst some apprenticeships are funded via the levy, the Trust would have to pay for people's time during an extended training period. Therefore, further support to fund this will be required.

PC referred to the patient experience feedback in the report, noting that demographics for the respondents had been collated but there was nothing indicated in terms of questions and/or actions referencing back to demographics. The differential needs of these people need to be addressed and the Trust need to demonstrate how it is doing this. IG agreed, noting that this challenge links back into the health inequalities work. JDy explained that the demographic data is useful, e.g., it is understood, that those patients from a Black, Asian, Minority Ethnic (BAME) background are higher risk from a maternity perspective.

SH noted that in terms of demographics, the piece missing in the reports is what the Trust is doing about it and how do we demonstrate that.

TB1 9/3/5.4 **Maternity Survey 2022**

JDy presented the Maternity Survey 2022 results and action plan. The following key points were noted:

- The Maternity Survey was conducted in January and February of 2022. 300 women were included in the survey and 182 women responded. The response rate was 61% which is significantly higher than the average national response rate, for this survey, of 48%.
- In terms of national comparisons, the Trust received average scores for 39 questions, above average for 25 questions and below average in 5 questions. A
- Action plans are already in place to address areas of improvement.
- Antenatal screening is an area we are focused on as it is recognised this is not robust enough, largely due to the size of the maternity department at SFT.

Discussion:
IG referred to the respect, dignity and patient care elements of the responses and the need to focus on those. HB noted that the data was collected a year ago and assured the Board that since then a lot of work has been done to work on the areas highlighted as part of this survey.

SH noted the good performance when compared nationally, considering the pressure the team has been under. SH noted that the new leadership team has been embedded and the focus is now trying to manage

vacancies. Whilst there is more work to do, the safety metrics are positive and overall patients have been complementary about their care.

RH noted the action plan arising from this and the several other action plans that had been presented at Board. RH asked the executive how the Trust manages conflicts of priorities, resources, and risks. IG explained that this is part of a prioritisation process and will be tied up in operational and financial planning.

The Board thanked HB and she left the meeting.

TB1 9/3/6 PEOPLE AND CULTURE

TB1 9/3/6.1 Nursing Skill Mix Review

Deferred to April

TB1 9/3/7 GOVERNANCE

TB1 9/4/7.1 Constitution Annual Review 2023

FMc presented the report which provides the Board noting that the constitution is reviewed and approved by the Trust Board and Council of Governors on an annual basis. The Board was being asked to consider and support amendments to the constitution and discuss the composition of appointed governors. FMc summarised the amendments made and asked the Board to consider if the partnership governors, within the Appointed Governors category, were the most appropriate.

Discussion:
SH commented on the duplicating conversations that will arise, particularly with ICB representatives as the Trust s working alongside these organisations closely. There are now formal partnership Boards which were not established when Foundation Trusts were introduced and therefore there needs to be consideration if this is the best use of people's time.

MvB noted that he supported the Military representative on the CoG but suggested it was worth contacting the local army contact to re-establish if this is the most appropriate position to represent the local army interests.

RA noted that it would be useful to be more explicit around community involvement and perhaps create space to have a broader conversation about the value of partnerships. RA noted that umbrella organisations are not particularly representative and there are opportunities to be more innovative.

Decision:
The Board supported the suggested amendments in the constitution. IG noted that the constitution would be going to the Council of Governors in May for approval and to initiate a similar conversation around Appointed Governors, with a hope to update this in the next 12 months.

TB1 9/3/7.2 **Trust Board 2023 Cycle of Business (Public/Private)**

FMc presented the business cycles for both public and private Trust Board. The Board noted that they had been updated to reflect the new meeting structure, noting that there will be a full Trust Board eight times a year, with development sessions planned for March, June, August and November.

Decision:
The Board approved the business cycles.

TB1 9/3/8 **CLOSING BUSINESS**

TB1 9/3/8.1 **Any Other Business**

There was no further business.

TB1 9/3/8.1 **Agreement of Principle Actions and Items for Escalation**

- IG highlighted the key areas of discussion, including:

  - The discussion around the Board's shared responsibility regarding safeguarding.
  - The need to have a further Board session on health inequalities
  - There will be a development session on Improving Together to remind the Board of the commitment and how this work is taken forward.
  - There will be a separate Trustee's meeting to discuss the strategic intent of the charity.
  - A good level of assurance was received in terms of quality around complaint responses and the Board discussed the challenges around timeliness of these.
  - Hydration and nutrition are a key theme in the Patient Experience Report but assurance was received that actions are being put in place to improve this position.
  - Good assurance was received around the improvements and actions underway in Maternity. Further clarity is being sought on what detail is expected at Board level.
  - Key successes were picked up throughout the meeting and all staff groups are working extremely hard.

TB1 9/3/8.3 **Public Questions**

There were no public questions.

TB1 9/3/6.4 **Date of Next Public Meeting**

Thursday 6th April 2023, Board Room, Salisbury NHS Foundation Trust

TB1 9/3/9 **RESOLUTION**

TB1 9/3/9.1 Resolution to exclude representatives of the media and members of the public from the remainder of the meeting (due to the confidential nature of the business to be transacted).

Master Action Log

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

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

Committee	Organiser	Reference Number	Deadline	Owner	Action	Current progress made	Completed Status (Y/N)	RAG Rating
Trust Board Public	Sasha Grandfield	TB1 12/1/2.5 Integrated Performance Report (IPR) (M8)/ Stroke	06/04/2023	Peter Collins, PC	PC to check the IPR for clarity to ensure wording around Stroke and thrombolysis reflects the current situation.	**PC noted that he had sent an email to Stroke to clarify the narrative. PC to feedback at the next meeting.**	N	2
Trust Board Public	Sasha Grandfield	TB1 9/3/2.1 Clinical Governance Committee (CGC) 28th February 2023	06/04/2023	Peter Collins, PC Kylie Nye, KN	SH suggested that the Board need to have a broader conversation about ensuring Health Inequalities is considered in strategic decisions going forward. A Health Inequalities session to be scheduled into the Board Development schedule.	**Scheduled for August. Item closed**	Y	3
Trust Board Public	Sasha Grandfield	TB1 9/3/3.3 Charitable Funds Strategic Update	TBC	Lisa Thomas, LT Tony Mears, TM	SH suggested that the Trustees of the charity should have a separate session to discuss the strategy of the Charity and how this aligns to the Trust's strategy.	**Date TBC**	N	4
Trust Board Public	Sasha Grandfield	TB1 9/3/5.3 Maternity Quality and Safety Report Q3 22/23	06/04/2023	Eiri Jones, EJ	SH asked EJ, in her role as Maternity Champion, if she would contact the Chief Midwife to get further clarity on what is expected at Board.		N	2

NHS Salisbury NHS Foundation Trust

Report to:	Trust Board	Agenda item:	2.1
Date of meeting:	06/04/2023		

Report tile:	Annual Operating Plan Narrative			
Status:	Information	Discussion	Assurance	Approval
				Yes
Approval Process: (where has this paper been reviewed and approved):	Content in different format approved by F&P Components submitted to ICB as part of system planning round.			
Prepared by:	Tony Mears, Associate Director of Strategy			
Executive Sponsor: (presenting)	Mark Ellis, Chief Finance Officer			

Recommendation:

The Board approve the annual plan for 2023/24 and notes the risks and mitigations.

Executive Summary:

This document is the annual plan for 2023/24 outlining the key objectives of the Trust. The plan pulls together the key improvement plans on reducing length of stay, reducing waiting times for planned care whilst continuing to focus on improving patient experience and the quality of care.

The key elements for the plan for the Board to note include:

The Trust is projecting to achieve all mandated standards for 2023/24 apart from – 92% bed occupancy and Elective inpatient activity 103% of 2019/20 activity. There are improvement plans in place to work towards achieving these standards including Reducing length of Stay, system plans increasing out of hospital care, and the building of a new ward to open Spring 2024.

The financial plan for 2023/24 is challenging with a savings plan target of 5% c£15.3m. This is a significant ask for the Trust. Improvement plans are in place however the pace and scale required must be seen in the context of operational pressures and capacity.

The key focus for 2023/24 is a continuation of a focus on workforce. Without a stable, skilled, and motivated workforce our plans will not be fully realised. The Trust has a clear plan in line with the NHS People promise to improve the experience of our workforce.

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):	

Annual Plan

Salisbury Hospital NHS Foundation Trust

Contents

Foreword

By Stacey Hunter, Chief Executive Officer

Everything we do at SFT is about providing an outstanding experience for our patients, their families, and our colleagues. To do that we have an evidenced based approach that puts our patients and our best opportunities for improvement at the forefront of our plans

I am extremely proud of what the Salisbury team has been able to achieve over the past 12 months, we continue to experience tremendous pressure on our services and the professionalism of our teams has been paramount in helping us progress our ambitions to provide outstanding care for every patient. Looking ahead to 2023/24 I know we want to support our colleagues to build on their success to secure further progress against the priorities in our plan

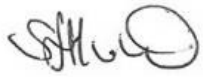
We cannot escape the challenging national context. Industrial action, the financial outlook, workforce challenges – all compound one another and make the delivery of our plan more complex. This shouldn't stop us being ambitious for improvement and, we have chosen to set ambitious targets that represent the things that will make the biggest difference for our local communities.

Our plans set out exciting changes in the way we will deliver care – for example, the work our clinical teams are leading to develop Same Day Emergency Care, a continued focus on reducing waiting times for planned care, and a relentless focus on recruitment and retention of staff.

We are fortunate to have excellent teams whose commitment to our local communities is exceptional. This gives me confidence that despite some of the continued challenges the NHS is facing, we have the will and determination to continue to make the improvements set out in this plan.

During the next 12 months we will also be working on plans that will increase our capacity in 2024/25 – this includes building a new ward that is expected to open in Spring 2024 and working with our partners in the ICS to increase the capacity in virtual wards. This will ensure that we can continue to improve access for our population to key services, reduce waiting times further and ensure we continue to support our teams to develop their specialities.

I would like to thank all our colleagues for their continued support – without this we wouldn't have a hospital that I know the Board and our local community are very proud of.



Stacey Hunter, Chief Executive Officer

1. Executive Summary

2023/24 is going to be a challenging year. To continue to reduce the time patients are waiting, alongside improving urgent care will be difficult, particularly given the ongoing challenges to recruit and retain staff in the NHS. 2023/24 is made more testing with a financial outlook where funding is more constrained and the need to increase productivity and drive efficiency is even more pertinent.

Over the past year the Trust has made significant progress on reducing long waiting times. The Trust achieved the reduction in patients waiting over 78 weeks in February, waiting times for diagnostics has started to slowly improve. Urgent care was more challenging, in 2022/23 we had a record number of escalation beds open, driving financial and workforce pressures which are unstainable moving into 2023/24. Building on the successes of last year and addressing the national and local ambitions, our focus is on these key areas:

The focus for 2023/24, articulated in the form of our “Breakthrough Objectives”, are focused primarily on

- Improving our urgent and emergency care pathways, ensuring patients remain at SFT for the optimum amount of time therefore reducing patient length of stay (LOS) and the number of open beds.

- Reducing the number of patients that are waiting for planned care, both outpatients and inpatient activity and reducing the number of unnecessary follow up appointments.

- Continuing to focus on reducing harm to our patients, focusing particularly on preventing falls for patients in our care.

- Ensuring we have the right skilled workforce to deliver our plans, this encompasses the NHS People Promise, not only making sure we recruit the right number of people, but we continue to improve on the experience of staff at SFT through education, training, wellbeing, flexible working and ensuring everyone has a voice that counts.

These objectives are measured through targeted metrics where we will track our improvement throughout the year aligned to strategy delivery:

- **Reducing our Bed occupancy**
- **Reducing time to first outpatient appointment**:
- **Increasing Staff availability**:
- **Reducing falls**:

All of this sits within a challenging fiscal context. BSW exits 2022/23 with a balanced plan but a significant underlying deficit, owing to financial pressures across all partner organisations. The financial improvement programme itself is ambitious, representing 5% of the organisation’s cost base in the year ahead.

Despite the challenges articulated we expect to reduce waits across diagnostics and cancer pathways to meet the six-week diagnostic standard, projecting to achieve the national standards for 28 week cancer performance, deliver the national 76% ED standard, and reduce waiting times for those currently waiting over 65 weeks. We will make improvements on recruitment and retention, on quality, and reduce our bed base closer to core numbers to enter 2024/25 on a much stronger fiscal footing.

Our plan for 2023/24 will ensure we continue to pursue our vision[1] of an outstanding experience for our patients, their families, and the people who work with and for us.

2. National Context

Operational planning guidance[2] was issued by NHS England (NHSE) on December 23rd 2022 which set out the operational targets for 2023/24 (see Appendix 1)

Most pertinent are the national recovery objectives, those applicable to us as an acute provider are set out in ***Table 1*** against our plan.

Table 1 – SFT Plan against national NHS objectives 2023/24[3]

	Area	Objective	SFT Plan
Recovering our core services and improving productivity	Urgent & Emergency Care	76% of patients seen in ED within 4 hours.	Achieve
		Reduce Adult General & Acute bed capacity to 92% or below.	Low confidence
	Elective Care	Eliminate waits of over 65 weeks for elective care.	Achieve
		Deliver system specific activity targets (103%)	Low confidence
	Cancer	Reduce the number of patients waiting over 62 days.	Achieve

[1] ourstrategy_2022-2026.pdf (salisbury.nhs.uk)
[2] NHS England » 2023/24 priorities and operational planning guidance
[3] PRN00021-23-24-priorities-and-operational-planning-guidance-v1.1.pdf (england.nhs.uk) PAGE 7

	Area	Objective	SFT Plan
		Ensure 75% of patients receive diagnosis within 28 days.	Achieve
	Diagnostics	Increase the number of patients that receive a diagnostic test within 6 weeks.	Achieve
		Deliver diagnostic activity that supports plan to address elective and cancer backlogs.	Achieve
	Use of Resources	Delivery a balanced net system financial position.	Achieve
LTP and transformation	Workforce	Improve retention of staff and attendance through a focus on the people promise.	Achieve
	Prevention & Health Inequalities	Continue to address health inequalities and deliver on the Core20PLUS5 approach.	Achieve

SFT's biggest challenges is delivering the national ask will be delivering 92% bed occupancy and related - delivering elective inpatient activity levels above 2019/20, which relies on an increase in bed capacity.

3. Local Context

BSW exits 2022/23 with a significant underlying deficit, owing to financial pressures across all partner organisations.

For the first time SFT is part of a *system* planning return. The Trust have worked closely with Acute Hospital Alliance partners as well as BSW and Southwest region colleagues to arrive at a credible, if stretching, plan. This was submitted to BSW on the 16th of March, and by BSW to the Southwest NHS England regional team on the 30th of March.

As regards to our locality, a key plank of our planning at 'place' will be the ability to remove escalation beds, reduce the length of stay for patients waiting for onwards care, and increase elective activity. Without our partners in the system none of this will be possible.

Work with partners across Wiltshire is ongoing around a suite of transformation plans aiming to drive at these goals; including but not limited to urgent community response (UCR), virtual wards, home first, a range of activity looking at specific pathways focusing on getting patients to their usual place of residence, and internal work such as discharge optimisation and Same Day Emergency Care (SDEC).

Tangential to our annual operating planning work, we continue to lean into partnerships at place level to influence wider Trust priorities such as a reduction in health inequality.

Trust strategy and the annual planning guidance align well, and our Improving Together approach to delivering our strategy and continually improving will be maturing beyond initial implementation throughout 2023/24.

Cascading from our vision are our three strategic priorities, known by staff across the organisation as 'the three P's'. **People**, **Population**, and **Partnerships**.

4. Our Demand

For 2023/24 the demographic profile of our patient population remains broadly static, with a marginal increase in adults over 65's in line with the rest of the country. On this basis we have not assumed a significant increase in demand for our services.

Cancer referral growth trajectories from the Somerset Wiltshire Avon and Gloucestershire (SWAG) cancer alliance network assume a 7% growth in referrals through the two week wait pathway. The expectation nationally is for a 20% increase in diagnostic capacity, and the introduction of community diagnostic centres (CDC) will support this. We will continue to expand our own capacity through productivity and recruitment plans with a plan of delivering 7% more diagnostic activity than 2019/20.

Whilst we don't expect our referrals or number of patients using our urgent care services to increase, we are planning to improve our efficiency and productivity which will allow us to see more patients during the year.

5. Our Capacity

The national expectation is to continue recovering elective services following Covid. The metrics subject to focus within the planning guidance are:

- Reducing outpatient follow-ups by 25%
- Increasing productivity to meet the 85% day case and 85% theatre utilisation expectations
- Deliver 30% more elective activity by 2024/25 than before the pandemic.
- 92% bed occupancy

Our biggest capacity challenge is the number of beds to support inpatient elective activity. We have worked hard to increase our numbers of patients treated as day cases; however, we

have struggled to achieve inpatient elective activity to 2019/20 levels due to the lack of surgical beds. Elective recovery targets have been set across BSW, and SFT has been asked to find elective capacity/activity of 103% against 2019/20 levels – we are unlikely to meet this target and anticipate activity levels closer to 96%.

The Trust has been successful in being awarded funding for a new Ward (~£14m capital) – this is currently being constructed and will open spring 2024 which will help address bed capacity and will make significant progress in reaching the aim of 30% more elective activity by end of 2024/25. Recruitment and theatre productivity programmes continue to focus on how capacity can be increased ready for when the beds open.

Our bed occupancy will average 97% against a national target of 92%. We have opened a significant number of escalation beds in 2022/23 – resulting in an escalated capacity of ~500 beds. We plan to return to our core capacity of 410 general and acute beds (G&A) (excludes NICU, Maternity, and Hospice) in 2023/24 which will allow us to increase elective activity, reduce agency spend, and release the productivity potential of a workforce less spread across escalated capacity.

Bed modelling forecasts high occupancy and a requirement for Day Surgery Unit (DSU) beds as escalation capacity in quarter four – improvements required to length of stay, reducing the number of patients waiting for onward care (medically fit for discharge) are necessary to protect what elective capacity we have been able to model.

We will meet a national target on theatre utilisation of 85%, though this is dependent on our bed capacity – any utilisation beyond this will reignite workforce capacity issues as we currently do not have the workforce to utilise theatres at 100%, recruitment plans continue to ensure we have the right capacity for patient demand.

Improving staff retention and increasing availability are part of the Trust strategic planning framework, delivered in part through our People Plan. Driver metrics for the plan are designed to measure the impact of our actions in three key areas:

- Improving our staff engagement to be within the upper quartile for acute trusts;
- Reducing unwanted turnover to the Trust target of 10%; and
- Recognition of SFT as an inclusive employer, achieving the median for benchmark trusts across workforce equality standards.

Our people promise work has enabled us to focus activity and resource on priority actions.

Improving staff availability is a breakthrough objective designed to ensure the right staff are in the right place to improve patient care and reduce agency spend, thus delivering the financial target of a £2M reduction in year against agency spend.

This will be achieved by reducing short term absence and improving retention through an improved health and wellbeing offer and targeted absence management interventions. Attraction campaigns will target hard to fill and niche skills sets, as well as broader campaigns to rapidly recruit high volume roles such as HCAs, resulting in a reduction of vacancies across the Trust.

Our International Nursing recruitment plan will target theatres staff to enable increased elective work to be conducted, as well as registered nursing posts and AHP staff in identified high vacancy areas, we anticipate a requirement for c135 overseas staff to be recruited.

Finally, short-term projects will enable establishment control, improved processes for roster management to ensure efficient use of available staff and an improved onboarding experience that is more efficient, with lower wastage rates.

6. What will we do differently?

To achieve and deliver our ambitions, the Trust must continue to adapt and change. We are working with our acute partners in BSW, embedding our structured improvement programme - Improving Together. This will allow us to align and enable the collective abilities of our workforce to transform and continually improve our services.

Through Improving Together, we seek to align our direction, goals and objectives whilst empowering teams across the organisation to make everyday changes to improve patient care.

Within Improving Together the Operating Management System (OMS) enables us to focus on making improvement part of our daily work, fostering a culture of continuous improvement and developing leaders as coaches. The OMS integrates improvement into the daily life of teams at three levels. Executives reduce the number of priorities and coach teams to solve problems; managers work on a set of focussed priorities with clear and consistent performance reviews; and frontline teams understand the Trust's strategy and priorities and their role in delivering them. Our goal is for all staff to be empowered to make improvements.

The Strategic Planning Framework (SPF) sets out our areas of focus to achieve our vision and strategy. Nine vision metrics, three under each pillar of the strategy, describe our overarching goals for the next 7-10 years. The vision metrics are how we will measure the progress of achieving our vision across People, Population and Partnerships (see above).

The strategic initiatives focus on the things we must do and can't fail at to build the foundation for the delivery of our vision. These are large programmes of work with a 3-5 year lifespan.

Breakthrough objectives are focused at a Trust level and targeted for significant improvement (30+%) within 12 months. Using data to guide our decision making, these have been selected to make the most positive impact on achieving our annual plan and our overall vision.

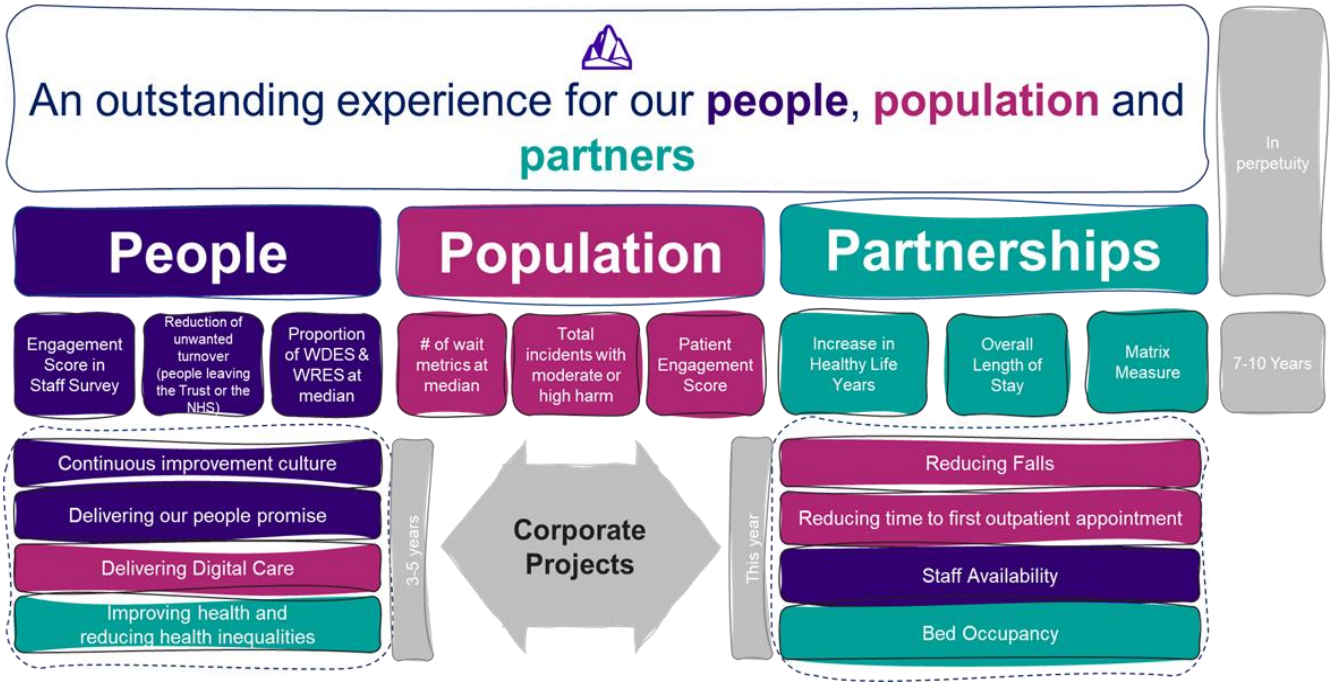


Figure 4 – *SFT Strategic Planning Framework*

Leadership behaviours

Surrounding the rollout of the OMS are our leadership behaviours. These provide a framework to support our colleagues in developing a culture of continuous improvement. Over the next 12 months we will begin to rollout and use our behavioural framework, building it into our appraisals, recruitment and promotion processes so we can recognise and reward the right behaviours.

Delivering difference

In our annual plan we have a range of areas where we need to look toward different approaches to deliver against our forecast demands. These include:

- System opportunities and working is discussed fortnightly at the BSW Elective Recovery Meeting (which feeds onto the BSW Elective Care Board) at which all system NHS providers are present. Strategic and tactical options are discussed e.g., shared system waiting list development through the IECCP programme, mutual aid, and specialty collaboration, e.g. System wide paediatric oral surgery 'Super Saturdays' to help address collective backlogs in paediatric surgery across BSW.

- Regarding theatres we continue to work on programmes developed through the regional theatre improvement programme supported by Four Eyes. For Salisbury this includes, enhanced pre-operative screening including, digital pre-op and day case by default approach when listing.

- Scheduling is being improved with greater oversight of waiting lists and waiting list management through the IECCP Programme, enhancing communication and list formation between clinical and administrative teams (including theatres).

- GIRFT and HV/LC principles will underpin metric setting, monitoring and achievement, with theatre utilisation and day case rates being the key focus in 2023/24.

- Our new ward continues to be developed with work having now commenced on site, which will place the Trust in a stronger position to ring fence elective capacity and allow for greater utilisation of our theatre estate, and support increased activity, improving further already improved day case rates now at 82% to above and beyond the 85% national aspiration.

The elements listed above will be overseen by both the Planned Care Board and the Urgent and Emergency Care Board, two improvement boards which will allow operational focus on improvement aligned to the breakthrough objectives in year. The key focus areas will include, Theatre Utilisation and Productivity, and Outpatient activity and transformation, Emergency Department standard, Length of Stay reductions.

With the improvement programmes outlined our planned activity in response to demand will seek to:

- Deliver 10% more elective activity than before the pandemic to reduce long waits
- Deliver a reduction in total outpatient follow-ups on pre-pandemic levels
- Deliver 20% more diagnostic activity on pre-pandemic levels
- See over 76% of patients in ED within 4 hours
- Remove all those waiting over 65 weeks
- Reduce those waiting over 52 weeks for elective procedures

Our ability to meet demand will rely on the de-escalation of beds and working closely with community partners to reduce hospital Length of stay and quality onward pathways that reduce the risk of re-admission.

Quality

We will aim to deliver quality through the Improving Together methodology and the work that feeds into the selection of our breakthrough objectives. As per the Health and Social Care Act of 2012, the NHS has a duty to continually improve the quality of care being delivered across a range of health services. Quality is defined as having three dimensions: patient safety, clinical effectiveness, and patient experience, and each of these areas are represented by their own steering groups at SFT.

Specific priorities and objectives identified from these steering groups are regularly discussed, and upwardly reported to our Trust Quality Board (CMB). Through this process, and in addition to driving up quality through Improving Together, key priorities for 2023/24 will be focused on the adoption of the new Patient Safety Incident Framework (PSIRF), improving our internal processes for managing clinical audit, and for managing complaints.

The Care Hours per patient day (CHPPD, a measure of our staffing in ward areas have been particularly challenged in 2022/23, this has started to improve with a sustained recruitment and retention campaign. 2023/24 will build on this success with a targeted focus on the quality of care. This is reinforced with a ward accreditation programme, training and development for ward leaders and embedding improvement huddles at ward level.

More broadly we continue to pursue a range of partnership and system working that will deliver longer term benefits. Some of this is very specific such as our Acute Hospital Alliance (AHA) clinical strategy and amalgamation work around sleep services or ophthalmology; other elements remain quite nebulous and embryonic such as our work with partners on increasing *healthy* life expectancy and reducing health inequalities within our population.

We are also aware of the need to innovate and the limitations that can sometimes by symptomatic of an *improvement* centric approach – the electric light was not the product of an incremental improvement of the candle[4]. Our Improving Together 'problem scoping' focus will allow us to spot the need for more radical change in overcoming some of our challenges, and we continue to engage with wider partners including the AHSNs, academia, and the private sector in securing the best innovation for our patients such as surgical robotics.

7. Outcome Expectations

Despite the challenging context we expect our activity and performance to yield several positive outcomes in the year ahead.

Performance

We expect that at least 85% of patients wait no longer than 6 weeks for diagnostic tests, and that we will see over 76% of patients in ED within 4 hours, as well as reducing ambulance hospital handover delays to support a system improvement in the category 2 response time to an average of 30 minutes.

We expect to continue providing at least 75% of patients on a cancer pathway with a diagnosis within 28 days of referral, and reducing the number of patients waiting longer than 62 days for cancer treatment.

Within 2023/24 we will eradicate waits over 65 weeks for elective care and reduce those waiting over 52 weeks for elective procedures.

[4] Quote from Oren Harari, University of San Francisco school of management.

	Aligned 19/20 Activity	Aligned 19/20 Activity	22/23 FOT Activity	23/24 Plan Activity	23/24 Plan vs 22/23 Activity	23/24 Plan Aligned Activity
A&E (excl SWIC)	51,507		51,068	51,208	100%	
Day cases	23,572	24,279	23,285	24,779	106%	102%
Electives	4,872	5,018	3,587	3,519	98%	70%
Non Electives	35,195		32,204	32,319	100%	
Outpatient First	98,450	101,404	103,900	105,409	101%	104%
Outpatient Procedures	70,070	72,172	54,995	57,663	105%	80%
Outpatient Follow ups	163,947		173,966	174,255	100%	

Workforce

We will reduce turnover rates by 2%, improve vacancy rates by 2%, and reduce absence towards the 3% target.

We will see some workforce modernisation in 2023/24, including the deployment of physicians' associates, mitigating the need for high-cost agency on hard to recruit posts.

Finance

BSW has a system planning objective to ensure all providers are as close to breakeven as possible. As a consequence, SFT's planned deficit after savings would be largely mitigated by a financial risk share payment (£22.4m) from within the system in 2023/24, this should protect cash reserves heading into 2024/25.

	22/23 Budget £000s	22/23 Forecast £000s	23/24 Plan £000s
Operating Income			
NHS Clinical income	260,775	285,659	291,277
Other Clinical Income	8,573	11,102	9,563
Other Income (excl Donations)	34,540	39,140	37,513
Total income	**303,888**	**335,901**	**338,353**
Operating Expenditure			
Pay	(199,429)	(212,042)	(206,457)
Non Pay	(96,646)	(103,972)	(112,556)
Total Expenditure	**(296,075)**	**(316,014)**	**(319,013)**
EBITDA	**7,813**	**19,887**	**19,340**
Financing Costs (incl Depreciation)	(20,213)	(19,887)	(19,340)
NHSE&I Control Total	**(12,400)**	**0**	**0**

The saving programme to achieve the breakeven position for 2023/24 is £15.3m, this is not without significant risk. The pace and depth of transformation required is a significant step change for the organisation in the context of many operational pressures. The main improvement plans include

- Reducing agency expenditure
- Reducing the number of escalation beds and associated staffing costs
- Improving theatre productivity
- Reducing follow up outpatient appointments
- Improving efficiencies and processes across all functions

From an improvement perspective our 2023/24 plan will look to recover the bed base and allow the Trust to enter 2024/25 on a much stronger financial footing from an elective recovery perspective.

The total capital programme for 2022/23 for SFT is £32.4m including those projects covered by national funding. The spend for the purposes of the CDEL is £15.2m. The most significant spend for 2023/24 relates to the new ward £12m and £5m on digital EPR replacement project. Other notable investments include refurbishment of Whiteparish ward, replacement Digital system for Pathology (LIMS) and investment in net zero carbon enabling.

8. Delivery Risks

We go into 2023/24 carrying significant risks and external dependencies to our plan. Our ability to deliver on our reduction in length of stay, investment in our substantive workforce, delivering the transformation programme to improve our financial position, and our elective targets all represent risk areas to monitor. At the highest level the trust will continue to do so through the Board Assurance Framework (BAF) and risk register.

There are significant risks within the financial plan, delivering 5% savings is a significant ask against a backdrop of operational pressures. Inflation levels remain a concern and the final pay settlement for 2023/24 has yet to be finalised.

External dependencies

We are dependent upon working closely with community and system partners regarding our plan to reduce length of stay and those patients waiting for onwards care. This in turn has several clinical model change dependencies such as the rapid deployment and scale up of step-down virtual wards, and different workforce models to ensure success.

We may see novel factors affecting demand in-year. No annual plan predicted Covid or industrial action; it is possible that an unexpected demand materialises that would affect our ability to deliver this plan. This would also impact our surge capacity which is carefully balanced as part of our bed modelling.

Sequential delivery risk

In the event of overperformance there are second order consequences - if we solve our length of stay challenges, for example, and seek to ramp up elective activity at pace we would encounter a theatre staffing challenge.

Mitigations

To mitigate the above risks, we are pursuing a number of actions internally and with partners across the system. As the plan outlines the Trust has a number of improvement programmes in place to address the systemic opportunities to improve patient experience, care and efficiency. The plan will be monitored through the normal embedded governance processes to identify risks early and ensure mitigating actions can be instigated.

9. APPENDICES

APPENDIX 1 – NHS England 'National NHS Objectives 2023/24'

National NHS objectives 2023/24

	Area	Objective
Recovering our core services and improving productivity	Urgent and emergency care*	Improve A&E waiting times so that no less than 76% of patients are seen within 4 hours by March 2024 with further improvement in 2024/25
		Improve category 2 ambulance response times to an average of 30 minutes across 2023/24, with further improvement towards pre-pandemic levels in 2024/25
		Reduce adult general and acute (G&A) bed occupancy to 92% or below
	Community health services	Consistently meet or exceed the 70% 2-hour urgent community response (UCR) standard
		Reduce unnecessary GP appointments and improve patient experience by streamlining direct access and setting up local pathways for direct referrals
	Primary care*	Make it easier for people to contact a GP practice, including by supporting general practice to ensure that everyone who needs an appointment with their GP practice gets one within two weeks and those who contact their practice urgently are assessed the same or next day according to clinical need
		Continue on the trajectory to deliver 50 million more appointments in general practice by the end of March 2024
		Continue to recruit 26,000 Additional Roles Reimbursement Scheme (ARRS) roles by the end of March 2024
		Recover dental activity, improving units of dental activity (UDAs) towards pre-pandemic levels
	Elective care	Eliminate waits of over 65 weeks for elective care by March 2024 (except where patients choose to wait longer or in specific specialties)
		Deliver the system- specific activity target (agreed through the operational planning process)
	Cancer	Continue to reduce the number of patients waiting over 62 days
		Meet the cancer faster diagnosis standard by March 2024 so that 75% of patients who have been urgently referred by their GP for suspected cancer are diagnosed or have cancer ruled out within 28 days
		Increase the percentage of cancers diagnosed at stages 1 and 2 in line with the 75% early diagnosis ambition by 2028
	Diagnostics	Increase the percentage of patients that receive a diagnostic test within six weeks in line with the March 2025 ambition of 95%
		Deliver diagnostic activity levels that support plans to address elective and cancer backlogs and the diagnostic waiting time ambition
	Maternity*	Make progress towards the national safety ambition to reduce stillbirth, neonatal mortality, maternal mortality, and serious intrapartum brain injury
		Increase fill rates against funded establishment for maternity staff
	Use of resources	Deliver a balanced net system financial position for 2023/24
LTP and transformation	Workforce	Improve retention and staff attendance through a systematic focus on all elements of the NHS People Promise
	Mental health	Improve access to mental health support for children and young people in line with the national ambition for 345,000 additional individuals aged 0-25 accessing NHS funded services (compared to 2019)
		Increase the number of adults and older adults accessing IAPT treatment
		Achieve a 5% year on year increase in the number of adults and older adults supported by community mental health services
		Work towards eliminating inappropriate adult acute out of area placements
		Recover the dementia diagnosis rate to 66.7%
		Improve access to perinatal mental health services
	People with a learning disability and autistic people	Ensure 75% of people aged over 14 on GP learning disability registers receive an annual health check and health action plan by March 2024
		Reduce reliance on inpatient care, while improving the quality of inpatient care, so that by March 2024 no more than 30 adults with a learning disability and/or who are autistic per million adults and no more than 12–15 under 18s with a learning disability and/or who are autistic per million under 18s are cared for in an inpatient unit
	Prevention and health inequalities	Increase percentage of patients with hypertension treated to NICE guidance to 77% by March 2024
		Increase the percentage of patients aged between 25 and 84 years with a CVD risk score greater than 20 percent on lipid lowering therapies to 60%
		Continue to address health inequalities and deliver on the Core20PLUS5 approach

**ICBs and providers should review the UEC and general practice access recovery plans, and the single maternity delivery plan for further detail when published.*

7 | 2023/24 priorities and operational planning guidance

NHS Salisbury NHS Foundation Trust

Report to:	Trust Board (Public)	**Agenda item:**	3.1
Date of Meeting:	6th April 2023		

Report from: (Committee Name)	Clinical Governance Committee		**Committee Meeting Date:**	28th March 2023
Status:	**Information**	**Discussion**	**Assurance**	**Approval**
	X	X	X	
Prepared by:	Miss Eiri Jones, Chair CGC			
Board Sponsor (presenting):	Miss Eiri Jones, Chair CGC			

Recommendation

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

The Board is required to consider and discuss the maternity and neonatal workforce review as part of the Ockenden and Maternity Incentive Scheme requirements.

Key Items for Escalation

- Key information / issues / risks / positive care to escalate to the Board are as follows:
  - Following on from the two previous divisional presentations on quality governance, the committee today heard from the surgical division. The Head of Nursing outlined how the division has a monthly programme rotating between safety, effectiveness and experience so each was considered on a quarterly basis. A slide pack was used which is shared across the division. The division also reviews its risk register weekly and feeds into the weekly patient safety meeting led by CNO and CMO. A governance assistant role has been developed. This individual works with all services in the division and this has strengthened front line to DMT information sharing and learning. The division is also planning to appoint a governance clinical lead per speciality. There is a focus on addressing the division's complaints backlog and this is being done through clinical engagement. The committee felt there was good assurance around the division's focus on quality governance and improvement and that learning had been shared across the divisions who had presented at CGC to date. This is a valuable addition to the CGC agenda.
  - The discussion about the Integrated Performance Report section confirmed that there has been some improvement in quality metrics relating to diagnostic performance but noted this was only one month change. Of note was no breaches in cardiology. The two key areas discussed related to increased bed

moves and increased grade 2 pressure ulcers. During this period, it was noted that nearly half the Trust's beds were either allocated to people with no criteria to reside or respiratory viruses and therefore the increased moves were mainly due to infection prevention and control measures with a focus on maintaining safety and reducing cross infection. The CNO outlined all measures being undertaken in relation to preventing pressure ulcers and that this is being triangulated with the nutrition and hydration improvements underway.

- An update was provided on the ongoing impact and planning around industrial action, noting the potential enhanced risks likely due to the next planned action falling immediately after Easter. This is to be discussed further at Trust Board.
- The internal audit report referred from the Audit committee was presented and it was good to note that this was a positive and low risk report. This is due to the work that is already underway under the leadership of the Head of Clinical Effectiveness. The report identified 2 medium and 1 low risk. The committee was assured that good work is being undertaken in relation to the clinical audit programme improvements.
- The quarterly learning form deaths report was presented by CMO. The committee was informed that the Trust now has a new medical lead for this work. Following on from previous committee meeting discussions, as mortality data remains above expected range, the CMO will discuss with regional CMO what further action is recommended. He will also discuss through the Acute Hospital Alliance to share any relevant learning and improvement opportunities.
- The maternity and neonatal workforce review was presented and discussed. This is a mandatory requirement as is its presentation at Board. The correct process has been followed in terms of the review using Birthrate Plus (BR+) and British Association of Perinatal Medicine (BAPM) guidance. A new BR + review will take place this year. Mitigation was outlined to manage the risk of the current vacancies (around 20WTE) in maternity and continued focus on recruitment is in place. It was positive to note that the neonatal staffing is stable with a settled team and no vacancy concerns.

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

NHS Salisbury NHS Foundation Trust

Report to:	The Trust Board (Public)	Agenda item:	3.2
Date of meeting:	6th April 2023		

Report from (Committee Name):	Finance & Performance Committee		Committee Meeting Date:	28 March 2023
Status:	Information	Discussion	Assurance	Approval
			x	
Prepared by:	Debbie Beaven (NED)			
Executive Sponsor: (presenting)	Debbie Beaven (NED)			
Appendices				

Recommendation:

The Trust Board are asked to note the items escalated from the Finance & Performance meeting held on 28 March 2023.

The following recommendations are made from the Committee to the Board for consideration and approval:

1. **Decarbonisation Contract** – As part of a funding allocation of £11.3m to support SFT in reducing its carbon emissions towards net zero, the Committee were asked to support and recommend to Board a delegated approval process for the contract award for a total spend of £10.2m. The preferred supplier selection will not complete ahead of the Board meeting but is expected by 10th April. This will be followed by the urgent procurement of core equipment (by end of April latest) to minimise the impact of long lead times. The urgency and need for flexibility is necessitated by the conditions of funding, with the need to ensure it is all spent within the FY23/24.

2. **Geothermal Feasibility Study** – the other part of the £11.3m funding is £1.1m, which is proposed to be used for a feasibility study into the delivery of Geothermal power on the SDH site.

   Following a robust discussion the Committee was supportive of the proposals and encouraged to that the journey to net zero had funding support, although the financial and sustainability benefits were not yet identified in the paper.

   Concerns were expressed around a potential residual financial risk if the timetable is not met, however this will be mitigated by strong project management and monitoring of costs, with the project reverting quickly to normal governance process through Estates Committee and the Strategic Capital Committees. The Committee asked to see the key milestones and how this project would fit with the other Estate's priorities. This is to be addressed in an update to the paper presented to the Board, which will also highlight headline estimates of financial and carbon benefits.

   The Committee were conscious that this is a significant spend to be taken outside of the normal governance process, but also mindful that it is funded and if not used would be lost. The "Chair's action" would be a delegated approval involving 2 NEDs, Chair, CEO and CFO.

3. **Catering Managed Service** – a proposal to move the procurement and its associated administration for the catering service, at a total contract value of £2,75m (incl VAT) over a maximum five year period was supported by the Committee. The case was made on the basis that it will tackle administrative challenges and resulting inefficiencies and should create some small savings which will contribute to the CIP. It will not change the way food is prepared and served to staff and patients, although the Committee did feel that the lack of engagement and input from staff and patients was a missed opportunity. The Committee took further assurance that the contract with Allmanhall Limited will be manged effectively with clear and robust SLAs and, as a material contract, fall within the Contract Management Governance Process, including quarterly supplier meetings and regular price reviews.

4. **"Final" plan submission for 23/24** – the Committee were asked to consider proposals to improve our deficit position by a further £2.1m following challenge from the ICB as it aims to reduce the system deficit gap of £7.4m. The Committee was reminded of the regulatory risks of not submitting a "balanced plan" and secondly not delivering to plan. In that context two proposals were explored:

   a) **Capitalise £700k of workforce costs** – the Committee took assurance that this would be an appropriate treatment, and is normal practice, particularly within the development of intangibles such as IT. We heard that the majority of costs relate to the paperlight and data warehouse projects, with revenue impact through depreciation likely to be from 2025-2030.

      The Committee supported this change.

   b) **Reduce our general inflation reserves by £1.4m** - The SFT plan includes £8.4m of inflation over and above national funding (£4m of which relates to the cumulative impact of 2022/23). Known items have been budgeted for and there is a central reserve of £2.5m for general pressure in year. The recommendation from the region (based on other systems' treatment) is to reduce this amount and transfer to 'risks'. The proposal was made to reduce SFT's general inflation reserve to £1.1m.

      The Committee expressed its concern over the increasing risk given the insufficient funding to cover inflationary pressures. The context that other Trusts are not including inflation above the funded level and highlighting inflation above that as a key risk, gave the Committee some comfort that SFT would not be an outlier in the event of sustained levels of high inflation. There is acceptance that continued levels of inflation above plan would compromise our ability to achieve plan, but that they would be a justifiable deviation. Although we would do what we could to mitigate impact, we would not be able to control or significantly influence inflationary forces.

      The Committee felt it was important to be able to properly track inflation and report clearly any deviation from plan. We were assured that this will be done and reported to F&P regularly.

      On the basis that we would be in line with other trusts and that we would track the impact of adverse inflationary pressure the Committee supported the proposal to reduce the general reserve by £1.4m.

   The Committee were reminded of the other significant risks, as laid out in the paper, which include industrial action, pay awards, system support to reduce NCTR, productivity increases and the ambitious £15.3m of CIPs. A review of the BAF, to reflect the plan risks is recommended ahead of the next meeting.

With support from the Committee for the changes recommended and subject to final approval by the delegated members of the Board (Chair, Chair of F&P, CEO, CFO), the deficit will reduce from £25.8m to £23.7m before any non-recurrent system support and will the basis of the submission to the ICB on Thursday 30 March 2023. The £23.7m will be the target that we report to during 23/24, but we will continue to highlight what is within our control and what needs system support, such as reduction in NCTR and LoS.

Executive Summary:

A number of other key topics were discussed and challenged in the Committee

1. **CIPs –** The Committee continues to seek more assurance on the ability, capacity and confidence in delivering £15.3m (5%) of savings in 23/24, given that this is a scale never delivered before. The key question is "what will be different in 23/24 to ensure delivery of significant cost reductions"?

   Given that approx. 50% of savings (called efficiencies) in 22/23 are non-recurring and mainly from vacancies, which were not planned, the Committee would like to understand what went well in 22/23 with the delivery of recurring efficiencies/savings, what got in the way of delivering recurring savings and how we can mitigate against blockages in 23/24.

   There remains a risk around capacity, however the Committee heard that workstreams are already underway and are being driven by the Improving Together culture. The detail on workstreams/programmes/initiatives is forming and will be ready to share by the end of May.

   In the April Committee we expect to see an overarching paper on the governance structure, list of programmes that are already in progress, key milestones and a report template (albeit without data) which will be produced monthly evidencing progress to targets.

   From the May Committee there is an expectation of a regular report, with the occasional deep dive as and when needed or appropriate.

1. **Bed Plan –** A review of the progress with bed planning gave assurance to the Committee. We heard that the model, which is used across the system, can be relied on as it is based on our historic data and has independent sense checking of outputs.

   SDEC went live on Monday 27th March, which will support the reduction in LoS. The current model shows that even with a 10% reduction in LoS there are still pressure points, however the data is dynamic and not static. The key objective of the modelling is to inform the actions required to get the right patients, in the right beds at the right time for the right amount of time.

2. **Financial Report 22/23 –** the financial position to the end of February is not materially different from forecast. The Committee received assurance that we will spend all our capital allocation this year. Thanks were extended to the procurement team who have been pivotal in achieving our spend goal for capital.

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

NHS Salisbury NHS Foundation Trust

Report to:	Trust Board (Public)	Agenda item:	3.5
Date of meeting:	6th April 2023		

Report from (Committee Name):	Audit Committee		Committee Meeting Date:	23 March 2023
Status:	Information	Discussion	Assurance	Approval
	x		x	
Prepared by:	Richard Holmes, Non-Executive Director			
Board Sponsor: (presenting)	Richard Holmes, Non-Executive Director			
Appendices	N/A			

Recommendation:

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

Executive Summary:

Key Items for Escalation

- **Deep Dives**: Deep Dives are one of the primary internal mechanisms for the Committee to obtain assurance on the effectiveness of the Trust's first and second lines of risk management defence: its management culture and capability, and its internal control processes. The Executive will propose an annual schedule for Deep Dives for future meetings, recognising that circumstances may require a reactive Deep Dive to be considered instead. The next Deep Dive will focus on the effectiveness of International Recruitment.
- **Standing Financial Instructions**; the Committee **Recommends to the Board the APPROVAL** of the updated Trust SFIs, which have been updated solely to reflect new job titles.
- **Internal Audit**: The Committee received three reports:
    - Procurement as a Provider – High Risk (score 17) – 4 actions. Key issue is lack of supplier Conflicts of Interests disclosures in Procurement processes.
    - IT Password Configuration - Medium Risk (score 14) – 3 actions. Key issue is lack of password monitoring of the POETS patient information system.
    - Clinical Audit – Medium Risk (score 7) – 3 actions

  The Committee were reassured that the actions proposed to mitigate the risks were proportionate and appropriate.
- **Counter Fraud Review**: The annual SFT Counter-Fraud Functional Standards (CFFS) return to Government is due for submission by May 2023. The Committee reviewed the Trust's compliance with the requirements, and it is anticipated that all components will achieve a Green rating this year, except for component 12 which is in respect of Declarations of Interest (DoIs) which will achieve an Amber rating. The Committee noted the Auditor's view that Trust has robust policies and processes

in place, but compliance reporting of DoIs is not yet sufficient. The Executive will lead a final push to increase compliance by the year end.

- **External Audit:** Although not available at the meeting, the CFO assured the Committee that the detailed plan for the year end audit as proposed by Grant Thornton was tight but achievable. As part of the Audit pre-work, the Committee received the external auditor's Audit Risk Assessment, a comprehensive review undertaken with the Executive of the critical risk areas where the Auditors are required to make inquiries of the Audit Committee under auditing standards. The Auditors confirmed that they had identified no cause for concern with the contents of the review, and as such the Committee approved the Audit Risk Assessment as presented to it.
- **Going Concern principle**: As part of the process to approve the accounts, the Board of Directors will be required to satisfy themselves that the accounts can be prepared on a going concern basis. This obligation has recently been clarified by regulators to acknowledge that even though the underlying services provided by an entity would continue to be provided elsewhere if that entity were to cease, the going concern principle must be considered against the continuation of the entity itself.

  In summary terms, the financial statements should be prepared on a going concern basis unless the Trust either intends to apply to the Secretary of State for the dissolution of the NHS foundation trust without the transfer of the services to another entity or has no realistic alternative but to do so. Notwithstanding the tight financial position of the Trust and the risks of ongoing industrial action, the Committee considers that whilst this represents a significant challenge, it is reasonable to expect that the Trust has adequate resources to continue in operational existence for the next financial year.

  The Committee therefore **Recommends to the Board** that the 2022/23 accounts should be prepared on the basis that SFT is a going concern.

- **Other items for Audit Committee approval and noting**
  The Committee noted the Register of Losses and Compensation and Payroll Overpayments reports as presented.

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

NHS Salisbury NHS Foundation Trust

Report to:	Trust Board (Public)	Agenda item:	3.6
Date of meeting:	6th April 23		

Report tile:	Integrated Performance Report			
Status:	Information	Discussion	Assurance	Approval
			Yes	
Approval Process: (where has this paper been reviewed and approved):	Sections approved by responsible committee: - Operational performance and resources: Finance and Performance Committee - Quality and care: Clinical Governance Committee - Workforce: People and Culture Committee			
Prepared by:	Louise Drayton, Performance and Capacity Lead Amanda Hardie, Head of Performance			
Executive Sponsor: (presenting)	Judy Dyos, Chief Nursing Officer			

Recommendation:

The Trust Board are asked to note the Trust's performance for Month 11 (February 2023)

Executive Summary:

Overall performance is similar to previous months, the Trust continues to manage the balance between urgent care pressures on bed occupancy against the need to see and treat more people waiting for planned care. The Trust faced additional challenges in February following industrial action impacting the cancellation of services, and the capacity of staff to manage both strike action and the much-needed transformational change to address key performance and quality improvement opportunities.

The key planned care metrics of time to first outpatient appointment and the total elective waiting list have marginally increased, this whilst disappointing is unsurprising given the level of cancellations in January of 2000 patients who have subsequently been re-booked into February. The areas of biggest challenge remain ENT, Gastro, Colorectal and General surgery. The Trust remains focused on theatre productivity work to maximise the number of patients we can see and treat through a limited bed capacity, the number of escalation beds open in DSU has reduced giving more capacity to meet planned care day case targets. Outpatients remain a focus with the Trust looking ahead to 2023/24 with an aim to reduce outpatient follow ups in line with the national standards.

Diagnostics has improved in month, representing a reduction in breaches in MRI and Ultrasound specifically. Cardiology Echo services is a vast improvement and for the second month in a row has reported zero breaches. Diagnostic improvements are an ongoing area of focus with additional MRI capacity planned for April 2023 which will further improve the DM01 trajectories in coming months.

Urgent care continues to be below performance trajectories, staffing challenges particularly in the nursing skill mix do challenge the ability to achieve the process and pathway changes all recognised to improve flow. The biggest challenge remains flow from ED into the wider hospital, where bed occupancy remains high, moves are happening later in the day leaving a higher number of patients in ED impacting capacity to see and treat new patients. Ambulance handover delays remain fairly static with some improvement in February.

The focused quality metrics show ongoing challenges with pressure ulcers remaining high in February, the Trust has implemented a new investigation process to ensure learning can be identified and actions for teaching can be taken forward. Infection control metrics show a static position which is positive although the Trust is not being complacent in taking key actions forward.

From a workforce perspective agency spend remains high at 8.5% of the total pay bill compared to a target of 3.7%, underneath there are some positive movements in sickness reducing to 4.17 the lowest monthly rate for over a year and turnover reducing slightly. The vacancy rate continues to slowly creep down. The ability to appropriately establish our workforce is vital to the success of the financial and operational plan in 2023/24.

The financial position reflects the challenges outlined above, the level of agency spend and number of beds open drives a significant proportion of the challenges, the pay costs reduced in month but were still above the average for the year.

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Partnerships: Working through partnerships to transform and integrate our services	Yes
People: Supporting our People to make Salisbury NHS Foundation Trust the Best Place to work	Yes
Other (please describe):	N/a

Integrated Performance Report

NHS
Salisbury
NHS Foundation Trust

February 2023

Summary

February 2023

Salisbury NHS Foundation Trust

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Urgent care Continues to be below performance trajectories, staffing challenges particularly in the nursing skill mix do challenge the ability to achieve the process and pathway changes all recognised to improve flow. The biggest challenge remains flow from ED into the wider hospital, where bed occupancy remains high, moves are happening later in the day leaving a higher number of patients in ED impacting capacity to see and treat new patients. Ambulance handover delays remain fairly static with some improvement in February.

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What we are measuring – our Strategic Priorities

Improving the health and well being of the Population we serve

Working through Partnerships to transform and integrate our services

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

Our focus – Breakthrough Objectives and Strategic Initiatives

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

What is an Integrated Performance Report (IPR)?

NHS Salisbury NHS Foundation Trust

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

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

Business Rules - Driver Metrics

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

Business Rules - Watch Metrics

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

Business Rules - Statutory/Mandatory Metrics

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

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

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

NHS
Salisbury
NHS Foundation Trust

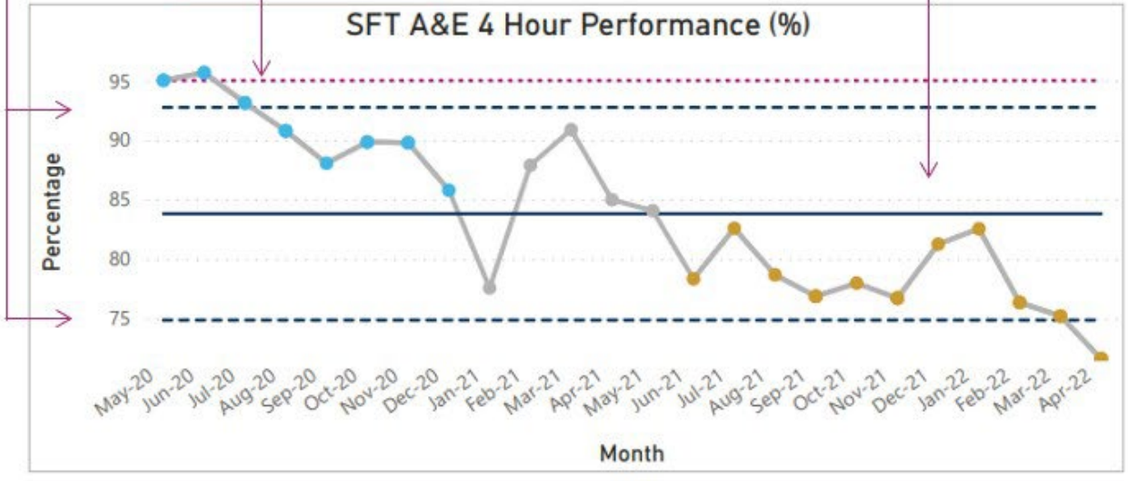
Reading a Statistical Process Control (SPC) Chart

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

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

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

The solid grey line shows the mean value for the dataset



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

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

Grey markers show normal behaviour with no significant cause for variation

Part 1: Quality of Care, Access and Outcomes

Performance against our Strategic Priorities and Key Lines of Enquiry

Salisbury NHS Foundation Trust

Our Priorities

Population

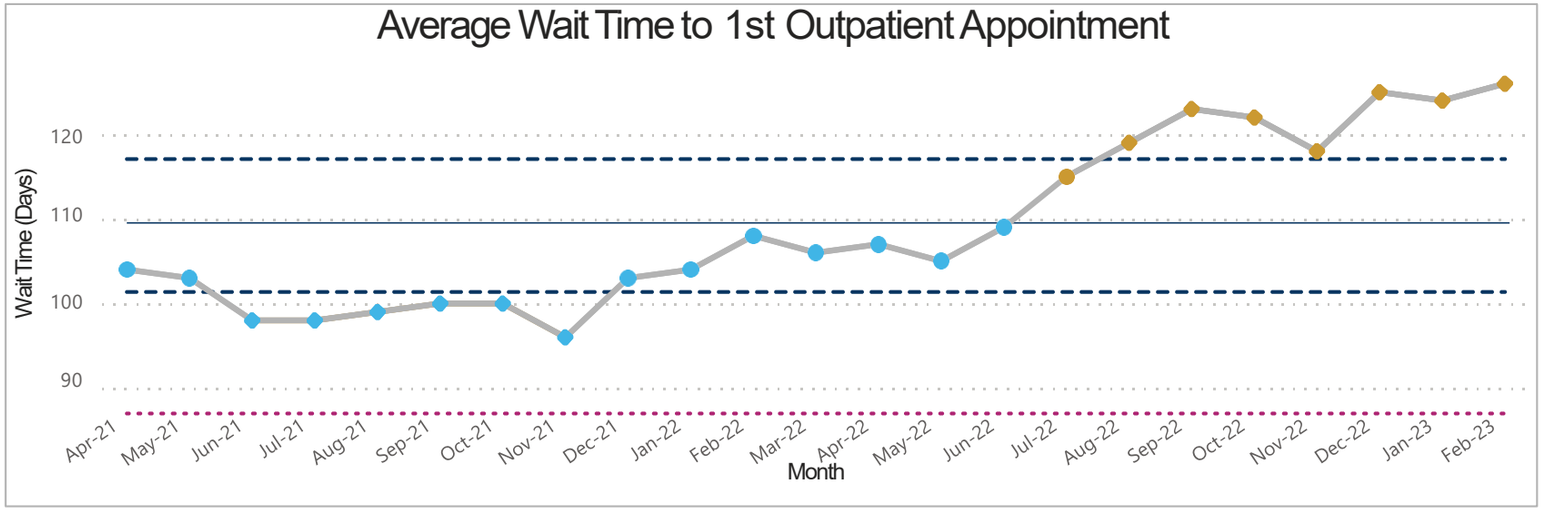
Partnerships

People

Reducing Patient Waiting Times

Target 87 days

Breakthrough Objective



We are driving this measure because…

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

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

Understanding the performance:

The performance data high average wait to first appointment at the end of February (126 days) , this is not entirely surprising given the large number of cancelled appointments due to the industrial action at the start of the year. In addition staffing and operational pressures continue to challenge a number of specialties, resulting in steady increases in the number of longer waits specifically over 52 week waits which are driving up the overall average waiting time. The Trust continues to focus on seeing patients in line with clinical need, referral type, e.g. Cancer 2 week wait and Urgent referrals, and by longest wait, in line with NHSE requirements. The Trust continues to have success in driving down its longest waits, achieving the national 78 week wait target on 28th February, in line with its internal stretch target (despite the industrial action) and 1 month ahead of the national ask.
Over 52 week waits continued to see an increase in February, predominantly driven by a number of Surgical Specialties, predominantly Dermatology, Plastics, Oral Surgery and Rheumatology. These increasing waits across these specific specialities served to offset some of the improvements experienced across others.

Actions (SMART):

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

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

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

Draft options plan for Dermatology has been completed and submitted (to be presented at the next TMC).

Outpatient Summit planned for March 30th 2023.

Risks and mitigations:

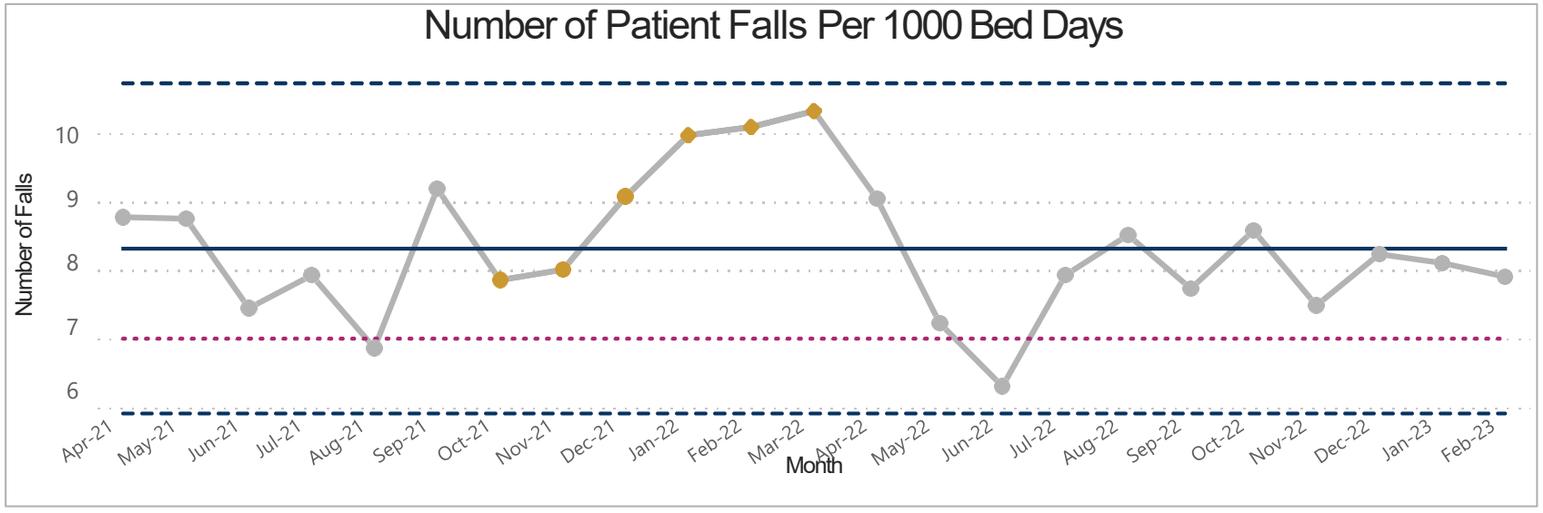
Limitations continue in relation to the Trust's ability to comprehensively map demand and capacity at a subspeciality/pathway level, however the performance team are supporting this work with the Divisions and specialities. Resource limitations at both DMT and Speciality level have been raised and a paper proposing enhanced Divisional structures has been drafted to be discussed at TMC.

Staffing pressures exist across a number of specialities not least Dermatology which present a potential individual speciality pressure into next financial year. The Division of surgery is drafting a set of possible proposals for consideration by the Executive Team.

Reducing Patient Harm

Target 7

Breakthrough Objective



We are driving this measure because...

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

Understanding the performance:

February's falls per 1000 bed days was 8.65, a decrease of 2.94 per 1000 bed days from February 2022. (25%). There were 4 falls with harm in February, all were presented at The Patient Safety Summit with no new learning. These cases will be presented at Share and Learn in March.

Comittment for training is currently at HCA induction and new Overseas nurses training programme. Informal training is still occurring at the bedside. Ward based team training will resume when a Band 6 has been appointed. The on line training is still available but has low uptake.

Bay watch has been sustained on Farley Ward but has not been sustained on Pitton , Spire or Amesbury Ward due to multifactorial reasons. Other wards have commenced Improving Together with Whiteparish having a reduction in falls as one of their Driver metrics.

Lying and standing BP complaince has been variable. Monthly audits are completed monthly. In February the overall compliance rate was 33% with 31% compliance in patients who have fallen.

Actions (SMART):

The strategy suggests that 95% of nursing staff should receive formal training.

The target falls rate for the end of the year (financial) is 7 (20% reduction).

Research suggests that introducing bay watch and falls huddles post patient falls could reduce them by 50%.

Lying and standing Blood pressure compliance has a target of 95%

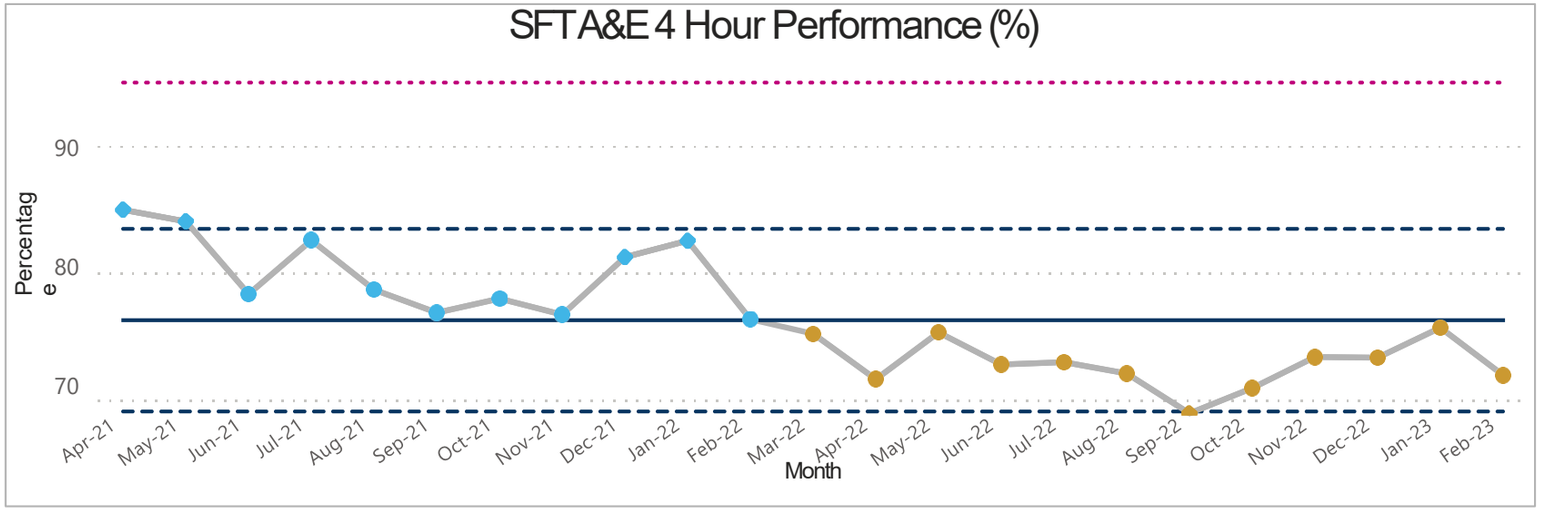
Risks and mitigations:

The Falls Reduction Specialist has reduced her working days with the hope that a Band 6 could be recruited to work alongside her. This has not been possible as interest was low. It is hoped that a nurse who needs redeployment will soon be able to work alongside the Lead to take on such tasks as bedside teaching and patient reviews.
A half-day interactive training package is being developed and will be available in the summer months. The discussions around mandatory training continues. Nursing staff have had high vacancy rates and also days of Industrial action in February that may have had an influence on compliance with patient falls.
The electronic documentation roll out has had an impact on risk assessments, namely that they were not being completed fully, accurately or in a timely manner. This will be audited monthly through documentation audits and is already showing an improvement.
The implementation of 'bay watch' and post fall huddles has been discussed with heads of nursing and matrons. The falls lead needs assistance in sustaining and monitoring from more senior nursing and therapy staff. This will be discussed through Improving Together A3 review in March.

Emergency Access (4hr) Standard

Target 95%

National Key Performance Indicators



Performance Latest Month:	71.9%
A endances:	5619
>12 hrs in ED Breaches:	91

Understanding the performance:

•The improvement against the 4-hour standard performance target stalled in M11 and performance remains low. There was an increase of circa 11 patients per day (5%). This daily increase was predominantly Type 4 Attendances. This would indicate that more patients self-presented with lower acuity issues. The conversion rate for emergency admissions via ED remained static at 27.8%. This supports the narrative that the fluctuations in attendances are in the Type 3/4 patients who should primarily be treated in the community.

•The number of 12-hour breaches rose in Feb to 91. Flow out of the department has remained challenged with only an average 11% of patients being discharged before midday and 40.2% of patients discharged after 17:00. This leads to a lack of movement out of ED and causes large challenges with admitted performance.

•M11 saw little change in Decision to Admit (DTA) performance with 54.33% of patients with a DTA remaining in the Emergency Department >4 hours. This still equates to the equivalent of 6 ED spaces lost daily, 40% of the overall ED capacity.

•Expected patients diverted to ED, increased in M11 to 122 from 95 in M10. This equates to an average of 5 patients per day that are diverted to ED. The top 3 specialties were Medicine (49), Orthopaedics (24) and ENT (19).

Actions (SMART):

- A streaming trial to take place in M12, this will help contribute to a reduction in time to initial assessment and forms part of the divisional driver metrics through "Improving Together".

•Agreement from Executive team to protect medicine SDEC from escalation starting in M12. This will help support the DTA to Admission divisional driver metric by increasing discharges and preventing the medical take from being diverted to ED.

•Review the current treatment culture and explore whether more patients could be treated in a "fit to sit" environment to release more cubicle space and prevent de-conditioning of patients.

Risks and mitigations:

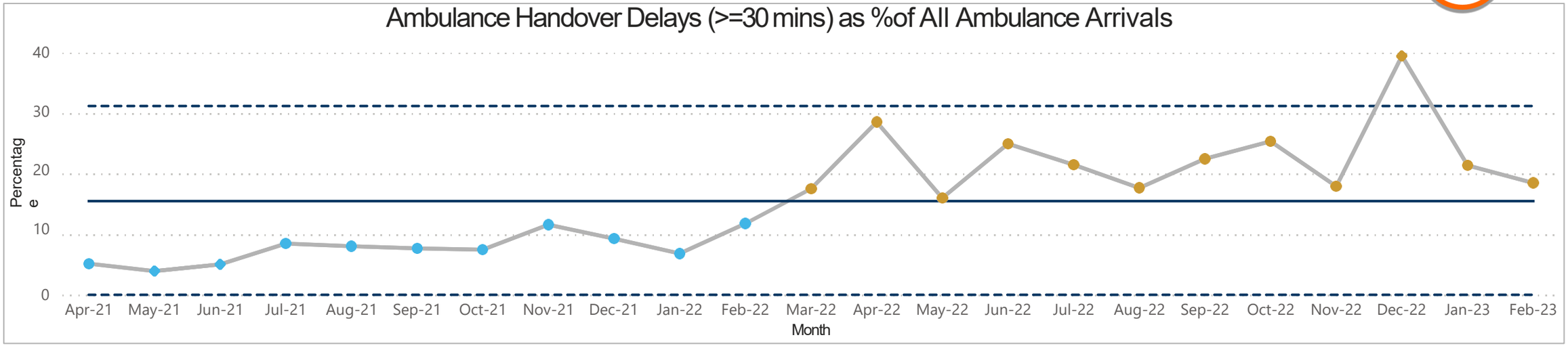
- Nursing staffing vacancies remain high at 19.4 (42% of workforce) whole time equivalent (WTE) B5 Nurses, with a further 11.04 WTE HCA's (46% of workforce). A rolling advert is out to recruit both qualified and unqualified Nursing, with an ED recruitment day planned for Month 12.

•Within the medical workforce there remains 4.0 WTE (40%) gaps in the Middle Grade rotas and 2.6 WTE Consultants. Overseas junior doctors recruited in M7/8 have commenced with shadow shifts over Months 9 – 11. This will support filling the middle grade gaps to bolster increased senior decision making in the department from M12. Further Interviews for 1 overseas consultant and 1 middle grade doctor planned for M12.

•Flow out of the Emergency Department continues to impact 4 and 12-hour performance targets, with high bed occupancy levels continue across the Trust resulting in limited capacity to see and treat patients. Escalation areas such as Paediatric ED and Interventional Radiology are used as required, dependent on staffing.

Ambulance Handover Delays

National Key Performance Indicators



Understanding the performance:

M11 saw an improvement in Ambulance handover performance with 18.48% (unvalidated) patients waiting over 30 mins to offload; this remains above average though. There was a decrease in ED arrivals to 1037 compared to 1054 in M9, however this actually equates to 3 more ambulances per day in M11. The main driver for improvement has been delivered by the concerted efforts of the ED, Hospital Ambulance Liaison Officer (HALO) and patient flow teams to ensure ambulances are offloaded as quickly as possible into suitable locations. This performance has been further supported by the improvements in Time to initial assessment and the time between DTA and admission.

Actions (SMART):

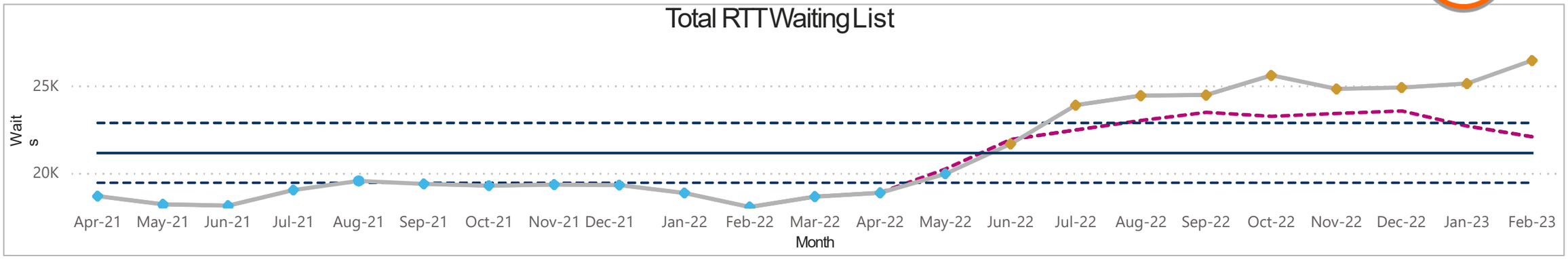
- Emergency Department Escalation Levels (EDEL) launched and embedded within the trust to accurately articulate the ED pressures at a given time and give clear actions for both ED and the Trust to support.
- Review current processes to ensure all patients receive a timely clinical review when being held in ambulances or in the corridor.
- Current Ambulance handover process is lengthy and duplicates work. Review benefit and consider whether the ePCR could be printed to replace the current document.

Risks and mitigations:

- High bed occupancy and staffing challenges across the Trust remains the biggest challenge to timely ambulance offloads. The introduction of a discharge lounge has proved beneficial to generating earlier flow.
- Nursing staffing vacancies remain a high at 19.4 (42% of workforce) whole time equivalent (WTE) Band 5 Nurses, and a further 11.04 WTE HCA's (46% of workforce). This leads to challenges in being able to take handover. A rolling advert is out to recruit both qualified and unqualified Nursing, with an ED recruitment day planned for Month 12.
- Respiratory conditions (Flu A, Covid and RSV) continue to pose challenges. This is due to the requirement for patients to go to a suitable area to ensure isolation processes are followed. This slows the flow out of ED whilst these areas are identified.
- Industrial Action for both the Ambulance Service and Nursing Staff negatively impact on flow/performance with less staff able to facilitate timely offloads, treatment and discharges; mitigating actions to minimise risk remain ongoing.
- Collaborative working continues between SWAST (South West Ambulance Service) partners and the SFT HALO to mitigate risk by cohorting of patients waiting to off-load in order to release crews.

Total Elective Waiting List (Referral to Treatment)

National Key Performance Indicators



Month	Mar-22	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23
Longest Waiting Patient (Weeks)	116	120	99	99	95	98	94	95	87	83	85	73

Understanding the performance:

The Total RTT Waiting list size position at the end of January stood at 26,640 and increase of 1,508 from January. This has resulted in a deterioration from plan with the Trust now being 4,563 behind plan (a deterioration of 2122 against plan in month). This, however, needs to be put into the context of the impact of the industrial action (IA) by the NMC in January, which resulted in circa 2,000 appointments being cancelled and rebooked into new slots and a reducing February planned trajectory.

Aside from the IA, there are a small number of specialties that account for a disproportionate proportion of the waiting list increase since April 2022. The top five specialties with the greatest increase in their respective waiting list are all Surgery, being comprised of the following: ENT, Gastroenterology, Colorectal, General Surgery and Oral Surgery. These collectively account for circa 50% of the in-year increase, and approx. 97% of the variance from plan.

Actions (SMART):

SFT remains behind plan and it is clear that the post-covid assumptions made in the original annual planning have not been reflected by both the activity delivered and the number of referrals received. Indeed the number of new clock starts has been consistently higher than anticipated, which has been exacerbated by winter pressures and industrial action.

The largest proportion of the waiting lists sits within the non-admitted pathways. There remains a number of specialities that have remained below their current YTD average, including a number of specialities with considerable operational and staffing pressures, e.g. Dermatology.

The division of surgery has a number of actions it is taking, including:

- Dermatology Paper to TMC (March)
- Introduction of additional capacity via 7Pas of GPwSI into ENT

•Support Requirement Assessment to be undertaken for whole GI Service and paper drafted and presented to Surgical DMT (March)

However, there remains a need to better understand the demand and capacity by specialty, which is currently being developed by the performance and BI teams, and is supporting the planning round for 2023/24 to support achievement of national requirements, and ensure specialities are best placed to meet the referral demand being experienced.

Risks and mitigations:

The risk of non-achievement of plan is heightened by the Junior Doctor Industrial Action, which will further place pressure on a deteriorating position. Whilst mitigations are in place to support safety for those most clinically urgent patients, the volume of activity affected cannot be entirely mitigated and recovered in the remaining month of 2022/23.

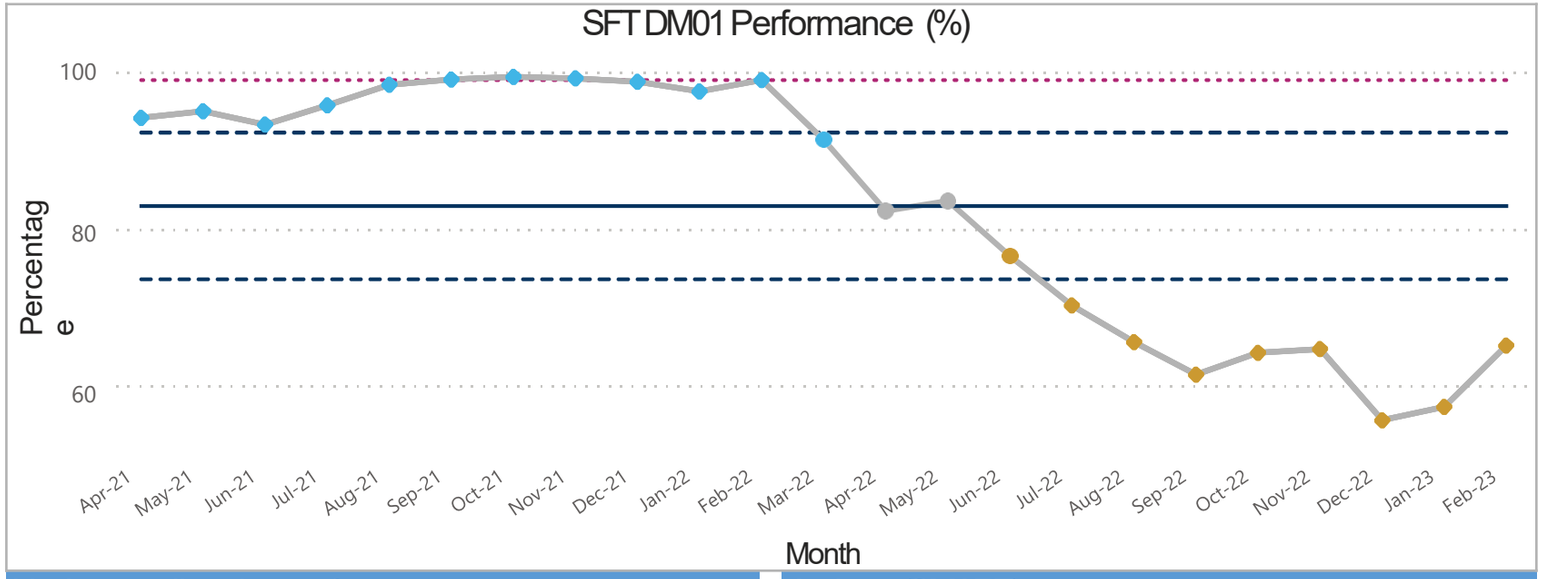
In addition non-elective flow has continued to place significant pressure on the elective programme. The use of DSU continues to mitigate safety for non-elective activity, but leaves a reduced number of options to mitigate the resulting impact on SFTs waiting list volume, however, all activity is assessed for suitability for most appropriate modal delivery and moved to a safe alternative setting where possible.

An OPD summit has been scheduled for March 30th 2023 to review OPD Delivery and assess what areas of focus are required going into 23/24 to address growing demand and increase activity across the specialties.

Diagnostic Wait Times Performance (DM01)

Target 99%

National Key Performance Indicators



Performance Latest Month: 65.1%

Waiting List Volume: 3283

MRI	62.5%	CT	99.8%
US	54.4%	DEXA	100.0%
Audio	60.8%	Cardio	100.0%
Neuro	100.0%	Colon	71.2%
Flexi Sig	52.2%	Gastro	88.3%

Understanding the performance:

Overall DM01 performance has improved in M11 compared to M10 (from 57.3% to 65.1%) but remains low. This represents a reduction in breaches from 2372 to 2107. There has been an increase in total waiting list size of 485.

Areas that continue to report high numbers of breaches are MRI (433 in M11, down from 569 in M10), USS (1430 in M11, down from 1598 in M10), Audiology (107 in M11, up from 66 in M10) and Endoscopy (136 in M11, down from 139 in M10). Cardiology Echo has significantly improved and for the second month in a row has reported zero breaches.

The largest constraint impacting DM01 performance remains as workforce capacity.

Actions (SMART):

1)Delay with ultrasound (USS) insource arrangement (continued slow start but some capacity online during M11)

2) Increase overbooking to USS to mitigate some of 4% DNA rate

3)Continue with agency backfill and incentivised overtime rates in Radiology to increase weekend scanning provision

Risks and mitigations:

Possible power supply issues to MRI1 being monitored by Estates

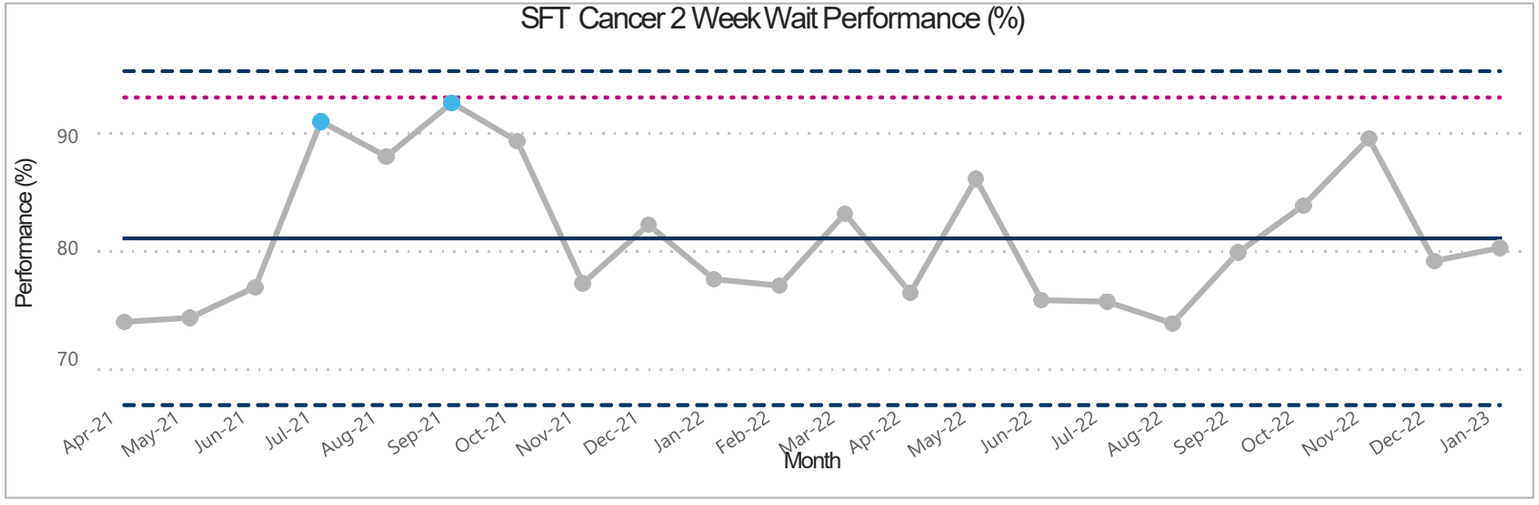
Echocardiography, Radiography and Sonography remain dependent on high volume of agency/locum/overtime staffing to maintain capacity.

Recruitment ongoing. Admin resource within Radiology and Endoscopy experiencing some resourcing issues which is challenging for booking and overall booking efficiency (further constrained by postal strikes etc.) Recruitment plans in place.

Cancer 2 Week Wait Performance

Target 93%

National Key Performance Indicators



	Performance	Num	Den	Breaches
Two Week Wait Standard:	80.2%	819	1021	202
Two Week Wait Breast Symptomatic Standard:	90.0%	36	40	4

Understanding the performance:

The Trust's 2WW performance in January is 80.2% - This was a slight improvement on our December position although challenges remained challenged within Skin and Lower GI as outlined in the previous month's IPR.

There were a total of 98 2WW Skin breaches in January with 87 of them being attributed to inadequate outpatient capacity. The average first wait for a 2WW suspected skin cancer appointment was 14.5 days. There were continued challenges within 2WW Lower GI with a total of 68 breaches in January with 41 of these being attributed to outpatient capacity with an average wait of 14.3 days for the first 2WW lower GI appointment.

Challenges are anticipated in February with Skin capacity and a 100 further skin breaches expected due to lack of capacity.

Actions (SMART):

Colorectal 2ww Capacity: The performance team have provided each service with their demand and capacity for 2WW alongside the Cancer trajectories for PTL numbers. This performance was influenced by the implemented FIT Guidance. Cancer Services have been working with the ICB's to monitor practices that send incomplete referrals, to provide communications and training where appropriate.

Skin 2ww Capacity: The performance team have provided each service with their demand and capacity for 2WW alongside the Cancer trajectories for PTL numbers.

Risks and mitigations:

RCN Strikes: There was disruption in January due to RCN strikes within the organisation. This involved challenges within Endoscopy. Assurance received that further planned strikes should be supported by weekend work in March.

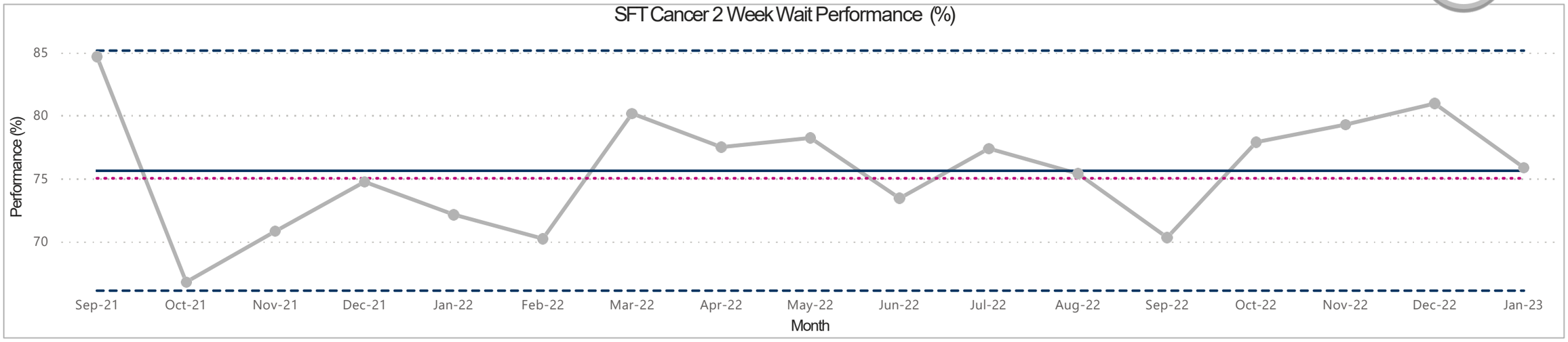
Pathway Improvement: The Cancer Improvement Group (CIG) will support with engagement from DMT with work streams feeding in from Cancer PTL Meeting and onto Cancer Board. CIG is using BPTP Milestones alongside the CQUIN data submitted to measure the success of the current pathways.

Colorectal Pathway: Endoscopy capacity should be BAU by February as staffing returns to normal. New 2WW Colorectal referral form finalised and uploaded for GP Practices to use. Pathways shared with Wessex Cancer Alliance to streamline process for practices within Hants. Skin Pathway: Surgical division currently undertaking an audit of Cynapsis Advice and Guidance to 2WW uptake. Provisional discussions around GP education for tele-dermatology to help with patient flow into the trust. Currently lack of dermatology cover for advice and guidance for medical tele-dermatology. This action is currently being monitored by CIG.

Cancer 28 Day Faster Diagnosis Standard Performance

Target 75%

National Key Performance Indicators



Understanding the performance:

The 28-day performance for the Trust in January was 75.4% and we are having continued success against this cancer waiting times standard. Our performance reflects high performance of the Breast team in being able to provide a benign diagnosis within 28 days of referral with a 96.6% success rate as well as the Skin team in their ability to offer a decision to treat within 28 days with a success rate of 97.7%. We have successfully achieved this target for 10 of the last 11 months.

Challenges remain with this target in Urology with an average wait of 35 days and Gynaecology at 32 days respectively. The main breach reasons for Urology involved patients requiring multiple diagnostic tests which held up our ability to reassure patients and administrative delays to benign results letters being sent. For Gynaecology the main breach themes were around administrative delays to benign results letters and capacity delay reasons for diagnostics.

Cancer Services anticipate success against this measure in February with an unvalidated position of 77%.

Actions (SMART):

Urology Pathway: Urology have implemented the new CNS-led triage system which enables patients to be triaged to diagnostic as quickly as possible. The average wait to first appointment is now 1-3 days. However, the challenges still exist within the diagnostic element of the pathway. A new Prostate Biopsy booking process is being trialled and the surgical DMT are identifying additional capacity. Cancer Services have been working with Radiology to highlight MpMRI to be reported 9 days from request. Challenges have been identified with demand and capacity planning with prostate biopsies due to slot issues and there being no designated cancer 2ww slots; this has been raised with the Surgical DMT and is being monitored by the Cancer Improvement Group (CIG).

Gynaecology Pathway: Additional 2WW Capacity has enabled Gynaecology to bring their average wait down to 5.4 days for the first appointment but challenges remain within the diagnostic side of the pathway. The new CNS will facilitate straight to CT requesting which will reduce the number of days from request to report. Also, the new Gynaecology Navigator will support the use of the benign template letter which will enable patients to be reassured sooner. There is also scope for a potential clinic to be held after MDT for breaking bad news to ensure we are not delaying the pathway for patients post-MDT.

Risks and mitigations:

Pathway Improvement: Weekly Cancer Improvement will support with engagement from DMT with work streams feeding in from Cancer PTL Meeting and onto Cancer Board. Cancer Services are using BPTP Milestones alongside the CQUIN data submitted to measure the success of the current pathways.

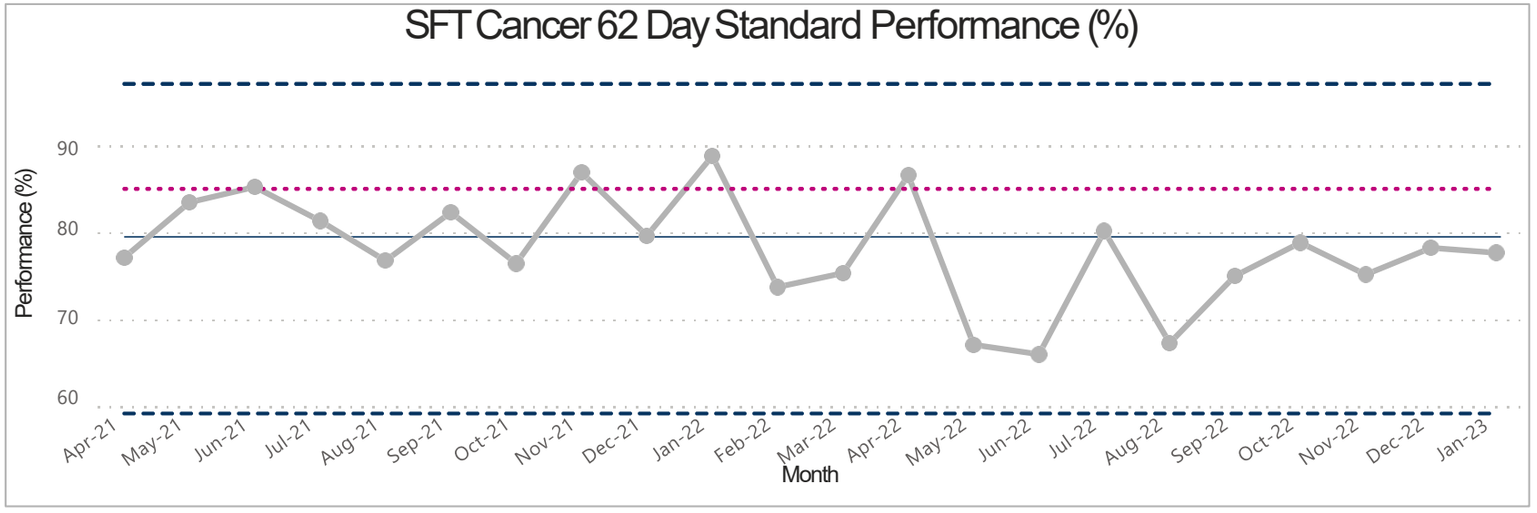
Colorectal Pathway: New 2WW Colorectal referral form finalised and uploaded for GP Practices to access. Pathways shared with Wessex Cancer Alliance to ensure streamlined process for practices within Hampshire. Also discussions around recruitment of additional nursing support to support triage protocol for patients. PID to be submitted in due course to SWAG Cancer Alliance.

Skin Pathway: The surgical division are currently undertaking an audit of Synapsis Advice and Guidance to 2WW uptake. Provisional discussions around GP education for tele-dermatology to help with patient flow into the Trust. Currently lack of dermatology cover for advice and guidance for medical tele-dermatology. This action is currently being monitored by CIG.

Cancer 62 Day Standard Performance

Target 85%

National Key Performance Indicators



	Performance	Num	Den
62 Day Standard:	77.7%	70	90
62 Day Screening:	54.8%	9	16

Understanding the performance:

The Trust's 62-day Performance for January was 77.7% which remains below target.

The main themes around the breaches were due to delays in diagnostic timeframes with 11 of our 18 breaches being due to this reason. Two patients breached due to delaying their own pathways, and a mixture of complex cases and inconclusive diagnostic results making up the remainder of the breach reasons.

This position continues to be challenged due to the capacity challenges with diagnostics - especially PET-CT and Histopathology delays.

Actions (SMART):

Prostate Biopsy Capacity: The process for Prostate Biopsy booking has been reviewed and a new process has been implemented between the Urology Cancer Navigator and Central booking which involves identifying potential prostate biopsy candidates as well as screening of biopsy forms by the Urology CNS prior to being booked for all 2WW and Surveillance Prostate Biopsies.

RCN Strikes: We unfortunately had disruption due to the RCN Strikes within the organisation. We have had assurance from the Surgical team that they will try to minimise the disruption for diagnostics and surgeries during any future planned strike action.

Risks and mitigations:

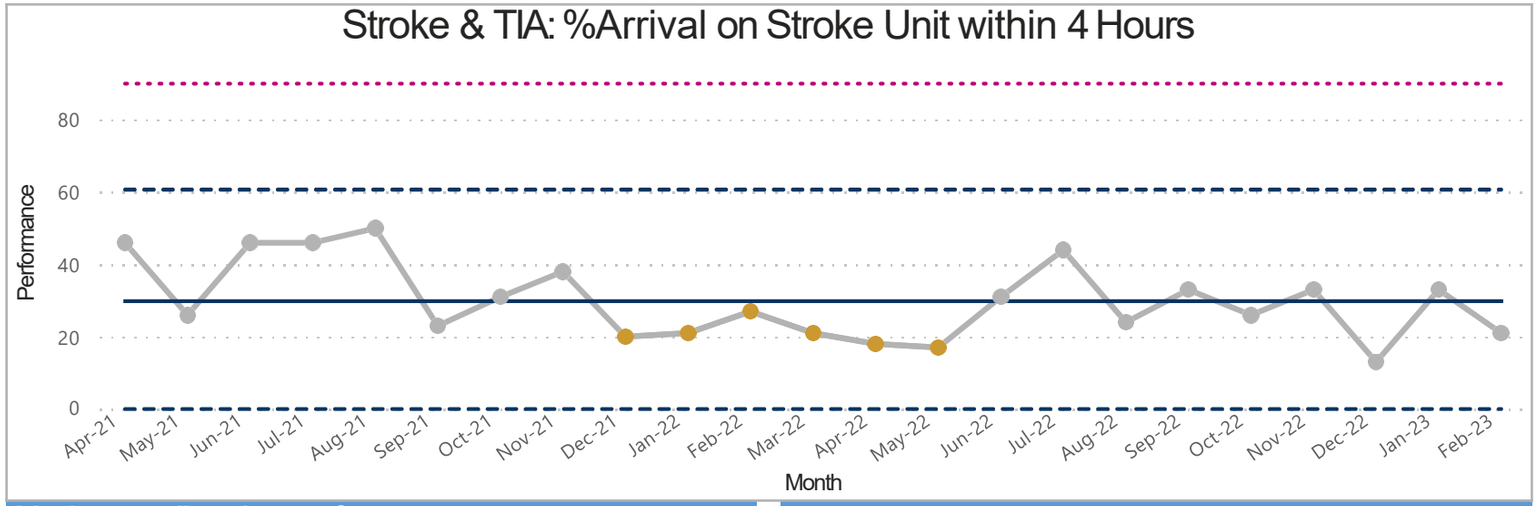
Chemotherapy at the Trust: The new principal pharmacist has started within the organisation which will enable Pharmacy to be at BAU by March 2023. In January there was limited provision for Chemotherapy with the service with aseptics.

Trajectory against performance standards / Planning: As part of the CIG, each speciality has been asked to complete a piece of work on their trajectory against the performance standards with the support of the Cancer Services. This has been completed and these trajectories have been submitted as part of our 23/24 planning. Cancer Services to look at potential trajectory for success against the 62-day Pathway which is currently ongoing and is expected to be completed by April 23.

Histopathology / Radiology: As above the service improvement should support the diagnostic pathways for Cancer Services for patients with increased capacity for scanning and additional histopathology capacity to support the services.

Stroke Care

National Key Performance Indicators



SSNAP Case Ascertainment Grade

Highest Level = Grade A
Lowest Level = Grade E

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

Understanding the performance:

The national target for arrival on stroke unit within 4 hours is 90%. The Trust's M11 month-end performance was 21% . This was mainly due to bed capacity within the trust. The impact of high bed occupancy trust-wide has had an impact on timely availability of beds on the Stroke Unit. The length of stay (LOS) for patients on the Stroke Unit has decreased from January, with January having an average LOS of 20 and February LOS at 16. This is due to short length of stay patients that did not require much therapy input.

Organisational bed pressures have led to more general medicine patients being out-lied to stroke beds limiting the beds available to stroke patients.

Staffing vacancies for Farley Stroke Ward remain high. Two new Band 5s are joining the team this month, and 2 overseas nurses have joined the team and will be taking their OSCEs in May. Throughout February there were several occasions where staff were moved to support other wards due to a lack of staff across the division. The Stroke Ward has also been supporting escalation areas such as South Newton and Breamore ward.

Actions (SMART):

1.Simulation training to be implemented to increase staff understanding and ability to recognise stroke symptoms. This in turn will ensure timely transfer of priority patients from ED staff, date to be confirmed.

2.Prioritisation of bed moves out of Farley to facilitate stroke patients transferring is ongoing. This action includes daily identification of patients who are suitable to move off the ward, such as medical non-stroke patients or patients that no longer need therapy input. This will feed into daily team huddles to discuss issues with delayed transfers and how this can be improved. The use of the GP assessment room is also discussed daily to see if patients are appropriate to be seen there rather waiting in ED.

3.Meeting with ED Matron, ED consultant and stroke consultant took place on the 24/2/23. A further meeting with the bed managers took place on the 3/3/23. These meetings were to discuss actions to improve patient transfers within 4 hours from the decision to admit to admission to the stroke unit.

Risks and mitigations:

Hyperacute stroke patients are currently at risk of worse outcomes without access to specialist care in the appropriate time frame. To mitigate this, there are monthly meetings with the working group to discuss: the speed of stroke patients arriving on the stroke unit, and issues of transferring patients off the ward. These meetings will enable us to facilitate bed moves when a potential stroke patient has been identified in ED more promptly as bed capacity allows.

Risk of significant staffing shortages, particularly during periods of significant operational pressures whereby stroke nurses are moved to support other clinical areas. We still have staff nurses redeployed to other areas currently. This has an impact on stroke services ability to receive patients from ED, especially those that are thrombolysed and require 1:1 input. The service is hoping to be able to protect staff going forward by recognising stroke as an acute ward. However, bed managers will only move staff from the stroke unit as a last resort to help protect our staffing levels where possible.

Bed allocation remains a significant risk in the context of the Trust's operational position. The service hopes to ensure adequate allocation of beds for stroke patients to improve transfer time as well as improve identification of patients for transfer to medical wards to allow allocation for stroke patients.

Maternity

Are We Safe?

	SFT Assurance Dashboard	Guidance	Standard	RAG Target 2021-22 Q4	RAG rating: Red	RAG rating: Green	Improvement Direction	Rolling 6 months: Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Rolling 6m average
Perinatal Morbidity and Mortality (MBRRACE-UK)	Number of late fetal losses (22+0 to 23+6 weeks excl TOP)			NA	>= 2	= 0	Down	0	0	0	0	0	0	0
	Number of stillbirths (>+ 24 weeks excl TOP) per 1,000 Live (reg) Births	ONS	3.8 per 1000 live births	NA	>= 3.9	<= 3.7	Down	0.0	0.0	0.0	0.0	0.0	0.0	0
	Number of neonatal deaths : 0-28 days per 1,000 Live (Reg) Births	ONS	2.7 per 1000 live births	NA	>= 2.8	<= 2.6	Down	0.0	0.0	0.0	0.0	0.0	0.0	0
	Medical termination over 24 +0 registered			NA	NA	NA	Down	0	0	0	0	0	0	0
Maternal MBRRACE-UK	Number of Maternal Deaths per 100,000 Maternal Deaths	ONS	9.1 per 100,000 women who delivered	NA	>= 9.2	<= 9	Down	0.0	0.0	0.0	0.0	0.0	0.0	0
	Number of women requiring admission to ITU	6 month SFT rolling		NA	>= 2	= 0	Down	0	0	0	0	0	0	0
Insight	Number or Datix incidents - moderate or above	6 month SFT rolling		1	>= 2	= 0	Down	2	1	2	1	1	2	2
	Datix incidents moderate harm (not SII)	6 month SFT rolling		1	>= 2	= 0	Down	2	1	2	0	1	1	1
	Datix incidence SII	6 month SFT rolling		0	>= 1	= 0	Down	0	0	0	1	0	1	0
	HSIB referrals	6 month SFT rolling		0	>= 1	= 0	Down	1	0	0	1	0	0	0
	HSIB/NHSR/CQC or other organisation with a concern or request	6 month SFT rolling		0	>= 1	= 0	Down	0	0	0	0	0	0	0
	Coroner Reg 28 made directly to trust	6 month SFT rolling		0	>= 1	= 0	Down	0	0	0	0	0	0	0
Workforce	Minimum safe staffing in maternity services :Obstetric cover	RCOG guidence		40	<= 39	>= 40	Up	40	40	40	40	40	40	40
	Midwife to Birth ratio	RCM;NHSR;BR +	1.28	1.31	>= 1.32	<= 1.31	Down	1.35	1.33	1.29	1.31	1.31	01:27	NA
	Midwifery vacancy rate (black= over establishment; red =under establishment)			NA	>= 1	NA	Down	19.65	18.84	18.84	19.96	20.9	20.9	NA
	Provision of 1 to 1 care in established labour (%)	NICE, RCM, MIS	100%	100	<= 94	>= 100	Up	100	100	100	100	100	100	NA
	Datix relating to workforce	6 month SFT rolling		NA	>= 2	= 0	Down	1	1	0	1	1	2*	1
	Compliance with supernumery status of the LW coordinator - %	NICE;RCM;NHSR	100% rostered	100	<= 94	>= 100	Up	100	100	100	100	100	100	NA
	Numbers of times maternity unit on divert	6 month SFT rolling		NA	>= 2	= 0	Down	0	0	0	0	0	0	0
Involvement	Service user feedback : Number of Compliments	6 month SFT rolling		15	NA	>= 15	Up	31	10	26	10	10	31	20
	Service user feedback : Number of Complaints	6 month SFT rolling		1	>= 2	<= 1	Down	2	1	2	2	1	3	2
	Number of SOX	6 month SFT rolling		4	NA	>= 4	Up	7	4	7	3	3	6	5
Assurance	Progress in achievement of 10 safety actions (CNST)	NHSR	10	NA	<= 5	>= 10	Up	5	6	7	5	5	5	6
	Training compliance - MDT PROMPT %	NHSR	90%	NA	<= 84	>= 90	Up	77	82	93	91	93	91	NA

Understanding the performance:

Midwifery vacancies remain high, however numbers of births this month have been lower contributing to an improved midwife to birth ratio. Births are expected to rise to average rates again for March.

Datix relating to workforce increased at 2 – relating to missed breaks.

One SII commissioned.

Actions (SMART):

Midwifery staffing vacancies remain a Driver for Improving Together (IT) which ensures action and around recruitment and retention.

To continue with training session on fetal heart monitoring and Prompt (obstetric emergencies) to maintain/achieve compliance with safety action.

Multi disciplinary team meeting was had in February and plan to achieve CNST compliance formulated for 2023.

Risks and Mitigations:

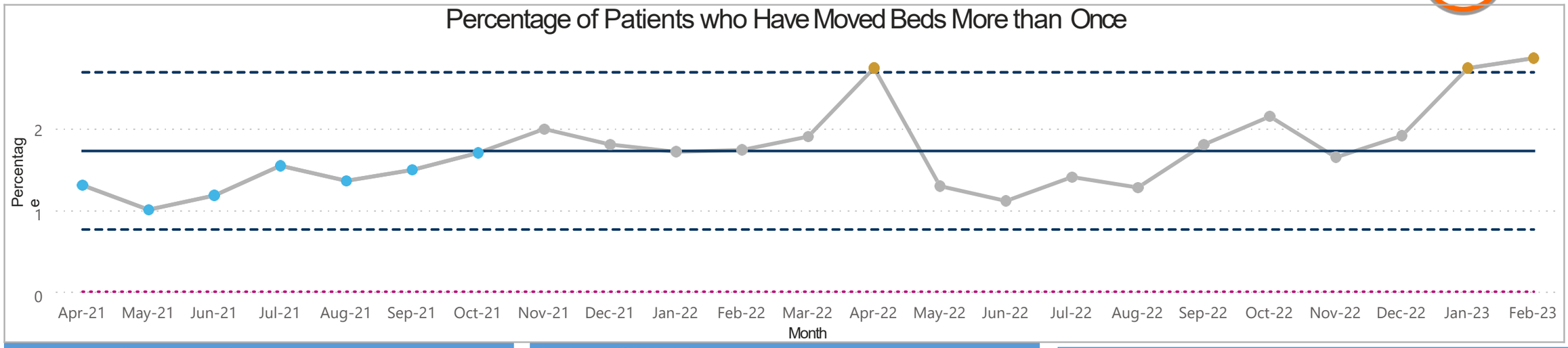
Staffing
– Recruitment drive in progress.

International recruitment in process and x1 midwife to date has passed her OSCE and is awaiting NMC registration, another 5 to complete in March and April.

Overercruited by 2 WTE labor ward coordinators. This will provide balance and support to a workforce that is predominantly junior.

Patients Who Have Moved Beds More Than Once

Are We Safe?



Understanding the performance:

The percentage of patients moved more than once in February 2023 remains very high. The need to create capacity with the acute wards has resulted in patients being moved several times to accommodate the new acute admissions.

Patients have been identified throughout the medical and surgical divisions to be transferred to South Newton to await discharge planning. These patients often result in multiple moves via Breamore to ensure that patients are able to be placed in the correct speciality ward within an appropriate time.

The use of the discharge lounge is still a work in progress, trying to get teams to identify patients that can go there awaiting discharge to allow for early release of beds for the non-elective admissions.

There continue to be ongoing infection control outbreaks which have resulted in patients being moved into cohorted areas following IPC policies.

Actions (SMART):

Working closely with the divisional teams to ensure that patients are placed within the correct speciality area post admission. There has been a recognition to ensure that the specialities need to collate a rolling list of patients that need to be on their clinical areas to receive their treatment.

The work with the E-whiteboards to identify the patients moves continues and aims to minimise total moves per patient and allow of an opportunity to improve the patient experience.

Aiming to reduce the escalation beds back into the main trust footprint, to reduce the number of moves experience by patients.

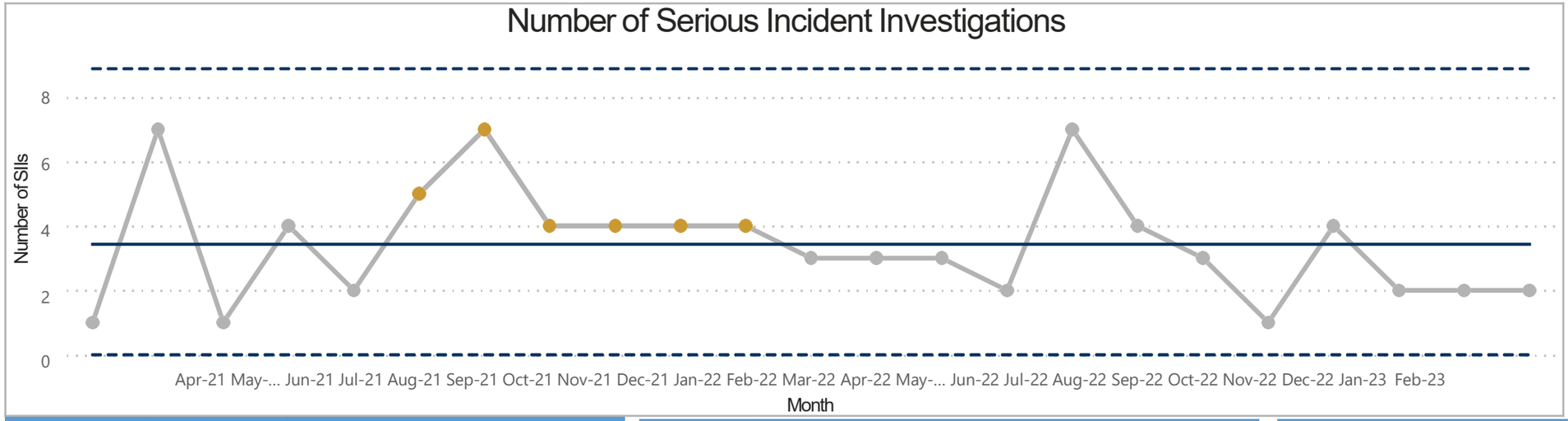
Risks and mitigations:

Recognising that staffing has been challenging and along with Industrial Action throughout this period across the MDT, site, and admin which has impacted the patient experience.

Work continues with E-Whiteboards at ward level and the provider to improve.

Incidents

Are We Safe?



Year	2021-2022	2022-2023
Never Events	3	0

Understanding the performance:

4 SIIs were commissioned in February:

SII 544 - delay in insertion of a chest drain
SII 546 - failure to escalate to CCOT
SII 547 - delay in triage/treatment of child
SII 548 - Term admission to NICU.

Actions (SMART):

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

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

Risks and mitigations:

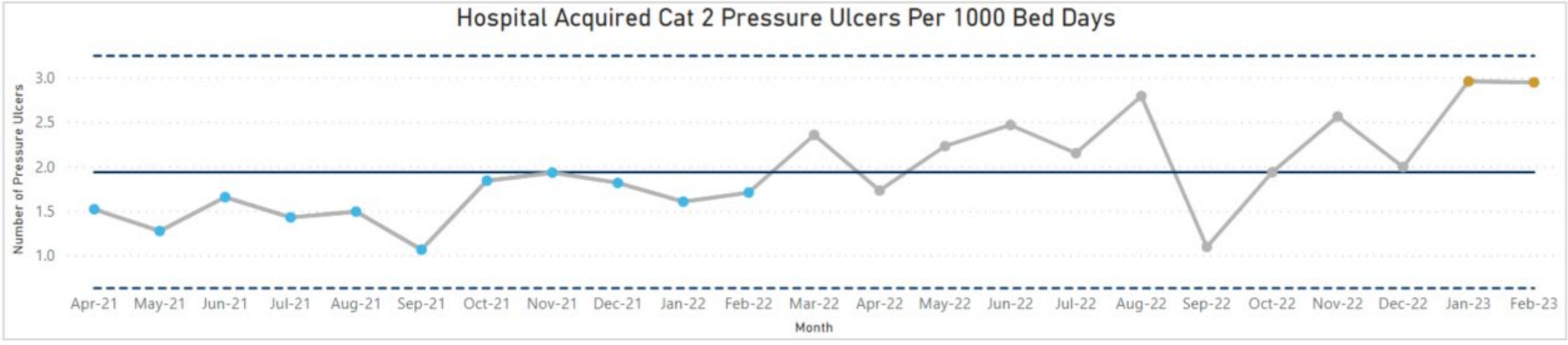
•Once an incident has been identified and a 72 hour report completed, it will be established as to whether there are immediate safety actions that need to be implemented or escalated immediately.

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

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

Pressure Ulcers

Are We Safe?



Understanding the performance:

Hospital acquired grade 2 Pressure injuries have gone down slightly to 41 but remain high overall, additionally we have seen 9 Suspected Deep Tissue Injuries (DTIs), 3 of which can be attributed to long waiting times in the Emergency Department (ED).

Swarm investigations have been instigated and actions have been implemented including new pressure reducing devices deployed to the ED and review of the management of patients while in the care of the ambulance teams at the point of cohorting .

No grade 3 or 4s have been reported.

42 pressure injuries were noted on admission.

Actions (SMART):

New Hospital acquired PU investigation process being implemented; there has been good engagement from ward leads with the SWARM investigations and actions. Learning has been identified and actions undertaken for teaching on wards with areas of concern.

Electronic datix validation on Lorenzo has completed testing and is now live. All validation for patients in December will be completed in duplicate on Lorenzo and on excel spreadsheet to ensure the data collected for monthly PU figures is accurate.

All staff to be reminded to include as much information as possible when referring patients. This will minimise the number of inappropriate referrals which can delay reviews.

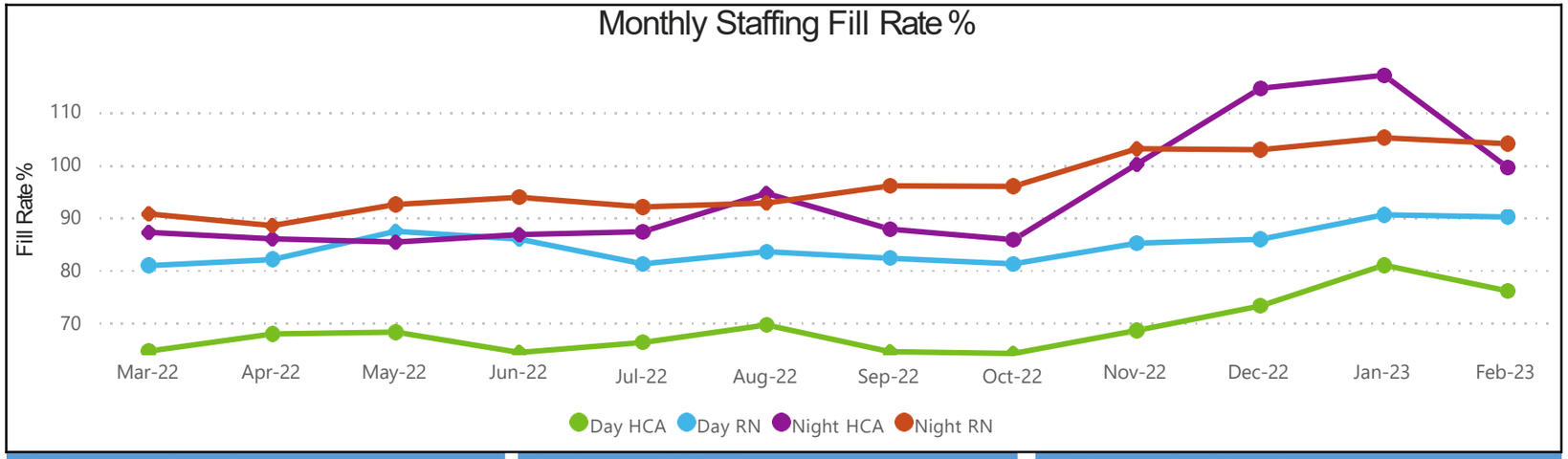
Ward leads to ensure that their staff have completed medical photography training and are competent in taking required images and uploading to PACS.

Risks and mitigations:

An extraordinary Tissue Viability(TV) meeting was undertaken with all matrons and Improving Together methodology was used to develop a number of counter measures. There will be a focus for TV for the month of May which will include an education programme, trolley dashes and ward competitions to raise understanding for new staff and refresh knowledge for others.

Nurse Staff Fill Rate

Are We Safe?



Ward	Day RN	Night RN	Day HCA	Night HCA
Amesbury	107%	121%	85%	112%
Britford	90%	100%	97%	100%
Chilmark	85%	91%	78%	66%
Downton	115%	129%	90%	154%
Farley	82%	100%	72%	79%
Hospice	86%	101%	85%	104%
Longford	89%	121%	88%	102%
Maternity	93%	93%		
Odstock	106%	89%	93%	102%
Pembroke	94%	100%	98%	89%
Pitton	122%	152%	79%	112%
Radnor	80%	82%	32%	63%
Sarum	86%	103%	85%	
Spire	96%	128%	74%	97%
Tisbury	80%	98%	51%	79%
Whiteparish	87%	101%	76%	104%

Understanding the performance:

The 4 markers show some variation this month - most noticeable is reduction in night HCA although this position is still at 104% and there is a slight reduction in daytime HCA from 80% down to 76%.

RN fill remained static compared to last month. It can be seen that in previous months HCA rates for nights were in excess of 100% - this is driven by additional duties in ward areas predominantly to support patients with enhanced supervision requirements.

CHPPD is 7.6 in month, 7.2 when ICU is excluded - this is a slight reduction on the previous month.

Actions (SMART):

The uplift of substantive workers from Band 2 to Band 3 has been completed in March - with all staff except 1 accepting the offer.

Additional action to review the payrate and JD for bank workers - awaiting outcome

effect on bank fill rate for HCA.

Ward assistant pilot project: first candidates commenced in post, matrons providing oversight and developing KPIs to evaluate project eg improve hydration, reduce additional staffing for enhanced care.

Winter incentive remains in place and due review by OD+P before end of March.
RMN review meeting set for April and DHONs to review Enhanced Care policy and ensure being used to reduce reliance.

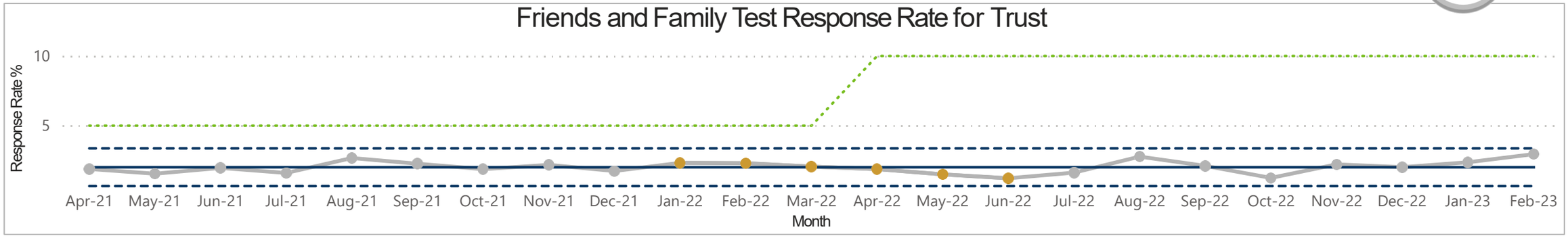
Risks and mitigations:

Risk: On-going highturnover rate for HCAs (19%) and RNs (12%)
Mitigations:
- Domestic and international recruitment
-OD+P led work on retention, turnover and inclusion

- On-going HCA recruitment and induction
-HCA retention and recruiment lead - fixed term

Friends and Family Test Response Rate

Our Care



Response Rate by Area	Mar-22	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23
FFT Response Rate - A&E	0.0%	0.2%	0.0%	0.2%	0.1%	0.3%	0.4%	0.3%	1.1%	0.3%	0.8%	1.6%
FFT Response Rate - Day Case	5.0%	4.8%	4.6%	3.3%	4.6%	8.9%	6.8%	3.1%	2.5%	1.4%	0.3%	2.0%
FFT Response Rate - Inpatient	7.1%	5.7%	7.1%	6.8%	7.5%	10.9%	11.5%	5.2%	10.5%	5.7%	11.8%	13.1%
FFT Response Rate - Maternity	5.9%	11.5%	0.9%	0.4%	1.6%	7.8%	1.1%	1.2%	0.0%	2.6%	2.2%	3.7%
FFT Response Rate - Outpatient	1.6%	1.3%	0.8%	0.6%	0.9%	1.5%	0.9%	0.9%	1.6%	2.0%	2.0%	2.2%

Understanding the performance:

The NHS Friends and Family Test (FFT) was created to help service providers and commissioners understand whether patients are happy with the service provided, or where improvements are needed. It is a quick and anonymous way to give views after receiving NHS care or treatment. Areas are encouraged to offer feedback forms to patients at discharge or during their stay. Weekly emails are sent to leads showing feedback received in the previous week, allowing them to pick up any immediate causes for concern and mitigate these where possible.
Negative feedback is review by the ward and PALS, twice a year.
FFT responses are noted to be steadily increasing this month. Staff are still being encouraged and reminded to offer FFT through the PALS outreach services although we appreciate that this sole method of obtaining response will inevitably mean fluctuations in activity consequent to pressures.
It is noted that in the last few months the average responses of patients who are satisfied with the service they received has fluctuated slightly.

Actions (SMART):

Medium-term action: Delay in the rollout of digital provider (see risk/mitigations) will now require interim actions to be developed.

Long-term action: Securing a provider to gather patient feedback vis SMS will be key to moving towards achievement of our objectives under the Improving Together Programme over the next 6-12months:
Aims:
- Increase overall response rates to FFT
-Diverse methods for completion (including, online, SMS, over the phone)
-Increased accessibility and options for inclusivity (sight impairments, languages and additional demographic options)
-Robust analysis of data for insight and meaningful comparison/benchmarking via a real-time dashboard
- Opportunity to align our processes in FFT across the ICS

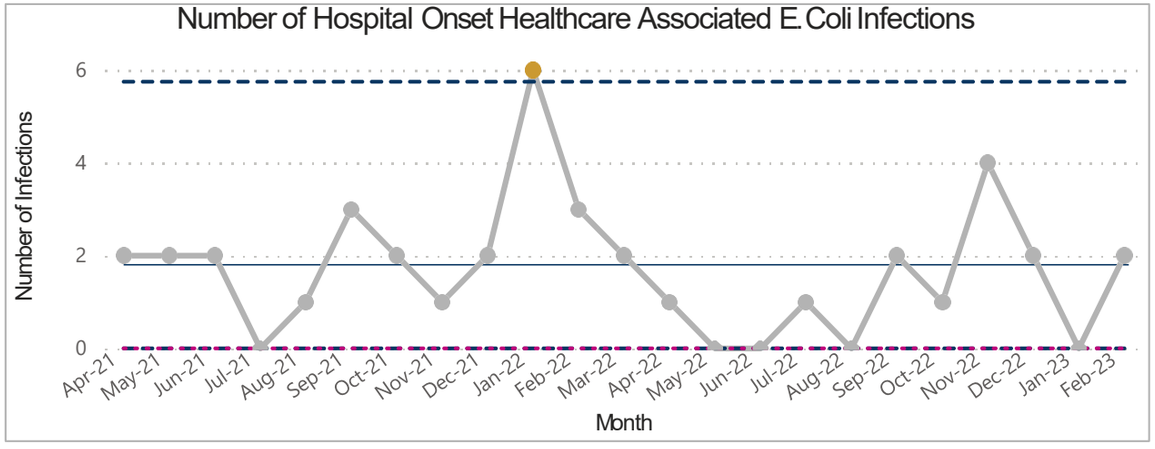
Risks and mitigations:

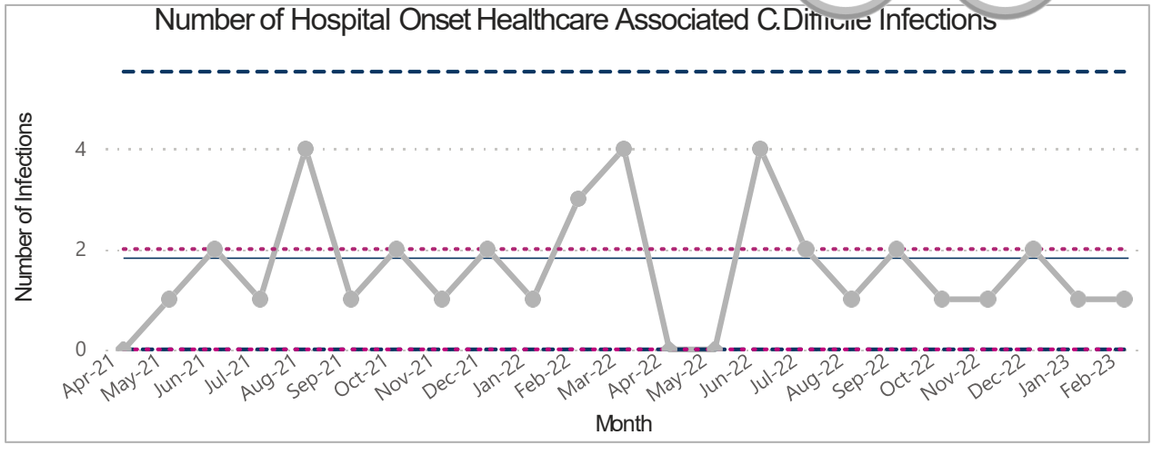
Continued low response rate due to limited methods for accessibility and the reliance on staff to promote completion of a physical card. This is directly impacted when there are staff shortages and operational pressures. The current method requires manual input and theming, which there is limited resource to undertake. Theming on a large scale is near impossible with the usual manual approaches - this makes presenting insightful data for the Trust difficult to assure.

Implementation of the new IT solution has had to be delayed due to capacity within the Informatics Team to assist with set-up and roll out. This has been agreed by Execs to delay until this capacity is available - estimated for December 2023. We will now begin working on interim solutions to boost response rates, however it should be noted that we will continue to be unable to achieve robust theme analysis of this data during this time.

Infection Control

Are We Safe?





Understanding the performance:

There have been two hospital onset healthcare associated reportable E.coli bacteraemia infections, and one hospital onset healthcare associated reportable C.difficile case this month. As previously reported, we have exceeded set trajectories for reportable healthcare associated C.difficile cases for 2022/23 (total now 28 cases).

The Infection Control Nurses (ICNs) have undertaken targeted ward visits and utilise educational opportunities with different staff groups. There have also been agreed additional face-to-face Infection Prevention and Control (IPC) sessions, as requested by the Practice Education team, which has included International Nurses.

Year	2021-2022	2022-2023
MSSA Bacteraemia Infections: Hospital Onset	12	7
MRSA Bacteraemia Infections: Hospital Onset	0	0

Actions (SMART):

Alternative approach for staff in ward areas to complete hand hygiene education and assessments remains ongoing. Changes to the original plan were agreed at the Infection Prevention & Control Working Group this month, to further test the process within the surgical division.

Ongoing action associated with the completion of required case investigations by clinical areas to identify good practice and any new learning. The Trust's IP&C team facilitate this process so that areas can take ownership and progress any actions or identified learning (including sharing good practice). It remains the responsibility of the ward/area/department lead and division to complete this.

The February 'Share & Learn' meeting to enable agreement of actions moving forward from any themes or trends identified from all cases was cancelled by the Chair. Involvement with BSW collaborative workstreams related to IPC and Gram-Negative Bloodstream Infections (GNBSIs). Any feedback communicated from the sessions to identified individuals in the organisation is to be shared at the Trust's Infection Prevention & Control Working Group (IPCWG) as part of a standing agenda item. Unfortunately, the Infection Control Doctor was unable to attend the meeting scheduled for February.

Risks and mitigations:

Sustained clinical workload for IPC nursing team including ongoing COVID-19 outbreaks and continued diarrhoea activity within the hospital, impacting on ability to focus on other Healthcare Associated Infection (HCAI) prevention work.
New IPC nursing staff member commenced in a secondment post as agreed during February.

An underlying risk continues to be a potential increase in incidence of reportable HCAI with poor patient outcomes and Trust exceeding all agreed trajectories.

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

Delays with return of completed case investigation documentation by relevant clinical areas, therefore unable to identify evidence of learning.
Limited evidence of IPC practice assurance provided by the clinical divisions due to ongoing operational challenges and workload pressures for teams.

Mortality

Are We Safe?

Metric Name	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22
Crude Mortality	63	76	62	68	69	65	64	79	94	86	84	84	88	84	77	88	82	73	75
HSMR District Hospital (excludes deaths recorded by Salisbury Hospice)	100.95	102.07	100.85	101.29	102.46	102.85	103.49	106.41	105.02	101.59	104.62	107.26	109.94	109.80	111.50	112.70	113.40	113.40	
HSMR Trust	110.91	108.00	109.43	107.97	107.96	109.00	109.66	109.88	113.00	113.00	109.08	111.34	116.00	115.00	117.20	118.00	119.10	119.00	
SHMI District Hospital (excludes deaths recorded by Salisbury Hospice)	98.21	100.17	101.28	101.78	101.88	102.61	102.69	102.81	102.70	104.38	105.48	107.66	106.80	106.05	106.48	106.90	106.98	107.03	106.64
SHMI Trust	103.39	105.00	106.29	106.22	106.22	107.07	106.90	106.67	106.77	108.47	109.13	111.34	110.00	110.00	110.01	111.00	111.16	111.00	111.06

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

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

Understanding the performance:

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

The SHMI for the 12-month rolling period of November 2021 to October 2022 for Salisbury District Hospital is 106.64.

The HSMR for the 12-month rolling period of October 2021 to September 2022 for Salisbury District Hospital is 113.4.

Actions (SMART):

N/A

Risks and mitigations:

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

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

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

Watch Metrics: Alerting

Quality of Care, Access and Outcomes

Metric	Two Months Ago	Last Month	This Month	Improvement Target	Na onal Target	Varia on	Varia on Detail	Target Met This Month?	Consecu ve Months Target Failed
Total Number of Compliments Received	12	68	39				Special Cause Concerning - Run Below Mean		
Ambulance Handovers 30-<60 mins	148	152	139				Special Cause Concerning - Run Above Mean		
Ambulance Handovers 60+ mins	281	136	120		0		Special Cause Concerning - Run Above Mean	X	23
Average hours lost to Ambulance Handover delays per day	34	14	18		0		Special Cause Concerning - Run Above Mean	X	23
ED 12 Hour Breaches (Arrival to Departure)	201	77	91		0		Special Cause Concerning - Run Above Mean	X	23
Propor on of pa ents spending more than 12 hours in an emergency department	4.8%	2.1%	2.4%				Special Cause Concerning - Run Above Mean		
Cancer 31 Day Performance Overall	90.7%	97.0%	85.8%		96%		Special Cause Concerning - Below Lower Control Limit	X	1
Trust Performance RTT %	61.8%	64.8%	61.8%		92%		Special Cause Concerning - Below Lower Control Limit	X	23
Average Pa ents with No Criteria to Reside	171	172	174	35			Special Cause Concerning - Above Upper Control Limit	X	23
DM01 Wai ng List Volume	6071	5555	6040				Special Cause Concerning - Above Upper Control Limit		
Pressure Ulcers Hospital Acquired Cat 2	31	46	51				Special Cause Concerning - Above Upper Control Limit		
% of Inpa ents Undergoing VTE Risk Assessment	%	98.7%	%		95%		Common Cause Varia on	X	1
Cancer 62 Day Screening Performance	85.7%	82.1%	54.8%		90%		Common Cause Varia on	X	5
Mixed Sex Accommoda on Breaches	22	9	9	0	0		Common Cause Varia on	X	6
RTT Incomplete Pathways: Total 52 week waits	549	578	694	550	0		Common Cause Varia on	X	2
Total (Excess) Bed Days from NC2R to Discharge - Internal Reasons only	335	816	468	150	0		Common Cause Varia on	X	23
Total Number of Complaints Received	11	9	25		0		Common Cause Varia on	X	9

Watch Metrics: Alering Narraive

Quality of Care, Access and Outcomes

Understanding the performance:

A range of indicators across the Emergency access pathway continue to alert, in particular the number of ambulance handover delays and the number of patients in the Emergency department for over 12 hours. Although still alerting there has been some progress, with the number of handover delays between 30-60 minutes, and over an hour improving for the second month. The proportion of patients spending more than 12 hours in the department increased slightly to 2.4%.

Actions (SMART):

Actions in relation to most metrics alerting are captured in the detailed key performance indicator slides earlier in the report.

The percentage of patients undergoing VTE risk assessment is alerting as 0% but this is due to a change in how this metric is reported with the new format not yet available. This will be available in the IPR again next month.

Risks and Mitigations:

Staffing risks remain high in terms of availability and vacancy, focused work continues with some improvement beginning to show in turnover.

Watch Metrics: Non-Alerting

Quality of Care, Access and Outcomes

Metric	Two Months Ago	Last Month	This Month	Improvement Target	National Target	Variation	Variation Detail	Target Met This Month?	Consecutive Months Target Failed
% of Total Incidents Resulting in High Harm (Mod/Maj/Cat)	22.0%	40.0%	36.0%				Common Cause Variation		
Ambulance Arrivals	1049	1057	1039			L	Special Cause Improving - Two Out of Three Low		
Ambulance Handovers 15-<30 mins	225	268	291				Common Cause Variation		
Cancer 2 Week Wait Breast Performance	96.1%	87.0%	90.0%		90%	H	Special Cause Improving - Two Out of Three High	✓	0
ED Attendances	6839	5863	5619				Common Cause Variation		
Neonatal Deaths Per 1000 Live Births	0	0	0		0	L	Special Cause Improving - Run Below Mean	✓	0
Number of High Harm Falls in Hospital	0	0	0	0	0	L	Special Cause Improving - Run Below Mean	✓	0
Pressure Ulcers Hospital Acquired Cat 3	0	0	0			L	Special Cause Improving - Run Below Mean		
Pressure Ulcers Hospital Acquired Cat 4	0	0	0			L	Special Cause Improving - Run Below Mean		
RTT Incomplete Pathways: Total 104 week waits	0	0	0	0	0	L	Special Cause Improving - Run Below Mean	✓	0
RTT Incomplete Pathways: Total 78 week waits	8	7		5	0		Common Cause Variation	✓	0
Serious Incident Investigations	2	2	2				Common Cause Variation		
Stillbirths Per 1000 Total Births	0	13	0				Common Cause Variation		
Stroke & TIA: % CT'd within 1 hour	50.0%	42.0%	62.0%		50%		Common Cause Variation	✓	0
Total Incidents (All Grading) per 1000 Bed Days	55	52	59				Common Cause Variation		

Part 2: People

Performance against our Strategic Priorities and Key Lines of Enquiry

Our Priorities

Population

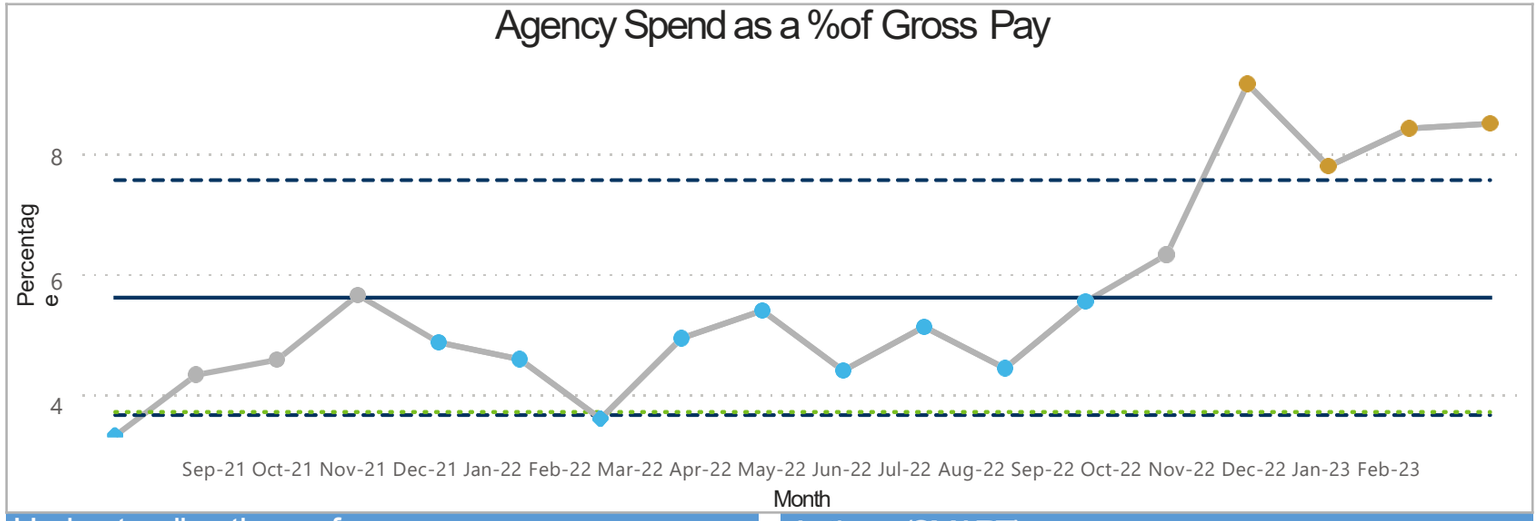
Partnerships

People

Staffing Availability

Target 3.7%

Breakthrough Objective



We are driving this measure because...

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

Understanding the performance:

Agency spend as a % of gross pay hit 8.5% in M11, against the target of 3.7%. This amounted to a monthly spend of £1.54M for February, of which c75% was attributed to Nursing Staff (£855K) and Medical Staff (£299K). Staff availability is impacted by a combination of high vacancy rates, high turnover, high levels of short-term absence and ineffective process control.

Medicine Division remain responsible for over 50% of Agency spend, but have made good progress in reducing their spend by c£60K this month. CSFS also contributed a modest reduction in Agency spend, whereas the remaining Divisions and the corporate area spend all increased.

Turnover, vacancies and absence are driver metrics for this breakthrough objective, all three are starting to show a downward trend since December 22, but these trends are not yet sufficient to reduce Agency spend against the target. Work has begun which seeks to improve process control in order to manage spend more effectively.

Actions (SMART):

Establishment Control: The e-roster and ESR project implementation work was completed on 14th March. E-Roster roll out will commence from April 23, and run through for 18 months and the first division (Medicine) to reconcile establishment with finance ledger on ESR will be complete by July 23. Oversight of the establishment will enable organisational design, improve visibility of vacancies across the Trust and improve workforce productivity.

Recruitment Services: Actions to overhaul the recruitment process work are delivering efficiencies, including updated web pages and access, a recruiting managers toolkit, and updated policies for RRP, Starting Salary and Relocation, enabling a greater targeting of hard-to-recruit posts.

Temporary staffing: Reconciliation of the Operating model and Agency support model for new contract, and recruitment of additional bank staff have all commenced.

Risks and mitigations:

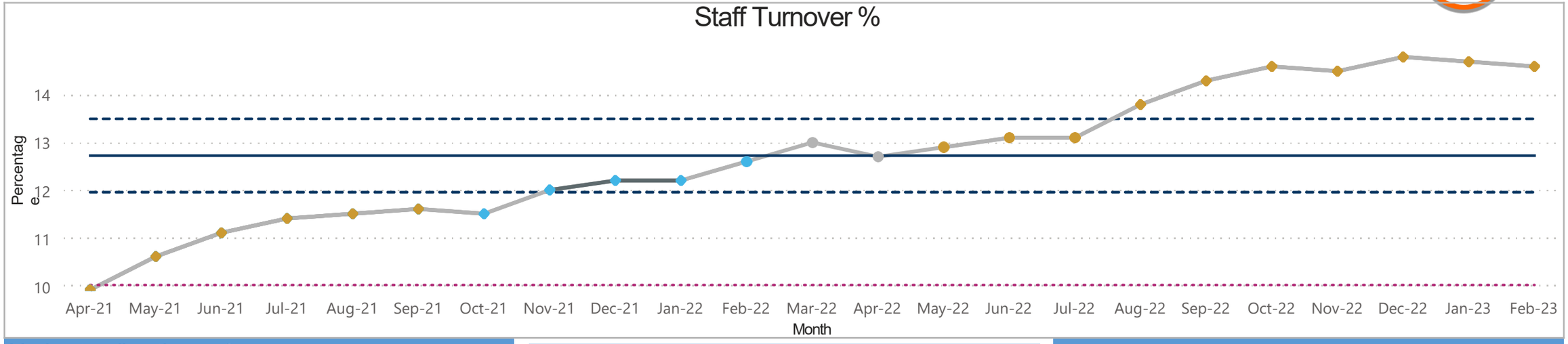
Corporate Risk – Sustainable Workforce
Mitigations:
Line Managers insufficiently trained to support People Promise and absence management initiatives. The roll out of Leadership training courses targeting Band 4-6 and 7-8 mangers commenced in February 23, alongside specific modules designed to improve management skills.

Vacancies not sufficiently understood – Support to DMT to establish organisational design and prioritise vacancies to enable effective targeting of attraction campaigns.

Workforce - Turnover

Target 10%

People



Understanding the performance:

All Divisions remain red against the Trust 10% target. In February, 32.61 (FTE) left the Trust, with 52.49 (FTE) staff starting work, a positive ratio, which has helped reduce the rolling average to 14.55% this month. This is an encouraging position, and represents a modest downward trend in 2023.

Surgery and CSFS remain closest to the 10% target at 13.45 and 13.35% respectively. Women and New Born remain at the highest level of turnover at 18.60%.

Of the 37 staff that left the Trust in February, only 4 completed a full exit questionnaire. Without the full questionnaire, it is difficult to triangulate reasons for leaving effectively and make decisions on where to focus retention efforts.

50% of staff cited Relocation and Work-life Balance as the reason for leaving on their ESR leavers survey.

Actions (SMART):

Staff survey results have been analysed and packs have been distributed to Divisional Management Teams, with action plans requested by April 23. The data has been divided by Division, profession and protected characteristics to enable effective management of action plans.

HR Business Partners have continued to support Divisional Line managers deliver appraisals and career conversations. Registered Nurses in the 45-55 age group represent a high risk area and plans are in place to ensure each nurse has a career conversation before 31 March 23 which seeks to understand options and intentions for this staff group. Currently 96/261 nurses in this category have been interviewed.

Risks and mitigations:

Corporate Risk – Sustainable Workforce.

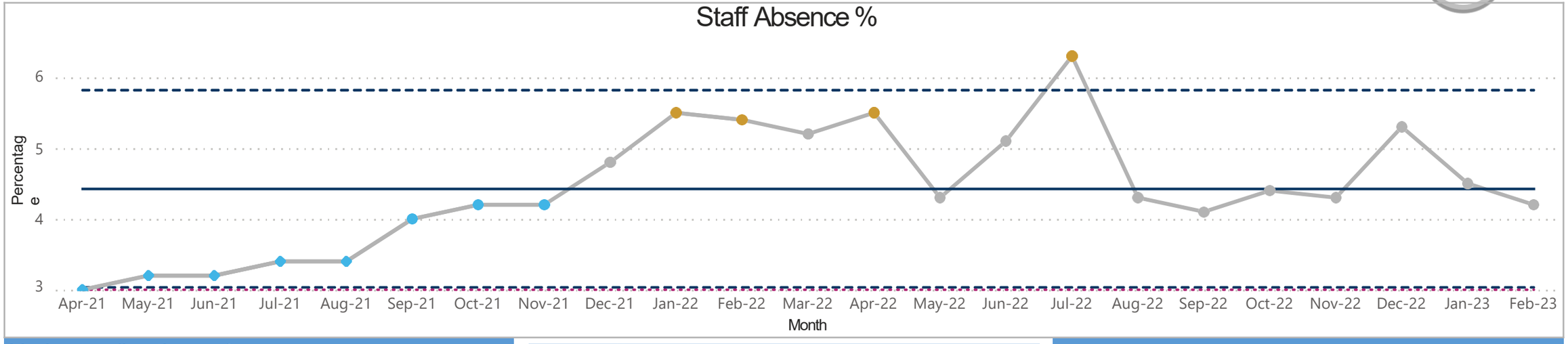
Improved toolkits to support Line Managers to deliver appraisals and other conversations have been delivered.

Training interventions to improve leadership and management skills will began roll out in February 23, with 120 places available in the first year for leadership and a suite of management modules available to improve line management skillsets.

Workforce - Sickness

Target 3%

People



Understanding the performance:

Sickness absence reduced to 4.17% for February, the lowest monthly rate for over a year and represents a continuing downward trend in 2023. Women and New Born and the Corporate area are both under 4% absence, with Women and New Born seeing a reduction of around 1.5% in month.

Staff from the Additional clinical services group have seen the highest absence rate over the past 3 months to February, but this month has seen a reduction in absences rate to 5.40%, still above target, but a circa 2% improvement on the average rate over the past quarter.

Sickness accounted for 4,218 FTE days lost to the Trust of which 2,701 were for short-term absence in February. Mental Health issues caused 1,033 days lost, twice as high as any other category of absence.

Actions (SMART):

Absence Management: The direct support pilot for 3 wards in Medicine (Pitton, Redlynch and Laverstock) has now been resourced and will commence 20th March. The pilot will seek to support managers to deliver effective absence management in accordance with policy. A report on the impact is due in 3 months.

Twenty-six well-being ambassadors have been trained and 14 have places on future courses. These staff will deliver well-being conversations to all staff by 31 March 23. Interventions will be targeted against areas with significant backlogs, which this month included Spire Ward where 19 conversations were facilitated.

An absence management workshop took place in Jan 23, which identified several areas where improvements could be made to policy, processes and management of absence cases. These ideas will be refined with the aim of introducing improvements in April 23.

Risks and mitigations:

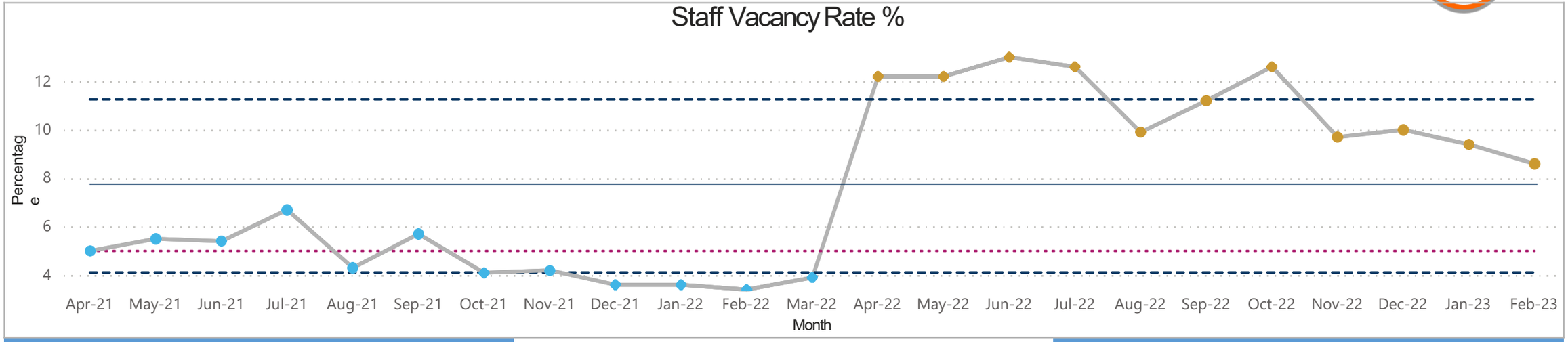
Corporate Risk – Delivery of OH service
Occupational Health staffing has improved. A Band 7 lead has now been recruited, starting in May. Increased counselling and physio hours are required. Delivery of a health intelligence capability is planned for Summer 23.

Corporate Risk – Sustainable Workforce
Absence management actions are not effective. AD HR Operations is now producing a targeted plan to reduce absence case work numbers.

Workforce - Vacancies

Target 5%

People



Understanding the performance:

The vacancy rate in February stood at 8.60%, maintaining the shallow downward trend of the last 2 months. The Trust welcomed 59 starters this month an FTE increase of 52.49. This is positive news and the third month running where starters have outnumbered leavers, which is starting to address the deficit of staff generated by establishment uplift in April 22.

Nursing staff remain the staff group with the highest number of vacancies, although the number has reduced from 134 to 121 FTE this month.

At 82 FTE, Theatres has the largest number of vacancies, partly due to its size and the specialisms required. Targeted campaign to attract new theatre staff, and focussing on London are underway.

Actions (SMART):

The Overhauling Recruitment project has delivered updated recruitment pages, a managers toolkit, and policy updates for RRP and welcome payments, Starting Salary and relocation payments – these policies will be live in April.

An assessment of social media presence was conducted in December 22, subsequent actions have resulted in 327% increase of hits on the updated recruitment web pages, daily hits average increased by 530%, linkedin page refreshed with a managers social media masterclass developed for April 23, and facebook campaign for HCAs resulted in 1,614 clicks on the job link.

Power BI data has enabled HR Business Partners to prioritise vacancies and this month an incentive scheme for Band 5 Midwives has been approved, an RRP scheme to attract Band 6 and 7 pharmacists has been developed and work has been completed to refresh and improve the attraction campaigns for Consultant Gastroenterologists and Skin and Trauma Consultants.

Risks and mitigations:

Corporate Risk – Sustainable Workforce
Resourcing Plans delivered.

Implementation of PWC 'Overhauling Recruitment' recommendations to generate more efficient processes.

Recruitment campaigns are being refreshed.

Communication of single version of recruiting picture across the Trust.

Creation of career pathways and improved career structures to better advertise roles and opportunities.

Watch Metrics: Alerting

People

Metric	Two Months Ago	Last Month	This Month	Improvement Target	Na onal Target	Varia on	Varia on Detail	Target Met This Month?	Consecu ve Months Target Failed
Mandatory Training Rate %	90.6%	90.2%	89.7%	90.0%	85%		Special Cause Improving - Run Above Mean	X	1
Medical Appraisal Rate %	86.9%	85.8%	86.3%	90.0%			Special Cause Improving - Run Above Mean	X	23
Non-Medical Appraisal Rate %	63.8%	63.9%	62.9%	86.0%			Special Cause Concerning - Below Lower Control Limit	X	23

Watch Metrics: Alering Narraive

People

Understanding the performance:

Mandatory training activity at 89.7% completion, has dropped below the target level of 90%. The impact of operational pressures in the hospital and close down of training courses and education centre rooms to support operational activity during the strike period in February are the main reasons behind this drop. Completion rates remain above the national target of85%.

Medical appraisal rates remain just under target at 86.3% completion against the 90% target.

Non-Medical appraisals remain some way below target at 62.9%, some way below the lower control limit. Ineffective management of appraisals remains an area of concern in Staff Survey and Pulse survey data, leading to low morale amongst staff. Time to complete is the most common challenge to increasing this rate.

Actions (SMART):

Mandatory Training: Reminders for Mandatory training will be communicated across the Trust, and additional classroom space in the Education Centre and Library is being made available to enable completion of on-line and in person training sessions.

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

The first of a series of Appraisal Workshops has been delivered for Line Managers, with more in the forward programme.

The option of completing paper forms (currently used by Facilities) is being explored in Medicine Division, alongside the wider simplification of the process through a new policy, which will seek to share ownership of appraisals between line managers and staff. This policy is expected to be delivered in May 23.

Risks and Mitigations:

Corporate Risk - Sustainable Workforce.

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

Watch Metrics: Non-Alerting

People

Metric	Two Months Ago	Last Month	This Month	Improvement Target	Na onal Target	Varia on	Varia on Detail	Target Met This Month?	Consecu ve Months Target Failed

Part 3: Finance and Use of Resources

Performance against our Strategic Priorities and Key Lines of Enquiry

Salisbury NHS Foundation Trust

Our Priorities

Population

Partnerships

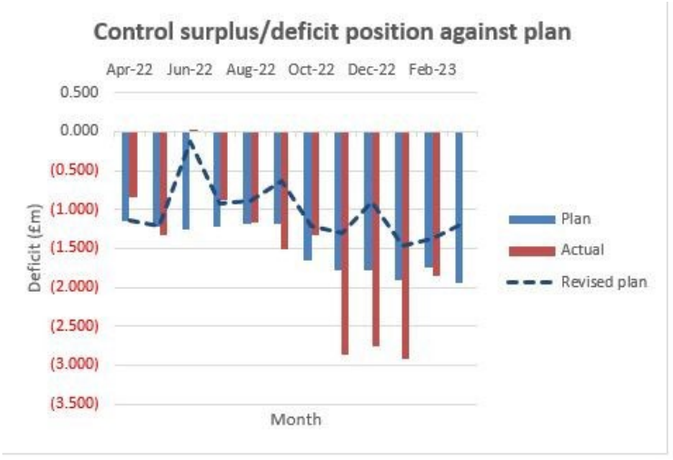
People

Income and Expenditure

Income & Expenditure:

Finance and Use of Resources

	Feb '23 In Month			Feb '23 YTD			22-23 Plan
	Plan £000s	Actual £000s	Variance £000s	Plan £000s	Actual £000s	Variance £000s	Plan £000s
Operating Income							
NHS Clinical income	21,946	21,174	(772)	242,061	243,484	1,423	260,775
Other Clinical Income	714	2,489	1,775	7,856	11,773	3,917	8,573
Other Income (excl Donations)	2,797	3,566	769	31,649	37,699	6,050	34,540
Total income	**25,457**	**27,228**	**1,772**	**281,566**	**292,957**	**11,390**	**303,888**
Operating Expenditure							
Pay	(16,934)	(18,107)	(1,173)	(185,602)	(193,257)	(7,655)	(199,429)
Non Pay	(8,177)	(9,485)	(1,308)	(88,690)	(99,762)	(11,072)	(96,646)
Total Expenditure	**(25,111)**	**(27,592)**	**(2,481)**	**(274,292)**	**(293,018)**	**(18,726)**	**(296,075)**
EBITDA	**346**	**(363)**	**(709)**	**7,274**	**(62)**	**(7,336)**	**7,813**
Financing Costs (incl Depreciation)	(1,723)	(1,489)	234	(18,491)	(17,372)	1,119	(20,213)
NHSI Control Total	**(1,377)**	**(1,852)**	**(475)**	**(11,217)**	**(17,434)**	**(6,217)**	**(12,400)**
Add: impact of donated assets	(68)	(64)	4	(748)	324	1,072	(816)
Add: gains/(losses) on transfers by absorption	0	0	0	0	(329)	(329)	
Surplus/(Deficit)	**(1,445)**	**(1,917)**	**(472)**	**(11,965)**	**(17,439)**	**(5,474)**	**(13,216)**
NHSI Control Total including BSW ICB support	**(344)**	**(819)**	**(475)**	**150**	**(6,067)**	**(6,217)**	**0**



Understanding the performance:

In Month 11 the Trust recorded an in month control total deficit of £1.852m against an original target of £1.377m - an adverse variance of £0.475m. The YTD control total deficit is £17.434m compared to the original plan of £11.217m. When the full year £12.400m ICB funding is taken into account (£11.367m at month 11) the deficit is adjusted to £6.067m against a surplus of £0.150m.

Pay costs reduced in month by £0.386m, across all contract types, although remain significantly above the average run rate for the year. The reduction is due to lower enhancements and incentive payment but there has been a continued requirement for mental health nursing support. driven by an increase in bank and agency costs, including bank incentive costs. Non pay costs fell by £0.518m across the majority of categories although 'Pass through' non pay costs continue to run in excess of those planned for and now account for 55% of costs above plan.

Actions (SMART):

Agreement was reached on the distribution of the BSW ICB planned surplus and £12.4m was paid to SFT in October. A further £7m has now been paid in March.

People workstreams are focusing on retention of staff, with the uplift of all Band 2s to the top of scale with effect from 1 December. A review of HCA roles that fulfil clinical competencies and can be regraded to Band 3 has been concluded with the expectation that this is effective from January and paid in March 2023.

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

Risks and mitigations:

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

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

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

A revised forecast of £6.4m deficit was approved by the Trust Board in early January and £7m was paid in March as part of the agreement with BSW ICB to mitigate this position.

Income & Activity Delivered by Point of Delivery

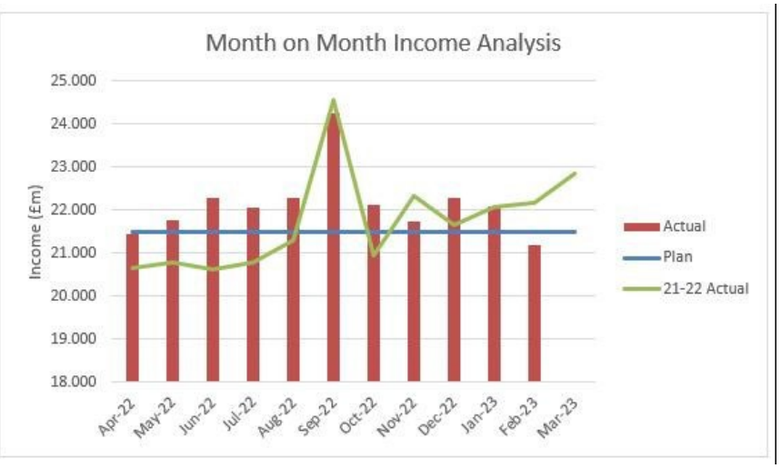
Clinical Income:

Finance and Use of Resources

Income by Point of Delivery (PoD) for all commissioners	February '23 YTD Plan (YTD) £000s	Actual (YTD) £000s	Variance (YTD) £000s
A&E	9,828	9,275	(553)
Day Case	18,484	17,709	(775)
Elective inpatients	12,141	12,531	390
Excluded Drugs & Devices (inc Lucentis)	20,204	22,170	1,966
Non Elective inpatients	64,072	66,215	2,143
Other	83,871	83,330	(541)
Outpatients	33,461	32,254	(1,207)
TOTAL	242,061	243,484	1,423

SLA Income Performance of Trusts main NHS commissioners	Contract Plan (YTD) £000s	Actual (YTD) £000s	Variance (YTD) £000s
BSW ICB	143,497	144,853	1,356
Dorset ICB	24,060	23,953	(107)
Hampshire, Southampton & IOW ICB inc Portsmouth	19,619	19,619	-
Specialist Services	34,907	36,547	1,640
Other	19,978	18,512	(1,466)
TOTAL	242,061	243,484	1,423

	Activity YTD Plan	Actuals	Variance	Activity Last Year Actuals	Variance last year
A&E	64,573	66,430	1,857	62,164	4,266
Day case	21,191	20,237	(954)	18,779	1,458
Elective	3,023	2,980	(43)	2,561	419
Non Elective	26,389	24,421	(1,968)	25,664	(1,243)
Outpatients	232,710	230,851	(1,859)	244,415	(13,564)



Understanding the performance:

The Trust is ahead of the Clinical income plan year to date due to BSW ICB ERF and pay award funding, overperformance within NHS England Specialised services cost and volume high cost drugs and devices which is being offset by the transfer of the Genetics service with an income reduction of £0.6m per month. Dorset ICB income has been adjusted for the agreement on the Sleep service.

A&E activity was lower in February than in January but with more attendances at the A&E department and less at the Walk-in-Centre. Day case activity in February was 79 less cases than in January with more activity undertaken in Trauma and Orthopaedics (23 cases) and General Surgery (18 cases) but less in Gastroenterology (115 cases) . Activity in Elective inpatients was marginally above plan in month by 4 cases and 17 more cases were undertaken than in January mainly within Plastic Surgery and General Surgery. Non Elective activity was lower than in January by 45 cases across medical specialties. Outpatient activity was lower than in January by over 3,500 attendances with less activity across most specialties.

Actions (SMART):

The BSW ICB contract has been signed by both parties.

The NHS England contracts are expected to be signed by 24th March 2023.

Risks and mitigations:

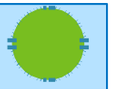
The BSW ERF funding has now been confirmed at £2,150k and is higher than originally planned.

£900k funding has been agreed for 14 South Newton beds.

Discussions are ongoing for the additional 10 beds funding for January to March.

Cash Position & Capital Programme

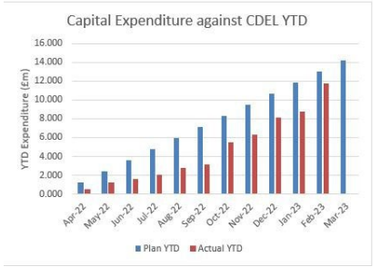
Capital Spend: 

Cash & Working: 

Finance and Use of Resources

	Closing Balance March 2022 £000s	Current Month Balance £000s	Actual In Year Movement £000s
Inventories (Stock)	7,939	8,793	854
Debtors	14,296	22,523	8,227
Cash	33,447	28,173	(5,274)
TOTAL CURRENT ASSETS	**55,682**	**59,489**	**3,807**
Creditors	(46,637)	(54,610)	(7,973)
Borrowings	(1,102)	(639)	463
Provisions	(1,235)	(638)	597
TOTAL CURRENT LIABILITIES	**(48,974)**	**(55,887)**	**(6,913)**
TOTAL WORKING CAPITAL	**6,708**	**3,602**	**(3,106)**

Payables age profile	Total Payables £'000	0-30 days £'000	31-60 days £'000	61-90 days £'000	90+ days £'000
Feb-23	**7,443**	4,654	331	1,064	1,394
Jan-23	**6,700**	4,509	766	198	1,427
Dec-22	**8,474**	6,286	425	439	1,324
Movement vs prev mth	*743*	*145*	*(435)*	*866*	*(33)*



Schemes	Position: Annual Plan £000s	February '23 YTD: Plan £000s	February '23 YTD: Actual £000s	February '23 YTD: Variance £000s
CDEL Schemes				
Building schemes CIR	3,684	3,377	1,534	1,843
Building projects	3,048	2,794	4,399	(1,605)
IM&T	3,828	3,509	2,698	811
Medical Equipment	4,072	2,981	1,728	1,253
Other	425	389	349	40
Total CDEL schemes	**15,057**	**13,050**	**10,708**	**2,342**
National Funding				
TIF - New ward	*2,048*	*720*	*720*	0
Pathology LIMS	*682*	*108*	*108*	0
MRI Acceleration Upgrades	*178*	*209*	*209*	0
Total National Funding	**2,908**	**1,037**	**1,037**	0
GRAND TOTAL	**17,965**	**14,087**	**11,745**	**2,342**

Understanding the performance:

Capital expenditure is significantly behind plan, circa 30% year to date, particularly within Medical Equipment and Building schemes. Forecast expenditure by capital sub group is reviewed each month at the Trust Capital Control Group to ensure full allocations will be spent by the year end. The forecast includes the refurbishment of the Douglas Arter Centre as part of the decant for the additional ward scheme together with further agreed investment in medical equipment and building schemes. TIF funding for the new ward (£14m) has now been formally agreed with £2.048m in 22/23. A further £2.726m of additional funding has been confirmed for nationally funded capital schemes.

The improvement in the cash position, following the receipt of the BSW ICB funding, mitigates any risk to the cash balance for the remainder of the financial year. It is anticipated that the cash balance will reduce markedly by year end due to capital expenditure within the last few months of the year.

Actions (SMART):

£300k BSW capital allocation was confirmed for Digital schemes. A further £300k has now been confirmed for Power Tools.

Proactive bidding for national funding has secured a further £546k Discharge Lounge and £301k Endoscopy funding. A surgical robot is being procured via GWH and has been secured using national funding. The asset will transfer to SFT for use from April 23 onwards.

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

Risks and mitigations:

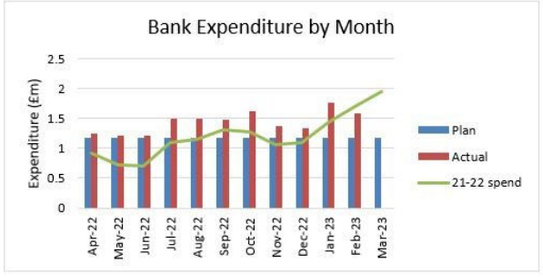
Supply chain disruption and inflationary pressures remain a significant draw of time on the procurement team. This gives rise to a risk in both lead times and overall procurement capacity.

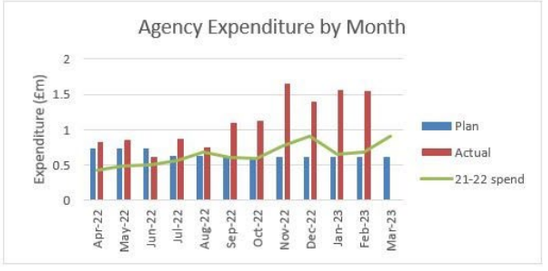
The constraint of both available cash and system capital expenditure limits gives rise to both a mid and long term risk to the Trust. The context of digital modernisation programmes, along with an aging estate and medical equipment means the Trust's five year capital requirement is well in excess of available resources. The Trust seeks to in part mitigate this risk through the proactive bidding for national funds where available.

Workforce and Agency Spend

Pay:

Finance and Use of Resources





	February '23 YTD		
	Plan £000s	Actual £000s	Variance £000s
Pay - In Post	164,304	164,524	221
Pay - Bank	13,090	15,822	2,731
Pay - Agency	7,119	12,256	5,137
Other (eg. Apprenticeship Levy)	1,089	655	(434)
TOTAL	**185,602**	**193,257**	**7,655**
Medical Staff	48,965	50,166	1,201
Nursing	44,070	50,655	6,585
Support to Nursing	13,410	15,788	2,379
Other Clinical Staff	30,427	27,784	(2,643)
Infrastructure staff	47,641	48,209	567
Other (eg. Apprenticeship Levy)	1,089	655	(434)
TOTAL	**185,602**	**193,257**	**7,655**

	February '23		
	Plan WTEs	Actual WTEs	Variance WTEs
Medical Staff	490.6	479.65	(11.0)
Nursing	1,103.6	1,181.21	77.6
Support to Nursing	515.1	594.68	79.6
Other Clinical Staff	689.8	610.54	(79.2)
Infrastructure staff	1,461.1	1,418.49	(42.6)
TOTAL	**4,260.2**	**4,284.6**	**24.4**

Understanding the performance:

Pay costs fell by £368k in month 11, with reductions across all contract types mainly due to bank holiday payments in January and lower Allocation on Arrival payments in month. This remains £592k above the average monthly run rate for the year and continues to be caused by higher patient acuity, with the escalated bed base continuing to drive the demand for temporary staffing at a premium cost. This is compounded by sustained turnover in excess of 14% against a target of 10%. Agency costs have remained at a level 80% higher than the average for the first 6 months of the year.

Pay savings target is £6.5m YTD, against which total achieved pay savings YTD are £3.2m - an adverse variance of £3.3m, with £0.23m recurrent delivery and £2.9m relating to non-recurrent savings from vacancies.

Costs fell across all substantive staff groups in February with the exception of Other Clinical staff groups, which saw a slight increase of £22k. Although substantive vacancy rates fell from 11 to 9%, the rate of unfilled shifts increased from 3% to 5% particularly across AHPs, Scientists and Technical staff and Infrastructure Support.

Actions (SMART):

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

Risks and mitigations:

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

Industrial action in March is expected to adversely impact on costs and disrupt patient pathways.

Data Sources: Narrative and Breakthrough Objectives

Understand the Data

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

Data Sources: Watch Metrics (1)

Understand the Data

Metric Type	Metric Name	Data Source	Executive Lead	Data Quality Rating
Watch	Ambulance Arrivals	Lorenzo via Trust Data Warehouse	Lisa Thomas	High
Watch	Ambulance Handovers 15-<30 mins	SWAST AR119 report	Lisa Thomas	
Watch	Ambulance Handovers 30-<60 mins	SWAST AR119 report	Lisa Thomas	High
Watch	Ambulance Handovers 60+ mins	SWAST AR119 report	Lisa Thomas	
Watch	Average hours lost to Ambulance Handover delays per day	Lorenzo via Trust Data Warehouse	Lisa Thomas	High
Watch	Average Patients with No Criteria to Reside	e-whiteboards via Trust Data Warehouse	Lisa Thomas	
Watch	Cancer 2 Week Wait Breast Breaches	Cancer Services	Lisa Thomas	High
Watch	Cancer 2 Week Wait Breast Den	Cancer Services	Lisa Thomas	High
Watch	Cancer 2 Week Wait Breast Num	Cancer Services	Lisa Thomas	High
Watch	Cancer 2 Week Wait Breast Performance	Cancer Services	Lisa Thomas	High
Watch	Cancer 62 Day Screening Den	Cancer Services	Lisa Thomas	High
Watch	Cancer 62 Day Screening Num	Cancer Services	Lisa Thomas	High
Watch	Cancer 62 Day Screening Performance	Cancer Services	Lisa Thomas	High
Watch	Cancer 62 Days Standard Den	Cancer Services	Lisa Thomas	High
Watch	Cancer 62 Days Standard Num	Cancer Services	Lisa Thomas	High
Watch	DM01 Waiting List Volume	Trust Data Warehouse	Lisa Thomas	High
Watch	ED 12 Hour Breaches (Arrival to Departure)	Lorenzo via Trust Data Warehouse	Lisa Thomas	Medium
Watch	ED Attendances	Lorenzo via Trust Data Warehouse	Lisa Thomas	High
Watch	MSSA Bacteraemia Infections: Hospital Onset	Infection Control Team	Judy Dyos	High
Watch	RTT Incomplete Pathways: Total 104 week waits	Lorenzo via Trust Data Warehouse	Lisa Thomas	High
Watch	RTT Incomplete Pathways: Total 52 week waits	Lorenzo via Trust Data Warehouse	Lisa Thomas	High
Watch	RTT Incomplete Pathways: Total 78 week waits	Lorenzo via Trust Data Warehouse	Lisa Thomas	High
Watch	Stroke & TIA: % Bedside Swallow Assessment within 4 hours	Stroke Team	Peter Collins	High
Watch	Stroke & TIA: % CT'd within 1 hour	Stroke Team	Peter Collins	High

Data Sources: Watch Metrics (2)

Understand the Data

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

Data Sources: Other Metrics (1)

Understand the Data

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

Data Sources: Other Metrics (2)

Understand the Data

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

Data Sources: Other Metrics (3)

Understand the Data

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

Data Sources: Other Metrics (4)

Understand the Data

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

Data Sources: Other Metrics (5)

Understand the Data

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

Data Sources: Other Metrics (6)

Understand the Data

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

NHS Salisbury NHS Foundation Trust

Report to:	Trust Board (Public)	Agenda item:	4.2
Date of meeting:	06 April 2023		

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

Recommendation:

The board is asked to note

1. the progress on delivery of the improving together programme and its impact
2. the key metrics for delivery of the Trusts vision and strategy
3. and the current maturity assessment of key elements continuous improvement

The board are further asked to consider the proposed roadmap for the next 18 months of the programme and further understand the important role board members have in its successful delivery.

Executive Summary:

Improving Together is now entering its second year at SFT. The programme's workstreams are currently on-track and roadmaps for each workstream are in development to take them to September 2024. The Associate Director of Improvement and Associate Director of Strategy are both now in post and the handover from KPMG to these people and their teams is due to be completed by the end of April 2023.

The key focus for the programme over the next 18 months is to increase the scale of training delivery to achieve the desired outcomes listed in Appendix 1. For this to be a success the linkages between Improving Together's budget and the work of the Organisation Development & Leadership (OD&L) and operational management teams are noted in particular.

Currently the four breakthrough objectives are not showing significant improvement. The depth of training and understanding of the approach along with operational pressures and industrial action have been factors in this performance. Interventions designed to initiate a step change in performance across all four of the breakthrough objectives are planned throughout March, April and May.

Awareness of Improving Together and how it is becoming our way of working is presented and shows a high level of awareness amongst survey respondents. The broadening of the awareness survey to include colleagues without regular access to a computer is a key action for next year's survey.

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

Improving Together Quarterly Report to Trust Board

1.1 Purpose

The purpose of this paper is to provide the Trust Board with a summary of the current position and performance of the Improving Together programme so the board can seek understanding and confirmation of the progress to date. It also describes the approach taken to defining the workplan for the next 18 months to achieve the identified programme outcomes by September 2024 (appendix 1).

1 Background

1.1 The Improving Together programme is the how of how we will achieve our strategy. The approach uses data to evidence where we should first focus our resources and energy to achieve our vision in the most effective way.

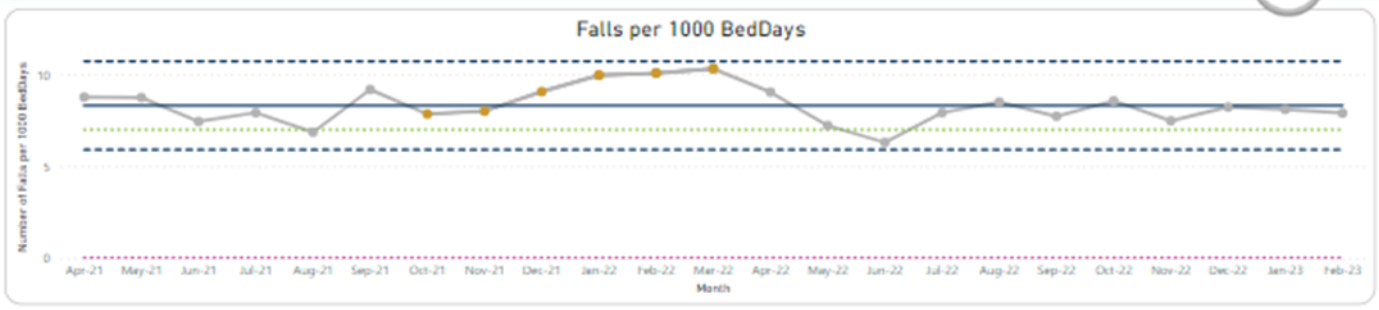
Figure 1: The Vision 'pyramid' showing the agreed vision metrics, strategic initiatives and breakthrough objectives going into 23/24.

The Vision Metrics and Breakthrough Objectives data can now be tracked on a monthly basis via the Improving Together Power BI scorecard: https://bi02sql-p2.salisbury.nhs.uk/Reports/powerbi/Corporate/Improving%20Together%20Scorecard

2 Summary of Breakthrough Objective performance

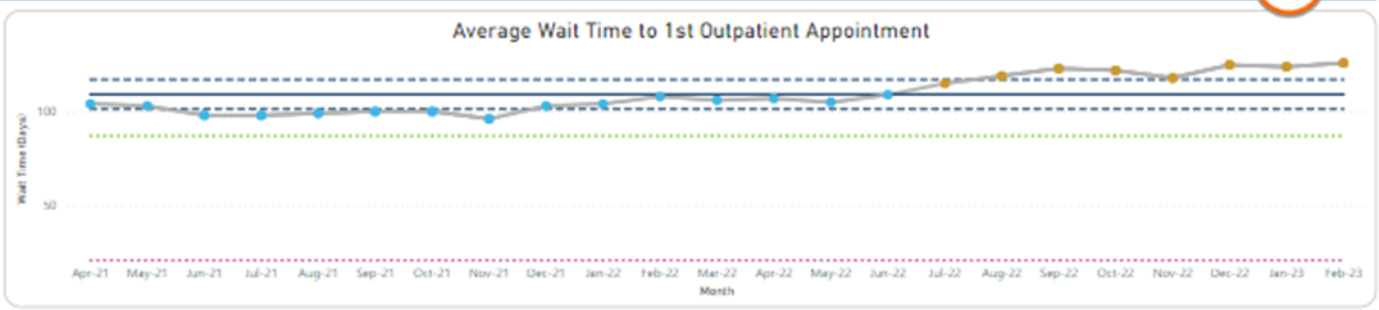
The following Statistical Process Charts (SPCs) provide a trend analysis of the performance in our four breakthrough objectives. The descriptions below each describe the target, current performance, and the next step to delivery of improvements within 12 months. Each breakthrough objective is aiming for a 20-30% improvement over the 12 month period.

Falls per 1000 BedDays



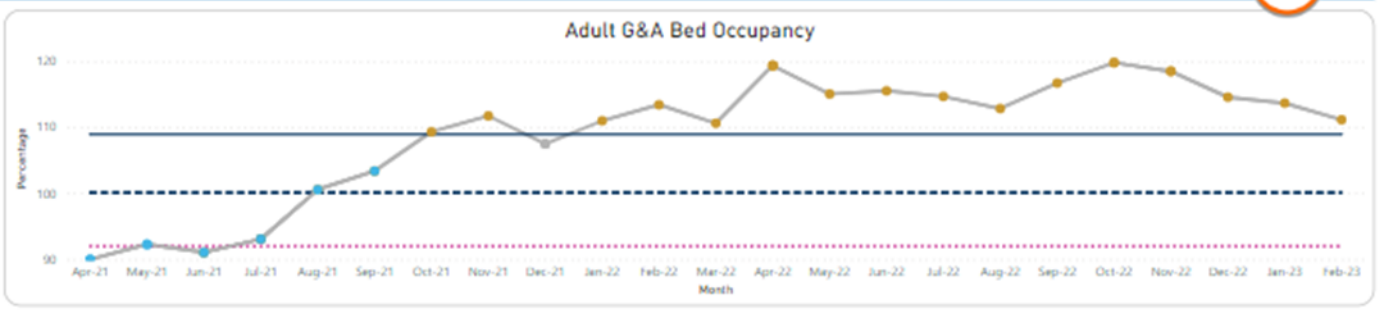
Common cause variation. Target = 7. Performance = 7.9. Action = check veracity of the countermeasures.

Reducing Patient Waiting Times



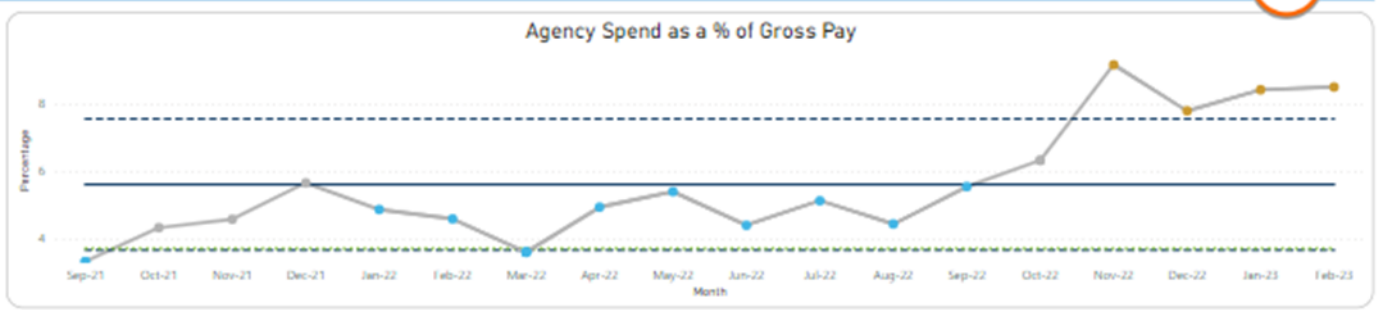
Special cause concern – high and run above the mean. Target = 87 days. Performance = 126 days. Action = Re-focus on top contributors via breakthrough objective workshop.

Bed Occupancy



Run above the mean. Target = 92%. Performance = 111% (11% over core bed stock). Action = Re-focus on top contributors via breakthrough objective workshop.

Staffing Availability



Special cause concern - high. Target = 3.7%. Performance = 8.5%. Action = identify top contributors per division and monitor countermeasure impact via the Executive Performance reviews.

3 Training rollout: Numbers and fill rates

As we move into the second year of rolling out Improving Together the training is now delivered by the internal Coach House team. They provide four levels of training. The number of people trained so far and fill rate for the next course date are summarised below:

Course	Numbers trained to date (people)	Percentage fill rate of next course (25 places a course)
Level 1: Improver Standard	60	April: 80%
Level 2: Improver Advanced	66	April: 84%
Level 3a: Improver Leader	First cohort in April	April: 83%
Level 3b: Improver Enabler	88	June: 0%

The numbers of people trained are below the number targeted at the start of 22/23. This is primarily due to the impact of operational pressures and industrial action on staff being unable to step away from their daily work to attend the training.

The fill rate shows an improving picture against the 22/23 position but continues to present a challenge to full utilisation of our training capacity. Closer working between the divisions, specialities and Coach House teams is focussing on how best to develop and plan the training pipeline. Work is underway to consider how Improver Enabler, aimed at deputy directors and senior managers, is best used going forward.

Improving Together training for the Trust Board is booked on the following dates: 8th June, 10th August and 9th November.

4 Improving Together Impact Report

Using survey data, microsite performance data, and data from events in 2022, this report summarised the impact of the engagement and communications activity of the last 12 months since the official launch in February 2022. The headline findings are outlined below and have informed the development of the 18 month roadmaps to build on the strengths and develop the identified weaknesses in the work to date:

- Engagement levels span the spectrum of knowing enough to easily explain to colleagues (28%), to 44% not understanding at all.
- The survey reveals awareness of Improving Together is on the increase, with **81%** of respondents knowing about it before completing the survey.
- Corporate channels are helping to build knowledge and awareness, particularly Daily Bulletin, CEO SOTW mentions, events, videos and microsite.

- The microsite was visited by **41%** of respondents. Content needs (continuous) updating.
- Small shoots of organic communication (advocacy) starting to appear: ***"Through speaking to colleagues. It's been useful to understand the language used."***
- However, for a few, impressions of elitism and managers/leaders not living the local empowerment ethos:

  "***It's for other, more important, members of staff."***

5 Developing maturity in the use of improving together methodology

The below table shows the current levels of maturity in our use of the various tools within the Improving Together approach. This will be reviewed on a quarterly basis and reported in this report to aid the Board's understanding of the use and spread of Improving Together across the Trust.

Where scores are provided it applies only to those teams and individuals who have completed at least one of the Improving Together training courses. Speciality triumvirates are due to start their training from April 2023.

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

Framework	Tool	Behaviour	Execs	Divisions	Specialty	Frontline
Align	Scorecard	Focus	2	3		2
	Project selection and resource management/ Strategic Filter and SDM		2	1		N/A
Enable	Monthly management system routines (e.g. Performance Review Meeting, Business Rules)	Humility	3	3		1
	Weekly management system routines (e.g. Weekly Drivers, Go & See walks)	Curiosity	2	2		N/A
	Daily management system routines (e.g. Improvement Huddles)	A3 Thinking	N/A	N/A	N/A	2
	Process and Leader Standard Work		2	2		2
	Process Confirmation	Go, See, Listen, Learn	1	1		1
	Structured Conversations		1	2		1
Improve	A3 Problem Solving	A3 Thinking	3	3		3

It is worth noting the strengthening use of A3 problem solving across the trust. This is the 'gateway' to Improving Together's full range of tools and forms a strong foundation on which to build a culture of continuous improvement through 23/24.

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

Using an 18-month timeframe, the Executive and Senior Management Team have identified the desired outcomes from the Improving Together programme. These are listed in Appendix 1.

To achieve these outcomes each of the nine workstreams within the programme have each developed a roadmap – an order of tasks and outputs to build towards achieving the outcomes. These roadmaps confirm we can achieve the identified outcomes within 18 months.

However, the options presented in the roadmaps have cost implications as we seek to align capacity with demand for training, supporting the teams to apply their learning and engaging the wider trust and system with the approach. It is also predicated on the operational management structure business case currently under development.

Work is now underway to confirm the net financial impact of the preferred options for each roadmap. Use of internal secondments for training delivery capacity and possible charitable funding for branding are being considered to minimise the overall cost implications to the Trust.

7 Finance

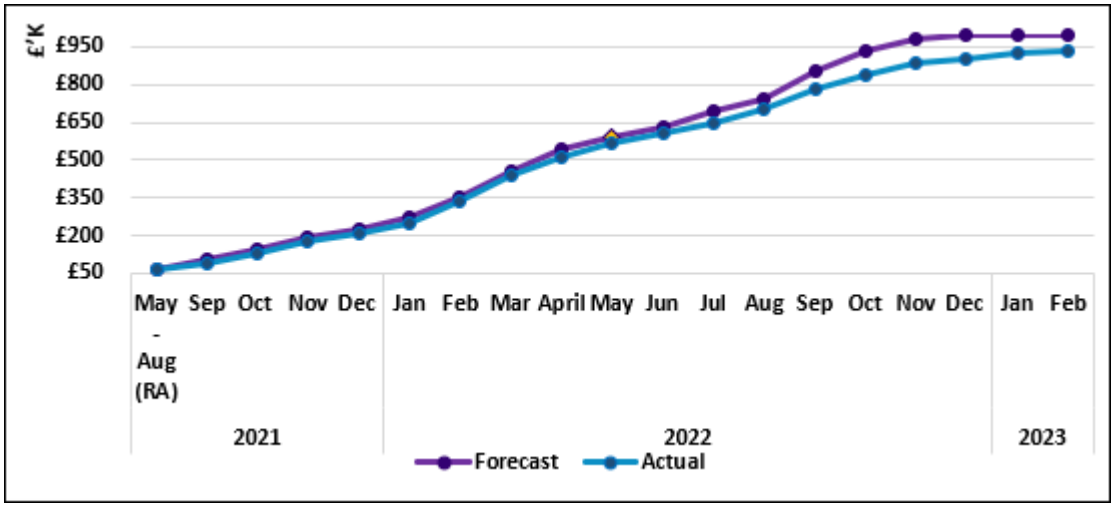
Internal budget and YTD position

The below table sets out the latest position for month 11. However, work is underway to clarify this position against spend in other teams connected to Improving Together, e.g. Organisational Development & Leadership and Communications. It is expected the reported underspend is not as large as shown.

	22/23 Budget	YTD Actual	YTD Budget	YTD Variance
Pay	£ 572,863	£ 333,072	£ 525,250	£ 80,342
Non-pay	£ 100,444	£ 11,683	£ 92,026	£ 192,177
Total	**£ 673,307**	**£ 344,755**	**£ 617,276**	**£ 272,519**

KMPG consultancy budget tracker

The below graph shows the spend against the budget for the consultancy support from KPMG. The underspend is predominantly due to the Board training being moved into 23/24 to enable new Board members to attend.



8 Benefits realisation

The Associate Director of Improvement has identified a deficit in current monitoring of the quantifiable benefits of the programme due to the gap between the Director of Strategy and Improvement leaving and him starting. Work is now underway to prioritise and ensure the monitoring and reporting of benefits from the use of the methodology across the Trust.

July 2023's quarterly update will include a report on benefits realisation and a trajectory for the delivery of benefits in 23/24.

9 Recommendations

The board is asked to note:

1. the progress on delivery of the improving together programme and its impact
2. the key metrics for delivery of the Trusts vision and strategy
3. and the current maturity assessment of key elements continuous improvement

The board are further asked to consider the proposed roadmap for the next 18 months of the programme and further understand the important role board members have in its successful delivery

Alex Talbott
Associate Director of Improvement

Salisbury NHS Foundation Trust

Appendix 1: Overarching desired outcomes by Sept 2024

Strategy Deployment, Annual Planning and Transformation

- The whole Trust lives the strategy
- Staff understand the strategy
- Planning doesn't feel "traditional" or "disruptive" to Trust ops
- Current planning cycle is linked into method and cascaded to teams
- A live program of strategically aligned transformation
- Alignment to ICS / AHA / Place strategy to maximise benefits
- 12 month forward look to align to Annual Plan is clear and well known

Board, Executive and Trust-wide Leadership Behaviours

- Board behaviours and actions align to Improving Together and our Leadership framework
- The behavioural framework is lived by the organisation
- We have a clearly articulated and understood LB
- We have a culture that supports continuous improvement

Operational Management System (OMS) rollout in divisions, specialities and teams

- The I/T methodology is how the divisions deliver their operational business targets
- Corporate functions are included in the management system
- There is a strong training pull from
- Specialty Tris can take their teams through the methodology
- The I/T methodology is how the specialties deliver their operational business
- There is a joint training approach with BSW
- The methodology becomes our way of working – it is 'mainstreamed'

Coach House, Communications & Engagement

- The Coach House are seen as a team of experts
- The Coach House is credible and confident
- People know that the Trust is trying to
- Our population understands the strategy and what we are doing about it
- Our workforce is well informed on Trust operations and strategy
- Advocates actively share the benefits of Improving Together

Report to:	Trust Board	Agenda item:	5.1
Date of meeting:	6 April 2023		

Report tile:	Review of Standing Financial Instructions			
Status:	Information	Discussion	Assurance	Approval
				x
Approval Process: (where has this paper been reviewed and approved):	Audit Committee, March 2023			
Prepared by:	Mark Ellis, Chief Finance Officer			
Executive Sponsor: (presenting)	Mark Ellis, Chief Finance Officer			

Recommendation:

It is requested that the Board approves of the updates to job and organisational titles, and the correction to the placing of contracts delegated limits to those approved by Board in 2019.

Executive Summary:

The Trust's delegated limit require formal review at least every two years, the last such review was undertaken in March 2022. Any changes to the SFIs must be approved by Trust Board on recommendation by the Audit Committee.

A review has been undertaken in March 2023 and no material changes are being recommended. There are three categories of amendments being put forward for consideration and approval:

1. Update of job titles
2. Update of organisational titles
3. Update of section on 'Placing of contracts' to correct omission from changes approved by Trust Board in 2019.

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):	

Purpose

1.1 The purpose of this report is to brief the Committee on the review of the Trust's Standing Financial Instructions, and to recommend amendments as appropriate.

2 Background

2.1 The Trust's Standing Financial Instructions (SFIs) have been in place since 1st December 2017. The SFIs are issued for the regulation of the conduct of the Trust's members and officers in relation to all financial matters with which they are concerned.

2.2 The SFIs should be reviewed for effectiveness and appropriateness on a regular basis, the last such review of the Trust's SFIs was March 2023.

2.3 Where the Board does elect to set delegated limits, the Chief Executive Officer remains ultimately accountable to the Board as Accountable Officer, retaining overall responsibility for the Trust's activities. All delegated powers can be re-assumed by the CEO should the need arise.

3 Cosmetic changes

3.1 Updates have been made to the following job titles:

i. Director of Finance (DOF) has been updated to Chief Finance Officer (CFO)
ii. Director of Nursing has been updated to Chief Nursing Officer
iii. Director of Human Resources has been updated to Chief People Officer
iv. Head of Procurement has been updated to Deputy Director of Procurement

3.2 Updates have been made to the following organisation titles:

i. Department of Health has been updated to Department of Health and Social Care (DoHSC)
ii. NHS England and NHS Improvement have been combined into NHS England & Improvement
iii. NHS Protect has been updated to NHS Counter Fraud Agency

4 Delegated limits correction

4.1 <u>Placing contracts (section 7.3)</u>

The public SFI document did not reflect changes agreed at Trust Board in August 2019, two corrections have been made to the document to reflect this:

i. The Director of Procurement delegated limit is now set to £350k excluding VAT (document previously stated £250k)
ii. Table 3 has been updated to be explicit the delegated limits exclude VAT.

4.2 Extract from Board paper August 2019:

Table###

Contract Value (Excl VAT)	Recommendation Report Requirement	Authorisation to place or sign Contract
<£10,000 (inclusive of zero nominal value)	No	Head of Procurement
£10,000 to <£25,000	Recommendation report required only if contract has not been awarded to the most economically advantages offer	Head of Procurement
£25,000 to <£100,000	Yes	Head of Procurement
£100,000 to <£350,000	Yes	Director of Procurement
£350,000 to <£750,000	Yes	Director of Finance
£750,000 to <£1,500,000	Yes	Finance and Performance Committee (minuted at trust Board)
>£1,500,000	Yes	Trust Board/Chairman

The Director of Finance, Director of Procurement, and Head of Procurement may sign and place contracts on the Trust's behalf, providing a valid Contract Approval Document is signed by the relevant Executive Director or Chairman on behalf of Trust Board. Where appropriate this should include a supporting recommendation report.

The Chief Executive shall nominate officers with delegated authority to enter into contracts of employment, regarding staff, agency staff or temporary staff service contract

4.3 Extract from Board minutes August 2019:

TB1 – 01/08/3.1 Standing Financial Instructions

M Ellis presented the report, asking the Board to approve the proposed amendments to the SFIs, including changes to the delegated limits set out and updated text to accurately reflect the current decision structure of the organisation.

Page **8** of **13**

Classification: Unrestricted

Public Board Minutes – 1 August 2019

Discussion:

- P Kemp reported that the SFIs had been discussed at length at the Audit Committee and had been recommended to the Board for approval.

Decision:

- The Board approved the revised SFIs.

5 Recommendation

There are no material recommended changes to the Trust's SFIs at this time. All amendments are included in the attached SFI document with tracked changes. It is recommended that the following amendments are reflected in the document:

1	Update of job titles	Throughout document
2	Update of organisational titles	Throughout document
3	Correction of table 3 in section 7.3. Table to be amended to state contract values exclude VAT, and Director of Procurement delegated limit is up to £350k.	Section 12.2.1 p.34

Salisbury
NHS Foundation Trust

Standing Financial Instructions

Version:	**Audit Committee March 2023**
Authorisation Committee:	**Trust Board**
Date of Authorisation:	
Signature of authorising Committee:	
Ratification Committee (Category 1 documents):	
Date of Ratification (Category 1 documents):	
Signature of ratifying Committee Group/Chair(Category 1 documents):	
Lead Job Title of originator/author:	**Chief Finance Officer**
Name of responsible committee/individual:	**Mark Ellis**
Date issued:	
Review date:	
Target audience:	**All Directorates**
Key words:	**Trust powers; Trust Board; Chairman; Directors; appointment; meetings; committees; delegation; declarations; interests; contracts; tenders; business conduct; signature; documents; approval. (See also contents to the document.)**
Main areas affected:	**All Directorates**
Consultation:	**Audit Committee** **Executive Directors**
Equality Impact Assessments completed and policy promotes Equity	
Number of pages:	**55**
Type of document:	

Standing Financial Instructions

STANDING FINANCIAL INSTRUCTIONS ("SFIs")

1. INTRODUCTION

1.1 General

1.1.1 Salisbury NHS Foundation Trust ("the Trust") became a Public Benefit Corporation on 1st June 2006, following authorisation by "NHS England & Improvement", the Independent Regulator of NHS Foundation Trusts pursuant to the National Health Service Act 2006 (the "NHS 2006 Act" or "2006 Act").

1.1.2 These Standing Financial Instructions (SFIs) are issued for the regulation of the conduct of its members and officers in relation to all financial matters with which they are concerned. They shall have effect, as if incorporated in the Standing Orders (SOs) of the Foundation Trust's Board of Directors (note that SOs are a statutory requirement for Foundation Trusts (FTs) but SFIs are not termed as such, although an equivalent set of rules is required by NHS England & Improvement, which this document represents).

1.1.3 The Single Oversight Framework details how NHS England & Improvement oversees and supports all NHS Trusts. Additional financial guidance is included in The Audit Code for NHS Foundation Trusts, and the Department of Health Group Accounting Manual (DoHSC GAM), all as updated, replaced or superseded from time to time. Other relevant guidance may also be issued.

1.1.4 These SFIs detail the financial responsibilities, policies and procedures adopted by the Trust. They are designed to ensure that the Trust's financial transactions are carried out in accordance with the law and with Government policy in order to achieve probity, accuracy, economy, efficiency and effectiveness. They should be used in conjunction with the Schedule of Decisions Reserved to the Board and the Scheme of Delegation adopted by the Trust (collectively called the "Scheme of Delegation").

1.1.5 These SFIs identify the financial responsibilities which apply to everyone working for the Foundation Trust. They do not provide detailed procedural advice and should be read in conjunction with the detailed departmental and financial policies and procedures.

1.1.6 Should any difficulties arise regarding the interpretation or application of any of the SFIs, then the advice of the Director of Finance must be sought before acting. The user of these SFIs should also be familiar with and comply with the provisions of the Trust's Standing Orders of the Board of Directors.

1.1.7 Failure to comply with Standing Financial Instructions and Standing Orders of the Board of Directors can in certain circumstances be regarded as a disciplinary matter that could result in an employee's dismissal.

1.1.8 Overriding Standing Financial Instructions – if for any reason these Standing Financial Instructions are not complied with, full details of the non-compliance and any justification for non-compliance and the circumstances around the non-compliance shall be reported to the next meeting of the Audit Committee for referring action or ratification. All members of the Trust Board and staff have a duty to disclose any non-compliance with these SFIs to the Director of Finance, as soon as possible.

1.2 Responsibilities and delegation

Foundation Trust Board of Directors

1.2.1 The Trust Board of Directors exercises financial supervision and control by:

a) Formulating the financial strategy;

b) Requiring the submission and approval of budgets within specified limits;

c) Defining and approving essential features in respect of important procedures and financial systems (including the need to obtain value for money);

d) Defining specific delegated responsibilities placed on members of the Board of Directors and employees as indicated in the "Scheme of Delegation."

1.2.2 The Board of Directors has resolved that certain powers and decisions may only be exercised by the Board in formal session. These are set out in the "'Schedule of Decisions Reserved to the Board" document, which is part of the Scheme of Delegation document. All other powers have been delegated to such executive directors in the Scheme of Delegation or, committees of the Board, as the Trust has established. The Board must approve the terms of reference of all committees reporting directly to the Board.

1.2.3 The Board will delegate responsibility for the performance of its functions in accordance with its Constitution, the SOs and the Scheme of Delegation adopted by the Trust. The extent of delegation shall be kept under review by the Board.

The Chief Executive and Director of Finance (CFO)

1.2.4 The Chief Executive and CFO will delegate their detailed responsibilities as permitted by the Constitution and SOs, but they remain accountable for financial control.

1.2.5 Within the SFIs, it is acknowledged that the Chief Executive is ultimately accountable to the Board, and as Accounting Officer, to the Secretary of State for Health, for ensuring that the Board meets its obligation to perform its functions within the available financial resources. The Chief Executive has overall executive responsibility for the Trust's activities; is responsible to the Chairman and the Board for ensuring that its financial obligations and targets are met and has overall responsibility for the Trust's system of internal control.

1.2.6 It is a duty of the Chief Executive to ensure that Members of the Trust Board and, employees and all new appointees are notified of, and put in a position to understand their responsibilities within these SFIs.

The Chief Finance Officer

1.2.7 The CFO is responsible for:

a) These SFIs and for keeping them appropriate and up to date;

b) Implementing the Trust's financial policies and for coordinating any corrective action necessary to further these policies;

c) Maintaining an effective system of internal financial control including ensuring that detailed financial procedures and systems incorporating the principles of separation of duties and internal checks are prepared, documented and maintained to supplement these instructions;

d) Ensuring that sufficient records are maintained to show and explain the Trust's transactions, in order to disclose, with reasonable accuracy, the financial position of the Trust at any time;

e) Without prejudice to any other functions of the Trust, and employees of the Trust, the duties of the CFO include:

i) Provision of financial advice to other members of the Trust Board and employees;

ii) Design, implementation and supervision of systems of internal financial control;

iii) Preparation and maintenance of such accounts, certificates, estimates, records and reports as the Trust may require for the purpose of carrying out its statutory duties.

Board of Directors and Employees

1.2.8 All members of the Board of Directors and employees, severally and collectively, are responsible for:

a) The security of the property of the Trust;

b) Avoiding loss;

c) Exercising economy and efficiency in the use of resources;

d) Conforming to the requirements of NHS England & Improvement, the Terms of Authorisation, the Constitution, Standing Orders, Standing Financial Instructions and the Scheme of Delegation.

Contractors and their employees

1.2.9 Any contractor or, employee of a contractor who is empowered by the Trust to commit the Trust to expenditure or, who is authorised to obtain income, shall be covered by these instructions. It is the responsibility of the Chief Executive to ensure that such persons are made aware of this.

1.2.10 For any and all directors and employees who carry out a financial function, the form in which financial records are kept and the manner in which directors and employees discharge their duties must be to the satisfaction of the CFO.

Emergency Powers

1.2.11 The powers which the Board has retained to itself within these Standing Orders may in emergency be exercised by the Chief Executive and the Chair after having consulted at least two Non-Executive Directors. The exercise of such powers by the Chief Executive and Chair shall be reported to the next formal meeting of the Board in public or private session (as appropriate) for ratification.

1.2.12 The process on utilising Emergency Powers, detailing required documentation, is set out in Annex 4.

2. AUDIT

2.1 Chief Finance Officer

2.1.1 The CFO is responsible for:

a) Ensuring there are arrangements to review, evaluate and report on the effectiveness of internal financial control, including the establishment of an effective internal audit function. An internal audit function is required by NHS England & Improvement's "NHS Foundation Trust Accounting
Officer Memorandum" (August 2015);

b) Ensuring that the Internal Audit service to the Trust is adequate and meets NHS England & Improvement's mandatory internal audit standards;

c) Deciding at what stage to involve the police in cases of misappropriation of assets and any other irregularities (subject to the provisions of SFI 2.4 in relation to fraud and corruption);

d) Ensuring that an annual internal audit report is prepared (with interim progress reports) for the consideration of the Audit Committee. The report(s) must cover:

i) A clear opinion on the effectiveness of internal control in accordance with current assurance framework guidance issued by the DoHSC, including for example compliance with control criteria and standards. This opinion provides assurances to the Accounting Officer, especially when preparing the "Annual Governance Statement" and also provides assurances to the Audit Committee;

ii) Any major internal financial control weaknesses discovered;

iii) Progress on the implementation of internal audit recommendations;

iv) Progress against plan over the previous year;

v) A detailed work-plan for the coming year.

2.1.2 The CFO and designated auditors are entitled without necessarily giving prior notice to require and receive:

a) Access to all records, documents and correspondence relating to any financial or other relevant transactions, including documents of a confidential nature;

b) Access during normal working hours to any land, premises or members of the Board or employee of the Trust;

c) The production of any cash, stores or other property of the Trust under a member of the Board and an employee's control; and

d) Explanations concerning any matter under investigation.

2.2 Role of Internal Audit

2.2.1 Internal Audit provides an independent and objective opinion to the Chief Executive, the Audit Committee and the Board on the degree to which risk management, control and governance support the achievement of the Trust's agreed objectives.

2.2.2 Internal Audit will review, appraise and report upon:

a) The extent of compliance with, and the financial effect of, relevant established policies, plans and procedures;

b) The adequacy and application of financial and other related management controls;

c) The suitability of financial and other related management data including internal and external reporting and accountability processes;

d) The efficient and effective use of resources;

e) The extent to which the Trust's assets and interests are accounted for and safeguarded from loss of any kind, arising from:

i) Fraud and other offences (responsibility for investigation of any suspected or alleged fraud is held by the Local Counter Fraud Specialist)

ii) Waste, extravagance, inefficient administration;

iii) Poor value for money or other causes;

iv) Any form of risk, especially business and financial risk but not exclusively so.

f) The adequacy of follow-up actions by the Trust to internal audit reports;

g) Any investigations / project work agreed with and under terms of reference laid down by the CFO;

h) The Trust's "Assurance Framework Statements" in accordance with guidance from the DoHSC;

i) The Trust's compliance with the Care Quality Commission Essential Standards of Quality and Safety.

2.2.3 Whenever any matter arises (in the course of work undertaken by internal audit) which involves, or is thought to involve, irregularities concerning cash, stores, or other property or any suspected irregularity in the exercise of any function of a pecuniary nature, the CFO must be notified immediately and, in the case of alleged or suspected fraud, the Local Counter Fraud Service (LCFS) must be notified.

2.2.4 The Head of Internal Audit or equivalent title, will normally attend Audit Committee meetings and has a right of access to Audit Committee members, the Chairman and Chief Executive.

2.2.5 The reporting system for internal audit shall be agreed between the CFO, the Audit Committee and the Head of Internal Audit. The agreement shall be in writing and shall comply with the guidance on reporting contained in the "Audit Code," the "DoHSC Group Accounting Manual" and the "NHS FT Accounting Officer memorandum."

2.3 External Audit

2.3.1 The External Auditor is appointed by the Council of Governors with advice from the Audit Committee.

2.3.2 The Audit Committee must ensure a cost-effective service is provided and agree audit work-plans, except statutory requirements.

2.3.3 The External Auditor must ensure that this service fulfils the functions and audit access and information requirements, as specified in Schedule 10 of the NHS Act 2006.

2.3.4 The Trust shall comply with the Audit Code and shall require the External Auditor to comply with the Audit Code.

2.3.5 If there are any problems relating to the service provided by the External Auditor this should be resolved in accordance with the Audit Code.

2.3.6 Prior approval must be sought from the Audit Committee (the Council of Governors may also be notified) for each discrete piece of additional external audit work (i.e., work over and above the audit plan, approved at the start of the year) awarded to the external auditors. Competitive tendering is not required and the CFO is required to authorise expenditure.

2.3.7 The External Auditor shall be routinely invited to attend and report to meetings of the Audit Committee, and shall be entitled to meet the Audit Committee in the absence of Trust employees, if they so desire.

2.4 Fraud, Corruption and Bribery

2.4.1 In line with their responsibilities, the Chief Executive and CFO shall monitor and ensure compliance with the NHS Standard contract Service Condition 24 to put in place and maintain appropriate anti-fraud, bribery and corruption arrangements, having regard to NHS Counter Fraud Agency's standards.

2.4.2 The CFO is the executive board member responsible for countering fraud, bribery and corruption in the Trust.

2.4.3 The Trust shall nominate a professionally accredited Local Counter Fraud Specialist ("LCFS"), to conduct the full range of anti-fraud, bribery and corruption work on behalf of the trust as specified in the NHS Counter Fraud Agency anti- crime Standards.

2.4.4 The LCFS shall report to the CFO and shall work with staff in NHS Counter Fraud Agency, in accordance with the NHS Counter Fraud Agency anti-crime Standards, the anti-fraud manual and NHS Counter Fraud Agency's Investigation Case File Toolkit.

2.4.5 If it is considered that evidence of offences exists and that a prosecution is desirable, the LCFS will consult with the CFO to obtain the necessary authority and agree the appropriate route for pursuing any action e.g. referral to the police or NHS Counter Fraud Agency.

2.4.6 The Local Counter Fraud Specialist will provide a written report, at least annually, on anti-fraud, bribery and corruption work within the Trust to the Audit Committee.

2.4.7 The LCFS will ensure that measures to mitigate identified risks are included in an organisational work plan which ensures that an appropriate level of resource is available to the level of any risks identified. Work will be monitored by the CFO and outcomes fed back to the Audit Committee.

2.4.8 In accordance with the Freedom to Speak Up (Raising Concerns Policy), the Trust shall have a whistle-blowing mechanism to report any suspected or actual fraud, bribery or corruption matters and internally publicise this, together with the national fraud and corruption reporting line provided by NHS Counter Fraud Agency .

2.4.9 The Trust will report annually on how it has met the standards set by NHS Counter Fraud Agency in relation to anti-fraud, bribery and corruption work and the CFO shall sign-off the annual self-review and authorise its submission to NHS Counter Fraud Agency. The CFO shall sign-off the annual qualitative assessment (in years when this assessment is required) and submit it to the relevant authority.

2.5 Security Management

2.5.1 In line with their responsibilities, the Chief Executive will monitor and ensure compliance with the NHS Standard Service Condition 24 to put in place and maintain appropriate security management arrangements, having regards to NHS England's standards.

2.5.2 The Trust shall nominate a suitable person to carry out the duties of the Local Security Management Specialist ("LSMS") as specified in the NHS England Violence Prevention and Reduction Standard.

2.5.3 The Trust shall nominate a Non-Executive Director to be responsible to the Board for NHS security management

2.5.4 The Chief Executive has overall responsibility for controlling and coordinating security. However, key tasks are delegated to the Security Management Director (SMD). who is the Chief Operating Officer and also to the appointed LSMS.

3. BUSINESS PLANNING, BUDGETS, BUDGETARY CONTROL, AND MONITORING

3.1 Preparation and Approval of the Trust Business Plan and Budgets

3.1.1 In accordance with the annual planning cycle, the Chief Executive will compile and submit to the Trust Board of Directors and to the Council of Governors the annual "Trust Business Plan" which takes into account financial targets and forecast limits of available resources. The Trust Business Plan will contain:

a) A statement of the significant assumptions on which the plan is based;

b) Details of major changes in patient care activity, delivery of services or resources required to achieve the plan;

c) The Financial Plan for the year;

d) Such other contents as may be determined by NHS England & Improvement (NHSE&I).

3.1.2 The annual plan must be approved by the Trust Board and submitted to NHSE&I in accordance with their requirements.

3.1.3 All executive directors, directorate management teams and corporate service managers shall be responsible for contributing to the integrated planning process, which shall incorporate plans for workforce, service delivery and quality, service capacity and activity, and efficiency planning.

3.1.4 The CFO will, on behalf of the Chief Executive, prepare and submit an annual budget for approval by the Trust Board of Directors. Such a budget will:

a) Be in accordance with the aims and objectives set out in the Trust Business Plan;

b) Accord with patient care activity and manpower plans;

c) Be produced following discussion with appropriate budget holders;

d) Be prepared within the limits of available funds;

e) Identify potential risks and mitigating actions;

f) Be based on reasonable and realistic assumptions; and

g) Enable the Trust to comply with the whole regulatory framework for Foundation Trusts.

3.1.5 The Trust Business Plan, which will include the annual budget, will be submitted to the Council of Governors in a general meeting.

3.1.6 The CFO shall monitor financial performance against budget, and report to the Finance and Performance Committee and Trust Board of Directors.

3.1.7 All budget holders must provide information as required by the CFO to enable budgets to be compiled.

3.1.8 Planned 'in year' businesses cases will be identified as much as is reasonably possible via the annual planning process. Only approved business cases will be included in the Annual Plan and budget setting. An adjustment to forecast will be made in year for those that are subsequently approved. Table 1 sets outs the delegated limits for the approval of business cases:

'In year' revenue value	Authorisation to approve
<£25k	Division Management Team
£25k to <£250k	Trust Management Committee Chief Executive
£250k to <£750k	Finance and Performance Committee
>£750k	Trust Board

Table 1

3.1.9 The CFO has a responsibility to ensure that adequate training is delivered on an on-going basis to budget holders to help them manage their budgets successfully.

3.2 Budgetary Delegation

3.2.1 The Chief Executive, through the CFO, may delegate the management of a budget to permit the performance of a defined range of activities. This delegation must be in writing and be accompanied by a clear definition of:

a) The amount of the budget;

b) The purpose(s) of each budget heading;

c) Individual and group responsibilities;

e) Achievement of planned levels of service;

f) Authority to exercise virements.

g) The provision of regular reports.

3.2.2 Except where otherwise approved by the Chief Executive, taking account of advice from the CFO, budgets shall only be used for the purpose for which they were provided.

3.2.3 Any budgeted funds not required for their designated purpose(s) revert to the immediate control of the CFO, subject to guidance on budgetary control in the Trust.

3.2.4 Non-recurring budgets shall be agreed by the Chief Executive or the CFO and should not be used to finance recurring expenditure without their authority in writing.

3.2.5 The Chief Executive and delegated budget holders must not exceed the budgetary total or virement limits set by the Board of Directors.

3.2.6 Clinical Directors or Service Leads, who are responsible for 'trading activities' must ensure the integrity and supply of information to other users. Price increases in such departments should be monitored by the CFO to ensure overall efficiency and value for money is maintained.

3.3 Budgetary Control and Reporting

3.3.1 The CFO will devise and maintain systems of budgetary control. These will include:

a) Monthly financial reports to the Finance & Performance Committee and Trust Board of Directors in a form approved by the Trust Board of Directors containing sufficient information to allow the Finance & Performance and the Trust Board of Directors to ascertain the financial performance of the Trust. This may include the following:
   i) Income and expenditure to date, showing trends and the forecast year-end position;
   ii) Workforce spend and WTEs;
   iii) NHS commissioner's contractual performance to date;
   iv) Movements in working capital (including cash);
   v) Capital project spend and projected outturn against plan;
   vi) Explanations of any material variances from budget;
   vii) Details of any corrective action where necessary and the Chief Executive's and/or CFO's view of whether such actions are sufficient to correct the situation;

b) The issue of timely, accurate and comprehensible advice and financial reports to each budget holder, covering the areas for which they are responsible;

c) Investigation and reporting of variances from financial, workload and manpower budgets;

d) Monitoring of management action to correct variances; and

e) Arrangements for the authorisation of budget transfers and virements.

3.3.2 No budget-holder is authorised to overspend their budget. Where overspending is occurring, the budget-holder must account to their Directorate Management Team or line manager for the overspending and identify the means of addressing it. It is accepted that a budget may be exceeded for a short period in the year due to the phasing of expenditure.

3.3.3 Each Budget Holder is responsible for ensuring that no permanent employees are appointed without the approval of the Trust's Vacancy Control Panel, other than medical and nursing staff provided for within the budgeted workforce establishment.

3.3.4 The Chief Executive will delegate to budget holders responsibility for identifying and implementing cost improvement programmes ("CIPs") and income generation initiatives in order to deliver a budget that will enable compliance with NHS England & Improvement's Single Oversight Framework, finance and use of resources metrics.

3.4 Capital Expenditure

3.4.1 General rules applying to delegation and reporting shall also apply to capital expenditure. Accounting for fixed assets must comply with the NHS Foundation Trust Annual Reporting Manual. The specific instructions relating to capital are contained in section 12 of these SFIs.

3.5 Performance Monitoring Forms and Returns

3.5.1 The CFO on behalf of the Chief Executive, will ensure that the appropriate monitoring forms and returns are submitted to NHSE&I in accordance with the national annual timetable. The performance figures to the Trust Board of Directors should reflect the same figures, though not necessarily presented in the same format.

4. ANNUAL REPORT AND ACCOUNTS AND QUALITY REPORT

4.1 The CFO, on behalf of the Trust, will:

a) Prepare annual financial accounts and corresponding financial returns in such form as NHS England & Improvement and HM Treasury prescribe;

b) Ensure these annual accounts and financial returns comply with current guidelines and directions given by NHS England & Improvement as to their technical accounting content and information/data shown therein, before submission to NHS England & Improvement.

4.2 The Chief Executive will prepare the Annual Report in accordance with the guidance in the DoHSC Group Accounting Manual.

4.3 The Director of Nursing will prepare the Annual Quality Report in the format prescribed by NHS England & Improvement /Care Quality Commission and in accordance with the DoHSC Group Accounting Manual. The Quality Report presents a balanced picture of the Foundation Trust's performance over the financial year and up to the agreed submission date.

4.4 The Trust's Annual Report, Annual Accounts and financial returns to NHS England & Improvement and Annual Quality Report must be audited by the external auditor in accordance with appropriate international auditing standard, where relevant.

4.5 The Annual Report, Accounts and Quality Report (including the auditor's report), shall be approved by the Board of Directors after review by the Audit Committee. The Clinical Governance Committee will also review the Quality Report prior to its submission to the Audit Committee.

4.6 The Annual Report, Accounts and Quality Report (including the auditor's report) is submitted to NHS England & Improvement (in accordance with its timetable) by the CFO and put forward to be laid before Parliament in accordance with the prescribed timetable.

4.7 The Annual Report and Accounts (including the auditor's report) must be published and presented to a general meeting of the Council of Governors by 30th September each year and made available to the public for public inspection at the Trust's headquarters and made available on the Trust's website. Any summary financial statements published are in addition to, and not instead of, the full annual accounts.

4.8 The Chief Executive, Chairman and CFO, as appropriate, will sign the various documentation relating to the Annual Report, Annual Accounts and financial returns to NHS England & Improvement and Annual Quality Report on behalf of the Trust Board.

4.9 Where a subsidiary is owned or partially owned by the Trust in a manner to require consolidation under the requirements of IFRS then the annual accounts of the subsidiary will be completed as a part of undertaking the consolidated accounts for the Trust. Should the Trust be involved with an Associate Company the results will be reported in line with recognised accounting requirements.

5. GOVERNMENT BANKING SERVICE BANK ACCOUNTS

5.1 General

5.1.1 The CFO is responsible for managing the Trust's banking arrangements and for advising the Trust on the provision of banking services and operation of accounts.

5.1.2 The CFO will review the banking needs of the Trust at regular intervals to ensure they reflect current business patterns and represent value for money.

5.1.3 The Trust Board will approve recommendations regarding the opening of any bank account in the name of the Trust.

5.2 Government Banking Service ("GBS") Bank Accounts

5.2.1 In line with public sector practice, the Trust's principal bankers are those commercial banks working in partnership with the GBS, referred to in 5.2.2(a) below. However, these SFIs will apply to any other accounts opened in the name of the Trust or its subsidiaries from time to time.

5.2.2 The CFO is responsible for:

a) GBS bank accounts and any non GBS bank accounts held for banking and merchant services.

b) Establishing separate bank accounts for the Trust's non-exchequer funds as appropriate;

c) Ensuring payments made from bank/GBS/RBS accounts do not exceed the amount credited to the account except where arrangements have been made, or there is a right of set-off with another account held with that bank;

d) Reporting to the Board of Directors any arrangements made with the Trust's bankers for accounts to be overdrawn;

f) Monitoring compliance with NHS England & Improvement or DoHSC guidance on the level of cleared funds;

g) Ensuring covenants attached to bank borrowings are adhered to.

5.3 Banking Procedures

5.3.1 The CFO will prepare detailed instructions on the operation of bank accounts which must include:

a) The conditions under which each bank account is to be operated, including the overdraft limit, if applicable;

b) Those members of staff with mandated authority to carry out transactions (by signing transfer authorities or cheques or other orders) in accordance with the authorisation framework of these GBS bank accounts.

5.3.2 The CFO must advise the Trust's bankers in writing of the conditions under which each account will be operated.

5.4 Tendering and Review (applicable to any non-GBS bank accounts only)

5.4.1 The CFO will review the commercial banking arrangements of the Trust at regular intervals to ensure they reflect best practice and value for money.

6. INCOME, FEES AND CHARGES AND SECURITY OF CASH, CHEQUES AND OTHER NEGOTIABLE INSTRUMENTS

6.1 Income Systems

6.1.1 The CFO is responsible for designing, maintaining and ensuring compliance with systems for the proper recording, invoicing, collection and coding of all monies due.

6.1.2 The CFO is also responsible for the prompt banking of all monies received.

6.2 Fees and Charges (including for private use of Trust assets)

6.2.1 The Trust shall follow the "Payment by Results" ("PbR") financial regime determined by the DoHSC where applicable.

6.2.2. The CFO is responsible for approving and regularly reviewing the level of all fees and charges other than those determined by the Department of Health or by Statute. Responsibility for arranging the level of property rentals, and for reviewing rental and other charges regularly shall rest upon the Director of Finance who shall take into account independent professional advice on matters of valuation. The Director of Finance shall be consulted about the pricing of goods and services offered for sale.

6.2.3 All Employees must inform the CFO promptly of money due arising from transactions which they initiate/deal with, including all contracts, leases, tenancy agreements, private patient undertakings and other transactions.

6.2.4 Contracts must conform to the strategy and business plans of the Trust and shall be approved according to the limits specified at SFI Annex 3.

6.2.5 Any employee wishing to use Trust assets for private use must comply with the Trust's policies, including those on use of the telephone and the loan of equipment.

6.3 Debt Recovery

6.3.1 The CFO is responsible for the appropriate recovery action on all outstanding debts.

6.3.2 Income and salary overpayments not received, after all attempts at recovery have failed should be written off in accordance with the following approvals limits;

6.3.3 The following VAT exclusive limits shall be applied to debt write offs:

Monetary Value	**Approval**
Up to £10,000	Financial Controller
£10,001 to £100,000	CFO
£100,000 plus	Audit Committee

The limits apply to individual items. A schedule of written off debt shall be presented to the Audit Committee at least annually. A schedule of debts written off in excess of £100,000 and approved by the Audit Committee should be presented to the Trust board for information.

6.4 Security of Cash, Cheques and other Negotiable Instruments

6.4.1 The CFO is responsible for:

a) Approving the form of all receipt books, agreement forms, or other means of officially acknowledging or recording monies received or receivable;

b) Ordering and securely controlling any such stationery;

c) The provision of adequate facilities and systems for employees whose duties include collecting and holding cash, including the provision of safes or lockable cash boxes, the procedures for keys, and for coin operated machines;

d) Prescribing systems and procedures for handling cash and negotiable securities on behalf of the Trust.

6.4.2 All unused cheques and other orders shall be subject to the same security precautions as are applied to cash. The Director of Finance shall be responsible for the arrangements for security and issue of bulk stocks of cheques.

6.4.3 Trust monies shall not, under any circumstances, be used for the encashment of private cheques or loans or IOUs.

6.4.4 All cheques, postal orders, cash etc. shall be banked intact. Disbursements shall not be made from cash received, before banking, except under arrangements approved by the CFO.

6.4.5 The holders of safe keys shall not accept unofficial funds for depositing in their safes, unless such deposits are in special sealed envelopes or locked containers. It shall be made clear to the depositors that the Trust shall not be liable for any loss, and written and signed “declarations of indemnity” must be obtained from the organisation or individuals fully absolving the Trust from responsibility for any loss.

6.4.6 Any loss or shortfall of cash, cheques, or other negotiable instruments, however occasioned, shall be reported immediately in accordance with the agreed procedure for reporting losses. (See Section 14 Disposals and Condemnations, Losses and Special Payments).

7. TENDERING & CONTRACTING PROCEDURES

7.1 Duty to comply with Standing Financial Instructions

The procedure for making all contracts on behalf of the Trust shall comply with these Standing Financial Instructions and Standing Orders

7.2 Thresholds Tender Guide/Placing Contracts/Waivers

The following tables outline the correct procurement process to be followed relative to value and the type of product or service being purchased.

Where goods, services, disposals and/or capital works are to be supplied over a period of time, the values listed must be taken as the value of the contract and include the whole life costs, not the annual value and should not seek to circumvent public sector procurement regulations.

For the purpose of these SFI's the definition of a Contract is a voluntary, deliberate, and legally binding agreement between two or more competent parties. Contracts are usually written but may be spoken or implied, and generally have to do with employment, sale or lease, or tenancy.

A contractual relationship is evidenced by (1) an offer, (2) acceptance of the offer, and a (3) valid (legal and valuable) consideration. Each party to a contract acquires rights and duties relative to the rights and duties of the other parties. However, while all parties may expect a fair benefit from the contract (otherwise courts may set it aside as inequitable) it does not follow that each party will benefit to an equal extent.

Table 2

Contract Value (Excl VAT)	**Quotations/Tenders**	**Min number invited to Quote/Tender where available**	**Form of Contract**
<£10,000	Single Quotation may be obtained by end user	1	Purchase Order
£10,000 - £24,999	Quotation Authorisation required from Procurement prior to obtaining quotes	2	Purchase Order
£25,000- £75,000	Quotation To be obtained by Procurement with appropriate advertising and market engagement	3	Contract and Purchase Order
£75,001 - Public Contract Regulations threshold	Tender by Procurement	4	Contract as specified in Tender and Purchase Order
> Public Contract Regulations threshold	Tender by Procurement	4	Contract as specified in Tender and Purchase Order

Where the opportunity has been advertised the Trust may shortlist suppliers, via a transparent supplier selection process, to take forward to the next stage

of the procurement process.

Threshold limits represent the contract's lifetime value (e.g. a 5 year contract of £25,000 per year requires £125,000 method and authorisation).

The cumulative amount spent with the supplier over a rolling 12 month period (e.g. 5 separate spends of £5k each will trigger the appropriate procurement process in line with the values above)

In circumstances after market engagement has been conducted, where the specified number of quotations/tenders cannot be obtained (e.g. where there is a limited number of suppliers), the reasons for receiving a lower number of quotations/tenders must be recorded in the recommendation report and in this event a waiver/ STA will not be required.

7.3 Placing Contracts

Authorisation to sign a Contract and recommendation report requirements are detailed in Table 3 below.

Under no circumstances should any member of the Trust sign and authorise a Contract from a supplier unless they are permitted under SFI's to do so as detailed in the Table 3.

Table 3

Contract Value (Excluding VAT)	Recommendation Report Requirement	Authorisation To Place or sign Contract
<£10,000 (Inclusive of zero nominal value)	No	Deputy Director of Procurement
£10,000 < £25,000	Recommendation report required only if contract has not be awarded to the most economically advantageous offer	Deputy Director of Procurement
£25,000 < £100,000	Yes	Deputy Director of Procurement
£100,000 < £350,000	Yes	Director of Procurement
£350,000 < £750,000	Yes	Chief Finance Officer
£750,000 < £1,500,000	Yes	Finance Committee
>£1,500,000	Yes	Trust Board/Chairman

The Director of Finance, Director of Procurement, Head of Procurement and Chief Pharmacist may sign and place contracts on the Trust's behalf, providing a valid Contract Approval Document is signed by the relevant Executive Director or Chairman on behalf of Trust Board. Where appropriate this should include a supporting recommendation report.

The Chief Executive shall nominate officers with delegated authority to enter into contracts of employment, regarding staff, agency staff or temporary staff service contract

7.4 Electronic Tendering

All invitations to tender should be on a formal competitive basis applying the principles set out below using the Trust E-Tendering Portal.

All tendering carried out through e-tendering will be compliant with the Trust policies and procedures as set out in SFIs 7.2 – 7.12 Issue of all tender documentation should be undertaken by the Procurement Department electronically through a secure website with controlled access using secure login, authentication and viewing rules.

All tenders will be received into a secure electronic vault so that they cannot be accessed until an agreed opening time. Where the electronic tendering package is used the details of the persons opening the documents will be recorded in the audit trail together with the date and time of the document opening. All actions and communication by both procurement staff and suppliers are recorded within the system audit reports.

7.5 Manual Tendering – General Exception Rules

No tenders should be conducted manually unless there is a clear valid exception that is signed off by the Director of Procurement. All invitations to tender on a formal competitive basis shall state that no tender will be considered for acceptance unless submitted in either:

a) A plain, sealed package bearing a pre-printed label supplied by the Trust (or bearing the word `Tender' followed by the subject to which it relates and the latest date and time for the receipt of such tender);

Or

b) In a special envelope supplied by the Trust to prospective tenderers and the tender envelopes/packages shall not bear any names or marks indicating the sender.

Every tender for goods, materials or manufactured articles supplied as part of a works contract and services shall embody such of the main contract conditions as may be appropriate in accordance with the contract forms described in Section 7.5.

Where appropriate tenders for building and works, shall embody or be in the terms of the current edition of the appropriate Joint Contracts Tribunal (JCT) or NEC 3 form of contract amended to comply with Concode. When the content of the works is primarily engineering, tenders shall embody or be in the terms of the General Conditions of Contract recommended by the Institutions of Mechanical Engineers and the Association of Consulting Engineers (Form A) or, in the case of civil engineering work, the General Conditions of Contract recommended by the Institution of Civil Engineers.

Every tender for goods, materials, services (including consultancy services) or disposals shall embody the NHS Standard Contract Terms and Conditions as are applicable. Every supplier must have given a written undertaking not to engage in collusive tendering or other restrictive practice.

7.6 Receipt, Safe Custody and Record of Formal Tenders submitted manually

All tenders on the approved form shall be addressed to the appropriate officer according to the appropriate limits specified in SFI 7.2.

The date and time of receipt of each tender shall be endorsed on the unopened tender envelope/package.

The appropriate officer shall designate an officer or officers, not from the

originating department, to receive tenders on his/her behalf and to be responsible for their endorsement and safe custody until the time appointed for their opening, and for the records maintained in accordance with SFI 7.7.

7.7 Opening Formal Tenders

As soon as practicable after the date and time stated as being the latest time for the receipt of tenders they shall be opened either electronically or if manually by two officers designated by the officer as appropriate.

Every tender received shall be stamped with the date of opening and if manually opened they shall be initialed by two of those present at the opening.

A permanent record shall be maintained to show for each set of competitive tender invitations dispatched:

a) The names of firms/individuals invited;

b) The names of and the number of firms/individuals from which tenders have been received;

c) The total price(s) tendered;

d) Closing date and time;

e) Date and time of opening; and

f) The persons present at the opening shall sign the record, where a manual process has been conducted.

Except as in the paragraph below, a record shall be maintained of all price alterations on tenders, i.e. where a price has been altered, and the final price shown shall be recorded. Every price alteration appearing on a tender and the record should be logged and where a manual process has been conducted it should be initialed by two of those present at the opening.

A report shall be made in the record if, on any one tender, price alterations are considered so numerous as to render the procedure set out in the paragraph above unreasonable.

7.8 Admissibility and Acceptance of Formal Tenders (Electronically & Manually)

In considering which tender to accept, if any, the designated officers shall have regard to whether value for money will be obtained by the Trust and whether the number of tenders received provides adequate competition. In cases of doubt they shall consult the Director of Finance, Director of Procurement or nominated officer. All decisions should be recorded in line with the procurement process.

Tenders received after the due time and date may be considered only if the Director of Finance or Director of Procurement or nominated officer decides that there are exceptional circumstances, e.g. where significant financial, technical or delivery advantages would accrue, and is satisfied that there is no reason to doubt the bona fides of the tenders concerned. The Director of Finance, or nominated officer, shall decide whether such tenders are admissible and whether re-tendering is desirable. Re- tendering may be limited to those tenders reasonably in the field of consideration in the original competition. If the tender is accepted the late arrival of the tender should be reported to the Board at its next meeting. All decisions in relation to tenders received after the due time and date should be recorded in the procurement log.

Technically late tenders (i.e. those despatched in good time but delayed through no fault of the supplier) may at the discretion of the Director of Finance or nominated officer be regarded as having arrived in due time. A record supporting this decision should be recorded in the procurement log.

Materially incomplete tenders (i.e. those from which information necessary for the adjudication of the tender is missing) and amended tenders (i.e. those amended by the supplier upon his own initiative either orally or in writing after the due time for receipt) should be dealt with in the same way as late tenders under SFI 7.8.

Where examination of tenders reveals a need for clarification, the supplier is to be given details of such clarifications and afforded the opportunity of confirming or withdrawing his offer.

Necessary discussions with a supplier of the contents of their tender, in order to elucidate technical points etc., before the award of a contract, will not disqualify the tender.

While decisions as to the admissibility of late, incomplete, or amended tenders are under consideration and while re-tenders are being obtained, the tender documents shall remain strictly confidential and kept in safekeeping by an officer designated by the Director of Finance.

Where only one tender/quotation is received the Director of Procurement /nominated officer (within delegated limits) shall, as far as practicable, ensure that the price to be paid is fair and reasonable.

All tenders shall be evaluated on the basis of MEAT (Most Economically Advantageous Tender) and in conjunction with published Award Criteria and Weightings.

Where the form of contract includes a fluctuation clause all applications for price variations must be submitted in writing by the tenderer and shall be approved by the Chief Executive or nominated officer (within 7.10 below).

All tenders should be treated as confidential and should be retained for inspection.

7.9 Extensions to Contract

In all cases where optional extensions to contract are outlined at the time of tendering, the authority to approve contract extensions is given to the Director of Procurement up to the value of the original contract (including formally agreed variations).

7.10 Quotation & Tendering Procedures

Unless permitted by SOs, competitive quotations/tenders will be sought for all contracts according to the financial limits specified in SFI 7.2 and will involve procurement department in line with Table 2.

Tender documents will be issued by procurement on behalf of the Trust. Procurement will arrange for them to be opened in accordance with the SFIs of the Trust.

No tender shall be considered which bears any mark or name indicating the sender.

Where the total contract value exceeds £25,000 the Trust has a legal obligation to ensure that they advertise through the appropriate portal in line with Public Contracts Regulations and must subsequently ensure the respective award is also published.

Where the total contract value exceeds the Public Contracts Regulations Thresholds then the Trust is committed to conducting a legally compliant procurement process in line with the Public Contracts Regulations.

Where appropriate, pharmacy orders will be placed against National or Regionally/Divisionally agreed Pharmacy Contracts, which should cover the majority of orders placed by the Pharmacy Department.

The values listed also apply to disposals (SFI 14). All other Financial Limits are detailed at SFI 7.2

Tender lists for building and engineering works will be compiled in conjunction with the Director of Corporate Development from “Construction line” the Trust’s approved list of Contractors.

Where there is a wide discrepancy between the estimate and / or approved funding and the final total tendered cost involving an increase in expenditure this is to be reported to the Director of Finance for further instructions.

The number of firms to be invited to tender for a particular contract shall be in accordance with the financial limits specified in SFI 7.2.

Quotation/tenders will be completed accordance with these SFIs.

Adjudication must be made in accordance with SFI 7.8 recommendation report shall be prepared by procurement for approval or to seek authorisation, according to delegated limits.

Acceptance of the tender/quotation must comply with the financial limits set out in SFI 7.2).

All contract documentation must be finalised promptly (ideally prior to the commencement of the contract) after the award of contact.

The waiving of variation of competitive tendering/quotation procedures shall be reported to the Audit Committee regularly.

A flow chart outlining the legally compliant competitive tendering process and contract requirements is outlined at Annex 2.

7.11 Quotation & Tendering Procedures Summary - Contracts

Competitive quotation/tenders will be obtained for all items according to the financial limits specified in SFI 7.2.

No Pre Qualifications stages should be conducted in accordance with Public Contract Regulations
Where goods, services, disposals and/or capital works are to be supplied over a period of time, the values listed must be taken as the value of the contract, not the annual value and should not seek to circumvent public sector procurement regulations. Signed Contracts will be required for all Single Tender Action waivers over £25,000.

Quotations/ tenders shall be invited for all purchases over a period of time in line with Table 2 in specified in SFI 7.2.

Quotations/ tenders will be issued in accordance with these SFI’s and shall

incorporate standard NHS Terms and Conditions of Contract.

After tenders/quotations have been opened, procurement will arrange for adjudication of the tenders/quotations. Adjudication must be made in accordance with SFI 7.8.

A Recommendation Report prepared by the Procurement Team should be submitted for approval or to seek authorisation as per Table 2 in SFI 7.3 according to delegated limits.

All waiving of variation of competitive tendering/quotation procedures shall be reported to the Audit Committee on a six monthly basis highlighting all waivers over £10,000 in line with STA's approved by the Director of Finance.

All competitive quotations/tenders should come through the e-tendering portal to ensure compliance and published in line with Public Contracts Regulations.

All Trust quotation/tenders or waivers over £25,000 in value must result in a signed contract between the supplier and the Trust under agreed terms and conditions, clear specifications and KPI's where appropriate. These will be retained through the Trust Procurement Source To Contract System. Any exceptions to this are at the discretion of the Director of Procurement.

7.12 Waiving or Variation of Competitive Tendering/Quotation Procedure

Signed Contracts will be required for all Single Tender Action waivers over £25,000.

In circumstances after market engagement has been conducted, where the specified number of quotations/tenders cannot be obtained (e.g. where there is a limited number of suppliers), the reasons for receiving a lower number of quotations/tenders must be recorded in the recommendation report and in this event a waiver/ STA will not be required.

Formal competition need not be applied (and therefore a waiver is not required) where:

a. The estimated expenditure does not, or is not reasonably expected to, exceed the Contract value out in in SFI 7.2 Table 2

b. The supply is proposed under special arrangements negotiated by the Department of Health, which the Trust is required by the Independent Regulator to comply with

c. The requirement is covered by an existing contract and the additional expenditure does not either constitute a material difference (eg/ change of scope, or increase in value of 20% of more), or result in a shift in the economic balance of the contract in favour of the contractor

d. The expenditure relates to agency pay however internal governance and authorisation will apply

e. National public sector or NHS agreements including NHS Supply Chain are in place and have been approved by the Department of Health

f. A direct award to a supplier on a national or regional framework is

permissible and recommended according to the rules of the framework. On these occasions a recommendation report will require authorisation in accordance with SFI 7.3 Table 2. The Trust will be required to demonstrate in the report, with supporting evidence, that a direct award offers value for money and is in the best interests of the Trust

g. The requirement is to attend a seminar, conference or similar unique event

h. A consortium arrangement is in place and a lead organisation has been appointed to carry out tendering activity on behalf of the consortium members

i. A commissioning body is market testing the whole business to ensure value for money and the Trust requires a partner or subcontractor to respond to the invitation to tender. The selection of the partner by the Trust need not be separately competed

j. The requirement is for the securing of a named individual on a temporary basis to fulfil a role and where substitution of another resource is not acceptable. In this case this does not constitute a procurement but the nominated Officer must still ensure value for money

8. CONTRACTS FOR THE PROVISION OF SERVICES

8.1 Service Contracts

8.1.1 The Trust Board shall regularly review and shall at all times maintain and ensure the capacity and capability of the Trust to provide the mandatory goods and services referred to in its Terms of Authorisation and related schedules.

8.1.2 The Chief Executive, as the Accounting Officer, is responsible for ensuring the Trust enters into suitable Service Contracts with NHS England/Clinical Commissioning Groups and other commissioners for the provision of services and for considering the extent to which any NHS Standard Contracts issued by NHS England & Improvement are mandatory for Service Contracts.

8.1.3 Where the Trust enters into a relationship with another organisation for the supply or receipt of other services, clinical or non-clinical, the responsible officer should ensure that an appropriate contract is present and signed by both parties.

8.1.4 All Service Contracts and other contracts shall be legally binding, shall comply with best costing practice and shall be devised so as to manage contractual risk, in so far as is reasonably achievable in the circumstances of each contract, whilst optimising the Trust's opportunity to generate income for the benefit of the Trust and its service users.

8.1.5 In discharging this responsibility, the Chief Executive should take into account:

(a) Costing and pricing (in accordance with Payment by Results) and the activity / volume of services planned;

(b) The standards of service quality expected;

(c) The relevant national service framework (if any);

(d) Payment terms and conditions;

(e) Amendments to contracts and non-contractual arrangements; and

(f) Any other matters relating to contracts of a legal or non-financial nature.

8.1.6 Prices should match national tariff, where appropriate, but the Trust can negotiate locally agreed prices, where services are not covered by the national tariff. Any local price should be at least equal to the appropriate cost of the service being provided.

8.1.7 Any local changes in the counting and coding of patient activity will need to be notified to the CFO prior to implementation

8.1.8 The CFO shall produce regular reports detailing actual and forecast income.

8.1.9 The CFO shall oversee and approve cash flow forecasts, including figures relating to the collection of all income due under the contracts.

Annex
8.1.10 The authorisation limits for signing service contracts are set out in Annex 3.

8.2 Involving Partners and Jointly Managing Risk

8.2.1 A good contract will result from a dialogue of clinicians, users, carers, public health professionals and managers. It will reflect knowledge of local needs

and inequalities. This will require the Chief Executive to ensure that the Trust works with all partner agencies involved in both the delivery and the commissioning of the service required. The contract will apportion responsibility for handling a particular risk to the party or parties in the best position to influence the risk in question and financial arrangements should reflect this. In this way the Trust can jointly manage risk with all interested parties.

8.3 Tendering (where SFT is a competing body)

8.3.1 Where SFT participates in a tendering exercise (whether in competition with others or not) for a health related service, approval must be sought according to the delegated authority limits.

8.3.2 Delegated authority limits associated with tendering:

	Directorate Management Team	**Trust Management Committe**	**Finance & Performance Committee**	**Trust Board**
Decision not to bid or Bid sign-off prior to submission				
Total value range	<£50k	<£5m	<£15m	>£15m
Annual value	£20k pa	<£1m pa	>£1m<£5m pa	>£5m pa

8.3.3 No tender must be submitted without sign-off from the relevant authority. For absolute clarity, no Trust employee should sign a tender or contract unless they have authority and the total contract value is within the above financial limits. All tender decisions will be reported to Executive Directors for noting.

9. TERMS OF SERVICE AND PAYMENT OF BOARD DIRECTORS AND EMPLOYEES

9.1 Remuneration Committee

9.1.1 The Trust Board shall establish a Remuneration Committee, with clearly defined terms of reference specifying which posts fall within its area of responsibility, its composition and its reporting arrangements.

9.1.2 Any Trust Board post and most Senior Manager Posts will be subject to the requirements of the Fit and Proper Persons Test which is administered by Human Resources. Human Resources are responsible for keeping the list of applicable posts up to date.

9.1.3 Appointments to senior management or Director Posts above the salary of the Prime Minister (currently circa £150k) must be referred to NHS England & Improvement and onward ratification by the Secretary of State.

9.2 Staff Appointments, Terminations and changes

9.2.1 An Employee or Director to whom a staff budget or part of a staff budget is delegated may engage employees, or hire agency staff subject to any approval that may be required by the Workforce Control Panel (if applicable) and provided the post is within the limit of their approved budget and affordable staffing limit. They may also regrade employees

after consultation with their Human Resources Manager and job evaluation has taken place in accordance with Trust policy.

9.2.2 The Trust's primary mechanism of engagement is for workers to be placed on payroll either through permanent employment or fixed term contracts. Where a requirement for temporary resourcing appears (or a specific short term skills shortage) alternative forms of resourcing may be used including Bank and Agency. The use of bank must be in line with the Trust's procedures for booking temporary staff. Agency bookings should be in line with the Trust procedures, ensuring required sign off is obtained and that NHS and Tax regulation are complied with. Any off payroll engagements must be approved by the CFO prior to contract signature.

9.2.3 Each employee shall be issued with a contract of employment by the HR Department which shall comply with current employment legislation. A copy of the signed contract shall be submitted to the Director of Finance at the earliest opportunity.

9.2.4 All agency staff engaged should be via an approved framework agency and through the Trust's agreed supplier. Any individuals directly engaged, who sit outside of these 2 categories, should have a suitable contractual agreement in place.

9.2.5 Any appointments should follow the Trust Recruitment and Selection Policy found on the intranet.

9.2.6 A "Notification of Termination" form and such other documents as the Director of Finance may require, shall be completed and forwarded to the payroll department immediately upon the date of; an employee's resignation, retirement, or termination, being known. Where an employee fails to report for duty in circumstances which suggest they have left without notice, the Payroll Manager shall be informed immediately.

9.2.7 Changes forms covering an Employee's Personal Details i.e. Name, Address or Job Details shall be completed and forwarded to the payroll department immediately upon the Manager becoming aware of the change.

9.2.8 The Trust Remuneration Committee will approve procedures presented by the Chief Executive for the determination of commencing pay rates, conditions of service etc. for employees on local contracts.

9.2.9 As a general principle the Trust will seek to avoid the requirement to make staff redundant. The Trust will therefore always seek to redeploy staff where appropriate.

9.2.10 In the event that redundancy cannot be avoided the Trust shall follow the processes as laid out in its Managing Implications of Organisational Change Policy.

9.2.11 The Trust must seek approval from NHS England & Improvement before commissioning Management Consultants above a cap of £50k.

9.3 Processing Payroll

9.3.1 The Director of Finance shall be responsible for the final determination of monetary pay, (including the verification that the rate of pay and relevant conditions of service are in accordance with Trust employment contracts), the proper compilation of the payroll and for payments made. No monetary payment may be made to staff other than that paid through the payroll system without the explicit approval of the Director of Finance.

9.3.2 All pay sheets, and other pay records including travel expense claim forms supported by vouchers/receipts where appropriate, shall be in a form approved by the Director of Finance (manual or electronic) and shall be certified and submitted in accordance with his/her instructions.

9.3.3 The Director of Finance shall determine the dates on which salaries and wages shall be paid.

9.3.4 All employees shall be paid by bank credit transfer, unless in exceptional circumstances agreed otherwise by the Director of Finance.

9.3.5 Payment shall not be made in advance of the pay dates determined as in 9.3.3 above except where prior approval has been obtained from the Chief Executive, Director of Finance (or duly appointed representative) or the Director of Organisational Development and People. In such cases the payment shall be limited to the estimated net pay due at the time of payment.

9.3.6 Where the Trust HR Policies so allow, loans may be made to staff and recovered in accordance with arrangements that the Director of Finance and Director of Organisational Development and People shall determine jointly.

9.3.7 The Director of Finance shall ensure adequate internal controls and audit review procedures are in place, and that suitable arrangements are made for the collection of payroll deductions and payment of these to appropriate bodies.

9.3.8 Managers and employees are jointly responsible and accountable for ensuring claims for pay and expenses are timely, correct and any under or over payments are highlighted as soon as discovered. The process and procedures related to pay related claims and under/ over payments is contained in the Trust's Pay policy. This policy sets out that pay claims in excess of normal contractual hours will only be paid within 3 months of the extra shift/ hours. Any claims over 3 months old will need to be approved by the CFO.

10. NON-PAY EXPENDITURE

10.1 Delegation of Authority and Service Development Business Cases

10.1.1 The Trust Board will approve the level of non-pay expenditure on an annual basis and the Director of Finance will determine the level of delegation to budget managers.

10.1.2 Council of Governors will be consulted on significant transactions.

10.2 Requisitioning and Ordering Goods and Services

10.2.1 The Director of Finance will set out:

a) The list of managers who are authorised to place requisitions for the supply of goods and services; and

b) The maximum level of each requisition and the system for authorisation above that level. Authorisation limits are specified at Annex 1.

10.3 Choice, Requisitioning, Ordering, Receipt and Payment for Goods and Services

10.3.1 The requisitioner, in choosing the item to be supplied (or the service to be performed) shall always obtain the best value for money for the Trust. In so doing, the advice of the Trust Director of Procurement shall be sought. Where this advice is not acceptable to the requisitioner, the CFO shall be consulted.

10.3.2 Once the item to be supplied (or service to be performed) has been identified the requisitioner should raise a requisition. Only for agreed goods and services (i.e. agency staff and utilities) should a good or service be obtained without a purchase order.

10.3.3 The CFO or if delegated, the Financial Controller, shall be responsible for the prompt payment of accounts and claims. Payment of contract invoices shall be in accordance with contract terms, or otherwise, in accordance with national guidance.

10.3.4 The CFO will:

a) Prepare procedural instructions (where not already provided in the Scheme of Delegation or procedure notes for budget managers) on the obtaining of goods, works and services incorporating these thresholds;

b) Be responsible for designing and maintaining a system of verification, recording and payment of all amounts payable. The system shall provide for:

i) **Authorisation:**

- a list of Directors and Employees authorised to authorise invoices and that the expenditure has been authorised by the officer responsible for the contract or budget which is to be charged

ii) **Certification:**

- Goods have been duly received, examined and are in accordance with specification and the prices are correct. Certification of accounts may either be through a goods received note or by personal certification by authorised officers;
- Work done or services rendered have been satisfactorily carried out in accordance with the order, and, where applicable, the materials used are of the requisite standard and the charges are correct;
- In the case of contracts based on the measurement of time, materials or expenses, the time charged is in accordance with the time sheets, the rates of labour are in accordance with the appropriate rates, the materials have been checked as regards quantity, quality, and price and the charges for the use of vehicles, plant and machinery have been examined and are reasonable;
- Where appropriate, the expenditure is in accordance with regulations and all necessary authorisations have been obtained;
- where an officer certifying accounts relies upon other officers to do preliminary checking he/she shall, wherever possible, ensure that those who check delivery or execution of work act independently of those who have placed orders and negotiated prices and terms and that such checks are

evidenced;

- In the case of contract for building and engineering works which require payment to be made on account during process of the works the CFO shall make payment on receipt of a certificate from the appropriate technical consultant or authorised officer. Without prejudice to the responsibility of any consultant, or authorised officer appointed to a particular building or engineering contract, a contractors account shall be subjected to such financial examination by the CFO and such general examination by the authorised officer as may be considered necessary, before the person responsible to the Trust for the contract issues the final certificate;

iii) **Payments and Creditors:**

- a timetable and system for submission to the CFO of accounts for payment; provision shall be made for the early submission of accounts subject to cash discounts or otherwise requiring early payment.

iv) **Financial Procedures:**

- Instructions to employees regarding the handling and payment of accounts within the Finance Department;

c) Be responsible for ensuring that payment for goods and services is only made once the goods and services are received (except as below).

10.3.5 Prepayments are only permitted where the financial advantages outweigh the disadvantages in such instances:

a) The appropriate Director must provide, in the form of a written report, a case setting out all relevant circumstances of the purchase. The report must set out the effects on the Trust if the supplier is at some time during the course of the prepayment agreement unable to meet his/her commitments;

b) The supplier is of sufficient financial status or able to offer a suitable financial instrument to protect against the risk of insolvency;

c) There are adequate administrative procedures to ensure that where payments in advance are made the goods or services are received or refunds obtained;

d) The CFO must approve the proposed arrangements before those arrangements are contracted; and

e) The Budget Manager is responsible for ensuring that all items due under a prepayment contract are received and must immediately inform the appropriate Director if problems are encountered.

10.3.6 Managers must ensure that they comply fully with the guidance and limits specified by the CFO and that:

a) All contracts (other than for simple purchase permitted within the Scheme of Delegation or delegated budget), leases, tenancy agreements and other commitments which may result in a liability are notified to the CFO in advance of any commitment being made;

b) No requisition/order is placed for any item or items for which there is no budget provision unless authorised by the CFO on behalf of the Chief Executive;

c) Changes to the list of Directors and Employees authorised to certify invoices are in accordance with the scheme approved by the Board;

d) Purchases from petty cash are restricted in value and by type of purchase in accordance with instructions issued by the CFO;

e) Petty cash records are maintained in a form as determined by the CFO;

f) Contracts above specified thresholds are advertised and awarded in accordance with EU and GATT rules on public procurement; and

g) In certain circumstances, where regular transactions are made for items such as travel, course and accommodation bookings and one off purchases, a Trust purchasing card can be an alternative means of procurement. All purchase card holders are required to follow the Trust purchasing card procedure and will be required to sign a declaration agreeing to the terms of the procedure.

10.4 Value Added Tax

10.4.1 Payment and recovery of VAT is the responsibility of the CFO who will ensure that procedures and systems are in place to enable regulations governing VAT in the NHS to be complied with.

10.4.2 Where managers are unsure of the VAT status of any particular transaction advice will be provided from the Finance Department.

11. EXTERNAL BORROWING, PUBLIC DIVIDEND CAPITAL AND CASH INVESTMENTS

11.1 External Borrowing

11.1.1 The Trust may borrow money for the purposes of, or in connection with, its strategic objectives and its operational functions.

11.1.2 The total amount of the Trust's borrowing must be affordable within NHS England & Improvement's Single Oversight Framework for Trusts.

11.1.3 Any application for a loan or overdraft facility must be approved by the Trust Board and will only be made by the CFO or a person with specific delegated powers from the CFO. Use of such loans or overdraft facilities must be approved by the CFO.

11.1.4 All short term borrowings should be kept to the minimum period of time possible, consistent with the overall cash position. Any short term borrowing requirement in excess of one month must be authorised by the CFO.

11.1.5 All long-term borrowing must be consistent with the plans outlined in the current Trust Business Plan approved by the Board.

11.2 Public Dividend Capital ("PDC")

11.2.1 Any application for an increase in public dividend capital on behalf of the Trust shall only be made by the Director of Finance or their nominated representative and will be notified to the Trust Board or the Finance and Performance Committee on the Board's behalf.

11.2.2 The Trust will comply with the guidance on dividend payments contained in the DoHSC Group Accounting Manual.

11.3 Investments

11.3.1 The Trust may invest money for the purposes of its strategic objectives and operational functions.

11.3.2 Investment of cash on a short or long term basis shall be in accordance with the Trust's Treasury Management Policy as approved from time to time by the Finance and Performance Committee. The Director of Finance shall compile and regularly review the Trust's Treasury Management Policy and advise the Finance and Performance Committee of any necessary changes.

11.3.3 Investments may be made in forming and / or acquiring an interest in bodies corporate where authorised by the Trust Board.

11.3.4 Temporary cash surpluses must be held only in investments permitted by NHS England & Improvement and meeting the criteria approved by the Treasury Management Policy. The Treasury Management Policy will be refreshed and approved by the Finance and Performance Committee on an annual basis.

11.3.5 The CFO is responsible for advising the Board on investments and shall periodically report the performance of all investments held, to the Finance and Performance Committee.

11.3.6 The CFO will prepare detailed procedural instructions on the operation of

investment accounts and on the records to be maintained.

11.3.7 The CFO (or a senior finance manager with specific delegated powers from the CFO) will authorise all investment transactions and ensure compliance with the Treasury Management Policy at all times, with no investment made which would be outside the laid-down parameters for investment risk management in the policy. All investments are subject to periodic review and monitoring by the Finance and Performance Committee.

12. CAPITAL INVESTMENT, PRIVATE FINANCING, FIXED ASSET REGISTERS AND SECURITY OF ASSETS

12.1 Capital Investment

12.1.1 The Trust will establish a Strategic Capital Committee (SCC) chaired by the Director of Finance to oversee its allocation of capital investment. The CFO will ensure that there is an adequate appraisal and approval process in place for determining capital expenditure priorities and the effect of each proposal upon the Trust's Business Planning process.

12.1.2 The SCC will oversee the development and monitoring of an annual capital plan, including any changes to the plan as necessary in year. The Trust Board will approve the annual capital plan.

12.1.3 The CFO shall establish systems to ensure that approved capital schemes are progressed effectively and that budgets, phasing and cash flows are properly monitored.

12.1.4 The financial performance of the Capital Programme shall be reported to the Trust Board on a monthly basis with fuller details of the larger schemes on a quarterly basis.

12.2 Approval of Capital Business Cases

12.2.1 Approval of Capital Business Cases will be as follows:

Table 4

Capital Plan	***Approval to proceed, or changes to previously approved Capital.***	**Forum**
N/A	<£20k	Buildings & Infrastructure Group, Medical Devices Management Committee, IT Capital Group
N/A	<£100k	CapCG (SCC informed via minutes)
N/A	£100k to <£350k	Strategic Capital Committee Director of Finance
N/A	£350k to <£500k	TMC Chief Executive
N/A	£500k to <£750k	Finance and Performance Committee
Full capital plan approved by Trust Board as part of Trust's Business Planning Process.	£750k+ Any proposed major scheme within FT compliance arrangements	Trust Board

Any proposed major scheme within FT compliance arrangements	Any proposed major scheme within FT compliance arrangements	NHS England & Improvement

Where a capital scheme is approved within the annual capital plan, full and final approval to proceed is still required as set out in the delegated limits in table 4.

Approvals for capital projects over £350k, will be itemised in a schedule to Trust Board on a quarterly basis.

Programme allocations within Capital Plan	**Group/ individual responsible for approval**
Building and Works	The Building and InfrastructureGroup
Medical Equipment	Medical Devices Committee
Information Systems	Information Systems Steering Group

12.3 Private Finance Initiative

12.3.1 Proposals for Private Finance must be submitted to the Investment Group for approval or review prior to request for approval by the Finance and Performance Committee or Trust Board if required.

12.4 Asset Registers

12.4.1 The CFO is responsible for the maintenance of registers to record capital fixed assets. Appropriate adjustments must be made to reflect actual Trust assets currently in use. All items over £5,000 must be recorded on the Fixed Asset Register.

12.4.2 The CFO shall prepare procedural instructions on the disposal of assets.

12.4.3 Additions to the fixed asset register must be clearly identified to an appropriate budget holder and be validated by reference to:

a) Properly authorised and approved agreements, architect's certificates, supplier's invoices and other documentary evidence in respect of purchases from third parties;

b) Stores, requisitions and wages records for own materials and labour including appropriate overheads.

12.4.4 Where capital assets are sold, scrapped, lost or otherwise disposed of, their value must be removed from the accounting records and each disposal must be validated by reference to authorisation documents and invoices (where appropriate).

12.4.5 The CFO shall approve procedures for reconciling balances on fixed assets accounts in the general ledger against balances on the fixed asset register.

12.4.6 The value of each asset shall generally be depreciated using appropriate methods and rates in line with accounting standards.

12.5 Security of Assets

12.5.1 The overall control of fixed assets is the responsibility of the Chief Executive.

12.5.2 Asset control procedures (including fixed assets, cash, cheques and negotiable instruments, including donated assets) must be approved by the CFO. This procedure shall make provision for:

a) Recording managerial responsibility for each asset;

b) Identification of additions and disposals;

c) Identification of all repairs and maintenance expenses;

d) Physical security of assets;

e) Periodic verification of the existence of, condition of, and title to, assets recorded;

f) Identification and reporting of all costs associated with the retention of an asset; and

g) Reporting, recording and safekeeping of cash, cheques, and negotiable instruments.

12.5.3 The CFO shall approve procedures for reconciling balances on fixed assets accounts in the general ledger against balances on the fixed asset register.

12.5.4 All discrepancies revealed by verification of physical assets to the fixed asset register shall be notified to the appropriate manager who shall inform the CFO who shall decide what further action shall be taken.

12.5.5 Whilst each employee has a responsibility for the security of property of the Trust, it is the responsibility of Directors and senior employees in all disciplines to apply such appropriate routine security practices in relation to NHS property as may be determined by the Trust Board. Any breach of agreed security practices must be reported.

12.5.6 Any damage to the Trust's premises, vehicles and equipment, or any loss of equipment, stores or supplies must be reported by Directors and Employees in accordance with the procedure for reporting losses and the requirements of insurance arrangements.

12.5.7 Whenever practicable, assets should be marked as Trust property.

12.5.8 Inventories shall also be maintained and receipts obtained for Equipment on loan.

12.6 Property (Land and Buildings)

12.6.1 Significant changes relating to the Trust's Estate must receive the prior approval of the Trust Investment Group and Trust Executive Committee.

12.6.2 The following matters related to property must be approved by the Trust Board:

a) An Estate Strategy;

b) Acquisition of freehold property over £200,000 (excluding VAT); and

c) Acquisition of property where the total value of the agreement is over £200,000 (excluding VAT) by means of a lease, whether it is deemed to be an operating or finance lease.

12.6.3 Property purchases, licences and leases up to £200,000 each (excluding VAT) may be authorised by the Chief Executive, provided that they fall within the Board's approved Estates Strategy and that the cost is within 10% of an independent valuation.

12.6.4 The complexity of any property reports to the Trust Board should be determined by the materiality of the consideration or lease payments and any contentious issues, and must contain:

a) Details of the consideration or lease payments;

b) Details of the period of the lease;

c) Details of the required accounting treatment;

d) Annual running costs of the property;

e) Funding sources within the Trust of both capital and revenue aspects of the acquisition;

f) The results of property and ground surveys;

g) Professional advice taken and the resultant cost;

h) Details of any legal agreement entered into;

i) Any restrictive covenants that exist on the property; and

j) Planning permission.

12.6.5 Any property acquisition should be in accord with, Department of Health guidance.

12.6.6 The contracts to acquire the property must be signed by two Executive Directors, one of whom should be the Chief Executive.

12.6.7 Appointment of professional advisors must be in line with the separate procedures for the appointment of advisors.

12.6.8 Trust Board approval must be obtained for the disposal of any property over £100,000 (excluding VAT) which is recorded on the balance sheet of the Trust. A business case must be presented to the Trust which must include:

a) The proceeds to be received;

b) Any warrants or guarantees being given; and

c) Independent valuations obtained.

12.6.9 The disposal must be effected in full accord with Estate code.

12.6.10 Disposals of protected assets requires the approval of NHS England & Improvement.

12.6.11 Major divestments as defined in the Foundation Trust Compliance Framework requires the approval of NHS England & Improvement.

12.6.12 The granting of property leases by the Trust must have prior Board approval where the annual value of the lease is in excess of £200,000

13. INVENTORY AND RECEIPT OF GOODS

13.1 Inventory Stores and Inventory

13.1.1 Inventory Stores, defined in terms of controlled stores and department stores (for immediate use) and stock held by the Trust should be kept to a minimum subjected to at least an annual stock take valued at the lower of cost and net reliable value. Inventory shall be controlled on a First in First out (FIFO) basis wherever possible; cost shall be ascertained on either this basis or on the basis of average purchase price. The cost of inventory shall be the purchase price without any overheads, but including value added tax where this cannot be reclaimed on purchase.

13.1.2 Subject to the responsibility of the CFO for the systems of control, overall responsibility for the control of Inventory Stores and Inventory shall be the responsibility of the Director of Procurement. The day-to-day responsibility may be delegated by him/her to departmental officers and stores managers and keepers, subject to such delegation being entered in a record available to the CFO. The control of pharmaceutical stocks shall be the responsibility of the Chief Pharmacist; and the control of fuel oil the Head of Estates.

13.1.3 The responsibility for security arrangements and the custody of keys for all Inventory Stores and locations shall be clearly defined in writing by the Logistics Manager wherever practicable; stocks should be marked as Health Service property.

13.1.4 The CFO, in conjunction with the Associate Director of Procurement, shall set out procedures and systems to regulate the Inventory stores and the inventory contained therein, including records for receipt of goods, issues, and returns to suppliers, and losses and specify all goods received shall be checked as regards quantity and/or weight and inspected as to quality and specification; a delivery note shall be obtained from the supplier at the time of delivery and shall be signed by the person receiving the goods; all goods received shall be entered onto an appropriate goods received/inventory record (whether a computer or manual system) on the day of receipt:

a) If goods received are unsatisfactory the records shall be marked accordingly. Where goods received are seen to be unsatisfactory, or short on delivery, they shall only be accepted on the authority of a designated officer and the supplier shall be notified immediately;

b) Where appropriate the issue of stocks shall be supported by an authorised requisition note and a receipt for the stock issued shall be returned to the designated officer independent of the storekeeper.

13.1.5 Stocktaking arrangements shall be agreed with the CFO and shall specify:

a) The procedures of system for the control of consignment stock will be defined in the Consignment Inventory Policy;

b) That there shall be a physical check covering all items in store at least once a year;

c) The physical check shall involve at least one officer other than the storekeeper, and a member of staff from the Finance Department shall be invited to attend;

d) The stocktaking records shall be numerically controlled and signed by the officers undertaking the check;

e) Any surplus or deficiencies revealed on stocktaking shall be reported in accordance with the procedure set out by the CFO.

13.1.6 Where a complete system of inventory control is not justified, alternative arrangements shall require the approval of the CFO.

13.1.7 The Director of Procurement shall be responsible for a system approved by the CFO for a review of slow moving and obsolete items and for condemnation, disposal, and replacement of all unserviceable articles. Any evidence of significant overstocking and of any negligence or malpractice shall be reported to the CFO (see also SFI 14, Disposals, Condemnations, Losses and Special Payments). Procedures for the disposal of obsolete stock shall follow the procedures set out for disposal of all surplus and obsolete goods.

13.1.8 Breakages and other losses of goods in stock shall be recorded as they occur. Tolerance limits shall be established for all stocks subject to unavoidable loss, e.g. natural deterioration of certain goods (see also SFI 14, Disposals, Condemnations, Losses and Special Payments).

13.1.9 Inventory that has deteriorated, or are not usable for any other reason for their intended purposes, or may become obsolete, shall be written down to their net reliable value. The write down shall be approved by the CFO and recorded.

13.1.10 For goods supplied via the NHS Supply Chain central warehouses, or Trust Supplies Stores, the Director of Procurement shall identify those authorised to requisition and accept goods from the store.

13.1.11 It is a duty of officers responsible for the custody and control of inventory to notify all losses, including those due to theft, fraud and arson, in accordance with SFI 14.

14. DISPOSALS AND CONDEMNATIONS, LOSSES AND SPECIAL PAYMENTS

14.1 Disposals and Condemnations (see also Trust Disposals Policy)

14.1.1 The CFO shall prepare detailed procedures for the disposal of assets including capital assets and condemnations.

14.1.2 When it is decided to dispose of a Trust asset, the Head of Department or authorised deputy will:

a) Establish whether it is needed elsewhere in the Trust;

b) Determine and advise the Finance Department of the estimated market value of the item, taking account of professional advice or the assistance of the Procurement department where appropriate. The highest possible disposal value will be realised, taking into account potential risks and reputational impacts.

14.1.3 All unserviceable articles shall be:

a) Condemned or otherwise disposed of by an employee authorised for that purpose by the CFO;

b) Recorded by the condemning officer in a form approved by the CFO which will indicate whether the articles are to be converted, destroyed or otherwise disposed of. All entries shall be confirmed by the countersignature of a second employee authorised for the purpose by the CFO.

14.1.4 The condemning officer shall satisfy him/herself as to whether or not there is evidence of negligence in use and shall report any such evidence to the CFO, who will take the appropriate action.

14.1.5 Disposals of assets valued between £100,001 - £200,000k (higher of either market value or net book value) must be approved by the Chief Executive.

14.2 Losses and Special Payments Procedures

14.2.1 The CFO must prepare procedural instructions on the recording of and accounting for condemnations, losses and special payments in accordance with DoHSC Group Accounting Manual and prepare a register.

14.2.2 The CFO must also prepare a 'fraud response plan' that sets out the action to be taken both by persons detecting a suspected fraud and those persons responsible for investigating it. (See the Trust's Fraud, Bribery and Corruption Policy).

14.2.3 Any employee discovering or suspecting a loss of any kind must immediately act according to the Trust's Fraud, Bribery and Corruption Policy.

14.2.4 The CFO is responsible for monitoring compliance with the Directions of the Secretary of State and with any other instructions issued by NHS Counter Fraud Agency.

14.2.5 The Directorate or Service Manager shall inform the CFO of all other losses or recoveries of previous reported losses so that they can be entered in the losses and special payments register.

14.2.6 For losses apparently caused by theft, arson, neglect of duty or gross carelessness, except if trivial, the CFO shall inform the Chief Executive in cases where the loss may be material or where the incident may lead to adverse publicity.

14.2.7 The CFO shall be authorised to take any necessary steps to safeguard the Trust's interests in bankruptcies and company liquidations.

14.2.8 For any loss, the CFO should consider whether any insurance claim can be made against insurers.

14.2.9 All losses and special payments (other than compensation payments) shall be recorded without delay in the Trust's Losses Register, to be maintained by the CFO and investigated in such a manner as the CFO may require. Write-off action shall be recorded against each entry in the register.

15. INFORMATION TECHNOLOGY

15.1 Computer Systems and Data

15.1.1 The Senior Information Risk Owner (SIRO), supported by the Chief Information Officer, who is responsible for the accuracy and security of the computerised financial data of the Trust, shall devise and implement any necessary procedures to ensure adequate (reasonable) protection of the Trust's data, programs and computer hardware for which he/she is responsible from accidental or intentional disclosure to unauthorised persons, deletion or modification, theft or damage, having due regard for the Data Protection Act 1998;ensure that adequate (reasonable) controls exist over data entry, processing, storage, transmission and output to ensure security, privacy, accuracy, completeness, and timeliness of the data, as well as the efficient and effective operation of the system ensure that adequate controls exist such that the computer operation is separated from development, maintenance and amendment ensure that an adequate management (audit) trail exists through the computerised system and that such computer audit reviews as he/she may consider necessary are being carried out ensure procedures are in place to limit the risk of, and recover promptly from, interruptions to computer operations.

15.1.2 The CFO shall be satisfied that new financial systems and amendments to current financial systems are developed in a controlled manner and thoroughly tested prior to implementation. Where this is undertaken by another organisation, assurances of adequacy will be obtained from them prior to implementation.

15.1.3 The CFO shall ensure that contracts for computer services for financial applications with another health organisation or any other agency shall clearly define the responsibility of all parties for the security, privacy, accuracy, completeness, and timeliness of data during processing, transmission and storage. The contract should also ensure rights of access for audit purposes.

15.1.4 Where another health organisation or any other agency provides a computer service for financial applications, the CFO shall periodically seek assurances that adequate controls are in operation.

15.1.5 Where computer systems have an impact on corporate financial systems the CFO shall be satisfied that:

a) Systems acquisition, development and maintenance are in line with the Trust's Informatics Strategy;

b) Data produced for use with financial systems is adequate, accurate, complete and timely, and that a management (audit) trail exists;

c) Finance staff have access to such data;

d) Have adequate controls in place; and

e) Such computer audit reviews as are considered necessary are being carried out.

15.1.6 No software package for use on trust equipment (PCs, laptops, tablets) should be purchased without the knowledge of the Informatics department. Any quotes to purchase software should therefore be managed through the IT helpdesk.

No hardware equipment should be connected to the network without the approval of the Informatics department.

It will be at the discretion of the Director of Corporate Development or the Director of Informatics whether a case requires discussion at ISSG.

16. PATIENTS' PROPERTY

16.1 Patients' Property and Income

16.1.1 The Trust has a responsibility to provide safe custody for money and other personal property (hereafter referred to as "property") handed in by patients, in the possession of unconscious or confused patients, or found in the possession of patients dying in hospital or dead on arrival. Staff have a duty of care to make every effort to take care of patients' possessions, which are **not** handed in for safe keeping, particularly if the patient does not have the capacity to look after their own possessions, This includes items of daily living such as glasses, false teeth, hearing aids etc.

16.1.2 The Chief Executive is responsible for ensuring that patients or their guardians, as appropriate, are informed before or at admission, (by notices and information booklets, hospital admission documentation and property records, and/or the oral advice of administrative and nursing staff responsible for admissions), of the Trust's policy that the Trust will not accept responsibility or liability for patients' property brought into Health Service premises, subject to the exceptions identified above, unless it is handed in for safe custody and a copy of an official patients' property record is obtained as a receipt. Patients electing not to conform to this guidance must indemnify the Trust against any loss.

16.1.3 The CFO will provide detailed written instructions on the collection, custody, investment, recording, safekeeping, and disposal of patients' property (including instructions on the disposal of the property of deceased patients and of patients transferred to other premises) for all staff whose duty it is to administer, in any way, the property of patients. Due care should be exercised in the management of a patient's money.

16.1.4 Where Department of Health instructions require the opening of separate accounts for patients' monies, these shall be opened and operated under arrangements agreed by the CFO.

16.1.5 In all cases where property of a deceased patient is of a total value in excess of £5,000 (or such other amount as may be prescribed by any amendment to the Administration of Estates, Small Payments, Act 1965), the production of Probate or Letters of Administration shall be required before any of the property is released. Where the total value of property is £5,000 or less, forms of indemnity shall be obtained.

16.1.6 Staff should be informed, on appointment, by the appropriate departmental or senior manager of their responsibilities and duties for the administration of the property of patients.

16.1.7 Where patients' property or income is received for specific purposes and held for safekeeping the property or income shall be used only for that purpose, unless any variation is approved by the patient or patient's representative as appropriate, in writing.

16.1.8 Patients' income, including pensions and allowances, shall be dealt with in accordance with current Department of Health and Department of Social Security instructions and guidelines**.**

17. CHARITABLE FUNDS HELD ON TRUST

17.1 Introduction

17.1.1 The Trust Board is legally the 'Sole Corporate Trustee' of Salisbury District Hospital Charitable Fund Charity (registered charity number 1052284), and is responsible for the management of funds it holds on trust. For the purposes of these SFI's the Trust Board members shall be termed Trustees. Although the management processes may overlap with those of the Trust, the Trustee responsibilities must be discharged separately and full recognition given to the accountability to the Charity Commission for charitable funds held on trust.

17.1.2 This section of SFIs is intended to provide guidance to persons who have been delegated to act on behalf of the corporate Trustee. As management processes overlap, most of the sections of these SFIs will apply to the management of funds held on trust with the exception that expenditure from Charitable Funds shall be restricted to the purpose(s) of the appropriate fund and be made only with the approval of the Fund Manager appointed by the Trustees or the Trustees themselves. This section covers those instructions which are specific to the management and governance of funds held on trust.

17.1.3 The over-riding principle is that the integrity of each fund must be maintained and statutory and fund obligations met. Materiality must be assessed separately from Exchequer activities and funds.

17.1.4 The CFO has primary responsibility to the Trust Board for ensuring that these SFIs are applied in respect of Charitable Funds.

17.2 Administration of Charitable Funds

17.2.1 The CFO shall:

a) Maintain such accounts and records as may be necessary to record and protect all transactions and funds of the Trust Board as Trustees of charitable funds. These shall be maintained in accordance with legislative requirements and any directions from the Charity Commission.

b) Ensure that each fund has a specific fund objective and that funds are spent appropriately, timely and in line with the donor wishes;

c) Produce codes of procedure covering the financial management of funds held;

d) Ensure funds are held within designated or restricted accounts in accordance with charity law;

e) Periodically review the funds, rationalise funds within statutory guidelines, and report changes to the Salisbury District Hospital Charitable Fund Committee;

f) Recommend additional funds where this is consistent with good practice for ensuring the safe and appropriate management of restricted/designated funds, in particular ensuring that the new fund could not adequately be managed as part of an existing fund;

g) Ensure that all charitable funds are banked in accordance with the Trust's SFI for banking arrangements;

h) Report income and expenditure totals to the Salisbury District Hospital Charitable Fund Committee at their quarterly meetings;

i) Ensure that charitable funds' income and expenditure is managed with due regard to taxation implications;

j) Prepare the annual accounts and Trustee's report in the required format for timely submission to the Auditors, Salisbury Hospital Charitable Funds Committee and the Charity Commission.

17.3 Fundraising and Incoming Funds

17.3.1 All gifts, donations and proceeds of fund raising activities are the responsibility of the Trustees and shall be handed immediately to the CFO to be banked in the Charitable Funds bank account.

17.3.2 All gifts accepted shall be receipted and held in the name of the Trustees and administered in accordance with the Trustees' policies, subject to the terms of specific trusts. As the Trustees can accept gifts only for all or any purposes relating to the Health Service, managers shall, in cases of doubt, or where there are material revenue expenditure implications, consult the CFO before accepting gifts.

17.3.3 The CFO shall advise the Trustees on the financial implications of any proposal for fund raising activities which may be initiated, sponsored or approved.

17.3.4 The CFO shall be kept informed of all enquiries regarding legacies and shall keep an appropriate record. All correspondence concerning legacies shall be dealt with on behalf of the Trustees by the CFO who alone shall be empowered to provide an executor a good discharge.

17.4 Investments and Investment Income

17.4.1 The Trustees shall be responsible for:

a) Appointing investments advisors to manage investments and provide relevant investment advice on these. Charitable funds shall be invested in a manner to maximize medium term value,

c) Monitor the performance of investments and seek clarification from the investment advisors on any relevant issues;

d) Report any significant concerns to the Trust Board;

17.4.2 The CFO will allocate dividends, interest, and realised and unrealised gains and losses across the funds appropriately.

17.5 Expenditure

17.5.1 Expenditure from any Charitable Fund shall be conditional upon the item being within the terms of the appropriate trust, the procedures approved by the Trustees and sufficient funds being available.

17.5.2 Day to day management of individual expenditure is delegated to Fund Managers who shall not enter into any transaction which will result in any fund under their control becoming overdrawn without first obtaining authorisation in writing from the CFO.

17.5.3 The CFO shall act on behalf of the Trustees in ensuring that all expenditure incurred is in accordance with the purposes identified by the donor.

17.5.4 The powers of delegation available to commit resources are detailed in the table below. The levels of authority relate to single orders or connected multiple orders.

17.5.5 A connected multiple orders could be for example:

a) The refurbishment of a room where several suppliers are involved

b) An ECG machine and its trolley

c) An order to cover a period of more than one year (the whole value of the order is considered rather than each annual value).

17.5.6 **Levels of Authority**

No expenditure can take place without the approval of the following:

£	**Orders can only be processed once the following people give their authority**
Up to £10,000	The Fund Manager
Over £10,000	The Fund Manager + The Salisbury District Hospital Charitable Funds Committee (reported to the Trust Board)

17.5.7 Where charitable fund expenditure has an impact on NHS costs, the approval of the Trust shall be sought prior to contractual commitment.

17.6 Asset Management

17.6.1 Assets granted by the Charity to the ownership of or to be used by the Trust, shall be maintained along with the general estate and inventory of assets of the Trust.

17.6.2 The Charity accepts no responsibility, financially or otherwise, for any liabilities arising out of the expenditure.

17.6.3 The Charity shall not be responsible for replacement of the equipment, if it is to be replaced, when it comes to the end of its natural life.

17.7 Risk Management

17.7.1 The CFO will be responsible for updating an annual risk register for

agreement by the Salisbury District Hospital Charitable Funds Committee. This will address the following key areas of risk for the charity:

a) Governance risks – e.g. inappropriate organisational structure, conflict of interest;

b) Operational risks – e.g. Service quality or development, security of assets, fund-raising activity;

c) Financial risks – e.g. accuracy and timeliness of financial information, adequacy of reserves and cash flow, investment management, recession;

d) External risks – e.g. Public perception and adverse publicity, government policy;

e) Compliance with law and regulation – e.g. Breach of charity law, lottery regulations.

18. STANDARDS OF BUSINESS CONDUCT

18.1 The Chief Executive shall ensure that all staff, volunteers and any other person associated with the Trust are made aware of, and comply with, the Trust's Conflicts of Interest Policy. This policy details the behaviour expected of individuals with regard to:

a) Interests (financial or otherwise) in any matter affecting the Trust and the provision of services to patients, public and other stakeholders;

b) Conduct by an individual in a position to influence purchases;

c) Employment and business which may conflict with the interests of the Trust;

d) Relationships which may conflict with the interests of the Trust;

e) Hospitality and gifts and other benefits in kind such as sponsorship.

Declarations relating to the above must be made to the Head of Corporate Governance for inclusion in the Register of Interests.

18.2 The Bribery Act 2010 reforms the criminal law of bribery, making it easier to tackle this offence proactively in the public and private sectors.
It introduces a corporate offence which means that organisations are exposed to criminal liability, punishable by an unlimited fine, for negligently failing to prevent bribery. In addition, the Act allows for a maximum penalty of 10 years' imprisonment for offences committed by individuals.

Under the Bribery Act 2010 it is a criminal offence to:

a) Bribe another person by offering, promising or giving a financial or other advantage to induce them to perform improperly a relevant function or activity, or as a reward for already having done so, and

b) Be bribed by another person by requesting, agreeing to receive or accepting a financial or other advantage with the intention that a relevant function or activity would then be performed improperly, or as a reward for having already done so.

These offences can be committed directly or by and through a third person and, in many cases, it does not matter whether the person knows or believes that the performance of the function or activity is improper. It is, therefore, extremely important that staff adhere to this and other related policies (specifically, Fraud, Bribery and Corruption, Conflicts of Interest and Freedom to Speak Up: Raising Concerns policies, available via the intranet).

The action of all staff must not give rise to, or foster the suspicion that they have been, or may have been, influenced by a gift or consideration to show favour or disadvantage to any person or organisation. Staff must not allow their judgement or integrity to be compromised in fact or by reasonable implication.

Staff should not be afraid to report genuine suspicions of fraud, bribery or corruption and should report all suspicions to the Local Counter Fraud Specialist (LCFS) who is responsible for tackling any concerns. Alternatively, suspicions can be reported via the National fraud and corruption reporting line (0800 028 40 60) or via the National Fraud Reporting website www.reportnhsfraud.nhs.uk.

19. RETENTION OF RECORDS AND INFORMATION

19.1 The Chief Executive shall be responsible for maintaining archives for all records, information and data required to be retained in accordance with NHS England & Improvement / DoHSC guidelines. The delegated responsibility for holding and safekeeping of contracts, in secure storage where applicable, shall be as follows:

Document	Held By
Property Deeds	Director of Corporate Development
Building & Engineering Contracts	Director of Corporate Development & Director of Procurement
Estate Maintenance Contracts	Director of Corporate Development & Director of Procurement
Maintenance Contracts	Director of Procurement
Commissioner Contracts	Director of Finance
Contracts for goods and services other than the above	Director Procurement

The managers noted in the table above will also be responsible for maintaining registers of the contracts held by them. Any other contracts not covered by the above which may be held by other Managers must be reported to the Director of Procurement for a register to be maintained.

19.2 The records held in archives shall be capable of retrieval by authorised persons.

19.3 Records and information held in accordance with latest NHS England & Improvement / DoHSC guidance shall only be destroyed before the specified guidance limits at the express authority of the Chief Executive or CFO. Proper details shall be maintained of records and information so destroyed.

20. GOVERNANCE, RISK MANAGEMENT AND INSURANCE

20.1 Risk Management

20.1.1 The Chief Executive shall ensure that the Trust has a risk management policy and procedures and sound processes for risk management which will be monitored by the Board and its delegated sub committees with responsibility for Risk Management.

20.1.2 The risk management and associated policies shall include:

a) A process for identifying and quantifying risks;

b) The authority of all managers with regard to managing the control and mitigation of risk;

c) Management processes to ensure all significant risks and potential liabilities are addressed, including effective systems of internal control

cost effective insurance cover, and decisions on the acceptable level of residual risk;

d) Contingency plans to offset the impact of adverse events;

e) Audit arrangements including: internal audit, external audit, clinical audit, health and safety review.

The existence, integration and evaluation of the above elements will provide a basis to make a statement on the effectiveness of Internal Financial Control within the Annual Report and Accounts as required by current Department of Health /NHS England & Improvement guidance.

20.2 Insurance

20.2.1 On an annual basis, the CFO shall review membership of the Non-Clinical Risk Pooling Scheme plus other insurance arrangements and recommend whether or not to continue with current arrangements

20.2.2 The Financial Controller shall act as the Trust's contact on insurance matters, liaising with Insurance Brokers over queries and negotiating renewal terms.

20.2.3 The Financial Controller shall ensure timely reporting of incidents against insurance provision on the third party liability scheme.

20.2.4 The Financial Controller shall ensure timely reporting of losses and the submission of claims against insurance provision on the third party liability scheme in line with the agreed limits set in these SFIs.

20.3 Clinical Risk Management/CNST

20.3.1 The Director of Nursing shall:

a) Provide a central point of contact within the Trust for NHSLA/CNST issues;

b) Report on claims to Trust Board within the set limits and values.

21. LITIGATION PAYMENTS

21.1 Claims from Staff, Patients and the Public

21.1.1 Out of court settlement of claims from staff, patients and the public shall be made where the NHS Resolution (formerly NHS Litigation Authority)/Claims Handler considers it appropriate to do so. Occupier liability claims carry an excess of £3k and employer liability claims carry an excess of £10k. Any occupier liability cases handled in house by the trust within the excess of £3k will be notified to the Head of Litigation and Insurance Services for acknowledgement only.

21.1.2 The limits for notification of individual damages payments are as follows, given that financial responsibility for the payment of all claims is the responsibility of the NHS Resolution with the Salisbury NHS Foundation Trust as the defendant.

Up to £100k	NHSLA/Claims handler	Head of Litigation
£100k-£250k	NHSLA/Claims handler	Chief Nursing Officer
£250k-£500k	NHSLA/Claims handler	Chief Executive
>£500k	NHSLA/Claims handler	Trust Board

The DoHSC must be consulted before making any special payments that are novel, contentious or repercussive. Any payments made contrary to legal advice must be approved by the CEO and Trust Board.

21.2 Health and Social Care Act 2003 – NHS Charges

21.2.1 Part 3 of the Health and Social Care (Community Health and Standards) Act 2003 makes provision for the establishment of a scheme to recover the costs of providing treatment to an injured person in all cases where that person has made a successful personal injury compensation claim against a third party.

21.2.2 Regarding any claim settled by the Trust and/or by the NHS Resolution, there is a requirement to report all such matters in advance of settlement to the Compensation Recovery Unit (DWP). In the event that any NHS charges are payable these will be met in full by the compensator i.e. any other NHS Trust. In the event the compensator is Salisbury NHS Foundation Trust the act provides that SFT is exempt from repaying their "own" costs.

22. EMPLOYMENT TRIBUNALS

22.1 All settlement agreements must be approved by the Chief People Officer.

22.2 Any settlement agreement in excess of contractual entitlement must be approved by the Chief People Officer and the CFO. In certain cases, additional approval should be sought from NHS England & Improvement and/ or HM Treasury.

22.3 The out of court settlement of Employment Tribunal applications shall only be made where the Chief People Officer advises it to be prudent so to do and only after taking into account the monetary sum involved and any legal advice received. The limits are as follows:

Value of Payment	**Approval**
Up to £30,000	Chief People Officer
£30,001 to £100,000	Chief Executive
£100,000 plus	Trust Board

22.4 NHS England & Improvement must be consulted before making any special payments that are novel, contentious or repercussive. The Chief People Officer, in the case of any compromise agreements, shall submit a business case to be approved by Treasury. Any payments made against/contrary to legal advice must be approved by the Trust Board.

23. WHOLLY OWNED SUBSIDIARIES

23.1 Subsidiary companies are separate, distinct legal entities for commercial purposes and have distinct taxation, regulatory and liability obligations. As a separate, independent company, wholly owned subsidiaries are subject to their own governance arrangements, which are the responsibility of the subsidiary's board of directors, and therefore these Standing Financial Instructions are not applicable. Reference to the subsidiary's documentation will need to be made.

24. RESEARCH

24.1 The undertaking of research by Trust employees within the Trust's premises shall be strictly in accordance with the Trust's policies and strategies on research and shall be subject to approval accordingly.

24.2 Proposals to undertake research shall be fully costed, in accordance with the national guidance, 'Attributing the costs of health and social care research and development' (AcoRD DH2012) using the national costing guidance/templates. Excess treatment costs should be submitted to CRN:Wessex for funding.

24.3 The undertaking of research shall not commit the Trust to future expenditure and no relationship may be entered into with a third party that could affect the impartiality of a future procurement.

24.4 The Standing Orders and other sections of the SFIs apply equally to the undertaking of research and this includes declaration of interests, security of assets, budgetary control, purchasing and contracting, charitable funds, and the section on casual gifts, hospitality and commercial sponsorship.

24.5 The submission of grant applications to support research shall be signed by the Director of Finance or designated representative.

24.6 The agreement covering any undertaking of research shall give cognisance to Trust policies governing Intellectual Property rights. Where there is any lack of clarity this shall be resolved prior to undertaking the project.

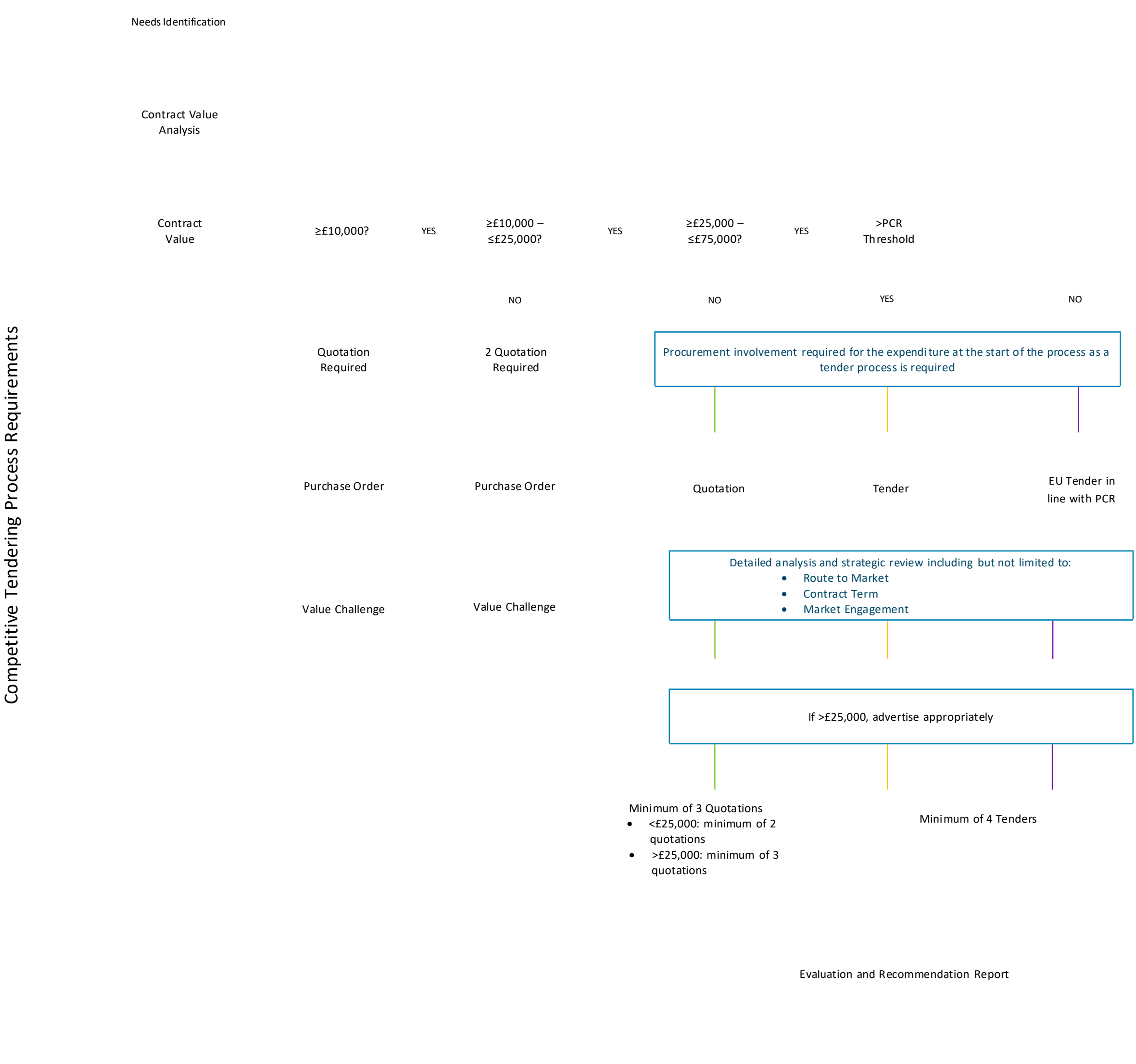
24.7 The principles governing probity and public accountability shall apply equally to work undertaken through research.

Annex 1

Authorisation Levels For Electronic Requisitioning System

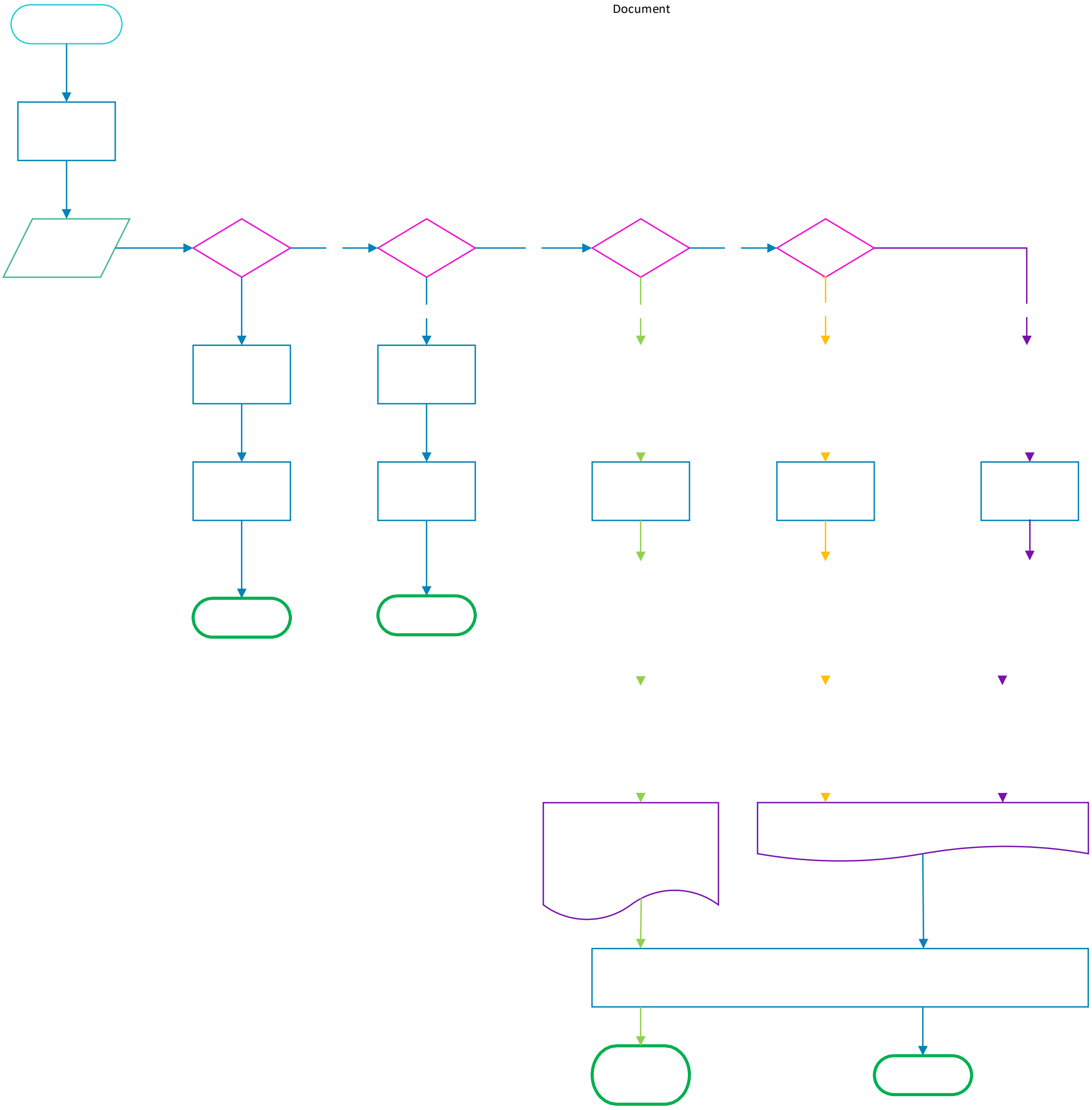
Hierarchy	Abbreviated	iProc Function	Role	Indicative Band for Responsibility	Financial Approval Authority Limit (Financial approval limits are gross (including tax) based on value of transaction)	Non PO Invoice Approval Hierarchy	R12 Invoice Approval Position
Level 1	L1R	Requisitioner	Any	Preferably Band 2 or 3 (several per sub service)	£0	No	RNZ_INVOICE_APPROVER_0000000
Level 2	L2A	Approver	Band 5 if A&C or Band 6 if clin	Band 5 / 6	£1,000	Yes	RNZ_INVOICE_APPROVER_0001000
Level 3	L3A	Approver	Ward Lead or Sub-Service Ma	Band 7	£2,500	Yes	RNZ_INVOICE_APPROVER_0002500
Level 4	L4A	Approver	Head of Service or Clinical Le	Band 8a+ or Clinical Lead	£5,000	Yes	RNZ_INVOICE_APPROVER_0005000
Level 5	L5A	Approver	DMT Core Operational Member	Band 8b or above (8a if delegated DMT member)	£9,999	Only for escalation	RNZ_INVOICE_APPROVER_0009999
Level 5A	L5AA	Approver	DMT Core Operational Member	Band 8b or above (8a if delegated DMT member)	£10,000	Only for escalation	RNZ_INVOICE_APPROVER_0010000
Level 6	L6A	Approver	Divisional Director of Operations (DDO)	Band 8d or 9	£25,000	Only for escalation	RNZ_INVOICE_APPROVER_0025000
Level 7	L7A	Approver	Deputy Director of Finance / Financial Controller/Director of Procurement		£50,000	Only for escalation	RNZ_INVOICE_APPROVER_0050000
Level 8	L8A	Approver	Chief Operating Officer / Director of Nursing / Medicial Director / Director of OD&P		£100,000	Only for escalation	RNZ_INVOICE_APPROVER_0100000
Level 9	L8A	Approver	Chief Executive / Director of Finance		Over £100,000	Only for escalation	RNZ_INVOICE_APPROVER_9999999
Level U	L8A	Approver	Chief Executive / Director of Finance		Over £100,000	Only for escalation	RNZ_INVOICE_APPROVER_9999999
Procurement authority to process pre-authorised orders							
		Approver	Director of Procurement		£350,000	Processing Orders only	RNZ_INVOICE_APPROVER_350,000
		Approver	Deputy Director of Procurement		£50,000	Processing Orders only	RNZ_INVOICE_APPROVER_350,000

Annex 2 Tendering & Contracting Procedures (where SFT is the procuring body)



Contract Approval Document

Contract Signed



Annex 3

Contracting for Income - Financial Limits

NON NHS
All limits **exclude** Value Added Tax where applicable.

Lifetime Contract value	**Approval**
Up to £20,000 (Inclusive of zero nominal value)	**Deputy Director of Finance/Director of Procurement**
£20,000 to < £300,000	CFO
£300,000 to <£1.5million	**CEO**
£1.5m +	**Trust Board**

Lifetime Contract value (NHS)
Service Level Agreements
Up to £100,000,000 Director of Finance
Over £100,000,000 Chief Executive

Annex 4

Emergency Powers (Chair's Action)

1. A recommendation to utilise Emergency Powers must be made by the Chief Executive (or Deputy Chief Executive if responsibilities have been delegated) by email to the Chair and at least two other Non-Executive Directors.

2. The request must include the justification for the recommendation, and the reasons for the need to override normal governance procedures.

3. Agreement to proceed is contingent on the approval of CEO, Chair, and at least two Non-Executive Directors. Evidence of the approval must be recorded (email records are sufficient).

4. The exercise of emergency powers shall be reported to the next formal meeting of the Board in public or private (as appropriate) for ratification.

5. Utilising Emergency Powers does not remove the need to subject the recommendation to Trust governance procedures. Business cases, recommendation reports, and any other paper falling within the scope of the Scheme of Delegation should still be reviewed in the forums and committees as set out in the SFIs as a matter of good practice and to ensure risks, mitigations, and benefits have been appropriately explored and challenged.

6. A schedule of decision taken under Emergency Powers should be presented to Audit Committee on a quarterly basis. This schedule should include the reasons for the escalation, as set out in (2.).

NHS
Salisbury
NHS Foundation Trust

Report to:	Trust Board (Public)	Agenda item:	6.1
Date of meeting:	28 March 2023		

Report tile:	Q3 Learning from Deaths Report 2022-23			
Status:	Information	Discussion	Assurance	Approval
	Yes	Yes	Yes	
Approval Process: (where has this paper been reviewed and approved):	Mortality Surveillance Group / Clinical Effectiveness Steering Group CGC 28 March 2023			
Prepared by:	Mr Richard Cole, Trust Mortality Lead Ben Browne, Head of Clinical Effectiveness Dominador De Castro, Clinical Audit Facilitator			
Executive Sponsor: (presenting)	Peter Collins, Chief Medical Officer			

Recommendation:

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

Executive Summary:

Please refer to the summary of learning which is outlined on pages 3-5 of this report. There was a total of 254 inpatient deaths in Q3 (inclusive of patients who died in either the Emergency Department or Hospice).

During Quarter 3 there was/were:

- 1 death where COVID-19 was the primary cause of death (recorded as 1a on the death certificate)
- No stillbirths or neonatal deaths
- No maternal deaths
- 1 death reported in a patient with learning disability
- 4 deaths in patients considered to have a serious mental illness

A total of 225 deaths were scrutinised by the Medical Examiners in Quarter 3 (89% if all inpatient deaths) and 13 Structured Judgement Reviews (SJRs) were requested.

End of Life Care

The Your Views Matter Bereavement survey aims to capture the views and experience of bereaved families.

During Quarter 3:

- 108 families gave consent for the Trust's Your Views Matter bereavement survey to be posted.
- A response rate of 20% (n~ 22) was achieved. This is lower than the average response rate for 2021-22 (39%) and the average response rate seen in Q1 & Q2 (30%)
- 73% of respondents rated the overall end of life care as good or very good. This is an increase on both Q1 and Q2.

National Benchmarks

Latest SHMI (as reported by NHS Digital at the time of publication):

- The SHMI for Salisbury District Hospital for the twelve-month period ending in August 2022 is 1.0698 and for Salisbury Trust is 1.1116. Both are within the expected ranges.

HSMR:

A two-month time lag continues to be applied to the HSMR data to improve the accuracy of our data reporting for the 12-month period (allowing for any potential coding delays). Therefore, the latest HSMR is for the 12-month rolling period ending in August 2022.

- The HSMR (relative risk) for the Trust for the twelve-month period ending in August 2022 is 119.1 and is statistically higher than expected (110.7 – 128.0, 95% confidence limits).
- The HSMR (relative risk) for Salisbury District Hospital (excludes hospice data) for the twelve-month period ending in August 2022 is 113.4 and is statistically higher than expected (104.7 – 122.6).
- Weekday HSMR is 118.2 and weekend HSMR is 125.1. Both are statistically higher than expected.

Although the Trust's SHMI is within the expected range (Sept 2021 - Aug 2022) the HSMR is still statistically (using 95% confidence limits) higher than expected. The HSMR in August 2022 was lower than in July 2022 but still higher than expected, with the gap between the observed rolling 12-month trend and the expected rate widening.

Commissioned reviews have been set up in response to Dr Foster-Telstra alerts and reports. These include a review of a large sample of previously un-reviewed pre-Nov 2022 Covid cases using the new mortality checklist (48 cases); this historic cohort is considered unlikely to reveal concerns or issues because none of the deaths had been flagged by the MEs, but it was felt that an analysis should still be performed of this group with the results being presented to the MSG in Feb 2023.

Pneumonia mortality cases were flagged as a potential outlier (i.e., patients with a diagnosis of pneumonia on admission); a further review of these cases has been established and will be presented at the April MSG. As well as the structured approach to analysis of the Phases of care there will be a focus on EoLC and MCCD.

Regarding acute and unspecified renal failure mortality cases, also an area flagged by Dr Foster-Telstra, deeper analysis showed that no single age range group was an outlier so the whole group is being reviewed using full SJR methodology.

Acute myocardial infarction relative risk mortality in the Trust has been lower than expected statistically between May 2021 and July 2022.

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

Quarter 3 2022/23 Learning from Deaths Report

February 2023

GLOSSARY OF TERMS

CUSUM
A cumulative sum statistical process control chart plots patients' actual outcomes against their expected outcomes sequentially over time. The chart has upper and lower thresholds and breaching this threshold triggers an alert. If patients repeatedly have negative or unexpected outcomes, the chart will continue to rise until an alert is triggered. The line is then reset to half the starting position and plotting of patients continues. The CQC monitor CUSUM's at a 99.9% threshold to determine outliers.

HSMR
The Hospital Standardised Mortality Ratio (HSMR) is the ratio of observed deaths to expected deaths for a basket of 56 diagnosis groups, which represent approximately 80% of in hospital deaths. It is a subset of all and represents about 35% of admitted patient activity.

ME
Medical examiners (MEs) are senior medical doctors who are contracted for a number of sessions a week to undertake medical examiner duties, outside of their usual clinical duties. They are trained in the legal and clinical elements of death certification processes. The purpose of the medical examiner system is to provide greater safeguards for the public by ensuring proper scrutiny of all non-coronial deaths, ensure the appropriate direction of deaths to the coroner, provide a better service for the bereaved and an opportunity for them to raise any concerns to a doctor not involved in the care of the deceased, improve the quality of death certification, and improve the quality of mortality data. The Medical Examiner (ME) system was introduced in April 2020 and was established in the Trust by August 2020.

MSG
The Mortality Surveillance Group (MSG) meets bi-monthly and is responsible for reviewing deaths to identify problems in care and commissioning improvement work, to reduce unwarranted variation and improve patient outcomes. To identify the learning arising from reviews and improvements needed.

PALS
The Patient Advice and Liasion Service (PALS) offers confidential advice, support and information on health-related matters and they provide a point of contact for patients, their families and their carers. A complaint is an expression of dissatisfaction made to an organisation, either written or spoken, and whether justified or not, which requires a formal response from the Chief Executive. A concern is a problem raised that can be resolved/responded to by the clinical or non-clinical teams concerned. Concerns include issues where the patient/family member has said that they don't want to make a formal complaint.

SFT
Salisbury NHS Foundation Trust.

SHMI
The SHMI is the ratio between the actual number of patients who die following hospitalisation at the trust and the number that would be expected to die on the basis of 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.

QUARTER 3 (Q3) LEARNING FROM DEATHS MORTALITY REPORT 2022/23

1. Purpose

To comply with the national requirements of the Learning from Deaths framework, Trust Boards must publish information on deaths, reviews and investigations via a quarterly report to a public board meeting.

2. Background

The Learning from Deaths initiative aims to promote learning and improve how Trusts support and engage bereaved families and carers of those who die in our care.

3. Summary of Learning in Q3

The Trust MSG met on 8th Nov 2022, Chaired by the new Trust Mortality Lead; further learning, improvement themes, and actions relevant to in-hospital deaths were discussed. Consideration to be given to targeted subgroup analysis of Dr Foster-Telstra flagged areas (diagnosis groups where the Trust was an outlier based on statistical modelling). It was agreed to work towards standardisation of Trust Morbidity and Mortality meetings with an emphasis on documentation of learning points and also actions which might be applicable beyond the individual specialty.

3.1. SJRs and The Medical Examiner System

89% of deaths were scrutunised by the MEs in Q3, with thirteen Structured Judgement Reviews (SJRs) requested, an increase on Q2. Indications for these reviews are indicated in the relevant section of this report. The SJR form is being upgraded to include MCCD (cause of death) and a section to capture additional learning points or any change in practice which might have been identified. Medical Examiner (ME) community roll-out is due to become statutory by Spring 2023. An additional Medical Examiner Officer (MEO) has been appointed which takes the Trust's whole-time equivalents from 1.6 to 2.2, closer to the national benchmark. Additional office space for this work would be beneficial and a business case in progress.

3.2. Serious Incidents Requiring Investigation (SIIs) / Case Reviews

There were no reports relating to SIIs resulting in death.

The Intensive Care National Audit and Research Centre (ICNARC) presentation to the MSG in November 2022 confirmed that the Trust's good quality of care (for example, Covid ICU mortality being lower than nationally) was not due to lower risk cases being admitted to ICU.

Case reviews - for Morbidity and Mortality meetings, adoption of new standardised Review forms was agreed and now in process. This is for non-ME triggered SJRs and consists primarily of a checklist for all specialties' lower-level reviews together with a section for learning points. These have been tailored initially to each specialty's requirements but with the intention for these to converge into a standard dataset to allow interrogation of the new mortality audit online platform once this has been introduced. Learning relevant outside the individual specialty will be shared across the Trust.

A LeDeR nurse has been appointed by the Trust who will work closely with the mortality team, for example, in reviewing relevant cases needing SJR completion.

3.3. Bereavement

The majority of bereaved families continue to rate the end-of-life care (EoLC) as being "good" or "very good" (73%). EoLC was noted by PALS to constitute fewer than 1% of their total complaints received in Q3. Areas such as relief of symptoms, communication and compassion & dignity had no scores in the "very poor" category, with the majority scored as "very good". Further information can be found in the relevant section of this report.

The new mortality checklist for non-ME triggered Morbidity & Mortality meeting reviews includes a section on detail of end-of-life care, therefore, once incorporated into routine practice, will give further data on the quality of this part of the service and highlight areas for learning and improvement.

3.4. Formal Alerts and Reports

Although the Trust's SHMI is within the expected range (Sept 2021 - Aug 2022) the HSMR is still statistically (using 95% confidence limits) higher than expected. The HSMR in August 2022 was lower than in July 2022 but still higher than expected, with the gap between the observed rolling 12-month trend and the expected rate widening.

Commissioned reviews have been set up in response to Dr Foster-Telstra alerts and reports.

These include a review of a large sample of previously un-reviewed pre-Nov 2022 Covid cases using the new mortality checklist (48 cases); this historic cohort is considered unlikely to reveal concerns or issues because none of the deaths had been flagged by the MEs, but it was felt that an analysis should still be performed of this group with the results being presented to the MSG in Feb 2023.

Pneumonia mortality cases were flagged as a potential outlier (ie, patients with a diagnosis of pneumonia on admission); a further review of these cases has been established and will be presented at the April MSG. As well as the structured approach to analysis of the Phases of care there will be a focus on EoLC and MCCD.

Regarding acute and unspecified renal failure mortality cases, also an area flagged by Dr Foster-Telstra, deeper analysis showed that no single age range group was an outlier so the whole group is being reviewed using full SJR methodology.

Acute myocardial infarction relative risk mortality in the Trust has been lower than expected statistically between May 2021 and July 2022.

4. Summary of Mortality Data for Q3

Summary Of Mortality Data 2022/2023												
Categories	Quarter 1				Quarter 2				Quarter 3			
	April	May	June	**Q1 Total**	July	August	September	**Q2 Total**	October	November	December	**Q3 Total**
All inpatient Deaths (inc. ED and Hospice)	88	84	87	259	88	82	73	243	75	77	102	254
Deaths Reviewed/Scrutinised by the ME	79	72	65	216(83%)	66	64	65	195(80%)	61	71	93	225(89%)
SJRs requested by ME	6	6	5	17	5	1	1	7	1	5	7	13
ED Deaths	5	4	5	14	4	7	4	15	6	5	9	20
Hospice Deaths	9	12	17	38	14	14	12	40	15	10	20	45
SFT Nationally Reported Covid-19 Deaths*	31	6	5	42	19	11	3	33	9	0	2	11
Covid-19 as Primary cause of death (recorded as Covid 1a)	6	1	1	8	6	1	0	7	1	0	0	1
Stillbirth	0	0	1	1	1	0	0	1	0	0	0	0
Neonatal Deaths	0	1	0	1	0	0	0	0	0	0	0	0
Maternal Deaths	0	0	0	0	0	0	0	0	0	0	0	0
Learning Disability Deaths**	0	0	2	2	2	0	0	2	0	0	1	1
Serious Mental Illness**	0	0	0	0	0	0	0	0	0	3	1	4

indicates where an individual has either died within 28-d of a positive swab result and/or COVID-19 has been reported on the death certificate

****as reported by the Medical Examiner***

5. Medical Examiner (ME) and Structured Judgement Reviews (SJR)

The ME system was introduced to ensure excellence in care for the bereaved and learning from deaths to drive improvement. The Medical Examiners aim to scrutinise all acute hospital deaths, and a local network of MEs exists to share learning and provide an independent review facility if needed.

- **13 Structured Judgement Reviews were requested by the Medical Examiners in Q3.**

The requests (identified through ME screening) have been categorised into problem themes and stage of care (see Table 1 below).

Table 1: Problems in Care Identified by ME Screening–Quarter 3, 2022-23

Type of problem	*Stage of Care* →							
	Admission and initial assessment (first 24 hours)	Ongoing care	Care during a procedure	Perioperative/procedure care	End of life care (or discharge care)	Concerns about over all care	**2022/23 YTD**	***2021/22 YEAR TOTAL***
Problem in assessment, investigation or diagnosis (including assessment of pressure ulcer risk, venous thromboembolism (VTE) risk, history of falls)	*2*	2					***5***	*17*
Problem with medication / IV fluids / electrolytes / oxygen							***1***	*3*
Problem related to treatment and management plan (including prevention of pressure ulcers, falls, VTE)						*1*	***5***	*7*
Problem with infection control							***0***	*0*
Problem related to operation/invasive procedure (other than infection control)		*1*					***1***	*4*
Problem in clinical monitoring (including failure to plan, to undertake, or to recognise and respond to changes)	*1*					*1*	***2***	*13*
Problem in resuscitation following a cardiac or respiratory arrest (including cardiopulmonary resuscitation (CPR))							***0***	*0*
Problem of any other type not fitting the categories above						5	***22***	*24*
2022/23 YTD	***3***	***5***	***0***	***0***	***3***	***26***		
2021/22 YEAR TOTAL	*9*	*24*	*3*	*3*	*4*	*25*		

6. Your Views Matter Survey & End of Life Care

The Your Views Matter Bereavement survey was established in 2020 and was created to capture the views and experiences of bereaved relatives. This is an opportunity for families to feedback their experiences about the support they themselves received and the end of life care their loved one was given during their last days of life in Salisbury Hospital. Whilst the feedback is anonymous, relatives are able to name individuals they would like to acknowledge and thank for making a difference. Likewise, where the experience was less than satisfactory those completing the survey also have the option to enclose their contact details and be followed up by the PALS team.

Table 1.1 Overall rating of experience for Q3 2022-23 –

Very poor & Poor	Adequate	Good & Very good	Not rated
14% (n~3)	14% (n~3)	73% (n~16)	0% (n~0)

In Q3, 108 families gave consent for the Trust's Your Views Matter bereavement survey to be posted. A response rate of 20% (n~ 22), was achieved but this is noted to be considerably lower, than the average response rate for 2021-2022 (39%) and the average response rate seen in Q1 & Q2 (30%).

Figure 1.3 Relief of symptoms

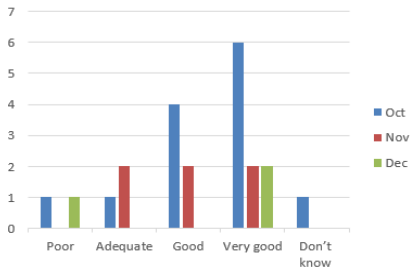


Figure 1.4 Communication

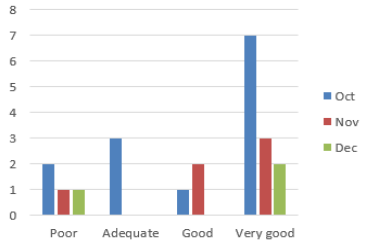


Figure 1.5 Compassion and dignity

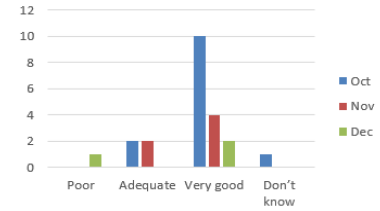
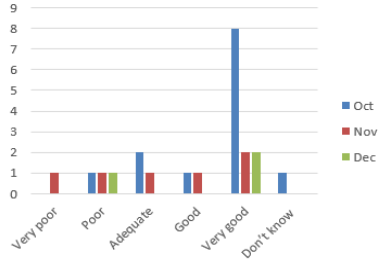


Figure 1.6 Support for loved ones



73% of respondents rated the overall end of life care as good or very good. This is an increase on both Q1 and Q2.

Figures 1.3 to 1.6 show the overall ratings in the key areas of patient experience:

- Relief of symptoms
- Communication
- Compassion and Dignity
- Support for loved ones

In Q1 and Q2 'End of Life Care' was noted as significant theme for complaints being received into PALS, however, this theme is noted to be at less than 1% of the total number of complaints received during Q3.

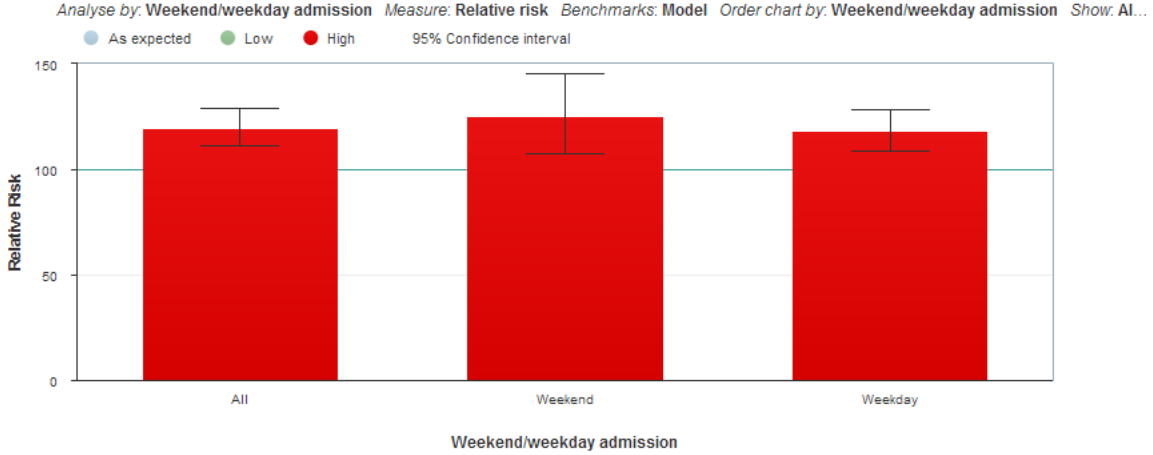
7. Mortality Benchmarking

A two month time lag has been applied to the HSMR data to improve the accuracy of data for the 12-month time period. This is due to a potential coding backlog for the two most recent months of discharge data. Therefore, the latest HSMR is for the 12-month rolling period ending in August 2022.

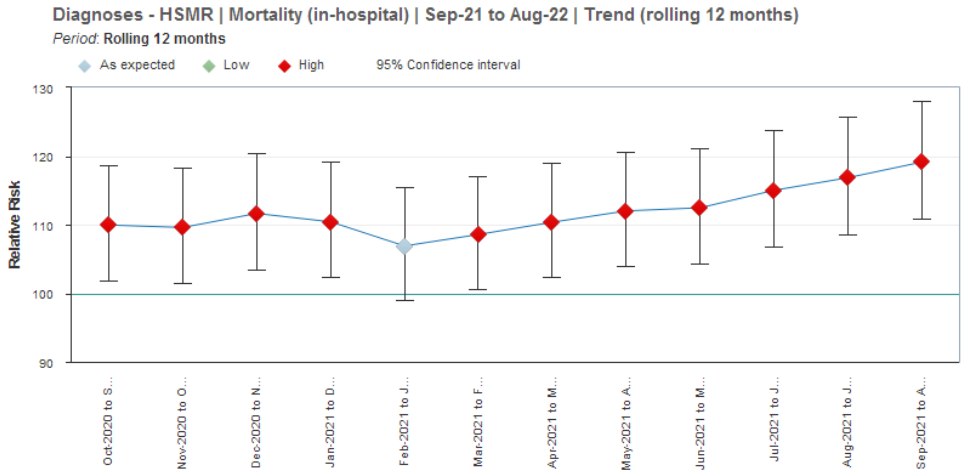
7.1. HSMR rolling 12-month trend to August '22

- The HSMR (relative risk) for the Trust for the twelve month period ending in August 2022 is 119.1 and is statistically higher than expected (110.7 – 128.0, 95% confidence limits).
- The HSMR (relative risk) for Salisbury District Hospital (excludes hospice data) for the twelve month period ending in August 2022 is 113.4 and is statistically higher than expected (104.7 – 122.6).
- Weekday HSMR is 118.2 and weekend HSMR is 125.1. Both are statistically higher than expected.

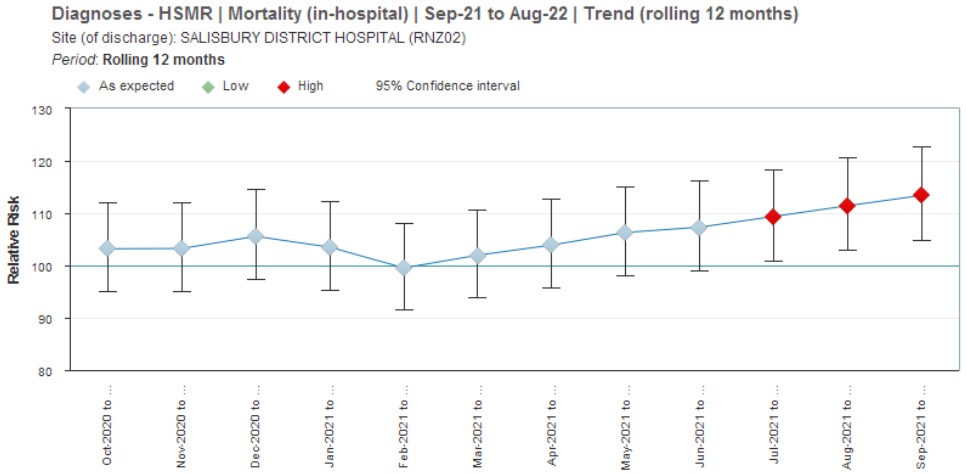
Weekend/weekday HSMR



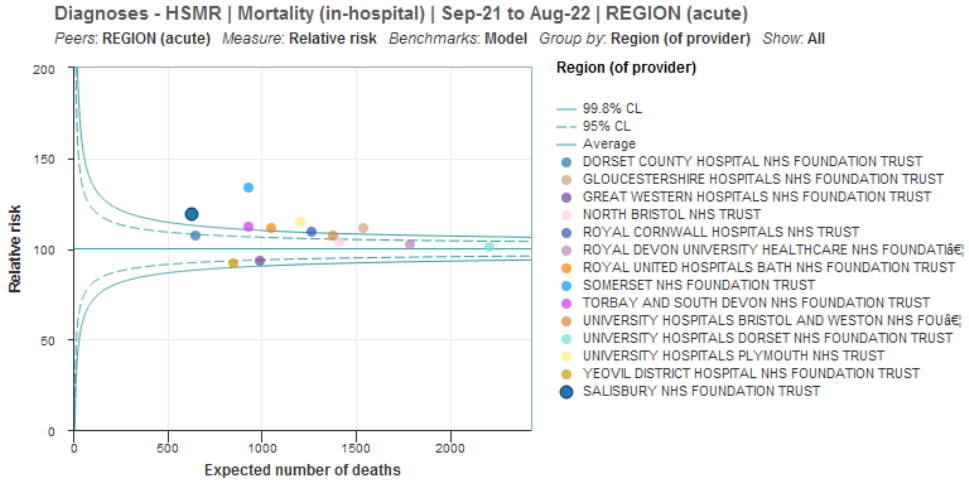
Trust HSMR - Rolling 12-month trend to year-end August 2022



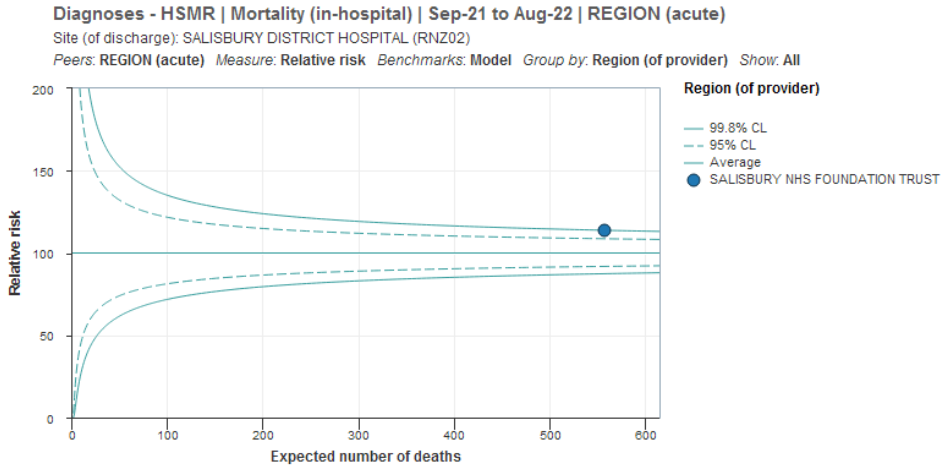
District Hospital HSMR (excludes hospice data) – Rolling 12-month trend to year-end August 2022



Peer comparison of Trust HSMR - Rolling 12-month trend to year-end August 2022



District Hospital HSMR - Rolling 12-month trend to year-end August 2022



7.2. Summary Hospital-Level Mortality Indicator (SHMI) for September 2021 – August 2022

The SHMI is an indicator which reports on mortality at Trust level across the NHS in England and it is published as an official statistic by NHS Digital. The latest available data is published in this report.

- **SHMI is 1.1116 for the twelve month period ending in August 2022 for SFT. When comparing SHMI by site, Salisbury District Hospital is 1.0698 and Salisbury Hospice is 2.2986.** When compared with regional peers, the Trust has a SHMI within the expected range.

Site code	Site name	Provider spells	Observed deaths	Expected deaths	SHMI value
RNZ02	Salisbury District Hospital	33,735	955	890	1.0698
RNZ78	Salisbury Hospice	105	70	30	2.2986

- The tables in the supplementary data pack show additional SHMI data for SFT as a breakdown for specific conditions for the twelve month period ending August 2022.

7.3. Alerts

- All new alerts continue to be discussed at the Trust MSG meeting where a further review or investigation into these deaths may be requested. A representative from the information services team and coding department have been invited to attend future meetings to improve our understanding of the data.

8. Recommendations

The report is provided for assurance that the Trust is learning from deaths and making improvements.

Lead Author:
Mr Richard Cole, Trust Mortality Lead
Contributors:
Dr Ben Browne, Head of Clinical Effectiveness
Dominador De Castro, Clinical Audit Facilitator
Approved by Dr Peter Collins, Chief Medical Officer, February 2023 [TBC]

9. *Supplementary Data*

SHMI Data for the 12 Month Period Ending August 2022

SHMI – Summary Hospital Mortality Indicator

Period: Sep 21 - Aug 22

Provider: RNZ - SALISBURY NHS FOUNDATION TRUST

Region: NHS ENGLAND SOUTH WEST (SOUTH WEST NORTH)

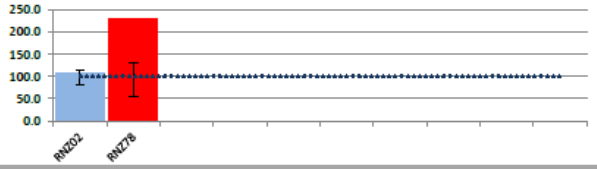
☐ Click to enable bespoke peer

SHMI - Published (With Over Dispersion)

** click group name to filter; click header title to clear*

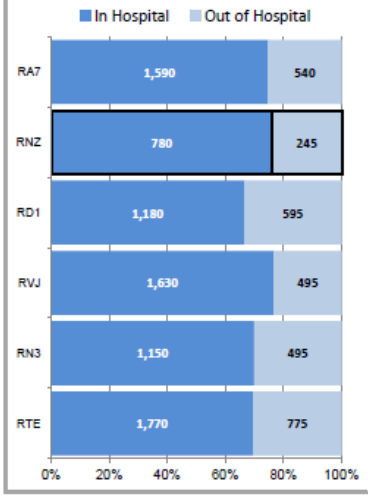
	Provider	Denominator	Obs	Exp	Obs-Exp	SHMI	Low	High
RTE	Gloucestershire Hospitals NHS Foundation Trust	92,975	2,545	2,265	280	112.45	89.56	111.66
RN3	Great Western Hospitals NHS Foundation Trust	54,050	1,645	1,585	60	103.80	89.27	112.02
RVJ	North Bristol NHS Trust	82,515	2,120	2,210	-90	95.97	89.54	111.68
RD1	Royal United Hospitals Bath NHS Foundation Trust	56,175	1,775	1,720	55	103.18	89.34	111.93
RNZ	Salisbury NHS Foundation Trust	33,840	1,025	920	105	111.16	88.61	112.86
RA7	University Hospitals Bristol And Weston NHS Foundation Trust	81,700	2,135	2,150	-15	99.34	89.52	111.71
Group		401,255	11,245	10,850	395	103.64		

Site - All Diagnosis	Den	Obs	Exp	SHMI	Low	High
SALISBURY DISTRICT HOSPITAL	33,735	955	890	106.98	84.92	117.76
SALISBURY HOSPICE	105	70	30	229.86	68.33	146.35

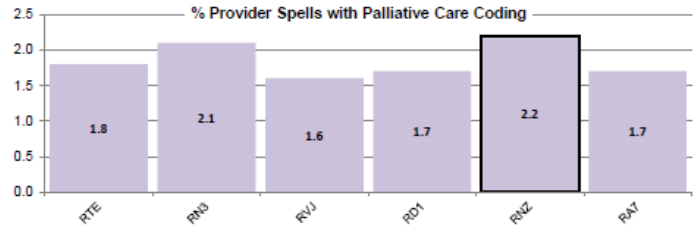


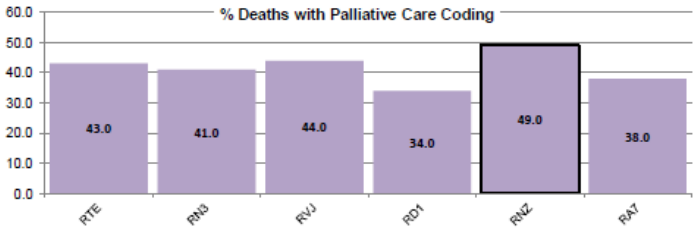
SHMI Group	Obs	Exp	SHMI	Low / High
Septicemia (except in labour), Shock	50	55.00	89.63	75.60 132.27
Cancer of bronchus, lung	35	25.00	139.28	67.64 147.84
Secondary malignancies	40	35.00	112.75	72.25 138.41
Fluid and electrolyte disorders	*	10.00	*	*
Acute myocardial infarction	15	25.00	69.02	67.37 148.43
Pneumonia	135	110.00	119.42	81.10 123.30
Acute bronchitis	20	10.00	154.26	56.34 177.50
Gastrointestinal haemorrhage	10	15.00	85.24	59.31 168.60
Urinary tract infections	25	20.00	116.10	63.10 158.47
Fracture of neck of femur (hip)	25	25.00	97.82	66.49 150.40

Deaths: In / Out Hospital

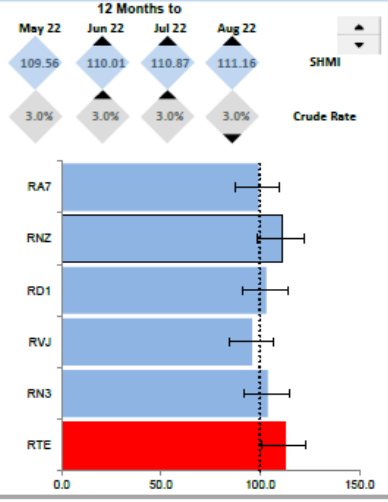


% Palliative Care Coding





Trend / Rate



SHMI Group - With 95% CI (Dr Foster)

SHMI Group	Obs	Exp	SHMI	Low / High
(113) Other connective tissue disease	20	10	200.00	122.11 308.90
(13) Cancer of pancreas	20	10	200.00	122.11 308.90
(99) Acute and unspecified renal failure	30	20	150.00	101.18 214.14
(75) Chronic obstructive pulmonary disease and bronchiectasis	30	20	150.00	101.18 214.14
(140) Allergic reactions, Rehabilitation care, fitting of prostheses, and adjustment of	15	10	150.00	83.89 247.42
(66) Acute cerebrovascular disease	60	55	109.09	83.24 140.42
(42) Mental retardation, Senility and organic mental disorders	20	15	133.33	81.41 205.93
(65) Congestive heart failure, nonhypertensive	35	30	116.67	81.25 162.26

** Dr Foster "SHMI Group" values based on published, rounded values with 95% CI's*

HSMR for the 12 month period to August 2022 for SFT (Includes Hospice Data)

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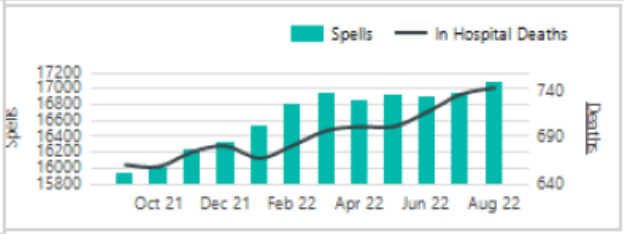
Mortality Summary for 12 months to Aug-2022 as at 01/02/2023

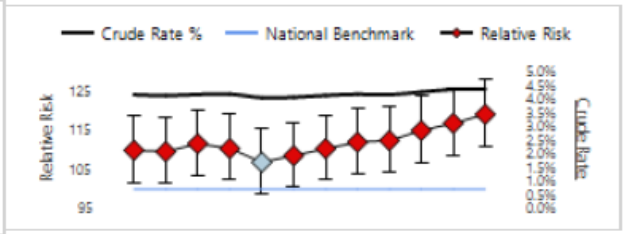
SALISBURY NHS FOUNDATION TRUST - All Sites

Rolling 12 month trends

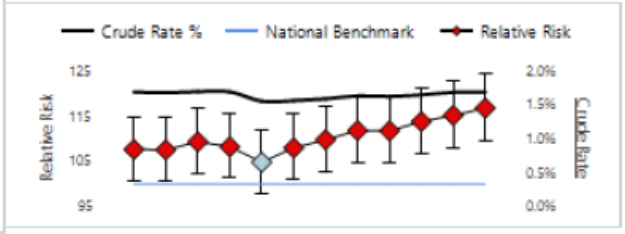
HSMR



HSMR



SMR



Mortality Influencers

Performance	Site	Trust	Peer	National
HSMR		119.1	107.7	100.5
SMR		116.8	107.3	100.2
Non-elective (HSMR)		119.6	107.7	100.2
Weekday, emergency (HSMR)		118.2	105.9	98.7
Weekend, emergency (HSMR)		125.1	113.8	104.5
Saturday, emergency (HSMR)		129.2	113.3	104.4
Sunday, emergency (HSMR)		118.6	114.6	104.6
Coding/Casemix	**Site**	**Trust**	**Peer**	**National**
% Non-elective deaths with palliative care (HSMR)		52.8%	41.0%	40.1%
% Non-elective spells with palliative care (HSMR)		6.5%	4.8%	5.0%
% Spells in Symptoms & Signs chapter		6.3%	6.6%	6.2%
% Non-elective spells with Charlson comorbidity score = 0 (HSMR)		47.6%	42.8%	41.3%
% Non-elective spells with Charlson comorbidity score = 20+ (HSMR)		13.3%	15.1%	15.9%
% Non-elective spells in Risk Band (0-10%) (HSMR)		84.3%	84.4%	83.9%

Diagnosis Groups

Relative Risk Alerts (Top 10)	CUSUM	Obs	Exp	RR	LCI	Trend
Chronic obstructive pulmonary disease and bronchiectasis	2	30	14.0	213.6	144.1	
Acute and unspecified renal failure	1	31	18.1	171.4	116.4	
Pneumonia	1	136	106.7	127.5	107.0	
Secondary malignancies	1	31	19.8	156.8	106.5	
CUSUM 99% Threshold (Top 6)	**CUSUM**	**Obs**	**Exp**	**RR**	**LCI**	**Trend**
Chronic obstructive pulmonary disease and bronchiectasis	2	30	14.0	213.6	144.1	
Acute and unspecified renal failure	1	31	18.1	171.4	116.4	
Pneumonia	1	136	106.7	127.5	107.0	
Secondary malignancies	1	31	19.8	156.8	106.5	
Other connective tissue disease	1	14	9.8	142.2	77.7	
Respiratory failure, insufficiency, arrest (adult)	1	9	6.3	142.2	64.9	
CUSUM 99.9% Threshold (Top 6)	**CUSUM**	**Obs**	**Exp**	**RR**	**LCI**	**Trend**
Chronic obstructive pulmonary disease and bronchiectasis	1	30	14.0	213.6	144.1	
Other connective tissue disease	1	14	9.8	142.2	77.7	
Patient Safety Indicators		**Obs**	**Exp**	**RR**	**LCI**	**Trend**

HSMR for the 12 month period to August 2022 for Salisbury District Hospital (Excludes Hospice Data)

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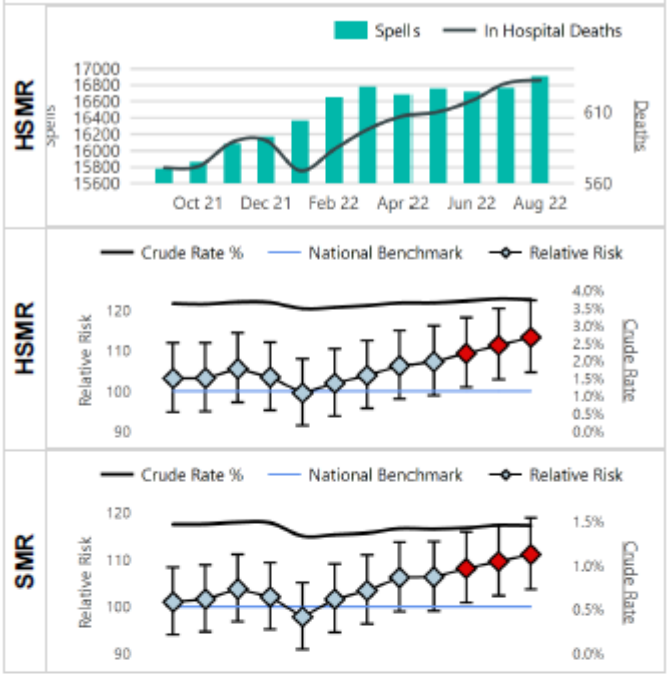
Mortality Summary for 12 months to Aug-2022 as at 01/02/2023

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
Chronic obstructive pulmonary disease and bronchiectasis	2	30	14.0	213.6	144.1	
Acute and unspecified renal failure	1	30	17.6	170.4	114.9	
Pneumonia	1	129	102.0	126.5	105.6	

CUSUM 99% Threshold (Top 6)	CUSUM	Obs	Exp	RR	LCI	Trend
Chronic obstructive pulmonary disease and bronchiectasis	2	30	14.0	213.6	144.1	
Acute and unspecified renal failure	1	30	17.6	170.4	114.9	
Pneumonia	1	129	102.0	126.5	105.6	
Respiratory failure, insufficiency, arrest (adult)	1	9	6.3	142.2	64.9	
Other haematologic conditions	1	1	0.2	560.5	7.3	
Pathological fracture	1	1	0.8	120.3	1.6	

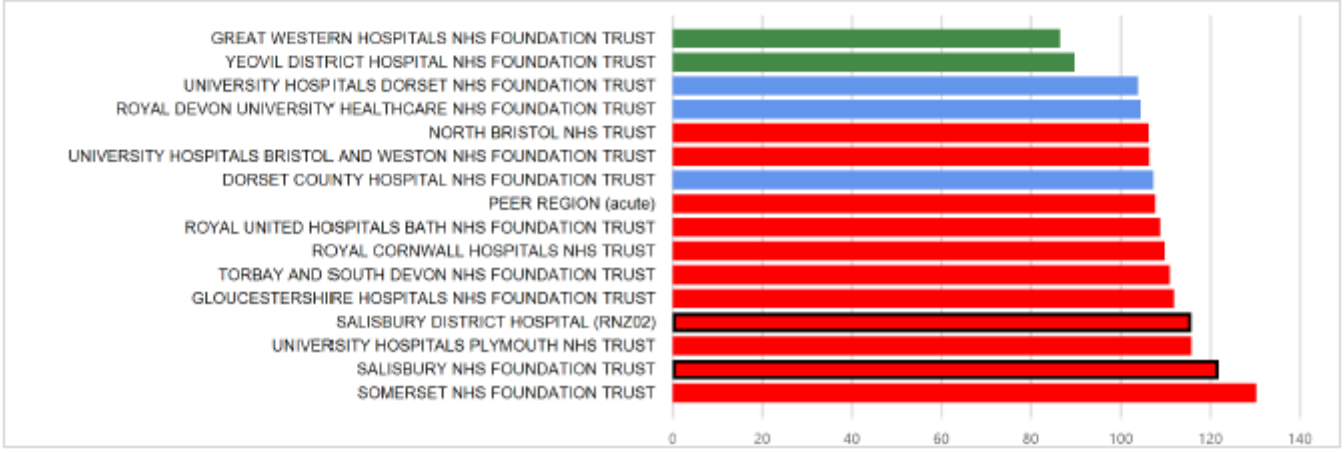
CUSUM 99.9% Threshold (Top 6)	CUSUM	Obs	Exp	RR	LCI	Trend
Chronic obstructive pulmonary disease and bronchiectasis	1	30	14.0	213.6	144.1	

Patient Safety Indicators	Obs	Exp	RR	LCI	Trend

Mortality Influencers

Performance	Site	Trust	Peer	National
HSMR	113.4	119.1	107.7	100.5
SMR	111.1	116.8	107.3	100.2
Non-elective (HSMR)	114.1	119.6	107.7	100.2
Weekday, emergency (HSMR)	112.7	118.2	105.9	98.7
Weekend, emergency (HSMR)	119.0	125.1	113.8	104.5
Saturday, emergency (HSMR)	119.1	129.2	113.3	104.4
Sunday, emergency (HSMR)	116.4	118.6	114.6	104.6
Coding/Casemix	**Site**	**Trust**	**Peer**	**National**
% Non-elective deaths with palliative care (HSMR)	44.6%	52.8%	41.0%	40.1%
% Non-elective spells with palliative care (HSMR)	4.9%	6.5%	4.8%	5.0%
% Spells in Symptoms & Signs chapter	6.3%	6.3%	6.6%	6.2%
% Non-elective spells with Charlson comorbidity score = 0 (HSMR)	48.3%	47.6%	42.8%	41.3%
% Non-elective spells with Charlson comorbidity score = 20+ (HSMR)	12.8%	13.3%	15.1%	15.9%
% Non-elective spells in Risk Band (0-10%) (HSMR)	85.7%	84.3%	84.4%	83.9%

HSMR Peer Comparison

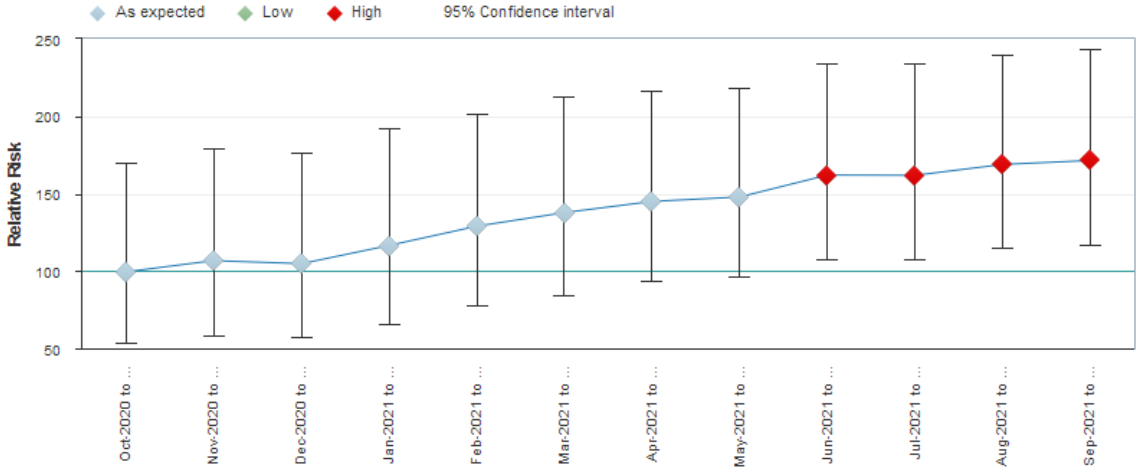


12-Month Trends in Relative Risk for High Risk Diagnosis Groups

Acute and unspecified renal failure | Mortality (in-hospital) | Sep-21 to Aug-22 | Trend (rolling 12 months)

Diagnosis group: Acute and unspecified renal failure

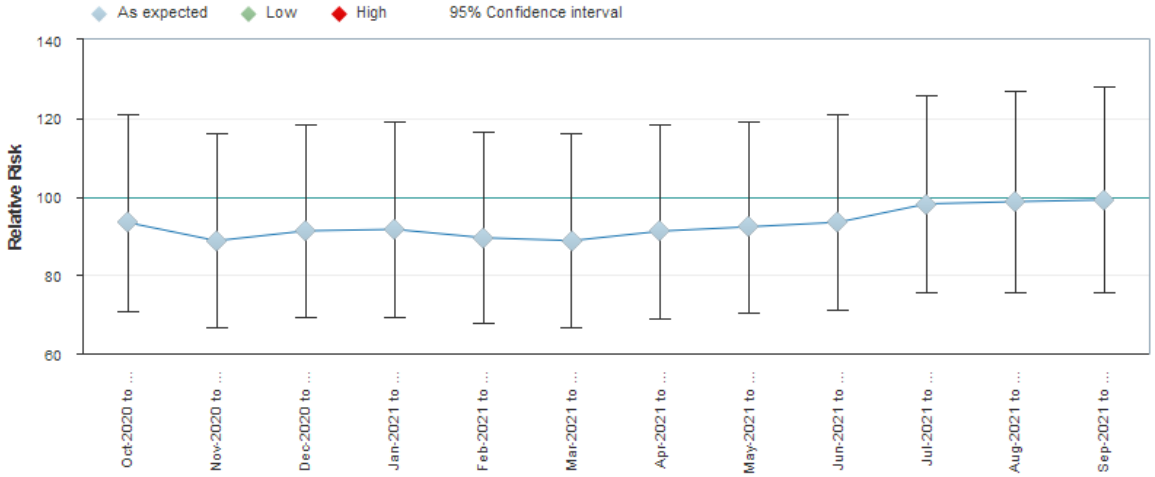
Period: **Rolling 12 months**



Acute cerebrovascular disease | Mortality (in-hospital) | Sep-21 to Aug-22 | Trend (rolling 12 months)

Diagnosis group: Acute cerebrovascular disease

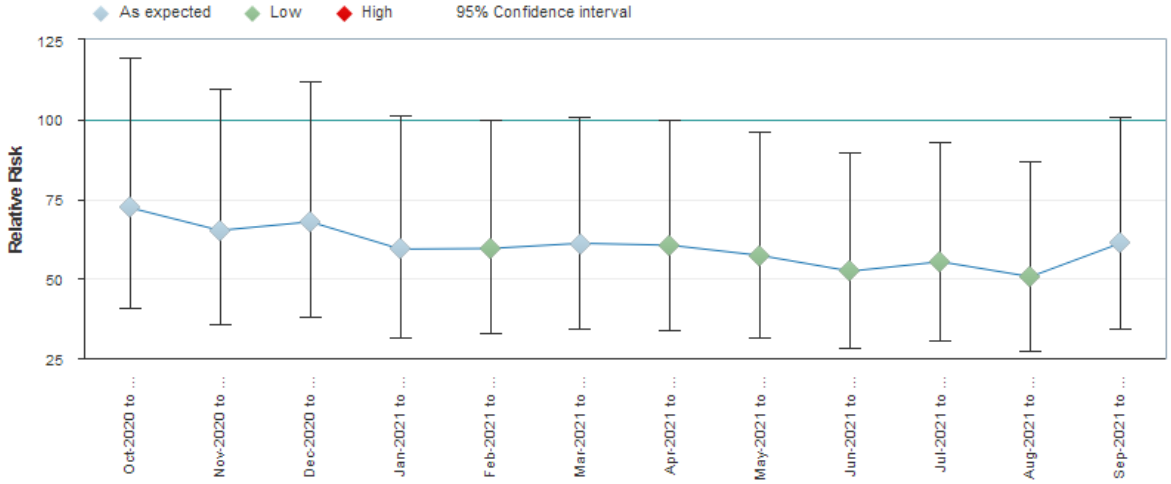
Period: **Rolling 12 months**



Acute myocardial infarction | Mortality (in-hospital) | Sep-21 to Aug-22 | Trend (rolling 12 months)

Diagnosis group: Acute myocardial infarction

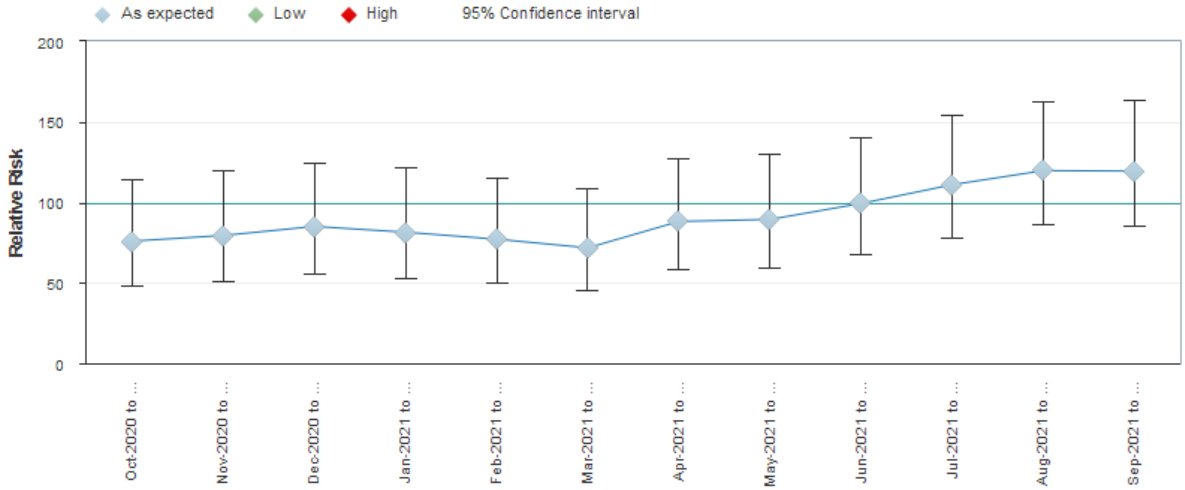
Period: **Rolling 12 months**



Congestive heart failure, nonhypertensive | Mortality (in-hospital) | Sep-21 to Aug-22 | Trend (rolling 12 months)

Diagnosis group: Congestive heart failure, nonhypertensive

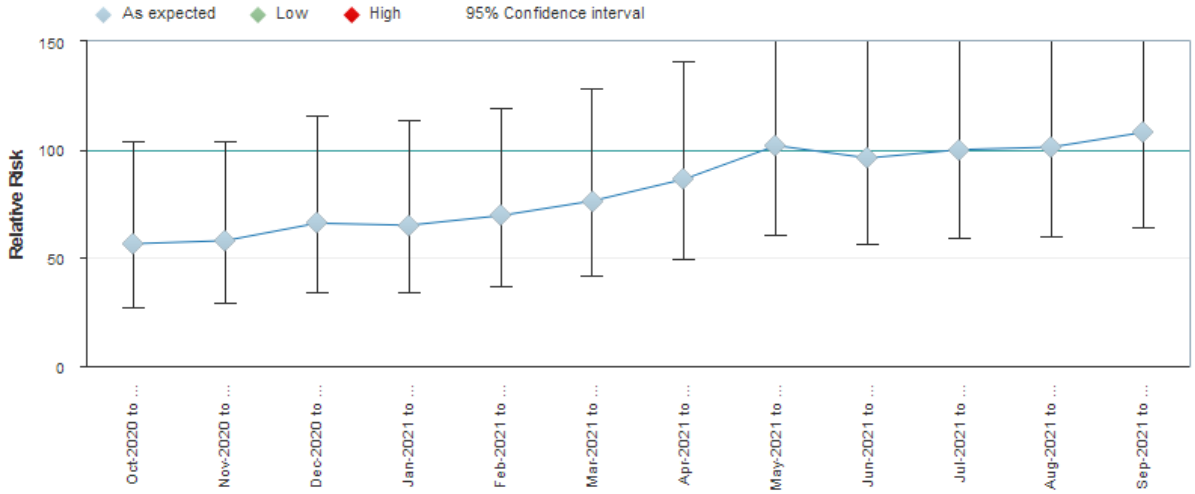
Period: **Rolling 12 months**



Fracture of neck of femur (hip) | Mortality (in-hospital) | Sep-21 to Aug-22 | Trend (rolling 12 months)

Diagnosis group: Fracture of neck of femur (hip)

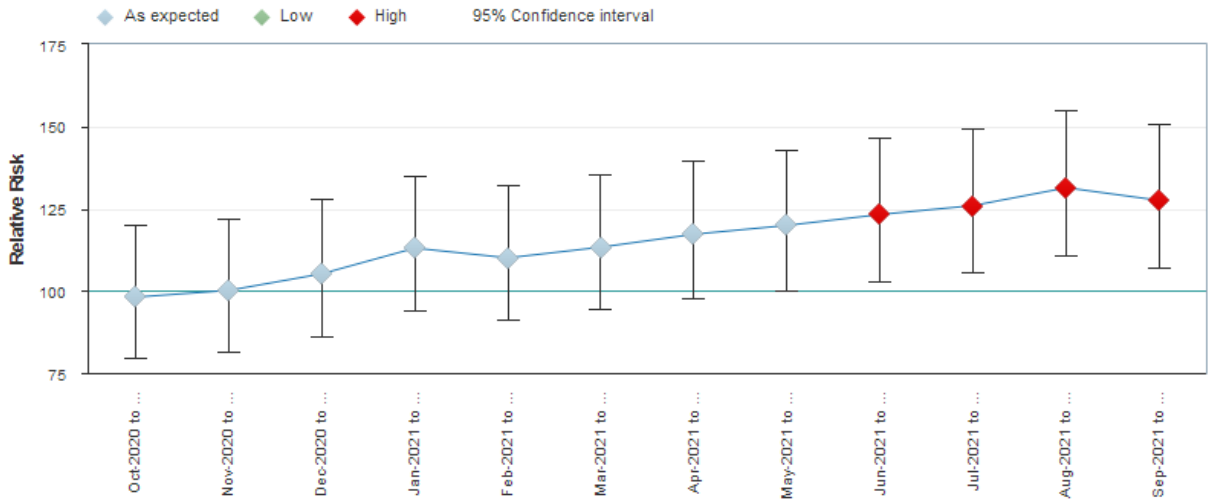
Period: **Rolling 12 months**



Pneumonia | Mortality (in-hospital) | Sep-21 to Aug-22 | Trend (rolling 12 months)

Diagnosis group: Pneumonia

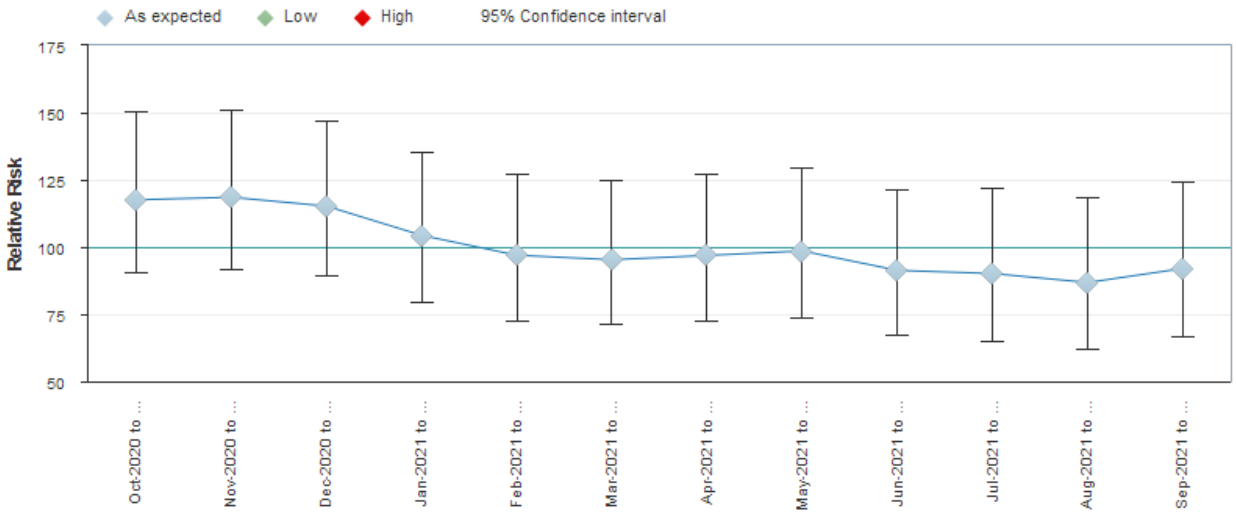
Period: **Rolling 12 months**



Septicemia (except in labour) | Mortality (in-hospital) | Sep-21 to Aug-22 | Trend (rolling 12 months)

Diagnosis group: Septicemia (except in labour)

Period: **Rolling 12 months**



END

Salisbury NHS Foundation Trust

Report to:	Trust Board (Public)	**Agenda item:**	7.1
Date of Meeting:	06 April 2023		

Report Title:	Nursing skill mix review – mid year			
Status:	**Information**	**Discussion**	**Assurance**	**Approval**
	X	X	x	
Prepared by:	Fiona Hyett , Deputy Chief Nursing officer Judy Dyos Chief Nursing officer			
Executive Sponsor (presenting):	Judy Dyos Chief Nursing officer			
Appendices (list if applicable):	Maternity and Neonatal staffing report			

Recommendation:

To note the findings of the Trust position in relation to adherence to the monitored metrics on nurse staffing levels, specifically:

- Temporary staff - % of temporary staff used on rosters
- Approvals – % of rosters fully approved 6 weeks in advance
- Hours balance – maintaining individual staff over/under-contracted hours balance
- Unavailability – % of total time staff are unavailable due to absence broken down by various leaves (study, parenting, sickness, AL) within set limits (headroom)
- Additional Duties - % of duties that are in addition to the agreed demand template levels
- Unfilled duties – % of duties that remain vacant in that roster period
- Hours balance – the balance of net hours utilised within the 4 week rota period
- Care Hours Per Patient Day

Executive Summary:

The last full skill mix review was presented to Trust Board in September 2022. This paper is presented to provide an update and report on key areas and provide assurance of current staffing levels.

This review is intended to provide an update and will focus on the following areas:

- Update and review of recommendations from 2022 skill mix review

- Overview of Insights Data to assure the workforce is deployed efficiently and effectively
- Care Hours Per Patient Day summary
- Maternity/Neonates
- Reflection of winter 2021/22 and impact of Covid-19
- Next steps and relationship with BSW

Positives points within the report
Improved Care Hours Per Patient Day (CHPPD)
Developing partnership across the Acute Hospital Alliance
Neonates fully staffed

Opportunities for improvement
Increased grip and control over agency and bank spend as bed base decreases after winter period
Increased Midwives in pipeline via overseas joint working

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):	

Trust Board March 2023

Title	Nurse Skill Mix Review Update
Meeting Date	April 2023
Executive Sponsor	Judy Dyos – Chief Nursing Officer
Author	Fiona Hyett - Deputy Chief Nursing Officer

1.0 Background

This report provides an update on the full skill mix review that took place in August 2022 and forms part of the reporting requirements that every Trust is expected to have in place. The National Quality Board guidance on Safe Staffing (2016) sets out in expectation 1 that *' Boards should ensure there is an annual staffing review, with evidence that this is developed using a triangulated approach. …. This should be followed with a comprehensive staffing report to the Board after 6 months to ensure workforce plans are still appropriate. There should also be a review following any service change or where quality or workforce concerns are identified.'*

The last full skill mix review was presented to Trust Board in September 2022. This paper is presented to provide an update and report on key areas and provide assurance of current staffing levels.
It is important to note that nursing requirements do change overtime and within the year, due to the acuity/dependency and overall case mix changes. The legacy of the Covid-19 pandemic and maintenance of elective recovery programme will continue to impact on nurse staffing levels.

This review is intended to provide an update and will focus on the following areas:

- Update and review of recommendations from 2022 skill mix review
- Overview of Insights Data to assure the workforce is deployed efficiently and effectively
- Care Hours Per Patient Day summary
- Maternity/Neonates
- Reflection of winter 2021/22 and impact of Covid-19
- Next steps and relationship with BSW

2.0 Review of Previous Recommendations

In August 2022 a total of £918,581 additional funding to support changes to ward establishment was requested, which following review and prioritisation £514,736 was supported and approved by Board subject to budget setting process and cycle. The table below summarises the requests approved to go into budget setting for 2023/24.

WARD	BANDING and WTE	ROLE/SHIFT	COST
ED	B7 1.0 wte	Practice Educator	£63,932
	B7 1.0 wte	Paediatric Lead	£63,932
	Uplift of 4.5 wte B5 to B6	Additional B6 on LD and N shift to provide safety, oversight and leadership	£52,002
	B6 1.11 wte	Headroom uplift 24% to 27%	£64,980
AMU	B5 3wte	Ensure minimum standard of 1:6 ratio maintained 24/7	£142,551
Amesbury	B5 to B6 1.0 we	Enable B6 allocation 24/7	£11,556
Longford	B6 1.96wte	Additional RN on late and night and senior leadership presence across ward footprint.	£115,783
		TOTAL	**£514,736**

Extract from 2022 Skill Mix review, costings correct at the time of Board report September 2022.

Given the budget setting process for 2023/24 is ongoing, these recommendations are yet to be implemented and therefore impact fully realised.

On-going turnover rates above 10% (12% for RNs and 19% for HCAs), high sickness and absence rates, and ongoing escalation areas which whilst funded are not recruited to, results in wards remaining challenged in realising the impact of skill mix reviews.

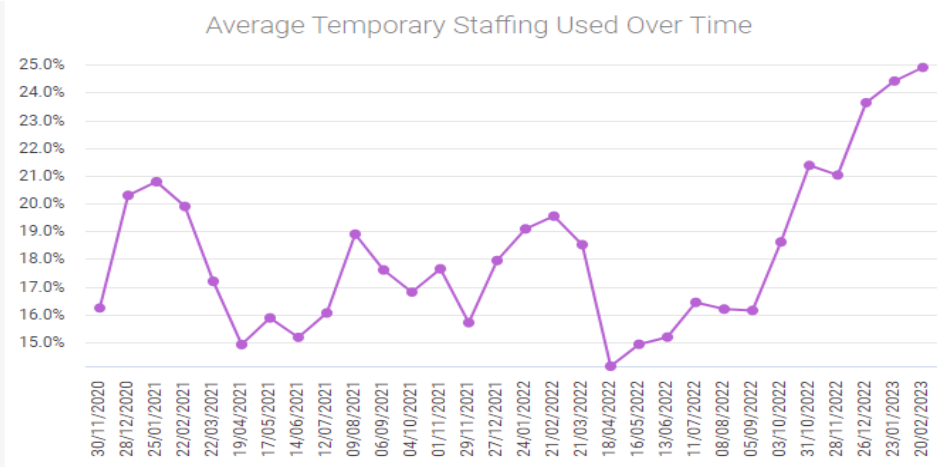
3.0 Overview of Insights Data to assure the workforce is deployed efficiently and effectively

The Safe Staffing Steering Group monitors seven core KPIs to assess the efficient and effective use of the nursing workforce against establishment. In addition to this monitoring, the E-Roster lead regularly supports and proactively engages with leads and services at risk of deviation and puts measures in place to make improvements with stakeholders.

- **Temporary staff** - % of temporary staff used on rosters
- **Approvals** – % of rosters fully approved 6 weeks in advance
- **Hours balance** – maintaining individual staff over/under-contracted hours balance
- **Unavailability** – % of total time staff are unavailable due to absence broken down by various leaves (study, parenting, sickness, AL) within set limits (headroom)
- **Additional Duties** - % of duties that are in addition to the agreed demand template levels
- **Unfilled duties** – % of duties that remain vacant in that roster period
- **Hours balance** – the balance of net hours utilised within the 4 week rota period

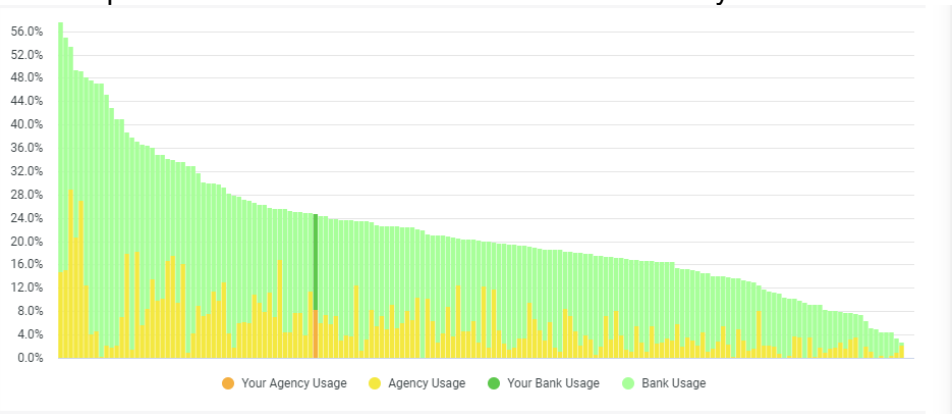
These metrics are viewable via an additional portal from rostering supplier Allocate, which provides a view of our performance internally as a Trust, with ability to read data and comparisons at both ward/dept level as well as against other Trusts (who use the software) including those of similar size, Foundation Trusts and Acute Trusts. Analysis below provides detail of each key metric and our current performance.
An overview graph and narrative has been provided for each metric.

3.1 Temporary staffing

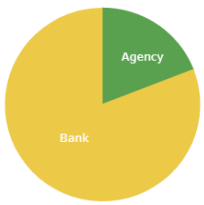


The Trust average over the past year varies significantly but with a pattern of peaks in the winter period. However, since October 22 this can be seen to have increased considerably and for March 23 is at 24.9% (with agency at 8.4%) – this is a likely combination of both winter pressures and additional activity being open and staff using up leave at the end of the year. Over the last 2 months there has also been an increase in the number of patients requiring mental health support.

The graph below shows how we compare to other Trusts and whilst we compare favourably this is a position that has deteriorated over the last few years:



Over the last year the temporary staffing split between bank and agency:

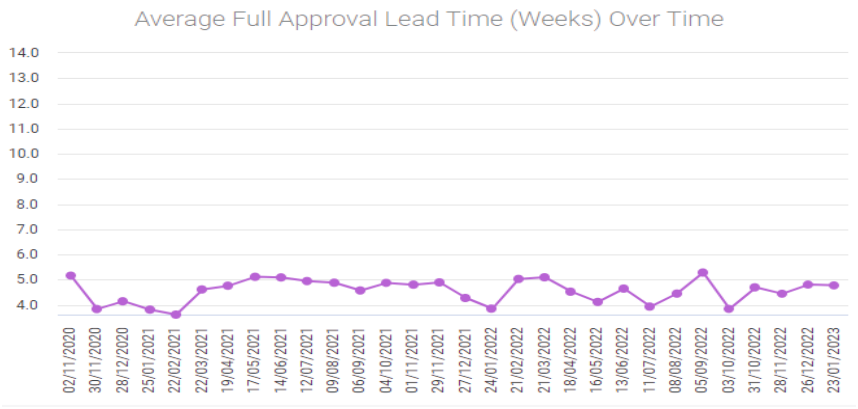


9,327 shifts were filled by agency
39, 427 with bank

Analysis of bank shows that proportionately equal numbers or RN and HCA shifts are covered and across the week there is an equal spread of shifts going out to bank across the

days of the week, with a slight peak on Sundays. Night shifts and weekends have a better fill rate due to the higher rates of pay offered.

3.2 Approvals

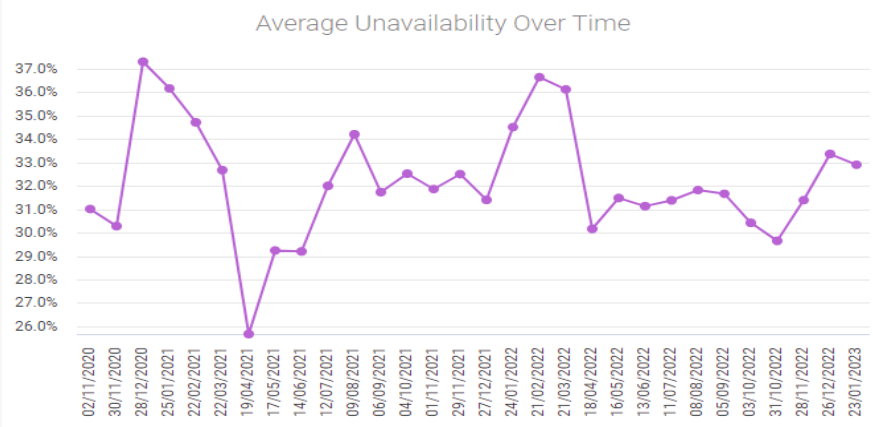


Approval lead time March 2022 to February 2023 was an average of 4.5 weeks against a KPI of 6 weeks in advance. The 6 week lead time has been proven to have a positive effect on other metrics such as reducing sickness levels and temporary staff use as well as qualitative measures such as improved staff satisfaction and wellbeing. Some Trusts have 10-12 week approval lead times to realise further on these benefits but this needs to be balanced against impact of disadvantaging new starters and additional work when someone leaves as notice period is less than lead time.
In comparison to other Trusts we sit mid point with a range of 2-10 weeks.

Most wards aim to complete their rotas six weeks in advance and some areas consistently achieve this, there are delays with 2nd sign off process where a matron has not approved the roster. The E-roster manager highlights these delays in the monthly report to safe staffing and follows this up individually. Reasons for rosters not being approved in time are generally because there is a good level of challenge from the matrons to ensure other KPI's (such as AL, hours balance etc) are being met.

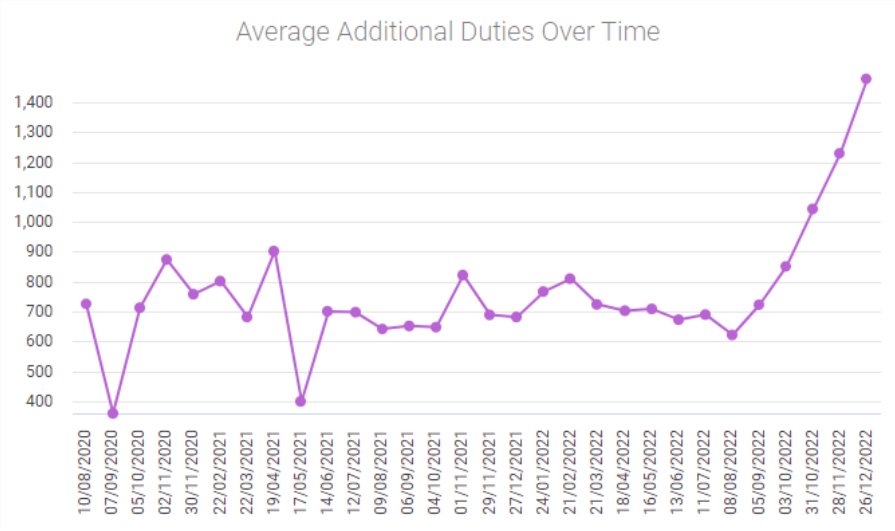
3.3 Unavailability

Unavailability of staff from March 2022 to February 2023 was an average 32% (including parenting) or 27.89 % when benchmarked against our organisational headroom of 24%. Unavailability is made up of Annual leave, sickness, study leave, working days and other leaves (emergency, birthday, carers etc).
January 2023 had an increase of other leave due to the RCN strike and 247 staff recorded as absent that otherwise would have been at work.



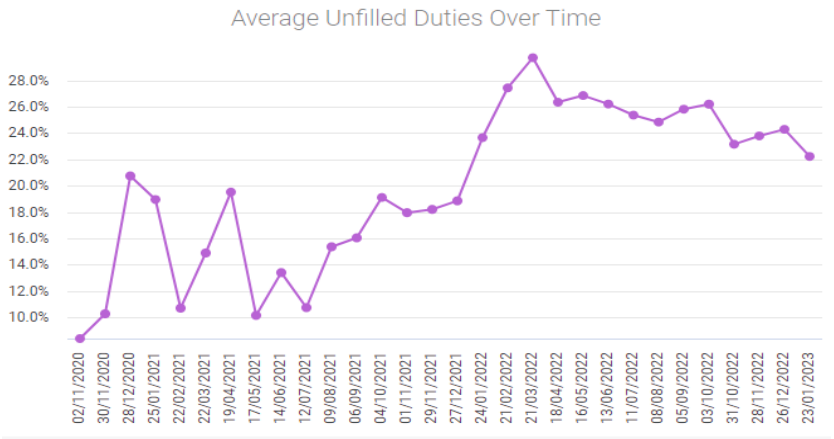
3.4 Additional Duties

Average additional duties over the last year have sat around 800, though since September there has been a month on month increase to a high of 1400. Additional duties are shifts that are added to the rosters above and beyond the established templated duties. Reasons vary from legitimate reasons, such as high patient acuity, seasonal pressures and enhanced care, to avoidable reasons, such as using up staff hours & staff requests.
The most common reasons in the last 12 months are enhanced care, additional beds/capacity (highest in areas such as DSU, Longford and ED) and RMN requirement which have been needed in areas such as Sarum, Whiteparish and Pitton.
The increase in additional duties can be linked to the increase in nurse agency costs – additional duties are normally fulfilled by temporary staff or staff doing additional hours.
The spike in additional duties will be reviewed to understand actual drivers and ways of reducing demand.



3.5 Unfilled duties

Average unfilled duties March 2022 to February 23 was 25.5%- which is an increase of 7% compared to last years report. Unfilled duties are shifts that go unworked or are not cancelled back/removed from a roster if they are not required. Some unfilled duties will also be driven by our own tactics in achieving whatever form of coverage of temporary staffing we can, by making additional shifts on some wards in the hope they will fill and can support other areas. However, aspects of general roster housekeeping should be maintained by way of wards cancelling back any unrequired shifts, but with concurrent pressures, this has not always been consistently achievable.
This is an ongoing focus of the Safe Staffing Steering Group and E-Roster lead, as these artificial additional unfilled 'planned' shifts will also adversely impact our CHPPD figures (see section 4.0).



3.6 Hours Balance

Average hours balance between March 2022 and February 2023 was 2.95%. The net hour percentage is the calculated balance between over-contracted and unused hours on the demand template for substantive staff. Best practice has shown that the recommended threshold for both net hours and four weekly hours balance should be +/- 2%.
In comparison to other Trusts we are in the lowest quartile demonstrating good control over hours balances. Monthly analysis of this at Safe Staffing steering group confirms this and often the % with poor compliance that affect our figure are non ward based areas included in our overall trust %. Ward areas have good control and is part of the scrutiny required when signing off a roster.

4.0 Care Hours Per Patient Day

In Lord Carter's Review (2016) Operational Productivity and Performance in English NHS Acute Hospitals: Unwarranted variations.; an approach of reporting Care Hours Per Patient Day (CHPPD) was recommended, to provide a single comparable metric for recording and reporting nursing and care staff deployment. Revised guidance was produced by NHS England (NHSE) in March 2021. The guidance mandates the use of planned versus actual CHPPD to measure deployment of the workforce and this report reflects this methodology.

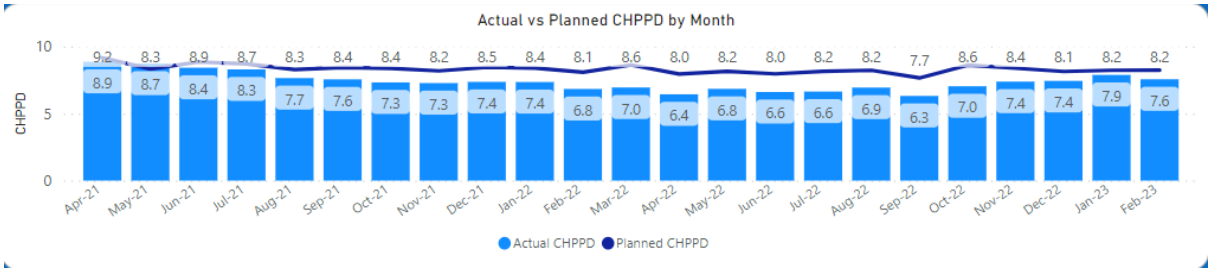
CHPPD data is designed to offer a picture of how staff are deployed and how productively, comparing a ward's CHPPD figure with that of other wards in the hospital, or with similar wards in other hospitals.

Every month, the hours worked during the day and night shifts by registered nurses and midwives and healthcare assistants are added together. Each day, the number of patients occupying beds at midnight is recorded. These figures are added up for the full month and divided by the number of days in the month to calculate the daily average. Then the figure for total hours worked is divided by the daily average number of patients to produce the rate of care hours per patient day.

It is worth noting that CHPPD does not reflect the total amount of care provided on a ward (some staffing groups are not included eg students, therapists, medical staff) nor does it directly show whether care is safe, effective, or responsive. To incorporate these aspects, the use of an acuity tool to inform the 'required' CHPPD must be utilised together with the 'planned' and 'actual' CHPPD figure. Embedding the use of Safer Nursing Care Tool as described in section 5.0 will ensure that the required CHPPD is set appropriately in ward establishments.

Planned CHPPD represents what our wards are established to and the number of RNs and HCAs rostered to work a shift in line with their funded establishment. Actual CHPPD represents that number of staff who actually worked the relevant shift. Therefore, if a shift is short staffed, there will be a discrepancy between actual and planned CHPPD with actual CHPPD being lower than the planned figure.

The graph below shows actual vs planned combined CHPPD, with actual moving closer to planned over recent months. Some variation is expected as adjustments are made to staffing templates in response to skill mix reviews, patient needs in the form of enhanced care needs (use of specials) and how effective staffing coverage and roster housekeeping is maintained.



4.1 CHPPD by ward for selected months

CHPPD should not be used to compare wards against wards, but rather to show a trend in an individual ward over time.

		March 2022			August 2022			February 2023	
WARD	**Speciality**	**RN**	**HCA**	**Total**	**RN**	**HCA**	**Total**	**RN**	**HCA**
AMU	Gen Medical	4.69	2.07	6.76	4.65	2.41	7.06	5.3	2.5
Breamore	Stroke	2.18	2.06	4.24	2.37	2.19	4.56	2.6	2.4
Durrington	Gen medicine	2.76	2.39	5.16	2.71	2.26	4.96	3.1	2.7
Farley	Stroke	3.41	2.45	5.85	3.1	2.07	5.28	3.8	2.6
Hospice	Palliative	5.19	2.85	8.04	6.09	3.15	9.24	6.3	3.8
Laverstock	Resp medicine	3.02	1.66	4.68	2.94	1.85	4.79	3.8	2.0
Longford	Spinal	4.44	3	7.44	4.42	3.81	8.24	4.4	3.8
Pembroke	Oncology	5.54	2.58	8.12	5.97	1.93	7.9	6.4	2.4
Pitton	Geriatric Med	2.78	2.39	5.17	2.5	2.25	4.75	3.0	2.4
Redlynch	Gastroenterology	3.09	2.06	5.15	2.61	2.15	4.76	3.1	2.3
Spire	Geriatric Med	2.53	3.11	5.64	2.65	2.98	5.64	2.9	3.4
S Newton	Gen Med - NCR	n/a	n/a	n/a	n/a	n/a	n/a	4.0	3.6
Tisbury	Cardiology	4.33	1.34	5.66	3.77	1.04	4.82	4.5	1.2
Whiteparish	Gen medicine	3	2.1	5.1	2.88	2.37	5.25	3.4	2.4
Amesbury	T&O	3.29	2.51	5.8	2.81	3.12	5.94	3.2	2.9
Britford	Gen Surgery	6.15	3.2	9.35	5.53	3.06	8.59	5.9	2.9
Chilmark	T+O/Elective	1.69	2.19	3.88	3.24	2.43	5.67	3.1	2.4
Downton	Gen Surgery	3.06	2.81	5.87	3.29	2.58	5.87	3.6	2.8
Radnor	Critical care	24.51	0.96	25.47	24.68	1.14	25.82	28.3	2.0
Odstock	Plastic & Burns	4.48	2.34	6.82	4.73	3.06	7.79	4.9	2.8
Sarum	Paediatrics	8.61	1.59	10.2	11.94	1.74	13.68	10	2.3
Maternity	Obstetrics	8.97	2.77	11.74	9.41	1.83	11.23	9.1	2.0
NICU	Neonatology	15.03	n/a	15.03	10.35	n/a	10.35	13.2	n/a

Data from 2021 sourced from NHSE NHS England » Care hours per patient day (CHPPD) data
Data for January 2022 informatics NHSE submissions

4.2 Peer Comparison

The table below shows comparison of CHPPD across the ICB – a reasonable comparator as the Trusts are similar in size:

	December 2022			June 2022			December 21		
	SFT	RUH	GWH	SFT	RUH	GWH	SFT	RUH	GWH
RN/RM	4.78	4.93	4.5	4.28	4.74	4.06	4.7	4.96	4.82
HCA	2.64	2.96	3.26	2.04	2.98	3.32	2.47	3.25	2.83
Total	7.43	8.12	7.94	6.32	7.91	8.03	7.18	8.54	7.77

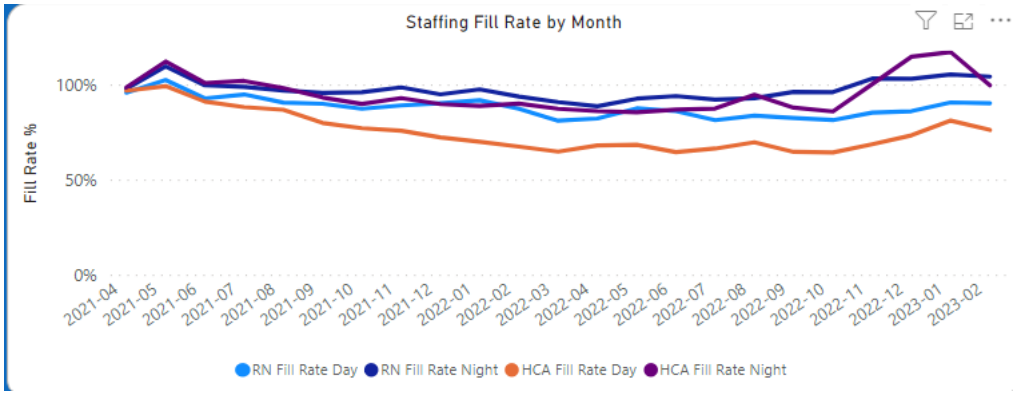
Data extracted from NHS England » Care hours per patient day (CHPPD) data

Whilst CHPPD is a useful comparator with other organisations, some caution should be applied as the total number of ITU services and similar high nurse/patient ratios (where CHPPD rates are consistently much higher) can influence overall data, whereas comparing similar services will be more beneficial. National comparators should be avoided as they are disproportionately impacted by large acute Trusts and specialty hospitals.

4.4 Fill Rates

Fill rates are reported to Trust Board monthly via the IPR. Fill rates refer to the actual staffing levels achieved against the requested shifts. These figures are related to planned CHPPD but will also include the additional shifts posted designed to capture and increase temporary staff coverage.

Fill rates can be seen to be improving, particularly in HCAs where there has been a focused recruitment campaign, and the use of Allocation on Arrival incentive which is particularly popular amongst HCA staff.



5.0 Safer Nursing Care Tool

Developing Workforce Safeguards underpins the requirements for Trusts to undertake a systematic annual staffing review in which evidence-based staffing levels are triangulated with nurse sensitive indicator data and professional judgement. To date the trust has taken the evidence-based staffing element of this from SafeCare, part of the electronic e-rostering system (Allocate). Whilst the actual values and approach are similar between SafeCare and SNCT, current licencing restrictions has meant that for future skill mix reviews we adopt the licenced and evidenced based tool Safer Nursing Care Tool (SNCT), which is currently the only tool to have been endorsed by NICE.

SafeCare provides a good indicator of patient acuity and dependency in the moment and supports daily staffing decisions whereas SNCT provides a robust review of highest acuity/dependency score in preceding 24hrs and should be carried out a minimum of 3 times per year to understand base establishment for a clinical area.

Focus on using SafeCare for daily bed meetings has been replaced by using RAG rating status in staffing escalation policy. The re-introduction of a Safer Staffing Matron will encourage matrons to revert to using SafeCare as this provides supported evidence for daily decisions.

Whilst licenses for the use of SNCTs (adult wards, children and young people and acute admission unit) were obtained in August 2021, and subsequently the ED SNCT tool, both Sarum and ED have only undertaken 1 data collection.

A refreshed training programme is commencing with Sarum and ED to ensure that data collection is completed by fully trained senior staff in line with SNCT guidance and licence.

6.0 Acute Health Alliance

The CNO and DCNOs for the three acute Trusts continue to work together to drive a consistent approach to nurse staffing across the ICS. The agreed areas of focus are:

- To work towards a skill mix of 70:30 (currently this is 65:35) recognising that in some areas it will be higher than this due to nature of ward.
- To work towards a minimum staffing ratio of 1RN:7patients across day and night shifts (August skill mix will identify the impact this will have for SFT)
- Regular benchmarking of CHPPD (comparison included in section 4.2)
- Agree standardised approach to the use and proportion of Nursing Associates in skill mix (acknowledging are a valuable resource but the role is not yet fully evaluated in impact on patient outcomes and harm)

7.0 Maternity and Neonatal

The Midwifery workforce is reviewed on a monthly basis alongside acuity and activity, using the evidence-based tool Birthrate+©. Over the last few years the midwife to birth ratio has decreased from 1:30 to 1:28, which is the nationally recommended level and also needs to be seen in the context of rising acuity levels amongst pregnant women. As referenced in the previous skill mix review, maternity services requested an uplift of 1.96 wte (Birthrate Plus) + 4.29 wte (Continuity of Carer at 35%), and the service continues to carry a vacancy of around 10 WTE.

As reported separately through W&NB governance and reporting structures the midwife to birth ratio is tracked trough the dashboard.

Midwives to Births Ratio
(excluding HOM & non clinical time)

Month	Actual Establishment (minus mat leave, sickness and vacancy)	Total Births	Midwife to Birth ratio (rounded) Actual establishment	Midwife to Birth ratio (rounded) budgeted establishment
Aug-23	70.2	191	1:33	1:26
Sep-23	70.2	206	1:35	1:28
Oct-23	65.4	181	1:33	1:25
Nov-23	70.58	170	1:29	1:23
Dec-23	68.2	175	1:31	1:23
Jan-23	68.2	151	1:27	1:24

The ‘birthrate plus’ calculation is included in a 6 monthly staffing review/paper which is due to be presented at CGC in March 2022, with the official birth-rate calculation needing to be done every 2 -3 years.

Table 5. Continuity of Carer modelling from Birthrate Plus® report (May 2021)

SALISBURY NHS TRUST	24% uplift	Version date: 13/05/2021		DRAFT							
TOTAL BIRTHS	2193	The figures are an indication only and should be reviewed as more caseload teams are set up. The staffing totals assume the annual births, community exports and imports remain as in the baseline and there are no other changes to services. The CoC staffing is based on a caseload ratio of 36 cases to 1wte. Factored into core staffing is that 20% of CoC women will require care from core staff on D/S and that 90% of women will require transfer to the p/n ward for maternal and/or fetal reasons. The % may reduce as CoC becomes established. It is advisable to consider minimum staffing on D/S and Maternity Ward as higher % of women are allocated to a CoC team.									
TOTAL COMMUNITY CASES	2756										
ELIGIBLE FOR COC	2023										
Minimum Staffing 24/7 x 1 m/w	Baseline exc CoC	*Core Staffing Nos. per Shift*	CoC 20%	*Core Staffing Nos. per Shift*	CoC 35%	*Core Staffing Nos. per Shift*	CoC 51%	*Core Staffing Nos. per Shift*	CoC 75%	*Core Staffing Nos. per Shift*	CoC 100%	*Core Staffing Nos. per Shift*
5.56												
Core Hospital Services												
Delivery Suite	33.86	*6.09*	30.85	*5.55*	27.86	*5.01*	24.67	*4.44*	19.88	*3.58*	14.90	*2.68*
Maternity Ward	20.95	*3.77*	20.91	*3.76*	20.27	*3.65*	19.59	*3.52*	18.58	*3.34*	17.52	*3.15*
OPD/MAU	7.96		7.96		7.96		7.96		7.96		7.96	
Core Community	25.45		21.99		18.75		15.29		10.10		4.70	
Home births	2.38											
Caseload Teams *includes home births*	0.00		11.24		19.67		28.66		42.15		56.19	
Total Clinical wte PN Band 3s to Band 7/8s	**90.60**		**92.94**		**94.51**		**96.17**		**98.67**		**101.28**	
Variance from BR+ baseline in CLINICAL WTE	0.00		2.35		3.91		5.57		8.07		10.68	
Incremental Variance in Clinical wte			2.35		1.56		1.67		2.50		2.60	
TOTAL CLINICAL, SPECIALIST, MANAGEMENT WTE	**98.75**		**101.31**		**103.01**		**104.83**		**107.55**		**110.39**	
Variance from BR+ baseline in TOTAL WTE			**2.56**		**4.26**		**3.52**		**4.54**		**5.56**	

The Neonatal Service remains a level 2 Local Neonatal unit with 10 cots and continues to comply with the standards set by the British Association of perinatal Medicine (BPAM); an expectation of the National Neonatal network. The department is fully staffed but key challenge within the neonatal service continues to be maintaining level 2 status within the network, where this is a drive to re-designate smaller units alongside a national drive to keep babies out of neo-natal unit.

8.0 Safe Staffing approach

Daily ward staffing numbers have remained challenged over the past six months in the post-pandemic period. Staff sickness (average 5.4% but higher in some clinical areas) and turnover (12% RNs and 19% HCAs) remain high although early signs show improvements in these areas alongside focused recruitment campaigns.
Nurse staffing remains a corporate risk (ID 7039) although the risk score has been reduced from 20 to 15.

To ensure oversight of staffing resources across the Trust three times per day staffing meetings are held. Whilst a RAG staffing matrix is included in the staffing escalation policy this is currently being reviewed to reflect the changes in ward specialities. During the pandemic the focus has faltered on the use of SafeCare to support decision making at staffing meetings and the re-introduction of the Safe Staffing matron will deliver training out to wards to ensure this is re-established and reviewed at staffing meetings to give evidence to judgements on daily staffing levels.

Winter incentives have been from the end of December 2022 – which have included an increase in the standard rate for all bank shifts, Allocation on arrival shifts (£10 and £5 additional payment per hour for RN and HCAs) and Super-enhanced (RNs £40 per hour) aimed at reducing shifts sent to TNS. The introduction of SE shift has influenced behaviours with some areas declining to fill shifts until SE rate offered. However, since the end of January there has been a significant reduction of TNS (except for RMNs). The winter

incentive is subject to a separate cost benefit analysis and consideration for any incentives going into new financial year.

ED is currently an area of concern given pressures on the front door and a high number of vacancies.
A focused approach is being taken to understand the issues and ensure the right solutions are embedded – the department will commence on intensive support which will be broader than nursing.

9.0 Summary and Recommendations

The Board is asked to:

- To note the findings of the 6 monthly skill mix review and the Trust position in relation to adherence to the monitored metrics on nurse staffing levels.
- To note the analysis completed which will be further updated in next full skill mix review expected to completed August/September 2023.
- To note the improvement in rate of CHPPD and fill rates as result of focused and sustained recruitment campaigns.
- To note the delay to date in the roll out of Safer Nursing Care Tool across the Trust to ensure future skill mix reviews will have fully evidence-based staffing data as a triangulation point, with plan to commence with Sarum and ED rapidly followed by ward areas.
- To note that nurse staffing is subject to change due to changes in acuity and dependency and patient volume and these will be reported on in subsequent skill mix reviews.

CLASSIFICATION: please select

Report to:	Trust Board (Appended to Skill Mix Report)	Agenda item:	7.1c
Date of meeting:	28th March 2023		

Report tile:	Maternity and Neonatal bi-annual Staffing report - March 2023			
Status:	Information	Discussion	Assurance	Approval
	Yes		Yes	
Approval Process: (where has this paper been reviewed and approved):	Approved by Women and Newborn Divisional Management Team 14.3.2023			
Prepared by:	Vicki Marston - Deputy Director of Maternity and Neonatal Services			
Executive Sponsor: (presenting)	Judy Dyos - Chief Nursing officer			

Recommendation:

The Board is asked to note the contents of this report which has been provided for information and assurance processes.

In order to demonstrate compliance with the Maternity Incentive scheme the committee is asked to note the specific expectations in relation to demonstrating effective midwifery workforce planning as detailed on page 1-2 of the report.

Executive Summary:

6 Monthly oversight staffing report to be compliant with Maternity Incentive Scheme (Year 4)

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

Maternity and Neonatal Staffing Report - SFT March 2023

This report provides a summary of key midwifery staffing standards within the maternity service at Salisbury NHS Foundation Trust to assure that safe staffing levels are in line with National guidance.

Introduction and purpose

The maternity workforce is reviewed utilising National published responses to maternity staffing:

- Safer Childbirth: Minimum standards for the organisation and the delivery of care in labour (RCOG, RCM 2007, NICE 2019).
- Birthrate Plus (Salisbury assessment 2019 – updated 2021).
- National Quality Board (2018). Safe, sustainable, and productive staffing - An improvement resource for maternity services.
- National Maternity Review: - 'Better Births' (2016) – A five year forward view for maternity care.
- Maternity Workforce Strategy- Transforming the Maternity Workforce HEE March 2019.
- Safer Midwifery Staffing for Maternity Settings (NICE 2015).

In addition, the Maternity Incentive Scheme, (MIS Clinical Negligence Scheme for Trusts), Year 4, sets out clear expectations in relation to demonstrating an effective system of midwifery workforce planning. The required standards are as follows:

a) A systematic, evidence-based process to calculate midwifery staffing establishment is complete.

b) Trust Board to evidence midwifery staffing budget reflects establishment as calculated in as above

c) The Midwifery Coordinator in charge of Labour Ward must have supernumerary status (defined as having no caseload of their own during a shift) to ensure there is an oversight of all birth activity within the service.

d) All women in active labor receive one-to-one care.

e) Submit a bi-annual midwifery staffing oversight report that covers staffing / safety issues to the Board.

Following the cultural and safety reviews that were commissioned within the Trust in 2020 into Maternity services, and reported at the beginning of 2021, a review into the midwifery workforce was completed. Both reviews recommended a significant change to the leadership structure within the service. A revised Maternity structure was agreed in March 2021 and new posts have now been recruited into in. The new structure ensures an increase in leadership roles within the service to meet demand from the regional and national work streams and to ensure clear accountability and responsibility at all levels in the service.

The National Maternity Transformation programme details a particular focus around an increase in continuity of care and personalisation for women alongside the national ambition to reduce the stillbirth, neonatal and maternal death and neonatal brain injury by 50% by 2025. We recognise and embrace the need to make our service as safe as possible for women and babies and are keenly embracing and implementing the recommendations from our safety review, along with acknowledging and actioning the recommendations and points raised in the cultural survey. It was highlighted in both reports the significant impact that appropriate staffing levels have on both safety and staff wellbeing.

Alongside this work, we acknowledge the current media attention around safety as being a high priority agenda within the maternity service, and especially considering the Final report of the Ockenden Review, which was published in early 2022. We are keenly embracing and working towards the recommendations set out by Ockenden.

Methodology

The current midwifery establishment at SFT was calculated using a midwife/birth ratio of 1:26 as recommended by the SFT Birthrate Plus® report in December 2019. Birthrate Plus® is the national workforce tool recommended by NICE (2014). Current funded establishment is based upon a projected total of 2200 births per annum. To monitor the safety of this approach we also use the Birthrate Plus® acuity tool, inputting precise data detailing risk and acuity of inpatients on Labour Ward 4 hourly, and Postnatal 8 hourly. This gives us up to date feedback on the level of safe staffing against the acuity and activity regularly across the day. The tool also measures, by exception, where 1:1 care is not possible for labouring women, and when the labour ward co-ordinator is not able to maintain supernumerary status.

Birthrate Plus® is the only recognised national tool for calculating midwifery staffing levels and provides a robust and proven methodology for determining midwifery staffing establishments. It was recognised that the figures of current clinical establishment presented to Birthrate Plus® in Summer 2019 (that informed the report published in December 2019) included some non-clinical roles within the variance report, and was therefore, inaccurate in this calculation and subsequent recommendations.

Following liaison with Birthrate Plus® in May 2021 and a recalculation of the service requirements, using 2019 clinical data, Birthrate Plus® recalculated our staffing requirements. Table 1 is the updated report from Birthrate Plus® May 2021.

Birth-rate plus recommendation May 2021

Total Births	**2193**
Core Hospital Services	
Delivery Suite	33.86
Postnatal Ward	20.95
Maternity DAU	7.96
Community Inc. Homebirth provision	27.83
Total Clinical wte Band 3-7	**90.60**

Table 1

In addition to the clinical workforce recommendations from Birthrate Plus® the non- clinical workforce is calculated based on a standard % of 9%. This would mean that the non-clinical wte should be 8.15wte. These roles include Named Midwife for Safeguarding Children, Antenatal and Postnatal Screening Leads, Perinatal Mental Health Lead Midwife, Birth Environment Lead, Practice Educator, Fetal Surveillance Lead and Midwifery Matrons. Our non-clinical roles currently sit just above this 9% but this is in part due to external funding of some specialist roles via the LMNS.

The recommendations for clinical staffing for clinical midwives and the budgeted establishment versus current staffing levels (February 2023) are shown in Table 2:

Banding		Clinical Budgeted Establishment Midwivesband 5-7 89.15 (wte)	Actual clinical Headcount (wte) February 2023	Maternity Leave (wte) January 2023	Variance (wte) budget vs actual	Variance (wte) **actual available to work (incl mat leave)** vs Birthrate Plus® 2021 report
Band 5		12.09	5.52	0	-6.57	-2.37
Band 6		70.58	53.86	2.52	-16.72	-19.24
Band 7		6.48	6.8	1	+0.32	+0.32

Table 2

Midwife to Birth Ratio

Birthrate Plus has calculated an individualised midwife to birth ratio for Salisbury, recommending a rate of 1:26. Following review of individualised data this takes into account anticipated levels of risk and safeguarding which both affect the amount of time and care required for women and their families. This rate is reached via calculations between monthly birth numbers and available numbers of midwives. The ratios are analysed monthly and are affected by fluctuating birth numbers and variations in establishment month to month.

Midwives to Births Ratio
(excluding HOM & non clinical time)

Month	Actual Establishment (minus mat leave, sickness and vacancy)	Total Births	Midwife to Birth ratio (rounded) Actual establishment	Midwife to Birth ratio (rounded) budgeted establishment
Aug-23	70.2	191	1:33	1:26
Sep-23	70.2	206	1:35	1:28
Oct-23	65.4	181	1:33	1:25
Nov-23	70.58	170	1:29	1:23
Dec-23	68.2	175	1:31	1:23
Jan-23	68.2	151	1:27	1:24

Table 3

1:1 Care in Labour

The NICE clinical standards dictate that each woman should receive 1:1 care during established labour and childbirth by a trained Midwife or a Trainee Midwife under direct supervision. This is audited monthly and demonstrates excellent compliance as the care of labouring women is always the priority and escalation is utilised when needed to ensure this. Between July and December 2021 compliance with this standard was 100%.

August 2022	100%
September 2022	100%
October 2022	100%
November 2022	100%
December 2022	100%
January 2023	100%

Table 4

Supernumerary Status of Coordinator

One of the safety standards mandated by CNST is the need to have a supernumerary Labour Ward Coordinator leading on every Labour Ward 24-hours a day. We have ensured that our rostering reflects this requirement.

The Birthrate Plus acuity tool monitors this, alongside other red flags, every 4 hours. It also takes into account risk factors, acuity and dependency of women, environmental factors and skill mix enabling the co-ordinator to flex staffing to the need of the service within a shift by redirecting staff and prioritising care. A detailed escalation policy also ensures the coordinator retains this supernumerary status enabling oversight of activity. Supernumerary status of the coordinator was maintained over 99% of the measured occasions in the 6 months this report relates to (Table 4). Detail has been obtained to understand the times this wasn't achieved to ensure we are striving to maintain supernumerary status 100% of the time, and we are assured that the escalation policy is followed at any time this is not achieved.

Number of episodes measured via birthrate plus acuity tool between 1/2/2022 – 31/7/2022	Supernumerary status of Labour Ward coordinator not maintained
1104	7

Table 4

Recruitment

Recruitment to Band 5 and Band 6 clinical posts has been variable in the last 12 months. We recognise that there is a need to balance the junior workforce with experienced staff and the recruitment into senior Band 6 positions is a challenge for Salisbury. Although this is not just isolated to Salisbury, the military population, lack of city lifestyle and size of the maternity service are all contributory factors.

The recruitment team are currently providing focussed individual support, including weekly meetings with the Deputy Director of Maternity responsible for workforce, to ensure recruitment is advertised and promoted as widely as possible and that new starters are assisted into positions in the most efficient timeframes possible.

In recent months there has been a need for a more flexible approach to working across the entire midwifery workforce. An example of this has been to reduce Community Midwifery staffing levels at a weekend to meet acuity demands within the hospital environment – using staff flexibly across areas to meet service needs.

The concept of flexible working across the maternity pathway, rather than having fixed areas of working, as an alternative approach to providing maternity care, is seen as not only a more cost-effective way of working but supports the future vision for continuity of carer. We have adapted to look at varying processes to attract staff, including supporting return to practice

midwives. From a flexible working perspective, we have trialled an increase in requesting for staff, stepping out of the policy dictating numbers of request and doubling them to allow staff more opportunity to balance work and home life.

We have been involved in a collaborative with GWH and Gloucester around recruitment of international midwives, this is a new approach nationally and we have been allocated 6 midwives who are now with us, 1 has completed her OSCE and successfully passed. 5 further international midwives are awaiting an OSCE date. We are expecting another international midwife to join us which will complete this cohort.

In considering the workforce and national shortage of midwives we have considered how we can utilise other clinicians to work within maternity services. We have employed four nurses to assist in caring for women within maternity. They care for women post operatively and support with many of the tasks that the midwives complete; they have been a huge asset to the service and workforce.

We have also been working on a forecast trajectory, looking at vacancies rates against budgeted establishment and factoring in predicted starters (including OSCE qualified International midwives and newly qualified midwives), leavers, agency staff and maternity leave.

	2022/2023					2023/2024											
	M9	M10	M11	M12		M1	M2	M3	M4	M5	M6	M7	M8	M9	M10	M11	M12
BUDGETED WTE B2-4 (MCA)	22.81	22.81	22.81	22.81		21.61	21.61	21.61	21.61	21.61	21.61	21.61	21.61	21.61	21.61	21.61	21.61
TOTAL VACANCY MCA	3.78	4.18	4.49	4.49		0.90	0.90	0.90	0.90	0.90	0.90	0.90	0.90	0.90	0.90	0.90	0.90
BUDGETED WTE CLINICAL MIDWIFE B5-7	89.15	89.15	89.15	89.15		89.15	89.15	89.15	89.15	89.15	89.15	89.15	89.15	89.15	89.15	89.15	89.15
TOTAL VACANCY CLINICAL MW	18.79	21.58	20.49	20.87		15.81	15.81	13.81	13.81	12.81	12.81	13.11	1.91	1.93	3.93	3.93	3.93
CLINICAL MIDWIVES MATERNITY LEAVE	2.92	3.53	3.53	3.53		4.74	7.58	9.02	10.02	9.02	9.02	8.02	8.02	7.10	7.10	6.49	6.49

Table 5

Safety and Overview

In order for the service to demonstrate safe staffing on a daily basis the role of the Maternity Duty Manager plays a fundamental role in responding to the constant changing clinical situations within maternity, both in the building and in the community environment. The Duty Manager is available to provide a 24/7 support to the Maternity and Neonatal Service, providing a helicopter view across all areas and maintaining safety at every level. The Maternity Duty Manager rota is covered by Band 7 and Band 8 midwifery leaders and provides visible responsive leadership to Maternity and Neonatal Services.

Maternity Services continue to report missed breaks via Datix and when the coordinator is unable to maintain their supernumerary status. At such a time the involvement of the Duty Manager and use of the Maternity Escalation Policy ensures oversight and transparency when staffing and incidents occur. Additionally, Red Flag reporting is discussed monthly at the Maternity Risk meeting, with any themes being fed into the Trust Clinical Risk Group.

Staffing is discussed at Maternity Risk monthly, forms part of the Executive Performance Review monthly meetings (as an Improving together divisional driver) and is discussed with the Board level Safety Champions monthly. The reporting mechanisms ensure clear escalation and visibility of staffing challenges.

Challenges and Mitigations

Maternity Leave

Maternity leave has consistently been high in the Maternity Department year on year, and over the past 2-3 years is consistently around 8-10 WTE at any one time. This has impacted on the ability to staff the department on a daily basis. Rates are currently low however they are due to rise significantly from May 2023 throughout this year with up to 9 WTE expected to be on maternity leave form July onwards.

Staffing Levels

With the recalculated Birthrate Plus assessment of the recommended safe staffing levels, maintaining staffing levels is a constant challenge.

This has been escalated to Board level and is being managed accordingly, through a sharing of staffing resources across the midwifery pathways. In addition, we have:

- Utilised Bank Midwives.
- Community staff working flexibly in the unit as and when required.
- Use of Agency Midwives when available.
- Support of Duty Manager day and night as required to coordinate the escalation process ensuring coordination of staff and work as acuity dictates necessary.
- The daily staffing/safety huddle involving clinical leaders across all areas of maternity services, to ensure a team approach to day to day working also contributes to ensuring staff are assigned to clinical areas according to fluctuating activity levels.
- International recruitment of midwives.
- Recruitment of nurses to the maternity Service.

These measures have provided assurance of safety for all women and babies in our care.

It is important to recognise staff wellbeing is impacted with the shortfall of staff within the service and staff are feeling the pressure of this. It is recognised that although staff have undertaken Bank work to close day to day gaps this is not a sustainable long-term solution.

From a pastoral support perspective, we have a retention Professional Midwifery advocate (PMA) in post and have recently received LMNS money to support funding a retention lead for MSW. The PMA post has proved valuable in supporting staff and understanding the reasons they may be considering leaving the service and helping them to find solutions to remaining with us i.e., flexible working for example.

Risks

Delivery of Continuity of Carer Model

In February 2016 Better Births, the report of the National Maternity Review, set out the Five Year Forward View for NHS Maternity Services in England to become safer and more personal. At the heart of its vision is a recommendation that there should be Continuity of Carer to ensure safe care based on a relationship of mutual trust and respect in line with the woman's decisions. In Salisbury a pilot study for Continuity of Carer was established in 2019 and the 'Ivy Team' offered midwives and women the opportunity to foster the recommended pathway of care for certain cohorts of women (birth trauma and previous caesarean birth). The pilot ended in March 2021 due to concerns around entire midwifery workforce skill mix and vacancy rates at Salisbury. When moving towards the continuity model, it is recognised nationally that this will require an increased number of midwives as opposed to the traditional working model. In addition, in the Ockenden report (2022) there was clear guidance advising that if adequate staffing levels were not in place, then continuity of carer should be paused until full establishment of staff was reached. With our vacancy rates we have followed this advice and paused our rollout of continuity at present.

Table 5 demonstrates the required staffing levels needed to achieve Continuity of Carer using SFT data and staffing establishment figures.

It is clear within the report that in order to develop Continuity of Carer to 35% of women the service requires the establishment of 89.16 WTE clinical midwives to be fully recruited into, and with the current vacancy rate this is not currently feasible.

Table 5. Continuity of Carer modelling from Birthrate Plus® report (May 2021)

SALISBURY NHS TRUST	24% uplift	Version date: 13/05/2021			DRAFT							
TOTAL BIRTHS	**2193**	**The figures are an indication only and should be reviewed as more caseload teams are set up**. The staffing totals assume the annual births, community exports and imports remain as in the baseline and there are no other changes to services. The CoC staffing is based on a caseload ratio of 36 cases to 1wte. Factored into core staffing is that 20% of CoC women will require care from core staff on D/S and that 90% of women will require transfer to the p/n ward for maternal and/or fetal reasons. The % may reduce as CoC becomes established. It is advisable to consider minimum staffing on D/S and Maternity Ward as higher % of women are allocated to a CoC team.										
TOTAL COMMUNITY CASES	**2756**											
ELIGIBLE FOR COC	**2023**											
Minimum Staffing 24/7 x 1 m/w	**Baseline exc CoC**	*Core Staffing Nos. per Shift*	**CoC 20%**	*Core Staffing Nos. per Shift*	**CoC 35%**	*Core Staffing Nos. per Shift*	**CoC 51%**	*Core Staffing Nos. per Shift*	**CoC 75%**	*Core Staffing Nos. per Shift*	**CoC 100%**	*Core Staffing Nos. per Shift*
5.56												
Core Hospital Services												
Delivery Suite	33.86	*6.09*	30.85	*5.55*	27.86	*5.01*	24.67	*4.44*	19.88	*3.58*	14.90	*2.68*
Maternity Ward	20.95	*3.77*	20.91	*3.76*	20.27	*3.65*	19.59	*3.52*	18.58	*3.34*	17.52	*3.15*
OPD/MAU	7.96		7.96		7.96		7.96		7.96		7.96	
Core Community	25.45		21.99		18.75		15.29		10.10		4.70	
Home births	2.38											
Caseload Teams	0.00		11.24		19.67		28.66		42.15		56.19	
includes home births												
Total Clinical wte PN Band 3s to Band 7/8s	**90.60**		**92.94**		**94.51**		**96.17**		**98.67**		**101.28**	
Variance from BR+ baseline in CLINICAL WTE	0.00		2.35		3.91		5.57		8.07		10.68	
Incremental Variance in Clinical wte			2.35		1.56		1.67		2.50		2.60	
TOTAL CLINICAL, SPECIALIST, MANAGEMENT WTE	**98.75**		**101.31**		**103.01**		**104.83**		**107.55**		**110.39**	
Variance from BR+ baseline in TOTAL WTE			**2.56**		**4.26**		**3.52**		**4.54**		**5.56**	

Inability to Recruit

If we continue to have difficulty recruiting, we will continue to utilise Agency and Bank staff, looking at working creatively across all areas of maternity to utilise Community Midwives working in inpatient areas, as and when required. Use of an incentive scheme for Bank work from Dec 2022 has been successful in maintaining safe levels of staff, although it required some adaptability to fit to the challenges within maternity – primarily the cover of nights and skill mix. This is a scheme which is well received, and successful in supporting safe staffing levels. We are also currently awaiting the outcome of a proposal for a recruitment and retention incentive to be paid to new starters and again on completion of a year in post at the trust. This aligns with other units, and in this competitive market it is necessary to ensure we remain as attractive and competitive as possible.

Conclusion and Next Steps

The paper demonstrates the current staffing establishment in the maternity service, challenges, risks, and mitigations in place. The ongoing work to recruit and retain is key to the long-term staffing within the service. Next steps are detailed:

- Continue with the recruitment campaign work utilising all options available to the Trust for recruitment and retention incentives.
- Utilise Bank and Agency staff.
- Review working patterns and flexibility models within the current service.
- Monitor staffing monthly through staffing dashboard and escalate concerns accordingly.
- Where opportunities to over recruit become an option ensure this is available to the team.
- Review the Maternity Care Assistant competency framework with the LMNS to ensure their role is included in workforce planning and skill mix – ultimately reducing midwifery staffing in the postnatal ward environment.
- Continue with retention work and input from PMA to support staff
- Continued consideration of any exit interview themes.

Neonatal Staffing report 2022 Q3&4

1. Purpose

The review has been undertaken utilising National published recommendations for Neonatal staffing:

- British Association of Perinatal Medicine (BAPM) June 2018
- National Quality Board (2016). Safe, sustainable, and productive staffing - An improvement resource for neonatal care Supporting NHS providers to deliver the right staff with the right skills, in the right place at the right time- Safe, sustainable and productive staffing.
- National Institute for Health and Care Excellence (NICE) quality standard (QS4) for neonatal specialist care (2010),

The Neonatal Matron and Deputy Director of Maternity and Neonatal Services review the service and workforce in line with the recommendations and standards outlined in the above documents monthly.

2. Neonatal Services staffing review methodology

2.1 The department has been in escalation for 11 days from September 2022 to the end of February 2023. The service has had a mixture of higher acuity and cot capacity against plan in this time because of a rise in the number of overall admissions (26% increase). This was successfully mitigated by NICU staff, Maternity staff, and the use of bank nurses, despite the ongoing high sickness rates and COVID isolation periods.

2.2 All units within the local Neonatal network are utilising a recognised acuity tool (Badger) which enables staff to consider the staffing, capacity and activity in real time and activate escalation when necessary. The senior nurse produces a monthly acuity report so there is clarity around activity.

2.3 Within the staffing numbers 70% of RNs/RCNs are expected to be Qualified in speciality (QIS) and the unit is currently at 69%. This is a slight decrease from 74% in 2021.The QIS training has been removed from university education and is now being delivered by the neonatal network with the backing of Health Education England (HEE). We will continue to secure 1 to 2 places on the QIS course each year to ensure we continue to meet national targets on specific neonatal nurse training. We currently have 1.0WTE equivalent nurse taking on this training. In September 2023 a further 2 nurses will commence their QIS training (0.6WTE & 0.8WTE respectively).

2.4 The service received a significant uplift in funding in April 2022. This funding is central funding allocated to us from the National Clinical Care Review (NCCR)

fund. £128,809/year. This extra money is for investment into practice education & patient facing care and has been invested and recruitment is complete. The roles recruited into include practice education roles at band 7 and 6, band 5 development roles and an increase to the infant feeding team to support development within the team.

2.5 Going forward in 2023 we have secured additional external funding for neonatal SALT provision of 0.2WTE. This budget has been moved to the spire team and they will be recruiting in April 2023.

2.6 In April 2023 0.2WTE will be available from NICU budget to employ a band 7 psychotherapist for neonatal and maternity.

3. Challenges:

A key challenge within the neonatal service has been a mixture of medium and short-term sickness, this is now improving and is currently at 3.4% (reduced from 5.3%). The unit has utilised enhanced & super enhanced rates, to encourage bank shift pick up and the continued use of an ad hoc on call system, when acuity in the unit is low. Flexibility across the post-natal ward and Sarum ward has reduced the need for agency staff required. In this period, we have not been successful in securing any agency cover, so the super enhanced shifts have been of particular use.

There is a national initiative (ATAIN) to reduce the number of babies admitted to a neonatal service. This demands a transitional care provision which was developed within SFT in 2018, and the neonatal nurses are providing an outreach service to the postnatal ward for transitional care babies. The neonatal unit has been able to continue this service, despite the challenges of the last year.

Going forward there are going to be gaps in the rota created due to maternity leave and ongoing sickness.

4. Strategies in place for maintaining recruitment and retention of staff

- The following strategies are being utilised to maintain the recruitment and retention across the Neonatal workforce:
- 1 staff member (1.0WTE) undertaking QIS training 2022-23.
- 2 staff members to undertake QIS training 2023-2024 1.4WTE (collectively)
- Continue drive in ensuring staff are trained in advanced New-born life support (in addition to basic annual new-born life support). We have sent 4 staff this year and have another 4 places secured for the coming months.

- Monthly assessment of staffing and effective forecasting.

- The infant feeding team continues to deliver their agenda but has moved to be under Neonatal management. This change has aided us in getting central funding to roll out baby friendly standards within NICU to mirror the certification that maternity has already gained. We now have an infant feeding team that can cover 6 days/week continuously despite AL etc. which is more robust – please see neonatal funding tracker for out line.

- Employ Psychotherapist & SALT practitioners in the next financial year

5.0 Conclusion and next steps

- To note the improvements and the on- going progress in recruitment.

- To note and continue to support the plan to maintain the current staffing to manage maternity leave and sickness.

- For maternity and neonatal services to continue to work collaboratively to implement an explicit staffing model for transitional care in line with CNST safety action 3.

- To recruit a nurse/midwife to support the full operational delivery of the transitional care model to support safety action 3 of CNST (as per the CNST response action plan).

NHS Salisbury NHS Foundation Trust

Report to:	Public Trust Board	Agenda item:	7.2
Date of meeting:	06.04.2023		

Report tile:	Staff Survey Results 2022			
Status:	Information	Discussion	Assurance	Approval
	X		X	
Approval Process: (where has this paper been reviewed and approved):	Previous papers outlining the staff survey results have been to Private Board, Trust Management Committee, OD & Management Board and the People Committee, This is the first presentation of the benchmarked results since the embargo was lifted on 9 March 2023.			
Prepared by:	Susan Young, Interim Director of Organisational Development and Learning			
Executive Sponsor: (presenting)	Melanie Whitfield, Chief People Officer			

Recommendation:

Board are asked to note Sft 2022 staff survey results benchmarked against other acute providers and to be assured of the oversight and actions in response

Executive Summary:

Each year, staff at SFT take part in the national NHS staff survey. The last survey took place in the autumn 2022 and the results have just been published as national statistics. We are now therefore able to have more open conversations with colleagues about our response to the survey as the previous embargo has been lifted with effect from 9 March 2023.

The purpose of this paper is to inform Public Board of the published results and the planning which has so far been undertaken to prepare for our response and discussions with staff. The attached slides cover the background to the survey, a brief overview of the results, which compare SFT with other trusts in the acute and acute/community sector of the NHS.

In summary, SFT had an above average response rate to the survey but remains in a disappointing position with regard to the overall results, and in particular those results which we are measuring as part of our Vision Metrics. SFT has seen a statistically significant improvement in the People Promise element of 'We work flexibly', but a significantly worse performance in 'We are always learning', and in relation to Staff Engagement. Although colleagues feel more involved in the Trust, and feel more able to make improvements than previously, there has been a sharp fall in advocacy, i.e., the extent to which colleagues would recommend the Trust as a place to work or to receive treatment. There are some concerning results in relation to how colleagues feel about raising concerns, which continue the trend on these questions in recent years. The poor performance on the People Promise element 'We are always learning' is driven by the questions on appraisals, both the completion of them and the quality.

The paper also provides information about next steps and how colleagues will be engaged in the response.

Should anyone want to view the results in full, they are contained in the following link. You will need to scroll down and type 'Salisbury' in the blue box: https://www.nhsstaffsurveys.com/results/local-results/

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):	

NHS
Salisbury
NHS Foundation Trust

Staff survey 2022:
Listening and Improving Together

Board: April 2023

Background to the 2022 national staff survey

NHS Salisbury NHS Foundation Trust

- Annual NHS staff survey with 8+ weeks' fieldwork, in October and November each year
- Questionnaire developed nationally by the NHS Staff Survey Co-ordination Centre
- One of the world's largest workforce surveys – in 2022, 264 NHS organisations took part, including 215 trusts. Over 1.3 million NHS employees were invited to complete the survey. 636,348 responded
- Aggregated results are published as official statistics so results were embargoed for external use until official publication on 9 March 2023
- Changes made in 2021 to align with the NHS People Promise have been retained in 2022
- Initial results from our contractor, Picker Institute Europe, compare SFT with 64 other Acute and Acute and Community Trusts
- Full results, which were published last week, compare SFT to 123 other Acute and Acute and Community Trusts
- 97 questions use the 'positive score' as the primary unit of measurement; 92 of those questions can be compared historically
- Results include every question where the trust received at least 11 responses (the minimum required for reporting)
- Now the embargo has been lifted, results are available publicly: https://www.nhsstaffsurveys.com/results/

Responding to the staff survey

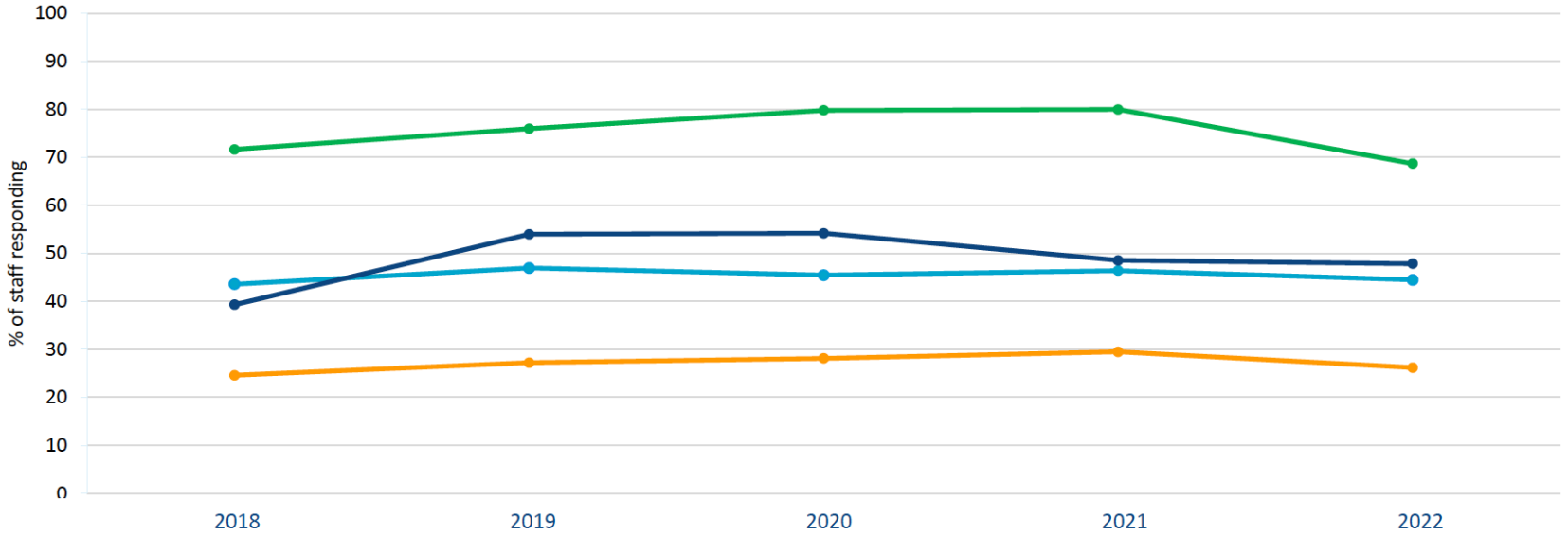
NHS Salisbury NHS Foundation Trust

- SFT's planning for our response to the staff survey began earlier this year, prior to the embargo being lifted.
- Initial results were shared at Board and People Committee in February and resource packs have been shared with the divisions, along with their results.
- A facilitators pack has been prepared to support divisions, OD & P colleagues and line managers with understanding and interpreting the results.
- The packs provide information about the staff survey data available to us, how to use those results, some prompts to aid thinking and links to other resources available.
- Divisional leads and managers are asked to organise a divisional/team meeting to share the results with the division/team.
- There will also be large, corporate 'listening events' with opportunities to discuss the survey and our response.
- We want to celebrate the successes, identify the areas for improvement and plan actions in those meetings, ensuring that owners have been identified for each action
- To support the response to the survey and to enable assurance, divisions will submit their insights, plans and progress quarterly to the Trust Management Committee
- We are aiming to work as a team to deliver the improvements our staff have identified and we need colleagues to keep the survey on their team meeting agendas to track progress.
- We will also continue to track progress against our quarterly pulse survey. Whilst we have seen improving scores already from our January survey we recognise the need to increase completion rates and will continue to promote extensively

SFT response rate for 2022

Salisbury NHS Foundation Trust

Although our response rate fell slightly, this was in line with the trend in other trusts, and we have maintained our position with an above average response rate



	2018	2019	2020	2021	2022
Your org	39.3%	54.0%	54.2%	48.5%	47.8%
Highest	71.6%	76.0%	79.8%	79.9%	68.7%
Average	43.6%	46.9%	45.4%	46.4%	44.5%
Lowest	24.6%	27.2%	28.1%	29.5%	26.2%
Responses	1344	1958	2062	1881	1861

Salisbury NHS Foundation Trust Benchmark report

2022 NHS Staff Survey

Alignment to the People Promise

Salisbury NHS Foundation Trust

- The questions in the NHS Staff Survey are aligned to the People Promise as well as two themes, staff engagement and morale. The People Promise sets out, in the words of our NHS people, the things that would most improve our working experience – like health and wellbeing support, the opportunity to work flexibly, and to feel we all belong, whatever our background or our job. The People Promise is made up of seven elements:

- The people who work in the NHS are best placed to say when progress has been made towards achieving our People Promise. Everyone's answers will be used to better understand what it's like at the moment and where more change is needed. SFT is one of 23 exemplar sites and as such looks to achieve progress against all 7 elements.

Summary headlines for SFT 2022 results

NHS Salisbury NHS Foundation Trust

- Response rate (47.8%) slightly lower than 2021 (48.5%), but above average for comparable trusts (44.5%), with 1861 people completing the survey
- The People Promise element '*We work flexibly*' is significantly better than last year; some of the wellbeing questions have the most favourable results when compared with other Picker trusts, as does the ability to make suggestions for improvement
- *"We are always learning*' and the theme of 'Staff engagement' are significantly worse than last year (based on statistical significance testing) – see next slide
- Poorest results were around advocacy (place to work and to receive treatment), patient safety (addressing/learning from incidents/concerns) and personal development questions (accessing opportunities and receiving an appraisal)
- To be expected there is divisional variation and across the professional groups , additional clinical services and registered nursing and midwifery colleagues report the least positive scores
- BAME staff generally experience more harassment, bullying and abuse than white staff but score more highly on motivation, we note some variation across different ethnic groups
- Those who prefer not to state their gender or sexual orientation report poorer experiences than others
- Our commitments to increase staff engagement, improve retention and be a fair and equitable employer shape both our long term people plan and our focus for the year ahead

Significance testing – 2021 v. 2022: How we compare against last year

NHS Salisbury NHS Foundation Trust

The table below presents the results of significance testing conducted on the theme scores calculated in both 2021 and 2022*.

People Promise elements	2021 score	2021 respondents	2022 score	2022 respondents	Statistically significant change?
We are compassionate and inclusive	7.1	1816	7.1	1857	Not significant
We are recognised and rewarded	5.6	1851	5.6	1855	Not significant
We each have a voice that counts	6.6	1786	6.6	1842	Not significant
We are safe and healthy	5.8	1809	5.8	1846	Not significant
We are always learning	5.0	1744	4.7	1763	Significantly lower
We work flexibly	5.7	1839	5.9	1846	Significantly higher
We are a team	6.4	1822	6.5	1855	Not significant
Themes					
Staff Engagement	6.8	1858	6.7	1859	Significantly lower
Morale	5.5	1848	5.4	1859	Not significant

* Statistical significance is tested using a two-tailed t-test with a 95% level of confidence. For more details please see the technical document.

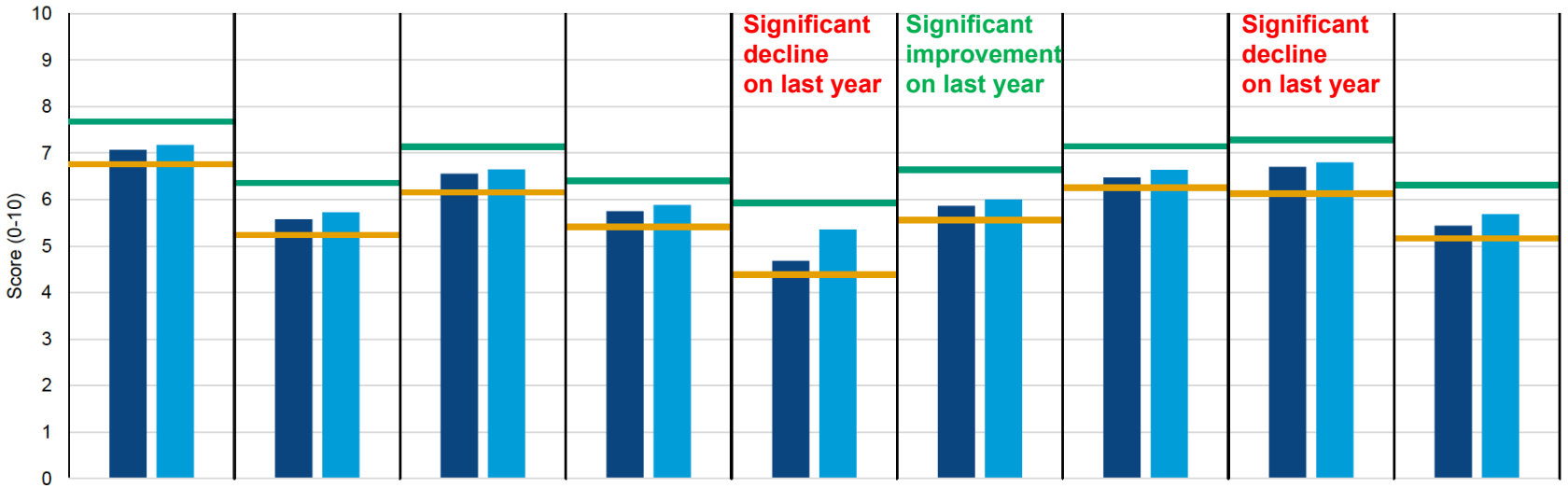
source: https://cms.nhsstaffsurveys.com/app/reports/2022/RNZ-benchmark-2022.pdf

Overview of the full benchmark results: People Promise elements and themes (2022)

How we compare against other acute trusts

Salisbury NHS Foundation Trust

All of the People Promise elements, themes and sub-scores are scored on a 0-10 scale, **where a higher score is more positive than a lower score**.



	We are compassionate and inclusive	We are recognised and rewarded	We each have a voice that counts	We are safe and healthy	We are always learning	We work flexibly	We are a team	Staff Engagememt	Morale
Your org	7.1	5.6	6.6	5.8	4.7	5.9	6.5	6.7	5.4
Best	7.7	6.4	7.1	6.4	5.9	6.6	7.1	7.3	6.3
Average	7.2	5.7	6.6	5.9	5.4	6.0	6.6	6.8	5.7
Worst	6.8	5.2	6.2	5.4	4.4	5.6	6.3	6.1	5.2
Responses	1857	1855	1842	1846	1763	1846	1855	1859	1859
2021 score for SFT	7.1	5.6	6.6	5.8	5.0	5.7	6.4	6.8	5.5

Patient Centred & Safe | Professional | Responsive | Friendly | Progessive

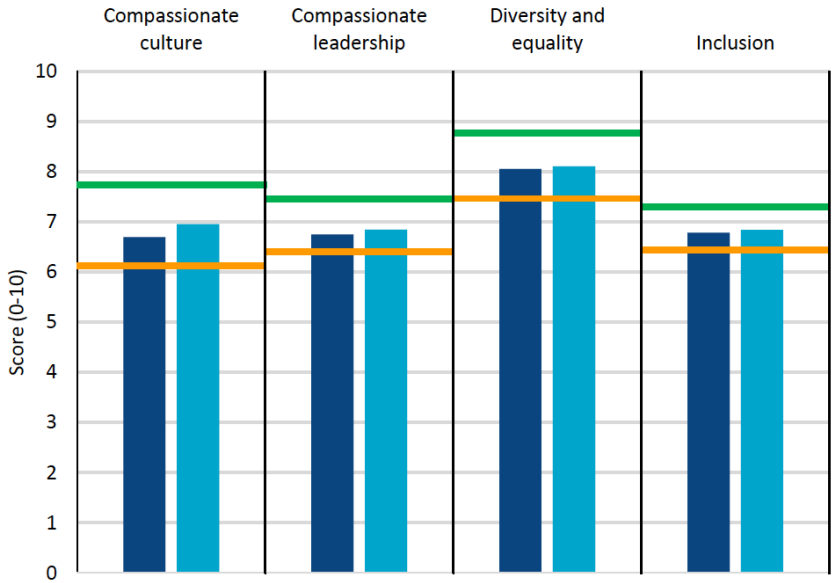
People Promise elements 1 & 3

How we compare against other acute trusts

Salisbury NHS Foundation Trust

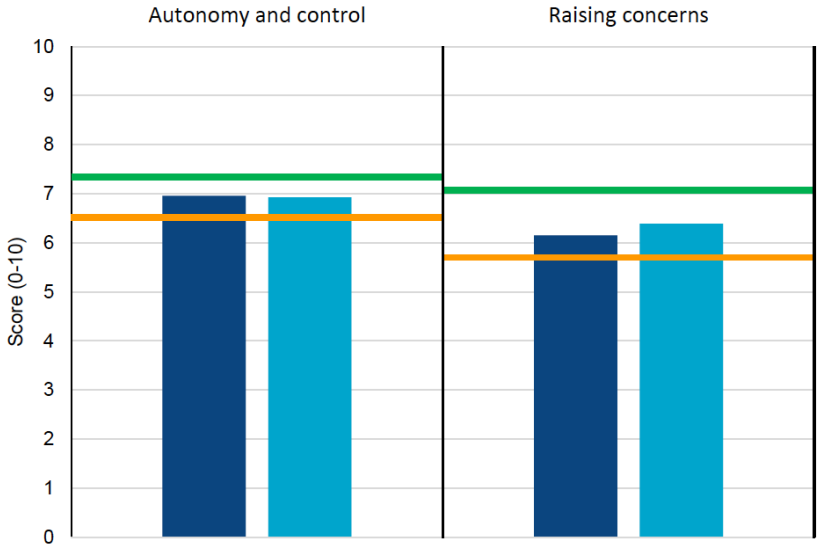
All of the People Promise elements, themes and sub-scores are scored on a 0-10 scale, **where a higher score is more positive than a lower score.**

Promise element 1: We are compassionate and inclusive



	Compassionate culture	Compassionate leadership	Diversity and equality	Inclusion
Your org	6.7	6.7	8.1	6.8
Best	7.7	7.4	8.8	7.3
Average	7.0	6.8	8.1	6.8
Worst	6.1	6.4	7.5	6.4
Responses	1851	1855	1855	1858

Promise element 3: We each have a voice that counts



	Autonomy and control	Raising concerns
Your org	7.0	6.2
Best	7.3	7.1
Average	6.9	6.4
Worst	6.5	5.7
Responses	1859	1844

N.B. People Promise Element 2 'We are recognised and rewarded' does not have any sub-scores.

People Promise elements 4 & 5

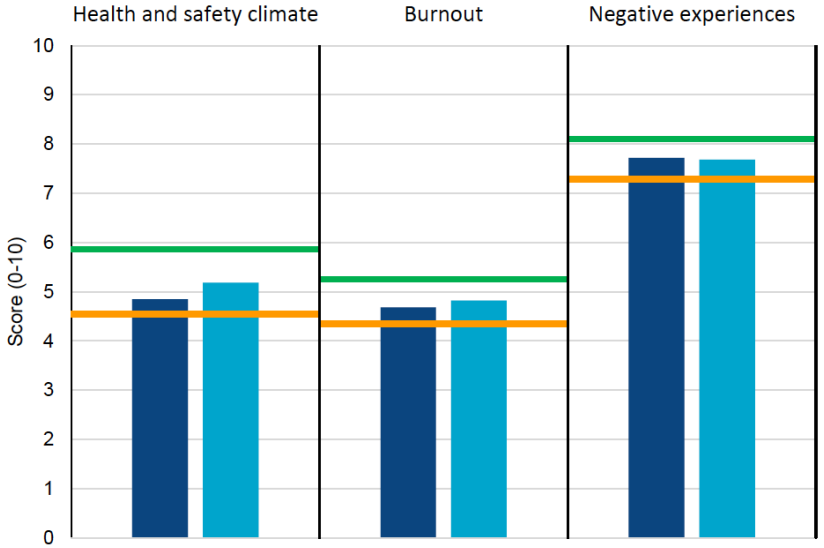
How we compare against other acute trusts

NHS Salisbury NHS Foundation Trust

All of the People Promise elements, themes and sub-scores are scored on a 0-10 scale, **where a higher score is more positive than a lower score.**

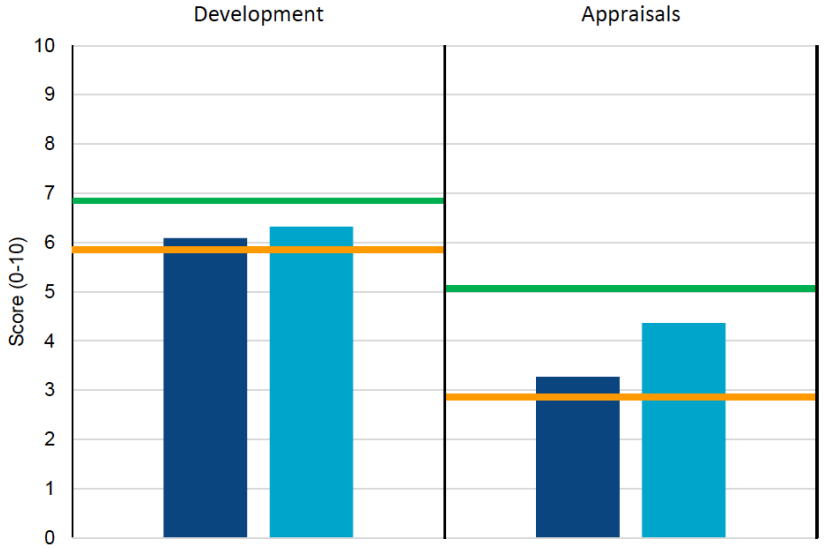
Significant decline on last year

Promise element 4: We are safe and healthy



	Health and safety climate	Burnout	Negative experiences
Your org	4.8	4.7	7.7
Best	5.9	5.3	8.1
Average	5.2	4.8	7.7
Worst	4.6	4.4	7.3
Responses	1858	1854	1854

Promise element 5: We are always learning



	Development	Appraisals
Your org	6.1	3.3
Best	6.8	5.1
Average	6.3	4.4
Worst	5.9	2.9
Responses	1853	1768

People Promise elements 6 & 7

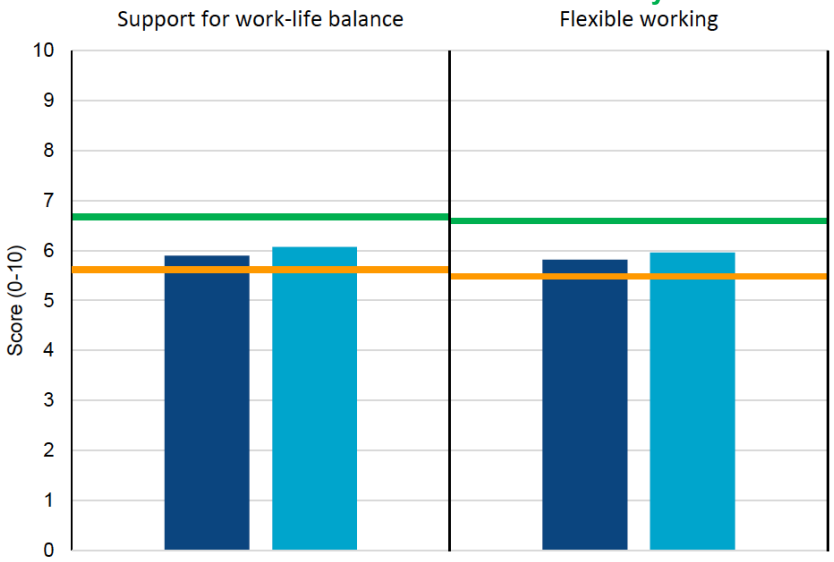
How we compare against other acute trusts

Salisbury NHS Foundation Trust

All of the People Promise elements, themes and sub-scores are scored on a 0-10 scale, **where a higher score is more positive than a lower score.**

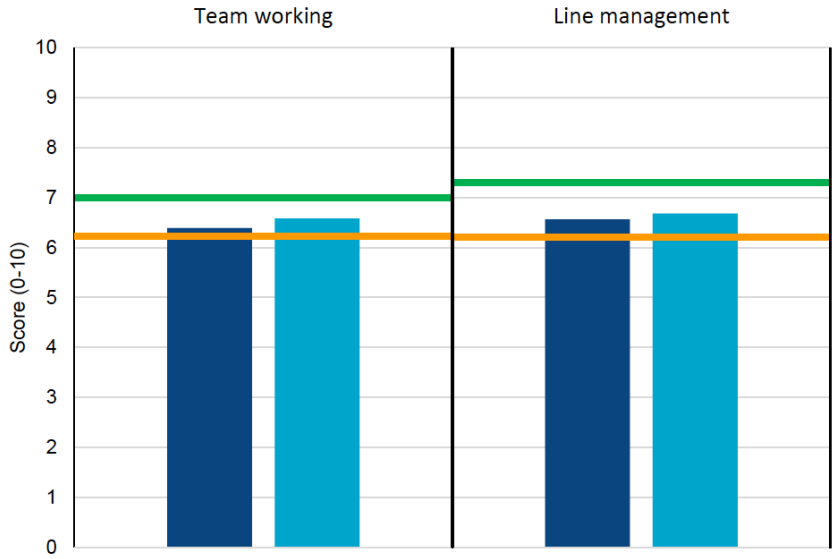
Promise element 6: We work flexibly

Significant improvement on last year



	Support for work-life balance	Flexible working
Your org	5.9	5.8
Best	6.7	6.6
Average	6.1	6.0
Worst	5.6	5.5
Responses	1854	1851

Promise element 7: We are a team

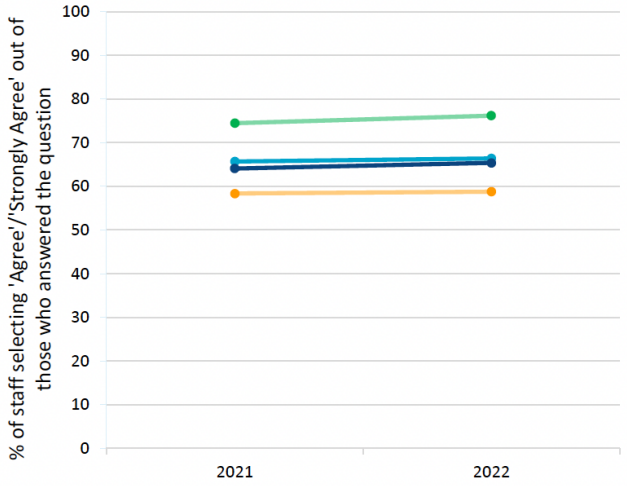


	Team working	Line management
Your org	6.4	6.6
Best	7.0	7.3
Average	6.6	6.7
Worst	6.2	6.2
Responses	1858	1856

Some small improvements in some ‘compassionate leadership’ questions on the element ‘we are compassionate and inclusive’

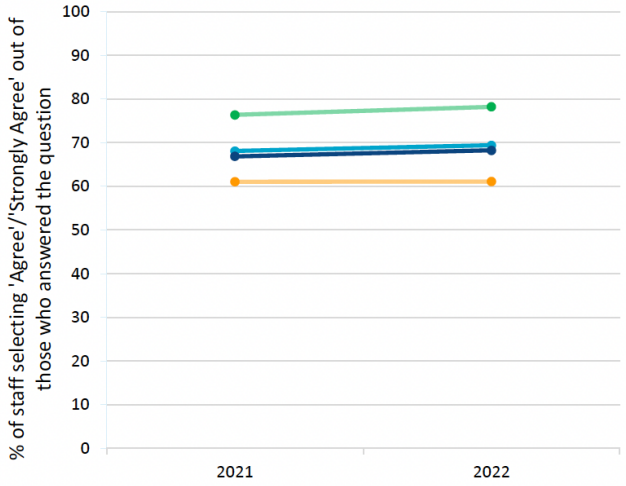
Salisbury NHS Foundation Trust

Q9f My immediate manager works together with me to come to an understanding of problems.



	2021	2022
Your org	64.1%	65.4%
Best	74.5%	76.2%
Average	65.7%	66.4%
Worst	58.4%	58.8%
Responses	1816	1854

Q9g My immediate manager is interested in listening to me when I describe challenges I face.



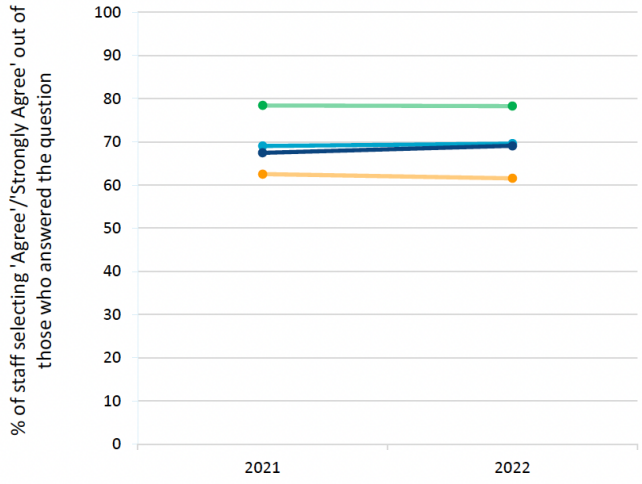
	2021	2022
Your org	66.9%	68.2%
Best	76.4%	78.2%
Average	68.1%	69.4%
Worst	61.1%	61.1%
Responses	1818	1853

Salisbury NHS Foundation Trust Benchmark report

Some small improvements in some ‘inclusion’ questions on the element ‘we are compassionate and inclusive’

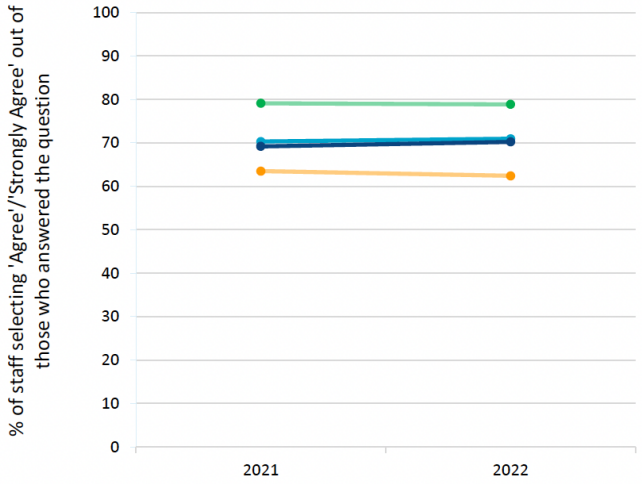
Salisbury NHS Foundation Trust

Q8b The people I work with are understanding and kind to one another.



	2021	2022
Your org	67.4%	69.1%
Best	78.4%	78.3%
Average	69.0%	69.6%
Worst	62.5%	61.6%
Responses	1824	1858

Q8c The people I work with are polite and treat each other with respect.

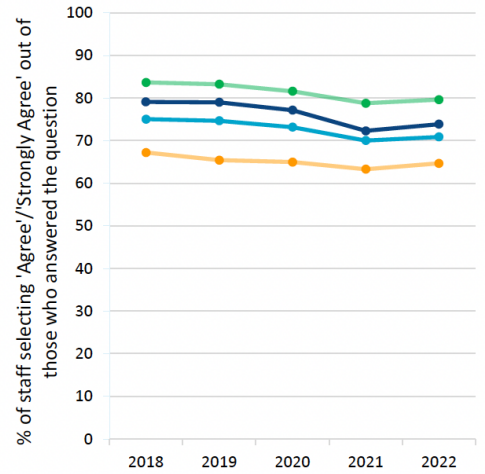


	2021	2022
Your org	69.2%	70.3%
Best	79.1%	78.9%
Average	70.3%	71.0%
Worst	63.5%	62.4%
Responses	1822	1856

Some improvements in the ‘autonomy and control’ questions on the element ‘we each have a voice that counts’

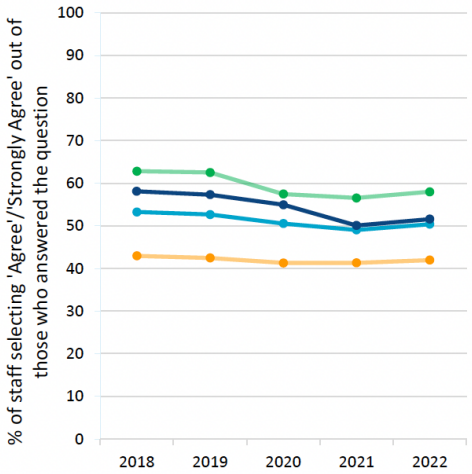
Salisbury NHS Foundation Trust

Q3d I am able to make suggestions to improve the work of my team / department.



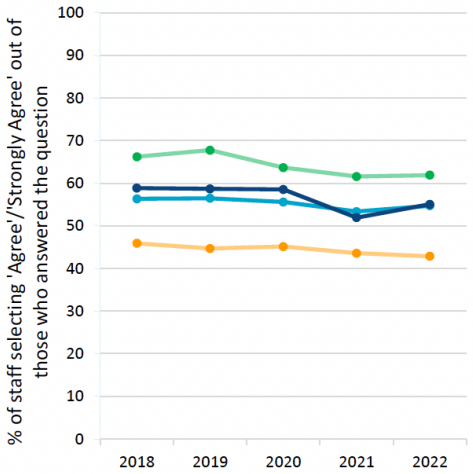
	2018	2019	2020	2021	2022
Your org	79.1%	79.0%	77.2%	72.3%	73.9%
Best	83.7%	83.3%	81.6%	78.8%	79.6%
Average	75.0%	74.7%	73.2%	70.0%	70.9%
Worst	67.2%	65.4%	65.0%	63.3%	64.7%
Responses	1334	1948	2041	1851	1854

Q3e I am involved in deciding on changes introduced that affect my work area / team / department.



	2018	2019	2020	2021	2022
Your org	58.1%	57.3%	55.0%	50.1%	51.6%
Best	62.8%	62.5%	57.5%	56.5%	58.0%
Average	53.3%	52.7%	50.6%	49.1%	50.4%
Worst	43.0%	42.5%	41.3%	41.3%	42.0%
Responses	1335	1948	2039	1851	1858

Q3f I am able to make improvements happen in my area of work.



	2018	2019	2020	2021	2022
Your org	58.9%	58.7%	58.5%	51.9%	55.1%
Best	66.2%	67.8%	63.7%	61.6%	61.9%
Average	56.4%	56.5%	55.6%	53.4%	54.7%
Worst	45.9%	44.7%	45.1%	43.6%	42.9%
Responses	1330	1947	2032	1845	1856

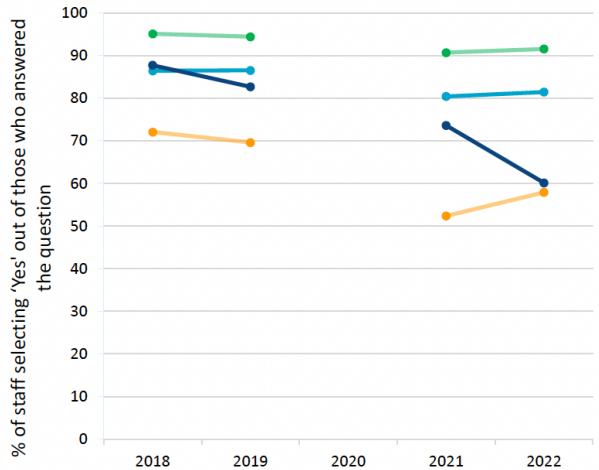
Our most significant decline: We are always learning

Salisbury NHS Foundation Trust

The poor score here is largely driven by the questions on appraisals

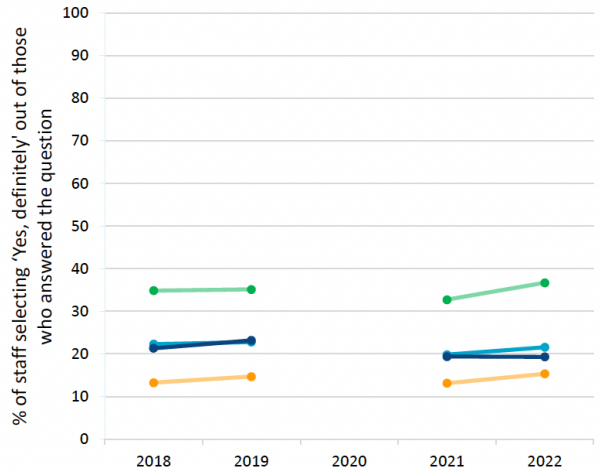
*Q21a is a filter question and therefore influences the sub-score without being a directly scored question.

Q21a In the last 12 months, have you had an appraisal, annual review, development review, or Knowledge and Skills Framework (KSF) development review?



	2018	2019	2020	2021	2022
Your org	87.7%	82.7%	-	73.6%	60.1%
Best	95.1%	94.4%	-	90.7%	91.5%
Average	86.4%	86.5%	-	80.4%	81.4%
Worst	72.1%	69.6%	-	52.4%	57.9%
Responses	1292	1908	-	1805	1849

Q21b It helped me to improve how I do my job.



	2018	2019	2020	2021	2022
Your org	21.3%	23.2%	-	19.4%	19.3%
Best	34.8%	35.1%	-	32.7%	36.7%
Average	22.3%	22.8%	-	19.8%	21.5%
Worst	13.2%	14.7%	-	13.1%	15.3%
Responses	1126	1571	-	1314	1119

Staff survey reports available now

Appendix 1

Salisbury NHS Foundation Trust

The following reports are available now (on an embargoed basis) from your HR Business Partners:

- **Picker Management report** - Initial overview of the results including historical comparisons and comparisons with 60 other trusts
- **Frequency tables (Excel)** - Shows how many people answered each question, and how, by each of the breakdown categories: Picker average and historic comparators, divisions, teams, staff group, age, disability, ethnicity, gender identity, sexual orientation & religion
- **RAG reports (Excel)** - Shows positive scores by the following categories: Picker average and historic comparators, divisions (locality 1), teams (locality 2), staff group, age, disability, ethnicity, gender identity, sexual orientation & religion.
- **Bank RAG report (Excel)** - Shows positive scores for bank only staff by the following categories: Picker average and historic comparators, divisions (locality 1), teams (locality 2), staff group, age, disability, ethnicity, gender identity, sexual orientation & religion
- **Workforce Race Equality Standards (WRES) and Workforce Disability Equality Standards (WDES)** reports – Shows the key indicators by divisions (locality 1), teams (locality 2), staff group, age, disability, ethnicity, gender identity, sexual orientation & religion
- **Staff engagement scores report (Excel)** - Shows staff engagement scores by the following categories: Picker average & historic comparators, divisions, teams, staff group, age, disability, ethnicity, gender identity, sexual orientation & religion
- **NHS Staff survey benchmark report for SFT (pdf)** - Contains the results for the 2022 staff survey and historical results back to 2018. The results are presented in the context of the best, average and worst results for similar organisations where appropriate. Data in this reports are weighted to allow for comparisons between organisations
- **NHS Staff survey breakdown report for SFT (pdf)** - Contains the results by division for the People Promise elements and theme results. These results are compared to the unweighted results for SFT as a whole.

Free text break down by division and staff group (Excel) - still awaited. This will contain all the free text responses by division

Action planning template (example)

Salisbury NHS Foundation Trust

Copied below is 1 of 3 tables providing an action plan framework for teams to use

Listening and improving Together: Our response to the 2022 staff survey

Name of division/team……

PEOPLE PROMISE ELEMENT	2021 ELEMENT SCORE / CHANGE FROM 2021	2022 ELEMENT SCORE	WHERE ARE WE DOING WELL	AREAS FOR IMPROVEMENT	STEPS TO TAKE	OUTCOMES	MEASURES	TIMESCALES	TEAM MEMBERS
		*You could compare your score to the organisation or benchmark average.* *You may also want to look at the sub scores for each element.*	*What are the areas you want to celebrate?* *Where have you improved since last year?* *Which areas are you doing well on compared with others?*	*What are the areas to work on or problems that need to be solved?* *Why are we prioritising this project; why is it important?* *Understanding the needs, who will benefit and why we need to do this work?*	*What are the tasks or steps that need to be completed to deliver this piece of work?* *What are the deliverables that will be developed?*	*What outcome is expected when the actions are taken, and what is the impact of this on our teams, individuals, and patients?*	*What measures will be used to ensure the actions have had an impact and been successful? How will we know that we have achieved what we set out to do and solve the problems? What can you use to measure this? E.g., increased engagement or People Promise scores?*	*Include start date and delivery date.* *Consider if this is a short-, medium-, or long-term piece of work.*	*Names of team members taking this forward.*
 **We are compassionate and inclusive** We do not tolerate any form of discrimination, bullying or violence. We are open and inclusive. We make the NHS a place where we all feel we belong.									

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NHS Salisbury NHS Foundation Trust

Report to:	Trust Board (Public)	Agenda item:	8.1
Date of meeting:	6 April 2023		

Report tile:	2023 Annual Review of Directors Interests/Annual Review Fit and Proper Persons Test			
Status:	Information	Discussion	Assurance	Approval
	✓		✓	
Approval Process: (where has this paper been reviewed and approved):	Board Approval required. Annual Register of Interests published on website			
Prepared by:	Kylie Nye, Head of Corporate Governance			
Executive Sponsor: (presenting)	Fiona McNeight, Director of Integrated Governance			
Appendices (list if applicable):	Annual Register of Interests			

Recommendation:

To review and note the annual Register of Interests and the outcome of the annual Fit and Proper Person Review as at March 2022.

Executive Summary:

There is a requirement as part of the Trust's licence agreement to publish the annual Register of Directors' interests to the Board. In 2020 it was agreed that the annual requirement would extend to all decision-making staff, described as those at band 8d and above or equivalent.

The corporate governance team have reviewed any positive declaration and any agreed action is documented on the register. The Senior Independent Director has also had sight of the register of interests. No concerns have been raised as part of this process.

A proactive review of the Declaration of Interests process during 2021/22 was undertaken by TIAA and identified several recommendations to improve compliance. The outcome of an improved process, with focused communications and escalation to individuals, resulted in an improved compliance rate of 60% in 2021/22. Compliance with this process is reported as part of the Counter Fraud Annual Risk Assessment submission. The Counter Fraud assessment has rated our 2022/23 compliance of 53% as amber. There is no recommended threshold to move compliance to a green rating. However, TIAA suggested a compliance level of 80% to achieve this. Ongoing actions to improve compliance have been put in place and were discussed at the Audit Committee on 23rd March.

There is also a requirement for all Executive and Non-Executive Directors to complete an annual form of declaration confirming that they continue to be a fit and proper person. This has been completed and no concerns have been raised.

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

Salisbury NHS Foundation Trust Register of Interests 2023/24

Includes: Trust Board / Directors

Name	Job Title	Company	Position	Action / Notes
Mark Ellis	Director of Finance	Nil return	Nil return	No action
Melanie Whitfield	Chief People Officer	Nil return	Nil return	No action
Fiona McNeight	Director of Integrated Governance	Nil return	Nil return	No action
Peter Collins	Chief Medical Officer	Orchestra Live	Trustee	No action
Stacey Hunter	Chief Executive Officer	BSW ICB	Board Member	Will declare any conflicts agenda with items at the start of any Board/ Committee meeting.
		Salisbury NHS Foundation Trust	Partner is contracted by Chief Medical Officer to undertake consultancy work	No action
Lisa Thomas	Chief Operating Officer	Sterile Services Ltd (SSL)	Director	No action
		Healthcare Storage Solutions Ltd	Director	No action
		My Trust Co Ltd	Director	No action
		Salisbury Trading Ltd (STL)	Director	No action
		Dauntsey Academy Primary School	Governor	No action
Judy Dyos	Chief Nursing Officer	Nil return	Nil return	No action
Michael Von Bertele	Non-Executive Director	Grenadenburg Consulting	Owner / Director	No action
		Rutherford Health	Non-Executive Director	No action
		Rutherford Innovations	Non-Executive Director	No action
		Rutherford Diagnostics	Non-Executive Director	No action
		Rutherford Infrastructure	Non-Executive Director	No action
		Rutherford Estates	Non-Executive Director	No action
		Trayned Insight	Director	No action
		Aspen Medical	Non-Executive Director	No action
		Ultra-Genetics Ltd	Director	No action
		Ministry of Defence: Army HQ	Chairman of Appeal Body for employment related complaints	No action
David Buckle	Non-Executive Director	Society for Assistance of Medical Families	President	No action
		East and North Hertfordshire NHS Hospital Trust	Non-Executive Director	No action
		Stroke Association	Vice President	No action
Tania Baker	Non-Executive Director	Nil return	Nil return	No action
Rakhee Aggarwal	Non-Executive Director	Nil return	Nil return	No action
Eiri (Margaret) Jones	Non-Executive Director	EJP ltd.	Director	
		Borough Welsh Chapel London	Trustee	
		Dorset County Hospital	Clinical Non-Executive Director	
		Allocate Professional Advisory Board	Member	
Ian Green	Chair (Non-Executive Director)	Terrence Higgins	CEO (until March 2023)	To note: Terrence Higgins has contracts with a number of NHS providers/ Commissioners.
		Cruisaid	Director	No action
		Accession Homes	Director	No action
		South Central Ambulance NHS FT	NED	No action
Richard Holmes	Non-Executive Director	The Wallscourt Foundation (Charity in connection with University of West England)	Trustee	no action
Debbie Beaven	Non-Executive Director	Isle of Wight NHS Trust	NED	No action
		Community Forest Trust	Trustee	No action
		Leap Confronting Conflict	Trustee	No action
		Newbury Building Society	NED	No action

Salisbury NHS Foundation Trust Register of Interests 2023/24

Includes: All decision making staff, agenda for change band 8D and above or equivalent.

Name	Job Title	Company	Position	Action / Notes
Tamsin Griffiths	Consultant Paediatrician	Nil return	Nil return	Nil return
Bhavisma Shah	Consultant Anaesthetist	Nil return	Nil return	Nil return
Guy Barham	Consultant Orthopaedics	Wessex Medical Surgical Services	Consultant/ Directors	No conflict of interest / Secondary employment
Natalia Roszowski	Consultant Radiologist	Nil return	Nil return	Nil return
Dr W Garrett	Consultant Anaesthetist	Private pratice	Consultant Anaesthetist	No conflict of interest / Secondary employment (signed by Dr Linton)
Ian Crowley	Deputy Director of OD & People	Nil return	Nil return	Nil return
Anna Aertssen	Consultant Surgeon	Nil return	Nil return	Nil return
Ian Robinson	Head of Facilities and Sustainability Lead	Nil return	Nil return	Nil return
Mark Szymankiewicz	Consultant Colorectal and General Surgeon	SWIFTSS	Trustee	No action
		Ruth Grace Foundation	Surgical Trustee	No action
		University of Winchester	Visting Fellow/ Lecturer	No action / Secondary employment
Claire Page	Consultant	HEE Wessex	Trained Facilitator	no action/ no conflict of interest
Toby Black	Consultant Physician Geriatric and Stroke Medicine	Nil return	Nil return	No action
Annalise McNair	Orthodontic Consultant and CCIO	INSPIRE ORTHODONTICS	OWNER AND CLINICAL LEAD SINCE MAY 2013	No action
Susan Hegarty	Consultant Radiologist	Nil return	Nil return	No action
Jonathan Linton	Consultant Anaesthetist	J&F Linton Ltd	Director	No action
		New Hall Hospital	Private Clinical Practice since 2014	No action
Danielle Bagg	Consultant Acute Physician	Nil return	Nil return	No action
Susana Bull	Speciality Dr Pallative Care	Nil return	Nil return	No action
Niki Meston	Consultant Chemical Pathologist	Nil return	Nil return	No action
James Haslam	Consultant in Anaesthesia & ICM	Nil return	Nil return	No action
Stephen Davies	Consultant	Nil return	Nil return	No action
Tracey Farnon	Consultant Paediatrician	23rd Salisbury Scout Group	Treasurer	No action
Carmen Carroll	Consultant Geriatrician and Physician.	Nil return	Nil return	No action
Gavin McCoubrey		Spire Southampton	Private Clinical Practice	No action
	Consultant Plastic Surgeon	Sarum Road Hospital Winchester	Private Clinical Practice	No action
Samuel Leach	Consultant Radiologist	Ramsey Healthcare	Radiology Consultant / Private Practice	No action
Layth Alsaffar		BIOFIX ltd	Director / 50% ownership	No action
		19-22 Summerseat Close Owners Ltd	Director / 25% ownership	No action
		Dorset Health Care	Consultant Microbioloist	No action
	Consultant Microbioloist	Portsmouth Queen Alexandra Hospital	Consultant Microbioloist	No action
Timothy Burge	Consultant Plastic Surgeon	Self Employed	Medical Reporting since 2001	No action
Aisling Coy		Purple Medical Ltd	Director	No action
		Consultant Connect	Ad hoc Telephone advice	No action
		New Hall Hospital (since 2008)	Consultant in Rheumatology and Rehab/ Private Practice	No action
	Consultant in Rheumatology and Rehab Medicine	South Newton (contract on hold as SFT using site)	Consultant in Rheumatology and Rehab/ Private Practice	No action
Victoria Brown	Consultant in Breast and Endocrine Surgery	Nil return	Nil return	No action
Jo Baden-Fuller	Clinical Director CSFS, Obstetric and Gynaecology Consultant	Nil return	Nil return	No action
Dr G R Smith	Consultant Rheumatologist	Dr G R Smith Ltd	Co-Director (wife is co-director)	No action
		INSPIRE	Trustee	No action
		STARS	Ambassador	No action
		Janssen and Eli Lilly	Education Work	No action
		LNC	Member	No action
		SIMP	Consultant Rheumatologist (private clinical practice	No action
Vienna-Jayne Birchell	Orthoptist	Nil return	Nil return	No action
Duncan Wood	Consultant Clinical Scientist	Odstock Medical Limited (OML)	B' Shareholder (NHS Contract also includes 0.2 wte)	No action
Steven Crook	Consultant Clinical Scientist	Odstock Medical Limited (OML)	B' Shareholder	no action
		University College London (UCL)	Lecturer (from 2015)	no action
James Barr	Consultant Anaesthetist	New Hall Hospital	Private Clinical Practice	no action
Paul Downie	Consultant Chemical Pathologist	Novartis Daichii-Sanko	Speaker (Ad Hoc)	no action
		Amarin	Speaker (Ad Hoc)	no action
		Sobi	Speaker (Ad Hoc)	no action
		Wessex AHSN	CVD Advisor ro Wessex AHSN	no action
Andrew Nash	Consultant Anaesthetist	New Hall Hospital	Private Clinical Practice	no action
Clare Raubusch	Consultant Biomedical Scientist	Nil return	Nil return	No action
Annie Hawkins	Consultant Gynaecologist	Nil return	Nil return	No action
Simon Williams		SPW Medical Limited	Director (wife also director)	No action
	Consultant Anaesthetist	Supplies Medical Care	Anaesthetic services for NHS and private patients at New Hall Hospital.	No action
Emma Halliwell	Director of Medical Education and Consultant Anaesthetist	Nil return	Nil return	No action
Julian Hemming	Consultant Microbioloist	Nil return	Nil return	No action
Sebastian Gray	Paediatric Consultant	BSW ICS	Children and Young People lead for Asthma (March 2022) 1PA	No action
Jonathan Cullis	Consultant Haematologist	CRESSUK charity	Trustee	No action
		Coombe Bissett and Homington Parochial Church Council	Member	No action
		T3 Pharma	Clinical Trial Advice	No action
		SFT	Clinical Private Practice	No action
Katharine Johnson	Consultant Radiologist	Aidence Software	Talks on Lung Nodule Analysis	No action
		Southampton NHS Trust	Consultant Radiologist	No action
Graham Lloyd-Jones	Consultant Radiologist	Radiology Masterclass	Director	No action
		'Long COVID support'	Voluntary Advisor	No action
		Federation Dentaire Internationale (FDI – World Dental Feder	Voluntary Member	No action
		University Hospital Southampton	Honorary research contract	No action
		New Hall Hospital	Consultant Radiologist	No action
Alexandra Crick	Consultant	Nil return	Nil return	No action
Louise Gamble	Consultant Haematologist	Nil return	Nil return	No action
Tracey Parker	Consultant Haematologist	Nil return	Nil return	No action
Anne Goggin	Consultant in Palliative Medicine	Nil return	Nil return	No action
Phil Pettit	Consultant Orthopaedics	Director of PNP Orthopaedics Ltd	Director	No action
		Ramsay Healthcare	Consultant	No action
Martin Smith	Consultant Endocrinologist	New Hall Hospital	Director of Salisbury Endocrinology Partnership Ltd	No action
Sarah Needle	Divisional Director Operations Medicine	Nil return	Nil return	No action
Effie Grand	Consultant Haematologist	Nil return	Nil return	No action
Simon Dennis	Head of Commercial	Nil return	Nil return	No action
Alice Veitch	Consultant Radiologist	SW Veitch Orthopaedics Ltd	Shaerholder	No action
Melanie Halliday	GP Clinical Assistant Breast Department	Souchez Gardens Management Company	Director	No action
		Salisbury Medical Practice	Salaried GP	No action
Ali Vandyken	Divisional Director of Operations Surgery	Nil return	Nil return	No action
Gurd Shergill	Consultant Orthopaedics	New Hall Hospital	Orthopaedic Hospital	No action

Naeem Haq		MWNH Ltd	Co Owner	No action
	Consultant Ophthalmologist	Sarum Eye Clinic Lts	Co Owner	No action
Georgina Morris	Consultant in Sexual Health and HIV	British Association for Sexual Health and HIV Genital Dermatc	Chair	No action
		ViiV	Clinical Advisor	No action
Rob Padwick	Consultant Colorectal and General Surgeon	Nil return	Nil return	No action
Hannah Boyd	Divisonal Director Operations Women and Newborn	Nil return	Nil return	No action
Peter Ellis	Consultant	Nil return	Nil return	No action
Abigail Kingston	Consultant Gynaecologist	New Hall Hospital	Consultant Gynaecologist	No action
John O'Keefe	Head of Estates	Nil return	Nil return	No action
Andrew Agombar	Consultant Colorectal Surgeon	Nil return	Nil return	No action
Ginette Phippen	Lead Speech & Language Therapist & Deputy Clinical Director for CSFS	Nil return	Nil return	No action
Saboor Ghauri	Consultant	Nil return	Nil return	No action
Angshuman Rick Panigrahi		HM Coroner Wiltshire	Pathologist	No action
	Consultant Histopathology	Ramsay Healthcare	Pathologist	No action
Lee Anthony Grimes	Consultant Haematologist	Jersey General Hospital	Locum Haematology Consultant	No action
Marley Blake	Consultant Diabetes	Nil return	Nil return	No action
Joanne Cowan	Director of Maternity and Neonatal Services	Nil return	Nil return	No action
Lynn Fenner	Consultant Anaesthetics	Nil return	Nil return	No action
Stuart Henderson	Consultant Physician and Clinical Director	Nil return	Nil return	No action
Alistair Morton	Consultant Oral Surgeon	Nil return	Nil return	No action
Alexander Talbott	Associate Director of Improvement	Nil return	Nil return	No action
Mark Wills	Consultant Radiologist	Ramsay Healthcare	Consultant Radiologist	No action
		SDH	Consultant Radiologist	No action
Helen Armstrong	Senior Nurse	HHFT	Senior Nurse	No action
		Old Basine Village Café	Secretary	No action
Xantha Holmwood	Consultant Anaesthetist	Nil return	Nil return	No action
Alistair Smith	Consultant Haematologist	Nil return	Nil return	No action
Sally Bugg	Consultant Haematologist	Nil return	Nil return	No action
Russell Mellor	Consultant Elderly Care	Nil return	Nil return	No action
Clare Hennebry	Consultant Anaesthetist	Captiosus Consulting Ltd	Director (since 2022)	No action
Alastair Raynes	Chief Pharmacist	Nil return	Nil return	No action
James Lawrence	Consultant Endocrinologist/ Diabetes	Nil return	Nil return	No action
Richard Harrison	Consultant Respiratory Physician	KPI Health	Son is governance lead	KPI contract for NHS Services but not SFT (no action required)
Ali Samar	General Surgeon & Training Lead Endoscopy	Nil return	Nil return	No action
Roger Humphry	Consultant Ophthalmologist	Nil return	Nil return	No action
Matthew Flynn	Consultant Histopathologist	Personal Ltd company	Director (private work HM Coroner/ New Hall/ Dental Clinics	All private work declared and discussed at Appraisal
Jonathan Arnott	Consultant Radiologist	New Hall	Self employed Consultant Radiologist	No action
Stephen Lester	Consultant Geriatrician	Nil return	Nil return	No action
Andrew Agombar	Consultant Colorectal Surgery	Nil return	Nil return	No action
Damian James Mayo	Consultant Surgeon (Gen surg)	Nil return	Nil return	No action
R P Cole	Consultant Plastic Surgery	Self Employed	Clinical Private Practice	No action
Elisa Porretta	Consultant Stroke Medicine	Nil return	Nil return	No action
Laurence Arnold	Programme Director	Nil return	Nil return	No action
Rob Ritchie	Consultant Urologist	UHS	Consultant Urologist 2.5PAs	No action
Harriet Bush	Consultant Palliative Care	Nil return	Nil return	No action
Michael J Hughes		UHS	Consultant Radiologist	No action
	Consultant Radiologist	New Hall - self-employed	Consultant Radiologist	No action
Amy Pearce	Consultant Sexual Health	G4S	Sexual Offences Examiner	No action
Belinda Cornforth	Consultant Anaesthetist	Hartley Medical	Director of company (husband is other Dirctor and an ortho surgeon)	No action
Duncan Murray		DM Clinical and Professional Services	Director	No action
	Deputy Chief Medical Officer	New Hall Hospital	Private Clinical Practice (aneasthetist)	No action
Andy James	Financial Controller	League of Friends Salisbury Hospitals	Treasurer	No action
Graham Branagan		G&PB Ltd. (private medical practice)	Director (Wife is also a director)	no action
		Coloproctology GB&I	Honorary Secretary Association	No action
		Bishop Wordsworth Grammar	Governor	No action
	Consultant Surgeon	Bishop Wordsworth Trust	Trustee	No action
Aarti Umranikar	Consultant in Reproductive Medicine	No name given	Director of private limited company	No action
Paul Flanagan	Consultant Microbiologist	Nil return	Nil return	No action
Martin Smith		New Hall	Private Medical Practice	No action
	Consultant Endocrinologist	Salisbury Endocrinology Partnership (ltd)	Director	No action
Jonathan Burwell	Chief Information Officer	Nil return	Nil return	No action
Simon Dennis	Ear, Nose and Throat Consultant	New Hall Hospital	Private Practice	No action
Marcel Geyer		New Hall Hospital	Consultant Surgeon	no action
	Ear, Nose and Throat Consultant	Practice Plus Group (2 sessions/ month)	Consultant Surgeon	no action
Matthew Wakefield		Eye Surgery Limited	Director	Private practice is either conducted entirely separately to Trust activities or any performed on site is arranged via the SFT private practice office.
		MWNH Limited	Director	no action
		Independent Health Group (IHG)	Practising privileges	no action
		Medcentres Plus	Practising privileges	no action
	Consultant Ophthalmology	BSW ICB	Ophthalmology Lead Clinician (1PA)	no action
Paul Russell	Consultant Microbiologist	MoD – Army Reserves	Consultant Microbiologist	no action
Anna Barton	Consultant Physician	Nil return	Nil return	No action
Aram Mashoof Fard		AMFMED Ltd	Director	No action
	Consultant in Spinal Cord Injuries	Renovocare	Consultant in Rehab Medicine (ended Dec 2022)	No action
Manas Sinha		Olima Medical Ltd	Director	No action
	Consultant Cardiologist	Nuffield Health Bournemouth	Consultant Cardiologist	No action
Swarna Guttikonda	Consultant O&G	Nil return	Nil return	No action
William Garrett	Consultant Anaethetist	New Hall Hospital	Private Clinical Practice	no action
Ben Siggars	Consultant Anaethetist	Siggars Medical Ltd	Director	
		New Hall Hospital	Private Clinical Practice via Siggars Medical Ltd since 2008	
		South Central Ambulance Service Trust	Medical Incident Advisor since 2016	no action
		Hampshire and Isle of Wight Air Ambulance	Consultant in Prehospital Emergency Medicine since 2013	for addditional duties only. The majority of this work is contracted via service level agreement with SFT.
Jonathan Quayle	Consultant Orthopaedics	New Hall Hospital	Private Clinical Practice	no action
Melanie Halliday	GP - Clinical Assitant in Breast Care	Salisbury Medical Practice	Primary role as a GP (SFT is secondary role)	No action
Tim Wells		T.A.N.T Medical Ltd	Director	
		New Hall Hospital	Private Clinical Practice	
		Spire Hospital Southampton	Private Clinical Practice	
	Consultant Cardiologist	Bournemouth Nuffield Hospital	Private Clinical Practice	no action
Kate Jenkins	Consultant Psychologist	Self employed - since 2007	Psychologist	no action
Anisa Nazeer	Associate Specialist - Medicine	Nil Return	Nil Return	no action
Syed Abbas	Consultant Anaethetist	Property Rental Business	Manager	no action
		Member of the Anaesthetic Consortium	Self Employed/ Consultant Anaethetist	no action
Mohammed Elsaghir	Consultant Urology	New Hall	Private Clinical Practice	no action
Sridhar Rao Sampalli	Associate Specialist - Trauma and Orthopaedics	OPSLLP	Director	no action
		New Hall	Orthopaedic Surgeon (since April 2021)	no action

		SRS Orthopaedics	Owner	no action
Polly Ford	Consultant Gynaecologist	Complete Fertility	Consultant in reproductive medicine	no action
		Spire Southampton	Private clinical pratice (since 2022)	no action
Ian Jenkins	Consultant in Anaesthesia and ICM, Lead Clinician for Intensive Care	New Hall Hospital	Private Medical Practice	no action
Christopher Couzens	Consultant in Anaesthesia and intensive care	Salisbury Anaesthetic Group - New Hall Hospital	Consultant Anaesthetist	no action
		CAS medical Services Ltd	Director	no action
James Brewin	Consultant in Urology/ Surgery	Salisbury Urology Ltd	Director (Private medical practice)	no action
		New Hall Hospital	Choose and Book work (this will cease in 2023)	no action
Stuart Verdin	Consultant	Nil Return	Nil Return	no action
Ian Cook	Consultant Histopathologist	New Hall Hospital	Consultant Histopathologist	no action
Hazel Woodland	Consultant Hepatologist and Gastroenterologist	Nil Return	Nil Return	no action
Julia Bowditch	Consultant Anaesthetist	Bowditch Medical Ltd	Director	no action
Fiona Hyett	Deputy Chief Nurse	7th Southampton (Bassett) Scout group	Chairperson	no action
Sergio Nabais De Araujo	Consultant Cardiologist	TMLEP	Medico-Legal Advisor	no action
Laszlo Zavori	Consultant in Emergency Medicine	Saudi German Hospital	Consultant in Emergency Medicine (started 06/03/2023)	no action
Max Johnston	Consultant Urologist	Southampton Hospital	Secondary NHS Work - consultant urologist	no action
Philippa Ridley	Paediatric Consultant	Nil Return	Nil Return	no action
Catherine Thompson	Consultant in Respiratory Medicine	Nil Return	Nil Return	no action
Kush Duggal	Consultant Anaesthetist	Nil Return	Nil Return	no action
Jeremy Hill	Consultant Anaesthetist	Nil Return	Nil Return	no action
Temitayo Gandon	Paediatric Consultant	Nil Return	Nil Return	no action
Nola Lloyd	Consultant Burns and Plastics	Nil Return	Nil Return	no action
Roanne Fiddes	Consultant Breast Surgeon	nil return	nil return	no action
Kostas Marinakis	Consultant ENT	Southern Health NHS Foundation Trust	Consultant ENT	no action
Maqbool Jaffer	Consultant Anaesthetist	Maqbool Jaffer Ltd	Director (private clinical practice since 2015)	no action
Rob Webb	Director of Procurement and Supply Chain	Nil return	Nil return	No action