Bundle Trust Board Public 6 July 2023

1 OPENING BUSINESS

1.1 Presentation of SOX certificates
Presentation of SOX certificates:
May SOX of the month – Laura Lawes, HCA Durrington Ward and Endoscopy Nursing Team
June SOX of the month – Hannah England, Recruitment and the Estates team .
May Patient Centred SOX – Tina Dickenson, Pitton Ward Clerk and Harriet Hudson, Switchboard
June Patient Centred SOX – Leanne Mitchell HCA and Holly Jarvis, HCA – Downton Ward

1.2 Staff Story
Introduced by Melanie Whitfield

1.3 Welcome and Apologies
Apologies received from

1.4 Declaration of Interests, Fit & Proper / Good Character

1.5 Minutes of the previous meeting
Minutes attached from Public meeting held on 4 May 2023, 8 June and 22 June
For approval
1.5 Draft Public Board mins 4 May 2023 V2.docx

1.6 Matters Arising and Action Log
1.6 Trust Board Public Action Log.pdf

1.7 Shadow Board Feedback

1.8 Chair's Business
Presented by Ian Green
For information

1.9 Chief Executive Report
Presented by Stacey Hunter
For information
1.9 CEO report July 23.docx

2 ASSURANCE AND REPORTS OF COMMITTEES - To note by exception

2.1 Clinical Governance Committee - 27 June
Presented by Eiri Jones
For assurance
2.1 Upward Report from June CGC to July Board 2023.docx

2.2 Finance and Performance Committee - 27 June
Presented by Debbie Beaven
For assurance
2.2 June Escalation Report from F^0P.docx

2.3 Trust Management Committee – 28 June
Presented by Stacey Hunter
For assurance
2.3 TMC Escalation Report July 2023.docx

2.4 People and Culture Committee – 29 June
Presented by Rakhee Aggarwal (Verbal)
For assurance

2.5 Audit Committee – 22 June
Presented by Richard Holmes
For Assurance
2.5 Audit Committee Escalation Report July 2023.docx

2.6 Integrated Performance Report to include exception reports
Presented by Lisa Thomas
For assurance
2.6a IPR cover sheet - Trust Board 2023-07.docx
2.6b Integrated Performance Report July 23 FINAL v3.pdf

3 STRATEGY AND DEVELOPMENT

3.1 Review of Trust Strategy Progress Report
Presented by Lisa Thomas
For assurance
3.1 Strategy Update.docx

3.2 Improving Together Quarterly Update Report
Presented by Peter Collins
For assurance
3.2 Improving Together Quarterly Trust Board Report July 2023.docx

3.3 BREAK

4 FINANCIAL AND OPERATIONAL PERFORMANCE

4.1 SIRO Annual Data Security & Protection Assurance Report (includes Toolkit Self-Assessment and Data Protection Annual Report and GDPR) - deferred to September

5 QUALITY AND RISK

5.1 Risk Management Strategy 3 yearly report - deferred to Sept
Presented by Judy Dyos
For assurance

5.2 Patient Experience Report - Q4 / Annual Report
Presented by Judy Dyos
For assurance
5.2a Patient Experience - Patient Feedback Report Q4 22-23 v3.0 without docs.pdf
5.2b Corporate Risk Register June 2023.pdf
5.2c Appendix 2i Consultants Programme - Communication Skills and Intro to Complaints Mar 2023 v4.pptx
5.2d Appendix 2ii Consultants Programme - Communication Skills and Intro to Complaints Mar 2023 v4.pptx
5.2e Appendix 3.pdf
5.2f Appendix 4 - Bi-Annual FFT Update - PESG March 2023 v2.pptx
5.2g Appendix 5 - RTF Report -Q4 22-23 for PESG March 2023.pptx
5.2h Appendix 6 Your Views Matter - Bereavement Survey Report Q4 2022-23 v1.docx
5.2i Appendix 7.pdf

5.3 Learning from Deaths Report – Q4/Annual Report
Presented by Peter Collins
For assurance
5.3a Q4 2022-23 Learning from Deaths Cover Sheet.pdf
5.3b Learning from deaths report Q4 2022-23v1.0.pdf

5.4 Annual DIPC Report
Presented by Judy Dyos
For assurance
5.4a Trust Board Summary sheet annual DIPC reoport 2022-2023.docx
5.4b Annual DIPC Report 2022-23 (Draft v.1) (002).docx

5.5 Q4 Risk Report Card
Presented by Judy Dyos
For assurance
5.5 RMRC and risk report annual report For trust Board.pdf

5.6 Q4 Maternity Quality and Safety Report
Presented by Judy Dyos
For assurance
5.6a Front sheet Q and S report Q4 trust board.docx
5.6b Quality and Safety report Q4 2023.docx
5.6c Front sheet Perinatal quality surveillance May 2023.docx
5.6d Perinatal Quality Surveillance monthly report to board (VM update).pdf

5.7 Q4 Research Report
Presented by Peter Collins
For assurance
5.7a Quarterly research report Q4 2223.pdf

5.7b Appendix 1 Results of Patient Research Experience Survey.pdf

5.8 Board Assurance Framework and Corporate Risk Register
Presented by Fiona McNeight
For assurance

5.8a Trust Board BAF Cover sheet July 2023.docx
5.8b Board Assurance Framework June 2023 V1 Draft.pdf
5.8c Corporate Risk Register June 2023.pdf
5.8d CRR tracker v1 June Board Committees 2023.pdf

6 PEOPLE AND CULTURE

6.1 Equality and Diversity Annual Report - Deferred to September (new reporting schedule)
Presented by Melanie Whitfield
For assurance

6.2 Health and Safety Annual Report 22/23
Presented by Melanie Whitfield
For assurance

6.2a H&S Report - Public Board Cover Sheet July.docx
6.2b Annual H&S Report 2223.doc

6.3 Modern Slavery Statement
Presented by Melanie Whitfield
For assurance

6.3a Modern slavery statement July Board.docx
6.3b Modern Slavery Human Trafficking Statement DRAFT v0.3.docx

6.4 Medical Revalidation and Appraisal Annual Report Including Statement of Compliance (to follow)
Presented by Peter Collins
For assurance

6.4a Cover Sheet annual board report and statement of compliance Responsible officer and revalidation 06.07.23.docx
6.4b SFT 22.23

7 GOVERNANCE

7.1 Non-Executive Director Responsibilities and Committee Composition
Presented by Ian Green
For assurance

7.1 NED Responsibilities Paper July 2023 v2_Public Board.docx

7.2 Registration of Seals - no new seals added since last report
Presented by Fiona McNeight
for noting

8 CLOSING BUSINESS

8.1 Agreement of Principal Actions and Items for Escalation

8.2 Any Other Business

8.3 Public Questions

8.4 Date next meeting
Next Public Meeting - 7 September 2023

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 4th May 2023, MS Teams
Salisbury NHS Foundation Trust
Boardroom

Board Members:

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

In Attendance:

Fiona McNeight (FMc)	Director of Integrated Governance
Kylie Nye (KN)	Head of Corporate Governance (minutes)
Victoria Aldridge (VA)	Head of Patient Experience (item TB1 4/5/1.2)
Lucinda Herklots (LH)	Lead Governor (observer)
Kathy Wolff (KW)	Public (observer)

ACTION

TB1 4/5/1 OPENING BUSINESS

TB1 4/5/1.1 Presentation of SOX (Sharing Outstanding Excellence) Certificates

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

April SOX of the month – Kay Dubach, Wessex Rehabilitation and Nadine Crook, Speech, and Language Therapist

April Patient Centred SOX – Alex Beck, Physiotherapist, Children's Orthopaedics

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

SH noted that all three examples demonstrated the contribution of therapies and the impact of those staff groups which make a huge impact on individuals.

TB1 4/5/1.2 Patient Story

VA presented the patient story which was pre-recorded from a mother describing her experience of a home birth and the Trust's support in relation to this. VA noted that the patient had agreed to share their story as a result

of a complaint they had made about their experience. The story highlighted the positive outcome of a successful home birth with the support of community midwives. However, the story also indicated the difficulties the patient had experienced in relation to continuity of care, her voice being heard by senior clinicians and being treated like an individual.

Discussion:
The Board expressed their thanks to the patient and to the Patient Experience team for sharing the story in an effective way. The Board discussed, highlighting the following reflections:

- The importance of patient inclusion and listening to the patients as part of people's treatment plans.
- The difficulties in balancing the priorities of the individual and the collective.
- The importance of supporting clinicians to have honest and open conversations with patients, being mindful of time barriers and supporting an understanding that shared decision making is shared risk taking.
- As part of this patient's experience, there were aspects that could have been improved in relation to communication and interpersonal skills. However, the treatment journey described is what should be expected when a multidisciplinary team is required.
- The story is a good reminder that clinicians might see several people in one clinic but everyone is on their own personal health journey and should be treated as an individual.
- As the Trust as we move to Patient Safety Incident Response Framework (PSIRF), this will help support improvement in those themes.
- VA confirmed that the video had already been used for learning purposes.
- JDy reflected that for someone on a small baby pathway there was a lack of continuity which has been highlighted as an area of improvement. The role of family liaison midwife has been introduced which will help women and their families to ensure they're on the right pathway and understand the options available.
- SH reflected that the woman sharing her story appeared confident and able to advocate for herself. However, there will be others not as confident and willing to speak up for themselves and this should be considered going forward.

IG thanked VA for attending to present and asked her to feedback the Board's thanks to the mother and team for filming this story.

VA left the meeting.

TB1 4/5/1.3 **Welcome and Apologies**

IG welcomed everyone to the meeting and noted that no apologies had been received. IG welcomed members of the public who had joined the meeting and they would be given the opportunity to ask questions at the end of the meeting.

TB1 4/5/1.4 **Declarations of Conflicts of Interest**

There were no declarations of conflict of interest pertaining to the agenda. However, the following items were noted:

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

TB1 4/5/1.5 Minutes of the Part 1 (Public) Trust Board meeting held on 6th April 2023

IG presented the public minutes from 6th April 2023 and the minutes were approved as an accurate record of the meeting.

TB1 4/5/1.6 Matters Arising and Action Log

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

- **TB1 9/3/5.3 Maternity Quality and Safety Report Q3 22/23 –** EJ has been put in touch with the person who is covering the National Chief Midwife role and is expecting to be able to meet them and feedback at July's meeting. Action carried forward to July.
- **TB1 6/4/3.6 Integrated Performance Report (IPR) (M10)/ Stroke–** PC narrative reflects IT methodology – there has been a lot of work to update this and would welcome feedback. Item closed.
- **TB1 6/4/4.2 Improving Together Quarterly Update Report Q4 -** PC noted that front line teams had been invited to the Board Development Session in June. Item closed.

EJ referenced a point on page 5/15 in April's Board minutes, clarifying that the new ward is due to open in Spring 2024 and therefore any benefit from this will not be seen until 2024/25.

TB1 4/5/1.7 Chair's Business

IG highlighted the impact of the continued industrial action and wanted to thank everyone on behalf of the board in their response to the several occurrences that had recently taken place. IG noted that staff have worked tirelessly to keep patient's safe but this has also been balanced with the respect to those people who have chosen to be part of the industrial action.

There was a positive meeting with John Glen, MP, last week with the key focus on conversation being the urgent requirement of a new Day Surgery unit at the Trust. IG reiterated the significant challenges with the current Day Surgery Unit, that has been discussed at length in the past few years. IG noted that further action will be taking place to understand how the Trust can work collaboratively to ensure this vital service continues to deliver for the local population.

TB1 4/5/1.8 Chief Executive's Report

SH presented her CEO report and highlighted the following key points:

- The progress made in urgent care over the last 6 weeks, noting the small but positive incremental steps in improving performance which is being driven by the Trust's Improving Together programme.
- The report outlines the impact of the last junior doctor industrial action in terms of rearranging appointments which was requested at the last Board meeting. Regrettably, some elective work was cancelled and rearranged but it should be noted that bookings for outpatient's appointments were reduced upon notification of strike action. SH extended her thanks to the Senior Nursing team, Deputy Chief Operating Officer, Deputy Chief People officer and their teams for their time and contribution in managing the strike action.
- As of today, there has been a decision to accept a pay award made to Agenda for Change staff but this does not mean there will not be any further industrial action. There are unresolved issues in relation to junior doctor pay and whilst there is some discussion underway, the outcome of that is awaited.
- NHSE have undertaken a review of Delivery of Continuous Improvement over the last 12 months and shared their findings and recommendations in a publication on 19th April 2023. This work is called NHS Impact – Improving patient care together and is consistent with the Improving Together work the Trust has already started.
- It is important to recognise that communications colleagues and Dr Kate Jenkins were recently nominated at the National Smarter Living Award for the Covid recover project.

Discussion:
The Board discussed the impact of industrial action. TB reflected that if the recent pay disputes are resolved, the broader issue remains unresolved as there is a disparity between private and public sector pay which will still impact recruitment and retention in the long-term. TB noted the encouraging signs that operationally, there had been some small improvements. However, TB noted the Trust's slow progress in terms of 'Same Day Emergency Care (SDEC) in relation to other Trusts and asked what plans were in the pipeline to move this work forward. LT summarised the work to protect beds and allow more effective utlisation but noted the areas of improvement required, e.g., allowing other professionals including paramedics to access. The next steps will also be to expand confidence in other specialities but it is positive to note that it is being organically driven by the clinicians.

DBe noted the decreased vacancy rate which is positive. DBe queried how well the Trust is doing in creating an inclusive culture for the overseas staff coming to work at the Trust and additionally, what work is underway to encourage apprenticeships and growing our own talent. SH explained that the south-west is reliant on overseas recruitment and it is acknowledged that via the People and Culture Committee, there is still further work to do around measuring inclusivity. There are inconsistencies in pastoral care with overseas colleagues but there have been some small improvements. MW explained that the team have overhauled the recruitment and induction process and they have started to run career workshops. The pastoral care process has been developed to ensure the people arriving are aware of the expectations beforehand. Further work has gone into community provision and speaking to home care. Additional support has also been given to support networks, with executives championing these groups. MW

referenced the query around apprenticeships, acknowledging that there is more to do and this will be a focus as part of the ongoing partnership forming with Coventry University.

In terms of retention of overseas nurses, JDy explained that more overseas nurses are now being successfully recruited into senior roles and it is important for other employees to see this progression and a potential career pathway.

RA discussed the issues in terms of the wider community and explained that the Head of Equality, Diversity, and Inclusion (EDI) has been part of a lot of networking around connecting with community and commercial colleagues to understand the value of having diversity in Wiltshire.

RH referenced the new initiatives in place to support overseas nurses and asked if the Trust have had feedback from them to see how much they value these efforts. MW noted that the Trust have held listening forums, focus groups with BAME staff to understand what well-being initiatives they would like to see. Additionally, all new staff get to attend a 100 day and 1-year meetings to give feedback about their time in the Trust.

RH noted the positives around a national focus on continuous improvement but asked if the national programme will align with the Trust's Improving Together plans. SH noted that NHS Impact is consistently aligned with Improving Together programme. She explained that the commitment from NHSE is genuine and it is likely that Trust's will be asked to demonstrate their approach, rather than the method being prescribed.

TB1 4/5/2 **ASSURANCE AND REPORTS OF COMMITTEES**

TB1 4/5/2.1 **Clinical Governance Committee (CGC) 25th April 2023**

EJ presented the report, providing a summary of escalation points from the meeting held on 25th April 2023. EJ asked for the report to be taken as read highlighting the key points as follows:

- Further to discussions on Mortality, the CMO has discussed the Trust's position with the regional CMO. A regional review is being planned as several Trusts are in a similar position. The outcome of this review will report to CGC in due course. PC explained that NHS England has been collating data and Public Health directors have been reviewing statistics from a different perspective. Currently, triangulation looks at whole population mortality and death certificate data. In the southwest, the Trust's catchment area has the lowest mortality. Whilst the Trust is experiencing more patient mortality in hospital wards, it means people are dying in hospital, rather than in the community. This provides some more data and indicates a requirement to think about provision in community.
- Following on from the last 6-month update from the Mental Health Group, a presentation was provided on the audit that had been undertaken in relation to compliance with detention under the Mental Health Act. Noting some process issues, the two outcome issues of concern were communication with families and helping patients

understand the reason for their detention. Actions for improvement have been identified and are in progress.

- The Committee received the quarterly maternity report which had been appended to the escalation report in the Board papers. Earlier in the day at F&P and in the CGC when discussing the IPR maternity dashboard, concern had been raised that stillbirths were flagging as red in month. The CD was able to confirm that the Trust wasn't an outlier with very few stillbirths occurring. It was noted that the reporting method had been changed to meet national requirements. There is an insight visit next month and there needs to be a clear message why BadgerNet is not yet live.
- Health inequalities updates have been added to the workplan.

Discussion:
The Board discussed the Clinical Negligence Scheme for Trust's (CNST) work, noting that the Trust expected to be in a better position and there is further work underway towards declaring compliance. It was agreed that further assurance around this would be useful going forward as part of the maternity update to CGC **ACTION: JDy.** JDy noted that there is due to be a national plan to provide consistency and the team is reviewing the internal improvement plan alongside this. **JDy**

SH referenced the discussion around the implementation of BadgerNet and the delay, explaining that the delay was linked to a strategic decision in relation to the shared EPR work and aligning the three acute Trusts in terms of this decision. PC recognised the concerns and noted that as Shared EPR develops there is a need to ensure the correct infrastructure is in place. Assurance on this will report through F&P as part of the digital updates. EJ noted that there are a number of people who live outside of the Trust's catchment and suggested it would be useful to understand how the risks relating to shared information and medical notes are managed in the interim. **ACTION: ND/ JB** **ND/ JB**

TB1 4/5/2.2 **Finance and Performance Committee 25th April 2023**

DBe presented the report providing a summary of escalation points from the meeting held on 18th April and 25th April 2023. DBe asked for the report to be taken as read, noting the following key points:

- On 18th April extraordinary meeting, the Committee considered and approved the decarbonisation project on behalf of the Board. Once drafted, the contract terms will come back to F&P Committee.
- 25th April – The Committee considered a number of business cases and there were robust conversations around those. The CDC business case provoked a discussion around role of Trust as system. The request for approval was in relation to the Trust being co-commissioners to those projects.
- The Committee received and discussed the Finance report, noting that the Trust ended the year with a breakeven position. This is reassuring given the challenges faced throughout the year.
- The Committee was encouraged to receive the presentation of the governance structure and report template for the CIP programme. The Committee felt that they had been provided with significant assurance that there will be good oversight on this.

Discussion:
SH explained that the financial recovery plan is linked to the system and they have appointed someone to support this work. The financial recovery will therefore report through F&P Committee but on a wider scale will also be fed through the system's reporting mechanisms.

ME noted that there was an evolving situation with CDC contractual arrangement which will be discussed in the private Board meeting.

TB1 4/5/2.3 **Trust Management Committee 26th April 2023**

SH presented the report, providing a summary of escalation points from the meeting held on 26th April 2023:

- The Committee received eight business cases and 2 policy approvals, providing TMC with the opportunity to review and support. SH provided context in relation to the Trust's rigorous business planning process, noting the work done at Trust Investment Group (TIG) to review business cases prior to them reporting to TMC. The outcome of those items for approval was summarised in the escalation report.
- TMC received the Integrated Governance and Accountability Framework which was supported and is on the Board agenda for final ratification.

Discussion:
IG referenced the additional Dermatology provision that had been approved and queried the future decisions to be made about how this service is resourced. SH explained that medical Dermatology is a constraint across the country and there is work reviewing the potential sustainable models nationally, as well as in the Acute Hospital Alliance (AHA), which will influence the choices to be made going forward.

DBe made a general reference to the additional cost pressures that some of the business cases referred to and asked if they're adding to the agreed plan. ME explained that the business cases are part of the plan, as these are within the envelope of already agreed investment. Where there is no planned investment attached to a business case, this will go through a prioritisation process at May's TMC to ensure consistency and effective use of the funding there is to spend. EJ noted that this linked to a request at F&P Committee, where it was suggested that business cases and recommendation reports identify if the work is being funded by newly identified money, current money or if it is unfunded.

EJ queried the need of chairs action for two business cases that had taken place between Committee meetings. ME explained that this happens typically where the Trust has been on a tight procurement timeline and when national funding is concerned. Ideally, these cases would be considered in advance but there is not always enough notice when the funding is made available. SH explained that processes had changed slightly and there is a new TIG chair. SH further explained that a formal TMC meeting is only held everyone other month, with the other months allowing for a senior leadership discussion.

TB noted that the approval of some of these cases is encouraging but queried if teams being ambitious enough, i.e., recruiting 4 physician associates seems to be a low number. PC explained that this was discussed at the meeting and the full business case describes the plan of recruiting up to 16 in the longer term.

TB1 4/5/2.4 **People and Culture Committee 27th April 2023**

MvB presented the report, providing a summary of escalation points from the meeting held on 27th April.

- There has been an early but encouraging change in direction on agency spend, exit interviews and vacancy rates. The OD&P department, which is now nearly up to establishment, has made a huge impact on improving some of these performance measures.
- The Committee received the mandated reports which review race equality and disability standards. There is a lot more work to be done and this is recognised. A further Equality, Diversity, and Inclusion (EDI) Board Development session will be taking place in June.

The report was noted. MvB left the meeting.

TB1 4/5/2.5 **Integrated Performance Report (IPR) (M11)**

PC presented the Integrated Performance Report which provided a summary of March 2023 performance metrics. PC noted that the Board Committees had discussed the IPR in detail but highlighted two key points:

- Despite the challenges around industrial action and operational pressures, there is some indication of small improvements in some of the KPIs. PC highlighted the welcomed improvement in DM01, with 69.4% achieving the 6-week standard.
- There are ongoing challenges with pressure ulcers which have remained high in March, and a new investigation process has been implemented.

Discussion:
DBe queried if there were plans in place for the IPR to provide a view of performance trajectories, taking account of planned improvements, actions, and investments. LT explained that this is challenge due to the complexities of the performance metrics but reported that the team is working to produce a quarterly report with the first one expected in July.

SH noted that further to the action around the Stroke narrative in the IPR, there was still further work to ensure the message was explicit to provide the correct level of assurance that beds are being protected for Stroke patients. PC explained that there is a paradigm shift required but assured the Board that whilst on call the previous day there were no beds in the hospital other than a protected Stroke bed. However, it is acknowledged that there is further work to do to reiterate the importance with the nursing and radiology teams. LT explained that the issue has been communicated around process between ED and Farley Ward and a SOP has been put in place. IG asked if further assurance discussed could be included going forward. **ACTION: PC** **PC**

JDy referenced the challenges around pressure ulcers, noting that she would meeting the new tissue viability lead to work through a whole range of actions to mitigate the current situation. JDy provided further assurance on a reported CAT 3 pressure injury, explaining that it was a grade 2 on admission but it had deteriorated during the patient's stay. JDy acknowledged that the narrative needed to be updated to include the mitigating actions, noting she would work with the new lead on this.

IG observed the steady improvement in some of the people metrics and asked if this was as a result of a consistent focus from the OD&P team, or if there were other factors of influence. MW explained that the resourcing team have focused on being proactive and applicant focused. There has also been a heightened focus on the pace of recruitment which has been continuous in recent months, with the team undertaking successful recruitment drives. Retention is now a key focus as there will be large number of staff who have joined the Trust who will be considering their own career progression. The OD&P team have also been supporting the close and continuous management of absence and listening to colleagues as part of well-being discussions and appraisals.

TB1 4/5/3 STRATEGY AND DEVELOPMENT

TB1 4/5/3.1 Digital Strategy Update

ND presented the Digital Strategy update report and noted the following key points.

- The report will be called the Digital Plan going forward, to recognise that the Trust has a single strategy with supporting plans to deliver.
- In relation to the Shared EPR programme, there was a recent joint session across the three sites which was productive. There is confidence that the full business case (FBC) will be completed by May '23. There is a tight schedule to submit to NHS England with the case being submitted to 14 separate meetings for approval across the three acute Trusts. The FBC is expected to come to Board in August.
- The expansion of Power BI has progressed well during 2022/23 with a roadmap for development this year. There is a need to migrate more into the cloud and a business case is being finalised to hopefully move this work forward.
- ND reference the insufficient staff capacity, which is being experienced across the Trust, noting that a business case is being finalised to support a tutor/trainer to teach and develop clinical coders. ND referred to the challenges in recruiting digital staff noting that often the pay scale does not match the private sector. Location is also a problem and there needs to be more done to make SFT more attractive in the recruitment market.

Discussion:
IG referenced the shared EPR and asked if the Trust is currently on track to deliver the key decision-making milestones. ND confirmed. SH noted that the implementation of last patient record system was not a positive experience and therefore the Board need to pay attention to the shared EPR implementation plan.

DBe asked if AI (Artificial Intelligence) could have an influence on coding in the future. DBe also suggested that a future update includes the Trust's approach to data quality following a discussion at F&P about low engagement resulting from incomplete data, inability to access the correct data, or the timeliness of data. ND explained that the NHS will need to be cautious about where, if at all it utilises AI. There is a big exercise of data transfer and archiving and it has to be accurate and timely. The team is conscious of the importance of BI and the decisions taken from this data. There is ongoing work, with a data quality focus, to progress and get this data to all staff in real time.

TB1 4/5/4 FINANCIAL AND OPERATIONAL PERFORMANCE

TB1 4/5/4.1 Review of Trust Strategy Progress Report – deferred to July

The Board noted that this had been deferred to July.

TB1 4/5/5 QUALITY AND RISK

TB1 4/5/5.1 Risk Management Strategy 3 yearly report – deferred to July

The Board noted that this had been deferred to July

TB1 4/5/6 GOVERNANCE

TB1 4/5/6.1 NHS England Governance Publications Briefing

FMc presented the report which summarised the 3 documents published by NHS England and the implications to the Trust. These are:

1. The new NHS Provider Licence – comes into force 1 April 2023.
2. Changes to the enforcement guidance setting out how NHSE intend to deal with breaches of the Provider Licence (consultation closed 9 December 22. Awaiting publication 2023/24).
3. New Code of Governance for Trusts and related governance documents - comes into force 1 April 2023.

FMc summarised the changes to the NHS Provider Licence and Code of Governance which were detailed within the report.

Discussion:
LT referenced the Trust's enforcement action issued in 2018, noting that the Trust has not been able to remove this. The Board discussed and FMc noted that the new guidance due to be published this year will hopefully provide some clarity on this.

IG noted the positive focus in the Code of Governance on EDI. The Board discussed the greater involvement of NHSE in the recruitment and appointment process of NEDs and questions were raised about what this would involve. SH considered that this might link to the region's involvement in talent management and consistency but noted she would raise this with the NHSE Southwest Regional Director Elizabeth O'Mahony.

DBe queried if the Trust's partner organisations have to agree to similar arrangements, particularly around collaboration. IG explained that this just applies to NHS partners. There might be future changes but this is currently unknown. SH noted that the three local authority leaders are members of the ICB.

The Board also noted the change that the appointment of the Company Secretary needs to be decision made by the Board.

RH queried if there were any immediate behaviours or actions that needed to be considered to ensure compliancy in 12 months' time. FMc explained that the Board needed to be mindful of the updated conditions to ensure the Trust is able to evidence and demonstrate compliancy for next year's submission. IG noted that the Board need to need to be mindful throughout the year. SH have time to cover this at Board development session.

MW noted that it was positive to see more areas addressed regarding workforce in these newly published documents.

The Board noted the changes to Provider Licence and Code of Governance.

TB1 4/5/6.2 Corporate Governance Statement NHSE Self-Certification (FT4, G6, CoS7)

FMc presented the report which had been supported at F&P Committee. FMc noted that NHS Foundation Trusts are required to self-certify on an annual basis, as to whether they have:

- Effective systems to ensure compliance with the conditions of the NHS Provider Licence, NHS legislation and the duty to have regard to the NHS Constitution (Condition G6)
- Complied with governance arrangements (condition FT4)
- The required resources available if providing commissioner requested services (CRS) (condition CoS7
- Have provided Governors with the necessary training.

The statements and evidence have been reviewed and the proposal is that the Trust Board responds with confirmed for all elements. The evidence to support the response is outlined in Appendix 1 of the paper.

Decision:

The Board approved the response, including the evidence, noting that it would be published on the Trust website prior to the end of May 2023.

TB1 4/5/6.3 Integrated Accountability and Governance Framework – deferred from April

FMc presented the report which historically came to Board as two separate documents for approval. As part of the Trust Improving Together Programme and a review of the operating framework at both Trust, Division and Specialty level and to align to the recently published NHS Oversight Framework, the Trust Accountability Framework, and Integrated Governance Framework ('the framework') have been merged to create one document. FMc noted that it had been discussed at TMC and had been supported.

Discussion:

IG queried the large number of meetings as displayed on the Organisational Committee structure. FMc noted that it is a good challenge and there are regular reviews of the meeting structure to help avoid duplication and unnecessary workload. However, when considering the complex regulatory environment Foundation Trusts exist in and the performance metrics reported, this partly demonstrates why there are so many meetings. PC noted that there was a lab safety genetics sub-group and it was agreed this would be picked up with the Health and Safety Manager outside of the meeting.

EJ referenced the sentence in the report on pg.16, noting that CGC's responsibility is gaining assurance on clinical governance, not delivering. It was agreed the wording would be updated. **ACTION: KN/FMc** **KN/ FMc**

Decision:
The Board approved the Integrated Governance and Accountability Framework.

SH gave thanks LT and FMc for simplifying and aligning the document.

TB1 4/5/7 **CLOSING BUSINESS**

TB1 4/5/7.1 **Any Other Business**

ND noted that prior to publishing the shared EPR FBC she was happy to meet people to discuss prior to the Board meeting in August. DBe asked if it could be circulated to members of the F&P Committee in advance of the normal publishing date. KN to remind ND/JB to send FBC to F&P Committee 10 days before the meeting. **ACTION: KN** **KN**

TB1 4/5/7.1 **Agreement of Principle Actions and Items for Escalation**

IG highlighted the key areas of discussion:

- The Board recognised some early indications of improved performance measures.
- The Board received a useful update on the changes to the Code of Governance and Licence Conditions.
- The Board approved the self-certification against the Provider Licence conditions which will be published on the Trust's website.

TB1 4/5/7.2 **Public Questions**

N/A

TB1 4/5/7.3 **Date of Next Public Meeting**

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

TB1 4/5/8 **RESOLUTION**

TB1 4/5/8.1 Resolution to exclude representatives of the media and members of the public from the remainder of the meeting (due to the confidential nature of the business to be transacted).

Master Action Log

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

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

Committee	Organiser	Reference Number	Deadline	Owner	Action	Current progress made	Completed Status (Y/N)	RAG Rating
Trust Board Public	Sasha Grandfield	TB1 9/3/5.3 Maternity Quality and Safety Report Q3 22/23	~~06/04/2023~~ ~~04/05/2023~~ 06/07/2023	Eiri Jones, EJ	SH asked EJ, in her role as Maternity Champion, if she would contact the Chief Midwife to get further clarity on what is expected at Board.	**May Update - EJ expected to feedback at July's meeting.** April Update - EJ explained that the National Chief Midwife has moved to a new role and she is therefore waiting to hear who she can contact to find out what is expected in terms of Maternity Board reports. JDy has also contacted the Maternity Improvement Associate.	N	2
Trust Board Public	Sasha Grandfield	TB1 6/4/3.6 Integrated Performance Report (IPR) (M10)/ Stroke TB1 4/5/2.5 Integrated Performance Report (IPR) (M11)	~~04/05/2023~~ 06/07/2023	Lisa Thomas, LT Peter Collins, PC	Concerns around the operational response around protecting Stroke Beds is clear in the report. This needs to be revisited. PC noted that he would support JDi as the action discussed earlier was to improve the narrative that has been produced by the team. SH noted that further work is required to better represent the improvement in an objective way.	**May Update - SH noted that further to the action around the Stroke narrative in the IPR, there was still further work to ensure the message was explicit to provide the correct level of assurance that beds are being protected for Stroke patients.**	N	2
Trust Board Public	Sasha Grandfield	TB1 4/5/2.1 Clinical Governance Committee (CGC) 25th April 2023/ Maternity	06/07/2023	Judy Dyos, JDy	The Board discussed the Clinical Negligence Scheme for Trust's (CNST) work, noting that the Trust expected to be in a better position and there is further work underway towards declaring compliance. It was agreed that further assurance around this would be useful going forward as part of the maternity update to CGC	**Added to CGC Action Log - Maternity report expected at June CGC**	Y	3
Trust Board Public	Sasha Grandfield	TB1 4/5/2.1 Clinical Governance Committee (CGC) 25th April 2023/ Maternity	25/07/2023	Naginder Dhanoa, NG Jon Burwell, JB	Following a discussion re the implementation of Badgernet, EJ noted the there are a number of people who live outside of the Trust's catchment - further assurance was requested on how the risks relating to shared information and medical notes are managed in the interim to ensure patient safety.	**Added to F&P Action Log - next Digital Update July's meeting**	N	4
Trust Board Public	Sasha Grandfield	TB1 4/5/6.3 Integrated Accountability and Governance Framework	06/07/2023	Kylie Nye, KN Fiona McNeight, FMc	EJ referenced the sentence in the report on pg.16, noting that CGC's responsibility is gaining assurance on clinical governance, not delivering. It was agreed the wording would be updated.	**Wording Updated - Item closed**	Y	3

Salisbury NHS Foundation Trust

Report to:	Trust Board (Public)	**Agenda item:**	1.9
Date of Meeting:	06 July 2023		

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

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

Executive Summary:
The purpose of the Chief Executive's report is to highlight developments that are of strategic and significant relevance to the Trust and which the Board of Directors needs to be aware of. This report covers the period since the last public board meeting in May 2023. The report highlights: • Key national communications for Board awareness and information • Operational context including impact of industrial action during the period • Relevant updates from key partnership activities including BSW Integrated Care System and the BSW Acute Hospital Alliance • Communication and engagement highlights

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

This report covers the May and the first half of June and builds on the information shared with the Board at our last public board meeting which related to April 2023.

I signalled at that stage that the performance against our 23/24 plan was showing early positive signs most of which have been sustained. There was more pressure in respect of the numbers of escalation beds open compared to April, however this was in part due to the number of bank holidays in the month which impact flow and delivery of the plan to close White parish ward to allow it to be refurbished. As Board colleagues will be aware it was always going to be challenging to do this and I know you will want to join me in thanking the Chief Operating Officer and the team for their efforts in securing this.

The detailed performance is shared in the Integrated Performance Report and whilst there are still improvements to deliver it is positive to see progress in reducing bed occupancy, delivery of the diagnostic standard, staff availability and reduction if agency spend and sustaining the position in relation to urgent care and elective recovery.

Our Same Day Emergency Care (SDEC) has continued to deliver a better experience for patients and is making a significant contribution to reduction in our overall length of stay. The Finance and Performance committee heard from the Clinical Director and team leading this transformation following a request for a deep dive into SDEC. It is evident from the data and the contributions from those leading this work that our investment in Improving Together training and development for colleagues is supporting them to deliver positive changes.

As Board members will be aware there has been further Industrial Action with junior doctors striking continuously from 7am on the 14th of June to 7am on the 17th of June. Our clinical, operational and EPRR colleagues once again did a fantastic job in both preparing for the strikes and oversight of activities during that week. As Board members will appreciate this takes a considerable amount of time for our leadership teams. I would like to offer my thanks and appreciation to them and to all our colleagues who stepped in to cover during this period. I know for some colleagues this involved changing their personal plans to ensure that we had the minimum number of doctors available to maintain safe services.
Regrettably, we had to cancel and rearrange some of our elective work to release medical staff to cover the junior doctors who were exercising their right to take industrial action. The cumulative impact of the strikes is now putting the delivery of 78 weeks waiting time standard at risk which we will keep the board appraised of via the Finance and Performance committee.

The BMA have announced further dates with a continuous walkout for 5 days (the longest period to date) from 13th July to 18th July. Colleagues have started the preparation and it is important to share with Board colleagues the impact this has on key leaders' time. I will ask the Chief Medical Officer to give a verbal update at Board . We anticipate it more of a challenge in securing the cover for these 5 days from substantive medical colleagues given the persistent nature of this dispute.

The Board will want to note that Royal College of Nursing did not reach the turnout threshold (50%) required to secure a mandate for further strike action in their recent ballot.

1.2 Financial sustainability

Unsurprisingly we entered the new budget year with a stretching efficiency programme, this has been compounded by the on-going costs and disruption of industrial action. Despite this challenging backdrop we were only £0.3m off plan at the end of May. This delivery is driven factors including a programme to increase same day emergency care gaining traction, improved staffing levels driving down temporary staffing costs, and reductions in utilities. While the successes should be celebrated, it should be noted that further reductions in the cost base are required if we are to deliver against our 2023/24 financial plan in full.

The BSW system remains under significant financial strain, drifting off plan in April and May. Further action required by all partners to deliver on the commitments made in our financial and operational plans, and as such the decision has been taken to voluntarily enact several financial recovery protocols to underpin the continued development and delivery of organisational and system recovery plans.

1.3 Bed Capacity Risk

As colleagues will know the Trust has been using wards at the South Newton sire since Autumn as part of core bed capacity in response to sustained elevated levels of patients who discharge from hospital is delayed (circa 27 percent of beds). This has been funded by the ICB and given the funding constraints in the system a decision has been taken to close these beds at the end of July.
This presents a significant risk to us in delivering the elective care programme and sustaining the improvements in the emergency care standard and ambulance handover times. It will also impact the system's ability to deliver Elective Recovery Fund income.
The Chief Operating Officer has raised this to our Finance and Performance committee and is leading work on behalf of SFT with Wiltshire system partners to respond to this. I will ask her to provide a verbal update to Board.

2.0 Our People

2.1 Staffing

Supporting our breakthrough objective to increase staff availability remains a key focus for our OD&P and Operational management teams and is yielding good results. Improving our absence rates through illness as one of the three driver metrics which includes a pilot to provider targeted support to line managers in three areas with the greatest burden . The OD and P team have also revised the policy to make it easier for line managers to apply Greater capacity in our Occupational Health team and increased physiotherapy, psychological and counselling support, has also improved the support available to staff. The latest metric shows a reduction to 3.3% staff absence against the 3% target, good news in the short term, and a firm base from which to continue to improve
Our vacancies driver metric has increased slightly in the last 2 months due to an Establishment increase in line with our end of year workforce plan. Our resources team continue to work extremely hard to support line managers to fill these vacancies and has delivered a net gain of c 25 staff every month this year and as a result the long-term trend on vacancies continues to move in the right direction. Managing the hard to fill posts in key areas remains a significant challenge which is being worked on through targeted advertisements campaigns.

Our enabling projects are making satisfactory progress. An NHS Business Services Authority team has been engaged to manage the initial steps in reconciling the finance ledger with the ESR Establishment Control function, generating a simpler understanding of the Establishment, and improving the time to hire for established vacancies. With trained staff now in place we will also commence the roll-out of Health Roster to our medical staff in

the next few months, improving visibility and streamlining rostering, absence management and leave planning for our medics. Finally timely progress has been made against the Temporary Staffing five-point plan, notably the auto-enrolment of all Band 5 nurses onto the Bank, a re-design of bank HCA recruitment and a new contract signed with Locum's Nest, providing greater visibility of use through an improved reporting system.

Retaining our staff is key to ensuring a sustainable workforce, a strategic initiative. As an exemplar site for the NHS led People Promise we have already made progress and recent good work from the OD&P team has updated plans for the next 2 years across all seven elements of the people promise. These plans have been informed by the Trust Strategy and People Plan, results from the Annual Staff Survey and most recent quarterly pulse survey. Priority areas of work seek to improve advocacy and engagement in the Trust, alongside setting the inclusive culture which maintains Salisbury as the best place to work .

2.2 Education

Our education centre continues to manage and deliver a wide range of training interventions necessary for the personal and professional development of our staff, something our staff survey results identified as key element of the offer for staff. Recently we have launched a new mandatory training module instigated following the Oliver McGowan inquiry, which stipulated that all staff would be required to receive learning disability and autism training appropriate to their role. From April this year, BSW have piloted the delivery of the tiered national training package across Wiltshire for all health staff. This has involved recruitment of a clinical trainer and subject matter experts with lived experience of the conditions to deliver a combination of face-to-face and web-based training. Our Education department, Learning Disabilities Nurse & Safeguarding Team have collaborated with the BSW working group to launch the initial training sessions on site here in SFT. Four cohorts of approximately 120 SFT staff, identified by Divisions, have been trained in Jun, with further sessions booked for Jul and August, which will be open for BSW staff living local to SFT, as well as our own staff.

3.0 Our Partnerships

3.1 National Communications

NHS E communications over this period have related to the operational plans for 23/24 and the work to mark the NHS 75th birthday on the 5th of July 2023.
We received confirmation that BSW remained in segment two of the oversight framework for quarter 4 22/23 with all three acute providers rated overall as a two. This is as expected and for Board to note.

3.2 BSW Integrated Care System

The focus for the ICB over this period has been on oversight and delivery of the BSW financial recovery plan for 23/24. The Chief Finance Officer and I are members of the overarching governance group and will provide regular updates to the Board as we progress through the year.
There are some early pressures emerging at month two which I will ask the CFO to detail in our private session including a set of specific asks to all partners regarding finance protocols as part of this escalation.

3.3 Provider Collaborative - Acute Hospital Alliance (AHA)

The focus of work over the last 2 months have centred on the FBC for the joint EPR which is being considered by our Board meeting today and a revision of the AHA Executive Board to a programme Board complimented by bi-monthly meetings of all Executive colleagues. This

is in response to the feedback from colleagues and the insights we gained from the recent governance review.
All executives continue to participate in collective coaching as part of our commitment to maximise the benefits the provider collaborative can deliver for patients.

3.4 Other partnerships, communications, and engagements

3.4.1 New technology

The modern technology that will alter the way we communicate with staff – which includes screens in staff rooms and some public areas – is well underway and roll out is expected over the summer months into the autumn

3.4.2 Car Parking

Always a hot topic colleagues will be aware we had to pause the introduction of the new ANPR car parking charges scheme earlier this year. The relaunch of the car parking changes went well with only minor glitches. This was down to some thorough planning from the facilities team and lots of work from the communications team.

3.4.3 SFT podcast *The Cake*

I am pleased to announce that the second series of The Cake has started recording – this series asks the question Why am I ….? and explores the events and influences that propelled staff to the careers they have chosen or their activities outside of work. The first three episodes have been recorded and are currently in edit – they cover careers such as cancer nursing, chaplaincy, science, charity and journalism and process change.

3.4.4 Anniversary activity

This year is both 80 years since the hospital opened as a US Military Hospital and the 75th anniversary of the NHS being founded in 1948. The first major event was held on 26th June with a service of celebration at Salisbury Cathedral. This service premiered new work from poets Martin Figura and Saili Katebe and writer Paula B Stanic. The service highlighted our diverse workforce with readers from many backgrounds and staff groups. It achieved good media coverage with BBC South going live from outside the Cathedral – plus usual local outlets.

In addition, SFT produced an Acute Alliance video for the NHS Assembly consultation to support NHS 75 and BBC South have filmed a segment on the Spinal Unit.

Plans are moving ahead with the Hospital Open Day on 22nd July and Tent Talks. Tent Talks will take place over two days, 24th and 25th July, they are designed to continue our 75th celebrations and provide opportunities for personal and leadership development. I hope that you can attend as many of the sessions as possible.

3.4.5 Work experience has returned

For the first time since 2019 work experience is back – and smart students in distinctive red T Shirts have been seen across the Trust. In addition, South Wilts Grammar School have had two groups of teenagers undertaking projects with the hospital on recruitment and sustainability.

3.4.6 Ice creams, Pride and Armed Forces

We have celebrated Pride month and Armed Forces Day with flag raising and ice creams – Armed Forces Day was supported by Art care history project and 243 Wessex Field Hospital

3.4.7 Staff Awards and Thank You Week

The 2023 Staff Awards have been launched and already there are over fifty submissions – which is a great start. Planning is also underway to thank staff with a music night, Family Fun and Sports Day, Long Service Awards and Volunteers Lunch – all down at the cathedral. While those having to work on the night shift on Awards night (7th September) will be treated to posh pizza.

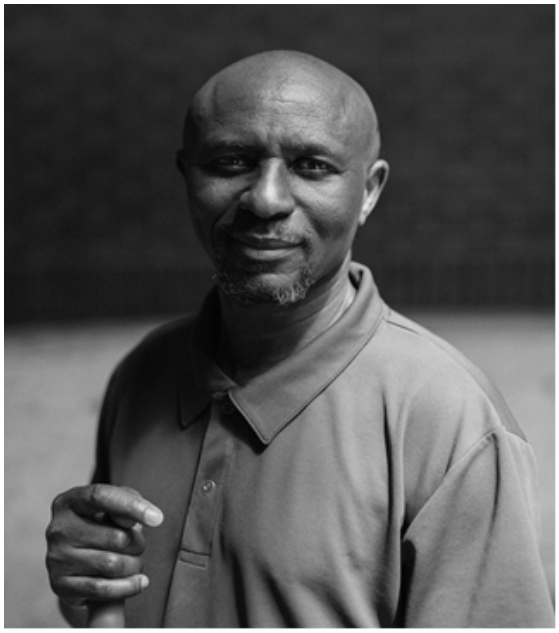
3.4.8 Podium finish and champions of BSW

A team of eight bold souls represented SFT at the Inter NHS Military Challenge – Operation Medical Endeavour. After two days of thinking, pulling, jumping, and running – and for SFT some smart drill our merry band picked up a well-earned Bronze – keeping the tradition of SFT success in this competition alive.

3.4.9 SFT Photographer graces the national stage

I was thrilled to learn that Jason Dimmock, Clinical Photographer, has made the shortlist of 75 NHS staff and volunteers in the national photography competition. His stunning picture of fellow SFT colleague Francis Obiri-Korang is pictured below. A very well-deserved accolade. What is even more lovely is what Jason says about Francis:

"Francis always finds the time to help staff members and patients, and is the epitome of a considerate, amiable, hardworking healthcare worker."



NHS Salisbury NHS Foundation Trust

Report to:	Trust Board	Agenda item:	2.1
Date of meeting:	6th July 2023		

Report tile:	Upward Report from Clinical Governance Committee (CGC)			
Status:	Information	Discussion	Assurance	Approval
	Yes	Yes	Yes	
Approval Process: (where has this paper been reviewed and approved):	N/A			
Prepared by:	Miss Eiri Jones, Non-Executive Director, Chair CGC			
Executive Sponsor: (presenting)	Miss Eiri Jones, Non-Executive Director			

Recommendation:

Trust Board members are asked to note and where relevant, discuss the items escalated from the Clinical Governance Committee (CGC) meeting held on 27th June 2023.

The report both provides assurance and identifies areas where further assurance has been sought and / or is required.

The Board is asked to consider the information provided by the Maternity service as part of the ongoing Ockenden requirements.

Executive Summary:

The report covers the topics included in the June CGC. It was a very busy agenda with detailed discussions on several of the papers.

Those areas which require sharing of detail with the Board are expanded in the full report below.

- Care Quality Commission (CQC) general update
- Quality Account sign off final draft
- Divisional Governance presentation – Women and Newborn
- Quality and service update from Gastroenterology service
- Board Assurance Framework (BAF)
- Integrated Performance Report (IPR) – Quality and Care
- Annual Reports:
  - Risk Report
  - Cancer Report
  - Medication Safety
- Quarterly Reports (Quarter 4):
  - Learning from Deaths

- Research
- Patient Experience
- Safeguarding Adults and Children

- Bi-annual Getting It Right First Time (GIRFT) report
- National Patient Safety Programme Update
- Patient Safety Incident Response Framework (PSIRF) Update
- Upward Report from Clinical Management Board (CMB)

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

Salisbury NHS Foundation Trust

Clinical Governance Committee (CGC) Upward Report June 2023

Purpose

1.1 The purpose of this report is to provide information for the Board so that it gains assurance in relation to the delivery of quality care across the Trust or identifies areas where further assurance is required.

2 Background

2.1 The CGC is one of the Board sub-committees. Its purpose is to gain assurance in relation to quality across the Trust. It meets 10 times a year (a change from 12 meetings in 2022-23).

3 Upward Report from June committee

3.1 CQC update:

The Deputy CNO provided an update in relation to CQC changes. For South Newton, the CQC have extended its registration for the Trust ward till January 2024, though the committee noted that the funding for South Newton from the ICB ceases shortly. The committee heard of the latest relationship arrangements with the new CQC local engagement officers now in place. The latest relationship meeting confirmed that the good work undertaken in maternity and spinal services was positive though 2 areas needed further attention in spinal (environment of care and user involvement). The positive work around governance and the establishment of the maternity improvement board (MIB) was also recognised.

Quality Account:

The final draft of the Quality Account for 2022-23 was presented to the committee. It was noted that stakeholder comments had been added and that the document had been to the Council of Governors. The discussion explored how the document would be used in practice, with members of the committee confirming that it would be referenced to in the review of quality objectives through the year. The final draft was therefore approved on behalf of the Trust Board for uploading to the Trust website.

Divisional Governance:

The fourth divisional governance presentation was received. It was presented by the Clinical Director and Deputy Director of Midwifery and covered the Women and Newborn division. A three month overview was provided from the divisional governance meetings. Focus in the recent and coming months are on: Clinical Negligence Scheme for Trusts (CNST) Year 5, learning and sharing learning and using Improving Together to embed quality improvement. It was also positive to note that Badgernet (electronic maternity and newborn record) is being commissioned alongside partners in BSW acute alliance, that 7 overseas midwives have been recruited and that the divisional behaviour charter has been launched. The team outlined the changing dashboard and that there would be a report on the new metrics appended to the IPR to the Board as part of the new national requirements.

Gastroenterology:

A detailed presentation was provided by the Gastroenterology team. This updated the committee on the current position, outlining the top three service risks as: Endoscopic Retrograde Cholangio Pancreatography (ERCP) provision, Endoscopy and Inflammatory Bowel Disease (IBD) / Nutrition. It was noted that whilst there had been some success in recruiting substantive consultants, one of the

new consultants had decided to leave. Workforce remains the biggest challenge for the service and the agreement with the locum agency continues. This is a national issue. What has been positive over the past 12 months since the last update to the committee is that the service leads are clear on what they need to do and how they need to work in partnership with other providers whilst also focussing on continuing to recruit new consultants when possible. It was also noted that the next Joint Advisory Group on Gastrointestinal Endoscopy (JAG) accreditation visit is due soon.

Board Assurance Framework (BAF):

It was noted that there were no surprises in relation to the information provided in the BAF and Corporate Risk Register (CRR). Triangulation with other sub committees was also taking place and moving forward the BAF and CRR will reflect on what is happening at system level. This is on the Board agenda.

Cancer annual report:

The Trust continues to do well performance wise regionally and nationally. The 28 day performance is positive though the 62 performance remains challenging in some pathways. The lead cancer nurse who joined in the last year has had a positive impact on the personalised care agenda and it was noted that there is also psychology support available for people with cancer. The Trust performed well in the last national cancer patient survey and will take part in the forthcoming one. The service is being supported to strengthen its management reporting and no harms have been identified through the clinical reviews of the waiting list.

Learning From Deaths:

Following previous concerns in relation to mortality data, the CMO met with the regional CMO and also attended a regional meeting alongside several other Trusts who are outliers. It was noted from that summit that the South West mortality is a positive outlier with death rates lower than in other parts of the country. By triangulating mortality data with other quality metrics, no concerns have been identified and the new Trust mortality lead outlined the robust surveillance in place across the Trust. Ongoing review of quality of coding as well as reviewing impact of delayed discharges, especially those with no criteria to reside is underway and will be reported on in a future report.

GIRFT:

The Trust GIRFT lead updated the committee outlining that the six months in question had been busy from a GIRFT perspective. No surprises in relation to quality had been identified with some good practice – SDEC, orthopaedics and cardiology and other areas for improvement. It was noted that more support information is becoming available from the national GIRFT team with webinars and information widely available. The Trust is using this to continue its improvement. The Trust GIRFT lead also reported that divisions are starting to strengthen the embedding of GIRFT governance into their business as usual.

Research:

The research lead outlined the following points:

- There is a need to increase commercial recruitment
- There is a focus on recruiting well rather than numbers
- Patient experience reports from studies about the Trust are positive though it was noted that there was a lack of ethnic diversity in respondents
- There has been a successful bid for capital for research equipment.

IPR:

The IPR was presented with a Never Event reported. This was the first in over a year and was currently being reviewed. It was positive to note the progress in breakthrough objectives and reduction of falls with harm. Concern continued in relation to access to a stroke bed and also the number of bed moves some patients are experiencing. VTE performance was also underperforming. Further assurance to a future committee is being sought in relation to impact of bed moves, VTE incidents and stroke performance.

Annual Risk report:

Whilst numbers of incidents reported had increased, the number of moderate and above harms had remained static. This suggests a healthy reporting culture. No Never Events had been reported in the year 2022-23. The Executive oversight of closure of actions has been reinstated post pandemic though completion of all stages of Duty of Candour needs to improve.

Patient Experience report:

The number of PALS inquiries had increased this quarter with many calls relating to the new car parking arrangements. Themes of complaints remain the same – patient care, communication and access and was concerning to note a doubling of reopened complaints (though still small numbers). The number of out of time complaint responses remains challenging and this has been prioritised for action as part of the Quality Account priorities. Positively Q4 had the best family and friends test (F&FT) response rate.

National Patient Safety Programme:

The Deputy CNO provided an update on current activity, noting the progress and plans in relation to the new mechanisms to support Patient Safety Incident Response Framework (PSIRF). Plans to recruit the patient safety specialists and partners remains under discussion across the system.

Safeguarding - Adults:

Training uptake is positive. There has been an increase in Deprivation of Liberty Standards (DOLS) requests. It was positive to note the impact of the new Learning Disability nurse, especially in relation to raising awareness and rolling out the Oliver McGowan training.

Safeguarding – Children:

Training data is also positive. Supervision is being provided but needs to increase uptake. Of the Multi Agency Safeguarding Hub (MASH) referrals, 25% relate to mental health, especially the challenge of finding available Tier 4 beds.

The current safeguarding midwife is retiring and there will be a review of the role to ensure alignment with the other safeguarding professionals.

Medicines Safety annual report:

The lead pharmacist reported on what has been an extremely busy year, compounded by workforce challenges (66% vacancy at one point). It was positive to note that the aseptic service had reopened and that this will be subject to external audit later this year. The neonatal formulary has been updated. The Trust performed best in the country on the CQUIN (commissioning for quality) relating to urinary catheters, achieving 89% compliance. New dashboards are being developed to strengthen reporting in key areas such as medicines reconciliation, missed doses and venous-thromboembolus (VTE). A risk in the home care team was noted as this is run by one individual.

Patient Safety Incident Response Framework (PSIRF):

An update was provided on the Trust's progress with preparation for PSIRF launch. It was positive to hear that the implementation group was well attended, including the system quality lead. Phases 1- 4 have been completed with phase 5 underway and with a plan to report through the Board by December. Whilst the comms team have been actively involved there is more work to do to ensure the plan and policy under development aligns with the current relevant HR policies.

Clinical Management Board (CMB):

Two reports were presented, these aligned well with the topic on the CGC workplan.

3.2 The content of and discussion in the meeting aligned with the people and partnership strategic objectives and also worked within the Trust's Assurance Framework requirements. It was agreed that in future meetings, consideration would also be given to the system priorities.

4 Summary

4.1 This month's meeting had a full agenda and current areas of priority were discussed in detail. Assurance was sought and where relevant, further assurance was requested. This has been logged in the action log for future meetings.

5 Recommendations

Trust Board members are asked to note and where relevant, discuss the items escalated from the Clinical Governance Committee (CGC) meeting held on the 27th June 2023.

The report both provides assurance and identifies areas where further assurance has been sought and / or is required.

The Board is asked to consider the information provided by the Maternity service as part of the ongoing Ockenden requirements.

Eiri Jones, Non-Executive Director

Chair, Clinical Governance Committee

NHS Salisbury NHS Foundation Trust

Report to:	The Trust Board	Agenda item:	2.2
Date of meeting:	6 July 2023		

Report from (Committee Name):	Finance & Performance Committee		Committee Meeting Date:	27 June 2023
Status:	Information	Discussion	Assurance	Approval
			x	
Prepared by:	Debbie Beaven (NED)			

Recommendation:

The Finance and Performance Committee met on 27th June 2023 with an extended meeting to accommodate the significant number of papers presented including the EPR Business case.

Following a good level of discussion and challenge regarding the business cases and contract award the Committee was assured on the quality, cost, benefit and necessity of the each of the business cases, which are recommended to the Board for approval:

1. **Acute Hospital Alliance Electronic Patient Record** – the Committee was asked to consider the full business case (FBC), which is an update on the outline business case (OBC) approved by the Board in late 2021, and to make its recommendation to the Board to approve. The FBC will be submitted to NHS England for national funding approval in early August 2023.

   Ahead of the Committee meeting, Board members had the benefit of engagement sessions with the Trust's project sponsors, who reported the following themes of challenges from those sessions:
   - Confidence of delivery
   - Benefits – realism, maturity, tracking and reporting.
   - Governance relating to decision making and delegated authority.

   The Committee acknowledge the quality of the business case and discussed the following:

   - Although there is a recognised risk on the resourcing of the project, the alliance will work together to share resources and capabilities strengths, with collaboration agreement to underpin the approach. A plan will be developed to detail the resources needed from SFT and how to backfill them. Efforts will be ongoing to ensure there is a strong collaborative culture across all partners in the alliance.

   - The budget will be managed at a system level, with shared risk, so every member of the alliance has a stake in ensuring they play their part in successful delivery. The process of benefits capture and reporting is being developed and the Committee will be updated regularly on the progress.

   - The governance structure is a bit complicated and may slow decision making and project delivery. There is an appetite to simplify it, with SFT wanting assurance that it isn't overly streamlined prematurely, as we need to evaluate how the planned governance is working effectively, particularly given the scale, risk and significance of this project. Essentially, we

would like to see incremental simplification as we gain more assurance that the governance process is working.

- There was agreement that a meeting of the SFT Committee chairs would be beneficial in agreeing how we consider the quality impact of the project, cost and benefit tracking, risk landscape and the governance reporting.

The Committee commends the FBC to Board for approval.

1. **Linen and Laundry –** the Committee was asked to approve the award of the contract for the provision of Linen and Laundry Services for a period of three years, with an option to extend for two periods of twelve months, at a total cost of £3,693,658 (based on 3 years).

   This recommendation follows a competitive tender process. The Committee noted the sensitivity of this procurement and was assured that there was a fair and competitive process, avoiding any potential conflict of interest, using NHS Shared Business Services (SBS).

   Having scored highest in both quality and price, the preferred supplier is recommended for the contract award. Although there is a small annual inflationary price increase over the current pricing structure, it was considered that a £20k increase was moderate (less than 2%) given the price pressures in this market. When asked about the quality of service the Committee was informed that the preferred supplier has always performed well, with one measure of performance being a <1% level of rejects, which is significantly better than others in the market.

   The Committee supported the decision to award the contract to the preferred supplier but said that there had been a missed opportunity to engage the clinical users in the process. The recommendation report will be going to private Trust Board on 6th July for final approval.

The Committee commends the award of the contract to STL for Board approval.

Executive Summary:

The Board is asked to note the following items from the F&P meetings in April:

1. **West of England Imaging Network P1** – The Committee was presented with the Strategic Outline Case (SOC) for the West of England Imaging Network's image sharing programme and was asked for any feedback to be incorporated into the Outline Business Case (OBC) and to give their support for the direction of travel and for the continued further exploration using existing resources at no additional operating cost.

   There is currently uncertainty as to whether there is external funding, but if we do not participate now and funding becomes available, we will be precluded for being part of the network. On the basis that there is negligible risk and no additional cost at this stage, the Committee felt it was sensible to continue with the development of the business case with the West of England Network.

2. **Finance Recovery Group (FRC) Terms of Reference (TOR) -** In the context of the underlying deficit of both the Trust and the wider system, a financial recovery meeting chaired by the CEO has been set up. The meeting acts as focused forum for intervention and support in the delivery of the

Trust's savings programme. This group will report into Finance and Performance Committee via a monthly CIP update.

The Committee suggested that some strategic context be added to the TOR. It also suggested that the reporting to TMC be included.

Following discussion, it was felt that the FRC would probably run for around 3 years, given the need and scale of ongoing financial improvement needed. The FRC will review the frequency of meetings and its effectiveness each quarter, varying it as appropriate given the environment and financial situation.

The Committee approved the TOR, subject to some minor additions.

1. **Integrated Performance Report** – A few areas of performance were highlighted and discussed in the Committee, with deeper discussions anticipated in CGC later in the afternoon.
    a. the improvement in DM01, with the mobile CDC van being a contributing factor.
    b. The pressure on bed capacity as a result of bank holidays (3 in May), industrial action, which resulted in a peak in occupancy in the 2nd half of the month. The closure of Whiteparish was also a contributing factor. The risk a further significant pressure on beds resulting from the closure of South Newton in the next few months was highlighted in a paper under AOB. Lisa was commended for her determination to close Whiteparish, despite the pressures, thereby enabling the much needed refurbishment of the ward.
    c. Although some of the cancer metrics are not improving, the work of the cancer improvement group and the new leadership is expected to have a positive impact.
    d. Stroke metrics are still significantly lower than target with no marked improvement. We are concerned about the availability of dedicated beds and the impact on patient health and outcomes of delays. We heard that currently there is no indication from our metrics that outcomes are detrimentally impacted.
    e. Bed moves – referred to CGC and suggested to be a topic for a deep dive.

2. **Breast Reconstruction Update –** the Committee received a report which highlighted the capacity challenges resulting in very long waits for patients waiting breast reconstruction services, the change in reporting requirements and its impacts, and the actions taken to date to mitigate the ongoing demand and capacity gap.

    The Committee heard that the Trust does not have the capacity alone to clear the waiting list (it would take more than a year) and that discussions are ongoing with PHT (who are in the same position) to work through the challenges.

    The change in reporting means that all patients who have been medically optimised and are therefore fit for surgery onto an RTT pathway from the date they were ready for surgery, which has increased our reported waiting times and numbers and may have a detrimental reputational impact. There was discussion around the numbers who are medically fit, as individuals can come in and out of fitness during their wait, which adds to the challenge.

    The Committee thanked the surgical team for an honest paper, for what is a deeply emotive issue and was assured that the Trust is keeping in regular contact with the patients who are waiting for surgery. Counselling and support is available and offered. The Committee took assurance that any reputational risk would be mitigated by the communication of a clear plan, helpfully assisted by the Hampshire and IOW Communications team.

3. **Performance Deep Dive SDEC –** the committee heard of the great early results from the SDEC, which started in late March 2023. Data already shows improvements in the Length of stay, time to

nurse assessment, time to consultant assessment, and an increase in the number of patients discharged same time, resulting in reduced overcrowding in ED.

There was a passionate testimonial to the power of "improving together" and how this approach had improved morale in the teams and patient experience. The environment is such that people now enjoy working there, compared to before, when there was a struggle to motivate to resource the area.

The cost saving is estimated to be £750k pa and will be more when expanded. The Committee asked how much more could be done and heard that the next steps are to expand it to 7 days per week, although this would need the rate of recruitment to keep up with demand.

We also asked what could be learned from this experience to inspire others. The advice was to stop firefighting, to create time and space and to step back and work out what needs to change. The clinical teams have identified 6/7 workstreams to improve using "improving together" methodology.

The Committee took substantial assurance from the progress and further opportunities for performance improvement resulting for the SDEC.

4. **Q1 Forecast** – we were given a heads-up on the pressures and potential risks to our financial plan, with an estimate of a possible downside to our plan of £6m (deficit). In the event of a deterioration, we would need to dig deeper to find more efficiencies and cost savings through the financial recovery group and engagement with all divisions.

   A risk was highlighted in relation to Wiltshire Health and Care, of which the Trust are joint owners. Work is ongoing to mitigate the risk and understand the potential in-year impact.

   The Committee will get an update on the forecast as more of the detail is worked through.

5. **CIPs –** The Committee received the latest report and commended management on the commitment and ownership across divisions/teams to cost savings. Progress has already made with some teams reporting potential to deliver more than their target CIPs. The quality of the reporting is very good, even at this early stage. It acknowledged the significant challenges ahead but felt encouraged by the culture and governance.

6. **M2 Finance report** – the variance to plan could be attributed to the cost of the IA, although there are a number of compensating ups and downs in the detail. The consequence of "system" reported underperformance at M2, has led to the ICB being in "finance protocols" with consequences around the level of assurance reporting required, adding to the administrative burden in the teams. There is now a £100k threshold for now or above plan investment. The process is not totally clear, and the Committee will seek further clarity ahead of the next meeting.

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

NHS Salisbury NHS Foundation Trust

Report to:	Trust Board Public	Agenda item:	2.3
Date of meeting:	6th July 2023		

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:	Gemma O'Brien and Stacey Hunter Chief Executive Officer			
Executive Sponsor: (presenting)	Stacey Hunter Chief Executive Officer			

Recommendation:

The Board is asked to note the report from the Trust Management Committee held on Wednesday 28th June 2023.

Executive Summary:

The Trust Management Committee was held on the 28th of June and was a full committee this month following the Senior Leadership Meeting being held last month.

In addition to the standard escalation reports which the Board receive assurance from via the IPR and the Board committee reports, TMC received 7 business cases. All of these business cases are being considered within the provision we have agreed within our operational and financial plan for 23/24.

TMC members had the opportunity to review this and support decisions and approvals which are detailed in this report.

1. **Divisional Structure Business Case**

   This Business Case was previously discussed at TMC who requested further information be added which is now complete. The Business Case was recently tabled at TIG who recommended this updated version for approval at TMC.

   Following a consultation process in January 2020, a structure of three Divisional teams was implemented which aligned the leadership team at Divisional level, however as the pandemic took hold, the wider leadership model underpinning at service/specialty level, was not fully addressed. The Trust since has moved to a four divisional structure, with the creation of Women & Newborn, recognising the need to put additional leadership and focus on maternity in response to both the local CQC action plan but wider in terms of national expectations and requirements following both the Ockendon and East Kent reviews.

   This updated Business Case reviews the current operational structure of the clinical divisions with a view to ensuring that there is a clear structure enabling service, specialty level management and

leadership. The clear aim is to ensure the clinical lead, operational lead, and nursing lead, together, form an effective partnership leading the day-to-day management of clinical services through triumvirate teams. The posts are a critical enabler to realising the full benefits of the Trusts Improving Together programme and capitalising on associated costs.

The Board are asked to note that the equity of responsibility and capability has been achieved in the proposal outlined by the Business Case by drawing on local expertise and the knowledge and skills framework (KSF) and proposes implementation of the preferred option to recruit 9 WTE operational managers (some of these posts have been funded at budget setting)

TMC members discussed the case noting that they would like to see engagement from the Divisions with the OD&P Team and asked that consideration is given to the interview process to ensure it is robust and diverse. TMC further requested that a paper outlining the benefits realisation of the Business Case is brought back to the Committee in August/Sept. **TMC approved this case and asked to see further detail on the benefits realisation in 6 months**

2. Cardiology Business Case

This Business Case was previously discussed at TIG on 6th April and was tabled at TMC on 28th June. The paper outlines the need to recruit 2x WTE Cardiology Consultants, 1 WTE B3 secretary and 1 WTE B7 clinical nurse specialist with the Board asked to note that over 4694 new Cardiology outpatients' referrals were received to the service in 21/22. The Business Case seeks to ensure there is sufficient capacity within the department to keep up with the demands on the current service. This mismatch is most clearly seen in the increase in waiting time for outpatient appointments from 52 days in 2019 to 110 days in 2022. The business case delivers a material contribution over and above the associated costs via the PBR tariff.

TMC approved this case

3. Pharmacy Homecare Services Business Case

This self-funding business Case will enable the Pharmacy Homecare service to become resilient by removing reliance on a single point of failure and implement national standards for homecare. It will assure continuity of care for patients and will facilitate the expansion of the service to benefit more patient groups

TMC approved this case.

4. Clinical Coding Improvement Plan

This Improvement Plan was put forward by The Chief Information Officer and addresses how the backlog of clinical coding can be removed. Several options were considered in the plan which noted that a key challenge with agency contractors is the ability to find high quality candidates who can work on site. The recommendation is to outsource records that can be coded remotely to a third party. GWH and other Trusts are already undertaking this exercise with success, and it is proposed that SFT would use the same supplier as GWH.

The resourcing element of the plan looked to ensure the backlog does not grow again. The only realistic option is to recruit trainees however they take 18 months to 2 years to become fully trained. With staff seeking to retire this year, the recommendation is to look at appointing trainees ahead of this to help reduce the impact of their departures. Recruitment of a two-year fixed term scanning resource to support scanning of operation notes until the Shared EPR is implemented is also recommended to help

enable coders to code remotely and support retention of existing and future staff. This business case is not seeking additional resource as the costs can be covered by existing budget with Informatics.

TMC approved the case

5. Overseas Practice Educators Business Case

The Education and Resourcing Teams put forward this Business Case to gain approval for two WTE International (overseas) recruit Practice Educators on a 12-month fixed term contract to support the recruitment campaign of 90 band 5 international registered nurses arriving by November 2023 (recruitment already commenced to ensure arrivals between April and November in cohorts of 10).
This case is to provide additional support and training to our INRs to increase the numbers who pass their OSCEs at their first attempt. The pass rate has reduced significantly over the last2 years aligned with widening participation.
The costs of this for this year are 100k which is expected to avoid 400k in bank and agency costs by increasing the pass rate.

TMC approved this business case

6. OSCE Training Support for Current Staff Business Case

The Head of Resourcing submitted this case to request additional support for 18 international nurses currently employed in the Trust but who are working in a non-nursing role. This support will enable these staff to complete their OSCE and then be able to become registered nurses at the Trust. The recommended option is to fund the qualification of internationally recruited existing SFT employees to become RNs with a total investment of £110,910 . This is expected to have a payback of circa 4 months given this would enable a reduction in RN vacancy rates and a reduction in bank and agency use.

TMC approved the Business Case.

7. EPR Full Business Case

The Full Business Case (FBC) for a Shared Electronic Patient Record (EPR) was commissioned by the Acute Hospital Alliance (AHA) which comprises of the Great Western Hospitals NHS Foundation Trust, Swindon (GWH); the Royal United Hospitals NHS Foundation Trust, Bath (RUH); and Salisbury Hospital NHS Foundation Trust (SFT). The AHA is a provider partnership organisation within the BANES, Wiltshire and Swindon (BSW) Integrated Care System (ICS). TMC were asked to note that the paper has been socialised across the Trust to 14 sets of groups.

The case updates the OBC approved by Trust Boards in November and December 2021, explaining the key changes since this point. It draws together the outcome of the subsequent procurement process and further analysis of costs, risks and benefits, to make the case for an investment in a shared EPR for the BSW AHA. The FBC adheres to the central NHS business case guidance, in accordance with the HMT Green Book and describes how it aligns with ICS and AHA strategies, using the three acute established Improving Together Methodologies to help deliver the change requires for successful implementation and benefits realisation. The FBC outlines the clinical leadership model to ensure this is owned and led but the correct areas of the organisations with expert support from digital services.

A recommendation report accompanied the FBC for the contract award to the Preferred Bidder, Oracle Health (previously Cerner). The procurement and commercial negotiations have been supported by an

experienced specialist supplier, Nautilus which has ensured both a fair and comprehensive process leading to a single supplier who was shortlisted and subsequently named Preferred Bidder. The planned contractual model will see a new single domain build across the three Acute providers with separate (but identical) contracts. The contract assumes common decision making and aligned single change control to drive the ambition of standardisation and reduction in variation. A collaboration agreement is being finalised to help outlines the expectations of each organisation as part of this partnership.

The FBC requires individual Trust approval, with the business case ultimately being submitted to NHS England for national funding approval in early August 2023. **TMC supported this business case being progressed to the Trust Board**

TMC received the Board Assurance Framework & Corporate Risk Register which had been cross referenced with the IPR following a suggestion from February's Board but did not identify any further risks.

TMC approved the Modern Slavery Statement which is tabled at July's Board for approval for statutory publication on the Trust Website.

TMC received the Spinal QA & Action Plan following the recent quality audit and the Spinal Team thanked The Execs and DMT for their compassion and support during the period of their Intensive Support.

TMC received the Maternity Safety Support Programme Progress Report which highlighted that a new Quality and Safety Matron has been appointed to start in August and that the Director of Maternity has resigned. Recruitment to this post is expected to start imminently.

TMC received the Health & Safety Annual Report with the Chair expressing thanks to Troy Ready, Head of Health & Safety for the noticeable improvement in the quality of the report.

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

NHS Salisbury NHS Foundation Trust

Report to:	Trust Board (Public)	Agenda item:	2.5
Date of meeting:	21 June 2023		

Report from (Committee Name):	Audit Committee		Committee Meeting Date:	
Status:	Information	Discussion	Assurance	Approval
	X		X	
Prepared by:	Richard Holmes (Audit Committee Chair)			
Executive Sponsor: (presenting)	Richard Holmes			
Appendices				

Recommendation:

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

Executive Summary:

Key Items for Escalation:

The purpose of this meeting was solely to consider two matters:

- the Trust Annual Report and Financial Statements for the year ended 31 March 2023, and if appropriate approve them under the powers delegated to it at the Trust Board Meeting dated 8 June 2023, and
- the final year end reports from the Trust's Internal Auditors and from the Trust's Counter-Fraud Auditors, together with reports from Auditors completed in the period.

Annual Report and Financial Statements

The Committee received assurance from the External Auditors by way of their Audit Findings report and their Auditors Annual Report that there were no material issues that had arisen during the audit, and that as a consequence the Auditor's anticipated audit report opinion will be unmodified.

Of particular note is the Auditor's view following their annual review of Value for Money arrangements that the Trust is in a very good position compared to other Trusts nationally, in that it recorded "no significant weaknesses in arrangements identified, or improvement recommendations made", the most favourable opinion that can be provided by the Auditors.

The Committee received the Trust Annual Report, including the Annual Governance Statement, and the Financial Statements and offered a few comments for their improvement, none of which were significant. The Committee were further reassured that there had been no material changes to the Trust's NHSE Control Total since its submission on 'Day 7' (in April).

The deadline for submission of the Annual Report and Financial Statements to NHSE, together with the Auditor's final opinion, is 30 June 2023.

The Committee noted that there would still need to be a few cosmetic changes to the submissions over the subsequent few days to meet the target date, together with a process for signing the accounts as required.

The Committee **APPROVED** the Letter of Representation from the Trust to the Auditors.

Under the powers delegated to it from the Board, the Committee therefore **APPROVED** the Trust's Annual Report and Financial Statements for the year ended 31 March 2023 for submission, on the condition that it received POSITIVE CONFIRMATION jointly from the CFO and the Auditors prior to submission that all of the cosmetic changes had been completed and no final significant matter of note had arisen.

Following submission to NHSE&I by the deadline of 30 June 2023, the Audit Committee noted that the Annual Report and Financial Statements would be combined and formatted in line with Parliamentary guidelines, and submitted to be laid before Parliament prior to the Summer Recess on 7 July 2023, in line with previous Trust practice.

The Audit Committee thanked and congratulated all those involved with preparing the Annual Report and Financial Statements, recognising the substantial effort and workload involved.

Internal Audit

The Internal Audit Annual Report noted that sufficient Internal Audit work had been carried out during the year to allow the Auditors to come to an opinion as to the effectiveness of the Trust's Internal Control Environment, and the findings of the Audits carried out gave the Auditors "Reasonable/moderate assurance" that controls were effective, an unchanged opinion from last year. This is the second highest level of assurance, of four.

The Committee received three Internal Audit Reports rated Medium risk or lower, but the Human Resources: Repeated Sickness Absence and Wellbeing report was rated at High risk.

Ian Crowley, Deputy Chief People Officer, joined the meeting to respond to the Report and to explain to the Committee the actions being taken to address the issues raised. The Committee noted that this report when taken with other similar audit reports represented a challenging pattern that needed to be addressed. However, the Committee also noted that there had been recent changes in the structure, strategy and approach of the O&PD function of the Trust that had already resulted in operational improvements to the overall HR approach within the Trust, not just within the O&PD. The Committee urged the OP&D team to continue its trajectory of improvement, recognising that such improvements would take time.

Counter-Fraud Audit

The Counter-Fraud Annual Report and End of Year Return, prepared in accordance with the Government Functional Standard 013 Counter Fraud, assessed the Trust with an overall rating of GREEN for 2022/23.

Of the12 requirements required to be reviewed, 11 were assessed at Green, and one was assessed at Amber, relating to rates of return of Declarations of Interest from Staff regarding Conflicts of Interest, where the Trust rates of return at 53% fell short of the 'Green' target of 60%.

Ongoing provision of Audit Services

Following an AHA-wide procurement process, Internal and Counter-Fraud Audit Services to the Trust will in the future be delivered by newly appointed Auditors, and as a consequence this was the last Audit Committee that PWC and TIAA would be attending.

A final recommendation as to the appointment of External Auditors is being brought to the July Audit Committee, thence to the Council of Governors for Approval, which may or may not see GT continuing in post.

The Audit Committee thanked them for their support over what have been a number of difficult years for the Trust, and together agreed with the auditor teams attending the meeting that they leave the Trust “in a good state” and with a “continued positive trajectory.

AQUA Well Led Review

The meeting was observed by AQUA as part of their “Well Led Review” commissioned by the Board earlier this year.

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

CLASSIFICATION: please select

NHS Salisbury NHS Foundation Trust

Report to:	Trust Board (Private)		Agenda item:	2.6
Date of meeting:	6th July 2023			
Report tile:	Integrated Performance Report			
Status:	Information	Discussion	Assurance	Approval
			Yes	
Approval Process: (where has this paper been reviewed and approved):	Sections approved by responsible committee: - Operational performance and resources: Finance and Performance Committee - Quality and care: Clinical Governance Committee - Workforce: People and Culture Committee			
Prepared by:	Louise Drayton, Head of Performance and Capacity			
Executive Sponsor: (presenting)	Lisa Thomas, Chief Operating Officer			

Recommendation:

The Trust Board are asked to note the Trust's performance for Month 2 (May 2023)

Executive Summary:

There has been some improvement in the four breakthrough objectives in month 2. Bed occupancy has risen slightly in M2, which was not unexpected with the planned closure of a ward for refurbishment. The loss of beds is mitigated with the transfer of an escalation ward into core capacity which does reduce the number of escalation options. Staff availability continues to improve, with agency spend representing 5.5% of total pay, down from a peak of 9.28% in Nov 22. Performance against the Reducing Falls breakthrough objective has remained static (8.36 against a target of 7). Disappointingly, performance against the Reducing Time to first Outpatient breakthrough objective remains challenged, with the wait static in comparison to month 1 and significantly above the target (133 days against target of 87). Industrial Action had some impact upon this with ongoing recovery from strike periods in addition to an increased number of Bank Holidays. The impact of this is also seen in the total waiting list size and the number of patients waiting over 52 weeks, both of which exceeded plan at the end of month 2.

The Trust made great strides in the recovery of the 6-week Diagnostic standard, with performance increasing from 75% in M1 to 85% in M2, significantly ahead of the ask from NHSE to achieve 85% by March 24. Improvement was largely driven by big reductions in the volume of breaches in MRI and Ultrasound, with further improvement expected in M3. Endoscopy and Audiology are both behind plan in terms of recovery and are now the focus going forward to improve compliance against the recovery trajectory at modality level.

Pressure on the urgent and emergency care pathways remained high throughout the month, with a high number of patients no longer meeting the criteria to reside and occupancy levels remaining high despite some reduction in the number of escalation beds open. Performance against the ED four-hour standard and ambulance handover delays remained static, however there was deterioration in the number of Stroke patients reaching the Stroke Unit within 4 hours (29% against a target of 90%).

There has been a positive reduction in the number of category 2 pressure ulcers for the second consecutive month (a decrease from 61 in March to 35 in May), which is thought to be due to the positive increase in staffing numbers across our wards. Agency spend has decreased and sickness absence has continued the downward trend with the lowest levels (3.3%) since June 2021

In Month 2 the Trust recorded a control total deficit of £2.422m against a target of £2.185m - an adverse variance of £0.237m. The underlying position was broadly in line with that planned with additional income offsetting the premium costs of staffing mainly to cover vacancies and increased non pay costs due to extra activity in month. The costs of Industrial action have been assessed at £0.265m with £0.201m at Month 2.

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

Integrated Performance Report

NHS
Salisbury
NHS Foundation Trust

May 2023

Summary

May 2023

Salisbury NHS Foundation Trust

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Vision

To provide an outstanding experience for our patients, their families and the people who work for and with us.

NHS Salisbury NHS Foundation Trust

People
working for us

Population
our patients and their families

Partnerships
working with us

Vision metrics 7 – 10 years

- Engagement Score in Staff Survey
- Reduction of unwanted turnover (people leaving the Trust or the NHS)
- Proportion of WDES & WRES at median
- # of wait metrics at median
- Total incidents with moderate or high harm
- Patient Engagement Score
- Increase in Healthy Life Years
- Overall Length of Stay
- Matrix Measure

Strategic initiatives 3-5 years

- Continuous improvement culture
- Delivering our people promise
- Delivering Digital Care
- Improving health and reducing health inequalities

Corporate Projects

Breakthrough Objectives 12-18 months

- Reducing Falls
- Reducing time to first outpatient appointment
- Staff Availability
- Bed Occupancy

What is an Integrated Performance Report (IPR)?

NHS Salisbury NHS Foundation Trust

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

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

Business Rules - Driver Metrics

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

Business Rules - Watch Metrics

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

Business Rules - Statutory/Mandatory Metrics

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

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

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

NHS
Salisbury
NHS Foundation Trust

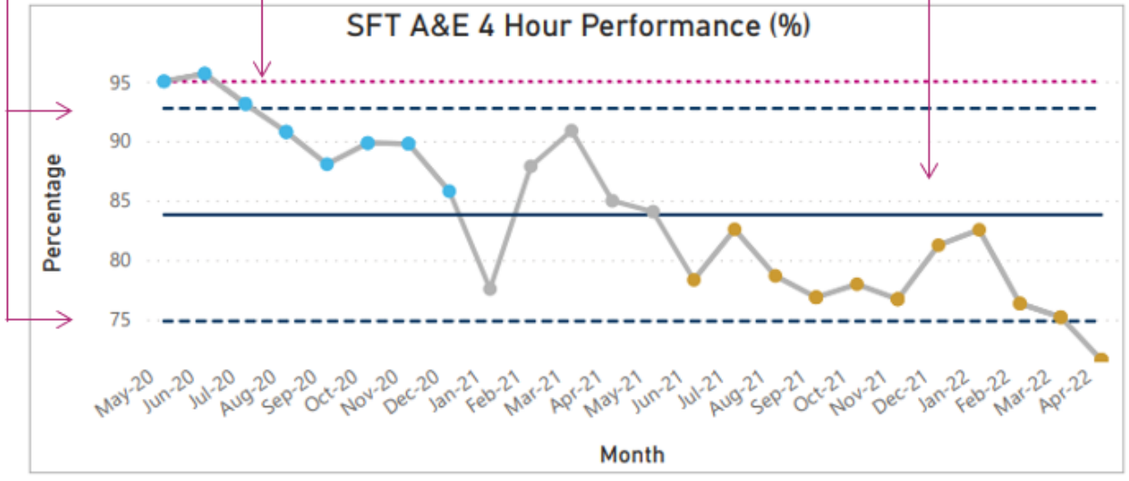
Reading a Statistical Process Control (SPC) Chart

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

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

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

The solid grey line shows the mean value for the dataset



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

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

Grey markers show normal behaviour with no significant cause for variation

Part 1: Quality of Care, Access and Outcomes

Performance against our Strategic Priorities and Key Lines of Enquiry

Salisbury NHS Foundation Trust

Our Priorities

Population

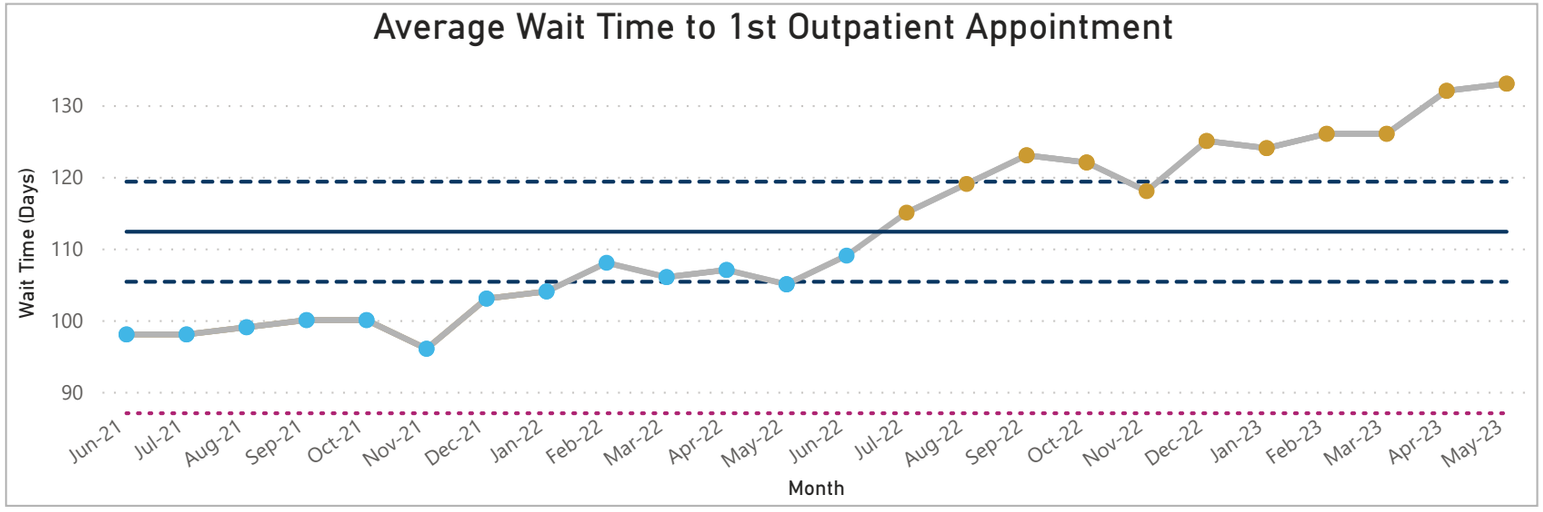
Partnerships

People

Reducing Patient Waiting Times

Target 87 days

Breakthrough Objective



We are driving this measure because...

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

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

Understanding the performance

The performance data shows a slight deterioration of a single day between April and Mays position, from 132 days to 133 days and remains behind the local target of 87 days. Whilst disappointing, this is not entirely surprising given the reduced number of working days in May resulting from increased number of bank holidays and the impact of half term, as well as ongoing recovery from the previous month's industrial action (IA). The Trust continues to focus on seeing patients in line with clinical need, referral type, e.g. Cancer 2week wait and Urgent referrals, and by longest wait, in line with NHSE requirements, the impact of the reduced number of working days, and lost capacity owing to the junior doctor IA impacts those patients carrying the lest clinical risk and therefore most significantly the longest waiting patients. Increased levels of 2ww and urgent referrals in some areas is compounding the tension between clinical priority and longest waits.

The position is largely driven by Surgical specialties (average time to first appt 145 days) and to a lesser extent performance within the Division of Medicine (average time to first appointment 113days), with a number of staffing and operational pressures challenging a number of specialties, resulting in steady increases in the number of longer waits specifically over 52week waits which are driving up the overall average waiting time.

However, despite constraints, SFT continues to have success in driving down its longest waits, achieving the year-end target of zero 78week waits. This has been maintained throughout April and May, with forecast to continue through June.

CSFS has seen a reversal in its previous improvement, deteriorating from 77 to 81.7days with

Actions (SMART)

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

Patients to continue to be booked in line with NHSE recommendations weekly validation of long waiting patients. Specialty Managers and challenged key specialties have been supplied with historic trajectory booking performance to assist forward planning.

Delivery Group to provide focussed weekly monitoring on progress the longest waiting patients across the eight specialities with the number of >52week waits.

The key contributors have been identified with intensive support transformation team planned through weekly OPD speciality huddles continue through June with oversight from the Planned Care Board.

The insourcing plan for Dermatology was been approved at both with progress continuing with the procurement of an insourcing s

Risks and Mitigations

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

Staffing pressures exist across a number of specialities not least Dermatology and Plastics which present a potential individual speciality pressure into next financial year. The Division of Surgery has an approved business case currently under mobilisation to provide insourcing support.

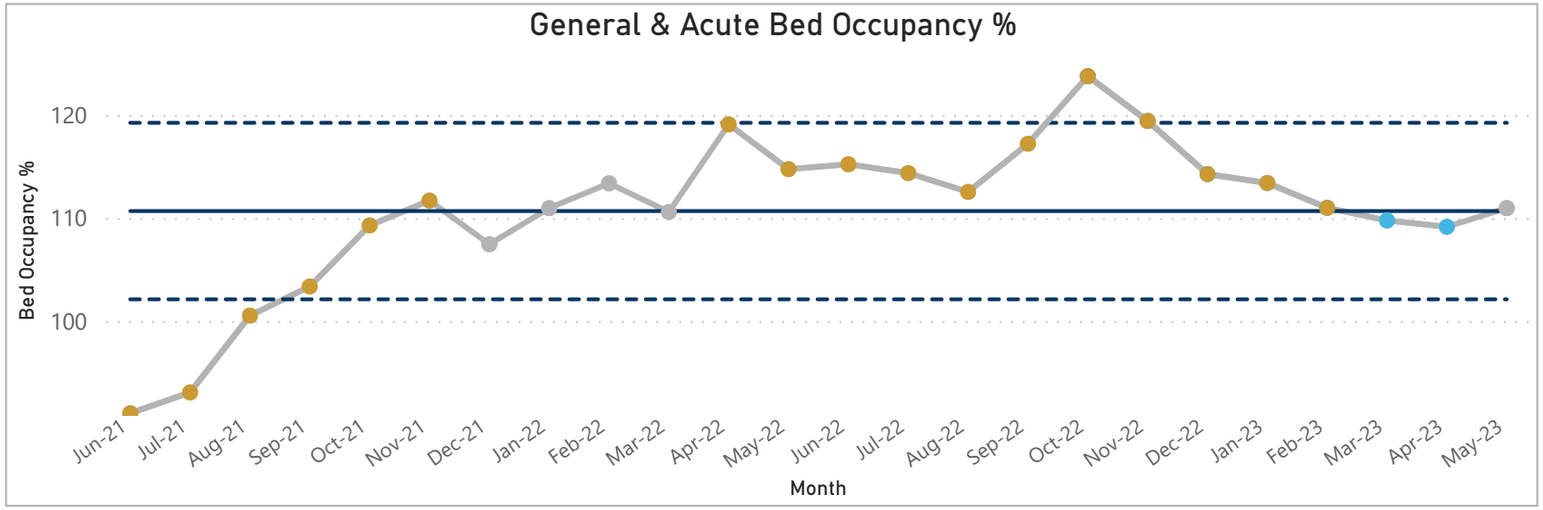
New consultant staff due to commence in June will improve Gastro and Endoscopy position.

Ongoing junior doctor IA, present significant risk to maintaining levels of capacity, with mitigations options limited

Optimising Beds

Target 92%

Breakthrough Objective



We are driving this measure because…

Bed occupancy is used as a driver metric as it is closely linked to length of stay.

Lower bed occupancy generally is associated to optimised clinical practice and lower lengths of stay, the combination of the two are known to demonstrate good outcomes and patient experience. An additional positive consequence is also lower temporary staffing costs.

Understanding the performance

High levels of hospital bed occupancy are an important indicator of a health system under pressure. Hospitals cannot operate at 100% occupancy, as spare bed capacity is needed to accommodate variations in demand and ensure that patients can flow through the system. Unnecessary days in hospital may lead to increased hospital-acquired patient complications (e.g., healthcare-associated infections, falls) and increased costs for patients and healthcare systems.

Bed occupancy has decreased significantly over the past 7 months, although did slightly increase in month 2, in part due to the planned closure of a ward for refurbishment. The trend of improvement is due to a number of internal actions such as Medical Same Day Emergency Care (SDEC) coming on line and a decrease in patients requiring specific management relating to IPC challenges. This has also resulted in improved flow generally with improved ambulance handover times.

The number of patients in hospital no longer meeting the criteria to reside (NCTR) have not seen any significant decrease during this period of time.

Actions (SMART)

- SDEC methodology and process to be rolled out across other surgery specialities by September, A3 completed. Cinapsis needs to be rolled out across surgery to facilitate this.
- Meeting with radiology regarding increasing need for appointments to align with SDEC.
- Full roll out of new ewhiteboard software mid July will ensure visibility and ability to audit patient flow management.
- Frailty working group set up, Launch of frailty SDEC proposed to be early Sept 23 (pilot starting July), focusing on length of stay (LoS), discharges by pathway, % readmissions.
- Discharge Hub to go live end of June. This means that decisions regarding patient discharge (P1-3 pathways) will be made by all system providers in one location (SFT site) so that conversations with patients and families can take place in real time, it is estimated that this could take up to 2 days off pathway allocation for each patient.
- LoS and Bed occupancy workshop across all divisions, site and discharge team to take place on 22nd June to identify cross cutting challenges that need a corporate focus rather than divisional action.

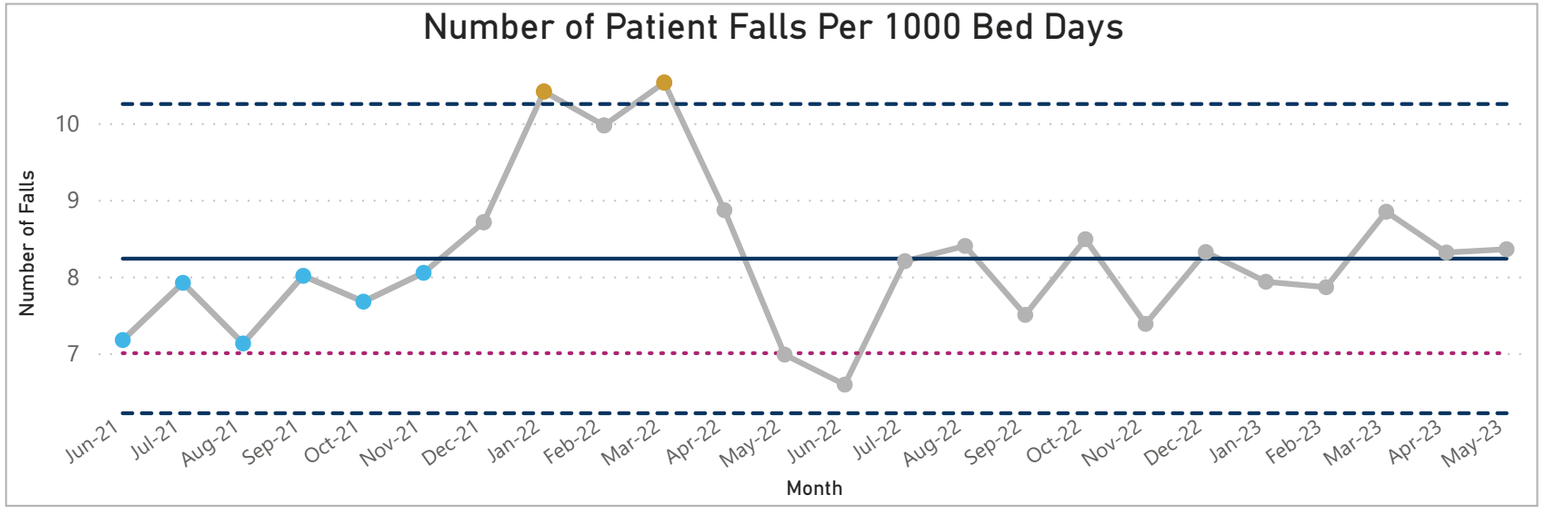
Risks and Mitigations

- Pathway P1 and P2 beds to decrease from the end of June. With South Newton closing fully on 31st July, loss of 17 beds (ICB beds) by end of June and additional 24 (SFT beds); mitigation still being worked through.
- An increase in IPC challenges such as COVID or other will impact the ability to keep escalation areas closed.

Reducing Patient Harm

Target 7

Breakthrough Objective



We are driving this measure because...

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

Understanding the performance

Overall falls in May rose by 0.01 per 1000 bed days with a target of 7.
There were 7 falls with moderate or above harm. Two of these falls can be attributed to 1 patient who fell twice, extending a brain bleed on the second fall.
All of the cases were presented at the weekly patient safety summit group with the double fall commissioned as an SII.
There were no new themes to these falls, therefore a reason for the increase can not be surmised.
It has been recognised that ward teams need more awareness of falls risks and mitigation of risk and work has commenced with The deputy CNO to raise this awareness.

Actions (SMART)

Data has been standardised to ensure that per 1000 bed days is attributed to adult in-patients only. This will not hinder reporting and investigation into harms in other areas e.g. ED.
All wards and departments (and other key areas) have been asked for at least 1 member to form a new falls workstream. This will become the new falls group and will meet monthly. It is hoped that this can commence in August.
Share and Learn is going through a process of change to highlight areas of good practice and shared learning-plans are on going.
It has been decided to focus on 3 areas who report high incidences of falls-Amesbury, Spire and Durrington. Using Improving Together methodology, senior divisional nurses will be "going and seeing" throughout the summer months to encourage positivity and provide some actions for the workstream.
An equipment review has taken place with the falls reduction lead, manual handling specialist and 2 senior therapy staff and a "wish list" completed

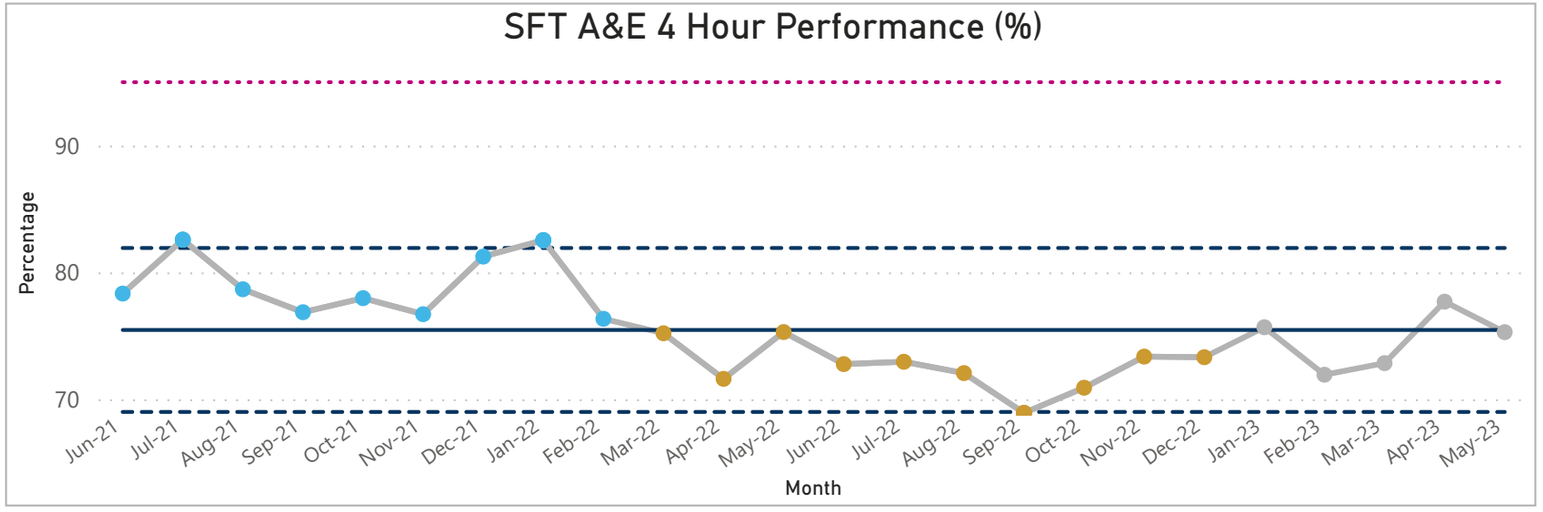
Risks and Mitigations

An assitant to the falls lead will be advertised by the end of July for 22.5 hours per week substantively.
Negotiations will commence in June/July for the purchase of falls and manual handling equipment.

Emergency Access (4hr) Standard

Target 95%

National Key Performance Indicators



Performance Latest Month:	75.3%
Attendances:	6561
>12 hrs in ED Breaches:	60

Understanding the performance

M2 saw a reduction in the trust 4-hour performance to 75.3% (77% in M1). This was driven by a significant increase in overall attendances of 503 in M2 compared to M1, this equates to an average of 16 additional patients per day. Whilst there was a small increase in Category 1 patients of 15 in M2, there was a significant increase in month of Category 4 & 5 patients who present with lower acuity issues. This is supported by the significant decrease of 4% of in patients being admitted in M2.

For the first time in 4 months, we have seen a significant increase in the number of 12-hour breaches from 43 in M1 compared to 60 in M2. Flow out of the department continues to be the biggest challenge to achieving the 4-hour standard. This has been particularly difficult in M2 with the closure of Whiteparish Ward for refurbishment resulting in the loss of 23 beds. This was demonstrated by the Trust escalating into both Interventional Radiology and SDEC for the first time this calendar year. Further evidence of the challenges in flow are shown by the increased numbers of patients with a Decision to Admit remaining in the Emergency Department >4hours, this increased in month to 54.88%. The time lost by these patients is the equivalent of 5.7 ED spaces daily, 38% of the overall capacity.

Actions (SMART)

ECIST visit in M3 to assist a workforce review of ED, support with Streaming processes and how the department deals with pressures/workload.

Successful secondment into a new ED SLT Coordinator role commencing in M3. The Role will support the SLT with the many workstreams currently being implemented within the department.

Handover working group has been established to assist with help in improving handover times trust wide which will positively impact flow.

Risks and Mitigations

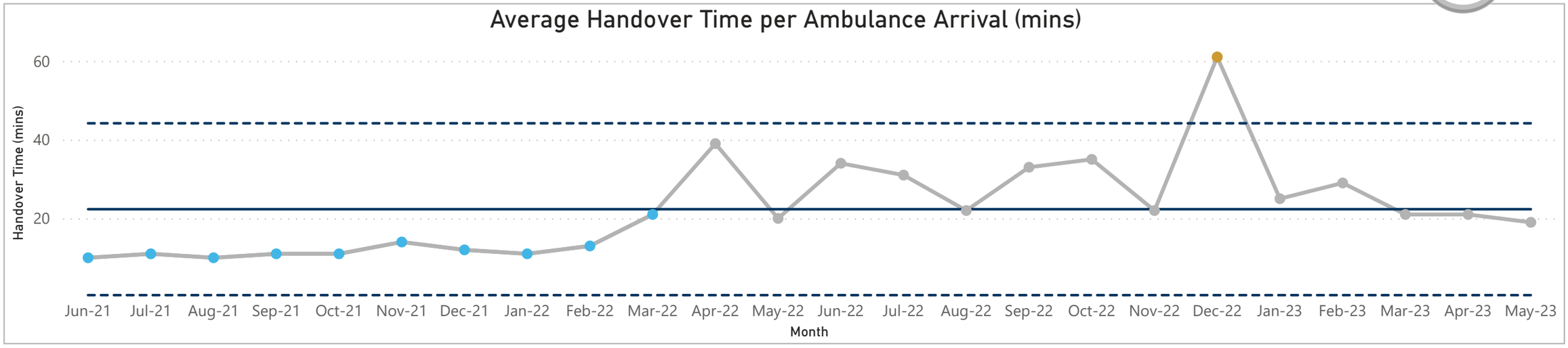
Nursing staffing vacancies continue to remain high for RN's and HCA's. The Matron and existing Band 7's are driving recruitment and the development of existing staff. Skill mix review has approved the change to Increase Band 6 WTE from 7.45 – 11.14 which will improve the core skills across the department. This increase has been offset by a reduction in the Band 5 WTE. Medical workforce vacancies also continue to impact the department with 2.6 WTE vacant Consultant posts and 3.4 WTE Middle Grade Posts. The Clinical Leads continue to lead on recruitment for these vacancies.

Timely flow out of the department continues to impact 4 and 12-hour performance, with high bed occupancy levels continuing across the Trust, further hindered by the closure of 23 beds (Whiteparish Ward) in M2.

Further Junior Doctor Strikes are planned for M3, an alternative rota has been produced to mitigate the junior doctor gaps.

Ambulance Handover Delays

National Key Performance Indicators



Understanding the performance

There was a small increase in the number of ambulances presenting in M2 of 58 to 1155, compared to 1097 in M1, equating to ~1 additional per day. The protection of Medical SDEC from escalation which started in M12 continues to have a positive impact. Fewer medical patients are being diverted to ED, minimising delays to offload at the Front Door. The average handover time in M2 was 18.5 minutes, with the breakdown in performance as:

- 56.3% of patients off loaded <15 minutes in M2 compared to that of 53.5% in M1
- 80.8% of patients off loaded <30 minutes in M2 compared to that of 77.9% in M1
- 90.8% of patients off loaded < 60 minutes in M2 compared to that of 89.7% in M1

Actions (SMART)

The department continues to explore options identifying a Trust Cohort area to cohort patients awaiting to be off loaded at times of surge. This supports the safety of patients waiting for ambulances, releasing SWAST crews back into the system to attend urgent priority calls and assisting performance.

The Band 7's continues to explore ways in assisting to streamline the handover process offloading patients into the department.

Risks and Mitigations

As reported in M1 the HALO service is currently holding significant vacancies at SFT with a 70% vacancy with only 1 WTE permanent member of staff currently provided by SWAST. SWAST actively continue to work at ways to recruit into this position and will provide HALO support by removing a crew from the road at times of surge when there is not a permanent HALO in situ.

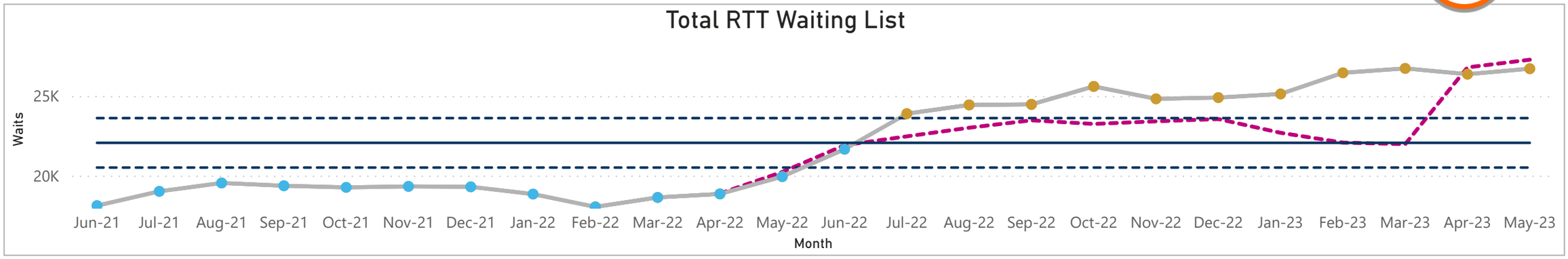
Workforce vacancies, both medical and nursing remain challenging within the department, reducing the ability to Stream and RAT patients. This is being picked up in an ECIST visit in M3 assisting with workforce review, Streaming processes, and ambulance handovers.

High bed occupancy levels and staffing challenges across the Trust, continues to impact timely flow out of the department, with an average daily loss of 5.7 spaces to patients awaiting admission in M2. This continues to be the biggest challenge in being able to offload patients swiftly and safely into the department.

The continued Agreement of protection of Medicine SDEC remains beneficial in generating earlier flow out of the department and enabling SWAST to convey patients to the most appropriate area

Total Elective Waiting List (Referral to Treatment)

National Key Performance Indicators



Month	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23	Apr-23	May-23
Longest Waiting Patient (Weeks)	99	95	98	94	95	87	83	85	73	75	76	75

Understanding the performance

The Total RTT Waiting list size position at the end of May stood at 26717 an increase of 344 from April (26373). However, this is 564 ahead of the May 2023/24 plan.

However, there are a small number of specialties that account for a disproportionate proportion of the waiting list increase since April 2022. Of the top five specialties with the greatest increase in their respective waiting list all are from the Division of Surgery, being comprised of the following: - ENT (1st), Urology (2nd), General Surgery (3rd), Gastroenterology (4th) and Colorectal (5th). They collectively account for 56% of the increase in waiting list size since April 2022.

Actions (SMART)

The largest proportion of the waiting lists sits within the non-admitted pathways. There remains going into 2023/24 a number of specialities with large increases in waiting list size over the last year, including a number of specialities with considerable operational and staffing pressures, e.g. Dermatology.

A number of actions planned for March have either been delayed or only partially implemented including: -

- The Dermatology business case has been approved at TMC and TIG and is progressing through the procurement process with estimated active mobilisation to commence August 2023.
- The challenges in providing additional capacity via 7Pas of GPwSI into ENT have been broadly mitigated through alternative capacity provision, however, additional capacity and options continue to be explored.
- Monitoring of Long Waits to continue with a mirrored process for the 65ww target as was implemented for the 78ww in 2022/23, with the Trust's clearance rate remaining ahead of plan.
- Focussed speciality support to the most challenged specialties in the form of weekly huddles supported by the Transformation Team.
- Additional consultant to commence in post in Gastroenterology (June 2023).
- Ongoing recruitment in Plastics.
- Explore opportunities with BSW partners for Super Saturday Paeds lists

The need to better understand the demand and capacity by specialty, which is currently being developed by the performance and BI teams, and will be a key objective for the new Performance Manager due to commence on 18th August.

Risks and Mitigations

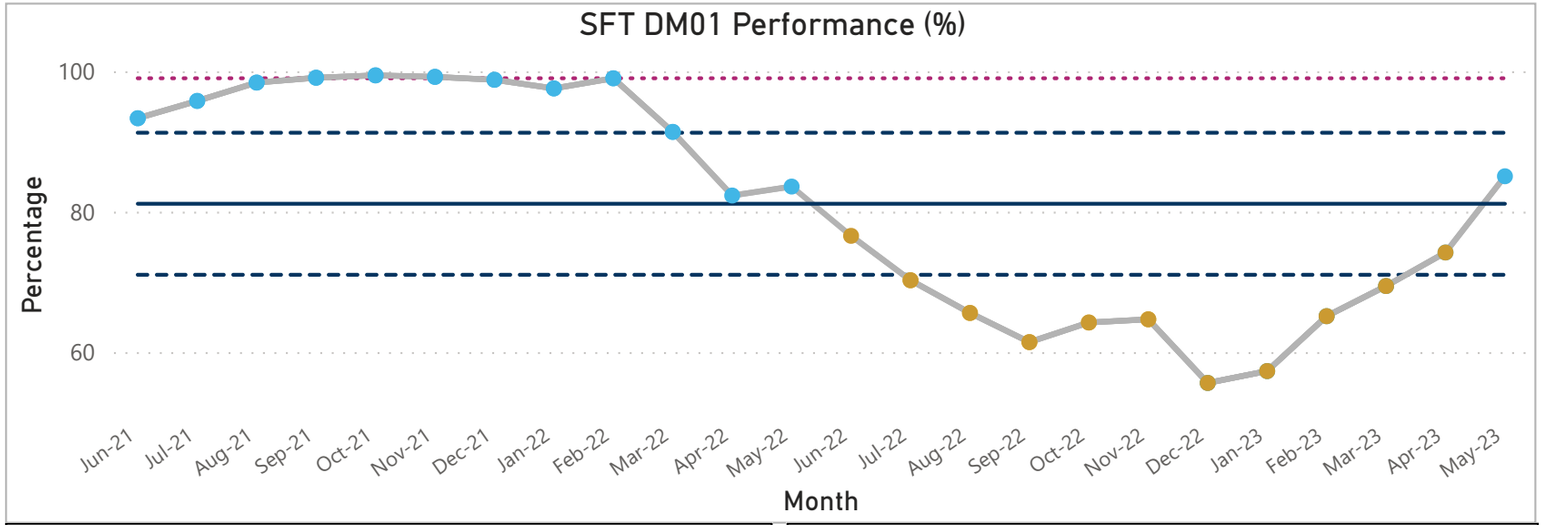
The risk of the industrial action remains, not least the Junior Doctor strike w/c 12th June. Whilst mitigations are in place to support safety for those most clinically urgent patients, the volume of activity affected cannot usually be entirely mitigated.

Support into operational teams to enhance level of focus on the non-admitted pathways, through further OPD workshop and weekly huddles in line with Improving Together Methodology throughout Quarter 1, with roll out to further specialties into Quarter 2.

Diagnostic Wait Times Performance (DM01)

Target 99%

National Key Performance Indicators



Performance Latest Month: 85.0%

Diagnostic Activity: 8656

	Performance	Breaches		Performance	Breaches
MRI	76.4%	138	CT	99.8%	1
US	83.8%	286	DEXA	100.0%	0
Audio	60.7%	96	Cardio	100.0%	0
Neuro	100.0%	0	Colon	76.7%	47
Flexi Sig	67.0%	37	Gastro	88.3%	12

Understanding the performance

M2 DM01 performance has increased from 74.19% in M1 to 85.04% in M2 with performance significantly ahead of the Trust's trajectory position of 75%.

Total number of patients breaching the standard reduced from 1172 in M1 to 617 in M2 with reductions across all key influencing modalties:

MRI reducing from 220 breaches to 138 breaches
USS reducing from 702 breaches to 286 breaches
Audiology reducing from 104 breaches to 96 breaches
Endoscopy reducing from 139 breaches to 96 breaches

Cardiology Echo continues to report 0 breaches
All modalties focussing on reduction of 20+ week waiters

Actions (SMART)

1) Submit extension request for USS insoucing arrangement beyond current arrangement (volumes in current contract used by end of July 23 - aim to extend for lesser volume per month until March 24 as a minimum). DDO for CSFS to lead.
2) Working with BSW diagnostic performance group, ensure full utilisation of CDC scanner on site from July. DDO for CSFS and Ops Lead Radiographer to lead.
3) Confirm audiology waiting list numbers (previous data quality issue identified) and confirm course of action through delivery group by end of June 2023). Surgery DM/HoS to lead.
4) Continue with weekly long waiter validation across all modalities to ensure managing to < 20 week waiters with a view to < 13 week waiters by March 24. DDO for CSFS to lead with modality leads input.

Risks and Mitigations

Risk to sustained USS compliance if insourcing can not continue beyond July 23. Extension request paper to be submitted to Execs for approval by 23rd June.

Risk to ability to fill MRI CDC capacity and so cost of scanner will not be off set by activity. Liaising with system partners to identify demand that could fill capacity.

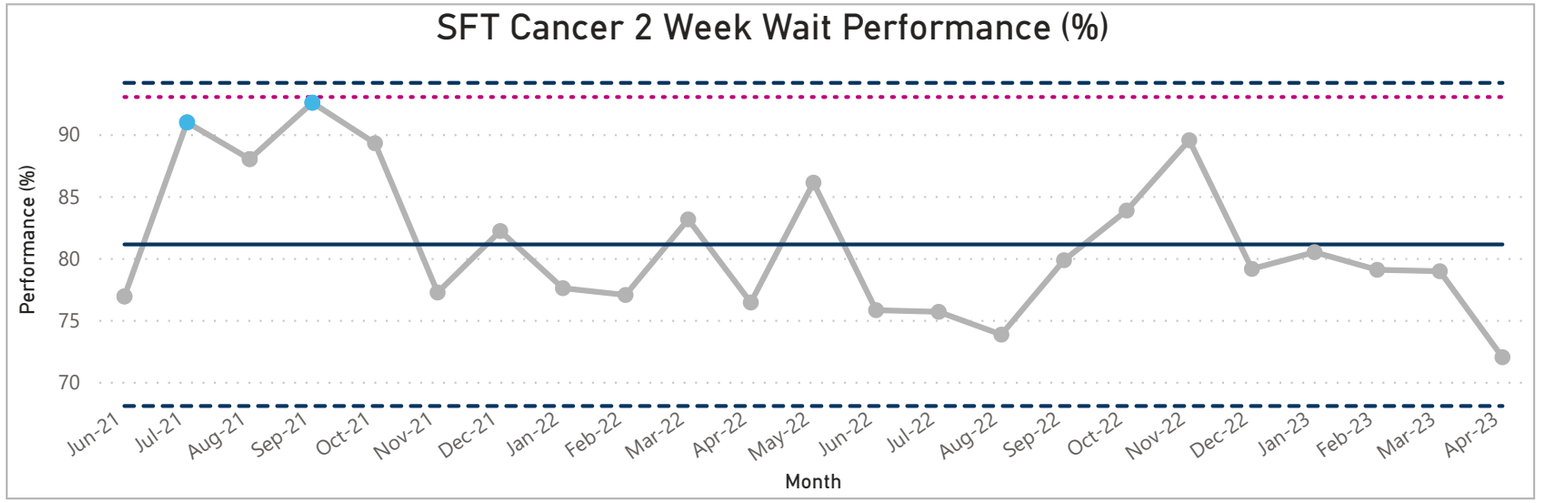
Resolution of audiology data quality issue will likely increase reportable audiology breaches from June. Potential to off set this with continued improvement in Radiology and so trajectory position may not be signficantly impacted.

Resignation and sickness in endoscopy staffing is impacting capacity. Bookings team focusing on long waiter booking.

Cancer 2 Week Wait Performance

Target 93%

National Key Performance Indicators



	Performance	Num	Den	Breaches
Two Week Wait Standard:	72.0%	668	928	260
Two Week Wait Breast Symptomatic Standard:	100.0%	28	28	0

Understanding the performance

71.98% 2WW performance reported in M2. 2WW position unobtainable mostly due to large volume of breaches in Dermatology pathway (with 119 patients impacted in M2).

Of note, whilst Dermatology do not achieve 2WW compliance, the patient pathway is such that 28 day FDS and 62 day standard are (in most months) achieved.

Lower GI also not achieving compliance against the 2WW standard in M2 due to staffing constraints across the rota.

Actions (SMART)

1) Future piece of work to consider 'carve out' of 2WW capacity in Dermatology clinics. Would need to consider impact on routine. Not current priority as Dermatology are achieving 28d and 62d standards, and Dermatology insourcing scheduled to commence August 23.
2) Continue to raise the profile of 2WW performance through cancer improvement group and delivery group.
3) Demand and capacity work for 2WW (and other cancer standards) to be commenced (Service Manager for Cancer with Performance Lead) to establish weekly demand for 2WW on specialties with a view to discussion across all re 'carve out' in templates.

Risks and Mitigations

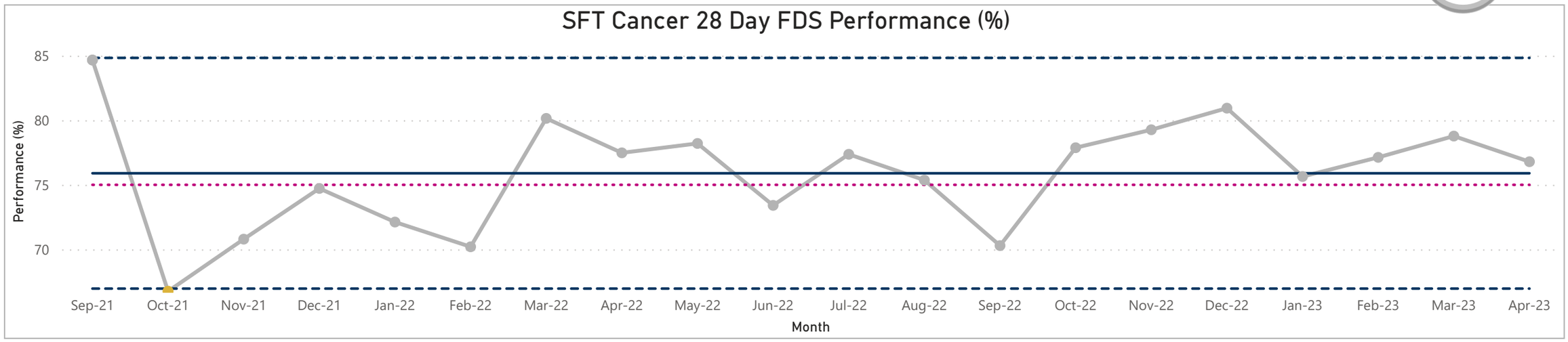
Anticipate Dermatology continuing to impact the 2WW Trust position due to high volume of breaches. Mitigation as per actions.

Instability within gastro/endoscopy workforce and pathways likely to continue and potential to impact cancer pathways (particularly for 2WW and diagnostic elements).

Cancer 28 Day Faster Diagnosis Standard Performance

Target 75%

National Key Performance Indicators



Understanding the performance

28d FDS standard achieved for M2 - 76.79%.

Specialty level stratified data required to understand improvements needed at specialty level but Breast and Dermatology successes with this pathway ensure the Trust is compliant overall.

Actions (SMART)

1) A3 thinking, stratified data development for vision metric required. DDO for CSFS to lead this, anticipate being able to complete initial A3 by end of M4.
2) Focused Urology PTL meetings (started on 7/6/23) will improve PTL management across the Urology pathways and likely to have positive impact on 28d in coming months.

Risks and Mitigations

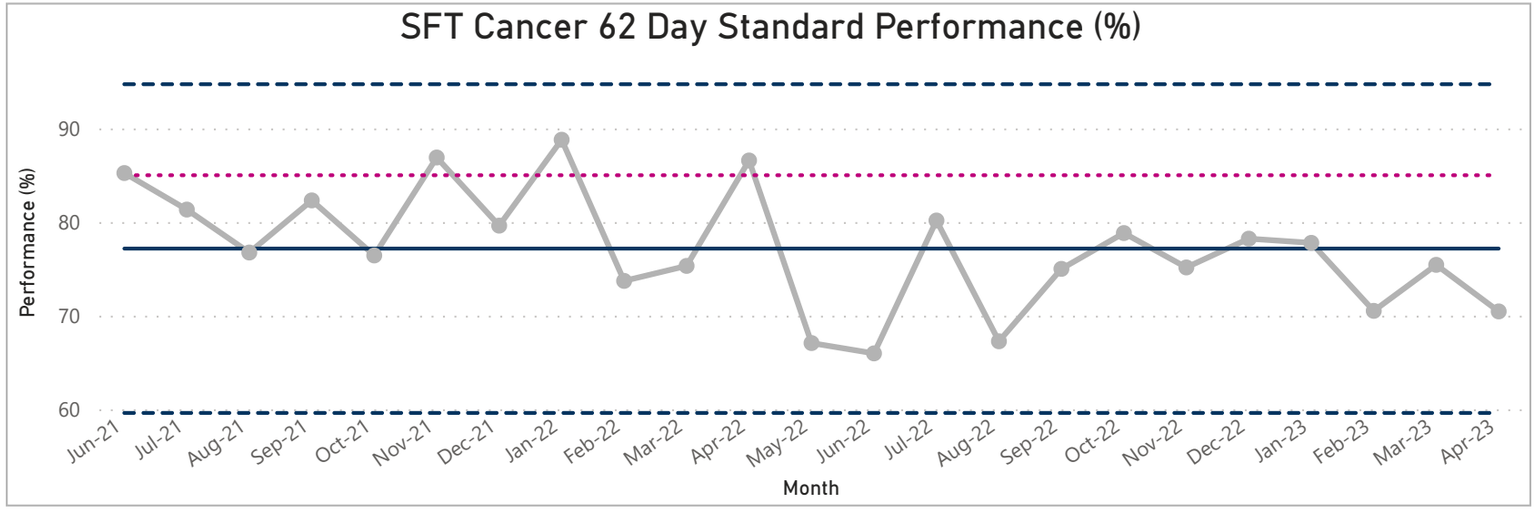
Anticipate good performance against the 28d FDS and not expecting for the Trust position to deteriorate significantly.

There will remain a risk to some sub specialty achievement of this standard, i.e. Urology. A3 development will support root cause analysis for next level of improvement/increase in 28d performance for the organisation.

Cancer 62 Day Standard Performance

Target 85%

National Key Performance Indicators



	Performance	Num	Den
62 Day Standard:	70.5%	47	66
62 Day Screening:	57.1%	2	4

Understanding the performance

62d standard was not achieved in M2 - submitted position reported at 70.45%. This was following full validation between Cancer Services Team and DDO for CSFS.

Primary area of non compliance within the Urology pathway with 15 patients impacted. Urology will remain the key area of improvement focus for the next 1-2 months whilst new systems and processes are embedded to improve the pathway management.

Actions (SMART)

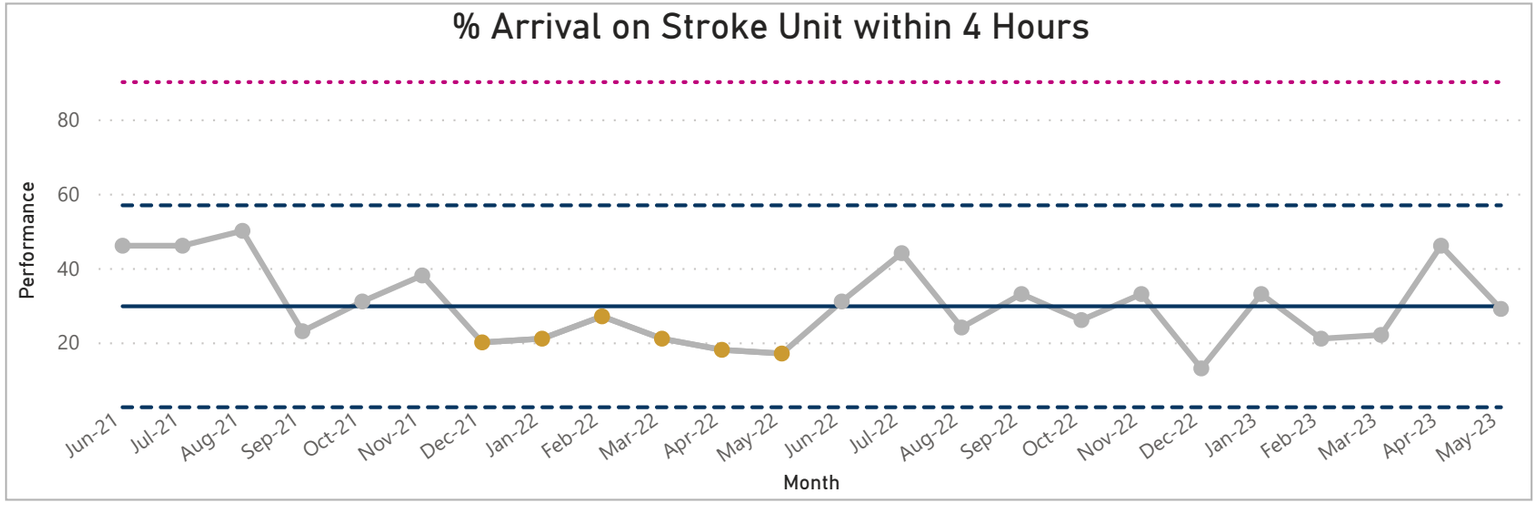
1) Urology cancer PTL meeting commenced from 7/6/23 involving cancer services, Urology Nurse Consultant and Central Bookings.
2) Weekly cancer report to be distributed to cancer multi disciplinary team (MDT) leads and other key stakeholders for awareness and oversight of performance and key issues and risks.
3) Awaiting recruitment of additional MDT co-ordinator and MDT navigator for Urology to support focus of pathway tracking within the MDT cancer services team (and cover during absence).
4) Final performance position to be signed off by DDO for CSFS following full validation with cancer services team.

Risks and Mitigations

Performance across 62d is likely to continue to below target for at least Q2 whilst improvement work to reduce backlog continues. CAN PTL (over 62 day patients) backlog is reducing as a result of work on the Urology PTL meeting but this will result in breaches being reported as actions within patient pathways are taken/closed and not left waiting.

Stroke Care

National Key Performance Indicators



SSNAP Case Ascertainment Grade

Highest Level = Grade A
Lowest Level = Grade E

Fyear	Q1	Q2	Q3	Q4
2021-2022	C	C	C	C
2022-2023	D	C	C	C

Understanding the performance

The national target for arrival on stroke unit within 4 hours is 90%; May '23 month end performance of 29% (An decrease in comparison with April '23, 46%). The impact of high bed occupancy trust wide has an impact on timely availability of beds on the stroke unit. The length of stay (LOS) for patients on the stroke unit has increased slightly from April, with April having an average LOS of 12 and May LOS at 15. Organisational bed pressures had led to more general medicine patients being out lied to stroke beds limiting the beds available to stroke patients.
Throughout May there were several occasions where staff were moved to support other wards due to a lack of staff across the division. This along with additional escalation beds open, reduced skill mix and number of staff trained to manage stroke patients not able to be released to see patients in the emergency department. This ward has also been supporting escalation areas such as South Newton and Breamore ward.

Actions (SMART)

1.Simulation training to be implemented to increase staff understanding and ability to recognise stroke symptoms. This in turn will ensure timely transfer of priority patients from ED staff, date to be confirmed.
2.Prioritisation of bed moves out of Farley to facilitate stroke patients transferring is ongoing. This action includes identification of patients which are suitable to move off the ward daily, This will feed into improving together daily huddle and to discuss issues with delayed transfers and how this can be improved. The use of the GP assessment room is also discussed daily to see if patients are appropriate to be seen there rather waiting in ED.
3. A Standard operating procedure has been comprised which provides an overview of the stroke pathway from presentation to transfer to the stroke unit. The purpose of this is to give clear guidelines for utilising escalation spaces on stroke unit to enable rapid transfers and avoid delays.

Risks and Mitigations

Hyperacute stroke patients are at risk of worsening outcomes without access to specialist care in the appropriate time frame, which in turn increases length of stay. To help mitigate against this, monthly meetings with the working group to discuss the progress of stroke patients arriving on the stroke unit within 4 hours These meetings will enable bed moves to be facilitated more promptly when a potential stroke patient has been identified in ED.
Nursing staff continue to be redeployed to other areas. This has an impact on stroke services ability to receive patients from ED, especially those that are thrombolysed and require 1:1 input due to the delays in handovers in both transferring patients off the ward and admitting patients onto the stroke unit. The service is hoping to be able to protect staff going forward by recognising stroke as an acute ward. However, bed managers will only move staff from the stroke unit as a last resort to help protect staffing levels where possible.

Maternity

Are We Safe?

01/05/2023	<- Reporting Month (Input the first of the REPORTING month)												
				RAG rating			Rolling 6 months						
SFT Assurance Dashboard		Guidance	Standard	Red	Green	Improvement Direction	Dec-22	Jan-23	Feb-23	Mar-23	Apr-23	May-23	Rolling 6m average
Perinatal Morbidity and Mortality (M&M)	Number of late fetal losses (22+0 to 23+6 weeks excl TOP)			>= 2	= 0	Down	0	0	0	0	0	0	0
	Number of stillbirths (> + 24 weeks excl TOP)			NA	NA	Down	0	2	0	1	0	0	1
	Number of neonatal deaths : 0-28 days			NA	NA	Down	0.0	0.0	0.0	0.0	0.0	0.0	0.0
	Number of neonatal deaths : 0-28 days per 1,000 Live (Reg) Births	ONS	2.7 per 1000 live births	>= 2.8	<= 2.6	Down	0.0	0.0	0.0	0.0	0.0	0.0	0.0
	Medical termination over 24 +0 registered			NA	NA	Down	0	0	0	0	0	0	0
Maternal M&M	Number of Maternal Deaths			NA	NA	Down	0	0	0	0	0	0	0
	Number of Maternal Deaths per 100,000 Maternal Deaths	ONS	9.1 per 100,000 women who	>= 9.2	<= 9	Down	0.0	0.0	0.0	0.0	0.0	0.0	0.0
	Number of women requiring admission to ITU	6 month SFT rolling		>= 2	= 0	Down	0	0	0	0	0	0	0
Insight	Datix incidence SII	6 month SFT rolling		>= 1	= 0	Down	1	0	1	1	0	0	0.5
	HSIB referrals	6 month SFT rolling		>= 1	= 0	Down	1	0	0	1	0	0	0.3
	HSIB/NHSR/CQC or other organisation with a concern or request	6 month SFT rolling		>= 1	= 0	Down	0	0	0	0	0	0	0
	Coroner Reg 28 made directly to trust	6 month SFT rolling		>= 1	= 0	Down	0	0	0	0	0	0	0
Workforce	Obstetric cover - labour ward	RCOG guidence		<= 39	>= 40	Up	40	40	40	40	40	40	40
	Midwife to Birth ratio	RCM,NHSR,BR+	1:26	>= 1:28	<= 1:26	Down	1:31	1:31	1:27	1:31	1:25	1:31	NA
	Midwifery vacancy rate (black= over establishment; red =under establishment)			>= 1	NA	Down	20.0	20.9	20.9	21.9	21.9	23.2	NA
	Provision of 1 to 1 care in established labour (%)	NICE, RCM, MIS	100%	<= 94	>= 100	Up	100	100	100	100	100	100	NA
	Datix relating to workforce	6 month SFT rolling		>= 2	= 0	Down	1	1	2*	2	3	1	1.6
	Compliance with supernumery status of the L/W coordinator - %	NICE,RCM,NHSR	100% rostered	<= 94	>= 100	Up	100	100	100	100	100	100	NA
	Numbers of times maternity unit on divert	6 month SFT rolling		>= 2	= 0	Down	0	0	0	0	0	0	0
Involvement	Service user feedback : Number of Compliments	6 month SFT rolling		NA	>= 15	Up	10	10	10	25	31	22	18
	Service user feedback : Number of Complaints	6 month SFT rolling		NA	NA	Down	2	1	3	1	0	2	1.5
	Number of SOX	6 month SFT rolling		NA	>= 8	Up	3	3	6	17	2	12	7

Understanding the performance

The midwife to birth ration is static but artificially improved in April due to low birth numbers.
Compliments remain improved since the beginning of the six-month period.
Increase in SOX for staff members recognising staff going above and beyond

Actions (SMART)

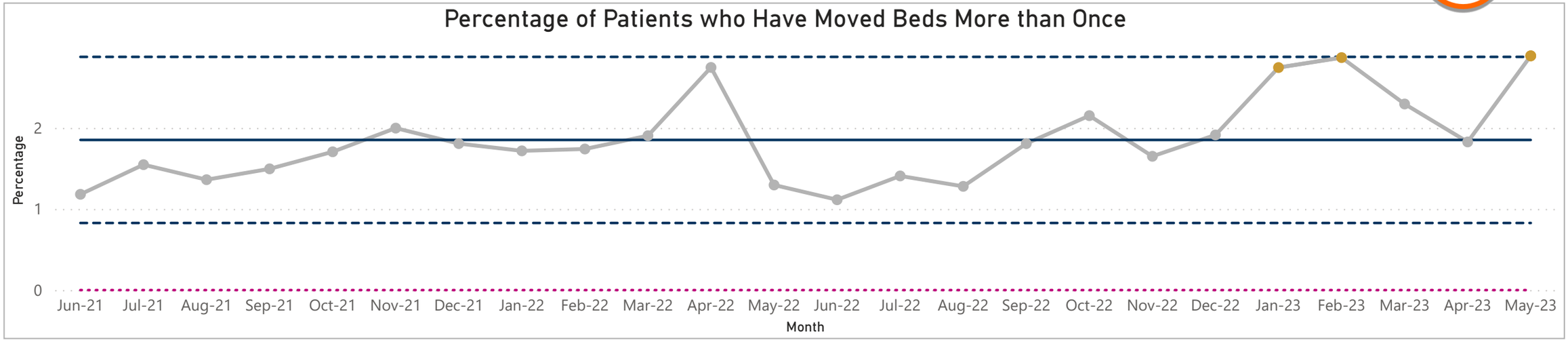
Targeted recruitment drive in place with welcome incentive. 11 WTE band 5 midwives to start in October. Three further band 5 midwives to be interviewed.
2.6 WTE band 6 midwives offered roles to start as soon as notice periods completed.
One further band 6 bank midwife recruited.

Risks and Mitigations

Midwifery staffing remains a risk, mitigated by long line agency usage until qualification and employment of band 5 midwives.
Escalation policy followed to ensure one to one and safe care maintained.
Maternity care assistants supporting with non midwifery care.
Registered nurses employed within maternity services, supporting with non midwifery specific roles, e.g. working alongside midwives in postnatal care

Patients Who Have Moved Beds More Than Once

Are We Safe?



Understanding the performance

Patients experiencing wards moves on more than one occasion during their admission increased sharply in May to 2.89% of inpatients. This means that patients have experienced changes in teams and environments during their stay.

Every effort is made to ensure patients are placed in the safest and most appropriate setting for their care first time, however this graph demonstrates this was difficult to achieve in May.

Actions (SMART)

Pembroke ward is proposing a SOP that is to be reviewed in June that protects specialist beds in haematology

The whole Trust and its partners is working to reduce the number of escalation beds in use, which are recognised as being a factor in having to undertake multiple moves for patients resulting in an extended length of admission.

Maximising the use of community capacity releases capacity in all inpatient beds, making them available for use when required. Additional actions have been undertaken and will continue into June to ensure patients are in the right place at the right time across the system.

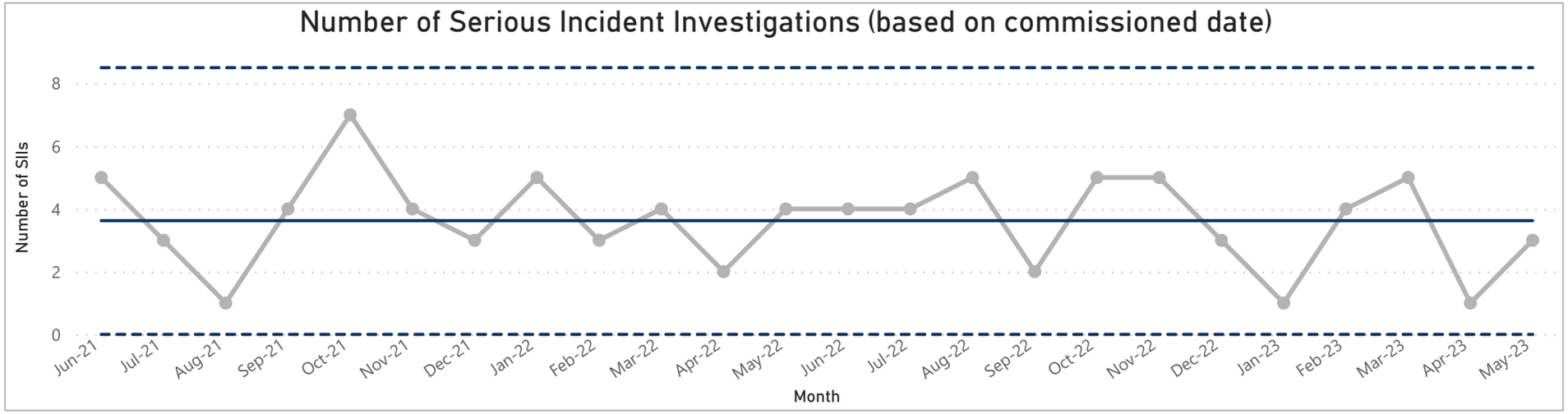
Risks and Mitigations

Risks to the success of these include sustained escalation meaning additional SFT capacity is used, inevitably adding moves to a patients experience. Any further infection control risks that lead to closure of areas will affect the success of plans, as will community capacity to support with discharge services for patients requiring additional care and support on discharge. Any increase in the number will mean we have to consider patients for moving to release capacity in the beds most required.

Mitigations include regular contact at all levels with system partners to support flow, regular review and ensuring the ward areas are confident of the next specialist bed to be used at the capacity meetings.

Incidents

Are We Safe?



Year	2021-2022	2022-2023
Never Events	3	0

Understanding the performance

For May there were 3 SIIs commissioned:

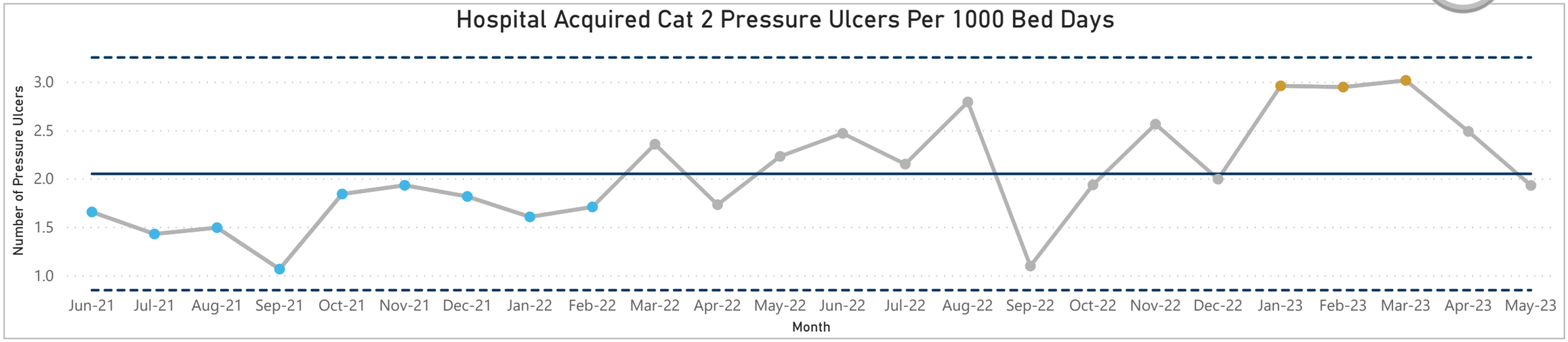
559- catastrophic fall
561- Catastrophic fall
562- Incorrect identification of body in mortuary

Actions (SMART)

Risks and Mitigations

Pressure Ulcers

Are We Safe?



Understanding the performance

- For the second month in a row we have seen a reduction in Hospital acquired pressure ulcers (from 61 in March to 47 in April and now 35 in May). The increase in staffing numbers noted across the trust may well be attributed to this reduction
- An increase in device related pressure injuries was noted from 1 last month to 6 this month
- MASD has increased from 21 to 35 and 47 in the same time period. This is likely due to the increase in temperature and due to Tissue Viability team undertaking and promoting head to toe skin reviews highlighting issues which may not have been referred.

Actions (SMART)

- Tissue Viability team are continuing to increase bedside education during patient reviews, be aware that this does increase time required to review each patient.
- Wards have requested Tissue Viability education sessions which we are aiming to facilitate as time and staffing allows.
- Tissue Viability team are currently leading on heel offloading devices which we hope will be available Trust wide in the near future.

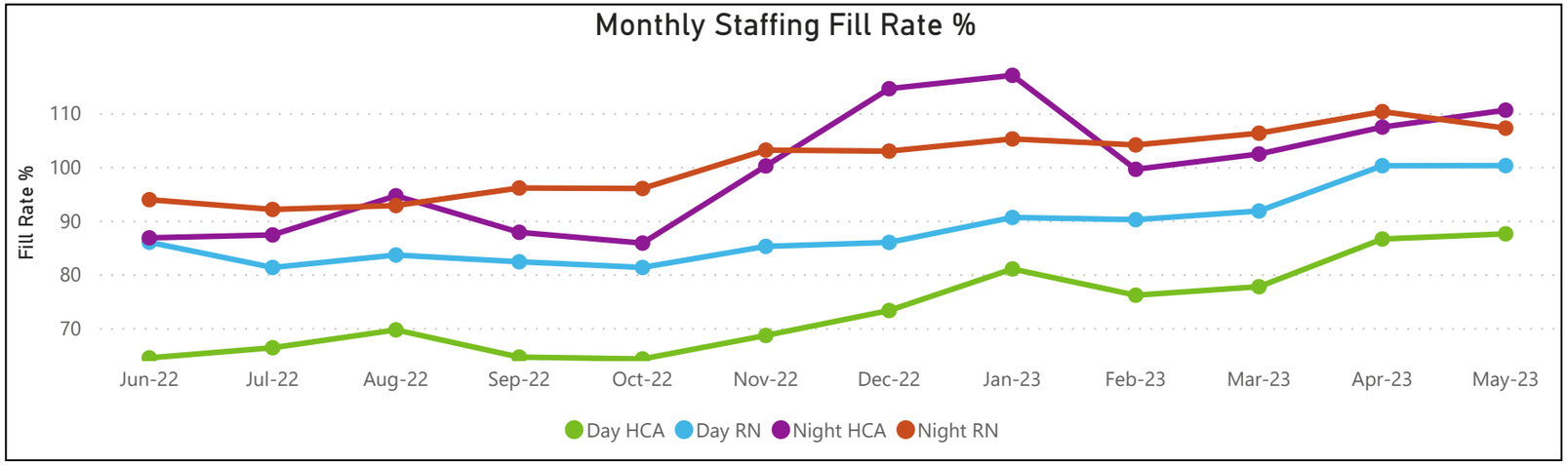
Risks and Mitigations

We continue to see a large volume of referrals which at review are not appropriate for Tissue Viability input, wards are requested to ensure all relevant information is included when referring to allow appropriate use of Tissue Viability team time

- South Newton are unable to upload photos. This prevents timely review and support. Tissue Viability team are unable to support in person reviews off site at this time
- Pressure Ulcer Prevention Policy under continued review.

Nurse Staff Fill Rate

Are We Safe?



Ward	Day RN	Night RN	Day HCA	Night HCA
Amesbury	140%	173%	95%	123%
AMU	97%	103%	79%	93%
Breamore	144%	146%	89%	224%
Britford	95%	98%	97%	108%
Chilmark	96%	101%	94%	111%
Downton	113%	142%	96%	104%
Durrington	101%	102%	85%	110%
Farley	93%	99%	72%	115%
Hospice	104%	101%	89%	101%
Laverstock	95%	105%	70%	97%
Longford	102%	103%	91%	101%
Maternity	94%	99%		
NICU	104%	100%	39%	
Odstock	101%	100%	98%	100%
Pembroke	97%	100%	94%	100%
Pitton	109%	117%	102%	154%
Radnor	94%	98%	60%	73%
Redlynch	98%	103%	75%	89%
Sarum	87%	112%	128%	
South Newton	94%	100%	87%	100%
Spire	102%	131%	97%	140%
Tisbury	91%	98%	72%	94%
Whiteparish	101%	99%	73%	106%

Understanding the performance

All 4 markers of fill rate remain fairly static with normal variation – fill rate continues to be affected by ward leaders not pulling back unrequired demand.

CHPPD in month is 7.9 (7.3 when ICU/NICU and maternity excluded) which is similar to last month position. The issue relating to all maternity staff being included but not all maternity beds is not yet resolved which impacts on CHPPD for maternity and Trust overall.

Actions (SMART)

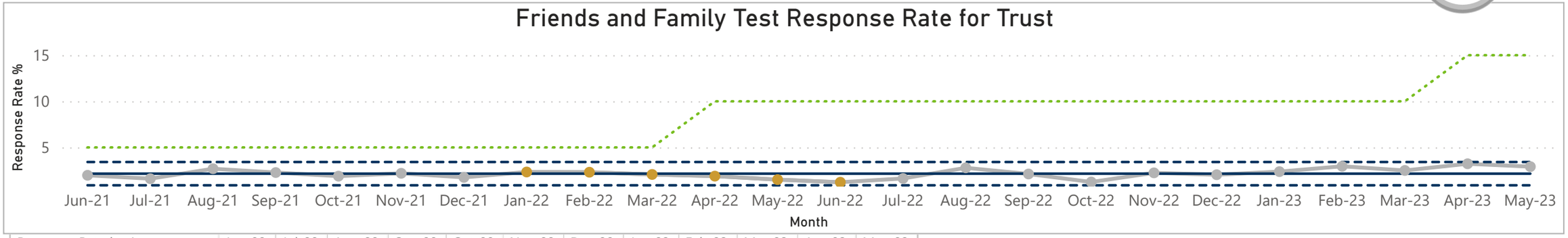
Band 2 to Band 3 uplift - work on-going with temporary staffing to rollout uplift to bank workers - anticipated completion date of end of June 23.
Ward assistant project - awaiting KPI measures from matrons to measure impact- overdue.
Winter incentive review - ongoing review.
Additional 30 IENs to be recruited by end of Dec making total 120 for 23/24.
Awaiting outcome on business cases for HCA recruitment/retention lead and additional practice educators to support IEN recruitment
A3 being developed with DHoNs for reducing reliance on temporary staff for enhanced care
Additional work being undertaken on RNDA business case - expect to resubmit to TIG within 2 months
Rectify maternity CHPPD data by next month

Risks and Mitigations

On-going turnover for HCAs and RNs impacting on effectiveness of recruitment (risk)
Increased demand on numbers of patients requiring RMN support (risk)
Additional beds remain open across the Trust which are reliant on temporary workforce and not in establishment (risk)
Domestic and international recruitment campaigns (mitigation)
OD+P led work on retention, turnover and inclusion (mitigation)
HCA recruitment and retention lead – fixed term (mitigation)

Friends and Family Test Response Rate

Our Care



Response Rate by Area	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23	Apr-23	May-23
FFT Response Rate - A&E	0.2%	0.1%	0.3%	0.4%	0.3%	1.1%	0.3%	0.8%	1.6%	1.0%	0.6%	0.6%
FFT Response Rate - Day Case	3.3%	4.6%	8.9%	6.8%	3.1%	2.5%	1.4%	0.3%	2.0%	2.5%	3.4%	4.2%
FFT Response Rate - Inpatient	6.8%	7.5%	10.9%	11.4%	5.1%	10.5%	5.8%	11.5%	13.0%	3.2%	14.5%	12.9%
FFT Response Rate - Maternity	0.4%	1.6%	7.8%	1.1%	1.2%	0.0%	2.6%	2.2%	3.7%	1.4%	0.0%	0.5%
FFT Response Rate - Outpatient	0.6%	0.9%	1.5%	0.9%	0.9%	1.6%	2.0%	2.0%	2.2%	2.1%	2.5%	2.3%

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. Weekly emails are sent to leads showing feedback received in the previous week, allowing them to pick up any immediate causes for concern and mitigate these where possible.
Negative feedback is review by the ward and PALS, twice a year.
FFT response figured have started to increase now. Staff are still being encouraged and reminded to offer FFT through the PALS outreach services although we appreciate that this sole method of obtaining response will inevitably mean fluctuations in activity consequent to pressures.
New cards have gone to all areas and offer free postage. Gender options have also now been extended in line with national guidance.

Actions (SMART)

Medium-term action:
Delay in the rollout of digital provider (see below risk/mitigations) will now require interim actions to be developed.
These could include :
• Use of QR codes on posters, outpatient letters and within discharge packs
• Text messaging via Dr Doctor
• More volunteers to input cards
We are also working with the new digital provider on other interim solutions to develop the data analysis dashboard in the meantime.
Long-term action:
Rollout of the SMS feedback function with the new digital provider which will be key to moving towards achievement of our response rate objectives under the Improving Together Programme over the next 12months:
Aims:
- Increase overall response rates to FFT
- Diverse methods for completion (including, online, SMS, over the phone)
- Increased accessibility and options for inclusivity (sight impairments, languages and additional demographic options)
- Robust analysis of data for insight and meaningful comparison/benchmarking via a real-time dashboard
- Opportunity to align our processes in FFT across the ICS

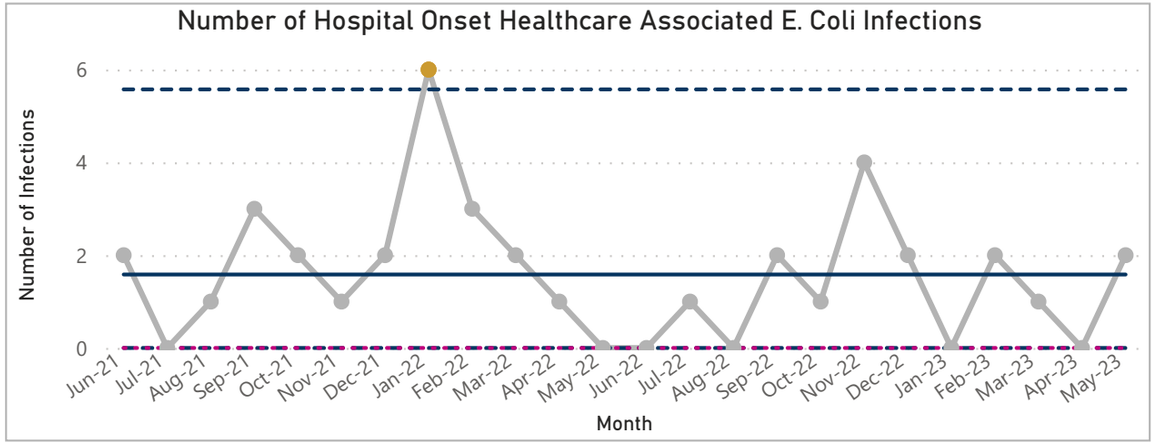
Risks and Mitigations

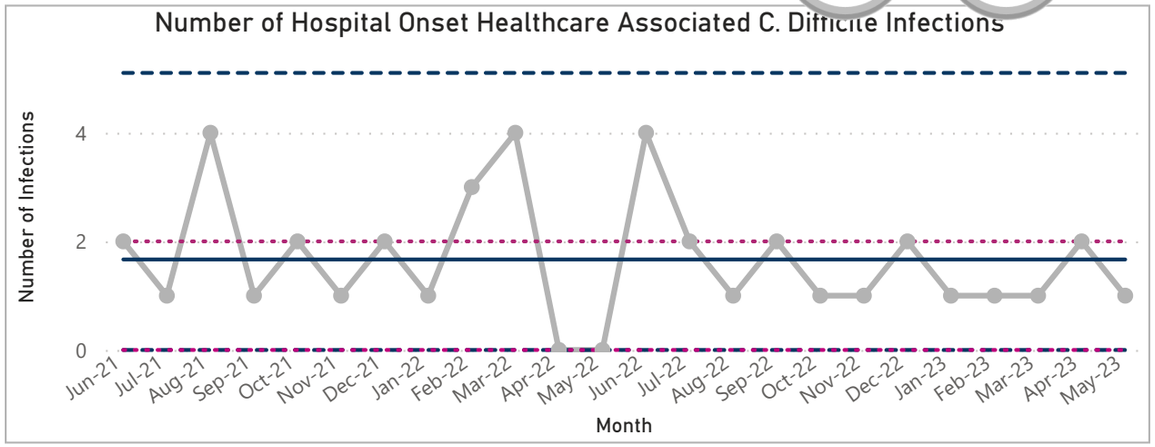
Continued low response rate, due to limited methods for accessibility and the reliance on staff to promote completion of a physical card, this is directly impacted when there are staff shortages and operational pressures. The current method requires manual input and theming, which there is limited resource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

Implementation of the new IT solution has been delayed due to capacity within the informatics team to assist with set-up and roll out. This has been agreed by Execs to delay until this capacity is available - estimated for December 2023.

Infection Control

Are We Safe?





Understanding the performance

- There have been two hospital onset healthcare associated reportable E.coli bacteraemia infections, and one hospital onset healthcare associated reportable C.difficile case this month. There have been two hospital onset healthcare associated MSSA bacteraemia infections this month.
- The Infection Control Nurses (ICNs) have undertaken targeted ward visits and use educational opportunities with different staff groups.

Year	2021-2022	2022-2023	2023-2024
MSSA Bacteraemia Infections: Hospital Onset	12	10	2
MRSA Bacteraemia Infections: Hospital Onset	0	0	0

Actions (SMART)

- Progress with an alternative approach for staff in ward areas to complete hand hygiene education and assessments remains ongoing on a surgical ward, with positive feedback from the Ward Lead.
- Completion of required case investigations by clinical areas to identify good practice and any new learning continues. SFT IP&C team facilitate this process so that areas can take ownership and progress any actions or identified learning (including sharing good practice).
- Of the reviews completed, lapses in care have been identified but no action plans developed. This continues to be followed up by the divisions. The 'Share & Learn' Chair met with the Deputy CNOs in March to feedback progress and agree further requirements for this group. Future meetings have been cancelled whilst a review of the format is undertaken by key members.
- Involvement with BSW collaborative workstreams related to IPC and Gram-Negative Bloodstream Infections: Any feedback communicated from the sessions to identified individuals in the organisation is to be shared at the SFT Infection Prevention & Control Working Group as part of a standing agenda item. The Infection Control Doctor attended one of the HCAI collaborative meetings.

Risks and Mitigations

- Increased clinical workload for IPC nursing team due to continuing and new COVID-19 outbreaks being declared and continued diarrhoea activity within the hospital. This continues to impact on ability to focus on other HCAI prevention work.
- Having commenced on the team in February, the new IPC nursing staff member decided to end their secondment this month and returned to Main Theatres Department.
- An underlying risk continues to be a potential increase in incidence of reportable healthcare associated infections with poor patient outcomes. (Of note: Trust trajectories for 2023/24 have been published this month).

Mortality

Are We Safe?

Metric Name	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23	Apr-
Crude Mortality	62	68	69	65	64	79	94	86	84	84	88	84	77	88	82	73	75	77	102	106	88	95	
HSMR District Hospital (excludes deaths recorded by Salisbury Hospice)	100.85	101.29	102.46	102.85	103.49	106.41	105.02	99.28	101.69	103.59	105.96	106.95	108.70	110.68	112.45	113.10	114.88	115.13	114.58				
HSMR Trust	108.20	109.96	111.61	112.07	114.35	116.13	118.21	106.53	108.20	109.96	111.61	112.07	114.35	116.13	118.21	118.85	120.98	121.33	121.49				
SHMI District Hospital (excludes deaths recorded by Salisbury Hospice)	101.28	101.78	101.88	102.61	102.69	102.81	102.70	104.38	105.48	107.66	106.81	106.05	106.48	106.90	106.98	107.03	106.65	107.29	106.83				
SHMI Trust	106.29	106.22	106.22	107.07	106.90	106.67	106.77	108.47	109.13	111.34	110.43	109.56	110.01	110.87	111.16	111.41	111.08	111.79	111.52				

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

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

Understanding the performance

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

The SHMI for the 12-month rolling period of Dec-22 for Salisbury District Hospital is 106.83.

The HSMR for the 12-month rolling period of Dec-22 for Salisbury District Hospital is 114.58.

Actions (SMART)

N/A

Risks and Mitigations

The Trust's Mortality Surveillance Group (MSG) meet every two months, and our mortality data is reviewed at this meeting. A representative from our Partner organisation, Telstra Health UK (Dr Foster), is invited to attend in order to help us to interpret and analyse our mortality data and identify variations in specific disease groups.

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

Watch Metrics: Alerting

Quality of Care, Access and Outcomes

Metric	Two Months Ago	Last Month	This Month	Improvement Target	National Target	Variation	Variation Detail	Target Met This Month?	Consecutive Months Target Failed
Average Patients with No Criteria to Reside	118	118	124	120		L	Special Cause Improving - Run Below Mean	X	1
Ambulance Handovers 60+ mins	144	112	107		0		Common Cause Variation	X	26
ED 12 Hour Breaches (Arrival to Departure)	54	43	60		0		Common Cause Variation	X	26
Mixed Sex Accommodation Breaches	14	13	16	0	0	L	Special Cause Improving - Run Below Mean	X	9
Number of High Harm Falls in Hospital	4	6	7	0	0		Common Cause Variation	X	10
RTT Incomplete Pathways: Total 52 week waits	768	919	1093	831	0	H	Special Cause Concerning - Above Upper Control Limit	X	5
RTT Incomplete Pathways: Total 65 week waits	84	143	181	141	0	L	Special Cause Improving - Run Below Mean	X	26
Total Number of Complaints Received	22	10	11		0		Common Cause Variation	X	12
Stroke: % CT'd within 1 hour	30.0%	52.0%	48.0%		50%		Common Cause Variation	X	1
Cancer 62 Day Screening Performance	53.3%	64.7%	57.1%		90%		Common Cause Variation	X	8
Trust Performance RTT %	60.2%	59.5%	61.7%		92%	L	Special Cause Concerning - Below Lower Control Limit	X	26
% of Inpatients Undergoing VTE Risk Assessment	%	%	%		95%		Common Cause Variation	X	4
Cancer 31 Day Performance Overall	89.8%	93.1%	92.1%		96%		Common Cause Variation	X	4

Please note: due to a process change in February the data to % of Inpatients undergoing VTE risk assessment is currently absent and expected to remain so until July 2023.

Watch Metrics: Alerting Narrative

Quality of Care, Access and Outcomes

Understanding the performance

There are two metrics alerting due to concerning special cause, both in relation to Referral to Treatment waiting times – the total number of patients waiting over 52 weeks, and the percentage within 18 weeks. The number of patients waiting over 52 weeks is higher than the forecast plan, linked largely to the increased number of public holidays in M2, and also the continuation of Industrial Action for nursing and junior medical staff. Despite this the Trust continues to have zero patients waiting longer than 78 weeks.

The proportion of patients waiting for treatment that have waited under 18 weeks improved slightly in month, although this is not expected to increase significantly as the Trust continues to focus on treating patients in order of clinical priority and waiting time, thereby treating more patients that have waited the longest. Metrics in relation to Cancer 62 Day Screening and Cancer 31 Day standard continue to alert. The screening metric represents a very small volume of patients (3.5 due to shared breaches). Two patients were treated in target, meaning that 1.5 patient breached their target. 62 day screening performance has been consistently low for several months, the majority of these breaches are associated with long delays for first investigation dates at tertiary centres.

Similarly the number of breaches on the 31 Day standard was also small – in total 10 patients breached, with a combination of clinical complexity, patient choice and capacity constraints.

Actions (SMART)

Non admitted pathways are by far the bigger proportion of the waiting list and further outpatient improvement streams are being developed. Work associated with the Wait to first Outpatient Breakthough objective is described early in this report.

Weekly reporting of long waits to Chief Operating Officer and Chief Executive with support provided to divisions. Robust monitoring of patients ‘at risk’ in place.

Risks and Mitigations

Ongoing junior doctor Industrial Action, present significant risk to maintaining levels of capacity, with mitigations options limited

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

Watch Metrics: Non-Alerting

Quality of Care, Access and Outcomes

Metric	Two Months Ago	Last Month	This Month	Improvement Target	National Target	Variation	Variation Detail	Target Met This Month?	Consecutive Months Target Failed
% of Total Incidents Resulting in High Harm (Mod/Maj/Cat)	2.5%	4.1%	3.6%				Common Cause Variation		
Cancer 2 Week Wait Breast Performance	95.7%	94.6%	100.0%		90%	H	Special Cause Improving - Run Above Mean	✓	0
Cancer Patients with a DTT waiting > 62 days		102	109	121				✓	0
DM01 Activity	8080	7133	8656	7853		H	Special Cause Improving - Above Upper Control Limit	✓	0
ED Attendances	6217	6201	6561				Common Cause Variation		
Neonatal Deaths Per 1000 Live Births	0	0	0		0	L	Special Cause Improving - Run Below Mean	✓	0
Pressure Ulcers Hospital Acquired Cat 2	45	36	29				Common Cause Variation		
Pressure Ulcers Hospital Acquired Cat 3	1	1	0				Common Cause Variation		
Pressure Ulcers Hospital Acquired Cat 4	0	0	0			L	Special Cause Improving - Run Below Mean		
Proportion of patients spending more than 12 hours in an emergency department	1.3%	1.1%	1.3%				Common Cause Variation		
RTT Incomplete Pathways: Total 78 week waits	0	0	0	0	0	L	Special Cause Improving - Below Lower Control Limit	✓	0
Serious Incident Investigations	5	1	3				Common Cause Variation		
Stillbirths Per 1000 Total Births	6	0	0				Common Cause Variation		
Total Incidents (All Grading) per 1000 Bed Days	62	51	58				Common Cause Variation		
Total Number of Compliments Received	68	41	34				Common Cause Variation		

Part 2: People

Performance against our Strategic Priorities and Key Lines of Enquiry

Salisbury NHS Foundation Trust

Our Priorities

Population

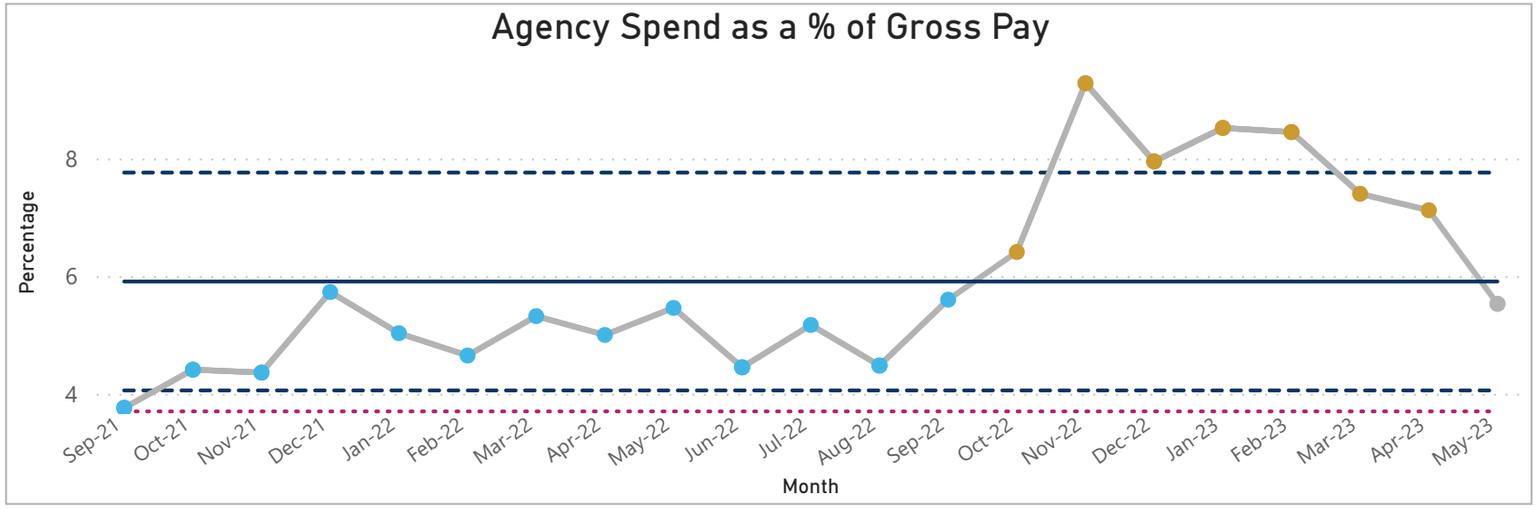
Partnerships

People

Staffing Availability

Target 3.7%

Breakthrough Objective



We are driving this measure because...

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

Understanding the performance

Agency spend has reduced to 5.53% of total pay in May. This represents the first time that the spend has been under the long term average since Sep 22 and continues the trend of reducing spend in 2023. All staff groups have shown a reduction in agency spend. Nursing and Medical staffing remain the two largest contributors to Agency spend accounting for 71% and 20% of total spend respectively.

Medicine dominate Agency spend accounting for nearly 62% of total spend this month. Elderly medicine accounted for c20% of all agency spend this month, with emergency medicine the next highest spend at a little under 10%

For the first time this year, CSFS and Surgery sit below the target 3.7% of spend at 3.0 and 3.5% respectively. The Surgery total has been achieved by a significant reduction in spend on Theatres, counterbalanced by an increase in cheaper Bank staffing.

Actions (SMART)

Establishment Control: A team from NHS BSA has started work on the implementation of ESR Establishment Control modules this month. The project remains on track to have completed reconciliation of finance ledger with organisational design on ESR by end Sep 23. Oversight of the establishment will improve visibility of vacancies across the Trust and improve workforce productivity.

Recruitment Services: Actions delivered under the overhauling recruitment services project, and the work of the resourcing team continue to support divisions in their efforts to reduce vacancy numbers and improve time to hire statistics

Temporary staffing: The first elements of temporary staffing improvements are being designed, these will concentrate on recruiting into the Bank, centralising booking mechanisms and setting consistent pay rates with suppliers.

Risks and Mitigations

Corporate Risk – Sustainable Workforce
Mitigations:

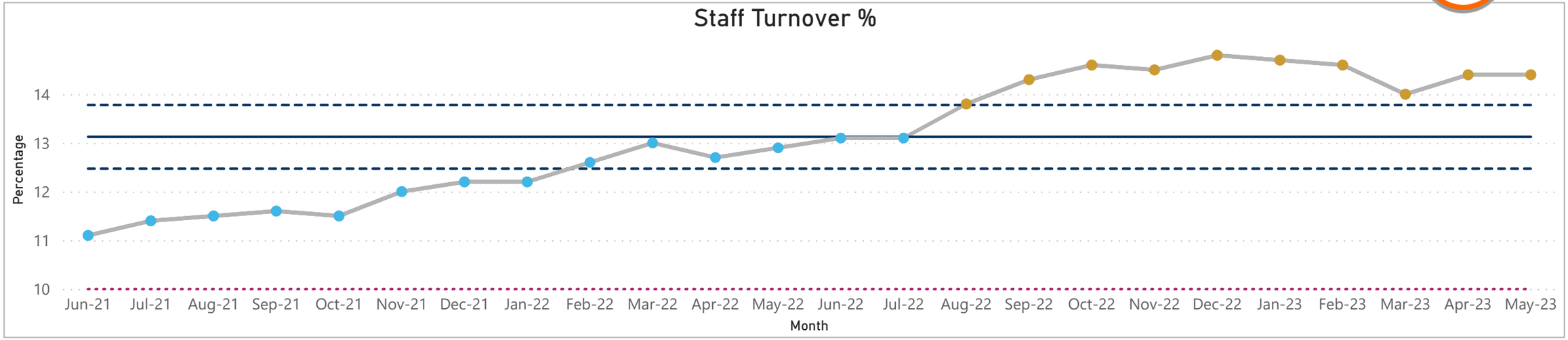
Line Managers insufficiently trained to support people promise and absence management initiatives - The roll out of Leadership training courses targeting band 4-6 and 7-8 mangers commenced in Feb 23, and continues delivering training for c 30 managers per month alongside specific modules designed to improve management skills.

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

Workforce - Turnover

Target 10%

People



Understanding the performance

In May 23, 32.83(FTE) left the Trust, with 44.20 (FTE) new staff starting work, a gross gain of 11.37 FTE to the trust establishment. Through the first 5 months of 2023 the trust has seen an average increase of 22 FTE per month, but leaver rates remain high, keeping the 12 month rolling average for turnover at 14.4% this month.

All Divisions remain red against the Trust 10% target. The highest level of turnover is with Women & New Born (17%), reflecting the impact of individual moves in the smallest division. Staff within the additional clinical services group have consistently had the highest turnover rates in 2023.

A total of 39 staff left the trust in May, of which 8 completed a full exit questionnaire. Three staff declared a move to another NHS organisation and nine retired. The other main categories for leavers were Work/life balance (7) and relocation (8).

Actions (SMART)

Divisional Actions plans to address staff survey results were analysed at TMC in May and are being implemented.

The new appraisals form and process was launched on 31st May providing a streamlined and simpler method of completing the key elements of the appraisal, supporting staff in recognising their performance, setting effective objectives and understanding career development aspirations and training requirements.

Completing the last 15% of career conversations for RNs in the 45-55 age group remain a challenge due to operational pressures and absence due to sickness and leave.

Risks and Mitigations

Corporate Risk – Sustainable Workforce.

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

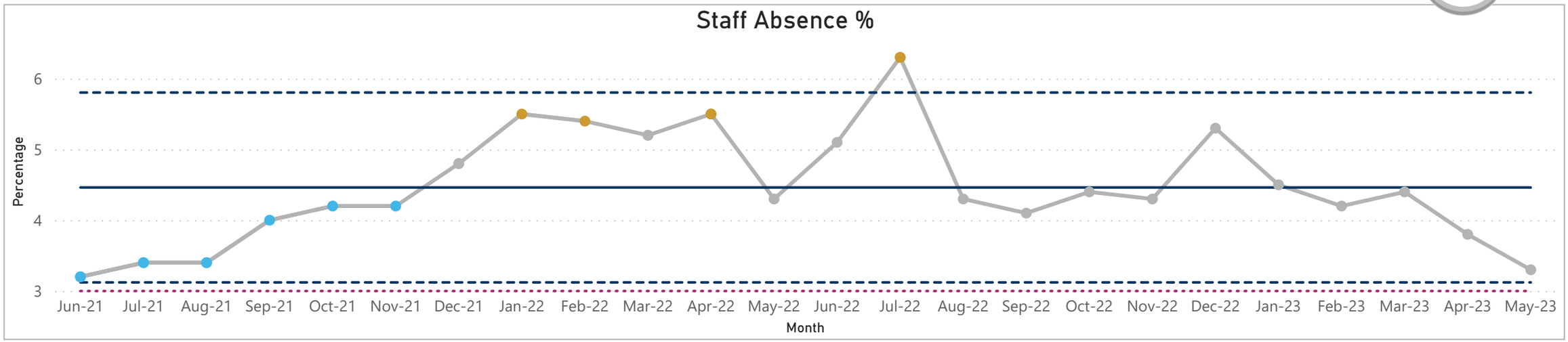
Divisional Staff Survey Action Plans

Line Manager Training interventions

Workforce - Sickness

Target 3%

People



Understanding the performance

Sickness absence dropped close to target at 3.3% for the first time since Aug 21. This represents a continuing downward trend in 2023. Notably, CSFS achieved a sickness absence rate of 2.45% this month. Medicine remain the division with highest absence rates at 4.00%, a reduction of 1.41% on last months figure, and a major contributor to the overall reduction this month

Staff from Additional Clinical Services remain the staff group with the highest absence rate at 5.16%. This group includes HCAs, Therapy assistants and Radiography helpers.

Sickness accounted for 3719 FTE days lost to the Trust, of which 2178 were for short term absence. Anxiety and stress continues to be the major reason for absence accounting for c25% of all absence in the month. Musculo-Skeletal conditions have seen a fall for a second month, a positive trend.

Actions (SMART)

Absence Management: The direct support pilot for 3 wards in Medicine (Pitton, Redlynch and Laverstock) commenced on 20th March and is continuing. A report on the impact is due in late Jun. Several areas where improvements could be made to policy, processes and management of absence cases have been identified as part of the pilot.

Work is underway following publication of the Annual H&S report to develop the Health Surveillance Capability in the Trust, seeking to focus on MSKI in the Spinal area and Stress and Anxiety prevention in Medicine, particularly the Elderly Medicine wards.

Risks and Mitigations

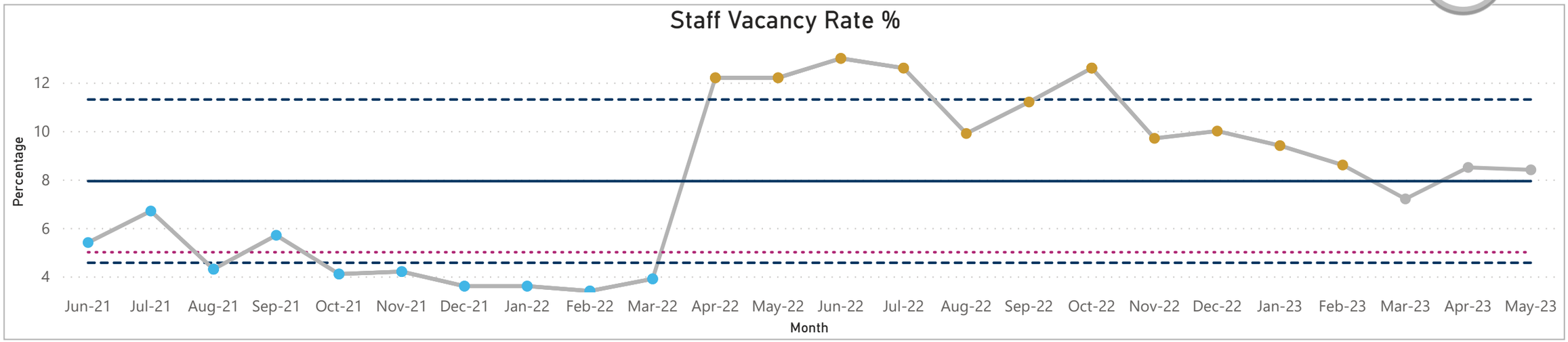
Corporate Risk – Delivery of OH service
OH staffing has improved. A band 7 lead has now been recruited, starting in May. Increased counselling and physio hours are required. Delivery of a health intelligence capability is planned for Summer 23.

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

Workforce - Vacancies

Target 5%

People



Understanding the performance

Vacancy rates have stabilised for May, standing at 8.4% which should indicate that the increase to establishment numbers in Apr is now being matched by recruitment activity. Total vacancies stand at 335, of which active recruitment is in place for 89 equivalent WTE posts, and further campaign plans in place for a further 90.

Nursing staff remain the staff group with the highest number of vacancies, proportionally. This gap is being targeted through the international recruitment campaign this year.

Medicine division have the highest vacancy rate at 8.11%, whilst Elderly medicine (42) and theatres Staff (27) hold the highest number of vacancies by speciality, this position is consistent with the high agency spend in these areas.

Actions (SMART)

The focus of Advertisement campaigns remains Theatres, The Emergency Department, Maternity, HCA and Housekeeping.

Work to reconcile vacancies through Finance ledger and ESR is ongoing as part of the ESR Establishment Control project

The new managers toolkit to support recruitment activity is now live and has been advertised through LM communication channels.

Risks and Mitigations

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

Watch Metrics: Alerting

People

Metric	Two Months Ago	Last Month	This Month	Improvement Target	National Target	Variation	Variation Detail	Target Met This Month?	Consecutive Months Target Failed
Mandatory Training Rate %	89.3%	88.5%	88.6%	90.0%	85%		Special Cause Improving - Run Above Mean	X	4
Non-Medical Appraisal Rate %	62.5%	60.8%	60.9%	86.0%			Special Cause Concerning - Below Lower Control Limit	X	26

Watch Metrics: Alerting Narrative

People

Understanding the performance

Mandatory training activity has remained stable this month at 88.6%, which is above the national target of 85%, but remains below the 90% improvement target. The impact of operational pressures in the hospital remain the key determinant of staff capacity to improve mandatory training activity. Work is also required to reconcile staff numbers with the MLE system, to ensure data is reported accurately an in a timely manner.
Data for medical appraisals was not available at the time of compilation of this report.
Non-Medical appraisals remain just above 60% completion against a target of 86%. Ineffective management of appraisals remains a key area of concern in Staff Survey and Pulse survey data, leading to low morale amongst staff. Time to complete and complexity of the process are the most common challenges put forward to explain the challenges to correct this reducing completion rate.

Actions (SMART)

Mandatory Training: At the core of ensuring that statutory and mandatory training are improved is the ability for Line Managers to remind staff of their responsibility and enable the time to complete activity. Trust wide comms will continue to remind all staff of their responsibilities, alongside specific updates to line managers from the MLE system, identifying staff who are out of date.

Appraisals: A simplified process for appraisals has been rolled out as of 31st May. Next months data will indicate the impact of the new system for staff.

Risks and Mitigations

Corporate Risk - Sustainable Workforce.

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

Part 3: Finance and Use of Resources

Performance against our Strategic Priorities and Key Lines of Enquiry

Salisbury NHS Foundation Trust

Our Priorities

Population

Partnerships

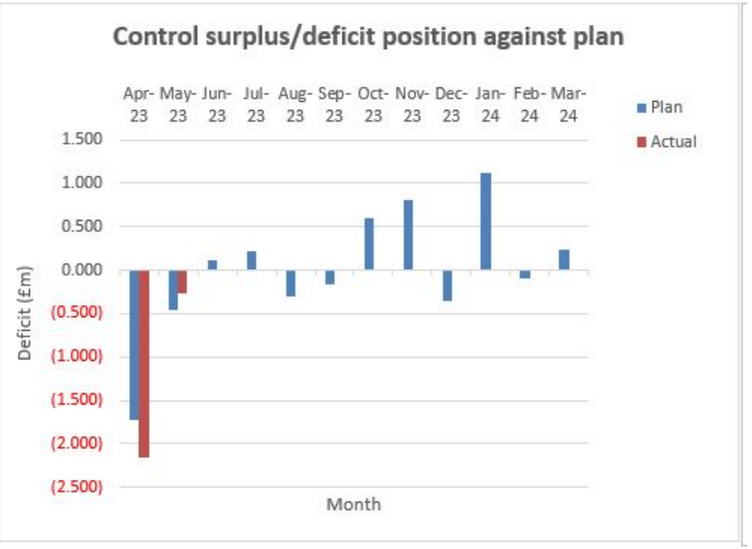
People

Income and Expenditure

Income & Expenditure:

Finance and Use of Resources

	May '23 In Month			May '23 YTD			23-24 Plan
	Plan £000s	Actual £000s	Variance £000s	Plan £000s	Actual £000s	Variance £000s	Plan £000s
Operating Income							
NHS Clinical income	22,936	24,788	1,852	44,151	47,742	3,591	268,960
Other Clinical Income	790	1,361	571	1,571	2,708	1,137	9,478
Other Income (excl Donations)	4,448	3,812	(636)	8,910	7,051	(1,859)	70,426
Total income	**28,174**	**29,962**	**1,788**	**54,632**	**57,501**	**2,869**	**348,864**
Operating Expenditure							
Pay	(17,729)	(18,896)	(1,167)	(34,947)	(38,016)	(3,069)	(206,279)
Non Pay	(9,313)	(9,476)	(163)	(18,697)	(18,407)	290	(112,722)
Total Expenditure	**(27,042)**	**(28,373)**	**(1,331)**	**(53,644)**	**(56,422)**	**(2,778)**	**(319,001)**
EBITDA	**1,132**	**1,589**	**457**	**988**	**1,079**	**91**	**29,863**
Financing Costs (incl Depreciation)	(1,586)	(1,859)	(273)	(3,173)	(3,500)	(327)	(29,863)
NHSI Control Total	**(454)**	**(270)**	**184**	**(2,185)**	**(2,422)**	**(237)**	**0**
Add: impact of donated assets	(68)	(110)	(42)	(136)	(222)	(86)	9,989
Surplus/(Deficit)	**(522)**	**(380)**	**142**	**(2,321)**	**(2,643)**	**(322)**	**9,989**



Understanding the performance

The financial plan submitted to NHS England on 4 May shows a breakeven control total position for the year. The 2023/24 financial arrangements have moved to the 2023/25 NHS payment scheme with fixed and variable elements of an Aligned Payment Incentive (API) arrangement following the transitional arrangements from COVID block payments in 2022/23. Although the majority of the Trust's NHS contractual income base is fixed, the guidance allows for additional income to be earned through the variable element of the API and the Elective Recovery Fund (ERF) from commissioners. SFT has not assumed any ERF income within the 2023/24 plan as the Trust's planned activity levels do not meet the thresholds for payment. In Month 2 the Trust recorded a control total deficit of £2.422m against a target of £2.185m - an adverse variance of £0.237m. The underlying position was broadly in line with that planned with additional income offsetting the premium costs of staffing to cover vacancies and non pay costs due to extra activity in month. The costs of Industrial action have been assessed at £0.265m with £0.201m at Month 2.

Actions (SMART)

The 2023/24 plan includes an efficiency requirement of £15.3m and the Financial recovery group was established in April, as a sub committee of the Finance and Performance committee, to provide scrutiny and support to the savings programme.

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. Delivery of productivity increases which are contingent on both length of stay reductions and the recruitment of staff. The Trust's forecast of £15.3m efficiency savings includes more than 25% non recurrent delivery and signals a risk if further recurrent efficiencies cannot be idenitifed. Actions are in place to mitigate non delivery of specific schemes. Pay settlement funding assumes costs can be recovered through revenue streams other than those for clinical activity from other NHS bodies although the reality is that c20% of the income base will not increase.

Income & Activity Delivered by Point of Delivery

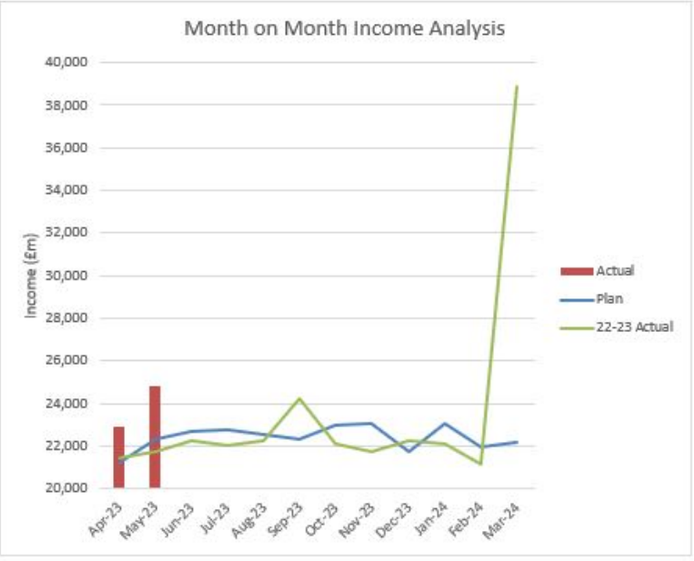
Clinical Income:

Finance and Use of Resources

Income by Point of Delivery (PoD) for all commissioners	May 23 Year to Date (YTD) Plan (YTD) £000s	Actual (YTD) £000s	Variance (YTD) £000s
A&E	1,741	1,797	56
Day Case	3,113	3,343	230
Elective inpatients	2,078	2,156	78
Excluded Drugs & Devices (inc Lucentis)	4,006	3,847	(159)
Non Elective inpatients	12,873	12,475	(398)
Other	14,815	18,185	3,370
Outpatients	5,525	5,939	414
TOTAL	44,151	47,742	3,591

SLA Income Performance of Trusts main NHS commissioners	Contract Plan (YTD) £000s	Actual (YTD) £000s	Variance (YTD) £000s
BSW ICB	25,399	29,588	4,189
Dorset ICB	4,688	4,521	(167)
Hampshire, Southampton & IOW ICB	4,045	3,934	(111)
Specialist Services	6,532	6,318	(214)
Other	3,487	3,381	(106)
TOTAL	44,151	47,742	3,591

	Activity YTD Plan	Actuals	Variance	Activity Last Year Actuals	Variance last year
A&E	12,317	12,259	(58)	12,339	(80)
Day case	3,408	4,036	628	3,586	450
Elective	493	513	20	578	(65)
Non Elective	4,594	4,465	(129)	4,670	(205)
Outpatients	39,311	41,885	2,574	40,999	886



Understanding the performance

The Trust is ahead of the Clinical income plan year to date mainly due to BSW ICB risk share funding and overperformance on cost and volume points of delivery offset by underperformance on Dorset and Hampshire ICBs, NHS England commissioner contracts and other commissioners.

The level of uncoded day cases and inpatient spells is 45% in April and 93% in May at the time the activity was taken for reporting purposes. April's activity was fully coded at the SUS submission.

Activity was higher in May than in April across the majority of points of delivery with notable increases in Day cases 386 more cases, Elective inpatients 93 spells, Non Elective 205 spells and 4,406 Outpatient attendances.

Actions (SMART)

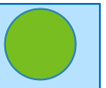
The contracts with ICBs and NHS England remain under negotiation at this stage. Several contract schedules have been agreed with ICB commissioners but discussions are ongoing around the finance schedules. Further guidance is anticipated around Dental commissioning arrangements.

Risks and Mitigations

The impact of industrial action constrains the elective programme, introducing risk to income. All commissioner contracts outside BSW are required at 103% of 2019/20 Elective activity levels. The Trust is seeking to mitigate the impact by maximising activity recording opportunities and via the contract negotiations.

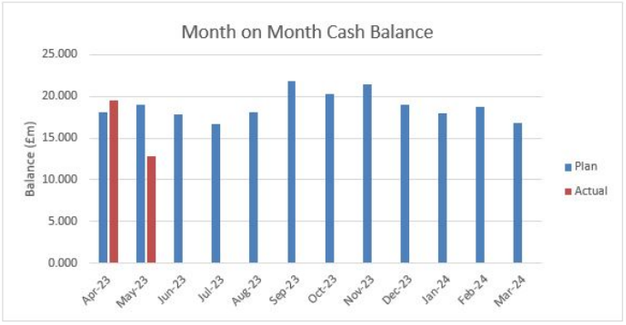
Cash Position & Capital Programme

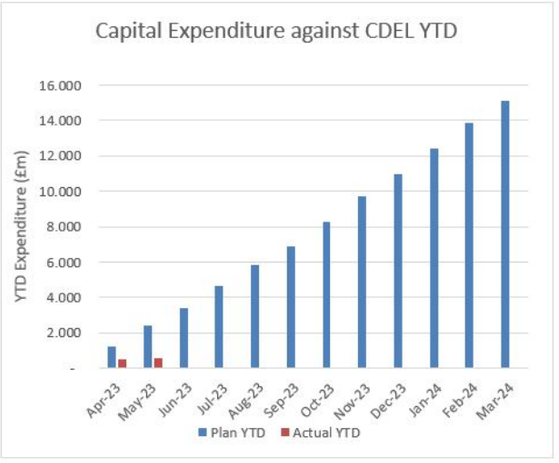
Capital Spend: 

Cash & Working: 

Finance and Use of Resources

	Closing Balance March 2023 £000s	Current Month Balance £000s	Actual In Year Movement £000s
Inventories (Stock)	7,954	8,557	603
Debtors	24,999	32,699	7,700
Cash	28,891	12,765	(16,126)
TOTAL CURRENT ASSETS	**61,844**	**54,021**	**(7,823)**
Creditors	(58,026)	(52,953)	5,073
Borrowings	(641)	(632)	9
Provisions	(474)	(478)	(4)
TOTAL CURRENT LIABILITIES	**(59,141)**	**(54,063)**	**5,078**
TOTAL WORKING CAPITAL	**2,703**	**(42)**	**(2,745)**





Schemes	Annual Plan £000s	May '23 YTD Plan £000s	May '23 YTD Actual £000s	May '23 YTD Variance £000s
CDEL Schemes				
Building schemes CIR	2,800	467	20	447
Building projects	6,235	1,039	668	371
IM&T	3,451	483	327	156
Medical Equipment	2,713	452	55	397
Total CDEL schemes	**15,199**	**2,441**	**1,070**	**1,371**
National Funding				
New Elective Ward TIF	*11,952*	*285*	*285*	0
Salix Decarbonisation	*10,005*	*6*	*6*	0
Shared EPR - national element	*3,760*	*0*	*0*	0
Digital Pathology	*1,053*	*269*	*269*	0
Pathology LIMS	*310*	*87*	*87*	0
SW Imaging (ATVS)	*174*	*1*	*1*	0
Total National Funding	**27,254**	**648**	**648**	**0**
GRAND TOTAL	**42,453**	**3,089**	**1,718**	**1,371**

Payables age profile	Total Payables £'000	0-30 days £'000	31-60 days £'000	61-90 days £'000	90+ days £'000
May-23	**7,462**	5,942	802	125	593
Apr-23	**7,010**	6,309	188	95	418
Mar-23	**12,413**	10,193	311	950	959
Movement vs prev mth	*452*	*(367)*	*614*	*30*	*175*

Understanding the performance

Month 2 expenditure continues to lag behind plan but forecast expenditure by capital sub group will be reviewed each month at the Trust Capital Control Group to ensure full allocations will be spent by the year end. Specific projects, including Salix, do have expenditure profiles weighted towards the end of the year and actions will to taken to maximise the funding in year and manage any slippage. Cash reserves are now below plan following a reduction in cash balance of £6.7m in month 2. The movement since year end is a result of the reduction in creditors and increase in debtors as outlined above. The Trust has recorded a deficit of £2.6m YTD which has also impacted on cashflow.

Actions (SMART)

The Trust will be actively seeking opportunities for additional capital funds as they arise. Regular engagement with the regional capital team is taking place on the availability of Leases funding so that this can be fully utilised within year. Additional cash funds have been paid by BSW ICB in June to mitigate any adverse impact of the June pay award payments on the Trust's cash position. Monthly review of the cash position and forecast to ensure that sufficient funds are available to meet payments as they arise and that capital funding is in place as early as possible to mitigate working capital requirements.

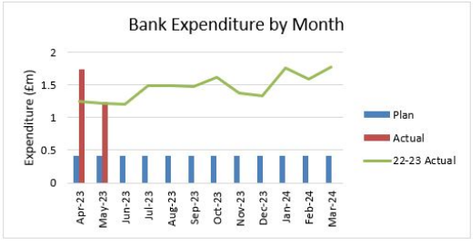
Risks and Mitigations

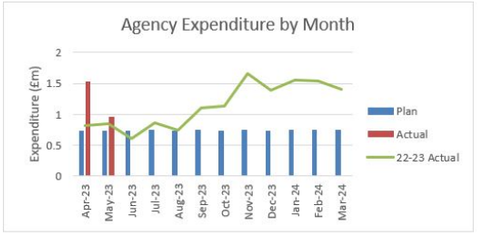
Additional capital pressures are emerging in year and such risks will have to be managed within the overall capital envelope if additional funding cannot be secured. Following the resubmission of financial plans on 4th May 2023 the Trust is awaiting confirmation from NHS England of the Capital leases funding of £5m. This funding is expected to be used to purchase CT scanners and C-arm equipment on a leased basis. The constraint of both available cash and system capital expenditure limits gives rise to both a mid and long term risk to the Trust. The context of digital modernisation programmes, along with an aging estate and medical equipment means the Trust's five year capital requirement is well in excess of available resources. The Trust seeks to in part mitigate this risk through the proactive bidding for national funds where available. Supply chain disruption and inflationary pressures remain a significant draw of time on the procurement team. This gives rise to a risk in both lead times and overall

Workforce and Agency Spend

Pay:

Finance and Use of Resources





	May '23 YTD		
	Plan £000s	Actual £000s	Variance £000s
Pay - In Post	32,610	32,476	(133)
Pay - Bank	831	2,983	2,152
Pay - Agency	1,506	2,483	977
Other (eg apprenticeship levy)		73	73
TOTAL	**34,947**	**38,016**	**3,069**
Medical Staff	9,199	9,480	281
Nursing	9,163	10,469	1,306
Support to Nursing	2,507	3,601	1,093
Other Clinical Staff	4,955	4,970	15
Infrastructure staff	9,123	9,422	300
Other (eg apprenticeship levy)		73	73
TOTAL	**34,947**	**38,016**	**3,069**

	May '23 YTD		
	Plan WTEs	Actual WTEs	Variance WTEs
Medical Staff	494.6	482.0	(12.6)
Nursing	1,165.9	1,129.7	(36.2)
Support to Nursing	534.4	632.1	97.7
Other Clinical Staff	649.3	619.2	(30.1)
Infrastructure staff	1,539.5	1,395.3	(144.2)
TOTAL	**4,383.7**	**4,258.3**	**(125.4)**

Understanding the performance

Pay costs totalled c£18.9m in Month 2: an adverse variance to plan in month of c£1.2m and year to date £3.1m. The position includes the agreed Agenda for Change pay award that will be paid in June which has been centrally provided for and the cumulative pay savings target at month 2 of £1.3m. All clinical divisions exceeded planned levels of pay in month although run rates have reduced. This was driven by reductions in bank and agency spend across all Divisions, with the exception of Women and Newborn Agency expenditure, and offset by an increase of 39 substantive WTEs of which 33 WTE were Infrastructure staff. The reduction in bank spend was driven largely by reductions in sickness and annual leave since April with the largest changes within Housekeeping and the Medicine and Surgery divisions across Medical staffing teams within the ED Department, AMU, Respiratory, Anaesthetics and Plastics. A major contribution to the reduction in agency is a reduction in the number of specials due to long stay complex patients being discharged, particularly in Medicine. Divisional nursing leaders have commenced a review of booking processes and a structured approach to bookings, including enhanced care and specials, to ensure appropriate agency use.

Actions (SMART)

Detailed actions on the response to the Trust's workforce challenges are set out in the People section of the IPR. These focus on establishment, recruitment, temporary staffing and sickness.

Risks and Mitigations

Staff availability initiatives are in train to mitigate workforce gaps and the need for premium agency and bank, although in the short term it is likely that the Trust will require both. The impact of Industrial action which drives the costs of increased cover.

Data Sources: Narrative and Breakthrough Objectives

Understand the Data

Metric Type	Metric Name	Data Source	Executive Lead	Data Quality Rating
Breakthrough Objective	% Beds Occupied	Lorenzo via Trust Data Warehouse	Lisa Thomas	Medium
Breakthrough Objective	Staffing Availability	Oracle	Melanie Whitfield	High
Breakthrough Objective	Total Patient Falls per 1000 Bed Days	DATIX Team	Judy Dyos	High
Breakthrough Objective	Wait time to first OPA (non-admitted)	Lorenzo via Trust Data Warehouse	Lisa Thomas	High
Narrative	% of patients moved more than once	Lorenzo via Trust Data Warehouse	Judy Dyos	High
Narrative	Ambulance Handover Delays >30 mins as a % of all handovers	Lorenzo via Trust Data Warehouse	Lisa Thomas	High
Narrative	Average Ambulance Handover Time	Lorenzo via Trust Data Warehouse	Lisa Thomas	High
Narrative	C Difficile Hospital onset Healthcare associated	Infection Control Team	Judy Dyos	High
Narrative	Cancer 2 Week Wait Performance	Cancer Services	Lisa Thomas	High
Narrative	Cancer 28 Day Faster Diagnosis Standard	Cancer Services	Lisa Thomas	High
Narrative	Cancer 62 Day Standard Performance	Cancer Services	Lisa Thomas	High
Narrative	Cat 2 Pressure Ulcers per 1000 Bed Days	Infection Control Team	Judy Dyos	High
Narrative	DM01 Performance	Trust Data Warehouse	Lisa Thomas	High
Narrative	E Coli Hospital onset Healthcare associated	Infection Control Team	Judy Dyos	High
Narrative	ED 4 Hour Performance	Lorenzo via Trust Data Warehouse	Lisa Thomas	High
Narrative	Friends and Family Test Response Rate - All Trust	Trust Data Warehouse	Judy Dyos	High
Narrative	Staff Sickness Absence %	Health Roster	Melanie Whitfield	High
Narrative	Staff Turnover	ESR	Melanie Whitfield	High
Narrative	Stroke: % Arrival on Stroke Unit within 4 hours	Stroke Team	Peter Collins	Medium
Narrative	Total Waiting List	Lorenzo via Trust Data Warehouse	Lisa Thomas	High
Narrative	Vacancies	ESR	Melanie Whitfield	High

Data Sources: Watch Metrics (1)

Understand the Data

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

Data Sources: Watch Metrics (2)

Understand the Data

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

Data Sources: Other Metrics (1)

Understand the Data

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

Data Sources: Other Metrics (2)

Understand the Data

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

Data Sources: Other Metrics (3)

Understand the Data

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

Data Sources: Other Metrics (4)

Understand the Data

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

Data Sources: Other Metrics (5)

Understand the Data

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

Data Sources: Other Metrics (6)

Understand the Data

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

NHS Salisbury NHS Foundation Trust

Report to:	Trust Board	Agenda item:	3.1
Date of meeting:	6th July, 2023		

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

Recommendation:

To note the below updates.

Executive Summary:

Progress against our 2022-2026 strategy is promising with many of our high-level metrics showing promising trajectories.

The Trust has a clear strategic delivery mechanism in 'Improving Together' and there is a clear path to having this embedded throughout the organisation allowing us to drive our strategy through operational activity.

Service and specialty level 'responses' to the strategy are underway and offer a further opportunity for us to make the strategy real for teams as well as informing next year's annual planning round and the medium-term ambitions by specialty right across the trust.

AHA and ICS wide strategic work is progressing with a 'reset' underway of AHA strategy work and the ICS strategy publication due in the coming months (as well as the ICS Strategy Implementation Plan.

A board seminar is planned over the summer for a deeper dive into the Trust's strategy work and our future direction / activity.

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

Strategy Update

1. Background

1.1 In August 2022 SFT published its four-year strategy[1] (2022-2026). This set out the trust vision of an outstanding experience for our patients, their families, and the people who work with and for us.

1.2 It distilled our three priorities that flow from that vision – People, Population, and Partnerships.

1.2.1 **People** | To ensure we offer an outstanding experience to the people who use our services, we need to be the Best Place to Work for our teams and our partners. We will focus on the health and wellbeing of the people who work for us – giving them the best opportunity to achieve a fulfilling career which makes a real difference to the lives of the people who access our services. Our people will be recognisable through our shared values that they demonstrate in everything they do.

1.2.2 **Population** | Alongside our partners, we will tackle the wider determinants of health and focus attention on prevention and wellbeing.

1.2.3 **Partnerships** | We will work at all levels of integration to ensure their success, and we will work with our partners to deliver on our shared clinical priorities. We will integrate our teams and services wherever possible with our partners. We will focus on playing an active role in our health and care systems – being a trusted and active partner in our Integrated Care System.

1.3 Throughout 2022 SFT was also beginning to deploy the 'Improving Together' methodology, while primarily an operational excellence framework 'Improving Together' is also our strategy delivery function within the trust.

1.4 The method has allowed us to arrive at nine 'vision metrics' that allow us to measure our progress against the vision – something the executives do in the 'engine room' – and it has allowed us to define four 'must do, can't fail' 3-5 year strategic initiatives (i.e. delivering digital care).

[1] ourstrategy_2022-2026.pdf (salisbury.nhs.uk)

1.5 The other acute providers within BSW have also deployed this methodology to deliver their strategies.

1.6 BSW itself has not, and in parallel to this activity has published its own strategy and strategy implementation plan.

2. Our Progress

2.1 Our three strategic priorities of people, population, and partnerships are measured and actioned through improving together and our strategic planning framework. This allows us to deploy 'vision metrics' to measure our progress against the vision and these three priority areas.

People

2.2 On 'people' our strategy makes clear that we will offer an outstanding experience to the people who use our services, we need to be the Best Place to Work for our teams and our partners. We will focus on the health and wellbeing of the people who work for us – giving them the best opportunity to achieve a fulfilling career which makes a real difference to the lives of the people who access our services.

2.3 We will do this through:

- 2.3.1 Our improving together programme.
- 2.3.2 Our compassionate leadership programme.
- 2.3.3 Leadership, making health and wellbeing everyone's responsibility.
- 2.3.4 Prevention, integrating a positive culture and healthy behaviours to support staff in embedding prevention in our day-to-day business and promote positive health and wellbeing within the workplace.
- 2.3.5 Intervention, delivering targeted interventions to address specific areas of need.
- 2.3.6 Support, connecting and communicating our support for staff and managers.
- 2.3.7 Data and metrics, using data and metrics to support health and wellbeing initiatives.

2.4 We're improving staffing levels, increasing our recruitment and reducing turnover.

2.5 We're measuring this through 'engagement in staff survey', 'reduction in unwanted turnover', and our diversity score in people survey responses (WDES and WRES).

2.6 The strategic projects underway include the 'delivery of our continuous improvement culture', and the 'delivery of our people promise'.

Population

2.7 On 'population' our strategy sets out we will work alongside our partners, and tackle the wider determinants of health with a focus on prevention and wellbeing.

2.8 We will do this through:

- 2.8.1 Recovering our planned services post covid.
- 2.8.2 Ensuring our organisation is sustainable.
- 2.8.3 Delivering our vaccination programme.
- 2.8.4 Delivering digital healthcare.
- 2.8.5 Developing our campus plans.

2.9 We are improving the time patients are waiting for care, the number of patients coming to harm while in our care, and improving our partnership working to foster healthy citizens.

2.10 This is being achieved through our theatre improvement programme, our outpatient programme, and our falls reduction work (our top contributor to harm).

2.11 We measure this through ensuring the number of patients waiting is no worse than the national average, that the total number of high/moderate harm incidents is falling, and our patient engagement score.

2.12 The strategic projects already underway include our campus redevelopment, our digital care work including a the shared EPR programme, and our sustainability strategy work.

2.13 Our next steps are improvements in maternity including the implementation of national enquiry findings and recommendations; as well as CQC recommended services improvements to spinal.

Partnerships

2.14 On 'partnerships' our strategy is clear we will work at all levels of integration to ensure their success, and we will work with our partners to deliver on our shared clinical priorities. We will integrate our teams and services wherever possible with our partners. We will focus on playing an active role in our health and care systems – being a trusted and active partner in our Integrated Care System.

2.15 We will do this through:

2.15.1 Working with our BSW ICS
2.15.2 Working with partners at our 'place' (Wiltshire)
2.15.3 Working with RUH and GWH through our acute hospitals alliance (AHA)
2.15.4 Engaging with our national and regional networks

2.16 We are improving (by shortening) the time our patients spend with us beyond the moment they are medically fit for discharge, integrating pathways with a particular focus on elderly frail patients, and reducing admission wait times in some specialties – particularly spinal.

2.17 This is being delivered through our care co-ordination hub, our frailty pathways, discharge process improvements, and engaging with our patients, their families and carers, and our wider population.

2.18 We measure this through reduction in length of stay, our environmental and financial sustainability, and increasing years of life lived in good health by our population.

2.19 We are missing alignment of finance as a strategic initiative, and the care model implications of AHA and BSW wider clinical strategy work / service redesign ambitions.

2.20 Our specific strategic initiatives that flow from the three priorities are:

2.20.1 **Embedding our continuous improvement culture** | we measure this through the number of staff trained in our methodology and we are slightly off track against our target. However, a case to approve additional resource to speed up that training and cultural embedding is due. Our concerns remain this capacity to train enough staff quickly enough, getting leadership behaviours right, and countering a permission seeking culture. To address these concerns we are:

- Training the Matron cohort
- Training priority specialties
- Driving leadership change from the executive and senior management teams
- Tracking training against our targets and escalating
- Leveraging incoming service level management to help drive the programme forward

2.20.2 **Delivering our people promise** | OD&P are pursuing a significant suite of activity around our people promise however, we are concerned about our ability to analyse our workforce planning due to a lack of effective strategic workforce planning; retention; talent management; and inclusion. To address these concerns we are:

- Bringing in a strategic workforce planning lead

- Working to understand the drivers of retention internally to spread this
- Developing a talent management approach
- Adopting south-west region inclusion plans.

2.20.3 **Delivering digital care** | our shared EPR programme with AHA partners is going to be the key plank of this strategic initiative – this project will significantly increase our digital maturity and unlock other digital opportunities in line with what our patient population has come to expect. We are concerned about moving at sufficient pace to achieve our HIMMS level 5 maturity by 2025; the digital capability of our staff; the cyber security of our future state; inconsistent access to business intelligence; and our access to key external health data for the purpose of decision support. To address these concerns we are:

- Procuring a shared EPR across the AHA
- Rolling out a digital improvement network to improve digital literacy
- Upgrading our connectivity and completing a server replacement programme
- Expanding PowerBI
- Expanding our shared care record work and developing a roadmap for personally held records.

2.20.4 **Improving health and reducing inequalities** | much of this work must be delivered in partnership across the ICS and work is underway through our co-chairship of the Wiltshire Health Inequality Group to influence project spend in line with what our methodology tells us are critical areas (CVD, Neoplasms, specific neighbourhood geographies, and the CORE20PLUS5 defined groups). While we have now delivered this work we remain concerned about how much of the success is dependent on external organisations and wider determinants of health beyond the influencing sphere of our organisation. To address these concerns we are:

- Playing a leading role in place based inequalities forums and steering funding and resource toward this activity.
- Focussing on levers we can pull to make as much of a difference as possible to health equity and healthy life expectancy.

3. Activity & Forward Look

3.1 It is the considered view of the executive body that we are not seeking a proliferation of strategies from teams across the organisation. Instead of divisional strategies, specialty strategies, and ward strategies – each layer and pillar of the organisation will 'respond' to the strategy – and in so doing create a local direction of travel and action plan, operationalising the SFT strategy throughout the organisation.

3.2 This work is underway and will generate pan-organisational insight ahead of the next planning round, as well as working with services to understand how they can plan to deliver on the elements of the strategy that they are well placed to drive forward.

3.3 These 'responses' are facilitated through, and aligned to, the improving together strategic planning framework.

3.4 Further to this a board seminar on strategy will be taking place in August with opportunities for the executive and non-executive body to drill into our collective ambition and look at the bigger picture for SFT. More detail will follow in the coming weeks.

3.5 Open strategic questions remain for the Trust around which work continues. Areas such as the future of community services[2], our organisational sustainability, and how we package our nationally significant specialties for wider organisational opportunities – all remain open for the board to influence in the coming months.

3.6 Further to the above there are future changes likely to impact the organisation, in the medium term from a general election almost certain to yield a change of government or minority administration, and over the longer term the sustainability of the NHS.

4. External Alignment

4.1 While the internal work of service and specialty responses to our strategy can be considered a process of internal alignment, there is a need to ensure *external* alignment.

4.2 We are operating within the contexts of an ICS strategy (and implementation plan), Acute Hospital Alliance (AHA) clinical strategy work, neighbouring ICS and organisation strategies that affect us significantly (such as UHS and the HIOW ICS – particularly given their financial position), and regional / national strategies.

4.3 The ICS strategy is a deliberately high level given the breadth of activity it should inform. The principal focus is of a left shift for care, moving to as much community and preventative intervention as possible – it is the key success measure for the ICS. While this has positive implications for our demand position, and for patients getting the right care in the right place at the right time, it does little for our short-term discharge / no criteria to reside challenges.

[2] Adults Community Services and / or Children's Community Services to NHS Bath and North East Somerset, Swindon and Wiltshire Integrated Care Board - Contracts Finder

4.4 The ICS strategy will be refreshed annually, and their main focus is socialising the strategy as widely as possible. Place based feedback was used in it's created but no BSW wide consultation or citizen engagement.

4.5 Local authorities were involved, public health directors and CEOs. There is some frustration that 'the NHS is finally seeing this their way', and a keenness not to cede control to NHS organisations in this space. As such the ICS strategy is positioned as an ICP document.

4.6 The ICS strategy team recognise that 'excellent care/services' is what everyone would be striving for anyway, the real 'value add' in the strategy from the ICS perspective is the prevention and inequalities focus.

4.7 The Clinical Strategy Programme is being reset, supported by CMOs and COOs due to complete in July. This will reflect emerging priorities in BSW as well as our programme of specialty deep dives. Thus far the focus has been on dermatology, ophthalmology, and pharmacy. Additionally, the AHA single capital programme is focusing on five themes: Urgent & Emergency Care, Elective Care, Infrastructure, Women & Children, and Digital. The vision being for AHA Trusts to work together to maximise available capital resources in BSW.

4.8 We are pursuing alignment (in part) of our strategic planning frameworks across the AHA and the AD of Strategy and AD of Improvement are jointly bringing a paper to AHA executives in July 2023 setting out a suite of options for that strategic alignment.

4.9 Tangential but contextually important national strategies and reviews that may be of interest to the board are:

4.9.1 The Hewitt Review[3]
4.9.2 The NHS Workforce Plan[4]
4.9.3 'Support Guaranteed:'?'a The Roadmap to a National Care Service'[5]
4.9.4 Longer hospital stays and fewer admissions: How NHS hospital care has changed in England 2019-2022[6]

[3] The Hewitt Review: an independent review of integrated care systems - GOV.UK (www.gov.uk)
[4] Publication due 30/06/2023
[5] Support guaranteed | Fabian Society
[6] Longer hospital stays and fewer admissions - The Health Foundation

NHS Salisbury NHS Foundation Trust

Report to:	Trust Board	Agenda item:	3.2
Date of meeting:	06 July 2023		

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

Recommendation:

The board is asked to note

1. The progress on delivery of the improving together programme and its impact
2. The current maturity assessment of key elements of continuous improvement

Executive Summary:

Across the nine workstreams making up the programme six are on track and three are off track. The off track workstreams are: Strategy Deployment and Transformation, Leadership Behaviours and Coach House. All three have identified actions and mitigations to bring them back on track over the next quarter.

The training trajectory is on-track for the Advanced level. It is behind trajectory for the Standard and Leader levels. Work is ongoing with divisional DMTs and Deputy Directors to ensure we achieve 100% fill rates for training courses and to ensure a swift recruitment of a colleague(s) to the Coach House if the business case is approved at July's Trust Management Committee. Both will help regain our training trajectory.

The maturity assessment provides insight into how the Executive, Divisions and Teams are using the Improving Together approach. The levels of maturity shown are expected at this time of the programme.

A range of benefits from using the Improving Together approach across the Trust are presented, including £125,000 of savings from the medical Same Day Emergency Care (SDEC) service.

Board Assurance Framework – Strategic Priorities	Select as applicable:
Population: Improving the health and well-being of the population we serve	Yes
Partnerships: Working through partnerships to transform and integrate our services	Yes

People: Supporting our People to make Salisbury NHS Foundation Trust the Best Place to work	Yes
Other (please describe):	N/a

1.1 Purpose

The purpose of this paper is to provide the Trust Board with a summary of the current position and performance of the Improving Together programme so the board can seek understanding and assurance of the progress to date.

1 Background

The Improving Together programme is the how of how we will achieve our strategy. It links together improvement tools, with the behaviours needed to support a culture of continuous improvement and an operational management system (OMS) to form a golden thread from ward to board.

It is the shared improvement approach used across the Acute Hospital Alliance in the BSW system.

2 NHS Impact

Since the last report in April 2023 NHS England have released the NHS delivery and continuous improvement review. This review established NHS Impact as the new, single, shared NHS improvement approach. This approach is non-prescriptive on which methodology should be used, but outlines five components which form the 'DNA' of all evidence-based improvement methods, which underpin a systematic approach to continuous improvement:

1. Building a shared purpose and vision
2. Investing in people and culture
3. Developing leadership behaviours
4. Building improvement capability and capacity
5. Embedding improvement into management systems and processes

When these five components are consistently used, systems and organisations create the right conditions for continuous improvement and high performance, responding to today's challenges, and delivering better care for patients and better outcomes for communities.

A diagnostic against these five components will be released in late June/early July for Trusts to complete. Ahead of that an internal review against the five components has confirmed Improving Together includes each component and these are reflected across the programme's nine workstreams.

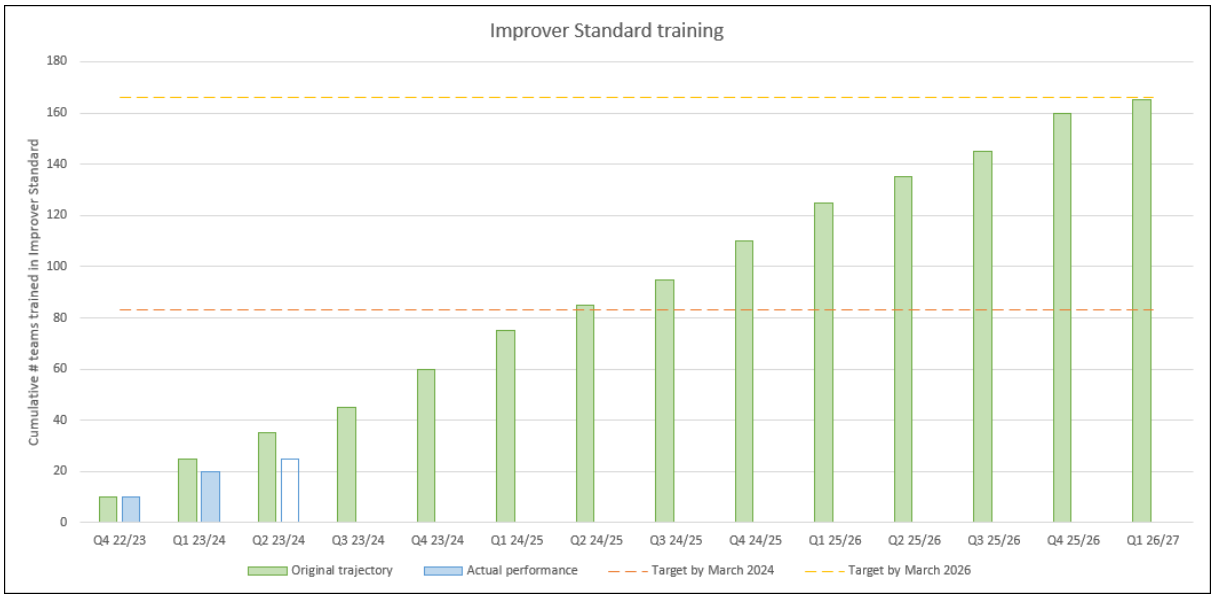
3 Training rollout: Numbers and fill rates

The table and charts below set out the training and numbers for 23/24 Q1 and predicted numbers for Q2. Since the April update to Board we have removed the Improver Enabler course and combined it with the Improver Leader course. There are therefore now three levels of training at SFT:

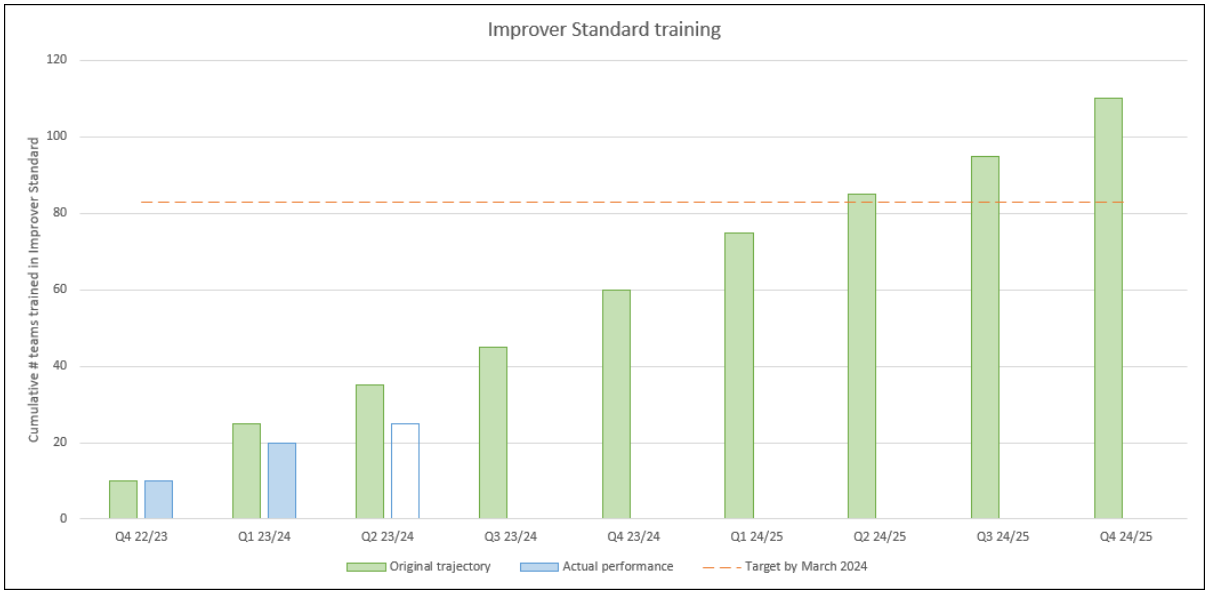
Course	Numbers trained to date (people)	Percentage fill rate of next course (25 places a course)
Level 1: Improver Standard	138	September: 68%

Level 2: Improver Advanced	27	July: 92%
Level 3a: Improver Leader	59	July: 100%

The following charts show the performance against the roadmap trajectory for each course (the unfilled bars reflect our projected performance for the next quarter).



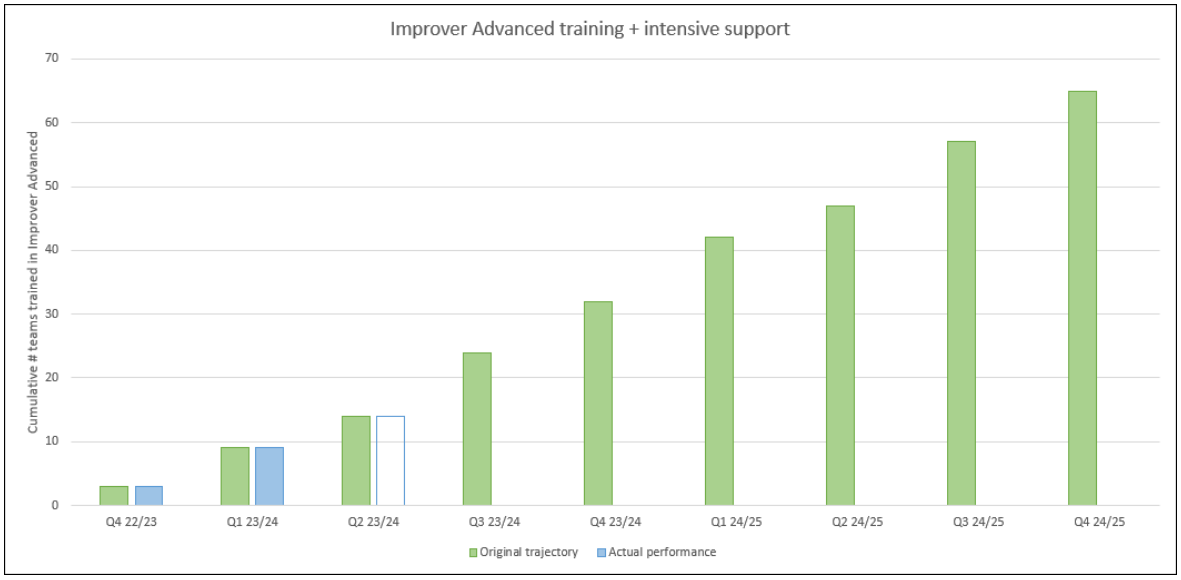
The current trajectory is for representatives of 100% of teams to have attended Improver Standard by March 2027.



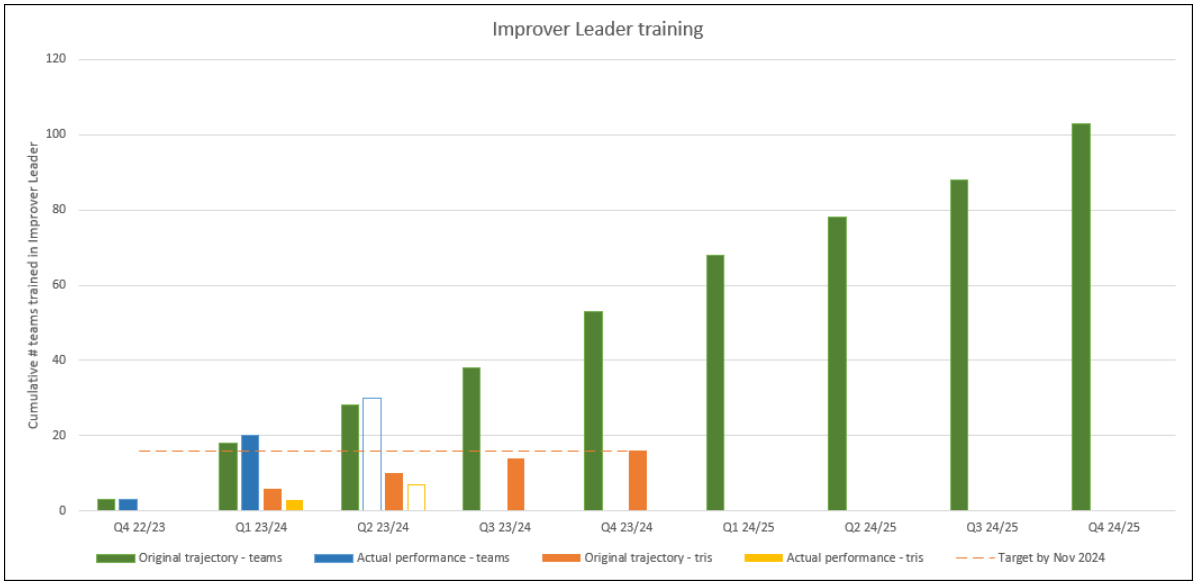
The count of the number of teams in the Trust has risen since the original trajectory (green bar) was developed, from 156 to 166.

The shortfall in performance for Improver Standard is because of:

1. Underutilised Improver Standard capacity. This accounts for 5 less teams trained than planned
2. Postponed Improver Standard courses in July (due to turnover in the Coach House team). This accounts for a further 5 less teams trained than planned by the end of Q2 in 23/24.



Improver Advanced training numbers remain on track. There is good pull from the teams who have completed Improver Standard to go on to attend and complete Improver Advanced.



The speciality triumvirate training trajectory is being revised. When the original roadmap and target was set, it was understood there were 16 specialties in the Trust – we now know there are 40+ specialties.

4 Developing maturity in the use of improving together methodology

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

The scores supplied for divisions were assessed in April, when their formal coaching came to an end. A new self-assessment tool has been launched for divisions to assess their maturity. The first benchmark will be completed by the divisions with facilitation from the Coach House at the 'Sharing It' session on 6th July. This will then be reported to the next July Improving Together board. Alignment of the timing of future assessments will ensure the freshest assessment can be reported in the quarterly Board report.

Scores for frontline teams who have completed at least the Improver Standard training and coaching are provided using the original KPMG assessment tool. A new front line maturity assessment tool is being developed by the Coach House to align to the SFT training approach.

The maturity assessment is not a 'marking of your homework'. It represents a structured reflection on where our teams are strongest and where we should focus our energies to develop our understanding and use of the Improving Together approach.

Where areas of development are identified they will then be focused on at the 'Sharing It' sessions with divisions, specialities and teams.

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

Framework	Tool	Behaviour	Execs	Divisions (Mar 23)	Specialty	Frontline (8 teams, Jun 23)
Align	Scorecard	Focus	2	3	0	2
	Strategic Filter and SDM		2	1	0	NA
Enable	Monthly routines (Performance/Executive Review Meeting + A3 Summary)	Humility Curiosity A3 Thinking Go, See, Listen, Learn	3	3	0	1
	Weekly Routines (Weekly Driver meetings, Go & See, OMS Exec routines, weekly Exec huddles)		2	2	0	NA
	Daily routines (Improvement Huddles, Performance and improvement boards)		N/A	N/A	N/A	2
	Process and Leader Standard Work		2	2	0	2
	Process Confirmation		1	1	0	1
	Structured Conversation		1	2	0	1
Improve	A3	A3 Thinking	3	3	1	2

The number of improvement huddles has increased, with eight teams now using huddles on a regular basis. Four more teams who have completed the Improver Standard training are being coached and supported to introduce improvement huddles within their teams. Improvement huddles are a crucial way of spreading a culture of continuous improvement by "doing a little bit every day".

5 Benefits realisation from using Improving Together across the Trust

The use of Improving Together across the Trust has a leading role in the delivery of the Trust's 23/24 financial plan.

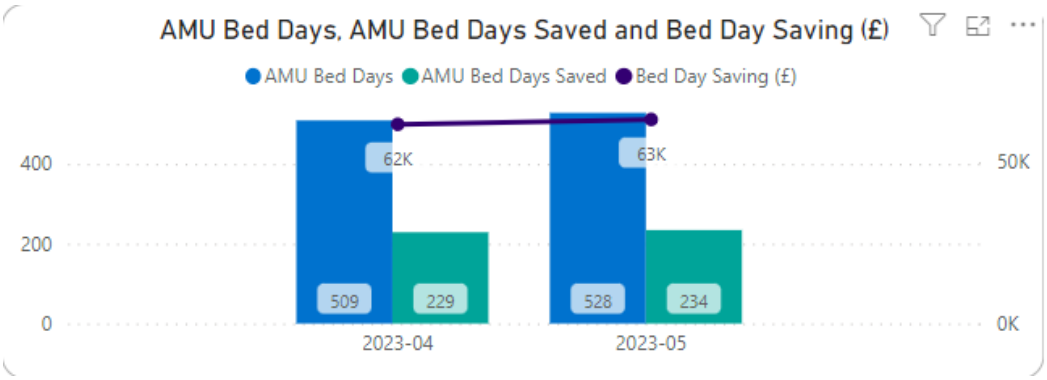
Through Improving Together (aka Operational Excellence, in the table below) we are focusing on the delivery of our four breakthrough objectives. Improvement in each will directly impact our financial position via lower bed occupancy, reduction in falls (and resultant reductions in LoS), less spending on agency staffing and improved elective performance (decreasing time to 1st outpatient appointment).

		Target		
		%	£'m	Comments
Housekeeping	Procurement	0.3%	1,000	£0.7m identified
	Medicines Management	0.2%	700	Identified
	Divisional CIP (incl waste reduction)	0.6%	2,000	TBC
	Income generation	0.5%	1,500	£1m identified
	N/R vacancy	0.8%	2,500	£1.6m identified, patent opportunity
Operational Excellence	Bed occupancy	0.5%	1,600	Based on 10% reduction in LOS
	Staff availability	0.6%	2,000	Return to 3.7% of total paybill
	Elective productivity	0.3%	1,000	ESRF opportunity
AHA/BSW collabroration	Discharge processes			Opportunity to close
	Non-tariff prescribing			system transformation gap
	Non clinical support service collaboration			
	AHA clinical strategy			
		4.0%	**12,300**	

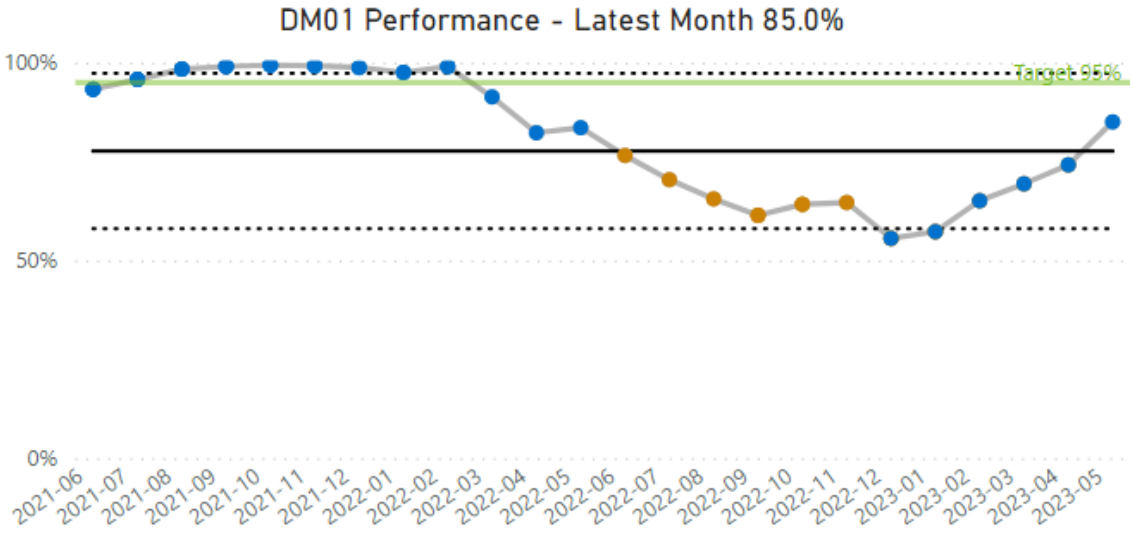
Housekeeping	2.5%	7,700
Operational Excellence	1.5%	4,600
AHA/BSW collabroration	0.0%	0

Against these targets we are beginning to see quantifiable and non-quantifiable/cashable and non-cashable improvements driven out by teams using the Improving Together approach:

- Through persistent focus at the monthly Executive Performance Reviews (EPRs) and in divisions' weekly driver meetings we have reduced trust-wide staff agency spend as a % of total pay from 8.52% in January to 5.53% in May.
- Since the introduction of a medical Same Day Emergency Care (SDEC) service we have saved 463 bed days. This equates to the avoidance of £125,000 worth of cost.
- Medical SDEC has helped:
    - Reduce the average length of stay (LoS) on AMU by 9 hours (33 hours versus 24 hours)
    - Increased the % of 0 day LoS for non-elective admissions by 7.2% (26.8% versus 34%
    - Delivered % 0- Day LoS pathway for 46% of patients seen in medical SDEC
    - Reduced the time to Junior Doctor Assessment by 55 mins, or 43% (127 mins versus 72 Mins)
    - Reduced the time to 8-hour Consultant review by 32 mins, or 12% (267 Mins versus 235 Mins)



- Using A3 thinking and data to identify the top contributors teams have increased our DM01 performance from 57.3% in January to 85% in May



- In November 2022 we went live with the "DrDoctor" system, providing video consultations as an alternative to face-to-face, and text reminders for Outpatient appointments. The text reminders have helped to reduce our Did not attend (DNA) rate (-23%). The result has been that the team can see more patients more quickly, and within the same resource. With approximately 600 more patients being seen per month.

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

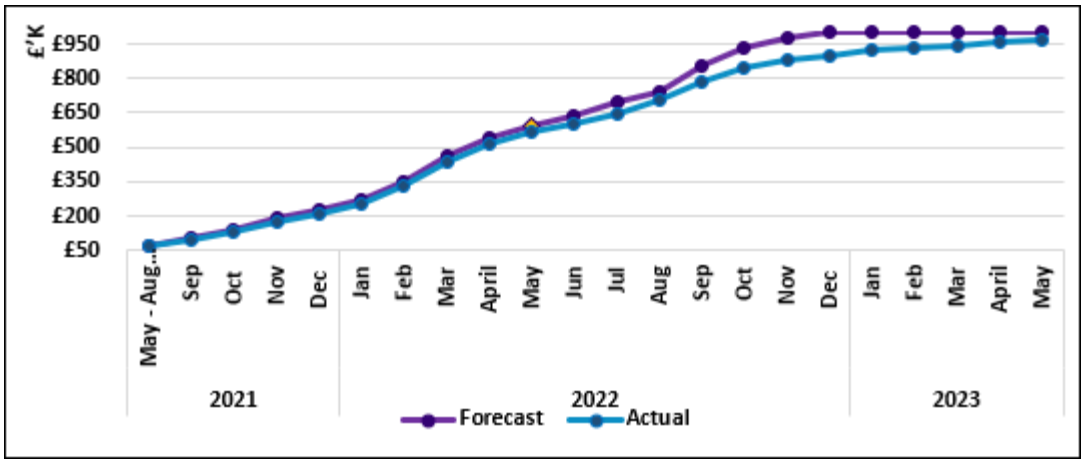
Across the nine workstreams making up the programme six are on track and three are off track. The off track workstreams are: Strategy Deployment and Transformation, Leadership Behaviours and Coach House. All three have identified actions and mitigations to bring them back on track over the next quarter.

The outcome of the Improving Together business case for additional OD&L, Coach House, Consultancy and communications (collateral) funding will be known after Trust Management Committee on the 26th July. The outcome will trigger a refresh of the roadmap and workstreams against the known resources and expected recruitment timescales.

7 Finance

KMPG consultancy budget tracker

The below graph shows the spend against the budget for the consultancy support from KPMG. Board training has commenced with the first session focusing on the leadership behaviours needed for improvement. Two further development sessions are planned to ensure the Board is supported to learn and develop in their individual and collective use of Improving Together.



8 Recommendations

The board is asked to note:

1. The progress on delivery of the improving together programme and its impact
2. The current maturity assessment of key elements of continuous improvement

Alex Talbott
Associate Director of Improvement

Report to:	Trust Board (Public)	Agenda item:	5.2
Date of meeting:	6 July 2023		

Report tile:	Patient Feedback Report - Q4 and Annual Summary 2022/23			
Status:	Information	Discussion	Assurance	Approval
	Yes	Yes	Yes	Yes
Approval Process: (where has this paper been reviewed and approved):	*CGC* *Presented to Patient Experience Steering Group – 24th May 2023*			
Prepared by:	Victoria Aldridge - Head of Patient Experience			
Executive Sponsor: (presenting)	Judy Dyos - Chief Nursing Officer			
Appendices (list if applicable):	APPENDIX 1: FFT Inpatient Feedback Sample – Q4 APPENDIX 2 - Complaints and Communications Leadership Training Days APPENDIX 3: Complaints Process Review – Action Plan Progress APPENDIX 4: Bi-Annual FFT Update and Interim Action Plan APPENDIX 5: Real-time Feedback Progress Report for PESG – March 2023 APPENDIX 6: Your Views Matter – Bereavement Survey Report – Q4 APPENDIX 7: MAT22 Headline report Salisbury NHS FT			

Recommendation:

This report is for assurance and noting by the Committee.

Executive Summary:

This report provides a summary and insights drawn from the various methods by which our service users feedback on our services. This includes analysis of complaints, concerns, compliments, Friends and Family Testing and National surveys covering or reported during Q4 of 2022-23.

To summarise the contents of this paper:

Complaints/concerns/compliments and enquiries:

The number of formal complaints made in Q4 has been relatively consistent with previous quarters. In Q4, 57 were received, compared with 56 in Q3. 59 and 49 complaints were received in Q2 and Q1 respectively. Total number of complaints/concerns received for 2022/23 was 459. 221 of these were formal complaints.

There were 354 comments/enquiries logged by the PALS team in Q4, a significant increase than the number see in Q3. In total, the PALS team have logged 1,217 comments and enquiries (in addition to complaints and concerns) for 2022/23.

For Q4 the most common high-level theme for complaints were largely the same as Q3. These were in relation to Patient Care (including nutrition and hydration) (42%), Communication at (23%), and Access to Treatment (9%).

These themes continue when reviewing the complaint themes across the year. Nursing care and further complications came through as the highest sub-categories under the patient care theme. Lack of or insensitive communications were the most common causes for complaints under communications and delays in receiving treatment were the most prevalent in the access to treatment category.

The number of reopened complaints/concerns between Q3 and Q4 has doubled (n~6 in Q3 to n~12 in Q4). The total number of reopened for 2023 was 41.

Friends and Family Test: The Trust wide average response rate for Q4 has increased significantly on Q3 and is the highest quarterly response rate this year. Inpatient areas continue to have the highest response rate and work is ongoing to improve response rates in outpatient and day case areas. The annual average response rate is currently 2.25% for the Trust as a whole and this continues to be significantly lower than the Improving Together metric target of 10% which was set for 2022-23.

Friends and Family Test experience ratings have been largely unchanged from Q2, achieving 97%. We continue to be unable to theme the comments following the Board decision to delay new FFT digital dashboard set up until December 2023.

National Surveys: The National Maternity Survey 2022 was presented to the Patient Experience Steering Group in February 2023. Higher than national response rate (61%). With a Mean Rating Score of 78.2% (lower than 2021). Scoring in the top 20% of Trusts for 15 questions and in the bottom 20% for 5 questions.

Local Surveys: Re-launch of inpatient real-time feedback happened in Q4, although rollout has been inconsistent and slow owed to issues with the Ipads. Q4 and annual report from Bereavement Surveys feedback is summarised and full report can be found in appendix 6 of this report.

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

Patient Experience - Patient Feedback
Q4 and Annual Report 2022/23

Purpose of paper

To provide assurance that the Trust is responding appropriately to complaints and demonstrate that learning and actions are being taken to improve services in response to feedback.

This paper will also outline the other methods of patient feedback that the Trust collects, and as these processes develop will seek to triangulate these various data sets to provide balanced insight to how patients experience our hospital.

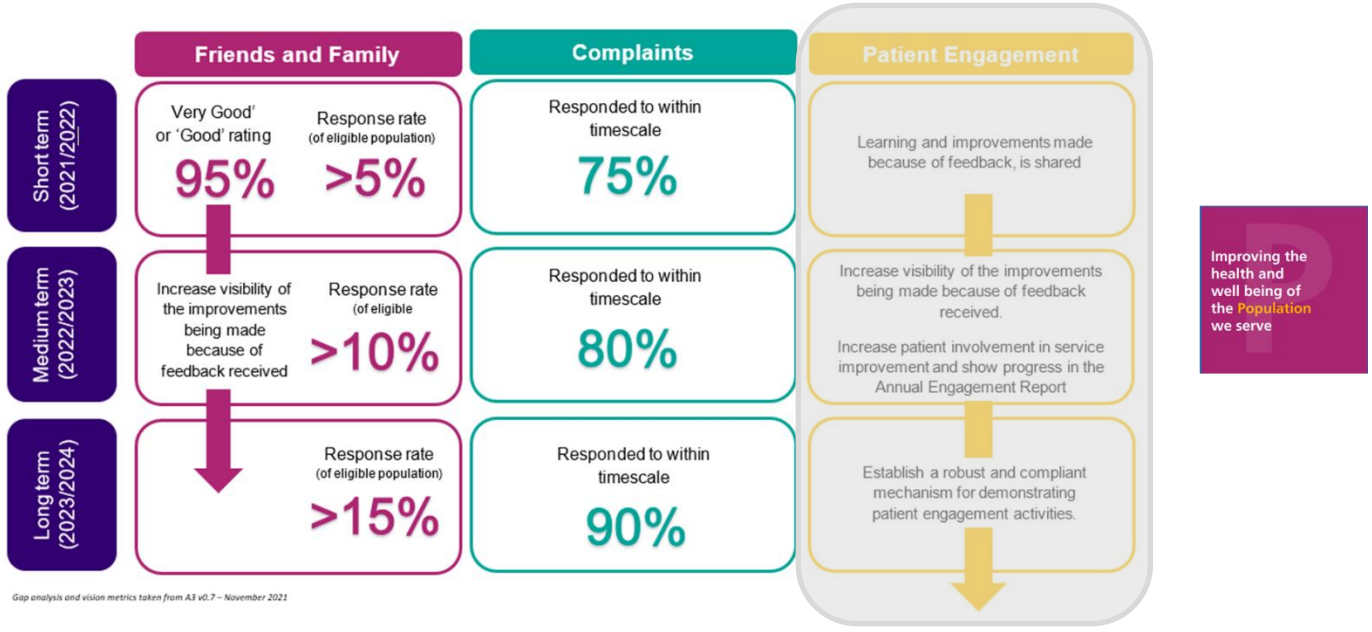
Background

Patient experience is defined as “the sum of all interactions, shaped by an organisation’s culture that influence patient perceptions across the continuum of care”. Nationally, the scrutiny in relation to compassionate healthcare, as well as in engaging with the public, is to understand their voice and feedback is an imperative. This includes learning from feedback, transparency and honesty on when healthcare goes wrong.

Concerns and complaints can surface, and the quality of the investigation, response and actions allow improvements in the safety and quality of care delivery. We strive to create an open culture where concerns and complaints are welcomed and learnt from. This can also be said of the many compliments received that far outweigh these complaints and concerns. Compliments can also help improve practice by allowing good practice to be disseminated and shared where possible.

Below is a summary of the Improving Together metrics originally developed in 2021 with a 3-year plan. Friends and Family Testing and Complaints are covered in this Patient Experience report. Progress against the Patient Engagement objectives are covered separately under the Patient Engagement annual report.

Patient Experience – Improving Together Summary



Contents

1. Complaints, Concerns and Compliments - Trust Overview

There were 4 items of feedback posted on the NHS Website* in Q4.

Average rating on responses: ★★★☆☆

	Positive	Negative	Average star rating
Q1 22/23	3	2	★★★
Q2 22/23	3	2	★★★★
Q3 22/23	4	0	★★★★★
Q4 22/23	2	2	★★★

*All feedback is available here: Ratings and reviews - Salisbury District Hospital - NHS (www.nhs.uk)

Compliments are sent directly to the Chief Executive, PALS or via the SOX inbox and are acknowledged and shared with the staff/teams named. Where individual staff members are named in a compliment the PALS team complete a SOX which is sent to the SOX administrator for forwarding onto the individual and their line manager. Compliments continue to be recorded (in their numbers) through cards, letters, gifts sent received directly to these areas. From February 2023 all compliments are now allocated a Datix entry for more robust reporting and utilised for individual staff feedback where applicable. This is facilitated through PALS.

Table 1.1 shows the breakdown for patient activity across the Divisions and total for the trust and this is used to calculate this feedback on a per 1,000 basis (see Figure 1.1).

Table 1.1 – Patient activity

Patient Activity by Division / Quarter	Clinical Support and Family Services	Medicine	Surgery	Women & Newborn	Total
Q1 2022-23	30,147	29,026	34,242	4,482	97,897
Q2 2022-23	29,779	28,414	34,493	4,526	97,212
Q3 2022-23	31,906	29,040	35,374	4,802	101,122
Q4 2022-23	34,107	28,406	35,310	3,795	101,618
Total	125,939	114,886	139,419	17,605	397,849

Figure 1.1 Total Number of Complaints, Concerns, Compliments and FFT per 1,000 of total Trust activity

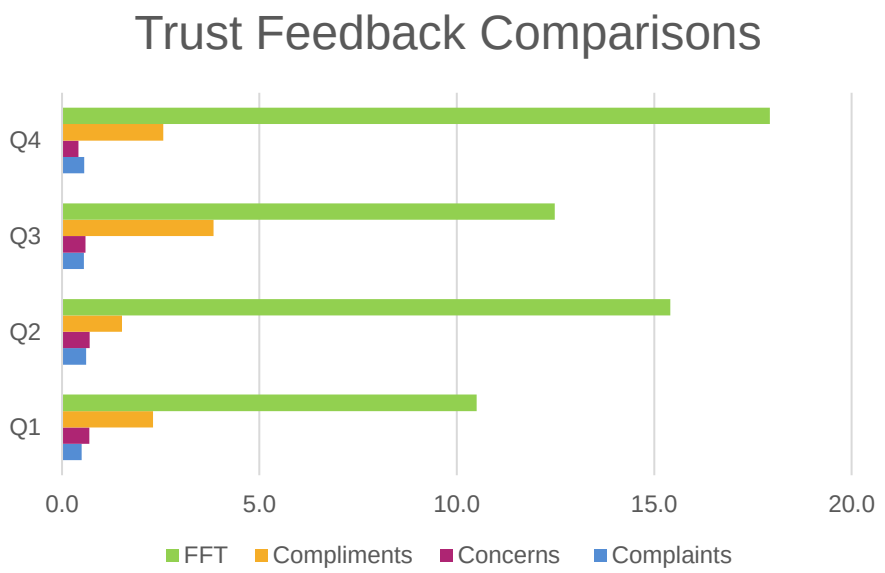


Figure 1.1 shows a steady decrease in the total number of both complaints and concerns over the past 12months. FFT feedback continues to increase, though compliment numbers have reduced slightly in Q4. However, this could be owed to the transition of how compliments are recorded (not just numbers but as Datix entries).

In Q4 the PALS department logged 354 comments/enquiries. This is the highest number seen this year. This equates to an average of 3.5 contacts per 1,000 patient activity across the Trust.

Table 1.2 shows the high-level theme for complaints received in Q4 and the most prevalent theme continues to be in relation to, **patient care, including nutrition and hydration**. This theme has continued to be the most prevalent across the Trust from both Q1, Q2 and Q3. This is followed by **communications** and **access to treatment or drugs.** Both of these themes were also noted in the top three for Q3.

Table 1.2 Raw data - Themes from Q4 Complaints

	CSFS	Medicine	Surgery	Women & Newborn	% of total by theme
Access to treatment or drugs	0	3	2	0	9%
Admissions, discharge and transfers excluding delayed discharge due to absence of care package	0	3	0	0	5%
Appointments including delays and cancellations	0	1	1	0	4%
Clinical Treatment	0	1	2	0	5%
Communications	0	11	2	0	23%
End of Life Care	0	1	0	0	2%
Facilities Services	0	1	0	1	4%

Other	0	2	0	0	4%
Patient Care including Nutrition / Hydration	1	7	10	6	42%
Values and behaviours (Staff)	0	1	0	1	4%
Total by Division	**1**	**31**	**17**	**8**	
Divisions Total	**57**				

Table 1.3 Raw data - Themes from Complaints (annual summary)

	Total number of complaints	% of total by theme
Access to treatment or drugs (including decisions made by Commissioners	21	9%
Admissions, discharge and transfers excluding delayed discharge due to absence of care package	13	5%
Appointments including delays and cancellations	15	6%
Clinical Treatment	6	2%
Commissioning Services	0	0%
Communications	32	15%
Consent to treatment	2	1%
Covid-19	1	0%
End of Life Care	11	5%
Facilities Services	4	2%
Integrated Care	0	0%
Mortuary and post-mortem arrangements	0	0%
Other	3	1%
Patient Care including Nutrition / Hydration	108	45%
Prescribing errors	3	1%
Privacy, Dignity and Wellbeing	4	2%
Restraint	0	0%
Staffing numbers	0	0%
Transport (Ambulances only)	0	0%
Trust Administration	0	0%
Values and behaviours (Staff)	13	5%
Waiting Times	1	0%
Total	237	100%

The following tables show a further breakdown for the most prevalent high level themes across the Trust.

Nursing care and further complications came out as the highest sub-category for complaints.

In regards to communication - lack of or insensitive communications were the most common causes for complaints.

Delays in receiving treatment were the most prevalent in the access to treatment category.

Patient Care including Nutrition / Hydration	106	45%
Further complications	23	22%
Nursing Care	18	17%
Unsatisfactory treatment	16	15%
Correct diagnosis not made	14	13%
Delay in making diagnosis	12	11%
Neglect	9	8%
Inappropriate treatment	5	5%
Pain management	3	3%
Harm	3	3%
Ward moves	1	1%
Assistance not given	1	1%
Falls	1	1%

Communications	32	15%
Insensitive communication	13	41%
Lack of communication	12	38%
Wrong information	3	9%
Information not given to family	2	6%
Information not given to patient	2	6%

Access to treatment or drugs	21	9%
Delay in receiving treatment	16	76%
Operation cancelled following admission	2	10%
Treatment unavailable	2	10%
Operation delayed following admission	1	5%

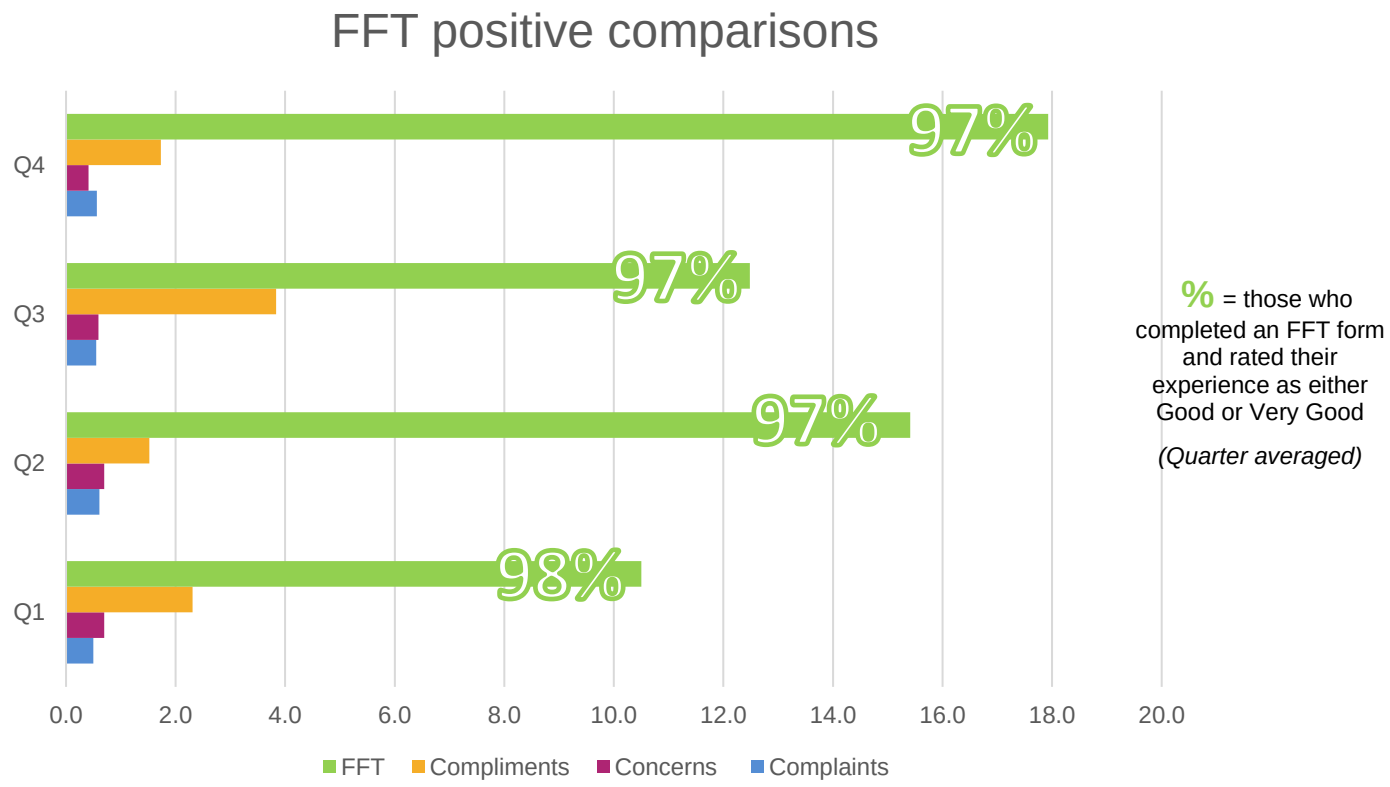
Patient Care is noted to have been heavily linked with staffing numbers and stretched resources. This is somewhat anecdotally evidenced by the significant variation in quantity of FFT responses received vs complaints (see Figure 1.2) as we continue to see average ratings of 97- 98% rating their experience as good or very good. This feedback also somewhat evidences the conclusion that even during the most

difficult staffing challenges, our staff are striving to provide the best possible patient care (See sample selection of Q4 Inpatient FFT comments appendix 1)

Communication as a theme has been actively targeted through encouragement of staff to access the accredited EOLC Communications course. These courses have also been funded for further dates over the coming year. There are also efforts to consolidate this further through the trialing of new approaches within the communication skills and introduction to complaints training packages currently offered.

These revised communication skills and introduction to complaints training programs have also been adapted to include communications, empathy as focus points. This has been trialed with two cohorts of Band 7 ward leads through development days, F2 Doctor inductions and newly qualified consultants leadership day. (slides from presentations are contained in appendix 2)

Figure 1.2 – Reiterates the FFT feedback rates compared with complaints, concerns and compliments (based on a per 1,000 patient activity) but also demonstrates the patient experiences rates obtained from these.

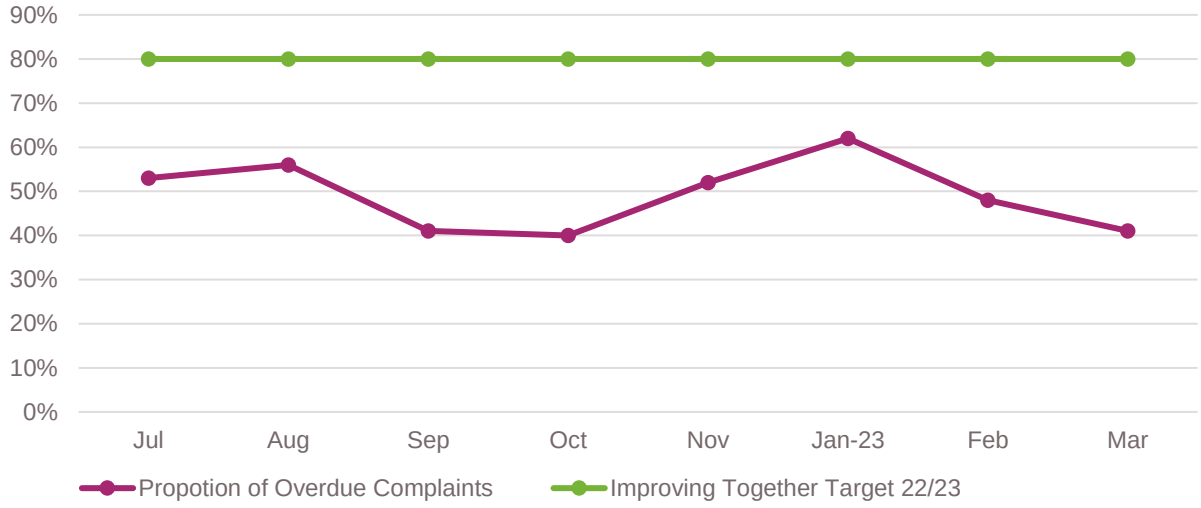


Overdue Complaints

Monitoring of the Trust's overall compliance with our complaint response timescales continues to be scrutinised through the Patient Experience Steering Group, with escalation to the Clinical Management Board (CMB) where appropriate.

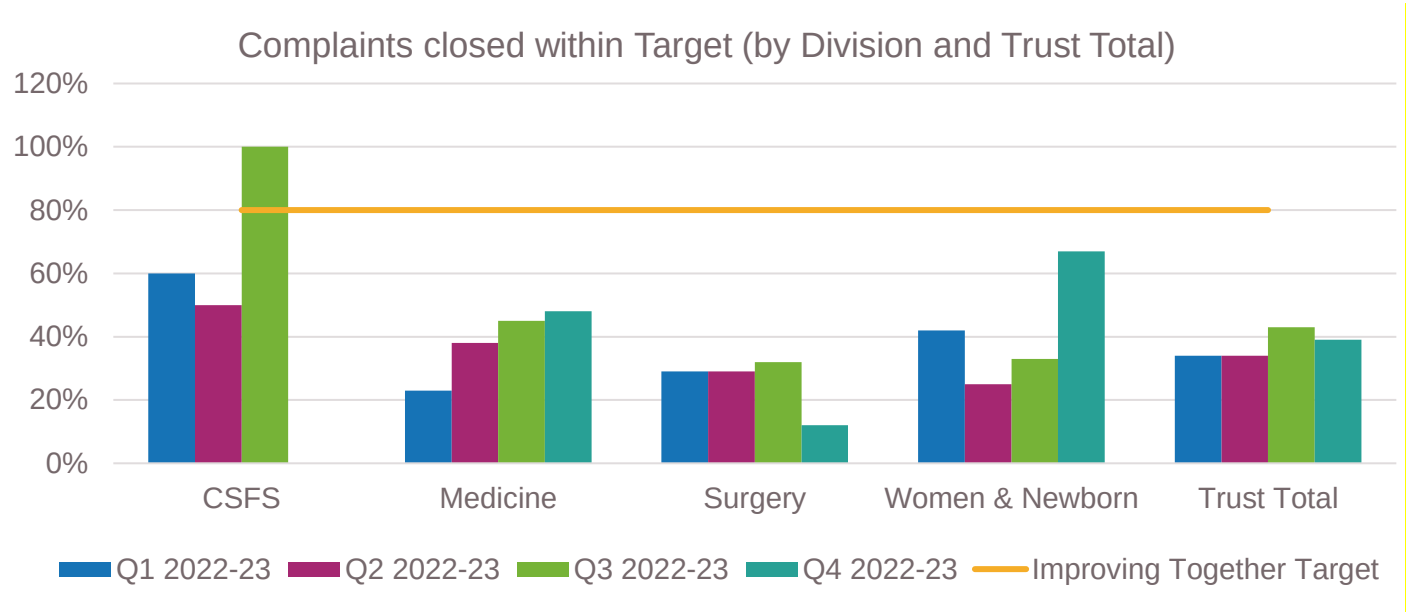
This aspect of the complaints process continues to be an area of focus as we continue to implement various mitigations to reduce these delays. This forms part of our workstream aimed at moving the Trust towards alignment with the new PHSO Framework, also taking into consideration our Improving Together Targets referenced at the start of this report.

Figure 1.3 Proportion of Total Open Complaints which are Overdue (Trust Wide)



The Trust overall is seeing an increase in the number of complaints being closed within the target timeframe. However, this continues to be significantly below our A3 Improving Targets of 80% for 2022-23. This will challenge further as we move into 2023-24 where the target increases again to 90%.

Figure 1.4 – Complaints closed within Target (by Division and Trust Total)



CSFS were unable to close any of their complaints on target for Q4, however for context, this was only two complaints. We continue to see improvements from Medicine and Women & Newborn in terms of response rates. Surgery have experienced some challenges in the last quarter with difficulties in reducing the backlog of complaint responses, however they continue to work closely with the PALS team on this backlog and are engaged with new ways of working to address this. (see Section 3 Division Summaries – Complaints, Concerns and Compliments) for more detailed breakdowns for each Division.

Figure 1.5 – Number of re-opened complaints or concerns

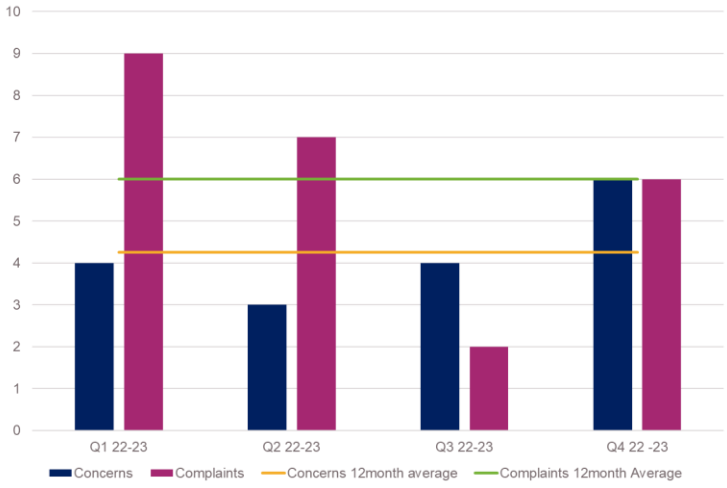


Figure 1.5 shows the number of reopened complaints and how this compares with the rolling average (since Q4 of 21/22).

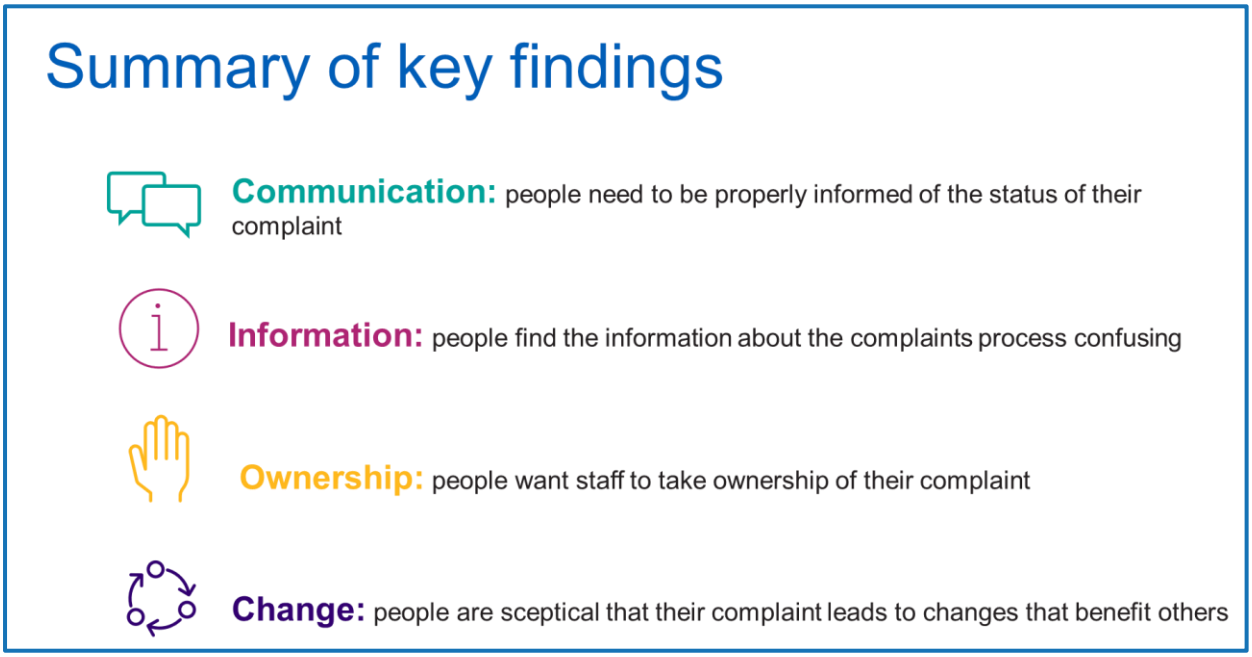
The average number of reopened complaints have increased slightly on last reporting going from 5.75 to 6.
We have seen an increase in both the number of reopened concerns and complaints for Q4, with the majority of these being due to the complainant being unhappy with the outcomes contained in the final response.

This indicates we may need to do more work with the complainant and the responding department in relation to understanding what these expectations are from the outset and whether these are realistic and proportionate to the complaint.

Re-opened complaints could be an indicator determining whether a complaint has been managed and responded to in the best way and a potential indicator for the quality of this process.

Since January 2023 weekly PALS complaints review meetings review all reopened complaints and concerns, recording the reasons for reopening and exploring options for prompt resolution (if possible).

2. Complaints Project Action Plan progress update



As referenced in the Q3 report a full action plan was developed in response to the key findings (above) of our complaints review project, co-developed with Healthwatch Wiltshire. All actions are largely in progress and/or completed. Appendix 3 contains the details of each action, including most recent update and RAG status.

The full HWW publication and response to the findings from SFT can be found (here).

Next steps

From May 2023 the complaints process survey used to undertake this project will become an integral part of the follow-up with all closed complaints and concerns. So, we may continue to assess the effectiveness of the actions we have implemented following these initial findings.

3. Division Summaries – Complaints, Concerns and Compliments

Non-Clinical Divisions (Facilities, Trust Offices, Corporate etc.)

0 Complaints/concerns were recorded for **non-clinical** divisions in Q4.

In total this year, there have been a total of 6 complaints/concerns recorded for the non-clinical divisions. There were however, 51 comments/enquiries logged.

42% of these were in relation to the carpark. This was varied in theme, but largely related to charges, communication, signage and lack of spaces. 95% of these were recorded during Q4 of 2022/23.

Clinical Support and Family Services (CSFS)

- There were a total of 6 complaints and concerns received during Q4
- 2 complaints were closed in Q4; however, both of these were not closed within timescale. It was unfortunate to not continue the 100% target achievement seen in Q3.
- 0 complaints/concerns were reopened.

Table 3.1 Summary of number of received, reopened and response within timeframe – annual comparison and quarterly averages.

- Positive downward trajectory on previous quarter
- Negative downward trajectory on previous quarter
- No change on previous quarter
- Positive upward trajectory on previous quarter
- Negative upward trajectory on previous quarter

	Q1 22-23	Q2 22-23	Q3 22-23	Q4 22-23	Annual Summary	Quarterly average for 22/23
Complaints	▲ 5	▼ 2	▲ 5	▼ 1	13	3.25
Concerns	▼ 7	▼ 6	▼ 5	▶ 5	23	6.0
Compliments	▲ 4	▼ 3	▲ 6	▲ 21	34	8.5
FFT Responses	80	▲ 93	▲ 206	▲ 349	728	182
Re-opened complaints/concerns	▲ 3	▼ 0	▲ 1	▼ 0	4	1
% closed complaints responded to within agreed timescale	▶ 60%	▼ 50%	▲ 100%	▼ 0%	Total patient activity for 2022/23	53%
Complaints closed in this quarter	5	2	4	2		3
Complaints by Division activity (per 1,000)	▼ 0.2 (30,147)	▼ 0.1 (29,779)	▲ 0.2 (31,906)	▼ 0.0 (34,107)	125,939	Average quarterly activity for the Division
Concerns by Division activity (per 1,000)	▼ 0.2 (30,147)	▶ 0.2 (29,779)	▶ 0.2 (31,906)	▼ 0.1 (34,107)		31,485
Compliments by Division activity (per 1,000)	▶ 0.1 (30,147)	▶ 0.1 (29,779)	▲ 0.2 (31,906)	▲ 0.6 (34,107)		

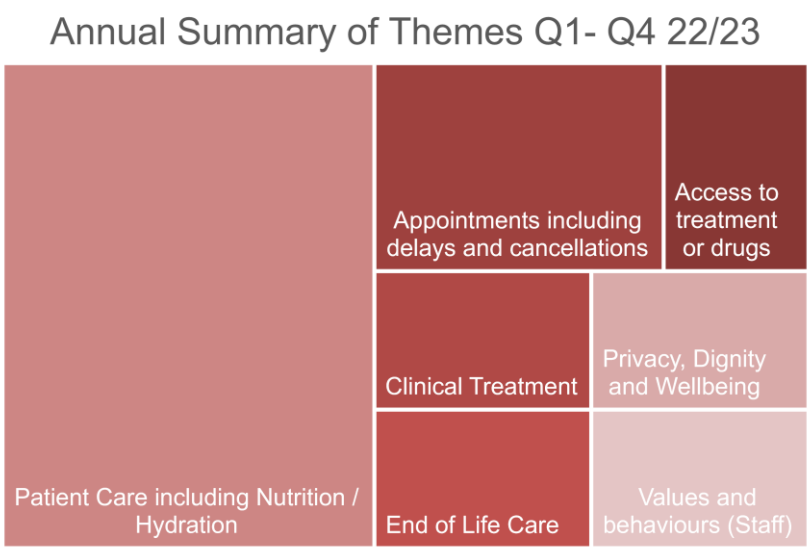
Figure 3.1 demonstrates the most prevalent high-level themes for opened complaints during Q4.

Figure 3.1 – Summary of themes for CSFS Complaints and Concerns – Q4 2022/23

100% = related to Patient Care including Nutrition/ Hydration

This was 1 complaint and was related to a delay in diagnosis.

Figure 3.2 – Annual summary of themes for complaints and concerns for the CSFS Division



46% = related to Patient Care including Nutrition/ Hydration

15% = related to Appointments including delays and cancellations

Within these two most prevalent theme(s), the following shows a sub-category breakdown for further context of the themes of these complaints:

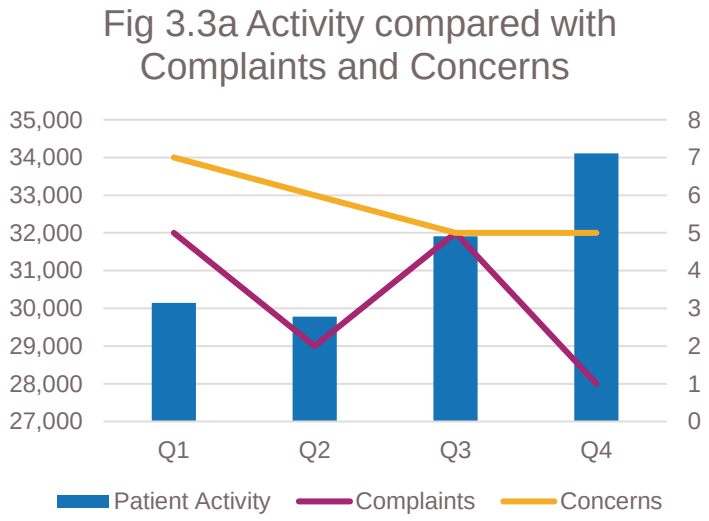
Patient Care including Nutrition / Hydration	6	46%
Delay in making diagnosis	2	33%
Pain management	2	33%
Inappropriate treatment	1	17%
Unsatisfactory treatment	1	17%

Appointments including delays and cancellations	2	15%
Appointment system - procedures	1	50%
Delay in receiving appointment	1	50%

Compliments – Clinical Support and Family Services

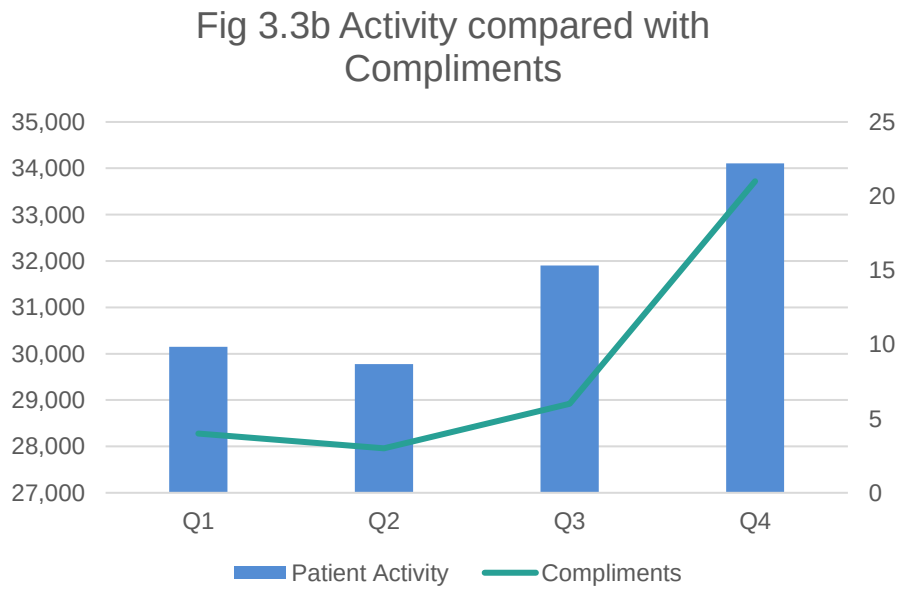
There were a total of 21 compliments for CSFS across Q4, this is the highest number seen so far this year for the Division. All of these have been logged on Datix formally.

Figure 3.3a and 3.3b shows correlation of number of complaints, concerns and compliments by patient activity for Clinical Support & Family Services.



Figures 3.3a is showing a positive downward trend on both complaints and concerns in the context of an increased patient activity for this quarter.

Figure 3.3b also shows a positive correlation with the number of compliments being recorded increasing alongside the Divisions patient activity numbers.



Women and Newborn

- There were a total of 11 complaints and concerns for Q4
- 6 complaints were closed in Q4; with 67% being responded to within the agreed timescale. This is a notable improvement on all three previous quarters.
- 1 complaint was reopened.

Table 3.2 Summary of number of received, reopened and response within timeframe – annual comparison and quarterly averages.

- Positive downward trajectory on previous quarter
- Negative downward trajectory on previous quarter
- No change on previous quarter
- Positive upward trajectory on previous quarter
- Negative upward trajectory on previous quarter

	Q1 22-23	Q2 22-23	Q3 22-23	Q4 22-23	Annual Summary	Quarterly average for 22/23
Complaints	▼ 7	▲ 8	▼ 7	▲ 8	30	7.5
Concerns	▶ 7	▼ 5	▶ 5	▼ 3	20	5
Compliments	▼ 8	▲ 21	▼ 19	▲ 34	82	20.5
FFT Responses	46	▼ 42	▼ 19	▲ 114	221	55.3
Re-opened complaints/concerns	▲ 1	▶ 1	▼ 0	▲ 1	3	0.75
% closed complaints responded to within agreed timescale	▼ 42%	▼ 25%	▲ 33%	▲ 67%	Total patient activity for 2022/23	42%
Complaints closed in this quarter	12	4	9	6		8
Complaints by Division activity (per 1,000)	▲ 1.6 (4,482)	▲ 1.8 (4,526)	▼ 1.5 (4,802)	▲ 2.1 (3,795)	17,605	Average quarterly activity for the Division
Concerns by Division activity (per 1,000)	▲ 1.6 (4,482)	▼ 1.1 (4,526)	▼ 1.0 (4,802)	▼ 0.8 (3,795)		4,401
Compliments by Division activity (per 1,000)	▼ 1.8 (4,482)	▲ 4.6 (4,526)	▼ 4.0 (4,802)	▲ 9.0 (3,795)		

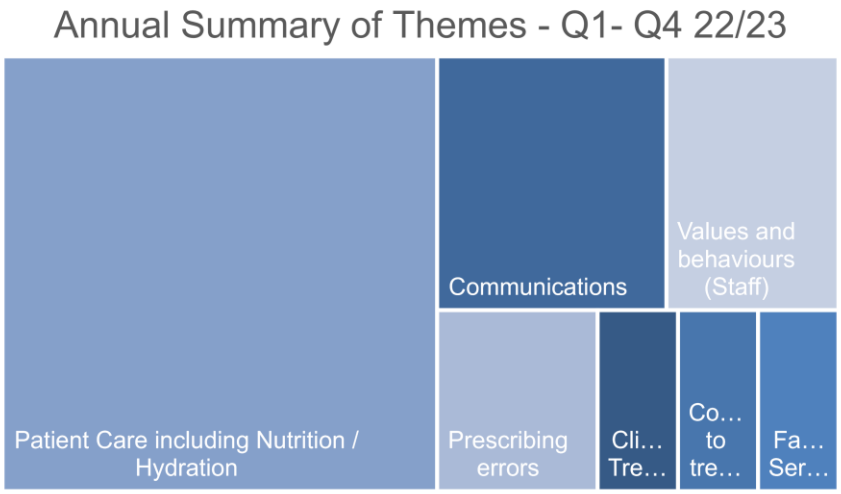
Figure 3.4 – Summary of themes for W&N Complaints and Concerns – Q4 2022/23

75% = related to Patient Care including Nutrition/ Hydration

13% = Facilities Services

13% = Values & Behaviours of Staff

Figure 3.5 – Annual summary of themes for complaints and concerns for the Women & Newborn Division



52% = related to Patient Care including Nutrition/ Hydration

16% = Communications

12% = Values & Behaviours of Staff

Within these two most prevalent theme(s), the following shows a sub-category breakdown for further context of the themes of these complaints:

Patient Care including Nutrition / Hydration	13	52%
Unsatisfactory treatment	5	29%
Neglect	3	18%
Nursing Care	3	18%
Correct diagnosis not made	2	12%
Further complications	2	12%
Assistance not given	1	6%
Inappropriate treatment	1	6%

Communications	4	16%
Insensitive communication	3	75%
Lack of communication	1	25%

Values and Behaviours (staff)	3	12%
Attitude of staff - medical	3	100%

Compliments – Women & Newborn

There was a total of 34 recorded compliments for W&N across Q4, this is the highest number recorded for 22/23. 26 of these compliments were formally recorded on Datix.

Figure 3.6a and 3.6b shows correlation of number of complaints, concerns and compliments by patient activity for Women & Newborn.

Fig 3.6a Activity compared with Complaints and Concerns

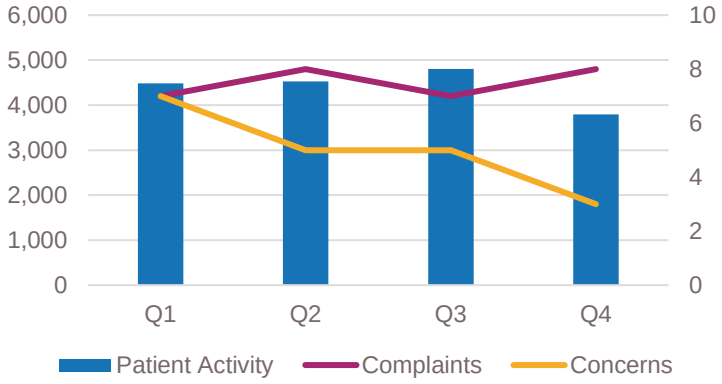
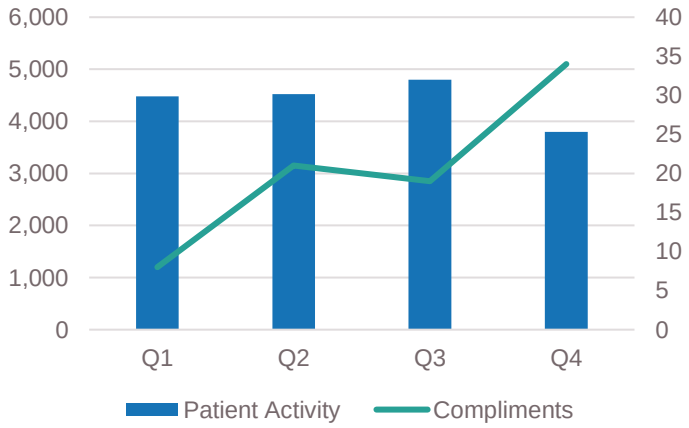


Figure 3.6a has shown an increase on the number of complaints despite the patient activity for Q4 being slightly lower, however concerns have reduced.

Figure 3.6b shows a significant increase in compliments on comparison with previous quarters, and despite a decrease in patient activity.

Fig 3.6b Activity compared with Compliments



Medicine

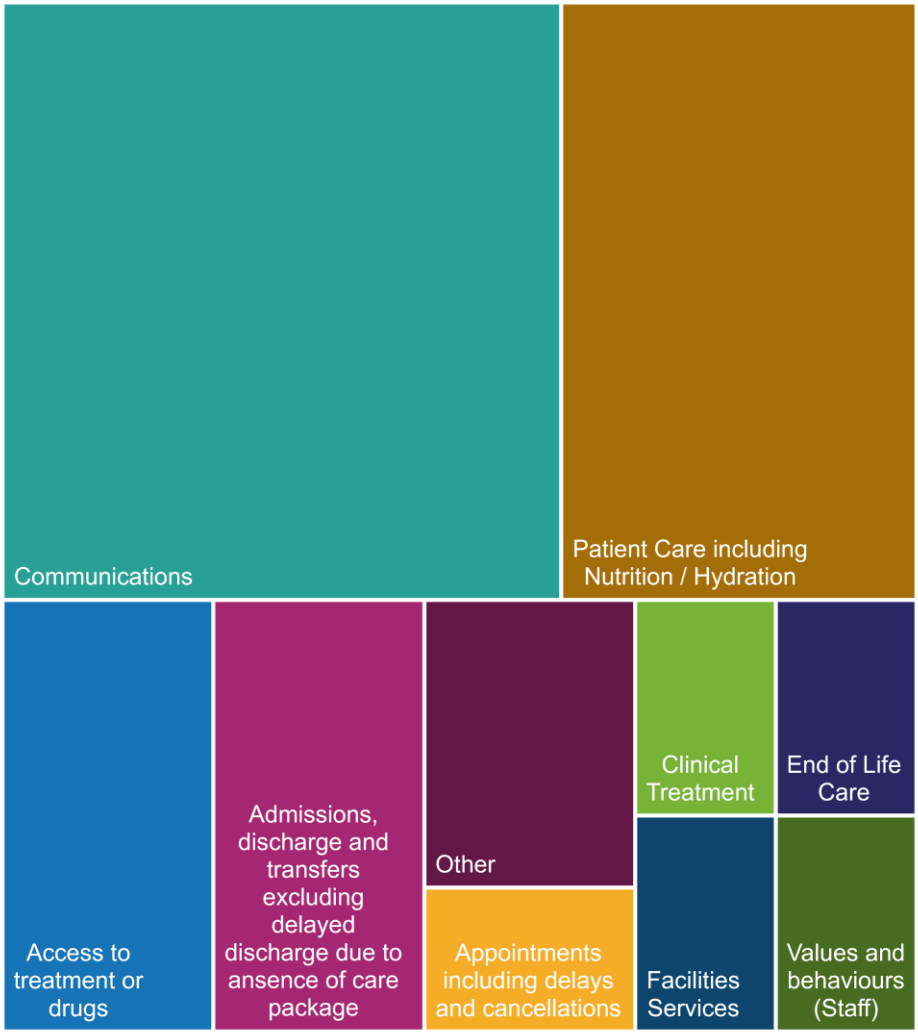
- There were a total of 49 complaints and concerns for Q4, slight increase on Q3.
- 19 complaints were closed in Q4; with 58% being responded to within the agreed timescale. This is a notable improvement on all three previous quarters.
- 2 concerns and 3 complaints were reopened this quarter.

Table 3.3 Summary of number of received, reopened and response within timeframe – annual comparison and quarterly averages.

- Positive downward trajectory on previous quarter
- Negative downward trajectory on previous quarter
- No change on previous quarter
- Positive upward trajectory on previous quarter
- Negative upward trajectory on previous quarter

	Q1 22-23	Q2 22-23	Q3 22-23	Q4 22-23	Annual Summary	Quarterly average for 22/23
Complaints	▲ 20	▲ 24	▼ 18	▲ 31	93	23.25
Concerns	▲ 32	▼ 31	▼ 24	▼ 18	105	26
Compliments	▼ 139	▼ 85	▲ 251	▼ 134	609	152.2
FFT Responses	320	▲ 649	▼ 383	▲ 482	1834	458.5
Re-opened complaints/concerns	▼ 2	▲ 5	▼ 2	5	14	3.5
% closed complaints responded to within agreed timescale	▼ 23%	▲ 38%	▲ 45%	▲ 58%	Total patient activity for 2022/23	41%
Complaints closed in this quarter	13	24	29	19		21
Complaints by Division activity (per 1,000)	▼ 0.7 (29,026)	▲ 0.8 (28,414)	▼ 0.6 (29,040)	▲ 1.1 (28,406)	114,886	Average quarterly activity for the Division
Concerns by Division activity (per 1,000)	▼ 1.1 (29,026)	▶ 1.1 (28,414)	▼ 0.8 (29,040)	▼ 0.6 (28,406)		28, 722
Compliments by Division activity (per 1,000)	▲ 4.8 (29,026)	▼ 3.0 (28,414)	▲ 8.6 (29,040)	▼ 4.7 (28,406)		

Figure 3.7 – Summary of themes for Medicine Complaints and Concerns – Q4 2022/23



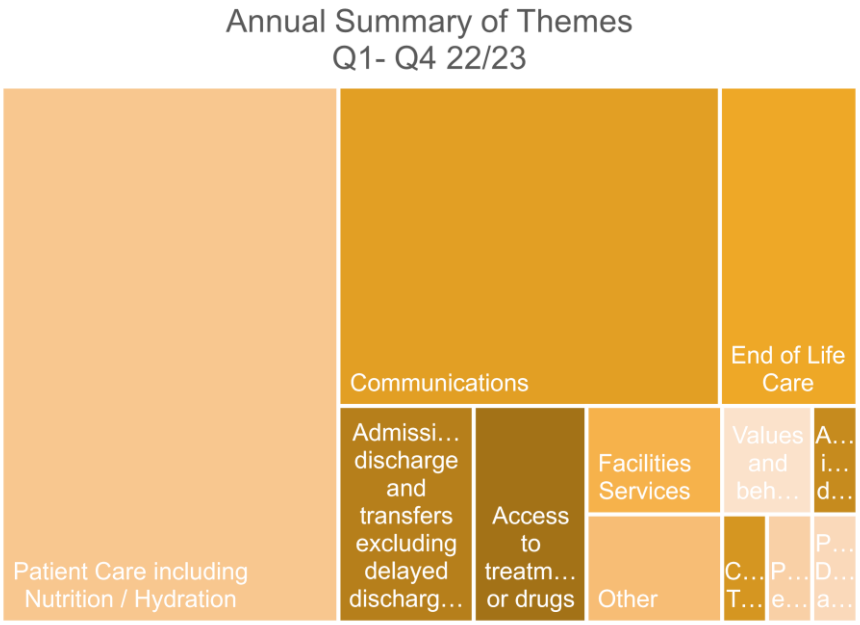
35% = Communications

23% = related to Patient Care including Nutrition/Hydration

10% = related to access to treatment, admissions/discharge/transfers (respectively)

For comparison, the top themes common for Q3 were still in relation to **communication, patient care** and **access to treatment**.

Figure 3.8 – Annual summary of themes for complaints and concerns for the Medicine Division



39% = Patient Care including Nutrition/Hydration

27% = Communications

10% = End of life care

Within these three most prevalent theme(s), the following shows a sub-category breakdown for further context of the themes of these complaints:

Patient Care including Nutrition / Hydration	37	39%
Nursing Care	11	30%
Correct diagnosis not made	7	19%
Neglect	6	16%
Unsatisfactory treatment	6	16%
Further complications	2	5%
Falls	1	3%
Harm	1	3%
Inappropriate treatment	1	3%
Pain management	1	3%
Ward moves	1	3%

Communications	25	27%
Lack of communication	11	44%
Insensitive communication	8	32%
Information not given to family	2	8%
Information not given to patient	2	8%
Wrong information	2	8%

End of Life Care	9	10%
Poor communication	6	67%
Death	1	11%
Dignity in End of Life Care	1	11%
Lack of Care	1	11%

Compliments - Medicine

There was a total of 134 compliments for Medicine for Q4, this was noted to be lower than Q3, but consistent with Q1 and Q2 for 22/23. All of these compliments were formally recorded on Datix.

Figure 3.8a and 3.8b shows correlation of number of complaints, concerns and compliments by patient activity for Medicine.

Fig 3.8a Activity compared with Complaints and Concerns

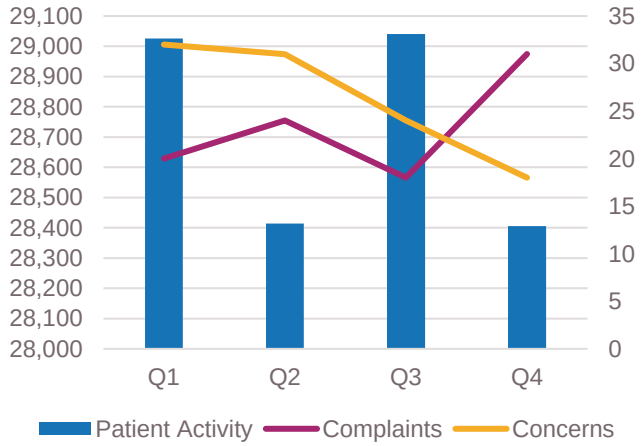
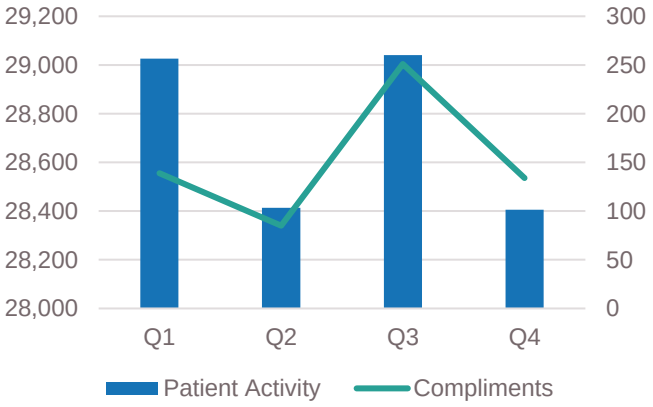


Figure 3.8a is showing an overall decline in the number of concerns recorded for Medicine – this is despite a similar patient activity number being noted in Q2.

Complaints numbers have increased on Q3. This division has been actively engaged since the Summer in trialling new processes and department leads have demonstrated commitment to changing the culture of how complaints are managed - adopting the PHSO principles of early resolution and meaningful apology.

Figure 3.8b has shown a reduction in compliments, but this is positively correlated with the reduced patient activity seen in Q4.

Fig 3.8b Activity compared with Compliments



Surgery

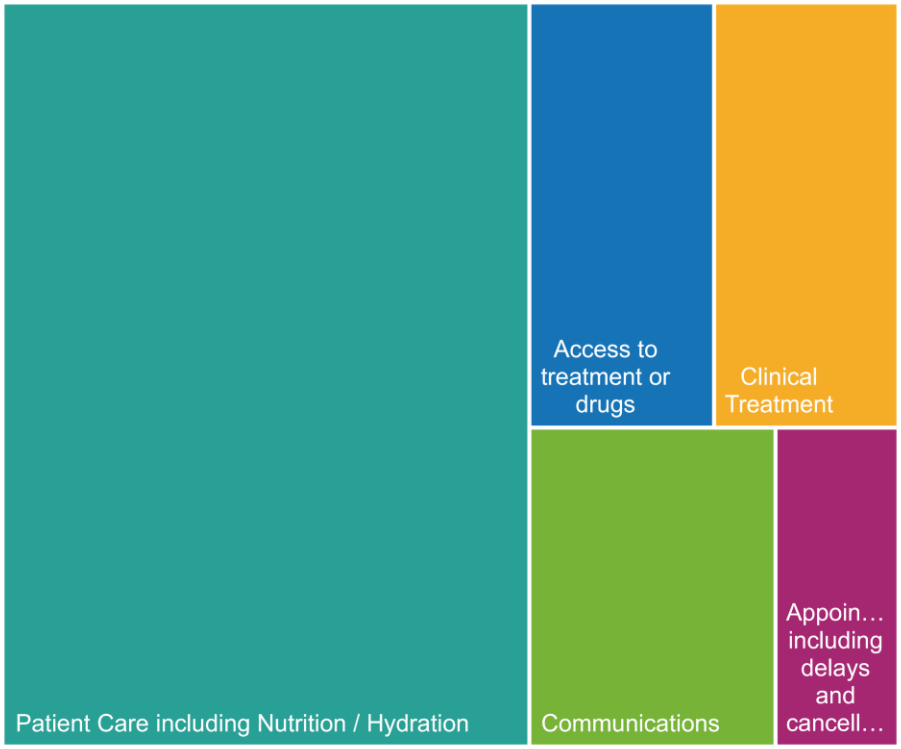
- There were a total of 33 complaints and concerns for Q4, a decrease on Q3.
- 17 complaints were closed in Q4; with 12% being responded to within the agreed timescale. This is the lowest response on target achievement for the Division this year.
- 4 concerns and 2 complaints were reopened this quarter.

- Positive downward trajectory on previous quarter
- Negative downward trajectory on previous quarter
- No change on previous quarter
- Positive upward trajectory on previous quarter
- Negative upward trajectory on previous quarter

Table 3.4 Summary of number of received, reopened and response within timeframe – annual comparison and quarterly averages.

	Q1 22-23	Q2 22-23	Q3 22-23	Q4 22-23	Annual Summary	Quarterly average for 22/23
Complaints	▼ 17	▲ 25	▲ 26	▼ 17	85	21.25
Concerns	▶ 22	▲ 26	▶ 26	▼ 16	90	23
Compliments	▲ 75	▼ 39	▲ 112	▼ 72	298	74.5
FFT Responses	582	▲ 771	▼ 661	▲ 877	2831	707.7
Re-opened complaints/concerns	▲ 7	▼ 4	▼ 3	▲ 6	20	5
% closed complaints responded to within agreed timescale	▲ 29%	▶ 29%	▲ 32%	▼ 12%	Total patient activity for 2022/23	26%
Complaints closed in this quarter	17	17	19	17		18
Complaints by Division activity (per 1,000)	0.5 (34,242)	▲ 0.7 (34,493)	▶ 0.7 (35,374)	▼ 0.5 (35,310)	139,419	Average quarterly activity for the Division
Concerns by Division activity (per 1,000)	0.6 (34,242)	▲ 0.8 (34,493)	▼ 0.7 (35,374)	▼ 0.5 (35,310)		34, 855
Compliments by Division activity (per 1,000)	▲ 2.2 (34,242)	▼ 1.1 (34,242)	▲ 3.2 (35,374)	▼ 2.0 (35,310)		

Figure 3.9 – Summary of themes for Surgery Complaints and Concerns – Q4 2022/23



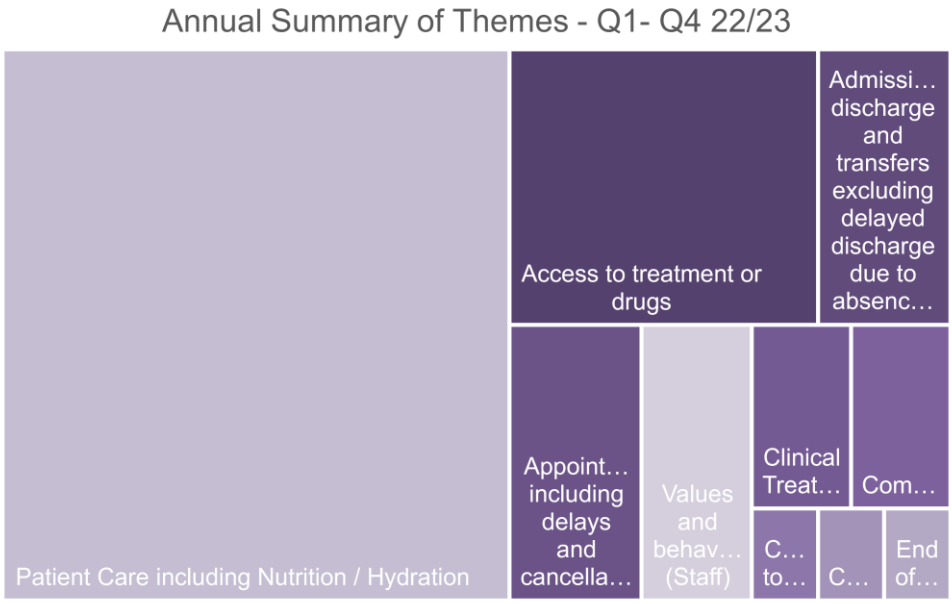
59% = related to Patient Care including Nutrition/Hydration

12% = related to Access to Treatment, clinical treatment and communications (respectively)

6% = related to appointments, including delays and cancellations

For comparison, the top themes common for Q3 22/23 were also reported to be in relation to **Patient Care, Access to Treatment and Communications.**

Figure 3.10 – Annual summary of themes for complaints and concerns for the Surgery Division



53% = related to Patient Care including Nutrition/ Hydration

16% = Access to treatment or drugs

7% = Appointments (including delays and cancellations) and admission/discharges and transfers (respectively)

Within the two most prevalent theme(s), the following shows a sub-category breakdown for further context of the themes of these complaints:

Patient Care including Nutrition / Hydration	**46**	**53%**
Further complications	19	41%
Delay in making diagnosis	10	22%
Correct diagnosis not made	5	11%
Nursing Care	4	9%
Unsatisfactory treatment	4	9%
Harm	2	4%
Inappropriate treatment	2	4%

Access to Treatment or Drugs	**14**	**16%**
Delay in receiving treatment	11	79%
Operation cancelled following admission	2	14%
Operation delayed following admission	1	7%

Compliments – Surgery

There was a total of **72** compliments for Surgery for Q4, this was noted to be slightly lower than last quarter, but consistent with Q1. 32 of compliments were formally recorded on Datix following the change in process back in February 2023.

Figure 3.10a and 3.10b shows correlation of number of complaints, concerns and compliments by patient activity for Surgery.

Fig 3.10a Activity compared with Complaints and Concerns

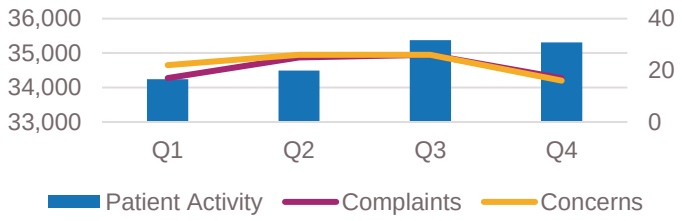
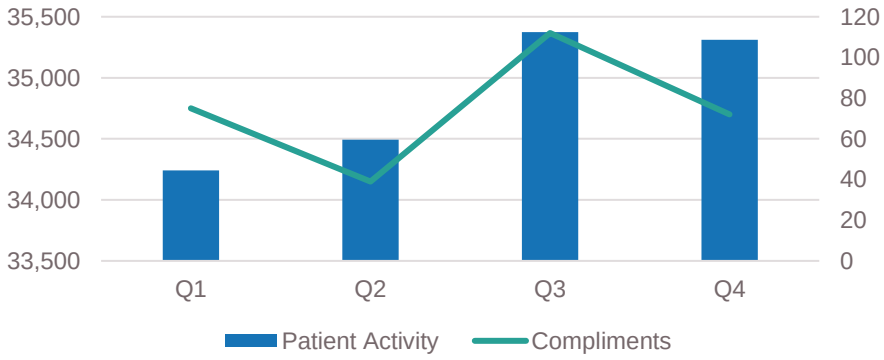


Figure 3.10a is showing a positive correlation between patient activity and number of complaints and concerns raised during this quarter.

Figure 3.10b shows a slightly negative correlation with the number of compliments recorded this quarter despite seeing similar patient activity numbers.

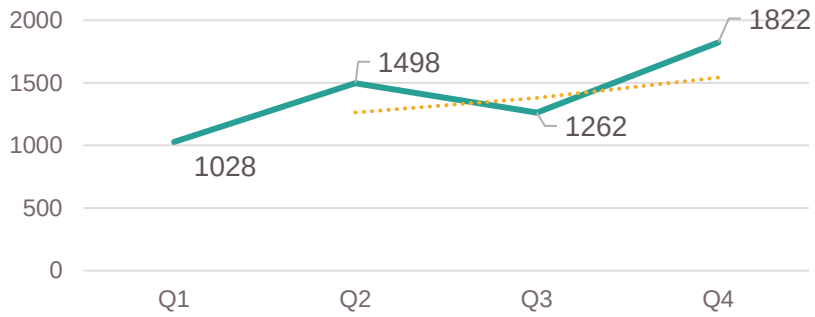
Fig 3.10b Activity compared with Compliments



4. Friends and Family (FFT)

Response Rates

Figure 4.1 Number of FFT Responses



A total of **1822** patients provided feedback through the paper Friends and Family Test (FFT) in Q4 of 22/23. For comparison, this is highest number of responses of any quarter this year - see Figure 4.1.

The orange line shows the average for this year as a trendline.

We are still unable to delve into these data sets without using a time consuming and subjective interpretation or the comments to produce any reliable theming.

Implementation of the new provider system has been delayed until December 2023. The mitigation plans were outlined to the Patient Experience Steering Group in March 2023 and are referenced in Appendix 4 of this report.

97% Of those surveyed rated their experience of our hospital as Good or Very Good (average for Q4 2022-23)

2.7%* Response rate (*of eligible population and averaged for Q4 2022-23)

The target response rate continues to be significantly below our Improving Together target of >10% of eligible patients for 2022/23. This is largely owed to the sole reliance on the paper FFT cards in the inpatient areas and subsequently little visibility in the outpatient areas. An audit on the existing FFT boards now complete, which has identified improvements with location and presentation of these boards to encourage more uptake in the interim of the new provider solution. The new solution will encompass alternative ways to engage feedback i.e. interim use of QR codes on posters and other patient facing communications.

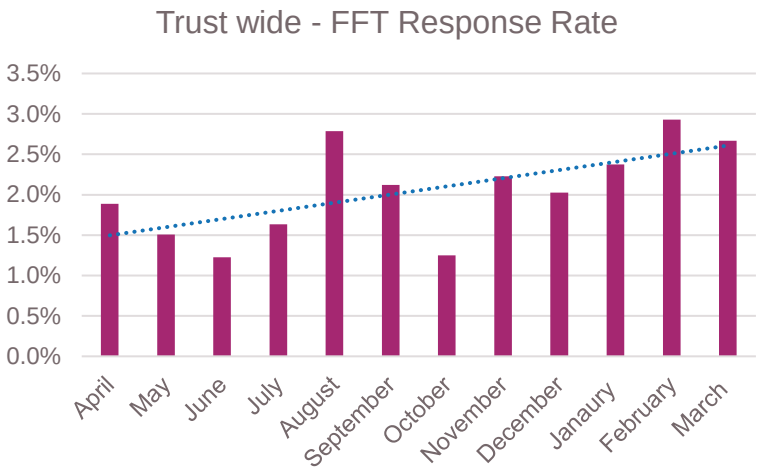
Table 4.1 summarises the response rates in accordance with patient activity.

Table 4.1 Response rate across the Trust by per 1,000 patient activity – rolling annual comparison

	Q1 22-23	Q2 22-23	Q3 22-23	Q4 22-23
Across all Directorates	▼ 10.5 (97,897)	▲ 15.4 (97,212)	▼ 12.5 (101,122)	▲ 17.9 (101,618)

Benchmarking against Improving Together Targets

Figure 4.1 – Response rate (based on eligible population) – Trust wide



As Figure 4.1 demonstrates - we continue to be far from our **Improving Together** targets as we go into 2023.

10%

Response rate target

(2022/23)

The response rates are overall increasing, which is positive, and this is without any significant changes to current processes. However, we do still have a long way to go to achieve our improving together targets.

We have successfully secured a digital provider to improve these response rates utilising SMS messages and increasing other digital options, however implementation of this has been delayed until December 2023 currently.

For 2022/23 the following activity for Friends and Family test has been recorded:

5,616 Responses received Trust wide

2.25%* Response rate
(*of eligible population and averaged)

97% Rated their experience as either "Good" or "Very Good"
(averaged)

We continue to regularly promote positive feedback received via FFT through weekly social media plugs under "*#ThankyouThursday*" and "*#FeedbackFriday*" hashtags. Most recent examples below from January and March 2023:

5. Patient and Public Feedback – Local Surveys

Real-Time Feedback

Real-time feedback was relaunched in Q4 of 2022/23 following a revision to align more closely with the annual inpatient surveys. This is now available on Tendable and can be completed by ward staff, volunteers or governors. There have been some challenges with roll-out caused by insufficient access to enough Ipads, which has subsequently reduced capacity to undertake these. There has been raised with the IT team for urgent resolution.

10 inspections were completed between 1st January 2023 - 27th March 2023. The average satisfaction score for these were **75.7%**. Full findings and insights were presented to the Patient Experience Steering Group in March 2023 and the full presentation can be found in Appendix 5.

Your Views Matter – Bereavement Survey – Q4 Report Summary

Background: In July 2022 the administration of the "Your Views Matter" EOLC surveys was moved over to the PALS team due to constraints on resources within the End of Life services and was seen as an opportunity to improve the transition of feedback into compliments or complaints as necessary.

This change in administration has also prompted review of the process and data collection and seek to improve the data correlation alongside our complaints and concerns.

This report will be presented to the Patient Experience Steering Group in May 2023 and elements are also included with the quarterly Learning from Deaths Report.

Summary of analysis: Overall, there has been a slight drop in overall experience and subsequent satisfaction ratings previously noted in the Q3 report. 68% of those surveyed rated their overall experience as Good or Very Good, compared with 73% last quarter. Poor experience ratings have also increased on last quarter.

Response rates have noted to have increased from 20% in Q3, to 33% in Q4. This has created an average annual response rate of 28% (lower than the 39% we saw in 2021/22).

2 survey participants requested a call-back from PALS, 1 of these went on to record a formal complaint or concern. This is a reduction from what was seen in Q3.

There was a positive theme for the experience with both the bereavement and medical examiner's office this quarter. Facilities continue to be a recurring theme, with privacy and dignity of both the patient and

grieving families being impacted due to lack of private spaces at point of death. See Appendix 6 for full report.

6. Patient and Public Feedback – National Surveys

National Maternity Survey 2022

The results from the National Maternity Survey were presented at Patient Experience Steering Group in February 2023, along with action plan.

Summary of findings:

- Higher than national response rate (61%). With a Mean Rating Score of 78.2% (*lower than 2021*).
- **Scoring in the top 20% of Trusts for 15 questions**. They were in relation to:
    - Antenatal check-ups (informed of history and able to answer questions)
    - Help provided by the midwifery team
    - Involvement of partners
    - Enough support during worrying times
    - Involvement with decision making (postnatal, feeding and care after birth)
    - Support with mental health
- The Trust scored in the **bottom 20% for 5 questions**. They were in relation to:
    - Being communicated with in a way that could be understood
    - Treatment with dignity and respect
    - Information and explanation post birth
    - Cleanliness of the hospital room or ward
    - Care after birth out of hours
- **1 question showed at least 10% improvement**. This was in relation to enabling those involved with care to stay with the mother as much as needed.
- **1 question scored worse by more than 10%.** This was in relation to accessing support or advice out of hours (evenings and weekends.)

Action plan was reflected to be very comprehensive with actions largely on track or completed. Full report can be found in Appendix 7.

Scheduled Surveys:

Urgent & Emergency Care 2022 – will be reported in Q1 – 2023/24

National Inpatient Survey 2022 – will be reported in (TBC) 2023

Children and Young People Survey 2023 – will be reported in (TBC) 2024

APPENDIX 1: FFT Inpatient Feedback Sample – Q4


Amesbury
Nothing was too much trouble, everyone so kind and helpful even though at times they were very busy. A credit to their calling.
Chilmark
Lovely staff, nothing was too much trouble. Clean, safe space too. Gold star to Chilmark.
Downton
The noise, the bustle, the attention, all added to the sense of inclusion and care. I loved it. Thank you so much.
Britford
The care and attention was outstanding at all times. All staff were positive and professional at all times.
Odstock
The staff were very good. Polite, explained everything and very helpful. 10/10.
Whiteparish
Excellent staff. Very empathetic towards patients.
Spire
The staff made my stay so much better. They were all so caring and very helpful, even down to the cleaners but especially night nurse Hilda *** Also staff nurse Miranda.
Pembroke
Excellent care throughout my chemo. Nurses are all lovely and go above and beyond.
Tisbury
The care and attention of all staff was amazing, so caring and kind despite being so busy. Communication excellent.

APPENDIX 2 - Complaints and Communications Leadership Training Days

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APPENDIX 3: Complaints Process Review – Action Plan Progress

Recommendation	Actions taken	Responsibility	By when	Status	Evidence to demonstrate actions have been completed
Disseminate information about the complaints process across all Trust departments and ensure all staff can explain the role of PALS.	PALS Outreach Service	PALS team	Ongoing since August 2022 – make BAU	Complete	Now business as usual, fully embedded with the PALS team. Each member has 3-4 inpatient wards they visit on a recurring 6weekly basis. These visits review complaints, FFT, and general discussions related to patients experiences i.e. lost property etc. (example attached) PALS Outreach Ward Visit Tisbury V Friends and Family Feedback February 2
	Regular attendance at DMT meetings	PALS Lead / Head of Patient Experience	Ongoing since August 2022	Complete	Now business as usual, quarterly presentations at all divisional governance meetings (patient experience focus, covering complaints, compliments and FFT) Surgical Governance - Patien W&N - Patient Experience Update CSFS - Patient Experience Update - Medicine DMT - Patient Experience L
	PALS leaflet currently being developed Posters to be designed and audit undertaken as where these need to be located	PALS Lead / Head of Patient Experience	~~March 2023~~ June 2023	In Progress	Work continues to collate content and also working with external design agency to bring this resources into line with the Trusts new branding
	Opportunities for shadowing PALS enquiries	PALS Lead	Ongoing since November 2022 – make BAU	Complete	Now business as usual, so far 8 staff members have shadowed the PALS team since November 2022. This shadowing has been undertaken by a mixture of clinical and non-clinical colleagues from Radiology, information governance, catering, clinical psychology, and ward clerks. We will continue to facilitate this as part of our business as usual. We have developed a feedback form to help us to continue to maximise the benefit of what staff can get from this exposure

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	Staff development – F2 doctor training, B7 development days, Admin Training Collaboration with Mentor4Leaders. Consideration with standard Trust Induction timetable	Head of Patient Experience	January 2023 March 2023 *TBC*	Complete Complete **Not started**	PALS Services - Admin Presentation Consultants Programme - Comm Patient Experience - F2 Core Teaching Pr Patient Experience - Staff Development F
Provide regular updates to complainants and inform them of revised timescales as appropriate.	Weekly meetings between PALS Lead and complaints co-ordinators for escalation and ensure regular communications	PALS Lead and complaints co-ordinators	January 2023	Complete	Cycle of meetings added – format continues to develop with focuses on overdue and complex complaints, escalation and communication/update to complainants
	Review of holding letter timescales. Change to acknowledgement letters to be clearer on timescales, reference numbers and who is overseeing their complaint.	PALS Lead / Head of Patient Experience	January 2023	Complete	Updated acknowledgement letters. Acknowledgement letter 25 working da
Identify potential communication barriers with complainant at first contact.	Record of discussion re-designed to include: Summary of the key points to address	PALS Lead / Head of Patient Experience	January – March 2023 ~~January – March 2023~~ Extended to Summer 2023 to coincide	Complete In Progress	Updated Record of Discussion template to incorporate 48hour review process – and launched with Divisions. Changes to Complaints Process Division 48-hour Initial Complaints R Record of discussion v2 Dec 2(

	Embedding the 48hr review template to highlight challenges from department/divisions	PALS Lead / Head of Patient Experience	January – March 2023	Complete	As above.
Improve signposting to additional support e.g., advocacy services.	Acknowledgement letters, leaflets amendments Building links with local advocacy services	PALS Lead / Head of Patient Experience	~~January – March 2023~~ Extended to Summer 2023	In Progress	Talk from Local Advocacy Services – PALS Team Meeting – February 2023. Talk postponed as speaker is currently unwell. Rescheduled talk date to be confirmed.
Publicise and celebrate improvements made to services as a direct result of complaints raised e.g., you said, we did.	Review of FFT Boards (location, information etc.) Implementation of new digital provider to allow for insightful analysis of feedback and meaningful triangulation with complaints.	PALS Lead / Head of Patient Experience / Engagement Lead	January – March 2023 ~~April 2023 – ongoing~~ December 2023	Complete In Progress	Orders for new and replacement FFT boards currently underway. Requirements presented to PESG on March 2023. Bi-Annual FFT Update - PESG Marc Digital provider rollout delayed until December 2023. Interim actions to continue to drive response rates included in the above presentation.
	Reporting on outputs and learning from complaints – exploring the use of the actions recording and reporting function on Datix	PALS Lead / Head of Patient Experience	Ongoing	In Progress	Limited with exploration due to changes to Datix being limited as new system is anticipated under the PSIRF project.
	Introduction of a new standard to response letters which bullet point/summarise actions being taken Embedding cultures for following up closed complaints with "you said, we did".	PALS Lead / Head of Patient Experience	January 2023 March 2023	Complete In Progress	Updated process with Divisions and use of examples. FW_ Changes to complaint response Example letter.pdf
Continued monitoring	Complaints process feedback, survey to be updated to reflect this project and continued monitoring. Use of survey monkey and SOP for completion will also be drafted.	PALS Lead / Complaints Coordinators	May 2023	In Progress	Survey monkey created and draft SOP due to be approved at PESG in May 2023. New feedback survey will be launched with all closed complaints from the 9th May 2023.

APPENDIX 4: Bi-Annual FFT Update and Interim Action Plan

APPENDIX 5: Real-time Feedback Progress Report for PESG – March 2023

APPENDIX 6: Your Views Matter – Bereavement Survey Report – Q4

APPENDIX 7: MAT22 Headline report Salisbury NHS FT

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Patient Experience

Complaints and PALS Services

January 2023

Victoria Aldridge - Head of Patient Experience
Sophie Brookes – PALS Lead

Session key points

Salisbury NHS Foundation Trust

- ✓ The Complaints Process:
  - ✓ Who can make a complaint
  - ✓ Common complaints and examples
  - ✓ SFTs complaints process
  - ✓ What happens when a complaint cannot be resolved?
  - ✓ Introduction to the new Parliamentary Health Service Ombudsman(PHSO) framework
  - ✓ Healthwatch Wiltshire Complaints Review Project
  - ✓ Improvements and changes we are making to the complaints process
  - ✓ Tips for managing a complaint
- ✓ Its not all doom and gloom!
  - ✓ Friends and Family Test and other feedback
  - ✓ National Inpatient Survey Results 2021
  - ✓ PALS services including Patient Engagement
  - ✓ Contact details

Salisbury NHS Foundation Trust

Complaint Handling

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Why are complaints important?

- To ensure our patients, visitors and carers have a voice
- To enable our staff to deal with comments, concerns or complaints from patients, carers or members of the public
- To help us all to take personal responsibility for improving patient care and servicers we offer. (The Trust's vision is to provide an outstanding experience for every patient).
- To improve the services we offer

Who can raise a complaint?

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- ✓ Patients
- ✓ Carers/relatives
- ✓ Visitors
- ✓ MP, acting on behalf of and by instruction from a constituent.
- ✓ Members of hospital staff and other health professionals including the General Practitioner may also complain about aspects of a patient's care or raise it through the **Freedom to Speak Up: Raising Concerns Policy**.
- ✓ Commissioners
- ✓ Advocacy Service on behalf of a patient.

What are our most common causes for complaints?

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Communication (lack of or poor)

Attitude of staff

Delays (in treatment, diagnosis or appointments)

Unsatisfied with quality of care or outcome of treatment

Source: Complaints data Q3 & Q4 2021/22 and Q1 & Q2 2022/23.

Why do people complain?

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How do you feel when you receive a complaint?

Patient Centred & Safe | Professional | Responsive | Friendly | Progessive

Discussion Point

Salisbury NHS Foundation Trust

Think about a time when you have had to make a complaint yourself

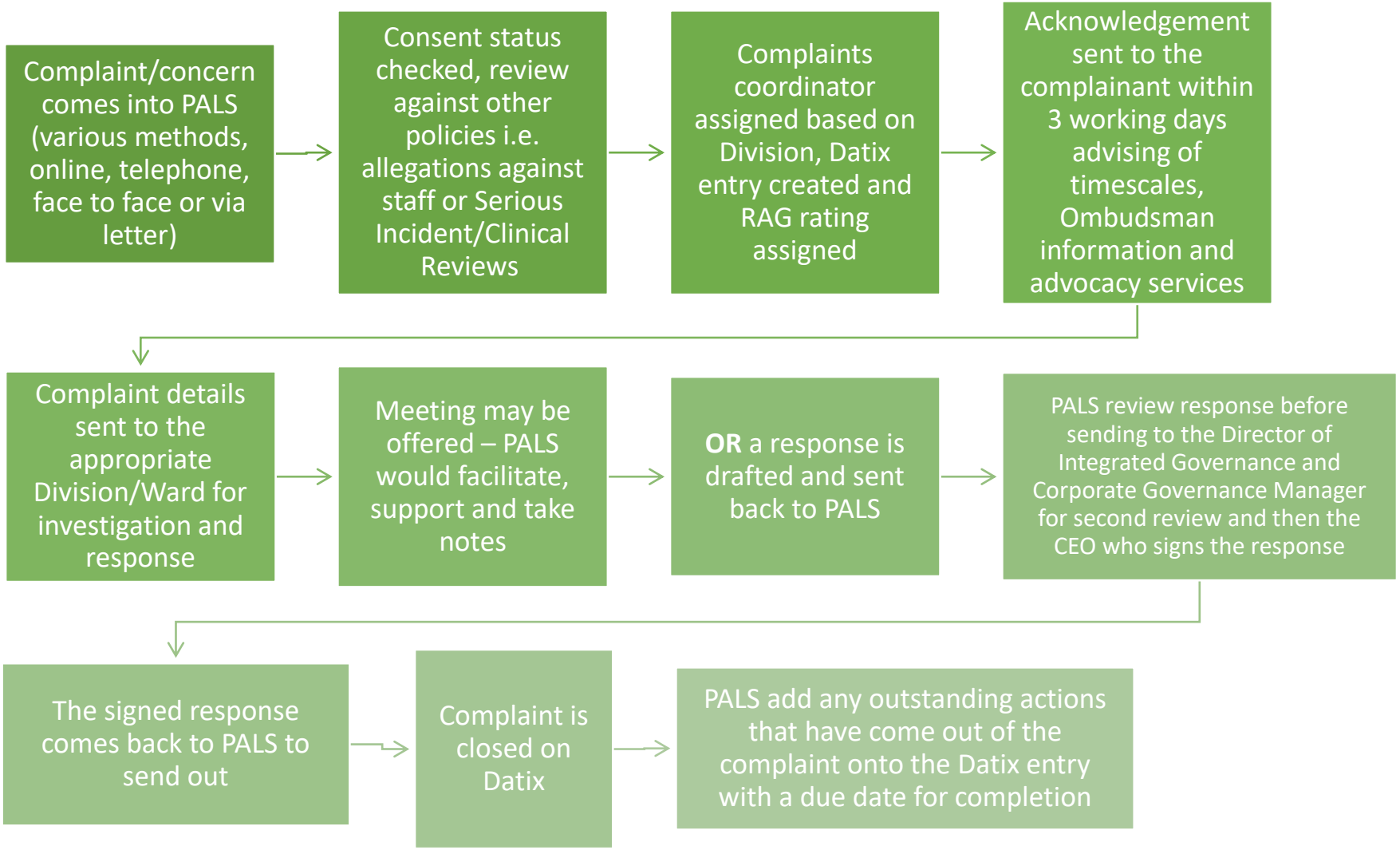
What made it a poor experience for you?

What made it a positive experience?

A poor example of complaints management – courtesy of Mr Basil Fawlty !

SFT's current complaints process

NHS Salisbury NHS Foundation Trust



Response RAG Rating

Categorisation and time scales allocated to complaints

GREEN
Response in
25 working

Green – Response in 25 working days

- Delayed appointments or treatment.
- No adverse outcome or injury.
- NON complex and 1 or 2 Services involved.

AMBER
Response in
40 days

Amber – Response in 40 working days

- Adverse outcome or minor injury noted (which is not subject to an SII, CR or LR)
- Complex case +/- involving 2-4 Services
- Contact with the media suggested or confirmed
- Patient is vulnerable and complainant may suggest neglect or significant failings in care.
- Investigating team need additional time due to absence (sick/annual leave) within relevant clinical team
- A statement is required form a staff member who no longer works for the Trust or who is employed by an Agency.

RED
Response in
60 days

Red - Response in 60 working days

- Adverse outcome or SII, CR or LR running alongside the complaint.
- Very complex and involving more than 4 Services
- Contact with the media confirmed / suggested
- Patient is vulnerable and complainant suggests neglect or abuse by staff.

What happens when a complainant is not satisfied with the response?

Salisbury NHS Foundation Trust

Further meeting may be offered

Parliamentary and Health Service Ombudsman

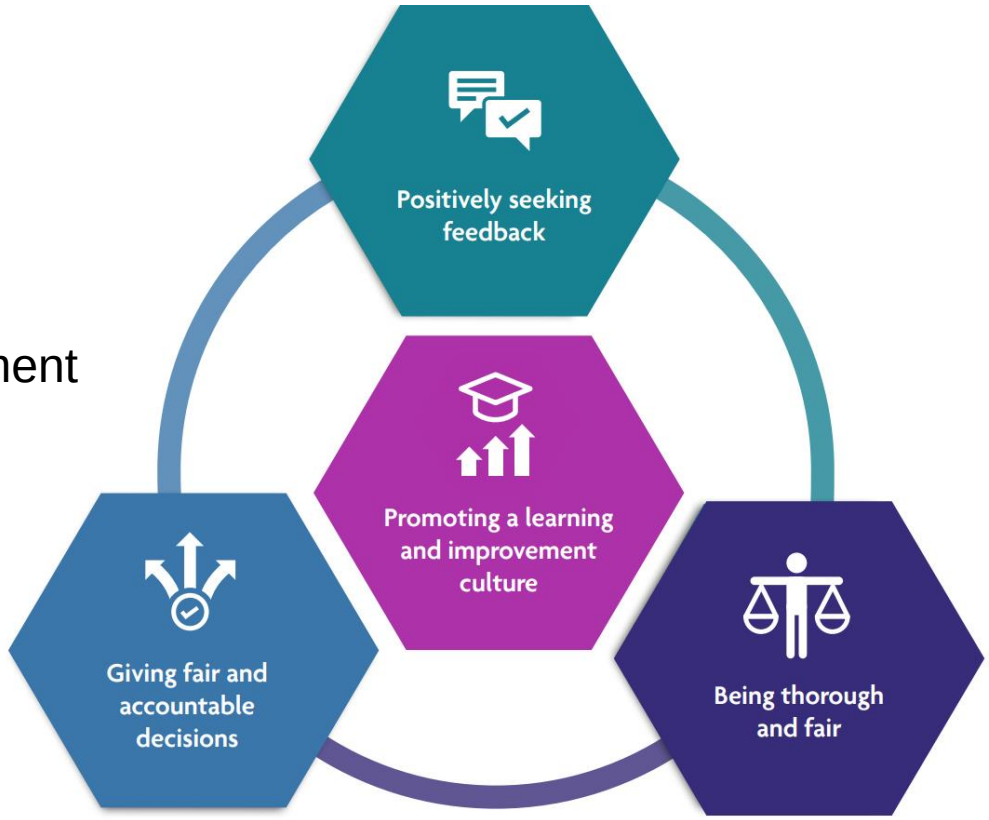
Referral to the Parliamentary and Health Service Ombudsman

Complainant may wish to take legal action and would be advised to seek independent representation.
The SFT legal team would be informed of the complaint details at this stage

Principles of the New PHSO Complaints Framework

Summary of the key focuses of the new Framework

- Early resolution
- Meaningful apology
- Full and thorough investigation
- Promotion of learning and improvement culture
- Training and support for staff



Source: [Complaint_Standards_Framework-Summary_of_core_expectations .pdf (ombudsman.org.uk)]

Our journey so far…

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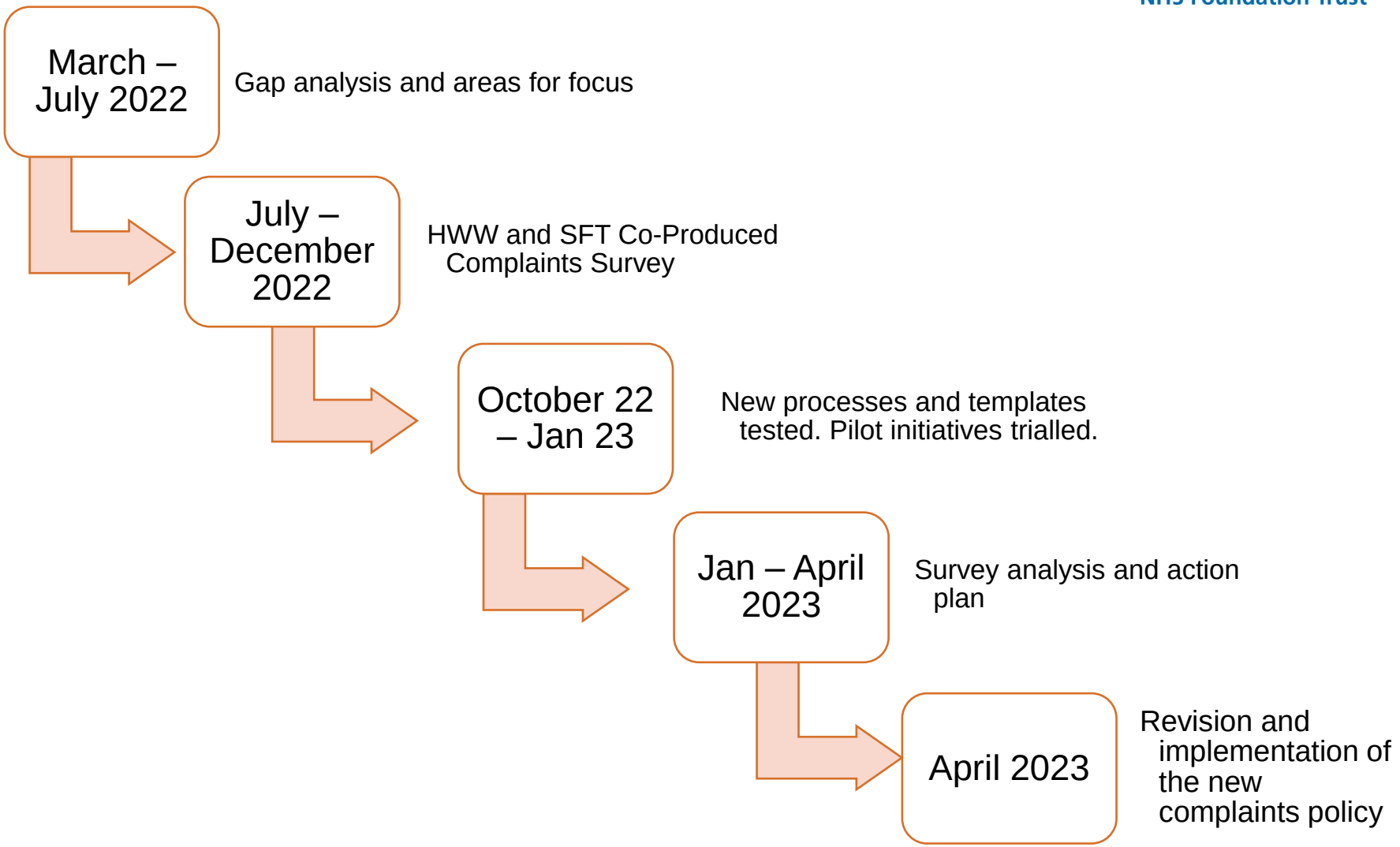


HWW and SFT Co-Produced Complaints Survey

What we did:

50%

Response rate target

90

Participants to be invited

Criteria = closed complaint between 1st of January 2022 and 30th June 2022

Process and resources co-produced in partnership

Options offered for completion of the survey include by post, over the phone or online

Quantitative questions with option for open narrative to include qualitative analysis

Equal opportunities information collected

Principles of the New PHSO Complaints Framework

Salisbury NHS Foundation Trust

A user led vision for raising concerns and complaints

Source: [Complaint_Standards_Framework-Summary_of_core_expectations .pdf (ombudsman.org.uk)]

Complaints Survey Results

NHS Salisbury NHS Foundation Trust

86% 

Did not feel their final response contained a meaningful apology

82% 

Did not feel reassured that learning was taken following their complaint

68% 

Did not feel they were kept informed about the progress of their complaint

63% 

Did not feel that they were made properly aware of the support that was available to help them make their complaint

Responses indicated that the way the complaint is handled, as much as its outcome, defined the experience of the complainant.

PALS was not always immediately recognised, or its function fully understood

So what do we want to change?

Salisbury NHS Foundation Trust

- ✓ Training for staff and awareness of the complaints process – all staff should understand and be able to explain the role of PALS
- ✓ Improve accountability and complaints ownership – working closer with our Division colleagues
- ✓ Better communication throughout the complaints process, particularly if original timescales may not be met
- ✓ Working with complainants to better:
  - ✓ Identify potential communication barriers
  - ✓ They are fully informed of available advocacy and support services
  - ✓ Support them to clearly define what answers and outcomes they want
- ✓ Improved outcomes recording so that we can publicise and celebrate improvements made to services as a direct result of complaints raised e.g., "*you said, we did…*"

NEW* 48 Hour Complaints Review

Salisbury NHS Foundation Trust

Same day/next working day

Complaint documented by PALS

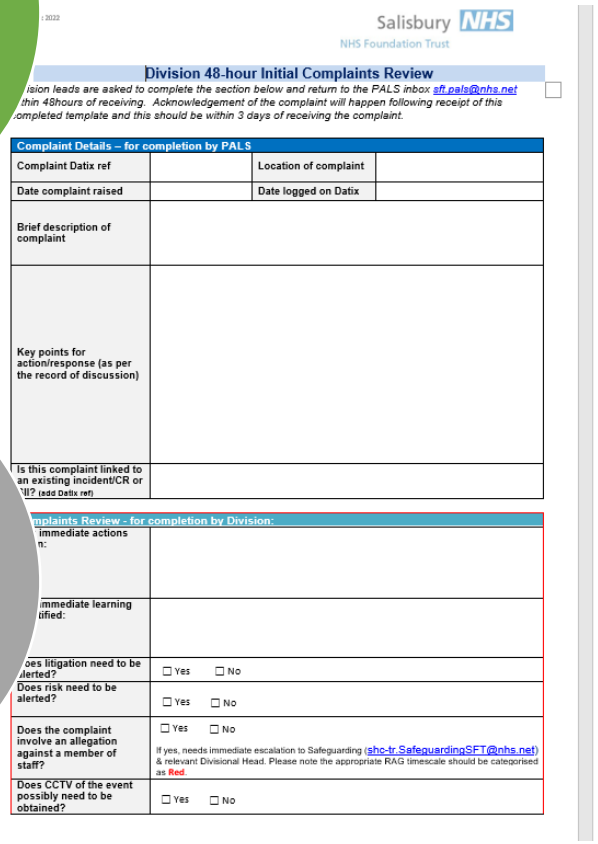
First section of Complaint Review form completed and sent to Division Leads with record of discussion or complaint letter

Within 2 working days

Complaint is reviewed and second and third sections of the Complaint Review form is completed.

Form is returned to PALS to alert relevant departments and send acknowledgement letter with response timescale

*allegations against staff must be notified to the safeguarding team immediately.



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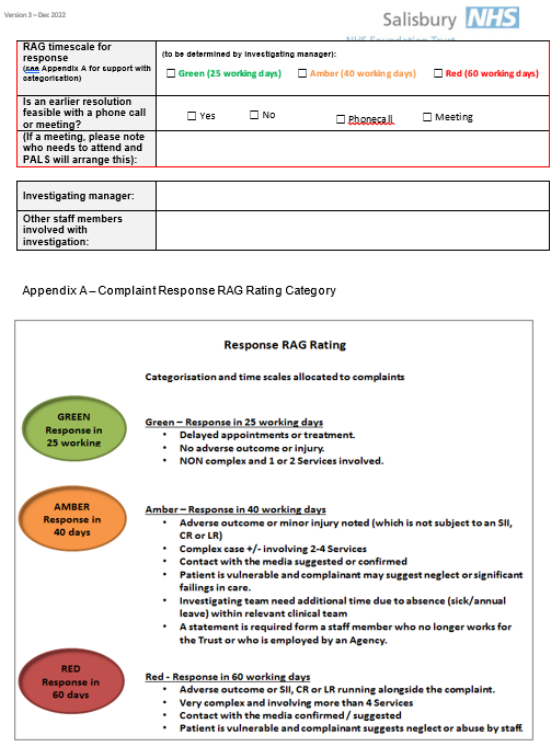
Division 48-hour Initial Complaints Review

ision leads are asked to complete the section below and return to the PALS inbox sft.pals@nhs.net thin 48hours of receiving. Acknowledgement of the complaint will happen following receipt of this completed template and this should be within 3 days of receiving the complaint.

Complaint Details – for completion by PALS			
Complaint Datix ref		Location of complaint	
Date complaint raised		Date logged on Datix	
Brief description of complaint			
Key points for action/response (as per the record of discussion)			
Is this complaint linked to an existing incident/CR or SII? (add Datix ref)			

mplaints Review - for completion by Division:	
immediate actions n:	
immediate learning tified:	
oes litigation need to be lerted?	☐ Yes ☐ No
Does risk need to be alerted?	☐ Yes ☐ No
Does the complaint involve an allegation against a member of staff?	☐ Yes ☐ No If yes, needs immediate escalation to Safeguarding (shc-tr.SafeguardingSFT@nhs.net) & relevant Divisional Head. Please note the appropriate RAG timescale should be categorised as Red.
Does CCTV of the event possibly need to be obtained?	☐ Yes ☐ No



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RAG timescale for response (see Appendix A for support with categorisation)	(to be determined by investigating manager): ☐ Green (25 working days) ☐ Amber (40 working days) ☐ Red (60 working days)
Is an earlier resolution feasible with a phone call or meeting?	☐ Yes ☐ No ☐ Phone call ☐ Meeting
(If a meeting, please note who needs to attend and PALS will arrange this):	

Investigating manager:	
Other staff members involved with investigation:	

Appendix A – Complaint Response RAG Rating Category

Response RAG Rating

Categorisation and time scales allocated to complaints

GREEN Response in 25 working

Green – Response in 25 working days
- Delayed appointments or treatment.
- No adverse outcome or injury.
- NON complex and 1 or 2 Services involved.

AMBER Response in 40 days

Amber – Response in 40 working days
- Adverse outcome or minor injury noted (which is not subject to an SII, CR or LR)
- Complex case +/- involving 2-4 Services
- Contact with the media suggested or confirmed
- Patient is vulnerable and complainant may suggest neglect or significant failings in care.
- Investigating team need additional time due to absence (sick/annual leave) within relevant clinical team
- A statement is required form a staff member who no longer works for the Trust or who is employed by an Agency.

RED Response in 60 days

Red - Response in 60 working days
- Adverse outcome or SII, CR or LR running alongside the complaint.
- Very complex and involving more than 4 Services
- Contact with the media confirmed / suggested
- Patient is vulnerable and complainant suggests neglect or abuse by staff.

Managing a complaint

Top Tips from our Complaints Handlers

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- **Listen, understand and value** – listen with empathy, understand what the issues are. What do they want the outcome to be? Thank them for raising their issue.
- **Early resolution** – what information can we find out easily now? What actions can we take now? What method of response is the most appropriate?
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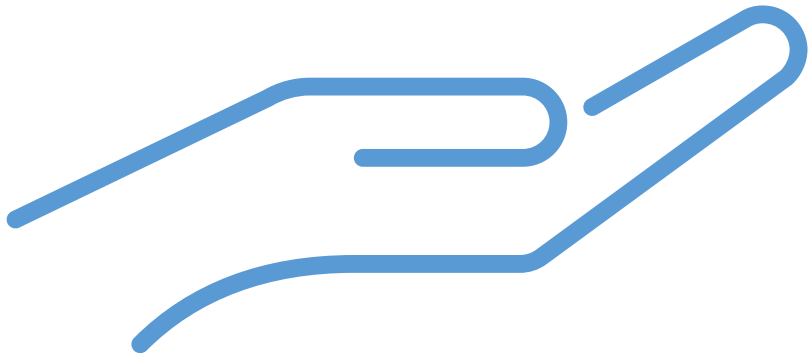
Ask for help – if you're struggling with how to respond to a complaint then talk to us – we're here to help!

Lastly, trying to put yourself in their shoes…

Empathy: The Human Connection to Patient Care - YouTube



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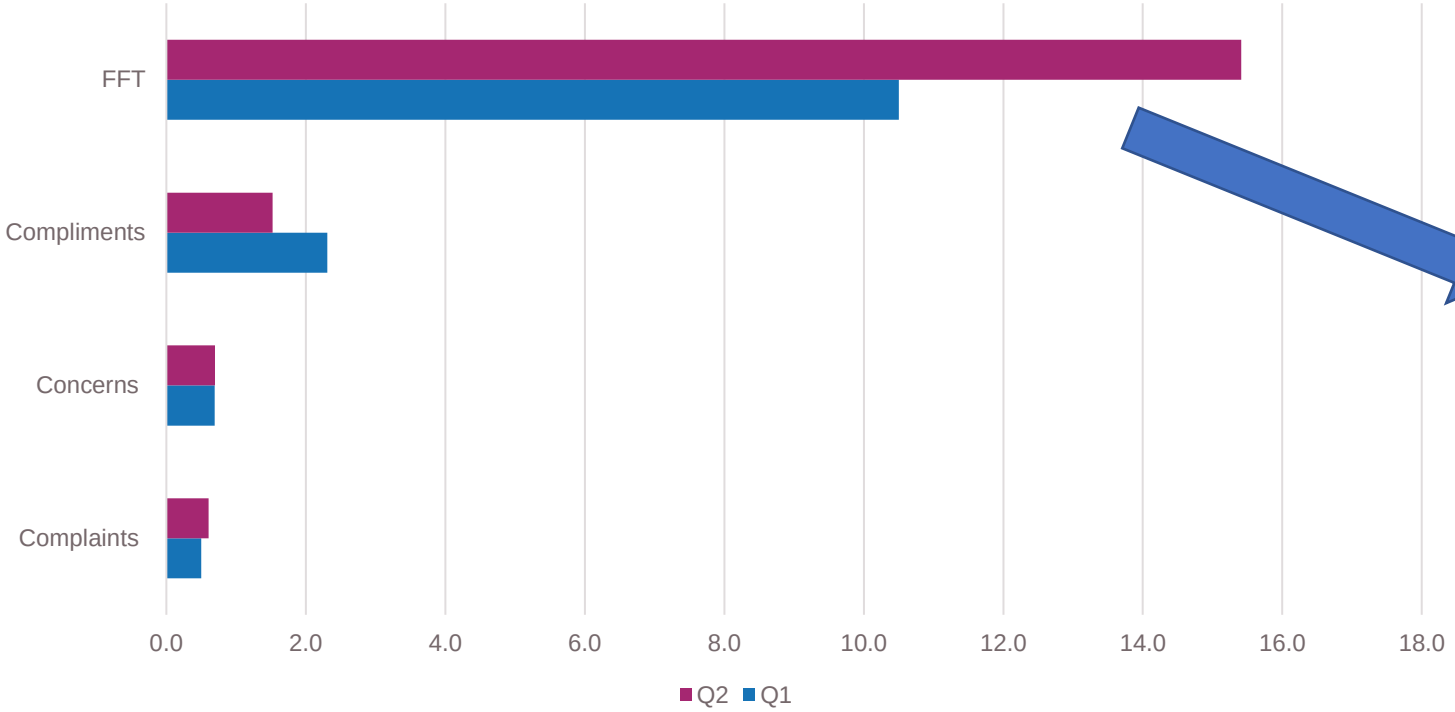
Any questions?

Its not all doom and gloom!

Salisbury NHS Foundation Trust

Figure 1.1 Total Number of Complaints, Concerns, Compliments and Friends and Family Feedback. (per 1,000 of total Trust activity)



97.5%

Of those who completed an FFT form rated their experience as either Good or Very Good

Day surgery unit outpatients

PATIENT FEEDBACK

Absolutely outstanding.
I was treated with care, compassion, warmth, reassurance, kindness and dignity.
I felt safe, valuable and an overall sense of complex gratitude.
I have no words to express how humble I am to have received this care.
Forever in your deb

Tisbury ward

PATIENT FEEDBACK

All staff were very confident, efficient, respectful, friendly, supportive, cheerful and diligent.
I knew I was in good hands and in the best place.
Questions were answered and all procedures explained fully.
Visitors were made to feel welcome. There was a good choice of tasty food.
Thank you. Thank you. Thank you.

Durrington ward

PATIENT FEEDBACK

Excellent, friendly, helpful staff who went above and beyond to make things as comfortable as possible.
They also kept me well informed about all that was going on.

Mammography

PATIENT FEEDBACK

All staff were extremely kind and patient which made quite a daunting experience much easier.
Thank you.

#FeedbackThursday

#ThankyouFriday

Patient Centred & Safe | Professional | Responsive | Friendly | Progessive

Other ways to feedback

NHS Salisbury NHS Foundation Trust

- ✓ Friends and Family Test (FFT)
- ✓ NHS Choices
- ✓ Real Time Feedback – relaunching Feb 2023
- ✓ Local and National Surveys
- ✓ Patient and Public Involvement Initiatives

SOX Sharing Outstanding Excellence

sft.sox@nhs.net

Feedback on care or services that are delivered well **is just as important** as feedback on when we haven't got it quite right.

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National Inpatient Survey Results 2021

CQC Benchmark Report:

https://nhssurveys.org/all-files/02-adults-inpatients/05-benchmarks-reports/2021/

Summary of comparisons

Salisbury NHS Foundation Trust

134 NHS Acute Trusts involved

62, 235 Total responses received (return rate of 39.5%)

585 Total responses received for SFT

48.07% Response rate

No. of questions where SFT scored better than other Trusts = 0

No. of questions where SFT scored about the same as other Trusts = 45

No. of questions where SFT scored worse or somewhat worse than other Trusts = 2*

Q5.4 Were you ever prevented from sleeping at night by hospital lighting?

Q15 During your time in hospital, did you get enough to drink?

Summary – areas for attention

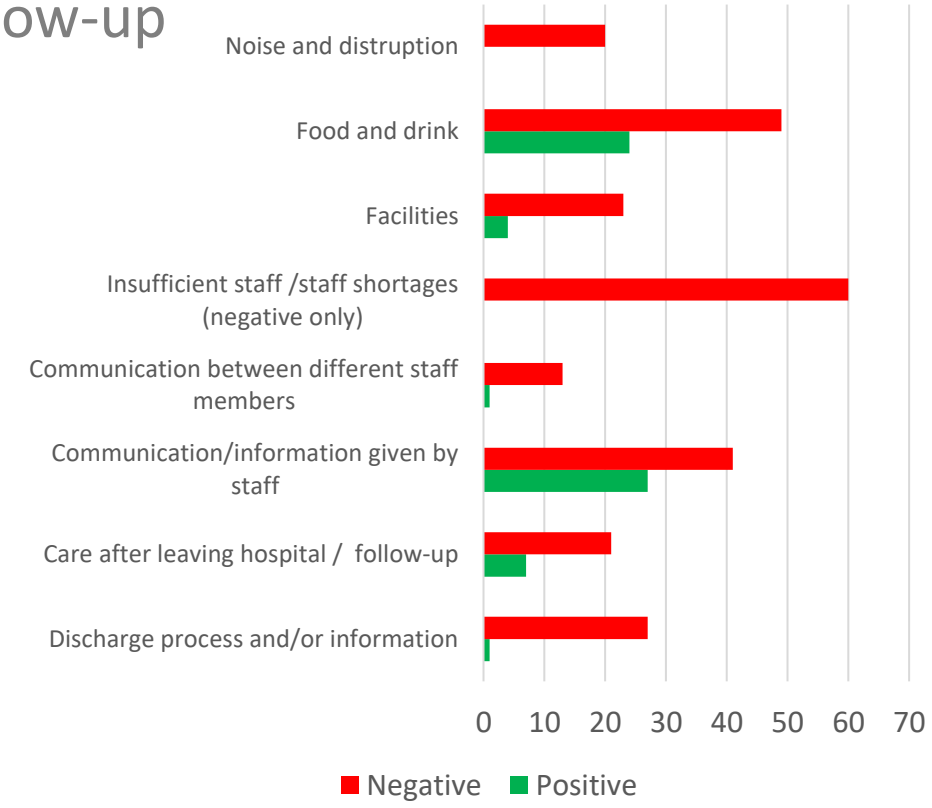
Salisbury NHS Foundation Trust

Discharge process and follow-up

Communication

Staffing levels

Food and drink, noise and disruption, facilities



PALS Services

we are so much more than just complaints !

Salisbury NHS Foundation Trust

Patient clothing & TV cards – provided by the Stars Appeal

Friends and Family Tests

Message to a loved one

Virtual visiting

Interpreting Services

Lost property

PALS Outreach Services

Patient engagement

Hearing Aid Batteries
(new for Sept 2022)

Insurance forms

Your Views Matter Bereavement survey
(new for July 2022)

Compliments

Patient Centred & Safe | **Professional** | **Responsive** | **Friendly** | **Progessive**

NHS
Salisbury
NHS Foundation Trust

Any questions?

NHS
Salisbury
NHS Foundation Trust

PALS information:

PALS Office - Block 62
Green Entrance

Direct dial: 01722 429044
Extension - 5244

sft.pals@nhs.net

24th March 2023

NHS
Salisbury
NHS Foundation Trust

Senior Clinician Leadership Development Programme

Introduction to Complaints

Victoria Aldridge - Head of Patient Experience
Judith Leach – Head of Legal Services (Barrister)

Session key points

Salisbury NHS Foundation Trust

- ✓ Complaints – The NHS Pledge to complaints and redress
- ✓ Common themes for complaints
- ✓ What have we learnt about communication
- ✓ SFTs current complaints process
- ✓ What happens when a complainant is unsatisfied with the outcome
- ✓ Saying sorry, Do’s and Don'ts!
- ✓ Apologising and liability – myth busting from our legal team
- ✓ What about when we didn’t make a mistake?
- ✓ Tips for managing a complaint
- ✓ PALS – we are more than just complaints!
- ✓ Contact details

The NHS pledge to complaint and redress

Salisbury NHS Foundation Trust

Source: NHS Constitution for England

Complainants are treated with courtesy and receive appropriate support throughout the handling of a complaint; and that the fact that they have complained will not adversely affect their future treatment

When mistakes happen or if patients are harmed while receiving health care they receive an appropriate explanation and apology, delivered with sensitivity and recognition of the trauma they have experienced, and know that lessons will be learned to help avoid a similar incident occurring again

The organisation learns lessons from complaints and claims and uses these to improve NHS services

What are the most common themes for complaints?

NHS Salisbury NHS Foundation Trust

Patient Care

Values and behaviours of staff

Communication

Access to treatment

What have we learnt about complaints?

NHS Salisbury NHS Foundation Trust

1. Communication will probably always be our greatest challenge
2. Reality does not always meet expectations
   Fawlty Towers: An Interesting View
3. Right process, but right communication?
4. Relationships are key – *patients don't want to complain about people they like!*
5. Early resolution of the small things can make a huge difference
6. Empathy – try to understand someone else's point of view Empathy: The Human Connection to Patient Care - YouTube

Current Complaint Process

NHS
Salisbury
NHS Foundation Trust

Complaint comes in

Record of discussion taken, key points and defining of outcomes

48hr template sent to Division leads.

Template is returned with RAG response, next actions for investigation and identification of early resolution

Investigations and statements are undertaken, learning identified and response drafted/ meeting arranged

Holding letter may be sent with extended timeframe if RAG response time is exceeded

Actions and responses are revied by PALS and response has second review with the Quality Team

Response is send to complainant

Meeting may be arranged instead of response letter to discuss and address the points of the complaint

RAG Status	
Green	25 w/days
Amber	40 w/days
Red	60 w/days

The complainant is not satisfied

What happens next?

NHS Salisbury NHS Foundation Trust

Further meeting may be offered

Parliamentary and Health Service Ombudsman

Referral to the Parliamentary and Health Service Ombudsman

Complainant may wish to take legal action and would be advised to seek independent representation.

The legal team would be informed of the complaint details at this stage if not alerted already.

Saying sorry…

NHS
Salisbury
NHS Foundation Trust

- ✓ Is always the right thing to do
- ✓ Is not an admission of liability
- ✓ Acknowledges that something could have gone better
- ✓ Is the first step to learning from what happened and preventing it recurring

Source: NHS Resolutions – publication 2018

Do's and Don'ts

Source: NHS Resolutions – publication 2018

NHS Salisbury NHS Foundation Trust

Do say:

- ✓ I'm sorry … happened
- ✓ We're truly sorry for the distress caused
- ✓ I'm sorry, we have learned that…

Don't say:

- ✗ I'm sorry you feel like that
- ✗ We're sorry if you're offended
- ✗ I'm sorry you took it that way
- ✗ We're sorry, but...

What if we didn't make a mistake – why are we apologising?

Salisbury NHS Foundation Trust

Making a complaint for most, is a last resort and takes time, effort and sometimes courage.

Apologising can be a powerful tool to reconcile a relationship and to initiate the restoration of trust.

Is being right more important than their resolution?

Are you winning the battle, but losing the war?

Sometimes, we have to take one for the team

An apology vs accepting liability

NHS Salisbury NHS Foundation Trust

Apology ≠ Liability

One does not equate to the other

Do not let the fear of litigation prevent an apology

Duty of candour is a statutory and regulatory requirement

Some caveats…

NHS Salisbury NHS Foundation Trust

- Apology with admissions of causation should have evidential backing

When it is not clear an error has caused the damage either:

- Obtain specialist view to confirm
- Advise if the short term and long term effect is unclear.

Should a claim be pursued – The Trust's acceptance of causation can be used by a claimant and is more difficult to address.

This can send a patient down the litigation route unnecessarily.

Managing a complaint

Top Tips from our Complaints Handlers

NHS
Salisbury
NHS Foundation Trust

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NHS
Salisbury
NHS Foundation Trust

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Message to a loved one

Virtual visiting

Patient engagement initiatives

Accessibility and Interpreting Services

PALS Outreach Services

Lost property

Real-time Feedback (RTF)

Your Views Matter Bereavement survey

Hearing Aid Batteries

Insurance forms

Patient Stories

Compliments

Local and National Surveys

Any questions?

NHS
Salisbury
NHS Foundation Trust

Victoria Aldridge

PALS Office - Block 62, SDH North
Green Entrance

Telephone: 01722 336262
Extension - 5246

Victoria.aldridge3@nhs.net

Judith Leach

Legal Dept - Block 24, SDH South

Direct dial: 01722 425 169
Extension – 2169 / 2030

Judith.leach1@nhs.net

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Salisbury
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NHS
Salisbury
NHS Foundation Trust

Patient Experience

Introduction to Complaints and Communications Skills

January 2023

Victoria Aldridge - Head of Patient Experience
Sophie Brookes – PALS Lead

Session key points

NHS
Salisbury
NHS Foundation Trust

- ✓ Who can make a complaint
- ✓ Common complaints and examples
- ✓ SFT's complaints process
- ✓ What happens when a complaint cannot be resolved?
- ✓ Introduction to the new Parliamentary Health Service Ombudsman(PHSO) framework
- ✓ Healthwatch Wiltshire Complaints Review Project
- ✓ Improvements and changes we are making to the complaints process
- ✓ Tips for managing a complaint

NHS
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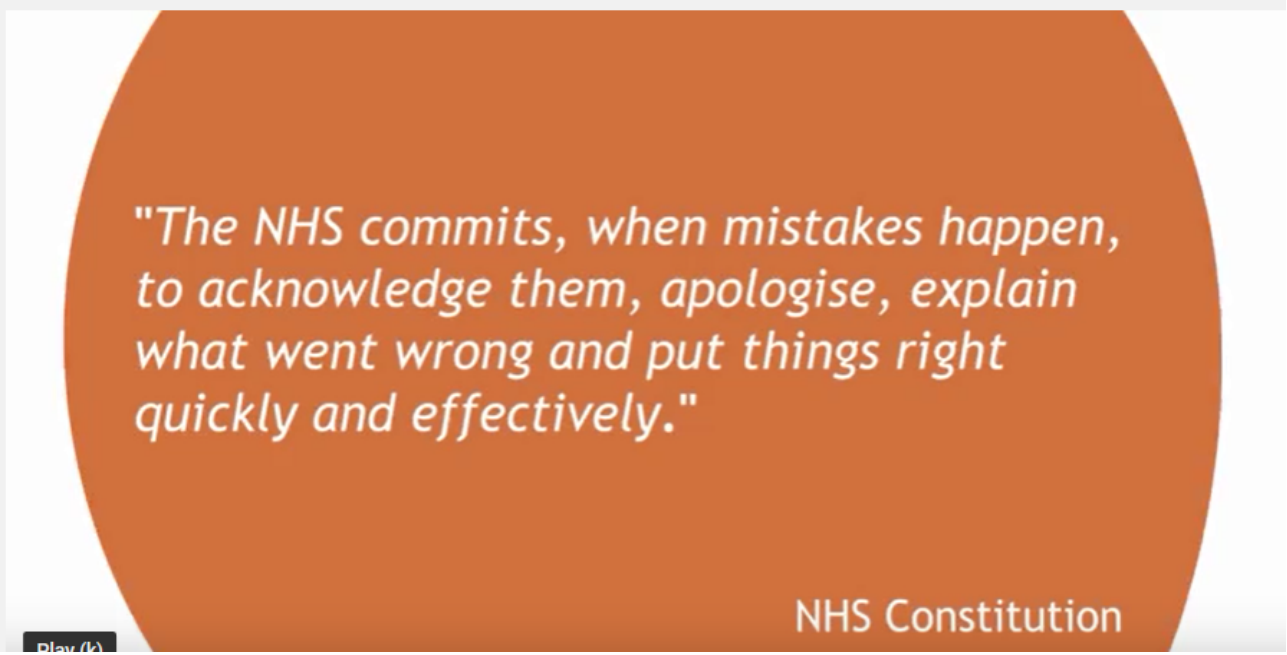
NHS Foundation Trust

Complaint Handling



NHS
Salisbury
NHS Foundation Trust

Why are complaints important?

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- To enable our staff to deal with comments, concerns or complaints from patients, carers or members of the public
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- To improve the services we offer

Who can raise a complaint?

NHS
Salisbury
NHS Foundation Trust

- ✓ Patients
- ✓ Carers/relatives
- ✓ Visitors
- ✓ MP, acting on behalf of and by instruction from a constituent.
- ✓ Members of hospital staff and other health professionals including the General Practitioner may also complain about aspects of a patient's care or raise it through the **Freedom to Speak Up: Raising Concerns Policy**.
- ✓ Commissioners
- ✓ Advocacy Service on behalf of a patient.

What are our most common causes for complaints?

Salisbury NHS Foundation Trust

Communication (lack of or poor)

Attitude of staff

Delays (in treatment, diagnosis or appointments)

Unsatisfied with quality of care or outcome of treatment

Source: Complaints data Q3 & Q4 2021/22 and Q1 & Q2 2022/23.

Why do people complain?

NHS
Salisbury
NHS Foundation Trust

How do you feel when you receive a complaint?

Discussion Point

Salisbury NHS Foundation Trust

Think about a time when you have had to make a complaint yourself

What made it a poor experience for you?

What made it a positive experience?

NHS
Salisbury
NHS Foundation Trust

A poor example of customer service and communication skills

Courtesy of Mr Basil Fawlty !

SFT's current complaints process

Salisbury NHS Foundation Trust

Complaint/concern comes into PALS (various methods, online, telephone, face to face or via letter)

Consent status checked, review against other policies i.e. allegations against staff or Serious Incident/Clinical Reviews

Complaints coordinator assigned based on Division, Datix entry created and RAG rating assigned

Acknowledgement sent to the complainant within 3 working days advising of timescales, Ombudsman information and advocacy services

Complaint details sent to the appropriate Division/Ward for investigation and response

Meeting may be offered – PALS would facilitate, support and take notes

OR a response is drafted and sent back to PALS

PALS review response before sending to the Director of Integrated Governance and Corporate Governance Manager for second review and then the CEO who signs the response

The signed response comes back to PALS to send out

Complaint is closed on Datix

PALS add any outstanding actions that have come out of the complaint onto the Datix entry with a due date for completion

Response RAG Rating

Categorisation and time scales allocated to complaints

GREEN
Response in 25 working

Green – Response in 25 working days

- Delayed appointments or treatment.
- No adverse outcome or injury.
- NON complex and 1 or 2 Services involved.

AMBER
Response in 40 days

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- Complex case +/- involving 2-4 Services
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RED
Response in 60 days

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NHS Salisbury NHS Foundation Trust

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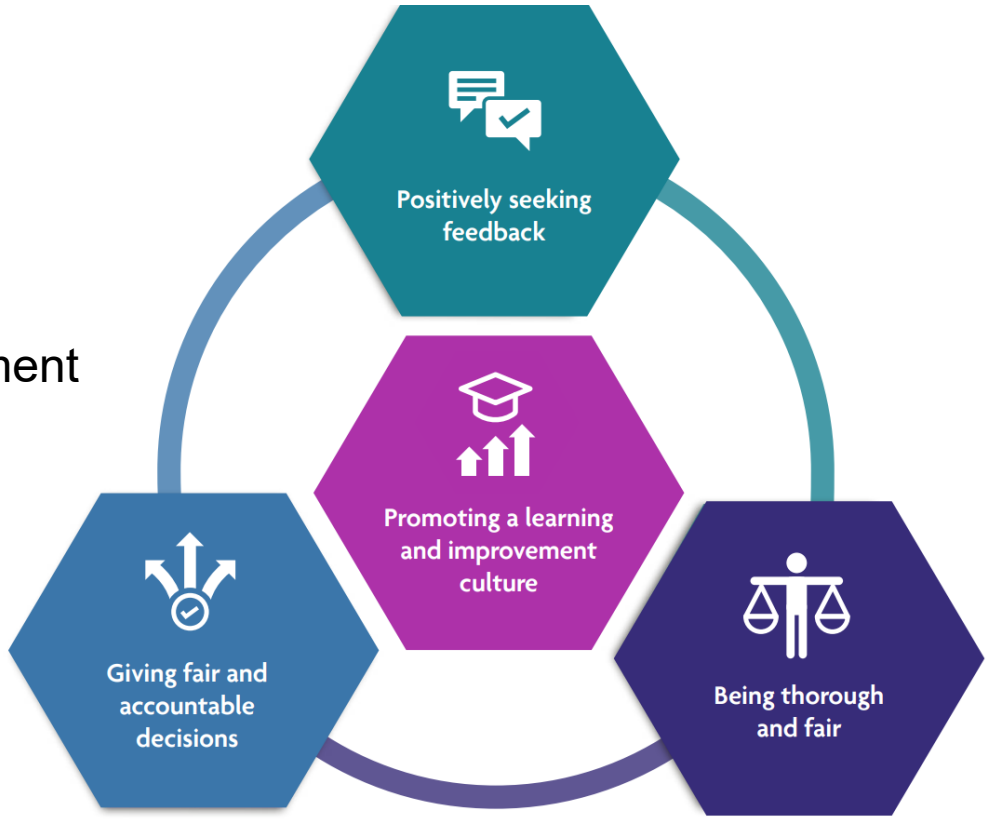
Principles of the New PHSO Complaints Framework

Summary of the key focuses of the new Framework

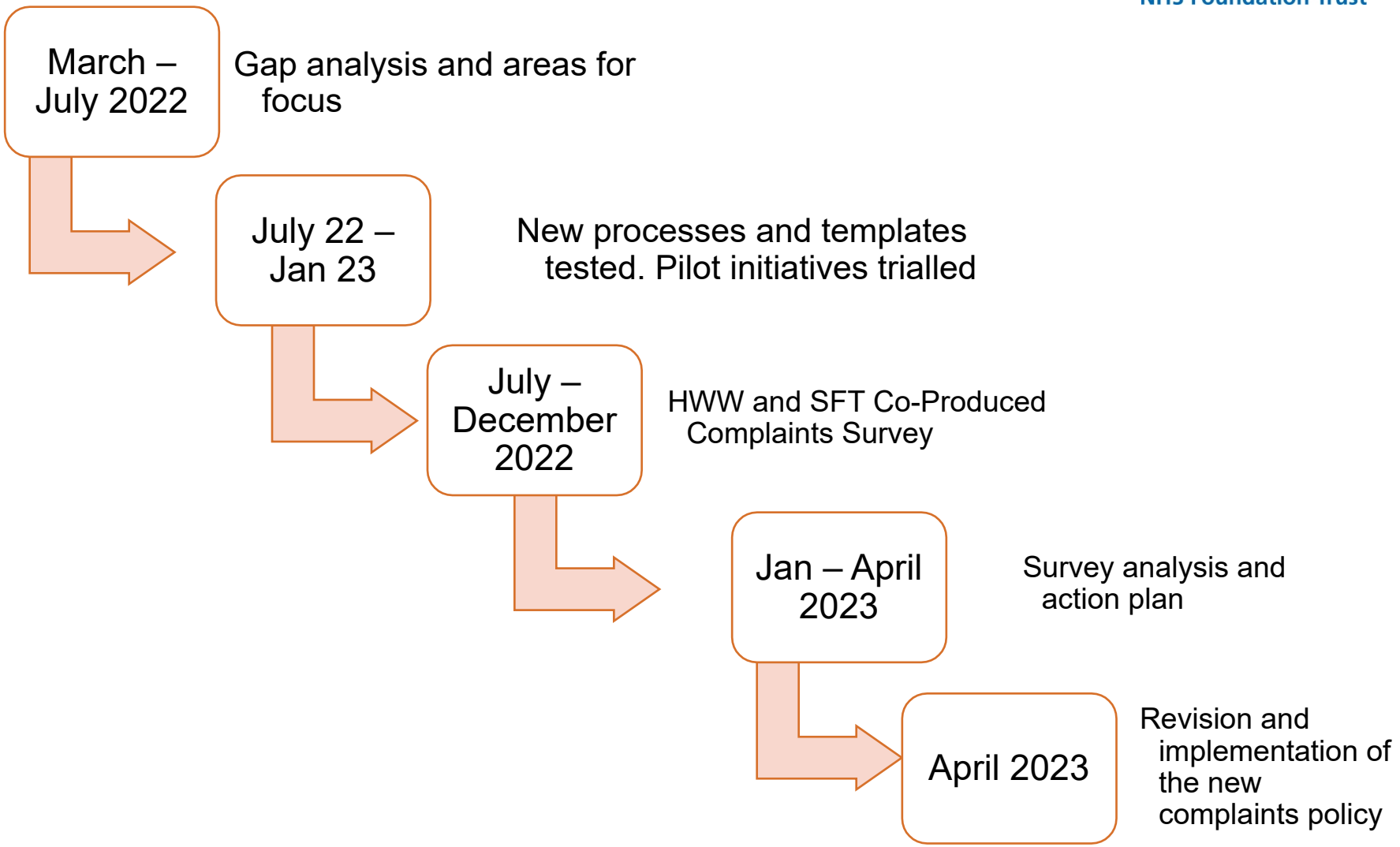
- Early resolution
- Meaningful apology
- Full and thorough investigation
- Promotion of learning and improvement culture
- Training and support for staff



Source: [Complaint_Standards_Framework-Summary_of_core_expectations .pdf (ombudsman.org.uk)]

Our journey so far…

Salisbury NHS Foundation Trust



HWW and SFT Co-Produced Complaints Survey

What we did:

50%

Response rate target

90

Participants to be invited

Criteria = closed complaint between 1st of January 2022 and 30th June 2022

Process and resources co-produced in partnership

Options offered for completion of the survey include by post, over the phone or online

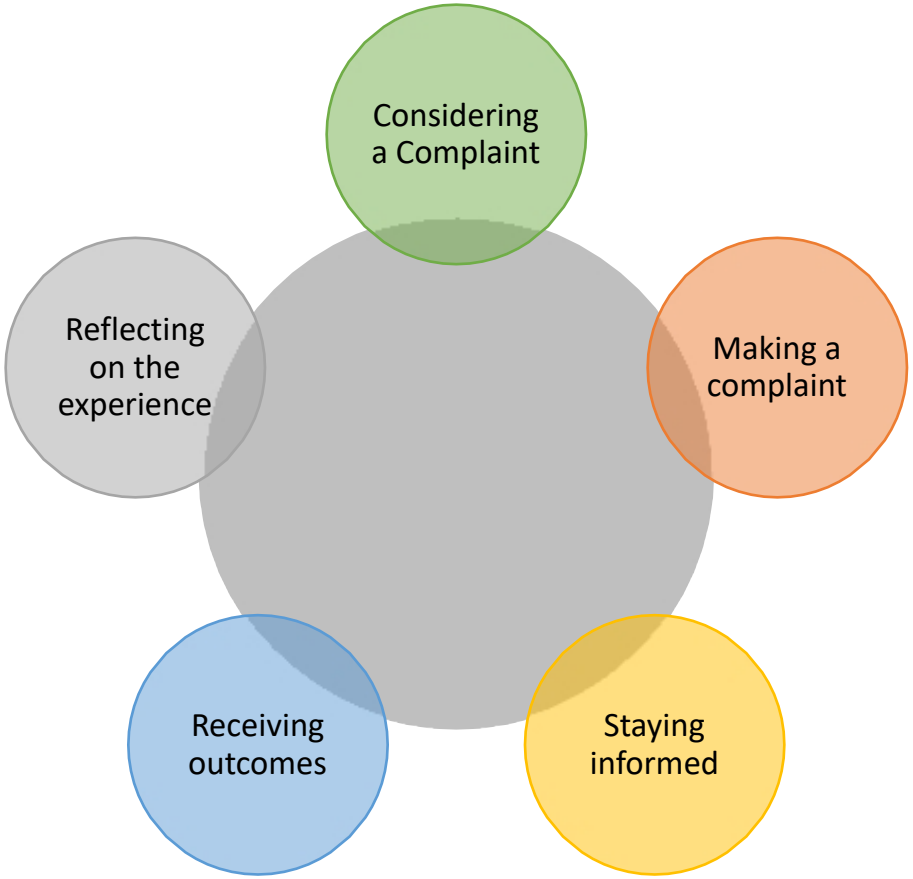
Quantitative questions with option for open narrative to include qualitative analysis

Equal opportunities information collected

Principles of the New PHSO Complaints Framework

A user led vision for raising concerns and complaints

Salisbury NHS Foundation Trust



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Complaints Survey Results

NHS Salisbury NHS Foundation Trust

86% 

Did not feel their final response contained a meaningful apology

82% 

Did not feel reassured that learning was taken following their complaint

68% 

Did not feel they were kept informed about the progress of their complaint

63% 

Did not feel that they were made properly aware of the support that was available to them to make their complaint

Responses indicated that the way the complaint is handled, as much as its outcome, defined the experience of the complainant.

PALS was not always immediately recognised, or its function fully understood

So what do we want to change?

NHS Salisbury NHS Foundation Trust

- ✓ Training for staff and awareness of the complaints process – all staff should understand and be able to explain the role of PALS
- ✓ Improve accountability and complaints ownership – working closer with our Division colleagues
- ✓ Better communication throughout the complaints process, particularly if original timescales may not be met
- ✓ Working with complainants to better:
  - ✓ Identify potential communication barriers
  - ✓ They are fully informed of available advocacy and support services
  - ✓ Support them to clearly define what answers and outcomes they want
- ✓ Improved outcomes recording so that we can publicise and celebrate improvements made to services as a direct result of complaints raised e.g., "*you said, we did…*"

Managing a complaint

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NHS
Salisbury
NHS Foundation Trust

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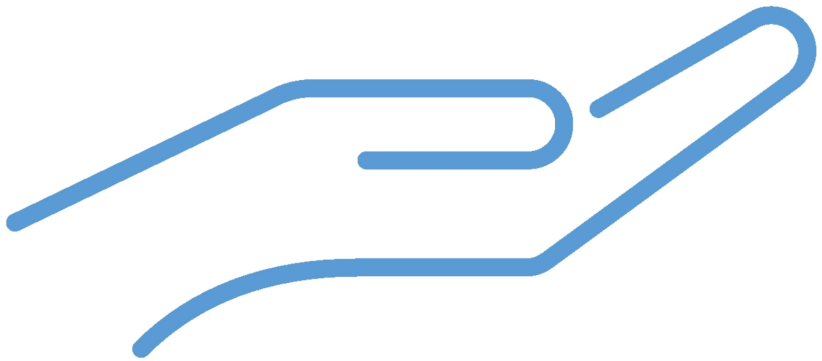

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sft.pals@nhs.net

NHS
Salisbury
NHS Foundation Trust

Patient Experience

Complaints and PALS Services

January 2023

Victoria Aldridge - Head of Patient Experience
Sophie Brookes – PALS Lead

Session key points

Salisbury NHS Foundation Trust

- ✓ The Complaints Process:
  - ✓ Who can make a complaint
  - ✓ Common complaints and examples
  - ✓ SFTs complaints process
  - ✓ What happens when a complaint cannot be resolved?
  - ✓ Introduction to the new Parliamentary Health Service Ombudsman(PHSO) framework
  - ✓ Healthwatch Wiltshire Complaints Review Project
  - ✓ Improvements and changes we are making to the complaints process
  - ✓ Tips for managing a complaint
- ✓ Its not all doom and gloom!
  - ✓ Friends and Family Test and other feedback
  - ✓ National Inpatient Survey Results 2021
  - ✓ PALS services including Patient Engagement
  - ✓ Contact details

Salisbury NHS Foundation Trust

Complaint Handling

NHS
Salisbury
NHS Foundation Trust

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NHS
Salisbury
NHS Foundation Trust

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Salisbury NHS Foundation Trust

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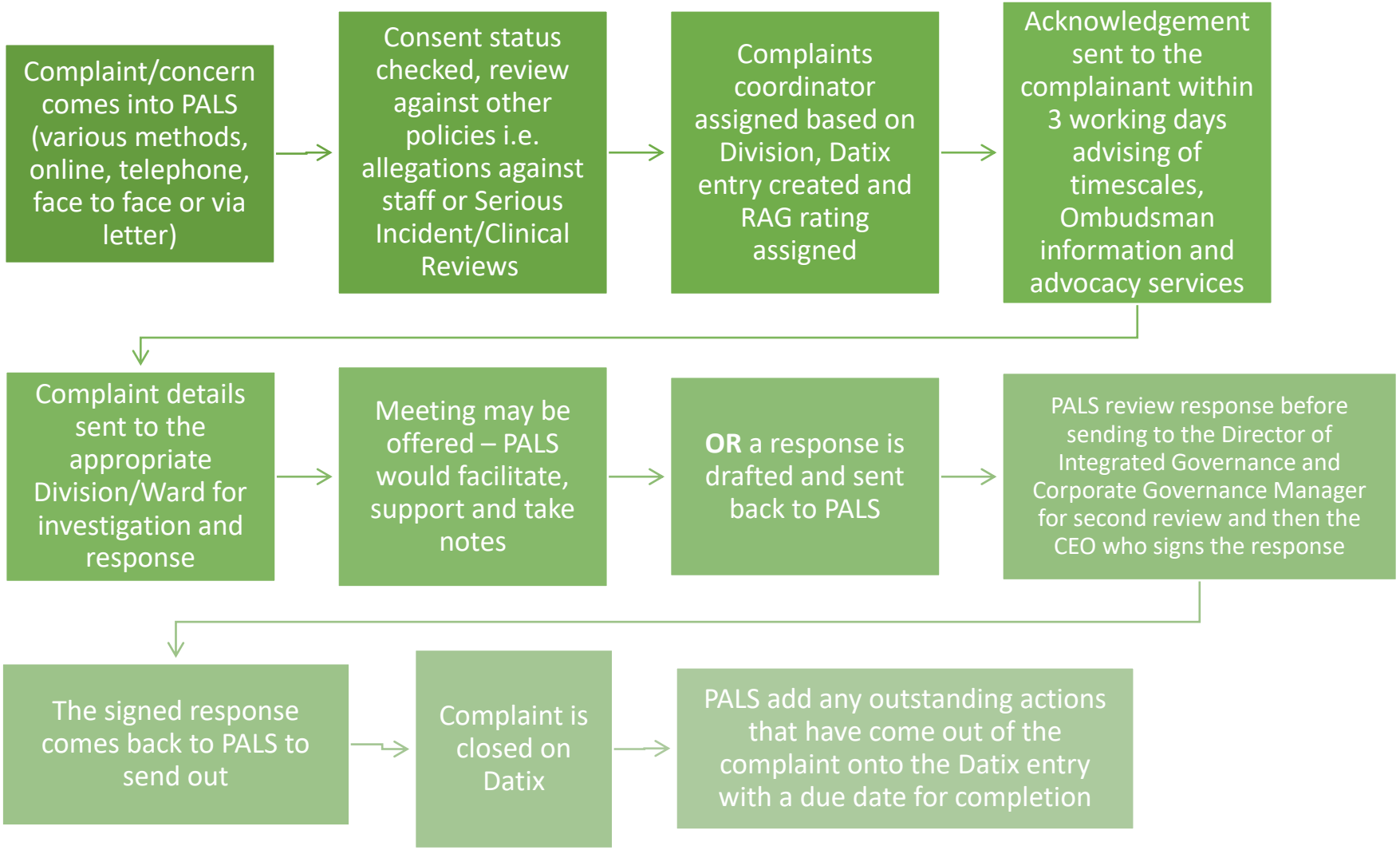
A poor example of complaints management – courtesy of Mr Basil Fawlty !

SFT's current complaints process

NHS Salisbury NHS Foundation Trust



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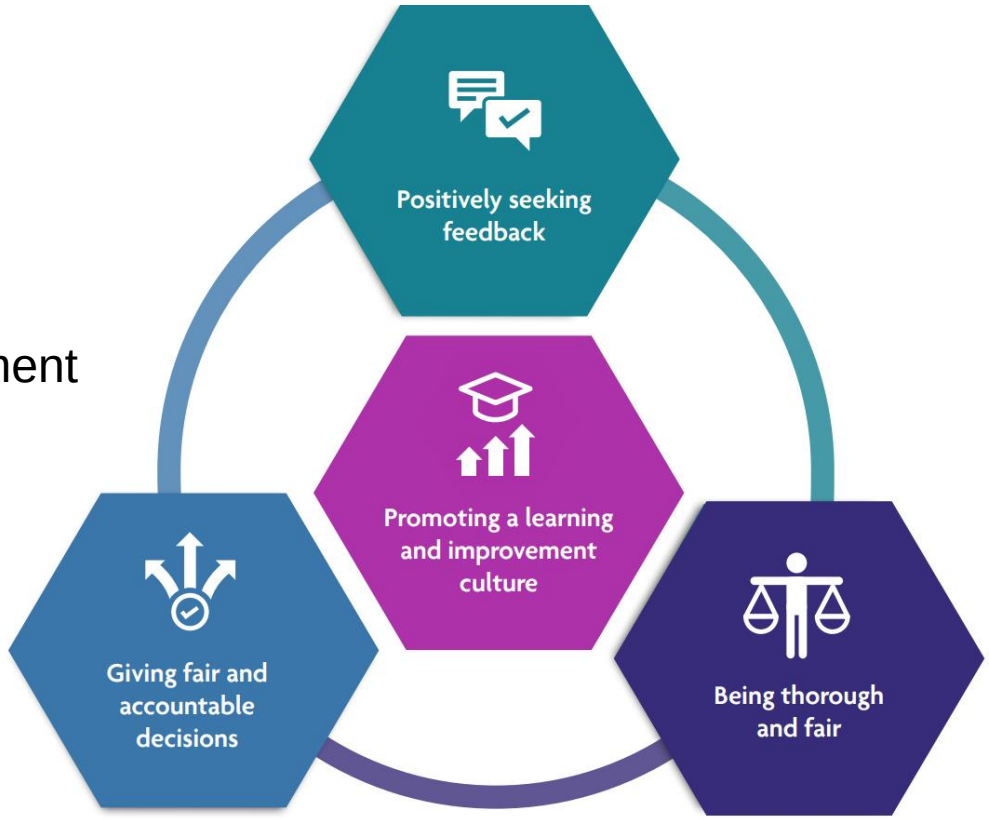

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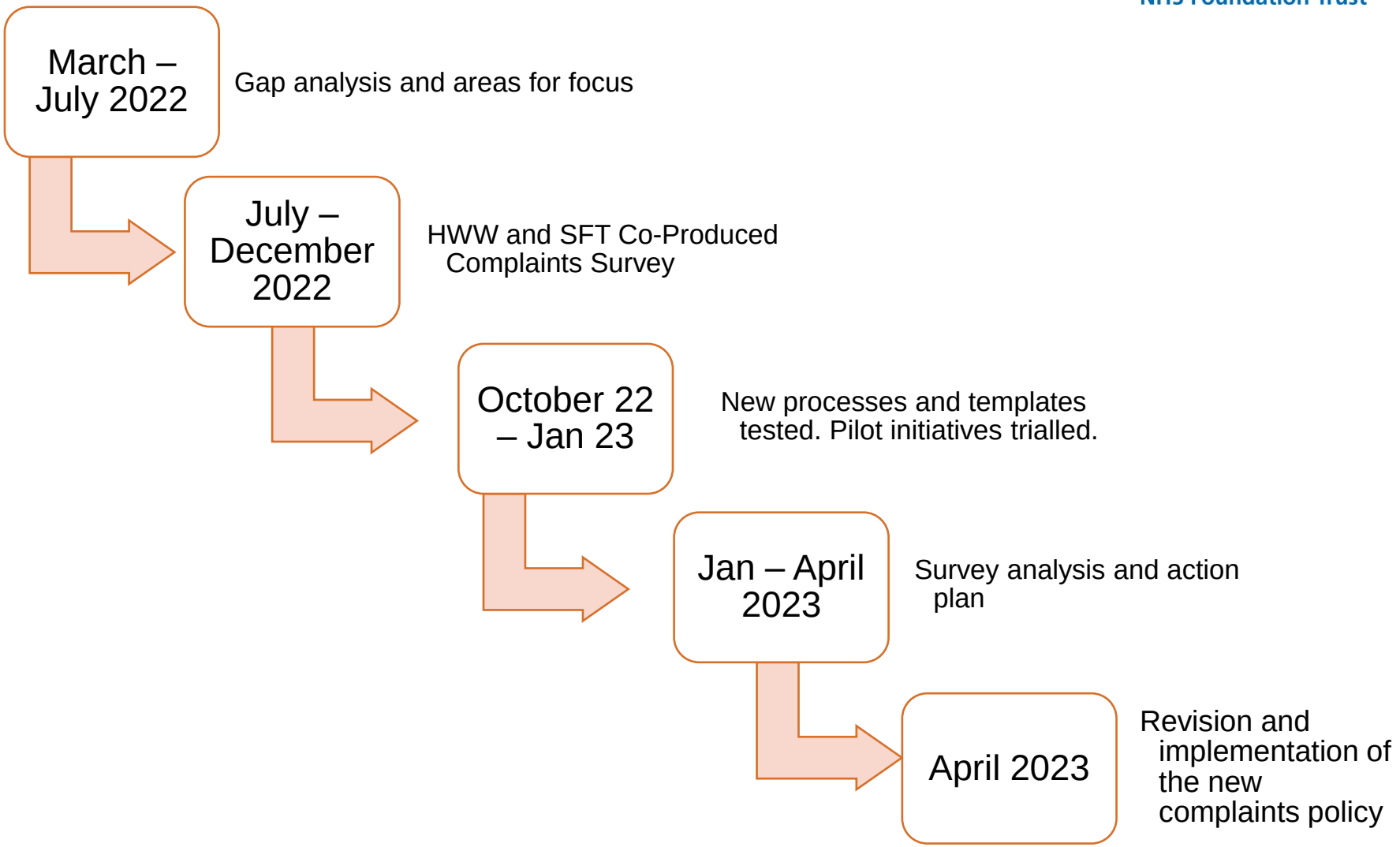
Our journey so far…

Salisbury NHS Foundation Trust



HWW and SFT Co-Produced Complaints Survey

What we did:

50%

Response rate target

90

Participants to be invited

Criteria = closed complaint between 1st of January 2022 and 30th June 2022

Process and resources co-produced in partnership

Options offered for completion of the survey include by post, over the phone or online

Quantitative questions with option for open narrative to include qualitative analysis

Equal opportunities information collected

Principles of the New PHSO Complaints Framework

Salisbury NHS Foundation Trust

A user led vision for raising concerns and complaints

Source: [Complaint_Standards_Framework-Summary_of_core_expectations .pdf (ombudsman.org.uk)]

Complaints Survey Results

NHS Salisbury NHS Foundation Trust

86% 

Did not feel their final response contained a meaningful apology

82% 

Did not feel reassured that learning was taken following their complaint

68% 

Did not feel they were kept informed about the progress of their complaint

63% 

Did not feel that they were made properly aware of the support that was available to help them make their complaint

Responses indicated that the way the complaint is handled, as much as its outcome, defined the experience of the complainant.

PALS was not always immediately recognised, or its function fully understood

So what do we want to change?

Salisbury NHS Foundation Trust

- ✓ Training for staff and awareness of the complaints process – all staff should understand and be able to explain the role of PALS
- ✓ Improve accountability and complaints ownership – working closer with our Division colleagues
- ✓ Better communication throughout the complaints process, particularly if original timescales may not be met
- ✓ Working with complainants to better:
  - ✓ Identify potential communication barriers
  - ✓ They are fully informed of available advocacy and support services
  - ✓ Support them to clearly define what answers and outcomes they want
- ✓ Improved outcomes recording so that we can publicise and celebrate improvements made to services as a direct result of complaints raised e.g., "*you said, we did…*"

NEW* 48 Hour Complaints Review

Salisbury NHS Foundation Trust

Same day/next working day

Complaint documented by PALS

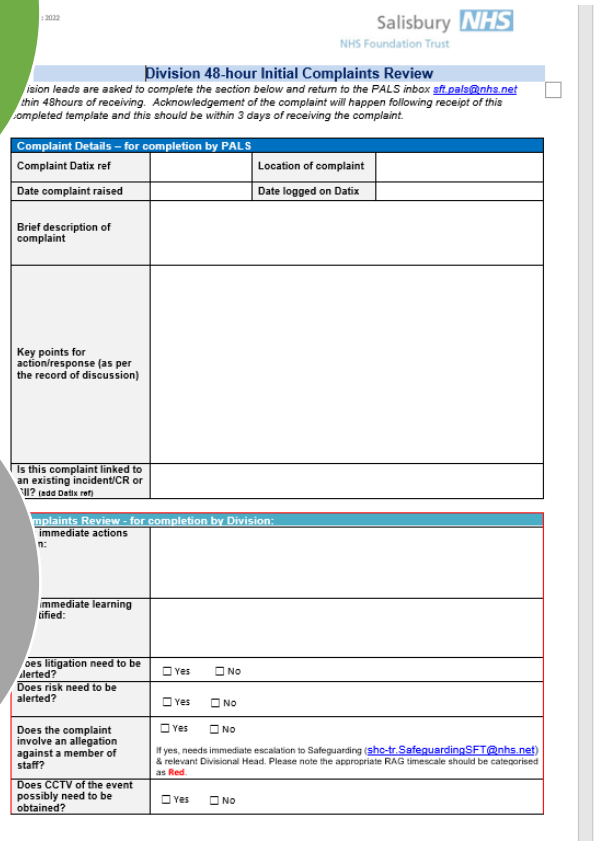
First section of Complaint Review form completed and sent to Division Leads with record of discussion or complaint letter

Within 2 working days

Complaint is reviewed and second and third sections of the Complaint Review form is completed.

Form is returned to PALS to alert relevant departments and send acknowledgement letter with response timescale

*allegations against staff must be notified to the safeguarding team immediately.



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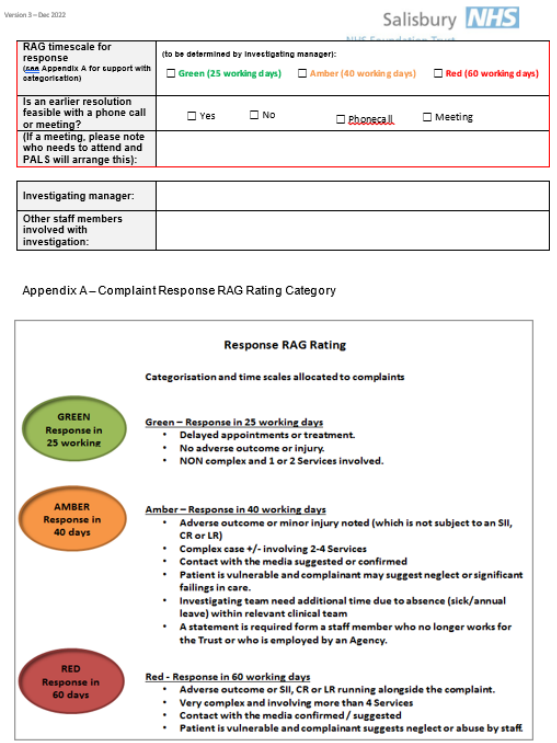
NHS Foundation Trust

Division 48-hour Initial Complaints Review

ision leads are asked to complete the section below and return to the PALS inbox sft.pals@nhs.net thin 48hours of receiving. Acknowledgement of the complaint will happen following receipt of this completed template and this should be within 3 days of receiving the complaint.

Complaint Details – for completion by PALS			
Complaint Datix ref		Location of complaint	
Date complaint raised		Date logged on Datix	
Brief description of complaint			
Key points for action/response (as per the record of discussion)			
Is this complaint linked to an existing incident/CR or SII? (add Datix ref)			

mplaints Review - for completion by Division:	
immediate actions n:	
immediate learning tified:	
oes litigation need to be lerted?	☐ Yes ☐ No
Does risk need to be alerted?	☐ Yes ☐ No
Does the complaint involve an allegation against a member of staff?	☐ Yes ☐ No If yes, needs immediate escalation to Safeguarding (shc-tr.SafeguardingSFT@nhs.net) & relevant Divisional Head. Please note the appropriate RAG timescale should be categorised as Red.
Does CCTV of the event possibly need to be obtained?	☐ Yes ☐ No



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NHS Foundation Trust

RAG timescale for response (see Appendix A for support with categorisation)	(to be determined by investigating manager): ☐ Green (25 working days) ☐ Amber (40 working days) ☐ Red (60 working days)
Is an earlier resolution feasible with a phone call or meeting?	☐ Yes ☐ No ☐ Phone call ☐ Meeting
(If a meeting, please note who needs to attend and PALS will arrange this):	

Investigating manager:	
Other staff members involved with investigation:	

Appendix A – Complaint Response RAG Rating Category

Response RAG Rating

Categorisation and time scales allocated to complaints

GREEN Response in 25 working

Green – Response in 25 working days
- Delayed appointments or treatment.
- No adverse outcome or injury.
- NON complex and 1 or 2 Services involved.

AMBER Response in 40 days

Amber – Response in 40 working days
- Adverse outcome or minor injury noted (which is not subject to an SII, CR or LR)
- Complex case +/- involving 2-4 Services
- Contact with the media suggested or confirmed
- Patient is vulnerable and complainant may suggest neglect or significant failings in care.
- Investigating team need additional time due to absence (sick/annual leave) within relevant clinical team
- A statement is required form a staff member who no longer works for the Trust or who is employed by an Agency.

RED Response in 60 days

Red - Response in 60 working days
- Adverse outcome or SII, CR or LR running alongside the complaint.
- Very complex and involving more than 4 Services
- Contact with the media confirmed / suggested
- Patient is vulnerable and complainant suggests neglect or abuse by staff.

Managing a complaint

Top Tips from our Complaints Handlers

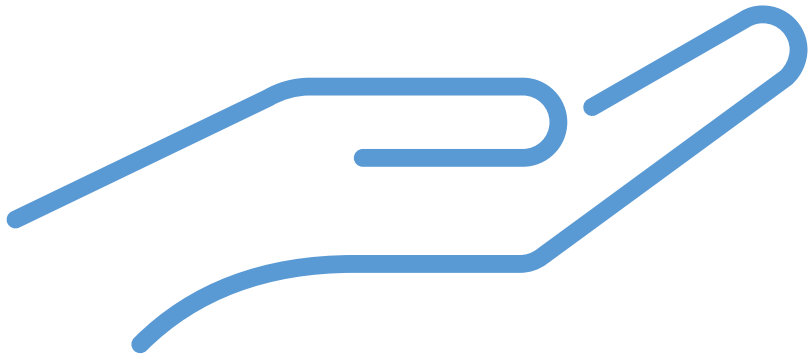
NHS
Salisbury
NHS Foundation Trust

- **Listen, understand and value** – listen with empathy, understand what the issues are. What do they want the outcome to be? Thank them for raising their issue.
- **Early resolution** – what information can we find out easily now? What actions can we take now? What method of response is the most appropriate?
- **Communication** – keep in touch. Don't make promises you cant keep. Stick to timescales and keep the complainant informed, ***especially*** when timescales may not be met. Joining up internal communications where possible for the benefit of the complainant
- **Meaningful apology** – saying sorry **is not** an admission of error or guilt. A meaningful apology is also about demonstrating we have taken actions to prevent this from happening again.
- **Comprehensive and comprehensible** – Ensure you have addressed all of the concerns. Be clear with your language and avoid using jargon or acronyms.

Ask for help – if you're struggling with how to respond to a complaint then talk to us – we're here to help!

Lastly, trying to put yourself in their shoes…

Empathy: The Human Connection to Patient Care - YouTube



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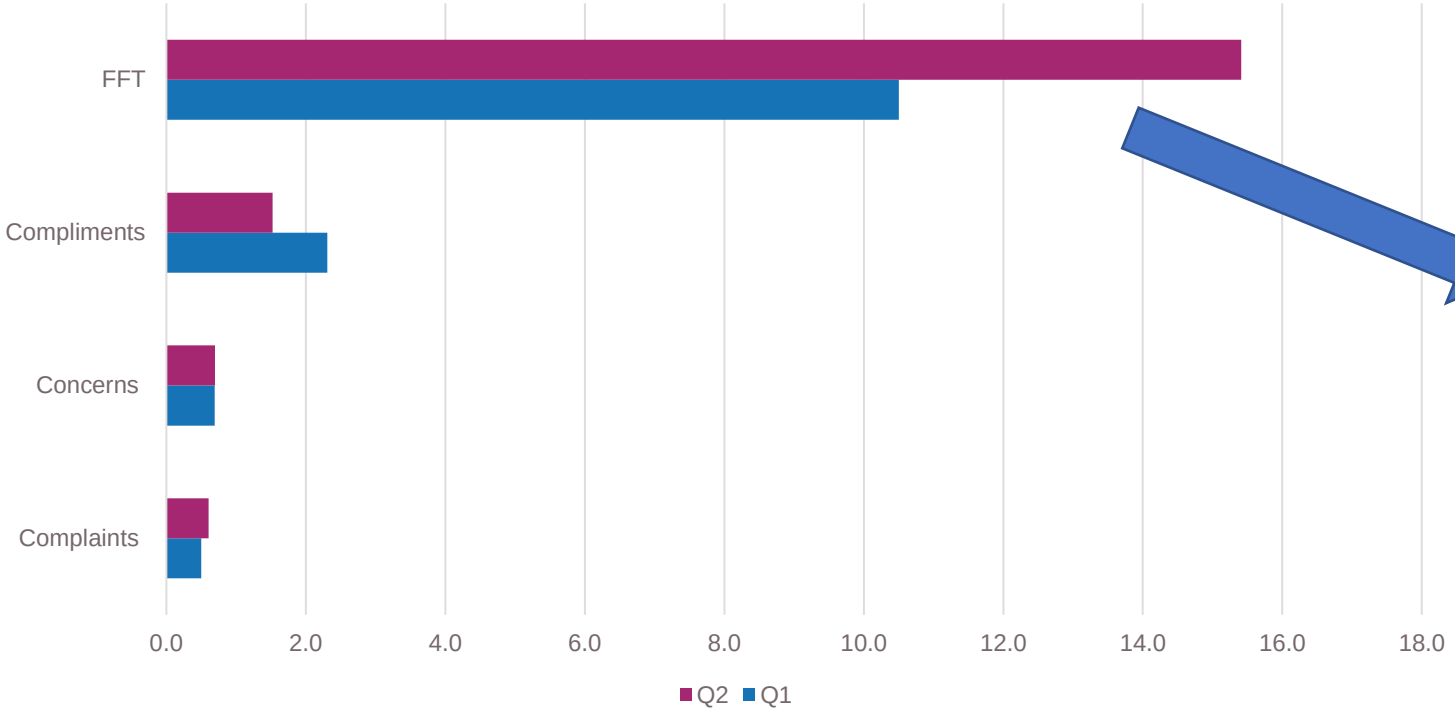
NHS Foundation Trust

Any questions?

Its not all doom and gloom!

Salisbury NHS Foundation Trust

Figure 1.1 Total Number of Complaints, Concerns, Compliments and Friends and Family Feedback. (per 1,000 of total Trust activity)



97.5%

Of those who completed an FFT form rated their experience as either Good or Very Good

Day surgery unit outpatients

PATIENT FEEDBACK

Absolutely outstanding.
I was treated with care, compassion, warmth, reassurance, kindness and dignity.
I felt safe, valuable and an overall sense of complex gratitude.
I have no words to express how humble I am to have received this care.
Forever in your deb

Tisbury ward

PATIENT FEEDBACK

All staff were very confident, efficient, respectful, friendly, supportive, cheerful and diligent.
I knew I was in good hands and in the best place.
Questions were answered and all procedures explained fully.
Visitors were made to feel welcome. There was a good choice of tasty food.
Thank you. Thank you. Thank you.

Durrington ward

PATIENT FEEDBACK

Excellent, friendly, helpful staff who went above and beyond to make things as comfortable as possible.
They also kept me well informed about all that was going on.

Mammography

PATIENT FEEDBACK

All staff were extremely kind and patient which made quite a daunting experience much easier.
Thank you.

#FeedbackThursday

#ThankyouFriday

Patient Centred & Safe | Professional | Responsive | Friendly | Progessive

Other ways to feedback

NHS Salisbury NHS Foundation Trust

- ✓ Friends and Family Test (FFT)
- ✓ NHS Choices
- ✓ Real Time Feedback – relaunching Feb 2023
- ✓ Local and National Surveys
- ✓ Patient and Public Involvement Initiatives

SOX Sharing Outstanding Excellence

sft.sox@nhs.net

Feedback on care or services that are delivered well **is just as important** as feedback on when we haven't got it quite right.

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Salisbury
NHS Foundation Trust

National Inpatient Survey Results 2021

CQC Benchmark Report:

https://nhssurveys.org/all-files/02-adults-inpatients/05-benchmarks-reports/2021/

Summary of comparisons

Salisbury NHS Foundation Trust

134 NHS Acute Trusts involved

62, 235 Total responses received (return rate of 39.5%)

585 Total responses received for SFT

48.07% Response rate

No. of questions where SFT scored better than other Trusts = 0

No. of questions where SFT scored about the same as other Trusts = 45

No. of questions where SFT scored worse or somewhat worse than other Trusts = 2*

Q5.4 Were you ever prevented from sleeping at night by hospital lighting?

Q15 During your time in hospital, did you get enough to drink?

Summary – areas for attention

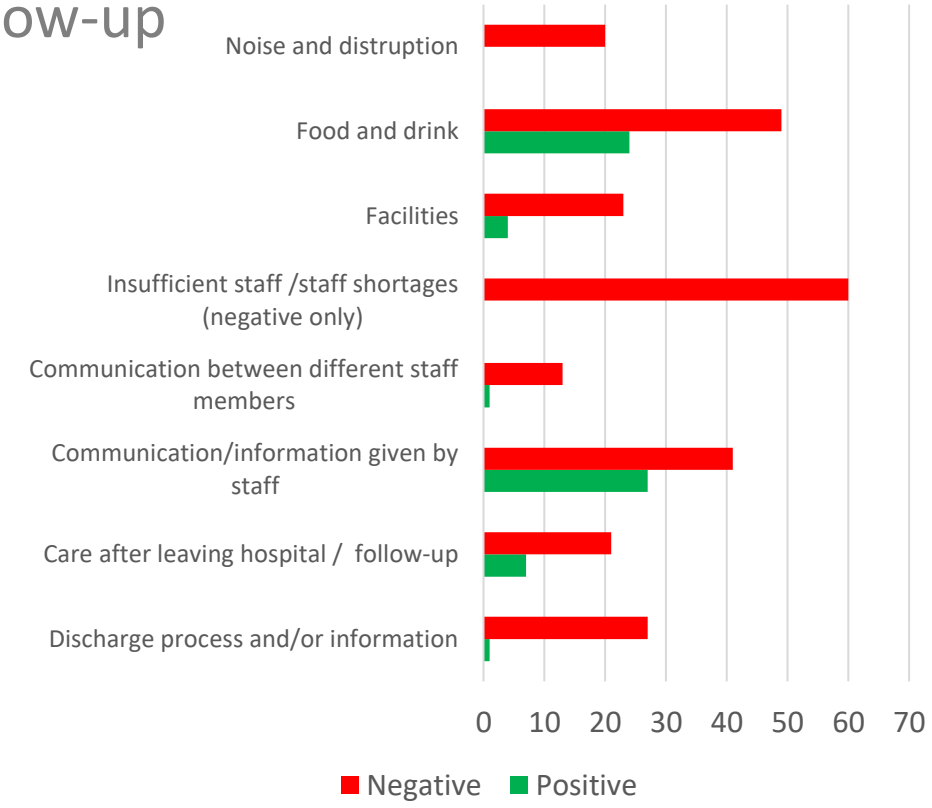
Salisbury NHS Foundation Trust

Discharge process and follow-up

Communication

Staffing levels

Food and drink, noise and disruption, facilities



PALS Services

we are so much more than just complaints !

Salisbury NHS Foundation Trust

Patient clothing & TV cards – provided by the Stars Appeal

Friends and Family Tests

Message to a loved one

Virtual visiting

Interpreting Services

Lost property

PALS Outreach Services

Patient engagement

Hearing Aid Batteries
(new for Sept 2022)

Insurance forms

Your Views Matter Bereavement survey
(new for July 2022)

Compliments

Patient Centred & Safe | **Professional** | **Responsive** | **Friendly** | **Progessive**

NHS
Salisbury
NHS Foundation Trust

Any questions?

NHS
Salisbury
NHS Foundation Trust

PALS information:

PALS Office - Block 62
Green Entrance

Direct dial: 01722 429044
Extension - 5244

sft.pals@nhs.net

NHS
Salisbury
NHS Foundation Trust

Bi-Annual
Friends and Family Test Update

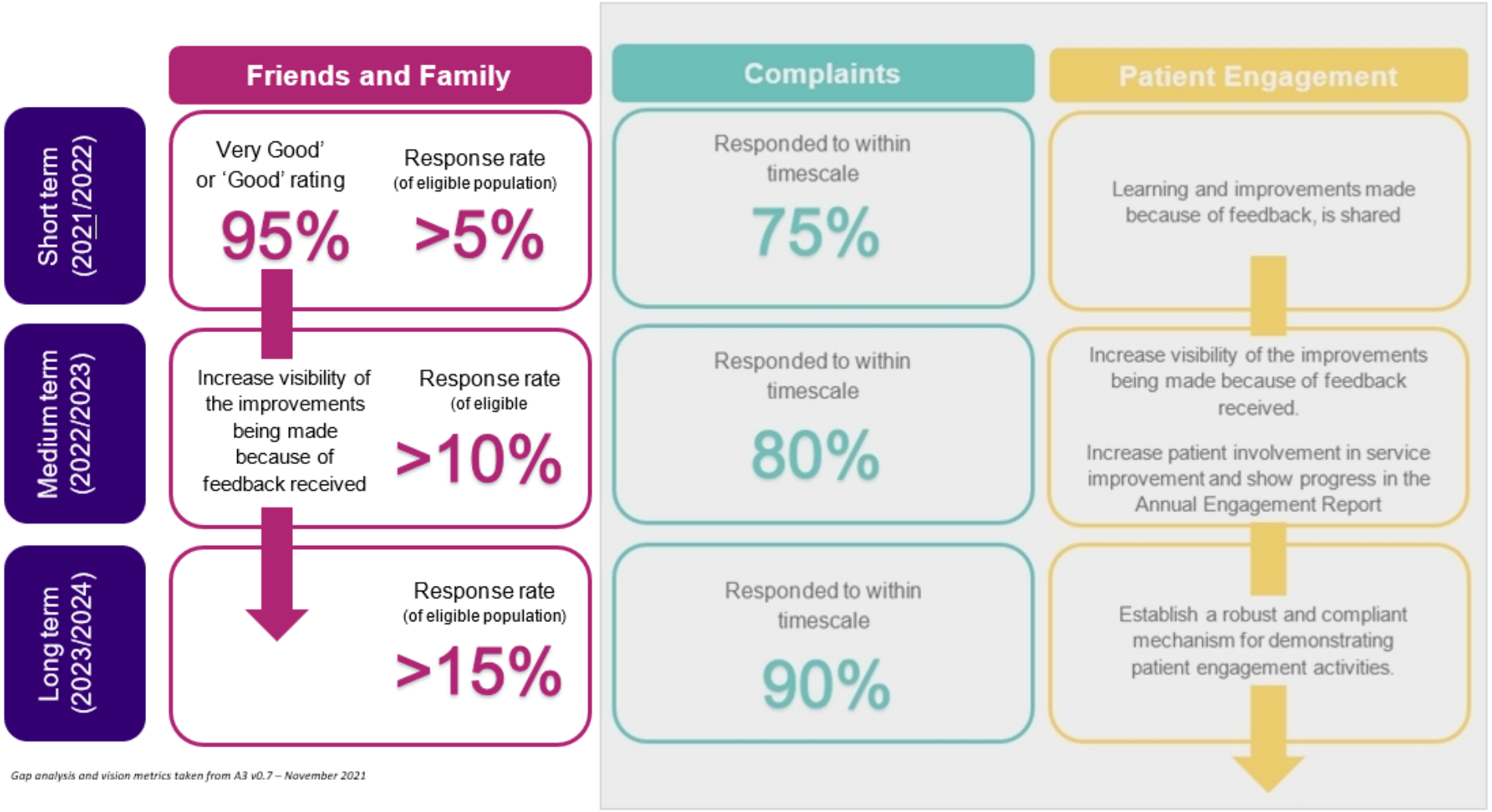
March 2023

Victoria Aldridge - Head of Patient Experience
Helen Rynne – Patient Engagement Lead

Patient Experience – Improving Together Summary

Salisbury NHS Foundation Trust

Improving the health and well being of the Population we serve



Gap analysis and vision metrics taken from A3 v0.7 – November 2021

Person Centred & Safe | **Professional** | **Responsive** | **Friendly** | **Progressive**

Friends and Family Test - Trust Performance

(Apr 2022 – Feb 2023)

NHS Salisbury NHS Foundation Trust

4,714 Responses received Trust wide

1.9%* Response rate

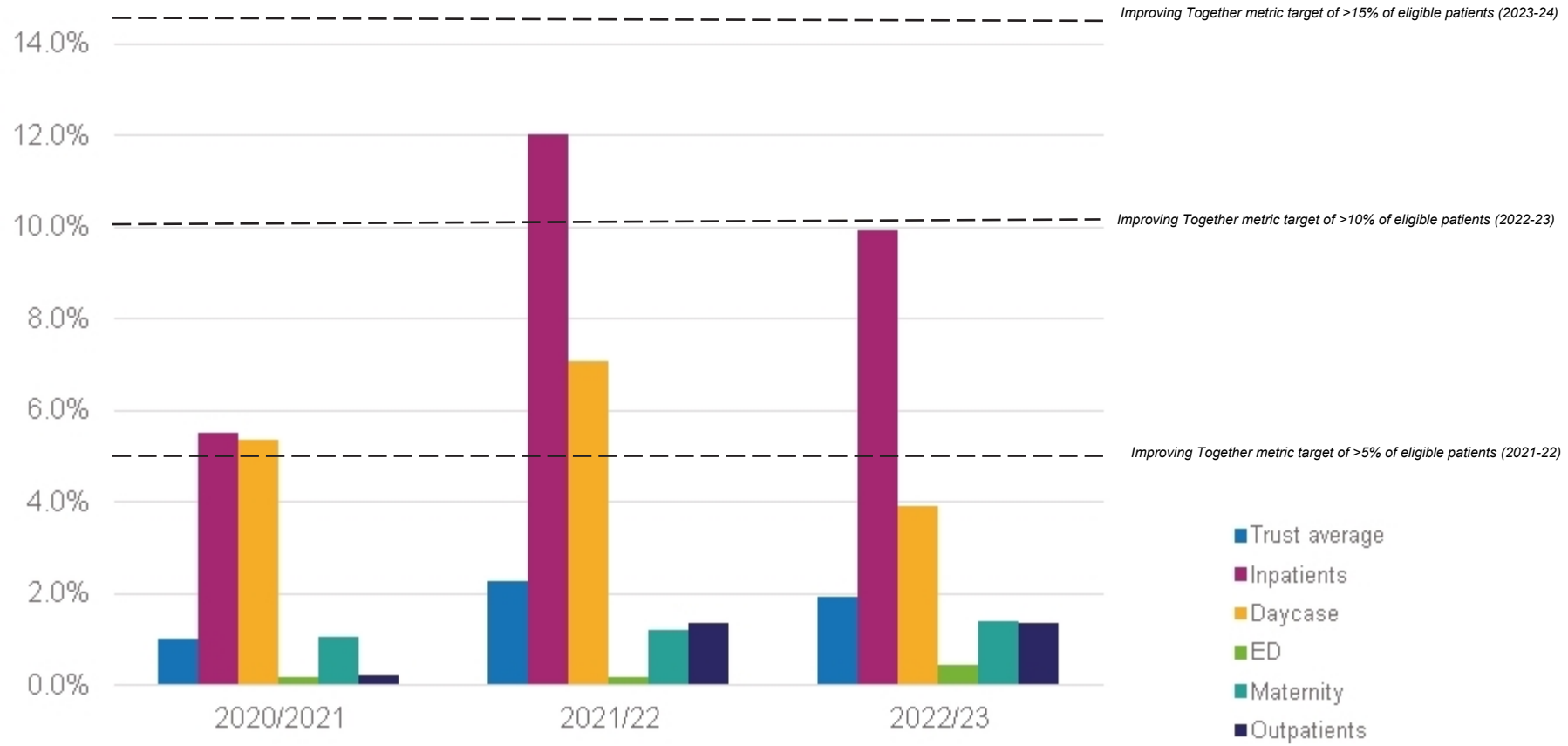
(*of eligible population and averaged)

97.2% Rated their experience as either “Good” or “Very Good”

Friends and Family Feedback - Inpatients (average response rate by area)

Salisbury NHS Foundation Trust

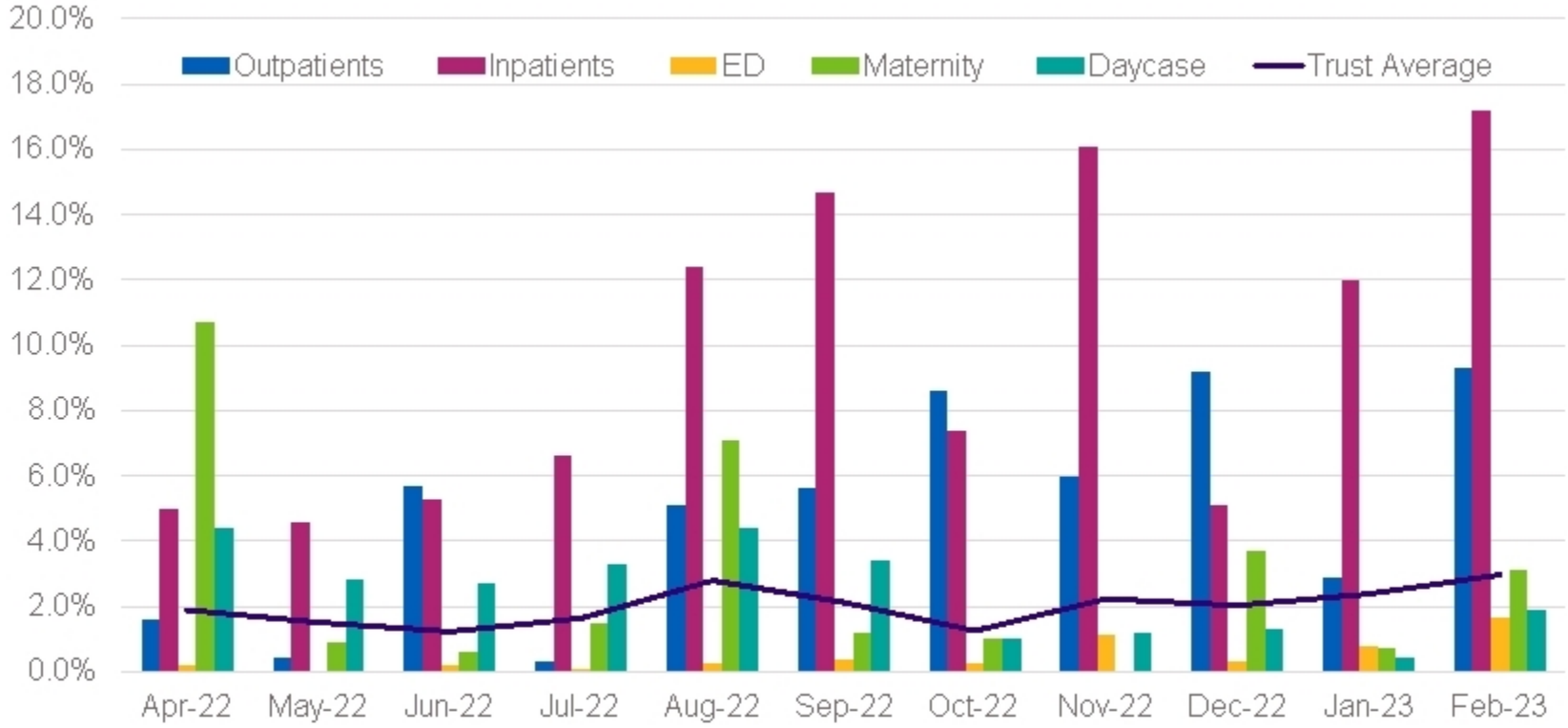
FFT Response Rates – 3year trend



Friends and Family Feedback
(response rate – breakdown for Apr 2022 - Feb 2023)

Salisbury NHS Foundation Trust

Response rate (%) based on total number eligible to respond, by area of the Trust



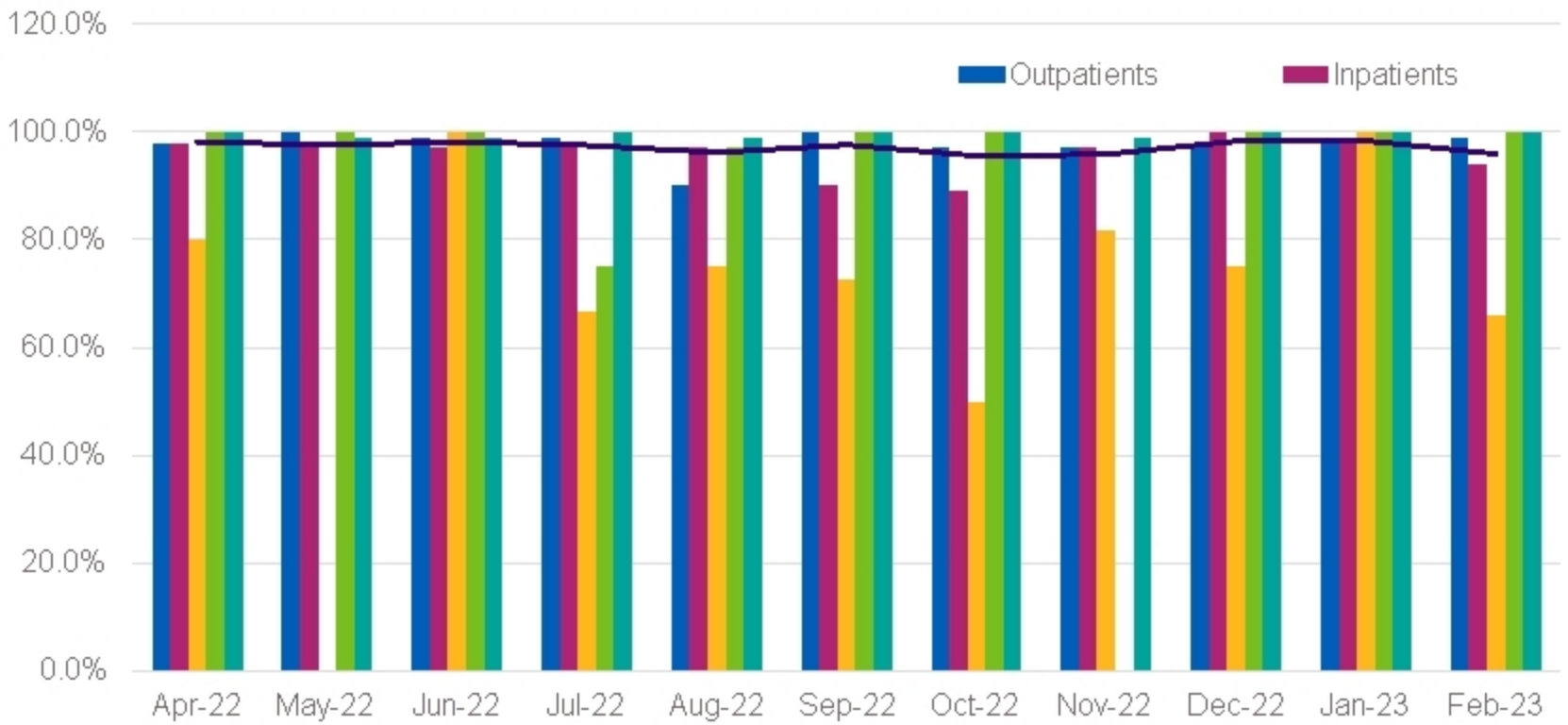
1.9%
(average)
Response rate for the whole Trust

NOTE:
Data anomalies noted in Outpatients for June, August, September, October, November, December and February for DSU & Burns – this would have impacted performance %'s for outpatient areas. These were added adjusted to 100% to prevent from affecting the averages.

Friends and Family Feedback
(experience rating – breakdown for Apr 2022 - Feb 2023)

NHS Salisbury NHS Foundation Trust

Experience rating (% Good or Very Good) based on those who responded, by area of the Trust



97.2%
(total average)
Rated experience as
Good or Very Good

Visions for improvement

Digital provider successfully procured, phased roll-out of digital solution planned, commencing with ED.

Roll-out delayed until December 2023

Problem statement:

Problem statement taken from A3 v0.7 – November 2021

FFT feedback demonstrates that patients do not consistently have a positive experience of care.

The main way that patients feedback their experiences is via paper-based Friends and Family Test cards. The pandemic has affected this as cards were removed as a national requirement.

Ward areas have re-started FFT, but responses are not received from every service; this results in not having a representative and diverse view of all patients' experiences.

Long term benefits:

- ✓ Increase overall response rates to FFT
- ✓ Diversify methods for access (including, online, SMS, over the phone to make this more accessible to difficult to reach areas of the Trust)
- ✓ Increased accessibility and options for inclusivity (sight impairments, languages and additional demographic options)
- ✓ Robust analysis of data for insight and meaningful comparison and benchmarking through a real-time dashboard
- ✓ Flexibility to report by Division
- ✓ Opportunity to align our processes in FFT across the ICS

Interim mitigations

Salisbury NHS Foundation Trust

Due to the delay in the new system rollout – the following interim solutions for increasing response rates are being discussed:

- **Use of QR codes on posters, outpatient letters and within discharge packs**. Needs further scoping due to the issues with licensing of QR codes
- **More volunteers to input cards** – current single point of failure, will also require training.
- **Incentives to drive completion** – league tables/rewards, promotion through divisional governance meetings
- **Continued promotion through PALS outreach –** use of FFT posters to display feedback and remind ward/service leads to encourage completion
- **FFT board audit and actions** *(see next)*

Plan - discussion at PESG for further suggestions…

FFT Inpatient Audits Results

Salisbury NHS Foundation Trust

Audits undertaken between December 2022 and February 2023

Cards not displayed	Not displaying correct cards	No holders for cards	No post-box nearby	Boards do not contain up to date information	PALS information not correct	FFT Board not suitably located	FFT Board not in good repair state
33%	33%	33%	17%	17%	17%	17%	0%

Notes

- Sarum ward could not be audited as no FFT board on the ward
- Opportunity identified to improve patient information on PALS services
- Audit for outpatient areas still pending completion

FFT Inpatient Audits – Action Plan

NHS Salisbury NHS Foundation Trust

Action	Progress update	Ward area	Timescale for completion
Revised PALS posters/ information	In progress. New posters under review with readership group. New PALS leaflet under development.	All areas	April 2023
Printing of more FFT cards to include new scoring	FFT cards have now been approved for printing – awaiting delivery.	Durrington, Spire Laverstock, Odstock, Tisbury, Whiteparish	March 2023
Purchase leaflet holders x 6 (for replacement)	Not purchased yet. Needs clarification whether additional holders needed for new PALS information leaflet being developed.	AMU, Durrington Spire, Laverstock Odstock, Whiteparish	April 2023
Develop child-friendly FFT cards	In development with Sarum Ward.	Sarum ward	April 2023
Purchase post-boxes x 5 (3 for no post-box, 2 for replacement following damage)	Not purchased yet.	Odstock, Tisbury Whiteparish, Amesbury, Downton	April 2023
FFT feedback poster template to be developed	Template being trialled with Whiteparish and Tisbury – as part of PALS Outreach visits	All areas	Ongoing
Review location of the existing FFT Boards	Asked Amanda to consider this with the spinal group on Longford – consider communal/dining areas	Durrington, Laverstock, Longford, Tisbury, Sarum	April 2023

Salisbury NHS Foundation Trust

Real-Time Feedback (Inpatients)

Q4 – 2022/23

Patient Experience Steering Group Presentation

29th March 2023

Victoria Aldridge – Head of Patient Experience

Helen Rynne – Patient Engagement Lead

Background and Purpose

Salisbury NHS Foundation Trust

Real-Time Feedback is a face to face opportunistic survey undertaken by the patient's bedside whilst they are in hospital. This can be undertaken by staff, volunteers or governors.

The aim of the feedback to give a "real-time" view of a patients perspective of their care.

Real-time feedback is not currently undertaken within the maternity inpatient areas or on Sarum ward.

The survey mirrors the focuses of the National Inpatient survey and includes questions to assess the following areas:

- Admission to hospital
- The ward environment
- Doctors
- Nurses
- Care and treatment
- Operations and procedures
- Leaving hospital
- Respect and Dignity
- Overall experience

Go Live – Feb 2023

Questions are rated 1 - 5 (1 = very poor and 5 = very good)

Questions are weighted and averaged to present an overall performance score %

Experience Description

Weighting	
n/a	*No value* = Not applicable
1	0% = Very Poor
2	25% = Poor
3	50% = Adequate
4	75% = Good
5	100% = Very Good

Inpatient Summary – Q4 2022-23

NHS Salisbury NHS Foundation Trust

Total inspections completed

between Jan 1, 2023 and Mar 27, 2023

10

Area Name	Patient Experience (Real Time Feedback) = Average Score	Number of responses
Pembroke	98.4%	1
South Newton	83.9%	1
Whiteparish	81.3%	2
Longford Ward	68.8%	6

Average score

between Jan 1, 2023 and Mar 27, 2023

75.7%

Key Theme	Question Text	Average Score (%)
Respect and dignity	Have you felt treated with dignity and respect during your stay?	100
Operations and procedures	How well did the staff explain how you might feel following your operation or procedure?	95
Hospital and ward	How would you describe the level of assistance you receive for basic care such as eating, drinking and washing?	91.7
Operations and procedures	How would you describe the quality of written information provided about your operation or procedure?	85
Hospital and ward	How would you rate the cleanliness of the ward you are in?	83.3
Care and treatment	How would you describe your pain management?	83.3
Clinicians	How would you describe the trust and confidence you have in those involved in your care?	80.6
Overall Experience	Overall, how would you rate your experience so far with the hospital?	77.8
Care and treatment	How would you rate the level of privacy when being examined or treated?	77.8
Care and treatment	How would you describe your involvement with decisions around your care and treatment?	75
Hospital and ward	How would you describe the quality and selection of dietary options available to you?	69.4
Hospital and ward	How would you describe the noise level on the ward at night?	69.4
Clinicians	How well have medical staff explained things to you?	66.7
Admission to hospital	How would you rate your overall wait time for your admission to hospital?	58.3
Clinicians	How would you describe the numbers of medical staff on duty during your stay?	55.6
Leaving hospital	How would you describe your understanding or involvment with your discharge plan?	50

23%

of Inpatient wards surveyed this quarter

0 = *requested to speak further with PALS*

1 = *had a carer*

1 = *identified as a veteran*

Person Centred & Safe | Professional | Responsive | Friendly | Progressive

Pembroke Ward

Total inspections completed
between Jan 1, 2023 and Mar 27, 2023

1

Average score
between Jan 1, 2023 and Mar 27, 2023

98.4%

Overall experience rating:

100%

Carers

0 = had a carer

0 = unaware of the Carers Passport

Veterans

0 = identified as a veteran

0 = never asked if was a veteran previously

0 = requested to speak further with PALS

Questions summary:

NHS Salisbury NHS Foundation Trust

Two lowest scoring questions

No questions scored below 25%

Two adequately scoring questions

No questions scored below 50%

Two highest scoring questions

75.0% *"How would you describe the quality and selection of dietary options available to you?"*

100.0% *"Have you felt treated with dignity and respect during your stay?"*

For full report see Tendable – Patient Experience Inspections

South Newton

Total inspections completed
between Jan 1, 2023 and Mar 23, 2023

1

Average score
between Jan 1, 2023 and Mar 23, 2023

83.9%

Overall experience rating:

100%

Carers

0 = had a carer

0 = unaware of the Carers Passport

Veterans

1 = identified as a veteran

1 = never asked if was a veteran previously

0 = requested to speak further with PALS

Questions summary:

NHS Salisbury NHS Foundation Trust

Two lowest scoring questions

No questions scored below 25%

Two adequately scoring questions

50.0%

"How would you describe our understanding or involvement with your discharge plan?"

"How well have medical staff explained things to you?"

Two highest scoring questions

75.0%

"How would you describe the noise level on the ward at night?"

"How would you describe your involvement with decisions around your care and treatment?"

For full report see Tendable – Patient Experience Inspections

Whiteparish Ward

Total inspections completed
between Jan 1, 2023 and Mar 27, 2023

2

Average score
between Jan 1, 2023 and Mar 27, 2023

80.8%

Carers

0 = had a carer

0 = unaware of the Carers Passport

Veterans

0 = identified as a veteran

0 = never asked if was a veteran previously

0 = requested to speak further with PALS

Overall experience rating:

87.5%

For full report see Tendable – Patient Experience Inspections

Questions summary:

NHS Salisbury NHS Foundation Trust

Two lowest scoring questions

No questions scored below 25%

Two adequately scoring questions

62.5%

"How would you describe the nose level on the ward at night?"

"How would describe the numbers of medical staff on duty during your stay?"

Two highest scoring questions

87.5%

"How would you rate the cleanliness of the ward you are in?"

100.0%

"Have you felt treated with dignity and respect during your stay?"

Longford Ward

Total inspections completed
between Jan 1, 2023 and Mar 23, 2023

6

Average score
between Jan 1, 2023 and Mar 23, 2023

68.8%

Carers

1 = had a carer

1 = unaware of the Carers Passport

Veterans

0 = was identified as a veteran

0 = never asked if was a veteran previously

0 = requested to speak further with PALS

Overall experience rating:

70.8%

For full report see Tendable – Patient Experience Inspections

Questions summary:

NHS Salisbury NHS Foundation Trust

Two lowest scoring questions

37.5%

"How would you describe our understanding or involvement with your discharge plan?"

"How would you describe the numbers of medical staff on duty during your stay?"

Two adequately scoring questions

62.5%

"How would you describe the quality and selection of dietary options available to you?"

"How would you describe the noise level on the ward at night?"

Two highest scoring questions

100.0%

"Have you felt treated with dignity and respect during your stay?"

91.7%

"How well did the staff explain how you might feel following your operation or procedure?"

Longford Ward Comments

NHS Salisbury Foundation Trust

[rated staff numbers as poor]
"But quality over quantity is preferred, having the right skills is more important than the numbers"

[response to overall rating]
"Everything they do here is completely different to what I've experienced before. There is a good mix of cultures here and they are really good at what they do, and they're lovely!"

"Noise is fine, but it's too hot!"

Comments taken from RTF's scoring
50% - 74%

Comments taken from RTF's scoring
75% or more

[response to explanations given by medical staff]
Always explain things well, I didn't know what to expect. Continuity of staff is good

[response to further comments]
"I was expecting more one to one therapies"

"Continuity of staff makes it hard to build relationships, they say different things. The permanent nursing staff are really good. Some of the agency are not so good . Communication can be hard when English not the first language".

[response to staffing levels]
"Sometimes they are short staffed, but they are very good. The staff work really hard to get everything done"

[response to cleanliness of ward]
"Cleaners are brilliant"

Interested in undertaking Real Time Feedback?

NHS Salisbury NHS Foundation Trust

If you are interested in undertaking Real-Time Feedback please do contact us – we'd like to be able to undertaken more!

Patient Engagement Leads

Victoria.Aldridge3@nhs.net

Helen.Rynne@nhs.net

Direct dial: 01722 429044
Extension – 5246 / 5248

Report to:	Patient Experience Steering Group	**Agenda item:**	2.3
Date of Meeting:	24 May 2023		

Report Title:	**Q4 2022/23 Your Views Matter – Bereavement Survey Report**			
Status:	**Information**	**Discussion**	**Assurance**	**Approval**
	x		x	
Approval Process (where has this paper been reviewed and approved)	Mortality Surveillance Group (5th June 2023) - (extract included in Learning from Deaths Report)			
Prepared by:	Victoria Aldridge - Head of Patient Experience			
Executive Sponsor (presenting):	Angie Ansell – Deputy CNO			
Appendices (list if applicable):	None.			

Recommendation:
This report is asked to be noted by the steering group and feedback on the contents and focuses of the report. For note - elements of this report are extracted for inclusion within the quarterly Learning from Deaths Report, presented to the Mortality Surveillance Group.

Executive Summary:
Overall, there has been a slight drop in overall experience and subsequent satisfaction ratings previously noted in the Q3 report. 68% of those surveyed rated their overall experience as Good or Very Good, compared with 73% last quarter. Poor experience ratings have also increased on last quarter. Response rates have noted to have increased from 20% in Q3, to 33% in Q4. This has created an average annual response rate of 28% (lower than the 39% we saw in 2021/22. 2 survey participants requested a call-back from PALS, 1 of these went on to record a formal complaint or concern. This is reduction from what was seen in Q3. There was a positive theme for the experience with both the bereavement and medical examiners office this quarter. Facilities continue to be a recurring theme, with privacy and dignity of both the patient and grieving families being impacted due to lack of private spaces at point of death.

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) -	☐

Q4 2022/23 and Annual Summary
Your Views Matter (Bereavement Survey) Analysis

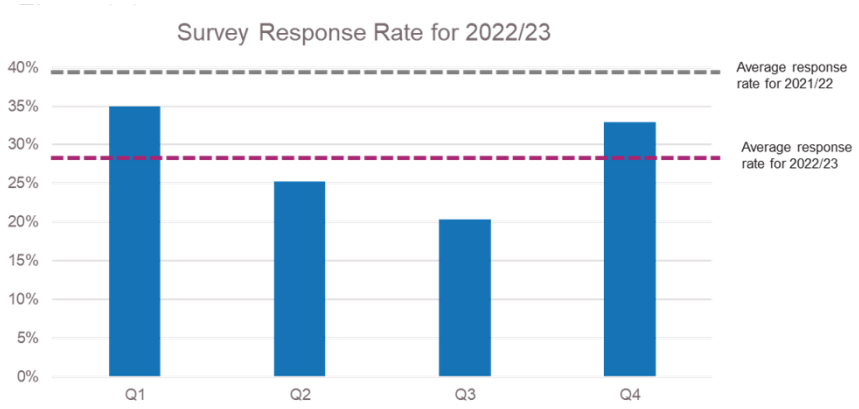
Background

The Your Views Matter Bereavement survey was established in 2020 and was created to capture the views and experiences of bereaved relatives. This is an opportunity for families to feedback their experiences about the support they themselves received and the end of life care their loved one was given during their last days of life in Salisbury Hospital. Whilst the feedback is anonymous, relatives are able to name individuals they would like to acknowledge and thanked for making a difference. Likewise, where the experience was less than satisfactory those completing the survey also have the option to enclose their contact details and be followed up by the PALS team.

Metric Data

During Q4 of 2022-23 the Trust saw 289 deaths, of which 29% (n~85*) were sent a bereavement survey after follow-up with the Medical Examiner's Office. This is the lowest proportion of bereaved families sent this survey so far this year. In 2021/22, on average 52% of bereaved families were sent the YMV survey.

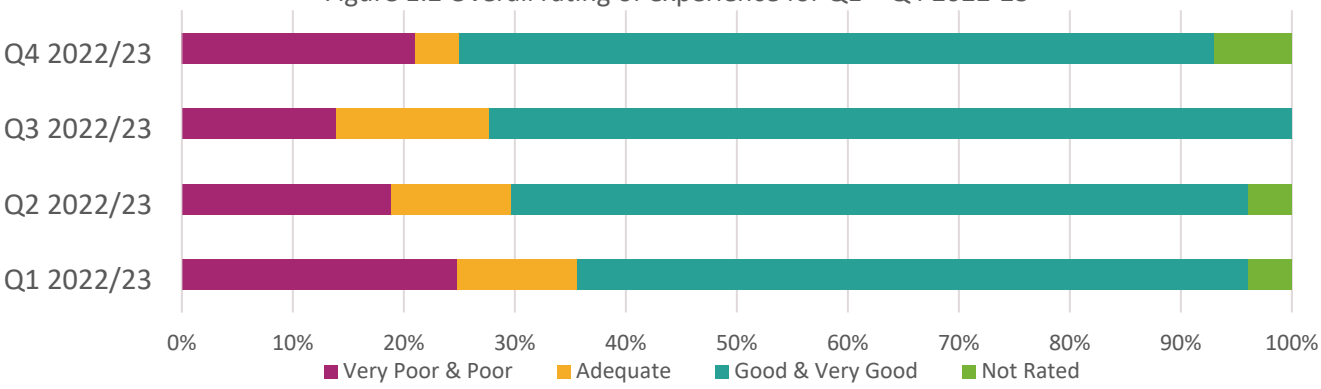
It is noted that the return rate for surveys was at its highest in Q1 – achieving 35% return rate, this reduced in Q2 to 25% and again in Q3 to 20%. The Q4 return rate however increased to 33%. The average return rate therefore for 2022/23 was 28%. This is lower than the average return rate we saw in 2021/22, of 39%.



In Q4 **68%** of those surveyed rated their overall experiences with End of Life Care as good/very good. This is a slight reduction seen on Q3, and marginally lower the annual average which is 70%. This average is less than 2021/22 where this was 79%.

21% rated their overall experience as poor/very poor, this is higher than seen in Q3 and higher than the annual average which was 14%. This annual average has seen an increase on 2021/22, where this was 10%.

Figure 1.2 Overall rating of experience for Q1 – Q4 2022-23



Insights and Analysis

68% of those surveyed rated their experience as **good or very good** (n~19).

Of those who rated their experience as good or very good – the following further breakdowns are noted:

- **18/19** felt that on reflection the hospital was the right place for your loved one to be
- **17/19** felt that the room in which they spent their last days or hours was appropriate
- **14/19** said that if they had any questions or concerns that they able to talk to someone about their loved one's care. The remaining **5** noted this question as not applicable.
- **10/19** received support from the chaplaincy services. These services were rated as either good or very good.
- **0** requested further contact by PALS.

YVM 360 (Britford)

Just please continue with the level of care and consideration that we witnessed first hand. With staffing levels and difficult working conditions at this present time, you made a difficult job look easy.

YVM 355 (Whiteparish)

Abby and Nicky were excellent. Abby took time to meet my brother and I in the ward and answer any questions. She supported me to sing Happy Birthday to mum two days before her death via the phone.

YVM 352 (Radnor)

There was continuity of care where possible when the nurses came on shift. Brenda, Helen and Jess and several other lovely nurses who really looked after mum, several days/nights. There was such a lovely ward sister who even made me a bed on the staff room floor the evening when I had no where to stay Another nurse booked the hospital bungalow for me.

21% of those surveyed rated their experience as **poor or very poor** (n~6).

Of those who rated their experience as poor – the following further breakdowns are noted:

- **5/6** either did not have an advanced care plan in place or the family were unaware of it
- Only **1** had an advanced care plan in place, but did not know whether this was taken into account when their loved one was admitted
- **2/6** felt that the hospital was not the right place for their loved one to be
- **4/6** did not feel that the room/ward in which they spent their last days or hours was appropriate.
- **1/6** received support from the hospital chaplaincy team in the days before or after their loved ones death. This was rated as Very good. **1** was unaware of these services.
- **3/6** did feel able to talk to someone about further questions they had.
- **2/6** requested further contact by PALS, **1** has since been formally raised as a concern.

YVM 354 (Pitton)

I tried for 3 days, several times to contact the ward. In the end I asked PALS to get me contact, which worked once. During whole time of stay (over 2weeks) only ONCE did I get through to the ward. I t was horrible. I live many hours drive from Salisburv.

YVM 350 (Redlynch)

Nurses were respectful but ward was horrendous with noise and shouting (other patients) – day and night! All patients and family quiet room to allow respectful and dignified death.

Figures 1.3 to 1.6 show the overall ratings in the key areas of patient experience:

- Relief of symptoms
- Communication
- Compassion and Dignity
- Support for loved ones

All four areas have a significant proportion of the overall good/very good rating. This is comparative for what was seen in Q3. January saw the highest peak of good/very good rating, in all four areas.

Figure 1.3 Relief of symptoms

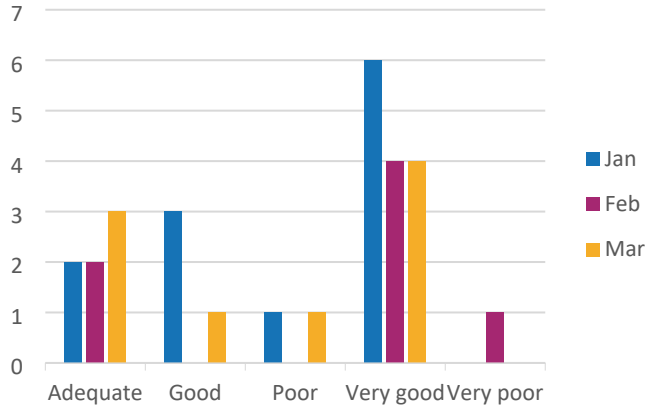


Figure 1.4 Communication

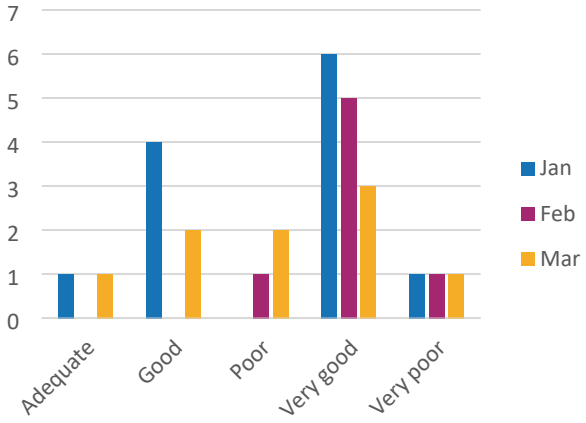


Figure 1.5 Compassion and dignity

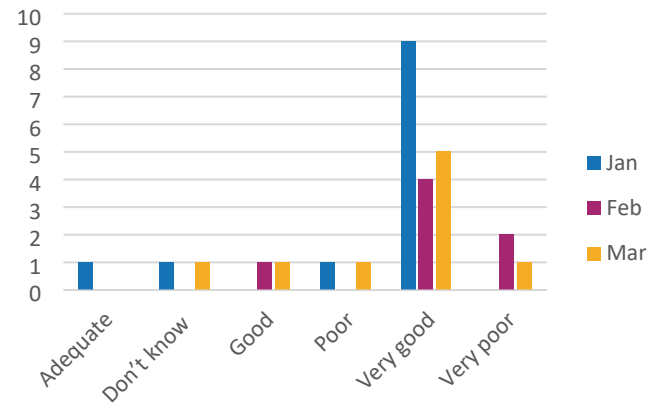
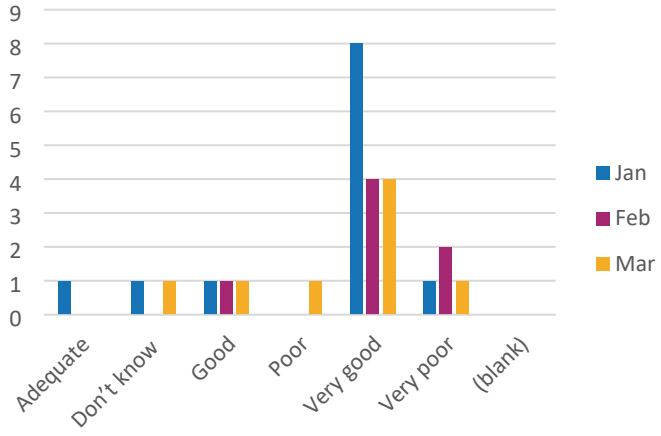


Figure 1.6 Support for loved ones



Correlation with Complaints:

In Q2 we saw a high-level theme related to End of Life Care. Themes within this were noted to be in relation to lack of communication when patients were deteriorating or had passed away.

We have not seen the same correlation with complaints in Q3 noted in Q2 have received one complaint during Q4, which was related to dignity at end of life. Durrington and Redlynch saw the highest number of complaints, receiving 3 each during this period.

In total, since the beginning of Q1, there have been 16 complaints/concerns logged by PALS in relation to end of life care. 38% of these were in relation to poor communication. Death and dignity in end of life followed as next highest themes (25% and 19% respectfully).

Other noted themes

In Q4 there were a total of 6 comments made in relation to the room where their loved one passed away, these comments all referenced the lack of privacy and dignity of both the patient and the grieving families. There were various references to the noise levels on the ward and the fact that a quieter space or single occupancy/private room would have greatly impacted that experience.

Facilities/environment have continued to be highlighted throughout the year as an area for attention. Based on the comments reviewed it is clear that there are links between the environment at the time of end of life and the impact this has on the overall experience of end of life care.

In Q4, several comments were made in relation to the experiences with the bereavement office and medical examiners office. None of these comments were negative.

These are depicted on the word cloud opposite. The size of the word indicates how many times this word was used within these comments:

Report written by Victoria Aldridge - Head of Patient Experience

patient PERSPECTIVE

Rigorous survey methods, reliable results.

PATIENT EXPERIENCE SURVEY HEADLINE REPORT

Salisbury NHS Foundation Trust

National Maternity Survey 2022

Sample: Women who received maternity services in January and February 2022

Note: to access full reporting go to www.patientperspective.co.uk

EXECUTIVE SUMMARY

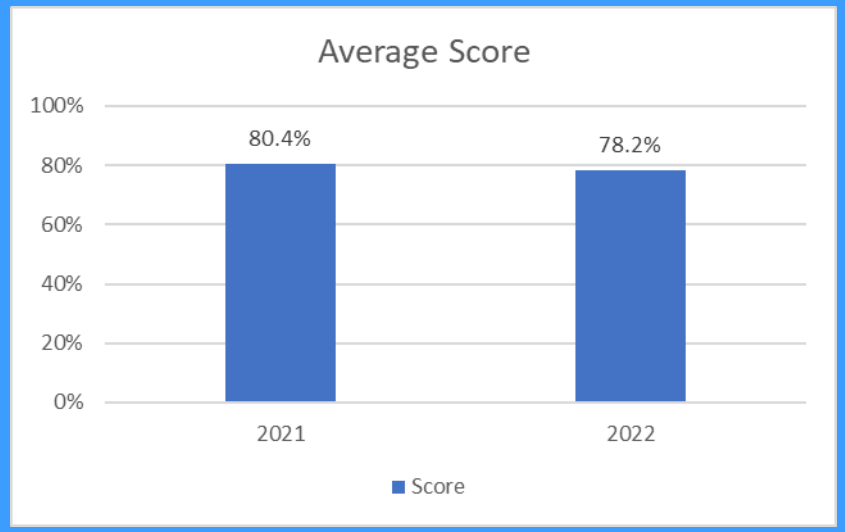
This report summarises the headline findings of the **2022 National Maternity Survey**.

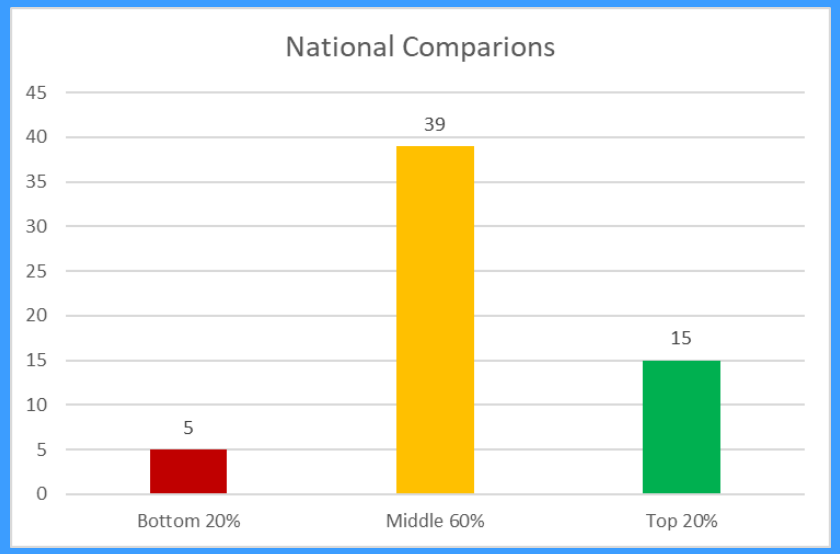
- The National Maternity Survey is required by the CQC for all NHS Trusts providing maternity services.
- Women receiving maternity services in January and February 2022 were selected for the survey.
- 300 women were included in the survey and 182 responded **(61%)**. The Patient Perspective average response rate for all 31 Trusts it surveyed was 48%.
- The average Mean Rating Score was **78.2%,** lower than in 2021.
- You scored in the **top 20% of Trusts** on **15** questions and in the **bottom 20% of Trusts** on **5** questions out of a total of 59 questions.
- **1** question showed **at least 10% improvement** on the 2021 score, and for **1 question** the score was **worse by 10%** or more.

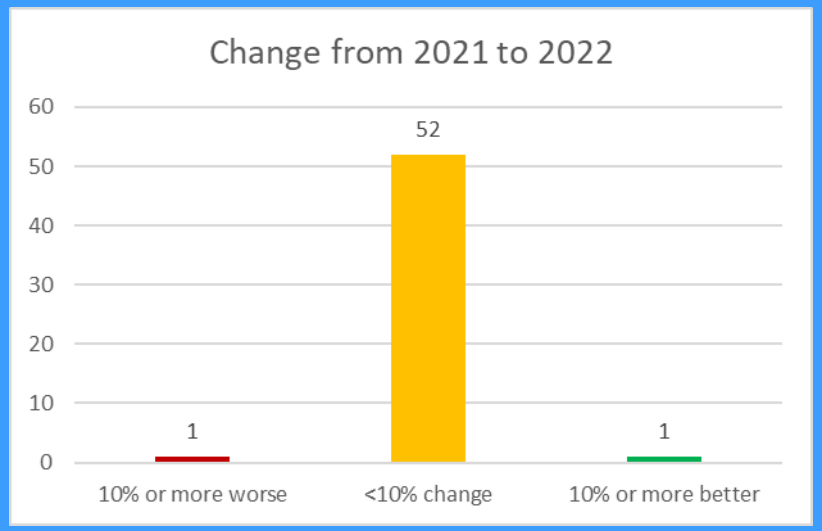
Full results including tables, free text comments, trends and benchmarks can be found at www.patientperspective.co.uk

patient PERSPECTIVE

RESULTS DASHBOARD
NATIONAL MATERNITY SURVEY 2022







patient PERSPECTIVE

Questions and scores #1

Salisbury NHS Foundation Trust					
Question	Question Text	2021 Score	2022 Score	Change since 2021	National Comparisons
Antenatal Care					
B3_1	Were you offered a choice about where to have your baby: Yes – a choice of hospitals	46%	48%	<10% change	Middle 60%
B3_2	Were you offered a choice about where to have your baby: Yes - at home	27%	23%	<10% change	Middle 60%
B3_4	Were you offered a choice about where to have your baby: No – I was not offered any choices	81%	83%	<10% change	Middle 60%
B4	Did you get enough information from either a midwife or doctor to help you decide where to have your baby?	65%	62%	<10% change	Middle 60%
B5	At the start of your care in pregnancy, did you feel that you were given enough information about coronavirus restrictions and any implications for your maternity care?	61%	60%	<10% change	Middle 60%
B8	During your antenatal check-ups, did the midwives appear to be aware of your medical history?	69%	70%	<10% change	Top 20%
B9	During your antenatal check-ups, were you given enough time to ask questions or discuss your pregnancy?	86%	89%	<10% change	Top 20%
B10	During your antenatal check-ups, did your midwives listen to you?	89%	89%	<10% change	Middle 60%
B11	During your antenatal check-ups, did your midwife ask you about your mental health?	89%	91%	<10% change	Top 20%
B12	Were you given enough support for your mental health during your pregnancy?	90%	88%	<10% change	Middle 60%
B13	During your pregnancy, if you contacted a midwifery team, were you given the help you needed?	93%	88%	<10% change	Top 20%
B14	Thinking about your antenatal care, were you spoken to in a way you could understand?	93%	90%	<10% change	Bottom 20%
B15	Thinking about your antenatal care, were you involved enough in decisions about your care?	88%	88%	<10% change	Middle 60%
B16	During your pregnancy did midwives provide relevant information about feeding your baby?	62%	62%	<10% change	Middle 60%
B17	Did you have confidence and trust in the staff caring for you during your antenatal care?	n/a	81%	n/a	Middle 60%
B18	Thinking about your antenatal care, were you treated with respect and dignity?	n/a	90%	n/a	Bottom 20%

patient PERSPECTIVE

Questions and scores #2

Question	Question Text	2021 Score	2022 Score	Change since	National
Your labour and the birth of your baby					
C4	Were you given enough information on induction before you were induced?	75%	70%	<10% change	Middle 60%
C5	And before you were induced, were you given appropriate information and advice on the risks associated with an induced labour?	n/a	65%	n/a	Middle 60%
C6	Were you involved in the decision to be induced?	87%	86%	<10% change	Middle 60%
C7	At the very start of your labour, did you feel that you were given appropriate advice and support when you contacted a midwife or the hospital?	90%	86%	<10% change	Middle 60%
C12	If your partner or someone else close to you was involved in your care during labour and birth, were they able to be involved as much as they wanted?	91%	94%	<10% change	Top 20%
C14	Did the staff treating and examining you introduce themselves?	92%	92%	<10% change	Top 20%
C16_1	Were you (and/or your partner or a companion) left alone by midwives or doctors at a time when it worried you: Yes, during early labour	90%	92%	<10% change	Top 20%
C16_2	Were you (and/or your partner or a companion) left alone by midwives or doctors at a time when it worried you: Yes, during the later stages of labour	97%	94%	<10% change	Middle 60%
C16_3	Were you (and/or your partner or a companion) left alone by midwives or doctors at a time when it worried you: Yes, during the birth	98%	99%	<10% change	Middle 60%
C16_4	Were you (and/or your partner or a companion) left alone by midwives or doctors at a time when it worried you: Yes, shortly after the birth	94%	93%	<10% change	Top 20%
C16_5	Were you (and/or your partner or a companion) left alone by midwives or doctors at a time when it worried you: No, not at all	84%	83%	<10% change	Top 20%
C17	If you raised a concern during labour and birth, did you feel that it was taken seriously?	84%	81%	<10% change	Middle 60%
C18	During labour and birth, were you able to get a member of staff to help you when you needed it?	90%	89%	<10% change	Middle 60%
C19	Thinking about your care during labour and birth, were you spoken to in a way you could understand?	93%	90%	<10% change	Middle 60%
C20	Thinking about your care during labour and birth, were you involved in decisions about your care?	90%	86%	<10% change	Middle 60%
C21	Thinking about your care during labour and birth, were you treated with respect and dignity?	94%	91%	<10% change	Middle 60%
C22	Did you have confidence and trust in the staff caring for you during your labour and birth?	92%	89%	<10% change	Middle 60%
C23	After your baby was born, did you have the opportunity to ask questions about your labour and the birth?	62%	65%	<10% change	Middle 60%
C24	During your labour and birth, did your midwives or doctor appear to be aware of your medical history?	n/a	77%	n/a	Middle 60%

patient PERSPECTIVE

Questions and scores #3

Question	Question Text	2021 Score	2022 Score	Change since 2021	National Comparisons
Postnatal care					
D2	On the day you left hospital, was your discharge delayed for any reason?	62%	61%	<10% change	Middle 60%
D4	If you needed attention while you were in hospital after the birth, were you able to get a member of staff to help you when you needed it?	80%	73%	<10% change	Middle 60%
D5	Thinking about the care you received in hospital after the birth of your baby, were you given the information or explanations you needed?	78%	71%	<10% change	Bottom 20%
D6	Thinking about the care you received in hospital after the birth of your baby, were you treated with kindness and understanding?	86%	82%	<10% change	Middle 60%
D7_1	Thinking about your stay in hospital, if your partner or someone else close to you was involved in your care, were they able to stay with you as much as you wanted: Yes	27%	38%	10% or more better	Top 20%
D7_2	Thinking about your stay in hospital, if your partner or someone else close to you was involved in your care, were they able to stay with you as much as you wanted: No, as they were restricted to visiting hours	52%	54%	<10% change	Top 20%
D7_3	Thinking about your stay in hospital, if your partner or someone else close to you was involved in your care, were they able to stay with you as much as you wanted: No, as there was no accommodation for them in the hospital	91%	89%	<10% change	Middle 60%
D8	Thinking about your stay in hospital, how clean was the hospital room or ward you were in?	89%	83%	<10% change	Bottom 20%
Feeding your baby					
E2	Were your decisions about how you wanted to feed your baby respected by midwives?	91%	92%	<10% change	Top 20%
E3	Did you feel that midwives and other health professionals gave you active support and encouragement about feeding your baby?	75%	74%	<10% change	Middle 60%
Care after birth					
F1	Thinking about your postnatal care, were you involved in decisions about your care?	n/a	82%	n/a	Top 20%
F2	If you contacted a midwifery or health visiting team were you given the help you needed?	89%	84%	<10% change	Middle 60%
F5	Would you have liked to have seen a midwife...	75%	68%	<10% change	Middle 60%
F6	Did the midwife or midwives that you saw appear to be aware of the medical history of you and your baby?	81%	78%	<10% change	Middle 60%
F7	Did you feel that the midwife or midwifery team that you saw or spoke to always listened to you?	90%	85%	<10% change	Middle 60%
F8	Did the midwife or midwifery team that you saw or spoke to take your personal circumstances into account when giving you advice?	89%	84%	<10% change	Middle 60%
F9	Did you have confidence and trust in the midwife or midwifery team you saw or spoke to after going home?	86%	86%	<10% change	Middle 60%
F11	Did a midwife or health visitor ask you about your mental health?	98%	98%	<10% change	Top 20%
F12	Were you given information about any changes you might experience to your mental health after having your baby?	75%	71%	<10% change	Middle 60%
F13	Were you told who you could contact if you needed advice about any changes you might experience to your mental health after the birth?	88%	79%	<10% change	Middle 60%
F14	Were you given enough information about your own physical recovery after the birth?	74%	69%	<10% change	Middle 60%
F15	In the six weeks after the birth of your baby did you receive help and advice from a midwife or health visitor about feeding your baby?	73%	68%	<10% change	Middle 60%
F16	If, during evenings, nights or weekends, you needed support or advice about feeding your baby, were you able to get this?	70%	46%	10% or more worse	Bottom 20%
F17	In the six weeks after the birth of your baby did you receive help and advice from health professionals about your baby's health and progress?	80%	81%	<10% change	Top 20%

patient PERSPECTIVE

POINTS TO DISCUSS

Points to discuss:

- ❑ What is your overall impression of these results?
- ❑ What are you most pleased about in these results?
- ❑ What are you most unhappy about in these results?
- ❑ What works? What have you learned from your successes in other areas that you can use to help you make improvements to women's experiences of maternity care?
- ❑ What hasn't worked so far? What have you learned from what hasn't worked that you can either avoid doing in future or can do differently next time?
- ❑ What do you see as the priority areas for improving women's experiences of maternity services?

Factors to consider when setting priorities for improvement:

- ❑ **Organisational Fit** – how do these results triangulate with other performance data and existing organisational priorities and service improvement initiatives?
- ❑ **Commissioning requirements** – what external priorities have been set?
- ❑ **National comparisons** – in which areas are you scoring lower than other organisations and National averages
- ❑ **Internal benchmarks** – how do services/departments/wards/teams/parts of the pathway compare?
- ❑ **Actionable topics** – is this an area you can actually do something about? Are there any quick wins that will help get the patient experience improvement programme started?

NEXT STEPS AND ACTIONS

- ❑ **Detailed review of the results**
- ❑ **Dissemination of results** – consider with which stakeholder groups (internal and external), in which level of detail and in what format to share the results widely
- ❑ **Identify your priority areas for improvement** – ensuring these are linked with current priorities and are fully integrated into existing service improvement initiatives will mean they are more likely to be acted upon
- ❑ **Involve staff and service users** in deciding upon the actions to take to make the improvements real and lasting
- ❑ **Set up a process for ongoing monitoring** of the actions and improvements and regular communication about progress to stakeholders

- ❑ **Consider whether any further detailed analysis or support would be helpful** in supporting your quality improvement initiatives and whether there is anything else we can help you with. Our enhanced services include:
  - ❑ Detailed thematic analysis of written comments from women to improve the depth of reporting about experiences of care
  - ❑ Training for staff (including train the trainer programmes) in the interpretation of survey results and how to get the most from your survey programme will build capacity for improvement
  - ❑ Dedicated service improvement workshops and events built around your patient experience survey results

To discuss how we can help you further please contact our Senior Project Manager, Chris Henderson:

chris.henderson@patientperspective.org

Report to:	Trust Board (Public)	Agenda item:	5.3
Date of meeting:	27th June 2023		

Report tile:	Q4 Learning from Deaths Report 2022-23			
Status:	Information	Discussion	Assurance	Approval
	Yes	Yes	Yes	
Approval Process: (where has this paper been reviewed and approved):	Mortality Surveillance Group CGC			
Prepared by:	Mr Richard Cole, Trust Mortality Lead Dr Ben Browne, Head of Clinical Effectiveness			
Executive Sponsor: (presenting)	Peter Collins, Chief Medical Officer			

Recommendation:

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

Executive Summary:

Please refer to the Q4 summary of learning (which is outlined on pages 3-5 of this report) and the year-end summary (outlined on pages 7-9 of the report).

There was a total of 289 inpatient deaths in Q4 (inclusive of patients who died in either the Emergency Department or Hospice).

During Quarter 4 there was/were:

- 3 deaths where COVID-19 was the primary cause of death (recorded as 1a on the death certificate)
- 3 stillbirths
- No maternal deaths
- 2 deaths reported in patients with a learning disability
- 2 deaths in patients considered to have a serious mental illness

A total of 275 deaths were scrutinised by the Medical Examiners in Quarter 3 (95% of all inpatient deaths) and 15 Structured Judgement Reviews (SJRs) were requested.

End of Life Care

The Your Views Matter Bereavement survey aims to capture the views and experience of bereaved families.

During Quarter 4**:**

- 85 families gave consent for the Trust's Your Views Matter bereavement survey to be posted.
- A response rate of 33% (n~ 28) was achieved.
- 68% of respondents rated the overall end of life care as good or very good.

National Benchmarks

Latest SHMI (as reported by NHS Digital at the time of publication):

- The SHMI continues to be within the expected range at both Trust-level and with our hospice data removed.
- The SHMI for Salisbury District Hospital for the twelve-month period ending in December 2022 is 1.0683 and for Salisbury Trust is 1.1152.

HSMR:

A two-month time lag continues to be applied to the HSMR data to improve the accuracy of our data reporting for the 12-month period (allowing for any potential coding delays). Therefore, the latest HSMR is for the 12-month rolling period ending in December 2022.

- The HSMR (relative risk) for the Trust for the twelve-month period ending in December 2022 is 121.5 and is statistically higher than expected (113.0 – 130.5, 95% confidence limits).
- The HSMR (relative risk) for Salisbury District Hospital (excludes hospice data) for the twelve-month period ending in December 2022 is 114.6 and is statistically higher than expected (105.8 – 123.9).
- Weekday HSMR is 119.1 and weekend HSMR is 130.8. Both are statistically higher than expected.

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

Quarter 4 2022/23 Learning from Deaths Report

June 2023

GLOSSARY OF TERMS

CUSUM
A cumulative sum statistical process control chart plots patients' actual outcomes against their expected outcomes sequentially over time. The chart has upper and lower thresholds and breaching this threshold triggers an alert. If patients repeatedly have negative or unexpected outcomes, the chart will continue to rise until an alert is triggered. The line is then reset to half the starting position and plotting of patients continues. The CQC monitor CUSUM's at a 99.9% threshold to determine outliers.

HSMR
The Hospital Standardised Mortality Ratio (HSMR) is the ratio of observed deaths to expected deaths for a basket of 56 diagnosis groups, which represent approximately 80% of in hospital deaths. It is a subset of all and represents about 35% of admitted patient activity.

ME
Medical examiners (MEs) are senior medical doctors who are contracted for a number of sessions a week to undertake medical examiner duties, outside of their usual clinical duties. They are trained in the legal and clinical elements of death certification processes. The purpose of the medical examiner system is to provide greater safeguards for the public by ensuring proper scrutiny of all non-coronial deaths, ensure the appropriate direction of deaths to the coroner, provide a better service for the bereaved and an opportunity for them to raise any concerns to a doctor not involved in the care of the deceased, improve the quality of death certification, and improve the quality of mortality data. The Medical Examiner (ME) system was introduced in April 2020 and was established in the Trust by August 2020.

MSG
The Mortality Surveillance Group (MSG) meets bi-monthly and is responsible for reviewing deaths to identify problems in care and commissioning improvement work, to reduce unwarranted variation and improve patient outcomes. To identify the learning arising from reviews and improvements needed.

PALS
The Patient Advice and Liasion Service (PALS) offers confidential advice, support and information on health-related matters and they provide a point of contact for patients, their families and their carers. A complaint is an expression of dissatisfaction made to an organisation, either written or spoken, and whether justified or not, which requires a formal response from the Chief Executive. A concern is a problem raised that can be resolved/responded to by the clinical or non-clinical teams concerned. Concerns include issues where the patient/family member has said that they don't want to make a formal complaint.

SFT
Salisbury NHS Foundation Trust.

SHMI
The SHMI is the ratio between the actual number of patients who die following hospitalisation at the trust and the number that would be expected to die on the basis of average England figures, given the characteristics of the patients treated there. It covers in-hospital deaths and deaths that occur up to 30 days post discharge for all diagnoses excluding still births. The SHMI is an indicator which reports on mortality at trust level across the NHS in England and it is produced and published as an official statistic by NHS Digital.

SII
Serious Incident requiring Investigation.

SJR
The Structured Judgement Review (SJR) is a process for undertaking a review of the care received by patients who have died.

SMR
A calculation used to monitor death rates. The Standardised Mortality Ratio (SMR) is the ratio of observed deaths to expected deaths, where expected deaths are calculated for a typical area with the same case-mix adjustment. The SMR may be quoted as either a ratio or a percentage. If the SMR is quoted as a percentage and is equal to 100, then this means the number of observed deaths equals that of expected. If higher than 100, then there is a higher reported mortality ratio.

SOX
Sharing Outstanding Excellence (SOX) is a method of paying a compliment to a team or a member of staff. It is a way of learning from when things go well.

1. Purpose

To comply with the national requirements of the Learning from Deaths framework, Trust Boards must publish information on deaths, reviews and investigations via a quarterly report to a public board meeting.

2. Background

The Learning from Deaths initiative aims to promote learning and improve how Trusts support and engage bereaved families and carers of those who die in our care.

3. Summary of Learning in Q4

The Trust MSG met on 14th February 2023 during Q4, where learning, improvement themes, and actions relevant to in-hospital deaths were discussed.

Targeted subgroup analysis of Dr Foster-Telstra flagged areas (diagnosis groups where the Trust was an outlier based on statistical modelling) were reported including a more in-depth analysis of a sample from the pneumonia mortality cohort.

Further progress was also reported on the standardisation of Trust Morbidity and Mortality (M&M) meeting mortality reviews with an emphasis on documentation of learning points and also actions which might be applicable beyond the individual specialty.

Including these M&M mortality reviews alongside formal SJRs, some of which are part of commissioned reviews focussed on specific Dr-Foster-Telstra alerts, there has been a substantial increase in total mortality reviews from Q1 & Q2 (11) to Q3 & Q4 (133).

3.1. SJRs and The Medical Examiner System

87% of deaths were scrutinised by the MEs in Q4, with fifteen Structured Judgement Reviews (SJRs) requested, an increase on Q3. Indications for these reviews are documented in the relevant section of this report.

The SJR form has been upgraded to include MCCD (cause of death) and a section to capture additional learning points or any change in practice which might have been identified.

Medical Examiner (ME) Community roll-out has been delayed nationally from the original start date of Spring 2023.

Additional office space for this Bereavement suite work would be beneficial particularly in the context of the shift from paper documentation (such as Form ME-1 and the Summary of Death Certification form) to on-line form completion, requiring more desk space and network points and quiet areas for conversations with relatives.

3.2. Serious Incidents Requiring Investigation (SIIs) / Case Reviews

There were no reports in Q4 relating to SIIs resulting in death.

The Perinatal Mortality Review Tool (PMRT) report confirmed that there were no outstanding cases for review, and compliance with the required standard was achieved.

The National Child Mortality Database Programme report confirmed compliance with the relevant recommendations.

Case reviews: for Morbidity and Mortality meetings, the new standardised Review proformas are now being used in several specialties for non-ME triggered SJRs, consisting primarily of a checklist for lower-level reviews, together with a section for learning points. The intention is for these to converge into a standard dataset to allow interrogation of all mortality data via the new Audit Management and Tracking (AMaT) mortality audit online platform scheduled to be introduced in Autumn 2023. Learning which is of relevance beyond the individual specialty will be shared across the Trust.

A LeDeR nurse has been appointed by the Trust who will work closely with the mortality team, for example, in reviewing relevant cases needing SJR completion, and it is hoped that that complex LeDeR learning disability mortality reviews will in future be processed more efficiently.

3.3. Bereavement

The majority of bereaved families continue to rate the End-of-life care (EoLC) as being "good" or "very good" (68%) via the Bereavement postal survey, with a response rate of 33% in Q4. Scores in areas such as relief of symptoms, communication, compassion & dignity and support for loved ones had the majority scoring as "good" or "very good" with a few scores in the "poor" or "very poor" category; this is an increase on Q3 when there were none rated as "very poor" in the first 3 fields. Further information can be found in the relevant section of this report.

The new Mortality checklist proforma for non-ME triggered M&M meeting reviews includes a section on detail of EoLC, therefore, once incorporated into routine practice, will give further data on the quality of this part of the service and highlight areas for learning and improvement; preliminary review of mortality cases admitted with a diagnosis of acute and unspecified renal failure confirmed that there is scope for some improvement. There are five key care items relating to EoLC, including Discussion with family/carers and Respect form completed. Out of 23 cases with complete data in this EoLC section, 105/115 items (91%) had been carried out.

3.4. Formal Alerts and Reports

The Trust's SHMI is within the expected range (November 2021 - October 2022) and slightly decreased from the previous published figure, but the HSMR is still statistically (using 95% confidence limits) higher than expected.

Analysis of SMR [All diagnoses], as with the HSMR, shows that the monthly figure is trending away from being higher than expected, but the rolling 12-month HSMR trend is still increasing. This has been discussed and it was agreed to examine in more detail the Co-morbidity scoring attributed to subgroups where the score was reported as zero.

Commissioned reviews have also been set up in response to Dr Foster-Telstra alerts and reports.

These include a proforma-based review of previously un-reviewed pre-November 2022 Covid cases using the new mortality checklist (48 cases). This revealed that the overall level of care of this August 2021 - October 2022 cohort was good, with no mortality case being >50 % avoidable. All cases had been seen by a consultant within 14 hours of admission. Possible areas for improvement included assessment of capacity for consent to inpatient treatment.

Pneumonia mortality cases were flagged as a potential outlier (ie, patients with a diagnosis of pneumonia on admission). A more detailed secondary review of 19 SJRs from these cases showed that although all were admitted with a diagnosis of pneumonia, the MCCD 1a was stated as bronchopneumonia or pneumonia in only nine (others included heart failure, PE and MI). Overall Assessment of Care (OAoC) was rated as good in 12 cases, adequate in 4 and poor in one, for which further action was requested in the form of discussion at that team's M&M meeting (2 cases had missing OAoC score). Only one case had not been seen by the consultant within 14 hours of admission. There were no Trust-wide themes in this heterogeneous group but there were several specific learning points including incomplete documentation of inpatient falls (one patient) and one case admitted to an inappropriate ward.

Regarding Acute and unspecified renal failure mortality cases, which is also an area flagged by Dr Foster-Telstra, preliminary analysis had shown that no single age range group was an outlier so the whole group (27 cases) was reviewed using the M&M checklist proforma. An initial review, with a further report to be presented at the MSG meeting in June 2023, confirmed an average age of 76 years (range 53-99) and average Overall assessment of Care as 4 (Good) with formal SJRs triggered in 2 cases, neither of which led to further action being required.

Septicaemia (non-labour related) has seen a reducing trend in Relative risk over the last twelve periods; volumes within this group have also declined and crude rates are now below expected rate

Mortality Dashboard

Summary Of Mortality Data 2022/2023																
Categories	Quarter 1				Quarter 2				Quarter 3				Quarter 4			
	April	May	June	**Q1 Total**	July	Aug	Sep	**Q2 Total**	Oct	Nov	Dec	**Q3 Total**	Jan	Feb	March	**Q4 Total**
All inpatient Deaths (inc. ED and Hospice)	88	84	87	259	88	82	73	243	75	77	102	254	106	88	95	289
Deaths Reviewed/Scrutinised by the ME	79	72	65	216/ 83%	66	64	65	195/ 80%	61	71	93	225/ 89%	103	81	91	275/ 95%
SJRs requested by ME	6	6	5	17	5	1	1	7	1	5	7	13	6	4	5	15
ED Deaths	5	4	5	14	4	7	4	15	6	5	9	20	3	6	2	11
Hospice Deaths	9	12	17	38	14	14	12	40	15	10	20	45	19	14	17	50
SFT Nationally Reported Covid-19 Deaths*	31	6	5	42	19	11	3	33	9	0	2	11	N/A	N/A	N/A	N/A
Covid-19 as Primary cause of death (recorded as Covid 1a)	6	1	1	8	6	1	0	7	1	0	0	1	1	0	2	3
Stillbirth	0	0	1	1	1	0	0	1	0	0	0	0	2	0	1	3
Neonatal Deaths	0	1	0	1	0	0	0	0	0	0	0	0	0	0	0	0
Maternal Deaths	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Learning Disability Deaths**	0	0	2	2	2	0	0	2	0	0	1	1	1	1	0	2
Serious Mental Illness**	0	0	0	0	0	0	0	0	0	3	1	4	1	1	0	2

indicates where an individual has either died within 28-d of a positive swab result and/or COVID-19 has been reported on the death certificate

****as reported by the Medical Examiner***

Year – End Summary (2022/23)

During 2022/23 there has been an increase in the crude number of deaths observed at Salisbury NHS Foundation Trust and we continue to monitor these trends closely. This rising trend is also one which has been observed nationally since the COVID-19 pandemic.

The total number of deaths and the total number of SJRs (including checklists) completed during each quarter of 2022/23 were as follows:

	Quarter 1	Quarter 2	Quarter 3	Quarter 4	**YEAR TOTAL**
Inpatient Deaths (inclusive of Emergency Department and Hospice)	259	243	254	289	1045
1st Scrutinised by the Medical Examiner	216	195	225	275	911/ 87%
Additional reviews (SJRs) completed	32	14	115	92	253
SJRs undertaken related to deaths during 2022/23	10	1	68	65	144
SJRs undertaken related to deaths during 2021/22	22	13	47	27	109
Patient deaths judged more likely than not to have been due to problems in the care provided to the patient (Hogan Score)	<5	<5	<5	<5	<5

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

Most deaths that occur at Salisbury NHS Foundation Trust are reviewed (scrutinised) by the ME shortly after death. An internal review (known as a structured judgement review or SJR) may be requested should there be potential learning identified following the death of a patient. This could be identified through a review of the medical records or following consultation with the relatives or carers of the bereaved. In addition to cases flagged up by the ME, reviews may be commissioned or undertaken by clinical specialties through peer learning and/or at Mortality and Morbidity (M&M) meetings.

During 2022/23 we commissioned reviews looking at specific diagnosis groups where alerts had been raised through statistical modelling. This included undertaking a review of all COVID-19 deaths up to and including November 2022, and a review of specific clinical diagnosis groups which include COPD and Bronchiectasis, Pneumonia, and Acute Renal Failure. Patient deaths judged more likely than not to have been due to problems in the care provided to the patient.

Several changes have been made in 2022/23 to improve how we are learning from deaths and responding to feedback. A Trust Mortality Lead and a learning disability nurse were both newly appointed and have been supporting our learning from deaths programme. A particular focus has been on supporting clinical specialties to undertake reviews, whilst ensuring that there is a wider pool of professionals who are able to undertake these reviews across the Trust as a whole. A new abbreviated version of the SJR (a checklist) is being piloted to help increase the uptake of reviews whilst ensuring that there is a greater focus on any learning and actions.

Other Developments:

A new electronic system to manage mortality reviews and learning from deaths will be adopted in 2023/24. The procurement of this will closely mirror that of clinical audit, as the same system will be used to manage both processes using two separate modules. One of the benefits will be to increase the visibility of data and enable real-time reporting and sharing of learning. Reducing the administrative burden will also ensure that more resources can be channelled into learning and the delivery of actions.

In addition, during 2022/23 we started to develop an in-house mortality dashboard (using the Power-Bi capabilities which have been adopted by our informatics team). We hope to go-live with this in 2023/24, and the data should provide the Trust with new insights in relation to our mortality data. This tool will also support clinical specialties with reviewing their mortality data and this will be another tool for sharing learning across the organisation. In addition, members of our informatics and mortality teams have been undergoing structured training, provided by our external partners (Telstra Health U.K), to further improve our understanding of the local and national mortality data which is accessible to staff members using the Dr Foster toolkit.

Preparations for the community ME roll-out have been ongoing, with several GPs having been newly appointed to the role of ME during 2022/23.

Summary:

- **The Trust's Mortality Surveillance Group (MSG) continues to meet every two months**
- **Several commissioned reviews were undertaken during 2022/23 and learning was shared and discussed at the Trust Mortality Surveillance Group (MSG)**
- **A new electronic system for managing mortality reviews and learning from deaths will be adopted in 2023/24**

- **A mortality dashboard is being newly developed using new Power-Bi software to provide new data insights**
- **Structured training has been provided to staff to improve our understanding of local and national mortality data**
- **New staff were appointed during 2022/23 and will help support the Trust's learning from deaths programme**

5. Medical Examiner (ME) and Structured Judgement Reviews (SJR)

The ME system was introduced to ensure excellence in care for the bereaved and learning from deaths to drive improvement. The Medical Examiners aim to scrutinise all acute hospital deaths, and a local network of MEs exists to share learning and provide an independent review facility if needed.

- **15 Structured Judgement Reviews were requested by the Medical Examiners in Q4.**

The requests (identified through ME screening) are categorised into problem themes and stage of care (see Table 1 below). Please note that some requests may occasionally fall into multiple categories. Where requests do not fit into any of the categories below, this may be because the ME has requested a review for a specific group of patients, e.g. where a serious mental illness or learning disability has been identified, but no obvious problems in care were identified during their initial screening.

Table 1: Problems in Care Identified by ME Screening–Quarter 4, 2022-23

Type of problem	*Stage of Care* →							
	Admission and initial assessment (first 24 hours)	Ongoing care	Care during a procedure	Perioperative/procedure care	End of life care (or discharge care)	Concerns about over all care	**2022/23 YEAR TOTAL**	***2021/22 YEAR TOTAL***
Problem in assessment, investigation or diagnosis (including assessment of pressure ulcer risk, venous thromboembolism (VTE) risk, history of falls)	*1*	1					***7***	*17*
Problem with medication / IV fluids / electrolytes / oxygen	*1*	*2*			*1*		***5***	*3*
Problem related to treatment and management plan (including prevention of pressure ulcers, falls, VTE)	*1*	2					***8***	*7*
Problem with infection control							***0***	***0***
Problem related to operation/invasive procedure (other than infection control)		*1*					***2***	*4*
Problem in clinical monitoring (including failure to plan, to undertake, or to recognise and respond to changes)		*4*			*1*		***7***	*13*
Problem in resuscitation following a cardiac or respiratory arrest (including cardiopulmonary resuscitation (CPR))							***0***	***0***
Problem of any other type not fitting the categories above						4	***26***	*24*
2022/23 YEAR TOTAL	***6***	***15***	***0***	***0***	***5***	***30***		
2021/22 YEAR TOTAL	*9*	*24*	*3*	*3*	*4*	*25*		

6. Your Views Matter Survey & End of Life Care

The Your Views Matter Bereavement survey was established in 2020 and was created to capture the views and experiences of bereaved relatives. This is an opportunity for families to feedback their experiences about the support they themselves received and the end of life care their loved one was given during their last days of life in Salisbury Hospital. Whilst the feedback is anonymous, relatives are able to name individuals they would like to acknowledge and thank for making a difference. Likewise, where the experience was less than satisfactory those completing the survey also have the option to enclose their contact details and be followed up by the PALS team.

In Q4, 85 families gave consent for the Trust's Your Views Matter bereavement survey to be posted. Achieving a response rate of 33% (n~ 28). Although an improvement on previous quarters, this is noted to be lower than the average response rate seen for 2021-2022 (39%).

Average response rate for 2022/23 is 28%.

Figure 1.1. Overall rating of experience for Q4 2022-23

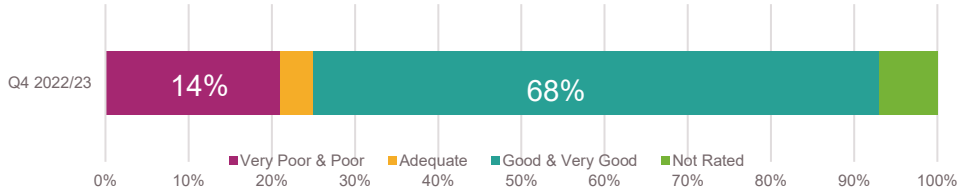
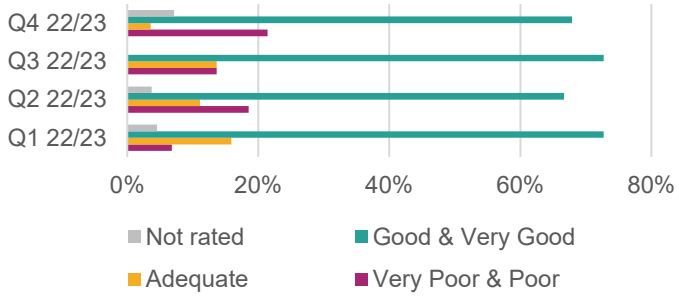


Figure 1.2. Overall Satisfaction Rating



Sixty-eight percent of respondents rated the overall end of life care as good or very good. This is a slight reduction seen on Q3, and marginally lower the annual average which is 70%. This average is less than 2021/22, where this was 79%.

Figure 1.3 Relief of symptoms

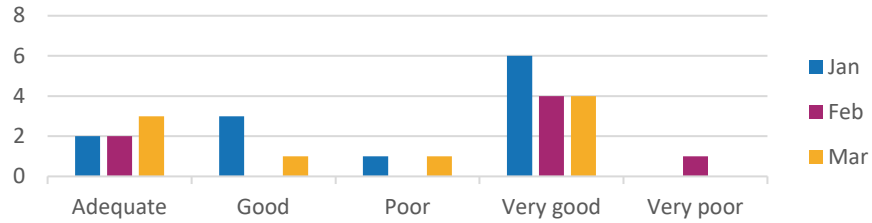


Figure 1.4 Communication

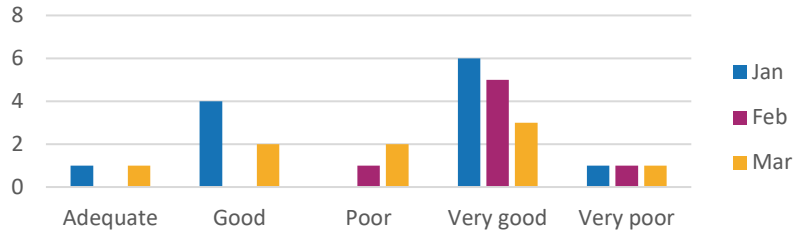


Figure 1.5 Compassion and dignity

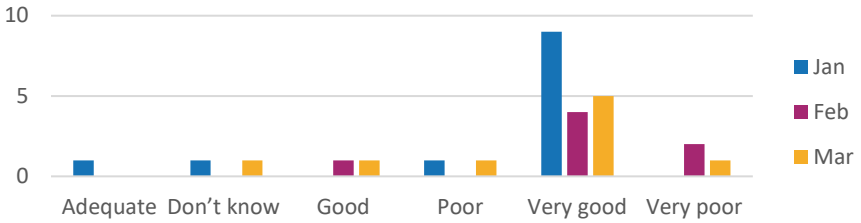
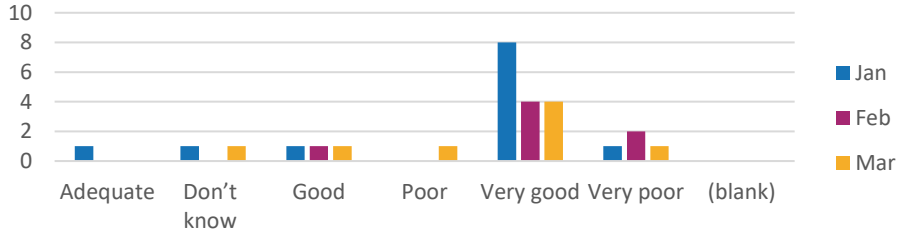


Figure 1.6 Support for loved ones



Figures 1.3 to 1.6 (above) show the overall ratings in the key areas of patient experience:

- **Relief of symptoms**
- **Communication**
- **Compassion and Dignity**
- **Support for loved ones**

Facilities/environment have continued to be highlighted throughout the year as an area for attention. There were various references in Q4 to the noise levels on the ward and the fact that a quieter space or single occupancy/private room would have greatly impacted that experience of both the patient and the grieving families at time of death.

In Q4, several comments were made in relation to the experiences with the bereavement office and medical examiner's office. None of these comments were negative (Fig 1.7).

Figure 1.7 – Feedback word Cloud

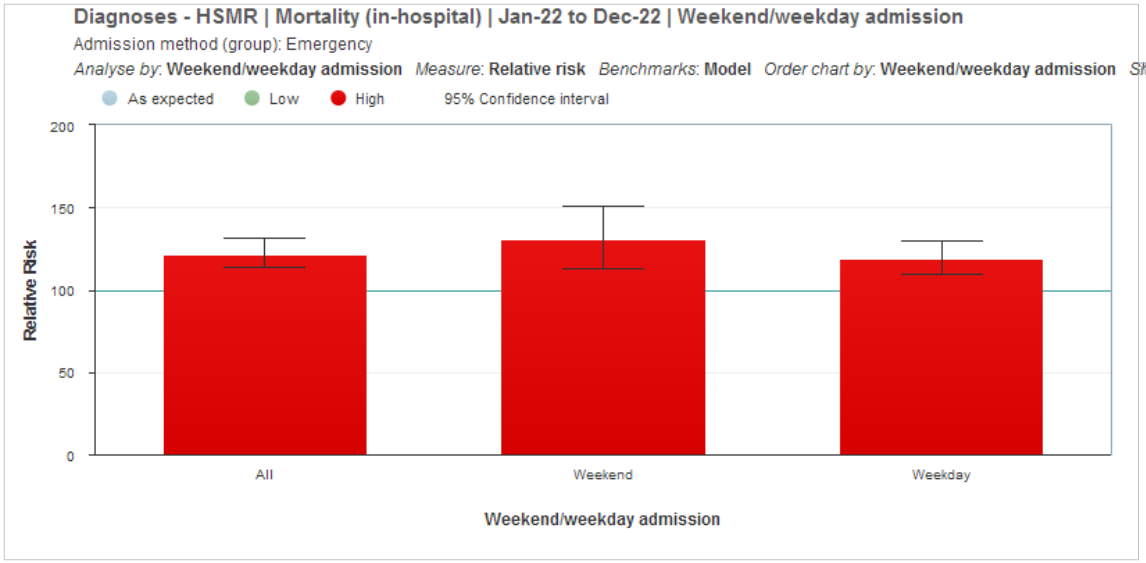
7. Mortality Benchmarking

A two month time lag has been applied to the HSMR data to improve the accuracy of data for the 12-month time period. This is due to a potential coding backlog for the two most recent months of discharge data. Therefore, the latest HSMR is for the 12-month rolling period ending in December 2022.

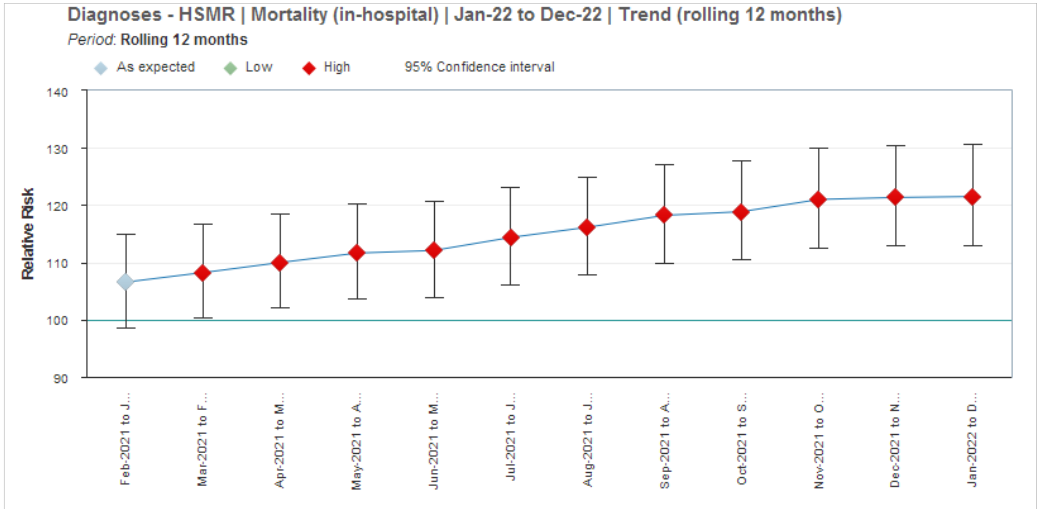
7.1. HSMR rolling 12-month trend to December '22

- The HSMR (relative risk) for the Trust for the twelve month period ending in December 2022 is 121.5 and is statistically higher than expected (113.0 – 130.5, 95% confidence limits).
- The HSMR (relative risk) for Salisbury District Hospital (excludes hospice data) for the twelve month period ending in December 2022 is 114.6 and is statistically higher than expected (105.8 – 123.9).
- Weekday HSMR is 119.1 and weekend HSMR is 130.8. Both are statistically higher than expected.

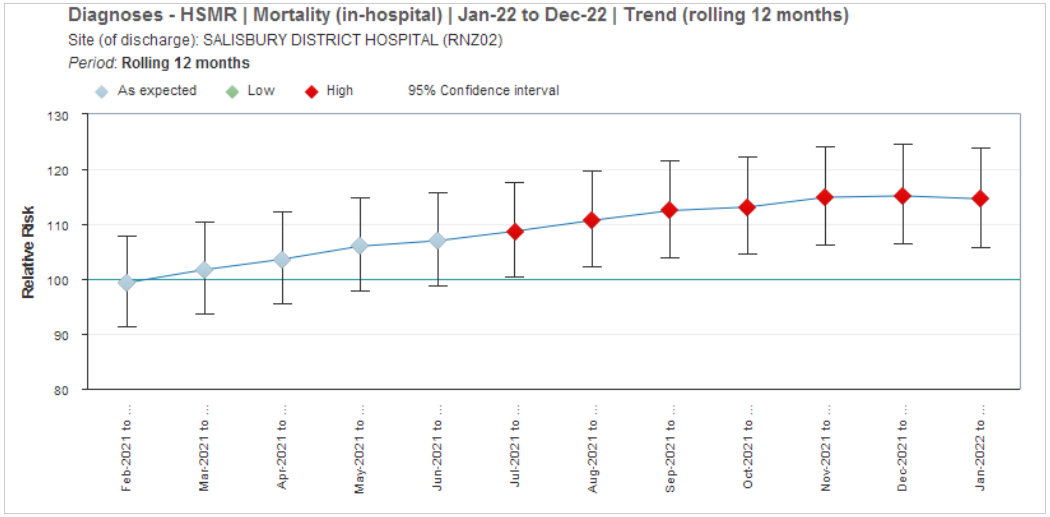
Weekend/weekday HSMR



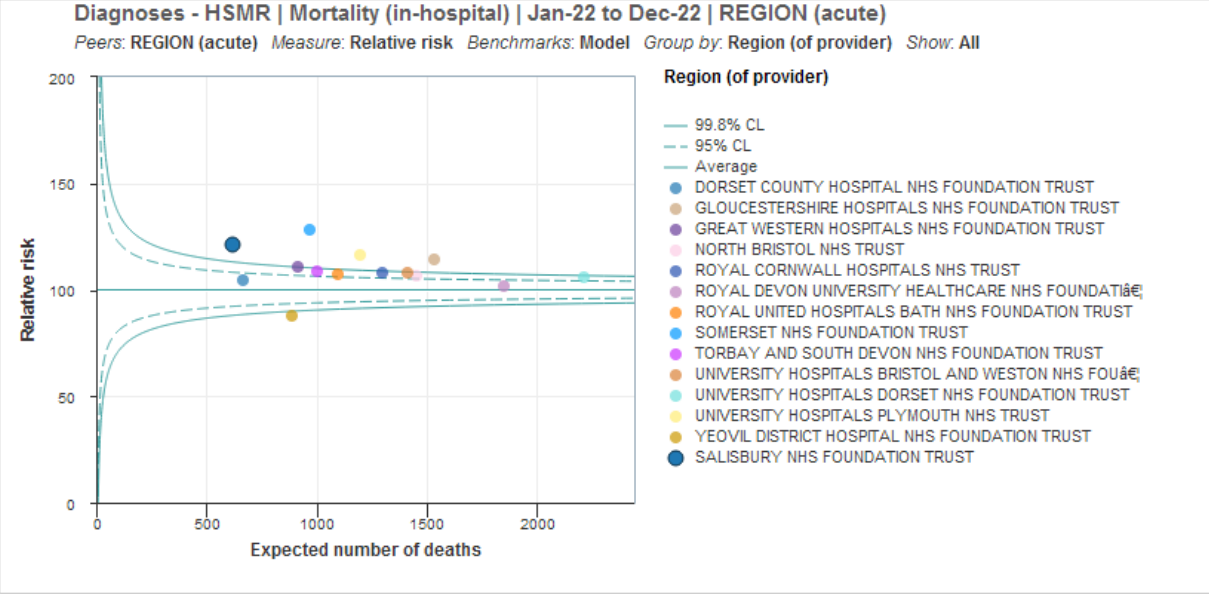
Trust HSMR - Rolling 12-month trend to year-end December 2022



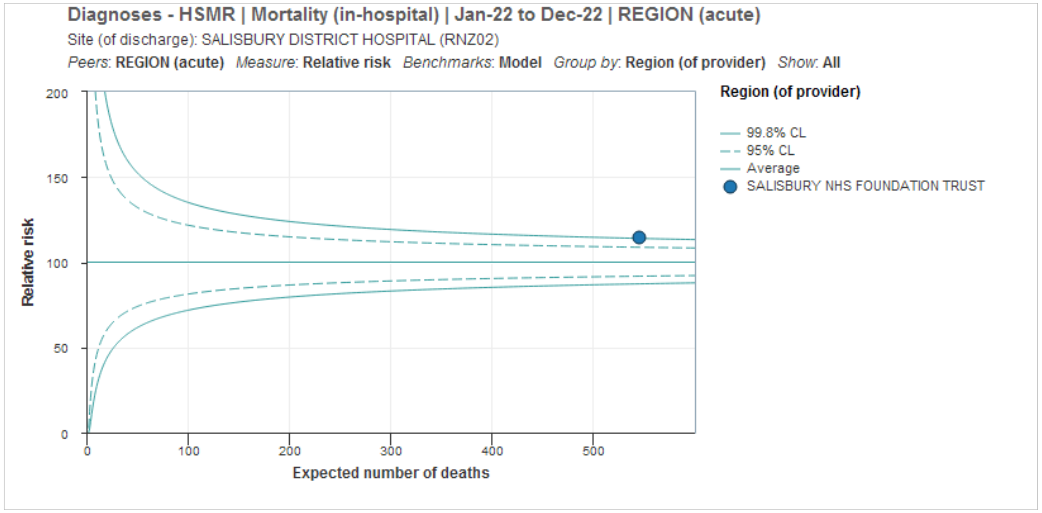
District Hospital HSMR (excludes hospice data) – Rolling 12-month trend to year-end December 2022



Peer comparison of Trust HSMR - Rolling 12-month trend to year-end December 2022



District Hospital HSMR - Rolling 12-month trend to year-end December 2022



7.2. Summary Hospital-Level Mortality Indicator (SHMI) for January 2022 – December 2022

The SHMI is an indicator which reports on mortality at Trust level across the NHS in England and it is published as an official statistic by NHS Digital. The latest available data is published in this report.

- **The SHMI continues to be within the expected range at both Trust-level and also with our hospice data removed.**

- **SHMI is 1.1152 for the twelve month period ending in December 2022 for SFT. When comparing SHMI by site, Salisbury District Hospital is 1.0683 and Salisbury Hospice is 2.3136.** When compared with regional peers, the Trust has a SHMI within the expected range.

Site code	Site name	Provider spells	Observed deaths	Expected deaths	SHMI value
RNZ02	Salisbury District Hospital	32,135	930	870	1.0683
RNZ78	Salisbury Hospice	110	80	35	2.3136

- The tables in the supplementary data pack show additional SHMI data for SFT as a breakdown for specific conditions for the twelve month period ending in December 2022.

7.3. Alerts

- All new alerts continue to be discussed at the Trust MSG meeting where a further review or investigation into deaths may be requested. A representative from Telstra Health U.K (Dr Foster) attends and provides a regular report of our mortality data and all new alerts. A member of the Trust Information Services team and coding department also attend to further support our understanding of the data.

8. *Recommendations*

The report is provided for assurance that the Trust is learning from deaths and making improvements.

Lead Author(s):
Mr Richard Cole, Trust Mortality Lead / Dr Ben Browne, Head of Clinical Effectiveness

9. *Supplementary Data*

SHMI Data for the 12 Month Period Ending in December 2022

SHMI - Summary Hospital Mortality Indicator

Period: Jan 22 - Dec 22

Provider: RNZ - SALISBURY NHS FOUNDATION TRUST

Region: SOUTH WEST

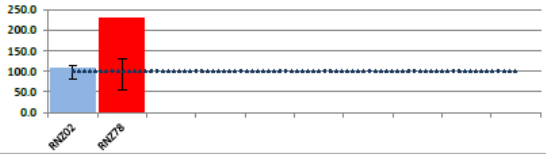
Click to enable bespoke peer

SHMI - Published (With Over Dispersion)

** click group name to filter; click header title to clear*

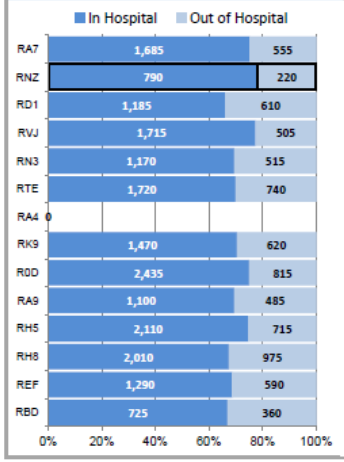
	Provider	Denominator	Obs	Exp	Obs-Exp	SHMI	Low	High
RBD	Dorset County Hospital NHS Foundation Trust	24,510	1,085	950	135	114.43	88.66	112.79
REF	Royal Cornwall Hospitals NHS Trust	55,890	1,875	1,900	-25	98.71	89.44	111.81
RH8	Royal Devon University Healthcare NHS Foundation Trust	85,075	2,985	3,075	-90	97.04	89.76	111.41
RH5	Somerset NHS Foundation Trust	74,110	2,825	2,860	-35	98.70	89.72	111.46
RA9	Torbay And South Devon NHS Foundation Trust	36,260	1,585	1,530	55	103.43	89.25	112.05
R0D	University Hospitals Dorset NHS Foundation Trust	85,895	3,250	3,645	-395	89.16	89.84	111.31
RK9	University Hospitals Plymouth NHS Trust	64,815	2,090	1,935	155	108.04	89.46	111.79
RA4	Yeovil District Hospital NHS Foundation Trust	0	0	0	0	0.00	0.00	0.00
RTE	Gloucestershire Hospitals NHS Foundation Trust	91,260	2,460	2,215	245	111.23	89.56	111.66
RN3	Great Western Hospitals NHS Foundation Trust	53,945	1,685	1,505	180	111.99	89.23	112.07
RVJ	North Bristol NHS Trust	84,515	2,220	2,235	-15	99.22	89.56	111.65
RD1	Royal United Hospitals Bath NHS Foundation Trust	55,590	1,795	1,770	25	101.48	89.38	111.88
RNZ	Salisbury NHS Foundation Trust	32,245	1,010	905	105	111.52	88.59	112.88
RA7	University Hospitals Bristol And Weston NHS Foundation Trust	84,595	2,240	2,230	10	100.36	89.56	111.66
Group		828,705	27,105	26,755	350	101.31		

Site - All Diagnosis	Den	Obs	Exp	SHMI	Low	High
SALISBURY DISTRICT HOSPITAL	32,135	930	870	106.83	84.41	118.47
SALISBURY HOSPICE	110	80	35	231.36	69.08	144.76

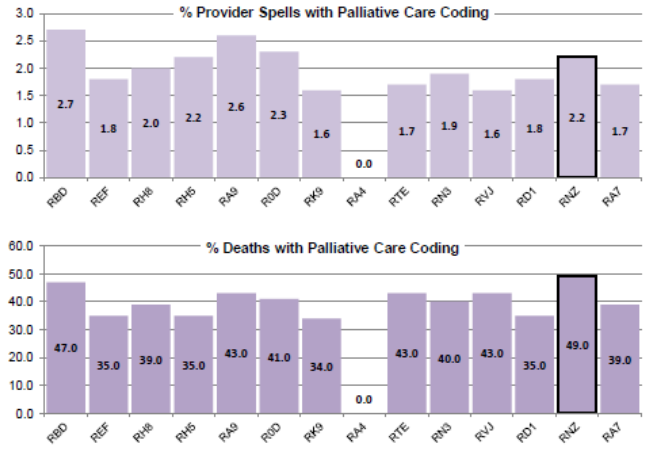


SHMI Group	Obs	Exp	SHMI	Low / High
Septicemia (except in labour), Shock	45	45.00	101.67	74.05 135.05
Cancer of bronchus, lung	35	25.00	142.42	68.08 146.89
Secondary malignancies	40	30.00	120.41	70.55 141.75
Fluid and electrolyte disorders	*	10.00	*	*
Acute myocardial infarction	15	20.00	75.29	65.37 152.98
Pneumonia	130	115.00	111.23	80.78 123.79
Acute bronchitis	15	10.00	123.80	55.83 179.11
Gastrointestinal haemorrhage	10	15.00	71.15	59.29 168.68
Urinary tract infections	15	20.00	71.73	61.87 161.63
Fracture of neck of femur (hip)	20	20.00	85.60	65.05 153.73

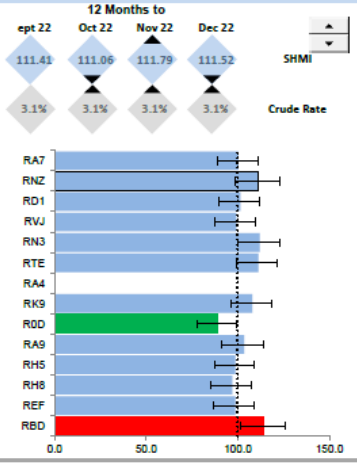
Deaths: In / Out Hospital



% Palliative Care Coding



Trend / Rate



SHMI Group - With 95% CI (Dr Foster)

SHMI Group	Obs	Exp	SHMI	Low / High
(75) Chronic obstructive pulmonary disease and bronchiectasis	40	20	200.00	142.87 272.35
(99) Acute and unspecified renal failure	25	15	166.67	107.83 246.04
(66) Acute cerebrovascular disease	65	55	118.18	91.21 150.64
(140) Allergic reactions, Rehabilitation care, fitting of prostheses, and adjustment of	15	10	150.00	83.89 247.42
(113) Other connective tissue disease	15	10	150.00	83.89 247.42
(82) Influenza, Acute and chronic tonsillitis, Other upper respiratory infections, Other upper respiratory	15	10	150.00	83.89 247.42
(8) Cancer of oesophagus	15	10	150.00	83.89 247.42
(42) Mental retardation, Senility and organic mental disorders	20	15	133.33	81.41 205.93

** Dr Foster "SHMI Group" values based on published, rounded values with 95% CI's*

ll_Jan22_Dec22

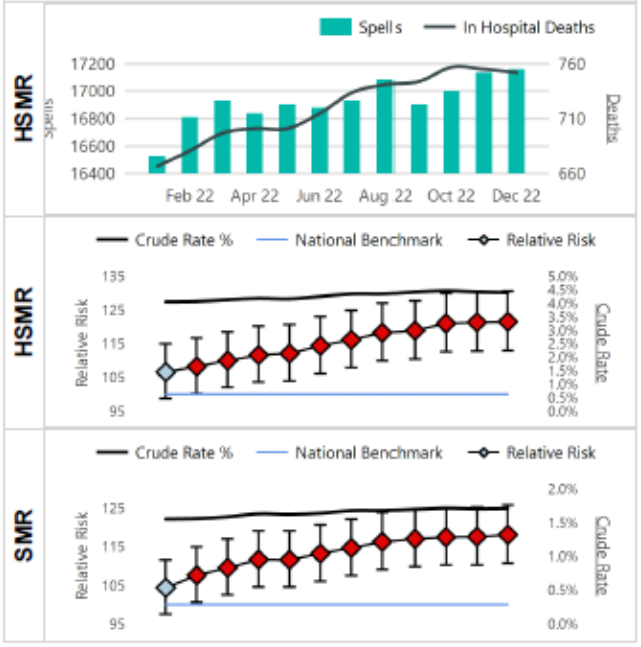
HSMR for the 12 month period to December 2022 for SFT (Includes Hospice Data)

dr foster. HEALTHCARE INTELLIGENCE PORTAL

Mortality Summary for 12 months to Dec-2022 as at 24/05/2023

SALISBURY NHS FOUNDATION TRUST - All Sites

Rolling 12 month trends



Diagnosis Groups

Relative Risk Alerts (Top 10)	CUSUM	Obs	Exp	RR	LCI	Trend
Chronic obstructive pulmonary disease and bronchiectasis	2	34	17.0	199.5	138.1	
Secondary malignancies	1	32	16.6	192.6	131.7	
Cancer of kidney and renal pelvis	0	5	1.5	330.0	108.3	
Acute and unspecified renal failure	1	29	18.5	156.6	104.9	
Pneumonia	1	132	108.1	122.2	102.2	
Skin and subcutaneous tissue infections	0	10	4.8	210.1	100.6	

CUSUM 99% Threshold (Top 6)	CUSUM	Obs	Exp	RR	LCI	Trend
Chronic obstructive pulmonary disease and bronchiectasis	2	34	17.0	199.5	138.1	
Secondary malignancies	1	32	16.6	192.6	131.7	
Acute and unspecified renal failure	1	29	18.5	156.6	104.9	
Pneumonia	1	132	108.1	122.2	102.2	
Other psychoses	1	5	2.1	239.5	77.2	
Other upper respiratory disease	1	4	1.5	258.2	69.5	

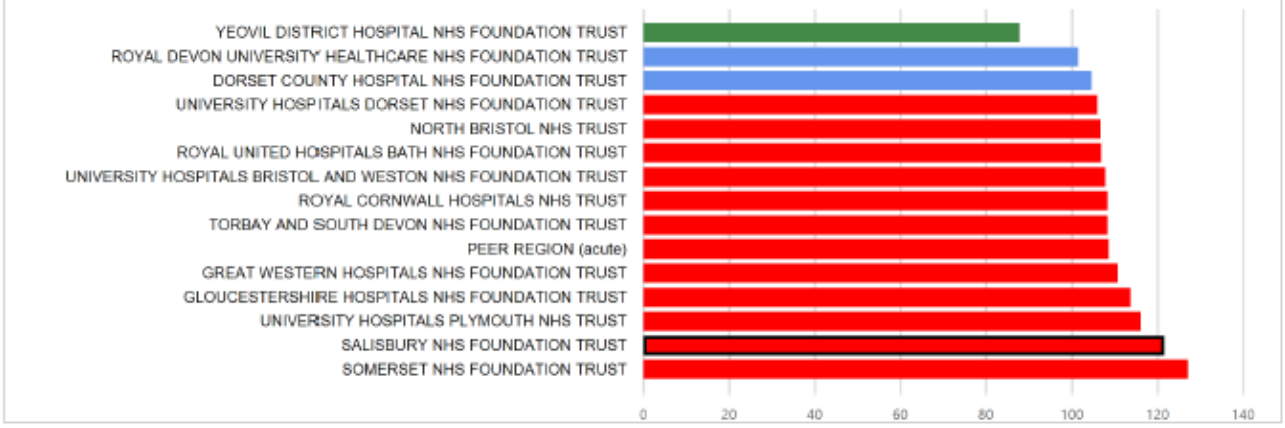
CUSUM 99.9% Threshold (Top 6)	CUSUM	Obs	Exp	RR	LCI	Trend
Chronic obstructive pulmonary disease and bronchiectasis	2	34	17.0	199.5	138.1	
Secondary malignancies	1	32	16.6	192.6	131.7	
Cancer of bronchus, lung	1	31	21.9	141.4	98.1	
Other connective tissue disease	1	12	8.2	146.2	75.4	

Patient Safety Indicators	Obs	Exp	RR	LCI	Trend

Mortality Influencers

Performance	Site	Trust	Peer	National
HSMR		121.5	108.6	101.2
SMR		118.1	107.5	100.8
Non-elective (HSMR)		121.3	108.6	100.9
Weekday, emergency (HSMR)		119.1	106.7	99.6
Weekend, emergency (HSMR)		130.8	114.7	104.9
Saturday, emergency (HSMR)		128.4	115.0	104.8
Sunday, emergency (HSMR)		131.3	114.7	104.8
Coding/Casemix	**Site**	**Trust**	**Peer**	**National**
% Non-elective deaths with palliative care (HSMR)		50.9%	41.3%	40.7%
% Non-elective spells with palliative care (HSMR)		6.2%	4.8%	5.0%
% Spells in Symptoms & Signs chapter		6.4%	6.8%	6.0%
% Non-elective spells with Charlson comorbidity score = 0 (HSMR)		49.0%	42.9%	41.4%
% Non-elective spells with Charlson comorbidity score = 20+ (HSMR)		12.9%	15.1%	16.0%
% Non-elective spells in Risk Band (0-10%) (HSMR)		84.9%	84.3%	83.8%

HSMR Peer Comparison



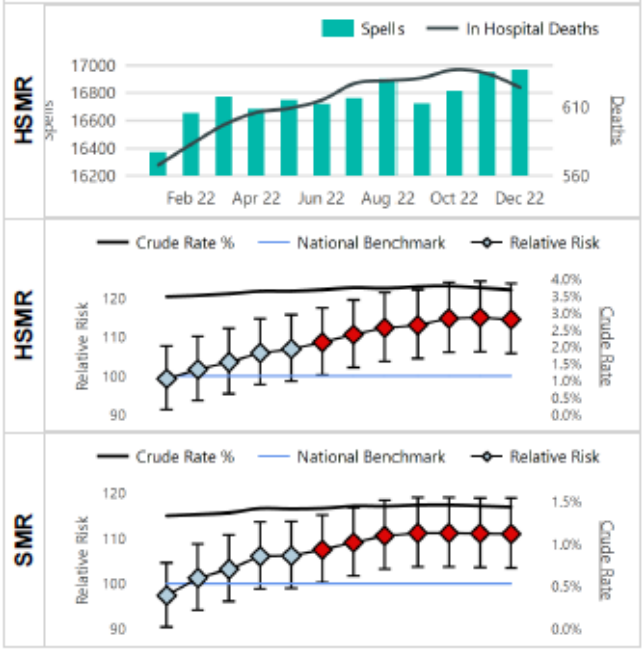
HSMR for the 12 month period to December 2022 for Salisbury District Hospital (Excludes Hospice Data)

dr foster. HEALTHCARE INTELLIGENCE PORTAL

Mortality Summary for 12 months to Dec-2022 as at 24/05/2023

SALISBURY NHS FOUNDATION TRUST - SALISBURY DISTRICT HOSPITAL (RNZ02)

Rolling 12 month trends



Diagnosis Groups

Relative Risk Alerts (Top 10)	CUSUM	Obs	Exp	RR	LCI	Trend
Chronic obstructive pulmonary disease and bronchiectasis	2	33	16.4	200.6	138.1	
Cancer of kidney and renal pelvis	0	4	0.8	492.2	132.4	
Acute and unspecified renal failure	1	28	18.0	155.3	103.2	
Pneumonia	1	127	104.4	121.6	101.4	

CUSUM 99% Threshold (Top 6)	CUSUM	Obs	Exp	RR	LCI	Trend
Chronic obstructive pulmonary disease and bronchiectasis	2	33	16.4	200.6	138.1	
Acute and unspecified renal failure	1	28	18.0	155.3	103.2	
Pneumonia	1	127	104.4	121.6	101.4	
Other psychoses	1	5	2.1	239.5	77.2	
Other upper respiratory disease	1	4	1.5	258.2	69.5	
Respiratory failure, insufficiency, arrest (adult)	1	7	6.0	117.2	47.0	

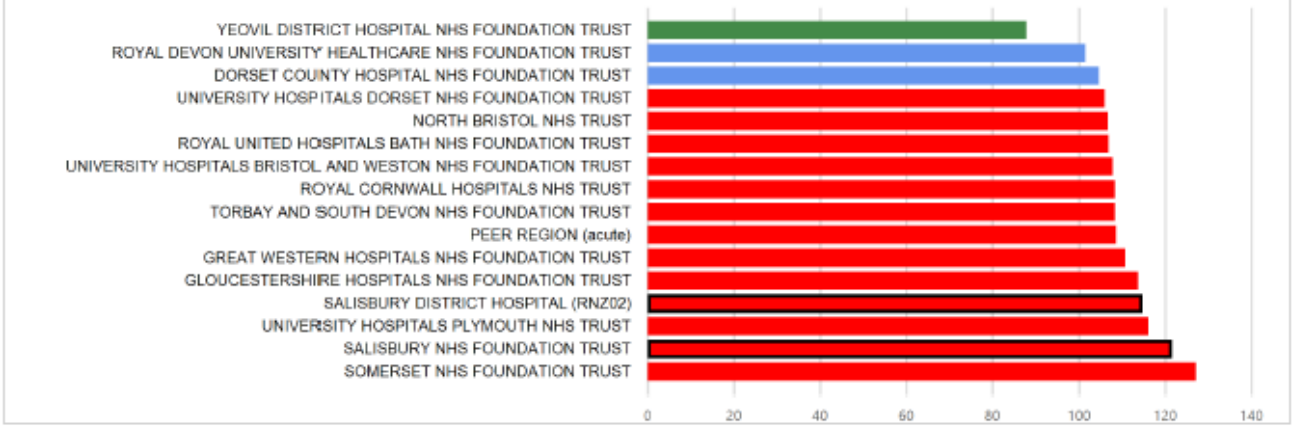
CUSUM 99.9% Threshold (Top 6)	CUSUM	Obs	Exp	RR	LCI	Trend
Chronic obstructive pulmonary disease and bronchiectasis	2	33	16.4	200.6	138.1	

Patient Safety Indicators	Obs	Exp	RR	LCI	Trend

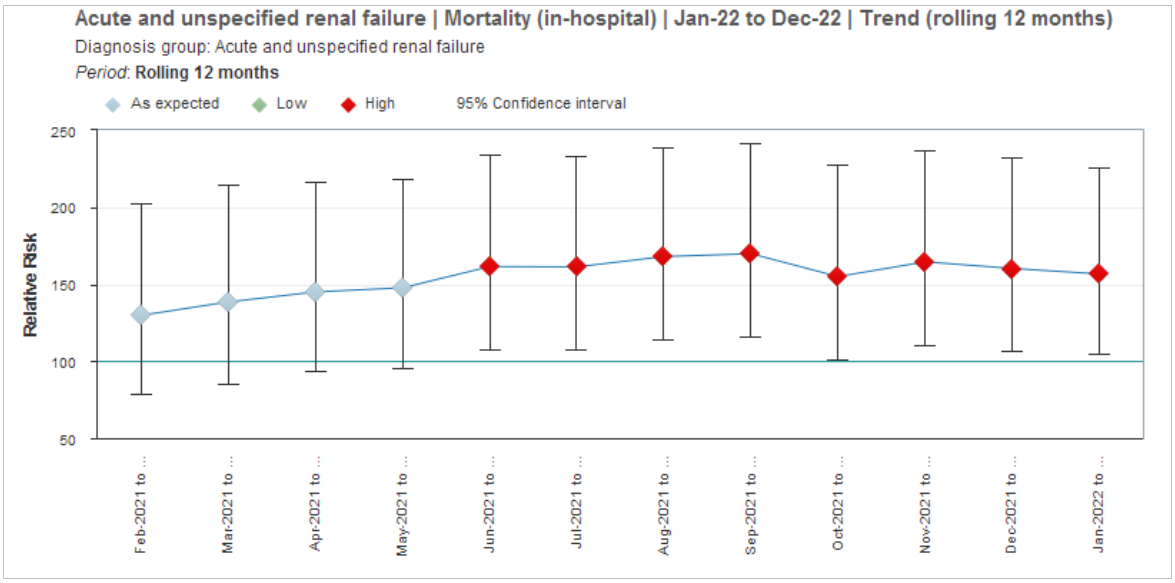
Mortality Influencers

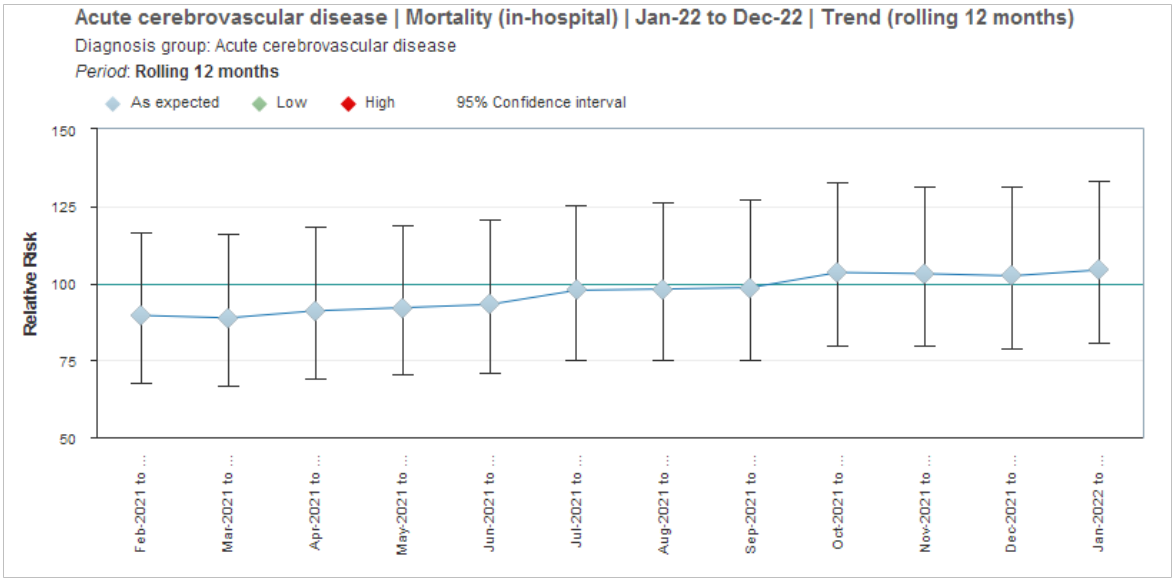
Performance	Site	Trust	Peer	National
HSMR	114.6	121.5	108.6	101.2
SMR	111.0	118.1	107.5	100.8
Non-elective (HSMR)	115.0	121.3	108.6	100.9
Weekday, emergency (HSMR)	113.3	119.1	106.7	99.6
Weekend, emergency (HSMR)	122.9	130.8	114.7	104.9
Saturday, emergency (HSMR)	117.5	128.4	115.0	104.8
Sunday, emergency (HSMR)	126.4	131.3	114.7	104.8
Coding/Casemix	**Site**	**Trust**	**Peer**	**National**
% Non-elective deaths with palliative care (HSMR)	41.2%	50.9%	41.3%	40.7%
% Non-elective spells with palliative care (HSMR)	4.5%	6.2%	4.8%	5.0%
% Spells in Symptoms & Signs chapter	6.4%	6.4%	6.8%	6.0%
% Non-elective spells with Charlson comorbidity score = 0 (HSMR)	49.8%	49.0%	42.9%	41.4%
% Non-elective spells with Charlson comorbidity score = 20+ (HSMR)	12.4%	12.9%	15.1%	16.0%
% Non-elective spells in Risk Band (0-10%) (HSMR)	86.5%	84.9%	84.3%	83.8%

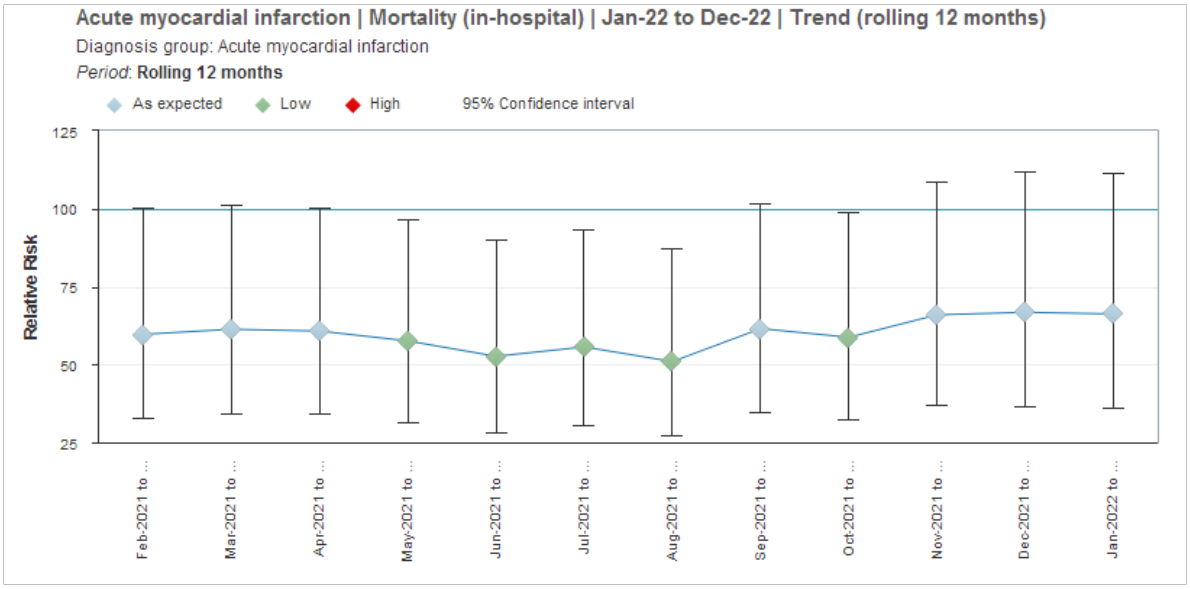
HSMR Peer Comparison

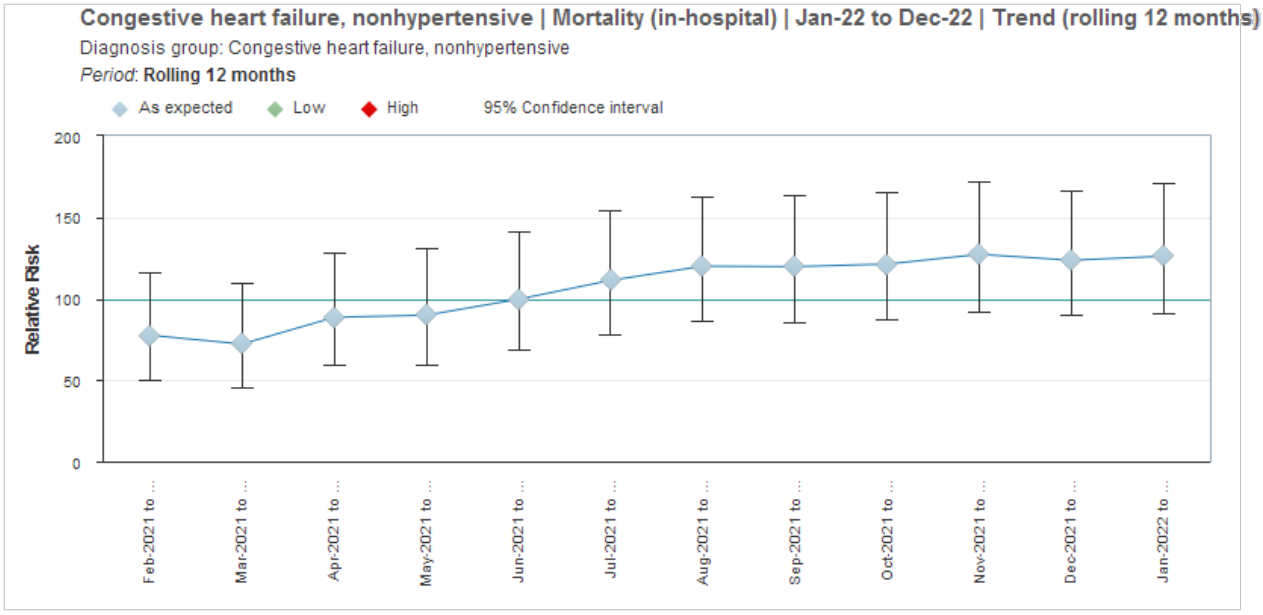


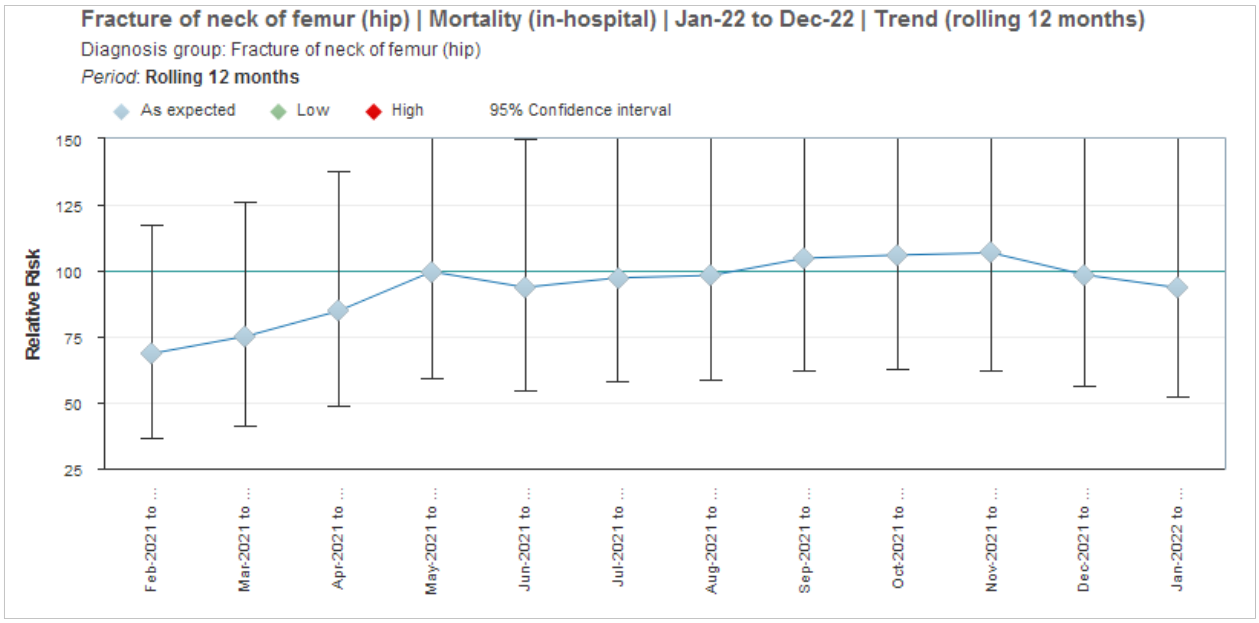
12-Month Trends in Relative Risk for High Risk Diagnosis Groups

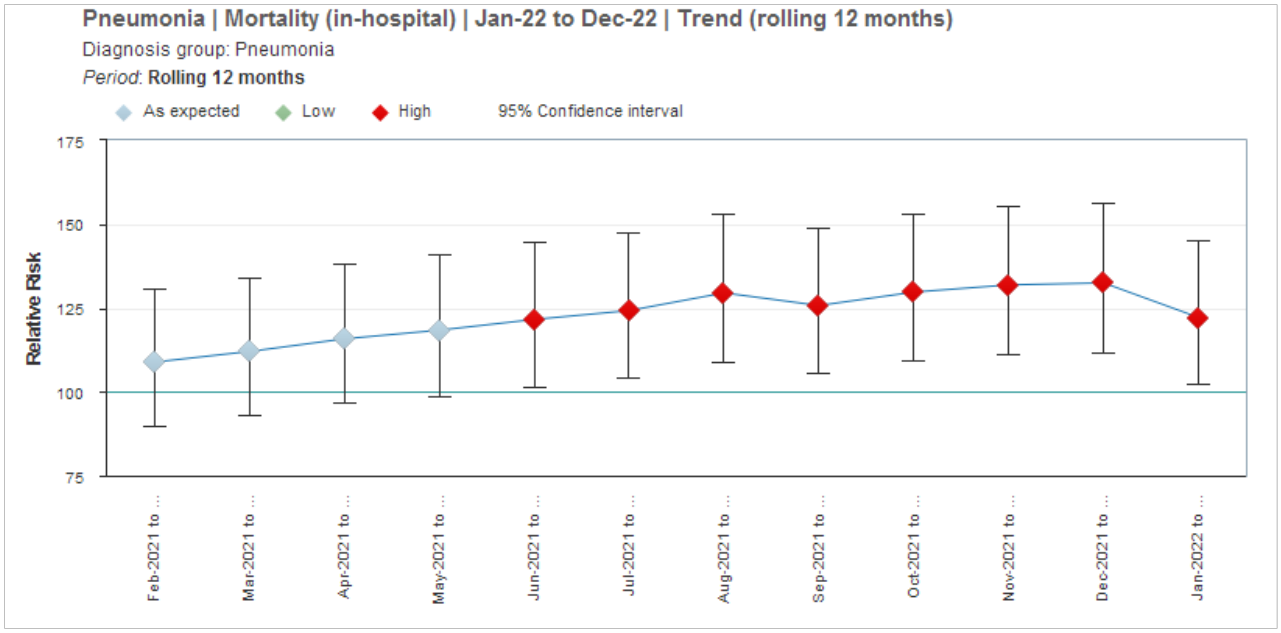


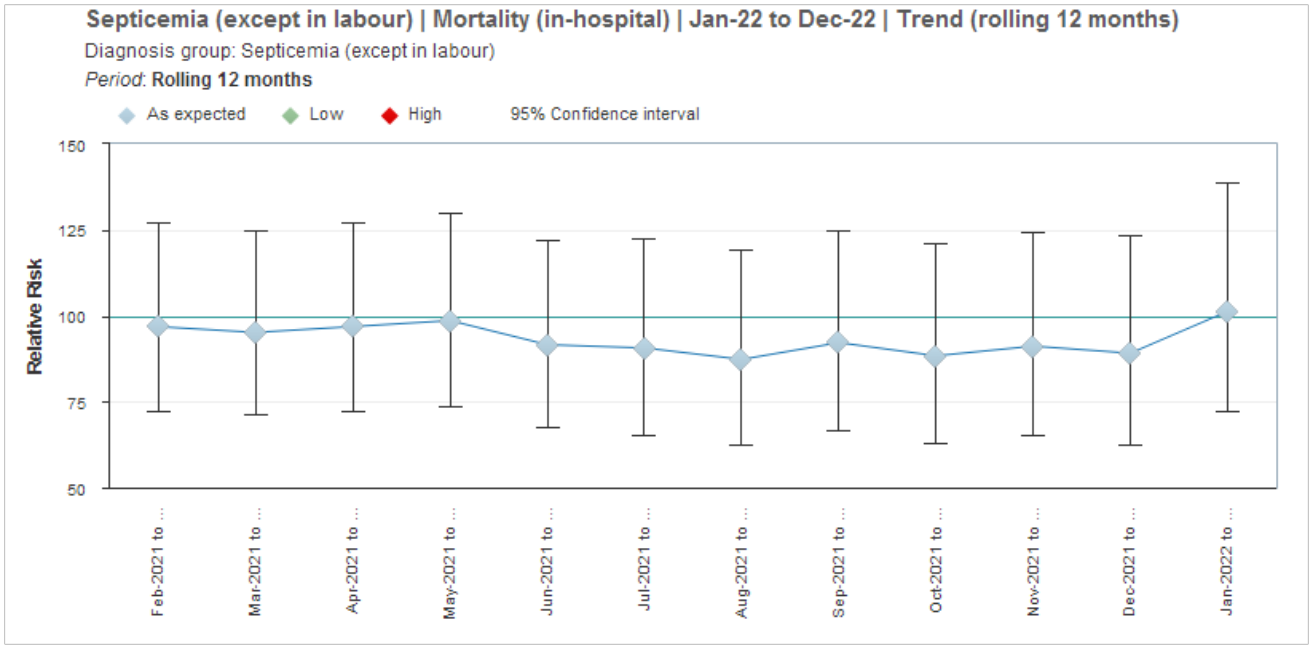





Congestive heart failure, nonhypertensive | Mortality (in-hospital) | Jan-22 to Dec-22 | Trend (rolling 12 months)
Diagnosis group: Congestive heart failure, nonhypertensive
Period: Rolling 12 months
As expected
Low
High
95% Confidence interval
Relative Risk
200
150
100
50
0
Feb-2021 to ...
Mar-2021 to ...
Apr-2021 to ...
May-2021 to ...
Jun-2021 to ...
Jul-2021 to ...
Aug-2021 to ...
Sep-2021 to ...
Oct-2021 to ...
Nov-2021 to ...
Dec-2021 to ...
Jan-2022 to ...


Fracture of neck of femur (hip) | Mortality (in-hospital) | Jan-22 to Dec-22 | Trend (rolling 12 months)
Diagnosis group: Fracture of neck of femur (hip)
Period: Rolling 12 months
As expected
Low
High
95% Confidence interval
Relative Risk
150
125
100
75
50
25
Feb-2021 to ...
Mar-2021 to ...
Apr-2021 to ...
May-2021 to ...
Jun-2021 to ...
Jul-2021 to ...
Aug-2021 to ...
Sep-2021 to ...
Oct-2021 to ...
Nov-2021 to ...
Dec-2021 to ...
Jan-2022 to ...


Pneumonia | Mortality (in-hospital) | Jan-22 to Dec-22 | Trend (rolling 12 months)
Diagnosis group: Pneumonia
Period: Rolling 12 months
As expected
Low
High
95% Confidence interval
Relative Risk
175
150
125
100
75
Feb-2021 to ...
Mar-2021 to ...
Apr-2021 to ...
May-2021 to ...
Jun-2021 to ...
Jul-2021 to ...
Aug-2021 to ...
Sep-2021 to ...
Oct-2021 to ...
Nov-2021 to ...
Dec-2021 to ...
Jan-2022 to ...


Septicemia (except in labour) | Mortality (in-hospital) | Jan-22 to Dec-22 | Trend (rolling 12 months)
Diagnosis group: Septicemia (except in labour)
Period: Rolling 12 months
As expected
Low
High
95% Confidence interval
Relative Risk
150
125
100
75
50
Feb-2021 to ...
Mar-2021 to ...
Apr-2021 to ...
May-2021 to ...
Jun-2021 to ...
Jul-2021 to ...
Aug-2021 to ...
Sep-2021 to ...
Oct-2021 to ...
Nov-2021 to ...
Dec-2021 to ...
Jan-2022 to ...

END

NHS
Salisbury
NHS Foundation Trust

Report to:	Trust Board (Public)	**Agenda item:**	5.4
Date of Meeting:	6th July 2023		

Report Title:	Director of Infection Prevention & Control (DIPC) Annual report 2022-2023			
Status:	**Information**	**Discussion**	**Assurance**	**Approval**
	X		X	
Prepared by:	Fiona McCarthy Lead Nurse, Prevention and Control Nurse, Infection Prevention & Control Team			
Executive Sponsor (presenting):	Judy Dyos, Director of Nursing and DIPC			
Appendices (list if applicable):	Appendix A: Annual action plan Appendix B and C Tendable Infection and Prevention audit results			

Recommendation:

The Board is asked to:

1. Note the report, and the performance against Infection Prevention and Control requirements for the year.

2. Minute/document that the Board continues to acknowledge their collective responsibility as described within the DIPC report and confirm receipt of assurance on IPC actions and controls for the year.

Executive Summary:

The purpose of the annual DIPC Report is to inform the Trust Board of the progress made against the annual plan and to reduce healthcare associated infections (HCAI) and sustain improvements in infection prevention and control practices.

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

This report takes the opportunity to celebrate the successes and highlights the challenges of managing infection risk in an acute Hospital trust .

Successes

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

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

In 2022-2023 there were zero cases of community or hospital acquired MRSA , there were 10 cases of hospital onset MSSA which was similar to levels seen in hospitals across the Acute Hospital Alliance, the trust benchmarked well regarding e coli cases with 4 hospital onset cases .

During 2022/23, the Trust has reported 16 cases of hospital onset Clostridioides difficile . Incident investigations are conducted for all hospital onset cases using a 'SWARM' approach. Benchmarking against the southwest shows that SFT continues to be in line with other southwest trusts.

The Antimicrobial Reference Group (ARG) has a new chair which is the Lead Antimicrobial Pharmacist who started in late June 2022. Antimicrobial stewardship (AMS) ward rounds have continued weekly (every Tuesday) with a Consultant Microbiologist, Antimicrobial Pharmacist and Antimicrobial Pharmacy Technician. In addition to this, a truncated round occurs every Thursday depending on staff availability and workload.

<u>Challenges</u>

It was necessary for the Trust to implement the planned outbreak response process during 2022/23, with the declaration of twenty-seven COVID-19 outbreaks for inpatient areas within the medical and surgical divisions, and at the South Newton Hospital site. To note an outbreak is still classified as 2 or more people for Covid 1 and demonstrates how highly infectious this virus continues to be, albeit much less risky than at the start of the pandemic.

During quarters 1 and 2 of 2022/23, there have been cases of Influenza A identified for both adults and children admitted to the Trust. The patients were nursed under isolation precautions, with no onward transmission or links identified. Cases of Respiratory Syncytial Virus (RSV) were also identified, with the majority of cases in children.

The DIPC commissioned the divisions to undertake a clinical review of the four viral gastroenteritis (Norovirus) outbreaks declared during quarter 4 of 2021/22 from 11th to 24th March 2022

At Salisbury, there were 5 cases of Monkey Pox diagnosed during 2022/23 (all identified in quarters 1 and 2 of 2022/23). All patients with a positive result were managed at home by the GUM Team as per national and local guidance and there were no severe infections requiring hospital admission to SFT

Surgical site infections
Over the course of the year, four surgical sites have been identified as infected of 200 cases entered into the SSI database, this makes SDF an outlier and UKHSA have provided formal notification. Actions have already been identified within the orthopaedic team including additional auditing of practices.

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

DIRECTOR OF INFECTION PREVENTION AND CONTROL

ANNUAL REPORT

April 2022 – March 2023

JUDY DYOS
Director of Infection Prevention and Control (DIPC)

May 2023 (Draft v.1)

CONTENTS

APPENDICES

1. INTRODUCTION

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

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

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

The action plan focuses on the Trust achieving the standards identified in *'The Health and Social Care Act 2008: Code of Practice on the prevention and control of infections and related guidance' (revised December 2022),* to ensure that patients are cared for in a clean and safe environment, where the risk of HCAI is kept as low as possible.

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

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

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

- Trust identified as a high outlier for mandatory surgical site infection surveillance (SSIS) for the category of repair of neck of femur (NOF) surgery.
- Continued low hand hygiene assessment compliance despite new process being undertaken.
- Trust involvement with infection prevention and control (IPC) collaboratives with regional colleagues has not progressed regularly.

2. GOVERNANCE ARRANGEMENTS

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

3. INFECTION PREVENTION & CONTROL ARRANGEMENTS

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

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

4. ASSURANCE ACTIVITIES

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

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

5. HEALTHCARE ASSOCIATED INFECTION (HCAI) STATISTICS AND SURVEILLANCE

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

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

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

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

Additional information regarding alert organisms can be accessed from the UKHSA website:
UK Health Security Agency - GOV.UK (www.gov.uk)

The ICNs provide clinical teams with infection control advice, support, and education on a daily basis to all inpatient and outpatient areas. The management of patients admitted with suspected and known alert organisms is discussed, and risk assessments undertaken. The Isolation Risk Assessment Tool (IRAT), Flowchart for the Management of Inpatients with Diarrhoea, and Diarrhoea Pathway have been developed and implemented to assist staff competency and confidence in the management of cases.

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

5.1 SARS-CoV (COVID-19)

The Trust continued to experience COVID-19 activity during 2022/23, and the ICNs worked closely with the divisions and Clinical Site Team around COVID-19 management. All newly identified COVID-19 positive cases for inpatients were discussed at the Virtual Board Round (VBR) meetings. This group is chaired by the Deputy DIPC, with core attendance including Consultant Microbiologists, ICNs, and divisional representatives. All cases are reviewed to ensure the correct management and classification of positive cases; the management of any identified patient contacts; and consideration of any potential links between positive cases. Staffing continues to be an agenda item at the VBR meetings, with attendees reporting any identified trends or concerns around COVID-19 related staff sickness for discussion. Any matter deemed to require escalation from the VBR group is taken by the chair to the existing IPC groups and Operational Working Group (OWG) following the Incident Management Team (IMT) being stood down on 6th January 2023.

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

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

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

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

5.2 COVID-19 outbreak prevention and management

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

It was necessary for the Trust to implement the planned outbreak response process during 2022/23, with the declaration of twenty-seven COVID-19 outbreaks for inpatient areas within the medical and surgical divisions, and at the South Newton Hospital site (SFT beds). **Table 1** overleaf provides a breakdown of information:

Ward/ Department	Hospital onset	Linked to the outbreak cohort	Date outbreak	Date outbreak

(linked to outbreak)	definite healthcare associated (15 or more days after admission)	Total number of positive patients	Total number of staff members positive	declared by the Trust	closed by the Trust
Farley Ward (Acute Stroke Services)	3	6	0	06.04.22	11.05.22
Tisbury CCU (Cardiology)	2	3	0	27.04.22	01.06.22
Amesbury Suite (Trauma/Orthopaedics)	5	8	0	27.04.22	01.06.22
Whiteparish Ward (Endocrinology)	3	8	0	27.04.22	09.06.22
Laverstock Ward (Respiratory)	11	19	0	14.06.22	26.08.22
Tisbury CCU **(2nd outbreak)**	4	11	0	20.06.22	15.08.22
Redlynch Ward (Gastroenterology)	9	21	0	21.06.22	01.09.22
Pitton Ward (Acute Frailty)	14	18	0	30.06.22	06.10.22
Britford Ward (Surgery)	6	10	0	30.06.22	15.08.22
Day Surgery Unit (Escalation area)	1	6	0	06.07.22	03.08.22
Downton Ward (Surgery)	7	13	0	06.07.22	01.09.22
Breamore Ward (Stroke Rehabilitation)	10	11	0	07.07.22	24.08.22
Whiteparish Ward **(2nd outbreak)**	7	14	0	12.07.22	24.08.22
Durrington Ward (Acute medical)	5	13	0	14.07.22	02.09.22
Redlynch Ward **(2nd outbreak)**	9	23	0	12.09.22	24.11.22
Whiteparish Ward **(3rd outbreak)**	5	8	0	06.10.22	10.11.22
Laverstock Ward **(2nd outbreak)**	4	8	0	06.10.22	01.12.22
South Newton (Trust inpatient areas)	7	8	0	17.10.22	11.11.22
Durrington Ward **(2nd outbreak)**	3	6	0	28.10.22	01.12.22
Farley Ward **(2nd outbreak)**	4	10	0	03.11.22	02.12.22
Redlynch Ward **(3rd outbreak)**	5	10	0	22.12.22	09.02.23
Breamore Ward **(2nd outbreak)**	12	12	0	03.01.23	13.02.23
Britford Ward **(2nd outbreak)**	6	9	0	05.01.23	13.02.23
Downton Ward **(2nd outbreak)**	6	16	0	05.01.23	04.04.23
Pitton Ward **(2nd outbreak)**	12	20	0	12.01.23	04.04.23
Durrington Ward **(3rd outbreak)**	3	7	0	03.02.23	12.03.23
Redlynch Ward **(4th outbreak)**	3	7	0	23.02.23	04.04.23

(Table 1)

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

For these outbreaks, the Outbreak Management Group (OMG) was formed with review meetings held throughout. The meetings were well attended by all required individuals and departments within the Trust

and by representatives from UKHSA and Bath and North East Somerset (BaNES), Swindon and Wiltshire (BSW) Integrated Care Board (ICB). The OMG ensured that appropriate arrangements were in place to care for the affected patients and staff, instigating and monitoring the effectiveness of the control measures implemented in containing the spread of infection. The impact on service delivery was constantly reviewed, with communication to all relevant groups, including patients, relatives, carers, and staff completed as appropriate. The production and distribution of meeting notes and actions was facilitated by the ICNs.

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

During quarter 2, following discussion at the IPCWG and with approval of the DIPC, the internal timeframe for an outbreak was reduced to 14 days since the last positive case related to the outbreak cohort. IPC practice and monitoring measures continued to be in place for the subsequent 14 days until the external reporting criteria of 28 days was met.

For the declared COVID-19 outbreaks, application of the national COVID-19 case definitions to these 305 patient cases classifies 166 as hospital onset; definite healthcare associated. The Trust recognises that where any infections are classified as hospital onset healthcare associated then there is clearly scope for learning, and that this is the same for COVID-19 infections.

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

5.3 Respiratory Illnesses including Influenza

During quarters 1 and 2 of 2022/23, there have been cases of Influenza A identified for both adults and children admitted to the Trust. The patients were nursed under isolation precautions, with no onward transmission or links identified. Cases of Respiratory Syncytial Virus (RSV) were also identified, with the majority of cases in children.

From December 2022 onwards, there were higher numbers of respiratory illnesses identified, including COVID-19, Influenza and RSV cases, with the subsequent requirement for increased admissions of positive patients. With a greater demand for isolation facilities, cohort positive bays were created on identified medical wards.

A Seasonal Illnesses Working Group (SIWG) was formed with the involvement of key staff to agree management plans, which included service delivery and patient flow, treatment, cohorting requirements, and isolation priorities, isolation duration, personal protective equipment (PPE) and cleaning practices. Information from this group was communicated and cascaded by the divisions to the relevant staff groups to support staff across the areas.

5.4 Norovirus (viral gastroenteritis)

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

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

provision. The Trust Norovirus Outbreak Management policy was followed with the appropriate internal and external personnel involved.

5.5 Monkeypox virus

Monkeypox is an infectious viral disease that became a global problem after cases were detected around the world in May 2022. There have been 3,570 cases confirmed up to 21st November 2022 in the UK.

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

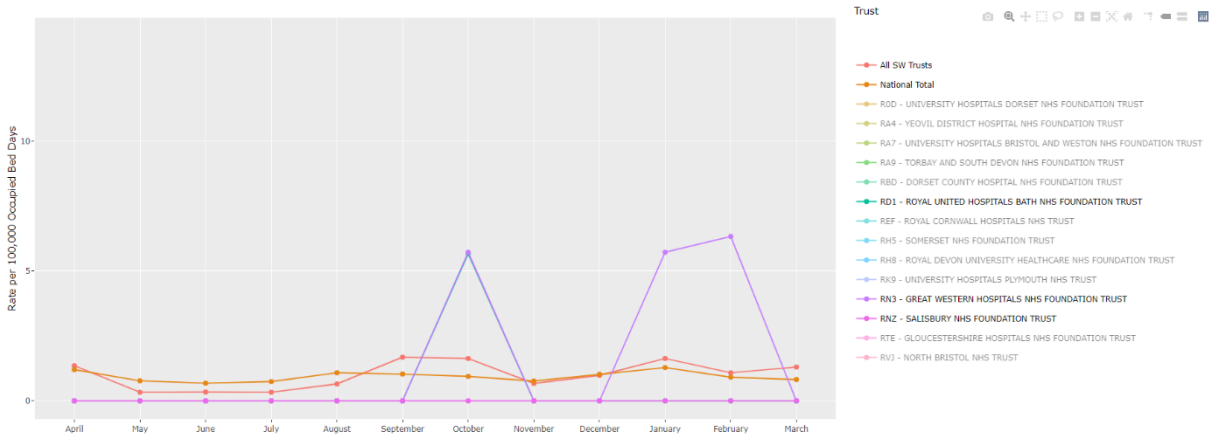
At Salisbury, there were 5 cases diagnosed during 2022/23 (all identified in quarters 1 and 2 of 2022/23). All patients with a positive result were managed at home by the GUM Team as per national and local guidance and there were no severe infections requiring hospital admission to SFT. Contacts were followed up and managed by UKHSA.

6. MANDATORY SURVEILLANCE

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

6.1 Methicillin Resistant *Staphylococcus aureus* (MRSA) bacteraemias

During 2022/23, there have been no hospital or community onset MRSA bacteraemia cases reported by the Trust. The Trust's MRSA hospital onset case target for 2022/23 is zero. **Table 2** below taken from the BSW ICS HCAI report for quarter 4 of 2022/23 indicates that SFT benchmark well for MRSA rates against national and southwest data.



(Table 2 Trust MRSA data)

6.2 Methicillin Sensitive *Staphylococcus aureus* (MSSA) bacteraemias

During 2022/23, there have been 16 unrelated healthcare associated MSSA bacteraemia cases, of which 6 cases were community onset and 10 cases were hospital onset. For the hospital onset cases the sources of infection were identified as:

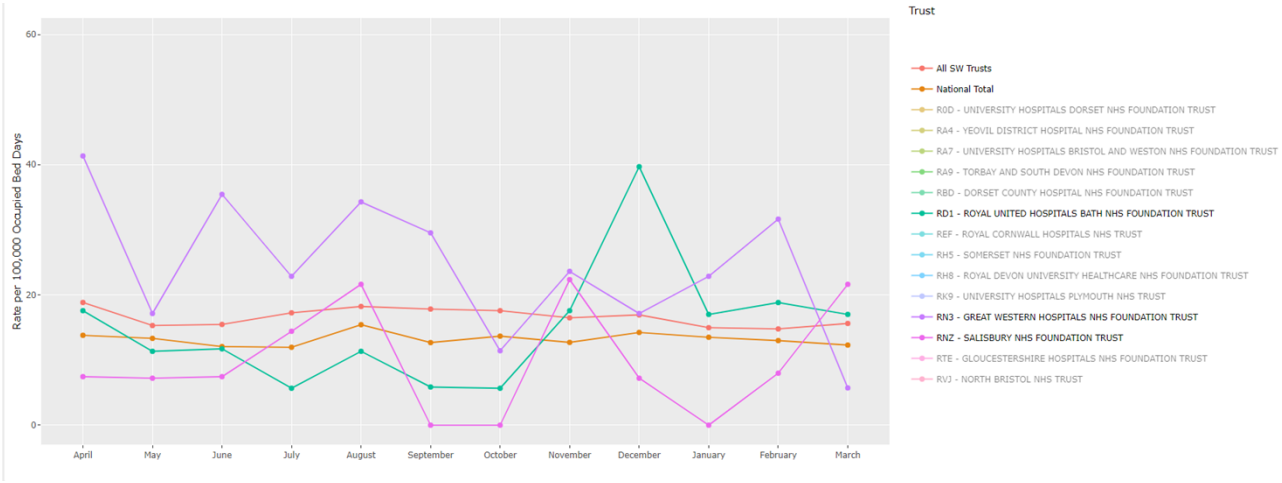
- Endocarditis (1 case)
- CVC associated (1 case)
- Pneumonia (1 case)

- Septic arthritis (1 case)
- Unknown/unclear source (6 cases).

Post infection reviews were requested to be completed by the ward teams. Of those reviews completed, one of these infections was associated with a vascular access device. Key learning identified the requirement for continued monitoring of all invasive devices by staff, adherence to the relevant Trust policies relating to the taking of blood cultures and skin disinfection/decontamination and maintaining the required care documentation.

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

Table 3 below demonstrates that SFT benchmark well against national data in general.



(Table 3 Trust MSSA data)

6.3 Gram-negative organism bloodstream infections (GNBSIs)

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

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

6.3.1 *Escherichia coli (E.coli)*

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

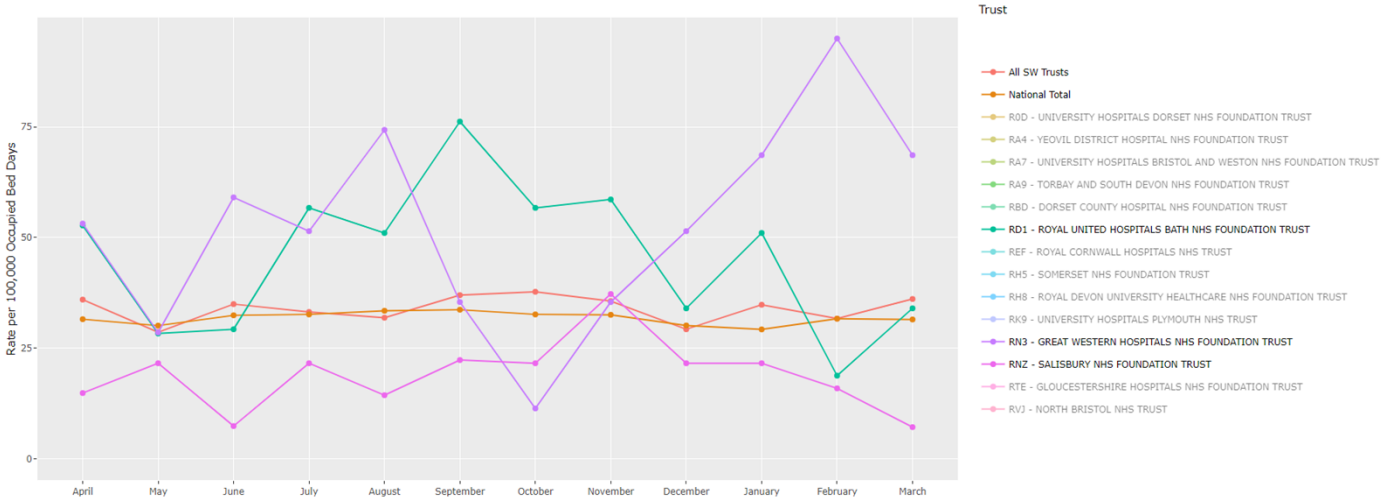
During 2022/23, there have been 31 unrelated healthcare associated *E.coli* bacteraemia cases, of which 17 cases were community onset (with one case being identified from an OPD sample), and 14 cases were hospital onset. Of the 14 hospital onset cases identified, an unknown or no underlying focus of infection was identified for three cases, and the remaining 11 cases had a source of infection identified. Of these unrelated 11 cases, the sources of infection were:

- Upper urinary tract (1 case)
- Lower urinary tract (6 cases)

- Gastrointestinal or intra-abdominal collection (1 case)
- Hepatobiliary (1 case)
- Genital system (1 case)
- Lower respiratory tract (1 case).

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

The Trust's *E.coli* case threshold for 2022/23 is no more than 35 healthcare associated cases (*as detailed in the Official NHS Standard Contract 2022/23 document (version 1) published 27th April 2022).* **Table 4** below demonstrates that SFT benchmark well against national and local case numbers.



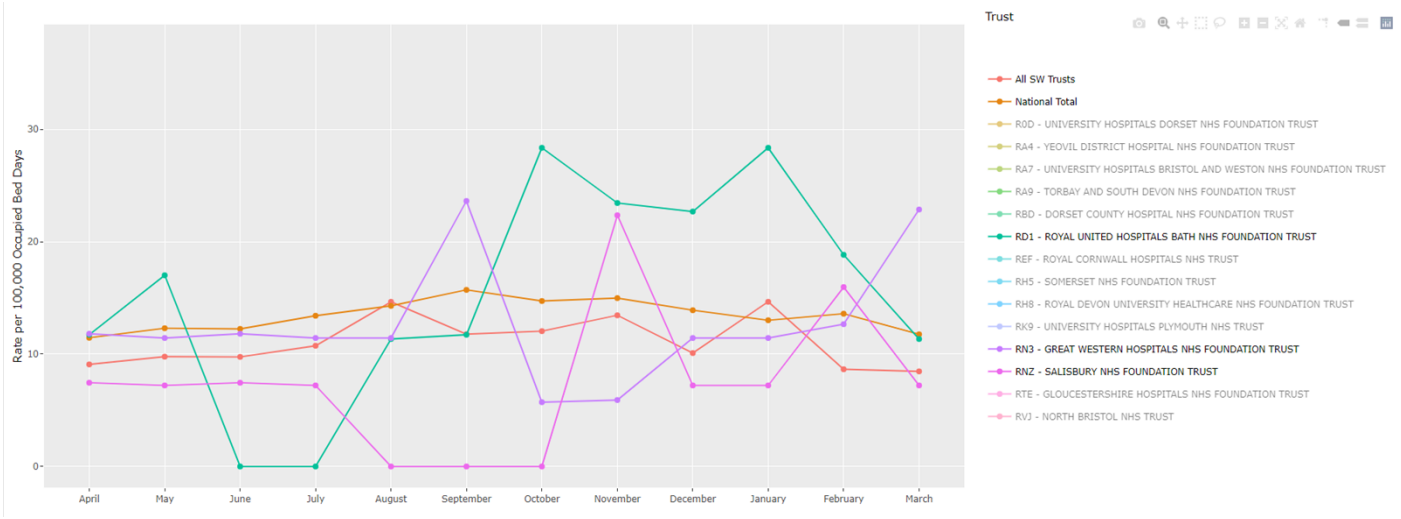
(Table 4 Trust E.coli data)

6.3.2 *Klebsiella spp.* and *Pseudomonas aeruginosa*

During 2022/23, there have been 12 unrelated healthcare associated *Klebsiella spp.* bacteraemia cases, of which 5 cases were community onset and 7 cases were hospital onset. There have been 10 unrelated healthcare associated *Pseudomonas aeruginosa* bacteraemia cases, of which 3 cases were community onset and 7 cases were hospital onset.

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

Further information relating to official statistics and benchmarking of performance can be found at:
Statistics at UKHSA - UK Health Security Agency - GOV.UK (www.gov.uk)
However, local data taken from the BSW ICS HCAI report for quarter 4 of 2022/23 (**Table 5** overleaf), demonstrates a spike in November 2022 but that overall SFT benchmarks well for levels of *Klebsiella* nationally.



(Table 5 Trust Klebsiella spp. data)

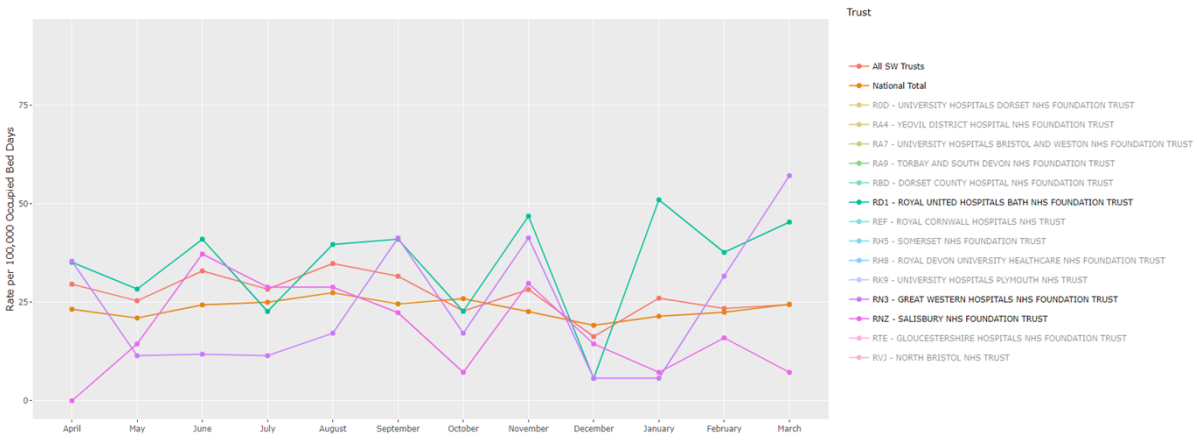
6.4 *Clostridioides difficile (C.difficile) Infection*

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

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

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

During 2022/23, the Trust has reported 29 healthcare associated *C.difficile* cases to UKHSA, of which 13 cases were community onset and 16 cases were hospital onset. Incident investigations are conducted for all hospital onset cases using a 'SWARM' approach. This process is facilitated by the ICNs with the relevant clinical leader and divisional Matron to assess whether there were any lapses in quality care provided to the patient and whether this contributed to the case. In addition, the ICNs review the community onset cases to establish whether any lapses in care occurred during their previous hospital admission (in the preceding 4 weeks). **Table 6** below demonstrates a spike in June 2022, but that overall SFT are in line with other Trusts in BSW which benchmarks well overall nationally.



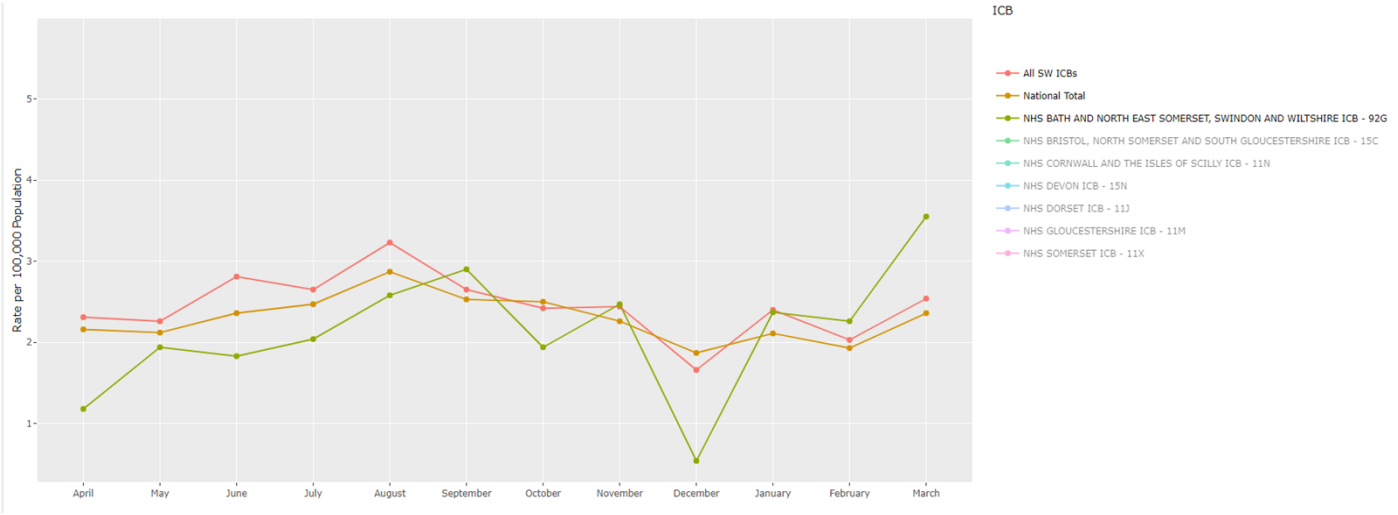
(Table 6 Trust C.difficile data)

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

In addition, the ICNs have completed extra investigations for the *C.difficile* cases identified within the community setting, where these patients have previously had a recent inpatient episode of care at the Trust. This has resulted in the implementation of enhanced environmental cleaning of identified clinical areas.

Representatives from the Trust were involved in the Southwest Regional HCAI *C.difficile* infection improvement collaborative event held during quarter 2 of 2021/22. The aim being to reduce harm to the population of the Southwest Region from *C.difficile* infection and share wider learning, with outcomes fedback to the DIPC and IPCWG. Due to continued workload pressures, it has not been possible for the IPCT to regularly attend collaborative events held during 2022/23.

Table 7 below shows that the BSW ICB benchmarks positively against national data for *C.difficile* infection rates



(Table 7 BSW C.difficile data)

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

During 2022/23, there were a total of five unrelated PIIs of *C.difficile* declared within the medical and surgical divisions for five separate wards (Farley, Downton, Durrington, Spire and Whiteparish Wards). The required incident investigations were completed for the positive cases with the involvement of relevant personnel. Further measures were also implemented across the areas, including additional environmental cleaning by Housekeeping and extra audits, and monitoring of practices, overseen by the relevant senior staff including the Heads of Nursing (HoN) and Matrons. From the positive samples sent for ribotyping, the ICD noted that the results were all different, with no links identified.

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

6.5 NHS Standard Contract 2022/23

Table 8 overleaf summarises the threshold levels for the Trust's count of healthcare associated (i.e., hospital onset healthcare associated (HOHA) and community onset healthcare associated (COHA)) cases for 2022/23 (*as detailed in the Official NHS Standard Contract 2022/23 document; Minimising Clostridioides difficile and Gram-negative bloodstream infections (version 1) published 27th April 2022).*

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

(Table 8)

6.6 Surgical Site Infection Surveillance (SSIS)
The ICNs and IPCT secretary coordinate data collections for the national SSIS programme of various surgical procedures, which are applicable to the Trust. For the mandatory surveillance of SSI following orthopaedic surgery, Trusts must participate in a minimum of one surveillance period in at least one category of orthopaedic procedures during a financial year. The Trust complies with this annual requirement to undertake SSIS. Active data collection for the category of repair of neck of femur (NOF) surgery has continued during 2022/23.

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

Final data collection for quarter 1 of 2022/23 was reconciled within the required timeframe. There were a total of 48 cases entered onto the national database. Unfortunately, one patient from the quarter 1 cohort was readmitted during quarter 2 of 2022/23 with an identified SSI. The IPCT received notification from the UKHSA of the required actions for recording this case on the national database. The delay in adding this information by the Trust has been due to insufficient data being available to enable a final decision to be made.

Final data collection for quarter 2 of 2022/23 was reconciled within the required timeframe. There were a total of 46 cases entered onto the national database, with one organ/space SSI identified. This was confirmed following feedback from the orthopaedic consultant surgeon for the patient. The ward nursing team completed a timeline/summary of the admission period for the patient and identified additional supportive information.

Final data collection from quarter 3 of 2022/23 was reconciled within the required timeframe. There were a total of 56 cases entered onto the national database, with one deep incisional SSI identified (patient readmitted). The ward nursing team completed a timeline/summary of the admission period for the patient and identified practice improvements to be actioned related to wound care and aseptic technique (assessed against the National Institute for Health and Care Excellence (NICE) guideline 125 for SSIs). The IPCT are awaiting additional information from the orthopaedic surgeons.

Data collection continued in quarter 4 of 2022/23, with final records to be entered onto the national database and submitted for reconciliation by the end of quarter 1 of 2023/24.

The IPCC have acknowledged that SFT will trigger as a high outlier for repair of NOF surgery SSI risk with the expectation that UKHSA will provide formal notification to the organisation (as per protocol). Actions have already been identified within the orthopaedic team including additional auditing of practices. This follows on from the review of the NG125 facilitated by the surgical divisional Matron with progress updates provided at the IPCWG. This audit work will be undertaken annually by the division.

(Of note: It has been noted that on reconciliation of data, the number of patients included within the reporting periods, have reduced from those first identified. This is a result of the clinical code allocated to the operation, being different from those being included within this category of surveillance, as set out by UKHSA).

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

6.7 MRSA screening

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

Feedback is provided to DMTs about compliance rates and any identified missed screens for follow up actions. For 2022/23, the Trust compliance rates for MRSA emergency screening ranged from 83.59% - 93.23%. For MRSA elective screening, the Trust compliance rates ranged from 68.57% – 79.55%. However, it must be acknowledged that the number of elective patients within the elective screening cohorts remains exceptionally small.

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

6.8 Infection in Critical Care Quality Improvement Programme (ICCQIP)

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

6.9 Private Healthcare Information Network (PHIN)

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

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

7. HAND HYGIENE

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

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

As previously reported, there have been no audits completed by the external auditor during quarters 1, 2 and 3 of 2022/23. This work recommenced during quarter 4 of 2022/23 with a total of 8 inpatient areas being audited. There was a delay in the ICNs receiving the audit feedback which identified non-compliance of staff with IPC practices being observed. Unfortunately, these findings were not addressed by the auditor or fedback to the nurse in charge at the time of the audit. This has been followed up by the Lead Nurse as the data was not shared with the clinical leads/areas.

The clinical divisions have been undertaking some peer cross auditing within their areas and specialities to further validate audit processes.

Detailed analysis was undertaken to identify the key areas of non-compliance, which were predominantly staff missing moment number 5, handwashing after contact with patient surroundings and following removal of gloves. The results were reported via the DIPC, and the IPCC and feedback was provided to the clinical leaders and DMTs to address the shortfall in practice. Additional education and support have been provided by the ICNs to staff groups focusing on these audit findings.

For the internal hand hygiene audits completed, the overall average compliance rate for 2022/23 ranges from 75.37% - 100%. It should be noted that completion of these audits has been variable across all divisions, which the divisions have reported as being due to reduced staffing levels and ongoing operational/bed capacity challenges.

The 'Red, Amber and Green' (RAG) rating for the hand hygiene compliance audits continues and includes actions to be identified for areas that do not achieve the 'pass threshold' of 85% or show improvements. This RAG rating was further revised, and the impact of these measures being monitored by the IPCWG, DMTs and Patient Led Assessment in the Clinical Environment (PLACE) Steering Group. *(Of note: during 2022/23, there have only been three PLACE Steering Group meetings held (May and July 2022; and January 2023).*

8. ANTIBIOTIC STEWARDSHIP

The Antimicrobial Reference Group (ARG) has a new chair which is the Lead Antimicrobial Pharmacist who started in late June 2022. Antimicrobial stewardship (AMS) ward rounds have continued weekly (every Tuesday) with a Consultant Microbiologist, Antimicrobial Pharmacist and Antimicrobial Pharmacy Technician. In addition to this, a truncated round occurs every Thursday depending on staff availability and workload.

A review of AMS ward round data indicates, the AMS team has seen 746 patients and made 300 interventions during quarters 2, 3 and 4 of 2022/23. *(Of note: quarter 4 data still needs to be accounted for therefore the figure indicates under reporting).* Subjectively, most interventions made, involved inappropriate duration of antibiotics, differing antibiotic prescribing compared to Trust guidance and some late intravenous (IV) to oral (PO) antibiotic switches.

Pharmacy have also started undertaking *C.difficile* ward rounds alongside Consultant Microbiologists and ICNs initially occurring once a month, however the frequency of which, will hopefully be increased.

8.1 Commissioning for Quality and Innovations (CQUINs)

CQUINs restarted in April 2022, with SFT being assigned the urinary tract infection (UTI) CQUIN: "CCG2: Appropriate antibiotic prescribing for UTI in adults aged 16" (extended from previous UTI CQUIN). The current UTI CQUIN will involve patients aged 16 or over, including patients with catheter associated UTI (CAUTI), looking to achieve a targeted compliance of 40-60%. This CQUIN has officially been concluded, with quarter 1 and quarter 2 figures having indicated 80% and 79% compliance respectively, and quarter 4 of 2022/23 achieving 89% compliance.

As of 1st April 2023, the Trust will be undertaking "CQUIN04: Prompt switching of IV antimicrobial treatment to the oral route of administration as soon as patients meet switch criteria". The CQUIN will be led by the Consultant Microbiologists and Pharmacy.

The AMS team and a member of the clinical audit team have met to discuss the logistics of running the CQUIN throughout each quarter, with the following actions:

- Appointed CQUIN leads to cover clinical aspects of CQUIN from both Consultant Microbiologists and Pharmacy.
- A health improvement/education component which will run alongside the CQUIN for its advertisement but also to provide support/educate prescribers to improve compliance throughout the year. This will be led by the Antimicrobial Pharmacy Technician and clinical auditor.
- The Trust previously had no guidance on criteria relating prompt switching from IV antibiotics to PO antibiotics, but guidance has now been created, reviewed, and published on Microguide.

- Lead pharmacist has e-mailed guidance to Junior Doctors to disseminate IV to PO guidance criteria to other prescribers working within the Trust. The AMS team are looking to publicise CQUIN using Trust Communications team.
- Draft collection form and tool created by clinical auditor.

8.2 Total antibiotic consumption

Total antibiotic consumption within SFT has increased during October 2022 to April 2023, with an increase in defined daily doses (DDDs) from 20,656 to 24,219. Extrapolation of data indicated that in March 2023, Emergency Department (ED), AMU, Britford and Laverstock Wards, and Haematology have high DDDs compared to other hospital wards.

SFT does have a higher consumption of antibiotics from the WHO AWaRe 'Watch' category compared to the WHO AWaRe 'Access' category with highest usage of antibiotics being: Co-Amoxiclav, Clarithromycin, Levofloxacin, Cefuroxime and Piperacillin/Tazobactam.

8.3 Electronic Prescribing and Medication Administration (EPMA)

EPMA is currently live in all medical wards and is currently being implemented in surgical wards at present. The Lead Antimicrobial Pharmacist has been in contact with the EPMA team/Database Warehouse team to implement a filter programme to identify all patient on antibiotics in real time, however this is still in process.

8.4 Guidance

- National COVID-19 guidance might change pending review from NICE Technical appraisals (TA). This would alter treatment options significantly and therefore guidance is currently being updated and will be uploaded onto Microguide when logistics have been resolved.
- Oseltamivir and Influenza vaccine guidance has been completed and requires final sign off.
- IV to PO switch guidance has been completed and published on Microguide and in effect.
- Vancomycin Continuous Infusion policy is published on Microguide and in effect.
- Bronchiectasis guidance to be completed during quarter 1 of 2023/24 and submitted for ARG review.
- UTI Trimethoprim guidance has been reviewed by ARG with changes required by the SOP author.
- Pharmacy is currently liaising with IPC regional leads to implement faecal microbiota transplant (FMT) as a treatment option for *C.difficile*.

8.5 Ongoing challenges

- National COVID-19 guidance might change pending review from NICE TA indicating that one COVID-19 treatment options might no longer be cost effective. Additionally, the process of regional mutual aid for supply has now officially ceased, therefore acquisition and supply of treatment options will have to be made by each individual Trust. Regional logistics are still being formulated.
- AMS referrals to review patient specific antibiotics are currently still reliant on the wider clinical Pharmacy staff as reporting on EPMA is limited. A filter programme is still in progress with an unknown estimated time of arrival. Furthermore, staffing and workload pressures are leaving less time to refer patients on IV antibiotics.
- Pharmacy has identified several current stock issues as listed below:
  - Remdesivir – mutual aid no longer available and supply procurement pending. Pharmacy currently have limited stock available.
  - Ciprofloxacin 200mg IV infusion unavailable, however Ciprofloxacin 400mg IV infusion available.
  - Clarithromycin liquid unavailable but variable supply regarding clarithromycin tablets, but pharmacy have stock available.

8.6 Antibiotic Reference Group (ARG) Action Plan for 2023/24

- National COVID-19 guidance to be reviewed in view of pending publication of NICE TA.
- CQUIN04 commenced on 1st April 2023 with continual data collection.
- First Microguide update has started with reviews in Gastroenterology and Respiratory speciality sections.
- ARG to discuss ongoing antibiotic input/protocols within EPMA system.
- Review of antibiotic related patient group directives (PGDs).

9. AUDIT

The ICNs have not undertaken any formal policy audit during 2022/23 due to staffing resources and increased clinical workload but have been involved in supporting identified clinical areas to complete the Tendable inspections *(formerly Perfect Ward Application)* for infection prevention and control. This process ensures that audit is clinically focused and targeted at improving infection prevention and control practices for all disciplines across the Trust. (*Of note: these inspections include policy practice standards as part of audit criteria).*

Any observations/findings are fedback verbally to the clinical leader/nurse in charge at the time with instruction to access the results report to identify any required actions. The results are also available for the HoN and Matrons to access (via the application), with formal reports fedback via the PLACE Steering Group. (*Completion of these audits has been in addition to the 'spot checks' and observational practice audits undertaken by the ICNs during clinical visits to ward areas*).

The HoN, Matrons and clinical leaders also complete the additional Tendable quick COVID-19 assessment inspections within identified clinical areas. These focus on monitoring and assurance around several measures, including signage, provision of hand hygiene opportunities, provision of PPE and observations of PPE practices, and adherence with the relevant COVID-19 pathway in the area. It also includes the questioning of staff around COVID-19 symptoms for patients and staff and the resulting actions indicated, isolation and decontamination practices, and demonstrating awareness of visiting guidance and how to escalate any staffing concerns. When required, the ICNs have continued to support the areas and staff with addressing any concerns arising from these inspections. For 2022/23, the overall average IPC compliance scores reported have ranged from 86.58% - 98.07%.

Please see Appendix C for further details, the results continue to provide transparency across a number of IPC indicators at practice level.

10. EDUCATION AND TRAINING ACTIVITIES

Education and training continues to be an important part of the work of the IPCT. Mean compliance scores for 2022/23 were 79% for staff completion of hand hygiene assessments and 95% for staff completion for IPC computer-based learning (CBL) package *(LEARN data accessed 01.04.2023).*

The low hand hygiene assessment compliance is an ongoing concern. In response, the ICNs have continued to focus on the promotion of different working opportunities for staff to complete their hand hygiene assessment. This has included arranging extra sessions within specific work areas and enabling identified staff to be trained to undertake hand hygiene assessments. Furthermore, the clinical divisions facilitated the completion of hand hygiene assessments for staff by utilising an ultra-violet (UV) light box for rotation through their divisional areas and departments. In addition, the ICNs continue to work with the Education Department to improve compliance for staff completing these mandatory training modules.

During March 2022, the DIPC requested a review of the method currently used for assessing hand hygiene technique to simplify the process and improve compliance. It was agreed to trial an alternative process with one of the clinical wards reporting a low compliance, with the support of the Practice Education Team. The hand hygiene assessment trial commenced on Pitton Ward, with the ward leader assessing the hand hygiene technique of staff members by observing hand washing in the ward environment. This was supported by the ICNs to ensure a clear and systematic process was followed for the assessments. However, it has since been identified that the LEARN reports are not reflecting full compliance for the ward team, which has been followed up. Another ward area was nominated for the extension of this work; however this has not progressed, and the division have been asked to identify another area.

During quarters 3 and 4 of 2022/23, this work was progressed on another ward within the surgical division, with positive outcomes reported via the IPCWG.
The ICNs have contributed to formal and informal teaching sessions within clinical areas and other Trust departments. Several of the core infection prevention and control sessions have been delivered for different staff groups, in addition to specific topic requests. The ICNs have also met with small groups and teams or

on a one-to-one basis, to provide guidance and aid improved understanding of policies and practices. There has been a continued focus on promoting learning through the daily clinical visits undertaken by the ICNs.

There has been a delay in the Trust implementation of the national programme *'Every Action Counts'* due to the IPC nursing vacancy and the ongoing clinical (including COVID-19) workload impacting roll out.

Formal 'virtual' meetings with the Infection Control Link Professionals (ICLPs) group have been held during 2022/23. Communications via e-mail and through discussions with various ICLPs as part of both routine and additional visits undertaken by the ICNs to clinical and non-clinical areas have continued. Details of education opportunities provided are available from the ICNs.

11. DECONTAMINATION

11.1 Key Success stories of 2022/23

The Trust successfully undertook a tendering exercise for the post of Authorised Engineer for Decontamination (AE(D)), and the contract commenced in June 2022. This transition is a natural opportunity for a 'fresh eyes' approach to decontamination, assessing our existing processes and identifying where improvements can be made. Our new AE(D) also holds the post at Royal United Hospitals (RUH) Bath NHS FT, which will facilitate opportunities for shared learning and benchmarking.

The Trust's new Authorised Person for Decontamination (AP(D)) continues to gain experience under the support of our AE(D) and successfully completed their formal external training. It is positive to have this role filled again, and they are gradually reviewing our processes to ensure any gaps in compliance which occurred whilst the post was vacant are identified and addressed. There is also work underway creating a centralised electronic record of equipment servicing history and reports. This will improve the system currently in use, which tends to be held in a variety of locations/departments and involves several staff.

The Sterile Services Limited (SSL) contract review between SFT and Steris has been completed. The review facilitated discussions to ensure the contract reflects current practice and outlines expectations. The governance arrangements have also been reviewed and regular meetings to discuss contractual and operational issues commenced in quarter 3 of 2022/23.

Work to replace both Laboratory autoclaves has commenced, with associated environmental enhancements. One machine has been installed and commissioned with the work on the second machine imminent. This will make considerable improvements in the reliability of the service to dispose of hazardous Category 3 waste. Breakdowns during quarters 3 and 4 of 2022/23 have been challenging, with only one autoclave available for lengthy periods of time.

11.2 Progress on actions during 2022/23

The transition of the decontamination audits onto an electronic platform, Tendable, has made progress with test audits completed and feedback enabling improvements to be made before they go live. It is anticipated that the audit process will go live during quarter 1 of 2023/24, offering evidence to support our IPC Board Assurance Framework (BAF) and relevant National Patient Safety Alerts (NPSA) to be monitored.

The project to refurbish SSL is progressing well and work will commence in April 2023. The project is being carefully managed to minimise the interruption to clinical services. The first phase is the flexible endoscope reprocessing area and includes the phased replacement of all the endoscope washers. It is anticipated this will ultimately create a more efficient decontamination service which will benefit patients and be less stressful for staff.

The Trust's fleet of automated devices to undertake high level disinfection of invasive ultrasound probes has been extended to include Interventional Radiology. The introduction of a device into Fertility Clinic remains unresolved.

The Decontamination policy reviews are not yet completed.

11.3 Key challenges for quarters 1 and 2 of 2023/24

- Undertaking the refurbishment of SSL at a time when operational activity is increasing will be a challenge, however all involved are keen to ensure disruption is kept to a minimum.
- Completing the introduction of an automated high level disinfection device to decontaminate invasive ultrasound probes in Fertility Clinic.
- Completing the policy reviews.

12. CLEANING SERVICES

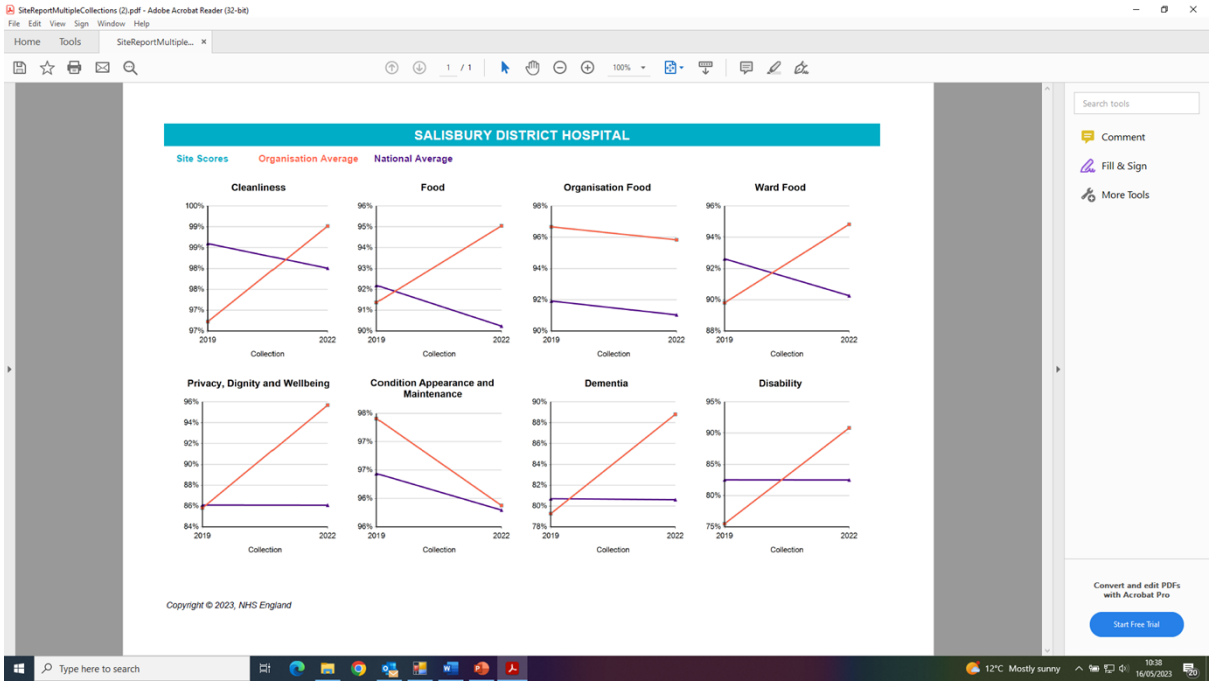
This section summarises the key components of the Trust's cleaning programme, to ensure the provision of a safe and clean environment for patients and their relatives, visitors and staff. The following areas of work are managed by the Housekeeping Department and Facilities directorate.

12.1 Patient led assessment of the care environment (PLACE) internal audits

The Trust has undertaken a programme of PLACE audits which commenced in June 2022. We have already completed 33 audits with a further 27 planned over the coming year. The result of each PLACE assessment is submitted to the Health and Social Care Information Centre using the PLACE Lite tool and discussed with ward leaders at the monthly PLACE Steering Group.

12.2 National PLACE

We undertook the National PLACE inspection on the 16th November 2022. Results are shown in **Table 9** below, highlights being that we have seen a Cleaning, Ward Food, Privacy and Dignity, Dementia and Disability score improvements above national average and a drop for Organisational Food, Condition and Maintenance, being slightly above national average.



(Table 9)

12.3 Deep clean programme/rapid response team

The deep clean programme commenced in April 2022 and was successfully completed in April 2023, ahead of schedule. The plan for 2023/24 commenced in April 2023 *(a copy of the Deep Clean programme is available from the Housekeeping Department).*

12.4 Improvement Work Over the past 6 months

Recruitment drives of group interviews, working alongside Organisational Development and People (OD&P) to attract new Cleaning Assistants in preparation of the implementation of the new cleaning standards and vacancies. Reached 99.6% or above each month for our KPIs linked to the operational response times in

starting a clean within 3 hours. **Table 10** below identifies the past 3 years indicating the increased activity during the pandemic.

2022/23 MONTH	APR	MAY	JUN	JUL	AUG	SEP	OCT	NOV	DEC	JAN	FEB	MAR	TOTALS
POST INFECTIONS	1305	741	855	1176	717	687	807	755	1262	1017	980	837	**11139**
ENHANCED HRS	66.50	50	73	112.75	102	63.25	87.50	104.25	79.75	138.75	103	124	**1104.75**
DOUBLE CLEANS HRS	42.25	50.25	64.25	84.75	51.25	50	17.50	24	53	44.25	30	23.75	**535.25**
BIOQUELL	34	47	32	30	42	33	27	46	43	35	44	20	**433**
2021/22 MONTH	**APR**	**MAY**	**JUN**	**JUL**	**AUG**	**SEP**	**OCT**	**NOV**	**DEC**	**JAN**	**FEB**	**MAR**	**TOTALS**
POST INFECTIONS	1076	934	850	1106	1105	1127	1180	1114	1386	1322	1436	1807	**14443**
ENHANCED HRS	67.75	67.50	50	66.5	70.75	70.25	73.50	71	65.50	86.50	124.75	113.75	**927.75**
DOUBLE CLEANS HRS	104	84.75	79.5	88.0	93.25	60.50	44.75	35.75	50.50	91	51	65.75	**846.75**
BIOQUELL	39	40	38	61	56	49	36	35	60	40	38	51	**543**
2020/21 MONTH	**APR**	**MAY**	**JUN**	**JUL**	**AUG**	**SEP**	**OCT**	**NOV**	**DEC**	**JAN**	**FEB**	**MAR**	**TOTALS**
POST INFECTIONS	1564	1726	1558	1408	1121	1180	1200	1304	1575	2589	1694	1341	**18260**
ENHANCED HRS	38.5	48.25	47.5	72.25	95	56	53.75	96.5	105.5	102.25	65.25	57	**837.75**
DOUBLE CLEANS HRS	4.5	0	40.25	82.25	60.25	77.5	105	149.5	140.25	0	26.25	27	**712.75**
BIOQUELL	30	29	37	62	36	42	39	30	50	10	58	50	**473**

(Table 10)

12.5 Successes for 2022/23

Housekeeping have been successful in securing further funding towards the new cleaning standards and there will be a rolling implementation plan which has been drafted. Housekeeping continue to provide cleaning services at South Newton Hospital site wards with SFT beds to enable extra bed capacity.

12.6 Challenges for quarters 1 and 2 of 2023/24

Housekeeping are working towards the new National Cleaning Standards including key elements, task lists, risk categories, audit requirements over a phased implementation period.

Recruitment is still an ongoing challenge due to a reduction in applicants and the incentives associated with clinical posts (e.g. Health Care Support Workers (HCSWs)). Recruitment is required to undertake the new Cleaning Standards and we continue to work with OD&P and recruitment agencies to support this recruitment drive. The recent pay award will support this initiative.

13. WATER SAFETY MANAGEMENT

This section summarises the water safety management precautions that the Trust has taken over 2022/23. The Trust manages the safety of water systems in line with the Health Technical Memorandum (HTM) 04-01 (Part B) Safe Water in Healthcare Premises and HTM 04-01 (Pt C) *Pseudomonas* (guidance for augmented care units), together with the technical guidance document HSG274 (Part 2).

To assist the management process in respect of the water systems across the site, regular meetings of teams (Responsible Person (RP) and designated Responsible Person (dRP) water) from Estates Technical Services (ETS) Team and FES Ltd (PFI maintenance contractor) are held monthly, to review progress with planned preventative maintenance (PPMs) and actions in respect of water safety.

13.1 *Legionella*

The Trust continues to keep the domestic hot water temperature elevated above 65°C as a precaution in the challenge of *Legionella* control. The water systems within hospitals are complex; therefore, the testing and controls we have in place are designed to mitigate the risks to our patients and staff.

Emergency review meetings (**Table 11**) for *Legionella* (listing counts reported >1000 cfu/l) and high counts for *Pseudomonas* (**Table 12**) have taken place in the Trust as a result of the sample results. The actions and results of the ongoing checks have been circulated to senior members of the Trust in a series of e-mails as events occur, and as regular reports to the Water Safety Group (WSG) and IPCC. Actions taken have included the cleaning and disinfection of outlets, with temperature checks and increased flushing where necessary.

Legionella						
	Ward/Department	LG Ref	Location	Action plan	Test result as of 18/04/2023	
					Pre	Post
1	Emergency Department	33	Majors cubicle 11	Outlet left in use, PALL filter fitted. Additional sample to be taken for Cubicle 9.	6100	740
2	AMU	60	Sink Rm 2.2.22	Fit PALL to sink and sample shower in sideroom 1 (2.2.24).	400	<20
3	SSEU	31	SSEU Nurse Base	Fit PALL, clean disinfect and resample.	1000	200
4	Tisbury CCU	112	Bay 2 WHB	PALL fitted on LG 112, sample showers in sideroom 1 and 4.01.63.	26000	1400
5	Pathology Laboratory	93	Blood Room	Lack of use or system issue, action to sample local showers in Rooms 3.14.27 and 3.14.23.	1600	800
6	Block 05	119	Room 6 WHB	Outlet tap replaced, additional samples required.	560	20
7	Main switchboard	40	Kitchen	PALL fitted, test outlets in adjacent in Rooms 3.05.06 and 3.05.14.	22000	1700
8	Main Switchboard	41	Kitchen	PALL fitted, test outlets in adjacent Rooms 3.05.06 and 3.05.14.	8400	4000
9	Ear Nose & Throat (ENT) Department	13	3.04.14	Fit PALL, investigate issues with system (temperature/circulation).	1000	1800
10	ENT	15	3.04.24	Lack of use or system issue, sample outlets 3.04.01 and 3.04.05.	42000	940
11	Level 3 Laboratories (Labs)	86	3.14.37	Fit PALL, investigate issues with system (temperature/circulation).	30000	20
12	L3 Labs	87	3.14.37	Fit PALL, investigate issues with system (temperature/circulation).	1000	920
13	L3 Labs	88	3.14.17A	Fit PALL, investigate issues with system (temperature/ circulation).	2800	1000
14	L3 Labs	92	3.15.13	Fit PALL, investigate issues with system (temperature/circulation).	3200	120
15	Level 4 Labs	103	4.14.27	Lack of use? Take additional sample from outlet 4.14.18.	10000	400
16	L4 Labs	104	4.14.12	Fit PALL, investigate issues with system (temperature/circulation).	2600	1000

(Table 11)

13.2 *Pseudomonas* Sampling

Six monthly testing (250 samples) has now been completed on NNU, Radnor, Pembroke, Sarum and Odstock Wards, live counts are being managed on Odstock Ward with PALL filters fitted on the outlets with elevated counts (see **Table 12** below).

Pseudomonas						
	Ward/ Department	PS Ref	Location	Action plan	Test result as of 18/04/2023	
					Pre	Post
1	Odstock Ward	197	SHW 4.11.20	Remedial works required, PALL fitted.	>100	
2	Odstock Ward	200	SHW 4.11.21	Remedial works required, PALL fitted.	100	
3	Odstock Ward	209	SHW 4.11.39	Remedial works required, PALL fitted.	79	
4	Odstock Ward	216	SHW 4.11.33	Remedial works required, PALL fitted.	>100	
5	Odstock Ward	231	SHW 4.11.41	Remedial works required. PALL fitted.	>100	
6	Odstock Ward	22	SHW 4.11.53	Remedial works required. PALL fitted.	>100	

(Table 12)

13.3 Pool Water Quality

Following a positive sample from microbiological testing completed on 26th September 2022, the Spinal Unit Pool was shut at 11am on 28th September 2022. Remedial works were completed by the ETS Team, and the pool was resampled on 29th September. Following a clear sample, the pool was reopened on 4th October 2022.

For quarters 3 and 4 of 2022/23, routine testing has been completed on the Hydro Pool (twice a week) and monthly testing on the main and learner leisure pools, with no adverse results recorded requiring action in this reporting period.

13.4 Achievements for 2022/23

- Full site wide risk assessment completed by the Water Hygiene Centre, the risk assessment covers all generation and storage of hot and cold water systems. This includes identifying risks associated with the design, installation, and maintenance of these systems.
- Audit completed on water safety; the audit is completed in line with the Premises Assurance Model (PAM). The water Authorised Engineer (AE) has noted that there has been an improvement in elements of water, however, noting that further work is required.
- Trial of an electronic system for the PPM of shower head/hose quarterlies and PALL point of use (POU) filter replacements.
- Completion of routine *Legionella* and *Pseudomonas* testing and development of subsequent action plans.
- Maintenance and monitoring of the temperature of the main circulated hot and cold water systems across the SFT Estate.
- Capital funded works completed on the replacement of the hot and cold water pipework on Breamore Ward. The works were completed as part of an action plan as a result of high counts of *Legionella* on the ward.
- Improvements in flushing compliance for Priority 1 areas (inpatient wards); with compliance rates at 78% for quarters 1 and 2 of 2022/23 and 84% compliance for quarters 3 and 4 of 2022/23.
- Recruitment of substantive staff member to complete the flushing of 'little used outlets' in clinical areas, these outlets are flushing twice a week in line with the Trust policy/operating procedure.
- The installation of two UV systems on the Spinal Hydro Pool and learner pool at the Leisure Centre. These systems work in conjunction for the existing chemical dosing; however, they reduce the volume

of chemical required and the physical backwashes required. This in turn reduces the water and energy use for these pools and improves the water quality.

13.5 Key Focus for quarters 1 and 2 of 2023/24

- Maintaining the level of flushing compliance for Priority 1 areas to circa 75%.
- Work on a programme for the delivery of actions related to the survey completed on the sites hot and cold water systems (water risk assessment).
- Recruitment of a Band 5 (for Water Safety), this post will be tasked with ensuring that PPMs related to water safety are delivered and will manage the flushing team.
- Delivery of PPMs related to water safety, to include temperature monitoring (source and outlets), thermostatic mixer valves (TMVs) maintenance and shower head/hose replacements.
- Completion of water sampling to include *Legionella, Pseudomonas* and Pool Water Quality.
- Installation of UV system for the main pool at the Leisure Centre.

14. SPECIALIST VENTILATION

This section summarises the actions/precautions that the Trust has taken over 2022/23 in relation to the critical ventilation systems. The Trust manages the safety of ventilation systems in line with the HTM 03-01 and operates a permit to work system to ensure that approval has been sought by the key stakeholders (e.g. Main Theatres Department (MTD), Pharmacy and Laboratories), of the system prior to its isolation.

The annual PPM has been completed on the air handling units (AHUs) that supply MTD, SSL, Pharmacy Aseptic Unit, Radiology Xray, Sarum Ward, SSL Clean Room, MRI 2, Eye Clinic, ED, Tisbury CCU and Catheterisation Laboratories. The next areas scheduled to be completed include the AHUs that supply the main laboratories (Genetics, Pathology & Microbiology).

Air change rate (AC) survey works have now been completed in wards areas. This has highlighted some spaces that have AC rates below 6 air changes per hour. The ETS Team are investigating these areas, and to date a fault has been identified with the ventilation system supplying Downton Ward and Sarum Ward, which have been rectified.

A full PPM including the replacement of the supply fans, inverters and unit filters was completed on the 9th July 2022 on the Pharmacy Aseptic Unit. As part of these works, the alignment of the motor and fan pulley has been checked and adjusted, and this has resulted in significant improvements to its performance.

The annual clean and de-grease of the main extract system for the kitchens was completed on the 9th June 2022.

An overhaul including the replacement of the supply motors and unit filters was completed on 27th August 2022 on the SSL Clean Room AHU. As part of the works, both the motors have been replaced along with new bearings for the fan and this has resulted in significant improvements to its performance.

Authorised Persons (APs) were appointed formally for the Trusts specialist ventilation systems by the designated Person (dP) on the recommendations of the Authorised Engineer (AE) on 28th August 2022. The annual Theatres and Laboratories verifications were completed in September 2022 (September 20th and 22nd).

14.1 Achievements for 2022/23

- The formation of a Ventilation Safety Group (VSG) as recommended by HTM 03-01 with representation from the ICNs, Microbiological Consultants, the Surgical Division and Pharmacy. This steering group is chaired by the Head of Estates and held quarterly.
- The formal appointment of the Head of Estates and Estates Officer Mechanical as Ventilation AP, these appointments were made in line with the HTM 03-01 by the Director of Estates as the dP.
- Introduction of a Permit to Work process to ensure critical ventilation systems are only removed from service following approval from the area/department that the system serves.

- Completion of a survey of AC rates for ward areas (these areas are not subject to annual verifications e.g. Theatres). This information has identified some remedial work, to date remedial works have been completed on the systems that supply Sarum, Britford and Downton Wards.
- Verifications completed for all operating theatres, this process should be completed annually to ensure that the air changes rate and balance of the system is in line with the recommendations of HTM 03-01.
- Annual PPMs completed on Downton, Laverstock and Radnor Wards, Radiology and the Mortuary.
- Repair/replacement of motors/fans that provide the extract air for the ventilation systems that serve Longford Ward.
- Replacement of motors and control/pulleys on the AHU that supply the Pharmacy Aseptic Suite.
- Robust procedures now in place for the isolation of critical ventilation systems, the process is managed by the Ventilation AP and the Estates Mechanical Officer.

14.2 Key Focus for quarters 1 and 2 of 2023/24

- Completion of PPMs to include 40 point check for critical systems as per the guidance in HTM 03-01.
- Delivery of contract for the testing and maintenance of fire dampers, a full survey and asset list will be developed by the contractor as part of the scope of the contract.
- Feasibility and tender for the delivery of capital works associated with the ventilation systems that supply Pathology, Microbiology and Histopathology Laboratories. An AC survey has been completed and identified areas that have little/no air changes currently.
- Review of capital projects involving the replacement of air handling systems to include Whiteparish Ward and SSL.
- Cleaning/maintenance of kitchen extract systems.

15. CONCLUSION

This annual DIPC Report has provided the Trust Board with evidence of the measures in place that have made a significant contribution to improving infection prevention and control practices across the Trust. The report has detailed the progress against the Action Plan for 2022/23 in reducing HCAI rates for the Trust.

For quarters 1 and 2 of 2023/24, the key ambitions for the Trust will include:

- Ongoing focus on the reduction of all reportable HCAIs and ensure preventable infections are avoided
- Continued reinforcement to improve compliance with hand hygiene practices and behaviours
- Maintaining achievements with antimicrobial stewardship
- Sustain progress with contingency planning and improvement plans for decontamination services
- Maintaining progress with education, training and audit relating to infection control practices and policies
- Monitor and manage water and ventilation safety
- Maintaining a clean and safe environment for patients and staff through the Trust Housekeeping service.

16. ACKNOWLEDGEMENTS

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- Vinesh Perumal, Lead Pharmacist – Antimicrobials and HIV (Section 8)
- Clare Goodyear, Trust Decontamination Lead and Medical Device Safety Officer (Section 11)
- Michelle Sadler, General Manager, Facilities and Amanda Urch, Head of Housekeeping and Portering (Section 12)
- Terry Cropp, Technical Services Manager, Estates Department (Sections 13 and 14)
- Connie Timmins, Lead IPC Nurse, BSW ICS for benchmarking data (Section 6).

APPENDIX A

Infection Prevention & Control – Annual Action Plan 2022/23

Please note: The numbering **does not** depict the order of priority for the Trust but reflects the numbered duties within the Hygiene Code.

Domain and Key Actions	Who By	Status
1 Management, Organisation and the Environment **1.1 General duty to protect patients, staff and others from HCAIs** **1.2 Duty to have in place appropriate management systems for Infection Prevention and Control**		
Continue to promote the role of the DIPC in the prevention & control of HCAI	CEO	Continuous
DIPC as Chair of the Infection Prevention & Control Committee (IPCC)	CEO	In place
Lead infection prevention & control in the Trust and provide a six-monthly public report to the Trust Board	DIPC	In place
Monitor and report uptake of mandatory training programme	IPCT	In place
Continue contribution to implementation of the Capacity Management policy	DIPC	In place
Ensure a programme of audit (incorporating Saving Lives High Impact Interventions) is in place to systematically monitor & review policies, guidelines and practice relating to infection prevention & control	IPCWG/IPCC	Monthly
Continue to review staffing levels via Workforce Planning	Deputy CNO	Continuous
Complete bedpan washer replacement and dirty utility room upgrade programme within the Trust (for inpatient clinical areas), including the Spinal Unit.	DIPC	Complete
1.3 Duty to assess risks of acquiring HCAIs and to take action to reduce or control such risks		
Maintain the role of DIPC as an integral member of the Trust's Clinical Governance & risk structures (including Assurance Framework)	CEO	Continuous
Ensure active maintenance of principle risks relating to infection prevention and control, and that the system of Root Cause Analysis (RCA) is used to review risks relating to these	DIPC/ICD/ICNs	In place
Active Surveillance & Investigation:		
Continue implementation of mandatory Surveillance Plan for HCAI & produce quarterly reports for IPCC	IPCT	In place
Review implementation of 'alert organism' & 'alert condition' system	ICD/Microbiologists	Continuous
Use comparative data on HCAI & microbial resistance to reduce incidence & prevalence	ICD/Microbiologists	In place
Promote liaison with Public Health England (PHE) for effective management & control of HCAI.	DIPC/ICD/ICNs	Continuous

Domain and Key Actions	Who By	Status
1.4 Duty to provide and maintain a clean and appropriate environment for health care		
Ensure maintenance and monitoring of high standards of cleanliness via policy management and audit, and environmental audits	DIPC/Housekeeping Manager	Monthly
Review schedule of cleaning frequency and standards of cleanliness, making them publicly available	DIPC/Housekeeping Manager/Matrons	Monthly
Ensure adequate provision of suitable hand washing facilities, hand products/alcohol gel and continued implementation of 'WHO - Five Moments' and use of 'CleanYourHands' resources	ICNs	Continuous
Continue IP&C involvement in overseeing all plans for construction & renovation	Head of Estates	Continuous
Ensure effective arrangements are in place for appropriate decontamination of instruments and other medical devices/equipment	DIPC/Decon. Lead	Continuous
Ensure the supply and provision of linen and laundry adheres to health service guidance	Head of Facilities	Continuous
Ensure adherence to the uniform and Bare below the elbow (BBE) policies and workwear guidance through audit and formal reporting via the PLACE Steering Group meetings.	DIPC/HoNs/Matrons	Continuous
1.5 Duty to provide information on HCAIs to patients and the public **1.6 Duty to provide information when a patient moves from one health care body to another** **1.7 Duty to ensure co-operation**		
Ensure publication of DIPC report via the Trust website	DIPC	6 monthly
Review Capacity Management policy & documentation to ensure communication regarding an individual's risk, nature and treatment of HCAI is explicit	DIPC	Completed
Include obligations under the Code to appropriate policy documents.	DIPC	Ongoing
1.8. Duty to provide adequate isolation facilities		
Continue implementation and monitoring of the Isolation policy and monitoring of practice via audit.	HoNs/Matrons/ IPCT	Ongoing
1.9. Duty to ensure adequate laboratory support		
Ensure the microbiology laboratory maintains appropriate protocols and operations according to standards acquired for Clinical Pathology Accreditation.	ICD/Microbiologists/ Laboratory Manager	Continuous

Domain and Key Actions	Who By	Status
1.10 Duty to adhere to policies and protocols applicable to infection prevention and control		
Core policies are:		
Standard infection control precautions	ICNs	In place
Aseptic technique	ICNs	In place
Major outbreaks of communicable infection (Outbreak policy)	ICNs	In place
Isolation of patients	ICD	In place
Safe handling and disposal of sharps	H&S Lead	In place
Prevention of occupational exposure to blood-borne viruses (BBVs), including prevention of sharps injuries	ICNs	In place
Management of occupational exposure to BBVs and post exposure prophylaxis.	H&S & OH Lead	In place
Closure of wards, departments and premises to new admissions (Outbreak & Capacity Management)	IPCT	In place
Disinfection policy	Facilities GM	In place
Antimicrobial prescribing	ICD/Lead Pharmacist	In place
Mandatory reporting HCAIs to Public health England (PHE)	ICD	In place
Control of infections with specific alert organisms; MRSA and *C.difficile*	IPCT	In place
Additional policies:		
Transmissible Spongiform Encephalitis (TSE)	ICD/Decon. Lead	In place
Glycopeptide Resistant Enterococcus (GRE)	ICD	Included in
Acinetobacter species	ICD	Isolation
Viral Haemorrhagic fever (VHF)	ICD	Policy
Prevention of spread of Carbapenem resistant organisms	ICD	In place
Diarrhoeal infections	ICD	In place
Surveillance	ICNs	In place
Respiratory viruses (RSV)	NNU Lead	In place
Infection control measures for ventilated patients	ITU Lead/Matrons	In place
Tuberculosis	ICD	In place
Legionellosis risk management policy and procedures, including pseudomonas	Head of Estates	In place
Strategic Cleaning Plan & Operational Policy	Facilities GM	In place
Building & Renovation – Inclusion of Infection Control within Building Change, Development & Maintenance	Head of Estates	In place
Waste Management Policy	Waste Manager	In place
Linen Management Policy	ICNs	In place
Decontamination of medical devices, patient equipment & endoscopes	Decon. Lead	In place

Domain and Key Actions	Who By	Status
1.11 Duty to ensure, so far as is reasonably practicable, that healthcare workers are free of and are protected from exposure to communicable infections during the course of their work, and that all staff are suitably educated in the prevention and control of HCAIs		
Ensure all staff can access relevant Occupational Health & Safety Services (OHSS)	Head of OD&P & OH Lead	Continuous
Ensure occupational health policies on the prevention and management of communicable infections in healthcare workers, including immunisations, are in place	OH Lead	Continuous
Continue the provision of infection prevention and control education at induction	IPCT	Continuous
Continue the provision of ongoing infection prevention and control education for existing staff	IPCT	Continuous
Continue recording and maintaining training records for all staff via the MLE	Education Dept.	Continuous
Ensure infection prevention and control responsibilities are reflected in job descriptions, appraisal and objectives of all staff	DIPC/DMTs	In place
Enhance and monitor the role of the Infection Control Link Professionals.	HoN/Matrons/ICNs	Continuous

		Clostridioides difficile - all cases (reportable and not reportable)		Bacteraemias - all cases are reportable to UK Health Security Agency (UKHSA)																	
		Sample taken		*MRSA*			*MSSA*			*E.coli*			*Pseudomonas aeruginosa*			*Klebsiella sp.*			Outbreak declared	PII declared	Hand Hygiene (mean %)	IPC Tendable (mean %)
Clinical Divisions	Inpatient areas/wards	Hospital onset healthcare associated	Community onset healthcare associated	Hospital onset HA	Community onset HA	Community onset CA	Hospital onset HA	Community onset HA	Community onset CA	Hospital onset HA	Community onset HA	Community onset CA	Hospital onset HA	Community onset HA	Community onset CA	Hospital onset HA	Community onset HA	Community onset CA	See main repot for details	PII of C.difficile		
Clinical Support Family Services	Sarum Ward (inc. Children DAU)	1	2					2	1		1	1									→100%	↓98.07%
	Hospice Unit																				↑100%	↑97.13%
	Longford Ward	1 + 1					1			1											↓95.39%	↓91.13%
	CS&FS Totals:	2 + 1	2				**1**	**2**	**1**	**1**	**1**	**1**										
Women & Newborn	Labour Ward	1								2											↑99%	None completed
	Neonatal Unit																				→100%	
	Post-natal Ward																				↓94.5%	
	W&N Totals:	1								**2**												
Medicine	AMU	2	2 + 1						3		2						1				↑99.51%	↓86.58%
	Breamore Ward	2								1									C19 x2		→100%	↑95.8%
	Durrington Ward	2 + 3	1				2			2									C19 x3	17.11.22	↓86.51%	↑93.78%
	ED (inc. SSEU)		2					4	14		9	59		2	1		2	9			↓91.08%	↑94.6%
	Farley Ward	1 + 1	2				1			1		2							C19 x2	09.06.22	↑96.48%	↓93.12%
	Laverstock Ward	2										1							C19 x2		↑98.09%	↓88.11%
	Pembroke Ward	2	1							1			1			1					↓98.67%	↑94.5%
	Pembroke Suite										1						1				↓97%	N/A
	Pitton Ward	1																	C19 x2		↓83.87%	↑91.1%
	Redlynch Ward	2 + 2					1			1						1			C19 x4		↓94.37%	↑94.29%
	Spire Ward	1 + 3	1										2			1				12.12.22	↑94.23%	↓94.92%
	Tisbury CCU	3																	C19 x2		↑92.75%	↓94.1%
	Whiteparish Ward	1 + 2					1						1			1			C19 x3	28.12.22	↑98.56%	↑93.05%
	Nunton Unit																				→100%	N/A
South Newton	Nadder Ward																		C19		100%	95.33%
South Newton	Pembroke Lodge																				100%	
	Medicine Totals:	11 + 19	6 + 4				**5**	**4**	**17**	**6**	**12**	**62**	**4**	**2**	**1**	**4**	**4**	**9**				

Surgery	Amesbury Suite		1				1												C19		↑75.37%	↓87.66%
	Britford Ward including SAU	1	1							2	2	3	1	1		1	1		C19 x2		↓84.76%	↑91.86%
	Chilmark Suite																				↓77.63%	↓87.2%
	Day Surgery Unit		1																C19		↑87.18%	↑96.16%
	Downton Ward	1 + 3	1				2			1	1								C19 x2	10.08.22	↑88.63%	↓89.81%
	Odstock Ward	1 + 1								1						1					↑94.29%	↑94.43%
	Radnor Ward						1			1			2		1	1					↓88.88%	↓94.52%
	Surgery Totals:	2 + 5	2 + 2				4			5	3	3	3	1	1	3	1					
Additional info: Other *C.difficile* samples, e.g. GP, Emergency Assessment, SAU, OPD, Mortuary, Private or Community Hospitals			5 + 3																			

***C.difficile*: All SFT samples including inpatient and outpatient areas, GP and other e.g., Emergency Assessment** *C.difficile* **reportable** cases = **red** *C.difficile* **not** reportable cases = **blue**

Bacteraemia classification codes:

- Hospital onset healthcare associated, is shown as Hospital onset HA
- Community onset healthcare associated, is shown as Community onset HA
- Community onset community associated, is shown as Community onset CA

Outbreak codes: C19 is COVID-19 outbreak declared

Tendable (previously Perfect Ward) scoring for IPC inspection:

	More than 90%
	70% - 90%
	Less than 70%
	No inspection completed

(Where more than 1 audit has been completed during a month, colour rate according to the lowest compliance score achieved)

Hand hygiene scoring:

	Score above 85%
	Score 61% - 84%
	Score below 60%

(Where more than 1 audit has been completed during a month, colour rate according to the lowest compliance score achieved)

Arrows indicate comparison with Q1 and Q2 mean scores for hand hygiene compliance and Tendable IPC inspections (↓ reduction; ↑ increase; → no change)

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APPENDIX C

Tendable Infection Prevention & Control (IPC) Inspection Compliance scores for Quarters 1 & 2 of 2022/23

Ward/ Dept	Division	April 2022	May 2022	June 2022	July 2022	August 2022	September 2022
Sarum Ward	Clinical Support & Family Services	11.04.2022 (98%) 28.04.2022 (97.8%)	23.05.2022 (95.7%)	19.06.2022 (100%)	22.07.2022 (100%)	18.08.2022 (100%)	18.09.2022 (100%)
Hospice Unit	Initially Medicine, then moved to CSFS	19.04.2022 (96.1%)	13.05.2022 (96.2%)	06.06.2022 (95.5%)	05.07.2022 (92.3%)	12.08.2022 (93.9%) 23.08.2022 (96.2%)	28.09.2022 (98%)
Longford Ward	Initially Medicine, then moved to CSFS	06.04.2022 (94.3%)	11.05.2022 (90.2%)	07.06.2022 (94.3%) 20.06.2022 (90.6%)	07.07.2022 (88.7%) 28.07.2022 (92.3%)	03.08.2022 (98.1%) 09.08.2022 (88.5%)	15.09.2022 (92.3%)
Acute Medical Unit	Medicine	06.04.2022 (88.5%)	02.05.2022 (90.4%)	05.06.2022 (86.3%)	30.07.2022 (90.2%)		05.09.2022 (82.7%)
Breamore Ward	Medicine	18.04.2022 (98.1%)	25.05.2022 (98.1%)		11.07.2022 (74.5%) 18.07.2022 (90.2%) 29.07.2022 (92%)	05.08.2022 (93.8%) 15.08.2022 (92.5%)	14.09.2022 (94.3%)
Durrington Ward	Medicine	26.04.2022 (88%)	25.05.2022 (79.2%)	10.06.2022 (94.3%) 27.06.2022 (94.3%)	15.07.2022 (88.5%) 27.07.2022 (88.5%)	08.08.2022 (100%) 15.08.2022 (86.8%) 19.08.2022 (92.5%)	02.09.2022 (98.1%) 28.09.2022 (98.1%)
Emergency Dept	Medicine	21.04.2022 (89.6%)	21.05.2022 (95.8%)	09.06.2022 (93.5%)			01.09.2022 (89.6%)
Farley Ward	Medicine	17.04.2022 (96.2%)	19.05.2022 (94.1%)	13.06.2022 (98.1%)	24.07.2022 (100%)	15.08.2022 (98.1%)	19.09.2022 (92.3%)
Laverstock Ward	Medicine	05.04.2022 (96.2%)	12.05.2022 (92.3%)	09.06.2022 (100%) 15.06.2022 (80%) 21.06.2022 (86%) 28.06.2022 (88%)	04.07.2022 (96.2%) 11.07.2022 (96.2%) 19.07.2022 (84.9%) 25.07.2022 (94.3%)	01.08.2022 (84.6%) 08.08.2022 (83%) 16.08.2022 (84.3%) 24.08.2022 (81.1%)	13.09.2022 (96.2%)
Pembroke Ward	Medicine	01.04.2022 (86.5%)	16.05.2022 (96.1%)	21.06.2022 (96.2%)	11.07.2022 (94.3%)		26.09.2022 (92.3%)
Pitton Ward	Medicine	20.04.2022 (100%)	11.05.2022 (94.2%) 25.05.2022 (82%)	20.06.2022 (86.5%) 30.06.2022 (88.2%)	08.07.2022 (84.6%) 22.07.2022 (96.2%)	01.08.2022 (92.5%) 18.08.2022 (94.2%)	02.09.2022 (84.9%) 15.09.2022 (90.4%) 20.09.2022 (96.2%)
Redlynch Ward	Medicine	09.04.2022 (88.7%) 11.04.2022 (96.1%) 17.04.2022 (88.7%)		22.06.2022 (98.1%) 23.06.2022 (94.1%) 24.06.2022 (98.1%) 26.06.2022 (94.2%) 27.06.2022 (92.5%)	08.07.2022 (80.8%) 12.07.2022 (84%) 25.07.2022 (90.2%) 29.07.2022 (96.1%)	05.08.2022 (94.2%) 22.08.2022 (90.2%) 24.08.2022 (92.2%)	07.09.2022 (90.4%) 13.09.2022 (96.2%) 18.09.2022 (94.2%) 20.09.2022 (96.2%) 25.09.2022 (96.2%)
Spire Ward	Medicine	15.04.2022 (94.2%)		12.06.2022 (96.2%)	19.07.2022 (94.2%)	16.08.2022 (96.2%)	18.09.2022 (94.3%)
Tisbury CCU	Medicine	03.04.2022 (98.1%)	02.05.2022 (98.1%) 07.05.2022 (98.1%) 16.05.2022 (88.5%) 22.05.2022 (96.2%) 28.05.2022 (92.5%)	04.06.2022 (92.5%) 22.06.2022 (94.1%) 29.06.2022 (100%)	06.07.2022 (96.2%) 13.07.2022 (97.8%) 20.07.2022 (94.3%) 26.07.2022 (94.3%) 31.07.2022 (96.1%)	07.08.2022 (98.1%) 14.08.2022 (98.1%)	01.09.2022 (92.3%) 09.09.2022 (94.3%)
Whiteparish Ward	Medicine	05.04.2022 (96.2%)	10.05.2022 (94.3%) 21.05.2022 (86.8%) 29.05.2022 (86.5%)	02.06.2022 (90.6%)	07.07.2022 (90.2%) 15.07.2022 (86.8%) 18.07.2022 (94.2%) 26.07.2022 (96.2%) 31.07.2022 (94.2%)	06.08.2022 (92.5%) 13.08.2022 (96.2%) 19.08.2022 (92.3%)	27.09.2022 (91.8%)

Amesbury Suite	Surgery	23.04.2022 (81.3%)	07.05.2022 (76.5%) 12.05.2022 (81.1%) 19.05.2022 (88.5%)	02.06.2022(88%) 16.06.2022 (90.2%)	02.07.2022 (90.4%)	18.08.2022 (82.4%)	29.09.2022 (80.4%)
Britford Ward	Surgery	22.04.2022 (93.9%)	04.05.2022 (97.8%) 18.05.2022 (64.7%)	02.06.2022 (88.2%) 30.06.2022 (94.1%)	05.07.2022 (92.5%) 14.07.2022 (92.3%) 25.07.2022 (90.4%)	09.08.2022 (98.1%) 16.08.2022 (96.2%)	01.09.2022 (100%)
Chilmark Suite	Surgery		26.05.2022 (78.7%)	30.06.2022 (82.4%)	31.07.2022 (97.7%)	22.08.2022 (98%)	30.09.2022 (80.4%)
Day Surgery Unit	Surgery	25.04.2022 (92.9%)	27.05.2022 (97.6%)	08.06.2022 (56.5%) 27.06.2022 (91.1%)	05.07.2022 (57.8%) 06.07.2022 (65.3%) 13.07.2022 (62.2%) 18.07.2022 (78.4%) 25.07.2022 (95.6%)	01.08.2022 (86%) 08.08.2022 (91.1%) 15.08.2022 (88.9%) 23.08.2022 (90.9%)	16.09.2022 (93.3%)
Downton Ward	Surgery		06.05.2022 (98.1%)	13.06.2022 (100%)	05.07.2022 (78.8%) 14.07.2022 (90.4%) 14.07.2022 (86.8%) 18.07.2022 (96.2%) 26.07.2022 (84.9%) 27.07.2022 (88.5%) *2 inspections recorded 14.07.2022*	01.08.2022 (98.1%) 10.08.2022 (96.2%) 18.08.2022 (86.5%) 25.08.2022 (90.6%)	07.09.2022 (90.6%)
Odstock Ward	Surgery	15.04.2022 (90.2%)	07.05.2022 (92.5%) 18.05.2022 (92%)	19.06.2022 (94.2%)	12.07.2022 (94.1%)	22.08.2022 (96.1%)	26.09.2022 (98%)
Radnor Ward	Surgery	04.04.2022 (86.3%)	16.05.2022 (92.3%)	24.06.2022 (98%)	16.07.2022 (100%)	15.08.2022 (97.8%)	21.09.2022 (94.1%)
Maternity	Women & Newborn		10.05.2022 (90.9%) 10.05.2022 (92.7%) *2 inspections recorded 14.07.2022*				

Tendable (previously Perfect Ward) scoring:

	More than 90%
	70% - 90%
	Less than 70%
	No inspection completed

(Where more than 1 audit has been completed during a month, colour rate according to the lowest compliance score achieved)

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APPENDIX C

Tendable Infection Prevention & Control (IPC) Inspection Compliance scores for Quarters 3 & 4 of 2022/23

Ward/ Dept	Division	October 2022	November 2022	December 2022	January 2023	February 2023	March 2023
Sarum Ward	Clinical Support & Family Services	31.10.2022 (98%)		13.12.2022 (94.2%)	01.01.2023 (100%)	25.02.2023 (100%)	15.03.2023 (100%) 20.03.2023 (96.2%)
Hospice Unit	CSFS	24.10.2022 (96.0%)	02.11.2022 (96.1%)	04.12.2022 (95.0%)	04.01.2023 (98%)	27.02.2023 (100%)	01.03.2023 (97.7%)
Longford Ward	CSFS	12.10.2022 (86%)	09.11.2022 (88.5%)	12.12.2022 (88.5%) 19.12.2022 (92.5%)	11.01.2023 (84.3%)	13.02.2023 (100%)	18.03.2023 (98.1%)
Acute Medical Unit	Medicine		22.11.2022 (88.5%)		03.01.2023 (82.7%)	20.02.2023 (86.5%)	03.03.2023 (88.5%)
Breamore Ward	Medicine	10.10.2022 (98.1%) 17.10.2022 (98.05%) 24.10.2022 (97.9%)	01.11.2022 (98.1%) 08.11.2022 (97.7%)		03.01.2023 (88.2%) 05.01.2023 (98.0%) 16.01.2023 (90%) 25.01.2023 (95.6%)	10.02.2023 (94.1%)	23.03.2023 (98.1%)
Durrington Ward	Medicine	17.10.2022 (90.4%)	01.11.2022 (96.2%) 10.11.2022 (96.2%) 17.11.2022 (88.7%) 21.11.2022 (98.1%) 28.11.2022 (98.1%)	29.12.2022 (98.1%)	25.01.2023 (67.3%)	09.02.2023 (98.1%) 22.02.2023 (96.1%)	01.03.2023 (100%) 30.03.2023 (98.1%)
Emergency Dept	Medicine	12.10.2022 (91.1%)	10.11.2022 (93.6%)	01.12.2022 (93.9%)	16.01.2023 (97.6%)	09.02.2023 (93.5%)	04.03.2023 (97.9%)
Farley Ward	Medicine	07.10.2022 (88.7%) 21.10.2022 (90.2%)	05.11.2022 (84.9%) 14.11.2022 (94.3%) 21.11.2022 (94.3%) 25.11.2022 (94.3%)	05.12.2022 (92.5%) 12.12.2022 (94.3%) 19.12.2022 (92.5%) 28.12.2022 (94.1%)	08.01.2023 (96.2%)	13.02.2023 (98.1%)	13.03.2023 (96.2%)
Laverstock Ward	Medicine	06.10.2022 (88.5%) 13.10.2022 (88.2%) 20.10.2022 (90.2%) 27.10.2022 (96.1%)	02.11.2022 (88.5%) 04.11.2022 (96%) 09.11.2022 (98.1%) 16.11.2022 (96%) 23.11.2022 (86.5%) 28.11.2022 (88%)	05.12.2022 (96.1%) 27.12.2022 (92.3%)	02.01.2023 (94.2%) 09.01.2023 (80%) 16.01.2023 (86.5%) 23.01.2023 (82.4%) 30.01.2023 (80.4%)	13.02.2023 (86.3%)	06.03.2023 (82.7%) 22.03.2023 (76.5%) 27.03.2023 (76.9%)
Pembroke Ward	Medicine		07.11.2022 (96.2%)	30.12.2022 (91.5%)	28.01.2023 (92.5%)	22.02.2023 (98%)	10.03.2023 (94.3%)
Pitton Ward	Medicine	03.10.2022 (86.8%) 17.10.2022 (88.5%)	03.11.2022 (94.2%) 06.11.2022 (76.9%)		13.01.2023 (96.2%) 23.01.2023 (96.2%)	02.02.2023 (94.3%) 09.02.2023 (98.1%) 16.02.2023 (90.6%) 23.02.2023 (86.5%)	09.03.2023 (94.3%) 24.03.2023 (90.6%)
Redlynch Ward	Medicine	01.10.2022 (96.2%) 12.10.2022 (88.2%) 16.10.2022 (90.2%) 23.10.2022 (92.2%) 25.10.2022 (94.3%)	01.11.2022 (96.2%) 05.11.2022 (92.5%) 18.11.2022 (98%) 20.11.2022 (96.2%) 26.11.2022 (96.2%)	28.12.2022 (90.6%) 31.12.2022 (96.1%)	04.01.2023 (90.2%) 08.01.2023 (94.1%) 13.01.2023 (94.2%) 18.01.2023 (96.2%) 26.01.2023 (98%) 31.01.2023 (98.1%)	10.02.2023 (94.2%) 18.02.2023 (96.1%) 24.02.2023 (98.1%)	06.03.2023 (94.1%) 10.03.2023 (88.5%) 30.03.2023 (94.2%)
South Newton site – SFT beds	Medicine		14.11.2022 (98%)	05.12.2022 (96.2%)	12.01.2023 (98%)	08.02.2023 – 2 inspections (96.1% and 94.2%)	03.03.2023 (92.3%) 17.03.2023 (92.5%)

Spire Ward	Medicine	18.10.2022 (98.1%)	01.11.2022 (96.2%)	18.12.2022 (94.1%)	13.01.2023 (83%)	25.02.2023 (98.1%)	01.03.2023 (100%)
Tisbury CCU	Medicine	03.10.2022 (90.4%) 27.10.2022 (94.3%)	05.11.2022 (92.5%) 12.11.2022 (96.2%) 19.11.2022 (96.2%) 26.11.2022 (96.2%)	01.12.2022 (94.3%)	02.01.2023 (90.4%)	03.02.2023 (96.2%)	05.03.2023 (94.3%)
Whiteparish Ward	Medicine	06.10.2022 (83%) 14.10.2022 (94.3%) 15.10.2022 (98.1%) 22.10.2022 (92.5%) 30.10.2022 (94.3%)	06.11.2022 (94.3%) 19.11.2022 (97.15%) 26.11.2022 (100%)	07.12.2022 (90.6%) 17.12.2022 (100%)	07.01.2023 (96.2%)	05.02.2023 (90.2%) 17.02.2023 (88.5%) 19.02.2023 (86.8%) 26.02.2023 (88.7%)	04.03.2023 (88%) 18.03.2023 (100%) 31.03.2023 (92.2%)
Amesbury Suite	Surgery	20.10.2022 (98.1%)	10.11.2022 (81.1%) 21.11.2022 (76.5%)	03.12.2022 (84.6%) 28.12.2022 (84.6%)	25.01.2023 (86.5%) 31.01.2023 (90.2%)	11.02.2023 (80.8%) 17.02.2023 (86.5%) 25.02.2023 (90.6%)	05.03.2023 (96.2%) 14.03.2023 (96.2%)
Britford Ward	Surgery	13.10.2022 (94.1%)	25.11.2022 (92.3%) 30.11.2022 (82.7%)	15.12.2022 (92.2%)	05.01.2023 (90.4%) 09.01.2023 (94.3%) 20.01.2023 (92.2%) 27.01.2023 (95.8%)	03.02.2023 (92.3%)	03.03.2023 (92.3%)
Chilmark Suite	Surgery	31.10.2022 (78%)	19.11.2022 (88.2%)	24.12.2022 (86.5%)	02.01.2023 (82.4%) 08.01.2023 (88.7%)	11.02.2023 (94.3%)	26.03.2023 (92.3%)
Day Surgery Unit	Surgery	18.10.2022 (91.7%)	28.11.2022 (93.6%)	22.12.2022 (91.7%) 28.12.2022 (100%)	04.01.2023 (98.1%) 09.01.2023 (90%) 13.01.2023 (100%) 20.01.2023 (95.3%) 30.01.2023 (98.1%)	07.02.2023 (97.9%) 20.02.2023 (98.1%)	01.03.2023 (100%) 07.03.2023 (95.6%)
Downton Ward	Surgery	03.10.2022 (92.3%) 27.10.2022 (88.7%)	14.11.2022 (90.4%)	13.12.2022 (77.4%)	04.01.2023 (88.7%) 09.01.2023 (88.5%) 20.01.2023 (86.5%) 26.01.2023 (94.2%)	02.02.2023 (92.3%) 09.02.2023 (84.9%) 15.02.2023 (88.7%) 23.02.2023 (94%)	03.03.2023 (86.8%) 09.03.2023 (94.2%) 15.03.2023 (96.1%) 23.03.2023 (96.2%) 28.03.2023 (86.8%)
Odstock Ward	Surgery	20.10.2022 (94.2%)	22.11.2022 (98.1%) 25.11.2022 (84%)	28.12.2022 (96.2%)	16.01.2023 (96.2%)	04.02.2023 (96.2%)	30.03.2023 (96.1%)
Radnor Ward	Surgery	22.10.2022 (96.2%)	28.11.2022 (94.2%)		26.01.2023 (95.8%)	24.02.2023 (92.3%)	20.03.2023 (94.1%)
Maternity	Women & Newborn						

Tendable (previously Perfect Ward) scoring: (Where more than 1 audit has been completed during a month, colour rate according to the lowest compliance score achieved)

	More than 90%
	70% - 90%
	Less than 70%
	No inspection completed

Report to:	Trust Board (Public)	Agenda item:	5.5
Date of meeting:	6 July 2023		

Report tile:	2022/23 Risk Management Annual Report			
Status:	Information	Discussion	Assurance	Approval
	X	X	X	
Approval Process: (where has this paper been reviewed and approved):	Clinical Management Board			
Prepared by:	Kim Melbourne Deputy Risk Manager			
Executive Sponsor: (presenting)	Judy Dyos Chief Nurse			

Recommendation:

Information - To note the themes and trends identified in the Executive Summary.

Discussion – To note the report and identify any areas requiring further clarity or focus.

Assurance – To note the numbers of reported incidents with associated low levels of harm.

Executive Summary:

In 2022-2023 the Trust Risk objectives were set as:

- Monitoring of incidents to highlight trends and areas requiring further investigation/action
- Embedding risk management at all levels of the organisation – embedding a just culture
- Promoting reporting
- Ensuring there is appropriate provision of datix incident training
- Ensure compliance of ‘duty of candour’ reports.

Monitoring of incidents to highlight trends and areas requiring further investigation/action

All patient safety incidents classified as moderate harm or above are reviewed at the weekly Patient Safety Summit. A total of 74 reviews were commissioned in 2022-23. Of these, 40 were Serious incidents and 34 were clinical reviews

In addition, there were 38 SWARMs for falls resulting in moderate and above harm completed. These are broken down as 25 moderate, 12 major and 1 catastrophic. In comparison, in the year 2021-2022, there were 54 falls with harm, hence a significant decrease.

67 SII/CRs have been completed and closed during the year 2022-2023. 5 of these were within the 60 day timeframe, with the remaining 62 breaching.

40 SII/CRs remain open. 25 of these are within the original 60-day timeframe, the other 15 have breached the 60-day timeframe.

SII/CR recommendations compliance

Recommendations and learning continue to be extrapolated from reviews. There are currently just short of 200 open actions which have breached their specified time frame. These compliance reports are addressed in the divisional deep dive meetings that are held with the executives. However only 50% of the divisions are in date with these meetings.

Embedding risk management at all levels of the organisation – embedding a just culture

Each Department and Division continues to maintain a comprehensive risk register. Divisional risk registers are formally reviewed in Divisional Governance Meetings and through Executive Performance reviews, in addition to a risk deep dive as described above.

Promoting reporting

There has been an overall increase of 2.9% in the reporting of incidents in 2022/23 (9864) compared to 9582 in 2021/22. The largest reporting group continues to be nursing and allied health professionals.

Reviewing data from our National Reporting Learning System (NRLS) the rate of patient safety incidents reported showed a decrease from 51.6 incidents per 1000 bed days in 2020/21to 49.9 incidents per 1000 bed days in 2021/22The number of incidents resulting in severe harm or death has decreased from 0.6% in 2020/21 to 0.5% in 2021/22.

The NRLS system will be replaced by the Learning from Patient Safety Events (LFPSE) in September 2023. This is a large ongoing piece of work within the risk department at present to ensure the Trust is ready to go live by the specified national date.

Ensuring there is appropriate provision of datix incident training

Datix incident training continues to be provided via an MLE package as well as teaching sessions via TEAMS. The datix administrators have also recently began to go back out into departmental meetings to provide face to face problem solving.

Training will change shortly in order to reflect the upcoming LFPSE launch.

Ensure compliance of ‘duty of candour’ reports.

Duty of Candour compliance continues to be reported on monthly and is overseen by the Patient Safety Summit.

2022-23 has seen a significant drop in compliance as opposed to 2021-22. The delays in the completion of SIIs and consequently being able to share with families, does have an impact on compliance at stage 3.

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

2022-2023 Risk Management Annual Report

Introduction

The Trust recognises that risk management must be fully embedded for the organisation to function safely and effectively. Robust risk management processes must be in place for the Trust Board to be assured on performance and standards. To achieve this, the Trust Board needs to be confident that the systems, policies and staff it has put in place are operating in a way that is effective, focused on key risks, and driving the delivery of the corporate objectives.

Good risk management has the potential to impact on performance improvement, leading to:

- Improvement in service delivery
- More efficient and effective use of resources
- Improved safety of patients, visitors and staff
- Promotion of innovation within a risk management framework
- Proactive management of incidents and a reduction in time spent 'firefighting'
- Assurance that information is accurate, and that controls and systems are robust and defensible.

To monitor the effectiveness of the risk management processes and policies the following strategic objectives have been set and will be monitored via the Patient Safety Steering Group, Clinical Management Board, Clinical Governance Committee, Divisional Executive Performance Meetings and Assurance Committees.

These objectives are set as:

- Monitoring of incidents to highlight trends and areas requiring further investigation/action
- Embedding risk management at all levels of the organisation – embedding a just culture
- Promoting reporting
- Ensuring there is appropriate provision of datix incident training
- Ensure compliance of 'duty of candour' reports.

1. Monitoring of incidents to highlight trends and areas requiring further investigation/action

1.a *Weekly review of all moderate, major, and catastrophic patient safety incidents through the weekly Patient Safety Summit.*

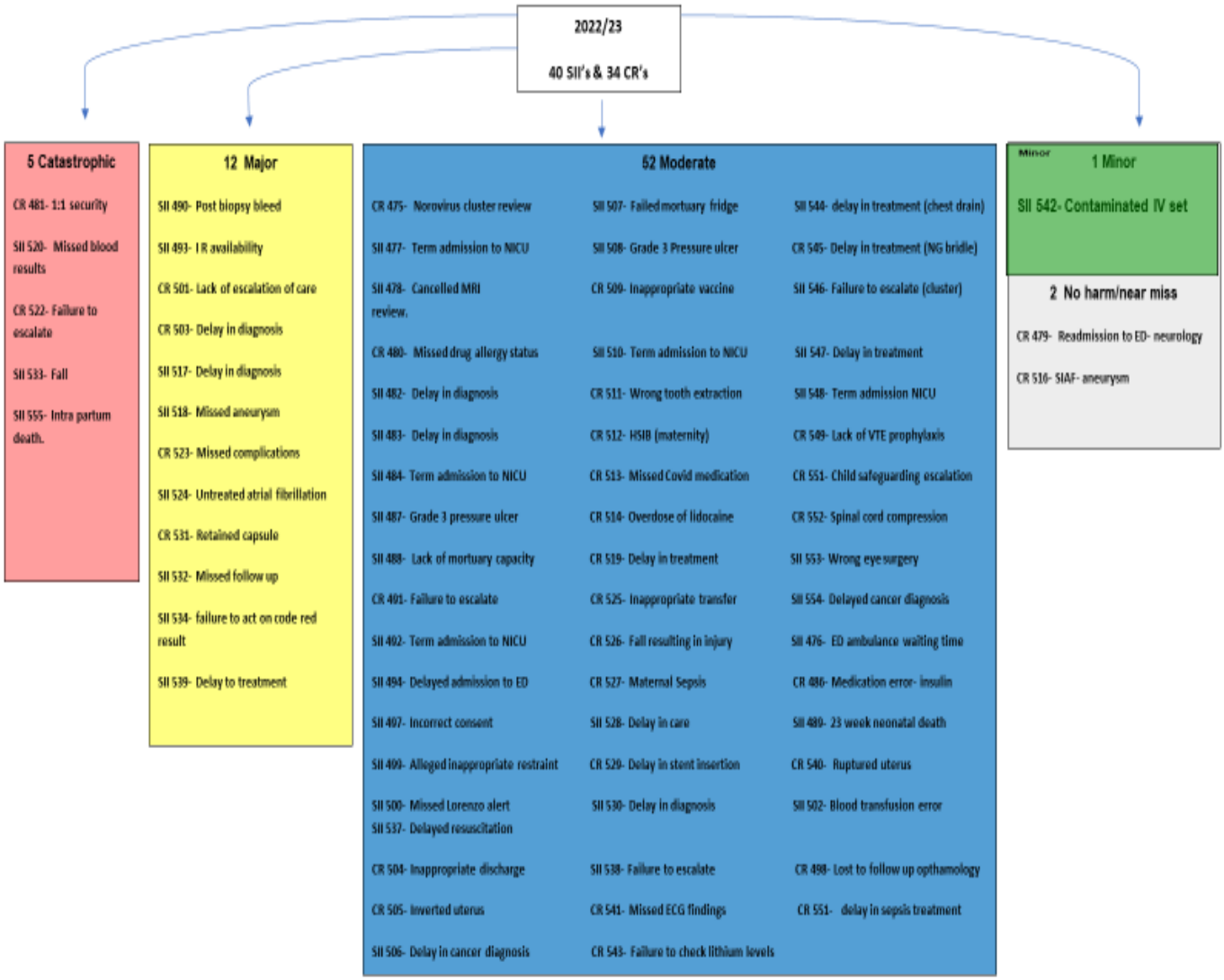
The weekly Patient Safety Summit (PSS) provides a means of systematically reviewing and managing patient safety incidents within the organisation. The main purpose of the group is to ensure incidents are managed effectively and consistently, and any quality or safety themes can be identified and escalated to the required governance channels as appropriate. This also includes the sharing and communication of best practice. Assurance is sought to understand what has been put in place to mitigate a repeated incident / what still needs to be done and what learning for the team involved and wider learning can be drawn upon. Prior to the meeting the Head of Nursing / Divisional Matron will have arranged for a 72-hour report to have been completed.

Using the Serious Incident / Adverse Incident reporting guidance, the meeting will agree whether the incident is:

- A Serious Incident, requiring external reporting to our commissioners and an investigation and delivery of a report within 60 working days that is presented to CRG.
- A high-risk incident requiring a clinical review and a report presented to CRG.
- An incident requiring local investigation and management (Recorded on Datix)
- For an external agency/organisation to undertake a review.
- A potential joint investigation with another organisation(s)

Through the PSS, 74 reviews were commissioned in the year 2022-2023. Of these, 40 were Serious Incidents and 34 were clinical reviews

In addition, there were 38 SWARMs for falls resulting in moderate and above harm completed. These are broken down as 25 moderate, 12 major and 1 catastrophic. In comparison, in the year 2021-2022, there were 54 falls with harm, hence a significant decrease this year.



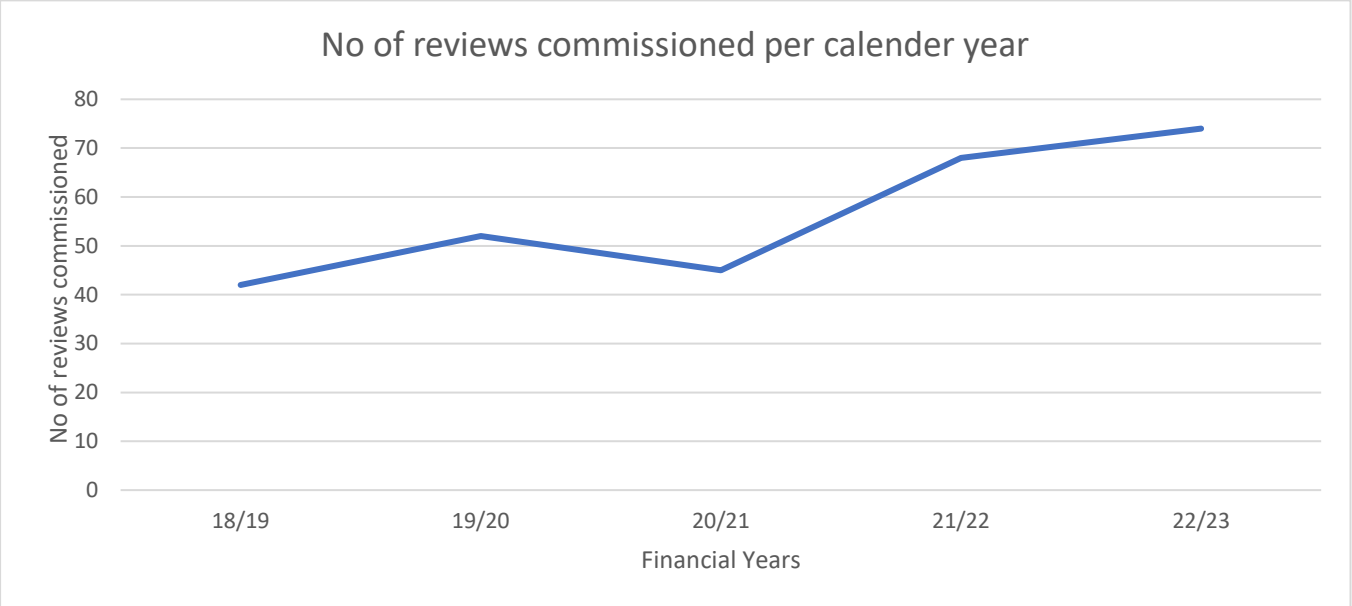
The broad themes as to the reason for the reviews being commissioned include:

- Delay in diagnosis
- Failure to escalate abnormal findings
- A delay in commencing treatment.
- Documentation has been noted as a contributory/incidental finding in a large number of reviews, although has not been the primary reason for the commissioning of a review.

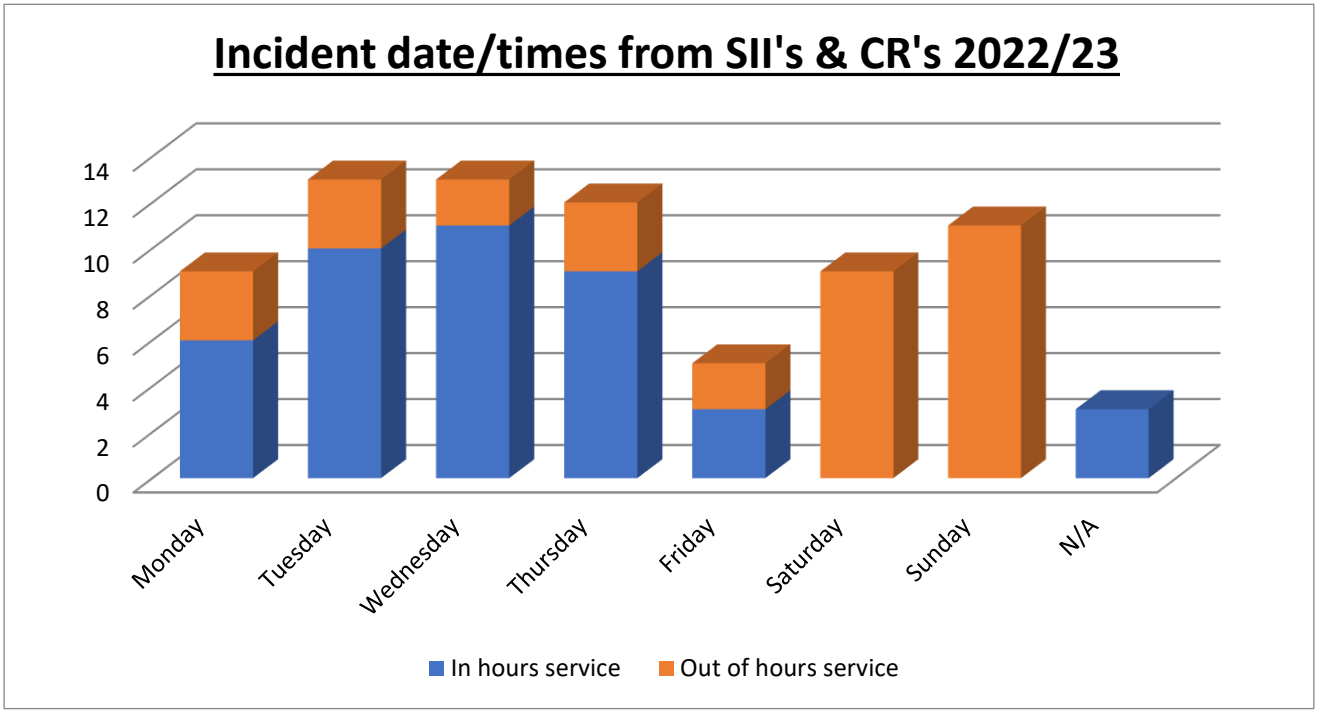
There has been a reduction in the number of reviews commissioned due to harm from a fall. This is because focused falls work falls within one of the Trust break through workstreams. Whilst a SWARM is always completed, a review will only be commissioned if there is considered to be new learning that will be extrapolated.

There have been no Never events in 2022-23

The chart below indicates the trend over the last 5 financial years of commissioned reviews. Following the introduction of the weekly patient safety summit (PSS), in December 2020, there has been a steady increase in the number of reviews commissioned.



The chart below identifies the timings of incidents. Overall, there is a slightly higher occurrence of incidents within '9-5' hours (39) as opposed to out of hours (33).



1.b Compliance against SI/CR KPI timeframes

Looking at the SII/CR data for 2022-2023

67 SII/CRs have been completed and closed during the year 2022-2023.

- 5 of these reviews met the standard of commissioned to completion within 60 days, the remaining 62 all breached the recommended timeframe.

40 SII/CRs remain open.

- 25 of these are within the original 60-day timeframe, the other 15 have breached the 60-day timeframe

Members of the Quality Team within the ICS have attended the weekly PSS and are in receipt of timely progress updates of SII's therefore specific extension dates are no longer necessary.

Processes are constantly being reviewed in order to identify and address where the delays are and how these can be minimised. However, the evidence suggests that the reviews carried out with a single reviewer, rather than a full panel, have faced their own challenges and time delays due to clinical pressures and limited resources to collate evidence.

Compliance report for SII/CR open actions

The below table illustrates the number of actions within the reviews that remain open and have breached their completion date. Alongside the risk registers, the compliance reports are discussed within the deep dives that are held between the divisional leads and the execs. The table below also demonstrates when each division last had their deep dive meeting and all have breached the recommended three to six monthly meet for these.

Directorate	Breached (Red)	Breached but work in progress (Amber)	Total breached	last deep dive
Medicine	69	18	**87**	03/11/2021
Surgery	30	22	**52**	>1 year ago
CSFS	25	13	**38**	21/11/2022
W and NB	7	13	**20**	18/11/2022

Attendance at Clinical Risk Group (CRG) and Patient Safety Steering Group (PSSG).

As part of the governance process, SIIs and CRs are presented at CRG for approval prior to being presented to the executives for final sign off.

An overall review of all completed reviews alongside the RMRC are presented monthly at the PSSG.

Appendices B and C demonstrate the attendance of core membership for 2022 for these 2 meetings.

The attendance at these meetings has been variable over the last 12 months, with operational pressures playing a large part in the absence of some core members. Meetings have continued to go ahead, despite not always being quorate, to ensure that reports are moved through the system as quickly as possible within the given restraints that exist.

1.c Provision of monthly incident report card at the Patient Safety Steering Group to support theming of all incidents and monitoring of high harm incidents.

The Risk Report Card is reviewed monthly by the Patient Safety Steering Group and quarterly through the Clinical Governance Committee. Key themes and trends are identified along with feedback on work streams being taken forward to improve patient safety and reduce risk. An example for this financial year is the appointment of a learning disability nurse specialist who will work towards driving the national agenda going forward.

There has been an overall increase of 2.9% in the reporting of incidents in 2022/23 (9864) compared to 9582 in 2021/22, this is a good reflection of reporting within the organization

The top 5 incident categories for the year are:

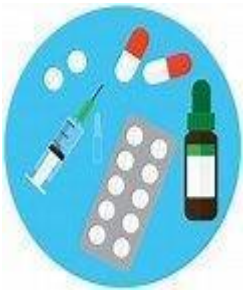
Implementation of care or ongoing monitoring/review

A 7% increase in possible delay or failure to Monitor (128-137)
A 92% increase in Safeguarding concerns relating to inpatient care (from 12 to 23)

Accident that may result in personal injury

A 63% increase in Slips on wet area (non-cleaning or bodily fluids) (8 to 13)
A 2.6% increase in slips, trips, falls and collisions. 1519 in 2022/23
10% decrease in injury from dirty sharps (10 to 9)
5.9% decrease in needlestick injury or other incident connected with sharps.

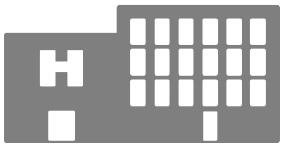
Medication



An 18.4% increase in the number of medication incidents submitted in 2022/23.
1200% increase in Wrong drug/ dose prescribed, dispensed and administered (from 1 to 13)
58% increase in Recording error (from 12 to 19)

Access, appointment, admission, transfer, discharge

31% increase in Inappropriate Discharge (13 to 17)
29% decrease in Delay (14 to 10)
311% increase in Unplanned admission / transfer to specialist care unit (9 to 37)



100% increase in Damage to property (non-security) (from 4 to 8)
25.7% increase in environmental issues
34.9 % decrease in adverse events that affect staffing levels.

Learning from completed reviews.

The following are a small number of areas of learning that have been extrapolated from SII/CRs.

- A small number of reported incidents were noted involving the transfer of patients between EPMA and non-EPMA wards, whereby prescriptions had not been transferred to the appropriate format in a timely manner, resulting in some patients missing doses of critical medicines. This

learning was highlighted on the Trust Medical Bulletin and was also added to the risk register whilst the EPMA program continued to be rolled out.

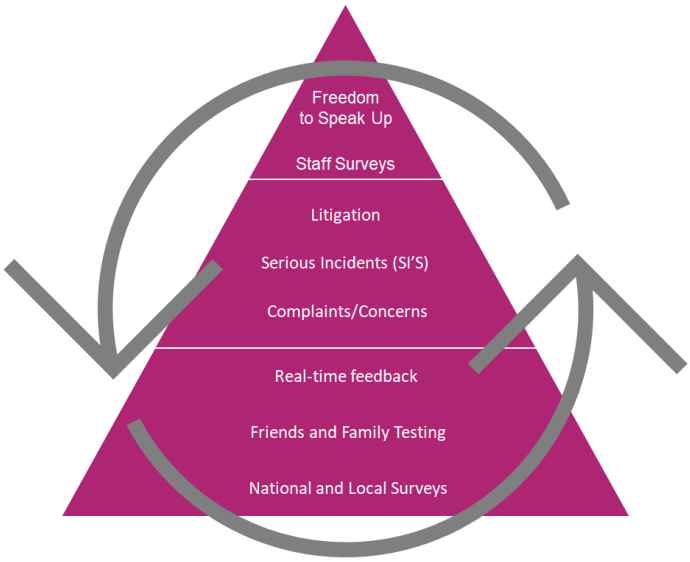
- Following a missed complication on an Xray, resulting in a poor outcome for the patient, the lead consultant for ED is using examples of such test results for teaching within the department.
- A working group has been established to look at patients requiring enhanced care/one to one supervision/oversight from security. These specific needs are very different and inappropriate use of security guards has been highlighted through the SII/CR review process.
- Orthopaedic teams are required to continue regular reviews of patients with on-going care needs when they are transferred to outlying areas until they are medically fit from the view of the orthopaedic team.

- The importance of early and prompt RESPECT discussions at the doctors first review of the patient who have a known treatment escalation plan at home.
- The importance of discussion and documentation around patient's capacity to consent when considering restrictive interventions, making sure the appropriate assessments & documentation are completed appropriately and including the patient and their relatives in these discussions.
- The importance of senior eyes on review for patients in the emergency department. The review of patient's observation prior to discharge if there is an increased NEWS2 score or if the patient has a long period between last review and leaving the department
- Escalation of clinical deterioration and use of SBAR Discussion with the designated medical team if patient is to be transferred out of the designated ward area. Effective doctor to doctor handover when out of specialty
- A need to find ways to better manage ambulance queues and clinically reviewing patients who are forced to remain in an ambulance when capacity in ED is limited.

***1.d** Triangulation with PALS, Freedom to Speak Up and the legal Team to look at broader themes and learning.*

Background

Throughout 2022/23 leads from Patient Experience, Risk, Freedom to Speak Up and the Legal team have been exploring ways to compare data sets in an attempt to triangulate these to better understand if there were opportunities to improve both patient and staff experiences.



We recognised that there were various data sets available across the Trust, varying in scale, method and threshold for reporting. It was therefore an important first step to develop a baseline by which we could attempt to make meaningful comparisons.

We started to explore in the first instance, recorded complaints, serious incidents, clinical reviews along with freedom to speak up events. So far this year, we have held 3 meetings (on a quarterly basis) and through these have considered different ways to compare our data. We have most recently trialled collating the numbers of risk incidents (SI's and Clinical Reviews), along with Freedom to Speak Up records and numbers of Complaints, allocating a figure for relative comparison based on a per 1,000 patient activity (at Division level). The idea behind this was to help understand if there were any commonalities across these areas, as well as be able to compare (relatively) the scale of these across divisions.

Summary

On applying this method to Q1 data, Risk and Patient Experience saw a common prevalence amongst the Women & Newborn division for recorded incidences – but were limited at this stage on being able to drill down on themes. Freedom to Speak Up noted a higher number of recorded incidents within Corporate Services and these were largely themed as being related to patient safety & quality, inappropriate behaviours and bullying/harassment.

In Q2, we saw a commonality with complaints and Freedom to Speak Up in terms of prevalence amongst the Women & Newborn division and general themes were related to patient care (for complaints) and patient and worker safety (for Freedom to Speak Up). In addition, Women & Newborn were also noted to be the most prevalent for Risk for the proportion of SIIs and Clinical Reviews raised during that period. There was a wider discussion at that stage that there was a potential theme linking a few complaints and SI's that related to hospital processes not being followed due to inherent cultural beliefs around death. Freedom to Speak Up noted some concerns being raised by those being recruited from overseas in relation to integration, training and support with resettlement. It was recognised at that stage that the total number of incidences across these areas may be too small to make meaningful insight, but it was agreed that this should be a conscious area of note as we move into Q3 particularly as the Trust was still continuing with its overseas recruitment efforts.

No meeting was held for Q3.

In Q4 we had started to explore how to incorporate legal data, and this continues to be a work-in progress. One of the issues with legal claims is that the period from the time of any related complaint can be many months or even years later, i.e. a complaint made in 2022 may not reach the legal team until 2033 just checking this date was intended (10 years) or later.

During this period a total of 57 complaints were raised; 5% of these subsequently had a litigation alert attached to them. No particular themes for these were noted with the data that was available at this stage.

Complaints noted a prevalence amongst Medicine and Women and Newborn divisions for number of complaints raised, patient care (this was a top theme across all four clinical divisions), as well as communication and access to treatment and admission/discharge.

Women & Newborn were noted again as the most prevalent for risk reporting, and there was a theme related to term admission to NICU and failure to escalate.

Freedom to Speak Up saw a prevalence in reported events from the Surgical divisions, themes were largely related to inappropriate behaviours, patient safety and quality and bullying/harassment. Patient safety/quality was largely in relation to lack of staffing (poor behaviours being linked to long term sickness and therefore reduction in clinical capacity).

Next steps
We will be looking to develop this triangulation further by incorporating Friends and Family Test feedback (once theming capabilities are in place, planned for Q3/Q4 of 2023/24). We will also be looking a more robust method of considering litigation alerts vs number of enquiries to litigation (both successful and unsuccessful claims).
Meetings will continue each quarter and we aim to produce an annual summary of our findings. When necessary, any notable themes that may require escalation will need to have a clear and defined route of escalation.

2. Embedding risk management at all levels of the organisation – creating a safety culture

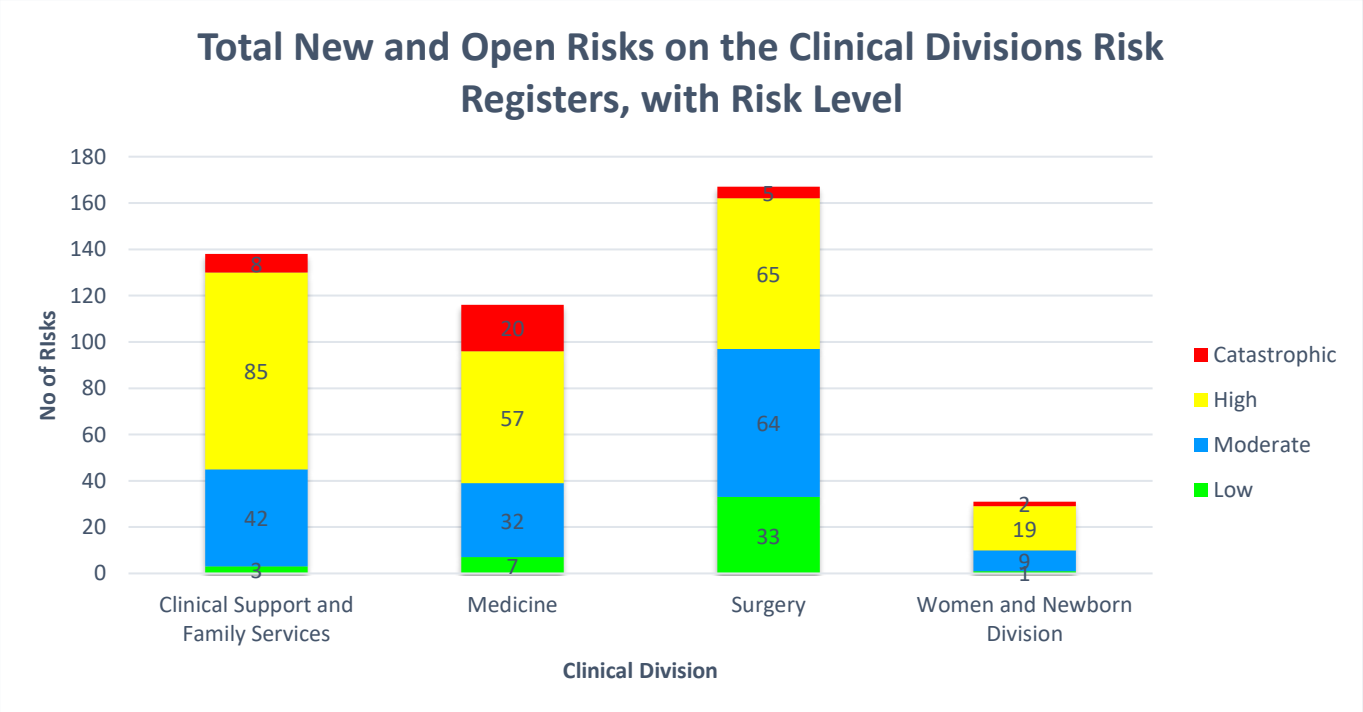
2.a Ownership of risks at a local level

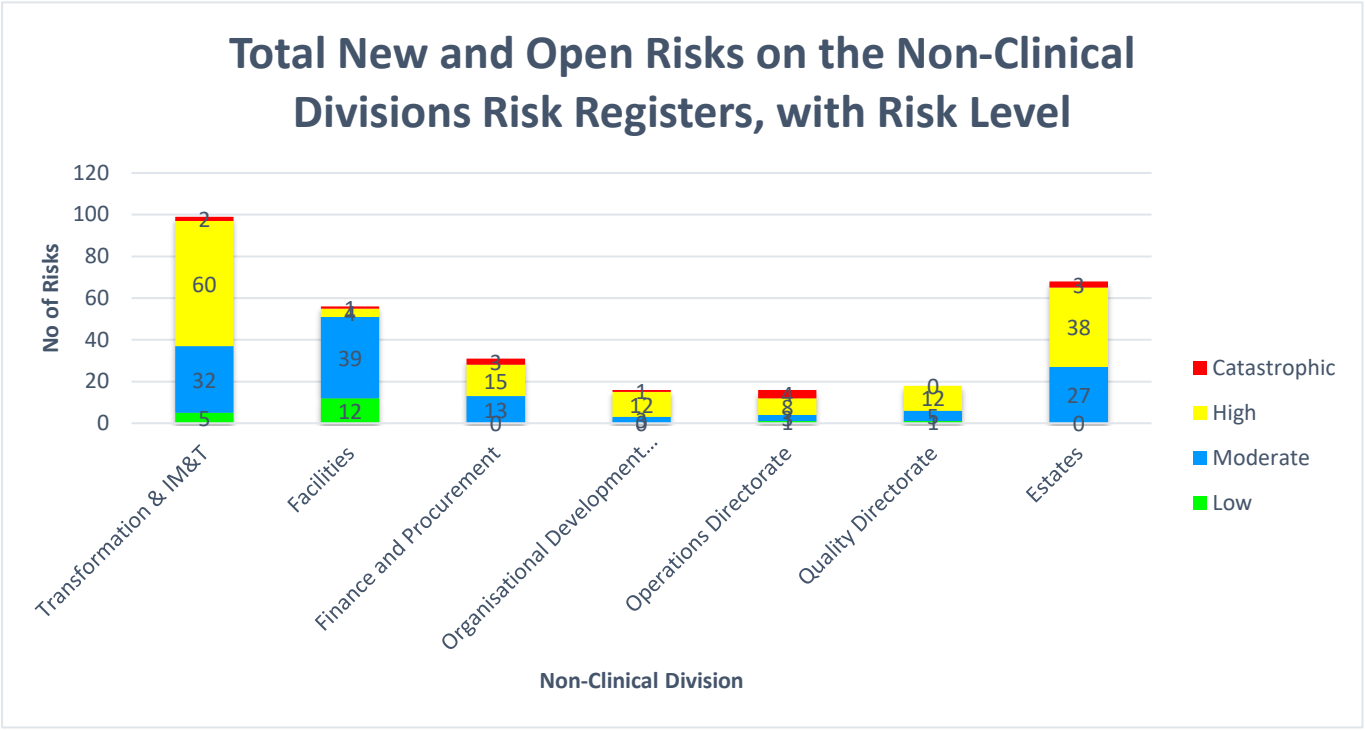
Each Department continue to carry out risk assessments which are held on Datix. A single framework for the assessment, rating, and management of risk is used throughout Datix to ensure a consistent approach. The number of staff that has undertaken training in order for them to have access and utilise the risk register for 2022/23 was 57.

2.b Enhance the use of risk registers at Departmental and Divisional level

Each Department and Division continues to maintain a comprehensive risk register .Divisional risk registers are formally reviewed in Divisional Governance Meetings and through Executive Performance reviews. A deep dive process was introduced in 2020 with development of criteria to initiate a review of risks on the divisional Risk Registers. A template has been developed to support this process and this review of specific risks has resulted in improved description and scoring of risks, together with improved scrutiny of the effectiveness of mitigating actions.

The below table demonstrates the current open risks for each directorate, alongside the grading.





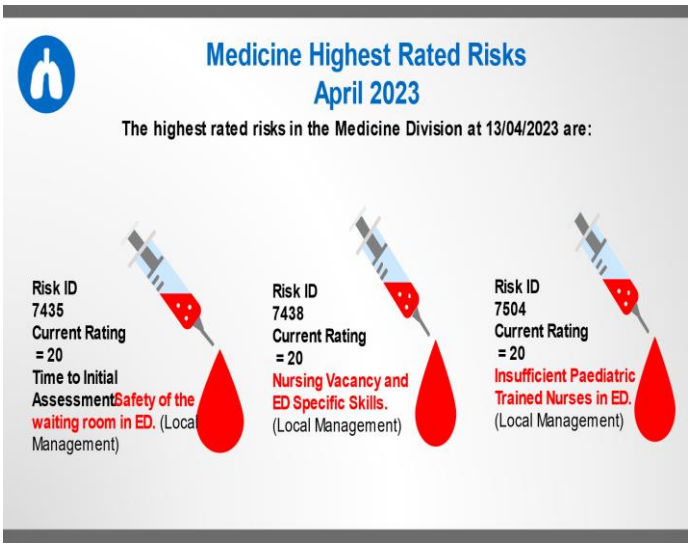
2.c Evidence that dynamic risk registers are held within all departments covering key risks.

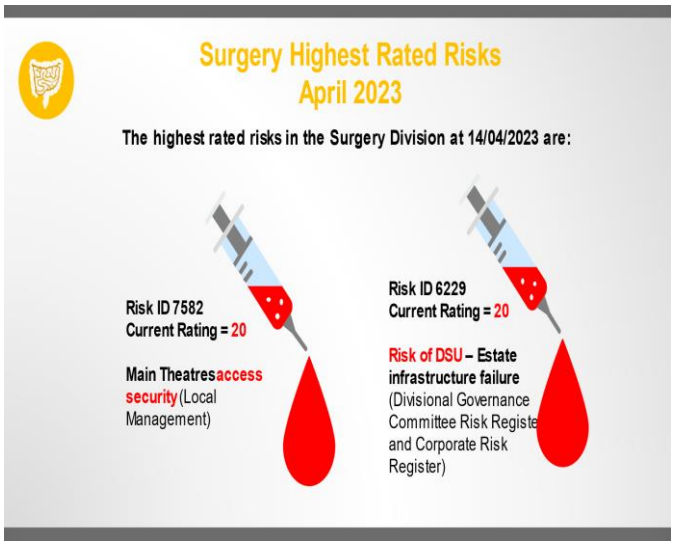
Any new risk is flagged to the risk owner, monitored and compliance reported to each of the Divisions monthly. Email reminders are sent to Risk owners to remind them to review risks that are overdue for review.

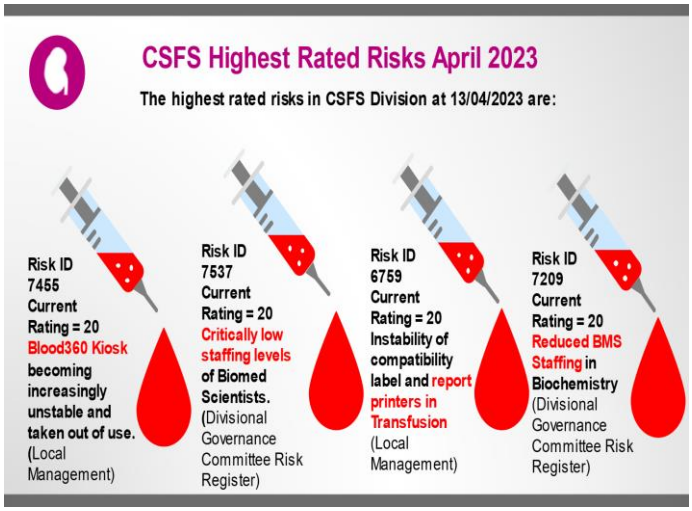
2.d Ensuring a transparent system for aggregation and escalation between departmental and Divisional risk registers with the Corporate Risk Register and Assurance Framework.

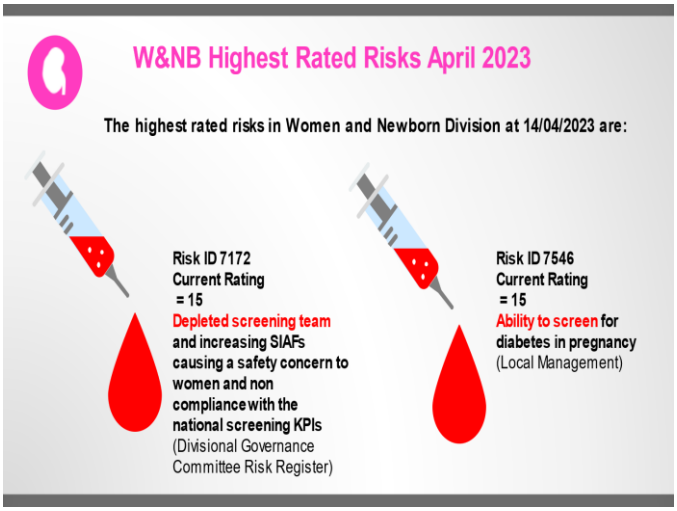
All Divisions have risk registers, which include high risks (10+) and any lower scoring risks that require DMT oversight. Those that require executive support are escalated and monitored via the executive performance meetings. During 2021/22 work has continued to ensure that monitoring within the performance meetings is adequately documented within the minutes and the Trust Risk Register is updated accordingly. Following publication of the Trust's Accountability and Integrated Governance frameworks the process has been strengthened.

The below tables demonstrate the top risks by Division.









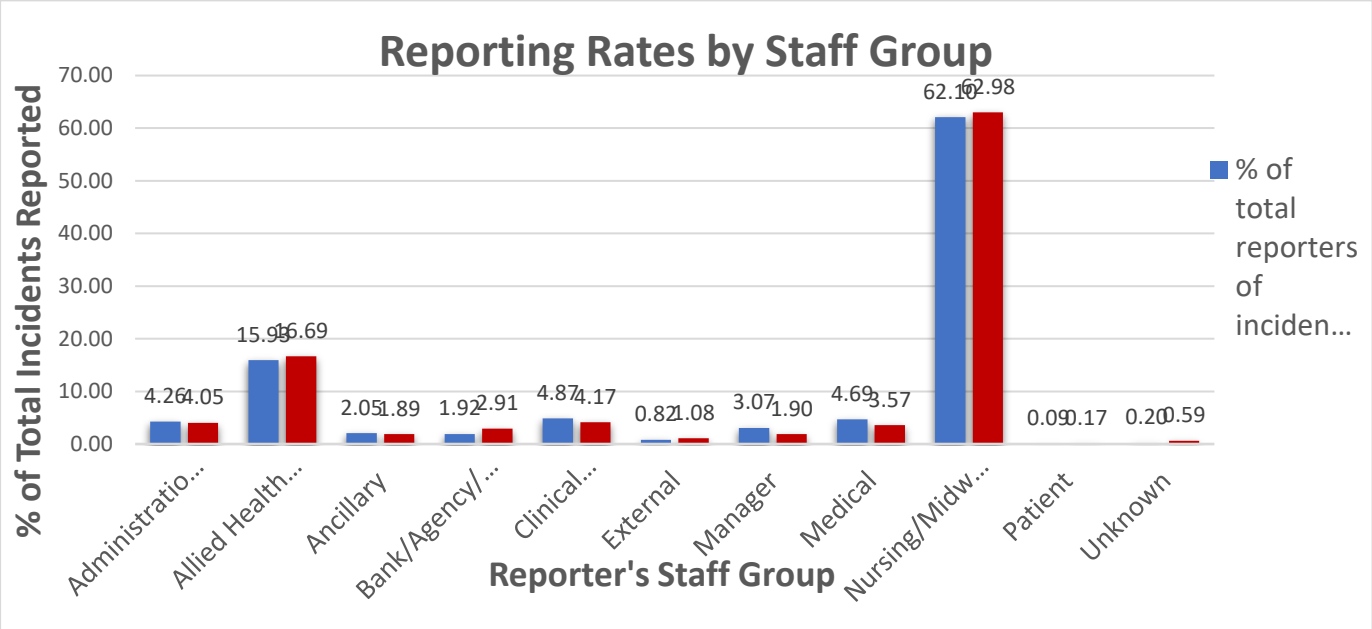
3. Promoting Reporting

3.a Ensure all staff are aware of their responsibility for reporting incidents.

There has been an overall increase of 2.9% in the reporting of incidents in 2022/23 (9864) compared to 9582 in 2021/22, this is a good reflection of reporting within the organization.

Job Type	2021/22	2022/23	%Change
Administration/Clerical/Secretarial	414	404	-2.4
Allied Health Professional	1546	1666	7.8
Ancillary	199	189	-5.0
Bank/Agency/Locum	186	290	55.9
Clinical Assistant	473	416	-12.1
External	80	108	35.0
Manager	298	190	-36.2
Medical	455	356	-21.8
Nursing/Midwifery	6029	6286	4.3
Patient	9	17	88.9
Unknown	19	59	210.5
Total	**9708**	**9981**	

The above table indicates the reporting rates by staff groups.



Reviewing data from our National Reporting Learning System (NRLS) the rate of patient safety incidents reported showed a decrease from 51.6 incidents per 1000 bed days in 2020/21 to 49.9 incidents per 1000 bed days in 2021/22. The number of incidents resulting in severe harm or death has decreased from 0.6% in 2021/22 to 0.5% in 2022/23.

	Apr 20 – Mar 21				Apr 21 – Mar 22			
	SFT	National Average	Highest	Lowest	SFT	National Average	Highest	Lowest
Number of patient safety incidents	6655	N/A	37572	3169	7462	14,368	49603	3441
Rate of patient safety incidents (per 1,000 bed days)	51.6	N/A	118.7	27.2	49.9	57.5	205.5	23.7
Number of patient safety incidents that resulted in severe harm or death	37	N/A	261	4	37	57.8	216	3
% of patient safety incidents that resulted in severe harm or death	0.6%	N/A	2.8%	0%	0.5%	0.42	1.70	0.03

Salisbury NHS Foundation Trust considers that this data is as described as it is taken from the national dataset using data provided by the Trust. We have good collaborative working across the organisation, which actively promotes an open and fair culture that encourages the honest and timely reporting of adverse events and near misses to ensure learning and improvement actions are taken. Incident data is regularly uploaded to the National Reporting Learning System (NRLS).

The new National Learning From Patient Safety Events (LFPSE) is replacing the current national reporting and learning system (NRLS). Our local datix system needs to be upgraded to be compatible, in order to report patient safety incidents which will then automatically be uploaded directly to the national system. IT are engaged to provide the necessary support. The commencement date of this has nationally been extended from April 2023 to September 2023. LFPSE will play an important role within the PSIRF agenda and identifying themes, trends and areas for learning. Datix have a deadline to upgrade all their clients test systems to the LFPSE enabled version by the end of March.

3.b Participation in local meetings, M and M meetings and Clinical governance sessions.

The risk management team continue to work closely with local teams and alongside the Divisions to support the risk management agenda ensuring that there is representation at the appropriate governance forums to support the learning and reinforce key messages.

3.c Facilitation of Board Safety walk rounds to support staff to raise safety concerns within their areas.

There were 52 Board Safety Walks scheduled between April 2022 and March 2023 –18 were cancelled due to a variety of reasons which are illustrated below. The walk arounds allow the Executives, Non-Executives and Quality Leads to meet with Ward/Department Team members to see first-hand all the good work happening throughout the Trust and to hear firsthand of safety concerns from staff. Although there has been significant delays in minutes and action plans being submitted to the risk team, the meetings enable issues to be raised and solved quickly and for new initiatives to be introduced.

Some examples of issues raised for further actions include:

- A business case to be raised for theatre maintenance
- The review and redevelopment of the leg ulcer pathway
- Exploring space for breast feeding mothers returning after maternity leave and wishing to express during their breaks.
- OD and P to further explore staff retention.

Quarters	Scheduled	Complete	Cancelled	Reasons for cancellation
Quarter 1	13	9	4	Gynae- team on leave
				Amesbury-? reason
				DSU- No exec available
				Sexual health-No exec available
Quarter 2	12	9	3	radiotherapy- Cancelled by exec
				Breast Unit- No exec
				Medical records- team on leave
Quarter 3	13	10	3	Therapies- No exec
				Medical records- Not all team members fr
				Med/Surg OP- Not all team, members fre
Quarter 4	14	6	8	endoscopy- conflicting meetings
				Therapies- Dr strike planning
				Vascular- rescheduled,? Reason
				Laverstock- Junior drs strike
Total	**52**	**34**	**18**	Staff accommodation- rescheduled, ? Re
				Pitton- No execs
				Wessex rehab- No exec
				Plastic OP-Dr strike planning.

4. Ensuring there is appropriate provision of training in line with:

4.a Datix Incident Module training (NB these sessions were only held from September 2022)

Course:	**Datix Incident Reporting**
Description:	This training covers how to report an incident on Datix and the purpose and importance of incident reporting.
Training Method:	MLE package
Staff Group:	All staff on induction
Assessment:	Multiple choice questions at end of MLE package
No of staff accessed MLE package in 22-23:	171
No of staff completed MLE package 22-23:	**146**

4.b Datix Incident Investigation training

Course:	**Datix Incident Investigation /Management**
Description:	This training provides an overview of the Datix Incident Module and instructs staff on how to complete a Datix Incident Investigation. This training is a pre-requisite to obtaining a Datix log for access to the Incident Module.
Training Method:	Microsoft Teams Session (45 minutes)
Staff Group:	Staff (generally band 6 or above) who are required to complete incident investigations on Datix.
Assessment:	None
No of training sessions held in 22-23:	15
No of staff who booked this training and did not attend in 22-23	4
No of staff who completed this training in 22-23:	**72**

4.c Datix risk module training

Course:	Datix Risk Register Module
Description:	This course trains staff on how to use the Risk Module on datix for submission and ongoing management of Risk's on the Trust's Risk Register
Training Method:	MLE package
Staff Group:	Staff who need to add, review and manage risks on the Trust Risk Register. Generally managers and department leads, but can also be a nominated individual who has been given responsibility to manage and maintain theirs department's Risk Register. Band 6 or above.
Assessment:	Multiple choice questions at end of MLE package
No of staff accessed MLE package in 22-23:	81
No of staff completed MLE package 22-23:	**57**

5 Ensuring compliance with 'Duty of Candour' requirements

5.a Ensure all staff are aware of their responsibilities through cascade of the Duty of Candour and Being Open Policy.

The Trust has continued to uphold the principles of being open and recognises that promoting a culture of openness is essential to improve the safety and quality of services and benefits staff, patients and families. Families and patients are encouraged to identify questions that can be addressed within reviews and this contributes to learning for staff. Ongoing support and communication with a nominated point of contact takes place for staff, patients and families whilst they go through the Serious Incident Inquiry, Clinical review and SWARM process, as per the "Duty of Candour and Being Open Policy". Staff are also given details of the Trust's Staff Counsellor and Clinical Psychology Department who can be accessed independently for support.

As part of our ongoing commitment to promoting a learning culture we continue to monitor Duty of Candour compliance when patients suffer moderate, major or serious harm and report it monthly to the Patient Safety Summit to drive and monitor further improvement. Whilst our staff have complied with their professional duty of candour, the statutory duty requires clear documentation of our explanation and an apology followed up by a letter. This requirement is now embedded within the Datix web reporting form so that compliance can be monitored at all 3 stages of the incident process, these measures that are in place then assist to understand when compliance fails to identify where the gaps are.
Patients (or other relevant persons) were informed about 'notifiable safety incidents' and support was provided to that person. The investigations into incidents graded them to include any that invoked the duty of candour.

The table below outlines the Trust as a wholes current position with duty of candour across the four divisional groups. The data for this is obtained via the Datix system. Compliance in stage 2 is notably low and after discussion with divisional leads, they feel confident that the required letters have been sent to

patients and families but have unfortunately not been uploaded to Datix. The 60-day timeframe and subsequent delays in the completion of SIIs being completed and consequently being able to share with families, does have an impact on compliance at stage 3.

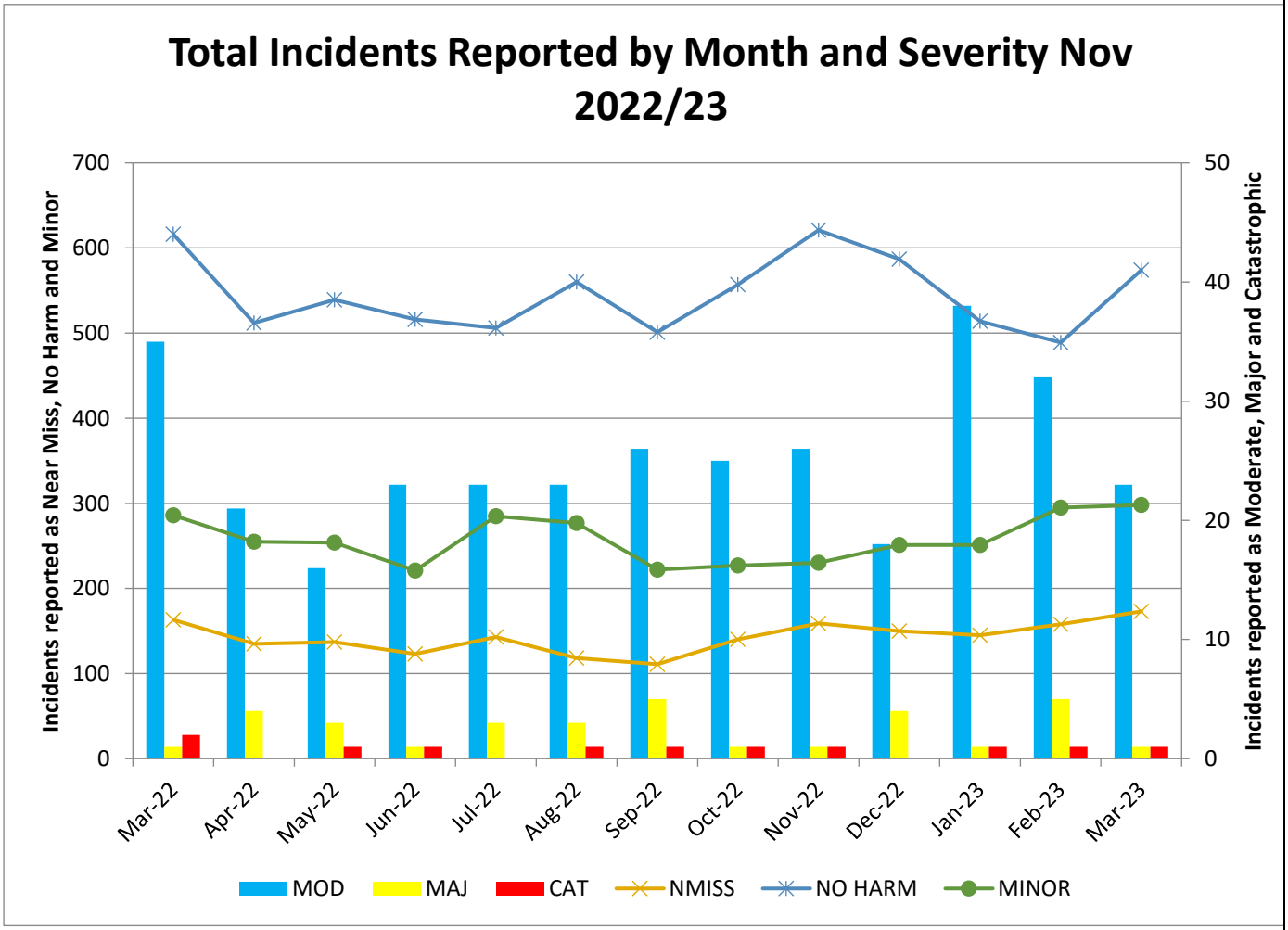
Trust Compliance 2019/20 to 2022/23									
	Duty of Candour Stage 1			Duty of Candour Stage 2			Duty of Candour Stage 3		
	No. of DoC Applicable Incidents	No. Compliant	% Compliant	No. of DoC Applicable Incidents	No. Compliant	% Compliant	No. of DoC Applicable Incidents	No. Compliant	% Compliant
2019/20	72	71	98.61	60	58	96.67	53	51	96.23
2020/21	83	82	98.80	62	58	93.55	52	47	90.38
2021/22	137	119	86.86	105	72	68.57	89	49	55.06
2022/23	209	147	70.33	180	62	34.44	155	18	11.61
Total	**501**	**419**	**83.63**	**407**	**250**	**61.43**	**349**	**165**	**47.28**

Following the production of this annual report, the duty of candour compliance became a focus for the divisions. The data below has been drawn from 01/04/2023-09/06/2023 and has shown compliance improvement in all three stages.

Stage 1 increase from 83.63% to 89.8%
Stage 2 increase from 61.43% to 72.3%
Stage 3 increase from 47.28% to 61.5%

2023/24	52	30	57.7%	42	7	16.7%	39	2	5.1%
Total	**547**	**491**	**89.8%**	**405**	**293**	**72.3%**	**330**	**203**	**61.5%**

5.b Monitoring of incidents through the weekly Patient Safety Summit to ensure appropriate grading.



The below table illustrates the number of incidents of moderate and above broken down into the four divisions

	moderate incident	major incident	catastrophic incident	Total
Clinical Support and Family Services	13	1	0	14
Medicine	112	18	7	137
Women and Newborn Division	18	0	2	20
Surgery	48	7	1	56

5.c Where Duty of Candour triggered liaison with clinicians to ensure they are aware of the correct notification and follow up procedures, feeding back to DMC's and teams where gaps identified.

In the event of a high harm incident Risk Management provides oversight and support with the DoC. A report is subsequently pulled monthly from the risk management team which highlights any incidents with remaining outstanding DoC compliance. These are sent directly to the Divisional Heads of Nursing to follow up specific outstanding cases within their divisions. These are also discussed on a monthly occurrence at the weekly Patient Safety Summit.

5.d Monitoring of duty of Candour compliance

The outstanding DoC compliance is updated monthly and is monitored through the Patient Safety Summit

Moving forward in 2023/24 the priority areas going forward are :

- Patient safety Incident response Framework (PSIRF)
- LFPSE
- Establishment of Learning from Incidents Forums.
- Setting up regular Datix drop-in Clinics.

Patient safety Incident response Framework (PSIRF)

To improve our approach to responding to patient safety incidents SFT have begun a 12-month period of preparation ahead of transitioning from the existing Serious Incident Framework (SIF) to NHS England's new Patient Safety Incident Response Framework (PSIRF) in September 2023.

A patient safety incident is any unintended or unexpected incident which could have, or did, lead to harm for one or more patient's receiving healthcare

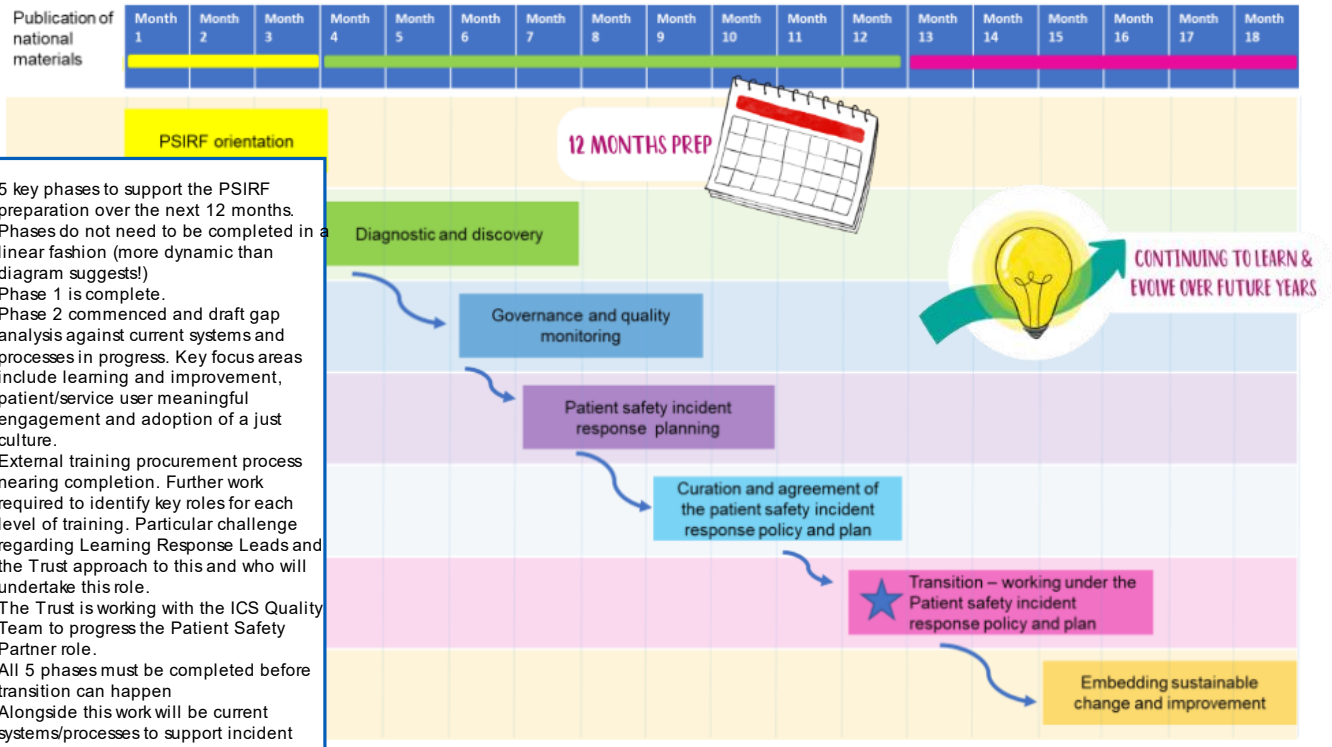
PSIRF sets out new guidance on how NHS organisations respond to patient safety incidents and supports compassionate engagement with all those affected. It supports the key principles of a patient safety culture, focusing on understanding how incidents happen, rather than apportioning blame, allowing for more effective learning, and ultimately safer care for patients. Adopting a compassionate approach when engaging and involving those affected by patient safety incidents is central to the PSIRF approach. The remit nationally for investigations has become increasingly broad over time due to an attempt to be more efficient, by trying to address the many and varied needs of different investigations in a singular approach (i.e. establishing liability/avoidability/cause of death). This has limited the learning that the NHS set out to achieve in relation to patient safety. We know that an in-depth analysis of a small number of incidents brings greater results than routinely examining larger numbers.

In some cases, where it is already clear why the incident happened, it will be more appropriate to concentrate on making improvements rather than spending more time on investigations. Essentially, there will be fewer formal investigations of incidents, but patients and staff will be more likely to be involved in other approaches to learn from incidents and improve patient safety.

There will be a welcomed focus on improvements in patient safety rather than producing numerous investigation reports which often do not result in meaningful change.

What happens next?

At SFT we are currently reviewing how developed our systems and processes are for responding to patient safety incidents and how these need to be adapted to optimise opportunities for learning and improvement in line with PSIRF recommendations. This will identify areas which require strengthening as we transition across and adopt the new framework. SFT are preparing a patient safety incident response plan (PSIRP) which sets out how we will respond to patient safety incidents reported by staff and families to continually improve the quality and safety of the care SFT provides. The plan will set out how the Trust plans to respond to patient safety incidents to learn and improve through patient safety incident investigations.



- 5 key phases to support the PSIRF preparation over the next 12 months.
- Phases do not need to be completed in a linear fashion (more dynamic than diagram suggests!)
- Phase 1 is complete.
- Phase 2 commenced and draft gap analysis against current systems and processes in progress. Key focus areas include learning and improvement, patient/service user meaningful engagement and adoption of a just culture.
- External training procurement process nearing completion. Further work required to identify key roles for each level of training. Particular challenge regarding Learning Response Leads and the Trust approach to this and who will undertake this role.
- The Trust is working with the ICS Quality Team to progress the Patient Safety Partner role.
- All 5 phases must be completed before transition can happen
- Alongside this work will be current systems/processes to support incident response (i.e. SIF)

Annual Comparison Infographic Summary – 2021/22 vs. 2022/23

Salisbury NHS Foundation Trust

REPORTED INCIDENTS

Major / Catastrophic Reported Incidents

0%

39 – 2021/22

39 – 2022/23

Near Miss Reported Incidents

5%

1607 – 2021/22

1688 – 2022/23

Total Number of Reported Incidents

9582 – 2021/22

vs

9864 – 2022/23

2.9%

16.4%

New SII/CR

67 – 2021/22

78 – 2022/23

Abusive, violent, disruptive or self-harming behaviour	2021/22	2022/23	% change
	404	433	7.2%

Abuse etc of patient by patient

33.3%

30 – 2021/22

20 – 2022/23

116% increase in Abuse by the staff to the patient (6 to 13)

Self-harm during 24-hour care

17.6%

34 – 2021/22

40 – 2022/23

88% increase in Attempted suicide, whether proven or suspected (8 to 15)

Access, Appointment, Admission, Transfer, Discharge	2021/22	2022/23	% change
	616	750	21.8%

Appointment

180 – 2021/22

196 – 2022/23

8.9%

Discharge

208 – 2021/22

267 – 2022/23

28.4%

1% decrease in Failure in booking process (82 to 81)

31% increase in Inappropriate Discharge (13 to 17)
29% decrease in Delay (14 to 10)
311% increase in Unplanned admission / transfer to specialist care unit (9 to 37)

Accident that may result in personal injury	2021/22	2022/23	% change
	1744	1746	0.1%

Needlestick Injury or other incident connected with sharps

5.9%

101 – 2021/22

95 – 2022/23

10% decrease in injury from dirty sharps (10 to 9)

2.6%

Slips, trips, falls & collisions

1481 – 2021/22

1519 – 2022/23

63% increase in Slipped on wet area (non cleaning or bodily fluids) (8 to 13)

Anaesthesia	2021/22	2022/23	% change
	5	13	160%

Clinical assessment (investigations, images and lab tests)	2021/22	2022/23	% change
	821	803	2.2%

Laboratory investigations

681 – 2021/22

635 – 2022/23

7.2%

Images for diagnosis (scan / x-ray)

3.4%

87 – 2021/22

90 – 2022/23

38% increase in Failure to act on adverse test results or images (13 to 18)

200% increase in Lack of clinical or risk assessment (7 to 21)

Consent, confidentiality or communication	2021/22	2022/23	% change
	444	415	6.5%

Communication between staff, teams or departments

0.7%

140 – 2021/22
139 – 2022/23

Communication with the patient

27.3%

66 – 2021/22
48 – 2022/23

12% decrease in Inadequate handover of care (from 34 to 30)

Diagnosis, failed or delayed	2021/22	2022/23	% change
	86	59	31.4%

67% increase in Diagnosis – wrong (from 6 to 10)

11% decrease in Delay in diagnosis for no specified reason (from 19 to 17)

Implementation of care or ongoing monitoring / review	2021/22	2022/23	% change
	1802	1942	7.8%

Possible delay or failure to Monitor

7%

128 – 2021/22
137 – 2022/23

Infection Control

24.8%

109 – 2021/22
82 – 2022/23

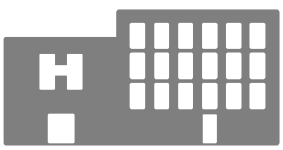
92% increase in Safeguarding concern relating to inpatient care (from 12 to 23)

Infrastructure or resources (staffing, facilities, environment)	2021/22	2022/23	% change
	996	751	24.6%

Environmental matters

25.7%

105 – 2021/22
132 – 2022/23



Adverse events that affect staffing levels

34.9%

641 – 2021/22
417 – 2022/23

100% increase in Damage to property (non security) (from 4 to 8)

23% decrease in Failure or overload of IT or telecommunications system (from 124 to 96)

Medication	2021/22	2022/23	% change
	942	1115	18.4%

Preparation of medicines / dispensing in pharmacy

96 – 2021/22
135 – 2022/23

40.6%

1200% increase in Wrong drug/ dose prescribed, dispensed and administered (from 1 to 13)

Administration or supply of a medicine from a clinical area

479 – 2021/22
534 – 2022/23

11.5%

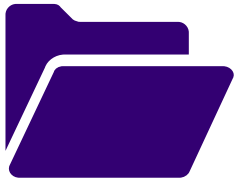
58% increase in Recording error (from 12 to 19)

Patient information (records, documents, test results, scans)	2021/22	2022/23	% change
	291	307	5.5%

Electronic Patient Record

16.5%

79 – 2021/22
66 – 2022/23



Patient's case notes or records

170 – 2021/22
176 – 2022/23

3.5%

57% increase in Records missing, believed lost, damaged or stolen (from 7 to 11)

Treatment, procedure	2021/22	2022/23	% change
	562	579	3%

Skin

274 – 2021/22
222 – 2022/23

19%

Arteries and veins

19 – 2021/22
9 – 2022/23

53%

225% increase in Treatment / procedure – failed from 4 to 13

32% increase in Infusion injury (extravasation) from 28 to 19

Appendix B

CRG Attendance Record 2022

	Chair	Vice Chair/Matron for Quality and safety	Deputy Chief Nurse	Deputy Chief Medical Officer	Head of risk management	Deputy Head of Risk management	Risk/Incident facilitators	Divisional matron/senior nurse	Divisional Clincal Director	maternity Quality and Safety Matron	Pharmacist	MDSO/Contamination lead	Head of Compliance	Consultant Aneasthatist	Junior Doctor	Head of legal services.	Consultant radiologist	Numbers at meeting
13th January 2022	√	√				√	√	√					√	√				7
27th January 2022	√	√			√	√	√	√		√			√					8
10th February 2022	√	√			√	√	√	√		√		√	√					9
17th Febuary 2022		√		√	√	√	√		√				√					7
24th Februaury 2022	√	√		√	√	√	√						√					7
10th March 2022	√	√		√		√	√			√			√					7
31st March 2022				√	√	√	√	√	√	√		√	√					8
14th April 2022		√		√		√	√			√		√	√	√				8
28th april 2022		√		√		√	√					√	√					6
12th May 2022	√	√		√	√	√	√	√	√	√			√	√				11
26th May 2022	√	√		√		√	√	√				√	√					8
9th June 2022		√		√		√	√	√				√	√	√				8
23rd June 2022	√	√		√		√	√	√		√		√		√				9
14th July 2022		√		√		√	√			√		√	√					7
28th July 2022	√	√		√		√							√	√				6
11th august 2022	√					√	√						√					4
25th august 2022	√		√			√		√		√			√					6
8th Septemebr 2022																		
22nd September 2022		√		√	√		√	√	√	√			√					8
13th October 2022		√	√	√		√	√	√				√	√					8
27th October 2022	√	√		√		√						√	√					6
10th November 2022	√	√				√	√			√			√	√				7
24th November 2022		√		√		√	√		√			√	√					7
8th December 2022	√	√		√	√		√						√					6
REPRESENTATION	Y	Y	N	N	Y	Y	N	N	N	N	N	N	N	N	N	N	N	

Quorum shall be at least half the members being present including the Chair or Vice Chair, a Medical or Nursing representative from each division.
Members are expected to attend scheduled and extra-ordinary meetings.
Deputies may attend to cover annual leave, sickness and exceptional circumstances as agreed by the Chair (or Vice Chair in absence of).

Appendix C
Patient Safety Steering Group Attendance Record 2022

	January	Febuary	March	April	May	June	July	August	September	October	Novembe	December
Head of risk Management/Chair	√	√	√									
Vice Chair/Divisional Head of Nursing CSFS	√		√			√		√	√	√	√	
Associate Chief Medical Officer			√		√	√		√	√		√	
Deputy Chief Nurse					√	√	√					
Matron for Safety and Quality	√	√			√	√	√	√		√	√	
Deputy Head of Risk management	√	√	√		√	√	√	√		√	√	
Risk/Incident facilitators											√	
Divisional matron/senior nurse or Clinical director			√			√	√	√			√	
Safeguarding Named Nurse Children	√				√	√				√	√	
Safeguarding Named Nurse Adults	√											
Infection Prevention and Control Team												
maternity Quality and Safety Matron								√		√	√	
Pharmacist	√						√					
MDSO/Contamination lead	√	√	√		√	√	√	√	√	√	√	
Head of Quality Improvement/Coach House												
Head of Compliance	√	√			√	√	√	√		√	√	
Representative from Resuscitation Committee	√	√	√				√	√			√	
Falls lead	√	√	√				√			√		
Tissue Viability Lead	√	√			√	√	√	√	√			
Health and Safety rep												
Ward level Nurse												
Head of legal services.	√	√	√								√	
Chief Registrar	√	√	√									
Numbers at meeting	14	10	10		8	10	10	10	4	8	12	

Quorum shall be at least half the members being present including the Chair or Vice Chair, a Medical or Nursing representative from each division. Members are expected to attend scheduled and extra-ordinary meetings. Deputies may attend to cover annual leave, sickness and exceptional circumstances as agreed by the Chair (or Vice Chair in absence of).

NHS
Salisbury
NHS Foundation Trust

Report to:	Public Trust board	Agenda item:	5.6
Date of meeting:	6th July 2023		

Report tile:	Maternity Quality and Safety Report for Quarter 4 2022/23.			
Status:	Information	Discussion	Assurance	Approval
	X	x	X	
Approval Process: (where has this paper been reviewed and approved):	• Noted at Divisional Governance – 21 April 23 • Maternity governance – 16 May 23 • CGC on 27th April 2023			
Prepared by:	Vicki Marston- Deputy Director of Maternity and Neonatal Services.			
Executive Sponsor: (presenting)	Judy Dyos – Chief Nursing Officer			
Appendices	Perinatal Quality Surveillance Monthly			

Recommendation:

The Committee are asked to note the report.

CNST requirements state board minutes to note the following:

1. PMRT findings to be noted in board minutes
2. Compliance with labour ward coordinator being supernumerary and women receiving 1:1 care =100% in Q4

Executive Summary:

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

It will evidence current compliance with national reporting to include Care Quality Commission (CQC), Maternity Incentive Scheme (MIS) and Ockenden 2020 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 4 22/23.

Positive points to note:

- Patient experience
- Safety Champions staff engagement

- Stillbirth and Neonatal death rate

Points needing to focus on

- Screening quality assurance action plan
- Ockenden compliance
- Progress on the Maternity safety support programme

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

QUALITY AND SAFETY REPORT QUARTER 4 2022/23.

1. EXECUTIVE SUMMARY

This report outlines locally and nationally agreed measures to monitor maternity and neonatal safety. The purpose of the report is to inform the LMNS Board and the Board of Directors of present or emerging safety concerns. The information within the report reflects actions in line with Ockenden and the CNST Maternity Incentive Scheme, and progress made in response to any identified concerns, alongside key information regarding quality and safety.

2. GOOD NEWS STORIES

We now have 6 international midwives recruited at Salisbury, the first midwife undertook and passed her OSCE exam in February following a comprehensive collaborative education programme delivered by practice education team at SFT, GWH and Gloucester. We have one further international midwife joining us in the next few weeks to complete our intake and commitment to employ 7. This has been an extremely successful collaboration with GWH and Gloucester, with the midwives already being hugely valued members of the team.

3. PERINATAL MORTALITY RATE

The following graphs demonstrate how Salisbury Foundation Trust is performing against the national ambition to reduce rates of stillbirths, neonatal and maternal deaths and brain injuries in babies that occur during or soon after birth by 20 per cent by 2020 and 50 per cent by 2025.

3.1 Stillbirth over 12 months

In 2023 we have so far had 3 stillbirths as detailed in the chart below.

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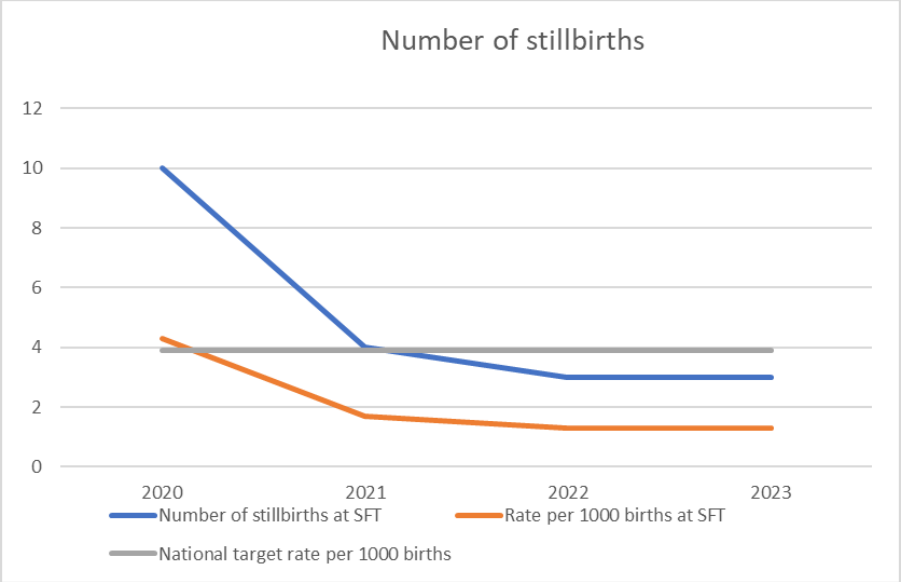
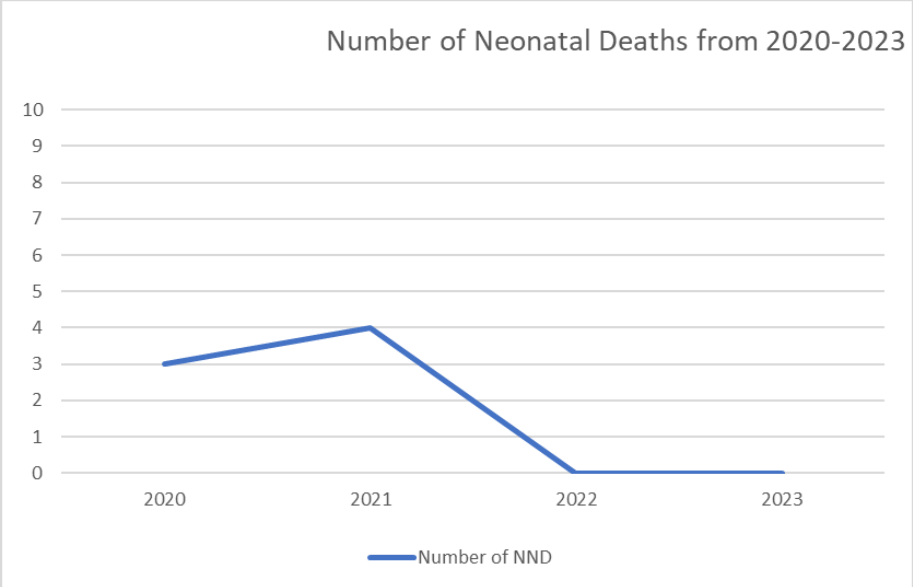
SFT stillbirth rate per 1000 births over past 3 years



3.2 Neonatal deaths over 12 months

There were no neonatal deaths for Quarter 4 2-22/23.

.SFT neonatal Death rate over past 3 years



4 PERINATAL MORTALITY SUMMARY FOR QUARTER 3 2022/23 / Safety Action 1 (MIS)

4.1 Perinatal Mortality

The Maternity Safety Incentive Scheme (MIS), Year 4 has now closed and been reviewed. Standards for safety action one will continue until year 5 MIS safety actions are published with timescales. Safety Action One requires evidence that Trusts are using the National Perinatal Mortality Review Tool (PMRT) to review perinatal deaths to the required standard.

Safety Action One sets required standards, as below:

a) All perinatal deaths eligible to be notified to MBRRACE UK must be notified to MBRRACE-UK within seven working days and the surveillance information where required must be completed within one month of the death.

b) A review using the Perinatal Mortality Review Tool (PMRT) of 95% of all deaths of babies, suitable for review using the PMRT, will have been started within two months of each death. At least 50% of all deaths of babies (suitable for review using the PMRT) who were born and died in the Trust, including home births, 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.

c) For at least 95% of all deaths of babies who died in the Trust, 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.

d) MIS, Year 4, also requires that a report is sent to the Trust Board each Quarter. This must include details of the deaths reviewed and the subsequent action plans. The report should evidence that the Perinatal Mortality Review Tool (PMRT) has been used to review eligible perinatal deaths and that the required standards a), b) and c) have been met and that for standard c) for any parents who have not been informed about the review taking place, reasons for this should be documented within the PMRT review.

PMRT was designed and will be further developed with user and parent involvement to support high quality standardised perinatal mortality reviews on the principle of 'review once, review well'. Introduced in 2018 PMRT is a collaboration led by MBRRACE-UK, who were appointed by the Healthcare Quality Improvement Partnership (HQIP) to develop and establish a national standardised tool building on the work of the DH/Sands Perinatal Mortality Review 'Task and Finish Group'.

Q4 22/23

During Q4 22/23 there were 10 pregnancy losses in Salisbury Maternity Unit, 3 fitted the criteria for MBRRACE notification, MBRRACE surveillance and PMRT review.

All 3 cases had MBRRACE notification, surveillance completed within safety action 1 timescales (Standard A).

During Q4 22/23 there were no outstanding cases to be reviewed by the PMRT group from previous quarters.

2 of the 3 stillbirths in Q4 were reviewed through the PMRT meeting within Q4 (Standard B)

PMRT ID – 85523- Stillbirth unattended at home at 30 weeks and 5 days

Factual information entered into PMRT tool within safety action timescale completed. (Standard B)

Parental engagement took place and feedback was given by the family. (Standard C)

Cause of death- Undetermined despite placental investigations.

Grading of care

Grading of care of mother and baby up to the point the baby was confirmed as having died

A- The review group concluded that there were no issues with care identified up the point that the baby was confirmed as having died

Grading of care of the mother following confirmation of the death of her baby

A-The review group concluded that there were no issues with care identified for the mother following confirmation

Actions

No actions generated at the end of the review.

Report to be published within Safety action 1 timescales to meet standard B

PMRT ID 85525 – Stillbirth 24 weeks and 2 days

Factual information entered into PMRT tool within safety action timescale completed. (Standard B)

Parental engagement took place and feedback was given by the family. (Standard C)

Cause of death- Undetermined despite post- mortem and placental investigations

Grading of care

Grading of care of mother and baby up to the point the baby was confirmed as having died

A-The review group concluded that there were no issues with care identified up the point that the baby was confirmed as having died

Grading of care of the mother following confirmation of the death of her baby

A -The review group concluded that there were no issues with care identified for the mother following confirmation

Actions

There were no actions generated at the end of the review.

Report to be published within safety action 1 timescales to meet standard B

This report will be presented at the Mortality Surveillance Group meeting in June 2023.

HSIB referral

PMRT ID- 86616- Intrapartum Stillbirth 39 weeks and 3 days.

MBRRACE notification and surveillance completed (Standard A)

Factual information to be entered into the PMRT tool within safety action one timescales to meet standard B

Case referred to HSIB and will be reviewed through PMRT following the final HSIB report.

This report will achieve compliance with the required standard D and will be submitted on a quarterly basis.

This report will be presented at the Mortality Surveillance Group meeting in June 2023.

5 HEALTHCARE SAFETY INVESTIGATION BRANCH (HSIB) AND MATERNITY SERIOUS INCIDENTS

HSIB undertake maternity investigations in accordance with the Department of Health and Social Care criteria (Maternity Case Directions 2018) taken from Each Baby Counts and MBRRACE-UK. In accordance with these defined criteria, eligible babies include all term babies (at least 37 completed weeks of gestation) born following labour who have one of the following outcomes:

- Maternal Deaths
- Intrapartum stillbirth
- Early neonatal death

• Severe brain injury diagnosed in the first seven days of life

In Quarter 4 2022/23 one case was referred:

A woman in early labour at term was in the care of our labour ward and during this time the staff were unable to auscultate the fetal heart. Sadly the baby was confirmed to have no heart rate present and the baby was confirmed as suffering from an intrauterine death. This case fitted the criteria for HSIB, was referred and they have agreed to take this case on for investigation. The notes have been shared via the portal and they will contact staff soon. The staff have been offered TRiM support and an immediate debrief was done. Duty of Candour with the family was completed in accordance with local policy. Leaflet on the role of HSIB and EN scheme given to family.

5.1 Investigation progress update to follow

Ref	HSIB reference	Confirmed level of investigation	Date Confirmed investigation	External Notifications & Other Investigations
SII545 Datix number 154163	MI-024309	HSIB referral	6/12/22	The next step is for HSIB to do their initial multidisciplinary review and then staff will be approached for interviews.

5.2 CORONERS REGULATION 28 MADE DIRECTLY TO TRUST

Not Applicable

5.3 MATERNITY SERIOUS INCIDENTS to follow

During Quarter 4 there was one Serious Incident. All cases referred to HSIB are also investigated as Serious Incidents in the Trust

Datix no	Category	Outcome	Immediate Learning
January	None		
February	None		
March	one		
154163	Intrapartum Stillbirth	Baby died during early labour, referred to HSIB	Immediate learning recommended guidance should be followed in relation to auscultating fetal heart rate in latent phase of labour.

6 MIDWIFERY CONTUNITY OF CARER

We have no midwifery continuity of care teams at present. Due to increased midwifery vacancies, plans to implement this model is paused as per recommendation from NHSE and as advised following the publication of Ockenden. It is recognised that when staffing significantly improves consideration will be given to reviewing a team for continuity of carer in line with national recommendations.

7 MATERNITY SUPPORT IMPROVEMENT PROGRAMME (NHSE)

Formal support from the NHSE programme continues. Work remains ongoing with SFTs allocated Maternity Improvement Advisor. Attached are monthly reports for February and March 2023.

The Maternity Improvement plan is being refined within the division to ensure that fits with the improving together framework and aligns with the Trust and divisional strategies and is being amalgamated into a single action plan to address all recommendations, both local and national.

NHS E.I MSSP Progress Monthly Re

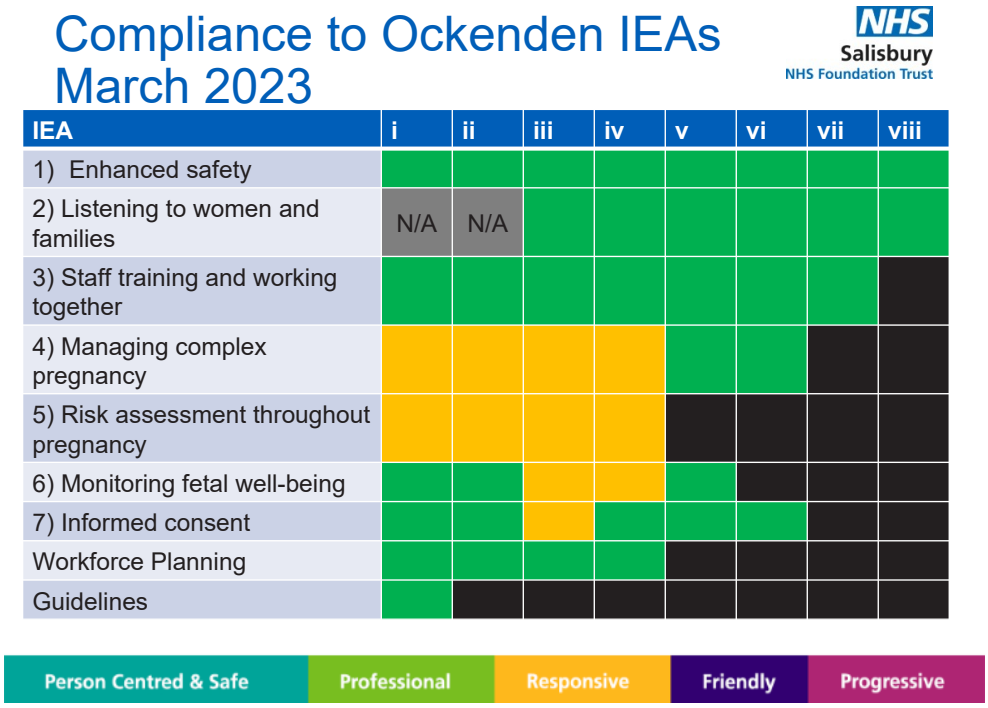
NHS E.I MSSP Progress Monthly Re

7.1 Maternity Improvement Plan (MIP)

The maternity improvement plan was finalised at the end of March with input from the MDT, DMT and our NHS Maternity Improvement Advisor from NHS England. Our first Maternity Improvement Group meeting is on the 4th May, which will monitor progress against the identified actions and feed into the divisional governance process. The executive team will also have oversight of the MIP via the executive performance review monthly meetings.

8 OCKENDEN

We recognise that we remain non-compliant with some elements of the initial 7 immediate and essential actions of the Ockenden report. Ockenden actions form part of the MIP and progress will be reviewed within the MIP working group to ensure we are working towards full compliance. We are also working closely with the LMNS to look at the outstanding actions.



9 TRAINING /Safety Action 8 (MIS)

As part of the Maternity Incentive Scheme and the Core Competency framework, work has been on going to achieve compliance for all our staff groups in key specified training.

Training is currently a divisional driver for Improving Together due to recognition of concerns around meeting targeted outcomes for numbers of staff trained. We will continue to focus on compliance with 6 key training programmes that are particularly relevant to both obstetricians and midwives:

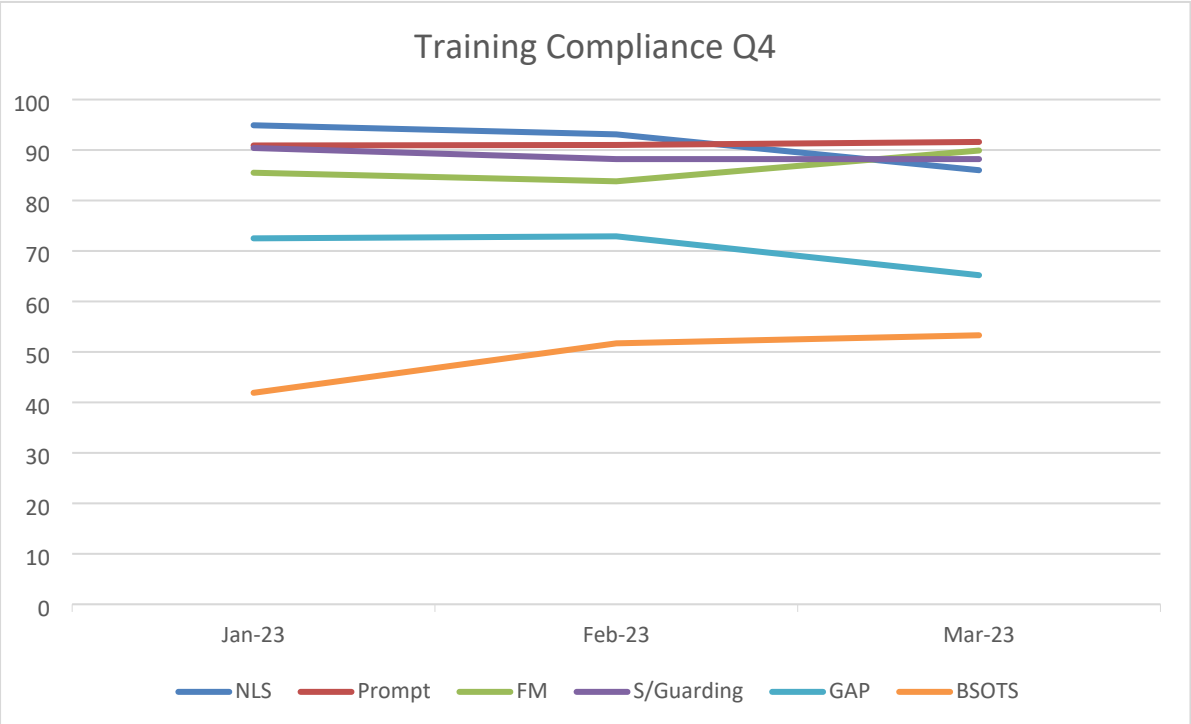
- PROMPT (Practical Obstetric Multi-Professional Training)
- Safeguarding Children (Level 3)
- BSOTS (Birmingham Symptom Specific Obstetric Triage System)
- GAP (Growth Assessment Protocol - identifying growth restricted babies in utero)
- Neonatal Life Support (NILS)
- Fetal Monitoring

Compliance with PROMPT and NLS feed into Safety Action 8 of the Maternity Incentive Scheme (CNST).

As part of our work with the Maternity Support Programme it was identified that SFT maternity did not have a current Training Needs Analysis. This has now been written and is anticipated to go through the governance and approval process in quarter 1.

9.1 Training data

Chart 4 Key Maternity training /aligning with Improving Together driver.

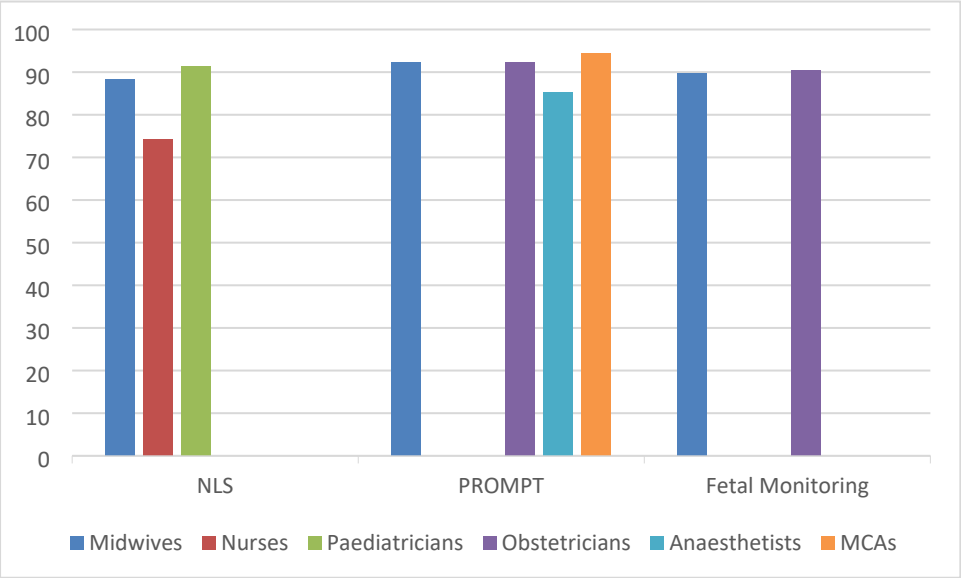


BSOTS training has been identified as being the most prominent area of non-compliance in 2022/23. In Quarter 1 of 2023/24, BSOTS training will be relaunched and focussed on staff groups working in the areas using this triaging system as a priority, before rolling out to wider staff groups.

Within the MIS 3 key areas are identified with a requirement set to achieve compliance by individual staff group of over 90% in 3 areas:

- PROMPT – Multidisciplinary Obstetric Emergencies
- Newborn Life Support
- Fetal Monitoring

Key training by staff group (01.03.2023)



This chart shows full compliance for fetal monitoring training. PROMPT is non-compliant for anaesthetists only – equating to 29 out of 34 – this is due to conflicting service needs and has been escalated to the divisional management team. NLS is non-compliant for nurses and midwives – data for this commenced in February 2022 so compliance has been grouped. Measures to improve this include newly trained NLS instructors and NLS being included on PROMPT. This will improve compliance in Q1 of 2023. This data is correct as of 1st March 2023.

10 SAFETY CHAMPIONS PRODUCTION BOARD MEETINGS/ Safety Action 9 (MIS)

In Quarter 4 bi monthly meetings for the Safety Champions continued in accordance with Safety action 9 of the Maternity Incentive Scheme.

Minutes can be accessed:

Safety Champion minutes January 202

Safety Champion minutes March 2023

10.1 Board Safety champions Walkabouts were undertaken

- January 2023- Ned safety Champion and executive safety champion
- February 2023 – NED safety champion walkaround cancelled due to industrial action, also attended PMRT in February additionally
- March 2023 -Executive safety walkaround on labour and postnatal ward
- March 2023 – NED safety Champion walkaround.

Feedback and themes identified were fed back to DMT and actioned accordingly.

11 SAVING BABIES LIVES version 2- Safety Action 6 (MIS)

To meet the requirements of the saving babies lives care bundle, we have formed a Maternity improvement plan working group, with a dedicated lead for each element of saving babies lives incorporated into this. This working group will enable monthly oversight of progress and assurance of a trajectory to meet the requirements.

13 CNST / MATENRITY INCENTIVE SCHEME YEAR 4

SFT self-declared that they were compliant with 5 out of the 10 safety action as defined in the Maternity Incentive Scheme year 4.

Criteria for Maternity CNST		RAG SCORING
1	Are you using the National Perinatal Mortality Review Tool to review perinatal deaths to the required standard?	
2	Are you submitting data to the Maternity Services Data Set (MSDS) to the required standard?	
3	Can you demonstrate that you have transitional care services in place to minimise separation of mothers and their babies and to support the recommendations made in the Avoiding Term Admissions into Neonatal units Programme?	
4	Can you demonstrate an effective system of clinical workforce planning to the required standard?	
5	Can you demonstrate an effective system of midwifery workforce planning to the required standard?	

6	Can you demonstrate compliance with all five elements of the Saving Babies' Lives care bundle version 2?	
7	Can you demonstrate that you have a mechanism for gathering service user feedback and that you work with service users through you maternity voices partnership (MVP) to co-produce local maternity services?.	
8	Can you evidence that a local training plan is in place to ensure that all six core modules of the Core Competency Framework will be included in your unit training programme over the next 3 years, starting from the launch of MIS year 4? In addition, can you evidence that at least 90% of each relevant maternity unit staff group has attended an 'in house', one-day, multi-professional training day which includes a selection of maternity emergencies, antenatal and	
9	Can you demonstrate that there are robust processes in place to provide assurance to the Board on maternity and neonatal	
10	Have you reported 100% of qualifying cases to Healthcare Safety Investigation Branch (HSIB) and to NHS Resolution's Early Notification (EN) Scheme from 1 April 2021 to 5 December 2022	

The submission was taken to Board in January 2023 and sent to NHS Resolution in February 2023 once reviewed and signed by the board and the Senior Responsible Officer for the Local Maternity and Neonatal System. There was an MDT meeting held in March 2023 to review the submission and work through a plan for improvement in anticipation of publication of year 5 standards which we expect to be published in May. Regular meetings and actions have been set up to maintain traction on these standards and ensure that we are working towards improved compliance for 2024 submission. We have also received agreement for funding to progress these actions.

14 MIDWIFERY STAFFING / Safety action 5 (MIS)

A bi-annual staffing review paper was submitted to clinical governance committee as per Maternity Incentive Scheme Safety Action 5 in Quarter 4 2022/23. Midwifery Vacancies are monitored monthly through IPR and highlighted at EPR. Staff vacancies across the division remain one of our drivers for improving together, with midwifery vacancies the highest vacancy rate in the division. This challenge is reflected both nationally and in other local units- countermeasures relating to staffing are also monitored weekly through our driver meetings.

Safety metrics are reviewed monthly through the safety assurance dashboard at the Individual Performance Review shown below providing evidence that whilst midwifery staffing remains a challenge.

Midwifery staffing safety measures

Measure	Aim	Jan 22	Feb 23	March 23
Midwife to Birth Ratio	1:28	1:31	1:27	1:30
Supernumerary labour ward coordinator status	100%	100%	100%	100%
1.1. care in labour	100%	100%	100%	100%

Whilst midwifery vacancy remains an ongoing challenge, several initiatives have been employed to maintain a safe service

- robust maternity escalation plan
- Registered General Nurse employed in clinical areas
- Over recruitment of maternity care assistants
- Engaged in collaboration to recruit International Midwives- we have 6 within the service, 1 has passed her OSCE further 5 awaiting exam.
- Use of agency midwives
- Incentivised shift payments
- Recruitment campaign to include executive agreed incentivised payment once in post
- Relocation package promoted
- Flexible working party to review working patterns
- Return to Midwifery placement
- Workforce planning with the BSW Academy

15 ADVOCATING FOR EDUCATION AND QUALITY IMPROVEMENT (A-EQUIP) AND PROFESSIONAL MIDWIFERY ADVOCACY

Professional Midwifery Advocates (PMAs) work within the A-EQUIP model to work with women in three ways:

• Supporting midwives to advocate for women

• Providing direct support for women within a restorative approach and

• Undertaking quality improvement in collaboration with women

At SFT we received funding from NHSE and have a bespoke joint role of Lead PMA and retention Midwife utilising the A-EQUIP model to provide midwifery support via restorative supervisors and, in turn, this supports retention of midwives

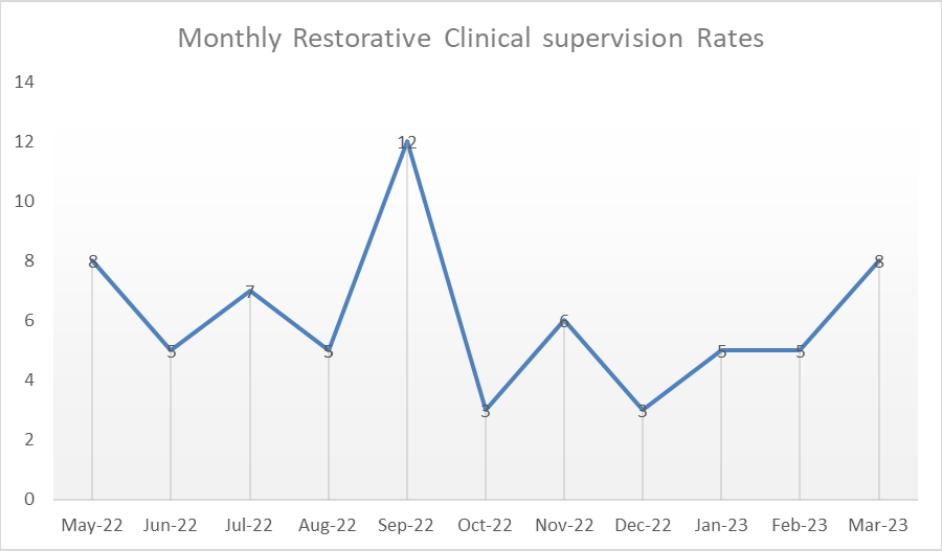
The NHSEI Unit Based Midwifery Retention support programme was developed to support retention within Midwifery in response to increasing leaver rates nationally. The programme aims to support improving the experience and retention of midwives within the NHS and to reduce turnover between providers, recognising that it is time consuming, expensive, and challenging for trusts to recruit when staff leave. Supporting midwifery retention through job

satisfaction and job fulfilment can support midwives to stay and thrive. The programme supports the commitment to increase the number of midwives nationally. A key part of this is retaining midwives and existing learners.

15.1 PMA Update

•Restorative Clinical Supervision

- RCS supports the Restorative element of the A-equip model. Through Q4, all Midwives returning from long term sick or Maternity leave, and all new starters have received a RCS session.
- Intensive RCS support for all NQMW and international midwives has continued through Q4
- Secure data is kept on the number of RCS sessions taking place, and themes are collected (whilst ensuring confidentiality is maintained). If any themes emerge from RCS, they are fed up to the Director of Maternity.
- It has been agreed at DMT that all sessional PMA's will be given 2 days/month each for their PMA work. This will commence from May 2023.



18 RCS sessions were carried out in Q4, an increase from 12 in Q3. 3 of these were Midwives returning to work after long term sickness, 2 were international midwives who have recently joined SDH and 1 was a new starter. The other 12 were Midwives who had a work related issue they needed support with.

PMA Training

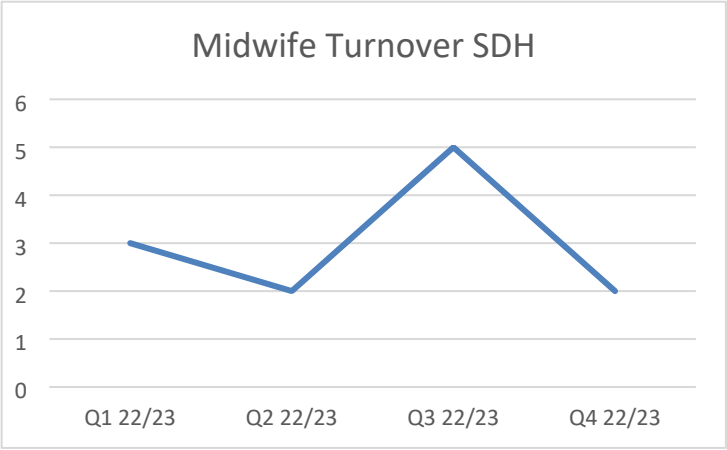
No further new PMA's qualified, 1 PMA training ongoing.

- PNA/PMA collaborative working –

  The Lead PMA has written a 'PMA/PNA plan to deliver the a-equip model at Salisbury NHS Trust'. This is currently sitting with deputy Director of Nursing for ratification. This joint plan will form the basis of collaborative working between the PMA's and the wider trust so that each service can benefit from the experiences of the other.
  There is a plan to deliver joint monthly meetings and training sessions with the PNA's and going forward regular supervision from the psychology department has been agreed for both PNA's and PMAs to ensure their wellbeing.

15.2 **Retention Update**

The retention improvement plan has been written following advice and guidance from regional networks. There are work streams within it which will also contribute to other programmes (such as Improving together) and the Retention lead is working collaboratively with Dom and Deputy Dom to ensure work is focused, shared where appropriate and that work streams do not double up.



SDH Midwife Turnover

- There were 2 Midwives who left SDH during Q4, a reduction down from 5 Midwives in Q3. 1 of these midwives retired however is maintaining a bank contract, and the other was in the 44-49 age bracket and left to work for another local NHS trust.
- 1 exit interview was completed.

15.3 Other Retention/Wellbeing Interventions

- Enhanced support offered to International Midwives via RCS (Restorative Clinical Supervision)
- The Behaviour Charter for Maternity and neonatal has been finalised and signed off by the DMT. Planning is now underway with regard to launching the charter.
- Lead PMA/retention lead teaching around Civility Saves lives and new behaviour charter at NQMW study day.
- Monthly supervision has been established for non-clinical roles within Maternity who are most at risk of vicarious trauma and burnout, positive feedback received from participants.
- Planning underway for PMA team to hold a 'Civility Awareness Event' within Maternity in May 2023
- PMA shift now included on maternity non-clinical roster, for ease of visibility.

Recommendations

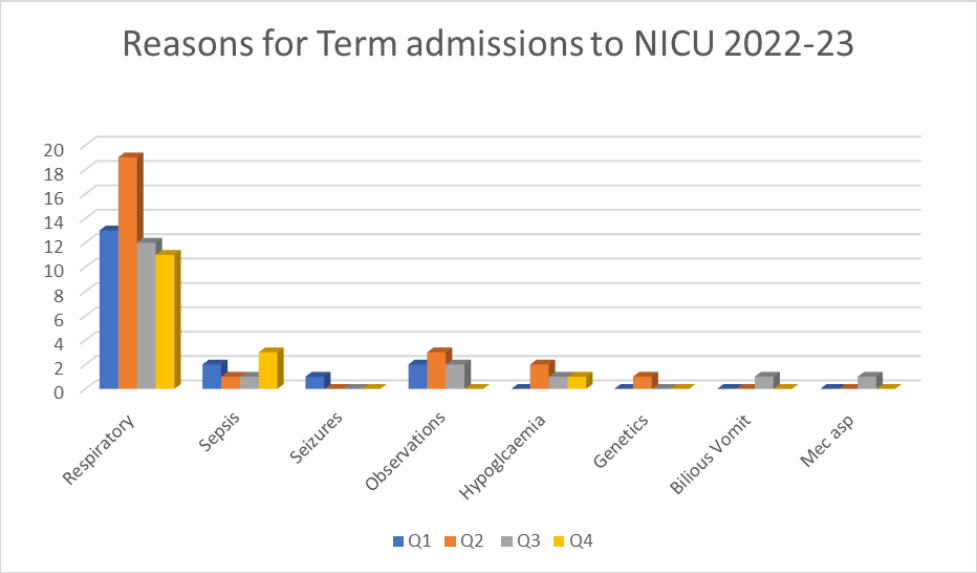
- Teaching around mental health in the workplace and Mental health within Midwifery to be included in Mandatory training.
- Survey to be designed and implemented around long term sick and the experience of the staff who go through this, with a view to improving process and support and optimising earlier return to work.
- Civility 'spot check' to be conducted by using the Clarks Workplace civility index. This will help us to understand what improvements need to be made and also provide a benchmark for measuring improvement.

16 AVOIDING TERM ADMISSIONS INTO NEONATAL UNIT (ATAIN) AND TRANSITIONAL CARE / (MIS 3).

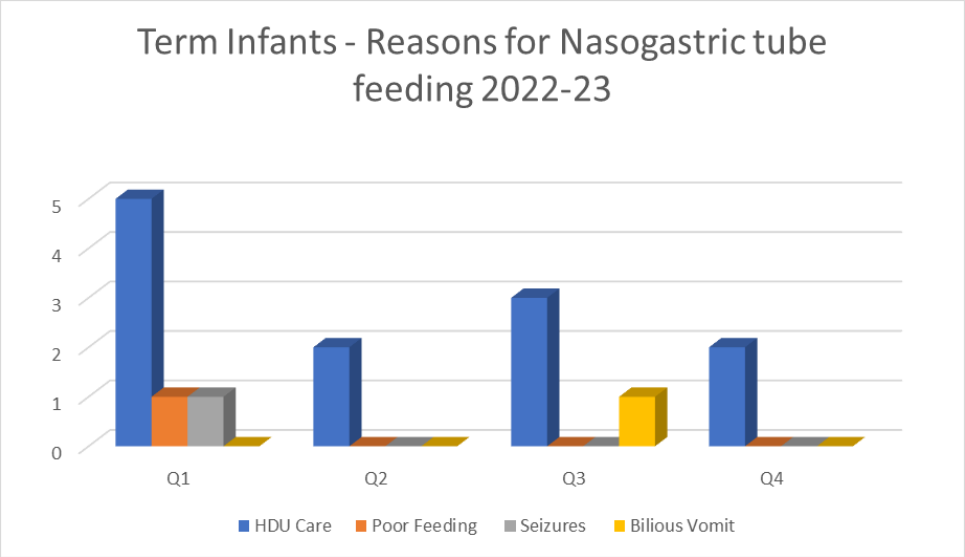
Avoiding term admissions into neonatal units forms part of the national maternity transformation agenda with the recommendation to keep mothers and babies together as much as possible. Transitional care refers to a model whereby the neonate and mother are not separated, despite the baby fitting a criteria for needing extra neonatal support. The aim is for both to be cared for in transitional care, on either a post-natal ward or the neonatal unit, with the baby receiving extra care at the bedside delivered by the neonatal team.

Data in the charts below from the requirement for safety action 3 as part of the maternity incentive scheme.

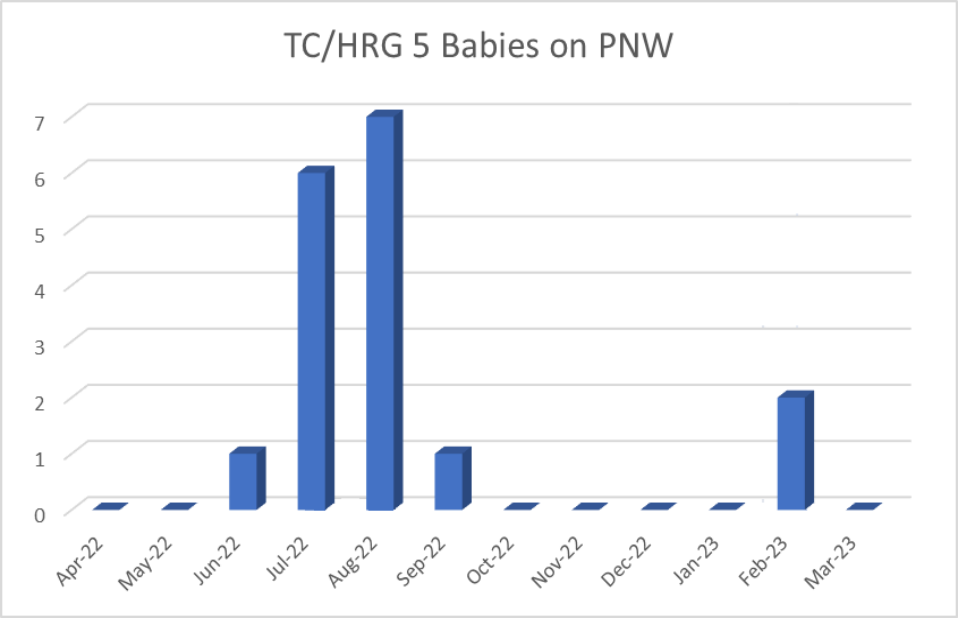
Term admission into the neonatal unit – diagnoses.



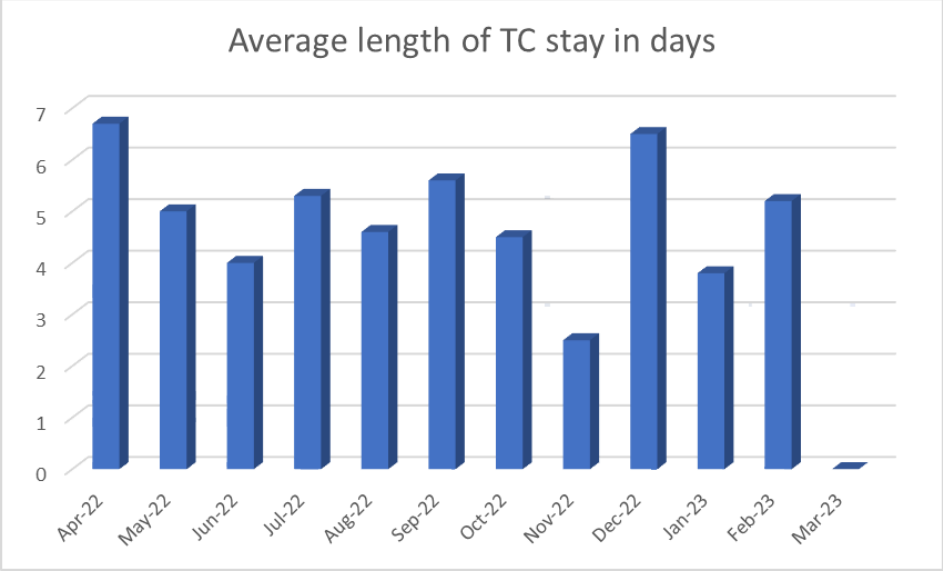
Term babies – reasons for NG feeding



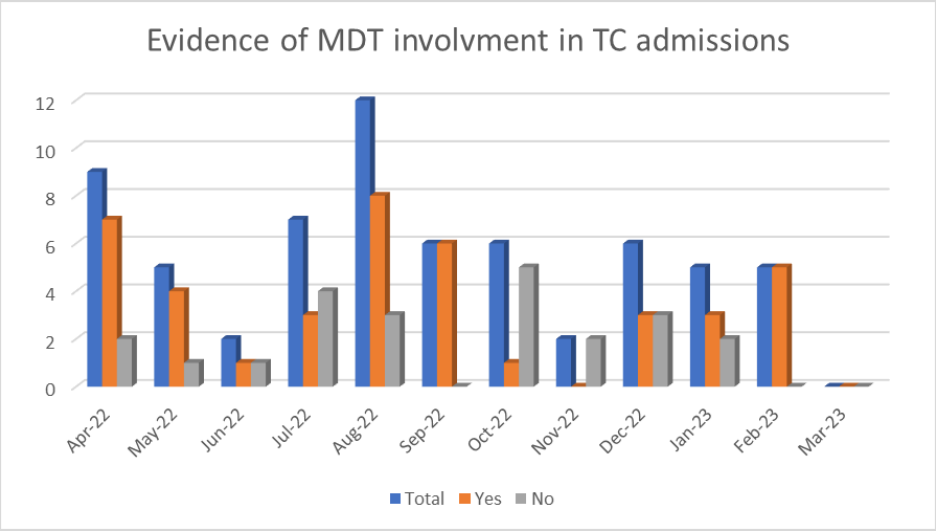
Numbers of TC babies on ward, with mother



Days spent in TC pathway



Evidence of MDT involvement



All term babies that are required to spend time in the neonatal unit have a formal MDT review via ATAIN meetings. This is a systematic and thematic review, deep diving into the reasons for admissions retrospectively, to identify whether they could have remained on the ward, as opposed to being admitted to the neonatal unit, and observe any themes. This aids learning (via perinatal meetings) and enables a level of scrutiny to ensure that best and most appropriate care is being provided.

The national ambition is for the percentage of babies admitted to NICU to be <6%, however our local Operational Delivery Network aims for a rate of <5%. The Q4 rate in Salisbury was 4.1%, with an overall rate below the 5% for the past financial year 2022-23.

Percentage of ATAIN admissions over last 3 quarters.

South West Region							National							
Measure	**Min**	**Medin**	**Max**	**Improve direction**	**RED**	**GREEN**	**Mar-21**	**Jan 23**	**Feb 23**	**Mar 23**	**Q1 Total**	**Q2 Total**	**Q3 Total**	**Q4 Total**
Babies (incl Non Reg)	170	186	206	Up				137	143	162	**549**	**588**	**351**	**442**
Term babies admitted to NNU unexpectedly %	1.7%	3.8 %	5.3%	Down	<5.8%	>5.5%	<5.8% NMPA	1.5%	7.7%	3.1 %	**2.7%**	**4.4%**	**3.7%**	**4.1 %**

16 SCREENING SERVICES

Following a quality assurance visit in September 2022, an action plan was issued to SFT in November 2022. This is being implemented and worked to at present.

A monthly face to face meeting has been commenced with NHSE screening team (QA) to support our progress to review and close the recommended actions from the QA team.

A band 7 screening coordinator has been recruited and has now started in the trust; she is currently working alongside the UHS screening team to ensure a robust induction to the post.

A business case is being worked on to reflect the structure that is needed to deliver the 6 screening programmes that we are commissioned to deliver.

The QA report from the visit and subsequent action plan can be accessed here.

(USE THIS ONE)
Screening Progress I

17 RISK REGISTER

Number	Title	Rating
7172	Depleted screening team and increase in SIAF's causing a safety concern to women and non-compliance with the national screening KPI's	15
7586	Sickness in quality and safety team	12
7517	Risk of not responding to emergency calls as call bell system not alerting correctly across maternity wards	10
7221	There is a risk of cases with harm not being escalated due to the large number of Datix	10

5713	Shortage of midwives which may pose a risk to deliver safe care throughout the maternity care pathway	10

There has been one maternity risks submitted for Quarter 4 2022/23 – these are waiting for approval

- Maternity information system not fit for purpose. Delay with digitalisation

18 DIGITIAL TRANSFORMATION

The maternity service recruited to the digital midwifery post in October 2022. This will enable us to deliver on the national and local digital agenda.

Work is ongoing, with the other digital midwives in the acute Trusts in the Local Maternity and Neonatal System, to align processes to deliver a joint digital roadmap best suited to our staff and service users.

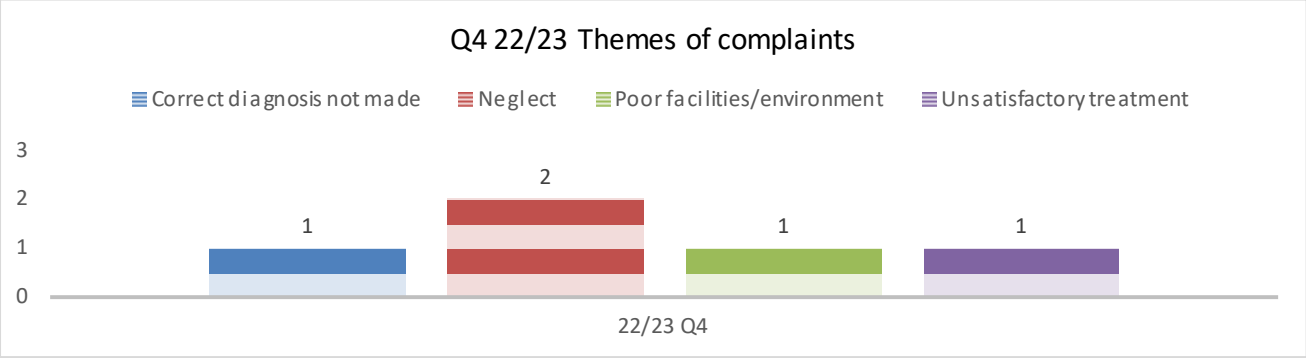
The business case for the new maternity information system, in collaboration with RUH and GWH, is due for completion end of April 2023 and will go to trust investment group in May 2023. The difficulty and impact assessment has been completed and will form part of the investment prioritisation process in May.

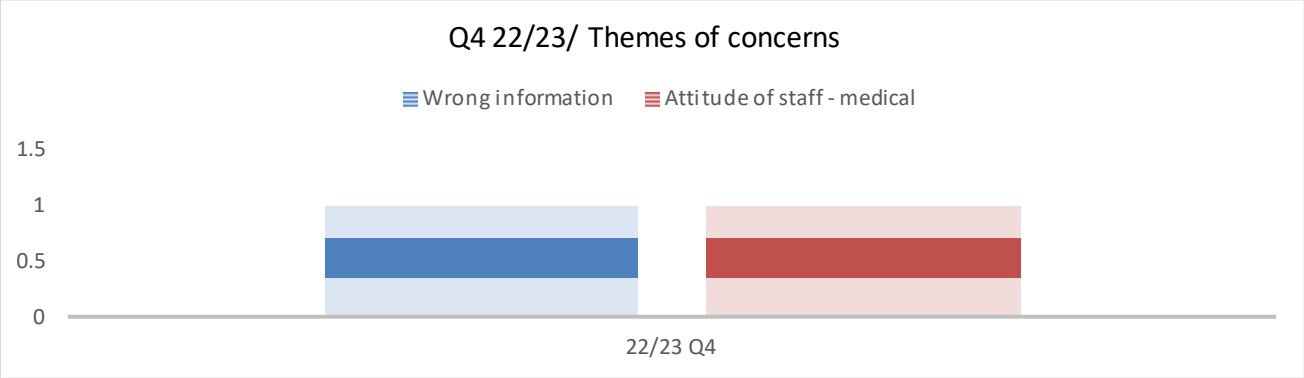
This workstream will ensure alignment with the strategic initiative of improving digital care.

19 FAMILY EXPERIENCE

19.1 Themes of complaints and concerns

22.1 THEMES OF COMPLAINTS AND CONCERNS





We have seen a slight reduction in the number of complaints and concerns received this quarter. Sadly, the theme of complaints would appear to be 'neglect'. however, it is important to note that these are small numbers (2). Those cases where neglect is offered as a primary sub- subject, it would appear that the complainants were dissatisfied with certain aspects of their care.

19.2 Details of complaints and concerns reported in Q3.

Description	Opened	Location (exact)	Response due	closed	Replied due	Outcome
Retroscetive complaint in regards to presceived complaintaction (partial hearing loss) asscoiated with birth asphyxia.	24/03/2023	Labour ward	05/05/2023	ongoing	19/05/2023	
Negligence in labour and aftercare.	10/02/2023	Labour ward	21/04/2023	ongoing	05/05/2023	
Lack of care, poor experience resulting in PTSD.	09/01/2023	Labour ward	13/03/2023	ongoing	27/03/2023	
Negligence, incompetence, lack of note taking and a total failure by several medics to keep her informed, give her proper due care and attention and an extremely spoiled early parenting experience.	27/02/2023	Postnatal	10/04/2023	ongoing	24/04/2023	
Malfunctioning call bells, Excessively high room temperature, bruising of arm and lack of proficient in English.	27/02/2023	Postnatal	22/03/2023	13/04/2023	03/04/2023	Aid call system error resolved, Estates plan to review the temperature of the ward. No concerns regarding the competency member of staff cited in the complaint.

19.3 Actions from Complaints:

Action taken	Deadline	Current progress made	Date Completed	RAG Rating
As a result of our investigation into the complaint learning from your case will be shared with alit the doctors in the department at our next teaching day	Mar-23	Consultant Obstetrician		Amber
Bleeding in early pregnancy pathway shared with the community teams.	Jan-23	Out patient manager	Jan-23	Green
Pt was seen by Consultant Paed- reassurance and apology offered. Pt has planned follow up appt.	Dec-22	Paediatric consultant	22/12/2022	Green
To discuss the feedback from the resolution meeting with the staff member.	Dec-22	Family Experience Midwife	Dec-22	Green
To liaise with the Day Assessment Unit (DAU) lead , to ensure measures are in place to make certain that women who decline a ECV have a follow up appointment.	Jan-23	Family Experience midwife	Jan-23	Green
Reminder to all staff of the important of ensuring that a feeding assessment is carried out for all women prior to their discharge form the postnatal ward.	Nov-22	Family Experience midwife	Nov-22	Green
Appointment of a dedicated diabetic specialist midwife, who will be a point of contact to women and their families.	No fixed dat	In patient Matron		Amber
Newly appointed Postnatal/ Antenatal lead, who will be largely undertaking clinical duties and be instrumental in embedding the Trust's values and behaviours within the team.	Jan-23		Jan-23	Green
Education programme to include the importance of compassionate communication. Consideration will be given to extending this training to the ward clerks.	Mar-23	Family Experience Midwife		Amber
Introduction of a new theatre trolley which is appropriately sized to enable the smooth transfer of women from recovery to the NNU, in order for the mothers to be repatriated with their babies.	Dec 22/Jan 2	NNU Manager	Dec22/Jan 23	Green
Newly appointed Antenatal Clinic Lead will support the Diabetic Specialist Midwife.	Mar-23	Outpatient Matron		Amber
The Ultrasound Department intends to discuss the concern at their next team meeting, in order to establish any learning from the case.	Jan-23	Lead Sonographer	03/01/2023	Green
The consultant anaesthetist will discuss the case at an anaesthetic department meeting with the anaesthetist involved, for personal refection	Feb-23	Consultant lead for Anaesthetics		Amber
Education to be offered to midwifery staff on the importance of observing that the epidural catheter is secure.	Dec 23	Consultant lead for Anaesthetics	28/12/2022	Green
Patient experience survey to be undertaken on DAU	Nov-22	DAU lead and Family experience Midwife	Oct-22	Green
Facilities in place to support partners on the postnatal ward, over night.	Dec-22	In patient Matron		Over due
The subject of 'compassionate communication' will be circulated to staff, as an opportunity for reflection and learning, for future discussion.	Dec-23	Family Experience Midwife	ongoing	Green
As a result of our investigation into your complaint we have spoken to the doctor involved and learning from your whole case will be shared with all the doctors in the department at our next teaching day.	Mar-23	Consultant Lead		Amber
reminder to be sent to the Community teams RE management of bleeding in early pregnancy	09/01/2023	Out patient Matron		Amber

19.4 Compliance with target times:

Metric	Q4 22/23
Quality: % of Complaints Closed within Agreed Timescale	66.6%
Quality: % of Concerns Closed within Agreed Timescale	50%

Maternity Voices Partnership

We have continued to maintain and build on relationships with our maternity voices partnership colleagues and have worked collaboratively, both with and without the LMNS, on a variety of workstreams to ensure that women and families have a strong voice in service provision and development as well as ensuring we are hearing and acting on feedback.

Latest MVP survey undertaken Dec22-Feb 23.

You said we did MVP.docx

Key areas:

- Continuity of carer
- Consultant Led Care
- Feeling listened to
- Postnatal home visits
- Beatrice birth centre
- Health visiting
-

The report has been shared with service leads for their consideration. A series of meetings will be held with the Service leads and the MVP. The intention is that we can work in collaboration with the MVP to implement service improvement.

Click on the link to review the full report.

Feedback Infographic Dec22Fe

23 QUALITY AND SAFETY NEWSLETTER

Newsletter Q4 2023.docx

24 RECOMMENDATION AND NEXT STEPS

- CNST working group meetings commenced
- Maternity improvement group set up to implement Maternity improvement plan actions
- Quality and Safety Matron role currently out to advert
- Consultant Obstetric Risk lead appointed
- Interim Quality and Safety Matron commencing at SFT to cover the vacancy temporarily and support progress.

The Committee of the Clinical Governance Committee is asked to receive and discuss the content of the report

CLASSIFICATION: please select

Report to:	Trust Board	Agenda item:	5.6.1
Date of meeting:	6th July 2023		

Report tile:	Perinatal Quality Surveillance - Salisbury NHSFT Maternity & Neonatal services			
Status:	Information	Discussion	Assurance	Approval
	x	x	x	
Approval Process: (where has this paper been reviewed and approved):	Reviewed at CGC 27.6.2023			
Prepared by:	Vicki Marston – Deputy Director of Midwifery and Neonatal Services			
Executive Sponsor: (presenting)	Judy Dyos			

Recommendation:

The trust board are asked to note the contents of the first monthly Perinatal Quality Surveillance Report. This report is prepared to demonstrate assurance to the board on Maternity and Neonatal Quality and Safety issues as required by Maternity Incentive Scheme – year 5 – Safety Action 9.

As per CNST Maternity Incentive Scheme requirements this will be a monthly report to Trust Board.

Executive Summary:

The Maternity Incentive Scheme (safety action 9) states an expectation that discussions regarding safety intelligence, including the number of incidents reported as serious harm, themes identified, and actions being taken to address any issues; staff and service user feedback; minimum staffing in maternity services and training compliance take place at Board level monthly. The perinatal Quality Surveillance Models sets out a model to report this and the information required is shared in the Perinatal Quality Surveillance report for SFT for May 2023.

Summary:

Staffing:

- Staffing noted and remained a driver for improving together.
- Midwifery vacancies and maternity leave mitigated by bank and agency usage
- Midwife to birth ratio 1:31
- 1:1 care in labour achieved at all times
- Supernumerary status of labour ward maintained 100% time
- Datix relating to workforce 1

PMRT

- No outstanding actions

Incidences reported as moderate

- 4 – No themes identified

Training

- Compliance shows slight decrease in PROMPT and NLS training, Plan in place to address this and improve compliance for June/July.

Service user and staff feedback

- As detailed and actions taken forward to address any concerns or areas for improvement

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

NHS
Salisbury
NHS Foundation Trust

Virtual Meeting Etiquette:

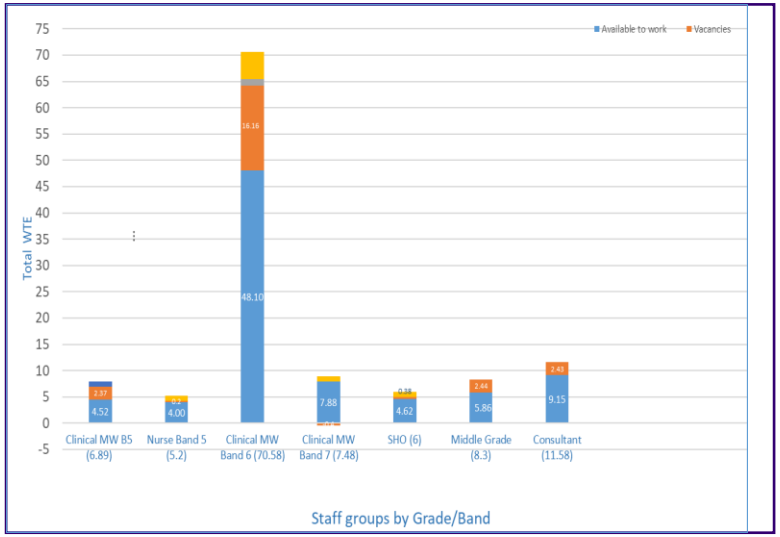
- Mute microphones when not speaking (to minimise background noise)
- Turn cameras off – unless speaking (to maximise call quality)
- Please use the *Raise Your Hand* to ask a question
- Please note, this event will be recorded

Perinatal Quality Surveillance

Salisbury NHSFT Maternity & Neonatal services

Safe - workforce

Salisbury NHS Foundation Trust



Concern	Cause	Countermeasure	Owner	Due Date
Recruitment of MWs and middle grades	Attraction Materials	Utilise R and R policy requirements to implement a financial incentive to join the trust as a clinical band 5 or 6 midwife to attract new staff members. **Incentive agreed and completed – launched with advert in April.**	Vicki M, Sharon Holt, C.Richardson	Complete
		Practice Education Midwife visiting Southampton and Bournemouth University in April to showcase our preceptorship programme and incentive package. Band 5 midwives interviewed and accepted posts – 12 Band 5 midwives booked for interview - 4 Band 6 midwives interviewed and accepted posts – 2.6	S.Leahy	Complete 30/06/23
	International recruitment	Update: • 7 international Midwives commenced in service • 4 taken OSCE • 2 completed and passed her OSCE • 2 awaiting retake for some elements of exam • 1 taking OSCE in July • 1 recruited and commenced in June.	Vicki M/International Recruitment lead	Ongoing
	Alternative medical doctor	SAS Doctor position – going out to advert	GAP/AJK	30/04/23
	Development opportunities	2 x places secured on Nurse to Midwife conversion course. Commencing Jan '24 funded by HEE, completion Jan'26. 2 x places secured for Midwifery apprenticeship which will be open to current MSW with appropriate education (education fees funded by apprenticeship levy). 3 year apprenticeship starting Jan '24	VM	Ongoing
	Workforce Total	Birthrate plus scheduled for meeting in June 23 to inform start date – this will inform workforce numbers based on current activity and acuity	VM	June 23
Retention of MW and MCAs	National picture	To discuss with Mark Docksey support to MCA staff group – retention Meeting held, job role does not include MCA retention	VM	07/06/23
	Education and Training	Medled human factors training bespoke to MCA's planned for June 23 – funded by NHSE monies – to extend to whole MDT to facilitate group training	VM	30/06/23
Data Format		RGN'S included against clinical midwives in stratified data to ensure they are represented.	VM	complete
Flexible Working		Task and finish group ongoing with monthly meetings. Link to divisional work with staff survey	VM/CR/NB	ongoing

Is the standard of care being delivered?

- 1:1 care in labour was achieved at all times
- Supernumerary Labour Ward coordinator status maintained 100% in April
- Midwife to birth ration is stable
- There is a -22 WTE midwifery workforce gap

What are the top contributors for over/under achievement?

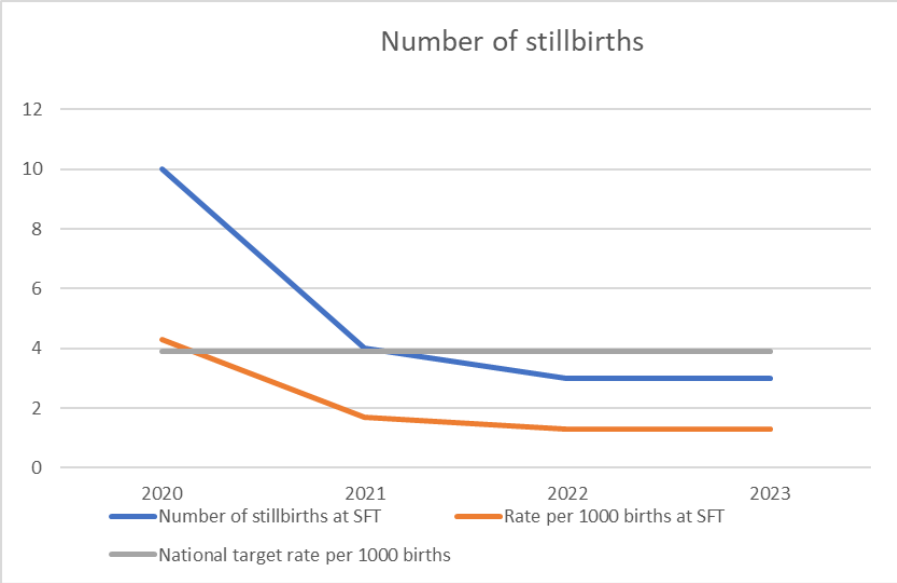
- Vacancy rate
- Maternity leave
- Challenges in recruiting midwives
- Challenges with midwifery retention
- Accuracy of data capture for fill rates
- MSW workforce fully recruited -no Vacancy

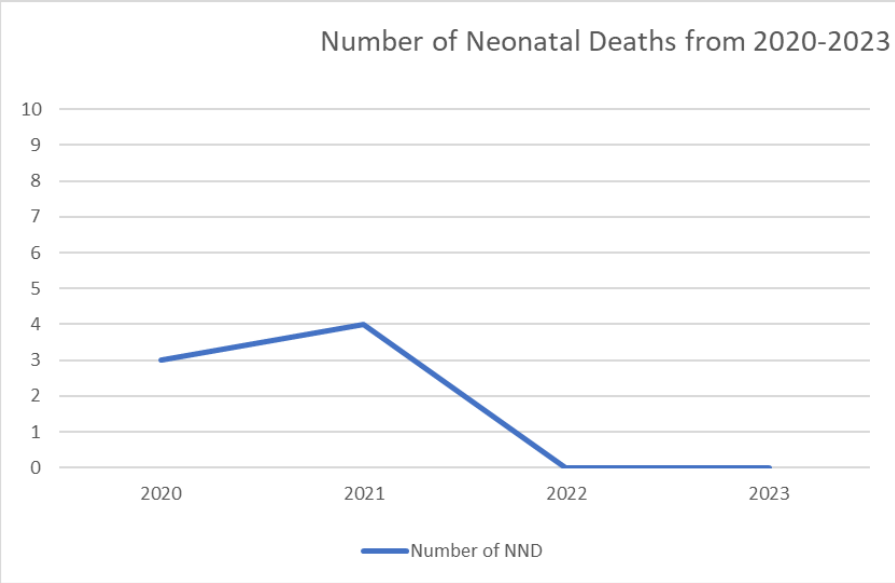
Safe - workforce

Salisbury NHS Foundation Trust

Workforce	Obstetric cover - labour ward	RCOG guidence		<= 39	>= 40	Up	40	40	40	40	40	40	40
	Midwife to Birth ratio	RCM;NHSR;BR +	1.26	>= 1.28	<= 1.26	Down	1.31	1.31	1.27	1.31	1.25	1.31	NA
	Midwifery vacancy rate (black= over establishment; red =under establishment)			>= 1	NA	Down	20.0	20.9	20.9	21.9	21.9	23.2	NA
	Provision of 1 to 1 care in established labour (%)	NICE, RCM, MIS	100%	<= 94	>= 100	Up	100	100	100	100	100	100	NA
	Datix relating to workforce	6 month SFT rolling		>= 2	= 0	Down	1	1	2*	2	3	1	1.6
	Compliance with supernumery status of the LW coordinator - %	NICE;RCM;NHSR	100% rostered	<= 94	>= 100	Up	100	100	100	100	100	100	NA
	Numbers of times maternity unit on divert	6 month SFT rolling		>= 2	= 0	Down	0	0	0	0	0	0	0

Safe – perinatal mortality review





PMRT action plans update				
Case ID	Action plan	Responsible person	Target date	completion
No outstanding actions				

Incidents

Salisbury NHS Foundation Trust

SIIs, CRs and LRs Commissioned in May 2023				
ID	**Directorate / Ward / Dept**	**Summary of incident**	**Incident date**	**Date commissioned**

SIIs, CRs and LRs In Progress May 2023							
ID	**Directorate / Ward / Dept**	**Summary of incident**	**Incident date**	**Date commissioned**	**CRG**	**Date Due to CCG**	**Progress Notes**
425	Maternity / W&NB	CoV-positive transfer from ICU	8/3/2021	9/2/2021			Report share 08/06
SII 492	W&NB	Term admission to NICU	7/13/2022	7/19/2022			Next CRG
CR 509	W&NB	Hep B vaccine		8/30/2022	11/10/2022		Report being drafted after panel
CR 512	W&NB	Unexpected NICU admission		9/20/2022			Report finalised, awaiting feedback from HSIB
CR 527	W&NB	Maternal sepsis	10/19/2022	11/1/2022			Awaiting updated draft from chair, then for Exit.
SII 548	Maternity/W&NB	Term admission to NICU	2/23/2023	2/28/2023			Report in writing.
SII 554	Maternity / W&NB	Delayed cancer diagnosis	11/25/2022	3/21/2023			Awaiting confirmation of panel date.
SII 555	Maternity / W&NB	Intrapartum stillbirth - HSIB	3/16/2023	3/21/2023			Further interviews to be arranged (HSIB)

SIIs, CRs and LRs Signed off in May 2023					
ID	**Directorate / Ward / Dept**	**Summary of incident**	**Incident date**	**Date Signed Off**	**Duty of Candour Update**

Incidents - actions

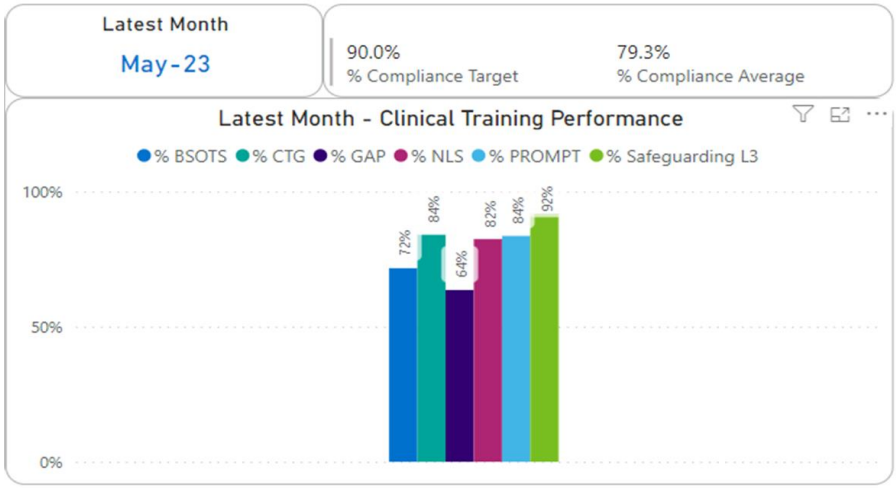
Salisbury NHS Foundation Trust

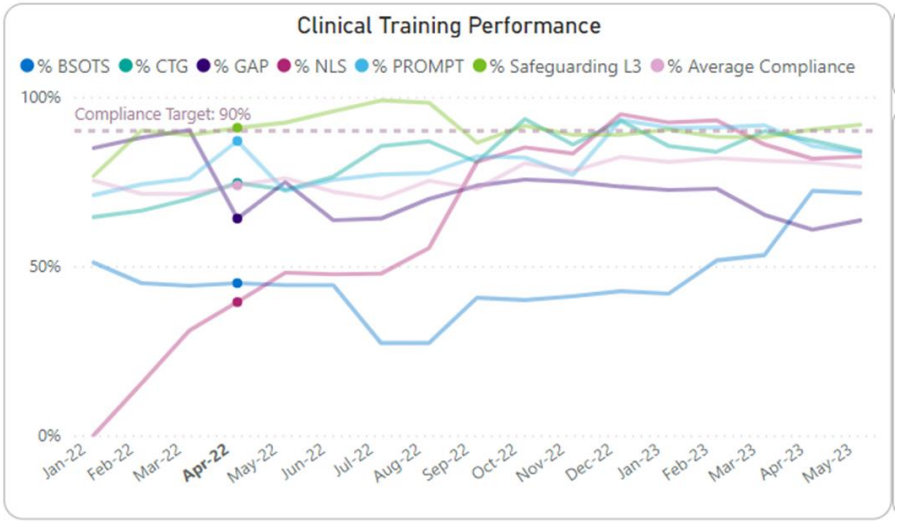
W&NB SII / CR Open Compliance Matrix

SII/CR No.	Link to Sheet	Directorate	Incident Date	Recommendation RAG Rating (Green = Completion Date, Amber/Red: Target Date)										
				1	2	3	4	5	6	7	8	9	10	11
SII 432	Click	W&NB	September 2021	Q3 21-22	June 22	Q2 22-23	Q2 22-23	Q2 22-23	Q2 22-23	Q2 22-23				
SII 437	Click	W&NB	October 2021	Q2 22-23	Q3 22-23	Q3 22-23	Q3 22-23	July 22						
CR 453	Click	W&NB	October 2021	Q3 21-22	Aug 22	Q3 22-23	Q3 22-23	Q3 22-23						
CR 454	Click	W&NB	December 2021	Oct 22	Oct 22	Oct 22	Q4 22-23							
CR 462 (PA)	Click	W&NB	January 2022	Sept 22	July 22	Q3 22-23	Q2 22-23	Q2 22-23						
CR 462 (PB)	Click	W&NB / Medicine	March 2022	Sept 22	Med.	Q2 22-23	Q2 22-23							
SII 472	Click	W&NB	February 2022	Q1 22-23	Oct 22	Oct 22	Q3 22-23	Q3 22-23						
SII 477	Click	W&NB	April 2022	Q1 22-23	Jan 23	Jan 23	Q4 22-23	Q4 22-23	Q4 22-23	Q3 22-23	Q4 22-23	Jan 23		
SII 484	Click	W&NB	May 2022	Q4 22-23	Jan 23	Jan 23	Jan 23	Jan 23	Jan 23					
SII 489	Click	W&NB	May 2022	Q1 22-23	Dec 22	Nov 22	Oct 22	Q3 22-23	Q3 22-23					
CR 505	Click	W&NB	August 2022	Q2 22-23	Dec 22	Q4 22-23	Dec 22							

Training Compliance May 2023

Salisbury NHS Foundation Trust





Training-

New training database in place to support allocation of all required maternity training, with oversight by divisional workforce lead to ensure staff are appropriately allocated study leave to improve training compliance.

Slight decrease in PROMPT and NLS this month – plan agreed with surgery for training to be prioritised for anaesthetists. Anaesthetists subsequently allocated which should see an increase in June/July in overall compliance.

Trajectory for BSOT's training completed, all midwifery staff to have completed training by end June 23

Trajectory for Registrars to be completed and training plan implemented.

Fetal monitoring team and PDM to create a sustainability plan for keeping compliance at or around 90%

Service user and Staff Feedback

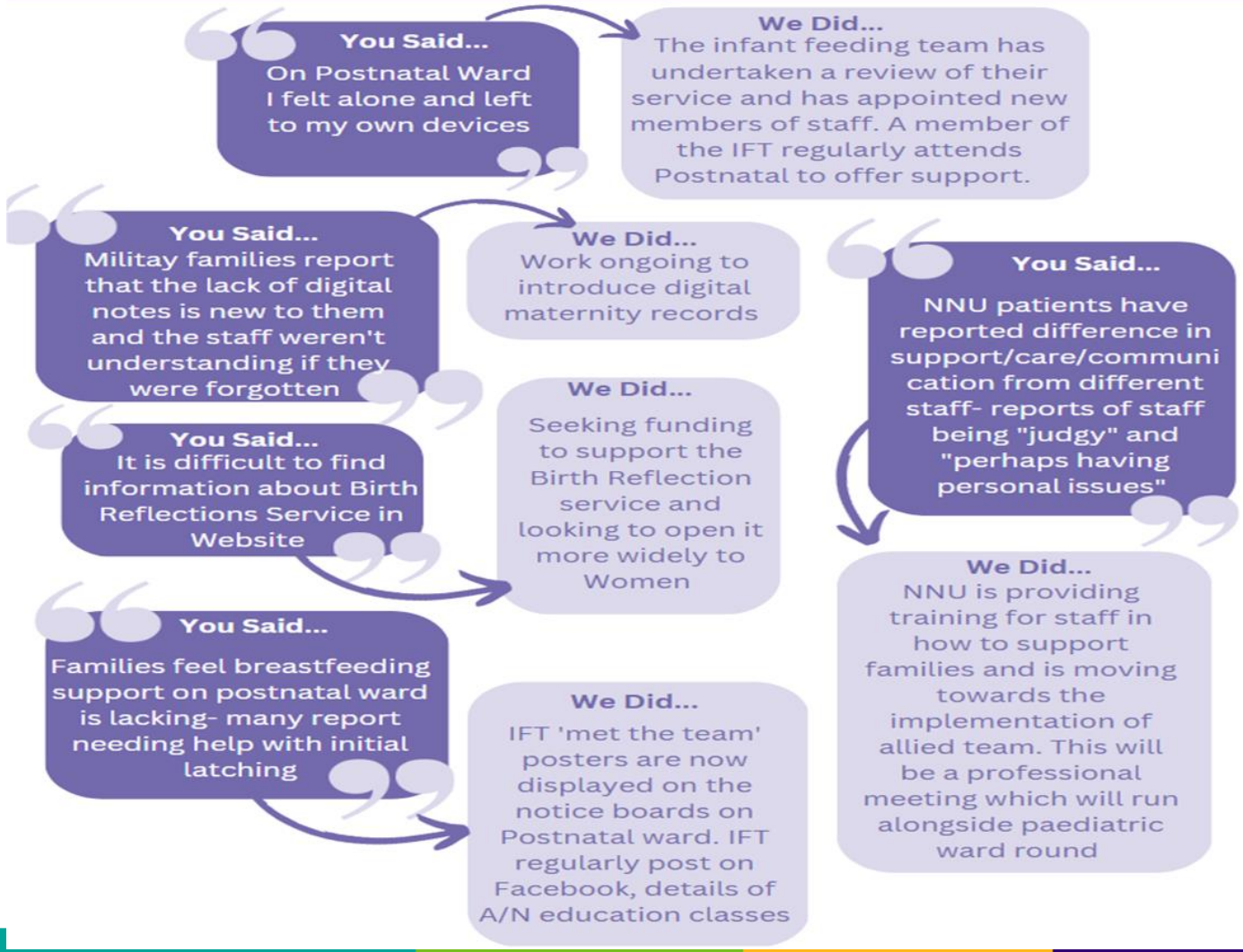
NHS Salisbury

Feedback from families (MVPP)	Feedback from staff –Safety Champions
Positive from the MVP survey: Wonderful support, met several different Midwives throughout but they were all absolutely lovely, friendly and made me feel really comfortable Mum had a super positive birth experience & consultant was lovely despite previous negative experience with them Midwife listened to mother and was sensitive but also firm in suggesting a change of position would help Postnatal community care was wonderful, it was so nice to visit our Midwife after having our baby so she could have a cuddle and meet him **Areas for improvement suggested in the MVP survey:** A more team centred approach to care if continuity cannot be maintained A personalised approach to risk assessments Encourage Mothers to listen to and work with their intuition/what they're feeling Listen to women's choices and encourage two-way conversations around making decisions Ensure women who cannot use the birth centre are assigned a pool room if possible - perhaps some work on social media around setting up a labour ward room like the birth centre	**Feedback** • Queries around increase in leadership roles following new structure and number of band 7/8 roles from clinical staff • Concerns over covering shifts due to sickness and vacancy • Concerns from community teams about working hours and rostering, shared at meeting with CNO. • Concerns around confidentiality • Lack of equipment available **Actions**: • New structure discussed at maternity staff meetings • Meeting with community midwives with CNO, DDOM, Matrons to discuss concerns and collaboratively design action plan • Flexible working focus group in place, actioning rostering concerns • Incentive and recruitment drive in place – 15 midwifery roles offered and accepted to start Sept/Oct • Focus on confidentiality and individual feedback • Process for obtaining new equipment shared with community staff.

Compliments	Concerns	Complaints
22	0	2

You Said... We Did...

NHS Salisbury NHS Foundation Trust



Report to:	Trust Board (Public)	Agenda item:	5.7
Date of meeting:	6 July 2023		

Report tile:	Q3 Research Assurance Report 2022/23			
Status:	Information	Discussion	Assurance	Approval
	Yes	Yes		Yes
Approval Process: (where has this paper been reviewed and approved):	CGC			
Prepared by:	Louise Bell, Interim Head of Research			
Executive Sponsor: (presenting)	Peter Collins, Medical Director			

Recommendation:

Recommendation – the report is presented for information and assurance.

Assurance – The trust level national Key Performance Indicators (KPIs) for research are currently suspended. CRN Wessex wide KPIs are discussed in this report.

Risks – N/A

Executive Summary:

Salisbury NHS Foundation Trust has been contributing to Wessex High Level Objectives (or KPIs). The Trust's contribution in recruiting to time and target for non- commercial research (closed to recruitment in 22/23 and predicted) is either exceeding national ambition and is doing well in comparison to partners. The Trust has not met ambitions regarding commercial research and a substantial effort is being made to increase this portfolio.

Recruitment is also less than previous years. This is a Wessex-wide phenomenon. As a Trust we are looking at our approach to recruitment both to increase overall recruitment and make it more strategic.

The Patient Research Experience Survey (PRES) showed that the participant experience of research is overwhelmingly positive (appendix 1). We will look addressing any areas of criticism and increasing the scope of this survey.

Our sponsored projects are currently complying to RESET and are on target or have taken sufficient remedial action in order to not have funding withdrawn.

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

Salisbury NHS Foundation Trust

Q3 Research Assurance Report 2022/23

1. Purpose

1.1. The quarterly research reports provide the Committee with assurance regarding Trust compliance with the Trust Key Performance Indicators (KPIs) for research, also referred to as High Level Objectives by the National Institute for Health and Care Research (NIHR) and the Department for Health and Social Care.

2. Background

2.1. The NHS is encouraged to support the NIHR Clinical Research Network (CRN) portfolio research. The Trust is part of the CRN Wessex and receives infrastructure funding from the network to support research staff and NIHR research activity. The Trust is normally performance managed by both the NIHR and CRN: Wessex against a number of KPIs.

2.2. Trust level KPIs are currently suspended and are under review. This report describes the Trust recruitment activity and contribution to CRN Wessex High Level Objectives.

3 Contribution to CRN Wessex Wide High Level Objectives (appended in Table 1 for ease of reference)

Wessex performance on High Level Objectives was generally positive (Table 1). Only two objectives were missed: objective 1 closed to recruitment commercial studies which achieved their recruitment target and number of GP practices that were research active. Table 2 explores Salisbury NHS Foundation Trust's (SFT) to these. SFT did not recruit to commercial studies in the last financial year. Salisbury opened one commercial study which closed early without recruiting due to a temperature deviation which meant no IMP was available for recruitment. We are exploring all avenues to restart a commercial portfolio.

On other KPIs, Salisbury has performed well including when compared to other Wessex Trusts. A Table 3 and Table 4 (provided by CRN Wessex) describes SFT performance compared to other partners on recruitment to time and target. Salisbury met the national ambition of 80% of studies closing having recruited to the site target in 22/23 achieving 85% in this financial year. Similarly, the predicted recruitment to time in target is performing well compared to other Trusts in the Wessex area. Currently SFT is the top performing acute Trust (rag rated green and blue) for predicted achievement of time to target in 23/24. The difference between ambitions reflects, that many amber rated studies and some red rated studies will achieve their ambitions, but initial recruitment may be slow due to local or national teething problems. These KPIs will continue in 23/24.

We contribute to Patient Research Experience Survey (PRES) (table 1, objective 4). This year initial uptake at this Trust was slow despite offering regular opportunities for participants to provide feedback through PRES. In Q1 to Q3 we only had 2 responses to this survey. We changed our approach to PRES, mailing out information. This resulted in a more respectable final tally of 44. The responses were generally very positive (please see Appendix 1 for more detail). All but one of the responses were from a White British background, and it will be interesting to see if this changes with increased initiatives around under-represented communities. Qualitative feedback emphasised the friendliness and caring approach of staff and feeling that they were contributing to care and knowledge in the future. The negative feedback mainly surrounded the geographical location of the clinics and feedback of results which is dictated nationally. There was some national qualitative feedback suggesting that the way expenses are processed should be looked at. Feedback from PRES is now available as survey responses in almost real time; therefore, we can consider how to report back on patient feedback more regularly.

Recruitment

The Trust recruited 1078 study participants into 50 NIHR portfolio research projects during Q1Q2Q3Q4 22/23 (Table 4). This is up from 193 in Q1Q2Q3. The Trust performed poorly compared to our exceptional standard. Trusts in the country ranking 4th on number of studies offered to our population and 7th for the number of participants recruited into those studies, (compared to 4th and 1st respectively at the end of last year). Reasons for slower recruitment this year include decrease in staffing levels post-pandemic, concentrating on responding to a culture review and a changing management team leading to increased time for study set-up. However, this is a Wessex-wide phenomenon, as the CRN dropped its ranking in recruitment compared to other CRNS from 8th in 20/21 to 14th of 15 in 22/23. We have been working hard to increase our recruitment rate for the next financial year. Early indicators suggest that this will be Q1 23/24 will be higher that Q1 22/23.

The Trust recruitment for this period is shown in Table 4. The Trust has 69 projects in total that are open to recruitment, and a further 44 in long term follow up (see Table 5 for full listing). The majority of research projects are national projects where we are one of a number of host organisations, but also includes 4 Trust-led research projects.

Reset – Trust sponsored studies

The NIHR has been undergoing in national Reset programme. Sponsors are under an obligation to consider closing their studies early if the study is unlikely to meet their targets. This financial year we have not been forced to close any studies early.

- HIIT closed as scheduled recruiting 23 of its 40 target sample size.
- Bowman is behind its recruitment schedule, however funders have agreed a costed extension and we are now including participant identification centres to increase recruitment
- ELABs is projected to be slightly behind target of 150. A no cost extension of one month and a reduction of sample size to 140 (due to a lower attrition rate than expected) will mean that it is likely that ELABS will over-recruit on the reduced target by the time it closes to recruitment.

It is important to note that these are feasibility studies which may lead on to larger studies. Analysing how well a study has recruited and what can increase recruitment is part of the objective of the study rather than reaching a set target to ensure statistical significance. As results are analysed this will inform whether a larger scale study is likely to show the appropriate significance, how long recruitment would take in order to show statistical significance and to decrease the likelihood of teething problems before a larger more costly study is funded.

Finally, STEPS has not been part of this process as it officially began its set up in March 2023 with recruitment to start in Autumn 2023.

4 Summary

4.1 The attached assurance report provides an update on Trust research recruitment activity and outputs during Q1Q2Q3 2022/2023

5 Recommendations

5.1 The report is presented for information

Louise Bell
Interim Head of Research

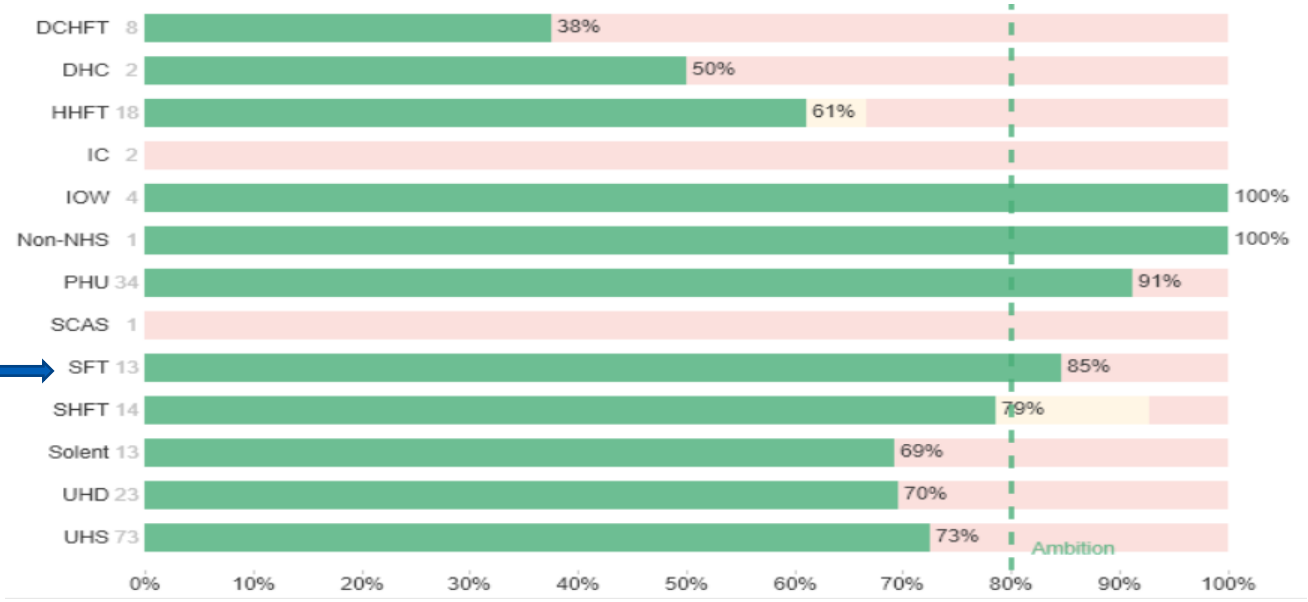
Table 1 Wessex wide performance on Key Performance Indicators (KPIs)

Objective		Measure	Ambition	Wessex	England
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	80%	60% (6/10 Wessex-led studies)	80%
		(2) Percentage of closed to recruitment non-commercial studies which have achieved their recruitment target	80%	86% (50/58 Wessex-led studies)	90%
		(3) Percentage of open to recruitment commercial contract studies which are predicted to achieve their recruitment target	60%	65% (24/37 Wessex-led studies)	68%
		(4) Percentage of open to recruitment non-commercial studies which are predicted to achieve their recruitment target	60%	63% (95/150 Wessex-led studies)	66%
Provider participation	Widen participation in research by enabling the involvement of a range of health and social care providers	(1) Percentage of General Medical Practices with recruitment in NIHR CRN Portfolio studies	45%	42% (111/262)	44%
		(2) Percentage of NHS Acute trusts with recruitment in NIHR CRN Portfolio studies every quarter	99%	Q1 100% (7/7) Q2 100% (7/7) Q3 100% (7/7) Q4 100% (7/7)	Q1-4 100%
		(3) Percentage of NHS Acute trusts with recruitment in commercial contract NIHR CRN Portfolio studies every quarter	70%	Q1 71% (5/7) Q2 71% (5/7) Q3 71% (5/7) Q4 86% (6/7)	Q1-4 74%
		(4) Percentage of NHS Ambulance, Care and Mental Health trusts with recruitment in NIHR CRN Portfolio studies every quarter	95%	Q1 100% (4/4) Q2 100% (4/4) Q3 100% (4/4) Q4 100% (4/4)	Q1-4 94%
Participant experience	Demonstrate to participants in NIHR CRN supported research that their contribution is valued through collecting their feedback and using this to inform improvement in research delivery	Number of NIHR CRN Portfolio study participants responding to the Participant Research Experience Survey	1,237	1,516 (123%)	18,000 ambition (national response TBC)

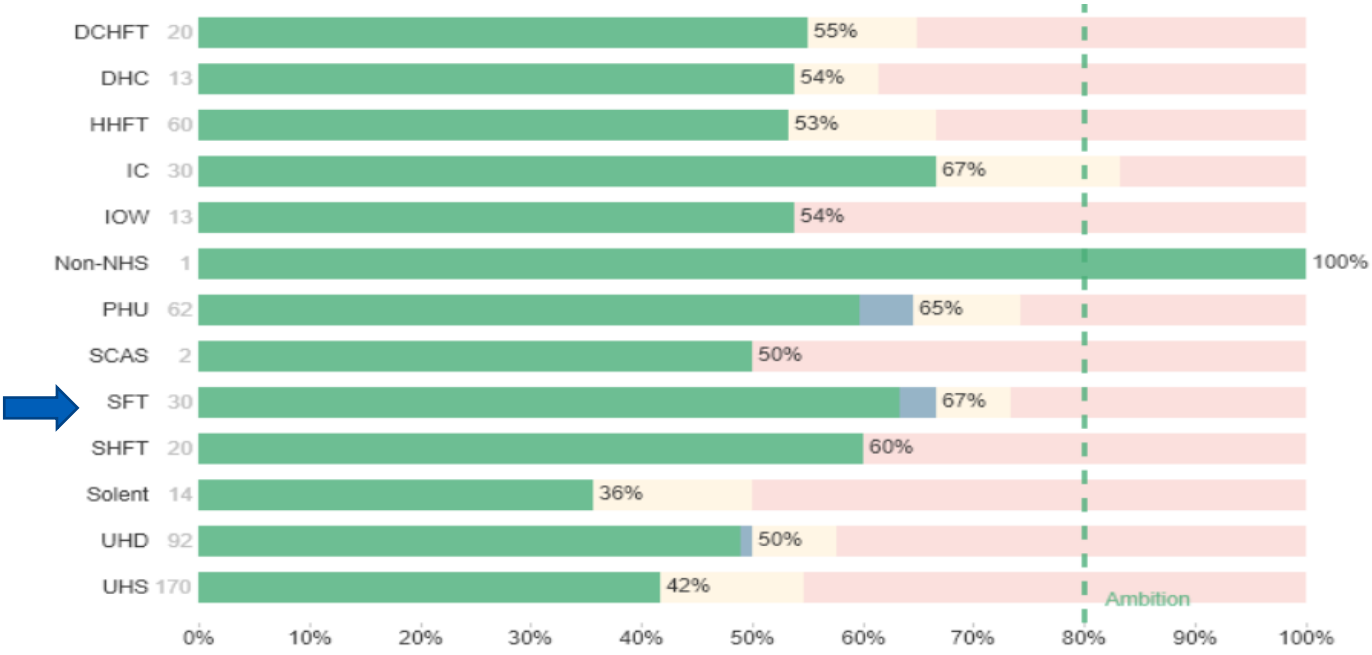
Table 2 Salisbury contribution to KPIs

Wessex organisation performance - study sites closed in FY 2022/23

Objective	Definition	Measure	Ambition	Comments
1. 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	80%	None closed
		(2) Percentage of closed to recruitment non-commercial studies which have achieved their Recruitment target	80%	85% achieved
		(3) Percentage of closed to recruitment commercial studies predicted to achieve their recruitment target	0%	Harmonie closed prematurely, therefore not achieved
		(4) Percentage of closed to recruitment non-commercial studies which are predicted to achieve their Recruitment target	60%	67% predicted achievement rate for 2023/24
2. 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%	Collaborations set up with three Chequers
		(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%	Not commercially active
		(4) Percentage of NHS Ambulance, care and Mental Health Trusts with recruitment into NIHR Portfolio every quarter	95%	Collaborations with SCAS being set up
3. 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	Contributed 41 responses to PRES



Wessex organisation performance - study sites closing in FY 2023/24



Red RAG rated
Amber RAG rated
Blue RAG rated
Green RAG rated
Grey numbers on axis count study sites

Blue studies have met their target, but the planned closure date has elapsed. Most of these studies will have the closure date extended and the site will therefore become green by the time the study is confirmed closed.

Table 2: Recruitment to time and target achieved (objective 1.2)

NIHR Portfolio ID	Main Speciality	Project Short title	Principal Investigator	site target recruitment	Recruited
42290	Anaesthesia, Perioperative Medicine and Pain Management	ObsQoR	Dr Xantha Holmwood	4	5
18432	Cancer	PLATFORM	Dr Alaaeldin Shablak	4	3
15938	Cancer	AML18	Dr Jonathan Cullis	5	9
32907	Cancer	Myeloma XII (ACCoRd trial)	Dr Jonathan Cullis	5	2
31701	Cardiovascular Disease	The BHF SENIOR-RITA TRIAL	Dr Manas Sinha	6	1
37105	Cardiovascular Disease	CLEAR SYNERGY (OASIS 9)	Dr Tim Wells	6	18
42347	Cardiovascular Disease	CHAPS	Dr Jonathan Cullis	10	10
51978	Children	HARMONIE	Dr Sebastian Gray	6	0
43704	Children	Germ's Journey Education Resources: Handwashing for Children	Sarah Diment	1	16
53022	Dementias and Neurodegeneration	OPTIM-PARK 2	Mr James Lee	5	9
33029	Dermatology	PLUM	Dr Serap Mellor	5	4
45272	Diabetes	Impact of hypoglycaemia on QoL	Lijo Joy	3	44
49944	Health Services Research	Designing HRM practices to support NHS employees of BAME backgrounds	Sarah Diment	1	29
48890	Infection	HEAL-COVID trial	Dr Jonathan Cullis	1	37
37410	Neurological Disorders	REGAIN	Dr Jim Baird	4	7
36723	Reproductive Health and Childbirth	The 'Big Baby Trial'	Jo Baden-Fuller	19	48
39971	Reproductive Health and Childbirth	The POOL study	Mrs Abby Rand	120	400
49615	Stroke	PREPARE: imPRoving End of life care Practice in stroke cARE, 1.0	Alpha Anthony	0	0
40221	Surgery	PITSTOP	Mr Graham Branagan	20	4
44426	Trauma and Emergency Care	SHED - Subarachnoid Haemorrhage in the Emergency Department	Peter Ellis	1	48

Table 3 Recruitment to time and target predicted (objective 1.4)

NIHR Portfolio ID	Main Speciality	Project Short title	Principal Investigator	target Recruitment	Recruited
12255	Cancer	OPTIMA.	Dr Jenny Bradbury	23	43
42281	Cancer	Myeloma XIV (FiTNEss)	Dr Tracey Parker	8	8
16675	Cancer	FLAIR	James Milnthorpe	6	10
47442	Cancer	Urine Biomarkers for detecting prostate cancer	Miss Melissa Davies	10	0
45002	Cancer	The EMBED Study: Early Markers for Breast Cancer Detection	Miss Roanne Fiddes	5	124
17059	Cancer	SERENADE	Mr Graham Branagan	36	69
51104	Cancer	CITRuS	Mr Graham Branagan	35	1
20443	Cancer	TRACC - Tracking mutations in cell free tumour DNA to predict Relapse in Early Colorectal Cancer	Mr Graham Branagan	24	58
17006	Cancer	IMPRESS.	Mr Graham Branagan	15	51
35640	Cancer	COMET (Previous title Crumpet)	Mr Graham Branagan	6	26
20576	Cancer	TRIGGER Trial	Mr Graham Branagan	1	9
47994	Cancer	TRACC C	Mr Graham Branagan		1
53310	Cancer	QLG Survivorship 4	Mrs Victoria King	20	5
44010	Cancer	Body composition and chemotherapy toxicity in breast cancer (CANDO-3)	Ms Victoria Brown	40	36
43791	Cardiovascular Disease	ORBITA-2	Dr Manas Sinha	10	10
38382	Cardiovascular Disease	ORION-4	Dr Tim Wells	86	88
20479	Cardiovascular Disease	ARTESiA: Apixaban in patients with device-detected sub-clinical AF	Dr Tim Wells	8	8
16436	Children	Identification of factors associated with speech disorder-cleft palate	Mrs Ginette Phippen	30	61
47485	Children	SLUMBRS2	Dr Nefer Fallico	6	2
31531	Children	CF START	Dr Sebastian Gray	2	0
49271	Children	Covid impact on RSV Emergency Presentations: BronchStart	Dr Sebastian Gray	1	186
38197	Critical Care	REMAP-CAP	Dr Phil Donnison	30	47

30540	Critical Care	GenOMICC	Dr Phil Donnison	6	46
18437	Dementias and Neurodegeneration	Parkinson's and Movement Disorders Families Project (PFP)	Dr Diran Padiachy	7	16
49143	Dermatology	Early Laser for Burn Scars (EL4BS)	Dr Mark Brewin	10	30
10646	Dermatology	Biomarkers and Stratification To Optimise outcomes in Psoriasis (BSTOP)	Dr Serap Mellor	17	42
8090	Dermatology	BADBIR	Dr Serap Mellor	13	62
9689	Diabetes	ADDRESS-2	Dr Chris Anderson	5	16
43148	Gastroenterology	Ustekinumab Real World Evidence Study	Mrs Alpha Anthony	8	13
20664	Gastroenterology	IBD Bioresource	Mrs Lijo Joy	25	98
4961	Haematology	UKAITPR	Dr Jonathan Cullis	16	16
14145	Haematology	UK Childhood ITP Registry	Miss Sarah Diment	20	15
51471	Health Services Research	DALLI	Mrs Karen Drake	5	6
54611	Health Services Research	The Career Aspirations of the Research Delivery Workforce	Mrs Abby Rand	5	7
45388	Infection	RECOVERY trial	Dr Manas Sinha	1	192
52724	Infection	Development of Improved Methods for the Diagnosis of Wound Infections	Dr Paul Russell	25	8
48260	Musculoskeletal Disorders	High Intensity Interval Training in Acute Spinal Cord Injury_v1	Dr Aram Fard	40	23
44431	Musculoskeletal Disorders	IMID BioResource	Dr Michael Clynes	3	70
39576	Musculoskeletal Disorders	Baricitinib therapy for Rheumatoid Arthritis: an Observational Study	Dr Zoe Cole	5	5
52908	Musculoskeletal Disorders	Flexor tendon repairs - FIRST Study	Megan Robson	10	12
44971	Neurological Disorders	BOWMAN V. 12.0	Tamsyn Street	36	20
41819	Ophthalmology	PINNACLE	Dr Rashi Arora	5	22
42795	Reproductive Health and Childbirth	LOCI: Letrozole Or Clomifene for Ovulation Induction	Dr Aarti Umranikar	12	36
47078	Reproductive Health and Childbirth	Giant PANDA	Dr Annie Hawkins	20	14
14362	Reproductive Health and Childbirth	The Cleft Collective Cohort Studies	Ginette Phippen	347	618

37933	Reproductive Health and Childbirth	OPHELIA study - Causes of Gestational Diabetes	Mrs Abby Rand	50	135
39901	Reproductive Health and Childbirth	TTTS Registry	Mrs Abby Rand	1	4
51339	Respiratory Disorders	REDUCE- Carbon	Mrs Sophia Strong-Sheldrake	50	33
30705	Stroke	Determinants of prognosis in stroke	Dr Toby Black	150	159
40836	Stroke	OPTIMAS Trial	Dr Toby Black	15	10
52006	Surgery	Reconstruction in Extended MArgin Cancer Surgery (REMACS)	Mr Graham Branagan	10	5
40430	Surgery	Short or Long Antibiotic Regimes in Orthopaedics (SOLARIO)	Mr Neal Jacobs	1	12
49972	Trauma and Emergency Care	Collar or no collar for peg fracture	Mr Nicholas Evans	4	3
37822	Trauma and Emergency Care	PROFHER2 Trial - Version 1.0	Mr Sridhar Rao Sampalli	8	4
41515	Trauma and Emergency Care	Surgery or Cast for Injuries of the EpicoNdyle in Children's Elbows	Mr Sridhar Rao Sampalli	1	2

Table 4 Recruitment 2022-2023

CPMS Study ID	Managing Specialty	Short Name	Recruitment - responding to selections
51104	Cancer	CITRuS Stage 1; Feasibility	1
47442	Cancer	Urine Biomarkers for detecting prostate cancer	18
45002	Cancer	The EMBED Study: Early Markers for Breast Cancer Detection	109
44010	Cancer	Body composition and chemotherapy toxicity in breast cancer (CANDO-3)	18
43032	Cancer	MEDICI	13
42281	Cancer	Myeloma XIV (FiTNEss)	5
20443	Cancer	TRACC - Predicting Relapse in eArly Colorectal Cancer	11
12255	Cancer	OPTIMA	6
43791	Cardiovascular Disease	ORBITA-2	4
42347	Cardiovascular Disease	CHAPS; version 1.0	1
38382	Cardiovascular Disease	ORION-4	1
37105	Cardiovascular Disease	CLEAR SYNERGY (OASIS 9)	9
31701	Cardiovascular Disease	The BHF SENIOR-RITA TRIAL	1
49271	Children	Covid impact on RSV Emergency Presentations: BronchStart	66
47485	Children	SLUMBRS2	2
43704	Children	Germ's Journey Education Resources: Handwashing for Children V1	16
16436	Children	Identification of factors associated with speech disorder-cleft palate	6

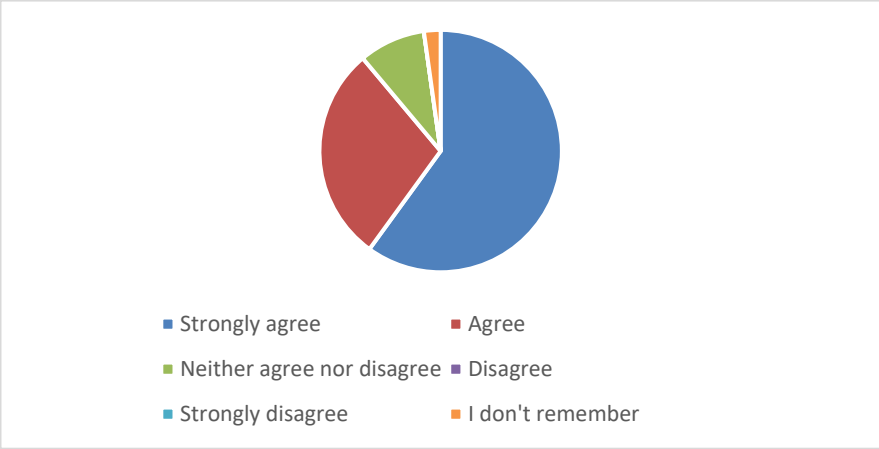
30540	Critical Care	GenOMICC	7
53022	Dementias and Neurodegeneration	OPTIM-PARK 2	9
49143	Dermatology	Early Laser for Burn Scars (EL4BS)	23
10646	Dermatology	Biomarkers and Stratification To Optimise outcomes in Psoriasis (BSTOP)	6
8090	Dermatology	BADBIR	4
45272	Diabetes	Impact of hypoglycaemia on QoL V1	44
55158	Gastroenterology	CLARITY IBD (Follow up)	15
43148	Gastroenterology	Ustekinumab Real World Evidence Study	7
20664	Gastroenterology	IBD Bioresource	37
54611	Health Services Research	The Career Aspirations of the Research Delivery Workforce	7
51857	Health Services Research	IDA v1.0	1
51471	Health Services Research	DALLI	6
49944	Health Services Research	Designing HRM practices to support NHS employees of BAME backgrounds	33
54791	Infection	SIREN Winter Pressures	25
52724	Infection	Development of Improved Methods for the Diagnosis of Wound Infections	8
48890	Infection	HEAL-COVID trial	9
45388	Infection	RECOVERY trial	2
14460	Infection	Positive Voices: National Survey of People with HIV	13
52908	Musculoskeletal Disorders	Flexor tendon repairs - FIRST Study	7
48260	Musculoskeletal Disorders	High Intensity Interval Training in Acute Spinal Cord Injury_v1	14
44431	Musculoskeletal Disorders	IMID BioResource	51
50554	Neurological Disorders	Tetragrip II - restoring hand function to people with tetraplegia	2
44971	Neurological Disorders	BOWMAN V. 12.0	4
41819	Ophthalmology	PINNACLE	6
47078	Reproductive Health and Childbirth	Giant PANDA	11
42795	Reproductive Health and Childbirth	LOCI: Letrozole Or Clomifene for Ovulation Induction	16
39971	Reproductive Health and Childbirth	The POOL study	212
37933	Reproductive Health and Childbirth	OPHELIA study - Causes of Gestational Diabetes	94
36723	Reproductive Health and Childbirth	The 'Big Baby Trial'	10
14362	Reproductive Health and Childbirth	The Cleft Collective Cohort Studies	54
51339	Respiratory Disorders	REDUCE- Carbon	1
49615	Stroke	PREPARE: imPRoving End of life care Practice in stroke cARE, 1.0	3
40836	Stroke	OPTIMAS Trial	2
52006	Surgery	Reconstruction in Extended MArgin Cancer Surgery (REMACS)	4

40430	Surgery	Short or Long Antibiotic Regimes in Orthopaedics (SOLARIO)	2
49972	Trauma and Emergency Care	Collar or no collar for peg fracture	2
44426	Trauma and Emergency Care	SHED - Subarachnoid Haemorrhage in the Emergency Department	40

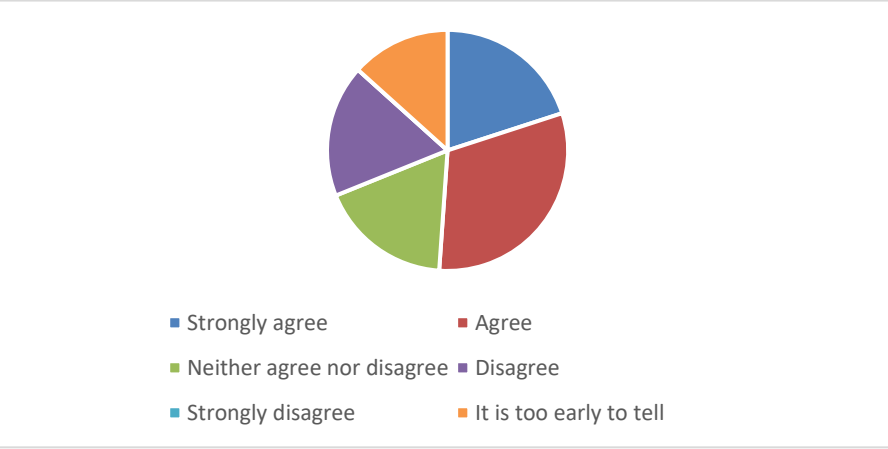
Please note table represents current count of 1078 for 22/23. Official figures are 1070 at data cut

Appendix 1 Results of Patient Research Experience Survey

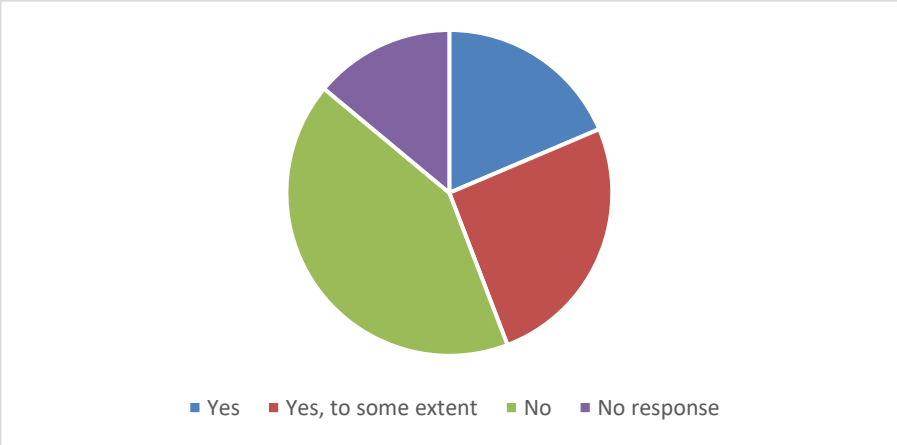
1)The information that I received before taking part prepared me for my experience on the study



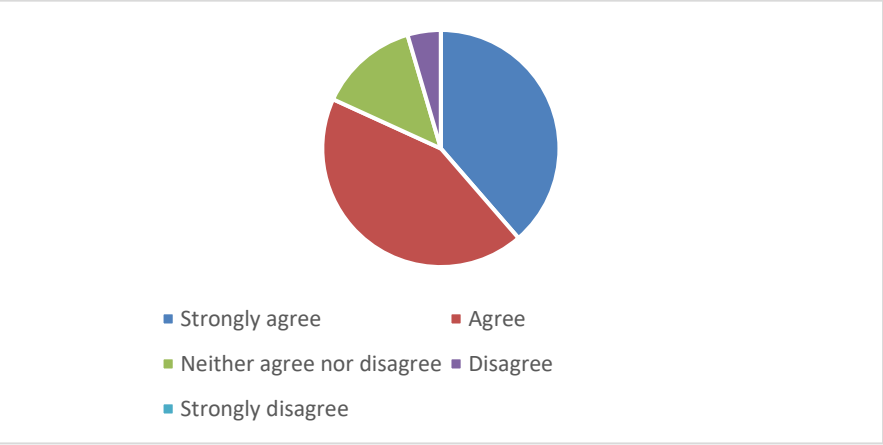
2) I feel I have been kept updated about this research study / the research



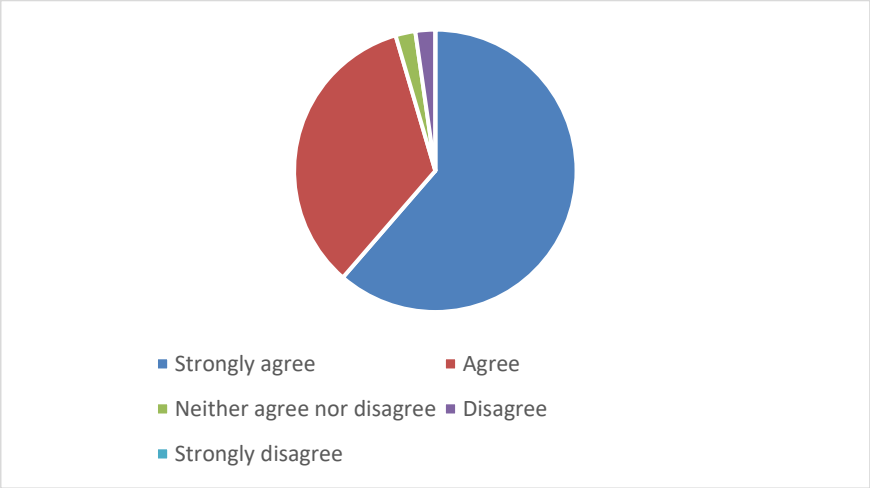
3) I know how I will receive the results of this research study / the research



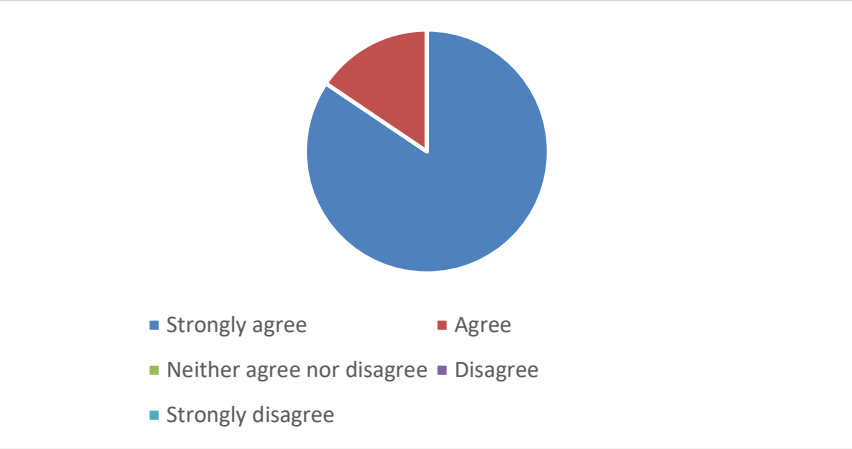
4) I know how to contact someone from the research team if I have any questions or concerns



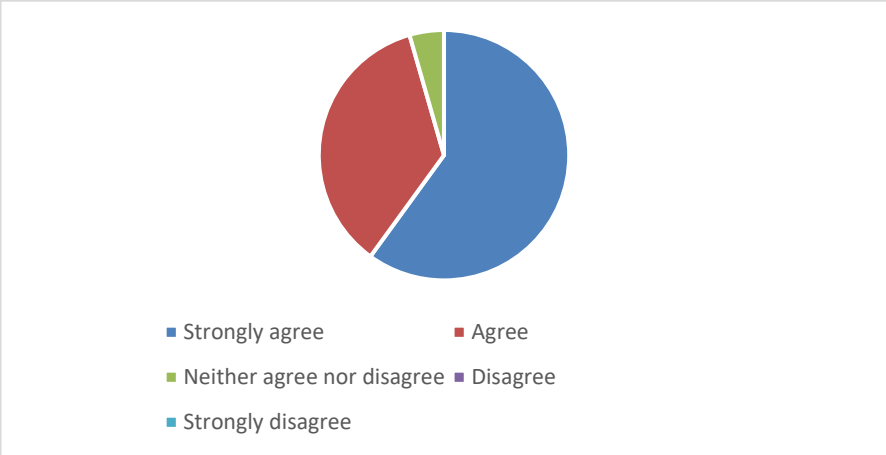
5) I feel research staff have valued my taking part in this research study / The researchers have valued my taking part in the research



6) Research staff have always treated me with courtesy and respect



7) I would consider taking part in research again



Please note no participants chose strongly disagree

Free Text responses

8) What was positive about your research experience? (Free text)
A sense of pleasure that my contribution, albeit very small, will help professionals to more effectively deliver care and treatment not just to me but to my fellow humans.
All the staff where very helpful explaining to me the different procedures, as I went from test to test.
Appointments for blood tests are made easier by being accompanied by the contact researchers.
Before the pandemic bloods were always collected the same day as an appointment at the hospital. I was met by a TRACC representative and immediately had my blood taken. Had the pandemic not occured I would of been able to contribute more to the research.
Comprehensive information from both internet contact and representatives from research in hospital.
Easy to do
Explained clearly and listened to what I had to say.
Feeling I was being useful
For me, contributing to others in which this research can assist mankinds well-being. The team and the pathology dept have always been totally supportive. The overall feeling I get is pride as my 5 yrs is up.
Helping the treatment and understanding of the survey.
Helping to advance eye care.
Helping to find a cure!
Hoping that I would help in a small way.
I felt happy to be contributing to something positive. Everyone involved always treated me very well.
I felt I could ask questions
I felt I was doing something that could benefit both the medical profession and also anyone who later goes through what I have experienced.
I felt it may help to find a cure.
I felt valued. Empathetic behavoir from researcher. Boost in confidence on how I was coping with my treatment.
I have always been treated respectively and kindly by everyone who I have been involved with concering this research. As someone involved with statistics, I felt quite excited to have been invited to take part. Many thanks!
Informative and friendly staff.
It feels a useful piece of research. Also it means I can keep up to date with the health of my own blood.
Appoints - staff have endeavoured to make them convenient time wise.
It was conducted by caring people who answered every question that I asked.
Kind research nurses who were truly interested in their study
My eyesight was being monitored very regularly.

Nurse was very informative & friendly.
Pleasant, helpful manner of research assistant. Seen immediately on arrival.
Quick and easy
Quick, very little to do outside of what treatment requires.
Satisfaction in being part of research and benefiting from latest technology.
Skipping the queues in the bloods dept!! Happy and grateful staff always result in happy and grateful patients. You were all fabulous. Thank you.
Staff agreeing to help.
Staff very courteous.
The kindness of the nurses and complete lack of pressure to undertake joining the research programe
The research nurse was excellent.
Very glad to provide data which may help in finding even better treatments, prevention or even cures for bowel cancer.
When I was asked, I felt anything that would help future problems I would like to be part of.

9) What would have made your research experience better? (Free text)

Better explanation about it all.
Better liaison over blood tests.
Don't know.
Having a dedicated space, not the fault of the researcher but not sure if the research is supported by the Breast Unit enough?
Having the hospital nearer.
I couldn't think of anything until I saw the question about receiving the results. Maybe I was told in the very begining? I assumed that I wouldn't get any results. However I am most interested in receiving the results!
I have a lung issue which makes getting to appointments early somewhat difficult. I did make requests for later appointments but did not receive a reply.
I think more explanation as to the point of the research.
I would like to have known a little more about exactly what the research was aiming to do and how it proposed to do it.
If it was closer to my home as I had to drive 45 minutes to the hospital.
It was fine.
It would be interesting to be given more information on the results of the research.
Maybe a yearly update on how things are going in the research world.
More information

More information about the Pinnacle research study before I started the program.

N/A

N/A

Not applicable as my experience was 100% satisfactory.

Nothing

Nothing

Nothing specific - all satisfactory.

Nothing that I can think of!

Nothing. Everyhting was great.

Regular updates about the study - email?

See 2nd and 3rd answers on page 3.

Since Feb 2020 and lockdown I have had blood taken at my local surgery for the colorectal team and as far as I know these have not been sent for research. Now the pandemic is over it suits me to stay local as it it a 36 mile round trip to the hospital, but if bloods could be sent for the research from my surgery that would be helpful to me and TRACC.

Some confusion during COVID but was able to give 2020 bloods in November as restrictions eased.

Too early to tell.

NHS Salisbury NHS Foundation Trust

Report to:	Trust Board (Public)	Agenda item:	5.8
Date of meeting:	6th July 2023		

Report tile:	Board Assurance Framework and Corporate Risk Register			
Status:	Information	Discussion	Assurance	Approval
		X	X	
Approval Process: (where has this paper been reviewed and approved):	N/A			
Prepared by:	Fiona McNeight, Director of Integrated Governance			
Executive Sponsor: (presenting)	Fiona McNeight, Director of Integrated Governance			

Recommendation:

The Board Committees are asked to review, discuss and make any recommendations to the following:

- Board Assurance Framework (BAF)
- Corporate Risk Register
- The Corporate Risk Tracker

Specifically, the Committee is required to:

- Review the overall risk profile for each strategic priority and agree this reflects all current and future risks.
- Review the risks out with tolerance and request any further assurance required in respect of risk mitigation.
- Review the principle strategic risks (BAF) and any associated gaps in control or assurance

Agree escalation points for the Trust Board, to include any emerging risk/s or control concerns.

Appendices

Revised Board Assurance Framework June 2023 (draft)

Draft Summary CRR tracker v1 June 2023

Corporate Risk Register June 2023

Executive Summary:

The Board Assurance Framework (BAF) provides the Trust Board with a mechanism for satisfying itself that its responsibilities are being discharged effectively. It identifies through assurance where aspects of service delivery are being delivered to internal and external requirements. It informs the Board where the delivery of principal objectives is at risk due to a gap in control and/or assurance.

There has been an improvement in the risk profile overall since the last report in January 2023 with reduction in scores for 5 strategic risks. There is one additional corporate risk out with tolerance since the last report.

The risks within the BAF and CRR have been considered in conjunction with the Integrated Performance Report and there have been no further risks identified.

Summary Strategic Risk Profile

- There are 12 strategic risks which is unchanged since the last report in January 2023.
- BAF risk 12 - Risk of sustained deterioration across key performance metrics has moved within tolerance following improvement in the DM01, cancer performance, theatre productivity and less occupied beds since January 2023.
- Progress has been made in risk mitigation for BAF risks 1, 5, 7, 8 and 12 which has resulted in reduction in score contributing to the improvement in the risk profile.

There are 5 strategic risks out with tolerance compared to 6 reported in January 2023:

- BAF 4 - Risks associated with critical plant and building infrastructure that may result in utility or system failure impacting on service delivery.
- BAF 5 - As a result of inadequate nursing staff and additional open capacity there is a risk of poor quality of care and poor patient experience. This risk score has decreased back to 20 from 25.
- BAF 7 - Inability to effectively plan for, recruit and retain staff with the right skills which will impact staff experience, morale and well-being which can result in an adverse impact on patient care.
- BAF 8 - Demand for services that outweighs capacity, resulting in an increased risk to patient safety, quality, and effectiveness of patient care.
- BAF 9 - An irreversible inability to reduce the scale of financial deficit

All of the above risks have a score greater than 15. These all fall within an open risk appetite and therefore any score over 12 is out with tolerance. The risk tolerance has not identified any unexpected risks out with tolerance and reflect the challenges discussed at Board and Board Committees and evidenced through the Integrated Performance Report metrics and individual reports.

There is an improvement recommendation from the Trust's External Auditors as part of their annual assessment and report, for the Trust to establish a process for considering how risks in the ICB risk register impact the Trust and update the BAF accordingly.

Feedback from Board Committees

It was noted that the resourcing of the Electronic Patient Record (EPR) project may have an impact on BAF risk 4 as funding will be constrained for backlog maintenance. This will be considered in that context.

In respect of Corporate risk 7574, it was acknowledged that the closure of beds within the system would likely increase this risk score given this relates to pressure within urgent care and the impact on the Trust ability to deliver planned care.

Summary Corporate Risk Profile

The risk type, risk appetite and risk tolerance is now applied to all CRR risks. There are 20 risks on the CRR compared to 24 in January 2023. There are 9 risks out with tolerance compared to 8 reported in January 2023:

- Risk 5704: Inability to provide a full gastroenterology service due to a lack of medical and nursing workforce. Score 15. This risk is now out with tolerance with a score increase from 9 to 15 following resignation of one of the substantive consultants (leaves end of July) and the fixed term consultant

going on maternity leave mid-June. A paper is scheduled to be presented at CGC this month regarding the gastroenterology service.

- Risk 5751: Risk of patient harm caused by a delayed discharge from hospital. Score 20.
- Risk 7039: The Trust is currently experiencing increased demand and patient acuity across all in-patient areas, at a time of increased nursing sickness, maternity leave, leavers and retirement and reduced recruitment. This causes a shortfall in Care Hours per Patient Day (CHPPD), increases risk of burnout for remaining staff, causes delay to flow and discharges and inability to provide required care for all patients. The risk score reduced from 20 to 15 in January but remains out with tolerance.
- Risk 7573 (Population) - The risk of sustained use of escalation bed capacity (e.g. DSU, Discharge lounge, intervention radiology) has an impact on patient safety due to not enough substantive staff for increased bed capacity, patients not always placed initially in most appropriate ward. The more beds the Trust has open the impact on operational effectiveness, e.g. ward rounds, clinical support services. Score 20.
- Risk 7574 (Population) - The continued pressure from urgent care flow alongside the increases in length of stay, compromises the ability for the Trust to undertake planned care. Score 15.
- Risk 7472 (People) - As a result of unmanageable staff absences, poor retention of existing staff and ineffective recruitment activity to fill vacancies, there is a risk that SFT is unable to manage service provision and operate in a safe hospital. Score 16.
- Risk 6954 (People) - As a result of the national pay award for nurses not being accepted by the Royal College of Nursing, there is a risk of industrial action by members of the RCN. This could result in staffing shortages or staff working to rule. This risk score has decreased from 20 to 15.
- Risk 7308 (Partnership) - The financial plan for 2022/23 is a deficit plan with assumed 2.2% savings. There is a material risk that the deficit will be larger than planned due to the operational constraints, inability to achieve financial savings and ongoing pressures related to patients with no criteria to reside. Therefore, there is a risk that cash flow is challenged during the year resulting in the Trust having to take emergency cash measures. This risk score has further increased from 16 to 20.
- Risk 6229 (Population) - The DSU building is 'end of life' and has been identified as priority for replacement. Score 20.

Risk 508: The absence of a comprehensive Health and Safety Management System for the Trust runs the risk that legislative requirements will not be embedded into the Trust standards to which departments are expected to work. Without those standards, we cannot expect the Trust be compliant, so the consequences of non-compliance with health and safety law results in Staff and all persons on site at risk of harm and the Trust at risk of prosecution and claims. The risk score has reduced from 12 to 9 which has moved this risk within tolerance (previously out with tolerance in January 2023).

New risks since January 2023

- Risk 6229 (Population) - The DSU building is 'end of life' and has been identified as priority for replacement. Score 20.

Risks removed

- Risk 7283 (Population): Covid testing and patient pathway management. This risk was closed as testing has ceased.
- Risk 7359 (Population): Assessment and authorisation of Deprivation of Liberty legislative changes. This risk has been closed following announcement that the legislative changes are on hold and no known date for review.

- Risk 7515 (Population): Risk of reverse boarding. This risk was closed due to minimal risk. Risk 7516 (Boarding) remains open.
- Risk 7276 (People): Risk to Occupational Health Service. This risk was closed due to mitigation of the risk relating to staffing resources.

Risks with an increased score

- Risk 5704 (People): Inability to provide a full gastroenterology service due to a lack of medical and nursing workforce. This risk is now out with tolerance with a score increase from 9 to 15 following resignation of one of the substantive consultants (leaves end of July) and the fixed term consultant going on maternity leave mid-June. A paper is scheduled to be presented at CGC this month regarding the gastroenterology service.
- Risk 7308 (Partnerships): The financial plan for 2022/23 is a deficit plan with assumed 2.2% savings. There is a material risk that the deficit will be larger than planned due to the operational constraints, inability to achieve financial savings and ongoing pressures related to patients with no criteria to reside. Therefore, there is a risk that cash flow is challenged during the year resulting in the Trust having to take emergency cash measures. Score 16 to 20.

Risks with a decreased score

- 5972 (Population): Risk that improvement and transformation is not delivered in a timely manner. Score 12 to 9.
- 6143 (Population): Risk to the ability of SFT to provide the same quality of service 24 hours a day, 7 days a week, with a potential impact to patient care. Score 12 to 9.
- 508 (Population): The absence of a comprehensive Health and Safety Management System for the Trust runs the risk that legislative requirements will not be embedded into the Trust standards to which departments are expected to work. Score 12 to 9.
- 6570 (Population): As a result of the fact that the highly contagious Covid, Flu and RSV variants are still circulating within the community, there is a risk that an outbreak of one of these could occur either for staff and/or patients. Score 12 to 9.
- 6954 (People): As a result of the national pay award for nurses not being accepted by the Royal College of Nursing, there is a risk of industrial action by members of the RCN. This could result in staffing shortages or staff working to rule. Score 20 to 15.
- 7078 (People): As a result of competing priorities and deliverables there is a risk of slippage of the Improving Together Programme deadlines. Score 9 to 6.

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

Salisbury NHS Foundation Trust

Board Assurance Framework

V1 June 2023

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

An outstanding experience for every patient

Board Assurance Framework

The Board Assurance Framework (BAF) provides the Trust Board with a mechanism for satisfying itself that its responsibilities are being discharged effectively. It identifies through assurance where aspects of service delivery are being delivered to internal and external requirements. It informs the Board where the delivery of principal objectives is at risk due to a gap in control and/or assurance.

Trust Values

The core values and behaviours to support the achievement of the Trust vision:

Person Centred & Safe
Our focus is on delivering high quality, safe and person focussed care through teamwork and continuous improvement.

Professional
We will be open and honest, efficient and act as role models for our teams and our communities.

Responsive
We will be action oriented, and respond positively to feedback.

Friendly
We will be welcoming to all, treat people with respect and dignity and value others as individuals.

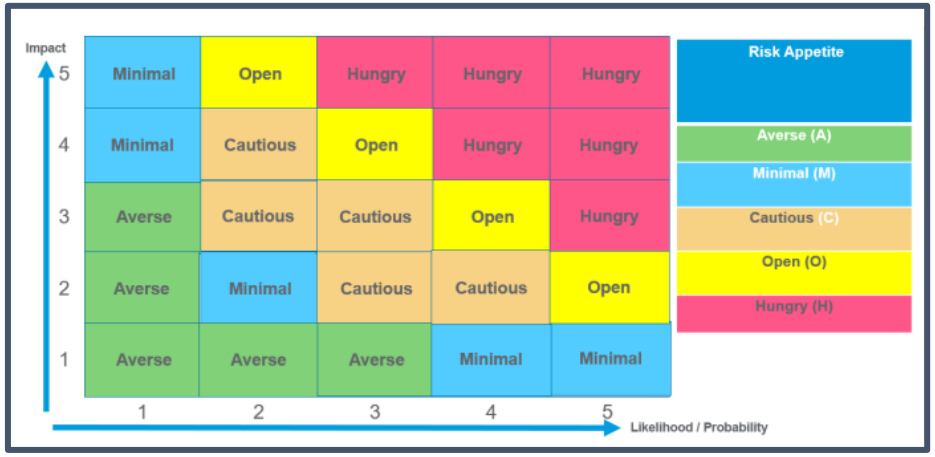
Progressive
We will constantly seek to improve and transform the way we work, to ensure that our services respond to the changing needs of our communities.

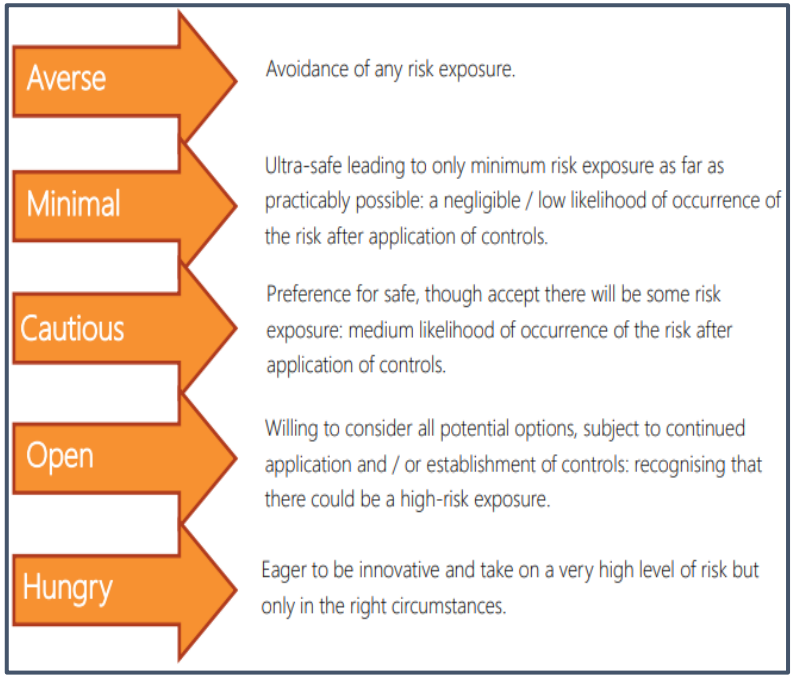
Strategic Priorities

Risk Matrix

Risk Matrix					
Likelihood/ Frequency ↓	Consequence/Impact →				
	Insignificant 1	Minor 2	Moderate 3	Major 4	Catastrophic 5
5 Almost Certain	Moderate 5	High 10	Significant 15	Significant 20	Significant 25
4 Likely	Moderate 4	High 8	High 12	Significant 16	Significant 20
3 Possible	Low 3	Moderate 6	High 9	High 12	Significant 15
2 Unlikely	Low 2	Moderate 4	Moderate 6	High 8	High 10
1 Rare	Low 1	Low 2	Low 3	Moderate 4	Moderate 5

Risk Appetite





Risk Scores	Risk Appetite Level
15+	Hungry
10-12	Open
6-9	Cautious
4-5	Minimal
1-3	Averse

Risk Tolerance	
within tolerance	
outwith tolerance	

Board Assurance Framework Dashboard

Strategic Risk	Risk Title	Exec Lead	Initial Score	Jan-22	Apr-22	Jul-22	Oct-22	Jan-23	Jun-23	Target
Risk Detail			Score Trend							
POPULATION - Improving the health and wellbeing of the population we serve										
BAF 1	The impact on service delivery as a result of Covid, impacting on the ability to recover activity to pre-Covid levels. Risk of delay to treatments, impact on quality of care and performance	Chief Operating Officer	15	12	20	20	12	12	8	8
BAF 2	The scale of and demand for certain Specialist or Sub-Specialty services provided at SFT are not compatible with long-term sustainability. This confers a risk that patients will not have access to either a quality service or a local service.	Chief Medical Officer	15	10	10	10	10	10	10	8
BAF 3	Lack of capability and capacity to deliver the digital strategy, resulting in poor quality services, reputational damage and inability to attract and retain high quality staff.	Chief Digital Officer	16	12	12	12	12	12	12	9
BAF 4	Risks associated with critical plant and building infrastructure that may result in utility or system failure impacting on service delivery.	Chief Executive Officer / Director of estates	12	16	16	16	16	16	16	8
BAF 8	Demand for services that outweighs capacity, resulting in an increased risk to patient safety, quality, and effectiveness of patient care.	Chief Operating Officer	20			20	20	20	16	9
People - Supporting our people to make Salisbury NHS Foundation Trust the best place to work										
BAF 5	As a result of inadequate nursing staff and additional open capacity there is a risk of poor quality of care and poor patient experience.	Chief Nursing Officer	20			20	20	25	20	9
BAF 7	Inability to effectively plan for, recruit and retain staff with the right skills which will impact staff experience, morale and well-being which can result in an adverse impact on patient care.	Chief People Officer	20			20	20	20	16	9

Risk Score Key

Low Risk 1-3
Moderate Risk 4-6
High Risk 8-12
Extreme Risk 15-25

Board Assurance Framework Dashboard Cont.

Strategic Risk	Risk Title	Exec Lead	Initial Score	Jan-22	Apr-22	Jul-22	Oct-22	Jan-23	Jun-23	Target
BAF 6	Lack of a National clear model for small rural DGH services places future strategic planning uncertainty at SFT.	Chief Finance Officer	12	8	8	8	8	8	8	6
BAF 9	An irreversible inability to reduce the scale of financial deficit	Chief Finance Officer	12			12	16	16	16	9
BAF 10	Failure to establish and maintain effective partnerships to support the Integrated Care System with the potential to impact the Trust at PLACE level.	Chief executive Officer/ Chief Operating Officer	9			9	9	9	9	6
BAF 11	Significant failure of supply chain which could result in substantial or prolonged disruption to services.	Chief Finance Officer	12			12	12	12	12	9
BAF 12	Risk of sustained deterioration across key performance metrics (new risk)	Chief Operating Officer	16				16	16	12	9

Risk Score Key

Low Risk 1-3
Moderate Risk 4-6
High Risk 8-12
Extreme Risk 15-25

BAF Risk 1	The impact on service delivery as a result of respiratory viruses , impacting on the ability to delivery activity to pre-19/20 levels. Risk of delay to treatments, impact on quality of care and performance		
Strategic Priority	**Population**		
Linked Corporate Risks	6570		
Executive Lead	Chief Operating Officer		
Lead Committee	Finance and Performance		
Risk Type	Covid Recovery	**Risk Appetite/Tolerance**	**Open**

Risk Score 2022/23									
Initial Score	July 21	Sept 21	Jan 22	April 22	July 22	Oct 22	Jan 23	June 23	Target score
15	16	12	12	20	20	12	12	8	8

Context	Controls/ Assurance
The potential increase in respiratory outbreaks (e.g. Covid, Flu, RSV) has an ongoing impact on the Trust's ability to operate effectively and efficiently. The impact of increases in respiratory viruses impacts on the staffing levels across the organisation, the numbers of patients admitted to hospital, the types of beds and need to segregate for infection control purposes and the length of stay. All of which impact on the quality of care across the whole organisation and the impact on bed occupancy. High levels of bed occupancy impact the ability to deliver planned care and subsequently increase waiting times.	Vaccination programme for staff and patients Infection control protocols for management of outbreaks Escalation capacity for both ITU and ward beds Monitoring/prediction of outbreak information EPRR Planned care monitoring

Progress

What is going well/ Future Opportunities?	What are the current challenges including future risks?	How are these challenges being managed?
Respiratory infections steady state Escalation protocols in place across Trust to mitigate bed capacity shortfalls Infection control guidance to minimise outbreaks and manage patients effectively. Bed model in place to help anticipate bed capacity requirements and use as modelling tool to plan scenarios.	Bed occupancy high therefore the ability to cope with outbreaks and continue normal planned activity is challenging. Staffing levels remain significant concern during times of outbreak due to impact on community and patients. Ongoing recruitment and retention plans underway. Trust reliant on external partners response to reducing NCTR to help mitigate bed occupancy pressures.	Planned and urgent care boards in SFT BSW urgent and Emergency Care BSW infection and prevention controls in Care homes Implementation of the People Promise to improve recruitment and retention.

BAF Risk 2	The scale of and demand for certain Specialist or Sub-Specialty services provided at SFT are not compatible with long-term sustainability. This confers a risk that patients will not have access to either a quality service or a local service.		
Strategic Priority	Population		
Linked Corporate Risks	5704, 6836		
Executive Lead	Chief Medical Officer		
Lead Committee	Finance and Performance		
Risk Type	Innovation	**Risk Appetite / tolerance**	**Open**

Risk Score 2022/23

Initial Score	July 21	Sept 21	Jan 22	April 22	July 22	Oct 22	Jan 23	June 23	Target Score
15	10	10	10	10	10	10	10	10	8

Context

Increasing public professional and regulatory requirements resulting in sub-specialisation which is resource intensive and difficult to provide in a Trust of this size.

The 3 most vulnerable specialties include GI, dermatology and the sleep service.

Controls/Assurance

Trust contribution into the AHA clinical strategy moved to implementation phase with set up of oversight Board chaired by the CMO.
Dermatology mutual aid agreement with RUH
GI bleed service being managed in partnership with Bournemouth (UHD)
Reconfiguration of sleep services across BSW – agreed clinical model presented to the AHA Programme Executive. Agreement to proceed to full business case.

Progress

What is going well/ Future Opportunities?	What are the current challenges including future risks?	How are these challenges being managed?
Acute Hospital Alliance clinical strategy is developed specifically looking at small for scale services and the opportunity for cross organisational working or service reconfiguration to support sustainability Recruitment of an Associate Director of Strategy successful – commenced in post December 22.	Pace of change required for large scale reconfiguration Current fragile services could be at risk of regulatory enforcement action. Risk that patients will not have access to state of the art services Current substantive workforce gap in GI Medicine precludes on site GI bleed service. Lack of capacity in the sleep service to meet demand	Clinical governance processes ensure minimum safe standards are maintained. AHA clinical strategy work being led by Chief Medical Officer. External medical workforce and model of care commissioned for completion by end of January 2023. GI bleed service being managed in partnership with Bournemouth (UHD) Trust leading on Reconfiguration of sleep services across BSW

BAF Risk 3	Non delivery of programmes within the Digital Plan could result in poor quality services, reputational damage and inability to attract and retain high quality staff		
Strategic Priority	Population		
Linked Corporate Risks	5360 (Cyber)		
Executive Lead	Chief Digital Officer		
Lead Committee	Finance and Performance		
Risk Type	Infrastructure	**Risk Appetite / tolerance**	**Open**

Risk Score 2022/23

Initial Score	July 21	Sept 21	Jan 22	April 22	July 22	Oct 22	Jan 23	June 23	Target Score
16	16	12	12	12	12	12	12	12	9

Context

The Trust is digitally immature when benchmarked nationally. The Trust's digital plan sets out a significant agenda to improve integration of systems, maximise the existing Electronic Patient Record (EPR) whilst working towards a more sustainable longer term joint approach across the ICS, expanding the use of data and ensuring we have infrastructure that enables us to effective use technology and stay safe.
As technology touches on most transformation programmes, there is insufficient capacity and funding to deliver all that is asked with our appropriate prioritisation. This constraint risks the Trust not being able to maintain all desired level of improvements alongside participating in all local and regional initiatives with peers. Anticipated to meet the target score of 9 from January 2024.

Controls/ Assurance

Digital Steering Group in place with robust digital governance below this, including programme governance.
BSW shared EPR programme board in place.
Clinical digital leadership in place including CCIO, CNIO, MIOs and Digital Midwife.
Digital Innovation Launched to increase digital profile including digital champions and digital superusers to support change and ownership.
Cyber security team set up within IT Operational to manage cyber risk mitigation activities.
Joint CDO, CIO and Deputy CIO roles across SFT & GWH.

Progress

What is going well/ Future Opportunities?	What are the current challenges including future risks?	How are these challenges being managed?
EPMA implementation on track for completion by Sept 2023. Refreshed Digital Plan approved at Trust Board in November 2022. Shared EPR OBC approved, Preferred Bidder selected in December 2022. FBC going through approval governance in June/July 2023. Leadership strengthened with introduction of joint CIO and Deputy CIO roles across SFT and GWH.	1. Some infrastructure hardware procurement delays remain globally. 2. Funding for new shared EPR not confirmed until Full Business Case is developed and approved. 3. There remains a large agenda of projects with a digital component which are not resourced, funded or prioritised. 4. Some digital programmes are behind original plans. 5. Lack of funding to deliver full Digital Plan including removing all unsupported technologies. 6. Clinical engagement is limited due to operational pressures.	1. Reprioritisation of existing infrastructure stock usage to help deliver programmes as quickly as possible. 2. Informal funding commitment from NHSE/I. Routine updates with NHSE/I region to resolve emerging concerns. 3. Prioritisation of programmes through Corporate Projects Prioritisation Group. Discussion planned to consider impact EPR programme will have on wider transformation plans. 4. Programmes are rebased as part of existing programme governance and strong PMB challenge on delivering against this rebased targets in place. Risk mitigations put in place where appropriate. 5. Seeking opportunities for national funding to support programmes 6. Clinical leads supporting identifying champions for key activities (Shared EPR, implementation activities). Implementing new communication software to support different digital communication methods.

BAF Risk 4	Risks associated with critical plant and building infrastructure that may result in utility or system failure impacting on service delivery.		
Strategic Priority	Population		
Linked Corporate Risks	7573		
Executive Lead	CEO/ Director of Estates		
Lead Committee	Finance and Performance		
Risk Type	Infrastructure	**Risk Appetite/Tolerance**	**Open**

Risk Score 2022/23

Initial Score	July 21	Sept 21	Jan 22	April 22	July 22	Oct 22	Jan 23	June 23	Target Score
12	16	16	16	16	16	16	16	16	8

Context

SFT has a substantial estates backlog (£75.2m – 2023) which impacts service delivery, quality of estate and public/patient experience. Limitations via CDEL and lack of investment capital impact the Trust ability to reduce the estates backlog and creates a corresponding increase in Trust risks; costs to operate and maintain the existing estate, likelihood of future infrastructure and estate failures, compromised service delivery and patient care. Equally environmental sustainability investment is limited reducing the Trust ability to achieve net carbon zero.
Whilst National and/or targeted funding may become available, careful planning and prioritisation of requirements is essential yet remains consistently insufficient to make any marked progress in the reduction of long term risks, or exceed the inflationary rate of change to the backlog value. The clinical strategy and the estates strategy are key long term plans for the Trust evolution and delivery of effective and reliable services over the next 10 years (and beyond), but require significant investment to achieve.

Controls/ Assurance

A 6 Facet survey of the whole site was completed in 2022, providing an up to date and independent assessment of the campus in accordance with National guidance (NHS Estate Code).
The 6-facet data is reviewed annually and adjusted to reflect capital investment made in year and increases due to inflation. Last annual update May 2023 (revised data submitted to NHSEI for ERIC)
Significant improvements in estates governance and risk management introduced in last 12 months, including the 10 year capital programme compiled, with investment forecasts for estates backlog.
Quarterly estates reporting to Trust Board. Annual capital plan reviewed via Strategic Capital committee.
Internal audit on management of backlog maintenance completed in 2023 and recommendations being followed through.

Progress

What is going well/ Future Opportunities?

- 10 year capital programme compiled, includes investment forecast for estates backlog. Program subject to annual prioritisation process
- Additional elective ward mobilised (replaces poor condition estate)
- Estates strategy renewal, mobilised with procurement underway, Target completion May 2024.
- Estates compliance status clearly recorded. 2022-23 targets achieved. Continued progress to mitigate and conclude compliance actions for 2023-24 year end.
- Estates strategy update will incorporate Campus project for long term development
- Successful bid for national investment to begin decarbonisation of energy infrastructure, £10m for 2023/24, further bids to be submitted for future years.
- Completion of DAC refurbishment to increase space available and permit wider Trust decants

What are the current challenges including future risks?

- Insufficient capital. Inflation pressures alone continue to significantly increase backlog value year-on-year
- Competing demands for Trust capital each year.
- Estates backlog value (£75.2m) is not actual cost to deliver (due to Estate code national reporting methodology). Likely value £120.3m
- Limited electrical infrastructure on campus impacting future redevelopment opportunities
- Current decarbonisation (Salix) investment does not encompass whole site. Further investment required to realise decarbonisation. Decarbonisation strategy reduces fossil fuel use but increases electrical demand which is a higher cost, Trust utility costs will rise as we become more environmentally sustainable.
- Lack of adequate investment means infrastructure continues to degrade – level of backlog maintenance increases. Cost to maintain Trust estates and infrastructure increases.
- Day surgery unit remains Trust highest priority, with no funding source available.
- Aged areas of the Estate are not fit for purpose or occupation (SFT South and central) but require investment for continued use and are at higher risk of failure.
- Trust ‘space’ is in high demand and appetite to remove poor quality buildings challenged with space use.
- Clinical strategy limitations inhibit the estates strategy.
- National targeted resources do not address key resilience issues
- Patient environment quality being compromised e.g., spinal unit
- Quality of on-site residential accommodation poor with little investment

How are these challenges being managed?

- Categorisation and prioritisation of Trust capital. Review and prioritisation within Trust framework (alongside digital, medical equipment etc)
- Continued lobbying for major service developments – DSU
- Funding applications made for environmental sustainability and energy decarbonisation (e.g. Salix)
- Estate’s strategy procurement documents mobilised
- Board paper planned to present options for on-site residential accommodation
- Investigations into strategic partnership models to allow development and investment of the estate.
- Monthly meetings with regional NHSEI colleagues to highlight priorities and risks
- Continued review of poor quality accommodation use, identifying opportunities to vacate (e.g remove and dispose archive material) with potential to demolish and remove risk
- Increased scrutiny of estate requests via space allocation committee. Management of space utilisation ‘creep’

BAF Risk 5	As a result of inadequate nursing staff and additional open capacity there is a risk of poor quality of care and poor patient experience.		
Strategic Priority	People		
Linked Corporate Risks	5704, 7039, 6143, 7472, 6954, 7516		
Executive Lead	Chief Nursing Officer		
Lead Committee	People and Culture Committee		
Risk Type	Capability and skills	**Risk Appetite / tolerance**	**Open**

Risk Score 2022/23

Initial Score	July 21	Sept 21	Jan 22	April 22	July 22	Oct 22	Jan 23	June 23	Target score
20					20	20	25	20	9

Context

Due to the number of RN vacancies, and overall unavailability, staffing levels are challenging at times. This is contributing to an overall poor experience for staff and patients, contributing to increased sickness and increased turnover. Potential ongoing strike action will impact this further.
CHPPD has improved. This position overall has improved due to significant HCA recruitment however, this poses ongoing skillmix challenges given the RN vacancies and new to care HCAs.
Maternity leave is high
Morale is improving but strike action and Covid legacy still impacting
Heavy reliance on RMN due to MH needs and unavailability of specialised MH beds. In addition, use of specials for complex patients
NCTR high on avg >100 patients
Agency spend remains a financial challenge in relation to RMN and RN usage
OSCE nurses taking longer to convert since the change to external training provider (from internal provision)
Inability to close additional capacity

Controls/ Assurance

3 x daily staffing meetings and early escalation to agency
Monthly safer staffing meeting
Recruitment events
Block booking and use of bank staff
Apprenticeship to Registered Nurse in place (limited funding)
Successful overseas and HCA recruitment
HCA away days to boost retention
HCA rebanding completed
Revised HCA induction and competencies
Risk assessments and SOP in place for boarding

Progress

What is going well/ Future Opportunities?	What are the current challenges including future risks?	How are these challenges being managed?
Registered nurse recruitment ongoing. Additional bid for an additional 40 RNs to NHSE HCA Apprenticeships including Maths and English to attract staff with low educational attainment. HCA support workers in place to support wellbeing and education OSCE support educators business case in progress Partnership working to review future workforce requirements and further opportunities	Overall vacancy rate for RNs and HCAs (63 HCA vacancies) Sickness absence rate increasing across RN and HCA. Staffing demand is likely to increase based on levels of NCTR and Bed capacity modelling which will increase required number of HCA and RN's Retention of current staff Deterioration in key quality metrics Inability to release staff for training Enacting boarding and reverse boarding to improve flow	Recruitment events ongoing Run HCA Recruitment event Revised induction for RNs New to Care HCA programme Utilising Improving Together methodology to focus on improvement areas. Active sickness management deep dive underway Ongoing focus on tissue viability and falls prevention management

BAF Risk 6	Lack of a National clear model for small rural DGH services places future strategic planning uncertainty at SFT.		
Strategic Priority	**Partnership**		
Linked Corporate Risks	6858		
Executive Lead	Chief Operating officer		
Lead Committee	Finance and Performance		
Risk Type	Integration & Partnership	**Risk Appetite / tolerance**	**Open**

Risk Score 2022/23

Initial Score	July 21	Sept 21	Jan 22	April 22	July 22	Oct 22	Jan 23	June 23	Target score
12	8	8	8	8	8	8	8	8	6

Context

There is a risk that smaller non specialist acute providers operate at too small a scale to be financially sustainable - whilst providing a high quality of care. International policy changes have seen attempts to rationalise care, consolidating services at larger hospitals which serve more densely populated areas.

Without a national policy recognising specifically the challenges of smaller hospitals there is a risk that a one size all fits payment regime and policy approach (particularly clinical standards) fails to recognise the significant challenges in achieving high quality service delivery at scale, addressing sub specialty challenges and meeting recruitment and retention challenges.

Controls/ Assurance

Partnership working with Acute Alliance on shared back-office functions to reduce cost.

Working with partners on wider partnerships e.g., Pathology south Six, radiology network.

Working in hub and spoke models for clinical services to mitigate risk.

Progress

What is going well/ Future Opportunities?	What are the current challenges including future risks?	How are these challenges being managed?
Move of specialist commissioning services to ICB will allow more flexible approach to service delivery models. Looking at technology to enable recruitment and retention e.g. robotic surgery. AHA rolling programme of deep dives by specialty	Cost of 7 day a week services shows high cost for level of patient numbers. Lack of fully developed ICB financial recovery plan addressing underlying deficit. Lack of national change in funding regime to reflect rurality and size of organisation. further work required to influence tariff developments.	Partnership working with Acute Alliance on shared back-office functions to reduce cost. Working with partners on wider partnerships e.g., Pathology south Six, radiology network. Working in hub and spoke models for clinical services to mitigate risk. Use of technology to support service delivery

BAF Risk 7	Inability to effectively plan for, recruit and retain staff with the right skills which will impact staff experience, morale and well-being which can result in an adverse impact on patient care.		
Strategic Priority	**People**		
Linked Corporate Risks	5704, 7039, 6143, 6954, 7472		
Executive Lead	Chief People Officer		
Lead Committee	People and Culture Committee		
Risk Type	Capability and Skills	**Risk Appetite / tolerance**	**Open**

Risk Score 2022/23

Initial Score	July 21	Sept 21	Jan 22	April 22	July 22	Oct 22	Jan 23	June 23	Target Score
20					20	20	20	16	12

Context

12-month Turnover of 14.44% (April 23) against 10% target
Vacancy rate 8.5% (April 23)
Sickness absence 3.84% (April 23) – below 4% target for first time in 12 months
Trust compliance is 88.5% (April 23) for staff mandatory training (target 90%).
Non-medical appraisal rate is 60.8% (target 86%) / medical appraisal rate 85.4% (target 90%) (April 23)
National Pay award and negative impact on specific staff groups
Staff perception of insufficient focus on well-being, low appraisal, training and career opportunity
Exemplar site for the People Promise
There is a National shortage of workforce across a range of professions and BSW mirror the National picture. Attraction to geographical area through recruitment and retention premia, Golden Handshake welcome payment, offer of relocation payment and re-launched 'Refer a friend scheme'.
National Industrial Action despite implementation of the national pay award

Controls/ Assurance

Workforce Control Panel overseeing vacancies
Financial recovery programme includes 6 workforce interventions including establishment control
Exit interview process re-established
International RN and Midwife recruitment
HCA recruitment and retention facilitator in post
Staff availability now a breakthrough objective with clear focus
Appointment of a Health and wellbeing facilitator
All OD&P policies reviewed and ratified
Workstreams for all 7 elements of the People Promise benchmarked against staff survey
Newly established leadership development programme plus a proposed people management skills modular programme
Newly appointed Head of EDI and Wellbeing
Lifted all Band 2 hourly rate to real living wage rate
All clinical HCAs Band 2 moved to Band 3

Progress

What is going well/ Future Opportunities?	What are the current challenges including future risks?	How are these challenges being managed?
Recruitment & attraction process and practices overhaul in conjunction with PWC – implementation phase near completion. Focussed recruitment campaign for HCA, porters and housekeeping Student reservist campaign Launch of the wellbeing champion & the financial wellbeing hub Reviewing approach to training needs analysis – appointed to Head of Clinical Learning Launching wellbeing survey	Recruitment to Associate Director of Leadership and Training Understanding reasons for staff leaving Manager's capacity to manage staff absence due to operational pressures. Lack of management time from operational pressures to undertake appraisals. Lack of Strategic workforce planner	Exploring interim opportunity Exit interview process relaunched through ESR. Pilot of HR employee relations advisor supporting ward based areas with high absence Revised appraisal form and process launched in June 23 Out to advert for strategic workforce planning post

BAF Risk 8	Demand for services that outweighs capacity, resulting in an increased risk to patient safety, quality, and effectiveness of patient care.		
Strategic Priority	Population		
Linked Corporate Risks	5751, 6143, 7574, 7516		
Executive Lead	Chief Operating Officer		
Lead Committee	Finance and Performance		
Risk Type	Capacity	Risk Appetite / tolerance	Open

Risk Score 2022/23

Initial Score	July 21	Sept 21	Jan 22	April 22	July 22	Oct 22	Jan 23	June 23	Target score
20					20	20	20	16	9

Context

Our operational context remains challenging with escalation beds , demand for urgent services consistently pressurised, the on-going need to deliver elective recovery and staff availability day to day creating significant pressure for the teams. The continued use of escalation capacity compromises efficiency and effectiveness of the operational flow and compromises patient care.

Despite the challenges our elective recovery is currently on track in respect of delivering the headline requirements for waiting times i.e., no patients waiting over 104 weeks for care by end of July, continued reduction in those waiting over 78 and 52 weeks respectively. The underlying constraint is insufficient capacity in respect of the skilled workforce required alongside system wide change to respond to an aging population .

Controls/ Assurance

- 52/78 week performance is on trajectory
- BSW Virtual ward and care co-ordination centre
- Outsourcing arrangement for additional capacity in pathology, theatres and radiology.

Progress

What is going well/ Future Opportunities?	What are the current challenges including future risks?	How are these challenges being managed?
Trust internal programme to reduce bed occupancy including implementation of SDEC, developing new frailty pathways and improving discharge processes through a new discharge hub. ED improvement work ongoing with ECIST support to identify new opportunities to improve workforce offer.	The time it takes for Patients to flow out of ED Increasing NCTR bed occupancy as a result of insufficient community care provision and pathway reconfiguration Theatre staffing and recruitment challenges Continued escalation into DSU compromising surgery rates Outpatient waits not reducing in line with expectations – further improvement work targeted to reduce follow up's increase PIFU and improve pathways for patients	Recruitment into vacant nursing, medical and admin posts in ED ongoing. Theatre productivity improvement programme – linking into Planned Care Board urgent care board to oversee transformation Programme Daily focus on site flow to maximise bed efficiency ED Huddle

BAF Risk 9	An irreversible inability to reduce the scale of financial deficit		
Strategic Priority	Partnership		
Linked Corporate Risks	6857, 7308		
Executive Lead	Chief Finance Officer		
Lead Committee	Finance and Performance		
Risk Type	Finance	**Risk Appetite / tolerance**	Open

Risk Score 2022/23

Initial Score	July 21	Sept 21	Jan 22	April 22	July 22	Oct 22	Jan 23	June 23	Target Score
12					12	16	16	16	9

Context

The Trust has had an underlying deficit greater than 5% of turnover for a number of years. This has led the Trust to be disadvantaged in terms of capital spend due to managing cash flows. Restricted capital expenditure limit is compounded by GWH PFI impact on system allocation.
The financial position emerging from Covid remains with SFT being in material deficit. This position has deteriorated and despite increased funding, SFT remains challenged particularly due to high numbers of patients waiting for onward packages of care. The Trust is not alone with BSW ICS reporting an underlying deficit relative to allocation funding.
The inability to deliver a breakeven position risks the ability to deliver safe and effective care and or regulatory action associated with breach of license conditions.

Controls/ Assurance

Ongoing discussions to agree the distribution of centrally held ICB funding by system Directors of Finance and People workstreams are focusing on retention of staff, with planned interventions ranging from the onboarding process through to retire and return conversations.
The BSW-wide procurement workplan levies the ICS spending power to mitigate the impact of inflation.
Breakthrough objective initiatives focus on patients no longer clinically requiring an acute hospital bed, as well as fall reduction, in order to reduce the demand on the Trust's bed base.

Progress

What is going well/ Future Opportunities?	What are the current challenges including future risks?	How are these challenges being managed?
Focus on increase in productivity to mitigate further decline in financial position and maximise opportunities for ERF. Acute Alliance programme of benchmarking to identify opportunities.	Identifying CIP plans in context of significant operational challenges. Increasing proportion of savings programme will have to be delivered through clinical service transformation. Adequate cash reserves to service capital programme Medium term financial outlook is uncertain Long term capital programme needs to be assessed against available CDEL and additional funding sources. BSW transformation programme immature and not fully developed.	Improving together programme improving a structured approach to change. Working with ICS to develop BSW sustainability programme. Development of CIP teams within corporate and divisional teams Oversight on delivery of CIP through the Financial Recovery Group Cash flow monitoring and NHSE support in place if required.

BAF Risk 10	Failure to establish and maintain effective partnerships to support the Integrated Care System with the potential to impact the Trust at PLACE level.		
Strategic Priority	**Partnership**		
Linked Corporate Risks	6858		
Executive Lead	Chief Executive Officer/ Chief Operating Officer		
Lead Committee	Finance and Performance		
Risk Type	Integration & Partnership	**Risk Appetite / tolerance**	Open

Risk Score 2022/23

Initial Score	July 21	Sept 21	Jan 22	April 22	July 22	Oct 22	Jan 23	June 23	Target Score
9					9	9	9	9	6

Context

The Integrated Care Alliance is in early stages of development alongside recruitment of new members to the ICB. In turn this places risk to how quickly trusted successful partnership working can enable service integration and delivery.

Without partnership working one of SFT's strategic aims of integrating care and partnership working is compromised leading to disjointed services for patients.

The Community services tender is expected to run during the next twelve months which has a strategic impact on the ability to develop integrated services locally for SFT.

Controls/ Assurance

ICB with SFT representation
Established AHA with SFT representation
SFT executive representation within ICS workstreams

Progress

What is going well/ Future Opportunities?	What are the current challenges including future risks?	How are these challenges being managed?
ICB board now recruited and permanent members of team now in place. Work with the Acute Hospital Alliance continues to develop and gather momentum. Acute Alliance Clinical strategy Elective and Urgent care well established forums	The immaturity of the ICB and ICB policies and strategy could result in a lack of understanding of roles and responsibilities and response to critical operational challenges Place based working still in infancy, further work to progress placed based strategy for integrated care, particularly with community services	The Trust is represented at appropriate meetings at PLACE, Acute Providers and the ICS

BAF Risk 11	Significant failure of supply chain which could result in substantial or prolonged disruption to services.		
Strategic Priority	**Population**		
Linked Corporate Risks	Nil		
Executive Lead	Chief Finance Officer		
Lead Committee	Finance and Performance		
Risk Type	Covid Recovery	**Risk Appetite / tolerance**	Open

Risk Score 2022/23

Initial Score	July 21	Sept 21	Jan 22	April 22	July 22	Oct 22	Jan 23	June 23	Target score
12					12	12	12	12	9

Context

The Supply Chain service at SFT has been disrupted from global supply issues which have led to considerable challenges across various product ranges over the past 2 years. These global issues of supply are against a back drop of the UK exiting from the EU and commodity pricing increasing and global economic challenges with currency.

There are significant risks to service delivery due to a shortage and/or distribution challenges, with a large number of clinical and digital supplies. This currently is manifesting through a global shortage of digital component parts impacting digital project lead in times of over six months. This is impacting services like sleep apnoea where distribution of machines is severely disrupted leaving longer patient waiting times.

Controls/ Assurance

Focus on inventory management
Reallocation of procurement staff to work on supply disruption
Investment in niche solutions to digitise aspects of the supply chain increasing resilience

Progress

What is going well/ Future Opportunities?	What are the current challenges including future risks?	How are these challenges being managed?
Procurement monitoring of supply chain and alerting early to significant issues.	Patient waiting times increasing due to equipment shortfalls Lead in times for digital and estates projects delayed due to component parts delayed	Procurement managing product substitutions Project planning identifying key digital infrastructure inputs. Supply chain monitoring through procurement systems Communication to staff where supply chain is disrupted

BAF Risk 12	Risk of sustained deterioration across key performance metrics		
Strategic Priority	**Population**		
Linked Corporate Risks	5751, 7573, 7574		
Executive Lead	Lisa Thomas, Chief operating Officer		
Lead Committee	Finance and Performance		
Risk Type	Covid Recovery	**Risk Appetite / tolerance**	**Open**

Risk Score 2022/23

Initial Score	Sept 21	Jan 22	April 22	July 22	Oct 22	Jan 23	June 23	Target score
16					16	16	12	9

Context

Due to significant gaps in workforce across a number of functions (e.g Theatres, Diagnostics, central booking) alongside demand being greater than capacity, key performance and quality metrics are showing sustained deterioration.

Slow improvement in DM01, cancer, theatre productivity and less occupied beds showing some improvement since January 2023

Controls/ Assurance

- 52/78 week performance is on trajectory
- BSW Virtual ward and care co-ordination centre
- Outsourcing arrangement for additional capacity in pathology, theatres and radiology.
- Planned care and urgent Care boards being established

Progress

What is going well/ Future Opportunities?	What are the current challenges including future risks?	How are these challenges being managed?
- BSW plan for 57 additional beds in community - BSW Virtual ward and care co-ordination centre - Outsourcing arrangement for additional capacity in pathology, theatres and radiology.	• Financial position of Councils impacting on out of hospital/care capacity. • Lack of specialist skilled staff to reduce patient waiting times in specific specialities (e.g cardiac Echo). • Number of Patients waiting for planned treatment is increasing • Cancer performance targets (particularly 62 day standard) is deteriorating • No reduction in NCTR (reduction expected from system plans) • Quality metrics e.g. Stroke, pressure ulcers deteriorating • Bed occupancy is increasing (beyond efficient bed base)	- Improved governance processes for oversight of performance (delivery group. Cancer improvement group) - Hard to recruit plan in place linked to People Plan. - Planned Care and Urgent Care SFT Boards in place to support transformation - BSW Urgent care and Planned care boards well established to help support delivery.

ID	Directorate	Location (exact)	Opened	Source of Risk	Rating (initial)	Description	Likelihood (current)	Consequence (current)	Rating (current)	Actions	Action Due Date	Action Done Date	Action Lead	Source of Review	Review Date	Rating (target)	Assurance Framework link (AF Risk Ref)	Assurance Committee	Executive Lead	Risk Owner	Date Escalated to Corporate Risk
6836	Women and Newborn Division	Neonatal Unit	24/02/2021	Directorate risk assessment	12	There is a risk that the re-designation of the neonatal intensive care unit will result in families needing to receive intensive care (or any care when the baby is under a specific gestation) in Neonatal units across the region and not local to Salisbury or Wiltshire. This will have an impact on quality and safety for families.	Will undoubtedly recur, possibly frequently	None	5	SFT NICU Service designation strategy to be completed to ensure patient safety following re-designation.	26/02/2021	01/09/2021	Boyd, Hannah	Trust Board	01/07/2023	2	Care	Trust Board (Corporate Risk Register)	Chief Medical Officer	Kingston, Miss Abigail	24/02/2021
										Finance review of re-designation NICU. To include 3 scenarios. 27 week's, 32 week and 34 weeks gestation To include income related to births.	30/09/2021	28/09/2021	Boyd, Hannah								
										Review of impact to clinical Income to the organisation if redesignation process proceeds with the DoF.	21/01/2022	25/03/2022	Boyd, Hannah								
										Division to work on scenario options to help Trust better understand the implications to local population of any proposed changes.	31/07/2023		Kingston, Miss Abigail								
7078	Transformation & IM&T	Trust Offices	12/10/2021	Trusts Objectives	12	As a result of competing priorities and deliverables there is a risk of slippage of the Improving Together work programme deadlines	Do not expect it to happen again but it is possible	Moderate	6	Use of existing PMB groups to address issues on A3 content	22/11/2021	14/01/2022	Cox, Emma	Executive Director Meeting	31/08/2023	6	People	Trust Board (Corporate Risk Register)	Chief Medical Officer	Talbott, Alex	13/10/2021
										SRO leads to prioritise the work and engage with specific task and finish groups	30/11/2021	14/01/2022	Cox, Emma								
										Executive to agree new road map by end of July.	31/07/2022	31/10/2022	Provins, Esther (Inactive User)								
										Commence recruitment for Programme Director.	30/08/2022	29/12/2022	Collins, Peter								
										Sustainability workshop completed with Execs and KPMG. Produced roadmap and key area of priorities and assumption in the next 18 months. Detailed roadmaps and requirements to be presented to the Improving Together Programme Board in March 2023.	20/03/2023	09/06/2023	Cox, Emma								
6857	Finance and Procurement	Trustwide	12/03/2021	Financial management	6	There is a risk that weaknesses in controls give rise to an opportunity for fraud, in turn meaning the Trust incurs financial losses.	Will probably recur, but is not a persistent issue	Minor	8	continue programme of fraud awareness and prevention with Counter Fraud team	31/03/2022	13/04/2022	Thomas, Lisa	Departmental Team meeting	30/09/2023	8	Resources	Trust Board (Corporate Risk Register)	Director of Finance	Ellis, Mark	12/03/2021
										Address the drivers of fraud- financial wellbeing of staff	30/06/2022	21/06/2022	Thomas, Lisa								
6858	Finance and Procurement	Trustwide	12/03/2021	Trusts Objectives	9	There is a risk as new guidance and models of working emerge the immaturity of partnerships between SFT and wider BSW organisations will impact on progress to achieve key objectives. With the delay to the ICS formal start date and a double running with ICB's this may delay progress in system transformation.	May recur occasionally	Moderate	9	Executive team participate in Place based leadership development within the ICS to help shape collaborative arrangements. workshop 13th July	31/08/2021	12/10/2021	Thomas, Lisa	Trust Board	29/09/2023	6		Trust Board (Corporate Risk Register)	Chief Operating Officer	Thomas, Lisa	12/03/2021
										Trust developing committee in common with Acute Alliance - progress towards provider collaborative in line with national guidance	31/12/2021	11/01/2022	Thomas, Lisa								
										Trust to work in partnership with new emerging leadership structure to develop transformation plans to meet national operating targets.	31/03/2023	13/06/2023	Thomas, Lisa								
6570	Quality Directorate	Trustwide	15/07/2020	COVID-19/Coronavirus	15	As a result of the fact that the highly contagious Covid, flu, and RSV variants are still circulating within the community, there is a risk that an outbreak of one of these could occur within the Trust either for staff and/or patients. This may result in patient and/or staff sickness and potential mortality.	May recur occasionally	Moderate	9	COVID positive cohort wards to have daily COVID-19 inspections on PWA, all other wards weekly to be implemented by HoN and Matrons.	29/01/2021	22/01/2021	Major, Denise (Inactive User)	Infection Prevention and Control Committee	31/12/2023	9	Care	Trust Board (Corporate Risk Register)	Director of Nursing	Hyett, Fiona	15/01/2021
										The IT support for data to support swabbing dates being more easily accessed.	16/06/2021	05/05/2021	Burwell, Jonathan								
										Outbreak review to be undertaken and SII to be completed.	30/09/2021	01/09/2021	Major, Denise (Inactive User)								
										SJR of all patient that died of Covid to be undertaken and report completed.	30/09/2021	17/01/2022	Cornforth, Dr Belinda								
										Completion and approval of action cards to facilitate reduction in contact period of exposed patients and mixing of contacts	14/01/2022	13/01/2022	Major, Denise (Inactive User)								
										Ongoing review at daily VBR of increasing and emerging potential transmission.	14/02/2022	14/02/2022	Major, Denise (Inactive User)								
										Continue to adhere to national IPC guidance, enhanced cleaning and monitoring using the Tenable audit tool. Daily outbreak meetings.	01/09/2022	21/12/2022	Dyos, Judy								
										Trust compliance is assessed on an add hoc basis by Health & Safety. Yearly corporate and self assessment audits are conducted in 2 clinical and 2 non-clinical	01/10/2019	08/02/2021	Knight, Paul (Inactive								

508	Organisational Development and People	Trustwide	21/11/2002	Other assurance not listed	8	The absence of a comprehensive Health and Safety Management System for the Trust runs the risk that legislative requirements will not be embedded into the Trust standards to which departments are expected to work. Without those standards, we cannot expect the Trust be be compliant, so the consequences of non-compliance with health and safety law results in Staff and all persons on site at risk of harm and the Trust at risk of prosecution and claims.	May recur occasionally	Moderate	9	areas. Compliance results are reported to the H&S Committee, the Workforce Committee and then onto the board.	01/10/2019	08/02/2021	(Inactive User)	Health and Safety Committee	31/03/2024	6	People	Trust Board (Corporate Risk Register)	Director of Organisational Development and People	Ready, Troy	06/04/2022
										Reviewed the scope of the risk assessment and have not found any significant gaps in our provision of health & safety instruction, training and baseline support.	20/07/2022	06/10/2022	Adams, Peter (Inactive User)									
										5/5/22 Recruit permanent H&S Manager. Transparent escalation and communication of the risk in the first instance is intended to draw attention to the work required to create a comprehensive H&S Management System. Recruitment of a permanent H&S Manager is underway whose task it will be to determine the long-term resources required to deliver and maintain (i) the polices and standards that define how the Trust will address H&S compliance, and (ii) the form of the audit system that will measure the gaps between the legal requirements and the Trust's policies and standards; and the gaps between those policies & standards and their implementation by divisions and directorates. In addition the H&S Management system requires support of divisions and directorates in activities such as: H&S Training; risk assessment; and accident investigation; and the administration and contribution to corporate governance activity through the provision of data dashboards, performance reports, attendance and contribution to H&S committee & sub-committees and escalation reports	01/08/2022	07/09/2022	Adams, Peter (Inactive User)									

										The polices and standards required by H&S legislation have been identified and a plan of work is being drawn up to resource their implementation, estimated 47 documents requiring 70 days' work. Auditing of activities to assess implementation of legislative requirements is underway and upon the arrival of the new H&S Manager on 1/8/22 a long-term scheme of audit will be devised. Recruitment of a H&S Adviser is underway and consideration of how to resource policy and audit workload in the long term will be led by the H&S Manager.	30/12/2022	06/10/2022	Adams, Peter (Inactive User)									
										7 policies approved by OMB 19/7/22	19/07/2022	19/07/2022	Adams, Peter (Inactive User)									
										Create a H&SMS that provides measurement, audit and assurance to the Trust Board	30/12/2022	07/06/2023	Ready, Troy									
										Review gaps in current H&S procedures and policies and update where required	30/12/2022		Ready, Troy									
5955	Finance and Procurement	Trustwide	13/08/2019	Trustwide risk assessment	15	Insufficiently robust management control procedures across the organisation which pose a financial, reputational, legal and operational/clinical risk.	May recur occasionally	Moderate	9	Reviewing Trust wide risk training, aiming to roll out programme to all middle managers	31/03/2020	17/06/2020	Thomas, Lisa	Trust Board	30/09/2023	9	Resources	Trust Board (Corporate Risk Register)	Director of Finance	Ellis, Mark	13/08/2019
										Process mapping underway for business critical controls	31/12/2019	16/12/2019	Thomas, Lisa									
										Trust identifying additional procurement training for those areas of non compliance across the organisation. New process targeting individuals starts in November 2019.	29/03/2020	17/06/2020	Willoughby, Kelly									
										Trust developed draft risk training specification for additional support for directorates- view to tender and award before December 2019.	31/12/2020	07/01/2021	Thomas, Lisa									
										Introduce a monthly informatics department management committee that feeds into monthly executive performance reviews	31/10/2019	18/10/2019	Burwell, Jonathan									
										Approval of IT General Controls plan at Informatics DMC and ratify at exec performance review	31/01/2020	02/03/2020	Scott, Andy									
										Approach to testing of backups agreed	20/03/2020	02/03/2020	Cowling, Andrew (Inactive User)									
										All IT system contracts reviewed with IAA and IAO confirmed and delivery of duties being monitored	31/12/2020	15/12/2020	Burwell, Jonathan									
										Full review of informatics standard operating procedures including putting in place monitoring processes	30/06/2022	06/01/2023	Scott, Andy									
										Full implementation of IT general controls framework	31/12/2021	12/03/2021	Scott, Andy									
										Complete a stocktake of all IT operational infrastructure	31/01/2020	02/03/2020	Burwell, Jonathan									
										Implement a robust asset management system	30/10/2020	01/07/2020	Burwell, Jonathan									
										Implement a centralised rolling replacement programme for computers, laptops and iPads	01/04/2020	28/04/2020	Burwell, Jonathan									
										Complete review of IT security policies	30/10/2021	09/12/2021	Burwell, Jonathan									
										Review of existing storage locations of Informatics SOPs to centralise and improve searchability though using modern software such as CITO or Sharepoint	31/08/2021	16/08/2021	Burwell, Jonathan									
										Embed improving together methodology in performance review reporting structure.	31/01/2023	04/05/2023	Ellis, Mark									

5972	Transformation & IM&T	Trustwide	23/08/2019	Trusts Objectives	16	As a result of deeply rooted historic ways of working, resistance to change and the absence of a mature continuous improvement culture, there is a risk that improvement and transformation is not delivered in a timely manner. This may result in poor quality services, reputational damage, financial impact, ineffectiveness, an inability to attract and retain high quality staff and non-delivery of strategic and or corporate priorities.	May recur occasionally	Moderate	9	Review of role and purpose of Innovation Committee; develop a clear approach for innovation	13/12/2019	21/02/2020	Provins, Esther (Inactive User)	Trust Board	01/07/2023	6	Innovation (Resources)	Clinical Governance Committee, Trust Board (Corporate Risk Register), Workforce Committee	Chief Medical Officer	Collins, Peter	23/08/2019
												Introduce a Dragon's Den event to inspire, promote and reward innovation	30/07/2020	19/08/2020	Provins, Esther (Inactive User)							
												Develop a comms and engagement plan to promote innovation, linked to QI and continuous improvement	31/12/2019	11/12/2019	Provins, Esther (Inactive User)							
												Review effectiveness of Quality Improvement plan.	01/06/2020	19/08/2020	Provins, Esther (Inactive User)							
												Implement Quality Improvement plan (see also risk 6138).	31/03/2021	22/06/2021	Provins, Esther (Inactive User)							
												Finalising procurement of external support to develop a QI coach network.	31/10/2019	06/11/2019	Provins, Esther (Inactive User)							
												Develop a business case and procurement approach for an OD/Trust transformation intervention jointly with GWH.	31/03/2021	20/04/2021	Provins, Esther (Inactive User)							
												Strengthen capability and capacity of theatres operational staff; review benefits of this and whether it has mitigated the current risk	28/08/2020	03/09/2020	Hyett, Andy (Inactive User)							
												Escalate discussions with system partners regarding levels of DToCs. *Action covered by Corporate Risk 5751. Please see risk 5751*	31/12/2019	04/03/2020	Hyett, Andy (Inactive User)							
												Provide increased oversight of flow programme and links to Trust KPIs, in particular length of stay, as per GIRFT data pack received 10/12/19	28/08/2020	19/08/2020	Provins, Esther (Inactive User)							
												Review workforce transformation programme progress for 19/20 and provide support to develop the programme for 20/21	31/01/2020	21/02/2020	Provins, Esther (Inactive User)							
												Undertake a CIP assurance exercise for 19/20	11/01/2020	21/02/2020	Provins, Esther (Inactive User)							
												Delivery of Best Place to Work programme.	31/03/2021	22/06/2021	Lane, Lynn (Inactive User)							
												Delivery of phase 1 of NHS Improvement Cultural Leadership Programme.	31/07/2020	18/08/2020	Lane, Lynn (Inactive User)							
												Delivery of 20/21 Transformation Priorities.	31/03/2022	11/04/2022	Provins, Esther (Inactive User)							
												Development of the Operational Excellence Workplan.	31/12/2021	11/01/2022	Wood, Paul							
												Implement a benefits realisation tracking approach to understand the impact of Improving Together	30/08/2022	29/12/2022	Provins, Esther (Inactive User)							
												Executive to commence monthly improvement huddle on all breakthrough objectives.	30/08/2022	29/12/2022	Provins, Esther (Inactive User)							
6143	Medicine	Trustwide	20/12/2019	Trustwide risk assessment	16	Risk that inadequate medical staffing in the organisation (due to insufficient budgeted workforce and/or failure to recruit and retain staff) will impact on the ability of the Trust to maintain safe and effective services across 7 days.	May recur occasionally	Moderate	9	Weekend safety and effectiveness action plan reported to Board on a quarterly basis.	01/04/2020	28/04/2020	Blanshard, Dr Christine (Inactive User)	Trust Board	30/12/2023	6	Care	oard (Corporate Risk Register)	Chief Medical Officer	Collins, Peter	02/01/2020
										Report containing triangulation of all relevant information and associated action plan to be submitted to Clinical Governance Committee.	30/06/2020	07/07/2020	Blanshard, Dr Christine (Inactive User)								
										Reinstate the weekend working Task and Finish Group.	31/03/2021	24/02/2021	Collins, Peter								
										The work reviewing the weekend working arrangements to be carried out as part of the Medical Division workforce review and overseen by new Medical workforce group.	30/03/2023	09/06/2023	Cole, Zoe								

										Physicians Associates training programme to be commenced.	01/09/2021	31/08/2021	Murray, Dr Duncan					Trust B			
										Medical e-roster business case to be refreshed by Medical Director and reconsidered by TIG and TMC.	29/10/2021	20/12/2021	Collins, Peter								
										Medical Workforce recruitment and retention strategy to be developed through Medical Workforce Group.	30/09/2023		Murray, Dr Duncan								
5360	Transformation & IM&T	Information Technology	28/02/2018	Data Protection	15	Risk of a cyber or ransomware attack, resulting in the potential loss of IT systems, compromised patient care and financial loss.	Do not expect it to happen again but it is possible	Catastrophic	10	02/10/18 IT Technical group on 8/10/18 to discuss what Anti virus software should be purchased	10/10/2018	14/12/2018	Noble, Bob (Inactive User)	Information Governance Steering Group	21/07/2023	6	Resources	Trust Board (Corporate Risk Register)	Director of Finance	Dhanoa, Naginder	11/02/2020
										Technical Group made decision to extend current product. Quotes being obtained for 1, 2 and 3 year extension.	28/02/2019	20/02/2019	Noble, Bob (Inactive User)								
										Review of practicalities of getting ransomware with financial controller.	24/07/2019	09/09/2019	Burwell, Jonathan								
										Development of Cyber Essentials plus plan to support achievement of the standard by 2021	17/01/2020	03/02/2020	Carman, Mr Stephen								
										Review of options for SIEM automated logging and impact of this on resource	31/03/2020	28/04/2020	Carman, Mr Stephen								
										Business case to TMC for agreement of option, associated resources an risk management	18/03/2020	28/04/2020	Carman, Mr Stephen								
										Windows 10 migration complete	31/03/2022	13/04/2022	Arnold, Jon								
										Cyber essentials plus accreditation achieved	30/06/2021	09/07/2021	Carman, Mr Stephen								
										Completion of outstanding penetration test actions prior to moving into cyber essentials plus plan	28/02/2020	17/03/2020	Burwell, Jonathan								
										Implementation of SIEM solution with regional leads	30/06/2020	10/07/2020	Carman, Mr Stephen								
										ATP to be installed on Servers	31/12/2020	08/01/2021	Gibson, Richard								
										External CORS review to be undertake to support progress review	31/01/2021	24/02/2021	Burwell, Jonathan								
										Test implementation of IT Health Assurance Dashboard	31/05/2021	09/07/2021	Burwell, Jonathan								
										Review of proposed actions outlined by NHSD cyber team and CORS assessment to develop a 2021/22 updated cyber plan.	30/07/2021	12/10/2021	Gibson, Richard								
										Implementation of offline backup storage	21/12/2021	12/01/2022	Gibson, Richard								
										Completion of KPI report for Cyber	17/09/2021	12/10/2021	Badham, Gareth								
										Completion Log4j Critical CareCERT mitigations that are currently available.	30/03/2023	22/05/2023	Gibson, Richard								
										Implement Privileged Access Management solution	30/06/2023		Gibson, Richard								
										Rollout of SpecOps	16/12/2022	16/12/2022	Gibson, Richard								
										Procure a solution to monitor networked medical devices	31/03/2023	22/05/2023	Gibson, Richard								
										Undertaken awareness of Metacompliance training, focusing on Phishing	30/05/2023		Burwell, Jonathan								
7516	Trustwide	Trustwide	15/11/2022	Bed meeting, Departmental risk assessment, Directorate risk assessment, Trustwide risk assessment	12	With the increasing demand and acuity on admitting environments (ED, AMU, SAU) coupled with reduced flow and timely and insufficient ward discharges, admitting and ambulatory areas can become overcrowded, unsafe and cause ambulance delays (off loading current patient and inability to attend subsequent 999 calls). To redress and evenly apply this burden of risk across all in patient areas the use of Boarding is utilised in conjunction with SFT own internal escalation procedures and full capacity protocols. Boarding = the acceptance and transfer of a patient on to a ward when a ward discharge is anticipated and planned for later in the day, regardless as to whether the discharge patient can 'sit out' or not.	May recur occasionally	Major	12	Write Standard Operating Procedure regarding use of Boarding	17/11/2022	21/12/2022	Dyos, Judy	Executive Director Meeting	31/03/2023	6		Trust Board (Corporate Risk Register)	Director of Nursing	Dyos, Judy	
										Establish rhythm of push model and expectation of number of patients proactively allocated to wards to Board each day	17/11/2022	21/12/2022	Collins, Peter								
										Undertake local ward risk assessment as to location and type of boarding patient able to accommodate and mitigations required	15/11/2022	15/11/2022	Wilding, Mr Henry (Inactive User)								
										CNO/DCNO review of local ward risk assessments to ensure fair and proportionate and in keeping with accepted risk appetite.	31/03/2023		Ansell, Angie								
										Discharge and flow project to eliminate the risk of needing to board.	31/12/2023		Dickinson, Jane								
7574	Operations Directorate	Trustwide	16/01/2023	Service Delivery Plan	15	The continued pressure from urgent care flow alongside the increases in length of stay, compromises the ability for the Trust to undertake planned care.	Will undoubtedly recur, possibly frequently	Moderate	15	Outpatient transformation programme request for additional support - to ensure progress in reducing patients waiting, reduction in follow ups and increased in PIFU	29/09/2023		Thomas, Lisa	Weekly Delivery Group	31/08/2023	12	Care	Trust Board (Corporate Risk Register)	Chief Operating Officer	Thomas, Lisa	
										Work with Wiltshire Alliance to reduce NCTR impacting on elective beds through the development of virtual wards, discharge hub and pathway changes for non bedded capacity.	29/09/2023		Thomas, Lisa								
										Ongoing recruitment drive.	30/09/2019	25/04/2019	Clarke, Lisa								
										Continual clinical prioritisation to ensure that high risk areas are covered.	01/04/2019	17/04/2019	Clarke, Lisa								
										Continuing insourcing of private provider to endoscopy.	30/06/2019	25/04/2019	Vandyken, Mrs Ali								
										Quantification and mitigation of the risk to bowel scope.	01/04/2019	17/04/2019	Vandyken, Mrs Ali								

5704	Surgery	Trustwide	31/01/2019	Directorate risk assessment	16	A risk that the current lack of substantive Gastroenterology medical and nursing workforce will impact on the ability of the service to deliver sustainable comprehensive safe and effective care to patients.	Will undoubtedly recur, possibly frequently	Moderate	15	Tender for elements of the Gastroenterology service.	01/04/2019	17/04/2019	Stagg, Andrew	Intensive Support Meeting	30/09/2023	6	Local Services (Care, People)	Trust Board (Corporate Risk Register)	Chief Medical Officer	Collins, Peter	31/01/2019
										Monthly update to F&P Committee and CGC.	10/05/2019	25/04/2019	Hyett, Andy (Inactive User)								
										Presentation of gastro strategy to Finance and Performance Committee.	31/05/2019	12/06/2019	Hyett, Andy (Inactive User)								
										Put together a workshop with CDs and Clinical Leads to discuss options for service provision.	01/10/2019	22/10/2019	Hyett, Andy (Inactive User)								
										Continue conversations and meetings with alternative NHS providers for likely future joint partnership for delivery of service	30/09/2019	29/08/2019	Henderson, Dr Stuart								
										Medical Director to link with other STP partners around system wide solution.	31/12/2019	21/02/2020	Blanshard, Dr Christine (Inactive User)								
										Case for change to develop a GI unit to be completed	31/12/2019	04/03/2020	Hyett, Andy (Inactive User)								
										New GI unit to be launched on 1st April	01/04/2020	07/05/2020	Hyett, Andy (Inactive User)								
										To recruit medical and nursing staff for the GI Unit.	30/06/2023		East, Rachael								
										Confirm Southampton will be able to take over full responsibility for the GI Bleed out of hours service.	23/04/2021	23/04/2021	Branagan, Mr Graham								
										Secure support for existing junior doctors	30/07/2021	31/08/2021	Branagan, Mr Graham								
										Ongoing regular review of workforce strategy in GI unit	01/12/2021	20/12/2021	East, Rachael								
										Recruitment to Nutrition Service Vacancy required.	31/01/2022	28/03/2022	East, Rachael								
										Develop joint governance meeting between medicine and surgery	30/06/2023		East, Rachael								
										Recruitment of new clinical lead for GI Unit	31/05/2023		Stephens, Mr Paul								
										CMO to report outcome of GI services review once complete.	30/09/2023		Collins, Peter								
										Surgical division to provide assurance report on oversight of operational delivery and any impacts to quality to CGC on 27th June 2023.	27/06/2023		East, Rachael								
6954	Trustwide	Trustwide	22/06/2021	Union Activity	8	As a result of the National Pay Award for nurses and other health professionals not being accepted by unions, there is a risk of industrial action by members. This could result in staffing shortages or staff working to rule, as well as patient	May recur occasionally	Catastrophic	15	Active monitoring of National Outcomes.	01/10/2021	13/12/2021	Dyos, Judy	Trust Board	28/02/2023	4	People (Care)	Trust Board (Corporate Risk Register)	Director of Nursing	Dyos, Judy	22/06/2021
										Active monitoring of National outcomes.	31/07/2022	01/07/2022	Dyos, Judy								
										Negotiation with unions regarding derogation.	28/02/2023	14/06/2023	Dyos, Judy								
7039	Trustwide	Trustwide	13/09/2021	Bed meeting, Departmental risk assessment, Incident reports, Trustwide	15	The Trust is currently experiencing increased demand and patient acuity across all in patient services, at a time of increased nursing sickness, maternity leave, leavers and retirements, and reduced recruitment. This causes a shortfall in CHPPD, increases risk for patient harm, increases risk of burnout for remaining staff, causes delay to flow and discharges, and inability to	y recur, possibly frequently	Moderate	15	Communication and reporting of red flag for staffing regionally to NHSI/E	02/08/2021	02/08/2021	Merrifield, Tracey (Inactive User)	nagement Team Meeting	30/09/2023	4	People	Corporate Risk Register)	ctor of Nursing	lyett, Fiona	01/07/2022
										Explore use of agencies (including off cap) to support block booking	09/08/2021	09/08/2021	Wilding, Mr Henry (Inactive User)								
										Explore use of agency HCAs to support wards	20/09/2021	13/12/2021	Wilding, Mr Henry (Inactive User)								
										Establish HCA recruitment event - webinar and associated interview dates	30/09/2021	13/09/2021	Holt, Sharon								
										Use of Specialist Nurses/Out patient Nursing to support ward areas	01/11/2021	04/03/2022	Dyos, Judy								
										Development of B2 non-clinical support worker role (housekeeper) to support wards	13/12/2021	13/12/2021	Wilding, Mr Henry (Inactive User)								
										Request for use of volunteers from non-patient facing teams to support wards with delivery of meals, answering phone, runner, drink round	01/01/2022	04/03/2022	Wilding, Mr Henry (Inactive User)								
										Develop winter incentive scheme for bank workers	01/01/2022	13/12/2021	Ashley, Simon								
										Explore of use of short, fixed term use of over time payments for part time staff.	27/12/2021	04/03/2022	Wilding, Mr Henry (Inactive User)								
										Extension of winter incentive scheme until 02/04/22 to support ongoing escalation and acuity	04/03/2022	04/03/2022	Wilding, Mr Henry (Inactive User)								

				risk assessment		burnout for remaining staff, causes delay to flow and discharges, and inability to provide the required care for all patients.	Will undoubtedly			Develop specific Easter holiday incentive scheme to support and encourage additional shift coverage	08/04/2022	08/04/2022	Wilding, Mr Henry (Inactive User)	Directorate Ma			Trust Board (C	Direc	H		
										Ongoing use of golden incentive to support short notice sickness/gap	01/09/2022	05/10/2022	Wilding, Mr Henry (Inactive User)								
										Revise incentive scheme framework with established triggers and values, and process of sign off	01/08/2022	05/07/2022	Ashley, Simon								
										Review action card/BCP regarding deployment of available resources in times of extemis	31/10/2022	05/10/2022	Cox, Emma								
										Commission task and finish group to explore all options and opportunities to recruit, retain and incentivise additional nursing hours and support	28/10/2022	13/12/2022	Wilding, Mr Henry (Inactive User)								
										Recruit substantively to 'allocation on arrival' team to support wards/areas as required	30/11/2022	10/10/2022	Ashley, Simon								
										Develop and recruit to non-clinical support worker role	06/01/2023	14/06/2023	Hyett, Fiona								
										Commission development of and recruitment to the use of a discharge lounge, supporting earlier discharge on the day and release of current nursing hours on wards facilitating TTOs, transport, collections	06/01/2023	13/12/2022	Osman, Laura								
										Recruitment of discharge coordinators to support specific wards, releasing nursing time and availability	30/06/2023		Dickinson, Jane								
										Temporary staffing winter incentive scheme approved by execs. To go live from 30/12/22	30/12/2022	21/12/2022	Ashley, Simon								
7472	Organisational Development and People	Organisational Development & People Department	12/10/2022	Trustwide risk assessment	16	As a result of unmanageable staff absences, poor retention of existing staff and ineffective recruitment activity to fill vacancies, there is a risk that SFT is unable to manage service provision and operate a safe hospital.	Will probably recur, but is not a persistent issue	Major	16	Staff resource plans identified and agreed with Divisional Management Teams.	31/03/2024		Crowley, Ian	Trust Board	31/01/2023	6	People	Trust Board (Corporate Risk Register)	Director of Organisational Development and People	Whitfield, Melanie	12/10/2022
										Mechanism to manage career pathways and career conversations delivered.	14/01/2023	07/06/2023	Crowley, Ian								
										Delivery of the widening participation initiative.	31/03/2024		Crowley, Ian								
										Recruitment processes optimised (pwc recommendations implemented).	30/04/2023	07/06/2023	Crowley, Ian								
										Movers and leavers project delivered.	31/03/2024		Crowley, Ian								
										People Promise actions for this year to be delivered.	31/03/2024		Crowley, Ian								
										Health and Well-being plan delivered.	30/09/2023		Crowley, Ian								
7308	Finance and Procurement	Trustwide	19/04/2022	Trusts Objectives, Trustwide risk assessment	15	The financial plan for 2023/24 is for an underlying deficit plan with assumed 5% savings. There is a material risk that the deficit will be larger than planned due to the operational constraints, inability to achieve financial savings and ongoing pressures related to patients with no criteria to reside. Costs associated with inflation and winter are forecasted to be higher than planned, placing further pressure on financial performance. Therefore there is a risk that the financial plan will not be delivered and cash balances will deplete during 2023.	Will undoubtedly recur, possibly frequently	Major	20	Grip and Control processes reviewed in all Divisions to ensure robust financial governance	29/07/2022	11/10/2022	Thomas, Lisa	Finance and Performance Committee	30/09/2023	9		Finance Committee, Trust Board (Corporate Risk Register)	Director of Finance	Ellis, Mark	19/04/2022
										Divisions asked to identify full CIP and or productivity plans to ensure they manage within Budget for 2022/23	29/07/2022	11/10/2022	Thomas, Lisa								
										Deployment of winter plans.	30/11/2022	15/12/2022	Ellis, Mark								
										Seeking support for unfunded pressures from the ICB and SpecCom.	31/01/2023	31/03/2023	Ellis, Mark								
										Review of agency booking process.	31/01/2023	31/03/2023	Whitfield, Melanie								
										3-year forecast being undertaken in Q1, including risks and impact on cash flow.	30/06/2023		Ellis, Mark								
										Identification of additional savings opportunities managed through Divisions with oversight from FRG.	30/09/2023		Ellis, Mark								
										Winter director managing Trustwide ECIST actions.	01/05/2019	12/06/2019	Hyett, Andy (Inactive User)								
										Winter Director coordinating trajectory for delivery of DTOC target.	01/05/2019	12/06/2019	Hyett, Andy (Inactive User)								
										Trust actions being led by COO and Medicine CD and managed through weekly delivery meeting and monthly PMB.	01/05/2019	12/06/2019	Hyett, Andy (Inactive User)								
										Weekly expert panel meeting to challenge discharge pathways chaired by CCG director of quality.	01/05/2019	12/06/2019	Hyett, Andy (Inactive User)								
										Trust implementing discharge PTL	01/07/2019	04/09/2019	Hyett, Andy (Inactive User)								
										Escalation to EDLDB non delivery of trajectory	01/07/2019	04/09/2019	Hyett, Andy (Inactive User)								
										Mitigation actions being prepared to mitigate lack of capacity in the community.	01/08/2019	04/09/2019	Hyett, Andy (Inactive User)								

5751	Operations Directorate	Discharge Team	11/03/2019	Directorate risk assessment	16	Risk of patient harm caused by patients remaining in hospital when their clinical need does not require this (no right to reside). This risk is caused by lack of capacity within social care services.	Will undoubtedly recur, possibly frequently	Major	20	All providers required to present their winter plans to EDLDB in September.	30/09/2019	22/10/2019	Hyett, Andy (Inactive User)	Trust Board	29/09/2023	12	Local Services (Care)	Trust Board (Corporate Risk Register)	Chief Operating Officer	Thomas, Lisa	11/03/2019
										Business case to expand ESD service going to TMC in September and COO and DoF meeting Wiltshire Health and Care to align services	30/11/2019	10/12/2019	Hyett, Andy (Inactive User)								
										CEO DOF and COO representing SFT at system wide winter summit on 25th October 2019.	31/10/2019	10/12/2019	Hyett, Andy (Inactive User)								
										COO representing Trust at Regional Workshop w/b 9th December	14/12/2019	04/03/2020	Hyett, Andy (Inactive User)								
										System wide actions to be monitored through the ED local delivery board.	01/04/2020	28/04/2020	Hyett, Andy (Inactive User)								
										COO escalating the need for an ED LDB risk log reflecting the risks carried by each provider organisation.	19/12/2019	04/03/2020	Hyett, Andy (Inactive User)								
										Risk to be captured on newly developed ED Local Delivery Board Risk Register.	31/03/2020	28/04/2020	Hyett, Andy (Inactive User)								
										Action plan to be developed for 2021 by Urgent Care Board.	31/03/2021	04/05/2021	Hyett, Andy (Inactive User)								
										Reinstate the challenge of stranded patients by the Medical Director by the end of October.	01/11/2020	20/10/2020	Hyett, Andy (Inactive User)								
										Development of Transformation Programme for improved Discharge processes.	31/05/2021	28/06/2021	Hyett, Andy (Inactive User)								
										Agreement of system escalation triggers.	31/05/2021	28/06/2021	Hyett, Andy (Inactive User)								
										Review of bed modelling in light of increased urgent and elective activity.	31/05/2021	30/06/2021	Humphrey, Kieran (Inactive User)								
										Agreement of Improvement Trajectory with system partners.	30/07/2021	08/10/2021	Hyett, Andy (Inactive User)								
										Delivery of the Transformation Improvement Plan.	30/11/2021	30/12/2021	Wood, Paul								
										Delivery of the BSW Urgent Care Board discharge improvement plan which the Trust is contributing to	31/10/2022	11/10/2022	Thomas, Lisa								
										Trust working with BSW on delivery of 57 additional community beds at South newton from November.	30/11/2022	28/12/2022	Thomas, Lisa								
										Trust developing winter plan for implementation focusing on pathway 0 patients to maximise available bed capacity	31/10/2022	28/12/2022	Thomas, Lisa								
										Discharge Hub being established at SFT to support efficient and effective discharge process and improve partner working	29/09/2023		Cavill, Emma								
6229	Surgery	Day Surgery Unit	04/03/2020	Access targets, Complaints, Departmental risk assessment, External audit reports, Incident reports, Other assurance not listed, Service Delivery Plan, Waiting times	12	The DSU building is 'end of life' and has been identified as priority for replacement. The fabric of the building is problematic and leads to numerous rook leaks and delayed / cancelled procedures. Failure of the air handling unit is becoming a regular occurrence, this in turn affects the overall environment, prevents activity from taking place owing to infection control policies and results in cancellations of elective procedures. Incidents relating to the building condition are increasing and impacting on patient safety, care and experience.	Will undoubtedly recur, possibly frequently	Major	20	DSU risk escalated to wider stakeholders to ensure remains priority scheme for BSW and South West Region	13/06/2023	13/06/2023	Arnold, Laurence	Trust Board	30/04/2023	4	Resources	Trust Board (Corporate Risk Register)	Chief Operating Officer	O'Keeffe, John	13/01/2023

Corporate Risk Register Summary - January 2023 v1

Risk (Datix) ID	Risk Title	Exec Lead	Date Risk Added	Initial Score	Apr-22	Jul-22	Oct-22	Jan-23	Jun-23	Target
Risk Detail				Score Trend						
POPULATION - Improving the health and wellbeing of the population we serve										
5704	Inability to provide a full gastroenterology service due to a lack of medical and nursing workforce	Chief Medical Officer	31-Jan-19	16	12	12	9	9	15	6
5751	Risk of patient harm caused by a delayed discharge from hospital.	Chief Operating Officer	11-Mar-19	16	20	20	20	20	20	12
7039	The Trust is currently experiencing increased demand and patient acuity across all in-patient areas, at a time of increased nursing sickness, maternity leave, leavers and retirement and reduced recruitment. This causes a shortfall in Care Hours per Patient day (CHPPD), increases risk of burnout for remaining staff, causes delay to flow and discharges and inability to provide required care for all patients	Chief Nursing Officer	01-Jul-22	15		20	20	15	15	4
5360	Risk of a cyber or ransomeware attack resulting in the potential loss of IT systems, compromised patient care and financial loss	Chief Finance Officer	11-Feb-20	15	10	10	10	10	10	6
5955	Insufficient organisation wide robust management control procedures **Risk tolerated**	Chief Finance Officer	13-Aug-19	15	9	9	9	9	9	9
5972	Risk that improvement and transformation is not delivered in a timely manner	Chief Medical Officer	23-Aug-19	16	12	12	12	12	9	6

6143	Risk to the ability of SFT to provide the same quality of service 24 hours a day, 7 days a week, with a potential impact to patient care. Difficulties in recruiting vacant posts, funding for new posts and restrictive medical contracts contribute to this risk.	Chief Medical Officer	02-Jan-20	16	9	12	12	12	9	6
508	The absence of a comprehensive Health and Safety Management System for the Trust runs the risk that legislative requirements will not be embedded into the Trust standards to which departments are expected to work. Without those standards, we cannot expect the Trust be compliant, so the consequences of non-compliance with health and safety law results in Staff and all persons on site at risk of harm and the Trust at risk of prosecution and claims.	Chief People Officer	30-Jun-21	16	9	15	12	12	9	6
6229	The DSU building is 'end of life' and has been identified as priority for replacement. The fabric of the building is problematic and leads to numerous rook leaks and delayed / cancelled procedures. Failure of the air handling unit is becoming a regular occurrence, this in turn affects the overall environment, prevents activity from taking place owing to infection control policies and results in cancellations of elective procedures. Incidents relating to the building condition are increasing and impacting on patient safety, care and experience	Chief Operating Officer	02-Jan-23	12				20	20	4

7573	The risk of sustained use of escalation bed capacity (e.g. DSU, Discharge lounge, intervention radiology) has an impact on patient safety due to not enough substantive staff for increased bed capacity, patients not always placed initially in most appropriate ward. The more beds the Trust has open the impact on operational effectiveness, e.g. ward rounds, clinical support services.	Chief Operating Officer	16-Jan-23	20				20	20	12
7574	The continued pressure from urgent care flow alongside the increases in length of stay, compromises the ability for the Trust to undertake planned care.	Chief Operating Officer	16-Jan-23	15				15	15	12
6570	As a result of the fact that the highly contagious Covid, Flu and RSV variants are still circulating within the community, there is a risk that an outbreak of one of these could occur either for staff and/or patients. This may result in patient and/or staff sickness and potential mortality.	Chief Nursing Officer	01-Jan-23	15				12	9	9
7516	As a result of demand outweighing capacity and the impact on patient flow there is a risk of boarding and the potential impact of this on patient care.	Chief Nursing Officer	15-Nov-22	12				12	12	6
6836	There is a risk that the re-designation of the Neonatal Intensive Care Unit (NICU) will result in restricted access to neonatal intensive care for women in Wiltshire with the impact on quality and safety - **tolerated risk**	Chief Medical Officer	24-Feb-21	12	5	5	5	5	5	2
People - Supporting our people to make Salisbury NHS Foundation Trust the best place to work										

7472	As a result of unmanageable staff absences, poor retention of existing staff and ineffective recruitment activity to fill vacancies, there is a risk that SFT is unable to manage service provision and operate in a safe hospital	Chief People Officer	12-Oct-22	16			16	16	16	6
6954	As a result of the national pay award for nurses not being accepted by the Royal College of Nursing, there is a risk of industrial action by members of the RCN. This could result in staffing shortages or staff working to rule	Chief Nursing Officer	22-Jun-21	8	8	8	8	20	15	4
7078	As a result of competing priorities and deliverables there is a risk of slippage of the Improving Together Programme deadlines	Chief Medical Officer	13-Oct-21	12	9	15	12	9	6	6
PARTNERSHIPS - Working through partnerships to transform and integrate our services										
6857	There is a risk that weaknesses in controls give rise to an opportunity for fraud, in turn resulting in the Trust incurring financial losses **Risk tolerated**	Chief Finance Officer	12-Mar-21	6	6	8	8	8	8	4
6858	There is a risk as new guidance and models of working emerge, the immaturity of partnerships between the Trust and wider BSW organisations will impact on progress to achieve key objectives	Chief Operating Officer	12-Mar-21	9	9	9	9	9	9	6

7308	The financial plan for 2022/23 is a deficit plan with assumed 2.2% savings. There is a material risk that the deficit will be larger than planned due to the operational constraints, inability to achieve financial savings and ongoing pressures related to patients with no criteria to reside. Therefore there is a risk that cash flow is challenged during the year resulting in the Trust having to take emergency cash measures.	Chief Finance Officer	12-Mar-21	15	15	15	12	16	20	9

Risk Score Key

Low Risk 1-3
Moderate Risk 4-6
High Risk 8-12
Extreme Risk 15-25

Risk Appetite

NHS Salisbury NHS Foundation Trust

Report to:	Trust Board Meeting - Public	Agenda item:	6.2
Date of meeting:	6 July 2023		

Report tile:	Health and Safety Annual Report FY22/23			
Status:	Information	Discussion	Assurance	Approval
	X		X	
Approval Process: (where has this paper been reviewed and approved):	TMC			
Prepared by:	Troy Ready – Health and Safety Manager			
Executive Sponsor: (presenting)	Melanie Whitfield – Chief People Officer			

Recommendation:

The Board is asked to note the H&S performance rates across the Trust and the change of tack from broad trust-wide initiatives to specific department initiatives in response to local performance. There is still a need for broad based initiatives that cut across the Trust, such as zero tolerance of violence and aggression, but the Trust can achieve a greater impact on H&S performance by focusing on those areas of concern highlighted within this report.

Executive Summary:

Health and safety (H&S) management during much of 23FY was reactive in nature with no formal performance objectives, performance reports against these objectives or assurance programmes to identify opportunities to improve. This type of reactive H&S management system results in a scattergun approach to H&S initiatives that do not always achieve reductions in injury rates. The previous H&S report to the Board identified the intention to develop a more structured, systematic and risk based approach to H&S management based on performance measures by Division and Department. This report identifies H&S performance against traditional H&S performance measures by Division and the priority actions for the Trust and the H&S team in FY24. The report shows:

Performance results against traditional H&S metrics are higher than expected and each Division (but for Women and Newborn and Estates) have unique performance results that require distinct actions, rather than broad based Trust wide initiatives.

1. Violence and aggression accounts for 48% of all injury reports, and 25% of all time lost due to work related injuries. There is a clear trend the risk to staff is from patients with confusion, dementia and delirium, rather than anti-social behaviour.
2. whilst slips and trips are the second most reported incident across the Trust, many injuries were due to slips in outdoor spaces across the Trust during colder and darker months
3. Manual handling injuries are predominantly reported in theatres and the spinal ward

But what is also clear is the need to improve the immediate response to staff who sustain an injury and to provide ward leaders and managers with the skills to have discussions about return to work.

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

Health and Safety Annual Review 2022/23 FY

Salisbury NHS Foundation Trust

A. Introduction

Health and safety (H&S) across Salisbury NHS Foundation Trust (the Trust) has seen a considerable change in direction and personnel over the past 18 months. The H&S team saw the departure of the H&S Manager in early 2022 and an interim Health and Safety Manager assigned whilst a permanent H&S Manager was recruited. 2022 also saw the departure of the trust H&S Advisor. The current H&S Manager commenced in post in August 2022 and was tasked with formalising a H&S management system (H&SMS). The lack of which was a risk documented on the Trust Risk Register.

Risk 508 provides: *"the absence of a comprehensive Health and Safety Management System (H&SMS) for the Trust runs the risk that legislative requirements will not be embedded into the Trust standards to which departments are expected to work. Without those standards, we cannot expect the Trust be be compliant, so the consequences of non-compliance with health and safety law results in Staff and all persons on site at risk of harm and the Trust at risk of prosecution and claims". [sic].*

An effective H&SMS does not ensure legal compliance with H&S legislation, prevent a risk of prosecution, or eliminate the risk of improvement directives from the Health and Safety Executive (HSE). A H&SMS is a tool to drive the continuous improvement of the management of the risks to H&S staff are exposed to as a result of the activities conducted across the trust. It is a structured approach, with a defined process that provides for a suite of objectives and targets that can be used to measure performance, enables performance reports, investigation tools, and auditability to provide informed decision making about the effectiveness of H&S management. In doing so, the Trust can reduce the risk H&S laws are breached by virtue of a planned and structured approach to H&S management.

Yet the reverse also applies - the absence of a H&SMS does not mean non compliance to H&S legislation. The lack of a H&SMS means there is no planning, no performance objectives, performance reporting or formal audit program. But legal compliance can still be achieved. For a complex organisation, such as the Trust, and in recognition of Professor Patrick Hudson's widely accepted model on Safety Culture, the lack of a comprehensive H&SMS has resulted in a 'reactive H&S culture'. The objective of the H&S team in the coming years is to move the H&S culture dial from being reactive to calculative planned, systematic and measurable, or what is coined a 'calculative H&S culture'.

This Annual H&S Report is one step in moving from a reactive culture

B. Summary and Key Actions

Since August 2022, significant work has been completed to develop the structure of a H&SMS at the Trust. The basis of which was to develop a H&S plan, develop performance objectives, introduce an internal audit program and a task analysis program. In doing so it is expected the:

1. H&S team will obtain first hand knowledge of H&S practices or gaps that need addressing, and
2. The Trust can understand performance and key areas for improvement,
3. Decisions can be made in areas of greatest need and with the greatest impact.

This annual review provides an overview of the Trust H&SMS, performance against standard H&S performance measures, identifies key risks by division (and in some cases by department) and actions to reduce injury rates and therefore the risk to the H&S of staff.

Report headlines include:

i. Injury performance measures are higher than expected,
ii. Violence and aggression accounts for 48% of all injury reports, and 25% of time lost due to all work related injuries. Within Medicine there is also a clear divide between patients who are confused and lack capacity against antisocial behaviour by individual's with capacity.
iii. There is a clear need to review manual handling practices within Longford ward and Theatres.
iv. Slips and trips across the Trust occur frequently but are attributed to by outside areas such as parking areas and garden paths.
v. There is a need for greater H&S action locally, especially the completion of risk assessments within divisions.
vi. There is a need to improve investigation of work related injury reports on Datix to determine root cause, rather than focus on immediate causation.

C. Health and Safety Management System

Towards the end of 2022/23 the H&S Manager created the framework for a H&SMS at the Trust based on the International Organisation for Standardisation Standard for Occupational Health and Safety Management Systems (ISO 45001:2018) (45001). 45001 was not developed specific to the management of H&S in a hospital setting, but is an international standard, adopted by large and complex organisations required to manage considerable risk, has access to a competent H&S team and can be internally and externally audited against. There are a number of number of technical elements required to implement H&S against 45001. Those elements of most relevance to the Trust are outlined below.

Key Priorities for the Trust to Action				
1 Performance objectives	2 H&S plan	3 Procedures and reporting	4 Internal audit program	5 Formal H&SMS review

1. Performance Objectives

There have been no H&S targets developed against standard objectives that measure H&S performance across the Trust. H&S reporting has previously listed where and what incidents have been reported, and if incidents resulted in an injury that must be reported under the Reporting of Injuries, Diseases and Dangerous Occurrences Regulations (RIDDOR) to the Health and Safety Executive (HSE). Basic reporting of performance shows a modest, but consistent, increase in incidents reported year on year.

Incidents Reported	
20/21	516
21/22	523
22/23	549

The Annual H&S Report completed in 2021/2022 stated: "*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*". Effective H&S management, as espoused by H&S system standards, requires an understanding of injury trends to identify the likelihood and consequence of an injury beyond monitoring. Monitoring alone in this fashion does not provide meaningful data to inform decisions on how to improve H&S performance.

To better understand where injuries of greater consequence are located, to provide meaningful analysis of injuries and therefore identify actions that are visible, targeted, relevant, meaningful and in response to an actual risk, all injuries and incidents reported on Datix for 2022/23 where cross referenced with the Sickness and Other Absence Report provided by OD&P.

1.1 Analysis of Lost Time Injuries by Type, Location and Consequence

Some of the analysis tools available in H&S include measuring and reporting **Lost Time Injuries** (LTI), defined as an injury that prevents someone returning to work the following day and is a useful measure to use when embarking on a journey of safety management maturity. **Time Lost** records the amount of time lost due to LTI's. The more significant an injury the greater the expected amount of time lost. In this way the Trust can measure the frequency and consequence of injuries that are significant enough to warrant time off work.

Data analysis show there were 143 lost time injuries and 1296 days lost as a result of work related injuries. This excludes:

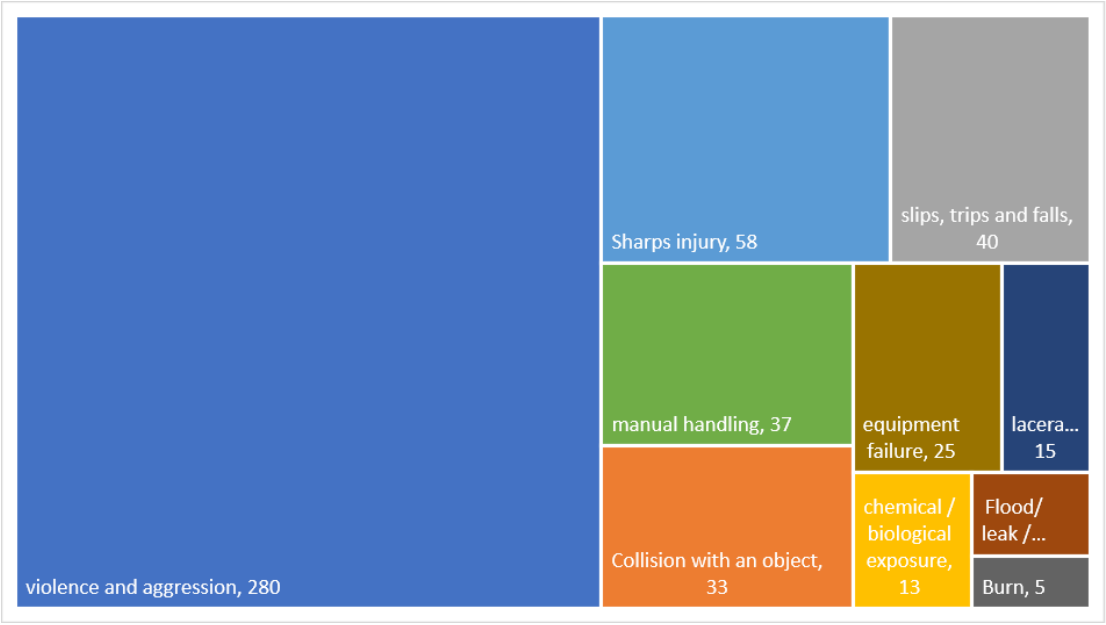
- any absences due to infectious disease (that includes Covid acquired at work), and
- time lost for injuries sustained prior to 22/23 FY who remain off work.

Further performance measures include; **Lost Time Injury Frequency Rates** (LTIFR), as a frequency of the number of LTI's reported for every million hours worked, and the **Lost Time Frequency Rate** (LTFR) as a measure of the total time lost for every 10,000 hours worked.

Using these performance measures the Trust can determine where injuries are more prevalent and the consequence of such injuries. Furthermore, because these performance measures are routinely measured by most large employers, and industries, we can determine if the Trust H&S performance is strong, average or poor.

1.1.1 Lost Time Injury, Time Lost and Injury Frequency Rates

The diagram below shows the breakdown of all incidents and injuries reported in 2022/23.



Not all of those incidents reported above resulted in an injury and absence from work. The table below shows LTI's, Time Lost LTIFR and LTFR by Division.

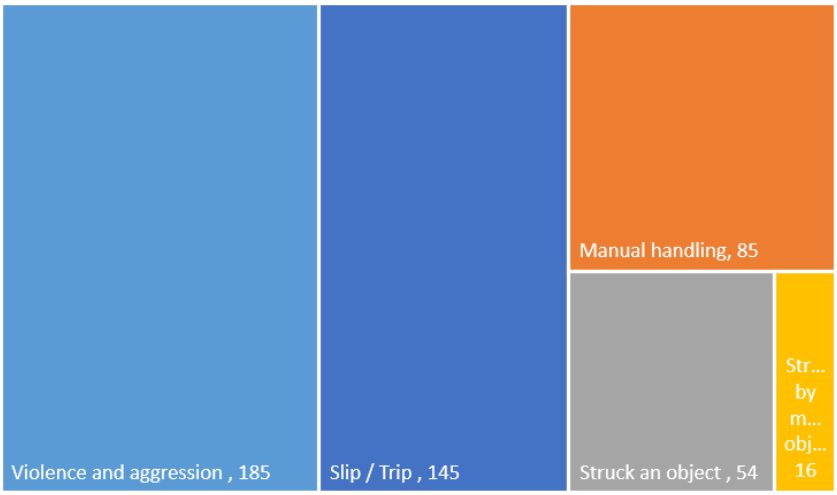
Division	Time Lost Injuries	Time Lost (FTE days)	LTIFR	LTFR
Medicine	57	484	29	19
Surgery	45	394	17	11
CSFS	25	222	11	7
Facilities	16	196	27	25
Total	143	1296	15	10

NHS trusts do not generally report non patient H&S performance making comparisons with the Trust difficult. However, it is generally accepted that employers should seek to achieve an LTIFR below 3.

An LTIFR of 15 is therefore high, and whilst the health sector generally has a higher injury LTIFR than other industries, it is the lack of focus in identifying and managing targeted risk areas within the Trust that has created a scattergun approach to H&S management. Understanding performance by risk type, Division and consequence can focus the management of H&S in specific areas and make considerable improvements in H&S performance.

1.1.2 Medicine

The table above shows there were 484 days lost as a result of 57 lost time injuries in medicine. No other Division reported more LTI's, sustained more time lost or a higher LTIFR. LTI results show the following:



Number of lost time injuries reported		Average time lost per injury
Violence and aggression	24	8
Slip / Trip	10	14
Manual handling	7	12
Struck an object	7	8
Struck by moving object	2	8

1. Violence and aggression accounts for 48% of lost time injuries reported in Medicine last year and 38% of all time lost.
2. Slips and trips accounts for 17% of lost time injuries and slips and trips resulted in the greatest average time lost at 29% of time lost across the Division.
3. Manual handling accounts for 12% of lost time injuries and 17% of time lost.

Whilst the impact of slips and trips and manual handling has the greatest consequence, it is the prevalence of violence and aggression that results in the greatest amount of time lost and LTI's reported. 85% of all time lost associated with violence and aggression can be attributed to the following wards.

Ward	FTE days lost	Lost time injuries reported
Pitton	74	7
Radnor	35	3
Redlynch	30	3
Spire	13	4

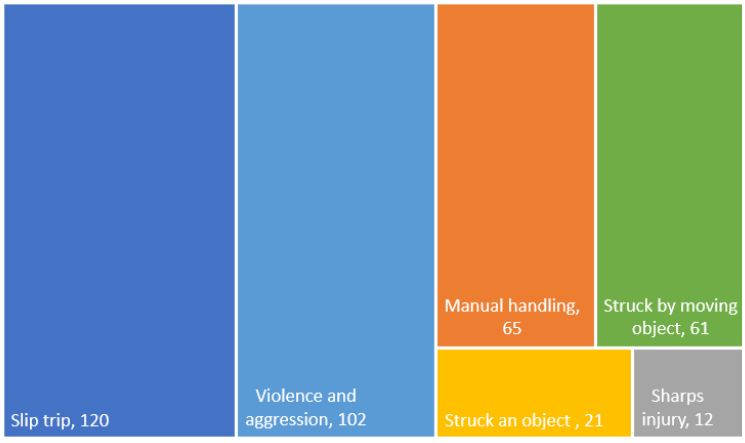
Further analysis of LTI's and Time Lost, due to violence and aggression, shows a clear divide between patients with capacity displaying anti social behaviour, and those patients with organic confusion such as dementia, infection and confusion.

Behaviour	Lost time injuries	FTE days lost
Antisocial	7	75
Confusion	19	110

There is considerable work required in the coming 12 months to understand the management of confused patients and why there are such high levels of aggression towards staff.

1.1.3 Surgery

The table above shows there 394 work days were lost due to injury in Surgery. Injury statistics present a different picture to Medicine and from each of the other Divisions. Lost time injuries LTI's are identified across a wider variety of causes as seen in the diagram below. The prevalence of violence and aggression in Medicine due to confusion is echoed on Amesbury Ward (as a result of pre and post orthopaedic surgery related to falls) but otherwise violence and aggression in Surgery is just as likely to be a result of anti social behaviour.



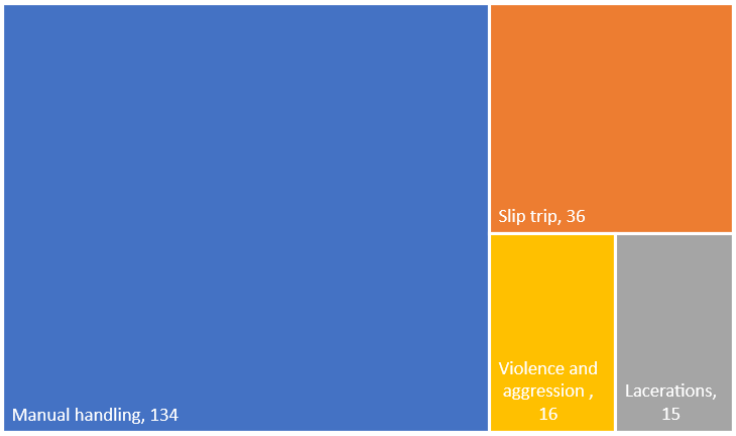
Number of lost time injuries reported		Average time lost per injury
Manual handling	9	7
Violence and aggression	8	13
Slip / Trip	5	24
Struck by moving object	4	15

1. Slips and trips account for 13% of lost time injuries reported and 25% of time lost. However, slips and trips were reported across a number of departments that do not point to specific areas and were often the result of walking through carparks and gardens. The average time lost for a slip trip injury is over 3 weeks.
2. Manual handling injuries account for 23% of LTI's and 16% of time lost. LTI's were related to manual handling were predominantly reported from Theatres.
3. Violence and aggression accounts for 21% of LTI's reported and 26% of time lost. 75% of all reports of violence and aggression and 91% of time lost related to violence and aggression were reported from Amesbury Ward.

4. Being struck by moving objects such as doors, equipment that has fallen over or by moving trolleys accounts for 10% of lost time injuries reported and 15% of time lost. But again, reports are across a number of departments that do not point to specific areas of concern.

1.1.4 CSFS

Violence and aggression is less prevalent within CSFS, as is expected with non patient facing departments. But the clear trend within CSFS is manual handling, and more specifically manual handling on Longford ward (spinal unit).

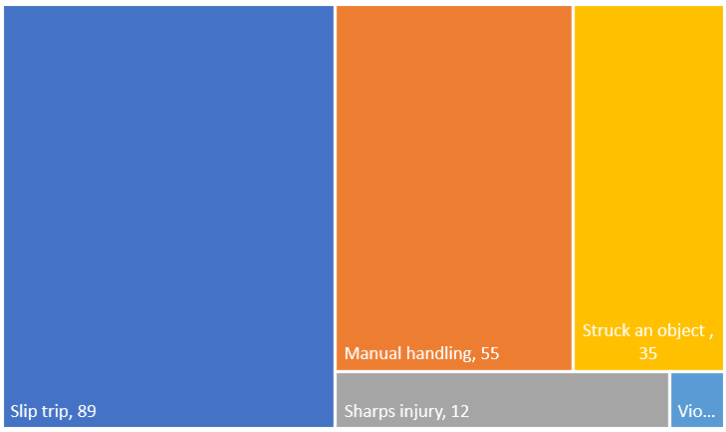


Number of lost time injuries reported		Average time lost per injury
Manual handling	7	19
Slip / Trip	6	6
Sharps and lacerations	6	4
Violence and aggression	2	16

1. Manual handling injuries on Longford accounts for 30% of time lost injuries and 60% of all time lost.
2. Slips and trips are the second most reported lost time injury, but there are no clear trends evident. Many of the slip/ trip injuries, as with Medicine, were reported across the grounds of the Trust. For example, walking from the carpark, or through the gardens and generally during winter weather. These slips and trips accounted for 36 days lost.
3. Sharps injuries sustained within pathology were the third most reported lost time injury and were due to lacerations within mortuary services or using the microtome in the lab.

1.1.5 Facilities

There were 197 days lost within the Facilities division often due to slips and trips, manual handling or walking into fixed objects.



Number of lost time injuries reported		Average time lost per injury
Struck an object	5	7
Slip / Trip	4	22
Manual handling	3	18

There is little of surprise in these results given the nature of the cleaning and portering work undertaken by the Facilities team. What is of note, but again of little surprise, is the extended time taken off work when a lost time injury occurs. Staff who report lost time injuries remain off work on average for 13 days because of what are predominantly strains and sprains.

There is no injury data of significance for Woman and Newborn, or the Estates Technical Team.

2. H&S Plan

During the early part of 2022 there was no H&S management plan and initiatives were linked to a review of tugs and work within the ETS team. Towards the latter part of 2022, a H&S management plan was developed with a view to design and implement a number of key actions that would provide the basis for a H&SMS. These included:

KEY OUTCOME 1	By November 2024, the Trust will have an embedded H&SMS with measurable performance objectives, a documented risk profile based on first hand task analysis activity completed by the H&S team and a robust audit program that provides assurance to TMC, and Board of Directors, that H&S is being managed effectively, and identifies and actions gaps in the management of H&S.

Progress
Performance objectives have been developed that include:

- Reducing the total amount of hours lost from work related injuries across the Trust
- Reducing the LTIFR,
- Reducing the time lost as a ratio of hours worked,
- Completing tasks analysis and audits as scheduled, and

As seen within this report, performance across the trust has now been established and initial objectives are to focus on any type of reduction in these performance targets. The first performance report for Q1 (April – June) will measure each of these indicators by Division. Audit and task analysis activity has commenced as scheduled.

KEY OUTCOME 2	H&S reports will measure performance against objectives: 1. Quarterly reports will focus on granular activity and performance. 2. Half year reports will look at areas of improvement to steer direction and resources towards objectives not achieved, and 3. An annual review will provide strategic gaps and assurances for the Board to consider.

Progress
The H&S Committee met every second month during 2022. This has changed to a quarterly meeting. H&S reports will provide a quarterly update, rather than bimonthly. Quarterly H&S reports are scheduled for the H&S Committee meeting in June, September and December. A half year report is scheduled for completion in September and this annual report for 2022/23 provides an overview of what annual reporting will look like.

KEY OUTCOME 3	The H&S team will develop a divisional task analysis calendar and complete task analyses to identify hazards, determine the effectiveness of controls and alert the Trust to current risk exposure. The completion of Divisional and Department task analysis will be measured as a positive performance indicator to show preventative H&S initiatives and will prioritise areas of higher lost time injury rates and incident reports.

Progress
A task analysis calendar has been developed and agreed to by the H&S Committee. Task analysis activity commenced in February and continues as scheduled. To date task analysis activity has been completed by the H&S team in a number of departments within Kitchens, Portering, Facilities, Medical Engineering and Theatres.

The quarterly H&S reports will provide an update on recommendations from task analysis completed.

KEY OUTCOME 4	Implement a robust audit program to review the effectiveness of H&S management, by Division and Department. Audits are expected to identify gaps in the management of H&S and provide a local action plan. The need for quality auditing is a further obligation leaders at SFT must ensure to demonstrate H&S is effectively managed.

Progress
An internal H&S audit calendar has been developed and agreed to by the H&S Committee. Audit activity also commenced in February and continues as scheduled. To date task analysis activity has been completed by the H&S team within ETS and is continuing in ED and AMU.

As above, quarterly reports will provide an update on recommendations and findings from each audit completed.

3. Performance and Reporting

The third element of an effective H&SMS is to ensure processes are available to manage H&S. These include risk assessments, inspections, training, hazard management procedures, consultation with committees, reporting, Datix reporting and investigation. This is the resource heavy aspect of H&S implementation that can only succeed with divisional ownership.

3.1 Risk Assessment
Risk assessments are an integral requirement in demonstrating compliance to both H&SMS and H&S legislation. The prosecution of many organisations starts with the lack of corporate knowledge surrounding a risk to the H&S of worker - knowledge that is demonstrated only through the provision of a documented risk assessment to identify the hazards staff are exposed to, the likelihood and consequence of an injury occurring, and the actions taken to eliminate or reduce that risk to a worker's H&S.

There is a need to ensure risk assessments are completed and not generic in nature. Audits and task analysis conducted by the H&S team suggest there is a trust wide trend that risk assessments are not completed, or are indeed generic in nature. The H&S team has developed a number of risk assessments that evidence the trust approach to managing risks from violence and aggression and manual handling. These need to be reviewed by local departments to ensure nuanced controls to manage both risks are considered and effective.

3.2 Policies and Procedures

An analysis of outstanding policies and procedures in 2021/22 identified 47 documents that were either missing or out of date. But many of the policies identified were generic in nature, too broad a topic or would duplicate existing procedures. Of the 47 procedures listed:

a) 20 did not require updating or development.
b) 18 procedures from this list have been updated or developed
c) 8 are available but need revision. These include:

- Bariatric Policy,
- Electromagnetic fields,
- Event management,
- Health surveillance,
- Lone working,
- Reporting injuries and incidents,
- Smoking, and
- Young Persons at work.

The H&S team is working through this list of procedures.

3.3 Incident Reporting and Investigation

Datix reporting should be an effective way to collect, record, track and analyse injuries, but it is clear there is significant under reporting across the Trust and a review of Datix investigations show root cause investigation methodology is not routinely applied. Improved reporting is a long term outcome achieved by demonstrating to staff the benefit reporting has when a positive response to a risk occurs. But the ability to affect change in response to a Datix report relies upon an effective investigation. Much of the Datix investigations reviewed across the Trust do not demonstrate an understanding of root cause analysis that identify underlying causes and instead rely upon the presence of an immediate factor. For example, Datix investigations into violence and aggression will identify the patient is confused and overlook any number of other contributing factors. There is a need to provide some further training on root cause analysis investigations, but this is a longer term target. A readily available solution to improve investigation outcomes, is for the H&S Team to assist in the investigation of all LTI's and provide mentoring of staff who conduct investigations.

An informal performance measure used by the H&S team is to become more involved in LTI investigations. The effectiveness of which will be reported in quarterly H&S reports.

3.4 H&S Committee and Sub Committees

H&S Committee
The H&S Committee has undergone considerable changes in the past 12 months. Chaired by the Chief People Officer (CPO) in 2022, the committee met every 2 months after initial oversight from the Director of Integrated Governance. In 2023, the H&S Committee now meets quarterly, works effectively with each of the sub committees that report to the H&S Committee and remains under the Chair of the CPO.

Sub Committees
There are 14 sub-committees reporting to the H&S Committee (down from 19 in 2022). terms of reference of these sub-committees with the intention of improving assurance and escalation in preference to a commentary of work being undertaken. Each sub committee has agreed to provide an Alert, Assure and Advise (AAA) Report and an Annual Review to the H&S Committee as per a Committee Calendar agreed for the 2023/24 FY.

AAA Reporting is designed to alert the H&SC to areas of non-compliance, or matters that need urgent action, advise the H&SC on issues subject to on-going monitoring, update on previous actions or new developments the H&S Committee need be aware of and assure the H&SC of issues raised to the sub committee are being managed.

Annual reporting is expected to provide a snapshot of sub committee attendance, activity, effectiveness and areas of improvement.

4. Internal audit program

Auditing across the NHS is generally undertaken by local H&S leads within a department using a standardised checklist and submitted to the H&S team for review. ‘Audits’ completed in previous years were reviewed as part of this annual review and are more indicative of a detailed inspection of the workplace rather than an analysis of gaps in the management of H&S that can be used to identify targeted areas of improvement.

As documented above at Key Outcome 4, the H&S team has developed an audit tool against the elements of 45001, has published an audit calendar and has commenced conducting audits of departments and divisions as scheduled between 2023-24. This audit program is integral to the published H&S plan for 2023/24.

To date audits have been completed within ETS and AMU and are currently being conducted in ED. But the audit schedule has been amended to audit, Pitton Ward.

Audit outcomes will be provided in the subsequent quarterly H&S reports.

5. Formal review of the H&SMS – and key actions for the next 12 months

The type of analysis in this annual review provides an example of how a H&SMS is formally reviewed and can be expected in the half year and subsequent annual reports. It is clear there are a number of key actions, in specific areas of the Trust, where targeted actions are expected to have a marked improvement in the management of H&S to the benefit of staff and overall performance. These include the development of specific action plans for:

1. **Violence and Aggression (Medicine) -** The number of staff injured through aggressive acts by patients without capacity and with underlying confusion, whether transient, or permanent, will be a priority area for the H&S team in the next 12 months. Strategies in dealing with antisocial behaviour such as zero tolerance are likely to have a limited impact on the management of confusion and dementia patients but create an expectation with staff that such behaviour is not tolerated and are expected to help within the Surgery Division.

   The H&S Manager chairs the Violence Prevention and Reduction Working Group (VP&RWG) is a sub committee that reports to the H&S Committee and was chaired during 2022 by the H&S Manager. Violence and aggression is predominantly a clinical issue, yet there has been limited representation by clinical staff to this working group. Understanding, or effectively actioning, concerns is simply not possible if clinical attendance is poor. The H&S Manager, and Deputy Director of Nursing, now co-chair this working group and each meeting in 2023 has seen a significant increase in clinical representation and actionable discussions. This momentum is expected to continue throughout the year.

   The V&APWG will be a key function in assessing the risk to staff and developing strategies to improve the management of violence and aggression in the next 12 months. There will be a specific focus of the management of violence and aggression arising from confused patients especially on Pitton, Radnor, Redlynch and Spire wards.

   The H&S Manager will develop a strategy plan to identify gaps associated with learning and education, the management of confusion and injury response as well as action plans to manage those gaps identified.

2. **Manual Handling Practices on Longford Ward (CSFS) and in Theatres (Surgery) –** Injury analysis shows manual handling within Theatres and Longford Ward requires closer inspection, assessment and stronger investigations to identify corrective actions. The H&S team will reach out to the Manual Handling Lead for the Trust and nursing leadership on the wards to develop a targeted plan.

3. **Audit and Task Analysis Activity by the H&S Team –** This is a key task to understand the management of H&S across each Division and understand first hand any gaps that may exist that present a risk to the H&S of staff. Audit and Task Analysis activity continues as scheduled.

4. **Department Specific Risk Assessments –** The completion of H&S risk assessments for each of the hazards identified within a Division is a significant piece of work. There is evidence of risk assessments within Pathology, in areas of Estates and Facilities, or in response to some local risks, but there is a reliance of generic Trust wide risk assessments that need to be reviewed divisionally.

   There is a need to ensure Divisional Management Teams lead on the completion of risk assessments, with the support of the H&S Team.

5. **Greater H&S Team Involvement in the Management and Investigation of LTI's (Trust wide) –** The H&S team has access to Datix and is aware of all work related injuries that are reported. The H&S team has been tasked with responding to all Datix reports, determine if an injury has resulted in lost time and to reach out to the reporter and manager. Responses from reporters and managers is currently slow, but as this approach becomes further bedded in, it is expected that responses to the H&S Team will improve and so too will investigations and management of return to work.

Report authored by:

Troy Ready
Health and Safety Manager
Salisbury NHS Foundation Trust

May 2023

NHS Salisbury NHS Foundation Trust

Report to:	Trust Board	Agenda item:	6.3
Date of meeting:	6th July 2023		

Report title:	Modern Slavery Statement			
Status:	Information	Discussion	Assurance	Approval
			X	X
Approval Process: (where has this paper been reviewed and approved):	Trust Management Committee (TMC) 28.06.2023			
Prepared by:	Harjinder Bahra, Head of Inclusion, Health and Wellbeing			
Executive Sponsor: (presenting)	Melanie Whitfield, Chief People Officer			

Recommendation:

The Board is invited to: Approve and Ratify the Trust's Modern Slavery Statement

Executive Summary:

NHS organisations are required to publish an annual statement under Section 54 the Modern Slavery Act 2015. The slavery and human trafficking statement should set out what steps organisations have taken to ensure modern slavery is not taking place in their business or supply chains. The attached document is the Trust's slavery and human trafficking statement for the year ended 31 March 2023. It has been approved by the Trust Management Committee (TMC).

The Trust has included on its intranet, additional information and specific advice and resources to support colleagues on this topic and what they should do if they suspect someone of being subjected to slavery.

The statement must be approved by the Board and the statement should clearly state that members' approval has been given, with the date of approval. The statement is to be signed and dated by the CEO and Chair once approved, and ratified by the Board, so that it may then be published in a prominent place on the homepage of the Trust's website.

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

Salisbury NHS Foundation Trust

Modern Slavery & Human Trafficking Statement

This statement is made pursuant to section 54(1) of the Modern Slavery Act 2015 and constitutes the Trust's slavery and human trafficking statement for the financial year ending 31 March 2023. The statement sets out the steps that Salisbury NHS Foundation Trust (SFT) has taken, and is continuing to take, to make sure that modern slavery or human trafficking is not taking place within our business or supply chain, or in any part of our business during the year ending 31 March 2023 and the next financial year.

Modern slavery encompasses slavery, servitude, human trafficking and forced labour. SFT has a zero tolerance approach to any form of modern slavery. We are committed to acting ethically and with integrity and transparency in all business dealings, and to putting effective systems and controls in place to safeguard against any form of modern slavery taking place within the business or our supply chain.

Our Commitment

We are fully aware of the responsibilities we bear towards our service users, staff and local communities. We aim to follow good practice and take all reasonable steps to prevent slavery and human trafficking.

We aim to design and provide services, implement policies and make decisions that meet the diverse needs of our service users and carers, the population we serve and our workforce ensuring that none are placed at a disadvantage.

We are guided by a strict set of ethical values in all our business dealings and expect our suppliers to adhere to these same principles. We are committed to ensuring there is no modern slavery in any part of our business and, in so far as possible, require our suppliers to hold similar ethos.

We are committed to ensuring that all our staff are aware of the Modern Slavery Act 2015 and their safeguarding duty to protect and prevent any further harm and abuse when it is identified or suspected that an individual may be or is at risk of modern slavery and human trafficking.

We ensure modern slavery guidance is embedded into the Trust safeguarding policies. Staff are expected to report concerns about slavery and human trafficking, and management are expected to act upon them in accordance with our policies and procedures. Guidance on modern slavery and human trafficking – what it means, what are the types and who is affected, what to do if you suspect someone of being subjected to slavery, and further advice, support and resources – can be found on the Trust's intranet site.

We adhere to the National NHS Employment Checks/Standards this includes right to work in the UK, employees' UK address and factual references.

Due Diligence

To identify and mitigate the risks of modern slavery and human trafficking in our business and in our supply chain, we:

- Operate a robust recruitment and selection policy, including appropriate pre-employment checks reflecting the national NHS Employment Checks/Standards requirements on directly employed staff. Agencies on approved frameworks are audited to provide assurance that pre-employment clearance has been obtained for agency staff, to safeguard against human trafficking or individuals being forced to work against their will.
- Implement a range of controls to protect staff from poor treatment and/or exploitation which comply with all respective law as and regulations; these include provision of fair pay rates, fair terms of conditions of employment and access to training and development opportunities.
- Consult and negotiate with Trade Unions/Staff-side on proposed changes to employment, work organisation and contractual relations.
- Have systems to encourage the reporting of concerns including a whistleblowing policy so that all staff know that they can raise concerns about how colleagues or people receiving our services are being treated, or about practices within our business or supply chain, without fear of reprisals; and the promotion of our Freedom to Speak Up Guardian and Ambassadors.
- Regular Freedom to Speak Up reports are provided to the Trust Board which includes an overview of the concerns raised by staff and the category they fall into.
- Have a standards of business conduct policy which explains the way we behave as an organisation and about how we expect our staff and suppliers to act.

Our approach to procurement and our supply chain includes:

- Working with NHS Supply Chain and other partners to ensuring that our suppliers are carefully selected through our robust supplier selection criteria and processes
- Ensuring a human rights issue clause as related in the NHS Terms and Conditions for goods and services is included in specification and tender documents with a requirement for suppliers to have suitable anti-slavery and human trafficking policies and processes in place and that they comply with the provisions of the UK Modern Slavery Act (2015)
- Evaluate specifications and tenders with appropriate consideration and weighting is given in ethical sourcing and social value is in the process
- Using the NHS Terms and conditions of contract ensuring that appropriate clauses are contained within the contract agreements with suppliers for goods and services.
- Encourage suppliers and contractors to take their own action and understand their obligations in their processes
- Uphold professional codes of conduct and practice relating to procurement and supply.
- Trust staff must contact and work with the Procurement department when looking to work with new suppliers so appropriate checks can be undertaken and adhere to the Trust procurement policy and other relevant policies.

Policies

Our policies and procedures are devised to reflect we take all reasonable steps to achieve these commitments as part of our due diligence. This includes, but is not limited to, the following policies:

- Procurement policy
- Adult safeguarding policy
- Safeguarding children and adults training policy
- Serious incident requiring investigation (SI) policy
- Overseas visitors policy

Training

All staff have a personal responsibility for the successful prevention of slavery and human trafficking. Advice and training on modern slavery and human trafficking is available to staff through our safeguarding policies, procedures and training, and our safeguarding leads. Safeguarding training on identifying and supporting victims of modern slavery is mandatory for all staff via our online training system.

Modern Slavery awareness training is included for all staff as part of the Trusts Level 1 Adult Safeguarding Training.

Members of the Procurement teams who are Chartered Institute of Procurement and Supply (CIPS) qualified, or studying to become qualified, abide by the CIPS code of ethics and undertake an annually revised CIPS Ethics Test.

During 2023/24, the procurement team will undertake the CIPS Corporate Ethics Training with all relevant staff within the Procurement & Supply Chain Department taking the annual ethics test.

Confirmation

The Board of Directors has considered and approved this statement and will continue to support the requirements of the legislation.

NHS
Salisbury
NHS Foundation Trust

Report to:	Trust Board (Public)	Agenda item:	6.4
Date of meeting:	6th July 2023		

Community Diagnostic Centre Business Cases	Annual board report and statement of compliance (Responsible Officer and Revalidation for Doctors and Dentists)			
Status:	Information	Discussion	Assurance	Approval
				X
Approval Process: (where has this paper been reviewed and approved):				
Prepared by:	Zoe Cole (Associate Medical Director and Appraisal Lead) Mark Poultney (Appraisal and Revalidation Administrator)			
Executive Sponsor: (presenting)	Peter Collins, Chief Medical Officer			

Recommendation:

- To receive approve the annual NHS England assurance document regarding the Responsible Officer function for Medical appraisal and revalidation.
- To approve the signing of the statement of compliance

Executive Summary:

NHS England require the Chief Medical Officer to prepare an annual report assuring the board that the processes required for effective revalidation of doctors. The Responsible Officer is accountable for the processes to allow any doctor with a prescribed connection (doctors whose main work is with the Trust and who are not in a formal training programme) to collect the required information to allow for revalidation on a 5 yearly cycle.

The reporting period for 2022/23 has resulted in a period of continuity post pandemic. During this period there were 299 prescribed connections. The completed (215), approved exceptions (4) and missed appraisals (38) add up to 257 as 42 prescribed connections at 31 Mar 23 were not due an appraisal until the 2023-24 cycle, mainly due to relatively late trust start dates. Whilst we are still seeing that 24% of doctor's appraisals are overdue only 7% have been overdue for more than 3 months which represents significant improvements since last year.

This period of stability has enabled the appraisal team to provide better governance and oversight of the appraisal system. The locally employed doctor's appraisal system has been overhauled and all new starters are offered a Premier IT account allowing electronic appraisal along with what is expected from them depending on years of training and length of fixed term contract. MAG forms have now been phased out completely. A new audit system has been stated to evaluate appraisal output forms which is used by many of our colleagues in the South West and there has been validation.

Regular appraisal update has been reintroduced into the trust and there is training from the South West team to the RO and lead appraiser. During the reporting year these were all virtual but have more recently moved face to face with GMC presence and shared learning form significant events.

Work over the next year will include whether we continue with Premier IT or look at other providers as the licence is up for renewal. There is also a potential option of a joint procurement with RUH.

We look forward to continuing with our audit tool providing individual feedback to all appraisers and for participating in the peer review network.

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

Classification: Official

Publication reference: PR1844

NHS England

A framework of quality assurance for responsible officers and revalidation

Annex D – annual board report and statement of compliance

Version 1.1 Feb 2023

Contents

Introduction:

The Framework of Quality Assurance (FQA) for Responsible Officers and Revalidation was first published in April 2014 and comprised of the main FQA document and seven annexes A – G.

In 2019 a review of the Annual Organisational Audit (AOA), Board Report template and the Statement of Compliance concluded with a slimmed down version of the AOA (Annex C) and a revised Board Report template (Annex D), which was combined with the Statement of Compliance (previously listed as Annex E) for efficiency and simplicity.

The AOA exercise has been stood down since 2020 but has been adapted so that organisations have still been able to report on their appraisal rates.

Whilst a designated body with significant groups of doctors (e.g., consultants, SAS and locum doctors) will find it useful to maintain internal audit data of the appraisal rates in each group, the high-level overall rate requested in the table provided is enough information to demonstrate compliance.

The purpose of this Board Report template is to guide organisations by setting out the key requirements for compliance with regulations and key national guidance, and provides a format to review these requirements, so that the designated body can demonstrate not only basic compliance but continued improvement over time. Completion of the template will therefore:

a) help the designated body in its pursuit of quality improvement,
b) provide the necessary assurance to the higher-level responsible officer,
c) act as evidence for CQC inspections.

Designated Body Annual Board Report

Section 1 – General:

The board of Salisbury NHS Foundation Trust can confirm that:

1. An appropriately trained licensed medical practitioner is nominated or appointed as a responsible officer.

Dr Peter Collins is the nominated responsible officer and has received appropriate training. He attends the regional updates regularly. Dr Zoe Cole is the appraisal lead and also attends the RO updates. She is planning on formal training in case of unexpected CMO absence.

2. The designated body provides sufficient funds, capacity and other resources for the responsible officer to carry out the responsibilities of the role.

Yes In the last year all doctors previously using MAG forms have been supported to transition to the electronic system provided by Premier IT. Additional licences have been provided to the trust. The license for Premier IT is due for renewal hence options are being worked through with procurement and potential to include RUH next year.

3. An accurate record of all licensed medical practitioners with a prescribed connection to the designated body is always maintained.

The Chief Medical Officer and appraisal and revalidation administrator update a list of connected medical practitioners on a quarterly basis and this is triangulated with electronic staff records, HEE information under the oversight of the trusts medical workforce group.

4. All policies in place to support medical revalidation are actively monitored and regularly reviewed.

Policies associated with medical workforce are reviewed and updated through the trusts Joint Local Negotiating committee. Recent reviews/ rewrites that have been completed include study leave and professional leave policy (now merged) and job planning policy. All other policies have been reviewed by our solicitors and deemed as being compliant with regulatory and legal requirements and are therefore in date. We have plans to review MHPS/managing concerns, annual leave, acting down and additional payments within the next 12-18months

5. A peer review has been undertaken (where possible) of this organisation's appraisal and revalidation processes.

No recent review has taken place but we are aware that the South West NHS team are currently organising reviews within the region.

Discussion and advice have been sought re appraisal and revalidation within the BSW and the South West region

6. A process is in place to ensure locum or short-term placement doctors working in the organisation, including those with a prescribed connection to another organisation, are supported in their continuing professional development, appraisal, revalidation, and governance.

All fixed term doctors within the organisation who are expected to remain at the trust for 6 months or longer are offered an appraisal. For those who are in training this is usually their educational supervisor. A policy for locally employed doctors has been followed since August 2022. Appraisal output forms are generated using Premier IT.

Continued training and revaluation for those that are appraising these locally employed doctors is ongoing.

Section 2a – Effective Appraisal

All doctors in this organisation have an annual appraisal that covers a doctor's whole practice, which takes account of all relevant information relating to the doctor's fitness to practice (for their work carried out in the organisation and for work carried out for any other body in the appraisal period), including information about complaints, significant events and outlying clinical outcomes.[1]

There is a mechanism for all doctors to undergo formal appraisal with access to the trusts electronic system Premier IT. Sufficient numbers of appraisers are trained and updated and provided with SpA time recognised to allow appraisers to perform this duty. Appraisals are now audited using the premier IT ASPAT facility which is to be included in next update

[1] For organisations that have adopted the Appraisal 2020 model (recently updated aby the Academy of Medical Royal Colleges as the Medical Appraisal Guide 2022), there is a reduced requirement for preparation by the doctor and a greater emphasis on verbal reflection and discussion in appraisal meetings. Organisations might therefore choose to reflect on the impact of this change. Those organisations that have not yet moved to the revised model may want to describe their plans in this respect.

7. Where in Question 1 this does not occur, there is full understanding of the reasons why and suitable action is taken.

There is a mechanism to remind doctors that their appraisal is overdue and to escalate to the lead appraiser and ultimately CMO if required. Due to the suspension of appraisal during the pandemic we have now reset some of our appraisal dates although this was not fully reflected in the 2022/23 data.

We need to better record the reasons for agreed postponement for the figures in the audit

8. There is a medical appraisal policy in place that is compliant with national policy and has received the Board's approval (or by an equivalent governance or executive group).

An updated appraisal policy was agreed by the Joint Negotiating Committee and the trusts internal governance processes in 2021

9. The designated body has the necessary number of trained appraisers to carry out timely annual medical appraisals for all its licensed medical practitioners.

Sufficient numbers of appraisers are trained and updated and there is sufficient SpA time recognised to allow appraises to perform this duty

10. Medical appraisers participate in ongoing performance review and training/ development activities, to include attendance at appraisal network/development events, peer review and calibration of professional judgements (Quality Assurance of Medical Appraisers[2] or equivalent).

The appraisal lead is responsible for annual updates to all appraisers. New appraisers are trained via Miad Healthcare and certification is essential. There is an annual quality assurance process where a panel to include the Chief Medical officer, associate director of education and lead for locally employed doctors to access anonymised appraisal output forms using he ASPAT audit tool to provide both assurance and feedback to appraisers.

As part of the South West network face to face meetings have recently restarted having been online since the pandemic. There have been validation form lead appraisers over output forms specifically using the audit tool we are now using.

[2] http://www.england.nhs.uk/revalidation/ro/app-syst/

11. The appraisal system in place for the doctors in your organisation is subject to a quality assurance process and the findings are reported to the Board or equivalent governance group.

The appraisal assurance process described above has been reported to the board via the annual ROs report Action from last year:

Section 2b – Appraisal Data

1. The numbers of appraisals undertaken, not undertaken and the total number of agreed exceptions can be recorded in the table below.

Name of organisation:	
Total number of doctors with a prescribed connection as at 31 March 2023	299
Total number of appraisals undertaken between 1 April 2022 and 31 March 2023	215
Total number of appraisals not undertaken between 1 April 2022 and 31 March 2023	38
Total number of agreed exceptions	4

Section 3 – Recommendations to the GMC

1. Timely recommendations are made to the GMC about the fitness to practise of all doctors with a prescribed connection to the designated body, in accordance with the GMC requirements and responsible officer protocol.

Action from last year: Comments: Any concerns about fitness to practice that are raised by a doctor via internal or external routes are dealt with by the Chief Medical Officer of the Deputy Chief Medical Officer both of whom have been trained in GMC requirements and attend an RO meeting at least annually. Both CMO and Deputy meet regularly with GMC Employee Liaison Officer Action for next year: Trusts MHPS policy has been updated and will enable formation of a consistency panel and a tracker of any concerns raised about

doctors and dentists with a connection to the Trust. This will also provide better monitoring of equality.

2. Revalidation recommendations made to the GMC are confirmed promptly to the doctor and the reasons for the recommendations, particularly if the recommendation is one of deferral or non-engagement, are discussed with the doctor before the recommendation is submitted.

All doctors receive email confirmation of actions taken. Doctors are involved in deferment decisions usually by direct correspondence with this chief Medical Officer. Non-engagement decisions are only considered after at least one formal meeting with the chief medical Officer.

Section 4 – Medical governance

1. This organisation creates an environment which delivers effective clinical governance for doctors.

There is effective clinical safety and governance structure with well attended meetings and evidence of positive assurance in all significant domains such as audit, medicines management, mortality and morbidity and incident reporting.

The governance structure feeds into clinical effectiveness, patient safety and patients experience. Divisions have their only governance structure which links into these three main themes and seek assurance through regular senor leadership meetings with departments and wards. The head of clinical effectiveness and associate medical director have helped support this.

2. Effective systems are in place for monitoring the conduct and performance of all doctors working in our organisation and all relevant information is provided for doctors to include at their appraisal.

There are mechanisms in place for the reporting and escalation of concerns about doctors from a number of routes (performance concerns, involvement in serious incidents staff or patient concerns or complaints, freedom to speak up guardian reports and doctors 360 feedback)

Information on serious incidents and complaints is provided to doctors to use at the time of appraisal and forms part of their input form.

The current update of managing concerns form medical and dental staff policy will be setting up of a consistency panel to ensure the fair treatment of all doctors.

3. There is a process established for responding to concerns about any licensed medical practitioner's[1] fitness to practise, which is supported by an approved responding to concerns policy that includes arrangements for investigation and intervention for capability, conduct, health and fitness to practise concerns.

There is a current process described in the trust's managing concerns about medical or dental staff policy which has been updated to ensure it includes elements of compassion and just culture

The management of serious concerns can be discussed with the local GMC ELA officer who provides meetings and updates to trust.

4. The system for responding to concerns about a doctor in our organisation is subject to a quality assurance process and the findings are reported to the Board or equivalent governance group. Analysis includes numbers, type and outcome of concerns, as well as aspects such as consideration of protected characteristics of the doctors.[3]

Reporting of concerns raised about doctors or dentists in the trust are collated by the Chief medical Officer and Deputy Medical Director. There are regular meetings with the trusts ELA to ensure external triangulation and consistency. Learning from these events is shared at the regional RO updates.

5. There is a process for transferring information and concerns quickly and effectively between the responsible officer in our organisation and other responsible officers (or persons with appropriate governance responsibility) about a) doctors connected to your organisation and who also work in other

[3] This question sets out the expectation that an organisation gathers high level data on the management of concerns about doctors. It is envisaged information in this important area may be requested in future AOA exercises so that the results can be reported on at a regional and national level.

places, and b) doctors connected elsewhere but who also work in our organisation.[4]

> Information transfer requests are responded to by a combination of Medical HR, appraisal leads/ administrator as well as the CMO if there are active or historic concerns re an individual practitioner.

6. Safeguards are in place to ensure clinical governance arrangements for doctors including processes for responding to concerns about a doctor's practice, are fair and free from bias and discrimination (Ref GMC governance handbook).

> The trust has a policy in place for the reporting and investigation of concerns raised by practitioners regarding any form of discrimination or bias.
>
> The CMO has accountability for assuring the board that all processes managing doctors (including recruitment, job planning management of conduct or capability concerns and career progression) are fair and free from bias.

Section 5 – Employment Checks

1. A system is in place to ensure the appropriate pre-employment background checks are undertaken to confirm all doctors, including locum and short-term doctors, have qualifications and are suitably skilled and knowledgeable to undertake their professional duties.

> There are a robust set of pre-employment checks that is carried out on all doctors employed by the trust in line with GMC guidance. Oversight is provided by the trust's medical workforce group with assurance to trust board.

Section 6 – Summary of comments, and overall conclusion

> **Please use the Comments Box to detail the following:**
>
> The reporting period for 2022/23 has resulted in a period of continuity post pandemic. During this period there were 299 prescribed connections. The completed (215), approved exceptions (4) and missed appraisals (38) add up to 257 as 42

[4] The Medical Profession (Responsible Officers) Regulations 2011, regulation 11: http://www.legislation.gov.uk/ukdsi/2010/9780111500286/contents

prescribed connections at 31 Mar 23 were not due an appraisal until the 2023-24 cycle, mainly due to relatively late trust start dates. Whilst we are still seeing that 24% of doctor's appraisals are overdue only 7% have been overdue for more than 3 months which represents significant improvements since last year.

This period of stability has enabled the appraisal team to provide better governance and oversight of the appraisal system. The locally employed doctor's appraisal system has been overhauled and all new starters are offered a Premier IT account allowing electronic appraisal along with what is expected from them depending on years of training and length of fixed term contract. MAG forms have now been phased out completely. A new audit system has been stated to evaluate appraisal output forms which is used by many of our colleagues in the South West and there has been validation.

Regular appraisal update has been reintroduced into the trust and there is training from the South West team to the RO and lead appraiser. During the reporting year these were all virtual but have more recently moved face to face with GMC presence and shared learning form significant events.

Work over the next year will include whether we continue with Premier IT or look at other providers as the licence is up for renewal. There is also a potential option of a joint procurement with RUH.

We look forward to continuing with our audit tool providing individual feedback to all appraisers and for participating in the peer review network.

Section 7 – Statement of Compliance:

The Board / executive management team – [*delete as applicable*] of [*insert official name of DB*] has reviewed the content of this report and can confirm the organisation is compliant with The Medical Profession (Responsible Officers) Regulations 2010 (as amended in 2013).

Signed on behalf of the designated body

[(Chief executive or chairman (or executive if no board exists)]

Official name of designated body: _ _ _ _ _ _ _ _ _ _ _ _

Name: _ _ _ _ _ _ _ _ _ _ _ _ Signed: _ _ _ _ _ _ _ _ _ _ _

Role: _ _ _ _ _ _ _ _ _ _ _ _

Date: _ _ _ _ _ _ _ _ _ _

NHS England
Skipton House
80 London Road
London
SE1 6LH

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

Publication reference: PR1844

NHS Salisbury NHS Foundation Trust

Report to:	Trust Board (Public)	Agenda item:	7.1
Date of meeting:	6 July 2023		

Report tile:	Non-Executive Directors (NED) Review of Responsibilities including NED Champion Roles			
Status:	Information	Discussion	Assurance	Approval
		x		x
Approval Process: (where has this paper been reviewed and approved):	N/A			
Prepared by:	Fiona McNeight, Director of Integrated Governance			
Executive Sponsor: (presenting)	Fiona McNeight, Director of Integrated Governance			

Recommendation:

To note the changes of the NED responsibilities, particularly the change to the Chairs of the Board Committees.

To note the review of the NED Champion role and agree if the Trust is to adopt the two remaining recommended roles of Doctors Disciplinary and Security management NED Champion which are currently not covered. In addition, to consider any other NED Champion roles to be adopted.

Executive Summary:

With recent changes to the Non-Executive Director (NED) composition of the Board, the Chair has held objective setting meetings with each NED and is proposing a change to current responsibilities. The changes noted in Table 1 will take effect from 1st September 2023. There will be a change of the Chair for Clinical Governance Committee, People and Culture Committee, Charitable Funds Committee and Remuneration Committee. These changes are being made now in advance of the departure of two long standing NEDs in 2024.

From 1 September 2023, Eiri Jones will replace Tania Baker as Senior Independent Director.

As part of the review of the NED responsibilities it is timely to re-consider the NHS guidance of the “New Approach to Non-Executive Director Champion Roles” (Issued December 2021). The Trust has to date discharged the activities and responsibilities traditionally held by some NED Champion roles through its governance structure. This aligns to the current guidance although it is timely to review the current arrangements. The NHS guidance issued in December 2021 was a recommendation and not mandated. It is for individual Trusts to determine the approach.

The roles identified from the review which were historically undertaken by a NED Champion are all covered within the Trust committee governance structure.

3 of the 5 recommended NED Champion roles to be retained are currently covered; Maternity Board Safety Champion, Freedom to Speak Up and Equality, Diversity and Inclusion and Wellbeing Guardian. The two roles not covered are the Doctors Disciplinary NED and Security Management. Further consideration is required as to whether the Trust wishes to adopt the Doctors Disciplinary and Security Management NED Champion roles or any other roles.

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):Governance	x

NHS Salisbury NHS Foundation Trust

Non-Executive Director Responsibilities

Purpose

1.1 The purpose of the report is to set out the revised NED responsibilities to take effect from 1st September 2023 and to outline the NED Champion roles for consideration in line with latest guidance.

2 Background

2.1 With recent changes to the NED composition of the Board, the Chair has held objective setting meetings with each NED and is proposing a change to current responsibilities.

2.2 The Trust has historically had few NED Champion roles and as part of the review of the NED responsibilities it is timely to re-consider the NHS guidance of the "New Approach to Non-Executive Director Champion Roles" (Issued December 2021).

3 NED Responsibilities and Committee Membership

3.1 The current Board membership is set out in Table 1 below. Proposed changes from 1 September 2023 are noted in green.

Table 1

	Trust Board	Audit	Finance and Performance	Clinical Governance	People and Culture	Charitable Funds	Remcom
Ian Green	Chair					Chair	~~Chair~~ **Member**
Tania Baker	✓	✓			✓		✓
Michael von Bertele	✓	✓			**Member from 1st September**		✓
Richard Holmes	✓	Chair	✓				✓
Debbie Beaven	✓		Chair	✓		✓	~~✓~~
Eiri Jones	✓		~~✓~~	~~Chair~~ **Member**	**Chair**		~~✓~~
David Buckle	✓			~~Member~~ **Chair**		✓	~~✓~~
Rakhee Aggarwal	✓				✓		✓ **Chair**
Executive Director	All	Mark Ellis	Stacey Hunter Mark Ellis Lisa Thomas	Judy Dyos Peter Collins Lisa Thomas	Melanie Whitfield Peter Collins Judy Dyos	Mark Ellis	

3.2 **Senior Independent Director**

From 1 September 2023, Eiri Jones will replace Tania Baker as Senior Independent Director.

3.3 **NED Champion Roles**

The Trust has to date discharged the activities and responsibilities traditionally held by some NED Champion roles through its governance structure. This aligns to the current guidance although it is timely to review the current arrangements.

The NHS guidance issued in December 2021 was a recommendation and not mandated. It is for individual Trusts to determine the approach. Table 2 below sets out the NED champion roles within scope of the review and their status under the new approach.

Table 2

Roles to be retained				
Maternity Board Safety Champion	Wellbeing Guardian	Freedom To Speak Up	Doctors Disciplinary	Security Management
Roles to transition to new approach				
Hip fracture, falls and dementia	Learning from deaths	Safety and Risk	Palliative and end of life care	Health and safety
Children and Young People	Resuscitation	Cyber security	Emergency Preparedness	Safeguarding
Counter Fraud	Procurement	Security management, violence & aggression		

Table 3 outlines the current NED Champion roles and responsibility:

Table 3

Champion Role	Responsible NED
Maternity Board Safety Champion	Eiri Jones
Freedom to Speak Up	Michael von Bertele
Equality, Diversity & Inclusion and Wellbeing	Tania Baker

Table 4 outlines the matters listed in Table 3 that are overseen through Committee structures with NED membership.

Table 4

Topic	Committee with oversight
Hip fracture, falls and dementia	Clinical Governance
Children and Young People	Clinical Governance
Counter Fraud	Audit Committee
Learning from deaths	Clinical Governance
Resuscitation	Clinical Governance
Procurement	Finance and Performance
Safety and Risk	Clinical Governance
Cyber security	Finance and Performance
Security management- violence and aggression	People and Culture
Palliative and end of life care	Clinical Governance

Emergency Preparedness	Finance and Performance
Health and Safety	People and Culture
Safeguarding	Clinical Governance

The roles identified from the review which were historically undertaken by a NED Champion are all covered within the Trust committee governance structure.

The guidance sets out the roles which are statutory or that continue to require an individual to discharge those responsibilities or the review considered having an individual NED to be the most effective way of delivering the required changes. These are provided in Table 5 below with a brief description.

Table 5

Role	Legal Status	Description
Maternity Board Safety Champion *	Recommended	Applies to all Trusts providing maternity services. Role recommended in response to Morecombe Bay investigation (2015) and Ockenden Review (2020)
Wellbeing Guardian *	Recommended	Originated from the Health education England Pearson Report 2019 and adopted in policy through the 'We are the NHS People Plan for 2020/21 – action for us all'
Freedom To Speak Up *	Recommended	Role recommended in response to Robert Francis Freedom To Speak Up Report (2015)
Doctors Disciplinary NED Champion/independent member	Statutory	Under the 2003 'Maintaining High professional Standards in the Modern NHS- A framework for the initial handling of concerns about doctors and dentists in the NHS' there is a requirement for Chairs to designate a NED member as the 'designated member' to oversee each case to ensure momentum is maintained (does not have to be the same NED for each case). **The framework was issued to NHS FTs as advice only.**
Security Management	Statutory	Under the 'Directions to NHS Bodies on Security Management Measures 2004 there is a statutory requirement to have a designated NED or non-officer member to promote security management work at Board level (includes counter fraud, violence and aggression, security of assets and estates). Relevant committees can oversee specific functions – referenced in Table 4

*Role currently covered

Further consideration is required as to whether the Trust wishes to adopt the Doctors Disciplinary and Security Management NED Champion roles or any other roles.

4 Summary

4.1 The responsibilities of the Non-Executive Directors have been reviewed. There are changes to the Chairs and attendance of Board Committees.

4.2 The Trust currently has 3 of the 5 recommended NED Champion roles and this requires further consideration. Further consideration as to any additional champion roles is also required.

4.3 There is oversight of all topics previously covered by NED Champion roles in the NHS through the existing governance structure.

5 Recommendations

5.1 To note the changes of the NED responsibilities, particularly the change to the Chairs of the Board Committees.

To note the review of the NED Champion role and agree if the Trust is to adopt the two remaining recommended roles of Doctors Disciplinary and Security management NED Champion which are currently not covered. In addition, to consider any other NED Champion roles to be adopted.

Fiona McNeight
Director of Integrated Governance