Bundle Trust Board Public 8 September 2022

1 OPENING BUSINESS

1.1 10:00 - Presentation of SOX certficates

July SOX of the month - Lauren Jackson and Farley Ward
July Patient Centred and Safe SOX - The Early Supported Discharge Team
August SOX of the month -
August Patient Centred and Safe SOX -

1.2 10:10 - Staff Story

1.3 Welcome and Apologies

Apologies received from Lucinda Herklots

1.4 Declaration of Interests, Fit and Proper/Good Character

1.5 10:30 - Minutes of the previous meeting held on 4th August

Minutes attached from meeting held on 7 July 2022
For approval

1.5 Draft Public Board mins 7 July 2022.docx

1.6 10:35 - Matters Arising and Action Log

1.6 Action Log Public Trust Board.pdf

1.7 10:40 - Chairman's Business

Presented by Nick Marsden
For information

1.8 10:45 - Chief Executive Report

Presented by Stacey Hunter
For information

1.8a CEO Board Report - August for Sep 22.docx

1.8b Appendix 1 Next steps in increasing capacity and operational resilience in urgent and emergency care ahead of winter_120822.pdf

1.8c Appendix 1a UEC Assurance Framework Aug 22.pdf

1.8d Appendix 1b Guidance for emergency departments - Initial assessment - definitions and recommendations_August2022.pdf

1.8e Appendix 2 COVID-19 testing in periods of low prevalence.pdf

1.9 10:55 - Register of Attendance

1.9 Register of Attendance - Public Board 2022-23.docx

2 ASSURANCE AND REPORTS OF COMMITTEES

2.1 11:00 - Clinical Governance Committee - 30 August

Presented by Eiri Jones
For assurance

2.1 Escalation report - from August 2022 CGC to Sept Board 2022.docx

2.1a Maternity Cover sheet Quarterly report CGC Aug 22.docx

2.1b CGC Maternity Quality_Safety Report for Q1 22 23 JH for CGC_.docx

2.2 11:05 - Finance and Performance Committee - 30 August

Presented by Eiri Jones
For assurance

2.2 Finance and Performance Committee escalation paper 30th August 2022.docx

2.3 11:10 - Trust Management Committee - 24 August

Presented by Stacey Hunter
For assurance

2.3 TMC Escalation Report for Board.docx

2.4 11:15 - Integrated Performance Report to include exception reports

Presented by Judy Dyos
For assurance

2.4a IPR Trust Board cover 080922.docx

2.4b IPR September 2022 FINAL.pdf

3	QUALITY AND RISK
3.1	11:45 - Research Annual Report *Presented by Peter Collins* *For assurance* 3.1a Trust Board Research cover sheet template 2122.docx 3.1b Annual Report 202122 revised 250822.docx 3.1c Research Annual report 2122 presentation.pdf
4	STRATEGY AND DEVELOPMENT
4.1	11:55 - Estates Strategy Approach *Presented by Brian Johnson* *For assurance* 4.1 ETS Report to Public Board_September 2022.docx
4.3	12:05 - BREAK
5	GOVERNANCE
5.1	12:35 - Annual Review of Board and Committee Effectiveness *Presented by Fiona McNeight* *For assurance* 5.1 Trust Board and Committee Effectiveness Report 2022.docx
5.2	12:45 - Approve Board and Committee dates for 2023 *Presented by Fiona McNeight* *For assurance* 5.2a Cover sheet Trust Board, Committee and Council dates 2023.docx 5.2b Trust Board & Committee dates 2023.docx
6	PEOPLE AND CULTURE
6.1	12:55 - Guardian of Safe Working Hours Annual Report *Presented by Juliet Barker* *For assurance* 6.1 GoSW Annual Report 21-22.docx
6.2	13:05 - Freedom to Speak up Guardian Annual Report *Presented by Lizzie Swift* *For assurance* 6.2 FTSU Annual Report 2021-22 (Final).docx
6.3	13:15 - Formal update on Equality Diversity and Inclusion progress (from action log) *Presented by Melanie Whitfield* *For assurance* 6.3 Trust Board cover sheet- Progress on EDI Sept 22.docx
6.4	13:25 - Health and Safety Annual Report *Presented by Melanie Whitfield* *For assurance* 6.4a Trust Board cover sheet H&S.docx 6.4b Health and Safety Annual Report 2021-2022 .Final.docx
6.5	Nursing Skill Mix (Deferred to November Public Board)
7	FINANCE AND PERFORMANCE
7.1	13:35 - EPRR NHSE Framework - Accountability and Responsibility *Presented by Lisa Thomas* *For assurance* 7.1 Cover sheet cover Sept 2022 EPRR Update.docx
8	CLOSING BUSINESS
8.1	13:45 - Agreement of Principle Actions and Items for Escalation
8.2	13:50 - Any Other Business
8.3	13:55 - Public Questions
8.4	Date next meeting *3 November 2022*
9	Resolution *Resolution to exclude Representatives of the Media and Members of the Public from the Remainder of the Meeting (due to the confidential nature of the business to be transacted)*

Salisbury NHS Foundation Trust

Draft

Minutes of the Public Trust Board meeting held at 10:00am on Thursday 7th July 2022, MS Teams Salisbury NHS Foundation Trust Boardroom

Board Members:

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

In Attendance:

Esther Provins (EP)	Director of Improvement and Partnerships
Jon Burwell (JB)	Chief Information Officer
Ian Robinson (IR)	Head of Facilities
Kylie Nye (KN)	Head of Corporate Governance (minutes)
Fiona McNeight (FMc)	Director of Integrated Governance
Lucinda Herklots (LH)	Lead Governor (observer)
Jane Podkolinski (JP)	Governor (observer)
Victoria Aldridge (VA)	Head of Patient Experience
Louise Couzens (LC)	Integrated Care Board (observer)
Peter Kosminsky (PK)	Governor (observer)

ACTION

TB1 7/7/1 OPENING BUSINESS

TB1 7/7/1.1 Presentation of SOX (Sharing Outstanding Excellence) Certificates

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

- **May SOX of the month –** Dr Prashant Dwivedi, Specialty Registrar, Gastroenterology
- **May Patient-centered and Safe SOX –** Sarah Singleton, Simon Dennis, Callum Hunter, Kasia Konieczny, Marcel Geyer and the ENT Team
- **June SOX of the month –** Chippy Joy, Staff Nurse, Day Surgery Unit
- **June Patient centered and Safe SOX –** Jo Pyke, Receptionist ED and Dr Jen Kelly, Oral Surgery

NM noted the wide variety of nominations that are put forward each month and the great work underway during extremely challenging

times. NM and the Board congratulated the members of staff who had received a SOX award.

The Board suggested that SOX nominees are invited into the Boardroom to receive their awards if possible. Currently executives are visiting the nominees in their departments to present the SOX awards.

TB1 7/7/1.2 **Patient Story**

VA joined the meeting and provided the Board with a patient story in relation to a young patient and his family's experience in the Emergency Department and in Sarum ward. VA noted that this story had been shared widely across the Trust.

The patient in question reflected on the many visits to the hospital he had experienced and noted the friendliness and kindness of staff, which resulted in alleviating feelings of concern or worry.

The staff in both ED and Sarum Ward listened and demonstrated empathy. The family were always clear about their son's care and felt that communication was great, making them feel like the whole family context was considered as a result of the care their son received.

The patient explained that on his way to surgery his mother was not permitted to be there due to COVID restrictions and the porter was friendly, funny and helped to calm him on his way to surgery.

Discussion:
VA reflected that this story highlighted the consistency in the experience the patient had every time he visited the hospital.

PC thanked VA for bringing this story to the Board and asked how this and the positive SOX nominations are fed back to staff who are having a particularly tough time currently. SH suggested that Dave Roberts, Head of Communications, would have some helpful suggestions on how to disseminate the messages from the story to the wider hospital.

EP noted the welcome positive messages about colleagues on Sarum Ward who continue to support a wide range of young patients, some of whom have extremely challenging mental health needs.

TB1 7/7/1.3 **Welcome and Apologies**

NM welcomed everyone to the meeting and noted the following apologies:

- Andy Hyett, Chief Operating Officer

TB1 7/7/1.4 **Declarations of Conflicts of Interest**

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

TB1 7/7/1.5 **Minutes of the part 1 (public) Trust Board meeting held on 5th May 2022.**

NM presented the minutes from 5th May 2022.

The Board noted that a few minor typos had been highlighted outside of the meeting.

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

TB1 7/7/1.6 **Matters Arising and Action Log**

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

TB1 10/3/2.4, TB1 7/4/1.6 - IPR / Maternity Dashboard – JD noted that the Trust was awaiting the Local Maternity Services (LMS) dashboard to ensure there is a consistent approach across Trusts. JD noted she would chase this and the Board agreed this would stay on the action log for future follow up. **ACTION: JD** **JD**

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

TB1 7/7/1.7 **Chairman's Business**

NM noted that it had been positive to hear all the encouraging SOX nominations and the positive feedback as part of the patient story, particularly when the organisation is under extreme pressure.

During June there has been a particular focus on operational plans and working with colleagues in the ICS as they bought together members of their Board.

Currently the Trust needs to focus on two priorities, respond to the significant pressure currently felt to improve the working environment for staff and ensure better outcomes for patients. There also needs to be consideration of how the Trust moves forward and prepares to manage this into the future.

NM noted that LT had provided a useful presentation for Private Trust Board to consider the options in how the Trust can move forward and hopefully improve morale across the organisation.

NM's report was noted by the Board.

TB1 7/7/1.8 **Chief Executive's Report**

SH presented her report and highlighted the following key points:

- As alluded to by NM, the operational context over the last few weeks has become increasingly challenged. This relates to high bed occupancy, with high numbers of No Criteria to Reside (NCTR) patients. There is increased turnover and a high level of staff sickness which is challenging in itself, without additional pressures. In terms of the variables in the Operational Plan, COVID-19 provides one of the biggest areas of risk. There are currently 55 patients who have COVID-19 and the Trust has

seen an increase with the new variant six times more likely to spread. Due to this, a third of those inpatients with COVID-19 have experienced nosocomial spread which is inevitable given the current context and is being experienced across a number of other NHS organisations.

- The key challenge is currently staffing and availability has become even more challenged due to COVID-19. The staff left in those impacted areas are showing signs of distress.
- In terms of modelling COVID-19 numbers, it is anticipated that it is likely to increase in numbers similar to the last wave. The Trust is doing everything it can, but this does also pose a risk on elective activity and on ambulance handover times.
- Those providers who manage to retain staff are the ones who will fair best. There are external limitations to workforce mitigations but there is ongoing work to look at new recruitment and retention methods.
- Despite the challenging circumstances, the Trust is delivering against the elective recovery plan. There are some organisations in the southwest who are struggling in comparison and have requested mutual aid for surgery, particularly where some patients have been waiting in excess of 3 years for treatment.
- From a partnership perspective the Clinical Commissioning Group (CCG) formally transferred to safely handover to the Integrated Care Board (ICB) on 1st July 2022. They have had their first meeting and SH was in attendance to represent the acute sector. The meeting largely focused on governance processes.
- The Acute Hospital Alliance (AHA) is progressing work well. Comments about the report received at Board have been fed back. The Chairs and Chief Executives will take time to consider this as the report needs to suit all three Boards.

Discussion:

- TB reflected that there could quite possibly be another large wave of COVID over the winter and a large proportion of people are not sighted on long-COVID impacts which are already occurring. The Board needs to be realistic about this impact and that it is continuing to ask staff to work in an extremely difficult environment. TB asked if the Trust has or plans to reintroduce mask wearing and what the stance on visiting the hospital will be in the coming months. SH noted that a GOLD meeting would be held later that day to discuss reintroducing mask wearing.
- JD noted that there is an explicit requirement nationally to not restrict visiting, which was instigated by the previous Health Secretary. TB and SH discussed visiting guidance of short vs long length of stay and the balance which SH noted will be considered. TB reiterated that the Trust and wider NHS do not have a ‘living with covid’ strategy, we’re just expected to manage as best we can.
- JD noted that with any infection outbreak, visiting is managed accordingly. LT noted that COVID will ebb and flow and the Trust needs a pragmatic response to manage this.

- DB asked if the Trust was at risk of any concerns in relation to safety which would be difficult to manage. SH noted that the Trust had already tipped into concerns relating to safety in the last wave of COVID. The Trust works to minimise these risks but inevitably, due to the current challenges, the Trust does have more risk which impacts safety of care. This is escalated appropriately.
- PC noted that the Trust works hard to find a balance with staff, allowing them to focus on immediate and emergency care, whilst reminding them that governance processes are there for a reason.
- JD reported that in terms of staffing challenges the Trust have recently recruited 25 healthcare assistants from a recruitment event.
- PK noted that in terms of safety he is content with the current measures in place but highlighted his concerns that further escalation of challenges would result in the hospital having to stop services. SH noted that these scenarios are included in regional discussions and currently the Trust and system is far from that point. The Board discussed that the current scenario is replicated across the NHS and it is important to note that suddenly halting a service in one Trust, impacts another organisation. The Trust cannot operate in isolation from its partners.
- NM reiterated the NEDs support for the day-to-day decision making required by the executive team to make timely decisions.
- MVB queried if the Trust, when considering staffing challenges, had revised its approach to flexible working as many staff do not wish to align to the current employment structures in place. SH reflected on this point noting that the whole health sector is struggling and work-life balance should be considered as part of flexible working.

TB1 7/7/2 ASSURANCE AND REPORTS OF COMMITTEES

TB1 7/7/2.1 Clinical Governance Committee (CGC) 28th June 2022

EJ presented the report, providing a summary of escalation points from the meeting held on 28th June. EJ asked for the report to be taken as read and highlighted the key points detailed in the report.

The report was noted.

TB1 7/7/2.2 Finance and Performance Committee (F&P) 28th June 2022

PM provided a summary of escalation points from the Finance and Performance Committee held on 28th June. PM asked for the report to be taken as read and highlighted the following key points detailed in the report.

The report was noted.

TB1 7/7/2.3 **Trust Management Committee (TMC) – 22nd June 2022**

SH presented the escalation report from TMC held on 22nd June. SH asked for the report to be taken as read and noted the key points detailed in the report, including the business cases which were considered.

SH took the opportunity to inform board that changes were being made to the structure of TMC. The meeting will continue to run as it currently does on a bi-monthly schedule and on the other months the group will be taking time to consider broader leadership issues and strategic plans.

Discussion:
PK noted he was confused by the language in relation to reference to the 'chair'. SH noted that she would ensure the language was more explicit in future reports.

SH explained that in terms of business cases the executive team was working hard to support and challenge divisional teams to improve the standard of business cases whilst trying not to slow the process down.

EJ referred to the IRMER breach highlighted as part of the Health and Safety escalation report and asked if there had been any associated harm as a result. SH noted that no harm had been caused and the challenge was that the Trust missed the deadline and therefore there were concerns highlighted in relation to internal processes and failure to get a timely response.

TB1 7/7/2.4 **People and Culture Committee (P&C) – 30th June 2022**

RA provided a summary of escalation points from the People and Culture Committee held on 30th June. RA asked for the paper to be taken as read but and noted some key points as detailed within the report.

Discussion:
EJ noted that there are a number or projects underway in OD & People and asked how manageable and deliverable these initiatives are. MW explained that the team have nearly delivered 18 improvement programmes and the implementation of projects to deliver the 7 elements of the people promise are in hand. EJ noted that the Board will need to see evidence of the impact of these programmes of work in due course.

TB1 7/7/2.5 **Integrated Performance Report (IPR) (M2)**

MW presented the Integrated Performance Report which provided a summary of May 2022 performance metrics. MW noted that the operational challenges to the Trust had been discussed in detail but highlighted a few key points which were discussed in detail.

Discussion:

There was a notable positive impact of the SAFER event which lasted 5 weeks. Whilst improvement in the Trust's position was shown, it would be an exceptional way of working for a sustained period.

Stroke performance is not where it should be which has resulted in the Trust's SSNAP performance being affected. There are planned improvements in therapeutic input although the Trust will not see the impact of these improvements until Autumn. PC noted that whilst the reduction in score should not be ignored, the Trust is not seeing higher mortality or any deterioration in patient outcomes. There is more work underway to understand the data and how the department fails to meet the required standards. PC noted that all NHS Trusts in the South West have seen a deterioration in SSNAP scores.

DB highlighted that there is going to be a national drive by the Stroke Association. PC noted he was aware and had planned a meeting with the Stroke Network. There needs to be further consideration about resource into stroke. SH noted that this will drive a consolidated model and TB noted that might be the best solution as to provide the best outcomes for patients.

There have been challenges in meeting some cancer standards, but performance has been sustained in some areas despite equipment issues.

As discussed earlier in the meeting, staffing remains a key challenge. The Trust currently has 160 live vacancies and whilst sickness absence continues to impact staffing levels the Trust has reported steady figures over the last few months.

PK referred to appraisals and the lack of improvement in increasing performance. MW noted that the appraisal form in ESR is quite extensive and what the team have found is that appraisals have been completed but not signed off on the system. It is acknowledged that this is not the position the Trust would like to report and other methods of appraisal are being reviewed. The OD & People team are formally piloting wellbeing conversations given the operational reality regarding time. PK noted that IT has been a perpetual problem in terms of recording appraisals and whilst other pressures are involved, from a governance perspective it is not reassuring.

MVB referred to diagnostics and the Trust not meeting the target. SH explained that there is contingency around the MRI scanner but the biggest problem now is the workforce pressure in echo, audiology, and MRI. All have been asked to develop a recovery trajectory.

TB referred to mortality indicators noting that SHMI is within the expected range and HSMR is out of range. PC noted that going forward hospital data will now be split out in the Q4 paper.

EJ highlighted the positives in the IPR despite the challenging operational picture. There is some good practice, e.g., falls with harm are slowly reducing and the number of falls per thousand bed days. JD noted that the reduction in falls might be related to having more visitors. JD noted that the two grade four pressure injuries did not

happen in the organisation and it has been agreed these will not be recorded as a Serious Incident (SI).

SH noted the relentless nature for everyone in the circumstances and noted the efforts of all staff and the senior managers on call who have demonstrated great commitment in trying to improve the situation for staff and patients.

TB1 7/7/3 QUALITY AND RISK

TB1 7/7/3.1 Q4 Patient Experience Report

JD presented the Q4 patient experience report and highlighted the key points as detailed in the report.

Discussion:
JD noted that the report relates to earlier in the year during the last wave of COVID.

The Board noted that there has been a deterioration in the timeframe to respond which reflects the complex demands in delivery of care. There has been an increase in reopened complaints and the Head of Patient Experience is working effectively with divisions to respond appropriately.

MvB noted that the Friends and Family test is mandated and asked what benefit the Trust gets from it. The Board discussed that other feedback might be more valuable but the Friends and Family test is a useful barometer and provides useful data about how the services feel for people using the hospital. SH noted that like all data, it is often more useful when triangulated with other sources of feedback.
JD noted that VA will analyse from a thematic perspective and this will report through to the Patient Experience Group.

TB1 7/7/3.2 Q4 Learning from Death Report

PC presented the report to provide assurance that the Trust is learning from deaths and making improvements.

- There has previously been a noted disparity between SHMI and HSMR data which is provided from two different data sources. In relation to deaths by site, HSMR has looked higher than expected as the main hospital and the hospice are counted as one site and this has therefore been split.
- Weekend and weekday HSMR are within the expected ranges and therefore there is little to escalate.
- The Mortality Group continues to review details and learning.
- There is an outstanding action which focuses on output measures and Ben Browne is reviving the SJR (Structured Judgement Review) process and improving understanding in relation to thematic learning.

Discussion:
TB reflected that the Trust should be careful when splitting mortality data between hospice and hospital as it could be perceived as the

Trust not being as transparent as it could be. TB noted that the Trust should seek to find other hospitals which have a hospice on site and understand how they record mortality. The Board discussed that this can be difficult as it depends on the relative size of the hospital and hospice. PC noted that the executive team do not want to give false assurance. The rationale is clear but the Trust does want to ensure that the hospice is performing as well as the Trust. PC noted that he will do some further work on this and TB volunteered to support if required. **ACTION: PC**

TB1 7/7/3.3 **Director of Infection Prevention and Control Annual Report**

JD presented the annual Director of Infection Prevention and Control (DIPC) report and noted the following key points:

- For the reported period, the Trust has experienced a challenging twelve months for infection prevention and control, with the major incident response to the ongoing COVID-19 pandemic.
- There has been one Norovirus outbreak period lasting less than 15 days.
- The Trust continues to report low HCAI rates overall and remains in the top 25% of lowest cases regionally and nationally, with no Methicillin Resistant *Staphylococcus aureus* (MRSA) bacteraemia cases identified.
- Significant amounts of work have been completed and remain ongoing for antibiotic stewardship, decontamination, cleaning services and water safety.
- The gap in the antimicrobial Pharmacist position has been filled but not yet in post.
- There is low hand hygiene assessment compliance with a review of the process being undertaken.

Discussion:

- The Board discussed deaths associated with covid infections and it was noted that they are monitored at the mortality group to see if there have been any omissions of care.

TB1 7/7/4 **STRATEGY AND DEVELOPMENT**

TB1 7/7/4.1 **Improving Together Highlight Report – Quarter 1 2022/23**

EP presented the Improving Together Report highlighting the key points from the report:

- The Trust has paused formal training due to operational pressures but have embedded some practical tools, e.g. SAFER and using tools for problem solving which has been helpful from an engagement and buy in perspective. The teams are using learning from the last 6 months to set up a new roadmap after a small pause.
- There will be challenges and risks to the programme but the Coach House is, on a weekly basis, working with colleagues to be flexible enough to support and practice this new way of working.

- Divisional training has commenced and one of the key messages will be about divisional colleagues using their time more wisely e.g., attending meetings that add value.

Discussion:
SH noted that in the recent Chief Executive meeting with NHSEI there was a discussion relating to improvement in the NHS. A challenge was put to the national team around the need to industrialise improvement. This matter has gained some real traction and it is positive that the Trust has started the journey to embedding continuous improvement. SH noted that the Board needs to focus on taking this forward from a leadership perspective.

MvB referred to the previous conversation around appraisals and asked if people's development needs could be incorporated into the coaching programme. SH noted that this is coaching for improvement so would not identify gaps in skills and knowledge in that way as it is a specific set of coaching. EP explained that the focus is around process improvement. MW noted that there is a skills intervention as part of the Improving Together programme to enable a shift from command and control to an enabling culture.

TB referred to the report which indicated that there might be an overlap of processes running alongside each other and asked for further clarification. EP noted that this is symptomatic of embedding a new way of working and explained that some colleagues have been trained on a new performance management framework but they have not yet adopted the same approach within their teams.

RA referred to the issue around appraisals and commented that the Trust should consider a new approach to appraisals, moving away from a formalised sit-down conversation. SH noted that there were other reasons, other than the timely process of adding to ESR, why appraisals were not being completed. However, SH acknowledged that there is an opportunity to completely rethink appraisals within the professional requirements.

TB1 7/7/5 FINANCIAL AND OPERATIONAL PERFORMANCE

TB1 7/7/5.1 SIRO Annual Data Security and Protection Assurance Report

JB presented the report providing an update on progress made by the organisation since the last report, noting the areas of improved compliance and areas of concern. The following key points were highlighted:

- The Trust has submitted the Standards Met DSPT for 2021-22 as the deadline was 30th June 2022.
- The outcome of the DSPT NHS National Cyber Security Audit conducted in February 2022 was favourable and highlighted no areas for concern or risk.
- The Trust self-declared three incidents to the Privacy Regulator, the Information Commissioners Office (ICO). The ICO assessed each and found no actions would be taken against the Trust.

Discussion:
The Board thanked JB for a positive report and the work to ensure the Trust remains compliant.

The Board discussed key risks and it was noted that cyber risks are greater than they used to be particularly in the environment of distributed systems and data processing offsite. The Board was assured that protective processes are in place, acknowledging the heightened risk of cyber-attacks globally.

JB noted that one of the Trust's key challenges is progressing collaborative working as SFT can only have so much influence and control in these circumstances.

SH noted her thanks to JB and Heidi Doubtfire-Lynn, Head of Information Governance.

TB1 7/7/5.2 **Housekeeping Review**

NM welcomed IR to the meeting who came to present a housekeeping review paper. IR noted the following key points:

- In May 2021 NHSE/I published new NHS mandated cleaning standards with an expectation that Trusts would adhere to these new standards from May 2022.
- The Trust current adheres to the 2007 NHS Cleaning specifications for very high- and high-risk areas, with the lowest spend (in England), per occupied metre for small acute Trusts. The investment we are required to make (to deliver these new standards) is significant and greater than all other small acute Trusts.
- As a staged approach to full implementation of these new standards £408k pa (recurring), an 18.1% increase on the 2021/22 housekeeping budget, is requested, and reduced in 2022/23 to reflect the lead time for implementation. Investment at this level will not deliver compliance with the new NHS cleaning standards. Therefore, it was felt important that the Board should review this proposal to support housekeeping in the Trust, whilst acknowledging that the Trust will be non-compliant against the new standards.

Discussion:
The Board discussed the challenge in relation to the new standards and which are challenging as they require an increase in cleaning frequency which we are unable to achieve with current resource.

IR noted that if the full £1.12m was approved there would be exceptional recruitment challenges equating to 24 vacancies to recruit to in the next 12 months.

There is one element of high risk that the Trust do not currently comply with in relation to public spaces and public toilets. The additional £408k this year would focus on addressing those cleaning issues in

public spaces and public toilets and then also provide an opportunity to look at outpatient areas.

PK asked that if the recommendation position results in non-compliance, what are the key risks. IR noted that the risk would be a sanction by the Care Quality Commission (CQC) who would ask for a recovery plan which will need to be drafted imminently.IR further explained that the Trust's position to implement would mean a huge recruitment drive and a staged approach will be mapped to our ability to recruit and train new staff and measure the benefits of further investment. In the longer term the Trust will aim for option 2 but option 3 is currently more realistic.

EJ noted that CGC had looked at this paper in detail and the Committee had noted that it was an uncomfortable position for the Trust to be in. Whilst there is a noted commitment to reach compliance it will take some time.

TB asked what the immediate benefits will be from the staged approach. IR explained that several public areas which executive colleagues and others have highlighted as below standard will be cleaned more frequently. IR also noted that patients are asked to score immediate surroundings and this will include corridors and public spaces which will benefit from the additional resource.

EJ noted that if there is an opportunity to escalate recruitment the Trust should consider this. LT noted that any expedited recruitment would have to be within the agreed in-year funding. LT suggested that IR comes back to the Board by exception if he is able to recruit in full before year-end.

PK asked if the Trust had completed any outsourced review of cleaning. IR noted that this would be a good option but it would be an expensive approach. The Board discussed outsourced provision for cleaning but again noted this would be significantly more expensive than the in-house team.

Decision.
The suggested approach to staged housekeeping funding was supported by the Board.

TB1 7/7/6 PEOPLE AND CULTURE

Health and Safety Annual Report – deferred to September

Freedom to Speak Up Guardian – deferred to September

TB1 7/7/7 GOVERNANCE

TB1 7/7/7.1 Annual Report and Accounts

FMc presented the Annual Report and Accounts 2021/22 which had been laid before parliament and will now be published on the website.

Everyone involved was thanked again for their input and the final report noted.

The Communications team will produce an Annual Review summary which will be ready to distribute prior to the Annual General Meeting.

TB1 7/7/7.2 **Q1 Register of Seals**

FMc presented the report noting the two Register of Seal entries that had been signed off.

The Board noted the two entries.

TB1 7/7/8 CLOSING BUSINESS

TB1 7/7/8.1 **Agreement of Principle Actions and Items for Escalation**

NM noted the key points from the meeting as follows:

- IPR performance and the continued support for executives to make key day to day operational decisions.
- Approved the housekeeping funding approach.
- Approved the annual SIRO report.

TB1 7/7/8.2 **Any Other Business**

There was no other business.

TB1 7/7/8.3 **Public Questions**

There were no public questions.

TB1 7/7/8.4 **Date of Next Public Meeting**

Thursday 8th September 2022, Board Room, Salisbury NHS Foundation Trust

TB1 7/7/9 RESOLUTION

TB1 7/7/9.1 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
Open Actions

Contact Kirsty McAllister, kirsty.mcallister@nhs.net, 4439, for any issues or feedback

1	Deadline passed
2	Progress made, please detail
3	Completed
4	No progress made

Committee	Organiser	Reference Number	Deadline	Owner	Action	Current progress made	Completed Status (Y/N)	RAG Rating
Trust Board Public	Sasha Grandfield	TB1 10/3/2.4, TB1 7/4/1.6 - IPR / Maternity Dashboard	08/09/2022	Judy Dyos, JD	Further work required to maternity dashboard in the IPR as it is difficult to understand . JD to speak with TB.	**July: awaiting LMS dashboard- keep on action log** JD explained that the improvements on the Maternity dashboard will be coming to Clinical Governance Committee (CGC) in May. Item to remain open until then	N	2
Trust Board Public	Sasha Grandfield	TB1 7/4/1.6, TB1 13/1/5.4 - Equality, Diversity and Inclusion (EDI) Annual Report/ Staff Networks	08/09/2022	Melanie Whitfield, MW	A formal update on EDI progress to come to the Board in July.	**Defer to September's meeting - On Sept agenda**	Y	3
Trust Board Public	Sasha Grandfield	TB1 7/4/3.2 - Outcome focus at the Board/ Learning from Death Report Q3.	~~04/08/2022~~ 08/09/2022	Peter Collins, PC Fiona McNeight, FMC Stacey Hunter, SH Judy Dyos, JD	TB reflected that the Board does not spend time looking at outcome measures and there needs to be a way of building and demonstrating these. It was agreed that SH and FMc would liaise with JD and PC to think about introducing an outcome focus at Board.	**SH and FMc to work with JD and PC to consider outcome measures and how this is tied into assurance delivery at Board level. Sept 22**	N	2

Salisbury NHS Foundation Trust

Report to:	Trust Board (Public)	**Agenda item:**	1.8
Date of Meeting:	08 September 2022		

Report Title:	Chief Executive's Report			
Status:	**Information**	**Discussion**	**Assurance**	**Approval**
	X			
Approval Process (where has this paper been reviewed and approved)	N/A			
Prepared by:	Stacey Hunter, Chief Executive Officer			
Executive Sponsor (presenting):	Stacey Hunter, Chief Executive Officer			
Appendices (list if applicable):	Appendix 1: NHSE/I Next Steps in increasing capacity and resilience in urgent and emergency care ahead of Winter Appendix 2: COVID-19 testing in periods of low prevalence			

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

Executive Summary:
The purpose of the Chief Executive's report is to highlight developments that are of strategic relevance to the Trust and which the Board of Directors needs to be aware of. This report covers the period since the last public board meeting on the 7th July 2022. Key points to note: • The executive team have welcomed Lisa Thomas to the Chief Operating Officer role and Mark Ellis to the Chief Finance Officer role. These changes have been delivered from within the existing senior leadership team to give stability over the course of the next year. • SFT is delivering in line with the 22/23 plan which is positive given the recent wave of COVID and continued challenges in our operating context. The details are provided within the IPR and finance report. • The Trust delivered on the requirement to ensure that no patients wait exceeds 104 weeks by July and I know the Board will want to congratulate our teams in achieving this important milestone. The current performance against the trajectory

for the next elective milestone of no patients waiting longer than 78 weeks by the end of March 2023 is on track.

- The Board will note that the number of people who no longer have criteria to reside in an acute setting remains high at circa 105 since the last Board meeting. This continues to place material pressure on bed occupancy and on our teams with all escalation beds still open and flow out of the Emergency Department significantly impacted. This has resulted in continued breaches of the ambulance handover standards and some patient experiencing long waiting times.

- The Board will receive the Winter plan from the Chief Operating Officer (COO) at the finance and performance sub-committee in September and at our Board meeting in October. Our plan is dependent upon the BSW system response alongside our internal actions. The COO is leading work with system colleagues to secure additional capacity off-site to manage the expected peaks in demand during the winter months. NHSE/I have shared their priorities for winter (see appendix 1) and the Board will note as part of this a rigorous approach to scrutiny and assurance across urgent and emergency care pathways.

- Performance against the 6-week diagnostic standard and the cancer standards remains challenged. The Divisions have been asked to bring forward a recovery plan.

- Our **Improving Together** work continues and the Board will note the changes in format of our Integrated Performance Report (IPR) aligned to our strategic initiative and breakthrough objectives. A similar approach has been implemented in relation to Executive Performance Reviews (EPR) which will support focus on our areas of agreed priority.

- We have received a recent (24/08/22) communication from NHSE/I regarding changes to the approach for COVID testing during periods of relatively low levels of community COVID. This will impact both patients and staff. Our Medical Director will update the details at the Board meeting.

- The Wiltshire Place Joint Committee (JC) terms of reference have been agreed and the first meeting for the JC is planned for October. Wiltshire Council will chair the JC for the first 12 months beyond which this role will rotate across the partner members annually.

- The BSW Integrated Care Board (ICB) is now established and set to detail arrangements for performance oversight and the framework to deliver the transformation priorities. This includes a significant piece of work to review the form and function of Adult Community services across BSW over the next 18 months as all current contracts can end in March 2024. This is a good opportunity to influence the ambition and outcomes that community health services can contribute to our population as part of our BSW Health and Care Model.

- Our colleagues in OD & P are leading our work in relation to being a People Promise Exemplar site and hosted a positive visit from the national leads in August.

- At the time of writing this report we are in the final planning stages of our Thank You week for staff which will include the Staff Awards ceremony, long service awards, a lunch for our volunteers and the Annual General Meeting. We have been hugely impressed by the number and calibre of nominations for the staff awards this year demonstrating the absolute talent and dedication we are fortunate to have within Team Salisbury.

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

1.0 Our Population

1.1 Operational Context

Patient Flow within and out of the hospital remains exceptionally challenged. The most material constraint is the number of people with No Criteria to Reside (NCTR) occupying circa 25-27% of the available bed capacity. This is having a knock-on impact to ambulance handover times, the emergency care standard and the length of wait patients are experiencing in our Emergency Department. It is also impacting our ability to deliver optimal nurse staffing levels on our wards as we have been unable to reduce the number of escalation beds.

The underlying constraints in the system in respect of reducing the numbers of people with NCTR that require on-going support relate to the inability to source sufficient domiciliary care capacity and constraints in community health capacity. There is on-going scrutiny and active work to increase capacity outside of Acute Hospitals including additional funding for a specific programme of work related to mobilise additional bed capacity at a site in South Wiltshire for winter.

Elective recovery has been sustained in respect of delivering the key waiting time standards in the current operating plan. Our performance against the 6-week diagnostic standard has deteriorated over the last 3-4 months with the teams struggling to increase capacity due to staffing constraints in several modalities. This is having a knock-on consequence on our cancer pathways and is impeding our ability to improve performance across the cancer standards.

This is a concern and the CSFS Division have been asked to detail further options for recovery of this standard and bring them via F & P board sub-committee in September. The other acute trusts in BSW and the South West are experiencing similar challenges with their performance against this standard.

The levels of COVID in the community and those requiring hospital admission has significantly reduced over the last 4-6 weeks with the subsequent reduction in staff absence related to COVID.

1.2 Quality and Safety

Our quality and safety metrics have remained consistent with the last period the detail of which is shared in the IPR. There are some early signs of improvement in the number of people who sustain significant harm when they fall in hospital which is one of our Improving Together breakthrough objectives.

The NHS have now published the reforms on how NHS organisations should respond to patient safety incidents. “The Patient Safety Incident Response Framework” will replace the current serious incident framework and provides guidance on how and when trusts should conduct investigations. A key aim of the reform is to allow trusts to focus resources on where investigations will have the greatest impact rather than investigating all incidents. Our Chief Nurse and Chief Medical Officer will lead the work to implement the changes in the coming months.

1.3 Financial sustainability

The Trust recorded a control surplus position of £0.876m against a target deficit of £0.93m in month 4. This is in line with plan albeit vacancies are mitigating the premium rate costs for agency staff aligned to nurse staffing levels and pressure in our urgent and emergency pathways.

The Board will be aware that our overall forecast of £8.8m efficiency savings is predicated on 45% non-recurrent delivery.

Emerging issues around the national pay award funding, winter plan and inflation costs are driving a significant financial challenge for the remainder of 2022/23. Work is ongoing to drive down excess costs, identify further efficiencies and engage with system partners on cost reduction measures to mitigate the financial risk.

The BSW ICB is currently undertaking a review of providers against system oversight framework (SOF) ratings and we are asking them for support to remove the Trust’s historic financial undertakings. We have met the requirements that remain relevant and BSW have submitted break even plan for 22/23 in line with national requirements.

1.4 COVID Testing Changes

NHSE/I have requested that organisations review COVID-19 testing in periods of low prevalence and implement changes from Sep 1. The Chief Medical Officer will provide an update of the changes agreed for the Board.

2.0 Our People

2.1 Staffing

Our staffing situation has not significantly improved and remains a concern. Turnover is above the target of 10% and staff sickness peaked in July which impacts team's ability to sustain their expected staffing levels.

Our vacancy rate is high albeit it is important to note that this is in part driven by investment in additional staffing agreed as part of the 22/23 plan. It is clear we need to ensure that we continue to prioritise recruitment and that our processes are fit for purpose given the market constraints. There are ongoing campaigns in place for the recruitment of HCAs (maternity and nursing), admin and clerical staff and theatres.

We have welcomed some new internationally recruited nurses during August and are anticipating the arrival of 5 international midwives during September.
We are getting anecdotal feedback from colleagues who are leaving the Trust that the cost-of-living crisis is driving them to jobs outside the NHS where the can secure better hourly rates of pay.

Our Chief People Officer has been working with our Chief Finance Officer reviewing the impact of the recent pay award and the changes in pension contributions (due October) across our staffing groups. This will be shared with the Board at the planned development session in October.

2.2 Retention of staff

Retaining our staff is one of the most important factors for us to continue to deliver care to our population in the forthcoming years. Board colleagues will be aware we are focused on a range of retention actions alongside our cultural work aimed at making SFT the Best to Work to support this.

Our Chief People Officer and her team are supporting the prioritisation and implementation of the themes that relate to this in the NHS People Promise and it will need to efforts of the whole Board and organisation to support this work.
We are taking steps to improve our data and in turn our understanding of the experience of our staff including the reasons for people leaving our organisation and continuing to gather feedback and ideas from them. It is imperative we listen to their views and act on what they tell us.

We have addressed a concern that has been raised with us over the last few months by staff who use their cars in the course of their work and increased the mileage allowance. Staff who can carry out some of their work from home have welcomed the opportunity to continue with this approach as it can be more flexible as well as reduce the costs of travelling to the site every day. We have also introduced an at cost hot meal for staff.

Our health and well-being offer is being evaluated so we can ensure that we are targeting the areas our staff find value adding and there is a specific piece of work to consider this in respect of the diversity within our teams.

There have been expert seminars offered on the NHS pension which have been well attended and received by colleagues. We know for some of our colleagues the impact of the HMRC rules re pension is directly impacting their decisions to retire from or leave the NHS.

There is more for us to do in relation to the education, training and development offer for staff and consistent effective line management at all levels in the organisation. The Board will be sighted on this via the OD& People Board sub-committee in the coming months. These are areas that our staff survey indicates we need improvement and are well evidenced in the broader literature to have a significant impact on employee retention.

2.3 Thank You Week

By the time we are in our Board meeting we will be hours away from the Staff Awards evening which kick starts a whole host of activities designed to highlight the incredible work our teams deliver and say a huge thank you to everyone who works and volunteers on behalf of the Trust.

I know our awards evening will be a brilliant opportunity to reflect and celebrate everyone at SFT and whilst there be will some individual winners reading the record number of nominations, we received has been an excellent reminder of what makes our organisation special. There were so many examples of exceptional care and commitment from colleagues across the Trust I know the judging panels have felt very humbled and had a really difficult time choosing the finalists.

I want to place my thanks to our communication team who are central to the events of thank you week. Their energy and creativity are fantastic, driven by their desire to ensure staff have a great time and feel valued. We would not be able to deliver this without them. I hope those Board members who can join in with some of the events planned this week all enjoy the experience.

2.4 Annual General Meeting

The above is due to take place on the 9th September with the annual report available for members and the general public. This allows the organisation to reflect on our activities during 21-22 and highlights the achievements and progress in our efforts to recover from the impact of the pandemic.

2.5 Digital Transformation

Our Digital Transformation journey continues through adopting a Digital Care visual identity and regular updates in the staff daily bulletin. Recent work has included migrating staff to using Office 365, the benefits of Power BI to analyse patient data and the introduction of Dr Doctor - our new video conferencing and appointment reminder system.

The Digital Care team have held a roadshow at Springs restaurant and have been out and about on wards ahead of Lorenzo EPR improvements going live across all inpatient areas in the autumn. Staff saw first-hand the new clinical documentation, the electronic prescribing and medicines administration (EPMA) system and new look discharge summaries. In addition, over 30 people have volunteered to be Digital Champions and Superusers to ensure localised support for a smooth roll out of the new technologies

And finally, I am pleased that our *Reflection on a Pandemic* project that involved the creation of an original poetry collection (My Name is Mercy) based on staff experience - and the moving *We Reflect* service at the cathedral - has been shortlisted for an NHS communications award for staff engagement.

3.0 Our Partnerships

3.1 Winter plan securing additional capacity – Urgent Care Board and Wiltshire ICA

The above activity is taking priority with Wiltshire based partners and ICB colleagues. The Chief Operating Officer (COO) is leading this on behalf of SFT and has set up a programme of work to develop the clinical and workforce model and the mobilisation plan. Board colleagues will appreciate the importance of delivering this additional capacity to minimise the risks of the hospital being overwhelmed by demand during winter. The overarching plan for BSW details a gap of circa 351 beds worth of activity for 22/23 and the system has received additional financial support to increase out of hospital capacity.
There are several risks to delivery of the plan, and I have asked the COO to escalate anything material to the Board as part of our Winter plan which is due in October.

3.2 Wiltshire Place Joint Committee

The Wiltshire ICA leadership team has now agreed the terms of reference and chair arrangements for the above. Wiltshire Council will chair the committee during the first 12 months, and I have agreed to be the Deputy Chair.

The committee meets for the first time in October and will take opportunity to determine the work plan for the next year. This is a significant development for place and needs to be used to agree and accelerate the pathways and services which will benefit most from further integration. In due course I will agree with you how we share in the outputs of the committees work with the Board.

3.3 BSW ICB

There is a meeting of the ICB Board on the 30th August and I will update at our Board meeting any relevant matters.

3.4 Specialist Commissioning

Dorset, Southampton, Hampshire and Salisbury specialist commissioning group have undertaken work looking at setting up a spinal network to develop the current clinical model for spinal patients. Our Chief Medical Officer has led this work with colleagues from across the South West and South East and we have recently agreed a business case for hosting this new network at SFT.

Classification: Official

Publication reference: PR1929

To:
- Integrated Care Board Chief Executives and Chairs
- NHS Foundation Trust and NHS Trust:
  - Chief Executives
  - Chairs

NHS England
Wellington House
133-155 Waterloo Road
London
SE1 8UG

12 August 2022

cc.
- Regional Directors

Dear colleagues

Next steps in increasing capacity and operational resilience in urgent and emergency care ahead of winter

This week the NHS reached its first key ambition on recovering services, focusing on patients who had been waiting more than 104 weeks. We delivered this important milestone despite having to contend with further waves of COVID-19, including more than a quarter of our COVID-19 inpatients occurring since publishing the Elective Recovery Plan, an unprecedented heatwave, and other significant pressures. It shows once again that when we prioritise, invest, and innovate, the NHS can, acting as a national service, deliver for patients.

Urgent and Emergency Care is currently under significant pressure. Staff have faced one of their busiest summers ever with record numbers of A&E attendances and the most urgent ambulance call outs, all alongside another wave of COVID-19. Thanks to the professionalism and commitment of those staff, the NHS continues to provide care to over 100,000 urgent and emergency care patients each week. Despite their best efforts, these pressures have meant that there have been too many occasions when staff have not been able to provide timely access for our patients in the way they would have wanted.

Our immediate response has been to focus on ambulance performance, and the linked issue of speeding up discharge. We have provided extra funding to ambulance services, offered intensive support to those trusts most challenged by ambulance delays, and rolled out virtual wards across the country, enabling patients who would otherwise be in hospital to receive support at home.

And we have begun planning for the coming winter earlier than usual, recognising pressure on the NHS is likely to be substantial, particularly in UEC, making the most of the opportunity created by the formation of ICBs to maximise the benefits of system working.

In addition to maintaining progress on 2022/23 operational priorities and building on the significant successes in delivering our Elective Recovery plan, with a strong focus on 62 day cancer backlogs and elective long waits, today we are setting out the next steps in our plans to rapidly increase capacity and resilience ahead of winter, building on the operational plans we have worked on together.

Core objectives and key actions for operational resilience

Our collective core objectives and actions are to:

1) **Prepare for variants of COVID-19 and respiratory challenges**, including an integrated COVID-19 and flu vaccination programme.
2) **Increase capacity outside acute trusts**, including the scaling up of additional roles in primary care and releasing annual funding to support mental health through the winter.
3) **Increase resilience in NHS 111 and 999 services**, through increasing the number of call handlers to 4.8k in 111 and 2.5k in 999.
4) **Target Category 2 response times and ambulance handover delays**, including improved utilisation of urgent community response and rapid response services, the new digital intelligent routing platform, and direct support to the most challenged trusts.
5) **Reduce crowding in A&E departments and target the longest waits in ED**, through improving use of the NHS directory of services, and increasing provision of same day emergency care and acute frailty services.
6) **Reduce hospital occupancy**, through increasing capacity by the equivalent of at least 7,000 general and acute beds, through a mix of new physical beds, virtual wards, and improvements elsewhere in the pathway.
7) **Ensure timely discharge**, across acute, mental health, and community settings, by working with social care partners and implementing the 10 best practice interventions through the ‘100 day challenge’.
8) **Provide better support for people at home**, including the scaling up of virtual wards and additional support for High Intensity Users with complex needs.

This letter and the appendix sets out the important actions, developed in partnership with you, to help deliver these core objectives, as well as how NHS England will support you. Taking these actions should help manage pressure across the pathway, supporting improved flow for patients in emergency departments.

Clearly, expanding capacity is dependent on both sufficient workforce and workforce wellbeing. This is why it is important that the plans have been built from the bottom up, with ICBs responsible for developing plans that are based on realistic assumptions, including how many staff can be recruited and at what speed. We will fully fund the recent pay award nationally, avoiding the need to cut frontline services for winter.

Similarly, ICBs have been clear with us that much of the pressure on urgent and emergency care is driven by the current, significant, growing strain in social care. Too many patients are spending longer in hospital than they need to, creating pressure along the entire pathway. We will continue to work with the Government, and national local government partners, to help, as far as possible, address these issues. At a local level, the creation of ICSs offers an opportunity for all partners in a local system to work together to deliver local solutions. This includes making best use of the Better Care Fund, building on the work you are doing locally to map local demand and capacity.

Performance and accountability: A new approach to working together

This plan is underpinned by a new approach to how organisations in the NHS work together – the Health and Care Act 2022 has enshrined Integrated Care Systems in law. Although this winter presents significant challenges, it is an opportunity to show how these new ways of working can make a real difference to patients and join up the entire urgent and emergency care pathway in ways we've been unable to do before. The plan empowers system leaders to do this in a number of critical areas, and where you can go further, please do so.

System working also means a new approach to accountability. ICBs are accountable for ensuring that their system providers and other partners deliver their agreed role in their local plans and work together effectively for the benefit of the populations they serve. ICBs are responsible for initial problem solving and intervention should providers fail, or be unable, to deliver their agreed role. Intervention support can be provided from NHS England regional teams as required, drawing on the expertise of our national level urgent and emergency care team as needed.

That line of accountability does mean that we will want to continue to work with you to stress test your plans and to 'check and challenge' progress in delivering them. We will expect that you work with us to report on local performance and collaboratively, but quickly, tackle problems where they occur.

On performance metrics, the overall objective remains the provision of safe and effective care. Until the adoption of the Clinically-led Review of Standards is agreed with the Government, current standards remain for emergency department performance and flow. Likewise, objectives set out in Planning Guidance, which includes reducing 12 hour waits and increased clinical input in 111, remain. These should continue to be used to understand flow through your emergency departments.

Working with ICBs we have identified the following six specific metrics, key to the provision of safe and effective urgent and emergency care, that NHS England and ICBs will use to monitor performance in each system through the Board Assurance Framework:

- 111 call abandonment.
- Mean 999 call answering times.
- Category 2 ambulance response times.
- Average hours lost to ambulance handover delays per day.
- Adult general and acute type 1 bed occupancy (adjusted for void beds).
- Percentage of beds occupied by patients who no longer meet the criteria to reside.

We will work with you through the Assurance Framework to develop local performance trajectories to sit alongside these measures.

The work on elective care and the 100 day discharge challenge demonstrates the value of using an improvement approach based on data, easy to access best practice guidance, as well as senior clinical and executive peer review in spreading solutions focused on those facing the greatest challenges. We will launch new improvement offers to support ambulance handover and response times in the coming weeks.

To support ICBs, we will provide you with a Board Assurance Framework to monitor progress monthly against the combined System Capacity Plans, Actions and Good Practice basics and improvement priorities developed with colleagues over time. This is aimed at supporting and ensuring trusts continue to implement best practice. Each BAF will be unique to each ICS to reflect the specific capacity gaps that you have identified.

While these plans represent substantial work to increase capacity and improve operational resilience, clearly epidemiological modelling suggests reasonable worst-case scenarios for Covid-19 which would require a more significant set of actions. We will work with you to develop plans for these scenarios.

Thank you to you and your teams across the NHS for your continued hard work. While there is no doubt that we are going to experience challenges over the winter, when the NHS unites as it has over the past two and half years of the pandemic and works closely with wider partners, we know we can best serve patients, support our teams and maintain the momentum of the NHS's recovery from the pandemic.

Yours sincerely,

Amanda Pritchard
NHS Chief Executive

Julian Kelly
Chief Financial Officer
NHS England

Sir David Sloman
Chief Operating Officer
NHS England

Appendix – Actions: Further details on increasing capacity and operational resilience in urgent and emergency care ahead of winter

Each ICB plan has been discussed, and agreed, with the relevant NHS England region and a series of specific actions have been agreed between NHS England and each ICB in the following areas:

1. **New variants of COVID-19 and respiratory challenges**

SPI-M scenarios for COVID-19, combined with scenarios for flu, suggest that even in optimistic scenarios, high numbers of beds may be needed for respiratory patients during winter. Resulting IPC requirements will make bed management complex, especially if bed occupancy remains high. We will do further work with you in the coming months on stress-testing planning for the operational response to realistic worst-case scenarios. We are working with local areas to:

- Deliver an integrated COVID-19 booster and flu vaccination programme to minimise hospital admissions from both viruses.
- Implement UKHSA's IPC guidance in a proportionate way and develop strategies to minimise the impact of 'void' beds.

2. **Demand and capacity**

A lack of capacity across the NHS has an impact on all areas of the system. It is essential that ambulance and NHS 111 services have the necessary capacity in place and that access to primary care, community health services and mental health services for urgent patients is sufficient to ensure patients do not need to present to emergency services. We are working with local areas to:

- Open additional beds across England, to match the additional capacity identified by ICSs to be able to deliver against expected winter demand. This should create the equivalent of 7,000 additional general and acute beds, through a mix of new physical beds, scaling up virtual wards, and improvements in discharge and flow.
- Increase the number of NHS 111 call handlers to 4,800 and the number of NHS 999 call handlers to 2,500.
- Increase provision of High Intensity User services.
- Support good working relationships with the independent sector, building on the success so far, and facilitating patient choice.

In community care:

- Increase two-hour Urgent Community Response provision by maximising referrals from the ambulance service and other providers, aiming to maintain and improve the current standard of responding to 70% of call outs within two hours.
- Increase the number of virtual wards to create an additional 2,500 virtual beds.

In primary care:

- We will maximise recruitment of new staff in primary care across the winter, including care co-ordinators and social prescribing link workers.
- ICBs to actively support and engage with PCNs to work with each other and other providers to develop collaborative models to manage seasonal preparedness and

specific winter pressures (such as oximetry monitoring for COVID-19 patients) alongside the digital development of primary care.

In mental health, cancer, and elective care:

- Share mental health best practice between systems and work with the VCS and LA sector to alleviate capacity constraints.
- Releasing £10m of annual funding to support MH through the winter, in addition to continued planned growth in community and crisis provision.
- Maintain and increase elective capacity to eliminate waits of over 18 months, as per the Elective Recovery Plan, except for patients who choose to wait longer or require alternative plans due to clinical complexity.
- Reduce the number of people waiting more than 62 days from an urgent cancer referral back to pre-pandemic levels by March 2023.
- Ensure the preservation of the standard clinical pathway for CYP elective surgery, critically ill children, and emergency, general and specialist services.

3. Discharge

While challenges are often seen at the ‘front door’, we know that their root cause is often in the ability to discharge patients from, and flow through, hospitals. There is a significant number of patients spending longer in hospital than they need to, often due to a lack of availability of social care. While the provision of social care falls outside of the NHS’s remit, the health service must ensure patients not requiring onwards care are discharged as soon as they are ready and can access services they may need following a hospital stay. We are working with local areas to:

- Implement the 10 best practice interventions through the 100-day challenge.
- Encourage a shift towards home models of rehab for patients with less severe injuries or conditions.
- Maximise support available from the Seasonal Surge Support Programme, provided by VCS partners.

4. Ambulance service performance

While ensuring there is enough capacity for ambulances to respond to the most urgent calls and take patients to hospital is essential, it is also important to focus on what can be done to reduce avoidable ambulance activity, through treating patients at the scene. We are working with local areas to:

- Implement a digital intelligent routing platform and live analysis of 999 calls.
- Agree and implement good practice principles for the rapid release of queuing ambulances in response to unmet category two demand.
- Work with the most challenged trusts on ambulance handover delays to develop solutions, including expanding post-ED capacity.
- Increase the utilisation of rapid response vehicles, supported by non-paramedic staff, to respond to lower acuity calls.
- Model optimal fleet requirements and implement in line with identified need.
- Implement the ambulance auxiliary service which creates national surge capacity to enhance the response and support for ambulance trusts.

- Deploy mental health professionals in 999 operation centres and clinical assessment services and deliver education and training to the workforce.
- Increase the use of specialist vehicles to support mental health patients.

5. NHS 111 performance

The NHS 111 service can only work if it has sufficient clinical capacity to provide consultations if required and patients are able to be directed to the right service for their needs. We are working with local areas to:

- Improve call handling performance through the implementation of regional call management which will enable better integration between providers and ensure the entire NHS 111 capacity is used effectively.
- Continue pilot of national Paediatric Clinical Assessment Service and build on what we are learning.
- ICBs to update details of the 24/7 urgent mental health helplines for patients experiencing a mental health crisis, and ensure these services are promoted.

6. Preventing avoidable admissions

A full range of urgent care services should be available to ensure patients can access the right care in the right place. The Directory of Services should be used by staff to direct patients to the most appropriate place, while same-day emergency care, frailty and 'hot' outpatient services should also be available for patients requiring urgent specialist treatment but not necessarily via an ED. We are working with local areas to:

- Increase number and breadth of services profiled on the Directory of Services to ensure only patients with an emergency need are directed to A&E.
- Develop and protect capacity for same-day emergency care services so that operational hours are profiled against demand and surgical availability.
- Review non-emergency patient transport services so that patients not requiring an overnight hospital stay can be taken home when ready.
- Improve the provision of the Acute Frailty service, including the delivery of thorough assessments from multidisciplinary teams.
- Implement out of hospital home-based pathways, including virtual wards, to improve flow by reducing hospital attendances. Reduce unnecessary attendances for patients with mild illness through revised NHS @home pathways that incorporate broader acute respiratory infections.

7. Workforce

NHS staff have worked incredibly hard throughout the pandemic and both current and future pressures on the health services mean teams will remain stretched. The health and wellbeing of the workforce is crucial and interventions targeting recruitment and retention will be important in managing additional demand this winter. We are working with local areas to:

- Implement your recruitment and retention plans including staff sharing and bank arrangements.
- Utilise international support for UEC recovery, identifying shortages of key roles and skills and targeting recruitment as such.

- Implement the Wellbeing Practitioners' Pack.
- Develop roles for volunteers that reduce pressure on services and improve patient experience, such as community first responders and support in discharge.

8. Data and performance management

Making the full use of data at a local, regional, and national level will help inform operational decision-making and improve the delivery of services. We are working with local areas to:

- Ensure timely and accurate submission to the Emergency Care Data Set.
- Encourage use of the A&E Forecasting Tool.

9. Communications

We are undertaking the following actions to enable strong communications:

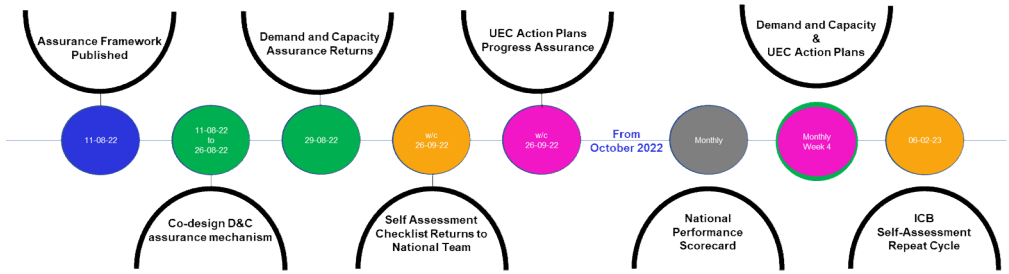
- Implement your winter communications strategy to support the public to minimise pressures on urgent and emergency services.
- Deliver the NHS 111 and GP Access strands of the Help Us Help You campaigns.

UEC Assurance Framework: Introduction

- The UEC Assurance Framework in its entirety is designed to be a helpful tool to support ICB in their responsibilities to both support and hold the system to account on committed deliverables. We have a unique opportunity to co-design how we evolve this assurance mechanism in a way that it brings the NHS together with a strong sense of responsibility and accountability. ICBs are asked to consider during their September Boards what their trajectories should be against the key metrics identified in the plan. These will be used to monitor progress and delivery in collaboration with the NHSE regional teams, performance against key metrics; sample **Scorecard** and indicative **Dashboard** included.
- **(1) Demand and Capacity Assurance:** NHS England has committed to fund system demand and capacity plans to enhance bed capacity across the country. ICBs and NHSE regional teams are asked to work collaboratively develop a mechanism for monitoring the delivery of your agreed additional capacity plans. We anticipate a first return of the agreed monitoring mechanism for the agreed capacity (by region) and progress to date by **29 August**. The assurance mechanism agreed must have an agreed set of definitions and thresholds to allow for an aggregated view nationally and by region whilst highlighting any areas of concern, remedial action and escalation required.
- **(2) UEC Action Plan 2022-23:** NHS England will be publishing an action plan to support with winter preparedness and wider system resilience. The Assurance Framework includes a **Tracker** that identifies the actions that are directly deliverable by ICBs and Providers. The first return will be due **w/c 26 September** and **monthly thereafter**; **Week 4**.
- **(3) Operational Self-Assessment Good Practice Checklist:** The Operational Self Assessment Checklist is being published as part of the System Letter and the wider Assurance Framework due to be released on **11 August**. NHSE regional teams are asked to work with ICBs to collate returns to inform an aggregated return – with any escalation required - by **w/c 26 September.** Themes and gaps will be aggregated by the national UEC team by **the 1st week in October** and used to inform the development of future support offers. ICBs however, should use this tool as appropriate to assure themselves of their system's operational good practice and progress on areas where gaps have been identified.
- **(4) Good Practice Checklist:** The Assurance Framework also includes a 'Library' of good practice in the system that can support you where areas of concerns are identified.

Lastly, we want to assure you this is the start of a collaborative mechanism that is intended to assure and actively help manage all parts of the system. NHSE will continue to work with you in the co-design and collectively using this as the vehicle to deliver a great service to our patients.

UEC Assurance Framework: Timeframes



Name

Integrated Care Board - Indicative Dashboard

Month 2022

Region

ICB	Provider Name	999 Mean Call Answer	Cat 2 Mean Response	Amb Handover Delays >60	A&E 4h	% Attends >12h in dep	Adult G&A Occ	Ambulance Hours Lost Per Day	% of patients with no CTR discharged after 5pm	Beds occupied by patients with no CTR with a LOS 7+ days	This Period	Last Period	Vs Last Period	Commentary and Escalation to National or Regional Team
ICB or Region	Name										0%	0%		
	Name													
	Name													
	Name													
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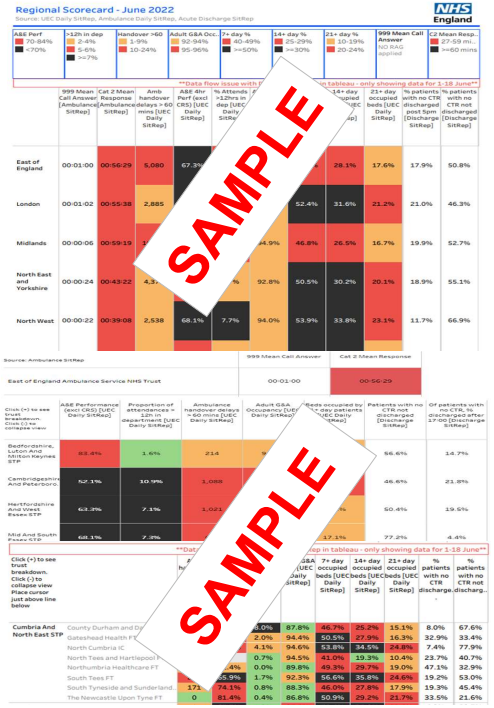
Sample of National Scorecard



Aggregated Position by Region - Each ICB and Region to locally agree assurance and monitoring process

Region	ICB	Virtual Wards Planned Beds	Virtual Wards Actual YTD Beds	Change from previous month	Enhanced discharge Planned Beds	Enhanced discharge Actual YTD beds	Reduce length of LOS reduction Planned Beds	Reduce length of LOS reduction Actual YTD Beds	Admission prevention Planned Beds	Admission prevention Actual YTD Beds	2 hour UEC Planned Beds	2 hour UEC Act	Out of hospital pathway d Beds	Out of hospital pathway Actual YTD Beds	Other Planned Beds	Other Actual YTD Beds	Action	Action Due By	Implementation Status	Deadline	Risk/Issue Escalation
Midlands	Birmingham & Solihull	94	17	9							16										
	Coventry and Warwickshire	50																			
	Derbyshire																				
	Herefordshire & Worcestershire	40																			
	Leicester, Leicestershire & Rutland																				
	Lincolnshire																				
	Northamptonshire	42																			
	Nottinghamshire	45							62												
	Shropshire, Telford & Wrekin	50			4		5		2				15								
	Staffordshire & Stoke														94						
	Black Country	181			84																
	Total	502	17		88	0	5	0	64			0	15	0	94	0					

Interventions - Winter 2022

Region	ICB	Virtual Wards Planned Costs (£'000)	Virtual Wards Actual YTD Costs £££	Enhanced discharge Planned Costs £££	Enhanced discharge Actual YTD Costs £££	Reduce length of LOS reduction Planned Costs £££	Reduce length of LOS reduction Actual YTD Costs £££	Admission prevention Planned Costs £££	Admission prevention Actual Y Cost	r UEC tual YTD Costs £££	Out of hospital pathway Planned Costs £££	Out of hospital pathway Actual YTD Costs £££	Other Planned Costs £££	Other Actual YTD Costs £££	Action	Action Due By	Implementation Status	Deadline	Issue/ Escalation
Midlands	Birmingham & Solihull	£5,277																	
	Coventry and Warwickshire																		
	Derbyshire																		
	Herefordshire & Worcestershire																		
	Leicester, Leicestershire & Rutland																		
	Lincolnshire																		
	Northamptonshire																		
	Nottinghamshire																		
	Shropshire, Telford & Wrekin																		
	Staffordshire & Stoke																		
	Black Country																		
	Total	502	17	9	88	0	5	0	64	0	31	0	15	0	94					

UEC ACTION PLAN									
RP#	Strategic Objective	Action	Deadline	Implementation Status	Risks	Gaps	Controls In Place	Deadline	Escalation To (NHSE regional or national team)
1.1	**Aligning Demand & Capacity**	**1.1 Ensure sufficient capacity to meet expected demand for this winter**							
1.1.1	Aligning Demand & Capacity	Implement the additional capacity identified through the demand and capacity planning to effectively deliver against expected winter demand. Nationally this amounts to an additional 6,000 G&A beds.	Jul-22						
1.4	**Aligning Demand & Capacity**	**1.4 Managing demand and aligning capacity**							
1.4.1	Aligning Demand & Capacity	UTC provision operating at top of specification with capacity matched to local demand.	Oct-22						
1.4.2	Aligning Demand & Capacity	Ensure all Emergency Departments have appropriate streaming services in place to redirect all appropriate patients to Type 3 services.	Sep-22						
1.4.3	Aligning Demand & Capacity	Increase the provision of High Intensity Use services (HIU) from current position of approx. 50% of A&E departments having access to services	TBC						
1.5	**Aligning Demand & Capacity**	**1.5 Community health care at home services**							
1.5.1	Aligning Demand & Capacity	Urgent Community Response – increase 2-hour UCR provision by maximising referrals from the ambulance service and other appropriate providers, with the ambition of at least 70% of 2-hour UCR demand to be seen within two hours in each ICB.	Dec-22						
1.5.2	Aligning Demand & Capacity	Rapidly scale virtual wards to support patients who would otherwise be in a hospital bed to receive acute care at home –with a focus on ARI and frailty. The VW system plans will likely create an additional 1,146 VW 'beds' of capacity by September 2022 and 2,514 Virtual Ward beds by December 2022.	Dec-22						
1.6	**Aligning Demand & Capacity**	**1.6 Primary Care**							
1.6.1	Aligning Demand & Capacity	ICB to resource a dedicated primary care team to actively engage and support General Practices and Community Pharmacies with seasonal preparedness and operational.	Dec-22						
1.6.2	Aligning Demand & Capacity	ICBs to complete system framework for supporting General Practice to rapidly prioritise practical interventions to improve patient experience of access and staff workload locally and engage in national process to secure potential funding for technology/estates solutions	Dec-22						
1.6.3	Aligning Demand & Capacity	Consider and support PCNs working with each other and other providers to develop collaborative models to manage specific winter pressures (for example oximetry monitoring for COVID; winter hubs; community and VCS led support for vulnerable)	Dec-22						
1.6.4	Aligning Demand & Capacity	Rapid recruitment of up to: 1000 additional SP Link Workers and health and wellbeing coaches, each to boost staff numbers who target and work with stepping down from High Intensity User services with non-medical needs where social and lifestyle issues are a significant risk factor 1000 additional Care Coordinators to support the development of PCSPs for high risk individuals with MLTC, within the Anticipatory Care prioritised cohorts, with use of Personal Health Budgets where appropriate.	Nov-22						
1.6.5	Aligning Demand & Capacity	ICBs to offer intensive hands-on quality improvement support to practices working in the most challenging circumstances (such as areas of high deprivation, areas with highest need or workforce challenges) via the national 'Accelerate' support programme available to 400 practices for 22/23 alongside addressing barriers outside the scope of the support	Oct-22						
1.6.6	Aligning Demand & Capacity	Technology and Telephony to digitally enable Primary Care - **Cloud Based Telephony in General Practice:** Expand number of practices on cloud-based telephony, supporting transition from analogue to cloud-based through expanded scope and pace of current pilots in advance of the national cloud based telephony framework going live in April 2023. **Business Intelligence tools roll out to General Practice:** Expand availability of Business Intelligence tools (to understand demand and capacity). Provide support to build capability to use them for improvement Use of a **unified directory of services** across ICS to direct patients to the right services and communicate clearly on primary care pathways and processes	Oct-22						
1.6.7	Aligning Demand & Capacity	Promote use of the following community pharmacy services the expansion of CPCS to divert demand away from general practice into community pharmacies aligned to metrics outlined in the Primary Care Investment and Impact Fund the Discharge Medicines Service to community pharmacies to help prevent readmissions to hospital	Oct-22						
1.8	**Aligning Demand & Capacity**	**1.8 Elective Recovery**							
1.8.1	Aligning Demand & Capacity	Maintaining and increasing elective capacity to eliminate waits of over 18 months by April 2023	Apr-23						
1.8.3	Aligning Demand & Capacity	Reducing the cancer 62-day backlog back to pre-pandemic levels	Mar-23						
1.8.4	Aligning Demand & Capacity	Reducing the number of 78-week elective long waiters to zero	Apr-23						
1.8.5	Aligning Demand & Capacity	Ensure inclusive recovery of elective services through use of data on health inequalities, children and young people and other population factors	Jul-22						
1.10	**Aligning Demand & Capacity**	**1.10 Diagnostics**							
1.10.1	Aligning Demand & Capacity	Enable over 89 CDC sites which are currently operational to deliver nearly 3 million tests to patients. These are located away from acute secondary care hospital sites and into the community health care settings. This supports improved access and timeliness for reprioritisation of key diagnostic modalities CT, MRI and Endoscopy for in-patient urgent testing and discharge prioritisation.	Mar-23						
2.1	**Discharge**	**2.1 Building on best practice**							
2.1.3	Discharge	Continue and expand use of small, one-off Personal Health Budgets (PHBs) to facilitate early discharges	Ongoing						
2.2	**Discharge**	**2.2 Increase capacity on discharge pathways**							
2.2.1	Discharge	Increase capacity of pathway one discharge teams to match demand and supply for this winter	Sep-22						
2.2.2	Discharge	Reduce length of stay in community rehab wards/units and bed days lost for each delayed discharge in every community rehabilitation ward/unit and shift from bedded to home models of rehab for lower acuity people.	Oct-22						
2.2.3	Discharge	Monitor P0 discharges at weekend to maintain flow 7 days a week.	Ongoing						
3.4	**Improvements in Ambulance service performance**	**3.4 Ambulance Fleet**							

3.4.1	Improvements in Ambulance service performance	Ambulance trusts to model their optimal fleet requirements to improve performance, including the use of Rapid Response Vehicles by August 2022 and implement in line with identified need by November 2022	Nov-22							
3.6	**Improvements in Ambulance service performance**	**3.6 Improve the ambulance response to mental health**								
3.6.1	Improvements in Ambulance service performance	All ICBs to use Long Term Plan ambulance and mental health funding in full to: •Deploy mental health professionals in 999 emergency operation centres (EOCs) and clinical assessment services (CAS) •Enable a joint on-scene response to mental health patients •Provide mental health education and training to the ambulance workforce	Mar-24							
4.5	**Improving NHS 111 performance**	**4.5 Improve the ambulance response to mental health**								
4.5.1	Improving NHS 111 performance	All ICBs to profile and update details of 24/7 urgent mental health helplines on the local Directory of Services (DOS)	Nov-22							
4.5.2	Improving NHS 111 performance	All ICBs to seek to increase local comms to ensure people are aware of local 24/7 urgent mental health helpline numbers, or it can be promoted at www.nhs.uk/urgentmentalhealth	Nov-22							
4.5.3	Improving NHS 111 performance	Increase the use of specialist vehicles to support mental health	Nov-22							
5.1	**Avoiding admission and alternative 'in hospital' pathways to Improve Flow**	**5.1 Increase the number and breadth of services profiled on the DoS**								
5.1.3	Avoiding admission and alternative 'in hospital' pathways to Improve Flow	Ensure only patients with an emergency need are directed to ED, through ensuring alternative services are available on the DoS	Oct-22							
5.2	**Avoiding admission and alternative 'in hospital' pathways to Improve Flow**	**5.2 Standardise appropriate alternatives to inpatient care to avoid admissions and reduce pressure on beds**								
5.2.2	Avoiding admission and alternative 'in hospital' pathways to Improve Flow	Improve Acute Frailty service provision including delivery of MDT assessment to ensure that treatment plans support transition from hospital to home4, where admission is not appropriate	Nov-22							
5.2.3	Avoiding admission and alternative 'in hospital' pathways to Improve Flow	Review non-emergency patient transport services to transport patients who do not need to be admitted back to their homes and avoid unnecessary overnight admissions	Oct-22							
5.3	**Avoiding admission and alternative 'in hospital' pathways to Improve Flow**	**5.3 Standardise specialist input and subsequent management at the earliest appropriate point in the patient's journey**								
5.3.1	Avoiding admission and alternative 'in hospital' pathways to Improve Flow	Speciality in reach within 60 minutes of referral from an emergency portal for the main admitting medical specialities (Cardiology, Respiratory and Care of the Elderly) Delivery of care within speciality where appropriate through provision of direct speciality admission	Nov-22							
5.3.2	Avoiding admission and alternative 'in hospital' pathways to Improve Flow	7-day provision of services which support acute care	Jan-23							
5.4	**Avoiding admission and alternative 'in hospital' pathways to Improve Flow**	**5.4 Out of hospital services**								
5.4.1	Avoiding admission and alternative 'in hospital' pathways to Improve Flow	Implement 'out of hospital' home-based pathways (including virtual wards) to improve flow by reducing hospital attendances through Urgent Integrated Care approaches for patients who need same day urgent clinical assessment and would otherwise attend or be conveyed to an urgent appointment in primary care or an emergency department.	Nov-22							
5.4.2	Avoiding admission and alternative 'in hospital' pathways to Improve Flow	Reduce unnecessary primary and secondary care attendances for patients with mild coughs, colds, flu, and Covid by publishing revised NHS @home COVID pathways that incorporate broader Acute Respiratory Infections (including Flu, RSV etc) with accompanying patient self-management and escalation pack including patient diaries, oximeters, thermometers and safety netting advice.	Sep-22							
6.2	**Preparing for new COVID-19 variants/respiratory challenges**	**6.2 Infection Prevention and Control**								
6.2.1	Preparing for new COVID-19 variants/respiratory challenges	Implement UKHSA IPC guidance and develop strategies to minimise the impact of 'void' beds to maximise capacity. Embed reservist model in each ICS to increase capacity and capability to respond to surge and major incidents	Dec-22							
7.1	**Workforce**	**7.1 Wellbeing**								
7.1.1	Workforce	All ICBs to sustain, develop and promote staff MH hubs in line with guidance	Nov-22							
7.2	**Workforce**	**7.2 Recruitment and retention**								
7.2.1	Workforce	Implement recruitment and retention plans which include: •Staff sharing arrangements and maximising collaboratives banks •Embed reservist model in each ICS to increase capacity and capability to respond to surge and major incidents •Develop and launch managing attendance challenge toolkit •International Support to support UEC recovery plans - identify shortages for key roles & skills and implement recruitment programme targeting towards shortages to support UEC and winter pressures •Ensure plans to maximise the use of the national protocol and reduce the pull-on registered healthcare professionals to deliver this autumn's COVID-19 and flu vaccination programme.	Dec-22							
7.3	**Workforce**	**7.3 Utilisation of VCS and Volunteers**								
7.3.1	Workforce	Enhancing resilience through identifying and scaling high impact roles for volunteers that reduce pressure on services, enhance patient experience and support staff wellbeing. (for example, Community First Responders, Discharge Support, ED support)	Oct-22							
8.2	**Improved data and performance management**	**8.2 Ensure real-time system monitoring**								
8.2.1	Improved data and performance management	Work with cross-system partners to put provisions in place to monitor data and pressures across the system and patient pathway, including primary care, acute and mental health services, and workforce pressures								
9.2	**Communications**	**9.2 Campaigns**								
9.2.1	Communications	Deliver the 'Help Us, Help You' NHS 111 (October 22) and GP Access (February 23) campaigns; to increase the number of people using NHS 111 when they have an urgent, but non-life-threatening medical need and of people using online access routes to contact their practice. ICBs to deliver local campaigns including messaging on triage, prioritisation and MDTs/ARRS staff by December 2022.	Feb-23							

	Trust Name		*If it is N or Partial - ICB may want to formulate an action plan.*			DD-MM-YY									
#	Good Practice Basics	Y	N	Partial	#	Good Practice Basics	Y	N	Partial	#	Good Practice Basics	Y	N	Partial
	Out of Hospital					**Emergency Department**					**Inpatient Management**			
1	Directory of services reviewed monthly by ICB executives and with clinical service leads		X		16	Streaming of all patients who could be apprpriately managed by a co-located urgent/primary care service in place at times matching the demand.				30	Minimum of twice Daily Consultant Led MDT Board Rounds in every ward			
2	Co-located urgent treatment centre operating as the front door to the hospital (or streaming) (or equivalent primary and urgent care service)			X	17	Minimum Consultant management > 16 hours a day (or as required by other specialist centres)				31	Acute Medical Unit should be in place for maximum 72 hours length of stay. All other specialty patients should be bedded in alternative appropriate areas.			
3	111 clinical contact > 50%	X			18	Speciality and acute call down within 1 hour of referral. For tertiary units, acute physician presence in ED > 16 hours a day				32	Daily senior medical review (by a person able to make management and discharge decisions) seven days a week			
4	Abandoned 111 call rate	X			19	ED are granted one way referral rights with no patient being given back to ED at any time				33	Red to Green Process or equivalent in place and audited weekly			
5	Ambulance conveyance to ED <49%			X	20	Mental health 24/7 liaison service				34	All patients reviewed by a senior decision maker 7 days a week			
6	Virtual wards in place that support admission avoidance and length of stay reduction		x		21	SDEC > 12 hours a day/ 7 days a week at least but ideally open at times of demand. Open access criteria to be in place for all system partners. These units should never be bedded. Capacity cap				35	Trust IPS clearly communicated, adhered to, escalated and audited.			
7	Ensuring primary care have extended hours for evenings and weekends		X		22	Acute frailty service > 70 hours over 7 days At least but ideally open at time of demand				36	IPC protocol in place that adheres to the latest national guidance and balances IPC risk with flow and delays related harm risks			
8	Urgent community response within 2 hours			X	23	Dedicated, separate to adults, Paediatric ED / secure area in place					**Discharge**			
	Site/Operational Discipline				24	All Minor illness streamed to GPs				37	Expected Date of Discharge set within first 24 hours of admission. Patients should clearly have an acute reason to reside within the acute provider.			
9	Focused site/bed management 24/7 with minimum 3 times per day site meeting following a structured FOCUS model (or equivalent) with appropriate accountable actions				25	All Minor injuries streamed to an emergency nurse practitioner (ENP)				38	Discharge is profiled against admission demand with a focus on early in the day discharge and weekend discharges.			
10	Site management support & presence within ED to deliver timely flow and support to ED team					**Emergency Department Environment**				39	Identify patients in ED or at admission who are likely to need complex discharge support and highlight for early intervention			
11	Daily Executive Director oversight responsible for all escalation and delivery of mitigations				26	Required capacity (numbers of cubicles and Fit to sit) in place to meet demand				40	Where in place, protect discharge lounge capacity from being bedded			
12	Bed/site management function should ideally be clinical or as a minimum has access to clinical colleagues 24x7. Site function should have annualised competency/training.				27	CDU adjacent or equivalent short stay Emergency patient area				41	7-day Transfer of Care Hub in place			

13	Senior Clinical and Management Directorate staff 24/7 rota to support min twice daily meetings			
14	Full capacity protocol in place – infection, prevention and control (IPC) compliant Along with BCPs for every acute service so that no service functions stops or defaults to ED			
15	Exec signed off internal professional standards in place appropriately managed with escalation for non-compliance			

28	GIRFT data should be used to effectively plan against demand and capacity			
	Emergency Department IT			
29	ED system in place to enable patient flow against national standards			

	System and Trust Oversight			
42	Trust and ICB executive review weekly as a minimum (taking into account variance by provider in an ICB)			
43	ED Performance: Over 4 hours in department + 12 hour DTAs + Over 12 hours in department			
44	Ambulance Performance: Response times + Hospital Handover delays + Longest handover + Any identified patient harm including SUI			
45	Potential patient harm: Overview of all patient related incidents and serious incidents with regards to ambulance delays			
46	Overview of all incidents and serious incidents for patients in ED over extended periods			
47	Right to reside/delayed discharges			
48	In and out of hours clear bronze, silver and gold escalation with recorded actions and outcomes with appropriate training & support programme. Reflective practice should be used to inform			
49	Monthly review of agreed data sets and this checklist at trust and ICB boards			

UEC Improvement Framework	Link to tab
111 Service (IUC) Ambition - Patients are signposted to the most appropiate service for their needs everytime, all the time.	IUC
Ambulance (AMB) Ambition - Patients receive timely emergency and urgent ambulance care and conveyance, with minimal delays.	AMB
High Intenity Users (HIU) Ambition - Patients recieve consistent care at all times, minimising the need to access acute and emergency services unless clinically needed.	HIU
Alternative Acute and Community Pathways/Services (AAP) - Alternative to ED attendance and hospital admission including direct access from Community and ED Ambition - Patients are treated in the right care setting, at the right time, by the right person. This includes access to alternative acute pathways and the appropiate voidance of attendance to the Emergency Department.	AAP
Emergency Department (ED) Ambition - Patients with an emergency need will be managed in a timely manner within the Emergency Department.	ED
Treatment in the Emergency Department (TiED) Ambition - Clinical care and treatment will be delivered on time - aligned with best practice. Safety is never compromised.	TiED
Staffing (STF) Ambition - Staff will be in the right place, at the right time with the appropriate skills to care for patients and keep them safe	STF
Urgent Treatment Centres (UTC) Ambition: Patients with urgent and minor ailments/illnesses will be managed in Urgent Care settings everytime, at all times.	UTC
Flow Ambition - No patient will reside in an acute hospital bed once their clinical care has been completed. Everyday (7-days a week) spent in the acute trust should be free from delay with clinical led by a senior clinical decision maker	FLOW
Operational Management & Escalation (OME) Ambition - Patients on an urgent and emergency pathway are managed in the right care setting at the right time to maximise their health outcomes with operational processes in place to deliver this.	OME
Intergrated Care Boards (ICB) Ambition - Integrated Care Boards take responsibility for oversight of UEC recovery, improvement and transformation through the implementation of robust governance arrangements across the ICS and place-based systems	ICB

UEC Improvement Framework

Key lines of enquiry (KLOEs)	Implementation Questions	Implementation Answers	National guidance/ Best Practices (Links)
111 Service (IUC) Ambition - Patients are signposted to the most appropriate service for their needs every time, all the time.			
IUC - 1. Are services within the Directory of Service correctly profiled and what is your assurance process to ensure the right patients are being directed to the right service? DoS returns the most appropriate, lowest acuity services, based on time of day, service capacity, and the patient's location. If alternative services to ED are available these should be given higher order and ED should be profiled last.			DoS Profiling Principles
IUC - 2. Are 111 services undertaking revalidation of primary care, urgent care, emergency department and ambulance dispositions?			Urgent Care Service Specification Integrated Urgent Care Service Specification addendum: NHS 111 First
IUC 3 - Does 111 service redirect patients to CPCS for community pharmacy needs via online and telephony and what are the total numbers redirected per month?			https://www.england.nhs.uk/primary-care/pharmacy/pharmacy-integration-fund/community-pharmacist-consultation-service/
IUC 4 - Can patients make a direct referral to 24/7 MH crisis via NHS 111 (national IVR option) and how many per month?			NB - Link to MH futures page

UEC Improvement Framework

Key lines of enquiry (KLOEs)	Implementation Questions	Implementation Answers	National guidance/ Best Practices (Links)
Ambulance (AMB) Ambition - Patients receive timely emergency and urgent ambulance care and conveyance, with minimal delays.			
AMB - 5. 999 call handling capacity with trajectory in place to achieve consistently a mean call response of less than 10 seconds.			https://www.england.nhs.uk/wp-content/uploads/2018/10/ambulance-response-programme-review.pdf
AMB - 6. Accessible system-wide capacity with activity to each per month, to reduce unnecessary ambulance conveyance to ED, including an updated Directory of Services for ambulance service referral to e.g. UCR; frailty services; mental health; SDEC and UTCs			planning-to-safetly-reduce-avoidable-conveyance-v4.0.pdf (england.nhs.uk) Reducing avoidable ambulance conveyance in England: Interventions and associated evidence Safely Reducing Avoidable Conveyance Programmes - aace.org.uk-
AMB - 7. Escalation processes to reduce excessive handover delays (>60) , including the use of Hospital Ambulance Liaison Officers (HALOs) and how are you assured that minimum care standards are provided to any patient delayed in an ambulance?'			Reducing_ambulance_handover_delays_-_key_lines_of_enquiry_v1.1.pdf (england.nhs.uk)
AMB - 8. Is current demand / opportunity for clinical capacity being met in EOCs to optimise Hear and Treat rates.			National framework for healthcare professional ambulance responses
AMB - 9. Outline activity per month to enhance current paramedic access to clinical advice to improve See and Treat and time on scene e.g. through Clinical Assessment Service; 'call before convey' and ED virtual consultation models.			Direct ambulance access to acute speciality criteria Final 25th January 2021 Version 1.0 - ECIST Network - FutureNHS Collaboration Platform
AMB - 10. Improve the integration of NEPTS as part of discharge planning to reduce the time spent 'waiting for transport'.			NEPTS Review
AMB - 11. Increase awareness of the Healthcare Travel Cost Scheme to support patient discharge.			NEPTS Review
AMB - 12. How does the NEPTS service in the local systems meet the requirements of the NEPTS Review?			NEPTS Review

UEC Improvement Framework

Key lines of enquiry (KLOEs)	Implementation Questions	Implementation Answers	National guidance/ Best Practices (Links)
High Intensity Users (HIU) Ambition - Patients recieve consistent care at all times, minimising the need to access acute and emergency services unless clinically needed.			
HIU - 13. Does the Emergency department have access to a High Intensity Use scheme, supporting frequent users of A&E through a non-clinical approach to coach through issues, sign-post, etc and is this scheme ICS owned/engaged with?			https://www.england.nhs.uk/publication/high-intensity-user-service-resource-pack-supporting-documents/
HIU - 14. For commissioned HIU services, who provides this (organisation & Contact details) and to what date is it commissioned?			https://www.england.nhs.uk/publication/high-intensity-user-service-resource-pack-supporting-documents/
HIU - 15. Are evaluation results re cost of delivery for HIU and impact of the service available?			https://www.england.nhs.uk/publication/high-intensity-user-service-resource-pack-supporting-documents/

UEC Improvement Framework

Key lines of enquiry (KLOEs)	Implementation Questions	Implementation Answers	National guidance/ Best Practices (Links)
Alternative Acute and Community Pathways/Services (AAP) - Alternative to ED attendance and hospital admission including direct access from Community and ED Ambition - Patients are treated in the right care setting, at the right time, by the right person. This includes access to alternative acute pathways and the appropiate voidance of attendance to the Emergency Department.			
AAP - 16. Complete a system exercise to ascertain available alternatives to ED attendance and admission eg Alternative to ED and hospital admission tool (AtED and AtA) and Missed Opportunities tool.			Improving referral pathways between Urgent & Emergency Services
AAP - 17. Agreed pathways available to support a safe reduction in ambulance conveyance to ED - improving access to the wider health & socail care service, including access to clinical advice. what are the pathways and what is the activity currently versus ambition activity.			planning-to-safetly-reduce-avoidable-conveyance-v4.0.pdf (england.nhs.uk) Reducing avoidable ambulance conveyance in England: Interventions and associated evidence Safely Reducing Avoidable Conveyance Programmes - aace.org.uk-
AAP - 18. All acute alternative pathways accept direct referrals from system wide healthcare professionals. What is the activity per month per service? And is the access criteria open and in line with the CQC Patient First ideology : the patient goes to the right care setting for their need and that ED should not be a default for assessment.			Improving referral pathways between Urgent & Emergency Services
AAP - 19. ED streamers and triage nurses empowered to stream to all hospital services (eg all SDECS, AMU, SAU, GAU, Ortho, ENT, Paeds etc) and with streaming activity to each of these areas a month outlined.			Improving referral pathways between Urgent & Emergency Services
AAP - 20. Regularly reviewed Directory of Service in place to support accurate service profiling and re-direction.			Directory of Services Profiling Principles Quick guide -Improving access to UTC using the directory of services
AAP - 21. SDEC Services with rapid diagnostic access are operational to meet patient demand profile.			SDEC -NHSE/I
AAP - 22. Acute Frailty Services are operational to meet patient demand profile.			Acute Frailty - NHSE/I Same Day Acute Frailty Services
AAP - 23. Hot clinic capacity is aligned to patient demand.			Principle and approach to deliver a personalised out-patient model
AAP - 24.Virtual wards are operational to support admission avoidance and LOS reduction and are led by a relevant specialist and delivered by the Community.			Virtual Wards - NHSE/I A guide to setting up technology-enabled virtual wards

UEC Improvement Framework

Key lines of enquiry (KLOEs)	Implementation Questions	Implementation Answers	National guidance/ Best Practices (Links)
Emergency Department (ED) Ambition - Patients with an emergency need will be managed in a timely manner within the Emergency Department.			
ED - 25. All Emergency Departments have a comprehensive streaming model so all non-emergency patients are directed from the ED with a structured competency programme, and outline % of patients are streamed per month OUT of the ED.			Principles for clinical streaming A&E department RCEM - Initial Assesment of ED Patients Improving Emergency Patient flow - Streaming in the emergency department
ED - 26. The ED shop floor is well-led: - real time 'command and control' achieved through a senior medical, nursing, and administrative team. - regular board rounds, walk-throughs and active progress chasing in line with the 4-hour performance standard. - senior support (silver or above) should be provided for ED decompression during times of excessive (over 1hour) ambulance handover delays and patients in the department exceeding 12 hours as well as a defined & tested escalation process should be in place.			https://future.nhs.uk/ECISTnetwork/view?objectID=123216133
ED - 27. Patient assessed by the emergency department team as needing specialty assessment are accepted directly by that team and reviewed within 1 hour. There will be no ED hand backs (unless clinically required) The specialty teams should have time scheduled to make sure this is feasible. An agreement drawn up and signed by all clinical leads and the medical director. Specialty clinicians do not physically review patients in the emergency department - helping to improve flow, social distancing and infection control.			Internal professional standards examples Patient First 2021
ED - 28. Direct admission to hospital assessment area (eg AMU, SAU, GAU) or other specialty area from GPs etc. available 24/7			https://www.england.nhs.uk/wp-content/uploads/2021/05/aec-same-day-emergency-care-clinical-definition-patient-selection-metrics.pdf https://www.gettingitrightfirsttime.co.uk/wp-content/uploads/2021/11/EM-overview.pdf
ED - 29. Direct access to "hot" clinics eg ENT, Max-fax, orthopaedics, Obs & gynae, ophthalmology (from GP, NHS-111 or ED) 24/7 availability and bookable access without discussion and activity per month for each one.			https://www.england.nhs.uk/wp-content/uploads/2021/05/aec-same-day-emergency-care-clinical-definition-patient-selection-metrics.pdf https://www.gettingitrightfirsttime.co.uk/wp-content/uploads/2021/11/EM-overview.pdf
ED - 30. Direct referral to frailty, falls service from NHS-111, ambulance service or ED, available: 10 hours a day, 7 days a week with activity per month outlined.			https://www.england.nhs.uk/wp-content/uploads/2021/05/aec-same-day-emergency-care-clinical-definition-patient-selection-metrics.pdf https://www.gettingitrightfirsttime.co.uk/wp-content/uploads/2021/11/EM-overview.pdf
ED - 31. Direct to specialty referral 24/7 (from NHS-111, ambulance service or ED) (streamer, traiger, navigator or clinician) if the patient is under active specialty care or has a problem relating to that care eg post-op complications, or a complaint that is best managed by that specialism.			https://www.england.nhs.uk/wp-content/uploads/2021/05/aec-same-day-emergency-care-clinical-definition-patient-selection-metrics.pdf https://www.gettingitrightfirsttime.co.uk/wp-content/uploads/2021/11/EM-overview.pdf
ED - 32. Specialty advice / guidance available 24/7 by telephone with consultants for GPs, paramedics etc. (A-tED 2021) A single point of access which external healthcare professionals can contact directly 24/7 GPs to 'call before they send' patients to ensure the patient is seeing the right specialty first time. (Patient FIRST 2021)			Patient First 2021 https://www.england.nhs.uk/wp-content/uploads/2021/05/aec-same-day-emergency-care-clinical-definition-patient-selection-metrics.pdf https://www.gettingitrightfirsttime.co.uk/wp-content/uploads/2021/11/EM-overview.pdf
ED - 33. Using Non-clinical navigators / coordinators within emergency departments and GPs to make sure patients have a GP, support them through the GP registration process and chase/check diagnostic results when flagged ready to view. (Patient FIRST 2021)			Patient First 2021
ED - 34. Pathways in place for specific groups of patients whose needs may best be met elsewhere eg percutaneous endoscopic gastrostomy (PEG) tube problems; catheter problems; peripherally inserted central catheter (PICC) line problems. (Patient FIRST 2021) List all pathways available and the activity per month each pathway sees.			Patient First 2021

ED - 35. Emergency departments has 24/7 liaison mental health services to ensure that people of all ages presenting with acute mental health needs receive timely assessment by a skilled mental health professional, including direct referral to adult mental health and CAHMS service eg on site MH ambulatory unit (from NHS-111, ambulance service or ED). 24/7 availability . Escalation process in place to ensure mental health admissions are completed in a timely manner, within 1 hour of streaming or referral and do not utilise an acute bed unless clinically required . Access to in-house psychiatric liaison team (Mental health practitioner review within 1 hour) that is safe, responsive, transparent with clear escalation processes. (Patient FIRST 2021)			https://www.england.nhs.uk/wp-content/uploads/2021/05/aec-same-day-emergency-care-clinical-definition-patient-selection-metrics.pdf https://www.gettingitrightfirsttime.co.uk/wp-content/uploads/2021/11/EM-overview.pdf https://rcem.ac.uk/wp-content/uploads/2021/10/Mental_Health_Toolkit_June21.pdf Patient First 2021
ED - 36. Urgent treatment centre (UTC) with GP presence co-located with ED, with bookable access from ED, GP or NHS-111 and available 12 hours a day, 7 days a week (A-tED 2021) and available at times of urgent care demand (ie no primary care or urgent care issue is seen in ED).			https://www.england.nhs.uk/wp-content/uploads/2021/05/aec-same-day-emergency-care-clinical-definition-patient-selection-metrics.pdf https://www.gettingitrightfirsttime.co.uk/wp-content/uploads/2021/11/EM-overview.pdf
ED - 37. External – urgent treatment appointments via GP, dental, pharmacy, optometry available 8am to 6pm,5 days a week and activity per month to each outlined.			Patient First 2021
ED - 38. External - General practice appointments available 24/7 from NHS111, with these practices listed by how many appts per month?			Patient First 2021 https://www.england.nhs.uk/wp-content/uploads/2021/05/aec-same-day-emergency-care-clinical-definition-patient-selection-metrics.pdf https://www.gettingitrightfirsttime.co.uk/wp-content/uploads/2021/11/EM-overview.pdf
ED - 39. All staff to actively encourage patients to call GPs or NHS 111 first and to only 'go to A&E' in an emergency, with assurance and monitoring process outlined (Patient FIRST 2021).			Patient First 2021
ED - 40. Regular review of the staffing of the emergency department so that capacity meets variation in demand, rather than average demand.			https://rcem.ac.uk/wp-content/uploads/2021/11/RCEM_Medical_and_Practitioner_Staffing_in_EDs.pdf

UEC Improvement Framework

Key lines of enquiry (KLOEs)	Implementation Questions	Implementation Answers	National guidance/ Best Practices (Links)
Treatment in the Emergency Department (TiED) Ambition - Clinical care and treatment will be delivered on time - aligned with best practice. Safety is never compromised.			
TiED - 41. All emergency department staff telephonic or messaging platform for teaching, training, regular communication and escalation of pressure. All staff have access to the group to receive information, though only a few staff can post information - limiting less important information. Requires systems to manage risk of non-receipt and changes to on-call rotas etc. (Patient FIRST 2021)			Patient First 2021
TiED - 42. A full, locally led and delivered MDT quality governance which will regularly review: performance, quality, risks, incidents, mortality, safety alerts, complaints and audit. (Patient FIRST 2021). Process measures (Patient FIRST 2021) include: time to diagnostics, time to antibiotics for sepsis (Sepsis 6 - delivered in first hour), time to ECG electrocardiogram) and sign off for chest pain, frailty/ dependency score in ED, reporting medication errors and near misses, left without being seen (LWBS), time to definitive treatment length of wait for specialty review , NEWS2, hip X-ray for patients with fracture neck of femur (NOF) - performed in first hour, CT for possible stroke - performed within an hour, Time to pathology, senior sign off for RCEM recommended clinical presentations.			Patient First 2021 RCEM - Initial Assesment of ED Patients
TiED - 43. Effective delivery of time critical medication - including new prescriptions (antibiotics) and medication that the patient is already taking - for example medication for Parkinson's disease, epilepsy, diabetes, with assurance and monitoring process outlined.			Patient First 2021
TiED - 44. Urgent care standard operating procedures in place and regularly reviewed. (Patient FIRST 2021) along with Business continuity plans for all services that deliver flow out of ED so that no service 'defaults' to ED when capacity or business continuity issues occur.			Patient First 2021
TiED - 45. Active use of National Safety Standards for Invasive Procedures in place, with assurance process outlined. (NatSSIPs). (Patient FIRST 2021)			Patient First 2021 https://www.england.nhs.uk/wp-content/uploads/2015/09/natssips-safety-standards.pdf
TiED - 46. Use of an adult mental health triage tool that includes recording of 15-minute observations. (Patient FIRST 2021)			Patient First 2021
TiED - 47. ECG for patients presenting with chest pain - performed and reviewed by ST3 or above clinician within 30 minutes of arrival (Patient FIRST 2021)			Patient First 2021
TiED - 48. Immediate review and sign off of point of care blood results so that timely management can begin. (Patient FIRST 2021)			Patient First 2021
TiED - 49. Senior clinician review of patients with high (eg NEWS >3) or increasing NEWS (Patient FIRST 2021)			Patient First 2021
TiED - 50. Early senior review (as soon as the red flag identified and no later than one hour from arrival) of infants, children and young people presenting with red flags for sepsis, with complex needs or safeguarding concerns. (Patient FIRST 2021)			Patient First 2021
TiED - 51. Regular review of diagnostic standards eg time to CT and time to Pathology. (Patient FIRST 2021)			Patient First 2021

TiED - 53. Adherence to nationally agreed clinical standards with regular compliance auditing eg standards from NICE, the British Thoracic Society (BTS) and the Royal College of Emergency Medicine (RCEM). (Patient FIRST 2021)			Patient First 2021 NICE Standards RCEM - Initial Assesment of ED Patients
TiED - 54. Timely diagnosis and treatment of patients with acute pain to include regular audit of: assessment, treatment and continuing reassessment to be carried out monthly. (Patient FIRST 2021)			Patient First 2021

UEC Improvement Framework

Key lines of enquiry (KLOEs)	Implementation Questions	Implementation Answers	National guidance/ Best Practices (Links)
Staffing (STF) Ambition - Staff will be in the right place, at the right time with the appropriate skills to care for patients and keep them safe.			
STF - 54. Staffing models for at least the next 12 months in place to enhance the urgent care pathway with increased staffing where appropriate, and new roles such as: redirection, streaming, early senior decision makers, specialty support. (Patient FIRST 2021) Recognised standards and regional benchmarking in place, such as the baseline emergency staffing tool (BEST-RCN) for staffing and assessing the skills mix throughout the department. (Patient FIRST 2021)			Patient First 2021
STF - 55. For new joiners (including locums) a clear induction programme in place that includes infection prevention and control as well as wellbeing support, regular teaching and communication.			
STF - 56. All EDs where children attend have in place: a paediatric emergency medicine (PEM) consultant, at least two children's nurses per shift, and a play specialist in a dedicated secure area separate to adult patients. (Patient FIRST 2021)			Patient First 2021
STF - 57. Consider new or extended practitioner roles in emergency departments such as: AHPs, paramedics, physician's assistants etc. (Patient FIRST 2021)			Patient First 2021
STF - 58. Review existing models and job plans for non-ED consultants and workforce. For example, to place appropriate value on generalists and medical on call and support specialists to provide 'in-reach' and senior specialty review to ED. (Patient FIRST 2021)			Patient First 2021
STF - 59. Support staff by providing robust, clearly signposted ways to report and manage moral injury and support wellbeing. (Patient FIRST 2021)			Patient First 2021
STF - 60. Support staff by providing robust ways to manage their wellbeing at work. Including: ways to regularly give and collect feedback to all staff; 100% of leavers should be offered an exit interview. Results should be formally monitored, actioned upon where appropriate and shared; undertake regular reviews of the establishment for all staff groups; provide mandatory training for all staff and this should be formally monitored and actioned. (Patient FIRST 2021)			Patient First 2021
STF - 61. Undertake regular reviews of establishment requirements for all staff groups at least yearly pre winter. (Patient FIRST 2021)			Patient First 2021

UEC Improvement Framework

Key lines of enquiry (KLOEs)	Implementation Questions	Implementation Answers	National guidance/ Best Practices (Links)
Urgent Treatment Centres (UTC) Ambition: Patients with urgent and minor ailments/illnesses will be managed in Urgent Care settings everytime, at all times.			
UTC - 62. Do all your UTCs meet or, have plans in place to meet, the UTC standards? This as a minimum should include: -In line with local demand, open for at least 12 hours a day, 7 days a week for both walk-in and booked appointments. Booked appointments for UTCs should be available from ED, GP or NHS111. -Provide minor illness and injury treatments to patients of all ages. -Access to bedside diagnostics and plain x-ray facilities. Where facilities are not available on site, clear access protocols should be in place. -Receive ambulance conveyed patients (including stretcher) where clinically appropriate. - the ICS needs to ensure that there is an urgent care service available as alternative to EDs available 24/7			UTC Principles Standards *** This document is currently under review and updated version will be sent for publishing approval by 08/07/2022 *** All designated UTCs to meet the revised standards by October 2022.
UTC - 63. Are plans in place to designate any remaining type 3 or 4 services as a UTC, or as an alternative service where more appropriate?			https://www.england.nhs.uk/wp-content/uploads/2022/02/20211223-B1160-2022-23-priorities-and-operational-planning-guidance-v3.2.pdf
UTC - 64. Has a co-located UTC at the front door of the ED been considered to support streaming and diversion? If no, outline reason, alternatives and review processes in place.			https://www.england.nhs.uk/wp-content/uploads/2022/02/20211223-B1160-2022-23-priorities-and-operational-planning-guidance-v3.2.pdf February 2021 UTC Principles and Standards - East of England Region - UEC Improvement Network - FutureNHS Collaboration Platform
UTC - 65. Where a UTC at the front door is not possible / appropriate, enhanced streaming should be in place for example use of GP streaming or a digital streaming and redirection tool, with % of patients are streamed away from ED outlined. *Pending approval of UTC standards approval*- *All Type 1 EDs should have in place, or robust plans in place to enact, a UTC at the front door by March 2024 where it is clinically appropriate for the local health economy. Where this is not cost-effective or appropriate, this should be discussed with regional teams and ICBs are asked to explore forms of enhanced streaming that could maximise opportunities to divert low acuity patients away from ED.*			https://www.england.nhs.uk/wp-content/uploads/2017/07/urgent-treatment-centres-faqs-v2.0.pdf UTC Principles for DoS profiling v0.9 - DoS Collaborative online Workspace (CoW) - FutureNHS Collaboration Platform
UTC - 66. Each ED should review what % of attendees are primary or urgent care patients who are then seen by an ED clinician rather than an UTC. The system should monitor and create plans to reduce this % as part of their UEC strategy.			

UEC Improvement Framework

Key lines of enquiry (KLOEs)	Implementation Questions	Implementation Answers	National guidance/ Best Practices (Links)
Flow Ambition - No patient will reside in an acute hospital bed once their clinical care has been completed. Everyday (7-days a week) spent in the acute trust should be free from delay with clinical led by a senior clinical decision maker			
Flow - 67. Minimise handover delays between ambulance and hospital in line with 22/23 operational planning guidance e.g. eliminating handover dalys >60mins - contribute towards achieving the ambulance response standards.No patient should wait in an ambulance outside of ED when they could be streamed to another service for their needs.			2022/23 priorities and operational planning guidance Reducing_ambulance_handover_delays_-_key_lines_of_enquiry_v1.1.pdf (england.nhs.uk)
Flow - 68. Acute takes are owned by the relevant specialities with a Senior Decision Maker in place 7 days a week.			NHS Services 7 days a week forum ECIST Safer Patient Flow Bundle - S.Senior Review
Flow - 69. Red 2 Green (or alike) is embedded with an escalation process to overcome delays.			Rapid Improvement Guide to Red & Green Bed Days Red2Green Q&A with Dr Ian Sturgess & Pete Gordon ECIST
Flow - 70. 7-day a week ward / board rounds operational in line with RCP guidelines. With all patients receiving a senior review (ST4 or above) every day.			Guidance on Safe Medical Staffing - RCP London Modern Ward Rounds: Good practice for multidisciplinary inpatient review Seven Day Working - NHS England
Flow - 71. Internal professional standards are adhered to in a clear and unambigous manner with description of values and behaviours expected in the organisation (Patient FIRST) for diagnostics and speciality review. (within 24hours of referral as a maximum - 7 days a week)			Acute Care Tool Kit - Delievering a 12hr 7 day consultant presence on the acute medical unit Patient First 2021
Flow - 72. Weekend discharges maintain patient flow over 7 days including usage of Criteria Led Discharge.			Improving Hospital discharge (Policy & Action cards) Improving Hospital Discharge (Good Practice & Guidance) Criteria Led Discharge - Policy Guidance

UEC Improvement Framework

Key lines of enquiry (KLOEs)	Implementation Questions	Implementation Answers	National guidance/ Best Practices (Links)
Mental Health (MH) Ambition - Patients receive timely services and treatment as needed, with a greater focus on early intervention services that can prevent mental health crises.			
MH - 73. (MH Trust specific) Systems should ensure anyone admitted to an adult mental health acute ward has a clearly documented purpose for admission and an estimated discharge date.			acute mental health guidance in development
MH - 74. (MH Trust specifc) The average length of stay for mental health hospital spells is no more than the current national average of 40 days.			LTP update in development
MH - 75. (MH Trust specific) Systems should drive local reductions in long length of stay in mental health adult acute wards - this should include a focus on reducing the number of working age adults in acute care with a length of stay (LoS) over 60 days and older adults with a length of stay over 90 days, and below the current set threshold of 8 people per 100k population.			https://future.nhs.uk/MHLTPat/view?objectId=122600101
MH - 76. (MH Trust specific) Systems must use baseline funding increases for therapeutic and purposeful mental health inpatient admissions e.g. through expanding the staff skill mix (focusing on psychologists, occupational therapists, peer support workers and other Allied health Professionals), the type of interventions and activities offered to patients, and ensuring the inpatient environment is therapeutic.			https://future.nhs.uk/MHLTPat/view?objectId=122600101
MH - 77. (MH Trust specific) Systems should continue to focus on delivering timely and effective discharge following the additional funding made available for enhanced post-discharge mental health support during 2021/22. Where new schemes proved successful in reducing length of stay, waits in A&E, inappropriate OAPs, and preventing further admissions, they should be continued in 2022/23. [using baseline funding increases where required]			https://future.nhs.uk/MHLTPat/view?objectId=122600101
MH - 78. (MH Trust specific) Systems should continue to deliver and maintain the ambition to eliminate all inappropriate mental health adult acute out of area placements (OAPs) and continue delivering the 72-hour post discharge follow-up standard.			https://future.nhs.uk/MHLTPat/view?objectId=122600101
MH - 79. AAP Local Winter plans include demand and capacity analysis for mental health, inclusive of the following service areas for all ages: i. Community mental health team referrals and capacity ii. Capacity in primary care to support mental health needs, via Mental Health Practitioner ARRS roles iii. Open access crisis care, i.e. crisis lines and SPA's as well as CRHTT iv. VCSE sector capacity inclusive of alternatives in community, i.e. sanctuaries, crisis houses, etc. (e.g. patients seen vs anticipated need) v. Acute MH inpatient capacity (e.g. number of bed days available and anticipated bed days required) vi. Emergency Department (e.g. number of MH attendances at ED and % of MH patients waiting over 12 hours)			Demand and Capacity Network
MH – 80. Consider the workforce required to deliver and maintain commissioned service capacity across all age mental health pathways this winter, drawing on guidance availble regarding new ways of working and the use of new roles in mental health.			http://www.hee.nhs.uk/our-work/mental-health/new-roles-mental-health https://haso.skillsforhealth.org.uk/news/peer-worker-apprenticeship-progress-update/ https://www.hee.nhs.uk/our-work/workforce-transformation/hee-roles-explorer
MH - 81. All ICBs to sustain, develop and promote staff Mental Health hubs in line with guidance.			https://future.nhs.uk/SMHS/view?objectId=131092165

UEC Improvement Framework

Key lines of enquiry (KLOEs)	Implementation Questions	Implementation Answers	National guidance/ Best Practices (Links)
Operational Management & Escalation (OME) Ambition - Patients on an urgent and emergency pathway are managed in the right care setting at the right time to maximise their health outcomes with operational processes in place to deliver this.			
OME - 82. Handover framework/ actions in place (i.e rapid handover protocol) to be enacted when ambulance pressures, (i.e hospital handover delays, Cat 2 calls, lost hours) exceed a pre-agreed(ICS and ambulance service jointly) tolerance.			Delayed hospital handovers: Impact assessment of patient harm
OME - 83. Minimum twice daily site meetings, with senior leadership (executive level Opel 3&4). These are action focussed and conducted in line with a recognised framework – working example ECIST FOCUS model.			FOCUSED site management model
OME - 84. Fit for purpose and regularly reviewed full hospital protocol is in place that is compliant with the latest IPC guidance and enables capacity to be created to meet surge needs.			https://rcem.ac.uk/wp-content/uploads/2021/10/ED_Crowding_Overview_and_Toolkit_Dec2015.pdf
OME - 85. In and out of hours clear bronze-silver-gold line of escalation with recorded actions and outcomes.			Site management and escalation video
OME - 86. Weekly board level review and identified improvement actions of: -Ambulance waits and root cause. -Patient harm because of excessive waits at any point across the UEC pathway. -Over 12hrs in ED and 12hour DTA patients -4hr performance and breach rational.			FOCUSED self-assessment tool

UEC Improvement Framework

Key lines of enquiry (KLOEs)	Implementation Questions	Implementation Answers	National guidance/ Best Practices (Links)
Intergrated Care Boards (ICB) Ambition - Integrated Care Boards take responsibility for oversight of UEC recovery, improvement and transformation through the implementation of robust			
ICB - 87. ICB responsibilities - ICBs should ensure they have aligned with national guidance (as provided in the links)			https://nhsengland.sharepoint.com/sites/thehub/SitePages/Integrated-Care.aspx https://www.england.nhs.uk/integratedcare/consultations/
ICB - 88. ICB to establish an UEC improvement steering group/board or equivalent with senior membership from all partners across system and place. *Recommendation for ICB executive to chair this board with support from ICS UEC clinical and operational leads Responsibilities include : - To review membership to include health, social care and system partners representative of system and place - To ensure system and place based improvement groups report to the board to enable oversight of all UEC improvement efforts, challenges and constraints to enable system wide solutions and sharing of good practice. - To receive and review national and local data to inform priority deliverables and opportunities for improvement across UEC. - To complete a review of current progress and opportunities for improvement using data and local intelligence to prioritise areas of focus as outlined within this improvement framework			https://www.england.nhs.uk/integratedcare/consultations/ https://www.england.nhs.uk/wp-content/uploads/2021/06/B0642-ics-design-framework-june-2021.pdf https://www.england.nhs.uk/wp-content/uploads/2021/06/B0660-ics-implementation-guidance-on-thriving-places.pdf https://www.england.nhs.uk/wp-content/uploads/2021/06/B0905-vcse-and-ics-partnerships.pdf Model Health System GIRFT SEDIT
ICB - 89. Process measures (Patient FIRST 2021) include: Admission conversion rates, Re-attendance rates to ED, Proportion of patients clinically assessed and directed to SDEC, Proportion of patients clinically assessed and directed to another service off-site (for example urgent primary care/urgent treatment centres) or on-site (co-located urgent treatment centre, specialty assessment units, clinics) , Proportion of patients sent to the emergency department by GP or other community provider without prior communication; To be monitored, discussed and acted upon at each ICS UEC Board.			Patient First 2021 SDEC -NHSE/I https://www.gettingitrightfirsttime.co.uk/wp-content/uploads/2021/11/EM-overview.pdf
ICB - 90. Agreed assurance process in place across all ICSs to support a rapid return to sustainable ambulance performance, focused on C1 and C2. What is the agreed assurance process and trajectory across all ICSs to achieve and maintain C1 and C2 performance?			NHS England - Lord Carter's review into unwarranted variation in NHS ambulance trusts National framework for healthcare professional ambulance responses ambulances-response-programme-review
ICB - 91. Agreed assurance process in place with the role of the ICBs outlined in challenging whether a co-located UTC at the front door would be beneficial.			https://www.england.nhs.uk/wp-content/uploads/2022/02/20211223-B1160-2022-23-priorities-and-operational-planning-guidance-v3.2.pdf *Pending approval of UTC standards approval*- All Type 1 EDs should have in place, or robust plans in place to enact, a UTC at the front door by March 2024 where it is clinically appropriate for the local health economy. Where this is not cost-effective or appropriate, this should be discussed with regional teams and ICBs are asked to explore forms of enhanced streaming that could maximise opportunities to divert low acuity patients away from ED.

ICB - 92. Each ICB has appointed a lead SRO for NEPTS across the system. This requirement is a recommendation from the review, with guidance awaiting approval which includes what is expected from the Lead SRO, such as: - Oversight of all NEPTS for patients for whom the relevant commissioner has responsibility - Oversight and co-ordination of all commissioning of NEPTS with the region / ICB / place, where applicable - Promoting the benefits of integrated working across the ICS that encompasses the key role of NEPTS in wider provision.			NEPTS Review
ICB - 93. External: Use of regional level system risk assessment tools or apps that work in real time. An agreed set of associated actions and responsibilities can be triggered from this data (Please outline triggers and actions). These actions could then be filtered to the appropriate services. (Patient FIRST 2021)			Patient First 2021

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The Royal College of Emergency Medicine

NHS England

Guidance for emergency departments

Initial assessment: definitions and recommendations

August 2022

Contents

1. Introduction

The 2022/23 NHS planning guidance specifies the need for more structured streaming arrangements between urgent treatment centres (UTCs) and emergency departments (EDs), and as such they must have robust processes that match patients with the service most suited to meet their clinical need; for example, a UTC (which may or may not be co-located with an ED) or same day emergency care (SDEC) service.

The rationale for changing the way in which we look at and understand the performance of UEC was set out in the Interim report of the clinically led review of access standards (March 2019) and subsequently in Transformation of urgent care: models of care and measurement (December 2020) makes it clear that UEC needs to identify the sickest patients early and their treatment begun as soon as possible after arrival. Urgent and emergency care (UEC) attendances continue to increase across England. Effective patient flow that supports early senior clinical decision-making is therefore imperative.

This guidance makes recommendations for models of initial assessment of patients arriving at EDs and provides standard definitions of the processes that classify as initial assessment: streaming, triage, and rapid assessment and treatment. It recognises that initial assessment and flow from the front door of a hospital are a crucial first step on a patient's journey. Decisions made at the first point of interaction can frame much of the subsequent process of care and are an essential component in managing risk and ensuring a high quality service.

It builds on and replaces Clinical streaming in the accident and emergency department (2017) and Initial assessment of emergency department patients (RCEM 2017), which recommended beginning initial assessment of patients presenting to ED within 15 minutes[1] . This document has been developed with the Royal College of Emergency Medicine (RCEM) after consultation with key stakeholders,[2] and agreed for England. RCEM will consult the other UK nations to achieve consistency wherever possible.

[1] SDDC_Intial_Assessment_Feb2017.pdf (rcem.ac.uk)
[2] NHS England and NHS Improvement, RCEM, Royal College of Nursing (RCN), Care Quality Commission, regional UEC clinical advisors, Society of Acute Medicine, emergency department clinicians across England.

‘ED’ in this document refers to the location where the initial patient assessment takes place. Assessment can be performed by a type 1 (ED) or type 3 (UTC) service. Hospitals may have a UTC at the front door which performs the streaming function.

The following are **not** within the scope of this document:

- initial assessment of patients presenting during a major incident
- initial assessment processes used by NHS111.

2. Patient flow into emergency departments

The core principle is that on arrival at hospital, patients are directed to a treatment area or service staffed with appropriate healthcare practitioners to manage their clinical needs.

Patient arrival

Most patients who arrive at emergency departments (EDs) self-present (they are unheralded). Since the COVID-19 pandemic, hospitals have changed the way that patients access services due to increased infection prevention and control (IPC) measures, including rapid testing of patients for COVID-19. Consequently, a proportion of patients who attend ED may have had earlier contact with a clinician in another setting, such as NHS 111.

Heralded patients

These patients have contacted NHS 111 and been advised to go to hospital. NHS 111 books them into ED arrival slots. Providers should use the NHS national standard for booking and referral and should make the ED aware of the patient’s attendance in advance of their arrival.

Patients who are conveyed by ambulance are also heralded.

Ambulance handover

Ambulances will pre-alert the ED if they are conveying a patient who needs to be received by a clinical team. These patients must be received by the appropriate team immediately on arrival.

Handover of non-pre-alerted patients from an ambulance crew to the ED should be completed following locally agreed processes within 15 minutes of arrival, as per NHS ambulance services pre-alert criteria guidance. Responsibility for patient clinical assessment and treatment lies with the hospital from the point the ambulance arrives at the department. Ambulance clinicians need to return to their vehicle immediately after handover to prepare and makes themselves available for patients needing an ambulance response in the community.

Unheralded patients

These patients are not expected by the ED. They include patients who self-present with no previous contact with a clinician in another healthcare setting and those advised to attend ED by a clinician in 999, primary or community care.

3. Initial assessment

Patients should be assessed promptly by locally agreed processes within 15 minutes of arrival. However, patients who have a booked appointment via NHS 111 at a co-located UTC are not required to have a further assessment on arrival if they are seen within 30 minutes of their appointment time. An exception to this would be if the patient's clinical condition has deteriorated before arrival and in this case further clinical assessment would be of value.

Clinical governance of any assessment must be unambiguous. The service assessing and directing the patient should ensure joint governance arrangements are in place for clinical responsibility, until the patient is next assessed by a clinician.

Patients should be assessed according to two main factors:

- **chief complaint or suspected diagnosis:** the chief complaint is the primary problem the patient is presenting with, as initially assessed by a clinician
- **acuity:** acuity is a measure of the severity of the patient's condition and the urgency with which they need to be seen and assessed by a clinician qualified to do this through training and experience. Defined in the data dictionary.[3]

[3] EMERGENCY CARE ACUITY (SNOMED CT) (datadictionary.nhs.uk)

In the Emergency Care Data Set (ECDS) acuity is assigned a score of 1 to 5. If an explicit (formal) triage system is not used, implicit triage that flows patients to resus (1), majors (3) or minors (4) is currently used.

Table 1: Acuity coding in ECDS

ECDS	A&E coding
1 Immediate emergency care	1 Resuscitation
2 Very urgent emergency care	3 Majors
3 Urgent emergency care	4 Minors
4 Standard emergency care	
5 Low acuity emergency care	

Initial assessment must add value to the patient's journey and not cause inappropriate clinical duplication. Although initial assessment models may differ across the country and be based on one or more of the processes defined below. They should encompass the recommendations in Table 3 below.

The main objectives of initial assessment are to:

- identify patients with potentially life-threatening conditions and injuries to ensure those with the most time-critical conditions are prioritised
- accurately assess non-life-threatening conditions and injuries so that appropriate prioritisation occurs for these patients and they are seen by the right service within appropriate timeframes
- prevent ED crowding and support infection prevention and control (IPC)
- recognise potentially vulnerable patients and consider their immediate safeguarding concerns.

Initial assessment recommendations

Table 3: Recommendations

1	Identify patients with life-threatening conditions/injuries and ensure they are prioritised.
2	Identify patients with non-life-threatening conditions/injuries and ensure appropriate service allocation and prioritisation occurs.
3	Identify immediate clinical care needs (e.g. medication administration/diagnostics) and deliver care or enable prompt transfer to an area that can deliver care.
4	Identify potentially vulnerable patients including those with safeguarding concerns, learning disabilities, acute mental health illness and high risk of absconding.
5	Initial assessment should begin at soon as possible after a patient arrives.
6	Patients should be made aware of who is responsible for their care.
7	Initial assessment processes should be resourced to meet variation in demand.
8	There must be clear signage and processes to ensure patients know where they can access care.
9	When patients are advised to attend ED by other providers, the initial assessment process must account for this.
10	Where clinicians from other providers work within an initial assessment system, service development and governance structures should be shared.
11	Initial assessment areas must facilitate confidential conversations, enable access to patients with disabilities and their careers, and maintain patient dignity.
12	Staff should have support to assess patients who do not speak or understand English.
13	Initial assessment processes must support IPC measures, including minimising crowding in ED.

4. Clarification of definitions of activity that constitutes initial assessment

The terminology surrounding patient flow – pre-hospital and from the ED front door – is inconsistent, with terms such as streaming, assessment and triage used interchangeably. Since national implementation of streaming models in EDs in 2017/18, providers have said clearer definitions of initial assessment would be helpful.

On arrival at an ED, patients undergo an initial clinical assessment. This includes one or more of the processes described in Table 2. While navigation, redirection and referral are also defined and described to clarify terminology around flow, they are not classed as part of the initial assessment but could be an output.

Figure 1: Initial assessment flow

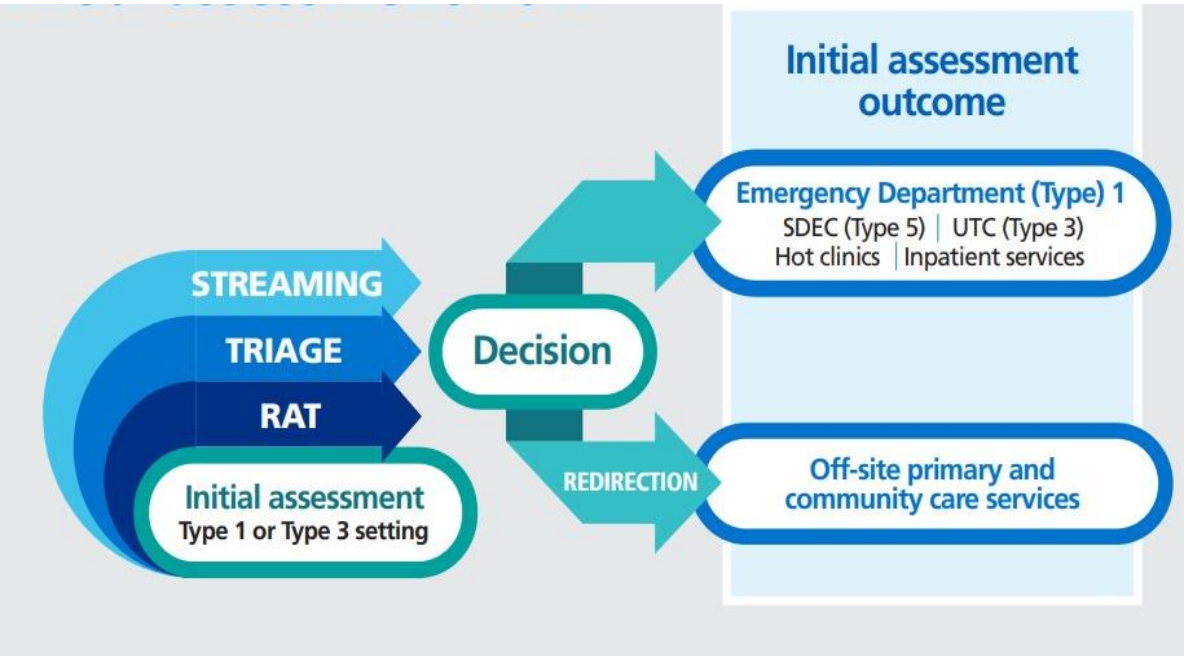

Table 2: Definitions of initial assessment and context in which terms should be used

Definition	Context
Streaming: a clinical activity to direct patients to the most appropriate service based on their presenting symptoms, chief complaint and acuity.	Streaming manages queues and matches patients' needs to the practitioner and area with the right clinical skills and diagnostic and treatment capabilities at the earliest opportunity. Streaming of patients is carried out within an ED (type 1) or a co-located UTC (type 3) and is likely to be the first clinical activity the patient experiences when arriving. It focuses on determining who will see the patient next, and results in a transfer of care. It is based on a clinical assessment that typically involves taking a brief medical history and may include performing basic observations. Some sites may include other measures such as NEWS (National Early Warning Score) or PEWS (Paediatric Early Warning Score), basic first aid measures, simple analgesia and simple tests. It is not appropriate to perform complex investigations at this point in the patient journey. Streaming should be done only by clinicians who are registered and trained in local guidelines and bound by local clinical governance. Patients may also be asked to use digital streaming tools (digital enablers) and where they are staff should be available to support them to do so if required; the clinical governance and accountability remain with the clinical service. Streaming is the first clinical activity the patient is likely to experience when arriving at the ED. The streaming activity should be brief, to avoid queues developing, and completed as soon as possible. However, the overall system must incorporate safeguards to ensure the further assessment of those patients who require this Streaming environments must be conducive to a patient's needs, with sufficient privacy to allow the exchange of confidential information. They should be situated close to clinicians who can provide support if needed, and as close to the main entrance and waiting room as possible. Outcomes of streaming are likely to be varied and can include:

	• UTC (if present on-site) • ED clinical assessment (resuscitation room, majors, minors) • streaming to another service such as SDEC, or a specialty assessment unit (medial, surgical, gynaecology, children's, etc) • redirection off-site. Streaming explicitly assumes protocols are in place that allow patients to be immediately transferred to the ED if clinically required and appropriate. Streaming allows rapid referral into services such as SDEC but pre-hospital referral to services such as SDEC is recommended at an integrated care system (ICS) level, to avoid presentation at the ED where appropriate. Patients arriving by ambulance may be suitable for streaming and there should be joint working and governance between ED, the ambulance service and any streaming provider.
Triage: the clinical process to prioritise patients, completed before a full assessment to support effective management of demand and flow, identifying time critical requirements for patients.	Triage is part of the process to prioritise patient treatment so that the most acutely unwell patients are seen first. Triage may be done in isolation from streaming or completed after a patient has been initially streamed on arrival. This process and model of care will depend on capacity and demand. When EDs are under pressure, triage may be used to help clinicians identify the order in which patients should be seen, but it can also be part of normal business to support the flow of patients within the ED. Triage is a meaningful face-to-face clinical assessment which may include observations and the use of triaging tools to support decision-making. It typically takes longer than streaming. The outcome is a priority assigned to the patient, thus helping manage workload and ensuring the sickest patients are seen first. Triage should be performed by a clinician who is trained and competent in using the specific triage system being applied. Its correct use ensures robust and reproducible assessment. The triage process should start as soon as possible after the patient arrives in the department, and if the patient has not already been streamed will also be the patient's initial assessment. Sufficient resources need to be

	allocated to triage to cope with variations in demand (both in numbers and time taken to complete triage), not average demand. Triage should be performed in an environment that is sufficiently private for exchange of confidential information but not isolated from the department. Several validated triage systems are in use across England, such as the Manchester Triage System, Canadian Triage and Acuity Scale and the Emergency Severity Index.
RAT: rapid assessment and treatment is the initiation of investigations and treatment as determined by a team including senior decision-makers.	RAT is the most complex form of initial assessment and incorporates both streaming and triage. It is commonly but not exclusively used for the most unwell patients arriving to the ED. A RAT process requires a team that includes a senior decision-making clinician, nursing, and support staff. Clinicians are usually senior doctors such as consultants, middle grades or advanced clinical practitioners who can make decisions about care, order investigations and prescribe early treatments. It takes longer than streaming or triage (often 20 to 30 minutes, depending on the patient) and therefore, if insufficiently resourced, could create a queue to access it. However, it can improve the overall emergency care episode by initiating investigations and treatments early.
Note on digital enablers: External providers and NHS England and NHS Improvement have developed digital tools across England to support the initial assessment process and they are becoming a key part of the initial assessment process. More tools are emerging and being implemented to help reduce overcrowding in waiting rooms and to offer patients the ability to self-triage as they enter a type 1 or type 3 site. These tools are clinically designed and governed by the site where they are used.	

Definitions of activity that is associated with flow and may be an outcome of initial assessment (but is not part of the initial assessment)	
Redirection: patients may be redirected to an appropriate service after streaming or triage contact with a clinician or digital clinical tool. Redirection is a choice offered to patients with the full awareness that there is no transfer or formal handover of care.	Redirection involves signposting the patient to services that are suitable for their care needs after a clinician or digital tool has streamed or triaged them. It is different from streaming, navigation, and triage as it involves directing patients to off-site care. The patient should be able to access the services offered within an appropriate timescale. This is not a direct transfer of care as it is for the patient to decide if they should act on. The responsibility to utilise the advice lies with the patient, and there is not a direct transfer of care. Technical streaming tools used in EDs may assist in this process. Redirection options are agreed by the hospital on implementing the digital enablers. Examples are community pharmacies, dental services, or other specialist services in primary and community care.
Referral: occurs when a patient has been assessed by an appropriately qualified practitioner in an emergency care facility and the decision made to refer them to another specialty for further care. In this case, a full ECDS ED episode has occurred.	To differentiate streaming from referral, it is important to understand that referral happens **after** a patient has been assessed by an appropriately qualified practitioner in an emergency care facility and the decision made to refer them to another specialty for further care. The ECDS ED episode has been completed. The clinical governance of this process is subject to local agreements; that is, it may be a negotiated or non-negotiated transfer of care. In the case of streaming there is not a full ECDS ED episode for the attendance, just an ECDS streaming episode. The clinical governance of this process is subject to local agreements: i.e. may be a negotiated or non-negotiated transfer of care.
Navigation: a process to direct patients to services that may be suitable for their care needs. It is not based on clinical judgement or assessment.	Navigation typically happens before the patient comes under the responsibility of the ED and is not a counted activity in the patient's journey. This activity, at an early point of a patient's experience, may not involve a clinician and therefore is not based on clinical judgement. Navigation should not be confused with redirection, which is conducted by a clinician. Positive or adverse outcomes as a consequence of navigation cannot be recorded. This has clinical governance issues, specifically an absence of accountability or ability to recognise good practice. This process lacks an ability to be counted.

5. Counting and coding

Initial assessment activity should be recorded using the Emergency Care Data Set v3 regardless of whether the streaming episode occurs in a type 1 or 3 ED. Consistent data supports management of demand and capacity, enables comparisons between sites and supports improved processes for patients. Streaming does not currently attract a national tariff under payment by result; however, local arrangements may apply.

- To record an initial assessment episode in ECDS these fields need to be completed: arrival mode,
- attendance source
- date/time of attendance
- date/time of initial assessment
- chief complaint
- acuity, including NEWS-2 score if relevant, injuries fields if relevant.

If the patient is streamed to another service (eg SDEC or UTC), the episode would include discharge status, discharge destination and, if relevant, safeguarding should also be recorded.

Treatments, investigations, or diagnosis would be necessary.

Providers should refer to the most up-to-date technical standards in the data dictionary for the clock start and stop times for any patient's journey. Policy guidance should be followed when recording the patient journey on ECDS.

It is critical that patient registration is the first step in any patient journey, so that ECDS can then accurately record all episodes of care whether the outcome of initial assessment is for the patient to remain in the ED, be streamed to a UTC or an SDEC, or to flow into another part of the hospital or offsite.

Example	Streamed to co-located UTC	Streamed to co-located SDEC
Acuity	4 or 5	3, 4 or 5
Chief complaint	From the standard ECDS list	From the standard ECDS list
Discharge status	Streamed to primary care	Streamed to ambulatory emergency care*

* Ambulatory emergency care is now referred to as SDEC, but this change has still to be made in some systems. NHSI SDEC.

The NHS UEC Daily SitRep uses the same definitions for streaming and acuity, and submissions to this collection should be consistent with those made to ECDS.

6. Training in initial assessment

Staff undertaking initial assessment should be registered healthcare professionals who are competent in UEC and have received appropriate training.[4] They will need to demonstrate well-developed interpersonal skills so they can communicate effectively with patients and their families in what is often a stressful situation. Individual departments should have an agreed and documented auditable training process for staff that includes a competency framework.

Experienced reception staff have always had a role in identifying extremely unwell patients presenting to an ED or UTC and will often alert a clinical colleague if they are concerned about a patient who has yet to have a formal clinical assessment. However, their role must be viewed as an adjunct to safety mechanisms in place and never a replacement for a timely initial assessment by a trained registered clinician.

When digital tools are used to support initial assessment, staff trained in using them should be available to support their use by patient using the tools.

[4] RCN recommends the National Curriculum and Competency Framework for Emergency Nursing level 1 and 2.

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This publication can be made available in a number of other formats on request.

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NHS England

To:
- ICB leads
- All NHS Foundation Trust and Trust:
  - Chief executives
  - Medical directors
  - Chief nursing officers
  - Chief people officers and HR directors
- All PCNs and all GP practices
- All community pharmacy
- All NHS primary care dental contract holders
- All Primary Care optometrists and dispensing opticians
- All pathology incident directors
- All regional Chief Scientific Officers

cc.
- ICB chairs
- NHS trusts and foundation trusts chairs
- All local authority chief executives
- NHS regional directors
- NHS regional directors of commissioning

NHS England
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24 August 2022

Dear colleagues,

COVID-19 testing in periods of low prevalence

The government today, acting upon advice from UKHSA, has set out plans for COVID-19 testing in periods of low prevalence. This letter sets out our approach to delivering UKHSA's advice in relation to staff and patient testing. We will keep these arrangements under review along with our partners at UKHSA.

Prevalence in the community has fallen and remains at a comparatively low level as we emerge from the current Omicron wave. This means that the likelihood that individuals entering high-risk settings such as the NHS are infectious has also reduced and the relative risk of onward transmission into these settings is lower. Therefore, **routine asymptomatic testing in a number of settings will pause from 31 August**.

This means the majority of asymptomatic staff and patient testing will pause.

The full list of scenarios where testing in the NHS should continue after this date is listed

below. NHS organisations are asked to review their COVID-19 testing protocols in light of this new guidance, and implement changes as required.

Symptomatic testing will continue for both patients and staff, based on the current list of COVID-19 symptoms. Although the main symptoms of COVID-19 include fever, a new and continuous cough, anosmia (loss of smell) and ageusia (loss of taste), it is important to remember that COVID-19 can present as a wide range of other symptoms including, for example, shortness of breath, fatigue, loss of appetite, myalgia (muscle ache), sore throat, headache, nasal congestion (stuffy nose), runny nose, diarrhoea, nausea and vomiting.

Testing that should continue in NHS settings from 31 August

Use case	**Type of test**
High-risk patients identified for COVID-19 MAB and antiviral treatment	Polymerase Chain Reaction (PCR) or Lateral Flow Device (LFD)
Symptomatic patients for clinical diagnostic pathway	PCR; primary care testing may use LFD
Early release from self-isolation for patients in acute settings	LFD testing from day 5 onwards until two negative tests are obtained
Symptomatic or immunocompromised patients who are admitted as an emergency or for maternity care	PCR
Symptomatic or immunocompromised elective care patients prior to acute day case/overnight pre-admission	LFD (can be conducted at home)
Symptomatic or immunocompromised elective day care patients for example, learning disability and mental health pre-admission testing	LFD (can be conducted at home)
Transfers into or within hospital for immunocompromised patients	PCR
Discharge patients to care homes/hospices	PCR (unless patient has been positive for COVID-19 within 90 days, in which case an LFD test should be undertaken)
Symptomatic NHS staff and staff in NHS-commissioned independent healthcare providers (including return to work testing)	LFD at home
Outbreak testing in healthcare settings	Both PCR and LFD dependent on specified local protocol

Local healthcare organisations, with appropriate advice (including from medical directors, nursing directors or directors of infection prevention and control), may also exercise local discretion to continue testing for specific individuals or cohorts in line with broader infection prevention and control measures. Examples of this could include **asymptomatically testing staff or patients who are at higher risk of serious illness**

from COVID-19 and/or those staff who may be in contact with patients who are at higher risk of serious illness from COVID-19. Return to work protocols for COVID-19 positive staff will remain in place.

Employers are encouraged to involve local health and safety representatives where local arrangements are being put in place for staff.

Ordering tests

There are no changes to the existing mechanisms for ordering tests.

The online digital portal will still be available for those patients and staff who need to access tests as instructed by their clinician or manager at https://www.gov.uk/order-coronavirus-rapid-lateral-flow-tests Organisations who order tests to test patients on site can continue to do so through current arrangements.

IPC and reporting of infections

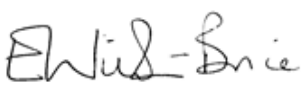
There are no changes to reporting requirements and existing UKHSA guidance on the management of COVID-19 patients remains in place, along with the appropriate IPC measures detailed in the IPC Manual for England. This guidance will continue to be reviewed in line with the latest scientific evidence including the potential impact of COVID-19 and other respiratory diseases on NHS services in the coming months.

Research studies

Any NHS staff undertaking COVID-19 tests as part of a research study (eg SIREN) should continue to follow the protocols of their study. Please contact your local study coordinator if further details are required.

Thank you again for all your work in support of the COVID-19 response to date.

Yours sincerely,




Professor Em Wilkinson-Brice
National Director for People
NHS England

Ruth May
Chief Nursing Officer
NHS England

Professor Stephen Powis
National Medical Director
NHS England

Dr Ursula Montgomery
Director of Primary Care
NHS England

Register of Attendance – Public Board 2022/23

	7 April	5 May	7 July	8 Sept	3 Nov	Jan 2023	Mar 2023	attendance rate
Nick Marsden	✓	✓	✓					3/3
Tania Baker	✓	✓	✓					3/3
Michael von Bertele	x	✓	✓					2/3
Paul Kemp	✓	✓	✓					3/3
Paul Miller	✓	✓						2/2
Stacey Hunter	✓	✓	✓					3/3
Lisa Thomas	✓	✓	✓					3/3
Andy Hyett	✓	✓	x					2/3
Judy Dyos	✓	✓	✓					3/3
Melanie Whitfield	✓	✓	✓					3/3
Eiri Jones	✓	✓	✓					3/3
Rakhee Aggarwal	✓	✓	✓					3/3
David Buckle	✓	✓	✓					3/3
Peter Collins	x	✓	✓					2/3
Mark Ellis								/4

Attended - ✓

Apologies – X

Governor Observer	7 April	5 May	7 July	8 Sept	3 Nov	Jan 2023	Mar 2023
Lucinda Herklots	✓	x	✓				
Jayne Sheppard	x	x	x				

Salisbury NHS Foundation Trust

Report to:	Trust Board (Public)	**Agenda item:**	2.1
Date of Meeting:	8th September 2022		

Report from: (Committee Name)	Clinical Governance Committee		**Committee Meeting Date:**	30th August 2022
Status:	**Information**	**Discussion**	**Assurance**	**Approval**
	X	X	X	
Prepared by:	Miss Eiri Jones, Chair CGC			
Board Sponsor (presenting):	Miss Eiri Jones, Chair CGC			

Recommendation

Trust Board members are asked to note and where relevant, discuss the items escalated from the Clinical Governance Committee (CGC) meeting held on the 30th August 2022. The report both provides assurance and identifies areas where further assurance has been sought and is required.

Key Items for Escalation

- Key information / issues / risks / positive care to escalate to the Board are as follows:
  - The Committee has in previous years received an annual Clinical Governance Report. This was not done last year due to Covid pressures and changes in personnel. The senior team have reviewed the information contained in this report and proposed that it was no longer needed as all the information is also contained in other annual reports. The Committee agreed to remove this from its workplan noting that it did not create any gaps in assurance and reduced the workload for the team.
  - A paper was presented in relation to palliative care coding. This was in response to a query from a Governor. The CMO was able to provide assurance that the approach at SFT is lifted from the national manual. This confirmed that the Trust was not deviating from national coding guidance. The report also provided data in relation to coding numbers. This information confirmed that the Trust is not an outlier in relation to coding numbers in this area.
  - The Executive approach to quality impact assessments (QIAs) and equality impact assessments (EQIAs) was presented to the committee. The committee received assurance that these would be completed either in relation to a major change in service or in relation to savings programmes.
  - The committee were updated on the support being provided to spinal services (also discussed at F&P). The committee noted the plan underway and asked for an update in 3 months' time, when all the beds would be back in use. Any urgent concerns would be escalated before then if required.

- The IPR was presented in its new format. It was noted that the Divisions have been more involved in this iteration and that work is ongoing to ensure assurance against strategic quality objectives is provided.
- The annual patient experience report was presented. It was noted that there have been several staff changes in the team. A forward plan was also presented, noting that this will be reviewed through the newly formed patient experience group. Updates will come to CGC through the quarterly reports.
- The Clinical Audit plan for 2022-3 was presented having been omitted in error from last month's meeting. A good discussion was held in relation to the importance of focusing on audits which added value to patient care in addition to the mandated audits.
- The quarterly children and adults safeguarding reports were presented. Key focus has been on embedding the new learning system in the Trust (LEARN). Whilst this will provide benefits in the long term it has changed the way it records training so there has been an adverse shift in the percentage of staff trained. Supervision in child health and maternity remains a challenge whilst an improvement in deprivation of liberty standards (DOLS) documentation was reported. It was also positive to note that a new Learning Disability nurse commences in the Autumn.
- The Dementia annual report was provided to the committee. A key focus for 2022-3 will be participation in the 6th National Audit. This will include patient / carer feedback in this version of the audit and will provide benchmarking information for the Trust. Training continues across the Trust and is oversubscribed. Positively the workplan is aligned with one of the breakthrough objectives in relation to falls reduction.
- The upward report from CMB focussed on the consent work underway. The committee asked for a deep dive into consent practice to come to the October meeting. The patient experience group have noted adverse feedback in relation to the cleanliness of the front entrance of the hospital. This is being addressed.
- The quarterly maternity services report was received (attached to this report for all Board members to receive). Several positives were outlined – the Beatrice unit centenary celebrations, changemakers visit, national Insight visit and CQC relationship meetings. Ongoing risks / issues included vacancies, maternity incentive scheme and Ockenden compliance (mainly training and audit workstreams) and compliance with the CQC action in relation to fluid charts usage. The system had asked for information in relation to mitigation of the vacancy position. The Director of Midwifery outlined multiple approaches being undertaken. The team are also using the Trust wide Improving Together methodology to address key challenges.
-

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

CLASSIFICATION: please select

Report to:	Clinical Governance Committee	**Agenda item:**	6.4
Date of Meeting:	30 August 2022		

Report Title:	Maternity Quarterly and Safety report – Quarter one 22/223			
Status:	**Information**	**Discussion**	**Assurance**	**Approval**
			X	
Approval Process (where has this paper been reviewed and approved)	Approved Women's and Newborn DMT			
Prepared by:	Joanne Hayward, Director of Midwifery.			
Executive Sponsor (presenting):	Judy Dyos, Chief Nurse Nursing Officer			
Appendices (list if applicable):				

Recommendation:
For committee to note for assurance against safety and quality metrics and workstreams

Executive Summary:
This Quality and Safety report for maternity services will highlight achievements and demonstrate current position against local and nationally agreed measures to monitor maternity and neonatal safety. The purpose of this report is to inform the Salisbury Foundation Trust Board of present and emerging safety concerns. It will evidence current compliance with national reporting Maternity Incentive Scheme (MIS) and Ockenden 2020 recommendations. It will also demonstrate patient experience and feedback and learning. Clinical outcomes will be reviewed against local and national benchmarks to demonstrate safety in maternity and key improvements and service development will be identified. This report reflects data from quarter 1 22/23.

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) -	☐

Quality and Safety Report

Women and Newborn Division

Quarter one

2022/23

Joanne Hayward

Director of Maternity and Neonatal Services.

Rachel Coleman

Quality and Safety Matron.

1 Executive Summary

This Quality and Safety report for maternity services will highlight achievements and demonstrate current position against local and nationally agreed measures to monitor maternity and neonatal safety. The purpose of this report is to inform the Salisbury Foundation Trust Board of present and emerging safety concerns.

It will evidence current compliance with national reporting Maternity Incentive Scheme (MIS) and Ockenden 2020 recommendations. It will also demonstrate patient experience and feedback and learning.

Clinical outcomes will be reviewed against local and national benchmarks to demonstrate safety in maternity and key improvements and service development will be identified.

This report reflects data from quarter 1 22/23.

2 Women and Newborn Division successes.

100 years of Being Beatrice

The Maternity Team celebrated the 100th anniversary of 'Beatrice Maternity' unit on 8th July 2022. The celebrations were led by Abi Kingston, Clinical Director for the Women & Newborn division, who gave a humorous speech regarding midwifery care over the past 100 years.

The celebration was attended by many staff to include Joanne Hayward, Director of Maternity and Neonatal Service and Judy Dyos, Chief Nurse for the Trust.

Abi Kingston, Clinical Director.

Joanne Hayward, Director of Maternity and Neonatal services and Judy Dyos, Chief Nurse- cutting the celebratory cake.

We were also joined at the celebration by baby Archie and his parents. They were recent service users and presented us with a beautiful canvas of their baby who has Trisosmy 21. This will be displayed on our postal ward.

Hannah Rickard, Consultant Obstetrician, Joanne Hayward with baby Archie, Archies mummy, Becky Roberts, Inpatient Matron for Maternity.

Insight Visit

We had a visit from the regional midwifery and obstetric leads alongside representatives from the Clinical Commissioning Group (CCG)_and the Local Maternity Neonatal System, the maternity voices partnership was also well represented with the local, LMNS and regional lead in attendance.

The main aim of the visit was to assess compliance with the Ockenden report of 2021.

Following a presentation, wards an department were visited, where members of the visiting team spoke to staff and women.

Initial feedback was overwhelmingly positive, whilst recognising the challenges to us achieving full compliance. We are awaiting a formal feedback report.

The presentation to the team can be accessed here.

Insight visit 7 june 22 JH FINAL v2 .ppt

Change makers

Numerous ‘changemaker’ sessions were held and was well attended by all maternity staff groups. This was part of our wider cultural improvement work.

All attendees gave positive feedback and were encouraged to identify all the good work that is ongoing in maternity.

Teams worked together to co produced a vison statement that was meaningful for maternity . Also, they identified key workstream that would improve staff and womens experience in maternity.

Our Vision for Maternity
We deliver high quality safe care for women and babies. We achieve this by working as a cohesive and supportive team in a positive and nurturing environment where everyone can flourish.

3 Service Provisions

This report refers to women and people who are pregnant. For simplicity of language, the document uses the term women throughout, but this should be taken to also include people who do not identify as women but who are pregnant, in labour and in the postnatal period.

During quarter one (Q1- 22/23) we continue to have significant midwifery vacancies. At the end of the quarter, we were 17 WTE midwives short against an establishment of 90 WTE clinical midwives. Mitigation against this will be demonstrated in part 4 / Safer Staffing aspect of this report.

Despite staff shortages all services continued with no home births declined or diverted due to staffing pressures. Our home birth rate is consistently above the national average of 2% at

between 3.3 – 4.8 % for this quarter. Staff worked flexibly across the community and unit to provide safe care for women.

The Beatrice Birthing Unit is nearly ready to receive labouring women. We are aiming to open this service early in the next quarter but are currently awaiting key equipment to be delivered before we plan the opening and inform the public. This unit will offer women a further birth choice option in accordance with national strategy, alongside home birth and hospital birth. It is anticipated that it will open in quarter one of 2022.

4 Safer Staffing - Maternity Workforce

Midwifery workforce remains a challenge. We continue to work with support from NHSE/I to decrease our staffing vacancy.

We are currently in a collaboration with Glouster and Swindon to recruit midwives from over sea countries. So far this has had limited success, however we are anticipating two midwives joining our team in the next quarter. We have recruited a retention and training support midwife specifically for our international midwives. This post has been funded for 6 months by NHSE/I. The main aim for this role is to support the midwives to upskill the with specific training alongside providing support as they join us from another country. She will support them to complete their OSCE in due course thus allowing them to join the NMC register.

Workforce models and have been reviewed successfully recruited four registered general nurses to work within our postnatal ward areas. Two will be joining the team in August 22 with the remaining joining in November 22. This mitigates against the significant midwifery vacancy.

This quarter we have also utilised agency midwives throughout the summer to support the workforce and over recruited on our support workers. This risk remains on our divisional risk register.

A more detailed six-monthly report will be written in the next quarter. This is line with the stipulation of the Maternity Incentive Scheme year 4.

5 Care Quality Commission (CQC)

A CQC relationship visit was had in quarter 1.

The division was well represented, and a presentation was shared detailing improvements throughout the division.

Feedback was positive with no concerns raised.

The presentation can be accessed here

CQC Engagement Pack 170622.pptx

We are complaint with all our 'Must Do's'

Regarding the 'should do's', there is one outstanding in relation to the WHO safety checklist audit – it is due for presenting at maternity governance in August 22 – this will close this action.

6 Maternity Incentive Scheme (MIS) year 4

We are currently online to achieve 8 out of 10 safety actions.

The evidence of work towards achieving year 4 MIS was forwarded for Audit during Q1 22/23.

A report of compliance is due for return early in Q2.

Safety Action	Standard	Compliant	Gap /Action
1: Are you using the National Perinatal Mortality Review Tool to review perinatal deaths to the required standard?	All perinatal deaths eligible to be notified to MBRRACEUK from 1 September 2021 onwards must be notified to MBRRACE-UK within two working days and the surveillance information where required must be completed within one month of the death.		
COMPLIANT	A review using the Perinatal Mortality Review Tool (PMRT) of 95% of all deaths of babies, suitable for review using the PMRT, from 8 August 2021 will have been started within two months of each death. This includes deaths after home births where care was provided by your Trust.		
	At least 50% of all deaths of babies (suitable for review using the PMRT) who were born and died in your Trust, including home births, from 8 August 2021 will have been reviewed using the PMRT, by a multidisciplinary review team. Each review will have been completed to the point that at least a PMRT draft report has been generated by the tool within four months of each death and the report published within six months of each death		
	For at least 95% of all deaths of babies who died in your Trust from 8 August 2021, the parents will have been told that a review of their baby's death will take place, and that the parents' perspectives and any questions and/or concerns they have about their care and that of their baby have been		

	sought. This includes any home births where care was provided by your Trust staff and the baby died either at home or in your Trust. If delays in completing reviews are anticipated parents should be advised that this is the case and be given a timetable for likely completion.		
	Quarterly reports will have been submitted to the Trust Board from 8 August 2021 onwards that include details of all deaths reviewed and consequent action plans. The quarterly reports should be discussed with the Trust maternity safety and Board level safety champions		
2.Are you submitting data to the Maternity Services Data Set (MSDS) to the required standard	Trust Boards to assure themselves that at least 9 out of 11 Clinical Quality Improvement Metrics (CQIMs) have passed the associated data quality criteria on the national Maternity Services Dashboard for data submissions relating to activity in January 2022. The data for January 2022 will be available on the dashboard during April 2022.		Currently 7 out of 11 – BI work has identified how to achieve 9/11 and E3 has been updated to achieve this
NON COMPLIANT	January 2022 data contained height and weight data, or a calculated Body Mass Index (BMI), recorded by 14+1 weeks gestation for 90% of women reaching 14+1 weeks gestation in the month.		
	January 2022 data contained Complex Social Factor Indicator (at antenatal booking) data for 95% of women booked in the month.		93% Jan 22 97% Feb 22 95% March 22
3: Can you demonstrate that you have transitional care services in place to minimise separation of mothers and their babies and to support the recommendations made in the Avoiding Term Admissions into Neonatal units Programme?	Pathways of care into transitional care have been jointly approved by maternity and neonatal teams with a focus on minimising separation of mothers and babies. Neonatal teams are involved in decision making and planning care for all babies in transitional care.		
NON COMPLAINT Anticipated compliance by submission	The pathway of care into transitional care has been fully implemented and is audited quarterly. Audit findings are shared with the neonatal safety champion, Local Maternity and Neonatal System (LMNS), commissioner and Integrated Care System (ICS) quality surveillance meeting each quarter.		Audit shared LMNS June 22
	A data recording process for capturing existing transitional care activity, (regardless of place - which could be a Transitional Care (TC), postnatal ward, virtual outreach pathway etc.) has been embedded. If not already in place, a secondary data recording process is set up to inform future capacity management for late preterm babies who could be cared for in a TC setting. The data should capture babies between 34+0-36+6 weeks gestation at birth, who neither had surgery nor were transferred during any admission, to monitor the number of special care or normal care days where supplemental oxygen was not delivered.		
	Commissioner returns for Healthcare Resource Groups (HRG) 4/XA04 activity as per Neonatal Critical Care Minimum Data set (NCCMDS) version 2 are available to be shared on request with the operational delivery network (ODN), Local Maternity and Neonatal System (LMNS) and commissioners to inform capacity planning as part of the family integrated care component of the Neonatal Critical Care Transformation Review and to inform future development of transitional care to minimise separation of mothers and babies.		
	Reviews of term admissions to the neonatal unit continue on a quarterly basis and findings are shared quarterly with the Board Level Safety Champion. The reviews should report on		

	the number of admissions to the neonatal unit that would have met current TC admissions criteria but were admitted to the neonatal unit due to capacity or staffing issues. The review should also record the number of babies that were admitted to, or remained on Neonatal Units because of their need for nasogastric tube feeding, but could have been cared for on a TC if nasogastric feeding was supported there. Findings of the review have been shared with the maternity, neonatal and Board level safety champions, LMNS and ICS quality surveillance meeting on aquarterly basis.		
	An action plan to address local findings from the audit of the pathway (point b) and Avoiding Term Admissions Into Neonatal units (ATAIN) reviews (point e) has been agreed with the maternity and neonatal safety champions and Board level champion.		
	Progress with the revised ATAIN action plan has been shared with the maternity, neonatal and Board level safety champions, LMNS and ICS quality surveillance meeting.		Evidence shared with LMNS June
4: Can you demonstrate an effective system of clinical workforce planning to the required standard? Required standard a) Obstetric medical work	The obstetric consultant team and maternity senior management team should acknowledge and commit to incorporating the principles outlined in the RCOG workforce document: 'Roles and responsibilities of the consultant providing acute care in obstetrics and gynaecology' into their service https://www.rcog.org.uk/en/careerstraining/workplace-workforce-issues/rolesresponsibilities-consultant-report		
NON COMPLAINT Anticipated compliance by submission	A duty anaesthetist is immediately available for the obstetric unit 24 hours a day and should have clear lines of communication to the supervising anaesthetic consultant at all times. Where the duty anaesthetist has other responsibilities, they should be able to delegate care of their non-obstetric patients in order to be able to attend immediately to obstetric patients. (ACSA standard 1.7.2.1		
	The neonatal unit meets the British Association of Perinatal Medicine (BAPM) national standards of junior medical staffing.		Non-compliant will need evidence that board accept this risk
5: Can you demonstrate an effective system of midwifery workforce planning to the required standard?	A systematic, evidence-based process to calculate midwifery staffing establishment is completed.		
COMPLIANT	The midwifery coordinator in charge of labour ward must have supernumerary status; (defined as having no caseload of their own during their shift) to ensure there is an oversight of all birth activity within the service		
	All women in active labour receive one-to-one midwifery care		
	Submit a midwifery staffing oversight report that covers staffing/safety issues to the Board every 6 months, during the maternity incentive scheme year four reporting period.		
6: Can you demonstrate compliance with all five elements of the Saving Babies' Lives care bundle version two?	Percentage of women where Carbon Monoxide (CO) measurement at booking is recorded. B. Percentage of women where CO measurement at 36 weeks is recorded.		CO monitoring at 36/40 – audits ongoing to demonstrate compliance and E3 updated to achieve this

NON COMPLIANT Anticipate compliance by submission	Percentage of pregnancies where a risk status for fetal growth restriction (FGR) is identified and recorded using a risk assessment pathway at booking and at the 20 week scan		Action against Doppler at 24/40 weeks if non compliant
	A.Percentage of women booked for antenatal care who had received reduced fetal movements leaflet/information by 28+0 weeks of pregnancy. B. Percentage of women who attend with RFM who have a computerised CTG (a computerised system that as a minimum provides assessment of short term variation).		
	The Trust board should specifically confirm that within their organisation: • 90% of eligible staff (see Safety Action 8) have attended local multi-professional fetal monitoring training annually as above. • A dedicated Lead Midwife (0.4 WTE) and Lead Obstetrician (0.1 WTE) per consultant led unit have been appointed by the end of 2021 at the latest.		Training – links with action 8
	A. Percentage of singleton live births (less than 34+0 weeks) receiving a full course of antenatal corticosteroids, within seven days of birth. B. Percentage of singleton live births occurring more than seven days after completion of their first course of antenatal corticosteroids. C. Percentage of singleton live births (less than 30+0 weeks) receiving magnesium sulphate within 24 hours prior birth. D. Percentage of women who give birth in an appropriate care setting for gestation (in accordance with local ODN guidance).		
7.Can you demonstrate that you have a mechanism for gathering service user feedback, and that you work with service users through your Maternity Voices Partnership (MVP) to coproduce local maternity services	Terms of Reference for MVP		Documentation from MVPs received and sent for audit
	Minutes of MVP meetings demonstrating how feedback is obtained and evidence of service developments resulting from coproduction between service users and staff		
	Written confirmation from the service user chair that they are being remunerated		
	The MVP's work programme, minutes of the MVP meeting which agreed it and minutes of the LMS board that ratified it		
COMPLIANT	Written confirmation from the service user chair that they and other service user members of the MVP committee are able to claim out of pocket expenses, including childcare costs in a timely way.		
	Evidence that the MVP is prioritising hearing the voices of women from Black, Asian and Minority Ethnic backgrounds and women living in areas with high levels of deprivation, given the findings in the MBRRACE-UK reports about maternal death and morbidity and perinatal mortality.		Work with BAME, military and vulnerable women – evidence has been sent for Audit
8: Can you evidence that a local training plan is in place to ensure that all six core modules of the Core Competency Framework will be included in your unit training programme over the next 3 years, starting from the launch of MIS year 4? In addition, can you evidence	A local training plan is in place to ensure that all six core modules of the Core Competency Framework, will be included in your unit training programme over the next 3 years, starting from the launch of MIS year 4 in August 2021.		Training schedule submitted for audit

that at least 90% of each relevant maternity unit staff group has attended an 'in house', one-day, multiprofessional training day which includes a selection of maternity emergencies, antenatal and intrapartum fetal surveillance and newborn life support, starting from the launch of MIS year 4?			
	90% of each relevant maternity unit staff group have attended an 'in-house' one day multi professional training day, to include maternity emergencies starting from the launch of MIS year four in August 2021?		Midwives 94.8% Anaesthetists 90.6% O & G 90.5%
	90% of each relevant maternity unit staff group have attended an 'in-house' one day multi professional training day, to include antenatal and intrapartum fetal monitoring and surveillance, starting from the launch of MIS year four in August 2021.		Midwives 96% O & G 70%
	Can you evidence that 90% of the team required to be involved in immediate resuscitation of the newborn and management of the deteriorating newborn infant have attended your in-house neonatal life support training or Newborn Life Support (NLS) course starting from the launch of MIS year four in August 2021.	Driver	Multiple planned sessions to increase attendance Midwives 69.6% Paediatricians 27.3% NN nurses 46.4%
9: Can you demonstrate that there are robust processes in place to provide assurance to the Board on maternity and neonatal safety and quality issues?	The pathway developed in year 3, that describes how safety intelligence is shared from floor to Board, through local maternity and neonatal systems (LMNS), and the Regional Chief Midwife has been reviewed in line with the implementing-a-revised-perinatal-qualitysurveillance-model.pdf (england.nhs.uk) The revised pathway should formalise how Trust-level intelligence will be shared with new LMNS/ICS and regional quality groups to ensure early action and support is provided for areas of concern or need.		
	Board level safety champions present a locally agreed dashboard to the Board on a quarterly basis. To include, as a minimum, the measures set out in Appendix 2 of the Perinatal quality surveillance model, drawing on locally collected intelligence to monitor maternity and neonatal safety at board meetings.		
	Board level safety champions have reviewed their continuity of carer action plan in the light of Covid-19. A revised action plan describes how the maternity service will work towards Continuity of Carer being the default model of care offered to all women by March 2023, prioritising those most likely to experience poor outcomes.		
	Board level and maternity safety champions are actively supporting capacity and capability building for staff to be involved in the Maternity and Neonatal Safety Improvement Programme (MatNeoSIP)		
10: Have you reported 100% of qualifying cases to Healthcare Safety Investigation Branch (HSIB) and to NHS Resolution's Early	Reporting of all qualifying cases to HSIB for 2021/22.		

Notification (EN) scheme for 2021/22?			
	For qualifying cases which have occurred during the period 1 April 2021 to 31 March 2022 the Trust Board are assured that:		
	The family have received information on the role of HSIB and the EN scheme;		
	There has been compliance, where required, with Regulation 20 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 in respect of the duty of candour.		

8 Ockenden

We presented our compliance with the Ockenden immediate and essential actions (IEAs) to the Insight team.

Ockenden overview

NHS Salisbury NHS Foundation Trust

	Compliance	Challenges/barriers	RAG
IAE1 : Enhanced Safety	6/7	• Digital system – submission to MSDS	
IEA 2: Listening to Women and Families	5/5		
IEA 3 :Staff Training and Working Together	5/6	• PROMPT) • O & G 90.5% • Midwives 94.8% • anaesthetists 65.6% Expect compliance in June	
IEA 4: Managing Complex Pregnancy	5/6	• SBLv2 - Element 1 – CO monitoring 92% @ booking ; 82% @ 36 weeks • Element 2-UAD- awaiting pathway then implement /audit	
IEA 5: Risk Assessment Throughout Pregnancy	2/3	• Risk assessment at every contact 85% via PCSP • Place of birth –not documented	
IEA 6: Monitoring Fetal Wellbeing	2/4	• Element 1 & 2 • PROMPT	
IEA 7: Informed Consent	3/5	• Written accessible information- website • SOP equal decision making	

We are compliant with many aspects of each action however only fully compliant with IEA 2. The main challenges are our immature digital system and compliance with Saving babies Lives (version 2). The latter remains a key action within the Maternity Incentive Scheme in which we hope to achieve by quarter 2. Talks are ongoing regarding a maternity specific digital system.

To be able to increase compliance at pace, as these actions directly affect safety, we aim to recruit to an assurance midwifery role in quarter 2 to directly address this.

9 Maternity Safety Improvement Programme (NHSE/I)

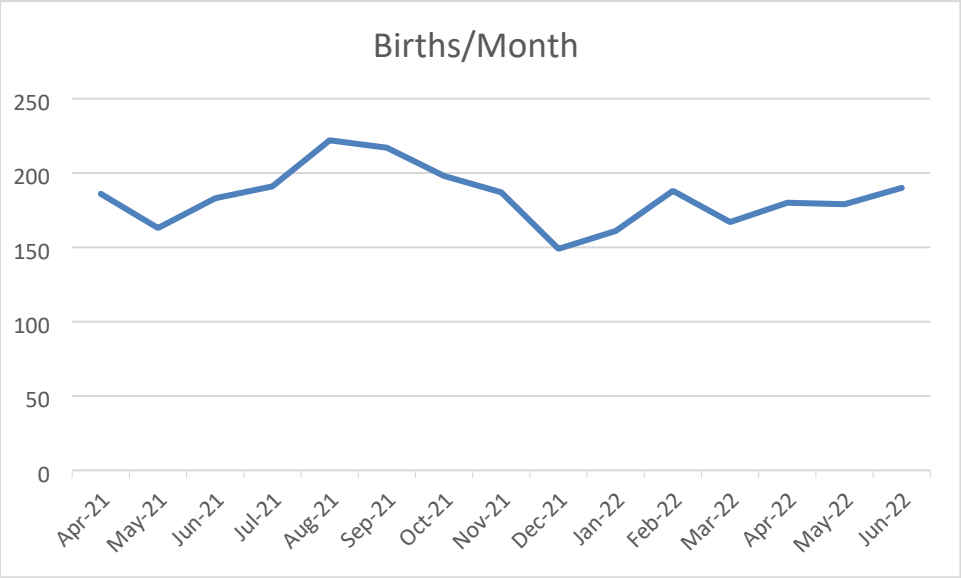
We continue to work with the Maternity Safety Improvement advisor, the latest report can be accessed here.

NHS E.I MSSP
Progress Monthly Rep

A governance ‘deep dive’ is planned for quarter 2

10 Birthing Activity

Our birth rate remains generally static.



11 Clinical Outcomes

All clinical outcomes continue to be within expected limits. A thematic review for PPH's has been undertaken and actions are being generated.

South West Region							National														
Measure	**Min**	**Median**	**Max**	**Improve direction**	**Green**	**Red**	**Mar-21**	**Apr-22**	**May-22**	**Jun-22**	**Jul-22**	**Aug-22**	**Sep-22**	**Oct-22**	**Nov-22**	**Dec-22**	**Jan-23**	**Feb-23**	**Mar-23**	**Q1 Total**	**Year To Date**	**FY 2021-22**
Babies (incl Non Reg)	179	180	190					180	179	190										**549**	**549**	**2212**
Women Delivered	175	176	188					175	176	188										**539**	**539**	**2197**
Homebirth rate	3.3%	3.4%	4.8%					3.3%	3.4%	4.8%										**3.8%**	**3.8%**	**3.6%**
Inductions %	36.4%	43.1%	43.4%					43.4%	36.4%	43.1%										**41.0%**	**41.0%**	**37.4%**
Instrumental deliveries %	8.4%	11.7%	13.7%	Down	12.0%	12.5%	12.5% NMPA	11.7%	8.4%	13.7%										**11.3%**	**11.3%**	**12.4%**
Apgar less than 6 @ 5 min %				Down	1.2%	3.5%	Green <1.2%, red >3.5% NMPA	0.6%	0.6%	0.5%										**0.5%**	**0.5%**	**0.5%**
Neonatal deaths within 28 days %				Down				0.0%	0.0%	0.0%										**0.0%**	**0.0%**	**0.1%**
Shoulder dystocia (severe & moderate)	0.0%	0.0%	0.0%	Down				0.0%	0.0%	0.0%										**0.0%**	**0.0%**	**2.0%**
PPH >= 1, 500 %	2.7%	4.0%	4.5%	Down	2.7%	5.6%	Green <2.7%, red >5.6% NMPA	4.0%	4.5%	2.7%										**3.7%**	**3.7%**	**3.4%**
Post partum Hysterectomies %				Down				0.0%	0.0%	0.0%										**0.0%**	**0.0%**	**0.0%**
Third & Fourth degree tears SVD	0.9%	2.7%	2.7%	Down				2.7%	0.9%	2.7%										**2.1%**	**2.1%**	**1.7%**
Third & Fourth degree tears assisted	0.0%	7.7%	13.3%	Down				0.0%	13.3%	7.7%										**6.5%**	**6.5%**	**5.1%**
Total 3 + 4 degree tears	2.3%	2.4%	3.6%	Down	3.5%	6.5%	green <3.5%, red >6.5% NMPA	2.3%	2.4%	3.6%										**2.8%**	**2.8%**	**2.4%**
Term babies admitted to NNU unexpectedly %	1.7%	2.1%	4.5%	Down	5.5%	5.8%	<5.8% NMPA	1.7%	4.5%	2.1%										**2.7%**	**2.7%**	**3.0%**

12 Training

Clinical training is a driver for the division. By using the Improving Together methodology six key modules were identified as needing further analysis to understand why lack of compliance is a challenge.

The six key modules most relevant to maternity are

- PROMPT
- Safeguarding
- Neonatal life support
- Gap/ Grow
- BSOTS
- CTG

The methodology has identified that NLS; BSOTS and gap / grow were the modules that made the biggest contribution (ie the lowest compliance). Further stratification of the data identified that certain staff groups were less compliant than others. This has allowed us as a division to target these groups to increase compliance.

Measure	Target	Apr-22	May-22	Jun-22
NLS Midwives	90%	55.2%	70.7%	69.0%
NLS NICU Nurses	90%	35.7%	46.4%	46.4%
NLS Paediaticians	90%	27.3%	27.3%	27.3%
Total NLS	90%			
BSOTS midwives	100%	45.2%	44.4%	44.4%
BSOTS obstetricians	100%			
Total BSOTs	100%			
GAP training TOTAL	90%	93.7%	74.8%	63.6%
K2 and CTG OVERALL (Midwives)	90%	96.0%	97.0%	96.0%
K2 and CTG OVERALL (Obstetricians)	90%	70.0%	70.0%	70.0%
PROMPT training TOTAL	90%	72.6%	72.2%	75.5%
PROMPT midwives attendance	90%	89.7%	94.8%	94.8%
PROMPT Obstetricians attendance	90%	76.2%	90.5%	90.5%
PROMPT Anaesthetists attendance	90%	75.0%	65.6%	90.6%
PROMPT MCA attendance	90%	57.1%	71.4%	71%

MCA PROMPT compliance is a focus for quarter 2.

CTG training compliance fell for obstetricians and is being tackled. Midwife compliance is over 90%.

NLS training was identified as the biggest contributor to non-compliance and stratified data showed that the Paediatric compliance was low at 27.3% - this has been escalated to the DMT and an RCA completed using Improving Together methodology, actions are pending.

BSOTS training is also a big contributor to non-compliance and will be the next focus for the training team.

13 Audit

Routine audits continue, but it is recognised that compliance fluid balance remains poor. This has become a driver and by working with the IT methodology we hope to identify and understand the root causes to be able to target these can improve compliance. This audit is key in assuring the CQC we are improving and embedding practice following the last CQC assessment.

May 2022				
Audit		Compliance May 2022	Trend From previous audit	Standard requiring improvement
Fluid Balance		70%		Record anything that is an input or output at least 4 hourly in labour
		60%		Record all input and output 4 hourly post-delivery for women with a catheter
		22%		Total input and output should be calculated every 12 hours and a negative or positive balance calculated
		48%		If the patient had a catheter, has a fluid balance been completed for 12 hours after the removal of the catheter, or until discharge home
Named Consultant Audit		80%	↓ 20%	Does the high-risk woman have a named consultant clearly identified either on the stamp or hand written on the inside of the front cover of her hospital notes
MEOWS		70%	↔	Frequency of observations in accordance with the care plan or guideline
		80%	↓ 20%	Name, Date of Birth and Ward completed on each chart
		75%	↓ 18%	Temperature recorded at each entry if appropriate
		70%	↑ 4%	Yellow and red scores calculated at each entry and action taken as required
Emergency Equipment Labour Ward		97%	↔	
Emergency Equipment Postnatal Ward		94%	↑ 7%	
1:1 Care		100%	↔	
Decision to Delivery audit		100%	↔	Cat 1
		100%	↔	Cat 2
BSOTS		80%	↑ 5%	Women triaged within 15 minutes
		95%	↑ 15%	Correct triage level
		95%	↑ 20%	Reviewed within correct time frame
		85%	↓ 5%	Women who had their SBAR completed
Swab Count		80%	↔	Documentation within the intrapartum records to show that a swab count was undertaken pre and post delivery
Pool Cleaning Checks	Rm 4	97%	↑ 14%	
	Rm 7	94%	↑ 21%	

14 HSIB

No referrals to HSIB during this quarter.

15 Coroner referrals

No referrals or reg 28 during this quarter.

16 Perinatal Mortality Report Tool (PMRT)

The Maternity Safety Incentive Scheme (MIS) requires achievement of ten Safety Actions. Safety Action One requires evidence that Trusts are using the National Perinatal Mortality Review Tool (PMRT) to review perinatal deaths to the required standard. We are fully compliant with this safety action.

Safety Action 1
(MBRRACE and PMRT

17 Antenatal and Newborn Screening

5.3-Nipe Action Plan
Update January 22.do

We continue to work with colleagues at NHSE/I to implementing the above action plan. We have no SIAFs (screening incident reports) in relation to our Newborn Physical examination programme.

We are planning to have our screening quality assurance visit in quarter 2 of 2022.

18 Serious incidents (SI)

Three Serious Incidents Investigations were commissioned during Q1 22/23 with Panels planned for early Q2 22/23.

Overall (as of 18/8/22) we have 7 outstanding actions (out of 32 actions from 4 SIIs and 1 CR) four are overdue. Future reports will be able to give more accurate quarterly data.

19 Family Experience - Listening to women and their families

Complaints:

Ref	Location (exact)	Closed	Description	Outcome
8613	Antenatal Clinic	27/04/2022	Patient very concerned regarding questions asked during her 12 week dating scan.	Within Maternity we plan to start a workstream to discuss how we can support women from our BAME community.
8656	Labour ward	Ongoing	Forced wife to have a natural birth, completely inappropriate conduct and procedures during the emergency c-section, incompetent consultants and a lack of care, compassion and common sense in operations.	
8607	Antenatal Clinic	05/05/2022	Whole sequence of events have caused her trauma and have ruined her pregnancy and labour.	Meeting held with Head of Maternity and Family Liaison midwife and concerns have been addressed.

Concerns:

Ref	Location (exact)	Closed	Description	Outcome
46506	Postnatal	09/06/2022	Discharged without any advice re home visits or community postnatal care and no red book provided.	A reminder has been sent to all staff to ensure that all women who live in Wiltshire receive a red book.
46715	Postnatal	Ongoing	Care a disgrace to the NHS.	
46508	Labour ward	Ongoing	Mismanagement on ward prolonged her stay.	
46620	Labour ward	Ongoing	Concerns regarding the doctor who performed her vagina examinations.	

Top 2 themes from complaints and concerns are:

- inappropriate treatment
- insensitive communications

Complaints - actions and learning:

April 22

- The sonography department regularly reviews any incidents and complaints/concerns and shares the outcome of these with the staff members involved. Detail of complaint will be discussed at the next review meeting.
- Email to be cascaded out to the Paediatric team to highlight the importance of appropriate communications
- Respectful communication was the subject of 'live learning' – Completed Feb 22.
- Within Maternity we plan to start a workstream to discuss how we can support women from our BAME community. The complainant has very kindly offered to be part of the group, as a service user representative of her input would be invaluable.
- Middle grade Doctor has reflected on the case with his supervisor

May 22

- Complainant's feedback shared with the staff member cited in the complaint. The staff member has shown real insight in how their communication could be misinterpreted.
- Consideration given to relocating the office on ANC, this will further preserve patient's confidentiality, as it will prevent professional conversations being overheard.
- Weekly memo sent to staff to act as a reminder to ensure that women receive the jaundice information leaflet when jaundice is suspected, particularly in those cases where treatment is required.

June 22

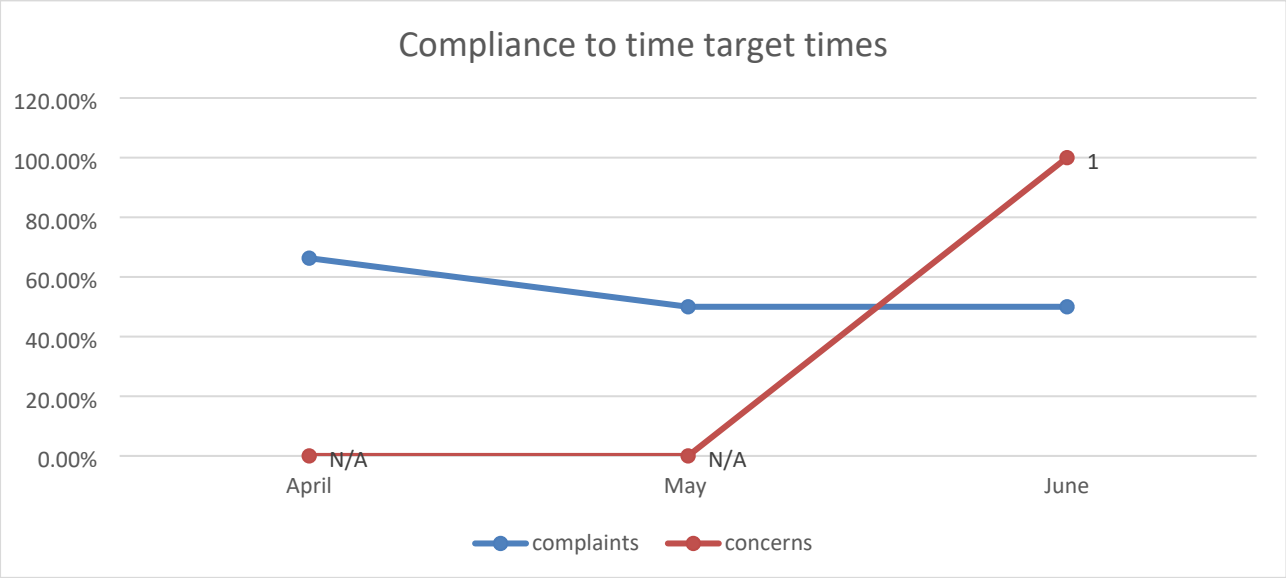
- Information cascaded to the workforce regarding the allocation of the Personal Child Health records or red book. - Weekly Memo was sent on 30/05/22

- Robust action plan in terms of escalation of complaints under the Allegation Against Staff policy:

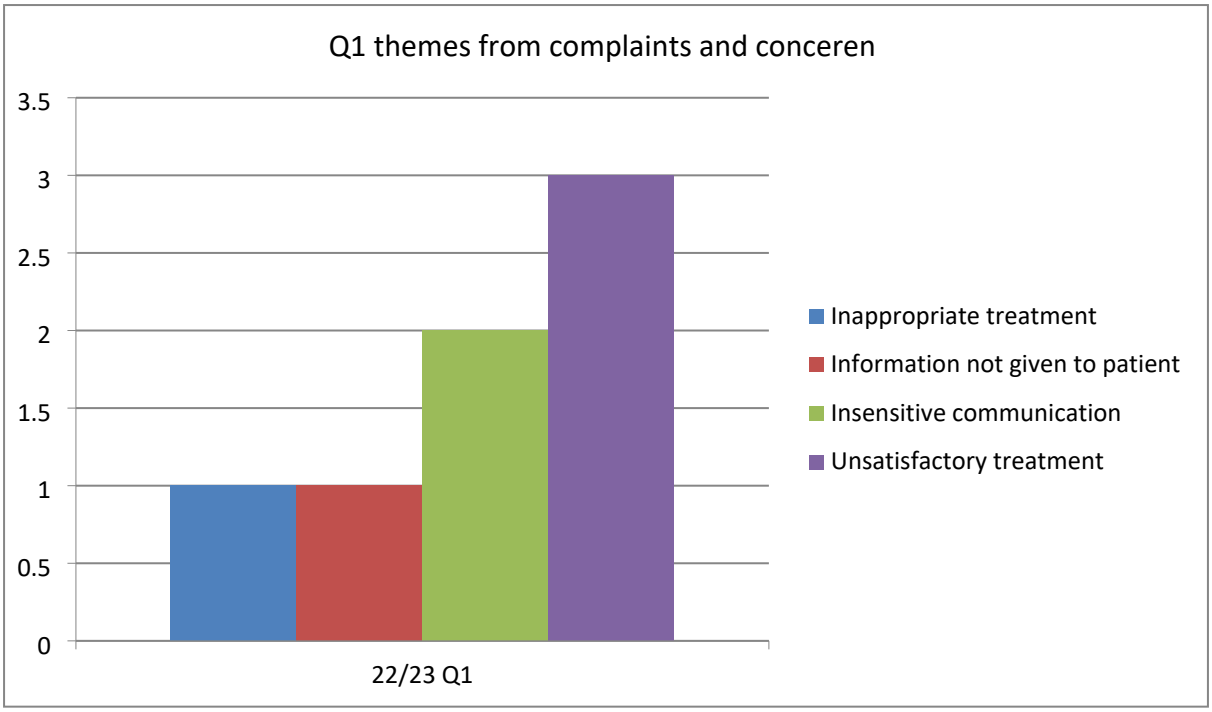
    1. Actions in relation to the staff's personal and professional devolvement was requested.

    2. Amendments were also made to the current 'Complaint, Concern and Comment' guideline.

Compliance to target times:

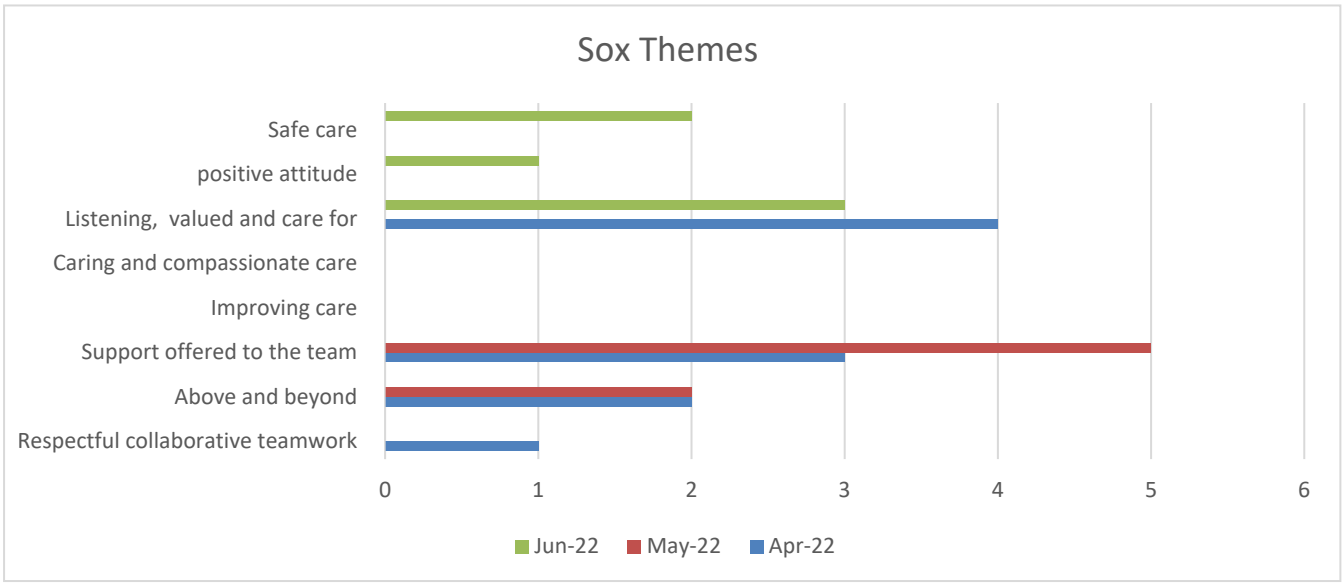


Focus has been given to ensure that complaints and concerns are responded to within the agreed target times.



Just over half of complaints responded to are responded within the target time. All concerns closed in this quarter have been responded to within 28 working days.

Sharing Outstanding Excellence (SOX)



Top 2 themes:

- Support offered to the team
- Listening, valued care for

Compliments

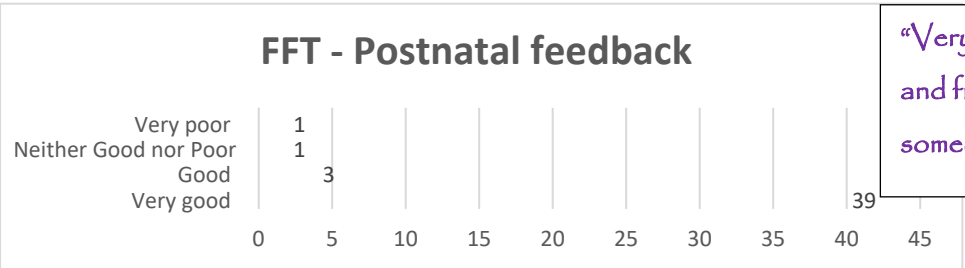
WAND	April 22	May 22	June 22
BEREAVEMENT	1	6	2
ANTENATAL	1		
COMMUNITY	7		2
LABOUR		13	2
MATERNITY			
NICU	5	5	
POST NATAL	3	4	5
	17	**28**	**7**

Ongoing public and patient engagement (PPI) outreach:

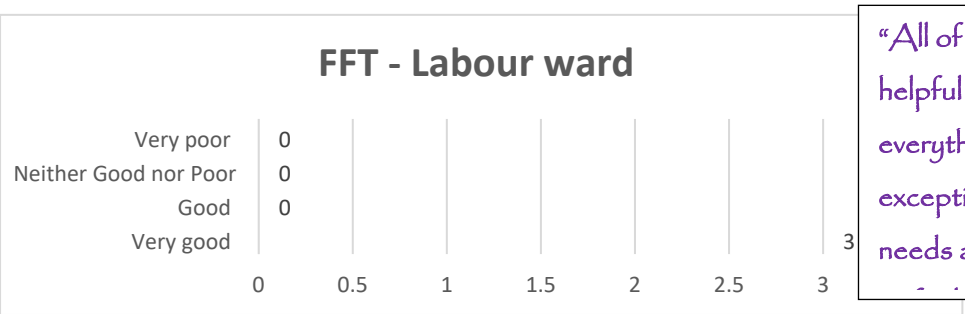
In support of the work we are undertaking to explore how we can provide equitable care to women from our BAME community and minority groups, we have worked in collaboration with our local MVP and the Minority and Traveller Achievement Services from Wiltshire Council to explore what women from the commonwealth (Nepelese and Fujian) want from their maternity services.

Friends and Family Test (FFT) Data from Jan 22 – May 22.

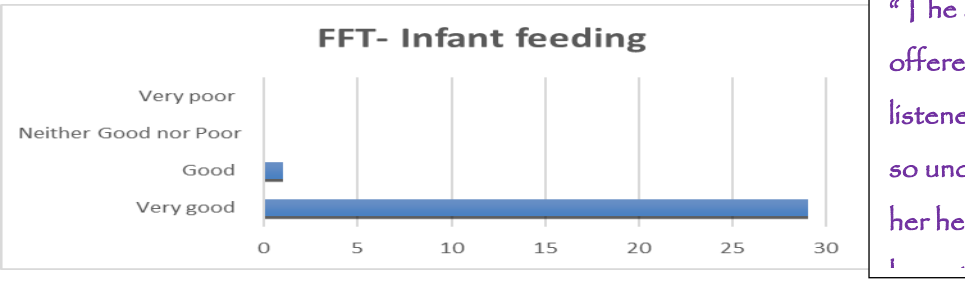
Overwhelmingly positive feedback.



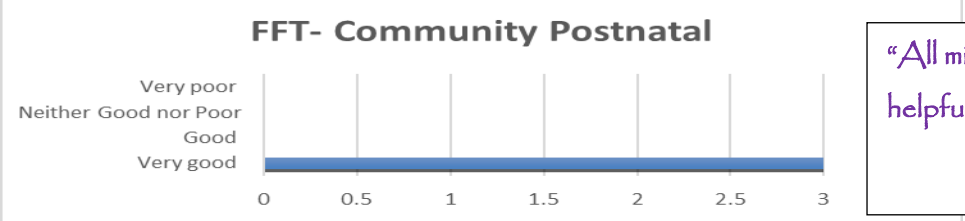
"Very well looked after. Great and friendly staff. Always someone to help."



"All of the staff were attentive and helpful and took the time to explain everything to us. They were exceptionally courteous of our needs and preferences and made



"The advice and support Jen offered was excellent. She listened to my concerns and was so understanding. I really valued her help and it has saved our



"All midwives have been very helpful, caring and genuine."

20 Safeguarding.

Level 3 compliance ii currently 95.2%. This will fall towards the end of the year as 2019 saw the introduction of the GCP2 when midwives were trained. SVPP training has been emailed out to midwives and they are aware that they need to book onto training, so they remain compliant.

Community Midwives are 100% compliant with their supervision.
All 6 of the required 1:1's by the Named Midwife are compliant for this quarter.
Safeguarding supervision sessions are 3 x per month and remain on Teams, although adhoc sessions have been done face to face.

- Child Protection plans 11.
- Child in Need plans 4
- Level 2B 3.
- Single assessments currently in progress 14.
- 30 MASH requests for information were sent These are sent by the CMW's if a woman has disclosed a history of police or social care involvement and the CMW needs to check that this is correct information. This is a good example of communication with our colleagues in MASH. There have been several that have required a MASH referral as CSC had further information that a further pregnancy would escalate their concerns. The women generally don't mind if explained.

During Q1 there were 10 safeguarding admissions to Maternity and NICU. 3 of these were out of area and communication at times was challenging. 6 of these babies were preterm so have required a longer length of stay on NICU. There have been 9 discharge planning meetings and all babies have gone home with their mother.

The Named Midwife for Safeguarding applied to NHS England's bids to become part of the pilot for Hope boxes (Hold On Pain Eases) for mothers who are separated from their baby. There are 2 boxes, 1 for the mother and 1 for the baby to have on discharge from hospital, contents will include blankets, a cuddly toy, letters, and poems. We were successful in our bid and will be one of fifteen Trusts selected Nationwide to be part of the pilot.
The Named Midwife has also started to give fathers who are not living in the family home, the option of having a blanket that has been with the baby, a congratulations notification of

birth certificate and a cot card to take home. Three fathers received these in Q1 22/23 and feedback around inclusivity was positive.

20 Avoiding Team Admission into Neonatal (ATAIN)

In line with Maternity Incentive Scheme (MIS) following a departmental relaunch, all babies admitted to NICU are reviewed in the monthly ATAIN meeting, using the recommended documentation from the MIS. This includes babies that are not admitted on badgernet - this was not done previously. All learning shared through governance meetings and quarterly at the LMNS.

21 Conclusion

The Women's and Newborn division are committed to improving quality and safety and continue to work to deliver against out maternity improvement plan, to include national drivers.

We continue to work with our NHSE/I support colleagues to co-produce an overarching maternity improvement plan. This will focus the division on the key safety priorities to include developing a maternity strategy.

Over the next quarter we will continue to use the improving together methodology to improve against the six identified drivers.

Appendix 1 - Provider Board Level Measures (Quarter 4 2022/2023)

RAG rated using the below method:			
Complete/action resolved/no risk	On track to achieve actions by completion date/low risk	Off track/plan in place/medium risk	Off track/no plan in place/high risk

		2022		
		April	**May**	**June**
1	Maternity Support programme	Yes	Yes	Yes- governance deep dive
2a	The number of incidents logged graded as moderate or above	2 moderate	2 moderate	3 moderate
2b	Themes of incidents graded moderate & above What actions are being taken?	1 term admission to the neonatal unit which is an SII 1 appropriate ITU admission	1 preterm neonatal death which is an SII 1 term admission to the neonatal unit which is an SII	2 appropriate ITU admissions 1 baby slip which is a local review
3	Themes from reviews of perinatal deaths	None	None	None

4	Did 100% of perinatal mortality reviews include an external reviewer?	Yes	Yes	Yes
5a	HSIB referrals made in month	No HSIB referrals this month	No HSIB referrals this month	No HSIB referrals this month
5b	HSIB referral criteria met	N/A - no referrals made	N/A - no referrals made	N/A - no referrals made
6	Audit findings relating to safety/quality	Audit spreadsheet monitored monthly through monthly audit and maternity governance.	Audit Lead commenced the role	Work commenced with Trust Audit Lead
7a	Safeguarding allegations against providers *Any Section 42 investigations reported to LADO*	No allegations have been received.	No allegations have been received.	No allegations have been received.
7b	Issues affecting wider safeguarding which could affect maternity	No changes within the last month.	No changes within the last month.	No changes within the last month.

8	Feedback from safety champions & walkabouts	Neonatal • too warm in summer • accomodation - no access for shower for disabled women • workforce - on call payments	Labour ward • Equipment - not enough to do role especially in 4 bedded bay • Drug cupboard for 4 bedded bay needed • Break 'chill out rooms	None this month due to sickness and acuity of workloads.
9a	Service user voice feedback *Patient experience outliers*	Monthly MVP meeting	MVP involved in Insight Meeting	Successful work with MVP: BAME, Military and vulnerable women Translation work Guideline work
9b	Complaints *Number*	complaints in maternity 2	complaints in maternity 0	complaints in maternity. 1
10a	External reviews or actions requested from CQC, RCOG, HSIB, HEE, NHSR,			Relationship meeting with CQC Meeting with new HSIB Lead for Trust

10b	Coroner Reg 28	None	None	None
11a	Workforce- concerns regarding staffing levels or skill mix	Sickness 5.47 %	Sickness 3.17%	Sickness 6.66%
11b	Training compliance for all staff groups in maternity related to the core competency framework and wider job essential training (Target 90%)			**Trajectories in progress.** **End of Q1 22/23:** **PROMPT** Midwives 94.8% Anaesthetists 90.6% O & G 90.5% **Basic Newborn Life Support** Midwives 69.6% Paediatricians 27.3% NN nurses 46.4%
12	**Progress / challenges in meeting CNST year 4 safety actions**	MIS Year 4 relaunched	Work continues to achieve	Compliance Report due to be presented at Clinical Governance committee in November – predicted 7/8-10

13	Significant gaps in NHSI maternity self-assessment tool	Assessment tool completed 2020. Will need to be revisited.	To be a driver for Improving Together	A driver for Improving Together

CLASSIFICATION:

Report to:	Trust Board	**Agenda item:**	SFT X
Date of Meeting:	8th September 2022		

Committee Name:	Finance and Performance		**Committee Meeting Date:**	30th August 2022
Status:	**Information**	**Discussion**	**Assurance**	**Approval**
			X	
Prepared by:	Eiri Jones, Non-Executive Director			
Board Sponsor (presenting):	Eiri Jones, Non-Executive Director			

Recommendation
To note and discuss key aspects of the Finance and Performance (F&P) Committee meeting held on the 30th August 2022.

Items for Escalation to Board

(1) RTT

The first of a series of updates was provided on RTT. It was positive to note that both the 104 and 78- week waits are being achieved as per national expectation. A risk identified was the increasing numbers of new referrals, which are likely to create a waiting list 'bubble'. The committee therefore asked for a further assurance update when the potential impact on efficiency had been analysed. The Committee also requested benchmarking information when available to understand whether the Trust was an outlier or not.

(2) New ward change of scope

Following approval at the last meeting in relation to the new ward business case, a change of scope paper was presented at the Committee. This related to the development of the Douglas Arter Centre as admin facilities to support the new ward scheme as it would enable better clinical decant and provide more admin space. Assurance was provided in relation to the

procurement work for this change of scope. It was noted that there would be an impact on this year's capital programme. This paper will be discussed at Board noting that the F&P committee supported this approach.

(3) Integrated Performance Report (finance and performance)

It was noted that many metrics remain static. The highlights this month related to the deteriorating 4-hour position and the impact this has on ambulance handover. No criteria to reside numbers remain high though static. Further assurance in relation to diagnostics and cancer performance are being worked through currently with an update on diagnostics coming to the next F&P.

(4) South Newton development

The committee was appraised of the plan to use facilities at South Newton to enable a ward to decant for essential upgrading. This is an example of partnership working. The CQC registration for these patients will remain the responsibility of SFT with medical support provided by South Newton. A risk review has been undertaken with identified infection prevention and control risks being mitigated. Further update will be provided at the next F&P meeting.

(5) Spinal services

An update was provided following last month's discussion in relation to a temporary reduction of spinal beds on site. A call has taken place with specialised commissioning. The Trust has agreed that 4 beds will be re-opened in October with the remaining beds re-opening in November. Staffing remains the biggest risk though the committee was updated in relation to ongoing support for the team. This was also be discussed at August CGC (see separate escalation report).

(6) Finance Report

It was positive to note that the finance position was on plan though recognising that this is mainly due to vacancies. Risks continue in relation to temporary staffing costs, pay rise impact and inflation.

(7) Contracting

The contracting report was noted. A key issue remains the coding staff position. All avenues to address this have been explored and will continue to be focused on. A long term solution underway is the development of our own workforce and the plan for an electronic patient record.

(8) SIRO quarterly report

Assurance was received that the planning to achieve the 2022/23 DSPT is underway following achievement of last year's DSPT in June 2022. Achieving information governance training remains the focus alongside networked medical device monitoring. The next Penetration Test is planned for December and all actions from the last test will be completed by then. The threat of a cyber-attack is under continuous review. Key practices such as patch management help reduce the risk of attack and these continue to evolve as new threats are identified. It was noted that there was a robust approach to this in the Trust and that this area was subject to both internal and external audit to provide assurance.

(9) Digital update

This report outlined that progress continues across the range of programmes under the digital agenda, including key areas such as EPMA and data warehouse. It was noted that the pathology LIMS system replacement (a pathology network programme with 5 other Trusts) was delayed for SFT and that this was outside the Trust's control. Rebasing of this programme is expected in October 2022.

Assurance was sought in respect on the number of recent outages. Information was provided that some of these were planned with unplanned ones being repaired as soon as possible and the department has actions to respond to learning from these events. The committee will continue to monitor this.

The Board is asked to note and, where relevant, discuss the content of this upward report.

NHS Salisbury NHS Foundation Trust

Report to:	Trust Board (Public)	**Agenda item:**	2.3
Date of Meeting:	08 September 2022		

Report Title:	Trust Management Committee Escalation Report			
Status:	**Information**	**Discussion**	**Assurance**	**Approval**
	X		X	
Approval Process (where has this paper been reviewed and approved)	Reviewed and signed off by Stacey Hunter Chief Executive Officer.			
Prepared by:	Gavin Thomas, Executive Services Manager			
Executive Sponsor (presenting):	Stacey Hunter Chief Executive Officer			
Appendices (list if applicable):				

Recommendation:
The Board is asked to note the report from the Trust Management Committee.

Escalation Summary:
The Trust Management Committee was scheduled for 24th August and took place in the Boardroom. This month was a return to our normal committee arrangements with x2 Business cases for review and approval along with the escalation reports from the sub committees. The committee received a business case in respect of the additional ward for Salisbury, and the committee heard that the business case sets out the case of need for an additional ward to allow the reopening of three theatres to support the Trust's elective recovery plan. If successful, the bid will be funded from the Elective Care Recovery fund at a value of £14m for the construction costs. The committee heard that the case set out using a shortened version of the five-case model, the case of need for an additional ward and describes how that scheme will be developed and managed. The proposed £14m investment funds will enable the Trust to build an additional inpatient ward to allow the Trust to move from the current 13 theatres to its full complement of 16 theatres. The committee were told that with an operational date of Autumn '23, key next steps are to: secure an approved decant approach for the buildings to be demolished, continue the procurement process under a national framework approach, engage in pre-app conversations with the planners, whilst finalising the design.

The committee noted that this had been approved by finance and performance committee and Board and is being supported by the region. The Trust Management committee shared this with the membership and noted the above.

The second business case which the committee heard was in relation to the South West Spinal Network. The committee heard that in 2019, NHS England's Specialised Commissioning, Health & Justice and Armed Forces Strategy Group approved the case for change in relation to spinal cord injury (SCI) services. This was based on the need to address wide variation in standards of care, inequity of access across the service and the need to invest in local capacity to meet local need, and as a result of this, an options appraisal was developed with a recommendation for SFT spinal unit to host the South West Spinal Network.

Following review of the business case, the committee approved the business case whilst noting that there was an outstanding question in respect of funding the risk of redundancy which needed to be resolved before any recruitment could be commenced.

In respect of the sub-committee escalation reports, the committee noted that the health and safety committee is currently reviewing its structure and attendee list in order to maximize its effectiveness following a period of stagnation with multiple changes within the wider estates team.

The committee also heard that in respect of the financial plan, we are currently on plan to deliver our commitments, but it should be noted that there is still a requirement to identify further recurrent savings moving forward.

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) -	☐

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Report to:	Trust Board (Public)	**Agenda item:**	2.4
Date of Meeting:	08 September 2022		

Report Title:	**Integrated Performance Report**			
Status:	**Information**	**Discussion**	**Assurance**	**Approval**
			x	
Approval Process (where has this paper been reviewed and approved)	Sections approved by responsible committee: Operational Performance & Resources – Finance & Performance Committee Quality and Care – Clinical Governance Committee Workforce – People and Culture Committee			
Prepared by:	Louise Drayton, Performance & Capacity Manager			
Executive Sponsor (presenting):	Judy Dyos, Chief Nursing Officer			
Appendices (list if applicable):				

Recommendation:
The Trust Management Committee are asked to note the Trust's performance for Month 4 (July 2022).

Executive Summary:
The number of excess bed days related to delays with discharge rose from 281 in M3 to 391 in M4, and the average number of patients not meeting the criteria to reside increase to 128 (120 in M3). A high number of escalation beds were opened as a result to accommodate the demand on the emergency pathways. Bed occupancy levels remain high at just under 97% despite several escalation areas open. There was some improvement in the number of stroke patients arriving in the Stroke unit within 4 hours, but high occupancy levels and poor flow around the organisation continue to affect the ability to transfer patients to the Stroke Unit more quickly. The average wait to first appointment reduced from 101 days to 93, reflecting ingoing work to reduce the longest waiting times. The number of falls per 1000 bed days increased slightly in M4, after 4 continued months of reduction. Positively, in M4 there were no falls with moderate or above harm. SFT now sits at a rate of 7.17 falls per 1000 bed days. This has improved from a peak of 11.03 in February this year and is now much closer to the nationwide average of 6.7. Pressure on the emergency pathways remains high, with performance against the 4-hour standard in the Emergency Department at 73%, and 86 breaches of the 12-hour decision to

admit standard. Flow in the hospital continues to be the main contributor to the delay in admitting patients within 12 hours.

Staffing fill rates continue to be challenging, with availability for Health Care Support workers through the day the most pressured area. Vacancies is further impacted by high rates of maternity and sickness absence (6.3%), and turnover increasing further to 13%. The bank incentive scheme has been revised, with further overseas recruitment and block booking of agency staff all aimed at improving the fill rate further. Agency costs increased by £256k in month, mainly driven by use of high-cost agency to fill nursing gaps.

The number of ambulance handover delays over 30 minutes reduced from around 25% to 21%, with a total of 555 hours lost to handover delays.

There was further deterioration of the 6-week diagnostic standard, reducing to 70.2%. Cardiology Echocardiograms, MRI and Audiology are the main contributors, with pressures also in the Ultrasound service. Capacity in the MRI service is reduced whilst MRI1 is replaced, and workforce availability for both core hours and additional hours to reduce backlogs is limited.

Performance against the cancer standards is fairly static, with 75.8% of patients receiving an initial appointment within 2 week (standards 93%), 73.41% of pathways meeting the 28-day faster diagnosis standard (target 75%), and performance against the 62-day referral to treatment standard falling further to 66% (target 85%).

Positively, the longest waiting time for patients referred for elective treatment reduced further to 95 weeks. The number of patients waiting over 78 weeks reduced to 66, and the total number over 52 weeks reduced to 509. The total waiting list volume is 23,893 and has grown month on month for 5 consecutive months. Day case activity was just under plan and elective activity remains above plan.

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

Integrated Performance Report

NHS
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NHS Foundation Trust

July 2022

Summary

July 2022

Salisbury NHS Foundation Trust

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The average wait to first appointment reduced from 101 days to 93, reflecting ongoing work to reduce the longest waiting times.

The number of falls per 1000 bed days increased slightly in M4, after 4 continued months of reduction. Positively, in M4 there were no falls with moderate or above harm. SFT now sits at a rate of 7.17 falls per 1000 bed days. This has improved from a peak of 11.03 in February this year and is now much closer to the nationwide average of 6.7.

Pressure on the emergency pathways remains high, with performance against the 4-hour standard in the Emergency Department at 73%, and 86 breaches of the 12-hour decision to admit standard. Flow in the hospital continues to be the main contributor to the delay in admitting patients within 12 hours.

Staffing fill rates continue to be challenging, with availability for Health Care Support workers through the day the most pressured area. Vacancies is further impacted by high rates of maternity and sickness absence (6.3%), and turnover increasing further to 13%. The bank incentive scheme has been revised, with further overseas recruitment and block booking of agency staff all aimed at improving the fill rate further. Agency costs increased by £256k in month, mainly driven by use of high-cost agency to fill nursing gaps.

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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.

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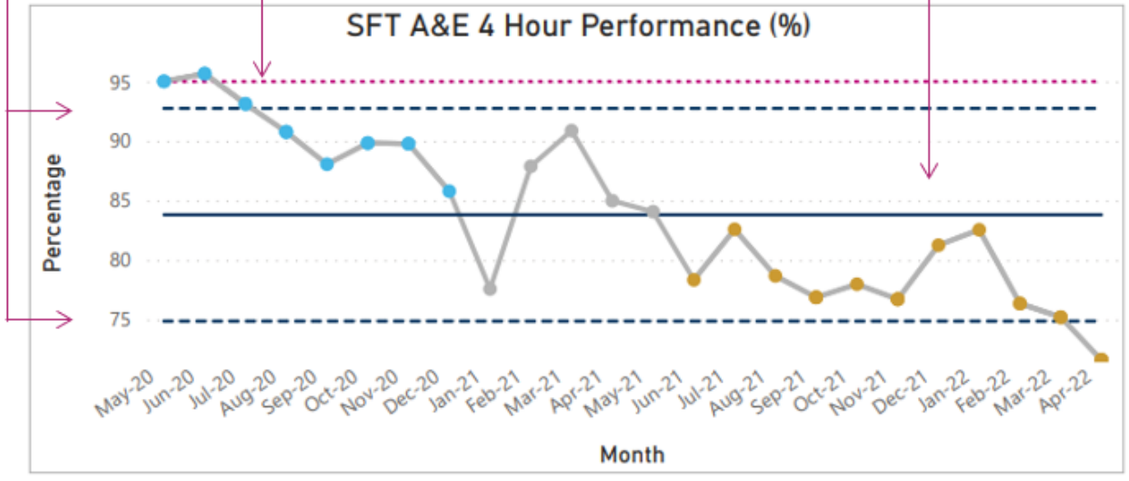
Reading a Statistical Process Control (SPC) Chart

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

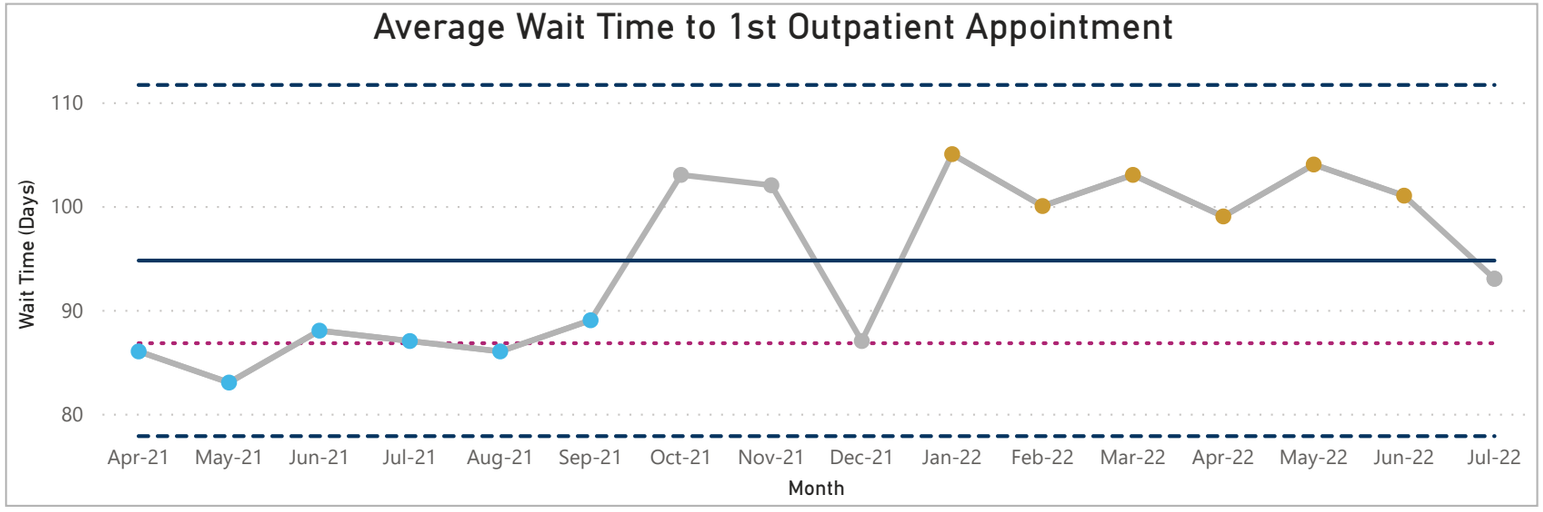
Partnerships

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 Trust continues to have no over 104 week waits and following challenges in April and the beginning of May, with regard to non-elective demand and NC2R patients, is now well ahead of its trajectories for both >78week waits and >52week waits. There has been a significant reduction in those patients who would breach by March 2023, reducing from 1788 to 1295 in July alone.
The focus on long waiting patients and the 78week 'at risk' cohort has resulted in the observed reduction in average time of patient waits.
Increased capacity provided for by the relaxation of Covid restrictions has improved activity for first and follow up appointments further supporting this improving position.

Actions (SMART):

In line with nationally dictated targets, there has been an increased focus upon long waiting patients, with regard to both admitted and non-admitted pathways (particularly non-admitted over 52week waits and all patients whose pathways would breach 78 weeks in March 2023).

-Demand and capacity planning underway in relation to top 6 Trust contributors (Plastics, ENT, Ophthalmology, Oral Surgery, Dermatology and Gynaecology) to establish changes in demand profiles and therefore potential capacity gaps.
-Patient pathway reviews taking place at speciality level with the objective of converting increased numbers of Follow Up activity to PIFU, thus releasing increased capacity for First Attendances.
There has been a further relaxation of Covid Infection
-Prevention Measures and capacity constraints across the OPD footprint

Risks and Mitigations:

Limitations remain in relation to the Trust's ability to comprehensively map demand and capacity at Specialty and Sub-Speciality/Pathway level. This is currently being worked thorough with support provided via EPR Meetings.

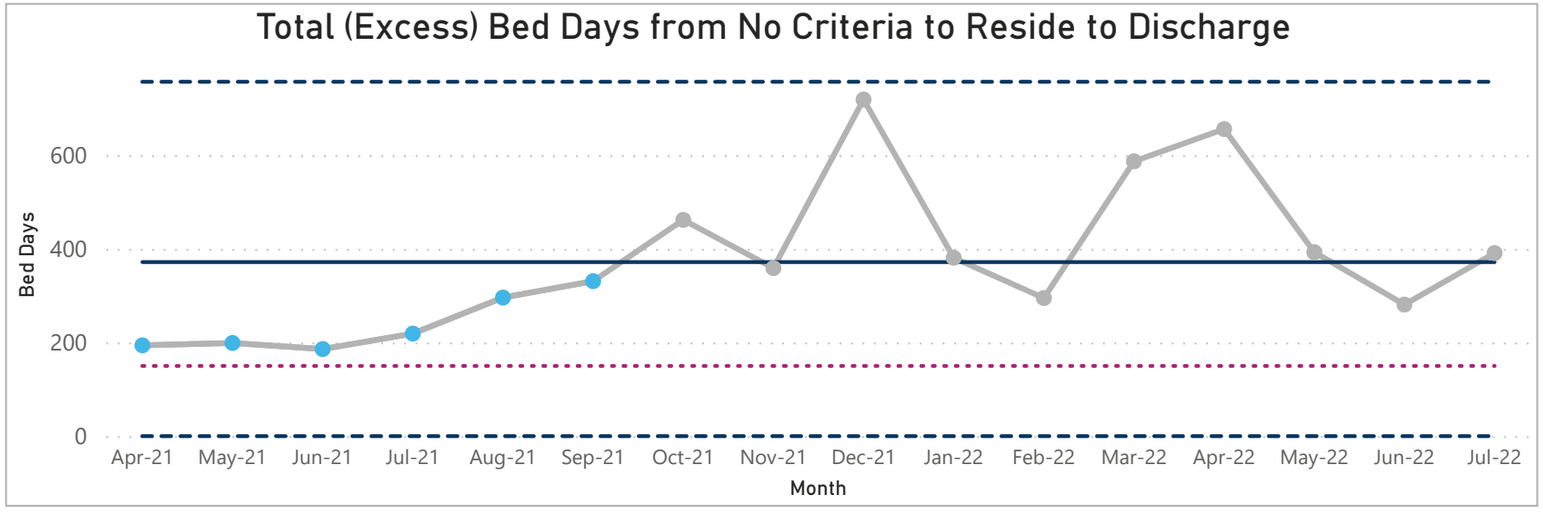
Resource limitations at both DMT and Speciality level continue to be a challenge for Divisional Teams.

Further support to the Surgical Division has been requested and granted with a Project Manager providing further support going forward to help accelerate Improving Together Metric Progress.

Optimising Beds

Target 150 days

Breakthrough Objective



We are driving this measure because…

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

Understanding the performance:

July saw a continued steady increase in the number of bed days spent with inpatients no longer meeting criteria to reside. It is an increase on July 2021 and is reflective of several challenges.

Staffing in nursing, therapies and doctors has been below ideal levels, and to facilitate discharge for patients with complex plans in pathways 1-3 requires the resource to prioritise this work. The increase in escalation bed use stretches the workforce across additional areas compounding the requirement from an already pressured staff. Covid both in the acute setting and in community settings also impacted capacity to achieve flow in July, as restrictions for transferring into 24 hour care settings is determined by infection control restrictions at times of outbreak.

Actions (SMART):

There is considerable effort to improve flow for patients needing pathways 1-3 across both the acute and community settings, including pathway 2 model review ongoing, additional ICB on site support for complex planning, Therapies using whiteboard information to support prioritisation, and there is a planned refresh of the SFT discharge team roles to ensure support for the most complex cases. A MADE even is planned for August/Sept with an anticipated outcome of releasing capacity to support the refurbishment of Breamore ward.

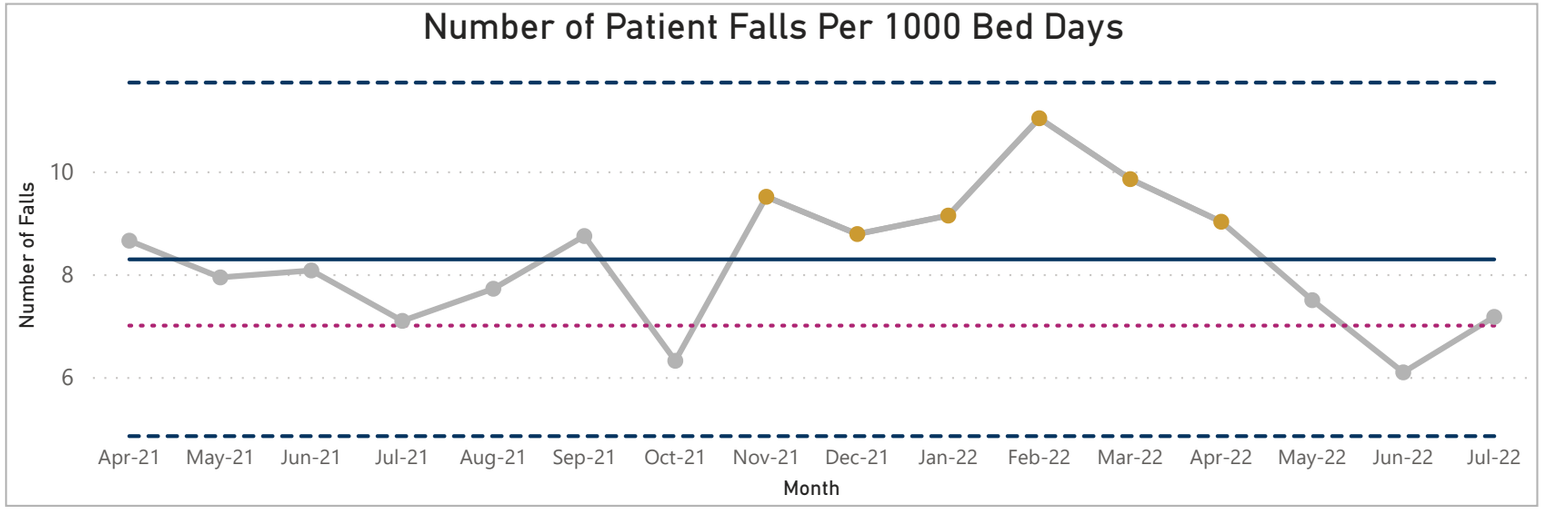
Risks and Mitigations:

Risks to the actions shared here include ongoing staffing challenges, capacity in community services to accommodate identified needs of patients, and ongoing reviews at system level of modelling and process that will require education and training in SFT to facilitate.

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:

The falls per 1000 bed days had dropped month on month for quarter 1 but rose slightly in July to 7.17.

There were no falls in July that caused moderate or above harm.

National figures for falls per 1000 bed days is at 6.7. From 10.2 at its height, the 30% reduction is almost achieved (0.03 off).

Actions (SMART):

-Formal training programme being delivered at ward level and at Induction from September. eLearning national module now available on Kalidus

-Improving Together Falls reduction breakthrough drivers for Pitton Ward and Farley Ward

-Revision of bed rails assessments and falls risk assessment to include visual test

-Review of equipment availability including ultra-low beds, falls sensor alarms and crash mats

-Falls Policy review (minor amendments)

Risks and Mitigations:

Availability of staff to attend training on the ward has declined in July. Acknowledging that there is a direct correlation with vacancies/sickness and available care hours.

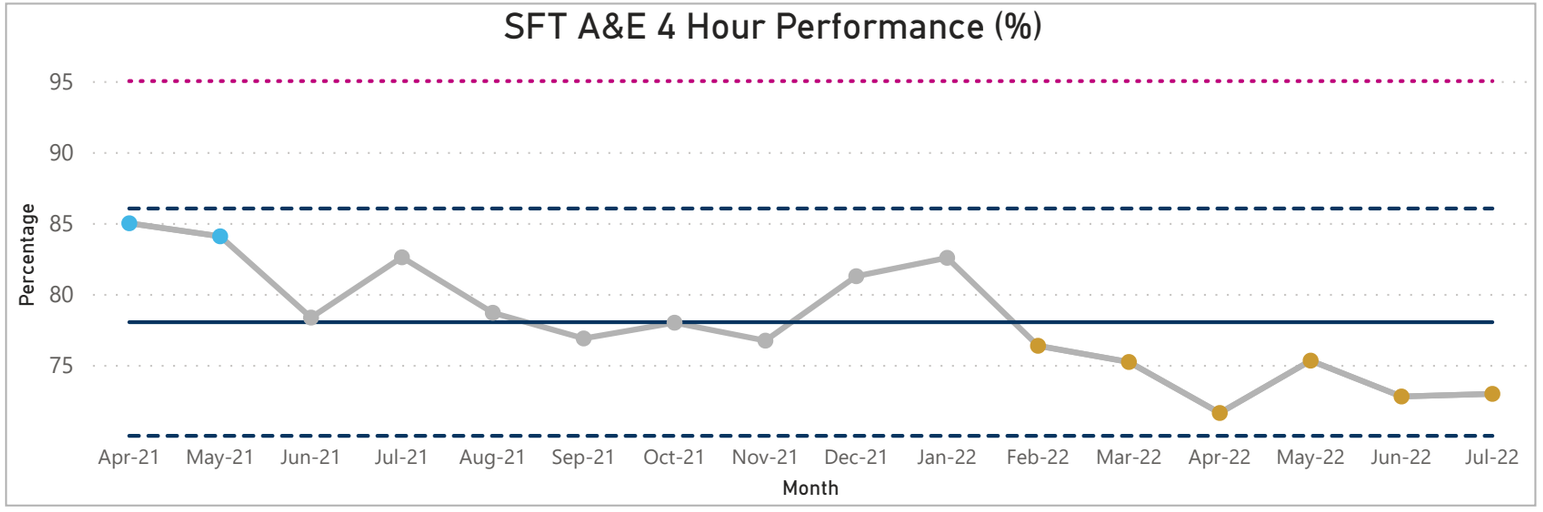
Attendance at the module training has been variable (due to staffing shortages on the wards), however data collection has commenced. These need to be trialled with PDSA cycles with an aim to produce final documents by the end of the year.

There is an increase in demand for falls reduction equipment. Discussions with Divisional Management Team regarding budgetary responsibility.

Emergency Access (4hr) Standard

Target 95%

National Key Performance Indicators



Performance Latest Month:	73.0%
Attendances:	6538
12 hour Breaches:	86

Understanding the performance:

Performance against the 4 hour standard remains challenging with M4 performance at 73%, slightly above the England average of 71%.

Attendances remain fairly static for Type 1 and 2, but the Type 3 Walk in centre activity continues to be high (1912 attendance in M4 compared to 1414 in M4 2019/20). The number of patients requiring admission via ED also remains static.
Flow out of the department remains one of the biggest factors, with average time in the department for patients requiring admission at over 8 hours, and average time in department for patients that were discharged at just under 4 hours. There were 14 patients that waited longer than 12 hours from decision to admit to admission.

Actions (SMART):

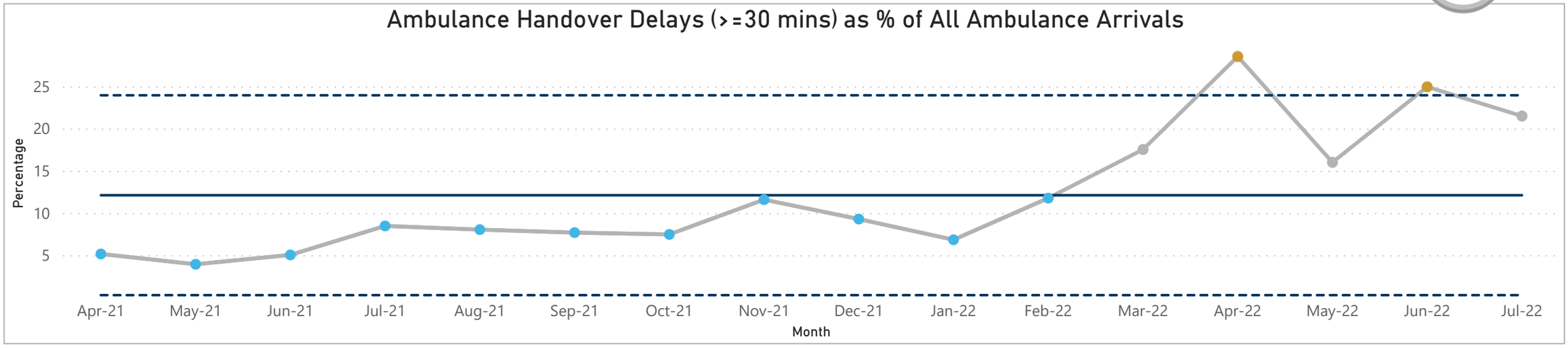
-New Matron for ED/AMU leading working group to refresh Handovers, focused on streamlining the handover process to enable more timely transfers out of the Emergency Department.
-ED departmental meetings starting in M5
-Creation of tracker role to assist nurse in charge and consultant in charge with escalation of delays in the department and arranging ward transfers out of the department – to be advertised in M6.
-Workforce review underway with external support. As part of this the requirement for a Practice Educator role has been identified – this is to develop and enhance the skill mix of nursing staff. Post to be advertised in M5.
-A training position for one ACP has been secured and an internal candidate selected to begin training in M7.
-Establish weekly operational group supporting the strategic priority to reduce the time from Decision to Admit to Admission.

Risks and Mitigations:

-Large amount of Middle Grade and Junior Doctor Gaps in order to make 24/7 compliant rota – shifts out to locum cover and reviewed daily to maximise fill rate. Consultant vacancies out to advert in M5.
-Nursing workforces vacancies – recruitment underway with overseas and newly qualified nurses scheduled to come into role over coming months. ENP shifts also offered out to junior doctors. Skills and training opportunities for the nursing team, which has been restricted due to vacancies/sickness within the department – practice education role identified to support and improve skills.
-Flow within the hospital - patients remaining in the department for long periods awaiting admission resulting in delays to treatment for other patients presenting at the Front Door. As part of the program of work to reduce time to admission, length of stay has been identified as a concern. A weekly working group focused on reducing time to admission will commence from M5, and length of stay opportunities will form part of this work.

Ambulance Handover Delays

National Key Performance Indicators



Understanding the performance:

The number of ambulance handover delays exceeding 30 minutes remains high with 28% of ambulance arrivals waiting over 30 minutes. There were 187 patients arriving by ambulance that waited over an hour. Overall 555 hours were lost due to handover delays.

The total number of patients arriving by ambulance remains fairly static, with Mondays, Fridays and Sundays being days of highest numbers. Capacity in the department in terms of a trolley space to move the patient to remains the biggest cause of handover delay.

Actions (SMART):

Trial of 7 day HALO cover at SFT to start in M5 with three individuals recruited for this. The HALO will assist with identification of clinical priority for offload when more than one crew waiting, provide support to crews and the safe management of patients.

Interventional Radiology area adjacent to ED has been used to assist with offloading ambulances in recent heatwaves and continued use of SOP to flip Paediatric area in times of escalation.

Pilot being worked up for M6 involving Wiltshire Health & Care ACP, SWAST and ED to enable support in community to avoid admission of patients from ED, but also potentially stop patients from being conveyed to the department if they can be safely managed at home with access to right support and advise.

Review of escalation process in Emergency Department to ensure that delays are escalated quickly. Tracker role to be developed and trialled with intention to advertise in M6.

Risks and Mitigations:

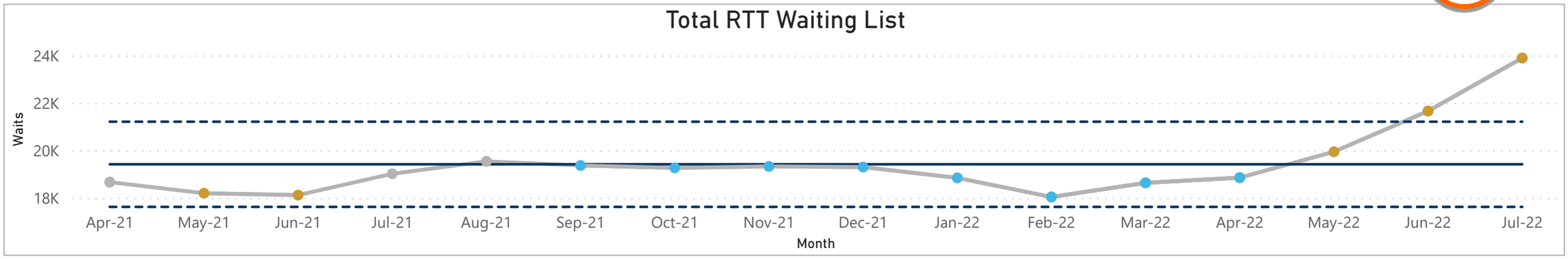
Workforce issues (high vacancies and challenges recruiting) remain contributory factor to flow in and out of department along with inpatient capacity.

Ambulatory/SDEC area in AMU remains escalated into overnight contributing to number of ambulances presenting to ED, when Medical take is diverted.

Delays in being able to off load when paramedic crews do not have COVID lateral flow tests in trucks.

Total Elective Waiting List (Referral to Treatment)

National Key Performance Indicators



Month	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22	Jul-22
Longest Waiting Patient (Weeks)	103	106	110	110	107	111	116	116	120	99	99	95

Understanding the performance:

The national expectation is that throughout Covid Recovery there will be a growth in the size of waiting lists across the country before any reduction is seen. Initial modelling, for 2022-23 Plan, indicated that SFT was consistently not experiencing the increases in referrals, (clock starts) witnessed in other areas, with only a relatively modest increase being profiled across the year.

-Referral rates have significantly increased from an average of 4747 for the last 4 months of 2021-22 to 5245 for the first 4 months of 2022-23.

-Whilst total admitted clock stops have remained relatively strong against performance across 2021-22, non-admitted clock stops were lower.

-Whilst overall growth has been experienced in line with national expectations, there continues to be significant success in addressing long waiting patients. The Trust achieved the national target of zero >104week waits at the end of July, and is ahead of plan/trajectory for both >78ww and 52ww.

Actions (SMART):

Analysis of performance demonstrated a number of contributory factors:-

- Increased trauma demand;
- Ongoing impact of non-elective pressures and NC2R above and beyond forecast for SFT and across the System.
- Theatre Workforce
- Increased absence (including Covid related absence) at consultant level resulting in re-allocation of duties to cover on call, ward cover, and elective operating (including a focus on treating those clinically prioritised P2 patients and nationally mandated targets, such as long waits targets).

Further actions include: -

- Ongoing support for weekend lists, including specialties such as Plastics
- Theatre access optimised to support planned activity by speciality, including capacity for clinically prioritised patients (including Cancer) and long waiting patients.
- Focussed and dedicated OD and Recruitment support for Theatres.

Risks and Mitigations:

Ongoing challenges across the workforce continue to present challenges, with mitigation balancing the tensions between financial prudence and target achievement, in sourcing locum cover and/or agency staff to cover gaps in staffing.

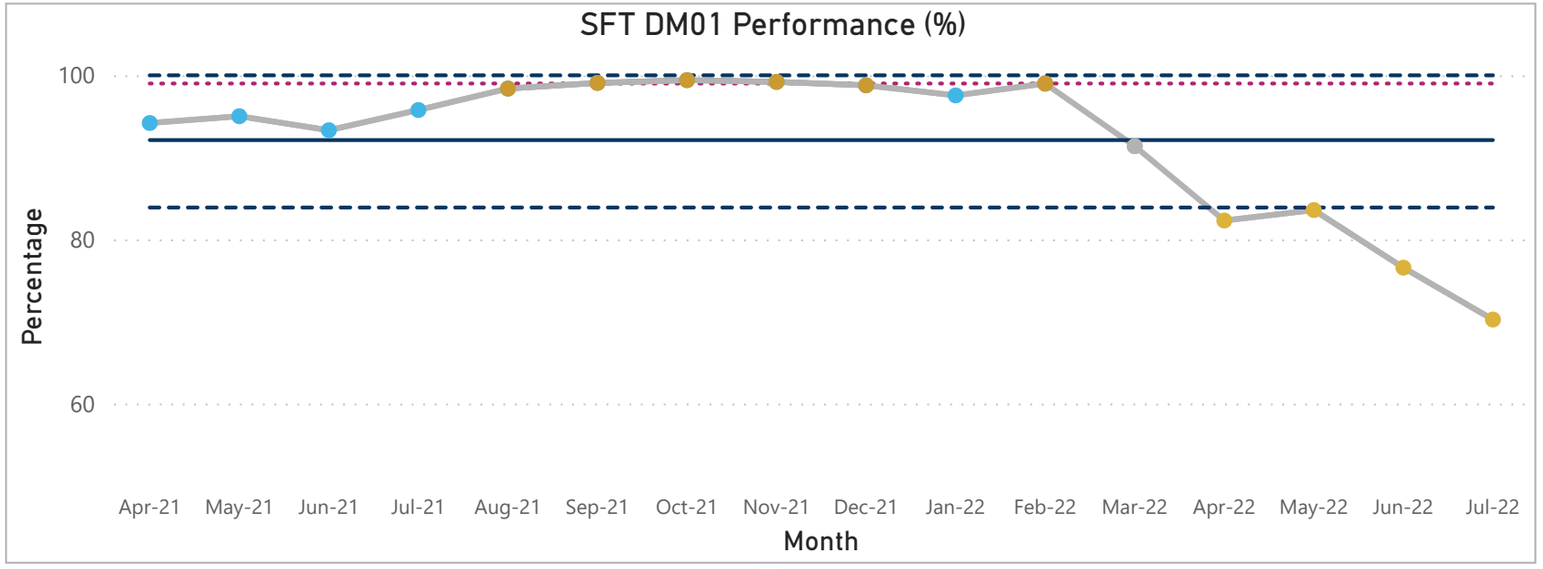
Management of Covid related absence continues to Trust guidance.

The winter plan is being developed to mitigate the effects of increased non elective demand upon the elective recovery programme.

Diagnostic Wait Times Performance (DM01)

Target 99%

National Key Performance Indicators



Performance Latest Month: 70.2%

Waiting List Volume: 3283

MRI	52.8%	CT	100.0%
US	67.5%	DEXA	100.0%
Audio	59.0%	Cardio	49.2%
Neuro	99.5%	Colon	97.7%
Flexi Sig	86.1%	Gastro	97.0%

Understanding the performance:

MRI, USS and Cardiology Echo continue to be the modalities with the lowest performance (representing 1608 of the total 1670 breaches).

MRI and Cardiology Echo both slightly improved on breach numbers when comparing M4 to M3. USS has had a significant increase in the number of breaches, increasing from 324 in M3 to 721 in M4. All three of these concerning modalities are experiencing significant workforce challenges, driving the deterioration in performance (circa 30% vacancy factor across CT, MRI, USS and Echo)

Actions (SMART):

- Incentivising overtime in MRI to increase weekend activity. Monitored through weekly WTAG meeting for uptake and to be continued for at least duration of MRI1 replacement project
- Implemented standard agenda discussion at weekly Radiology access meeting to address long waiters, turnaround times and efficiencies etc.
- DNA reduction actions, reminder services etc. under review with target of resolution of technical and process issues by end of September 2022. Some reliance on software upgrades, coordinating with IT.
- Cardiology continuing to deploy agency resource and internal overtime, to be kept under review by Head of CIU and Medicine DMT
- USS discussions with procurement re insourcing options having had less success/reliability from agency locum options but with limited success Full trajectory paper to be submitted to September F&P committee

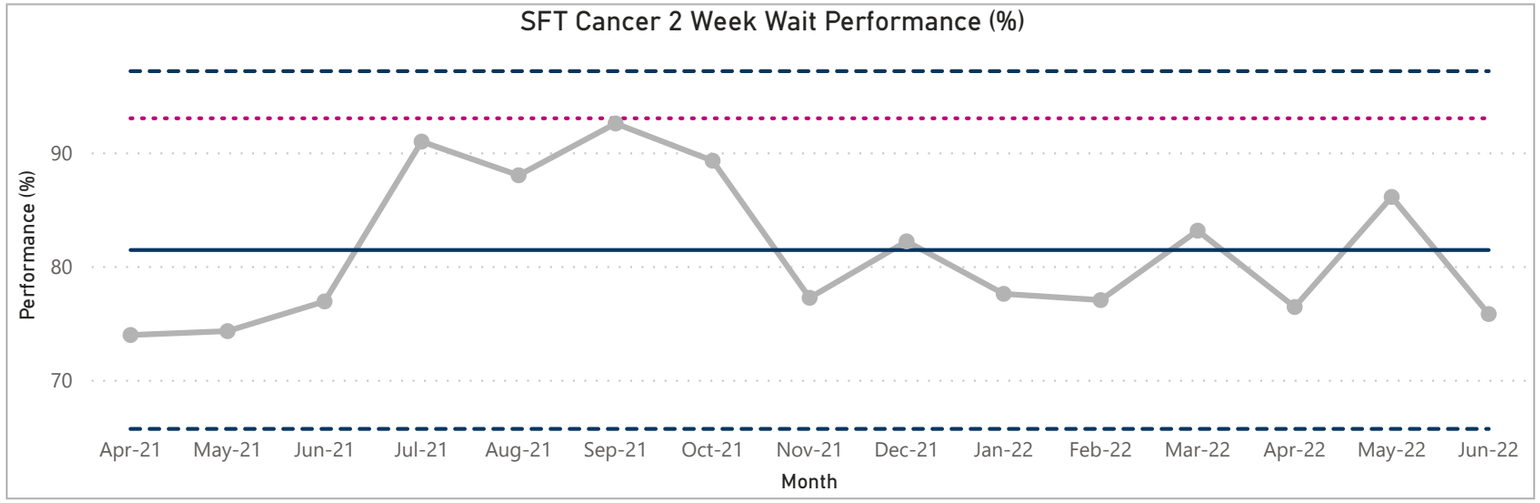
Risks and Mitigations:

- MRI1 replacement project reducing MRI infrastructure from three scanners to two – project due to conclude late November 2022
- MRI mobile scanner of poorer image quality causing case mix constraints for booking – working with procurement and supplier to ascertain concerns of scanner quality
- Hard to recruit to posts in USS and Echocardiology – exploring incentivisation for long term recruitment and in/outsourcing for short term W/L management
- Reliant on overtime and agency cover to provide core hours service as well as backlog clearance – scoping managed service options for sustainable insourcing options for USS initially
- Lengthy training pipeline for sonography (trainees to be qualified during 2023 and future pipeline being identified) – further training post to be offered in August with identification of next opportunity asap

Cancer 2 Week Wait Performance

Target 93%

National Key Performance Indicators



	Performance	Num	Den	Breaches
Two Week Wait Standard:	75.8%	773	1020	247
Two Week Wait Breast Symptomatic Standard:	75.7%	28	37	9

Understanding the performance:

Timeliness of triage for Head and Neck 2WW patients is a challenge, impacting on ability to book within two weeks.

Colorectal 2WW referrals consistently high over May, June and July, in addition to lack of workforce

.

Skin 2WW referrals high over May and June. Workforce depleted due to COVID-19 and needing to also cover other non-cancer services such as Burns and Trauma.

Actions (SMART):

Ongoing review of Neck lump pathway in Head and Neck, in order to send patients straight to test where appropriate.

Locum Colorectal Consultant supporting Endoscopy lists (Upper and Lower GI) and 2WW OPA clinics.

Currently out to recruit for a Locum Consultant in Skin which will increase 2WW capacity. Also using some Dermatology capacity. Plan to link with Comms and Primary Care to ensure patients are avaialble to attend their appointments to due increase in patient choice delays.

Risks and Mitigations:

Piece of work regarding a 2WW triage algorithm to streamline the process. Conversations underway with Radiology around straight to test pathway involving ultrasound.

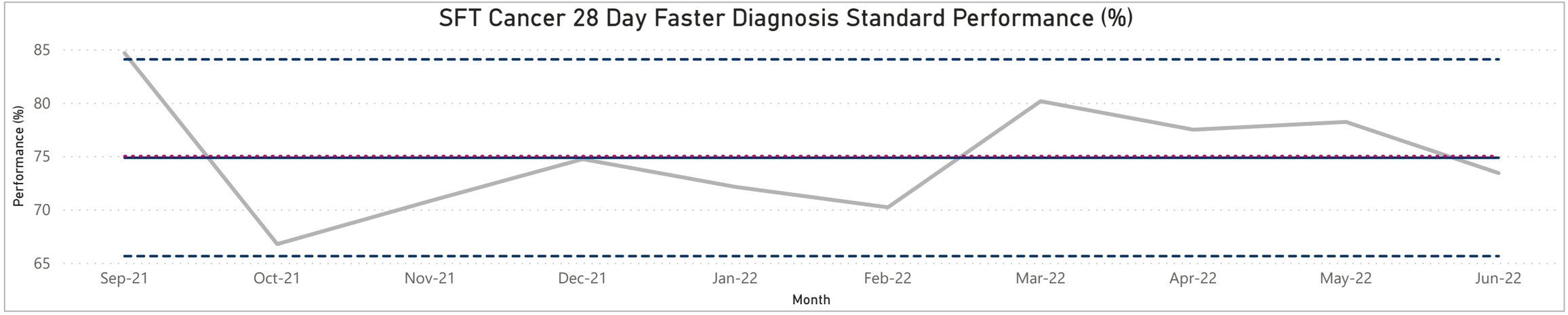
Anticipating this will see a reduction in the number of 2WW breaches attributed to Endoscopy capacity.

Anticipating this will see a reduction in the number of 2WW breaches attributed to Plastics OPA capacity.

Cancer 28 Day Faster Diagnosis Standard Performance

Target 75%

National Key Performance Indicators



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

Understanding the performance:

Template biopsy capacity within prostate pathway is a major bottleneck, causing major delays at the start of the prostate pathway.

Histopathology workforce still very challenged, current workforce very stretched and many cases needing to be outsourced.

PET CT currently managed by external company Alliance Medical. Significant delays with booking and reporting due to capacity issues and causing delays in pathways.

CQUIN 22/23 focussing on best practice timed pathways and associated milestones.

Actions (SMART):

-New Urology Consultant starting in October. Exploring options of Specialist Nurses being trained to undertake template biopsies. Navigator being point of contact prior to template biopsies to ensure patients are ready to attend.
-New Consultant Scientist starting in Histopathology who is undertaking some GI reporting, which will alleviate some workload from existing Consultant workforce and need for outsourcing..
-Plan in place to obtain mobile PET CT scanner on site. Working group set up to manage this. Some outstanding issues regarding the environment - further meetings needed to resolve issues
-Will require changes to current pathways and will require input from multiple teams across the Trust. A balance of other work in the Trust will need to be considered i.e. non cancer

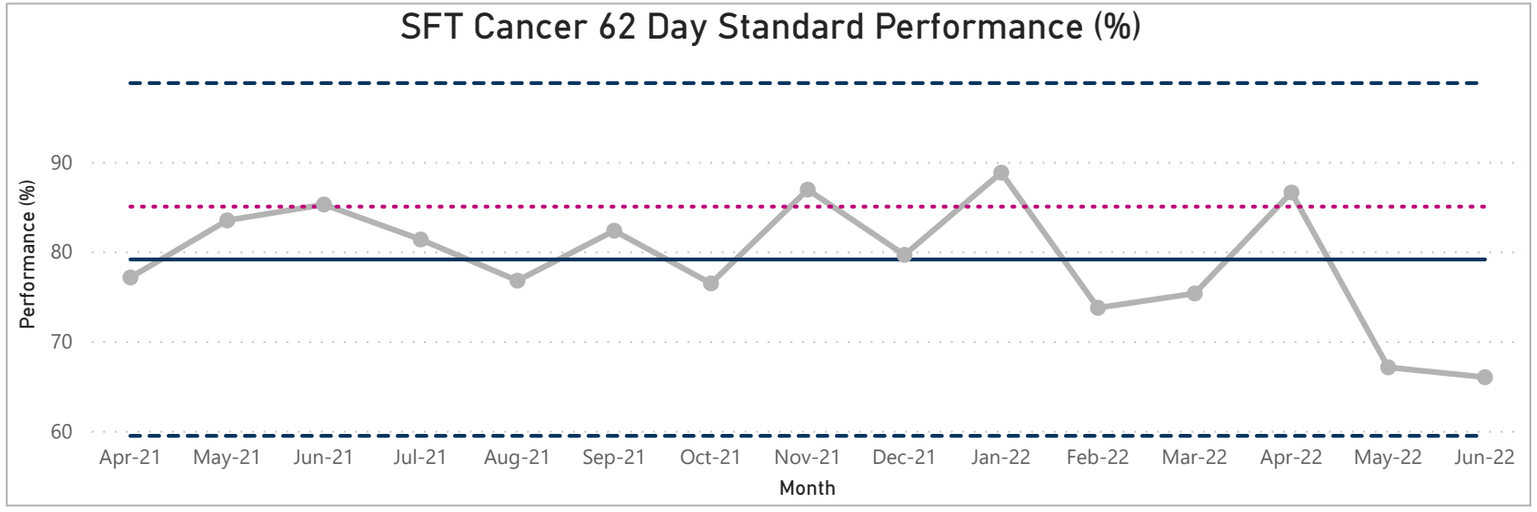
Risks and Mitigations:

-Training of nurses to do template biopsies will take time, and new Consultant not due to start until October. Triage processed has been changed and MRI scans being requested at point of triage which will help with wait times.
-Even with additional workforce, the existing workforce is still very stretched. Recruitment of additional Histopathologists ongoing. MDT team highlight any cases needed using the escalation process.
-Clinicians and MDT team continue to raise cases with Alliance Medical and document in tracking on Somerset Cancer Register. Datixs are recorded when needed.
-Anticipate the 28 day FDS performance should improve as the CQUIN is worked on, as the milestones and best practice timed pathways are closely linked to this.

Cancer 62 Day Standard Performance

Target 85%

National Key Performance Indicators



	Performance	Num	Den
62 Day Standard:	66.0%	48	72
62 Day Screening:	28.6%	1	4

Understanding the performance:

Unable to deliver chemotherapy treatment in a timely manner due to constraints around pharmacy and aseptics.

Radiotherapy and surgery capacity issues at tertiary centres are ongoing; focus on 28 day pathway to ensure our patients are referred to tertiary centre in as timely manner as possible.

Long wait times meant that some treatments were pushed over to June and so the breaches impacted the performance all at once. The denominator of patients treated was also lower than in May, affecting the overall percentage.

Actions (SMART):

Out to advert for an accountable Pharmacist. Aniticipate if recruitment successful should be in post by end of year.

Ongoing communication within Cancer services with tertiary centres regarding radiotherapy/surgery waiting times, escalating patients where possible.

Implementation of Cancer Improvement Group to focus on pathway improvement and reducing backlog.

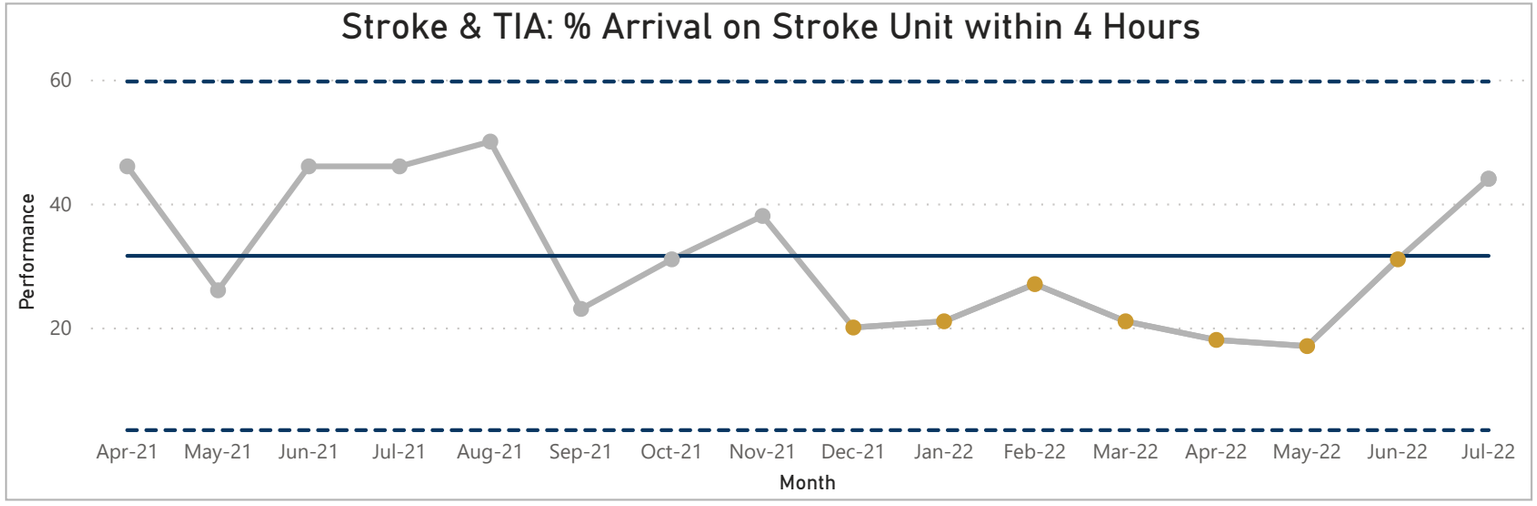
Risks and Mitigations:

Recruitment underway in Pharmacy to support service and therefore manufacture chemotherapy. Current controls for aseptics in place. Still quite some time before seeing some reduction in waiting times in this area.

Ongoing waiting times, requires input from tertiary centres to reduce wait times.

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			

Understanding the performance:

The national target for arrival on a Stroke Unit within 4 hrs is 90%. Our average of below 40% puts us in the E SSNAP grading. Good scores in other areas means our average grade is D, but this is recognised nationally as substandard.

The increase in June and July correlates to the unit moving back to the Farley template and a more productive patient flow.

Ongoing challenges include bed pressures, with General medicine patients in Stroke beds and moving the Nursing staff to other wards often means that Farley does not have the appropriate staff numbers to give the specialist care a new admission needs.

Actions (SMART):

Renew focus/understanding of priority transfers from ED to Farley

Prioritise bed moves out of Farley to facilitate Stroke patients transferring in

Try and avoid moving Farley Nurses off of the unit.
This will also help with other SSNAP grading areas such as time to swallowing assessment.

Risks and Mitigations:

Hyperacute Stroke patients are at currently risk of worsening outcomes without access to the specialist care in the appropriate timeframe, which in turn increases length of stay. This can be solved by focus on bed availability on Farley.

To adhere to the licence for Thrombolysis treatment all patients receiving this treatment should be overseen by Stroke specialist teams. We often breach this.

Maternity

Are We Safe?

	SFT Assurance Dashboard	Guidance	Standard	Improvement Directi	Rolling 6 months ####	####	####	####	####	Jul-22	Rolling 6m average
Perinatal Mortality and Morbidity (MBRRACE)	Number of late fetal losses (22+0 to 23+6 weeks excl TOP)			Down	0	0	0	0	0	0	0
	Number of stillbirths (>24 weeks excl TOP)	ONS	3.8 per 1000 live births	Down	0	2	0	0	0	1	1
	Number of neonatal deaths (0-28 days	ONS	2.7 per 1000 live births	Down	0	0	0	1	0	0	0
	Medical termination over 24+0 re-ptured			Down	0	0	0	0	1	0	0
Matern al (MBRR	Number of Maternal Deaths	ONS	9.1 per 100,000 women who delivered	Down	0	0	0	0	0	0	0
	Number of women requiring admission to ITU	6 month SFT rolling		Down	0	0	0	0	2	0	0
Insight	Number of datix incidents - moderate or above	6 month SFT rolling		Down	2	1	1	2	3	1	2
	Datix incidents moderate harm (not SII)	6 month SFT rolling		Down	2	1	0	1	3	3	2
	Datix incidence SII	6 month SFT rolling		Down	0	1	0	1	0	3	1
	HSIB referrals	6 month SFT rolling		Down	0	0	0	0	0	0	0
	HSIB/MNHSR/CQC or other organisation with concern or request	6 month SFT rolling		Down	0	0	0	0	0	0	0
	Coroner Reg 28 made directly to trust	6 month SFT rolling		Down	0	0	0	0	0	0	0
Workforce	Minimum safe staffing in maternity services (Obstetric care)	RCOG guidance		NA	40	40	40	40	40	40	40
	Midwife to Birth ratio	RCM;NHSR;BR+	1:28	NA	1:31	1:28	1:31	1:32	01:32	1:32	NA
	Midwifery vacancy rate (black - over establishment; red - under establishment)			up	14.65	14.65	17.2	17.4	17.4	20	NA
	Provision of 1 to 1 care in established labour (x)	NICE, RCM, MIS	100%	Up	NA	NA	100	100	100	100	NA
	Datix relating to workforce	6 month SFT rolling		Down	0	2	3	1	0	2	1
	Compliance with supernumerary status of the LW coordinator - %	NICE;RCM;NHSR	100% ratified	Up	NA	NA	100	100	100	100	NA
	Number of times maternity unit on divert	6 month SFT rolling		Down	0	0	0	0	0	0	0
Involvement	Service user feedback: Number of Compliments	6 month SFT rolling		Up	31	32	27	27	31	31	30
	Service user feedback: Number of Complaints	6 month SFT rolling		Down	4	2	2	0	1	1	2
	Number of SOI	6 month SFT rolling		Up	11	7	8	7	6	5	7
Assurance	Progress in achievement of 10 safety actions (CNST)	NHSR	10	Up	4	4	5	5	5	5	5
	Training compliance - MDT PROMPT %	NHSR	90%	Up	74.2	75.2	72.3	83.63	86.5	86.2	NA

Understanding the performance:

System collaboration to recruit international midwives
Recruitment of a Lead Professional Midwifery Advocate/retention role to provide pastoral support to preceptee midwives
Recruited a retention midwife to support /train the international midwives
Plan to over recruit maternity support workers to mitigate
Registered General Nurses (RGN) in to the workforce to support post natal areas
Continual recruitment drive

Actions (SMART):

2 international midwives join us in September
2 RGN in workforce – 2 plan to join in Oct/Nov
4 newly qualified preceptee midwives to join early Oct
Recruited from outside Trust to Digital Midwife role
September 10th recruitment day for support workers
Reviewed flexible working requests to aid retention

Risks and Mitigations:

National Shortage of Registered midwives

Sickness – compounded by vacancies every shift

Maternity Clinical Dashboard

Are We Safe?

	South West Region						National															
Measure	Min	Median	Max	Improve direction	Green	Red	Mar-21	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23	Q1 Total	Year To Date	FY 2021-22
Babies (incl Non Reg)	179	180	190					180	179	190										549	549	2212
Women Delivered	175	176	188					175	176	188										539	539	2197
Homebirth rate	3.3%	3.4%	4.8%					3.3%	3.4%	4.8%										3.8%	3.8%	3.6%
Inductions %	36.4%	43.2%	43.4%					43.4%	36.4%	43.2%										41.0%	41.0%	37.4%
Instrumental deliveries %	8.3%	11.7%	13.7%	Down	12.0%	12.5%	12.5% NMPA	11.7%	8.4%	13.7%										11.3%	11.3%	12.4%
Apgar less than 6 @ 5 min %				Down	1.2%	3.5%	Green <1.2%, red >3.5% NMPA	0.6%	0.6%	0.5%										0.5%	0.5%	0.5%
Neonatal deaths within 28 days %				Down				0.0%	0.0%	0.0%										0.0%	0.0%	0.1%
Shoulder dystocia (severe & moderate)	0.0%	0.0%	0.0%	Down				0.0%	0.0%	0.0%										0.0%	0.0%	2.0%
PPH >= 1, 500 %	2.7%	4.0%	4.5%	Down	2.7%	5.6%	Green <2.7%, red >5.6% NMPA	4.0%	4.5%	2.7%										3.7%	3.7%	3.4%
Post partum Hysterectomies %				Down				0.0%	0.0%	0.0%										0.0%	0.0%	0.0%
Third & Fourth degree tears SVD	0.9%	2.7%	2.7%	Down				2.7%	0.9%	2.7%										2.1%	2.1%	1.7%
Third & Fourth degree tears assisted	0.0%	7.7%	13.3%	Down				0.0%	13.3%	7.7%										6.5%	6.5%	5.1%
Total 3 + 4 degree tears	2.3%	2.4%	3.6%	Down	3.5%	6.5%	green <3.5%, red >6.5% NMPA	2.3%	2.4%	3.6%										2.8%	2.8%	2.4%
Term babies admitted to NNU unexpectedly %	1.7%	2.1%	4.5%	Down	5.5%	5.8%	<5.8% NMPA	1.7%	4.5%	2.1%										2.7%	2.7%	3.0%

Understanding the performance:

There is ongoing work within Women and Newborn Division to review the clinical dashboard to ensure more robust benchmarking is included.

Actions (SMART):

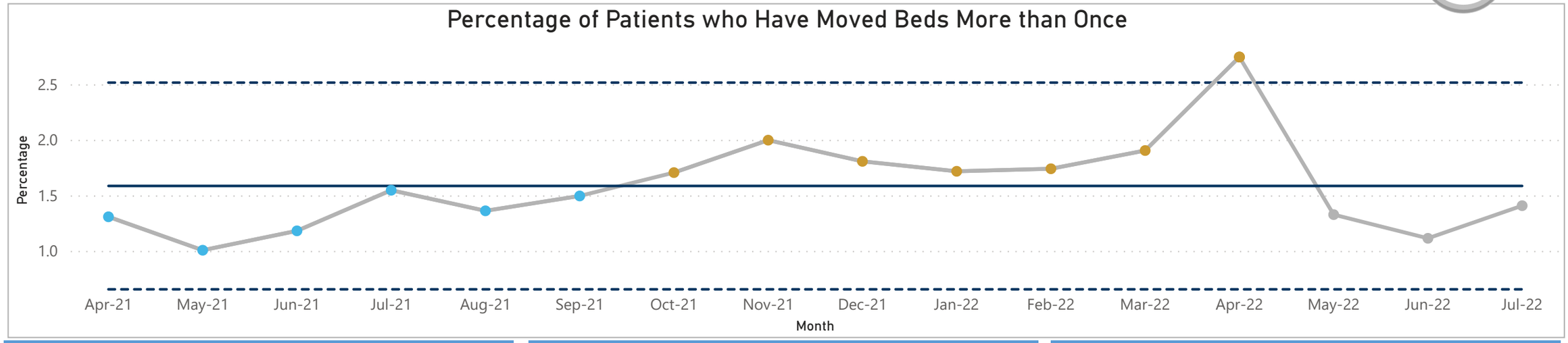
Work has begun across the Local Maternity and Neonatal System (LMNS) to align dashboards across the three acute providers – this work is in its infancy.

Risks and Mitigations:

N/A

Patients Who Have Moved Beds More Than Once

Are We Safe?



Understanding the performance:

The number of patients moved more than once fell in July 2022 from June and is below the level seen in July 2021, indicating an opportunity for improvement in the quality of care delivered at SFT.

Actions (SMART):

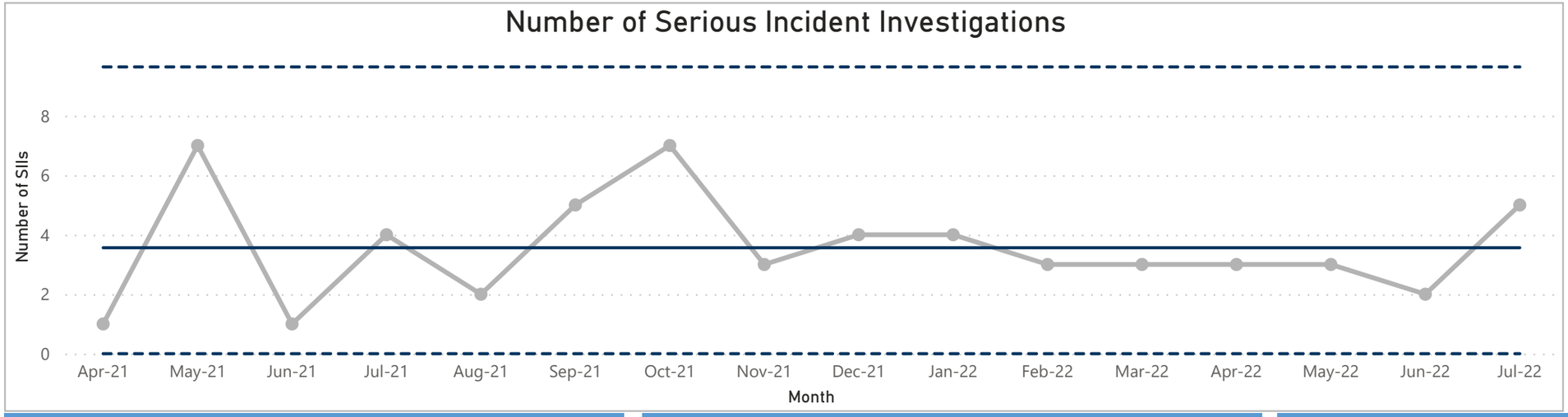
It remains a priority of all teams to deliver the care required in the right place at the right time. Communication with specialties regarding patient needs has improved and there is an ongoing focus with Farley to support patients with a stroke to access timely care.

Risks and Mitigations:

Risks to the continued ability to maintain right place right time include COVID/infection control outbreaks, the decreased flow, staffing challenges and the use of escalation beds.

Incidents

Are We Safe?



Year	2021-2022	2022-2023
Never Events	3	0

Understanding the performance:

Newly commissioned SIIs for July - 5

SII 492 Women and Newborns - Term admission to NICU

SII 493 Medicine - Delay in diagnosis due to lack of IR availability

SII 494 Medicine - Delayed admission from Emergency Department due to bed capacity

SII 497 Surgery - Incorrect consent form for surgery resulting in an unnecessary GA

SII 499 Medicine - Alleged inappropriate restraint

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.

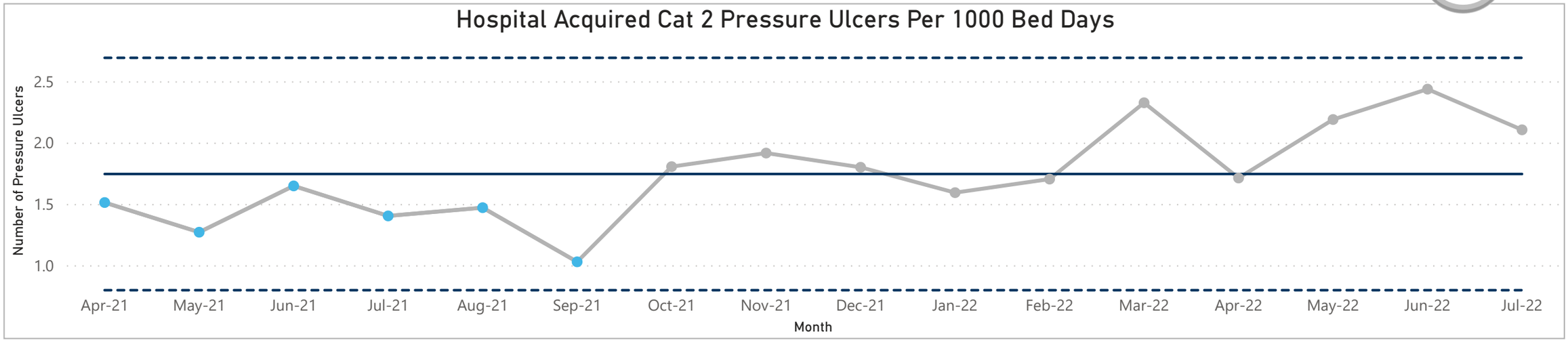
Risks and Mitigations:

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:

There were **32** Category 2 PUs in July
There were **0** Category 3 and **0** Category 4 PUs

The Number of Category 2 PUs has been steadily rising since April 2022. There has been a slight decrease in July 2022 but not significant.

There is a target of a 20% reduction in hospital acquired PUs for 2022-2023 (versus previous year).

Actions (SMART):

Business case for Practice Educator role is being considered by the Divisional Management Team.

There is an agreement for a new Risk assessment tool - roll out date to wards to be confirmed.

Bitesize teaching sessions to be arranged with ward leads to facilitate effective teaching sessions at appropriate times.

Planned update of Risk assessment tool (Braden)

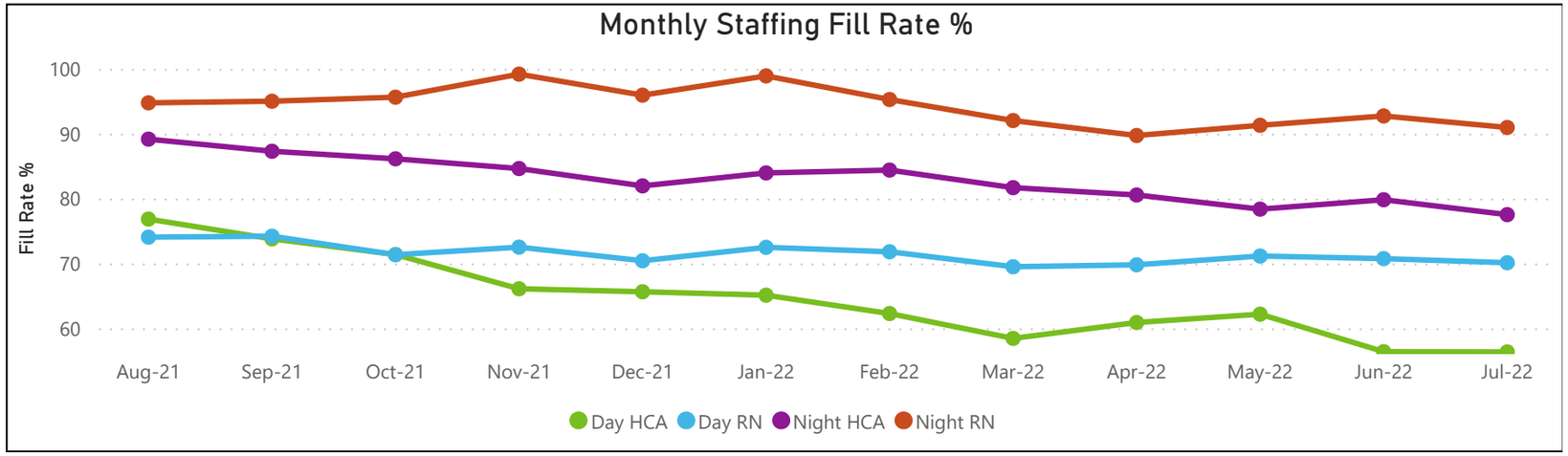
Adhoc teaching on wards/areas of concern.

Risks and Mitigations:

Poor uptake on education sessions will likely negatively impact hospital acquired PU numbers. Poor staffing levels on wards also has negative impact on ability to provide pressure area care in a timely and adequate manner.
-20% reduction not achieved last year despite all appropriate actions in place to reduce PU numbers. Tissue Viability team will have 2 vacancies within the next 3 months (2 WTE) which may impact the ability the service has to provide education as well as advice and validation of PUs while training new staff within the Tissue Viability Service.
- Practice educator role requires further discussion- staff turnover within Tissue Viability may impact any decisions regarding this potential new role.
-Decreased staffing on wards due to sickness/vacancies/maternity impacts the ability to undertake effective ward based teaching. Times/dates for ward teaching are subject to short notice change or cancellation due to ward or Tissue Viability workload.

Nurse Staff Fill Rate

Are We Safe?



Ward	Day RN	Night RN	Day HCA	Night HCA
Amesbury	78%	98%	62%	87%
AMU	70%	101%	63%	86%
Breamore	71%	107%	43%	88%
Britford	98%	90%	80%	87%
Chilmark	74%	57%	61%	97%
Downton	107%	103%	71%	123%
Durrington	57%	68%	70%	103%
Farley	86%	104%	54%	86%
Hospice	93%	101%	67%	127%
Longford	73%	105%	63%	70%
Maternity	85%	93%	69%	75%
NICU	103%	101%	0%	
Odstock	103%	99%	96%	97%
Pembroke	96%	100%	69%	77%
Pitton	70%	81%	86%	102%
Radnor	80%	82%	46%	45%
Sarum	132%	133%	69%	
Spire	77%	104%	81%	85%
Tisbury	71%	81%	50%	90%
Whiteparish	71%	72%	71%	97%

Understanding the performance:

Revised current ward incentive scheme, suspended previous 'golden shift' with generic uplift in rates across all temp staffing shift undertaken in ward environments.
Development of Allocation on Arrival shift (increased incentive for flexibility).
Requesting agency block booking for specific areas of concern – AMU, ED, Longford, Redlynch. Some limited success with ED shifts, but even with increased agency rates and support of NHS workforce alliance, limited fill rates and ongoing reliance on high cost agency.
Block booking requested with high cost agency for high risk area of AMU for 3/52 over July/Aug. Liaison and networking with ICS colleagues Ongoing International Recruitment

Actions (SMART):

Initial data suggests no significant change (pos or neg) in change in incentive approach especially in view of concurrent holiday/leave season and worsening vacancy position (caused by turnover and increase in establishment).

Soft data suggest incentive adjustment positively received by staff promoting equity and acknowledgement.
40 IR in process to arrive over next 3 months, with further 15 being sought

15 newly qualified RN due to start September.

Risks and Mitigations:

High vacancy rate across Trust (currently HCA 113 wte, RN 153 wte)

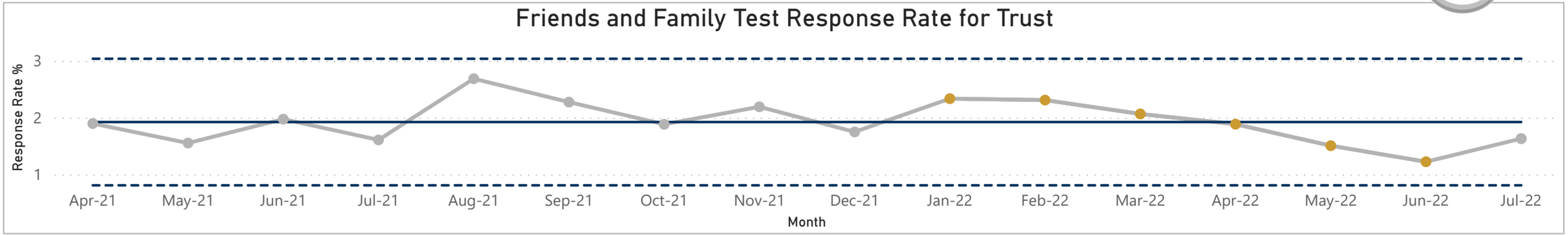
High and increasing turnover rates

High maternity rates across most wards

Despite good a/l management, unavailability exceeding 24% due to high maternity leave and sickness rates

Friends and Family Test Response Rate

Our Care



Response Rate by Area	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22	Jul-22
FFT Response Rate - A&E	1.0%	0.3%	0.3%	0.0%	0.0%	0.1%	0.1%	0.0%	0.2%	0.0%	0.2%	0.1%
FFT Response Rate - Day Case	7.7%	7.8%	5.8%	7.1%	6.9%	10.1%	5.3%	5.0%	4.8%	4.6%	3.3%	4.6%
FFT Response Rate - Inpatient	11.2%	8.0%	8.0%	11.2%	6.9%	13.4%	9.5%	7.1%	5.7%	7.1%	6.8%	7.5%
FFT Response Rate - Maternity	0.0%	0.3%	2.4%	6.6%	10.8%	0.9%	2.5%	5.9%	11.5%	0.9%	0.4%	1.6%
FFT Response Rate - Outpatient	1.5%	1.4%	1.1%	1.1%	0.8%	0.9%	1.6%	1.6%	1.3%	0.8%	0.6%	0.9%

Understanding the performance:

The NHS Friends and Family Test (FFT) was created to help service providers and commissioners understand whether patients are happy with the service provided, or where improvements are needed. It's a quick and anonymous way to give views after receiving NHS care or treatment Areas are encouraged to offer feedback forms to patients at discharge or during their stay.

Weekly emails are sent to leads showing feedback received in the previous week, allowing them to pick up any immediate causes for concern and mitigate these where possible.

Negative feedback is review by the ward and PALS, twice a year.

Actions (SMART):

-Escalated with IT the use of QR codes to maximise access to the current online FFT form on the Trust website.
-Securing a provider to gather patient feedback via SMS will be key to moving towards achievement of our objectives under the Improving Together Programme over the next 6-12 months:
- Increase overall response rates to FFT
- Diverse methods for completion (including, online, SMS, over the phone)
- Increased accessibility and options for inclusivity (sight impairments, languages and additional demographic options)
- Robust analysis of data for insight and meaningful comparison/benchmarking via a real-time dashboard
- Opportunity to align our processes in FFT across the ICS

Risks and Mitigations:

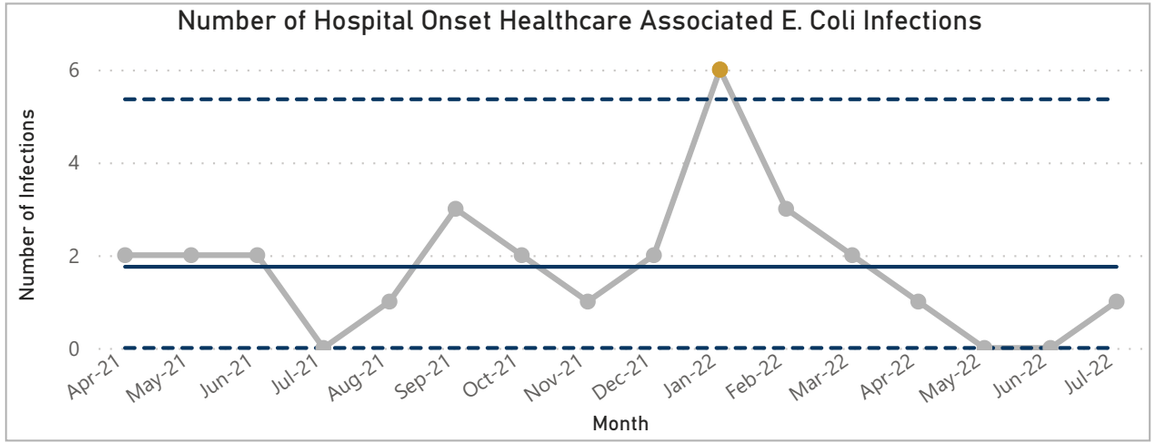
Continued low response rate, due to limited methods for accessibility and the reliance on staff to promote completion of a physical card, this is directly impacted when there are staff shortages and operational pressures.

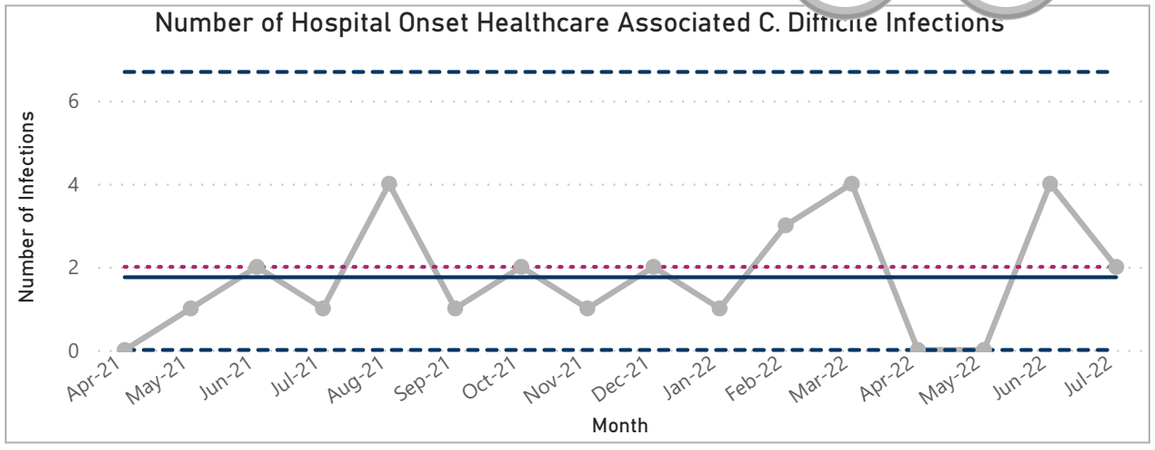
The current method requires manual input and theming, which there is limited resource to undertake. Theming on a large scale is near impossible without the usual of manual approaches - this makes presenting accurate data for the Trust difficult to assure.

Procurement for a suitable provider to address both risks (as per the Actions) are in progress.

Infection Control

Are We Safe?





Year	2021-2022	2022-2023
MRSA Bacteraemia Infections: Hospital Onset	0	0
MSSA Bacteraemia Infections: Hospital Onset	12	2

Understanding the performance:

There was 1 Hospital onset Healthcare Associated reportable E.Coli and 2 reportable C.Diff infections this month. There have been only 2 reported E.Coli infections so far this year which is an improvement on last year's comparable performance. We are not exceeding set trajectories for 2022/23 for specific reportable HCAI cases.

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

Small practice improvements with Infection, Prevention and Control (IPC) compliance noted from individual staff interactions undertaken, with the aim of sharing information with their colleagues.

Actions (SMART):

-Completed trial of alternative approach for staff in ward areas to complete hand hygiene education and assessments. Process for evaluation and review with roll out date to other ward areas to be confirmed.
-Completion of required case investigations by clinical areas to identify good practice and any new learning.
-Feedback expected by clinical areas at 'Share & Learn' meeting to enable agreement of actions moving forward from any themes/trends identified from all cases.
-Involvement with BSW collaborative workstreams related to IPC and Gram Negative Bloodstream Infections (GNBSIs).

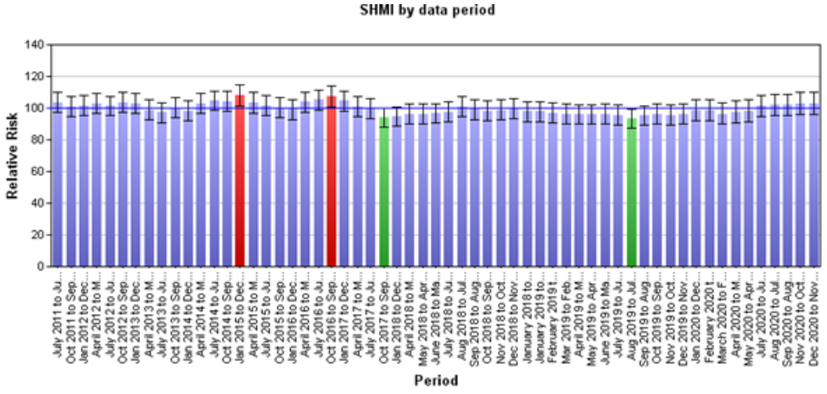
Risks and Mitigations:

Increased workload for IPC nursing team managing COVID-19 outbreaks (10 in total currently), impacting on ability to focus on other HCAI prevention work.
-Variable staffing levels reported by clinical areas affecting ability to facilitate learning in ward environment.
-Varied completion of case investigation documentation by relevant clinical areas, with limited evidence of learning.
-An underlying risk continues to be a potential increase in incidence of reportable healthcare associated infections with poor patient outcomes and Trust exceeds agreed trajectories.
-Ongoing nursing vacancy within the IPC team which has delayed the ability for the service to undertake additional educational activities and policy practice reviews.
-Limited progress to date on IPC collaboratives with BSW colleagues.

Mortality

Are We Safe?

Rolling 12 Months	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22	Jul-22
Total Mortalities	68	66	63	79	94	87	84	84	88	84	74	86



Site code	Site name	Provider spells	Observed deaths	Expected deaths	SHMI value
RNZ02	Salisbury District Hospital	34,260	990	920	1.0766
RNZ78	Salisbury Hospice	100	65	25	2.3559

Understanding the performance:

The latest SHMI for Salisbury District Hospital (as reported by NHS Digital) is for the 12-month rolling period of April 2021 to March 2022 and is 1.0766. This is within the expected range.

The latest HSMR is for the 12-month rolling period of April 2021 to March 2022 and is 112.7. This is higher than expected. However, as mortality statistical models compare across all acute hospital trusts (the majority of which will not contain hospice services) the number of expected deaths at Salisbury NHS Foundation Trust is likely to sit above expected levels. When the main hospital site is separated from the hospice our SHMI sits within the expected range.

Actions (SMART):

N/A

Risks and Mitigations:

The Trust's Mortality Surveillance Group (MSG) meet every two months, and our mortality data is reviewed at this meeting. A representative from our Partner organisation, Telstra Health UK (Dr Foster), is invited to attend in order to help us to interpret and analyse our mortality data and identify variations in specific disease groups. Where alerts are generated, these are discussed and a further review of the patient's records may be undertaken.

Watch Metrics: Alerting

Quality of Care, Access and Outcomes

Metric	Two Months Ago	Last Month	This Month	Improvement Target	National Target	Variation	Variation Detail	Assurance
% Beds Occupied	96.6%	97.0%	96.7%				Special Cause Concerning - Two Out of Three High	
% of Total Incidents Resulting in High Harm (Mod/Maj/Cat)	24.0%	32.0%	29.0%				Special Cause Concerning - Run Above Mean	
Ambulance Handovers 30-<60 mins	117	135	132				Special Cause Concerning - Run Above Mean	
Ambulance Handovers 60+ mins	113	198	187		0		Special Cause Concerning - Run Above Mean	
Average Patients with No Criteria to Reside	125	120	128	35			Special Cause Concerning - Above Upper Control Limit	
DM01 Waiting List Volume	5297	5729	5647				Special Cause Concerning - Above Upper Control Limit	
Trust Performance RTT %	68.5%	65.9%	62.5%		92%		Special Cause Concerning - Below Lower Control Limit	

Watch Metrics: Alerting Narrative

Quality of Care, Access and Outcomes

Understanding the performance:

Actions (SMART):

Risks and Mitigations:

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	Assurance
Ambulance Arrivals	1181	1142	1140				Special Cause Improving - Run Below Mean	
Ambulance Handovers 15-<30 mins	282	267	253				Common Cause Variation	
Cancer 2 Week Wait Breast Performance	57.8%	79.3%	75.7%		90%		Common Cause Variation	
Cancer 62 Day Screening Performance	33.3%	0.0%	28.6%		90%		Common Cause Variation	
ED 12 Hour Breaches	25	59	86		0		Common Cause Variation	
ED Attendances	6575	6611	6538				Common Cause Variation	
Hours Lost to Ambulance Handover Delays	259	578	555				Common Cause Variation	
Number of High Harm Falls in Hospital	3	2	0	0	0		Common Cause Variation	
Pressure Ulcers Hospital Acquired Cat 2	33	36	32				Common Cause Variation	
Pressure Ulcers Hospital Acquired Cat 3	1	0	0				Common Cause Variation	
Pressure Ulcers Hospital Acquired Cat 4	0	0	0				Common Cause Variation	
RTT Incomplete Pathways: Total 104 week waits	0	0	0		0		Common Cause Variation	
RTT Incomplete Pathways: Total 52 week waits	551	524	509				Special Cause Improving - Below Lower Control Limit	
RTT Incomplete Pathways: Total 78 week waits	99	75	66				Special Cause Improving - Two Out of Three Low	
Serious Incident Investigations	3	2	5				Common Cause Variation	
Stroke & TIA: % CT'd within 1 hour	55.0%	47.0%	42.0%				Common Cause Variation	
Total Incidents (All Grading) per 1000 Bed Days	53	51	52				Common Cause Variation	
Total Number of Complaints Received		15					Common Cause Variation	

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	Assurance
% of Inpatients Undergoing VTE Risk Assessment	99.3%	99.5%	99.1%		95%		Common Cause Variation	
Cancer 31 Day Performance Overall	98.4%	97.5%	94.5%		96%		Common Cause Variation	
Mixed Sex Accommodation Breaches	98	16	0	0	0		Common Cause Variation	
Neonatal Deaths Per 1000 Live Births	0	0	0				Special Cause Improving - Run Below Mean	
Stillbirths Per 1000 Total Births	0	5	5				Common Cause Variation	
Total Number of Compliments Received	0	6	0				Common Cause Variation	

Part 3: People

Performance against our Strategic Priorities and Key Lines of Enquiry

Salisbury NHS Foundation Trust

Our Priorities

Population

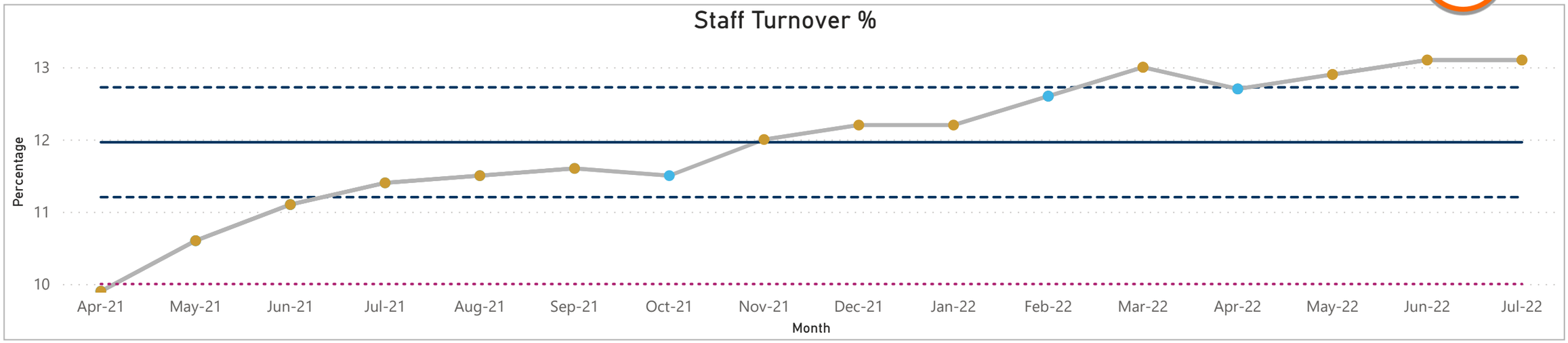
Partnerships

People

Workforce - Turnover

Target 10%

People



Understanding the performance:

12 month rolling average turnover continues to rise. While this remains a low rate of attrition, the upward trend from the high stability target of 10% is a concern. Turnover is high for some groups of staff such as HCAs, with C40% in first 2 years. We do not fully understand all the reasons for leaving because around 25% of staff withhold their reasons. Of the reported reasons, retirements and relocations figure heavily. There are some notable successes in Turnover reducing such as in CSFS which has dropped below the Trust average month on month.

Actions (SMART):

- We are beginning the review of HCA grading which will run for a targeted 90 days starting WC August 22nd, 2022.
- Listening events continue with outputs being fed into divisional and OD&P strategic responses
- Revisions to Porters rota expected to help arrest an area of dissatisfaction
- Roll out of wellbeing conversations in Surgery

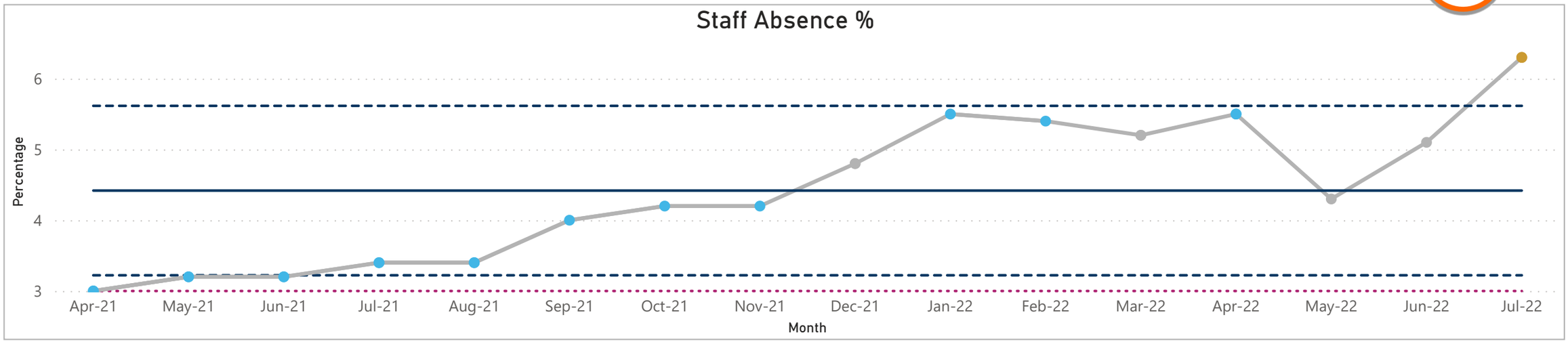
Risks and Mitigations:

- Under reporting of reasons for leaving prevents us from accurately targeting solutions. BPs will remind everyone of the importance of exit interviews, and we will continue to monitor and report compliance.
- A task and finish group is being directed to improve the returns of the next staff survey. It is hoped this will improve our insights into turnover and intentions to leave, and the reasons that make people consider leaving.
- Opportunities to undertake well-being conversations and stay conversations are limited by workload/staffing shortages but will be mitigated by deployment of well-being facilitator role (funded by Stars Appeal 3 days per week) that will deliver additional management training and create a cohort of 200 well-being champions over the next 24 months.

Workforce - Sickness

Target 3%

People



Understanding the performance:

Since we began reporting absence via Healthroster, reporting compliance appears to have improved and this, coupled with a significant temporary spike in coronavirus absences has caused our figures to rise to 6.3% from 5.5% and 5.1% in the two previous months and a mean figure of 4.4%. We expect this to show a natural improvement in August.

Actions (SMART):

- ER team is working on all long-term absence cases and are targeting 30 to be rehabilitated. It is difficult to target a date of return as case management is notoriously unpredictable.
- BPs are being asked to give training on absence management and to support absence management conversations if requested.
- Absence management processes are being refreshed to include scripting the return-to-work meeting and trigger point meetings that can lead to warnings about attendance. At the time of writing, we do not have a time-scaled plan or specific targeted numbers but will be working to that discipline.

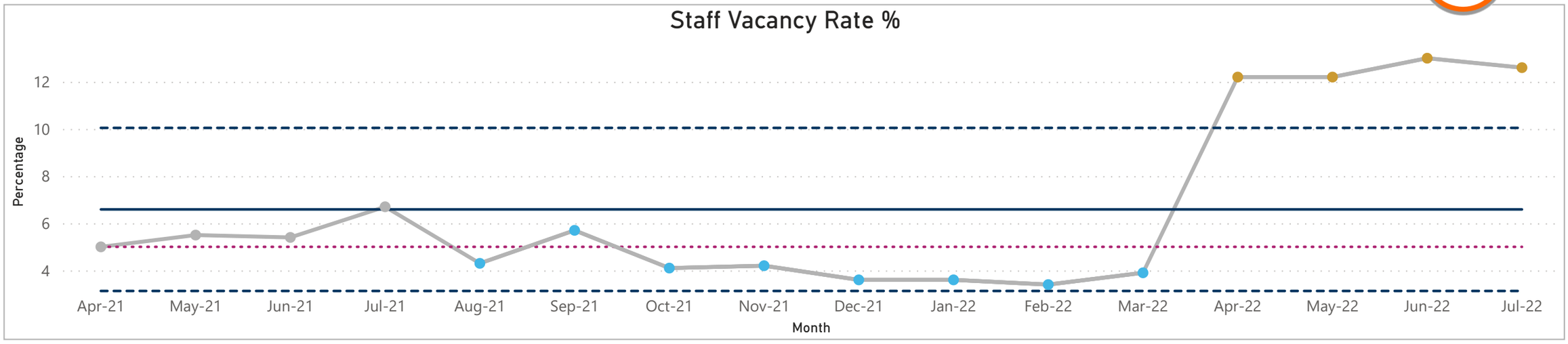
Risks and Mitigations:

- Occupational Health dept. remains under-resourced and rehab programmes are therefore tricky to support. We are hiring an interim head of service who will focus on compliance first, then recruitment of a new team and additional work like rehab will necessarily need to be a third-tier priority
- Change to covid sickness rules and the end of provision of free tests will increase risk of untested staff coming to work with Covid 19. This will not help us to reduce absence, though including covid in sickness triggers may have an impact in the next few months.
- To reduce the possibility for missing some absence triggers, the stats on short term and long-term absences reviewed at weekly workforce cell.
- Workforce cell are also are targeting systematic absence management practices, dealing with the worst cases first.
- More actions are under consideration, such as alerting staff when they reach 2 absences that a 3rd one would trigger formal review.

Workforce - Vacancies

Target 5%

People



Understanding the performance:

Vacancy rate rose with budget uplift in April.
This creates a sizeable gap to fill which has so far remained steady at over 12%.

Actions (SMART):

- 100 interview slots available Aug and Sept for HCAs
- Recruitment specialist roles to be hired and embedded in parts of the trust that are struggling to process recruitment – starting with theatres starting on 15.08 and facilities targeted next, this will alleviate some of the pressure on our line managers
- Maternity HCA campaign for September delivery
- First cohort of international recruits to arrive on 11.08
- 5 International midwives' recruitment being finalised for arrival in September

Risks and Mitigations:

- While there are only 150 job ads out at present for over 700 vacancies, many of them are for multiple roles e.g., HCAs. However recruitment on this mass scale has to be phased to match our capacity to hire and induct.
- DELAYS for INTERNATIONAL RECRUITS – These include delayed/cancelled flights, delays in visa approval and agencies which do not complete all their checks on time – mitigation includes factoring these realities into our timescales
- Cost of living increases and "bad press" about how hard it is to work in our NHS environment means that we must make our advertising work much harder. Traditional approaches will yield decline in returns and change needs to happen. Additional adverts via radio, social media etc. are commissioned to help our attraction strategy, but we still need to work on the "offer" in terms of intrinsic attractiveness and targeted extrinsic rewards (pay etc.) and the location and find a way to improve how these are portrayed, to make it look and feel more compelling.

Watch Metrics: Alerting

People

Metric	Two Months Ago	Last Month	This Month	Improvement Target	National Target	Variation	Variation Detail	Assurance
Non-Medical Appraisal Rate %	69.3%	69.2%	67.0%	86.0%			Special Cause Concerning - Run Below Mean	

Watch Metrics: Alerting Narrative

People

Understanding the performance:

Non-Medical Appraisals

Non-medical appraisals running at 69.2% have not improved in 2 months and are an ongoing concern.

Actions (SMART):

A project team was formed to review the practices, process and the form being used for non-med' appraisal. All indications from our line manager focus group are that we need to make the following changes if we are to arrest the decline in compliance. Most of these actions will be completed by mid-September.

1. A shorter, simpler form, featuring fewer but better questions.
2. Some processing guidance to be incorporated into training and placed in a crib sheet for managers and employees.
3. Process changes to include provision for managers to trigger appraisal instead of waiting for employees to trigger it.
4. A review of spans of control in our management structure that will set a maximum limit on how many appraisals any one individual has to carry out.
5. A paper-based employee preparation form for facilities and estate etc where staff are not skilled with or do not have access to IT platforms and software.

Risks and Mitigations:

Risk that the NHS will reintroduce a mandatory requirement for staff to have completed their objectives and training before a merit pay award is authorised. This would mean around 35% of staff would not get an increase at a time when we desperately need to help staff earn as much as possible to retain them and avoid the risk of winter fuel poverty. Mitigation is to adjust the appraisal tools and renew focus on completion.

Some line managers have become used to putting appraisal on the back burner and we need to monthly report by directorate and section to get increased focus.

Watch Metrics: Non-Alerting

People

Metric	Two Months Ago	Last Month	This Month	Improvement Target	National Target	Variation	Variation Detail	Assurance
Mandatory Training Rate %	86.3%	91.8%	92.1%	90.0%	85%		Special Cause Improving - Above Upper Control Limit	
Medical Appraisal Rate %	69.3%	67.0%	87.1%	90.0%			Common Cause Variation	

Part 4: Finance and Use of Resources

Performance against our Strategic Priorities and Key Lines of Enquiry

Salisbury NHS Foundation Trust

Our Priorities

Population

Partnerships

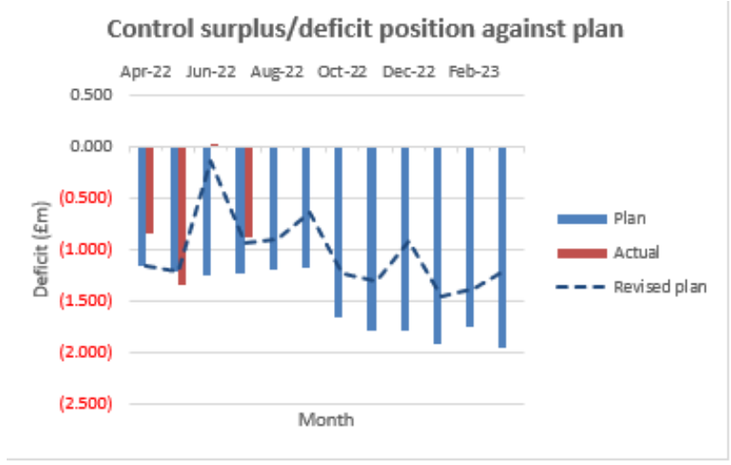
People

Income and Expenditure

Income & Expenditure:

Finance and Use of Resources

	Jul '22 In Month			Jul '22 YTD			22-23
	Plan £000s	Actual £000s	Variance £000s	Plan £000s	Actual £000s	Variance £000s	Plan £000s
Operating Income							
NHS Clinical income	21,731	22,046	315	86,925	87,539	614	257,761
Other Clinical Income	715	1,027	312	2,858	3,536	678	11,587
Other Income (excl Donations)	2,897	2,901	4	11,682	12,499	817	34,540
Total income	**25,343**	**25,974**	**631**	**101,465**	**103,574**	**2,109**	**303,888**
Operating Expenditure							
Pay	(16,510)	(16,769)	(259)	(66,107)	(66,305)	(198)	(199,429)
Non Pay	(8,093)	(8,437)	(344)	(32,133)	(33,546)	(1,413)	(96,646)
Total Expenditure	**(24,603)**	**(25,206)**	**(603)**	**(98,240)**	**(99,851)**	**(1,611)**	**(296,075)**
EBITDA	**740**	**768**	**28**	**3,225**	**3,723**	**498**	**7,813**
Financing Costs (incl Depreciation)	(1,670)	(1,643)	27	(6,649)	(6,749)	(100)	(20,213)
NHSI Control Total	**(930)**	**(876)**	**54**	**(3,424)**	**(3,027)**	**397**	**(12,400)**
Add: impact of donated assets	(68)	(71)	(3)	(272)	(283)	(11)	(816)
Surplus/(Deficit)	(998)	(946)	52	(3,696)	(3,310)	386	(13,216)



Understanding the performance:

In month 4 the Trust recorded a control total deficit of £0.876m against a target of £0.930m - a favourable variance of £0.054m. The over achievement on high cost devices and private and Channel islands patient income was not fully offset by additional pay and non pay costs.

Higher than planned vacancies continue to offset temporary staffing costs in all areas except nursing and support to nursing. Pay costs have increased substantially in July due to increased nursing bank and agency expenditure with an increase in bank incentives of c£37k in month.

Actions (SMART):

Ongoing discussions to agree the distribution of centrally held ICB funding by system Directors of Finance.

Work is ongoing to identify recurrent savings and recruit to vacancies.

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.
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 Trust has a target of £9.7m efficiency savings with a forecast delivery of £8.8m split 55% recurrent and 45% non recurrent. This signals a significant risk if further recurrent efficiencies are not identified.

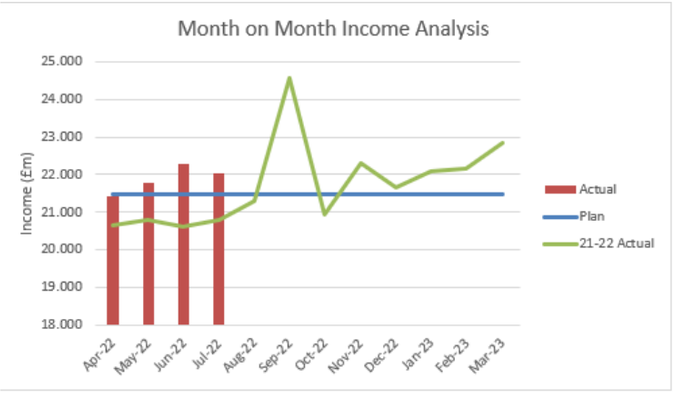
Income & Activity Delivered by Point of Delivery

Clinical Income:

Finance and Use of Resources

Income by Point of Delivery (PoD) for all commissioners	July'22 YTD Plan (YTD) £000s	Actual (YTD) £000s	Variance (YTD) £000s
A&E	3,555	3,408	(147)
Day Case	6,700	6,160	(540)
Elective inpatients	4,071	4,491	420
Excluded Drugs & Devices (inc Lucentis)	7,375	7,933	558
Non Elective inpatients	23,144	24,404	1,260
Other	29,936	30,041	105
Outpatients	12,144	11,102	(1,042)
TOTAL	86,925	87,539	614

SLA Income Performance of Trusts main NHS commissioners	Contract Plan (YTD) £000s	Actual (YTD) £000s	Variance (YTD) £000s
BSW CCG	51,445	51,445	-
Dorset CCG	8,622	8,622	-
Hampshire, Southampton & IOW CCG inc Portsmouth	7,030	7,030	-
Specialist Services	13,435	13,939	504
Other	6,393	6,503	110
TOTAL	86,925	87,539	614



	Activity Plan	Activity Actuals	Activity Variance	Activity Actuals	Variance last year
A&E	23,586	25,011	1,425	23,206	1,805
Day case	7,767	7,388	(379)	6,694	694
Elective	1,018	1,141	123	901	240
Non Elective	9,639	8,925	(714)	9,606	(681)
Outpatients	85,292	80,810	(4,482)	89,298	(8,488)

Understanding the performance:

The Trust is ahead of the Clinical income plan due to additional income from NHSE specialised services in respect of cost and volume devices activity and Channel islands patient income. The level of uncoded day cases and inpatient spells is 32% in June and 91% in July at the time the activity was taken for reporting purposes. A&E activity has been lower in July than in June with increased attendance at the A&E department but lower walk in centre activity in month. Day case activity in July was 45 more cases than in June but lower than plan by 57 cases and remains behind plan YTD mainly due to lower Endoscopy demand. Increased activity was seen in Plastics (31 cases) and Gastroenterology (139) with less activity in General surgery (138). Activity in elective inpatients continued to be above plan in month by 68 cases with 57 additional cases undertaken in Urology. Non Elective activity was higher than in June mainly within Obstetrics (103 cases) and Outpatient activity was lower than June mainly

Actions (SMART):

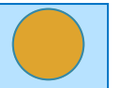
The commissioner contracts are not yet signed although the BSW ICB contract is progressing and is expected to be signed during August. Further work is required to review and agree the contract documents shared to date by NHS England.

Risks and Mitigations:

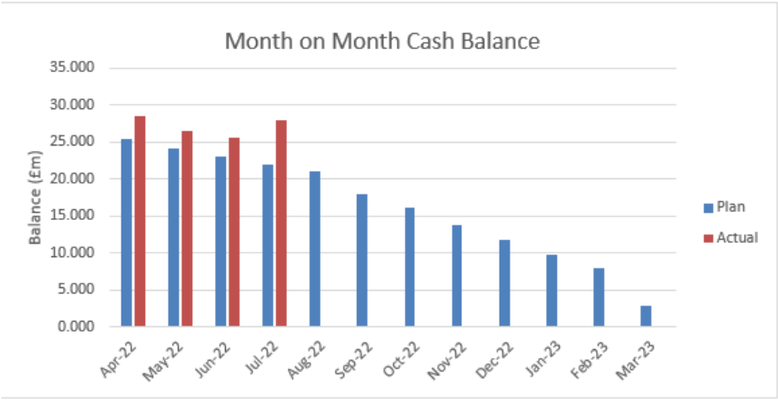
Pay award funding will flow in September from commissioners with monthly payments expected to increase by c1.66%. Pay award funding has been allocated to ICB systems on a fair shares basis but is expected to be lower from the BSW ICB.

Cash Position & Capital Programme

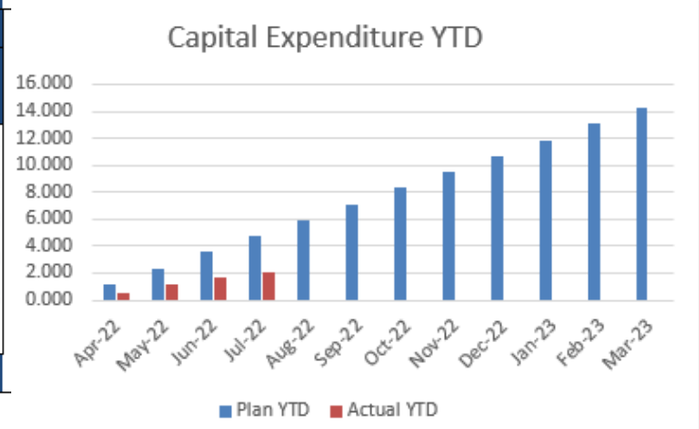
Capital Spend: 

Cash & Working: 

Finance and Use of Resources



Position				
	Annual	July'22 YTD		
	Plan	Plan	Actual	Variance
Schemes	£000s	£000s	£000s	£000s
Building schemes CIR	3,758	1,228	284	944
Building projects	2,740	1,016	581	435
IM&T	4,106	1,276	508	768
Medical Equipment	2,207	1,084	605	479
Other	1,414	142	109	33
TOTAL	14,225	4,746	2,087	2,659



Understanding the performance:

Capital expenditure is significantly behind plan, particularly within Building Projects. A material of c£780k IM&T order has recently been placed for Network kit. The forecast of the capital plan is in progress and whilst the international chip shortage has impacted some schemes, mainly within IM&T and Estates, some lead times are now reducing.

The Trust cash balance is currently healthy, partly due to slippage in the 22-23 capital plan. Due to the size of the deficit planned for 22-23 the cash balance is forecast to reduce significantly over the year.

Actions (SMART):

Work is progressing to review the prioritisation of Capital schemes via CapCG.

Ongoing discussions to agree the distribution of centrally held ICB funding by system Directors of Finance.

Risks and Mitigations:

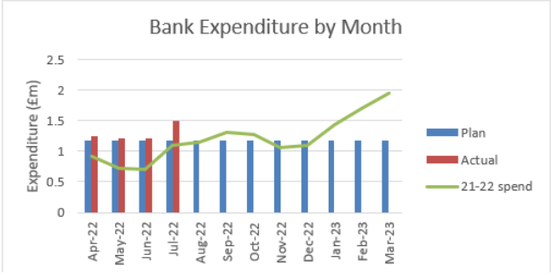
Revised Capital forecasts are expected to full utilise the capital allocation.

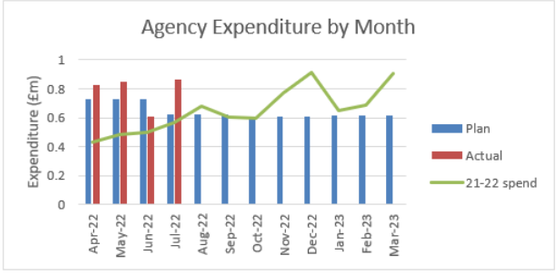
The expectation is that this will be largely mitigated by the distribution of BSW funding currently held centrally by the ICB.

Workforce and Agency Spend

Pay:

Finance and Use of Resources





Position	July'22 YTD		
	Plan £000s	Actual £000s	Variance £000s
Pay - In Post	58,217	57,735	482
Pay - Bank	4,680	5,177	(497)
Pay - Agency	2,814	3,143	(329)
Other (eg. Apprenticeship Levy)	396	250	146
TOTAL	**66,107**	**66,305**	**(198)**
Medical Staff	17,574	17,056	518
Nursing	15,603	17,084	(1,481)
Support to Nursing	4,777	5,176	(399)
Other Clinical Staff	10,731	9,967	764
Infrastructure staff	17,026	16,771	255
Other (eg. Apprenticeship Levy)	396	250	146
TOTAL	**66,107**	**66,305**	**(198)**

Position	July'22		
	Plan WTEs	Actual WTEs	Variance WTEs
Medical Staff	490.6	452.6	38.0
Nursing	1,103.6	1,071.0	32.6
Support to Nursing	516.3	498.4	17.9
Other Clinical Staff	717.4	657.2	60.2
Infrastructure staff	1,432.2	1,413.5	18.7
TOTAL	**4,260.1**	**4,092.7**	**167.4**

Understanding the performance:

Pay expenditure increased by £492k (3.0%) in month 4, bringing the year to date position to an adverse variance of £198k.
Expenditure on substantive staff reduced by £47k in month. The total worked WTE across the Clinical Divisions increased by 47 WTE in month due to 70 WTE on Agency and 5 WTE Bank offset by a reduction of 28 WTE Substantive. This reflects a reduction in Nursing filled vacancies from 17% at Month 3 to 11% at Month 4.
Agency costs have increased by £256k in month of which £205k was within the Medical Division. This was predominantly due to an increase of 177 agency shifts in month with the majority of the shifts placed with Thornbury nursing services. The agency run rate reduced in M3 and July's expenditure is in line with the levels seen in April and May.

Actions (SMART):

Work is ongoing to recruit to vacant posts and identify recurrent pay savings.

Risks and Mitigations:

The pay award has now been announced and is expected to be paid in September. Funding has been allocated to ICBs on a fair shares basis and analysis suggests a shortfall of c£1m.

Data Sources: Narrative and Breakthrough Objectives

Understand the Data

Metric Type	Metric Name	Data Source	Executive Lead	Data Quality Rating
Breakthrough Objective	Total (Excess) Bed Days from NC2R to Discharge - Internal Reasons only	e-whiteboards	Lisa Thomas	Medium
Breakthrough Objective	Total Patient Falls per 1000 Bed Days	DATIX Team	Peter Collins	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	Peter Collins	High
Narrative	C Difficile Hospital onset Healthcare associated	Infection Control Team	Peter Collins	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	Peter Collins	High
Narrative	DM01 Performance	Trust Data Warehouse	Lisa Thomas	High
Narrative	E Coli Hospital onset Healthcare associated	Infection Control Team	Peter Collins	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	Peter Collins	High
Narrative	Staff Sickness Absence %	Health Roster	Melanie Whitfield	High
Narrative	Staff Turnover	ESR	Melanie Whitfield	High
Narrative	Stroke & TIA: % Arrival on Stroke Unit within 4 hours	Trust Data Warehouse	Peter Collins	High
Narrative	Total Ambulance Handover delays	Lorenzo via Trust Data Warehouse	Lisa Thomas	High
Narrative	Total Waiting List	Lorenzo via Trust Data Warehouse	Lisa Thomas	High
Narrative	Vacancies	ESR	Melanie Whitfield	High

Data Sources: Watch Metrics (1)

Understand the Data

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

Data Sources: Watch Metrics (2)

Understand the Data

Metric Type	Metric Name	Data Source	Executive Lead	Data Quality Rating
Watch	DM01 Waiting List Volume	Trust Data Warehouse	Lisa Thomas	High
Watch	Hours Lost to Ambulance Handover Delays	SWAST M032 report	Lisa Thomas	High
Watch	Ambulance Handovers 15-<30 mins	SWAST AR119 report	Lisa Thomas	High
Watch	Ambulance Handovers 30-<60 mins	SWAST AR119 report	Lisa Thomas	High
Watch	Ambulance Handovers 60+ mins	SWAST AR119 report	Lisa Thomas	High
Watch	% Beds Occupied	Lorenzo via Trust Data Warehouse	Lisa Thomas	Medium
Watch	Ambulance Arrivals	Lorenzo via Trust Data Warehouse	Lisa Thomas	High
Watch	ED 12 Hour Breaches	Lorenzo via Trust Data Warehouse	Lisa Thomas	Medium
Watch	ED Attendances	Lorenzo via Trust Data Warehouse	Lisa Thomas	High
Watch	RTT Incomplete Pathways: Total 104 week waits	Lorenzo via Trust Data Warehouse	Lisa Thomas	High
Watch	RTT Incomplete Pathways: Total 52 week waits	Lorenzo via Trust Data Warehouse	Lisa Thomas	High
Watch	RTT Incomplete Pathways: Total 78 week waits	Lorenzo via Trust Data Warehouse	Lisa Thomas	High
Watch	Trust Performance RTT %	Lorenzo via Trust Data Warehouse	Lisa Thomas	High
Watch	Average Patients with No Criteria to Reside	e-whiteboards via Trust Data Warehouse	Lisa Thomas	Medium
Watch	Cancer 2 Week Wait Breast Breaches	Cancer Services	Lisa Thomas	High
Watch	Cancer 2 Week Wait Breast Den	Cancer Services	Lisa Thomas	High
Watch	Cancer 2 Week Wait Breast Num	Cancer Services	Lisa Thomas	High
Watch	Cancer 2 Week Wait Breast Performance	Cancer Services	Lisa Thomas	High
Watch	Cancer 31 Day Performance Overall	Cancer Services	Lisa Thomas	High
Watch	Cancer 62 Day Screening Den	Cancer Services	Lisa Thomas	High
Watch	Cancer 62 Day Screening Num	Cancer Services	Lisa Thomas	High
Watch	Cancer 62 Day Screening Performance	Cancer Services	Lisa Thomas	High
Watch	Cancer 62 Days Standard Den	Cancer Services	Lisa Thomas	High
Watch	Cancer 62 Days Standard Num	Cancer Services	Lisa Thomas	High

Data Sources: Other Metrics (1)

Understand the Data

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

Data Sources: Other Metrics (2)

Understand the Data

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

Data Sources: Other Metrics (3)

Understand the Data

Metric Type	Metric Name	Data Source	Executive Lead	Data Quality Rating
Other	FFT Response Rate - A&E	Trust Data Warehouse	Peter Collins	High
Other	FFT Response Rate - Day Case	Trust Data Warehouse	Peter Collins	High
Other	FFT Response Rate - Inpatient	Trust Data Warehouse	Peter Collins	High
Other	FFT Response Rate - Maternity	Trust Data Warehouse	Peter Collins	High
Other	FFT Response Rate - Outpatient	Trust Data Warehouse	Peter Collins	High
Other	HSMR rate	Telestra Health	Peter Collins	High
Other	Maternity Clinical Dashboard: Apgar less than 6 @ 5 min %		Peter Collins	Medium
Other	Maternity Clinical Dashboard: Babies (incl non reg)		Peter Collins	Medium
Other	Maternity Clinical Dashboard: Elective caesarean sections %		Peter Collins	Medium
Other	Maternity Clinical Dashboard: Emergency caesarean sections %		Peter Collins	Medium
Other	Maternity Clinical Dashboard: Homebirth Rate		Peter Collins	Medium
Other	Maternity Clinical Dashboard: Inductions %		Peter Collins	Medium
Other	Maternity Clinical Dashboard: Instrumental deliveries %		Peter Collins	Medium
Other	Maternity Clinical Dashboard: PPH >= 1, 500 %		Peter Collins	Medium
Other	Maternity Clinical Dashboard: Term babies admitted to NNU unexpectedly %		Peter Collins	High
Other	Maternity Clinical Dashboard: Total CS rate (planned & unscheduled)		Peter Collins	Medium
Other	Maternity: Training compliance - MDT Prompt %		Peter Collins	Medium
Other	MRSA Bacteraemia Infections: Hospital Onset	Infection Control Team	Peter Collins	High
Other	Never Events	DATIX Team	Peter Collins	High
Other	SHMI Relative Risk	Telestra Health	Peter Collins	High
Other	Total Mortalities	Trust Data Warehouse	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	Lisa Thomas	High
Other	Financing Costs	Finance Division	Lisa Thomas	High
Other	Income by PoD: A&E Actual	Finance Division	Lisa Thomas	High
Other	Income by PoD: A&E Plan	Finance Division	Lisa Thomas	High
Other	Income by PoD: Daycase Actual	Finance Division	Lisa Thomas	High
Other	Income by PoD: Daycase Plan	Finance Division	Lisa Thomas	High
Other	Income by PoD: Elective IP Actual	Finance Division	Lisa Thomas	High
Other	Income by PoD: Elective IP Plan	Finance Division	Lisa Thomas	High
Other	Income by PoD: Excluded Drugs & Devices Actual	Finance Division	Lisa Thomas	High
Other	Income by PoD: Excluded Drugs & Devices IP Plan	Finance Division	Lisa Thomas	High
Other	Income by PoD: Non Elective IP Actual	Finance Division	Lisa Thomas	High
Other	Income by PoD: Non Elective IP Plan	Finance Division	Lisa Thomas	High
Other	Month on month I&E Surplus/(Deficit) Actual	Finance Division	Lisa Thomas	High
Other	Month on month I&E Surplus/(Deficit) Plan	Finance Division	Lisa Thomas	High
Other	NHS Clinical income	Finance Division	Lisa Thomas	High
Other	NHS Clinical income Plan	Finance Division	Lisa Thomas	High
Other	Non Pay	Finance Division	Lisa Thomas	High
Other	Other Clinical income	Finance Division	Lisa Thomas	High
Other	Other Clinical income Plan	Finance Division	Lisa Thomas	High
Other	Other income (excl donations)	Finance Division	Lisa Thomas	High
Other	Other income (excl donations) Plan	Finance Division	Lisa Thomas	High
Other	Pay	Finance Division	Lisa Thomas	High
Other	Share of Gains on Joint Ventures	Finance Division	Lisa Thomas	High
Other	Surplus/(Deficit)	Finance Division	Lisa Thomas	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	Lisa Thomas	High
Other	Activity by PoD: Day case	Finance Division	Lisa Thomas	High
Other	Activity by PoD: Elective	Finance Division	Lisa Thomas	High
Other	Activity by PoD: Non Elective	Finance Division	Lisa Thomas	High
Other	Activity by PoD: Outpatients	Finance Division	Lisa Thomas	High
Other	Capital Expenditure: Building Projects Actual	Finance Division	Lisa Thomas	High
Other	Capital Expenditure: Building Projects Plan	Finance Division	Lisa Thomas	High
Other	Capital Expenditure: Building Schemes Actual	Finance Division	Lisa Thomas	High
Other	Capital Expenditure: Building Schemes Plan	Finance Division	Lisa Thomas	High
Other	Capital Expenditure: IM&T Actual	Finance Division	Lisa Thomas	High
Other	Capital Expenditure: IM&T Plan	Finance Division	Lisa Thomas	High
Other	Capital Expenditure: Medical Equipment Plan	Finance Division	Lisa Thomas	High
Other	Income by PoD: Other Actual	Finance Division	Lisa Thomas	High
Other	Income by PoD: Other Plan	Finance Division	Lisa Thomas	High
Other	Income by PoD: Outpatients Actual	Finance Division	Lisa Thomas	High
Other	Income by PoD: Outpatients Plan	Finance Division	Lisa Thomas	High
Other	Month on month cash balance	Finance Division	Lisa Thomas	High
Other	Month on month Income Analysis Actual	Finance Division	Lisa Thomas	High
Other	Month on month Income Analysis Plan	Finance Division	Lisa Thomas	High
Other	SLA Income: BSW CCG	Finance Division	Lisa Thomas	High
Other	SLA Income: Dorset CCG	Finance Division	Lisa Thomas	High
Other	SLA Income: Hampshire, Southampton and IoW CCG	Finance Division	Lisa Thomas	High
Other	SLA Income: Other	Finance Division	Lisa Thomas	High
Other	SLA Income: Specialist Services	Finance Division	Lisa Thomas	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	Lisa Thomas	High
Other	Agency Total Plan	Finance Division	Lisa Thomas	High
Other	Bank total Actual	Finance Division	Lisa Thomas	High
Other	Bank total Plan	Finance Division	Lisa Thomas	High
Other	Capital Expenditure: Additional funds approved in year Actual	Finance Division	Lisa Thomas	High
Other	Capital Expenditure: Additional funds approved in year Plan	Finance Division	Lisa Thomas	High
Other	Capital Expenditure: Medical Equipment Actual	Finance Division	Lisa Thomas	High
Other	Capital Expenditure: Other Actual	Finance Division	Lisa Thomas	High
Other	Capital Expenditure: Other Plan	Finance Division	Lisa Thomas	High
Other	Month on Month CAPEX Actual	Finance Division	Lisa Thomas	High
Other	Month on Month CAPEX Plan	Finance Division	Lisa Thomas	High
Other	Month on Month total pay Actual	Finance Division	Lisa Thomas	High
Other	Month on Month total pay Plan	Finance Division	Lisa Thomas	High

Salisbury NHS Foundation Trust

Report to:	Trust Board (Public)	**Agenda item:**	3.1
Date of Meeting:	08 September 2022		

Report Title:	Research Annual Report 21/22			
Status:	**Information**	**Discussion**	**Assurance**	**Approval**
	x		x	
Approval Process (where has this paper been reviewed and approved)	CMB			
Prepared by:	Louise Bell, Head of Research			
Executive Sponsor (presenting):	Dr Peter Collins, Chief Medical Officer			
Appendices (list if applicable):	Appendix A: Trust recruitment per trial Appendix B: Publications from Trust trials Appendix C: Managed recovery studies Appendix D: High Level Objectives 22/23			

Recommendation:
The report is presented for information and assurance.

Executive Summary:
The Trust has performed well in comparison to other Small Acute Trusts in 21/22. We have also had an increase in grants secured over the last 2 years which will in due course increase our RCF funding. The research department faces challenges with regards to staffing which will require new smarter ways of working

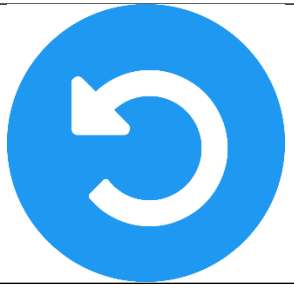
Board Assurance Framework – Strategic Priorities	Select as applicable
Population: Improving the health and well-being of the population we serve	☒
Partnerships: Working through partnerships to transform and integrate our services	☒
People: Supporting our People to make Salisbury NHS Foundation Trust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

NHS
Salisbury
NHS Foundation Trust

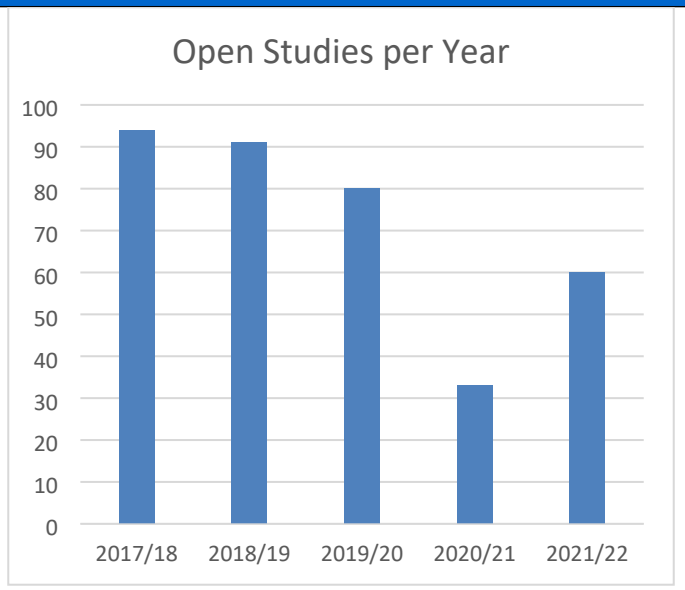
Research Performance Report 2021/22

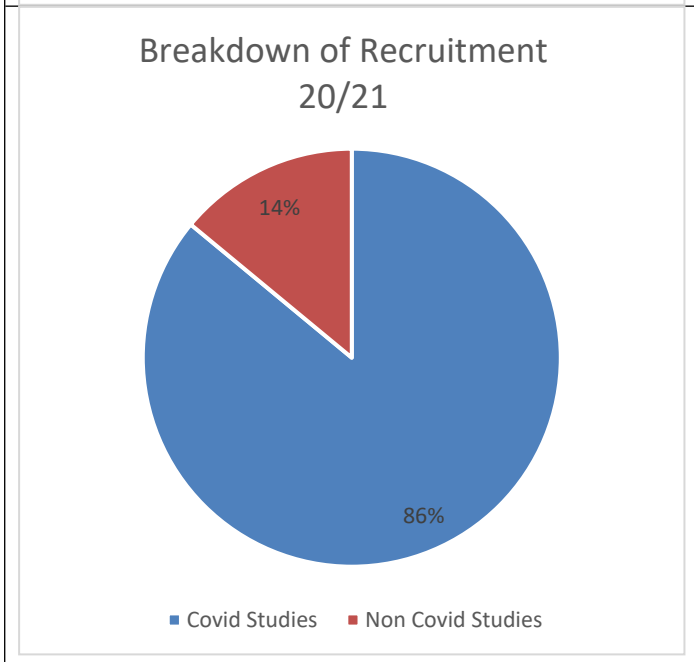
Contents

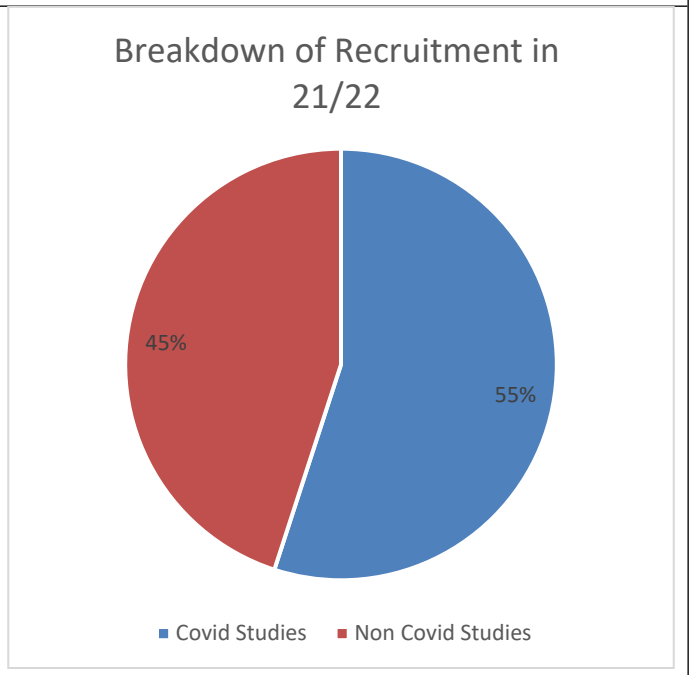
Summary

	**Trust recruitment begins to return to pre-covid levels**		**The Trust performed well compared to other Trusts of a similar size**
	**£1,529,668.61 research funding secured for 1 new research grants** **£705,320 research funding secured for 3 ongoing research grants**		**Research impact: New treatments for Covid continue to be discovered**
	**CRN:Wessex funding for well-being events**		**restarting our portfolio and managed recovery:** **Our contribution to NIHR high level objectives**
	**Challenges of supporting research post pandemic: staffing, space and culture**		

Trust recruitment into COVID-19 & non-COVID-19 trials







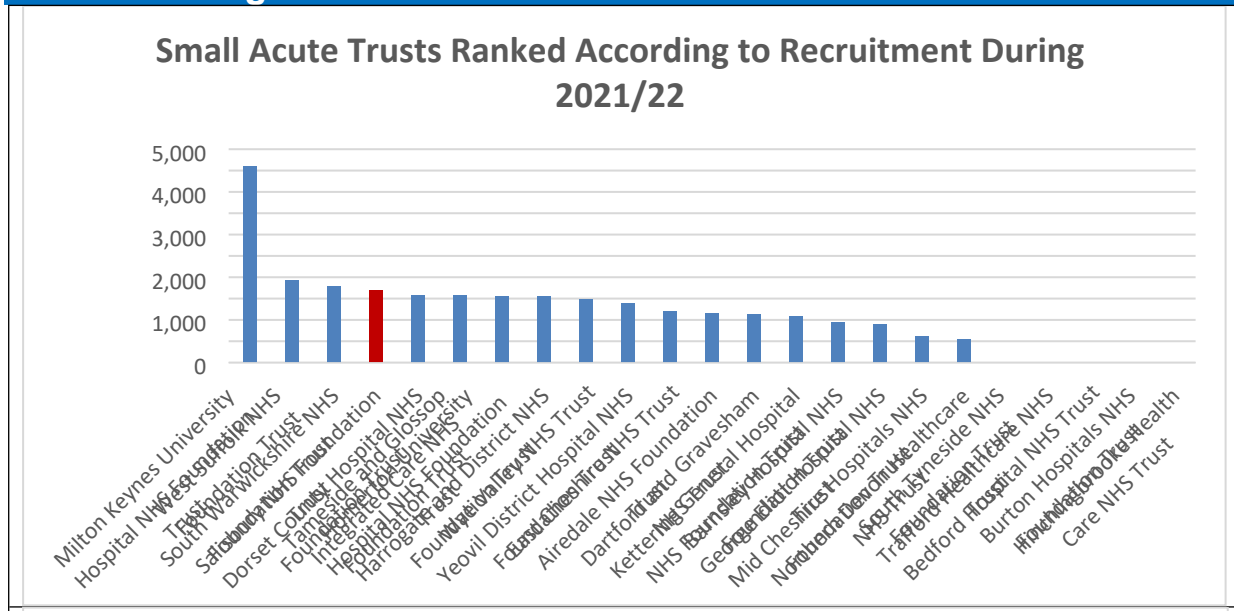
The Trust recruited 1669 study participants into NIHR portfolio research projects. This mirrors pre-covid recruitment. 60 studies recruited study participants, which is considerably lower than previous years than pre covid, however it is a substantial improvement on last year.

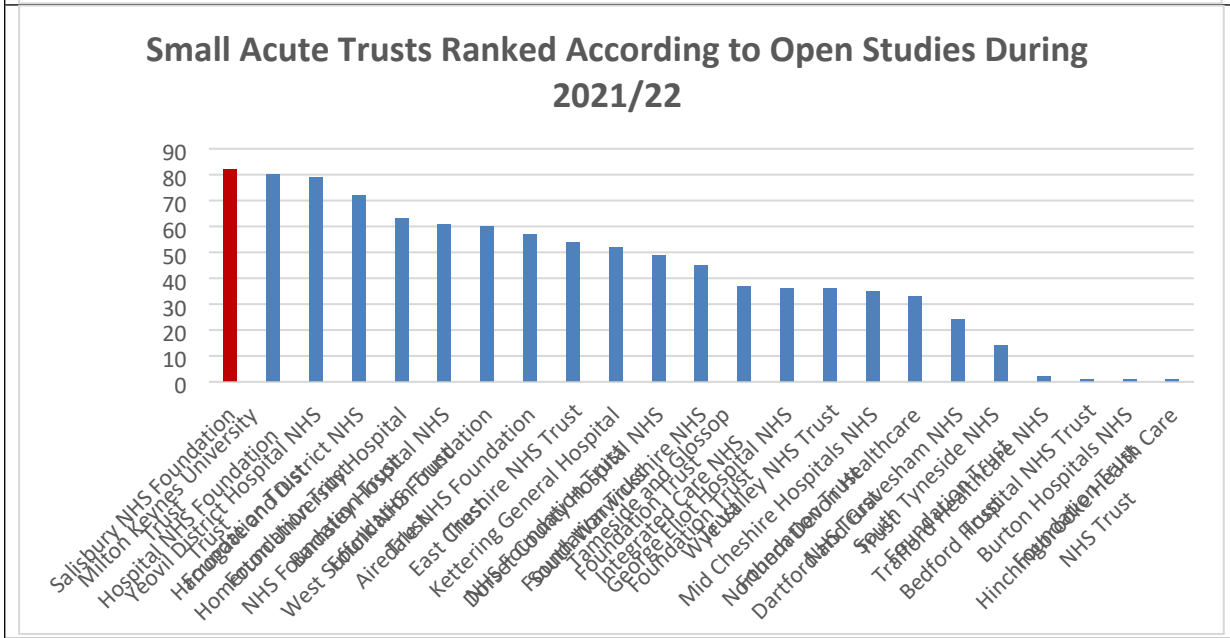
Recovery and resilience of our non-covid portfolio was a major theme in 21/22 whilst continuing to support Covid-19 studies. The majority (55%) of recruitment of participants was still to COVID-19 studies. However this is a substantial reduction in the percentage of recruitment to covid studies from last year. This includes recruitment to 13 new non-covid studies.

There are ongoing challenges and opportunities regarding the recovery and resilience of the portfolio. This is recognised nationally and the NIHR are taking steps to consider which studies continue to be viable. Further discussion on this will take place later in this report.

Ordinarily CRN:Wessex use a funding formulae and performance against targets to allocate funds to NHS Organisations. In the absence of Trust targets for 2020/21, the Trust is expected to receive flat funding from the network of £643,101.

Benchmarking – Small Acute Trusts





The Trust performed well on recruitment during 2021/22 when compared to other small acute trusts, ranking 4th overall. Milton Keynes was the only small acute trust to recruit over 2000 participants. This trust continues to recruit well into the NCSS study, which only recruits in the Milton Keynes area.

The Trust has the highest number of studies open compared to other small acute trusts. This reflects the work that has been done to re-open or replace the non-covid portfolio.

Research Grants Secured

Grants secured & recruitment started in 2021/22:

ELABS
Early Laser for Burn Scars – A prospective randomised, controlled trial to study the effectiveness of the treatment of hypertrophic burn scars with Pulsed Dye Laser and standard care compared to standard care alone

PI: Dr Mark Brewin
Funding: NIHR RfPB £348,209 over 36 months
Design: interventional

HIIT
A Feasibility Study of High Intensity Interval Training to Reduce Cardio-metabolic Disease Risks in Individuals with Acute Spinal Cord Injury

PI: Prof James Bilzon- Uni Bath
Funding: NIHR RfPB £250,000 over 27 months
Design: interventional

BOWMAN
A Randomised, Sham-Controlled, Proof of Principle Study of Abdominal Functional Electrical Stimulation for Bowel Management in Spinal Cord Injury

PI: Dr Tamsyn Street
Funding: Inspire Foundation £107,111 over 36 months
Design: interventional

Grants secured & recruitment starting in 2022/23:

STEPS II
The Efficacy of Peroneal Nerve Functional Electrical Stimulation for the Reduction of Bradykinesia in Parkinson's Disease: An Assessor Blinded Randomised Controlled Trial

PI: Prof Paul Taylor
Funding: NIHR EME £1,529,668.61 over 44 months
Design: interventional

3 research projects secured £705,320 external grant funding and are in the process of being set up. The 3 grants are predicted to recruit 60 participants between them in 2021/22.
A fourth grant is currently under consideration by the NIHR EME funding scheme.

Research Capacity Funding (RCF) is awarded to research active NHS Organisations that recruit >500 participants (£20k) OR received NIHR income in the previous calendar year (0.28 of income), whichever is greater. The Trust received £20k RCF funding for both 2020/21 and 2021/22. The grant income secured should provide a RCF income of £50k for 2022/23 and £64k for 2023/24. This is estimated to rise to over £117k in 2024/25 with the success of STEPS II grant application. This funding will be used to increase the research capacity in the Trust.

Global Impact of Local Involvement in Research

UK Public Health response to C19

The Trust continues to participate in Covid-19 research. We are still learning more about how to treat Covid. Results published from the research that is recruiting at the Trust includes the effectiveness of monoclonal antibodies and Baracitinib to treat patients with Covid-19. Aspirin and Convalescent Plasma has been shown to be ineffective. With new mutations we continue to participate in research looking at treatments for Covid-19 as some current treatments may be less effective against the latest variants

Long covid

The ISARIC study has found that one in two 7ospitalized Covid-19 patients develop a complication. We have been participating in long-covid studies including Phosp which will look at the impact of long covid in the first wave of covid. This study has recently closed but paricipants had the option to participate in treatment studies that follow on from the original data gathering. We also are currently involved in Heal-COVID which aims to prevent long-covid by adding medications. Compared to other Trusts we have recruited well to this study.

Vaccines

In 20/21 our staff supported the development of Covid-19 vaccines. This year Siren published results on the effectiveness of covid vaccines based on longitudinal data from healthcare staff. This can help inform booster vaccine schedules.

Non-covid research

There are fewer non-covid studies that have made us aware of their publications. This may be because of slow recruitment during 20/21.

A full list of publications may be found at Appendix B

CRN:Wessex Well being funding

In March 2022, CRN Wessex welcomed bids for funding for well-being within the research team and the wider Trust. £6,182 amount of funds were used towards 2 events and smaller well-being contributions including improving shared areas.

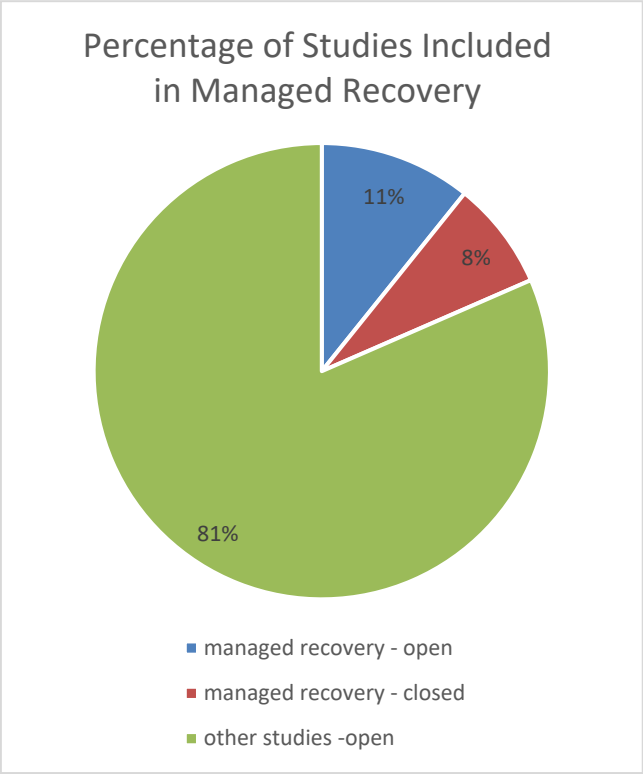
The first event saw the research department deliver over 4000 pizzas to staff across the Trust over 2 days. We received many thank you emails from across the Trust

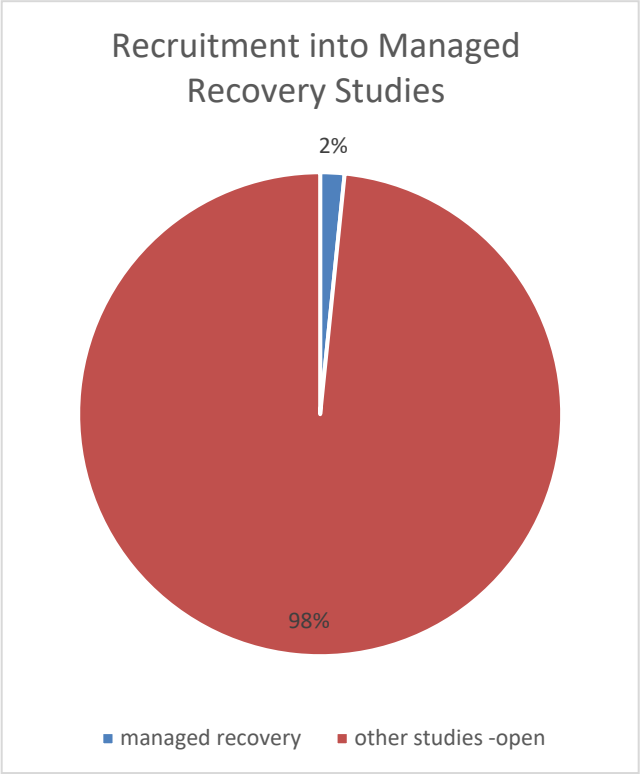
The second was a silver jewellery making event organised by Artcare for research staff which was attended by 19 of our staff

NIHR Portfolio Restart (non COVID-19 studies).

NIHR High level objectives for 2021/22

- 80% of new commercial studies recruiting to time and target (RTT)
- 80% of new commercial studies in the managed recovery process RTT
- 99% of NHS Trusts recruiting into NIHR portfolio studies
- 70% of NHS Trusts recruiting into NIHR portfolio commercial studies
- 12,000 study participants responding to the Participant Experience Survey (PRES)





The majority of the Trust research portfolio was suspended during the pandemic, alongside suspension of the clinical services and the national focus on running COVID-19 UPH therapeutic trials.

The NIHR proposed priorities for restart which included a recognition that covid-19 studies were ongoing and still a priority but that where possible Trusts focus on re-opening their non-covid studies. This started with an emphasis on non-covid treatment studies and then moved on to 'managed recovery' studies a subset of the portfolio deemed most important by funders. Trusts could choose whether to reopen these. This then informed the NIHR high level objectives are shown on the left. These high level objectives applied to CRN Wessex rather than the Trust.

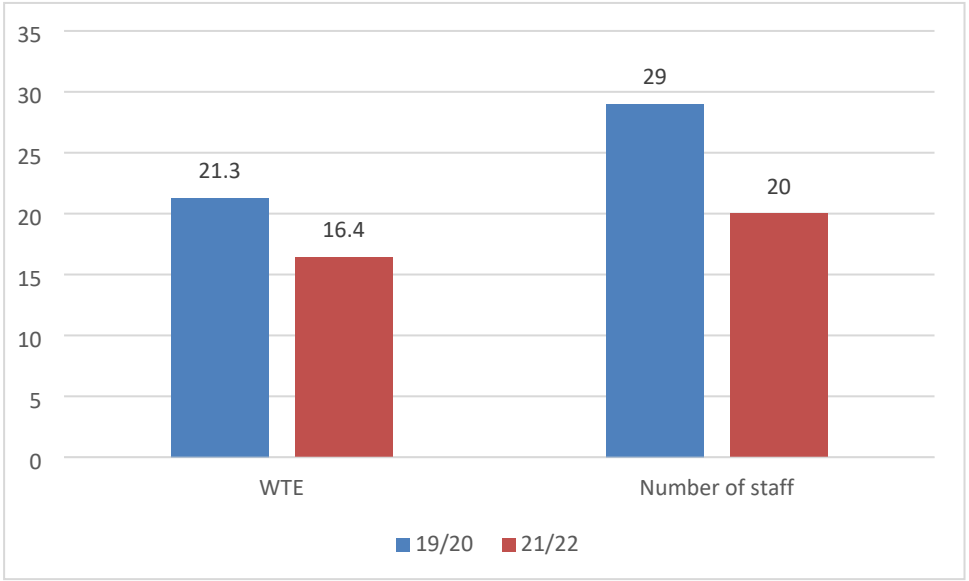
The Trust hosts both commercial and non-commercial NIHR portfolio studies. However only a small proportion of the Trust's pre-pandemic portfolio falls into the 'managed recovery' category. A total of our pre-pandemic 12 studies were chosen as part of the managed recovery portfolio. No commercial studies fell into this category. 5 of the 12 studies were not deemed feasible to reopen at site. A total of 27 participants were recruited to the remaining 7 studies. Of the 5 studies that closed at site 3 are closed nationally. 1 study achieved its target without prior to the start of the pandemic

Appendix 3 offers a list of individual studies.

The Trust offered participants the opportunity to complete a PRES (participant research experience survey). CRN Wessex hit the High level Objective target. SFT percentage contribution to this is unclear

Challenges in Research

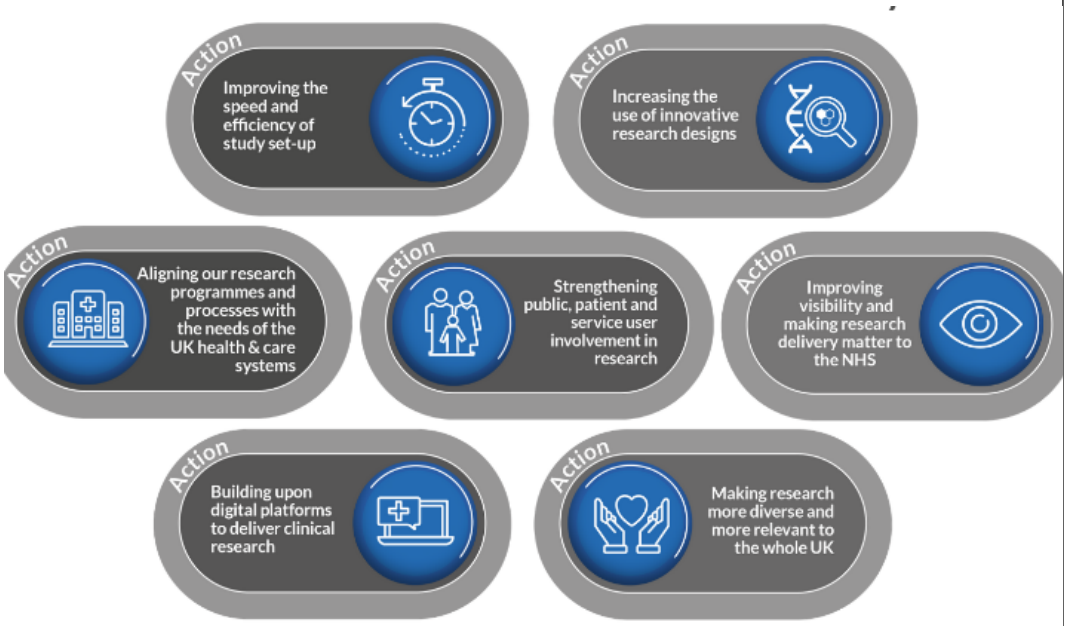
Research Dept Staffing levels



The majority of the Trust research portfolio was suspended during the pandemic, alongside suspension of the clinical services and the national focus on running COVID-19 UPH therapeutic trials. Suspension of these studies meant that there was little/no income from these funding sources – a loss of approximately £75 -150k income per year of the pandemic. When research staff came to the end of contracts, or left, funding was not available to replace them. The staffing levels in the research dept at the end of March 2021 was therefore 20% lower than March 2020. This has meant the department has had to analyse how to start research.

The department also underwent a culture review. The last interviews were concluded in March 2022. It is expected that the results of this review will be published in early 2022/23.

Strategic Plan for 2022/23



No going back

The challenges that the research department is now facing means that we could no longer support specialities having their own research nurse contact. The department now works in two teams to support the research across the Trust and to provide cover to studies.

In order to provide the best service that we can we are looking at working smarter. We can provide a more reliable service to those departments whose research patients come in on specific days or studies whose recruitment is so reliable that it warrants daily support. We will encourage departments to think about how they can facilitate this. In addition we will maximise opportunities to run our own virtual/telephone clinics to improve efficiency.

Dedicated space for research clinics is also a priority. We have been moved from rooms with little notice. This is disruptive and confusing for our participants. The lack of clinical space also means that our staff are using their time moving around the hospital. Furthermore there is a risk that if one patient appointment runs late, the next might be missed as it is taking place in a different part of the hospital. Finally it can mean that it is difficult for us to make appropriate adjustments for staff if mobility is an issue.

We expect that next year there will be a strong focus on improvements that can be made as a result of the culture review report. It is expected that implementing recommendations will improve our department's well-being and resilience as well as improving the way we work in line with the Trust values.

We will continue to develop our non-clinical research delivery roles, and support healthcare professionals to develop research skills relevant to their clinical roles (e.g. associate PI scheme). We will also continue to contribute to CRN Wessex's achievement of NIHR High Level Objectives. The challenge for this year will be restarting a commercial portfolio.

Appendix A – Research recruitment 2021/22

Table 1: Recruitment into non COVID studies

CPMS Study ID	Managing Specialty	Short Name	Design Type	Recruitment	Principal Investigator
41168	Anaesthesia, Perioperative Medicine and Pain Management	Children's Acute Surgical Abdomen Programme	Observational	15	Fenner, Lynn
42290	Anaesthesia, Perioperative Medicine and Pain Management	ObsQoR	Observational	5	Holmwood, Dr Xantha
49713	Anaesthesia, Perioperative Medicine and Pain Management	SNAP 3	Observational	40	
12255	Cancer	OPTIMA	Interventional	5	Bradbury, Dr Jenny
17006	Cancer	IMPRESS Trial	Interventional	12	Branagan, Mr Graham
17059	Cancer	SERENADE	Both	12	Branagan, Mr Graham
20576	Cancer	TRIGGER Trial	Interventional	2	Branagan, Mr Graham
35640	Cancer	The COMET Trial	Interventional	21	Branagan, Mr Graham
44010	Cancer	Body composition and chemotherapy toxicity in breast cancer (CANDO-3)	Observational	16	Brown, Ms Victoria
18218	Cancer	AML19	Both	1	Cullis, Dr Jonathan
42281	Cancer	Myeloma XIV (FiTNEss)	Interventional	3	Parker, Dr Tracey
42347	Cardiovascular Disease	CHAPS; version 1.0	Interventional	9	Cullis, Dr Jonathan
43791	Cardiovascular Disease	ORBITA-2	Interventional	5	Sinha, Dr Manas
37105	Cardiovascular Disease	CLEAR SYNERGY (OASIS 9)	Both	6	Wells, Dr Tim
49687	Children	Breathe4T – Stage 3	Both	1	Gray, Sebastian
49143	Dermatology	Early Laser for Burn Scars (EL4BS)	Interventional	3	Brewin, Dr Mark
8090	Dermatology	BADBIR	Observational	6	Mellor, Dr Serap
10646	Dermatology	Bio-markers of systemic treatment outcomes in Psoriasis	Observational	10	Mellor, Dr Serap
9689	Diabetes	DRN 552 (Incident and high risk type 1 diabetes cohort – ADDRESS-2)	Observational	2	Anderson, Dr Chris
43484	Ear, Nose and Throat	CLEARA	Observational	3	Phippen, Ginette
43148	Gastroenterology	Ustekinumab Real World Evidence Study	Observational	4	Anthony, Alpha
14145	Haematology	UK Childhood ITP Registry	Observational	1	Diment, Sarah
47124	Health Services Research	The use of locum doctors in the NHS	Observational	1	no local investigator
47506	Health Services Research	National AHP Research RCC Survey	Observational	36	no local investigator

48260	Musculoskeletal Disorders	High Intensity Interval Training in Acute Spinal Cord Injury_v1	Both	9	Fard, Dr Aram
35622	Neurological Disorders	Neuro LTC Study Version 1.0	Observational	11	Anthony, Alpha
44971	Neurological Disorders	BOWMAN V. 12.0	Interventional	35	Street, Tamsyn
50554	Neurological Disorders	Tetragrip	Interventional	2	Taylor, Dr Paul
37410	Neurological Disorders	Regain	Observational	1	Baird, Dr Jim
41819	Ophthalmology	PINNACLE	Observational	5	Arora, Dr Rashi
44414	Renal Disorders	Survey: Professionals' Education & Awareness of Continence care SPEAC	Observational	48	No local investigator
36723	Reproductive Health and Childbirth	The 'Big Baby Trial'	Both	5	Baden-Fuller, Jo
14362	Reproductive Health and Childbirth	The Cleft Collective Cohort Studies	Observational	23	Phippen, Ginette
37933	Reproductive Health and Childbirth	OPHELIA study – Causes of Gestational Diabetes	Observational	41	Rand, Mrs Abby
39971	Reproductive Health and Childbirth	The POOL study	Observational	306	Rand, Mrs Abby
40836	Stroke	Optimas	Interventional	2	Black, Dr Toby
42795	Reproductive Health and Childbirth	LOCI: Letrozole Or Clomifene for Ovulation Induction	Interventional	15	Umranikar, Aarti
35821	Surgery	The CIPHER study	Observational	1	Branagan, Mr Graham
40430	Surgery	Short or Long Antibiotic Regimes in Orthopaedics (SOLARIO)	Interventional	1	Jacobs, Mr Neal
44426	Trauma and Emergency Care	SHED	Observational	8	Ellis, Dr Peter
			TOTAL	754	

Table 2: Recruitment into COVID-19 studies

CPMS Study ID	Managing Specialty	Short Name	Design Type	Recruitment	Principal Investigator
45932	Infection	FALCON C-19	Observational	31	Anthony, Alpha
46443	Respiratory Disorders	PHOSP-COVID	Observational	126	Anthony, Alpha
48890	Infection	HEAL-COVID trial	Interventional	29	Cullis, Dr Jonathan
30540	Critical Care	GenOMICC	Observational	27	Donnison, Dr Phil
38197	Critical Care	REMAP-CAP	Interventional	13	Donnison, Dr Phil
14152	Infection	Clinical Characterisation Protocol for Severe Emerging Infection (ISARIC)	Observational	444	Donnison, Dr Phil
45621	Mental Health	Psychological Impact of COVID-19	Observational	187	Fennelly, Mrs Ruth
45388	Infection	RECOVERY trial	Interventional	81	Sinha, Dr Manas
			TOTAL	**938**	

Appendix B –Research publications

-

study	specialty	summary	link
PRESSURE 2	Dematology	Study findings have usefully informed the scientific and practical issues of blinded assessment of PU status to reducing the risk of bias in medical device trials. The reliability of central blinded expert photography was found to be 'very good' (PABAK). Photographs have been found to be an acceptable method of data validation for participants.	https://trialsjournal.biomedcentral.com/articles/10.1186/s13063-021-05262-0
Cleft collective	children	Early Communication Behaviors in Infants With Cleft Palate With and Without Robin Sequence: A Preliminary Study finds that Both groups reported similar levels of early communication	https://journals.sagepub.com/doi/pdf/10.1177/10556656211031877
RECOVERY	COVID-19	Convalescent plasma in patients 14ospitalized with COVID-19	https://www.thelancet.com/journals/lancet/article/PIIS0140-6736(21)01064-3/fulltext?utm_campaign=lancetcovid21&utm_source=twitter&utm_medium=social
RECOVERY	COVID-19	Colchicine in patients admitted to hospital with COVID-19 (RECOVERY): a 14ospitaliz, controlled, open-label, platform trial	https://www.medrxiv.org/content/10.1101/2021.05.18.21257267v1
RECOVERY	COVID-19	Monoclonal antibody treatment saves lives of seronegative 14ospitalized COVID-19 patients	https://www.nihr.ac.uk/news/recovery-trial-monoclonal-antibody-treatment-saves-lives-of-seronegative-hospitalised-covid-19-patients/27922
RECOVERY	COVID-19	RECOVERY trial finds aspirin does not improve survival for 14ospitalized COVID-19 patients	https://www.nihr.ac.uk/news/recovery-trial-finds-aspirin-does-not-improve-survival-for-hospitalised-covid-19-patients/27872
ISARIC	COVID-19	Landmark study finds one in two 14ospitalized Covid-19 patients develop a complication	Characterisation of in-hospital complications associated with COVID-19 using the ISARIC WHO Clinical Characterisation Protocol UK: a prospective, multicentre cohort study – The Lancet
SIREN	COVID-19	COVID-19 vaccine coverage in health-care workers in England and effectiveness of BNT162b2 mRNA vaccine against infection (SIREN): a prospective, multicentre, cohort study	COVID-19 vaccine coverage in health-care workers in England and effectiveness of BNT162b2 mRNA vaccine against infection (SIREN): a prospective, multicentre, cohort study – The Lancet
RECOVERY	COVID-19	Colchicine in patients admitted to hospital with COVID-19 (RECOVERY): a 14ospitaliz, controlled, open-label, platform trial – Cochicine In adults 14ospitalized with COVID-19, colchicine was not associated with reductions in 28-day mortality, duration of hospital stay, or risk of progressing to invasive mechanical ventilation or death.	https://www.thelancet.com/journals/lanres/article/PIIS2213-2600(21)00435-5/fulltext#.YW7YTRIyM9w.twitter
RECOVERY	COVID-19	REGN-COV2 synthetic monoclonal antibodies that we used as part of RECOVERY trial have now been licensed for treatment of COVID-19 patients.	
Pressure ulcer prevention after spinal cord injury	Neurological	Detection of posture and mobility in individuals at risk of developing pressure ulcers	https://www.sciencedirect.com/science/article/abs/pii/S1350453321000291?via%3Dihub

Appendix C –Managed Recovery Studies

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CPMS ID	IRAS ID	Short Name	Commercial / Non-commercial	Managing specialty	Status	Recruitment in 2021/22	Total recruitment at SFT	Target recruitment at SFT	Target achieved
10622	74277	CR UK Stratified Medicine Pilot study	Non-Commercial	Cancer	Closed to Recruitment, did not reopen	0	76	60	✓
12255	95626	OPTIMA	Non-Commercial	Cancer	Open	5	37	23	✓
16675	126738	FLAIR	Non-Commercial	Cancer	Open	0	10	6	✓
18067	120104	Add-Aspirin	Non-Commercial	Cancer	Closed to recruitment at site only, did not reopen	0	77	153	✗
31982	191168	IRONMAN	Non-Commercial	Cardiovascular Disease	Closed to Recruitment, did not reopen	0	3	6	✗
32907	188554	Myeloma XII (ACCoRd trial)	Non-Commercial	Cancer	Closed to recruitment at site only, did not reopen	0	2	5	✗
36723	229163	The ‘Big Baby Trial’	Non-Commercial	Reproductive Health and Childbirth	Open	5	38	19	✓
37822	238346	PROFHER2 Trial	Non-Commercial	Trauma and Emergency Care	Open	0	4	8	ongoing
40836	249552	OPTIMAS Trial	Non-Commercial	Stroke	Open	2	7	15	ongoing
41515	259931	SCIENCE	Non-Commercial	Trauma and Emergency Care	Open	0	1	1	✓
42795	257918	LOCI	Non-Commercial	Reproductive Health and Childbirth	Open	15	15	12	✓
43740	265559	WAX	Non-Commercial	Trauma and Emergency Care	Closed to Recruitment, did not reopen	0	6	24	✗

	Total	**27**

Appendix D –High Level Objectives

-

Objective	Definition	Measure	Ambition	Comments
Efficient Study Delivery	Deliver NIHR CRN Portfolio studies to recruitment target	(1)Percentage of closed to recruitment commercial studies which have achieved their recruitment target	TBC	None open
		(2)Percentage of closed to recruitment non-commercial studies which have achieved their Recruitment target	TBC	reviewed regularly. We have a strong feasibility process.
Provider participation	Widen participation in research by enabling the involvement of a range of health and social care providers	(1) Percentage of GP practices with recruitment into NIHR Portfolio	45%	We can support this with collaborations
		(2) Percentage of NHS Acute Trusts with recruitment into NIHR Portfolio every quarter	99%	Achieved
		(3) Percentage of NHS Acute Trusts with recruitment into commercial NIHR Portfolio every quarter	70%	Currently not achieving this
		(4) Percentage of NHS Ambulance, care and Mental Health Trusts with recruitment into NIHR Portfolio every quarter	95%	Likely to be achieved

Participant experience	**Demonstrate to participants in NIHR portfolio research that their contribution is valued**	**Number of NIHR Portfolio study participants responding to Participant Research Experience Survey (PRES)**	**1650**	• **Contribute to this** • **PRES lead**

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Research Annual report 21/22

8 Sept 22

An outstanding experience for every patient

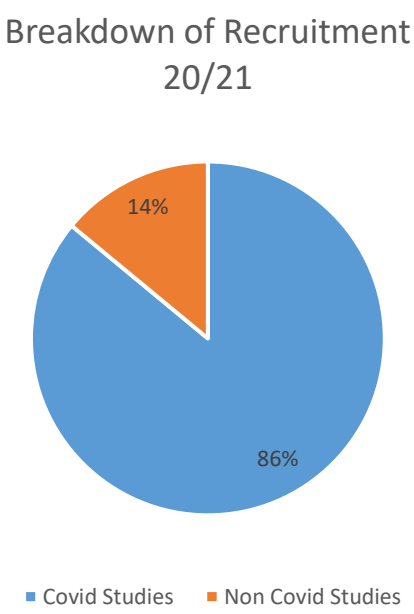
Research Annual report 21/22

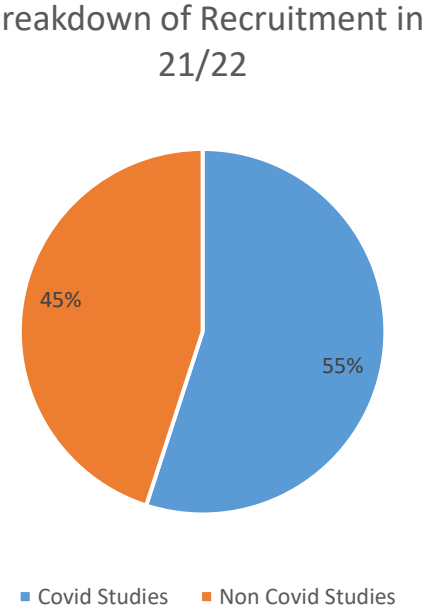
Some key things to think about:

- Apologies
- Managed recovery
- New High Level Objectives published
- Current situation
- Opportunities for the future

Apologies

Incorrect graphs





Managed Recovery

- The High Level Objective was CRN Wessex wide
- Participating/restarting managed recovery studies was optional
- Most of previous portfolio were not managed recovery studies
- We chose not to restart some of the managed recovery portfolio
- Managed recovery has now been abandoned nationally

New High Level Objectives

Objective	Definition	Measure	Ambition	Comments
Efficient Study Delivery	Deliver NIHR CRN Portfolio studies to recruitment target	(1)Percentage of closed to recruitment commercial studies which have achieved their recruitment target	TBC	None open
		(2)Percentage of closed to recruitment non-commercial studies which have achieved their Recruitment target	TBC	reviewed regularly. We have a strong feasibility process. ✓
Provider participation	Widen participation in research by enabling the involvement of a range of health and social care providers	(1) Percentage of GP practices with recruitment into NIHR Portfolio	45%	We can support this with collaborations ✓
		(2) Percentage of NHS Acute Trusts with recruitment into NIHR Portfolio every quarter	99%	Achieved ✓
		(3) Percentage of NHS Acute Trusts with recruitment into commercial NIHR Portfolio every quarter	70%	Currently not achieving this ✗
		(4) Percentage of NHS Ambulance, care and Mental Health Trusts with recruitment into NIHR Portfolio every quarter	95%	Likely to be achieved ✓
Participant experience	Demonstrate to participants in NIHR portfolio research that their contribution is valued	Number of NIHR Portfolio study participants responding to Participant Research Experience Survey (PRES)	1650	• Contribute to this • PRES lead ✓

Current situation

- Culture review
- New people in key roles, some internal restructuring
- Staffing levels are down compared to pre-pandemic
- Not back to activity-based funding
- Reset- important for our grant funded studies

Opportunities

- Successful grant applications will bring increased RCF in the next few years
- Taking advantage of digital technology and pandemic-proofing of studies to look at working smarter
- Opportunities to support our staff to become more research active
- Opportunities to increase our collaborations with other partners

Salisbury NHS Foundation Trust

Report to:	Trust Board (Public)	Agenda item:	4.1
Date of Meeting:	08 September 2022		

Report Title:	Estates Technical Services – Status Report September 2022			
Status:	Information	Discussion	Assurance	Approval
	x			
Prepared by:	Brian Johnson, Director of Estates			
Executive Sponsor (presenting):	Brian Johnson, Director of Estates			
Appendices (list if applicable):	Appendix A – Estates Technical Services Report September 2022			

Recommendation:

The Board is asked to note the content of the paper summarising the work of the Estates Technical Services (ETS) and Capital Projects teams, including the current status and ongoing risk position.

Executive Summary:

This report provides updates from the previous report to the Private Board of Directors 7th July 2022.

As noted in the previous report, the timing of this report is shorter than usual to re-align the report to quarterly, the next report due to Trust Board will be December 2022.

We are in a reasonable position for staffing across the Estates team, but continue to struggle to recruit to key vacancies. We have revaluated the job descriptions and routes through which we seek to recruit but this has not generated any immediate improvement. We have one agency staff member and utilise bank staff to fill current vacancies whilst we try to recruit. We are continuing to use some resource from the RUH within both Estates and Capital teams, although this has reduced from our position last year.

The Trust undertakes maintenance of the estate via our in-house team, the prolonged hot weather during July and August caused some issues with our ventilation and cooling systems but did not significantly increase the reactive maintenance requests beyond what we typically experience month to month.

We continue to make good progress with our compliance action plan and whilst we are closing and/or reducing Estates risks through action and mitigation, this work is expected to continue throughout the remainder of this financial year.

Capital project delivery is progressing well and largely reflects our plan for the year. We are currently assessing potential slippage with the replacement of our main gas fired

boilers in the energy centre, this is directly linked to the availability of national funding for sustainability and decarbonisation of our heat infrastructure. The team are undertaking further investigations and coordinating via the Capital Control Group committee.

Development of the new elective recovery ward block is progressing in line with program and we have now identified decant plans that will allow us to commence moves across the Estate utilising the previously empty Douglas Arter Building.

The sterile services refurbishment project tenders are due for return in mid August, with a project steering Board convened to review the responses and next steps due in late August. The current program is for works to commence December 2022.

We were unsuccessful with our bid for Salix funding in July (for fees associated with decarbonising our heat infrastructure). We are currently working with CEF to develop a c£10m bid for the next round of funding due in September 2022, which will increase electrical capacity on site and move to 'electrification' allowing us to significantly reduce our reliance on natural gas to generate heat and hot water.

The final submission of the annual Estates Return Information Collection (ERIC) was made by the 30th June deadline. We have received queries from NHSEI and are currently working through these.

The National submission of the NHS Premises Assurance Model (PAM) is due for submission on 9th September 2022. The Estates team has compiled the data and associated evidence and our formal report has been approved by the Chief Operating Officer. A copy of the full report will be issued to the Finance & Performance committee in September for transparency and governance. This year's submission has seen improvement from last year with most areas progressing by at least one rating.

The Trust environmental sustainability position is gaining increasing focus and we are looking more closely at a long-term strategy to achieve net carbon zero. A key part of this strategy will be the need to improve our existing estate fabric performance through the improvement of insulation, windows, reducing heat loss and energy efficiency. We also understand that future funding opportunities will expect Trusts to demonstrate such actions have been taken or are planned, in order to qualify. We are currently looking more closely at new strategies for sustainability and energy and an updated estates strategy.

We have previously highlighted the Trust Board of Directors the competing demands for capital investment across the SFT estate, all of which are significant. Notwithstanding our high estates backlog position there is a need for significant investment in sustainability to move toward net carbon zero and investment in the redevelopment and update of our estate to provide modern, fit for purpose facilities. These are clear priorities for Estates and Capital projects but we recognise the Trust needs to invest in Digital, IT, Medical Equipment and the delivery of all our patient services.

The Trust is not isolated from the current risks of inflation and we expect our gas and electricity unit costs to rise. We will provide further commentary within our report to the next Trust Finance & Performance committee.

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) -	☐

Appendix A – Estates Technical Services Report September 2022

1.0 Introduction

This is the quarterly update to the Trust Board of Directors for activity within the Estates Technical Services (ETS) and Capital Project teams.

There are no extraordinary elements to report this period for Estates activity and we continue to make steady progress with the Estates compliance action plan as previously reported to the Trust Board of Directors. Whilst we are closing and/or reducing Estates risks through action and mitigation, this work is expected to continue throughout the remainder of this financial year. We are targeting conclusion of many actions within the year so as to be able to re-balance our attention between business-as-usual planned and reactive maintenance, and governance and compliance.

Our regular planned and reactive maintenance continues to be delivered via the in-house team. The prolonged hot weather during July and August caused additional challenges with our cooling and ventilation systems, but these were addressed and some further work on ventilation system resilience is being investigated as a result.

The senior Estates team (Director, Heads of Estates and Capital) meet monthly and produce progress reports to aid decision making, prioritisation, resource and governance. With good progress to date on compliance activity we are now turning our attention to the environmental sustainability of the Estate via a sustainability strategy, plus an energy strategy and an update to the existing estates strategy. Each of these strategies requires further work before they are ready to submit to the Trust Board of Directors and each strategy is closely interlinked, also requiring appropriate coordination with the work undertaken to date with the site redevelopment plan and the more recently emerging development of the elective recovery ward.

Capital project delivery is progressing well and we expect September to be the peak of cashflow expenditure in line with our forecast.

Development of the new ward block is progressing in line with program and we have now identified decant plans that will allow us to commence moves across the Estate utilising the previously empty Douglas Arter Building.

Although the Trust was unsuccessful in its bid for Salix funding in July (for fees associated with decarbonising our heat infrastructure) we are working closely with CEF and developing a c£10m bid for the next round of funding due in September 2022.

2.0 Staff

We continue to develop the team with significant investment this year via our training budget. As the year progresses we are able to access more courses and realise bookings as training providers return to normal capacity following the pandemic. Where necessary, training is being prioritised to match our higher risks and where we have the appropriate staff in the team to undertake training.

Additional training has been delivered between SFT and FES colleagues for the main energy centre where there are shared responsibilities, particularly in the event of emergency or out-of-hours call out.

The Head of Estates chairs a weekly team meeting with the senior team, with specific focus on our compliance action plan progress alongside activity through the week and the week ahead. This forum also provides staff an update on matters from wider Trust meetings and committees.

The Deputy Operations Manager delivers weekly tool-box talks to the operational team and we maintain and update the schedule to ensure relevant topics are included and key topics regularly refreshed.

The monthly meeting between the Director of Estates, the Head of Estates and the Head of Capital projects continue with monthly update reports from Estates and Capital.

Recruitment to the Estates team continues and remains challenging, particularly for skilled trades such as electricians where NHS AfC rates may not compare to salary rates in the private sector and we have observed pay rate differentials as a factor for some staff turnover.

Over recent months we have reduced our use of contractors to assist with Estates maintenance activities as we have stabilised in-house operational resource and are better placed to utilise bank resource, although we are still using some bank and one agency staff member.

The current Estates team structure comprises:

Description	No.	Notes
Estates Posts	40	Includes vacancies.
Permanent Vacancies	10	
Sub Total	**30**	
Bank Staff	6	
Agency Staff	1	
Overall Current Position	**-3**	

As previously advised, the number of vacancies compared to 2021 has not significantly reduced. We have recruited through the year and had success appointing to new posts, the apparent static number is due to some staff turnover and the revised Estates structure. As noted we have some posts (e.g. Senior Estates Officer – Mechanical) where we have struggled to receive applicants or suitable candidates.

Estates team mandatory training status continues to remain high in most categories as demonstrated via the data below.

Top Level by Training Title

KEY: 0-79% 80-84% 85-100%

Report database last refreshed on 24/08/2022 at 03:38:05

Training Title	Number complete	Number incomplete	Number in target group	Compliance
Equality and Diversity 122014	27	2	29	93%
Fire Safety 122014	29		29	100%
Hand Hygiene Assessment 122014	27	2	29	93%
Infection Control 122014	29		29	100%
Information Governance 122014	29		29	100%
Moving and Handling 122014	29		29	100%
Prevent - 122014	29		29	100%
Safeguarding Adults Level 1 - 122014	28	1	29	97%
Safeguarding Children Level 1 122014	28	1	29	97%
Overall:	255	6	**261**	98%

Department	Training Title	Number complete	Number incomplete	Number in target group	Compliance
ETS Support Staff (Dept)	Equality and Diversity 122014	12		12	100%
	Fire Safety 122014	12		12	100%
	Hand Hygiene Assessment 122014	11	1	12	92%
	Infection Control 122014	12		12	100%
	Information Governance 122014	12		12	100%
	Moving and Handling 122014	12		12	100%
	Prevent - 122014	12		12	100%
	Safeguarding Adults Level 1 - 122014	12		12	100%
	Safeguarding Children Level 1 122014	12		12	100%
ETS Support Staff (Dept) Overall		107	1	108	99%

Department	Training Title	Number complete	Number incomplete	Number in target group	Compliance
Maintenance & Improvements (Dept)	Equality and Diversity 122014	13	2	15	87%
	Fire Safety 122014	15		15	100%
	Hand Hygiene Assessment 122014	14	1	15	93%
	Infection Control 122014	15		15	100%
	Information Governance 122014	15		15	100%
	Moving and Handling 122014	15		15	100%
	Prevent - 122014	15		15	100%
	Safeguarding Adults Level 1 - 122014	14	1	15	93%
	Safeguarding Children Level 1 122014	14	1	15	93%
Maintenance & Improvements (Dept) Overall		130	5	135	96%

We continue to monitor contact from the Estates team via the Freedom to Speak Up guardian, noting there have been no contacts in the last reporting period and continuing the zero/low level contact of the last 16 months. Whilst this is clearly positive we do not take this for granted. In June we re-commenced a monthly meeting with the whole Estates team to engage and share information and updates. The format for these meetings is developing and changing as we seek to idientify a format that best engages all colleagues and generates discussion.

With support from the HR team we are investigtaing some engagement sessions suppotred by ChangeMakers, a local organisation that has assisted other teams across the Trust. We have held an initial investigative meeting and provided the brief summarised below;

- Requirement for a Team building element, bringing closer the operational and management teams.
- Requirement to split the team into two groups, for operational purposes.
- To improve communications across the whole team, addressing any ‘silo' areas.
- To provide skills and techniques the team can continually adopt to improve communication and relationshsip across the whole team.
- Establish a clear structure and approach that we can implement for the long term (the skills and techniques referenced above), but also that provides grounding and a pre-cursor to the Trust Improving Together program.
- To recognise the importance of co-creation across the team
- To support a team review of the current Estates vision; what do the team want and how do they take ownership and deliver the vision.

We envisage this external input would comprise three to four sessions with the whole team, over the course of twelve months, but this is also subject to final scope, costs and benefits. Whilst we work through this we will continue the monthly meetings with the team.

3.0 Compliance

We have regularly updated the Private Board of Directors on the status of the Estates team and our compliance position. This has also been reported monthly to the Trust Finance and Performance committee, although at the last F&P meeting in August, the report frequency was requested to move to quarterly.

Our overall Estates compliance position continues to improve and is a key focus for the team, with the compliance plan providing our single and central point of reference from which we manage, monitor and progress Estates activity.

Whilst we are achieving a regular overall reduction in compliance actions and reducing the Trust risks, some of our actions involve mitigations which reduce initial risks and transfer them (once mitigated) to lower risk categories, this is reflected in the status between ‘Initial’ and ‘current’ shown in the table below.

	Extreme %	High %	Moderate %	Low %
Initial Risks	74%	25%	1%	0%
Current Risks	36%	46%	4%	14%

Since the compliance action plan has become the Estates ‘go-to’ document for compliance, we also add new items if/when they arise and this is normally linked to the receipt of Authorising Engineer (AE) audits. We have previously captured all AE audit actions, although the next phase of annual audits is planned to commence in the next few months.

The most recent additions to the compliance plan have been actions associated with the AE audit for confined spaces in June. The Audit re-confirmed all spaces (there was no change or de-classification) and the actions relate to installing updated signage and training for Estates staff, many of which have already been completed. We have previously checked and verified that all confined spaces across the Estate are secure.

There have been no new additions to the compliance plan in the last month.

Whilst we are mitigating, reducing and closing risks from the Estates compliance plan, the overall number of risks to the Trust still remains high. As previously advised to the Trust Board we expect it will take the remainder of this financial year to close a number of risks and reduce the quantity to a reasonable level. A considerable amount of additional effort is being contributed by the Estates team to close actions and manage these risks. Our strategy is to continue this increased focus throughout the year and beyond, recognising we cannot close every risk due to time and investment requirements. The overall quantity and level of Estates risks are reviewed each month by the Estates team.

We are pleased to confirm that the majority of Estates policies have been ratified via the relevant Trust committees, the latest status of Estates policies is shown below.

Policy	**Status**
Fire and arson	In place
Electrical - Low voltage	Approved OMB July 2022
Water safety	In place
Medical Gas	With Medical Gas Committee for comment
Specialist ventilation	In place
Pressure Systems	In place
Lifts	In place
Working at Height	In place
Confined spaces	In place
Asbestos Management Plan	Incorporating comments from AE
Control of Contractors	Submitted to H&S Committee Sept 2022
Natural Gas	Draft in progress

The Director of Estates has previously clarified to the Trust Board of Directors their responsibilities for Estates systems and services as defined through the Health Technical Memorandums (HTMs). The new Estates polices (the majority now approved) recognise these responsibilities and delegate from the Chief Executive Officer (CEO) or the Trust Board via the Director of Estates a Designated Person. Within the policies, the Designated Person may then delegate some aspects further to relevant colleagues and sub-committee's (i.e. Head of Estates, Water Safety Group etc).

The table below reflects the Estates responsibilities as defined in the policies (note this lists Designated Person only, not beyond to others or sub-committees).

Specialist Discipline	Duty Holder	Designated Person
Asbestos	Chief Executive	Director of Estates
Confined Spaces	Chief Executive	Director of Estates
Electric (Low Voltage)	Chief Executive	Director of Estates
Lifts	Chief Executive	Director of Estates
Ventilation	Chief Executive	Director of Estates
Water	Chief Executive	Director of Estates
Working at Height	Chief Executive	Director of Estates
Fire	Chief Executive	The Chief Executive discharges the day-to-day operational responsibility for fire safety through the Director with fire safety responsibility
Pressure Systems	Chief Executive	Director of Estates

During September an internal Trust audit will commence with Estates via our auditors PWC. The Terms of Reference have been agreed with the focus on backlog maintenance.

We reported in July to the Trust Board of Directors, that Fire risk assessments (FRA) for all SFT buildings were complete and in place. We have now commenced a review of existing FRA's to maintain their validity.

Fire compartmentation remedial works continue in high priority/high risk locations, via allocated in-year budget of £250k, to Spinal Unit, Day Surgery, Accommodation and SFT North areas. Further budget is allocated and is being used to address further findings from the ongoing compartmentation surveys. We will deliver fully against available fire budget within the financial year.

Work continues on other aspects of fire safety including upgrades of the fire alarm system and continued survey and replacement of fire doors. These works are planned via the Capital program with budget in year and contractors delivering.

Electrical Installation Condition Report (EICR) testing commenced at the start of the financial year and a number of Trust areas have now been completed. Progress continues according to our plan with the test and inspection undertaken by an appointed third party specialist electrical contractor. A limited quantity of urgent remedial works have arisen and immediately addressed directly by the Estates team (on the same day they are identified). Lower priority actions are collated and categorised, allowing prioritisation within the EICR budget (a contingency provision was included in the contract to address matters arising).

We continue on program with the EICR works with testing ongoing throughout the remainder of this year to achieve the necessary Estates compliance with regulatory requirements.

Work continues for the implementation of a new and updated Asbestos Management Plan, led by our Head of Estates. We have worked closely with our external Authorising Engineer (AE) and are now in the process of finalising the new policy and associated operating procedures. Whilst this work is underway we will continue to utilise the existing Asbestos Management Plan.

The final submission of the annual Estates Return Information Collection (ERIC) was made by the 30th June deadline. We have received queries from NHSEI comparing this submission to the previous year, with a due date for response of 5th September. Queries were not limited to Estates and both Estates and Facilities colleagues are reviewing and compiling the necessary clarifications.

During August, the Trust received contact from Councillor Sam Charleston (Salisbury City Councillor for St Paul's Ward) highlighting concerns from a National report regarding the presence of Reinforced Autoclaved Aerated Concrete (RAAC) in a number of buildings at 16 different Health Trusts across the country.

The Director of Estates provided assurance to the Chief Executive Officer that all Trusts nationally were required to undertake an audit for the presence of RAAC and confirm back to NHSIE in 2019/20. This was undertaken for SFT and confirmation provided that no RAAC is present at the Odstock Road campus. This was checked and reviewed again when the Director of Estates joined the Trust in April 2021. The Director of Estates supported the Chief Executive Officer with a formal response to Councillor Charleston;

> Dear Councillor Charleston,
>
> Thank you for your letter and concerns regarding the potential presence of reinforced autoclaved aerated concrete (RAAC) within buildings at Salisbury Foundation Trust.
>
> I can reassure you that during 2019/2020 all NHS Trusts were formally requested by NHS England/Improvement to review their campus buildings for the presence of RAAC used in building structures, we undertook the necessary checks and investigations to confirm this construction method is not present in the buildings here on our campus at Odstock Road. We have previously confirmed this to NHSEI.

The national submission of the NHS Premises Assurance Model (PAM)[1] is due for submission on 9th September 2022. The submission is intended to provide an overview for Board level assurance of the organisational management of the Trust, split across five domains (with the Safety domain sub split into hard and soft facilities management). The review for SFT has been undertaken using the 2018 PAM model and reflects the Trust's position as of the 31st March 2022 for the 12 months prior.

The Estates team has compiled the data and associated evidence and our formal report has been approved in late August by the Chief Operating Officer. A copy of the full report will be issued to the Finance & Performance committee as a sub-committee of the Board of Directors for transparency and governance.

The Trust has seen significant improvement from last years (April 2020-March 2021) submission with most areas progressing by at least one rating. Hard FM has the most progression with some areas of Soft FM moving to outstanding. This year we are required to report on three new areas of Efficiency, Governance and Effectiveness.

The NHS Premises Assurance Model (PAM) average scores for the Trust shows that there is a broad cross section of ratings spanning from Outstanding to Inadequate. The change in position from last years submission to this year is shown in the table below:

[1] The NHS Premises Assurance Model (PAM) has been developed by the English Department of Health, with the Service, to assist Trusts in reviewing their management structures and processes in a consistent manner. In order to meet some of the additional challenges that came out of the Mid Staffordshire NHS Foundation Trust Public Inquiry chaired by Robert Francis QC and published in February 2013, the Model and associated notes were updated and re-issued in May 2014 and January 2016.

Rating	April 2020 – March 2021	April 2021 – March 2022	
Outstanding	1%	6%	↑
Good	37.8%	47%	↑
Min Improvement	23.1%	28%	↑
Mod Improvement	29.1%	18%	↓
Inadequate	9%	1%	↓

The following table shows the change in ratings from last year's submission to this years rating.

Domain	Outstanding	Good	Requires minimal improvement	Requires moderate improvement	Inadequate
Hard FM - Safety	-1	22	20	-17	-14
Soft FM - Safety	11	-2	7	0	-1
Patient Experience	1	5	-1	0	0
Total	11	25	26	-17	-15

The PAM review for 2021/2022 has shown the Trust has improved from last year, with more areas rated as outstanding and good. This is the second year of submission and areas requiring improvement are already part of an action plan with measures in place to continuously improve. New areas identified from this submission will be added to the current plan, risk rated and assigned to domain leads for improvement over the year ahead.

At present the estimate of revenue consequences to achieve all necessary improvements is not known but we will develop costed action plans as necessary. A programme of review for PAM 2021/2022 will also now be put in place.

4.0 Estates Maintenance

Work continues on CAFM system improvements, increasing asset data content and working on feedback from the initial roll-out of CAFM hand held tablets. We have held initial discussions with the RUH team about opportunities for a future shared CAFM system and will prepare an options appraisal in due course, although this is a long term opportunity and we need to continue to improve the existing SFT CAFM system.

Trust meetings with the PFI provider occur quarterly and we have now reinstated monthly Estates specific meetings. The template for the monthly PFI report to Estates has also been modified to provide additional data and increased assurance regarding matters such as water safety, inspection and testing and more closely align with regular reporting within Estates.

Pressure systems (steam infrastructure) remains a high priority risk across the estate given the ageing nature of the installation. Estates has completed a number of system improvements over recent months including the installation of a new clean steam generator serving the Sterile Serviced Department. This latter action removing a major Trust risk arising from potential steam system failure. A second clean steam generator is on site and installation is planned to commence in September, further increasing Trust resilience.

The Estates compliance plan captures this and other risks and we are working through infrastructure replacements and upgrades to improve pressure systems resilience, although this is an ongoing plan extending beyond the current financial year.

Some Estates activity has suffered small delays due to procurement changes, with supply chain provider purchase orders resulting in deliveries being withheld. We have worked closely with the procurement team to highlight and address these issues and now have a member of procurement spending a dedicated day per month in the Estates department, to help address issues and improve communications.

Monthly estates maintenance performance is reasonable, although as reported previously we expect to see improvements in data capture as we improve the performance of the CAFM system.

The extreme temperatures of July and August caused problems with cooling systems and ventilation, particularly to the Day Surgery unit. Whilst all issues have been resolved the Day Surgery ventilation resilience is now the subject of some further investigation and we are taking steps to identify options (and associated costs) for further consideration. The prolonged hot weather increased the number of reactive maintenance requests for cooling systems and ventilation.

Extreme weather and climate change are clear concerns for the Trust and we are coordinating in more depth with the Head of Facilities and sustainability lead regarding climate change adaptation plans, where further adjustments will be needed across the Estate.

Work is in progress between the Head of Estates and Head of Capital Projects to improve the specification of future projects and reduce the variation in products and manufacturers, which will simplify Estates stores and maintenance in due course. We are also working closely on improving the commissioning, handover and acceptance process between the two teams.

There are planned shutdowns of the gas, water and High Voltage supplies to the Trust over the months ahead. Essential works are required by each of the utility providers and we are coordinating the requirements and planning ahead with support from Trust EPRR colleagues. Early notifications have previously been raised at Trust committees and all work will be subject to clear program, resilience planning and assurances that disruption to services will be minimised.

The Trust environmental sustainability position is gaining increasing focus. Within Estates we are looking more closely at a long term strategy which moves us to a net carbon zero position, largely through wholesale transition to a fully electrically powered Estate and omitting the use of natural gas to produce heat and hot water. A significant amount of work and further investigations are required to develop a full strategy and we recognise this approach is adopted due to the lack of alternatives to natural gas to operate our existing boilers and produce the necessary heat and hot water. A key part of this emerging strategy is the importance of improving our existing estate fabric performance through the improvement of insulation, upgrading windows, reducing heat loss, energy efficient equipment (e.g. LED lighting). We equally understand that future funding sources will expect Trusts to demonstrate such actions have been taken or are planned, in order to qualify for funding. This also prompts us to consider the ageing areas of our Estate (e.g. SDH South) and consider whether the necessary investments to retain parts of the estate that are currently in a poor condition warrant the necessary expenditure needed, compared to replacing them with new facilities.

All of these considerations are also impacted by the availability of capital funding, either from within Trust capital or from external sources. We are building the energy strategy in combination with an update to the estates strategy and alignment with work completed to date for the site redevelopment plans.

Some shared resource between RUH and SFT is ongoing for Estates specialist disciplines.

5.0 Capital Delivery

In July the Trust made an application for Salix funding via the Phase 3 Low Carbon Skills Fund (LCSF). This funding availability was for fees associated with the appointment of consultancy services to design solutions for de-carbonising heat infrastructure and was open to all public sector organisations (not just the NHS). Applications were on a first come first served basis but unfortunately SFT was unsuccessful.

The next round of funding will be released in September 2022 and we are already preparing an extensive capital bid for £10m of funding. Following previous Trust Board approval to develop and update the current Estates Strategy, the Carbon and Energy Fund (CEF) have been appointed to assist SFT with developing solutions to reduce Trust greenhouse gas emissions and help us move toward net zero carbon ambitions set by the NHS, via the Phase 3b funding route. CEF will present their proposals to the Trust at the end of August 2022, but the scope is c£10m with spend in either 12 or 24 months, depending on the carbon reduction measures.

This next round is again open to all public sector organisations and we expect it to be significantly oversubscribed. We will hear in December, but Funding is dependent on a 12% capital contribution from the Trust which will need to be identified in the 23/24 Capital Plan if we are successful. If successful, the bid will follow the emerging Estates approach for electrification across the Estate and will substantially reduce dependency on fossil fuels by upgrading the electrical infrastructure.

A further complication of national funding highlights that funding will not be available if existing boiler systems are less than three years old. We have a £1m capital inclusion this year to replace all of our existing main gas fired boilers in the energy centre, although if we do replace these as planned it will preclude us from accessing national funding. Having considered this dilemma further, we are now proposing to amend the capital project work to replace only one of the three main boilers this year. There is risk associated with this approach and we are re-visiting the existing boiler survey and inspection data and have commissioned an additional condition survey of the boilers to further validate this approach. If we proceed on this basis it will release capital funding back into the Trust. The approach, risks and funding implications have previously been tabled and discussed at the monthly capital control group.

The remaining capital plan for this financial year is well underway with the appointments of external consultants and contractors supporting delivery of projects. Our ‘long list’ of capital requirements is in place and will remain a dynamic document capturing new and emerging requirements for the Trust and informs our future capital planning.

Capital project expenditure to M4 is as predicted, ramping-up to a mid-year peak of £470k spend in August, £1.2m Sep, £718k Oct, £956k Nov and £713k Dec.

We are working closely with clinical and operational teams to ensure access to clinical areas for planned capital works and avoid delay. We recognise there is never an opportune time to undertake capital works in live clinical environments and our lack of a reasonable decant facility further compounds this. We are actively looking at wider opportunities for decant space and this is partly being enabled through works now planned within empty accommodation such as the Douglas Arter Centre on site and a sequence of internal department moves, although this strategy is mainly linked to the elective recovery ward plan.

We are looking ahead to 2022/23 and beyond and our ability to successfully deliver projects within year is predicated on our ability to mobilise enabling works and activities such as detailed design, in the preceding year. With this in mind we are trying to work through the long term planning with finance and procurement colleagues that will benefit us in future years.

The elective recovery ward project short form business case for £14m has been submitted with accompanying design to RIBA Stage 2. A 9-week approval period has now commenced. With approval from the Finance & Performance committee, we have committed further expenditure for the continuation of design, surveys and resource to support the project and in anticipation of approval of the business case. We have commenced procurement of a principal contractor via the Procure Partnerships South West framework with a 6-week mini competition due back in early September.

The sterile services refurbishment project tenders are due for return in mid August, with a project steering Board convened to review the responses and next steps, in late August. The current program is for works to commence December 2022.

Development of the current Estates strategy is needed to incorporate the current redevelopment plan and to address various challenges presented by the estate (age, condition etc) and the need to integrate both sustainability and energy strategies, each of which require developing. The Head of Facilities is leading on Trust sustainability and the Director of Estates, Heads of Capital and Estates and Laurence Arnold are meeting monthly to discuss the Estates strategy in more detail. Further discussion is needed as the sustainability and energy strategies are necessary to inform the estates strategy. There may be some identified opportunity to utilise aspects of the RUH energy and sustainability strategies (which are both Board approved) to help fast track some aspects of strategy, particularly given some similarities between the two estates. We are currently investigating options for consultancy support for energy and estates strategies. A further update will be available in late September as the approach to these interdependent elements becomes clearer.

Some shared resource between RUH and SFT is ongoing for capital project management.

6.0 Governance and Risks

The Trust continues to hold a number of estates risks and this is anticipated to continue through the remainder of this year. We continue to work through actions and mitigations and regularly report progress through a series of committees (Health & Safety committee, Finance & Performance Committee etc).

As reported previously the Trust has the second highest Estates backlog position in the South West region. Whilst we have an annual capital investment program in place it is insufficient to reduce the backlog position and inflation impact alone will see the backlog continue to increase year on year. We continue to seek and apply for additional external funding to mitigate this position and continue to work closely with regional NHSEI colleagues to seek solutions. The update of the estate strategy, development of sustainability and energy strategies are in early stages but will also be key components for reducing the Trust backlog risks.

Having received Trust ratification of a number of Estates specific polices we can now remove a number of high risk actions from our plan (out of date policies were rated as high risk).

The Estates specialist discipline sub-committees are all in place and meet quarterly, with Terns of Reference in place and producing upward reports to the Health & Safety committee. Note the Medical Gas Committee is chaired by the Chief Pharmacist with attendance from Estates.

Committee	Previous Meeting	Next
Fire Safety	May 2022	Aug 2022
Electrical Safety Group	June 2022	Sept 2022
Water Safety Group	July 2022	Oct 2022
Asbestos Safety Group	July 2022	Oct 2022
Ventilation Safety Group	July 2022	Oct 2022
Safer Environment group	July 2022	Oct 2022
Medical Gas Committee (Pharmacy)		

As referenced through this report, there are numerous requirements competing for capital investment across the SFT estate, all of which are significant. Notwithstanding our estates backlog position there is a need for significant investment in sustainability to move toward net carbon zero and investment in the redevelopment and update of our estate to provide modern, fit for purpose facilities.

The Trust is not isolated from risks of inflation, particularly rising energy costs and we expect our gas and electricity unit costs to rise through the latter part of this year. Some further detail will be included within reporting to the Trust Finance & Performance committee.

No new risks are reported in this period.

NHS Salisbury NHS Foundation Trust

Report to:	Trust Board (Public)	**Agenda item:**	5.1
Date of Meeting:	08 September 2022		

Report Title:	Board and Committee Effectiveness Annual Report			
Status:	**Information**	**Discussion**	**Assurance**	**Approval**
			x	
Approval Process (where has this paper been reviewed and approved)	Committee Effectiveness is reviewed at each Board Committee			
Prepared by:	Kylie Nye, Head of Corporate Governance			
Executive Sponsor (presenting):	Fiona McNeight, Director of Integrated Governance			
Appendices (list if applicable):	A - F&P Committee Effectiveness Report 2021/22 B - CGC Committee Effectiveness Report 2021/22 C – Audit Committee Annual Activity Report 2021/22 D – People & Culture Committee Effectiveness Report 2020/2021 (reported in Nov 2021) E – Charitable Funds Committee			

Recommendation:
For the Trust Board to note the process and outcome for the annual review of Board and Committee Effectiveness.

Executive Summary:
The NHS FT Code of Governance sets out the requirements that the Trust Board should undertake a formal and rigorous annual evaluation of its own performance and that of its committees and individual directors. The Trust Board Committees, as part of their annual Committee business cycle, undertake a self-assessment of their own effectiveness. These reviews have been completed over the last few months (apart from People and Culture Committee, where the reporting schedule will be realigned to the other Committees) and concluded that the Committees were meeting the requirements as set out in their terms of reference (appendices attached). All Committee Terms of Reference have been reviewed and agreed at Trust Board in April 2022 as part of the revised Integrated Governance Framework. The Board has utliised several methods to review and improve effectiveness in the last year. This includes:

- Undertaking a self-assessment aligned to the CQC Well-led framework in late 2021. The Board then focused on the outcome of this assessment, the improvement themes, and priorities for the future at a Board Seminar in March 2022. An external Well-Led assessment is currently being scheduled jointly with Royal United Hospitals Bath NHS Foundation Trust (RUH) and Great Western Hospital NHS Foundation Trust (GWH) for late autumn/winter 2022.
- Participating in Board Seminar sessions including Equality, Diversity and Inclusion, Risk Appetite and a Digital Development session led by NHS Providers.
- The seminar around Risk Appetite aligned to a complete review of the Board Assurance Framework (BAF). The newly revised BAF ensures the Board is focused on the strategic risk profile and the reporting will now focus on those risks out with tolerance, as agreed by the Board.
- Participating in sessions in relation to the Trust's "Improving Together" programme to learn and understand how to support the organisation in developing and sustaining a culture of continuous improvement.
- A Board meeting was independently reviewed and feedback was provided on areas of improvement around Board behaviours. A further session with the Board is scheduled for autumn to take this work forward.
- The executive team have participated in focused development sessions with an external provider to develop individual and group executive leadership skills.
- In addition to this, each executive and non-executive director completes an annual appraisal which focuses on individual performance. The executive appraisals are reviewed at the Remuneration Committee and the non-executive appraisals reviewed and discussed at the governor Performance Committee.

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) -	☐

Appendix A - Annual Review of Finance and Performance (F&P) Committee April 2021 – March 2022

1. Introduction

The purpose of this report is to formally report on the work of the F&P Committee during 2021/22 and to indicate the key priorities for 2022/23 and beyond.

The Finance and Performance Committee is a formal sub-committee of the Board and therefore chaired by a Non-Executive Director. The Committee is an assurance committee to enable a greater insight into the Trust's performance in terms of performance and financial outcomes. In doing so, it may request additional management information on specific areas as well as providing knowledge to the Board on those areas if it is considered they may impact the delivery of the Trust's strategic objectives.

2. Work undertaken in 2021/22

The Committee has ensured that it has given due focus to each of the areas of finance and operational performance over the year. The Committee operates under a standard agenda which is structured in line with the Board Assurance Framework (BAF). The BAF was revised in 2021/22 in line with the approval of the Trusts new Strategy, which outline 3 strategic priorities and the Finance and Performance Committee focuses on the financial aspects of each:

- Population
- People
- Partnerships

Despite the ongoing Covid-19 pandemic the Finance & Performance Committee has met (remotely or face to face) on 12 occasions during the year. The work and priorities of the Committee in 2021/22 naturally reflected the challenges of the ongoing pandemic and the need to recover services, but despite these significant issues the Committee's work also reflected the routine consideration of monthly reports on the following issues:

- Oversight of (a) the how the Trust met the Covid-19 challenge and (b) how the Trust has tried to minimise and mitigate the impact that Covid-19 has had on non-Covid-19 services (see below)
- Operational performance of the Trust, including reporting on key service targets e.g. 18 week RTT, 52 week Elective and Cancer Waiting Times, A&E 4 hour waits, Diagnostics, MRSA and C Difficile
- Deep dives and service reviews looking into key areas of where performance needed to improve e.g. cancer, stroke and diagnostics
- Financial performance of the Trust, including cash, balance sheet and capital programme
- Contractual and funding issues with the Trust's key commissioners
- Service Transformation, early in 2020/21 the cost improvement focused programme of projects, was refocused towards a broader range of prioritised service improvement projects. Which has in turn transformed during 2021/22 into the Trust Improving Together programme
- Board Assurance Framework and risk registers
- Benchmarking and value for money information e.g. Model Hospital, service line reporting, reference costs.
- Resilience and continuity planning e.g. Winter Plan for 2021/22 and ongoing Covid-19 pandemic response planning
- Planning process for 2022/23 and beyond
- Integrated Care System (ICS) working

- Review of key business cases
- Salisbury Hospital Strategic Campus Development programme

The Committee undertook its role by receiving and questioning papers and presentations; discussion of key issues; seeking of assurance; making suggestions and recommendations where appropriate; and drawing significant issues to the attention of the Board of Directors.

The Chairman of the Committee has been involved in setting the agenda with the Director of Finance. The minutes of the meeting are reported to the subsequent Board meeting for information, with highlights and issues for escalation presented by the Chair.

Committee attendance at Finance & Performance Committee meetings April 2021 to March 2022.

Member	Designation	Meetings attended (12)
Paul Miller (Committee Chair)	Chairman	12
Paul Kemp	Non-Executive Director	11
Eiri Jones	Non-Executive Director	11
Stacey Hunter	Chief Executive	9
Lisa Thomas	Chief Finance Officer	12
Andy Hyett	Chief Operating Officer	9
Melanie Whitfield	Chief People Officer	4 (out of 6)

3. Work Plan for 2022/23

The Committee's overarching objective is to continue to improve understanding of the financial and operational performance control processes of the Trust to provide assurance to the Board. In particular it will focus on the following key areas.

- The first key priority for next year is to ensure the Trust recovers its performance back to pre Covid-19 levels and beyond
- The second key priority is to work both internally and externally with ICS partners to develop an agreed financial recovery plan to achieve future financial sustainability. Given the size of our 2022/23 financial challenge (planned £18m deficit) this financial recovery will take a number of years to achieve
- As part of this recovery process, ensure that the Trusts service transformations programme (Improving Together) aligns with both the short-term operational priorities, as well as our long-term strategic ambitions
- Continue to improve our approach to capital and revenue planning and forecasting and work with the ICS to agree a long-term system capital programme
- Support the ongoing development Salisbury Hospital Strategic Campus Development programme.
- Ensure the Trust continues to implement its approved digital strategy and an effective operational digital delivery service
- Raising financial awareness throughout the Trust and empower staff to improve
- Assessment of financial risks in delivering financial plans agreed with NHS England and Improvement
- Working with our system partners to ensure the Trusts 2022/23 operational and strategic ICS plans help the Trust achieve long term sustainability

4. Terms of Reference

The Terms of Reference have been revised as part of the annual update of the Integrated Governance Framework which was presented to and approved by the Board in April 2022.

5. Conclusion

Notwithstanding the very significant ongoing challenges of Covid-19 during the second year of the pandemic, the Committee is functioning effectively and meeting its objectives. However, despite this assurance role being effectively undertaken, the reality is because of a wide range of ongoing issues e.g., ongoing impact of the pandemic and workforce pressures, key parts of the Trusts non Covid-19 performance have not recovered as hoped for over the last year and the challenge for 2022/23 is to fully recover performance and start to move back towards financial sustainability.

Appendix B- SALISBURY NHS FOUNDATION TRUST
ANNUAL SELF ASSESSMENT OF THE EFFECTIVENESS OF THE CLINICAL GOVERNANCE COMMITTEE 2019 - 2020

1.0 Introduction

The purpose of this review is to provide assurance to the Trust Board and the Council of Governors that the Clinical Governance Committee (CGC) is complying with its duties as set out in the terms of reference in the Integrated Governance Framework 2022 and to indicate the priorities for 2022/23. The period covers the last 12 meetings from April 2021 to March 2022 and is set out in accordance with the annual review of committee guidance.

2.0 Background

The Integrated Governance Framework 2022 makes it clear that clinical governance is the responsibility of the Trust Board. This is supported by the Clinical Governance Committee which is a formal sub-committee chaired by a Non-Executive Director. The Clinical Governance Committee is responsible for continuously improving the quality of services and safeguarding high standards of care by creating an environment in which excellence in clinical care will flourish.

The terms of reference outlines that the CGC has the power to act on behalf of the Trust Board. Its purpose is to assure the Trust Board that high quality care is provided to patients throughout the Trust. The principal function is to provide assurance to the Board on:

- Patient safety
- Clinical effectiveness
- Patient experience
- Service improvement and change management

3.0 Conduct of business

The Committee has ensured that it has focussed on each of the areas of quality over the year. The Committee operates under a standard agenda which is structured in line with the Board Assurance Framework which outlines 6 strategic priorities. The CGC focuses on the following two:

- Innovation
- Care

Despite the ongoing Covid-19 pandemic, the Committee met (mostly remotely) on 12 occasions during the year. Whilst the work and priorities of the Committee continued as outlined in the workplan for 2021/22, to reflect the ongoing and changing demands of the pandemic, the Committee's work also reflected the routine consideration of monthly or periodic reports in the following areas:

- Impact and management of Covid-19
- Quality performance of the Trust (Integrated Performance Report covering safety, effectiveness and experience)
- Deep dives and performance reviews in key areas such as Maternity, Stroke and Spinal services and areas of harm such as serious incidents and falls / pressure ulcers
- Board Assurance Framework and Risk Registers
- Mortality and Learning from Deaths
- Safeguarding Adults and Children
- Patient Experience and feedback
- Clinical Effectiveness, research, and audit activity
- GIRFT
- Mental Health and Learning Disability workstreams

- Freedom to Speak Up Guardian
- Transformation, quality improvement (QI) and innovation
- Upward Report from Clinical Management Board

The Committee undertook its role by:

- receiving and questioning papers and presentations.
- discussing key issues.
- seeking assurance.
- making suggestions and recommendations; and
- drawing significant issues to the attention of the Board of Directors.

The Chairman of the Committee has been involved in setting the agenda with the Chief Nurse and Chief Medical Officer and Head of Clinical Effectiveness on occasion with the Director of Integrated Governance in a monthly meeting. The minutes of the meeting are reported to the subsequent Board meeting for information, with highlights and issues for escalation presented by the Chair.

3.1 Membership and attendance (Appendix 2)

The Committee consists of:

- Three Non-Executive Directors
- Medical Director and Director of Nursing
- Chief Operating Officer

In attendance:

Regular attendees included:

- the Chief Executive Officer.
- a Registered Nurse representative; and
- key members of the Chief Nurse and Chief Medical Officer teams.
- Director of Integrated Governance

3.2 Quorum

All meetings were quorate.

3.3 Administration

In 2021/22, the PA to the Director of Nursing and Medical Director acted as the Secretary to the Committee, supporting the administration of the Committee and produced the minutes and action tracker alongside collating papers for each meeting. Where required, these activities were supported by the Director of Integrated Governance or the Head of Corporate Governance.

3.4 Frequency

Meetings were held twelve times during the year.

3.5 Notice of meetings

The agenda and call for papers were sent to each member of the Committee two weeks before and supporting papers sent out one week before the meeting. Due to the pandemic, on occasion, permission was sought and received from the Chair for late submission of some papers. Some topics were also moved to later meeting dates to ensure that the right information could be provided with the required attendees.

4.0 Duties of the Committee

4.1 Developments and review

- **Agree the annual quality plan (quality account priorities) and monitor progress**

The Clinical Governance Committee agreed the quality account priorities and reviewed progress against these. The report for 2021-22 was approved for submission to the Board.

- **Extend the Boards monitoring and scrutiny of the standards of quality, compliance and performance of Trust services.**

Each of the Board assurance committees reported performance within their scope of responsibility. The Clinical Governance Committee reviewed an integrated performance report on quality and care at each meeting and escalated risks and mitigation to the Board. In turn, the Board monitored overall performance through escalation reports and the integrated performance report which triangulates information on quality, performance, workforce and finance.

- **Make recommendations to the Board on opportunities for improvement in the quality of services.**

The following key items were escalated to the Board in 2021/22:
- Ongoing development of the Clinical Strategy in line with the new Trust Strategy
- Maternity services
- Spinal services
- Stroke services
- Mortality
- Impact of Covid-19 including harm reviews and lessons learned
- Infection Prevention and Control
- NatSS atSSips and LocSSips (safer systems work)
- Pressure Ulcers and Falls
- Management of Serious Incidents and harms
- Patient experience
- Safeguarding children and adults
- Child and Adolescent Mental Health challenges
- Any other gaps in assurance

- **Support and encourage quality improvement where opportunities are identified**

Information in relation to the establishment and embedding of the Improving Together programme was reported to the committee. Ongoing learning from the positive changes made during the early learning from COVID-19 continued into 2021/22.

Improvement programmes in both maternity and spinal services were presented to the committee.

- **Working in conjunction with the Audit Committee, Workforce Committee and Finance and Performance Committee, cross referencing data and ensuring alignment of the Board assurances derived from the activities of each committee**

The Board Assurance Framework document is presented in totality every 2 months to facilitate assessment of risks. Escalation reports are provided from each Committee to the Board on a monthly basis. Where required, the Committee felt able to refer matters to other Committees. A focus on requests from the audit committee continued in this year.

- **Review the Trust's annual quality report prior to submission to the Trust Board of Directors for approval**

The quality report (quality account) for 2021-22 was presented to the April 2022 Clinical Governance Committee and upwards to the Board in May 2022. It will also be presented to the Council of Governors.

- **Monitor the status of the Trusts' quality objectives as set out in the annual plan.**

Detailed discussion was undertaken in relation to the quality priorities and metrics prior to sign off of the quality report (quality account).

- **Review the quality indicator report (forming part of the Integrated Performance report) prior to inclusion in the Trust Integrated Performance Report**

The quality indicator report was discussed at each Clinical Governance Committee as part of the IPR, triangulating with the discussions held at the Finance and Performance Committee.

- **Consider relevant regional and national benchmarking statistics when assessing the performance of the Trust.**

The following reports provided national benchmark data compared with the Trust's performance:

- Infection prevention and control compared with Public Health England data
- Bi-annual national clinical audit reports compared with national average/median.
- Mortality compared to regional peer group.
- GIRFT programme compared with national average/median
- Research activity compared with regional network and national standards.
- National patient surveys benchmarked with national data.
- Freedom to Speak Up work compared with the national Guardian's office data.

- **Review quality impact assessment reviews for significant cost improvement schemes and their potential impact on quality, patient experience and patient safety.**

A discussion in relation to quality impact assessments was held with agreement that QIAs should be considered for any change which could impact on quality. The process was completed for the pharmacy development from 2020-21.

- **Provide oversight of relevant internal audit recommendations as directed by the Audit Committee**

The Divisional Governance arrangements were discussed and reviewed as part of the internal audit programme. A focus on requests from the audit committee continued in this year.

4.2 Review of Trust activity in assigned areas

The assigned areas reviewed are outlined in section 4.1 above.

5.0 Review

5.1 The terms of reference will be subject to an annual review. The Committee shall conduct an annual self-assessment on the performance of its duties as set out in the terms of reference and report any conclusions and recommendations for change to the Board

The Terms of Reference have been revised (minor amendments) as part of the annual update of the Integrated Governance Framework. The CGC reviewed the ToRs in March 2022 and this was upwardly reported to Board in April 2022.

5.2 As part of this assessment, the Committee shall consider whether or not it receives adequate and appropriate support in fulfilment of its role and whether or not its current workload is manageable.

The annual workplan was reviewed in year and each agenda planned to align with the current challenges from the pandemic. Each meeting has had a full agenda using up the time allocated. The Committee has had the full support of the Board with items of escalation. The Committee will continually formally review its effectiveness towards the end of each financial year.

6.0 Priorities 2022/23

The CGC will focus on:

High priority areas 2022/23:

- Continue the recovery programme from Covid-19
- Focus on the breakthrough objectives in the Improving Together programme
- Continue to focus on the improvements underway in maternity and spinal services
- Focus on improvements in the 'Deteriorating Patient' workstreams
- Continue to invite Divisional teams to present their services for assurance on quality of care
- Focus on learning through internal audit reports related to quality

7.0 Summary

Despite the very significant ongoing challenges of Covid-19 during the last year, especially on the workforce, the Clinical Governance Committee is functioning effectively and meeting its objectives. However, despite this assurance role being effectively undertaken, some key quality challenges have continued during this year.

The report is presented for assurance that the Clinical Governance Committee is complying with its duties as set out in the terms of reference.

Eiri Jones
Chair Clinical Governance Committee
April 2022

Agreed at the Clinical Governance Committee on 26th April 2022

Appendix C - *Audit Committee Annual Activity Report*

1 Purpose

1.1 The purpose of this report is to summarise the activity of the Committee over the 2021/22 financial year in order to provide the Board with assurance. Further details of any of the items raised in this report are available in the papers and minutes stored in the iBabs system.

2 Background

2.1 The Audit Committee has been put in place to provide the Governors, the Board and the Chief Executive with a point of focus to review and assure the effectiveness of non-clinical processes in the Trust and compliance of the Trust's personnel with those processes. In doing this the Committee will provide assurance to the Board, Governors and other key stakeholders.

3 Key Activity During 2021/22

3.1 Impact of Management of Covid Pandemic within the Hospital

Although the peak of the direct impact of the pandemic on patient numbers occurred during 2020/21, the delta variant in the early part of the current year and the subsequent omicron variant were significant factors in the management of the hospital. Although public restrictions were reduced in the latter part of the year, many of the hospital virus control measures were maintained. There was also a significant, if indirect, impact on the ability to be able to release otherwise fit patients, with the numbers tagged as having No Criteria to Reside rising significantly and disrupting patient flows throughout. This latter problem has not yet been resolved and continues to disrupt patient flow. These phenomena are prevalent across the whole of the NHS and are not particularly focused in Salisbury.

3.2 Review of 2020/21 Annual Report

As is required, the committee reviewed the draft financial statements and governance statements for the 2020/21 annual report and recommended their adoption to the Board. As in the previous year, there were some disruptions to the process and the final signing off of the accounts was slightly delayed. However, these issues related to delays in the audit process, rather than issues with the accounts and did not impact the final outcome. The Audit Committee signed off the Annual Accounts on the 18th June 2021, acting on the delegated authority of the Board.

3.3 Internal Audit Reviews

Overall, the Head of Internal Audit Opinion remained the same as for the last two years. That is to say that the formal opinion was that the control environment within the Trust was independently judged to be "***Generally satisfactory with some improvements required****. Governance, risk management and control in relation to Trust critical areas is generally satisfactory. However, there are some areas of weakness and non-compliance in the framework of governance, risk management and control which potentially put the achievement of objectives at risk. Some improvements are required in those areas to enhance the adequacy and effectiveness of the framework of governance, risk management and control.*"

Over the financial year 2021/22, PWC carried out reviews in eight areas, agreeing a total of 39 actions with management. Three of the eight reports were rated as "High Risk"

overall. Table 1 below summarises the number of findings by risk intensity for each of the reports.

On a positive note, the auditors were complimentary about the attention that was being given by management to the closure of agreed actions. Unlike previous years, there were only three actions still open relating to reviews from previous periods, and these were long term actions that were not yet due for completion.

Table 1
Results of individual assignments

Review	Report classification	Number of findings			
		Critical	High	Medium	Low
SSL Review	Medium risk	-	-	5	-
Human Resources – EDI	High risk	-	-	6	-
Safeguarding	Medium risk	-	-	3	1
Capacity Management and Discharge	Medium risk	-	1	-	1
Key Financial Systems – Accounts Payable	Medium risk	-	1	-	2
Key Financial Systems – Fixed Assets	Low risk	-	-	-	5
IT Disaster Recovery	High risk	-	1	2	-
Workforce planning	High risk	-	1	4	1
Five steps to safer surgery	Medium risk	-	-	4	1
	Total	-	4	24	11

However, there was some concern expressed that the trend of number of findings reported has grown over the last three years, particularly in the area of medium risk findings. The analysis of this trend is shown in Table 2.

Table 2
Direction of control travel

Finding rating	Trend between current and prior year	Number of findings		
		2021/22	2020/21	2019/20
Critical	⟷	0	0	0
High	↑	4	3	0
Medium	↑	24	13	12
Low	↑	11	7	6
Total	↑	**39**	**23**	**18**

3.4 Counter Fraud Activities

During the year the Local Counter Fraud Officer (LCFO) continued to work with management on both proactive and reactive work packages, linking in with guidance from the NHS Counter Fraud Authority. Local proactive work during the year included reviews of potential for staff working elsewhere whilst reporting as sick to the Trust. There was also a review of the process around managing declarations of interests.

There were no incidents reported in the year that required an investigation by the LCFO. Items from previous years were closed out, awaiting final disposal through referrals to either the GMC or NMC.

Good progress was achieved through the year on the actions required to improve the Trust's rating in the NHS Counter Fraud Functional Standard Return, with the two outstanding red rated items improved to green. The exercise on the Declaration of Interest process completed in the year has significantly improved the response rate from staff, but remains rated as amber. The Executive regard this as an appropriate level of response, which the members of the committee agreed with.

3.5 Pro-active Process Reviews

During the year, the committee continued its practice of inviting management teams to give a detailed presentation on a specific management process or area of concern.

Through the year, the Committee received presentations on the implementation of the new financial ledger system, programme management processes, diagnostic wait time management and improvements in medicine controls in the pharmacy. All the presentations were of a good standard and led to a good discussion in the committee on the issues raised.

3.6 Other Activities

Other regularly scheduled matters dealt with during the year included,

- Two reviews of the processes used by the Trust to manage risk and the Business assurance Framework,
- A discussion on the effectiveness of the committee and a review of its terms of reference,
- Review and discussion of the internal audit and counter fraud plans for 2022/23
- Review of the effectiveness of the Standing Financial Instructions and management proposals for changes

4 Summary

Given the externally driven constraints and environment encountered by the Trust during the 2021/22 financial year, it is pleasing to see that the control environment remained effective and that the level of management control was generally maintained. There has also been evidence that management's understanding of internal control matters and use of the internal audit services available to it has become more effective, although there will always be room for improvement.

5 Recommendations

The Board is recommended to note this report.

Paul Kemp
Audit Committee Chairman

Appendix D- Annual Review of People and Culture Committee April 2020 – March 2021

1. Introduction

The purpose of this report is to formally report on the work of the People and Culture Committee during 2020/21.

The People and Culture Committee, formerly the Workforce Committee, is a formal sub-committee of the Board, chaired by a Non-Executive Director. The purpose of the Committee is to ensure that the Trust has a workforce strategy in place that recognises the importance and value of all of the people who work within the Trust, and that will enable it to recruit and retain sufficient numbers of people with the necessary skills, training and motivation to deliver its clinical objectives. Specifically:

- That the Trust has a clear understanding of its strategic workforce needs and that plans are in place to deliver these.
- That the Board receive assurance that all legislative and regulatory requirements relating to the workforce are met;
- That workforce risks are understood by the Board and that appropriate mitigating actions have been identified and are being implemented.

2. Response to Internal Audit Findings

Internal Audit in 2019/2020 identified weaknesses in the operation of the Workforce Committee and made recommendations for improvement. These were implemented in July 2020 and included:

- A new executive board, the OD and People Management Board, was formed to coordinate and manage much of the transactional activity that was being reported and discussed at the Workforce Committee. It is chaired by the Chief People Officer Director of OD and People. This will elevate the sights of the committee to more strategic matters.
- Frequency of meetings was increased to 10 per year, reducing the number of items to be considered at each committee.
- Production, quality and timeliness of papers for the committee were to be improved under oversight of the new Director of OD and People.

3. Work undertaken in 2020/21

The year was dominated by the pandemic. It was agreed early in the year that the focus of effort would shift from some strategic priorities onto operational outputs, enabling the OD and P team to support redeployment of staff, increased Occupational Health support, and retention initiatives.

Despite the Covid-19 pandemic the Committee met remotely and in person on 8 occasions during the year. The work and priorities of the Committee in 2020/21 naturally reflected the current pandemic, but despite this significant issue the Committee maintained a focus on its statutory and routine work:

- Review of the Board Assurance Framework and specifically risks related to the People, Culture and Workforce
- Workforce KPIs were discussed at each meeting with particular focus on, retention and turnover, sickness absence and well-being, mandatory training, and appraisals.

- Updates were received on OD and cultural change strategies, including progress on the People Plan both within the Trust and the ICS, and the transformation initiatives that affect our people.
- Progress and action plans resulting from the National Staff Survey and local surveys (Best Place to Work) were reviewed and approved.
- Routine and Annual reports were received and approved relating to:
    - Equality Diversity and Inclusion
    - Freedom to Speak Up
    - Health and Safety
    - Guardian of Safe Working
    - Medical Education and Training
    - Medical Revalidation and Appraisal

The Committee undertook its role by receiving and questioning papers and presentations, discussing key issues, seeking of assurance, making suggestions and recommendations where appropriate, and drawing significant issues to the attention of the Board of Directors.

The Chairman of the Committee has been involved in setting the agenda with the Chief People Officer. The minutes of the meetings are reported to the subsequent Public Board meeting for information, with highlights and issues for escalation presented by the Chair.

Attendance at People and Culture Committee meetings April 2020 to March 2021.

Member	**Designation**	**Meetings attended**
Michael von Bertele *	Non-Executive Director & Chair of P&C Committee	7/8
Lynn Lane *	Interim Chief People Officer	7/8
Nick Marsden	Trust Chairman	
Cara Charles –Barks (left the Trust in August 2020)	Chief Executive	
Stacey Hunter (joined the Trust in September 2020)	Chief Executive	
Peter Collins * (Christine Blanchard until 23 July 20)	Chief Medical Officer	3/5 (2/3)
Judy Dyos * (Lorna Wilkinson until 28 May 20	Chief Nursing Officer	6/7 (1/1)
Rakhee Aggarwal *	Non-Executive Director	7/8
Glennis Toms	Deputy Director of OD & People	
Esther Provins *	Director of Transformation	
Jenny Lisle	Governor Observer	7/8

* Core members

4. **Work Plan for 2021/22**

The Committee's overarching objective is to ensure that the Trust maintains a workforce of the right size, with the right training, qualifications and motivation, to deliver safe and effective healthcare that meets the needs of the population we serve. It will do this by providing assurance to the Board that the development and delivery of the People Plan and all supporting transformation and operational priorities are being properly executed. In particular it will focus on the following key areas.

- The key priority for next year is to ensure the Trust recruits and retains the staff it needs to recover its performance back to pre Covid-19 levels.
- As part of this recovery process, ensure that the Trust supports the health and well-being of all staff.

- Supporting development and delivery of a strategic Equality, Diversity and Inclusion plan for the Trust that affirms our intention to be a compassionate and inclusive place for all of our staff to work and thrive.

5. Terms of Reference

The Terms of Reference have been revised as part of the annual update of the Integrated Governance Framework which was presented to and approved by the Board in March 2021.

6. Conclusion

Notwithstanding the very significant challenges of Covid-19 during the last year, the Committee has improved its performance. The Trust has experienced significant churn in leadership of the OD and People function with 2 interim Directors and Deputy directors over the past 18 months. It now has an opportunity to make improvements by working with the newly appointed Chief People Officer and the OD and People committee. It aims to ensure that papers presented to the committee reflect accurately the performance against Trust mandated KPIs, that individual projects are delivered efficiently and effectively, that progress is made against multiple transformation projects and objectives, and significant risks to the safe and effective delivery of care are identified and managed.

Appendix E – Annual review of Charitable Funds Committee
April 21 – March 22

1. Summary

The purpose of this report is to formally report on the work of the Charitable Funds Committee during 2021/22 and to indicate the priorities for 2022/23.

The Charitable Funds Committee is a formal sub-committee of the Board and therefore chaired by a Non-Executive Director. The Committee is an assurance committee to provide the Board of Directors with assurance on the appropriate management and use of charitable funds it holds on trust.

The Board was presented with a comprehensive report in May detailing the challenges and achievements for the Charity in the past 2 years, detailing the progress made with the governance review to date as well as the COVID-19 impact and mitigations on fundraising and charitable activities. In contrast, this report focus on the work of the Charitable Funds Committee during the financial year 21/22 and the outcomes arising from it within this period.

2. Work undertaken in 2021/22

The Committee has given due focus to the maintenance and further improvement of the governance of the Hospital Charity, the Stars Appeal. The Committee operates under a standard agenda which is structured in line with the Board Assurance Framework. The Charitable Funds Committee focuses on the following strategic priorities:

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

The Charitable Funds Committee met on 5 occasions during the year, with 4 quarterly meetings and an extra workshop session in November 21.

The work and priorities of the Committee in 2021/22 focused in reviewing the impact of the refreshed governance implemented in the previous financial year, monitoring the Charity's finance performance and supporting the development of the Stars Appeal. To that end, the carried out by the Charity within this period focused on the following key areas;

- Charity Governance
- Charity Development
- Controlling & Auditing
- Fundraising Activities
- Charitable Activities

The main outputs resulting from the work carried out within this period are further described below.

2.1 - Charity Governance

- Monitoring and further developing processes and best practices in line with the agreed guiding principles for the Charity.

- Reviewing and advancing Charity documentation including policies, guidance and templates to support and assure the processes implemented. There are 9 documents available on the intranet in addition to other internal documents such as Terms of References and Workplan which are primarily for the Charity Committees use.

- Supporting the establishment and effectiveness of the Stars Appeal Investment Committee (IC), endorsing the decisions made by the forum and giving direction to matters for escalation. Between April 21 and March 22, the Investment Committee has met 8 times and considered 20 funding applications of which 18 were approved, 1 declined and 1 deferred to the Charitable Funds Committee. In addition, other 7 funding applications were presented to the Charitable Funds Committee in the same period of which 6 were approved and 1 was declined.

2.2 - Charity Development

- Recruiting a Charity Manager to take the lead on the assurance, governance and strategy framework. The Stars Appeal Charity Manager has been in post since in September 2021.

- Supporting the investment on additional dedicated headcount for the Charity needed to improve the Charity performance in two main areas: finance processes and communication strategy.

- Endorsing of new and significantly improved Stars Appeal website launched in May 21.

- Championing a brand review for the Charity, led by specialist consultants and long supporters of the Stars Appeal, Unstuck Design, and in active collaboration with the Trust's Communications Department and ArtCare.

2.3 – Controlling and Auditing

- Continuing support the charitable funds rationalization work which has successfully reduced the number of active designated funds to 105, excluding legacies, fundraising initiatives/campaigns, and internal controlling codes such as investment income and committed expenditure.

- Escalation points for the risks, mitigations and recommendations to ensure the charity's financial processes were adherent to the Trust's new finance system led by SBS.

- Approval of Charity Operating Budget for 2022/23 as well as a consolidated view of unrealised commitments carried over from previous years and financial commitments forecasted for the next 5 year.

- Approval of proposed classification of expenditure on annual accounts to better illustrate efficiency over the Charity spent in line with the guidelines of the Charity Commission's SORP

2.4 - Fundraising Activities

- At the end of the financial year, the Committee has welcomed Stephen Oxley as the new chair for the Fundraising Committee, an external forum which focuses on high-end events and major donor work led by the Charity's President Lord Pembroke. Mr Oxley has succeeded Penny Brown as chairman.

- Acknowledging the impact of Covid 19 on the Charity, the Committee sought reassurance the challenges arising from the pandemic were being managed effectively and provided guidance and support as requested to ensure that.

  - ✓ As restrictions were being reduced, the Charity worked with the relevant areas of the Trust on SOPs, risk assessments and mitigations to restart all the fundraising activities safely, particularly large-scale events and the suspension of the Stars Appeal volunteers-led activities onsite.

  - ✓ Steady stream of income was received from fundraising disciplines less affected by the pandemic such as Charitable trusts and major donors, community fundraising, individual giving, in memory giving, corporate support, the Staff Lottery, and legacies.

- Despite the challenges presented by the Covid 19 pandemic, the Committee noted the Charity still experienced a strong fundraising performance. From April 21 to **December 21**, the charitable income totalled £1.165M. The financial report from January 22 to March 22 has not been completed by the time this report was produced.

2.5 - Charitable Activities

- Support efforts in raising the profile of the Charity amongst its beneficiaries and potential donors/supporters, endorsing practices where relevant such as naming projects funded by the Charity, introducing Charity uniforms, professionally branding goods and equipment's as well as ensuring funding and donor recognition will be appropriately displayed at the Hospital environment.

- Visibility of all projects approved at Committee and SRO levels and its delivery status enabling the reporting and escalation of issues preventing financial commitments from being realized in a timely manner.

- Encouragement to proactive funding, an approach that led the Charity to start the new financial year with charitable investment of £282,861 (confirmed) in medical equipment alone.

The Committee undertook its role by receiving and questioning papers and presentations; discussion of key issues; seeking of assurance; providing recommendations, making decisions on applications for large grant applications, as well as drawing significant decisions and issues to the attention of the Board of Directors.

Summary of the decisions made for grant applications April 2021 to March 2022*

FUNDING REQUEST	DATE	FORUM	INVESTMENT (£)	DECISION
IT Hut for clinical staff	Apr-21	IC	£ 18,936.00	APPROVED
Stars Appeal Gardener	Apr-21	IC	£ 14,000.00	APPROVED
Stars Appeal Watercoolers-phase 2	Apr-21	IC/CFC	£ 14,000.00	APPROVED
Spoken Word - phase 1	Apr-21	SRO	£ 3,000.00	APPROVED
Spoken Word - phase 2	May-21	IC	£ 7,000.00	DECLINED
Stars Appeal Emergency Toiletry's Pack - pilot	May-21	IC	£ 9,420.00	APPROVED
Stars Appeal Engagers	May-21	IC	£ 35,562.00	APPROVED
Stars Appeal Live	May-21	IC	£ 90,000.00	APPROVED
Partner's Recliner Chair for Labour Ward	May-21	IC	£ 16,000.00	APPROVED
Microscope dedicated to Plastic Surgery OPD Th 9	Jul-21	IC	£ 69,481.00	APPROVED
Contribution to Staff Awards Ceremony	Aug-21	SRO	£ 5,500.00	APPROVED
End of Summer party & Family Fun day for staff	Aug-21	SRO	£ 10,000.00	APPROVED
Wall mounted Sani Stations (18 units)	Aug-21	SRO	£ 10,000.00	APPROVED
DNA extraction robot EZ1 Advanced XL (genetics)	Sep-21	IC	£ 34,528.50	APPROVED
Medical Engineering Refurbishment	Sep-21	IC	£ 41,480.00	APPROVED
Irrigation tower for Urology surgery patients	Sep-21	SRO	£ 4,700.00	APPROVED
Psychological Wellbeing Practitioner	Oct-21	CFC	£ 19,685.00	APPROVED
Project Wingman – staff wellbeing offer	Oct-21	CFC	£ 5,000.00	DECLINED
Stars Appeal Guest Wifi	Oct-21	CFC	£ 36,024.64	APPROVED
Support to Chaplaincy Services	Oct-21	CFC	£ 240,000.00	APPROVED
Hospital-wide Christmas décor & activities	Oct-21	SRO	£ 9,471.00	APPROVED
Genetics lab refurb	Nov-21	IC	£ 36,670.80	APPROVED
Support to capital bids 22-23: 2 Section Medi Plinth Electric Outpatient Couches	Nov-21	IC	£ 24,465.00	APPROVED
Support to capital bids 22-23: Finapres Nova	Nov-21	IC	£ 43,188.00	APPROVED
Support to capital bids 22-23: Hysteroscopy couch	Nov-21	IC	£ 11,900.00	APPROVED
Support to capital bids 22-23: Plaster Room - Chairs and Operator Saddle Stool	Nov-21	IC	£ 7,900.00	APPROVED
Support to capital bids 22-23: Plusoptix Paediatric Autorefractor	Nov-21	IC	£ 5,344.00	APPROVED
Support to capital bids 22-23: Sara Plus UK	Nov-21	IC	£ 5,864.00	APPROVED
Free visitor car park on Xmas eve, Xmas day, boxing day and New years day	Nov-21	SRO	£ 1,080.00	APPROVED
ArtCare - 3 years funding (22-25 £86k pa)	Dec-21	CFC	£ 258,000.00	APPROVED
New OPD Dept: Artworks and coordinating Furnishings	Dec-21	CFC	£ 20,000.00	APPROVED
Support to capital bids 22-23: AST solution for Microbiology	Jan-21	IC	£ 140,000.00	WITHDRAWN
Support to capital bids 22-23: 3D Ultrasound for Gynae	Mar-22	IC	£ 90,000.00	APPROVED
Support to capital bids 22-23: Additional BP monitors	Mar-22	IC	£ 75,000.00	APPROVED

**List excludes small expenditure and grant requests below 10k which are within Fund Signatories' discretionary limits to approve*

The Chairman of the Committee has been involved in setting the agenda with the Director of Finance. The minutes of the meeting are reported to the subsequent Board meeting for information, with highlights and issues for escalation presented by the Chair.

Committee attendance at Charitable Funds Committee meetings April 2021 to March 2022

Member	Designation	Meetings attended, including workshop
Nick Marsden (Committee Chair)	Chairman	5/5
Paul Miller	Non-Executive Director	5/5
David Buckle	Non-Executive Director	4/5
Lisa Thomas	Director of Finance	4/5
Andy Hyett	Chief Operating Officer	3/5

3. Priorities for 2022/23

The Committee will continue to improve the governance and processes for the effective management of charitable funds and to develop a strategic vision and operational plans for the Charity in line with Trust-wide policies, practices, and priorities.

To that end, the Committee's priorities for 2022/23 remain on the key areas outlined above but focused on the following activities:

- Completion of Brand Review with the launch of a refreshed identity and brand guidelines in collaboration with ArtCare and the Internal Comms team.
- Work in collaboration with the Communications Team on the development of a policy for funding recognition and maximise exposure of the Stars Appeal as to encourage support and attract fundraising.
- Give focus to the evaluation and assessment of actual demand and benefit impact of the initiatives funded by the Charity, especially those relying on ongoing funding for the Charity
- Appointment of Stars Appeal Communications and Engagement Officer as well as Finance Assistance roles
- Investigate alternatives for expanding the Charity's facilities to accommodate the increased headcount, ideally all within the same location.
- Explore opportunities for upgrading charitable funds and fundraising databases
- Review of capital assets which have charitable benefit (eg residential properties)
- Review of long term investments portfolio (HSBC)
- Appointment of a new Auditor replacing Grant Thornton UK LLP
- Seek specialist advise outside the Trust for compliance and strategies matters applied to Charitable organisations.
- Further progress with the fund review work, reviewing fund objects and signatories and encouraging clear expenditure plans
- Further engage with Divisional and Corporate finance functions on the planning of charitable expenditure

- Resume proactive walk arounds across the hospital to help staff/patients/visitors identify improvement suggestions suitable for Stars Appeal funding.

- Give focus to facilitate the delivery of charitable funded initiative in a responsive, timely manner preventing accumulating multiple unrealised financial commitments from previous financial years.

- Return to pre-pandemic fundraising plan and activity, retaining the elements that worked well on a "hybrid" virtual/physical format (e.g. Walk for Wards returning to Wilton House; Christmas Raffle remains available both via physical tickets and online)

- The Stars Appeal will continue to benefit from all funding/grants available including those for qualifying NHS Charities arising from the national Covid-19 Emergency Appeal ran by the membership organisation, NHS Charities Together.

- Give focus and support to the development of a Legacy Strategy

- Development of fundraising campaign for a major project(s) aligned with a key Trust development or potentially an annual theme, in the event the decision over a major capital investment is not agreed in time.

4. Terms of Reference

The Terms of Reference have been revised as part of the annual update of the Integrated Governance Framework which was presented to and approved by the Board on in April 2022.

5. Conclusion

This report concludes the Committee is functioning effectively and meeting its objectives as demonstrable by the achievements of the last year and the clear set of priorities for 22/23. In addition, the Charity has carried out a self-assessment utilising the Charity Governance Code tool which supporters the premise the Charitable Funds Committee remains effective. The Charity Governance Code gap analysis is enclosed to this report for consideration of the Committee and wider Board of Trustees.

NHS Salisbury NHS Foundation Trust

Report to:	Trust Board (Public)	**Agenda item:**	5.2
Date of Meeting:	08 September 2022		

Report Title:	**Trust Board, Committee and Council of Governor dates 2023**			
Status:	**Information**	**Discussion**	**Assurance**	**Approval**
				x
Approval Process (where has this paper been reviewed and approved)	Trust Board for approval			
Prepared by:	Kylie Nye, Head of Corporate Governance			
Executive Sponsor (presenting):	Fiona McNeight, Director of Integrated Governance			
Appendices (list if applicable):	N/A			

Recommendation:
The Board is asked to review and approve the Trust Board, Committee and Council of Governor dates for 2023.

Executive Summary:
The attached outlines the dates for the 2023 meetings. Key points to note are: • As per previous years, in some months Trust Management Committee (TMC) falls after the Board Committees (F&P and CGC) depending on the weeks in the month. TMC cannot be moved to the week beforehand in these instances as the data will not be available for inclusion in the reports. • With a new chair expected to start in January 2023, the Board scheduling will be reviewed and therefore minor changes to the timetable should be expected from April 2023 onwards.

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) -	☒

Trust Board, Committees and Council of Governors – Meetings 2023

	Trust Board Thursday Week 1 All day	Reporting month	Operational Management Board Tuesday Week 3 11 - 12	OD & People Management Board[1] Tuesday Week 3 2 - 4	Clinical Management Board Wednesday Week 3 10.30-12.30	Corporate Project Prioritisation Board Wednesday Week 3 1-2	Audit Committee Thursday Week 3 9.30 - 12	Subsidiary Governance Committee Thursday Week 3 1 – 2.30	Charitable Funds Committee Thursday Week 3 3 – 5	Trust Management Committee Wednesday Week 4 or 5 10 - 12	Clinical Governance Committee Tuesday Week 4 or 5 13:00-15:30	Finance and Performance Committee Tuesday Week 4 or 5 09:30 – 12:00	People and Culture Committee last Thurs 10 - 12
Chair	TBC		Lisa Thomas	Melanie Whitfield	Peter Collins	Louise Arnett	TBC	TBC	TBC	Stacey Hunter	Eiri Jones	TBC	Michael Von Bertele
January M10	**12 Jan Public/ Private**	**M9**	**17**	**17**	**18**	**18**	**-**	**-**	**-**	**25**	**31**	**31**	**26**
February M11	**2 Feb Private**	**M10**	**21**	**21**	**15**	**15**	**-**	**-**	**-**	**22**	**28**	**28**	**23**
March M12	**9 Mar Public/ Private**	**M11**	**21**	**21**	**15**	**15**	**16**	**16**	**16**	**22**	**28**	**28**	**30**
April M1	**6 April Public/ Private**	**M12**	**18**	**18**	**19**	**19**	**-**	**-**	**-**	**26**	**25**	**25**	**27**
May M2	**4 May Public/ Private**	**M1**	**16**	**16**	**17**	**17**	**25**	**-**	**-**	**24**	**23**	**23**	**-**
June M3	**8 Jun Public/ Private / Rem com**	**M2**	**20**	**20**	**21**	**21**	**-**	**22**	**22**	**28**	**27**	**27**	**29**
July M4	**6 Jul public/private**	**M3**	**18**	**18**	**19**	**19**	**20**	**-**	**-**	**26**	**25**	**25**	**27**
August M5	**10 Aug private**	**M4**	**15**	**-**	**16**	**16**	**-**	**-**	**-**	**23**	**29**	**29**	**-**
September M6	**7 Sep public/private**	**M5**	**19**	**19**	**20**	**20**	**21**	**21**	**21**	**27**	**26**	**26**	**28**
October M7	**5 Oct private**	**M6**	**17**	**17**	**18**	**18**	**-**	**-**	**-**	**25**	**24**	**24**	**26**
November M8	**9 Nov public/private**	**M7**	**21**	**21**	**15**	**15**	**-**	**-**	**-**	**22**	**28**	**28**	**30**
December M9	**7 Dec private/rem com**	**M8**	**12**	**-**	**13**	**13**	**14**	**14**	**14**	**20**	**19**	**19**	**-**

	Council of Governors Monday (CoG)	Non-Exec/Governor informal Monday
Chair	TBC	TBC
January	-	-
February	**27**	**13**
March	-	-
April	-	**17**
May	**22**	**-**
June	-	**12**
July	24	-
August	-	-
September	**AGM-TBC**	-
October	-	**9**
November	**27**	**-**
December	-	-

BANK HOLIDAYS	
2 Jan	**Monday**
7 April	**Good Friday**
10 April	**Easter Monday**
1 May	**Monday**
29 May	**Monday**
28 Aug	**Monday**
25 Dec	**Monday**
26 Dec	**Tuesday**

To note:

- Trust Board – always book the room 9-5 – will include any RemCo & Seminar, Public Board starts at 10am.
- Always include a Teams' link for those joining virtually
- All meetings book room 30 minutes ahead of start and end times
- NEDs/Governors – book rooms D&E
- CoG – if not virtual book Boardroom from 2.30 pm (set-up plus 3 pm pre-meeting)

Salisbury NHS Foundation Trust

Report to:	Trust Board (Public)	**Agenda item:**	6.1
Date of Meeting:	08 September 2022		

Report Title:	**Guardian of Safe Working Annual Report 2021/22**			
Status:	**Information**	**Discussion**	**Assurance**	**Approval**
	x			
Approval Process (where has this paper been reviewed and approved)	Discussed at People and Culture Committee Received for assurance at Trust Board			
Prepared by:	Juliet Barker, Guardian of Safe working			
Executive Sponsor (presenting):	Peter Collins. Chief Medical Officer			
Appendices (list if applicable):	N/A			

Recommendation:
The Committee are asked to note the annual Guardian of Safe working report for 2022 and its recommendations.

Executive Summary:
The Trust expect to be allocated around 170 doctors in training who are subject to the conditions of the 2016 contract. Doctors 'exception report' breaches of their contracted working hours to allow the trust to monitor and act on recurrent themes around workload and rightsizing of the work force. The majority of exception reports comment on inadequate staffing. This is in part due to unfilled training posts, and trainees working less than full time. The trust looks to mitigate this and fill unallocated rota slots with locally employed doctors (LEDs) not in training. Overall fill rates for SFT range from 76-92%, mitigated by LEDs so that the mitigated position is 82-98-%. The non-fill rate is particularly high in senior training posts which can impact a smaller hospital disproportionately. This tier of doctors are considered senior decision makers and are key to high quality patient care and efficient patient flow. Unmitigated, this has been as low as 76% fill rate, with a best of 87% fill when mitigated. The deanery are aware of this and we hope to have a better senior fill rate going forward. In order to gain a better overall picture of medical workforce pressure and pinch-points, exception reporting for LED doctors is in the process of being introduced.

Two barely compliant rotas (ED and palliative care) are now compliant.

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) -	☐

Guardian of Safe Working Annual Report 2021/22

Purpose

The 2016 Junior doctor contract introduced the role of the guardian of Safe working and requires that the guardian reports to the board (or via a committee) every quarter and produces a consolidated annual report, which is included as a statement in the Quality Account

Background

The Trust is allocated approximately trainees (including LTFT) by the Deanery to fill c175 full-time rota 'spaces'. There is an overall shortfall in the number of doctors provided by the deanery with respect to the required number to fill the spaces. This results in gaps in the medical workforce rotas. Some of these spaces are filled with locally employed doctors, or locums.

Numbers of trainees across the region are controlled and limited by the General Medical Council and Health Education England. The junior doctors' contract was negotiated in 2016 but not formally adopted until 2019 at which time additional restrictions on hours, consecutive long shifts and weekend working were introduced, with the aim of protecting junior doctors from overwork and protecting their training opportunities.

Since 2016 trainees have been required to report any instance that they work beyond the hours in their work schedule (national and local guidance gives a leeway of up to 15 minutes), any missed training opportunities and "immediate safety concerns" when they believe patients are being put at risk by excessive hours or insufficient doctors. Excess hours can arise for reasons including:

- Rota gaps resulting in fewer doctors than planned – for example due to the Deanery failing to recruit trainees, less than full time trainees, maternity leave, sick leave or poor annual leave planning.
- Unrealistic work schedules that do not meet the needs of the service
- Junior doctor factors including capability, organisational skills and clinical experience
- Supervision factors including lack of support, unrealistic expectations
- Infrastructure issues particularly IT, but also bleeps and telephones
- Lack of support from other health care professionals including nurses, pharmacists and admin staff.

We also employ locally employed doctors at junior and senior trainee level to fill rota gaps and provide additional staffing. Although their work schedules mirror those of the deanery trainees, they are not required to exception report. Despite this, we are working towards adding them to the exception reporting process. Discussions and decisions need to be made about if this will be a data gathering exercise rather than as a mechanism for overtime payment (as their terms and conditions of payment are different from those on the 2016 contract), or whether to move them entirely onto the 2016 T&Cs.
The aim is that this will give the trust a much greater view of hours worked by its medical workforce and better highlight gaps and issues. It will also give a degree of parity between deanery and LED doctors and a 'voice' to those who might otherwise feel unheard.

Rota Gaps

The rota gaps in this report occurred between June 2021 and May 2022

Number of doctors / dentists in training (total): c170
Number of doctors / dentists in training on 2016 TCS (total): c170

For context, c114 of these posts are at junior level and c61 are at senior level. Thus, for a given number of WTE gap, the senior rota is disproportionately affected.

Covid-19

Again, Covid-19 has caused disruption to the working patterns of junior doctors. The data below does not consider redeployment of juniors to cover other areas (e.g., respiratory high care) nor does it cover sickness and isolation gaps. On the other hand, any reduction in elective services due to Covid is also not recognised. This has been less of an issue than in previous years, but covid has still had an impact on staffing.

Junior Trainees (F1-CT2) WTE Gaps by Specialty and Grade

Specialty/grade	June 2021	July	Aug	Sept	Oct	Nov	Dec	Jan 2022	Feb	Mar	Apr	May
Elderly care F1			1									
Elderly care CMT	1	1	1	1	1	1	1	1				
Elderly care IMT							0.2	0.2	1	1		
ED F2	1	1	2	2	2	2						
Anaesthetics CT1	0.1	0.1							1	1		
Anaesthetics CT2	1	1					1	1	1	1	3	3
Anaesthetics ST2	0.2	0.2	0.2	0.2	0.2	0.2						
ITU F1								1	1	1		
AMUF2											0.25	0.25
AMU IT3									1	1		
ACCS ST2	1	1		1	1	1	1	1	0.25	0.25	1	1
Palliative GPVTS	0.2	0.2	0.5	0.5	0.5	0.5	0.5	0.5				
Endocrine GPVTS			0.4	0.4	0.4	0.4	0.4	0.4	1	1	1	1
Respiratory							0.3	0.3	0.5	0.5		
Endocrine CMT			0.2	0.2	0.2	0.2						
CMT3			1									
O&G GPVTS	1	1	0.2	1.2	1.2	1.2	0.6	0.6	0.4	0.4	0.4	0.4
O&G GPVTS									2	2	2	2
T&O CST2	1	1	1	1	1	1	1	1	1	1	1	1
Paeds GPVTS	1	1		1	1	1						
Plastics CST2	1	1	0.4	0.4	0.4	0.4	0.4	0.4	0.4	0.4	0.4	0.4
Psych F1	0.3	0.3										

Surgical F1			1	2	2	2					0.2	0.2
Psych F2							1	1	1	1		
Radiology							1	1				
Haematology CMT1/2											1	1
GPVTS											0.4	0.4
GPVTS F2											0.3	0.3
Plastics F2											1	1
WTE unfilled gap	**6.8**	**6.8**	**6.9**	**8.7**	**8.7**	**8.7**	**8.4**	**9.4**	**7.55**	**7.55**	**2.75**	**2.75**

Senior Trainees ST3-7 WTE Gaps by Specialty and Grade.

Specialty/grade	**June 2021**	**July**	**Aug**	**Sep**	**Oct**	**Nov**	**Dec**	**Jan '22**	**Feb**	**Mar**	**Apr**	**May**
ED	0.9	0.9	0.8	1	1	1	0.5	0.5	0.3	0.3	0.6	0.6
ED			1	1	1	1	1	1	1	1	1	1
Anaesthetics			0.2	0.2	0.2	0.2	0.2	0.2	0.2	0.2	0.2	0.6
Acute medicine	3	3	1	1	1	1	1	1	1	1		
ITU/resp				1	1	1	1	1	1	1	1	1
Acute medicine			0.2	0.2	0.2	0.2						
Gastro	2	2	1	1	1	1	1	1	1	1	1	1
Gastro			1									
Respiratory							1	1	0.4	0.4	0.4	0.4
Respiratory IM3											0.2	0.2
Elderly Care	2	2									1	1
O&G				0.4	0.2	0.2	0.7	0.1	0.1	0.1	0.1	0.1
O&G MTI	1	1										
Ophth	2	2										
Oral surgery	1	1	1	1	1	1	1	1	1	1		
Paeds	0.2	0.2	0.2	1.2	1.2	1.2	1	1	1	1		
Paeds	1	1	1				0.2	0.2	0.2	0.2	1.2	1.2
General Surgery	0.2	0.2										
Plastics	2	2			1	1	2	2	2	2	1	1
Spinal/rehab	1	1	1	1	1	1	1	1	0.5	0.5	0.5	0.5
Histopath			0.4	0.4	0.4	0.4	0.4	0.4	0.4	0.4	0.4	0.4
Haematology				0.2	0.2	0.2	0.2	0.2	0.2	0.2	0.2	0.2
T&O					0.2	0.2	0.2	0.2	0.2	0.2	0.2	0.2
Paliative				0.2	0.2	0.2	0.2	0.2	0.2	0.2	0.2	0.2
Radiology							1	1				
Stroke							1	1	2	2	1	1
Stroke									0.4	0.4	0.4	0.4
Max fax											1	1
Urology											1	1
WTEGap total	**10.3**	**10.3**	**7.8**	**9.4**	**9**	**9**	**9.2**	**8.6**	**7.7**	**7.7**	**10.2**	**10.6**

Months	June - August	Sept-Nov	Dec - Mar	April-May
WTE LED gaps	4 unfilled gaps	1 unfilled gap	2 unfilled gaps	5 (?7) unfilled gaps

Yellow indicates LTFT working.
Green indicates a rota gap that is filled with a trust grade
Red indicated an unfilled gap.
Blue represents an overfilled gap e.g., where two >50% LTFT trainees share

Issues arising

Ongoing staff shortages from deanery gaps, sickness, isolation and other forms of leave (e.g., annual) result in very slim staffing on the wards quite regularly. Even a 'filled' rota can become unworkable very easily with such little slack in the system.
Overall fill rates for SFT range from 76-92%, mitigated by LEDs so that the mitigated position is 82-98-%.

The non-fill rate is particularly high in senior training posts which can impact a smaller hospital disproportionately. This tier of doctors is a senior decision-making tier and is key to high quality patient care and efficient patient flow.
Unmitigated, this has been as low as 76% fill rate, with a best of 87% fill when mitigated. The deanery is aware of this and we hope to have a better senior fill rate going forward.

Actions taken to resolve issues

- Significant numbers of rota gaps have been filled with trust grade doctors, across all specialties and grades. However, some of these are not contracted to cover night or weekend working, which makes the picture less clear.
- Internal locums have been provided to help during weekend medical takes and have had a notable effect on reducing the workload. Junior doctors have strict limits on working hours, so this reserve can be in short supply.
- Extra F1 posts were recruited to over this last year, which will continue in the future, with another 6 posts this August. These doctors will then continue onto F2 posts with us.
- The previously non-compliant rotas in ED and palliative care (compliant only due to special sign off by the CD and myself) are now both fully compliant.

Summary

There are significant rota gaps across all specialties at both junior and senior grades. These gaps are often, but not always, filled with locally employed doctors. The gaps are as a result of the deanery not supplying a doctor to a post, of less than full time working and a smaller number of other reasons.
Information on the number of locally employed doctors remains difficult to obtain.

Recommendations

That the trust continues to employ LED to fill deanery rota gaps and support the service.

That we collect overtime working data from LED as well as deanery appointed juniors to better describe our workforce's activity and potentially make Salisbury a more attractive place to work.

Dr Juliet Barker
Guardian for Safe Working Hours
Consultant Anaesthetist.
July 2022

NHS
Salisbury
NHS Foundation Trust

Report to:	Trust Board (Public)	**Agenda item:**	6.2
Date of Meeting:	08 September 2022		

Report Title:	Freedom to Speak Up Guardian Annual Report 2021-22			
Status: ☞(tick appropriate box)	**Information**	**Discussion**	**Assurance**	**Approval**
	✓		√	
Prepared by:	Elizabeth Swift, Freedom to Speak Up Guardian			
Executive Sponsor (presenting):	Melanie Whitfield - Chief People Officer			
Appendices (list if applicable):				

Recommendation:
The Board is asked to **note** the contents of the report which is provided for information and assurance.

Executive Summary:
For information: • FTSU Annual Report 2021-22

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

1 Purpose

1.1 To present an overview of the work of the Freedom to Speak Up (FTSU) Guardian over the year including high level details of the number of cases raised, a thematic analysis and any learning from these cases.

2 Background

2.1 The standard NHS contract requires that all trusts and foundation trusts employ a Freedom to Speak up (FTSU) Guardian. FTSU Guardians are now employed across the health and care sector, including in primary care, health charities, independent providers and arms' length bodies including health regulators. The FTSU Guardian's role is to ensure patient safety and staff wellbeing by providing a mechanism for staff to speak up when they see or hear something that is not right. The FTSU Guardian also provides support to staff raise concerns and supports the Board to develop a 'positive, compassionate, and inclusive' workplace culture in line with the vision set out in the NHS People Plan.

2.2 In addition, while the mission of the National Guardian's Office is to make speaking up business as usual in the NHS, the broader strategy is to effect cultural change.

2.3 Salisbury NHS Foundation Trust is committed to implementing the recommendations of the Francis Report 2015 and embedding a strong culture throughout the Trust.

3 National Guardian's Office

Freedom to Speak Up Annual Report 2021/22 will be presented to parliament by the Rt.Hon. Sajid Javid Secretary of State for Health and Social Care later in the year. The submission of data required for the publication of the annual report has been delayed to the pandemic. The FTSUG will give highlights to the Board when published.

Other highlights over the 2021/22 period include:

- Dr Hughes stepped down from her role as National Guardian in September 2021 and Dr Jayne Chidgey-Clark was appointed and accepted the role in December 2021.
- Progress continues to be made to improve the speak up culture across a range of organisations, systems, and processes across the health sector. Since the National Guardian Office last update to the Board in March 2021, there are now more than 820 Freedom to Speak Up Guardians supporting thousands of organisations across the healthcare sector, who have handled nearly 70,000 speak up cases to date, allowing workers to speak up who might otherwise not be heard.
- The National Guardian Office's was originally funded by a three-way arrangement with CQC, NHS Improvement and NHS England, now by CQC and NHS England. The current memorandum of understanding between CQC, Department of Health and Social Care and NHSE covers April 2019 – March 2023 and the National Guardian Office has an annual budget of £1.66m. This year we will be collaborating with partners to develop a further memorandum of understanding for the next three years to agree a new budget.

- Continuing support and development for Freedom to Speak Up Guardians, including revised training for new Guardians, refresher training for existing Guardians, refreshed Network Chair role in 2022, a new role introduced - Mentors to support FTSUG to do their role more effectively. The FTSUG from SFT has been selected to be one of these mentors.
- Work with NHSE and CQC supporting implementation of the new Universal Freedom to Speak Up policy and guidance.
- Working with NHSE to support development of WRES - Race Equality Training to Freedom to Speak Up Guardians (in support of People Plan implementation)

4 Freedom to Speak Up Annual Survey 2021

The annual survey was carried out identifying key areas for future focus, in particular Senior Leaders' essential role in Freedom to Speak Up. Recommendations include:

- Senior leaders should deepen their support for speaking up by taking action to demonstrate learning from speaking up, tackling detriment, and supporting further cooperation within organisations on all matters related to speaking up.
- To improve their ability to act as effective role-models for speaking up we encourage all senior leaders to complete the NGO / HEE 'speak up, listen up, follow up' training.
- There should be visible action on detriment for speaking up wherever this is reported.
- The frequency and status of training on speaking up matters should be reviewed so that guardians and leaders can satisfy themselves that workers and those who support them have the knowledge and skills they need to speak up, listen up, and follow up, well.
- Senior leaders should take the necessary steps to tackle the perception that speaking up is futile, including ensuring appropriate action is taken when individuals speak up and that they are offered timely and meaningful feedback.

The full report can be found with the link below:

https://nationalguardian.org.uk/wp-content/uploads/2022/03/2021-FTSUGuardian-Survey-Report.pdf

5 Freedom to Speak Up Guardian Activity

5.1 **National Work** – The FTSUG has continued to actively engage with the National Guardian's Office, including responding to surveys, timely submission of quarterly data returns and putting forwards ideas for future development of the Guardian role.

National data continues to show that workers from a BME background are less likely to raise concerns. The 2021 Workforce Race Equality Standard (WRES) report shows 16.7% of BME staff had personally experienced discrimination at work from a manager, team leader or other colleagues in 2020; the highest level since 2015 (14%) and 35.3% of staff from an "other" black background (i.e., other than African or Caribbean) experienced harassment, bullying or abuse from other staff in the last 12 months. This has increased from 32.8% in 2016.

The National Guardians Office approached the Trusts FTSUG to benefit from our experience of a joined-up approach to EDI and FTSU. In March 2022 the Trust's FTSUG delivered training nationally at a Community of Practice Session focussing on supporting vulnerable staff groups and those from protected backgrounds to speak up. This session also asked how FTSU Guardians can better support managers to break down barriers to speaking up. The session was well received and the FTSUG continues to provide support to other healthcare providers, including mental health and primary care providers.

This approach has proved effective as evidenced when the FTSUG at SDH supported a group of international nurses who felt they were experiencing discrimination from their line manager to the point where it was affecting their ability to provide safe care. The FTSUG worked with the divisional management team to support them to address the concerns, provide appropriate training and remain impartial. The outcome was very positive as the concern was dealt with effectively and compassionately, the division had clear oversight of where improvement was required, a plan was put in place and the nurses who spoke up said that they were now very happy at work and would speak up again as their concerns had been addressed.

Ockenden Report - Amanda Pritchard, Ruth May and Professor Stephen Powis have written a joint letter to NHS leaders in response to the Ockenden report. The letter includes a paragraph which states: *"The report illustrates the importance of creating a culture where all staff feel safe and supported to speak up. We expect every trust board to have robust Freedom to Speak Up training for all managers and leaders and a regular series of listening events. A dedicated maternity listening event should take place in the coming months. We will soon publish a revised national policy and guidance on speaking up."* The recommendations and guidance will form part of SFT's Speaking Up Strategy to be finalised in October 2022.

5.2 **Regional Work -** The FTSUG attends Regional Network meetings and actively participates in driving the FTSU agenda forward. As the health landscape continues to evolve with the development of integrated care systems (ICS), Regional Integration Plans have been produced to describe actions going forwards and how to measure progress and uptake. The National Guardian's Office is working with primary care organisations to show how this can work at system level consultancy. The FTSUG is in regular contact with the Guardians at Royal United Hospitals Bath and Great Western Hospitals. This relationship is key for peer support, benchmarking and working together to push the Speaking Up agenda forwards as part of the BSW partnership. The FTSUG at SFT has initiated a proposal that the FTSU Guardians and the Chief People Officers at SDH and RUH work closely together to provide additional training, support and expertise to both organisations.

FTSUG provides ongoing mentorship to new and existing Guardians in the South West region.

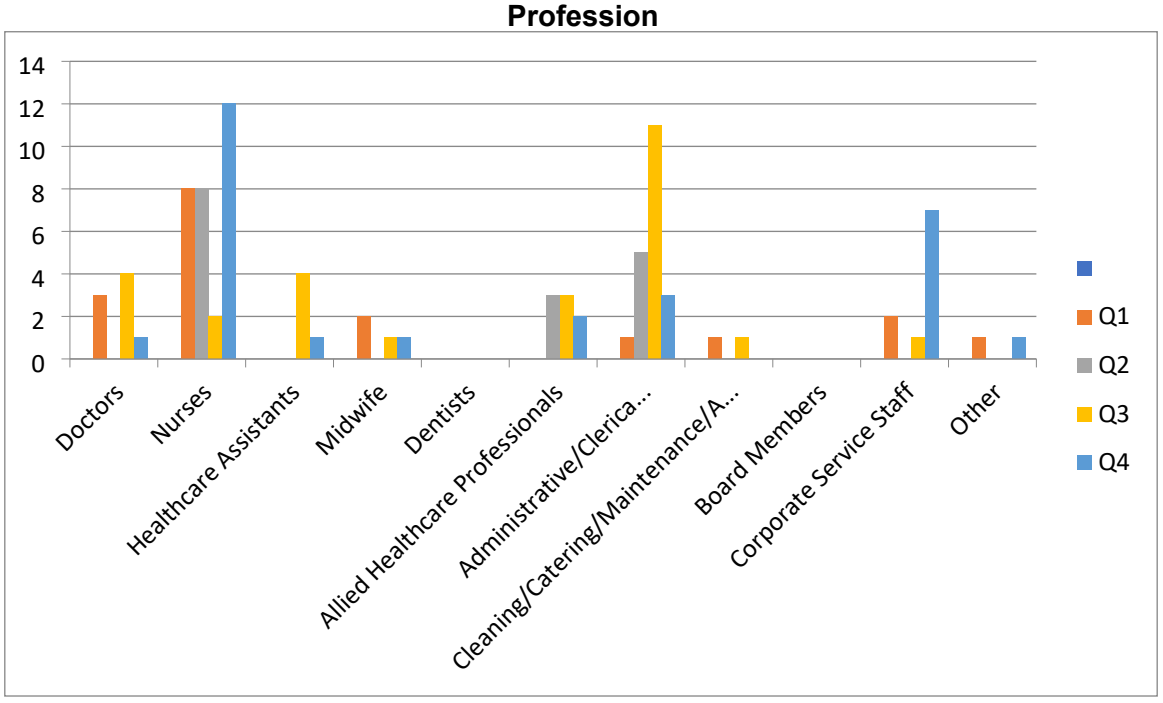
5.3 **Local work –**

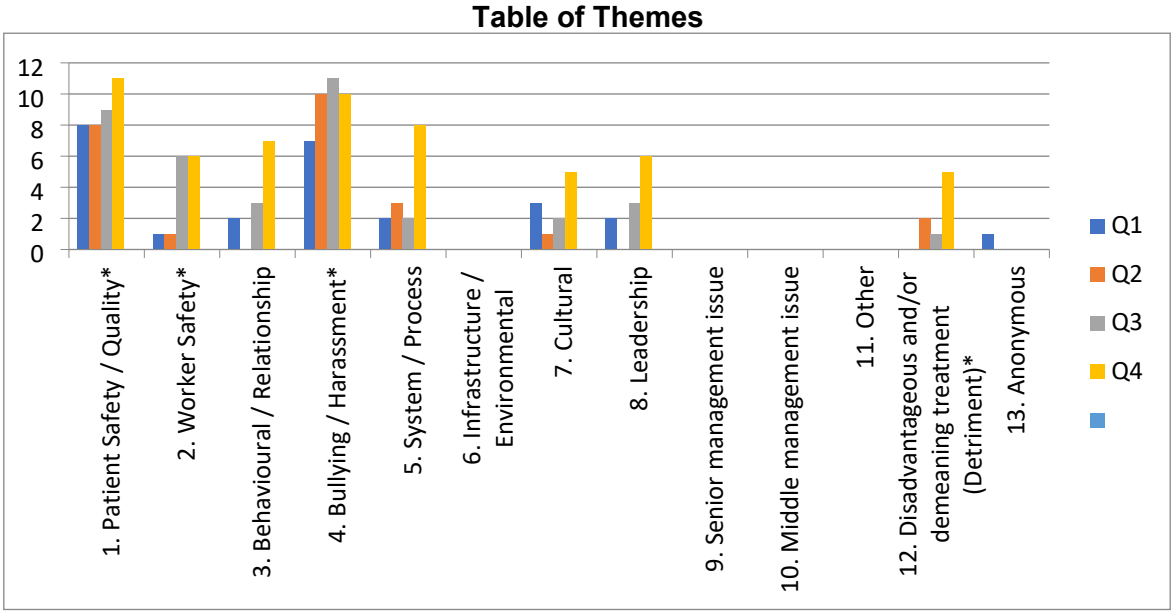
- **Care Quality Commission (CQC) –** CQC inspections understand the link between quality of leadership and management and the quality of service delivery. Listening and responding to people who speak up, tackling the barriers to speaking up are a significant element to the CQC rating process under the key line of enquiry (KLOE) 3 as part of the well led question. Although the last formal inspection was in 2018 the FTSUG continues to engage with the local CQC team providing information and assurance when needed.

- **Training** - The National Guardian's Office has launched, with Health Education England, training for all workers, and plan training for managers and leaders – with the view that everyone needs to take personal responsibility for their actions. In response to this, the Trust has agreed that this basic training 'Speak Up' became mandatory from 1st April 2021, giving current staff 12 months to complete the on-line package. From 1st April 2021 to 31st March 2022 1708 staff have completed this module (37.2%) of the 4587 workforce. 'Listen Up' is the next training package to be delivered as part of the Leadership and Management offer which targets staff with line management responsibilities. This module has just been released and is now available. In response to our own Maternity Services Review and the Ockenden Report, the Trust's Guardian presents at Midwives Study Days, Preceptee Study Days and meets regularly with the newly appointed Director of Women and Newborn.
- **Induction** - the Trust's Welcome Event has now returned to face to face. This event has been reviewed and re-styled with more emphasis on staff support and well-being. The FTSUG presents weekly at this event, supporting the Trust's aim to enable a compassionate and open culture.
- **Promoting FTSU** – Contact details for Freedom to Speak Up support is in the daily trust wide bulletins, and new posters have been produced and are placed in prominent places across the entire estate. The CEO and CPO do approximately 6 focussed FTSU bulletins throughout the year.
- **Key relationships** – the FTSUG continues to collaborate with many teams in order to support speaking up despite the challenges that COVID restrictions have brought. Regular meetings are held with People Business Partners, People Advisors, Risk, PALS, Litigation, Clinical Psychology, Staff Side, Chaplaincy, Guardian of Safe Working, Chief Resident, Executives and Non-Executives and protected groups such as the Race Equality Network and the Disability Network. FTSUG has also contributed to the Improving Together Programme, Best Place to Work initiative and supports line managers and leaders to develop a heathy speaking up culture. The FTSUG has access to the CEO, Chairman and CPO as Executive Lead as and when required, as well as having monthly 1:1's. Stronger links are being forged with the wellbeing team on actions from the NHS People Plan (health and wellbeing) to create a positive workforce culture.
- **FTSU Ambassadors** – SFT currently has 5 FTSU Ambassadors to support the Guardian. One of the original Ambassadors has left the organisation to which we were able to fill the vacancy with the Chief Resident. This has given FTSU further reach to the Junior Doctors, and the Chief Resident actively participates in Ambassador Supervision Sessions. SFT is fully compliant with the NGO's guidance on developing and maintaining ambassador networks, including ring fenced time for Ambassadors to support speaking up.
- **Cases** – 89 concerns were raised to the FTSUG during 2020-21down from 105 concerns during 2019-20, which is an decrease just over 15%. However, there were on 3 COVID-19 related concerns compared to 17 concerns during the previous year. Where issues are complex external investigations commissioned by the Executive Team have taken place. Approximately 15% of staff who raised concerns have left the organisation.

6 Summary of cases raised during 2020/21

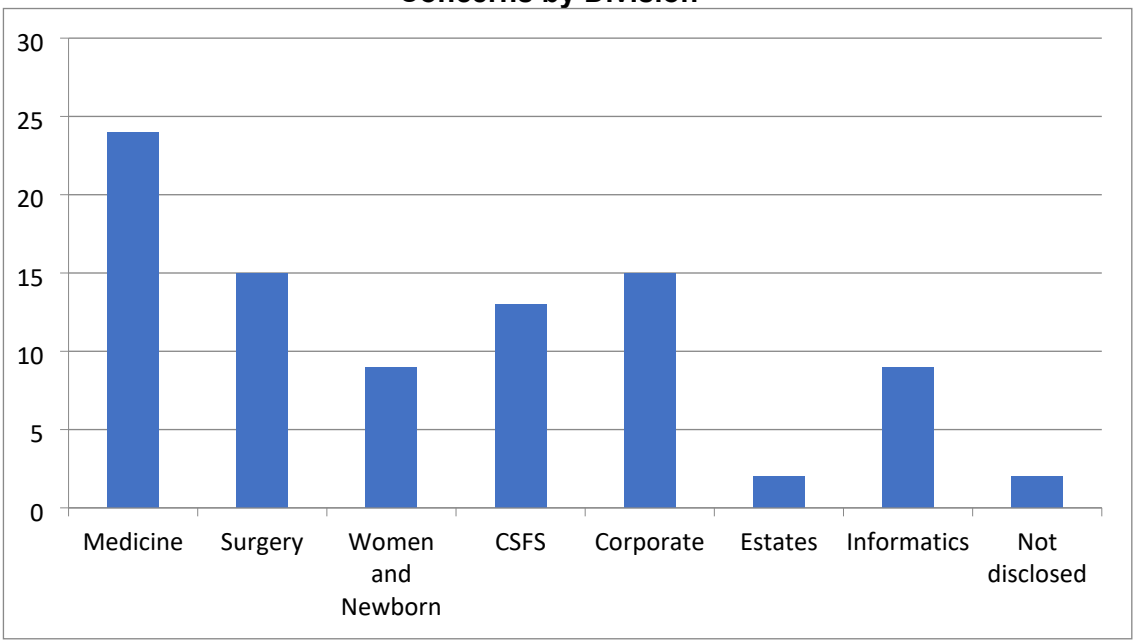
6.1 **Annual data - summary of issues raised 1st April 2021 – 31st March 2022**
During this period 89 cases were raised with the FTSUG and the charts below show the breakdown by professional group and National Guardian Office identified themes and trends.





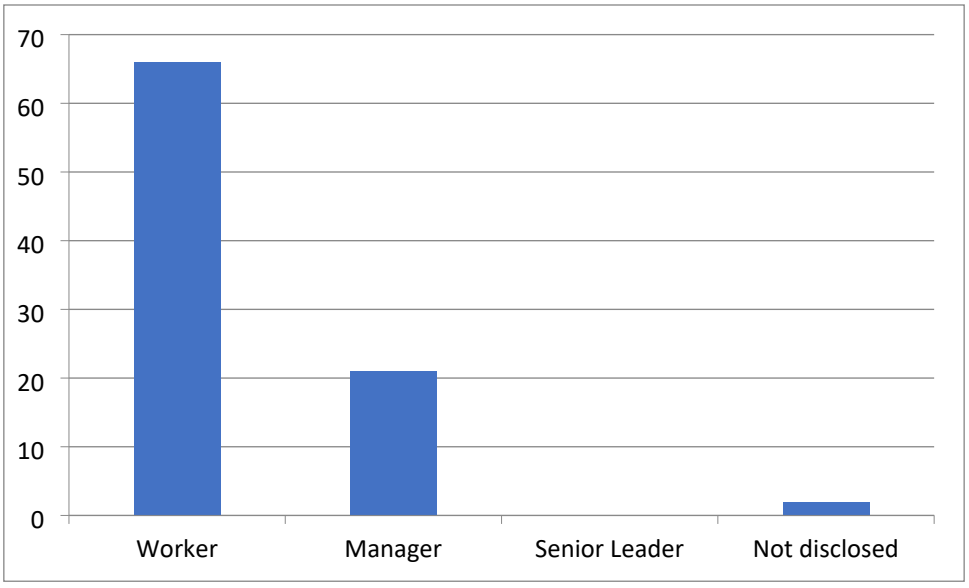
*Themes required to be reported to the National Guardians Office. The other themes are for local use. Some cases will contain more than one theme.

Concerns by Division



As we can see from the data, there are similar amounts of concerns being raised in the clinical divisions, with the Medicine Division being the highest.

Concerns by Professional Background



Cases that have an element of patient safety or quality have been reported to the Clinical Governance Committee and assurance provided that appropriate steps have been taken.

WRES data – during this period at SFT approximately 17% of the 4035 staff were from a Black, Asian or Minority Ethnic background. Of the 89 concerns raised, 17% were raised by staff from a Black, Asian or Minority Ethnic background which is a

proportional representation of the BAME workforce. The FTSUG works closely with the BAME Network to ensure that Speaking Up is promoted and barriers that this staff group may face are discussed and addressed.

7 Benchmarking

7.1 The national data is summarised below for 2017/18, 2018/19, 2019/20 and 2020/2021. There has been a delay due to the pandemic for the reconciliation and publication of the data for 2021/22 from the National Guardian's Office. Patient safety and worker safety have now been separated into two catagories.

	2017/18	2018/19	2019/20	2020/21	2021/22
Total cases	7,087	12,244	16,199	20,388	20,362
Element of Patient Safety/Quality	2,267	3,523	3,726	No data	No data
Worker Safety	No data	No data	No data	No data	No data
Element of Bullying & Harassment	3,189	4,969	5,831	No data	No data
Suffered Detriment	354	564	486	No data	No data
Anonymous	No data	1,491	2,105	No data	No data

SFT data for the same period:

	2017/18	2018/19	2019/20	2020/21	2021/22
Total cases	28	21	85	105	89
Element of Patient Safety/Quality	16	11	44	43	36
Worker Safety	No data	No data	No data	No data	14
Element of Bullying & Harassment	9	12	60	49	37
Suffered Detriment	No data	No data	16	11	8
Anonymous	1	0	1	1	1

The following should be noted from a comparison of the Trust data with the national data:

- The trends described, particularly the increase in the number concerns, reflects the picture seen nationally
- Nurses and midwives continue to be the staff group who raise the most concerns both nationally and locally.
- The Guardian has only received one anonymous concern
- Bullying and harassment is similar as is patient safety
- SFT reported 8 cases where there was a perception of negative treatment for speaking up

The below table shows the concerns raised in the BSW network during 2021/22.

Organisation	Q1	Q2	Q3	Q4	Total
Salisbury Hospital NHS Foundation Trust	**18**	**16**	**27**	**28**	**89**
Royal United Hospitals Bath NHS Foundation Trust	**45**	**22**	**51**	**30**	**148**
Great Western Hospitals NHS Foundation Trust	**2**	**8**	**No data**	**No data**	**10**

7.2 **Feedback** - A feedback form is sent to all staff who raise a concern, which asks if they would speak up again, how they found the experience and if they have suffered detriment due to speaking up. Approximately 18% of staff returned the form and the FTSUG also seeks verbal feedback when appropriate. There have been positive and negative experiences from staff who have raised concerns, below are a few examples:-

"My situation was helped immensely by speaking to the FTSUG. I am extremely grateful. Until I spoke to her I was despondent and felt completely let down by the Trust. As a result of her informative and helpful advice and also her presence at a meeting, the very distressing situation I was in has now been resolved. I found the Guardian to be very understanding. Would definitely recommend to colleagues"

"Talking through the situation through helped enormously and reduced my anxiety."

"After initial uncertainty, I am pleased I spoke up and I have the confidence in this service to speak up again. I was thanked for speaking up".

"Would speak up again. My experience was all positive, I felt comfortable to speak up and the help and advice was great. We got a meeting straight away and all felt listened to".

"After initial uncertainty, I am pleased I spoke up and I have the confidence in this service to speak up again, even though I did suffer detriment"

"Fast response, listened and provided with good verbal support and a supporting ear with good sign posting to help"

"Nothing has changed since I spoke up, so I am leaving the Trust. One of the Consultants said to me that the department has failed me, but still nothing has been done so I have no choice but to go".

All concerns have been followed up and feedback provided to the individual staff members. Of the concerns raised in 2020/21, 9 remain open with investigations in progress, and appropriate action has been taken whenever possible.

Other feedback would suggest that an area for improvement would be looking at the timeliness of responding to concerns and does the Trust have enough trained investigators.

7.3 **Board Self Review Tool –** SFT has recently recruited substantively to all the Executive roles, which has provided an opportunity for this document to be

discussed and reviewed by the Executive Board. This was led by the Chief People Officer who is the responsible Officer for FTSU in the Trust. The Trust continues to be fully compliant from a regulatory point of view, and recognises the need for further education and development particularly with line managers and those responsible for receiving concerns.

7.4 **NHS People Promise – We each have a voice that counts.** We all feel safe and confident to speak up. And we take the time to really listen – to understand the hopes and fears that lie behind the words. – FTSUG to work with the wider OD&P team to deliver this particular aspect of the People Promise. Actions include:-

- Using the Staff Survey results to establish current speaking up culture
- Using networks and digital spaces to convey staff experiences
- Making sure staff are empowered to speak up and when they do their concerns are heard
- We must make sure staff feel valued and confident that their insights are being used to shape improvements and learning

Staff Survey Results for SFT:

People Promise 3 (Age)
We each have a voice that counts

NHS Salisbury NHS Foundation Trust

	Comparator Information	Picker Average 2021	Organisation 2020	Organisation 2021			21-30	31-40	41-50	51-65	66+
Q	Description	n = 227091	n = 2062	n = 1881	SFT Change 2021 vs 2022	SFT vs Picker Average	n = 275	n = 448	n = 447	n = 571	n = 36
q3a	Always know what work responsibilities are	86.7%	86.7%	86.2%	0.50	-0.48	80.7%	89.0%	87.7%	85.4%	91.7%
q3b	Feel trusted to do my job	91.2%	91.1%	91.0%	0.12	-0.22	91.6%	92.2%	90.2%	90.8%	94.4%
q3c	Opportunities to show initiative frequently in my role	72.8%	73.7%	74.3%	-0.56	1.52	77.0%	75.9%	74.9%	70.5%	80.6%
q3d	Able to make suggestions to improve the work of my team/dept	70.5%	76.5%	72.1%	4.36	1.59	67.6%	72.7%	74.2%	72.5%	77.1%
q3e	Involved in deciding changes that affect work	48.7%	54.4%	49.5%	4.85	0.82	42.5%	50.3%	56.6%	47.4%	55.6%
q3f	Able to make improvements happen in my area of work	52.9%	58.1%	52.0%	6.09	-0.92	42.2%	55.6%	53.6%	52.5%	55.6%
q5b	Have a choice in deciding how to do my work	51.3%	57.1%	50.4%	6.71	-0.90	37.1%	50.0%	52.8%	54.4%	54.3%
q17a	Would feel secure raising concerns about unsafe clinical practice	73.5%	72.8%	71.7%	1.06	-1.80	71.8%	75.5%	69.0%	71.4%	77.1%
q17b	Would feel confident that organisation would address concerns about unsafe clinical practice	58.7%	56.8%	54.2%	2.62	-4.54	48.0%	56.0%	53.6%	55.8%	65.7%
q21e	Feel safe to speak up about anything that concerns me in this organisation	61.7%	68.1%	61.0%	7.11	-0.67	60.4%	63.3%	60.2%	59.9%	75.0%
q21f	Feel organisation would address any concerns I raised	49.6%	*	45.1%		-4.56	44.0%	47.2%	44.3%	43.9%	61.1%

Key:
100.0%
> 3 ppt above
< 3 ppt below
In between

11

These results show that confidence in the organisation to address concerns when they are raised has decreased. This has the potential to prevent workers from raising concerns in the future as they will see no point in doing so. An action plan needs to be agreed to work with those responsible for hearing and resolving concerns to ensure that these individuals have the skills and the confidence to address, resolve, learn and feedback on all concerns raised.

8 Summary of Learning from Speaking Up

The majority of the concerns raised have resulted in learning for the Trust. A summary of this learning is described below:

- After a case review by the National Guardian's Office at Blackpool Teaching Hospitals, which indicated that a speaking up case may not have been handled following good practice, the NGO produced a FTSU Gap Analysis Tool that collated all the recommendations from the 9 case reviews conducted by the NGO to prevent duplication. The FTSUG has completed the gap analysis against the national recommendations and although the Trust meets the majority of them , there are areas that have been identified that need improvement and actions against these include:-

FTSU GAP THEME	SFT ACTION	OUTCOME
Policies and processes should be supportive of all workers affected by the speaking up process, including those who are the subject of matters raised.	Updating all policies and procedures that relate to FTSU – currently in progress	To ensure all managers apply policies fairly and consistently
Ensure that leadership and management training is clear around the responsibilities for those dealing with concerns that are raised	Management training offer to include responsibilities for FTSU. The FTSUG is involved in the development of this training package.	All managers to be confident in addressing staff and dealing with concerns raised
Mediation should be actively promoted and facilitated, where appropriate, to resolve issues arising from speaking up.	Resource and train adequate number of mediators.	Resolution of concerns before they are escalated to a formal process.
Speaking up cases should be investigated within reasonable timeframes and without undue delay and where investigations are undertaken in response to speaking up issues raised by workers, feedback should be provided to those individuals regarding the progress of said investigations.	Ensure there are enough trained investigators with protected time to do the investigation. Relevant policies to be updated with correct process regarding feeding back to individuals regarding progress.	Investigations completed in a timely manner is less detrimental to both the individual(s) concerned and also the organisation.
Cultural review of SFT maternity services – not all aspects have been implemented	FTSUG working with new Dir.of Women & Newborn to support cultural change in the service. Tailored FTSU training delivered to midwives, preceptees and Maternity Health Support workers.	Improved retention and experience for new and established staff. Improved staff survey results.

In addition to these National recommendations there are actions which have taken place in response to local recommendations, which include:

- Focus groups arranged for staff to have a safe place to talk openly with feedback themed and anonymised for line managers to reflect on and action plans put in place.
- Identified support needed for redeployed individuals, including psychological support after being exposed to traumatic events that they have not been trained to manage.
- Clear role expectations put in place for redeployed Health Care Support Workers.
- Challenged poor behaviours to include openness and visibility of managers, disciplinary action taken where appropriate.
- Independent cultural review into the employee experience and wellbeing within a department where recurrent concerns were raised. Awaiting outcome and recommendations of review.
- Discriminatory behaviour has been addressed by appropriate training given to the individuals concerned with support put in place for those who spoke up.
- Managers should hold regular meetings with their teams to ensure that staff are aware of local changes and issues, as well as wider Trust changes that may affect them.
- FTSUG works with the Divisions looking at themes and trends of concerns raised. Action plans to be developed in response.

All these improvements will help our staff deliver an outstanding experience every time for our patients.

Speaking up is about anything that gets in the way of delivering high quality care.

9 Summary

9.1 All organisations which regulate or provide NHS healthcare should implement the principles and actions set out in the Freedom to Speak Up (FTSU) report and recent guidance from NHSI/E and the CQC: This paper provides the Committee with assurance that best employment practice for FTSUG has been adopted at Salisbury NHS Foundation Trust.

10 Recommendations

10.1 The Board is asked to note the Freedom to Speak Up Annual Report 2020/21 and consider appropriate actions for improvement going forwards.

It is recognised that improved leadership and management across the Trust will drive improvements in staff experience and wellbeing – this has been clear in our most recent Staff Survey and in ongoing conversations identified within this report.

Therefore, the author wishes to thank the Board for the continued support, scrutiny and awareness of our plans and their critical support in addressing the cultural changes and that appropriate resource is in place to enable.

Elizabeth Swift
Freedom to Speak Up Guardia

NHS Salisbury NHS Foundation Trust

Report to:	Trust Board (Public)	**Agenda item:**	6.3
Date of Meeting:	08 September 2022		

Report Title:	Improving Equality, Diversity, and Inclusion (EDI) - action taken in recent 12 months			
Status:	**Information**	**Discussion**	**Assurance**	**Approval**
	x	x	x	
Approval Process (where has this paper been reviewed and approved)	Update to the Board prior to development of the Annual Equality Report.			
Prepared by:	Rex Webb, Head of Diversity & Inclusion			
Executive Sponsor (presenting):	Melanie Whitfield, Chief People Officer			
Appendices (list if applicable):	Six High priority actions – Overhauling Recruitment Gender Pay Gap report 2022 WRES Report 2022 WDES Report 2022			

Recommendation:
The Board is asked to note the range of actions undertaken, the draft 5-year aspiration for developing a more inclusive culture in the organisation and to be assured of progress and compliance with our legal obligations including the Gender pay gap, NHS Workforce Race Equality Standard (WRES) and Workforce Disability Standard (WDES) reporting.

Executive Summary:
In August 2021 PwC produced an Audit report which was discussed at the Trust Finance and Audit Committee. Progress has been made against all six recommendations: 1. Formally define an EDI Strategy – in draft for consultation. 2. Revise the EDI Action Plan to include measures of success in response to the new strategy – in draft as part of our People Promise Strategy 3. Improve the data analysis capabilities for EDI metrics – monitoring data of new starters and leavers, promotion applications and those under formal review 4. Improve EDI governance structure and management information in order to successfully track progress – Re-established both EDI committee and staff network groups 5. Identify further opportunities for embedding EDI – Networks/ Board development – senior objectives/ review of refreshed polices and procedures

6. Review available EDI resources both within the Trust and across the system – Newly created role Head of Wellbeing and Inclusion with supporting specialist recently advertised for recruitment

The Audit recommendations included reference to the limited expert EDI resource within the Trust. The services of Ricky Somal, Deputy Director of OD & Inclusion, Isle of Wight Trust were secured for a time limited period to assist in developing actions to achieve the recommendations of the PwC Audit.

Ricky Somal worked with Rex Webb, Head of Diversity and Inclusion to identify the actions and deliver the products and/or interventions required against each of the recommendations.

The attached reports highlight the progress we have made and some of the associated activities which have taken place during the previous twelve months.

Attached documents highlight progress and recommendations on the following documents:

- Six High priority actions – Overhauling Recruitment
- Gender Pay Gap report 2022
- WRES Report 2022
- WDES Report 2022

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) -	☐

Progress of Equality Diversity and Inclusion since August 2021:

1. Background:

In August 2021 PwC produced an Audit report which was discussed at the Trust Finance and Audit Committee.

The report made the following six recommendations:

1. Formally define an EDI Strategy.
2. Revise the EDI Action Plan to include measures of success in response to the new strategy
3. Improve the data analysis capabilities for EDI metrics
4. Improve EDI governance structure and management information in order to successfully track progress
5. Identify further opportunities for embedding EDI
6. Review available EDI resources both within the Trust and across the system

Ricky Somal, Deputy Director of OD & Inclusion, Isle of Wight Trust was engaged as an independent expert to work alongside Rex Webb, Head of Diversity and Inclusion to help shape the response to the audit's recommendation, co- create the products and interventions that would respond to Sft particular situation and needs.

It is also important to note that the results of the 2021 Staff Survey remind us of the impact on our people when we don't always support a compassionate and inclusive place of work.
A summary of the Staff Engagement results by protected characteristics:

- 21–30-year-olds are less engaged than those of other age groups
- Time passes less quickly at work for disabled staff who also feel less able to make improvements at work.
- Some BAME groups are more highly engaged than white staff with mixed race staff less engaged in some aspects.
- Those people who prefer not to state their gender identity are less engaged than others
- Gay or lesbian staff are more highly engaged in some respects, as are those who stated their sexual orientation as 'other'.
- Those people who prefer not to state their sexual orientation, and bisexual staff are less engaged.
- Buddhist, Hindu and Muslim staff are more highly engaged than those other religions.
- Those people who prefer not to state their religion are the least engaged.

Progress on PwC Actions:

1.1. Formally define an EDI Strategy:

The draft EDI strategy has been developed with both the results of the staff survey and the aims of the People Plan and People Promise in mind.

The strategy was considered at the EDI Committee in July 2022, has been subject to further revisions following this meeting and currently with the Network Chairs for further comments.

The deadline for completion of the Strategy has been extended to carry out full consultation with staff Networks, Staff Side, and the Trust Board.

1.2. Revise the EDI Action Plan to include measures of success in response to the new strategy

We developed an Improving Together A3 on the subject of "Creating an Inclusive Culture – Improving Belonging in the NHS". This used evidence from the NHS staff survey, WRES, WDES, GPG reports and the PwC Audit. The A3 action plans are been used to inform the development of the EDI Strategy.

As a People Promise exemplar site, we have prepared our 3 -5-year strategy against each of the 7 elements of the People Promise

Our 3 to 5-year aspiration for Improving Belonging:
We will:

1. Continue to take regular quarterly checks on the lived experience of our staff, listening to their experience and progressing actions which make a positive difference to their work experience.
2. Design develop and host diverse network groups and development courses which provide safe forums for feedback, exploration and personal growth with all staff groups reporting fairer treatment and a sense of equality of opportunity.
3. Require all managers and leaders to attend both skill and behavioural training workshops building their personal sense of competence and demonstrating their successful application through continually improving results in sense of team, value of appraisals and the embedding of a compassionate culture.

Our Outcomes:

1. People can develop and thrive in a compassionate and inclusive environment where they can see that inequalities are being addressed
2. Leaders are clear on how they need to behave to perform effectively and deliver the NHS People Promise.
3. A single NHS framework for leadership competence and behaviour underpins recruitment, conduct, performance and personal or professional development.
4. A common curriculum provides open access to learning and career pathways.

We have identified the priority actions for the last 6 months of 2022/23, each of which has a stated outcome and indicative benefits measure

2. Improve the data analysis capabilities for EDI metrics

As part of his work Ricky Somal reviewed all available equality data using it to create the initial A3 on the subject of "Creating an Inclusive Workforce."

We have started to use equality data regarding starters and leavers and those applying for promotion within the quarterly and annual equality reports. This includes the annual WRES and WDEs reports.

The Trust has been exploring opportunities to work with BSW system partners to better understand community demographics.

We will also extend equality reporting for staff under formal review.

3. Improve EDI governance structure and management information to successfully track progress

In 2021 members of the EDI Committee discussed the future of the committee. It was agreed that a review would take place of Terms of reference and membership. This was carried out in a

wider governance review which looked at Organisational Development and People sub committees across the Trust.

This resulted in a refresh of the Terms of Reference and membership. The revised EDI Committee met for its first meeting in July 2022. It was agreed in the immediate future for the committee to me on a bi-monthly basis.

In future the EDI Committee will be responsible for monitoring the EDI Action plan identified within the future EDI Strategy.

In reinvigorating the Networks, we have also discussed their purpose and the value of their role in been more closely involved in the design and content of our improving people practises

4. **Identify further opportunities for embedding EDI:**

Over the past year several initiatives were identified under this action. These included:

- Trust Board Development EDI sessions.
- Working with Trust Executive Officers to identify sponsors for staff networks.
- Reinvigorating Staff Support Networks.
- Embedding EDI in the Trust Communication Plan
- Identifying actions under the People Promises program.

5. **Trust Board Development EDI sessions**

In December 2021 Ricky Somal and Rex Webb attended Board Development day. They ran a three-hour initial EDI session for the Board in preparation for a second session to set priorities.

In February 2022 Ricky Somal and Rex Webb ran a second development session with the Board to set EDI priorities for the future.

The Trust Board agreed to committing to Senior leaders and board members having performance objectives on workforce race equality built into their appraisal process. https://www.england.nhs.uk/wp-content/uploads/2019/01/wres-leadership-strategy.pdf

6. **Working with Trust Executive Officers to identify sponsors for staff networks.**

Executive sponsors have been identified for all networks, this is kept under review as personal changes and each is working with their Network Chair to agree a “schedule” of events for the remainder of this financial year.

Ricky Somal has sent a proposal to run a “Leaderfeast” to promote our inclusive culture offer across the organisation. Initial discussions have taken place with our Communication Team, resource and time dependent

7. **Reinvigorating Staff Support Networks.**

The development plan to re-invigorate the staff networks was presented to the Executive team and a number of staff network leads. The discussion resulted in a decision to also create an overarching Inclusion Network which was launched in April 2022

The Inclusion Network discussed the principles of a vibrant and effective Network community which included a wider discussion as to what they needed to flourish within the Trust. Unique to Sft in BSW we have agreed a paid day each month for Chairs to help secure time for preparation/ meeting members

Since this initial meeting in April the Chief People Officer has been meeting regularly with the identified Network leads to support their development. A member of the Communications Team joins the meeting to assist the Network Leads in developing a communication plan to encourage promotion and advanced visibility of events/ Trust wide communications for maximum exposure and impact

Network leads have been asked to identify the activity that their networks will be concentrating on in the coming months. This will include a schedule of events planned over the next twelve months.

8. **Embedding EDI in the Trust Communication Plan:**

To support a sense of belonging the Trust has

- Produced a series of podcasts (*Cake with Joe & Jayne*) based on the broad theme of Who am I, who are you, who are we? These are conversations between the hosts (Joe and Jayne) and staff members. The subjects covered in the series have included sexuality, race, faith, prejudice, mental health and disability. To date the podcasts have been downloaded over 2700 times and analysis indicates that the majority will have been by staff members. Staff involved have come from across the Trust and staff groups.

- Run a “Jigsaw” poster campaign highlighting that someone’s sexuality is only part of their identity.
- Supported a well-attended informal evening event to launch the Inclusion Network
- Focussed on celebrating Pride Month and other awareness events across the year. Developing with the Networks a calendar of events for the year ahead.

9. **Identifying actions under the People Promises program:**

We have been working with the people promise manager to identify and align equality actions around **People Plan ambition 2: Improve belonging in the NHS**.
“We continually listen to our staff adapting our efforts to make the culture of our Trust universally understanding, kind and inclusive”

We have identified five key themes:
- Six high impact actions to overhaul recruitment
- Promote Equality across all protected characteristics
- Reinvigorate the staff networks
- Implement a Just and learning culture
- Implement Listening Events.

You will see that some of the actions already underway following the EDI Audit link directly into this piece of work.

We have also included details of the progress in this area within the draft EDI Strategy.

With reference to the “six high impact actions to overhaul recruitment”, these have been included in the recommendations following the PwC review on the Trust recruitment and progressions processes. They have produced a number of recommendations which are fully documented on the attached update six-point action plan.

The Trust is also working with partners across the BSW ICS to identify best practice around the six-point plan. This also includes identifying possibilities for joint working.

The OD&P management team, including our people promise manager are currently working to identify the best ways to measure progress in these areas.

10. Review available EDI resource both within the Trust and across the system

As mentioned earlier in this report the Trust secured the services of Ricky Somal, Deputy Director of OD & Inclusion, Isle of Wight Trust to assist in driving the equality agenda forward. This involvement was for a limited period working alongside the Head of Diversity and Inclusion.

Ricky was able to assist in facilitation of a number of sessions with the Trust Board and Network Chairs. He also reviewed our equality data assisting in developing the EDI Strategy, completion of A3's and re-introduced us to the NHS Equality Delivery System 2.

Ricky has shared with us a wealth of data and baseline review which will assist us when the mandatory Equality Delivery System 3 is introduce next year.

After reviewing the resources required to drive the equality, diversity and inclusion agenda forward the Trust has identified two full time roles which will replace the current Head of Diversity and Inclusion upon his retirement in September 2022.

These are:

- Head of Diversity, Inclusion and Well Being - AfC Band 8a
- Diversity, Inclusion and Well Being Specialist – AfC Band 6

11. Resource available across BSW ICS:

Throughout 2021 the Head of Diversity & Inclusion continued working with the BSW CCG for 7.5 hours per week alongside his SFT contract. He continued in the role of BSW EDI Lead until March 2022 leading the BSW EDI Leads Network. At this point in time the BSW Academy was launched and the Leads Network transitioned into the Inclusion pillar of the academy. At this point a permanent inclusion pillar lead was appoint and they took the lead across the ICS.

During his time as the BSW EDI Lead the Head of Diversity and inclusion completed the following actions across the system:

- scoped and engaged with EDI resources/staff across the system
- set up and facilitated the BSW EDI Leads network, which meets regularly on a six-week basis
- identified active EDI staff support networks, best practice, learning and sharing.
- commenced work to collate WRES/WDES (and equivalent data from other system partners) to determine benefit of BSW system priorities/focus
- worked with the BSW EDI Leads Network to identify a set of standard EDI principles which underpin the BSW Academy Inclusion Pillar.

Salisbury NHS Foundation continues to be an active partner in the Inclusion Pillar and the new Head of Diversity, Inclusion and Well Being will be a member of that network.

The Inclusion Pillar will be responsible for identifying areas of EDI best practice, supporting organisations in their EDI journey and facilitating joint working.

12. NHSE/I Disability Confident Pilot Program

In November 2021 the Trust submitted an expression of interest in the NHSE/I Disability Confident Pilot Program. The program aimed to assist organisations in progressing to Level 3 of the Disability Confident program and become Disability Confident Lead organisations. It also includes a commitment to recruit people with learning difficulties into Health Care Support Workers (HCSW) role.

Working with a few staff with disabilities we completed a self-assessment against the Disability Confident standard which resulted in the Trust being awarded level 2 Disability Confident Employer status in March this year. The pilot program ended at that time and we were unable to achieve level 3 Leader status in that timeframe.

However, following advice from the Shaw Trust we have identified several actions we need to complete to get to level 3 within the next 12 months. At the present time the Actions are being reviewed by our re-established Ability network, of which the CNO is the Exec Sponsor.

13. EDI training:

During 2021 once the Covid restriction had been relaxed the Head of Diversity & Inclusion together with the Freedom to Speak up Guardian continued to facilitate a face-to-face induction session on EDI & FTSU.

They have also restarted the face to face 3-hour EDI and FTSU training sessions which were run before the pandemic. Take up for these sessions have been limited due to staffing issues and people not being able to be released to attend.

Those who have attended the sessions have found them useful and have commented positively. Suggestions have been made to develop a shorter offer retain the key items.

It is recommended that the EDI training be reviewed in conjunction with Education and the Head of Leadership Development to ensure that it is fully embedded across all areas of the Trust – First Line Leadership Programme for example

14. Gender Pay Gap Report 2022

This year's Gender pay Gap data was collected on the snapshot date of the 31st March 2022. The Gender Pay Gap Report has been discussed at OD& P management board and will be discussed at People and Culture Committee in September. The recommendation is that it is published by the deadline of the 30th March 2023, but subject to wider discussion by the Trust Board.

The main finding of the report was that the pay gap has reducing year on year, without any direct action been put in place. There is more we would like to consider on this topic for example detail by profession, age group etc.
(Copy of the report is attached)

15. Workforce Race Equality Report 2022

The WRES data was collected on the snapshot date of 31st March 2022. The data was submitted to the OD&P management board and the People & Culture Committee for assurance in July. The data has now been double checked and has been published on the NHS data collection site to meet the deadline of the 31st August 2022.

The WRES Report 2022 has now been drafted, which analyses the data. This report will be submitted to the People & Culture Committee in September to meet the deadline for publication, 31st October 2022.

The main findings of the report include an increase in the disparity ratio for progression of Black, Asian and Minority Ethnic Staff to White staff being 13.21 times more likely to progress from lower to upper bands within the organisation. This may have been influenced by the success in recruiting international nurse at AfC Band 5.

The following recommendations have been made in the report:
It is recommended that Salisbury NHS Foundation Trust:

- Continues to ensure that they take into consideration the findings of this report.
- Identify a mechanism for ensuring accurate data is collected regarding recruitment and non-mandatory training of diverse staff.
- Work with Royal United Hospitals Bath and Great Western Hospitals to identify consistent issues and provide joined up solutions.
- Continues to work with the BSW Academy Inclusion Pillar to identify best practices and areas suitable for joint working across BSW ICS.
- Fully implement the recommendations from PwC on the overhauling of recruitment and progression process.

(Copy of the report attached)

16. Workforce Disability Equality Report 2022

The WDES data was collected on the snapshot date of 31st March 2022. The data was submitted to the OD&P management board and the People & Culture Committee for authorisation in July. The data has now been double checked and has been published on the NHS data collection site to meet the deadline of the 31st August 2022.

The WDES Report 2022 has now been drafted, which analyses the data. This report will be submitted to the People & Culture Committee in September to meet the deadline for publication, 31st October 2022.

This year's report continues to note the disparity in data between those who share their disability status on ESR and those who identify anonymously on the NHS Staff Survey. 116 on ESR compared to 369 in the Staff Survey. Understanding the reason for this could prove helpful and could be part of our modernising our people practises as we recognise some colleagues choose to report living with a condition not a disability.

It is to be noted that the percentage of staff who do not think the organisation values their work has slightly risen since last year. That is 8% higher for staff with a disability and 10% higher for those without.

The WDES report includes several recommendations aimed at supporting staff with disabilities and creating an inclusive workplace.

- Develop an active and effective Ability Network supporting staff with disabilities.
- Overhaul the Trust Reasonable Adjustment process.
- Increase sharing of personal protected characteristics on ESR – or with key colleagues to help make adjustments where required.
- Achieve Disability Confident Leader Level 3 status.
- Research and review how the Trust collects data on progression of people with a disability through the pay bands.

- Regularly review the number of starters and leavers by the disability status.

(Copy of the report is attached).

17. Equality Impact Assessment process:

During 2020/21 the Equality Impact Assessment process was updated. This has been managed over the past 12 months by the Head of Diversity & Inclusion.

Two sessions have been recently arranged and published on the Managed Learning Environment (MLE). These will be advertised on the Daily bulletin for managers to attend.

CLASSIFICATION: please select

NHS Salisbury NHS Foundation Trust

Report to:	Trust Board (Public)	**Agenda item:**	6.4
Date of Meeting:	08 September 2022		

Report Title:	Health and Safety Annual Report			
Status:	**Information**	**Discussion**	**Assurance**	**Approval**
			x	
Approval Process (where has this paper been reviewed and approved)	Health and Safety Committee and Trust Management Committee (July)			
Prepared by:	Peter Adams, Interim Head of Health and Safety			
Executive Sponsor (presenting):	Melanie Whitfield Chief People Officer			
Appendices (list if applicable):				

Recommendation:
For the Trust Board to note and accept the Health and Safety Annual report for the period the period 1 April 2021 to 31 March 2022

Executive Summary:

The annual report provides a formal record to confirm that the Trust Board are discharging their responsibilities and duties in accordance with Health and Safety Executive legislation alongside the key issues and activity undertaken during the period 1 April 2021 to 31 March 2022.

The report makes a formal record of issues and performance in health and safety which lead to the aims and objectives for the year ahead in support of an organisational culture in which a positive and proactive approach is taken to health and safety management.

The subjects covered in the year should be considered against the backdrop of Covid-19 which diverted resource and attention from developing the formal system of health and safety management to operational activity.

Through the year H&S performance has improved slightly with regards to accident statistics. Compared with the previous year there were very similar numbers of incidents but with two less incidents reportable to the Health and Safety Executive (13, compared with 15 in 20-21). However, the backdrop of Covid has affected the type of reports received, for example a greater number of incidences causing harm were reported, but fewer no-harm incidents, indicating that there is potentially an underlying hidden increase in accidents but with an under-reporting of near-miss incidents.

CLASSIFICATION: please select

2022-23 is anticipated to be a year in which the Trust reverts towards business as usual. There will be continuing staff changes in Health and Safety with a change in both the H&S Manager and H&S Adviser in 2022. The emergence of a structured Health and Safety Management System provides a foundation for the new team to build on the workplan, the annual report therefore contains an overview of the H&S Management System and a description of the plan of work ahead to populate it. The overview identifies the two key priorities as the need for a comprehensive bank of policies and standards, and a programme of audits that provides assurance of their implementation.

The Trust Health and Safety Committee continued to meet during the year with bi-monthly meetings supported by a newly introduced bank of sub-committees. These sub-committees provide the mechanism through which key matters of assurance can be considered and escalated, if necessary up to Board level.

The reporting of risk has evolved through the year and a new corporate risk identifying the need for assurance of compliance with health and safety legislation has been produced. This is not because of an increase in the risk of non-compliance, but because previously unknown compliance issues have been identified there is a need to monitor the mitigation. To mitigate the risk the Health and Safety Management System provides an overarching model of continual improvement that interprets legislative requirements into Trust policies and standards which are then audited as the primary means of assurance.

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) -	☐

Health and Safety Annual Report

April 2021 – March 2022

Contents

1. Executive Summary

The report forms a formal record to confirm that the Trust Board are discharging their responsibilities and duties in accordance with Health and Safety Executive legislation alongside the key issues and activity undertaken during the period 1 April 2021 to 31 March 2022.

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Through the year H&S performance has improved slightly with regards to accident statistics. Compared with the previous year there were very similar numbers of incidents but with two less incidents reportable to the Health and Safety Executive (13, compared with 15 in 20-21). However, the backdrop of Covid has affected the type of reports received, for example a greater number of incidences causing harm were reported, but fewer no-harm incidents, indicating that there is potentially an underlying hidden increase in accidents but with an under-reporting of near-miss incidents.

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The Trust Health and Safety Committee continued to meet during the year with bi-monthly meetings supported by a newly introduced bank of sub-committees. These sub-committees provide the mechanism through which key matters of assurance can be considered and escalated, if necessary up to Board level.

The reporting of risk has evolved through the year and a new corporate risk identifying the need for assurance of compliance with health and safety legislation has been produced. This is not because of an increase in the risk of non-compliance, but because previously unknown compliance issues have been identified there is a need to monitor the mitigation. To mitigate the risk the Health and Safety Management System provides an overarching model of continual improvement that interprets legislative requirements into Trust policies and standards which are then audited as the primary means of assurance.

2. Recommendations

i. The Health and Safety team is to produce a schedule of the policies and standards required by health and safety legislation and create a single point of access to them on the intranet as a gateway for easily accessibility.
ii. Undertake a programme of work to populate that gateway with the necessary documentation.

iii. Develop an audit programme that enables the Trust to determine (a) any gaps between legislative requirements and the Trust's policies and standards, and (b) the implementation of those standards. Report the outcomes as a KPI and monitor through the Health and Safety Committee.
iv. Utilise the Health and Safety Committee to set goals and targets and develop KPIs to monitor performance.
v. Continue to refine the sub-committees of the H&S Committee with the aim of generating a manageable workload for the H&S Committee, focussing on key risks and priorities.
vi. Develop a health and safety Training Needs Analysis to determine the training that is desirable be provided centrally, and the additional training required by divisions and directorates.

3. Purpose

The purpose of this report is to provide the Trust Board with an overview of H&S performance, incorporating assurance of activity plus escalation of areas of concern to inform the leadership actions of the Board. The report also serves to be a formal record that the Trust Board are discharging their responsibilities and duties as required by the Health and Safety Executive. The report provides summary information on health and safety performance during the period April 2021 to March 2022.

The report forms a record of the key issues and activity undertaken during the year, and notes progress of the programme of work being delivered by the corporate Health and Safety Team in partnership with colleagues within the Divisions.

The report seeks to combine the record of issues and performance to develop aims and objectives for the year ahead and encourage and support an organisational culture in which a positive and proactive approach is taken to health and safety management.

4. Scope

The report covers the period from 1 April 2021 to 31 March 2022. This is in line with the changes to the previous reporting period that aligned the health and safety annual report to that of the financial year and reported from April 2020 to March 2021.

5. Background

The year has been a year of change and instability arising from Covid-19 and staff changes in the Health and Safety Team. Covid-19 has focussed attention on patient care and the well-documented pressure on staff. Health and Safety has had an important part to play in the re-shaping of ways of working in response to Covid-19 which has come at the cost of business-as-usual activities. There has been a significant impact on activities such as maintaining and updating documentation, attendance at committees and working groups, delivery of training and disruption to the opportunity to inspect and audit divisions and directorates.

The Health and Safety team has also seen continued staff turnover with the departure of the Health and Safety Manager in February 2022 which will be followed by the departure of the

Health and Safety Adviser in July 2022. An interim Health and Safety Manager has been in place since February 2022 with the permanent replacement arriving in August 2022, reporting to an interim Deputy Chief People Officer.

The 2020 – 2021 Annual Report made the following recommendations and progress against them is contained in the table below.

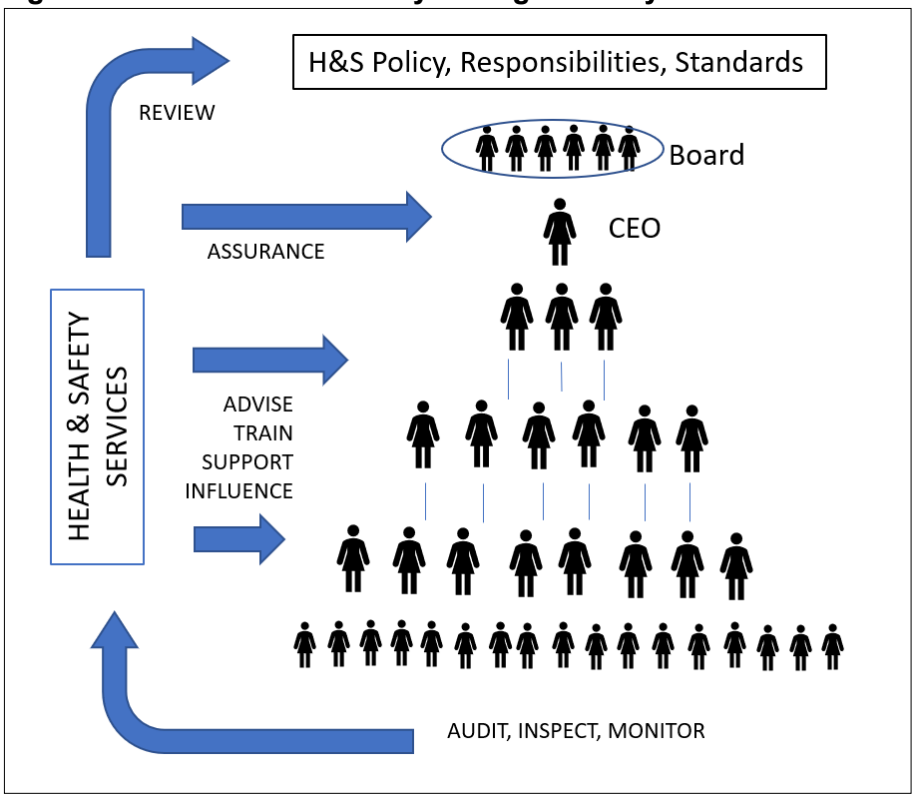
	2020 2021 Recommendation	**Outcome**
1	To halt the slight increase in RIDDOR reportable incidents that has checked a long-term downward trend.	The trend in RIDDOR reports is positive and shows a small improvement, from 15 to 13.
2	Initiate a strategic review of health and safety management at the Trust. This should incorporate an analysis of the gaps between the health and safety management system (such as ISO 45001 or the Health and Safety Executive's HSG65) and the system able to be delivered by the resources of the H&S team.	2021-22: a formal review has not taken place, however, as described in this report, there is movement and momentum behind the adoption of the principles of each part of HSG 65, including policy, governance, standards and auditing.
3	Prioritise and monitor the high level of incident causes of: • abuse of staff by patients or visitors' incidents • slips, trips & falls • needlestick injury • manual handling	Monitoring of the incident trends continue, while targeting specific areas has proved difficult in light of the priority given to Covid-19 response. However, a Slips, Trips and Falls audit was undertaken during April 2022 to evaluate the management of floors, paths and paving across the estate. The report is due to be released following consultation with the audited areas. The 2021 Staff Survey identified that fewer staff had experienced physical violence during the year, 88% had not experienced physical violence, an improvement from 86%, a figure that is above average against the other Trusts contributing to the survey. Regardless, this remains the most commonly reported accident cause by some distance and is a priority for 2022-23.
4	Identify a set of key performance indicators for health and safety with both leading and lagging indicators of performance. Set performance targets for improvement and for prioritisation in areas key to the Trust's vision.	This will be taken forward to 2022 - 2023
5	Provide sufficient resources to enable a prioritised programme of health and safety audits to be initiated, to address prominent incident causes and other areas of priority for the Trust, such as absence due to harm or ill-health and high incident rates in ED. Stroke Unit, Redlynch and the Sterilising Department.	Recruitment into Health & Safety is currently taking place with the case being made for administrative support to the team. Audits are the key priority for the H&S team and for informing committees, working groups and decision makers on H&S performance.

6. Health and Safety Management System

The corporate risk register identifies the risk arising from the demands of multiple pieces of health and safety legislation applicable to the Trust. Compliance with health and safety legislation cannot be assumed and a method of assurance has been created through a Health and Safety Management System.

There are several components to the Health and Safety Management System which are required in combination to enable the system to be successful and the risk mitigated. This is a cycle of continual improvement that ultimately enables the core function to be met – the implementation of the control measures identified by undertaking of a risk assessment for each hazardous activity.

Figure1. The Health and Safety Management System



6.1 The Components of a H&S Management System

6.1.1 Risk Assessment

Risk assessments are at the very heart of health and safety management and are required for every activity that presents a risk of harm. Health and safety risk assessment is often confused with the practice of risk management. The significant difference is that risk management requires the evaluation and and prioritisation of risk, whereas the purpose of health and safety risk assessments is to identify the legal requirements and produce systems of work to meet those requirements. (Ref Regulation 3 of the Management of Health and Safety at Work Regulations 1999).

The risk assessment should identify the statutory instruments that define the control measures that must be in place for the activity. It is only when a control measure is not defined by legislation, that a consideration of severity and likelihood should be made. Even

then there needs to be a significant imbalance between the risk and the resources to mitigate it if the residual risk is permitted to remain.

The *health and safety management system* is the framework that supports the undertaking of risk assessments for activities and comprises of:

i. **Policy**. This is a legal requirement under Section 7 of the Health and Safety at Work Act and the fundamental signal to staff and onlookers of the H&S culture of an organisation and should be prominently published.
ii. **Organisational Arrangements**. i.e., responsibilities, governance hierarchy
iii. **Subject policies and standards**. i.e., the interpretation of how the Trust will implement the H&S Regulations into the Trust's organisation structure
iv. **Support, advice & guidance**. Specialist expertise on H&S, from how to report accidents to advice on handling radioactive substances.
v. **Training**. The provision of training in the roles to be undertaken (e.g. the role of the fire warden) and in specific subject areas (e.g. how to safely use display screen equipment).
vi. **Monitoring**. Collating feedback through anecdotes, accident analysis, inspections, trends etc.
vii. **Auditing**. A formal check that the required actions have been undertaken
viii. **Reporting**. The provision of reports on performance to reward success or identify areas for improvement
ix. **Review**. Changes to the management system to implement improved ways of working.

6.2 Commentary on the Trust's H&S Management System

i. **Policy.** The statement of Health and Safety Policy is published on the staff intranet but is very difficult to find, listed under OD&P Collective Agreements. It is recently out of date but generally satisfactory. A revised statement of Policy has been produced and is undergoing consultation prior through the Trust Health and Safety Committee to approval at the Trust Management Committee.

ii. **Organisational Arrangements**. i.e., responsibilities, governance hierarchy, are all in order and are defined as part of the Health and Safety Policy.

iii. **Subject policies and standards**. There are few specific policies, and these are limited to CoSHH, DSE, Slips Trips & Fall, Manual Handling.

By comparison there are approximately 30 Regulations applicable to the NHS that are enforced by the Health and Safety Executive. In addition, further documents are required describing how fire safety, Covid and NQC requirements are implemented. An analysis has identified the need for 47 policies and standards to be produced to interpret the legislative requirements into the Trust's practices and procedures. Of these, good progress is being made with 12 Estates policies being produced and submitted for approval and a further 8 require only minor updates or review. A project to resource and publish the remaining policies and standards is a key priority for the first half of the year.

iv. **Support, advice & guidance**. This is provided on an ad-hoc basis by Health and Safety and through links to other specialists e.g., the Radiation Protection Adviser.

v. **Training.** H&S training provision relies upon the NHS Core Skills Training Framework. This sets a standard and frequency of training such that staff can transfer between Trusts with the necessary core knowledge. There is a need to undertake a review of what additional H&S training should be (a) expected and (b) offered to support the development of the health and safety management system and the health and safety culture at the Trust. This review has been incorporated into the plan of work for 2022-23.

vi. **Monitoring**. Datix enables all incidents to be collected, recorded, tracked and analysed. The system works well, if a little cumbersome for the ease of reporting. Other forms of performance monitoring are required, and the plan of work should incorporate KPIs, targets and goals that will initiate a review of monitoring procedures, particularly utilising the outcome of audits.

vii. **Auditing**. A system of audit is essential as an independent means of determining the correct application of legislation into the H&S Management System and the correct application of the Trust's policies and standards by each department. This enables the reactive monitoring of outcomes to be complemented by a proactive consideration of health and safety management performance. A programme of audits must be developed as a priority during 2022-23.

viii. **Reporting**. The governance mechanisms for reporting of health and safety are in place through the committee structure that reports up to the Board. The newly formed sub-committees will take time to become fully effective as the issues for escalation are. Attendance at the sub-committees needs improving due to the pandemic's demands on staff

ix. **Review**. Changes to the health and safety management system to implement improved ways of working will be an ongoing process, primarily building on the information received by auditing in addition to performance monitoring.

6.3 The Governance Structure

The Trust Board is responsible for providing leadership in the recognition and management of principal health and safety risks, and in the continuous improvement in health and safety performance. The Board aims to fulfil its obligations through the designated Board lead for health and safety, the Chief People Officer, who, in turn, is responsible for chairing the Trust Health and Safety Committee and, through her deputy, managing the Health and Safety team.

6.4 Trust Health and Safety Committee

The Committee met 6 times during 2021-2022 with this frequency of bi-monthly meetings planned to continue through 2022 – 2023.

The combination of the interruption to business-as-usual due to Covid and the high staff turnover in key positions appears to have had a major impact on the ability of the committee to be effective in its role. In addition, and surprisingly, the issue of Covid did not appear on the minutes of the committee meetings of March, May or July 2021,

although this was clearly managed as an integral part of the Trust's core day-to-day business. Similarly, the risks identified at the end of 2021 in Authorising Engineer reports regarding statutory estate compliance risks were raised at Board level, but not through the Health and Safety Committee. The Committee should seek to pull significant issues into its agenda in order to fulfil its remit.

As the work of the Trust reverts to pre-pandemic normality the H&S Committee has an important part to play in ensuring that the Trust's Health and Safety Management System is in place and is being implemented, in addition to overseeing risk, policies and in monitoring performance in key areas (i.e. sub-committees, see below).

6.5 Sub-committees

There are 19 sub-committees reporting to the Trust Health and Safety Committee, see below. During 2021 – 2022 work has progressed to review and re-define the terms of reference of these sub-committees with the intention of improving assurance and escalation in preference to a commentary of work being undertaken.

For 2022 – 2023

There is a considerable time commitment to attend and contribute to the large number of meetings created by the sub-committees. The decision to consolidate a number of Estates sub-committees has been made to streamline the governance process. These sub-committees exist for a specific purpose of governance, and the assurance and escalation mechanisms should not be lost simply to save time at committees, and the incoming Health and Safety Manager should continue the work of monitoring the effectiveness of the committees, helping to streamline agendas and escalation reports to achieve the balance of transparency and understanding that the sub-committees can bring.

List of Sub-Committees

1. Medical Devices Group
2. Medical Gases
3. Water Safety
4. Central Alerts System
5. Waste Management
6. Fire Safety
7. Security Management Committee
8. Radiation Protection
9. Lab Safety (genetics)
10. Lab Safety (pathology)
11. PUWER / LOLER Safety Group
12. Pressure Systems Safety Group
13. Asbestos Committee
14. Working at Height Group
15. Confined Spaces Safety Group
16. Ventilation Safety Group
17. Medical Gas Pipelines Systems
18. Decontamination Safety Group

7. Plan of Work 2022 – 2023

This plan of work relates describes the work to be undertaken by Health and Safety from through 2022 – 2023.

The goal of Health and Safety is to systematically prevent harm, damage and legal risk through the implementation of the components of a Health and Safety Management System. This plan of work utilises the resources available to Health and Safety to undertake a series of activities for the implementation and continual improvement of a robust Health and Safety Management System. The new Health and Safety Manager will be required to develop this overview into a detailed plan of work for the year ahead and beyond.

The plan describes the additional work to be achieved in addition to the day-to-day work that supports accident monitoring, committee attendance, production of the annual report, involvement in risk assessment reviews etc.

The new Health and Safety Manager's plan will be informed by three audits to be undertaken prior to his arrival, in three areas of work that explore priority areas of risk and activities. These are: the use of tugs; fire safety; and slips, trips and falls. These audits cover a broad range of activity by divisions and directorate; impact staff, patients and visitors alike; and cover three of the most significant pieces of health and safety legislation:

- The Management of Health and Safety at Work Regulations 1999
- The Regulatory Reform (Fire Safety) Order 2005
- The Workplace (Health Safety & Welfare) Regulations 1992

The implementation of the management system will lead the development of a culture of continual improvement in health and safety which no one walks by a safety hazard, that risk is not tolerated, and everyone reports hazards, influences good practice, sets high standards, and leads by example.

The workplan aims to reduce the risk by prioritising the interpretation of the legal requirements a suite of policies and standards that are required to be implemented by the Trust's managers. The implementation of those policies and standards will be assessed by a programme of audits, the outcomes of which will be reported through the governance mechanisms and opportunities for improvement implemented.

The focus on auditing is intended to reduce the risk in these areas and start the process of building a robust management system by presenting case studies that offer a deep dive into these areas of risk, the learning from which can be applied elsewhere.

Three areas of work have been selected that offer a consideration of the impact upon the health and safety of staff and patients alike.

(i) Slips, trips and falls feature prominently on accident reporting trends and analysis, and require the safe management of the external estate's paths and pavements, covered through-routes and indoor areas. As a frequently occurring cause of accidents that affects staff, patients and visitors alike it requires management across divisions and directorates alike. This is both high priority and high risk and will be indicative of how embedded health and safety requirements are into Trust management.

(ii) The use of Tugs is a prominent and highly visible activity which enables an examination of general risk assessments due to a wide range of hazards.

Hazards and issues include fitness to drive, control of noise, explosive atmospheres and fire risk from battery charging, provision and use of work equipment, planned maintenance regimes, pedestrian-vehicle interface etc.

(iii) Fire safety presents possibly the greatest health and safety risk to the Trust, from the challenge of patient evacuation to the potential for major business continuity issues from extensive loss of infrastructure. Despite this, fire safety does not currently come under the jurisdiction of Health and Safety and is the responsibility of the Director of Estates. Site inspections have identified numerous fire safety challenges including obstructed fire escape routes, propped open fire doors, the accumulation of litter and a vulnerability to arson, and the intention is to explore whether fire safety focus extends beyond an estate management activity and whether it is sufficiently well managed by building occupiers.

Each audit will comprise of an examination of the legal requirements relating to the subject or the activity and a gap analysis between the legislation and the Trust's documented policy or standards. A further gap analysis will be made between the legislative requirements and their application in practice. A report will be made from each audit that will be agreed with the relevant managers and reported through the Trust Health and Safety Committee.

Next Steps

The action arising from the audits will be determined by recommendations by the auditors to the Health and Safety Committee.

The permanent appointee to the role of Health and Safety Manager will arrive in August 2022. The findings of the audit reports will assist the new H&S Manager and the Trust's senior management team to develop an ongoing strategy and operational plan to prioritise risk and direct attention where most needed.

8. H&S Performance

There were 13 RIDDORs reported in 2021/2022 and this appears to indicate a declining trend in reportable incidents over the last seven years. However, it should be noted that this trend may be attributable to other causes such as:

- Increased working from home, where staff are exposed to fewer hazards, or where there is reduced recognition of the requirement to report incidents.
- Reduced adherence to administration such as incident in Datix due to the focus on the response to Covid-19. (e.g., While it is not uncommon for Datix reports to be submitted a few days after the incident, one of the "lifting or moving a patient" RIDDOR incidents was reported 3 months retrospectively.).

For the second consecutive year, the most common reported incident involves members of staff suffering violence or abuse perpetrated by patients and has increased by 15% over the previous year. One particularly challenging patient was the named aggressor in ten separate incidents across three wards, in a 21-day admission. Of additional concern is the 27% reduction in the number of 'no harm' reports of violence and aggression but an increase in those categorised as minor from 38 to 97, those categorised as moderate, from 1 to 7 and those categorised as major from 0 to 2. The concern arises from the increase in cases of actual harm which should be accompanied by an increase in no harm incidents, whereas this has reduced, probably caused by a reluctance of staff to report due to work and time pressures.

The incidents identified on Datix as physical abuse, assault or violence include pushing, grabbing, pulling hair, spitting, scratching, slapping, throwing objects, punching, kicking, strangling, assault with a weapon and one instance of the member of staff having their hair grabbed to facilitate the patient banging their head against the wall.

Next Steps.
There were 523 Datix entries concerning health and safety during the year, creating a workload that can only be monitored, not managed to the level of detail that staff might expect.

Incidences of violence and aggression to staff are of concern. The majority of which are believed to be attributed to clinical causes, but nevertheless the staff facing these risks require support, advice and training to help deal with incidents, and support and care following events. The Security Service continue to develop their approach in support of frontline staff and are the aspiration is for Health and Safety to work more closely with Security to take a closer look at accidents and incidents and provide enhanced support to managers and improved care and follow up to those who are suffer harm at work. The Prevention of Violence Working Group is an established forum in which to develop this work.

A breakdown of the accident causes is included in the Appendix, below.

9. Risks

The risk register has been subject to ongoing attention throughout the year with the aim of generating action to mitigate risks.

The health and safety risk register comprises of a range of risks from specific hazards to generic overarching corporate risk:

Risk 508. Meeting the requirements meet health and safety legislation. Legislative requirements are onerous and broad in scope, and while enforcement action is relatively rare and is usually in response to serious events, the legislation must be met to result in safe behaviour, processes, workplaces and equipment.

No employer can expect the absence of hazards or the accidents that accompany them, and the management of this compliance risk depends on an approach of continual improvement. That requires the ongoing monitoring of behaviour, standards and outcomes to learn from experience and improve. ISO / British Standard management systems recognise this by requiring a process to be in place for addressing the non-conformity that will inevitably arise. This risk is therefore not expected to ever be closed on the register, instead the aim is to implement, maintain and improve the health and safety management system and monitor the Trust's implementation of the H&S legal framework so that non-compliance is systematically identified.

The challenge for 2022-2023 is to continue to refine the risk register to mitigate the risks currently listed while presenting a portfolio of risk that accurately depicts the key health and safety issues that the Trust should focus on.

10. Subject Specific Areas to Note

10.1 Subject Specific Areas to Note: Estates

A series of Authorising Engineer audit reports (specialist external audits) undertaken in late 2021 / early 2022 present a number of issues of non-compliance across the management of the estate.

There are eight reports of concern:

i. Asbestos
ii. Confined Spaces
iii. Pressure Vessels
iv. Decontamination
v. Fire
vi. Electrical Safety
vii. Work at Height
viii. Passenger Lifts

The Board has been appraised of the reports through the *Estates Technical Services – Status Report March 2022.* Extensive action has been taken to address the issues identified in the reports, with a strategic lead by the Director of Estates and a reorganisation of the Estates department. Action is underway to address the risks identified in the report and the risk is being formally monitored and recorded through the corporate risk register.

The risks described in the report are also subject to the scrutiny of the Trust Health and Safety Committee and by engagement between the Director of Estates, the Chief People Officer and the Health and Safety Manager.

10.2 Subject Specific Areas to Note: Radiation

Radioactive Material (RAM) is used in two forms at SFT.

(i) There are a small number of sealed sources which are used for machine calibration and patient markers. These are held in the Nuclear Medicine Dept of radiology.

(ii) The other form of RAM is in the form of open sources, and these are short lived radioisotopes (Technesium 99m) used for imaging/diagnosis. On days when they are required, they are delivered in a custom package direct to Nuclear medicine. This material is then made into injections and administered to patients. Waste and contaminated material is stored and once decayed it leaves the Trust by an appropriate waste route (burn or tip, depending on biohazard)

(iii) Genetics used to use small amounts of Phosphorus-32 but this ceased in 2019.

SFT hold small amounts of radioactive material and receive deliveries of short-lived isotopes on a regular basis. These are all appropriately stored and handled as required by legislation including security and waste disposal.

Staff radiation doses are monitored monthly and inspected for any levels which may indicate increased workload or reduced attention to good working practices. There are currently no concerns from these records. Doses for persons that also work in other Trusts are exchanged as required by IRR17. A transit exposure in October 2021 has affected around 40 staff badges and the work to rectify records is in hand.

There have been no external inspections since 2017. The actions from that visit (CQC-IRMER & HSE) continue to be maintained with the following risks being accepted: Single point of failure for Physics support; no Physics technician; single point of failure - radiation protection supervisor in Theatres.

Learning from HSE inspections elsewhere has led to the view that nuclear medicine workers require to be Classified Workers within the meaning of IRR17 due to a risk of radioactive needlestick injury. The medical surveillance needed is currently a barrier and this is being tackled via Occupational Health, Health and Safety and Physics networks.

Older x-ray installations are being replaced on a rolling programme,

The above issues are given Executive oversight via the Radiation Protection Committee with escalation to the Health and Safety Committee as required.

Work is underway to address re-certification of the Trust RPA. This requires a comprehensive portfolio application and recent demands of time have prohibited progress but is a priority.

Next Steps

- The issue of RPA accreditation has been escalated through the committees and a solution is being sought as a priority.
- An Environment Agency visit is expected in June 2022.

10.3 Subject Specific Areas to Note: Fit Testing

Scope of the service

The Fit Testing service comprises of four substantive staff with bank staff utilised to cover staff absences. The service predominantly delivers a face fit testing service across the Trust, with additional activities in managing & maintenance of power packs, the integration of relevant policies and procedures, supporting the PPE group, statistical and compliance reporting, problem solving, liaison with OD&P and Occupational Health, liaison with departments, purchasing & auditing and emergency preparedness.

The service was created to provide a face fit testing service suitable for the Trust's rapid expansion of the use of Respiratory Protective Equipment (RPE) during the pandemic. The Trust has a statutory obligation under the Health and Safety at Work Act 1974 to ensure the health and safety of all employees and anyone affected by their work and RPE is the final line of defence providing protection to staff and patients. When a filtering face mask (FFP3) is required to be worn its effectiveness in containing any contaminated droplets must be 'fit tested' to ensure an adequate seal/fit between the mask and the user.

RPE to this standard is available as an FFP3 face mask, or through the use of powered and non-powered respirators. These are made available as an alternative for staff members who are unable to achieve an adequate seal with a single use FFP3 face mask. There are eight types of RPE, the disposable masks are provided by Public Health England / UKHSA, the remainder are purchased the other sundries.

Use of the Service

Since March 2020 monthly testing fluctuated between 500 and 1000 tests a month but has now stabilised at approximately 300 tests per month. 100 new doctors are expected this summer and each week an average of 20 new starters are tested, each one requiring testing tests on a range of masks they may use. Testing is required to be repeated every two years, or more frequently if there is a significant change (appearance, facial hair, changes to mask design etc.)

Issues faced during the year

The service has yet to reach a steady state since it was established with the creation of the service at short notice (e.g., no job descriptions with which to recruit against), changes in the Health and Safety Manager, sharing premises with various other departments, the opening and closing of Clarendon Ward, uncertainty of being moved and the lack of opportunity for formal training or induction.

Issues for coming year

The unpredictable nature of the department continues with further changes in Health and Safety personnel, uncertainty over the location of the service, and an evolving role as the service becomes gradually more integrated into business as usual.

One certainty is that the need for fit testing is here to stay and the recognition that fit testing will continue to be required to challenge the suitability of the RPE for the individual will remain. Due to the ongoing nature of Covid other respiratory diseases, flus and other emergency level 3 requirements, the service will continue to be required.

The service also contributes to the Emergency Response Plan and is working to re-start this for other Pandemics that may arise. Contingency plans are in place to cope with a new

wave or a new pandemic, and there are sufficient trained Fit Testers (circa 20) amongst the Trust's staff who would be able to step in and help (as previously).

Plans for the year ahead

The service has built up a considerable knowledge of the departments, staff and workings of the Trust, and discussions are taking place to explore the opportunity of utilising this knowledge to assist Occupational Health and Health and Safety in identifying where health surveillance is required due to workplace activity.

If possible, the service would benefit from its own base in the Trust, which would provide stability and assurance for the service and provide dedicated space for storage of supplies, maintaining powered respirators, space for testing and desk space for administration of the necessary records.

10.4 Subject Specific Areas to Note Health and wellbeing

The subject of health and wellbeing covers a range of issues that are increasingly prominent and of an increasing priority for the Trust. Leadership in this area emanates from the People Strategy and Health and Safety have an influential part to play in delivering the support and services required within a group of partners including OD&P and Occupational Health.

Whereas mental health and wellbeing is led at the Trust by OD&P, legislative requirements for health are led by Health and Safety. There is a need for the Trust to be assured that the legislative requirements relating to health and health surveillance is in place. Examples include

- Control of Substances Hazardous to Health
- Noise at Work Regulations
- Control of Vibration Regulations
- Control of Asbestos Regulations
- Ionising Radiation Regulations
- Display Screen Equipment Regulations
- Etc.

In addition, requirements arise from legislation such as the Working Time Regulations which aim to protect health risks from excessive working and variable working hours and require a programme of health surveillance for certain categories of night workers.

As part of the comprehensive and systematic approach to health and safety management, the plans for the coming year include the creation of an environment in which the health of staff, and the health risks arising from workplace activities, can be met. As stated above, opportunities are currently being explored to utilise the knowledge and influence of the Fit Testing team to further integrate Health and Safety and Occupational Health to proactively identify where additional health support can be given.

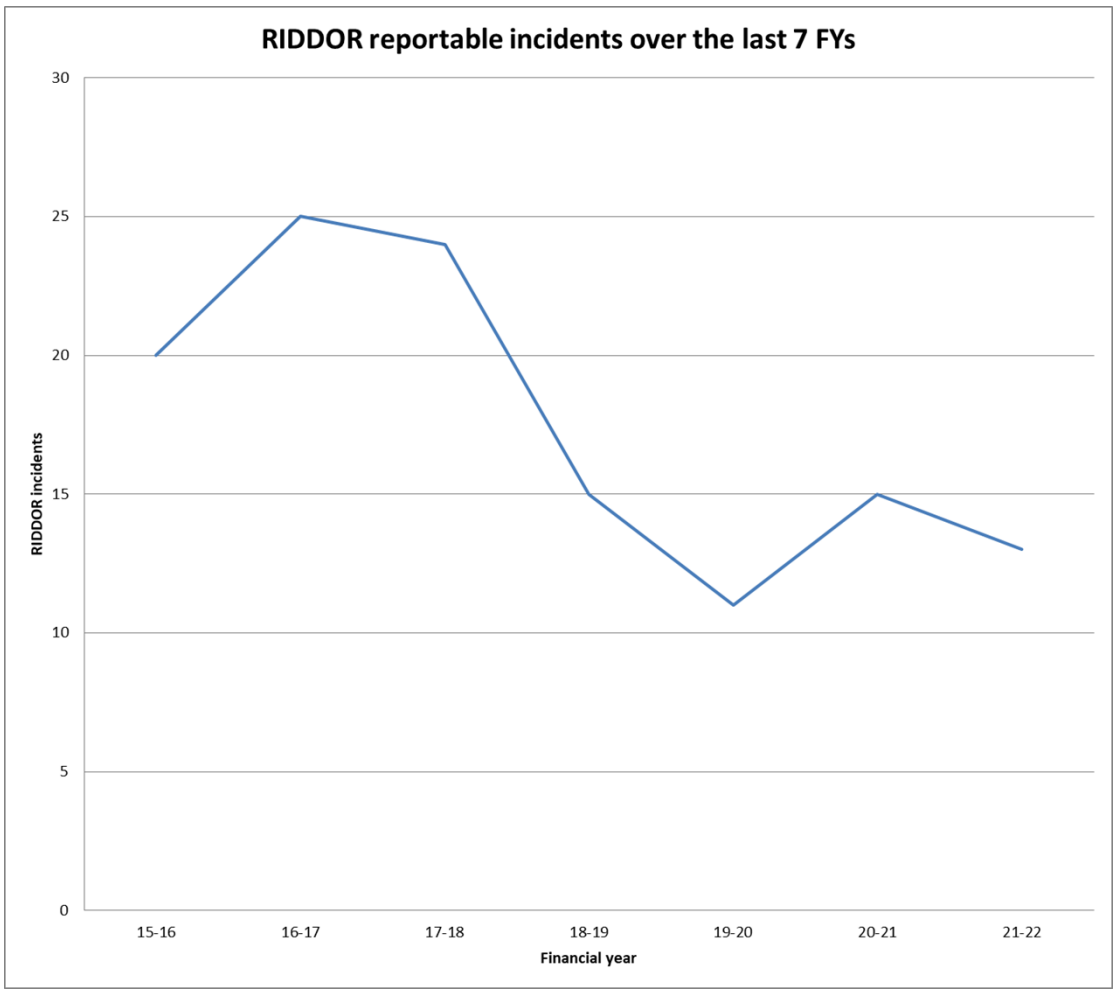
Peter Adams
Interim Health and Safety Manager

Appendix: Accidents and incident Statistics

A.1 Total reportable accidents each year for the last 7 years

The graphic demonstrates a downward trend in reportable accidents. On the face of it this shows a good level of performance, however, reducing numbers of no-harm reports and the work pressures faced by staff through the pandemic may indicate under-reporting.

(RIDDOR: Reporting of Injuries, Diseases and Dangerous Occurrence Regulations – Incidents that are reportable to the Health and Safety Executive due to specified harm occurring or more than 7 days absence as a result of the incident.)



A.2. Reportable accidents by cause

A breakdown of the cause of the reportable accidents shows that the categories of slips, trips, falls & collisions (42 over 7 years) and manual handling (36) to be the cause of most reportable accidents. Despite their regular occurrence, physical assaults result in very few occasions when a report to the authorities is required.

RIDDOR reportable incidents for the last 7 financial years

Year	Fell from a height	Lifting accidents	Slips, trips, falls and collisions	Exposed to, or in contact with, a harmful substance	Physically assaulted by a person	Another kind of accident	Unintended incident at work leading to Covid 19 exposure	Total
15-16	0	6	6	3	0	5	0	20
16-17	0	4	9	1	3	8	0	25
17-18	1	2	5	3	2	11	0	24
18-19	0	4	7	0	0	4	0	15
19-20	0	6	5	0	0	0	0	11
20-21	1	8	6	0	0	0	1	15
21-22	0	6	4	2	0	1	0	13

A.3. All incidents (regardless of severity)

As described above in chart 2, the domination of the statistics by issues of Violence and Aggression to staff is immediately apparent despite the absence of many incidents being reportable.

Needlestick and sharps injuries are the second most reported incident, and although these are overwhelmingly no-harm or minor incidents, the potential for harm and the anxiety that they cause increases the priority for attention in this area.

Of note are the numbers of incidents of all types that result in no harm or minor injuries. Theoretical studies show that with comprehensive reporting of all unwanted incidents that a common ratio for minor incidents to no-harm injuries can be in the region of 1 to 50. This is rarely achieved in practice and despite being less than the theory suggests, these statistics show healthy reporting of no-harm incidents being reported across all categories at the Trust.

Incidents by Detail and Severity FY 2021 / 2022

Detail	no harm	minor incident	moderate incident	major incident	Total
Abuse - other	18	7	0	0	23
Abuse etc of Staff by patients	104	97	7	2	210
Abuse of staff by other staff	13	4	0	0	17
Accident caused by some other means	5	19	2	0	26
Exposure to electricity, hazardous substance, infection etc	20	15	2	0	37
Lifting accidents	15	18	9	0	42
Needlestick injury or other incident connected with Sharps	45	48	0	0	93
Slips, trips, falls and collisions	19	45	9	0	73

A.4. Other incident statistics, 19/20 & 20/21

A comparison between the reports in the incident categories over the past two years shows clear consistency and indicates the key areas for priority.

Incidents by Detail and Severity	**20-21**	**21-22**
Abuse - other	24	23
Abuse etc of Staff by patients	182	210
Abuse of staff by other staff	19	17
Accident caused by some other means	28	26
Exposure to electricity, hazardous substance, infection etc	50	37
Lifting accidents	45	42
Needlestick injury or other incident connected with Sharps	94	93
Self-harm in primary care, or not during 24-hour care	1	2
Slips, trips, falls and collisions	73	73
Total	516	523

Salisbury NHS Foundation Trust

Report to:	Trust Board (Public)	**Agenda item:**	7.1
Date of Meeting:	08 September 2022		

Report Title:	EPRR NHSE Framework – Accountability and Responsibility			
Status:	**Information**	**Discussion**	**Assurance**	**Approval**
	X			
Approval Process (where has this paper been reviewed and approved)	Summary of changes to the NHS Emergency Preparedness Resilience and Response Framework V3.0 dated July 2022, provided to Andy Hyett (COO/AEO) and Jane Dickinson (DCOO) in form of presentation and verbal update from Tracey Merrifield, Head of EPRR on 3rd August 2022. Andy Hyett as COO & AEO requested a high-level summary of the change of COO/AEO and the changes regarding responsibility be shared with Trust Board for noting.			
Prepared by:	Tracey Merrifield			
Executive Sponsor (presenting):	Lisa Thomas, Chief Operating Officer			
Appendices (list if applicable):	n/a			

Recommendation:
For note by Trust Board, to ensure our changed and revised accountabilities and responsibilities are noted following the revision of the NHS Emergency Preparedness Resilience and Response Framework V3.0 dated July 2022

Executive Summary:
Following the resignation of Andy Hyett as Chief Operating Officer (COO) and Accountable Emergency Officer (AEO) from 31st August 2022, Lisa Thomas will take over the roles of both the COO and AEO from 1st September 2022. A significant change in the framework to be noted by Trust Board: What the Non-executive Directors (NEDs) bring is essential to being able to hold the AEO to account, but **responsibility for EPRR sits with the whole board** and **all NEDs should assure themselves that requirements are being met.** Given the synergies between the agenda for EPRR and other important issues such as security management and health and safety, triangulation between these areas through the Board and committees will be essential.

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) -	☐